Children and Young People's Joint Strategic Needs Assessment

(2017-2018 Update)

Newham London

NHS
Newham
Clinical Commissioning Group

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1.0 Changes Included in 2017-2018 Update

This 2018 Children and Young People (CYP) Joint Strategic Needs Assessment (JSNA) is an update on the 2016 CYP JSNA release. The indicators included in this document have been updated with information available up until March 16th, 2018.

2.0 Foreword

Newham is a borough of opportunities and untapped potential. Our objective is to work towards making it a place where young people choose to live, work and reside long term; where the health of all our young people will be comparable to the London average, and the quality of health services on offer will be as high as anywhere in the country.

The JSNA is a comprehensive document which describes the current health and wellbeing needs of Newham's residents; we focus on children and young people in this JSNA. It serves to inform the Council, NHS Newham CCG and other important stakeholders of the services which Newham should commission to make progress and move closer to our objective; to have a better Newham for all our children and young people.

We understand that the provision of services alone may not be sufficient action to guarantee good health and wellbeing, as there are social factors which interplay and can often negate the positive outcomes associated with high quality services. It is therefore imperative that we continue to deal with the social problems which contribute to poor health. Tackling all the determinants of health to provide high quality health services for our children and young people will require cooperation and partnership between several bodies, including NHS Newham CCG, the London Borough of Newham (LBN), private companies and voluntary organisations.

Poverty and inequality are key social determinants of health, which we are tackling by getting people to work, raising their incomes and aspirations, increasing housing opportunities, and ensuring that they have a stake in living in and contributing to the growth of Newham. Increasing the number of people in good employment is the most significant and sustainable change we can make in improving the health and wellbeing of people in Newham. We also want to encourage and support people to lead independent lives, improve their lifestyles and to be confident and able to participate in community life.

We look forward to building on previous achievements including the successful 2012 Olympic and Paralympic Games hosted in Newham. Recent key achievements include:

- More of our young people are in education or employment giving them choices in life (4.6% to 3.7% 16-18-year olds who are NEET).
- Educational achievements in our schools are better than London and improving (48.2% to 57.7% pupils achieving 5 A*-C GCSEs).

Although much has been achieved, there is still more progress to make and ground to cover, and we relish the opportunity to continue to make Newham a safe and healthy haven for all its residents, irrespective of background. Suggested priorities beyond 2016 are:

- Neighbourhoods, schools and families supporting healthy weight and mental well-being in addition to protection from common threats and diseases;
- Continue to work with communities and healthcare providers to ensure childhood immunisations and breastfeeding rates keep rising, and that the proportion of low birth weight babies reduces;
- Helping young offenders to be reintegrated into the community and become financially active members of Newham's community.

3.0 Acknowledgements

Many thanks to all who contributed to the production of this Joint Strategic Needs Assessment and the 2017-2018 update, with special thanks to:

The JSNA Steering Group:

London Borough of Newham (LBN);

Meradin Peachey, Director of Public Health; Rutuja Kulkarni-Johnston, Public Health Consultant; Lynne Kitson, Senior Public Health Analyst; Dr Logan Manikam, Children's Public Health Lead; Saiyeshen Naidoo, Public Health Analyst; James Thomas, Director of Children's Services and Community Neighbourhoods, Jane Senior, Head of Commissioning, Children's and Safeguarding; Susannah Beasley-Murray, Head of Child Protection; Claire Bridge, Early Help and Support Co-ordinator; Alison Matthews, Strategic Lead for Data & Impact; James Hourigan, Head of Commissioning Inclusion; Simon Reid, Adults Strategic Commissioning; Antony Bateman, Commissioning Impact; Russell Moffatt, Private Housing Operations Manager; Foizul Islam, Adults Strategic Commissioning; Rachel McNickle, Children's Health Commissioner; Sayha Sam, Commissioning Analyst; Jacquie Burke, Deputy Director, Children's Social Care; Tony Jobling, Learning Disability Strategic Advisor; Simon Munk, CYP Resilience Strategic Lead; Jane Kennedy, Strategic Policy & Research; Maura Cardy, Safeguarding Services; Andy Liggins, Public Health Consultant; Rebecca Harpley, Senior Research Officer; Janaki Mahadevan, Corporate Policy Manager; Michael Jones, Adults Commissioning; Leah Pratten, Senior Environmental Health Officer

2017-2018 Update with thanks to:

Andrew Blow, SEN Manager; Philip Williams, Head of Commissioning Children and Young People's Services; Derek Norton, Best for All Project Manager; Mohammed Rahman, SEN Strategic Data & Systems Lead; Beverley Latania, Mental Health, Strategic Commissioning and Community Adult Social Care; and the SEND Implementation Steering Group Team.

Newham Clinical Commissioning Group (CCG)

Satbinder Sanghera, Director of Partnerships and Governance; Lizi Goodyear, Clinical Lead for Young People; John Dunning, CYP Commissioning Lead; Alison Buchanan, Children's Commissioner; Kelly Simmons, Maternity Commissioner; Victoria Hill, Domestic and Sexual Violence Commissioner and Shola Yemi, Designated Nurse for Looked After Children.

2017-2018 Update with thanks to:

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Compiled and written by:

Dr Logan Manikam, Lynne Kitson, Rutuja Kulkarni-Johnston, Saiyeshen Naidoo, Dyfed Thomas, Kerrie Soares, Tracy Akposheri.

2017-2018 Update with thanks to:

Public Health Strategists Meghan A Cupp, Roeann Osman, Dr Jessica T Owugha and Alexandra Williams assisted in this 2017-2018 release by updating the 2016 JSNA release with data from publicly available sources and adding new indicators as appropriate. They were supervised by Dr Manikam. These updates are detailed in Section 13.0 Changes Since Last JSNA.

Additionally, involved in the production of the JSNA was a 2014-2016 CYP JSNA Reference Group with input from each of the members informing this JSNA. Quality Assurance was provided by the Public

Health Senior Management Team – Andrew Rixom, Andy Liggins, Heema Shukla and Meradin Peachey.

4.0 Executive Summary

Introduction

This is an update on the fourth Joint Strategic Needs Assessment (JSNA) produced by NHS Newham and the London Borough of Newham, since the Local Government and Public Involvement in Health Act (2007) and the first since the Health and Social Care Act 2012. This amended Act places an equal duty on NHS Newham CCG, LBN and the Health and Wellbeing Board to identify the health and wellbeing needs of the children and young people of Newham. The aim of this JSNA is to bring together key data and information in a way which is accessible to local commissioners, local communities and other stakeholders. The knowledge this yields underpins the evidence-based strategic plans that NHS Newham CCG and the London Borough of Newham are required to produce.

This document should also be used to:

- Identify possible health and wellbeing outcomes;
- Project and predict health and well-being needs of the future local population;
- Monitor the success of services commissioned;
- Make priority-setting processes easier to understand and identify.

This JSNA covers a wide range of issues and is a high-level needs assessment for children and young people in the borough. Although primarily concerned with health and wellbeing outcomes, this document also includes evidence on the wider determinants of health, neighbourhoods, social capital, crime, work, regeneration and deprivation. This 2017-2018 update refreshes and brings up to date the content of the 2015-2016 JSNA and reflects these wider determinants of health in identified priorities for improving the health and wellbeing of the borough.

Over 85,000 children and young people live in Newham. We are committed to ensuring each one of them grows up happy, healthy, and with an excellent education which prepares them for the next stage in their lives. As Ali Mohamed, Young Mayor of Newham said: *“children and young people are at the heart of a shared vision to make Newham a place where people choose to live, work and stay”*.

Key Indicators

Significant improvements in the health and wellbeing of Newham’s population have happened since the 2012 JSNA. The data available at the time of production of this JSNA update reflects the commitment and action that agencies in Newham have made to improve health and reduce health inequalities.

Whilst improvements can be seen, there is still considerable work to do. By working together to tackle a range of contributory factors to poor health and wellbeing, including improving services, as well as the factors that impact on people’s health and wellbeing, we will continue to see improvement in the areas that are progressing and start to see improvement where currently we are not.

Key Newham CYP Health and Wellbeing Indicators 2010-2017

Indicator	JSNA 2010	JSNA 2011/12	JSNA 2015/2016	JSNA 2017/2018	Direction of Travel
Maternal Health					
Smoking at time of delivery	4.5%	-	5%	5.2%	Worsening
Infant mortality (per 1000 live births)	5	-	3.6	3.3	Improving
Early Years					
Child mortality (per 1000)	13	-	13.9	16.1	Worsening
Low birth weight term babies (% of all live full term births)	4.5	-	4.4	4.4	Static
Breastfeeding initiation rates (%)	86%	-	90.3%	90.3%	Static
Average percentage of babies screened within 4	87%	-	98%	98.5	Improving
Uptake of the DTaP/IPV/HiB at one year	89%	-	91%	87.8%	Worsening
MMR (one dose) at two years	88	-	89.1%	88.8%	Worsening
MMR (second dose) at five years	80%	-	**80.7**	**77.3**	Worsening
Families					
Number of homeless families with dependent children	-	1050	700	**1091**	Worsening
Number of homeless families with pregnant women		85	45	**48**	Worsening
Percentage of children living in poverty	38.2%	-	24.6%	28.8%	Worsening
Hospital admissions for accidental and deliberate injuries to 0-4 year-olds (per 10, 000)	100	-	81.3	75.3	Improving
Hospital admissions for unintentional and deliberate injuries to children under 14 (per 10,000)	80	-	73.3	65.8	Improving
School Age Children					
Year 6 obesity (%)	24.6	24.7	27.4	27.5	Worsening
5 good passes at GCSE (5 A*-C) (%)	47	-	59.4	**57.6**	Worsening
Adolescents					
16-18 year olds who are NEET (%)	4.6	-	3.7	3.7	Static
STI testing rate (per 100,000)	22,000	-	26,000	25,400	Worsening
STI positivity (%)	6.1	-	5.4	1.94	Improving
Teenage pregnancy rate (per 1,000)	33.6	-	22.5	22.5	Static
Hospital admissions due to substance misuse (per 100,000)	55	-	63.2	66.3	Worsening
Special Groups					
Children in care identified as having a substance misuse problem (%)	8		3.7	4.2	Worsening
Children in care receiving immunisations (%)	79		78	93.6	Improving
Emergency hospital admissions for asthma (per 100,000)	225	-	260.6	234.2	Improving
Emergency hospital admissions for epilepsy (per 100,000)	80	-	73.9	-	-
First time entrants into the justice system (per 100,000)	2,300	-	444	444	Static
Young offenders who reoffended (%)	-	38%	43%	40.8%	Improving
Children in need with 5 A*-C GCSE's inc Maths and English (%)	-	30%	24.8%	24.8%	Static

DATA CHANGES IN THIS JSNA UPDATE

Information for each indicator included in this document has been updated from the 2016 release where available. Some notable indicators what were not available for update come from the 2014 PHE What About YOUth (WAY) survey from the National Child and Maternal Intelligence Network. This survey collected data about health and risk behaviours in young people and has not been updated since 2014 (*Figures 65, 66, 74, 96-104, 126*). We were also missing an update on the regional coverage for sreening of Hepatitis B and Syphilis, as these indicators have been discontinued (*Figures 13-14*). Percentage of Breastfeeding initation in Newham has not been updated since 2015 (*Figure 29*).

Domestic violence, sexual exploitation, and protection order indicators for Newham have not been updated since 2016 (*Figure 59, Tables 16, 17, 19*).

Data on A&E attendances and rates of STIs have not been updateed since 2015 (*Figures 78-85*). Data on the prevalence of asthma and diabetes has not been updated as these indicators are based on 2015 data from GPs (*Figures 127-128, 131-133*). Indicators based on census data have not been updated since the last census in 2011 (*Figure 47*). A new section on SEN is included in Section 11.0 Special Groups and 17 new figures have been included in this update (*Figures 144-160, Tables 24-30*).

Updates to the data included in the figures and tables iin this document are indicated in Section 13.0 Changes Since the Last JSNA.

KEY PRIORITIES

A potential method for identifying priorities that matter include identifying those that either; affect 1 in 10 or a large number of individuals in the population, addresses a specific health inequality, trends in the wrong direction, benchmarks poorly against statistical neighbours, or can be prevented or improved.

The priorities suggested below have been identified due to their impact on one or more of above on the health and wellbeing on the children and young people of Newham.

Early Years

- Continue to work with communities, Maternity Mates and healthcare providers to ensure childhood immunisations and breastfeeding rates keep rising, and that the proportion of low birth weight babies reduces.

Families

- Decrease the rate of unemployment in the borough, raise aspirations and incomes and break the cycle of deprivation to bring children out of poverty.
- Hospital admission rates for accidents and unintentional injuries are improving, but we need to continue to work with parents, community services, and hospitals to ensure these rates continue to decline.

School Age Children

- Children spend a good proportion of time in school. Educational attainment alongside healthy diet, physical activity, mental health, well-being and good physical health of children should be a priority for schools and families in Newham.
- Childhood obesity is a priority for Newham with a child obesity research proposal, action plan and a whole system child obesity physical activity plan in development.
- The mental health of children and young people in school is important. By developing resilience early in childhood, we prepare young people in Newham with the skills to cope with life. Future needs assessments with a focus on mental health and well-being across all age groups together with CAMHS data and metrics (i.e. waiting times to see a CAMHS specialist) will be needed to inform progress against improving mental health and well-being of school age children in Newham.

Adolescents

- By building resilience and aspirations during the early and school years, adolescents in Newham will feel able and better prepared to take on challenges. However, work needs to continue to provide a supportive environment to those who are unable to face challenges alone, whether those challenges are unemployment, sexual health, mental health, accident and injury, substance misuse or teenage conception.

- By monitoring the proportion of young people with a diagnosable mental health disorder who are seen by mental health practitioners, or an in depth look at substance misuse in young people in future JSNAs, the success of interventions can be assessed.
- By having robust polices between children, adult and health services, to ensure thatindividuals who access and trasnsition between these domains are not lost in the system.

Special Groups

- The rate of children with long-term conditions being admitted to hospital as an emergency has worsened since previous JSNAs. More work needs to be done with community services, primary and secondary care and families to make sure clear, easy to follow, and understandable care plans are in place, and care is taking place at the right time, by the right person, close to home.
- Work with young offenders has successfully reduced the number of first time entrants, but now needs to shift some of its focus on preventing reoffending.
- Children in need and those with special educational needs continue to do worse in their GCSEs. Schools need to work together with this group of children, their parents and carers, to make sure they are being offered the support they need at the right time to do well[1].
- The health and well-being of children looked after by the borough of Newham should act as a gold standard that all children living in Newham should aim to achieve. A more in depth look at the health and well-being of Looked After Children in Newham through a JSNA would provide vital information in identifying areas of improvement in their health and social care.
- A new assessment of Special Educational Needs and Disabilities (SEND) therapies services has been added in this 2017-2018 update.

5.0 DEMOGRAPHY

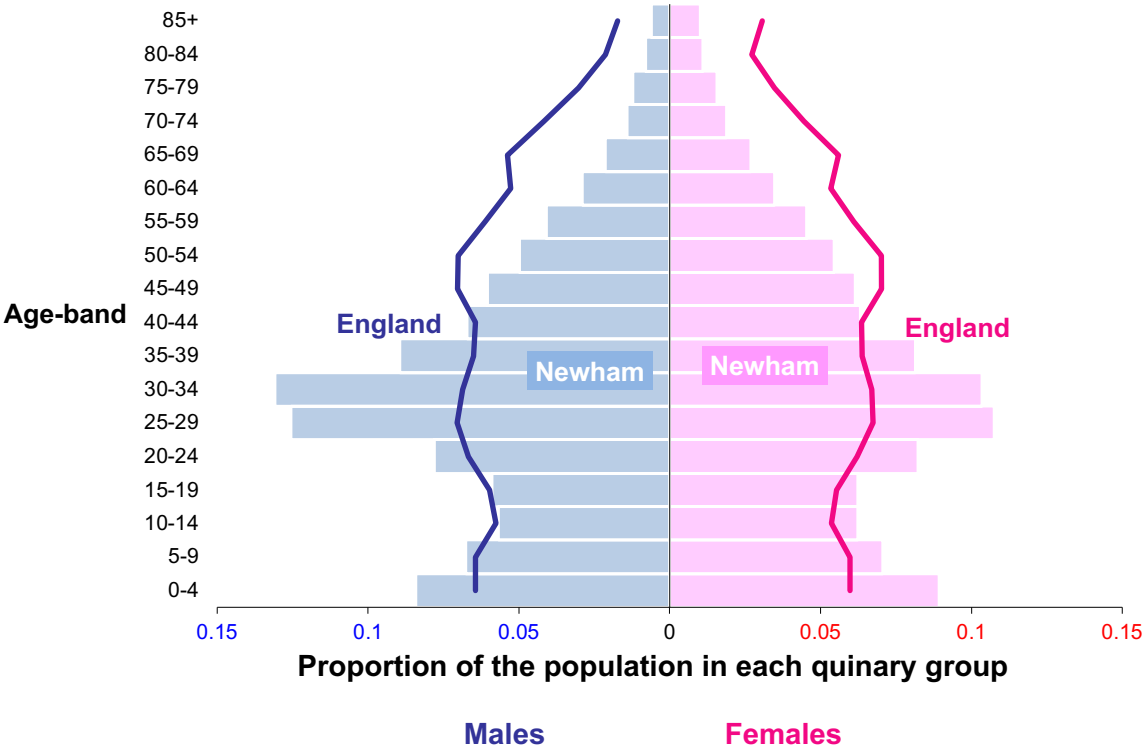
NEWHAM'S DEMOGRAPHIC PROFILE

Population

Newham is a fantastically diverse and population-dense borough in London. In 2010, Newham's population was estimated to be 270,000 and is projected to rise to 375,500 by 2031 (an increase of 39%). Most of its residents are from the Black and minority ethnic groups (BME) and under 45 years of age. Moreover, although the borough has maintained a high birth rate, it is ageing in line within national trends.

FIGURE 1 - POPULATION PYRAMID FOR NEWHAM COMPARED WITH ENGLAND (2016)

Source: ONS MYE



The age structure of Newham and England by sex in 2016 is denoted in *Figure 1*. For both sex groups, each proportion is expressed as a fraction of 1. The most obvious differences are in the 25-29 and 30-34 age groups for both sexes with the Newham male population having a 1.8 and 2.7 percent higher proportion; and Newham female population having a 4.1 population estimates, Newham's total dependency ratio is calculated at 40.27, considerably lower compared to the England value of 57.0 (In the presence of a warning triangle, please refer to the relevant subheading in Section 11.0 Methodology and Evidence).

Life Expectancy

The average life expectancy at birth for Newham, London and England for both sexes, in two year rolling averages from 2010 to 2015 is presented in *Figures 2* and *3*.

FIGURE 2 - MALE LIFE EXPECTANCY AT BIRTH, NEWHAM (95% CONFIDENCE INTERVALS) LONDON, ENGLAND 2010-2015

Source: PHE fingertips indicator 90366

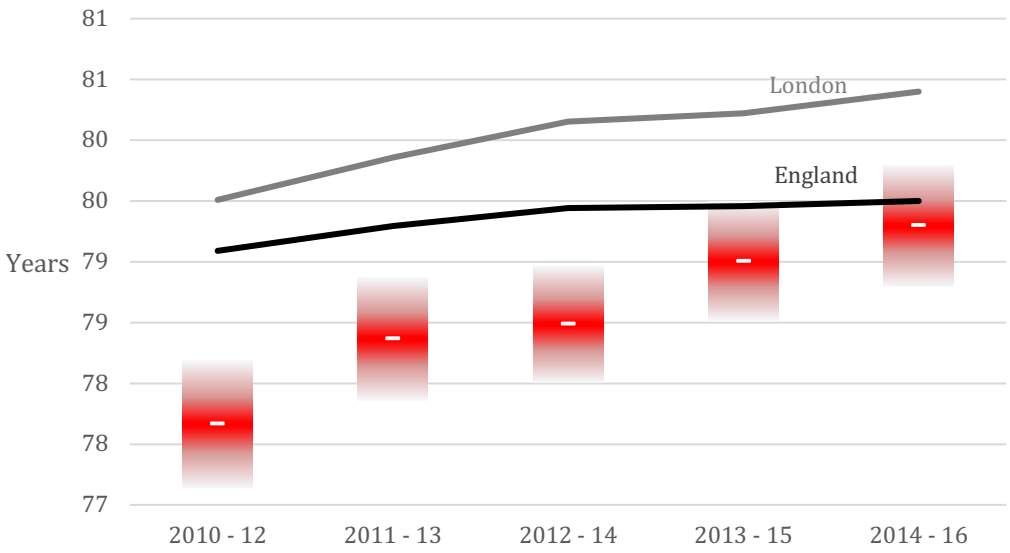
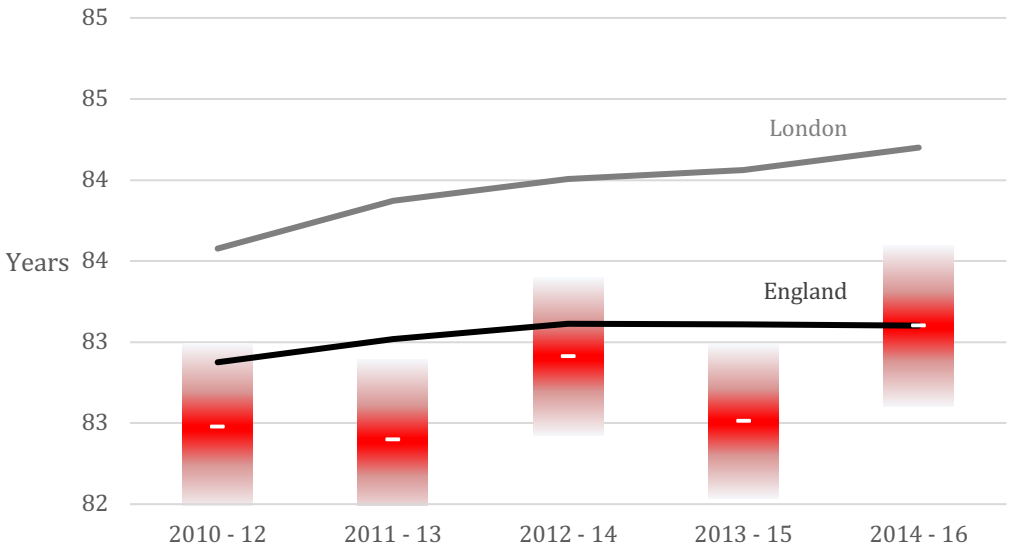


Figure 2 shows that the average life expectancy at birth for males in Newham has increased from 77.7 in 2010 – 2012 to 79.3 in 2014 – 2016. Although values remain significantly lower compared to London and England, the difference in male life expectancy between Newham and London has narrowed from 2 years between 2010 – 2012 to 1.1 years between 2014 – 2016. Similarly, when compared to England, the gap in life expectancy narrowed from 1.5 years between 2010–2012 to 0.2 years in 2014-2016.

FIGURE 3 - FEMALE LIFE EXPECTANCY AT BIRTH, NEWHAM (95% CONFIDENCE INTERVALS) LONDON, ENGLAND 2010-2015

Source: PHE fingertips indicator 90366



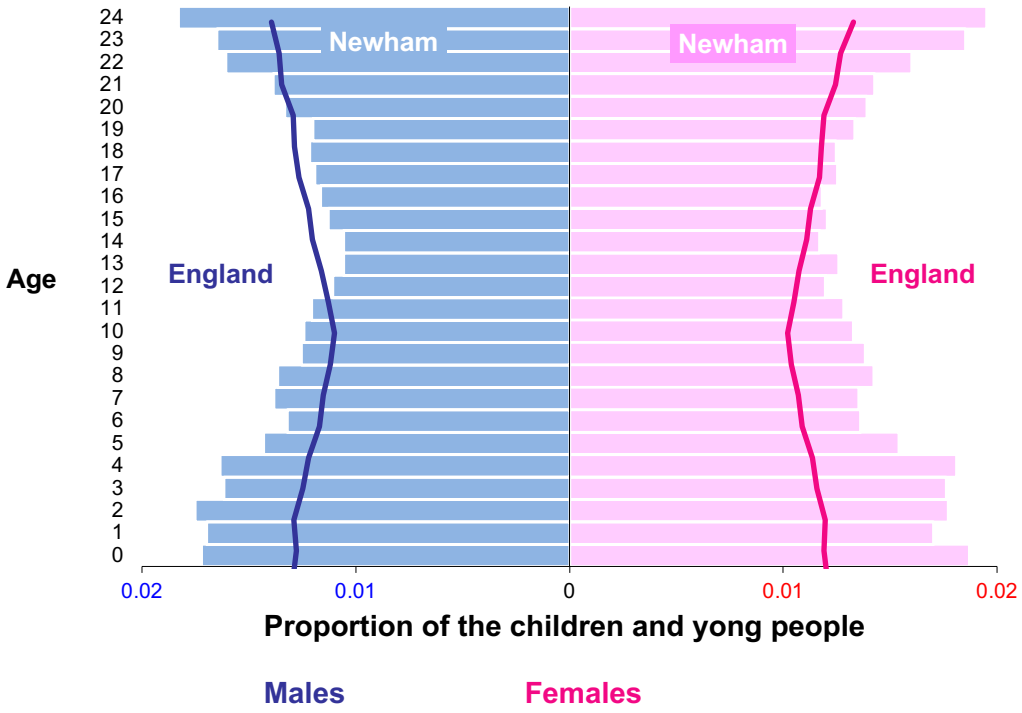
In contrast, *Figure 3* shows that the average life expectancy at birth for females in Newham fell between 2012-2014 and 2013-2015 but has increased in 2014-2016. In 2012-2014, it was similar to the England average with no significant differences between 2010-2015, but in 2013-2015 it is significantly lower than the England rate. There was no significant difference between the life expectancy of women in Newham and England between 2014-2016. Newham's values are significantly lower compared to London across the same period. The difference between Newham and England widened from 0.4 years in 2010-2012 to 0.6 years in 2013-2015, however between 2014-2016 there was no difference between the life expectancies. Whereas, the difference between Newham's and London's values widened from 1.1 years in 2010-2012 to 1.5 years in 2013-2015, and then reduced to 1.1 years in 2014-2016[2].

NEWHAM'S FAMILIES AND CYP DEMOGRAPHIC PROFILE

Population

FIGURE 4 - POPULATION PYRAMID FOR CHILDREN AND YOUNG PEOPLE AGED 25 YEARS AND UNDER IN NEWHAM AND ENGLAND

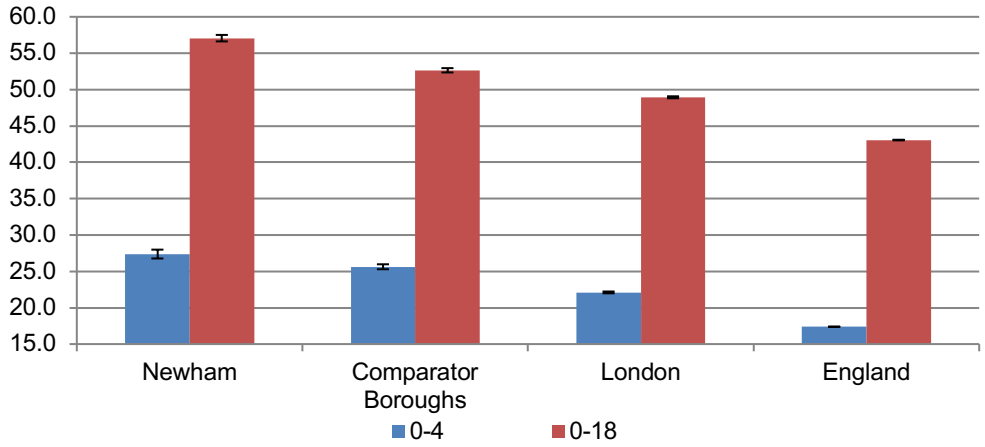
Source: ONS MYE 2016



The age structure of the children and young people (CYP) in Newham and England by sex in 2016 is denoted in *Figure 4*. For both sex groups, each proportion is expressed as a fraction of 1. Compared to England, Newham has a much higher proportion of CYP aged 0-11 and 20-24 for both sexes. Females aged 0-24 have a much higher proportion of CYP in Newham when compared to England. When comparing to CYP females in England, the proportion of females in Newham from ages 19 to 24 and 0 to 13 are greater. The proportion of CYP males in Newham aged 0 to 12 and 22 to 24, are larger than those in England. Furthermore, there is an overall higher proportion of females of CYP in Newham. This is not surprising given that the Office for National Statistics (ONS) live birth figures by area of usual residence estimate the crude live birth rate (per 1,000) for Newham at 18.7 in 2015, which is significantly higher than both London (14.9) and England (12.1) rates[3].

FIGURE 5 - PERCENTAGE OF HOUSEHOLDS WITH DEPENDENT CHILDREN AGED 0-4 AND 0-18 (2011)

Source: ONS, Census 2011

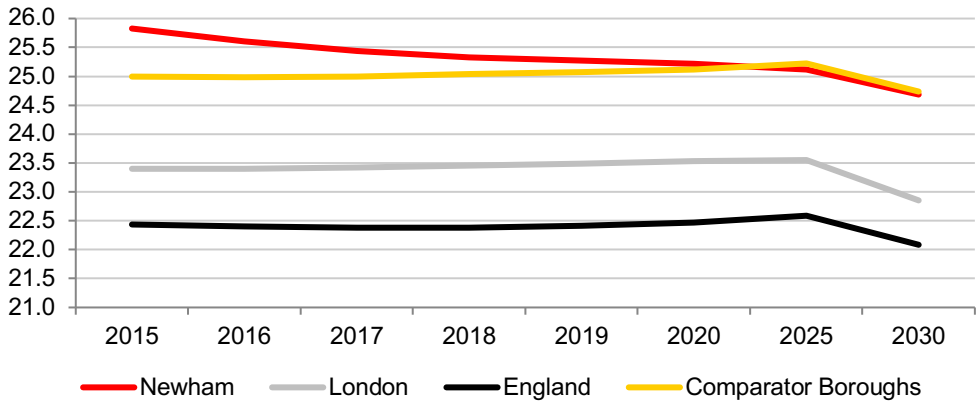


The proportion of households with dependent children in Newham, London, England and comparator boroughs (Barking & Dagenham, Brent, City & Hackney, Tower Hamlets and Waltham Forest) in the 2011 census is denoted in *Figure 5*[4] with Newham having the highest proportion of households with dependent children aged 0-4 (27.4%) compared to comparator boroughs (25.6%), London (22.1%) and England (17.4%). A similar pattern was observed in the proportion of households with dependent children aged 0-18 in Newham (57.1%) compared to London (48.9%) and England (43.1%)[4].

Projected Population

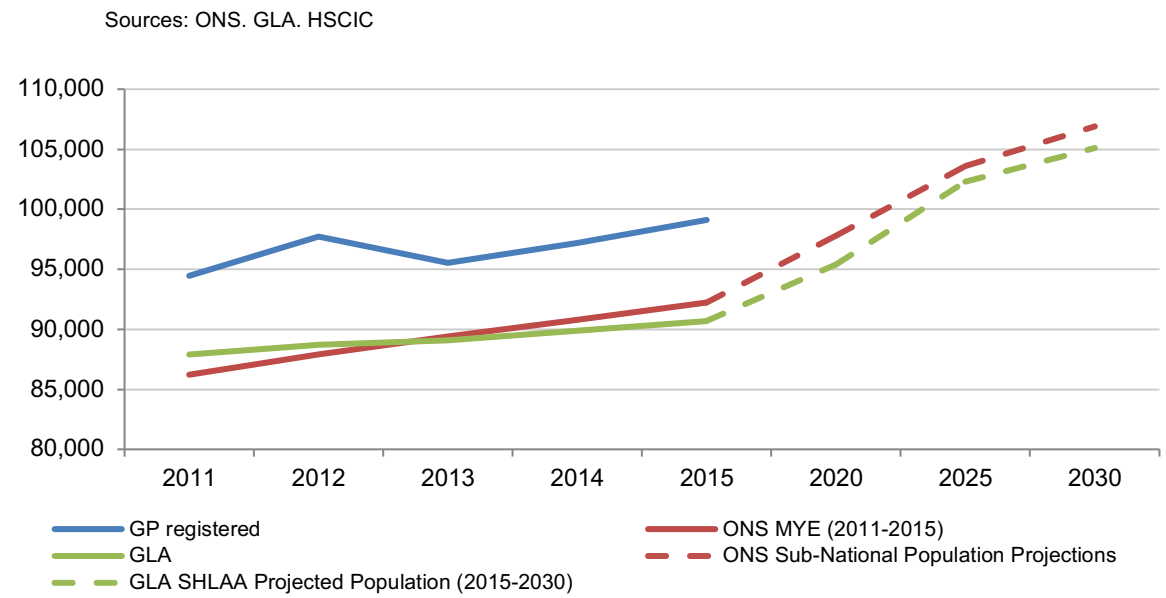
FIGURE 6 - PERCENTAGE OF THE POPULATION AGED 0-18 BETWEEN 2015 TO 2030

Source: ONS MYE and Sub-national projections



The proportion of the projected CYP population in Newham, London, England and comparator boroughs from 2015 to 2030 is denoted in *Figure 6*. A year on year decrease of 0.6% is estimated between 2015 to 2020 with minimal changes observed between 2020 to 2025 and more marked decrease from 2025 to 2030[5]. Despite this, Newham will consistently have a larger proportion of CYP compared to London and England.

FIGURE 7 - GROWTH IN THE 0-19 NEWHAM RESIDENT AND NHS GP REGISTERED POPULATIONS



In contrast, *Figure 7* denotes the growth in the number of Newham's under-18-year-old residents and GP registered populations which confirms that despite the falling proportion, the numbers of CYP in Newham will continue to increase into 2030[5].

Ethnicity

Newham is an ethnically diverse borough. *Table 1* below, shows ethnicity of the borough population aged under 18 years, compared with London and comparator boroughs, estimated for Mid 2016. These estimates were produced by the GLA, using their Amalgamated Ethnic Group categorization, where all White ethnic groups are combined, mixed White and Black are included in Black Other, and mixed White and Asian are included in Other Asian.

TABLE 1 - DIFFERENT ETHNIC GROUPS AND THEIR PERCENTAGES OF CYP AGED UNDER 18 YEARS IN NEWHAM, LONDON AND COMPARATOR BOROUGHS

Ethnic Group	Newham		London (%)	Comparator boroughs (%)
	number	(%)		
White	14,400	17.5	44.5	32.4
Black Caribbean	2,600	3.1	3.5	4.1
Black African	11,800	14.4	10.7	13.0
Black Other	7,400	8.9	9.3	9.5
Indian	8,500	10.3	5.7	5.3
Pakistani	9,900	12.0	4.1	5.9
Bangladeshi	14,200	17.2	4.6	13.0
Chinese	500	0.6	0.9	0.8
Other Asian	7,300	8.8	8.8	7.4
Other	5,900	7.1	7.9	8.7
All Ethnicities	82,500	100	100	100

The highest proportion of Newham's population is White (17.5%), followed by Bangladeshi (17.2%)[5]. Black African, Black Caribbean and Black Other make up one quarter of the population (26.4%), similar

to the comparator boroughs and London overall. Combined South Asian groups make up 40% of the population, which is much higher than the comparator boroughs (26%) and London overall (14%). Newham has a much lower proportion of those of White ethnicity compared with its comparator boroughs (32.4%) and London (44.5%).

Table 2 and *3* represent the proportions of ethnic groups in primary and secondary schools which reflect the general population in Newham. There is a high proportion of Asian and Black ethnicities with smaller White proportions, when compared with London and England.

TABLE 2 - THE PROPORTIONS OF ETHNIC GROUPS IN PRIMARY (STATE) SCHOOLS IN NEWHAM, ENGLAND, LONDON AND COMPARATOR BOROUGHS

Proportion of primary (state) school children recorded in each ethnic group[6]

Locality	White	Mixed	Asian	Black	Chinese / Other
England	75.5	5.8	10.7	5.7	2.3
Newham	18.4	6.2	45.8	23.5	6.1
London	42.2	10.4	20.4	20.6	6.4
Comparator Boroughs	31.0	8.8	30.7	23.8	5.7

TABLE 3 - THE PROPORTION OF ETHNIC GROUPS IN SECONDARY (STATE) SCHOOLS IN NEWHAM, ENGLAND, LONDON AND COMPARATOR BOROUGHS

Proportion of secondary (state) school children recorded in each ethnic group[6]

Locality	White	Mixed	Asian	Black	Chinese / Other
England	77.3	4.7	10.5	5.5	2.0
Newham	17.1	6.3	45.5	25.5	5.7
London	41.1	9.1	21.4	21.8	6.6
Comparator Boroughs	28.6	7.1	34.5	24.4	5.4

NEWHAM'S CYP SOCIO-ECONOMIC PROFILE

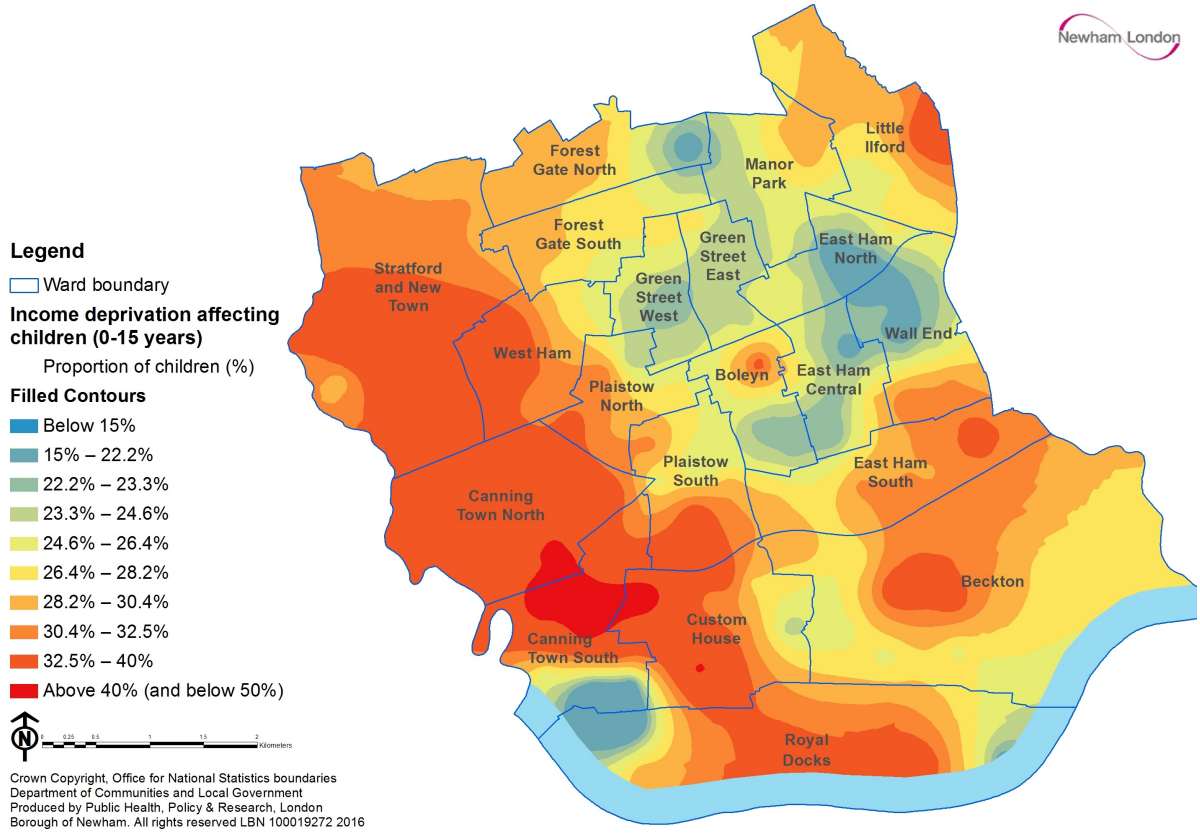
Newham has several local success stories across the child health life course. There are still inequalities within Newham which need to be addressed. Primarily, deprivation in Newham remains high (23rd most deprived out of 326 local authorities) and over a quarter of children under 16 years live in poverty.

The Income Deprivation Affecting Children Index (IDACI) is a measure of children aged 0-15 who live in households which experience income deprivation. IDACI scores from 2010 put the proportion of children in Newham living in income deprived households at 47.76%; much higher compared to the London average of 31.39%. More recent IDACI figures from 2015 are more encouraging, with 28.8% of children in Newham living in income deprived households; however, this proportion remains higher compared to the London average of 24.1%.

The IDACI heat map below denotes three main trends with high deprivation in the West of the Borough, low deprivation in the Northeast quadrant and a more mixed picture in the Southeast. The high deprivation areas center on Canning Town and extend up to Stratford, with the proportion of children experiencing income deprivation ranging from 30% to 50%.

Areas in East Ham/Wall End, Green Street West, and Forest Gate North show under 15% of children experiencing income deprivation. In the Southeast, high deprivation (above 30%) is seen in Beckton and in the East of the East Ham South ward. These areas are surrounded by lower prevalence of income deprivation; however, parts here contain large expanses of non-residential land use.

FIGURE 8 - HEAT MAP OF NEWHAM USING THE INCOME DEPRIVATION AFFECTING CHILDREN INDEX



6.0 MATERNAL HEALTH

INTRODUCTION

Experience before birth and in early life has a crucial impact on the life chances of each individual, not just through their childhood but also during their adult life. Healthy children start with healthy parents, so we have looked back to before birth to include the experiences of mothers, as well as reaching forward across the transition into adult life.

What are the issues in Newham?

In Newham, 28.9% of women are delivering their babies via caesarean section (C/S). This is higher than the target of 25% set nationally. Consequently, not enough women are delivering their babies naturally by vaginal birth (59.5%). The percentage of babies delivered before term (37 weeks' gestation) is 8.9% in Newham University Hospital (NUH), below the national target of <12%. There are a small proportion of women who are still smoking (5.2%) and drinking alcohol (1.4%) throughout their pregnancies. These proportions are in line with London levels; lower than England; although exceed the recommended rates for both during pregnancy, which is 0%.

What are the inequalities?

Health Inequalities are defined as differences in health between different population groups. These groups may include those of different sexes, ethnicity, socio-economic status, or locality. In maternal smoking, it has been noted that the highest rates of smoking were found in White British and Eastern Europeans with the lowest rates amongst Pakistani and Bangladeshi women. There is currently little additional data at borough level to aid us in identifying any specific inequalities between groups, although we know from anecdotal evidence that they exist.

What are we doing well?

Nearly 90% of women are breastfeeding their babies in the first 48 hours after birth, with further information available on the chapter "Breastfeeding". Antenatal screening for HIV, Sickle Cell and Thalassemia at Newham University Hospital have been considerably higher than other NHS Trusts over the past four years. LBN provides the Family Nurse Partnership (FNP) to children born to Newham teenage mothers; with Newham CCG running the Maternity Mates scheme, which provides support to anxious first time mothers and those who lack a support network, aiming for them to have a positive involvement during pregnancy and while caring for their new baby[6]. FNP are working with nearly 100 young mothers (aged under 19 years old) during pregnancy, birth and toddlerhood, to break the cycle of deprivation and help the mother and child reach their full potential.

What needs improving?

C/S rates need reducing via collaboration with obstetric hospital departments and educating women on the risks associated with them. Increasing the number of women who have an early antenatal booking (ideally before 10 weeks and 6 days' gestation) will help reduce pregnancy related complications during birth and improve normal vaginal deliveries. Further work is necessary to reduce the numbers of women smoking and drinking alcohol during pregnancy to 0%.

WHAT IS A HEALTHY PREGNANCY?

Introduction

Guaranteeing a healthy pregnancy and a child's best start in life begins before conception. Several modifiable risk factors, such as smoking, drinking, diet and physical activity can affect the pregnancy and may lead to pre-term (less than 37 weeks) delivery, low birth weight, stillbirth, and pregnancy complications. If a pregnant woman maintains a healthy weight, takes dietary supplements, doesn't smoke or drink and seeks support from a healthcare provider, they will reduce any risks during pregnancy and birth. These steps towards a healthy pregnancy will importantly offer improvements for mother and child later in life, for example obesity, mental wellbeing and heart disease. Early identification of pregnancy and booking (ideally before 10 weeks 6 days' gestation) will provide women with support for their emotional and physical wellbeing throughout the pregnancy.

Policies and Drivers

NHS England has published a resource pack containing a framework to support CCGs regarding the commissioning of maternity services. The framework focuses on obstetric and midwifery care across the antenatal, intrapartum and immediate postnatal periods and encourages CCGs to think in a holistic way about women's health, maternity services and early years. Emphasis is laid on pre-conceptual care, perinatal mental health, the rising birth rate, the complexity and acuity of pregnancy and integration with the early years' agenda[7].

The *National Maternity Review Report: Better Births* is a review which focuses on improving outcomes of maternity services in England. It sets out wide-ranging proposals to not only make care safer, but to empower women and give them more control over the decisions that involve them. Their vision is to ensure that women can access support which is centred around their individual needs and circumstances, delivered by teams which are well led and in cultures which promote innovation and continuous learning[8].

C/S rates in England continue to rise. More than 1 in 4 (26.2%) of women will have a caesarean rather than a vaginal delivery with C-Sections categorised as elective (planned) or emergency[9]. The National Institute for Health and Clinical Excellence (NICE) guidance (*Caesarean section*, *CG132)* is clear on when women should be offered a C/S, with the aim of trying to halt the increasing rate, as women who have a C/S will often spend longer in hospital, start breastfeeding later and may suffer post-surgical complications.

What's happening in Newham?

Healthy pregnancies and healthy births lead to the best start for children. The table below is taken from the Newham University Hospital (NUH) maternity dashboard in 2015-2016. Data are collected from maternity services and are rated red, amber or green based on performance against nationally set targets.

During 2015-2016 there were nearly 6,500 babies born in NUH. The percentage of babies delivered pre-term is 8.9% in NUH, which is below the target of less than 12%. Just over a half of all women have a normal vaginal delivery. This proportion is rated amber, which means it is higher than the lowest set target, but lower than the highest target.

More than 1 in 4 (28.9%) women are delivering their babies via caesarean section, which is rated red and above the target of 25%. When broken down by emergency and planned caesareans, only 8.4% of women had a planned caesarean (target = <10%) and 20.5% had an emergency caesarean (target = < 15%).

Smoking and alcohol at delivery are explored in more detail in the chapter "Smoking and Alcohol in Pregnancy".

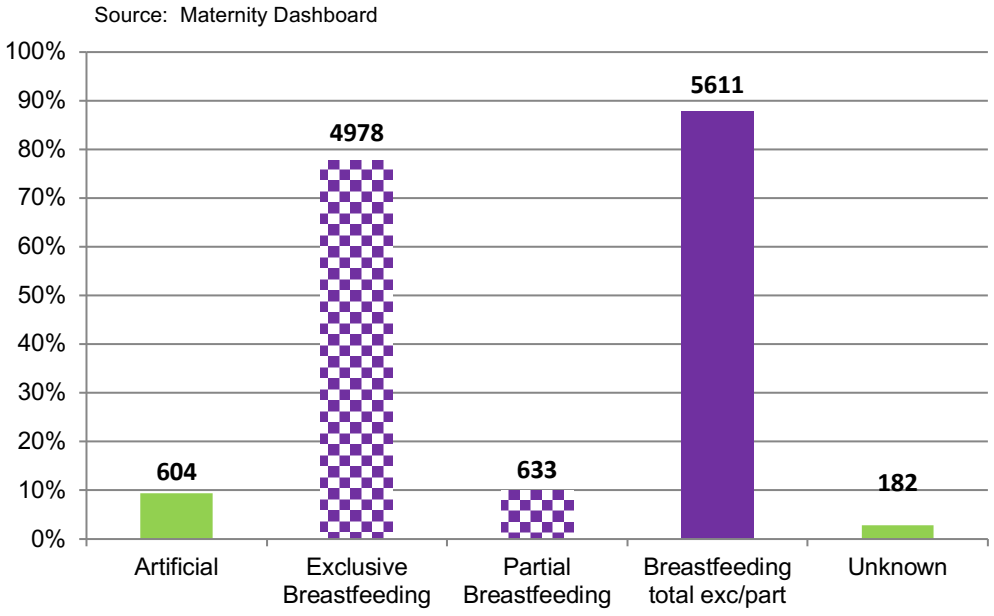
TABLE 4 - NEWHAM UNIVERSITY HOSPITAL MATERNITY DASHBOARD (2015-2016)

Newham University Hospital Maternity Dashboard: 2015-2016	
Total number mothers delivering	6397
Total number of babies born	6479
Obstetric unit deliveries	4862
Percentage of Deliveries in Obstetric Units	76.0%
Antenatal bookings	7991
Gestation at delivery <37 Weeks	571
Percentage of babies delivered with gestation < 37 weeks	8.9%
Low birth weight	491
Normal vaginal deliveries	3857
Percentage Normal vaginal deliveries	59.5%
Emergency Caesarean Section	1326
Percentage Emergency Caesarean Section	20.5%
Elective Caesarian section	547
Percentage Elective Caesarean Section	8.4%
Total Caesarean Section	1873
Total Percentage Caesarean Section	28.9%
Total Women booked	7991
Total Women booked by 12+6	5730
Referrals received after 12+6	1318
Smoking at Delivery	377
Percentage Smoking at Delivery	5.9%
Alcohol at delivery	88

Table 4 above denotes the results of various indicators collected from Newham University Hospital (NUH) during 2015-2016. Unfortunately, there was no update for 2016-2017, therefore no comparison can be made to assess changes in outcomes.

Figure 9 below denotes the feeding method for newborn babies in NUH for 2015-2016. Nearly 80% of babies were exclusively breastfed, and 10% partially breastfed in the first 48 hours after birth. Only 10% of babies born were formula fed. Further details on breastfeeding in Newham can be found in the chapter "Breastfeeding". Again, there was no update on outcomes for 2016-2017.

FIGURE 9 - FEEDING METHOD FOR NEWBORN BABIES (2015-2016)



What services are available in Newham?

Please see the *Parenting support: Family Nurse Partnership* sub-chapter below, for information on the voluntary services they provide to first time mothers under 19 years of age; aiding in healthy pregnancies.

Midwives undoubtedly play a major role in healthy pregnancies, with their services offered both in the community e.g. mother's homes, GP practices and children's centres, as well as in antenatal, labour and post-natal wards in hospitals. In addition, LBN offers Maternity Mates as part of the Women's Health and Family Services (WHFS) which focusses on recruiting, training and matching-up volunteer Maternity Mates with pregnant women in need of extra support. A Maternity Mate is a female volunteer trained by WHFS to provide practical and emotional support to women during pregnancy, childbirth and the early weeks of motherhood; including ensuring that the woman accesses the necessary healthcare she requires (scans, appointments). LBN has also incorporated the availability of Healthy Start for all infants in the modernised Health Visiting service.

Progress since last JSNA

There has been no update in the maternity indicators, so no comparisons were undertaken as previously published JSNA in from 2016, and the JSNAs from 2010 and 2011-2012, since they did not discuss maternity services.

Recommendations

The National Institute for Health and Clinical Excellence have provided several recommended steps of action to take to ensure women have the healthiest pregnancies possible[10, 11]. These include:

Level	Recommendations

Policy	• Pregnant women should be offered evidence-based information and support to enable them to make informed decisions about childbirth. Addressing women's views and concerns should be recognised as being integral to the decision-making process.
	• Give pregnant women evidence-based information about C/S during the antenatal period, because about one in four women will have a C/S. Include information about C/S, such as:
	  ○ indications for C/S (such as presumed fetal compromise, 'failure to progress' in labour, breech presentation)
	  ○ what the procedure involves
	  ○ associated risks and benefits
	  ○ implications for future pregnancies and birth after C/S.
	• Communication and information should be provided in a form that is accessible to pregnant women, taking into account the information and cultural needs of minority communities and women whose first language is not English or who cannot read, together with the needs of women with disabilities or learning difficulties.
	• Ensure health professionals have the appropriate knowledge and skills to give advice on the following:
	  ○ the nutritional needs of women and the importance of a balanced diet before, during and after pregnancy (including the need for suitable folic acid supplements)
	  ○ the rationale for recommending certain dietary supplements (for example, vitamin D) to pregnant and breastfeeding women
	  ○ the nutritional needs of infants and young children
	  ○ breastfeeding management, using the Baby Friendly Initiative (BFI) training as a minimum standard (www.babyfriendly.org.uk)
	• strategies for changing people's eating behaviour, particularly by offering practical, food-based advice

SCREENING IN PREGNANCY

Introduction

NHS England offers an antenatal screening programme to all pregnant women in England. It is a programme where the woman is offered a range of tests, including blood tests and ultrasound baby scans, designed to help make the pregnancy safer, check and assess the development and wellbeing of the mother and her baby, and to screen for specific conditions. Screening takes places for infectious diseases (including hepatitis B, HIV and syphilis), inherited conditions (sickle cell, thalassaemia and other haemoglobin disorders, Down's syndrome, Edward's syndrome and Patau's syndrome) and abnormalities (12 weeks and 18 to 21-week scan). Women are educated about the purpose of all the tests so that they can make an informed decision about whether to have them or not. Nevertheless, all are strongly encouraged to ensure that both mother and baby are as healthy and safe as can be.

Policies and Drivers

National

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health, which includes implementation of clinical guidelines around antenatal screening. NICE has also published a number of tools and resources (costing templates, costing reports, slide sets) to facilitate in putting the guidance into practice[10].

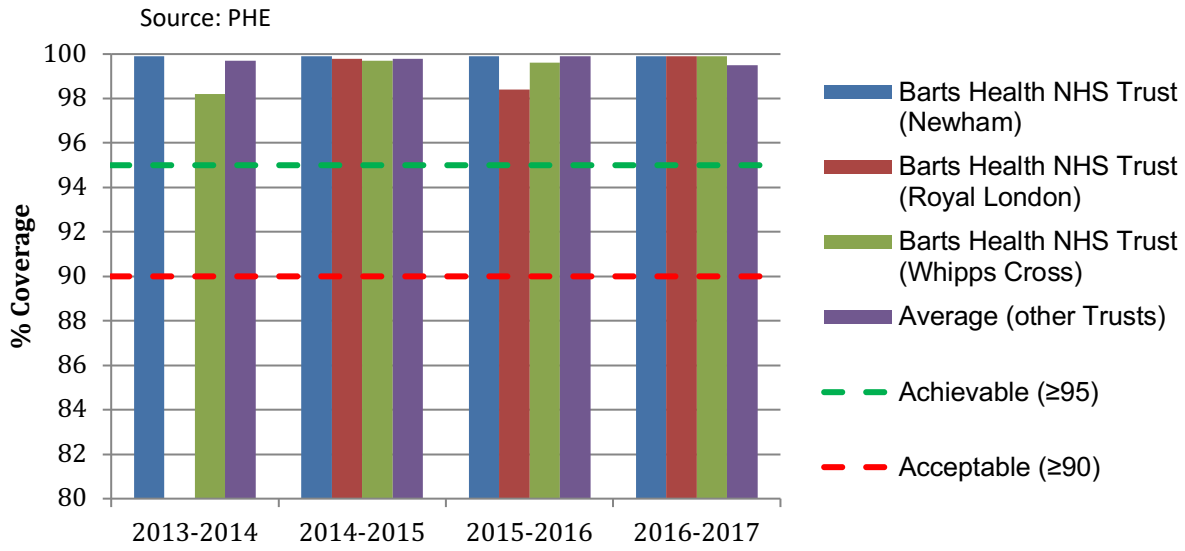
Local

Bart's Health Maternity Unit run an antenatal screening programme, to which pregnant women in Newham can be referred.

What's happening in Newham?

Due to the way that data is provided to PHE by hospital trusts, no borough level comparisons are possible. The graphs below denote the screening coverage of HIV, Sickle Cell and Thalassemia.

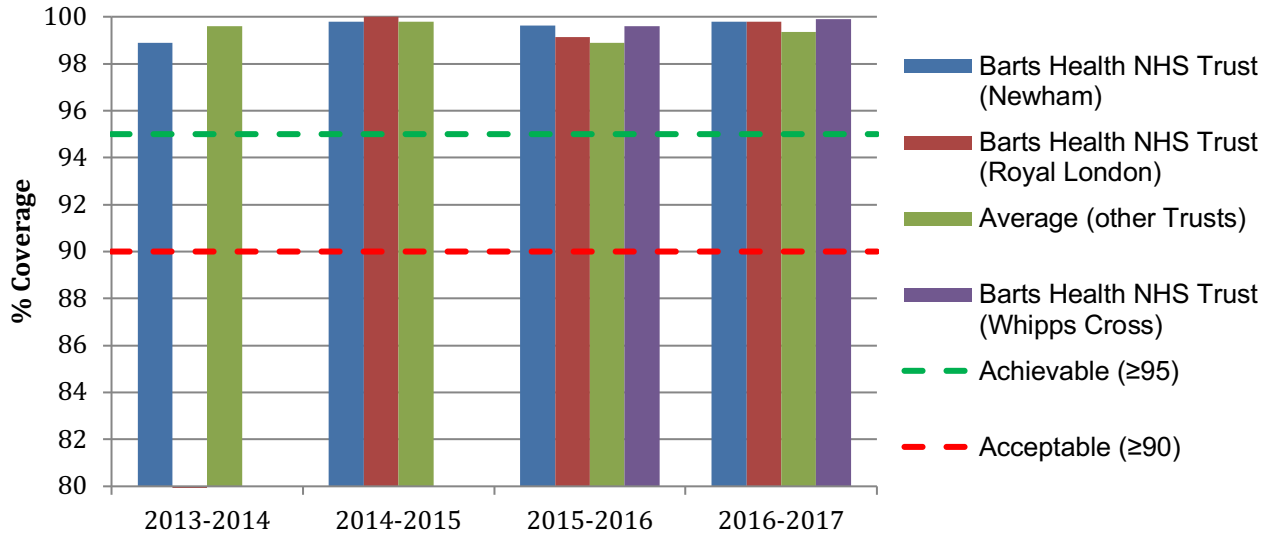
FIGURE 10 - ANTENATAL INFECTIOUS DISEASE SCREENING - HIV COVERAGE BY TRUST



Antenatal HIV coverage in Newham University Hospital has been the highest compared to other Trusts and is considerably above the acceptable and achievable targets or 90% and 95% respectively, showing a score of 99.9% over the years shown.

FIGURE 11 - ANTENATAL SICKLE CELL AND THALASSAEMIA COVERAGE BY TRUST, LONDON

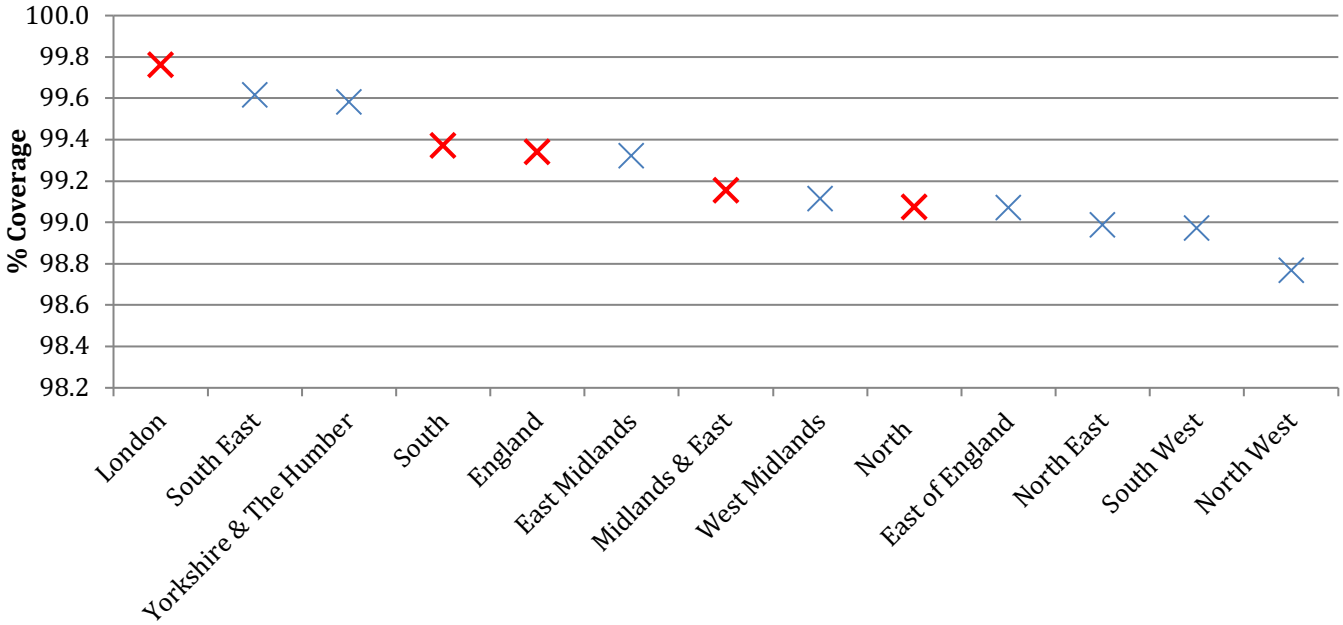
Source: PHE



Antenatal sickle cell and thalassaemia coverage in Newham University Hospital is also well above the acceptable target of 95%, and above the achievable target of 99% over the last 2 years.

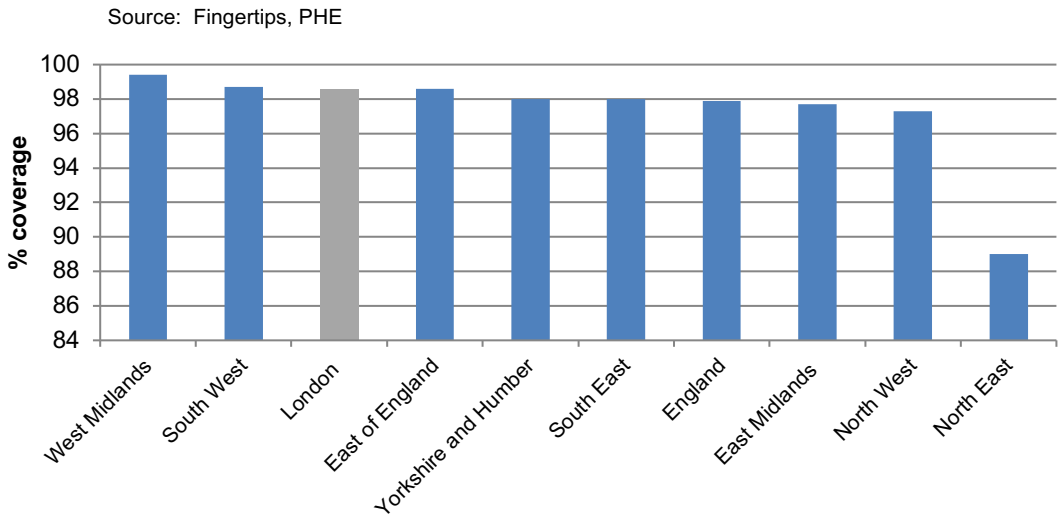
FIGURE 12 - ANTENATAL SICKLE CELL AND THALASSAMIEA SCREENING REGIONAL COVERAGE FOR 2016-2017

Source: PHE



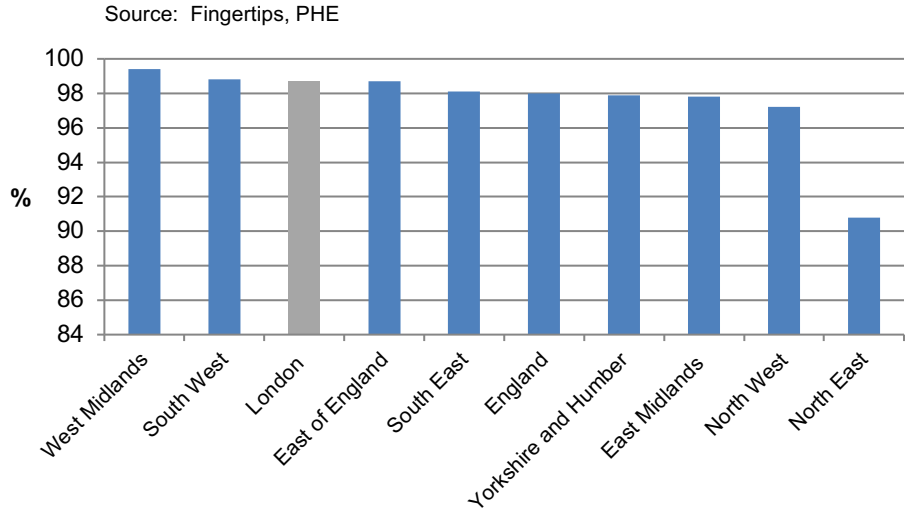
When comparing across regions, London had the highest coverage of antenatal sickle cell and thalassemia in 2016-2017, compared to all other English regions.

FIGURE 13 - ANTENATAL HEPATITIS B - REGIONAL COVERAGE (2013)



As can be seen in the graphs above and below, in 2013 London has similarly been performing well in for both antenatal Hepatitis B and Syphilis coverage. However, collection for regional data for Hepatitis B and Syphilis has been discontinued.

FIGURE 14 - ANTENATAL SYPHILIS - REGIONAL COVERAGE (2013)



What services are available in Newham?

As described in the chapter “What is a healthy pregnancy?”, Newham offers Maternity Mates as part of the Women’s Health and Family Services (WHFS), which focusses on recruiting, training and matching-up volunteer Maternity Mates with pregnant women in need of extra support.

Progress since last JSNA

Since the 2016 JSNA, antenatal screening coverage is still exceeding acceptable and achievable levels. Furthermore, rates have increased from 99.6 to 99.8% coverage in Newham for sickle cell and thalassaemia, whereas for antenatal coverage for HIV screening, this remained constant at 99.9%. No

comparisons could be made for antenatal syphilis or Hepatitis B coverage due to the discontinuation of these indicators regionally.

Recommendations

The National Institute for Health and Clinical Excellence have provided several recommended steps of action to improve antenatal screening uptake [7, 10].These include;

Level	Recommendations

Policy	• Ensure that the antenatal and newborn screening programmes external quality assurance is taking place
	• Continue to audit reasons for late referral to antenatal screening and implement an action plan based on findings.
	• Use NICE-provided tools which include:
	  ○ Slides highlighting key messages for local discussion
	  ○ Costing tools:
	  ○ costing report to estimate the national savings and costs associated with implementation
	  ○ costing template to estimate the local costs and savings involved
	  ○ Implementation advice on how to put the guidance into practice and national initiatives which support this locally
	  ○ Audit support for monitoring local practice.

Community	• Consideration should be given to financing/empowering local organisations which focus on raising awareness of the screening pathway • Consideration should be given to attempts to signpost women who are planning a pregnancy to the pathway starting with their GP

PARENTING SUPPORT: FAMILY NURSE PARTNERSHIP

Introduction

The Family Nurse Partnership (FNP) is a voluntary home visiting programme for first time young mums, aged 19 years or under. A specially trained family nurse visits the young mum regularly; from the early stages of pregnancy until their child is two. The FNP programme aims to enable young mums to have a healthy pregnancy, improve their child's health and development and plan their own futures and achieve their aspirations. The FNP programme is underpinned by an internationally recognised robust evidence base, which shows it can improve health, social and educational outcomes in the short, medium and long term, while also providing positive economic returns.

Policies and Drivers

National

Delivery of the FNP on a national scale is headed by the FNP National Unit, who are commissioned by the Department of Health and PHE; with this unit providing support and guidance to local organisations, to assist with implementation. Although the 2012-2013 Operating Framework for the NHS in England emphasized that CCGs[12] were expected to maintain existing delivery, and continue expansion of the Family Nurse Partnership programme, the commissioning responsibility of public services for children under the age of the 5 was shifted from the NHS to local authorities in October 2015. Moreover, a range of data is collected and reported on via the client based FNP Information System which shows how well the programme is being delivered per the programme's fidelity goals. If good progress against the fidelity goals is being made, then it is more likely improved outcomes for families will be achieved[13].

Local

The FNP Advisory Board oversees the FNP. The team meets annually to review progress, describe current vision and strategy, peruse over actions for developing the vision and strategy, and set targets around areas of action for the next 12 months.

What's happening in Newham?

FNP was introduced in Newham in 2013. Since then, the team have been working with mothers under 19 years of age and increasing the number of mothers seen each year. At full capacity, the team can support 100 young mothers. In 2013-2014, FNP's first year in Newham, they supported 47 mothers, 30% of whom were 16 years old or under. The following year, 2014-2015, they were supporting 51 young mothers.

TABLE 5 - FNP CAPACITY & CASELOAD

Year	Commissioned Capacity (maximum places)	Expected Capacity (based on team circumstances)	Actual Caseload
2013/14	100	54	47
2014/15	100	80	51

Table 6 below describes the targets related to the processes of FNP. For the programme to be effective, mothers should be enrolled by 16 weeks pregnant. In Newham in 2013-2014, 40.8% of mothers were recruited by 16 weeks. This reduced to 33.3% the following year. The goal is 60%. There are many reasons for this low enrolment rate and these may relate to late presentations to ante natal appointments before referral into FNP. In 2013-2014, 65.4% of those who were offered FNP were enrolled, in 2014-2015 this increased to 77.5% which is over the goal of 75%. There were no programme completers in 2014-2015.

TABLE 6 - FNP ENROLMENT AND ATTRITION

Description	2013/14	2014/15	Fidelity Goal
Recruitment by 16 weeks	40.8	33.3	60
% enrolled who are offered FNP	65.4	77.5	75
Attrition (Programme Completers)	7.1	0	40

The expected number of visits for women in pregnancy and infancy has decreased in the last year. Visits during toddlerhood are high at 100%.

TABLE 7 - FNP VISIT DOSAGE

Description	2013/14	2014/15	Fidelity Goal
Pregnancy	71	68	% receiving >80% of expected visits
Infancy	100	68	% receiving >65% of expected visits
Toddlerhood	N/A	100	% receiving >60% of expected visits

NB. Fidelity stretch goals states that all clients receive the expected % of visits

The length of visits across all areas of FNP is above the recommended 60 minutes. The lengths have decreased based on times from the previous year.

TABLE 8 - FNP AVERAGE LENGTH OF VISIT

Description	2013/14	2014/15	Fidelity Goal
Pregnancy	82.9	76.4	>60 mins
Infancy	77.6	71.9	>60 mins
Toddlerhood	N/A	N/A	>60 mins

Discussions and support around breastfeeding are an integral part of the FNP programme. All Family Nurses are trained under UNICEF breastfeeding. Breastfeeding initiation rates are high among FNP clients at nearly 90%. There is a challenge for Family Nurses around supporting continued breastfeeding until 6 months. The change to bottle feeding/mix feeding often happens in the very early postnatal period, which may be before the Family Nurse has commenced infancy visits, when breast feeding is establishing and is at the most challenging for the clients. Family Nurses have noticed a tendency towards early introduction of solid foods (before 6 months) which also impacts on sustained exclusive breastfeeding.

TABLE 9 - FNP BREASTFEEDING STATISTICS

Description	2012-15	2014/15
% initiating breastfeeding	60.1	58.4
% breastfeeding at 6 weeks	19.4	17.6
% breastfeeding at 6 months	8.3	7.8
% breastfeeding at 12 months	4.6	4.3

Between intake and 36 weeks of pregnancy, mothers enrolled in FNP report a decrease of 1% in smoking rates. All FNP clients report they have smoked fewer cigarettes during their pregnancy since joining the programme. Following birth there is an increase of 7.9% smoking by the time the babies are 6 weeks old. There is a reduction to levels at intake of 14.3 % by the time the babies reach 1 year. The issue for the team is to sustain reductions in smoking and prevent an increase following birth.

TABLE 10 - FNP SMOKING STATISTICS

Smoking	Percentage (%) of clients (Last three years 2012-2015)	Change (Latest year 2014/15)
Clients who smoked in last 48 hours at intake	14.3	 15.4
Clients who smoked in last 48 hours at 36 weeks' gestation	13.3	 19.0
Clients who smoked in last 48 hours at 6 weeks infancy	21.2	 16.7
Clients who smoked in last 48 hours at 12 months infancy	14.3	 14.3
Clients smoking fewer cigarettes at 36 weeks than at intake	100	 100

All babies on the programme were fully immunised by 1 year and 24 months. However, at 6 months the rate has decreased to 90% being fully immunised which suggests some babies are delayed with their immunisation.

Progress since last JSNA

These indicators were not updated; no comparisons were undertaken from previously published JSNAs.

Recommendations

The National Institute for Health and Clinical Excellence have provided recommended steps of action to take to improve outcomes from FNP[7, 10, 13]. These are considered alongside the FNP annual reports which are submitted to the national team at the Department of Health (DH) and are co-written with the FNP team and local commissioners.

Level	Recommendations
Policy	• Continue to promote and provide FNP up to 2 years of age • Facilitate a discussion with local stakeholders about the benefits of FNP and find a provider committed to improving children and young people's health and wellbeing
Community	• Consideration should be given to evidence-based community projects aimed at providing pregnant women under 20 years of age with information on FNP
Neighbourhood	• Maintain high rates of breastfeeding initiation and improve rates of breastfeeding at 6 weeks and beyond • Increase and sustain reductions in smoking during pregnancy by following NICE guidance. Successful interventions have generally offered support on an individual level and include cognitive behaviour and motivational interviewing; offering incentives; giving feedback to the mothers on foetal health status; and offered nicotine replacement therapy • Establish client feedback and participation in programme governance

	and children's academies and inform service delivery for FNP and other local services for children and families • Reach full capacity and meet fidelity goals • Strengthened notification pathway, with challenges to continue to improve enrolment by 16 weeks • Pathway development with health and social care partners as part of wider changes to service delivery for children and families in Newham

SMOKING AND ALCOHOL IN PREGNANCY

Introduction

Smoking and alcohol consumption during pregnancy are associated with hazardous health risks to both the unborn foetus and mother. Risks associated with smoking include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy[14, 15]. Smoking during pregnancy also increases the risk of infant mortality by an estimated 40%[16].

Children exposed to tobacco smoke in the womb are more likely to experience respiratory illnesses in childhood, such as wheezy episodes, asthma, pneumonia, and bronchiolitis.

Exposure to smoke in the womb is also associated with psychological problems in childhood such as attention and hyperactivity problems and disruptive and negative behaviour[17]. In addition, it has been suggested that smoking during pregnancy may have a detrimental effect on the child's educational performance[18].

Alcohol consumption during the first trimester in pregnancy is associated with an increased risk of miscarriage. Other associated risks include premature labour, still birth and low birth weight. The most harmful risk of alcohol consumption during pregnancy is fetal alcohol syndrome, which causes physical and mental retardation.

Policies and Drivers

Current NICE guidance recommends that all pregnant women who smoke, anyone who is family planning and all families with an infant aged less than 12 months, should be referred for help to quit smoking.

New UK-wide guidelines were published by the Royal College of Obstetrics and Gynaecology (RCOG) in January 2016 that recommended that there is no 'safe level' of alcohol consumption during pregnancy with pregnant women advised to completely abstain from alcohol.

What's happening in Newham?

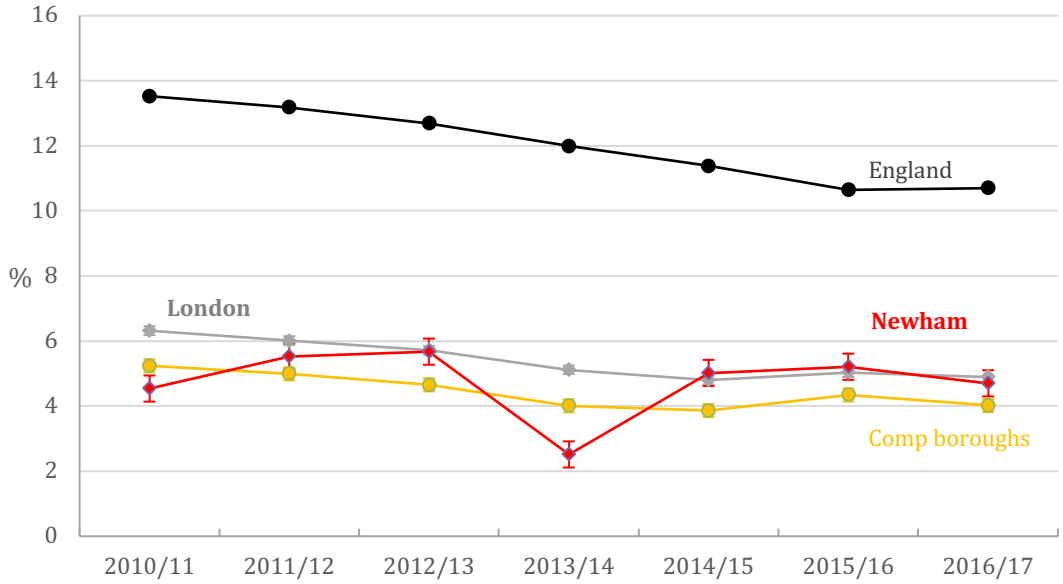
Current data (2016-2017) from PHE reveals that 4.7% of women in Newham were smoking at the time of delivery. This is just below the London mean at 4.9%, but lower than England at 10.6% (95% CI 10.6-10.7). While England's rate has fallen steadily in the past six years, it is now beginning to plateau. There has been no trend in Newham's data of the last six years, although the percentage is down from 2015-2016. Furthermore, the smoking prevalence in Newham has been consistently higher than that of comparator boroughs since 2014-2015.

Table 11 - Percent of women smoking at delivery

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Newham (%)	4.5	5.5	5.7	2.5	5	5.2	4.7
Comparator boroughs (%)	5.2	5.0	4.7	4.0	3.9	4.3	4.0
London (%)	6.3	6.0	5.7	5.1	4.8	5.0	4.9
England (%)	13.5	13.2	12.7	12.0	11.4	10.6	10.7

FIGURE 15 - SMOKING STATUS AT TIME OF DELIVERY 2010-2011 TO 2016-2017 IN NEWHAM, COMPARATOR BOROUGHS, LONDON, ENGLAND AS A PERCENTAGE (95% CONFIDENCE INTERVALS)

Source: PHOF



In contrast, 1.4% of women were consuming alcohol around delivery, despite RCOG recommendations of no 'safe level' of alcohol consumption during pregnancy. It is important to note that these figures are likely to be an underestimate due to the intense social pressure women feel not be forthcoming with their smoking or drinking habits during pregnancy. Furthermore, since maternity sources are not currently screening for Carbon Monoxide, it is possible that smoking status and frequency are under-reported.

What services are available in Newham?

Smoking cessation services are available when women contact their GP about their pregnancy or their intention to plan a pregnancy. Nevertheless, the current service is only available in 19 pharmacies with no sessional services by stop smoking advisers. However, GPs should continue to educate women on the dangers of smoking and alcohol consumption during pregnancy.

Progress since last JSNA

In 2010, highest rates of smoking were found in white British and Eastern Europeans with the lowest rates amongst Pakistani and Bangladeshi women. Nevertheless, the rates of smoking amongst women giving birth (6.6%) were significantly lower than the national average (14.1%) but comparable in London. As the figure is now 5.2%, we have therefore made progress compared with the 2010 JSNA. However, since 2014-2015 the prevalence has increased from 5%, meaning more woman are smoking at the time of delivery compared to the last JSNA.

Recommendations

The National Institute for Health and Clinical Excellence have provided a number of recommended steps of action to take to improve smoking cessation rates and reduce alcohol consumption in pregnancy[14, 19, 20]:

Level	Recommendations
Policy	• Continue to ensure that GPs are encouraging pregnant women or women planning pregnancy not to drink alcohol or smoke • Ensure services are delivered in an impartial, client-centred manner. This includes consideration around communication with women who are non-English speakers, as interpretation services are not routinely provided in Newham unless it is a statutory requirement • Midwives to: ○ Assess the woman's exposure to tobacco smoke through discussion and use of a CO test. Explain that the CO test will allow her to see a physical measure of her smoking and her exposure to passive smoke ○ Provide information (for example, a leaflet) about the risks to the unborn child of smoking when pregnant and the hazards of exposure to passive smoke for both mother and baby. Information should be available in a variety of formats ○ Explain about the health benefits of stopping for the woman and her baby ○ Explain that it is normal practice to refer all women who smoke for help to quit and that a specialist midwife or adviser will phone and offer her support ○ Refer all women who smoke, or have stopped smoking within the last 2 weeks, to NHS Stop Smoking Services ○ NICE recommendations state that midwives should follow Recommendation 1 in "Quitting smoking in pregnancy and following childbirth". This includes assessing exposure to tobacco including a CO assessment. It also includes women who do not smoke but register a CO level of 3 parts per million, where support should be offered to identify the cause of the exposure and take further action as appropriate. Other sources could include household or other second-hand smoke, traffic emissions or household heating appliances ○ Increase and sustain reductions in smoking during pregnancy: In a report by ASH, communication with the public regarding consistent messages around smoking in pregnancy is identified as one of the main drivers for reduction in smoking during pregnancy. In a survey completed by midwives in the North East during early 2011, the results revealed a lack of belief that brief advice and interventions to support stopping smoking during pregnancy were effective. As a follow-up to this questionnaire, key themes were identified by midwives to help support this and included: ▪ Training – mandatory sessions for staff including how to use a CO monitor ▪ Consistent message – 5 key points clearly demonstrating the effects and focusing on the baby's health and development ▪ Relationship with the women – addressing the challenges that discussing smoking may pose ▪ Resources – more staff and more CO monitors
Community	• Consideration should be given to evidence-based community projects aimed at highlighting the dangers of smoking and drinking alcohol during pregnancy or the planning of pregnancy.

	• Consideration should be given to targeted community action for white British and eastern European women who are pregnant or planning a pregnancy.

7.0 EARLY YEARS

INTRODUCTION

Birth to five are considered key developmental years during which their experiences and exposures lead to lifelong effects on a child's health and wellbeing. At the London Borough of Newham and Newham Clinical Commissioning Group, Early Years therefore represent an opportunity to invest in programmes and services that support and intervene early in a child's life.

What are the issues in Newham?

In 2015, the percentage of term live low birth weight (LBW) babies (>37 weeks) was higher (4.4%) in Newham than comparator boroughs, London (3.2%) and England (2.9%). Despite the national target of 100% of babies screened for serious conditions within 6 weeks of life, newborn hearing and bloodspot screening was low in Newham at 98% for both with us being the 5th worst borough in the country in the latter. Newham is underperforming in vaccination coverage compared to England in a range of vaccinations at 1 year (Men C, PCV, DTaP/IPV/Hib Rotavirus), 2 years (DTaP/IPV/Hib, Hib/Men C booster, MMR) and 5 years (Hib/Men C booster, MMR 1st & 2nd dose). Although breastfeeding at 48 hours is above London averages in Newham, breastfeeding at 6 weeks (55.4%) is behind London (60.6%). Finally, in oral health, the average number of decayed, missing or filled teeth (DMFT) in 5-year-olds in Newham is higher than London and England.

What are the inequalities?

In a Guttman Academic Partnership project between UCLPartners, Newham CCG and LBN on identifying and preventing LBW babies in Newham, early work has suggested that family responsibilities and lack of community support rather than ethnicity is a bigger factor influencing LBW. In Oral Health, preschool children from a White Eastern European, Bangladeshi and Pakistani background are likely to experience significantly poorer oral health than their White British counterparts[21].

What are we doing well?

Rates of infant mortality in Newham have fallen steadily and are now lower than England averages. In contrast to London, England and comparator boroughs, Newham also has the lowest hospital admissions for accidental and deliberate injuries in children aged 0-14 years. The number of children killed or seriously injured in road traffic accidents are lower in Newham compared to comparator boroughs and England.

Newham has significantly higher rates of mothers who start breastfeeding within 48 hours compared to London and England and children achieving good level of development at the end of reception. Finally, the percent of 3 and 4 year olds benefitting from funded early education places and achievement in EYFSP assessments in children aged 0-5 years in Newham is higher compared to comparator boroughs, London and England.

What needs improving?

The percentage of babies born with LBW could be addressed with targeted early antenatal interventions such as Maternity Mates. The uptake of newborn hearing and bloodspot screening needs more information on the importance of the screening tests. Breastfeeding at 6 weeks needs to be addressed by highlighting the benefits for the baby (nutrition) and mother (bonding). Vaccination uptake and oral health could improve with support from the Paediatric Alliance.

CHILD MORTALITY

Introduction

Infant, child and adolescent death rates in the UK have declined substantially and continue to fall. Despite this, the overall UK childhood mortality rate is consistently higher compared to other European countries with concern in deaths amongst infants, children and young people with long term conditions (LTCs).

After their first year of life, injuries are the most common cause of death in children. Although the largest proportions of these injuries are unintentional, our ongoing failure to reduce intentional injury deaths amongst young people across the UK remains a pressing concern.

Several reports have shown that children and young people experience the most health inequality, resulting in lives lost. In addition, there are marked social inequalities in the death rates of children and young people with infant death rates 4 times where parents are in routine occupations compared to higher managerial or professional occupations[22].

Policies and drivers:

Reducing infant deaths and stillbirths is a priority for the NHS and government, forming part of the NHS and Public Health Outcomes Framework. There is a range of specific policies, national guidance and programmes of relevance including the National Service Framework "*Healthy Child Programme: Pregnancy and the first five years of life*" amongst others[23, 24].

What's happening in Newham?

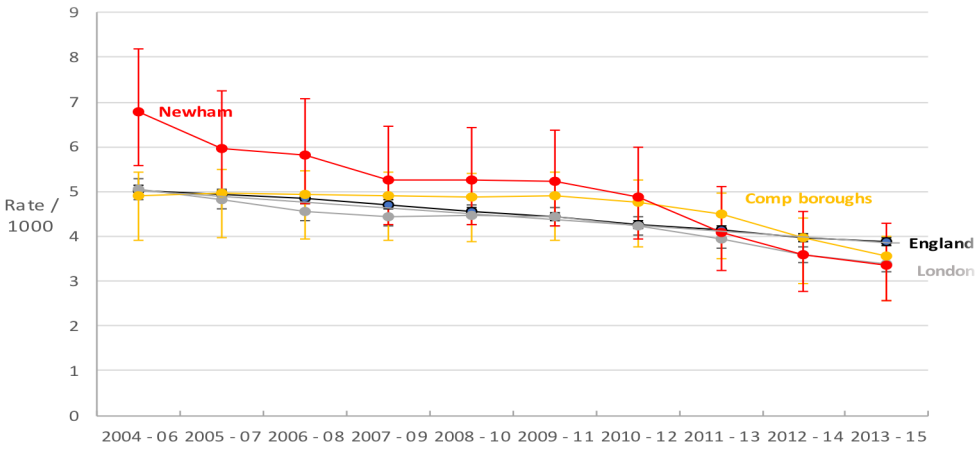
Infants (0-1 years)

Infant mortality figures have continued to steadily fall in Newham, London and England since 2004-2006. In Newham, the 2004-2006 rate of under 7 per 1000 live births has halved in under a decade, to 3.4 per 1000 live births in 2013-2015 (crude rates).

The 2013-2015 infant mortality rate in Newham was lower than in London and England comparators, but the difference was not statistically significant[23]. This is in contrast to 2004-2006 figures, where Newham's infant mortality rate was significantly higher than those of comparators London and England.

FIGURE 16 – INFANT MORTALITY RATE/1000 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2004-2006 TO 2013-2015 (95% CONFIDENCE INTERVALS)

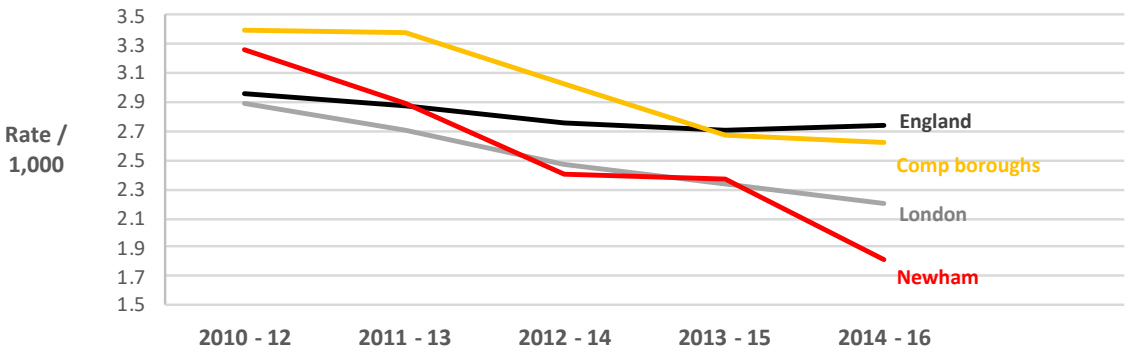
Source: PHOF



Neonatal death rates (birth to 28 days) in Newham during the 2014-16 reporting period remained at their lowest since 2010-2012: 2014-2016 rates were 1.81/1,000 births (33 deaths). Death rates fell sharply from 2010-2012 (3.3/1000 live births, 62 deaths) to 2012-2014 (2.4/1000 live births, 45 deaths), after which they plateaued from 2012-2014 to 2013-2015 (rate = 2.4/1000 live births, 44 deaths), and fell sharply again in this reporting period (2014-2016).

FIGURE 17 – NEONATAL MORTALITY (<28 DAYS) IN NEWHAM, COMPARATOR BOROUGHS, LONDON, ENGLAND 2010-2012 TO 2014-2016 RATE/1000

Source: PHOF indicator 92705

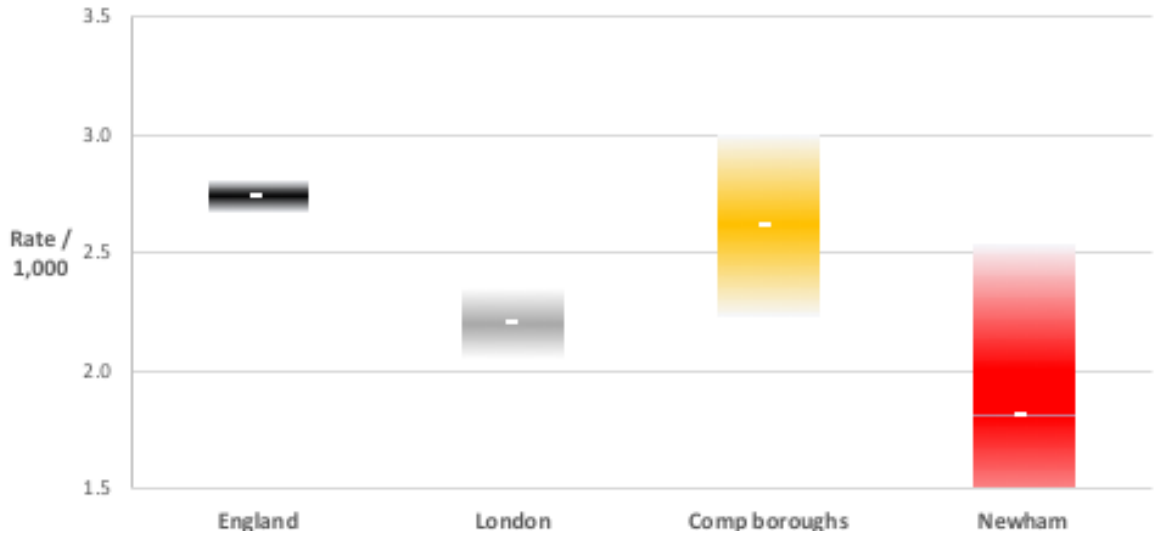


The downward trend in neonatal death rates in Newham reflected a London-wide decline over the same time-span. Across the capital, 2010-2012 death rates were 2.90/1,000 births (1,159 deaths) and declined to 2.20/1,000 births (847 deaths) in 2014-2016. This surpassed the steady decline of neonatal death rates across England, from 2.95/1000 births in 2010-2012 (6113 deaths), to 2.74/1000 births in 2014-2016 (5446 deaths).

2014-2016 neonatal death rates in Newham (1.81/1000 births, 33 deaths) were comparable to those across London (2.20/1000 births, 847 deaths), and lower but not statistically different to comparator boroughs (2.62/1000 births, 178 deaths) or across England (2.74/1000 births, 5446 deaths).

FIGURE 18 – NEONATAL MORTALITY (<28 DAYS) IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2014-2016 RATE/1000 (95% CONFIDENCE INTERVALS)

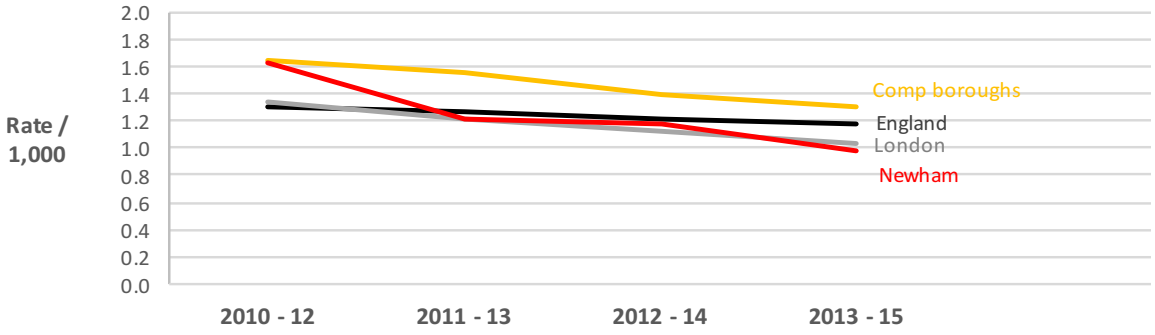
Source: PHOF indicator 92705



In Newham, post-neonatal mortality (28 days to 1 year) has consistently declined since 2010-12 (1.63/1000 births, 31 deaths) and is at the lowest in 2013-15 at 0.97/1000 births (18 deaths). This is in line with the downward trend in deaths across comparator boroughs, London and throughout England.

FIGURE 19 – POST-NEONATAL MORTALITY (28 DAYS – 1 YEAR) IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2012 TO 2013-2015 RATE/1000

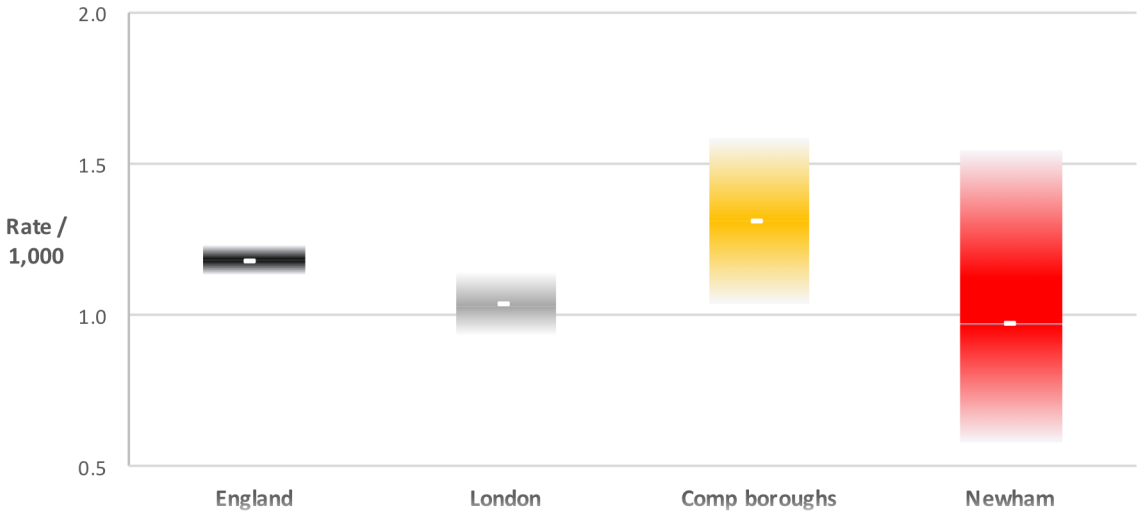
Source: PHOF indicator 92706



The step-wise decline in post-neonatal deaths in Newham since 2010-2012 has led to the borough having the lowest death rates amongst comparators in other boroughs (1.31/1000 births, 89 deaths), London (1.03/1000 births, 398 deaths) and across England (1.18/1000 births, 2344 deaths), although not statistically different.

FIGURE 20 – POST-NEONATAL MORTALITY (28 DAYS – 1 YEAR) IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2013-2015 RATE/1000 (95% CONFIDENCE INTERVALS)

Source: PHOF indicator 92706



Further details about low birth weight (LBW) babies, a risk factor for deaths in this age group, can be found in the chapter “Low Birth Weight”.

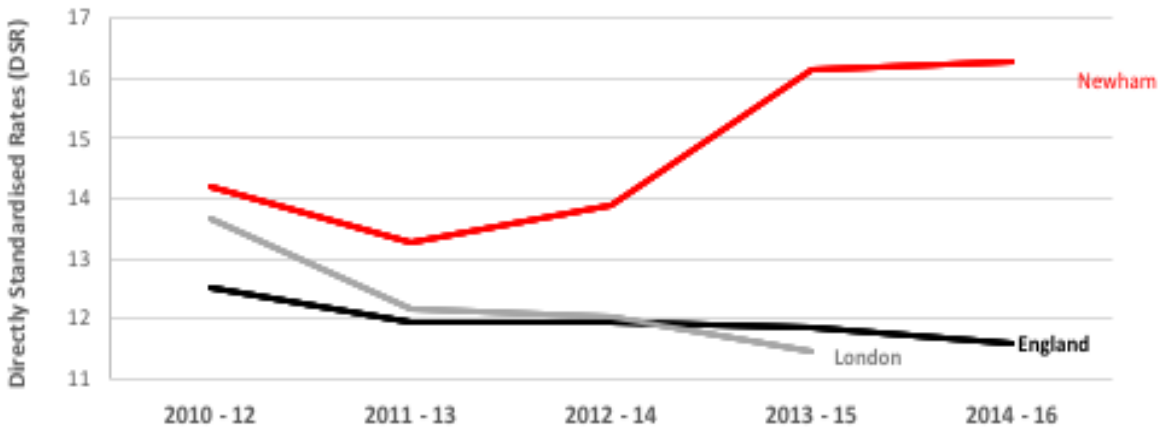
Children (1-17 years)

Deaths in the 1-17 age group in Newham were steady from 2010-2012 (Directly Standardised Rates, DSR = 14.22/100,000 Standard European Population, 32 deaths) to 2012-2014 (DSR = 12.05/100,000 births, 31 deaths). However, childhood mortality in 2014-2016 was at its highest in Newham since records began (16.30/100,000 births, 38 deaths), after an initial rise in 2013-2015 (16.13/100,000, 37 deaths).

Death rates since 2010-2012 have been consistently higher in Newham compared to across London and England. We note the omission of the most suitable comparator boroughs, due to the nature of the Directly Standardised Rates (DSR) measure: a calculation method that allows for comparison between areas with different population structures, it relies upon a detailed knowledge of the population age-structure in each area. In the case of comparator boroughs, insufficient available data prohibited DSR calculation and therefore inclusion of childhood mortality data.

FIGURE 21 – CHILD MORTALITY (1-17 YEARS) IN NEWHAM, LONDON AND ENGLAND 2010-2012 TO 2014-2016 DSR/100000

Source: PHOF indicator 90801



Newham 2014-2016 childhood mortality rates (16.13/100,000, 38 deaths) were comparable to those across London (11.46/100,000, 648 deaths) and England (11.60/100,000, 3882 deaths).

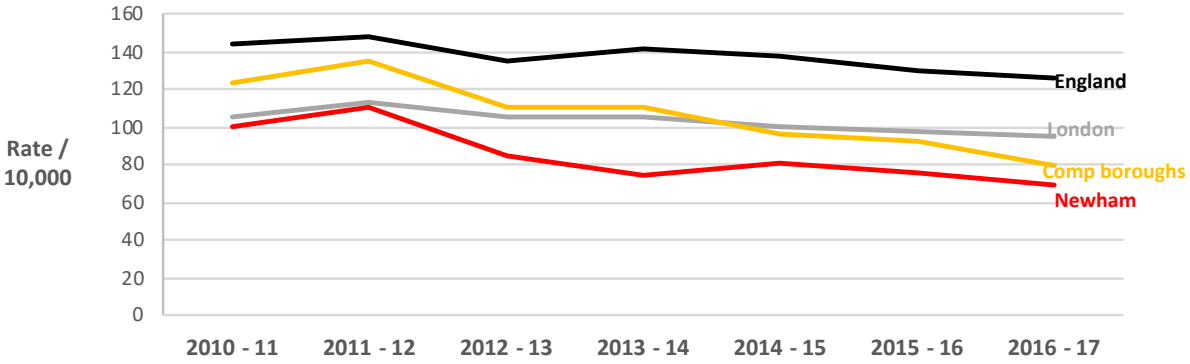
FIGURE 22 – CHILD MORTALITY (1-17 YEARS) IN NEWHAM, LONDON AND ENGLAND 2014-2016 DSR/100000 (95% CONFIDENCE INTERVALS)

Source: PHOF indicator 90801

Rates of hospital admissions for 0-4 year-olds for accidental and deliberate injury in Newham, have decreased overall since 2010-2011 (100.24/10,000 persons, 258 admissions), to 69.48/10,000 persons (205 admissions) in 2016-2017. This decline has been echoed within comparator boroughs, across London and England, with Newham's rates of childhood hospital admission consistently below those of comparators.

FIGURE 23 – HOSPITAL ADMISSIONS FOR ACCIDENTAL AND DELIBERATE INJURY TO CHILDREN AGED 0-4 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2011 TO 2016-2017 RATE/10000

Source: PHOF



Raw number of hospital admissions for accidental and deliberate injury in 0-4 year olds in Newham are tabulated below in *Table 11*.

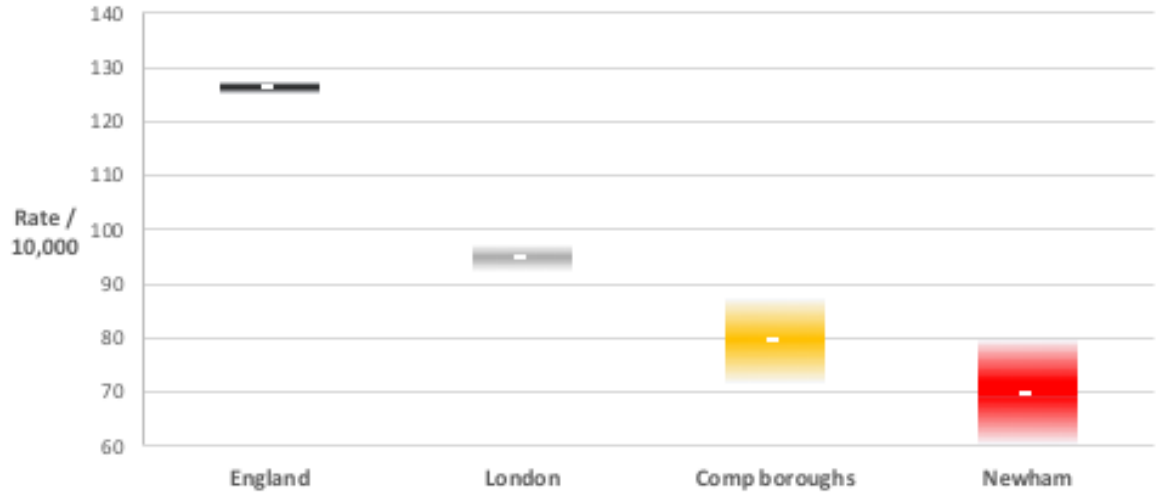
TABLE 11 – RAW HOSPITAL ADMISSIONS FOR ACCIDENTAL AND DELIBERATE INJURY IN 0-4 YEAR OLDS IN NEWHAM

2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
258	283	228	202	229	218	205

Newham's 2016-2017 rates of hospital admission was lower than those across London and England (at the 95% confidence level). Rates were highest across England (126.34/10,000 persons, 43,322 admissions), followed by London (94.83/10,000 persons, 6027 admissions).

FIGURE 24 – HOSPITAL ADMISSIONS FOR ACCIDENTAL AND DELIBERATE INJURY TO CHILDREN AGED 0-4 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2016-2017 RATE/10000 (95% CONFIDENCE INTERVALS)

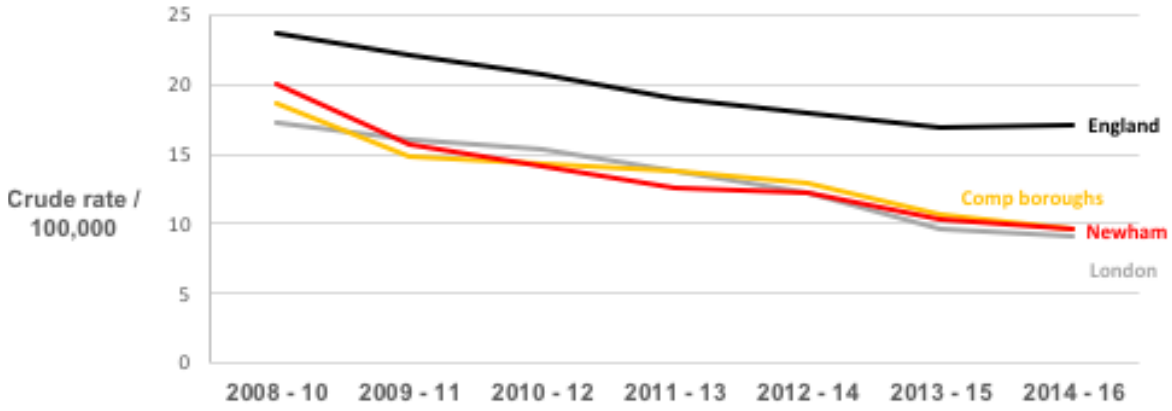
Source: PHOF



The number of children aged 0-15 years old killed or seriously injured in road traffic accidents in Newham in 2014-2016 (9.67/10,000 accidents, 22 deaths/injuries) has close to halved since 2008-2010 (20.11/10,000 accidents, 38 deaths/injuries).

FIGURE 25 – CHILDREN AGED 0-15 KILLED OR SERIOUSLY INJURED IN ROAD ACCIDENTS IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2008-2010 TO 2014-2016 CRUDE RATE/100000

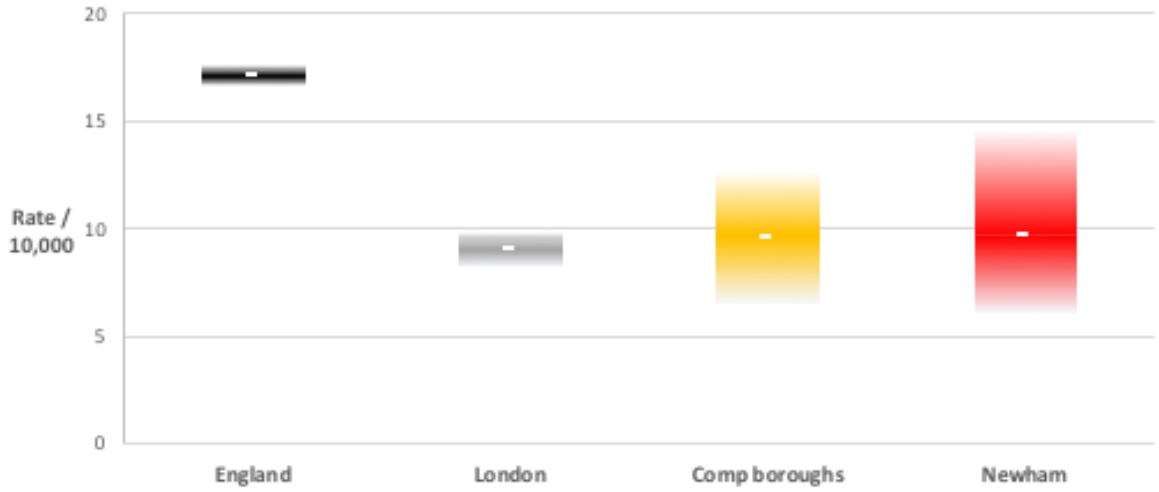
Source: PHE Fingertips



Road accident death rates in Newham have decreased in a stepwise manner, and have been consistently lower than those throughout England (2008-2010: 23.59/10,000 accidents, 7325 deaths/injuries; 2014-2016: 17.13/10,000 accidents, 5353 deaths/injuries), across London (2008-2010: 17.29/10,000 accidents, 821 deaths/injuries; 2014-2016: 9.05/10,000 accidents, 479 deaths/injuries) and comparator boroughs (2008-2010: 17.12/10,000 accidents, 128 deaths/injuries; 2014-2016: 9.62/10,000 accidents, 96 deaths/injuries)[22]. In 2014-2016, Newham's death/injury rates were lower than those across England, but similar to comparators of London and select boroughs (at the 95% confidence level).

FIGURE 26 – CHILDREN AGED 0-15 KILLED OR SERIOUSLY INJURED IN ROAD ACCIDENTS IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2014-2016 CRUDE RATE/100000 (95% CONFIDENCE INTERVALS)

Source: PHE Fingertips



Raw number of children aged 0-15 years old killed or seriously injured in road traffic accidents in Newham is tabulated below in *Table 12*.

TABLE 12 - RAW NUMBER OF CHILDREN 0-15 KILLED OR SERIOUSLY INJURED IN ROAD TRAFFIC ACCIDENTS

2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
38	30	30	27	27	23	22

Non-white ethnicity is a factor associated with an increased risk of infant mortality. In Newham, 74% of women aged 20-34 are in the non-white ethnic category (Greater London Authority, 2013). In addition, there is a socio-economic influence on infant mortality, with a higher rate of infant deaths (x4) where parents are in routine occupations compared to those in higher managerial or professional occupations. Further details around income can be found in the chapter on “Child Poverty”.

What services are available in Newham?

In line with the national Healthy Child Programme, Health Visitors routinely visit every family in Newham with a child aged 0-5 years to identify need and provide education about preventing unintentional injuries in children.

As part of LBN and Newham’s CCG commitment to better understand the reasons for deaths in childhood together with actions that may prevent future deaths, a Local Safeguarding Children’s Board reviews all childhood deaths in the borough.

Services targeted at improving the health outcomes in children with long-term conditions (LTCs) are detailed further in the chapter “Children with LTCs”.

Progress since the last JSNA

Neonatal mortality rates have remained similar compared to the last JSNA (2013-2015: 2.34/1000 vs. 2012-2014: 2.4), at a comparable level to rates for London (2.34), select boroughs (2.68) and across

England (2.71). Rates of post-neonatal (0.97/1000) and infant (2.38) mortality are similar to London's figures (post-neonatal: 1.03), whereas child mortality in Newham rose in the period since last JSNA (16.13), surpassing the London rate (11.46).

We have made progress on hospital admissions for unintentional and deliberate injuries and are now ahead of London, falling from 80 per 1000 to 75 (2015) compared to London (85/1000).

Finally, we have reduced levels for under-15 year olds killed or seriously injured in road traffic accidents from 12.3% in 2012-2014 to 10.3% in 2013-2015, comparably to comparator borough and London-wide reductions[25, 26].

Recommendations:

In a recent report by I Wolfe et al[24], action at; (1) government and the role of civil society, (2) health systems and organisations and (3) healthcare and public health services were highlighted as required to reduce the gaps in deaths in children and young people compared to the general population. Recent guidance from PHE, NICE and the Healthy Child Programme denote the following recommendations[23, 24, 27]:

Level	Recommendations
Policy	• A commitment should be made to increase Health Visitor efforts in educating families about preventing unintentional injuries • A commitment should be made to better support at-risk families (e.g. low socio-economic groups, teenage parents, families with a Sudden Unexplained Death in Infancy) in view of the higher risk of mortality in their children • A commitment to reduce the rate of LBW babies (Further details are denoted in the "Low Birth Weight" chapter below)
Community	• Dedicated support from community groups and non-government organisations (e.g. NSPCC) for at-risk families
Neighbourhood	• A commitment to invest in school nurses to ensure that at-risk children are identified early

LOW BIRTH WEIGHT

Introduction

Low birth weight (LBW) babies refers to babies weighing less than 2500g at birth irrespective of gestational age[28, 29]. It increases the risk of childhood mortality and developmental problems such as poorer cognition and health later in life[29-31]. LBW can be sub-categorised into term babies who are either small for gestation age (SGA) or pre-term babies (less than 37 weeks' gestation). The latter is the most common cause of death in newborn babies and the second leading cause of deaths in children under five[29].

Whilst non-modifiable risk factors such as ethnicity, infant sex, maternal parity and height influence the risk of having a LBW baby, so do modifiable risk factors such as deprivation, maternal weight, antenatal care and lifestyle choices. For example, in an analysis of the census, when comparisons were made between mothers from the most and the least deprived areas, an increased risk of having a LBW baby was noted controlling for their age at time of birth, ethnicity and limiting long-term illness[29]. By therefore addressing several modifiable risk factors across Newham, a proportion of LBW baby births can be avoided.

Policies and drivers

The percentage of term live and stillbirths born LBW in a locality is a key indicator in the Public Health England Children and Young People's Health (PHE CYP) Benchmarking Tool[32]. In addition, reducing the proportion of LBW babies is a key objective (Objective 2) of the Public Health Outcomes Framework (PHOF)[33].

In 2014, a comprehensive World Health Assembly plan on maternal, infant and young child nutrition was set specifying six global nutrition targets for 2025; the third being a 30% reduction of LBW babies[34]. When applied to the borough of Newham, it would correspond to Newham aiming to reduce its proportion of LBW babies from 4.4% of term live infants to 3.1%.

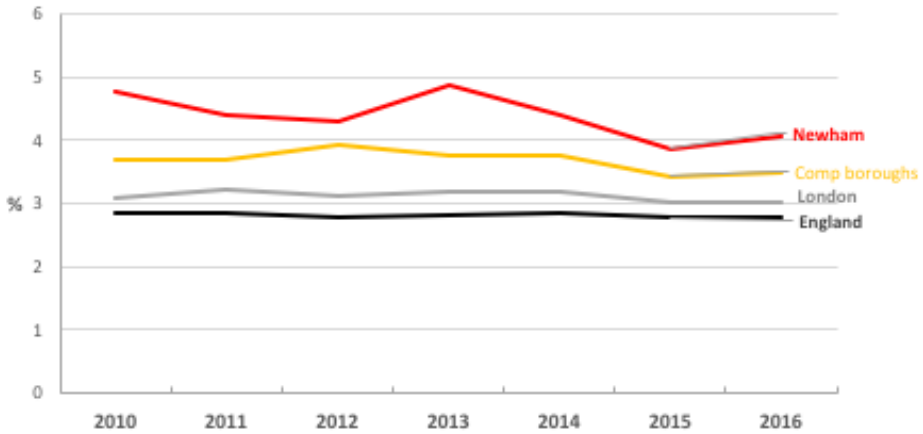
What's happening in Newham?

Summary

In Newham, the percentage of term live LBW babies (>37 weeks) has remained consistently higher than in England, London and comparator boroughs from 2010-2015.

FIGURE 27 – LOW BIRTH WEIGHT BABIES AS A % OF FULL TERM LIVES BABIES IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2016

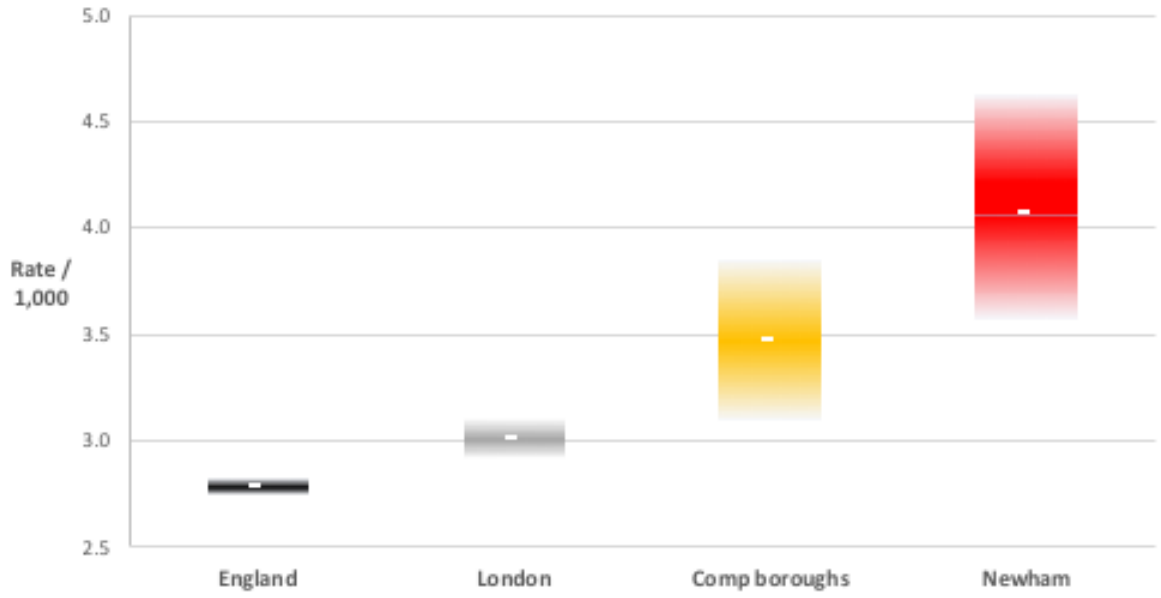
Source: PHOF indicator 20101



In 2016, this figure was 4.0% compared to 3.0% in London and 2.8% in England. Therefore, proportions across comparator boroughs (3.5%) and London were similar to Newham, only lower where proportions assessed across England (at the 95% confidence level).

FIGURE 28 – LOW BIRTH WEIGHT BABIES AS A % OF FULL TERM LIVE BABIES IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2015 (95% CONFIDENCE INTERVALS)

Source: PHOF indicator 20101



In contrast, when both live births and stillbirths are considered, Newham had the highest proportion of all comparators in 2015, with 10.0% compared to 7.6% in London and 7.4% in England.

Risk factors

A large proportion of Newham's residents are from deprived backgrounds and/or from BME groups, both risk factors for LBW babies. As described in the chapter "Smoking and Alcohol in Pregnancy", 1 in every 20 women in Newham reports being a smoker at the time of birth. We know that babies born to women who smoke are likely to weigh 200 grams less on average compared to their counterparts.

What services are available in Newham?

The Guttman Academic Partnership is a partnership involving UCLPartners, Newham CCG, Bart's Health NHS Trust, London Borough of Newham, Newham University Hospital and a local Patient and Public Involvement group. One of its projects, "Low Birth-Weight in Newham: Definitions, Antecedents and Prevention" features tackling the high rates of LBW babies in Newham.

An action workshop at the World Café was recently undertaken to develop a plan of action to prevent LBW babies, improve health outcomes for LBW babies, provide support for families with LBW babies and identify priorities to be implemented in the LBW research project. Twenty-two parents of LBW babies together with friends/extended families, professionals from Newham children's centres and health visitors.

The project focus has recently been expanded to healthy infant feeding including breastfeeding support, link to primary care data and inclusion of births outside the borough. A report on the pilot implementation

and evaluation of the prevention programme is due in March 2017 and plans to secure further funding to conduct a larger scale evaluation of the pilot programme and other related research is anticipated.

Progress since the last JSNA

Although the proportion of babies with LBW in Newham has been declining since last JSNA (4.79% vs. 3.87%), figures are still higher than across England. Action is required to accelerate the steady rate of decline[25].

Recommendations

Recent guidance from PHE, NICE and the Healthy Start Scheme advise the following recommendations to reduce the prevalence of LBW at borough level[23, 35-37]:

Level	Recommendations
Policy	• Effective antenatal work with mothers to support quitting smoking, alcohol consumption and substance misuse and maintaining a healthy weight in pregnancy • Ensure local education initiatives aimed at health professionals include information on the importance of folic acid supplements • Public health commissioners and managers should promote the Healthy Start scheme (as evident with Healthy Start vitamins now being included in the new specification for the Integrated Children's Community Health Service; distributed via Healthy Visitors) • Ensure an adequate supply of Healthy Start application forms are available and that the uptake of Healthy Start benefits is regularly audited • Ensure an adequate supply of both types of Healthy Start vitamin supplements (for women and for children from 6 months to 4 years) is available for distribution by health professionals when they see pregnant women and parents of children less than 4 years
Community	• Consideration should be given to adverts dedicated to the promotion of folic acid supplements • Consideration should be given to a scheme to community scheme to support less well-off mothers
Neighbourhood	• Consideration should be given to raising awareness of the importance of a healthy baby weight at local antenatal class groups including: Mums2be Meet-up in Stratford, NCT Essentials antenatal course in Stratford, Pregnancy Yoga Canning Town in West Ham and Best Start in Life (BSiL) hubs

BREASTFEEDING

Introduction

Breastfeeding has numerous short, long-term health and social benefits at the child (e.g. Allergies, obesity, and diabetes) and maternal level (e.g. Breast and ovarian cancer). Since 2002, the UK Department of Health (DH) formally adopted World Health Organisation (WHO) guidance recommending exclusive breastfeeding during the first six months of life[38, 39].

NICE public health guidance recommends that the UNICEF UK Baby Friendly Initiative should be the minimum standard for the NHS with a combination of interventions including antenatal education, peer support and, education and training for health professionals incorporated. However, despite both the impetus, there are still considerable variations in breastfeeding rates in the UK influenced by factors such as deprivation, ethnicity, social and cultural barriers[40].

Policies and drivers:

Within the PHOF, breastfeeding is a key indicator amongst the 'Health Improvement' section where the objective is for people to live healthy lifestyles, make healthy choices and reduce health inequalities[33].

NICE guidelines on maternal and child nutrition recommends that the UNICEF UK Baby Friendly Initiative be the minimum standard for the NHS with implementation of a structured programme to encourage breastfeeding within their organisations that includes training for health professionals, enlisting the help of breastfeeding peer supporters and antenatal education[10].

Within the DoH's Healthy Child Programme described in the chapter "Child Mortality", specific guidance on the best way to ensure the benefits of breastfeeding are optimised are also provided to families by health visitors.

What's happening in Newham?

Newham has been outperforming the capital and the country in mothers initiating breastfeeding within the first 48 hours of giving birth. In 2016/17 the figure stood at 96.7% of mothers in contrast to London's 90.6% and England's 74.5%. Newham also has the highest rates compared to comparator boroughs (89.2%) (at the 95% confidence level).

We note the changes in collection and publication of breastfeeding data, including strict quality assurance before returns are accepted. Public Health England currently shows incomplete data on breastfeeding rates at 6-8 weeks for 2014-2015, 2015-2016 and 2016-2017 (despite data previously available), as Newham University Hospital has been unable to report numbers of mothers totally and partially breastfeeding. Other CCGs and London boroughs are similarly placed; therefore, we are unable to report 6-8 week breastfeeding prevalence rates at the time of writing.

The following charts show the annual percentages of mothers initiating breastfeeding for Newham, London, England, and comparator boroughs, and the percentages for 2016-2017 with 95% confidence intervals. Data was not available for Newham and London for 2013-2014.

FIGURE 29 – BREASTFEEDING INITIATION IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2011 TO 2016-2017 (PERCENTAGE)

Source: PHOF

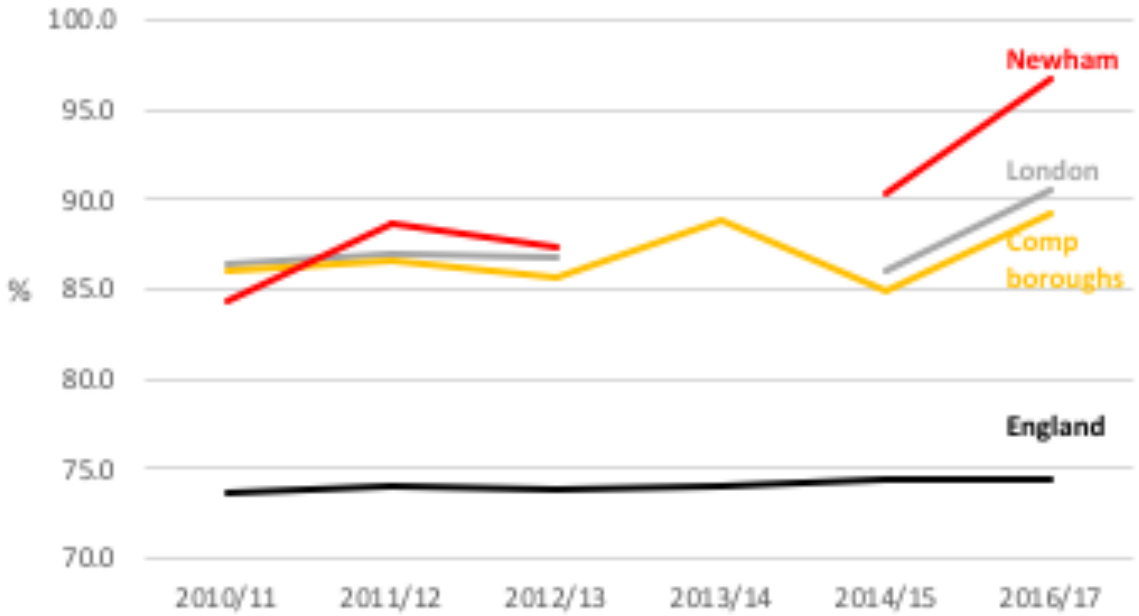
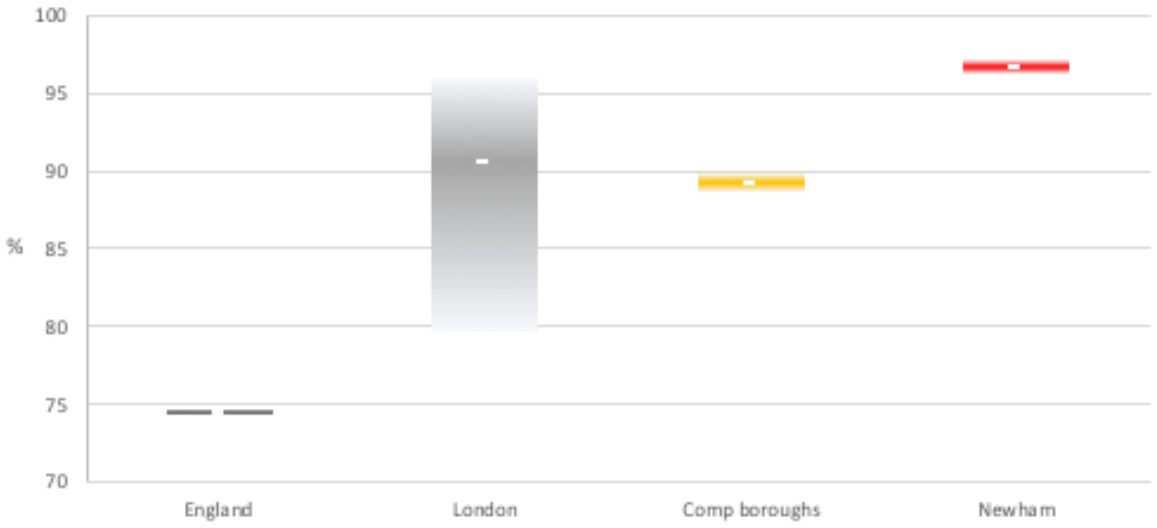


FIGURE 30 – BREASTFEEDING INITIATION IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2016-2017 (PERCENTAGE WITH 95% CONFIDENCE INTERVALS)

Source: PHOF



What services are available in Newham?

Newham commissions the Healthy Start Programme which aims to improve the health of pregnant women and families on benefits or low incomes. Women are sent vouchers that can be used to buy milk and food, and coupons which can be exchanged for free vitamins. Ongoing nutrition and health information relevant to the age of their oldest child are sent with the vouchers to reinforce the scheme's role as a public health measure. Newham also has the Best Start in Life (BSiL) 'guarantee' which begins with a strong health offer from pregnancy and provides support to parents throughout the early stages of their child's life. The programme integrates health, early learning and parenting practitioners and is delivered from a range of neighbourhood venues including a Children's Centre in each of Newham's eight community neighbourhoods, as well as a range of community venues including libraries and schools.

Progress since the last JSNA

Available breastfeeding initiation rate data was the same as last JSNA. In 2016-2017, percentage breastfeeding initiation in Newham was 96.7%, higher than both the London average (90.6%) and across England (74.5%). This followed an improvement from the 2012-2013 JSNA (when all comparator figures were last available), where breastfeeding initiation rates in Newham (87.4%) were similar to the London average (86.8%), but higher than the national average (73.9%).

Due to unavailability of 6-8 week breastfeeding rates, we are unable to comment on progress where the last JSNA cautioned continuation of support of breast feeding after initiation, as rates had fallen in the 2015-16 JSNA compared to the previous year's assessment[25].

Recommendations:

Recent guidance from PHE, NICE and the Healthy Start Scheme denote the following recommendations in improving breastfeeding at borough level[41, 42]:

Level	Recommendations
Policy	• Implement a structured programme that encourages breastfeeding, using UNICEF's Baby Friendly Initiative as a minimum standard • Adopt a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include: ○ Dedicated training for health professionals on support during breastfeeding ○ Breastfeeding peer-support programmes ○ Strengthen joint working between health professionals and peer supporters
Community	• Consideration should be given to activities to raise awareness of the benefits of – and how to overcome the barriers to – breastfeeding • Consideration should be given to starting community classes where pregnant women receive information on how to breastfeed
Neighbourhood	• Increase awareness of effective breastfeeding within the Day Assessment Units and Labour Wards

NEWBORN SCREENING: HEARING AND BLOODSPOT

Introduction

Newborn screening is offered to babies, to identify those at high risk of a specific condition for whom early treatment may be offered to improve their health outcomes, prevent severe disability and/or mortality.

In the UK, this constitutes a hearing test within the first three months of life and a blood spot test taken when the baby is five days old (usually by a community midwife) to identify conditions such as sickle cell, cystic fibrosis, congenital hypothyroidism and inherited metabolic diseases[43].

Policies and Drivers:

Together with achieving the national target of 100% of newborns screened, the latest PHE guidelines stress; (1) the importance of NBS screening in preventing severe disability and death, (2) steps to take if parents decline screening (plus new template letters), (3) why good quality samples are vital for accurate screening results, (4) how to complete the blood spot card and collect good quality spots first time and (5) what to do in different situations (i.e. baby who needs a repeat)[44].

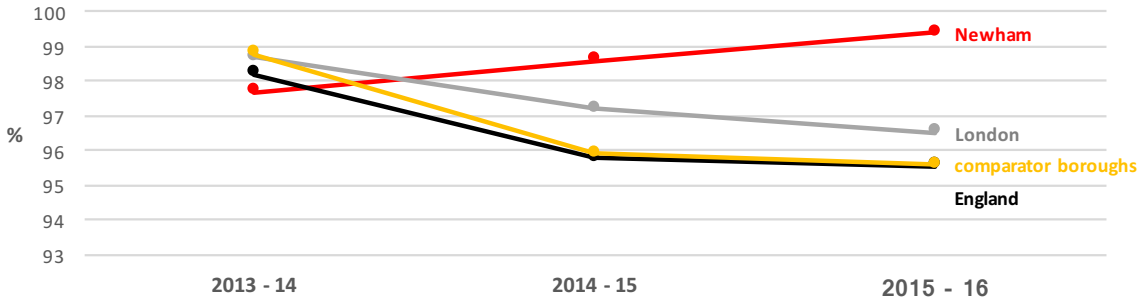
The UK National Screening Committee (UK NSC) advises on screening policy and supports the UK-wide implementation of screening programmes. Together with the Screening Quality Assurance Service, a significant component of this support is tailored towards providing information, education and training for multidisciplinary staff delivering, commissioning and performance-managing screening[45].

What's happening in Newham?

In 2013-2014, Newham had the 5th lowest percentage of blood spot screening coverage in England at 98%. In 2015-2016 Newham's coverage had improved so that it was higher than all the comparators, in above the "achievable" 99% level, at 99.4%.

FIGURE 31 – NEWHAM BLOOD SPOT SCREENING COVERAGE 2013-2014 TO 2014-2016 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

Source: KPI Reports



Note that some 2014-2015 data for Newham was missing, so the percentage shown relates to Quarter 4 of that year.

Blood spot screening figures align with London's positioning as above average for precentage of regional antenatal sickle cell and thalassaemia screens. London placed highest at 99.8%, above the national average of 99.1%.

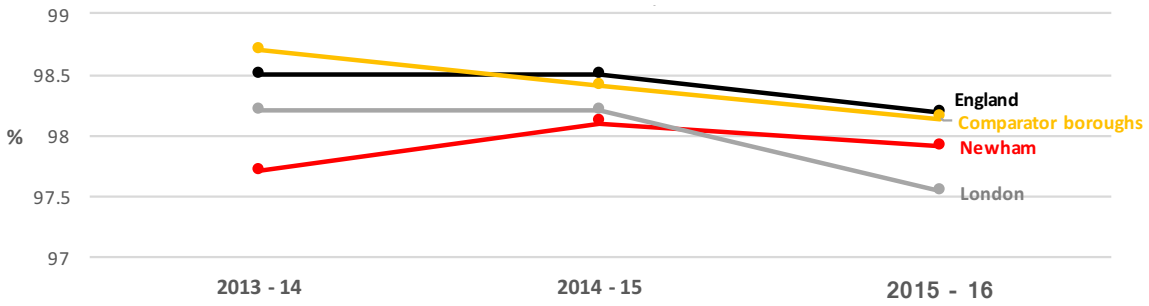
FIGURE 32 – ANTENATAL SICKLE CELL AND THALASSAEMIA SCREENING REGIONAL COVERAGE 2015-2016

Source: PHE Fingertips

The percentage of screening coverage for newborn hearing in 2015-2016 was 97.9% similar to proporions screened in England (98.2%), London (98.2%) and comparator boroughs (98.1%)[33].

FIGURE 33 – NEWBORN HEARING SCREENIGN COVERAGE 2013-2014 TO 2015-2016

Source: KPI Reports



What services are available in Newham?

As described in the chapters above, health visitors and community midwives routinely encourage young families to participate in the newborn bloodspot and hearing screening tests as part of the Healthy Child Programme in Newham.

Progress since the last JSNA

Proportions of newborn blood spot screening coverage have increased since last JSNA from 98.6% to 99.4%. The percentage of babies screened within four weeks of birth has been steadily increasing from 97.7% since the 2013-2014 JSNA.

Proportions of newborns screened in this reporting period (97.9%, 2015-2016) is similar to that of previous JSNAs (98.1% in 2014-2015; 97.7% in 2013-2014)[25, 26].

Recommendations:

Guidance from NICE, PHE and DH around newborn bloodspot and hearing screening focusses on raising parental awareness and ensuring uptake is maximised[44, 46]:

Level	Recommendations
Policy	• Raise awareness of the NHS NBS via health visitors (usually community midwives) • Ensure parents have access to the pre-screening booklet at least 24 hours before taking the sample. If not, ensure a copy of the booklet is available to parents • A healthcare professional should offer screening and record parental decision. They should explain the procedure to parents and record in the maternity/professional record that NBS has been discussed and recommended, the booklet given and verbal consent sought • Ensure each baby missed from the NHS NBS Programme is tracked with clear reasons for refusal documented • Parents should be asked if they wish to be contacted about research linked to the screening programme
Community	• Raise awareness of the NHS NBS in those areas with low uptake, particularly regarding sickle cell disease in the African and Caribbean population

IMMUNISATIONS

Introduction

According to the World Health Organization, the two public health interventions that have had the greatest impact on world health are clean water and vaccines. In the UK, responsibility for the vaccine programmes are jointly held by the Department of Health, Public Health England and NHS England with schedule changes issued by the Joint Committee on Vaccines and Immunisation.

There have been numerous changes to the routine childhood immunization schedule over the past decade with more recent variations including introduction of the Meningococcal B (MenB) and Rotavirus vaccines in infants under 1 years of age, Influenza (i.e. "Flu") vaccine in children between 2 – 4 years of age, Human Papilloma Virus (HPV) vaccine in females between 12 – 13 years of age and the removal of the Meningococcal C (MenC) vaccine given at three months of age. A summary of the current immunization schedule is listed in *Figure 34*[47].

FIGURE 34 – ROUTINE IMMUNISATION SCHEDULE 2016

The routine immunisation schedule from Spring 2016

Age due	Diseases protected against	Vaccine given and trade name		Usual site[1]
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Prevenar 13	Thigh
	Meningococcal group B (MenB)[2]	MenB[2]	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
Twelve weeks	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	Meningococcal group C (MenC)	MenC	NeisVac-C	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	MenB[2]	MenB[2]	Bexsero	Left thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
One year old	Hib and MenC	Hib/MenC booster	Menitorix	Upper arm/thigh
	Pneumococcal (13 serotypes)	PCV booster	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMR VaxPRO[3] or Priorix	Upper arm/thigh
	MenB[2]	MenB booster[2]	Bexsero	Left thigh
Two to six years old (including children in school years 1 and 2)	Influenza (each year from September)	Live attenuated influenza vaccine LAIV[4]	Fluenz Tetra[3]	Both nostrils
Three years four months old	Diphtheria, tetanus, pertussis and polio	DTaP/IPV	Infanrix IPV or Repevax	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMR VaxPRO[3] or Priorix	Upper arm
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (two doses 6-24 months apart)	Gardasil	Upper arm
Fourteen years old (school year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y disease	MenACWY	Nimenrix or Menveo	Upper arm
65 years old	Pneumococcal (23 serotypes)	Pneumococcal polysaccharide vaccine (PPV)	Pneumovax II	Upper arm
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple	Upper arm
70 years old	Shingles	Shingles	Zostavax[3]	Upper arm (subcutaneous)

[1] Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book. All injected vaccines are given intramuscularly unless stated otherwise.
[2] Only for infants born on or after 1 May 2015
[3] Contains porcine gelatine
[4] If LAIV (live attenuated influenza vaccine) is contraindicated and child is in a clinical risk group, use inactivated flu vaccine

Policies and Drivers

Immunisations for children are a key PHOF objective with a comprehensive surveillance programme; Cover of Vaccination Evaluated Rapidly (COVER) set up nationally to review vaccination coverage in the UK[48].

NICE guidelines on reducing differences in uptake in under 19s (PH21, 2009) recommend; (1) improving access to immunisation services, (2) providing parents and young people with tailored information and support, (3) check children and young people's immunisation status during health appointments and when they join nurseries, playgroups, schools and further education colleges, and offer them vaccinations and (4) ensure babies born to hepatitis B-positive mothers are given all recommended doses of the vaccine on time, a blood test to check for infection and, where appropriate, hepatitis B immunoglobulin[49].

What's happening in Newham?

Between 2014 and 2014-2015 Newham lagged behind England in coverage on several 0-5 year old immunisations. These include at:

One year:

- DTaP/IPV/Hib
- PCV

Two years:

- DTaP/IPV/Hib
- MMR (one dose) (higher than London)

Five years:

- Hib/Men C booster
- MMR 1st dose
- MMR 2nd dose (and behind London)

TABLE 13 - NEWHAM PERFORMANCE OF ROUTINE CHILDHOOD IMMUNISATIONS - 0-5 YEARS AND 12-13 YEAR OLD FEMALES

Source: Public Health England (Child Health Profiles Fingertips data[50]

Source for HPV: Gov.uk

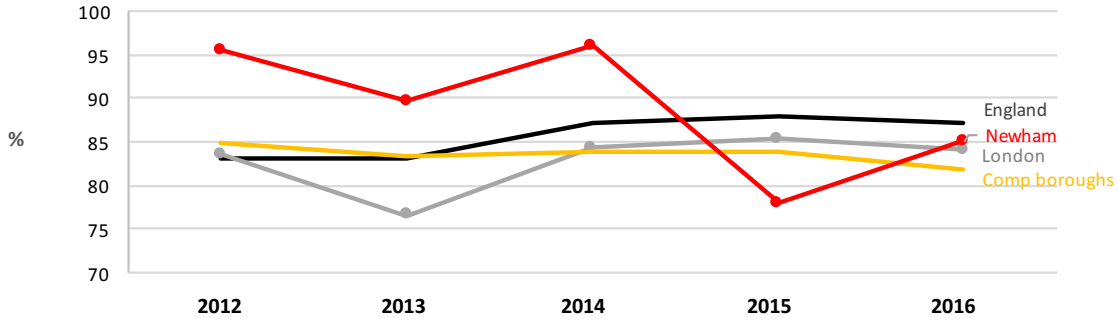
Indicator		Year	Coverage (%)		
			Newham	London	England
One year	DTaP/IPV/Hib	2015/16	87.8	-	93.6
	PCV	2015/16	87.7	-	93.5
	Men C	2015/16	90.1	-	N/A
	Hep B	2014/15	98.2	-	-
Two years	DTaP/IPV/Hib	2015/16	92.5	-	95.2
	Hib/Men C Booster	2015/16	86.9	-	91.6
	MMR (one dose)	2014/15	89.1	87.3	92.3
	PCV booster	2015/16	86.2	-	91.5
	Hep B	2014/15	94.0	-	-
Five years	DTaP/IPV/Hib				
	DTaP/IPV/Hib booster				
	Hib/Men C Booster	2014/15	87.7	87.3	92.4
	MMR 1st dose	2015/16	92.4	91.1	94.8
	MMR 2nd dose	2015/16	77.3	81.7	88.2
12-13 years (females)	HPV	2015/16	87.5	83.9	87

There is variation in immunisation uptake among certain general practices in Newham (Detailed further in *Tables 1-3* in the Appendix) with uptake varying from 0% in the Meningitis C vaccine to 100% in the PCV vaccine at 12 months. Whilst this could be partly due to the transient nature of Newham's population that makes it difficult to keep track of certain immunisations (e.g. those that require two or more vaccinations for a complete course), further investigation and action to reduce this variance remains necessary.

Amongst looked after children, immunisations in Newham saw an increase to 85.1%, recovering from a drop to 78% in 2015. Prior to this, Newham ranked above comparator boroughs in 2012 (95.6%), 2013 (89.7%) and 2014 (96.1%) compared to rates in comparator boroughs (2012 – 85.0%; 2013 – 83.4%; 2014 – 83.8%), across London (2012 – 83.5%; 2013 – 76.5%; 2014 – 84.3%) and England (2012 – 83.1%; 2013–83.2%; 2014 – 87.1%).

FIGURE 35 - LOOKED AFTER CHILDREN (LAC) WITH UP TO DATE IMMUNISATIONS IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

Source: PHE Fingertips



In 2016, Newham's 85.1% coverage of LAC immunisation was comparable to benchmarks London (84.1%) and comparator boroughs (81.8%), although below figures for England (87.2%).

What services are available in Newham?

As discussed in the chapter "What is a healthy pregnancy?", Newham offers Maternity Mates as part of the Women's Health and Family Services (WHFS) which focusses on recruiting, training and matching-up volunteer Maternity Mates with pregnant women in need of extra support.

In addition, Newham has a school nursing service for all school-aged children providing a school entry health assessment. Finally, as discussed in the chapter "Breastfeeding", health visitors in Newham routinely discuss vaccinations with new families; appointments which may be aided by the use of a personal child health recorded (PCHR) are given to parents before or after birth, usually in the shape of a "red book", which is used to record what medications and vaccinations a baby receives[51].

Progress since the last JSNA

Since the 2015-2016 JSNA, the only notable improvement in vaccination uptake is at one year old, MenC immunisations: an increase from 85.7% last JSNA to 90.1% this reporting season is marked compared to modest increases in MMR dose 1 at 3 years (91.5% to 92.4%) and overall modest decreases or plateaued uptake[52]. Immunisations in looked after children were not reported last JSNA: in 2015, there was a marked drop in rates to 78% compared to previous years (96% in 2014, 89% in 2013 and 95% in 2012), falling for the first time, below all benchmarks. In this reporting period, 2016 figures demonstrated a recovery in immunisation rates in LAC, rising to 85% in line with London-wide figures.

Recommendations:

Detailed guidance to improve the uptake of vaccinations in Newham are provided in the NICE guidelines on reducing differences in uptake in under 19s (PH21, 2009) with recommendations to be implemented at all levels from health visiting and school nursing teams to commissioners and public health teams[49, 53]. These include:

Level	Recommendations
Policy	• Ensure there is an identified healthcare professional in every GP practice who is responsible – and provides leadership – for the local childhood immunisation programme

	• Ensure all staff involved in immunisation services have access to the Green book. Also ensure updates to the childhood immunisation programme and schedule are monitored and services adapted appropriately
	• Ensure there is an identified person responsible for coordinating the local hepatitis B vaccination programme for babies at risk of hepatitis B infection
	• Develop and implement a clear process for the local infant hepatitis B vaccination programme
	• Ensure antenatal, postnatal, neonatal, paediatric, primary care and community support teams communicate effectively and share information so that the children and families affected can be contacted and followed up
	• Improve access to immunisation services. This could be achieved by extending clinic times, ensuring children and young people are seen promptly and by making sure clinics are child- and family-friendly
	• Ensure enough immunisation appointments are available so that all local children and young people can receive the recommended vaccinations on time
	• Send tailored invitations for immunisation. When a child or young person does not attend appointments, send tailored reminders and recall invitations and follow them up by telephone or text message
	• Provide parents and young people with tailored information, advice and support to ensure they know about the recommended routine childhood vaccinations and the benefits and risks. This should include details on the infections they prevent. Information should be provided in different formats, for example, for those whose first language is not English
	• Ensure parents and young people have an opportunity to discuss any concerns they might have about immunisation. This could either be in person or by telephone and could involve a GP, community paediatrician, health visitor, school nurse or practice nurse
	• Ensure young people fully understand what is involved in immunisation so that those who are aged under 16, but considered sufficiently capable, can give their consent to vaccinations, as advised in the 'Green book'
	• Ensure young people and their parents know how to access immunisation services
	• Consider home visits to discuss immunisation with parents who have not responded to reminders, recall invitations or appointments. Offer to give their children vaccinations there and then (or arrange a convenient time in the future). Such visits could include groups that may not use primary care services, for example, travellers or asylum seekers
	• Check the immunisation status of children and young people at every appropriate opportunity. Checks should take place during appointments in primary care (for example, as part of a child health review), hospital in- or outpatient and accident and emergency departments, walk-in centres or minor injuries units. Use the personal child health record (PCHR, also known as the 'Red book') as appropriate. If any vaccinations are outstanding:
	  ○ discuss them with the parent and, where appropriate, the young person. Where they have expressed concerns about immunisation and this is documented, these appointments should be used as an opportunity to have a further discussion
	  ○ offer vaccinations by trained staff before they leave the premises, if appropriate. In such cases, notify the child or young person's GP, health visitor or local child health information department so that records can be updated
	  ○ and, if immediate vaccination is not possible, refer them to services where they can receive any outstanding immunisations.
	• Ensure health professionals who deliver vaccinations have received training that complies with the 'National minimum standard for immunisation training
	• Ensure staff are appropriately trained to document vaccinations accurately in the correct records

Community	• Raise awareness of the National immunization schedule • Encourage a campaign warning mothers of the dangers of opting out of or not adhering strictly to the National immunization programme
Neighbourhood	• The Healthy Child team, led by a health visitor working with other practitioners, should check the immunisation record (including the personal child health record) of each child aged up to 5 years. They should carry out this check when the child joins a day nursery, nursery school, playgroup, BSiL children's centre or when they start primary school. The check should be carried out in conjunction with childcare or education staff and the parents • School nursing teams, working with GP practices and schools, should check the vaccination status of children and young people when they transfer to a new school or college. They should also advise young people and their parents about the vaccinations recommended at secondary school age • If children and young people are not up-to-date with their vaccinations, school nursing teams, in conjunction with nurseries and schools, should explain to parents why immunisation is important. Information should be provided in an appropriate format (for example, as part of a question and answer session). School nursing teams should offer vaccinations to help them catch up, or refer them to other immunisation services • Head teachers, school governors and managers of children's services should work with parents to encourage schools to become venues for vaccinating local children. This would form part of the extended school role

ORAL HEALTH

Introduction

Oral health problems include gum (periodontal) disease, tooth decay (dental caries), tooth loss and oral cancers (NICE guidance PH 55, Oct 2014). Dental treatment is a significant cost, with the NHS in England spending £3.4 billion per year on dental care (with an estimated additional £2.3 billion on private dental care)[54].

Despite significant investment in childhood education programmes, the percentage of children with decayed, missing or filled teeth (DMFT), a marker of child dental health, remains high with 28% of five-year-old children across England having observable decay with consequences such as pain, sleep loss, time off school and general surgery[54].

In a recent 2015 report by The Faculty of Dental Surgery at the Royal College of Surgeons in England, a persistently high rate of hospitalisations for dental caries in 5-9 year olds across England was observed with significant regional inequalities identified across water fluoridation and access to NHS dental care[55].

Policies and drivers

National

Tooth decay in five-year old children is a key indicator in the PHOF[33]. In addition, the NHS Outcomes Framework includes indicators related to patients' experiences of and access to NHS dental services. The Children and Young People's Health Outcomes Forum report published in 2012 and its 2014 annual report recommended improved integration and greater action to reduce regional variation in child dental health outcomes[33].

Finally, as a way of assessing progress, the Children's Dental Health (CDH) survey is carried out in children aged 5, 8, 12 and 15 in schools randomly every 10 years to assess progress in improving oral health across the UK[54].

Local

Oral health has been discussed at the Health and Wellbeing Board with a local Oral Health Factsheet produced for information and guidance for commissioners in December 2015[56].

What's happening in Newham?

Tooth Decay

The percentage of children with tooth decay in Newham fell from 39% in 2011-2012 to 28.9% in 2014-2015. This reduction resulted in lower levels of tooth decay than comparator boroughs who previously held lower rates than Newham (Barking and Dagenham: 2011-2012, 35% and 2014-2015, 31.4%; Waltham Forest 2011-2012, 26.5% and 2014-2015, 29.8%). While there has been a global reduction in the percentage of five-year olds with tooth decay across England, the rate of decline in Newham is proportionally greater than that in London or England overall.

Amongst comparator boroughs, Newham performed well in 2014-2015 results of percentage of five-year olds with tooth decay, with a rate of 28.9% only second to Hackney's 27%.

FIGURE 36 – CHANGES IN THE PERCENT OF CHILDREN AGED 5 WITH ONE OR MORE DECAYED, MISSING OR FILLED TEETH DURING 2011-2012 AND 2014-2015 IN NEWHAM, COMPARATOR BOROGUHS, LONDON AND ENGLAND

Source: PHE School Age Profiles

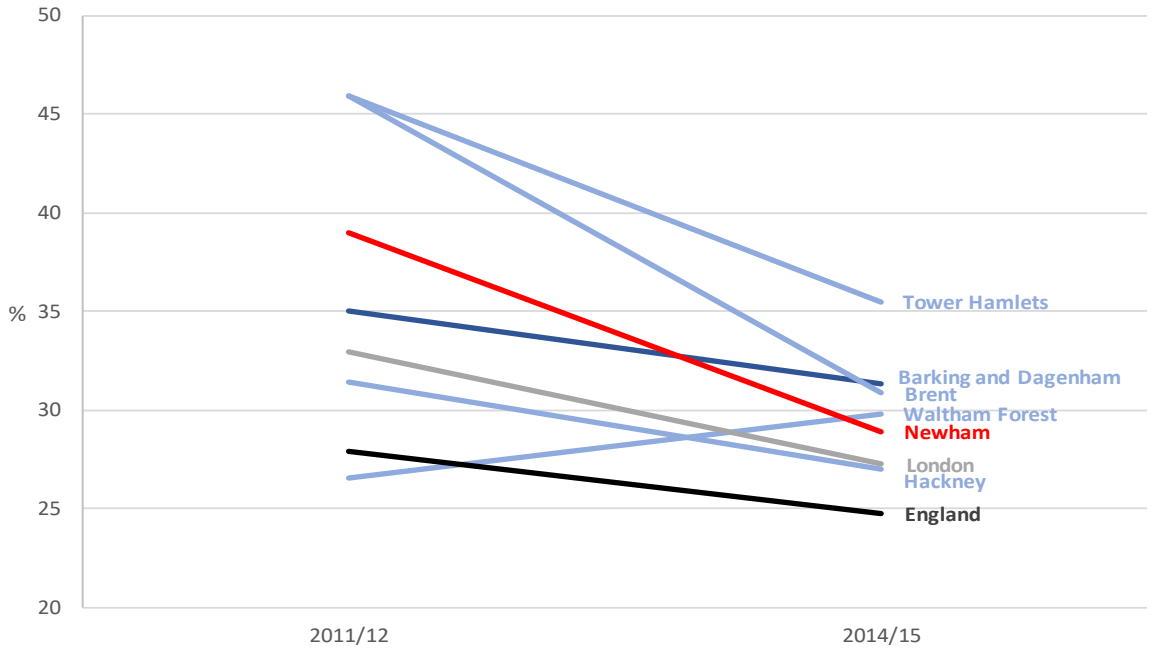
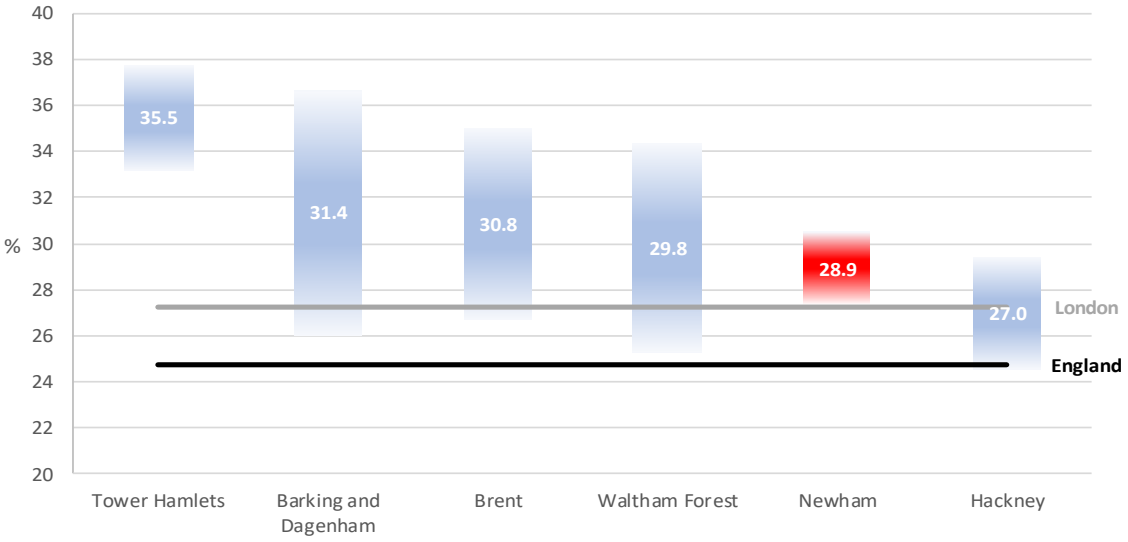


FIGURE 37 – CHANGE IN THE PERCENT OF CHILDREN AGED 5 WITH ONE OR MORE DECAYED, MISSING OR FILLED TEETH BETWEEN 2014-2015 IN NEWHAM, COMPARATOR BOROGUHS, LONDON AND ENGLAND (95% CONFIDENCE INTERVALS)

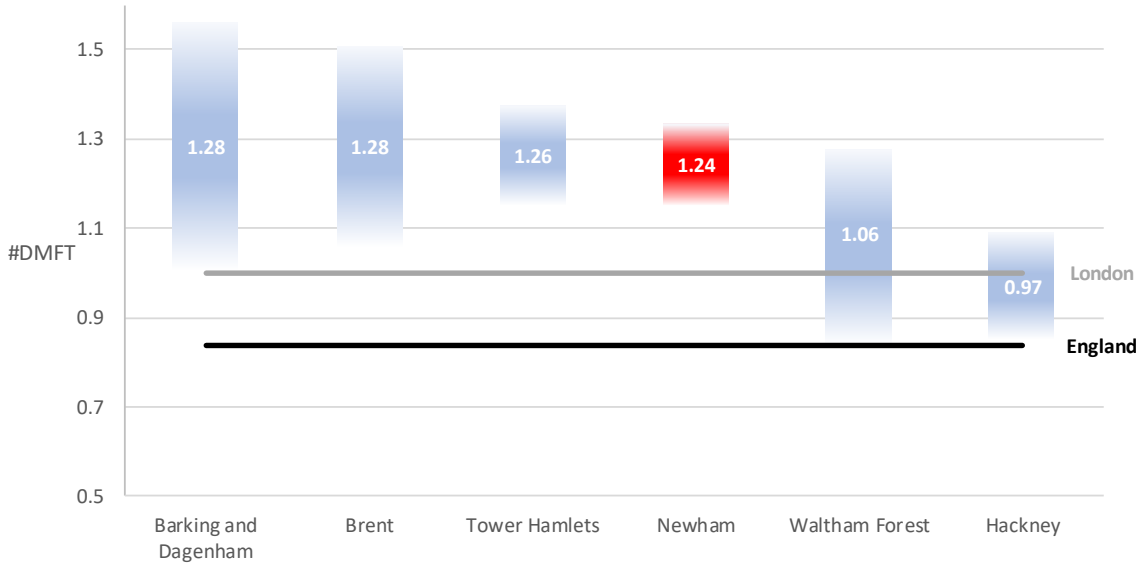
Source: PHE School Age Profiles



The average number of decayed, missing or filled teeth (DMFT), a marker of oral health, in five-year-olds during 2011-2012 in Newham was 1.6: in 2014-2015 it had fallen to 1.2. This is significantly higher than the rates for London (1.2 in 2011/12 and 1.0 in 2014/15) and England (0.9 in 2011-2012 and 0.84 in 2014-2015 respectively) overall[50].

FIGURE 38 – TOOTH DECAY IN CHILDREN AGED 5, AVERAGE NUMBER OF TEETH AFFECTED PER CHILD IN 2014-2015 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND (95% CONFIDENCE INTERVALS)

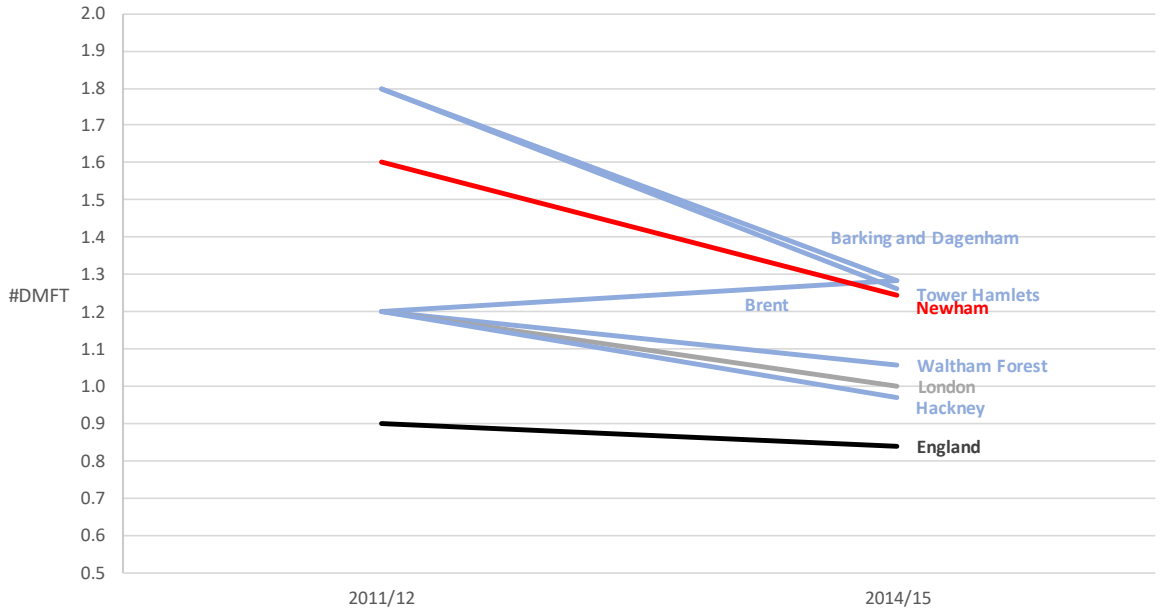
Source: PHE School Age Profiles



While there has been a global reduction in the average number of decayed, missing or filled teeth in five-year olds across the nation, the reduction in Newham is proportionally greater than those in London and England overall.

FIGURE 39 – TOOTH DECAY IN CHILDREN AGED 5, CHANGE IN THE AVERAGE NUMBER OF TEETH AFFECTED PER CHILD BETWEEN 2011-2012 AND 2014-2015 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

Source: PHE School Age Profiles

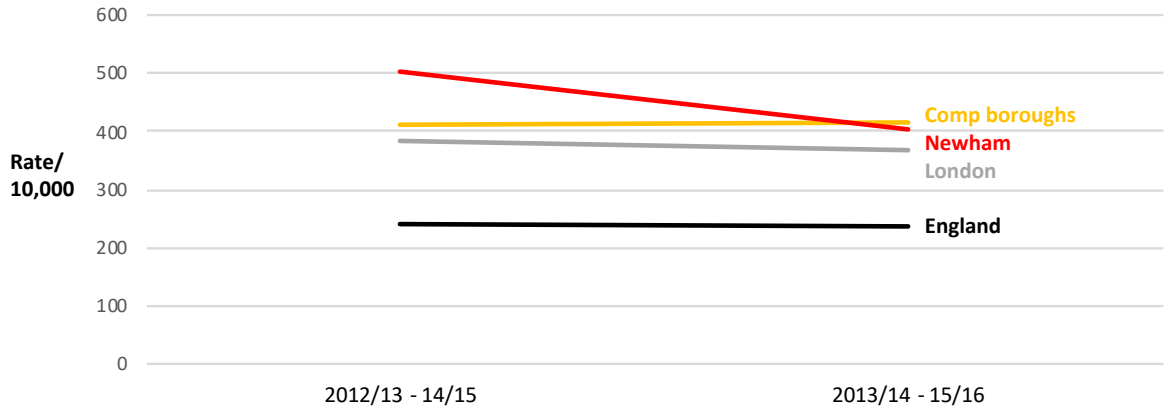


Hospital Admissions

Figures for hospital admissions for treatment of dental caries of children aged 0 – 4 years in Newham, 2013-2014 to 2015-2016, stood at 403.5/10,000 (n = 341 children), a reduction from the 504.5/10,000 (n = 415 children) rate of 2012-2013 to 2014-2015. In this 2013-2014 to 2015-2016 reporting period, Newhams' rates were similar to comparator boroughs (414.3/10,000), but higher than those across London (368/10,000) and significantly higher than those across England as a whole (241.4/10,000)[50].

FIGURE 40 – ADMISSIONS FOR DENTAL CARIES IN CHILDREN AGED 0-4 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2012-2015 TO 2013-2016 RATE/10000

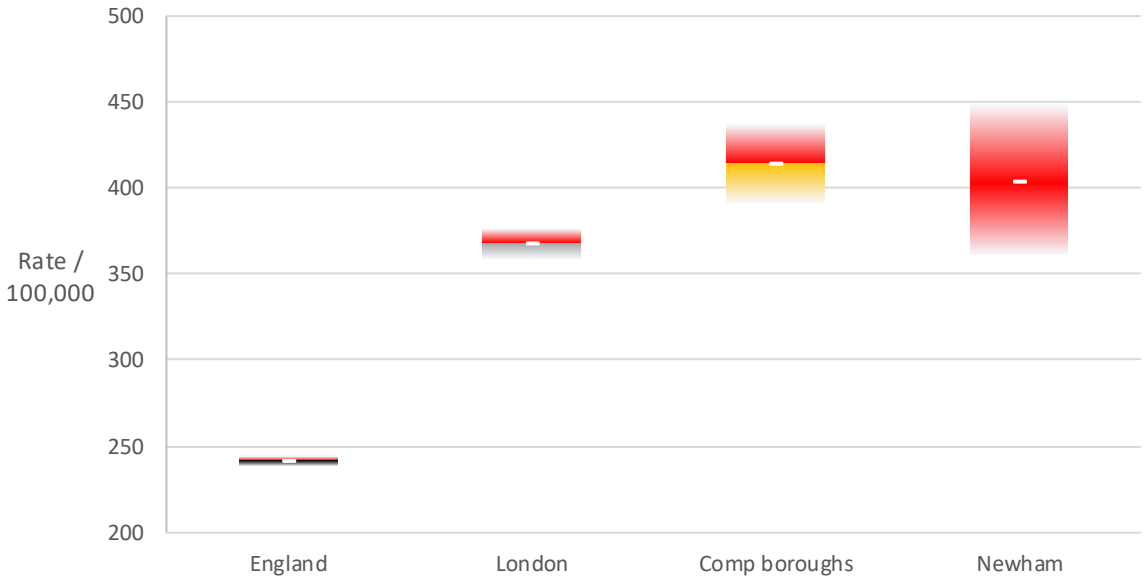
Source: PHE Fingertips indicator 92799



The following chart shows the most recent figures on admission rates for dental caries in children aged 0-4 years between 2012-2013 to 2013-2014 and 2013-2014 to 2015-2016 for Newham, London, England, and comparator boroughs. Hospital admission rates with 95% confidence intervals are displayed for each area.

FIGURE 41 – HOSPITAL ADMISSION RATES FOR DENTAL CARIES, CHILDREN 0-4 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2013-2015 RATE/100000 (95% CONFIDENCE INTERVALS)

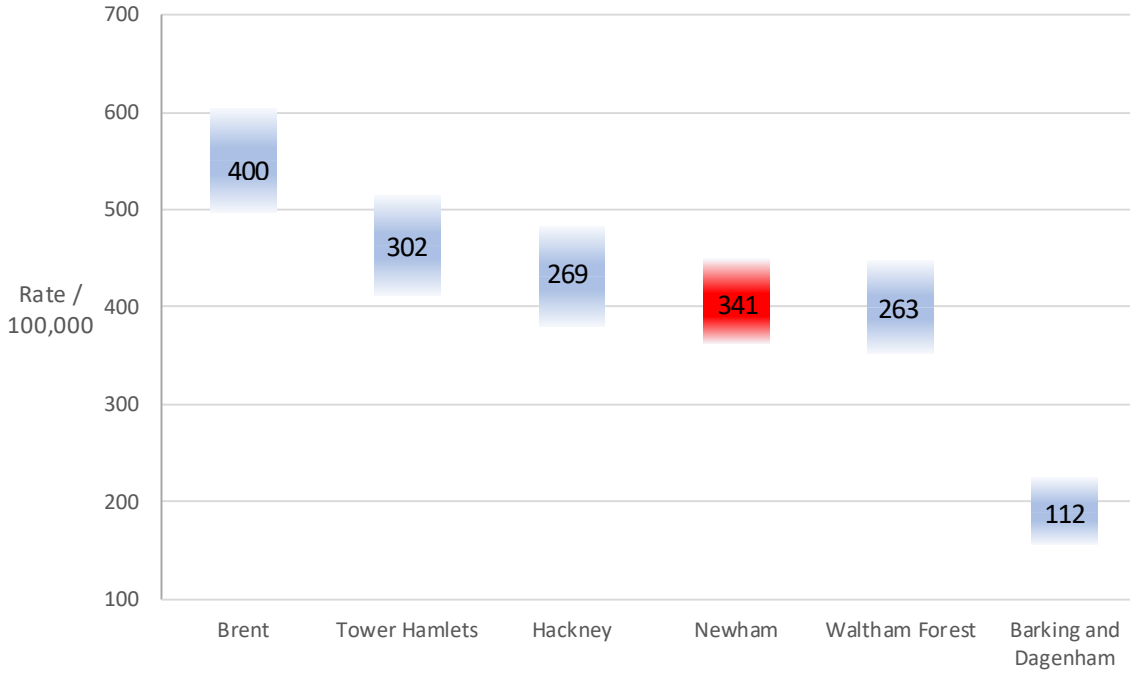
Source: PHE Fingertips indicator 92799



Amongst comparator boroughs, Newham's rates were significantly lower than Brent's (550/10,000), but higher than Barking and Dagenham's (190.1/10,000)[50].

FIGURE 42 – CHANGES IN HOSPITAL ADMISSION RATES FOR DENTAL CARIES, CHILDREN 0-4 IN NEWHAM AND COMPARATOR BOROUGHS RATE/10000 (95% CONFIDENCE INTERVALS)

Source: PHE Fingertips indicator 92799



Actual admission rates for each borough are indicated in *Figure 42*.

What services are available in Newham?

Newham is involved in several projects which includes the Fresh Start Project (partnership between Newham and GlaxoSmithKline) aimed at promoting good oral health in children born in Newham in the London 2012 Olympic year and the National Smile Month pioneered by the British Dental Health Foundation where, for example in 2015, dentists in Newham visited local supermarkets to hand out leaflets and speak to shoppers.

Newham is participating in The Bedtime Brush and Read Together to Sleep (BBaRTS) Children's Healthy Trial; a trial investigating whether children's dental health can be improved by increasing parents' confidence to develop and maintain healthy behaviours for their children[57]. As part of Primary Care Dental, NHSE also commissions the delivery of an Oral Health Promotion programme, which included participation in community events, alongside a fluoride varnishing scheme for children, provided by the Kent Community Health NHS Foundation Trust.

Progress since the last JSNA

Compared to the 2015-2016 JSNA, there have been improvements in the oral health of five-year old children. The percentage of children with tooth decay in Newham fell to 28.9% in the most recent period (2014-2015) from 39% in the last reporting period (2011-2012). Similarly, hospital admissions for treatment of dental caries of children aged 0 – 4 years in Newham, were lower in this JSNA (403.5/10,000, 2013-2014 to 2015-2016), compared to the last (504.5/10,000, 2012-2013 to 2014-2015).

In the most recent 2015 Child Dental Health (CDH) survey, 28% of five-year olds in Newham were found to have had decay, compared with 31% in 2013. Despite this reduction, rates of decay were higher than across England where 25% of 5 year olds were found to have tooth decay[25, 26, 58].

Recommendations:

PHE and NICE have both issued numerous recommendations to improve oral health of children and young people[59, 60]:

Level	Recommendations

Policy	• Addressing children's access to NHS dental services with attention to vulnerable groups highlighted
	• Targeted peer (lay) support groups/oral health workers
	• Set up a group that has responsibility for an oral health needs assessment and strategy. Ensure the following contribute to the work of the group:
	  ○ a consultant in dental public health
	  ○ a local authority public health representative
	  ○ an NHS England commissioner of local dental services
	  ○ a representative from a local professional dental network
	  ○ a representative from the local dental committee
	  ○ representatives from children and adult social care services
	  ○ a local Healthwatch representative
	  ○ a senior local government representative to lead on, and act as an advocate for, oral health
	  ○ representatives from relevant community groups

Community	• Oral health training for the wider professional workforce (e.g. health, education) • Integration of oral health into targeted home visits by health/social care workers • Targeted provision of toothbrushes and tooth paste (i.e. postal or through health visitors)

Neighbourhood	• Healthy food and drink policies in childhood settings
	• Ensure all public services promote oral health by:
	  ○ Making plain drinking water available for free.
	  ○ Providing a choice of sugar-free food, drinks (water or milk) and snacks (including fresh fruit), including from any vending machines on site
	• Review other 'levers' that local authorities can use to address oral health and the wider social determinants of health, for example, local planning decisions for fast food outlets

CHILDCARE AND EARLY EDUCATION

Introduction

Providing children with good-quality education and care in their earliest years can help them succeed at school and later in life. This contributes to creating a society where opportunities are equal regardless of background. Affordable and easily accessible childcare is also crucial for working families by helping to create more opportunities for parents who wish, or need, to work and raise children at the same time.

Policies and Drivers:

National

Official Government policy includes improvements to qualifications for the early years workforce, the introduction of early years educator qualifications, Teach First and working alongside OFSTED to reform the inspection system and challenge weak providers to improve more quickly[61].

Local

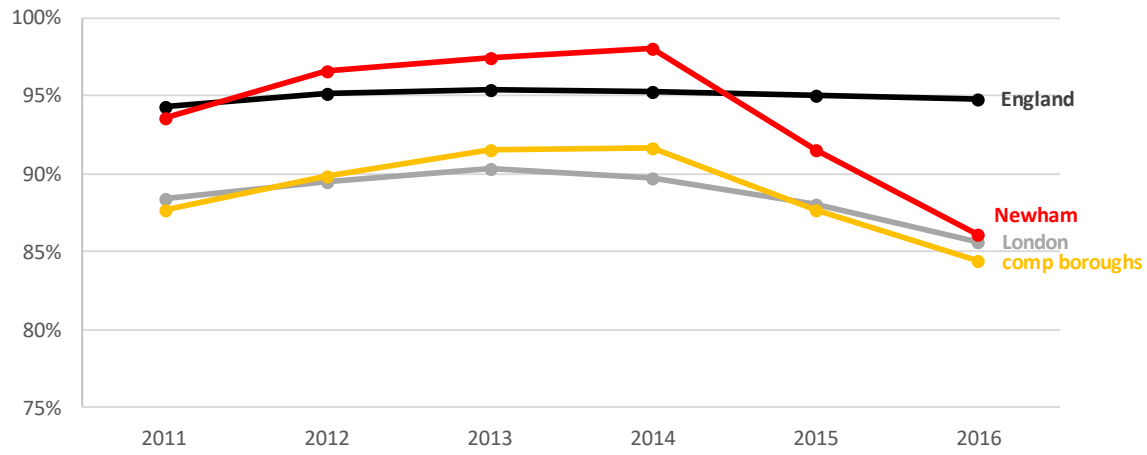
Between 2010-2015 as part of government policy, Newham extended early learning places for two-year-olds; helped parents arrange more informal childcare by allowing them to pay a neighbour or relative not registered with Ofsted for up to three hours of childcare a day; introduced new childminder agencies which provide rigorous training and match childminders with parents; encouraged more schools to offer nursery provision and extend provision from 8.00am to 6.00pm; helped schools to offer affordable after-school and holiday care; either alone or working with private or voluntary providers; and reduced regulations to help good nurseries expand their business[61].

What's happening in Newham?

From consistently high percentages of young children in Newham benefiting from funded early education places for three and four year olds between 2012 and 2014 (over 95%), above the national average, percentages in Newham were at an all-time low in 2016, at 86.2%[62]. This figure was fell below the average across England (94.8%) and approached those of comparator boroughs (84.4%) and across London (85.7%).

FIGURE 43 – PERCENTAGE OF CHILDREN BENEFITING FROM FUNDED EARLY EDUCATION PLACES 2011-2016 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

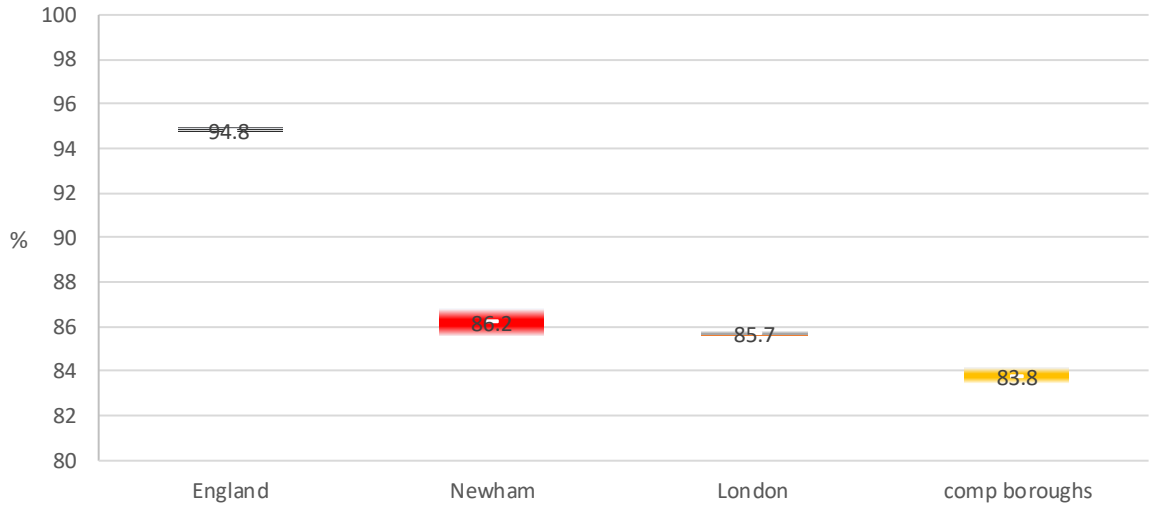
Source: National statistics SFR23_2016_UD



The percentage of children in Newham benefiting from funded early education in 2016, was significantly lower than across England, but significantly higher than in comparator boroughs (at the 95% confidence level). There was no significant difference in figures between Newham and across London.

FIGURE 44 – PERCENTAGES OF CHILDREN BENEFITING FROM FUNDED EARLY EDUCATION PLACES 2016 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND (95% CONFIDENCE INTERVALS)

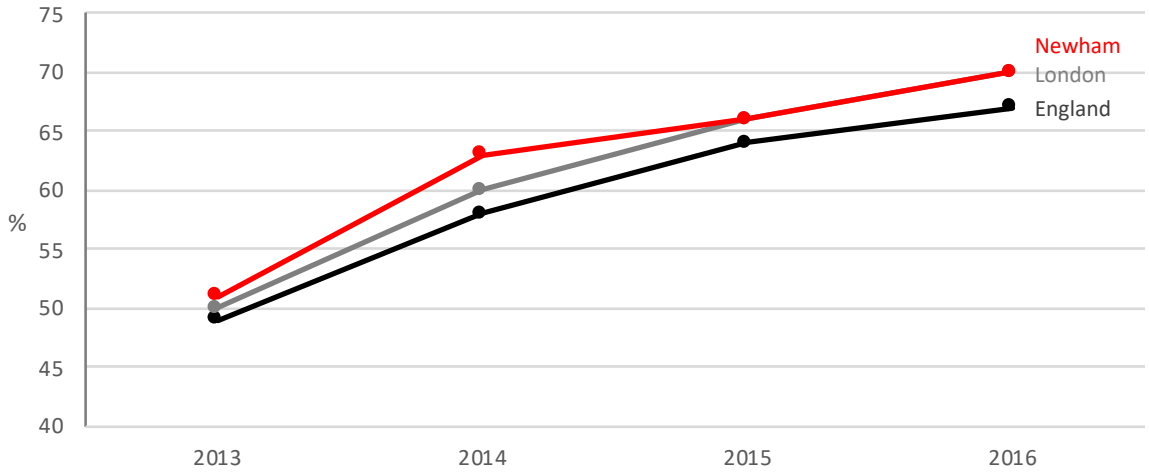
Source: National statistics SFR23_2016_UD



Whilst a year on year progress in attaining Early Years Foundation Stage (EYFSP) assessments reached peaked at 70% in 2016 (66% in 2015, 60% in 2014 and 50% in 2013), in line with the upward trend in London and England, a substantial gap to the target of 100% remains. Early intervention preceding three years of age is indicated to address this unmet need[62]. Confidence intervals and comparator borough data cannot be included as the source data are pre-calculated percentages at local authority level, and raw data are required to conduct such analyses.

FIGURE 45 – PERCENTAGE OF 0-5 YEAR OLDS ACHIEVING AT LEAST THE EXPECTED STANDARD IN EYFSP TEACHER ASSESSMENT 2013-2016 IN NEWHAM, LONDON AND ENGLAND

Source: ONS SFR20-2016 additional tables

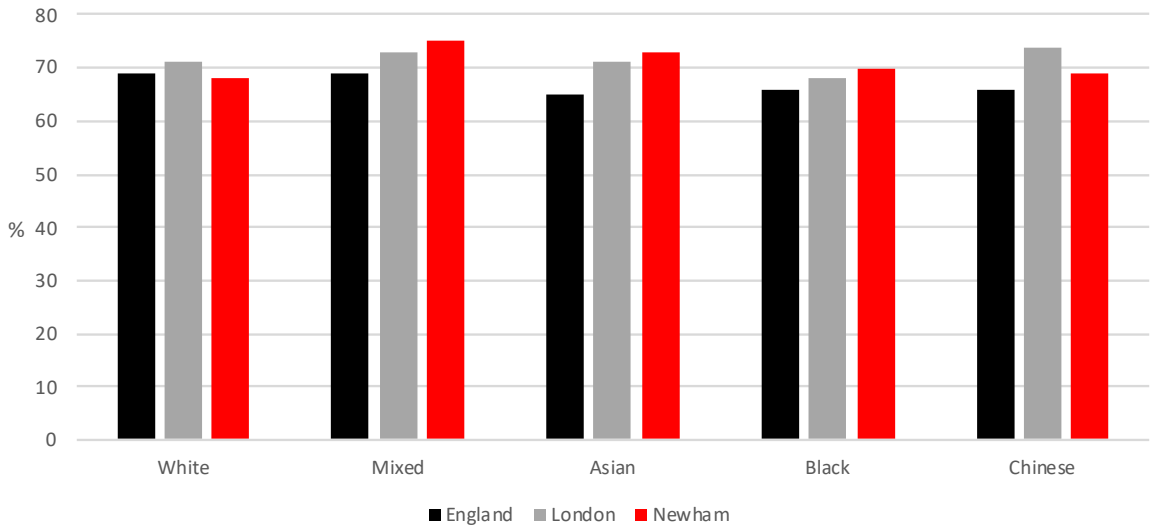


Newham's 2016 reporting of expected standard of EYFSP teacher assessment by ethnic group, indicated higher attainment amongst Mixed (75%) and Asian (73%) ethnic groups compared to White (68%), Black (70%) and Chinese (69%) groups. Newham performed above the national average in attainment amongst Mixed (75% vs. 69%), Asian (73% vs. 65%), Black (70% vs. 66%) and Chinese

(69% vs. 66%) groups. Of these, Newham reported higher attainment than the London average in Mixed (London, 73%), Asian (London, 71%) and Black (London, 68%) ethnic groups. Note that statistical significance was not calculated as source data was provided as percentages.

FIGURE 46 – PERCENTAGE OF 0-5 YEAR OLDS ACHIEVING AT LEAST THE EXPECTED STANDARD IN EYFSP TEACHER ASSESSMENT 2016 BY ETHNIC GROUP IN NEWHAM, LONDON AND ENGLAND

Source: National statistics SFR23_2016_UD



What services are available in Newham?

Newham offers free education for two-year olds for families who are in receipt of some forms of income support. Children can qualify on their own right; if the council looks after them, if they have a child protection plan, or are in receipt of disability living allowance or have a current statement of special educational needs. Newham is one of eight councils across England which has been handed a share of £13 milion to pilot the government's extension of free childcare for three- and four-year-olds. Newham also has several day nurseries available.

Progress since the last JSNA

Compared to the 2015-2016 JSNA, achievement in EYFSP teacher assessments has improved from 66% (2015 figures) to 70% (2016 figures), in parallel with London attainment levels.

Recommendations

PHE and NICE specify a number of recommendations to improve the delivery of effective early education and childcare[63, 64]. These include;

Level	Recommendations
Policy	• Ensure arrangements are in place for integrated commissioning of universal and targeted services for children aged under five. This includes services offered by general practice, maternity, health visiting, school nursing and all early years' providers • Ensure all vulnerable children can benefit from high quality childcare outside the home on a part- or full-time basis and can take up their entitlement to early childhood education, where appropriate
Community	• Managers and providers of early education and childcare services should ensure all vulnerable children can benefit from high quality services which aim to enhance their social and emotional wellbeing and build their capacity to learn. Services should: ○ promote the development of positive, interactive relationships between staff and children ○ ensure individual staff get to know, and develop an understanding of, children's needs (continuity of care is particularly important for younger children) ○ focus on social and emotional, as well as educational, development
Neighbourhood	• Health and early years' practitioners should work with community and voluntary organisations to help vulnerable parents who may find it difficult to use health and early years' services. The difficulties may be due to their social circumstances, language, culture or lifestyle

8.0 FAMILIES

INTRODUCTION

Family is the single most important influence in a child's life. It is therefore vital that at-risk families are supported to ensure improved outcomes for their children. Examples of such risks include; unemployment, household members with long-term health issues, and poverty.

What are the issues in Newham?

The percentage of Newham families in receipt of benefits and children living in relative poverty is still higher than that of London and England, despite a decline in rates of both since 2007. There are still children in Newham suffering from the effects of female genital mutilation (n=29), involved in domestic violence (n=1,390), under a protection order through section 47 of the Children's Act (n=987) and being sexually exploited (n=28). These sufferings come alongside a static number of domestic violence cases involving children over the past two years.

Fuel poverty affects 10.2% of households in Newham, which is higher than the proportion in London but lower than in England. Newham has higher proportions of households with one person suffering from a long-term condition (31%) than London (22%), England (18%) and comparator boroughs (25%).

What are the inequalities?

Children and young people in Newham are living in relative poverty compared to London and England. This aligns with existing research indicating that disadvantaged children are the most vulnerable to hardship and adverse short and long-term health outcomes together with having the least resources to overcome them. Whilst this may be due to low average household income and low economic activity in women, there is little data available to further investigate the causes of child poverty in Newham.

What are we doing well?

Newham's rates of hospital admissions for accidental and deliberate injuries in children aged 0-4 years and 0-14 years are lower than those in London and considerably lower than in England. The proportion of children living in households with no central heating is lower in Newham than comparator boroughs. In addition, the number of people homeless in Newham has decreased between 2015 and 2017.

What needs improving?

In 2015, data from Newham Families First showed that in 33% of cases of intensive family support provision, families took steps towards employment including attending interviews, enrolling on courses and volunteering. Consideration should be given to increasing capacity for the Families First team. The percentage of working families in receipt of key benefits has fallen, but it is still above London and England averages. Newham has made improvements in the percentage of children living in relative poverty, however rates are still higher than those in London and in England. It is important that we address the risk and causal factors for low income and unemployment, including educational achievement.

Efforts should be made for continued reduction of the proportion of children living in households without central heating. Finally, although homelessness is declining more can be done to ensure the numbers of homeless parents with dependent children are kept in safe environments.

HOUSEHOLDS AND FAMILIES

Introduction

Children in households with low income, no adults in employment or one person in the household suffering from a long term condition, face poorer health and social outcomes[65]. A complex range of factors impact on health and both social and emotional development in children. In order to assist at-risk families, early intervention tackling both health and social concerns as part of a bigger picture of employment, education and housing across an entire family is necessary.

Policies and Drivers

Under the Health and Social Care Act 2012, local authorities are responsible for promoting children's interests as part of their Health and Wellbeing Strategies[65].

The Royal College of Midwives has recently published the 'Stepping up to Public Health' model that emphasises the importance of family in improving children's outcomes[66].In addition, as Marmot sets out in "Fair Society, Healthy Lives", poorer health in families impacts on other areas of family life, making it harder to find and hold down a job or stay in school, or negatively impacting on self-esteem and emotional wellbeing[67].

Finally, PHE have been working with the Department of Communities and Local Government, NHS England, Local Government Association and the Department of Health (DH) to support a greater focus on improving the health of families[68].

What's happening in Newham?

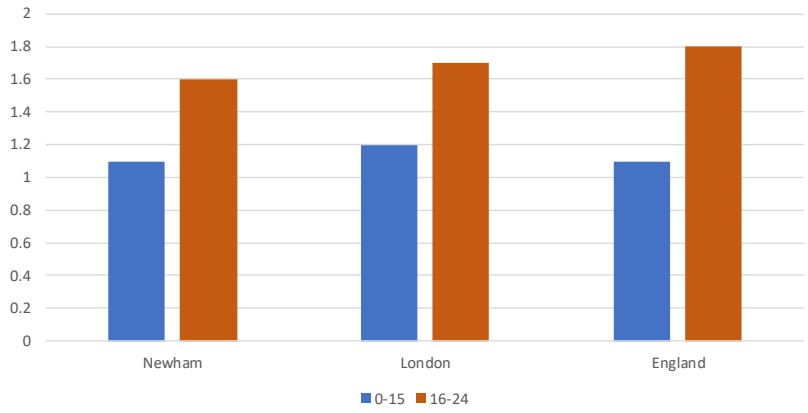
Fuel poverty

Fuel poverty can impact on mental health and general health; children diagnosed with asthma are 2-3 times more likely to live in cold and damp households. Being cold also reduces resistance to respiratory infections. Fuel poverty affects 10.2% of households in Newham. This compares to 9.2% in London and 14.6% in England[33].

The chart below shows by age band the percentage of children living in households where there is no central heating. Newham is lower than comparator boroughs for both age groups; on par with London and England in the 0-15 age band and lower than London and England for the 16-24 age bands[69].

FIGURE 47 – PERCENTAGE OF CHILDREN IN HOUSEHOLDS WITHOUT CENTRAL HEATING BY AGE BAND IN NEWHAM, LONDON AND ENGLAND (2011 CENSUS)

Source: NOMIS



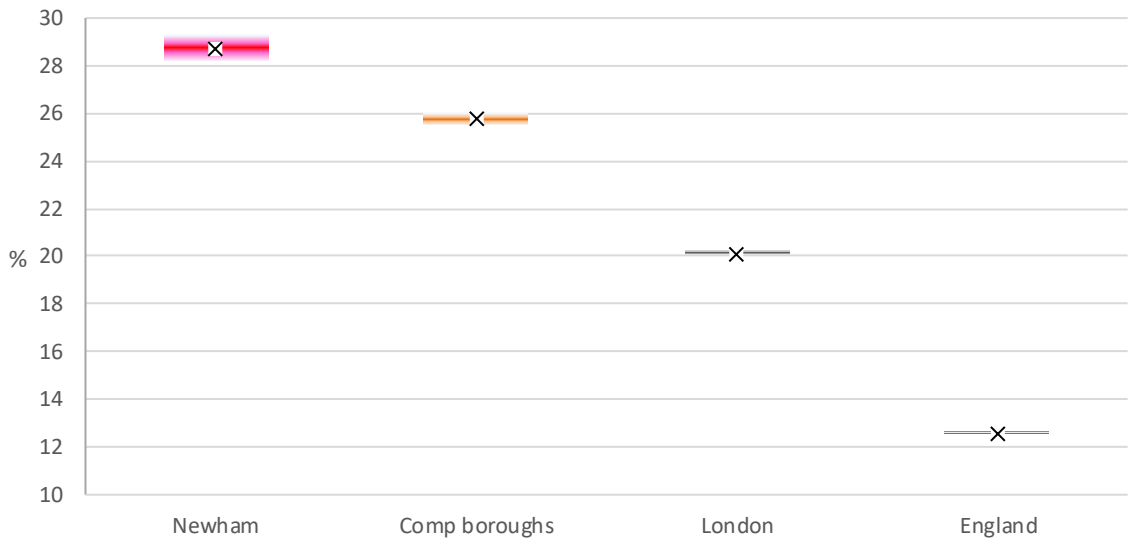
Unemployment

Unemployment in Newham during 2014-2016 was higher than average (5.8% compared to 4.9% in London and 3.8% in Great Britain). 7.9% of males in Newham were unemployed (compared to 6% in London and 5.2% in Great Britain) and 11% of females in Newham (compared to 6.3% in London and 5.1% in Great Britain). Moreover, 36% of employees living in Newham were low-paid, representing the highest rate in London in 2015-2016, while 22% of all employees in London were low paid. Averages from 2015 and 2016 suggest that between 28% and 32% of jobs based in Newham are low-paid. The rent to income ratio in Newham had the greatest increase of all London boroughs in 2015-2016, increasing from 63% in 2014-2015 to 72% in 2015-2016[70].

The chart below shows that in 2011, Newham had significantly higher percentages of households where none of the adults are employed which have with dependent children (29%)[71], than comparable boroughs combined (26%) London (20%) and England (12.5%)[69].

FIGURE 48 – PERCENTAGE OF HOUSEHOLDS WITH NO ADULT IN EMPLOYMENT WHICH HAVE DEPENDENT CHILDREN 2011 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND (95% CONFIDENCE INTERVALS)

Source: NOMIS 2011 census

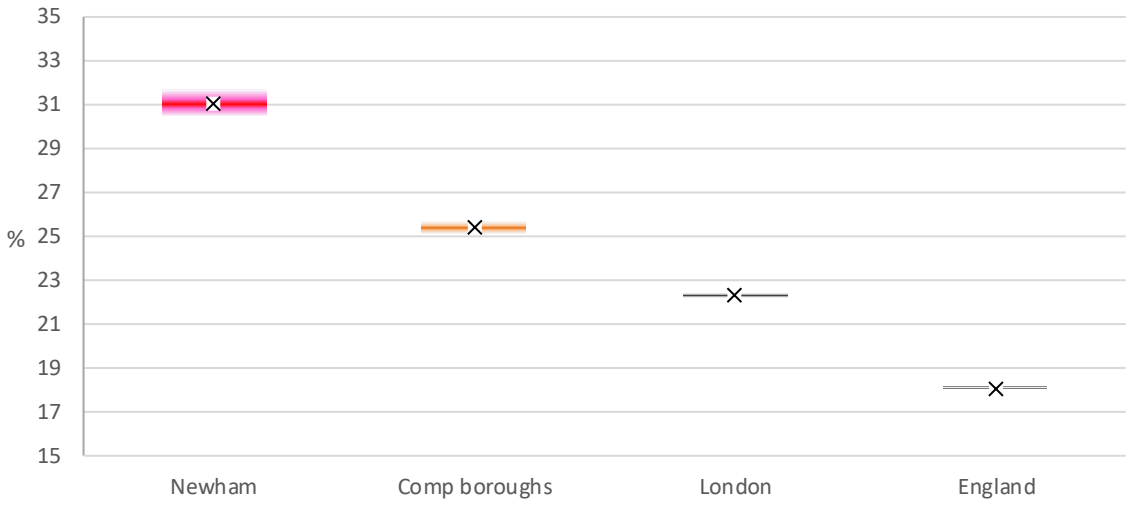


Long Term Conditions

The chart below shows households where one person has a long-term health problem which may affect their ability to be economically active and/or have high use of healthcare resources. Newham is significantly higher than comparator boroughs (31% compared to 25%), London at 22% and England at 18%[69].

FIGURE 49 – PERCENTAGE OF HOUSEHOLDS WITH A PERSON WITH A LONG-TERM HEALTH PROBLEM OR DISABILITY WHICH ALSO HAVE DEPENDENT CHILDREN 2011 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND (95% CONFIDENCE INTERVALS)

Source: NOMIS 2011 census

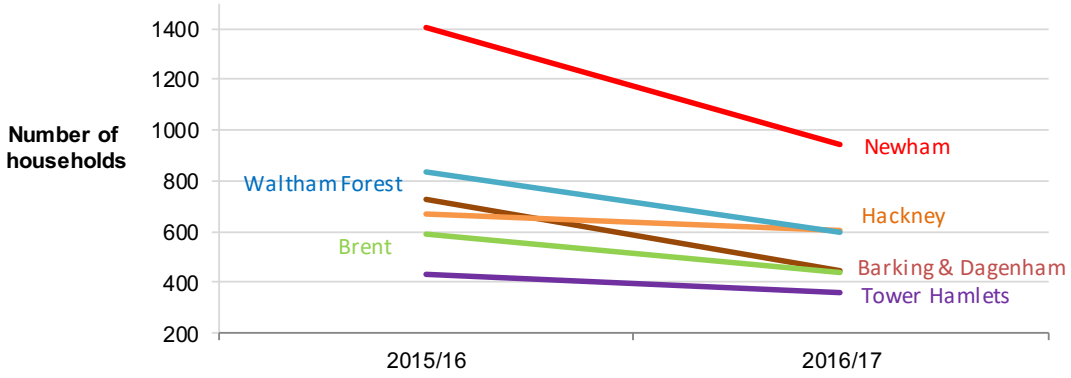


Homelessness

Data from Nomis below denotes households found to be eligible for assistance, unintentionally homeless and in priority need. The chart below denotes those with dependent children noting that Newham's figures have fallen from 1405 to 945 between 2015-2016 and 2016-2017. They are still much higher than all of the comparator boroughs[69].

FIGURE 50 – HOMELESS FAMILIES WITH DEPENDENT CHILDREN

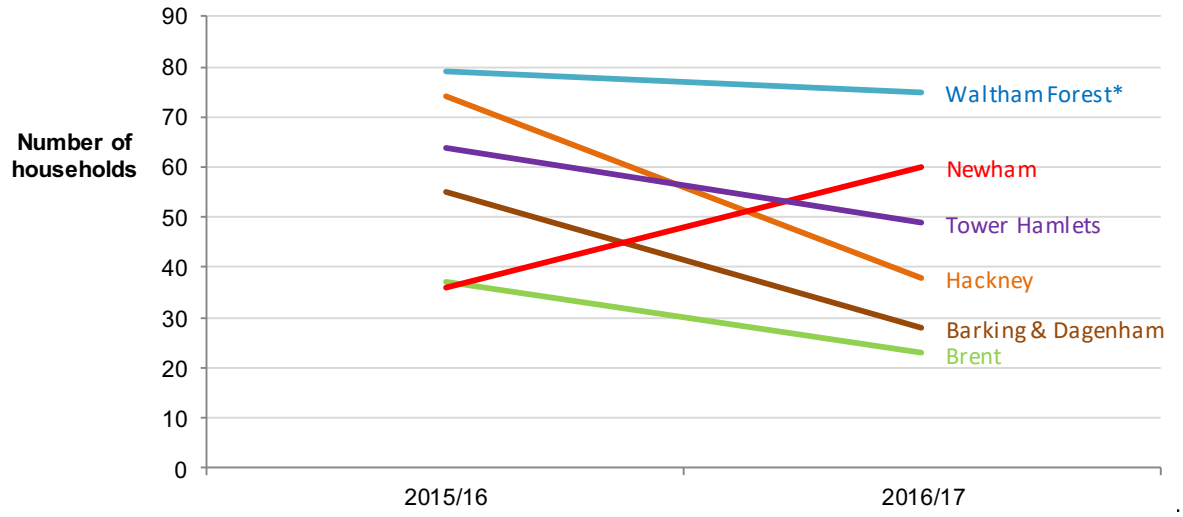
Source: NOMIS



The chart below shows homeless families with a pregnant woman but no other dependent children. Newham's figures rose from 36 households 2015-2016 to 60 households in 2016-2017.

FIGURE 51 – HOMELESS FAMILIES WITH PREGNANT WOMEN

Source: NOMIS



What services are available in Newham?

The Families First programme, developed to test evidence-based approaches to working with the most complex and vulnerable families is ongoing in LBN. This is a Government scheme under the Department for Communities and Local Government with the stated aim of helping troubled families turn their lives around. Following a successful pilot, the service was rolled out across the borough in 2013, involving experienced family intervention workers, mental health practitioners and Jobcentre Plus staff seconded from the DWP.

Progress since last JSNA

This chapter ties very closely to the chapter “Child Poverty” above. Compared to the 2011-2012 JSNA, the number of homeless families with dependent children and pregnant women have fallen from 1050 and 85 to 700 and 45 respectively. In 2007, 35.7% of children in Newham were in working age families receiving key benefits compared to 43.7% in London[26]. This was a proportional decrease of almost 5% from 2004 but was still 8% more than the London average. This indicator, alongside the percentage of children in households without central heating; adults not employment with dependent children in the household, and the number of families where there is one person with a long term health problem or disability and dependent children were not assessed in previous JSNAs[26].

Recommendations

The DH, the Department for Education (DfE) and PHE provide guidance around improving outcomes in at-risk households and families[37, 63, 72, 73]. These include:

Level	Recommendations
Policy	• Ensure the social and emotional wellbeing of vulnerable children features in the 'Health and wellbeing strategy', as one of the most effective ways of addressing health inequalities. The resulting plan should include outcomes to ensure healthy child development and 'readiness for school' and to prevent mental health and behavioural problems

	• Population-based models (such as PREview, a set of planning tools published by the Child and Maternity Health Observatory) should be considered as a way of determining need and ensuring resources and services are effectively distributed
	• Ensure arrangements are in place for integrated commissioning of universal and targeted services for children aged under 5. This includes services offered by general practice, maternity, health visiting, school nursing and all early years' providers. The aim is to ensure:
	  ○ vulnerable children at risk of developing (or who are already showing signs of) social and emotional and behavioural problems are identified as early as possible by universal children and family services
	  ○ targeted, evidence-based and structured interventions (see recommendations 3 and 4) are available to help vulnerable children and their families – these should be monitored against outcomes
	  ○ children and families with multiple needs have access to specialist services, including child safeguarding and mental health services
	• Local authority scrutiny committees for health and wellbeing should review delivery of plans and programmes designed to improve the social and emotional wellbeing of vulnerable children aged under 5
	• Health visitors or midwives should offer a series of intensive home visits by an appropriately trained nurse to parents assessed to need additional support
	• Trained nurses should visit families in need of additional support a set number of times over a sustained period (sufficient to establish trust and help make positive changes). Activities during each visit should be based on a set curriculum which aims to achieve specified goals in relation to:
	  ○ maternal sensitivity (how sensitive the mother is to her child's needs)
	  ○ the mother–child relationship
	  ○ home learning (including speech, language and communication skills)
	  ○ parenting skills and practice
	• The nurse should, where possible, focus on developing the father–child relationship as part of an approach that involves the whole family. This includes getting the father involved in any curriculum activities
	• Health visitors or midwives should regularly check the parents' level of involvement in the intensive home visiting programme. If necessary, they should offer them a break, to reduce the risk that they will stop participating. If the parents do decide to have a break, the nurse should continue to communicate with them on a regular basis
	• Managers of intensive home-visiting programmes should conduct regular audits to ensure consistency and quality of delivery
	• Health visitors or midwives should explain to parents that home visits aim to ensure the healthy development of the child. They should consider the parents' first language and make provision for those who do not speak English. They should also be sensitive to a wide range of attitudes, expectations and approaches in relation to parenting
	• Health visitors or midwives should try to ensure both parents can fully participate in home visits, by considering their domestic and working priorities and commitments. They should also try to involve other family members, if appropriate and acceptable to the parents
	• Health visitors and midwives should encourage parents to participate in other services delivered by children's centres and as part of the Healthy Child Programme
	• Health visitors and midwives should work in partnership with other early year's practitioners to ensure families receive coordinated support. This includes psychologists, therapists, family support workers and other

	professionals who deliver services provided by children's centres and as part of the Healthy Child Programme

Community	• Consideration should be given to evidence-based community projects which focus on the importance of strong family bonds
	• All health and early years' professionals should develop trusting relationships with vulnerable families and adopt a non-judgmental approach, while focusing on the child's needs. They should do this by:
	  ○ identifying the strengths and capabilities of the family, as well as factors that pose a risk to the child's (or children's) social and emotional wellbeing
	  ○ talking about the aspirations and expectations for the child
	  ○ seeking to understand and respond to perceived needs and concerns
	  ○ discussing any risk factors in a sensitive manner to ensure families do not feel criticised, judged or stigmatised
	• Health professionals in antenatal and postnatal services should identify factors that may pose a risk to a child's social and emotional wellbeing. This includes factors that could affect the parents' capacity to provide a loving and nurturing environment. For example, they should discuss with the parents any problems they may have in relation to the father or mother's mental health, substance or alcohol misuse, family relationships or circumstances and networks of support
	• Health visitors, school nurses and early year's practitioners should identify factors that may pose a risk to a child's social and emotional wellbeing, as part of an ongoing assessment of their development

Neighbourhood	• Consideration should be given to working alongside schools to run workshops educating children on how they can be better family members

SAFEGUARDING

Introduction

Safeguarding and promoting the welfare of children relates to; protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and acting to enable all children to have the best outcomes. Whilst Newham CCG and the London Borough of Newham have an overarching responsibility for safeguarding and promoting the welfare of all children and young people in Newham, everyone who lives in Newham has a responsibility to safeguard children and protect them from harm.

Policies and Drivers

National

The Government have agreed safeguarding principles that provide a foundation to achieve good outcomes for children and young people. These include; empowerment, protection, prevention, proportionality, partnership and accountability[74].

Local

Under the 1989 and 2004 Children Acts, Newham CCG and LBN have a number of statutory functions and duties in relation to children in need and children suffering, or likely to suffer, significant harm[75, 76].

The Director of Children's Services and Lead Member for Children's Services together with members of the Local Children's Safeguarding Board (LCSB) are the key points of professional and political accountability with responsibility for the effective delivery of safeguarding, information sharing (together with the Police Misper Unit) and the development of local strategy and action plans.

Missing from Care and Missing from Home strategy meetings are routinely undertaken together with a dedicated CSE/Missing Coordinator to identify additional risk factors such as Child Sexual Exploitation (CSE) and gang affiliation, with future meetings due to include Female Genital Mutilation (FGM) and Trafficking, in line with LBN's organisational priorities. In May 2016, a FGM protocol for health and social care professionals was launched.

What's happening in Newham?

Contacts to Newham Triage

Children who need support and protection should receive the right support at the right time with the aim of increasing the proportion supported through early help and reducing the current demand for a statutory social work service. The table below shows the numbers of contacts and referrals from 2014-2015 and 2015-2016. The numbers of contacts have increased by over 2,500 people. The number of referrals has reduced between 2014-2015 and 2015-2016.

TABLE 14 – CONTACTS TO NEWHAM TRIAGE

Quarter	Contact	Contacts change from previous	Referrals	Referral change from previous	% Contacts to Referral	% Referrals to Assessment
Q1 2014/15	6608	+2905	1624	+323	25%	89%
Q2 2014/15	5827	-781	1456	-168	25%	92%
Q3 2014/15	6517	+690	1649	+193	25%	90%
Q4 2014/15	6703	+186	1571	-78	23%	91%
2014/15	**25655**	**+6029**	**6300**	**+436**	**25%**	**91%**
Q1 2015/16	7037	+429	1711	+87	24%	88%
Q2 2015/16	6845	-192	1394	-317	20%	85%
Q3 2015/16	6954	+109	1547	+153	22%	81%
Q4 2015/16	7492	+538	1677	+130	22%	78%
2015/16	**28328**	**+2673**	**6329**	**+29**	**22%**	**83%**

Female Genital Mutilation

Female genital mutilation (FGM), also known as female circumcision or cutting, is a procedure where the female genitals are deliberately cut, injured or changed, but where there's no medical reason for this to be done. It's usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It is illegal in the UK and is child abuse. It's very painful with serious short and long-term physical (including sex and childbirth) and mental health consequences. In Newham in 2014-2015 there were 23 reported cases of FGM. In 2015-2016 this number had increased to 29 cases. According to statistics issued by NHS Digital on 4 July 2017, the number had risen to 110 in 2016-2017. It seems likely that this rise is a result of improved data recording rather than an increase in incidence, If the 110 cases, 15 were aged 18-24 at first attendance, and 25 aged 25-29. In no case was the age at which FGM was carried out, or the country where it took place recorded, and in only 15 cases was the country of birth or origin recorded.

TABLE 15 – CASES OF FEMALE GENITAL MUTILATION IN NEWHAM

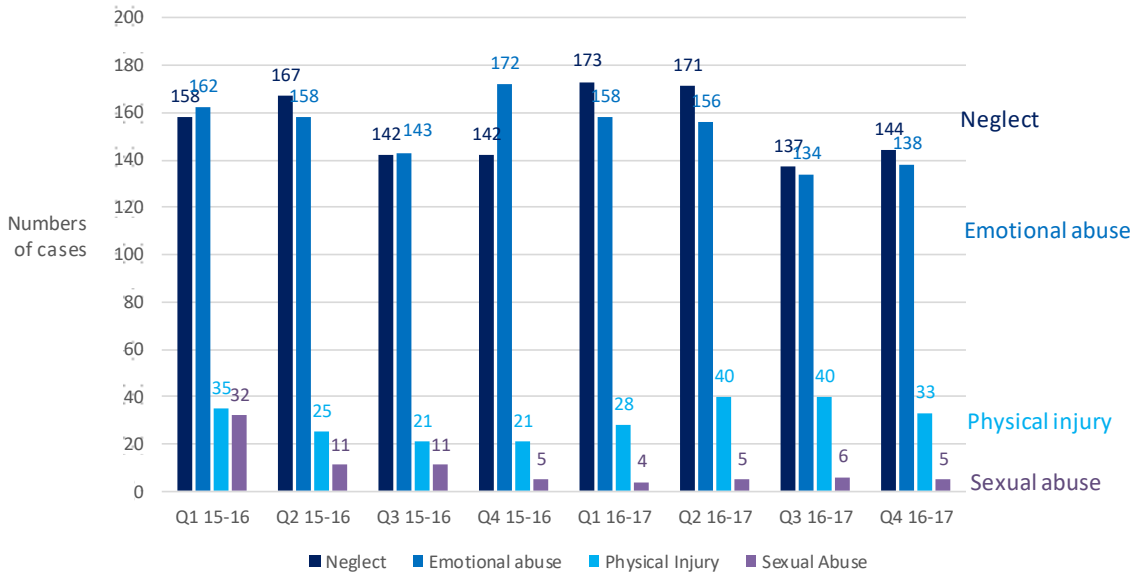
2014/15	2015/16	2016/17
23	29	110

Domestic Abuse

Domestic abuse is any type of controlling, bullying, threatening or violent behaviour between people in a relationship with often serious harm when children and young people are involved. Witnessing domestic abuse is child abuse, and teenagers can suffer domestic abuse in their relationships. Figures on the Category of Abuse for children subject to a child protection plan are shown below. Abuse in relation to emotion and neglect have the highest number of plans, emotional abuse rising from 609 in 2015-2016 to 625 in 2016-2017 and neglect falling from 635 in 2015-2016 to 586 in 2016-2017. The number of plans on physical injury and sexual abuse are lower. Physical injury rose from 102 in 2015-2016 to 141 in 2016-2017 and remain constant between 2014-2015 and 2015-2016. Sexual abuse fell by two thirds, from 59 in 2015-2016 to 20 in 2016-2017.

FIGURE 52 – CATEGORY OF ABUSE BY QUARTER (2015-2017)

Source: Data & Impact Team



Child Sexual Exploitation

Child sexual exploitation (CSE) is a type of sexual abuse in which children are sexually exploited for money, power or status. This can take place online, in gangs, and young people can be trafficked. Child sexual exploitation is a hidden crime. Young people often trust their abuser and don't understand that they're being abused. In 2015-2016 there were 28 cases of CSE; 20 from arrests and 8 from abduction notices.

TABLE 16 – CASES OF CHILD SEXUAL EXPLOITATION IN NEWHAM

	2015/16				
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Arrests	11	2	6	1	20
Abduction notices		3	5		8
Convictions		0	0	0	0

Section 47

Under Section 47 of the Children Act 1989, if a child is taken into Police Protection, is the subject of an Emergency Protection Order or, there are reasonable grounds to suspect that a child is suffering or is likely to suffer Significant Harm, a Section 47 Enquiry is initiated. The numbers of children who are the subject of an Emergency Protection Order in Newham are lower than they were in 2012-2013 but have been increasing in recent years. In 2015-2016, 987 children were the subject of a Section 47.

TABLE 17 – NUMBER OF CHILDREN WHO WERE THE SUBJECT OF A SECTION 47

2012/13	2013/14	2014/15	2015/16
1002	879	908	987

What services are available in Newham?

The Newham Children and Young People's Service can be readily contacted or visited in person if concern arises that a child is at risk of serious harm. In line with the national Healthy Child Programme, Health Visitors routinely visit every family in Newham with a child aged 0-5 years to identify needs that includes safeguarding. The national Troubled Families Programme is a Government scheme functioning in Newham under the Department for Communities and Local Government, which helps troubled families around and improve prospects for their children.

The Manor Gardens Welfare Trust currently provides the LBN FGM Prevention Service which includes one to one casework and group work with adult survivors of FGM, training for professionals on FGM and community engagement. This is part of the One Stop Shop, the borough's domestic and sexual violence resource.

Commissioned by LBN, Arc Theatre is currently delivering a multi-media programme, No More Whispers, designed to raise awareness of FGM in secondary schools in the borough. Funded by the Mayor's Office for Policing and Crime (MOPAC), the project runs until mid-2016 delivering in line with the school curriculum (up to 60 minutes in length) with up to 100 students per session, three sessions per day per school. Alongside the Manor Gardens Welfare Trust, training to school staff and parents on FGM is simultaneously delivered.

Progress since last JSNA

As the data displayed in this chapter are in absolute numbers, that do not consider population sizes, no formal comparisons on progress against previous JSNAs has been made.

Recommendations

NHS England and NICE both provide clear recommendations to improve safeguarding[74, 77-82]:

Level	Recommendations
Policy	• Develop or adapt and implement clear referral pathways to local services that can support children and young people affected by domestic violence and abuse • Ensure staff know how to refer children and young people to child protection services. They should also know how to contact safeguarding leads, senior clinicians or managers to discuss whether a referral would be appropriate • Provide a coordinated package of care and support that takes individual preferences and needs into account • Ensure the support matches the child's developmental stage (for example, infant, pre-adolescent or adolescent)
Community	• Consideration should be given to a community project aimed at highlighting the importance of keeping children safe and the services available
Neighbourhood	• Consideration should be given to subsidies for childcare to ensure that children are kept within safe environments

CHILDHOOD POVERTY

Introduction

Poverty can be defined in many ways. In this report, we will discuss absolute and relative poverty. Absolute poverty is defined as the lack of one or more basic human needs (i.e. food, water, clothing, housing and sanitation). In contrast, relative poverty is compared against a standard set for a specific area, with people deemed to be in relative poverty if they can't keep up with a society's standard of living (i.e. eating a restaurant meal).

There were 3.7 million children living in relative poverty in the UK in 2013-2014[83]. This is 28% of children, or 9 in a class of 30. More importantly, 63% of them lived in households where at least one adult was in paid employment. Long-term, child poverty leads to worsening educational attainment, increased morbidity from physical and mental health conditions (including maternal depression) and worsening healthy life expectancy.

Housing and Environment

The links between poor housing and negative health outcomes are well established. Children living in poor housing conditions, especially those living in overcrowded, cold or damp properties can experience poor health; because of exposure to those hazards. Those living in poverty are more likely to live in poor quality accommodation, are more likely to live in overcrowded conditions and are more likely to be exploited by unscrupulous landlords.

Environmental Health Officers (EHOs) employed in Private Housing and Environmental Health undertake inspections in privately rented accommodation, to identify and assess any hazards present. Those hazards can include those that are known to have a negative impact on the health of families with children including; excess cold, damp and mould, electrical hazards, overcrowding, falls on the stairs, falls between levels, poor lighting, burns and scalds, poor ergonomic design, and collision and entrapment. EHOs can serve notices on landlords to make them reduce those hazards to an acceptable level, thereby reducing the likelihood of poor health and physical injury resulting from defects in the home[84].

Policies and drivers

National

The goal of the Child Poverty Strategy 2014-2017 is to end child poverty by 2020, a target set in legislation by the Child Poverty Act 2010[73]. Actions include; (1) supporting families into work and increasing earnings and by creating more jobs and tackling low pay and (2) improving living standards and preventing poor children becoming poor adults by supporting educational attainment, support for education to get people into better paid jobs together with efforts made to "make work pay" (e.g. Childcare subsidies and free school meals for all school children).

Local

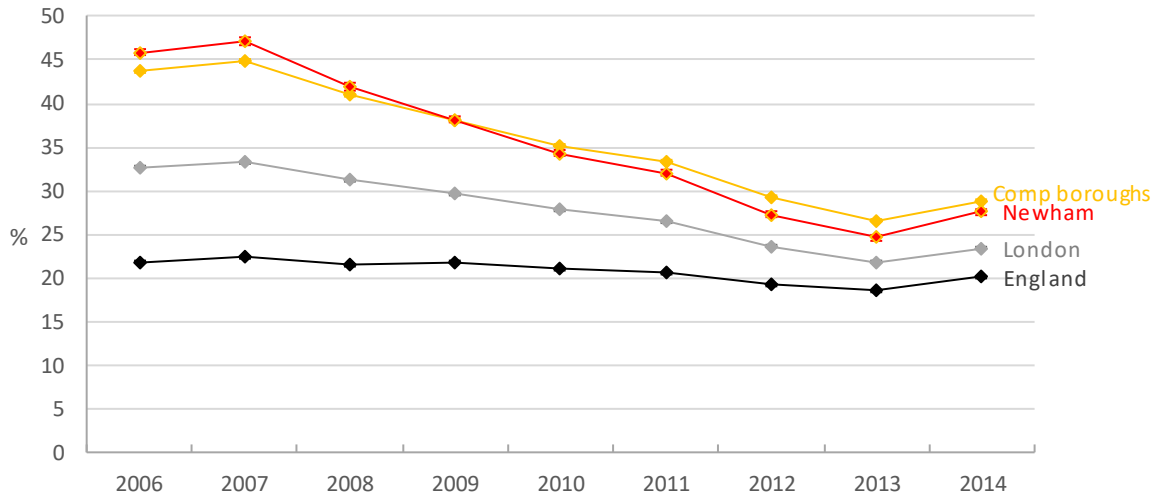
As one of the Mayor's Promises, Newham has had Free School Meals for children in maintained primary schools (including infants and juniors) since 2009.

What's happening in Newham?

Rates of child poverty in Newham are higher than London and England despite the percentage of children living in relative poverty falling substantially (47.1% to 24.6%) in Newham from 2007-2013. These differences are statistically significant at the usual 5% level. Since numbers involved are large, confidence intervals are small, and can barely be discerned in the chart. After reaching apparent minima in 2013, Newham and its comparators experienced an increase in child poverty in 2014. Rates in Newham increased to 27.6% in 2015.

FIGURE 53 – PERCENTAGE OF CHILDREN 0-15 IN POVERTY 2006-2014 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND (95% CONFIDENCE INTERVALS)

Source: PHOF



Unemployment in Newham overall has been, and remains higher, than London and England. The figures dropped from 2015-2016 (7.4%) to 2016/17 (5.8) and if the current trend continues then the figure should hopefully fall to match those of London in future years.

TABLE 18 – PERCENT UNEMPLOYMENT IN THOSE AGED 16 AND OVER

% - 2016/17	Newham	London	Great Britain
Males	N/A	5.0	4.7
Females	8.5	6.1	4.4
Total	5.8	5.5	4.6

Unemployment rates for men in Newham were unavailable for 2016-2017 due to the sample size being too small for a reliable estimate. Unemployment in women has fallen from19.7% in 2011-2012 to 8.5% in 2016-2017. In both sexes, year-on-year variability makes it uncertain whether there is a genuine underlying trend.

FIGURE 54 – PERCENTAGE OF MALES UNEMPLOYED AGED > 16

Source: ONS via NOMIS

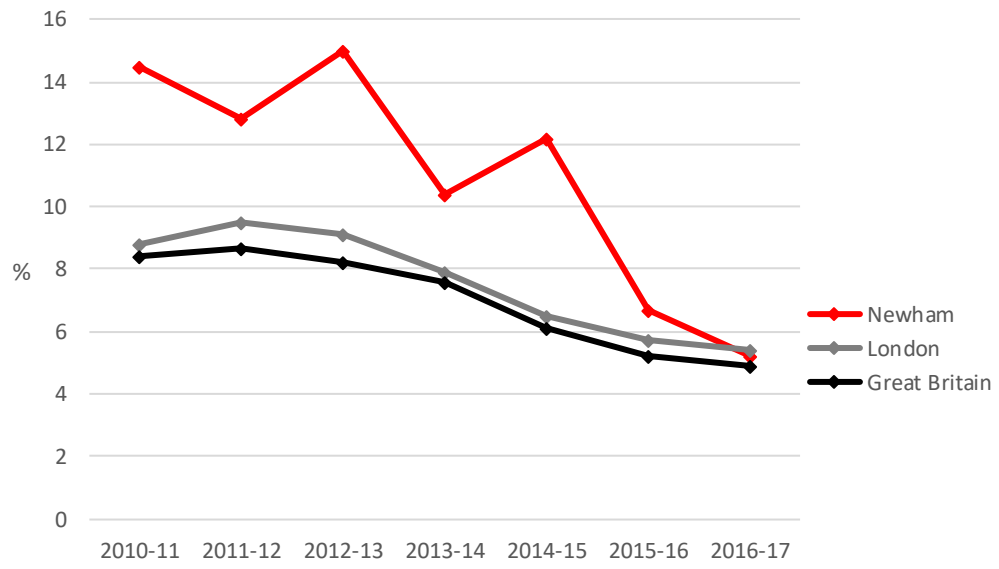
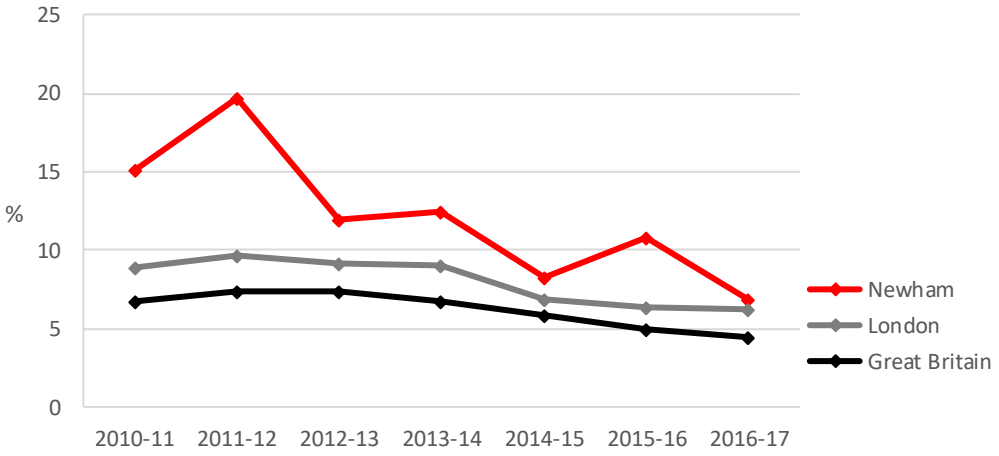


FIGURE 55 – PERCENTAGE OF FEMALES UNEMPLOYED > 16

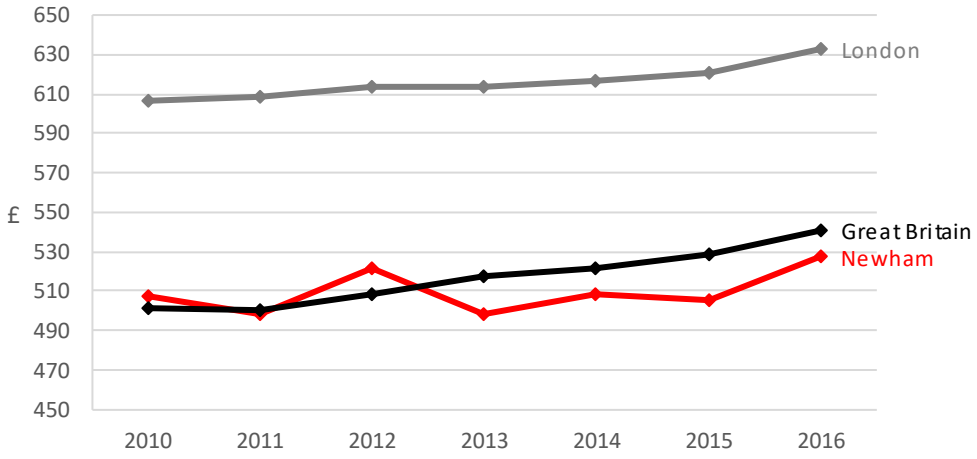
Source: ONS via NOMIS



In terms of gross weekly pay for full-time workers, Newham had been in line with Great Britain until 2013. Since 2013 it has remained below national averages. In 2016, Newham's average of £527.2 is 3% below the Great Britain average of £541, and 20% below the London average of £632.4.

FIGURE 56 – GROSS PAY IN FULL TIME WORKERS

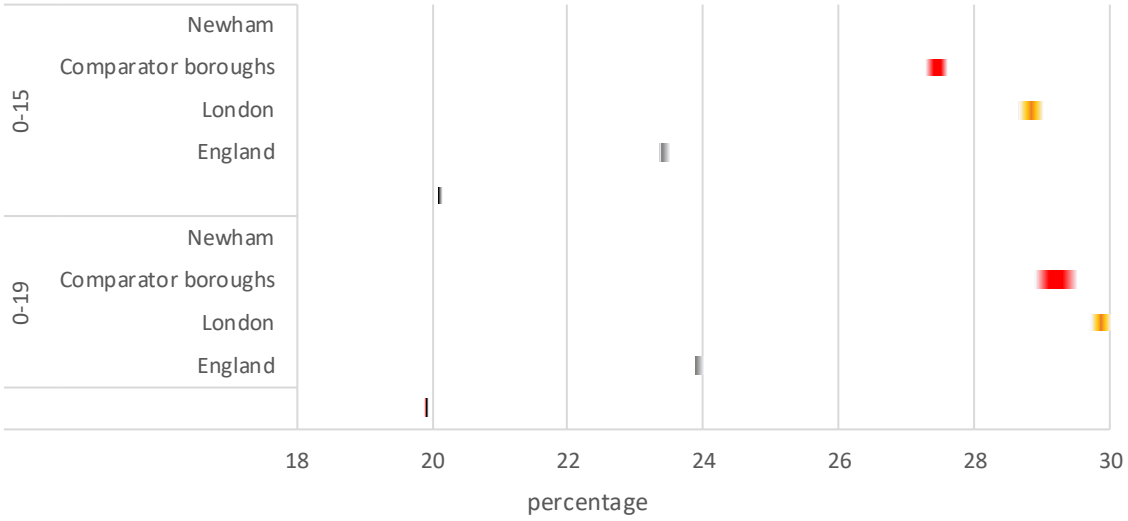
Source: ONS annual survey of hours and earnings, resident analysis via NOMIS



Newham's high unemployment rate and the lower than average weekly income both contribute to child poverty in the borough. The chart below denotes the percentage of children living in poverty under 16 and under 20 in Newham, compared to London, England and comparator boroughs in 2014[50].

FIGURE 57 – PERCENTAGE OF CYP LIVING IN POVERTY 2014 (95% CONFIDENCE INTERVALS)

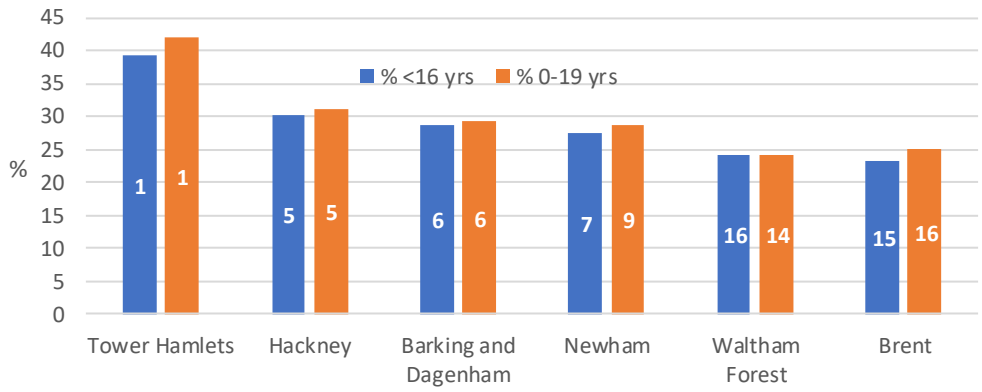
Source: PHOF



Similarly, the chart below denotes the percentage of children living in poverty under 16 and under 20 in Newham, compared to comparator boroughs[50].

FIGURE 58 – PERCENTAGE OF CHILDREN LIVING IN POVERTY 2014 WITH NUMBERS ON EACH BAR REPRESENTING THE RANKING OUT OF 33 BOROUGHS (HIGHEST = WORST)

Source: PHOF indicator 1.01



What services are available in Newham?

The Child Poverty Action Group is headquartered in Newham. In addition, Community Links has over 30 years' experience of working with the community of Newham with the aim to deliver support services to children, young people, adults, and families to make them easy to access and more localised. They also encourage neighbours to improve their communities through their Linking Neighbours programme. In line with the national Healthy Child Programme, Health Visitors routinely visit every family in Newham with a child aged 0-5 years to identify their needs.

Progress since the last JSNA

Newham is still ranked in the top third of boroughs with the highest percentages of children living in poverty. In 2010, 38.2% of children in Newham under 16 years were living in poverty compared to London's 29.7% and England's 21.9%. In 2011, 32% of children under 16 were living in poverty versus 26.5% in London. In 2016, 41% versus London's 37% were noted to be in poverty. We have unfortunately regressed in child poverty since the 2010 JSNA[26].

Recommendations:

Numerous published guidance on addressing childhood poverty at local authority level from PHE, NICE and the Government exists. When applied to Newham, several recommendations to tackle child poverty include[72, 73, 85]:

Level	Recommendations
Policy	• Ensure a local single point of contact health and housing referral service is commissioned to help vulnerable people who live in cold homes. A wide range of people are vulnerable to the cold • Ensure anyone who encounters vulnerable groups can refer people to the referral service. This includes: health and social care practitioners, fire prevention and safety services personnel and workers from charities and voluntary organisations, such as advice agencies • Ensure the referral service links with relevant national and local services that can provide a range of solutions. These are likely to include: health and social care providers, local housing providers, advice agencies (such as Citizens Advice Bureaux and money advice organisations),

	health and social care charities, voluntary organisations and home improvement agencies • Those in poor-quality privately rented accommodation should be referred to the Private Housing and Environmental Health Team at the Council so appropriate action may be taken to deal with disrepair and secure energy efficiency improvements where possible
Community	• Consideration should be given to community employment projects to tackle low pay • Consideration should be given to jobs fairs where employers can advertise employment
Neighbourhood	• Consideration should be given to working alongside Job Centre Plus to improve employment prospects for residents of Newham.

DOMESTIC VIOLENCE

Introduction

Domestic violence in families may include physical, emotional, sexual, financial or psychological violence. Even when this violence is confined to parents and other family members, it seriously harms children and young people. Due to this negative impact, witnessing domestic violence is a recognised form of child abuse.

Prolonged and/or regular exposure to domestic violence can have a serious impact on children's safety and welfare, despite the best efforts of parents to protect them. Domestic violence rarely exists in isolation. Many parents also misuse drugs or alcohol, experience poor physical and mental ill health and have a history of poor childhood experiences themselves.

The impact of domestic violence on children can foster serious anxiety and distress, and lead to an increased risk of physical injury during an incident, as well as distress from witnessing the physical and emotional suffering of a parent and parental conflict. Whilst domestic abuse can impact on parenting and caring capacity physically, due to injuries, the impact on parenting is subtler.

Exposure to psychological and emotional abuse can result in a loss of confidence, depression, feelings of degradation, problems with sleep, isolation, and increased use of medication and alcohol for women who are abused. The impact of domestic violence on children increases when they are directly abused, when they see the abuse of a parent, or help to conceal assaults. Support from siblings, wider family, friends, school and community can act as protective factors for children in these situations.

Policies and Drivers

National

Official Government policy involves the re-launch of the highly successful *This is Abuse* campaign, including collaborations with Hollyoaks and MTV, and with a new focus on reaching young male perpetrators[86].

In addition, roll-out of the national domestic violence disclosure scheme *(Clare's Law)* allows the police to disclose information to the public about a partner's previous violent offending. This works together with a domestic violence protection order started in 2014, which prevents perpetrators returning to their home for up to 28 days[87, 88].

NICE *[Domestic violence and abuse: multi-agency working, PH50]* have denoted recommendations to prevent and improving outcomes in domestic violence and abuse[89] alongside a DH policy paper on a public health approach to violence prevention for England[90].

Finally, *'16 Days of Action Against Domestic Violence'*, a campaign supported by PHE and the Corporate Alliance Against Domestic Violence is aimed at supporting businesses to address domestic abuse spanning across 16 days from 25th November, annually[91].

Local

As detailed in the chapter "Safeguarding", locally, the LSCB have detailed policies on service pathways to tackle domestic abuse and ensure positive outcomes for children living in families where this is an issue.

What's happening in Newham?

Domestic Violence

In Newham, there are approximately 500 children per quarter who are affected by domestic violence, equating to 1,828 in 2015-2016 (please see figure below). This figure is the same across all quarters and the figures for 2015-2016 are similar to previous year's figures.

FIGURE 59 - DOMESTIC VIOLENCE IN NEWHAM - FACTORS AT END OF ASSESSMENT, AGES 0-18

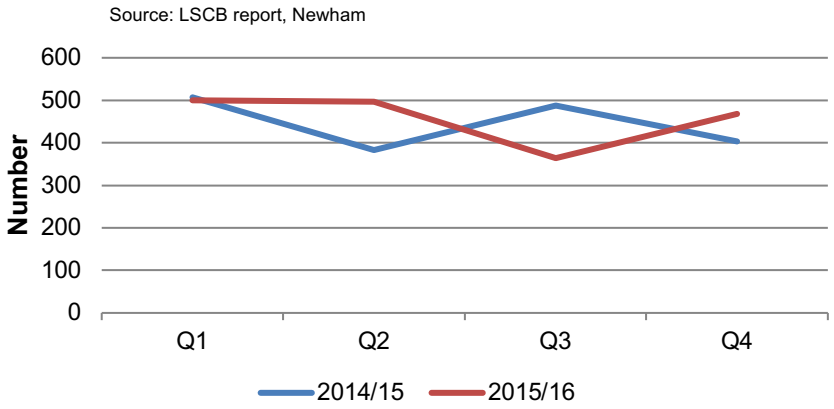


TABLE 19 – NUMBER OF CHILDREN AFFECTED BY DOMESTIC VIOLENCE

2014/15	2015/16
1782	1828

What services are available in Newham?

Professionals can easily refer domestic and sexual violence victims for support (including victims experiencing forced marriage, honour-based violence, female genital mutilation and those who require support to exit sex work) using a One Stop Shop Referral form. In addition, a local charity "Newham Action Against Domestic Violence (NAADV)" have been assisting victims of domestic violence over the past 13 years. The East London Black Women's Organisation provides education and training, childcare provision and youth development programmes at their resource centre to families affected by domestic violence. Finally, the PAUSE project at Newham works with women who have experienced, or are at risk of, repeat removals of children from their care aiming to break this cycle and give women the opportunity to develop new skills and responses that can help them create a more positive future.

Progress since last JSNA

In 2009-2010, there were 4870 incidents of domestic violence reported to the police. According to a Freedom of Information request (201706000968) to the MET Police, there were a total of 6498 incidents of domestic abuse reported in 2016-2017. These figure include: offences where an arrest could be made, "non-arrestable" incidents, and incidents classified as "other"[26]. As these data are absolute numbers and do not consider population sizes, no formal comparisons on progress against previous JSNAs has been made.

Recommendations

There is numerous published guidance on addressing domestic violence at local authority from PHE, NICE and the Government. Several recommendations to tackle domestic violence include[90-94]:

Level	Recommendations
Policy	• Set out a programme of work through the National Group on Sexual Violence against Children and Vulnerable People to prevent sexual abuse happening in the first place; to protect children online; to make sure the police can identify and deal with abuse; and ensure victims are at the heart of the criminal justice system • Ensure victims of sexual violence have access to specialist support (sexual violence advisers) • Enforce legislation that criminalised forced marriage in the Anti-Social Behaviour, Crime and Policing Act 2014 to ensure that this unacceptable practice can be robustly prosecuted • Ensure staff can recognise the indicators of domestic violence and abuse and understand how it affects children and young people. • Ensure staff are trained and confident to discuss domestic violence and abuse with children and young people who are affected by or experiencing it directly • Ensure staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse • Involve children and young people in developing and evaluating local policies and services dealing with domestic violence and abuse • Address the emotional, psychological and physical harms arising from a child or young person being affected by domestic violence and abuse, as well as their safety • Provide support and services for children and young people experiencing domestic violence and abuse in their own intimate relationships • Undertake a comprehensive mapping exercise to identify all local services and partnerships that work in domestic violence and abuse • Ensure there are integrated care pathways for identifying, referring (either externally or internally) and providing interventions to support people who experience domestic violence and abuse, and to manage those who perpetrate it • Ensure people who misuse alcohol or drugs or who have mental health problems and are affected by domestic violence and abuse are also referred to the relevant health, social care and domestic violence and abuse services • Ensure all service pathways have consistent, robust mechanisms for assessing the risks facing adults who experience domestic violence and abuse and any children who may be affected. This includes ensuring those affected by, and the perpetrators of, the violence and abuse are kept separate from each other when receiving support • Clearly display information in waiting areas and other suitable places about the support on offer for those affected by domestic violence and abuse • Take steps to ensure people who use the service are given maximum privacy, for example, by arranging the reception area so that people cannot be overheard • Establish a referral pathway to specialist domestic violence and abuse agencies (or the equivalent in a health or social care setting). This should include age-appropriate options and options for groups that may have difficulties accessing services, or are reluctant to do so

	• Ensure frontline staff know about the services, policies and procedures of relevant local agencies in relation to domestic violence and abuse • Provide ongoing training and regular supervision for staff who may be asking people about domestic violence and abuse • Establish clear policies and procedures for staff who have been affected by domestic violence and abuse • Ensure staff are given the opportunity to address issues relating to their own personal experiences, as well as those that may arise after contact with patients or service users
Community	• Consideration should be given to issuing a violence against women and girls fact pack in community centres and public buildings
Neighbourhood	• Consideration should be given to working alongside schools to educate pupils on the signs to look out for to identify domestic violence and abuse

ILLNESS AND UNINTENTIONAL INJURIES

Introduction

As described in the chapter "Child Mortality", unintentional injuries in and around the home are a leading cause of preventable death for children under five years and a major cause of ill health and serious disability. Analysis of the most recently available five years of data shows that each year approximately 60 children and young people (CYP) died, 450,000 CYP attended accident and emergency (A&E) and 40,000 CYP were admitted to hospital as an emergency. Unintentional injuries in and around the home accounted for 8% of all deaths of all children aged 1 to 4 years between 2008 and 2012[95].

They are linked to several factors including: child development, physical environment in the home, knowledge and behaviour of parents and other carers (including literacy), overcrowding or homelessness, availability of safety equipment; and new consumer products in the home.

Policies and Drivers

Unintentional injury to children is a major public health concern contributing to a significant cost to health, social care and education. This is recognised by the new Minister for Public Health and Innovation, Nicola Blackwood, who now routinely attends roundtable meetings with PHE, local government leaders, NHS England, professional bodies, national injury prevention groups and academics.

NHS Evidence has also published a summary of selected new evidence regarding strategies to prevent unintentional injuries among children and young people under 25[96]. Finally, NICE has issued three PH guidance documents on unintentional injuries; *Unintentional injuries on the road: interventions for under 15s [PH31], Unintentional injuries in the home: interventions for under 15s PH30* and *Unintentional injuries: prevention strategies for under 15s [PH29]*[27, 97].

What's happening in Newham?

Children aged 0-4

Numbers of hospital admissions.

The number of hospital admissions for unintentional and deliberated injuries in children aged 0-4 years fell from 2015-2016 (218) to 2016-2017 (205).

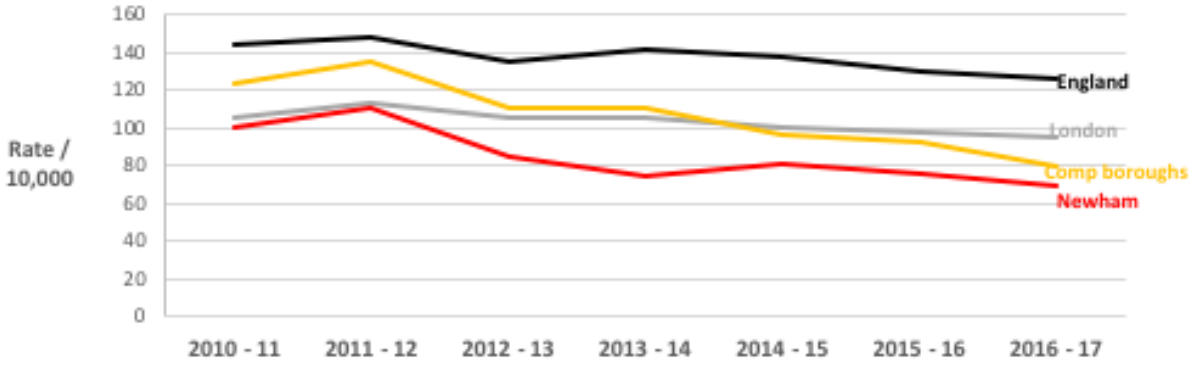
TABLE 20 - NUMBER OF HOSPITALISATIONS FOR UNINTENTIONAL AND DELIBERATE INJURIES IN CHILDREN AGED 0-4 YEARS

2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
258	283	228	202	229	218	205

The graph below shows rates per 10,000 persons for hospital admissions for 0-4 year-olds for accidental and deliberate injuries from 2010-2011 to 2016-2017. Newham's rates have been consistently lower than that of its comparators.

FIGURE 60 – HOSPITAL ADMISSIONS FOR ACCIDENTAL AND DELIBERATE INJURY TO CHILDREN AGED 0-4

Source: PHOF



The graph below shows rates per 10,000 persons for hospital admissions for 0-4 year-olds for accidental and deliberate injuries in 2016-2017, with 95% confidence intervals. Newham's rate of 69.48/10,000 was statistically significantly lower than all comparators, using the usual 5% level for statistical significance.

FIGURE 61 – HOSPITAL ADMISSIONS FOR ACCIDENTAL AND DELIBERATE INJURY TO CHILDREN AGED 0-4 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2016-2017 RATE/10000 (95% CONFIDENCE INTERVAL)

Source: PHOF

Children aged 0-14

Newham's number of admissions for accidental and deliberate injuries in children 0-14 years old was lower in 2015-2016 than in any year since 2010 (65.77 per 10,000). Rates were similarly low in 2016-2017 (63.38 per 10,1000) in contrast to London's rate of 78.15 per 10,000[33, 50].

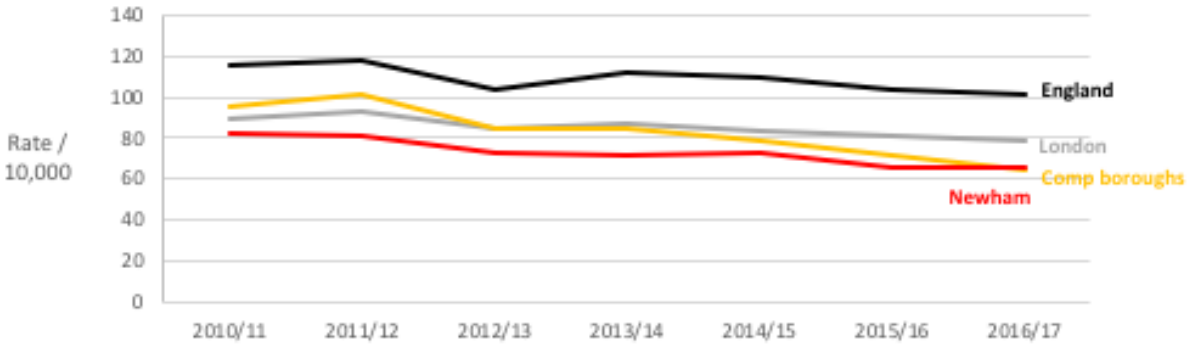
TABLE 21 - NUMBER OF ACCIDENTAL AND DELIBERATE INJURIES IN CHILDREN 0-14 YEARS IN NEWHAM

2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
540	534	493	496	516	472	479

The graph below shows rates per 10,000 persons for hospital admissions for 0-14 year-olds for accidental and deliberate injuries from 2010-2011 to 2016-2017. Newham's rates have been consistently lower than all the comparators'.

FIGURE 62 – HOSPITAL ADMISSIONS FOR ACCIDENTAL AND DELIBERATE INJURY TO CHILDREN AGED 0-14 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2011 TO 2016-2017 RATE/10000

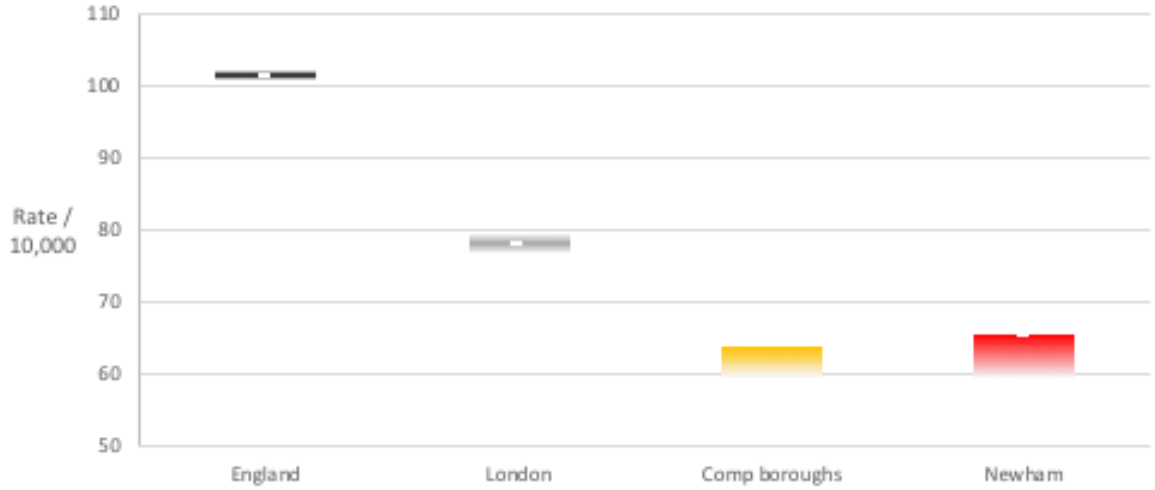
Source: PHOF



The graph below shows rates per 10,000 persons for hospital admissions for 0-14 year-olds for accidental and deliberate injuries in 2016-2017, with 95% confidence intervals. Newham's rate of 65.38/10,000 was statistically significantly lower than rates London and nation-wide, using the usual 5% level for statistical significance.

FIGURE 63 - HOSPITAL ADMISSIONS FOR ACCIDENTAL AND DELIBERATE INJURY TO CHILDREN AGED 0-14 IN NEWHAM, COMPARATOR BOROUGHS, LONDON, ENGLAND 2016-17 RATE/10,000 WITH 95% CONFIDENCE INTERVALS

Source: PHOF



Further details on children killed in road traffic accidents are given in the chapter “Child Mortality”.

Children and young adults aged 15-24

Newham’s number of admissions was stable in 2016-2017 at 475 (from 474 in 2014-2015) and lower than the period between 2010-2014, during which numbers declined from 665 to 515 in four years.

TABLE 22 - NUMBER OF ACCIDENTAL AND DELIBERATE INJURIES IN CHILDREN 15-24 YEARS IN NEWHAM

2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
665	597	525	515	474	475	459

In older children and young adults aged 15-24, Newham had a crude rate of 95.8 per 10,000 in 2016-2017 which was lower than England and similar to London. The following charts show the annual rate of admissions for accidental and deliberate injury for children aged 15-24 years in Newham, London, England, and comparator borough, and the rates for 2016-2017 with 95% confidence intervals.

FIGURE 64 – HOSPITAL ADMISSIONS FOR ACCIDENTAL AND DELIBERATE INJURY TO YOUNG PEOPLE AGED 15-24 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2011 TO 2016-2017 RATE/10000

Source: PHOF

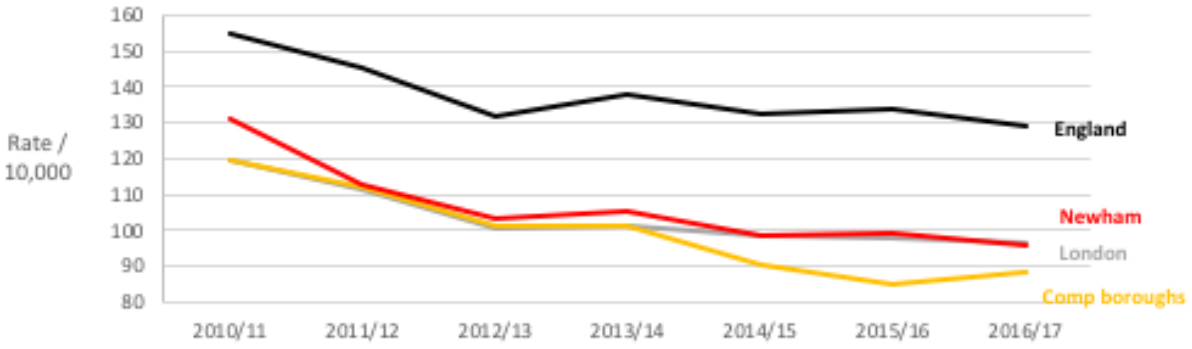
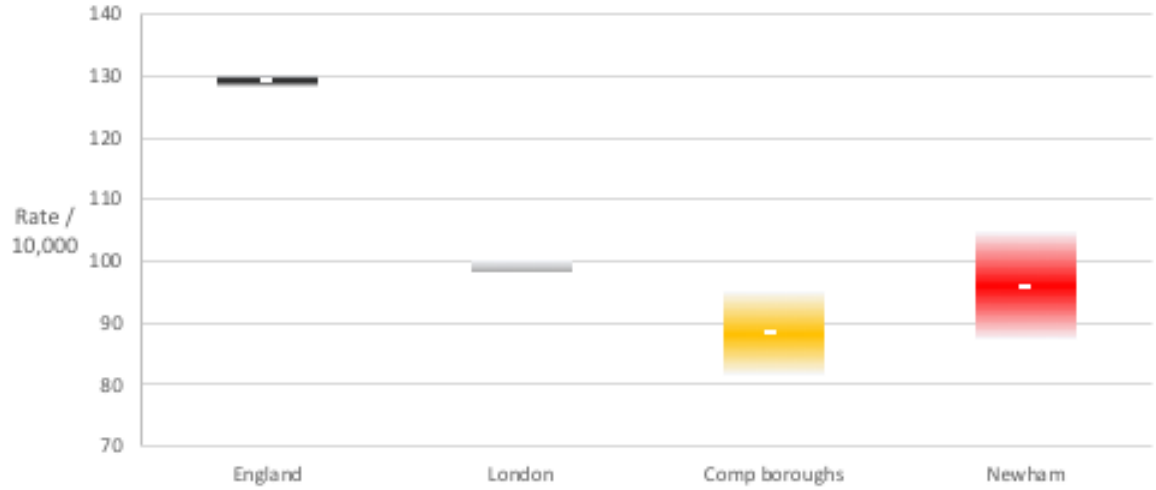


FIGURE 65 – HOSPITAL ADMISSIONS FOR ACCIDENTAL AND DELIBERATE INJURY TO YOUNG PEOPLE AGED 15-24 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2015-2016 (95% CONFIDENCE INTERVALS)

Source: PHOF



What services are available in Newham?

The Royal Society for the Prevention of Accidents works with Newham residents to reduce injuries and improve on accident prevention. In line with the national Healthy Child Programme, Health Visitors routinely visit every family in Newham with a child aged 0-5 years to identify need and provide education about preventing unintentional injuries in children.

Progress since the last JSNA

Compared to the 2010 JSNA, we have improved on reduced on hospital admissions in both categories. The rate of hospital admissions for 0-4 year-olds for accidental and deliberate injuries in Newham was 100 per 10,000 in 2010 but fell to 75 per 10,000 in 2015-2016, below both comparator boroughs and London. Hospital admissions for unintentional and deliberate injuries to children 0-14 in Newham was 80 per 10,000 in 2010 and fell to 66 per 10,000 in 2015-2016, below both comparator boroughs and London[26].

Recommendations

Numerous recommendations exist by NHS England and NICE to reduce unintentional injuries[27, 95-98]. These include:

Level	Recommendations

Policy	• Continue health visitor and integrated 0-5 staff training to further develop confidence and competence in this area
	• Determine the types of household where children and young people aged under 15 are at greatest risk of unintentional injury based on surveys, needs assessments and existing datasets (such as local council housing records)
	• Prioritise the households identified above for home safety assessments and the supply and installation of home safety equipment (see recommendations 2 and 3). 'Priority households' could include those with children aged under 5, families living in rented or overcrowded conditions or families living on a low income. It could also include those living in a property where there is a lack of appropriately installed safety equipment, or one where hazards have been identified through the Housing Health and Safety Rating System (HHSRS)
	• Ensure that where practitioners identify disrepair/defects in rented accommodation that give rise to hazards that may result in unintentional injury, that practitioners make a referral to the Private Housing and Environmental Health Team so they may take appropriate action to reduce those hazards. Similarly, if defects are identified in social housing, a referral should be made to the housing provider to undertake works to reduce hazards. Hazards might include electrical hazards, falls on stairs, falls between levels (from windows, balconies, accessible roofs etc.), poor lighting (no natural lighting), burns and scalds, poor ergonomic design etc.
	• Provide practitioners who visit children and young people at home with mechanisms for sharing information about households that might need a home safety assessment. This includes health visitors, social workers and GPs
	• Ensure practitioners adhere to good practice on maintaining the confidentiality and security of personal information. (For example, this includes using end-to-end encryption when sharing data with other agencies
	• Offer home safety assessments to the households prioritised in recommendations 1 and 2. Where appropriate, supply and install suitable, high quality home safety equipment. Home safety equipment should adhere to the British 'Kite mark' standards or the equivalent European standard. Where resources are limited, it may be necessary to narrow down further the households being prioritised (for example, to those with children under the age of 5 years)
	• Ensure the assessment, supply and installation of equipment is tailored to meet the household's specific needs and circumstances. Factors to consider include:
	  ○ the developmental age of the children (in relation to any equipment installed)
	  ○ whether a child or family member has a disability
	  ○ cultural and religious beliefs
	  ○ whether English is the first language
	  ○ levels of literacy
	  ○ the level of control people have over their home environment
	  ○ the household's perception of, and degree of trust in, authority

	• Ensure education, advice and information is given during a home safety assessment, and during the supply and installation of home safety equipment. This should emphasise the need to be vigilant about home safety and explain how to maintain and check home safety equipment. It should also explain why safety equipment has been installed – and the danger of disabling it. In addition, useful links and contacts should be provided in case of a home safety problem • Recognise the importance of measures to prevent unintentional injuries in the home among children and young people aged under 15, particularly among those living in disadvantaged circumstances • Provide child-focused home safety advice. If the family or carers agree, refer them to agencies that can undertake a home safety assessment and can supply and install home safety equipment • Encourage parents, carers and others living with children and young people aged under 15 to conduct their own home safety assessment. They should use an appropriate tool, as outlined in recommendation
Community	• Introduction of 20mph limits and the safe system approach can be embedded in strategic documents such as the LTP • Establish local partnerships with relevant statutory and voluntary organisations or support existing ones. Partners could include: ○ local community and parent groups ○ organisations employing health and social practitioners who visit children and young people in their homes (for example, health visitors) ○ child care agencies ○ others with a remit to improve the health and wellbeing of children aged under 15 ○ local umbrella organisations for private and social landlords ○ those involved in lifestyle and other health initiatives • Use these partnerships to: ○ help collect information on specific households where children and young people aged under 15 may be at greatest risk of an unintentional injury. The collection and sharing of information should adhere to the standards referred to in recommendation ○ help determine and address barriers to creating a safe home environment. (For example, the cost of equipment, cultural norms, issues of trust or a lack of control over the home environment may all be barriers to installing safety equipment) ○ get the community involved, for example, local 'community champions' could be used to promote home safety interventions and help practitioners gain the trust of householders ○ carry out home safety assessments and supply and install home safety equipment, in line with recommendations
Neighbourhood	• Schools to develop school travel plans that encourage active travel to and from school and address safety issues throughout the whole journey. School travel plans can be supported by road engineering measures to reduce vehicle speeds and activities to enforce traffic law

9.0 School Age children

Introduction

There are close links between health, education and achievement. Education departments, and through them, schools, have key roles to play in tackling health and inequalities. It also helps promote and sustain healthy lifestyles and positive choices, supporting and nurturing human development, human relationships and personal, family and community well-being[99].

What are the issues in Newham?

Only 10% of Newham's 15-year olds report being physically active for at least one hour a day, seven days a week, which is lower than London and England with nearly 70% of them sedentary for more than seven hours a day, similar to London and England.

Childhood obesity is high in Newham (12.2% of children aged 4-5 and 26.8% of children aged 10-11) compared to London, England and comparator boroughs. A similar picture exists for underweight children (2.38% of children aged 4-5 and 2.44% of children aged 10-11), which are higher compared with London, England and comparator boroughs. This is further compounded by a large majority (over 88%) of secondary schools, academies and colleges in Newham located within an 800m distance (10-minute walk) from one fast food takeaway.

The numbers of 0-19 year olds attending A&E departments has increased in the last year, with the highest surges seen in those aged between five and nine years of age.

What are the inequalities?

There is a strong relationship between deprivation and prevalence of excess weight in children aged both 4-5 and 10-11 years nationally, with 82% of students in both Year 6 and Year Reception in Newham residing within the most deprived quintile for their area of residence.

What are we doing well?

The proportion of children achieving 5A*-C grades at GCSE has increased since 2008-2010 and is now at 57.7% which is now higher than England but still lower than London and comparator boroughs. In conjunction, the total percentage of pupils permanently excluded from school has constantly been lower than London and England since 2007. The self-reported prevalence of 15-year-olds who eat 5 or more portions of fruit and vegetables a day in Newham is 56.9% which is higher than similar boroughs (55%), London (56.2%) and England (52.4%).

What needs improving?

A holistic and multisectoral approach (e.g. Food licensing policy, travel and infrastructure, physical activity) is required to address the high levels of excess weight and underweight children in Newham. Furthermore, awareness should be amplified on the appropriate use and timing of healthcare resources, including use of A&E departments.

PHYSICAL ACTIVITY AND GREEN SPACES

Introduction

Physical activity has been in decline since the 1960s; we are over 20% less active now and predicted to be 35% less active by 2030. Compelling evidence has shown that healthy diets, active lifestyles and a healthier weight can help the prevention and management of over twenty chronic conditions including Type 2 diabetes mellitus (T2DM), heart disease and some cancers. Whilst physical activity is therefore seen as an intervention in tackling obesity, compelling evidence denotes its huge independent benefits to both mental and physical health, as well as longer term educational attainment[92, 100]. However, currently only 21% of boys and 16% of girls meet the UK Chief Medical Officers' guideline of 60 minutes of physical activity per day[101].

Policies and Drivers:

National

Everybody Active Every Day aims to 'enable people to take control of their current and future health, and to boost parents' understanding of how active play and 'physical literacy' is essential for children[100]. *Moving More Living More (MMLM)* is a cross-Government campaign to deliver a physical activity legacy from the 2012 Olympic and Paralympic Games[102].

Healthy Lives, Healthy People recognises that "health considerations are an important part of planning policy" with an impetus for new housing, public facilities and transport routes developed with walking, cycling and access to green spaces and physical activities as priorities[101]. Finally, NICE has denoted numerous recommendations in promoting physical activity for children and young people in *Physical activity for children and young people [PH17]*[103].

Local

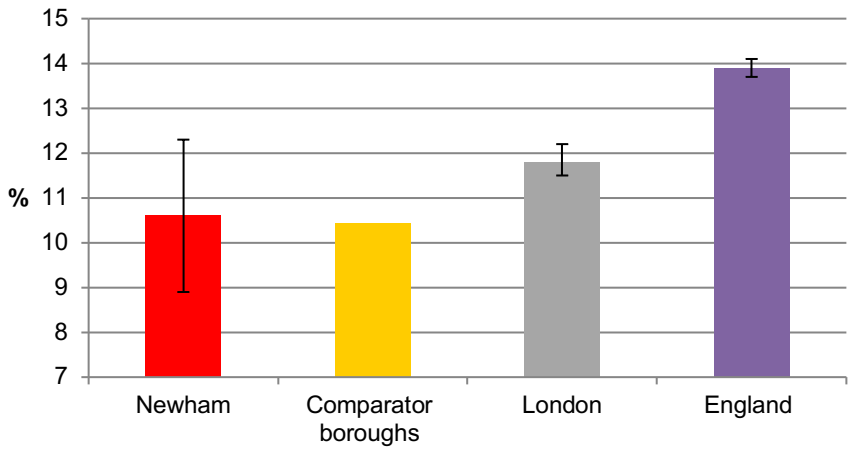
In the London 2012 Get Set Network, every single Newham school and college was enrolled, with over 54,000 young people aged 3-19 taking part in Games-related activities. Under the Newham's *Every Child a Sports Person* Programme, schools work closely to increase the amount of time pupils spend outside school hours on sport, together with encouraging primary school children to be coached by secondary school Sports Coaches.

What's happening in Newham?

The figure below illustrates self-reported prevalence of 15-year-olds who are active for at least one hour a day, seven days a week from the 2014-2015 WAY Survey. At 10.6%, prevalence of young people in Newham are similar to comparator boroughs (10.4%) and lower than London (11.8%) and England (13.9%).

FIGURE 66 – PERCENTAGE OF 15-YEAR-OLDS WHO ARE PHYSICALLY ACTIVE FOR AT LEAST ONE HOUR A DAY, 7 DAYS A WEEK

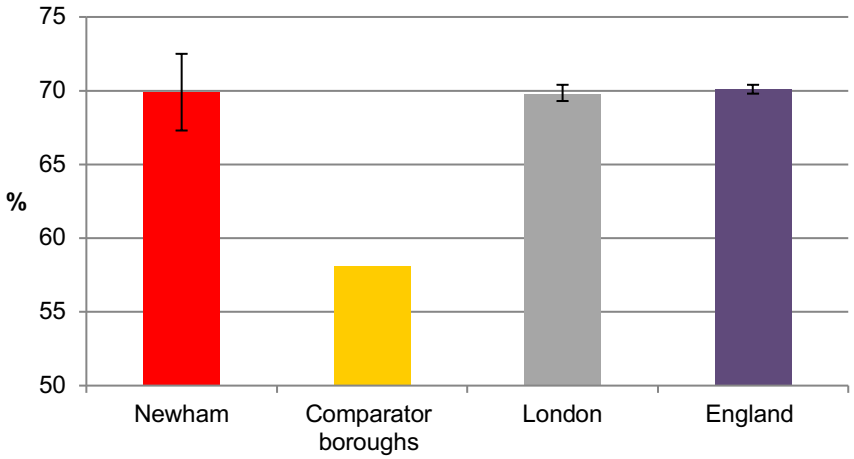
Source: WAY Survey from Fingertips, PHE



However, in contrast, the self-reported prevalence of 15-year-olds who had a mean daily sedentary time in the last week of over 7 hours a day was higher in Newham (69.8%) compared to comparator boroughs (58.1%) but similar to London (69.8%) and England (70.1%).

FIGURE 67 – PERCENTAGE OF 15-YEAR-OLDS WHO HAD A MEAN SEDENTARY TIME OF OVER 7 HOURS A DAY IN THE LAST WEEK

Source: WAY Survey from Fingertips, PHE



What services are available in Newham?

- Walking and cycling is promoted to children, staff, and parents at schools participating in the School Travel Plan programme (51/108 schools in 2014-2015 academic year)
- A recent *Beat the Streets* pilot around the Olympic park involved the residents of four London boroughs including Newham with 23,000 residents across 71 teams participating and a grand total of 221,000 miles recorded.

- Commissioned by LBN, Active Newham, provide a wide range of sport and activity for young people residents in LBN local estates to three leisure centres alongside participating in the Sport England '*This Girl Can*' initiative.
- Funded by Sport England in 2012, *Newham's Let's Get Moving* programme further developed and expand the physical activity care pathway in Newham by training all Newham's GPs about the benefits of physical activity and offering physical activity surgeries to support inactive people into health improving sports and physical activities.
- Newham hosts an annual multi-sport competition "*Mini Games*" for Newham's primary schools which also serves as a qualifying tournament for the London Youth Games School holiday programmes
- In 2014-2015 a total of 1513 school children and 450 adults received National Standard cycle training (including the Safer Urban Driving courses)
- LBN offers free swimming sessions to under 16s, schools and lessons specifically developed for children with disabilities alongside free tennis at tennis parks and paid for Mini Tennis Courses for players between 3 and 15-year-olds.

Progress since the last JSNA

As the WAY survey was first conducted in 2014, no comparisons with the 2010 and 2011-2012 JSNA have been made. Furthermore, there have been no further updates in the WAY survey since 2014.

Recommendations:

PHE and NICE have published guidance on improving physical activity amongst children and young people[103,104].These recommendations are incorporated alongside findings from a recently commissioned rapid review undertaken by UCLPartners in March 2016:

Level	Recommendations
Policy	• Ensure the continuation of a long-term (minimum five years) national campaign to promote physical activity among children and young people. The campaign should be integrated with and support other national health campaigns and strategies to increase participation in play and sport and reduce obesity (such as 'Change4Life') • Use research, consult and actively involve children and young people and their parents to determine the best media to use, the most effective messages and the most appropriate language for different groups • Ensure physical activity initiatives aimed at children and young people are regularly evaluated • Identify groups of local children and young people who are unlikely to participate in at least 1 hour of moderate to vigorous physical activity a day. Work with the public health observatory, schools and established community partnerships and voluntary organisations to achieve this • Involve these children and young people in the design, planning and delivery of physical activity opportunities, using the information gathered • Consult with different groups of children and young people and their families on a regular basis to understand the factors that help or prevent them from being physically active • Ensure physical activity facilities are suitable for children and young people with different needs and their families, particularly those from lower socioeconomic groups, those from minority ethnic groups with specific cultural requirements and those who have a disability • Provide children and young people with places and facilities (both indoors and outdoors) where they feel safe taking part in physical activities. These could be provided by the public, voluntary, community and private sectors (for example, in schools, youth clubs, local business

	premises and private leisure facilities). Local authorities should coordinate the availability of facilities, where appropriate. They should also ensure all groups have access to these facilities, including those with disabilities • Make school facilities available to children and young people before, during and after the school day, at weekends and during school holidays. These facilities should also be available to public, voluntary, community and private sector groups and organisations offering physical activity programmes and opportunities for physically active play • Actively promote public parks and facilities as well as more non-traditional spaces (for example, car parks outside working hours) as places where children and young people can be physically active • Make provision for children, young people and their families to be physically active in an urban setting. They should ensure open spaces and outdoor facilities encourage physical activity (including activities which are appealing to children and young people, for example, in-line skating). They should also ensure physical activity facilities are located close to walking and cycling routes • Ensure the spaces and facilities used for physical activity meet recommended safety standards for design, installation and maintenance. For example, outdoor play areas should have areas of shade from the sun and sheltered areas where children can play to reduce the impact of adverse weather • Assess all proposals for signs restricting physical activity in public spaces and facilities (such as those banning ball games) to judge the effect on physical activity levels
Community	• Encourage families to be more active - for example, walking and cycling to school and shops, going to the park or swimming • Encourage families to reduce sedentary activities – such as watching television or playing video games – and consider active alternatives such as dance, football or walking • Identify local factors that may affect whether children and young people are physically active by regularly consulting with them, their parents and carers • Find out what type of physical activities children and young people enjoy, based on existing research or local consultation (for example, some might prefer non-competitive or single-sex activities). Actively involve them in planning the resulting physical activities • Remove locally identified barriers to participation, such as lack of privacy in changing facilities, inadequate lighting, poorly maintained facilities and lack of access for children and young people with a disability. Any dress policy should be practical, affordable and acceptable to participants without compromising their safety or restricting participation • Provide regular local programmes and other opportunities for children and young people to be physically active in a challenging environment where they feel safe (both indoors and outdoors). Ensure these programmes and opportunities are well-publicised • Ensure physical activity programmes are run by people with the relevant training or experience
Neighbourhood	• Encourage children to participate in sport or other active recreation, and make the most of opportunities for exercise at school

HEALTHY WEIGHT

Introduction

The increasing global prevalence of childhood obesity has made it a prominent issue in public health, with the World Health Organisation (WHO) describing it as "one of the most serious public health challenges of the 21st century"[105]. In the UK, together with individual factors such as poor dietary choices and increasing trends of physical inactivity and population level factors such as availability of takeaways and unchecked urban planning, the prevalence of childhood obesity has dramatically risen. Evidence shows that childhood obesity leads to an increased risk in numerous health related conditions, both physical and psychological e.g. T2DM, asthma, musculoskeletal problems, cardiovascular disease (CVD) associated risk factors and depression, all of which can impact upon premature mortality[106]. Moreover, on the other end of the spectrum, it is important to recognise that children can be underweight through undernutrition or malnutrition, which also exposes them to short-term (e.g. infections) and long-term (e.g. stunting) health consequences.

Policies and Drivers

National

Healthy Lives, Healthy People: Our strategy for Public Health in England, 2010 policy gave rise to "The Healthy Child Programme" which both supports and advises families on ways in which they can reduce the risk of their children becoming obese. This is done through health promotion, development reviews and parental support[107]. *The Public Health Responsibility Deal*, 2011 involved voluntary pledges made by the food industry and local businesses, aimed at preventing excess weight levels through the promotion of healthy eating and physical activity[108].

Obesity and healthy eating, 2010-2015 aimed to see a "sustained downward trend in the level of excess weight in children" by 2020. Actions include helping people to make healthier choices (e.g. eat / drink more healthily - Change4Life programme) and encouraging responsible business practices (e.g. reducing salt and fat content / accurate calorie reporting on foods)[108].

The *Foresight report - Tackling Obesities: Future choices* clarified the broad range of factors which influenced obesity, identified effective interventions and analysed how future levels of excess weight may change[109].Finally, NICE has detailed guidance on recommendations to ensure good childhood nutrition - *Maternal and child nutrition [PH11]*[10].

Local

Utilising a whole school approach; *Healthy Schools London* increases access to healthy food throughout the school day, provides opportunities to be more physically active and awards school for work aimed at reducing childhood obesity in five key areas; Healthy Eating, Physical Activity, Emotional Health and Wellbeing, Environment & Sustainability and Community & Volunteering.

What's happening in Newham?

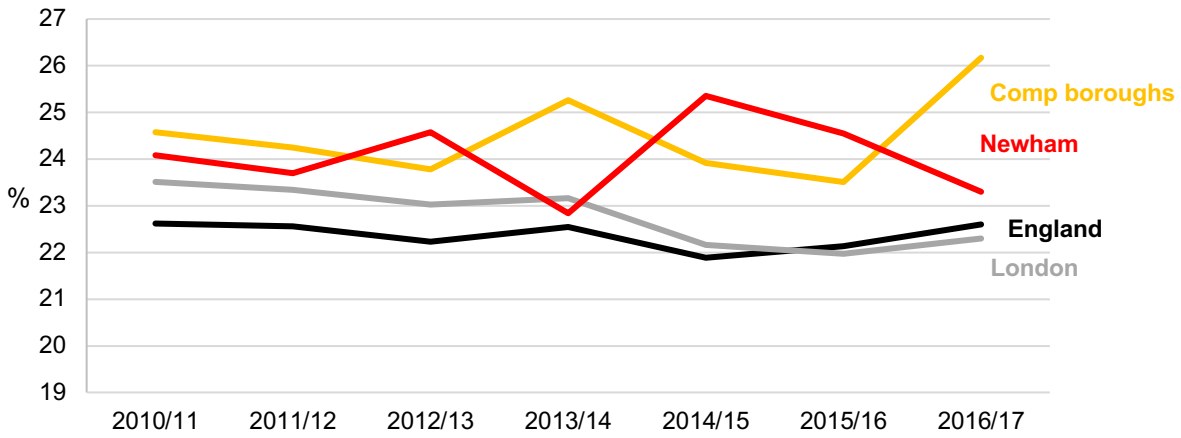
Excess Weight

Overall, Newham experienced high levels of excess weight in 2016-2017 with 12.2% and 20.0% of children aged 4-5 and 10-11 being obese respectively. In contrast, despite these high levels, when asked if their body is 'too fat', 15-year-olds in Newham report one of the lowest levels of positive responses in the country[110].

The figure below denotes the annual percentages of those overweight and obese (combined) from 2010-2011 to 2016-2017 in year Reception for Newham, London, England and comparator boroughs[33].

FIGURE 68 –PERCENTAGE OF CHILDREN AGED 4-5 WITH EXCESS WEIGHT IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2011 TO 2016-2017

Source: PHOF indicator 2.06i

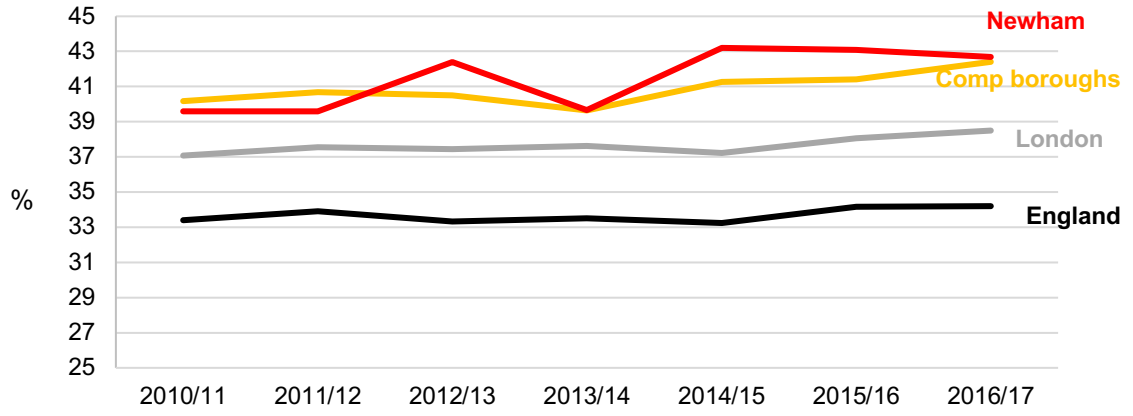


The figure above clearly shows the year-on-year variability; thus, no discernible trend can be identified. Furthermore, confidence intervals have not been presented because the annual variability is likely to lead to over-interpretation of statistical significance. However, since 2015/16 the prevalence has decreased from 24.6% to 23.3% in 2016/17.

The figure below denotes the annual percentages of those overweight and obese (combined) from 2010/11 to 2016/17 in year 6 for Newham, London, England and comparator boroughs[33].

FIGURE 69 – PERCENTAGE OF CHILDREN AGED 10-11 WITH EXCESS WEIGHT IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2011 TO 2016-2017

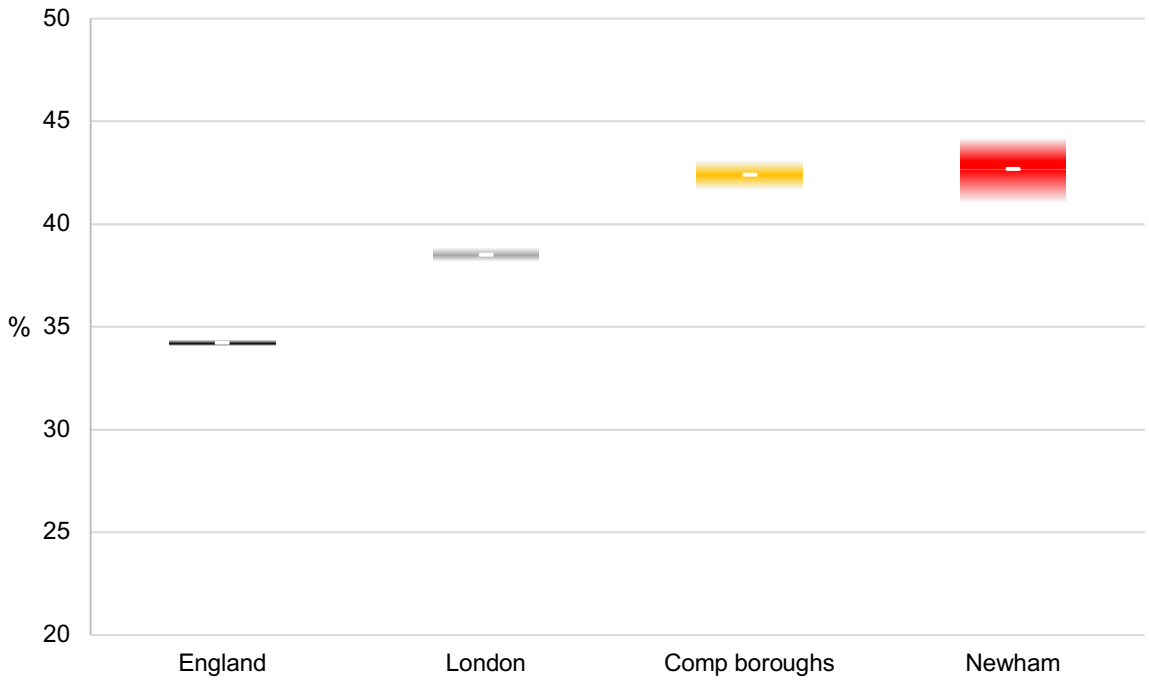
Source: PHOF indicator 2.06ii



While year-on-year variability prevents the identification of a genuine underlying trend, Newham's rate in 2016/17 (42.7%) was higher than those pre-2103/14, and has been consistently higher than those of London and England. As the following chart shows, these differences are strongly statistically significant.

FIGURE 70 – PERCENT OF CHILDREN AGED 10-11 WITH EXCESS WEIGHT IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2015-2016 (95% CONFIDENCE INTERVALS)

Source: PHOF indicator 2.06ii

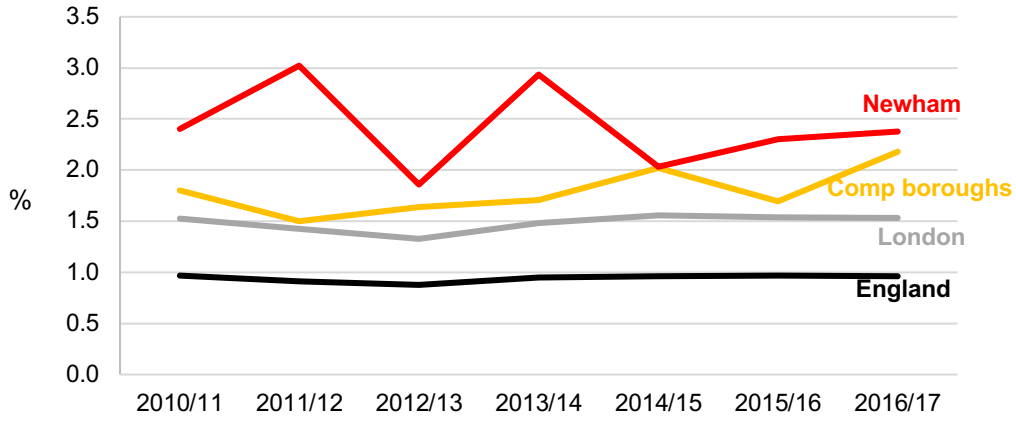


Underweight

As with excess weight, Newham has high rate of underweight children compared with London, England and comparator boroughs. The figures below show the prevalence of underweight in 4-5 year olds from 2010-2011 to 2016-2017. Newham's rate has been consistently higher than all the comparators, and the figure for 2016/17, 2.38%, is more than double that of England (0.96%) and 50% higher than the rate for London (1.53%).

FIGURE 71 – PERCENTAGE OF UNDERWEIGHT CHILDREN AGED 4-5 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2011 TO 2016-2017

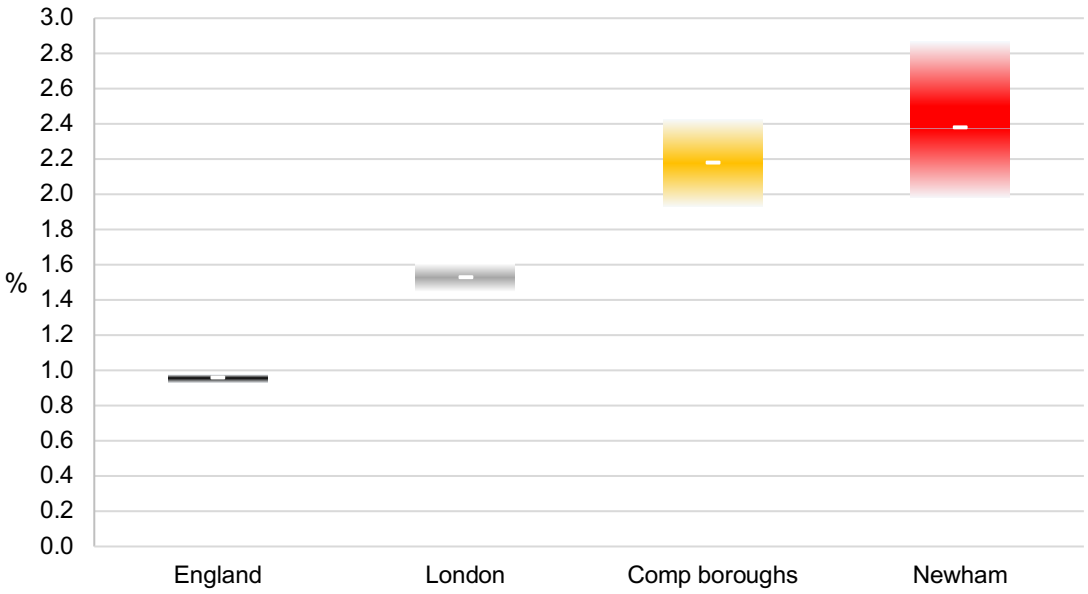
Source: PHE Fingertips indicators 90316



As the second chart shows, these differences are highly statistically significant. As well as issues relating to unhealthy over-eating, there may also be a problem with under-nourishment in the borough.

FIGURE 72 – PERCENTAGE OF UNDERWEIGHT CHILDREN AGED 4-5 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2016-2017 (95% CONFIDENCE INTERVALS)

Source: PHE Fingertips indicator 90316



Similarly, in the figure below detailing the prevalence of underweight 10-11 year olds, Newham fairs poorly compared with comparator boroughs, London and England.

The figures below show the prevalence of underweight in 10-11 year olds from 2010-2011 to 2016-2017. Newham's rate has been consistently higher than all the comparators, and the figure for 2016-2017, 2.44%, is 75% higher than that of England (1.34%) and 36% higher than the rate for London (1.6%).

FIGURE 73 – PERCENTAGE OF UNDERWEIGHT CHILDREN AGED 10-11 IN NEWHAM, COMPARATOR BOROOUGHS, LONDON AND ENGLAND 2010-2011 TO 2016-2017

Source: PHE Fingertips indicator 90320

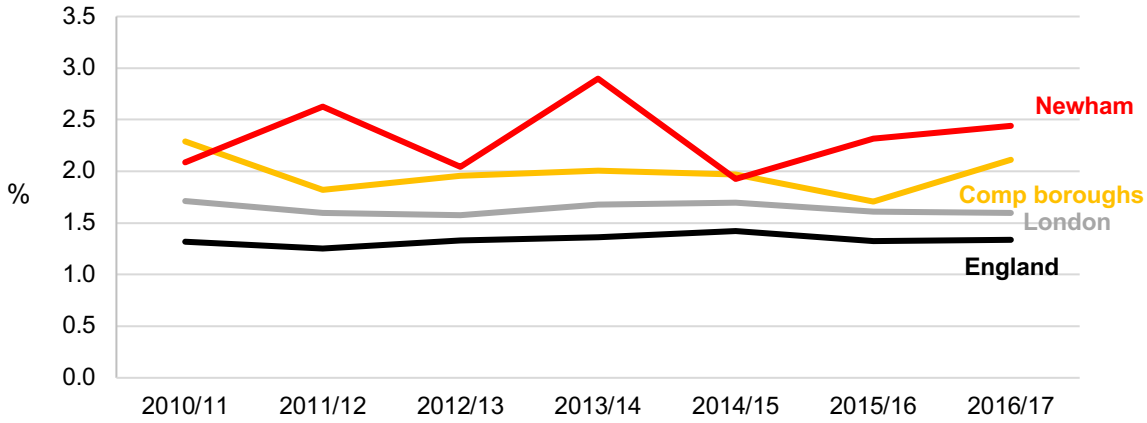
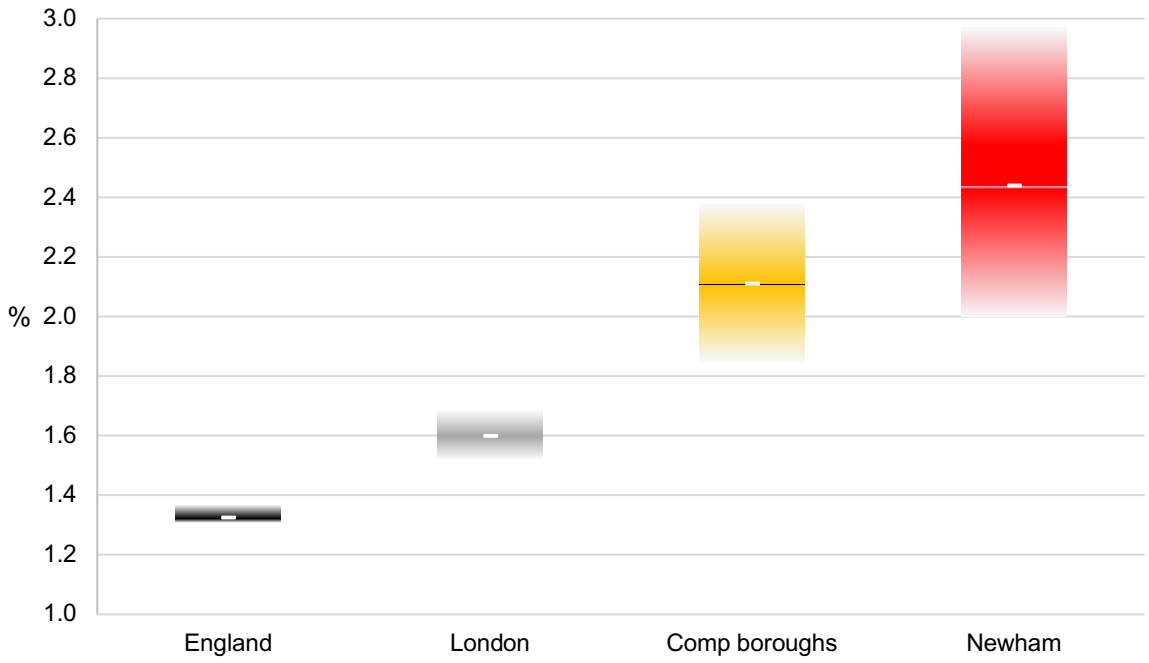


FIGURE 74 – PERCENTAGE OF UNDERWEIGHT CHILDREN AGED 10-11 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2015-2016 (95% CONFIDENCE INTERVALS)

Source: PHE Fingertips indicator 90320



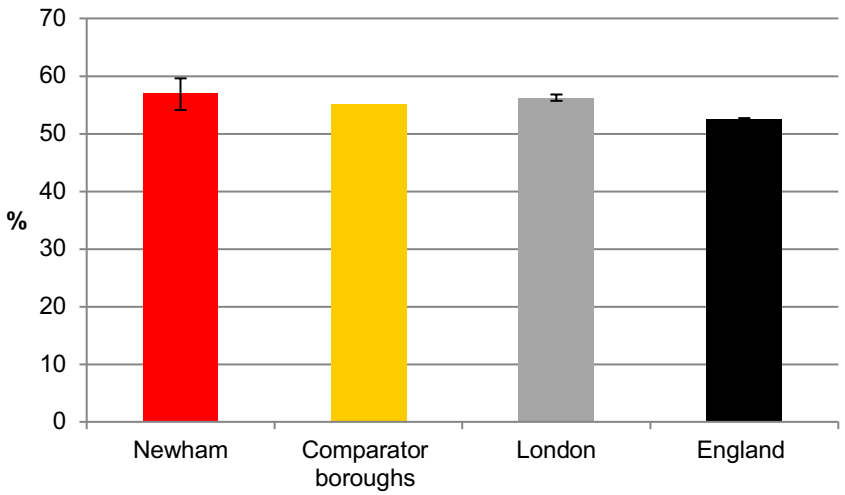
As the second chart shows, these differences are highly statistically significant. As well as issues relating to unhealthy over-eating, there may also be a problem with under-nourishment in the borough that persists throughout primary school ages.

Five-a-day

The figure below illustrates self-reported prevalence of 15-year-olds who eat five or more portions of fruit and vegetables a day with young people in Newham having the highest value at 56.9% compared to similar boroughs (55%), London (56.2%) and England (52.4%).

FIGURE 75 – PERCENTAGE OF 15-YEAR-OLDS WHO EAT 5 OR MORE PORTIONS OF FRUIT AND VEGETABLES A DAY

Source: Way Survey from Fingertips, PHE



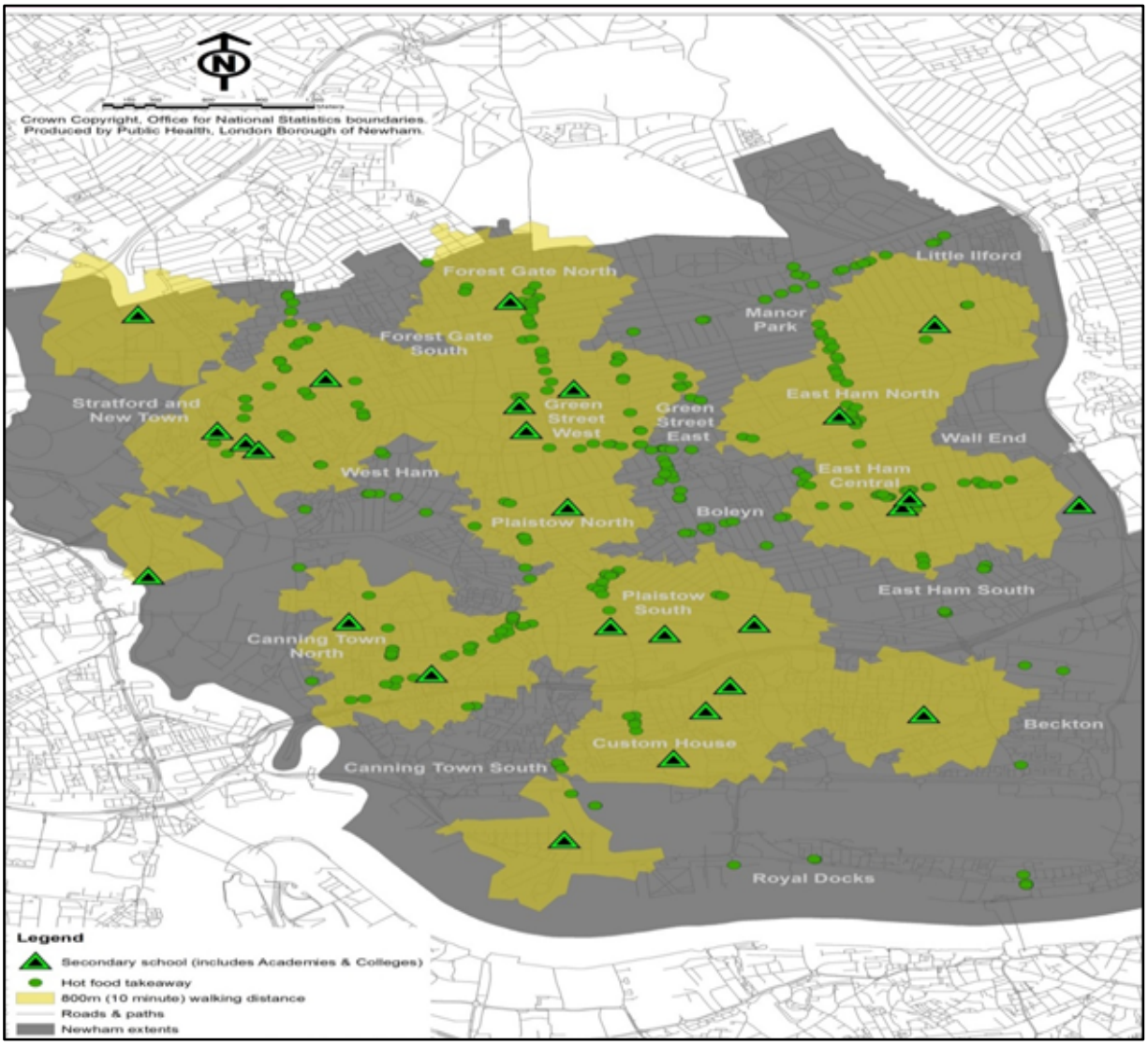
Deprivation

Using the Index of Multiple Deprivation (IMD) and National Child Measurement Programme (NCMP), a strong relationship between deprivation and prevalence for excess weight in children aged both 4-5 and 10-11 was noted with 2014-2015 data noting that 82% of students in both Year 6 and Year Reception in Newham are within the most deprived quintile for their area of residence IMD 2011 score.

Takeaways

Over 88% of secondary schools, academies and colleges in Newham are located within a 800m distance (10 minute walk) from a fast (fried) food takeaway. This is denoted in the figure below[33].

FIGURE 76 – LOCATION OF "FAST FOOD" TAKE AWAYS AROUND SECONDARY SCHOOLS



What services are available in Newham?

In the Schools Litter Project undertaken by the Cleaning, Waste & Recycling Division of LBN in 2014, the Eastlea Community School in Canning Town was noted to have developed a preferential relationship with three local fast food takeaways with information provision on the 6 inset days in exchange for use of healthier cooking oil to prevent stock loss on the days that children did not attend school. This is therefore a positive example for better engagement with schools across the borough with their local fast food retailers. Moreover, as mentioned above in *Physical Activity and Green Spaces*, there is a dedicated *Healthy Schools London* programme. Newham's school nursing service also play a vital role in the co-ordination, advocacy and delivery of the NCMP; which provides vital information on the weight of 4-5 and 10-11 year olds in all primary schools throughout the borough[111].

Progress since last JSNA

Compared to the 2010 JSNA, the rates of 4-5 year olds in Newham with excess weight was falling but since then it has now plateaued with fluctuations around 24% over the last five years up till date. In contrast, the rates of 10-11 year olds in Newham with excess weight was static at 40% but has since seen a rising trend (currently at 43%)[26].

Compared to the 2010 JSNA, the rates of underweight 4-5 year olds in Newham is constantly higher than comparator boroughs and London. A similar picture is noted for 10-11 year olds with rates persistently higher compared to comparator boroughs and London. Urgent action is needed to reduce the prevalence of excess weight and underweight in children and young people in Newham.

Recommendations

These are numerous recommendations to reduce the prevalence of excess and/or underweight from NICE, PHE, the Association of Directors of Public Health for London (London ADPH) and NHS Choices that focuses on emphasising the Eat Well Guide for Families[108,109,112-114].These recommendations are incorporated alongside findings from a recently commissioned rapid review undertaken by UCLPartners in March 2016[115]:

Level	Recommendation

Policy	• A commitment should be made to support a healthy food environment in schools and other public sector environments to ensure children eat a balanced healthy diet wherever possible
	• A commitment should be made to reduce the levels of overweight and obese children towards the England average
	• Local authorities should work with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned physical activity, addressing as a priority any concerns about safety, crime and inclusion, by:
	  ○ providing facilities and schemes such as cycling and walking routes, cycle parking, area maps and safe play areas
	  ○ making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes
	  ○ ensuring buildings and spaces are designed to encourage people to be more physically active (for example, through positioning and signing of stairs, entrances and walkways)

	○ particularly considering people who require tailored information and support, especially inactive, vulnerable groups
Community	• An evidence-based cost-effective community weight loss programme such as FBBM, MEND, Families for Health, WATCH IT or community sports coaching programme should be adapted and piloted, dependent on local resources. • A commitment should be made for ongoing commissioning of Tier 2 services (i.e. Lifestyle interventions) • Consideration should be given to increasing the sale of healthy food items in public sector environments by providing discounts on low calorie food or increasing availability of healthy food in vending machines
Neighbourhood	• A cost-neutral intervention such as the one described by Wardle et al. (to increase physical activity in schools) should be implemented • All schools have equitable access to important nutritional education materials and that these are incorporated into existing PE programmes • Consideration should be given to piloting and implementing calorie labelling in schools and/or colleges • Nurseries and other childcare facilities should: • minimise sedentary activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions • implement Department for Education and Skills, Food Standards Agency and Caroline Walker Trust guidance on food procurement and healthy catering • Head teachers and chairs of governors, in collaboration with parents and pupils, should assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active, in line with existing standards and guidance • All families should be encouraged to use the Eatwell guide to ensure that children receive the ideal nutrition they require

EDUCATIONAL ATTAINMENT

Introduction

If educational disadvantage starts from the early years, a profound impact across a child and young person's life course is certain. By therefore standardising and improving educational attainment, children from more disadvantaged backgrounds are better placed to close the gap both health and social inequalities with their peers.

Policies and Drivers

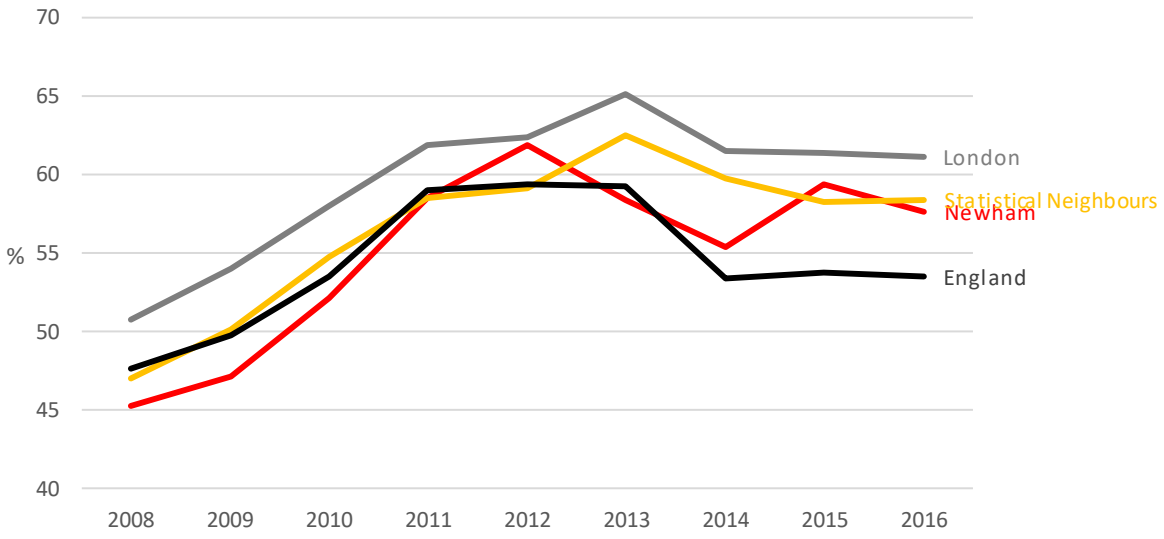
In 2010, the Government set out its education policy aims in the White Paper, *The Importance of Teaching*[116]. One of these was to reform GCSE qualifications and course structures, so that examinations are taken at the end of the course, as opposed to a modularised approach with Ofqual implementing this reform process.

What's happening in Newham?

The figure below shows the percentage of pupils achieving 5 A*-C GCSE grades (including English and Maths) from 2008 till 2016. Newham's rate rose from 2008 to 2012, since when, as with the comparators, it has fallen. Newham has shown an increase from 45.3% in 2008 to 57.6% in 2016. Newham has been consistently lower than London overall, but since 2012 has generally been higher than England. Note that the statistical neighbours are pre-selected by the local authority interactive tool (LAIT) and may not be the same as the five comparator boroughs used elsewhere in this JSNA. Furthermore, the source data on LAIT does not allow for the calculation of confidence intervals.

FIGURE 77 – PUPILS ACHIEVING 5 • A*-C GCSE INCLUDING ENGLISH AND MATHS (KS4) IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

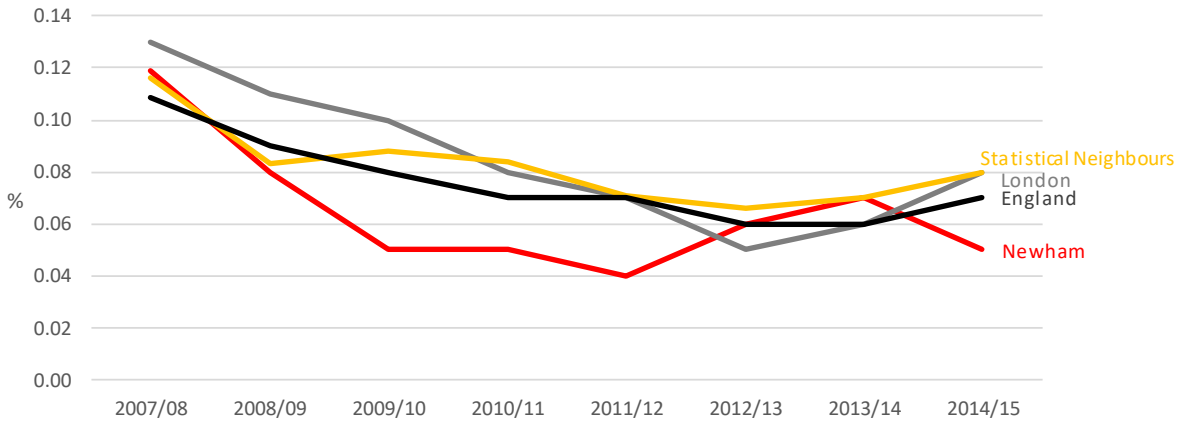
Source: LAIT



The total percentage of pupils permanently excluded from school in Newham has constantly been lower than London and England since 2007-2008 and remained lower than comparators, except in 2011-2012 to 2013-2014. However, at less than half a percent, the figures for all are low[117].

FIGURE 78 – TOTAL PERCENTAGE OF PUPILS PERMANETLY EXCLUDED FROM SCHOOLS IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

Source: LAIT



What services are available in Newham?

Newham offers free education, 15 hours of free education per week for 38 weeks for three and four-year olds, if they are from households in receipt of income support or tax credits. This is offered by all types of nurseries and nursery classes, playgroups and pre-schools, childminders and Sure Start Children's Centres across Newham.

Progress since last JSNA

Compared to the 2010 JSNA, we have improved in both the GCSE pass rate and percentage of pupils permanently excluded. However, as we still lag behind London, further improvement continues to be possible. In 2008, 45.3% of Newham's GCSE cohort achieved five good passes at GCSE (5 A*-C) and by 2016, this was 57.6% which is below comparator boroughs (60%) and London (62%). The percentage of pupils permanently excluded was 0.085% in 2007/08 and 0.055% in 2014/15 which is above comparator boroughs (0.05%) but below London (0.075%)[26].

Recommendations

These are numerous recommendations to improve educational attainment by NICE and the Department of Education. These include:

Level	Recommendations
Policy	• The Department of Education and local authorities need to combine their efforts to identify and support at-risk schools
Community	• Local authorities should: ○ provide sufficient training for governing bodies so that they can be effective in appointing head teachers and managing their performance ○ work with School Improvement Partners to analyse, monitor and better understand school performance

	○ provide speedy extra support (and funding if necessary) to all identified vulnerable schools and monitor their progress closely; and ○ be prepared to use their statutory powers to enforce changes in vulnerable schools that will not cooperate in accepting support ○ in conjunction with Ofsted, assess the potential of a poorly performing school to recover quickly. Where this is unlikely, they should take fast and effective action to replace the leadership team or close the school ○ support the school in addressing issues such as falling rolls and the relatively large numbers of vulnerable pupils that these schools often have, who may require relatively intensive support
Neighbourhood	• Schools should: • put teaching at the heart of the school's self-evaluation: including, for example, commitment to regular curriculum reviews and assessment of teaching quality • build effective leadership teams that provide collective leadership and responsibility, based on mutual trust and the high expectations of all staff and pupils that they will fulfil their potential; and • seek external support for school improvement, particularly from their local authority services and neighbouring schools • Pupils from poorer homes tend to perform worse than their wealthier peers, whichever secondary school they are in. This suggests pupil-level interventions to narrow the gap at each school are also essential • Around half of the achievement gap is already present by the time children enter secondary school. This suggests the early years and primary schools have a pivotal role to play and that intensive catch-up programmes at the start of secondary school should be widely used

EMERGENCY ATTENDANCES AND ADMISSIONS

Introduction

The problem of rising and inappropriate emergency care is complex and has many causes, including problems with hospital and community care, and changing population demographics. Nearly a quarter of all those attending Emergency Departments (ED) are aged under 16 with the number of attendances and emergency admissions rising for this age group[118, 119].

Reasons for unplanned attendance can be complex, and are often led by the parent's perception of the child's illness with perceptions about illness severity and misconceptions about being unable to access GP quickly identified as the biggest reasons for avoidable attendances[120, 121]. As a result, children who are acutely unwell with non-emergency problems often seek unplanned care for conditions which could be easily treated in primary care[122].These conditions include feverish illness, diarrhea, vomiting, rash and abdominal pain[123, 124]. Between 2000 and 2011, NHS hospital admission data for children aged less than 15 years noted that more than half of short-stay admissions were for potentially avoidable infectious and chronic conditions[125].

Policies and Drivers

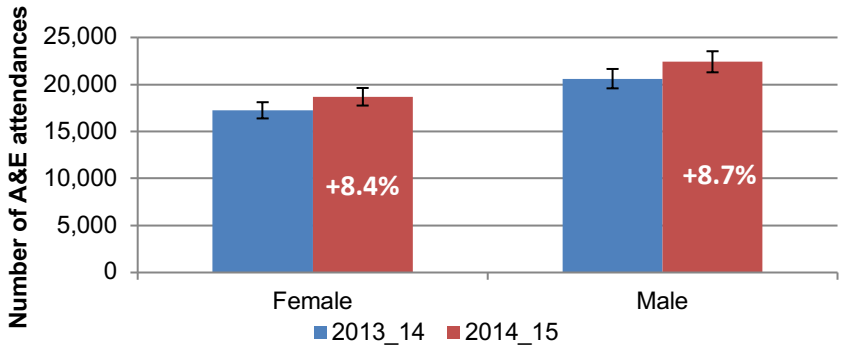
The *Urgent and Emergency Care Review* concluded that with rising demand and greater costs, the urgent and emergency care system is requiring ever increasing resources annually with currently fragmented services confusing to patients who may find it difficult to access care when they need it. As in childhood obesity, the adoption of a whole-system approach to commissioning more accessible, integrated and consistent urgent and emergency care services to meet patients unscheduled care needs is recommended[126].

What's happening in Newham?

The figure below shows the number for A&E attendances to Newham University Hospital (NUH) in 2014-2015 compared to 2013-2014. The data are for 0 – 19 year olds and are split by sex; male and female. In total, there were 41,109 A&E attendances to NUH for 0 – 19 year olds between April 2014 and March 2015. Between 2013-2014 and 2014-2015, the number of emergency attendances in Newham for both males and females 0 – 19 years rose by 8.7% for males and 8.4% for females.

FIGURE 79 – A&E ATTENDANCES IN NEWHAM IN 0-19 YEAR-OLDS BY SEX

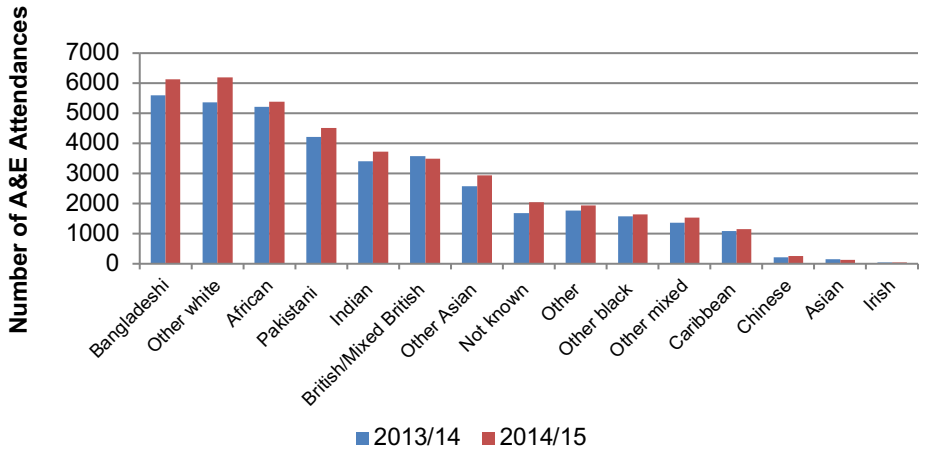
Source: Newham BI Portal



Looking at emergency attendances by ethnicity in 0 – 19 year olds in Newham, the Bangladeshi and Other White populations have the highest number of attendances (just over 12,000 per year in 2014-2015). This accounts for nearly one third (29.2%) of the total number of A&E attendances for that same year.

FIGURE 80 – A&E ATTENDANCES IN NEWHAM IN 0-19 YEARS-OLDS BY ETHNICITY

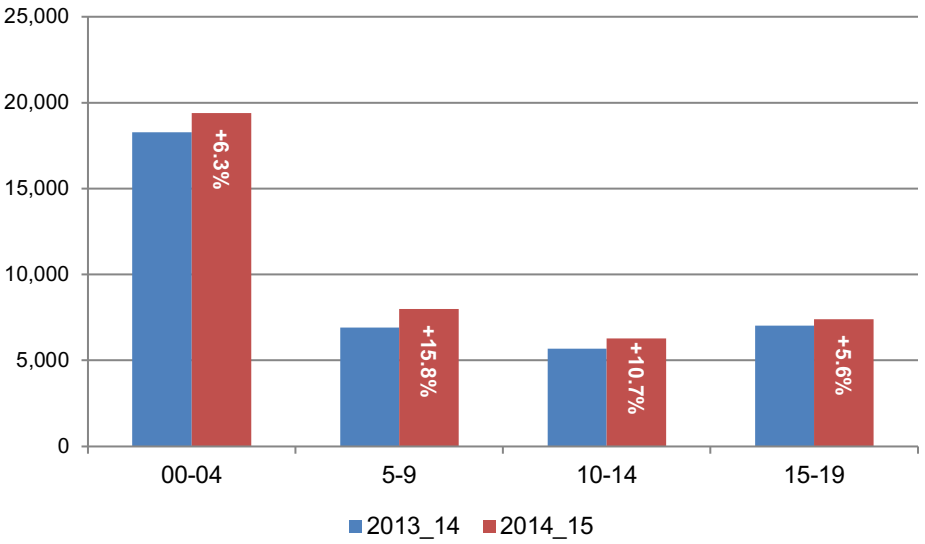
Source: SUS data from Newham BI Portal



In Newham in 2014-2015, the 0 – 4 age group accounted for 19,412 A&E attendances, just under half (47.2%) of all emergency attendances in 0 – 19 year olds. The 5 – 9 year olds accounted for 7,995 attendances (19.5%), the 10 – 14 age group 6,285 attendances (15.3%) and the 15 – 19 age group 7413 attendances (18.0%). Comparing 2013-2014 to 2014-2015 data, emergency attendances have increased across all age groups between 15.8% (5 – 9 year olds) and 5.6% (15 – 19 year olds).

FIGURE 81 – A&E ATTENDANCES IN NEWHAM BY AGE BAND

Source: SUS data from Newham BI Portal



The table below sets out the top reasons for emergency admissions to NUH for CYP aged 0 – 19 years, stratified by sex. In babies, the top reason for emergency admission is jaundice. In children aged 0 – 9 years it's viral infections (e.g. include illnesses such as gastroenteritis) followed by asthma. In males aged 10 – 19 years, the top reason for admission is asthma, and in females it's sickle cell anaemia. This information is vital to identify the scope of childhood illnesses that could easily managed in primary care settings.

TABLE 23 - REASONS FOR EMERGENCY ADMISSIONS TO NUH (2014-2015)

Source: SUS data from Newham BI Portal

Age	Males	Females	Babies
0-9	1. Viral* 2. Asthma 3. Bronchiolitis	1. Viral* 2. Asthma 3. Bronchiolitis	1. Jaundice 2. Low birth weight 3. Erythema toxicum (newborn rash)
10-19	1. Asthma 2. Abdominal pain 3. Sickle cell anaemia	1. Sickle cell anaemia 2. Lower abdominal pain 3. Other abdominal pain	

Further details on admissions for asthma, diabetes and epilepsy are given in the chapter "Children with Long Term Conditions (LTC)".

What services are available in Newham?

The Healthy London Partnership is the delivery arm of the London Health Commission, a partnership between National Health Service England and London's 32 CCGs. Within the Children and Young People Programme of the Healthy London Partnership, there is a focus on reducing unscheduled and acute care.

There is currently an ongoing Newham CCG/UCLPartners (UCLP) two-year project to explore the scope and feasibility of a peer-supported diabetes self-management programme for young people using a "story sharing" model.

A joint submission by Newham CCG, UCLP Peer Support Programme and the Bart's Health Young Adult team has recently been awarded national finalists in Quality in Care Awards for making transition better.

A research project funded by the NIHR exploring the role of group clinics for young people with diabetes in Newham led by Queen Mary University London (QMUL) is currently ongoing.

Finally, there is a programme of work to identify individuals at high risk of pre-diabetes, with options currently being developed for a pre-diabetes pathway of screening, user perceptions and impact.

Progress since last JSNA

A&E attendances in Newham across all age groups (0-4, 5-9, 10-14 and 15-19 years old) has increased since 2013-2014 by 6.3%, 15.8%, 10.7% and 5.6% respectively. A&E attendances across the sexes have also increased, with an 8.7% surge for males and 8.3% increase for females since 2013-2014. Attendances across ethnicities have also increased since 2013-2014.

Recommendations

These are numerous recommendations to reduce emergency attendances and admissions by NICE and NHS England. These include:

Level	Recommendations
Policy	• Moving care closer to home will help save money in the longer term and should be a priority • Provide more proactive care to prevent patients from entering crisis and reduce attendances and admissions • Prevent re-admission with active management of transitions, including timely and accurate information, good communication between hospital and primary care physicians, and a single point of co-ordination
Community	• Good quality data will help with evaluation and planning of new and existing services • Provide highly responsive urgent care services outside of hospital, so people no longer choose to queue in A&E • Ensure that those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery • Provide education and support for self-management for those with long term conditions, in particular COPD, asthma and heart failure • Ensure patients are able to see their preferred GP and able to speak to someone at the surgery when they want to
Neighbourhood	• Provide better support for self-care • Help people with urgent care needs get the right advice in the right place, first time • Connect all urgent and emergency care services together. Integrated working between health and social care can result in lower than expected emergency admissions and reduced use of beds • Offer rehabilitation for those who have recently suffered an exacerbation of COPD, exercise based rehabilitation for coronary heart disease • Provide structured discharge planning

10.0 ADOLESCENTS

INTRODUCTION

Adolescents, young people between the ages of 10 and 19 years, are often thought of as a healthy group. Nevertheless, adolescents die prematurely from preventable or treatable conditions such as accidents, suicide, violence or pregnancy-related complications, with many more suffering chronic ill-health and disability alongside unhealthy behaviors' such as tobacco use, sexually transmitted infections (STIs) including HIV, poor eating and exercise habits[127].

What are the issues in Newham?

The proportion of 16 – 18 year olds living in Newham in 2016 that were not in education, employment, or training (NEET) had reduced from 2015 to 2.7% which is the lowest percentage reported since 2011, but remains higher than the London average at 1.8%[128].

STI testing rate in Newham is lower than London and comparator boroughs, but higher than England. Moreover, in 2014, the chlamydia detection rate in the Newham 15 to 24 year-old population group was 20 percent lower than the minimum detection rate recommended under the Public Health Outcomes Framework (PHOF). Furthermore, over 13% all new STI diagnoses occur in the 15 to 19 year-old population group, with females aged 15 – 19 accounting for over 21% of new STI diagnoses in the female population.

Newham has low rates for hospital admissions for substance abuse in 15 – 24 year olds compared to comparator boroughs, London and England, but this is increasing.

Across all types of mental health disorders, Newham has a higher prevalence compared to London and England. Based on a recent survey in 2015, approximately 2,025 and 1,910 children were affected by an emotional and behavioural difficulty, respectively.

What are the inequalities?

There is currently little data at borough level to aid us in identifying any specific inequalities between groups in this section on Adolescent Health, although we know from anecdotal evidence that differences do exist.

What are we doing well?

Between 1998 and 2013, Newham achieved a 64.5% reduction in the under 18 conception rate[129], and it is now lower than England and comparator boroughs. In addition, the rate of teenage conceptions leading to abortions is lower in Newham, than London and comparator boroughs.

Young people in Newham report the lowest prevalence of cigarette smoking and e-cigarette use in contrast to comparator boroughs, London and England. Newham has a lower proportion (4.7%) of 15-year olds who self-report three or more risky behaviours compared to comparator boroughs (7.5%), London (10.1%) and England (15.9%). There is also lower prevalence of self-reported rates of being regular drinkers, drunk in the last four weeks, taking cannabis and other drugs in the last month in Newham compared to comparator boroughs, London and England.

What needs improving?

We need to increase access to contraception in young people; particularly long-acting reversible contraception, reduce the prevalence of abortions and continue to work with young people in Newham to ensure the rate of NEETs declines further.

Teenage conception rates and abortion rates following conception are declining. However, absolute numbers continue to be higher than in comparator boroughs. Risky behaviors are self-reported as low amongst 15-year olds in Newham, however work should continue with young people to reduce risky behaviors' such as smoking, drinking and drug-taking, improve safe sexual health practices, advocate for the use of contraceptives, and the improving the self-esteem of young women. The mental health of young people in Newham continues to require input and resources as the borough has higher rates than London and England.

NOT IN EDUCATION, EMPLOYMENT OR TRAINING (NEET)

Introduction

Excluding students or unpaid carers, NEET is defined as young people aged 16-18 who are unemployed or economically inactive. Being NEET however is often situational with young people often defined incorrectly as NEET when they're in-between educational courses or jobs[130].

Risk factors associated with long term NEET include; achieving less than five GCSEs grade A*- C, eligibility for free school meals, exclusion or suspension from school, teenage pregnancy, living with a physical or mental disability, deprivation, parental unemployment and low levels of parental support[130].Young people who are NEET have an increased risk of mental morbidity (e.g. depression), adopt unhealthy behaviours (e.g. drinking, drug use and smoking) and more likely to be involved in youth offending (e.g. young men who are NEET are approximately five times more likely to have a criminal record compared to those who are not NEET). These effects are amplified the with young age or the longer time spent in NEET.

Policies and Drivers

The Education and Skills Act (2008) placed a duty on LAs to support all young people resident to participate in education or training until the end of the academic year in which they turn 17[131].From summer 2015, this has increased to 18. Since 2015, the government has supported the development of new apprenticeships with a target to offer three million new apprenticeships by the year 2020[132].

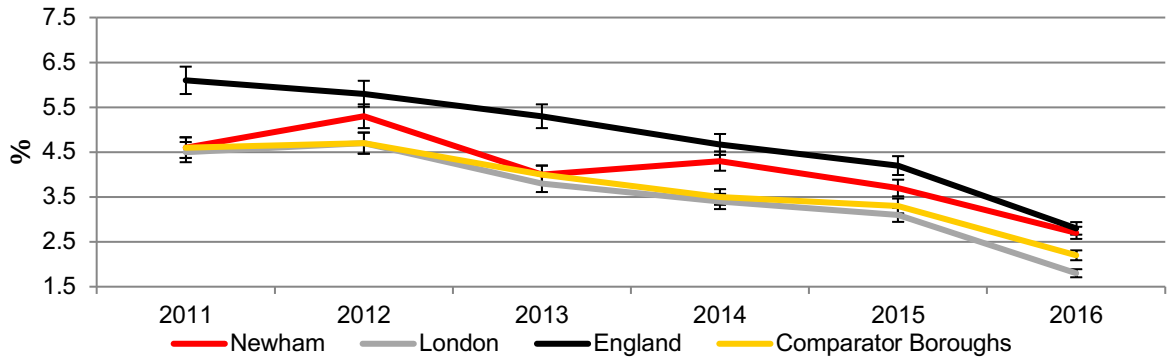
What's happening in Newham?

Summary

In 2016, 2.7% of 16-18 year olds living in Newham were defined as NEET, down 1% from 2015 and the lowest percentage reported since 2011. This is lower than both the England average of 2.8% and London average of 1.8%. In contrast to comparator boroughs, Newham has the 3rd highest proportion of 16-18 year olds NEET, with Barking and Dagenham higher at 3.5% and Tower Hamlets at 3.1% and the rest lower; Waltham Forest (1.6%), Hackney (1.3%) and Brent (1.5%)[128].

FIGURE 82 – PERCENTAGE OF 16-18 YEAR-OLDS WHO ARE NEET BETWEEN 2011-2016

Source: Department for Education



Risk Factors

As described in the chapter "Educational Attainment", the percentage of pupils in Newham achieving five GCSEs A*- C was 59.1% which was better than the national average of 53.8% but worse than the London average of 61.2%[133].

In contrast, as described in the chapter "Teenage Conceptions and Terminations" on page 140 under 18 conception rates for Newham in 2014 (22.5 per 1,000) was similar to both England (22.8 per 1,000) and London (21.5 per 1,000) rates[134].

What services are available in Newham?

A Newham Youth Employment Scheme (YES) has been running since 1991 and providing over 400 residents aged 16 – 18 with a two-year employment contract at Newham Council alongside achieving a National Vocational Qualification (NVQ) two qualification during the 1st year that advances to an NVQ 3 in the 2nd year in college. In the year 2014-2015, 86% of scheme entrants obtained permanent employment thereafter. Newham's raising of the participation age (RPA) team also work with young people who are NEET, helping them progress into education, training or full time-employment.

Progress since last JSNA

There has been no update in the data sources since 2015. However, since the 2010 JSNA, the percentage of 16 – 18 year olds who were NEET in Newham stood at 4.6% and has fallen since then to 3.7%. We have therefore improved but ongoing efforts are required to bring levels to below the London average (3.1%).

Recommendations

The Government and NICE have published guidance on reducing the proportion of young people who are NEET[131, 132, 135]. These recommendations include:

Level	Recommendation
Policy	• Act early to prevent young people being NEET in the first place • Local authorities working alongside schools to identify and provide support for young people who are at risk of becoming NEET • Schools to be supported and encouraged by local authority to take effective action e.g. promoting skills which can increase employability, providing more support during educational transitions and minimising or preventing permanent exclusions
Community	• Schools to be supported and encouraged by local authority to take effective action e.g. promoting skills which can increase employability, providing more support during educational transitions and minimising or preventing permanent exclusions
Neighbourhood	• Encourage them to provide apprenticeships, placements and job placements for the local NEET population. Employers should have input toward training provisions commissioned or delivered by the local authority, working with schools in order to increase the interaction they have with young people before the age of 16

SEXUALLY TRANSMITTED INFECTIONS

Introduction

Sexually transmitted infections (STI) comprise a variety of infections transmissible through sexual contact. Mutually-consenting sexual relationships have become commonplace in adolescence and sexual abuse or exploitation awareness has risen, resulting in increased presentations of children with sexual health concerns to the appropriate health services. Previously in the top ten, in 2010, England was in the bottom third of 43 countries in the World Health Organisation's European Region and North America for condom use among sexually active young people[136].

With the exception of HIV, young people aged 15 to 24 years continue to experience the highest rate of STIs, accounting for 55% of gonorrhoea, 52% of genital warts and 42% of genital herpes diagnosed in Genitourinary Medicine (GUM) and integrated GUM/ Sexual and Reproductive Health services (SRH) in 2014[137].

Untreated, STIs lead to long-term consequences such as ectopic pregnancy and infertility. Better prevention and frequent testing is therefore needed in addressing the unmet health needs in this population[138].

Policies and Drivers:

The Framework for Sexual Health Improvement in England (2013) outlines the Government's commitment to improving the population's sexual health and wellbeing[139]. Specific to young people, it aims to fortify their knowledge and resilience through; provision of good quality sex and relationship education (SRE) at home, school and in the community, accessible and confidential advice and support about wellbeing, sex, and relationships, increasing awareness and understanding of consensual sex, and abusive relationships and building confidence and emotional resilience to understand benefits of loving, healthy relationships and delaying age of sexual debut.

In addition, it aims to improve their sexual health outcomes through; targeted prevention, provision of accessible SRH services, comprehensively meeting sexual health needs regardless of gender and sexual preferences, raising awareness of risks of unprotected sex, benefits of stable relationships, issues around consent, and supporting responsible and informed decision-making[139]. Guidance for commissioners in local government, CCGs and NHSE is provided by Public Health England's "Making it Work" document, which outlines and describes the principles underpinning the commissioning responsibilities across these levels for sexual health, reproductive health and HIV[140].

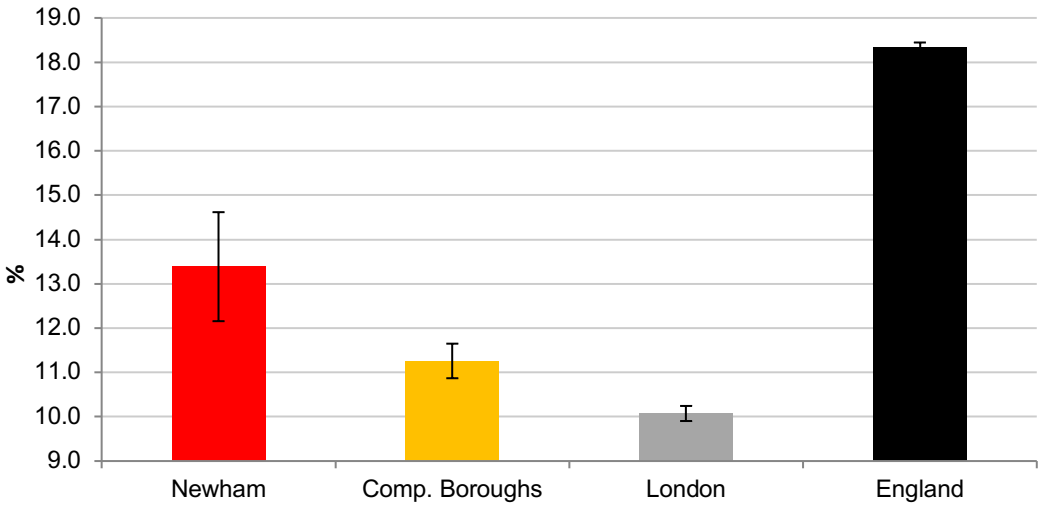
What's happening in Newham?

Sexually Transmitted Infections

In Newham, the 15 to 19 year old population group accounted for 13.4% of all new STI diagnoses made in GUM clinics in 2015; significantly higher than London (10.1%) and comparator boroughs (11.3%), however lower than England (18.3%)[141].

FIGURE 83 – PERVENTAGE OF ALL NEW STIS OCCURING IN THE 15-19 YEAR OLD POPULATION IN 2015

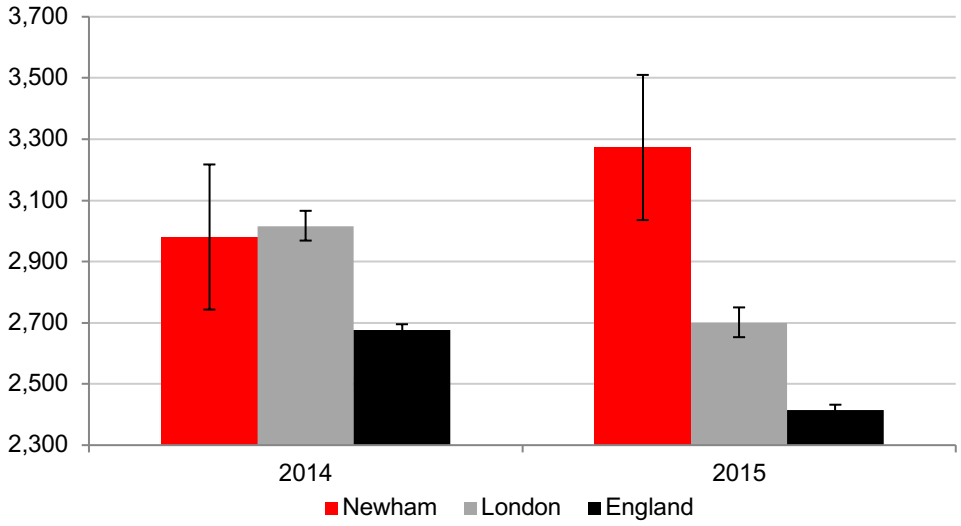
Source: PHE via Gum services



The rate of all new STI diagnoses accounted for in the 15 to 19 year-old population group from 2014 to 2015 has increased in Newham from 2,980 to 3,273 per 100,000. This is now significantly worse than the rates observed in London (2,700 per 100,000) and England (2,414 per 100,000).

FIGURE 84 – RATE (PER 100,00) OF ALL NEW STIS IN THE 15-19 YEAR OLD POPULATION BETWEEN 2014 TO 2015

Source: PHE via GUM services



When broken down by sex, females in Newham aged 15 to 19 account for 21.3% of all new STI infections in the female population, compared to just 7.1% for Newham males in the same age group. This difference in sex is reflected in all comparators, however proportions for both Newham males and females remain worse for both sexes, when compared to London and comparator boroughs; as shown in the figures below.

FIGURE 85 – PERCENTAGE OF ALL NEW STIS OCCURING IN THE FEMALE 15-19 YEAR OLD POPULATION IN 2015

Source: PHE via GUM services

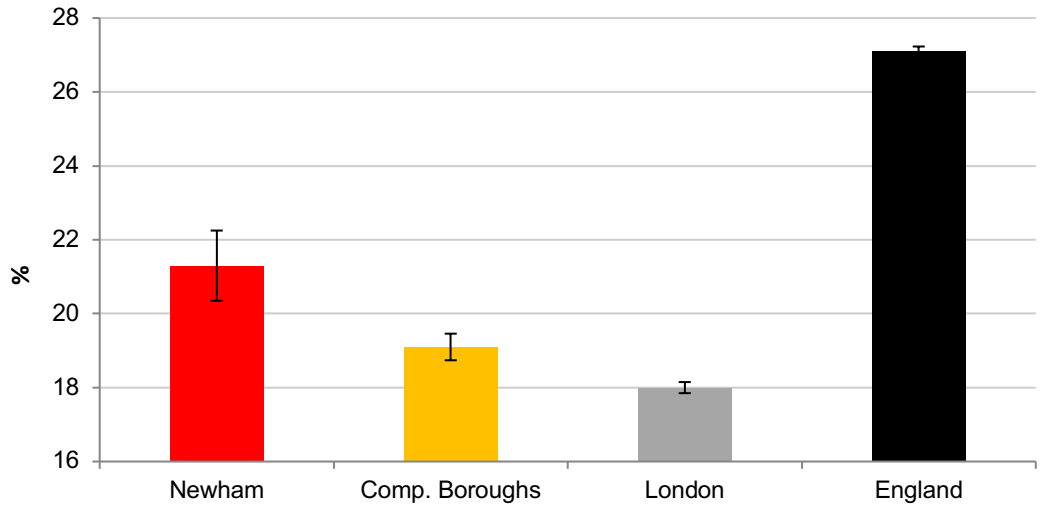
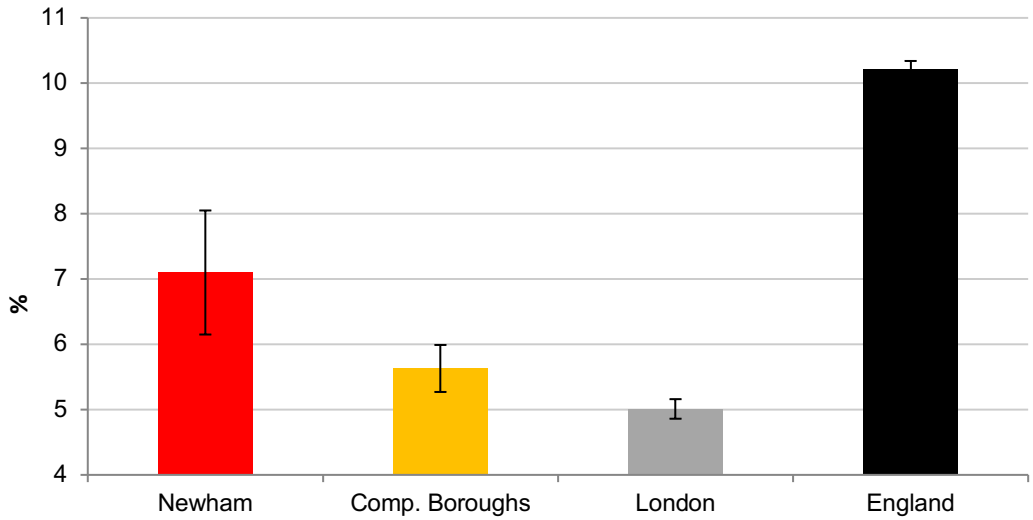


FIGURE 86 – PERCENTAGE OF ALL NEW STIS OCCURING IN THE MALE 15-19 YEAR OLD POPULATOIN IN 2015

Source: PHE via GUM services

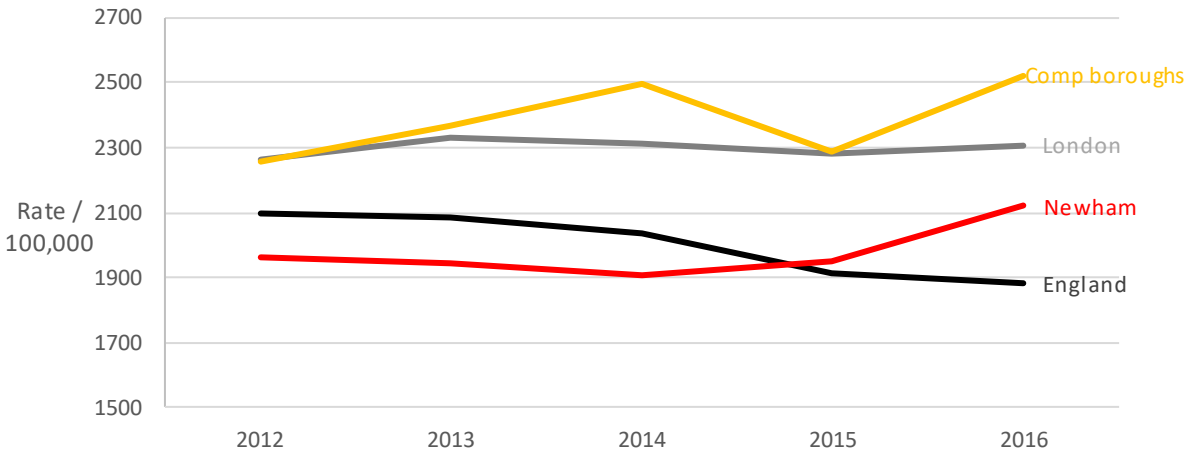


National Chlamydia Screening Programme

In 2016, under the National Chlamydia Screening Programme (NCSP), the chlamydia detection rate per 100,000 of the population aged 15 to 24 years in Newham was 2,120, a substantial increase over the 2015 rate. Increases in detection rates demonstrate an increase in control activity of chlamydia[129].

FIGURE 87 - CHLAMYDIA DETECTION PREVALENCE AGE 15-24 NEWHAM, COMPARATOR BOROUGHS, LONDON ENGLAND 2012 TO 2016 RATE/100,000

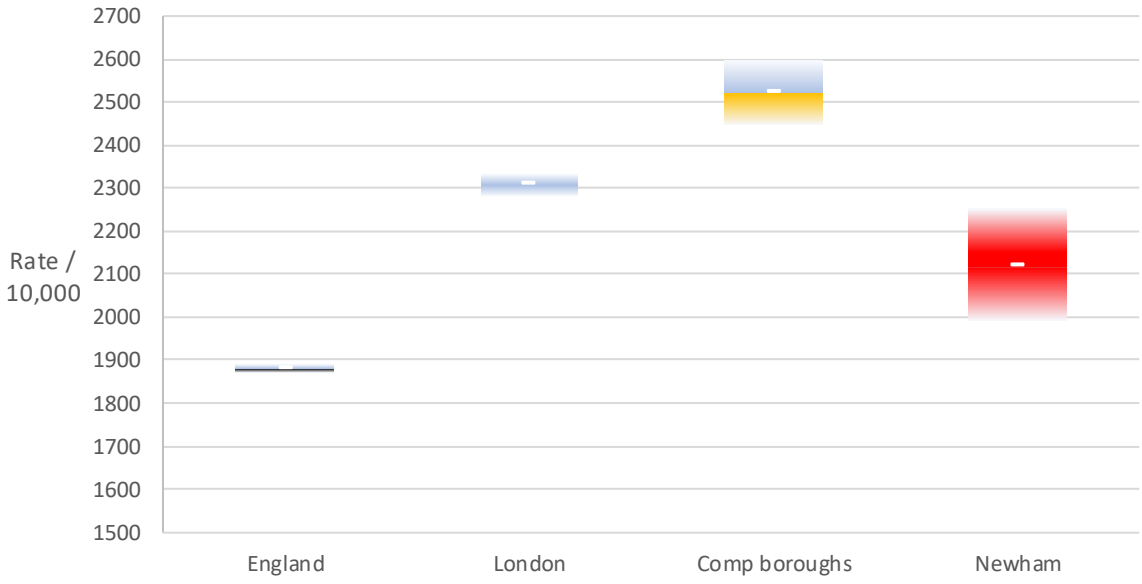
Source: PHOF PHE indicator 90776



Furthermore, in 2016, Newham's rate was statistically significantly higher than that in England, but significantly lower than those of the combined comparator boroughs and London.

FIGURE 88 – CHLAMYDIA DETECTION PREVALENCE AGE 15-24 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2016 RATE/100,000 (95% CONFIDENCE INTERVALS)

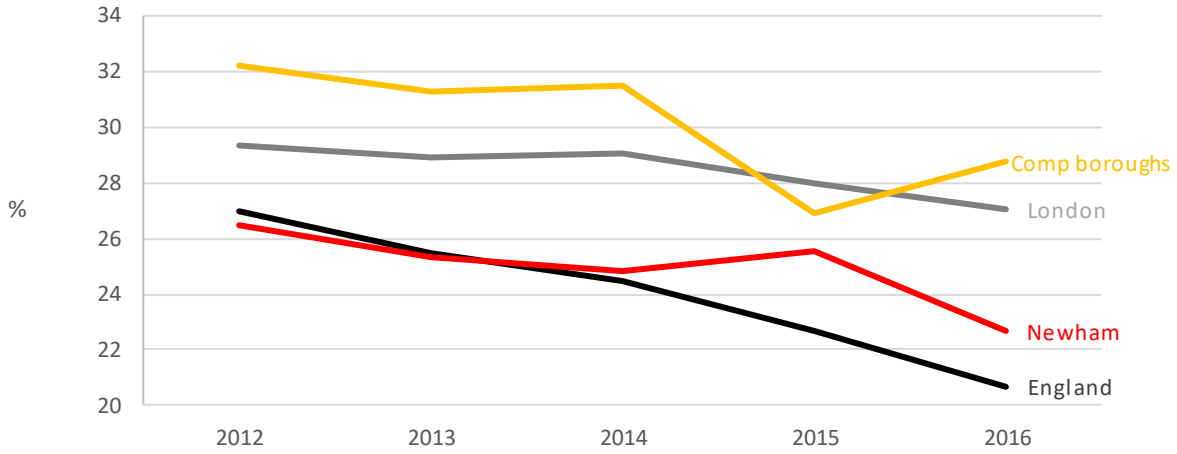
Source: PHE via GUM services



This was based on a low screening coverage of 22.7% of the eligible population which has been consistently lower than London and comparator boroughs, but higher then England[50].

FIGURE 89 – PROPORTION OF POPULATION AGED 15-24 SCREENED FOR CHLAMYDIA IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2012-2016 (PERCENTAGES)

Source: PHE indicator 90777



What services are available in Newham?

SHINE is Newham's Young People's Contraceptive & Sexual Health Service which offers a drop-in free and fully confidential service for young people aged 24 and under across six sexual health clinics in Newham. The service offers contraception, condoms, emergency hormonal contraception, pregnancy testing, STI screening and treatment, C-Card, abortions information & onward referral to GUM services, Pharmacy, General Practitioners and services such as Check Urself – where 16 – 24 year olds can order a free NHS Home Chlamydia test and get treatment, or Check Urself Plus where people aged 25 and over living in certain parts of London can access free testing kits for HIV, Chlamydia, Gonorrhoea, Syphilis and Hepatitis B and C screening. Bart's have a very high positive screening rate for chlamydia in young people when compared with comparator boroughs in east London. Therefore, referral to services or self-referral via the Check Urself route could lead to earlier diagnosis of a sexually transmitted disease and better prognosis for the individual and the population at large. This can be attributed to a reduction in transmissibility, as well as enhanced access to sexual health services and improved awareness of sexual health issues.

Over the last few years, focus groups, generally conducted by SHINE, have taken place to engage with young people in order to establish the requirements and future needs for sexual health services in Newham.

Progress since the last JSNA

Since the proportion of the 15 to 24-year olds in the population screened for chlamydia was not recorded robustly prior to 2012, no comparisons can be made with the 2010 JSNA. Nevertheless, trend views show the chlamydia detection rate in the 15-24 population to have increased from 2012 (1,961 per 100,000) through to 2016 (2,120 per 100,000). The proportion of the 15 to 24-year olds in the population screened for chlamydia has decreased since 2015 (25.5%) through to 2016 (22.7%); with the latest 2016 proportion being significantly higher than the England average (20.7%)

Recommendations

There are numerous NICE and PHE guidance on reducing the levels of STIs and improving screening uptake in young persons'[138, 141, 142]. These include:

Level	Recommendations
Policy	• Improve accessibility of sexual health services through well located and more effectively signposted clinics, providing confidential advice, and support • Aim to deliver a collaborative regional commissioning model for sexual health services; enabling robust clinical governance, safeguarding and quality assurance when commissioning GUM services; all of which lead to an improved patient experience and sexual health outcomes[143] • Identify individuals at high risk of STIs using their sexual history • Provide the patient and their partners with infection-specific information, including advice about possible re-infection. For chlamydia infection, also consider providing a home sampling kit
Community	• Prevention programmes which engage young people and which focus on safer sex practices • Coordination and delivery of robust Sex and Relationship Education in schools and the community, either through regionally or nationally commissioned programmes; with focus on sex and relationships education targeted at vulnerable young people, aided by signposting of sexual health services online (SHINE) and through social media. Ultimately, these should help build healthy relationships and delay the onset of sex • If necessary, refer patients to a specialist, who may be given the responsibility of partner notification

TEENAGE CONCEPTIONS AND TERMINATIONS

Introduction

Despite the falling under 18 conception rate, England has one of the highest teenage pregnancy rates in Western Europe with figures in 2010 estimating a rate of under 18 pregnancies of 35.5 conceptions per 1,000. Improving contraceptive services therefore has a key role to play in ensuring that young people are able to obtain the support needed and thereby reduce unintended/ unwanted pregnancies[144].

Emergency contraception (EC) is used to prevent unintended pregnancy following episodes of unprotected sexual intercourse (UPSI) or potential failed contraceptive methods. Since 2001, prescriptions dispensed for emergency contraceptives in SRH services and in the community has fallen with a part of this attributed to the reclassification of EC status, therefore allowing it to be sold over the counter in community pharmacies nationally[145].

In 2015, a total of 185,824 termination of pregnancies (TOPs) took place in England and Wales of which 43,383 were to residents of London. 1,853 of these terminations were to young persons under the age of 16 years; of which 509 were under 15-years of age, and 79 were under 14-years of age. Furthermore, repeat TOPs were undertaken in 13% (3359) of the women aged 19 and under[146].

Policies and Drivers:

Commissioning Responsibilities - Since local authorities' commission comprehensive open access sexual health services, there is considerable regional variation in how sexual health services are provided and commissioned. They are commissioned to meet the needs of the local population, including provision of information, and advice and support.

Local authorities' commission

- Comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP additionally-provided contraception
- Sexually transmitted infections (STI) testing and treatment, chlamydia screening and HIV testing
- Specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies

Some specialised services are directly commissioned by clinical commissioning groups (CCGs), and at the national level by NHS England.

CCGs commission

- Most abortion services, sterilization, and vasectomy
- Non-sexual-health elements of psychosexual health services
- Gynaecology including any use of contraception for non-contraceptive purposes

NHS England commissions

- Contraception provided as an additional service under the GP contract
- HIV treatment and care (including drug costs for PEPSE)
- Promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs
- Sexual health elements of prison health services
- Sexual assault referral centres
- Cervical screening
- Specialist fetal medicine services

NICE public health guidance on reducing unwanted pregnancies amongst young people in *Contraceptive services for under 25s [PH51]* recommends improving service and EC information provision (including method effectiveness) ensuring that, in specific circumstances, oral EC is provided in advance and supporting young people to choose a primary method of contraception for future use[144].

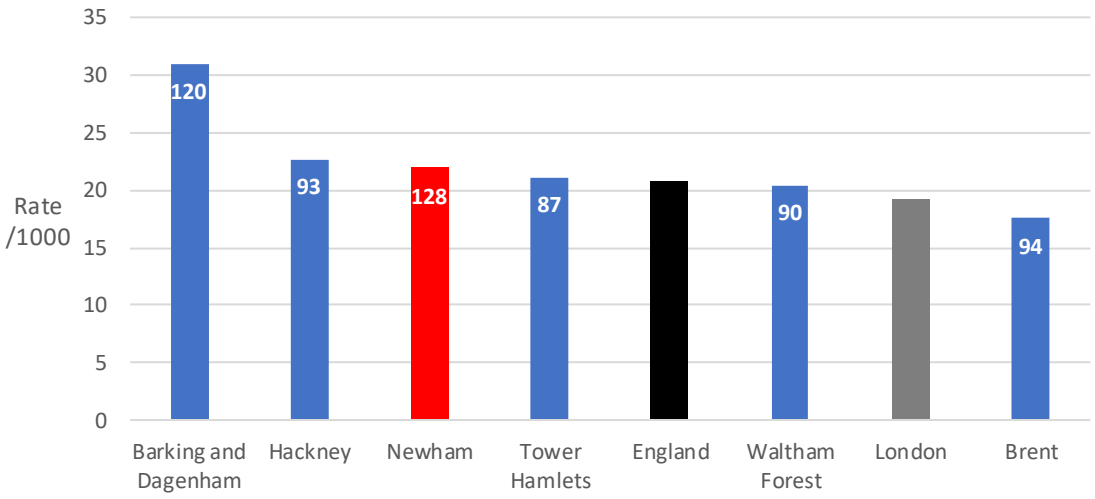
The DH *Framework for Sexual Health Improvement* (2013) sets out "reducing the under 18 and under 16 conception rates" as one of its key priorities, with a focus on reducing repeat terminations and unwanted pregnancy after childbirth, improving accessibility to appropriate counselling and support for all women who have requested a TOP, including post-TOP[33]. In addition, the "under 18 teenage conception rate" remains a key indicator in the PHOF.

What's happening in Newham?

The graph below shows the conception rates for females aged 15-17 in 2015 in Newham compared to London, England and comparator boroughs. Although the absolute figures in Newham are the highest, the rates in Newham (21.9 per 1,000 females under 18) are similar to England, higher than London but lower than some of the comparator boroughs[50].

FIGURE 90 – CONCEPTION RATE AGE 15-17 2015 RATE/1,000 WITH RAW COUNT IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

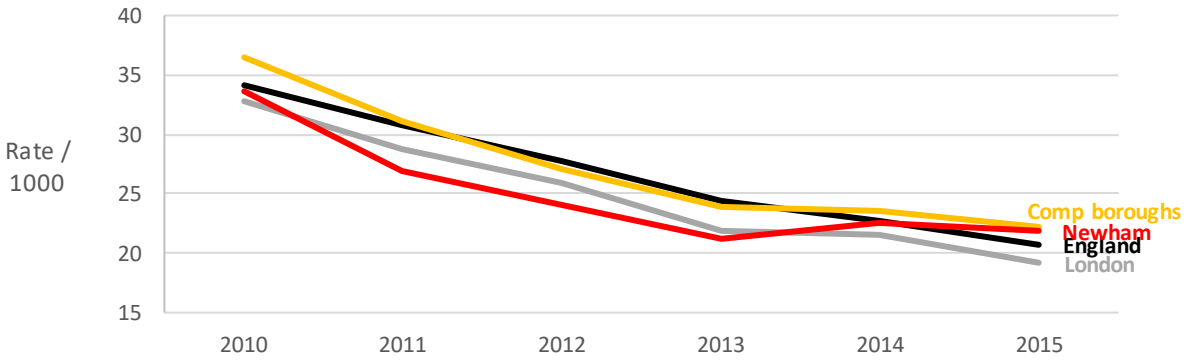
Source: PHE indicator 90777



The under 18 conception rate for females aged 15-17 years has been generally declining since 2010 (see figure below). This is similar to the trends in London, England and the comparator boroughs, though Newham's figure increased slightly in 2014, and remained higher in 2015 than in 2013.

FIGURE 91 – TEEN PREGNANCY RATES IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010 TO 2015 RATE/1,000

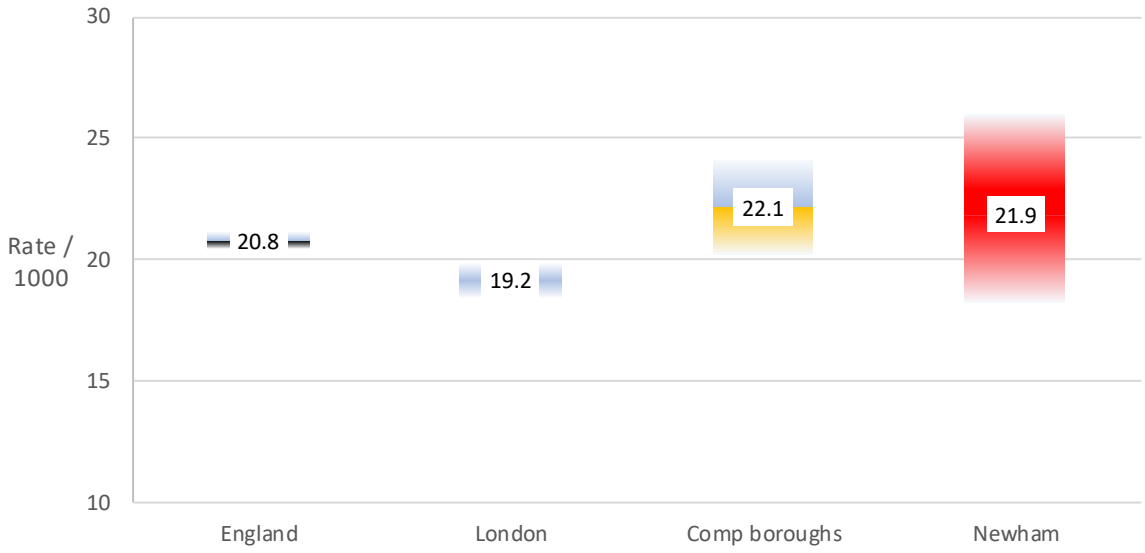
Source: PHOF fingertips indicator 20401



As the following figure shows, Newham's rate in 2015, 21.9 per thousand women aged 15-17, was not statistically significant different at the usual 5% level from those of London, England, and the comparator boroughs.

FIGURE 92 – TEENAGE PREGNANCY RATES IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2015 RATE/1,000 (95% CONFIDENCE INTERVALS)

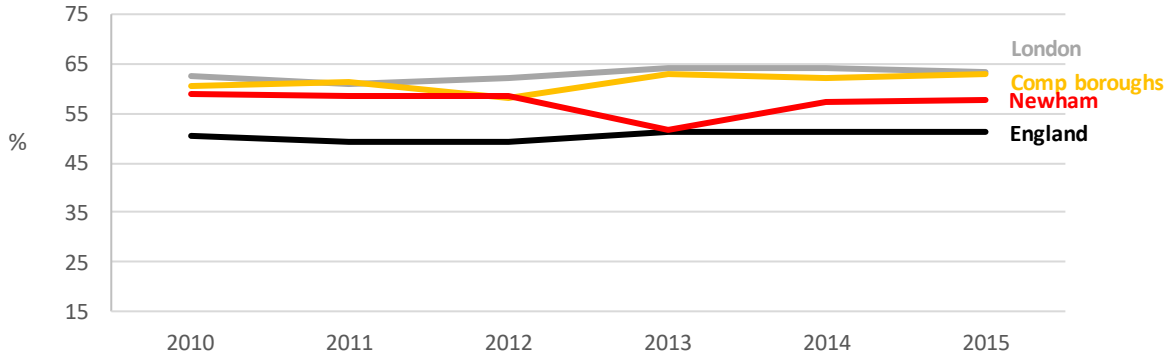
Source: PHE indicator 20401



The percentage of under 18 conceptions leading to abortion in those aged 15 to 17-years has been essentially static since 2010. However, since 2012 the rates in Newham have been consistently lower than comparator boroughs and London, but higher than the England average.

FIGURE 93 – TEENAGE PREGNANCY ABORTION RATES IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010 TO 2015 (PERCENTAGES)

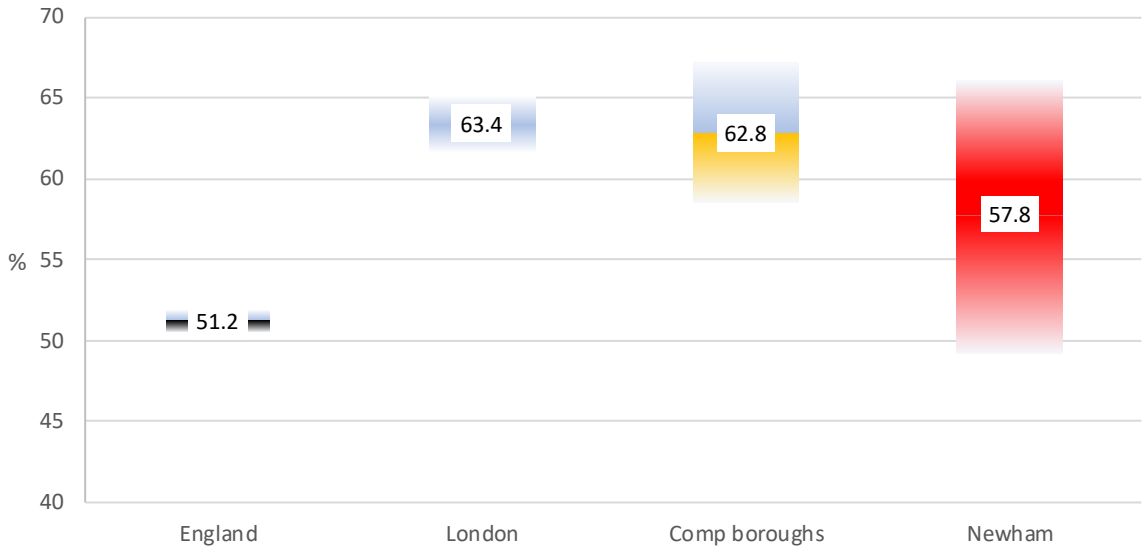
Source: PHE indicator 90731



As the following figure shows, Newham's rate of 57.8% in 2015 was not statistically significantly different at the usual 5% level from those of London, England and the comparator boroughs.

FIGURE 94 – TEENAGE PREGNANCY ABORTION RATE IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2015 PERCENTAGES (95% CONFIDENCE INTERVALS)

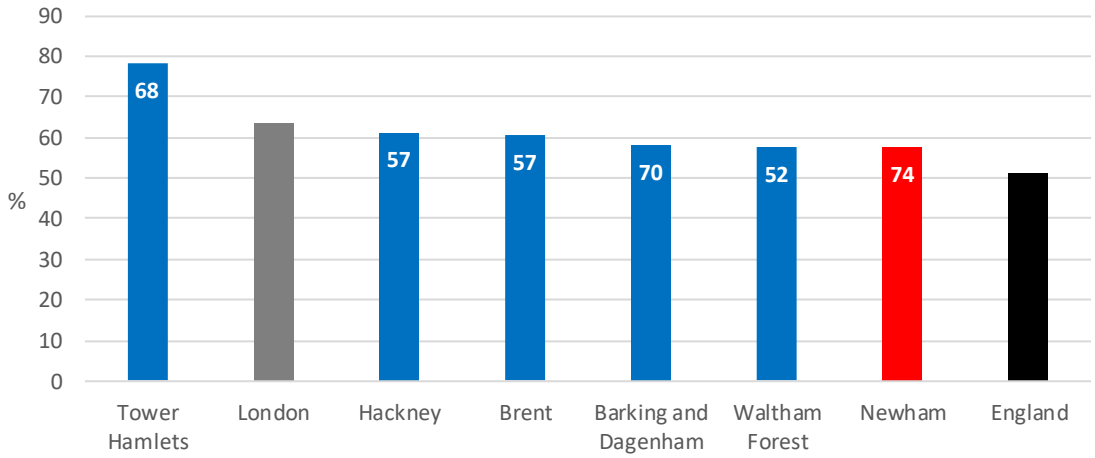
Source: PHE indicator 90731



Comparing the under 18 conceptions leading to abortion to London and comparator boroughs in 2015, Newham has the lowest proportion from all comparator boroughs and London, but higher than England. However, Newham has the highest absolute number of conceptions leading to abortion from all the comparator boroughs (n=74).

FIGURE 95 – TEENAGE PREGNANCY ABORTION RATE AGE 15-17, 2015 PERCENTAGES WITH RAW COUNTS IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

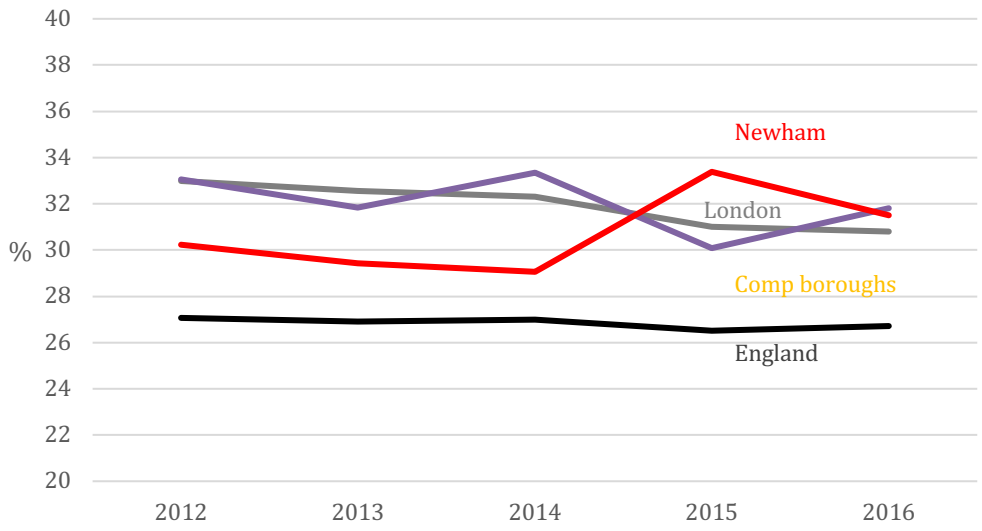
Source: PHE indicator 90777



The percentage of terminations in the under 25s which are repeats in Newham is 31.5%, this is lower than comparator boroughs, but higher than London and England. Over 200 (one third) of terminations in those aged less than 25 years were repeat terminations. This proportion is slightly lower than in 2015, decreasing from 33.4%. This may be a sign of statistical fluctuation or improved public health efforts.

FIGURE 96 – PERCENTAGE OF REPEAT ABORTIONS IN < 25 2012 TO 2016 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

Source: PHE indicator 90741



What services are available in Newham?

As described in the chapter “STIs”, SHINE, a dedicated service that offers contraception, emergency contraception, pregnancy testing, abortion information and referral is freely available across Newham. Bart’s Healthcare delivers terminations of pregnancy, and pharmacies, GPs and sexual health clinics offer emergency hormonal contraception to residents of Newham.

Progress since the last JSNA

There has been no update in the data since 2015, there no comparisons can be undertaken on terminations and abortions as previously published JSNAs from 2010, 2011/12 did not discuss this. Compared to the 2010 JSNA however, we have improved on the under-18 conception rates from 33.6 to 21.9 per 1,000 in 2016[26].

Recommendations

Numerous guidance from NICE and PHE on reducing teenage conceptions and terminations exists[141, 142]. Recommendations include:

Level	Recommendations
Policy	• Needs and attitudes of men and women aged 19-24 years shift constantly. Service providers and commissioners need to consider and understand those shifting needs and attitudes toward primary methods of contraception and continue to build them into provision • Tailor services considerate of the impact of culture on health seeking behaviour • Continue to extend patient group directives (PGDs) and local arrangements to improve access to EHC, including advanced provision of EHC (currently in 24 pharmacies across the borough) • Raise awareness of EC methods and where they can be accessed, among young people and health professionals; with an increased focus on long-acting reversible contraception (LARC) for emergency conception • Provision of on-going support for children and young people who have been abused to delay on-set of sex, and to reduce instances of teenage pregnancy, and patterns of unhealthy and unsafe sexual behaviours • Improve access to support and counselling services post-TOP
Community	• Raise awareness of EC methods and where they can be accessed, among young people and health professionals • Raise awareness of all contraceptive methods and improve young people's access to them • Improve young people's access to and uptake of contraceptive services; through increased and effective signposting of services; more and better located clinics; including use of alerts and reminders to contraceptive users when next course of contraception is due • Increase uptake and provision of contraception, including long-acting reversible contraceptives, at abortion services to reduce repeat abortions

SMOKING

Introduction

Each year, it is estimated that around 207,000 children in the UK begin smoking. The 2011 General Lifestyle Survey of adult smokers revealing that nearly 40 per cent had begun smoking regularly before the age of 16 years[147, 148].

Among children who try to smoke, an estimated third to half are likely to become regular smokers within two to three years (defined as smoking at least once cigarette per week)[149]. However most children smoke considerably more than this, with children classified as regular and occasional smokers smoking an average of 31.1, and 5 cigarettes per week respectively in 2014[149]. As smoking-related diseases (e.g. lung cancer, heart disease) are dose-dependent, children who smoke are therefore at greater risk of developing them.

In addition, children have a greater susceptibility to second hand smoke/ passive smoking, with an increased risk of chest infections such as bronchitis and pneumonia, asthma attacks, middle-ear infections, decreased lung function, and 'cot death' (sudden infant death syndrome) observed in those exposed[148]. Since smoke-free legislation was introduced in 2007, the primary source of exposure to tobacco smoke for young children is parental smoking[150].

Policies and drivers

The Government's 2011 publication, *Healthy Lives, Healthy People: a tobacco control plan for England*, sets out a strategy for tackling tobacco in England with commitments to examine evidence in support of plain packaging for tobacco products, and to end display of tobacco products in shops by 2015. It also outlines clear goals to reduce smoking prevalence among adults from 21% to 18.5%, reduce rate of smoking among 15 year olds from 15% to 12%, and reduce smoking in pregnancy from 14% to 11%[151]. In addition, a ban on smoking in vehicles when a child or children are present, came into force on 1 October 2015.

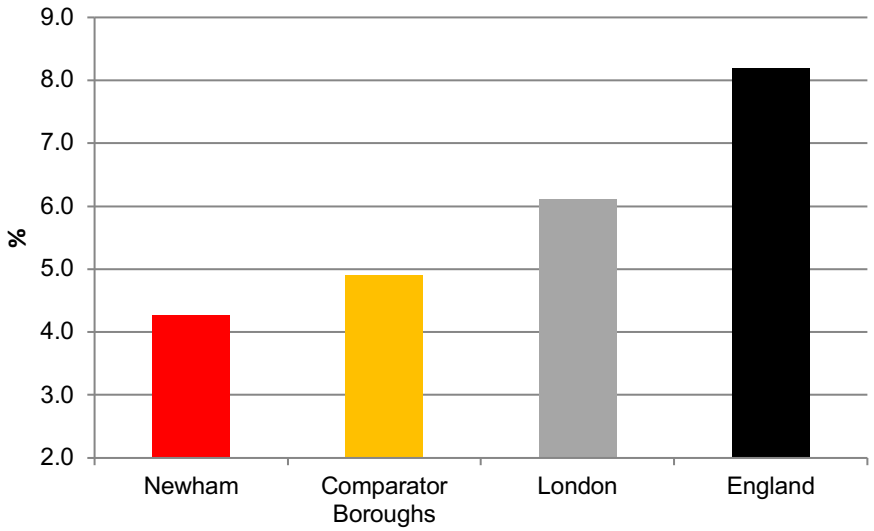
What's happening in Newham?

Following the gaps identified in the PHOF, the DH commissioned the *WAY* survey in 2014 with repeats planned every two years[152].

The figure below illustrates self-reported smoking prevalence in 15-year-olds with young people in Newham reporting the lowest prevalence of cigarette smoking in contrast to London and England but similar to comparator boroughs[152].

FIGURE 97 - SMOKING PREVALENCE AT AGE 15 2015 TO 2015

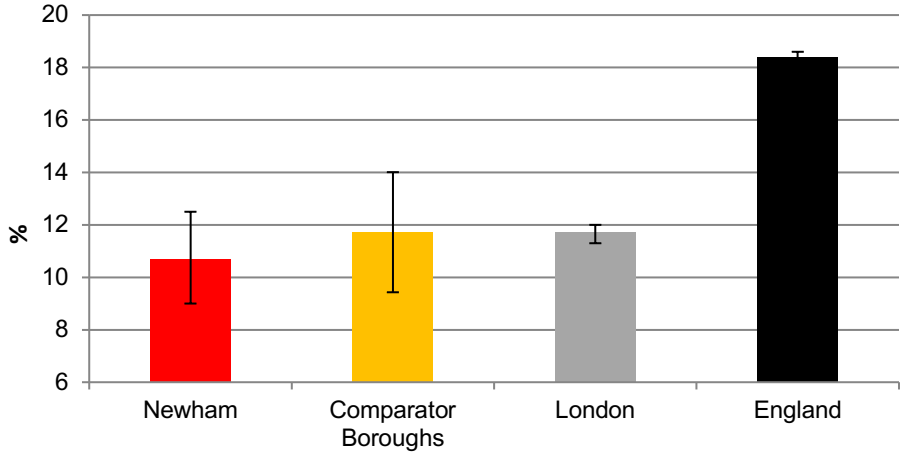
Source: PHOF Tobacco Profiles



In contrast, the figure below denotes self-reported use of e-cigarettes in 15-year-olds with young people in Newham reporting a similar prevalence to comparator boroughs and London but lower than England[152].

FIGURE 98 – USE OF E-CIGARETTES AT AGE 15 2014 TO 2015

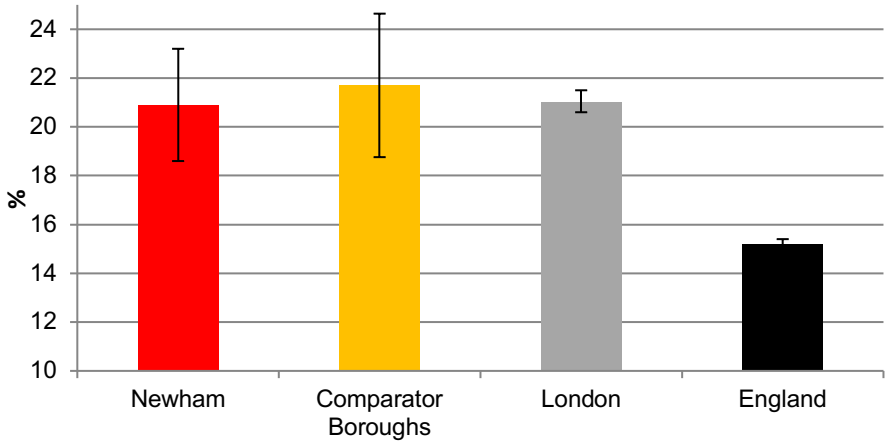
Source: PHOF Tobacco Profiles



Finally, the figure below denotes the self-reported use of other tobacco products (e.g. Roll-ups) in 15 year olds with young people in Newham reporting similar prevalence of use of other tobacco products with comparator boroughs and London but significantly higher than England[152].

FIGURE 99 - USE OF OTHER TOBACCO PRODUCTS AT AGE 15 2014 TO 2015

Source: PHOF Tobacco Profiles



What services are available in Newham?

Alongside improving physical activity levels in young persons in Newham, activeNewham works closely with LBN on a range of new campaigns to help young persons' give up smoking.

Progress since the last JSNA

As the WAY survey commenced in 2014, comparisons with previous JSNAs in 2010 and 2011-2012 were not undertaken. Furthermore, there have been no further updates in the WAY survey since 2014.

Recommendations

A raft of national guidance on supporting young persons to stop smoking is published by NICE[153-155]. A summary of these recommendations includes:

Level	Recommendations
Policy	• Determine the characteristics of the local population of people who smoke or use other forms of tobacco. Determine the prevalence of all forms of tobacco use locally • Ensure NHS Stop Smoking Services target minority ethnic and socioeconomically disadvantaged communities in the local population; in line with how they currently prioritise the under 25 population • Set realistic performance targets for both the number of people using the service and the proportion who successfully quit smoking. These targets should reflect the demographics of the local population. Services should: ○ aim for a success rate of at least 35% at 4 weeks, validated by carbon monoxide monitoring. This figure should be based on all those who start treatment, with success defined as not having smoked in the third and fourth week after the quit date. Success should be validated by a CO monitor reading of less than 10 ppm at the 4-week point. This does not imply that treatment should stop at 4 weeks ○ Audit performance data routinely and independently and publically publish quit rates by each provider. Audits should also be carried out on exceptional results – 4-week quit rates lower than 35% or above

	70% – to determine the reasons for unusual performance, and to help identify best practice and ensure it is being followed ○ Establish links between contraceptive services, fertility clinics and ante- and postnatal services. These links should ensure health professionals use the many opportunities available to them (at various stages of the woman's life) to offer smoking advice Offer behavioural counselling, group therapy, pharmacotherapy or a combination of treatments that have been proven to be effective (see the list at the start of this section) ○ Ensure clients receive behavioural support from a person who has had training and supervision that complies with the 'Standard for training in smoking cessation treatments' or its updates ○ Provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups. Provide services in the language chosen by clients, wherever possible • Ensure the local NHS Stop Smoking Service aims to treat ethnic groups in proportion to their representation in the local population of tobacco users
Community	• Build and maintain relationships with partners, thereby improving compliance with tobacco legislation such as stopping underage sales, promoting smoke-free laws, enforcing ban on smoking in a vehicle when a child or children are present, reducing the availability of illicit tobacco
Neighbourhood	• Address tobacco control through participating in strategic multi-agency partnership working; as is currently occurring through the North Central and North East regional tobacco network, bringing together commissioners, trading standards, enforcement, HMRC and PHE

ALCOHOL & SUBSTANCE MISUSE

Introduction

Adolescence is a common start point for tobacco, alcohol and substance abuse. Reasons for these include; desire for new experiences, use as a coping strategy or peer pressure, with factors such as domestic abuse or violence, mental illness and parental drug use specific to influencing substance abuse in young persons.

Policies and Drivers

The PHE (2013), *Alcohol and Drugs JSNA Support Pack: Good practice in planning young people's specialist substance misuse interventions* provides numerous guidance to support planning, commissioning and contract monitoring processes to reducing the prevalence of alcohol and substance misuse locally[156].

In addition, the Department for Education and the Association of Chief Police Officers (2013) *Drug Advice for Schools*, recommends that schools have a written drugs policy, pupils should have early access to support via schools and other local services and that a dedicated senior school staff member liaises with the local police and support services[157].

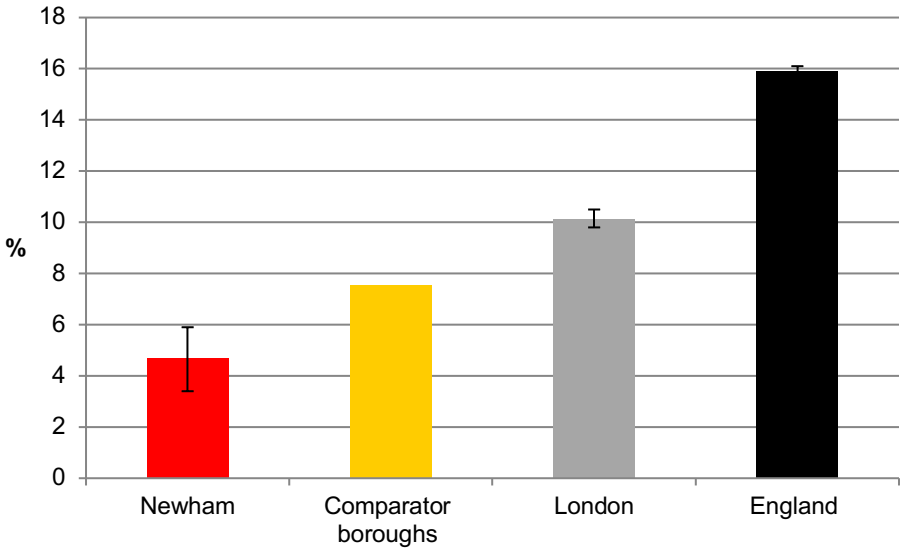
What's happening in Newham?

Risky Behaviours

The figure below illustrates self-reported prevalence of 15-year-olds who are involved in three or more risky behaviours. These can include smoking, drinking alcohol, cannabis use, other drug use, diet (fewer than five portions of fruit and veg a day) and physical activity (not active for 60 minutes or more on seven days in the last week). Newham has the lowest value (4.7%) compared to comparator boroughs (7.5%), London (10.1%) and England (15.9%).

FIGURE 100 – PERCENT OF 15 YEAR OLDS WITH 3 OR MORE RISKY BEHAVIOURS

Source: WAY Survey from Fingertips, PHE

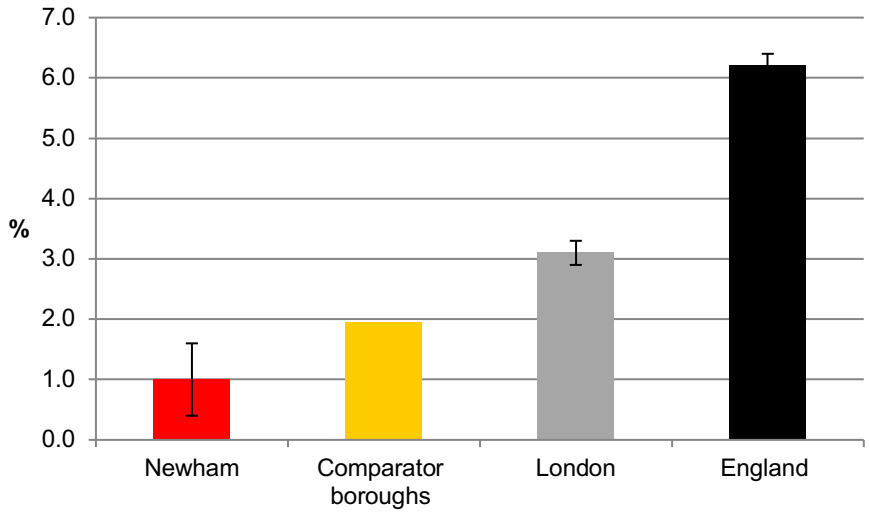


Alcohol Consumption

The figure below illustrates self-reported prevalence of regular drinkers in 15-year-olds in Newham who report the lowest prevalence (1%) compared to comparator boroughs (2%), London (3%) and England (6.2%).

FIGURE 101 – PERCENT OF 15 YEAR OLDS WHO ARE REGULAR DRINKERS

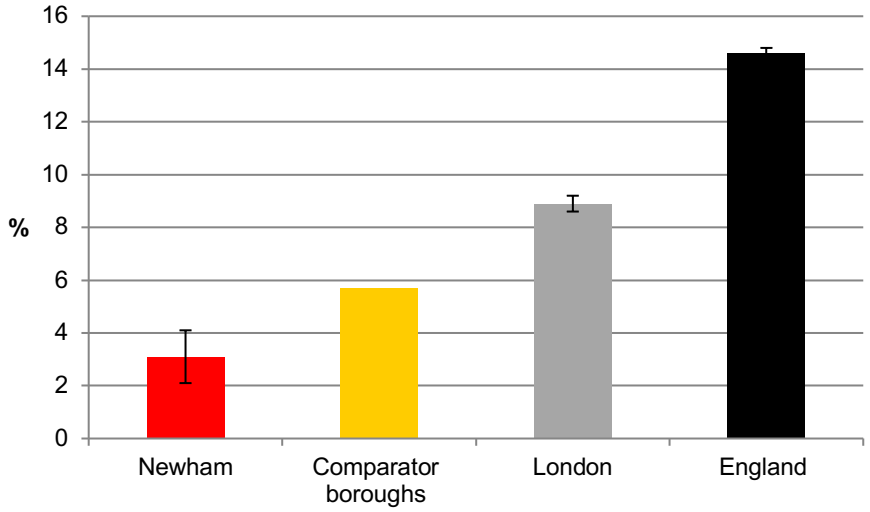
Source: WAY Survey from Fingertips, PHE



The figure below illustrates self-reported prevalence of 15-year-olds admitting to being drunk in the last four weeks, and young people in Newham report the lowest prevalence compared to comparator boroughs, London and England. As these figures are higher than the chart above, it can be inferred that young persons in the UK prefer binge drinking.

FIGURE 102 - PERCENT OF 15 YEAR OLDS WHO HAVE BEEN DRUNK IN THE LAST 4 WEEKS

Source: WAY Survey from Fingertips, PHE



Substance Misuse

The charts below illustrate self-reported prevalence of 15-year-olds who have admitted to trying or using cannabis over the past month. Although the number for Newham is still lower than its comparators, London and England, the percentage of young people misusing cannabis is noticebly higher than the percentage consuming alcohol.

FIGURE 103 – PERCENT OF 15 YEAR OLDS WHO HAVE EVER TRIED CANNABIS

Source: WAY Survey from Fingertips, PHE

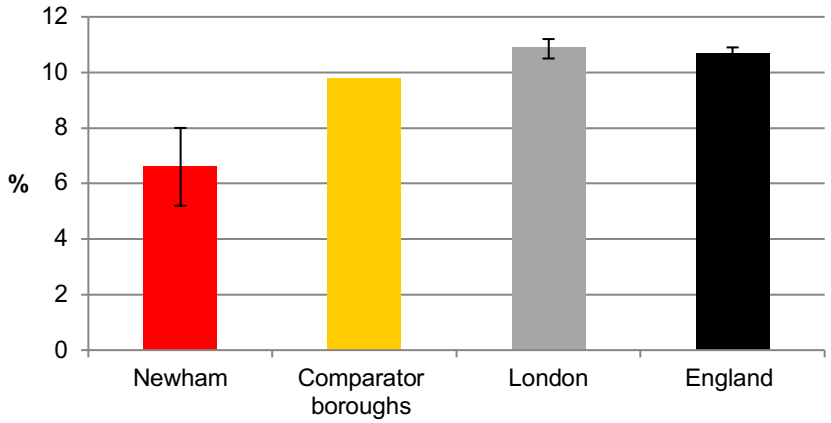
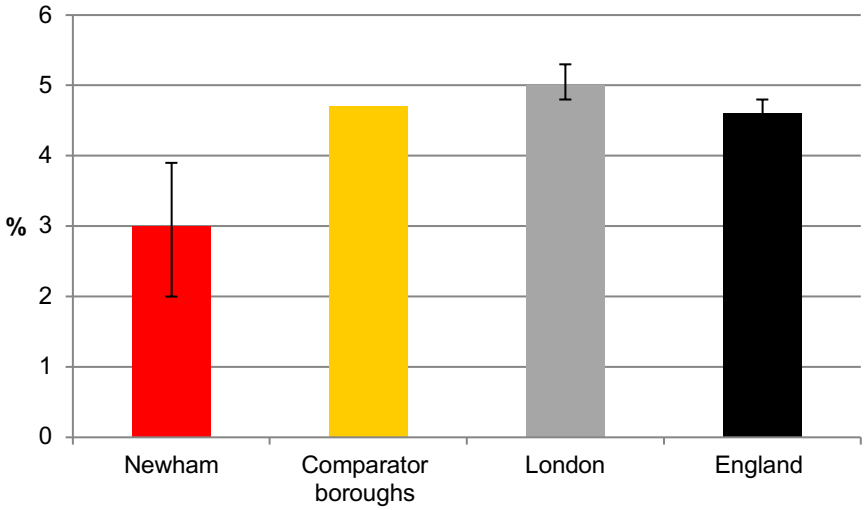


FIGURE 104 – PERCENT OF 15 YEAR OLDS WHO HAVE TAKEN CANNABIS IN THE LAST MONTH

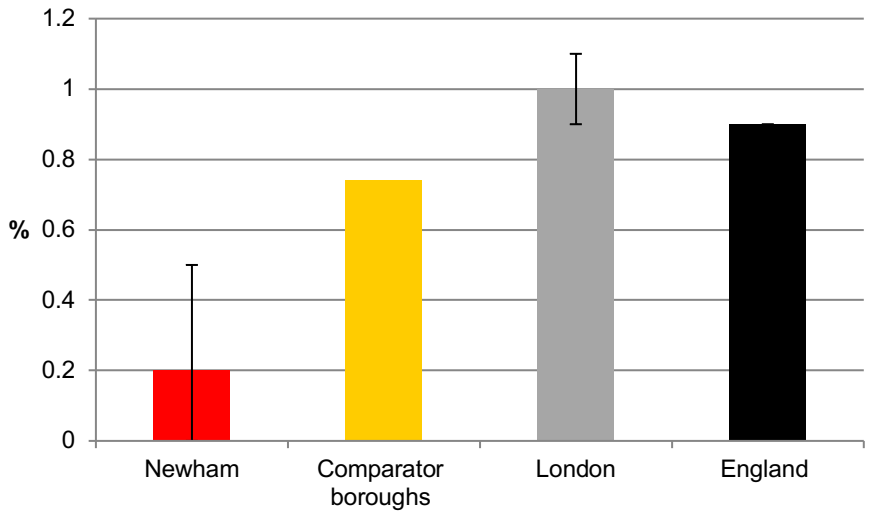
Source: WAY Survey from Fingertips, PHE



In contrast, the percentage of 15-year-olds who admit to having tried drugs other than cannabis is low overall, with a prevalence of 0.2% in young persons in compared to comparator boroughs at 0.7%, London at 1% and England at 0.9%.

FIGURE 105 – PERCENT OF 15 YEAR OLDS WHO HAVE TAKEN DRUGS OTHER THAN CANNABIS IN THE LAST MONTH

Source: WAY Survey from Fingertips, PHE



Finally, the figures below show the rates for hospital admissions for substance abuse in 15 to 24-year-olds from 2008-2010 to 2013-2016, three year rolling averages. While England has experienced a steady rise over the period, as did London to 2013-2015, the position for Newham and the comparator boroughs show no such trend. As the second figure shows, Newham's rates are very similar to those of London and the comparator boroughs, and significantly lower than those of England as a whole.

FIGURE 106 – HOSPITAL ADMISSIONS FOR SUBSTANCE MISUSE AGED 15-24 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2010-2011 TO 2015-2016 RATE/100,000

Source: PHE indicator 90808

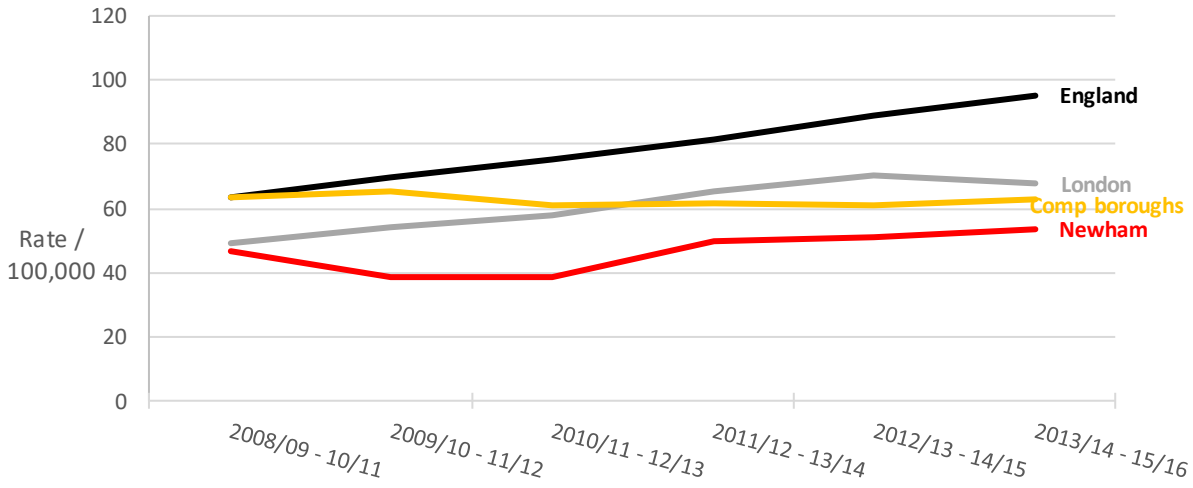
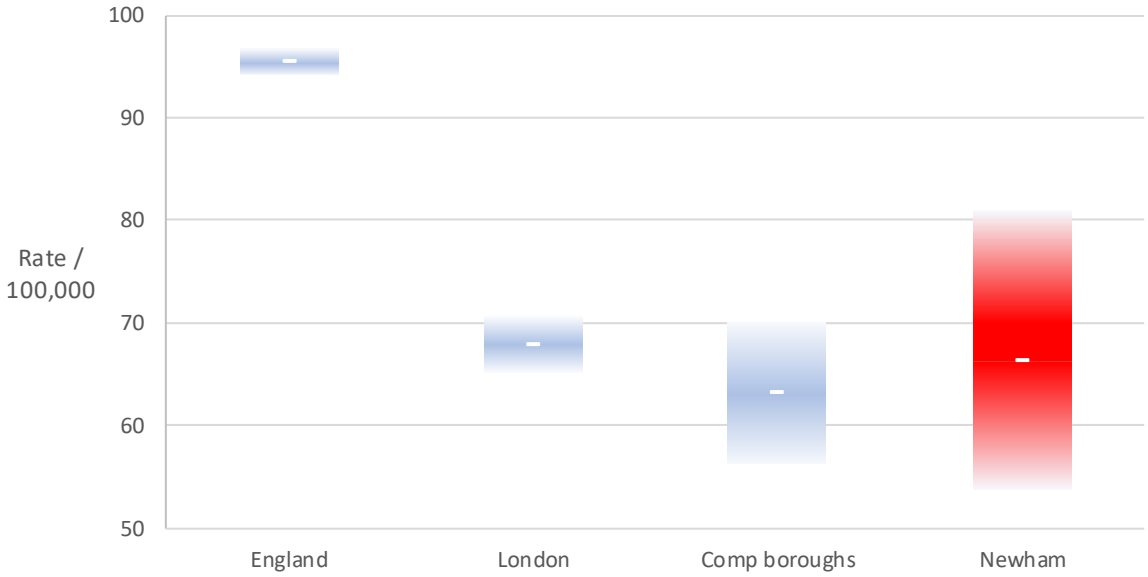


FIGURE 107 – HOSPITAL ADMISSIONS FOR SUBSTANCE MISUSE AGED 15-24 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2015-2016 RATE/100,00 (95% CONFIDENCE INTERVALS)

Source: PHOF



What services are available in Newham

The Drug and Alcohol Service for London, delivered by Change, Grow, Live (CGL) provides an integrated drug and alcohol recovering service to all residents in Newham.

In addition, LBN commissions a Young People's Substance Misuse Service (targeted up to the age of 19) who have emerging, serious or complex drugs and/or alcohol issues. Interventions include; early intervention and harm reduction to young people potentially or already exposed to substance misuse, assessment and care planning, specialist key working and 6-week group programmes.

Progress since last JSNA

As the WAY survey commenced in 2014, comparisons with previous JSNAs in 2010 and 2011-2012 were not undertaken. However, we have worsened compared to the 2010 JSNA for hospital admissions due to substance misuse amongst 15 to 24-year-olds, from 55 to 63 per 100,000 between 2008 and 2015[26].

Recommendations

NICE and PHE provide numerous guidance on reducing alcohol consumption and substance misuse amongst children and young people[158].These recommendations include:

Level	Recommendations
Policy	• Develop and implement a strategy to reduce substance misuse among vulnerable and disadvantaged people aged under 25, as part of a local area agreement. This strategy should be: ○ based on a local profile of the target population developed in conjunction with the regional public health observatory. The profile should include their age, factors that make them vulnerable and other locally agreed characteristics

	○ supported by a local service model that defines the role of local agencies and practitioners, the referral criteria and referral pathways • Use existing screening and assessment tools to identify vulnerable and disadvantaged children and young people aged under 25 who are misusing – or who are at risk of misusing – substances. These tools include the Common Assessment Framework and those available from the National Treatment Agency • Work with parents or carers, education welfare services, children's trusts, child and adolescent mental health services, school drug advisers or other specialists to: ○ provide support (schools may provide direct support) ○ refer the children and young people, as appropriate, to other services (such as social care, housing or employment), based on a mutually agreed plan. The plan should take account of the child or young person's needs and include review arrangements • Offer a family-based programme of structured support over 2 or more years, drawn up with the parents or carers of the child or young person and led by staff competent in this area. The programme should: ○ include at least three brief motivational interviews each year aimed at the parents/carers ○ assess family interaction ○ offer parental skills training ○ encourage parents to monitor their children's behaviour and academic performance ○ include feedback ○ continue even if the child or young person moves schools. • Offer more intensive support (for example, family therapy) to families who need it
Community	• Consideration should be given to offering the children group-based behavioural therapy over 1 to 2 years, before and during the transition to secondary school. Sessions should take place once or twice a month and last about an hour. Each session should: ○ focus on coping mechanisms such as distraction and relaxation techniques ○ help develop the child's organisational, study and problem-solving skills ○ involve goal setting • Consideration should be given to offering the parents or carers group-based training in parental skills. This should take place monthly, over the same period (as described above for the children). The sessions should: ○ focus on stress management, communication skills and how to help develop the child's social-cognitive and problem-solving skills ○ advise on how to set targets for behaviour and establish age-related rules and expectations for their children
Neighbourhood	• Establish drop in centres for residents with issues with alcohol and substance misuse

MENTAL HEALTH IN CHILDREN AND YOUNG PEOPLE

Introduction

Nearly 10% of children aged 5 to 16 in this country suffer from a clinically diagnosable mental health (MH) condition, but only a minority receive any form of effective intervention. This is damaging and costly, not only in terms of immediate distress to the children and families concerned but also because untreated childhood mental health problems have a strong tendency to persist into later life, often with a wide range of adverse consequences, including extra costs for individuals, taxpayers and society.

When wider impacts on wellbeing are included, mental ill-health costs an estimated £77 billion per year for England, and £49 billion for economic costs alone[159]. The most common mental health conditions affecting children and young people are conduct disorders (e.g. severe behavioural problems), anxiety, depression and attention deficit hyperactivity disorder (ADHD). In addition, according to recent surveys in England, bullying, a risk factor for anxiety, depression and self-harm that increases with increasing exposure to bullying, is reported by 34 – 46% of school children[159].

Policies and drivers

National

The *Future in Mind* government report, launched in 2015 and produced by the Children and Young People's Mental Health and Wellbeing Taskforce, made 5 key recommendations:

- Promoting resilience, prevention and early intervention;
- Improving access to effective support – a system without tiers;
- Care for the most vulnerable;
- Accountability and transparency;
- Developing the workforce[160].

In addition, the Government's 2011 Mental Health strategy, *No Health without Mental Health*, pledged to provide early support for mental health problems[161] with the Deputy Prime Minister's 2014 strategy, *Closing the Gap: priorities for essential change in mental health*, including actions such as improving access to psychological therapies for children and young people[162].

Local

The Children's Trust has made improving mental health and resilience one of its three strategic priorities since 2015. "Mental health and resilience" was discussed by the Trust in July 2015. The Trust signed off the following vision for Newham's young people:

"All young people in mainstream and alternative provision at risk of poor mental health, social and educational outcomes are effectively supported to be more resilient by all professionals they engage with, by their parents, their peers, by the online environment and through engagement in positive community activities. And all those with significant mental disorder are effectively engaged with and treated at an early stage with effective interventions which promote recovery. "

Newham's CAMHS transformation plan was subsequently developed in September 2015. The Newham HeadStart service proposal was developed in January 2016. The Children's Trust continues to provide multi-agency oversight of the implementation of improved mental health support for young people with emerging and more significant mental health disorder.

Within the Children and Young People Programme of the Healthy London Partnership, there is a focus on reducing variation in Mental Health by supporting CCGs in developing local CAMHS transformation plans, producing pathways for mental health crisis care alongside ED care, delivering workshops on specific areas of concern (e.g. Eating disorders/learning difficulties) and working with voluntary sector

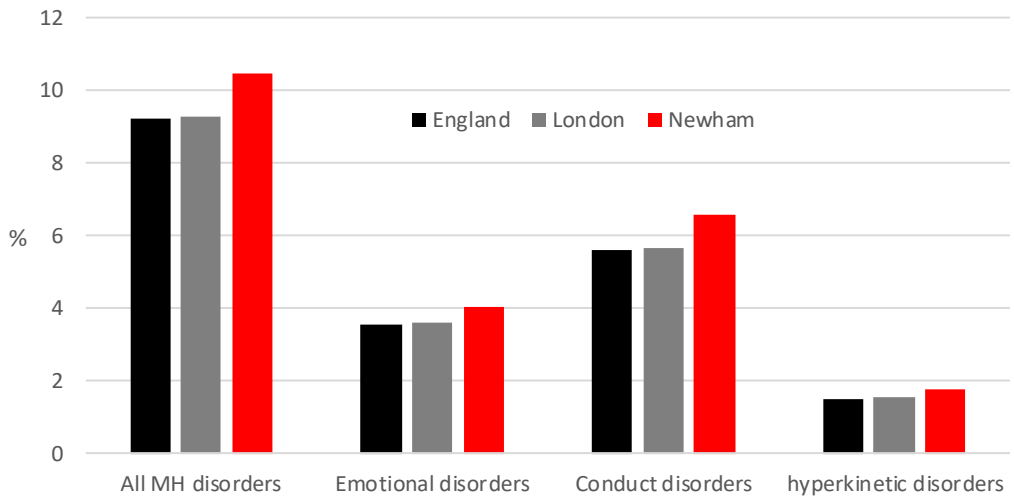
to support collaboration with CCGs. Additional future work in LAC, mental health in schools and linking in and supporting Improving Access to Psychological Therapies (IAPT) is anticipated in 2016.

What's happening in Newham?

The following figure shows estimated prevalence's for mental health disorders in 2015 for CYP aged 5 to 16-years of age, for Newham, London, and England. As these are estimated rates, it is impossible to produce an estimate for the combined comparator boroughs. Furthermore, no confidence intervals are available.

FIGURE 108 – ESTIMATED PREVALENCE OF MENTAL HEALTH DISORDERS IN NEWHAM AGED 5-16, 2015

Source: PHE indicators 92237, 91138, 91139, 91141



In 2015, an estimated 5,330 CYP aged 5 to 16 years living in Newham were affected by a MH disorder[50]. Across all types of MH disorders, Newham has a higher estimated prevalence compared to London and England.

The following charts show changes in the estimates from 2014-2015 for each of these estimates, for Newham, London, England, and each of the comparator boroughs. As may be seen, Newham's estimates are generally higher than comparator boroughs, and year-on-year changes are very small.

FIGURE 109 – ESTIMATED PREVALENCE OF ALL MENTAL HEALTH DISORDERS IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

Source: PHE indicator 91141

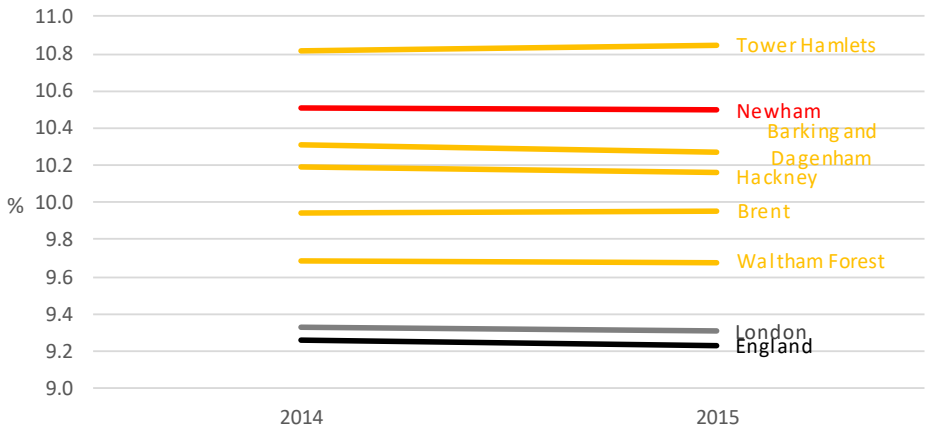


FIGURE 110 – ESIMATED PREVALENCE OF CONDUCT DISORDERS IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND AGED 5-16, 2014-2015

Source: PHE indicator 91138

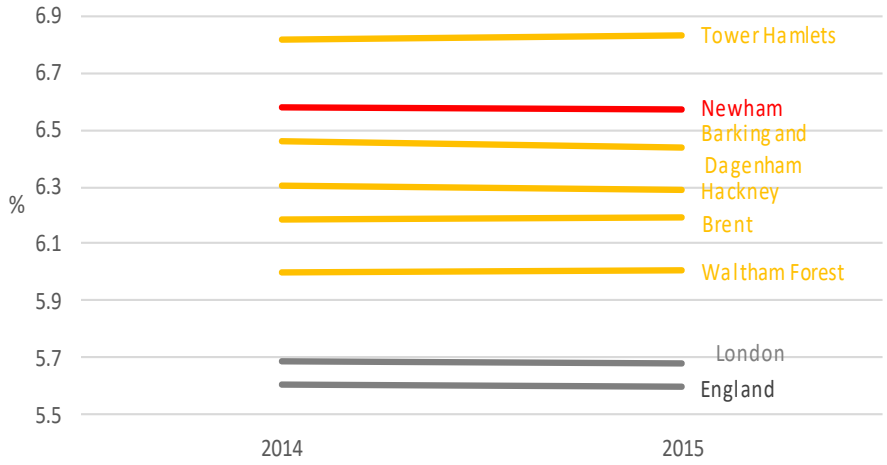


FIGURE 111 – ESTIMATED PREVALENCE OF EMOTIONAL DISORDERS IN NEWHAM, COMPARATORS BOROUGHS, LONDON AND ENGLAND AGE 5-16, 2014-2015

Source: PHE indicator 91137

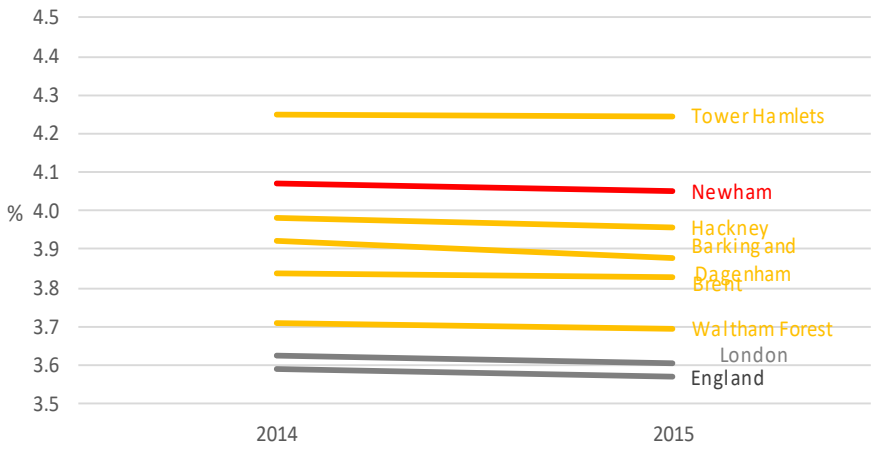
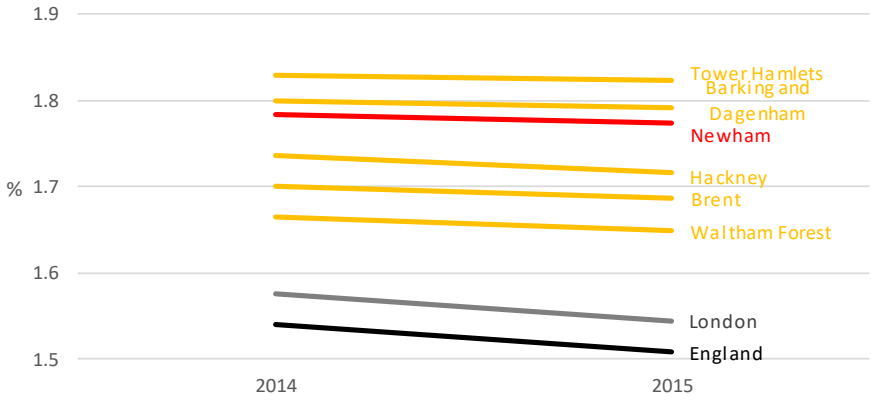


FIGURE 112 – ESTIMATE PREVALENCE OF HYPERKINETIC DISORDERS IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND AGE 5-16, 2014-2015

Source: PHE indicator 91139



HeadStart is a programme funded by the Big Lottery Fund. It aims to help young people and their families to cope with difficult circumstances, prevent common MH problems and support those who are already experiencing difficulties. A pilot study was carried out in Newham and a report compiled in Spring 2015. Based on the results, an estimated 10.6% and 10% of children in Years 6-9 (ages 10/11 – 13/14) in Newham schools demonstrated emotional and behavioural difficulties respectively. Based on population figures for Newham of children aged 10 – 14 inclusive (females 9,500 and males 9,600 taken from GLA SHLAA population prediction for 2015), this equates to approximately 2,025 children with emotional difficulties and 1,910 children with behavioural difficulties. Only a small number of primary and secondary schools took part in piloting the survey and often only with a cohort of their pupils. In the roll-out programme, the cohort of schools is anticipated to be much larger.

What services are available in Newham?

Newham CCG and Local Authority commissioners are working together to improve how our CYP mental health providers support the mental health of young people with emerging and more significant mental health disorder. Key priorities include:

- Implementation and evaluation of HeadStart adolescent targeted mental health targeted prevention programme across Newham's schools and community settings over next five years;
- Implementation of CAMHS transformation plan (described below);
- Work with CAMHS service and other providers to ensure that for all direct clinical interventions with young people routine validated mental health outcome monitoring is collected, analysed and provided to commissioners;
- Work with CAMHS service to ensure that the efficacy of consultation/case support to other practitioners is monitored against a validated competency framework in a uniform fashion;
- Extend capacity across borough to provide a range of evidence-based parenting training with the objective of preventing the development of mental health disorder in at risk young people and improving outcomes in children with existing mental health disorder;
- Increase capacity of Family Nurse partnership to support more vulnerable young mothers;
- Ensure through children's neighborhood services that all schools and GPs have access to effective mental health support for children with emerging mental health disorder;
- Ensure that all social workers, family support workers, Children's Centre staff, special schools/PRUs and YOT staff are supported to develop the competencies so that they can provide effective mental health support to the complex young people and families they are working with;
- Ensure that all foster carers are provided with effective mental health support so that the mental health outcomes of LAC are improved;
- Pilot online counselling and support for young people with mental health disorder;
- Ensure that CAMHS provides effective evidence-based interventions for children and families with severe mental health disorder and that this links effectively with neighborhood children's services and voluntary sector provision.

HeadStart, a preventative mental health service funded by Big Lottery, is a multi-faceted targeted preventative mental health service aiming to ensure that young people at risk of developing mental health problems are provided with effective support from their school, teachers, parents, peers, through community activities and the online environment. Keys to success have been that the activities are designed, promoted and often delivered by young people and their parents.

£840,000 have been spent on the pilot programme with a further £10 million (spread over five years) to scale up across borough. Each of the approaches below have been piloted and evaluated in schools and community settings this year and are now included in the roll out programme;

- **Academic resilience approach** – organisational development approach- training and consultancy for schools to support them to create a move resilient promoting environment.
- **Empowering parents empowering communities (EPEC)** – Local parents trained and supervised to facilitate structured parenting courses for other parents with much higher engagement than when led by professionals.
- **Achievement coach supported volunteering** – Vulnerable young people supported to take part in volunteering opportunities in the school and surrounding community.
- **Bounceback workbook and online resource** – Behaviour change workbook and online resource developed and successfully piloted by young people and academics in Newham.
- **More than Mentors peer mentoring –** Locally developed peer mentoring model- older adolescents trained and supervised by clinical psychologist to provide 1:1 mentoring to younger peers.

- **Targeted resilience building creative and sporting courses** – A menu of resilient sports and creative courses will be co-delivered by specialist instructors and youth practitioners in community settings across the borough. These courses will be specifically targeted at the HeadStart population of young people with youth practitioners to support these vulnerable young people to engage with these courses.

Progress since the last JSNA

These indicators have been in use since 2013, and the values have remained fairly linear thus since. Comparisons between boroughs indicate that Newham denotes a higher prevalence in MH disorders, possibly due higher detection rates or worse outcomes in Newham.

Recommendations

In line with national policy that includes a Five Year Forward View on Mental Health, there are numerous NICE and PHE guidance on improving the state of mental health in CYP[163, 164]. Recommendations include:

Level	Recommendations
Policy	• Yearly refresh of CAMHS transformation plan; Refreshed plans should detail how local areas will use the extra funds committed to support their ambitions across the whole system. Furthermore, plans must be shared with partners to ensure contunity and minimization of disruption. • Demonstrating a focus on joint-agency approach, early intervention and building resilience and improving access to high quality evidence-based treatment • Demonstrate "In line with the vision of *Future in Mind*", that local agencies are working together to ensure best use of existing as well as new resources, so that all available funds are used to support improved outcomes • Increase access to evidence-based treatments for CYP with diagnosable MH diagnoses from 25% (current estimate) to 35% • Report on the CAMHS transformation milestones • Demonstrate that additional funding is being spent on CAMHS • Report proportion of CYP showing reliable improvement in outcomes following treatment • Report proportion of CYP with an eating disorder receiving treatment within 4 weeks (routine) and 1 week urgent • Report number of CYP bed days in in patient CAMHS beds

11.0 SPECIAL GROUPS

INTRODUCTION

Every child deserves a fair start in life, with the very best opportunity to succeed. Local authorities have a democratic mandate to 'champion' the interests of their local communities and ensure that services work effectively for children, young people and families, regardless of whether they attend local authority-maintained schools and settings or others, such as academies, free schools and independent specialist settings, or whether they have a long-term condition or disability.

What are the issues in Newham?

The rates of Looked After Children (LAC) with at least one fixed term exclusion has fallen between 2008 and 2011 remains higher than the London average. Emergency hospitalisations for asthma and epilepsy in children in Newham are higher than the London average. The percentage of young offenders who re-offend continues to be consistently higher than the average for England. Whilst the rate of children in need has fallen, it remains higher than comparator boroughs, London and England. Concurrently, the percentage of children in need achieving 5 A*- C passes is also falling. This is in conjunction with data indicating that children with Special Educational Needs (SEN) statements achieve half the number of good GCSE passes compared to comparator boroughs, London and England.

What are the inequalities?

There are more males than females who are LAC. Moreover, the White and Black/Black British population have the highest percentages of children looked after. Children aged between 10 to 20 are the highest proportion of LAC, and figures have risen in the last year. Figures for those under one have dropped and between one and five years have fallen slightly.

What are we doing well?

The rates of LAC aged between 0 and 17 in Newham have dropped considerably since 2005 and remain similar to London and comparator boroughs. The rates of LAC having a substance misuse problem and percentage of LAC with convictions or final warnings has fallen and is now below London figures. Alongside this, the percentage of LAC having annual health assessments have been consistently higher than London, England and comparator boroughs.

Newham has the lowest self-reported children with long term conditions and hospital admissions for diabetes, compared to comparators boroughs, London and England. The rates of first time entrants to the Youth Justice System has consistently fallen and remain similar to London, England and comparator boroughs.

What needs improving?

There remain numerous areas where improvement across children in special groups can be strived for. This may necessitate provision of personal advisors or increasing the LAC nursing team capacity, focusing on preventing reoffending, increasing community care for children with LAC and more intensive school-based interventions for children in need and those with SEN.

LOOKED AFTER CHILDREN (LAC)

Introduction

A looked after child (LAC) is defined as a child cared for by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours. LAC are monitored closer than other children because of the higher probability of them having poor outcomes in education, physical and mental health[33]. These outcomes further deteriorate if they experience multiple relocations.

Furthermore, research confirms late entrants into care are more likely to have multiple placements; be in high cost residential placements; be more at risk from going missing from placement and have poorer outcomes from children who came into care at an earlier age and can achieve permanency in addition to increased financial implications compared to early entrants. Ensuring a stable and permanent placement for LAC is therefore paramount[165, 166].

In England, the majority of the looked after population is White (77%), with Mixed groups and Black or Black British making up approximately 9% and 7% of the looked after population, respectively. These minority ethnic groups appear to be overrepresented in the looked after population (around five percent of the child population of Great Britain is from Black/Black British and Mixed groups)[167].

Policies and Drivers

National

As with children in need, a clearly defined legal framework and rigorous statutory guidance for local authorities and providers of fostering services and children's homes exists[168]. The NICE quality standard, *Looked-after children and young people [QS31]* details the recommended service specification to ensure the health and wellbeing of LAC from birth to 18 years and care leavers (including young people planning to leave care or under leaving care provisions) across all settings and services irrespective of where they live[169].

The Children Act 1989, the Care Standards Act 2000 and accompanying regulations and statutory guidance provide the legal framework within which local authorities, providers of fostering services and children's homes must work.

Local

The term 'edge of care' incorporates several scenarios ranging from those young people who have met threshold for care proceedings to those at risk of entering care due to challenging behaviour and/or family breakdown. There is a comparatively high number of older children coming into care and remaining, leading to a review of the edge of care response for young people aged 16 and 17 years. To address the high turnover of children coming into care, Newham is in the process of devising an edge of care offer that enables children to live safely in their families and achieve positive outcomes in their school and communities, especially for young people at risk of late entry into care.

In line with national policy, Independent Reviewing Officers (IROs) chair statutory looked after meetings to review care plans of all LACs. IROs have specific responsibilities to ensure that care plans have taken an individual's child's wishes into account and is appropriate in view of both their personal and safeguarding needs.

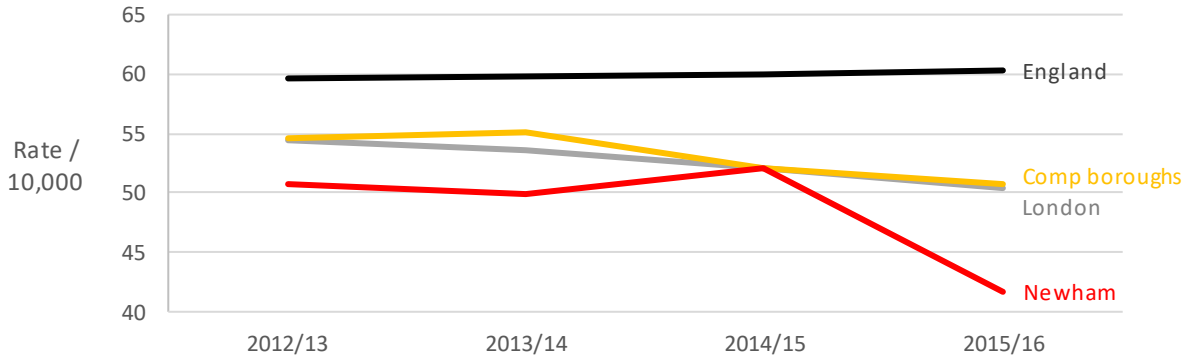
What's happening in Newham?

Summary

The rates of LAC aged 0 to 17 in Newham have generally been lower than those of London and the comparator boroughs. In 2014-2015 they were similar but dropped again in 2015-2016 from 52.1 to 41.8 per 10,000.

FIGURE 113 – LOOKED AFTER CHILDREN AGED 0-17 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2012-2013 TO 2015-2016 RATE/10,000

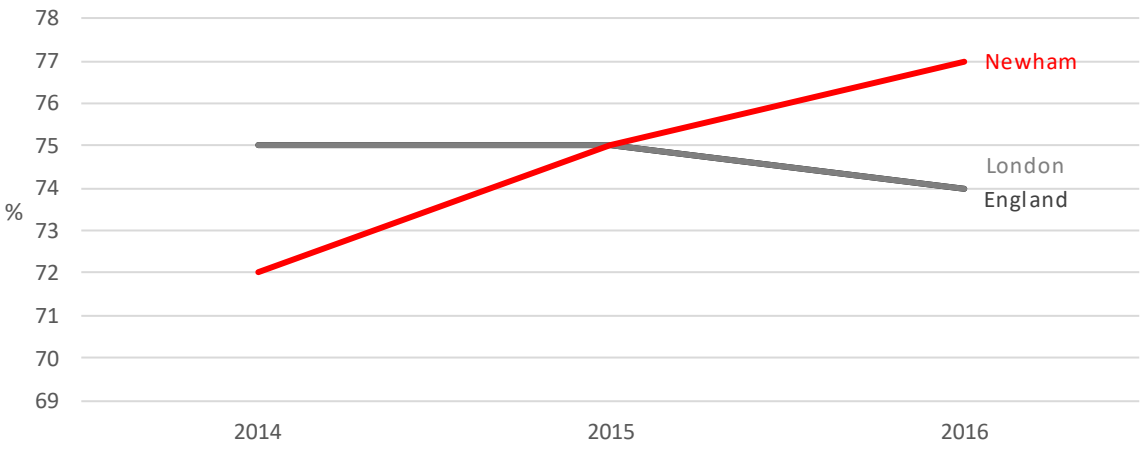
Source: PHE fingertips indicator 90401



The percentage of LAC in foster placements in Newham was lower in 2014 than London and England, equal in 2015, and higher than London and England in 2016. The percentage has increased from 2015 from 75% to 77%. Confidence interval data is not available, and as percentages are pre-calculated it is not possible to derive and overall figure for the comparator boroughs.

FIGURE 114 – PERCENTAGE OF LOOKED AFTER CHILDREN FOSTERED DURING THE YEAR 2014 TO 2016 IN NEWHAM, LONDON AND ENGLAND

Source: data.gov.uk LA tables SFR41/2016, SFR34_2015, SFR36_2014



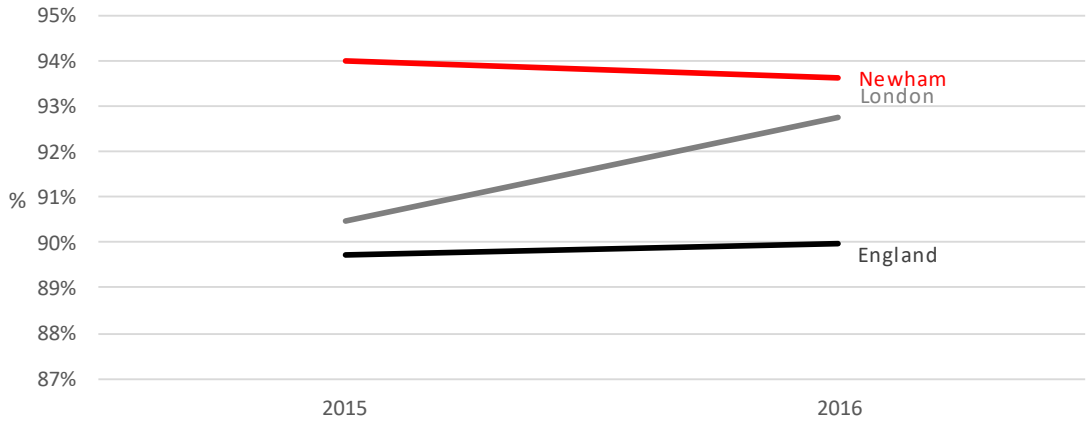
Source data was given rounded to whole percentages, and London and England had the same values at the same degree of precision. Source data did not present the placements of LAC in 2017 so it cannot be determined what percentage of LAC were in foster care for 2017.

Health Assessments

Health assessments/ checks are undertaken annually to ensure that any physical and/ or mental health issues in LACs are identified and intervened early. Statistics relate to LAC who have been looked after continuously for at least 12 months, The percentage in Newham is above that of London, and England. Source tables did not include data for this indicator for 2014, furthermore, confidence interval data is not available. Source data did not present the uptake of health checks for LAC in 2017 so it cannot be determined what percentage of LAC had health assessments for 2017.

FIGURE 115 – PERCENTAGE OF LOOKED AFTER CHILDREN WITH HEALTH ASSESSMENTS 2015-2016 IN NEWHAM, LONDON AND ENGLAND

Source: data.gov.uk LA tables SFR41/2016, SFR34_2015

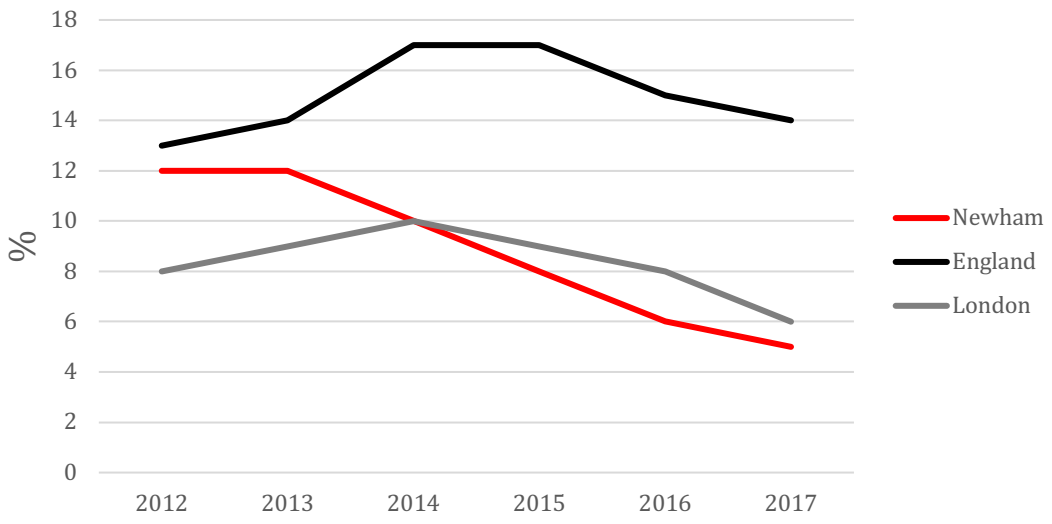


Adoption

The percentage of LAC adopted has more than halved between 2012 and 2017. In 2017, Newham's rate is below that of London, and very much lower than the England figure. Confidence interval data is not available, and as the percentages are pre-calculated and it is not possible to derive combined data for comparator boroughs. As the counts in the source data have been rounded to the nearest five percent for publication and the absolute numbers are small, these figures are not exact.

FIGURE 116 - PERCENTAGE OF LOOKED AFTER CHILDREN ADOPTED DURING THE YEARS 2013 TO 2016 IN NEWHAM, LONDON AND ENGLAND

Source: data.gov.uk LA tables SFR50/2017, SFR41/2016

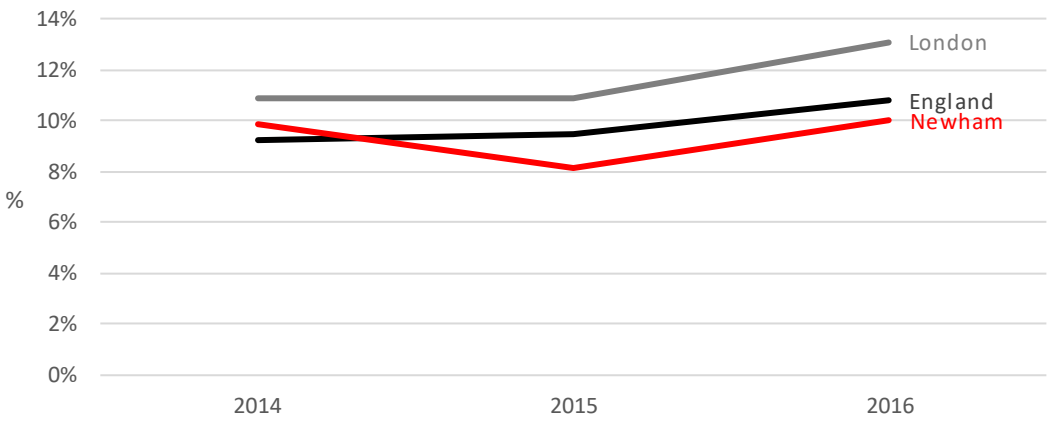


Secure units, children's homes and hostels

The percentage of LAC in secure units, children's homes and hostels is lower in Newham compared to, London and England. Source data did not report on LAC placements in 2017 so it cannot be determined what percentage of LAC were in secure units, homes or hostels in 2017.

FIGURE 117 – PERCENTAGE OF LAC IN SECURE UNITS, CHILDREN'S HOMES AND HOSTELS 2014 TO 2016 IN NEWHAM, LONDON AND ENGLAND

Source: data.gov.uk LA tables SFR41/2016, SFR34_2015, SFR36_2014

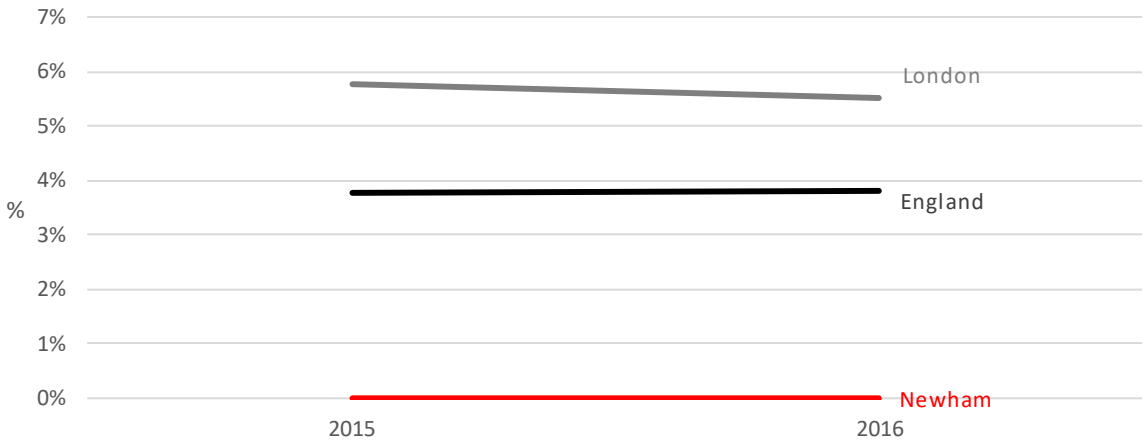


Substance Misuse

In 2015, the number of LAC who identified as having a substance misuse problem was below five, so was suppressed for data privacy reasons. In 2016, the figure was to be zero. Consequently, Newham's prevalence is well below those of London and England. Source data did not report on substance misuse in LAC for 2017.

FIGURE 118 – PERCENTAGE OF LAC IDENTIFIED AS HAVING A SUBSTANCE MISUSE PROBLEM DURING THE YEARS 2015 TO 2016 IN NEWHAM, LONDON AND ENGLAND

Source: data.gov.uk LA tables SFR41/2016, SFR34_2015

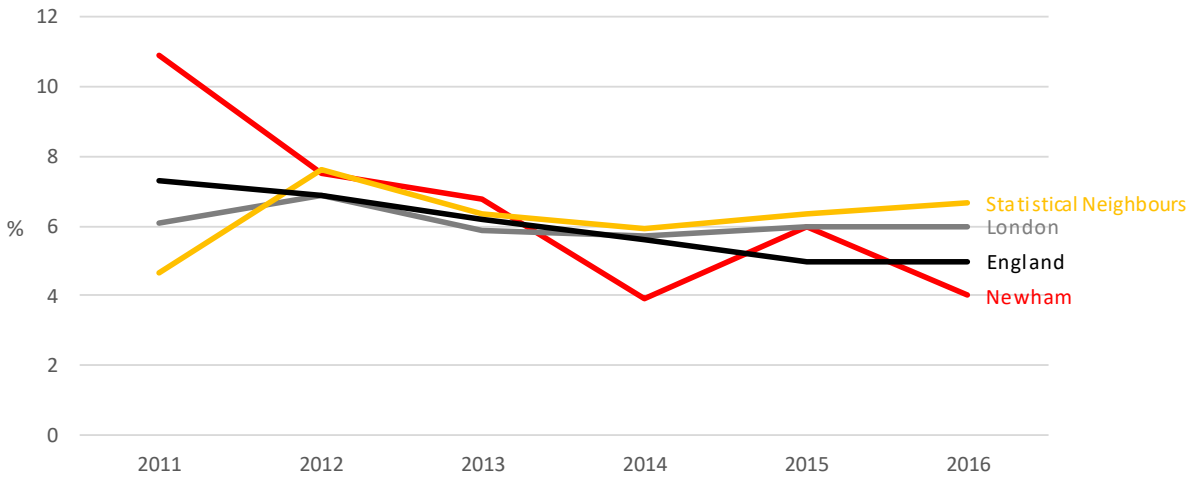


Youth Offenders

The chart below denotes the percentage of LAC convictions, final warnings, or reprimands in the year from 2011 to 2016 in Newham, London, England and statistical neighbours. The prevalence in Newham has generally declined over this period. Despite an increase in percentage in 2015, the prevalence has decreased in 2016. Furthermore, this percentage is lower than that observed in London, England and statistical neighbours. Again, confidence interval data was not available. The statistical neighbour data was pre-calculated and may not refer to the usual comparator boroughs used previously in this JSNA.

FIGURE 119 - LAC WITH CONVICTIONS, FINAL WARNINGS, OR REPRIMANDS DURING THE YEAR IN NEWHAM, COMPARATOR BOROUGHS, LONDON, AND ENGLAND BETWEEN 2011 AND 2016

Source: LAIT

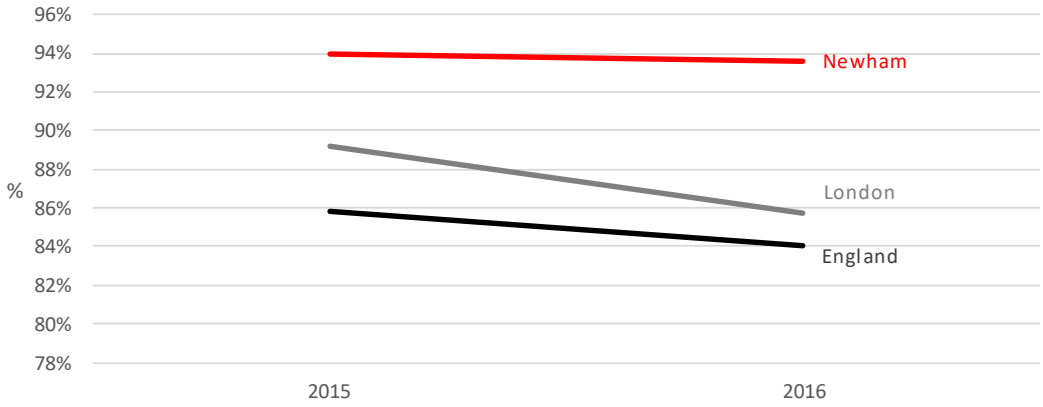


Dental Health

A higher proportion of LAC in Newham have had their teeth checked by a dentist, when compared to data from London and England. In 2015 and 2016, 94% of LAC had their teeth checked, while in London in 2016, the figure was 86% and in England was observed to be 84%. The source data tables did not include data for 2014. Again, confidence interval data is not available and was not calcuated.

FIGURE 120 – PERCENTAGE OF LOOKED AFTER CHILDREN WITH DENTAL CHECKS BETWEEN 2015 AND 2016 IN NEWHAM, LONDON AND ENGLAND

Source: data.gov.uk LA tables SFR41/2016, SFR34_2015

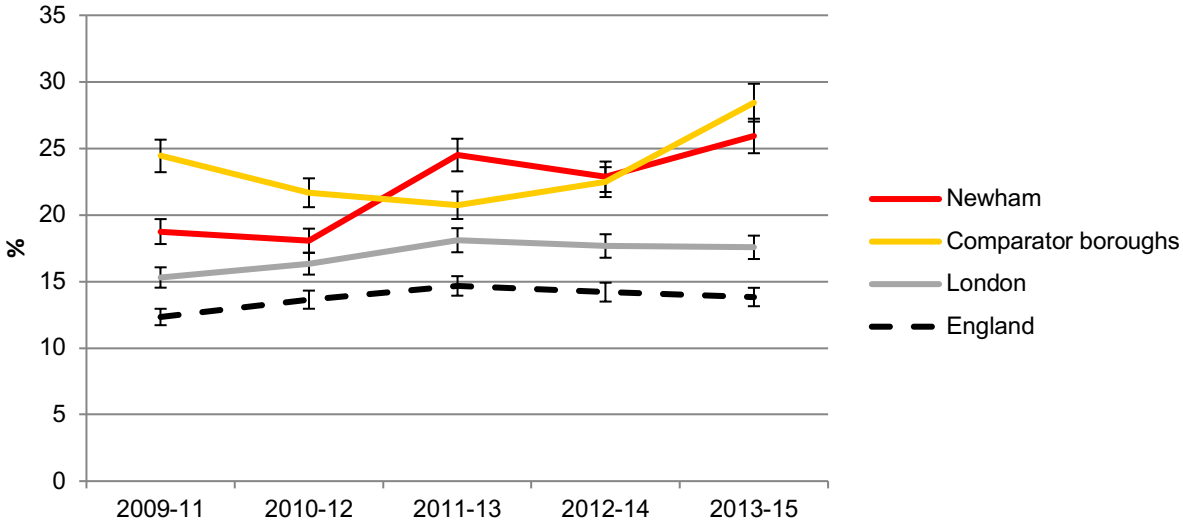


Schooling

Denoted in the graph below, LAC in Newham have consistently performed similarly to comparator boroughs in GCSEs and better when compared to London and England.

FIGURE 121 – PERCENT OF LOOKED AFTER CHILDREN ACHIEVING 5+ A*-C INCLUDING ENGLISH AND MATHS

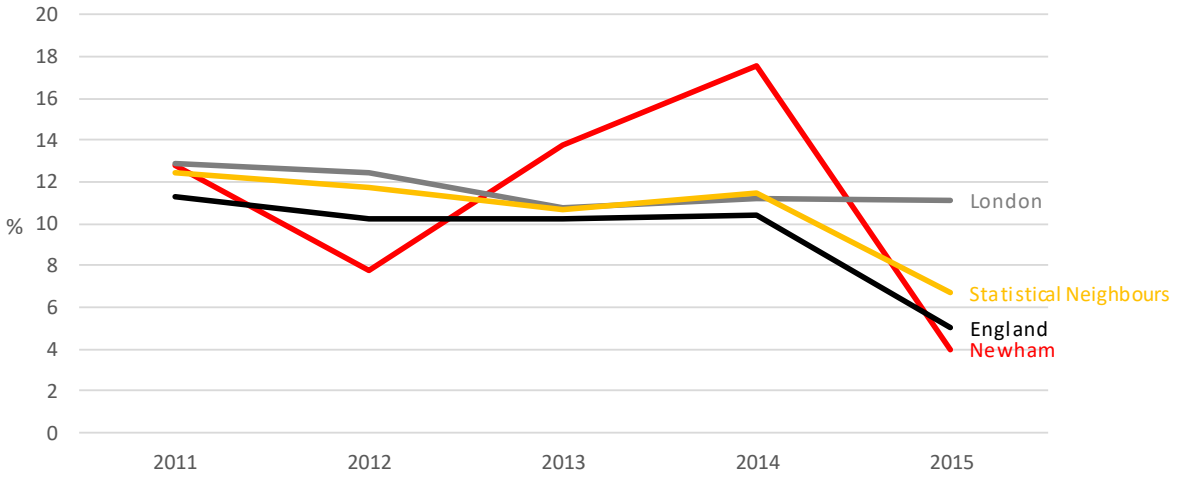
Source: LAIT



A fixed term exclusion is defined as a pupil who is excluded from school on a fixed term basis but remains on the register as they are expected to return when the exclusion period is over. In Newham, the percentage of LAC with at least one fixed term exclusion has been highly variable from year to year. Furthermore, confidence interval data was unavailable for calculation, and statistical neighbour data was pre-calculated and may not refer to the usual comparator boroughs.

FIGURE 122 – PERCENT LOOKED AFTER CHILDREN WITH AT LEAST ONE FIXED TERM EXCLUSION DURING THE YEAR IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND BETWEEN 2011 AND 2015

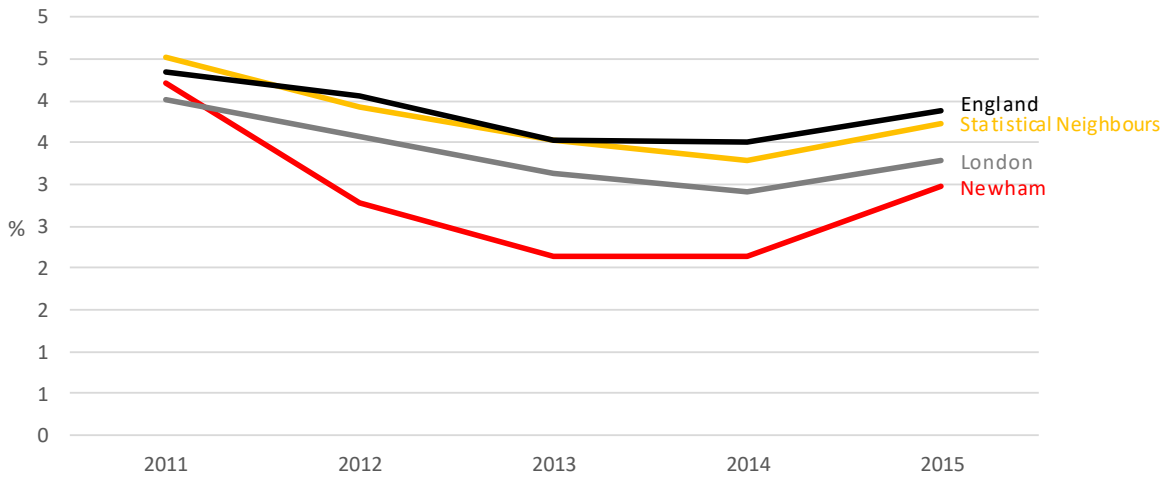
Source: LAIT



In general, the rate of exclusion of LAC in Newham has been higher than all other children in Newham. However, in 2015 the rates between both groups were very similar. Overall, Newham has had lower exclusion rates than its comparators.

FIGURE 123 – ALL SCHOOLS FIXED TERM EXCLUSION DURING THE YEAR IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND BETWEEN 2011 AND 2015

Source: LAIT

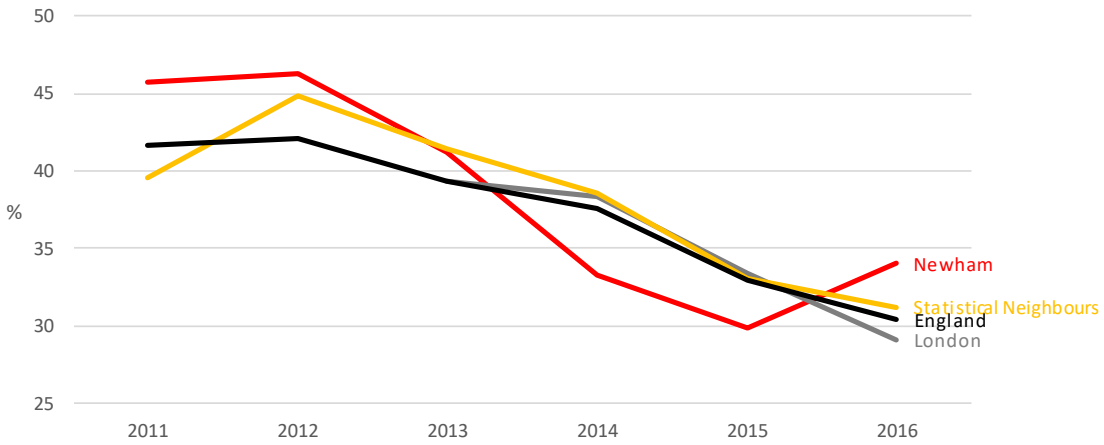


A statement is a formal document that details a child's learning difficulties and any help s/he may need. This is assessed by the local authority with views from the child's parents, the school, an educational psychologist, a doctor and social services (if the child is known to them), where all the information is collated into a statement. It is necessary if a school is unable to meet a child's needs without external support[170].

The following graph denotes the percentage of LAC with Special Educational Needs (SEN) *without* a statement. It is important to note however that only approximately 2% of children require a statement and even if a child has SEN, it doesn't automatically follow that a statement is mandatory.

FIGURE 124 – PERCENT OF LOOKED AFTER CHILDREN WITH SEN BUT NO STATEMENT IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND BETWEEN 2011 AND 2016.

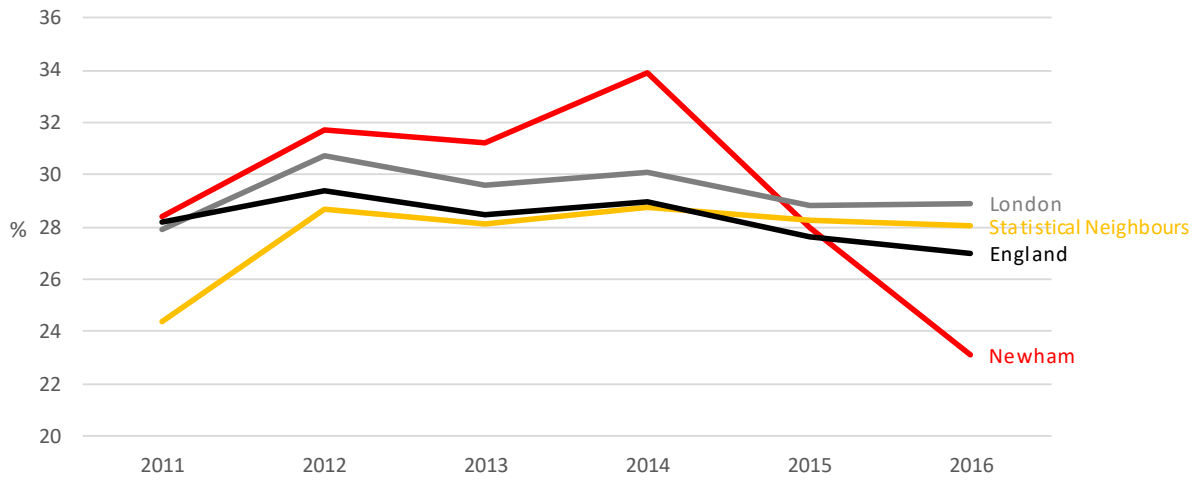
Source: LAIT



In contrast, the graph below denotes the percentage of LAC with SEN *with* a statement. In 2016, Newham prevalence fell below that of the comparators.

FIGURE 125 – PERCENT OF LOOKED AFTER CHILDREN WITH SEN WITH STATEMENT/EHCP IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND BETWEEN 2011 AND 2016

Source: LAIT



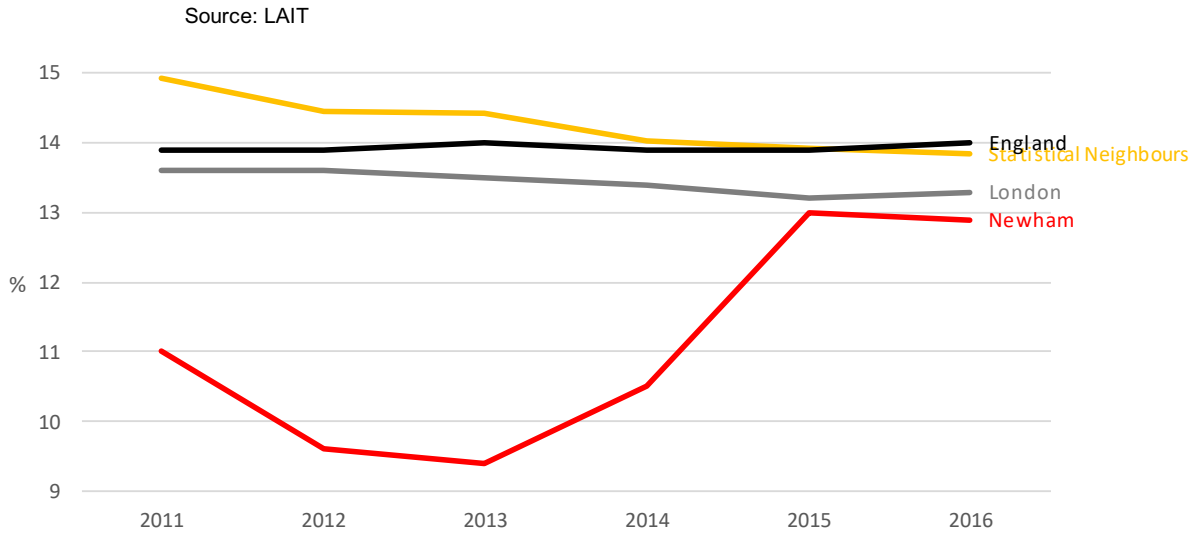
Emotional Wellbeing

Emotional wellbeing is assessed through a Strengths and Difficulties Questionnaire (SDQ) with a total difficulties score, ranging from 0-40. Whilst a score of less than 14 is considered normal, 14-16 is borderline cause for concern and 17 or over is a cause for concern.

As shown in the following chart, Newham's score was higher in 2015 and 2016 than in previous years. Confidence interval data is not available, so the degree of significance for the observed difference between Newham and comparators cannot be determined.

FIGURE 126 – MEAN VALUE OF CHILD LEVEL SDQ AS INDICATOR OF EMOTIONAL AND WELLBEING HEALTH IN LOOKED AFTER CHILDREN IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND

Source: LAIT



What services are available in Newham?

The Families First programme at Newham provides an opportunity to work differently with families in the cohort to address parenting and preventing their children from needing to come into care.

To address the ongoing numbers of LAC placed out of borough in high cost residential placements, a local placement sufficiency project is currently being devised to return our LAC closer to Newham with a concurrent aim to enhance our in-house fostering provision to incorporate the concept of a dedicated 'hub home' for our carers offering respite care, peer support, regular joint planning and social activities.

Foster carers and residential workers continue to play a significant role in the care of LAC. A Fostering Changes training programme is provided to all foster carers and residential workers to support them with behavior management. Alongside this, supervising social workers in the fostering team carry out 6 weekly support and supervision visits to ensure LAC receive appropriate care with a therapist supporting foster carers to address the needs of LAC with complex needs.

Progress since the last JSNA

Compared to the 2015-2016 JSNA, the rates of Looked After Children have decreased from last year from 52.1 to 41.8 per 10,000. Furthermore, the proportion of LAC fostered during the year has increased from 75% to 77%. The percentage of LAC who are adopted between 2012 to 2016 from 12% to 6%. The ppercentage of LAC in secure units, children's homes and hostels is increased from 8% to 10%. The percentage of LAC with convictions, final warnings or reprimands have decreased from 6% to 4%. The percentage of LAC with SEN and no statement has increased from 30% to approximately 34%, whereas the percentage of LAC with SEN with a statement decrease from 28% to 24%.

Recommendations

In line with national policy, there are numerous NICE and PHE guidance on improving the outcomes of LAC[169, 171, 172]. These include:

Level	Recommendations

Policy	• Create strong leadership and strategic partnerships to develop a vision and a corporate parenting strategy that:
	  ○ focuses on effective partnership and multi-agency working
	  ○ addresses health and educational inequalities for looked-after children and young people
	• Ensure that local strategic plans adhere to national guidance, primarily Statutory guidance on promoting the health and well-being of looked after children
	• Ensure local plans and strategies for children and young people's health and wellbeing fully reflect the needs of looked-after children and young people, and care leavers, and set out how these needs will be met. They should describe how to:
	  ○ 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

	• Ensure senior managers in partner agencies provide strong, visible leadership to raise aspirations and attainment, and promote joint working to meet the needs of looked-after children and young people • Ensure effective corporate parenting by complying with guidance on the role of lead members for children's services and directors of children's services in helping looked-after children and young people improve their aspirations and outcomes • Ensure services are developed taking account of the views of looked-after children and young people • Provide an annual report to the children-in-care council, the local authority overview and scrutiny committee, the director of public health, the NHS commissioner and the leader of the council. This report should cover the effectiveness of services for looked-after children and young people when evaluated against local plans for health and wellbeing, the local pledge to children in care, national indicators and local targets • Publish and update regularly a directory of resources for looked-after children and young people to aid social workers, and a resource guide for looked-after children and young people and care leavers • Ensure local authorities reflect in their yearly 'pledge' to looked-after children and young people the needs and challenges raised by children-in-care councils about improving services to achieve better outcomes
Community	• Build communication networks with key partner organisations and publish, publicise and update regularly a local map that identifies all agencies that are involved with looked-after children and young people
Neighbourhood	• Build communication networks with key partner organisations and publish, publicise and update regularly a local map that identifies all agencies that are involved with looked-after children and young people

CHILDREN WITH LONG TERM CONDITIONS (LTC)

Introduction

The 2012 Annual Report of the Chief Medical Officer identified that outcomes for children and young people in England are poorer than they could or should be. International evidence demonstrates that improvements are possible, with England being an extreme outlier in asthma mortality in the under 14s, with almost twenty-five times higher mortality than the best performing country studied in a recent review[173, 174].

Even within England, there are unacceptable variations in outcomes. The updated Atlas of Variation in Healthcare noted that there was more than thirteen fold variation in directly standardised rate of emergency admissions for children with epilepsy across local authorities[22]. More worryingly, data indicates that only 5.8% of all children and young people with diabetes receive the care needed to reduce risk of complications, with English outcomes poorer when compared internationally[175].

Policies and drivers:

National

NHSE and CCGs have a responsibility for enhancing the quality of life for people with LTCs that include reducing avoidable emergency admissions, improving the quality of life for children with LTCs and their families, as well as reducing pressures on local hospitals; all of which feature in the NHS Outcomes Framework[33].

These were also reflected in the 2012 Annual Report of the Chief Medical Officer, in which a subsequent National Institute for Health Research (NIHR) research call for long-term conditions in children and young people was issued[176].

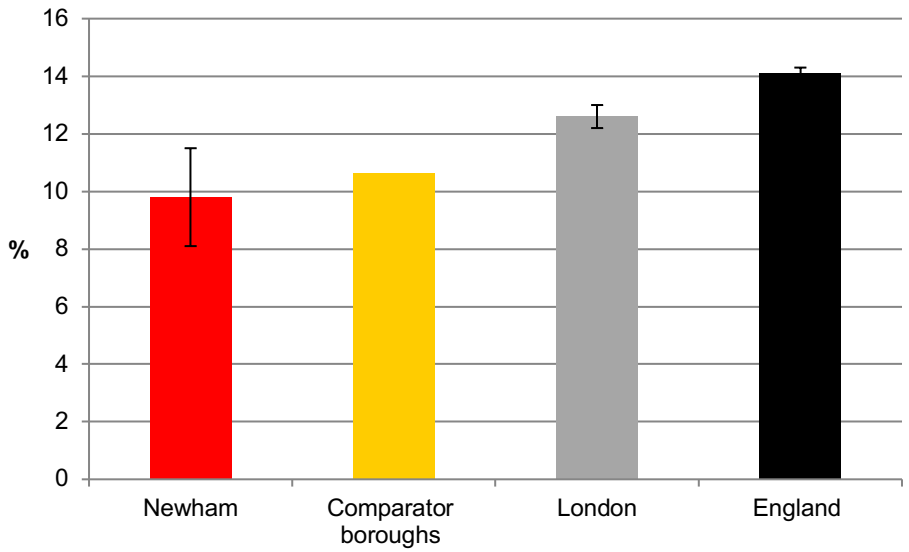
Local

What's happening in Newham?

The figure below illustrates the self-reported prevalence of 15-year-olds who have been diagnosed with a long-term illness, disability or medical condition by a doctor. Newham has the lowest figure at 9.8% compared to similar boroughs (10.6%), London (12.6%) and England (14.1%).

FIGURE 127 – PERCENT OF 15 YEAR OLDS WITH A LONG TERM ILLNESS, DISABILITY OR MEDICAL CONDITION DIAGNOSED BY A DOCTOR

Source: WAY Survey from Fingertips, PHE

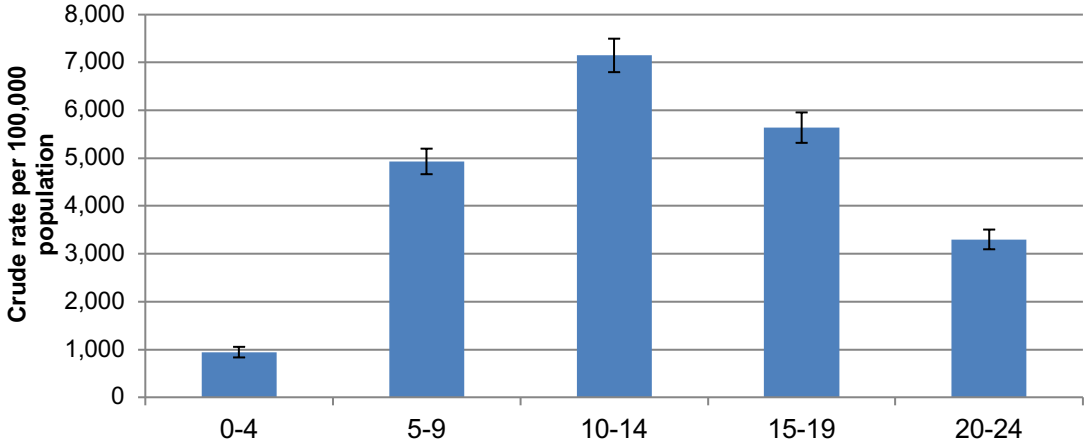


Asthma

The figure below notes the crude rate (per 100,000) of asthma by quinary age bands in children and young people Newham in 2015 based on local GP data.

FIGURE 128 – PREVALENCE OF ASTHMA BY QUINARY AGE GROUP

Source: CEG

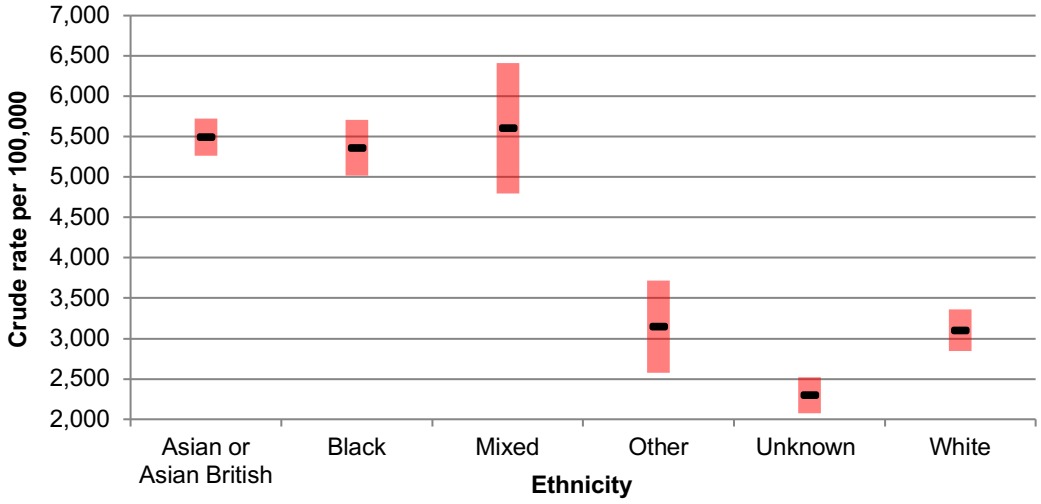


In Newham, Asthma is significantly more prevalent in 5-9, 10-14 and 15-19 age groups compared to 0-4 and 20-24 age groups[50].

Stratifying by ethnicity, asthma prevalence in Newham is noted to vary with Asian or Asian British, Black and Mixed backgrounds having significantly higher prevalence of asthma compared to White and Other ethnicities[50].

FIGURE 129 -PREVALENCE OF ASTHMA IN UNDER 19 YEAR OLDS BY ETHNIC GROUP

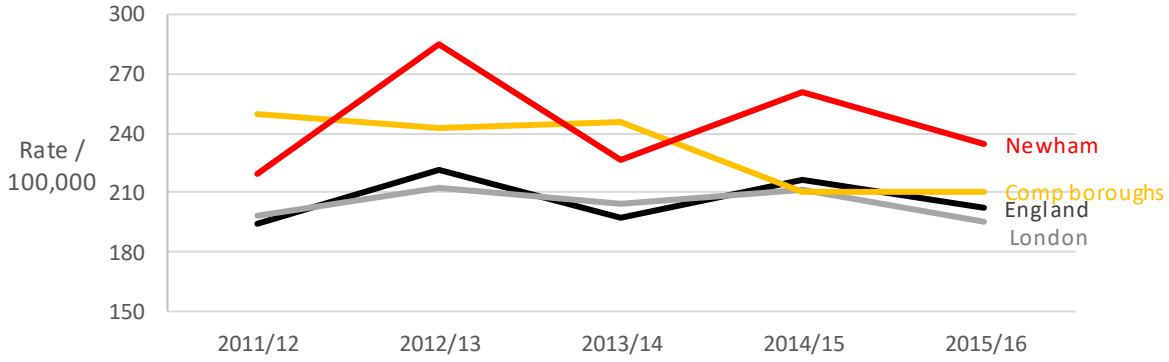
Source: CEG



As shown in the figure below, between 2011-2012 to 2015-2016 rates of emergency hospital admissions for asthma in Newham have been higher compared to London and England[50]. Although the rate has declined since 2014-2015, Newham is still trailing behind England, London and comparator boroughs. The rate for Newham is 234.2 per 100,000.

FIGURE 130 – HOSPITAL ADMISSIONS FOR ASTHMA AGED 0-18 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND FROM 2011/12 TO 2015/16 RATE/100,000

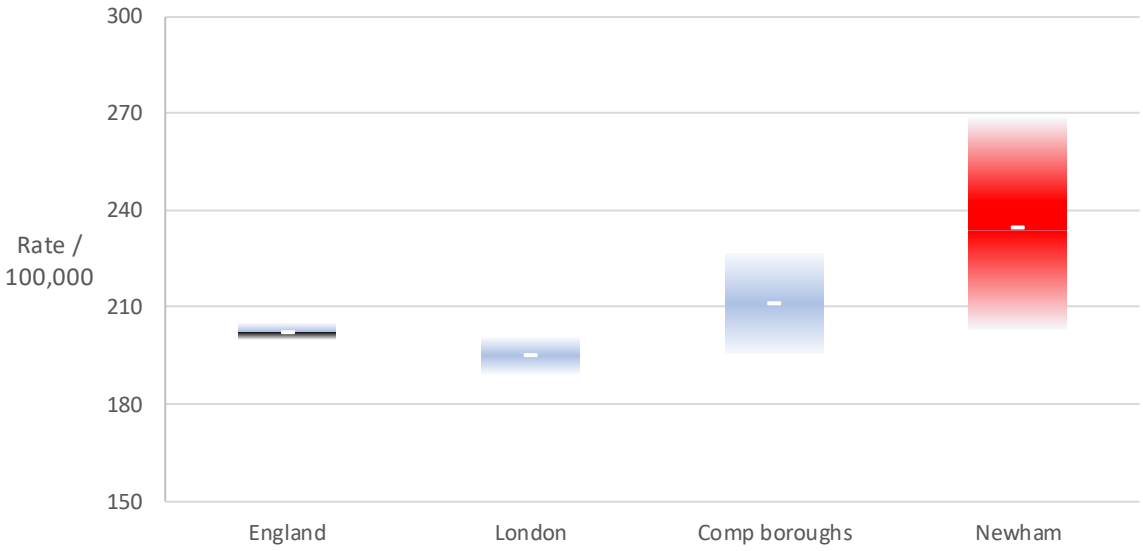
Source: PHE fingertips tobacco control profile indicator 90810



As shown on the following figure, the differences between Newham's rate and those of London and England are statistically significant at the usual 5% level.

FIGURE 131 – HOSPITAL ADMISSIONS ASTHMA AGED 0-18 IN NEWHAM, COMPARATOR BOROUGHS, LONDON AND ENGLAND 2015/16 RATE/100,000 (95% CONFIDENCE INTERVALS)

Source: PHE fingertips tobacco control profile indicator 90810

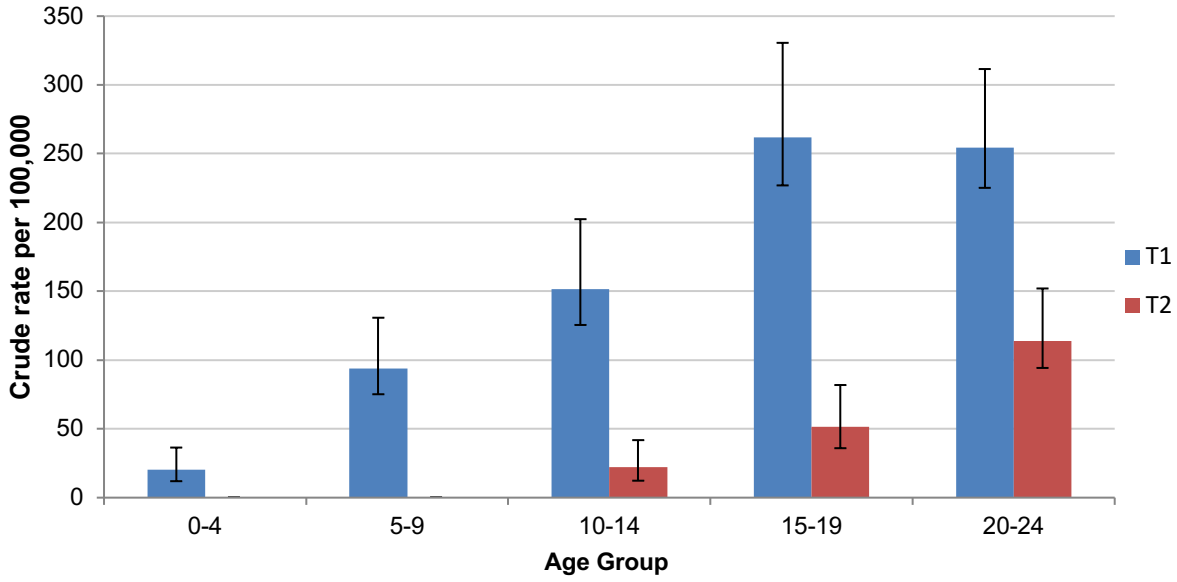


Diabetes

The figure below notes the crude rate (per 100,000) of asthma by quinary age bands and diabetes type in children and young people Newham in 2015 based on local GP data. Overall, Type 1 diabetes is more prominent, gradually increasing from 93 per 100,000 in the 5-9 age groups to 261 per 100,000, a similar pattern observed in the 2013-2014 National Paediatric Diabetes Audit[50].

FIGURE 132 – PREVALENCE OF DIABETES BY QUINARY AGE GROUP AND TYPE

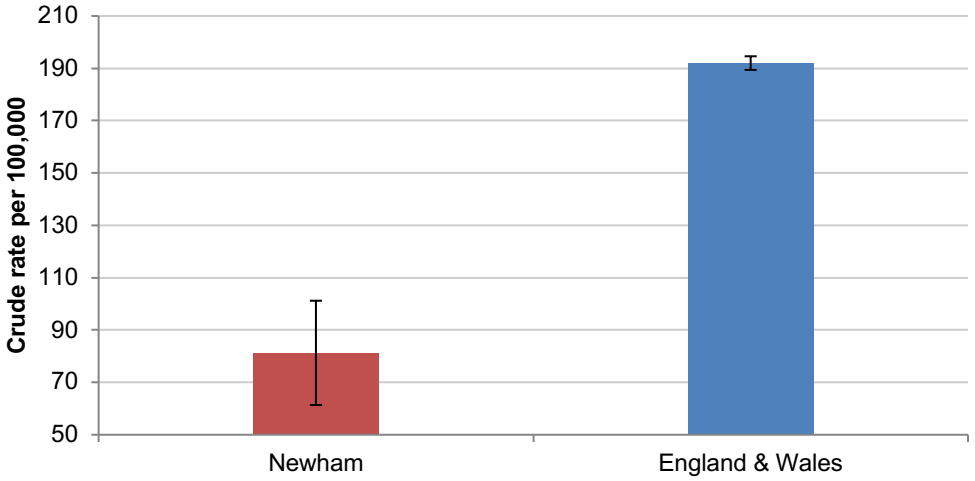
Source: CEG



When compared to estimated rates in the England and Wales in children and young people younger than 14 years, Newham has a significantly lower rate of Type 1 Diabetes[50].

FIGURE 133 – PREVALENCE OF TYPE I DIABETES IN NUDER 15 YEAR-OLDS

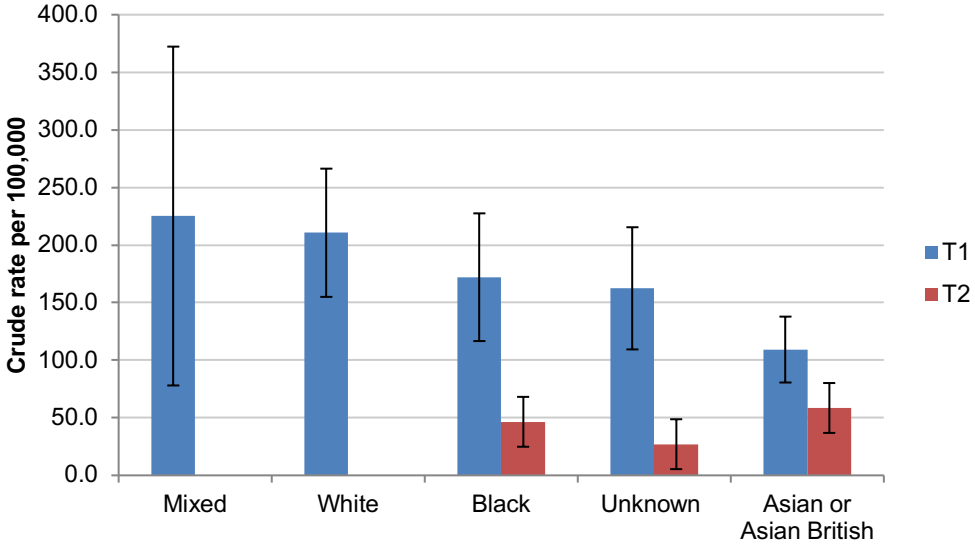
Source: CEG / National Paediatric Diabetes Audit



Stratifying by ethnicity, diabetes prevalence in Newham is noted to vary with Asian or Asian British (109 per 100,000), Black (172) and Unknown (162) backgrounds having the lowest prevalence of Type 1 diabetes but the highest prevalence of Type 2 diabetes. This was similarly observed in the 2013/14 National Paediatric Diabetes Audit which noted that children of Asian and Black origin almost 9 and 6 times respectively more likely to have Type 2 diabetes compared to children from White backgrounds[50].

FIGURE 134 – PREVALENCE OF DIABETES IN UNDER 25 YEAR OLDS BY ETHNICITY

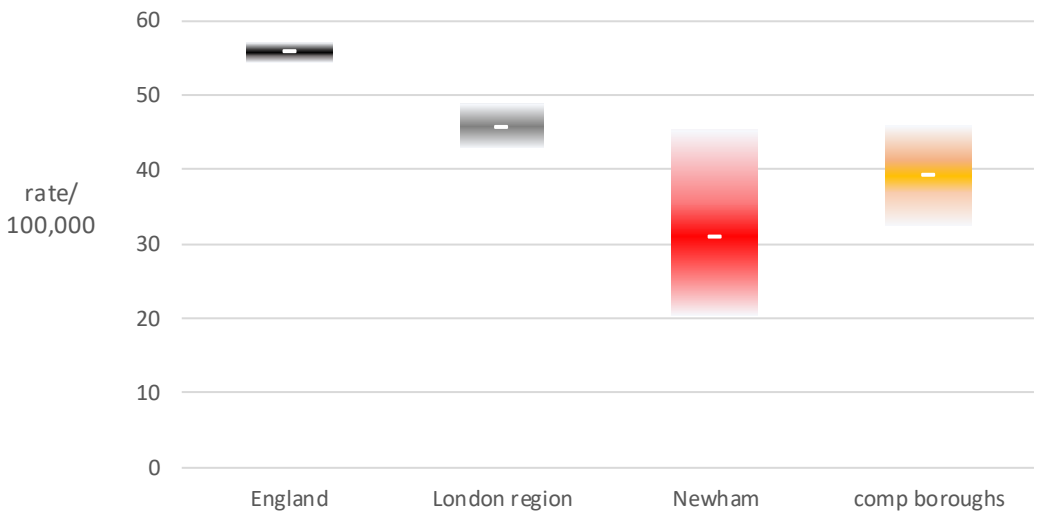
Source: CEG



In 2014-2015 Newham's rate of emergency hospital admissions for both types of diabetes (31.1/100,000) was significantly lower than that of England (55.8/100,000) and non-significantly lower than those of London (45.8/100,000) and the comparator boroughs (39.3/100,000).

FIGURE 135 – HOSPITAL ADMISSIONS FOR DIABETES AGE 0-18 IN 2014/15 RATE/100,000 PERSONS (95% CONFIDENCE INTERVALS)

Source: PHE fingertips indicator 92622

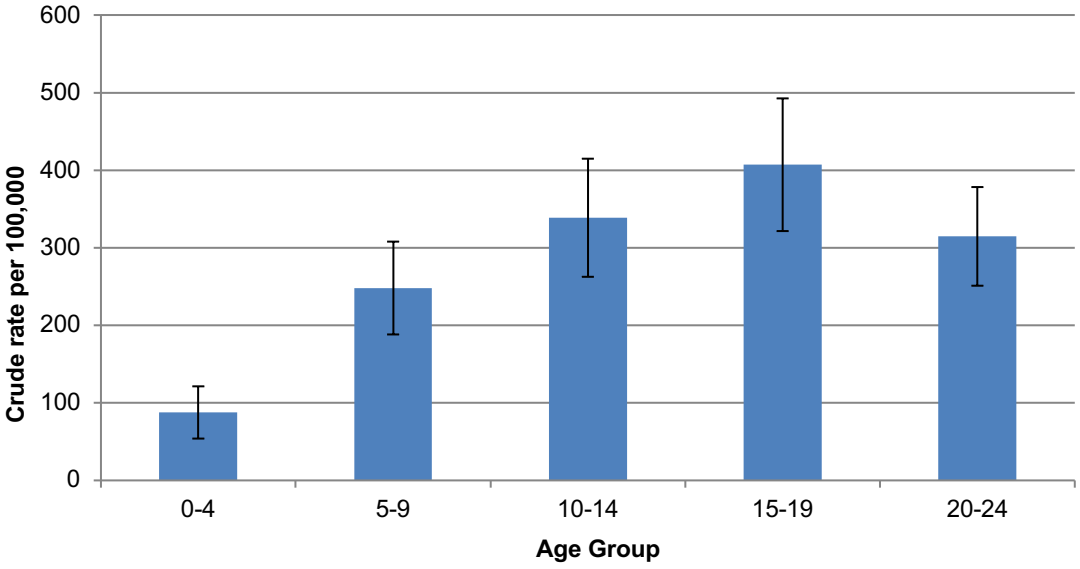


Epilepsy

The figure below notes the crude rate per 100,000 of epilepsy by quinary age bands in children and young people Newham in 2015 based on local GP data. An increasing trend by age groups is notable, similar to the 2011 Joint Epilepsy Council of the UK and Ireland national prevalence estimates.

FIGURE 136 – PREVALENCE OF EPILEPSY BY QUINARY AGE GROUP

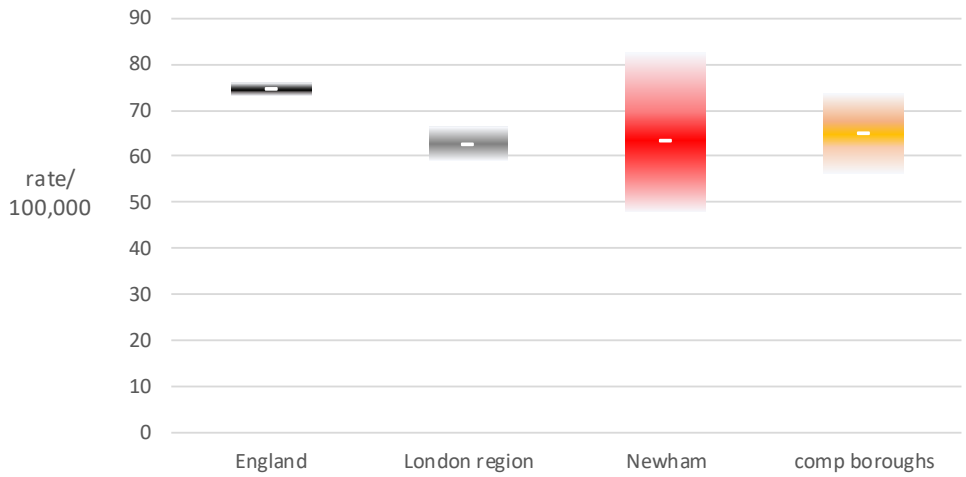
Source: CEG



In 2014-2015, Newham's rate of emergency hospital admissions for both epilepsy (63.4/100,000) was not significantly different from those of England (74.6/100,000), London (62.7/100,000) and the comparator boroughs (64.9/100,000). Furthermore, the rate of admissions in Newham, has decreased from 73.9 per 100,000 in 2013-2014 to 623.4 per 100,000 in 2014-2015.

FIGURE 137 – HOSPITAL ADMISSIONS FOR EPILEPSY AGE 0-18 IN 2014-2015 RATE/100,000 PERSONS WITH (95% CONFIDENCE INTERVALS)

Source: PHE fingertips indicator 92623



What services are available in Newham?

Within the Children and Young People Programme of the Healthy London Partnership, there is a focus on reducing variation in Asthma, Acute and Critical Care and Out of Hospital Care with recent examples including an Asthma Community Pharmacy Audit and the London Asthma Toolkit and setting London Acute Care Standards for children and young people.

Progress since the last JSNA

Compared to the 2010 JSNA, we have worsened in emergency hospital admissions for asthma (219.1 to 234.2 per 100,000) but improved with hospital admissions for epilepsy (80 to 63.4 per 100,000). Further action to improve outcomes for children with LTCs in Newham remains paramount.

Recommendations:

There are numerous NICE and PHE disease-specific guidance on improving outcomes in children with LTCs. Alongside recommendations by the Healthy London Partnership and a recently commissioned rapid review undertaken by UCLPartners, recommendations include[176]:

Level	Recommendations
Policy	• LBN should strive to become a leader in the development of prevention and health promotion interventions for CYP at risk of, or diagnosed with type 2 diabetes • A commitment should be made that no asthmatic child in Newham should live in sub-standard housing conditions • A commitment should be made to bring vaccination coverage up to the herd immunity level • Offer children and young people with type 1 diabetes and their family members or carers (as appropriate) a continuing programme of education from diagnosis • Tailor the education programme to each child or young person with type 1 diabetes, taking account of issues such as: ○ personal preferences

	○ emotional wellbeing ○ age and maturity ○ cultural considerations ○ existing knowledge ○ current and future social circumstances ○ life goals • Encourage young people with type 1 diabetes to attend clinic 4 times a year because regular contact is associated with optimal blood glucose control • Encourage children and young people with type 1 diabetes and their family members or carers (as appropriate) to discuss any concerns and raise any questions they have with their diabetes team • Give children and young people with type 1 diabetes and their family members or carers (as appropriate) information about local and/or national diabetes support groups and organisations, and the potential benefits of membership. Give this information after diagnosis and regularly afterwards • Encourage children and young people with type 1 diabetes to wear or carry something that identifies them as having type 1 diabetes • Explain to children and young people with type 1 diabetes and their family members or carers (as appropriate) how to find information about government disability benefits • Offer education for children and young people with type 1 diabetes and their family members or carers (as appropriate) about the practical issues related to long distance- travel, such as when best to eat and inject insulin when travelling across time zones • Ensure that where practitioners encounter serious damp, mould or excess cold hazards in privately rented accommodation, that a referral be made to the Private Housing and Environmental Health Team at the council so that they may take appropriate action to reduce those hazards. Where similar hazards are identified in social rented housing, a referral should be made to the housing provider
Community	• An intervention to prevent type 2 diabetes in CYP should be developed, implemented and evaluated • A health promotion and disease management intervention for CYP already diagnosed with type 2 diabetes should be developed, implemented and evaluated • All programmes implemented in the borough should be evaluated to ensure they are culturally and linguistically appropriate for the population, or separate culturally specific interventions provided if a large enough sub-population is identified • The public health department should work with the housing department to fund improvements in ventilation for CYP with asthma living in sub-standard environments • Consideration should be given to the development of a reminder/recall system for vaccinations in unvaccinated people that escalates in intensity, and may include text message reminders, letters, phone call or home visits, to improve vaccination uptake
Neighbourhood	• School-based delivery of interventions to improve self-care amongst CYP with chronic diseases should be considered

YOUNG OFFENDERS

Introduction

Fewer and fewer young people are committing crimes, but there are still too many young people encountering the criminal justice system. In particular, too many young people are re-offending with 73% of young people released from custody re-offend within a year.

Young offenders often have health, education and/or social care needs, which, if not addressed early, can lead to a lifetime of declining health, worsening offending behavior and increasing costs to both the taxpayer and victims of these crimes.

Whilst reforms to health and social care in England, and the emphasis on localism, provide a chance to improve joint working between youth justice and healthcare services, there remains a need to provide education and training to enable young offenders to return to school, college or find employment.

Policies and Drivers

National

The youth justice system (YJS) was set up under the Crime and Disorder Act 1998 with the aim to prevent young people offending or re-offending. The age of criminal responsibility in England is 10 years and the YJS covers children from 10 to under 18. The formal system starts once a child in this age bracket commits an offence and receives a reprimand or warning or is charged to appear in court.

Local

The Crime and Disorder Act requires local authorities, the police, probation, and CCGs to set up youth offending teams (YOTs) to work with children and young people offending or at risk of offending. YOTs must include representatives from the police, probation, health, education and children's services and continue to have an ongoing responsibility for children and young people sentenced or remanded to custody[22]. Reducing youth offending is an ongoing LBN business plan priority with close monitoring of both the impact and effectiveness of arrangements to increase youth safety and reduce youth violence, ensuring that children and young people in Newham are effectively safeguarded from harmful practices, from adults or their peers, within the local and wider community.

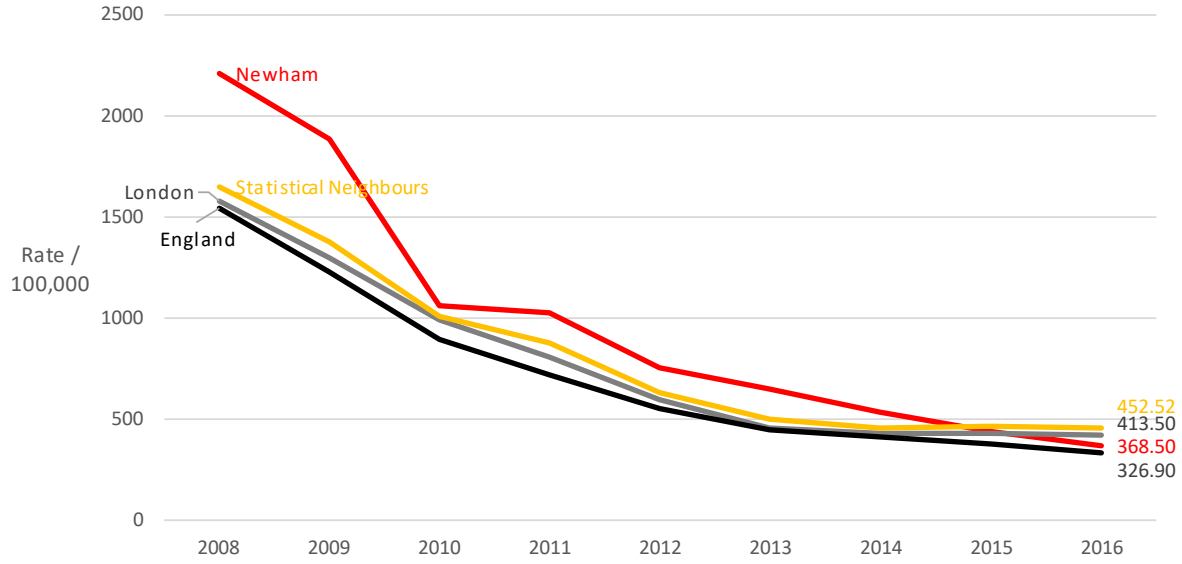
What's happening in Newham?

First time entrants to Youth Justice System

The rates of young people aged 10 between 17 entering the Youth Justice System (YJS) have dropped since 2008, both nationally and locally. In Newham, there was a sharp drop between 2009 and 2010, and a steady decline since 2011. Newham's rate in 2016 (369 per 100,000) is about one sixth of what it was in 2008. Newham's rate in 2016 is very similar to those of the comparators, but as the rates are pre-calculated, statistical significance cannot be determined.

FIGURE 138 – FIRST TIME ENTRANTS TO YOUTH JUSTICE SYSTEM, AGED 10-17 RATE/100,000 PERSONS

Source: LAIT

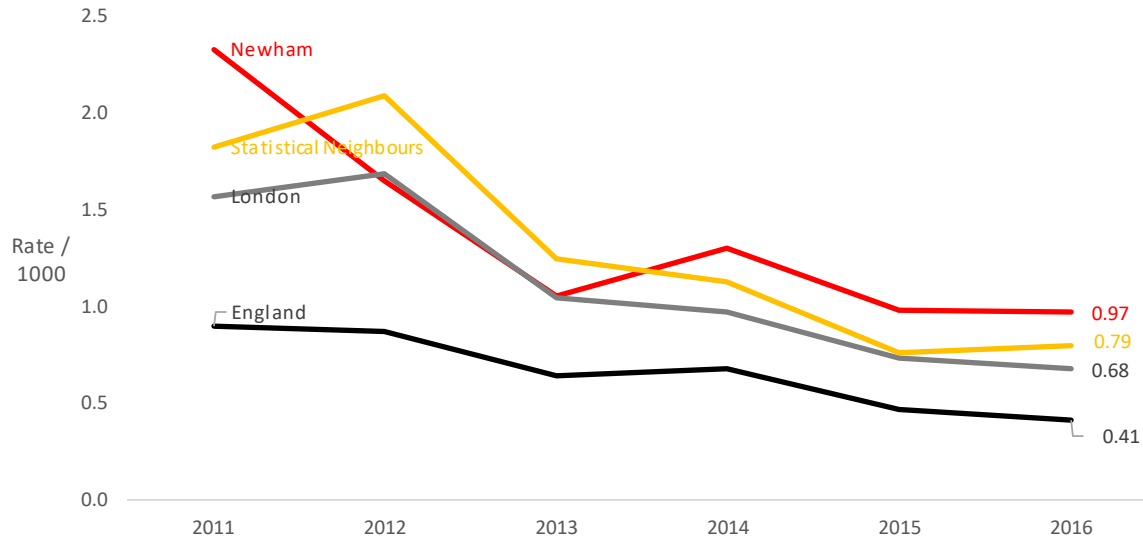


Young people receiving a conviction and custody

Rates for young people receiving convictions and sentenced to custody are generally falling both locally and nationally. The graph below shows rates for Newham continuing to fall up till 2016, despite a rise between 2013 and 2014. At one per thousand, Newham's rate for 2016 is 50% higher than that of London and more than double that of England.

FIGURE 139 -YOUNG PEOPLE RECEIVING A CONVICTION AND CUSTODY, AGED 10-17 RATE/1,000 PERSONS

Source: LAIT

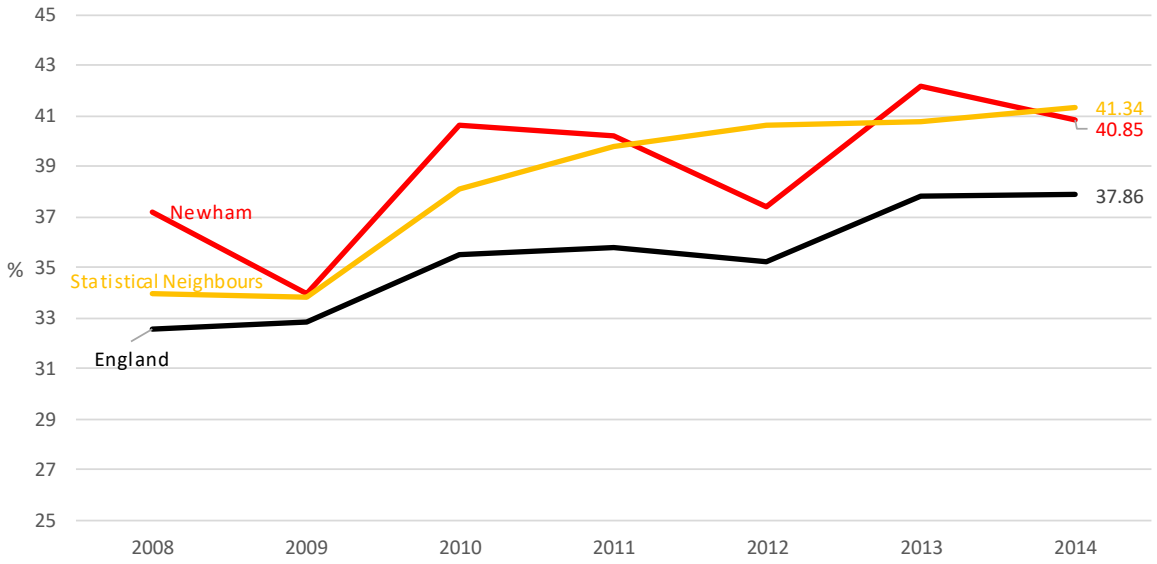


Re-offenders

Re-offenders are classed as those who re-offend after being cautioned, reprimanded, convicted or released from custody. The percentage of re-offenders is rising both locally and nationally, with rates in Newham above those of England but similar to comparator boroughs. Unfortunately, data was not available for London.

FIGURE 140 – YOUNG OFFENDERS WHO RE-OFFEND (PERCENT)

Source: LAIT



The breakdown of data by sex and ethnicity is unavailable at the local level. However, based on national of 12 months till March 2013 in England, males accounted for 79% of offenders but 85% of reoffenders. The age of offenders is also rising, with the average age nationally taken from the 12 months to March 2007 at 14.9 rising to 15.5 at the 12 months to March 2013 for offenders. For re-offenders, the average age rose (over the same time periods) from 15.4 to 15.9.

Information on youth offending in at-risk groups such as LAC are reported separately in the corresponding chapter above.

What's services are available in Newham?

Every local authority, acting in co-operation with partner agencies, have a statutory duty to establish one or more youth offending teams (YOTs) for their area under section 39(1) of the 1998 Crime and Disorder Act. The Youth Offending Team (YOT) in Newham is a multi-agency team comprising of staff from Probation, Child and Adolescent Mental Health Services (CAMHS) and the Metropolitan Police. The statutory functions of YOTs are broadly to: co-ordinate the provision of youth justice services for all those in the authority's area who need them, carry out such functions assigned in the local authority's youth justice plan; and contribute to the local authority's duty to take reasonable steps to encourage children and young persons' not to commit offences.

Progress since last JSNA

Since the 2010 JSNA, the rate of first time entrants into the justice system was 2,300 per 100,000 in Newham which fell to 500 in 2013 and was similar to London. Moreover, the rate of young people aged 10 – 17 receiving a conviction fell from 2.3 per 1000 to 1 per 1,000 but was still above comparator boroughs and London. The percentage of young offenders who re-offend increased from the last JSNA

from 38% to 43% today. Whilst we have made progress in reducing the rates of young people receiving a conviction, we have worsened in rates of re-offenders.

Recommendations

There are numerous recommendations from NICE and Ministry of Justice on improving outcomes amongst young offenders[177, 178]. These include:

Level	Recommendations

Policy	• Ensure there is an effective management board:
	  ○ Where all statutory partners are represented, together with other key delivery agencies and stakeholders
	  ○ Which meets at least quarterly, with a continuity of board membership and regular attendance
	  ○ Where the board works to agreed terms of reference defining its remit, membership, delegation, attendance and decision-making powers
	  ○ Where individual members are inducted into the role, are able act as local 'champions' for youth justice and have lead responsibility for key areas of activity
	  ○ Where the views of service users, victims of crime, sentences and the wider community are actively sought and considered
	  ○ Which actively oversees the formulation and implementation of the youth justice plan, as required by statute, and encourages the service to invest in self-assessment and peer review processes as ways of developing practice and improving outcomes
	  ○ Where YOT income, expenditure and commissioning activity are regularly reviewed
	  ○ Where the compliance with relevant statutory standards is regularly reviewed
	  ○ Where there is a culture of learning and wider dissemination of lessons from community safeguarding and public protection incidents, thematic inspections and other relevant processes through local safeguarding and public protection structures
	• The Ministry of Justice should set out a clear and measurable strategy for how it will work to reduce the risk of reoffending by these young offenders
	• The Youth Justice Board should use the lessons learned from the assessment and sentence plans undertaken by Youth Offending Teams to drive improvement in weaker Youth Offending Teams
	• The Ministry of Justice should focus on research that will enable them to assess which interventions are most effective and use the findings to direct funding into what is known to work
	• The Ministry should identify the strengths in the way the Youth Justice Board has operated and publish a plan showing how the best elements will be retained within the new structure for youth justice
	• The Youth Justice Board and the Ministry should encourage investment in prevention where reducing youth crime has been identified as a local priority. They should consider offering match-funding, piloting the use of other incentives such as payment by results, and sharing the proceeds of reduced custody levels

CHILDREN IN NEED

Introduction

A child in need (CIN) is defined as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services[76]. Early identification of these children at an early stage is vital with interventions implemented to ensure good health, education and social care outcomes.

Policies and Drivers:

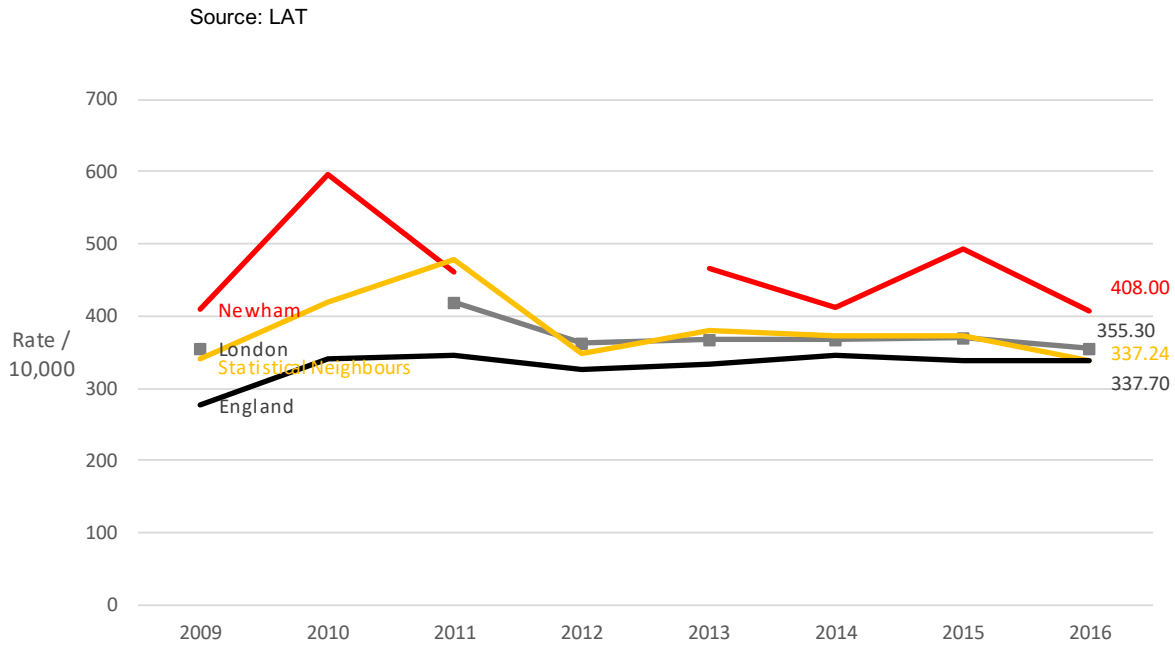
In *Every Child Matters*, a Government Green Paper informed by the findings of the inquiry into the death of Victoria Climbie. The government contended that "We need to ensure that we properly protect children at risk within a framework of universal services which support every child to develop their full potential and which aim to prevent negative outcomes."

What's happening in Newham?

The is considerable year-on-year variability in the rate of CIN in Newham but is has consistently been higher than the comparators. Data for Newham was not available in 2012 and for London in 2010.

FIGURE 141 – CHILDREN IN NEED RATE/10,000 PERSONS

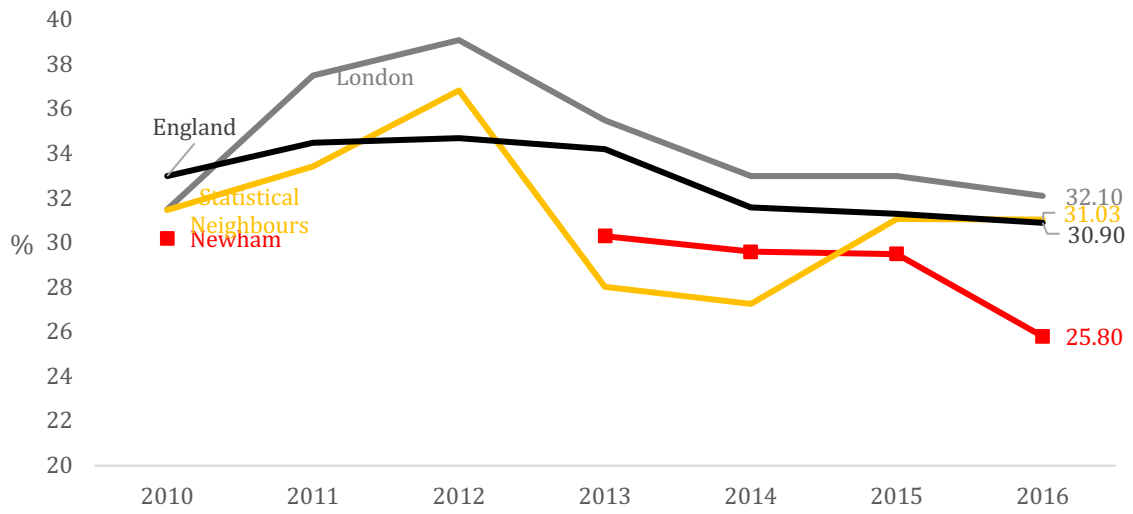
Source: LAT



The percentage of CIN in Newham has been consistently lower than those of London and England and fell further in 2016 from 500 to 408 per 10,000. Data for Newham was not available for 2011 and 2012.

FIGURE 142 – CHILDREN IN NEED FOR MORE THAN 2 YEARS (PERCENTAGE OF CHILDREN IN NEED)

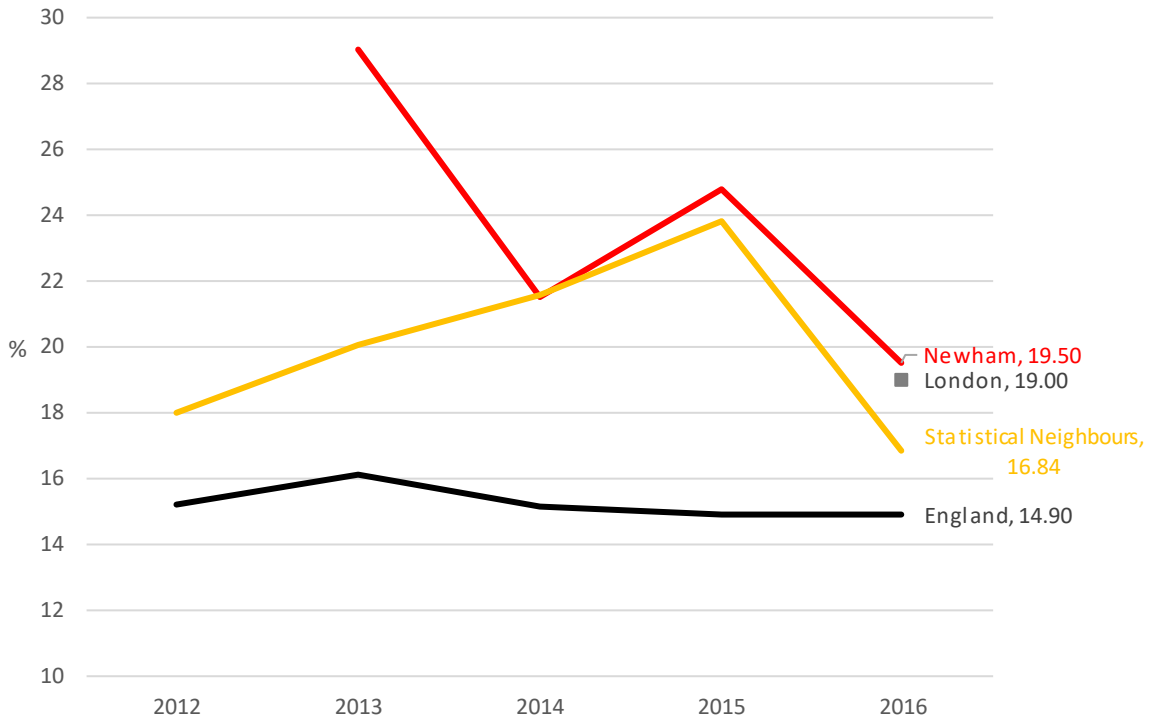
Source: PHE fingertips tobacco control profile indicator 90810



Worryingly, the percentage of CIN achieving 5 A*-C GCSEs including Maths and English has fallen from 29.0% in 2013 to 19.5% in 2016, though it remains higher than the comparators. Data for Newham was missing for 2012 and data for London only became available for 2016.

FIGURE 143 – PERCENTAGE OF CHILDREN IN NEED ACHIEVING 5 • A-C GCSES INCLUDING MATHS AND ENGLISH

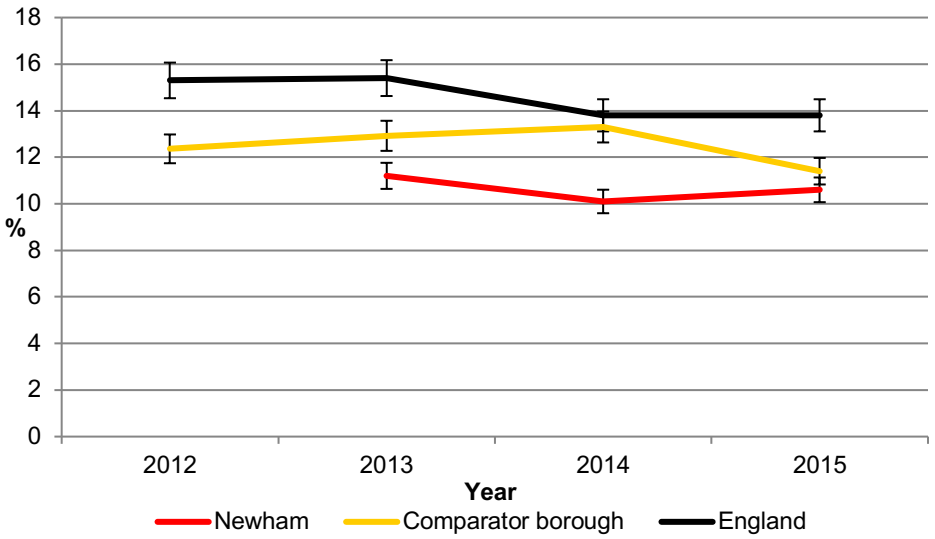
Source: LAIT



In contrast, the percentage of CIN who are persistent absentees in Newham has fallen marginally from 11.2% to 10.6% from 2013 to 2015 but remains below comparator boroughs (11%) and England (13.8%). This indicator has been discontinued and cannot be updated.

FIGURE 144 – PERCENTAGE OF CHILDREN IN NEED WHO ARE PERSISTENT ABSENTEES

Source: LAIT



Progress since the last JSNA

Compared to the 2010 JSNA, the rate of children in need and percentage of children in need for two or more years has remained decreased, with a worsening performance in GCSEs (including English and Maths) attainment. Further efforts to improve outcomes in CIN is therefore imperative to reverse any deceleration in gains.

Recommendations

There is numerous guidance from PHE on ensuring the best outcomes for children in need[179]. These include:

Level	Recommendations
Policy	• Have high aspirations for all children • Develop a shared understanding of the child with the parents and carers and develop positive partnerships through the work of the key person • Observe children's interests and understanding and use these as a basis for moving learning forward, promoting the characteristics of effective teaching and learning across a range of activities • Observe how children's play and leaning occurs across adult/child initiated and independent play activities • Plan a learning environment that responds to children's interests and needs across the seven areas of learning, but initially focusing on the Prime Areas of Personal, Social and Emotional development and Communication and Language and Physical Development

	• Plan time for adults to play alongside children to scaffold and extend learning, especially for those children who need further support
	• Organise and label resources so that children can access them independently
	• Undertake on-going formative assessments to monitor progress and plan for children's 'next steps' in their learning and development
	• Ensure children have daily independent access to;
	  ○ outdoors, sand, water, role play, construction, small world play.
	  ○ opportunities to develop both fine and gross motor skills, books, mark making, use of ICT
	  ○ opportunities to revisit, consolidate and extend their skills in all areas of learning across the EYFS
	  ○ creative experiences
	  ○ healthy living
	  ○ opportunities to explore and investigate their environment

Institutions	• Ensure all staff have suitable skills, knowledge and experience to support all young children's learning and interests • Provide sufficient staffing to enable all children to develop and learn effectively through independent and guided activities • Ensure that all practitioners promote independence and do not over support learners: Provide high quality, versatile resources which meet the needs and interests of individual children • Ensure there is a safe outside environment that children can access freely • Use assessment information to track progress and to inform provision during transitions

SPECIAL EDUCATIONAL NEEDS (SEN)

Introduction

Special educational needs (SEN) refers to children who have learning difficulties or disabilities that make it harder for them to learn or to take part in education. In most cases, additional support is identified and provided within the child's school at what is called "SEN support". Children with more enduring difficulties are provided an Education, Health and Care plan following a statutory assessment by the local authority.

Policies and Drivers

National

The Children and Families Act 2014 is forwarding work to tackle ineffective arrangements between education, health and social care agencies which have impacted on the ability of high needs learners to successfully transition from school, to post-16 provision and to adult life. The Care Act 2014 also focuses on improving services for individuals with SEN by promoting a focus on outcomes, overall wellbing, community support and personalisation of care. These acts call for legislative changes to the provision of CYP SEN services and the integration of education, health and social care in the hopes of improving service delivery and the value of services.

Amonst these changes, two years of short-term funding from central government to support implementation of the reforms is coming to an end. The independent supporters programme continues and the Parent Carer Forum who bring parents together provide invaluable support and advice for families.

These acts initiated a new process for Education, Health and Care Plans (EHCP) and the transfer of statements of SEN to EHC plans January 2016 marking just over one third of the way through the transition period (due to end by April 2018) for local authorities to transfer statements to EHCP[180]. The legal test of when a child or young person requires an EHCP remains the same as that for a statement under the Education Act 1996 (i.e. a child with SEN receives and EHCP when assessed as requiring one).

The requirements for statutory assessments for CYP with SEN are also undergoing a shift following the Department of Education's *Primary School Pupil Assessment: Rochford Review Recommendations* request to replace the P scales currently used to assess the attainment and progress of individuals with SEN who are not following the national curriculum standard assessments. The P scales were introduced to create a comparable scale for the attainment of individuals with SEN, however following the change to the national curriculum post-2014 these scales are no longer effective. The Rochford Review creates a new statuatory assessment for individuals with SEN to be implemented in 2019 and assess seven areas of engagement for congition and learning (responsiveness, curiousity, discovery, anticipation, persistence, initation and investigation).

A new inspection framework by Ofsted has been introduced. The framework considers how well a local area has identified the needs of children and young people with SEN and disabilities, how well they are assessed and provided for and how good outcomes are. All local authorities will be inspected over a five-year programme.

Local

Newham is at a pivotal stage of development. In Newham's school population, 13% of students have an identified special educational need with significant complexity. Newham recognises the complexity of change and as of September 2016 is using the *Best for All Strategy* to drive change forward. The

Newham Parent Coproduction is well established as a significant influence in strategic thinking. Coproduction with young people to ensure this also influences strategic thinking is underdeveloped but this will be an area of focus in the next planning period.

What's happening in Newham?

The 0-25 SEND service

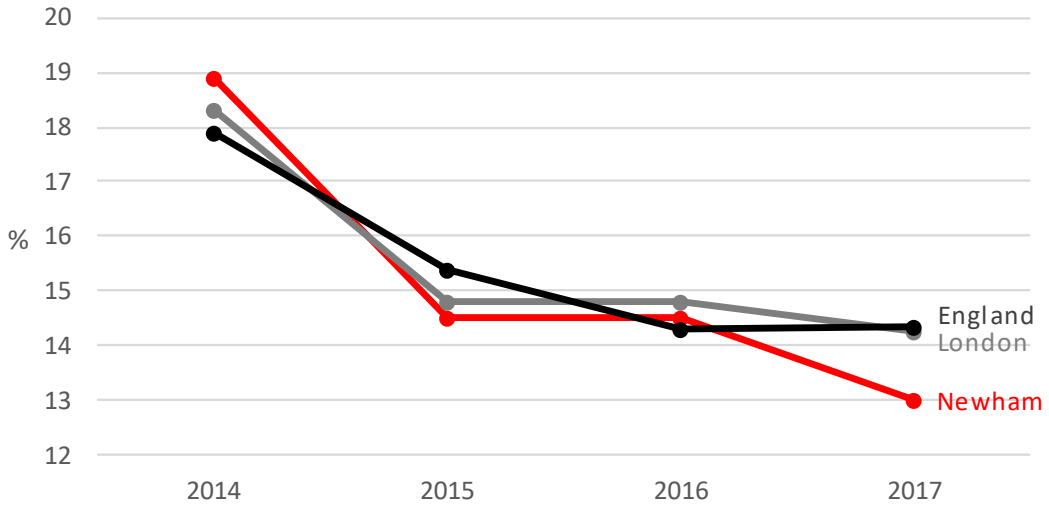
A new 0-25 SEND service was established in May 2016 to support the delivery of statutory assessments in a single venue rather than in several different teams. The role of this service is critical in delivering borough wide reforms which are guided by Newham's *Best for All Strategy* for CYP with SEN and inclusion. This 5-year strategy works in conjunction with new reforms to promote inclusion, integration and joint commissioning of health, education and social care. This strategy aims to reduce barriers to learning and encourage better outcomes in education and beyond for CYP with SEN. Currently, SEN statement transfers are underway and EHCP are being issued to a greater number of students. Alongside this shift, the criteria for EHCP are under review and the borough is focusing on assessing the quality of provision.

Prevalence and characteristics

The total number of pupils in the borough of Newham across all schools in January 2017 is 62,135. The total number of students with SEN is 8,092, which is 13.0% of the total number of pupils, of which 488 pupils possess statements or EHC plans (0.8%), and 7,604 (12.2%) of pupils have SEN support.

The percentage of all school age pupils with SEN, has decreased from 18.9% in 2014 to 13.0% in 2017. This is lower than the London and England values of 14.26% and 14.35%, respectively. It is important to note that this indicator is collected for the School Census through self-reporting by individual schools and is therefore an imperfect measure of the total SEN caseload. Historically, schools in Newham focus on an inclusive approach for their SEN students and this may result in lower reporting of SEN across the borough. This trend is depicted in the figure below.

FIGURE 145 – PERCENTAGE OF ALL SCHOOL AGED PUPILS WITH SEN IN NEWHAM, LONDON AND ENGLAND FROM 2014 TO 2017



The apparent decrease in pupils with SEN observed from 2014 to 2015 in *Figure 145* can be attributed to the introduction of a new Code of Practice in 2015 through the Department of Education and Department of Health's *Special educational needs and disability code of practice: 0 to 25 years*. Prior

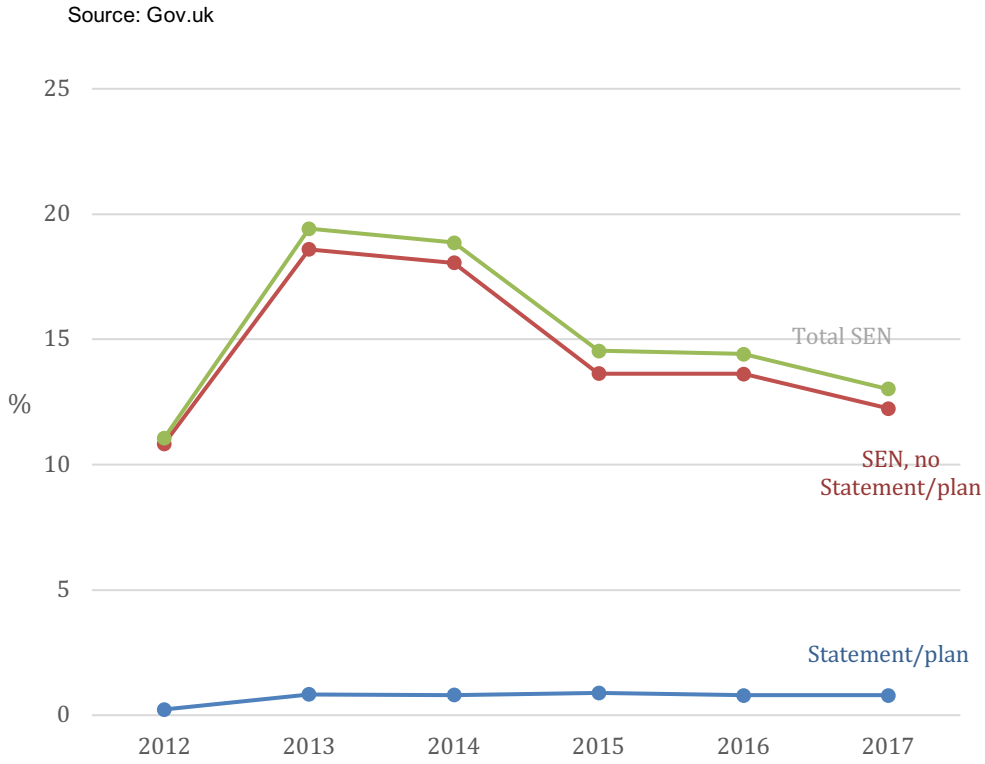
to the new code of practice, three layers of provision were offered to CYP with additional educational needs including school action plus, EHCP and SEN statements. However, school action was no longer offered after the implementation of the 2015 Code and the threshold for SEN increased due to higher standards for educational provision.

The 2015 Code of Practice included new expectations of provisions for students with SEN, calling for "…high quality teaching that is differentiated and personalised will meet the individual needs of the majority of children and young people. Some children and young people need educational provision that is additionally to or different from this" (High quality provision to meet the needs of children and young people with SEND - Code 1.24). This shift in the Code of Practice resulted in some previously SEN eligible students being provided for through Quality First Teaching, reducing the numbers of students with SEN. Although this shift resulted in a decrease in the number of SEN students in England, London and Newham, these numbers are expected to rise due to the increasing prevalence and complexity of need in CYP.

Across all schools, the number of pupils with special educational needs has decreased from 8,803 in January 2016 to 8,092 in January 2017. The percentage of all pupils that have special educational needs has decreased from 14.42% in January 2016, to 13.0% in January 2017. The percentage of pupils with SEN support, those with identified special educational needs but no statement or EHC plan has decreased from 13.62% in January 2016 to 12.24% in January 2017. These values are higher than national estimates, where the percentage of pupils with SEN support, but no statement or EHC plan is 11.6%. The percentage of pupils that have a statement or EHC plan has decreased from 0.80% in January 2016 to 0.78% in January 2017. This figure is also lower than the national value 2.8%. The figures for Newham, London and England are depicted below.

FIGURE 146 – TIME SERIES SHOWING THE PERCENTAGE OF PUPILS WITH SEN IN NEWHAM, FROM JANUARY 2012 TO 2017

Source: Gov.uk



The sex distribution of school-age pupils in Newham since 2015 till 2017, has been heavily skewed towards a male majority. The proportion of males is approximately two thirds of the total number of pupils that have special educational needs, irrespective of statementing or EHC plan provision. In 2017,

the proportion of males who have a statement/ EHC plan increased from 69.0% in 2016 to 70.1%. The proportion of males who have SEN support increased from 63.4% in 2016 to 66.3% in 2017. The reason for this skewed distribution is unlikely to be due to a true sex difference and is more likely to be due to a large unmet need and/ or poor identification in female CYP populations. This is akin to the distribution observed in England where SEN is more prevalent in boys than girls; 14.6% of boys were on SEN support compared to 8.1% of girls. Graphical representations of males and females who have a statement or EHC plan and those who require SEN support in Newham are depicted below.

FIGURE 147 – SEX DISTRIBUTION OF PUPILS WHO HAVE A STATEMENT / EHC PLAN IN NEWHAM SCHOOLS FROM 2015 TO 2017

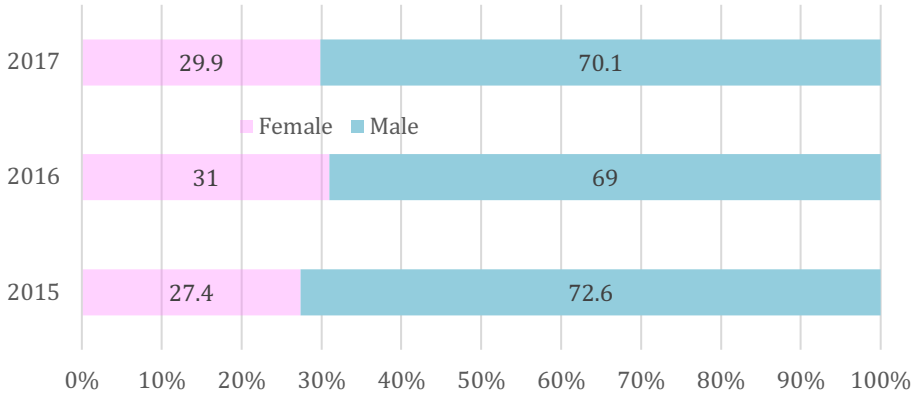
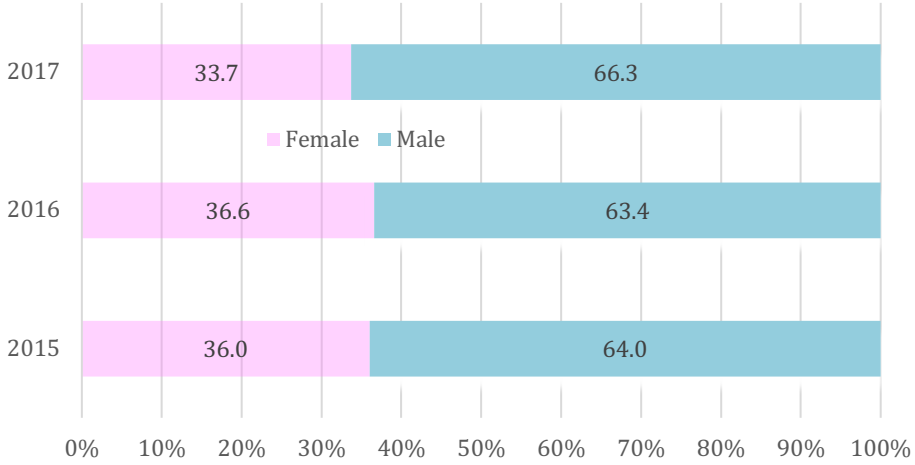


FIGURE 148 – SEX DISTRIBUTION OF PUPILS WHO HAVE SEN SUPPORT IN NEWHAM SCHOOLS FROM 2015 TO 2017

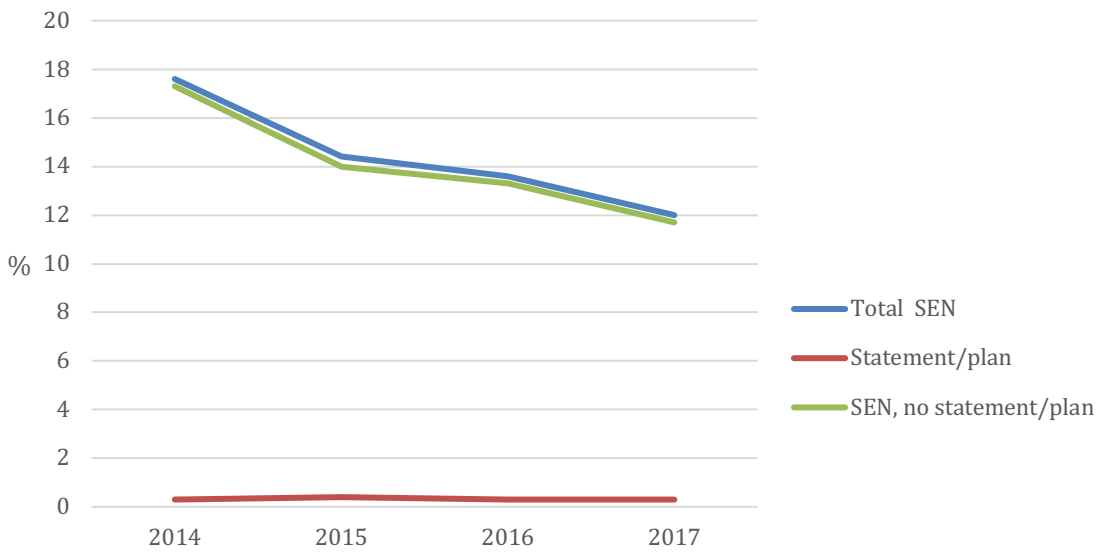


State primary school pupils:

In state primary schools, the proportion of pupils with SEN has seen a year on year decrease since 2014 from 17.6% to 12% in 2017. The percentage of SEN pupils with EHC/ plans has remained stable since 2014 at 0.3%. The proportion of pupils with SEN support has steadily decreased from 17.3% in 2014 to 11.7% in 2017. This representation is depicted below.

FIGURE 149 – TIME SERIES SHOWING THE PERCENTAGE OF PUPILS IN STATE PRIMARY SCHOOLS IN NEWHAM WITH SEN FROM 2014 TO 2017

Source: Gov.uk

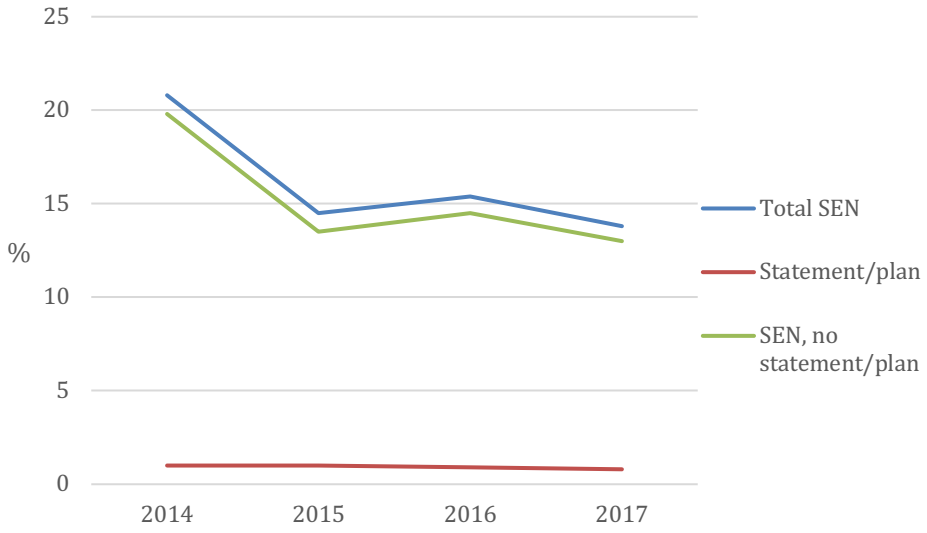


State secondary school pupils:

In state secondary schools, the proportion of pupils with SEN has seen a year on year decrease since 2014 from 20.8% to 13.8% in 2017. The percentage of SEN pupils with EHCP has remained relatively stable since 2014 at 1%. The proportion of pupils with SEN support has steadily decreased from 19.8% in 2014 to 13.0% in 2017. This representation is depicted below.

FIGURE 150 – TIME SERIES SHOWING THE PERCENTAGE OF PUPILS IN STATE SECONDARY SCHOOLS IN NEWHAM WITH SEN FROM 2014 TO 2017

Source: Gov.uk

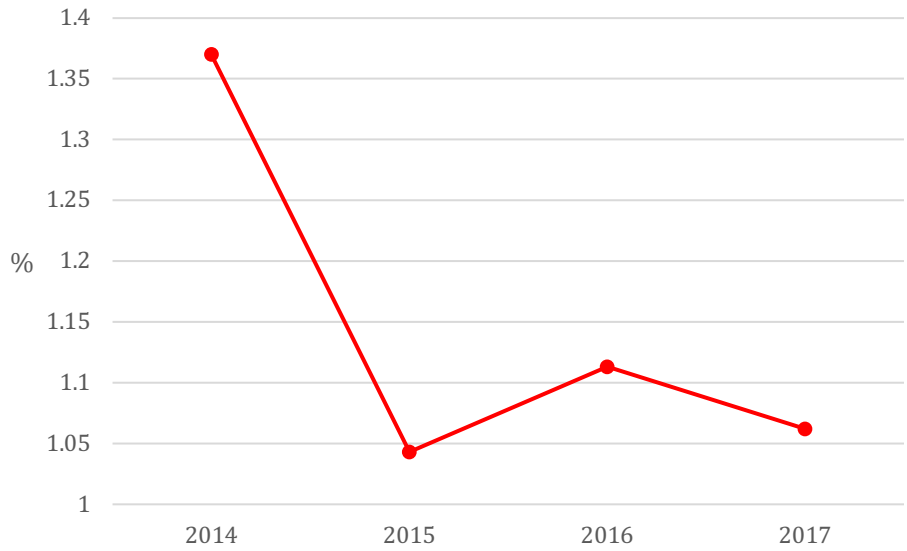


Pupil referral units:

The proportion of CYP in Newham with SEN in pupil referral units has decreased from 2014, 1.37% to 1.06% in 2017. There was a slight increase in 2016 to 1.1% from 2015, but this seems to have reversed. This representation is depicted below.

FIGURE 151 – TIME SERIES SHOWING THE PERCENTAGE OF CYP IN NEWHAM WITH SEN IN PRUS FROM 2014 TO 2017

Source: LA data and Gov.uk

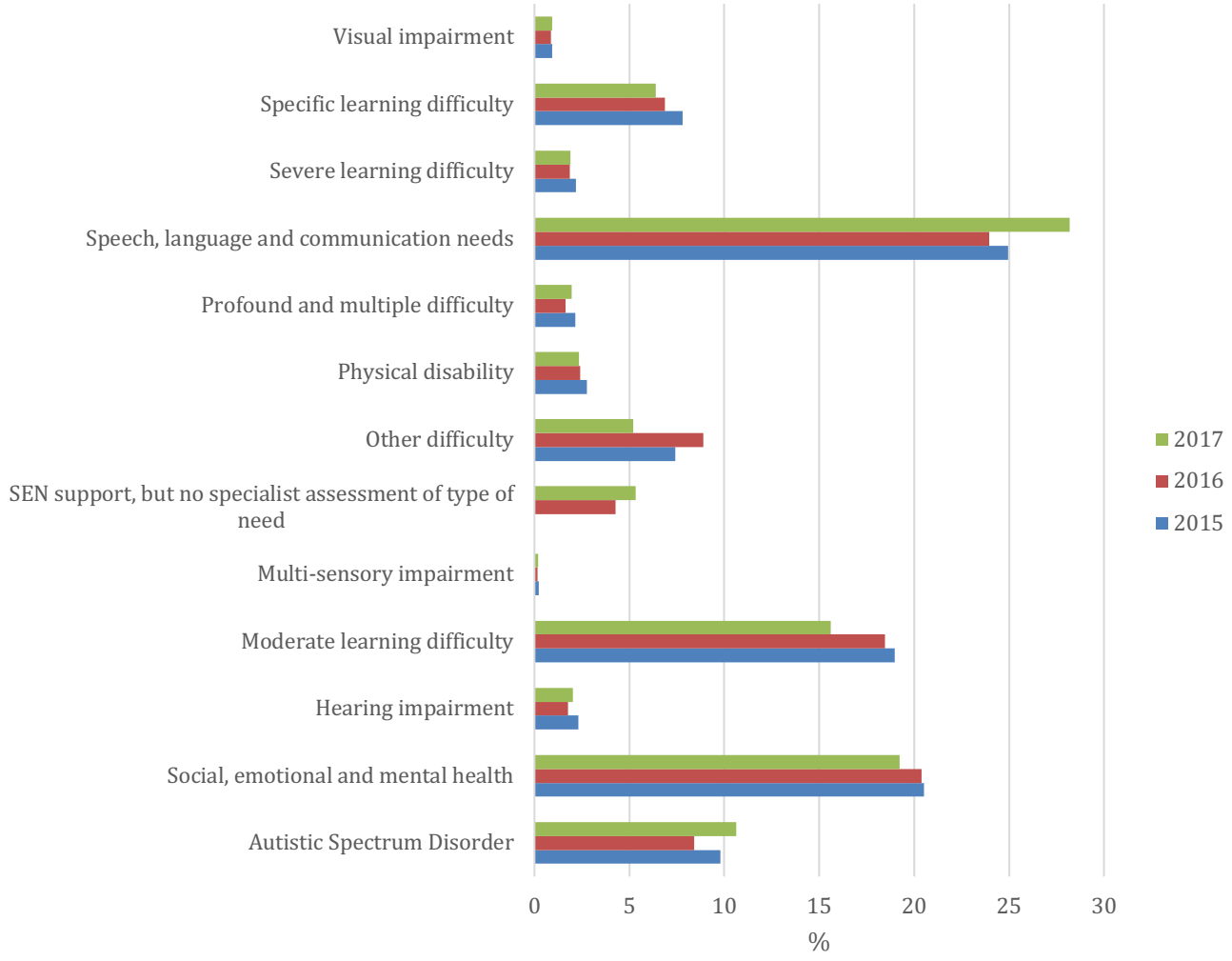


Primary type of need:

The graph below represents the percentage of pupils with each primary type of need who are identified as SEN, either on SEN support or with a statement or EHC plan, in state-funded nursery, primary, secondary and alternative provisions from 2015 to 2017. The trend in Newham over the past three years is fairly stable.

FIGURE 152 - THE PERCENTAGE OF PUPILS WITH EACH PRIMARY TYPE OF NEED WHO ARE IDENTIFIED AS SEN (EITHER ON SEN SUPPORT OR WITH A STATEMENT OR EHC PLAN) IN STATE-FUNDED NURSERY, PRIMARY, SECONDARY AND ALTERNATIVE PROVISIONS IN NEWHAM 2015 TO 2017

Source: LA data and Gov.uk

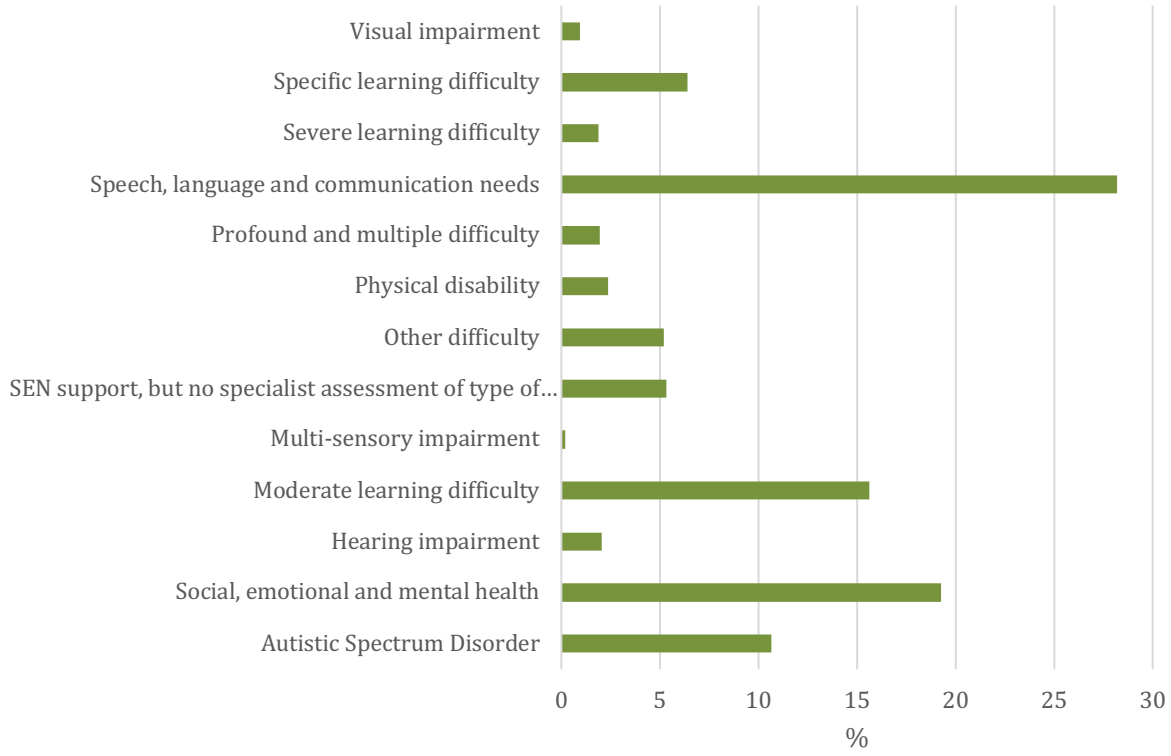


Speech, language and communication needs is the most common primary type of need in Newham in 2017 at 28%, this was also the case in 2016 at 24% and 2015 at 25%. This is followed by social, emotional and mental health at 20%, then moderate learning difficulty at 16%. The least common primary type of need in Newham is multi-sensory impairment, at 0.2%. This is depicted in the graph below. The most common primary type of need in England in 2017 is moderate learning difficulty at 23% of pupils with SEN. Source data was given rounded to whole percentages.

Quality Assurance work between 2016 and 2017 identified and addressed some disparities between settings in terms of classifying types of need. Procedures are currently being implemented to support schools in moderate self assessment and to scrutinise school data. Further work is also underway to ensure that the criteria used to identify the needs of CYP is consistent, especially in terms of moderate learning difficulties and complex learning needs.

FIGURE 153 - PERCENTAGE OF PUPILS WITH EACH PRIMARY TYPE OF NEED WHO ARE IDENTIFIED AS SEN IN STATE-FUNDED NURSERY, PRIMARY, SECONDARY, SPECIAL AND ALTERNATIVE PROVISIONS IN NEWHAM IN 2017

Source: LA data and Gov.uk



High-needs funding:

This fund is necessary for pupils who require a high-level of special educational needs and experience difficulties in speech, language and communication needs, physical difficulty, sensory impairment and social, emotional and mental impairment.

The number of pupils who receive high-needs funding in Newham has steadily increased in absolute and proportional terms from 2014 to 2017. This year represents the highest proportion of pupils in receipt of high-level funding, at 18.22% of the total SEN pupil population in Newham. This increase is likely to represent the identification of previously unmet need.

FIGURE 154 - PERCENTAGE OF PUPILS WHO RECEIVE HIGH-NEEDS FUNDING IN NEWHAM FROM 2014 TO 2017

Source: LA data and Gov.uk

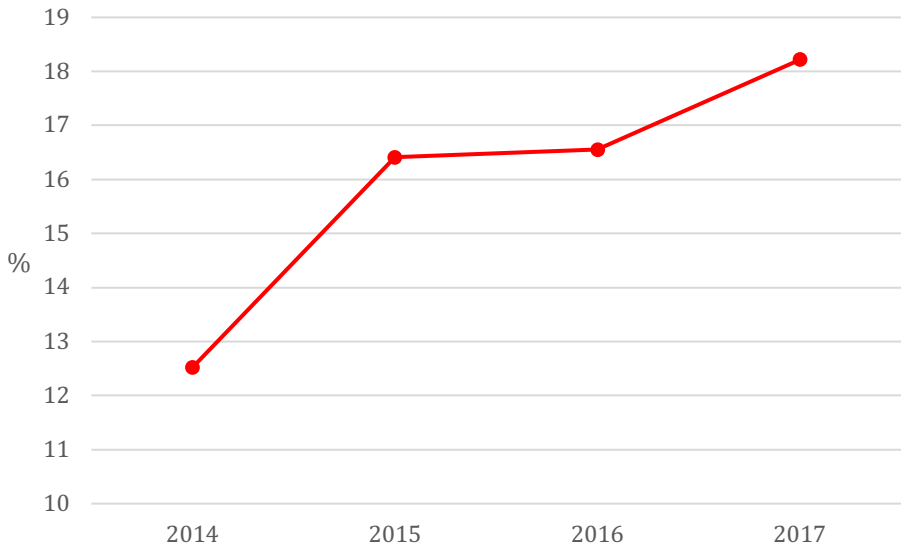


TABLE 24 – STUDENTS WITH HIGH NEEDS FUNDING FROM 2014 TO 2017

Source: LA data and gov.uk

	Number of students with high level funding	Percentage of students with high level funding
2014	1362	12.52%
2015	1416	16.41%
2016	1457	16.56%
2017	1474	18.22%

Early years foundation stage profile:

The early years foundation stage profile (EYFSP) assesses the learning, development and care of child from birth till the age of five against a set of standards.

The achievement in EYFSP teacher assessments by first language in Newham:

The total number of eligible pupils in EYFSP in Newham in 2016 is 5,037, and the average percentage achieving at least the expected standards in all early learning goals (ELGs) is 70%. Pupils whose first language is known to be other than English are more likely to have SEN, than those whose first language is known to be English. Following stratification by whether English is their first language, the percentage of pupils who achieve at least the expected standard in all ELGs is 73% of 1,441 pupils, conversely, the percentage of pupils whose first language is not English who achieve at least the expected standard in ELGSs is 70% of 3,278 pupils. This data was obtained from the Department of Education.

The achievement in EYFSP teacher assessments by SEN provision in Newham:

Of the total 5037 number of pupils in EYFSP in Newham, 595 were identified as SEN; 472 pupils required SEN support and 6 pupils had a statement or a EHC plan. Unfortunately, there was no data

available on the number of pupils at school action, or school action plus and therefore no data regarding their achievements in EYFSP teacher assessments. There was also no data on the percentage who achieved at least the expected standards in all ELGs, however 30% of pupils who required SEN support achieved at least the expected standard in all ELGs. This is higher than the London average of 29% and the England average of 25%. This data was obtained from the Department of Education.

TABLE 25 – 2017 RESULTS FROM THE EYFSP IN NEWHAM, LONDON AND ENGLAND

	Average total point score				% good level of development				% achieving all ELGs			
	Newham	London	England	*Rank*	Newham	London	England	*Rank*	Newham	London	England	*Rank*
Non-SEN	36.5	35.8	35.4	*23*	81%	79%	76%	*12*	79%	78%	77%	*17*
SEN	25.6	27.0	26.6	*117*	26%	31%	27%	*83*	23%	23%	25%	*93*
EHCP	18.7	19.5	19.5	*103*	0%	5%	4%	*N/A*	0%	4%	4%	*N/A*

The table above illustrates the 2017 results from EYFSP in Newham, London and England, alongside Newham's ranking amongst English local authorities. When compared with the attainment of SEN pupils in other local authorities, Newham performs relatively poorly. For example, Newham's average total point score for pupils with EHCP, which can vary between 17 to 51 for an individual child, was below the London and national average at 18.7. Furthermore, Newham was ranked 103rd nationally, out of a total of 151 local authorities. Amongst pupils who require SEN support, Newham ranks 117th and falls short of London and national averages in average total point scores. The percentage of pupils with a good level of development in Newham for children with SEN support and EHCP are 26% and 0% respectively. Again, Newham is performing worse than London and England and ranks 83rd. The percentage of pupils with SEN support achieving all ELGs in Newham is 23%, and is equal to the London average, but lower than the England average at 25%. Newham is ranked 93rd out of all England local authorities.

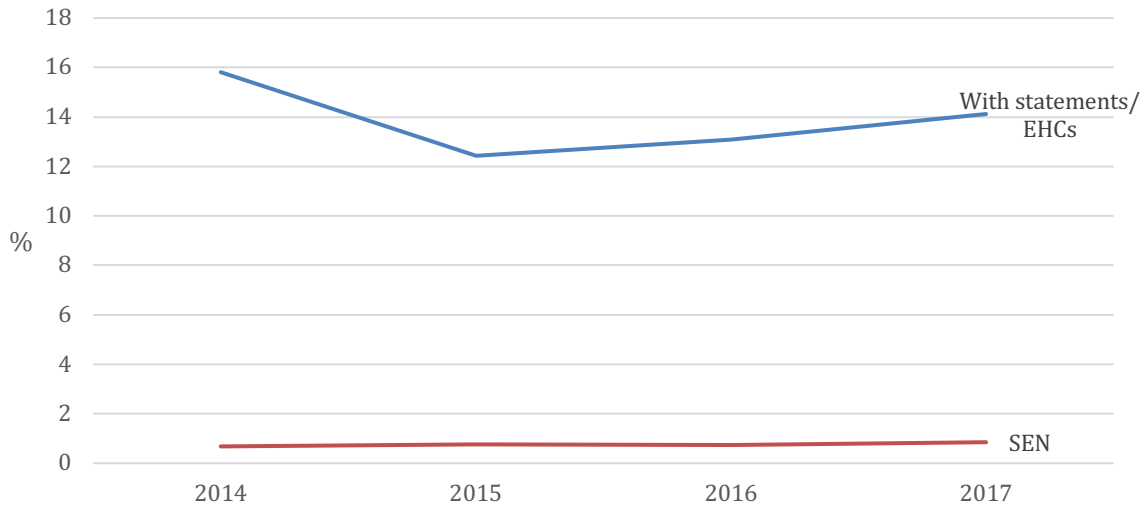
Despite Newham's apparent short comings in attainment scores according to EYFSP results, this data must be interpreted with caution. Newham has high standards for EHCP inclusion which is reflected in the relatively low percentage of students with EHCPs in primary (0.3%) and secondary schools (0.9%) reported, compared to students in primary (1.5%) and secondary schools (1.9%) from Newham's statistical neighbors[1], complicating the interpretation of comparative data. This low prevalence of EHCPs indicates that students with EHCPs in Newham may have more complexities than students holding EHCPs in other boroughs, resulting in lower reporting of EYFSP results for students with EHCPs.

The proportion of children whose parents are Newham residents with statements/EHC plans and with SEN in out of borough schools from 2014 till 2017 is highlighted below. There has been a steady increase in the number of children with both statements/ EHC and SEN since 2015, the figures for 2017 are 0.85% and 14.14%, respectively.

[1] Brent, Enfield, Slough, Waltham Forest, Ealing, Hacknet, Greenwich, Barking and Dagenham, Haringey, Birmingham

FIGURE 155 - TIME SERIES SHOWING THE PERCENTAGE OF CHILDREN WHOSE PARENTS ARE NEWHAM RESIDENTS WITH STATEMENTS/ EHC AND WITH SEN IN OUT OF BOROUGH SCHOOLS FROM 2014 TILL 2017

Source: LA data and Gov.uk

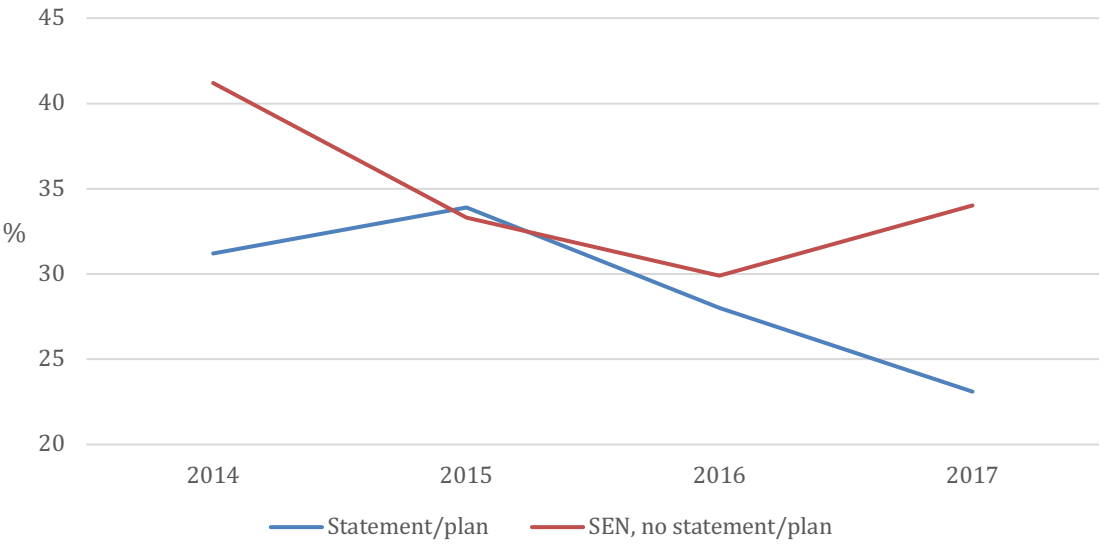


Looked after children:

The proportion of looked after children with a statement or EHCP has decreased from 31.2% in 2014 to 23.1% in 2017. There has been a downward trend since 2014, except from an increase in 2015 to 33.9%. Moreover, the percentage of looked after children with SEN support has decreased from 41.2% in 2014 to 34% in 2017. This is represented in the graph below.

FIGURE 156 - TIME SERIES SHOWING THE PERCENTAGE OF LAC WITH SPECIAL EDUCATIONAL NEEDS IN NEWHAM FROM 2014 TILL 2017

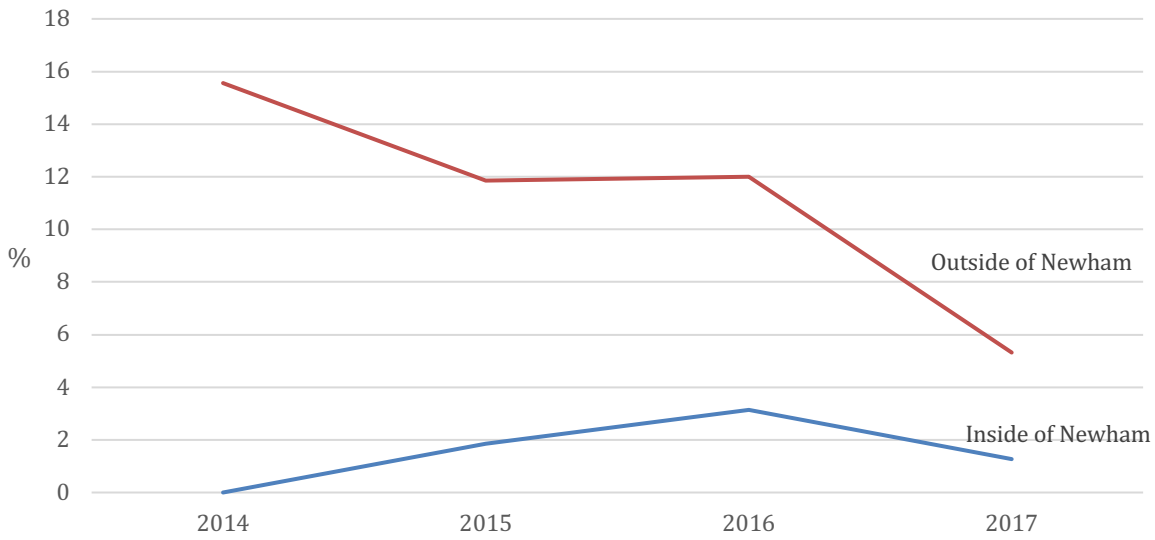
Source: LA data and Gov.uk



The proportion of Newham LAC children and young people with statements or EHCs in schools *in* and *out* of the borough of Newham is depicted in the figure below.

FIGURE 157 - TIME SERIES SHOWING THE PECENTAGE OF NEWHAM LAC CHILDREN AND YOUNG PEOPLE WITH STATEMENTS OF SEN OR EHCS FROM 2014 TILL 2017

Source: LA data and Gov.uk



The percentage of Newham LACYP with statements/EHCs in schools *in* and *out* of Newham has decreased from 2016 to 1.27% and 5.32%, respectively. The majority of Newham LACYP with statements/ EHCs are educated in schools in the borough Newham. Since 2014, the proportion of LACYP in schools outside of Newham has steadily decreased from 15.6% to 5.3%. Conversely, the proportion of LACYP in schools inside of Newham has increased from 0% to 1.27%. This indicator should assist in the planning of services to ensure that services provided are well-matched to demand in the borough.

Children in Need:

The proportion of children in need with a statement or EHCP has remained fairly stable around 9% since 2014. Conversely, the percentage of children with SEN support has decreased from 40.5% in 2014 to 31.3% in 2017. This is represented in the graph below.

FIGURE 158 – PROPORTION OF CHILDREN IN NEED WITH SEN WITH A STATEMENT / PLAN IN 2014 TO 2017

Source: LA data and Gov.uk

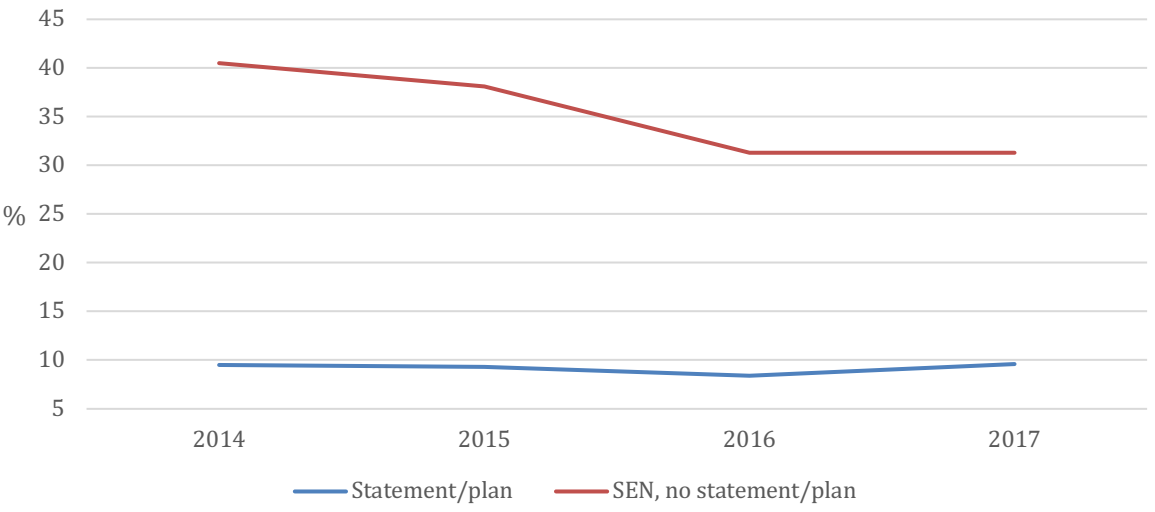


TABLE 26 - SCHOOL CENSUS DATA 2015-2017

	2015			2016			2017		
	Sex		Total	Sex		Total	Sex		Total
SEN provision	Female	Male		Female	Male		Female	Male	
No SEN	25821	23915	49736	26574	24519	51093	27585	25438	53023
SEN	2912	5178	8090	3033	5255	8288	2553	5028	7581
Statement/EHC	128	339	467	133	296	429	125	293	418
Total	28861	29432	58293	29740	30070	59810	30263	30759	61022

This data shows changes on the number of children identified as having SEN as schools move away from School Action/School Action Plus to SEN support.

According to school census data, the number of children with SEN in Newham has decreased since 2016, from 8288 to 7581. Furthermore, the number of children with statements or EHC has decreased since 2016, from 429 to 418.

Children and young people with SEN and disabilities in specific circumstances

Information gathering on children and young people with SEN and disabilities in specific circumstances is an area where more information and analysis is needed. This group of children includes:

- Looked after children
- Care leavers
- Children and young people who have special educational needs and disabilities and social care needs, including those who have a child in need or a child protection plan
- Children and young people educated out of area
- Children and young people who have special educational needs and disabilities who are educated at home
- Children and young people in alternative provision
- Children and young people who have special educational needs and disabilities who are in hospital
- Children and young people in youth custody or secure accommodation

The Best for All Inclusion Alliance programme

The Inclusion Alliance will be organised around the themes of:

- Achievement for All: securing the best possible outcomes for children and young people across education, health and care
- Preparing for Adulthood: giving our young people the skills and confidence for adult life, including maximising employment opportunities
- Co-Production: working together with children, young people, parents, carers, partners
- Building Centres of Excellence: investment in the best quality facilities

- A world class SEND workforce: the best quality training integrated across education, health and social care
- Keeping everyone safe: the best practice in safeguarding vulnerable children and young people and supporting resilient families

Outstanding Leadership: inspiring and courageous leaders making a difference to the life chances of children and young people with additional needs. In June 2016, the DfE produced a new national pack with outcomes data for children with SEN and disabilities with a focus on change since the Children and Families Act 2014. Outcomes for Newham[181] are highlighted in the table and narrative below, with comparisons to both London and England levels:

TABLE 27 - OUTCOMES FOR CHILDREN AND YOUNG PEOPLE WITH SEN AND DISABILITIES

OUTCOMES	2014			2015		
	NEW HAM	LON DON	NEW HAM	LON DON	NEW HAM	LON DON
Achievement of KS2 level 4 (RWM) for pupils on SEN support	54	53	54	53	54	53
Achievement of KS2 level 4 (RWM) for pupils with a statement or EHCP	13	18	13	18	13	18
GCSE 5* A-C Attainment (inc E&M) for pupils on SEN support	21	30.9	21	30.9	21	30.9
GCSE 5* A*-C Attainment (inc E&M) for pupils with a statement or EHCP	4	10.3	4	10.3	4	10.3
% Good level of development achieved - Pupils on SEN support (Foundation)	26	25	26	25	26	25
% Good level of development achieved – Pupils with an EHCP (Foundation)	0	3	0	3	0	3
GCSE 5 A*-G Attainment for pupils on SEN support	84.4	89.8	84.4	89.8	84.4	89.8
GCSE 5 A*-G Attainment for pupils with a statement or EHCP	22.2	41.3	22.2	41.3	22.2	41.3
Absence rates: SEN support	5.2	5.6	5.2	5.6	5.2	5.6
Absence rates: SEN statement/EHCP	10.1	7.1	10.1	7.1	10.1	7.1
Fixed term exclusion rates: SEN support	2.76	4.67	2.76	4.67	2.76	4.67
Fixed term exclusion rates: SEN statement/EHCP	9.6	5.39	9.6	5.39	9.6	5.39
Permanent exclusion rates: SEN support	0.17	0.23	0.17	0.23	0.17	0.23
Permanent exclusion rates: SEN statement/EHCP	0.7	0.13	0.7	0.13	0.7	0.13
% of year 1 pupils meeting the expected standard of phonic decoding: SEN support	52	48	52	48	52	48
% of year 1 pupils meeting the expected standard of phonic decoding: EHCP	0	19	0	19	0	19
% 19-year olds qualified to Level 2, inc English & Maths – SEN support	47.6	40.7	47.6	40.7	47.6	40.7
% 19-year olds qualified to Level 2, inc English & Maths – with statement or EHCP	19	14.8	19	14.8	19	14.8
% 19-year olds qualified to Level 3- SEN support	46.9	42.8	46.9	42.8	46.9	42.8
% 19-year olds qualified to Level 3 – with statement or EHCP	25.9	18.4	25.9	18.4	25.9	18.4
Percentage of KS4 SEN cohort in Education, Employment or Training one year later	87	88	87	88	87	88

Unfortunately, more up-to-date source information was not available at the time of writing to update the table or the narrative for the outcomes for CYP with SEN and disabilities.

Early Years

A higher percentage of children at SEN Support achieve a good level of development than nationally. The figure has increased steadily over the past 3 years but remains lower than London. This performance with be reviewed within a dedicated Early Years strand in the Best for All strategy/ Inclusion Alliance.

% of Year 1 pupils meeting the expected standard of phonic decoding by SEN provision

For phonics, performance for all SEN pupil groups in Newham is above the equivalent England average in all years 2012 -2015, both for boys and girls and comparative performance for Newham pupils was at its best in 2015, when the national rank position for all pupil groups was in the top 16 local authorities in England. This will be monitored within our newly refreshed School Improvement Support Service.

Absence rates: SEN statement EHC plan

In 2014 and 2015, absence rates for Newham pupils with statements / EHCs were worse than London and national levels. We have noted high figures for authorised and unauthorised absences in special schools and will be working to explore the date with these schools and address any issued arising.

Fixed term exclusions: SEN support / SEN statement EHC plan

In 2014, substantially lower percentage of pupils on SEN support received fixed term exclusions compared to London and national. Furthermore, in 2014, a significantly higher percentage of children with statements of SEN or EHC plans received fixed term exclusion in Newham compared to London and England. Newham figures in 2015 are lower than 2014 and we await publication of London and national figures.

Permanent exclusions: SEN support

In 2013-2014 permanent exclusions for Newham pupils at SEN support were at the same percentage level as London but lower than national figures. Newham figures in 2014-2015 are lower than 2013-2014. Publication of London and England figures for 2014 -2015 for comparison are awaited.

Permanent exclusions: SEN statement EHC plan

In 2013- 2014 permanent exclusions for pupils with statements /EHC plans are higher than London and national figures. The percentage remained the same in 2014-2015.

The broader context on permanent exclusions is that Newham experienced a sharp rise in permanent exclusions 2011- 2014 and the local priority has been to reduce the number of permanent exclusions regardless of whether a child has SEN or not.

The Local Authority and its schools have had some success with this project. For children with SEN, the impact of this work is that the number of permanent exclusions for children with SEN has reduced from 65% of exclusions in 2012- 2013, to 45% in 2013-2014 to 32% of pupils in 2014-2015 and 27% of pupils for the period September 2015- June 2016.There have been no permanent exclusions of children with statements or EHC plans between September 2015 and June 2016.

Outcomes at 19

In 2014 and 2015 a higher percentage of Newham's young people who were at SEN support achieved qualifications at level 2 compared to London and England. The percentage of young people with statements/ EHCs achieving level 2 dropped between 2014 and 2015 and in 2015 is below London and national.

In 2014 and 2015 a higher percentage of Newham's young people who were at SEN support achieved qualifications at level 3 compared to London and England. The percentage of young people with statements/ EHCs achieving level 3 was higher than London and national in 2014 but dropped in 2015 and is now below London and national levels. In 2014 a slightly higher proportion (87%) of the SEN cohort from Newham at KS4 is in Education, Employment or Training one year later than national (86%). This compares to 88% in London. We await 2015 figures.

SEN education attainment

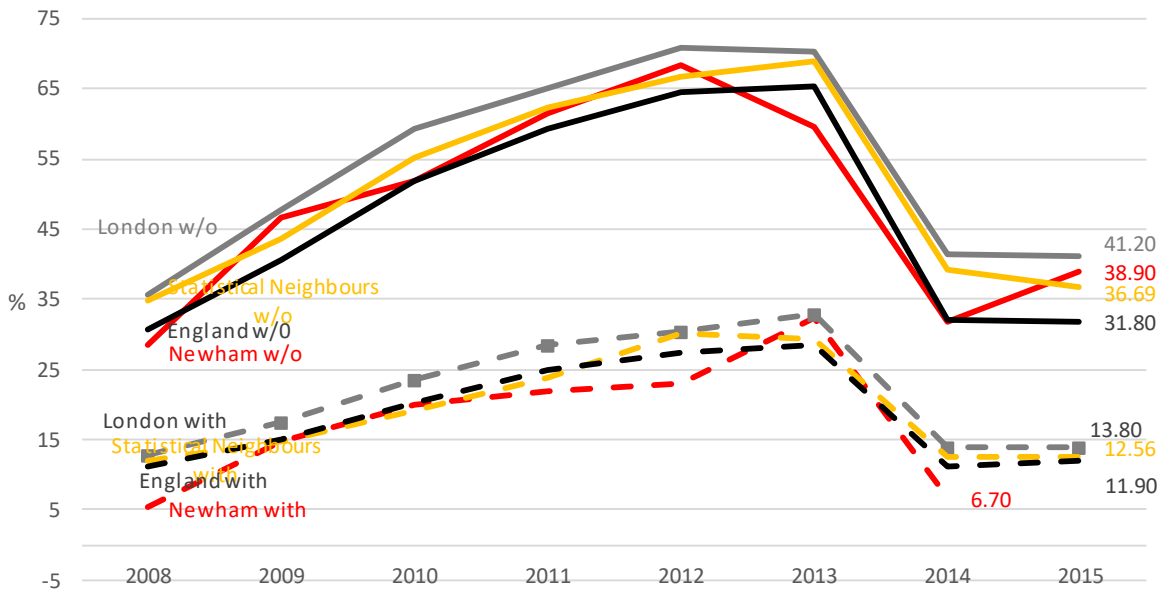
A higher percentage of 5 A*-C grade GCSEs are achieved by children with SEN without a statement in contrast to children with a statement. Nationally and locally figures rose from 2008 to 2013, but there was a sharp decline between 2013 and 2014, which was levelled off in 2015.

In 2015, the percentage of those achieving 5 A*-C grade GCSEs without a statement fell to 38.9% for Newham but was higher than comparator boroughs (35.8%) and England (31.8%) but lower than London (41.2%).

More disappointingly, the percentage of children with statements achieving 5 A*-C grade GCSEs in 2014 was 6.7%, which is far behind comparator boroughs (13.2%), London (13.9%) and England (11.3%). Data for Newham in 2015 is not available for SEN children without a statement.

FIGURE 159 – PERCENTAGE OF CHILDREN WITH SEN WHO HAVE 5 A*-C GCSES WITH OR WITHOUT A STATEMENT

Source: LAIT



Denoted in the following two charts, the percentage of pupils in both primary and secondary schools with a SEN statement in Newham is consistently lower than statistical neighbours, London and England, with figures in primary school pupils' constant but falling in secondary school pupils.

FIGURE 160 – PERCENTAGE OF SECONDARY PUPILS WITH A SEN STATEMENT

Source: LAIT

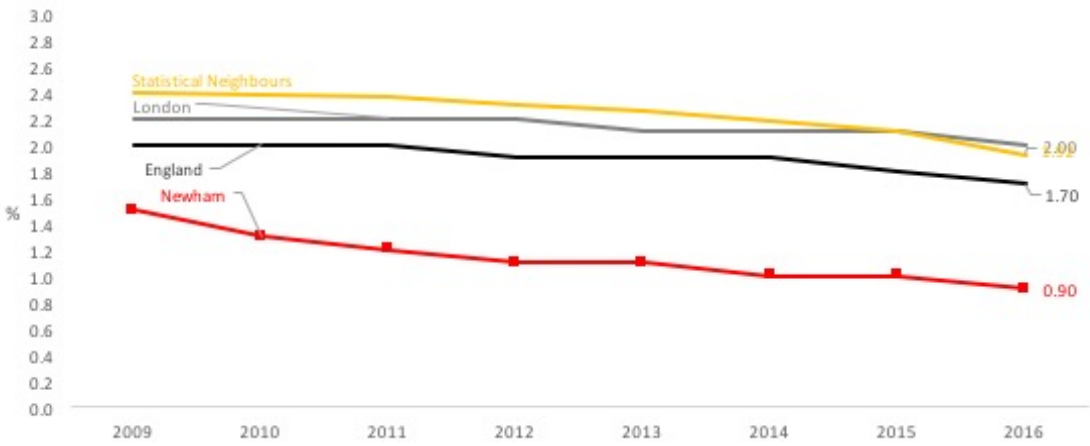
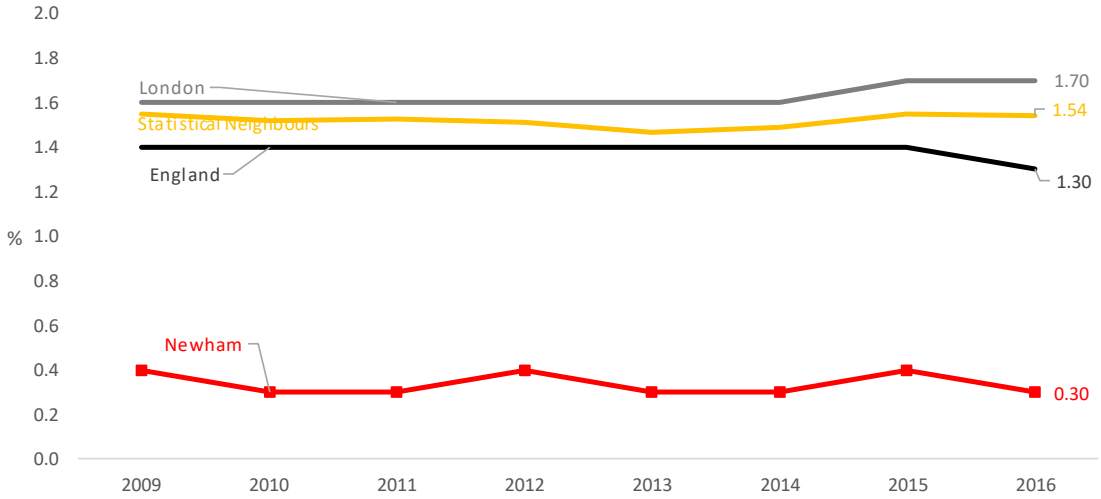


FIGURE 161 – PERCENTAGE OF PRIMARY PUPILS WITH A SEN STATEMENT

Source: LAIT



Key Stage 1 attainment

The table below illustrates the percentage of pupils achieving the expected level in reading, writing and mathematics at Key Stage 1 in 2017. The cohort sizes for these calculations are: Non-SEN (4197 pupils), SEN support (636 pupils) and EHCP (13 pupils).

TABLE 28 – KEY STAGE 1 PERCENTAGE OF PUPILS ACHIEVING THE EXPECTED ELVELS IN READING, WRITING AND MATHEMATICS

	Reading				Writing				Mathematics			
	Newham	London	England	*Rank*	Newham	London	England	*Rank*	Newham	London	England	*Rank*
Non-SEN	85%	86%	84%	*46*	80%	80%	77%	*33*	86%	85%	83%	*21*
SEN	42%	43%	34%	*24*	34%	33%	23%	*14*	44%	45%	35%	*23*
EHCP[a]	-	16%	14%	*114*[b]	-	11%	9%	*71*[c]	-	17%	14%	*111*[d]

[a] Based on 13 pupils, attainment of 8% means one pupil met the expected level; [b]out of 138 LAs; [c] out of 71 LAs; [d] out of 140 LA's.

The low comparative attainment of EHCP pupils is shown by Newham's much lower overall rank position, although the small cohort size of 13 pupils needs to be considered when interpreting this data.

Key Stage 2 attainment and progress from Key Stage 1:

This table illustrates the percentage of pupils achieving the expected level in: reading, writing and mathematics combined, as the progress made in each subject from Key Stage 1. The cohort sizes for these calculations are: Non-SEN (3656 pupils), SEN support (651) and EHCP (29 pupils).

TABLE 29 - KEY STAGE 2 PERCENTAGE OF PUPILS ACHIEVING THE EXPECTED LEVELS IN READING, WRITING AND MATHEMATICS

	Reading, writing and maths			
	Newham	London	England	*Rank*
Non-SEN	77%	76%	71%	*20*
SEN support	34%	29%	21%	*7*
EHCP[a]	10%	9%	8%	*30*

TABLE 30 - KEY STAGE 2 PERCENTAGE OF PUPILS ACHIEVING THE EXPECTED LEVELS IN READING, WRITING AND MATHEMATICS (INDIVIDUAL)

	Reading progress				Writing progress				Mathematics progress			
	Newham	London	England	*Rank*	Newham	London	England	*Rank*	Newham	London	England	*Rank*
Non-SEN	1.6	1.1	0.3	*1*	2.9	1.4	0.5	*1*	3.3	1.9	0.3	*2*
SEN support	1	0.1	-1.2	*12*	1.4	-0.6	-2.2	*1*	1.8	0.4	-1.1	*6*
EHCP[a]	-3.2	-2.8	-3.7	*62*	-4	-3	-4.3	*69*	-4.4	-2.6	-4.1	*93*

What services are available in Newham?

Newham Children and Young People's Service (CYPS) in Newham offers a *Behaviour Support Service* which is a team of teachers and a nursery nurse experienced in working with children exhibiting emotional, social and behavioural difficulties. The CYPS also provides a service made up of officers with specialist knowledge in special educational needs, and administrative officers who arrange and review educational support to children and young people with severe and complex special educational needs (SEN). Services for children and young people with SEN and disabilities are available to parents on Newham's Special Educational needs and Disabilities Local Offer website. Parent's feedback is that the website is not easy to navigate and work to address this is under way.

Progress since last JSNA

Compared to the 2010 JSNA, we have made little progress in improving the percentage of children with SEN achieving 5 A* - C GCSEs, irrespective of statementing. Further efforts to improve educational outcomes in this groups are therefore required.

Recommendations

There is numerous guidance from PHE and Newham's *Best for All Strategy* on ensuring the best outcomes for children in need[179]. These include:

Level	Recommendations
Policy	• Building on Newham's legacy for inclusion and the definition of inclusions outlined in paragraph 1.26 of the 0-25 SEN and Disabilities Code of Practice [182] (As part of its commitments under articles 7 and 24 of the United Nations Convention of the Rights of Persons with Disabilities, the UK Government is committed to inclusive education of disabled children and young people and the progressive removal of barriers to learning and participation in mainstream education. The Children and Families Act 2014 secures the general presumption in law of mainstream education in relation to decisions about where children and young people with SEN should be educated and the Equality Act 2010 provides protection from discrimination for disabled people). • Push for the universal collection of indicators for individuals with SEN over the age of 16 years and for indicators which focus on health and wellness outside of the educational setting. Collection and analysis of these indicators are vital in order to promote long-term wellness in the SEN population as well as the *Best for All* strategy for integration between

	education, health and social care. This data analysis is also key for Newham's direction of travel towards joint commissioning and integration of SEND provision for improvements in the four interconnected domains highlighted by *Best for All*: health and wellbeing, learning and achievement, resilience and responsibility and safety and stability.
Institutions	• Establish a five-year strategy around different types of need and vulnerability where officers in the local area and leaders in educational institutions look at data and progress to promote more effective commissioning. • Act as a system champion with a focus on driving up outcomes. • Identify effective pathways with common approaches to identification and interventions. • Encourage the participation of CYP and their families in defining their own care and focus on inclusive practices which remove barriers to learning. • Promote early identification of SEN to provide effective and efficience provision of services to ensure the best possible outcomes for each individual. • Review and define the needs of CYP with SEN and use this to inform the provision of offerings for SEN, including Speech and Language, Physiotherapy, and Occupational therapy. • Develop a sound model of partnership and collaborative working between educational and healthcare providers. • Make recommendations to the *Best for All Strategic Board* to support commissioning and de-commissioning of services. • Ensure that CYP with SEND are welcome in all schools and are values as individuals who will have a significance contribution to make to their school, community and wider society • Improve data and tracking and develop more effective systems for the collection and collation of data upon which to plan and commission services and track progress and attainment • Ensure sufficiency of provision and develop a clear conceptual model of universal, targeted and specialist support underpinned by Quality First teaching and professional development • Improve the assessment and identification of needs and embed person-centred planning in all schools and services • Make explicit admissions criteria, referral routes, transition arrangements and reintegration pathways

12.0 METHODOLOGY AND EVIDENCE

Methodology

Comparator boroughs: The comparator boroughs are Barking & Dagenham, Brent, City & Hackney, Tower Hamlets and Waltham Forest. Where individual count and denominator data have been available for each of the comparator boroughs, overall rates and confidence intervals have been calculated for the combined comparator boroughs. Where only pre-calculated rates are available, either the individual boroughs as presented, or the comparator boroughs have been omitted, as it is not valid to generate an average of rates for different populations. One source, the LAIT, presents pre-calculated rates for "statistical neighbours", which may not the be the same set as the comparator.

Three year rolling data: To produce a graph that is easier to compare, data is sometimes amalgamated into a three-year rolling graph. This calculates the average over three years moving up one year at a time, so for example, rather than the following individual years:

2008	2009	2010	2011	2012	2013	2014	2015	2016

Three-year rolling would cover data as follows:

2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16

This is advantageous particularly if some of the values are low, to prevent the graph from displaying outlying values, but the method is only valid where both numerator and denominator data are available for each year or when the denominator does not vary from year to year.

Age-dependency ratio: This is a measure of the number of dependents (population groups not of suitable working age, e.g. 0-14 and over 65s) to the total working age population (15-64). It is calculated by dividing the count of the dependant age population by the working age population (15-64) and multiplying by 100.

Confidence intervals: Where data on confidence intervals (CIs) have been pre-calculated by the source (e.g. Public Health England) these have been used. Where counts and denominator data are available these have been used to calculate 95% CIs for the combined comparator boroughs, using the Normal Approximation to the Binomial Distribution. This may not be the method used by organisation supplying data, but it has the merit of being familiar to most public health specialist and is relatively simple to calculate. Calculating CIs requires at least a count (sample size) and either a denominator figure or a pre-calculated rate. Where count and rates are available, estimates were calculated using the McCallumLayton online confidence interval calculator using proportions and sample sizes. Where two 95% CIs do not overlap, the two data items are considered statistically significantly different at the 5% level, where only rates were available, the data has been presented without any CI indication, and statistical significance cannot be calculated.

Confidence intervals and their use on line graphs and bar charts: Line graphs are used to show trends as they present a clear visual. However, where confidence intervals are included, it is sometimes difficult to interpret as all the values shown lie on the same point. Sometimes where this is an issue, a bar chart is included which makes it easier to assess whether values are significantly higher or lower than each other (seen for example in the graph "breastfeeding at initiation"). Usually, a line chart is used to show changes over time, and a separate chart is used to show 95% CIs for Newham and comparators for the most recent period only. Presentation of these CIs uses graduated shading to indicate the probability density of the distribution.

Crude rate: Rates unadjusted for other factors. For example, the crude birth rate is the total number of births per 1,000 of a population in a year. However, this rate is not adjusted to consider the proportion

of the population which is of childbearing age, and it is therefore very difficult to compare crude rates between two very different populations.

IDACI: The value of IMD IDACI score is applied to ONS mid-year population estimates to obtain numerator estimates (estimated number of children living in households) for each Lower Super Output Area (LSOA). This is then averaged across all LSOAs in the borough to attain an overall proportion.

Heat map: A heat map is created from data by LSOA administrative boundary, however these boundaries do not exist in reality, with prevalence abruptly changing as a boundary is crossed. The process of creating the heat map “smooths” the data, removing these abrupt changes. This process adds some error which is inherent in the process, however the result is a much more interpretable visualisation of the data.

Evidence

Screening in Pregnancy (Page 30)

Due to the way that data is submitted to Public Health England, providing data at the borough level is problematic. Different laboratories currently provide data by different geographies. For example, one may provide data by CCG while another may provide data by child health record department. These different boundaries can make it difficult to map results when comparing these geographies to a specific area or borough, which is why the smallest geography currently reported on is region.

The reported percentages (%) are the averages of data that has been supplied to PHE. In some quarters, no data was supplied, and reasons given as follows:

No Submission	The organisation did not make an expected submission attempt for this KPI or any other KPIs, communication was not received to offer mitigating circumstances.
Not Available	The organisation could not produce accurate and robust data to fulfil a KPI for this quarter. The organisation offered an explanation and it was satisfactory.
Withdrawn	The organisation submitted data in a timely manner, but the data was withdrawn later due to errors that could not be rectified.
Not Cohort	The organisation could not supply ID1 and/or ST1 data as per the matched cohort requirement required of these KPIs. Further information can be found in the KPI Guidance Document v1.12.

Smoking and Alcohol in Pregnancy (Page 38)

1.4% of women were noted to consume alcohol around delivery. No accurate data on London or England was available to make comparisons.

Child Mortality (Page 43)

Due to confidentiality reasons, local data on child mortality stratified by socio-economic status is not presented.

Breastfeeding (Page 55)

Graph on “Breastfeeding Initiation”: No data for 2013-2014 was available due to data quality issues (e.g. Missing data).

No trend views on breastfeeding at 6-8 weeks were presented due to Newham level data quality issues.

Table on “% Change in Breastfeeding at 48 hours to 6 weeks by CCG”: A dramatic % drop was noted in Tower Hamlets which could be due to data issues.

Table on % Change in Breastfeeding at 48 hours to 6 weeks in Newham compared to London/England”: Due to low data coverage, caution is advised in interpreting figures for England.

Newborn Screening: Hearing and Bloodspot (Page 58)

Graph on “Newborn Bloodspot Screening Coverage”: Data for 2014-2015 not available.

Immunisations (Page 61)

Data for Rotavirus uptake not presented as only data between 1st Feb 2014 to 31st Jan 2016 available.

Oral Health (Page 67)

Graph on “Hospital admission rates for dental caries”: Trend data unavailable.

Childcare and Early Education (Page 73)

Graph on “Percentage of 3 and 4-year olds benefiting from funded early education places”: As some 2-year-olds, may be erroneously included in the figures, percentages may exceed 100%.

Households and Families (Page 78)

Graph on “Homeless families with dependent children”: *As data for two quarters for Brent and Waltham Forest were suppressed, the remaining two quarters were doubled to give an approximate figure for the year (2013-2014).

Graph on “Homeless families with pregnant women”: *#As data for one quarter for Brent and Newham were suppressed, the remaining three quarters were divided by 3 and multiplied by 4 to give an approximate figure for the year (2014-2015).

Safeguarding (Page 84)

Quarterly data on FGM was not presented due to confidentiality issues. Data for FGM and Domestic Abuse for 2013-2014 was not presented due to differing data formatting in comparison to 2014-2016.

Domestic Violence (Page 94)

Data for Domestic Violence for 2013-2014 was not presented due to differing data formatting in comparison to 2014-2016.

Not in Education, Employment and Training (Page 128)

Graph on “% of 16-18 year olds who are NEET”: These figures are estimates based on information given by LBN to PHE on young people’s participation in education or training in their area.

Mental Health In Children and Young People (Page 153)

Graph on “Prevalence of Mental Health Disorders”: Data is an estimate based on the age, sex and socio-economic classification of the children in the area and based on the ONS Survey *Mental Health in Children and Young People in Great Britain* from 2004.

Caveats around the HeadStart Report data: -

Number of schools’ responses received from = 8. Only a small number of primary and secondary schools took part in piloting the survey and often only with a cohort of their pupils. In the roll out programme, the cohort of schools will be much larger.

The breakdown of returns is as follows: -

Year 6 (10/11-year-olds) = 32%

Year 7 (11/12 year-olds) = 39%

Year 8 (12/13 year-olds) = 21%

Year 9 (13/14 year-olds) = 8%

There is a considerable difference in the gender returns of the survey returns out of the 869 total - Males = 148 (17%) and Females = 721 (83%).

Looked after Children (Page 160)

Graph on “LAC in foster placements”: Data only available up to 2012 with 2010 data unavailable.

Graph on “LAC placed for adoption” and “LAC in secure units, children’s homes and hostels”: Data only available up to 2012 with 2010 data unavailable. Due to very small numbers (N<20) caution in interpretation is advocated.

Graph on “LAC identified as having a substance misuse”: Brent was noted to be an outlier in 2014 (Data confirmed as correct) which has led the average of comparator boroughs to rise.

Children with Long-Term-Conditions (Page 170)

Graph on “Prevalence of diabetes by quinary age group and type”: Figures for Type 2 diabetes in the 5-9 and 10-14 age groups were suppressed due low counts (N<5).

Graph on “Hospital admission rates for diabetes”: Trend data unavailable.

Children in Need (Page 182)

Graph on “% of CIN for 2 years or more”: Data for Newham and London in 2012 unavailable.

13.0 Changes Since Last JSNA

Figures

Key:

- Information updated since last JSNA
- Information not available to be updated from last JSNA
- Information not included in last JSNA and has been added for this update

Tables

Key:

- Information updated since last JSNA
- Information not available to be updated from last JSNA
- Information not included in last JSNA and has been added for this update

- **Table 28** – Key stage 1 percentage of pupils achieving the expected elvels in reading, writing and mathematics
- **Table 29** – Key stage 2 percentage of pupils achieving the expected levels in reading, writing and mathematics
- **Table 30** – Key stage 3 precentage of pupils achieving the expected levels in reading, writing and mathematics (individual)

14.0 REFERENCES

1. DfE. *Special educational needs and disability. A guide for parents and carers*. 2014; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417435/Special_educational_needs_and_disabilites_guide_for_parents_and_carers.pdf.
2. ONS. *Population Estimates for UK, England and Wales, Scotland and Northern Ireland*. 2016; Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland.
3. ONS. *Births by area of usual residence of mother, UK*. 2016; Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsbyareaofusualresidenceofmotheruk.
4. ONS. *Census 2011: Families with dependent children*. 2011; Available from: https://www.nomisweb.co.uk/census/2011/qs118ew.
5. ONS. *GLA 2014 round - SHLAA short-term population projections* 2014; Available from: https://files.datapress.com/london/dataset/gla-population-projections-custom-age-tables/2015-09-23T11:35:06/2014-round-shlaa-capped-household-size-ward-age-range-creator.xls.
6. CCG, N. *Maternity Mates - giving mums the best start possible*. 2016; Available from: http://www.newhamccg.nhs.uk/news-articles/Maternity-Mates---giving-mums-the-best-start-possible.htm.
7. NHS. *Commissioning Maternity Services - A Resource Pack to support Clinical Commissioning Groups*. 2012; Available from: https://www.england.nhs.uk/wp-content/uploads/2012/07/comm-maternity-services.pdf.
8. NHS. *Better Births - Improving outcomes of maternity services in England: A Five Year Forward View for maternity care*. 2016; Available from: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf.
9. NHS, *The NHS Maternity Statistics.* 2013-14.
10. NICE, *Antenatal care for uncomplicated pregnancies - CG62*, NICE, Editor. 2008.
11. NICE, *Caesarean section, NICE guidelines [CG132].* 2011.
12. NHS. *Family Nurse Partnership*. 2016 [cited 2016; Available from: http://fnp.nhs.uk/.
13. FNP. *Family Nurse Partnership*. 2016 [cited 2016; Available from: http://fnp.nhs.uk/.
14. NICE, *Smoking: stopping in pregnancy and after childbirth [PH26]*. 2010.
15. RCP. *Smoking and the young*. 1992; Available from: https://www.rcplondon.ac.uk/file/3563/download?token=uV0R0Twz.
16. DoH, *Departmental Report 2007*, D.o. Health, Editor. 2007.
17. Button, T.M., B. Maughan, and P. McGuffin, *The relationship of maternal smoking to psychological problems in the offspring.* Early Hum Dev, 2007. **83**(11): p. 727-32.
18. Batstra, L., M. Hadders-Algra, and J. Neeleman, *Effect of antenatal exposure to maternal smoking on behavioural problems and academic achievement in childhood: prospective evidence from a Dutch birth cohort.* Early Hum Dev, 2003. **75**(1-2): p. 21-33.
19. NICE, ed. *Cardiovascular disease: identifying and supporting people most at risk of dying early [PH15]*. 2008.
20. NICE, *Smoking: acute, maternity and mental health services [PH48]*. 2013.
21. Marcenes, W., et al., *Ethnic disparities in the oral health of three- to four-year-old children in East London.* Br Dent J, 2013. **215**(2): p. E4.
22. PHE, *National Child and Maternal Health Intelligence Network - Facts and Figures*. 2016.
23. PHE, *Reducing infant mortality in London: An evidence-based resource* 2015.
24. Wolfe, I., *Why children die: death in infants, children and young people in the UK - Part A*. 2014: Royal College of Paediatrics and Child Health.
25. NHS, *Newham Joint Strategic Needs Assessment 2011/12*. 2012.
26. NHS, *Newham Joint Strategic Needs Assessment 2010*. 2010.
27. NICE, *Unintentional injuries on the road: interventions for under 15s [PH31]*. 2010.
28. Wilcox, A.J., *On the importance--and the unimportance--of birthweight.* Int J Epidemiol, 2001. **30**(6): p. 1233-41.
29. Jefferis, B.J., C. Power, and C. Hertzman, *Birth weight, childhood socioeconomic environment, and cognitive development in the 1958 British birth cohort study.* BMJ, 2002. **325**(7359): p. 305.
30. Rich-Edwards, J.W., et al., *Longitudinal study of birth weight and adult body mass index in predicting risk of coronary heart disease and stroke in women.* BMJ, 2005. **330**(7500): p. 1115.

31. Rich-Edwards, J.W., et al., *Birthweight and the risk for type 2 diabetes mellitus in adult women.* Ann Intern Med, 1999. **130**(4 Pt 1): p. 278-84.
32. PHE, *Children and Young People's Health Benchmarking Tool*. 2016.
33. PHE, *Public Health Outcomes Framework - Overarching Indicators*. 2016.
34. WHO, *Maternal, newborn, child and adolescent health - Care of the preterm and/or low-birth-weight newborn*. 2016.
35. PHE, *Unequal at Birth*. 2006.
36. NICE. *Maternal and child nutrition overview - Strategy, policy and commissioning for maternal and child nutrition*. 2015; Available from: https://pathways.nice.org.uk/pathways/maternal-and-child-nutrition - path=view%3A/pathways/maternal-and-child-nutrition/strategy-policy-and-commissioning-for-maternal-and-child-nutrition.xml&content=view-node%3Anodes-services-involved-in-promoting-womens-and-childrens-health.
37. DOH, *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*. 2011.
38. NHS. *Pregnancy and baby - Benefits of breastfeeding.* 2016; Available from: http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/benefits-breastfeeding.aspx.
39. CancerResearchUK. *Breast cancer protective factors.* 2016; Available from: http://www.cancerresearchuk.org/about-cancer/type/breast-cancer/about/risks/breast-cancer-protective-factors.
40. NHS-England, *Analytical Services, NHS England - Statistical Release - Breastfeeding initiation and prevalence at 6 to 8 weeks - Quarter 3, 2013/14.* 2014.
41. NICE. *Strategy, policy and commissioning for maternal and child nutrition*. 2016; Available from: https://pathways.nice.org.uk/pathways/maternal-and-child-nutrition - path=view%3A/pathways/maternal-and-child-nutrition/strategy-policy-and-commissioning-for-maternal-and-child-nutrition.xml&content=view-node%3Anodes-services-offering-support-and-advice-about-breastfeeding.
42. DOH, *Improving outcomes and supporting transparency: Part 1: A public health outcomes framework for England, 2013-2016.* 2016.
43. NHS, *Public health functions to be exercised by NHS England - Service specification No.20 - NHS Newborn Hearing Screening Programme*, DoH, Editor. 2013.
44. PHE, *PHE screening: Newborn blood spot screening: new guidelines, leaflets and data published*. 2016.
45. NHSE, *NHS public health functions agreement 2016-17: Service specification no.19 - NHS Newborn Blood Spot Screening Programme.* 2016.
46. NICE, *Postnatal care up to 8 weeks after birth [CG37]*. 2015.
47. PHE, *The routine immunisation schedule from Spring 2016*. 2016.
48. PHE, *Cover of vaccination evaluated rapidly (COVER) programme 2014 to 2015: quarterly data*. 2015.
49. NICE, *Immunisations: reducing differences in uptake in under 19s [PH21]*. 2009.
50. PHE, *Public Health Profiles*. 2016.
51. NHS. *Your baby's health and development reviews*. 2016; Available from: http://www.nhs.uk/conditions/pregnancy-and-baby/pages/baby-reviews.aspx.
52. NHS, *Newham Joint Strategic Needs Assessment 2015-16*. 2016.
53. NICE, *Immunisation for children and young people: overview*. 2016.
54. PHE, *Local authorities improving oral health: commissioning better oral health for children and young people*. 2014.
55. RCS, *The state of children's oral health in England*. 2015.
56. Newham, *Improving the health of people in Newham: Newham's Health & Wellbeing Strategy*. 2015.
57. Cynthia Pine, P.A., Louise Robinson, *The BBaRTS Healthy Teeth Behaviour Change Programme for preventing dental caries in primary school children: study protocol for a cluster randomised controlled trial.* 2016. **17**(Trial 2016).
58. HSCIC, *Children's Dental Health Survey 2013*. 2013.
59. NICE, *Oral health: local authorities and partners [PH55]*. 2014.
60. NICE, *Oral health promotion: general dental practice [NG30]*. 2015.
61. DoH, *2010 to 2015 government policy: childcare and early education*. 2015.
62. DfE, *Statistics at DfE*. 2016.
63. NICE, *Social and emotional wellbeing: early years*. 2012.
64. PHE, *Health matters: giving every child the best start in life*. 2016.

65. PHE, *Best start in life and beyond: Improving public health outcomes for children, young people and families* 2016.
66. RCM. *Promoting Public Health*. 2016; Available from: https://www.rcm.org.uk/promoting-public-health.
67. UCLIoHE, *'Fair Society Healthy Lives' (The Marmot Review)*. 2010.
68. PHE, *Improving the health of vulnerable families*. 2014.
69. ONS. *Official Statistics*. 2016; Available from: https://www.nomisweb.co.uk/.
70. LPP. *London's Poverty Profile - Newham*. 2016; Available from: http://www.londonspovertyprofile.org.uk/indicators/boroughs/newham/.
71. Joyce, R., *Child poverty in Britain: recent trends and future prospects* IFS, Editor. 2014.
72. FPH, *Inquiry: Child Poverty and Health.* 2016.
73. Parliament, *Child Poverty Act 2010*. 2010.
74. DoH, *Safeguarding Adults: The Role of NHS Commissioners* 2011.
75. Government, *Children's Act 2004*. 2004.
76. Government, *Children's Act 1989*. 1989.
77. NHSEngland, *Safeguarding Policy*. 2015.
78. NICE, *Safeguarding*. 2016.
79. NHS. *Child sexual exploitation*. 2014; Available from: https://www.england.nhs.uk/ourwork/safeguarding/our-work/cse/.
80. NHS. *Female Genital Mutilation Prevention Programme: Requirements for NHS staff*. 2014; Available from: https://www.england.nhs.uk/2014/12/fgm-prevention/.
81. DoH, *FGM: mandatory reporting in healthcare*. 2016.
82. DoH, *Female genital mutilation (FGM): guidance for healthcare staff*. 2015.
83. DWP, *Households Below Average Income: An analysis of the income distribution 1994/95 – 2013/14*. 2015.
84. Newham. *Private rented housing*. 2016; Available from: https://www.newham.gov.uk/Pages/Category/Private-rented-housing.aspx.
85. Becky Fauth, Z.R., Enver Solomon, *Tackling child poverty and promoting children's well-being: lessons from abroad*. 2013.
86. Government, *'This is abuse' campaign*. 2013.
87. Government, *Clare's law to become a national scheme*. 2013.
88. Government, *Domestic violence protection orders.* 2011.
89. NICE, *Domestic violence and abuse: multi-agency working*. 2014.
90. DOH, *Protecting people - Promoting health*. 2012.
91. Government, *Domestic violence: What action are you taking?* 2014.
92. Government, *2010 to 2015 government policy: violence against women and girls*. 2015.
93. ELBWO. *East London Black Women's Organisation (ELBWO)*. 2016; Available from: http://find.redbridge.gov.uk/kb5/redbridge/fsd/service.page?id=Nbe45B2-F8U&familychannel=1_5_3.
94. Europa. *NAADV - Newham Action Against Domestic Violence*. 2016; Available from: http://ec.europa.eu/justice/grants/results/daphne-toolkit/en/content/naadv-newham-action-against-domestic-violence.
95. PHE, *Reducing unintentional injuries in and around the home among children under five years* 2014.
96. NHSEvidence, *Strategies to prevent unintentional injuries among children and young people aged under 15*. 2013.
97. NICE, *Unintentional injuries in the home: interventions for under 15s [PH30]*. 2010.
98. NICE, *Unintentional injuries: prevention strategies for under 15s [PH29]*. 2010.
99. Feinstein, L., et al, *What are the effects of education on health?." Measuring the effects of education on health and civic engagement: Proceedings of the Copenhagen symposium.* 2006.
100. PHE, *Everybody Active, Every Day - An evidence-based approach to physical activity* 2014.
101. Government, *Healthy Lives, Healthy People: A call to action on obesity in England* 2011.
102. Government, *Moving More, Living More: The Physical Activity Olympic and Paralympic Legacy for the Nation*. 2014.
103. NICE, *Promoting physical activity for children and young people [PH17]*. 2015.
104. NICE, *Physical activity: walking and cycling.* 2012.
105. WHO, *Global Strategy on Diet, Physical Activity and Health: Childhood overweight and obesity*. 2015.
106. HSCIC, *Children's body mass index, overweight and obesity*. 2014.
107. DoH, *Healthy Child Programme: From 5–19 years old*. 2009.

108. Government, *2010 to 2015 government policy: obesity and healthy eating*. 2015.
109. Government. *Reducing obesity: future choices*. 2007; Available from: https://www.gov.uk/government/publications/reducing-obesity-future-choices.
110. HSCIC. *Health and Wellbeing of 15-year-olds in England - Main findings from the What About YOUth? Survey 2014*. 2015; Available from: http://www.hscic.gov.uk/catalogue/PUB19244.
111. PHE. *National Child Measurement Programme Operational Guidance* 2016; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/531878/NCMP-Operational-Guidance.pdf.
112. Government, *Healthy child programme: rapid review to update evidence*. 2015.
113. NICE, *Diet, nutrition and obesity*. 2016.
114. ADPH, *Overview of progress and future plans*. 2016.
115. Choices, N. *Eatwell Guide*. 2016; Available from: http://www.nhs.uk/Livewell/Goodfood/Pages/the-eatwell-guide.aspx.
116. DfE, *The Importance of Teaching* 2010.
117. Government, *Local authority interactive tool (LAIT)*. 2014.
118. Gill, P.J., et al., *Increase in emergency admissions to hospital for children aged under 15 in England, 1999–2010: national database analysis.* Archives of disease in childhood, 2013: p. archdischild-2012-302383.
119. Clements, K., *Opening the door to better healthcare: ensuring general practice is working for children and young people.* London: National Children's Bureau, 2013.
120. Prince, M. and C. Worth, *A study of 'inappropriate'attendances to a paediatric accident and emergency department.* Journal of Public Health, 1992. **14**(2): p. 177-182.
121. Williams, A., P. O'Rourke, and S. Keogh, *Making choices: why parents present to the emergency department for non-urgent care.* Archives of disease in childhood, 2009. **94**(10): p. 817-820.
122. Dale, J., et al., *Primary care in the accident and emergency department: I. Prospective identification of patients.* Bmj, 1995. **311**(7002): p. 423-426.
123. Armon, K., et al., *Determining the common medical presenting problems to an accident and emergency department.* Archives of Disease in Childhood, 2001. **84**(5): p. 390-392.
124. Stewart, M., et al., *Medical and social factors associated with the admission and discharge of acutely ill children.* Archives of Disease in Childhood, 1998. **79**(3): p. 219-224.
125. Cecil, E., et al., *Impact of UK Primary Care Policy Reforms on Short-Stay Unplanned Hospital Admissions for Children With Primary Care–Sensitive Conditions.* The Annals of Family Medicine, 2015. **13**(3): p. 214-220.
126. NHSEngland, *Transforming urgent and emergency care services in England - Urgent and Emergency Care Review - End of Phase 1 Report*. 2013.
127. WHO. *Adolescent health*. 2016; Available from: http://www.who.int/topics/adolescent_health/en/.
128. Government, *NEET data by local authority*. 2016.
129. PHE. *Sexual and Reproductive Health Profiles*. 2016; Available from: http://fingertips.phe.org.uk/profile/sexualhealth/data -page/6/gid/8000035/pat/6/par/E12000007/ati/102/are/E09000025/iid/90776/age/156/sex/4.
130. Government, *Against the odds: Re-engaging young people in education, employment and training*. 2010.
131. Government, *Education and Skills Act 2008*. 2008.
132. Government, *Bill documents — Welfare Reform and Work Act 2016*. 2016.
133. Government, *Revised GCSE and equivalent results in England: 2014 to 2015*. 2016.
134. ONS, *Conception Statistics, England and Wales*. 2016.
135. DWP, *The Work Programme*. 2011.
136. Viner, R.M., et al., *Adolescence and the social determinants of health.* Lancet, 2012. **379**(9826): p. 1641-52.
137. Government, *Infection Report.* 2016.
138. PHE, *Sexual health, reproductive health and HIV in England: A guide to local and national data*. 2015.
139. DoH, *A Framework for Sexual Health Improvement in England* 2013.
140. PHE. *Making it work. A guide to whole system commissioning for sexual health, reproductive health and HIV*. 2015; Available from:

    https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf.
141. NICE, *Preventing sexually transmitted infections and under-18 conceptions overview*. 2016.

142. NICE, *Sexually transmitted infections and under-18 conceptions: prevention [PH3].* 2007.
143. Councils, L. *London Sexual Health Transformation Project*. 2015; Available from: http://www.londoncouncils.gov.uk/our-key-themes/health-and-adult-services/public-health/sexual-health-0/london-sexual-health.
144. NICE, *Contraceptive services for under 25s [PH51].* 2014.
145. HSCIC, *Prescription Cost Analysis England 2014.* 2014.
146. DoH, *Abortion Statistics, England and Wales: 2014.* 2014.
147. ONS, *General Lifestyle Survey*. 2011.
148. BMA. *Breaking the cycle of children's exposure to tobacco smoke*. 2007; Available from: http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/GR3GIR2QERK36MDPMLKEJ7AFL6AD8A.pdf.
149. HSCIC. *Health and Social Care Information Centre - Indicator Portal*. 2016; Available from: https://indicators.hscic.gov.uk/webview/.
150. RCP. *Passive smoking and children*. 2010; Available from: https://cdn.shopify.com/s/files/1/0924/4392/files/passive-smoking-and-children.pdf.
151. Government, *Healthy Lives, Healthy People: A Tobacco Control Plan for England*. 2011.
152. HSCIC, *What About Youth (WAY) Survey 2014: Questions to gather Local Authority preferences*. 2014.
153. NICE, *Stop smoking services*. 2013.
154. Government, *Smoking: supporting people to stop [QS43]*. 2013.
155. Government, *Smoking and tobacco*. 2016.
156. PHE, *Young people's drug, alcohol and tobacco use: joint strategic needs assessment (JSNA) support pack*. 2015.
157. Government, *Support for children and young people*. 2016.
158. NICE, *Substance misuse interventions for vulnerable under 25s*. 2007.
159. Government, *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century*. 2008.
160. DoH, *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. 2013.
161. Government, *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. 2011.
162. DoH, *Closing the Gap: Priorities for essential change in mental health* 2014.
163. NICE, *Mental health and wellbeing*. 2016.
164. PHE, *Mental health action plan: PHE response*. 2014.
165. DfE, *Fostering and Adoption: Placement stability and permanence*. 2014.
166. Boddy, J., *Understanding Permanence for Looked After Children: a review of research for the Care Inquiry.* 2017.
167. Harker, Y.Z.a.R., *Children in Care in England: Statistics*. 2015.
168. Government, *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*. 2015.
169. NICE, *Looked-after children and young people [QS31]*. 2013.
170. BBC. *Statement of special needs*. 2015; Available from: http://www.bbc.co.uk/schools/parents/statementing/.
171. DoH, *Promoting the health and well-being of looked-after children*. 2015.
172. NICE, *Looked-after children and young people [PH28]*. 2010.
173. Government, *Annual Report of the Chief Medical Officer 2012 - Our Children Deserve Better: Prevention Pays*. 2012.
174. Wolfe, I., et al., *Health services for children in western Europe.* Lancet, 2013. **381**(9873): p. 1224-34.
175. Curtis-Tyler, K., et al., *What makes for a 'good' or 'bad' paediatric diabetes service from the viewpoint of children, young people, carers and clinicians? A synthesis of qualitative findings.* Arch Dis Child, 2015. **100**(9): p. 826-33.
176. NIHR, *Long-term conditions in children and young people*. 2014.
177. Government. *Modern youth offending partnerships: Guidance on effective youth offending team governance in England*. 2013; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319291/youth-offending-partnerships-guidance.pdf.
178. Government, *The youth justice system in England and Wales: Reducing offending by young people*. 2011.
179. council, C.c., *Improving Outcomes for Children with Additional Needs*. Vol. 2.1. 2015.

180. Government, *Children with special educational needs and disabilities (SEND)*. 2016.
181. DfE, *Local Area Send Report*, Education, Editor. 2016.
182. DfE. *Inclusive Schooling Children with Special Educational Needs* 2001; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283623/inclusive_schooling_children_with_special_educational_needs.pdf.

15.0 APPENDIX

Child immunisation uptake by GP practices within Newham CCG in 2015-2016

Source: NHS England

Table 1: Child Immunisation Uptake by GP Practices at 12 months					
Practice Code	**Eligible Children**	**Dtap/IPV/Hib** %	**Men C** %	**PCV** %	**Hep B** As a % of eligible
F84004	204	90.7%	24.5%	90.2%	100.0%
F84006	212	92.0%	34.4%	90.6%	100.0%
F84009	127	88.2%	23.6%	86.6%	100.0%
F84010	172	86.0%	22.1%	86.0%	100.0%
F84014	95	93.7%	27.4%	93.7%	
F84017	228	82.9%	29.4%	82.0%	100.0%
F84022	65	90.8%	23.1%	90.8%	100.0%
F84032	44	86.4%	11.4%	86.4%	
F84047	183	89.1%	23.5%	90.2%	100.0%
F84050	155	90.3%	27.7%	89.7%	
F84052	110	95.5%	30.9%	95.5%	
F84053	113	91.2%	22.1%	90.3%	33.3%
F84070	66	87.9%	33.3%	89.4%	100.0%
F84074	153	90.8%	25.5%	89.5%	100.0%
F84077	156	91.7%	25.0%	91.0%	100.0%
F84086	90	92.2%	20.0%	92.2%	100.0%
F84088	39	82.1%	28.2%	82.1%	
F84089	16	93.8%	62.5%	100.0%	
F84091	64	98.4%	28.1%	98.4%	100.0%
F84092	110	90.0%	22.7%	89.1%	
F84093	304	93.4%	20.1%	93.4%	100.0%
F84097	146	97.3%	28.8%	97.3%	100.0%
F84111	98	87.8%	25.5%	86.7%	100.0%
F84121	232	89.2%	27.6%	89.2%	
F84124	59	94.9%	20.3%	93.2%	100.0%
F84631	43	88.4%	23.3%	88.4%	100.0%
F84641	37	86.5%	35.1%	89.2%	
F84642	61	85.2%	23.0%	85.2%	
F84654	0				
F84657	19	94.7%	26.3%	94.7%	
F84658	95	88.4%	22.1%	88.4%	
F84660	27	96.3%	18.5%	100.0%	
F84661	25	84.0%	28.0%	84.0%	
F84666	68	80.9%	23.5%	79.4%	
F84669	95	90.5%	25.3%	90.5%	100.0%
F84670	65	89.2%	21.5%	90.8%	100.0%
F84671	17	94.1%	17.6%	94.1%	
F84672	25	84.0%	16.0%	84.0%	

F84673	24	95.8%	33.3%	95.8%	
F84677	87	89.7%	20.7%	92.0%	100.0%
F84679	43	93.0%	23.3%	93.0%	0.0%
F84681	90	88.9%	20.0%	88.9%	100.0%
F84699	0				
F84700	7	85.7%	0.0%	85.7%	
F84706	47	91.5%	40.4%	91.5%	
F84708	86	87.2%	24.4%	87.2%	100.0%
F84713	37	94.6%	51.4%	94.6%	
F84717	97	91.8%	24.7%	91.8%	100.0%
F84724	193	93.8%	28.5%	94.8%	100.0%
F84727	20	85.0%	5.0%	85.0%	
F84729	54	79.6%	0.0%	79.6%	
F84730	114	85.1%	19.3%	84.2%	100.0%
F84734	121	96.7%	19.8%	96.7%	
F84735	164	69.5%	1.2%	70.7%	33.3%
F84739	74	78.4%	0.0%	75.7%	
F84740	94	87.2%	21.3%	87.2%	66.7%
F84741	22	95.5%	13.6%	95.5%	
F84742	26	80.8%	19.2%	80.8%	100.0%
F84749	237	88.2%	21.5%	89.0%	100.0%
Y00225	0				
Y02823	74	78.4%	37.8%	75.7%	100.0%
Y02928	168	87.5%	27.4%	88.1%	50.0%

Table 2: Child Immunisation Uptake by GP Practices at 12 months

Practice Code	Eligible Children	Dtap/IPV/Hib %	MMR %	Infant Men C %	Men C Booster %	PCV Booster %	Hep B
F84004	203	92.1%	84.2%	28.6%	83.3%	83.7%	66.7%
F84006	209	96.2%	90.9%	24.9%	89.0%	88.5%	100.0%
F84009	124	91.1%	83.9%	29.0%	84.7%	84.7%	50.0%
F84010	171	95.9%	91.2%	25.1%	90.6%	90.1%	100.0%
F84014	122	95.9%	88.5%	23.0%	89.3%	90.2%	0.0%
F84017	189	91.0%	82.5%	31.2%	85.7%	81.0%	100.0%
F84022	99	91.9%	84.8%	19.2%	85.9%	85.9%	
F84032	45	93.3%	93.3%	26.7%	93.3%	93.3%	
F84047	178	93.8%	85.4%	27.5%	84.3%	84.8%	100.0%
F84050	162	95.1%	90.1%	35.2%	92.6%	90.1%	100.0%
F84052	128	92.2%	83.6%	32.0%	84.4%	84.4%	0.0%
F84053	98	90.8%	85.7%	34.7%	84.7%	84.7%	
F84070	87	96.6%	93.1%	28.7%	94.3%	94.3%	100.0%
F84074	155	89.7%	85.8%	30.3%	85.8%	83.2%	
F84077	116	96.6%	85.3%	30.2%	84.5%	84.5%	
F84086	98	92.9%	88.8%	51.0%	88.8%	87.8%	0.0%

F84088	51	84.3%	82.4%	51.0%	82.4%	82.4%	
F84089	18	100.0%	94.4%	94.4%	94.4%	94.4%	
F84091	84	98.8%	96.4%	25.0%	96.4%	96.4%	100.0%
F84092	104	98.1%	89.4%	35.6%	89.4%	89.4%	100.0%
F84093	268	95.1%	90.3%	27.6%	88.4%	89.6%	100.0%
F84097	139	92.8%	85.6%	25.2%	84.2%	84.2%	100.0%
F84111	125	94.4%	84.0%	20.8%	86.4%	85.6%	100.0%
F84121	242	97.5%	88.8%	25.6%	88.8%	90.1%	0.0%
F84124	78	92.3%	88.5%	33.3%	88.5%	88.5%	0.0%
F84631	48	91.7%	85.4%	35.4%	87.5%	85.4%	100.0%
F84641	35	94.3%	82.9%	22.9%	82.9%	82.9%	100.0%
F84642	84	91.7%	86.9%	27.4%	86.9%	86.9%	
F84654	6	100.0%	100.0%	0.0%	100.0%	100.0%	
F84657	23	78.3%	73.9%	13.0%	73.9%	73.9%	
F84658	94	95.7%	93.6%	37.2%	93.6%	92.6%	
F84660	30	96.7%	96.7%	23.3%	96.7%	93.3%	100.0%
F84661	24	100.0%	91.7%	37.5%	95.8%	91.7%	
F84666	51	78.4%	80.4%	21.6%	82.4%	80.4%	
F84669	112	94.6%	85.7%	21.4%	85.7%	84.8%	100.0%
F84670	78	88.5%	92.3%	29.5%	91.0%	89.7%	100.0%
F84671	12	100.0%	100.0%	41.7%	100.0%	100.0%	
F84672	39	87.2%	87.2%	33.3%	84.6%	84.6%	
F84673	24	95.8%	87.5%	37.5%	87.5%	87.5%	
F84677	87	96.6%	90.8%	29.9%	93.1%	89.7%	100.0%
F84679	55	94.5%	85.5%	25.5%	85.5%	87.3%	100.0%
F84681	108	90.7%	83.3%	22.2%	85.2%	81.5%	
F84699	14	85.7%	78.6%	7.1%	78.6%	71.4%	
F84700	11	90.9%	90.9%	54.5%	90.9%	90.9%	
F84706	52	96.2%	90.4%	34.6%	94.2%	90.4%	100.0%
F84708	72	87.5%	87.5%	70.8%	84.7%	86.1%	100.0%
F84713	36	100.0%	88.9%	30.6%	88.9%	88.9%	
F84717	128	93.8%	87.5%	32.8%	85.9%	85.9%	
F84724	219	96.3%	92.2%	36.5%	91.8%	91.3%	66.7%
F84727	18	100.0%	94.4%	100.0%	94.4%	94.4%	
F84729	53	96.2%	94.3%	60.4%	94.3%	94.3%	
F84730	111	90.1%	77.5%	27.9%	79.3%	78.4%	100.0%
F84734	126	99.2%	96.0%	34.9%	94.4%	94.4%	66.7%
F84735	170	94.1%	90.0%	25.9%	90.6%	88.8%	
F84739	82	98.8%	95.1%	24.4%	95.1%	95.1%	
F84740	89	94.4%	93.3%	27.0%	87.6%	85.4%	100.0%
F84741	29	96.6%	93.1%	31.0%	89.7%	89.7%	
F84742	38	84.2%	89.5%	47.4%	89.5%	89.5%	
F84749	229	91.3%	83.0%	24.9%	81.2%	80.3%	100.0%
Y00225	*	100.0%	100.0%	0.0%	100.0%	100.0%	
Y02823	63	84.1%	76.2%	39.7%	74.6%	69.8%	100.0%

Y02928	173	90.2%	83.2%	32.4%	85.0%	83.8%	100.0%

Table 3: Child Immunisation Uptake by GP Practices at 5 years

Practice Code	Eligible Children	Dt/Pol Primary %	Dtap/IPV Booster %	Pertussis Primary %	Infant Hib %	Infant Men C %	Hib/Men C Booster %	MMR 1 %	MMR 2 %	Infant PCV %	PCV Booster %
F84004	234	91.0%	70.5%	91.0%	95.7%	92.3%	89.7%	88.0%	71.4%	91.0%	80.8%
F84006	180	95.0%	79.4%	95.0%	98.3%	90.0%	83.9%	95.6%	81.1%	86.7%	86.7%
F84009	115	93.0%	83.5%	93.9%	95.7%	89.6%	91.3%	94.8%	86.1%	89.6%	91.3%
F84010	141	89.4%	83.0%	89.4%	90.8%	83.7%	83.7%	90.8%	86.5%	82.3%	78.0%
F84014	99	99.0%	75.8%	99.0%	99.0%	93.9%	91.9%	93.9%	75.8%	91.9%	85.9%
F84017	200	94.0%	66.5%	94.0%	95.0%	94.5%	90.5%	93.5%	67.0%	92.0%	80.5%
F84022	74	95.9%	77.0%	95.9%	97.3%	89.2%	91.9%	95.9%	81.1%	91.9%	83.8%
F84032	52	94.2%	86.5%	94.2%	94.2%	86.5%	94.2%	92.3%	88.5%	94.2%	94.2%
F84047	191	97.4%	73.8%	97.4%	97.9%	94.8%	94.2%	94.8%	73.3%	93.2%	85.3%
F84050	188	94.7%	86.7%	94.7%	97.3%	88.8%	88.3%	93.6%	86.7%	88.3%	80.3%
F84052	124	89.5%	70.2%	89.5%	92.7%	90.3%	88.7%	88.7%	72.6%	88.7%	87.1%
F84053	104	87.5%	64.4%	87.5%	91.3%	89.4%	83.7%	87.5%	68.3%	83.7%	75.0%
F84070	81	90.1%	85.2%	90.1%	97.5%	92.6%	87.7%	95.1%	93.8%	84.0%	82.7%
F84074	165	93.3%	76.4%	93.3%	95.8%	90.9%	91.5%	95.2%	78.2%	90.9%	88.5%
F84077	109	95.4%	78.0%	95.4%	97.2%	92.7%	94.5%	93.6%	78.9%	91.7%	86.2%
F84086	102	92.2%	83.3%	92.2%	93.1%	92.2%	94.1%	94.1%	84.3%	92.2%	90.2%
F84088	45	88.9%	51.1%	88.9%	93.3%	91.1%	86.7%	93.3%	57.8%	88.9%	82.2%
F84089	13	92.3%	92.3%	92.3%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%
F84091	71	97.2%	77.5%	97.2%	97.2%	91.5%	95.8%	95.8%	80.3%	93.0%	83.1%
F84092	126	93.7%	80.2%	93.7%	95.2%	92.1%	93.7%	96.0%	80.2%	92.9%	88.1%
F84093	283	97.9%	90.8%	97.9%	97.9%	93.6%	90.5%	97.2%	88.3%	93.3%	88.7%
F84097	122	96.7%	78.7%	96.7%	98.4%	98.4%	90.2%	93.4%	79.5%	94.3%	91.0%
F84111	103	92.2%	69.9%	92.2%	93.2%	92.2%	85.4%	86.4%	68.9%	91.3%	81.6%
F84121	233	91.4%	80.3%	91.4%	97.0%	93.1%	94.0%	96.6%	82.8%	93.1%	93.1%
F84124	75	96.0%	68.0%	96.0%	97.3%	84.0%	93.3%	96.0%	68.0%	85.3%	84.0%
F84631	51	98.0%	72.5%	98.0%	98.0%	96.1%	96.1%	98.0%	70.6%	96.1%	96.1%
F84641	50	96.0%	76.0%	96.0%	98.0%	96.0%	96.0%	98.0%	80.0%	94.0%	96.0%
F84642	56	91.1%	55.4%	91.1%	91.1%	87.5%	91.1%	91.1%	60.7%	89.3%	89.3%
F84654	6	83.3%	66.7%	83.3%	100.0%	100.0%	83.3%	83.3%	66.7%	83.3%	83.3%
F84657	41	85.4%	65.9%	85.4%	90.2%	90.2%	80.5%	82.9%	68.3%	85.4%	78.0%
F84658	79	92.4%	78.5%	92.4%	96.2%	87.3%	89.9%	93.7%	82.3%	89.9%	83.5%
F84660	37	97.3%	75.7%	100.0%	97.3%	89.2%	83.8%	89.2%	75.7%	89.2%	75.7%
F84661	30	100.0%	83.3%	100.0%	100.0%	93.3%	86.7%	86.7%	83.3%	90.0%	83.3%
F84666	47	78.7%	40.4%	78.7%	83.0%	76.6%	76.6%	80.9%	46.8%	80.9%	78.7%
F84669	122	94.3%	79.5%	94.3%	95.9%	88.5%	91.8%	92.6%	80.3%	88.5%	86.9%
F84670	58	91.4%	65.5%	91.4%	91.4%	96.6%	93.1%	94.8%	74.1%	89.7%	89.7%
F84671	18	100.0%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%
F84672	32	87.5%	75.0%	87.5%	87.5%	81.3%	78.1%	81.3%	75.0%	81.3%	68.8%
F84673	35	94.3%	80.0%	94.3%	94.3%	94.3%	77.1%	94.3%	82.9%	85.7%	80.0%

F84677	83	94.0%	88.0%	94.0%	94.0%	90.4%	91.6%	94.0%	86.7%	89.2%	89.2%
F84679	52	92.3%	73.1%	92.3%	94.2%	90.4%	86.5%	88.5%	73.1%	88.5%	84.6%
F84681	123	90.2%	67.5%	90.2%	91.1%	91.1%	85.4%	87.0%	68.3%	87.8%	80.5%
F84699	10	100.0%	40.0%	100.0%	100.0%	100.0%	80.0%	90.0%	50.0%	90.0%	80.0%
F84700	18	94.4%	83.3%	94.4%	94.4%	94.4%	100.0%	100.0%	83.3%	100.0%	100.0%
F84706	46	82.6%	73.9%	82.6%	89.1%	87.0%	84.8%	91.3%	80.4%	82.6%	84.8%
F84708	79	94.9%	79.7%	94.9%	94.9%	93.7%	89.9%	88.6%	75.9%	91.1%	78.5%
F84713	50	96.0%	82.0%	96.0%	98.0%	86.0%	88.0%	94.0%	78.0%	94.0%	90.0%
F84717	137	97.1%	79.6%	97.1%	98.5%	95.6%	96.4%	97.1%	81.8%	95.6%	89.8%
F84724	210	94.8%	84.8%	94.8%	95.7%	87.1%	93.3%	93.8%	84.8%	89.5%	90.5%
F84727	30	86.7%	60.0%	86.7%	100.0%	93.3%	93.3%	96.7%	73.3%	96.7%	90.0%
F84729	85	88.2%	63.5%	88.2%	90.6%	87.1%	77.6%	88.2%	62.4%	87.1%	85.9%
F84730	79	83.5%	53.2%	83.5%	86.1%	83.5%	83.5%	87.3%	55.7%	82.3%	82.3%
F84734	156	93.6%	73.7%	94.2%	96.8%	90.4%	87.8%	87.8%	73.7%	91.7%	85.3%
F84735	165	92.1%	72.1%	92.1%	98.8%	93.9%	92.1%	98.8%	77.6%	90.3%	90.3%
F84739	85	98.8%	70.6%	98.8%	98.8%	94.1%	96.5%	98.8%	68.2%	94.1%	96.5%
F84740	75	84.0%	66.7%	84.0%	90.7%	85.3%	80.0%	86.7%	69.3%	74.7%	70.7%
F84741	34	97.1%	88.2%	97.1%	97.1%	97.1%	91.2%	94.1%	88.2%	94.1%	91.2%
F84742	32	81.3%	71.9%	81.3%	93.8%	78.1%	87.5%	93.8%	84.4%	68.8%	78.1%
F84749	199	86.4%	61.8%	86.4%	88.9%	86.4%	83.9%	90.5%	64.8%	85.9%	81.4%
Y00225	14	85.7%	42.9%	85.7%	92.9%	78.6%	85.7%	71.4%	42.9%	85.7%	85.7%
Y02823	72	90.3%	62.5%	90.3%	93.1%	84.7%	84.7%	88.9%	69.4%	90.3%	83.3%
Y02928	151	91.4%	72.8%	91.4%	94.0%	86.8%	86.8%	90.7%	68.9%	90.7%	86.8%