The Health of School Aged Children

The Annual Public Health Report of the Director of Public Health 2012/13

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Foreword

The focus of this year's Annual Public Health Report is the health and wellbeing of school aged children. Medway Council became responsible for the Healthy Child Programme (5-19) when public health responsibilities transferred from the NHS in April 2013. This report aims to inform the development of this programme as well as influence commissioners and providers of services that have an impact on the health of children and young people.

Overall the health of children in the UK has improved over recent years with falling mortality rates and lower rates of infectious diseases. But death rates from violence and injury are increasing in young people and our success in reducing infectious diseases such as measles depends on maintaining high levels of coverage in our immunisation programmes. A recent study by UNICEF placed the UK only 16th out of 29 advanced economies in its child wellbeing index so there is clearly scope for improvement.

There are many factors that influence the health and wellbeing of children and young people from genetics, social factors, education, lifestyle choices, services and the wider socioeconomic, cultural and environmental conditions. The recent NatCen report "Predicting Wellbeing" reviewed self-reported health in seven year olds and highlighted the importance of home life and family relationships in promoting wellbeing. It also identified greater levels of unhappiness and worry among children in more deprived areas. During teenage years levels of wellbeing decline and this is related to social context. For example, substance misuse, excessive computer gaming, being involved in or witnessing disruptive behaviour at school and lack of a supportive home life all had negative impacts on self-reported wellbeing.

Ensuring that children who grow up in Medway do so in an environment that promotes health and allows them to thrive and fulfil their potential has to be one of our most important ambitions. It is an investment both for today and for the future. I hope that this report will encourage all those who can do so, to work together to make this a reality for all children and young people in Medway.

Dr Alison Barnett
Director of Public Health

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Introduction

What happens in the early years of life, starting in the womb, has lifelong effects on many aspects of health and well-being - from obesity, heart disease and mental health, to educational achievement and economic status. Giving every child the best start in life is crucial to reducing health inequalities across the life course.[1]

Ideally a mother would start a pregnancy as a non-smoker, with normal weight, eating a healthy diet, living in adequate housing, with adequate income, having a supportive relationship with her partner, and also the support of family and friends. If she had been taking any regular medication she would have informed her clinicians that she was trying to conceive so that any drugs not recommended in pregnancy could be reviewed. In addition she would have taken low dose folic acid while trying to conceive to reduce the risk of spina bifida.

Ideally she would have accessed antenatal care by eight to 10 weeks gestation and have received excellent care and support including advice on parenting throughout her pregnancy and in the early days after birth. She would have been offered screening programmes during pregnancy for herself and later for her child. Her child would also be protected against the childhood diseases that are prevented by national vaccination programmes.

She would be making use of local services that encourage her child to develop, and their relationship to blossom. Having been introduced to her local Sure Start Children's Centre when visiting her midwife, she would regularly attend activities that support her and her child throughout the first few years of life. She would enrol her child in a pre-school group at the age of two, which would be completely free if she is on a lower than average income.

A development review of her child at two and a half by her health visitor would ensure any concerns are identified, and any additional support for speech and language or other needs would then be provided through the Children's Centre. At three and four years of age her child's free early years education will help ensure developmental milestones are met and the child is ready to start school.

Although children develop and learn in different ways and at different rates, by the time they start school they should have certain key skills as defined by the Statutory Framework for the Early Years Foundation Stage[2] such as being able to:

- follow instructions involving several ideas or actions, and answer questions about their experiences;
- show good control and co-ordination in large and small (e.g. writing with a pencil) movements;
- know the importance of physical exercise, and a healthy diet, and talk about ways to keep healthy and safe;
- wash, dress and go to the toilet independently;
- be confident enough to try new activities, speak in a familiar group, talk about their ideas, and say when they do or don't need help;

- talk about their own and others' behaviour, and its consequences, and know that some behaviour is unacceptable;
- play co-operatively, taking turns with others;
- show sensitivity to others' needs and feelings, and form positive relationships with adults and other children;
- count reliably with numbers from one to 20, place them in order and say which number is one more or one less than a given number;
- know about similarities and differences between themselves and others, and among families, communities and traditions;
- sing songs, make music and dance, and experiment with ways of changing them.

These skills enable a smooth transition into school years. Children who, for whatever reason, have not developed these skills should be identified prior to school admission so that support can be offered.

Table 1 shows the percentage of five-year-olds with a "good level of development" (defined until 2012 as attaining at least 78 points across the Early Years Foundation Stage with six points or more in each of the strands of communication, language and literacy, and personal, social and emotional development) as assessed by teachers. This indicator has been lower in Medway than the South East and England over recent years.

Table 1: The percentage of five-year-olds with a good level of development (pre 2013 definition)

Area	2010	2011	2012
Medway	55	57	60
South East	58	61	66
England	56	59	64

Source: Early Years Foundation Stage Profile

A new (more challenging) measure of "Good Level of Development (GLD)" for children at age five years was introduced in 2013. Each child's level of development is now assessed against 17 early learning goals at the age of five. Teachers indicate whether children are meeting expected levels of development, exceeding expected levels, or not yet reaching expected levels ('emerging').[3]

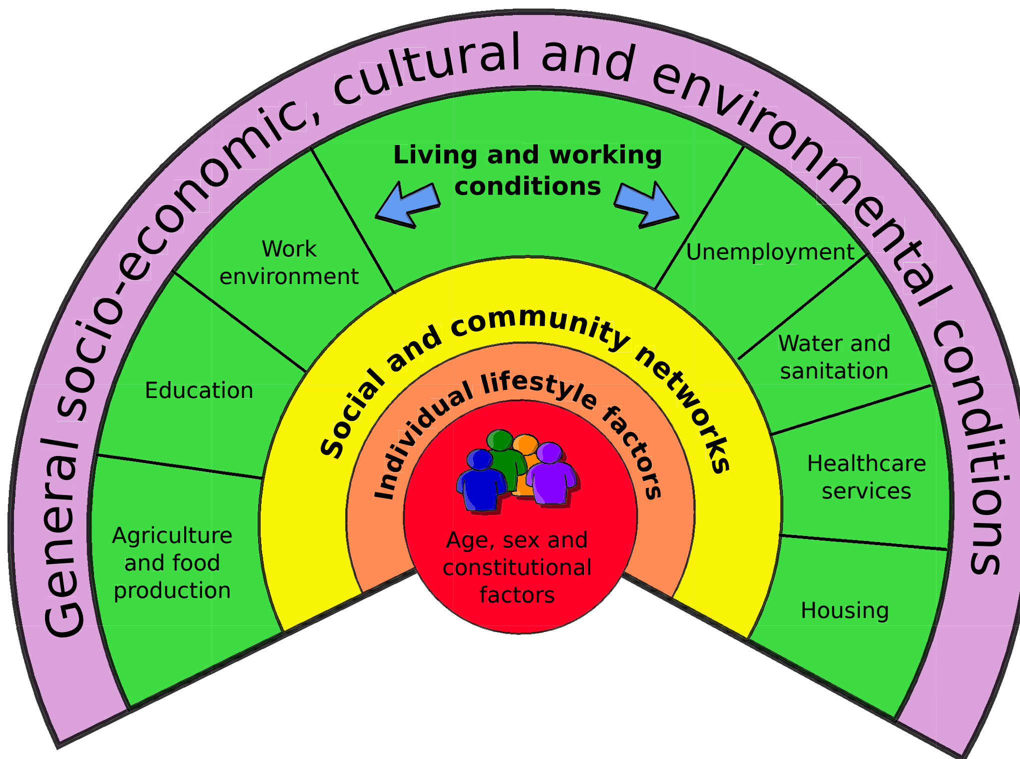
Provisional data for 2013 indicate that a higher proportion of children attained the GLD in Medway (57%) than England as a whole (52%).[4] It is anticipated that when comparators are published Medway will be approximately 5% above the national figure.

This relative improvement may have resulted from targeted activity to support the development and wellbeing of young children, and support for their families, primarily through the Sure Start Children's Centres - which coordinate health, learning, and family support services from pre-birth until starting school. Contact and engagement rates have increased significantly over the past three years, and targeted interventions are increasingly successful in supporting the children and families most in need. This, together with on-going support and challenge to ensure good quality teaching and learning in the Early Years Foundation Stage, is likely to have contributed to the improved outcome at age five years.

Ofsted inspections of eight Children's Centres in Medway since August 2012 have all resulted in Good or Outstanding grades. The latest published figures show that 69% of inspections in Medway and England achieved a Good or better rating, between 1st April 2010 and 30th June 2013.[5] Data collected locally show that as at 31st August 2013, Medway had achieved 73%.

Whilst the behaviour and lifestyle of the child's family has an impact on the health of the child, figure 1 shows that there are many more societal factors which influence health and life outcomes.

Figure 1: Wider determinants of health



Source: Dahlgren and Whitehead 1991

This report is focused on school age children and has been structured to look at the key conditions and issues that affect children in these years. It starts by describing the population of Medway, and then looks at common existing health issues for children and young people. This is followed by sections on lifestyle choices and the wider determinants of health and how these in turn impact on children's health and wellbeing.

Demographics
1

1 Demographics

This section brings together a summary of the available demographic information on children and young people of school age in Medway.

Resident and school populations of children and young people in Medway

The 2011 Census showed there were 50,882 children and young people aged between four and 18 resident in Medway, representing just under 20% of population. The proportion of young people is higher in Medway than the South East and England and this is particularly noticeable in males (table 2).

Table 2: The population of school aged children and young people, 2011

Area	Persons			Males			Females		
	All ages	aged 4-18	%	All ages	aged 4-18	%	All ages	aged 4-18	%
Medway	263,925	50,882	19.3%	130,825	26,016	19.9%	133,100	24,866	18.7%
South East	8,634,750	1,539,937	17.8%	4,239,298	790,686	18.7%	4,395,452	749,251	17.0%
England	53,012,456	9,341,520	17.6%	26,069,148	4,783,492	18.3%	26,943,308	4,558,028	16.9%

Source: Office for National Statistics Census 2011

The proportion of children and young people within each Medway ward is shown in table 3.

Table 3: Resident population in Medway by ward, 2011

Ward	Total population	age 4-18	% total population
Princes Park	10,433	2,227	21.3%
Chatham Central	16,413	3,424	20.9%
Gillingham North	17,854	3,707	20.8%
Luton and Wayfield	14,379	2,940	20.4%
Gillingham South	16,594	3,366	20.3%
Strood South	15,076	3,029	20.1%
Strood Rural	13,805	2,739	19.8%
Watling	9,243	1,828	19.8%
Twydall	13,048	2,565	19.7%
Strood North	13,766	2,704	19.6%
Walderslade	9,520	1,864	19.6%
Rochester South and Horsted	12,678	2,438	19.2%
Rainham South	13,273	2,511	18.9%
Cuxton and Halling	5,448	1,029	18.9%
Rochester East	10,351	1,946	18.8%
Lordswood and Capstone	9,079	1,691	18.6%
Peninsula	13,656	2,468	18.1%
Rochester West	10,779	1,904	17.7%
Rainham Central	12,252	2,156	17.6%
Hempstead and Wigmore	8,003	1,399	17.5%
Rainham North	8,563	1,455	17.0%
River	9,712	1,492	15.4%
Medway	263,925	50,882	19.3%

Source: Office for National Statistics Census 2011

Table 4: Number of pupils on the school roll in Medway schools

School type	Pupils
State Primary	23,254
State Secondary	18,879
Special	598
Pupil referral unit	123
Independent	1,559

Source: Department for Education, January 2013 school census

Population projections

Between 2011 and 2021, the populations of four- to eight-year-olds and nine- to 13-year-olds in Medway are projected to grow by 18.2% and 9.2% respectively. The population of 14- to 18-year-olds is projected to drop by 7.9% during the same period (table 5).[6] These projections take into account past migration, but do not take into account the potential effects of future migration which can be influenced by factors such as housing availability. Overall, the population in Medway aged four to 18 years will increase by 6.1% by 2021 (table 6).

Table 5: Population projections by five year age band for four to 18-year-olds, 2011 to 2021

Age band	2011	2021	% change
4-8	16,325	19,295	18.2%
9-13	16,352	17,856	9.2%
14-18	18,136	16,712	-7.9%

Source: Office for National Statistics Census 2011

Table 6: 2011 based population projections for four- to 18-year-olds

Year	Projected population 4-18 years	% change from 2011
2011	50,800	
2013	50,300	-1.0
2015	50,500	-0.6
2017	51,200	0.8
2019	52,300	3.0
2021	53,900	6.1

Source: Office for National Statistics Census 2011

Ethnicity

Overall, with respect to ethnic composition, Medway has a higher percentage of children and young people belonging to a White ethnic group than England (86.2% compared to 79.9%) (table 7). Medway is similar to the South East region, but has a higher percentage of children and young people of Black ethnicity (3.6% compared to 2%).

Table 7: Percentage of the area population of each ethnic group for children and young people aged five to 19 years, 2011

Ethnic group	Medway		South East	England
White: Total	44,628	86.2%	87.1%	79.9%
White: British	43,021	83.1%	83.5%	76.3%
White: Irish	101	0.2%	0.3%	0.3%
White: Gypsy or Irish Traveller	157	0.3%	0.3%	0.2%
White: Other White	1,349	2.6%	3.1%	3.1%
Mixed: Total	1,992	3.8%	4.1%	4.5%
Mixed: White and Black Caribbean	777	1.5%	1.2%	1.7%
Mixed: White and Black African	315	0.6%	0.6%	0.6%
Mixed: White and Asian	540	1.0%	1.5%	1.3%
Mixed: Other Mixed	360	0.7%	0.8%	0.9%
Asian/Asian British: Total	2,746	5.3%	6.1%	9.6%
Asian: Indian	1,268	2.4%	1.7%	2.5%
Asian: Pakistani	366	0.7%	1.7%	3.3%
Asian: Bangladeshi	385	0.7%	0.5%	1.4%
Asian: Chinese	210	0.4%	0.7%	0.6%
Asian: Other Asian	517	1.0%	1.6%	1.8%
Black/African/Caribbean/Black British: Total	1,872	3.6%	2.0%	4.7%
Black: African	1,415	2.7%	1.4%	2.7%
Black: Caribbean	307	0.6%	0.3%	1.1%
Black: Other Black	150	0.3%	0.3%	0.9%
Other ethnic group: Total	525	1.0%	0.7%	1.2%
Other ethnic group: Arab	131	0.3%	0.3%	0.5%
Other ethnic group: Any other ethnic group	394	0.8%	0.4%	0.7%

Source: Office for National Statistics Census 2011

Looking at census data from 2001 and 2011, there has been a significant change in the ethnic composition of Medway's five- to 19-year-old population over this time period.

The total population of five- to 19-year-olds has decreased by 1.6%, but within that the White British population has decreased from 91.9% to 83.1% of the total population. The White Other population has increased from 0.9% to 2.6% of the total population, the Asian/Asian British population has increased from 3.8% to 5.3% and the Black/African/Caribbean/Black British population has increased the most from 0.6% to 3.6%.

Table 8 and figure 2 show the ethnicities of school pupils in Medway. Children in primary education in Medway are more ethnically diverse than children in secondary education, with 20.9% of the primary school population not being White British compared to 18.2% of the secondary school population.

With regard to speakers of English as a first language, 11.5% (2,131) of primary school and 7.7% (1,453) of secondary school pupils in Medway do not have English as a first language.

This equates to 54% and 40% respectively of the Medway minority ethnic primary and secondary school populations (all other ethnic groups except the "White: British" category) and gives us some indication of the proportion of minority ethnic groups who are more likely to have arrived in this country more recently.

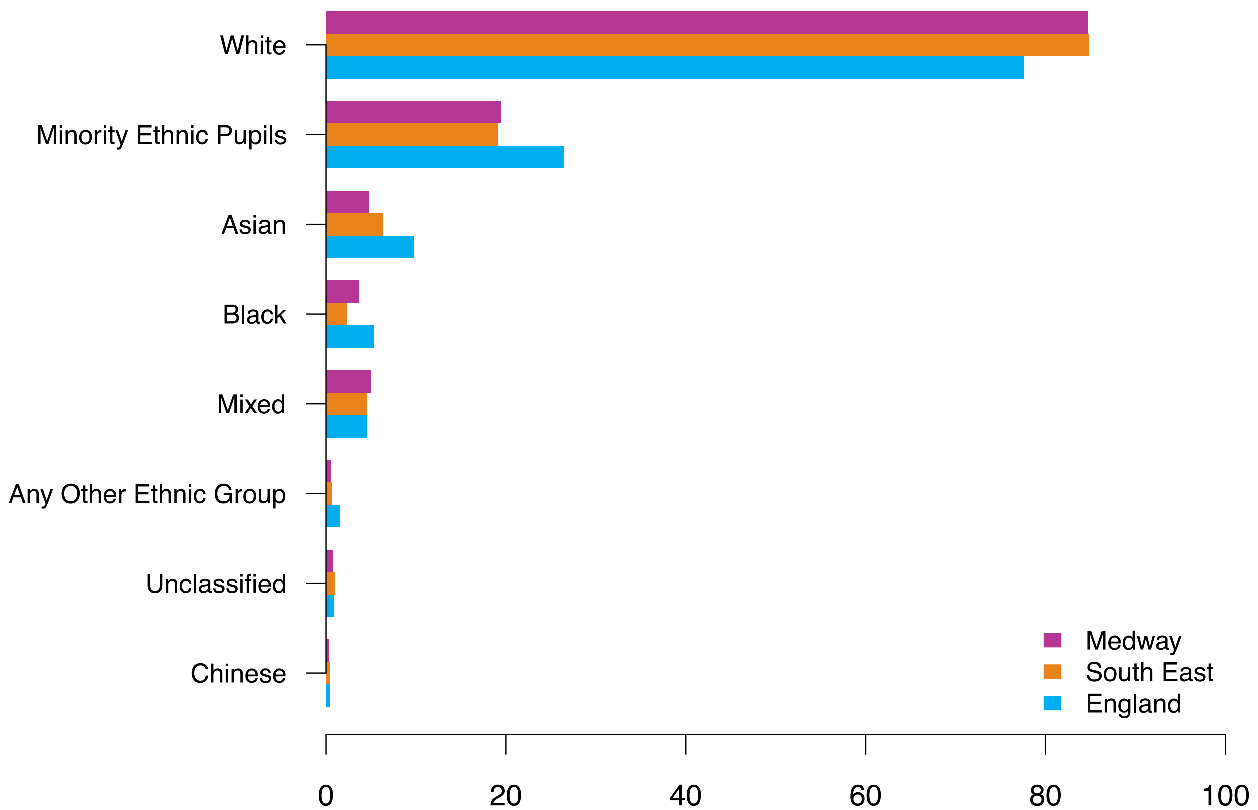
Medway has a smaller proportion of pupils who do not have English as a first language when compared to the South East, although Medway is very similar to the South East with respect to primary school children (table 9).

Table 8: Number of pupils in state-funded schools in Medway by ethnic group

Ethnic group	Primary	Secondary
White: British	14,502	15,252
White: Irish	60	33
White: Traveller Of Irish Heritage	8	7
White: Gypsy/Roma	131	99
White: Any Other Background	866	671
Mixed: White And Black Caribbean	263	227
Mixed: White And Black African	168	99
Mixed: White And Asian	197	202
Mixed: Any Other Background	437	286
Asian: Indian	402	524
Asian: Pakistani	133	141
Asian: Bangladeshi	153	158
Asian: Any Other Background	150	134
Black: Caribbean	83	91
Black: African	588	549
Black: Any Other Background	32	44
Chinese	55	65
Any Other Ethnic Group	135	105
Unclassified	104	193
All pupils	18,467	18,880

Source: Department for Education, January 2013 school census

Figure 2: Percentage of pupils on the school roll by ethnic group, local authority maintained primary and secondary schools combined



Source: Department for Education, January 2013 school census[a]

Table 9: Percentage of pupils in state-funded schools with and without English as a first language

	Primary school			Secondary school		
	Medway	South East	England	Medway	South East	England
Percentage with first language other than English	11.5% (2,131)	11.6%	18.1%	7.7% (1,453)	9.1%	13.6%
Percentage with English as first language	88.4% (16,319)	88.4%	81.8%	90.5% (17,084)	90.6%	86.1%
Percentage unclassified	0.1% (17)	0.1%	0.1%	1.8% (342)	0.3%	0.3%

Source: Department for Education, January 2013 school census

[a] *All ethnicities except White British*

Family composition

Tables 10 and 11 describe the family structures in Medway. Over half have no dependent children (aged under 18). Medway has statistically significantly more cohabiting couples and lone parents than the South East and England average.

Table 10: Percentage of families[b] who have the following number of dependent children, by the age of the youngest child

Area	Number of families	None	One, aged 5-11	One, aged 12-18	Two, aged 5-11	Two, aged 12-18	Three, aged 5-11	Three, aged 12-18
Medway	75,062	54.4	4.6	8.6	7.0	3.7	2.9	0.5
South East	2,458,022	57.6	4.1	7.7	6.7	3.7	2.7	0.5
England	14,885,145	56.9	4.5	8.2	6.3	3.5	2.7	0.5

Source: Office for National Statistics Census 2011

Table 11: Percentage of households[c] by household composition where there is at least one dependent child

Area	Total households	Households with with at least one dependent child	Married or same-sex civil partnership couple		Cohabiting couple		Lone parent		Other household types	
Medway	106,209	34,323	17,447	50.8%	5,695	16.6%	8,406	24.5%	2,775	8.1%
South East	3,555,463	1,044,637	608,251	58.2%	138,651	13.3%	216,366	20.7%	81,369	7.8%
England	22,063,368	6,423,941	3,375,890	52.6%	890,780	13.9%	1,573,255	24.5%	584,016	9.1%

Source: Office for National Statistics Census 2011

Table 12 shows the average cross border movement for all pupils in school years Reception to Year 11 (ages four to 16).[d]

Table 12: Percentage of pupils living in Medway and schooling in another local authority (LA) or living in another LA and schooling in Medway'

Area	School in area and live elsewhere	Live in area and school elsewhere
Medway	3.7	3.9
South East	4.3	4.1
England	5.7	5.6

Source: Department for Education, January 2013 school census

[b] A family is defined as a group of people who are either: a married, same-sex civil partnership, or cohabiting couple, with or without child(ren); a lone parent with child(ren); a married, same-sex civil partnership, or cohabiting couple with grandchild(ren) but with no children present from the intervening generation; or a single grandparent with grandchild(ren) but no children present from the intervening generation.

[c] A household is defined as one person living alone, or a group of people (not necessarily related) living at the same address who share cooking facilities and share a living room, sitting room or dining area. This includes: sheltered accommodation units in an establishment where 50% or more have their own kitchens, and all people living in caravans on any type of site that is their usual residence. This will include anyone who has no other usual residence elsewhere in the UK. A household must contain at least one person whose place of usual residence is at the address. A group of short-term residents living together is not classified as a household, and neither is a group of people at an address where only visitors are staying.
[d] excluding pupils reported to be boarders and those in special schools not following the curriculum

Table 13 shows the main local authorities Medway residents travel to for school and also the local authorities from which Medway receives pupils. At primary age, more pupils go from Medway to Kent than vice versa, but this reverses at secondary age.

Table 13: Cross border movement of state funded primary and secondary pupils in Medway

School type	Live elsewhere and school in Medway	Live in Medway and school elsewhere
Primary	Greenwich (4), Kent (475)	Greenwich (6), Bromley (7), Bexley (9), Kent (600)
Secondary	Bexley (3), Greenwich (4), Kent (873)	Lambeth (3), Bexley (6), Kent (803)

Source: Department for Education, January 2013 school census

Free school meals

The percentage of children in Medway primary schools who are eligible* for free school meals is similar to the England average and slightly lower in secondary schools (table 14), but rates are significantly higher than for the South East. There are 656 and 533 pupils in primary and secondary schools respectively eligible for free school meals in Medway.

Table 14: Number and percentage of pupils eligible for free school meals, by school location

Area		Maintained nursery and state-funded primary schools	State-funded secondary schools
Medway	Number eligible	4,270	2,500
	% eligible	18.4	13.2
South East	% eligible	12.8	10.1
England	% eligible	18.1	15.1

Source: Department for Education, January 2013 school census

**The number of children recorded as being eligible for free school meals is based on the number of children who have applied for the benefit, however not all families who would meet the criteria will have applied*

Recommendations

- The population structure is changing with a projected increase of 18.2% in the number of four- to eight-year-olds and a decrease of about 8% in 14- to 18-year-olds by 2021. This needs to be taken into account in any service planning.
- The ethnic composition of the school-age population in Medway has changed significantly from 2001 to 2011 and this needs to be taken into account in any service planning.

2 Health conditions affecting children and young people

2 Health conditions affecting children and young people

This chapter describes the common childhood illnesses and other health issues which affect children in Medway. It highlights issues for the physical, mental and dental health of our children and what action could be taken to improve their health and wellbeing.

Physical health

In England there are no comprehensive childhood disease databases,[7] neither are there comprehensive local ones which means it is difficult to establish the number of children with common conditions in Medway.

Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s is an indicator within the NHS Outcomes Framework and these common physical conditions are reviewed in this section. The reasons for overall hospital admissions for children and young people and childhood deaths are also included.

Diabetes

There are two main types of diabetes – type 1 (T1DM) and type 2 (T2DM). T1DM develops when the insulin-producing cells in the pancreas have been destroyed and the body is unable to produce any insulin. It can develop at any age but usually appears before the age of 40, and especially in childhood.[8] T2DM develops when the body can still make some insulin, but not enough to function properly, or there is insulin resistance.[9] While T1DM is not preventable, T2DM is linked to behavioural factors such as being overweight and physically inactive.

Most children with diabetes have T1DM which requires insulin replacement. Although the cause is unclear, T1DM is occurring more frequently, and is now one of the most common chronic childhood diseases, affecting approximately one in 600 children.[10] T2DM is also increasing in children and young people.[11]

Coming to terms with a diagnosis of diabetes, particularly of T1DM, and achieving consistent good self-management to avoid complications can be challenging for children and young people and their parents/carers.

The National Paediatric Diabetes Audit (NPDA)[e] includes data from 97% of the 171 registered hospitals in England providing a paediatric diabetes service. Recently the Department of Health has introduced a Best Practice Tariff[f], with the aim of driving up the quality of care and improving outcomes for children and young people with diabetes. Participation in the NPDA is one of the key requirements to receiving the Best Practice Tariff.

The 2010/11 NPDA found a total of 21,953 infants, children and young people under the age of 25 years registered as having diabetes and under the care of paediatric diabetes units in England. Of these 1,444 lived within the South East (Kent[g], Surrey, Sussex). There were 20,946 school aged children (five to 19 years) in England and 1,404 in the South East.

Table 15: Diabetes registrations in England and English Regions 2010/11

Area	Age group					
	0 - 4	5 - 11	12 - 15	16 - 19	20 - 24	Total
England	634	6,003	8,118	6,825	373	21,953
South East region	30	407	581	416	10	1,444

Source: NPDA report 2010/11

T1DM is the most common type of diabetes in children and young people (table 16). A larger proportion of children with diabetes in Asian and Black groups have T2DM (table 17).

Table 16: Percentage of infants, children and young people with diabetes by sex and type, England 2010/11

Area	Type 1 diabetes mellitus		Type 2 diabetes mellitus		Maturity onset diabetes of the young		Other Specified		Not Stated	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
England	94.3	92.6	1	2.4	0.3	0.3	3.4	3.8	1	0.9
South East region	99.2	97.6	0.3	1.3	0	0.1	0.5	1	0	0

Source: NPDA report 2010/11

Table 17: Percentage of infants, children and young people with diabetes by type and ethnic group, England 2010/11

Diabetes Type	Ethnic Group					
	White	Asian	Black	Mixed ethnic group	Other	Not stated
Type 1 Diabetes Mellitus	94.6	80.5	82.5	91.2	85.4	93.3
Type 2 Diabetes Mellitus	0.9	7.7	8.4	2.1	5.8	1.8
Maturity onset diabetes of the young	0.3	0.4	0.2	0.6	0	0.3
Other Specific	4	10.7	8.2	5.3	8	1.7
Not Specified	0.2	0.7	0.8	0.9	0.9	2.9

Source: NPDA report 2010/11

e. The National Paediatric Diabetes Audit (NPDA) is funded by the Department of Health and has been in existence for 8 years. Every year the number of paediatric hospital units that submit data increases. It seeks to collect a clinically meaningful dataset and produce a report which will be used to drive national policy.

f. Best Practice Tariff – an additional payment is paid to the provider provided specific criteria are met. It has been gradually introduced since 2010/11and is used in Medway. [134]

g. includes Medway

The paediatric diabetes service at Medway NHS Foundation Trust (MFT) provides the majority of specialist diabetes services for children and young people in Medway. The MFT paediatric diabetes service submitted data to the NPDA in 2010/11 and 2011/12 as shown in table 18. As the catchment area of MFT also includes a large proportion of Swale as well as Medway, this needs to be taken into account when looking at the following tables.

Table 18: Diabetes registrations reported by Medway NHS Foundation Trust[h]

Estimated age	Submission 2010/11		Submission 2011/12	
	Born between	Number	Born between	Number
0-4	2006-2010	4	2007-2011	9
5-11	1999-2005	60	2000-2006	59
12-15	1995-1998	85	1996-1999	82
16-24	1986-1994	68	1987-1995	78
Total under 25		217		228

Source: Medway NHS Foundation Trust

The vast majority of patients have Type 1 diabetes. In both years, fewer than five patients were diagnosed with T2DM. There were 26 children newly diagnosed in 2011/12 of which a higher number than usual (13) presented in diabetic ketoacidosis (DKA) and so needed hospital admission.

The NPDA collects information on the key care processes that monitor diabetes management and detect long term complications at the earliest treatable stage, as recommended in the 2004 NICE guidance.[12] A starting age of 12 years for commencing monitoring most of these is appropriate, whereas Glycosylated haemoglobin A1c (HbA1c) should be measured in infants, children and young people of all ages.

h. Certain items of data have either been removed or suppressed in the interests of patient confidentiality, resulting in age approximation. 'Registrations' refers to those patients under the care of the PDU regardless of the year of diagnosis.

HbA1c monitoring at MFT was better than the national average in 2010/11 and has improved since then. Table 19 shows that around 95% of paediatric diabetic patients had their HbA1c recorded in 2010/11 and 2011/12. The proportion of patients with HbA1c levels complying with NICE guidance has also improved (HbA1c should be less than 7.5%.[12] The 2011/12 national report has not yet been published for comparison.

Table 19: HbA1c monitoring and outcomes

	HbA1c recorded	HbA1c less than 7.5%	HbA1c between 7.5% and 9.5%	HbA1c greater than 9.5%
England (2010/11)	92.8%	15.7%	55.5%	28.8%
Medway (2010/11)	94.9%	12.1%	56.8%	31.1%
Medway (2011/12)	95.2%	18.0%	58.1%	24.8%

Source: National Paediatric Diabetes Audit 2010/11 and Medway NHS Foundation Trust

Epilepsy

Epilepsy is a tendency to have recurrent seizures (fits). There are over 40 different types of epilepsy consisting of at least 29 syndromes and a further 12 or so clinically distinct groups defined by the specific cause or underlying cause.[13]

NICE has estimated[i] from a sample of representative general practices across the UK that the proportion of children and young people aged 17 years or younger with a diagnosis of epilepsy and receiving antiepileptic drugs is 0.3%, which if extrapolated to Medway would be approximately 183 children and young people.

The estimated incidence of newly diagnosed epilepsy per year was:

- 50 per 100,000 in children aged 11 years or under (approximately 20 in Medway)
- 30 per 100,000 in young people aged 12 to 17 years (approximately 6 in Medway)

The nature of epilepsy means that it can be difficult to diagnose accurately. It has been reported that up to 40% of children referred to tertiary epilepsy clinics do not have epilepsy.[13]

For many children and young people diagnosed with epilepsy, seizures can be controlled through treatment with an anti-epileptic drug or other interventions including surgery which the Joint Epileptic Council of the UK and Ireland[j] state is offered to too few children.[13]

i. Primary care data were collected from the IMS disease analyser, which collects data from a sample of around 100 GP practice systems, with about 2.7 million patient records. The sample includes practices from England, Wales, Scotland and Northern Ireland and has a representative UK sample by age and sex. The database holds significant clinical events relating to any period in a patient's life that has been summarised into computer records by the practice. As in any observational database, data entered by panel doctors may be incomplete

j. Joint Epileptic Council of the UK and Ireland is the umbrella charity providing the representative voice working for the benefit of people affected by epilepsy

More than one in five people who have epilepsy have learning or intellectual disabilities[13] and prevalence of epilepsy is 25% higher in the most socially deprived areas compared to the least socially deprived.[13] Optimal management improves health outcomes and can help to minimise other detrimental impacts on social, educational and employment activity.[14]
As a diagnosis of epilepsy can have a wide-ranging impact on a child or young person's health and lifestyle a quality standard[14] was issued by NICE in February 2013. This consists of nine statements which include:

- children and young people presenting with a suspected seizure are seen by a specialist in the diagnosis and management of the epilepsies within two weeks of presentation;
- children and young people having initial investigations for epilepsy undergo the tests within four weeks of them being requested;
- children and young people with epilepsy have an agreed and comprehensive written epilepsy care plan.

Whether all the statements within the quality standard are met locally needs to be confirmed.

Asthma

Asthma is a long-term condition that affects the airways in the lungs of children, young people and adults. Classic symptoms include breathlessness, tightness in the chest, coughing and wheezing. Triggers that are known to exacerbate this condition include allergens (such as pollen), air pollution, cigarette smoke, exercise, upper respiratory infections and exposure to cold air.

The goal of management is freedom from symptoms with the ability to lead a normal, active life. This is achieved partly through treatment, tailored to the person, and partly by people identifying and avoiding triggers as much as possible.[15]

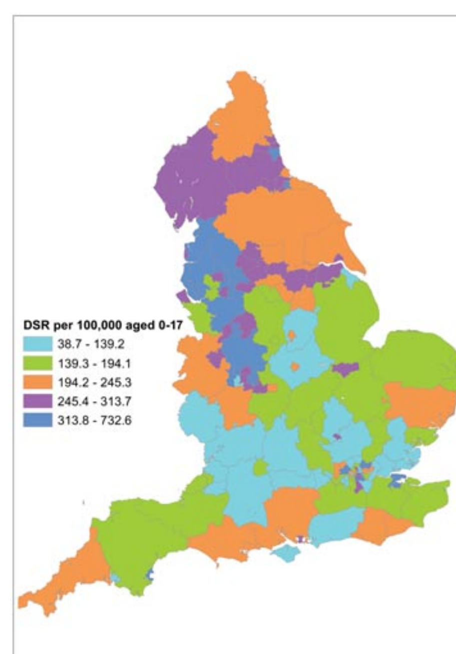
In the UK, it is estimated that 1.1 million children are receiving treatment for asthma.[16] This is one in every 11 children (about 4,600 in Medway). It is the most common long term condition in children and young people.[16] There were 15 deaths from asthma in children aged 14 and under in England in 2011,[17] but none of these occurred in Medway.

Unplanned hospital admissions for asthma, diabetes and epilepsy

Asthma is responsible for large numbers of accident and emergency (A&E) department attendances and hospital admissions. Most admissions are emergencies and 70% may have been preventable with appropriate early interventions.[18]

The Atlas of Variation for Respiratory Disease[19] shows that Medway admission rates for asthma in 2010/11 were in the top 15% of Primary Care Trusts (PCTs) - rank 19th out of 151. This is higher than 2009/10 and 2008/09 when Medway ranked 60th and 73rd respectively (table 20).[19,20]

Figure 3: Directly age-standardised rate of emergency hospital admissions for Asthma in children by Primary Care Trust, 2010/11



Source: NHS Atlas of Variation, Respiratory conditions

Preliminary investigation has established that emergency asthma admission rates for children and young people in Medway have increased while rates in statistical neighbours (Milton Keynes and Bexley) have decreased and in Kent have increased slightly over recent years.

Table 20: Directly standardised emergency admission rates for asthma per 100,000 population aged zero to 17 years

	Medway	Milton Keynes	Bexley	West Kent	Eastern & Coastal Kent
2008/09[21]	244	283	214	174	169
2009/10[20]	261	243	187	181	191
2010/11	359	163	113	186	186
% increase (from 2008/09 to 2010/11)	47.1%	- 42.4%	- 47.2%	6.9%	10.1%

Source: Atlases [19-21]

Table 21 shows trends in Standardised Admission Ratios[k] (SAR) for non-elective admissions for diabetes, epilepsy and asthma over the last 13 financial years. These data are limited to children aged zero to 14. SARs for asthma became significantly higher than expected in 2010/11 with the increase maintained subsequently. Admissions for epilepsy and diabetes have also been statistically greater than expected over the past two years and one year respectively.

Table 21: Trends in non-elective Standardised Admission Ratios for zero- to 14-year-olds, for selected conditions in Medway Primary Care Trust

Financial year	Population aged 0-14	Asthma		Diabetes		Epilepsy		Total	
		Admissions	SAR	Admissions	SAR	Admissions	SAR	Admissions	SAR
2000/01	53,433	117	86.3	29	109	168	128	314	107
2001/02	53,433	135	94.8	25	89	112	83.5	272	89.3
2002/03	53,433	110	86.3	21	73.7	124	93.3	255	88.3
2003/04	53,433	137	106	35	123	96	69	268	90.5
2004/05	53,433	177	119	24	82.5	117	86.1	318	102
2005/06	53,095	119	92.5	38	127	178	127	335	112
2006/07	52,556	183	122	32	108	200	147	415	132
2007/08	50,882	131	110	41	144	117	89.8	289	104
2008/09	51,171	142	105	32	115	105	80.5	279	95.1
2009/10	52,232	143	111	28	97.8	135	110	306	109
2010/11	52,338	211	170	28	97.5	124	99.6	363	131
2011/12	52,863	183	167	25	93.6	187	151	395	152
2012/13	52,863	193	176	44	165	170	137	407	157

Source: Dr Foster Intelligence

k. The SAR is the observed number of admissions divided by the expected number, multiplied by 100. The expected number is calculated from national average data adjusted for population size, age, sex and patient deprivation. Red and green font indicates a statistically significantly high or low ratio according to 95% confidence limits.

Possible explanations for the large degree of variation in the rate of emergency admissions include:

- suboptimal management in the community;
- suboptimal emergency care in the accident and emergency (A&E) department;
- differences in admission criteria among paediatric clinicians;
- variations in coding practice.

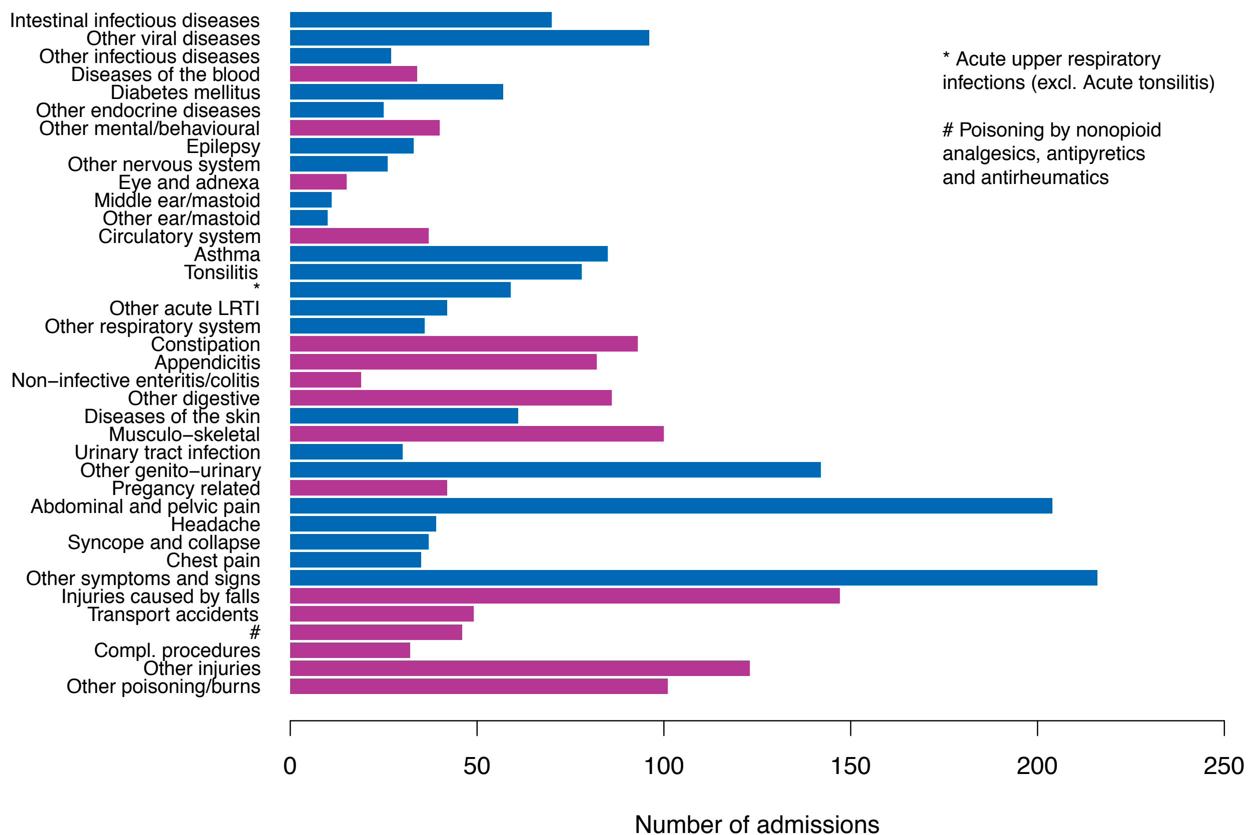
Further investigations are ongoing and a clinical audit, including of the coding of these types of admissions, is required to understand the root causes of this increase.

Hospital admissions for all causes

Figures 4 and 5 show the primary reasons for emergency and elective hospital admissions in children aged five to 19 in 2012/13. In both charts, the bars are ordered by ICD-10 chapter (alternating between colours) and restricted to where there is a count of at least 10.

In figure 4, it is clear that abdominal pain and the four bars that follow represent a large proportion of non-elective admissions. This is unsurprising as illnesses, particularly in young children, commonly commence with non- specific symptoms such as raised temperature, general malaise etc. In some cases the symptoms and signs subside within a short time period and the child discharged without a diagnosis.

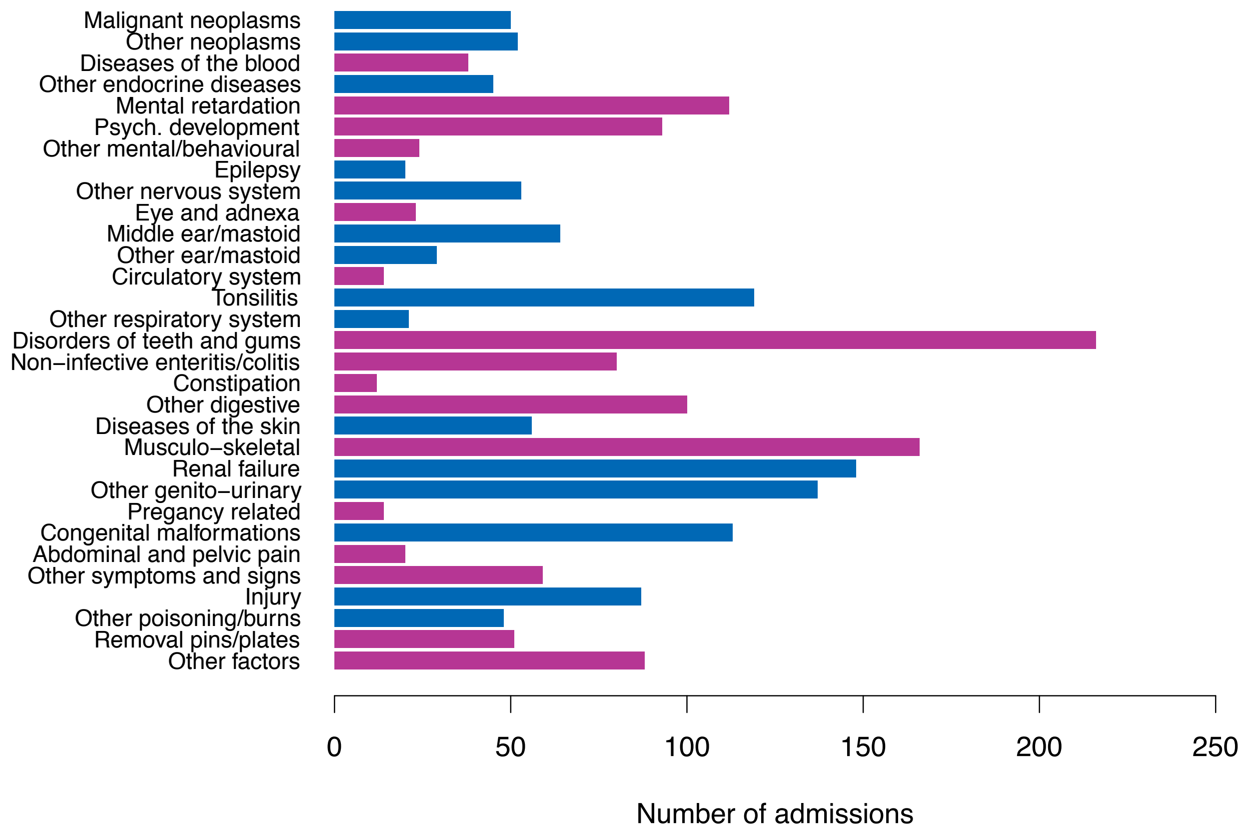
Figure 4: Primary reason for emergency hospital admission in Medway residents (aged five to 19) in 2012/13



Source: Secondary Uses Service
Colours define a change in ICD-10 coding chapter for reason of admission.

Figure 5 shows a different picture with the most common cause of elective admissions being for disorders of teeth and gums such as embedded and impacted teeth.

Figure 5: Primary reason for elective hospital admission in Medway residents (aged five to 19) in 2012/13



Source: Secondary Uses Service
Colours define a change in ICD-10 coding chapter for reason of admission.

Childhood deaths

Childhood deaths are fortunately rare – nationally fewer children die of infectious diseases now than in the past, but violence and injury-related death rates in young people aged 15 to 24 years have increased.[7] Every death in childhood is reviewed by the Child Death Overview Panel. In the last three calendar years (2010 to 2012) there were a total of 10 deaths in Medway residents aged five to 19 years.

Recommendations

- Conduct a clinical and coding audit of the notes of children and young people admitted as emergencies for asthma and epilepsy to aid understanding of the issues underlying the rise in admissions.
- Investigate whether the Audit Plus tool can be used to obtain prevalence (including historic) of asthma in children and young people in Medway.

Mental health

Mental health conditions account for almost one quarter of ill health in the UK, more than either cancer or heart disease,[22] and their prevalence is rising, with the World Health Organisation predicting that depression will be the second most common health condition worldwide by 2020.[23]

No Health without Mental Health (2011) places emphasis on early intervention to stop serious mental health issues developing, particularly amongst children. It highlights that in addition to Child and Adolescent Mental Health Services (CAMHS) professionals, there are a wide range of professionals and groups that can support and improve a child or young person's psychological well-being including midwives, health visitors, school teachers, school nurses and community workers.

Behavioural and emotional disorders which usually start in childhood and adolescence are classified into:

- emotional disorders (which include separation anxiety, generalised anxiety, social phobia, specific phobias and depression);
- conduct disorders (which include oppositional defiant disorder and both socialised and unsocialised conduct disorders);
- hyperkinetic disorders which include some forms of Attention Deficiency Hyperactivity Disorder (ADHD)[I] where the symptoms are sufficiently severe to cause the child distress or impairment in his/her social functioning;
- less common disorders such as autistic spectrum disorders (ASD), eating disorders, tic disorders, and selective mutism.[24]

Risk factors for mental health conditions in children and young people

Two national surveys in 1999[25] and 2004[26] examined the mental health of children and young people aged five upwards who lived in private households, and identified factors associated with increased risk of mental health disorders. Taking only emotional disorders and conduct disorders, the 2004 survey demonstrated the influence of:

- age – young people aged 11 to 16 are more likely to have both types of mental disorders than younger children;
- gender – more girls have emotional disorders than boys, whereas more boys than girls have conduct disorders;
- presence of a specific physical or developmental disorder – having an additional disorder e.g. coordination or speech and language difficulties increases the risk of both emotional and conduct disorders;
- family structure – living with a lone parent is a risk factor for both disorders. Experience of parents' separation almost doubles the risk of emotional disorders and conduct disorders. Living in a reconstituted family (i.e. with step- siblings) is a risk factor for generalised anxiety disorder and conduct disorder;
- family size – living in a household with three or more children increases the risk of emotional disorder and living in a household of four or more children increases the risk of conduct disorders;
- parental education and mental health – having a parent with no educational qualifications almost doubles the risk of both types of disorder and having a parent with indication of an emotional disorder themselves more than doubles it (although it may be that the child's problem has increased the risk within the parent);
- lower family income – a risk factor for both types of disorder;

I. ADHD is the name given to a broader (and therefore more common and milder disorder) defined by the American Psychiatric Association

- the survey also showed that smoking, drinking, drug use and recorded self-harm were all more common in both types of disorder.

Other vulnerable groups at greater risk of developing mental health conditions are:

- looked after children – Some of the risk factors for mental health disorders may be the very factors that result in children being taken into care (e.g. family dysfunction, parental illness), which makes this group of children at particular risk and in need of services;[24]
- children and young people with special educational needs (SEN) – The Office for National Statistics 2004 survey and follow up survey three years later showed that those with SEN were more likely to develop emotional (30% compared to 14%) and conduct disorders (51% compared with 12%) than those without SEN. They were also 16 times more likely to have a persistent mental disorder;
- children and young people who have entered the youth justice system – Reasons for this include:
  - o original risk factors that led to their offending also increase the risk of mental health problems. For example, inconsistent or erratic parenting, over-harsh discipline, hyperactivity as a child, or other types of stressors on families;
  - o aspects of the offending, including characteristically risky behaviour, may cause mental health problems;
  - o interactions with the criminal justice system are stressful, particularly those associated with custody, and may lead to anxiety and depression.[27]
- young carers – the responsibilities of caring increase the risk of developing mental health problems. Those with a parent who has mental health problems are at increased risk of developing a mental health problem themselves and those who are carers are at an even higher risk.[25,26]

m. note that the prevalence of disorders between girls and boys does not equate to the prevalence of all children. Prevalence rates are different for each gender and population.

Prevalence of mental health disorders

Using the 2004 national survey[26] the estimated prevalence of mental health disorders in children aged five to 16 years is shown in table 22.

Table 22: Estimated number of children living within private households with a mental health disorder by type of disorder in Medway

		Aged 5-10 years	Aged 11-16 years	Total
Conduct Disorders	Boys	678	875	1,553
	Girls	267	520	787
	All Children[m]	949	1,389	2,338
Emotional Disorders	Boys	216	432	648
	Girls	238	622	860
	All Children[m]	465	1,052	1,517
Hyperkinetic Disorders	Boys	265	259	524
	Girls	38	41	79
	All Children[m]	310	295	605
Less common disorders	Boys	216	173	389
	Girls	38	112	150
	All Children[m]	252	295	547

Source: Office for National Statistics, 2012. Green, H. et al (2004) [26]

(i) Autistic spectrum disorder and attention deficit hyperactivity disorder (ADHD)

Table 23 shows the number of children born between 01/09/1994 and 31/08/2009 (i.e. those of school age four to 19 years) living in Medway who have been identified as having autistic spectrum disorder and also the number with ADHD as recorded by CarePlus.[n] This may be an underestimate as some children with these conditions may be solely under the care of Child and Adolescent Mental Health Services (CAMHS) rather than community paediatricians.

n. The Kent and Medway Child Health Record system (CarePlus) holds health related information on children and is used in particular for childhood screening and immunisation programmes. It is also used by community paediatricians at Medway NHS Foundation Trust to record the diagnosis of children they see. School nurses started to record the diagnoses of children whom they see from 2013 and this will be useful for commissioning purposes in the future.

Table 23: Mental health conditions recorded on CarePlus

	Number of children
Autistic spectrum disorder (ASD) (includes childhood autism and Asperger's syndrome)	1,605
Attention deficit hyperactivity disorder (ADHD)	1,328

Source: Careplus, Medway NHS Foundation Trust, extracted 25/06/2013

The number of children with ASD (1,605 aged four to 19) in table 23 is almost three times the total number of children estimated to have to have less common conditions within table 22 (547 aged five to 16 years) which would include other conditions as well as ASD.

Information from the autism outreach team supports the likelihood that ASD is particularly high in Medway with 1,089 pupils being supported by the team as of June 2013. Their role is to support schools by providing training for staff which can also be applied to children with social communication difficulties. Table 24 shows the cumulative number of children diagnosed with ASD and supported by the autism outreach team service since it started in 2003. The team is made aware of a diagnosis by the paediatricians and is in contact with schools to ensure records are accurate as pupils enter and leave Medway.

Table 24: Number of children and young people diagnosed with ASD, and supported by the autistic outreach team, who attend mainstream schools in Medway

	Number of pupils
October 2004	284
April 2007	631
July 2008	899
September 2010	949
July 2011	986
June 2012	1,009
June 2013	1,089

Source: Autism Outreach Team

The number of children with ADHD is also much higher than predicted. This increased prevalence of ADHD and ASD has increased demand for diagnostic services for children and young people of all ages. Coordination between health and other key services such as education, social care and the voluntary sector is important. NICE recognised this in guidance issued in 2009 for ASD. A multi-agency approach has been piloted in Medway and demonstrated positive outcomes with faster decision making for complex cases and positive feedback from families. Sustaining the model was difficult owing to constraints on professional time and managing the demand.

(ii) Neurotic disorders

A study in 2001[28] estimated prevalence rates for neurotic emotional disorders (for example anxiety, depression and phobias) in young people aged 16 to 19 living in private households.[29]

Table 25: Estimated number of children with neurotic disorders living in private households in Medway

	Boys aged 16-19 years	Girls aged 16-19 years	Persons
Mixed anxiety and depressive disorder	400	923	1,323
Generalised anxiety disorder	125	82	207
Depressive episode	71	201	272
All phobias	47	156	203
Obsessive compulsive disorder	71	67	138
Panic disorder	39	45	84
Any neurotic disorder	674	1428	2,102

Source: Office for National Statistics, 2012. Singleton, N. et al (2001) [29]

This is used to estimate the number of young people aged 16 to 19 years with a neurotic disorder in Medway as 2,102 (table 25) compared to 1,389 in those aged 11 to 16 years (six years) and 949 in those aged five to 10 years (six years) (table 22). This type of mental illness therefore appears to become more common with age.

(iii) Psychosis

Psychosis is a major mental illness that can develop in childhood or adolescence. It alters perception, thoughts, mood and behaviour. The symptoms include hallucinations, delusions, emotional apathy and social withdrawal.

Most children and young people with short-lived or less-marked psychotic symptoms do not go on to develop psychosis or schizophrenia, but they do appear to be at higher risk of developing psychosis and schizophrenia up to 10 years after onset of symptoms.[30] The prevalence of psychotic disorders in children aged between five and 18 years has been estimated to be 0.4% nationally (the figure across all ages in the UK is 0.7%), which would be 190 cases in Medway.

Schizophrenia accounts for 24.5% of all psychiatric admissions nationally in young people aged 10 to 18 years (the overall admission rate is 0.46 per 1,000 for this age range), with an exponential rise across the adolescent years mostly from age 15 onwards. There is a worse prognosis for psychosis and schizophrenia when onset is in childhood or adolescence. About one-fifth of children and young people with schizophrenia have a good outcome with only mild impairment. However, one-third have severe impairment that needs intensive social and psychiatric support.

Psychosis and schizophrenia can have a major detrimental effect on children and young people's personal, social, educational and occupational functioning, placing a heavy burden on them and their families.[30]

(iv) Bipolar disorder

Bipolar disorder (previously called "manic depression") is a major mental illness characterised by severe mood swings which affects about one in 100 adults.[31,32] It is extremely rare in young children, but studies suggest that it may start in teenage years and in early adult life.[32] It can be hard to recognise in teenagers because mood swings can be part of this stage of life.[31]

There are several different types of bipolar disorder and treatment needs to be tailored to each individual. Young people with bipolar disorders are usually under the care of CAMHS services and it is very important that they and their families are helped to understand the condition. There may be triggers to episodes and/or early warning signs that an episode may be starting – being aware of these can help reduce the chance of episodes occurring, and getting help in the earliest stages of an episode can stop it from escalating.[32]

(v) Self-harm

Self-harm statistics indicate that the UK has one of the highest rates of self-harm in Europe at 400 per 100,000 population.[33] Self-harm can occur at any age, but is most common in young people.[34]

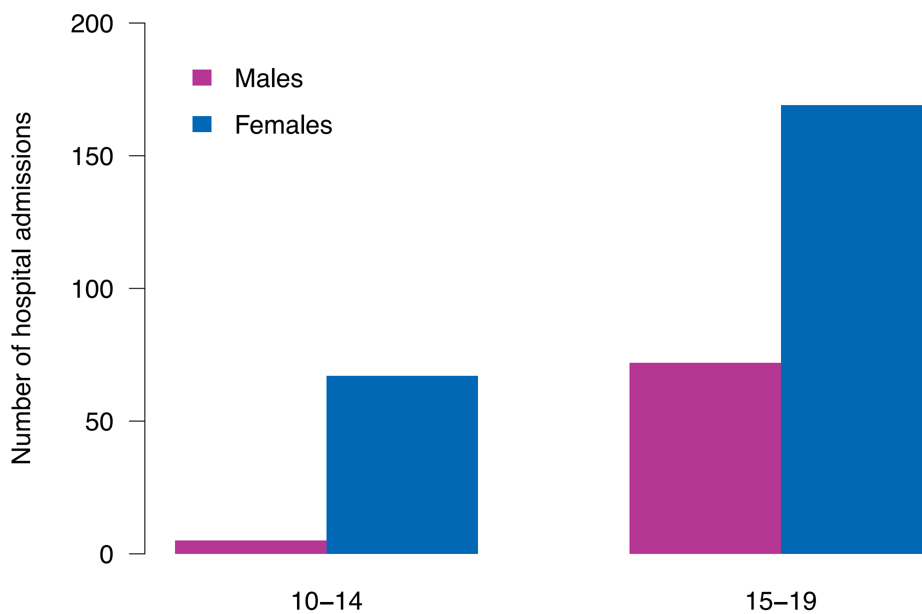
A wide range of mental health problems are associated with self-harm, including borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol use disorders. People who self-harm are 50 to 100 times more likely to die by suicide in the 12-month period after an episode than people who do not self-harm.[35,36]

In June 2013, NICE published a new Quality Standard[37] that recommends:

- people who have self-harmed should be treated with the same compassion, dignity and respect as everyone else using healthcare services;
- people who have self-harmed should have an initial assessment of physical health, mental state, social circumstances and risks of repetition or suicide;
- a comprehensive psychological assessment should be carried out each time a person presents with an episode of self-harm;
- a risk-management plan can help people who have self-harmed reduce their risk of self-harming again. This should be developed in collaboration with the person who has self-harmed, who should have joint ownership of the plan.

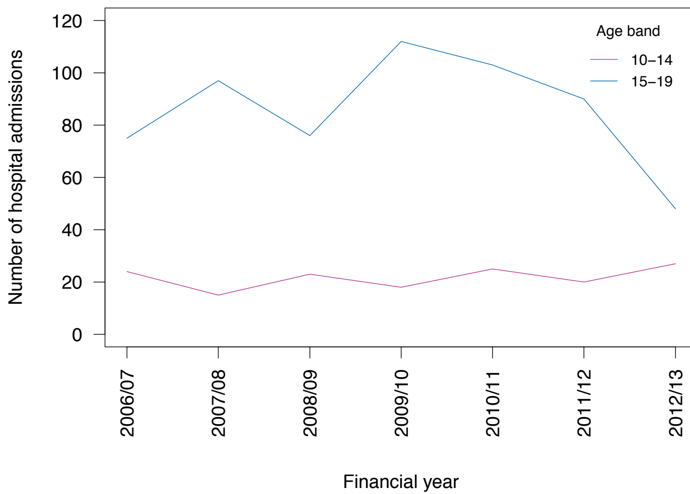
Self-harm has been clearly related to interpersonal difficulties: younger teenagers describe family problems and older teenagers cite partner issues. The most reliable source of data on the incidence of self-harm is hospital admissions (Secondary Care Uses Service) but it should be acknowledged that these cases represent a small fraction of the total number which may be treated in Accident and Emergency departments, Walk-in Centres or by some other means. Therefore, the analysis in figures 6 and 7 should be interpreted with a degree of caution. There appears to be a difference in the female to male ratio with increasing age, 8:1 females to males in 10- to 14-year-olds and 3.1:1 in 15- to 19-year-olds (figure 6).[34]

Figure 6: Emergency hospital admissions for Medway residents attending any hospital for self-harm by age and sex, April 2010 to March 2013



Source: Secondary Care Uses Service

Figure 7: Trends in emergency hospital admissions for Medway residents attending any hospital for self-harm by age-band



Source: Secondary Care Uses Service

Services in Medway

Child and Adolescent Mental Health Services (CAMHS) aim to meet the mental health and emotional wellbeing needs of children and young people up to 18 years of age. This includes both specialist CAMHS services as well as universal services which contribute to ensuring positive mental health in children and adolescents. CAMHS services are multidisciplinary and are formed of four tiers that recognise differing levels of need (box 1).

i) Tier 1

Promoting mental health is a priority within the CAMHS service. One in six mothers is affected by perinatal mental health issues and stress. Early intervention is crucial to better relationships and child development.[38]

Box 1: CAMHS service levels

Tier 1: Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.

Tier 2: Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 3: Services usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.

Tier 4: Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area.

Health visitors support the mental wellbeing of new mothers. Medway Community Healthcare, the health visitor service provider in Medway, has developed perinatal mental health champions and will be rolling out training to all health visitors. Medway Public Health also has a mental health promotion specialist who carries out work in this area.

Other support provided in Medway includes, but is not limited to:

- Triple P (Positive Parenting Programme) parenting groups for parents/carers of children and young people with ADHD;
- Place 2 Be Programme – early intervention mental health support in schools;
- Onside Project – counselling and psychotherapy for children and young people in secondary school;
- Relateen Service – a confidential counselling service for 10- to 25-year-olds who are upset by their parent's relationship problems;
- Stepahead – supports young people needing to become independent but facing difficulties;
- Parentis – a service for birth to 18-year-olds, providing support and advice for parents/carers;
- Freedom Project – providing support, advice, information and advocacy for women and children who have been or are experiencing domestic abuse.

ii) Single Point of Access (SPA)

Embedded in Tier 2 services, there is a single point of access for CAMHS services in Medway. The service received 1,296 referrals in 2012/13, the main referrers being general practitioners, educationalists and paediatricians. The service is looking to allow children and young people to self-refer. Of the referrals received by the SPA in 2012/2013, 329 resulted in consultations, 416 were referred onto Tier 2 services, and 389 were referred to Tier 3 services. Thirty referrals related to looked after children.

iii) Tier 2 Services

The child and adolescent support team (CAST) service is a multi-disciplinary, early intervention team that offers services to young people up to age 18 years and their families. They offer short-term work related to young people's emotional wellbeing.

They work with emerging emotional difficulties with regards to mild to moderate anxiety, including phobias, low mood, sleeping difficulties, eating difficulties, encopresis and enuresis, self-harming behaviour (if the young person is considered low risk), underlying issues expressed as anger, low-level psychosomatic presentation and young people who are at early risk of educational or social exclusion.

In 2012/13, Tier 2 accepted 170 referrals of which 85% related to individuals between the ages of 11 and 16. Of the accepted referrals, 18% related to self-harm and 17% to depression, with females aged between 11 and 16 featuring strongly in each group.

The CAST service meets regularly with Tier 3 services to review care plans in complex cases.

iv) Tier 3 Services

Sussex Partnership NHS Foundation Trust (SPNFT) became the provider of specialist community Children and Young People's Mental Health Services in September 2012.

SNPFT provides specialist services to children and young people under 18 years with complex mental health presentations. Services include:

- assessment /formulation/diagnosis of mental health disorders;
- therapeutic interventions including psychotherapy, psychiatric/psychological assessment, art therapy, family therapy, cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT);
- Children in Care team.

The Kent and Medway out of hours service also provides a crisis response service to the Medway NHS Foundation Trust Accident and Emergency department, local police custody suites and related service locations.

SPNFT inherited a waiting list of 143 children and young people in Medway who were waiting up to 63 weeks for an assessment. A challenging improvement trajectory was agreed to reduce the waiting time to assessment to four to six weeks and the waiting time to treatment to eight to 10 weeks by July 2013. The average waiting time for an assessment is now three weeks. In August 100% of urgent referrals were seen within five working days, 68.3% receiving an assessment waited less than six weeks and 51.7% receiving treatment waited less than 10 weeks.[39]

v) Tier 4 Services

Based at Woodland House Adolescent Unit in Staplehurst, Kent, South London & Maudsley NHS Foundation Trust provides inpatient and specialist outreach support for people aged 12 to 18 years. Referrals for this service are primarily received through CAMHS Tier 3 services. The service provides inpatient provision for young people in crisis, a dedicated in-patient and day service that focuses on eating disorders, and a management pathway for a range of specialist support such as those requiring neuropsychiatry, forensic services and secure provision.

Medway youth diversion service triage

The Medway youth diversion service triage commenced in August 2011 ensuring that low-level criminal behaviour is responded to via an appropriate diversion away from the criminal activity and out of the criminal justice system. This includes diversion to CAMHS where appropriate.

Young people's views

A local project – the Kent Youth Mental Health Project[40] – was undertaken in 2012. The objectives were to:

- build resources in local communities to support young people's mental wellbeing;
- hear from young people in Kent and Medway about what helps and what hinders their mental health;
- develop options for commissioning a youth mental health service.

The results were presented at a Kent and Medway meeting chaired and led by young people in August 2013. Key suggestions made by the young people (which included representatives of Medway's Youth Council) included:

- development of peer supporters in secondary schools;
- extension of "Place 2 Be" to all primary schools;
- for mental wellbeing to be addressed in Personal Social and Health Education (PSE) classes with young people themselves who have an interest being involved with the development of these sessions;
- much more clarity concerning how to get advice when a mental health problem arises – there are many different organisations but they have specific criteria and sometimes young people fall between the gaps;
- the need for information on mental wellbeing and mental ill health in a language that young people can understand.

It would seem from this that young people in Medway would welcome self-referral to the SPA and that members of the Youth Parliament very much want to be involved with commissioners in any service redesign.

Recommendations

- Review and develop ADHD and ASD pathways to offer an appropriate range of assessments and interventions, adopting a multidisciplinary approach to the long-term management of conditions.
- Review the self-harm pathway against the new NICE Quality Standard.
- Extend the single point of access service to allow self -referral.
- Commissioners to work closely with Medway Youth Parliament to develop key suggestions from the Kent Mental Health Project.

Dental Health

Oral health refers to the condition of gums, teeth, surrounding bone and soft tissues of the mouth enabling function and being free of disease and pain. Although the oral health of children in England has generally improved over the past few decades, there are still children with unacceptable tooth decay levels. Furthermore, the distribution of tooth decay varies geographically across Kent and Medway, with proportionately more children in the more deprived local authority areas experiencing tooth decay. Tooth decay in children is often not treated, leading to pain and discomfort on chewing, which may affect children's growth and development. This links to the section on hospital admissions earlier in the report as figure 5 shows that the most common reason for elective admission is 'disorders of teeth and gums'.

Tooth decay in children is largely preventable. The main risk factor is frequent and high consumption of sugary foods and drinks, which are metabolised by bacteria in the mouth resulting in the production of acids. These acids dissolve the substance of the tooth and over time, can eventually lead to the formation of cavities. Children of all ages are at risk of tooth decay. However, in common with other chronic diseases, those from socially deprived backgrounds are more likely to experience tooth decay.[41,42] Additionally, vulnerable groups such as children with a learning disability are more susceptible to tooth decay.

Fluoride in drinking water is protective against dental decay. In Medway the population does not benefit from fluoridated water as natural levels are low and none is added.[43]

The level of dental need may be estimated from national dental health surveys of five and 12-year-olds carried out in 2011/12[44] and 2008/09[45] respectively.

Of the 206 (6.1%) Medway five-year-olds examined, 19.2% were estimated to have at least one decayed, missing or filled deciduous (or milk) tooth (DMFT), compared to 21.6% in the last survey (2007/08). The percentage of five-year-olds with DMFT has also decreased nationally, reducing from 30.9% to 27.9% (table 26).

Of those with experience of tooth decay, an average 3.3 DMFT was reported for five-year-olds and an average 2.4 DMFT for 12-year-olds (table 26). Medway has statistically significantly lower prevalence of decay at the 95% level than the England average.

Table 26: Prevalence and severity of tooth decay experience in five- and 12-year-olds

Area	5-year-olds		12-year-olds	
	Prevalence	Severity	Prevalence	Severity
Medway	19.2	3.3	32.5	2.4
South East	21.2	3.2	27.3	2.0
England	27.9	3.4	33.4	2.2

Source: NHS Dental Epidemiology Programme for England: Oral Health Survey of five- and 12-year-olds in 2011/12 and 2008/09

Most NHS dental services for children are provided in the primary care setting. Dental services are commissioned geographically but individuals may access any dentist they wish. Since introduction of the new dental contract in 2006, primary care dental services have been procured in areas of need as identified in PCTs' oral health needs assessments. Medway is not affected by marked differences in geographical variation of services, however there are still variations in the uptake of services across Medway.

The use of dental services, as measured by the numbers of patients seen as a proportion of the population, also suggests that access in Medway is better than other parts of Kent (table 27). NHS dental access in Medway is relatively higher than in West Kent and Eastern and Coastal Kent. This difference in dental access may be due to geography, relatively easier access to services and greater awareness of dental services. It may also be because out of area patients are attending Medway services, but it is not possible to determine this with current published data.

Table 27: Dental access as a percentage of the population

Area	2006	2012
Medway	75.5%	83.6%
South East GOR	73.2%	68.7%
England	70.7%	70.9%

Source: Health and Social Care Information Centre
GOR=Government Office Region

There were 445 Looked after Children (LAC) in 2012 in Medway. This group accesses dental care in Medway through a recognised referral and dental care pathway. There is multidisciplinary input which can include initial assessment and treatment planning at the community dental service. This results in referral to specialist paediatric dentists if required or referral on to a general dental practitioner for treatment and regular recalls as appropriate.

Medway Council, in conjunction with Public Health England, is developing a more comprehensive local oral health promotion strategy for Medway. Initiatives include oral health and dietary advice given to targeted schools in the area.

A coordinated strategy is needed to reduce the oral health inequalities in children. A pilot fluoride varnish application programme was carried out on three- to 10-year-old children in Luton and Wayfield that achieved 60% initial participation. As the programme progressed, participation decreased, but there were many lessons learnt by the community dental service which can be applied to future projects.

Although most children in Medway enjoy good oral health, one in five experiences an average of at least two teeth affected by decay. Further oral health promotion services are therefore needed to address this disparity. To do this, Medway is developing a comprehensive oral health promotion strategy that will supplement the present provision of clinical prevention in some schools and children centres, to be more widely available and fully integrated with other health promotion activities. Current guidance recommends that all children should visit the dentist at least twice a year for prevention of tooth decay through topical fluoride therapy. Service use for prevention should therefore be promoted, especially in areas of high tooth decay prevalence.

In Medway the prevalence of five-year-olds with a decayed, missing or filled deciduous (or milk) tooth (DMFT) is 19.2% compared to a national average of 27.9%.

Recommendations

- Promote orientation of primary care dental services to focus on prevention in line with Delivering Better Oral Health – a toolkit for prevention.[46]
- Promote collaboration with other health workers such as health visitors to deliver oral health messages.

Vaccination

The aim of vaccination programmes is to protect against common infectious diseases that can result in severe illness. The schedule for routine vaccinations in childhood is defined by the Department of Health on the advice of the Joint Committee on Vaccination and Immunisation (JCVI) and has changed over time as new vaccines have become available.

Measles, Mumps and Rubella (MMR)

Most childhood vaccinations are given before school entry. In Medway vaccination uptake rates have been historically high but the uptake of MMR vaccine (which protects against measles, mumps and rubella) decreased following the publication of the, now discredited, research in 1998 that suggested a link between MMR and autism.

This means that some young people now aged 10 to 16 years are not protected against measles, mumps and rubella. An extensive outbreak of measles in Swansea which started at the end of 2012 has resulted in a national campaign in England to ensure these young people (estimated to number 330,000) are now vaccinated. The aim is that 95% of all young people aged 10 to 16 years will have received at least one dose of MMR before 30 September 2013.

Table 28 shows cases of measles in Medway, Kent and England since 2010. There were two confirmed cases of measles in Medway in the first four months of 2013; there have been none in the following four months to the end of August 2013.

Table 28: Measles cases, 2010 to 2012

Area		2010	2011	2012
England	All cases reported	2,235	2,354	5,145
	Confirmed cases	380	1,086	2,030
Kent	All cases reported	174	271	222
	Confirmed cases	6	60	28
Medway	All cases reported	29	85	51
	Confirmed cases	0	8	0

Source: Public Health England

Human Papillomavirus (HPV) and Tetanus, Diptheria and Polio (DTP)

The routine vaccinations given during the school years are:

- vaccination against Human Papillomavirus (HPV) which protects against four types of HPV which are implicated in the development of cervical cancer and also genital warts;
- vaccination against tetanus, diphtheria and polio (the School Leaving Booster).

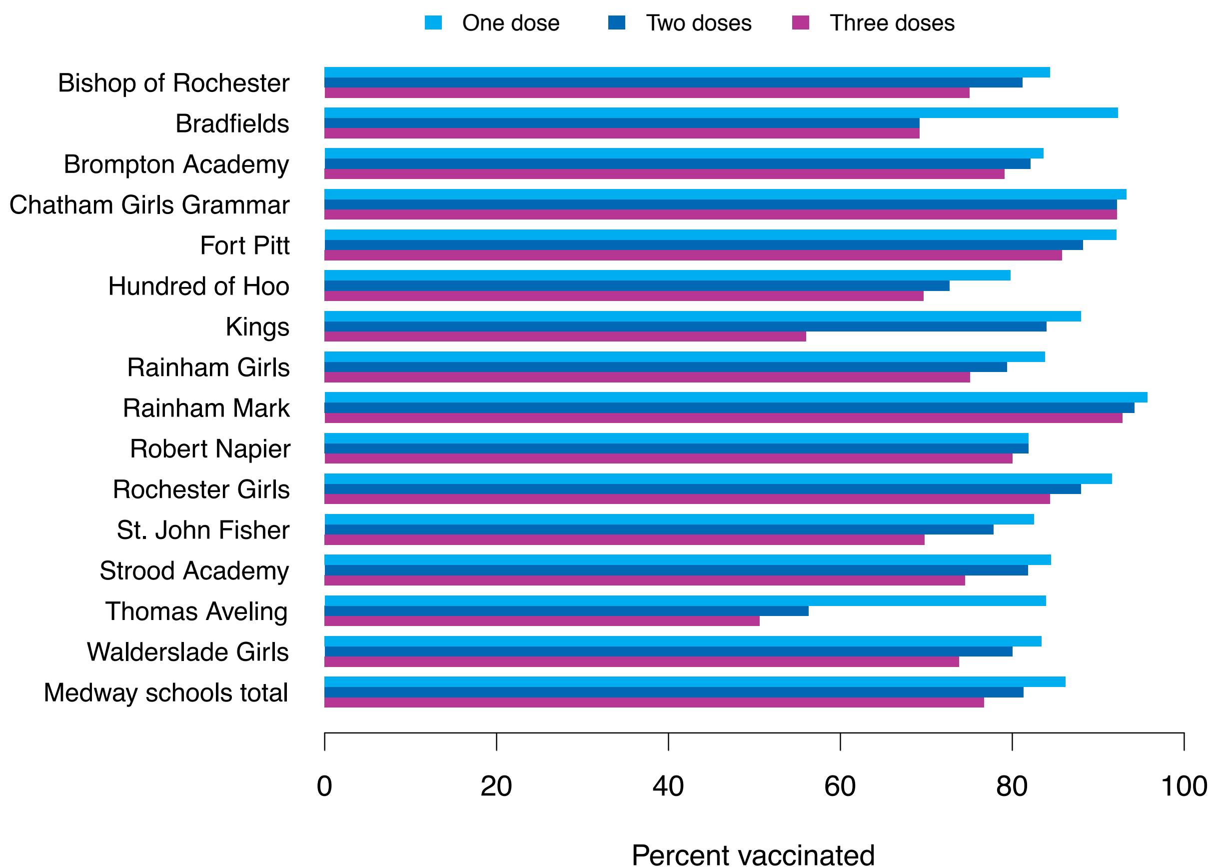
In Medway the school nursing service offers these vaccinations in school. GP practices provide vaccination when this has been missed in school. Table 29 and figure 8 show the uptake of HPV vaccine in Medway.

Table 29: The percentage of girls in Year 8 receiving the 1st, 2nd and 3rd doses of HPV vaccine

Survey year	Cohort number	Date of birth	Number of girls requiring vaccination	Percentage receiving the following doses by the end of year 8		
				1	1 and 2	all 3
2009/10	7	Sept 1996-Aug 1997	1,670	84.4%	80.8%	76.7%
2010/11	8	Sept 1997-Aug 1998	1,715	85.3%	82.9%	77.7%
2011/12	9	Sept 1998-Aug 1999	1,781	86.6%	85.1%	81.0%
2012/13	10	Sept 1999-Aug 2000	1,612	89.6%	87.2%	83.2%

Source: DH, Annual HPV vaccine uptake

Figure 8: HPV vaccine uptake in Year 8 students by school, 2012/13



*Source: Medway school health team**

** Figures for schools with less than 10 students eligible for vaccination have been suppressed.*

The uptake of HPV vaccination has increased year on year

In Medway the school leaving booster which protects against tetanus, diphtheria and polio is offered routinely to young people in school in Year 10, which is the school year when they are or become 15 years of age. For young people in Year 10 currently (born between 01/09/1997 and 31/08/1998) the uptake was 71.3%.

Other school age vaccinations

During the academic year 2013/14 a booster to protect against Meningitis C will be offered to young people at the same time as the school leaving booster.

Recommendations

- Continue to promote uptake of MMR vaccination in 10- to 16-year-olds
- Ensure successful introduction of the Meningitis C booster vaccination with the current school leaving booster and promote increased uptake.

Special Educational Needs and Disabilities

The Special Educational Needs (SEN) Code of Practice[47] describes children with special educational needs as having "a learning difficulty which calls for special educational provision to be made for them". A 'learning difficulty' is experienced by school-age children who:

(i) have significantly greater difficulty in learning than the majority of children of the same age: or

(ii) who have a disability which prevents or hinders them from using the regular educational facilities provided by the local education authority.

Recently the term Special Educational Needs and Disability (SEND) has become more widely used to describe this population, but it should be noted that some pupils with disabilities do not require SEN provision.

Those with SEND are recognised as being at higher risk of safeguarding issues, poverty and poor lifelong educational attainment. They may have restricted access to services due to lack of coordinated assessments and provision, and may be at increased risk of family breakdown.[48] Children and young people who are from vulnerable or disadvantaged backgrounds are much more likely to be identified as having SEND.

Research indicates that the number of children with SEND requiring specialist provision and services in Medway will increase over the next five years.[49] This is because of an increase in birth rate, the raising of participation age from 16 to 18 from September 2013, inward migration to the Medway area and increased survival of pre-term babies.

Table 30 shows the three levels of intervention for children and young people with SEND.

Table 30: Levels of intervention for SEN in England

Intervention	Description
School action	The school decides to make its own special provision that is in addition to or different from its usual differential approach to help children learn.
School action plus	The school provides support to the child but requires the support of external specialists and services
Statement	Local authority arranges provision for a child who requires support beyond which can be provided under the above two interventions

Source: SEN Code of Practice [48]

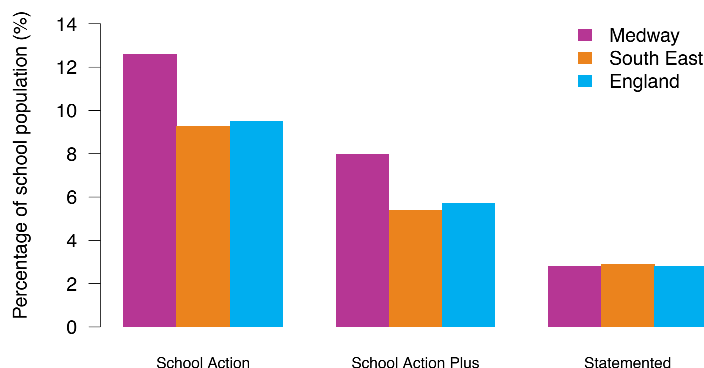
A statement of special educational needs (SSEN) is a formal document detailing a child's learning difficulties and the help that will be given. A statement is necessary where it is decided that a school is unable to meet a child's needs in spite of using all resources available at school action plus. To ascertain whether a statement is required, the local authority, where appropriate, carries out a statutory assessment and then has to decide whether to issue a statement.[50] The statement sets out the child/young person's needs, the educational provision and placement appropriate to meet them. The process currently takes 26 weeks from initial request to the issuing of a statement.

The January 2013 Medway school census showed 42,739 children and young people on the school roll, of which 9,992 have SEND[51] – 23.3% compared to 18.7% nationally.[52]

There is a relationship between SEND levels and poverty,[48] in general the more deprived wards in Medway have higher proportions of children with SEND.

Table 31 shows that there is a higher percentage of males than females with SEND at each level, with the percentage increasing with intervention level. Males are more prevalent in the cognition and learning difficulties category (over 77%), whereas young people with physical disabilities have a more even gender split. This mirrors the pattern nationally.

Figure 9: Percentage of the school population in each of the three intervention levels



Source: January 2013 School Census, Medway Council and Special Educational Needs in England, January 2013, Department for Education

Table 32 shows the number of pupils with SEND by ethnicity. Just under a quarter of White school pupils have SEND. Within this category, there are 252 pupils defined as Gypsy Roma, of which 48% are identified as having SEND.

Table 32: Ethnicity of pupils with SEND in Medway

Ethnicity	Total pupils	Pupils with SEND	% with SEND
White	36,132	8,822	24.4
Black	1,615	205	12.7
Mixed	2,195	470	21.4
Asian	2,044	277	13.5
Other	753	218	28.9

Source: January 2013 School Census, Medway Council

Table 31: The number and percentage of pupils with each level of need, by gender

Primary Need	Gender		Total Pupils	Gender %	
	Female	Male		Female %	Male %
School Action	2,054	3,321	5,375	38.2	61.8
School Action Plus	1,088	2,347	3,435	31.7	68.3
Statemented	334	848	1,182	28.3	71.7
Total	3,476	6,516	9,992	34.8	65.2

Source: January 2013 School Census, Medway Council

The age group with the largest number of SEND young people is nine-years-old representing 9.0% of the overall total. This is generally because schools or parents believe that although the pupil has managed in mainstream primary school, they would not be able to cope with mainstream secondary school. Pupils need a statement to access special schools and those places are generally requested at the end of Year five when the child is 10.

Rates of exclusion are rising in Medway, increasing the need for interim provision for both primary and secondary aged pupils. In academic year 2011/12, 1,118 young people received 2,475 fixed term exclusions (FTE) from Medway schools resulting in 7,244 school days lost. Of the total pupils with FTE, 96 had SSEN. The main SEN types were behavioural, emotional and social difficulties (47), autistic spectrum disorders (25), and moderate learning difficulties (15). This suggests that the needs of some pupils with SEND are not being addressed in all schools and are developing behavioural difficulties. Around 3% of the school population has SSEN, but accounts for around 10% of FTEs.

Services in Medway

There are four major areas of service provision in Medway:

- special schools – Medway has four special schools for pupils who have vulnerabilities including complex medical needs and complex, moderate, severe and profound and multiple learning difficulties;
- pupil referral units – these have an important role as Medway does not have any Emotional and Behavioural Disorder (EBD) special schools, although a bid has been submitted to enable The Oaks at Silverbank Park to become an EBD school. They work closely with the Inclusion Team to find alternatives to permanent exclusion;
- inclusive mainstream provision – additional resources are given where they would not normally be available in mainstream schools. A great variety of needs are catered for in this way, for example hearing impairment, speech and language;
- specialist services – schools and academies in Medway now hold much of the budget for purchasing these additional services. The Local Authority has statutory responsibility for providing some specialist services such as the Autism Outreach Team and Physical and Sensory Service, which increase schools' ability to meet the complex needs of those with SEND. In addition, the LA commissions support for schools from outreach teams based at Chalklands BESD unit, Danecourt primary and Bradfields secondary schools for those with significant behavioural or learning difficulties, sometimes with autism.

Educational psychologists are available when additional help is needed to understand why a pupil is not making progress or is struggling with aspects of school despite interventions being put in place.

The proportion of pupils with statements who are educated in local maintained provision has increased since 2009 and correspondingly, the number of pupils awaiting placement has significantly reduced and was zero in September 2012 (table 33).

Table 33: Placement of Medway pupils with SSEN

Placement	Percentage of total statemented pupils (as at September)			
	2009/10	2010/11	2011/12	2012/13*
Maintained LA	52.8%	51.0%	70.7%	83.7%
Not yet placed	29.1%	28.0%	12.0%	0.0%
Out area mainstream	1.4%	1.0%	1.1%	1.1%
Out area special	5.2%	6.0%	4.6%	4.2%
Independent- non maintained	9.4%	12.0%	10.2%	9.3%
Independent tuition	2.1%	2.0%	1.4%	1.6%

* Please note: 2012/13 has been adjusted following validation by the SEN manager
Source: Medway Council

The Onside Therapy Service, based on the Silverbank Park site, delivers therapeutic provision for young people at risk of exclusion and/or where emotional distress puts them at risk of developing further mental health issues. It is available for pupils with a variety of complex emotional needs, including those with SEN. The service has run since 2007 for secondary-aged children and has seen around 1,500 young people. There are a range of therapists including two reflexologists. Recently the service has started visiting primary schools.

From September 2014, the Government intends to replace SSENs with a single Education, Health and Social Care Plan (EHC Plan) which will detail a child/young person's educational, health and social care needs, and provision to meet them (including personal budget allocation). It is proposed that the EHC Plan could remain in place whilst a young person continues to access education up to the age of 19 years (and 25 years for a very small minority of those with the most complex needs).

Medway Council is one of 21 local authorities currently taking part in the Government "Pathfinder" project looking into new ways in which to assess the education, health and social care needs of children and young people, and the drafting of EHC Plans, to inform new legislation and the Code of Practice.

Under new legislation, each Local Authority will be expected to produce a Local Offer[o] detailing the support available to children and young people with SEND and their families and information about quality and outcomes achieved. Joint commissioning arrangements made by local authorities and clinical commissioning groups will underpin the health aspects of the local offer.

Recommendations

- Improve local interim provision for those with special educational needs and disabilities excluded from school.
- Consider commissioning local provision of residential or highly increased support for pupils with severe and complex needs to enable them to continue to benefit from local special. school education.

o. The Local Offer: LAs must publish, in one place, information about provision they expect to be available in their area to children and young people from zero to 25 years who have SEN (paragraph 4.1 draft Code of Practice).
The Local Offer must include information about: Education, health and care provision for children and young people with SEN (which should include information about its quality and destinations/outcome achieved by those who use it) (paragraph 4.5 draft Code of Practice).

You're Welcome in Medway

You're Welcome is a quality mark introduced by the Department of Health for all health services where young people aged 11 to 19 years are potential users. The aim is to develop a more young-people friendly service.

It is based on the principles that:

- all young people are entitled to receive appropriate health services;
- all young people's health services should take young people's needs into account;
- seamless service delivery for young people should be possible at all times and into adult services.

Services assess themselves against key quality criteria using a self-assessment toolkit. The criteria aims to improve acceptability, accessibility and the quality of services for young people and therefore also impacts on choice. There are ten quality standards that cover accessibility, confidentiality, publicity, safeguarding, staffing and training, together with some on specific health services. The active involvement of young people is embedded within the process to ensure that they have been consulted, listened to and responded to about the things that matter to them. Accreditation lasts for three years and services are required to update their assessments to secure continued accreditation.

Health services in Medway that have achieved You're Welcome accreditation:

- 2009 - CAST (CAMHS Tier 2)
- 2010 - Student Health Services in Hundred of Hoo secondary school
- 2010 - Student Health Services in Mid Kent College
- 2011 - Karsons City Way Pharmacy, Rochester
- 2012 - Student Health Services Thomas Aveling secondary school
- 2012 - Young Persons Drug and Alcohol service
- 2012 - Student Health Services delivered jointly at The Howard school and Rainham School for Girls

Health services in Medway working towards You're Welcome accreditation:

- Contraceptive and Sexual Health (CASH) Services at Balmoral, Rochester, Lordswood, Parkwood, Twydall and Keystone clinics
- Children and Adolescent Mental Health Services (CAMHS Tier 3)
- Dulwich Medical Centre, Walderslade
- Malling Health GP Practice, Rainham Healthy Living Centre
- College Health GP Practice, Stirling House, Luton
- Student Health Services Silverbank and Greenacre secondary schools and The Bishop of Rochester Academy
- School Nursing Service, MFT
- Young Offenders Institute, Cookham Wood
- Family Nurse Partnership

3 The lifestyle choices young people make

3 The lifestyle choices young people make

The Healthy Child Programme

The Healthy Child Programme (HCP)[53] sets out the good practice framework for prevention and early intervention services for children and young people aged five to 19 and recommends how health, education and other partners working together across a range of settings can significantly enhance a child's or young person's life chances. The foundations lie in the five Every Child Matters outcomes that children and young people identified as fundamental to their lives:

- being healthy: enjoying good physical and mental health and living a healthy lifestyle;
- staying safe: being protected from harm and neglect;
- enjoying and achieving: getting the most out of life and developing the skills for adulthood;
- making a positive contribution: being involved with the community and society and not engaging in anti-social or offending behaviour;
- economic well-being: not being prevented by economic disadvantage from achieving their full potential in life.

Healthy weight

Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the accumulation of excess body fat. This simplistic energy imbalance view is widely held to be true by health professionals and researchers, although alternative theories of the causes of obesity do exist. However, the general consensus is that there are many complex behavioural, biochemical and societal factors that combine to contribute to the causes of obesity.[54]

The Foresight report[54] referred to a "complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain". The report presented an obesity system map with energy balance at its centre. Around this, over 100 variables directly or indirectly influence energy balance. The following are some of the key variables that influence energy imbalance specific to children of a school age;

- access to opportunities for physical activity;
- children's control of diet;
- energy-density of food offerings;

- food exposure;
- genetic and/or epigenetic predisposition to obesity;
- level of recreational activity;
- level of transport activity;
- learned activity patterns in early childhood;
- portion size;
- TV watching.

Being overweight or obese in childhood has consequences for health in both the short term and the longer term. The emotional and psychological effects of being overweight are often seen as the most immediate and serious by children themselves. They include teasing and discrimination by peers; low self-esteem; anxiety and depression. Obese children may also suffer disturbed sleep and fatigue.[55]

Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity – for example, raised blood pressure, fatty changes to the arterial linings and hormonal and chemical changes, such as raised cholesterol and metabolic syndrome – can be identified in obese children and adolescents.[55]

Some obesity-related conditions can develop during childhood. Type 2 diabetes, previously considered an adult disease, has increased rapidly in overweight children as young as five. The global rise in obesity and Type 2 diabetes among children and adolescents has led to an urgent call for action, with the warning that the world is currently facing a twin epidemic of obesity and Type 2 diabetes in young people. Other health risks of childhood obesity include early puberty, eating disorders such as anorexia and bulimia, skin infections, asthma and other respiratory problems and some musculoskeletal disorders.[55]

The most recent government ambition is to achieve a sustained downward trend in the level of excess weight in children by 2020. From the mid-1990s, levels of childhood obesity have increased at a steady pace, and despite trend lines suggesting a plateau in the levels in the last few years, this target is particularly ambitious, and will require significant contributions from a wide range of partners and organisations to be achieved.[56]

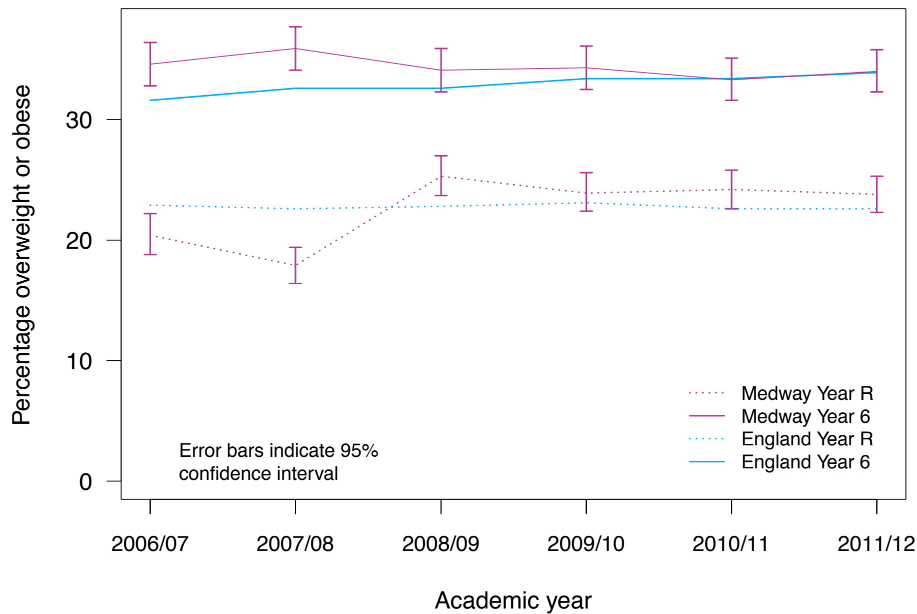
Levels of childhood obesity in Medway

The National Child Measurement Programme (NCMP) was established in 2006 and is operated jointly by the Department of Health (DH) and the Department for Education (DfE). Every year, as part of the NCMP, children in Reception (aged four to five years) and Year 6 (aged 10 to 11 years) have their height and weight measured to inform local planning and delivery of services for children; and gather population-level surveillance data to allow analysis of trends in growth patterns and obesity.

When measuring a population of children (for example reporting NCMP findings) weight status is defined using the following UK90 population cut points. These cut points are slightly lower than the clinical cut points; this is to capture those children with a weight problem and those at risk of developing a weight problem (ie those children who may be on the border line of the clinical definition). This helps ensure that adequate services are planned and delivered for the whole population.

Underweight: ≤ 2nd centile
Healthy weight: >2 - <85th centile
Overweight: ≥ 85th centile
Obese: ≥ 95th centile

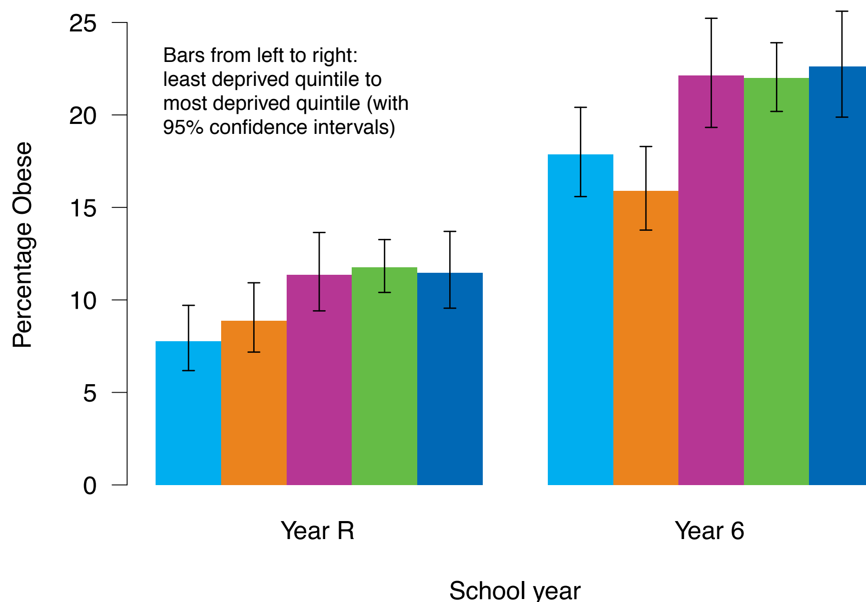
Figure 10: Trends in the percentage of pupils measured in NCMP classified as either overweight or obese



Source: NCMP online tables, Health & Social Care Information Centre

Figure 10 shows that in 2011/12, 23.8% of four to five-year-olds and 34.0% of 10 to 11-year-olds are classified as overweight or obese in Medway. This is slightly higher than the national average, which is 22.6% and 33.9% respectively, but the difference is not statistically significant. The Marmot Review reported that obesity is associated with social and economic deprivation across all age ranges and is becoming increasingly common.[1] In Medway there is a clear gradient in obesity prevalence across deprivation quintiles in both Year R and Year 6 (figure 11).

Figure 11: Percentage of Medway pupils measured in NCMP classified as obese by national deprivation quintile (2009/10 to 2011/12)



Source: NCMP pupil dataset, National Obesity Observatory, Public Health England

It is clear from table 34 that there is considerable variation in the proportion of pupils classified as obese, overweight and healthy weight among electoral wards in Medway. The cells have been shaded orange or blue depending on whether the proportion is significantly worse or better respectively than the England average by comparing the 95% confidence intervals.

Table 34: Percentage of pupils measured in NCMP classified as obese and being a healthy weight by electoral ward (2009/10 to 2011/12) ranked by deprivation score (from high to low)

Electorial ward	Reception			Year 6		
	Healthy weight	Overweight	Obese	Healthy weight	Overweight	Obese
Luton and Wayfield	75.6	12.9	10.7	61.0	12.9	**24.5**
Gillingham North	**72.2**	**16.3**	11.4	62.9	**11.5**	**24.2**
Chatham Central	**72.4**	15.8	11.1	66.4	12.3	20.6
Gillingham South	74.3	12.2	**12.9**	**61.0**	13.2	**24.3**
Strood South	**71.5**	13.4	**13.8**	**59.7**	16.5	**23.0**
Rochester East	76.9	11.6	9.8	67.5	13.0	18.8
River	77.1	15.1	6.5	65.1	15.4	17.9
Twydall	74.8	11.5	**13.5**	64.7	15.4	19.0
Strood North	76.5	13.1	10.0	64.3	13.3	20.3
Peninsula	74.6	15.7	9.7	63.8	14.8	20.0
Princess Park	73.0	15.4	11.7	64.2	11.3	**23.3**
Rochester West	77.6	13.3	9.0	**75.2**	**9.6**	13.8
Waterslade	75.8	13.5	9.7	**58.7**	15.5	**25.2**
Strood Rural	77.1	13.9	8.6	66.2	13.7	19.7
Lordswood and Capstone	75.8	14.3	9.6	65.7	12.4	20.1
Watling	80.5	11.0	8.1	69.8	**10.2**	18.5
Rainham North	77.2	12.9	9.9	67.9	12.1	18.3
Rainham South	**82.3**	10.6	7.1	66.7	14.3	17.6
Rochester South and Horsted	75.9	13.1	10.7	60.8	**19.2**	18.6
Cuxton and Halling	78.0	14.3	7.7	64.2	13.8	22.0
Rainham Central	78.2	13.6	7.6	**70.9**	14.6	**13.7**
Hempstead and Wigmore	82.5	11.3	5.6	**75.7**	14.0	**9.5**
Medway total	75.6	13.6	10.2	64.9	13.7	20.3
England total	76.3	13.2	9.6	65.2	14.6	19.0

Source: NCMP pupil dataset, National Obesity Observatory, Public Health England

Services in Medway

The Medway Public Health Directorate provides services that support children and young people to achieve a healthy weight. These projects include four MEND (Mind, Exercise, Nutrition, Do it!) programmes (2-4, 5-7, 7-13 and Graduates). A weight management programme for 13- to 17-year-olds is also being piloted during 2013.

MEND programme attendance and content is summarised in table 35.

Table 35: MEND weight management programmes run in Medway

Programme eligibility	Description	Start date	Number of children completing a programme
MEND 2-4 (previously called Mini MEND) Open to all two- to four-year-olds of any weight status. Targeted at families who are at risk of excess weight or children who are fussy eaters.	It helps families deal with fussy eating and encourages children to eat a wider variety of foods. Sessions take place during the daytime in children's centres and community venues across Medway One session a week for 10 weeks, lasting one hour 30 minutes	April 2009	146 children 24 programmes
MEND 5-7 For families with five- to seven-year-olds who are above a healthy weight for their age and height (BMI on or above the 91st percentile)	The programme helps families develop healthier habits and sets goals and rewards to encourage healthy behaviours. One session a week for 10 weeks, lasting one hour 45 minutes.	October 2011	12 children 3 programmes
MEND 7-13 For families with seven- to 13-year-olds who are above a healthy weight for their age and height (BMI on or above the 91st percentile)	The sessions allow families to explore healthy behaviours while having fun, being active, boosting confidence and self-esteem. Sessions are run after school,and use games, exercises and theory to promote a healthy lifestyle. Two sessions a week for 10 weeks, lasting one to two hours each.	January 2007	265 children 39 programmes

While MEND Central (national centre) produces a report after each programme showing the number of children who lost weight, as yet a whole service review in Medway has not been completed to assess the equitability and effectiveness of the programmes.

The adolescent pilot programme (FitFix) has been established based on health professional recommendations, as existing weight management support services are for children aged 13 years and younger, and for adults aged 18 years and over. Designed to help young people work towards a healthy weight, the 12 week FitFix course encourages healthy eating and physical activity to improve health and well-being. The course gives participants the chance to learn cooking skills and take part in weekly exercise classes and gym based personal trainer sessions.

The main concerns of the seven young people completing the first pilot were that weight is hard to lose, it may be gained quickly and that people's perceptions of them were negative. Influences on weight were identified as the media, family members, doctors and friends. Feedback on FitFix was all positive – portion control, fun ways to exercise, weight loss and boosted confidence and self-esteem were all mentioned with one participant saying, "it gave me strength to turn away from unhealthy foods and it gave me confidence."

The Public Health Directorate also provides a Community Food programme that encourages people to make healthy food choices and enjoy a healthy diet, providing training, resources, awareness road shows and healthy recipes. The Community Food team plays a key role in supporting external partners with similar tasks, acting as an expert resource.

Medway Community Healthcare is commissioned to provide a specialist dietetics and nutrition service within Medway. The service supports children who are classified as obese, with no co-morbidities or complex needs, providing one-to-one specialist dietetic input supporting them to lose weight and improve nutritional intake.

Reducing obesity levels is a complex problem, requiring a multi-agency approach. Departments within Medway Council contribute, for example, by offering free swimming to those under 11 years of age, encouraging more people to participate in sport, delivering mass participation events including the Medway Mile, managing over 1,900 hectares of land owned by Medway Council for public recreation, sport and play and promoting walking to school initiatives.

"it gave me strength to turn away from unhealthy foods and it gave me confidence."
- FitFix participant

Recommendations

- Ensure decision makers and all practitioners and professionals, understand the role that they can play in supporting children and young people to achieve a healthy weight, become more active and eat healthily.
- Raise awareness that being a healthy weight, active and eating a balanced diet is important to a child's health.
- Ensure that parents are aware of local services and facilities that can enable children to make lifestyle changes.
- Develop the physical environment so that healthy eating and physical activity becomes the norm rather than the exception, creating a less obesogenic Medway.

- Map the local assets to assess what services and facilities exist to support the healthy weight agenda, then consult with local residents and review the evidence base, to assess the gaps that may exist

Substance Misuse

The consequences of young people's use of alcohol and drugs have been widely researched through a number of studies. Strong correlations are known to exist between substance misuse and increased truancy, poor examination results, risky sexual behaviour, teenage pregnancy and a significantly increased likelihood of being in a road traffic accident. [57-59]

Parental substance misuse also has impact on young people's wellbeing. Not all parents would consider their substance misuse issues to adversely impact on their children's development.[60] However, the vast amount of research conducted which examines the effects of parental substance misuse, and specifically alcohol misuse on young people, has shown it can have a significant impact on many aspects of a young person's life. These have been seen to include issues around attachment, formation of family dynamics and wider relationships, while also putting them at an increased risk of being subjected to or witnessing instances of violence.[61]

Levels of substance misuse

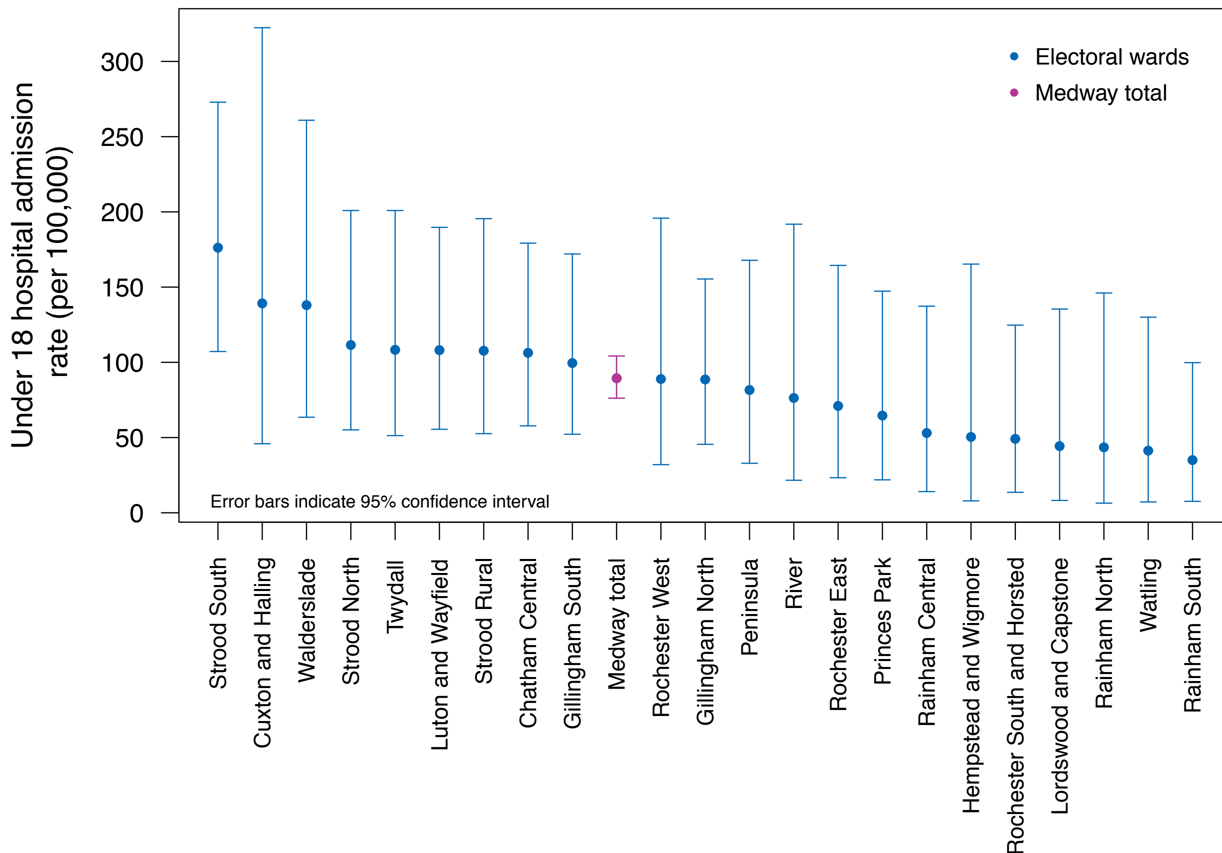
Published data indicate a downward trend nationally in the drug use of young people aged between 11 and 15. Reductions in numbers of pupils reporting having ever taken drugs has fallen from 29% in 2001 to 17% in 2011.[62] Individuals were more likely to have taken drugs within the last year the older they were, but no significant differences in use were observed between genders.[62] It was observed that a minority of those who have used a drug within the last year, did so on a regular basis with 35% of those who had taken drugs in the last year also reporting having used drugs once a month or more. This equates to 3% of the total population of 11 to 15-year-olds using a drug once a month or more, with cannabis being the most likely drug used, despite its overall use by young people in this age group reducing from 13.4% in 2001 to 7.6% in 2011.[62,63] Applying this to Medway's resident population aged 11 to 15 years suggests that 510 young people might be using a drug once a month or more.

Between 2003 and 2011, the proportion of 11- to 15-year-olds that reported never to have consumed alcohol rose from 39% to 55%. Between 2001 and 2011, of the 11- to 15-year-olds who did consume alcohol the proportion reporting to have not consumed alcohol within the last seven days reduced from 26% to 12%. Those who do drink often report drinking more frequently and in larger volumes than those in previous years. The most common methods of obtaining alcohol reported in a national survey were through a friend (23%), from parents (20%) and through a proxy purchase (15%), whereby a young person asks an adult often unknown to them to purchase the alcohol on their behalf.[64]

Locally, young people reporting having never had an alcoholic drink (defined as more than a sip) has increased since the last TellUs survey[65] was completed in 2010, from 48% to 51% in 2012. However, as with the national data, those who are drinking are doing so more regularly.

Figure 12 shows the rate of admissions to all hospitals of Medway residents under 18-years-old for alcohol attributable conditions. There is no statistically significant difference between the wards but Strood South is significantly higher than the Medway average. The number of admissions ranges from eight wards having a count less than five to Strood South with 20 admissions.

Figure 12: Under 18 average annual hospital admission rate for alcohol attributable conditions by Electoral ward (April 2010 to March 2013)



Source: Secondary Uses Service via KMHIS Data Warehouse

Between 2006/07 and 2012/13 the total number of admissions in Medway residents aged under 18 where substance misuse is mentioned (not only the primary diagnosis) has remained largely the same, varying between 22 and 28 admissions per annum. Substance misuse conditions in this instance include mental and behavioural disorders due to the use of opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants, hallucinogens, volatile solvents. Also poisoning by narcotics, psychodysleptics, psychostimulants with abuse potential and toxic effect of organic solvents, other gases, fumes and vapours.

Services in Medway

Young people's substance misuse treatment is provided by KCA. Young people present to the specialist service through various routes including self-referral but typically are referred by; youth justice, education, children and family services, friends and family, young persons' housing providers and mental health services. KCA also has a dedicated young person's intervention worker delivering training to professionals on how to use the DUST (Drug Use Screening Tool) to assist in the identification of young people with substance misuse issues.

During 2012/13 a total of 108 young people received treatment for their substance misuse issues. Of that number, 78 were new presentations to the treatment service. All young people were seen by the treatment service within three weeks of a referral being received. The two consistently most common substances used by young people in treatment are cannabis and alcohol.[63]

The types of treatment options, which are available include: cognitive behavioural therapy, young person psychosocial counselling, motivational interviewing, relapse prevention, family work, harm reduction and specialist pharmacological support.

Recommendations

- Review the current Personal, Social and Health Education (PSHE) provisions in conjunction with local schools for secondary age children.
- Undertake a review and needs assessment of current provisions for young peoples' substance misuse treatment and ensure provisions are made for transition to adult treatment services where appropriate.

Smoking and tobacco control

Smoking remains the leading cause of preventable death and disease in England and is one of the most significant factors that impacts on health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease. Reducing smoking prevalence therefore remains a key public health priority and a national focus.[66]

There were nearly 80,000 deaths due to smoking in England during 2011. There is also an impact on smokers' families; each year, UK hospitals see around 9,500 admissions of children with illnesses caused by secondhand smoke.[67]

Child and adolescent smoking causes serious risk to respiratory health both in the short and long term. Children who smoke are up to six times more susceptible to coughs, wheeziness and shortness of breath than those who don't smoke. This can lead to poor school attendance levels.[68]

There are still more than 8 million smokers in England. By the end of 2015, the government wants to reduce smoking rates to:

- 18.5% or less for adults (compared to 21.2% for April 2009 to March 2010) - meaning around 210,000 fewer smokers per year;
- 12% or less for 15-year-olds (compared to 15% in 2009);
- 11% or less for pregnant women, measured at the time of giving birth (compared to 14% in 2009/10).

The 2013-2016 Public Health Outcomes Framework (PHOF) includes reducing the prevalence of smoking among 15-year-olds as a specific smoking related outcome within the health improvement domain.[69] The Department of Health is currently assessing the feasibility of establishing a survey to provide this information.

Levels of smoking in children and young people

It was estimated in 2011 that over 200,000 children (aged 11 to 15 years) start smoking in the UK every year. This means that nearly 570 children are becoming smokers for the first time every day.[68] Around 40% of regular adult smokers started smoking before the age of 16 and 35% of 11- to 15-year-olds believe that it is acceptable to try smoking to see what it is like.[68] Local data on the prevalence of smoking amongst young people are limited and this is an area for development.

Why children and young people smoke

Smoking initiation is associated with a wide range of risk factors including parental and sibling smoking, the ease of obtaining cigarettes (commonly via underage sales and illegal tobacco), smoking by friends and peer group members, socio-economic status, exposure to tobacco marketing, and depictions of smoking in films, television and other media.[68] The illegal tobacco trade also contravenes the regulatory regime for tobacco. For example sellers often target children and young people who are finding it increasingly difficult to buy under the age of 18 from responsible retailers.[70]

In 2010, 'Explain' was commissioned to undertake a comprehensive piece of scoping research, designed to explore young people's experience and perception of smoking, which included an in-school survey of 444 Medway students aged 11 to 16 years. This research found that:

- the two main reasons for trying smoking are curiousity and encouragement from friends; 52% stated that they felt there was pressure in school to smoke;
- positive role models are very important and there is a need to 'de-normalise' smoking. Young people seemed to have the impression that "everybody smokes" (66% of the sample agreed with the statement 'most adults smoke') and this increased levels of curiousity and the feeling that smoking is normal and acceptable;
- the factors enabling young people to smoke were proxy sales, parents providing cigarettes, older siblings and friends, underage sales and the availability of illegal tobacco. A large number of the sample had smoked fake (41%) or foreign (56%) cigarettes before and the older the child, the more likely they were to have tried smoking;
- young people are interested in quitting; 77% of smokers in the sample had tried to quit in the past.

Evidence suggests that early uptake of smoking is associated with subsequent heavier smoking, higher levels of dependency, a lower chance of quitting and higher mortality.

Young people who played truant from school or who had been excluded from school in the previous 12 months were almost three times more likely to smoke regularly compared to those who had never truanted or been excluded[68]

Smoking in pregnancy

The impact of smoking during pregnancy on maternal and foetal health is significant and can result in an increased risk of miscarriage, preterm birth, low birthweight and still birth. It is associated with sudden infant death syndrome, childhood respiratory illness and attention deficit hyperactivity disorder.[66]

Secondhand (passive) smoking can increase the risk of other health problems including cancer. Breathing in secondhand smoke is particularly harmful for children. Children who breathe in secondhand smoke have an increased risk of:

- cot death (sudden infant death syndrome or SIDS) – this is twice as likely in babies whose mothers smoke;
- developing asthma – smoking can also trigger asthma attacks in children who already have the condition;
- serious respiratory conditions such as bronchitis and pneumonia – younger children are also much more likely to be admitted to hospital for a serious respiratory infection;
- meningitis;
- coughs and colds.

Children who grow up with a parent or family member who smokes are three times as likely to start smoking themselves.[71]

Table 36 shows the smoking status of mothers at time of delivery, taken from a maternity needs assessment conducted in 2009.[72] The table clearly shows that mothers in younger age groups are more likely to smoke at time of delivery. This is particularly pertinent in Medway as the under 18 conception rate is higher than both the England and South East averages.

p. regular = at least once a week

Table 36: Smoking status at time of delivery by mother's age, Medway

Smoking status	Mother's age						
	15-19	20-24	25-29	30-34	35-39	40-44	45+
Yes	41.7%	26.3%	16.2%	10.7%	14.3%	13.1%	25.0%
No	58.3%	73.7%	83.8%	89.2%	85.7%	86.9%	75.0%
Unknown	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%

Source: Acute Trust Maternity Dataset, KMPHO, 2008

The interventions aimed at pregnant women who smoke will also benefit the health of any other children already in the family.

Smoking prevalence in Medway in 2011 was estimated to be at 23.6%.[73] A study completed locally in 2013 of 1,000 pregnant women found a smoking prevalence of 23%.[74] Of the 647 participants aged 16 to 24 years, 25.2% smoked and of the 353 participants aged 25 to 35 years, 19.0% smoked.

Services in Medway

The primary role of the stop smoking service is to provide a high-quality clinical smoking cessation service to the population of Medway. The service is delivered following the abrupt model (quitting completely), supporting a motivated smoker to stop. Medway Stop Smoking Service (SSS) provides a range of services across the area and is delivered by Public Health and other trained staff at venues across the community.

Medway SSS is responsible for delivering evidence-based seven week stop smoking courses, drop-in clinics, workplace courses and telephone support. Access to the service in Medway is via referral from healthcare professionals/community health teams or self-referral by telephone, email or through the national helpline.

The evidence base for preventative strategies aimed at young people is improving. Stop Smoking Services are available for young people who want to stop smoking in Medway and a specialist adviser is in post to support those that want to quit.

Table 37 shows the number of young people under 18 accessing the SSS in Medway and the number who successfully quit smoking. More young people accessed the service in 2012/13, but a smaller proportion successfully quit compared to 2011/12 (23% compared to 33%).

Table 37: Quit success for young people aged under 18 in Medway

	2011/12	2012/13
Quit date set	76	88
Quit	25	20

Source: S3 Manager

The ASSIST (A Stop Smoking in School Trial) Programme has been commissioned in Medway. This is an evidence-based tobacco control programme aimed at reducing smoking amongst young people. Year 8 (age 12 to 13 years) students will be asked to nominate the most influential students in their year group. These students will then be invited to train as 'Peer Supporters' with the aim of disseminating new norms of smoking behaviour through students' established social networks. National research has shown ASSIST to reduce smoking prevalence by 2.1% and to be a cost effective intervention.[75] Other local area studies have shown ASSIST to result in significant changes in attitude to smoking in young people.

Peer supporter training will:

- enhance knowledge of harmful effects of smoking and the benefits of remaining smoke free;
- improve the communication skills needed to promote the smoke free message;
- increase confidence and thus enable Peer Supporters to have informal conversations with their peers about the risks of smoking and the benefits of being smokefree.

A challenge for Medway is to ensure implementation of the National Institute for Health and Care Excellence (NICE) Guidance 'PH23: School-based interventions to prevent smoking', which recommends that key partners should:

- develop a whole-school or organisation-wide smoke free policy;
- ensure the policy forms part of the wider healthy school or further education strategy;
- apply the policy to everyone using the premises for any purpose, at any time;
- widely publicise the policy and ensure it is easily accessible;
- ensure the policy supports smoking cessation in addition to prevention.[68]

Medway Council has commissioned Babyclear to provide training and support to midwives in order to reduce smoking in pregnancy. The training includes use of a risk perception tool, carbon monoxide monitoring and brief intervention, giving midwives the advanced skills to work effectively with pregnant women. New guidance released in February 2013 recommends monitoring the growth of a foetus of a pregnant smoker very closely because of the risks associated.[76]

Recommendations

- Roll out the ASSIST programme in secondary schools in Medway.
- Improve parental awareness of the harmful effects of second hand smoke and reduce their children's exposure to it.
- Continue to roll out Babyclear to decrease smoking during pregnancy.

Sexual health

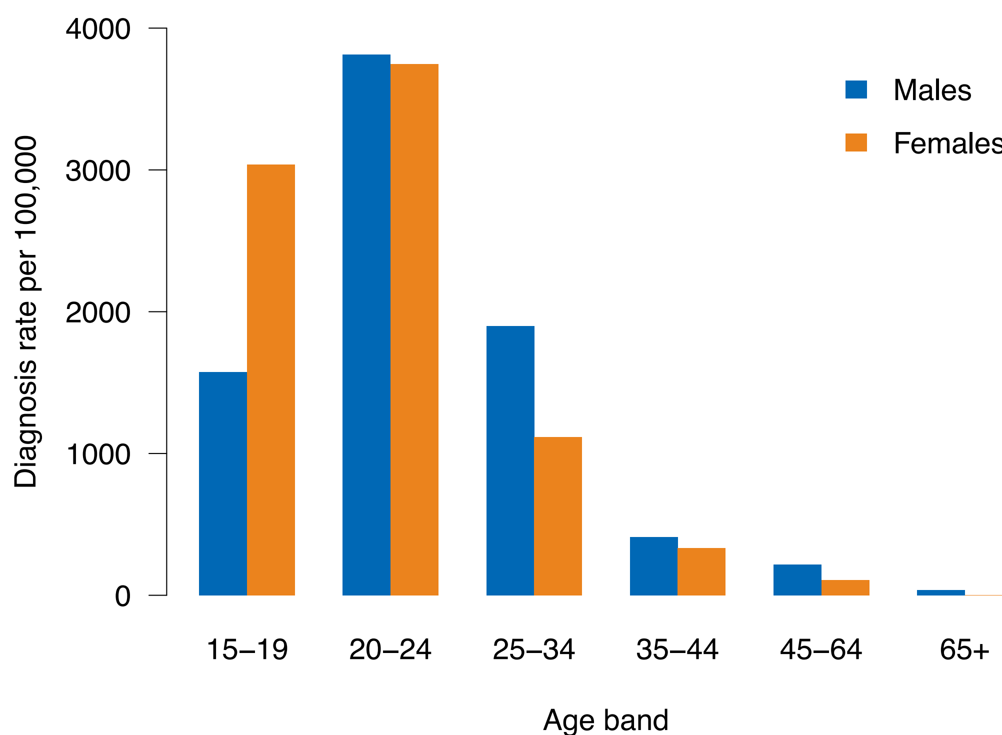
Sexual health includes sexually transmitted infections (STIs) (including HIV), contraception, relationships, and abortion. Achieving good sexual health is complex and there are variations in need for services and interventions for different individuals and groups. The National Framework for Sexual Health 2013/14 sets out a life course approach to achieving better sexual health. Broadly the ambitions for young people under the age of 16 are about improving access to relationships and sex education (RSE), advice and support as well as building resilience and skills to delay sexual activity. Ambitions for 16- to 24-year-olds identify that prevention should be prioritised and focus more on access to services.
Two indicators in the Public Health Outcomes Framework (PHOF), apply specifically to young people – chlamydia diagnoses for 15 to 24-year-olds and under 18 conceptions, both of which are explored in this section.

Sexually transmitted infections

Young people, aged 15 to 24 years, experience the highest rates of sexually transmitted infections STIs (figure 13). In 2012 in Medway, this age group comprised 72% of all newly diagnosed chlamydia cases, 56% of warts, 51% of herpes and 37% of gonorrhoea.

Increases in diagnoses reflect greater ascertainment of cases through more testing and improved diagnostic methods, as well as indicating increased unsafe sexual behaviour among young people.

Figure 13: Diagnosis rate of new acute STIs in Medway patients by age and gender in 2012

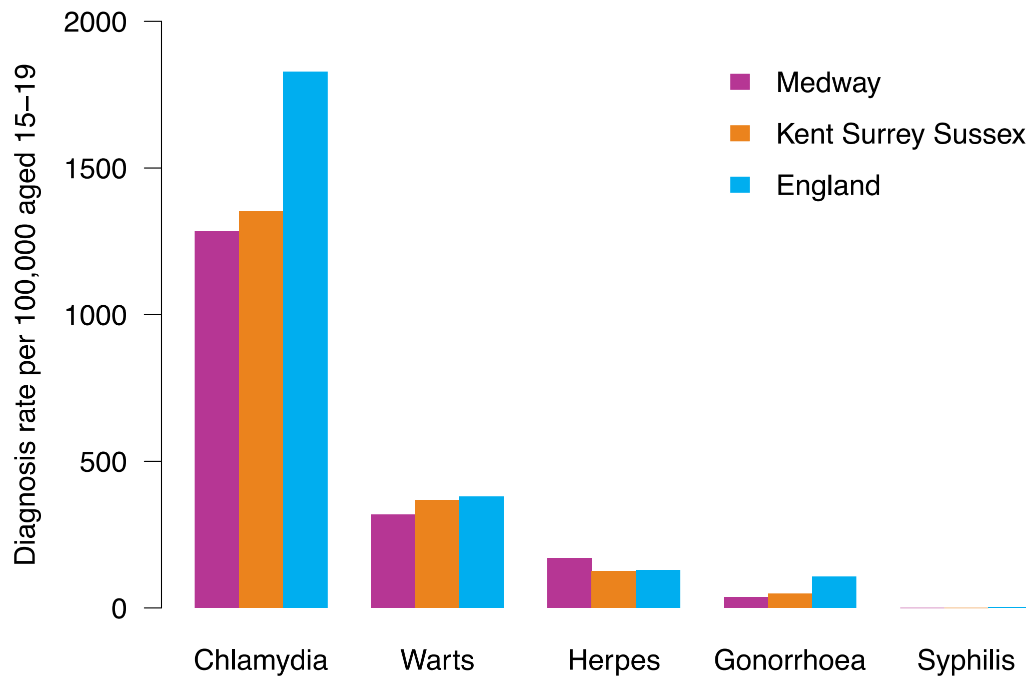


Source: GUMCAD system, Public Health England

q. Acute STIs include: chlamydia, gonorrhoea, non-specific genital infection (NSGI), syphilis (primary, secondary and early latent), lymphogranuloma venerum, chancroid, donovanosis, genital herpes simplex (first episode), genital warts (first episode), new HIV diagnosis, molluscum contagiosum, trichomoniasis, scabies, Pediculosis pubis

Figure 14 shows the diagnosis rate of sexually transmitted infections amongst 15- to 19-year-olds in Medway compared to the Kent, Surrey and Sussex Public Health England Centre and England overall. In 2012, there were 242 diagnoses of chlamydia, corresponding to a rate of 1,283 per 100,000. In addition there were 60 cases of warts, 32 cases of herpes and seven cases of gonorrhoea. The total cases of syphilis were less than five so the rate has been suppressed to protect patient confidentiality. The various rates in Medway are similar to the Kent, Surrey and Sussex Centre, but are significantly less than England for chlamydia and gonorrhoea.

Figure 14: Diagnosis rate of selected sexually transmitted infections in 2012



Source: GUMCAD and STI Annual Data Tables, Public Health England

Services in Medway

Sexual health services include the provision of advice and services for contraception, relationships, sexually transmitted infections (STIs) (including HIV) and abortion. Provision of sexual health services is complicated and there is a wide range of providers, including general practice, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sectors.

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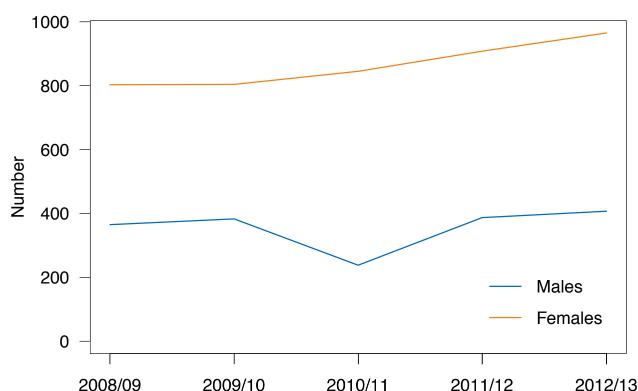
(i) Genito-Urinary Medicine (GUM) services

STIs are predominantly diagnosed in Genito-Urinary Medicine (GUM) clinics, apart from chlamydia where tests are also performed in community settings such as Contraceptive and Sexual Health (CASH) services, pharmacies and general practices.

Figure 15: Number of first attendances at a GUM clinic for Medway residents aged under 20



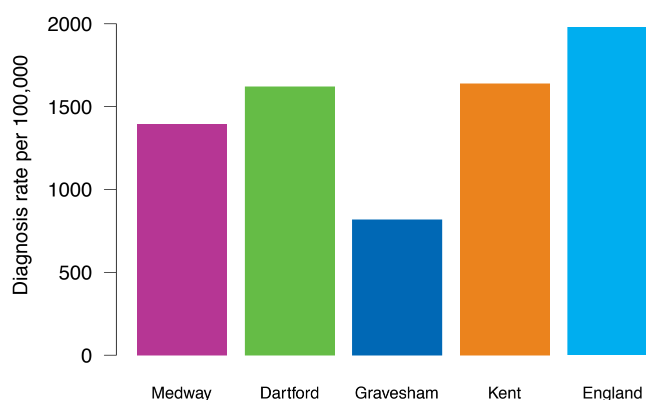
Source: GUMCAD, Public Health England

There are more than twice as many first GUM attendances for females aged under 20 compared to males. Over the last five years, the number of first GUM attendances in this age group has risen by about 17% compared to 18% for all ages.

(ii) Chlamydia screening

One of the aims of the National Chlamydia Screening Programme is to ensure that all local areas achieve a diagnosis rate of 2,300 per 100,000 15- to 24-year-olds in order to significantly reduce the prevalence of the infection within the population. In 2012, the rate in Medway was 1,394 compared to the overall England rate of 1,979.[77]

Figure 16: Chlamydia diagnosis rate for 15- to 24-year-olds



Source: Public Health England

(iii) Contraceptive and Sexual Health (CASH) services

Prevention of STIs is prioritised within Contraceptive and Sexual Health (CASH) and GUM services. Young people are a priority group within the specification for CASH Services. CASH provides open access clinics and young people only clinics to improve access and reduce any stigma. In addition, school based CASH services are currently available in six secondary schools and further education sites. Evidence from the 'Got it Covered' campaign in 2009 showed that young people did not want to carry condoms for fear of being perceived as promiscuous.[78] According to the National Framework for Sexual Health 2013/14 a recent study revealed that around 20% of young people said that they had recently had unprotected sex with a new partner and only one-third said that they always used a condom.[78]

Table 38: Number of attendances to CASH services in Medway of young people, August 2012 to July 2013

Setting	Under 16	16-18
Looked after children's nurse	64	107
School/college (Sept 2012 to July 2013)	235	249
Clinics	451	1,645
Outreach	85	327

Source: Kent Community Health NHS Trust

(iv) C Card scheme

Medway offers a C Card scheme, available to young people aged 13 to 20[r], which allows C Card holders to obtain free condoms from a range of outlets such as pharmacies and youth services as well as more traditional providers such as clinics. Broader advice on sexual health is also offered as part of these schemes. Within the school/college setting there were 130 C Card registrations between September 2012 and July 2013.

Over recent years developments have been made to improve access to sexual health services, work is currently being undertaken to improve C Card registration and access and a student health service regularly holds sessions at several schools in the Medway[s] area to reduce barriers to sexual health service access.

(v) Emergency hormonal contraception

Between April and August 2013, a total of 241 young people aged 14 to 18 years accessed emergency hormone contraception from pharmacies in Medway . This does not include those accessing it via another service or by prescription. Approximately half (124) of these patients reported having unprotected sex and the rest reported problems with contraception, condoms being the main method used.[106]

r. Young people accessing the service aged 13 to 15 will be required to meet the Frasier Guidelines to ensure competency and safeguarding are met

s. Emergency hormonal contraception is provided free of charge to young people under 20-years-old through pharmacies in Medway

(vi) Education and training

In 2012 Medway Public Health Directorate reviewed the training needs of the wider workforce, such as teachers, youth workers etc, in relation to sexual health. Lesbian/gay, transgender and those with a learning disability were identified as gaps when working with marginalised groups of young people; long acting reversible contraception (LARC), HIV and sex and the law were gaps in knowledge. As a result Public Health worked with partners to develop and publish RSE Policy and Practice guidance documents for use by Medway schools and other partners (lesson plans, tutor teaching notes, practical resources, Medway RSE policy, national and local policies and guidance). This policy aims to ensure that within Medway, the approach to RSE delivery is young person centred, evidence-based, aligned with legislative guidance, and delivered in an age appropriate manner. There is a need to ensure young people have access to high quality RSE across a variety of educational and other settings to equip them with the knowledge and skills to make safe, informed choices regarding their personal and sexual health. There are universal services available to all young people; however provision for one-to-one sexual health improvement work with young people identified as 'high risk' is limited. Work is being undertaken to explore ways of identifying and working with young people who may have additional risk factors.

Personal, Social, Health and Economic Education (PSHE) remains a non-statutory part of the curriculum despite being the subject of a Department for Education review published in March 2013.[79] In Medway there have been significant changes to schools recently with the introduction of Academies, but no formal review of PSHE provision has been undertaken. The Ofsted review of PSHE "Not yet good enough" identifies gaps in delivery nationally and makes recommendations on how to address these.

Teenage Pregnancy

Reducing under 18 conceptions has been a long standing national and local priority. Most teenage pregnancies are unplanned and,[80] as shown in table 39, around 50% of under 18 and 61% of under 16 conceptions result in pregnancy termination. In 2012 there were 77 abortions in women aged under 18 and 136 in women aged 18 or 19. These two groups represent just under 20% of all abortions for this year.[81] Of the 132 women aged under 19 resident in Medway CCG who had an abortion in 2012, 19 had repeat abortions – a proportion of 14.4% compared to 10.5% nationally.[82]

Table 39: Percentage of under 18 and under 16 conceptions leading to abortion

Area	Under 18, 2011			Under 16, 2009-2011	
	Conception rate per 1,000 females	Abortion rate per 1,000 females	Percentage leading to abortion	Conception rate per 1,000 females	Percentage leading to abortion
Medway	38.8	19.6	50.5	8.2	60.7
South East	26.1	13.5	51.7	5.4	61.8
England	30.7	15.1	49.3	6.7	61.1

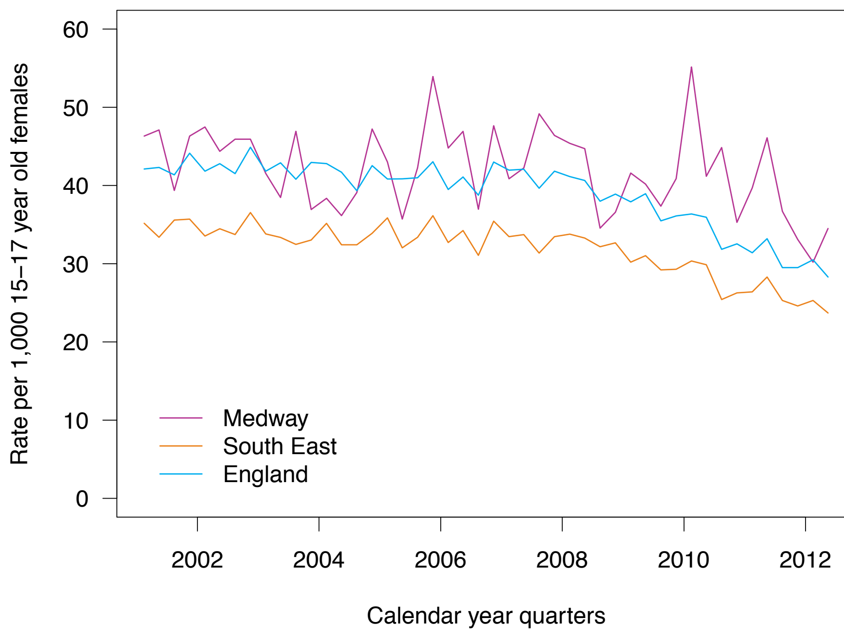
Source: Office for National Statistics, Conception Statistics

For many teenagers, bringing up a child can be difficult, resulting in poor outcomes for both the parent and child in terms of the emotional well-being of the mother, the baby's health and the long term likelihood of the child living in poverty.[80] The impact of poverty on health and life chances is well documented, creating health inequalities and a social gradient in health.[1] The cost of health inequalities can be measured in human terms, by years of life lost, and in economic terms by the cost of additional illness.

The potential impact of teenage pregnancy across the life course of both mother and child, highlights the need for a public health cross-organisational approach that seeks to improve health and reduce health inequalities through prevention and early intervention.

Medway is within the 41% most deprived areas nationally[83] and teenage conception rates are also higher than the South East and England as a whole.[84] In 2011 there were 206 conceptions to under 18s which is equivalent to a rate of 38.8 conceptions per 1,000 females aged 15 to 17 years (see figure 17). This has fluctuated over time, but 2011 is the lowest year since Medway became a Unitary Authority in 1998. However, there is still work to be done to further reduce the rate and improve outcomes for children and young people.

Figure 17: Under 18 conception rate, 2001 to 2011



Source: Office for National Statistics [recalculated using revised mid-year population estimates]

In 2009 to 2011 there were 122 conceptions to under 16s which is equivalent to a rate of 8.2 conceptions per 1,000 females aged 13 to 15 years (a reduction of 13 conceptions compared to 2008 to 2010). This is higher than the South East (5.4 conceptions per 1,000 females) and England (6.7 conceptions per 1,000 females).

Areas of high social disadvantage and deprivation typically correlate with high teenage pregnancy rates for reasons such as low aspirations, poor uptake of services and the cyclical nature of teenage pregnancy. Medway is typical of this trend, with Gillingham South, Gillingham North, Luton and Wayfield and Chatham Central having the highest rates of teenage conceptions and highest levels of deprivation.

Recommendations

- Develop a robust, evidence based Relationship and Sex Education (RSE) package with input from young people and provide support to schools to deliver this, using a range of formats.
- Develop and implement evidence-based targeted interventions for young people identified as being at high risk of or undertaking risky sexual behaviour.
- Ensure there is access to high quality sexual health services in a range of settings.
- Review the C Card scheme and update it to ensure adequate training has been delivered to all providers.

4

The wider determinants of health

4 The wider determinants of health

Looked after children and young people

Children and young people who are looked after are amongst the most socially excluded groups and have increased health needs, in comparison to children and young people from comparable socio-economic backgrounds. They face a number of challenges such as frequent changes of home and schools, discord within their own families and lack of support from a trusted adult. They share many of the same health risks as their peers, but often to a greater degree. They often enter care with lower immunisation rates and a worse level of health than their peers; this is in part due to the impact of poverty, neglect and abuse.[85]

Experiences in early life may have long-term effects on health and social development. Sixty per cent of looked after children and young people in England are reported to have emotional and mental health problems. A high proportion experience poor health, education and social outcomes on leaving care, attributed to early life experiences. Both young women and men in and leaving care are more likely than their peers to be teenage parents.[86] Whilst the health of children entering care may be worse than those who are not in care, there is a great deal of work undertaken to ensure looked after children's health needs are met through additional service provision and support to carers and the young people themselves.

The health inequalities faced by looked after children and the impact that these can have on their life course, highlights the need for early intervention and a preventative approach. Looked after children and young people should expect to have the same opportunities as their peers and should be provided with the opportunities needed to help them move successfully into adulthood.[86,87] The local authority and partner agencies have a statutory obligation in relation to looked after children which includes ensuring their health and educational needs are met, and they are supported to achieve their full potential. July 2013 saw an Ofsted inspection of Medway looked after children services which overall rated Medway as inadequate.

In 2012, the rate of looked after children in Medway was 73 per 10,000 children aged under 18. This figure only includes children who are both resident in Medway and registered as a Medway looked after child. This was higher than both the England(59) and South East(47) averages.[88] Between March

2008 and March 2012, the numbers of looked after children increased 13% nationally, but Medway saw a higher increase at 35%, which subsequently led to rapidly increasing demands on looked after children services (table 40).

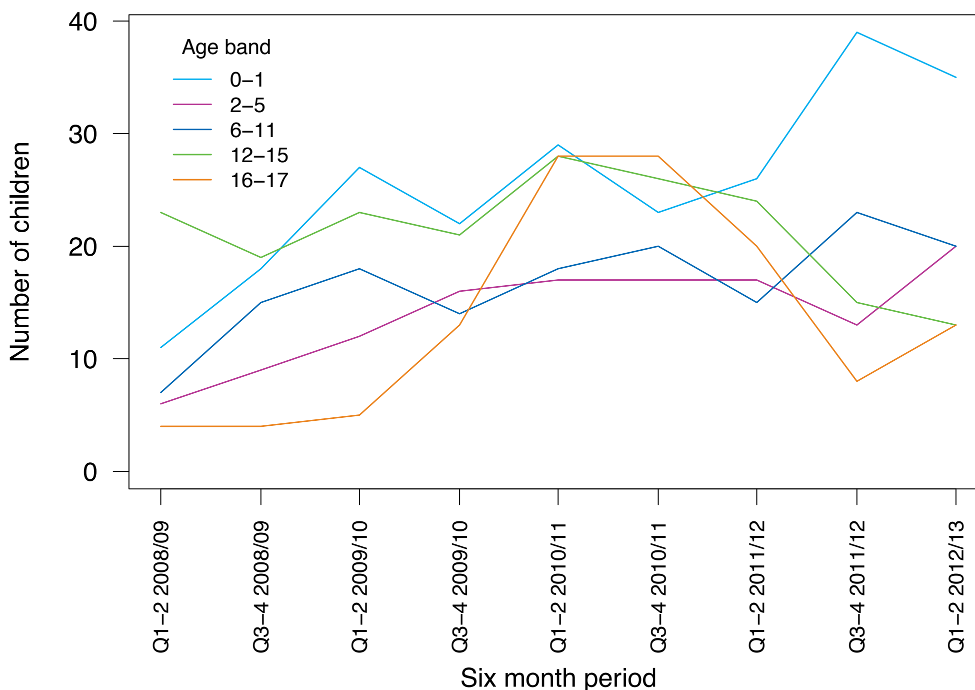
As of May 2013 there were a total of 742 looked after children resident in Medway, of whom 349 were placed here by other local authorities (POLA), i.e. 47% of the total number of looked after children resident in Medway.

Table 40: Number of Medway resident looked after children, registered as Medway looked after children, at 31st March each year

Year	Number of looked after children
2008	330
2009	310
2010	355
2011	425
2012	445

Source: Children in Care and Adoption Performance Tables, Department for Education

Figure 18: Children coming into care in Medway by age-band, 2008/09 to 2012/13



Source: LAC Performance digest, Medway Council

Outcomes for looked after children

Table 41 shows that Medway has a higher proportion than the national average of looked after children with up to date immunisations, dental treatment and annual assessments.

The percentage of looked after children under 16 who have been in care continuously for at least two and a half years and who have been in the same placement for two years or more was 71% as at March 2013, compared to 68% nationally.

Table 41: Healthcare of children, registered as Medway looked after children[t], who have been looked after continuously for at least 12 months, 2012

Area	Children whose immunisations were up to date	Children who had their teeth checked by a dentist	Children who had their annual health assessment
Medway *	285	260	270
(total: 300)	95.0%	86.6%	90.0%
South East	86.0%	86.9%	84.7%
England	83.1%	82.4%	86.3%

*Numbers are rounded to the nearest five
Source: Department for Education

The Strengths and Difficulties Questionnaire (SDQ) is a series of 25 questions asked of all looked after children aged four to 16 years at the date of their latest assessment (six-monthly for children under five and annually for children aged five and over) to measure their emotional and behavioural health. It provides a single score between zero and 40. On an individual basis a score of 13 or below is "normal", between 14 and 16 is "borderline" and 17 and above is a "cause of concern".[89]

In 2012, the average SDQ for emotional and behavioural health of looked after children in Medway was scored "borderline". However, 41% of individual children had a score that raised concern (table 42), higher than the England average of 36%.[90]

Table 42: Emotional and behavioural health of looked after children for whom a Strengths and Difficulties Questionnaire was completed, 2011/12

Area	Average score per child	Percentage of eligible children with an SDQ score considered		
		Normal	Borderline	Concern
Medway	14.8	42%	17%	41%
South East	15.1	44%	14%	42%
England	13.8	51%	13%	36%

Source: Department for Education

The percentage of looked after children under 16 who have been in care continuously for at least two and a half years and who have been in the same placement for two years or more was 71% as at March 2013, compared to 68% nationally. This is beneficial for the child or young person as it means consistency of carer which should have a good impact on their outcomes.

t. Includes children living in other local authorities who are Medway's responsibility

In 2012, 77.7% of children aged five to 15 years continuously looked after for at least 12 months had special educational needs (SEN), and 31.8% had a statement of SEN. This was very similar to the South East, but England was lower with 71.5% and 29.4% respectively, although these differences were not significant.[91]

The percentage of looked after children classed as persistent absentees in 2012 was 5.9% for Medway, 6.9% for the South East and 6.1% for England.[91] The percentage of looked after children achieving level 4 in English and maths at Key Stage 2 and achieving five GCSEs graded A*-C including maths and English was below the national average in 2012, but is expected to improve in 2013 as part of a gradually improving trend. The number of looked after children in Medway taking these qualifications each year is very small so no statistically significant conclusions can be drawn from this.

A looked after young person becomes a care leaver at 18 years of age and eligible for separate care leaving services. Support is available up to the age of 24 if remaining in full time education or else up to 21, and includes a clothes allowance, help with accommodation and a pathway plan based on need. Young people aged 14 years and above who have been in care for at least 13 continuous weeks are also eligible for care leaving services.

In 2011/12, 40% of care leavers in Medway were in education, employment or training on their 19th birthday compared to 58% nationally. This rose in 2012/13 to 51.3% in Medway. In 2011/12 90% of care leavers were in suitable accommodation on their 19th birthday compared to 88% nationally. This rose in 2012/13 to 94.8% in Medway.

Services in Medway

All children and young people (aged zero to 19 years) have access to universal health service provision under the Healthy Child Programme, which includes health visiting and school nursing services. Children and families are supported through the Common Assessment Framework, Child in Need and Child Protection processes. These provide additional support to children and families through a multi-agency approach to support any highlighted need.

There is a looked after children's health team based at Medway NHS Foundation Trust Hospital (MFT). This team is responsible for the health assessments of all looked after children resident in Medway including those placed in Medway by other local authorities. Medway looked after children resident elsewhere are assessed by the looked after children team of the local authority where they reside in conjunction with the Medway looked after children team.

The nurses support looked after children in one to one settings and groups offering advice on a number of health issues including smoking, alcohol, sexual health and emotional wellbeing. They arrange immunisations for looked after children, provide training for foster carers on health issues and support social workers. Due to a marked rise in the numbers of looked after children and new statutory guidance, further investment has been allocated to expand the looked after children health team.

A pilot project commenced in July 2012 to provide a sexual health nurse for looked after children. The project engaged with 423 looked after children offering a range of services including access to long acting reversible contraception (LARC). This project has been funded for a further year to continue with an extension in hours.

A one stop health shop was piloted for looked after children in community venues; this project brought together specialist sexual health and contraception services alongside other health improvement services. Due to low numbers of attendees this project has been opened up to allow any young person to attend not just looked after children.

Due to the marked rise in the numbers of looked after children and the Child and Adolescent Mental Health Services contract recently being awarded to a new provider, there needs to be on-going assessment to ensure the current contract can meet the emotional and mental health needs of looked after children.

Unmet need

The statutory guidance on promoting the health and wellbeing of looked after children, reissued in 2009[85] requires that all care leavers receive a copy of their health histories to equip them to make effective future health choices. This requirement is currently not being met by the health team due to lack of resources and was identified as an area for improvement by Ofsted.

Parenting

Good parenting reduces the risk that children experience poor behavioural outcomes, criminality and anti-social behaviour. After the age of three it becomes more difficult to make changes in both a child's development and in parental behaviour.[92]

Parents find that participation in evidence-based parenting programmes, which include such elements as relationship support, co-parenting, child development and advice on how to support their children's learning with simple activities in the home, can provide helpful support and advice to them in their role. When both parents take part (separately or together) gains are greater and better maintained and each parent's relationship with their child is enhanced.[92]

Some children and families have particular needs or circumstances which make them more vulnerable to poor outcomes. These groups include teenage mothers and young fathers, lone parents, some minority ethnic groups, children without adequate housing, disabled children and those with special educational needs, and looked after children. All foundation years services have an important role in identifying and supporting those families experiencing or at risk of problems.[92]

Services in Medway

The growing demand for parenting support in Medway prompted the creation of the Parenting Support Service within Medway Council in February 2009. The Parenting Support Service provides interventions for parents of children and young people aged zero to 18 years where there are emerging mental health, emotional well-being or behavioural difficulties. Parenting programmes can improve child behaviour and parenting skills. In Medway, two evidence-based parenting programmes are running, the Solihull Approach and Triple P (Positive Parenting Programme).

The Solihull Approach is a universal intervention implemented across Medway. Practitioners across the early years and Children's Centres are being trained to deliver this to parents who request lower level support in regards to their parenting style. The groups focus on the relationship between parent/carer and child and aim to develop a more positive and rewarding relationship.[93]

Triple P (Positive Parenting Program) is a targeted intervention for families who require parenting

support, delivered by the Parenting Support Service which offers higher level intervention for families with complex needs. Home visits are offered to those who cannot attend groups. The programme is not open for self-referral. It is acknowledged that more support is needed for parents of children with ADHD and this is reflected in the programme options:

- Triple P Group: Children aged four to 12 years;
- Triple P Group ADHD: Children with diagnosed or pre-diagnosed ADHD;
- Triple P Teen: Teenagers aged 12 to 17 years;
- Triple P Standard: One to one intensive model delivered in the home.

Referral criteria are where:

- little change is seen against a common assessment framework;
- social care is involved and the child has a child protection plan or is in need;
- there are parental mental health difficulties;
- there is a diagnosis of ADHD or conduct disorder;
- there are multiple and complex problems in the family.

Each group takes 10 to 14 parents and overall retention for Triple P is around 70%. Between 12th August 2012 and 10th September 2013, nine parents completed the one to one Triple P intensive, 33 parents completed the Triple P Group and eight families received systematic counselling. Between September and December 2013, 97 families are booked to attend the Triple P Group including the ADHD Group.

Locally the service has seen an overall reduction in strengths and difficulties (SDQ) score. The evidence gained nationally from these programmes demonstrates good outcomes for the families who attend.

Domestic Abuse

Children need a safe and secure home with parents or carers that love and protect them. They need to have a sense of routine and stability, so that when things go wrong in the outside world, home is a place of comfort, help and support. For some though, this is far from reality.[94]

Domestic abuse is defined as:[95]
Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This includes the following types of abuse:

- psychological;
- physical;
- sexual;
- financial;
- emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."[u]

The effects of domestic abuse on children are potentially life-long. At an early age, a child's brain is becoming 'hard-wired' for later physical and emotional functioning. Exposure to domestic violence threatens that development. Small children who are exposed to violence in the home experience so much emotional stress that it can harm the development of the brain and impair cognitive and sensory growth.[94]

u. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.From 31st March 2013 the definition of domestic abuse was altered to reflect the fact that a large number of 16- and 17-year-olds are victims.

As they grow, children who are exposed to violence may continue to show signs of problems. Primary-school-age children may have more trouble with school work, and show poor concentration and focus. In one study, 40% had lower reading abilities than children from non-violent homes. Behaviour changes can include excessive irritability, sleep problems, emotional distress, fear of being alone, immature behaviour, and problems with toilet training and language development.[94]

Personality and behavioural problems among children exposed to violence in the home can take the forms of psychosomatic illnesses, depression, suicidal tendencies, and bed-wetting. Later in life, these children are at greater risk for substance abuse, teenage pregnancy and criminal behaviour than those raised in homes without violence.[94]

Social development may also be damaged. Some children lose the ability to feel empathy for others. Others feel socially isolated, unable to make friends as easily due to social discomfort or confusion over what is acceptable. Many studies have noted that children from violent homes exhibit signs of more aggressive behaviour, such as bullying, and are up to three times more likely to be involved in fighting. There is a common link between domestic violence and child abuse. Among victims of child abuse, 40% report domestic violence in the home.[94]

The single best predictor of children becoming either perpetrators or victims of domestic violence later in life is whether or not they grow up in a home where there is domestic violence. Studies from various countries support the findings that rates of abuse are higher among women whose husbands were abused as children or who saw their mothers being abused.[94]

Table 43 shows the number of offences and secondary incidents of domestic abuse in 2012/13 with a victim aged 16 to 18 years. This is not a unique count of people so the same person may feature more than once.

Notifiable offences, or recorded crimes, are those that could be tried by a jury and some additional closely related offences. Secondary incidents (SI) are predominantly not crimes, but they are recorded on the crime management system which allows for management of risk, analysis of locations, frequency, descriptions of suspects/vehicles, etc. Where incidents of domestic abuse do not amount to a notifiable crime, an SI will be generated e.g. threats, unexplained injuries, "harassments".

Table 43: The number of victims age 16 to 18 years in Medway, 2012/13

Gender	Notifiable offences	Secondary incidents
Male	10	16
Female	66	133

Source: Kent Police

Table 44 shows the number of offences and secondary incidents of domestic abuse in 2012/13 with an involved party aged under 18. This is not a unique count of people so the same person may feature more than once. Involved parties are neither victims nor witnesses, but are related to the incident in some way, for example children present in a house at the time of a domestic assault.

Table 44: The number of involved parties aged zero to 18 years in Medway, 2012/13

Gender	Notifiable offences	Secondary incidents
Male	357	547
Female	361	556
Unknown	25	37

Source: Kent Police

In Quarter 3 of 2012/13, the percentage of families where a child is subject to a child protection plan where domestic abuse was a component was 29%.

Between 2008/09 and 2011/12, domestic abuse incidents for all ages increased by 14.1%[96] in Medway compared to 13.7% for the South East and 7.5% for England and Wales.[97]

Services in Medway

An independent domestic abuse advisor (IDVA) service has been commissioned for the support of high risk domestic abuse victims across Kent and Medway whose main role is to address the safety of victims and their children. Serving as the victim's primary point of contact, IDVAs normally work with victims from the point of crisis to reduce levels of risk, discuss the range of suitable options and develop safety plans as they work with other support services to help the victim onto a path to long term safety.[98]

Troubled Families

The Troubled Families Programme (known in Medway as Medway Action for Families) was launched in December 2011 by the Prime Minister with the aim of getting children back to school, reducing youth crime and anti-social behaviour, putting adults on a path back to work and reducing the amount public services spent on them.

A troubled family is defined as meeting two out of the three following criteria:

- involved in youth crime or anti-social behaviour;
- have children who have poor school attendance (under 85%), three or more exclusions or in a pupil referral unit;
- have an adult (16+) on out of work benefits.

In addition to meeting the Troubled Families criteria, Medway has decided that in order to address local need appropriately, one of the following local criteria should also be met before families can enter the programme:

- families where there is domestic violence;
- families living in the safer stronger wards (Luton and Wayfield, Chatham Central and Gillingham North);
- those with common assessment framework, child in need or child protection plans;
- large families (five or more children);
- families with children not engaging in pre-school provision;
- families with young people aged 16 to 18 not in employment, education or training where there is no adult working either;
- mental health concerns within the home;
- drug and alcohol concerns within the home;
- housing issues.

Troubled families are often engaged with several agencies which can focus on different issues without gaining a cohesive picture of the family.

The following are key features of effective family intervention practice:

- a worker dedicated to a family;
- practical 'hands on' support;
- a persistent, assertive and challenging approach;
- considering the family as a whole – gathering the intelligence;
- common purpose and agreed action.

Medway's aim for the programme is to look at the redesign of local services, with partners working together to identify local solutions with and for local families. Medway is looking to support and improve the lives of 560 families through this programme, but also produce a legacy of good practice for working with families with multiple and complex needs.

Medway has a slightly higher than average proportion of troubled families when compared to demographically similar local authorities.

Medway's plan is to work with 180 families in 2012/13, 257 in 2013/14 and 123 in 2014/15.

The 2012/13 target to work with 180 families was achieved, with an over 60% success rate compared with 15% nationally. Success is measured by better attendance at school, reductions in exclusions, offending and anti-social behaviour and family members being back in work or completing work related programmes.[v]

There are currently 330 families involved with the programme. Medway now has a pooled resource of professionals including: Family Workers, Probation Service, Youth Offending Team, Police, Kent Fire and Rescue Service, Job Centre Plus, Attendance Advisors and Medway Youth Trust working in an integrated way achieving better outcomes for families with multiple and complex needs.

Of the total participating families in the Medway Action for Families programme, 5.8% of families had looked after children and 2.9% had children with disabilities including special educational needs.

Families are assessed for three levels of intervention: standard, enhanced and intensive. Standard and enhanced cases/ families are picked up by existing services and receive additional support. Those that are identified as intensive are assigned a dedicated worker from the pooled resource.
Improving health involvement in the Medway Action for Families was identified as an area for action. As a result, Medway Action for Families and Public Health are putting in place a new post that aims to improve outcomes in health for the families and also joins up existing provision to avoid duplication.

Aspirations and Educational Attainment

Aspiration can be defined as "aiming for something high or great"[99] and is important for young people to help them develop their full potential. It does not have to be related to a career and could be related to a physical goal, for example, climbing a mountain. Higher aspirations can lead to higher educational attainment and better employment prospects and these in turn are linked to better health.

Aspirations begin early in a child's life and are modified by experience and environment. The early years are a key time in the formation and development of aspirations and parents may need support to overcome attitudinal and practical barriers. Aspirations tend to decline as children get older and their understanding of the world increases.[100] 11 to 14 years is a key age range, when young people move from idealistic to more realistic ambitions.[101] Constraints on their ambitions are imposed by previous choices and achievements. For those facing multiple barriers, the decline in aspirations is particularly significant. Attitude is very important, however. Young people with the belief they have the ability to achieve tend to have higher aspirations than their peers.[100] Socially disadvantaged groups such as teenage parents tend to have low aspirations for themselves and for their children. Young people from minority ethnic groups and from higher socio-economic backgrounds tend to hold

v. children being back in school with 85% attendance or higher over a minimum period of six months, fewer than three fixed term exclusions over six months, a 33% reduction in offending, a 60% anti-social behaviour reduction and family members are back in work or nearer work by completing Progress! or other work related programmes (for example the Work programme)

higher aspirations.[100] Because aspiration is a multi-faceted concept, there are various different ways of measuring it.

In Medway, the aspirations of young people are currently not measured. But there is a desire by partners in Medway to raise the ambitions and educational attainment of young people and to help them achieve greater success at certain key stages, particularly key stage two (last year of primary school) and later years in order to foster positive opportunities in later life.

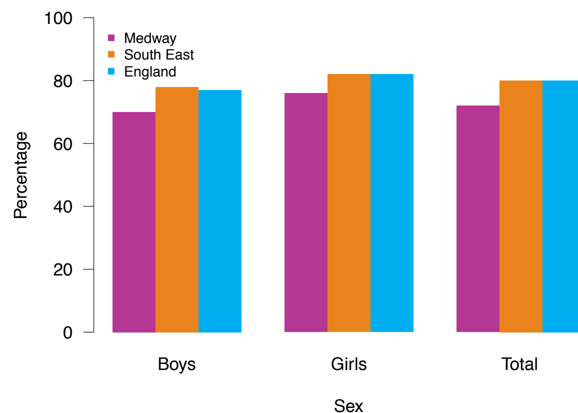
There are many organisations working in Medway to help young people. Youth and Employment Services (YES, formally Connexions) is a service for 13- to 19-year-olds offering information, advice, guidance and access to personal development opportunities.[102]

Educational attainment

Children from disadvantaged backgrounds are more likely to begin primary school with lower levels of personal, social and emotional development, and lower communication, language and literacy skills than their peers.[1] There is a strong relationship between deprivation and educational attainment. Inequalities in educational attainment affect physical and mental health as well as income, employment and quality of life.[1]

Figure 19 shows the percentage of pupils achieving level 4 or above in both English and mathematics in Key Stage 2 assessments by gender. At this stage, a higher percentage of girls meet the expected standard than boys. Between 2007 and 2012, the percentage of pupils achieving the expected standard has consistently been lower in Medway than the South East and England averages. Over this time period, the gap between Medway and England has widened from four percentage points in 2007 to eight percentage points in 2012.[103]

Figure 19: Percentage of pupils achieving level 4 or above in both English and mathematics in Key Stage 2 assessments, 2011/12



Source: Department for Education

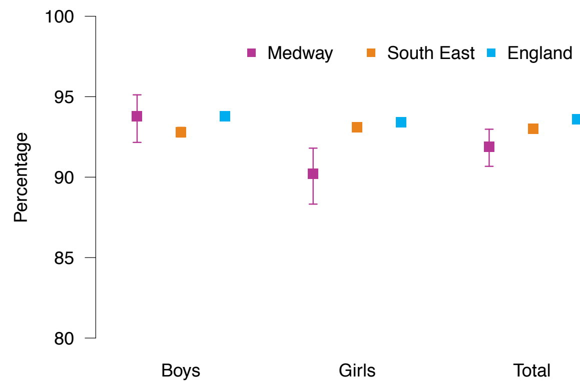
National Curriculum standards have been designed so that most pupils will progress by approximately one level every two years. Pupils are expected to achieve level 4 by the end of Key Stage 2 and to make two levels of progress between Key Stage 1 and Key Stage 2.[104] The percentage of pupils achieving this in 2011/12 was 82% for Medway, 86% for the South East and 87% for England (state-funded).

Figure 20 shows GCSE and equivalent results of pupils attending a state secondary school in Medway at the end of Key Stage 4 by gender. At this stage, girls achieve a statistically significantly higher percentage of five or more A*- C grades including mathematics and English compared to boys. The achievement level for boys and overall is statistically significantly higher in Medway than for England.

Figure 20: Percentage with five or more A*-C grades including English and mathematics, 2011/12

Source: Department for Education

Figure 21: Percentage of students achieving passes equivalent to at least two A-level passes (grade A*-E), 2011/12



Source: Department for Education

The percentage of pupils obtaining any five A*-C grades at GCSE is somewhat higher – 87.3% for boys, 90.0% for girls and 88.7% overall in Medway. Boys and girls are not statistically significantly different when all subjects are included and performance is statistically significantly better than both the South East and England.

Figure 21 shows the percentage of students, who attended a state secondary school in Medway, achieving passes equivalent to at least two A-level passes by gender. At this stage boys have a higher average pass rate than girls and Medway girls are significantly lower than England. Included within these figures are pupils attending MidKent College which offers a range of both academic and vocational qualifications that are not all equivalent to two A-level passes, but are designed to ensure that students build their skills, confidence and abilities which in turn, helps them improve their opportunities to take up meaningful employment.

Exclusion is a key factor in youth offending. Of the 4,300 cohort in the Edinburgh Study[w] starting secondary school in autumn 1998, 471 were excluded from school by age 14, 50% of whom were convicted of at least one offence by age 22.[105,106]
Tables 45 and 46 show the percentage of pupils subject to exclusion and the percentage of sessions missed due to absenteeism.

Table 45: Percentage of the school population subject to a fixed term or permanent exclusion, 2010/11

Area	Permanent	Fixed term
Medway	0.05	6.80
South East	0.06	4.87
England	0.07	4.34

Source: Department for Education

The percentage of students achieving with five or more A*- C grades including English and mathematics in 2011/12 in Medway was statistically higher than England

w. The Edinburgh Study of Youth Transitions and Crime is programme of research that aims to address a range of fundamental questions about the causes of criminal and risky behaviours in young people. The core of the programme is a major longitudinal study of a single cohort of around 4,000 young people who started secondary school in Edinburgh in the autumn of 1998. [135]

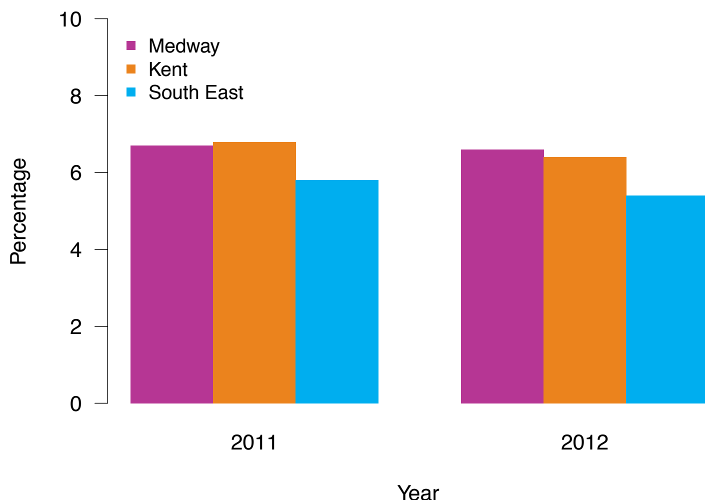
Table 46: Percentage of sessions[x] missed due to overall absence and percentage missed due to unauthorised absence

Area	Spring 2011		Autumn 2011		Spring 2012		Autumn 2012%	
Medway	5.6	1.2%	4.8	1.0%	5.4	1.1%	5.4	1.0%
South East	5.5	0.9%	4.6	0.8%	5.4	0.9%	5.1	0.8%
England	5.4	1.0%	4.7	0.9%	5.3	1.0%	5.2	0.9%

Source: Department for Education

The rate of young people aged 16 to 18 years not in education, employment or training (NEET) is a national indicator which reflects skill development during the school years and indicates those at greater risk of a range of negative outcomes, including poor health and early parenthood.[107] Medway's rate has been higher than the South East in the last two comparable years (figure 22). European Social Fund programmes are run throughout Kent and Medway and target young people aged 14 to 19 who are classed as 'not in employment, education or training' (NEET) or are likely to become so.[108]

Figure 22: Percentage of 16- to 18-year-olds not in education, employment or training, 2011 and 2012[y]



Source: Department for Education

Apprenticeships are also available as post-school practical learning opportunities with schemes such as '100 in 100' (Medway Council's challenge to businesses in Medway to generate 100 new apprenticeship places in 100 days which was successful) increasing the number of spaces. In 2011/12, 590 intermediate apprenticeships were started by young people aged under 19 living in Medway and 130 advanced apprenticeships were started.[109]

From summer 2013, the Government is increasing the age to which all young people in England must continue in education or training, requiring them to continue until the end of the academic year in which they turn 17, and from 2015 until their 18th birthday. This does not mean young people must stay in school, they will be able to choose from full-time education (such as school, college or home education), an apprenticeship or part-time education or training if they are employed, self-employed or volunteering full-time (which is defined as 20 hours or more a week).[110]

x. By law, schools are required to record in the attendance register - once at the beginning of the morning session and once in the afternoon. All maintained schools and non-maintained special schools must meet for the purpose to educate their pupils for at least 380 half-day sessions (190 days) in each school year. [136]

y. Figures for 2011 and 2012 cannot be compared with previous years because in the latest data young people have been recorded according to where they live, rather than where they study, as had been the case in the past.

Young carers

A young carer is a child or young person aged five to 17 years who provides unpaid care for family members, friends, neighbours or others because of long-term physical or mental ill-health, disability or problems relating to old age.[111] Young carers often have to provide a level of care which is inconsistent with their age and developmental level, assuming adult roles before they are ready. They may be performing a range of tasks, including domestic tasks such as shopping, cooking, cleaning and looking after siblings as well as other tasks such as administering medication and personal care, and providing emotional support.[112]

Many young carers do not realise they are carers and thus miss out on information, support or advice. Caring is associated with an increase in health problems in those providing the care. Common health problems include stress, anxiety, depression, physical injuries and musculoskeletal problems. Caring may also impact on relationships with friends and family, and social activities.

As well as the physical and mental health effects of caring, young carers are also at increased risk of their education being affected by their caring responsibilities. A high proportion of young carers miss school as a result of their caring responsibilities. In 2003, 22% of young carers reported that they had missed school or were experiencing educational difficulties. However, there are differences between young carers, depending on the condition of the person they are caring for. A much greater proportion (40%) of young carers providing care to someone with drug or alcohol problems reported missing school or experiencing educational difficulties.[113]

Factors such as fatigue and poorer school attendance mean they may leave school with fewer qualifications and have worse employment prospects than their peers who do not have caring responsibilities. They may also suffer from isolation, bullying and difficulty in spending time with friends.[114]

A 2004 report of a national survey of young carers in the UK, found that 56% of young carers lived in single parent families. In single parent families, the mother was the person receiving care in 70% of cases. In two parent families the sibling was receiving care in 46% of cases. In 12% of cases young carers were providing care for more than one person. Caring may be a long term commitment for many, with 64% caring for three years or more. Adults with care needs were unlikely to be in paid employment, which may result in the whole family being more vulnerable to poverty and social exclusion.[113]

Young people who have a parent with mental health problems are at increased risk of developing a mental health problem themselves, with carers being at even higher risk of this than non-carers. Young carers are also at increased risk of anti-social behaviour, self-harm and substance abuse.[112]

Young carers who do have health problems may face additional barriers accessing medical care, because of the difficulty their parents may have in accompanying them to medical appointments. Parents with disability may have particular difficulty accessing transport for their children's appointments. Services which would normally provide transport will not necessarily do so to allow them to accompany their child to an appointment rather than their own, and other services are not insured to carry children. While it is known that this has been a problem for some, the potential number of people affected by this is unclear.

The 2011 census identified that 2.1% of children aged five to 17 in the UK were acting as unpaid carers. The South East has experienced the greatest percentage increase in the number of young carers between the 2001 and 2011 census of 41.2% (an increase from 17,692 to 24,974). However, the South East has the lowest percentage of young carers in the population of any region at 1.9% (2.1% for England). If we apply this percentage to the five- to 17-year-old population in Medway, we can estimate that around 830 young people provide unpaid care in Medway.[111]

Services in Medway

Medway Carers' Centre is commissioned by Medway Council to provide an information, advice and support service to carers across Medway. Carers are able to refer themselves to the centre, or they can be referred by a range of agencies.[115] Staff from Medway Carers' Centre may accompany young carers to medical appointments if their parents are unable to take them.

All young carers who come into the Carers' Centre service receive an informal, non-statutory assessment, usually as a home visit. Young carers are supported in a variety of ways, for example through groups, one-to-one sessions and services are also provided in schools. Between 2009/10 and 2011/12, the Carers' Centre has carried out assessments on 301 young carers.

The 2004 national survey of young carers found that only 18% of young carers had received an assessment, with most (11%) being carried out under the Children's Act. Young carers from black and minority ethnic groups and those caring for a relative with a drug or alcohol problem were the groups most likely to receive an assessment. Support from social services was the most common support service received, however 21% of young carers received no services other than their contact with a young carers' project.[113]

Although some services for young people in Medway, for example youth services and Tier 2 Child and Adolescent Mental Health Services (CAMHS), report working with young carers they do not routinely record, in a readily accessible manner, whether a young person is a carer or not, making it difficult to obtain a clear picture of the support offered by these services to young carers.

As young carers become adults there is also a particular need for transition programmes. Young carers' projects need to work with services for adult carers, to ensure continued provision of support for young carers after they reach the age of 18. Young carers may be anxious about the fact that the support they are receiving from a young carers' project will finish when they are 18. This is an important time of life when carers need support with the life decisions they face. Nationally, young carers aged 16 and 17 have been found to know little about services available for adult carers and few young adult carers (aged 18 to 24) in one study had ever used an adult carers service. There is a perception that services for adult carers are geared towards the needs of much older carers and there is a need for something geared towards their own age group.[116]

The main areas where young carers could benefit from interventions were considered to be improved school attendance and reduced truancy, reduced risk of being taken into care, improved health and self-esteem and enabling the young carer to move from inappropriate to appropriate caring.[117]

Child poverty

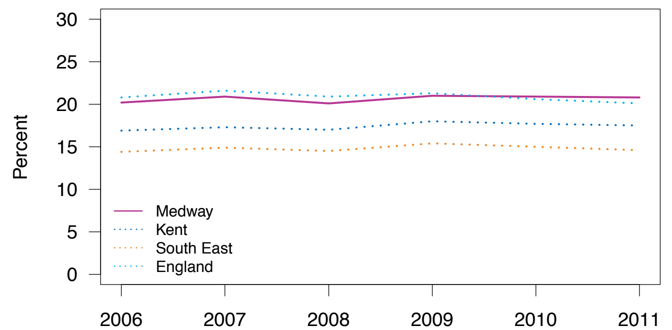
Poorer people are more likely to live in more deprived neighbourhoods which are more likely to have social and environmental characteristics presenting risks to health. These include poor housing, higher crime rates, lack of green spaces and places for children to play, and more risks to safety from traffic.[1]

The child poverty measure is defined as "the number of children under the age of 20 living in families in receipt of Child Tax Credit, whose reported income is less than 60% of the median income or in receipt of Income Support, or Income-Based Jobseekers Allowance, divided by the total number of dependent children under the age of 20 in the area" (determined by Child Benefit data).

In 2011, the latest available data, in Medway there were 12,850 children living in poverty (figure 23).[118]

The percentage of children eligible for Free School Meals (FSM) in 2011/12 was 19.5% at primary school and 14.3% at secondary school compared to a national percentage of 19.3% and 16.0% respectively.[119]

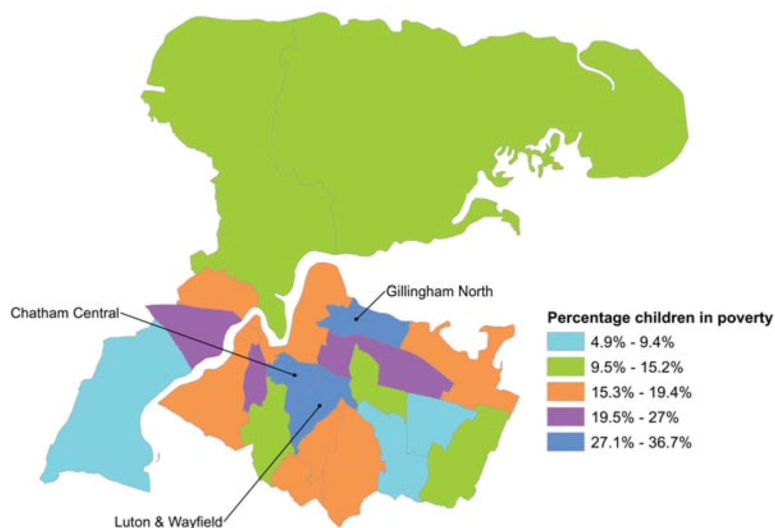
Figure 23: Percentage of children living in poverty, 2006 to 2011



Source: HMRC

Whilst overall the rate of child poverty in Medway is similar to the national level, it is well above the regional average, and disguises some high levels of poverty at neighbourhood and ward level within Medway. Figure 24 identifies Chatham Central, Gillingham North and Luton and Wayfield as having the highest percentage of children in poverty.

Figure 24: Child Poverty by electoral ward in Medway, 2010



Source: HMRC

Homelessness

Young people are often forced to leave the family home during a crisis and have few life skills to deal effectively with this. They are often unaware of the support that is available to them and they need to be sign-posted to appropriate services which have a specialist understanding of their needs. Young people are more likely to move between hostels, houses of friends or family (otherwise known as "sofa surfing") and are more likely to accrue rent arrears, increasing the barriers to achieving independent living. There is also an increasing financial cost of youth homelessness. The longer they remain homeless the more extra policing and health and social services costs may be incurred.

Following the Southwark Judgement (2009)[120] (case law that obliges Children's Services to provide accommodation and support to 16- and 17-year-olds) it has been clarified that the prime responsibility for assisting homeless 16- and 17-year-olds (including provision of accommodation) is with Children's Services. However any 16- and 17-year-olds who are assessed as not being owed a duty under section 20 of the Children's Act 1989 (Provision of accommodation for children), or refuse section 20 assistance, do need to be assessed by Housing Services under part seven of the Housing Act 1996 (and will be 'priority need' if homeless).

Over the last three years there has been a 120% increase (46 in 2009/10 compared to 101 in 2012/13) in the number of 16 to 24-year-olds accepted as homeless in Medway. As of the end of March 2013, there were 3,054 under 25s on the housing register, meaning that they had some sort of housing need (for example, being homeless or being in a home that they need to move from).[121] Applications for those asking to be placed on the housing register are assessed and prioritised into a banding system, A-D, with A having the greatest priority.[122] 56% of those on the register were placed in Band D and only 7% were in priority need Band A (36 in Band A, 166 in Band B, 1,128 in Band C and 1,724 in Band D).[123]

Services in Medway

Support for young people is based on meeting the needs of a relatively small high needs group who have been in care or had other involvement with social care. As part of the local authority's legal responsibilities a wide range of accommodation is provided in Medway for young people who are care leavers or eligible 16- or 17-year-olds. Most of it is commissioned by social services.

Sixteen or 17-year-olds in need of housing are supported directly by Medway Integrated Looked After Children team (MILAC) to go to appropriate supported housing. Care leavers and young people at risk may go into the Gateway[z] system, but may also be directed to a provider by MILAC and bypass the Gateway. In 2012/13 there were 483 young people (under 25s) referred to the Gateway for housing related support. Within the 483, there were 41 referrals for young people at risk and 39 referrals for young people leaving care.

Crime and Youth Justice

Crime and fear of crime adversely impact on quality of life, mental and physical health. Crime is associated with social disorganisation, low social capital, relative deprivation and health inequalities. The same social and environmental factors, which predict geographic variation in crime rates, may also be relevant in explaining community variations in health and well-being.[124]

z. The Gateway is an IT system implemented in 2009 that efficiently and effectively brings together accommodation and support providers and matches them to provide appropriate support packages.

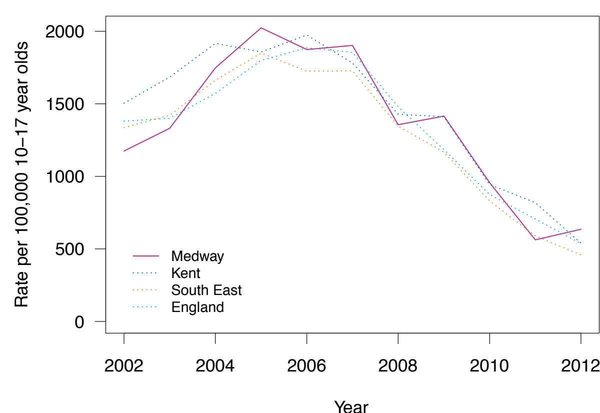
Medway Council is a responsible authority within Medway Community Safety Partnership (CSP) and contributes to the partnership requirements of consulting with the community, preparing a strategic assessment and preparing and implementing a plan for the area on behalf of the responsible authorities. The strategic assessment is an analysis of the levels and patterns of crime and disorder and substance misuse in the area, concluding with priorities the CSP should adopt to address those matters. The strategic assessment carried out in January 2013 highlighted the following as priorities in Medway for the coming year:[125]

- tackle drug and alcohol abuse;
- tackle anti-social behaviour and enviro-crime;
- reduce re-offending;
- tackle domestic abuse;
- reduce the number of people killed or seriously injured in road traffic collisions.

Figure 25 shows the rate of first time entrants to the youth justice system, where a young person is given a first reprimand, warning or conviction for a proven offence. There were 175 first time entrants in Medway in 2012, the second lowest number in the last ten years.

In more recent years, interventions have been put in place to divert young people away from the justice system, for example Triage[aa] and Restorative Justice.[bb] The aim is to divert young people who have committed less serious crimes away from formal sanctions.[126] The Triage Programme began in August 2011 in Medway custody with staff from the Medway Youth Diversion Scheme. A full time nurse was recruited in May 2012 to work alongside the diversion team to screen young people for health vulnerabilities.[127] In the Medway Community Safety Partnership Action Plan 2013-16,[125] an indicator has been introduced to measure the 'percentage of re-offending by use of those who have accessed the 'Triage' system', to ensure that early diversion has an effect on future criminal behaviour.[126]

Figure 25: Rate of juveniles receiving their first reprimand, warning or conviction per 100,000 of the 10 to 17-year-old population, 2002 to 2012



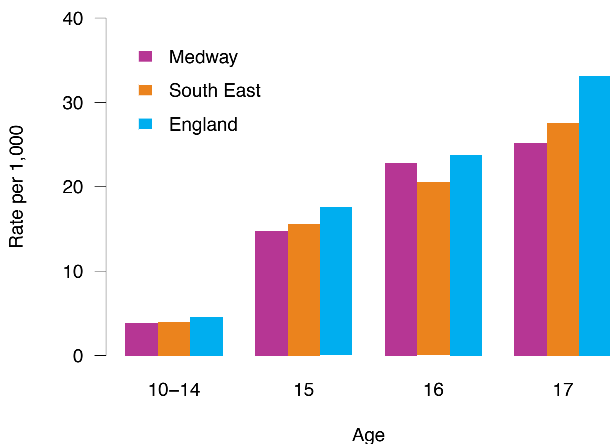
Source: Ministry of Justice

Figure 26 shows the comparative rate per 1,000 who received a substantive outcome in 2011/12. A substantive outcome is one where young people have to engage with the Youth Offending Team, this typically excludes reprimands and final warnings but does include repeat offenders.

There were 175 first time entrants into the youth justice system in Medway in 2012, the second lowest number in the last ten years.

aa. Triage schemes are based in police stations and aim to identify the needs of young people as they enter the youth justice system. A key objective of the schemes is to divert young people who have committed less serious crimes away from the formal youth justice system. [137]
bb. Restorative Justice (RJ) is a process whereby parties with a stake in a specific offence collectively resolve how to deal with the aftermath of the offence and its implications for the future. When delivered effectively, RJ gives victims the opportunity to explain the impact of crime upon them, to seek an explanation and apology from the offender, or to play a part in agreeing restorative or reparative activity for the offender to undertake. RJ seeks to hold offenders to account and enable them to face the consequences of their actions and the impact it has had on others. [138]

Figure 26: Young people receiving a substantive outcome, 2011/12



Source: Youth Justice Statistics, Youth Justice Board

In 2012/13, there were 175 repeat offenders[cc] in Medway aged 10 to 19 years, compared to 240 in 2011/12. The percentage of repeat offenders aged 10 to 19 years reduced from 32.6% in 2011/12 to 30.0% in 2012/13. This represents the third lowest percentage of all Kent and Medway districts.[128]

In 2012/13, there were 119 repeat victims in Medway aged zero to 19 years, compared to 129 in 2011/12. The percentage of repeat victims aged zero to 19 years is 9.0% for both years in Medway compared to 8.9% and 10.0% respectively for the whole Kent Police area.[128]

HMYOI Cookham Wood accommodates up to 131 males aged 15 to 17[129] and G4S staff run the Secure Training Centre, which accommodates 76 young people aged 12- to 17-years-old, who have been remanded or sentenced to periods of detention. The aim is to create a living environment that helps address the cycle of offending behaviour.[130]

Public Health services provide training for prison staff, especially at Cookham Wood, so they can influence the health of the young people. The services promoted are chlamydia screening, healthy eating and lifestyles, including access to Medway Cooks cookbooks and the Stop Smoking Service (SSS).

The Youth Offending Team (YOT) work with young people aged 10 to 18 who have offended or are at risk of offending or antisocial behaviour. This can mean offering intervention programmes with the young person and their parent /carer; supervising court orders; work whilst on bail or in custody; reports for court and youth offender panels. There is also an integrated prevention service in Medway Council which works with people at risk of offending, offering targeted and individual support for those showing risks through their behaviour at home, in school or in the community. The service works with partners to ensure the needs of young people and their families are met. The team has specialisms in youth offending, parenting and family conflict.[131]

Transport and road safety

Key transport issues which impact on the health of children include access to transport and road safety.

Access to transport

Medway has a good urban network of buses and rail but, not surprisingly, these reduce in coverage and frequency in rural areas. Schools in the main are well served and where children are entitled to free school travel this is provided.

The bus services are deregulated so bus operators have the commercial freedom to determine their networks and fares, with local authorities having only a small role in this, i.e., fares can only be set on routes that are under local authority control, services which are deemed to be unprofitable by the main operators, but which councils determine as meeting a social need. However, the local authority can provide concessions. For

cc. A repeat victim or offender is where an individual has been a victim or offender on two or more occasions in the previous 12 months. The victim or offender is only counted once no matter how many times they have been a victim/offender within the 12 month period.

example, the Medway Youth Pass gives a half fare in the morning for students who are not entitled to free travel.

National legislation requires all single deck buses to be fully accessible by 1st January 2016 and double decker buses by 1st January 2017, meaning that they are able to 'kneel' at stops and are also equipped with ramps for wheelchairs. The vast majority of buses in Medway are already fully accessible so it is anticipated that the target will be met before the legislation comes into effect. In support of this, the Council has provided raised kerbs at a third of all bus stops across Medway and this is a continuing rolling programme of improvement.

Road safety

Medway had 134 child (aged under 16) road traffic casualties in 2011, of which six were seriously injured. The number of overall casualties in 2011 was the highest since 2007 and 40 greater than in 2010. There were no child fatalities in Medway between 2007 and 2011, the most recent year of data available (table 47).

Because of the very low numbers of seriously injured children, the KSI rate fluctuates year on year. The rate of all child casualties in Medway in 2011 is statistically significantly higher than the South East and England.

Table 47: The rate of all child casualties and those killed or seriously injured (KSI) per 1,000 residents aged under 16 years, 2007 to 2011

	Area		2007	2008	2009	2010	2011
All casualties	Medway	Number	107	95	92	94	134
		Rate	2.00	1.78	1.73	1.76	2.51
	South East	Rate	2.02	1.81	1.67	1.59	1.65
	England	Rate	2.12	1.95	1.83	1.72	1.71
KSI	Medway	Number	14	10	10	14	6
		Rate	0.26	0.19	0.19	0.26	0.11
	South East	Rate	0.22	0.22	0.20	0.20	0.19
	England	Rate	0.27	0.24	0.23	0.22	0.21

Source: Department for Transport

Technology

One of the biggest changes in society over the last decade has been the increasing dominance of social media, gaming and accessibility to information with just a few clicks. Whilst the number of children in Medway with access to the internet and different forms of modern technology is unknown, there are undeniable effects, both positive and negative, on the lives of children and young people.

There are many research papers on the effects of media on issues such as physical activity, sleep disruption, hyperactivity and concentration and, whilst links have been made, not all are understood.

The technological improvements also provide opportunities for new methods of health promotion and quick information access. In Medway, QR (quick response) codes[dd] are used for sexual health services and chlamydia testing.

dd. These appear as a barcode block which can be scanned by a smartphone

The Medway Public Health Directorate maintains the 'A Better Medway' Twitter feed, website and Facebook page, which contain information on health improvement services, events and resources. There is also the Kent and Medway C Card App, which allows the user to find the nearest free condom pick up point and information on what to do in an emergency.

In a study conducted in 2010 of 23,420 children aged nine to 16 years across 25 European countries, 65% of children aged nine to 16 years in the UK were found to have a social networking site (SNS) profile. The likelihood of a child using SNS ranges from 20% for nine-year-olds to 90% for 16-year-olds.[132]

When asked about bullying online (cyber bullying), it was found to be more common in countries where bullying is more common, rather than where the internet is more established. This suggests online bullying is a new form of an established problem. Of the children asked in the study, 13% had been bullied face to face in the last 12 months, 5% on the internet (7% for 15 to 16-year-olds) and 3% by mobile phone. The most common methods of online bullying are social networking sites and instant messaging. In the UK, 20% of children asked had been bullied at least once in the last 12 months either online or offline, 8% had been bullied online. The average for all participating countries is 19% and 5% respectively.[133] In addition to cyber bullying there is growing awareness of sexting (sending sexually explicit messages or photographs, mainly by mobile phone), grooming and subsequent blackmail where the sent content is used as leverage.

If we assume all young people aged between nine and 16 in Medway have access to the internet, the study suggests that around 2,160 young people might have been bullied on the internet in the last 12 months.

Medway Council offers e-safety and anti-bullying services to schools and responds to issues as schools are made aware of them. An example of an e-safety course is "Know it All", a series of five short cartoons aimed at Key Stage 1 and 2 children, which covers issues such as spam/viruses, cyberbullying, meeting up and reliability of online material.

Key recommendations for the wider determinants of health

- Appropriate monitoring of new Child and Adolescent Mental Health Services (CAMHS) contract to ensure emotional and mental health needs of looked after children are being met.
- Looked after children with a SDQ score of 17 or above to be reviewed by the Looked After Children Health Team to ensure appropriate interventions are put in place.
- Increase support for the particular needs of young carers by primary care and other health services. This might include work on identifying young carers, how to refer young carers for an assessment and how to balance concerns about confidentiality of the patient with the need of the young carer for adequate information.
- Develop a single information booklet for young carers in Medway, detailing information on services available to them and important information such as how to claim Carer's Allowance.
- Offer life skills courses (e.g. cooking) to young carers, alongside subsidised or free travel and other local amenities, such as swimming.
- Work with partners to seek the views of young people on current communication channels and how we could improve them in order to better promote good health.

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