Health needs of children and young people in Northamptonshire, with emphasis on mental health

March 2014
This research has been undertaken by the Public Health Action Support Team (PHAST). The work was commissioned by Northamptonshire County Council.

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Executive Summary

In October 2013 The Director of Public Health for Northamptonshire commissioned the Public Health Action Support Team CIC (PHAST) to undertake a ‘deep dive’ needs assessment into the current and future health and social care needs of children and young people (C&YP). The needs assessment was conducted between November 2013 and January 2014 to inform the future decision making and investment of the Health and Wellbeing Board (HWBB) and its constituent partners. This paper sets out our findings and makes recommendations intended to improve the health and wellbeing of C&YP and thereby reduce the care and mental health burden across the county.

The report describes information about C&YP in Northamptonshire as a whole and, where possible, about its constituent individual districts. There is discussion about the information provided, and recommendations are made to tackle a range of local health and social care challenges, particularly those pertinent to those C&YP using Child and Adolescent Mental Health Services (CAMHS) or social care services, or both. The recommendations are intended to assist in determining future social care and health provision in Northamptonshire. They comprise three which are broad and underpin work across the county and across local agencies and others specific to a particular area of work, or agency, or challenge.

One of the reasons for commissioning this work was poor ratings received by Northamptonshire CC from a series of OFSTED inspections of safeguarding, child protection and adoption services, and secondly so that local public sector bodies could better understand why there appears to be a higher than expected number of C&YP known to the local CAMHS and looked after by Northamptonshire CC, or both.

Northamptonshire has examples of very good practice. The Targeted Mental Health in Schools (TaMHS) Programme has had very significant penetration into schools (covering 85% of them) and was recognised as an area of best practice by NICE in September 2013. The Talk Out Loud Anti-Stigma project was nominated for a CYP Now national award. The Serenity sexual assault referral centre and the support services received an award for outstanding service. Northampton Analysis has been established as an organised and annotated treasury of county wide data which can be interrogated by professional and non-professionals alike and has responsive support from well trained experts.

This project has tried to assess the status of Northamptonshire’s C&YP against England data wherever possible. The focus of this report is largely on CAMHS and social care because these currently present the challenges which Northamptonshire CC and its natural partners are finding difficulty in addressing.

The report highlights key policies and principles that are informing actions across the country on the issues facing Northamptonshire. There are recommendations for action that flow from these. For example, there is strong encouragement for commissioners and providers to listen carefully to those they are trying to support, and to take account of what they say. Within Northamptonshire there are examples, such as the Talk Out Loud project, where the voices of children and young people have been heard and used to inform which services were selected for development, and influenced the ways they are presented. However, there was no evidence of a structured approach to the engagement of C&YP and this report recommends investing in a programme that would
provide consistent opportunities to hold dialogue with C&YP, and to demonstrate that their views make a difference to the services they are offered.

PHAST reviewed relevant health and social care data to determine the scale and extent of some key challenges. Some areas, such as the plans agreed following the OFSTED inspections, had a body of good data which could be analysed to highlight key information and make specific recommendations. Others, such as child sexual abuse, were patchy, and populated with incomplete, recent data: here recommendations were made to develop intelligence which would in future inform commissioning.

To offer best advice for actions to improve health and wellbeing, PHAST reviewed the evidence of the most effective actions which, if taken locally, should make a real difference to the health and wellbeing of local C&YP. Some of these, such as programmes of supporting parenting, are already within the services offered within Northamptonshire, and the recommendation is to go further and expand these.

PHAST attempted to model health and social care data to pinpoint locations within Northamptonshire where interventions would have the greatest benefit. Unfortunately, local data had not been collected in a form that made this possible.

The project sought financial data to allow an analysis of where investment is made now and where the results of this work would suggest investment be altered to better fit local circumstances. This is an area where further local development is needed. For every pound used in preventive activity, where evidence suggests there will be substantial benefits in the future, a pound has to be withdrawn now from funding a service. Choosing which services should forfeit those funds needs to be undertaken through a clear and transparent process and was beyond the scope of this piece of work.

C&YP are important to Northamptonshire. Many people within local organisations and partnerships have worked to improve the lives of those in greatest need of help. They have achieved real improvements. This report is intended to add to local work and to set out how Northamptonshire can act wisely to develop services to support local C&YP to live lives of greater health and wellbeing.
Recommendations

The recommendations made throughout the report have been brought together here showing to which organisation, or group of organisations, each is addressed. The first three underpinning recommendations, and those to the Health and Wellbeing Board, will require especially close working between Northamptonshire CC and other agencies to bring them to fruition.

Underpinning recommendations

1 Data

This report recommends that Northamptonshire CC and its partners should review how data is collected and analysed to improve commissioning of local authority services, NHS services, and services from other agencies, and improve its partnership working across sectoral boundaries. The review should set out where there are data gaps, and devise ways to fill these either using the internal resource, such as Northamptonshire Analysis team, the BIPI team, and the BIRT unit, or by work with others. Good, verified data agreed by all partners will greatly assist in monitoring activity and provide clear evidence when changes are needed.

Within Northamptonshire the County has to date been subdivided by local government and police into districts and by the NHS into localities. The two are not coterminous. There would be benefit for all in agreeing a single set of common sub-County divisions used across all public sector organisations. C&YP with problems with drugs and alcohol, for example, may receive services from local government, and from the NHS, and data would be more easily compiled and verified if these boundaries coincided. Similarly, Northamptonshire Self Harm Task Group could recast the data on deliberate self harm by districts rather than by localities. This should allow those working to reduce the rate of self harming to prioritise those parts of the County most in need of resources to support agreed actions.

There are some areas where contract negotiations will be needed, such as gathering data from NHS trusts where detail is no longer supplied as it was prior to the change of arrangements in 2013.

Data from primary care will be very helpful in examining some service use, for example, the assessment and treatment of asthma which has led to short hospital stays for Northamptonshire C&YP. Such analysis of primary care data is important prior to the health visitors move to the local authority.

Data should be collected from all providers up to age 25 to fulfil, for example, the need to commission services for those with learning disabilities post transition to adulthood.

Where possible, Northamptonshire CC, or those from whom it collects data, should compile data by single year of life and by household or individual to allow close mapping. Such data include domestic violence, C&YP in care, persistent absentees from school, youth offending, CAMHS use, mental ill health in the household, long term conditions, child poverty, and other indices of deprivation. This will allow very specific targeting of resources to those small areas which will yield greatest benefit. To achieve the greatest benefit from this work, Northamptonshire CC should work with a specialist team from whom it could learn the techniques of modelling and projecting data.

This report recommends that case-level data be accessed and used to carry out an analysis that links multiple service data at the individual level. This will provide a more locally relevant
evidence base and framework allowing Northamptonshire CC to drill down to finer detail and determine what is driving the caseloads with more accuracy. Such data would permit very specific advice on where investment would yield most benefit.

2 Invest in prevention and early intervention

This report recommends all public sector organisations in Northamptonshire follow the advice within the 2010 Marmot report, the 2012 Chief Medical Officer report, and the 2011 Allen Report to resource preventive activities at the expense of intensive, high cost interventions as far as is practicable.

This will be exemplified by investing further in supporting parenting programmes, especially in those locations where the numbers coming into social care and CAMHS are high, eg Corby and the more deprived parts of Northampton, Kettering, Wellingborough and Daventry. Any further investment into these activities should be undertaken in line with NICE criteria.

Further, Northamptonshire should invest in the best evaluated programmes for children of school age as set out in Appendix A reviewing the published literature. These comprise

- Early education and childcare;
- Classroom based emotional and problem solving programmes for 3-7 year olds at risk of conduct disorder;
- Group-based parenting programmes 3-11 year olds at high risk or with conduct disorder;
- Child focused group social & cognitive programmes 9-14 year olds at high risk or with conduct disorder;
- Multi-modal interventions 11-17 year olds with conduct disorders eg multi-systemic therapy.

3 Learn from good practice

This report recommends that Northamptonshire learn from good practice elsewhere and apply that learning to local services. Learning may be through desk research, through visits, or through inviting successful programme leads from elsewhere to bring their expertise to Northamptonshire for discussion and to receive guidance on how best to use the expert advice.

Specific recommendations by organisation or partnership

Throughout the report there are a number of specific recommendations drawn from the presentation and discussion of information from a range of sources.

Northamptonshire CC

1. Northamptonshire CC should take action to address family homelessness alongside actions to narrow inequalities within the County.
2. Northamptonshire CC should produce those data from which the maps of risk factors for the need for early help and intervention were constructed. The data should be refreshed annually so that actions taken can be evaluated to show hoped for progress and to facilitate modelling and projection work in due course.
3. Northamptonshire CC should annually review the ethnicity of looked after children as any further dispersal of asylum seekers takes place.

4. This report recommends that Northamptonshire CC examine the findings from figure 47 showing LAC by category of need. This will inform tailored investment at sub-County level to meet localised needs.

5. Northamptonshire CC should annually review the numbers of looked after children by district of residence to see if the disparities noted in this report, which reflect the local picture of deprivation, are maintained. The information should be used to argue for a rebalancing of service provision to follow the needs of districts more closely.

6. Northamptonshire CC should continue to gather and analyse data on risk factors for entry to the social care system by district year on year. There would be benefit from analysing the data at sub-district level: trends should inform priorities for investment. The coding of reasons that C&YP are in social care should be investigated to assess if the differences between Northamptonshire and England might be explained by local interpretation differing from coding elsewhere. There should be a thorough examination of the findings from the Table 7 showing social services care use. There are many reasons for these disparities but they should be explored to make certain that classifications are accurate, and that services meet the needs of local C&YP.

7. Northamptonshire CC should undertake a review of local interventions in schools intended to avert mental ill health among C&YP, since the burden of mental ill health appears to be rising despite the local presence of a range of support programmes.

8. Northamptonshire CC should review how fully the interventions implemented to meet the Aiming High for Disabled Children policy improved life for the young learning disabled community and to learn where investment was most effective (especially from the viewpoint of the C&YP themselves). Learning from those actions should prove useful to deciding on actions in the coming year when some services will be recommissioned in different ways.

**Northamptonshire CC and partner organisations**

1. Northamptonshire CC, together with all participating agencies, should continue to comply with all the recommendations within the OFSTED inspection reports.

2. Immunisation rates for C&YP in social care, at 72%, should be improved to meet at least the England average, currently 82%.

3. Northamptonshire CC, the CCGs, and the Police, both separately and together, should review the distribution of public services across the County to better match them to those districts where need is greatest.

4. A group including Northamptonshire CC, primary care and secondary care should review hospital admissions with mental illness among C&YP. This review should focus on finding information to explain the substantial excess admissions to hospital with mental ill health among C&YP compared to the East Midlands and England average and seek ways to reduce this as quickly as possible. They should seek to match resource to well-evidenced interventions to stem the flow of C&YP into CAMHS. This activity should be closely monitored to ensure progress stays on track.

5. The Police and Northamptonshire CC should together gather domestic violence data to establish the current rate for each district of Northamptonshire CC, so allowing trend monitoring as actions are taken to tackle this challenge. Data should be collected at household and individual level to allow close mapping to highlight those locations within the County where investment would yield greatest benefit.

6. This report recommends that the Drugs and Alcohol Team (DAT) implement its agreed plans, including participation in the attitudinal survey started by Bath University, especially since recently the team has begun to listen to C&YP and understand how to arrange
services in ways which are more attractive to them. The DAT should take its planned actions while continuing to compile up to date evidence and evaluating the impact of any steps taken.

7. The LSCB should undertake audits of cases involving self harm where there are also safeguarding concerns to assess the response and outcomes of these.

8. This report recommends looking at evidence based interventions for LAC (see Appendix A) and identifies and visits places which have lower rates of LAC and better outcomes.

9. Northamptonshire CC and its partners collect data at single year of age bands and with as explicit geographical information as possible so as to allow sub-district modelling work to be performed.

**Northamptonshire Health and Wellbeing Board**

1. This report recommends that the Health and Wellbeing Board support the establishment of a programme across all member agencies for listening to Northamptonshire’s C&YP. The programme should have clear aims, use well attested methods to answer specific questions, and encourage agencies act on what they hear as far as they are able. This programme of listening to C&YP should extend to the transition from social care to adulthood, and the YP should be widely consulted on how services are offered so that support is given in ways that attract them to make best use of them.

2. Northamptonshire Health and Wellbeing Board should sign the 2013 Department of Health pledge to focus on mental health in C&YP. This pledge commits signatories to draft a JSNA that includes
   ♦ comprehensive local data, easily accessible and kept current
   ♦ specific actions to address the risk of mental health disorders and thereby their incidence and prevalence
   ♦ outcome measures to demonstrate impact of agreed actions

**Northamptonshire CCGs**

1. Nene and Corby CCGs should together investigate the reasons for the high number of short hospital admissions for common conditions among C&YP.

2. Northamptonshire CC, primary care and community mental health service providers should undertake a specific study of community mental health services to better understand why the caseload does not reflect deprivation as would be expected.

3. Nene and Corby CCGs should review the NHS early intervention provision for children and young people and ensure that there is a menu of services in place to prevent problems escalating.

**Northamptonshire CCGs, clinicians from primary care and clinicians from secondary care**

1. All clinicians treating C&YP with mental ill health, including those at NGH and NHFT, should be tasked with noting accurate diagnoses in the notes as a basic requirement of the contract with commissioners. Currently 20% of C&YP discharged from local secondary care mental health services had no diagnosis, an unacceptable figure.

2. Action should be taken by clinicians, pharmacists and the CCGs to assess whether the use of methylphenidate and atomoxetine is appropriate and producing improved outcomes for C&YP with ADHD.

**East Midlands Public Health Team**
1. The East Midlands team from Public Health England should coordinate work to better understand both why deliberate self harm is a greater problem in some counties, and to learn from the best performers how to arrange services to be most effective.

**Northamptonshire Police**

1. This report concurs with the recommendation in the Partnership Strategic Assessments produced by the Police during 2013 that further analysis should be undertaken by the Police to identify local hotspots for drug and/or alcohol related crime and anti-social behaviour and child sexual exploitation. This work would allow services to be focused where greatest benefit would accrue.

2. There should be further analysis of missing persons be undertaken to clarify information on them which would inform service developments. Examples of useful analysis would be their number by age, ethnicity and place of residence; details of those who are looked after; the number receiving CAMHS; the number who go missing from the range of placements (including the family home); the number where there is child sexual abuse; and the number who have associated problems such as drug and alcohol abuse, abuse and neglect, domestic violence and a household where there is mental ill health. It will be useful to compare Northamptonshire to England figures.

**Northamptonshire Self Harm Task Group**

1. The PHAST modelling team should work with Northamptonshire CC to further study districts where reductions in the prevalence of deliberate self harm have been seen to understand how this was achieved.

2. Those working to reduce the rate of self harming prioritise those parts of the County most in need of resources to support agreed actions. Prioritising include examining the ethnic mix of those C&YP who self harm, and a review to assess whether some schools have a higher number of cases than might be expected and thus may require greater resources to tackle their local problem.
Introduction

This section summarises the purpose of this report, the context for this review and some important reports that formed the background to our work.

Purpose of report

This document is a strategic needs assessment prepared for public sector organisations, and their partners, working to improve health and wellbeing in Northamptonshire. Because it draws data from a range of sectors, all of whom work together (and separately) for the benefit of the County’s C&YP, it is termed a joint strategic needs assessment (JSNA). A JSNA is a statutory obligation and the recent Health and Social Care Bill continues to acknowledge its role in informing the priorities of Health and Wellbeing Boards, outlining the responsibilities of local government, the local NHS and other partners such as the criminal justice system to collaborate in its production. It helps identify local priorities and supports commissioners in commissioning services and interventions that will achieve better health and wellbeing outcomes.

Each year the information can be updated in light of experience, or new data, or service developments, to monitor trends and allow changes to be made to improve the health and wellbeing of local people.

This project sought to provide some data for a JSNA, but also to respond to some key questions asked by Northamptonshire CC about children and young people (C&YP) and their health and wellbeing:

1. What inequalities are there in health status and access to services?
2. What are the most important causes of demand for health and social care for children and young people in Northamptonshire?
3. What patterns of behaviour in children and young people are likely to lead to entry to the care system and/or the specialist mental health system? How could these be changed?
4. What is the likely future need and demand for services to these two services, and associated costs, given current trajectories? How would these alter under plausible changes in those trajectories, including if those trajectories improved?
5. What would be the impact of these projections in terms of cost, staff time and numbers, foster placements, NHS beds and other practical units of resource use?
6. To what extent can interventions alter the future pattern of need and demand for health and social care for children and young people?
7. What can Northamptonshire do to improve the performance, resilience, sustainability and reputation of its services for children and young people?
Context

This Joint Strategic Needs Assessment will inform the development of joint delivery plans to tackle some key local C&YP priorities. It focuses particularly on those children who are among the most vulnerable – looked after children (LAC) - and those who suffer mental ill health and receive treatment and support from CAMHS in Northamptonshire.

The key aim for all partners contributing to the help and support these C&YP receive is to deliver the right help, at the right time, in the right place, and at the best value for money, reducing pressure on high cost services but most importantly increasing the life chances and quality of life of Northamptonshire’s young people.

Children and young people are important. Society, including the local Council and its partners such as the NHS and the criminal justice system, has a duty to protect them, to use resources wisely and effectively to support them and their families and to help them achieve their potential. They are the parents, leaders, workforce and citizens of the future and the evidence for identifying and addressing the needs of children and young people is clear. Children do not develop and grow in isolation: their life chances and the outcomes they achieve depend upon the ability of others, including their families, professionals and local communities to support, inspire and protect them. As everyone understands the outcomes for Northamptonshire children and the investments needed to improve those, public sector organisations should be able to plan better services, both now and in the future, for C&YP and adults.

A 2013 document, Overlooked and Forgotten¹, reviewed how well children and young people’s mental health was being prioritised in the current commissioning landscape. The authors reviewed the inclusion of children and young people’s mental health across 145 joint strategic needs assessments (JSNA) and 142 joint health and wellbeing strategies (JHWS). There is strong evidence that providing good prevention and early intervention services can have a significant impact in reducing the human cost of mental health problems amongst children and young people².

The report set out some criteria by which these JSNAs and JHWS indicate local importance attached to C&YP. There were several criteria, and these are set out below with comment on Northamptonshire’s document. The County meets most of the criteria, and would have been assessed as a place where C&YP were a substantial focus for the local authority.

<table>
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<tr>
<th>Criterion</th>
<th>Northamptonshire status</th>
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<tr>
<td>1</td>
<td>Two thirds of JSNAs did not have a section that specifically addressed children and young people’s mental health needs</td>
<td>JSNA in place</td>
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<td>2</td>
<td>One third of JSNAs did not include an estimated or actual level of need for children and young people’s mental health services. Levels of need where</td>
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<td>Criterion</td>
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<td>estimated commonly used three types of data:</td>
<td>Hospital admissions data was included.</td>
<td>Hospital admissions data was included.</td>
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<td>i hospital admissions data</td>
<td>CAMHS trend data on caseload was included.</td>
<td>CAMHS trend data on caseload was included.</td>
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<td>ii rates of referral to CAMHS</td>
<td>Estimated needs given using the Green 2004 method</td>
<td>Estimated needs given using the Green 2004 method</td>
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<td>iii calculating local prevalence rates for C&amp;YP mental disorders by extrapolating from national data (commonly from a national study undertaken in 2004 by Green et al)</td>
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<td>3 Data about the mental health needs of young people aged 16-25 was especially limited</td>
<td>5 to 16s only in Northamptonshire JSNA</td>
<td>16-25 data about the mental health needs of young people</td>
</tr>
<tr>
<td>4 The links between known risk factors and mental ill health were not linked</td>
<td>Links articulated in text but with no numerical analysis</td>
<td>Numerical analysis</td>
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<td>5 One third of JSHWs did not prioritise C&amp;YP mental health.</td>
<td>Mental health is in CYP Partnership Board plan specifically (but not the JSNA)</td>
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Using the criteria set out in Overlooked and Forgotten the Northamptonshire JSNA, meets some criteria but has room for improvement, in particular data for all ages to 25 and using local data to estimate needs for mental health services.

PHAST recommends that the Health and Wellbeing Board sign the DH 2013 pledge to focus on mental health in C&YP and deliver on its recommendations. The pledge states that all local JSNAs should include:

- comprehensive local data, easily accessible and kept current

Northamptonshire has well organised local data, though this work has exposed gaps, and areas where further work and analysis will help both decide where investment should be made and where investment is successfully tackling known challenges.

- specific actions to address the load and risk of mental health disorders
Northamptonshire has acted to pursue the better handling of the current load of mental health disorders partly through actions such as investing in further provision at specialist CAMHS sites, and partly through work with specific, known local categories of young people with problems, such as those where they or their households (or both) use drugs and alcohol. The work to address the risk of mental health disorders needs further investment in evidenced programmes of preventive activity with pregnant women, new parents, in nurseries and schools, and in other settings which C&YP frequent.

♦ outcome measures to demonstrate impact of agreed actions

Northamptonshire has established both local authority and cross sectoral fora where outcomes are monitored against plans with clear accountabilities, for example in response to the OFSTED reports. The importance of monitoring outcomes to maintain progress and improve services is well understood locally to be important and is expected to continue.

Northamptonshire had achieved much for its C&YP of which it can be proud. Examples include:

♦ The Targeted Mental Health in Schools (TaMHS) Programme has had a significant reach in schools (covering 85% of them) and was recognised as an area of best practice by NICE in September 2013.
♦ The Talk Out Loud Anti-Stigma project was nominated for a CYP Now national award
♦ The Serenity sexual assault referral centre and the support services received an award for outstanding service.

Northamptonshire CC has rated children and young people a priority, for example through the Children and Young People’s Partnership which agreed a Children’s Plan 2013 to 2015. Northamptonshire CC allocated substantial funds in 2013 in response to an analysis of early health needs assessment for the County undertaken in 2013.

All these positive examples are in contrast with some indicators where improvement is needed. These include:

♦ Three poor ratings by recent OFSTED inspections which identified significant safeguarding concerns across the partnership, and where specific improvement was needed for safeguarding, looked after children and adoption. The reports set out a number of recommendations for Northamptonshire and a comprehensive Children’s Service Improvement Plan has been developed, agreed with OFSTED and the Department of Education, and is being driven forward by the Children’s Services Improvement Board.
♦ A decline in the numbers of mothers breastfeeding at age 6 to 8 weeks over the last 2 years. This contrasts with the last England breastfeeding survey\(^6\) (2010) which showed improvements in breastfeeding at 6 to 8 weeks.
♦ High numbers of hospital admissions for substance misuse, mental health problems and (in one year) for self-harm.

This needs assessment project aimed to develop local understanding of the level of need which may be impacting on outcomes for C&YP and makes recommendations for action.
The assessment focused particularly on looked after children (LAC) and C&YP with mental health needs, both well recognised vulnerable groups, and where intervention is high cost.

**Key policies and documents which influenced this needs assessment**

There were some landmark policy documents that influenced this needs assessment:

- Chief Medical Officer *Our Children Deserve Better – Prevention Pays* (2012)
- Prof Eileen Munro’s report on child protection *A Child Centred System* (2011)

Four were inspection reports from national regulators:

- OFSTED NCC Adoption service inspection report, published March 2012
- OFSTED inspection of local authority arrangements for the protection of children, published March 2013
- OFSTED NCC Adoption service inspection report, published May 2013
- OFSTED inspection of looked after children services, published August 2013

**Policy documents**

**2012 Chief Medical Officer Report**

The 2012 Report of the Chief Medical Officer *Our Children Deserve Better – Prevention Pays* encouraged public sector bodies and others to focus on early years in their investment. The Chief Medical Officer report sets out an economic case for this focus, which should be used by Northamptonshire to inform investment decisions for both its own and partnership work. For example

- The annual cost to the public sector in England associated with children born preterm until age 18 is around £1.24 billion. Total societal costs including parental costs and lost productivity are around £2.48 billion in total. Across East Midlands in 2012/13, 5623 of 47016 babies delivered were born before 37 weeks gestation, including 524 born before 31 weeks gestation. Babies born preterm have higher rates of disabilities, especially respiratory complications and lung disease; problems with bowel function; and long-term neurological damage. The combination of the high cost interventions needed to support them through their early weeks of life, and outcomes where health and wellbeing are compromised, makes the prevention of early births important. Numbers of preterm births are higher for mothers who smoke in pregnancy, or abuse drugs and alcohol, challenges which Northamptonshire has been tackling for some years.

- The long-term costs of obesity in England are £588 to £686 million per annum. In Northamptonshire obesity rates of 9.4% (England average 9.5%) at age 4 to 5,
and of 17.5% in year 6 at school (England average of 19.2%)\(^8\), are a little lower than the England average, but still represent a sizeable public health challenge.

For mental health disorders, the annual short-term costs of emotional, conduct and hyperkinetic disorders among children aged 5–15 in the UK are estimated to be £1.58 billion, and the long-term costs £2.35 billion. Northamptonshire has a burden of these illnesses higher than the East Midlands and England averages and have been a key element in the commissioning of this needs analysis.

The Chief Medical Officer 2012 report encouraged “proportionate universalism” – improving the lives of all, with proportionately greater resources targeted at the more disadvantaged. This fits closely with Northamptonshire’s approach and the thinking that has informed this assessment. The 2012 report offered direct advice to commissioners and providers on actions that will have greatest impact, for example encouraging use of the locally successful Family Nurse Partnership programme to support the youngest mothers, alongside efforts to improve nutrition and opportunities for exercise for all children in the early years. Similarly, the Chief Medical Officer believed the Troubled Families programme would tackle the needs of some specific local families with targeted resources and will have significant impact. Northamptonshire has started a local Troubled Families programme and is undertaking activities to meet its criteria. The Troubled Families team identified 1137 families across the County that met the programme standards. By October 2013 it had started work with 648 of these and turned around 107 according to the criteria of the programme.

The Chief Medical Officer 2012 report urged public sector bodies to listen to children and young people so that any actions are agreed with them in ways that they can understand and with their participation in decision-making. Schools are seen as an important place to help children and young people develop healthy behaviours and attitudes. The report sets out the role of school nurses in supporting this work. Northamptonshire CC understands the importance both of appropriate mental health services and of compiling the data which will provide evidence on which future developments will be made.

**Fair Society, Healthy Lives**

Prof Sir Michael Marmot’s report *Fair Society, Healthy Lives* was published in 2010. It offered six policy directives which each needed actions to redress inequalities and improve the quality of life nationally:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention.
Prof Marmot was clear that the first – the best life chances for every child – was the most important. His advice comprised three well-evidenced policy objectives:

1. Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.

2. Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.

3. Build the resilience and well-being of young children across the social gradient.

These policy objectives were underpinned by three sets of recommended actions that Northamptonshire should heed as far as is practicable:

1. Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.

2. Support families to achieve progressive improvements in early child development, including giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy; providing paid parental leave in the first year of life with a minimum income for healthy living; providing routine support to families through parenting programmes, children’s centres and key workers, delivered to meet social need via outreach to families; developing programmes for the transition to school.

3. Provide good quality early years education and childcare proportionately across the gradient. This provision should be combined with outreach to increase the take-up by children from disadvantaged families; provided on the basis of evaluated models and to meet quality standards.

Some of these, e.g. for paid parental leave, would require Government to act. Others can be implemented locally, e.g. parenting programmes, programmes in schools to encourage healthy behaviours, and the emphasis on disadvantaged families. Northamptonshire should use the needs assessment evidence of where need is greatest, and the evidence of the interventions which are most effective (presented within the report and at Appendix A) and invest in activities to encourage C&YP to develop healthy lives.

Taken together, the 2012 Chief Medical Officer Report and Healthy Lives, Fair Society were an urgent call to action for the public sector, providing advice and evidence on key challenges and on appropriate interventions at both local and national levels. Within the recommendations of this report are several which were drawn from the principles of these landmark policy reports. In other parts of the country the public sector bodies have included these principles within the annual objectives of each employee, asking them to set out activities based on those principles and thus contributing to the reduction of inequalities, and the shift from intervention to prevention.
This needs assessment recommends all public sector organisations in Northamptonshire follow the advice within the 2010 Marmot report and the 2012 Chief Medical Officer report to resource preventive activities at the expense of intensive, high cost interventions as far as is practicable.

**Early intervention: smart investment, massive savings**

In July 2011 Graham Allen MP and four other leading national experts (Dame Claire Tickell, Rt Hon Frank Field MP, Prof Eileen Munro and Joyce Moseley OBE) published a report, *Early Intervention: Smart Investment, Massive Savings*[^9], with the aim of ensuring that every baby, child and young person grows up with the basic social and emotional competencies that will give them the bedrock skills upon which all else is built. The report set out the best evidenced early interventions to avoid underachievement, low skills and poor educational attainment. The case made was driven by the need to save money, but recognised that appropriate early intervention had the potential to both increase the numbers of people living healthy, fulfilling lives in which they made a contribution to society rather than drawing from it for their own needs, and saved a substantial proportion of the funds used to pay for the late, intensive interventions needed to support the most disadvantaged members of society. The foreword talks of, “reaping massive savings in public expenditure for the smallest of investments in better outcomes, and by avoiding expensive provision when things go wrong. By building out the immense costs of failure, it is in fact the best sustainable structural deficit reduction programme available.”

The Allen Report detailed the 25 best evidenced interventions from antenatal programmes to the end of secondary school. This needs assessment has reviewed these interventions and sets out those which appear most appropriate for Northamptonshire. These are presented within Appendix A and provide a ready source of information for those commissioning services locally. For example, the evidence suggests that Northamptonshire should invest further in supporting parenting programmes, especially in those locations where the numbers coming into social care and CAMHS are high, eg Corby and the more deprived parts of Northampton, Kettering, Wellingborough and Daventry. Investment into these activities should be undertaken in line with NICE criteria.

The interventions within the Allen Report cover:

- Early education and childcare
- Classroom based emotional and problem solving programmes for 3-7 year olds at risk of conduct disorder (in nurseries and schools)
- Group-based parenting programmes 3-11 year olds at high risk or with conduct disorder
- Child focused group social & cognitive programmes 9-14 year olds at high risk or with conduct disorder
- Multi-modal interventions 11-17 year olds with conduct disorders eg Multi-systemic therapy
The interventions named in this report should be introduced as appropriate in Northamptonshire as the best evidenced at present.

**A child centred system**

A report on child protection published by Prof Eileen Munro in 2011[^10] *A child centred system,* was commissioned by Government in the wake of several deaths of children who were either being looked after by local authority care systems, or deaths where social workers had not taken a child into care and who, with hindsight, lived in great danger and in very poor home circumstances. Prof Munro emphasised the prime importance for each child at risk of receiving effective help. The report explored reasons why a well-intentioned system had over very many years failed to properly protect those C&YP at risk, and laid out the principles for an effective approach to child protection. The key principle was that the system should be child-centred: everyone involved in child protection should pursue child-centred working and recognise children and young people as individuals with rights, including their right to participation in decisions about themselves in line with their age and maturity.

Prof Munro spoke of a system which had become increasingly focused on meeting targets and complying with documenting activities rather than on building the relationship with each individual child to allow those children to receive the support they needed in the ways they needed it, at the times they needed it, and according to their cultural and personal circumstances. The report set out seven key principles for enhancing the system for looking after children at risk:

1. The family is usually the best place for bringing up children and young people, but difficult judgments are sometimes needed in balancing the right of a child to be with their birth family with their right to protection from abuse and neglect.

2. Helping children and families involves working with them and therefore the quality of the relationship between the child and family and professionals directly impacts on the effectiveness of help given.

3. Early help is better for children: it minimises the period of adverse experiences and improves outcomes for children.

4. Children’s needs and circumstances are varied so the system needs to offer equal variety in its response.

5. Good professional practice is informed by knowledge of the latest theory and research.

6. Uncertainty and risk are features of child protection work: risk management can only reduce risks, not eliminate them.

7. The measure of the success of child protection systems, both local and national, is whether children are receiving effective help.

[^10]: Child Protection: Learning from Abuse[10] A child centred system, was commissioned by Government in the wake of several deaths of children who were either being looked after by local authority care systems, or deaths where social workers had not taken a child into care and who, with hindsight, lived in great danger and in very poor home circumstances. Prof Munro emphasised the prime importance for each child at risk of receiving effective help. The report explored reasons why a well-intentioned system had over very many years failed to properly protect those C&YP at risk, and laid out the principles for an effective approach to child protection. The key principle was that the system should be child-centred: everyone involved in child protection should pursue child-centred working and recognise children and young people as individuals with rights, including their right to participation in decisions about themselves in line with their age and maturity.

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7. The measure of the success of child protection systems, both local and national, is whether children are receiving effective help.
For Northamptonshire these principles appear to be an integral part of the plans agreed with OFSTED and the Department for Education to improve safeguarding and adoption services. The principles should be central to future thinking about services for these vulnerable C&YP and should be demonstrable in future work to improve services. The second principle concerning the quality of the relationship between child, family and professionals underlines the importance of listening to the wishes of the child and the family, and of being clear when their wishes can be met and when they cannot. As the first principle states, it cannot always be possible to meet the wishes of each party and the safeguarding professionals may have to make difficult judgements: they have a duty, however, to show that they have listened and to offer a clear explanation of any expressed wishes or desires of the family or the child have not been met.

The final principle is key for those working in safeguarding and should guide Northamptonshire CC in its own and its partnership working.

These four landmark documents were at the heart of the thinking behind this needs assessment.

**OFSTED and CQC inspections**

Between 2011 and 2013 there was a series of four local inspection reports which greatly concerned all those working with C&YP within local child protection (CP) systems, in social care, with children in need (CiN).

Northamptonshire services for those C&YP in social care safeguarding and those going through the process of adoption were in each report rated as inadequate, and the reports set out a series of recommendations to remedy the areas of concern to the inspectors. These covered governance and accountabilities across the agencies involved; management and leadership; robustness, quality and speed of systems and communications; listening to the C&YP; improvements to services outside office hours; and the capacity and capability of staff at all levels.

Some recommendations were to be adopted immediately, and others within three months or six months of each inspection report being published. In response, Northamptonshire organisations working with these C&YP worked together to establish new structures and arrangements, including a multi-agency services hub (MASH) to respond more effectively to safeguarding concerns. The range of organisations involved agreed a detailed remedial plan with the regulators and allocated funds to meet the costs of implementation. The plan is in the process of being implemented.

This section outlined the purpose of this needs assessment, and the key questions it sought to answer. It highlighted four policy documents that provide principles from which Northamptonshire can build local frameworks for action. It noted that Northamptonshire had plans to improve safeguarding and adoption services in light of a series of OFSTED inspections.
Why children and young people are important

The section below explains why Northamptonshire believes C&YP are important, and emphasises the desire for C&YP to have their voices heard, to engage them in developing services, and to work towards a system where local services are well integrated to the benefit of both the C&YP and the professional teams which support them.

Northamptonshire has a population of 691,952, of whom 171,604 (24.8%) are C&YP aged 0 to 19 years. That number is expected to increase by approximately 1,000 children annually until 2020. Northamptonshire knows that their health and wellbeing during childhood and teenage years will significantly impact their life chances and outcomes as an adult, including their ability to work, to learn, and to engage with their community, and to nurture and support their own children. Providing the right support for children and young people, at the right time, and in the right place is crucial to the future health and wellbeing of the whole population and effective investment now can have immediate and long term impact.

Local data confirms that there are significant inequalities across the County which contribute to the risk of poor outcomes for children. There are significant differences in educational attainment, a key contributor to the cycle of poverty and disadvantage most evident among young people who are looked after by statutory organisations and those living in areas of deprivation. Around 24,000 children in the County live in poverty and this impacts both educational attainment and health. For those in the most deprived areas of Northamptonshire, life expectancy is 10.5 years lower for men and 6.4 years lower for women than for those living in the least deprived areas. Approximately 1 in 6 children live in poverty; ranging from 21% in Northampton to 6% in South Northants. Seventy-five percent of these children live with a lone parent and 50% of families in poverty have a child aged 0-4. 14% of young people in the County are eligible for free school meals, a measure of inequality. These are among Northamptonshire’s most vulnerable children and to break the cycle of deprivation and poverty it is essential to know who they are and what is needed to do to keep them safe, ensure they are ready for school, supported to achieve and prepared for a happy, healthy and productive life. Failure to break this cycle and improve life chances for these children will bring increasing demands on all public services in the future. In order to understand the joint challenges to improve outcomes, and to monitor the impact of any change, it is important to understand the changing needs of local children and young people, how they move through the range of services and where those services need to be improved or increase capacity.

Nationally the pressures on health services, particularly accident and emergency services, are increasing but evidence suggests that approximately 75% of hospital admissions of children with asthma could have been prevented with better primary care and more than a third of short stay admissions in infants are for minor illnesses that could have been managed in the community. Diabetic control markers in children are significantly worse than in other countries with comparable information and hospital admissions associated with diabetes, asthma or epilepsy among 11-19 year olds has increased by 26% since 2002/03 This is mirrored locally. Parents say they sometimes find it difficult to access primary care and that they value the reassurance provided in the hospital environment. Statutory agencies in Northamptonshire need to understand
what changes are required to better meet the needs of families and improve these outcomes.

The challenges of caring for adults with severe and enduring mental illness are well understood. However, half of lifetime mental illness starts by the age of 14, so a good understanding of risk, prevention and effective treatment for young people is important. Young people in the County are more likely to self-harm and to be admitted to hospital for mental health problems than in other counties in the East Midlands. It is important to address the increasing demand for mental health services across all age ranges and the long term impact of enduring mental health problems for individuals, organisations and society as a whole.

Public sector organisations have a duty to protect children and young people. The inspection of local authority arrangements for the protection of children published in March 2013 judged child protection services for children and young people in Northamptonshire as inadequate. Further inspections of Adoption Services and Services for Looked after Children published in May and August 2013 respectively also judged those services as inadequate. Statutory agencies in Northamptonshire accept these judgements as a true reflection of local services and are all committed to delivering the change needed both to respond to the inspection recommendations and to deliver the systemic change needed to improve overall outcomes for children and their families. An Improvement Board has been established with specific responsibilities to act upon the recommendations within the inspection reports and to drive the improvements needed. The right level of investment, capacity and focus across all partners will be essential to deliver the pace of change needed to make Northamptonshire children safer.

To successfully respond to the OFSTED recommendations and reduce the pressure on high cost social care services, agencies in Northamptonshire need to understand the key risk factors for abuse and neglect and how to identify and address them. The most common reason for children of all ages to come to the attention of social care services is domestic abuse. Children aged 0-4 are also likely to come to the attention of social care services because of neglect and drug and alcohol misuse. Older children are likely to present with behavioural problems and as a result of family breakdown. It is important that local agencies work together to continue to develop early help and prevention services, improve social care services and make children safer.

There is strong evidence that lifestyle behaviours that impact on longer term health and social care outcomes in adults are closely linked to lifestyle in the teenage years. Breast feeding rates at 6-8 weeks are falling in the County. Breast feeding is well-evidenced to provide health benefits for both mother and baby and to promote attachment, however young mothers are among the groups least likely to breast feed. More than eight out of ten adults who have ever smoked regularly started before the age of 19 and eight out of ten obese teenagers go on to become obese adults.

Nationally, the diagnosis of sexually transmitted infections in young people, such as Chlamydia, has increased by 25% over the past ten years. Untreated sexually transmitted infections can have longer term health impact including fertility. Young people’s sexual behaviour may also lead to unplanned pregnancy which has significant health risks and damages the longer term health and life chances of both mothers and babies. Alcohol misuse is contributing to increased pressure on a wide range of agencies including health, housing, social care, police and the voluntary sector. Influencing positive lifestyle choices in teenagers will impact on health outcomes for young people and on future demand for a wide range of services by adults.
This section has provided information on C&YP in Northamptonshire and set out reasons why their health and wellbeing is very important. It has described some activities undertaken locally to understand the views of C&YP and their attitudes to some public sector services provided for them.
**PHAST Approach**

*This section describes how PHAST prepared this report and lists the methodological challenges. These were chiefly paucity of data in forms that allowed intra-County analysis.*

PHAST have sought to review a body of local knowledge within Northamptonshire pertinent to the key questions listed in the purpose of this report.

1. What inequalities are there in health status and access to services?
2. What are the most important causes of demand for health and social care for children and young people in Northamptonshire?
3. What patterns of behaviour in children and young people are likely to lead to entry to the care system and/or the specialist mental health system? How could these be changed?
4. What is the likely future need and demand for services to these two services, and associated costs, given current trajectories? How would these alter under plausible changes in those trajectories, including if those trajectories improved?
5. What would be the impact of these projections in terms of cost, staff time and numbers, foster placements, NHS beds and other practical units of resource use?
6. To what extent can interventions alter the future pattern of need and demand for health and social care for children and young people?
7. What can Northamptonshire do to improve the performance, resilience, sustainability and reputation of its services for children and young people?

This deep dive needs assessment used a range of activities to gather evidence and the views of some Northamptonshire staff, comprising:

- A review of a wide range of local documents and data sources
- A review of national policy documents and data sources
- Discussions and interviews with Northamptonshire CC, police and NHS staff
- A review of published evidence to address particularly the questions about entry to the care system and mental health services and to identify interventions which have the strongest evidence of success in preventing mental ill health
- A modelling exercise to analyse as far as was possible the importance of a range of risk factors.
- Drafting a report bringing the outcome of these strands of work together. This report highlights where there is evidence strong enough to allow a clear recommendation to be made, and where further work might be needed.

The modelling team had standard and specialist technical tools to address three specific questions:
1. Why is Northamptonshire such an outlier compared to other districts in the region regarding self-harm and mental health conditions hospital admissions for young people, and the numbers of looked-after children?
2. Are the high figures due to genuine higher numbers of ill health and need, higher capacity that is being filled, or higher referral behaviour at primary level?
3. What can be done to improve this and avoid future increases?

There were challenges in collecting and collating the information needed to answer the key questions including:

1. A recent change in public sector structures had led to discontinuities in the data gathered. For example, NHS trusts since April 2013 have provided a less detailed data set to commissioners, and some key items needed for monitoring trends which inform commissioning have been lost. For example, most of the data on mental health services data could not be split by district within the County. Other problems were caused by shifts in commissioning from local to national level, such as Tier IV CAMHS, which has moved to NHS England commissioners, and had entailed a substantial investment of the time of senior staff to build and maintain the detailed, current view of each individual necessary to ensure their needs were met at all points on their health and social care journey.

2. There were key data which were sparse or not available for review that PHAST had assumed would be up to date, available and well analysed. For example, it was not possible to obtain data by a number of dimensions, including by District, by social circumstances, by ages of those affected, by ethnicity or by other helpful axes, on domestic violence, or on abuse and neglect, within the County though these are well acknowledged to be strongly associated with C&YP receiving CAMHS or in the social care system.

3. Detailed data on some areas where there have been both new national requirements and an emerging understanding that there may be a local unmet challenge were not readily available, including that for child sexual exploitation. This has become an area where public sector bodies are expected to work to tackle a burden of need that incidents around the country suggest is important but not well understood in its scale. Similarly, there is little data collected in 5-year age bands up to age 25 as needed to support those with learning disabilities as they transition to adulthood.

4. The modelling part of this work sought to assess whether some parts of the county could be pinpointed for investment by showing that they had a greater burden of need. Unfortunately little data was collected by district, or by units smaller than districts. Similarly, little data is available by single year age bands or by relevant multi-year age bands. This meant that the modelling work could not be undertaken to yield the hoped for results.

5. There was commercial sensitivity around the re-commissioning and decommissioning of some Northamptonshire services. Some staff were therefore concerned about releasing funding data that might prejudice tendering work in progress at the same time as this work.
6. Information on workforce was incomplete and could not be used to assess the impact of service changes on staff needs.

These constraints mean that work on projections or change scenarios was not possible. Together they led to an underpinning recommendation on data for this report.

This report recommends that Northamptonshire CC and its partners should review how data is collected and analysed to improve commissioning of local authority services, NHS services, and services from other agencies, and improve its partnership working across sectoral boundaries. The review should set out where there are data gaps, and devise ways to fill these either using the internal resource, such as Northamptonshire Analysis team, the BIPI team, and the BIRT unit, or by work with others. Good, verified data agreed by all partners will greatly assist in monitoring activity and provide clear evidence when changes are needed.

Within Northamptonshire the County has to date been subdivided by local government and police into districts and by the NHS into localities. The two are not coterminous. There would be benefit for all in agreeing a single set of common sub-County divisions used across all public sector organisations. C&YP with problems with drugs and alcohol, for example, may receive services from local government, and from the NHS, and data would be more easily compiled and verified if these boundaries coincided. Similarly, Northamptonshire Self Harm Task Group could recast the data on deliberate self harm by districts rather than by localities. This should allow those working to reduce the rate of self harming to prioritise those parts of the County most in need of resources to support agreed actions.

There are some areas where contract negotiations will be needed, such as gathering data from NHS trusts where detail is no longer supplied as it was prior to the change of arrangements in 2013.

Data from primary care will be very helpful in examining some service use, for example, the assessment and treatment of asthma which has led to short hospital stays for Northamptonshire C&YP. Such analysis of primary care data is important prior to the health visitors move to the local authority.

Data should be collected from all providers up to age 25 to fulfil, for example, the need to commission services for those with learning disabilities post transition to adulthood.

Where possible, Northamptonshire CC, or those from whom it collects data, should compile data by single year of life and by household or individual to allow close mapping. Such data include domestic violence, C&YP in care, persistent absentees from school, youth offending, CAMHS use, mental ill health in the household, long term conditions, child poverty, and other indices of deprivation. This will allow very specific targeting of resources to those small areas which will yield greatest benefit. To achieve the greatest benefit from this work, Northamptonshire CC should work with a specialist team from whom it could learn the techniques of modelling and projecting data.
Local arrangements for services for children and young people in Northamptonshire

This section sets out information about the key bodies with responsibility for the health and wellbeing of C&YP in the County.

Northamptonshire has a strong track record of integrated working across health and social care characterised by a number of longstanding joint commissioning arrangements and governance structures.

The two Clinical Commissioning Groups in the County; NHS Nene CCG and NHS Corby CCG are recommissioning the majority of children’s community services during 2014, including child and adolescent mental health services (CAMHS), children’s community nursing and therapy services and Community Paediatrics. The Council is recommissioning its early help and prevention services, including the existing Children’s Centre Services and specialist support. Northamptonshire has an established a Troubled Families Programme and is commissioning additional support with alcohol and drug related problems where there are children in the family. The Council is reconfiguring Targeted Support Services to meet need and developing “step down” support for families who have previously been supported by social care.

Local organisations, partnerships and structures working with C&YP

There are several organisations and groups that work separately and together to promote good health and wellbeing for C&YP across the County.

1 Local Government

Northamptonshire has a two tier authority. The boroughs and districts provide leisure services and housing, while for C&YP Northamptonshire CC has lead responsibility for

♦ Child protection – Services designed to protect from physical, emotional, or sexual harm all children and young people who are underage and to encourage family stability

♦ Adoption – Services which cover support to those considering adoption, support to families throughout the adoption service, post-adoption support, with activities and services to help adoptees and adopting families at each stage

♦ Children’s Centres - There are 50 children’s centres in Northamptonshire which offer a variety of services to children under the age of five and their families, including family support, child and family health services, and education and childcare

♦ Children’s rights - Services for all children and young people who have a Northamptonshire social worker and young people that have left care to help make sure that they have a say about the way they are cared for

♦ Disabled children – Services for families with children aged 0-18 years, where the child has a disability or additional needs. These children often need services from more than one agency
Learning and education – Services encompass child minders, placements for under 2s, nursery, primary school, secondary school and post-16 education, as well as pupil referral units and special education. Across Northamptonshire there are

- 9 nursery-only schools
- 256 primary schools
- 3 middle-school only schools
- 35 secondary schools, of which 9 are Academies
- 2 pupil referral units, including one with hospital outreach services
- 12 special schools (though some are mainstream with SEN pupils)
- 4 All through schools
- 3 university technical colleges for pupils aged 14 – 19

There are 36 libraries. Apart from the learning resources provided, these run some extra services, including Bookstart for pre-school children, an elibrary scheme, homework clubs, Rhymetime for the under 5s, and holiday activities tailored to several age bands.

Fostering – Services to support looked after young people aged 10-18 years old who are in the youth justice system. The placements may be short term, permanent, remand, kinship (ie with someone connected to the young person), or family linked.

Looked after children – Services for C&YP who are looked after by the state, according to relevant national legislation. Some are subject to a care order or accommodated voluntarily. Northamptonshire CC has established a virtual school to which all looked after children belong (alongside the school where they are on roll). Virtual School exists to champion the educational needs of looked after children; improve the educational achievement of looked after children; and to raise awareness about every councillor’s responsibility towards the education of looked after children.

Some events and activities for children – services include library services, summer activities, music and performing arts events, and reading groups.

Services are organised according to four tiers of need.

Tier 1: Universal – Children, young people and families are generally progressing well and achieving expected outcomes. Their core needs are being met effectively by universal services without any additional support. Example local government services include mainstream schools and colleges; libraries and leisure services.

Tier 2: Early Help/Intervention – Children, young people and families are experiencing emerging problems which result in them not achieving expected outcomes. They are likely to require early help/intervention for a time limited period, to seek to move them back to Level 1. Example local government services include School Nurses (also Level
3); the Early Help Team for Disabled Children; Children’s Centres; and schools and colleges.

Tier 3: Targeted – Children, young people and families who are experiencing significant additional needs, which may be numerous or more serious/complex in nature. This is having a significant impact on their achievement of expected outcomes and is likely to require more targeted support, potentially from a number of agencies. This may require the identification of a lead professional to co-ordinate the support provided to the family. Example local government services include Targeted Prevention Services; Youth Offending Service; Children’s Centres (also Level 1 & 2); Connexions; and Social Workers.

Tier 4: Specialist – Children, young people and families who are experiencing very serious problems or have complex needs that are having a major impact on their achievement of expected outcomes. Their needs will be such that they require intensive support from specialist services. Example services include the Specialist Looked After Children Service; Children’s Continuing Care; Children in Need Team; Youth Offending Service (also Level 3); and Social Workers with specialist skills who work with complex cases.

Northamptonshire CC works with others in partnerships where appropriate.

2 NHS services

NHS services are commissioned through the 2 local clinical commissioning groups (CCGs). These are organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. For Northamptonshire there are two CCGs – Nene CCG which covers much of the county, and NHS Corby.

Local NHS services are provided through

♦ two acute trusts
♦ a community and mental health trust
♦ primary care at 387 GP surgeries
♦ dentists
♦ ophthalmologists
♦ pharmacists

Northampton General Hospital (NGH)

NGH is a district general hospital with a range of medical and surgical services. For C&YP services include maternity services, with a birthing centre and home birth team; a neonatal intensive care and special care unit; two children’s wards; outpatient services; a child development centre; and some specialist services such as hearing tests for newborns, and a bereavement service for children and adolescents. It also provides outreach nursing, children’s physiotherapy, and works with child protection and liaison teams. This hospital has a walk in centre, and provides services for most of the county.
Kettering General Hospital (KGH)

KGH provides general medical and surgical services mainly for the south of Northamptonshire and other counties. KGH has 35 maternity beds, a water birth unit, a neonatal intensive care and special care unit, a children’s ward, outpatient services and some specialist services such as for the assessment and treatment of squints.

Northamptonshire Healthcare Foundation Trust (NHFT)

Northamptonshire Healthcare NHS Foundation Trust provides a wide range of community and mental health services for C&YP across the county. Services include health visiting; CAMHS; services for C&YP with learning disabilities; services for C&YP in need of safeguarding; and sexual health services. The services are delivered in the child's home, GP practices, schools, or in a residential or hospital environment.

Tier IV mental health service provision for C&YP

Northamptonshire has a 10 space unit for C&YP with the most severe and complex mental illness (tier IV) within the County at The Sett. When the numbers of cases appropriate for this unit exceeded the number of spaces, Northamptonshire invested further and in December 2013 opened a second 10-bedded unit, The Burrows, in Berrywood Hospital in Duston (part of NHFT). This unit is open to C&YP outwith Northamptonshire, and at the end of December 2013, housed 2 young people from Northamptonshire.

For some very specialised interventions, and on occasions when local spaces are not available, Northamptonshire C&YP may be looked after in units outside County boundaries. At the end of December 2013 there were 7 such young people, mainly in units in neighbouring counties. There has been investment within Northamptonshire CC in a crisis intervention and home support team that has allowed the majority of C&YP with severe mental health illness to be cared for at or near home, with the NHS England Specialist Commissioner reporting that Northamptonshire very rarely refers inappropriately for a placement and is commonly quoted as a model that other counties are encouraged to replicate.

3 Police services

The police service offers general community safety and policing. Some services provide support to C&YP in particular, such as a domestic violence team, and the Sunflower Centre for those at high risk of domestic abuse. Police are well embedded within partnerships across the County, such as the CYPP, and child protection and safeguarding.

4 Local Safeguarding Children Board Northamptonshire

Local Safeguarding Children Board Northamptonshire (LSCBN) co-ordinates child protection work by all agencies in the county. It makes sure that all organisations in the county who work with children and families are cooperating to protect children and young people.

The LSCBN membership encompasses local government organisations ranging from schools to District and Borough Councils; NHS services including mental health service providers and ambulance services; third sector bodies such as the National Society for
the Prevention of Cruelty to Children (NSPCC); criminal justice organisations including police, probation and youth offending service; and Children and Family Court Advisory Service (CAFCASS)

5Northamptonshire Health and Wellbeing Board

Each local authority has a Health and Wellbeing Board that brings together a broad range of partners to agree and oversee a local strategy. The Northamptonshire strategy has been widely consulted on to reflect the views of both professionals and the wider community. A key plank of the strategy is to keep every child safe and give children the best start in life. It has set a priority target of increasing breast feeding prevalence by end of 2014 and has set four sub-targets to help achieve this:

1. 100% of Health Visitors to be trained in the Baby Friendly Initiative
2. 70% of all Children’s Centre staff to receive breast feeding awareness training
3. 10% of GP Practice staff to be trained in Baby Friendly Initiative
4. 50% of mothers still breastfeeding at 6 - 8 weeks.

6The Northamptonshire Children and Young People’s Partnership Board

The Children and Young People’s Partnership Board (CYPPB) was established as a result of the Children’s Act (2004), which places a duty on councils to promote co-operation between named partners to improve the well-being of children.

It brings together Northamptonshire’s District and Borough Councils; Northamptonshire’s CCGs; NHS England; the CYPPB; and local criminal justice organisations (youth offending service and police service)

The CYPP works closely with the LSCBN and has agreed a governance structure which links the two. It reports directly to the Northamptonshire Health and Wellbeing Board (NHWBB). The CYPP has published a plan for the years 2013 – 2015 which outlines priorities, key outcomes and proposals for action. The CYPPB has a number of Delivery Groups focusing on children with disabilities, Early Years, and CYP with emotional and mental health problems.

The priorities for 2013 - 2015 are

1. All children grow up in a safe environment.
2. All children and young people achieve their best in education, are ready for work and have skills for life.
3. All children grow up healthy, and have improved life chances.
4. Children who are looked after achieve at least as good outcomes as those who are not.

The LSCBN, as well as the other local bodies, has developed some strong partnership working practices, for example by establishing a multi-agency service hub (MASH). The MASH has streamlined processes across all partnership agencies, giving those professionals making decisions about vulnerable children quicker access to relevant information held by all organisations, so speeding up the response to that information.
This section has presented in brief the key organisations and partnership bodies which work to commission and monitor services for C&YP in Northamptonshire. Together they are responsible for the health and wellbeing of local C&YP.
What inequalities are there in health status and access to services?

This section of the report sets out some demographic details of children and young people in Northamptonshire. Narrowing the inequalities gap within the County would improve health and wellbeing, and the charts and maps within this section highlight the concurrence of deprivation with factors that impact the health of C&YP, such as lone parent households, and worklessness within the household. It draws on local intra-County work which highlighted the disparity between deprivation and service use.

Demographic information

The list below contains some basic facts about health and wellbeing of C&YP in Northamptonshire. There is a wealth of detail available on local inequalities, but those below have been chosen to highlight the areas of social care and mental ill health with which Northamptonshire has been concerned.

- Children and young people (0-19 years) make up 25% (176,015) of the 2013 population of 710407, with variations across the districts and boroughs.
- 32% of the children and young people population live in Northampton borough, with no other district or borough having more than 13% of the total children and young people population. Corby is one of the most deprived parts of the County but has the fewest C&YP. Elsewhere in England deprivation is associated with a higher proportion of C&YP, so Northamptonshire is unusual in this respect.

There is population information for Northamptonshire County as a whole below. It is typical for a county in England, but does not highlight the significant differences in the shape and experience of the populations within the constituent districts. The population pyramids of the districts within the County are set out below to show some of these differences.
There are only slight differences in the gender split of the population at a County level and at a district and borough level. In most districts and boroughs there are slightly more children and young people who are males, whilst there are slightly more adults who are female. This is a common picture across England.

In 2021, the County’s children and young people population is predicted to increase by 12% (20,652) compared to 2011 population figures. Again, there are differences across the County, with Corby seeing the greatest predicted increase (23%).

Around 68% of C&YP live in urban areas, 20% live on the fringe of conurbations and 12% live in villages, hamlets and isolated dwellings.

Northampton (22.4%) and Wellingborough (16.6%) have the largest proportion of 0 to 19 year olds from a black and minority ethnic background.

In 2005 there were 8,268 live births which increased to 9,288 in 2012.

Northampton had the highest number of live births in 2009 (3250).

South Northamptonshire has 400 extra reception year children entering school when comparing the number of live births that were recorded four years previously. This suggests that families may move into Northamptonshire with children of pre-school age, or that people living in neighbouring counties prefer Northamptonshire schools for their children’s education.
Population

In the figure below are population projections drawn from ONS data from mid-2011. These show only slight differences in the gender split of the population at a County level and at a district and borough level. In most districts and boroughs there are slightly more children and young people who are males, whilst there are slightly more adults who are females.

Figure 2: Gender and age breakdown of population in 2013 (ONS mid-2011 data)

<table>
<thead>
<tr>
<th>2013</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-19</td>
<td>20+</td>
<td>0-19</td>
<td>20+</td>
</tr>
<tr>
<td>Corby</td>
<td>50.4%</td>
<td>48.9%</td>
<td>47.3%</td>
<td>51.1%</td>
</tr>
<tr>
<td>Daventry</td>
<td>51.7%</td>
<td>49.6%</td>
<td>48.3%</td>
<td>50.4%</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>52.4%</td>
<td>48.7%</td>
<td>47.6%</td>
<td>51.3%</td>
</tr>
<tr>
<td>Kettering</td>
<td>50.6%</td>
<td>48.6%</td>
<td>49.4%</td>
<td>51.4%</td>
</tr>
<tr>
<td>Northampton</td>
<td>50.2%</td>
<td>48.9%</td>
<td>49.8%</td>
<td>51.1%</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>52.0%</td>
<td>48.6%</td>
<td>48.0%</td>
<td>51.4%</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>51.5%</td>
<td>49.5%</td>
<td>48.5%</td>
<td>50.5%</td>
</tr>
<tr>
<td>NORTHAMPTONSHIRE</td>
<td>51.0%</td>
<td>48.8%</td>
<td>49.0%</td>
<td>51.2%</td>
</tr>
</tbody>
</table>

Source: ONS Mid-2011 Population Projections

The distribution of children and young people varies across the County. Generally, the 0 to 4 year old population are more prevalent within Corby, Northampton, Kettering and Wellingborough. East Northamptonshire, Daventry and South Northamptonshire have a higher proportion of school aged children (aged 5 years and upwards).

Despite the variation in the children and young people five year age groups, the gender split across these groups are close to equal.
Population pyramids of CYP by district compared to Northamptonshire County

These pyramids show the percentage of males and females at 5 year age bands.

Figure 3: Corby 2013 population pyramid

Source: ONS Mid-2011 Population Projections

Corby has the largest number of under5s of any district in the County, with fewer children at age 5-9, though the prevalence is still greater than the average for the County. This has implications for commissioners, who will use this data to inform decisions on the provision of services such as children centres, nurseries, and schools in the coming years. District and borough commissioners similarly use this information to agree provision of libraries, leisure and housing to meet local demand.
Daventry has a fairly uniform pyramid, though numbers diminish when adulthood is reached (20 – 24 years). There are several possible reasons for this, for example, it may be that young adults leave Daventry to attend educational establishments or to take up employment elsewhere.

Source: ONS Mid-2011 Population Projections
East Northamptonshire has a uniform pyramid up until the 15-19 age band, but with fewer in the young adult (20 – 24) age band. As in Daventry, it may be that young adults leave East Northamptonshire to continue education or find employment.

**Figure 6: Kettering 2013 population pyramid**

Source: [ONS Mid-2011 Population Projections](#)

Kettering has many under5s living in the district, with a pyramid showing slight diminution of numbers at each 5-year age band. Commissioners can use information on these population reductions when deciding on provision of services for C&YP such as Children’s Centres, nurseries and schools, as well as other services for C&YP such as leisure facilities and libraries.
Figure 7: Northampton 2013 population pyramid

Source: ONS Mid-2011 Population Projections

Northampton has many babies and children under age 5, but fewer children between 5 and 14 years. This should inform those commissioning services such as Children’s Centres and nurseries. In adulthood (ages 20 – 24) numbers rise again. It may be that some of this number are studying at centres of further and higher education.

Figure 8: South Northamptonshire 2013 population pyramid

Source: ONS Mid-2011 Population Projections
South Northamptonshire has a fairly uniform pyramid though with lower numbers between ages 20 and 24.

**Figure 9: Wellingborough 2013 population pyramid**

Source: ONS Mid-2011 Population Projections

Wellingborough has a uniform pyramid though with somewhat higher numbers of pre-school babies and children than some other districts, with a shape similar to those more urban districts such as Corby, Kettering and Northampton.

**Figure 10: Northamptonshire 2013 population pyramid**

Source: ONS Mid-2011 Population Projections
Key: The added line to either side of the pyramid shows projected population for Northamptonshire in 2017.

The Northamptonshire population pyramid shows that the numbers of girls and boys under 10 (but especially girls) will grow. There will be a greater number of girls than boys under 10, but a greater number of boys than girls in the years 10 to 20. Population projection figures suggest that Northamptonshire expects to have an even greater number of girls in 2017, with girls outnumbering boys somewhat more than at present. Population projects for 2017 suggest that the numbers of people of both genders age 20 to 24 will decline slightly from those at present.

Figure 1 below suggests that the greatest increase in population is expected in Corby.

It is useful to note the distribution of pre-school age children across the County, since they will require services to be appropriately expanded and located in the places these families will reside. For example, primary care services will need to expand to cope with the high number of pregnancies, babies and young children; NHS trust maternity services will need to expand to cope with the extra births; Children's Centres, nurseries and schools will need to provide sufficient capacity for the extra children; and housing and other local government commissioned services will need to be supplied to meet any higher demand.

The map below is of population density of children and young people. It demonstrates that most live in towns, though even within towns there are substantial variations. Outside Northampton the south western half of the County is less densely populated than the north eastern half.

**Figure 11: Map of Northamptonshire population for those aged 0 - 19**
This map shows the relative uniformity of population density across the County. There are a few areas with a density greater than 1000 per population in some urban areas. There is an area with dense population of 0 – 19 year olds in the North East of the County coterminous with Oundle and may reflect the presence of the large school there with approximately 1100 pupils.

When looking at the population at middle level super output area\(^1\), it is evident that there are pockets of more densely populated areas of children and young people aged 0 to 19 years.

Around 68% of children and young people live in urban areas, 20% live on the fringe of conurbations and 12% live in villages, hamlets and isolated dwellings.

**Population projections**

\(^1\) Super output areas are a geography for the collection and publication of small area statistics. Middle level super output areas are automatically computer generated, fit within local authority boundaries, and have a minimum size of 5,000 residents and 3,000 households with an average population size of 7,500. Super output areas are used nationally in Neighbourhood statistics.
The total population of Northamptonshire is expected to increase from 693,967 in 2011 to 774,832 in 2021. This is a total increase of 12% (approximately 80,000 people). The population aged 0 to 19 is expected to increase by 20,000 between 2011 and 2021, with yearly increases of approximately 2,000.

There is some variation across the districts and boroughs within the County. Corby is expected to have the steepest of increases of children and young people; an increase of 23% by 2021.

**Figure 12: Population projections of CYP by district, 2011 to 2021**

Comparing the population in 2013 to 2007, the population aged 0 to 14 has increased across Northamptonshire, with some variation across the districts. However the population aged between 15 and 24 has decreased with the exception of Northampton, the only district to experience an increase in those aged 20-24. The overall County pattern matches that of national figures.

Source: [ONS Mid-2011 Population Projections](https://www.ons.gov.uk)

Source: [Local Health, Public Health England](https://www.gov.uk)
Figure 13: Population change by age group and by district, 2007 to 2013

This figure demonstrates the growth in the younger age groups across all districts, with a reduction in those from ages 15 and upwards. This may reflect young people leaving the County on adulthood. Information from this figure is useful for planning and commissioning services across the County. For example, some of those leaving in young adulthood may do so because there is a lack of employment locally, and local government will wish to support sources of employment that can be attracted to come to Northamptonshire. Alternatively, young adults may leave because they cannot find affordable housing, another area where local public sector bodies could support housebuilding which includes reasonably priced dwellings as part of any agreed development.

Other services can use this data for planning, including NHS primary care and secondary care services, and services within the criminal justice system. The population projections shown in the Northamptonshire population pyramid for 2017 suggests that there will be a greater number of babies and children for whom services will be needed, and public sector agencies need to balance this new source of demand with those demands described here, all within constrained budgets.

Adulthood and life outcomes

Life expectancy at birth, shown in the figure below, varies across the County by more than 10 years (on 2006 to 2010 data), with Corby men lagging well behind men and women in all other districts. South Northamptonshire and Wellingborough women appear to enjoy the longest life expectancy. Men in South Northamptonshire have the longest

Source: ONS Mid-2011 Population Projections
life expectancy in the County at 80.5 years. This discrepancy of approximately 10 years between more affluent and less affluent areas represents a stark indicator of inequalities.

**Figure 14: Life expectancy at birth by district, 2006-10**

![Life expectancy chart]

Source: **Local Health, Public Health England**

**Deprivation**

The level of child poverty, at 15.8% across the County, mirrors the overall levels of deprivation. Northamptonshire has lower levels of child poverty than the England average of 21%\(^2\). Both poverty and deprivation are more prevalent within the more urban areas of Northamptonshire, where the population is denser.

The figure below shows that some districts have sizeable numbers of children living in poverty.

\(^2\) PHOF 2013, using 2011 figure
The chart showing the percentage of children living in poverty can be compared to the plot below of the percentage of children in lone parent households. There are great similarities, with Corby, Northampton and Wellingborough being the districts with the highest proportion in both cases. It suggests that lone parenthood and child poverty are associated.

Source: [Northamptonshire Analysis](#)

Figure 16: Lone parents with dependent children, 2011

Source: [ONS, Census 2011](#)
Lone parents are often women who stay at home to look after their children and either do not work, or work less than full time, and often in poorly paying jobs that allow them to fulfil their homemaker role. This is a recognised picture nationally.

The map below shows this information on deprivation geographically. It uses the national standard dimension of deprivation\(^{11}\), ie income deprivation; employment deprivation; health deprivation and disability; education deprivation; crime deprivation; barriers to housing and services deprivation; and living environment deprivation.

**Figure 17: Map of Northamptonshire showing the distribution of deprivation**

Source: Department for Communities and Local Government

Urban areas – Northampton, Corby, Kettering, Daventry and Wellingborough - contain the greatest number of wards with higher deprivation. The map mirrors the findings from the charts of child poverty and of lone parents with dependent children, showing that these groups live mainly in the most deprived districts. Maps below reinforce the
association of deprivation with other indicators of inequality such as the number of people claiming job seekers allowance, and the number of children living in workless households. These households live chiefly in the urban areas, where the impact of inequalities on health and wellbeing are demonstrated in later sections where information on the distribution of families with a looked after child, or in receipt of mental health services, or being a victim of domestic violence, are seen to be closely associated with deprivation.

**Figure 18: Map of Northamptonshire showing the percentage of 0 – 15 years olds living in income-deprived households**

![Map of Northamptonshire showing the percentage of 0 – 15 years olds living in income-deprived households](image)

Source: Department for Education

This map confirms the association of poverty with deprivation and with urban living. It has been recognised, however, that rural poverty may be important but less obvious than urban poverty since the numbers of households are small. According to research carried out by Loughborough University, on behalf of the Joseph Rowntree Foundation, the cost of living in rural areas can be significantly higher than in urban centres. Figures from 2012 estimate that a family with two children living in a remote hamlet in England often need £80 more per week to get by than their city counterparts, mainly due to higher travel costs and more expensive energy bills.
Figure 19: Map of Northamptonshire young people receiving job seekers allowance

Source: ONS, NOMIS

Map of Northamptonshire showing distribution of deprivation (for comparison)

Source: Department for Communities and Local Government
The map of young people receiving jobseekers allowance closely aligns with that of income deprived households, as does the map of under school age children living in a household where nobody is in work.

**Figure 20: Map of Northamptonshire showing distribution of people living in workless households (2011)**

Source: Department for Work & Pensions

Map of Northamptonshire showing distribution of deprivation (for comparison)

Source: Department for Communities and Local Government
The chart below shows family homelessness in Northamptonshire in 2011/12.

The chart showing family homelessness in Northamptonshire in 2011/2012 reveals that homelessness in Northamptonshire is double both the East Midlands and England average. Homelessness is a key determinant of poor life outcomes for C&YP. There is strong evidence that acting to improve the wider determinants of health, such as employment, housing and improving the health status of mothers and babies has the greatest impact on improving the health and wellbeing of the whole community.

**Figure 21: Family homelessness in Northamptonshire in 2011/12**

![Family Homelessness Chart](chart.png)

Source: Child Health Profiles 2013, ChiMat

Note: Family homelessness represents statutory homeless households with dependent children or pregnant women per 1,000 households, 2011/12 data

Whilst these maps and charts are unsurprising in their similarity, they are a useful means of highlighting those areas where public sector support is likely to be needed for children and young people. As is clear in the Marmot 2010 report, giving children the best life chances improves both the quality and length of life.
Ethnicity

Black and minority ethnic group populations vary by district and borough. Northampton (22.4%) and Wellingborough (16.6%) had the largest proportion of 0 to 19 year olds from a black and minority ethnic background as recorded in the 2011 census.

The other districts and boroughs (Corby, Daventry, East Northamptonshire, Kettering and South Northamptonshire) recorded BME proportions below the Northamptonshire total of 12.4%.

Figure 22: Black and ethnic minority (BME) population by district, 2011

Source: ONS, 2011 Census

Note BME is the sum of: English/Welsh/Scottish/Northern Irish/British, Irish, Gypsy or Irish Traveller, Other White, Mixed/multiple ethnic group, Asian/Asian British, Black/African/Caribbean/Black British and Other Ethnic Group

Maternal, baby and child health

The early picture of health among C&YP in Northamptonshire is similar to that of England as a whole. The infant mortality rate is 4.4 per 1000 per year, and the child mortality rate is 11.3 per 100,000 per year, both similar to the England rates.

The proportion of babies born with low birthweight (less than 1500g), and the proportion that are obese at age four to five years are average for England, while the proportion of children obese at age 10 to 11 years is significantly lower than for England. Other child health markers where Northamptonshire is significantly better than average include:

- hospital admissions related to alcohol
breastfeeding initiation

- accident and emergency attendances before age five years
- admissions to hospital for asthma.

However, the County has significantly worse results than England for

- GCSE achievement
- family homelessness
- participation in physical education in schools
- tooth decay
- the proportion of births to girls under 18 years
- hospital admissions for substance misuse, mental health problems and (in one year) self-harm.

The health of women in pregnancy is important for giving children a healthy start in life. Both the recent Marmot report *Fair Society, Healthy Lives*, and the 2012 Chief Medical Officer Report *Our Children Deserve Better – Prevention Pays* stress the importance of maternal good health, and of giving children the best possible life chances. Both these and other work reviewed for later sections of this report strongly encourage investing in support to women during pregnancy and in the early years of motherhood.

The evidence suggests that programmes such as Family Nurse Partnership (FNP), present in Northamptonshire already, have a substantial impact on the health and wellbeing of both mother and child. Positive impact is demonstrable well beyond the 2 years of support the FNP programme offers. Studies in the USA have shown that, at age 4, children from households which have received support from FNP visited emergency treatment centres less frequently than those from a similar background who had not (on average 1 visit per child to emergency vs 1.5 for the control group). Impressively, the impact appears to continue into the teenage years. At age 15 there is evidence of less child abuse, fewer subsequent pregnancies, fewer months on welfare, and fewer arrests. Northamptonshire CC has embraced FNP and is recommended to continue to invest in the service, adhering strictly to all criteria as it does currently.

**Breastfeeding**

Breastfeeding offers the best start for babies. The figures below show the status of breastfeeding in Northamptonshire. The breastfeeding trend in Northamptonshire plateaued at its highest for both initiation and at 6-8 weeks between 2010 and 2012 but has dropped off since 2012. There is a significant drop off from initiation to 6-8 weeks, which seems to occur largely in the first 2 weeks.

Nationally numbers of women breastfeeding have increased over the same period. This report recommends investment in encouraging breastfeeding (note that FNP mothers are supported in breastfeeding). Exclusive breastfeeding is recommended by the World Health Organisation (WHO) up to six months of age, with continued breastfeeding
alongside appropriate complementary foods up to two years of age or beyond. Northamptonshire has recently signed up to become a baby friendly county and the actions needed to achieve this should positively impact the numbers of mothers breastfeeding.

**Figure 23: Percentage of Northamptonshire mothers initiating breastfeeding and breastfeeding at 6 to 8 weeks of age between 2007/8 and 2012/13**

![Figure 23](image)

Source: Pippa Gilbert, personal communication

**Figure 24 Percentage of Northamptonshire mothers breastfeeding during 2012/13 at intervals following the birth of a child**

<table>
<thead>
<tr>
<th></th>
<th>Initiation</th>
<th>Discharge</th>
<th>10-14 days</th>
<th>6-8 weeks</th>
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</thead>
<tbody>
<tr>
<td>2012-2013</td>
<td>73.00%</td>
<td>64.00%</td>
<td>54.22%</td>
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</tbody>
</table>

Source: Pippa Gilbert, personal communication
Many women decide how to feed their babies before they deliver, so it is important that they listen to advice antenatally. As the Health and Wellbeing Board breastfeeding strategy is implemented Northamptonshire will wish to ensure midwives are trained to strongly encourage, and support, new mothers in breastfeeding. Similarly, it will be important to strengthen links with the local National Childbirth Trust and other third sector groups who support pregnant women locally.

**Low birth weight babies**

Babies born at low birth weight are generally less resilient than those born at a normal weight. In Northamptonshire the map below demonstrates that a high proportion of these babies is born to mothers living in areas of greatest deprivation, but extends to other parts of the County. There are low birth weight babies born in and around Wellingborough and in some non-urban areas. The reason for this distribution is not known. Informal discussion confirmed that local health and public health professionals knew of this unexpected distribution but had not found any satisfactory explanation. They had explored known risk factors including a maternal age of 17 years or less; a maternal age of over 35 years; mothers from socio-economic class IV or V; smoking with or without drugs or substance abuse; mothers who had delivered a previous low birth weight baby; multiple pregnancy; the presence of congenital fetal anomalies; and intrauterine infection. These can, singly or together, lead to low birth weight babies either due to prematurity, or babies who are small for gestational age, or both.
Between 2005 and 2012, the number of live births in Northamptonshire steadily increased. In 2005 there were 8,268 live births which increased to 9,288 in 2012. There is some variation across the districts and boroughs, where as expected, the more densely population areas such as Northampton have the majority of births.

Using seasonality and existing trends to forecast future numbers of live births, the change from current figures in 2013 projected to 2017 show that Daventry, East Northamptonshire and South Northamptonshire may see a decrease in the number of live births. The urban areas of Northampton, Kettering, Daventry and Wellingborough look set to have a rising number of births. All these urban areas have higher proportions of deprived populations than much of the rest of the County, so helping these babies to get the best start in life is important.
Figure 26: Forecasted change in the numbers of live births in 2017

<table>
<thead>
<tr>
<th>District</th>
<th>Change from 2013-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corby</td>
<td>114</td>
</tr>
<tr>
<td>Daventry</td>
<td>-24</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>-90</td>
</tr>
<tr>
<td>Kettering</td>
<td>58.6</td>
</tr>
<tr>
<td>Northampton</td>
<td>137</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>-33</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>40.2</td>
</tr>
</tbody>
</table>

(a negative value denotes a decrease) Source: ONS Mid-2011 Population Projections

Figure 27: Number of live births by district in 2005-2012, including projected estimates 2013 to 2017

Source: ONS, Vital Statistics
**Immunisations**

Rates of childhood immunisation in Northamptonshire are significantly higher than average for England, except among children in the social care system, in whom rates are significantly lower than in such children in England as a whole. For example, in 2013, 97.8% of Northamptonshire’s babies had completed the diphtheria, tetanus, polio, pertussis, and Hib immunisations by age 2 years, compared with the national average of 96.1%. However, the same is not true of babies and children who are looked after, where the percentage in 2013 was 73% compared with the national average of 82.1%. The gap between Northamptonshire, East Midlands and England rates has remained for some years.

**Figure 28: Trends in immunisation status among looked after children 2008 to 2012**

Source: Child Health Profiles, ChiMat
Infant mortality

Figure 28: Trends in infant mortality per 1000 live births

Northamptonshire had a lower rate of infant mortality than the rest of the East Midlands across the years from 2003 to 2011, though the rest of the region improved to reach their rate of 4.4 per 1000 births, the same as the national average. However, this picture is not uniform across the county. The chart below demonstrates the differences between districts.

Source: Child Health Profiles, ChiMat
Figure 29: Infant mortality rates by district, 2009-2011

The highest rates are found in East Northamptonshire, Northampton and Wellingborough, reflecting as expected the relative deprivation within the two urban areas, but less easy to explain in East Northamptonshire, a less deprived area. It is noteworthy that Corby, one of the most deprived districts in the County, and Daventry, a relatively deprived urban district, have infant mortality rates well below the Northamptonshire average.

These findings should be further examined. Informal discussion with local professionals has shown that these differences between districts are known but that no clear reasons have yet been found.

Live births versus school entry

The number of live births in 2009 (where it has been assumed that the majority of reception year children are aged 4 years old) has been compared with the number of reception year entrants in 2013 by district.

The number of reception year children entering school across the districts in Northamptonshire, generally match the number of live births four years before.

However, there are two districts that show a different picture: Northampton, which had the highest number of live births in 2009 (3250), and South Northamptonshire which had over 400 more reception year children entering school than the number of live births. There is a range of explanations for this observation. The variation in the numbers may be due to factors such as migration flows in and out of the areas; or
children who were not picked up in the cohort due to being slightly older or younger than the standard for school entry; or people living outside Northampton may be choosing to send their children to schools within those districts.

**Figure 30: Number of live births in 2009 compared with reception year entrants in 2013 by district**

The maps and chart above paint a basic picture of Northamptonshire and its constituent districts. There are several sources of indicators that illustrate other aspects of local demography, including CHIMAT profiles and Public Health Outcome Framework local profiles.

Source: Vital Statistics, ONS and Northamptonshire CC.
Children at school

The 2012 Chief Medical Officer and 2010 Marmot reports, as well as the evidence reviewed by the 2011 Allen report (see page 150 and onward) all set out the importance of participation in exercise. There was an all-England survey in 2009/10 of participation in exercise at school by academic year using 120 minutes of exercise per week as the success measure.

Figure 31: PE and Sports survey results, 2009 to 2010

Northamptonshire C&YP took more exercise than the average for England as a whole up until academic years 12 and 13. The substantial decline in sport participation is not explained but could be due to attendance at colleges or centres of further education rather than remaining at school. The transition of young people to separate centres for post-GCSE study has been noted widely to coincide with a fall in participation in exercise.

It would be useful to look at exercise within Districts to assess whether participation in regular exercise, a good indicator of future good health and longer life span, reflects the distribution of deprivation or not.
**Obesity**

Northamptonshire data on obesity demonstrate a sizeable public health challenge for the county. Measurement has shown that at year 6 (~11 years old) obesity rates are well above what might be expected.

**Figure 32: Obesity prevalence of year 6 children in Northamptonshire, 2009/10 to 2015/16**

The obese C&YP are not evenly distributed across the county, but are concentrated in some more urban areas, particularly Corby, parts of Northampton, Daventry and Wellingborough. The maps below show this, and demonstrate also that obesity is a much greater problem in year 6 than in reception. It appears that once children go to school the numbers classed as obese rise across the County.

Obesity is an indicator of poor adult health and a shorter life span and is associated with deprivation. The message of the figures on educational attainment and obesity lead to the conclusion that deprivation, poor health and lower educational achievement are
linked. This again highlights the importance of all local agencies working together to tackle the wider determinants of health for maximum impact.

**Figure 33: Map showing percentage of children in Year 6 classified as obese, 2009/10 to 2011/12**

Source: Local Health, PHE
Figure 34: Map showing percentage of measured children in Reception year classified as obese, 2009/10 to 2011/12

Source: Local Health, PHE
Educational attainment

Educational attainment is a determinant of health and wellbeing in adult life. The chart below sets out the GCSE attainment of 5 GCSE in the grade range A* to C across the County.

**Figure 35: GCSE Attainment, 2011-12**

South Northamptonshire pupils achieve above the Northamptonshire average and live in the least deprived district of the County. Pupils from Corby and Northampton live in two of the most deprived districts and achieve GCSE grades below the County average. Other districts do not follow the association of deprivation with poor achievement. It could be useful to analyse educational attainment across the ethnic communities of the County.

Wellingborough children live in a deprived urban setting but gain GCSE grades at the Northamptonshire average. There could be a particular community living in the town who put great value on education, with their C&YP having strong home encouragement; or there may have been greater investment in the schools in that district which has led to a substantial rise in standards. Northamptonshire CC may wish to examine this and apply any findings in other districts.

Work by Dr J Campion in 2012 showed that Northamptonshire had a higher number of fixed period exclusions 7.8% (England 6.5%) and permanent exclusions 0.12% (England 0.08%) from school. The figures cannot be analysed by district, but it could be that these pupils were chiefly from the areas of poorest educational attainment, ie the areas of greatest deprivation.
Section summary

Northamptonshire has an unremarkable population picture at the County level, with 25% of its residents being C&YP, and urban centres having those living with the greatest deprivation. However, there are some points to note:

♦ The population is expected to grow over the coming 5 years, especially in some urban areas, such as Corby, with the rise in numbers of children will have implications for health, education and social service provision. On 2006 to 2010 data, there are 10 year differences in life expectancy within Northamptonshire, with Corby men lagging behind men and women in all other districts.
♦ Family homelessness is approximately twice the East Midlands and England average. This is such a key determinant of health and well being that this report recommends action to provide housing for those in need.
♦ The geographical distribution of low birth weight babies, and of infant mortality, do not follow closely that of deprivation, though no obvious reasons could be found.
♦ Among Northamptonshire mothers, numbers breastfeeding at 6 to 8 weeks have fallen recently, and efforts to redress this should be redoubled. Supporting pregnant women, new mothers and their babies in the first two years is very important: evidence shows the long term positive impact this has on the whole family.
♦ As in many parts of the country, obesity is common within Northamptonshire and is a challenge that requires work in a range of settings, such as schools, children centres, and primary care. Published evidence supports participation in sport at school as an important element of this work

There are two recommendations arising from this section.

This report recommends that Northamptonshire CC take action to address family homelessness alongside actions to narrow the inequalities within the County.

This report recommends that immunisation rates for C&YP in social care, at 72%, should be improved to meet at least the England average, currently 82%. 
The most important causes of hospital admission of children in Northamptonshire

This section examines hospital admissions for C&YP across Northamptonshire for some common conditions. It sets out some thoughts on activities which might reduce hospital admissions.

Common causes of hospital admission

The most important causes of unplanned admissions of children include asthma, diabetes and epilepsy. In 2011/12, Nene CCG’s standardised rate of unplanned admissions of people under 19 years for asthma, diabetes and epilepsy was the highest in the East Midlands (Figure 36). Corby’s was close to the regional average.

Figure 36: Directly age-standardised rates of hospital admission for asthma, diabetes and epilepsy in people under 19 years, East Midlands, 2011-12

* Vertical bars are 95% confidence intervals

Source: Public Health England

Looking at specific diagnoses, Northamptonshire’s admission rates are the highest in the region for diabetes (Figure 37) and epilepsy (Figure 38), and the second highest for asthma (Figure 39). In all three cases, the differences between Northamptonshire and the East Midlands average were statistically significant. However, average lengths of stay
in Northamptonshire for these children were the shortest in the region for diabetes and epilepsy, and below average in asthma (Figures 40, 41 and 42). The number of bed-days to which these admissions gave rise is correspondingly low.

**Figure 37: Directly age-standardised rates per 100,000 of hospital admission for diabetes in people under 19 years, East Midlands, 2011-12**

![Graph showing diabetes rates](image_url)

Source: Public Health England

**Figure 38: Directly age-standardised rates per 100,000 of hospital admission for epilepsy in people under 19 years, East Midlands, 2011-12**

![Graph showing epilepsy rates](image_url)

Source: Public Health England
Figure 39: Directly age-standardised rates per 100,000 of hospital admission for asthma, people under 19 years, East Midlands, 2011-12

Source: Public Health England

Figure 40: Average length of inpatient stay after unplanned admission for diabetes, days, people under 19 years, East Midlands, 2011-12

Source: Public Health England
Figure 41: Average length of inpatient stay after unplanned admission for epilepsy, days, people under 19 years, East Midlands, 2011-12

Source: Public Health England

Figure 42: Average length of inpatient stay after unplanned admission for asthma, days, people under 19 years, East Midlands, 2011-12

Source: Public Health England
These high rates of admission but short lengths of stay are unlikely to arise from higher prevalence of these conditions. One explanation is that primary care management of the diseases in Northamptonshire is leading to more children presenting as emergencies because of the occurrence of symptoms and/or parental anxiety. Another possible explanation is that paediatricians in Northamptonshire are more likely to admit children with these conditions than their counterparts elsewhere.

These admissions are usually very short, suggesting that the child was not seriously ill, and perhaps that the admission could have been avoided. The data suggest the issue is largely with Nene CCG since the numbers of admissions from Corby are smaller and the two CCGs share some providers.

**A&E attendance across Northamptonshire**

The all-cause rate of attendance of Northamptonshire children at accident and emergency departments is significantly lower than the East Midlands average (Figure 43).

**Figure 43: Unstandardised rates of accident and emergency attendance per 1000, people under five years, East Midlands, 2010-11**

Source: Public Health England
PHAST was not able to obtain further information on the diagnoses which led to admissions of children and young people in Northamptonshire, nor on the causes of disability in Northamptonshire children and young people.

**Section summary**

*The charts above set out information on hospital admissions for C&YP. They demonstrate that for asthma and epilepsy rates of admission were high, though lengths of stay were often short. Further work to elucidate the causes of this would be of benefit.*

There is one recommendation from this section.

This report recommends Nene and Corby CCGs investigate the reasons for the high number of short admissions for common conditions among C&YP.
Access and inequalities

This section reviews local data on access to services and demonstrates that there may be inequality of access across the County.

A local report on early health needs and an accompanying analysis prepared for Northamptonshire CC in May 2013 has a ‘tartan quilt’ table showing where within the County investment should be targeted to improve the match between need and access (using measures such as deprivation and community safety as proxies for need). The findings were that these localities would benefit from targeted investment:

- Northampton: town centre (Castle, Spencer and St James wards) and eastern district
- Wellingborough: town centre (particularly Croyland, Hemmingwell and Queensway wards)
- East Northants: Higham Ferrers (particularly Irlhlingborough wards)
- Daventry: the south part of the town (particularly Drayton and Hill wards)
- Corby: town centre (particularly Kingwood, Central and Exeter wards)
- Kettering: town centre (particularly Avondale, St Michael and Wickstead and William Knibb wards)

Within the same report there are maps of:

- Rate of contacts to children’s social care per 1,000 children
- Rate of Child In Need cases per 1,000 children ages 10-17
- Rate of Child Protection cases per 1,000 children aged 10-17
- Rate of domestic violence related contacts to children’s social care per 1,000 children
- Rate of abuse and neglect related contacts to children’s social care per 1,000 children
- Percentage of pupils excluded for a fixed period from school
- Rate of first time entrants to the criminal justice system per 1,000 young people aged 11 and over

All these maps demonstrated the greatest numbers of C&YP in each case were to be found in the MSOAs of greatest deprivation. There was a clear association between the numbers of children in child protection, the numbers suffering abuse and neglect, and the numbers where domestic violence had led to contact with social care.

Local data from which those maps were drawn could not be obtained. The PHAST team had hoped to use that data to address the modelling and projection questions posed by Northamptonshire CC (see page 24, PHAST approach), but were unable to do so.
Table 1 below lists local services within each district in Northamptonshire. The more deprived districts, with their greater need, would benefit from a greater availability of services. Northampton has the largest number of children and also the highest number of services. Corby has the fewest children and the fewest services. In these simple numerical terms, services are distributed equally. However, Corby is the most deprived district but has the fewest services, which suggests there is a possible inequity of distribution when considered against need.

It is to be expected that urban areas have a higher number and density of services than rural areas. However, Corby is classified as an ‘Other Urban’ district and has the fewest services. South Northamptonshire is classified as an R80 district but has the second highest number of services.

The table does not provide sufficient information to decide whether there are definitely inequities. For example, it could be that sites in the more deprived districts are larger, better resourced, and with a wider range of services than those elsewhere. It would be useful to undertake an analysis of the ratio of C&YP to services as a next step, and to act to match service availability to need wherever possible.
Table 1: Count of key services, children aged 0-18 and average IMD decile for districts in Northamptonshire

<table>
<thead>
<tr>
<th>District</th>
<th>Urban or Rural*</th>
<th>Urban IMD 2010 decile</th>
<th>Total children aged 0-18 MYE 2012</th>
<th>Rank of total children aged 0-18 MYE 2012**</th>
<th>Rank of total number of services**</th>
<th>Children’s Centre</th>
<th>GP</th>
<th>Hospital</th>
<th>Library</th>
<th>Police Station</th>
<th>School</th>
<th>Walk-in centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corby</td>
<td>OU</td>
<td>8</td>
<td>15678</td>
<td>7</td>
<td>4</td>
<td>9</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>28</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Daventry</td>
<td>R80</td>
<td>4</td>
<td>17800</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>44</td>
<td>0</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>R50</td>
<td>5</td>
<td>20820</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>14</td>
<td>0</td>
<td>6</td>
<td>2</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Kettering</td>
<td>SR</td>
<td>5</td>
<td>22493</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>41</td>
<td>3</td>
</tr>
<tr>
<td>Northampton</td>
<td>OU</td>
<td>6</td>
<td>51709</td>
<td>1</td>
<td>1</td>
<td>16</td>
<td>31</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>77</td>
<td>2</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>R80</td>
<td>3</td>
<td>19943</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>16</td>
<td>0</td>
<td>6</td>
<td>2</td>
<td>59</td>
<td>0</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>SR</td>
<td>6</td>
<td>18152</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>14</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td></td>
<td>5</td>
<td>166595</td>
<td>50</td>
<td>108</td>
<td>2</td>
<td>36</td>
<td>10</td>
<td>327</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OU means “Other Urban”. There are three urban categories that differ according to the number of residents living in urban centres, with Major Urban (MU) being the "most" urban authorities, Large Urban (LU) and lastly Other Urban (OU) for the least densely populated towns. Of the rural categories, Rural-50 (R50) authorities have between 50 and 80 % of their population living in rural settlements or large market towns. Rural-80 (R80) authorities have at least 80% of their population in rural settlements and large market towns. Significant Rural (SR) indicates that a district has between 26 and 50 percent of its population in rural settlements and large market towns. **Rank of 1 = highest number
Northamptonshire Prevention and Demand Management Commissioning Strategy has prioritised and agreed resources for

- Reducing incidence of domestic violence;
- Reducing incidence of abuse and neglect;
- Reducing the number of adolescents with challenging behaviour;
- Reducing impact of drug and alcohol use on children and their families;
- Services that support improved mental health / wellbeing;
- Support for parenting.

These priorities will require action both by Northamptonshire CC and by partnership bodies. The funds allocated for preventive activities should pay dividends as C&YP grow up living healthier lifestyles and with greater resilience.

Section summary

This section has outlined information on Northamptonshire and its population, especially C&YP, highlighting those districts where there is greater deprivation and shown that these are associated with indicators of poor health and wellbeing.

Northamptonshire CC and its partners know that poverty, deprivation and poor health and wellbeing are linked and seek to improve access to services for those communities. The work of the Northamptonshire Early Help and Needs Analysis compiled in 2013 was very helpful in identifying both priorities for action and those districts where investment should yield greatest benefits.

There are two recommendations arising from this section.

Northamptonshire CC should produce those data from which the maps of risk factors for the need for early help and intervention were constructed. The data should be refreshed annually so that actions taken can be evaluated to show hoped for progress and to facilitate modelling and projection work in due course.

This report recommends that Northamptonshire CC, the CCGs, and the Police, both separately and together, should review the distribution of public services across the County to match them to those districts where need is greatest.
What are the most important causes of demand for health and social care for children and young people in Northamptonshire?

This section focuses on the C&YP within Northamptonshire who come into contact with social services and particularly those who are looked after children (LAC). It sets out evidence from several local sources alongside published evidence on these C&YP. It asks some key questions and recommends actions arising from the examination of these. In some cases there are data that inform recommended actions, while in others the recommendation is to compile some data, or to record data in different ways to allow better analysis and inform commissioning decisions.

The looked after children of Northamptonshire

Children being looked after by social services are among the most vulnerable people in society. Across England there has been an increase in the number of children entering social care since 2007 from 64450 in 2009 to 68110 in 2013. The number of LAC nationally increased steadily by 2% each year and is now higher than at any point since 1985. The greatest rise was in the under 5s (5620 to 7690), but 5 to 9 year old looked after children’s numbers rose too (7550 to 9620). This rise in numbers was not nationally accompanied by longer periods in local authority social care: the average number of days spent remained steady at between 258 and 261 nights (less than nine months) over the years 2009 to 2013.

During these years the numbers of LAC in Northamptonshire was close to the East Midlands average each year (though the rate per 10000 dropped in Northamptonshire in 2013), with both being below the England average in every year. The majority of LAC (62 per cent in 2013) have suffered abuse or neglect.

Northamptonshire saw a decrease in rate between 2012 and 2013 from 51 to 46 per 10000 C&YP, whereas England saw an increase from 59 to 60 per 10000 C&YP in the same year.
The ages of those C&YP in the social care system within Northamptonshire broke down as shown in the table below.

Table 2: Children in social care in Northamptonshire in January 2013 by age

<table>
<thead>
<tr>
<th>Age band at Feb 1st 2013</th>
<th>Age band on entering care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 to 5</td>
<td>6 to 10</td>
</tr>
<tr>
<td>0 to 5</td>
<td>200 100%</td>
<td>0%</td>
</tr>
<tr>
<td>6 to 10</td>
<td>58 44%</td>
<td>73 56%</td>
</tr>
<tr>
<td>11 +</td>
<td>39 11%</td>
<td>140 40%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>297 44%</td>
<td>213 31%</td>
</tr>
</tbody>
</table>

Source: T Gutteridge, A study of children in and on the edge of care, 2013

The youngest children (aged 0 – 5) differed notably from those who entered care over the age of 11.
Children in social care aged 0 – 5

At the end of January 2013, there were 200 children aged 0 to 5 in care, equating to 30% of the looked after children population. Over the 12 months to January 2013, 158 children aged 5 and under entered care whilst only 119 left, representing a net gain of 39 children. The rate of 0 to 5 year olds in social care was higher in the County (37 per 10,000) compared to the national average of 32 per 10,000 and regional average of 30 per 10,000. Table 3 below sets out the number of children entering and leaving social care in Northamptonshire below the age of 6 years for the period between February 2012 and January 2013.

Table 3: Children under 5 years old in social care Feb 2012 to Jan 2013 in Northamptonshire

<table>
<thead>
<tr>
<th>(Feb 12-Jan13)</th>
<th>Entered care</th>
<th>Left care</th>
<th>In care &amp; entered aged 5 and under</th>
<th>In care and 5 and under</th>
<th>Rate of in care aged 0 to 5 (per 10000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corby</td>
<td>16</td>
<td>17</td>
<td>39</td>
<td>22</td>
<td>42.1</td>
</tr>
<tr>
<td>Daventry</td>
<td>15</td>
<td>6</td>
<td>25</td>
<td>16</td>
<td>30.8</td>
</tr>
<tr>
<td>East Northants</td>
<td>10</td>
<td>8</td>
<td>14</td>
<td>12</td>
<td>19.3</td>
</tr>
<tr>
<td>Kettering</td>
<td>12</td>
<td>17</td>
<td>41</td>
<td>27</td>
<td>36.3</td>
</tr>
<tr>
<td>Northampton</td>
<td>74</td>
<td>60</td>
<td>130</td>
<td>89</td>
<td>48.6</td>
</tr>
<tr>
<td>South Northants</td>
<td>4</td>
<td>3</td>
<td>11</td>
<td>7</td>
<td>12.0</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>18</td>
<td>14</td>
<td>29</td>
<td>22</td>
<td>37.3</td>
</tr>
<tr>
<td>Unknown/OOC</td>
<td>9</td>
<td>19</td>
<td>8</td>
<td>5</td>
<td>12.0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>158</strong></td>
<td><strong>144</strong></td>
<td><strong>297</strong></td>
<td><strong>200</strong></td>
<td><strong>36.9</strong></td>
</tr>
</tbody>
</table>

Source: T Gutteridge, Children in and on the edge of care (age 0 – 5)

119 of the 381 children who left social care in the 12 months to January 2013 were aged 5 and under, whilst 145 of the 381 leaving entered care before their 5th birthday. The average length of a placement was around 900 days (approx 2.5 years); however these placement lengths ranged from a couple of days to 5,500 (approx 15 years) in care. Northampton and Corby districts had the highest proportion of children from a minority ethnic background entering care (around 25%). No district had a higher proportion of children entering care from a black minority ethnic background than would have expected given the ethnic profile of all children in each area. The majority of children aged 0 – 5 entering social care were already known to Northamptonshire CC. 105 of the 158 children who entered social care were either subject to a child protection plan (63) or had been a child in need for a month (42) or more before entering the social care system. The most common destination on leaving care for the 119 children aged 5 and under who left care was to return home to live with their parents (38%). The average age of children who returned home was 2 and the average length of placement was less than a year.

Children in care age 6 – 11

Over the period February 2012 to January 2013 these 12% of children represented the smallest group of children in social care. They were most likely to be looked after due to reasons of ‘abuse and neglect’ (70%). The majority were looked after under placement or care orders. They had spent an average of slightly over two years looked after, but
less than one and a half years in their most recent placement. For the majority of these children (9 out of 10) this was their first time in the social care system. Adoption was the goal for the highest proportion of children (32%), though for 20% the plan was long term foster placement until independence, ie to spend over ten years in social care. These children were commonly placed with in house foster carers (40%), or with agency foster carers (36%).

**Children and young people in social care aged over 11**

At the end of January 2013, there were 346 children aged 11 and over who were looked after, equating to 51% of the care population. Over 50% of those in care aged 11 and over entered it before their 11th birthday, whilst 11% entered it before their 6th birthday. Over the 12 months to the end of December 2012, 118 children aged 11 and over entered care whilst 178 left. Only half of the children aged 11 and over in social care entered it over the age of 11: a considerable proportion of those leaving care aged 11 and over entered aged 10 and under, thus spending a considerable proportion of their childhood in care before leaving when they turned 18. More than half of the children aged 11 and over in care entered it before their 11th birthday while 60% of children aged 11 and over entering care started to be looked after aged 15 to 17. The rate of children aged 11 and over in care, at 58 per 10,000, was lower than the national average of 70 per 10,000. There was considerable variation at a district level, with Northampton (82.7 per 10,000) and Corby (77.1 per 10,000) having a higher rate of C&YP aged 11 and over in social care compared to the national average, as shown in the table below.

**Table 4 Children and young people over 11 years old in social care Feb 2012 to Jan 2013 in Northamptonshire**

<table>
<thead>
<tr>
<th>Entered care</th>
<th>Left care</th>
<th>In care and entered aged 11+</th>
<th>In care aged 11 and over</th>
<th>Rate of in care aged 11 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corby</td>
<td>11</td>
<td>15</td>
<td>15</td>
<td>41</td>
</tr>
<tr>
<td>Daventry</td>
<td>2</td>
<td>8</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>East Northants</td>
<td>14</td>
<td>13</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>Kettering</td>
<td>10</td>
<td>22</td>
<td>24</td>
<td>52</td>
</tr>
<tr>
<td>Northampton</td>
<td>52</td>
<td>69</td>
<td>69</td>
<td>146</td>
</tr>
<tr>
<td>South Northants</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>13</td>
<td>18</td>
<td>22</td>
<td>45</td>
</tr>
<tr>
<td>Unknown/OOC</td>
<td>12</td>
<td>26</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Grand Total</td>
<td>118</td>
<td>178</td>
<td>167</td>
<td>346</td>
</tr>
</tbody>
</table>

Source: T Gutteridge, Children in and on the edge of care (age 11+)

The 118 entrances to social care between February 2012 and January 2013 accounted for 107 children, with 11 children entering care twice within the year. Overall, of the 107 children entering care during the year, 32 (30%) had previously been a looked after child and 9 of these children had experienced at least three episodes of care.
Table 5 Number of episodes of social care experienced by children and young people over 11 years old in Northamptonshire between February 2012 and January 2013

<table>
<thead>
<tr>
<th>No. of LAC episodes</th>
<th>No. of children</th>
<th>% of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 episode</td>
<td>75</td>
<td>70%</td>
</tr>
<tr>
<td>2 episodes</td>
<td>23</td>
<td>21%</td>
</tr>
<tr>
<td>3 episodes</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>4 episodes</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>5 episodes</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>107</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Source: T Gutteridge, Children in and on the edge of care (age 11+)

Teenagers were most likely to enter social care as their parents were unable to manage their challenging behaviour. 50% were persistently absent from school in the year before they entered social care, 50% were excluded from school in the year before they entered social care, and 30% had offended in the 5 years before they entered care. The time spent in social care for the over 11 year olds varied greatly from a few days to their entire remaining youth till leaving on reaching adulthood. The Just over half of the children aged 11 and over leaving care either returned home (33%) or moved to independent living (22%). The rest moved to a range of destinations, though for one third of these care leavers there was no coding indicating the place the young person went. This is a recognised nationwide issue and occurs not only in Northamptonshire.

Children in need

At the 31st March 2013 there were over 4,000 children in need (CiN) in the County. 741 were LAC and 15 of these were also subject to a child protection plan (CPP). A further 459 children were subject to a child protection plan but not looked after. The proportion of LAC in each age group closely followed the national average.

Table 6: Social care service use: difficulties faced by families that end up needing support from higher cost services

<table>
<thead>
<tr>
<th>Age</th>
<th>0 to 4</th>
<th></th>
<th>5 to 10</th>
<th></th>
<th>11 +</th>
<th></th>
<th>No date of birth</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>CiN</td>
<td>858</td>
<td>28%</td>
<td>952</td>
<td>32%</td>
<td>1176</td>
<td>39%</td>
<td>30</td>
<td>3016</td>
</tr>
<tr>
<td>LAC</td>
<td>158</td>
<td>22%</td>
<td>160</td>
<td>22%</td>
<td>408</td>
<td>56%</td>
<td>0%</td>
<td>726</td>
</tr>
<tr>
<td>CPP</td>
<td>200</td>
<td>44%</td>
<td>160</td>
<td>35%</td>
<td>99</td>
<td>22%</td>
<td>0%</td>
<td>459</td>
</tr>
<tr>
<td>CPP &amp; LAC</td>
<td>8</td>
<td>53%</td>
<td>5</td>
<td>33%</td>
<td>2</td>
<td>13%</td>
<td>0%</td>
<td>15</td>
</tr>
<tr>
<td>England</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>29%</td>
<td>30%</td>
<td>40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1224</td>
<td>29%</td>
<td>1277</td>
<td>30%</td>
<td>1685</td>
<td>40%</td>
<td>30</td>
<td>4216</td>
</tr>
</tbody>
</table>

Source: Early help needs analysis, NCC 2013
Key:
CiN  Children in Need
LAC  Looked After Children
CPP  Child Protection Plan

Of those involved with social services, 59% were aged 10 and under and the remaining 41% were aged 11 and over. There was a much higher proportion of LAC aged 11 and over than aged 10 and under. Many of the over 11 year olds entered social care at a younger age and remained without a permanent home where their needs could be adequately met outside of the social care system. The Case Study of the Care System research completed by Dr T Gutteridge in 2012 showed that 7 out of 10 of the children in social care aged 11 and over entered before their 11th birthday.

The majority of children involved with social care (3 out of 4) had a need code of abuse and neglect (41%) and chronically inadequate parenting (family dysfunction, 33%). LAC and those subject to a CPP were more likely than CiN to have a need code of abuse and neglect. More younger children than older children had a need code of abuse and neglect.

These causes for involvement with the social care system are at variance with the national picture, which changed very little over the years 2009 to 2013. Across England 62% of children in social care were there because of abuse and neglect, while for Northamptonshire it was 41%, a substantially lower percentage. Family dysfunction was the named cause for 33% of Northamptonshire children in social care, compared with the England figure of 15%. These disparities are surprising and should be explored. There are structures in place within Northamptonshire, such as the MASH, which would allow close scrutiny of the caseload. All agencies should change their ways of working to ensure that, for example, abuse and neglect are not missed. Family dysfunction figures appear high locally. There are many possible reasons for this, including poor coding; a lack of support for parenting, especially parenting in the early years; and a high rate of families with drug and alcohol problems and mental ill health.

If the disparities in the balance of C&YP are chiefly due to coding errors, this should be investigated and training provided to address the problem.

Disability in a child was more frequently a cause for being in the social care system in Northamptonshire (9%) than in England as a whole (3%). Local partners should explore this difference, since other parts of the country appear able to support this group within their family home.

Parents were absent in just 2% of cases in the County, but in 5% of cases across England. Family in acute distress was the reason for only 1% of children being in the social care system in Northamptonshire but accounted for 9% nationally.

In both Northamptonshire and England as a whole, socially unacceptable behaviour and low income were rarely reasons for children being looked after by the local authority.
Effectively addressing parental needs at the earliest opportunity should help to prevent the needs of families escalating to a point where they cross the threshold for high cost, specialist services. The influence of supported parenting programmes is becoming better understood, and evidence shows that these help families build better relationships between their members, to build confidence in their lives, and to stay away from the criminal justice system.

Table 7: Category of need for Northamptonshire children in care, with England comparator

<table>
<thead>
<tr>
<th>Category</th>
<th>CiN</th>
<th>LAC</th>
<th>CPP</th>
<th>CPP &amp; LAC</th>
<th>Northants Total</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Abuse or Neglect</td>
<td>1112</td>
<td>37%</td>
<td>322</td>
<td>44%</td>
<td>273</td>
<td>59%</td>
</tr>
<tr>
<td>Family Dysfunction</td>
<td>1003</td>
<td>33%</td>
<td>229</td>
<td>32%</td>
<td>157</td>
<td>34%</td>
</tr>
<tr>
<td>Child's Disability</td>
<td>346</td>
<td>11%</td>
<td>37</td>
<td>5%</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>No Need Code</td>
<td>235</td>
<td>8%</td>
<td>0</td>
<td>0%</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td>Cases Other Than CiN</td>
<td>137</td>
<td>5%</td>
<td>19</td>
<td>3%</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td>Parental Illness or Disability</td>
<td>85</td>
<td>3%</td>
<td>31</td>
<td>4%</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>Absent Parenting</td>
<td>5</td>
<td>0%</td>
<td>68</td>
<td>9%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Family in Acute Distress</td>
<td>50</td>
<td>2%</td>
<td>11</td>
<td>2%</td>
<td>0</td>
<td>1%</td>
</tr>
<tr>
<td>Socially Unacceptable Behaviour</td>
<td>38</td>
<td>1%</td>
<td>9</td>
<td>1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Low income</td>
<td>5</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Totals</td>
<td>3016</td>
<td>100%</td>
<td>726</td>
<td>100%</td>
<td>459</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Early help needs analysis, NCC 2013, England figures from Government statistics; children looked after in England, including adoption
There is data on the C&YP in the care system within Northamptonshire, where an analysis was undertaken in two complementary papers published in 2013.

The vast majority of children entering care were already known to Northamptonshire CC social workers. 7 out of 10 had an initial contact 6 months before they entered and 64% were a ‘child in need’ for 6 months before entering care.

**Section summary**

The figures set out in this section have revealed distinct differences between the reasons C&YP are in contact with social care or are looked after when compared to England as a whole. Northamptonshire does not reflect the picture in England as a whole, but has lower percentages of C&YP in care with abuse and neglect, but higher percentages with family dysfunction, as well as many fewer families in acute distress than the national average. Disability in a child was a more frequent cause for being in the social care system in Northamptonshire than in England as a whole, though disability in a parent was slightly less common. Family in acute distress was the reason for only 1% of children being in the social care system in Northamptonshire but accounted for 9% nationally.

There are two recommendations that are made from this section.

Northamptonshire CC should continue to gather and analyse data on risk factors for entry to the social care system by district year on year. There would be benefit from analysing the data at sub-district level: trends should inform priorities for investment. The coding of reasons that C&YP are in social care should be investigated to assess if the differences between Northamptonshire and England might be explained by local interpretation differing from coding elsewhere. There should be a thorough examination of the findings from the Table 7 showing social services care use. There are many reasons for these disparities but they should be explored to make certain that classifications are accurate, and that services meet the needs of local C&YP.
Has the number of C&YP in social care changed over recent years? Are any changes in the rate of C&YP entering the social care system over recent years explicable?

This section examines the population of children within the local social care system and compares Northamptonshire with national data. It explores the effect of the dispersal of asylum seekers from parts of Eastern Europe to Northamptonshire during the late 2000s. It goes on to ask several key questions about C&YP known to social care and provides information to answer these as far as is possible. Those key questions are

- What do the profiles of risk factors for the presence of C&YP within the social care system tell us?
- Where do Northamptonshire looked after children live?
- Is there evidence of actions that could help C&YP within the social care system at different ages?

The population of children within the social care system in Northamptonshire

The numbers of C&YP in the social care system and LAC in Northamptonshire rose year on year from 2008 to 2012 before falling slightly in 2013. Throughout they have been below the England average, and whilst close to the East Midlands average for most of those years, they fell in 2013 to below the regional average.

**Figure 45:** Rates of looked after children under 18 per 10,000, as at March 31 2008 to 2013.

![Graph showing rates of looked after children under 18 per 10,000](https://example.com/graph.png)

Source: Department for Education

There is a possible explanation for the period between 2008 and 2012 when numbers increased and were slightly above the East Midlands average. There was a surge of
unaccompanied asylum seeking children (UASC) dispersed to Northamptonshire during the years 2008 to 2011. They were taken in the social care system while their family cases were considered. There were 70 of these young people in 2012/13, all of whom were age 11 or older. When these are separated from the remainder of looked after children the picture for Northamptonshire looks different. Indeed the numbers began to fall for both LAC and UASC in 2013.

**Figure 46: Looked after children trends, Northamptonshire, 2009–2013**

![Graph showing looked after children trends](image)

Source: DOE, National Statistics, Children looked after in England, including adoption

**Key**

- **LAC** Looked after children
- **UASC** Unaccompanied asylum seeking children
- **LAC – UASC** Number of children looked after once the unaccompanied asylum seeking children are removed from the numbers to show the underlying care caseload

**What do the profiles of risk factors for the presence of C&YP within the social care system tell us?**

The figure below of looked after children by key need from 2011 allowed comparison to be made by local district to both the Northamptonshire and England averages. Intra-County numbers were fairly small, so similar charts showing year on year trends would be needed to inform changes to services because annual fluctuations in numbers could be substantial.
In 2011:

- Daventry recorded higher levels of abuse and neglect among C&YP in the social care system than other districts at 73% cases, and higher than the England percentage of 62%
- Almost all districts recorded levels far higher than the national level of 14% of family dysfunction. Wellingborough had the highest rate at 48%, with Northampton and East Northamptonshire each having 42%
- South Northamptonshire at 13% and Kettering at 12% recorded disability of the child as a cause for entry into the social care system more often than other districts, and more often than the national average of 3%
- There were very few families recorded as “in acute distress”, with East Northamptonshire, Kettering, South Northamptonshire and Wellingborough recording none at all. This is in contrast to the England average of 9%.

There was no local data demonstrating examination of these variations from national norms, though as noted earlier there is a range of possible explanations which local work could elucidate. The expertise of a modelling team, which can work at individual and household level, could greatly help Northamptonshire to understand their very different picture better, and thus inform commissioning and funding priorities.

It is well recognised that the stigmata of abuse and neglect may be difficult to spot, and that people are anxious about acting on what they see. *Northamptonshire Thresholds and Pathways - early help, prevention and statutory services for children and families* contains advice and information for those working with possible abuse and neglect and has been seen locally as a useful means of communicating widely an approach that can be followed by all staff and others outside the public sector who may need to know what to do when abuse and neglect are suspected.
Figure 47: Breakdown of looked after children by category of need (2011)

Source: Northamptonshire Analysis
Where do Northamptonshire looked after children live?

This figure below shows differences in the rate per 1000 children in the social care system for each Northamptonshire district in March 2011. At that time Northamptonshire had a lower rate (48 per 1000) than the England average (59 per 000). Corby and Northampton had a higher rate than other districts, but both were below the England average. Daventry, East Northamptonshire and South Northamptonshire had rates of LAC well below the County and England average. Newer data would be very useful in seeing if the picture has changed. This figure strengthens the finding that Northamptonshire CC and its partners should review the distribution of services across the County to ensure they are best located to meet the needs of the C&YP.

There could be useful further work undertaken to identify the characteristics of LAC to explain their distribution across the County. For example, their ethnic background might be a useful indicator and inform service developments tailored to the needs of particular communities in Corby and Northampton.

**Figure 48: District of residence for looked after children, 2011**

![Graph showing rate of children who were looked after at 31 March per 1000 (2011)]

Source: Northamptonshire CC

Is there evidence of actions that could help C&YP within the social care system at different ages?

During the year ending 31st March 2013, there were 17,544 contacts made to children’s social care, equating to 48 per day. Just over half (51%) of the contacts recorded the
presenting issues “child concern”. This broad term did not give sufficient detail to allow analysis of the immediate reasons C&YP came into the social care system. There were 15 alternative presenting issue categories.

**Table 8: Presenting issues for children and young people going into care 2012/13**

<table>
<thead>
<tr>
<th>Presenting issue</th>
<th>0-4</th>
<th>5-10</th>
<th>11+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child concern</strong></td>
<td>3259</td>
<td>3169</td>
<td>2602</td>
<td>9030</td>
</tr>
<tr>
<td><strong>Domestic abuse</strong></td>
<td>1052</td>
<td>730</td>
<td>413</td>
<td>2195</td>
</tr>
<tr>
<td><strong>Abuse or neglect</strong></td>
<td>434</td>
<td>555</td>
<td>563</td>
<td>1552</td>
</tr>
<tr>
<td><strong>Family breakdown</strong></td>
<td>319</td>
<td>394</td>
<td>420</td>
<td>1133</td>
</tr>
<tr>
<td><strong>Emotional or behavioural issues</strong></td>
<td>123</td>
<td>252</td>
<td>478</td>
<td>853</td>
</tr>
<tr>
<td><strong>Adult LD, PD, MH, SM</strong></td>
<td>373</td>
<td>286</td>
<td>180</td>
<td>839</td>
</tr>
<tr>
<td><strong>Housing issues and poverty</strong></td>
<td>230</td>
<td>155</td>
<td>333</td>
<td>718</td>
</tr>
<tr>
<td><strong>Unsafe parenting</strong></td>
<td>285</td>
<td>223</td>
<td>148</td>
<td>656</td>
</tr>
<tr>
<td><strong>Adoption, fostering, kinship</strong></td>
<td>31</td>
<td>43</td>
<td>57</td>
<td>131</td>
</tr>
<tr>
<td><strong>Child PD, LLTI</strong></td>
<td>36</td>
<td>46</td>
<td>49</td>
<td>131</td>
</tr>
<tr>
<td><strong>Sexually harmful</strong></td>
<td>18</td>
<td>27</td>
<td>57</td>
<td>102</td>
</tr>
<tr>
<td><strong>Child SM</strong></td>
<td>7</td>
<td>13</td>
<td>52</td>
<td>72</td>
</tr>
<tr>
<td><strong>Sexual exploitation</strong></td>
<td>8</td>
<td>9</td>
<td>53</td>
<td>70</td>
</tr>
<tr>
<td><strong>Unaccompanied Asylum Seeking Children</strong></td>
<td>1</td>
<td></td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td><strong>Suicide</strong></td>
<td>1</td>
<td>2</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td><strong>Young carers</strong></td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>6178</td>
<td>5906</td>
<td>5460</td>
<td>17544</td>
</tr>
</tbody>
</table>

Source: Early help needs analysis, NCC 2013

For all age groups domestic violence, and abuse and neglect were among the 5 commonest presenting issues, accounting for 3,747 contacts with children in social care during the year, equating to 10 each day. For children under 11 these were the most common reasons for a request for social care involvement. Older children also commonly presented with emotional and behavioural issues, probably because as children grow older they begin behaving in challenging ways that parents cannot readily manage. This assertion is supported by data on school attendance within the report prepared by Tom Gutteridge which demonstrated that among older children entering care:

- ♦ 50% were persistently absent from school
- ♦ 47% were or had been excluded from school
- ♦ 30% were young offenders
In 2013 Northamptonshire CC used the tiers of need approach to choose where to invest to avoid those in Tier II from rising to Tier III, and to avoid those from tier III rising to tier IV. Their decisions were split between those activities which were

- age band specific
- for all C&YP
- aimed at parents.

The activities selected were those that the best published evidence demonstrated were most effective. They are set out here for easy reference by Northamptonshire CC and its partners.

**Age band specific activities recommended**

For those aged 0-4 the emphasis was on maternal good health; supporting breastfeeding; completing primary immunisations; avoiding events which culminated in attendance at A&E; and encouraging good social and emotional development.

For those in the age 5-10 group, the key focus was on a good attendance record at school to allow social and emotional development; and the laying down of healthy behaviours for life, for example by encouraging healthy eating and taking exercise.

The secondary school age activities were divided between support to achieve good attendance to allow them to reach better academic standards at key stages; support to avoid contact with the criminal justice system and, where offences were committed, to keep young people from moving up the scale of punishments for a greater number and a greater severity of offences; reducing numbers who were not in education, employment or training (NEETs); reducing time spent in hospital because of alcohol, substance misuse, mental health and self-harm; and reducing the incidence of teenage parenthood.

**All ages of C&YP activities recommended**

Northamptonshire CC agreed to invest in helping fewer children live in poverty; reducing the numbers of (mainly) young people using drugs frequently; reducing the numbers of young carers; better supporting C&YP with physical disabilities; and better supporting C&YP with mental ill health.

**Parent focused activities recommended**

For parents Northamptonshire CC agreed to allocate resources to help children whose parents abuse substances; to those where there is domestic abuse in the home; and those households where parents have mental ill health.

**Children and young people who go missing**

Northamptonshire Police provided data for missing C&YP (0 – 18 year olds) for the period September 2013 to February 2014. Over that six month period 224 individuals went missing, though some more than once, thus generating 425 “missing” reports. For C&YP known to social care during the 6 month period, there were 200 reports of missing persons involving 71 individuals. Across all ages of missing persons, approximately 43% are adults, 55% are aged between 12 and 18, and 2.4% are under age 12.
When a person goes missing more than 3 times in a 90 day period they are categorised as “frequent missing”, of which there were 66 C&YP during the six months. Only 1 of the 10 C&YP who most went missing was missing from a private care facility.

There were 19 missing C&YP who were possible victims of child sexual exploitation in that period.

**Is there learning from elsewhere that should inform future activities?**

The nationwide rise in numbers of LAC has occurred against a background of public spending cuts. A number of reports look at how other local authorities are meeting this challenge. A joint NSPCC and CIPFA report\(^{18}\) traced the rise in spending on children’s social care that occurred during the 2000s, and highlighted how from 2011 this was set to fall significantly—alongside cuts in overall public expenditure. It showed how the pattern of spending varied by different types of authority, and between English and Welsh councils in particular. It discussed how the spending reductions were likely to be applied within children’s social care. Prevention services appeared to be especially vulnerable. Although spending reductions do not automatically translate into cuts in services or worsening outcomes for children, the scale of the challenge suggested that some impact on children would be unavoidable. In particular, this report argued that cutting preventive services may prove costly. If cuts to preventive services result in more children becoming in need, child protection costs could spiral.

The Family and Parenting Institute\(^{19}\) undertook research to understand the impact of revenue spending cuts on Children’s Services across eight different local authorities in England. Researchers examined publicly available accounts and analysed spending fluctuations across two budget cycles: the financial years of 2011–12 and 2012–13. It described where savings had been made in children’s services and some of the effects on LAC services. Services for LAC were largely protected. There appeared to be a decline of universalism although it was noted that in practice many universal services were accessed by those who would be in a targeted group anyway. Service Integration and Team Around the Child approaches were seen as important.

The Association of Directors of Children’s Services\(^{20}\) highlighted that in some authorities prevention and early intervention may be resulting in more children being identified early, and thus allowing quicker decisions to start care proceedings, whilst in other local authorities it may be helping to reduce the numbers who enter the system.

In London a study was carried out\(^ {21}\) to understand why there was a decrease in the numbers of London’s LAC, which was in contrast to the rise in numbers outside London. The conclusions were that there were two key factors. Firstly, the need to provide sufficient resource to enable good social work to take place, and secondly, leadership in provision of a focused and nuanced approach to the flow of LAC in and out of the system.

The Social Research Unit in Dartington made\(^ {22}\) the distinction between prevention, targeted prevention and early intervention and noted that a portfolio of activities rather than a solitary big bet; scalability; creating demand; good supply chain; and being able
to adapt to local circumstances whilst holding the core of the intervention steady are all important for successful Children's Services. In Appendix B to this report, published evidence is presented in further detail.

**Section summary**

This section has examined several aspects of the social care system in Northamptonshire. An influx of UASC appears to have distorted the picture of social care use over between 2008 and 2012. There was a match between the districts of residence of C&YP within the social care system, with more deprived, urban areas having the highest rates per thousand C&YP. However, the risk factors for children in social care in different districts within the County did not simply mirror indices of multiple deprivation, with abuse and neglect being higher in Daventry, for example, than the national average.

There are interventions that have been well evidenced that Northamptonshire can use to help C&YP who are LAC or otherwise known to the social care system. Some are already being funded, and there is published evidence to which commissioners can turn when selecting which to continue to fund and where to change provision. The evidence has been divided across age bands and includes some activities to support parents.

Five recommendations have been made from this section.

1. This report recommends continuing to review the ethnicity of looked after children as any further dispersal of asylum seekers takes place.
2. This report recommends that Northamptonshire CC examine the findings from figure 47 showing LAC by category of need. This will inform tailored investment at sub-County level to meet localised needs.
3. This report recommends that Northamptonshire CC analyse the spread of looked after children by district of residence to see if the disparities, which reflect the picture of deprivation, have been maintained. The information should be used to argue for a rebalancing of service provision to follow the needs of districts more closely.
4. There should be further analysis of missing persons to clarify information on them which would inform service developments. Examples of useful analysis would be their number by age, ethnicity and place of residence; details of those who are looked after; the number receiving CAMHS; the number who go missing from the range of placements (including the family home); the number where there is child sexual abuse; and the number who have associated problems such as drug and alcohol abuse, abuse and neglect, domestic violence and a household where there is mental ill health. It will be useful to compare Northamptonshire to England figures.
5. This report recommends looking at evidence based interventions for LAC (see Appendix A) and identifies and visits places which have lower rates of LAC and better outcomes.
Mental Health

In this section the report explores mental health among C&YP. Some national and local data are given, as well as an outline of local services for C&YP with mental ill health. It goes on to review hospital admissions for mental illness and to review the local picture for deliberate self harm, a particular concern for Northamptonshire.

Mental health problems appear to have increased nationally over time.23 1 in 10 children aged 5-16 years old has a clinically significant mental health problem. 5.8% have clinically significant conduct disorders, and 3.7% have clinically significant emotional disorders. Conduct disorders account for a significant number of referrals to CAMHS. Some children experience more than one mental health disorder. Mental health disorders in children can be persistent particularly if the mother has a mental health problem too.24 Looked after children and social care leavers are between 4 and 5 times more likely to self-harm in adulthood. They are also at a five-fold increased risk of all childhood mental, emotional and behavioural problems and 6-7 times more likely to have conduct disorders.25

Just like adults, any child can experience mental health problems, but some children are more vulnerable to this than others. These include those children who have one or a number of risk factors in the following domains:26

- from low-income households
- families where parents are unemployed
- families where parents have low educational attainment
- who are looked after by the local authority
- with disabilities (including learning disabilities)
- from black and other ethnic minority groups
- who are lesbian, gay, bisexual or transgender (LGBT)
- who are in the criminal justice system
- who have a parent with a mental health problem
- who are misusing substances
- who are refugees or asylum seekers
- in gypsy and traveller communities
- who are being abused.
While children and young people in these groups may be at higher risk, this does not mean that as individuals they are all equally vulnerable to mental health problems. A range of protective factors in the individual, in the family, and in the community influence whether a child or young person will either not experience problems or will not be significantly affected by them.

There is data on the burden of mental illness within Northamptonshire, partly from national data applied to Northamptonshire, and partly from local work. There was a useful summary of C&YP mental ill health in the 2013 presentation CAMHS Needs Assessment and Service Review. It stated that

- Mental ill health is now recognised as the greatest challenge to services within England. 50% mental illness (excluding dementia) starts by age 14\(^27\) (and 75% by the mid-twenties\(^28\)) and pre-dates physical illness by decades, though imposing suffering to those individuals from the onset

- LAC\(^29\) (by the state) have a 5 fold increased risk of mental disorder

- Children with learning disability have a 6.5 fold increased risk of mental illness\(^30\)

- C&YP with Special Educational Needs have a 3.7 fold increased risk of mental illness\(^31\)

- For young male offenders age 15–17 who are in custody there is an 18 fold increased risk of suicide\(^32\)

The same 2012 report estimated the burden of mental ill health among 5-16 year olds in Northamptonshire:

- 3351 were estimated to have emotional disorder
- 5299 were estimated to have conduct disorder
- 2049 were estimated to have hyperkinetic disorder
- 1% had less common disorders (including autism, tics, eating disorders and selective mutism)

Dr Campion in 2012 estimated the burden of mental disorder among higher risk child and adolescent groups:

- 331 LAC in Northamptonshire were estimated to have a mental disorder
- 1580 children with Special Education Needs in Northamptonshire were estimated to have a mental disorder
- 879 children with learning difficulties in Northamptonshire were estimated to have a mental disorder
- 3324 children from one parent families in Northamptonshire were estimated to have a mental disorder
- 4058 children living in poverty in Northamptonshire were estimated to have a mental disorder
Mental health services in Northamptonshire

Northamptonshire has an array of services for C&YP with mental ill health, including a programme of preventive work. They comprise community mental health services and hospital mental health services.

Mental health promotion in Northamptonshire

Northamptonshire CC has invested in such programs, monitored and evaluated them and has rated them effective. The Young Healthy Minds Partnership commissions universal and targeted emotional wellbeing programmes and activities to promote good mental health prevention, as well providing some early intervention:

- Targeted Mental Health in Schools Programme (TaMHS)
- Talk Out Loud Anti Stigma Programme (Talk Out Loud Young Person’s Website http://talkoutloud.info/ )
- Ask Normen Service Gateway www.asknormen.co.uk

These programmes have received proper investment and been seen as very good practice when rated externally: two have won national awards.

Some schools also commission their own interventions, though was no data which would allow any assessment of the levels of these interventions and their impact.

Community mental health services for C&YP

The great majority of mental ill health is handled in the community. Many young people use their own networks of family and friends to seek help for problems such as depression, anxiety and some behavioural problems and never seek professional help. Schools, primary care and other community-based services provide support to young people with mild to moderate mental ill health, with modern therapies and peer counselling programs being popular and effective.

Some C&YP have mental ill health which requires professional intervention and can be treated by the local community mental health services. A snapshot in October 2013 of the Northamptonshire community mental health burden in C&YP was as in Table 9 below. The burden of mental ill health among the children and young people aged 5-19 was highest in Northampton South and East, Northampton West, and Kettering, while the deprived district of Corby had the fewest people using community mental health services. There was a similar picture for those aged 0-4, and for crisis and home treatment.
Table 9: Numbers of numbers of C&YP receiving community health services by locality, October 2013

<table>
<thead>
<tr>
<th>Locality</th>
<th>0-4yrs</th>
<th>5-19 yrs</th>
<th>Crisis and Home Treatment</th>
<th>Youth Offenders Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daventry South Northants (North)</td>
<td>13</td>
<td>323</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Daventry South Northants (South)</td>
<td>15</td>
<td>298</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>East Northants</td>
<td>10</td>
<td>286</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>4</td>
<td>276</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Northampton Central</td>
<td>24</td>
<td>346</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Northampton South &amp; East</td>
<td>24</td>
<td>421</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Northampton West</td>
<td>27</td>
<td>414</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Kettering</td>
<td>5</td>
<td>402</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Corby</td>
<td>5</td>
<td>273</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: NCC D Sackey, Dec 2013 (personal communication)

Note that these localities are not coterminous with Northamptonshire’s Districts. Maps showing the boundaries of districts and localities are attached at Appendix D.

These figures could be explained in many ways. They might reflect a lack of ready access to services by those living in Corby; a demand by those in more affluent boroughs for services; a dislike of the current service arrangements among those living in Corby; or a true lower level of need in Corby. Looking at other data, such a child poverty and lone parent households, it seems likely that Corby residents would have need for mental health services at all levels, so the more likely explanations are either that they do not have easy access to them or prefer not to use them when they are on offer.

Hospital mental health services for C&YP

Some C&YP cannot be fully treated in the community and are referred to secondary care for assessment and treatment at Northamptonshire Healthcare NHS Trust. The majority of these C&YP are seen as outpatients but some need admission.

Tier IV mental health service provision for C&YP

Tier IV is the most intensive mental health service provision for C&YP and comprises residential placements, each tailored to a specific child or young person. Placements are made through a specialist commissioners managed nationally by NHS England. This specialist service places C&YP at centres that best meet their needs as close as possible to their homes, though some are treated out of the County. The cost of this service is met through a levy on each CCG. The levies are agglomerated and contracts agreed with providers matching to the known body of C&YP in need of these complex and highly specialist care packages. The specialist commissioners have, by bringing together the
funds, been able to reduce costs and insist on standards from providers, to the benefit of those who are receiving these treatments.

From which localities within Northamptonshire do those admitted to NGH with mental ill health come?

Some risk factors for mental ill health among C&YP include those living in low-income households, those whose parents are unemployed, and those where parents have low educational attainment. These are all associated with deprivation and mental ill health commonly mirrors deprivation. Figure 49 below shows the localities within Northamptonshire where those C&YP who are admitted to hospital with mental illness live. The data was set out by localities, divisions used to date by the NHS in its work. The data could not be provided by district to allow easy mapping against the maps of deprivation referred to in this report. Further, it shows admissions at NGH only so does not offer a complete picture of Northamptonshire admissions for C&YP for mental ill health.

Figure 49: CAMHs admissions by locality

The localities that together cover Northampton have the highest admission rates. This could occur because these C&YP live relatively close to NGH, since Wellingborough, another urban centre in the County, has the fewest admissions. Some Wellingborough C&YP mental patients may be treated in other hospitals. Kettering has a relatively high number of 12 to 16 year olds among its admissions, as does Corby and East Northants.

Because numbers of admissions to NGH over this period are modest, with a total of 201
over 25 months, analysis to assess the proportion of those within other risk groups should be undertaken with care. The data do not show whether any of these admissions were recurrent admissions for a single individual or whether all were different people.

Data from elsewhere paint a more concerning picture. Public Health England (PHE) published rates of hospital admissions for mental illness in children and young people for 2011/12. The Northamptonshire figure was 287 for that single year, which appears startlingly high (Figure 50) when compared to the 201 over 2 years to NGH in the figure above. This was by far the highest admission rate in the East Midlands, nearly three times higher than both the regional average and the local authority with the next highest rate.

**Figure 50: Unstandardised rates of hospital admission with mental illness, per 100,000, people under eighteen years, East Midlands, 2011-12**

Source: Public Health England (PHE)

A significantly lower rate of C&YP under 17 were admitted with mental ill health (69 per 100000) to local acute trusts (NGH and KGH) than the England average (94 per 100000) over 2010/2011. In 2011/2012 this changed and the rate of admissions per 100000 among the under 17s in Northamptonshire rose very sharply to 287 per 100000, more than double the England average of 91 per 100000.

This high number of admissions appears to be confirmed from CHIMAT data as shown in Figure 51.
Reviewing the diagnoses for these C&YP admitted with mental ill health in Figure 52, some 20% had no diagnosis given. This could mean, for example, that they had no definitive diagnosis; that they had more than one diagnosis with no single lead diagnosis; that coding was poor; or that a number of C&YP with rare diagnoses have been pooled together and labelled “unknown”. This figure was drawn from data provided by NGH, a single provider. It may also be that some types of mental illness are treated by providers who specialise in certain conditions and that this figure should be viewed alongside analysis of services provided to Northamptonshire C&YP mental ill health patients in treatment in other secondary care centres.

In any case, the high proportion of unknown diagnoses are unhelpful to those commissioning services and should be queried, and steps taken to reduce it.

The commonest diagnoses named were mood affective disorders; neurotic, stress-related and somatoform disorders; and behavioural syndromes associated with physiological disturbances and physical factors.
At the end of 2013 a summary review of mental health services in Northamptonshire provided by Northamptonshire CC showed that

- Inpatient admissions had increased over the year but the length of stay had reduced
- Post discharge follow up was good but 80% of young people were seen post discharge
- The caseloads for the Crisis and Home Intervention Service decreased but the level of contact remained high
- The caseloads of the community teams had shown an increase in acceptance of cases by the community team though the referrals rates remained the same
- The number of LAC receiving support increased and was approximately 30% of the overall LAC population
These outcomes suggest that the mental health services have a high number of cases with which to deal. The teams appear to be coping but it is worrying that the LAC population has so many C&YP with mental ill health. Taken with the unexpectedly high numbers of C&YP admitted to hospital with mental illness, this should be reviewed as a matter of urgency.

The fluctuating numbers of monthly CAMHS referrals in Northamptonshire, show an overall increase over the last three years. In 2012/13, there was a 5% increase in the number of referrals to CAMHS when compared to 2010/11 (3,432 compared to 3,256).

Figure 53 below shows the trend increase of the number of monthly referrals, compared to a larger decrease in the proportion of patients that were signposted but not seen. The commissioners have information that has led to their thinking that some C&YP do not keep appointments made for them. If this is so then it would be useful to engage C&YP to gain their views on how to arrange appointments so that they attend and receive any treatment they need. The current situation is costly since the clinicians are present but not providing appropriate support to these C&YP.

Figure 53: CAMHs referrals versus patients signposted and not seen by month, Northamptonshire, 2010/11 to 2012/13

Source: Northamptonshire local data
Deliberate self harm

Within these admissions, Northamptonshire CC and local NHS bodies (including acute trusts) were aware of the County being an outlier in admissions for deliberate self harm. During 2010/11 the rate of admissions within the County for this reason were 164 per 100000, compared with the England average of 125 per 100000. Northamptonshire noted that it has adhered strictly to NICE guidelines and believes that this accounts for the higher apparent rate. Within Northamptonshire this figure led to a great deal of activity to address this specific challenge, and during 2011/12 the rate of deliberate self harm fell to 155 per 100000, compared with 116 per 100000 for England as a whole. While still above the average for the country, this fall brought Northamptonshire closer to the national average (which rose), as admissions for mental health generally had risen.

National rates of self-reported self-harm were 7% for 11 - 16 year olds but several times higher in those with:

- Emotional disorder (28%)
- Conduct disorder (21%)
- Attention Deficit Attention Disorder (ADHD) (18%)

Figure 54 below demonstrates that even with the high rate of deliberate self harm within the County, Northamptonshire is by no means the poorest performer within the East Midlands. In the same year, 2011/2012, Derby had substantially higher rates. There was significant variation between the East Midlands counties, with Leicestershire having 60 hospital admissions for self harm for age 0 – 17 per 100000 population and Derby 215 per 100000, approximately 3.5 times higher.
In Northamptonshire 253 C&YP presented at A&E for self-harm during 2011/12. The highest prevalence was for those aged 17 - 19, though admissions for the 11 - 16 year olds continued to rise. In 2012, applying national rates to Northamptonshire, 3590 11 – 16 year olds would have been expected to report self harm. The actual figure was much lower at 2940, suggesting that there are unreported cases. In 2012 in secondary schools anecdotal evidence suggested deliberate self harm rates could be as high as 50%.

Figure 54 below sets out the rate of admissions by Northamptonshire locality for the 0 - 19s where deliberate self-harm is within the diagnoses made. Western had the greatest number in 2012/13 and Northamptonshire South the least (fewer than half the number of Western). This NHS hospital data is divided by NHS localities, rather than the districts used by Northamptonshire CC. This makes it difficult to understand whether the caseload divides along deprivation lines as some earlier examples of risk factors, such as child poverty and lone parenthood, did. It is difficult, for example, to be sure of the rate for Northampton town because of the different locality/district boundaries.

However, it appears that these admissions do not simply follow patterns of deprivation. Kettering appears to have a higher rate of deliberate self harm admissions than Corby.
and Wellingborough, despite their having similar levels of deprivation. Figure 55 below sets out the change over 4 years of admissions where deliberate self-harm is at least one of the diagnoses. It helps pinpoint where within the County the problem has most increased. Wellingborough, East Northants and Kettering localities appear to have the greatest burden.

In some cases there have been safeguarding concerns for those who self harm, and this needs assessment recommends that the LSCB audit the caseload and outcomes to understand the path these C&YP took through assessment and treatment, with a view to developing improved systems for supporting these C&YP.

Northamptonshire has established a Self Harm Task Group which has been working to tackle this problem. The Group is developing a strategy to address deliberate self-harm, with new interventions for based on latest evidence. The strategy does not yet include actions to tackle common accompanying activities such as the use of alcohol or drugs, or risk taking behaviours, including risky sexual behaviours. The local public services expect to link initiatives with specialist services and safeguarding services wherever appropriate.

**Figure 55: Self-harm admissions by Northamptonshire locality 2012/13**

![Graph showing inpatient admissions aged 0-19 with secondary diagnoses amongst X60-X84 'Intentional self-harm, including poisoning' by locality 2012/13]

Source: Northamptonshire Healthcare NHS Foundation Trust

Work is underway with the Children and Young People Shadow Board to develop the self-harm strategy that is informed by the view of C&YP themselves. Latest evidence from consultations by Young Minds, Cello and others who have listened to C&YP should help
the Group to set out its ideas on the most appropriate settings and approaches for identifying and tackling deliberate self harm\textsuperscript{34}. Once a self-harm strategy is completed there are plans to hold events during 2014 to communicate it and engage widely with service providers including schools and other settings. The work includes a toolkit for widespread use in a range of settings.

**Figure 56: Paediatric inpatient admissions with secondary diagnosis of self-harm**

* ICD codes X60- to X84 cover deliberate self-harm

Source: Northamptonshire Healthcare NHS Foundation Trust
Section summary

In this section there are data setting out the scale of mental ill health both nationally and across Northamptonshire. It describes some local activity to promote mental good health and the services available for those C&YP with mental illness. It reviewed the admissions data for those with mental illness, finding that the data appeared to provide an incomplete picture both of the C&YP with mental illness and of their main diagnoses.

The section went on to discuss deliberate self harm. Northamptonshire has been an outlier for this and has established a Task Group charged with developing services to better tackle deliberate self harm. Their work includes using the outcomes of national and local listening to C&YP and taking their views into account as decisions on services are made

This section has led to seven recommendations.

1 This report recommends that Northamptonshire CC undertake a review of local interventions intended to avert mental ill health among C&YP, since the burden of mental ill health appears to be rising despite the local presence of a range of support programmes.

2 This report recommends that Northamptonshire CC, primary care and community mental health service providers undertake a specific study of community mental health services to better understand why the caseload does not reflect deprivation as would be expected.

3 This report recommends that all clinicians working with C&YP with mental ill health, including those at NGH and NHFT, are tasked with noting accurate diagnoses in the notes as a basic requirement of the contract with commissioners.

4 This report recommends that a group including Northamptonshire CC, primary care and secondary care review hospital admissions with mental illness in C&YP. The review should focus on finding information to explain this substantial excess admissions to hospital with mental ill health among C&YP compared to the East Midlands and England average and seek ways to reduce this as quickly as possible. They should seek to match resource to well-evidenced interventions to stem the flow of C&YP into CAMHS. This activity should be closely monitored to ensure progress stays on track.

5 This report recommends the East Midlands team from Public Health England coordinate work to better understand both why deliberate self harm is a problem in some counties, and to learn from the best performers how to arrange services to be most effective.

6 This report recommends that those working to reduce the rate of self harming prioritise those parts of the County most in need of resources to support agreed actions. This recommendation will best be followed by the Northamptonshire Self Harm Task Group. Their work should include examining the ethnic mix of those C&YP who self harm, and a review to assess whether some schools have a higher number of cases than might be expected and which thus may require greater resources to tackle their local problem.

7 The LSCB should undertake audits of cases involving self harm where there are also safeguarding concerns to assess the response and outcomes of these.
What patterns of behaviour in children and young people are likely to lead to entry to the care system and the specialist mental health system and how could these be changed?

In the section below this report examines some risk factors for developing mental ill health, for becoming looked after children, or both. The risk factors explored are

- Domestic violence
- Drugs and alcohol abuse
- Abuse and neglect
- Youth offending
- Child sexual exploitation
- Disabilities, including treatments for ADHD

The opening section sets out some published evidence, and there is further detail on published material in the accompanying Appendix A.

The risk factors for children needing local authority social care support and those needing emotional and mental health support are similar and the children are often in need of both types of service. In Northamptonshire there are relatively high referral rates to both social care and specialist mental health services and high rates of children in care and receiving inpatient mental health care. It is important to develop more effective prevention and early help support in these key areas. All partner agencies are aware of the increasing pressures on high cost services, the challenging financial situation, the national expectation that local authorities and health commissioners integrate services where appropriate and the overriding need to safeguard children.

Risk factors for both mental illness and entry into the social care system for C&YP: published evidence

Some factors which are associated with C&YP needing CAMHS also relate to entry into the social care system. The needs factors found by Bebbington and Miles to be most significant in relation to entry into care include:

- Children in one parent, and especially one adult, households
- Children in overcrowded accommodation
- Children in poor households, especially dependent on benefit
- Children of mixed ethnic parentage.

Carr-Hill et al identified the importance of the following factors relating the needs of local populations to their use of children’s personal social services:

- Children living in lone parent families
Children living in flats
Children in families on income support
Children living in densely populated areas
Children with a limiting long term illness.

A very recent systematic review of the risk factors associated with children entering care found for mothers - evidence of association with socio-economic status, benefit receipt, single parenthood, ethnicity, age, disability, smoking in pregnancy, mental illness, alcohol misuse and learning disabilities. For children there was an association between low birth weight and prematurity, disability, injuries and attendance at Accident and Emergency Departments. None of these risk factors were very specific. More research is needed to combine these into a cumulative risk model.37

There is clearly an inter-relationship between mental health and the children’s social care system both in terms of determining factors and in services required for those in the systems. Thresholds for the different levels or tiers of service can vary and over time, the size and characteristics of the looked after children population and CAMHS population are also likely to change in response to national legislative and policy changes as well as incidents and events.

**Domestic violence**

In January 2014 the Early Intervention Foundation, a Government Think Tank, published a report on domestic violence38. The report stated that current data is inconsistently gathered and presented, making it impossible either to understand the scale and extent of domestic violence or to evaluate the effectiveness of programmes of activity in place across the country. Current approaches to dealing with perpetrators appear to be particularly ineffective. The most fully invested and monitored perpetrator programmes, for example those in Holland, have proven unable to change the behaviours of those who abuse. Much of the report echoes the experience in Northamptonshire, where domestic violence, among other risk factors, has proven very difficult to scale and to address across the County.

Partnership Strategic Assessments for each district in Northamptonshire were drawn up in 2013 for the local Crime and Disorder Partnership. The domestic violence sections from each are presented for each District at Appendix C. They highlight domestic violence as a crime which affects young people and young adults. The ethnicity of most reported perpetrators of domestic violence is white across all districts. This could suggest under reporting from some ethnic groups.

A needs assessment for interpersonal violence was undertaken during July 2013 as part of the work to re-commission interpersonal violence services during 2014. The assessment was based upon a similar assessment undertaken in 2010.

The key headlines from this more recent assessment were similar to the previous assessment:

- Domestic abuse is still significantly under reported, particularly for males
- Reports of domestic abuse are increasing, mirroring the national trend
Women aged 20-29 are the biggest age group of domestic violence victims

Sexual violence is increasing both in absolute terms from data from the Police, and from the Crime Survey for England and Wales

Sexual assaults among females over age 23 and rape among females over 16 are the fastest growing specific crime codes within sexual violence (+35.6% and +25.6% between 2010/11 and 2012/13)

Where known, almost half of all domestic abuse victims in Northamptonshire during 2012/13 were aged 17 and under (49.7%, 905). This is significantly higher than the proportion of people aged 19 years and under who are estimated to be resident in Northamptonshire (25.0%).

The assessment found that domestic abuse incidents (including crimes) recorded by Northamptonshire Police have increased year-on-year over the last two financial years – an increase of 11.1% (1231) from 2010/11 to 2012/13.

However, figures suggest that Northamptonshire Police is made aware of only one in four victims of domestic abuse, which shows the scale of under reporting within the county. Unreported domestic abuse appears to be notably greater in Daventry and South Northamptonshire and to a lesser extent in East Northants.

Three districts – Corby, Kettering and Northampton - adopted domestic violence as a key priority for police work and for projects where Police work with others across sectoral boundaries, such as the CYPPB and the Health and Wellbeing Board.

**Assaults data**

A landmark study published in 2004 showed that 70% of domestic violence incidents cause injury. There have been no substantive national studies published since. In 2011, a local cross-sectoral project examined data on assaults in Northamptonshire. It included some information on domestic violence, largely drawn from NGH data and collected from those assaults which took place at home.

70% of assaults were of men against women, and about three quarters of these were perpetrated by a partner or ex-partner. The commonest age group for assaults were against women age 30 to 39, though more than 1 in 10 were carried out against women under 18 and among men 15% were perpetrated against men under 18. Weapons were used in fewer than one third of cases. Although 35% assaults were reported to be first time incidents, a further 13% were against women who stated that they had been assaulted more than 5 times previously. Alcohol was involved in a total of 45% of domestic violence cases, and drugs were involved in a total of 7.5% of cases.

As a result of this local assault study provision was made for a domestic violence worker to be linked to NGH A&E. Local organisations such as the local authority, the NHS and the police have long been concerned to improve services for those experiencing domestic abuse. There is currently support for further work in relation to cases where under-18s have been subjected to domestic violence, such as creating referral links to child protection and safeguarding services.

The map below shows the distribution of domestic violence related contacts in children in care. It is similar to the maps of deprivation earlier in this report. It is unfortunate that
the data from which this map was drawn could not be produced for this project.

**Figure 57:** Rate of domestic violence related contacts to children’s social care per 1,000 children

Source: Northamptonshire CC Early health and needs analysis May 2013
Drugs and alcohol

Northamptonshire has recognised that it has a substantial challenge to support those C&YP in households where there is substance abuse and excessive use of alcohol. It is one of 20 locations in England selected to receive Local Alcohol Action Area funding, awarded by the Home Office with the aims of tackling alcohol-related crime and disorder; reducing alcohol-related health harms; and promoting growth by establishing diverse and vibrant night-time economies. Northamptonshire has pledged to tackle all three aims.

Recently there has been a local data gathering exercise led by the drugs and alcohol team (DAT) that has revealed some helpful findings, including an understanding of the overlap between the drugs and alcohol in the home and the outcomes for C&YP.

There was evidence that:

- The most commonly used drug among 11 – 15s was cannabis, with 7.6% of pupils having used cannabis in 2011.
- It was estimated that over 4,000 young people in Northamptonshire aged between 11 and 15 used drugs at least once during 2011. Roughly half of these would have been age 15.
- About 70% of secondary school pupils who had taken drugs were given them by a friend on the first occasion.
- 96.0% of pupils who had received education about drugs in school found it had helped them think about the risks of taking drugs, though pupils who had taken drugs in the last month were the least likely to have found lessons helpful in this respect (88.0%). 70.5% of pupils found that the lessons had helped them understand where to get information or help about drugs; this percentage was highest for those pupils who had taken drugs in the last month (77.8%).
- Based on national pupil surveys, it was estimated that around 19,000 young people in Northamptonshire aged 11 to 15 have tried an alcoholic drink (2011 figures). Almost a quarter of pupils aged 15 drank at least once a week. The prevalence of drinking amongst secondary school pupils has decreased significantly over the last decade.
- In 2011-2012, a total of 1761 adult clients received treatment for drug misuse. Of these, 611 (34.7%) were parents to a total of 1,216 children. The number of parents amongst drug clients in treatment has increased since 2008-2009, but was at its lowest level since then in 2011-2012.
- Of the 519 adult clients treated for alcohol misuse in 2011-2012, 134 (25.8%) were parents to a total of 230 children. Alcohol clients with children were more likely to report living with their children than drug clients (93.3% compared to 61.7%). At a recent meeting, parents in one area of the County reported giving alcohol to their adolescent children to avoid their taking drugs, seeing this as a preferable option.
- National estimates suggest that 8% of under-16s live with at least one substance misusing parent. Based on 2011 population figures, this is equivalent to around
11,000 children in Northamptonshire. Local data for 2011-2012 suggest that there were 732 children living with known drug service users during that period, so there may be a much larger number not known to any agency.

Applying national rates of use of alcohol, illegal drugs and tobacco to Northamptonshire, Dr J Campion in his work indicated that:

- 5040 of 11-15 year olds would drink alcohol each week
- 2540 of 11-15 year olds would have used illegal drugs in each month of 2012
- 2100 of 11-15 year olds would be regular smokers and 3360 of 11-15 year olds would have smoked in the previous week

Northamptonshire DAT undertook work between December 2012 and December 2013 to better understand 20 young people known to its services and who were known to the social care system. Their findings included:

- All 20 young people lived in four Northamptonshire districts: East Northants, Kettering, Northampton and South Northampton
- There were 13 males and 7 females
- 14 had a primary problem with substance misuse, while six were primarily abusing alcohol
- These 20 young people used cannabis, heroin and its derivatives, solvents, and injected steroids, sometimes separately but often in combination. They rarely used cocaine
- Those using cannabis and referred to CAMHS had a history of missing appointments and therefore not receiving the support and treatments which would benefit them
Figure 58 demonstrates that just over 30000 Northamptonshire C&YP had problems with alcohol. Of these about 3600 also had substance abuse issues, about 4400 had mental health problems and that just short of 1400 experienced problems with all three – alcohol, mental ill health and drug abuse. The overlaps of alcohol, drugs and mental ill health affected 11600 C&YP, an important burden where close working across health, social care and criminal justice is needed for the most effective results. Two thirds of children and young people in social care with drug and alcohol problems are male, and one third female.

**Figure 58: Mental health, drugs and alcohol use of Northamptonshire children and young people**

Source: NCC BIRT (probably 2012 numbers)

It is noteworthy that, of those currently supported by the DAT, 70% have a primary problem with drugs, and 30% have a primary problem with alcohol. Local data from the DAT showed that across the County there are 1300 - 1400 C&YP living in families with adults in treatment. Over the years 75% of these people locally have gone on to continued abuse as adults (though the numbers are small) and reducing this percentage is a key local priority. 75% substance misusers have experienced substance misuse within their families as a child (though again numbers are small). Although the DAT team know that across England treatment for these C&YP typically lasts 6 to 7 months, in Northamptonshire the typical length of treatment is more than 1 year, and may take more than 2 years.

Northamptonshire DAT team has reviewed latest evidence on the most effective approach to young people involved with alcohol and substance abuse. There were two findings which have impacted on service arrangements:

1. Within the County evidence showed that the best working arrangements and outcomes were delivered by practitioners recruited and line-managed by the YOS teams. Between 50% and 75% of referrals derive from YOS, which makes an

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3 2013 Data from NCC DAT team
annual contribution to the cost of this service. The local DAT team has reported improved outcomes when working closely with the local YOS, where staff have been shared to improve both communication and to spread skills more broadly.

2. C&YP did not find social workers support helpful. As a result the DAT team has begun an occasional visitor scheme for those affected C&YP who are in care. Occasional visitors are adults trained to build a relationship with these young people, and to stay in touch with them by visiting every week or fortnight for up to 15 years.

Northamptonshire has joined a four year attitudinal survey of drugs and alcohol among the young led by Bath University and expected to report in 2018.

The Partnership Strategic Assessments produced by the Police during 2013 noted that reading across the findings of various surveys and assessments highlighted the issue of drugs and alcohol as a key local challenge, particularly in how it affects (either directly or indirectly) children and young people. The Partnership Strategic Assessments recommended that further analysis should be undertaken to identify local hotspots for drug and/or alcohol related crime and anti-social behaviour.

**Abuse and neglect**

The data set out in the earlier section on looked after children provides some evidence for the scale and impact of abuse and neglect. Although abuse and neglect were named less frequently in Northamptonshire as causes for C&YP to be looked after, they nonetheless were among the commonest causes of harm brought to the attention of social workers. Figure 59 below shows the distribution of abuse and neglect brought to the attention of social care at May 2013. The map closely follows that of deprivation, with key hot spots being the urban centre of Northampton, Daventry, Corby and Wellingborough.
Figure 59 Map of abuse and neglect related contacts to children’s social care per 1000 children

Source: Northamptonshire CC Early Health Needs Analysis, May 2013
A local 2012 report focused on neglect, older children and thresholds. For older children it found that they may be in contact with a range of organisations. They may present with poor behaviour or their behaviour may be viewed as risky when in fact it is they who are at risk. Some of these behaviours were brought to the attention of mental health services, rather than being reasons the C&YP become known to social services, and there may be cross over between the two systems and their support for these C&YP. It concluded that effective early intervention services are crucial and that using the social care system should be viewed by C&YP as a positive not a negative. It noted that Prof Eileen Munro had recommended a new duty for local authorities to secure sufficient provision of local early help services for children but that this had been rejected by the government.

**Youth Offending**

Data between 2011 and 2013 shows that numbers of offences, the disposals and the size of the offending population all fell.

**Figure 60: Offences, disposals and offending population, Northamptonshire, 2010/11 to 2012/13**

![Offences, Disposals and Offending Population Data 2010/11 to 2012/13](source)
A second chart of offences broken down by District within the County showed that the largest proportion was committed in Northampton and the smallest proportion in South Northants. The figures showed that some offences were committed out of County, and that a very few were not properly classified (NA).

**Figure 61: Offences by district and borough, 2010/11 to 2012/13**

These two charts evidence progress on working with young offenders over the last 2 or 3 years. They indicate where resources should be concentrated to achieve greatest impact. Northampton alone still has a larger number of offences than the five districts with the lowest numbers of offences added together.
Child sexual abuse and exploitation

In November 2013 the Office of the Children’s Commissioner published a report on child sexual exploitation if only someone had listened. It contained few facts and figures on the scale of the problem, but recognised its importance. The body of this report was concerned with advice on agencies working together and prioritising this issue, and on how best to build trust with young people and work closely with them in ways they would find helpful. It is worth noting that the report sets out how little has been achieved in reducing gang violence, and particularly gang sexual violence, against very young women.

Northamptonshire has already established a multi-agency service hub (MASH), a recommended means of facilitating work on child sexual exploitation, to encourage partnership working across health, social care and police which makes this work more likely to succeed.

In Northamptonshire the 2013 Early Help Needs Analysis engaged local health and social care professionals who echoed the concerns over child sexual exploitation, as well as concerns over young people displaying inappropriate sexualised behaviours. A multi-agency Child Sexual Exploitation team was established, comprising police officers, drugs and alcohol specialists, specialists in child sexual exploitation, and social workers co-located and tasked by the MASH. The team is governed by a multi-agency steering group which reports to the LSCB.

The police first gathered information systematically during 2013. This early data suggested that typical victims of child sexual abuse were typically:

♦ mid-teenage girls, often already known to the criminal justice system (eg have been missing persons

♦ people with convictions for other offences such as violence against the person, or for shoplifting)

♦ known to health professionals (eg have a history of substance abuse) or known to social care (eg are known to have demonstrated risky behaviours).

About 1 in 3 has a history of all three issues. Less than half were known to the social care system at the point of the reported abuse. The perpetrators of reported child sexual exploitation were predominantly white men around 30 years of age who already had criminal records, though few had records for sexual offences. In about half of all cases there was online contact between victim and perpetrator.

National work on child sexual exploitation had not raised immediate serious concerns about gang child sexual exploitation activity in the County where lone abusers have therefore been the focus of local work by the team.

Because this is the first data collected in Northamptonshire, this report has set out the general tenor of what has been found rather than giving numbers or rates. In future years the police and local child sexual exploitation team should be able to supply well-
evidenced data in a more complete form to support work to tackle this challenge. There could be work, for example, to ascertain if the picture to date of the ethnicity of perpetrators is accurate or if few of those abused in some communities report their experiences to police. As work progresses it will be important to link it with work on missing C&YP.

Disabilities and Learning Disabilities

Using national estimates, the percentage of children in Northamptonshire with a disability is estimated to be between 3.0% and 5.4%. The population of disabled children is growing as advances in medicine help to diagnose, treat and manage disabled children’s health and social needs. Children with disabilities are not a homogenous group and the types of long term disability are wide ranging. In turn the needs of disabled children and their families vary considerably. They often require multi-agency support across health, social services and education.

The millennium cohort study, a longitudinal study following the lives of around 19,000 children born in the UK in 2001/01, found that in the first years of a child’s life rates of lone parenthood climb rapidly for disabled children. The proportion of disabled children living with a lone parent were much higher at age three (33 per cent) than when the child is aged less than one (when 22 per cent live with a lone parent). Research indicated that disabled children were three times more likely to suffer abuse and were less likely to be able to protect themselves or seek help.

Using 2004 data, (the most recent available) in Northamptonshire there may be around 29,500 children and young people with a mild disability and 11,000 children and young people with a severe disability.

The data in Table 11 below have been split across the County’s districts.
### Table 11: Rate of children and young people with a mild disability per 1000 population, 2010

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Corby</th>
<th>Daventry</th>
<th>East Northants</th>
<th>Kettering</th>
<th>Northampton</th>
<th>South Northants</th>
<th>Wellingborough</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>males</td>
<td>101.8</td>
<td>114.5</td>
<td>118.5</td>
<td>105.0</td>
<td>95.7</td>
<td>123.2</td>
<td>112.0</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>92.9</td>
<td>106.4</td>
<td>105.0</td>
<td>104.0</td>
<td>92.9</td>
<td>113.0</td>
<td>101.7</td>
</tr>
<tr>
<td>5-9</td>
<td>males</td>
<td>236.1</td>
<td>270.8</td>
<td>250.0</td>
<td>241.1</td>
<td>241.7</td>
<td>250.0</td>
<td>250.0</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>169.4</td>
<td>180.0</td>
<td>187.5</td>
<td>167.1</td>
<td>168.0</td>
<td>186.4</td>
<td>180.0</td>
</tr>
<tr>
<td>10-14</td>
<td>males</td>
<td>211.8</td>
<td>207.4</td>
<td>200.0</td>
<td>203.4</td>
<td>200.0</td>
<td>208.3</td>
<td>208.3</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>201.2</td>
<td>197.9</td>
<td>196.8</td>
<td>190.0</td>
<td>193.4</td>
<td>190.0</td>
<td>190.0</td>
</tr>
<tr>
<td>15-19</td>
<td>males</td>
<td>189.5</td>
<td>180.0</td>
<td>190.9</td>
<td>188.1</td>
<td>186.4</td>
<td>187.5</td>
<td>187.5</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>177.8</td>
<td>166.4</td>
<td>165.5</td>
<td>162.5</td>
<td>166.2</td>
<td>167.3</td>
<td>167.3</td>
</tr>
<tr>
<td>0-19</td>
<td>males</td>
<td>180.1</td>
<td>194.9</td>
<td>190.8</td>
<td>181.8</td>
<td>176.0</td>
<td>192.4</td>
<td>188.0</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>156.8</td>
<td>163.7</td>
<td>163.9</td>
<td>155.4</td>
<td>149.7</td>
<td>166.5</td>
<td>159.4</td>
</tr>
</tbody>
</table>

Source: Children and young people’s disability needs assessment

### Table 12: Rate of children with a severe disability per 1000 population, 2010

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Corby</th>
<th>Daventry</th>
<th>East Northants</th>
<th>Kettering</th>
<th>Northampton</th>
<th>South Northants</th>
<th>Wellingborough</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>males</td>
<td>109.1</td>
<td>122.7</td>
<td>126.9</td>
<td>112.5</td>
<td>102.5</td>
<td>132.0</td>
<td>120.0</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>57.1</td>
<td>65.5</td>
<td>64.6</td>
<td>64.0</td>
<td>57.1</td>
<td>69.6</td>
<td>62.6</td>
</tr>
<tr>
<td>5-9</td>
<td>males</td>
<td>113.3</td>
<td>130.0</td>
<td>120.0</td>
<td>115.7</td>
<td>116.0</td>
<td>120.0</td>
<td>120.0</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>47.1</td>
<td>67.4</td>
<td>52.1</td>
<td>46.4</td>
<td>46.7</td>
<td>51.8</td>
<td>50.0</td>
</tr>
<tr>
<td>10-14</td>
<td>males</td>
<td>84.7</td>
<td>83.0</td>
<td>80.0</td>
<td>80.0</td>
<td>81.4</td>
<td>80.0</td>
<td>83.3</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>42.4</td>
<td>41.7</td>
<td>41.4</td>
<td>40.0</td>
<td>40.7</td>
<td>40.0</td>
<td>40.0</td>
</tr>
<tr>
<td>15-19</td>
<td>males</td>
<td>31.6</td>
<td>30.0</td>
<td>31.8</td>
<td>32.1</td>
<td>31.3</td>
<td>31.1</td>
<td>31.3</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>22.2</td>
<td>20.8</td>
<td>20.7</td>
<td>20.8</td>
<td>20.3</td>
<td>20.8</td>
<td>20.9</td>
</tr>
<tr>
<td>0-19</td>
<td>males</td>
<td>85.3</td>
<td>89.3</td>
<td>86.1</td>
<td>86.1</td>
<td>82.9</td>
<td>89.7</td>
<td>88.6</td>
</tr>
<tr>
<td></td>
<td>females</td>
<td>42.7</td>
<td>43.7</td>
<td>43.8</td>
<td>43.6</td>
<td>41.9</td>
<td>44.8</td>
<td>43.6</td>
</tr>
</tbody>
</table>

Source: Children and young people’s disability needs assessment

The most recent local strategy for C&YP with a learning disability, drafted in response to the 2007 Aiming High for Disabled Children policy was for 2009 to 2011. It spoke of some key areas for development, particularly short breaks, therapies, transport, equipment, support to individuals and to their families, and some multi-agency challenges.
According to ONS 5130 local children (under 18) receive disability living allowance (DLA), which is about 4% of the whole child population of the County, a percentage that mirrors England as a whole. 1700 of these children live in Northampton. In almost all age groups the number of boys in receipt of DLA is double the number of girls, especially in the 11-16 age group where 600 girls in the County receive DLA compared to 1410 boys.

Table 13: Breakdown of Northamptonshire learning disabled C&YP by district

<table>
<thead>
<tr>
<th>District</th>
<th>aged under 5</th>
<th>aged 5 to under 11</th>
<th>aged 11 to under 16</th>
<th>aged 16-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northamptonshire</td>
<td>580</td>
<td>1,850</td>
<td>2,010</td>
<td>690</td>
</tr>
<tr>
<td>Corby</td>
<td>70</td>
<td>180</td>
<td>210</td>
<td>70</td>
</tr>
<tr>
<td>Daventry</td>
<td>50</td>
<td>160</td>
<td>170</td>
<td>60</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>60</td>
<td>210</td>
<td>270</td>
<td>90</td>
</tr>
<tr>
<td>Kettering</td>
<td>80</td>
<td>280</td>
<td>280</td>
<td>100</td>
</tr>
<tr>
<td>Northampton</td>
<td>230</td>
<td>620</td>
<td>630</td>
<td>220</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>50</td>
<td>160</td>
<td>180</td>
<td>50</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>60</td>
<td>240</td>
<td>270</td>
<td>90</td>
</tr>
</tbody>
</table>

Source: ONS Nomis 2013

In 2012 a review by Campion set out the scale of C&YP with disability, including learning disability, in Northamptonshire. There were:

- 1070 primary school children with statements
- 1275 secondary school children with statements
- 3590 children with Special Educational Needs
- 916 children with Autistic Spectrum Disorder known to schools
- 2442 children with learning difficulties known to schools
- 879 children with learning difficulties estimated to have a mental disorder

The England comparisons were not given.

In September 2013 Northamptonshire reviewed those C&YP with disabilities classified as children in need (CIN). 440 were logged as having a disability. The most frequent diagnoses were of autism or Aspergers syndrome and a classification of special educational need.
The description of these disabilities was as shown below.

**Table 14: Disability description**

<table>
<thead>
<tr>
<th>Disability Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour – a condition entailing behavioural difficulties includes Attention</td>
<td>15</td>
</tr>
<tr>
<td>Deficit Hyperactivity Disorder (ADHD).</td>
<td></td>
</tr>
<tr>
<td>Communication – speaking and/or understanding others.</td>
<td>11</td>
</tr>
<tr>
<td>Consciousness – seizures.</td>
<td>6</td>
</tr>
<tr>
<td>Diagnosed with autism or Asperger Syndrome – diagnosed by a qualified medical</td>
<td>189</td>
</tr>
<tr>
<td>practitioner as having classical autism or Asperger syndrome.</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>6</td>
</tr>
<tr>
<td>Incontinence – controlling the passage of urine or faeces.</td>
<td>2</td>
</tr>
</tbody>
</table>
### Disability Description

<table>
<thead>
<tr>
<th>Disability Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning – having special educational needs, etc.</td>
<td>104</td>
</tr>
<tr>
<td>Mobility – getting about the house and beyond.</td>
<td>38</td>
</tr>
<tr>
<td>None</td>
<td>8653</td>
</tr>
<tr>
<td>Other DDA – one or more of the child’s disabilities under the Disability Discrimination Act 2005 does not fall into any of the above categories.</td>
<td>59</td>
</tr>
<tr>
<td>Personal care – eating, washing, going to the toilet, dressing, etc.</td>
<td>5</td>
</tr>
<tr>
<td>Vision</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9093</strong></td>
</tr>
</tbody>
</table>

C&YP with learning disabilities have a well-known association with being known to both the social care system and CAMHS. Northamptonshire is no exception. In the review undertaken by Campion in 2012, he stated that the rate of referral to social care for abuse of vulnerable persons with learning disability was 222 per 100000 in Northamptonshire, compared with an England average of 103 per 100000.

### Drug interventions for ADHD

Methylphenidate and atomoxetine are two drugs commonly used to treat attention deficit hyperactivity disorder (ADHD). The figures below demonstrate that their use across the County is very variable, and in some districts, such as Wellingborough, appears far greater than the England average. This finding should be explored further in case there is inappropriate (and costly) use of these drugs.

A recent study in the BMJ\(^4\) plotted the use of these drugs across England and noted wide variations in their use, though these do not appear to be accompanied with wide variations in outcomes for the C&YP for whom they are prescribed. This has been of concern to local pharmacists and clinicians who are working to better understand the appropriate use of these drug treatments.

\(^4\) [http://bmjopen.bmj.com/content/3/1/e001363.full](http://bmjopen.bmj.com/content/3/1/e001363.full)
Figure 63: Atomoxetine Hydrochloride cost per patient

Source: Nene CCG

Figure 64: Methylphenidate cost per patient

Source: Nene CCG
Section summary

In this section, evidence has been examined for several risk factors among those who are both within the social care system and receiving CAMHS. As reflected in the national data, domestic violence, drugs and alcohol in the home, and abuse and neglect are commonly found. It was not possible to determine whether any pair of these was more likely to be more detrimental than any other pair.

There was information on other risk factors, particularly youth offending, where the picture is one of improvement. The disabled and learning disabled were shown at higher risk of abuse, and with less ability to seek help.

The use of drugs to treat ADHD was discussed, and seen to be variable across the county. Data did not demonstrate an association between these drug interventions and improved outcomes.

This section has led to six recommendations.

1. Northamptonshire CC is undertaking work, including this review of health needs, to curtail the numbers of C&YP who move from early help through to more intensive interventions. This report recommends that the local CCGs review the NHS early intervention provision for children and young people and ensure that there is a menu of services in place to prevent problems escalating. Good communications across health and social care sectors will allow well-coordinated provision.

2. This report recommends police and Northamptonshire CC should together gather domestic violence data to establish the current rate for each district of Northamptonshire CC, so allowing trend monitoring as actions are taken to tackle this challenge. Data should be collected at household and individual level to allow close mapping to highlight those locations within the County where investment would yield greatest benefit.

3. This report concurs with the recommendation in the Partnership Strategic Assessments produced by the Police during 2013 that further analysis should be undertaken by the Police to identify local hotspots for drug and/or alcohol-related crime and anti-social behaviour and child sexual exploitation.

4. Northamptonshire CC should review how fully the interventions implemented to meet the Aiming High for Disabled Children policy improved life for the young learning disabled community and to learn where investment was most effective (especially from the viewpoint of these C&YP themselves). Learning from those actions should prove useful to deciding on actions in the coming year when some services will be recommissioned in different ways.

5. This report recommends that action be taken by clinicians, pharmacists and the CCGs to assess whether the use of methylphenidate and atomoxetine is appropriate and producing improved outcomes for C&YP with ADHD.

6. This report recommends that the Drugs and Alcohol Team implement its agreed plans, including participation in the attitudinal survey started by Bath University, especially since recently the team has begun to listen to C&YP and understand how to arrange services in ways which are more attractive to them. The DAT should implement its planned actions while continuing to compile up to date evidence and evaluating the impact of any steps taken.
What children and young people say
This section summarises the views of children and young people about local services. There have been some bespoke local consultations with C&YP, and there is a shadow CYPPB board with some C&YP heavily involved. This report did not find a structured, resourced and evidence-based programme for listening to the views of C&YP, with clear demonstration that those views are taken into account.

The views of C&YP themselves
The views of C&YP are key to understanding how best to change risk taking behaviour, engage with families to deliver effective early help, and enable timely and appropriate use of services. Northamptonshire CC understands that it must listen to the voices of all the C&YP of the County, engaging with them whenever practicable at an individual level while recognising that they should have a voice at a strategic and planning level.

Northamptonshire has some structures that assist in their quest to understand the wishes of C&YP. There is a well-established Shadow Board, where young people from across the County are supported to engage in planning, recruitment, procurement and needs assessments. These young people are themselves represented on the Children and Young People’s Partnership Board. The Shadow Board has engaged with consultations on young people’s services over the years. Young people have consistently stated that they want services to be local and easily accessible, highlighting the difficulties of access for those who rely on public transport, both in relation to cost and accessibility at appropriate times.

Specific local consultations
Children’s Plan 2013 - 2016
As part of the consultation that informed the Northamptonshire Children’s Plan 2013-16, the Shadow Board was asked what type of services C&YP thought would most help them. The young people were clear that they wanted to grow up in safe environments and said that CCTV, increased police presence in the community and in schools, and security on buses made them feel safer. They wanted to be protected from bullying, sexual exploitation, drugs and alcohol, road accidents and personal attacks in the street. They felt they needed to be protected from sexually transmitted infections. They wanted more accessible entertainment to distract them from potential negative behaviours such as drug taking and felt that local radio could be used to get young people friendly messages across.

To help them achieve their best in education, to be ready for work and to have skills for life, young people spoke of wanting “real life” education and specified politics, budgeting and how to get a mortgage as particularly important. They wanted help with developing their curriculum vitae and interview techniques and with choosing their study options. Work experience was important to them, along with support for those with special needs. They asked for better access to youth centres and educational activities but stressed that affordable transport would be important in allowing them to best use any of these services.
To help them to grow up healthy, C&YP wanted more education, specifically about drugs, alcohol and smoking. They wanted to eat more healthily but wanted access to cheaper healthy food in order to do so. Young people wanted to be active and indicated that gyms were their preferred option rather than sports or other activities. They wanted gyms to be cheaper, to have designated times for young people and for schools to make gym equipment more accessible out of school hours. The group who were consulted included a number of LAC who expressed a need for a wide range of information, for faster processing of care orders and better preparation for leaving care. They expressed a need to be taught about parenting.

Mental health was a key concern for the young people in this consultation and some of their comments were consistent with those made by a group of young people engaged in a wider consultation about mental health services. The Shadow Board felt that they needed more information on mental health, especially around anxiety, depression and self-harming. They expressed a belief that self-harm and panic attacks were common among their peers. They were particularly concerned about exam stress and felt that the exam system is designed around what schools want and not what young people need.

In the wider consultation it was clear that views differed depending on age, but it is difficult to interpret given the different sizes and makeup of the groups involved. The groups included eighteen 10-11 year olds, 520 young people aged 12-19 years and 31 CAMHS users. When asked if young people have positive hopes and direction, 17% of young people aged 12-19 strongly agreed, compared to only 2% of the adults surveyed. While it seems that young people’s views are very different to those of adults it should be noted that the adult group of 121 respondents were mainly professionals including 35 health professionals, thirteen police officers and 32 other professionals. There were only 38 parents and three grandparents involved (though some of the professionals would have been parents).

The most common concerns were relationship difficulties, either at home or with friends. Forty-five percent of the young people thought there was adequate emotional health support in the community to help young people compared with 18% of adults. Forty-four percent of young people responding felt they knew where to go to if they had concerns. Family and friends were both the most common source of problems and the most common source of help cited. Responses from the small group of 10–11 year olds were in general more positive than the “universal” cohort of 12-19 year olds. These C&YP wanted to know how to access support and what support was on offer.

Overall children, young people and families in Northamptonshire have said that they want services to fit with their lives and lifestyles rather than those of the health professionals lives and lifestyles. They would prefer one person who they can engage with and who will support them. Over the years young people have repeatedly explained that confidentiality is extremely important, although in practice the young people often describe not wanting anyone except the individual practitioner to know they are accessing a service. This seems particularly relevant in relation to accessing sexual health services and young people’s public health nurses in school settings. A Shadow Board consultation in 2012 indicated that young people’s preference was for the use of text message to book fixed appointments in discrete settings rather than “drop ins” where any one might see them. They requested clear information on these services on school websites and text or email access to book appointments, receive test results or
Domestic violence

During 2013 the police obtained the views of those families where domestic violence had led them to contact the police. An event was held where they were asked how services might improve. Their comments covered

- The services to support victims of domestic abuse should be more actively and innovatively advertised, to seek to ensure that all victims of domestic abuse can be made aware of the support that is available. For example, respondents favoured discreet messages in places such as GP surgeries, libraries, places of work and on the radio where victims can access information without putting themselves at risk.

- Currently victims are confused about which support organisations do what, feeling that some duplicate each other and others are unavailable in some areas of the County. Support services for victims of domestic abuse preferred one service, coordinated by one agency and coherently explained and offered to all victims.

- Services currently available to support the wider family and particularly children of domestic abuse victims should be reviewed to identify any gaps in provision, from which improved services should be developed to better meet their needs.

- Currently the onus is on victims of domestic abuse to collect or show evidence to prove their victimisation. This needs to change. Police officers should offer more help and support to victims ensuring they feel believed and officers should take responsibility for collecting appropriate evidence.

- Local authorities should review their powers to support victims of domestic abuse in cases where the victim is legally in the country but has insecure immigration status (for example where the victim is a partner of a British citizen who is their abuser), and provide more effective services to them. Victim support services should improve their knowledge to support victims in such circumstances and work collaboratively with local authorities to implement more effective services.

Drugs and alcohol team

During 2012 and 2013 the Northamptonshire DAT undertook in depth interviews with a number of C&YP and their families. The team focused on those C&YP who were LAC, and those households where there was mental ill health of either an adult or a child or both. They used this information to understand how these clients perceived their problems and how services should best be presented to meet their needs in ways which were attractive to them. Some key findings were divulged to the PHAST team informally through personal communication:

- The C&YP offered detailed information on their use of drugs and alcohol. This included the substances used, the combinations which were favoured, and the use of legal and illegal substances both separately and together.
Some cannabis users were referred to, and attended, CAMHS. However, for those C&YP for whom alcohol was the prime agent they used, many fewer attended CAMHS when referred.

Within a number of families in specific districts of Northamptonshire, parents who are heavy alcohol drinkers give their children alcohol to drink. Their adolescent children may drink as much as their parents. The same families reported that they would continue to allow their children to drink alcohol as long as they did not take other (illegal) substances as well.

Among those C&YP regularly drinking alcohol groups form of those with similar habits, eg those who both smoke and drink alcohol. These groups influence where the family money is spent, with parents tending to prefer to allow their children to continue drinking to avoid even riskier behaviours, or the potential for their children to commit criminal activity to obtain funds for their drugs and alcohol behaviours.

C&YP within these groups preferred not to deal with their drugs and alcohol problems with their social workers.

This information has already informed investment by the DAT, who are commencing a scheme of “occasional visitors”. These are lay people who volunteer to visit a young person regularly and to do so over a number of years providing adult support which can help them talk through their issues and act to change their behaviours long term.

**OFSTED**

In the OFSTED reports discussed earlier in this paper there was comment on the inconsistency of listening to C&YP, and concern about gaps in the understanding of their views. This was found in both the inspections of safeguarding and child protection and of the adoption service.

**Deliberate self harm**

As part of the work of the Deliberate Self Harm Task Group some work has been undertaken to obtain the views of those C&YP who had self harmed. The Task Group used national work, including that of Cello, a strategic marketing group whose Talking Taboos programme brought the views of C&YP on self harm together; and Young Minds, where there is information for C&YP, their families, and for health and social care professionals on a dedicated area of their website. These pieces of engagement work encouraged the Task Group to work with local C&YP to design a web page setting out the issues and inviting their peers to make contact with local services should the need arise.

**Section summary**

Northamptonshire has examples of good local practice and the use of national intelligence on involving C&YP. While these were laudable, there was no evidence of a consistent approach to hearing what C&YP wish to tell public sector bodies locally. It is important to have a means for C&YP to hold a dialogue with those who allocate resources on their behalf. The choice of services to provide, and the ways in which those services are presented to C&YP, will impact on their effectiveness. As Prof Munro said,
"The measure of the success [of child protection systems, both local and national,] is whether children are receiving effective help."

Success is more likely if C&YP feel comfortable in finding and using the services on offer.

There is one recommendation which was drawn from this section.

This report recommends that the Health and Wellbeing Board support the establishment of a programme across all member agencies for listening to Northamptonshire’s C&YP. The programme should have clear aims, use well attested methods to answer specific questions, and encourage agencies act on what they hear as far as they are able. This programme of listening to C&YP should extend to the transition from social care to adulthood, where the YP should be widely consulted on how services are offered so that support is given in ways that attract them to make best use of it.
What is the likely future need and demand for social care and CAMHS services, and associated costs, given current trajectories? How would these alter under plausible changes in those trajectories, including if those trajectories improved?

This section sets out the process and findings of modelling local health and social care data. The modelling sought to identify risk factors for the locally high uptake of care and CAMHS.

An expert PHAST team with expertise in identifying and modelling risk factors at the local level explored what risk factors are relevant to the uptake of C&YP mental health and social services, using an existing detailed case study within a coherent conceptual framework (Figure 65). The prevalence and trends of these risk factors within and across Northamptonshire were then examined.

Figure 65: Conceptual framework for evaluating risk


The theory is that if exposure to these risk factors could be reduced or managed better then need would reduce, leading to reduced demand, resulting in a more affordable service concentrated on the neediest cases.

In other boroughs elsewhere in England there were four key individual trigger risk factors that were highly predictive of either need for social care services or need for CAMHS. These were persistent school absence; youth offending; domestic violence; and
special educational needs (SEN). Domestic violence and youth offending were more predictive of the use of children’s social services than of CAMHS whereas SEN was more predictive of CAMHS than children’s social services. Persistent school absence tended to be equally associated with either.

The modelling team wanted to examine exposure to these four known trigger risk factors in Northamptonshire further. Unfortunately, in each case the data was not available in a format which allowed thorough analysis, other than for youth offending which showed that this is decreasing and therefore not driving the caseloads. Data at sub-district level or by smaller geographical areas, are necessary to undertake successful modelling and predictions, ideally at the household and individual level.

**National work on risk factors for social care and for CAMHS applicable to Northamptonshire**

ONS has examined additional risk factors nationally. These ONS risk factors confirm that BME children are less likely to be identified with mental disorders and that older children and families with step-children are at greater risk.

**Table 15: Additional risk factors associated with mental disorders**

<table>
<thead>
<tr>
<th>Factors from ONS survey</th>
<th>Odds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older children versus younger children</td>
<td>1.52</td>
</tr>
<tr>
<td>Non-white ethnicity</td>
<td></td>
</tr>
<tr>
<td>Black African</td>
<td>0.11</td>
</tr>
<tr>
<td>Indian</td>
<td>0.21</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.47</td>
</tr>
<tr>
<td>Step children</td>
<td>1.53</td>
</tr>
<tr>
<td>Parents with no educational qualifications</td>
<td>1.55</td>
</tr>
</tbody>
</table>

Source: ONS/Green et al 2005

ONS have also drilled down further and sub-divided mental disorders into different categories. The risk factors they found that specifically affect each sub-category is given in Table 16. These risk factors are universal across England as a whole and can be applied within Northamptonshire.
Table 16: More detailed classification of risk factors by mental disorder

<table>
<thead>
<tr>
<th>Any mental disorder</th>
<th>Emotional disorders</th>
<th>Conduct disorders</th>
<th>Hyperkinetic disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys more likely than girls</td>
<td>Girls more likely than boys</td>
<td>More likely to be boys and in older age group 11-16</td>
<td>More likely to be boys and white</td>
</tr>
<tr>
<td>Lone parent than 2 parent families</td>
<td>Aged 11-16 than younger</td>
<td>Live in households containing large number of children (4 or more)</td>
<td>Live with single or previously married lone parents</td>
</tr>
<tr>
<td>Reconstituted than no step-children families</td>
<td>Living with widowed, divorced or separated lone parent</td>
<td>Parents with no educational qualifications</td>
<td>Parents with no educational qualifications</td>
</tr>
<tr>
<td>Parent with no educational qualifications than degree</td>
<td>Living with stepchildren</td>
<td>Live in low-income families</td>
<td>Live in low-income families</td>
</tr>
<tr>
<td>Families with neither parent working than both parents working</td>
<td>Parents with no educational qualifications</td>
<td>Households with gross weekly income &lt;£300 per week</td>
<td>Households with gross weekly income &lt;£300 per week</td>
</tr>
<tr>
<td>Families with gross weekly household income &lt;£100 &gt;=£600</td>
<td>Low income families</td>
<td>Live in most economically disadvantaged circumstances</td>
<td>No parent working</td>
</tr>
<tr>
<td>Households receiving disability benefit than not</td>
<td>Households with gross income &lt;£300 per week</td>
<td>Parents with no educational qualifications</td>
<td>Households receiving disability benefit</td>
</tr>
<tr>
<td>Household reference person in a routine occupational group than in higher professional group</td>
<td>Have fair or bad general health</td>
<td>Households receiving disability benefit</td>
<td>Have fair or bad general health and/or specific physical or developmental problem</td>
</tr>
<tr>
<td>Living in social or private rented sector than owned</td>
<td>Specific physical or developmental problem</td>
<td>Have fair or bad general health and/or specific physical or developmental problem</td>
<td>95% of parents had sought help or advice on previous year, mostly professional</td>
</tr>
</tbody>
</table>

Source: ONS/Green et al. 2005
Prevalence and trends in service caseloads

**Mental health**

Expected need for CAMHS services was modelled as the estimated number of children aged 5-16 years with a mental health disorder for the 2011 population based on rates derived from the 2004 ONS survey (Green, H et al., 2005). The highest need was in Northampton, with an expected rate of 970 per 10,000. The lowest need was in East and South Northamptonshire at 943 per 10,000, but overall rates did not diverge greatly between districts. The estimated rate for the East Midlands as a whole was 960.

CAMHS community caseload was used as a proxy for met need. In Table 17 this is compared to expected need. Table 10 below shows that estimated need is approximately three times higher than met need, and this is consistent across all districts. This finding is common across England and has never been well explained.

**Table 17: Actual rates of CAMHS service use for 5-16 year olds in Northamptonshire by district 2013, compared with expected numbers 2011**

(ONS Mid-Year population estimates only available for 2012)

<table>
<thead>
<tr>
<th>District</th>
<th>CAMHS Community Caseload Aged 5-16 years October 2013</th>
<th>Population aged 5-16 MYE 2012</th>
<th>CAMHS rate per 10,000 5 to 16 year olds 2013</th>
<th>Estimated rate per 10,000 5-16 year olds 2011</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corby</td>
<td>262</td>
<td>9226</td>
<td>284</td>
<td>962</td>
<td>0.3</td>
</tr>
<tr>
<td>Daventry</td>
<td>333</td>
<td>11416</td>
<td>292</td>
<td>950</td>
<td>0.3</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>275</td>
<td>13270</td>
<td>207</td>
<td>943</td>
<td>0.2</td>
</tr>
<tr>
<td>Kettering</td>
<td>378</td>
<td>13846</td>
<td>273</td>
<td>958</td>
<td>0.3</td>
</tr>
<tr>
<td>Northampton</td>
<td>931</td>
<td>30302</td>
<td>307</td>
<td>970</td>
<td>0.3</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>431</td>
<td>12898</td>
<td>334</td>
<td>943</td>
<td>0.4</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>307</td>
<td>11054</td>
<td>278</td>
<td>953</td>
<td>0.3</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>2917</td>
<td>102012</td>
<td>286</td>
<td>957</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Source: Mayhew Harper Associates

**CAMHS inpatient modelling**

The CAMHS inpatient unit data relates only to hospital beds and hospital-based patient care, therefore the numbers are small, but were modelled using average monthly admission rates by district for ages 12 to 19 for April 2010 to September 2013. These data showed a downward trend, falling by 50% over the period, even though annual
admissions/discharges have been relatively level. The main reason is that average lengths of stay have been declining. Wellingborough locality has been the lowest referrer of patients over the period (11 admissions) and Northampton West locality the highest (31 patients).

**Deliberate self harm**
Numbers for self-harm inpatient admissions for 0-19 year olds by locality, and the rate per 100,000 population for 2012-13 is given in Table 18.

**Table 18: Self-harm inpatient admissions for 0-19 year olds 2009 to 2013 by locality in Northamptonshire**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Inpatient Admissions of 0-19's in 2009-10</th>
<th>Inpatient Admissions of 0-19's in 2010-11</th>
<th>Inpatient Admissions of 0-19's in 2011-12</th>
<th>Inpatient Admissions of 0-19's in 2012-13</th>
<th>Rate per 100,000 population 2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Northampton</td>
<td>51</td>
<td>60</td>
<td>64</td>
<td>55</td>
<td>267</td>
</tr>
<tr>
<td>Kettering</td>
<td>35</td>
<td>51</td>
<td>40</td>
<td>49</td>
<td>199</td>
</tr>
<tr>
<td>East/Southern Northampton</td>
<td>30</td>
<td>48</td>
<td>55</td>
<td>40</td>
<td>189</td>
</tr>
<tr>
<td>Central Northampton</td>
<td>44</td>
<td>43</td>
<td>55</td>
<td>28</td>
<td>148</td>
</tr>
<tr>
<td>East Northants</td>
<td>15</td>
<td>19</td>
<td>20</td>
<td>26</td>
<td>148</td>
</tr>
<tr>
<td>Daventry North</td>
<td>28</td>
<td>30</td>
<td>23</td>
<td>23</td>
<td>145</td>
</tr>
<tr>
<td>Corby</td>
<td>29</td>
<td>28</td>
<td>24</td>
<td>25</td>
<td>142</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>15</td>
<td>21</td>
<td>14</td>
<td>20</td>
<td>116</td>
</tr>
<tr>
<td>Daventry South</td>
<td>14</td>
<td>17</td>
<td>18</td>
<td>17</td>
<td>94</td>
</tr>
<tr>
<td>Oundle &amp; Wansford</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Not coded</td>
<td>#</td>
<td>#</td>
<td>#</td>
<td>#</td>
<td>#</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>281</strong></td>
<td><strong>332</strong></td>
<td><strong>337</strong></td>
<td><strong>299</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Local Safeguarding Children Board Northamptonshire, CAMHS Self-harm and Pathways presentation

Key (to avoid using small numbers that could be traceable to individuals)
* Values are less than 5
# Values are less than 25
On the basis of admissions, there is variation in prevalence between localities, ranging from 94 per 100,000 population in Daventry South, to 267 in Western Northampton locality. There was insufficient information at household or neighbourhood level to assess the reasons for those differences.

Numbers of admissions between 2009 and 2013 have generally increased in small numbers for each locality except for Central Northampton, Daventry North and Corby where there have been reductions (though there has been variation each year).

**Risk factor exposure**

The modelling showed that income deprivation, which became more severe between 2009 and 2012, has an association with entry to CAMHS and social services. Corby and Northampton remain the most deprived districts and are expected to have the highest numbers of C&YP using both services.

An example of a study that demonstrates these techniques and the value and the importance of individual level data is given in the accompanying Appendix B.

**What does all this mean for Northamptonshire?**

Whilst there are known risk factors leading to C&YP being referred to CAMHS and to children’s social services, these do not explain the whole picture. If it is possible to modify or reduce their prevalence there would be benefits but there are other important background factors that contribute too and which determine, for example, who will truant, and who will commit domestic violence. Any approach to reducing referrals beyond the short term must tackle these underlying causes as well as the immediate causes. Information must be shared within and across agencies and analysis undertaken in Northamptonshire on the prevalence and co-association of factors common to both services.

The modelling team reviewed the rising burden of CAMHS and LAC if the population grows on current trends and services continue much as now. The work showed that case numbers in CAMHS would increase by 16% on average, but that there would be very substantial variations across the County, with Corby experiencing nearly a 30% increase in caseload. For LAC the increase would be 11% across the County, again with substantial variations, with Corby having an increase of 20% in numbers of looked after children. This is based on population projections between 2013 and 2021 and is shown in full in the table below.
Table 19 Projected percentage changes in the population of LAC and C&YP receiving CAMHS if both service use and population trends continue as now.

<table>
<thead>
<tr>
<th>District</th>
<th>% projected change in LAC population 2021</th>
<th>% projected change in CAMHS population 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corby</td>
<td>20.4</td>
<td>29.6</td>
</tr>
<tr>
<td>Daventry</td>
<td>4.6</td>
<td>7.6</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>9.7</td>
<td>13.7</td>
</tr>
<tr>
<td>Kettering</td>
<td>13.4</td>
<td>18.4</td>
</tr>
<tr>
<td>Northampton</td>
<td>14.0</td>
<td>19.9</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>6.9</td>
<td>8.7</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>7.2</td>
<td>11.4</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>11.4</td>
<td>16.1</td>
</tr>
</tbody>
</table>


This modelling work could not be carried out as fully as intended for Northamptonshire. Local data has been gathered to meet local forces and drivers, and to allow Northamptonshire CC and its partners to fulfil reporting requirements to local and central Government. Information has never been used to drill down within the County and locate caseload by district or sub-District level. It is possible to gather data in a format useful for modelling should Northamptonshire CC wish to do so. Modelling to case-specific detail would give much closer insights into the disposition of local C&YP needing social care and CAMHS services, and would help predict where those who may need services in the future are likely to live, and what their risks actually are. In other places where neighbourhood data has been gathered it has been possible to obtain highly granular data to inform service development (see Appendix B) at household or even individual level.

Section summary

In this section, standard and specialist techniques of data modelling and projection have been used to try to answer some of Northamptonshire CC’s key questions. While this was not possible with the present data systems, it was clear that gathering data in different ways in future would allow an expert team to provide useful intelligence on which Northamptonshire CC and its partners could act.

The modelling did demonstrate the likely increase in caseload for LAC and for CAMHS should Northamptonshire population rise as predicted, and if services remain as now.

There were three recommendations from this section of the report.
This report recommends that Northamptonshire CC and its partners collect data at single year of age bands and with as explicit geographical information as possible so as to allow sub-district modelling work to be performed.

This report recommends that the PHAST modelling team work with Northamptonshire CC to further study districts where reductions in the prevalence of deliberate self harm have been seen to understand how this was achieved.

This report recommends that case-level data be accessed and used to carry out an analysis that links multiple service data at the individual level. This will provide a more locally relevant evidence base and framework allowing Northamptonshire CC to drill down to finer detail and determine what is driving the caseloads with more accuracy. Such data would permit very specific advice on where investment would yield most benefit.
What would be the impact of these projections in terms of cost, staff time and numbers, foster placements, NHS beds and other practical units of resource use?

This section sets out what is nationally and locally known about costs of services. This section proved difficult to complete because of a lack of information from public sector bodies.

CAMHS needs assessment 2013

A 2013 study drew together information on CAMHS from both commissioners and providers in Northamptonshire. The review noted that the national DH/Durham Child Health Mapping [year unclear] showed a national average £800k per 100,000 population spend on CAMHS.

Another national NHS benchmarking exercise undertaken in 2012 showed a funding average was £1.1m per 100,000 population nationally. In Northamptonshire in 2012 the spend was £810,624 per 100,000 for Tier 3 CAMHS. When including work in Tier 1, 2, and 3 the spend was £951,580 per 100,000 population, which was £150k less than the mean average expenditure by other CCGs who do not likely have pooled budgets with social work, education psychology etc. The costs set out in the local needs assessment were drawn from a Demos study of 2011/12 and may be underestimated.

Long term residential care is very expensive, and may not provide the best setting for supporting C&YP. YP leaving long term care have poorer educational outcomes, higher incidence of mental and emotional problems, are less employable and make healthy long term relationships less easily despite the high cost of their residential placements.

The cost of a care journey can vary widely and is dependent on the needs of the child and their parents as well as how quickly and effectively their needs can be addressed. The costs of taking a child into care are not only those associated with their placement but should include the costs of the range of other associated processes.
Demos study 2012

A recent publication by Demos, *In Loco Parentis*⁴⁷, provided average costs for each of the processes associated with taking a child into care. These costs can be seen in Table 20.

Table 20: Costs associated with taking a child into care

<table>
<thead>
<tr>
<th>Process</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>decide child should be looked after</td>
<td>£700</td>
</tr>
<tr>
<td>2</td>
<td>care planning</td>
<td>£131</td>
</tr>
<tr>
<td>3</td>
<td>maintaining placement (including social care activity)</td>
<td>£1,408 a month¹</td>
</tr>
<tr>
<td>4</td>
<td>exit from care</td>
<td>£288</td>
</tr>
<tr>
<td>5</td>
<td>transition to leaving care</td>
<td>£1,274</td>
</tr>
<tr>
<td>6</td>
<td>review at 6 months</td>
<td>£446</td>
</tr>
<tr>
<td>7</td>
<td>placement move</td>
<td>£224</td>
</tr>
<tr>
<td>8</td>
<td>legal process (e.g. getting a care order)</td>
<td>£3,000</td>
</tr>
</tbody>
</table>

¹ The monthly cost refers to the local monthly cost of care placements.

The weekly and annual costs of other local placement types are shown in Table 21.

Table 21: Weekly and annual costs of residential placements

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Actual Average Cost per week £</th>
<th>Actual Average Cost per year £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Residential</td>
<td>£2905</td>
<td>£151060</td>
</tr>
<tr>
<td>Supported Accommodation</td>
<td>£678</td>
<td>£35256</td>
</tr>
<tr>
<td>Secure - Remand</td>
<td>£5,218</td>
<td>£271336</td>
</tr>
<tr>
<td>In-House Fostering</td>
<td>£325</td>
<td>£16900</td>
</tr>
<tr>
<td>In House Residential (Mainstream and CWD)</td>
<td>£1,720</td>
<td>£89440</td>
</tr>
</tbody>
</table>

Source: Tom Gutteridge case study 2012
In a wide ranging review of mental health and care for Northamptonshire undertaken by Dr Jonathan Campion in 2012, the following national cost and outcome data were cited:

- Allocated average spend for mental health per head in Northamptonshire is £164.11 compared to England £182.85. However, 67.4% was spent on secondary care while only 1.7% was spent on prevention of mental disorder or promotion of good mental health.

- Lifetime costs of each one year cohort of 5-16 year olds with conduct disorder in Northamptonshire is £795 million.

- In 2008, the average annual UK costs for each child with mental disorder ranged from £11,030 to £59,130\(^{48}\). One study published in 2005 of children with severe and complex mental health problems estimated that overall average costs of their care to health, social care, education and criminal justice agencies amounted to more than £1,000 a week per child\(^{49}\).

- Treatment of conduct disorder with parenting interventions results in net savings of £8 for each £1 spent (70% of this is due to crime reduction).
School based social emotional learning programmes can result in net savings of £84 for each £1 spent although most school-based wellbeing promotion programmes have recently been cut.

**Northamptonshire spend by tier of need**

Northamptonshire has data on the 2013/14 budget by key local agencies on C&YP who are receiving CAMHS or are within the social care system. In the chart below this is summarised for tiers II and III together, and for tier IV.

**Figure 67 Spend in 2013/14 by source of funds for tiers II and III together and for tier IV**

Source: Northamptonshire CC (Lesley Anne Hamilton, Judith Cattermole and Jon Lee)

**Notes**

1. The tiers 2 and 3 column includes pooled budgets across health and social care.
2. The NHS England spend was derived from levies on the CCGs for tier IV residential placements which are commissioned centrally through contracts that may be agreed on behalf of single Counties, such as that at The Sett, a local Northamptonshire tier IV service, or may be agreed on behalf of several counties.

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5 Tier I is omitted because it was not possible to obtain figures for the NHS spend on universal community activities such as health visiting, school nursing and community midwifery, which is a substantial figure.
for very specialised conditions, such as mental health services for those with learning difficulties and who are also blind and deaf.

3. Government funded programme were Family Nurse Partnership and the Troubled Families Programme, specific national initiatives with a centrally allocated sum for their implementation. There was spending by Northamptonshire CC on Troubled Families in 2013/14 over and above the sum received from Government.

It was striking that across social care and health the spend on tier IV services appeared to be greater than that on tiers II and III together. Tier IV covered residential mental health placements and safeguarding. The safeguarding element included in-house and external provision for LAC and CIN. This budget was supported by one off reserves in 2013 in light of the OFSTED inspectorate recommendations to, for example, improve staff training, fully fund the staff establishment, remove all savings proposals relating to the service, and to establish frameworks and systems for better managing the caseload.

Looking forward to 2014/15 the Northamptonshire CC budget includes growth to permanently fund the increase required in the budget that was identified in 2013. The budget also reflects additional forecast increased demand for social care services.

To drive the improvements in children’s services the Council is investing in a Children’s Services Improvement Programme. Additional funds in 2014/15 and 2015/16 of £1.6m has been made available.

In respect of its tier IV services the Council is reviewing its social care workforce. There has been work to project future caseloads and quantify the social work staff needed. This review is currently ongoing and will reach its conclusion early in 2014.

**Implications of financial information**

At Tier IV there were, at 31 December 2013, 20 young people in specialised placements, making the average cost of each approximately £270,000 per annum. This contrasted with, for example, the Family Nurse Partnership project where the costs of supporting each family was approximately £3400 in 2013 (likely to fall in 2014 to £3000 with no new set up costs to cover). Evidence from the Family Nurse Partnership and other similar supporting parenting programmes consistently demonstrate a substantial return of approximately £8 for every £1 spent. Evidence demonstrates that such an intervention encourages normal child development and the forming of better quality relationships, both factors known to protect C&YP from CAMHS and becoming known to social services.

If one tier IV placement could be avoided in a year then a further 80 families could be supported in Northamptonshire if the cost was the same as the Family Nurse Partnership costs during 2013.

Similarly, the caseload for LAC and CIN at March 2013 was 4216, and were funded by Northamptonshire CC spending a little less than £ 82 million during 2013/14. Lowering the burden of social care by even the need to spend 1% of that sum, would have funded half the Children’s Services Improvement Plan for 2013/14.
What can Northamptonshire do to improve the performance, resilience, sustainability and reputation of its services for children and young people?

This final section sets out some underpinning recommendations for actions for Northamptonshire.

Drawing together the threads from the earlier sections, PHAST believes that there are actions which Northamptonshire could take which help support mothers, children, and young people and which will enhance the reputation of the County.

Locally there is a good deal of activity that reflects the clear messages set out in the 2012 Chief Medical Officer report, the 2010 Marmot report, and the 2011 Allen Report, including work with mothers and babies by community midwives; work in schools; and work within the Troubled Families programme. However, they contain much advice which is yet to be followed. Importantly, all three reports strongly advise allocating funds from within their budgets to shift from intensive, high cost interventions into preventive activities.

This report includes a review of the best evidence for tackling the challenges facing Northamptonshire CC – those of stemming the flow into social care and into CAMHS (or both). There are well described interventions in the published literature (attached at Appendix A), and some are offered within the County.

**Early years**

Published evidence demonstrates supporting parenting to be both an effective and a cost effective intervention. Already Northamptonshire has an established Family Nurse Partnership programme to support young women under 19 who have babies, and supports NorPip, a second local programme which provides more tailored supported parenting to a model in increasingly common use nationally. Although yet to be as well evidenced as Family Nurse Partnership, the PIP programmes are investing in monitoring and evaluation to assemble evidence of effectiveness. There is guidance from NICE on the best approach to investing in supporting parent programmes, with the promise of further guidance to be published in Spring 2014.

**Childhood and youth**

School age children have a capacity to develop resilience when encouraged to use interactive programmes where they are engaged with the material and ideas on offer. It is particularly important to identify those children and young people who may be at risk of developing mental ill health and to offer time, resources and well invested programmes. There is a commissioning exercise in train which will address some of the groups listed. It will be very important to explore a multi-modal programme for teenagers with conduct disorders since the evidence for efficacy is strong and the impact into adulthood clear.
Universally, it is important to invest in school programmes to encourage healthy lifestyle behaviours such as taking exercise, eating healthily and not smoking.

However, there is little investment locally in school nursing, where there is a modest staff body of 18 FTE. School is a key setting to educate children, to provide them with opportunities to take exercise and to lay down good eating habits. All these are activities where school nurses can help. Further, school nurses and teachers can support work in PHSE or similar lessons on relationship building and confidence building, which are both important to developing a healthy and robust life course.

There is a body of good practice from which Northamptonshire could learn. Across England there are locations where similar challenges have been tackled successfully, and Northamptonshire should seek these examples out and assess whether those approaches could be emulated within the County. Good practice may be published, as in the examples in the review attached at Appendix A. It can be useful to visit programmes of work to see how they are used in the field and assess their suitability for local implementation. For example, in Coventry there has been work to make the city a Marmot City, and to bring a strong focus on the reduction of inequalities across the public sector, using the work of professionals, politicians and others to use the advice in Fair Society, Healthy Lives. It may be helpful to invite experts to present their work to an appropriate audience locally and to offer advice on how best to implement their ideas.

**Recommendations**

These two recommendations should underpin the work of Northamptonshire in the future. The recommendations of most other chapters are made to specific organisations or partnership bodies whereas these should guide the public sector as a whole.

1. This report recommends all public sector organisations in Northamptonshire follow the advice within the 2010 Marmot report, the 2012 Chief Medical Officer report, and the 2011 Allen Report to resource preventive activities at the expense of intensive, high cost interventions as far as is practicable.

   This will be exemplified by investing further in supporting parenting programmes, especially in those locations where the numbers coming into social care and CAMHS are high, eg Corby and the more deprived parts of Northampton, Kettering, Wellingborough and Daventry. Any further investment into these activities should be undertaken in line with NICE criteria.

   Further, Northamptonshire should invest in the best evaluated programmes for children of school age as set out in Appendix A reviewing the published literature. These comprise

- Early education and childcare;

- Classroom based emotional and problem solving programmes for 3-7 year olds at risk of conduct disorder;
Group-based parenting programmes 3-11 year olds at high risk or with conduct disorder;

Child focused group social & cognitive programmes 9-14 year olds at high risk or with conduct disorder;

Multi-modal interventions 11-17 year olds with conduct disorders eg Multi-systemic therapy.

This report recommends that Northamptonshire learn from good practice elsewhere and apply that learning to local services. Learning may be through desk research, through visits, or through inviting successful programme leads from elsewhere to bring their expertise to Northamptonshire for discussion and to receive guidance on how best to use the expert’s advice.
Appendix A: A review of published literature

This review of published literature demonstrates clearly that the body of evidence shows that the most impactful interventions are those which concentrate on antenatal and the earliest years of life. Support to parents, particularly mothers, appears to offer the greatest impact. Close support helps mothers to build good relationships with their babies, and to enjoy helping them make both emotional and physical progress in their interactions with society around them.

The strong messages echo those at the start of this report from the Chief Medical Officer and the Marmot report. Northamptonshire can be confident that any expansion of programmes such as Family Nurse Partnership to include a greater number of new mothers will have positive impacts. The impacts will occur some time in the future when a healthier, better adjusted body of children will grow up requiring less intervention from public sector services. Similarly, activities in schools should help children build friendships, learn how to interact with others and to become familiar with eating healthily and taking exercise. School staff should be mindful of health and wellbeing.

The Appendix reviews the published literature and sets out the research evidence to help understand the options available.

It is based on existing sources of synthesised and quality assessed evidence. As the question is one about the effectiveness of interventions, systematic reviews based on randomised controlled trials are the best way to answer the question. This is because a good systematic review looks at all the available good quality trials and provides an overall assessment of how well an intervention works. The Cochrane Database of Systematic Reviews and The Campbell Collaboration are the two main recommended databases for systematic reviews on health and social care. NICE guidance is also included as NICE recommendations are based on the best available evidence of the most effective care and are nationally recognised.

The databases were searched for generic systematic reviews on:
- preventing entry to the looked after system
- preventing entry to specialist CAMHS

Based on knowledge of underlying factors in Northamptonshire the databases were also searched for the effect of more specific interventions on preventing entry to the looked after system and/or specialist CAMHS namely:
- domestic violence programmes
- substance misuse programmes for parents
- parental mental health programmes
- parenting programmes
- programmes for children’s conduct disorder/ challenging behaviour

Interventions supported by the evidence found are summarised in the table below.
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Population</th>
<th>Outcome measured</th>
<th>Magnitude of effect – standardised mean difference SMD- unless stated (statistical significance)</th>
<th>Source of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive home visiting ante-natally and post natally eg FNP</td>
<td>Various</td>
<td>Various</td>
<td>Various</td>
<td>(National Institute for Health and Clinical Excellence, 2012)⁵⁰</td>
</tr>
<tr>
<td>for vulnerable children and their families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early education and childcare</td>
<td>Various, most economically disadvantaged</td>
<td>Cognitive outcomes, social competence, child mental health</td>
<td>Various</td>
<td>(National Institute for Health and Clinical Excellence, 2012)⁵⁰</td>
</tr>
<tr>
<td>Group-based parenting programmes</td>
<td>Parents &gt;20yrs of children of all ages, with &amp; without behavioural problems</td>
<td>Parental psychosocial health. Standardised instrument</td>
<td>Short-term improvements in: depression -0.17 (95%CI -0.28; -0.07) anxiety -0.22 (95% CI -0.43; -0.01) anger -0.60 (95%CI -1.00; -0.20)</td>
<td>(Barlow J, 2012)⁵¹</td>
</tr>
<tr>
<td>Group based parenting programmes</td>
<td>Parents of 0-3year olds (some a bit older), with &amp; without behavioural problems</td>
<td>Child behaviour. Standardised instrument</td>
<td>Improvement in behaviour on both parent-report -0.25 (95%CI -.45; -0.06), and independent observations -0.54 (95%CI -.84; -0.23) Limited data on long term effects. Insufficient data for role in primary prevention.</td>
<td>(Barlow J, 2010)⁵²</td>
</tr>
<tr>
<td>Intervention</td>
<td>Population</td>
<td>Outcome measured</td>
<td>Magnitude of effect – standardised mean difference SMD- unless stated (statistical significance)</td>
<td>Source of evidence</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Family parenting programmes</td>
<td>Parents of &lt;5 year olds with and without behavioural problems. Most USA.</td>
<td>Child behaviour. Standardised instrument</td>
<td>Weighted 0.35 (95%CI 0.26; 0.44)</td>
<td>(Piquero A, 2008)53</td>
</tr>
<tr>
<td>Self-control interventions</td>
<td>Children &lt;10 years, average age 6. N. American, Israeli. Recruited in schools.</td>
<td>Child behaviour &amp; self-control Standardised instrument</td>
<td>Self control improved 0.28 (95% CI 0.07-0.48). Problem behaviour improved 0.30 (95%CI 0.13-0.46)</td>
<td>(Piquero A, 2010:2.)54</td>
</tr>
<tr>
<td>Classroom based emotional &amp; problem solving programmes for 3-7 year olds</td>
<td>High proportion of children at risk of developing oppositional defiant disorder or conduct disorder.</td>
<td>Child behaviour</td>
<td>Various</td>
<td>(National Institute for Health and Clinical Excellence, 2013)55</td>
</tr>
<tr>
<td>Media-based behavioural treatments for behavioural problems in children.</td>
<td>Children with behavioural problems</td>
<td>Standardised instrument of behaviour.</td>
<td>They could be used as part of a stepped approach. They might increase the numbers of families who could benefit. Improvements in behaviour. Effects sizes ranging from -0.12 (95%CI -1.65 to 1.41) to -32.60 (95%CI -49.93 to -15.27) and as an adjunct to medication with effect sizes ranging from -2.71 (95%CI -5.86 to -0.44) to -39.55 (95%CI-75.01 to -4.09). Significant improvements were made with the addition of up to two hours of therapist time.</td>
<td>(Montgomery P, 2006)56</td>
</tr>
<tr>
<td>Intervention</td>
<td>Population</td>
<td>Outcome measured</td>
<td>Magnitude of effect – standardised mean difference SMD- unless stated (statistical significance)</td>
<td>Source of evidence</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Group-based parenting for early onset conduct problems</td>
<td>3-12 year olds with behaviour and conduct problems</td>
<td>Child behaviour and conduct problems; positive parenting practices Standardised instrument</td>
<td>Reduction in child conduct problems, on parent reports -0.53 (95% CI -0.72; -0.34) &amp; independently assessed -0.44 (95% CI -0.77; -0.11). Improvements in parental mental health -0.36 (95% CI -0.52; -0.20) and positive parenting skills, based on parent reports -0.53(95% CI -0.90; -0.16) and independent reports 0.47 (95% CI -0.65; -0.29). Parent training produced a reduction in harsh parenting practices on parent reports -0.77(95% CI -0.96; -0.59) and independent assessments -0.42(95% CI -0.67; -0.16).</td>
<td>57 (Furlong M, 2012)</td>
</tr>
<tr>
<td>Group-based parenting programmes 3-11 year olds</td>
<td>Various but with or at high risk of conduct problems</td>
<td>Child conduct problems Standardised instrument</td>
<td>Reduction in conduct problems 0.5 (95%CI 0.38; 0.63) Economic evaluation favourable.</td>
<td>(National Institute for Health and Clinical Excellence, 2013)55</td>
</tr>
<tr>
<td>Child focused group social &amp; cognitive programmes 9-14 year olds</td>
<td>Various but with or at high risk of conduct problems</td>
<td>Child conduct problems Standardised instrument</td>
<td>Reduction in conduct problems 0.37(95%CI 0.19; 0.55) Economic evaluation favourable.</td>
<td>(National Institute for Health and Clinical Excellence, 2013)55</td>
</tr>
<tr>
<td>Multi-modal interventions 11-17</td>
<td>Various but with conduct problems</td>
<td>Anti-social behaviour. Parent</td>
<td>Reduction in anti-social behaviour 0.47 (95%CI 0.21; 0.74)</td>
<td>(National Institute for Health and Clinical Excellence, 2013)55</td>
</tr>
<tr>
<td>Intervention</td>
<td>Population</td>
<td>Outcome measured</td>
<td>Magnitude of effect – standardised mean difference SMD- unless stated (statistical significance)</td>
<td>Source of evidence</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>year olds eg Multi-systemic therapy</td>
<td></td>
<td>or observer reported.</td>
<td>Economic evaluation favourable.</td>
<td>Clinical Excellence, 2013(^{55})</td>
</tr>
<tr>
<td>CBT or other treatment for youths in residential settings</td>
<td>12-22 year olds in residential settings for anti-social behaviour, law breaking</td>
<td>Recidivism Objective measure.</td>
<td>Recidivism reduced OR = 0.69 (95%CI: 0.53-0.90)</td>
<td>(Armellius BA, 2009(^{58}))</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Risk of recidivism reduced from 53% to 43%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Number needed to treat 10.</td>
<td></td>
</tr>
</tbody>
</table>
Comparison with other evidence reviews

This important review focused on 0-3 year olds and children and young people up to 18 years who will in time become parents. It noted that the merits of early intervention were receiving increasing recognition but that provision remains patchy with a bias toward late intervention. It made a number of recommendations including:

♦ Family Nurse Partnership should be available for all vulnerable first time mothers who meet criteria and want it

♦ A national parenting campaign

♦ High quality, benchmarked pre-school education

♦ Progress towards a quality maternity and paternity settlement

♦ More coherent set of assessments for 0-5 year olds to detect and resolve social and emotional difficulties before they become intractable.

The review assessed interventions for effectiveness and impact and recommended that the top 19 interventions should be supported.

Dartington Social Research Unit
The Social Research Unit at Dartington is an independent charity that seeks to increase the use of evidence of what works in designing and delivering services for children and their families. They are strong advocates of prevention and early intervention based approaches. In September 2013 they launched a new website called Investing in Children at an event at the House of Commons co-sponsored by the Early Intervention Foundation.

Investing in Children provides free and independent advice on competing investment options in children’s services. The interventions listed focus on the health, educational attainment, emotional well-being, behaviour and relationships of children aged 0-22 years. Information provided about each programme includes what it comprises, the target group, the outcomes affected, how much it costs and what benefits it is predicted to yield.

The assessment of whether programmes work is based on standards of evidence that focus, respectively, on what the programme is, how it has been evaluated, what the evaluations show in terms of impact, and whether the programme is ready for implementation in public service systems. Programmes that meet the standards are badged as ‘Blueprints approved’. The evaluations are not necessarily systematic reviews (which is what PHAST focused on) so this gives a different perspective. The following programmes met the criteria for the outcome of not abused or neglected:

♦ Triple P Positive Parenting Programme (All Levels)
Family Nurse Partnership

Parent-Child Interaction Therapy (PCIT) for Families in the Child Welfare System

The following programmes met the criteria for the outcome of not depressed:

- Positive Family Support- Family Check-Up (formerly Adolescent Transitions)
- Adolescents Coping With Depression
- Triple P Positive Parenting Programme (All Levels)
- Cognitive Behavioural Intervention for Trauma in Schools (CBITS)
- Promoting Alternative Thinking Strategies (PATHS)
- Incredible Years- Parent Training
- Family Nurse Partnership
- New Beginnings
- Good Behaviour Game
- Multisystemic Therapy (MST) for Juvenile Offenders
- Strengthening Families (10-14)
- Guiding Good Choices
- Raising Healthy Children (formerly the Seattle Social Development Project)

Faculty of Public Health

The Faculty of Public Health (FPH) is the standard setting body for specialists in public health in the United Kingdom. It works collaboratively drawing on the specialist skills of its members as well as building relationships with a wide range of external organisations. It has developed an evidence based resource called Better Mental Health for All. This concludes that key risk factors are modifiable and that the most important modifiable risk factor for mental health problems in childhood, and thus in adult life in general, is parenting. It concludes that the key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating). Parental mental illness and parental lifestyle behaviours such as smoking, and drug and alcohol misuse are important risk factors for childhood mental health problems.

Schools offer another important opportunity for promotion and prevention. School, school ethos, bullying and teacher wellbeing all have an influence on children's current and future mental health. Mental health promotion programmes can modify these factors, and also mitigate mental health problems initiated from within the family.
All the risk factors for mental illness also impact on cognitive development, leaving children doubly disadvantaged. Supporting children’s emotional and social development is the most effective way to promote cognitive development and thus to mitigate the effect of educational inequality throughout the life-course. lx


This report focuses on neglect, older children and thresholds. It recognises that patterns of neglect may occur rather than specific incidents. For older children it recognised that they can be in contact with a range of organisations. They may present with poor behaviour or their behaviour may be viewed as risky when in fact it is they who are at risk. It concludes that effective early intervention services are crucial and that the care system should be viewed as a positive not a negative. It noted that Munro had recommended a new duty for local authorities to secure sufficient provision of local early help services for children but that this had been rejected by the government.

Interventions recommended by NICE include:

- Intensive home visiting ante-natally and post nataley eg FNP for vulnerable children and their families
- Early education and childcare
- Classroom based emotional & problem solving programmes for 3-7 year olds at risk of conduct disorder
- Group-based parenting programmes 3-11 year olds at high risk or with conduct disorder
- Child focused group social & cognitive programmes 9-14 year olds at high risk or with conduct disorder
- Multi-modal interventions 11-17 year olds with conduct disorders eg Multi-systemic therapy

The Northamptonshire strategy for emotional wellbeing and mental health for 2010 to 2013 was drafted with the emphasis on the services shown through best published evidence to target those with greatest need. The 2013 health and wellbeing strategy has similarly focused on the communities of greatest need, both geographically and in terms of health and social care needs.
Appendix B: Modelling exercise in Newham

Separately attached
Appendix C: Profiles of domestic violence in each district of Northamptonshire

Corby domestic violence profile

- White Other is slightly overrepresented, 82% of victims are White British & Irish, a higher figure than theft offences.
- Domestic violence victims spike at 20 – 24 (22%). This is 3.5 times more than the general population trend (6.5) of the population.

Source: Corby Partnership Strategic Assessment, 2013 2014
The vast majority of victims are White British & Irish (94%). Domestic violence victimisation peaks at 20 – 24 years old (16%), then gradually reduces to age 50, then drops off significantly.

Source: Daventry District and South Northamptonshire Partnership Strategic Assessment, 2013 2014
52% of victims are between 20 – 34, this demographic is only 18% of the general population.

Over 90% of victims are White British & Irish and four fifths of recorded victims are female.

Source: East Northamptonshire Partnership Strategic Assessment, 2013 2014
The ethnicity of victims tends to match the population, with White Other over-represented.
Similarly to non-domestic violence, victimisation peaks at 20 – 24, 20% of victims fall in this age range and 49% of victims are under 29 years old.

Source: Kettering Partnership Strategic Assessment, 2013 2014
Victimisation peaks between 20 –24 (twice the proportion of the general population). Ages 15 – 29 is the highest risk period.

The proportion of victims who are White Other is almost double the proportion of the general population (12.6% vs. 6.5%)

Source: Northampton Partnership Strategic Assessment, 2013 2014
Wellingborough domestic violence profile 2013

- Victims of domestic violence peaks at 20 – 24, accounting for 21% of all victims.
- White other ethnicities are overrepresented, and Black and Mixed Race ethnicities are too, but to a lesser extent.

Source: Wellingborough Partnership Strategic Assessment, 2013 2014
Appendix D: Maps of Northamptonshire by district and by locality
**Glossary**

**A**

**Age-standardisation**
Age-standardisation allows comparison of rates across different populations while taking account of the different age structures of those populations. Failure to take account of differing age structures can be very misleading when comparing rates in different populations. Age-standardisation allows the production of a rate (direct standardisation) or a ratio (indirect standardisation).

**Attributable fractions (population attributable fractions)**
Attributable fractions are the proportions of all cases (e.g. deaths or hospital admissions) that are thought to be caused by a particular exposure, for example alcohol or smoking. Fractions are calculated for conditions where there is considered sufficient evidence of a causal relationship between the exposure and the disease or injury.

**B**

**Body Mass Index [BMI]**
BMI is a measurement of a person’s weight, compared to their height. BMI is calculated as weight (in kilograms) divided by the height squared (in metres). Adults with a BMI of 25 or more are categorised as overweight and with a BMI of 30 or more as obese.

**C**

**Census**
A census is a count of all people and households within a defined area; here it is undertaken for England and Wales with simultaneous censuses in Scotland and Northern Ireland. The data gathered includes information on population, health, housing, employment, transport and ethnicity. In England and Wales it is undertaken every 10 years with the most recent Census conducted in 2011. The United Kingdom government is currently examining alternatives to the conventional model for the Census after 2011.

**Confidence Intervals [CIs]**
Confidence intervals are indications of the natural variation that would be expected around a rate and they should be considered when assessing or interpreting a rate. The size of the confidence interval is dependent on the number of events occurring and the size of the population from which the events came. Generally speaking, rates based on small numbers of events and small populations are likely to have wider confidence intervals. Conversely, rates based on large populations are likely to have narrower confidence intervals.

**Confidence limits**
The upper and lower boundaries of the confidence interval.

**D**

**Deprivation measures**
Indicators which estimate the level of deprivation in a given area (see also Index of Multiple deprivation).

**E**

**European age-standardised rate**
The European age standardised rate represents the overall rate you would get if the population had the same age-structure as a theoretical standard European population (direct age-standardisation). In order to calculate this we apply the rates which occur in each age band to the new (standard) population structure. The measure only allows for comparison between rates which have been
standardised; it is not a proportion or risk of an event occurring and does not, of itself, involve a comparison with rates across Europe. See *age-standardised rate* for further details.

F
**Fifths of deprivation (quintiles)**
Geographical areas are ranked from highest to lowest by deprivation score and then split into five equal bands, ranging from least deprived to most deprived fifth.

G
**General Fertility Rate [GFR]**
Live births per 1,000 women aged 15-44 years.

H
**Hypothesis**
Hypotheses usually come in pairs as a null hypothesis and an alternative hypothesis. Both relate to possible explanation of a phenomenon. The alternative hypothesis proposes an explanation for the phenomenon, whilst the null hypothesis refutes that explanation. For example, an alternative hypothesis might be that lung cancer is caused by tobacco smoking, whilst the null hypothesis might be that lung cancer is not caused by smoking. A study would be conducted to evaluate the competing hypotheses.

L
**Life expectancy**
The average number of years an individual of a given age is expected to live if current age-specific mortality rates continue to apply.

**List size**
The number of patients registered with the general medical practice

**Lower Super Output Area [LSOA]**
Defined geographical area based on Census output areas with an average of 1500 persons per LSOA.

M
**Marmot Review**
The Marmot Review into health inequalities in England was published on 11 February 2010. It proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. It draws further attention to the evidence that most people in England aren't living as long as the best off in society and spend longer in ill-health.

**Mid-year estimates**
Annual ONS estimates of the resident population, based on the Census and taking into account population change (births, deaths and migration).

**Middle Super Output Area [MSOA]**
Defined geographical area based on Census output areas with an average of 7500 persons per MSOA.

N
**National Institute for Health and Care Excellence (NICE)**
NICE guidance sets the standards for high quality healthcare and encourages healthy living. NICE guidance can be used by the NHC, Local Authorities, employers, voluntary groups and anyone else involved in delivering care or promoting wellbeing.
**National Statistics Socio-economic Classification (NS-SEC)**
The NS-SEC is an occupation-based classification created by the Office for National Statistics. Its aim is to help explain differences in social behaviour. Whereas deprivation indices such as WIMD are measured at the area level, which means that individuals living within the area can be mis-classified, the NS-SEC has the advantage of being measured at the household or individual level.

**O**
Older people living alone
The proportion of residents within the given geographical area aged 75 and over that live on their own. This indicator is derived from 2011 Census data.

**P**
Population density
Persons per square km.

**Population projections**
Population projections provide an estimate of the size of the future population and are based on assumptions about births, deaths and migration. The assumptions are based on past trends and only indicate what may happen should the recent trends continue.

**R**
Registered population
The number of people registered with a general practitioner within the given geographical area. An area’s registered population can therefore include people resident in a different area.

**S**
Statistical significance
A result may be deemed statistically significant if it is considered unlikely to have occurred by chance alone. The basis for such judgements is a predetermined and arbitrary cut-off, usually taken as 5% or 0.05. In some circumstances this cut-off may be lowered to 1%, for example where there is a greater need for certainty over the safety of a drug or procedure. Statistical significance must not be confused with clinical or other significance. A result may be clinically significant whilst not being statistically significant and vice versa.

**T**
Type I and type II errors
In making decisions about whether to reject a hypothesis two types of error are possible: a null hypothesis can be rejected when it is in fact true, or it is possible to fail to reject it when it is false. These are called type I and type II errors respectively. A significance test can never prove that a null hypothesis is either true or false.
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>ADBE</td>
<td>Annual District Birth Extract</td>
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<td>ADDE</td>
<td>Annual District Death Extract</td>
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<td>BME</td>
<td>Black and minority ethnic</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>CAPIC</td>
<td>Collaboration for Accident Prevention and Injuries Control</td>
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<td>CARIS</td>
<td>Congenital Anomaly Register and Information Service</td>
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<td>CDSC</td>
<td>Communicable Disease Surveillance Centre</td>
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<tr>
<td>CHD</td>
<td>Coronary heart disease</td>
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<td>CI</td>
<td>Confidence interval</td>
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<td>CKD</td>
<td>Chronic Kidney Disease</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
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<td>CVD</td>
<td>Cardiovascular disease</td>
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<td>DFLE</td>
<td>Disability-free life expectancy</td>
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<td>EASR</td>
<td>European age-standardised rate</td>
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<td>GFR</td>
<td>General fertility rate</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HBSC</td>
<td>Health Behaviour in School-aged Children Survey</td>
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<td>HLE</td>
<td>Healthy life expectancy</td>
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<td>HNA</td>
<td>Health needs assessment</td>
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<td>ICD-10</td>
<td>International Classification of Diseases 10th Revision</td>
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<td>IOTF</td>
<td>International Obesity Task Force</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>LA</td>
<td>Local authority</td>
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<tr>
<td>LE</td>
<td>Life expectancy</td>
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<tr>
<td>LSOA</td>
<td>Lower super output area</td>
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<tr>
<td>MMR</td>
<td>Measles, mumps, rubella</td>
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<tr>
<td>MSOA</td>
<td>Middle super output area</td>
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<tr>
<td>MYE</td>
<td>Mid-year population estimate</td>
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<td>NatCen</td>
<td>National Centre for Social Research</td>
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<td>NCCHD</td>
<td>National Community Child Health Database</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<td>SIDS</td>
<td>Sudden infant death syndrome</td>
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<td>SII</td>
<td>Slope Index of Inequality</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>VS</td>
<td>Vital statistics</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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