Needs Assessment for School-aged Children in Oxfordshire 2022

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OXFORDSHIRE COUNTY COUNCIL

Table of Contents

Executive Summary

Introduction

Ensuring every child has the best start in life is one the key priorities of the Office for Health Improvement and Disparities (OHID, formerly a part of Public Health England). Investing in children and families and enabling children to thrive is a crucial part of achieving the Governments 'Levelling Up' agenda to reduce inequalities seen across the country. Delays in identifying and meeting the health and wellbeing needs of children and young people can have far reaching effects, impacting their chance of reaching their full potential and leading happy, healthy adult lives. This Health Needs Assessment of school aged children (aged 5-19 years) has been carried out to gain a clearer picture of the needs of children, young people and their families across Oxfordshire. This will help to inform the delivery of the Healthy Child Programme, as part of the Local Authority's responsibility to commission public health services for children.

Background

The Healthy Child Programme is a universal programme of prevention and support for children and young people aged 0-19, and up to 25 years of age in those with a Special Education Need or Disability (SEND). It aims to bring together health, education, and other main partners to deliver an effective programme for prevention and support for children and young people. The 5-19 element of the Healthy Child Programme is delivered by School Health Nurses, who are specialist Public Health Nurses that work with children and young, both in and out of school settings. Partnership working and collaboration is vital in responding to the needs of children and young people. Services should be developed according to local need and have a robust workforce plan with appropriate skill mix of staff. By taking a place-based approach, local solutions can be developed that draw on all the assets and resources of the local area. A needs-led approach is vital to provide a personalised service that is 'universal in reach and personalised in response' to children and families' needs across time. There are no mandated reviews for school aged children but opportunities to develop a framework of reviews based on evidence and local need. This enables targeted and specialised support to be provided as early as possible, alongside the universal offer.

For this Needs Assessment the national guidelines and evidence base for the effective delivery of the Health Child Programme has been reviewed. The High Impact Areas of the Healthy Child Programme are central to the delivery model and provide an evidence based framework of those areas which have the biggest impact in improving outcomes in children and young people. Local data has been reviewed by High Impact Area and benchmarked alongside national data and surveys. Engagement has also been carried out with young people, parents, carers and professional. The outcomes and recommendations from this Needs Assessment will help to inform the Public Health commissioning of the Healthy Child Programme as well as the provision of other services for school-aged children in Oxfordshire, to help provide evidence based services that are responsive to the needs of children and young people.

Key Findings, Guidance and Evidence by High Impact Area

1. Resilience and wellbeing

- The mental wellbeing of children and young people closely interplays with risky behaviours, vulnerability, and deprivation. It can have far reaching effects on all aspects of children and young people's lives, and impact on educational attainment and employment in adulthood. Half of all mental health conditions begin before the age of 14.
- Mental wellbeing presents a significant need for children in Oxfordshire. From 2016/17 – 2019/20, there has been a substantial increase in referrals to Oxford Health CAMHS, 83% increase in 0-9years and 58% increase in 10-19 years.
- Oxfordshire has a significantly higher rate of hospital admissions for Mental Health conditions than England (108 vs 87.5 per 100,000 for England, 2020/21)
- The admission rate for self-harm in 15-19 year olds in Oxfordshire is also above than the England average.
- The COVID-19 pandemic has further negatively impacted the mental wellbeing of children and young people across England, with a disproportionate effect on those from disadvantaged background, females and those with pre-existing conditions.

- Results from the OxWell survey (2020) demonstrated that:
    - Mental wellbeing was positively correlated with feeling safe at schools and having access to mental health support within the school.
    - In those pupils who had received mental health support, this was most commonly from an adult within the school (58%).
    - Concerns around confidentiality was a common barrier to young people accessing support when they felt they needed it and having a means of accessing support services confidentially is important in making them more accessible to young people.
    - Nearly 1/3 of primary school pupils and 1/4 of secondary pupils did not know or were not sure who provides mental health support in school.

- Schools are well placed to build relationships with children and young people, which allows need to be identified and treated early. There must be a good system for identifying pupils who need additional support so that it can be provided as early as possible. Intervening early can provide support before patterns become ingrained and difficult to reverse, which in the long term can reduce costs associated with treating mental disorders.
- A whole school approach has been shown to be most effective in supporting mental wellbeing of children and young people. This should be informed by an awareness of need within the school with the development of a personalised action plan. It is essential to support the development of social, emotional, and behavioural competencies at a universal level, in addition to targeted support for mental health and behavioural difficulties

- Specific targeted interventions or programmes, when used, should be chosen based on need with a good evidence base (such as from the Early Intervention Foundation).

2. Improving health behaviours and reducing risk taking

- Good mental health and wellbeing, personal health literacy and resilience all closely interplay with reducing risky behaviours.
- Children with higher wellbeing scores are less likely to engage in risky behaviour and more likely to state that their general health is excellent. Health-harming behaviours are increased in children who have more exposure to adverse childhood experiences.

- Oxfordshire has a lower chlamydia detection rate than the national average. However, females aged 15-19 in Oxfordshire make up a larger proportion of new STIs diagnosed than males and have a higher reinfection rate than seen nationally.
    - Women are more vulnerable to the long term health consequences of STIs, and this is reflected in the focus on women in the updated National Chlamydia Screening Programme.
- It is important that Sexual Health Services are easily accessible to young people. When young people in Oxfordshire were asked about preferences for accessing sexual health services (2021):
    - 80% said Saturday was the most convenient day and half ranked early evening as the most convenient time of day for an appointment.
    - Nearly half ranked home testing kits as the preferred option for STI testing
    - 61% said condom distribution was the most useful outreach service
- Access to contraception and sexual health advice as part of the school/college nursing service is important and has the potential to reach large numbers of young people, as well as offering targeted support if needed.

- Two areas within Oxfordshire still have a significantly higher rate of teenage pregnancies than the national average, Blackbird Leys and Northfield Brook Ward.
- To reduce teenage pregnancy targeted prevention work in schools and community settings is recommended for young people who are more at risk, including young men.

- Oxfordshire has a higher rate of admissions for alcohol specific conditions in young people than seen nationally.
- National surveys found drinking levels were higher in young people with a higher affluence score and that drinking habits were most influenced by the adults they live with. Therefore, it is important drinking habits and attitude towards alcohol in the adult population are assessed to support behaviour in young people.

3. Supporting healthy lifestyles

- Nearly 4 in 5 children who are obese in their teens will remain obese as adults, leading to health problems in adulthood.

- Although Oxfordshire has a lower prevalence of children who are overweight or obese than nationally and across the South East:
    - Levels are still significant with 18.6% of reception age children overweight or obese, increasing to 29.4% in year 6 in 2019/20. This increase in prevalence between reception and year 6 is also seen nationally.
    - At ward level there is variation in the prevalence of overweight and obesity in children, with a much higher prevalence than the national average seen in some of the top 10 most deprived wards in the county.
    - Nationally, the prevalence of overweight/obese children has increased during the COVID-19 pandemic.
- Interventions to help reduce child obesity and increase physical activity should focus on areas of Oxfordshire with higher levels deprivation, where children are more at risk of obesity, and in the wards known to have with significantly higher prevalence of children who overweight/obesity than the Oxfordshire average.

- 49% of children in Oxfordshire were not meeting the daily physical activity guidelines in 2020/21, compared to 55% nationally.
- The OxWell survey found activity levels decline as young people move through secondary school but this decline is much steeper in females than males. Nationally, physical activity also declines with age particularly in girls.
- The charitable sector has a key role to play in helping to support children and young people to become more active.

- 21.3% of 5 year olds experience visually obvious dental decay, higher than the South East average but lower than England (23.4%).
- Oral health forms an important aspect of a child's overall health status and of their school readiness.
- Oral health should be included as part of the child healthy weight pathway to ensure partnership working and communication between services that contribute to good oral health in children.
- New national findings show that adding fluoride to drinking water can significantly reduce tooth extractions and cavities among children and young people in England.

4. Supporting vulnerable young people and improving health inequalities

- The social determinants of health into which children and young people are born, live and grow significantly shapes their physical, emotional, and mental wellbeing, which is turn impacts on their educational and employment outcomes.
- Whilst Oxfordshire has lower levels of deprivation and child poverty than other areas in the South East, there is still wide variation across the county with pockets of significant deprivation. The percentage of children in relative low-income families is increasing and within Oxford City 29% of children are estimated to live below the poverty line, after adjusting for housing costs.
- Within Oxfordshire the impact of deprivation and health inequalities can be seen across the life course with a significant difference in life expectancy at birth, and

years of healthy life expectancy, between the most and least deprived wards in Oxfordshire.

- This also impacts on educational outcomes. The gap in early years development between lower income pupils and other pupils in Oxfordshire has increased in the past 2 years of available data and is wider than seen nationally.
- The number of children achieving a good level of development at the end of reception was 49.9% in children with free school meal status, this was lower than England (56.5%) and the South East (55.4%). The average for all children was 73.5%, which was better than the England average (71.8%).
- The Attainment 8 score is significantly different between pupils eligible for free school meals and those who are not 35.9 vs 52.9, with a wider gap than seen nationally (39.1 vs 53.6).
- The attainment 8 score is also significantly lower for children in care (19.3) and similar to England (19.0).
- The number of children in care in Oxfordshire has been increasing at a faster rate than seen across England.

- The persistent absence rate for pupils in Oxfordshire secondary schools was worse than the national average in 2018/19 (pre covid-19 pandemic data) at 14.7% compared to 13.7% across both the South East and England.
- The number of electively home educated (EHE) registrations has increased since 2016/17, with the biggest rise in 2020/21 (a 31% increase).
- Both these groups are at risk of becoming isolated from the School Nursing Service and service provider are not always notified or provided with contact details for them.

- National data shows that, in children and young people aged 5 to 19 years, there was a higher proportion who had contact with the school nurse by level of deprivation 2.1% (most deprived 10%) vs. 0.8% (least deprived 10%).
- Children aged 5 to 19 with a recorded vulnerability had a higher proportion of contacts compared to those who did not 7.0% vs 2.6%.
- Safeguarding and liaison with other teams are the top areas of workload for primary and secondary school nurses in Oxfordshire.

- Primary prevention, early intervention, and mitigation are key to improving outcomes for vulnerable children and ensuring ‘no child is left behind.’ An essential part of reducing the number of children who are vulnerable to poorer outcomes is investing in early years and early intervention support.
- Providing intervention early, requires early identification of pupils who are at risk or vulnerable to poorer outcomes.
- Early help and support for children and young people also relies on organisations working together and having good paths of communication with early information sharing as required.
- Children who face the most adversity are least likely to have the resources needed to help them build resilience, schools can help to support and enable children and young people to build resilience.

- 4 key levers where interventions and resources can be targeted to impact health outcomes and reduce health inequalities for young people are:
    - Accessing services and support
    - Experiences of services and support
    - Health behaviours
    - Relationships with others (including parents/carers and peers)
- Having a single point of access into early intervention and support, such as early support hubs, helps to make service more accessible.

5. Supporting complex and additional health and wellbeing needs

- A child's health can impact their emotional and mental wellbeing, school attendance and their ability to access the full curriculum.
- Good provision for children and young people with SEN requires good co-operation between services and joint commissioning arrangements between Local authorities and Clinical Commissioning Groups (CCGs) that are informed by clear assessment of local needs.

- Complex and additional health and wellbeing needs are a key area of need in Oxfordshire as there is a higher percentage of school pupils with Social, Emotional and Mental Health needs (SEMH) than in England (3.1% vs.2.7%) and the South East (2.7%), and the percentage is increasing at a faster rate.
- There is a higher proportion of pupils with Special Education Needs and Disability (SEND) than in England and the South East, with 14.7% of pupils receiving SEN support compared to 12.2% across England. This is higher than all other local authorities in the South East apart from Southampton.
- The number of children with Special Education Needs support in Oxfordshire has increased at double the rate of England since 2015/16.
- For those children receiving SEN support, educational outcomes are worse than the national figures through early years, key stage 2 and key stage 4. However, children without a special education need, perform better than the national average for all of these stages. There is therefore a wider gap in educational outcomes between those with and without SEN compared to the national picture.
- Persistent absence rates are higher for SEN children in Oxfordshire than England both with an education and health care plan, EHCP (25.5% vs 24.6% England) and without an EHCP (19.6% vs 17.9% in England).
- Over one quarter of all EHE registered during 2020/21 had a Special Education Need (SEN).

6. Supporting self-care and improving health outcomes

- School/college based interventions to increase health literacy and boost understanding of self-care are a crucial starting point to embed a lifelong culture of self-care

- An important part of improving health literacy is helping to build young people's confidence in communicating with health professionals and accessing appropriate service.
- Digital provision can form an important part of improving health literacy and self-care and making services more accessible and youth friendly.
- Currently there are several different online resources with information on health and wellbeing, and relevant services in Oxfordshire.
    - This can make the online resources more confusing to navigate and there is not a good awareness of the websites that are available locally.
    - Having online/digital information on health and wellbeing, and services available from a clear single source, would help to empower young people and parents of school aged children to find resources and services available.
- Oxfordshire is considered to have low levels of digital exclusion and was ranked as 16th highest in the country for internet engagement. However, at ward level there was wide variation with areas of higher deprivation, such as Blackbird Leys, being classified as e-withdrawn (individuals who are least engaged with the internet). It is important that digital exclusion is considered in the planning of service provision to ensure they are accessible by other means.
- Providing a single point of access into services would help to make them more accessible for children and young people and empower them in managing their health and wellbeing needs.

Recommendations

Detailed recommendations for the local authority, public health service provider and education settings can be found in chapter 6 of the Needs Assessment. Broadly there were three key themes:

1. Visibility/accessibility of support services for children, young people and their parents/carers. Recommendations included:

- Having a single point of access into support services to improve accessibility and provide triaging/signposting to the most appropriate support.
- Provision of a digital service with streamlining of online resources, expansion of the current Text Messaging service and exploring options for digital mental health provision
- Ensuring effective advertising of services, appropriate to target groups e.g., parents or young people.

2. Identifying Need – services should be needs led and well informed by local data. Recommendations included:

- Use of available frameworks to identify need within schools
- Carrying out school surveys at key stages (transition into secondary school, at age 13/14 years) to identity as early as possible children who are at risk of or vulnerable to poorer outcomes and providing evidence-based early intervention and support as required.

- Initiatives and interventions should be focused in areas with identified need and higher levels of deprivation.

3. Communication between teams. Recommendations include:

- Regular meetings between key groups, for example school health nurses with mental health leads/pastoral support/MHSTs/Locality Community Service and initiatives such as the Link Programmes (bringing together education and mental health professionals).
- Clear pathways for sharing information, such as notifying school nurses of young people registered as electively home educated, pupils with persistent absence or other vulnerable groups.
- Effective sharing between (and within) local authority teams on current strategic work initiatives and consultation, to maximise learning, avoid duplication of work

1. Introduction

Ensuring every child has the best start in life is one the key priorities of the Office for Health Improvement and Disparities (OHID, formerly Public Health England). The Healthy Child Programme is a universal programme of prevention and support for children and young people aged 0-19, or up to 25 years in young people with a Special Education Need or Disability (SEND). It is delivered as part of the local authority's statutory responsibility to commission public health services for children and young people. Investing in children and families and enabling children to thrive is a crucial part of achieving the Governments 'Levelling Up' agenda to reduce inequalities seen across the country. Oxfordshire's County Council's current Coalition Cabinet recognises the importance of supporting children and young people, with one of its 9 key priorities being to 'create opportunities for children and young people to reach their full potential.'

The social determinants of health into which children and young people are born, live and grow significantly shapes their physical, emotional, and mental wellbeing.[1] An essential part of reducing the number of children who are vulnerable to poorer outcomes is investing in early years and early intervention support. Delivering help early relies on organisations working together, with a multi-agency approach, to deliver the best care and support to children, young people and their families. School Health Nurses, who deliver the 5-19 aged elements of the Healthy Child Programme, have a key role in providing a needs-led, personalised service that aims to deliver support and intervention early.

This Health Needs Assessment of school aged children (5-19 years) has been carried out to gain a clearer picture of the needs of children, young people and their families across Oxfordshire. Local data has been reviewed and benchmarked alongside national data, and the current national guidelines and evidence base for the effective delivery of the Health Child Programme has been reviewed. The outcomes and recommendations from this Needs Assessment will help to inform the public health commissioning of the Healthy Child Programme, to ensure the provision of an evidence based service that is responsive to the needs of children and young people across Oxfordshire.

National Policy and Guidance

2.1 The Healthy Child Programme

The Health and Social Care Act 2012[2] sets out the local authority's statutory responsibility for commissioning public health services for children and young people aged 0 to 19 years. Local authorities play a key role in ensuring integrated commissioning and delivery with a wide range of stakeholders, including the NHS, voluntary sector, and schools/colleges.

[1] Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010. - GOV.UK (www.gov.uk)
[2] Health and Social Care Act 2012: fact sheets - GOV.UK (www.gov.uk)

The Healthy Child Programme[3] aims to bring together health, education, and other main partners to deliver an effective programme for prevention and support for children and young people aged 0-19 (and those with SEND up to age 25). It is a universal programme, available to every child and aims to identify families that may need additional support and children who are at risk of poor outcomes, providing a personalised response. Originally published in 2009, it had a rapid review to update evidence in 2015 in relation to safeguarding guidance. Different elements of the Healthy Child Programme are co-ordinated by healthcare professionals with the 0-5 element of the Programme led by Health Visitors (HVs) and the 5-19 element led by School Health Nurses (SHNs). These services are delivered by a skill mix of staff and may be integrated with other services. In the 0-5 Healthy Child Programme there are several mandated child reviews that must be carried out. There are no mandated reviews for school aged children but recommendations for best delivery of the service and opportunities to develop a framework of reviews based on evidence and local need.

The Healthy Child Programme 5-19 element aims include:

- Immunisation and screening
- Promote oral health
- Reduce childhood obesity
- Support development of healthy relationships and good sexual and reproductive health
- Early identification of health and wellbeing issues, with support and early intervention
- Building resilience to cope with the pressures of life
- Helping children to thrive and gain maximum benefit from education
- Support parents, carers, and guardians to keep children healthy, safe and to reach their full potential

Local commissioning arrangements should also focus on the needs of children and young people, ensuring they are ready for school within both:

- Mainstream education for those with additional health needs
- Special schools for those with complex health needs

2.2 School Nursing Service Delivery Model

The 'Best Start in Life' has been identified as a priority within Public Health England's 5-year strategy for 2020-2025[4] and is also included in the Governments Prevention Green Paper.[5] In May 2021 the government published updated guidance on a modernised health visiting and school nursing service delivery model that is 'Universal in reach – Personalised in response'.[6] This superseded the 4-5-6 models used previously and was accompanied by an updated 3-part guidance to support local authorities in the commissioning of the Healthy

[3] Healthy Child Programme: 5 to 19 years old - GOV.UK (www.gov.uk)
[4] PHE Strategy 2020-25 Executive Summary (publishing.service.gov.uk)
[5] Advancing our health: prevention in the 2020s – consultation document - GOV.UK (www.gov.uk)
[6] Health visiting and school nursing service delivery model - GOV.UK (www.gov.uk)

Child Programme 0-19 titled 'Best start in Life and Beyond.[7]' This covers both health visiting and school nursing services but for the purpose of this document the focus will be on the guidance for school nursing services and commissioning of the 5-19 provision.

The new service model has 4 levels of service:

- Community
- Universal
- Targeted
- Specialist

All services and interventions should be personalised to respond to children and families' needs across time. Evidence from 'No child left behind'[8] and 'Childhood Vulnerability in England'[9] advocates for a holistic, multi-agency approach to addressing inequalities and the importance of a needs-led approach to school health nursing. School Nurses have the clinical judgement and public health expertise to identify the health and wellbeing needs of children and young people and provide the appropriate support.

The High Impact Areas were also updated to reflect new evidence and policy. The 6 High Impact Areas for the Health Child Programme 5 to 19 provide an evidenced based framework for those delivering child public health services and are central to the delivery model (figure 1). They are:

1. Supporting resilience and wellbeing
2. Improving behaviours and reducing risk taking
3. Supporting healthy lifestyles
4. Supporting vulnerable young people and improving health inequalities
5. Supporting complex and additional health and wellbeing needs
6. Promoting self-care and improving literacy

These are related to the 4 aims for school age children and young people, namely to:

- Reduce inequalities and risk
- Ensure readiness for school at 5 and for life from 11 to 24 years of age
- Support autonomy and independence
- Increase life chances and opportunity

[7] Healthy child programme 0 to 19: health visitor and school nurse commissioning - GOV.UK (www.gov.uk)
[8] Vulnerability in childhood: a public health informed approach - GOV.UK (www.gov.uk)
[9] Childhood vulnerability in England 2019 | Children's Commissioner for England (childrenscommissioner.gov.uk)

Figure 1: High impact areas for school age years. Source: [Health visiting and school nursing service delivery model - GOV.UK (www.gov.uk)]

School nurses are specialist public health nurses (SCPHN) who work with children and young people 5-19, both in and out of school settings. Whilst the service should be led by registered school health nurses, the skill mix within the team can be developed according to local needs and a robust workforce plan. It is important that the skill mix is 'appropriate to meet the needs of the local school age population and that team members have clearly defined roles and responsibilities, with robust job descriptions to support these roles.'[10] Utilising specialist public health nurse skills is cost effective, and they act as a key link to the Local Authority's early help systems. Partnership working and collaboration is vital in responding to the needs of children and young people[11]. PHE advise 'a place-based, or community-centred, approach' so that local solutions are developed 'drawing on all the assets and resources of an area.'

[10] An RCN Toolkit for School Nurses: Supporting your practice to deliver services for children and young people in educational settings | Royal College of Nursing
[11] Health visiting and school nursing service delivery model - GOV.UK (www.gov.uk)

Figure 2: Universal health and wellbeing reviews and contacts as part of overall support 5 to 19, (or 24 if appropriate). Source: [Health visiting and school nursing service delivery model - GOV.UK (www.gov.uk)]

Along with delivering against the 6 High Impact Areas for school-aged years, school health nurses also have a role in:

- Supporting transition for school-aged children, for example transition between health visiting and school nursing to support school readiness, transition into secondary school and into adult services
- Health promotion including the prevention of unintentional injuries and accidents and education on drugs, alcohol, and tobacco
- Health reviews and assessments at key points e.g., reception starters, Year 6 to 7 review, mid-teen health review
- Delivery of the National Child Measurement Programme, plus interventions on healthy weight and exercise
- Supporting vulnerable children and those not in school, for example, looked after children, young carers, or young offenders, home educated children
- Contribution to safeguarding of children and young people
- Targeted support
    - Early identification, support, and training for complex or additional health needs (including dental health)
    - Support for young carers' health needs; Looked After Children (and those on the edge of care); young offenders; children of military families; asylum

seeking or refugee children; young people at risk of abuse or violence including domestic violence and abuse, child sexual abuse, child sexual exploitation and Female Genital Mutilation (FGM), gangs and county lines
    - Providing the support offered as part of the Troubled Families programme refreshed health offer or local equivalent
- Sexual health and contraception – support to reduce teenage conceptions and reduce STIs including:
    - Puberty sessions, condom distribution
    - Pregnancy testing, enhanced service to prescribe contraception including long-acting reversible contraceptives (LARCs) and emergency hormonal contraception, Sexually Transmitted Infection (STI) testing
- Screening – vision screening between ages 4 and 5
- Immunisations in schools
- Use of research and audit to deliver and evidence-based service with clear outcomes, with evaluation as an integral part of the process.
- Developing a whole school health profile in partnership with other professionals.

2.3 Commissioning Guidance: Healthy Child Programme 0 to 19[12]

PHE guidance for commissioners on model specification for the Healthy Child Programme (HCP) 'Best Start in Life and Beyond' emphasises the importance of a needs-led approach and being responsive to local needs. The 3-part commissioning guidance outlines the model specification for the delivery of the healthy child programme, and how best to measure performance and outcomes. The local delivery requirements should particularly focus on the six High Impact Areas listed in figure 1.

School nurses also play an important role in safeguarding children and young people. Their professional knowledge and expertise are well place to identify signs of sexual, physical, or emotional abuse or neglect including domestic abuse, sexual exploitation, grooming and exploitation to support or commit acts of terrorism (radicalisation), Female Genital Mutilation, modern slavery, and gang and electronic media abuse, and escalate accordingly[13]. In 2018, PHE published a rapid review on safeguarding to inform the Healthy Child Programme 5 to 19.[14] In line with the remit of the HCP the focus is on prevention and early intervention, to try and provide support and services before problems escalate.

As part of a whole system approach to public health and prevention there is benefit in having a named school nurse linked to each GP practice and appropriate setting (e.g. schools/colleges) with an agreed schedule of regular contact meetings for referrals and collaborative service delivery. This aim is to provide improved access and delivery of the HCP and ensure direct partnership with schools. The support on offer to children and their families should be promoted, and children and young people encouraged to access the

[12] Healthy child programme 0 to 19: health visitor and school nurse commissioning - GOV.UK (www.gov.uk)
[13] 007-366.pdf
[14] Rapid review on safeguarding to inform the healthy child programme 5 to 19: executive summary and key findings (publishing.service.gov.uk)

service. School nurses can also link to wider stakeholder and services, for example, local emergency department and the local Troubled Families team. Providers of the service should work with commissioners to consider an appropriate level of service is provided throughout the year, including during school holidays. For example, with online, text or telephone support. Nurse prescribing allows school nurses to support families to manage minor illness and reduce hospital admissions. The prescribing module should therefore be completed within the first 2 years of practice for newly qualified school nurses.

2. Guidance and Evidence: Six High Impact Areas

The Six High Impact Areas form the core of the model for delivery of the healthy child programme for school aged children and young people, as they have the biggest impact in improving outcomes. This section will look at the guidance and evidence base[15] around each high impact area.

2.1 Supporting Resilience and Wellbeing

3.1.1 Government Guidance and Initiatives

Mental wellbeing of children and young people is a high priority, with clear evidence to support the association between good mental health, educational engagement, and academic achievement. Half of all mental health problems present before the age of 14.[16] The COVID-19 pandemic has seen the number of children aged 5 to 16 with a probable mental health disorder increase from 1 in 9 in 2017 to 1 in 6 in 2020.[17] This has disproportionately affected children from economically disadvantaged backgrounds, females and those with pre-existing mental health needs. Delays in identifying and meeting emotional wellbeing and mental health needs can have far reaching effects on all aspects of children and young people's lives, as well as impacting their chance of reaching their potential and leading happy, healthy adult lives.

Supporting children and young people's resilience and wellbeing has been a focus of government initiatives in recent years, with a green paper published in July 2018 on 'Transforming children and young people's mental health provision.[18]' This set out the creation of **Mental Health Support Teams (MHSTs),** proposals for making mental health education compulsory in schools and training of a member of staff in every state secondary school in Mental Health First Aid. MHSTs work with schools to offer support and advice, deliver evidence based early interventions for mild-moderate mental health issues, and

[15] A guide to help people working in the health sector, identify evidence and information to inform decision-making on maternal, children and young people's health and wellbeing (koha-ptfs.co.uk)
[16] School aged years high impact area 6: Supporting self-care and improving health literacy - GOV.UK (www.gov.uk)
[17] Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey - NHS Digital
[18] Transforming children and young people's mental health provision: a green paper - GOV.UK (www.gov.uk)

liaise with external specialist services as required. The MHST works alongside a senior mental health lead within schools (where established), who is a staff member trained to support the wellbeing and mental health needs of pupils. School nurses are also expected to work closely with the new MHSTs as part of their role in 'identifying issues early, determining potential risks and providing early intervention to prevent issues escalating.'

The green paper was further developed with **the Children's and Young people's Mental Health Implementation Programme** from Department for Education which set out to have:

- MHSTs for 30% of all pupils by 2023
- £9.5 million to train up 7,800 senior mental health leads in schools and colleges this financial year, all state schools by 2025[19]
- £7 million Wellbeing for Education Recovery[20]

The £7 million grant for 2021/22 was designed to build on the previous **Wellbeing for Education** return project which offered support to schools and colleges to better meet the wellbeing and mental health needs of their pupil and students in the recovery from the impact of COVID-19. The grant enables local authorities to choose where to spend the money to best meet the local needs of pupils in their areas. 2021 government guidance on 'Promoting children and young people's mental health and wellbeing' focuses on principles of a whole school approach to promoting mental health and wellbeing.[21] It highlights the importance of identifying needs and monitoring impact of interventions on a more formal bases, to help inform commissioning at a school level up to local authority level.

The **Link Programme**[22] is another established national initiative, with funding from the Department for Education, that is delivered by the Anna Freud Centre. It aims to link together education and mental health services under the leadership of Local Authorities (LAs) and Clinical Commissioning Groups (CCGs) to identify the support required by children and young people in their area. Independent evaluation of the first phases have shown it to strengthen communications and working between schools and Children and Young people's Mental Health Service (CYPMHS). It also improved awareness and knowledge of referral pathways/procedures, evidence-based practice and the mental health issues and risk factors relation to children and young people.

The **Anna Freud Centre** has also developed a framework for schools and Further Education (FE) colleges to support mental health and wellbeing for schools. The evidence-based 5 Step Framework helps schools to develop a personalised action plan (figure 3).[23] In the areas of understanding need there are free resources for schools to measure pupil wellbeing and identify pupils at risk.[24] Those found to be in need can then be given the appropriate support.

[19] Training launched for mental health leads in schools and colleges - GOV.UK (www.gov.uk)
[20] Wellbeing for education recovery: grant determination letter - GOV.UK (www.gov.uk)
[21] Promoting children and young people's mental health and wellbeing (publishing.service.gov.uk)
[22] The Link Programme | Anna Freud Centre
[23] 5 Steps to Mental Health and Wellbeing (annafreud.org)
[24] Understanding Need (annafreud.org)

Figure: 3 Steps to mental health and wellbeing – a framework for schools and colleges. Source: Anna Freud Centre

3.1.2 Evidence for Early Intervention

The Early Intervention Foundation published several reviews and reports in 2021 examining the evidence for the effectiveness of early interventions to support the mental health and wellbeing of children and young people. Intervening early can provide support before patterns become ingrained and difficult to reverse, which in the long term can reduce the costs associated with treating mental disorders.[25] Persistent depression during adolescence is associated with significantly increased risk of depression and poorer education and employment outcomes during adulthood. In supporting adolescent mental health, the emphasis should be on promotion, prevention and early intervention.[26] Schools are well placed to build relationships with children and young people, that allows need to be identified and treated early.

Some of key findings from these reports were:

- Universal social and emotional learning (SEL) interventions have good evidence of enhancing young people's social and emotional skills and reducing symptoms of depression and anxiety in the short term.[27]
- There is good evidence that universal and targeted cognitive behavioural therapy (CBT) interventions are effective in reducing internalising symptoms in young people.
- High-quality programme implementation is critical to achieving positive outcomes
- Universal interventions can be effectively delivered by teachers; however, there is no evidence that teacher-delivered interventions are effective in addressing the needs of students with symptoms of depression or anxiety

[25] The case for early intervention to support levelling up and Covid recovery | Early Intervention Foundation (eif.org.uk)
[26] adolescent-mental-health-summary.pdf
[27] Improving social and emotional learning in primary schools: Guidance report | Early Intervention Foundation (eif.org.uk)

- The impact of depression and anxiety prevention interventions and violence prevention interventions tends be stronger when they are targeted at young people with elevated but subclinical symptoms
- In addition to supporting mental health and behavioural difficulties it is essential to support the development of social, emotional, and behavioural competencies at a universal level.
- Bullying prevention interventions are effective in reducing the frequency of traditional and cyberbullying victimisation and perpetration
- Violence prevention interventions have been shown to have a small but positive effect in the short term
- There is limited evidence on the effectiveness of school-based interventions to prevent suicide and self-harm.
    - Similar results were found in a Cochrane UK review on interventions for self-harm in young people[28]. The only studies with positive effects were a relatively prolonged form of psychological therapy, called Dialectical Behaviour Therapy for Adolescents (DBT-A), for preventing repetition of self-harm.
- There was promising evidence on the effectiveness of interventions designed to reduce sexual violence and harassment when delivered to young people at risk of experiencing sexual violence.

The key recommendations within both reports for interventions in schools included:

- Supporting schools to implement evidence-based interventions or approaches to social and emotional learning and to preventing mental health problems.
- Further details on the of specific interventions or programmes can be found in the EIF reports. Examples include:
    - PATHS[29] – a universal programme for 6-12 year olds that teaches emotional and social competencies
    - Blues Programme[30] - targeted school-based group CBT intervention programme for pupils age 13 to 19 with depressive symptoms. Strong evidence for positive long term impact.
- Support schools to adopt a whole-school approach, as whole-school programmes are more likely to be effective and lead to enduing positive change in improving young people's mental health and behaviour.
- Implementing high quality teacher training to support young people's mental health and wellbeing
- Provide external mental health expertise to schools to support the most vulnerable.
- Ensuring that schools can access expert support delivered by external professionals, such as Cognitive Behavioural Therapy (CBT), for pupils who need extra help.
- As part of this, a system of identification is needed to better target the most vulnerable pupils at risk of developing mental health and behavioural problems, so they can receive timely early intervention.

[28] Interventions for children and adolescents who self-harm | Cochrane
[29] PATHS Elementary curriculum | EIF Guidebook
[30] Blues Programme | EIF Guidebook

3.1.3 Summary

- Supporting the mental health and wellbeing of children and young people is a current high priority within government.
    - COVID-19 pandemic has seen increase in number of children with a probable mental health disorder
        - Increase from 1 in 9 (2017) to 1 in 6 (2020)
        - Disproportionate effect on those from disadvantaged background, females, or those with pre-existing conditions.
    - Mental health and wellbeing impact on educational and employment outcomes in children and young people.
- Mental Health Support Teams (MHSTs) are to be available to 30% of pupils by 2023
- All state schools/colleges are to train a senior mental health lead by 2025
- Improving mental health and wellbeing requires a whole school approach
    - Universal interventions to improve social and emotional skills
    - Alongside targeted interventions/support for those with identified needs
- Providing the best support for the mental health needs of children and young people requires good joined up working/communication between schools, specialist mental health services (Children and Adolescent Mental Health Services - CAMHS) and the local authority (including between different teams within the LA).
    - This is supported by MHSTs and initiatives such as the Link Programme.
- It is important to identify local need and monitor the impact of interventions
    - To support commissioning of services
    - Develop a personalised action plan within schools
    - To identify needs early in those needing additional support
- The wellbeing for education recovery grant enables local authorities to choose where to invest funds to meet local mental wellbeing needs in the recovery from the impact of COVID-19.

2.2 Improving health behaviours & reducing risk taking[31]

Risky behaviours are 'those that potentially expose young people to harm, or significant risk of harm, which will prevent them reaching their full potential.'[32] Experimenting and seeking new experiences are a normal part of aging in young people and behaviour can be influenced by peers, friend, family, social media, and the local community. Health-harming behaviours are increased in children and young people who have been exposed to more adverse childhood experiences, this also contributes to poorer health outcomes. Good wellbeing plays a protective role in reducing risk taking in children. In the What About YOUth? Survey in 2014, children who report higher WEMWBS (a measure of wellbeing)

[31] School-aged years high impact area 2: Improving health behaviours and reducing risk - GOV.UK (www.gov.uk)
[32] School-aged years high impact area 2: Improving health behaviours and reducing risk - GOV.UK (www.gov.uk)

scores are less likely to engage in risky behaviours such as drinking or smoking and more likely to state that their general health is excellent.[33] Examples of risky/health-harming behaviours include binge drinking, smoking, violence, substance misuse and unintended teenage pregnancy.

3.2.1 Teenage Pregnancy, Relationships and Sex Education (RSE), and Child Sexual Exploitation (CSE)

Whilst there has been a reduction in under-18 conception by 60% since 1998, there is still variation seen between local authorities and at ward level. The teenage birth rate in England is also higher than other western European countries. Teenage pregnancy carries several risk factors such as increased risk of stillbirth, higher incidence of low birth weight of term babies, increased infant mortality rate and higher rates of poor mental health for up to 3 years after birth which is a risk factor for child developmental delay at 2 years. The 'Teenage Pregnancy Prevention Framework'[34] recommends 10 key factors of effective local strategies providing a whole systems approach that covers: targeted prevention work, support for parents to discuss relationships and sexual health, training for professionals on relationship and sex education (RSE) and sexual health advice in other services used by vulnerable young people. This recognises that there are individual risk factors associated with pregnancy before the age of 18 and highlights the importance of accessible and trusted health and community services.

Addressing individual risk factors is important in both young women and men. Young men experiencing fatherhood are more likely than older fathers to[35]:

- have experienced violent forms of punishment in childhood and twice as likely to have been sexually abused
- have poor health and nutrition
- have pre-existing serious anxiety, depression, and conduct disorder
- drink, smoke and misuse other substances (1 in 6 men under 25 accessing drug and alcohol services are young fathers[36])

Advice and access to contraception in non-health settings, such as schools, can provide universal support and targeted intervention with the potential to reach large numbers. Within schools a new curriculum for Relationship and Sex Education (RSE) was in place in from September 2020, although introduction was impacted by the COVID-19 pandemic. The new curriculum guidance has a requirement to teach cross-cutting skills such as mental health and wellbeing, personal health literacy and resilience as part of the curriculum, recognising the interplay between all these areas.[37]

[33] The wellbeing of 15-year-olds: analysis of the What About YOUth? survey - GOV.UK (www.gov.uk)
[34] Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)
[35] Fatherhood Institute Research Summary: Young Fathers: The Fatherhood Institute
[36] National Drug Treatment Monitoring System (NDTMS) data for 2014/15. Public Health England. 2016. NDTMS: reference data - GOV.UK (www.gov.uk)
[37] Relationships and sex education (RSE) and health education - GOV.UK (www.gov.uk)

In 2021 Ofsted carried out a review into school safeguarding policies to support victims of sexual abuse, alongside a NSPCC dedicated helpline[38]. The review found that in some cases incidents of harassment and abuse within in schools were 'normalised' by their frequency. Of 900 children and young people surveyed, the majority had experienced unsolicited images or sexist comments, in person at school or online/via mobile. The department for education is encouraging schools to dedicate time to train staff on how to deal with sexual abuse and harassment among pupils, building on the keeping children safe in education guidance[39], and strengthening the RSHE curriculum that is now compulsory in schools. There is also additional advice from Department of Education on sexual violence and harassment for schools and safeguarding leads which helps guide response to incidents that occur.[40]

Specific guidance on how public health can support prevention and intervention of Child Sexual Exploitation (CSE) was published by Public Health England in 2019[41]. The three key ways in which public health can contribute to an enhanced response are:

1. Lead:
    - Directors of Public Health can strengthen local response by improving CSE frameworks and the services that intersect with it such as school nursing, mental health services, and drug and alcohol misuse services.
    - Development of a Joint Health and Wellbeing Strategy (JHWSs)
2. Understand
    - Inclusion of CSE in Joint Strategic Needs Assessment (JSNAs) can help to map local manifestation of the issue.
    - Engagement with children and young people in development of JHWSs
3. Act
    - Commissioning based on JSNAs and JHWSs for a needs-informed locally responsive service.
    - Integrated nature in range of services such as school health services, public mental health services, alcohol and drug misuse services.
    - Local licensing to disrupt CSE

3.2.2 Substance Misuse

Young people's alcohol and drug treatment in England is commissioned by local authorities using the public health grant. Specialist substance misuse services for young people are normally separate from adult services because young people's drug and alcohol problems tend to be different from adults and needs a different response. The Public Health grant conditions make it clear that: "A local authority must, in using the grant: have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment

[38] How we're taking action to keep young people and children safe in our schools - The Education Hub (blog.gov.uk)
[39] Keeping children safe in education 2021 (publishing.service.gov.uk)
[40] Sexual violence and sexual harassment between children in schools and colleges (publishing.service.gov.uk)
[41] Child sexual exploitation: How public health can support prevention and intervention (publishing.service.gov.uk)

services."[42] Specialist interventions for young people's substance misuse are effective and provide value for money. A department for Education cost-benefit analysis[43] found that every £1 invested saved £1.93 within two years and up to £8.38 in the long term.

3.2.3 Accident and Injury Prevention

Children living in more deprived areas are at greater risk of unintentional injury than children living in more affluent areas. Whilst the number of children seriously injured in road traffic collisions have fallen in recent years, there are significant health inequalities remaining. If all children and young people had a risk of injury the same as those in the least deprived areas, there would be 810 fewer serious or fatal injuries to pedestrians per year and 100 fewer serious or fatal injuries to cyclist[44]. Preventing injuries in the home and on the roads needs a whole system approach, and school nurses and other professionals have an important role to play in this.

The **PHE guidance on reducing unintentional injuries on the road in under 25s** highlighted three priority actions for focus:

1. Improve safety for children travelling to and from school
2. Introduce 20mph limits and zones in priority areas as part of a safe system approach to road safety
3. Action to prevent traffic injury and improve health works best when it is coordinated

National Institute for Clinical Excellence (NICE) have also published **guidance on prevention of unintentional injuries for under 15s**, both out of[45] and within[46] the home. This presents several recommendations including local surveillance, modification in rented and social housing, regulations for outdoor spaces and coordinating prevention activities amongst others. Alongside this is the importance of education for staff working with children, young people and their families. The school nurses have a role in providing education and training in this area.

3.2.3 Summary

- Health harming behaviours are increased in children and young people who have exposure to more adverse childhood experiences
- Children with higher wellbeing scores (positive wellbeing) are less likely to engage in risky behaviour.
- To reduce teenage pregnancy targeted prevention work is recommended for young people who are more at risk, including young men.

[42] Young people's substance misuse treatment statistics 2020 to 2021: report - GOV.UK (www.gov.uk)
[43] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182312/DFE-RR087.pdf
[44] Reducing unintentional injuries on the roads among children and young people (publishing.service.gov.uk)
[45] Overview | Unintentional injuries: prevention strategies for under 15s | Guidance | NICE
[46] Overview | Unintentional injuries in the home: interventions for under 15s | Guidance | NICE

- Access to contraception within schools can provide universal support and targeted intervention with the potential to reach large numbers.
- The new RSE curriculum recognises how mental health and wellbeing, personal health literacy and resilience all interplay with reducing risky behaviours.
- DfE encourages schools to dedicate time to train staff on how to deal with sexual abuse and harassment among pupils, given how frequent this was found to be in a recent NSPCC/Ofsted survey.
- Children living in more deprived areas are at greater risk of unintentional injury
- In reducing unintentional injuries on the road in children and young people, PHE advises improving safety of children travelling to and from school, introducing 20mph speed limits and taking a coordinated approach.

3.3 Supporting Healthy Lifestyles[47]

3.3.1 Obesity Guidance

The **'Promoting healthy weight in children, young people and families'**[48] resource to support local authorities was published in October 2018. It highlights the critical role that Local Authorities play in 'creating healthy places in which children can thrive.' It followed the Government's 'Plan for action on childhood obesity'[49] with the 'national ambition to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030.'

The action plan highlights the significant problem posed by childhood obesity, with nearly a third of all children in the UK being obese or overweight by age 11. It is recognised that up to 79% of children who are obese in their teens are likely to remain obese as adults, leading to health problems in adulthood such as type 2 diabetes, heart disease and certain cancers[50]. Being overweight in childhood can also impact on self-esteem and quality of life, and cause depression[51]. Obesity-related conditions are estimated to cost the NHS £6.1 billion every year.[52] There is a strong relationship between obesity and deprivation, at the age of 5 a child living in one of the most deprived areas is twice as likely to be obese compared to those living in the least deprived areas, and this gap increases further by age 11.[53] Obesity rates are also higher amongst Black, Asian and other minority ethnic groups.

Tackling obesity in childhood requires a range of actions across different areas including sugar reduction, calorie reduction, advertising and promotions and work within local areas and schools. Supporting health eating and lifestyles within schools is particularly important as obesity rates double during primary school years.[54] Educating children about how to lead

[47] School-aged years high impact area 3: Supporting healthy lifestyles - GOV.UK (www.gov.uk)
[48] Promoting healthy weight in children, young people and families - GOV.UK (www.gov.uk)
[49] childhood-obesity-a-plan-for-action-chapter-2.pdf (publishing.service.gov.uk)
[50] Tackling obesities: future choices - GOV.UK (www.gov.uk)
[51] Microsoft Word - Obesity and mental health_editede&formatted_MG.doc (mindcharity.co.uk)
[52] Health matters: obesity and the food environment - GOV.UK (www.gov.uk)
[53] School-aged years high impact area 3: Supporting healthy lifestyles - GOV.UK (www.gov.uk)
[54] National Child Measurement Programme: operational guidance (publishing.service.gov.uk)

healthy lifestyles, alongside providing a balance diet within school is very important in helping children and young people develop healthy lifestyles and habits that they can carry into adulthood. The impact of COVID-19 on obesity, led to a new policy paper on tackling obesity from the Department of health and social care.[55]

The specific briefing for Local Authority Public Health Teams within the **Promoting healthy weight resource**[56] outlines how a place-based and collaborative whole system approach is needed to have an effective impact on promoting healthy weight in children. Involving the local community is important to allow them 'more influence on the factors that underpin good health.' There are a range of actions suggested which have evidence they could contribute to reducing childhood obesity levels, these include:

- Encourage schools to explore the free Change4life teaching resources for primary schools, and Rise Above lesson plans for secondary schools.
- Align actions with other disease-specific actions
- Develop links with existing services such as National Child Measurement Programme (NCMP) to enable referrals of overweight or children who are obese into weight management services.
- School Food Standards to reduce sugar consumption.
- Within the contract for 0-19 years' service, ensure that:
    - There is universal and targeted support around diet, physical activity, and healthy weight.
    - Oral health improvement is integrated into the service
    - Public health nurses apply All Our Health[57] on Childhood Obesity in their work

The **National Child Measurement Programme** (NCMP) is included as part of the contract for the current 5-19 service, and the school nursing workforce carry out the measurements of children in reception and year 6. The NCMP is a nationally mandated public health programme where all reception aged and year 6 children have their weight and height measured, and their Body Mass Index (BMI) calculated. Data collected contributes to the Public Health Outcomes Framework and allows excess weight to be monitored. This is part of the government's approach to tackling child obesity. For children found to be under or overweight during the measurements, a letter is sent with advice and support offered by school nurses to families who require it. The outcomes from the programme provide an opportunity for conversations with children and their families about weight management. Public Health England published a step-by-step guide to assist professionals in having these discussions and supporting families to make positive changes.[58] The everyday interaction impact pathway is a useful tool for looking at the impact of actions on childhood obesity.[59]

NICE have also issued Clinical Guidelines to support with the identification and management of childhood obesity; Clinical Guideline 189 (Nov 2014) '**Obesity: identification, assessment**

[55] Tackling obesity: empowering adults and children to live healthier lives - GOV.UK (www.gov.uk)
[56] Promoting healthy weight in children, young people and families - GOV.UK (www.gov.uk)
[57] Early adolescence: applying All Our Health - GOV.UK (www.gov.uk)
[58] Let's talk about weight: a step-by-step guide to brief interventions with children and families for health and care professionals (publishing.service.gov.uk)
[59] RSPH | Childhood obesity

and management'[60] and '**Obesity in children and young people: prevention and lifestyle weight management programmes, quality standard (QS94**)[61] (July 2015). The NICE Clinical guideline highlights the importance of providing a supportive environment both at home and in schools for a child who is overweight and their family. Care should be coordinated around the child and family needs, and decisions made with the child and family. The eight quality statements that make up Quality Standard 94 include 'children and young people identified as being overweight or obese, and their parents or carers as appropriate, are given information about local lifestyle weight management programmes (Statement 5).' Other particularly relevant recommendations from the guidelines include:

- Working with Clinical Commissioning Group (CCG) to put in place a locally agreed obesity care pathway that spans both prevention and management for children, young people, and families.
- Ensure that lifestyle weight management services are linked with universal services
- Undertaking mapping of the voluntary, community and social enterprise sector to support healthy lifestyles, increase physical activity and improve access to sustainable food. Ensure opportunities are utilised.

3.3.2 Physical Activity for children and young people[62]

The **NICE guideline on Physical activity** published in 2009 recommended a coordinated local strategy to increase physical activity among children and young people. School nurses will play a role in helping to promote physical activity alongside local and national policy to help support children and young people to be active. There is good evidence for the benefits of physical activity on wellbeing[63] and that participating in sport can build resilience in children[64].

In Sept 2019 the **UK Chief Medical Officers' Physical Activity Guidelines** were published[65] with specific activity guidelines for children and young people aged 5 to 18 years. Physical activity is associated with better physiological, psychological, and psychosocial health. Evidence globally and from the UK suggests physical activity levels are higher in boys and decline through childhood into adolescence. There is some evidence that activity levels track from childhood into adulthood. The guidelines were developed from the review of scientific evidence published from 2010-2018. The helpful infographic summary of the UK Chief Medical Officers Physical Activity Guidelines, 2019[66] can be seen in appendix 2.

The physical activity guidelines state that children and young people should:

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[60] Overview | Obesity: identification, assessment and management | Guidance | NICE
[61] Overview | Obesity in children and young people: prevention and lifestyle weight management programmes | Quality standards | NICE
[62] Overview | Physical activity for children and young people | Guidance | NICE
[63] The wellbeing of 15-year-olds: analysis of the What About YOUth? survey - GOV.UK (www.gov.uk)
[64] . Public Health Wales (2018). Sources of resilience and their moderating relationships with harms from adverse childhood experiences. Report 1: mental illness. Available at: ACE & Resilience Report (Eng_final2).pdf (wales.nhs.uk)
[65] UK Chief Medical Officers' Physical Activity Guidelines (publishing.service.gov.uk)
[66] Physical activity for children and young people: 5 to 18 years (publishing.service.gov.uk)

- Engage in moderate to vigorous physical activity (MVPA) for an average of at least 60 minutes per day across the week. This can include all forms of activity such as Physical Education, active travel, after-school activities, play and sports.
    - It is proposed at least 30 minutes of activity per day should be while at school[67]
- Engage in a variety of types and intensities of physical activity across the week develop movement skills, muscular fitness, and bone strength.
- Aim to minimise the amount of time spent being sedentary, and when physically possible should break up long periods of not moving with at least light physical activity.

Education in physical health and fitness, including maintaining a healthy weight and the benefits of exercise, is included in the statutory guidance for physical health and mental wellbeing by the department for education.[68] The benefits of healthy eating and risks associated with unhealthy eating (such as obesity, tooth decay and cancer) are also included as part of the curriculum. It is also important that healthy weight messages are communicated to children, young people and families in a consistent and evidence-based way, and specific guidance and resources have been published by the UK government to support this.[69]

3.3.3 Oral Health

Oral health forms 'an important aspect of a child's overall health status and of their school readiness.'[70] 23.4% of 5 year olds in England experience visually obvious dental decay[71] and toothache and treatment can lead to absence from school or work for parents. In 'delivering better oral health: an evidence-based toolkit for prevention'[72] updated in Nov 2021, the evidence base for the prevention of dental caries in children and young people is examined. Universal recommendations with strong evidence include brushing teeth twice a day, fluoride varnish, and minimising the amount and frequency of consumption of sugar-containing food and drinks. Educating parents, children, and young people in healthy eating, such as using the **Eatwell Guide**[73] helps to support better oral health. Public Health England have also carried out a rapid review of evidence looking at the cost-effectiveness of interventions to improve oral health in children.[74]

Areas with higher levels of deprivation experience poorer dental health, with most recent data showing that 45% of variation can be explained by deprivation (aged 5, 35% vs 14%, from most vs least deprived quartile). There is also an association with BMI, children who are overweight or obese are more likely to have dental decay than those of a healthy

[67] childhood-obesity-a-plan-for-action-chapter-2.pdf (publishing.service.gov.uk)
[68] Physical health and mental wellbeing (Primary and secondary) - GOV.UK (www.gov.uk)
[69] Promoting a healthier weight for children, young people and families: consistent messaging - GOV.UK (www.gov.uk)
[70] School-aged years high impact area 3: Supporting healthy lifestyles - GOV.UK (www.gov.uk)
[71] Child and Maternal Health - Data - OHID (phe.org.uk)
[72] Delivering better oral health: an evidence-based toolkit for prevention - GOV.UK (www.gov.uk)
[73] The Eatwell Guide - GOV.UK (www.gov.uk)
[74] Main heading (publishing.service.gov.uk)

weight. The impact pathway for everyday interactions on child oral health, is a useful tool for measuring the demonstrating the impact of actions, for example from school health nurses, on oral health.[75]

New findings from the Office for Health Improvement and Disparities (OHID) and the UK Health Security Agency (UKHSA) showed that adding fluoride to drinking water can significantly reduce tooth extractions and cavities among children and young people in England.[76] It found that children and young people in areas in England with higher fluoride concentrations in water were up to 63% less likely to be admitted to hospital for tooth extractions due to decay than those in areas with low fluoride concentration. The benefits seen were greater for those in more deprived areas, reducing inequalities and helping level up oral health.

3.3.4 Summary

- National ambition is to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030.
- Nearly a third of all children in the UK being obese or overweight by age 11.
- Up to 79% of children who are obese in their teens are likely to remain obese as adults, leading to health problems in adulthood such as type 2 diabetes, heart disease and certain cancers[77].
- Supporting health eating and lifestyles within schools is particularly important as obesity rates double during primary school years.[78]
- NCMP should link well with existing services to enable referrals for children who are obese to lifestyle and weight management services.
- Within the 0-19 years' service, ensure that:
    - There is universal and targeted support around diet, physical activity, and healthy weight.
    - Oral health improvement is integrated into the service
- Oral health forms an important aspect of a child's overall health status and of their school readiness.
- Universal recommendations with strong evidence include brushing teeth twice a day, fluoride varnish, and minimising the amount and frequency of consumption of sugar-containing food and drinks.
- Educating parents and children in healthy eating, from the earliest introduction of solid food in infancy, helps to support better oral health.
- Adding fluoride to drinking water can significantly reduce tooth extractions and cavities among children and young people in England

[75] RSPH | Child oral health
[76] New report confirms fluoridation can reduce tooth decay among children - GOV.UK (www.gov.uk)
[77] Tackling obesities: future choices - GOV.UK (www.gov.uk)
[78] National Child Measurement Programme: operational guidance (publishing.service.gov.uk)

3.4 Supporting vulnerable young people and improving health inequalities

In 2021, the government set out an aim to 'level up' the country, by increasing prosperity, widening opportunity, and reducing inequalities between different parts of the United Kingdom. 'Levelling up' the nation's health is a core part of this agenda. Evidence from the Early Intervention Foundation[79], highlights that investing in children and families and enabling children to thrive is a crucial part of achieving this agenda.

Health inequalities are 'unfair and avoidable difference in health across the population and between different groups within society.'[80] They arise due to several different determinants or conditions; the four main domains are summarised in figure 4.

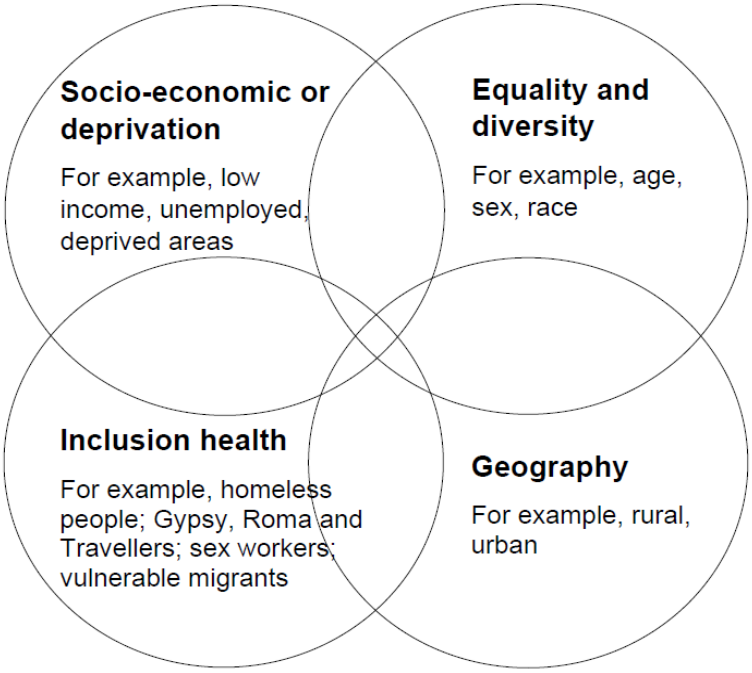


Figure 4: Four domains of health inequalities Source: : Health inequalities: place-based approaches to reduce inequalities - GOV.UK (www.gov.uk), adapted for SRH Toolkit

Vulnerable Children are defined as 'any children at greater risk of experiencing physical or emotional harm and/or experiencing poor outcomes because of one or more factors in their lives.'[81] In the **Children's Commissioner 2019 Childhood Vulnerability Report**[82] it was estimated that 2.3 million children are living with risk because of a vulnerable family background. At least a third of these are 'invisible' (in the sense of not being known to

[79] The case for early intervention to support levelling up and Covid recovery | Early Intervention Foundation (eif.org.uk)
[80] Health inequalities: place-based approaches to reduce inequalities - GOV.UK (www.gov.uk)
[81] No child left behind: understanding and quantifying vulnerability (publishing.service.gov.uk)
[82] Childhood vulnerability in England 2019 | Children's Commissioner for England (childrenscommissioner.gov.uk)

services) and are therefore not getting any support. In a typical class of 30, 6 children are growing up at risk due to family circumstances, 4 have an identified special education need (SEN) and 4 will have a mental health issue but only 1 of them will be accessing mental health services. The report highlights that 25% of the amount councils spend on children goes on the 1.1% of children who need acute and specialist services. The Office of the Children's Commissioner categorise groups of vulnerable children into 9 domains based on the type of vulnerability[83]:

- safeguarding concerns or in local authority care
- health and/or disability
- economic circumstances
- family circumstances and characteristics
- educational engagement
- involvement in offending and/or anti-social behaviour
- experience of abuse and exploitation
- and missing and absent children and minority populations

School readiness, defined as 'the broad range of knowledge and skills that provide the right foundation for good future progress through school and life,'[84] is a core part of the 0-5 healthy child programme. A good transition of children from the health visiting service to school nurses, can help support children to be ready to enter school and ensure they have the correct support. Five year olds with poor vocabulary are three times more likely to have mental health problems as adults, and 2/3 of 7-14 year olds with serious behavioural problems have language impairments.[85] By age 3 there is already a 17-month income-related language gap, with children from disadvantaged groups twice as likely to experience language delay. Children need support in preparing for school entry, including social and emotional preparation, and a plan to support children with special educational need or disability. Children should be supported to attend school every day, as this has been shown to result in better health, education, and socio-economic outcomes.

Children and young people who are vulnerable to adversity, abuse or neglect may not be willing to access conventional services. Vulnerable young people have increased rates of self-harm, and lesbian/gay/bisexual/transgender (LGBT) young people have increased smoking and recreational drug use. Persistent absence from school by age 14 and slower academic progress between 11-14 are risk factors for under-18 pregnancy. School nurses should work together with families, schools, and other partners to identify vulnerability early and provide appropriate support.

Children who are outside of school education also need particular focus to ensure they are not being missed within the Healthy Child Programme. These include children and young people who are:

- From Gypsy Travelling Families
- New to the UK including asylum seekers and refugees, who may be unaccompanied

[83] CCO-TP2-Defining-Vulnerability-Cordis-Bright-2.pdf (childrenscommissioner.gov.uk)
[84] Statutory framework for the early years foundation stage (publishing.service.gov.uk)
[85] School-aged years high impact area 4: Reducing vulnerabilities and improving life chances - GOV.UK (www.gov.uk)

- In Pupil Referral/Behavioural Units
- Electively Home Educated
- In Youth Offending Service
- Missing from education

There has been a reduction in spend of 48% between 2010/11 and 2019/20 in early intervention services (such as children's centres and youth work), and a 38% increase spending on crisis provisions (such as children's care services and youth justice). [86] This reflects some of the challenges in local government budgets and the resulting need in reduction of non-statutory services.[87] With the evidence for early intervention some areas have set up Early Support Hubs for young people under 25 that allow them to access mental health and wellbeing support.[88]

3.4.1 No child left behind

In September 2020, Public Health England published '**No child left behind: a public health informed approach to improving outcomes for vulnerable children.**'[89] This report aimed to support directors of public health, working with their local partners, to inform a coordinated approach to reduce the number of children who are vulnerable to poor health and wellbeing and to take action to mitigate risks of poor outcomes. There is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults.[90]

The report sets out a public health informed approach which encompasses preventing occurrence of adverse childhood experiences (primary prevention), intervening early when problems arise (early intervention) and creating an environment throughout the life course where negative impact is mitigated (mitigation). The social determinants of health into which children and young people are born, live and grow significantly shapes their physical, emotional, and mental wellbeing.[91] An essential part of reducing the number of children who are vulnerable to poorer outcomes is investing in early years and early intervention support. Figure 5 highlights the risk factors for vulnerability in childhood and the wide range of protective factors.

We know that early development of social and emotional skills in primary school makes a positive difference to children's long-term outcomes.[92] In secondary school universal and targeted prevention interventions can play a significant role in the reduction of depression and anxiety symptoms in young people.[93] Investing in evidence based early intervention has benefits in both the short and long term which can pay off for the economy as well as for

[86] Microsoft Word - CSFA Annual Funding Report 2021 v7 (probonoeconomics.com)
[87] GCR_2021_Summary_0.pdf (childrenssociety.org.uk)
[88] Fund The Hubs | Campaign | Mental Health Support | YoungMinds
[89] Addressing vulnerability in childhood - a public health informed approach (publishing.service.gov.uk)
[90] Fair Society Healthy Lives (The Marmot Review) - IHE (instituteofhealthequity.org)
[91] Strategic Review of Health Inequalities in England - post 2010 - Presentation of findings - IHE (instituteofhealthequity.org)
[92] What works in enhancing social and emotional skills development during childhood and adolescence? | Early Intervention Foundation (eif.org.uk)
[93] Adolescent mental health: A systematic review on the effectiveness of school-based interventions (emergingminds.org.uk)

local communities.[94] The estimated cost of late intervention in England and Wales for children and young people was estimated by the Early Intervention Foundation in 2016 to be £17 billion a year.

Resilience is the ability to adapt to stress and adversity[95] and is increased by protective factors. The successful management of risk promotes resilience and supportive relationships within the family or wider community provide protection against the impact of exposure to risk factors for vulnerability in children. Inequalities in resilience are likely to contribute to health inequalities due to a 'double burden' effect where those who face the most adversity

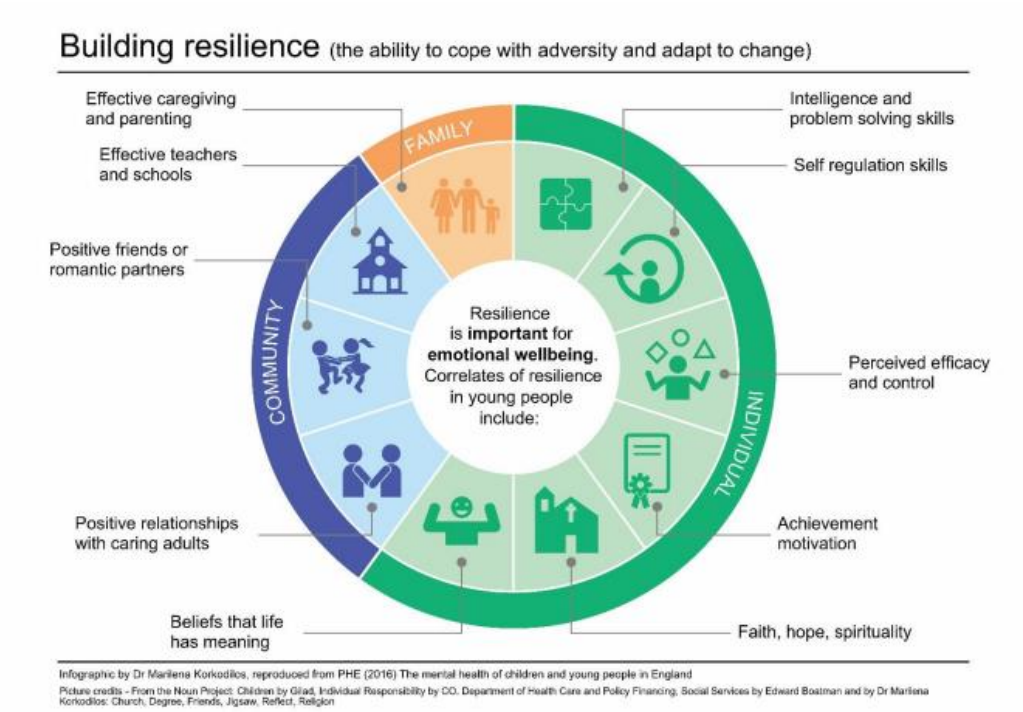


Figure 5: Building resilience
Source: PHE: The mental health of children and young people in England, 2016
Mental health of children in England (publishing.service.gov.uk)

are least likely to have the resources needed to help them build resilience.[96] Schools have an opportunity to ensure that children and young people are supported and enabled to build resilience[97].
Providing early help and support is an integral part of a whole system approach and school nurses play an important role in providing a universal, non-stigmatised, confidential service

[94] Realising the potential of early intervention | Early Intervention Foundation (eif.org.uk)
[95] Public Health England and UCL Institute of Health Equity. Building children and young people's resilience in schools. Health Equity Evidence Review 2. London: Institute of Health Equity; 2014. Review2_Resilience_in_schools_health_inequalities.pdf (publishing.service.gov.uk)
[96] Public Health England. Young people commissioning support: principles and indicators. London: Public Health England; 2018.
[97] Public Health England and UCL Institute of Health Equity. Building children and young people's resilience in schools. Health Equity Evidence Review 2. London: Institute of Health Equity; 2014. Review2_Resilience_in_schools_health_inequalities.pdf (publishing.service.gov.uk)

that is trusted by children and young people and ats as an essential protective factor. As can be seen in figure 5 the community and wider social and physical environment also has a key role to play, highlighting the importance of place-based approaches[98] to reducing inequalities and supporting vulnerable young people.

3.4.2 Clarifying what we mean by health inequalities for young people[99]

The Association for young people's health (AYPH) published a briefing paper in December 2021 supported by The Health Foundation looking at health inequalities and why they matter for young people. The report further clarified health inequalities in young people as 'the avoidable and unfair differences in physical and mental health outcomes between individuals or groups ages 10-25.' Young people are particularly sensitive to changes in their environment due to their developmental and life stages. The social determinants of health are complex with many overlapping factors but particularly relevant are education, employment, housing, transport, geography and the physical environment.

A conceptual model for young people's health inequalities by AYPH can be seen in figure 6 which highlights 4 key levers where young people are presented with either opportunities or barriers to achieving good health, namely:

- Accessing services and support
- Experiences of services and support
- Health Behaviours
- Relationships with others (including professionals, parents/carers and peers)

These present 4 key areas where interventions and resources can potentially be targeted to reduce young people's health inequalities.

[98] Health inequalities: place-based approaches to reduce inequalities - GOV.UK (www.gov.uk)
[99] AYPH_HealthInequalities_BriefingPaper1.pdf (youngpeopleshealth.org.uk)

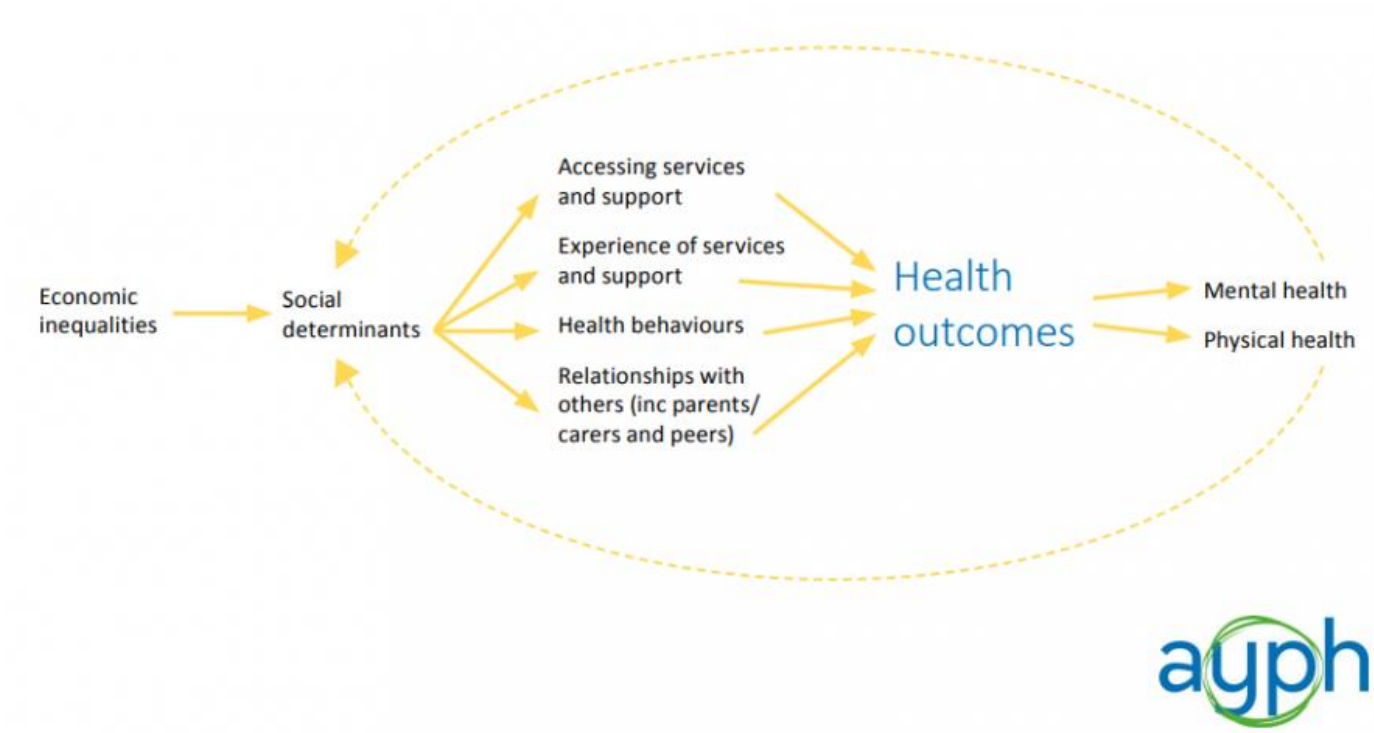


Figure 6: Model for young people's health inequalities
Source: AYPH_HealthInequalities_BriefingPaper1.pdf (youngpeopleshealth.org.uk)

3.4.3 Safeguarding

The publications from the UK Government Department of Education '**Working together to safeguard children'**[100] and '**Keeping Children Safe in Education 2021'**[101] both provide statutory guidance on safeguarding for local authorities, schools and colleges and people working with children and young people aged 18 and under. Local authorities, working with partner organisations and agencies, have specific duties to safeguard and promote the welfare of children in their area. Schools and their staff are an important part of the wider safeguarding system for children. The Children's Act 2004, which was amended by the Children and Social Work Act 2017, places new duties on key agencies, such as the police, clinical commissioning groups and the local authority to work together, with other local partners, to safeguard children in their area. Safeguarding is defined as:

- Protecting children from maltreatment
- Preventing the impairment of children's mental and physical health or development

[100] Working Together to Safeguard Children 2018 (publishing.service.gov.uk)
[101] Keeping children safe in education 2021 (publishing.service.gov.uk)

- Ensuring that children grow up in circumstance consistent with the provision of safe and effective care
- Raking action to enable all children to have the best outcome.

There should be a designated safeguarding lead within each school, and staff should be made aware of the key policies as part of their induction including child protection policy, behaviour policy, staff behaviour policy, safeguarding response in children who go missing from education and the role of the safeguarding lead. All staff should also be aware of their early local help process and receive safeguarding training. Staff should be able to look out for signs of abuse and neglect, child sexual or criminal exploitation, peer on peer abuse, and be alert to identifying children who need early help, particularly those who are vulnerable. Early help means providing support as soon as a problem emerges, and it relies on organisations working together, an assessment of the need for early help is carried out when a child or families are identified. Local areas should have a comprehensive range of effective, evidence-based services in place to address assessed needs early.

Early information sharing, with those who need to know such as the safeguarding lead, is critical in keeping children safe and vital for effective identification, assessment, and allocation of appropriate service provision. Specific advice on information sharing is available.[102] Figure 7 provides a summary of the assessment framework for child safeguarding and promoting welfare.

[102] Information sharing advice for safeguarding practitioners - GOV.UK (www.gov.uk)

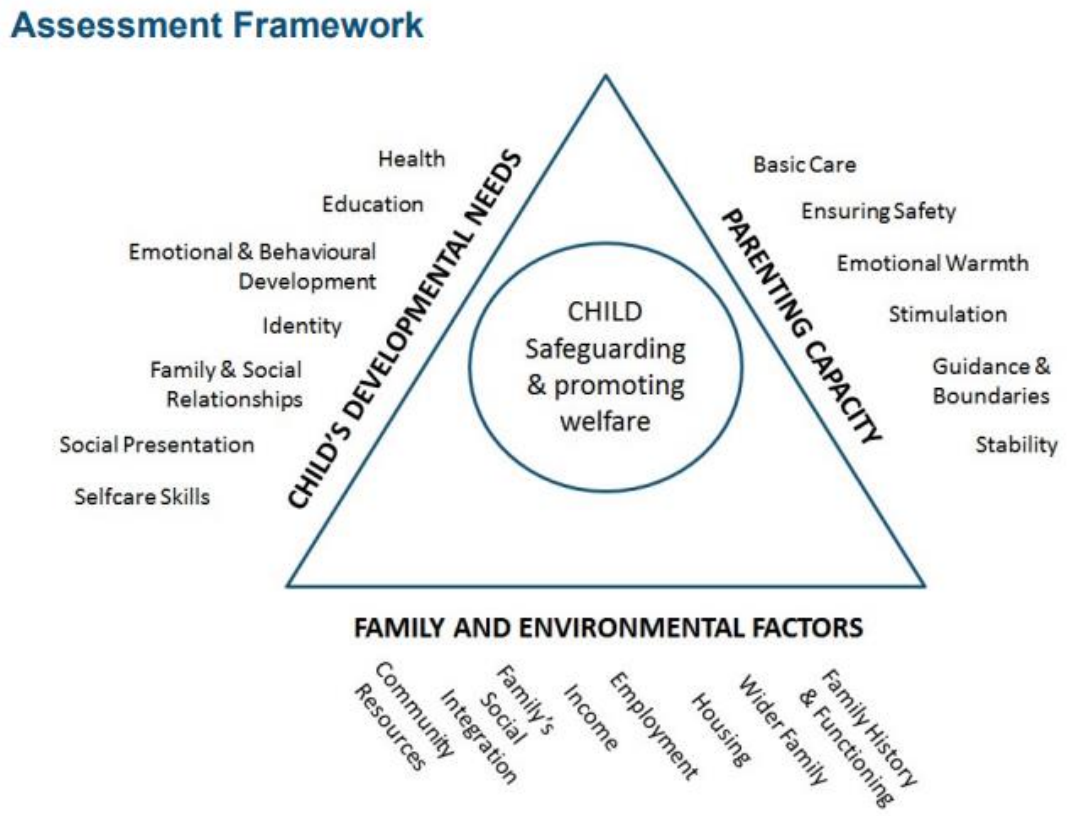


Figure 7: Assessment Framework for child safeguarding and promoting welfare. Source: Working Together to Safeguard Children 2018 (publishing.service.gov.uk)

3.4.4 Children in the criminal justice system

PHE published a framework[103] on preventing young people offending and re-offending setting out the CAPRICORN resource, which looks at the whole systems approach and upstream/downstream prevention. Figure 8 shows the CAPRICORN model and how the root causes link closely with risk factors in vulnerability for children. It highlights the importance of good support and early help in children with risk factors such as looked after children and children with neuro-disability. 41% of young offenders have experienced childhood bereavement.[104]

[103] Collaborative approaches to preventing offending and re-offending by children (CAPRICORN): summary - GOV.UK (www.gov.uk)
[104] Reaching marginalised young people - Association for Young People's Health (youngpeopleshealth.org.uk)

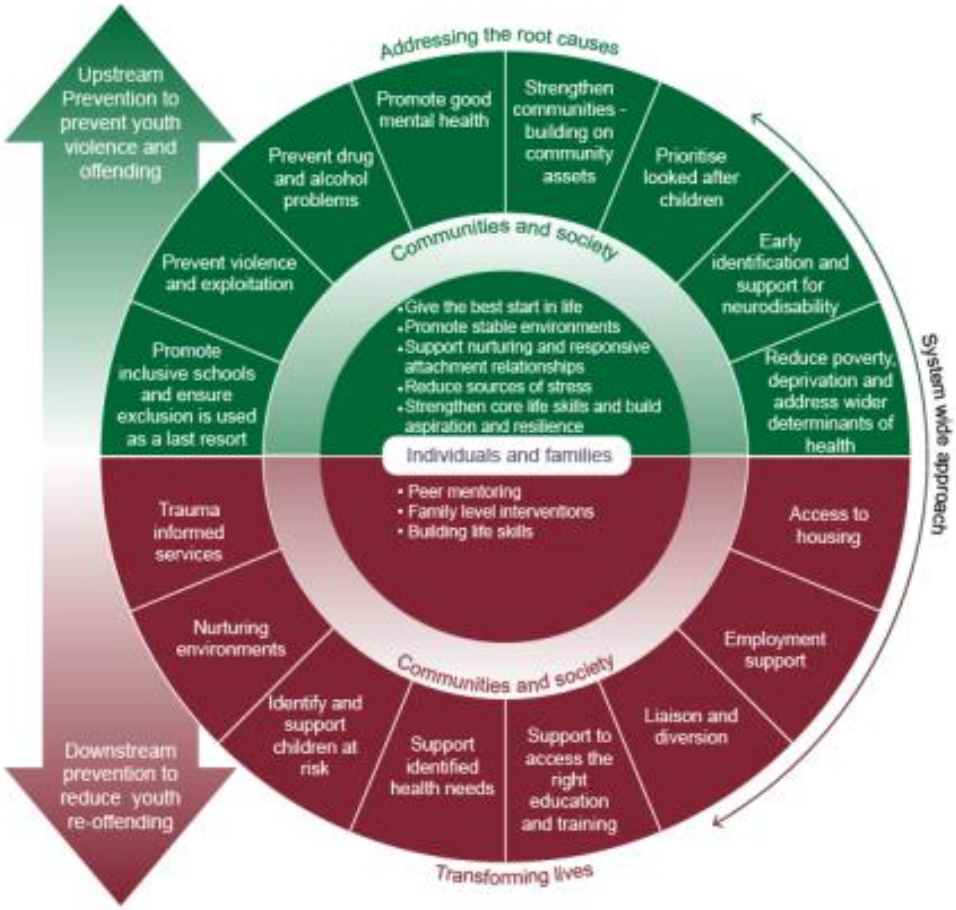


Figure 8: The CAPRICORN Model Source : [Collaborative approaches to preventing offending and re-offending by children (CAPRICORN): summary - GOV.UK (www.gov.uk)]

3.4.5 Interventions to improve mental wellbeing and resilience in children and young people living in poverty[105]

This evidence synthesis published by PHE in 2019 investigated the effectiveness of family and community based interventions to improve mental wellbeing and resilience in children and young people (aged 7-18 years) living in poverty. It highlighted that interventions are more likely to be effective if they include members of the population in the intervention design, staff are well trained, and the interventions are aimed at whole environment of children and young people, not just solely the children and young people themselves.

[105] Public Health England. Interventions to improve mental wellbeing and resilience in children and young people living in poverty. Feb 2019. PHE document (koha-ptfs.co.uk)

3.4.6 Children in Need

Children in Need, as defined by the Children Act 1989, encompasses all children receiving statutory support from social workers including those on a Children in Need Plan (CINP), on a Child Protection Plan (CPP) and Looked after children. 'Improving the educational outcomes of Children in Need of Help and Protection'[106], published by the Department for Education in Dec 2018, found that Children in Need experience trauma or adversity the lasting impact of which creates barriers to education across attendance, learning, behaviour, and wellbeing. Key points for action included:

- Skills and training to recognise the impact of trauma or adversity and to understand children's behaviour, enabling effective assessment of children's needs and long-term planning, particularly around transitions.
- Effective multi-agency working and information sharing between agencies and schools.
- Good relationships with children and families, through clear communication, empathy, and advocacy, underpinned by stability and consistency of support.
- Build on existing work to improve outcomes for vulnerable children more widely, particularly tackling domestic abuse, address exclusions from schools, and support children and young people's mental health.
- Need for more robust evidence of what interventions work to improve education outcomes of Children in Need.

3.4.7 Summary

- Investing in children and families and enabling children to thrive is a crucial part of achieving the levelling up agenda.
- There has been a reduction in spend of 48% between 2010/11 and 2019/20 in early intervention services (such as children's centres and youth work), and a 38% increase spending on crisis provisions (such as children's care services and youth justice). [107] This reflects some of the challenges in local government budgets and the resulting need in reduction of non-statutory services.[108]
- With good evidence for the impact of early intervention, some areas have set up Early Support Hubs for young people under 25 that allow them to access mental health and wellbeing support.[109]
- Early help and support for children and young people relies on organisations working together and having good paths of communication with early information sharing as required.
- The three key areas for a public health informed approach to improving outcomes for vulnerable children are: primary prevention, early intervention, and mitigation (where negative impact in the life course is mitigated)
- Early development of social and emotional skills in primary school makes a positive difference to children's long-term outcomes.

[106] Children in Need Review - Interim findings report (publishing.service.gov.uk)
[107] Microsoft Word - CSFA Annual Funding Report 2021 v7 (probonoeconomics.com)
[108] GCR_2021_Summary_0.pdf (childrenssociety.org.uk)
[109] Fund The Hubs | Campaign | Mental Health Support | YoungMinds

- The estimated cost of late intervention in England and Wales for children and young people was estimated by the EIF in 2016 to be £17 billion a year.
- Children who face the most adversity are least likely to have the resources needed to help them build resilience, schools can help to support and enable children and young people to build resilience.
- 4 key levers where interventions and resources can be targeted to impact health outcomes and reduce health inequalities for young people are:
    - Accessing services and support
    - Experiences of services and support
    - Health behaviours
    - Relationships with others (inc. parents/carers and peer)

3.5 Supporting complex and additional health and wellbeing needs

A child's health can impact their emotional and mental wellbeing, school attendance and their ability to access the full curriculum. In 2019, 23% of 11-15 year olds reported a long term illness or disability, with over half having asthma.[110] There is statutory guidance for governing bodies on supporting pupils at school with medical conditions.[111] It is important that pupils with medical conditions are supported so that they have full access to education, this includes school trips and Physical Education (PE). Governing bodies within schools must ensure there are appropriate arrangements in place to support pupils and that relevant professionals are consulted to ensure the needs of children are properly understood and effectively supported. The school nurse's role in supporting pupils at school with medical conditions includes supporting the implementation of a child's individual healthcare plan, providing advice and liaison, for example on training.[112] They should be notified by other healthcare professionals when a child has been identified as having medical condition that will require support at school.

The **SEND code of practice**[113] is a statutory code which contains details of legal requirements for organisations that work with and support children and young people with special education needs or disabilities. Around 1.4 million pupils in England have a special education need, defined by the SEND code of practice as a child or young person who has 'a learning difficulty or disability which calls for special educational provision to be made.' Children and young people with complex and additional needs may require an Education, Health and Care Needs Assessment (EHCNA) for the local authority to decide on the provision and support needed for the child, and an Education, Health and Care plan provided if required (EHCP).[114]

[110] Key Data on Young People 2019 - Association for Young People's Health (youngpeopleshealth.org.uk)
[111] Supporting pupils at school with medical conditions (publishing.service.gov.uk)
[112] Supporting pupils at school with medical conditions (publishing.service.gov.uk)
[113] SEND code of practice: 0 to 25 years - GOV.UK (www.gov.uk)

The scope of the SEND code of practice is broad and a brief summary is provided for the purpose of this document. Public Health services for children, delivered by the school health nurses, enable a whole population approach to health and wellbeing, with targeted support for the most vulnerable children and young people. The benefits of identifying SEN early are well recognised and within the school setting, pupils identified by the class or subject teacher will work with the school's Special Education Needs Coordinator (SENCO) to carry out a clear analysis of need. The Healthy Child Programme, with developmental assessments where concerns have been raised, can support early identification. The broad areas of need are:

- Communication and interaction
- Cognition and learning
- Social, emotional and mental health difficulties
- Sensory and/or physical needs

Good provision for children and young people with SEN requires good co-operation between services and joint commissioning arrangements between Local authorities and Clinical Commissioning Groups (CCGs) that are informed by clear assessment of local needs.

The **Schools guide to the SEND code of practice**[115] highlights the need to have high aspirations and expectations for children with SEN in education. All mainstream schools should provide support to children, whether or not they have an education and health care plan (EHCP). Every school should have a special education needs co-ordinator and parents should be informed of any provision made for their child. Under the **Equality Act 2010**[116] reasonable adjustments must be made to prevent children with SEND being put at a substantial disadvantage.

3.5.1 National strategy for autistic children, young people and adults: 2021 to 2026[117]

The Autism Act 2009 was the first disability-specific piece of legislation in England. This was followed by 2 strategies in 2010 and 2014. The latest strategy was published in 2021 and autism was also included as one of the top priorities in the NHS Long Term Plan in 2019. One of the 6 priority areas to be achieved by 2026 is around 'improving autistic children and young people's access to education and supporting positive transitions into adulthood.'

Special education needs data suggest 1.8% of all pupils in England now have an autism diagnosis but many autistic children and young people are still having poor experiences within school, and not reaching their potential or are struggling in the transition to adult life. To work towards the target in 2021/22 the government propose to:

- Provide £600,000 of funding for staff autism training and professional development in schools and colleges.

[115] Advice template (publishing.service.gov.uk)
[116] Equality Act 2010 (legislation.gov.uk)
[117] National strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK (www.gov.uk)

- Development of a new qualification for early years staff who want to specialise in SEND.
- Carry out a new anti-bullying programme in schools
- Opening 24 new special free schools that have provision specifically for autistic children and young people
- £8.6 million to facilitate engagement with families and children and young people.
- Supported internships, traineeships, and apprenticeships
- Support local areas to develop Supported Employment Forums

3.5.2 Summary

- A child's health can impact their emotional and mental wellbeing, school attendance and their ability to access the full curriculum. It is important that pupils with medical conditions are supported so that they have full access to education.
- School nurses should be notified by other healthcare professionals when a child has been identified as having a medical condition that will require support at school.
- Children and young people with a special education need or disability (SEND) are defined as those who have 'a learning difficulty or disability which calls for special educational provision to be made.'
- Good provision for children and young people with SEND requires good co-operation between services and joint commissioning arrangements between Local authorities and Clinical Commissioning Groups (CCGs) that are informed by clear assessment of local needs.
- The SEND code of practice highlights we should have high aspirations and expectation for children with SEND in education and that reasonable adjustments must be made to prevent children with SEND being put at a substantial disadvantage.
- It is estimated that 1.8% of all pupils in England now have an autism diagnosis but many autistic children and young people are still having poor experiences within school, and not reaching their potential or are struggling in the transition to adult life.

3.6 Supporting self-care and improving health literacy[118]

Healthy literacy is defined as the ability to obtain, read, understand and use healthcare information in order to make appropriate health decisions. The Department for Education's statutory guidance on '**physical health and mental wellbeing'**[119] lists areas of health and prevention, and basic first aid that pupils should know by the end of primary school. This includes how to recognise early signs of physical illness and areas of good self-care such as dental health, personal hygiene and dealing with common injuries. This should be further built on at secondary school to ensure all students have good health literacy at the end of the school education.

[118] School aged years high impact area 6: Supporting self-care and improving health literacy - GOV.UK (www.gov.uk)
[119] Physical health and mental wellbeing (Primary and secondary) - GOV.UK (www.gov.uk)

Self-care comprises 'the actions that individuals take for themselves, on behalf of and with others, to develop, protect, maintain and improve their health, wellbeing or wellness.'[120] A report was published in October 2021 by a coalition of health bodies on developing a blueprint for a self-care strategy for England titled '**Realising the Potential**.' One of the 9 key areas the government was advised to focus on was to 'enhance the national curriculum on self-care for primary and secondary age children.' School based interventions to increase health literacy and boost understanding of self-care are a crucial starting point to embedding a lifelong culture of self-care. The report highlights that more self-care techniques and signposting to appropriate NHS services should be included as part of curriculum, for example with workshops to teach school aged children self-care for common conditions, with an example case study[121]. This aligns closely with the high impact area 6 for school health nursing.

An important part of improving health literacy is helping to build young people's confidence in communicating with health professionals and accessing appropriate service. School nurses play a role in supporting young people to become health literate and educating them on how to access appropriate services for advice in supporting their physical and mental health. Health literacy supports the United Nations Convention on Rights of the Child Article 12 that states that children 'have the right to participate, engage and have a voice in decisions that relate to them'[122]. As young people move towards adulthood, it empowers them to make decision about their own health. Transition points are key moments, particularly the move from primary to secondary school, where empowering young people to take control of their own health and wellbeing can affect their future outcomes.[123] It is vital that young people have access to accessible, confidential services for health support and advice.

The Association for Young Peoples' health published a **school nurse toolkit** to assist school nurses in improving young people's health literacy[124]. A summary from the toolkit on supporting an extended approach to health and wellbeing across communities can be seen in figure 9. It includes ideas on how school nurses can support health literacy across a wider area, as it is not always possible to deliver face-to-face advice to all young people. Ideas include:

- A text service with a number available to all children and young people
    - For example, services such as ChatHealth which provides a secure, confidential messaging service for pupils.
    - Run a survey or questionnaire for pupils on health concerns, then deliver health literacy initiatives to address arising needs. This highlights the importance of a needs informed approach to service delivery.

[120] Realising-the-potential-developing-a-blueprint-for-a-self-care-strategy-for-England-WEB-VERSION_final.pdf (selfcarestrategy.org)
[121] Dr. Me project: Teaching children self-care for self-limiting illnesses in primary schools | RCP Journals
[122] OHCHR | Convention on the Rights of the Child
[123] Early adolescence: applying All Our Health - GOV.UK (www.gov.uk)
[124] AYPH_NursesToolkit_interactive.pdf (youngpeopleshealth.org.uk)

School nurses can also signpost to good online resources and community support services. Their knowledge of young people can be used to help inform local priorities and funding for young people's health. It is important that their role is well advertised, and their profile can be raised by raising awareness on school websites, at parents' evenings, attending school meetings, PHSE sessions, schools' assemblies and in immunisation sessions which can be an opportunity to deliver health literacy messages. Figure 9 highlights the school nurses' wider role in increasing health literacy and an extended approach to health and wellbeing across communities and the value of a place-based approach. Their role in the delivery of evidence-based interventions, such as immunisation programme, provides opportunities for health promotion.

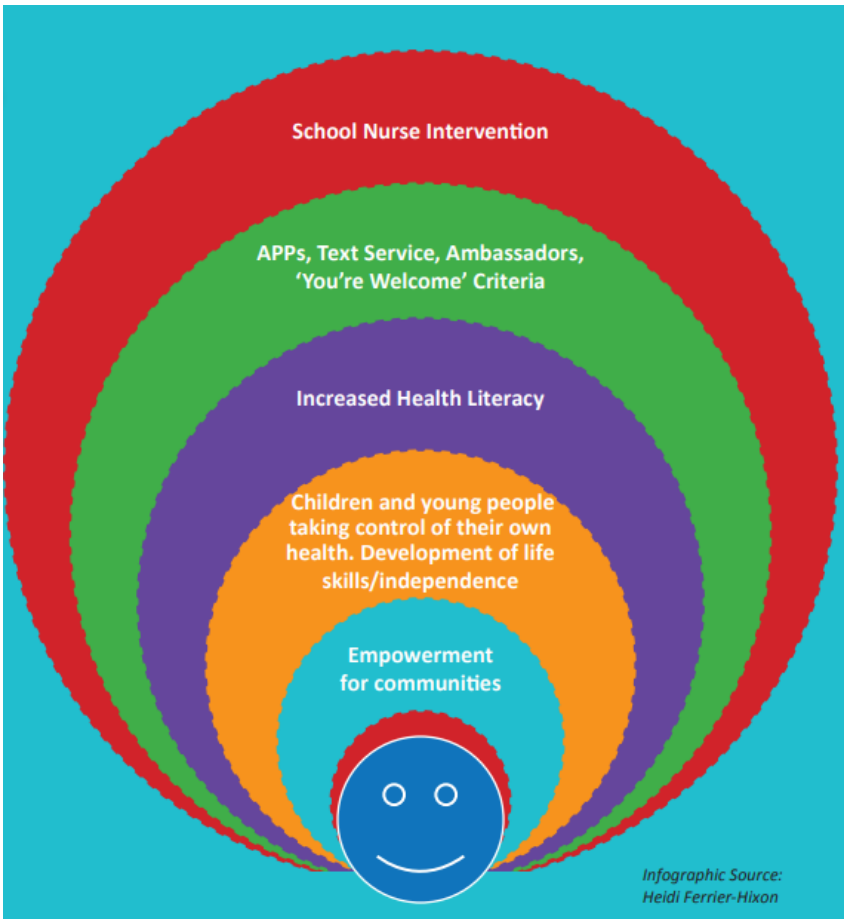


Figure 9: Supporting an extended approach to health and wellbeing across communities. Source: [AYPH_NursesToolkit_interactive.pdf (youngpeopleshealth.org.uk)]

3.6.1 Digital

Digital and virtual services allow school nurses and other professionals to work with children both in and out of school settings and can help to widen the reach to children and young

people. The need for good digital provision has been highlighted particularly by the emergence of the COVID-19 pandemic, and the impact it had on face to face services. Below some information is given on two digital providers who have been used by Local Authorities (LAs) nationally as a digital platform to provide health visiting, school nursing and mental health/wellbeing support for children young people and their carers.

ChatHealth[125] is an example of a secure text messaging based service that provides access to advice and support from school nurses for young people and parents. Some of the benefits identified by ChatHealth for young people include:

- Improved choice for young people on when and how to access confidential, non-personal help and advice.
- Overcomes stigma – half of all contacts begin anonymously.
- Breaks down social barriers – doubles the uptake of the service amongst male users compared to face-to-face clinics.
- Useful to extend hours of school nursing service, evening/out of term time.

An example of digital provision for mental health support for young people is Kooth[126]. This is a digital mental health platform for children and young people that provides four interactions within the platform:

- Therapeutic content and peer support
- Reactive/responsive therapeutic support – 1 to 9 sessions with a Kooth worker
- Structured therapy – offer of a series of chat sessions (max 10) by appointment with a named practitioner
- Ongoing therapeutic support - for those who need more than 10 sessions, this can be over a prolonged period, even years.

Some of the benefits of having a digital mental health support platform, such as Kooth, include ease of accessibility as needed (for those with digital access), quick response time, it is well informed by NICE recommendations and evaluated models, anonymity/no face-to-face can help young people to open up and have less fear of judgement. It is an example of how digital services can be used to widen the reach and availability of a service, and it has been commissioned by some areas as part of a mental health hub for young people.

3.6.2 Summary

- Healthy literacy is defined as the ability to obtain, read, understand and use healthcare information in order to make appropriate health decisions.
- Self-care is defined as the actions that individuals take for themselves, on behalf of and with others, to develop, protect, maintain and improve their health, wellbeing or wellness.
- School based interventions to increase health literacy and boost understanding of self-care are a crucial starting point to embedding a lifelong culture of self-care.

[125] Home Page - ChatHealth
[126] Home - Kooth

- An important part of improving health literacy is helping to build young people's confidence in communicating with health professionals and accessing appropriate service.
- School Nurses play a key role in supporting young people to improve their health literacy and self-care, as well as signposting them to good online resources and community support services.
- Opportunities for Making Every Contact Count and health promotion can be taken when delivering other parts of the SHN role such as when delivering immunisations.
- Digital provision of services can help to widen reach and make services more accessible to children, young people and their carers.

4. Oxfordshire

4.1 Local Authority Context

Below is a summary of the current Oxfordshire local authority political strategy and agenda relating to school-aged children and young people.

- **Oxfordshire County Council's Corporate Plan.** The Oxfordshire Fair Deal Alliance, Oxfordshire County Council's current Coalition Cabinet formed in 2021 and has 9 priority themes as part of the Strategic Plan 2022-2025.[127] Theme number 3 is 'to prioritise the health and wellbeing of residents' and number 7 is to 'Create opportunities for children and young people to reach their full potential.'
    - The cabinet 'will support all our children and young people, and their families, to achieve their very best and to prepare them for their future, including those more vulnerable and with additional needs.'[128]
    - Supporting children and young people, and their families is a key part of the local political agenda to make Oxfordshire a greener, fairer county and ties in with several the other cabinet priority themes.

- **The Oxfordshire Joint Health and Wellbeing Strategy** (2018-2023)[129] highlights several areas which closely align with the 0-19 commissioning priorities, the key message being to 'prevent, reduce, delay.'
    - Following recommendations from the Mental Wellbeing Needs Assessment for Oxfordshire carried out in 2021, there was recognition by the Board that the 16-24 age group has been particularly adversely impacted by the pandemic and specific interventions might be needed from across the system to address their needs
- The strategy includes prevention of childhood obesity as a priority.
- Start Well is one of the key overarching themes and focuses on the following three priority areas to focus action on:

[127] Our strategic plan 2022 - 2025 | Oxfordshire County Council
[128] Let's begin the conversation (oxfordshire.gov.uk)
[129] Oxfordshire Joint Health and Wellbeing Strategy

(a) A reform of the 0-5 offer to ensure a best start in life and improvements in school readiness
(b) Early help and early intervention including SEND support and those with neurodiversity
(c) Mental health and wellbeing of children and parents

- The new Health, Education and Social Care (HESC) model for commissioning was set out in 2020 as part of **Oxfordshire's Joint Commissioning Executive** (JCE) and has three tiers of need and life stage approach, the first being 'Start Well.' The organisational model aims to support a focus on outcomes and aims to have a Good Start in Life Strategy to support children and young people. [130]

- **The Special Educational Needs and Disability (SEND) strategy** for children and young people (0-25) in Oxfordshire for 2019 -2022 aims the have 'the right pupils in the right provision at the right place.'[131] It sets out how Oxfordshire County Council, along with the Clinical Commissioning Group (CCG) and partners (including education and health providers) will work together to provide services and support to improve outcomes for children and young people with SEND. They aimed to achieve this by:
    - Ensuring that all early year's providers and mainstream schools support an inclusive approach to education.
    - Strengthening co-production arrangements
    - Identifying children with additional needs at the earliest opportunity
    - Improving the experiences for families in assessment and support planning
    - Improving transition planning for all young people moving into Adulthood
    - Developing joint commissioning to support service delivery
- Work in currently underway to develop a new strategy for 2022-2025, with public consultation ongoing until March 2022.

- **The Oxfordshire Children and Young People's Plan 2018-2023**[132] and **'Improving Education Outcomes – a strategic review**' published in December 2019 by the **Children, Education and Families Services** at Oxfordshire County Council [133] highlight four areas of focus or 'obsessions' for all children and young people to:
    - Be Successful
    - Be Happy and Healthy
    - Be Safe
    - Be Supported
- The review recognised that to make a difference, children and young people need to be enabled to be well educated. This involves universal services working together with local, targeted and specialist services, and a focus on prevention and early help.

[130] Item 6.2 - s75 paper for JMG Nov 20-Appendix 1.pdf (oxfordshire.gov.uk)
[131] ESC_JUN2718R12- Send Strategy.pdf (oxfordshire.gov.uk)
[132] Childrens and Young Peoples Plan 2018 -2023 (oxfordshire.gov.uk)
[133] improvingeducationoutcomes-astrategicreview (oxfordshire.gov.uk)

Supporting the most vulnerable children was also highlighted, including those with SEND, to improve outcomes in this group.

- Children, Education and Families have developed the Community Around the School Offer (CASO) in collaboration with key partners which outlines early support to educational settings within Oxfordshire. The School nurse role as part of this offer is to:
    - Develop strong relationships across agencies who are working with and within schools to provide clarity of roles and avoid duplication.
    - Offering co-ordinated multiagency support, consultation and training to schools to identify and manage emerging concerns around safeguarding, mental health and wellbeing of young people.

- The **Public health** priorities include:
    - The **Director of Public Health Annual report** 2019/20 highlighted the hidden inequalities within Oxfordshire. This included the inequalities seen in child development at age 5, and in results at GCSEs from those children living in the most deprived wards in Oxfordshire.
    - The report also identified the key role that school health nurses have in supporting young people with their mental health and wellbeing.

4.2 Child Population in Oxfordshire

Oxfordshire's Child Health Profile from the Office for Health Improvement and Disparities (formerly Public Health England) can be found in appendix 3.

4.2.1 Population

23.7% of the local Oxfordshire population are aged between 0-19 years (figure 11). This is similar to the proportion of young people across the South East (23.7%) and England (23.6%). Housing-led population forecasts for Oxfordshire predict a 16% increase in the 0-17 age group from 146,950 in 2020 to 171,072 in 2030 (+24,122). ONS projections for the same period predict a decrease of 3.6% to 141,621 (-5,330), but these do not take into account housing growth within the area.

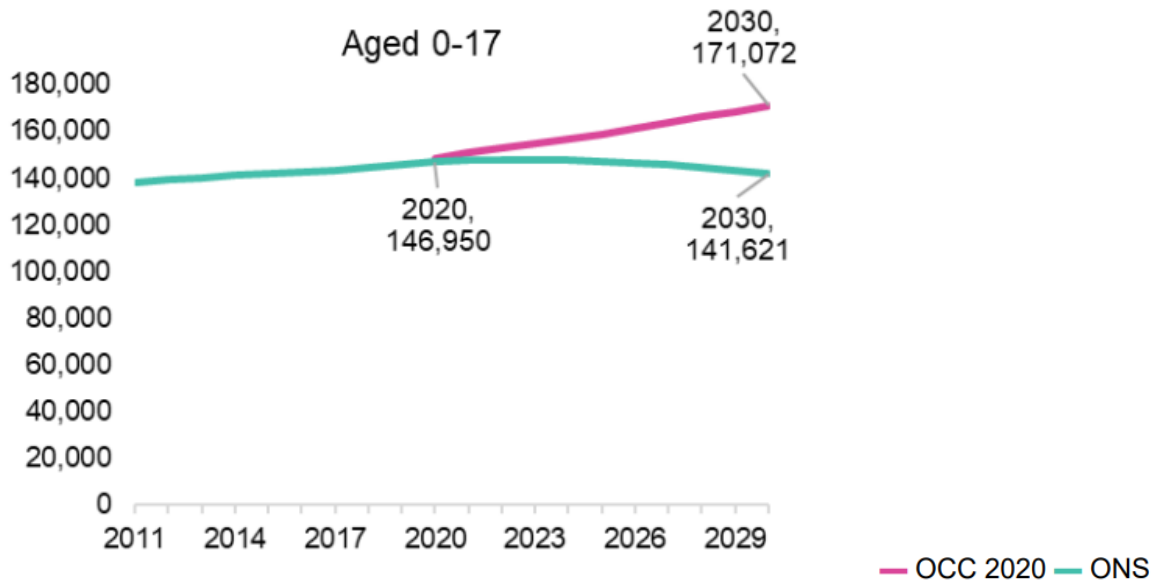


Figure 10: Population predicted growth in children aged 0-17 in Oxfordshire by Office for National Statistics and Oxfordshire County Council population forecasts (2020 -2030)
Source: Joint Strategic Needs Assessment Bitesize for Oxfordshire Feb 2022
JSNA_Bitesize_Population_Feb22.pdf (oxfordshire.gov.uk)

		Local	Region	England
Live births (2019)		7,287	93,664	610,505
Children aged 0 to 4 years (2019)		39,400 5.7%	520,700 5.7%	3,299,600 5.9%
Children aged 0 to 19 years (2019)		163,700 23.7%	2,173,500 23.7%	13,282,300 23.6%
Children aged 0 to 19 years in 2029 (projected)		164,600 22.8%	2,180,700 22.8%	13,483,800 22.9%
School children from minority ethnic groups (2020)		26,161 27.6%	351,482 27.7%	2,812,226 34.6%
School pupils with social, emotional and mental health needs (2020)		2,980 3.1%	35,224 2.7%	222,595 2.7%
Children living in poverty aged under 16 years (2018/19)		11.1%	13.7%	18.4%
Life expectancy at birth (2017-2019)	Boys	81.7	80.8	79.8
	Girls	85.0	84.3	83.4

Figure 11 Child population in Oxfordshire (Local), South East (Region) and England
Source: Child Health Profile Oxfordshire (March 2021), Public Health England Fingertips Child and Maternal Health

4.2.2 Minority Ethnic Groups

The proportion of school children from minority ethnic groups in 2020/21 was 28.6%, lower than England (34.6%) but similar to the South East (27.7%). There has been an increase in the ethnic diversity of the school age children from 23.4% in 2015/16.

The percentage of state funded nursery and school aged children with a first language other than English has increased from 12.4% in 2015/16 to 14.5% in 2020/21.[134] Nationally there has been an increase from 18% to 19.3% in the same time period.

4.2.3 Income and Deprivation

There are several different measures for poverty and deprivation. Absolute low income compares to the median income in 2010/11, which allows for comparison over time. Relative low income compares with the median income of the current year being measured. A family is defined as living in relative poverty if their income is less than 60% of the UK average.

In 2019/20, 8.8% of children under 16 in Oxfordshire live in absolute low-income families. This is lower than seen across England (15.6%) and the South East (11.1%). Figure 12 demonstrates that the percentage of children living in poverty in Oxfordshire is lower than or similar to other regions across the South East. 10.5% of children under 16 in Oxfordshire live in relative low-income families, an increase from 8.6% in 2014/15, but lower than England (19.1%) and the South East (13.3%). In the latest data from the Autumn term 2020 10.1% of children in Oxfordshire were eligible for free school meals, an increase from 8% in 2018. This was lower than England (19.7%) and the South East (15%), these have both also increased from 2018 figures (England 13.5%, South East 9.4%).

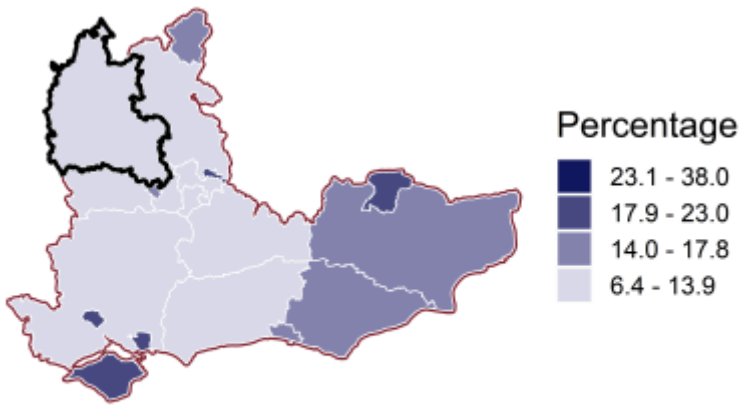


Figure 12: Children Living in Poverty. Map of the South East (Oxfordshire outlined in black), showing relative levels of children living in poverty. Source: PHE Child Health Profiles March 2021 for Oxfordshire.

[134] Create your own tables, Table Tool – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

Whilst Oxfordshire has lower levels of deprivation and child poverty than other areas in the South East, there is a wide variation across the county (see figures 13 and 14). Within Oxford City 29% of children are estimated to live below the poverty line after adjusting for housing costs.[135] In the 2019 Index of Multiple Deprivation, 10 of Oxford's 83 Middle Super Output Areas (MSOAs) are in the top 20% most deprived areas in England:

1. Northfield Brook
2. Banbury Ruscote
3. Rose Hill and Iffley
4. Blackbird Leys
5. Banbury Cross and Neithropp
6. Banbury Grimsbury and Hightown
7. Carfax
8. Barton and Sandhills
9. Abingdon Caldecott
10. Littlemore

This highlights that, despite Oxfordshire having relatively low levels of deprivation overall, there are pockets of significant deprivation. The high living costs in Oxfordshire also increase levels of children below the poverty line, as can be seen in figure 14.

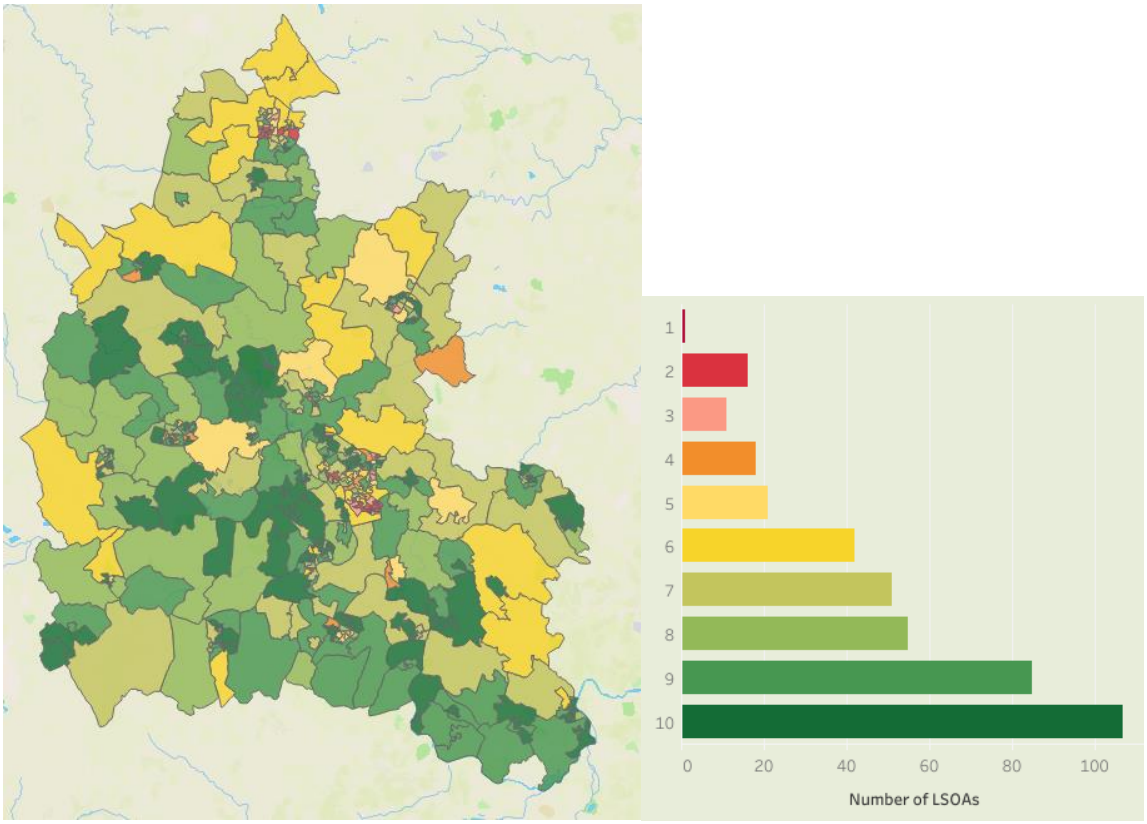


Figure 13: Index of Multiple Deprivation (IMD) 2019 for Oxfordshire LSOAs. Source: Deprivation dashboard | Oxfordshire Insight

[135] Poverty and Deprivation | Poverty and Deprivation | Oxford City Council

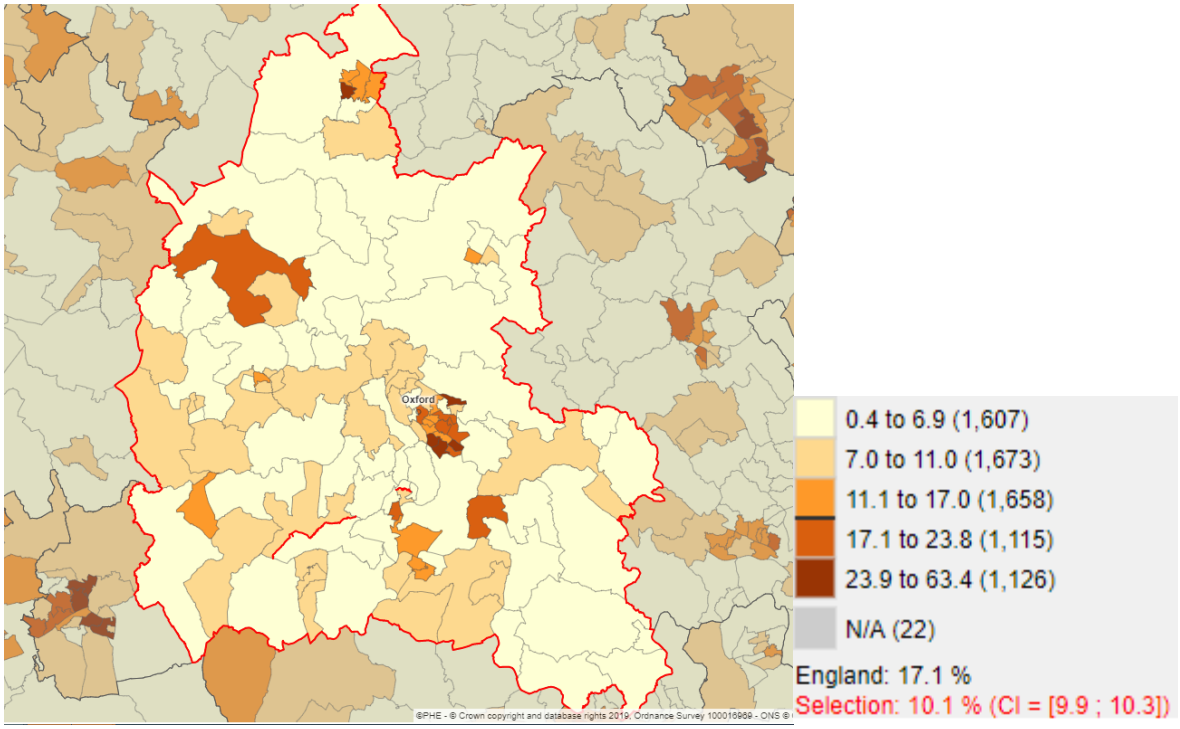


Figure 14: Child Poverty, Income Deprivation Affecting Children Index (IDACI), 2019 (%) for Oxfordshire Wards.
Source: Local Health PHE [Local Health - Public Health England - Indicators: maps, data and charts]

The life expectancy is higher in Oxfordshire than seen across the South East and England (figure 11), but this average figure again hides significant differences seen at ward level. For example, the life expectancy at birth for males born in the North ward, one of the least deprived wards in Oxford city, is 87 years compared with Northfield Brook ward, to the South of the city where it is 75.2 years or the central Carfax ward where it is 71.6 years. The healthy life expectancy inequality in Oxford between the most and least deprived areas is 20 years for males and 18.2 years for females.

4.2.4 Pupil Place Projections

As of October 2021, Oxfordshire is home to 243 state sector mainstream schools providing primary education. This includes three infant and two junior schools; the remainder provide education for children from age 4 to 11, and two also provide secondary education. 93% of pupils with on-time applications received their first preference primary school in September 2021.

There were 41 state sector mainstream schools providing secondary education. Most offer 11-18 with a sixth form, apart from four south Oxfordshire schools offering 11-16 study only and two schools providing for the 14-19 age range. As mentioned above, two of Oxfordshire's schools provide "all-through" primary and secondary education.

There are 15 state sector schools providing specialist provision for children with special education needs, including one Alternative Provision Academy (Pupil Referral Unit) and one Hospital School. Eight are community based special schools providing for children ages 2 to 19 with severe and/or profound and multiple learning difficulties. Two new special schools are planned, one in Bloxham (due to open Sept 2023) and one in South Oxfordshire, which will focus on social, emotional and mental health needs, and autism. In addition, some mainstream schools include a specialist resource base to provide additional support to children with SEN such as hearing impairment, autism, communication and interaction needs, physical disabilities and moderate learning disabilities.

Oxfordshire has a higher academy rate than the national rate, with 98% of secondary provision, 43% of primary provision and 47% of special school provision being academies. Nationally, 37% of primary schools and 78% of secondary schools are academies or free schools.[136] Academies are not accountable to the county council and receive their budget directly from central government.

Current pupil projections show a 5.8% increase in primary pupil numbers and a 7.8% increase in secondary school pupils between 2020/21 and 2025/26. This is higher than to the ONS predictions, as significant growth is expected due to high levels of housing development planned in the county. The special school population is also growing, with rapid growth particularly in pupils attending non-county special schools.

4.3 School Health Nurse Service in Oxfordshire

In Oxfordshire, public health services for children aged 5-19 are delivered by the School and College Health Nursing Workforce, with input from other partners as required. The workforce consists of Specialist Community Public Health Nurses and a skill mix of other staff who provide information, assessments, and interventions as part of the delivery of the Healthy Child Programme within schools. At present there is a named School Health Nurse in every Local Authority secondary school and identified FE College. Primary school provision is served by a team of Primary School Health Nurses and Community Staff Nurses who provide care across several schools by locality. There is a targeted Personal, Social and Health Education (PHSE) for Special Schools and provision of contraception outreach to vulnerable young people. For Special schools there is a separate provision for school nursing which funded by the Clinical Commissioning Group (CCG) rather than the Local Authority.

4.3.1 Impact of the COVID-19 Pandemic

The activity of the School Health Nurse Service was significantly impacted from 2019-2021 by the COVID-19 pandemic and the lockdown measures implemented to control the virus. School closures, apart from vulnerable and key worker children, were instigated in the summer term of 2019/20, and the spring term of 2020/21 alongside increased absence during other terms for those self-isolating. This has affected how the school/college health nurses (SHNs/CHNs) deliver the service and has impacted staffing levels, with some of the

[136] Schools, pupils and their characteristics, Academic Year 2020/21 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

workforce redeployed to other areas. In the summer term 2019/20 almost half the school health nursing team were redeployed to district nurse teams, community hospitals, children's community services and Intensive Care Units.

Covid-19 school closures gave SHNs unique opportunities to work in an alternative way – for example focusing on improving relationships with the senior leadership team in the school. The service adapted by providing support to families via digital means or other socially distanced measures such as 'walk and talk' meetings. Newsletters were sent more often, and online relaxation sessions were offered to students and staff. The primary school team had an increased number of direct referrals from parents during the lockdown, by email and telephone, with advice and support given virtually. Figure 15 demonstrates how the method of appointment delivery varied for the academic year 2020/21 and the subsequent easing of restrictions.

There was an increase in referrals to social care by all agencies and SHN were engage in supporting students and making assessments of needs for social care. There was also increased concerns regarding the emotional health of children and young people, in which SHNs play a key supportive role for students. SHNs in all schools noted an increase in reported self-harm as a managing strategy for emotional distress alongside an increase in other mental health issues, specifically anxiety, body image and eating disorders. There was an increase in referrals to social care by all agencies.

School health nurses offered a telephone support service and digital consultation during the Lock Down called 'Health advice for Oxfordshire parents/carers with children aged 5-19 during Lock Down (HOLD).' College nurses had some success with exploring and implementing different ways of working such as remote contraception assessment (followed by face to face or home delivery of pills), sexual health continued professional development (CPD) and clinical supervision on teams.

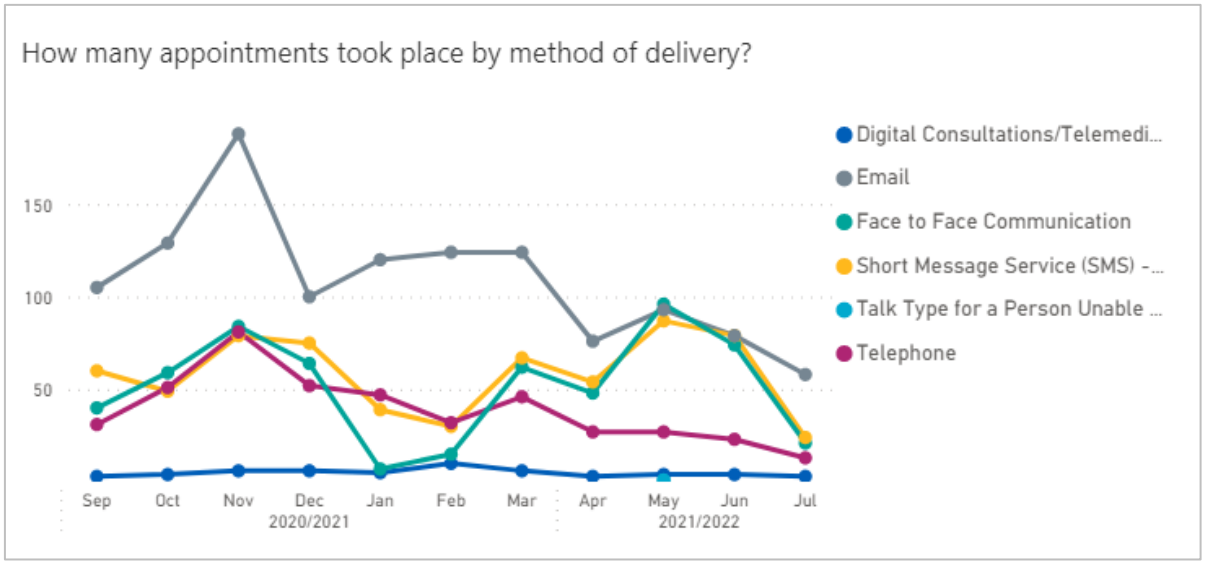


Figure 15: Number of appointments by method of delivery in college settings 2020/21 for Oxfordshire

4.3.2 Annual Reports Activity Data 2019-2021

1-1 appointments and drop in sessions with the school nurese are offered and publicised at every school/college. A summary of activity in the summer term from 2018/19 - 2020/21 is provided in figure 16, to give a picture of service activity across Oxfordshire (in primary, secondary and college settings) and the impact of COVID-19.

Activity	Apr	May	June	July	Aug	Total
F2F	520	1168	936	637	19	**3280**
NonF2F	1233	1919	2002	1889	365	**7408**
Total 20/21	**1753**	**3087**	**2938**	**2526**	**384**	**10688**
F2F	30	70	167	164	3	**434**
NonF2F	1169	1122	1605	1591	135	**5622**
Total 19/20	**1199**	**1192**	**1772**	**1755**	**138**	**6056**
F2F	836	1299	1319	932	40	**4426**
NonF2F	424	615	806	822	110	**2777**
Total 18/19	**1260**	**1914**	**2125**	**1754**	**150**	**7203**

Figure 16: Activity report for summer term 2018/19 – 2020/21 from Annual School Health nursing report Oxfordshire for primary, secondary and college settings.

In 2020/21 activity in the summer term surpassed pre-COVID total figures and face-to-face appointments increased from 2019/20 with a return of pupils to schools and colleges. Figure 16 provides a comparison of face to face (F2F) and non face to face (nonF2F) in the summer term of 2018/19, 2019/20 and 2020/21. The number of children being seen in all categories in 2020/21 showed a marked increase from pre-covid levels, including for those children classed as being in the universal group (figure 17). This highlights an increased need in children at all levels of risk.

Activity by Universal Rating	Apr	May	June	July	Aug	Total	
Universal	183	346	329	255	49	**1162**	**11%**
UP	826	1626	1289	1145	129	**5015**	**47%**
UPP	668	992	1187	993	180	**4020**	**38%**
Not Coded	76	123	133	133	26	**491**	**5%**
Total 20/21	**1753**	**3087**	**2938**	**2526**	**384**	**10688**	
Universal	56	59	89	72	2	**278**	**5%**
UP	477	514	637	673	61	**2362**	**39%**
UPP	642	591	975	947	65	**3220**	**53%**
Not Coded	24	28	71	63	10	**196**	**3%**
Total 19/20	**1199**	**1192**	**1722**	**1755**	**138**	**6056**	
Universal	124	178	178	127	8	**615**	**9%**
UP	600	900	935	659	38	**3132**	**43%**
UPP	324	503	595	560	68	**2020**	**28%**
Not Coded	212	333	417	408	36	**1406**	**20%**
Total 18/19	**1260**	**1914**	**2125**	**1754**	**150**	**7203**	

Figure 17: Activity by Universal rating in summer term 2018/19 - 2020/21 from Annual School Health nursing report Oxfordshire (for primary, secondary and college settings)

Appointments made with children, young people and families are categorised into a list of 42 possible outcomes, some appointments have more than one outcome listed. The activities are varied but the top reasons for appointments were as follows:

Primary schools

- Liaison
- Safeguarding
- Health promotion
- Medication review/emergency meds
- Attending child protection
- Multidisciplinary meeting
- Child Protection assessment

Secondary schools

- Liaison
- Safeguarding
- Worries/emotional health
- Emotional and psychological support
- Health promotion advice
- Sexual Health
- Attending child protection meetings
- Contraceptive advice

Colleges

- Liaison
- Sexual Health
- Contraceptive advice
- Emotional and psychological support
- Safeguarding
- Worries/emotional wellbeing
- Chlamydia test
- Health promotion

After liaison a significant amount of work in the college nurse service was related to sexual and reproductive health. Within college settings the use of email appointments increased during the times of increased COVID restrictions (Nov 2020, Jan-Mar 2021), with an increase in face to face communication when restrictions eased (figure 16)

A total of 90 prescriptions were issued by SHNs/CHNs in 2020/21 all in relation to sexual health and reproduction, including contraceptives and antibiotics. The condom distribution scheme had 169 contacts in schools and colleges.

4.3.3 Strengths/achievements/outcomes

At present each school nurse at a secondary school or college is required to carry out an annual School/College Health Improvement Plan (SHIP/CHIP). This provides a Health Improvement Plan/Public Health Profile for each school based on needs, with broader details such as numbers in each year group and ethnicity of pupils. It also details the number of children with identified needs or at increased risk such as looked after children, children with SEND or an EHCP, children with free school meals and known young carers. It is important that the school health nurse is aware of these young people and if they need any additional support. Many of these factors increase the risk of young people ending up as 'Not in employment or training' (NEET) and form part of the Oxfordshire 'RONI' Risk of NEET Indicators, children and young people identified can be offered services/support to help them to remain in education or training.[137]

[137] Microsoft Word - Oxfordshire RONI criteria

The SHIPs and CHIPs are standardised in an excel format to ensure approaches were consistent between schools to identify gaps and needs for their specific schools. They help to plan the services delivered by the School and College Nurses. SHIPS have allowed SHNs to regularly review their caseload and identify groups of young people that are not being seen such as males, 6th form, LGBTQ+ and BAME. This has allowed more targeted work to take place in each cohort in each specific school.

At one school a student survey was carried out and the school nurse worked closely with the welfare team to address the needs identified from the survey. This included arranging PHSE sessions around specific topic areas, such as self-harm and mental wellbeing. At present health reviews are offered to all pupils in Year 7 but are not requested/completed by all pupils.

A checklist/aide memoire was developed by SHNs/CHNs to be used to assess whether a child's needs are being neglected, particularly in adolescents. This then prompts the practitioner to complete the childcare and development checklist in the OSCB Neglect Toolkit.

4.3.4 Engagement

As part of the Health Needs Assessment engagement was carried out to gather views on the school/college nursing service and how children, young people and their families can be best supported in Oxfordshire. Two surveys were run on Let's Talk (Oxfordshire County Councils online consultation platform), one for young people and one for parents/carers/professionals. In addition, focus groups were run for young people and results from the surveys were discussed with the school nursing team to gain their insight on the current service and needs within the Oxfordshire school-aged population. A summary of the keys findings/learning are shared below but a more in depth survey report is available.

In total there were 25 responses to the young person's survey, 13 young people took part in focus groups and there were 14 responses to the parent/carer/professional survey. Whilst response numbers were small, they help to give a picture of how young people interact with the school nursing service. The key reasons for young people not using the service were:

- Confidentiality
    - This was a major barrier to accessing the service with concerns around 'too many people being told' or facing teasing/gossip/stigma from their peers
    - Having an email sent to the teacher for t
- Awareness of the service
    - Some young people would not use the service because they did not know how to see the school nurse or were not sure what support they offered.
    - Of the 38 young people who took part, 68% knew how to see the school nurse if they needed to and 43% knew what the school nurse does.
    - The majority who knew what the service did had heard about it through school assemblies or from their friends at school.
- Availability of the service

    - Some young people were unsure when the drop in services were available, or they found the school nurse was busy when they went to see them and were embarrassed to wait outside.
- Not needing to use the service
- Going to another service/trusted adult

Young people were asked how they would most like to see the school nurse. Face to face appointments were most popular (60% said they were likely/very likely to use this method), followed by drop ins and text messaging (both 48%), then email (44%). Some young people favoured text messaging as it could be more anonymous and less awkward, whilst others were concerned about confidentiality, finding it harder to communicate their problems and the time taken to get a reply. Only 20% would be likely/very likely to use video appointments, comments included that it was more awkward and finding a private location for a call might be difficult. The preference for contact method varied between young people, highlighting the importance of having a variety of methods to reach young people as there is no 'one size fits all' approach.

For parent/carers/professionals the most preferred way to access the school nursing service was by email or phone call. When asked how they would most like to receive information from the service, all said by emailed newsletter and over half said on the website or text messaging. The newsletter was less popular with young people, with only 2 saying they found it helpful. Online was a key source of advice/support for young people but they had concerns over knowing which websites were providing accurate information. There was very limited awareness in the focus groups of the Oxfordshire County Council website for young people, OxMe[138].

The main areas where young people felt they needed support were around mental wellbeing, body image, sexual health, sexuality, stress, self-esteem, depression, anxiety, eating disorders and keeping healthy. When asked specifically about contraception over 1/3 of young people in the survey said they would go to the school nurse for contraception with comments on it being more accessible than the sexual health clinics.

4.4 School Health Nurses: National Activity and Referrals

Public Health England (now Office for Health Improvement and Disparities, OHID) published data on activity and referrals by school nurses for 2019 to 2020[139]. Key data findings included:

- Young people aged 10-14 years had the highest proportion of contacts with the SHN nationally (figure 18).
- In children and young people aged 5 to 19 years there was a higher proportion who had contact with the school nurse by level of deprivation (figure 19).
- There was no significant difference between ethnic groups in terms of proportion of contacts.

[138] OXME.INFO | For young people in Oxfordshire
[139] School nursing activity and referrals in 2019 to 2020 - GOV.UK (www.gov.uk)

- Children aged 5 to 19 with a recorded vulnerability had a higher proportion of contacts compared to those who did not 7.0% vs 2.6%.
- Children with a preferred language other than English had a similar proportion of contacts compared to those with preferred language English.
- Face to face was the most common method of contact in 2019/20 where the method of contact was recorded (figure 20). This was prior to the COVID-19 pandemic.

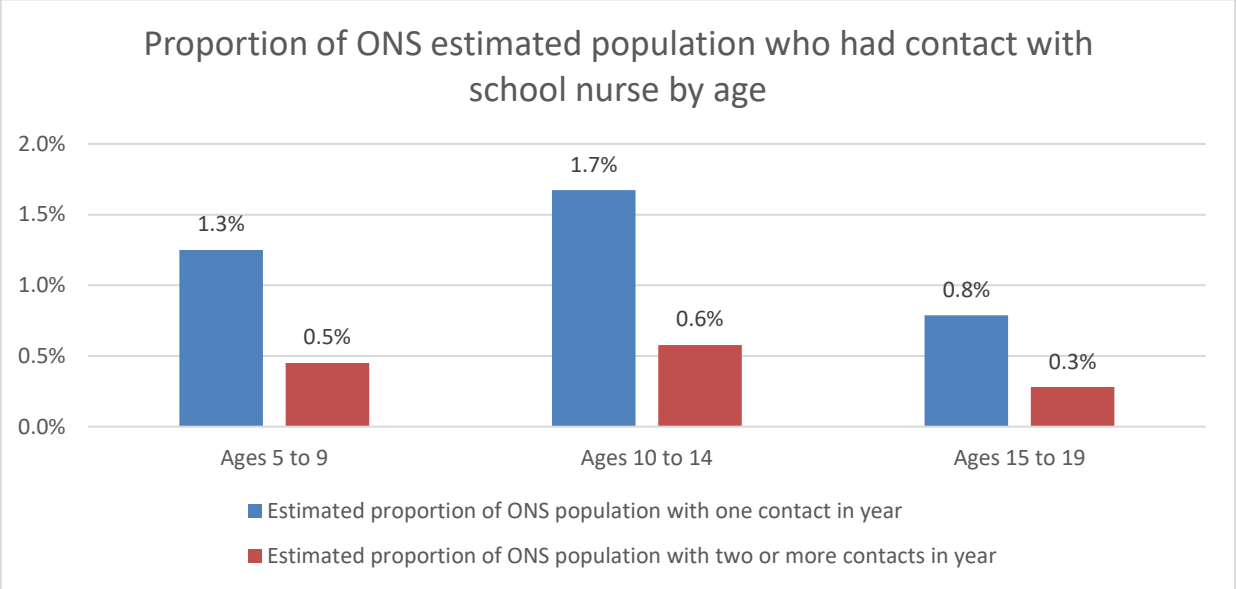


Figure 18: Proportion of ONS estimated population in England who had contact with school nurse by age. Source: PHE extract of Community Services Dataset, 2019 to 2020. Graph created using dataset from [Research and analysis overview: School nursing activity and referrals in 2019 to 2020 - GOV.UK (www.gov.uk)]

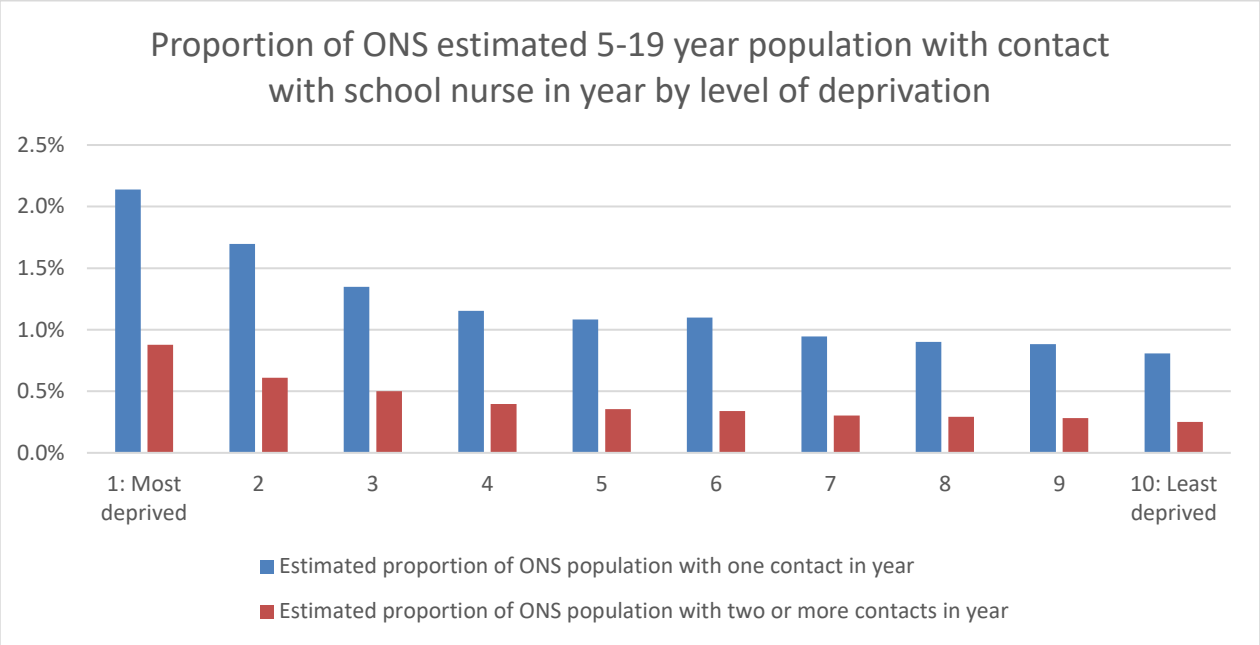


Figure 19: Proportion of 5-19 population with contact with school nurse by level of deprivation. Source: PHE extract of Community Services Dataset, 2019 to 2020. Graph created using dataset from [Research and analysis overview: School nursing activity and referrals in 2019 to 2020 - GOV.UK (www.gov.uk)]

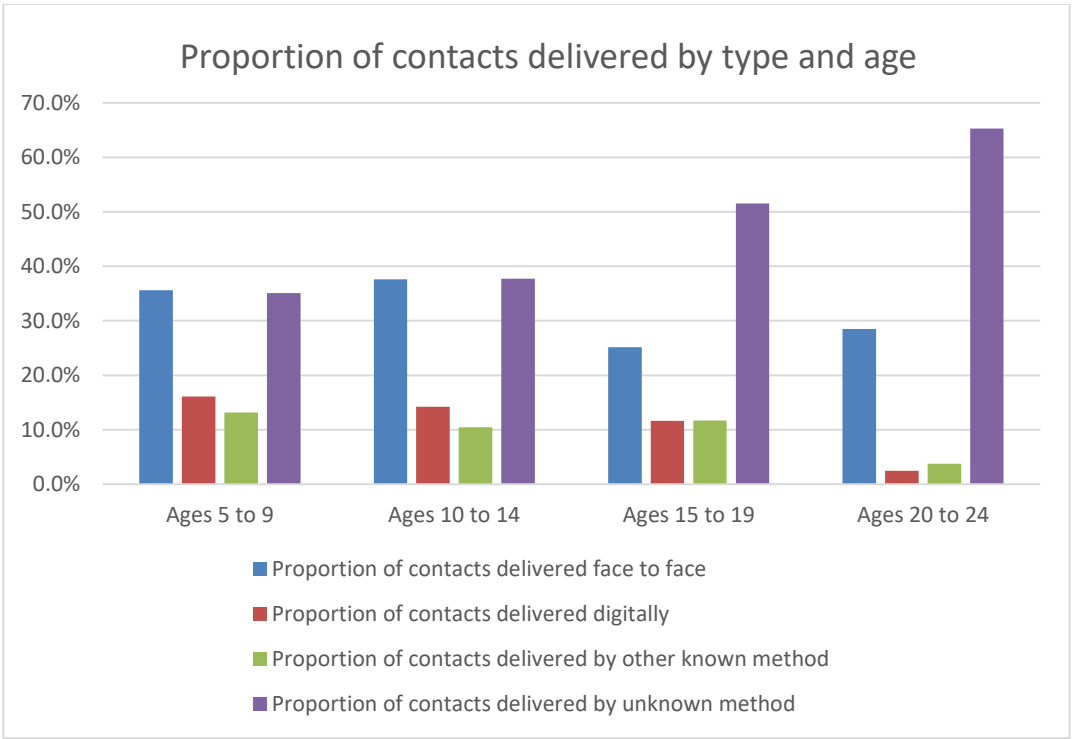


Figure 20: Proportion of contacts delivered by age and type. Source: PHE extract of Community Services Dataset, 2019 to 2020. Graph created using dataset from [Research and analysis overview: School nursing activity and referrals in 2019 to 2020 - GOV.UK (www.gov.uk)]

5. Data and local services by six high impact areas

The delivery model for the Healthy Child Programme led by School Health Nurses is centred around 6 high impact areas, that provide an evidenced based framework for those delivering child public health services that are 'Universal in reach – Personalised in response'. The high impact areas are those which have the biggest impact in improving outcomes for children and young people. National and Local data has been reviewed by High Impact Area below to gain a clearer view of the current health and wellbeing needs of children and young people within Oxfordshire and how this compares to the national picture. The data for each high impact area is followed by a summary of some of the current key services and interventions available to school-aged children relevant to the high impact area.

5.1 Supporting Resilience and Wellbeing

5.1.1 National Context/Surveys

In recent years mental health and wellbeing in children and young people has been increasingly prioritised and there have been a number of different national surveys that look at the current state of wellbeing in children and young people.

Mental Health of Children and Young People in England 2021[140]

This aimed to explore the mental health of children and young people during the coronavirus pandemic and the changes since 2017. Some of the key findings were:

- Increased rates of 6 to 16 year olds with a probable mental disorder, from 1 in 9 (11.6%) in 2017 to 1 in 6 (17.4%) in 2021. In 17 to 19 year olds it increased from 1 in 10 (10.1%) to 1 in 6 (17.4%).
- The proportion of children and young people with possible eating problems increased from 6.7% (2017) to 13% (2020) for 11 to 16 year olds, and from 44.6% (2017) to 58.2% (2020) in 17 to 19 year olds.
- Problems with sleep over 3 or more nights out of 7 affected 28.7% of 6-10 year olds, 38.4% of 11-16 year olds, and 57.1% of 17 to 23 year olds. These figures were much higher in those with a probably mental disorder.
- The proportion of 6-16 year olds with a laptop or tablet that they could work on at home increased from 89% in 2020 to 94.4% in2021. There is still an important minority of children (over 1 in 20) who do not have good digital access.

A national retrospective cohort analysis published in the Lancet in June 2019 looked at the prevalence of maternal mental illness between 2005 and 2017. It found that one in four children aged 0-16 years are exposed to maternal mental illness and the prevalence of

[140] Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey - NHS Digital

diagnosed and treated maternal mental illness is increasing.[141] Parental mental illness is associated with increased rates of mental health problems in children.[142]

Children's commissioner: The Big Ask, The Big Answer Sept 2021[143]

This survey was open to any child in England aged 4-17 and had over half a million children respond. Girls were found to be nearly twice as likely as boys to say they were unhappy with their mental health, as were older children and teenagers. 40% of girls ages 16-17 were unhappy with their mental health.

The key recommendations from this survey were:

- A package of measures to maximise the community offer available to children, including how best to utilise the Youth Investment Fund.[144]
- A more rapid expansion of Mental Health Support Teams, achieved by better utilisation of the voluntary and charitable sectors
- A more consistent approach to digital counselling provision across England. It emerged during the pandemic that many children preferred digital counselling.
- Community mental health hubs to provide children with an open-access point for NHS services, for both advice and treatment.
- An action plan to deliver on the goals of 100% of children accessing support when they need it, including the right support in place when children reach crisis point.
- Better in-school help for children in care, wider use of trauma informed practice.

The Good Childhood Report 2021[145]

This report has been carried out each year for ten years and looks at wellbeing in children as reported by children through an annual Household Survey carried out by The Children's Society. In 2021 nearly 12% of children aged 10-17 scored below the midpoint on the multi-item measure of life satisfaction, meaning they are deemed to have low well-being. Looking at pre-pandemic data, from 2009/10 to 2018/19 there was a decline in measure of happiness with life as a whole, friends, appearance and school in children aged 10-15. The study found that young people with low life satisfaction at 14 reported higher levels of psychological distress, emotional and behavioural difficulties, self-harming and suicide attempts at age 17.

Suicide in Children and Young People[146]

[141] Prevalence of maternal mental illness among children and adolescents in the UK between 2005 and 2017: a national retrospective cohort analysis - The Lancet Public Health
[142] School-aged years high impact area 1: Supporting resilience and wellbeing - GOV.UK (www.gov.uk)
[143] The Big Ask - The Big Answer (childrenscommissioner.gov.uk)
[144] Applying to the Youth Investment Fund Phase 1 - GOV.UK (www.gov.uk)
[145] GCR_2021_Summary_0.pdf (childrenssociety.org.uk)
[146] NCMD-Suicide-in-Children-and-Young-People-Report.pdf

This report was published by the National Child Mortality Database (NCMD) and looked at suicide in young people reviewed by the Child Death Overview Panel (CDOP) between April 2019 and March 2020. The relevant key findings were as follows:

- Rates of suicide were similar across all areas and regions in England, including urban and rural environments, and across deprived and affluent neighbourhoods.
- In 10-14 year olds the rate was 0.4 per 100,000, increasing to 4.7 per 100,000 in the 15-19 year age group. This represents 161 deaths in children and young people aged 10-19 years.
- 62% of children or young people had suffered a significant personal loss in their life prior to their death, including bereavement and "living losses" such as loss of friendships or routine due to moving home or school or other close relationship breakdown.
- Over 1/3 had never been in contact with mental health services.
- 16% had a confirmed diagnosis of neurodevelopmental condition at the time of their death, for example Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD). This appears higher than found in the general population.
- Nearly ¼ had experienced bullying (face to face or cyber), with the majority occurring in school.

Papyrus[147] is a charity which has developed a guide to suicide prevention, intervention and postvention in school and colleges. It is developed specifically to equip teachers with skills and knowledge to support school children who may be having suicidal thoughts. A 2017 survey by Papyrus found that one in ten (11%) of teachers said, on average, a student shares suicidal thoughts with them once a term or more.

5.1.2 Oxfordshire Data

Admissions for self-harm

In 2019/20 admissions for self-harm in people ages 10-24 years in Oxfordshire was 497.5 per 100,000. This is not significantly different to the England average (439.2 per 100,000) or the South East average (508.9 per 100,000).

Breaking the figures down by age range, admissions for 15-19 years are 722.5 per 100,000, higher than England (644.7 per 100,000) but lower than South East (795.2 per 100,000). In the 10-14 year age group, Oxfordshire has lower admissions for self-harm than both the South East (197.8 per 100,000) and England (219.8 per 100,000) at 169.9 per 100,000. The rate has shown no significant change in recent years for all age ranges.

Admissions for mental health conditions (<18 years)

108 per 100,000 under 18 year olds were admitted to hospital for a mental health condition in 2020/21. This is significantly higher than the average for England (87.5 per 100,000) and

[147] #SaveTheClass - Papyrus UK | Suicide Prevention Charity (papyrus-uk.org)

the South East (99.4 per 100,000). This figure has increased since 2014/15, when it was below the England average, with 2020/21 being the first year that the figure for Oxfordshire has been significantly worse than the England average.

Emotional wellbeing in looked after children

Emotional wellbeing is a cause for concern in 37% of looked after children in Oxfordshire (2019/20). This has shown no significant change in recent years and is lower than the South East (39.5%) and similar to England (37.4%).

Mental Wellbeing Health Needs Assessment for Oxfordshire

A Mental Wellbeing Needs Assessment was carried out in 2021, the results of which provide a clearer picture of wellbeing in young people across Oxfordshire.

Key findings

- Between 2016/17 and 2019/20, there has been a substantial increase in the number of referrals to Oxford Health NHS Foundation Trust (CAMHS) for children and young people.
    - 83% increase in aged 0-9 years and 58% increase in aged 10-19 years[148]
- Mental wellbeing was assessed as part of the OxWell survey in 2019 and 2020, and found:
    - Girls' wellbeing is lower compared to boys
    - Overall mental wellbeing is worse with increasing age: in year 12, almost 1 in 5 pupils reported low wellbeing scores in the 2019 survey
    - Life satisfaction decreases with age, especially in girls
    - During lockdown effects of the pandemic on loneliness, happiness and life satisfaction were worse with increasing age
    - During lockdown, 41% of those responding in 2020 often felt too worried to sleep
- Bullying is more commonly reported in younger ages
    - In 2019, 21% (1 in 5) of pupils in year 4 reported being frequently bullied and 10% (1 in 10) sometimes being bullied.
    - This had reduced to 8% and 6% respectively by year 10, and to 2% in year 12.
- When asked in the 2020 OxWell survey across the South East where they would turn to for help with mental health, the most important sources were carers, friends, someone at school, and online help (e.g. Childline, Mind)

OxWell School Survey

[148] Oxfordshire JSNA

The OxWell School Survey is an online pupil survey carried out in schools for children and young people aged 9-18 years. In 2019 it included over 4,000 pupils in Oxfordshire and in 2020 it was expanded to include over 19,000 children and young people from schools across Berkshire East, Berkshire West, Buckinghamshire, Gloucestershire, Oxfordshire, South Gloucestershire, and Wiltshire. This presented some challenges in comparing the data between the two years.

A mental wellbeing score was calculated from the data gathered uisng the Warwick-Edinburgh Mental Wellbeing Scale. The categories being high, average, below average and low wellbeing based on the distribution of repsonses in other populations (adults and adolescents). Wellbeing scores were compared with a number of different lifestyle factors to look for any significant correlation with levels of wellbeing for pupils in Oxfordshire.

Factors with a postive correlation with higher wellbeing score (that were statistically significant) in primary included:

- feeling safe at school and home
- feeling happy and satisfied
- ease of access to mental health support at school and
- knowing where to access support
- good family support.

Factors with a negtaive correlation resulting in a lower wellbeing score included:

- feeling left out
- loneliness
- stress (can't sleep).

At secondary school repsonses with a positve correlation were similar including:

- feeling safe
- feeling supported at school and home,
- easy access to mental health support at school
- hours asleep
- acess to garden.

Negative correlation for secondary pupils included:

- feeling lonely
- anxiety
- feeling worthless
- feeling left out
- trouble sleeping
- bullying
- Female gender

This paints a picture of some of the areas that can impact on the mental wellbeing of children and young people. Generally girls in secondary schools reported having a lower mental health and wellbeing score than boys, although there was less engagement with the survey from boys (36%) compared to girls (63%).

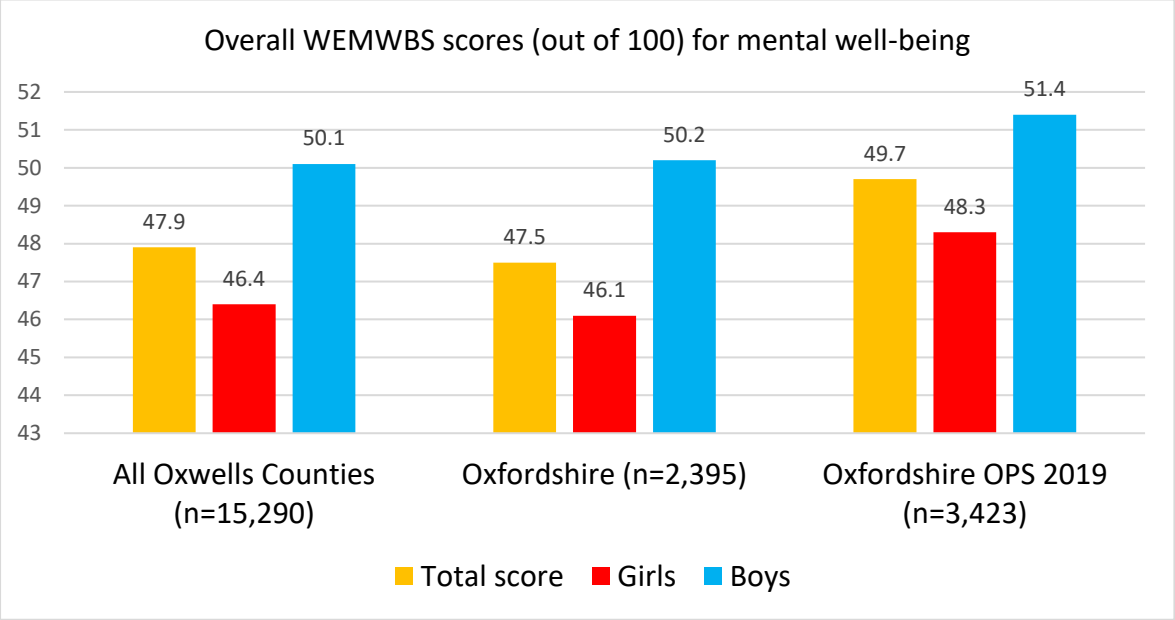


Figure 21: Overall WEMWBS Scores for mental wellbeing. Source OxWell Survey 2020

Mental wellbeing scores also reduced with age, once pupils reached year 7, the older they were the lower their mental wellbeing scores.

Bullying

Being bullied is negatively correlated at a highly significant level ($p>0.0001$) with mental wellbeing in both primary and secondary phases. As part of the survey pupils were asked if they had been bullied in the past year (at least twice a month). 83% of girls and 87% of boys overall reported never having been bullied or teased frequently in the past year. Levels of bullying declined in both genders as they got older, with the highest levels in year 5 for both genders. Verbal bullying and exclusion/isolation were the most common types of bullying (figure 23).

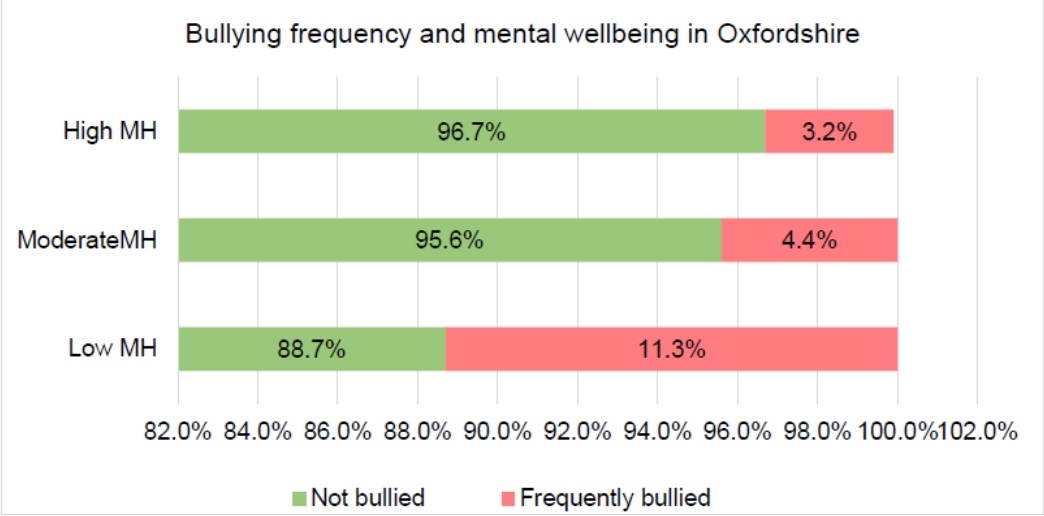


Figure 22: Mental wellbeing levels and bullying. Source: OxWell survey 2020

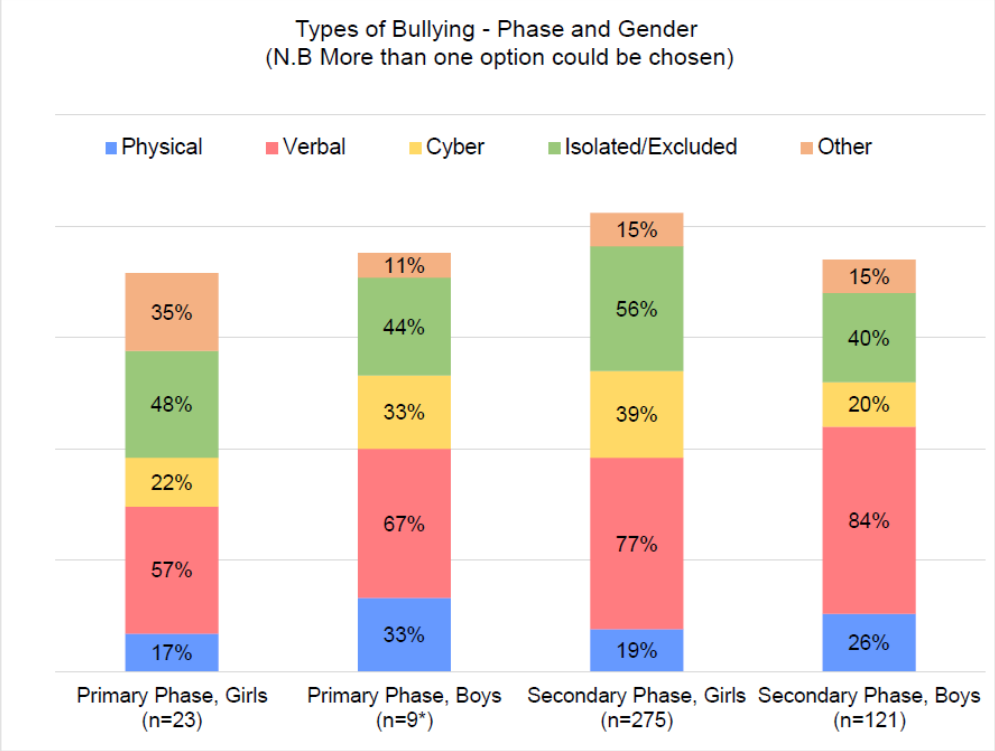


Figure 23: Types of bullying by phase and gender. Source: OxWell Survey 2020

Accessing mental health support in school

Nearly 1/3 of primary school pupils and 1/4 of secondary pupils did not know or were not sure who provides mental health in school.

Do you know who helps children in your school when they feel upset and need help (mental health support)?

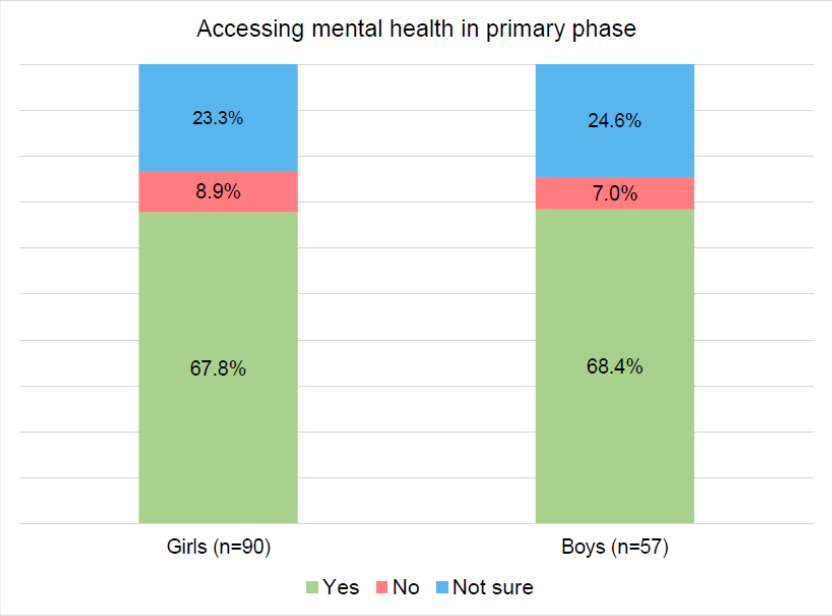


Figure 24: Mental health support – do you know who to go to for help? (primary) Source: OxWell Survey 2020

Do you know who provides mental health support in your school (where to go when you are worried and want to talk to an adult)?

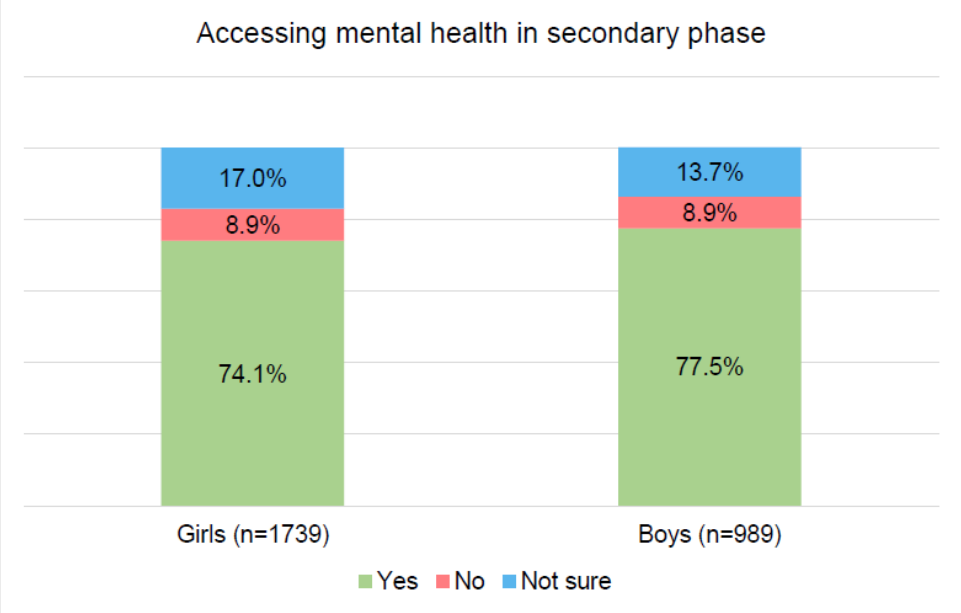


Figure 25: Mental health support – do you know who to go to for help? (secondary). Source: OxWell Survey 2020

Secondary pupils were asked where they receive their mental health support from, 58% received support from an adult at school, and a further 15% from a visitor to school. Nearly a 1/3 (29%) had support from CAMHS and almost half (47%) from another source (e.g.

counsellor/private psychologist). This demonstrates the importance of schools in supporting and signposting/referring pupils to other services for their mental health and wellbeing.

When asked how they first accessed mental health services, just over a third of girls' (34%) and 43% of boys had their parent/carer contact the service, 20% was through a teacher at school, GP was the first point of access for 16% of girls and 8% of boys and the school nurse for 12% of girls and 4% of boys. Only 3% made contact themselves, with most young people going through a trusted adult to access services.

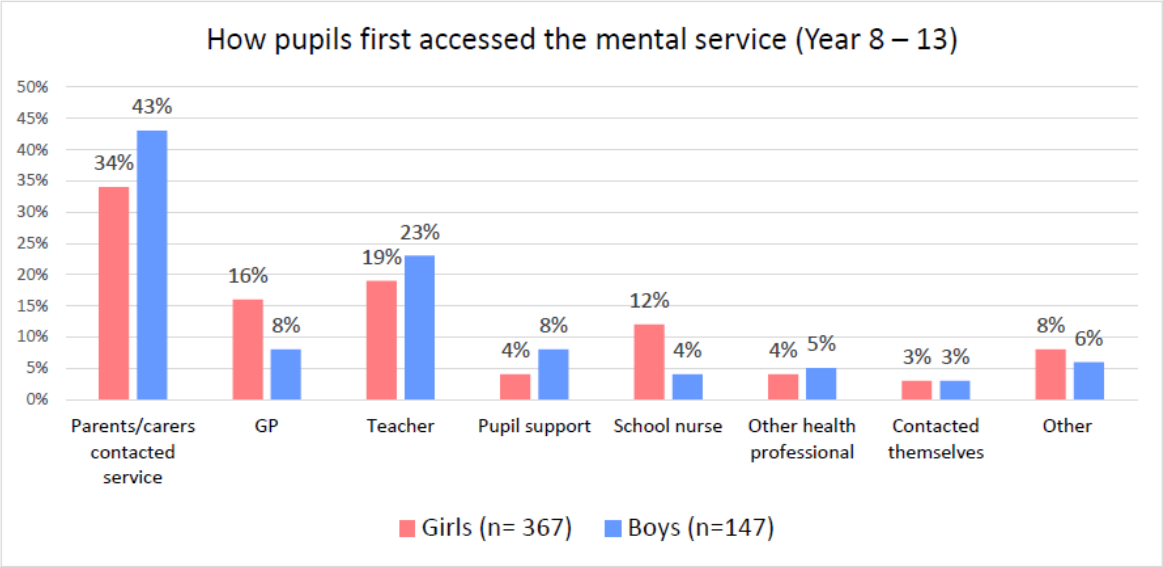


Figure 26: How secondary pupils first accessed the mental health service in Oxfordshire
Source: OxWell Survey 2020

33% of secondary aged girls and 15% of boys, who had not received mental health support, felt they could have benefited from using mental health services. Of these the most common barriers stated for not accessing services was not wanting parents, teachers, or other young people to know (figure 27). This was especially prevalent with girls. Highlighting the importance of confidentiality to young people.

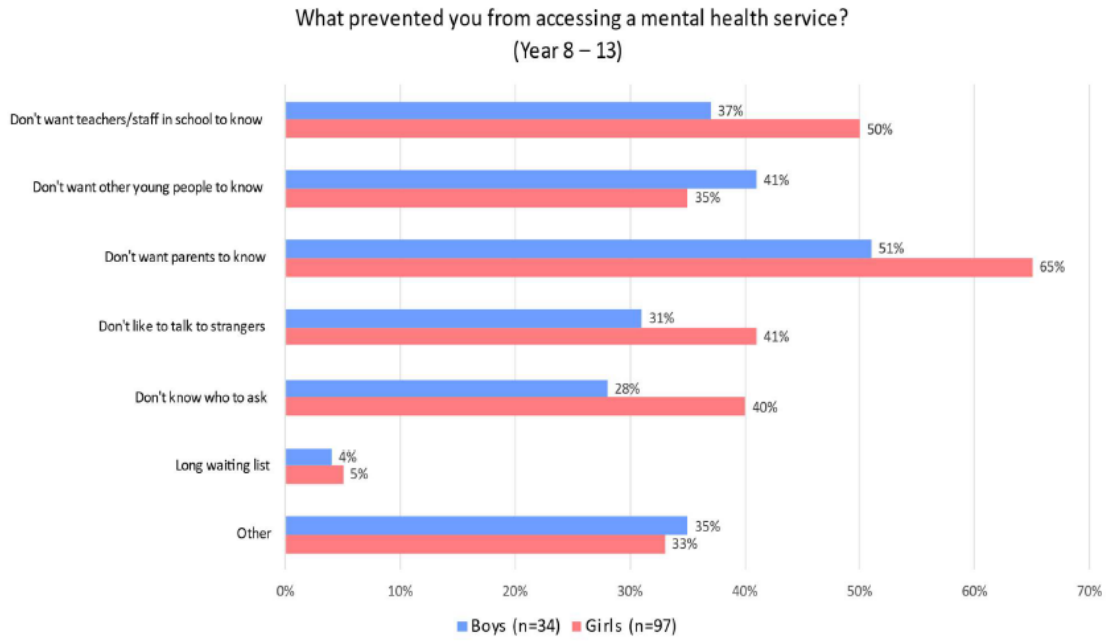


Figure 27: Barriers to seeking help from mental health services. Source: OxWell survey 2020

5.1.2 Summary: National and Local Data

Nationally:

- Rates of 6-16 year olds with a probable mental disorder have increased to 1 in 6 (17.4%) in 2021 from 1 in 9 (11.6%) in 2017.
- The COVID-19 pandemic has further negatively impacted the mental wellbeing of children and young people across England, with a disproportionate effect on those from disadvantaged background, females and those with pre-existing conditions.
- Girls were found to be nearly twice as likely to be unhappy with their mental health.
- Suicide rates in 2019/20 were similar across all of England and levels of deprivation.
    - In 10-14 year olds the rate was 0.4 per 100,000, increasing to 4.7 per 100,000 in the 15-19 year age group. This represents 161 deaths in children and young people aged 10-19 years.
    - Nearly 2/3 of children had suffered a significant personal loss prior to their death, 16% had a diagnosis of a neurodevelopmental conditions (higher than in general population), 1/4 had experienced bullying.
    - Over 1/3 had never been in contact with mental health services.
- Early positive impacts of MHSTs include - better partnership working, schools feeling more supported, and school staff feeling more confident talking about mental health issues.
- It emerged during the pandemic that many children preferred digital counselling. A more consistent approach to digital counselling provision is needed across England.

Oxfordshire:

- There has been a substantial increase in referrals to Oxford Health Children and Adolescent Mental Health Service (CAMHS) between 2016/17 and 2019/20 (83% increase in aged 0-9 years and 58% increase in aged 10-19 years).
- The admission rate for self-harm in 15-19 year olds is higher than the England average.
- The admission rate to hospital for mental health conditions in under 18 year olds was significantly higher than the England average in 2020/21 (108 vs 87.5 per 100,000 for England)
- Headline results from the OxWell survey for Oxfordshire include:
    - Life satisfaction decreases with age, especially in girls
    - Bullying is more commonly reported in younger ages
    - When asked where they would turn to for help with mental health, the most important sources were carers, friends, someone at school, and online help (e.g. Childline, Mind)
    - Good mental wellbeing scores were positively correlated with feeling safe at school and having access to mental health support within the school.
    - In those pupils who had received mental health support, 58% received support from an adult within the school.
    - Of those who felt they needed support but had not accessed it, not wanting the parents/teachers/other young people to know was a common barrier.
    - Nearly 1/3 of primary school pupils and 1/4 of secondary pupils did not know or were not sure who provides mental health support in school.

5.1.3 Current Offer

Relevant services and initiatives currently on offer in Oxfordshire related to supporting resilience and wellbeing include:

- Child and Adolescent Mental Health Service (CAMHS)
    - Provided by Oxford Health NHS Foundation Trust
    - Between 2016/17 – 2019/20 increase in referrals by 83% in aged 0-9 years and 58% increase in aged 10-19 years.
    - The median number of days of all children and young people waiting for CAMHS appointments peaked in August 2019 at 169 and had dropped to 36 by December 2020.[149]
    - In 2020/21, 33% of first time referrals for help were seen within 12 weeks.
    - The access rate for CAMHS in 2020/21 was 60.3% compared to a national target of 35% - this equates to 5,570 Children and Young People and demonstrated the continued increased demand to Oxfordshire CAMHS.[150]

- The Mental Wealth Academy

[149] CAMHS LTP Refresh 2020-22.pdf (oxfordshireccg.nhs.uk)
[150] CAMHS LTP Refresh 2020-22.pdf (oxfordshireccg.nhs.uk)

  - A partnership between Response, Oxfordshire Mind, Oxfordshire Youth, Ark-T, Banbury Young Homelessness Project (BYHP) and SOFEA, offers a 1:1 intervention programme of CBT and solution focused therapies.
  - Usually targeted to 18-25 year olds offering support, particularly for those who are falling through gaps in transition pathway between CAMHS to Adult Mental Health Services.
  - In response to the effects of the COVID pandemic the service has been temporarily extended to 16 and 17 year olds (usual target group 18-25 year olds).[151]

- Mental Health Support Team (MHST)
  - In Oxfordshire it is a partnership project between Response and Oxford Health NHS Foundation Trust.
  - The MHSTs in Oxfordshire work with the senior mental health leads within schools to offer 1:1 intervention and to provide workshops and groups.
  - It is part of the wider CAMHS offer within Oxfordshire and can link in with specialist services or care services for those with acute needs.
  - There are four established MHSTs in Oxfordshire that currently operate in 79 schools across Oxfordshire (in Oxford, Bicester and Banbury).
  - Each team has 4 education mental health practitioners (EMHPs), 3 Foundation Workers, 1 clinical supervisor, 1 admin support and 1 locality manager.
  - The Oxford team is based in Cheney School and the North team is based at Banbury Young Homelessness Project.
  - A self-referral service is not currently available in Oxfordshire, but a professional referral can be made to the service.
  - There is currently an application bid being made to NHS England for more MHST funding for the county to expand the reach of MHSTs to more schools.

- Within Public Health in Oxfordshire County Council, work is currently underway to develop a children and young people emotional wellbeing and mental health strategy.
  - Selected as a strategic priority in first year work plan following COVID-19 pandemic by Oxfordshire's Joint Commissioning Executive (JCE)
  - Build on findings from the mental wellbeing needs assessment for Oxfordshire
  - To help inform use of new funding opportunities available
  - Also supports work to address health inequalities within Oxfordshire, a key Public Health agenda.
  - Examples of services and projects in Oxfordshire (taken from the Oxfordshire Health and Wellbeing Strategy health and wellbeing board paper) can be seen in appendix 4.

- Within Schools:

[151] Mental Wealth Academy — Oxfordshire Mind

- Worries/emotional health, and emotional & psychological support are within the top 5 reasons for young people having contact with the school health nurse in secondary school and college.
- School nurses have an important role in support young people's health and wellbeing, assessing need within the school and providing universal support (such as classroom sessions or assemblies) or targeted support as required. Onward referral can be made to other support services if needed.
- Some primary and secondary schools have their own pastoral support team within the school, that can also offer additional support to children and young people who require it. This provision is variable across the county and determined by the school.

5.2 Improving health behaviours & reducing risk taking

5.2.1 National Data

Relationships and Sex Education[152]

The department for Education published most recent results from the sixth wave of the second Longitudinal Study of Young People in England (LSYPE2)[153]. This included questions about attitudes to Sex and Relationships Education and sexual risk taking. This data was collected before the introduction of compulsory Relationship Education in September 2020.

Some of the main findings were:

- Young people who did not receive any Relationship and Sex Education (RSE) in schools were more likely to go on to take more sexual risks, including intercourse before the legal age of consent, unprotected sex and contracting sexually transmitted infections (STIs).
- Just under half of young people described the RSE they received at school as 'fairly useful or 'very useful'
    - Nearly 1 in 5 said it was 'not at all useful' – these were more likely to be young people of minority sexual orientations, those with disabilities, and those who participated in other risky behaviours.
- Those taught about consent, LGBT relationships or relationships in general were more likely to describe the teaching as useful.
- Not learning about STIs, consent, relationships (including LGBT) in school was more likely for young people eligible for free school meals than those who are not (1 in 10 vs nearly 1 in 20)
- Findings suggest that in 2018 fewer young people had sex before they turned 18 but unprotected sex increased, with fewer young people favouring condom use as regular contraceptive.

[152] Experiences of Relationships and Sex Education, and sexual risk taking (publishing.service.gov.uk)
[153] Longitudinal study of young people in England: cohort 2, wave 3 - GOV.UK (www.gov.uk)

- Unprotected sex and contracting STIs was slightly more common in young people with certain characteristics: LGBT, taking part in other risk behaviours such as drinking and drug use.
- Young people experiencing higher psychological distress are more likely to have sex without precautions or contraception.

Child sexual abuse and Female Genital Mutilation

The Crime survey for England and Wales (CSEW) estimated that 7.5% of adults aged 18 to 74 years experiences sexual abuse before the age of 16 years, this accounts for approximately 3.1 million people.[154] In the year ending March 2019, police in England and Wales recorded 73,260 sexual offences where the victim was a child. In March 2019 there were 2,230 children in England and 120 in Wales on a child protection plan/on the child protection register for experience or risk of sexual abuse.

It is estimated in 2011 that 60,000 girls aged 0 to 14 were born to mothers with Female Genital Mutilation (FGM) across England and Wales. The NHS treated 106 girls aged under 18 with FGM between April 2015 and March 2016.

Alcohol, smoking and substance misuse among young people[155]

The proportion of children in the UK who drink alcohol is above the European average, and British children are more likely to binge drink or get drunk compared to children in most other European countries.[156] National Statistics on smoking, drinking and drug use among young people in England are usually reported by NHS Digital every 2 years, but due to COVID-19 the latest survey results available are from 2018 and found that:

- 10% of pupils had drunk alcohol in the last week (school years 7 to 11) and 22% of 15 year olds reported having been drunk in the last four weeks.
- Young people were much more likely to have drunk alcohol if they lived with a household member who drank, this increased by number of drinkers they lived with.
- Pupils were more likely to have drunk, either in the last week or ever, if they had a higher affluence score; 13% and 37% respectively for higher scoring pupils, compared with 7% and 27% for lower scoring pupils.
- 77% of young people would go to their parents as a helpful source of information on drinking alcohol, followed by teachers (62%), other relatives (around 50%), friends (40%) and other adults at school (35%). In terms of media sources, the internet (56%) and TV (56%) were the most popular sources followed by social media (46%).
- Nationally smoking rates have reduced with 5% of pupils in the survey current smokers, down from 22% in 1996. 16% of pupils had ever smoked cigarettes down from 19% in 2016 and 49% in 1996.

[154] Child sexual abuse in England and Wales - Office for National Statistics (ons.gov.uk)
[155] Smoking, Drinking and Drug Use among Young People in England 2018 [NS] - NHS Digital
[156] WHO/Europe | Spotlight on adolescent health and well-being. Findings from the 2017/2018 Health Behaviour in School-aged Children (HBSC) survey in Europe and Canada. International report. Volume 1. Key findings

- The All Party Parliamentary Group (APPG) on smoking 2020 found that for every three young smokers, one will quit and one of the remaining smokers will die from tobacco related causes.
- The percentage of young people reporting low life satisfaction nowadays was higher in recent smokers at 40% vs 18% for all pupils. It was 33% for pupils who had taken drugs in the last month and 28% in pupils who had drunk alcohol in the last week.
- 24% of pupils reported they had taken drugs at least once, this increased with age (38% of 15 year olds vs 9% of 11 year olds). 9% said they had taken drugs in the last month.

Smoking, drinking and drug use among hard to reach children and young people[157]

The review of evidence from 46 published academic papers found that smoking and drug use is much higher among hard to reach subgroups than the general population of children and young people. The evidence for alcohol was more mixed and also more limited, so it was not possible to determine if the prevalence was higher in particular subgroups or had seen less decline.

5.2.2 Oxfordshire Data

Sexual and Reproductive Health

The chlamydia detection rate, 15-24 years, has shown a decreasing trend and is lower than the national average. It is below the PHE target of 2,300 per 100,000 at 1,093 per 100,000 compared to 1,773 in the South East and 2,050 in England for 2019. A higher proportion of the female 15-19 population was tested for Chlamydia in 2019 than males, with females having a lower % of positive tests (see figure 28). Nationally a higher percentage of the estimated 15-19 population was tested 6.5% vs 4.6% in males and 20.6% vs 13.6% in females[158]. The Covid-19 pandemic had a significant impact on the chlamydia detection rate data from 2020 across the country, so 2019 data has been primarily used for the purpose of this needs assessment. In 2020 in Oxfordshire the detection rate was significantly reduced to 532 per 100,000 15 to 24 year olds, the lowest in the South East region for 2020 and below the England average (1408 per 100,000).

Of all new Sexually Transmitted Infections (STIs) diagnosed in 2019, females aged 15-19 made up a higher proportion of new diagnoses than males in the same age group (20% vs 10%). Reinfection with an STI is a marker of persistent risk behaviour and young people are more likely to become reinfected with STIs. In Oxfordshire, an estimated 12.3% of 15-19 year old women, and 8.8% of 15-19 year old men presenting with a new STI to sexual health services, were reinfected within 12 months from 2015-2019. Nationally it is 11.4% for women and 10.4% for men. Given the potential long term health consequences of STIs in women, such as pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility,

[157] Smoking, drinking and drug use among hard to reach children and young people; an evidence synthesis report (koha-ptfs.co.uk)
[158] GUMCAD STI Surveillance System - GOV.UK (www.gov.uk) Data accessed from HIV and STI Web Portal January 2022

and that they may be asymptomatic, opportunistic screening is an essential element of good quality sexual health services for young adults.[159]

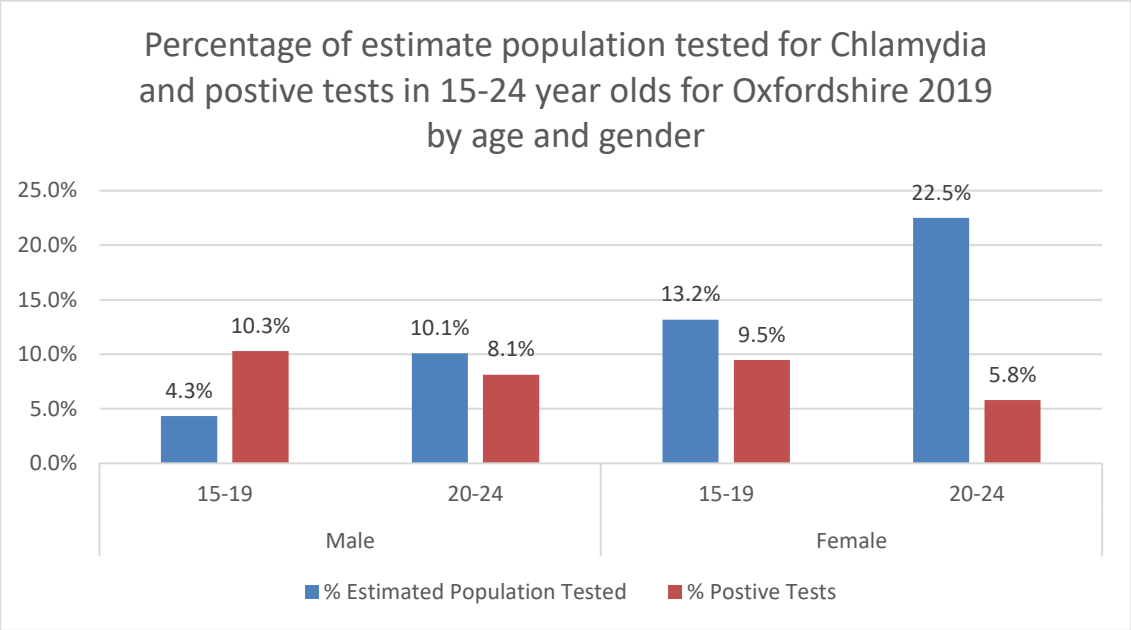


Figure 28: Chlamydia testing in 15-14 year olds in Oxfordshire in 2019.
Data Source: CTAD

The proportion of teenage mothers in Oxfordshire was 0.2% in 2019/20. This has shown a gradual reduction since 1.0% in 2010/11 in line with the national picture and remains below

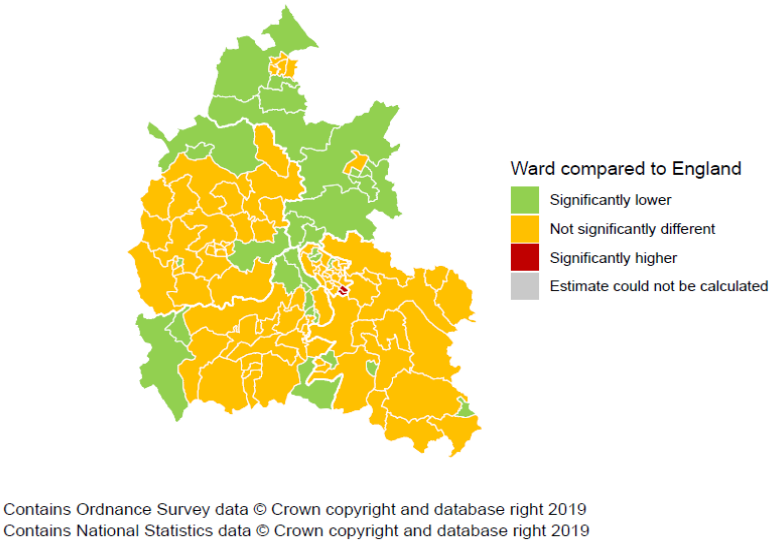


Figure 29: Under-18s conception in Oxfordshire by ward, compared to England 2016-2018
Source: SPLASH Oxfordshire, data sourced from Conception Statistics, England and Wales, ONS

[159] National Chlamydia Screening Programme (NCSP) - GOV.UK (www.gov.uk)

the rates for the South East (0.5%) and England (0.7%). Since 2015-17 there has also been a reduction in the number of wards in Oxfordshire that have under-18 conception rate significantly higher than the national average. Two areas still have a rate significantly higher than national average, Blackbird Leys and Northfield Brook Ward, both in the top 10 most deprived wards in Oxfordshire.

Oxfordshire Young People's Survey (Sexual Health)

This survey was carried out by Terrence Higgins Trust in 2021 and gathered information from 308 young people accessing sexual health services in Oxfordshire. Key findings from the survey were as follows:

- When asked the most convenient days to access the service, nearly 80% said Saturday. Friday was next most popular (48%), followed by Monday and Wednesday (nearly 40%), then Tuesday and Thursday (33%).
- Early evening was ranked as the most convenient time for an appointment for 50% with day time (12:00-15:00) ranked second by 44%, and morning third by 54%.
- When asked to rank in order of preference how they would like to access contraceptive care, 50% ranked drop in clinic without appointment number 1, 30% telephone consultation and 21% booked face to face appointment.
- Ranking for accessing STI testing showed 47.81% ranked home testing first, with a face to face appointment or drop in clinic without appointment ranked first by around 1 in 4. Only 7.19% put telephone consultation as their first choice.
- Condom distribution was ranked most useful outreach service by 61%, followed by pop-up STI testing events in colleges or community venues.

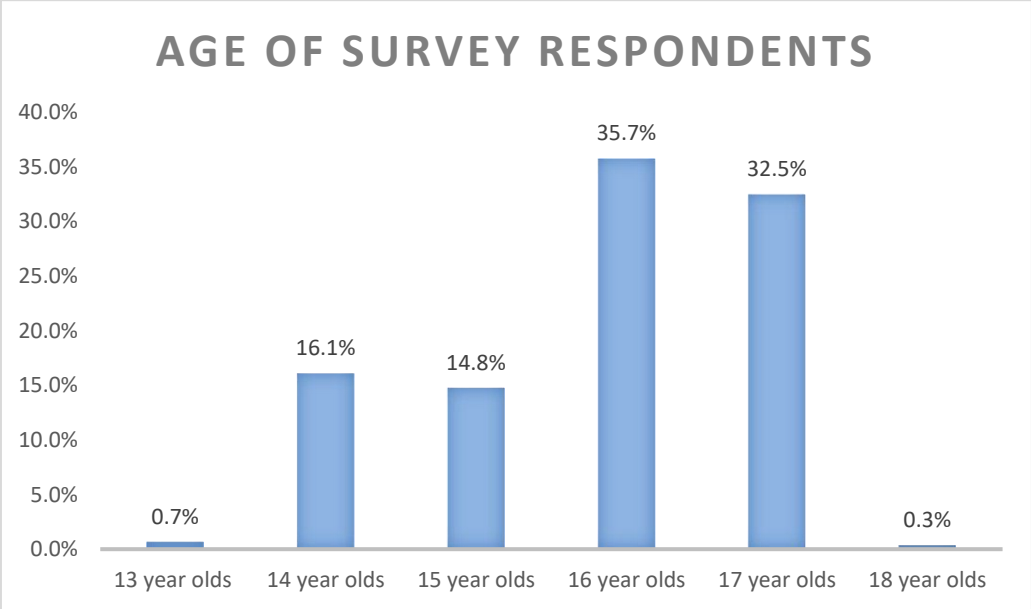


Figure 30: Age of respondents for Oxfordshire Young Person Survey from Terrence Higgins Trust

Whilst this only reflects sexual health services, as opposed to service within schools it does give a picture of how young people prefer to interact with sexual health services and testing.

Alcohol and substance misuse

Admissions for alcohol specific conditions in under 18s in 2018/19-2020/21 was 33 per 100,000, higher than the England rate (29.3 per 100,000) and the South East average (31.3 per 100,000). This is the first period that admissions have been statistically similar to the England rate, having previously been significantly worse than the England average from 2013/14 to 2019/20.

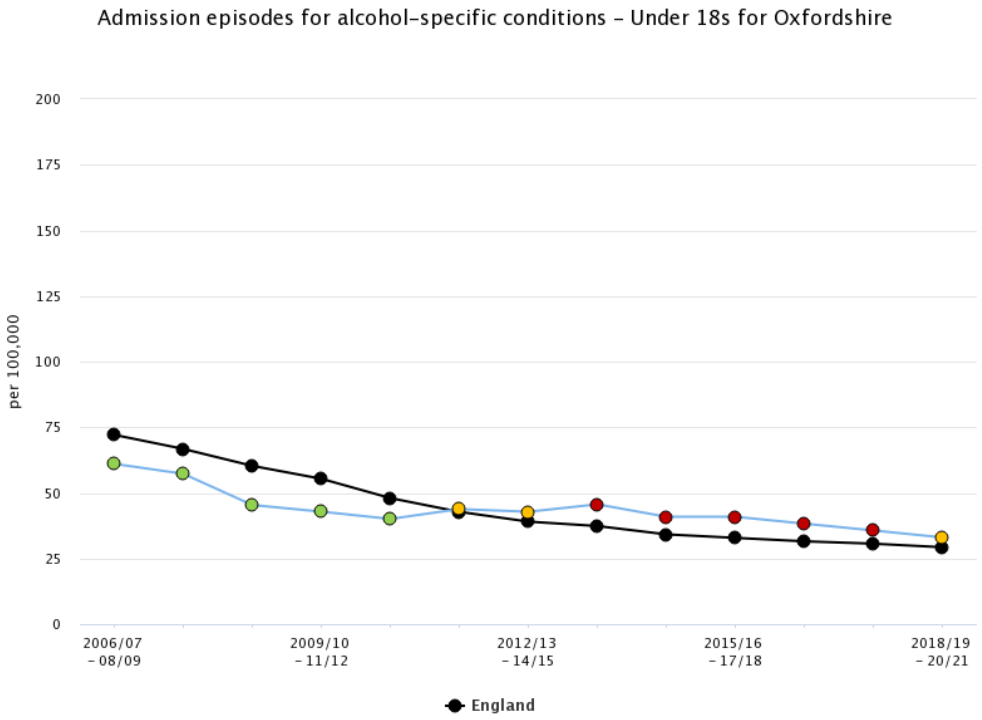


Figure 31: Admission episodes for alcohol specific conditions in under 18s Oxfordshire. Source: Child Health Profiles OHID Fingertips. Child and Maternal Health - Data - OHID (phe.org.uk)

Hospital admissions for substance misuse in 15-24 year olds was 65.9 per 100,000 in 2018/19-2020/21. This level has fluctuated over the years but has remained statistically better than England (81.2 per 100,000) and the South East (75.9 per 100,000) over the past 10 years.

2% of suspensions from Oxfordshire state funded schools in 2019/20 were related to drugs and alcohol (106 out of 4,454) compared with 3% nationally. 9% of permanent exclusions were related to drugs and alcohol compared to 10% nationally.

5% of children looked after for at least 12 months in Oxfordshire were identified as having a substance misuse problem in 2020/21 (30 out of 560) compared to 3% nationally. Of these children, 40% received an intervention for their substance misuse problem, similar to national figure of 44%.

Young People in substance misuse treatment in Oxfordshire in 2020/21[160]

The most recent data is from April 2020 to March 2021. The COVID-19 pandemic meant there were fewer opportunities for young people to be referred to substance misuse services. Nationally, there was a 23% reduction in the number of young people having contact with drug and alcohol service (down to 14,291) and a 55% reduction in the number in treatment since 2008/09.

As in England, around 1/3 (32%) of young people in treatment in Oxfordshire for 2020/21 are female, with around 2/3 (68%) male. 94 young people newly presented for treatment in 2020/21, with 128 young people receiving treatment in total. The majority were aged 14-15 (44%) or 16-17 (44%). There were less than 5% aged 14 years, and 7% were aged 18-24. In England, there was a lower proportion of new presentations aged 14-15 (30%), similar for aged 16-17 (42%) and a higher proportion aged 18-24 (23%). It should be noted that numbers within Oxfordshire are small so differences with the national picture should be interpreted with caution.

The most common source of referral in Oxfordshire was children and family services (47%), followed by education services (21%), then self/family/friends or health and mental health services (both 12%). 8% of referrals were from youth justice. Nationally there were more referrals from youth justice (22%) and fewer from children and family services (22%).

Cannabis was the most common reported problem substance for Oxfordshire in 2020/21 (figure 32) for 88% of young people (85% for England). 54% of all in treatment reported problems with alcohol, higher than for England (42%). There were no reported problems with heroin or crack for Oxfordshire. There was a lower proportion in treatment for problems with cocaine and nicotine than England. 35% were smoking when they started treatment compared to 27% in England.

[160] OHID, Young People substance misuse commissioning support pack 2022-23: Key data

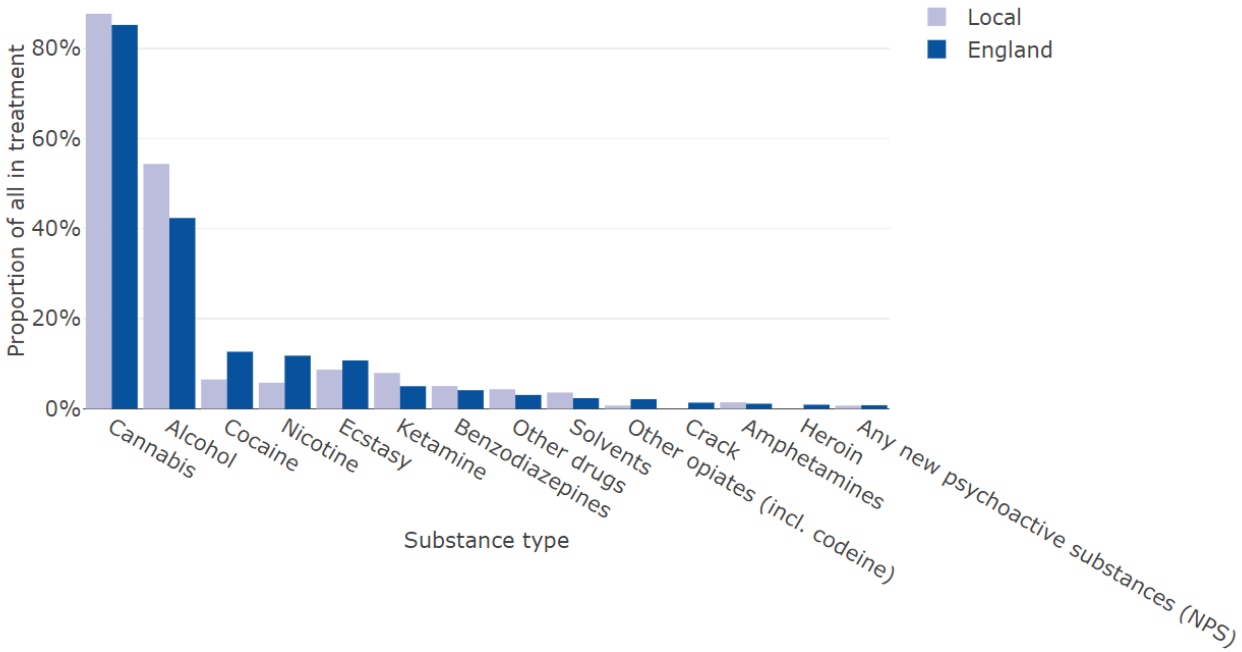


Figure 32: Proportion of young people (including 18-24 in young people's services) in treatment reporting problem substances for Oxfordshire and England (2020-21).

Those in treatment were asked to calculate the number of units of alcohol they had consumed in the 28 days prior to commencing treatment. In Oxfordshire 1 in 5 (21%) had not consumed no alcohol in the month prior to treatment, much lower than in England where 1 in 2(50%) had consumed no alcohol. Most young people in treatment in Oxfordshire had consumed 1-199 units (71%), in England less than half (44%) had consumed this amount in the month prior to treatment.

57% of young people in treatment were living in a household with other children, a minority were parents themselves (<5%). Nationally this figure was much lower, with 37% living in a household with other children. 95% of young people in treatment were living with parent, compared with 82% nationally. There were fewer young people living in care compared to England <5% vs 7%.

The most common vulnerabilities for those attending treatment services were early onset of substance use before 15 years of age (45%) and poly drug use (42%). 43% of those in treatment had a mental health need, similar to the national picture (42%). This was higher in females than males (59% vs 36%). Other vulnerabilities included anti-social behaviour (26%), which was more prevalent in males than females (32% vs 12%), self-harm (11%), being affected by domestic abuse (11%) and being affected by others substance misuse (20%). Being a looked after child and not being in education, employment or training are also key vulnerabilities.

Hospital admissions for injury

Hospital admissions caused by unintentional and deliberate injuries in children 0-14 years has shown a decreasing trend since 2014/15, following closely the average rate across England. In 2020/21 the rate was significantly better than England at 68.2 per 100,00 compared to 75.7 per 100,00 in England and 73.2 per 100,00 in the South East. In 15-24 year olds, hospital admission for injury was not significantly different to the England average in 2020/21 at 108.4 per 10,000, compared to 112.4 per 10,00 in England. Levels were higher in the South East at 130.8 per 100,000.

The number of children killed or seriously injured on England's roads (0-15 years) has remained consistently lower than the England average, at 11.8 per 100,000 from 2017-19, compared to 18 per 100,000 in England and 17.1 in the South East.

5.2.3 Summary: National and local data

National:

- The longitudinal study[161] of young people found that
  - Young people who did not receive RSE in schools were more likely to go on to take more sexual risks.
  - Young people experiencing higher psychological distress are more likely to have sex without precautions or contraception.
- 59% of all new chlamydia cases were in under-25s, with higher rates in females.
- The proportion of children in the UK who drink alcohol is above the European average
  - British children are more likely to binge drink or get drunk compared to children in most other European countries.
  - Pupils were more likely to have drunk, either in the last week or ever, if they had a higher affluence score
- Smoking and drug use is higher among hard to reach subgroups than the general population of children and young people.

Local:

- Oxfordshire has a lower chlamydia detection rate than the national average
- However, females aged 15-19 in Oxfordshire make up a larger proportion of new STIs diagnosed than males and have a higher reinfection rate than seen nationally.
- When asked about preferences for accessing sexual health services:
  - 80% said Saturday was the most convenient day
  - Nearly 50% ranked home testing kits as the preferred option for STI testing
  - 61% said condom distribution was the most useful outreach service
- Under 18 conception rates have reduced since 2015-17, but two areas still have a rate significantly higher than national average, Blackbird Leys and Northfield Brook Ward, both in the top 10 most deprived wards in Oxfordshire.

[161] Experiences of Relationships and Sex Education, and sexual risk taking (publishing.service.gov.uk)

- There is limited recent data on of smoking rates in young people in Oxfordshire.
- Admissions for alcohol specific conditions are above the England average, with levels reducing in England at a quicker rate than in Oxfordshire.
- For young people in substance misuse treatment in Oxfordshire
    - More report problems with alcohol than nationally 54% vs. 42%.
    - 79% had consumed alcohol in the month prior to starting treatment compared to 50% nationally.

5.2.4 Current Offer

Relevant services and initiatives currently on offer in Oxfordshire related to supporting health behaviours and reducing risk taking include:

- Sexual Health Services:
    - Oxfordshire currently operates 6 sexual health clinics across Oxfordshire[162]
        - Since the COVID-19 pandemic most of the clinics are appointment only with no drop-in service.
    - The Safety Condom Card (C-Card) Scheme runs in Oxfordshire and enables young people between 13-24 years to access free condoms and lube packets.
        - Cards can be signed up for online or at participating centres, including the School Health Nurse.[163]
    - At present under 18s are not able to access STI testing online but can attend clinics within the community.
    - School/College Health Nurses provide sexual health advice and prescribe contraception (see SHN activity in 4.3.2 for more details). They also provide contraception outreach to vulnerable young people.
    - The Terrence Higgins Trust[164] work with Integrated Sexual Health Services providing outreach and working with young people under 25, amongst other groups. Work includes:
        - Training for professionals working with young people and workshops for students in schools where there is a lack of sexual health provision.
        - The Step Out Programme which engages with young people under 18 who have experienced or are at risk of exploitation.
        - Work with SEN schools to create Relationship and Sex education lesson plans and resources for young people with Special Education Needs.
    - Following a deep dive with PHE in 2017 Oxfordshire changed from the National Chlamydia Screening Programme (NCSP) universal under 25 screening model to a more targeted approach to proactive chlamydia screening in groups at higher risk. The NCSP was updated in 2021 to change to focus on reducing reproductive harm of untreated infection in young

[162] Welcome to Oxfordshire Sexual Health Service - Sexual Health Oxfordshire
[163] Oxfordshire C-Card free condom scheme (oxfordshireccard.org.uk)
[164] Oxfordshire | Terrence Higgins Trust (tht.org.uk)

women from a more universal approach in the under 25s. Nationally, testing will only be proactively offered to young women in community settings.

- The Family Nurse Partnership in Oxfordshire is a preventative programme that works with first time young mothers (age 19 and under) and supports the family from pregnancy up until the child turns 2. FNP has good national evidence of improving child development and school readiness at age 5.

- The Aquarius Service offers support for children and young people who use substances and those who are affected by others drug and alcohol use.[165]
    - Services include: 1-1 therapeutic support, outreach with hard to reach young people, brief interventions and advice, group work, support for parents/carers/professionals.

- Protective Behaviours Programme
    - This is a programme for children base on two themes ('We all have the right to feel safe all the time' and 'We can talk to someone about anything even if it is awful, or small') using seven strategies.
    - It has a small but increasing evidence base on its effectiveness and addresses Adverse Childhood Experiences by focusing on the right to feel safe and developing skills to access support.
    - It is delivered to children in Key Stage 3.

- School Health Nurses deliver Puberty and relationship sessions (year 5&6) as part of Relationship and Sex Education (RSE) provided within the schools.

- Accident Prevention:
    - A pilot scheme called 'School Streets' is currently being trialled by Oxfordshire County Council
        - It aims to create a car free environment around some schools by restricting access for motor vehicles at school drop off and pick up.
        - This is designed to encourage active travel to school (such as walking and cycling) and make it safer for families.
        - Of the 9 schools in the trial, 5 have decided to continue with the scheme based on the success of the trial.
    - Other initiates to improve the safety of active travel to school within Oxfordshire include:
        - 20mph zones around schools,
        - Introduction of Low Traffic Neighbourhoods to some areas of Oxford City
        - Improved cycle lane network for those cycling to school
    - School Health Nurses provide information about water safety
    - Prior to the COVID-19 pandemic The Junior Citizens Trust[166] ran teaching for children in Year 6 about how to keep safe in everyday life

[165] The Aquarius Service | Oxfordshire County Council
[166] Junior Citizens Trust | Safety education for children

- The Trust is made up of a number of partners including Oxfordshire Fire and Rescue, Oxfordshire County Council, Chiltern Railways, First Great Western, Build Base and Thames Valley Police.
- The programme consists of scenarios on a wide range of topics including fire safety, home dangers, dog safety, road safety, water safety, internet safety, rail safety and personal protective awareness.
- They now offer an online safety quiz that can be carried out by year 6 children at school.

5.3 Supporting Healthy Lifestyles

5.3.1 National Data

National child measurement programme (NCMP) and obesity

Nationally, obesity rates are highest in the 10% most deprived of the population, more than twice that of the least deprived 10% (see figure 33). In 2021, 33.8% of young people who live in the most deprived areas are classified as obese, compared to 14.3% of those in the least deprived areas.[167] This was an increase from 27.5% and 11.9% respectively in 2019. Obesity rates have also been increasing in the most deprived areas for 10-11 year olds at a higher rate than in the lest deprived areas, so the gap has widened since 2006/07 to 2019/20, from an 8.5% difference in 2006/07 to a 13.3% difference in 2019/20 (figure 34). As can be seen in figure 33 rates of obesity increase between reception and year 6 for all groups of deprivation. Obesity rates were higher in some ethnic minority groups, in particular among children from Black and Bangladeshi ethnicities, though this is variable by age and sex of the child.

[167] What are health inequalities and why do they matter for young people? - Association for Young People's Health (youngpeopleshealth.org.uk)

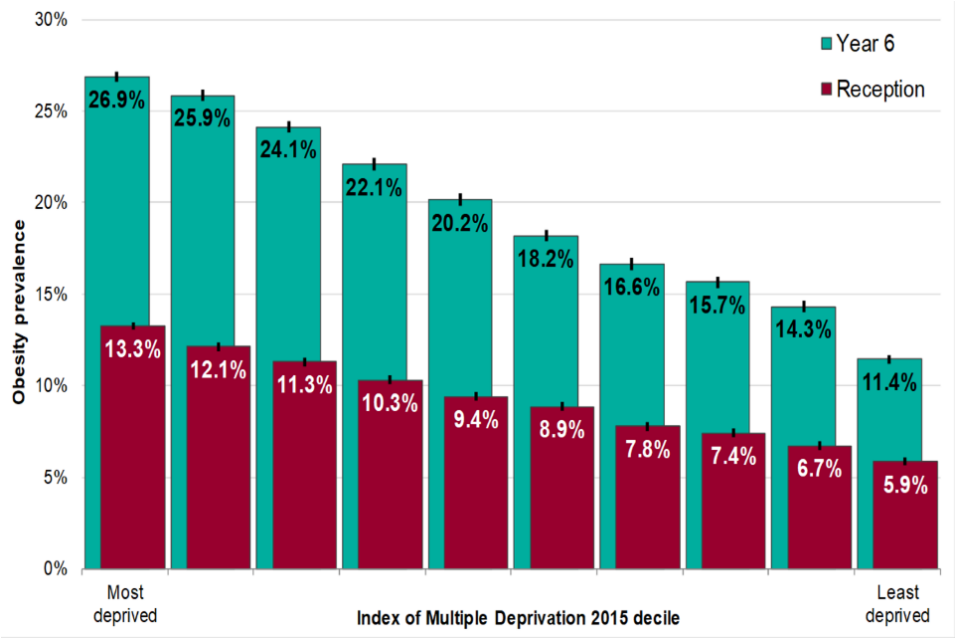


Figure 33: 2018 to 2019 National Child Measurement Programme data
[Childhood obesity: applying All Our Health - GOV.UK (www.gov.uk)]

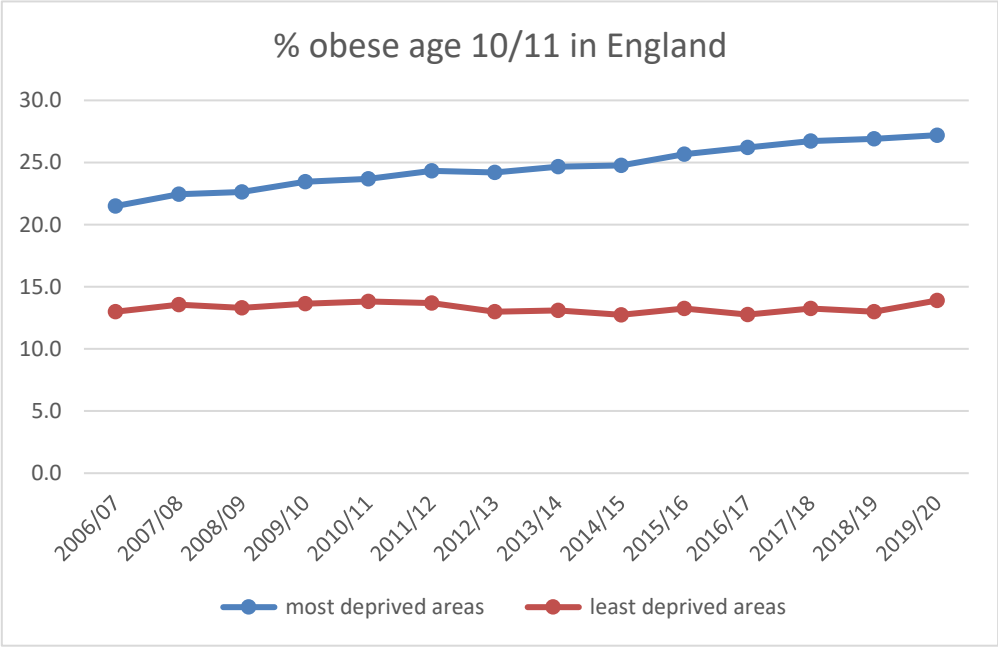


Figure 34: Percentage of obese children age 10-11 in England by year in most deprived and least deprived areas.
Source: Source NHS Digital – National Child Measurement Programme 2019/20
https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2019-20-school-year/deprivation

Figure 35 shows the proportion of children and young people reporting being overweight, including obese, by BMI, using data from the HSBC survey that included up to 30 countries in the OECD (Organisation for Economic Co-operation and Development) and Russia, by Family Affluence Scale (FAS - a proxy for socio-economic status in the survey). It demonstrates that difference between the percentage of overweight children in low FAS (lowest 20%) and High FAS (highest 20%) is widest in the UK compared to other countries.

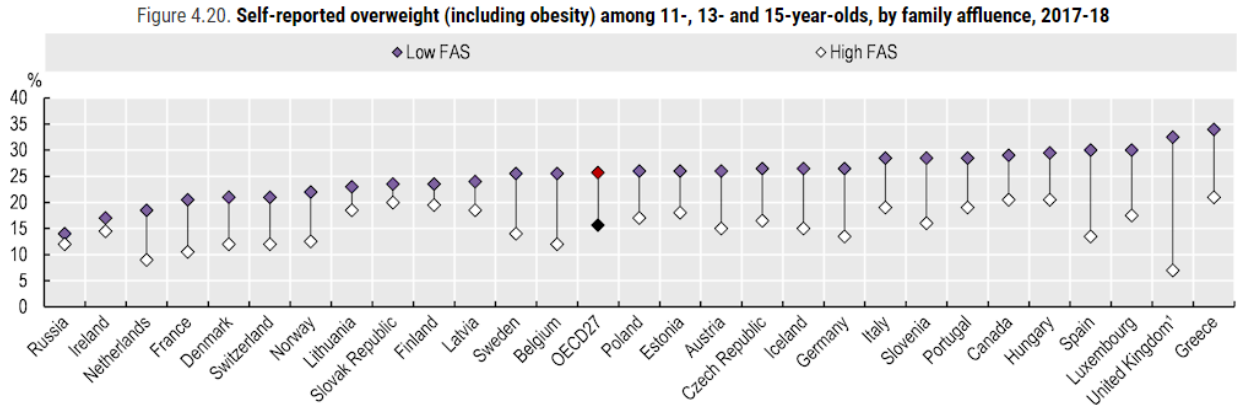


Figure 35: Overweight and obesity among adolescents in OECD countries. Source: Accessed from Health at a Glance 2021: OECD Indicators (Overweight and obesity among adolescents | Health at a Glance 2021 : OECD Indicators | OECD iLibrary (oecd-ilibrary.org))
Original paper: Inchley at al. WHO/Europe | Publications - Spotlight on adolescent health and well-being. Findings from the 2017/2018 Health Behaviour in School-aged Children (HBSC) survey in Europe and Canada. International report. Volume 2. Key data

The main risk factors for obesity in children include:

- Maternal health – evidence shows a significant relationship between maternal obesity and the birth of babies above normal weight range, and subsequent development of childhood and adult obesity.
- Parental health – children living in a family where at least on parent or carer is obese are more at risk of becoming obese themselves.
- Poor diet and low levels of physical activity are the primary causal factors to excess weight.

5.3.2 Oxfordshire Data

National Child Measurement Programme (NCMP) and Obesity

The closure of schools during the COVID-19 pandemic lockdowns, meant that the NCMP was halted nationally in 2019/2020. In 2020/21, as there was not enough time to deliver the whole programme, Public Health England issued a list of schools for each local authority that

would be representative sample. This meant measurements were not taken in all 242 schools in Oxfordshire and so caution is needed in interpreting the most recent data.

In 2019/20, 18.6% of reception age children in Oxfordshire were overweight (including obese) compared to 23% in England and 21.9% in the South East. In 2020/21, from the schools sampled nationally, obesity rates in both reception-aged and year 6 school children increased by around 4.5% from 2019/20 levels. This is the highest annual rise since the NCMP began in 2006/07, previously the highest rise was <1%. Based on the figures available for Oxfordshire from 2020/21, it seems Oxfordshire has followed a similar pattern. The Oxfordshire data available is from the service and has not yet been statistically weighted, so cannot be shared in this document.

In year 6 pupils in 2019/20, 29.4% of year 6 children were overweight (including obese) compared to 35.2% in England and 31.7% across the South East.

Although Oxfordshire has a lower prevalence of overweight and obesity in both age groups, there is variation at ward level, with several wards having higher levels than seen nationally. Figure 36 shows 3 year combined data (2017/18 – 2019/20) at ward level, the darker coloured areas have statistically higher prevalence of overweight/obese than the national average. The areas with the highest prevalence include Northfield Brook and Blackbird Leys, both in the top 10 most deprived wards in the county. A similar variation in prevalence at ward level is also seen in reception age children in Oxfordshire.

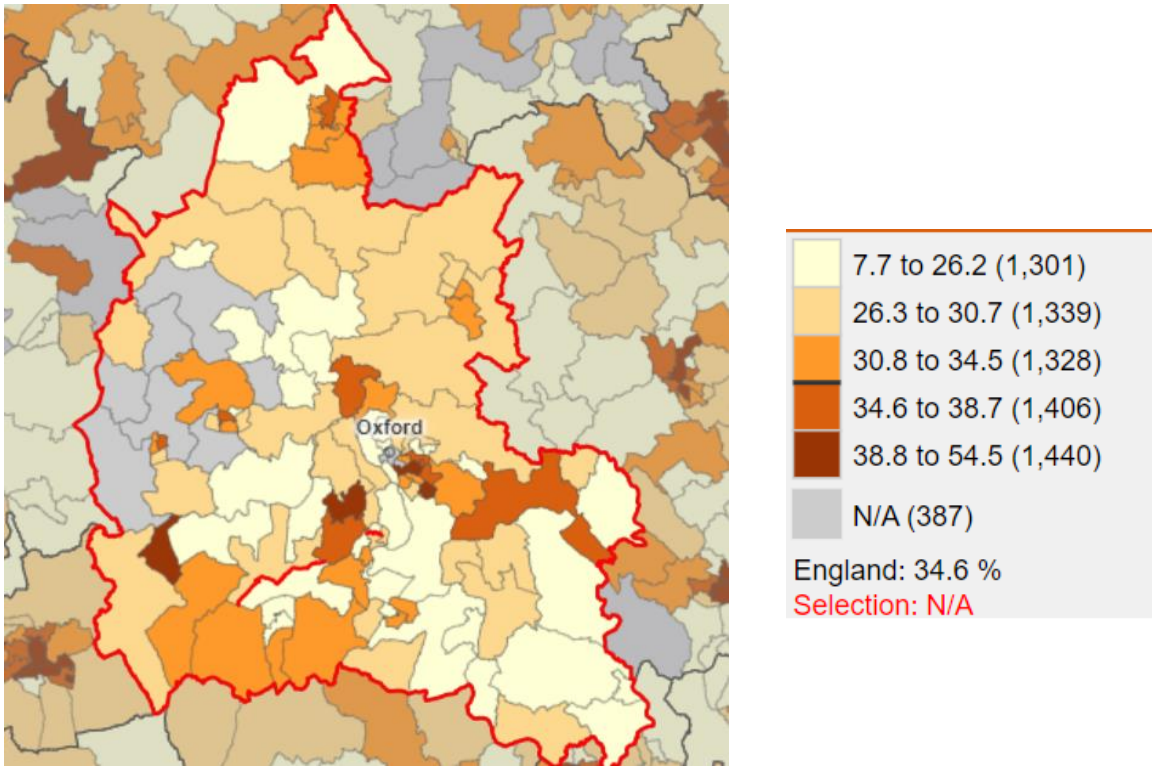


Figure 36: Prevalence of overweight (including obesity) in Year 6 pupils, 3 year data combined 2017/18-2019/20 (%) in Oxfordshire 112 Wards.
Source: Local Health - Public Health England - Indicators: maps, data and charts

Hospital admissions for asthma <19 years

Admissions for asthma in 2020/21 for children aged 0-9 was 43 per 100,000 and shows a decreasing trend, with lower rates than England (91 per 100,000) and the South East (70 per 100,000).[168] There was a dramatic reduction from 2019/20 to 2020/21 that was seen across the country, possibly impacted by the Covid-19 pandemic. 2019/20 figures were 134 per 100,000 for Oxfordshire, 192 per 100,000 for England and 153 per 100,000 for the South East.

Admissions for young people aged 10-18 in 2019/20 for Oxfordshire was 90.7 per 100,000. This has shown no significant change in recent years and is lower than the England (123.4 per 100,000) and South East average (94.7 per 100,000). Similar to the 0-9 age group there was a dramatic reduction in 2020/21 to 34.1 per 100,000 in Oxfordshire, 54.8 per 100,000 in England and 38.3 per 100,000 in the South East.

Access to outdoor play areas and green spaces

Access to green spaces has also been found to be beneficial for both physical and mental health. Nationally, 70% of children under 16 report spending time outside at least once a week, falling to 64% of 16 to 24-year-olds.[169] In the Office for National Statistics (ONS) data set for private outdoor spaces, 88% of households in Oxfordshire have access to private gardens, ranging from 84% in Oxford city to 91% in South Oxfordshire. For those living in flats in Oxford City 64% had access to private outdoor space.[170] The average number of parks, public gardens, or playing fields within a 1,000m radius in Oxfordshire was 4.14 similar to the England average of 4.39. It varied across Oxfordshire at 2.73 in more rural South Oxfordshire and 5.79 in Oxford city.

Physical Activity

42% of children in Oxfordshire were not meeting the daily physical activity guidelines (60 mins per day) in 2019/20.[171] This increased in 2020/21 to 49%.[172] Levels remain better than the England average where 55% of children did not meet physical activity guidelines both in 2019/20[173] and 2020/21.

[168] Public health profiles - OHID (phe.org.uk)
[169] Natural England (2019). Monitor of engagement with the natural environment children's report (MENE) 2017-2018. Available at: www.gov.uk/government/statistics/ monitor-of-engagement-with-the-natural-environment-childrens-report-mene-2017-2018
[170] Access to gardens and public green space in Great Britain - Office for National Statistics (ons.gov.uk)
[171] ExecSummary_JSNA20210331.pdf (oxfordshire.gov.uk)
[172] Physical Activity - Data - OHID (phe.org.uk)
[173] Physical activity data tool: statistical commentary, March 2021 - GOV.UK (www.gov.uk)

In the OxWell survey in 2020 pupils were asked how many hours of physical activity they did per week in and out of school before the lockdown. A higher percentage of girls were non-

Figure 3.1: Gender differences in low active respondents

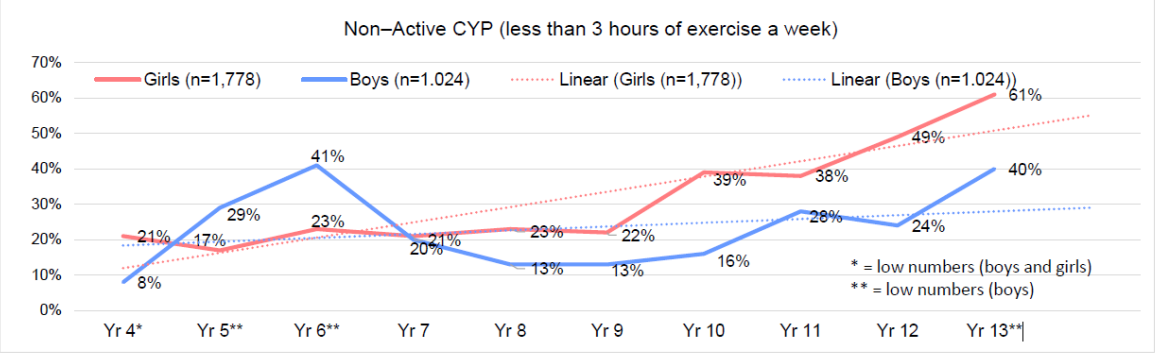


Figure 37: Low activity respondents (less than three hours a week) by year group and gender. Source: OxWell Survey 2020

active (less than 3 hours of exercise a week) than boys. Activity levels decline as both boys and girls get older, but the rate of decline is much steeper in girls than boys.
The Active Lives survey[174] demonstrated that in 2020 the percentage of children who are less active reduced by 2.4%, compared to an increase of 2.4% nationally. Nationally there was a larger drop in activity levels in children and young people from less affluent families and those from a black ethnic background.

Figure 3.2: Gender differences in low active respondents

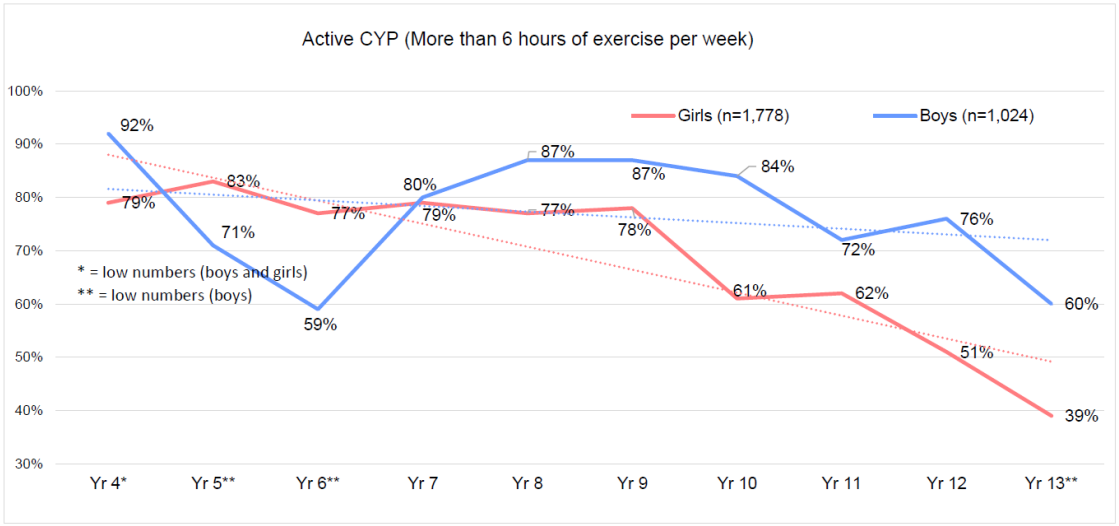


Figure 38: Active respondents (more than 6 hours per week) by year group and gender. Source: OxWell Survey 2020

[174] Active Lives | Home (sportengland.org)

Oral Health

In 2018/19 (most recent data available), 21.3% of 5 year olds in Oxfordshire had experience of visually obvious dental decay. This is worse than the average across the South East region (17.6%) but lower than the England average (23.4%). It has improved since 2011/12, when it was significantly worse than the England average (32.9% vs 27.9%). In 2018/19, 96.2% of people successfully obtained an NHS dental appointment in Oxfordshire, compared to 93.9% across the South East and 94.2% across England. At present, fluoride is not added to drinking water in Oxfordshire.

Immunisations

School closures due to the COVID-19 pandemic caused disruption to the Human Papilloma Virus (HPV)vaccine coverage across England in 2019/20. In 2018/19, 93.1% of 12-13 year old females had received one dose of HPV vaccine compared to 88% in England, and 89.3% in the South East. From 2014/15 to 2018/19 vaccination coverage for HPV has remained between 91.4% to 94.3% in Oxfordshire, above the average for England.

In 2019/20 Oxfordshire had a vaccine coverage for the first dose in females (12-13 years) of 83.6%, this is significantly better than seen across England (59.2%) and the South East (53.5%). This is likely to have been impacted by the timing of the HPV vaccine delivery, as local authorities who started their programme earlier in the year, had achieved a higher coverage before the school closures in March 2020. Coverage for two doses in females age 13-14 years was 89.5% in 2018/19 (83.9% in England) and 84.7% in 2019/20 (64.7% in England).

It was the first year of data for first dose coverage in males for 2019/20, Oxfordshire's coverage was 80.3%, well above England 54.4% and the South East 49.6%.

5.3.3 Summary: National and local data

- Nationally obesity rates increased by around 4.5% in both reception and year 6 children between 2019/20 – 2020/21. The highest annual rise since NCMP began. Oxfordshire data has followed a similar pattern.
- Although Oxfordshire has a lower prevalence of children who are overweight or obese than nationally and across the South East, levels are still significant with 18.6% of reception age children overweight or obese, increasing to 29.4% in year 6 in 2019/20. This increase in prevalence between reception and year 6 is also seen nationally.
- Nationally obesity rates are more than twice more in the 10% most deprived areas of the country compared to the least deprived 10%. This gap is widening, with obesity rates increasing more in children from more deprived areas since 2006/07.
- Similarly, at ward level in Oxfordshire there is variation in the prevalence of overweight and obesity in children, with a much higher prevalence than the national average seen in some of the top 10 most deprived wards in the county.

- In Oxfordshire the rates of obesity increase between reception and year 6, the same pattern is seen in national data.

- 49% of children in Oxfordshire were not meeting the daily physical activity guidelines in 2020/21.
- The OxWell survey found activity levels decline as young people move through secondary school but this decline is much steeper in females than males.

- 21.3% of 5 year olds experience visually obvious dental decay in 2018/19, higher than the South East average but lower than England (23.4%). This has declined form 2011/21 levels.
- Fluoride is not currently added to drinking water in Oxfordshire, but new national findings show that adding fluoride to drinking water can significantly reduce tooth extractions and cavities among children and young people in England.

5.3.4 Current Offer

- NCMP is currently included as part of the contract for the 5-19 service and is carried out by the school health nurses.
    - A letter is sent to families of all children who are overweight or underweight.
    - Advice and support is offered to families who require it

- An action plan is currently being developed for a Whole Systems Approach (WSA) to healthy weight in Oxfordshire.
    - The key themes of this plan are a family approach to healthy weight, physical activity in and around schools, and climate and food.
    - A childhood obesity subgroup was formed as part of the WSA to healthy weight.
    - Within schools focus includes:
        - Active lessons and challenging sedentary norms.
    - Activity outside of school includes focus on
        - Affordability
        - Sport perception
        - Engagement and fun
- There is a gap in provision for healthy weight in Children as there is currently no weight management service to refer children and their families to.
    - Work is currently underway to address gap in provision of healthy weight services for children in Oxfordshire with a Tier 2 child weight management service pilot.

- Health Promotion activities should be organised by School/College Health Nurses regularly in every school/college. This is based on the individual needs and preferences but is a combination of whole school assemblies, classroom sessions and targeted group work.

- As part of their work School/College Health Nurses in Oxfordshire should regularly review School/college travel plans and nutritional standards. Holistic food education, breakfast clubs and the principles of 'Everybody active, every day ' are actively endorsed.

- 'Eat Them to Defeat Them' schools programme
    - Oxfordshire County Council + the Food Sustainability and Health Partnership
    - Targeted to most deprived wards and based on NCMP results.
    - Aims to encourage children to eat more vegetables
- Holiday Activities and Food (HAF)
    - Funded by Department for Education, this programme provides healthy food and enriching activities to disadvantaged children during the school holidays
    - It is delivered by community based organisations who are able to provide healthy meals and activity sessions.

- Active Oxfordshire
    - A local charity dedicated to fighting inactivity and tackling inequality.
    - Works with Cherwell District Council to provide the FAST programme (Families Active Sporting Together) to encourage families to get more active in Banbury, Bicester and Kidlington.
    - Runs the Ready Set Go collaborative campaign to support every child to learn to swim and ride a bike.
    - Supports WOW (walk to school challenge) from Living Streets that encourages active travel to school
        - In participating schools 4 in 10 car journeys were swapped for a more active option.
    - Worked with Resilient Young Minds and Oxfordshire Mind to develop a mental health programme that combines physical activity with teaching on managing emotions and improving life skill such as resilience and self-esteem.
    - It also leads the Families activities working group, that are reviewing FAST and Holiday Activities and Food (HAF) programme[175].

- The Greenspace and Us project in currently underway
    - Designed to address issues around inequitable access to greenspace for teenage girls.
    - Project working group includes: Oxfordshire County Council, University of Oxford, Name It Project (Oxford Youth Enterprise), Fig and Resolve Collective.
    - Focuses on East Oxford, where 4 of the 10 most deprived wards are located
    - Uses participatory approach with teenage girls living in deprived areas to better understand and improve interaction with and access to greenspaces.

- Wayfinding School Travel Project

[175] Holiday Activities and Food (HAF) Programme: information for providers | Family Information Directory (oxfordshire.gov.uk)

  - Oxfordshire County Council school transport team with Sport England funding
  - Routes to school planned in 10 most deprived wards
  - Some joint working with Cherwell District Council who have a complimentary project in Kidlington.

- Oxford City council offer free swimming sessions for all children and young people aged 16 and under who live in Oxford.

- Oral Health
  - 5 year old dental epidemiology survey carried out every other year by Oxfordshire County Council. Commissioned work by Community Dental Services (CDS) to assess prevalence and incidence of oral disease.
  - Oral Healthy Improvement Team
    - Coordinate, facilitate and support a range of evidence based interventions to reduce oral health inequalities and promote better oral health.
    - Run 'Healthy Smiles' which supports service working with primary school children to adopt tooth-friendly practices.

5.4 Supporting vulnerable young people and improving health inequalities

5.4.1 National Data

Health inequalities have an impact across the life course for children and young people in England, as can be seen in figure 39. A report published by the National Child Mortality Database on data from April 2019 to March 2020 found a clear association between the risk of child death and the level of deprivation, for all categories of death except cancer. [176] The Child Mortality and Social Deprivation report states that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risks as those living in the least deprived. This equates to around 700 fewer child deaths per year in England. There was, on average, a relative 10% increase in the risk of death between each decile of increasing deprivation. This highlights the stark impact that deprivation has on the lives of children and, to quote Professor Sir Michael Marmot from the report's foreword, "in a rich society deprivation should be avoidable – particularly the kind that leads to deaths of infants and children".

[176] NCMD-Child-Mortality-and-Social-Deprivation-report_20210513.pdf

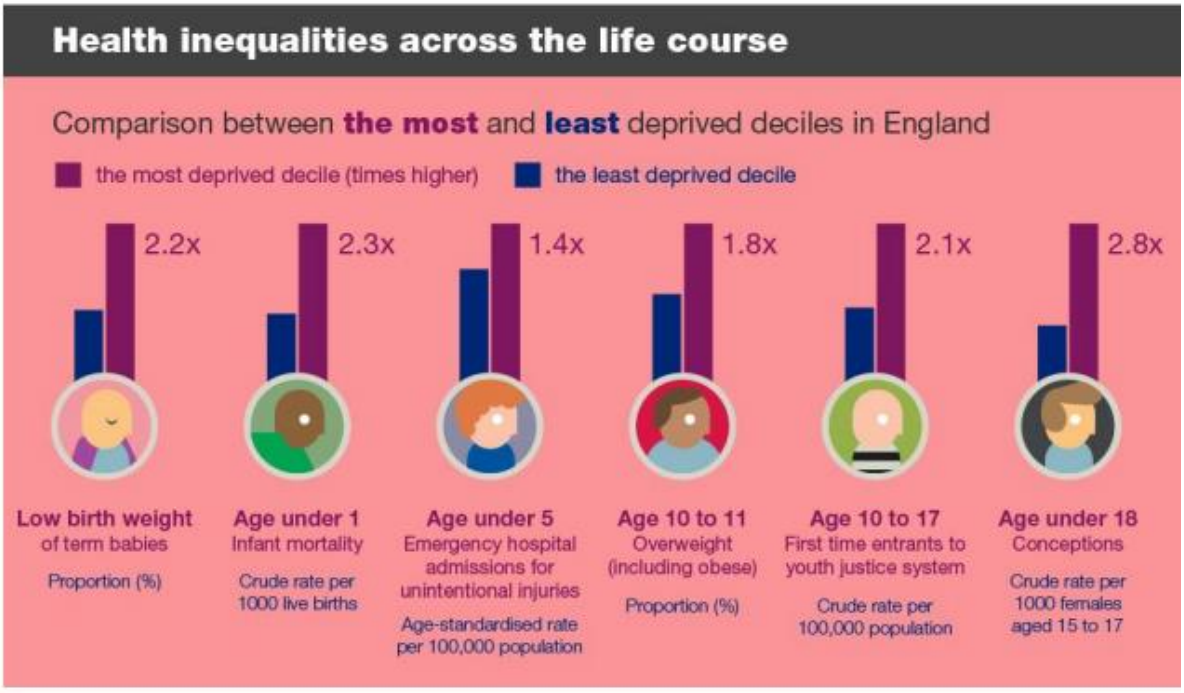


Figure 39: Health inequalities across the life course, PHE. Source: Public Health England. Health matters: Prevention - a life course approach. London: Public Health England; 2019.

Adverse childhood experiences can have a significant impact in health behaviours and other outcomes. A retrospective study found that people who had experienced 4 or more adverse experiences in childhood, compared to those who had no such experiences were:

- almost 4 times more likely to smoke
- almost 4 times more likely to drink heavily
- almost 9 times more likely to experience incarceration
- some 3 times more likely to be morbidly obese[177]

Children experiencing more adverse life experiences have also been shown to be more at risk of low mental wellbeing and life satisfaction, chronic health conditions, teenage pregnancy, poor educational attainment, and employment outcomes. These health inequalities can be seen across the life course can the impact from one generation to the next.[178]

Children in poverty: Measurement and targets[179]

This report from the House of Commons Work and Pensions Committee in September 2021 looked at how to measure and define child poverty and what can be done to reduce the

[177] Bellis M, Lowey H, Leckenby N, Hughes K, Harrison D. Adverse childhood experiences: Retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. Journal of Public Health (United Kingdom). 2013;36(1):81-91. Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population - PubMed (nih.gov)
[178] No child left behind: understanding and quantifying vulnerability (publishing.service.gov.uk)
[179] Children in poverty: Measurement and targets (parliament.uk)

numbers of children living in poverty. Children are more likely to be living in income poverty than adults, and there is clear evidence that families living in poverty were acutely affected by the pandemic. The department for work and pensions (DMPs) analysis showed that childhood poverty itself increased the risk of poverty in adulthood because of its effect on educational attainment. The report highlighted the importance of having more up to date data available and using a range of measures to assess child poverty. It also raised the importance of the development a UK wide child poverty strategy to tackle the problem and prevent departmental silo working with a lack of clear overall leadership.

State of Child Poverty 2021[180]

Buttle UK, a charity which helps children and young people in need across the UK, published a report looking at the impact of COVID on the vulnerable children and young people who have been supported by professionals from Buttle. Nearly 700 support workers responded to the survey in June/July 2021 and are estimated to have supported around 36,000 children. The report highlighted that for many children living in challenging home situations, it has worsened during the COVID-19 pandemic. From a survey carried out, support workers reported that all adverse childhood experiences (ACEs) had been made worse by COVID, 48% reported family mental illness was a lot more severe and 38% reported domestic violence was a lot more severe. Frontline support workers highlighted, lack of access to support, lack of parental respite, reduced time in education and reduced activity, poor diet, and isolation as all having contributed to the increasing severity of ACEs.

66% of children the support staff worked with had fallen behind in education, a lack of digital access was one of the biggest contributors for 60% of the children. 48% of the support workers felt that mental health support was the most crucial areas needed to support children in their learning going forward.

Children in Care and Children in Need

Around 3% of children living in England are in the social care system at any one time, nearly 1 in 5 of these children are children in care.[181] In 2021, the number of Children Looked After (CLA) rose to its highest level at 80,850. The number of children who became Children Looked After was particularly low during periods when national lockdown or restrictions were in place. There was also a reduction in CLA ceasing to be in care so the average duration of care increased by 79 days compared to the year before.[182] The number of CLA who were adopted fell by 18%, continuing a fall from a peak in 2015, this was impacted in 2021 by delays in court proceedings from the pandemic.

[180] SOCP-Report-21-FINAL.pdf
[181] No child left behind: understanding and quantifying vulnerability (publishing.service.gov.uk)
[182] Children looked after in England including adoptions, Reporting Year 2021 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

Studies, including findings from the **Looked-after children grown up projects**,[183] have found that children in care are more likely to have poorer educational attainment, mental and physical health:

- NICE reported in 2013 that 60% of children who are looked after in England have emotional and mental health problems.[184]
- In 2020, there were 31,260 care leavers age 19-21, 39% were not in Education, employment or training (NEET) compared with 11.6% for all young people aged 16-24.[185]
- They are 4x more likely to have special educational needs than the child population overall.
- Those who have been in care are more likely to return to education as an adult and gain further qualifications.
- Other risks include increased levels of offending, with 38% of children in Young offenders' institutions and 52% in secure training centres having previously been in care. These increased risks are often the result of many interrelated risk factors and exposures that increase the vulnerability of children and young people in the care system.
- There are higher rates of premature mortality for care leavers, with the gap widening in rates compared to those in the general population.
- Female care leavers are also three times more likely to become teenage mothers than those who have not been in care.

Recommendations from the Looked-after children grown up project included supporting foster parents to keep their children in education for longer and extending support during transition to adulthood for all care leavers.

In March 2019, around 7% of all children in care were living in children's homes in England (around 5,260 children). A report published in February 2021 looked specifically at **The education of children living in children's homes**.[186] The report found:

- 83% of children attended educational provision eligible for Ofsted inspection, 9% were in unregulated provisions, 6% were NEET, 2% attended provision inspected by the Independent Schools Inspectorate (ISI).
- Of those in provision eligible for Ofsted inspection, 57% were in special schools and 43% in mainstream education. This equates to children living in children's homes being 20 times more likely to be in special education than all children nationally.
- In all children living in children's homes attending state-funded nationally (approx. 2,500), 47% had education, health and care plans (EHCP) and 27% were receiving SEN support. Nationally for all children the proportions were 3% and 12% respectively.
- Children living in children's homes were 18 times more likely to be attending pupil referral unit (18% vs <1%)

[183] The-lifelong-health-and-wellbeing-trajectories-of-people-who-have-been-in-care.pdf (nuffieldfoundation.org)
[184] Overview | Looked-after children and young people | Quality standards | NICE
[185] AYPH_HealthInequalities_BriefingPaper1.pdf (youngpeopleshealth.org.uk)
[186] The education of children living in children's homes - GOV.UK (www.gov.uk)

Children in the criminal justice system

Children and young people who offend are more likely to experience a range of disadvantage and adverse risk factors. They are more likely to not be in education, employment and training. Young people entering youth custody have been found to have disproportionate health needs when compared to the general population, such as mental health needs (33%), substance misuse (45%), and learning difficulties or disabilities (32%).[187] 60% of young offenders have some form of communication difficulties, significantly higher than the general population.

Young Carers

Young carers include children and young people under 18 who provide care and emotional support to a family member with a physical or mental illness or disability, or substance misuse. The 2011 census reported 166,000 young carers (2021 results not yet published).[188] It may result in school absence for caring duties and 68% report bulling at school. Young carers are also 1.5 times more likely to have a special educational need or disability, and 38% reported having a mental health problem.[189] Young carers may be difficult to identify, and young people may not recognise themselves as 'young carers' as per the Children and Families Act 2014 assessment.[190] Public Health nurses and staff in schools play an important role in identifying and supporting young carers and their families.

Unaccompanied asylum seekers

This is defined as a young person under the age of 18, who is claiming for asylum in their own right, has been separated from both parents and is not being cared for by an adult who in law or by custom has responsibility to do so.[191] In recent years there has been a rise in unaccompanied asylum seeking minors (an increase of nearly 100% between 2012 and 2016). In March 2016, 22% were under the age of 16 years but the majority are males aged 16-17 years.

5.4.2 Oxfordshire Data

Readiness for school at the end of reception

As children come to the end of reception, their readiness for school is assessed. In Oxfordshire in 2018/19, 73.5% of children achieved a good level of development at the end of reception which is worse than South East region (74.6%) and better than England (71.8%). 49.9% of children with free school meal status achieved this level which is worse than South

[187] No child left behind: understanding and quantifying vulnerability (publishing.service.gov.uk)
[188] Young carers – Safeguarding Network
[189] School-aged years high impact area 4: Reducing vulnerabilities and improving life chances - GOV.UK (www.gov.uk)
[190] Children and Families Act 2014 (legislation.gov.uk)
[191] School-aged years high impact area 4: Reducing vulnerabilities and improving life chances - GOV.UK (www.gov.uk)

East region (55.4%) and is worse than England (56.5%). The gap in early years development between lower income pupils and other pupils in Oxfordshire increased in the past 2 years of available data. 2019/20 data for development is not available due to the impact of the covid-19 pandemic. In 2018/19, 85.2% of children had reached the expected level of development in communication in language skills at the end of reception, better than England (82.2%) and similar to the South East Region (85.1%).

Attainment 8 Score

Attainment 8 measures a pupil's average achievement in up to 8 qualifications, from GCSE or English Baccalaureate. Points are allocated according to grades, with English and maths double weighted. The 2020/21 results include grades awarded to pupils by teachers, when exams were cancelled due to COVID-19. In 2020/21 the Average Attainment 8 score in Oxfordshire for all pupils was 51.0, this was similar to the England average 50.9 and slightly lower than the South East 52.1.

	Total	FSM	FSM all other
England	**50.9**	**39.1**	**53.6**
South East	52.2	36.6	54.6
Cherwell	49.7	36.4	51.5
Oxford	48.5	35.4	51.8
South Oxfordshire	52.9	35.9	54.3
Vale of White Horse	51.2	36.3	52.7
West Oxfordshire	52	35.5	53.4

Figure 40: Attainment 8 score for pupils with and without Free School Meals 2020/21 (source: Create your own tables, Table Tool – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

The average attainment 8 score in 2020/21 was significantly different between pupils eligible to receive free school meals than those who do not 35.9 vs 52.9. There is a wider difference than compared to the average across England of 39.1 vs 53.6. This difference is seen across the county districts (figure 40)

Pre-covid data is also provided here to give a baseline, from the most recent exams sat by school pupils. In 2018/19 the attainment 8 score was 47.7 vs 46.9 across England. The score was significantly lower for children in care in Oxfordshire at 19.3. This is similar to the average seen in England (19.0). 2020/21 showed a similar difference with attainment 8 score for children in care 23.3 vs 50.6 average for all children.

Vulnerable Children

In 2019 the children's commissioner published projected proportions of children living in households where an adult has any of the so called 'toxic trio' risk factors present for vulnerability in children[192]. These factors are:

- Alcohol/substance misuse
    - In Oxfordshire 4.26% of households with children under 16 are projected to have an adult with alcohol/drug dependency
- Domestic abuse
    - In Oxfordshire 6.7% of children are projected to be in households where an adult has experienced domestic abuse in the last year, with an estimated 8,780 of 0-17 year olds affected.
- Mental Health problems
    - In Oxfordshire 11.4% of children are projected to live in households where an adult has severe mental ill-health symptoms, affecting an estimated 165,000 0-17 year olds.
- 0.97% of children in Oxfordshire are projected to live in a household with all three risk factors present, approximately 1400 children
    - This is similar to predicted levels in neighbouring counties but represents more children affected given the larger population of 0-17 year olds. Buckinghamshire 0.9% (1100 children), West Berkshire 0.89% (320 children).
- These figures are not actual data collected from each local area but are instead projections from a national survey combined with additional predictive modelling.

Across the UK, 31.6% of children live with at least one parent reporting symptoms if emotional distress (2018/19). If this percentage was applied to the population of Oxfordshire, then it would equate to approximately 46,000 children.

Young Carers receiving support

In the academic year 2020/21, Oxfordshire County Council recorded 554 children and young people being identified as young carers in schools in Oxfordshire. This figure is lower than actual numbers, as it is only collected at the beginning of an intervention and is not the number of open cases. It is likely there are also more young carers who have not been identified or are not receiving support.

Children in care

The number of children in care in Oxfordshire increased to 52 per 10,000 in 2020. This has been increasing since 2011 in Oxfordshire at a much faster rate than seen across England

[192] Children in families at risk - Local area maps | Children's Commissioner for England (childrenscommissioner.gov.uk)

(figure 41), although levels still remain below the England rate (67 per 10,000) but are now similar to levels across the South East (53 per 10,000), having previously been lower.

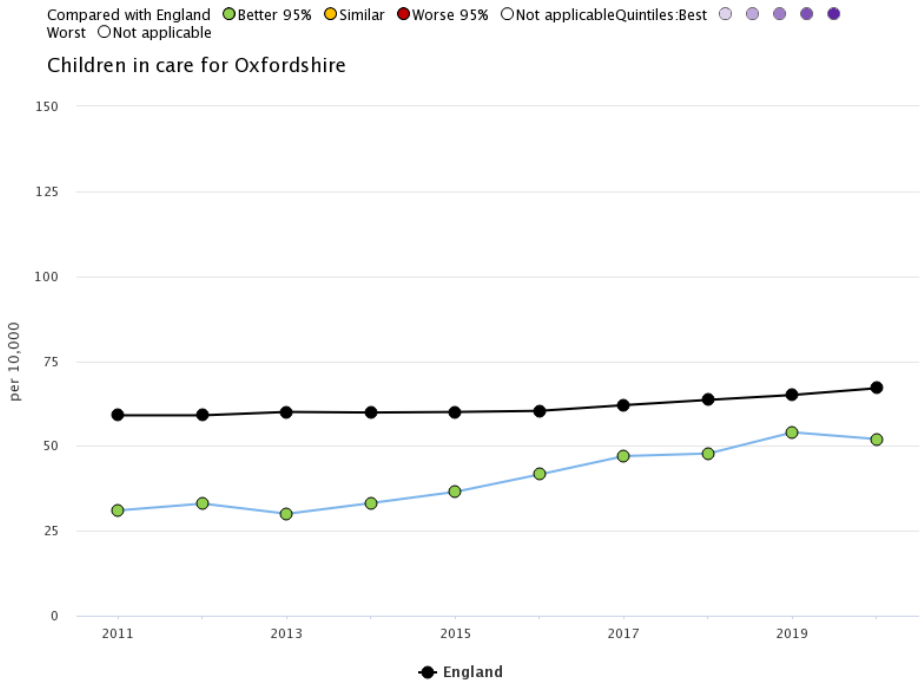


Figure 41: Children in care per 10,000 for Oxfordshire and England, PHE Child and maternal Health profile. Source: DfE Children looked after in England

The proportion of Oxfordshire's cared for children who were placed more than 20 miles from their home and outside Oxfordshire increased from 33% in March 2019 to 36% in December 2020.

The percentage of Oxfordshire's care leavers in employment, education or training was below the national average (2019/20) at 46% compared to 53% across England.[193]

A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. In 2020/21 the rate of children in need in Oxfordshire decreased to 289 per 10,000 children, however this remains above the current rate for all English county local authorities (265.5 per 10,000), (figure 42).

In Oxfordshire in 1,769 children identified as 'in need' had abuse or neglect identified as the primary reasons which represents 123.3 in 10,000 children, similar to SE (125.3 pe 10,000) and lower than England (181.4 per 10,000)

[193] Data and reports | LG Inform (local.gov.uk)

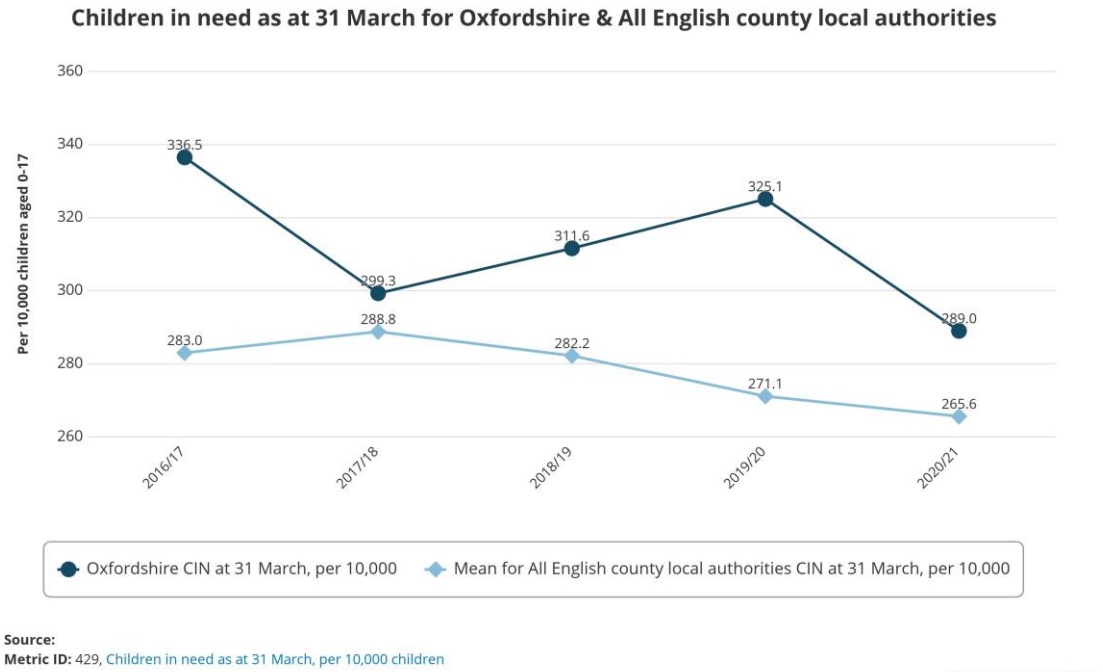


Figure 42: Children in need as of 31st March 2021 for Oxfordshire and all English county local authorities. Source: LGA Research: Children in Need and Care in Oxfordshire | LG Inform (local.gov.uk)

School attendance, pupil absence, 5-15 years

Pupil absence has shown no significant change since 2014/15 and is very similar to the national figures at 4.82% compared to England (4.73%) and the South East (4.71%). This represents general school attendance, and temporary absence from school, as opposed to pupils with persistent absence which is defined below.

Persistent absence is defined as a pupil missing 10% or more of their possible school sessions[194]. The persistent absence rate for pupils in Oxfordshire secondary schools was worse than the national average in 2018/19 at 14.7% compared to 13.7% across both the South East and England. The data from 2019/20 was significantly impacted by the COVID-19 pandemic so they have not been included in this report as caution is needed in their interpretation.

For children with SEN the persistent absence rate was 25.5% for those with a statement/EHCP or equivalent in Oxfordshire (24.6% in England) and 19.6% for those without a statement (17.9% England).[195]

194 Statistics: pupil absence - GOV.UK (www.gov.uk)
195 Data and reports | LG Inform (local.gov.uk)

Fixed period exclusions 2019/20

4.65% of state school pupils in Oxfordshire in 2019/20 had a fixed period exclusion, compared with 3.76% across England. This figure was significantly higher for looked after children at 10.32% but lower than the England average (11.38%).[196]

The levels of permanent school exclusion in Oxfordshire were slightly above the South East average in 2018/19 but below its nearest neighbours[197] (see figure 43).

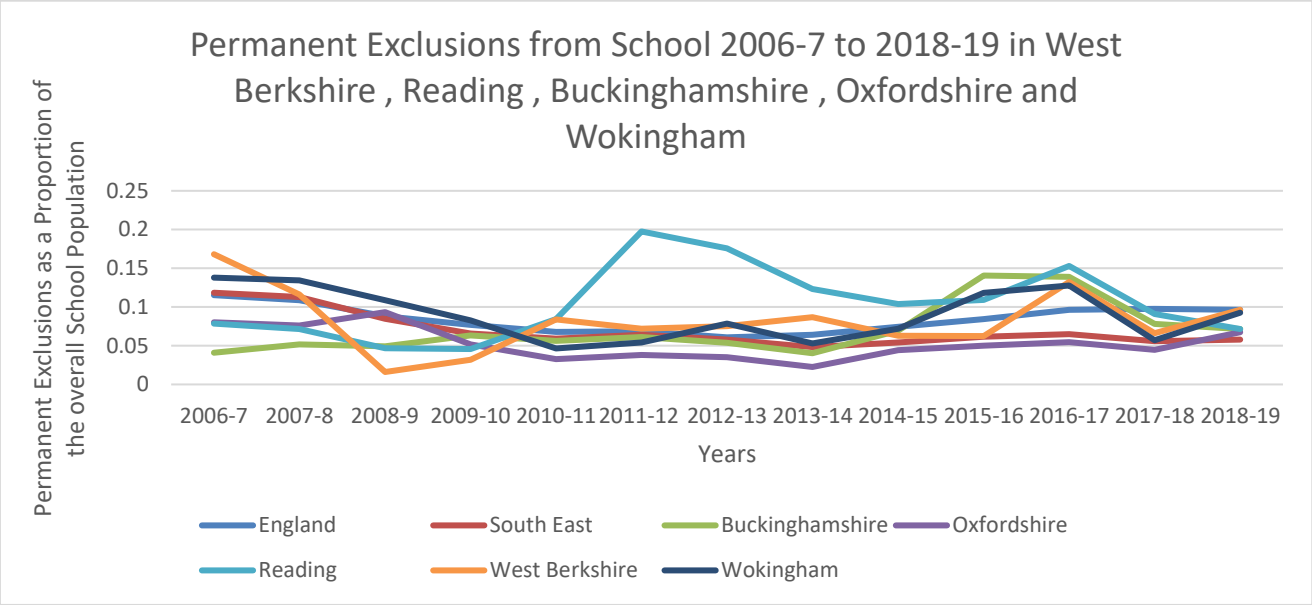


Figure 43: Permanent school exclusions by LA in the Oxfordshire area Integrated Care System (ICS) 2006/07 – 2018/19

Electively Home Educated

At the end of the 2020/21 academic year there were 846 children recorded as Electively Home Educated (EHE) in Oxfordshire, this was a 31% increase on 2019/20 with 648 EHE children (figure 44). The year groups with the highest number of EHE children were Years 10 and 11. Just over one quarter (27.2%) who were registered during 2020/21 had a Special Education Need (SEN). 6.5% of EHE children had an Education and Health Care Plan.
It is expected that changes in safeguarding arrangements will mean that parents will have to report that they are electively home educating their child. This is likely to lead to an increase in the number of children registered as EHE, as at present not all EHE children will be registered with the local authority.

[196] Data and reports | LG Inform (local.gov.uk)
[197] https://explore-education-statistics.service.gov.uk/data-tables/permanent-and-fixed-period-exclusions-in-england

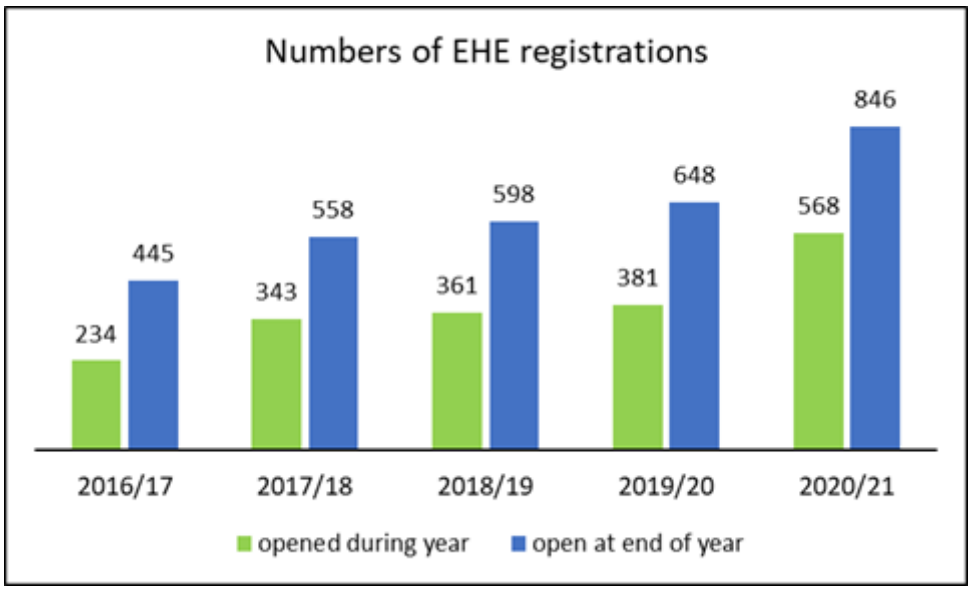


Figure 44: Number of Elective Home Education registrations in Oxfordshire from 2016/17 to 2020/21. Source: Oxfordshire County Council EHE data.

First time entrants to youth justice, 10-17 years

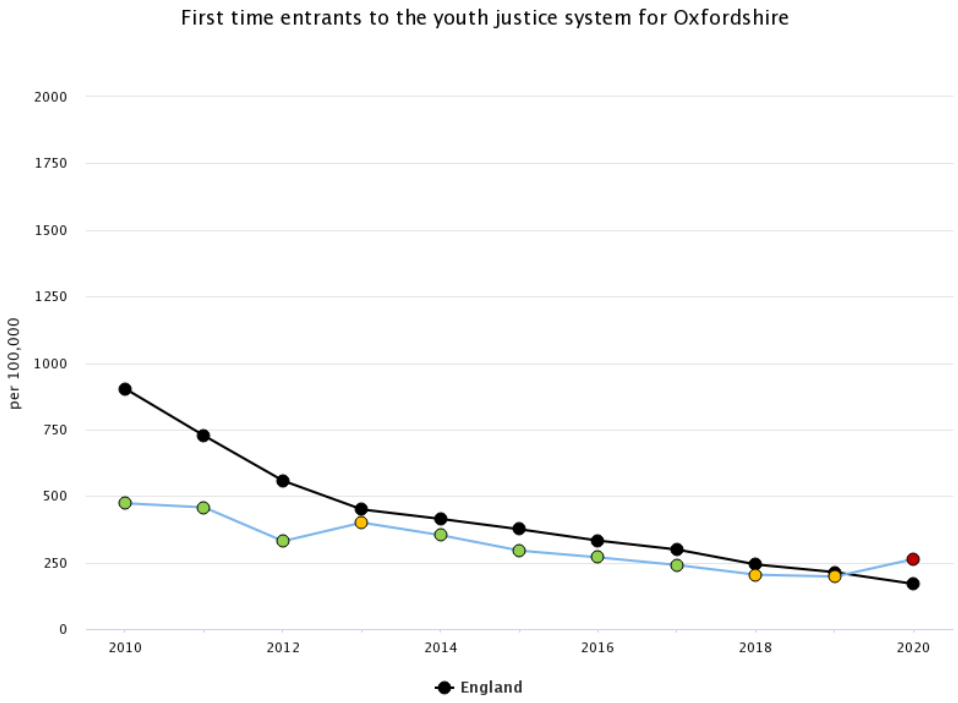


Figure 45: First time entrants to the youth justice system, PHE's Population Health Analysis Team 2010-2020. Data source: Ministry of Justice, ONS

This had shown a decline in recent years, although at a slower rate than nationally and was statistically similar to England in 2019. However, in 2020 there was an increase in Oxfordshire and a decline nationally, so that rates were significantly worse than the national average at 263.1 per 100,000 compared to 169.2 per 100,000 for England and 156.7 for the South East.

16-17 years olds not in education, employment, or training (NEET) or whose activity is not known

The proportion of 16-17 year olds not in education, employment or training was 3.7%, this was lower than England (5.5%) and the South East (6.4%).

During the COVID-19 pandemic the proportion of all young people, aged 16 1o 18 years, who are Not in Education, Employment or Training has increased significantly (from 1.6% in Dec 2019 to 2.6% in Dec 2020) with reduced advertised apprenticeship opportunities in Oxfordshire for young people.[198] For 16-24 year olds there was an increase of 2,105 people claiming unemployment benefit between Dec 2019 and Dec 2020.

Safeguarding

In January 2021, the Oxfordshire Safeguarding Children's Board carried out a review of child safeguarding practice[199] following the death of a child who was criminally exploited and had been persistently absent from school for 22 months. The review highlighted areas of improvement needed in supporting children who are at risk of criminal exploitation and exposed to serious levels of youth violence.

Key learning included the need for:

- Multi-agency assessments, plans and contingency to manage risk.
- Ensure the right support to help families and manage risks together
- The school's role is of paramount importance in keeping children safe
- An education package should be put into place in a timely manner for children who may show challenging behaviour.
- Children missing education should be known and action swift
- Education packages for children who may be at risk of exploitation and those who present a risk to others.
- Involve all the local safeguarding system to understand the extra-familial risk and harm in a timely manner.
- Ensure effective discussion at all levels of seniority result in collective responsibility and ownership which the family understands,
- Put robust systems in place which supports all levels when there is a difference of opinion.

[198] ExecSummary_JSNA20210331.pdf (oxfordshire.gov.uk)
[199] CSPR-for-Jacob-.pdf (oscb.org.uk)

Homelessness

In 2020/21, 6.4 per 1,000 households with dependant children were owed a duty under the Homelessness Reduction Act in Oxfordshire, that is families who needed additional financial support to prevent them becoming homeless. This was significantly better than England (11.6 per 1,000) and the South East (11.8 per 1,000).

5.4.3 Summary: National and Local Data

Nationally:

- Children and young people in the most deprived decile in England are at an increased risk of child death, obesity, entrance to you justice system and under 18 pregnancy.
- Children in care are more likely to have poorer educational attainment, mental and physical health.
- Young people entering youth custody have disproportionate health needs when compared to the general population such as mental health needs (33%), substance misuse (45%) and learning difficulties or disabilities (32%)

Within Oxfordshire:

- The number of children under 16 living in relative low-income families has increased from 8.6% in 2014/15 to 10.5% in 2019/20.
- Within Oxford city 29% of children are estimated to live below the poverty line after adjusting for housing costs
- There is a significant difference in life expectancy at birth, and years of healthy life expectancy, between the most and least deprived wards in Oxfordshire.

- The number of children achieving a good level of development at the end of reception was 49.9% in children with free school meal status, this was lower than England (56.5%) and the South East (55.4%). The average for all children was 73.5%, which was better than the England average (71.8%).
- The gap in early years development between lower income pupils and other pupils in Oxfordshire increased in the last two years of recorded data.
- The Attainment 8 score is significantly different between pupils eligible for free school meals and those who are not 35.9 vs 52.9, with a wider gap than seen nationally (39.1 vs 53.6).
- The attainment 8 score is significantly lower for children in care, similar to the national picture at 19.3 (19.0 for England)
- The persistent absence rate for pupils in Oxfordshire secondary schools was worse than the national average in 2018/19 (pre covid-19 pandemic data) at 14.7% compared to 13.7% across both the South East and England.

- The number of children in care in Oxfordshire has been increasing at a faster rate than seen across England.
- The number of electively home educated registrations has increased since 2016/17, with the biggest rise (a 31% increase) in 2020/21.

- Over ¼ registered during 2020/21 had a Special Education Need (SEN)

5.4.4 Current offer

- For Oxfordshire three safeguarding partners work together as an Executive Group with overall accountability for safeguarding and promoting welfare of children in the area. This consists of chief officers in the County Council, the Clinical Commissioning Group and the Police. They work with relevant partners through the Oxfordshire Safeguarding Children Board (OSCB) under an Independent Chair.[200]

- The Education, Employment and Training (EET) service
  - tracks all young people from the age of 16 years until the September after their 18th birthday
  - Provides learning and employment opportunities to the OXME website
  - Caseworkers for young people who are NEET to support them into jobs, further education, apprenticeships or other training.
  - Also identifies students most at risk of becoming NEET to provide extra support using RONI Criteria[201]
  - Delivers choices sessions for young people at children and family centres
- Targeted Youth Support Services in development due to launching in early 2022
  - Aim to have 4 workers within each district to support vulnerable 11-18s

- The Family Solutions Service provides early help and statutory support to children and families in Oxfordshire including Early help support such as Team Around the Family (TAF) and Early Help Assessments (EHA).
  - The service is delivered from 8 family centres across Oxfordshire, alongside other venues and remotely.
- Early Help and the Locality Community Support Service (LCSS)[202] in Oxfordshire County Council aim to provide support to children and their families who require it at the earliest opportunity, to try and identify and resolve problems early.
  - Staff, including SHNs, involved with families can complete an Early Help and arrange a Team Around the Family meeting.
  - Urgent safeguarding concerns can be referred to Multi-agency safeguarding hub (MASH)

- School/College Health Nurses have an aide memoire to help identify adolescents at risk of neglect. If indicated, the aide prompts the completion of the Childcare and development checklist from the Oxfordshire Safeguarding Children's Board Toolkit.
- School/College Nurses provide targeted support for vulnerable groups, linking to specialist services where required, such as CAMHS, Sexual Health Services, Kingfisher and children's social care.

[200] About Us - Oxfordshire Safeguarding Children Board (oscb.org.uk)
[201] Microsoft Word - Oxfordshire RONI criteria
[202] Early Help and the Locality Community Support Service (LCSS) | Oxfordshire County Council

- SHNs help to complete statutory health assessments and reviews for Looked After Children (LAC) on state school roles, and also initiate Early Help assessments when they identify children and young people in need of early help.

- At present, children and young people who are electively home educated are sent the school health nurse newsletter with contact details in September each year.
    - There are some difficulties with SHN obtaining up to date details of children and numbers of children who are electively home educated. A notification system for Oxford Health NHS Foundation Trust from Oxfordshire County Council on Electively Home Educated children began termly from September 2021.

- The Kingfisher Team[203] is a co-located team bringing together Thames Valley Police, Health and Children's Social Care to support and protect children and young people who are subject to or at risk of being sexually exploited.

- Oxfordshire Youth Justice & Exploitation Service is a multiagency service made up of youth justice, social workers, police, health, probation and education.
    - Practitioners work holistically with children, families and partners to deliver interventions to reduce the risk of offending and exploitation.[204]

- The charitable sector has a key role in supporting vulnerable young people. Not all charities can be included here but some examples of charities currently operating in Oxfordshire supporting young people include:
    - Be Free Young Carers[205]
        - Offering support and advice dedicated to improving the lives and well-being of young carers.
    - Oxfordshire Youth[206]
        - A youth development charity that supports young people aged 11-25 to realise their potential.
    - Banbury Young Homeless Project[207]
        - Supports all young people aged 13-25 with a range of services in three core areas, all known to help prevent the route cause of youth homelessness: health and wellbeing, training and employability, housing and homelessness advice.
    - SAFE![208]
        - Provides support to children and families around the Thames Valley who have been affected by crime or abuse through one-to-one and group sessions.

[203] PowerPoint Presentation (oxfordshire.gov.uk)
[204] Oxfordshire Youth Justice & Exploitation Service | Oxfordshire County Council
[205] About Us - Be Free YC
[206] Home - Oxfordshire Youth
[207] About BYHP, the Banbury Young Homelessness Project - BYHP
[208] SAFE! – Supporting young people in the Thames Valley who have been harmed by crime (safeproject.org.uk)

5.5 Supporting complex and additional health and wellbeing needs

5.5.1 National Data

Council for Disabled Children: Lessons Learnt from Lockdown: the pandemic's impact on disabled children and young people[209]

As part of the Making Participation Work programme (a programme funded by the Department of Education and delivered jointly by the Council for Disabled Children and KIDS) a consultation was carried out during February-March 2021. It included an online survey and focus groups to explore the impact of the pandemic on the lives of children and young people with special education needs and disabilities. In total, there were responses from 643 children and young people, 128 parents and 110 professionals.

The report highlights how challenging it was for many families during the COVID-19 pandemic, with a 'prefect storm of behavioural triggers' and a reduction/loss of many of the normal coping strategies available to young people and their families. There were benefits to some from increased individual time with family and working in smaller class sizes.

The key recommendations from the report were to prioritise emotional, social, and mental health recovery. Particularly focusing on re-engagement socially. Activity based youth clubs and other extra-curricular activities were highlighted as being particularly important. Other suggestions included sessions within the curriculum that support young people's mental health. Other recommendations were to prioritise family support, keep things that worked well and supporting a safe return to school.

The Disabled Children's Partnership also published a research report[210] on the impact of the pandemic, which shared similar themes. Key findings in the report were that many families had been isolated and felt abandoned, with many services stopped or reduced. Mental health and wellbeing of all the family had deteriorated and for some children their conditions had worsened, and their needs had become more complex. Delays in assessment had also meant needs had not been identified as early. A positive aspect raised in the report was how the charity sector had demonstrated agility and flexibility, as well as extending their reach to support families. Charitable programmes that were most effective were those which took a whole family approach, had emphasis on providing emotional support, were developed in co-production with disabled children and had blended approaches to service delivery (e.g. digital capacity).

5.5.2 Oxfordshire Data

[209] Lessons Learnt From Lockdown_0.pdf (councilfordisabledchildren.org.uk)
[210] Then-There-Was-Silence-Full-Policy-Report-10-September-2021.pdf (disabledchildrenspartnership.org.uk)

School pupils with social, emotional and mental health needs: % (DfE special educational needs statistics)

Oxfordshire has consistently had a higher percentage of school pupils with social, emotional and mental health needs than seen in England and the South East, with the latest 2020 figures at 3.11% for Oxfordshire, 2.73% for South East, 2.7% for England. The percentage is increasing at the faster rate than the England average (figure 46).

When school aged children are separated into primary and secondary, this same trend is still seen in both age groups, but the difference between Oxfordshire and the England average is largest in the primary school aged pupils and has seen the largest increase since 2015.

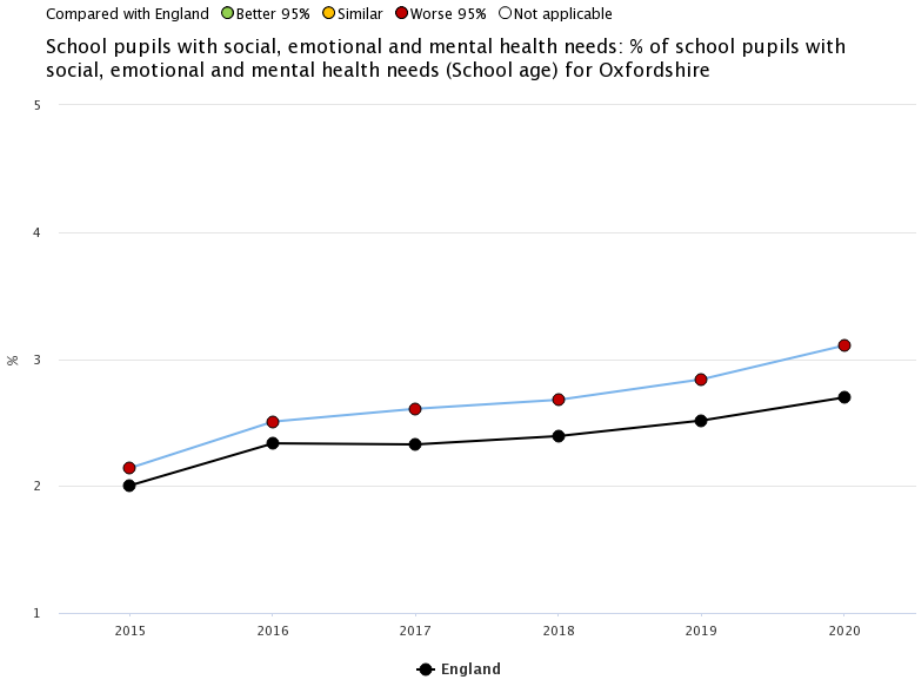


Figure 46: % of school pupils with social emotional and mental health needs (school age) for Oxfordshire 2020. PHE Fingertips Child Health Profile (Source DfE special education needs statistics 2020)

Pupils with SEN support

In Oxfordshire for 2020/21, 14.7% of pupils were receiving SEN support compared to an average of 12.2% in England. 3.1% of pupils had an EHC plan/statement of SEN, below the England average of 3.7%. The percentage of pupils receiving SEN support has increased in Oxfordshire at double the rate of England, from 11.7% in 2015/16 (figure 47). In 2020/21 Oxfordshire had a higher percentage of pupils with SEN support in 2020/21 than all the other local authorities in the South East, apart from Southampton (figure 48)

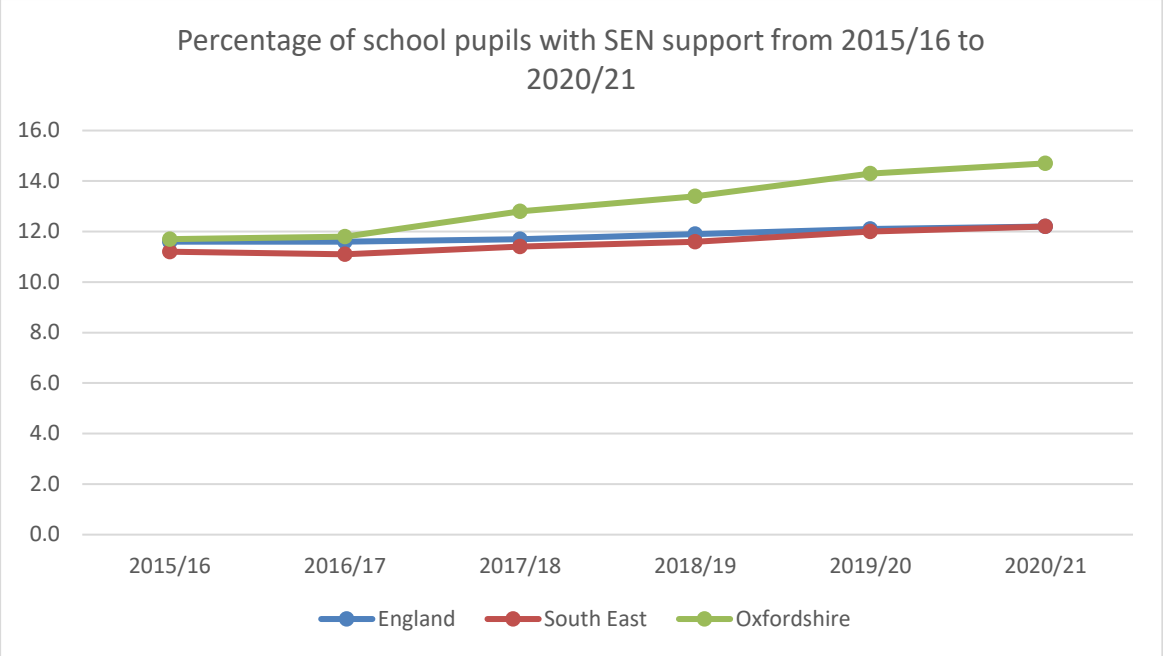


Figure 47: Percentage of school pupils with SEN Support in England, South East and Oxfordshire from 2015/16-2020/21
Source: Table created from [Special educational needs in England, Academic Year 2020/21 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)]

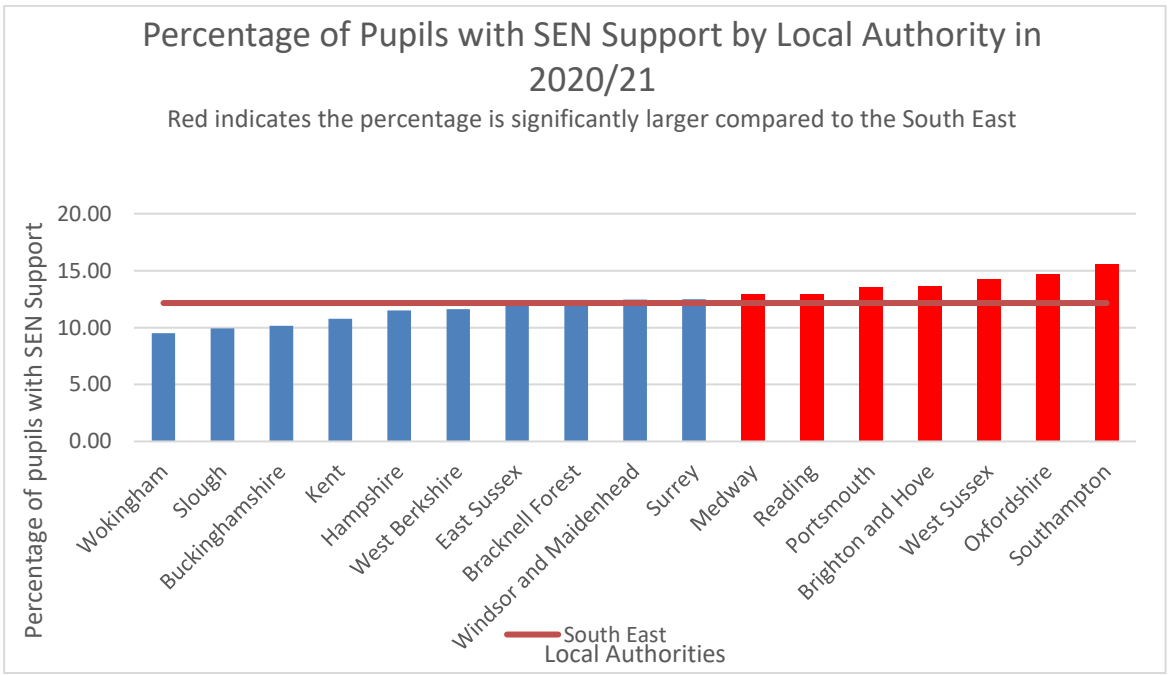


Figure 48: Percentage of pupils with SEN support by Local Authority in the South East in 2020/21.
Source: [Special educational needs in England, Academic Year 2020/21 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)]

Persistent absence rates are higher for SEN children in Oxfordshire than England both with a statement/EHCP (25.5% vs 24.6% England) and without a statement (19.6% vs 17.9% in England).

Compared to national data, Oxfordshire has a higher proportion of EHCPs/Statements for Autism (35.1% vs 30.5%), and severe learning difficulty (12.6% vs 10.3%), figure 49. Nationally, more children receiving SEN support are boys than girls (64.2% vs 35.8%) and more children who have an EHCP are boys (73.1% vs 26.9%). In England 38% of pupils with an EHC plan and 34.4% of children with SEN support received free school meals. The ethnic group with the highest proportion of children with SEN support nationally were those from Traveller of Irish heritage (24.4%) and the lowest rate was those from a Chinese ethnic group 5.4%.

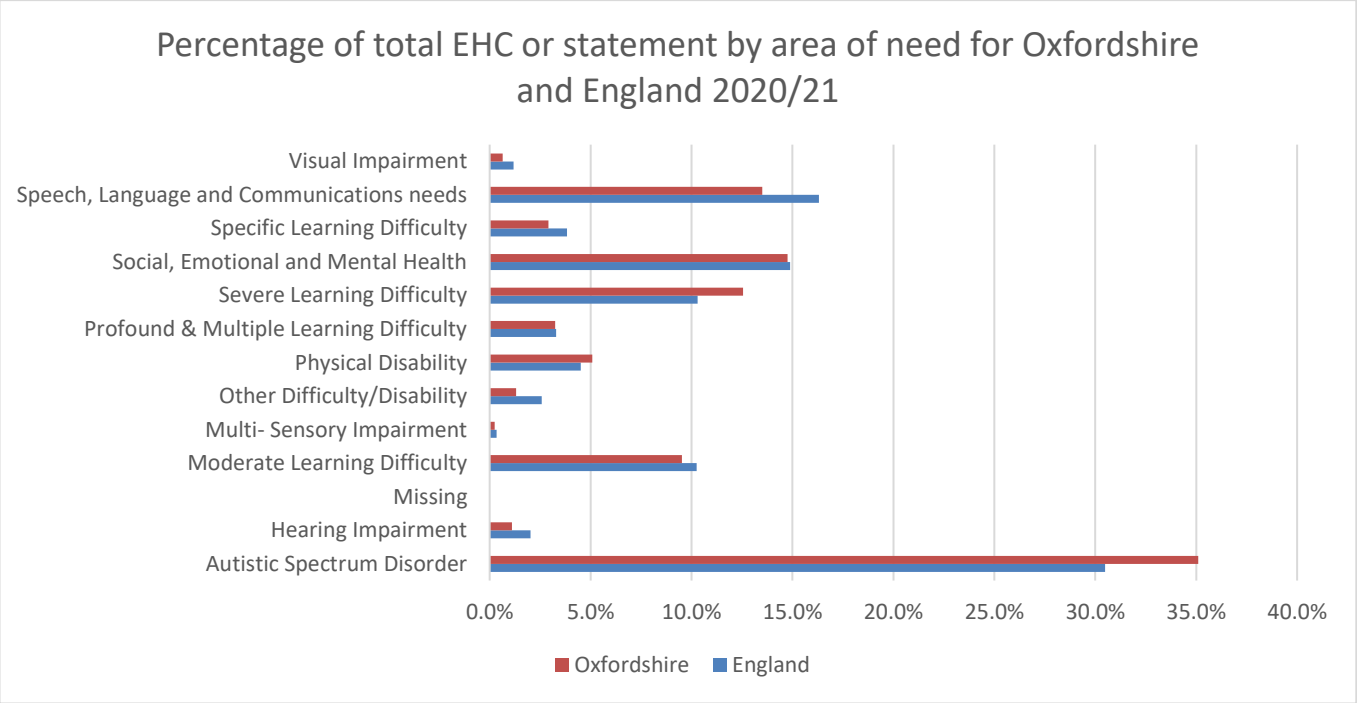


Figure 49: Percentage of total EHC or statement by area of need for Oxfordshire and England
Table created from [Create your own tables, Table Tool – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)]

Educational Outcomes for Children and Young people with SEND

Children and young people with SEN do less well than nationally from early years through to GCSE. Children without a SEN do better in Oxfordshire than seen nationally at each stage, the gap between children with and without SEN is therefore wider within Oxfordshire. Data here is from 2018/19 as 2019/20 and 2020/21 data was affected by the covid-19 pandemic.

2018/19	SEN support Oxfordshire	SEN Support England	No SEN Oxfordshire	No SEN England
Early years: % good level of development	25	29	78	77
Key Stage 2: % expected level in reading/ writing/ maths	22.2	25.4	75.5	74.9
Key Stage 2: progress in reading	-1.71	-1.01	0.45	0.35
Key Stage 4: average attainment 8 score	29.3	32.6	51.4	50.1
Key Stage 4: average progress 8 score	-0.56	-0.43	0.22	0.08

Figure 50: Attainment and progress of pupils with SEN support for Oxfordshire and England (Source: Oxfordshire Local SEND Draft Strategy 2022 – 2027).

2021 'Be Supported' Questionnaire[211]

The 'Be supported' questionnaire, first launched in 2019, by the Children's Trust Board in Oxfordshire, asking for feedback from children and young people aged 8-18 years with additional needs about how supported they feel by the services they use. 41% of the 159 respondents had accessed services within the school/college setting, 21% health based services (including CAMHS- 25%), 16% council services, 18% other services such as charities.

80% of respondents strongly agreed/agreed that they knew who to speak to when they needed support. 35% said they had a 'social and/or emotional, physical or mental wellbeing need.' And 15% were not engaged in education.

5.2.3 Summary: Data

- There is a higher percentage of school pupils with Social, Emotional and Mental Health needs (SEMH) in Oxfordshire than in England and the South East (3.1% vs.2.7%), and the percentage is increasing at a faster rate.
    - In both primary and secondary, but difference with England is more in primary.

[211] Voxy (oxfordshire.gov.uk)

- There is a higher proportion of pupils with Special Education Needs and Disability (SEND) than in England and the South East, with 14.7% of pupils receiving SEN support compared to 12.2% across England.
    - This is higher than all other local authorities in the South East apart from Southampton.
- The number of children with Special Education Needs support in Oxfordshire has increased at double the rate of England since 2015/16.
- For those children receiving SEN support, educational outcomes are worse than the national figures through early years, key stage 2 and key stage 4. However, children without a special education need, perform better than the national average for all stages. There is therefore a wider gap in educational outcomes between those with and without SEN compared to the national picture.
- A lower percentage of pupils have an EHCP for SEN than the England average 3.1% vs 3.7%.
- Persistent absence rates are higher for SEN children in Oxfordshire than England for pupils both with a statement/EHCP (25.5% vs 24.6% England) and without a EHCP (19.6% vs 17.9% in England).

5.2.4 Current Offer

- A SEND Public Consultation for Oxfordshire is currently underway to help inform the final Oxfordshire Local SEND Strategy 2022-2027.
- Details of current SEN School provision can be found in the Pupil Place Projection section.
- As children enter reception year the SHN send out an information leaflet on school readiness with an invite to contact the Health Visitor if the parent/carer has any concerns in terms of health or developmental needs. Children can then be triaged by health visitors.
- Children who are identified as having ongoing health concerns are referred from HV to SHN at age 5.
    - A Health review is offered by the SHN service
    - School Health Nurses can the provide additional support to these children starting school
    - Ongoing health concerns include child protection, children in need, Team around the family, emergency medication, physical health needs, behaviour support.

- School Health Nurses offer PHSE sessions to some Special Schools in Oxfordshire, with a particular focus on healthy relationships, sexual consent, and puberty. There work complements the clinical nurse specialists who work within the school.

- A new supported apprenticeship scheme[212] was launched in January 2022, run by Oxfordshire employment (OCCs supported employment service).

[212] New apprenticeship scheme launches | Oxfordshire County Council Intranet

    - Open to young people aged 16-21 with a health or disability need who might need additional support to enter work

- The Oxford Parent Carers Forum (OxPCF) is an independent group enabling parent carer participation to help inform the development and provision of services in Oxfordshire
    - They are hosted and supported by Oxfordshire Family Support Network (OxFSN)

- The charitable sector has a vital role in supporting children and young people with complex additional health needs and their families. Not all can be listed here but more information and links can be found on the Oxfordshire County Council's website[213]

5.6 Supporting self-care and improving health literacy

5.6.1 National Data

Use of services – Youth Health Data

The Association for Young People's Health (AYPH), a UK based charity, published a 'key data 2021' report of use of health services by young people.[214] They asked young people where they usually seek health advice, and parents, teachers and health professionals were cited as the main source of advice. In relation to drugs specifically, parents and teachers were the most common source of information. In 2017 almost half of 5-19 year olds with a mental disorder had contact with a teacher for mental health reasons. This highlights the important role schools play in health promotion. Special attention should be made to marginalised young people who may find it more difficult to access healthcare that they need.

Measures of digital access in 2021 found that 94.4% of 6-16 year olds had a laptop or tablet that they could work on at home, an increase from 89% in 2020. It emerged during the pandemic that many children preferred digital counselling.

ChatHealth[215]

ChatHealth published a data impact report from 2019/20. It provides an example for the potential impact of texting and digital services for school health nurses. ChatHealth is currently used by over half of all school nursing teams nationally and provides an anonymous messaging service for young people. During the COVID-19 response there was a 50% increase in young people seeking mental health support via ChatHealth. 88% of young people say their conversation helped.

[213] Charities for disabled children/SEN/additional needs | Family Information Directory (oxfordshire.gov.uk)
[214] Use of health services - AYPH - Youth Health Data
[215] ChatHealth-Digital-Impact-Report-2019-2020.pdf

5.6.2 Oxfordshire Data/Current offer

- There is no specific additional data on self-care and health literacy for Oxfordshire
    - Self-care is taught as part of the PHSE curriculum but how this is delivered can vary from school to school.
- There is a wide variety of online resources with information and advice on support for a range of health and wellbeing needs for children, young people and their families.
    - This can make it difficult to navigate and find the relevant service needed
    - People are often unaware of the local websites that are available.
- OXME[216] is Oxfordshire County Council's website for young people and includes information about health, opportunities, activities and services for children and young people in Oxfordshire.

Chat Health

Chat Health was Introduced in Jan 2022 in Oxfordshire with three different services:

- Oxford Patent line (those with children 0-4 years)
- Oxford Parent line (those with children 5-11 years)
- Oxford ChatHealth for young people (11-19 Years)

The 0-4 years Parent line Service had the highest number of conversations opened in March 2022 compared to the other 18 organisations/services providing 0-4 year ChatHealth services in England. In March 2022, 1193 conversations were opened, with 5135 messages received and 7959 messages sent.

There was no league table available for the 5-11 Parent line service but, in Feb/Mar 2022, 80 conversations were opened, with 360 messages received and 546 messages sent. Although these numbers are much lower than the 0-4 years parent line, service user feedback was positive with comments including:

- Very helpful advice and quick response. Very easy way to get advice
- …I'm glad I have someone to talk to, which I needed. Thank you.
- Very helpful answered all my questions promptly and politely

The Oxfordshire ChatHealth service for young people (11-19 years) ranked 33rd out of 50 organisations and services providing ChatHealth for use by young people in March 2022. Engagement was much lower than both Parentline Services. The service was provided in the Easter holidays only. In March 2022 there were 15 conversations opened, with 41 messages received and 59 messages sent. Nationally there is similarly less engagement with the young people ChatHealth service than the Parentline services. Suffolk was ranked first and had a total of 133 conversations opened.

[216] OXME.INFO | For young people in Oxfordshire

Digital Inclusion

Oxfordshire is considered to have a low level of digital exclusion. In 2020 96.5% of persons 16 years or older had used the internet in the last 3 months[217]. This was higher than the UK average (92.1%) and 16th highest in the country. However, how people interact with the internet varies at ward level. Areas of higher deprivation within Oxfordshire have lower levels engagement with the internet, such as areas of Blackbird Leys, which were classified by the Consumer Data Research Centre as being e-Withdrawn (individuals who are least engaged with the internet).[218]

6. Recommendations

The recommendations below have been divided into those relevant to the Local Authority, the 5-19 public health services provider/School Health Nurses and Education settings. It is recognised there is some overlap in responsibility within the recommendations, given the close interplay between these three groups. The recommendations are informed by data on local need within Oxfordshire and cover findings for all 6 high impact areas. It is important that national guidance is followed for each high impact area. A summary of guidance/evidence alongside local data by high impact area can be found in the Executive Summary for this Needs Assessment. Where 'school' is mentioned this refers to schools, colleges, and alternative education providers.

Local Authority

1. Increase visibility and accessibility of all support services for children, young people and their parents/carers (including School/College Health Nurses, Mental Health Support Teams, pastoral support/school counsellors, Locality Community Support Services) by:
    - Having a single point of access to support services for children, young people and their parents/carers which could:
        - Enable signposting/triaging to most appropriate support
        - Simplify advertising of services
        - Help encourage multi-agency working
        - Allow access by a single phone number, email or text messaging service (ChatHealth)
        - Form part of the new 'Family Hubs' if introduced in Oxfordshire
    - Increasing awareness of trusted online resources, such as OxMe (Oxfordshire's website for young people). This could be supported by having a single website from which all other online services and recommended information resources can be navigated to.
    - Providing good advertising and explanation of services available within schools, with information on services given to pupils and their parents on a regular basis

[217] Internet users - Office for National Statistics (ons.gov.uk)
[218] CDRC Mapmaker: Internet User Classification

(at least termly) through assemblies, form/tutor time, social media, posters/notice boards within schools and school newsletters
- Carrying out engagement with young people and parents/carers on how to best promote services/communicate news

2. Public Health service provision for children and young people should be well informed by local data to provide an effective needs-led service. This would be supported by:
   - Continued monitoring of numbers of children and young people with identified needs or health conditions each year via the School/College Health Improvement Plan (SHIP/CHIP)
   - Carrying out pupil survey at key points (see recommendation 4)
   - Monitoring 2021/22 NCMP data to see if increased prevalence in overweight/obesity since 2019/20 persists and note areas with higher prevalence to focus interventions.

3. There should be awareness of other current strategic work, initiatives, and consultation to ensure implementation of relevant recommendations and that results help to inform 5-19 commissioned services and programmes. This could be supported by keeping a record of current work with children and young people, that is updated termly by relevant teams. Examples of current work include:
   - Emotional Health and Mental Wellbeing Strategy
   - School Streets initiative to improve road safety and air quality for children travelling to and from school, focus in areas of higher deprivation.
   - Active school's framework pilot
   - Whole systems approach to healthy weight action plan
   - Tier 2 child weight management service pilot to address gap in healthy weight services for children.
   - Launching of Targeted Youth Support Service to support vulnerable 11-18 year olds
   - Consultation on draft Local Area SEND Strategy and proposals for system reform for SEND. Final SEND Strategy 2022-27 to be published autumn 2022.
   - Support Apprenticeship Scheme to help improve employment opportunities for young people with SEND

4. There should be effective joined up working and communication between different services and local authority teams supporting children, young people and their families. This would be supported by:
   - Regular meetings (e.g. termly) between the School Health Nurse and key teams/people working within the school (Mental Health lead, pastoral support team, Mental Health Support Team, Locality Community Support Services)
   - Use of the Link Programme[219] (which provides bespoke facilitation for local strategic leaders to support joint working) to strengthen communication and

[219] The Link Programme | Anna Freud Centre

joint working between education and mental health services for children and young people.

5. Continued provision of an evidence based programme that provides a school wide approach, with universal interventions, to support development of social skills, resilience, and emotional learning (such as the Protective Behaviours Programme).
   - At present this is delivered to Key Stage 3 but similar evidence based programmes with a focus on resilience, social and emotional learning should be considered for earlier key stages (primary age, Key stage 1 and 2).
   - Any programmes delivered should be differentiated to enable access for children with additional needs.

6. A digital service should be available to enable young people to access health support when they need it with:
   - Expansion/full introduction of CHATHealth and ensuring service is well advertised to young people and their families (newsletters, at transition into secondary school and within the school building).
   - Digital options for mental health provision should be explored as part of work on supporting mental wellbeing of young people in Oxfordshire, for example Kooth[220] which has been used in other areas of England.

7. Consider a review of drinking habits and attitudes towards alcohol among adults in Oxfordshire and explore opportunities to educate adults on the potential harms of drinking, especially to increase awareness of harms to health of drinking in young people.

8. A focus on pregnancy prevention is needed in schools and community settings in the areas with a higher proportion of teenage pregnancy, following guidance from the pregnancy prevention framework (see appendix 5). This should include targeted prevention work to areas of need with young people who are more at risk, including young men.

9. There should be continued provision of an evidence based teenage pregnancy pathway initiative (such as the Family Nurse Partnership), to support first time young mothers (under 19 years) and continued review to ensure service provision is sufficient to meet level of need.

10. To help make sexual health services and testing accessible to young people there should be:
    - Continued access to contraception (including condom distribution scheme) and sexual health advice as part of the school/college health nurse offer.
    - A review of provision for online ordering of home STI testing kits for under 18s, to see if it can be made safely available.

[220] Home - Kooth

- Engagement with young people on services preferences to consider having sexual health services available in the early evening, on Saturdays and as under-18 drop in clinics.
- A focus on increasing opportunistic testing in females in the 15-19 age group, as per the new National Chlamydia screening guidelines[221].

11. Continue to deliver initiatives to encourage physical activity, monitoring outcomes and expanding to other areas if effective. There should be a focus on areas with higher levels of deprivation and those with higher levels of children who are overweight/obese. Current examples include:
    - Families Active Sporting Together (FAST) programme
    - Holiday Activities and Food
    - Wayfinding school travel project

Public Health Service Provider/School Health Nurses

12. To help inform a needs led approach and identify children who are at risk of or vulnerable to poorer outcomes as early as possible, there should be:
    - Use of school survey to identify pupils at risk at key stages, namely transition into secondary school and during mid-teens (age 13/14 years)
        - This could be carried out using a survey such as the one available free from the Anna Freud Centre[222] and could be completed within a PHSE session to measure pupil wellbeing[223]
        - Additional support could be delivered by the SHN, MHSTs (if present) and the mental health lead or pastoral support team within the school as appropriate.
        - Schools in areas with higher deprivation levels, or those with more identified needs may require more SHN service provision
    - Early information sharing – with good communication across the pathway from teams both within the school and outside of the school:
        - Teams within school including safeguarding lead, pastoral care team, and school health nurse. This could be aided by regular meetings (for example termly) between teams with agreement on how information will be shared and names of leads being recorded in SHIP/CHIP
        - Teams outside of school including primary care, Mental Health Support Teams, other specialist children community services and Children's Services (Early Help and Locality Community Support Service

[221] Changes to the National Chlamydia Screening Programme (NCSP) - GOV.UK (www.gov.uk)
[222] blf17_20-second-school-measuresbl-17-03-17b.pdf (corc.uk.net)
[223] Measure pupil wellbeing (annafreud.org)

13. Ensure handover pathways are followed between early years/primary/secondary transitions (between health visitors and school nurses) and with wider system professionals.

14. There needs to be a clear pathway between Children, Education and Families (CEF) in Local Authority and School Health Nurses (SHNs) for providing numbers and contact details for electively home educated (EHE) children
    - Ensure new Notification System for Oxford Health NHS Foundation Trust from Oxfordshire County Council on Electively Home Educated children (beginning from September 2021) has been implemented successfully and information is being receive termly.
    - Details of the SHN should be sent to EHE families termly with an offer for an annual health review
    - Particularly important to ensure families have the SHN contact details where children are EHE due to additional health and special education needs, over one quarter registered for EHE in 2020/21 had a SEN.

15. Ensure support from School Health Nursing service for children and young people with persistent absence rates:
    - This group are at risk of missing out on SHN provision
    - If possible, schools to provide contact information to SHNs on these children and young people so that they can be contacted with information on SHN service and how to contact for support.

16. Review the current health literacy teaching that is carried out in schools and assess whether more provision is needed in this area. Additional teaching could be provided as:
        - Specific sessions by the school nurses and using opportunities to give very brief advice at NCMP and Immunisations.
        - Part of the PHSE curriculum
        - In the form of workshops led by charitable or other external providers outside the school if available locally.

Education Settings

17. Use of available funding to access the Mental Health Lead training to ensure there is a trained mental health lead available within every school.

18. Implement high quality teacher training to support children and young people's mental health and wellbeing, this should be included as part of annual training days and induction within all school settings.
        - This is important both within colleges, primary and secondary school
        - Including training on how to identify pupils who would benefit from additional support

19. Continue to ensure staff are safeguarding trained to a level appropriate for role and aware of early local help process with a designated safeguarding lead.

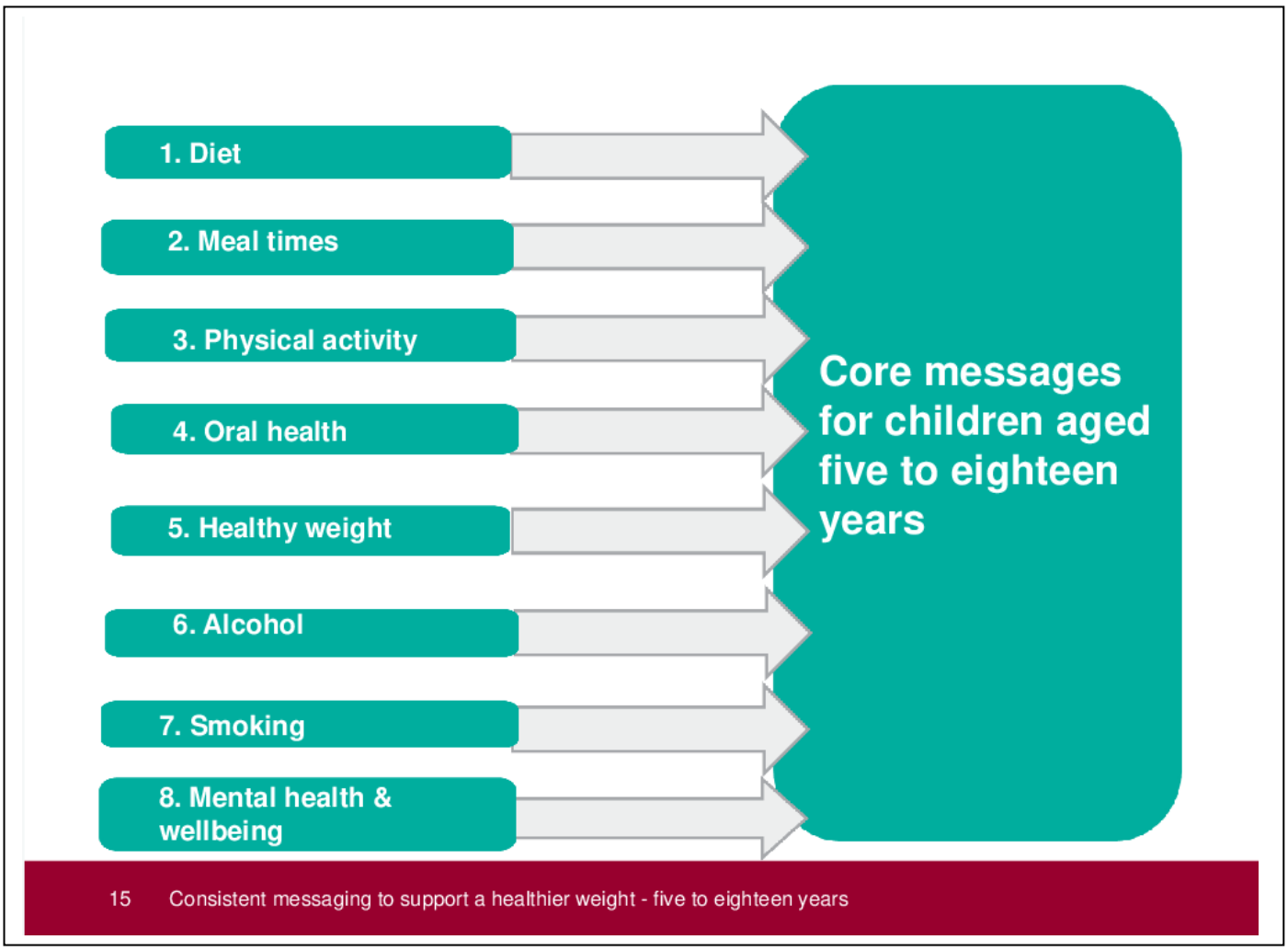
20. Schools should develop a whole school approach to supporting mental wellbeing, that is informed by needs identified within the school. This would be supported by:
    - Use of a framework, such as the 5 steps from Anna Freud Centre[224] to mental health and wellbeing for schools, to support schools in deciding on their approach to mental health and wellbeing. This would lead to development of a personalised action plan.
    - Or alternatively, 'The Lancaster Model' which provides a broader health needs assessment process with a web-based app where young people and families cans receive reviews at set life stages.[225] It is currently used by some areas across the South East /North West.
    - Results from school surveys (see recommendation 4) and OxWell survey reports
    - Actions identified being delivered by the mental health lead for the school with the support of SHNs and MHSTs (if present).

21. Settings should ensure they are meeting daily minimum of 30mins physical activity within school. They should use PE Premium Funding, alongside local authority funding and funding from other sources such as Sport England, to support initiatives such as:
    - The walk to school challenge (WOW) and ready set go (both from Active Oxfordshire)
    - Those that encourage girls to be physically active, particularly as they move through secondary schools, such as 'Girls Active' from the Youth Sport Trust.

22. Make alcohol a priority topic for PHSE sessions to educate young people on harms of alcohol and developing a healthy attitude towards drinking.

[224] 5 Steps to Mental Health and Wellbeing (annafreud.org)
[225] Home – The Lancaster Model

Appendix 1



UKHSA National Knowledge Hub - Messaging to support a healthier weight in 5-18 year olds.
Source: [Public library - UKHSA national - Knowledge Hub (khub.net)]

Appendix 2

UK Chief Medical Officers' Physical Activity Guidelines, 2019. Source: [Physical activity for children and young people: 5 to 18 years (publishing.service.gov.uk)]

Appendix 3

Oxfordshire Child Health Profile — March 2021

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

- No significant change
- Increasing/decreasing and getting better
- Increasing/decreasing and getting worse
- Trend cannot be calculated
- Not significantly different from the England average
- Significantly better than the England average
- Significantly worse than the England average
- Significance cannot be tested

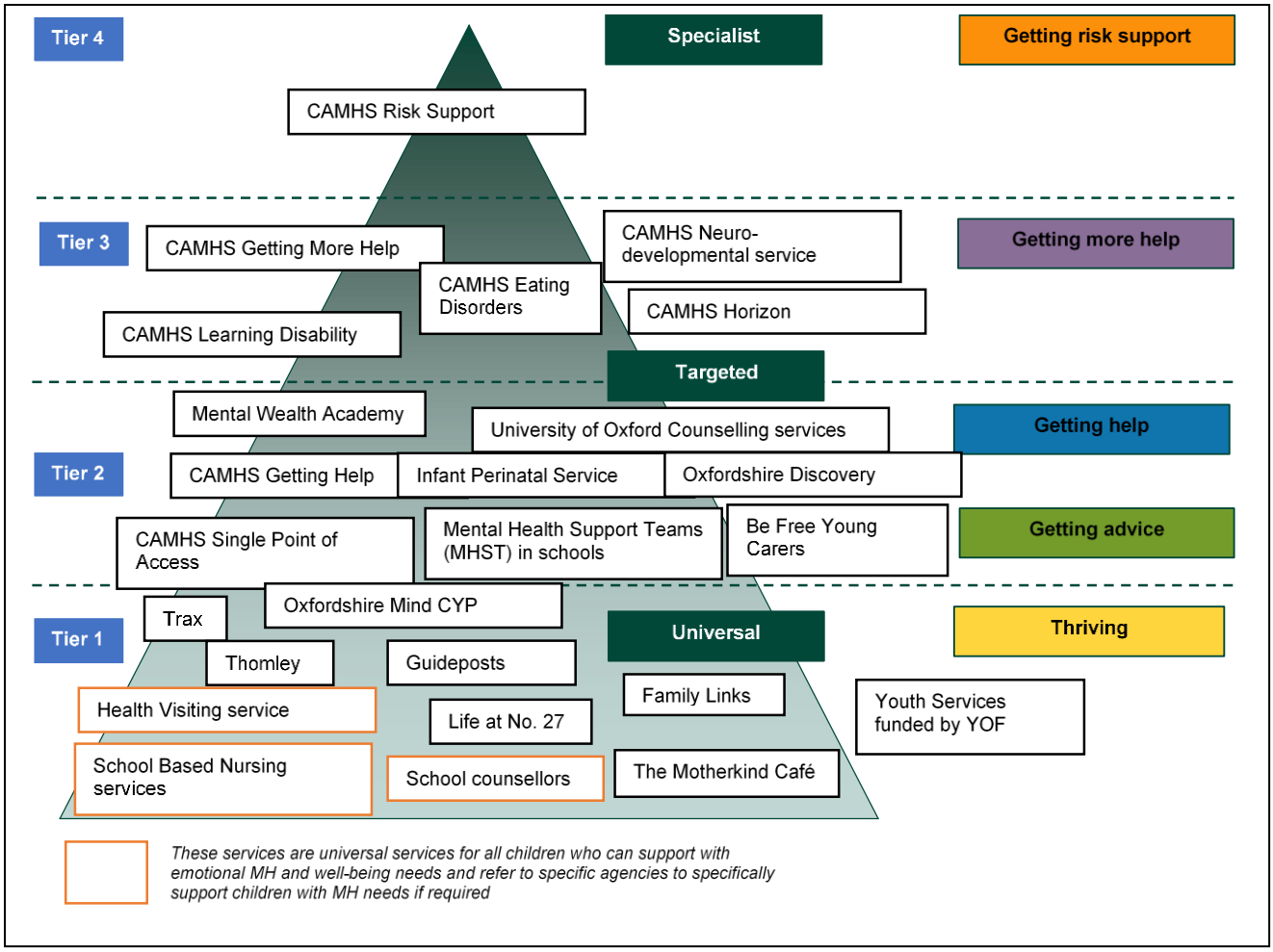
England average | Regional average | 25th percentile | 75th percentile

	Indicator	Recent trend	Local no. per year*	Local value	Eng. ave	Eng. worst	Eng. best
Premature mortality	1 Infant mortality rate	→	***18***	2.5	3.9	7.5	2.0
	2 Child mortality rate (1-17 years)	–	***15***	11.0	10.8	25.7	5.7
Health protection	3 MMR vaccination for one dose (2 years)	↓	7,148	94.1	90.6	77.1	97.6
	4 Dtap/IPV/Hib vaccination (2 years)	→	7,332	96.5	93.8	80.1	98.7
	5 Children in care immunisations	→	510	94.3	87.8	34.5	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of Reception	↑	5,502	73.5	71.8	63.1	80.6
	7 GCSE attainment: average Attainment 8 score	–	–	50.6	50.2	42.9	60.0
	8 GCSE attainment: average Attainment 8 score of children in care	–	–	19.3	19.2	10.6	28.1
	9 16-17 year olds not in education, employment or training (NEET)	–	470	3.7	5.5	15.0	1.5
	10 First time entrants to the youth justice system	↓	126	205.3	238.5	554.3	72.3
	11 Children in relative low income families (under 16s)	↑	14,427	11.1	18.4	38.0	5.4
	12 Households with children homeless or at risk of homelessness	–	737	9.5	14.9	31.2	4.7
	13 Children in care	↑	765	52	67	223	24
	14 Children killed and seriously injured (KSI) on England's roads	–	***15***	11.8	18.0	50.4	3.1
Health improvement	15 Low birth weight of term babies	→	156	2.3	2.9	5.2	1.3
	16 Obese children (4-5 years)	→	295	6.7	9.9	14.6	4.7
	17 Obese children (10-11 years)	→	680	16.1	21.0	30.1	11.1
	18 Children with experience of visually obvious dental decay (5 years)	–	–	21.3	23.4	50.9	9.7
	19 Hospital admissions for dental caries (0-5 years)	–	***50***	104.6	286.2	1,298.5	11.1
	20 Under 18s conception rate / 1,000	↓	110	10.1	16.7	39.4	3.6
	21 Teenage mothers	→	15	0.2	0.7	2.3	0.2
	22 Admission episodes for alcohol-specific conditions - Under 18s	→	***52***	35.7	30.7	111.5	7.7
	23 Hospital admissions due to substance misuse (15-24 years)	–	***62***	68.4	84.7	259.8	33.2
Prevention of ill health	24 Smoking status at time of delivery	→	455	7.1	10.4	23.1	2.1
	25 Baby's first feed breastmilk	–	6,485	98.7	67.4	43.6	98.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	→	4,459	61.2	48.0	–	–
	27 A&E attendances (0-4 years)	↑	17,345	440.3	655.3	1,917.4	126.3
	28 Hospital admissions caused by injuries in children (0-14 years)	↓	1,035	83.8	91.2	153.1	48.5
	29 Hospital admissions caused by injuries in young people (15-24 years)	→	1,160	129.8	132.1	269.9	55.1
	30 Hospital admissions for asthma (under 19 years)	↓	175	113.6	160.7	405.2	58.4
	31 Hospital admissions for mental health conditions	→	135	92.4	89.5	249.7	26.3
	32 Hospital admissions as a result of self-harm (10-24 years)	→	600	462.1	439.2	1,105.4	126.2

● ≥95% ● <90% ● 90% to 95%

Oxfordshire Child Health Profile, March 2021. Source: OHID Fingertips Public Health Data
E10000025 (13).pdf

Appendix 4



Examples of services and projects in Oxfordshire related to mental health and wellbeing (taken from the Oxfordshire Health and Wellbeing Strategy Paper for the Health and Wellbeing board, Author: Jack Gooding)

Appendix 5

Translating evidence into a 'whole systems' approach: 10 key factors of effective local strategies
Source: [Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)]