
JSNA
Joint Strategic Needs Assessment
START WELL
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NOVEMBER 2021
LONDON BOROUGH OF RICHMOND UPON THAMES

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Start Well

COVID-19 Impact on the JSNA Report

The COVID-19 pandemic has had multiple and wide ranging impacts on the population. It has increased and expanded the role of both statutory and voluntary sector organisations, and other community led services. The Pandemic has created a whole new set of challenges for carers, hospitals, GPs and care homes, leaving in its wake health and social care service backlogs, establishment and management of a new and significant vaccination programme. The impacts span the life course and wide-ranging issues from political, economic, social, technology, lifestyle and health.

The pandemic has highlighted more starkly, issues such as health and social inequalities and deprivation, anxiety and mental ill-health, and many others. The JSNA health outcomes and wider determinants data presented in this JSNA generally predate the pandemic and could be expected to deteriorate in areas such as life expectancy, mortality and morbidity rates. Mortality from COVID-19 has had an unequal impact on different population sub-groups and exacerbated health inequalities. However, this will not be fully reflected in this JSNA as the data is not yet available at a local level.

It remains important to monitor pre-Covid time trends to understand the baseline from which to measure the local effects of Covid-19on key statistics. The Protect Well chapter has more detail of the impact of COVID-19 on health outcomes. It is expected that detailed COVID-19 information will be available for analysis and consideration over the next 12 months.

1. Introduction

Our earliest experiences of life, starting in the womb, through pregnancy and birth and into our early years, are vital in laying the foundations for our future health and well-being. Research consistently shows that even short-term improvements in physical, cognitive, behavioural and social/emotional development can lead to benefits throughout childhood and later life.

The Marmot Review, Fair Society and Healthy Lives identified giving every child the best start as the highest priority in reducing the inequalities gap that exists between different groups of people. Action to reduce health inequalities needs to start before birth and be followed through the life of the child to improve adult health outcomes.

Unless otherwise stipulated, the term children and young people refers to those aged between 0–18 years old. For children and young people with special educational needs and disabilities (SEND) and for care leavers the age range is from 0–25 years old.

The Start Well Chapter is made up of the 2019 Children and Young People's Needs Assessment (CYPNA) which covers children aged 0-18 years. Additional information from Achieving for Children (AfC) who provide the Richmond Children's Services on the needs of children and young people and their families. The data covers children aged 0–18 years.

Link to the CYPNA :
https://www.Richmond.gov.uk/children_and_young_peoples_plan_2013_2017

When assessing need in children and young people, variations also exist between datasets in terms of the categorisation of needs and the consideration of primary or multiple needs. This can make it difficult to map trends in access to and provision of services across the children and young people population. Furthermore, care is required when interpreting data to ensure that a consistent population is used for comparison. For example, some datasets and secondary analyses consider borough residents, and others consider pupils attending schools who may or may not be borough residents. Where different populations or timescales have been used, or information is not held, comparisons becomes challenging.

Needs are individual and often complex, meaning children are known to multiple services. Information about their needs may be categorised or prioritised differently depending on the service they are accessing. Data is also held in different and incompatible systems which creates additional challenges in bringing them together to create a full picture of need.

It is positive to see that the general health and well-being of the population and of children and young people fares well in Richmond. However, there are inequalities and health outcomes are not fairly distributed across children and young people with some groups fairing disproportionately worse than others. Key findings overall, when comparing local indicators with England averages, show the health and well-being of children in Richmond upon Thames is better than England. The infant mortality rate is better than England. However, an average of four infants die before aged one each year. Indicators of population health and well-being among children and young people in Richmond are generally better or similar to the England average. Children in Richmond fare well against the England and London averages.

1.1 Key Demographics

- In Richmond 22.9% (44,489) of the total population are under 18 years old in 2021. The percentage of children in the borough is higher than the London average (21.8%) with all ages between 5-17 years making up a larger population percentage than in London
- Numbers of 0–17 year olds are projected to decrease by 9.6% between 2021 and 2031 (from 44.489 in 2021 to 40,207 in 2031)[1]
- The level of child poverty in Richmond is the lowest in London with 8.5% (2795) of children aged under 16 years living in low-income families
- Data suggests that just over a fifth of children and young people are from a Black, Asian and Minority Ethnic groups. These groups are often disproportionately affected by poor outcomes. Levels of development, for example, are disproportionately worse than those in non-Black, Asian and Minority Ethnic groups (72% compared to 81%)
- Educational achievement overall in Richmond is better than average. However, some groups fare worse. For instance, 80.6% of children have reached a good level of development by the end of Reception, but the equivalent figure for children on free school meals is 58.2% and ranks fourth worst of all London Boroughs.

1.2 Richmond Indicators of Health and Well-being

- Indicators of population health and well-being among children and young people in Richmond are generally better or similar to the England average.
- The infant and child mortality rate are summary measures of the overall health in this population. Children in Richmond fare well against the England and London averages.
- Levels of child obesity are better than England but 5.4% of children in Reception are obese and this doubles to 10.7% of children by the time they reach Year 6.
- The MMR immunisation level does not meet the recommended coverage of 95%. By age 2 years, only 87.0% of children have had one dose and by the age of five only 75.9% have received their second dose.
- Immunisation rates for looked after children have fallen to 79.7% in 2018/2019 below the rates for London 80.7% and England 86.8% .
- In Richmond the percentage of secondary school aged pupils with social, emotional and mental health needs has risen to 2.67% and is significantly higher than levels seen across England
- The rate of hospital admissions for self-harm in children aged 15–19 years in Richmond is the 3rd highest of all the London Boroughs

2. Population

2.1 Demographics

Note on population:
Greater London Authority (GLA) projections and population estimates. These are based on Office of National Statistics (ONS) estimates and projected new housing developments. The population estimates are based on ONS 2018 mid-year estimates. For latest demographic information go to the population explorer tool on DataRich.

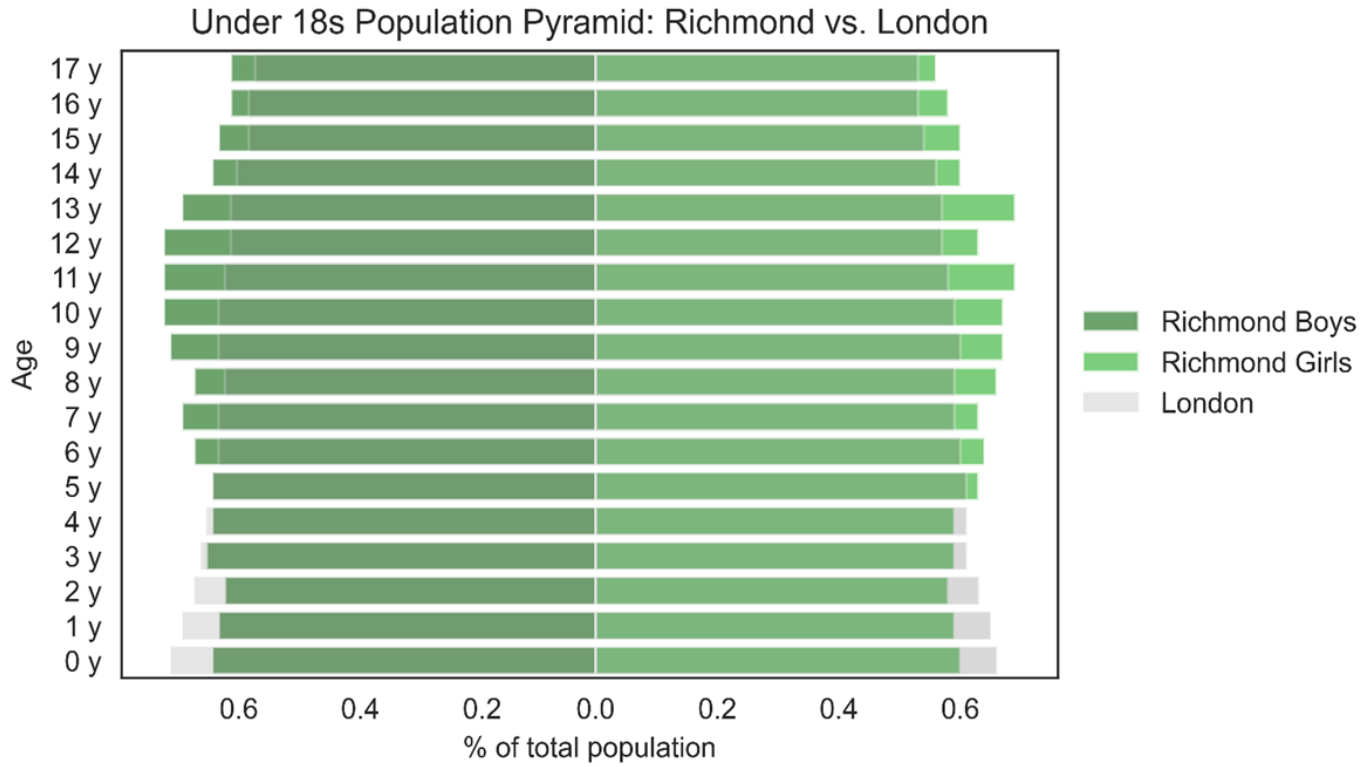
[1] 2016-based Demographic projection, housing-led model, Greater London Authority

In Richmond 22.9% (44,489) of the total population are under 18 years in 2021. The percentage of children in the borough is higher than the London average (21.8%) with all ages between 5-17 years making up a larger population percentage than in London. Only the number of children under 5 years of age is proportionately smaller than in London (**Figure 1**).

In Richmond:

- 6% of the Borough's population is made up of children aged under 5 years
- 13% are made up of 5- 14 year olds
- The greatest number of children aged under 14 years can be seen within the wards of St Margarets and North Twickenham, East Sheen, North Richmond, and West Twickenham
- 5% of the Borough is made up of 15–19 year olds
- The greatest numbers of children aged 15–19 years can be seen within the wards of South Twickenham, Hampton Wick and Heathfield

Figure 1: Under 18 years as percentage of Total Population - Comparison with London, 2021



Source: *©GLA 2018-based population projections ©Greater London Authority 2021.*

Overall, the rate at which the 0–17 year old population is growing in Richmond is much slower than that of outer London. Numbers of 0–17 year olds are projected to decrease by 9.6% between 2021 and 2031 (from 44,489 in 2021 to 40,207 in 2031):

- East Sheen ward has the highest percentage of 0–17 year olds as a proportion of their population at 27.1% (2018)
- the largest projected increases will be in St. Margarets and North Twickenham (+92%), Twickenham Riverside (+86%) and North Richmond (+85%), when comparing 2011 data with 2026.

Richmond is the least ethnically diverse Borough in London. However, 0–17 year olds are slightly more diverse, 79.1% identify as white and 20.9% from Black, Asian and Ethnic Minority groups.
92.9% of 3–15 year olds and 90.4% of the 16–24 year old population speak English as their main language (2011). The Black, Asian and Minority Ethnic population is younger with a higher percentage of children and relatively fewer seniors. Richmond's children's population is 21% Black, Asian and Minority Ethnic vs. 16% for the England population[2].

The most prominent religion of 0–15 year olds is Christianity at 54.2%, while 27.7% of have no religion (2011).

The proportion of the UK population (aged 16+) identifying as lesbian, gay or bisexual, trans or querying (LGBTQ+) has increased from 1.5% (2012) to 2.0% (2017). This is higher for males (2.3%), in London (2.6%) and for younger age groups (16–24 years, 4.2%). Local data is not available for children and young people but the application of the London percentage (2.6%) to the 15–18 year old population indicates an estimated LGBTQ+ total of 209 young people in Richmond.

2.2 Childhood Mortality Rates

Infant Mortality (aged under 1 year)

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn.

A report by the Nuffield Trust and the Royal College of Paediatrics and Child Health compares several child health indicators in the UK with those of comparable countries. The data show that the UK is performing well in multiple aspects of child health. However, the UK is behind several similarly developed countries with regards to the percentage of children who are overweight or obese, and the rates of breastfeeding. Where the UK previously outperformed comparable countries in relation to childhood mortality rates, the rate of improvement has slowed to such a degree that the UK now has some of the worst outcomes. Life expectancy, immunisation rates and low birth weight are health indicators that have also previously shown good progress but have worsened or plateaued in recent years.

These indicators are amenable to public health interventions and therefore at significant risk of cuts to Children's Services, particularly Early Years Services. While inter-country comparisons of health outcomes should be made with caution, it is evident that there is considerable room for improvement in relation to child health[3].

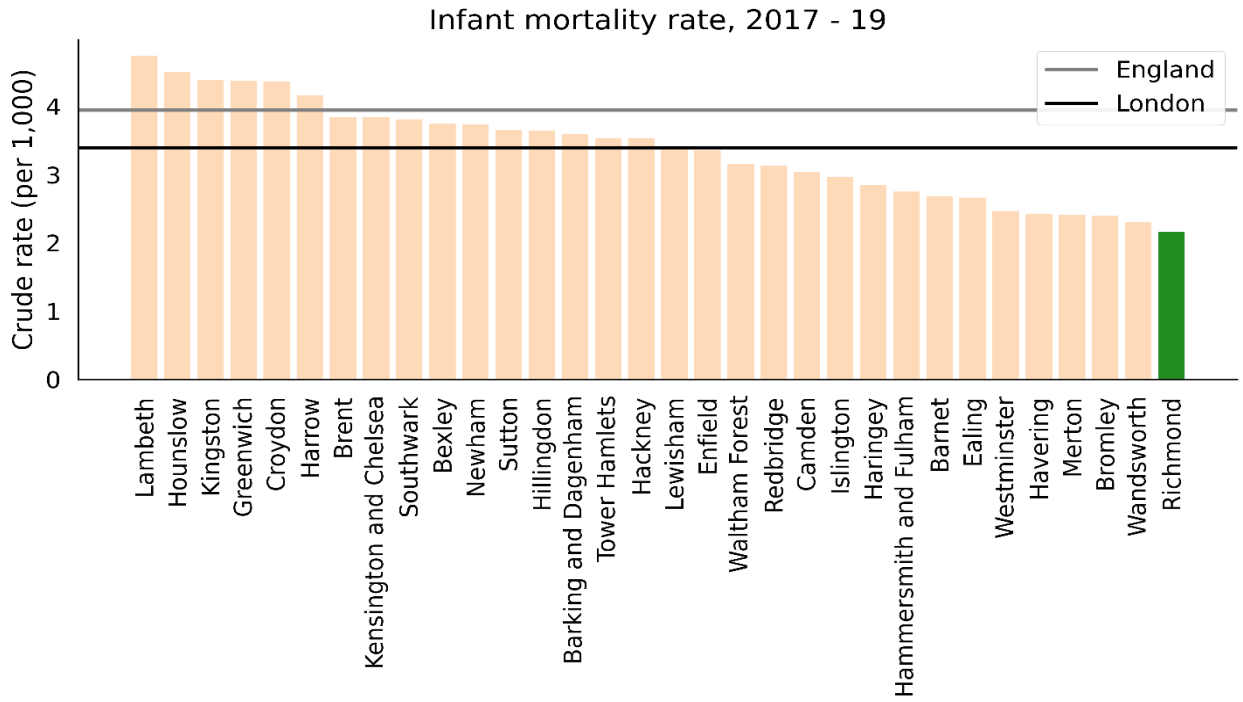
Overall, comparing local indicators with England averages, the health and well-being of children in Richmond is better than England. The infant mortality rate in Richmond is better than England, but on average four infants die before the age of one each year.

The infant mortality rate for England in 2017–19 was 3.9 deaths per 1,000 live births[4], Richmond had the lowest infant mortality rate for London at 2.2/1000 (**Figure 2**). Richmond's rate was 45.2% lower than the England average and

[2] See Richmond JSNA People chapter.
[3] Cheung. International comparisons of health and wellbeing in early childhood (Nuffield Trust and RCPCH). 2018: https://www.nuffieldtrust.org.uk/files/2018-03/1521031084_child-health-international-comparisons-report-web.pdf
[4] This is in comparison to the European Union (EU) average of 3.4 per 1,000 in year 2018. The United Kingdom had the 7th highest infant mortality rate in the EU back in year 2018.

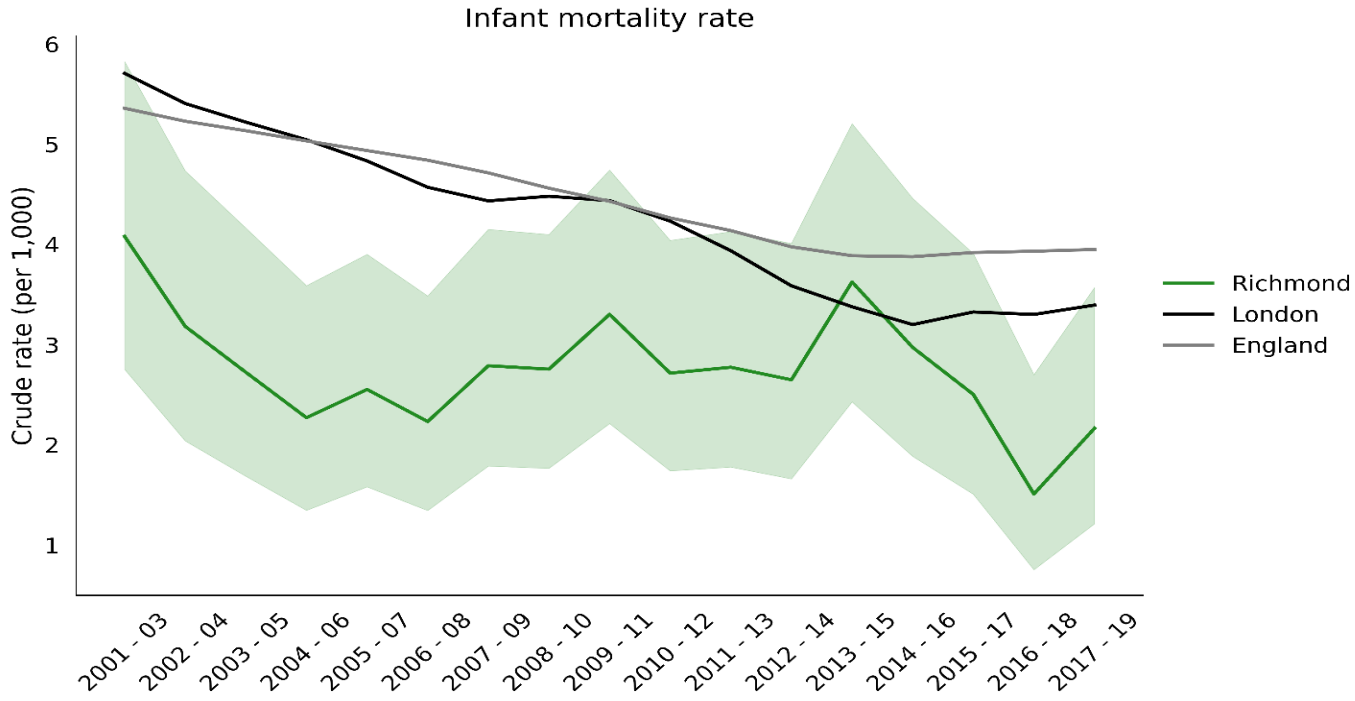
36.2% lower than the London average. The latest Borough figure was also 46.9% lower from year 2001–03, in comparison with a 26.3% decrease in England's rate in the equivalent time period (**Figure 3**).

Figure 2: Infant Mortality Rate by London Local Authority, 2017–19



Source: PHE Public Health Outcomes Framework

Figure 3: Infant Mortality Rate, 2001–2019, Richmond, London and England

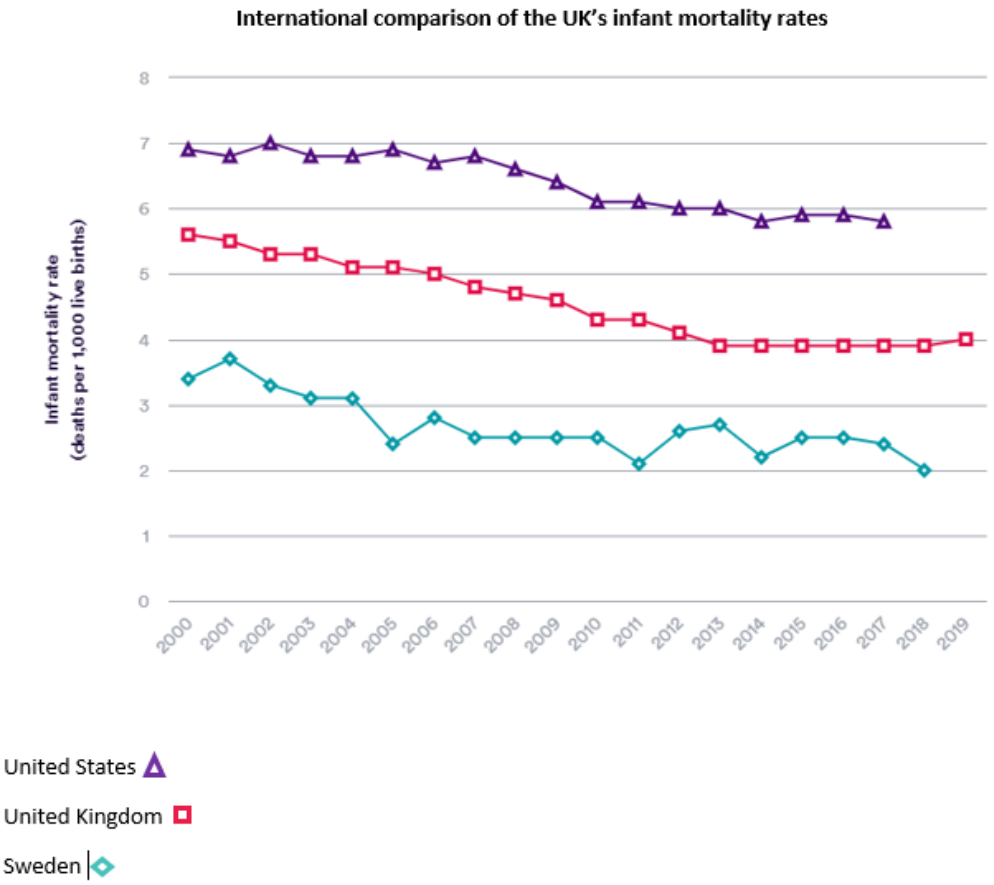


**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

Figure 4 below shows how the UK's infant mortality rates from 2000-2019 compared with that of other Organisation for Economic Co-operation Development (OECD) countries which have been identified as relevant comparators. The US had the highest rates of infant mortality between 2000 and 2017. In comparison, Sweden had one of the lowest rates between 2000 and 2018. Although the rates of infant mortality in the UK have been decreasing overall, as in the other OECD countries, this decline has somewhat plateaued in recent years and remained relatively high compared to other countries. The rate in 2019 was 4 deaths per 1,000 live births[5] [6].

Figure 4: International comparison of UK's infant mortality rates



Source: OECD, Health Status, Maternal and infant mortality. Office for National Statistics, Vital Statistics in the UK (taken from Quality Watch, Nuffield Trust) *https://www.nuffieldtrust.org.uk/resource/infant-and-neonatal-mortality#background*

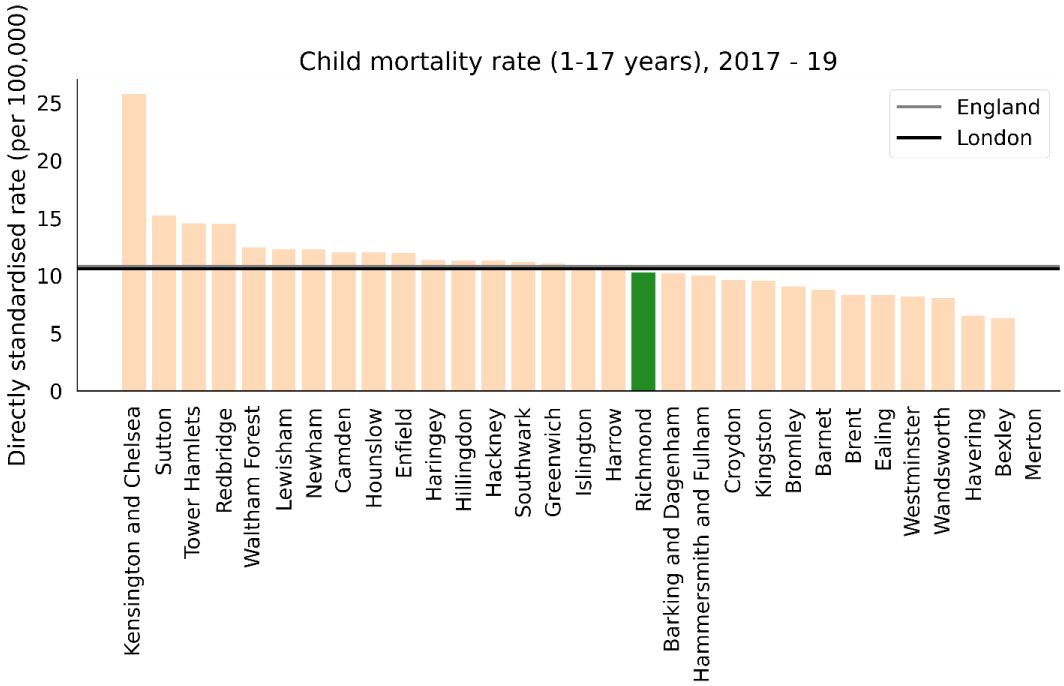
Mortality in 1–17 year olds

Recently, there have been 4 child deaths per year on average amongst 1–17-year-olds. Furthermore, the latest child mortality rate (death rate due to all causes for persons aged 1–17 years) for 2017–19 stands at 10.3 per 100,000 population (14th lowest in London, **Figure 5**), which is below the England national average of 10.8 per 100,000 population and London average of 10.6 per 100,000. The latest Borough figure was also 9.9% lower from year 2010–12, in comparison with a 13.7% decrease in England's rate in the equivalent time period.

[5] Quality Watch, Stillbirths and neonatal and infant mortality. Nuffield Trust. 2021 https://www.nuffieldtrust.org.uk/resource/infant-and-neonatal-mortality

[6] Cheung. International comparisons of health and wellbeing in early childhood (Nuffield Trust and RCPCH). 2018: https://www.nuffieldtrust.org.uk/files/2018-03/1521031084_child-health-international-comparisons-report-web.pdf

Figure 5: Child Mortality Rate (1–17 years) by Local Authority, 2017–19



Source: PHE Public Health Outcomes Framework

2.3 Education of School Age Children

This section contains data published in Richmond's 2019 Children and Young People's Needs Assessment (CYPNA)[7]. **Table 1** compares the educational attainment of Richmond's children and young people at different stages with the national and regional averages. Richmond's performance across all educational stages is higher than both the England and London averages. The most visible difference is at Key Stage 2, with 89% of Richmond's pupils achieving the expected standards in reading, writing and numeracy in comparison with a 77% in England and 81% in London.

Table 1: Educational Attainment for Children and Young People, 2017/18

	Richmond	London	England
Key stage 2 pupils meeting the expected standard in reading, writing and maths, 2017/18	89%	81%	77%
Key stage 4 average attainment 8 score, 2017/18[63]	55.6%	53.3%	50.3%
% of students achieving grade 5 or above in English and Maths GCSEs, 2017/18[64]	52.9%	48.7%	40.2%
% of A-Level students achieving at least AAB grades, of which at least two are in facilitating subjects*, 2017/18[65]	16.7%	15.0%	16.2%

*A level facilitating subjects are: Biology, Chemistry, Physics, Maths, Further Maths, Geography, History, English Literature, Modern and Classical Languages.

[7] London Borough of Richmond. Children and Young People Needs Assessment (CYPNA). 2019

Source: Richmond CYPNA, 2019

Schools

26,851 pupils attend schools in Richmond, of which 81% live in the Borough. In 2018, 90% of schools in Richmond were judged by Ofsted as good or better, compared to 86% in England; 85% of Richmond pupils attending a good or outstanding school. **Table 2** compares Richmond and England's Ofsted ratings for primary and secondary schools in 2018 and in March 2021.

Table 2: Ofsted ratings of good or better for primary and secondary schools in Richmond and England, 2018 - 2021

% Establishments rated good or better		
	Aug-18	**Mar-21**
Richmond		
Primary Schools	95%	96%
Secondary Schools	70%	81%
England		
Primary Schools	87%	88%
Secondary Schools	75%	76%

Source: Ofsted

Table 3 breaks down Richmond's schools and early years settings by type. There is only one nursery school in the borough. There are many more maintained nurseries attached to primary schools and other early years settings in the private, voluntary and independent sector.

Table 3: Early years and/or childcare settings and schools in Richmond by type, 2019

Number of schools in Richmond by type						
Maintained Nursery School	Primary	Secondary Schools	Special Schools	Pupil Referral Units	Independent Schools	Total
1	45	11	2	0	22	81
Early years and/or childcare settings registrations (Ofsted data - August 2020)						
Ofsted Childminders	Non-Domestic Premises	Domestic Premises	TOTAL			
145	147	2	294			
Early years and/or childcare settings registrations (local data – June 2021)						
Ofsted Childminders	Non-Domestic Premises *	Domestic Premises *	TOTAL			
158	152	2	312			

**- this comprises of 71 full day care settings, 40 sessional settings and 43 out of school settings*

Source: Children and Young People Needs Assessment (CYPNA), Achieving for Children: Early Years' Service

- There are 16,825 primary school pupils which are forecast to reduce slightly to 16,521 in 2023. There are 9,774 secondary school pupils which are forecast to increase to 11,838 in 2023.
- Richmond pupils have less absence at 4.1% than nationally at 4.8%. There is also less especially persistent absence at 7.9% compared to the national average of 11.2% .
- The number of children electively home educated in 2019 was 141, an increase from 50 since 2014–15.
- The pupil population is more diverse than the resident population. In 2017 the Richmond 0–18 years population was 79.1% White and 20.9% from Black, Asian and Minority Ethnic groups. The pupil population is 56.1% White and 42.9% Black, Asian and Minority Ethnic groups (2019). There is increasingly more diversity in the pupil population than in previous years. Heathfield, Kew and South Richmond are the most ethnically diverse wards.
- There are 6,750 pupils with English as an additional language (EAL). 37.4% of pupils in South Richmond and 34.6% in Heathfield have English as an additional language. The most common languages spoken, other than English are Polish, Spanish and Arabic.
- In 2019, 8.8% of pupils, or 2,424 pupils, were eligible for free school meals (FSM). 7.7% of primary school pupils in Richmond are eligible and claim, compared to 15.7% nationally; at secondary school age this is 9.9% compared to 14.1% nationally.
- The proportion of eligible pupils for free school meals in Richmond is notably lower than in outer London and nationally, at both primary and secondary school level. A greater percentage of secondary school pupils (9.9%) are eligible than primary school pupils (7.7%).
- A reducing number of eligible and claiming children has been seen both locally (primary was 8.3% in 2013 and secondary 14.2 in 2013) and nationally (primary 18.1% in 2013 to 15.7% in 2019, secondary 15.1% in 2013 to 14.1% in 2019). However, both settings show an increase in the proportion of eligible pupils for free school meals in 2019 compared to 2018.

Attainment

At Key Stage 2, 81% of pupils in 2018 achieved the expected standard, this was the highest in the country.
79% of pupils with English as an additional language. For boys the figure was 77%, this achievement was slightly below the average. For Black pupils, 66%, for children eligible for a pupil premium grant, 57% and children receiving special educational needs support, 34% did significantly less well. Girls' achievement was high at 85% and Chinese pupils at 94%.

At Key Stage 4, the average attainment score was 51.7 points in 2018. This is the 14th best in the country. Girls at 53.4% and pupils with English as an additional language at 53.3%, and Chinese pupils at 58.4% scored higher. Boys at 49.9%, Black pupils 42.1%, and pupils of mixed ethnicity at 48.7% all scored lower than the average attainment score. Children eligible for a pupil premium grant at 38.2%, children receiving special educational needs support at 38.2% and children with an Education and Health Care Plan at 24.2% did significantly less well.

A high number, 96.4% of 16–17 year olds, were in education or training during 2018. Of those, 91% were in full time education with 2.3% in apprenticeships. Children not in education, employment or training (NEET) or not known is 3.6% which is less than London at 5.9% and England at 6.4%. NEET or not known are more prevalent in Heathfield, Hampton North and Whitton wards.

In Richmond at the end of Quarter 3 2020, 25% of care leavers aged 19–21 years were NEET compared to a local population of 1.9% for 16–19 year olds.

The average points scores of young people completing A levels (or equivalent) was 36 in Richmond compared to 32 nationally and is the 17th best in the country.

In 2018/19, 899 young people attending Richmond's state schools and colleges completed Key Stage 5. 85% went onto education or employment compared to 90% nationally and 51% into higher education (level 4 or above), compared to 56% nationally[8]. The percentage moving onto education or higher education is less than in London and nationally. Local analysis conducted on 2016/17 data suggested that 11% of students moved onto Russell Group Universities (including Oxford and Cambridge) compared to 19% in Kingston and 15% in outer London[9].

Local Authorities do not have a remit to record any attainment or destination data for young people who are home educated meaning comparisons with mainstream school performance measures cannot be discerned. However, when those educated at home reach Key Stage 4, families are provided with the Next Steps post-16 booklet and information about the 14-25 service so they can self-refer.

2.4 Child Poverty

Living in Poverty

The number of looked after children in a local area provides a proxy indicator for the levels of general well-being in society. Children and young people in care are among the most socially excluded children in England. There are significant inequalities in health and social outcomes compared with all children and these contribute to poor health and social exclusion of care leavers later in life. Rates of those in care in Richmond (25/10,000) are significantly below the London 50/10,000 and England rates 65/10,000 and have remained at similar levels since 2011. Richmond retains the lowest rates of children and young people in care of all London Boroughs with just 125 young people in care in an average year.

The Indices of Multiple Deprivation (IMD) is published every 3–5 years by the Ministry of Housing, Communities and Local Government. It measures relative deprivation in England using a methodology that encompasses a wide range of living conditions including income, employment and health. Scores are calculated for each small, geographical area in England (almost 33,000) and the published product ranks these from most to least deprived. The Income Deprivation Affecting Children Index (IDACI) is also calculated and published in the same ranking-style format. The IDACI measures the percentage of children under 16 years that live in low-income households. The map presents Richmond IDACI 2019, relative to the rest of the Borough only e.g., '10% most deprived' is the 10% most deprived in Richmond, rather than England.

Relative to England, Richmond has low levels of deprivation (IDACI). Of the 115 local areas (LSOA) in Richmond, 59 (51%) are within the 20% least deprived in the country and only two LSOAs (1.7%) are within the 20% most deprived.

There are 557 children who live in the lowest 10% of Lower Super Output Areas (LSOA) nationally for deprivation affecting children (using the Income Deprivation Affecting Children Index – IDACI 2015). There are no LSOAs in Richmond which are in the lowest 10–20%. There are approximately 3,000 or 8.3% children under 16 years living in low-income families.

[8] Destinations of key stage 4 and 5 students: 2019 - GOV.UK (www.gov.uk)
[9] Children and Young People's Needs Assessment 2019 (www.richmond.gov.uk)

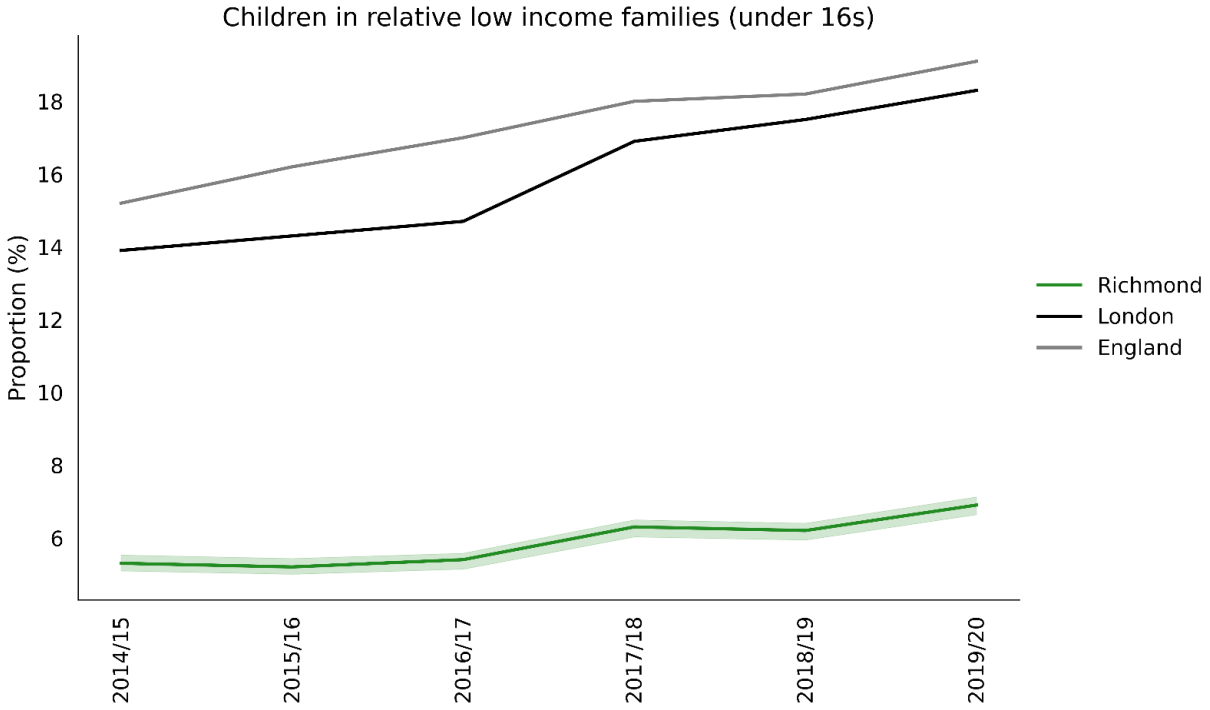
The Marmot Review[10] suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

Children in Low Income Families

The level of child poverty in Richmond is similar to England, with 6.4% (2,795) of children aged under 16 years living in low-income families[11] [12] and there is a welcome decreasing trend. In 2016 there were 3,260 children in low-income families 8.5%. This is much lower than either the London figure of 18.8% or the national figure of 17%. The percentage of children considered to be in poverty substantially increases when housing costs are factored in. The latest End Child Poverty Report indicates that after housing costs, 21% of Richmond's children are living in poverty, compared to 30% nationally. Wards with the highest percentage of children living in poverty are Heathfield (29%), Barnes (28%) and Hampton North (27%).

Richmond's latest proportion of children aged under 16 years in relative low income families was 6.9% (n=2862), which is the lowest percentage in London (**Figure 6**); 63.9% lower than the England average and 62.3% lower than the London average. The latest Borough figure was also 30.2% higher than in 2014/15, in comparison with 25.7% increase in England's rate in the equivalent time period (**Figure 7**). Relative low income is defined as a family in low income before housing costs in any given year. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income in these statistics.

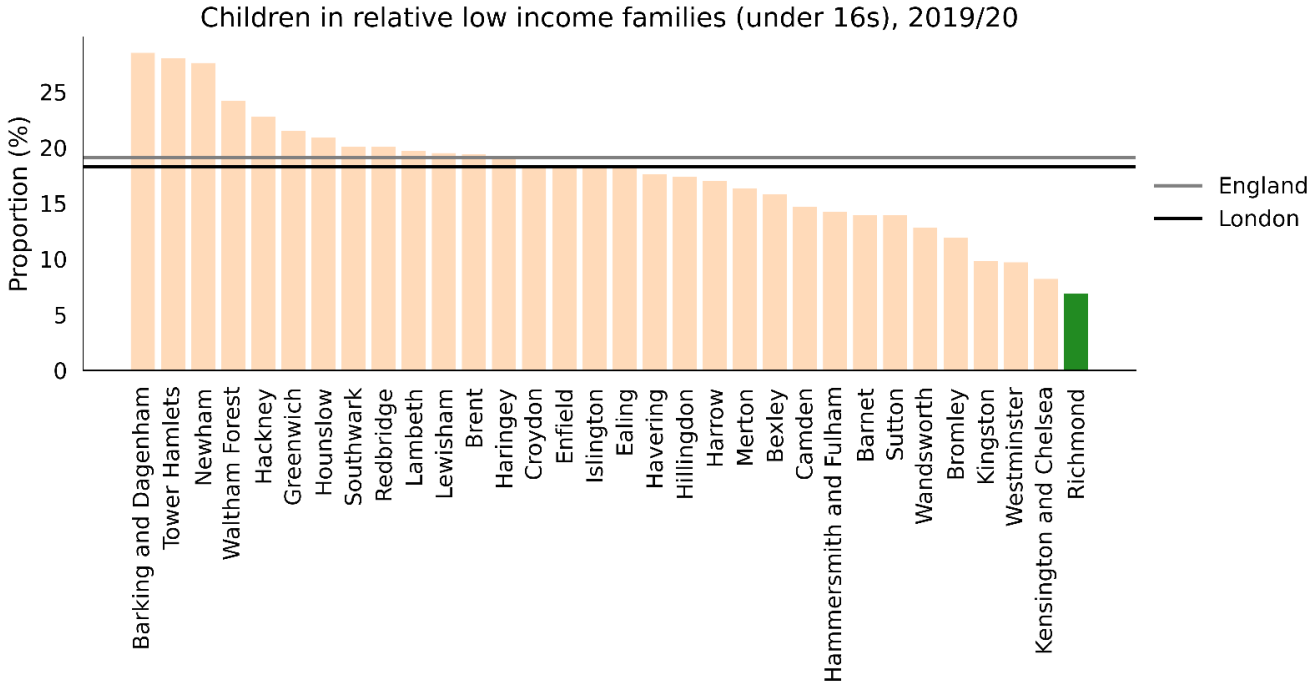
Figure 6: Children Aged Under 16 Living in Relative Low Income Families, 2006–2016



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

[10] Health Equity in England: The Marmot Review 10 Years On: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
[11] Defined as percentage of children aged under 16 living in families in receipt of Child Tax Credit whose reported income is less than 60 per cent of the median income or in receipt of Income Support or (Income-Based) Job Seeker's Allowance.
[12] Public Health England (2020) Child Health Profiles, London Borough of Richmond

Figure 7: Children Aged Under 16 Living in Low-Income Families by Local Authority, 2016



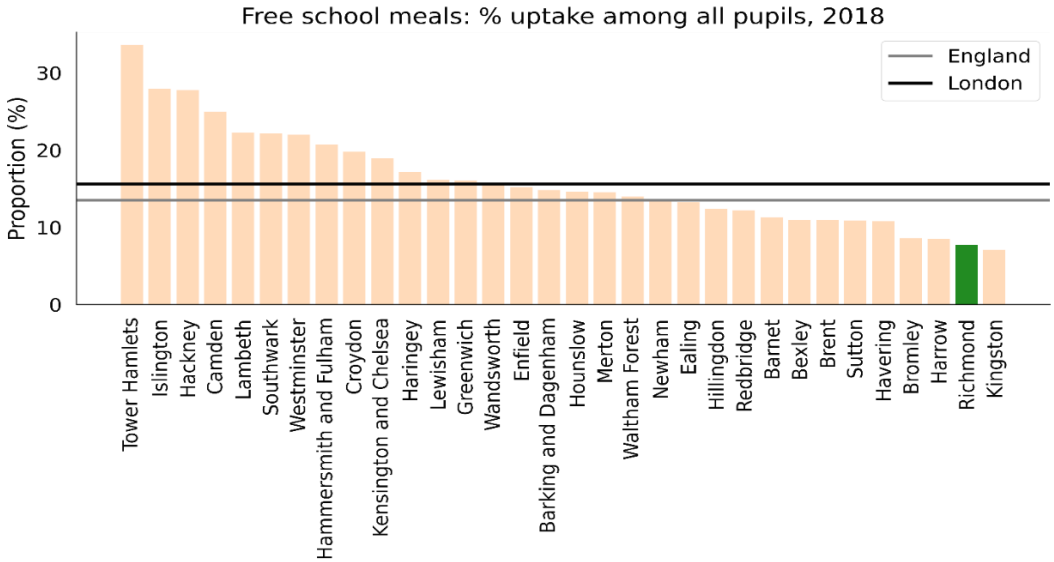
Source: PHE [Public Health Outcomes Framework]

Child deprivation is geographically concentrated in a few wards, including Barnes, Ham, Hampton North, Heathfield, Kew and Whitton.

Free School Meals

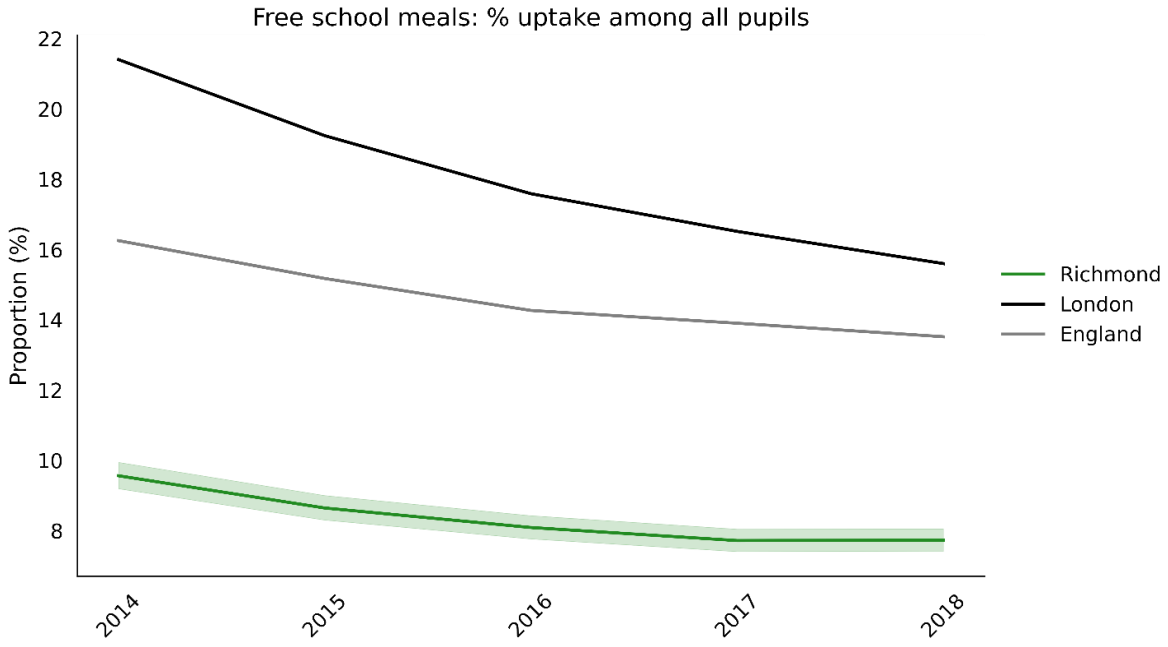
The number of children in receipt of Free School Meals (FSM) is frequently used as an indicator of poverty. Richmond's latest rate of children of school age (primary and secondary) claiming receiving FSM was 7.7 per 100 (2nd lowest in London, **Figure 8**). This is 42.8% lower than the England average and 50.5% lower than the London average. The latest Borough figure was also 19.2% lower from year 2014, in comparison with a 16.8% decrease in England's rate in the equivalent time period (**Figure 9**).

Figure 8: Free School Meals Uptake Among all School Age Children by Local Authority, 2018



Source: PHE [Public Health Outcomes Framework]

Figure 9: Free School Meals Uptake Among all School Age Children, 2012–2018

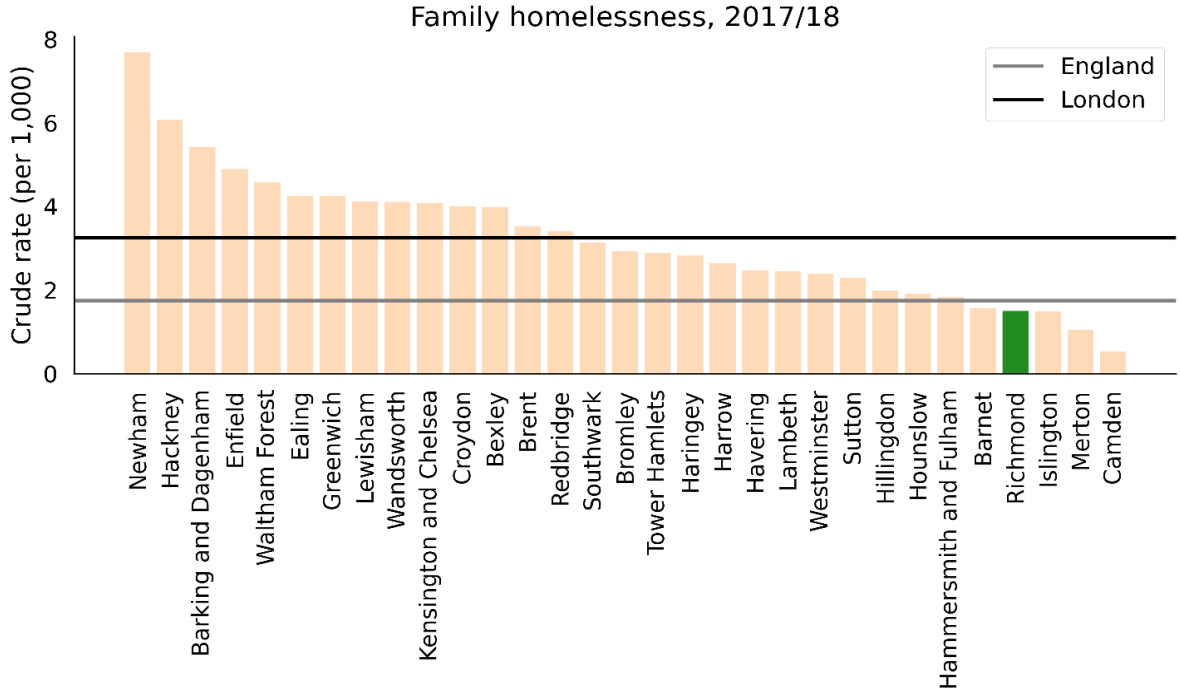


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Homeless Families

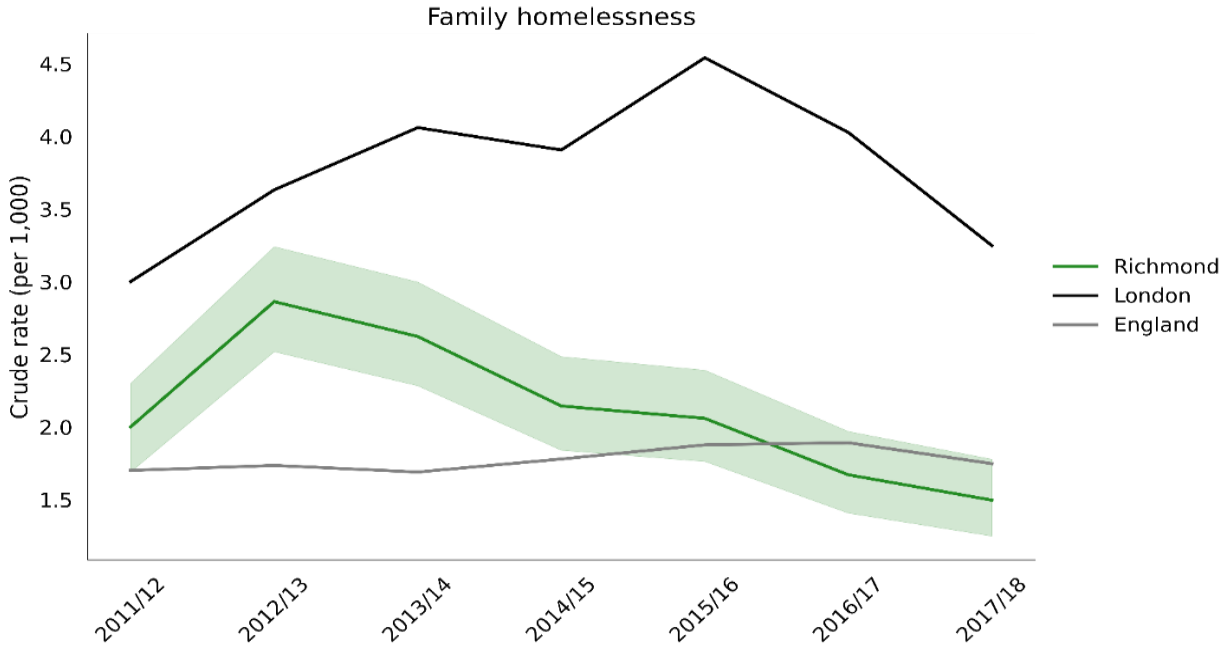
Richmond's latest (2017/18) rate of homeless families stands at 1.5 per 1,000 households and is the 4th lowest in London, (**Figure 10**) this is 14.4% lower than the England average and 53.9% lower than the London average. The latest Borough figure was also 25.2% lower from year 2011/12, in comparison with a 2.8% increase in England's rate in the equivalent time period (**Figure 11**).

Figure 10: Homeless Households with Children per 1,000 Households by Local Authority, 2017/18



Source: PHE Public Health Outcomes Framework

Figure 11: Homeless Households with Children per 1,000 Households, 2011–2018



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

In 2018/19, 301 children and young people were in temporary accommodation in Richmond. This is a decrease from 392 children in 2017/18. This indicates that alternative assistance such as prevention may be gaining traction locally. As of 31st March 2019, there were no families in temporary accommodation that were sharing facilities and no families were placed into bed and breakfast accommodation. As of 31st March 2019, there were 8 young people aged 16–18 years placed in temporary housing (self-contained or supported hostels). These young people were the main applicant rather than within a family. In 2018/19, 90% of the families with children who approached for homeless assistance were resolved successfully either through prevention work or being owed a duty to house. 16% of the positive decisions received were via prevention, negating the need of temporary accommodation.

According to the 2011 census 7.9% of households with dependent children are overcrowded compared to 23.6% in London and 9.2% nationally. The demand for social housing has steadily risen on both a national and local scale. Children on the housing queue in Richmond has increased from 2,561 in 2017/8 to 2,954 in 2018/19. Richmond can offer 200 homes which are provided by Housing Associations per year. Priority is accorded to those applicants with a high housing need.

Income Deprivation Affecting Children Index

The three most deprived IDACI wards in Richmond are Hampton North, Heathfield and Whitton, and located on, or near to the west of the Borough. There is a correlation between relatively poor IDACI outcomes and higher ethnic diversity. Heathfield (30% ethnic minority groups), Whitton (22%) and Hampton North (16%) are also the three most ethnically diverse wards in the borough. The least deprived wards include Twickenham, Riverside, East Sheen and South Twickenham, which are among the least ethnically diverse in the borough.

Educational attainment of children eligible for the pupil premium grant (on free school meals, in care, adopted or children with parents in the armed services) is significantly less than those of their peers.

3. Prenatal and Postnatal Health

Many of the health behaviours and risk factors for poor birth outcomes are established prior to pregnancy, often with limited potential to impact on these after conception (the start of pregnancy)[13]. For example, currently 13.7% of adult women smoke and whilst few, if any, take up smoking as a new behaviour while pregnant, in the UK 11% of women are still smoking through to the birth of their baby.

In recognition of the time required to embed healthy behaviours, address upstream determinants and reduce risk factors, the pre-conception period relates to both the weeks and months before pregnancy begins, and the period that women are of childbearing age. It also acknowledges that the life course approach to health and well-being will need to develop a more targeted approach for vulnerable individuals with more risk factors as they may often be the least likely or least able to proactively prepare for pregnancy.

3.1 Healthy Behaviours in Pregnancy

A mix of health-related behaviours, risk factors and wider determinants of health will affect a woman's ability to have a healthy pregnancy. Even among those who do plan their pregnancy relatively few will modify their behaviours[14]. Healthy behaviours include: a healthy diet (including folic acid supplements to reduce neural tube defects), regular physical activity and promoting emotional well-being, as well as ensuring immunisations, sexual health checks and smear tests are up to date. Preconception risk factors include smoking, alcohol, substance misuse, obesity, long term physical and mental health conditions, previous pregnancy complications, genetic risks, maternal age, adverse childhood experiences (ACEs), domestic violence and migrant health factors[15] and these will often be compounded. Furthermore, the wider determinants of health such as housing, education, skills, financial security, work and family relationships also influence pre-conception health. The impacts may be unequally distributed meaning that those with the greatest need may have most difficulty accessing care. It is of note that many areas covered across the whole of the JSNA will also impact on pre-conception health. Only a snapshot of health behaviours and risks factors for Richmond are included in this chapter.

Women who are overweight or obese before pregnancy have an increased risk of infertility as well as complications during pregnancy and birth. These include impaired glucose tolerance/gestational diabetes, miscarriage, pre-eclampsia, thromboembolism and maternal death. Babies born to obese women have a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity. In 2016/17 over 55% of women were overweight or obese in England and the prevalence of overweight and obese adults is predicted to reach 70% by 2034.

Maintaining good nutrition both pre-conception and during pregnancy is a protective factor and includes taking Folic Acid (vitamin B9) supplements to reduce the risk of neural tube defects such as spina bifida.

[13] Public Health England. Making the Case for Preconception Care Planning and preparation for pregnancy to improve maternal and child health outcomes. 2019.
[14] Inskip HM, Crozier SR, Godfrey KM, Borland SE, Cooper C, Robinson SM. Women's compliance with nutrition and lifestyle recommendations before pregnancy: general population cohort study. Bmj. 2009 Feb 12;338:b481.
[15] World Health Organization. Policy Brief: Preconception Care – Maximising the gains for maternal and child health. 2013.

There is currently no locally available data on the uptake of folic acid, however, research shows that uptake is generally lower in some groups such as non-white and young women under the age of 20[16].

Some pre-existing conditions such as those with epilepsy or severe mental illness can be a risk factor for maternal deaths either within pregnancy or for up to a year after the end of the pregnancy. Maternal suicide remains the leading cause of direct maternal deaths. Nationally 1 in 7 women die in the period between 6 weeks and one year after pregnancy by suicide[17]. Nationally, an estimated 20% of women will develop a mental illness during pregnancy or within the first year after having a baby.

It is estimated in Richmond:

- 182 to 273 women will develop mild to moderate depressive illness and anxiety
- approximately 273 to 547 women will develop adjustment disorders and distress
- 55 women will have post-traumatic stress disorder
- 55 women will have severe depressive illness
- 4 women will be living with chronic serious mental illness
- 4 women will be affected by postpartum psychosis.

Maternal age is a factor that can influence both pregnancy and childhood outcomes. Teenage pregnancy, for example, is associated with a higher risk of late booking antenatally, lower birth weight babies, stillbirth and infant mortality. The rate of under-18 years conceptions in Richmond has seen a substantial reduction over the last decade and has fallen more steeply than those seen at an England level[18]. The latest data for 2018 shows that in England 16.7/1,000 young women under-18 years became pregnant, a 6.2% decrease compared with 2017, and a 58% decline compared with 2008. Births to women aged 35 years and over also carry additional risks in relation to birth complications, congenital abnormalities, stillbirth and emergency section and increase with age. However, the exact age at which these risks increase is uncertain and co-existence of additional risk factors e.g., smoking, will increase the chance of adverse birth outcomes. The latest national ONS conception data released in 2018 indicates that for the third consecutive year, women aged 40 years and over were the only age group where the conception rate increased. In 2018, there were 16.3 conceptions per 1,000 women aged over 40 years[19].

Nationally, women are progressively delaying childbearing. The latest available data shows that over 10% of births in Richmond were to women aged 40+, which ranks the second highest in London and is above the England percentage of 4.4%. Trends in outcomes for newborns:

- the percentage of births delivered by caesarean section are statistically higher at 33.9% for women in Richmond than in England at 27.1%, and ranks the second highest in London
- the still birth and neonatal mortality rate at 6.9/1000 are statistically identical to England with no discernible increase or decrease in trends
- The premature birth rate (births at less than 37 weeks) at 77.6/1000 is statistically similar to England at 81.2/1000 with no discernible increase or decrease in trends
- while low birth weights are better than the England averages, very low birth weight of all babies at 1.13% is statistically similar to England at 1.14% with no discernible increase or decrease in trends.

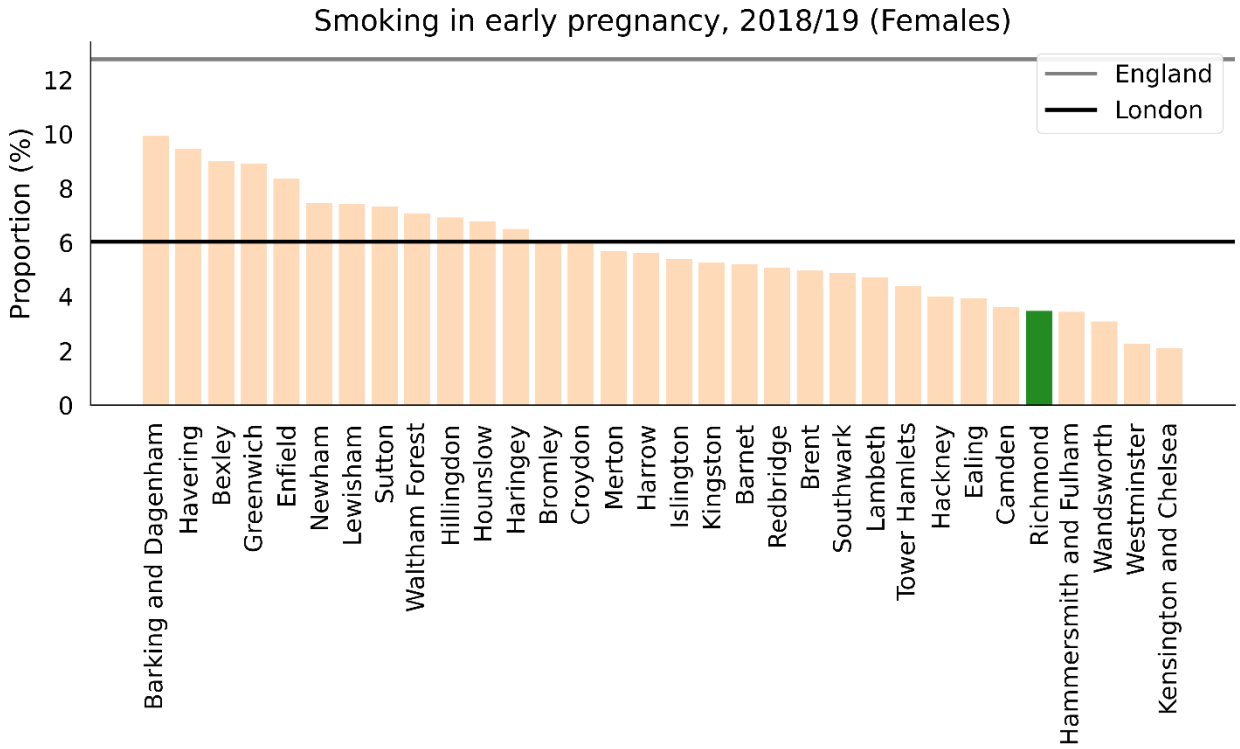
[16] Public Health England. Making the Case for Preconception Care Planning and preparation for pregnancy to improve maternal and child health outcomes. 2019.
[17] Office for National Statistics. Child mortality in England and Wales: 2016. 2016.
[18] Office for National Statistics. Conception and Fertility Rates. 2018.
[19] Office for National Statistics. Conception and Fertility Rates. 2018.

3.2 Smoking in Pregnancy

Smoking is the single biggest modifiable risk factor for poor birth outcomes. Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year[20]. It also increases the risk of stillbirth, complications in pregnancy, low birthweight and of the child developing other conditions in later life. Currently 13.7% of adult women in the UK smoke cigarettes and nearly 11% of women in England are still recorded as smoking at the time of delivery.

In 2018/19 the percentage of Richmond's mothers who were smoking at the time of booking their first appointment with midwife was the 5th lowest in London. 3.5%, is a quarter of England's average percentage and around half of the London average (**Figure 12**). This indicator is relatively new, with no time trend information available now.

Figure 12: Proportion of Pregnant Women who Smoke at the Time of Booking First Appointment with Midwife by Local Authority, 2018/19

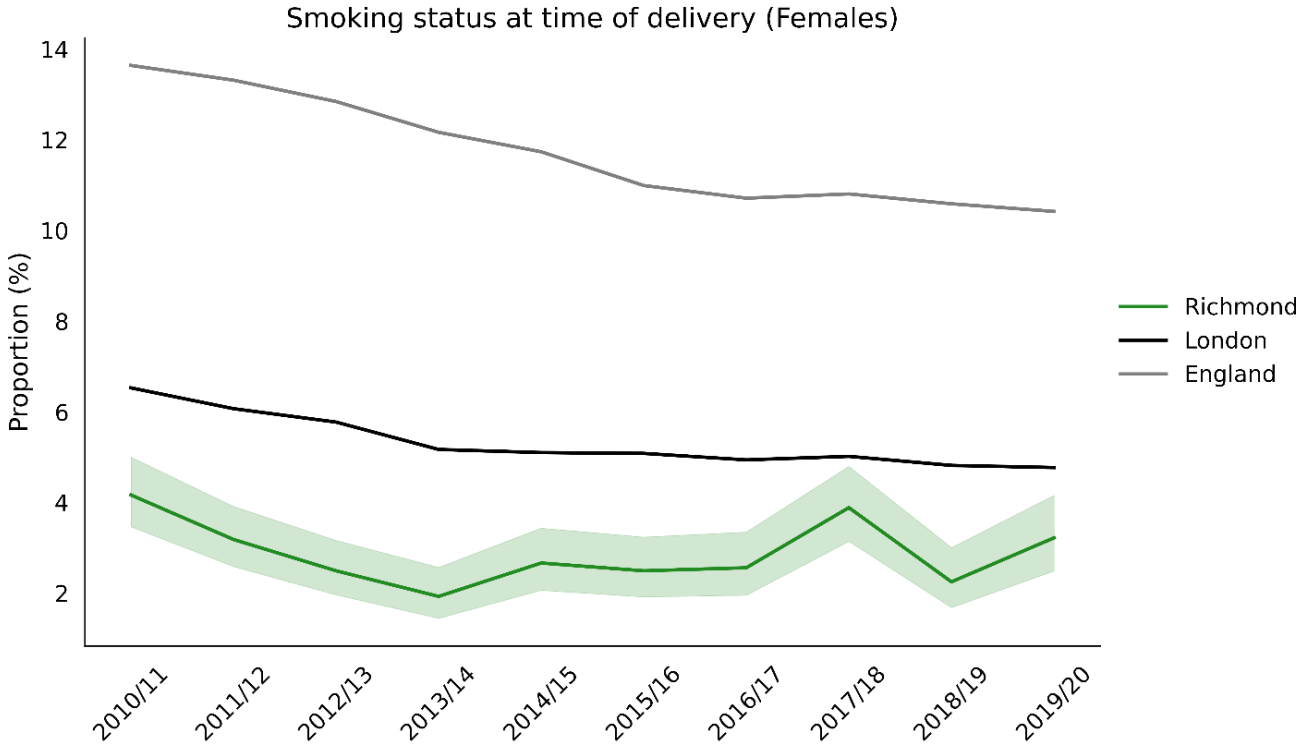


Source: PHE Public Health Outcomes Framework

In Richmond in 2019/20 only 3.2% of women were smoking at the time of delivery compared to 4.2% in 2010/11. The relative rate of decrease is substantially higher than in England and London. The latest borough figure was also 22.7% lower from year 2010/11, in comparison with a 23.6% decrease in England's rate in the equivalent time period (**Figure 13**). Richmond has the 6th lowest percentage of smoking mothers in late pregnancy in London (**Figure 14**). While this is encouraging, it is known that women from routine and manual occupations and teenagers are more likely to smoke throughout their pregnancy[21] with mothers under 20 years being 3 times more likely to smoke throughout pregnancy[22].

[20] Royal College of Physicians. Passive smoking and children. 2010.
[21] National Institute for Health Research. Themed Review: Better Beginnings – Improving Health for Pregnancy. 2017.
[22] Health and Social Care Information Centre, 2010. Infant Feeding Survey - UK, 2010.

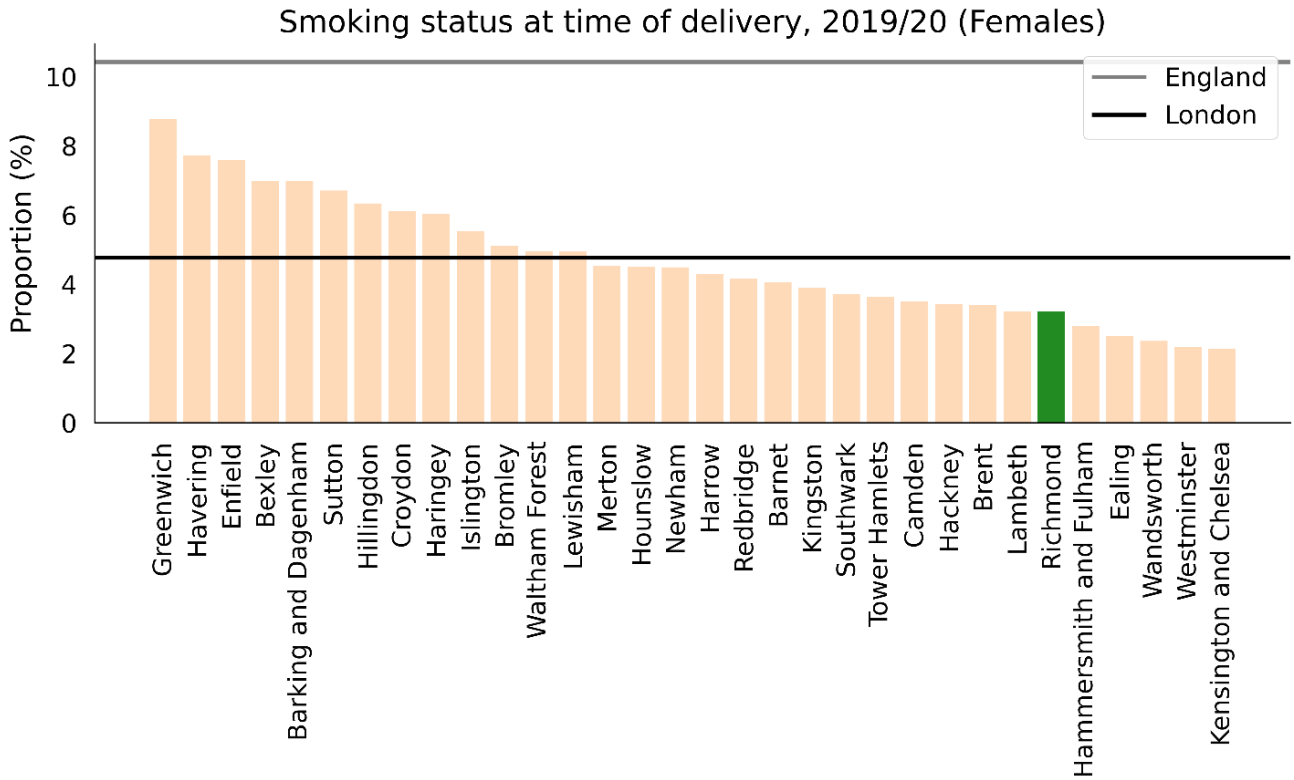
Figure 13: Smoking in Late Pregnancy, 2010–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE [Public Health Outcomes Framework]

Figure 14: Smoking in late Pregnancy by Local Authority, 2019/20

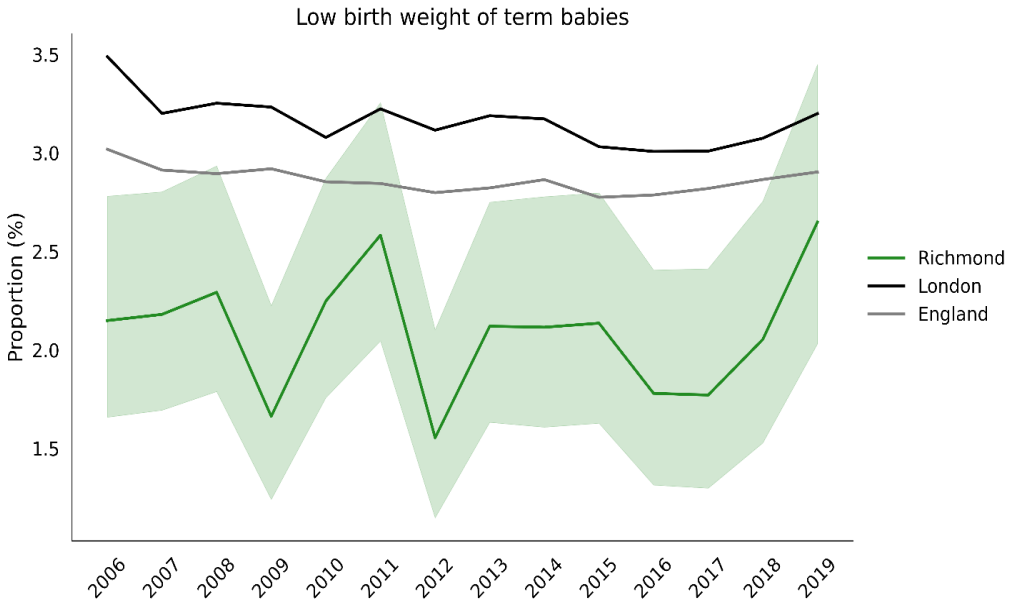


Source: PHE [Public Health Outcomes Framework]

3.3 Low Birthweight

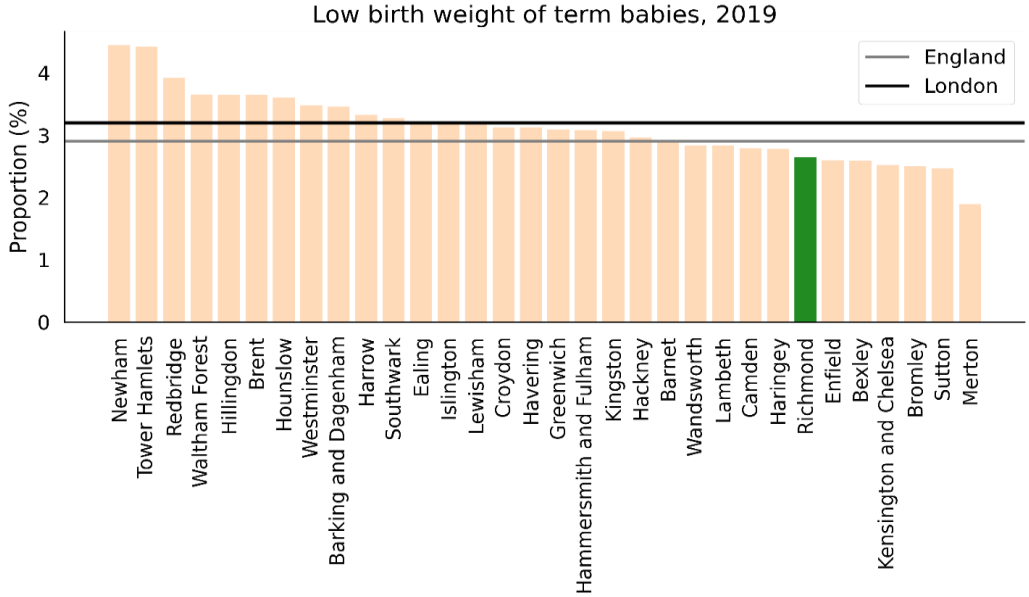
Low birthweight (under 2.5kg) is one of the known risk factors for infant deaths. In 2019 Richmond's low birthweight term babies was 2.6%, which was lower than England and London averages at 2.9% and 3.2% respectively. The latest Borough figure was also 23.3% higher from year 2006, in comparison with a 3.8% decrease in England's rate in the equivalent time period (**Figure 15**). Despite the increasing trend since 2017, the Borough's figure is 7th lowest in London **(Figure 16).**

Figure 15: Proportion of Term Babies Weighing Under 2.5kg, 2006–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Figure 16: Proportion of Term Babies Weighing Under 2.5kg by Local Authority, 2019



Source: PHE Public Health Outcomes Framework

3.4 Breastfeeding

The first 1001 days mark the moment of conception through to a child's second birthday and have been found to be crucial for laying the foundations for future development and preventing illness in later life.

Ensuring every child has the best start in life is both a national and local priority. Initiating breastfeeding from birth is one of the earliest interventions that can be undertaken to give a child the best possible start and can lay the foundations for future development and help to prevent illness in later life. Initial breastfeeding uptake in Richmond has seen increases in recent years, and currently stands at 86.7%, which is the third highest in London.

The World Health Organisation (WHO) and the United Nations International Children's Emergency Fund (UNICEF) recommend breastfeeding to be initiated within the first hour after birth and continued exclusively for the first 6 months and beyond with safe weaning onto solids foods. The UK, however, has one of the lowest breastfeeding rates in the world. The Nuffield International comparisons of health and wellbeing in early childhood (2018) suggests that only 1% of UK babies aged under 6 months are breastfed exclusively, compared with 34% in Portugal. 34% of UK babies are receiving some breastmilk at six months, compared with 62.5% in Sweden[23]. There is limited breastfeeding data available to compare trends particularly due to the different timescales for data collection internationally.

There are multiple explanations for these low breastfeeding rates. Sometimes mothers experience practical problems when establishing breastfeeding and fail to receive adequate practical support. There are also additional concerns on whether a child is receiving sufficient milk which is often due to advice from friends, family and professionals to supplement with formula milk. This reduces breastmilk production and is strongly associated with premature cessation of breastfeeding[24]. Anecdotal evidence reveals that social attitudes about women breastfeeding in public may lead to women feeling uncomfortable about breastfeeding.

There are several policy drivers in the UK promoting breastfeeding which include but are not limited to:

- Healthy Child Programme (2009) – Pregnancy & the first 5 years of life
- UNICEF Baby Friendly Initiative
- Public Health Outcomes Framework
- Public Service Agreements (PSA) targets such as reducing infant mortality rate & preventable infections, reducing hospital admissions in infancy, and reducing childhood obesity

Supporting women to breastfeed ensures babies have the best possible start and it has significant health benefits for both mother and baby. For the baby this includes protection against illness and infection, prevention of diarrhoea and respiratory infections, reduced risk of Sudden Infant Death Syndrome, and reduced risk of breast cancer, postnatal depression and ovarian cancer for the mother[25].

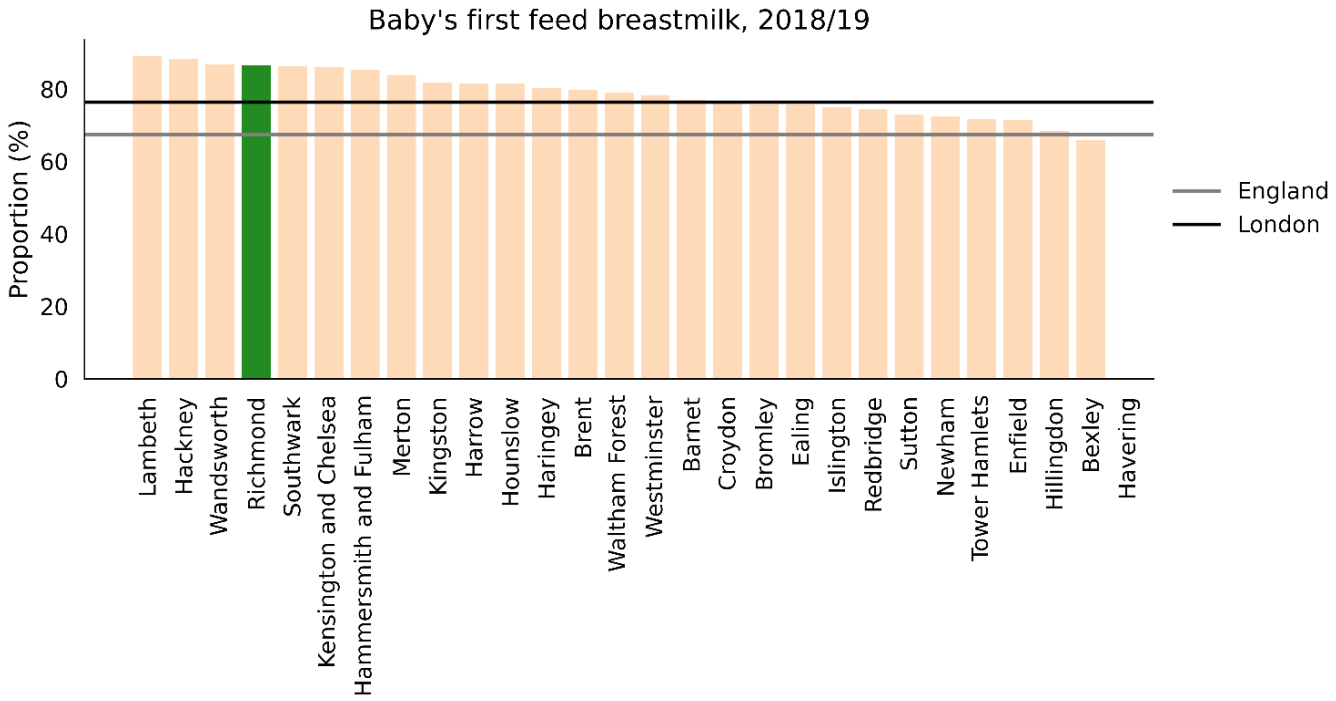
Breastfed children also perform well on intelligence tests and are less prone to diabetes in later life [26]. There is also growing evidence to suggest there to be an increased future risk of childhood obesity in those who have not been breastfed. In addition to health benefits of breastfeeding, a cost/benefit analysis carried out by UNICEF, indicated that

[23] https://www.nuffieldtrust.org.uk/files/2018-03/1521031084_child-health-international-comparisons-report-web.pdf
[24] McAndrew F, Thompson J, Fellows L, et al. Infant Feeding Survey 2010. NHS Health and Social Care Information Centre. 2012.
[25] Public Health England (2017) giving every child the best start in life: LGA Early Years Conference
[26] Public Health England. Child and Maternal Health Profile. 2020.

increasing the number of babies who are breastfed will help save the NHS up to £50 million each year[27] thereby reducing financial pressure on both local and national resources.

Richmond is among the top 4 boroughs in London with babies first fed breast milk (**Figure 17**); higher than London and England averages. In 2018/19 Richmond's rate was 86.6 per 100, which was 28.5% higher than the England average and 13.4% higher than the London average. The latest Borough figure was also 13.6% higher from year 2017/18).

Figure 17: Babies Whose First Feed is Known to be Breastmilk by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

Breastfeeding initiation (first 48 hours after birth) and uptake at 6–8 weeks are included in the National Institute for Health and Clinical Excellence (NICE) proposals for the Commissioning Outcomes Framework.

Breastfeeding prevalence at 6–8 weeks is defined as the percentage of infants that are totally or partially breastfed at age 6–8 weeks. **Table 4** shows that Richmond's performance in the last year is significantly better than the England average. Richmond has seen an overall improvement in 6–8 weeks prevalence rates between 2018 to 2019 from 67% in Q1 to 77% in Q4. The overall total for the year is 74.6%. Breastfeeding prevalence at 6–8 weeks for Richmond has remained higher than the England average. This is the first full annual data set available for Richmond since 2012. Going forward this should show an increase the rates of mothers breastfeeding.

[27] UNICEF. Baby Friendly Initiative. 2021.

Table 4: Prevalence of Breastfeeding at 6–8 Weeks in Richmond, 2018/19

	Breastfeeding prevalence at 6–8 weeks after birth %				
	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	YTD
Richmond	67%	74%	78%	77%	74.6%
London Average	No data available (coverage validation not passed)				
England Average	45%	46.4%	46.1%	31.9%	42.7%

Source: England and London data source[28] Richmond: data source[29]

There are a range of breastfeeding services on offer in the community and in the hospital. Public Health, in partnership with the Children's Commissioning Team, commission Central London Community Healthcare Trust (CLCH) to provide the Health Visiting Service for Richmond children from 0–19 years. This includes providing evidenced pathways for delivering each of the 6 high impact areas to all levels of family need. The high impact areas are part of the 4-5-6 model which provides an evidence-based framework on which health visitors who are leaders of the Healthy Child Programme, can maximise their contribution. These high impact areas include:

- transition to parenthood
- maternal mental health
- breastfeeding
- healthy weight
- healthy nutrition
- physical activity
- managing minor illness & accident prevention
- school readiness.

Breastfeeding support for Richmond is provided by the Health Visiting Service and supported by Infant Feeding Leads within the hospital and the community.

Hospital: Women receive breastfeeding support from maternity services at Kingston Hospital until around day 10, when the handover to the Health Visiting Service usually commences. The midwives in the hospital are trained to provide baby-friendly standard care by the infant feeding team. Additionally, Kingston Hospital have Breastfeeding Peer Supporters who support the Midwives to provide mothers with breastfeeding support where needed. This team is managed by the hospital's Infant Feeding Lead. Kingston Hospital offers a Specialist Breastfeeding Support Clinic for complex cases up to 28 days post birth.

Community: The community Infant Feeding Lead delivers training for the health visitors who provide breastfeeding support to mothers when they are discharged from the hospital, usually between day 10 to 14. Breastfeeding Support Clinics are available to support mother and they are led by the Health Team made up of health visitors, nursery nurses and lactation consultants. Additionally, there are voluntary independent organisations that run breastfeeding support groups led by La Leche League leaders and National Childbirth Trust (NCT) breastfeeding counsellors.

[28] Public Health England (2019). Available: https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-after-birth-2018-to-2019-quarterly-data

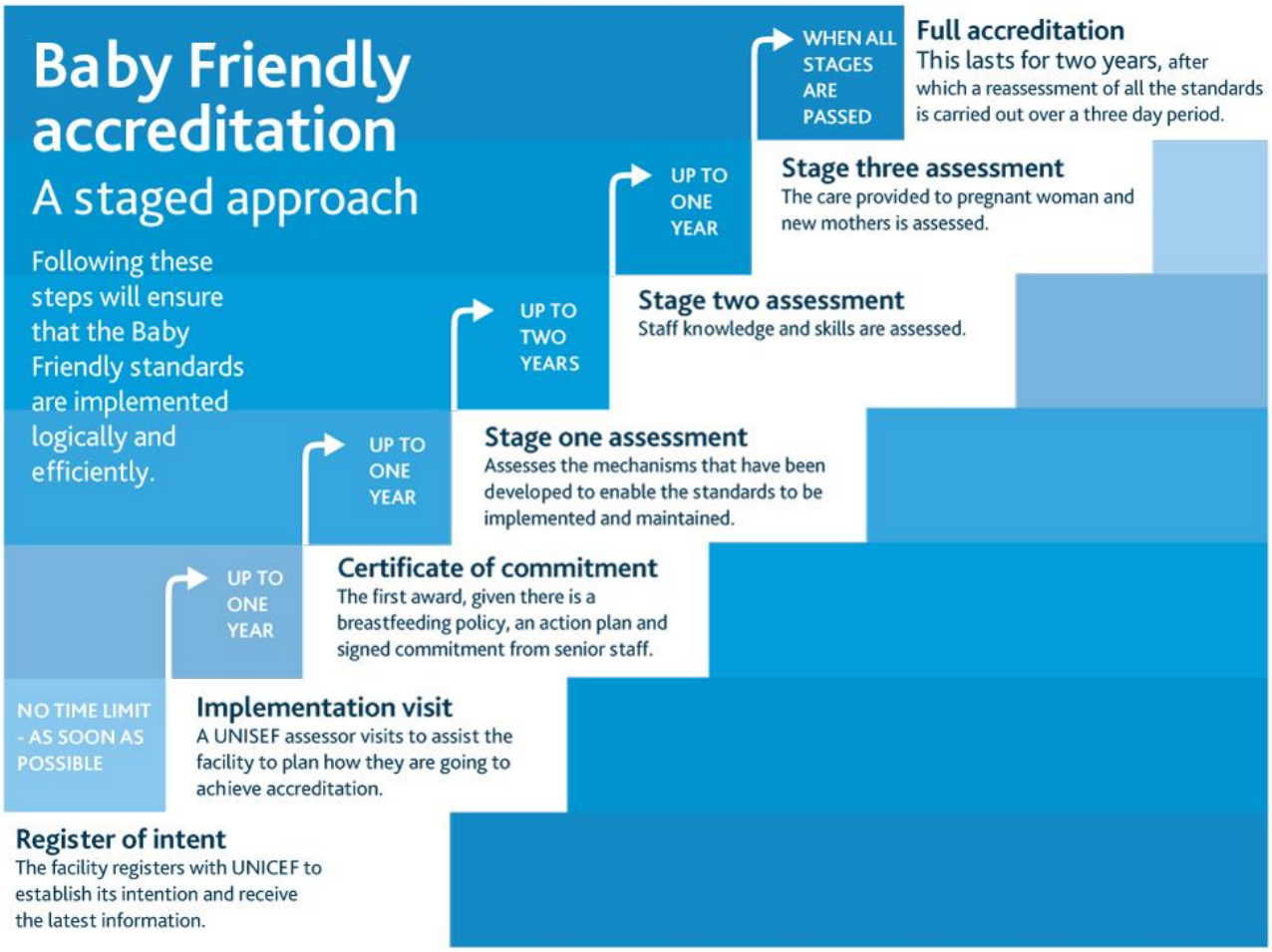
[29] Central London Community Healthcare (CLCH) breastfeeding data 2018/19 Q1-4

Richmond Council has a breastfeeding operational group chaired by the Public Health Children and Young People Lead. Members of the group include the infant feeding leads for both the hospital and community, breastfeeding lactation consultants from the voluntary sectors, health visitors and other Children Services support staff.

UNICEF Baby Friendly Initiative Accreditation (BFI)

The Richmond Public Health Team supports the BFI Accreditation. It is an evidence based, staged accreditation programme that supports Maternity, Neonatal, Health Visiting and Children's Centre Services to deliver effective breastfeeding support (**Figure 18**). It is an internationally recognised mark of quality care for babies and mothers. In Richmond the infant feeding leads for both the community and the hospital (Kingston Maternity) lead this programme. Our 0-19 years provider service were assessed to receive the Baby Friendly Initiative Stage 2 accreditation in 2019. Feedback provided identified that some health visiting staff required more practical training before accreditation could be awarded. While this was due to commence during 2020 all accreditation programmes were paused due to COVID-19. Reassessment for Stage 2 is now planned for the end of 2021 with the view to achieving Baby Friendly Initiative Stage 3 accreditation by the end of 2022.

Figure 18: UNICEF Baby Friendly Initiative



Source: UNICEF UK. Baby Friendly Initiative. 2020 (redesigned internally)

UNICEF has put out a "call to action" on the UK Government to enable mothers to breastfeed for as long as they wish and to protect all babies from commercial interests below[30]:

- to enable mothers to breastfeed for as long as they wish and to protect all babies from commercial interests
- to enable mothers to breastfeed for as long as they wish and to protect all babies from commercial interests
- implement evidence-based initiatives that support breastfeeding, including the UNICEF UK Baby Friendly Initiative, across all Maternity, Health Visiting, Neonatal and Children's Centre Services
- Protect babies and their families from harmful commercial interests by adopting, in full, the International Code of Marketing Breastmilk Substitutes ("the Code").

There are a range of evidence-based approaches to promoting breastfeeding in the UK. Some of these have been implemented in Richmond. There is overwhelming evidence that shows breastfeeding saves lives. "Breastfeeding practices are highly responsive to interventions delivered in health systems, communities and homes. The largest effects are achieved when interventions are delivered in combination" (Lancet Breastfeeding series, 2016).

Evidence shows that implementing a multi-faceted approach that considers the parents' whole journey from pregnancy to new parenthood improves breastfeeding rates significantly. This should include sensitive conversations during pregnancy, skilled support in the immediate post-birth period, ongoing guidance and social support to enable mothers to feel confident and breastfeed successfully for as long as they wish. Additional support from the wider community in welcoming breastfeeding, including in public spaces, in the workplace and through the media is pivotal to the process[31].

The Baby Friendly Initiative (BFI) is recommended by the National Institute for Health and Clinical Excellence (NICE) and cited in a wide range of policy guidance documents. The programme has been highly successful, with over 90% of maternity units and 80% of health visiting services actively engaged, and therefore breastfeeding initiation rates have improved by over 20%[32].

A systematic review carried out through the UNICEF Baby Friendly Initiative demonstrated that it increases breastfeeding rates up until the age of six weeks and that this is consistent with studies conducted in other resource rich countries[33]. Given the international evidence on the low take up of breastfeeding in the UK in comparison to other European countries, it is imperative that public health continue to prioritise and promote the UNICEF initiative.

Public Health in Richmond is working with the National Childbirth Trust (NCT) to create baby friendly places that promote breastfeeding. The programme includes the development of resources (posters, stickers, leaflets) for local businesses, GPs, libraries and other community settings to support their commitment to promote breastfeeding in their environment. Promotional material provides mothers with information on breastfeeding friendly places. Discussions are also in place to develop a 'Breastfeeding Peer Support Service' in the community with a timeline to achieve Stage 3 full accreditation within one year of achieving Stage 2 accreditation for the peer scheme.

[30] UNICEF(2019). A Call to Action on Infant Feeding in the UK. Available: https://www.unicef.org.uk/babyfriendly/about/call-to-action/
[31] UNICEF(2019). A Call to Action on Infant Feeding in the UK. Available: https://www.unicef.org.uk/babyfriendly/about/call-to-action/
[32] UNICEF(2019). A Call to Action on Infant Feeding in the UK. Available: https://www.unicef.org.uk/babyfriendly/about/call-to-action/
[33] Fallon, V.M., Harrold, J.A. & Chisholm, A. (2019). The impact of the UK Baby Friendly Initiative on maternal and infant health outcomes: A mixed-methods systematic review. Maternal and Child Nutrition, doi/abs/10.1111/mcn.12778

4. Antenatal and Newborn Screening

4.1 Newborn Blood Spot Screening

All babies, up to their first birthday, are eligible for the Newborn Blood Spot Screening (NBS), otherwise known as the 'Heel Prick Test'. The aim of the Screening Programme is to enable early identification, referral and treatment of babies with nine rare serious conditions, the last six of which are inherited metabolic diseases, including:

- Sickle Cell Disease
- Cystic Fibrosis
- Congenital Hypothyroidism
- Phenylketonuria
- Medium-Chain Acyl-Coa Dehydrogenase Deficiency
- Maple Syrup Urine Disease
- Isovaleric Acidaemia
- Glutaric Aciduria Type 1
- Homocystinuria

A healthcare professional will usually take a blood spot sample on day 5 (day of birth is Day 0) from a child's heel and send the sample for testing. Babies who are new to the country or are yet to have a blood spot test are eligible for testing up to a year old.

In 2018/19, 98.9% of babies registered within Richmond CCG that were eligible for NBS screening had a conclusive result recorded on the Child Health Information System (CHIS) by 17 days of age. Furthermore, 95.5% of those who either changed responsible CCG in the first year of life or moved in from another UK country, had a conclusive result recorded on the CHIS within 21 calendar days of notifying the CHRD of movement into Richmond.

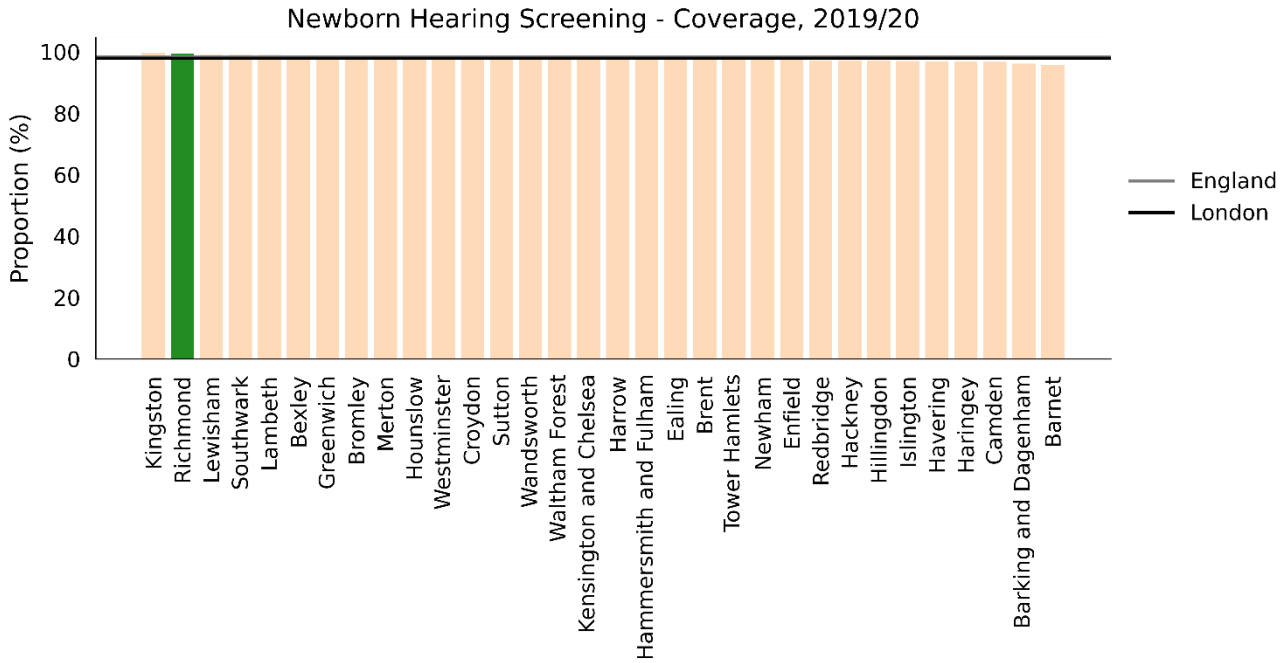
4.2 Newborn Hearing Screening

Newborn hearing tests help to identify most babies with significant hearing loss. Newborn hearing screening significantly reduces the risk of having undiagnosed hearing problems that can affect children's speech and social development[34].

In 2019/20 Richmond's newborn screening coverage was 99.4 per 100 , 2nd highest in London, (**Figure 19**), which was 1.2% higher than the England average and 1.7% higher than the London average. The latest Borough figure was also 0.6% higher from year 2013/14, in comparison with a 0.3% decrease in England's rate in the equivalent time period (**Figure 20**).

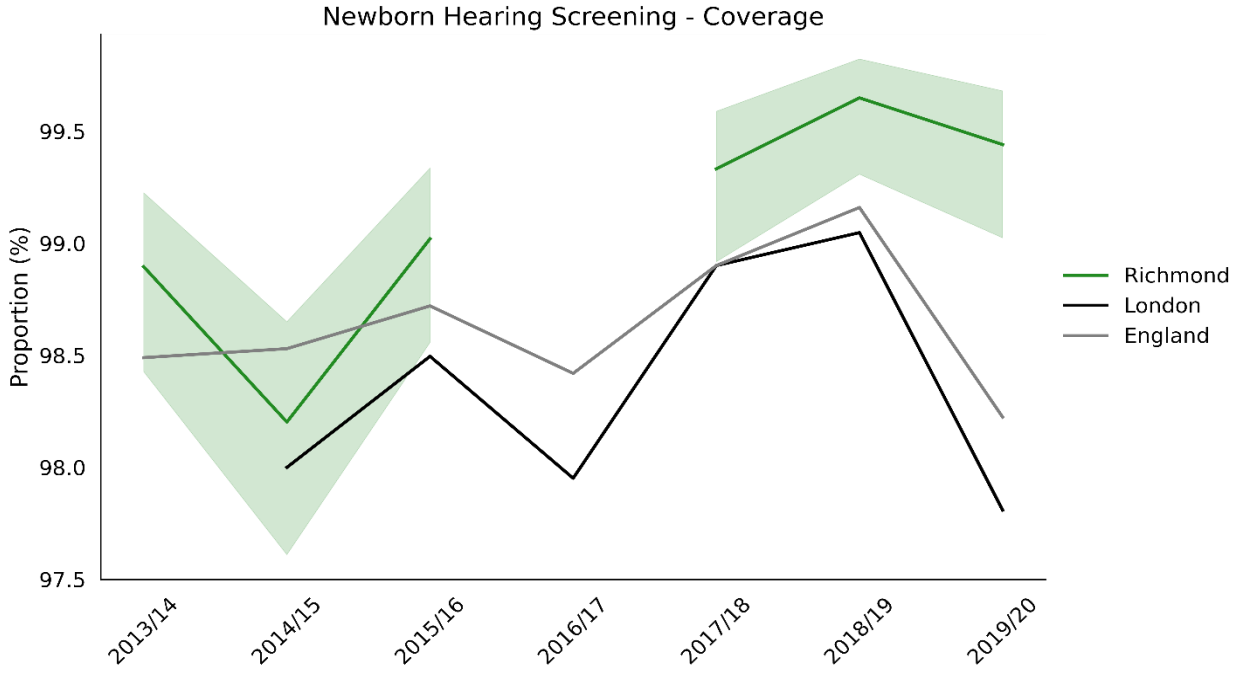
[34] NHS. Hearing tests for children. 2021.

Figure 19: Newborn Hearing Test Coverage by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Figure 20: Newborn Hearing Test Coverage, 2013–2020 (data for 2016/17 is not available)



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

5.NHS Childhood Vaccination Programmes and Uptake

Immunisations in the first few years of life can provide long-term protection against preventable diseases. The target for most immunisations is 95% of the eligible population which ensures that immunity is high enough for the infectious disease not to be passed to others. Immunisations for vaccine preventable diseases include Congenital Rubella Syndrome, Pertussis, Influenza and Hepatitis B infection and are an important element of protecting the health of mother and baby. Maternal Rubella Infection in pregnancy, for example, may result in foetal loss or Congenital Rubella Syndrome and Influenza Infection in pregnancy is associated with risks to the foetus, including still birth.

The complete childhood vaccination schedule[35] covers numerous diseases including Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio, Haemophilus Influenzae Type B (Hib) and Hepatitis B, Meningitis B and Rotavirus Gastroenteritis at 8 weeks old, and Measles, Mumps and Rubella (German measles) from the age of one. Vaccinations for cancers caused by Human Papilloma Virus (HPV) types 16 and 18 (and Genital Warts caused by types 6 and 11) are added at aged 12 years and Meningococcal Groups A, C, W and Y diseases at age 14 years (Year 9). In addition to whole population vaccinations the schedule also includes additional vaccinations for at risk groups such as annual influenza for babies born to Hepatitis B infected mothers and infants in areas of the country with high tuberculosis rates. Additional vaccines are also given to individuals with underlying medical conditions.

An overview of the picture for vaccine uptake across England and London in 2018/19 showed that coverage declined for all 13 routine vaccinations compared to the previous year. There was markedly lower coverage for booster vaccines and second doses of vaccines than for the first dose or primary course of all vaccinations.

Of the 14 Public Health Outcome Indicators relating to the Childhood Vaccination Programme, Richmond ranks significantly worse than both the London and England averages in all but 5 diseases.

The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against Diphtheria, Pertussis (Whooping Cough), Tetanus, Haemophilus Influenza Type B (an important cause of childhood Meningitis and Pneumonia) and Polio (IPV is an inactivated Polio vaccine). Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Monitoring coverage identifies possible drops in immunity before levels of disease rise. The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against these five diseases. The vaccine is offered when babies are two, three and four months old. Evidence shows that promoting vaccination programmes encourages improvements in uptake levels.

5.1 Routine Pre-School Immunisations

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in levels of immunity before the levels of disease rise.

[35] NHS (2020) The routine immunisation schedule: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/849184/PHE_complete_immunisation_schedule_Jan2020.pdf

Immunisations for vaccine-preventable diseases including Congenital Rubella Syndrome, Pertussis, Influenza and Hepatitis B Infection are an important element of protecting the health of mother and baby. Maternal Rubella Infection in pregnancy, for example, may result in foetal loss or Congenital Rubella Syndrome and Influenza infection in pregnancy is associated with risks to the foetus, including still birth.

The complete childhood vaccination schedule[36] covers numerous diseases. In addition to whole population vaccinations the schedule also includes additional vaccinations for at risk groups such as: Annual Influenza for babies born to Hepatitis B infected mothers, and infants in areas of the country with high Tuberculosis rates. Additional vaccines are also given to individuals with underlying medical conditions. To achieve community immunity the required coverage for the childhood vaccinations is 95% of the eligible population.

DTaP/IPV/Hib

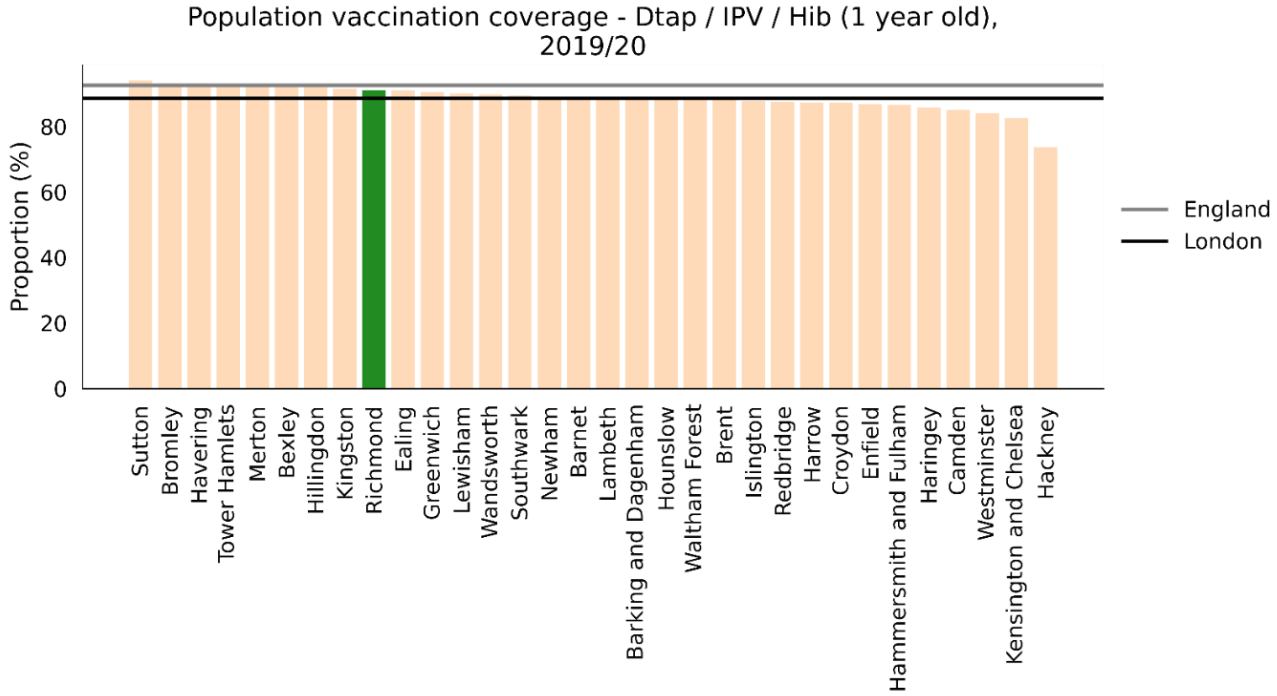
The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against Diphtheria, Pertussis (Whooping Cough), Tetanus, Haemophilus Influenza Type B (an important cause of childhood Meningitis and Pneumonia) and Polio (IPV is inactivated polio vaccine).

The vaccine is offered when babies are two, three and four months old. Evidence shows that promoting vaccination programmes encourages improvements in uptake levels. Monitoring coverage identifies possible drops in immunity before levels of disease rise. The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against these five diseases.

In 2019/20, coverage for the primary course of DTaP/IPV/Hib vaccine in Richmond was 91%, which was lower than the England average but higher than the London average (9th highest in London, **Figure 21**). The latest Borough figure was 2.7% lower from year 2019/20, in comparison with a 1.7% decrease in England's rate in the equivalent time period (**Figure 22**).

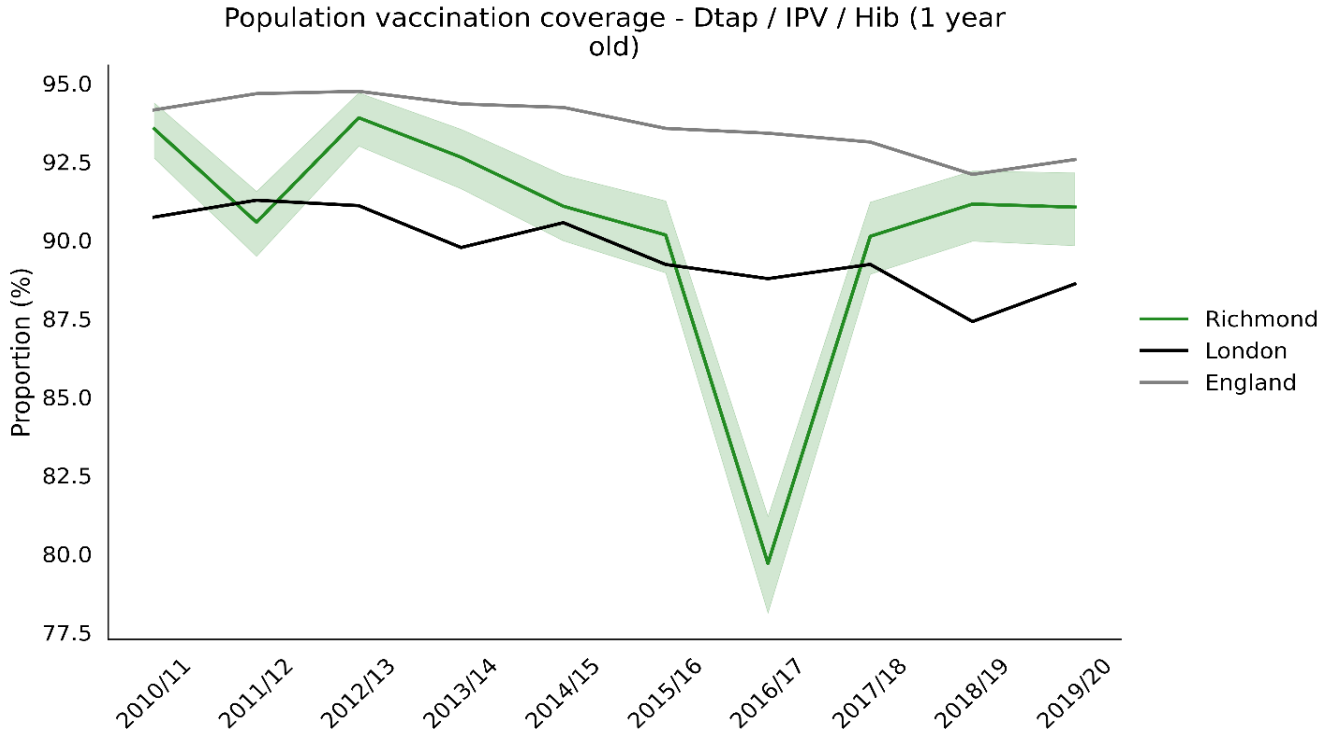
[36] NHS (2020) The routine immunisation schedule: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/849184/PHE_complete_immunisation_schedule_Jan2020.pdf

Figure 21: DTaP/IPV/Hib First Dose Uptake by Local Authority, 2019/20



Source: PHE [Public Health Outcomes Framework]

Figure 22: DTaP/IPV/Hib First Dose Uptake, 2010–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

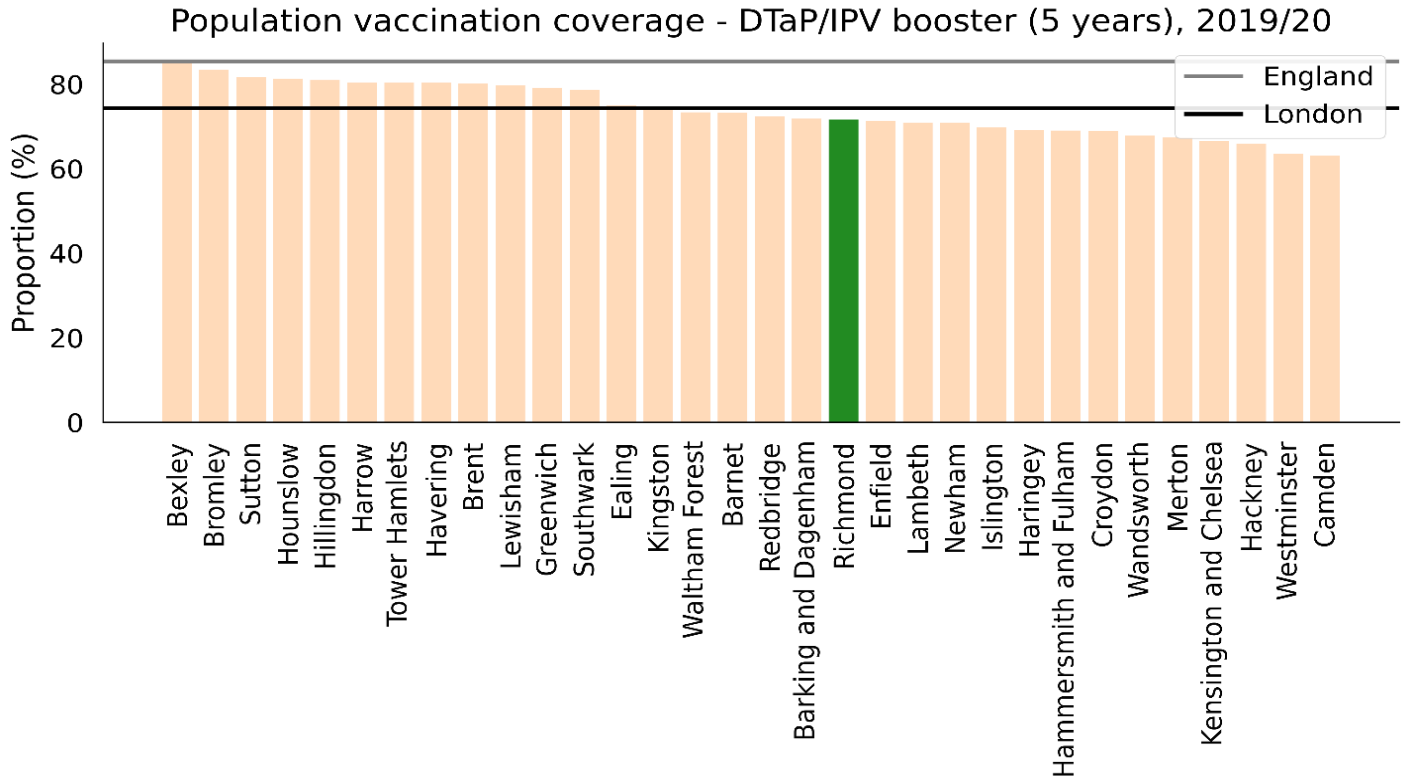
Source: PHE [Public Health Outcomes Framework]

The reasons for the pronounced dip in vaccine coverage in 2016/17 are not clear. From 1st April 2017 the 19 Child Health Information Service (CHIS) providers in London merged into 4 CHIS Hubs to cover the entirety of London. This was part of NHS England's Healthy Children: Transforming Child Health Information. The change coincided with the period of data submission for the Cover of Vaccination Evaluated Rapidly (COVER) programme.

The first data submitted from the new hubs are representative of the changes in the system although it is not clear whether this contributed to the marked decline seen in Richmond. It was expected that data quality issues could persist in some London COVER returns for the next few reports. PHE advised that changes in local authority vaccine coverage in London should be interpreted with caution Health Protection Report[37]. It has further been suggested by the Head of Information at the South West London CHIS that a change of clinical system, problems with data transfer or data extract from Richmond GP Practices, and issues with immunisation data recording may have affected the data.

By the time of the DTaP/IPV booster at 5 years of age, the coverage in Richmond is much lower. In 2019/20 it was 71.6% (14th Lowest in London, **Figure 23**), significantly lower than both the England and London averages at 85.4% and 74.4% respectively. The latest Borough figure was also 8.7% higher from year 2015/16, in comparison with a 1.0% decrease in England's rate in the equivalent time period (**Figure 24**).

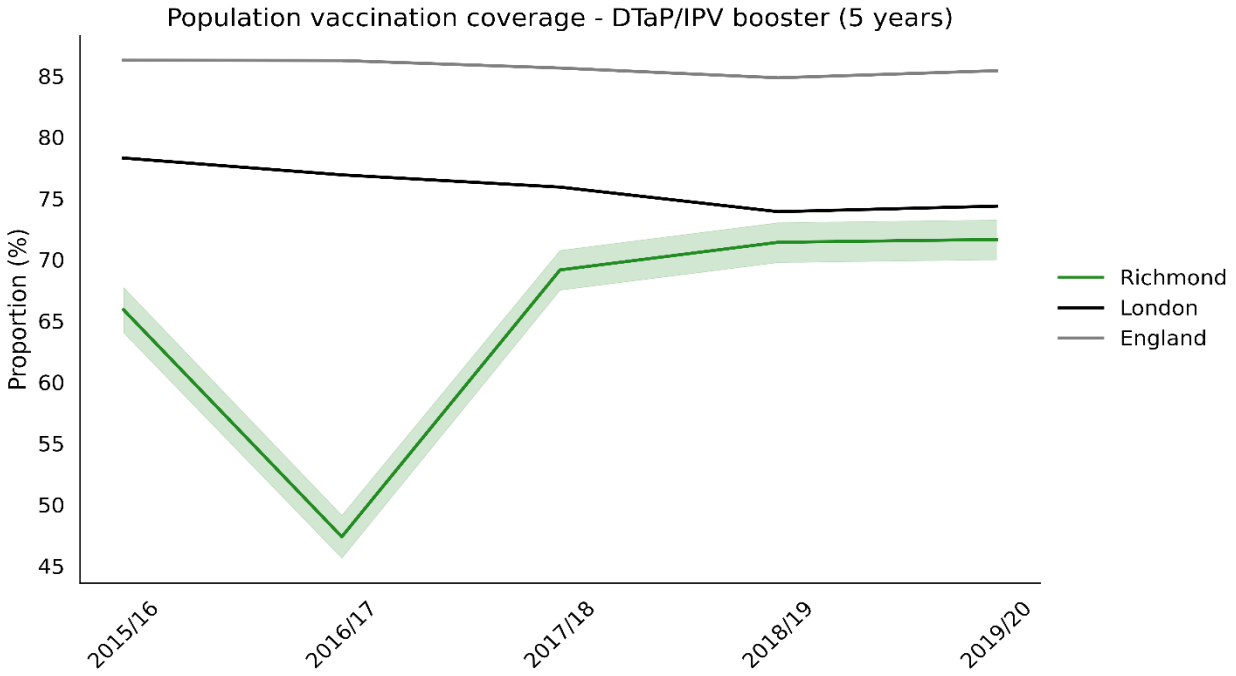
Figure 23: DTaP/IPV Booster Uptake by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

[37] www.publishing.service.gov.uk

Figure 24: DTaP/IPV Booster Uptake, 2015–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

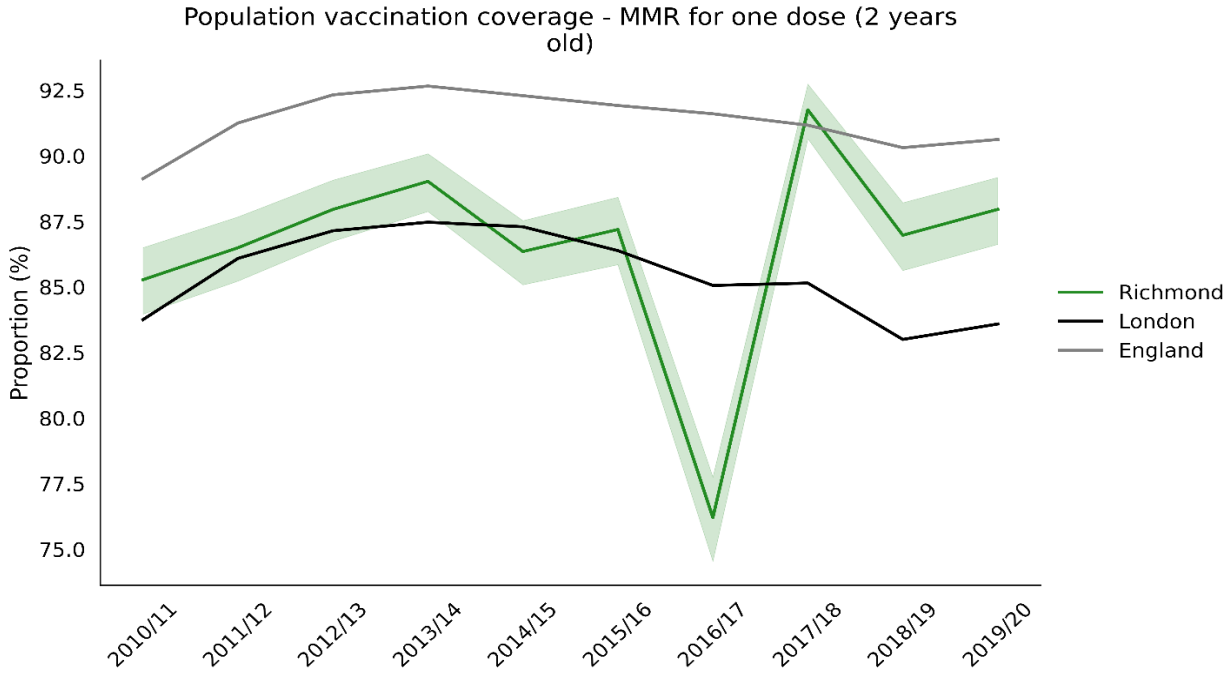
Measles, Mumps and Rubella (MMR) Vaccinations

MMR is the combined vaccine that protects against Measles, Mumps and Rubella. Measles, Mumps and Rubella are highly infectious, common conditions that can have serious complications, including Meningitis, swelling of the brain (Encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.

The first MMR vaccine is given to children as part of the routine vaccination schedule, usually within a month of their first birthday. They will then have a booster dose before starting school, which is usually between 3-5 years of age.

There was a rise in confirmed measles cases in England during 2018. In Richmond there has been a significant increase in the number of cases, from less than five in 2017 to 11 in 2018. Richmond has a similar rate for measles to London but is significantly higher than England. MMR vaccine coverage across London and England had been falling between 2013/14 and 2018/19 for all ages and for both doses since the previous period. The latest data for 2019/20 shows some improvement in the coverage for the first time in 6 reporting years. Similarly, to London and England, in Richmond the MMR immunisation uptake does not meet the recommended coverage of 95%. By age 2 years , 88% of Richmond's children were vaccinated, which was 2.9% lower than the England average and 5.2% higher than the London average. The latest Borough figure was also 3.1% higher from year 2010/11, in comparison with a 1.7% increase in England's rate in the equivalent time period (**Figure 25**).

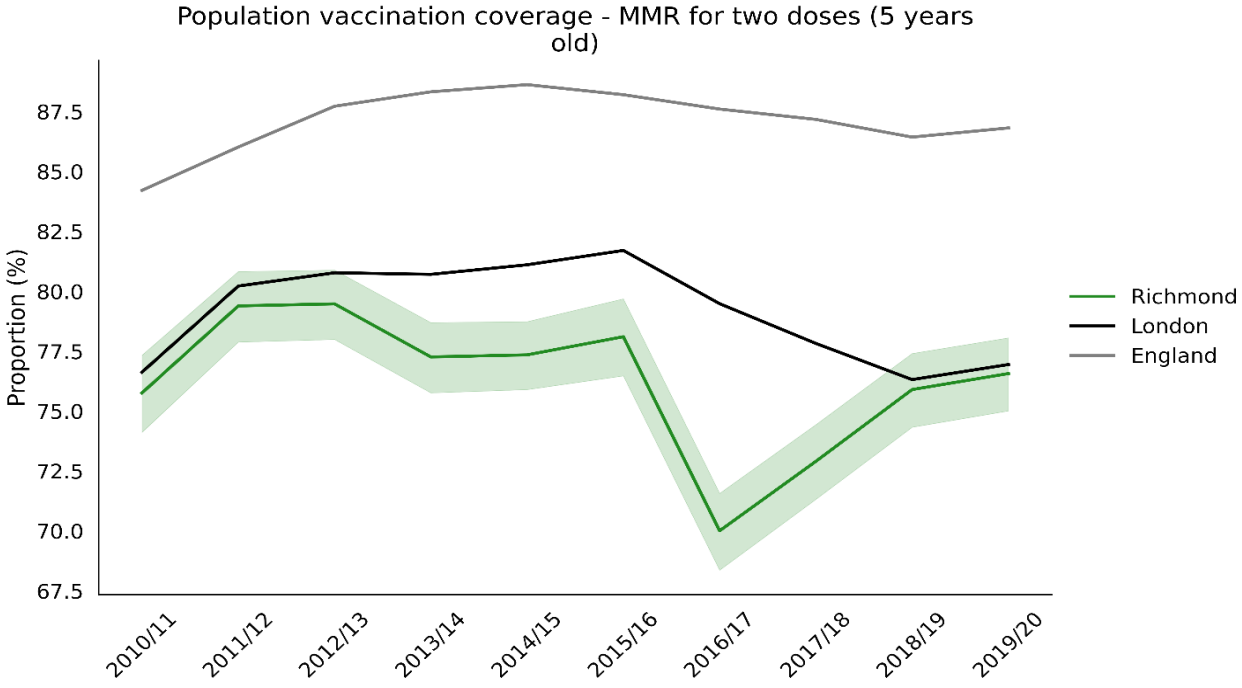
Figure 25: MMR First Dose Uptake, 2010–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

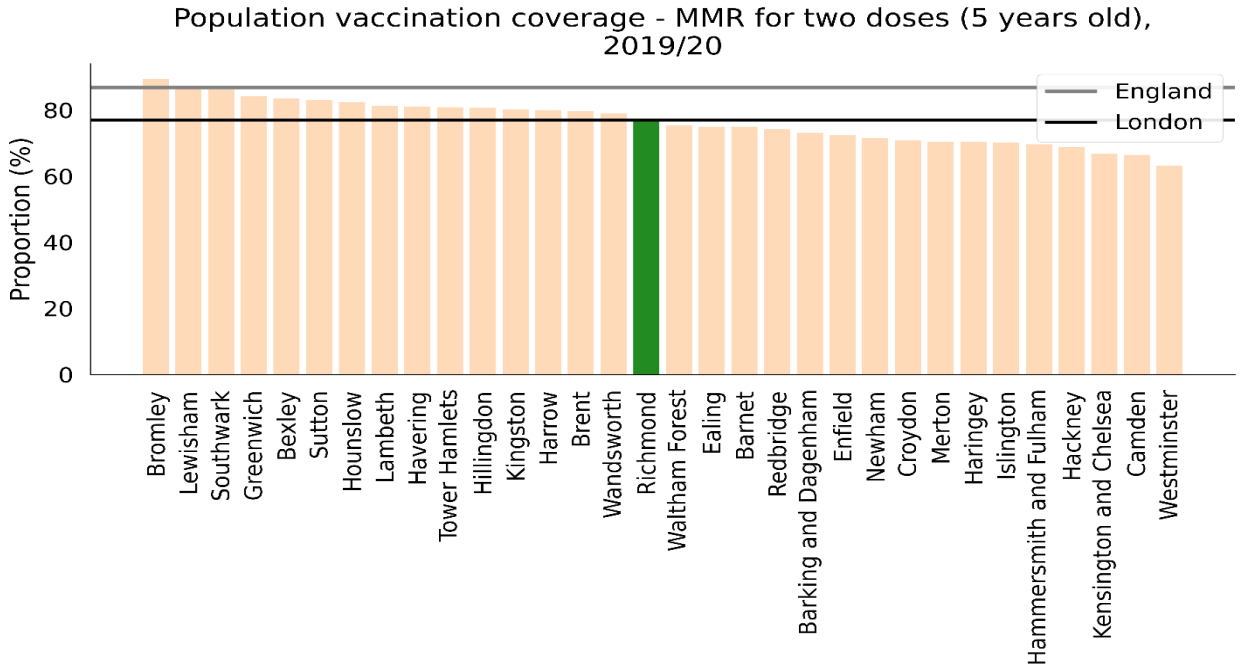
By 5 years old children should have two doses of MMR vaccine. Richmond's latest (2019/20) uptake for two doses was 76.6%, which was lower than both England and London averages of 86.8% and 76.9%. The latest Borough figure was also 1.1% higher from year 2010/11, in comparison with a 3.1% increase in England's rate in the equivalent time period (**Figure 26**). The percentage of 5 year olds immunised was 16th highest in London (**Figure 27**).

Figure 26: MMR Coverage for Two Doses Among Children Aged 5, 2010–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Figure 27: MMR Coverage for Two Doses Among Children Aged 5 by Local Authority, 2019/20



Source: PHE [Public Health Outcomes Framework]

5.2 School Age Immunisations

Human Papillomavirus (HPV) Vaccinations

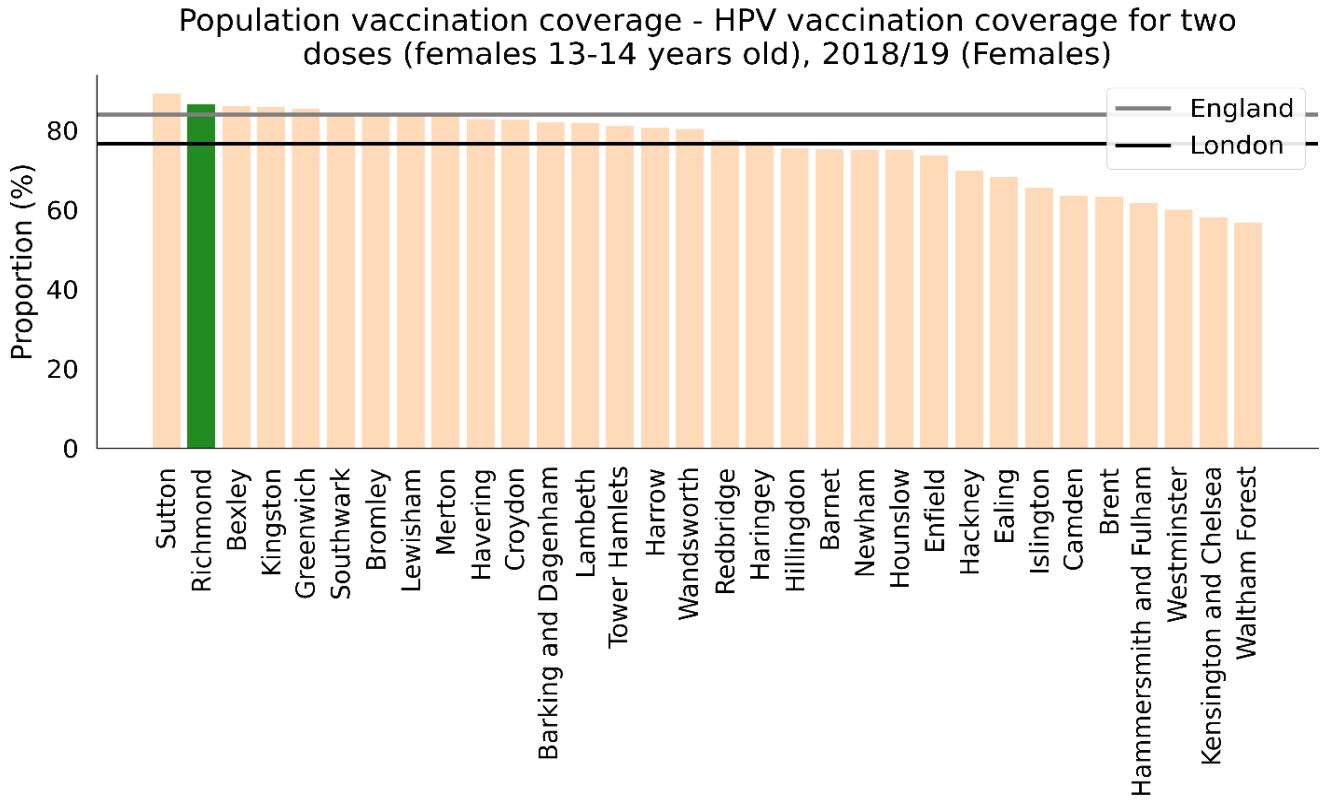
Some types of Human Papilloma Virus (HPV) are linked to the development of cancers, such as Cervical Cancer (more than 70% of these cancers are linked to HPV) , Anal Cancer, Genital Cancers, and cancers of the head and neck. Two doses of HPV vaccine protect against 4 types of HPV: 6, 11, 16 and 18. Type 16 and 18 are linked to significant increases in the chances of developing cancer.

The 1st dose of the HPV vaccine was routinely offered to girls aged 12 and 13 in school with the 2nd dose offered usually within 1 year from the first dose. From school year 2019/20 boys and girls in school Year 8 are both eligible for the HPV vaccine. However, 2019/20 data for Richmond is not available at the moment of writing this section[38].

In 2018/19 Richmond's HPV vaccination coverage among girls aged 13–14 years was 80.2%, 2nd highest in London (**Figure 28**), which was significantly higher than England and London averages. The latest Borough figure was also 12.2% higher from the year, in comparison with a 1.4% decrease in England's rate for the same time period (**Figure 29**).

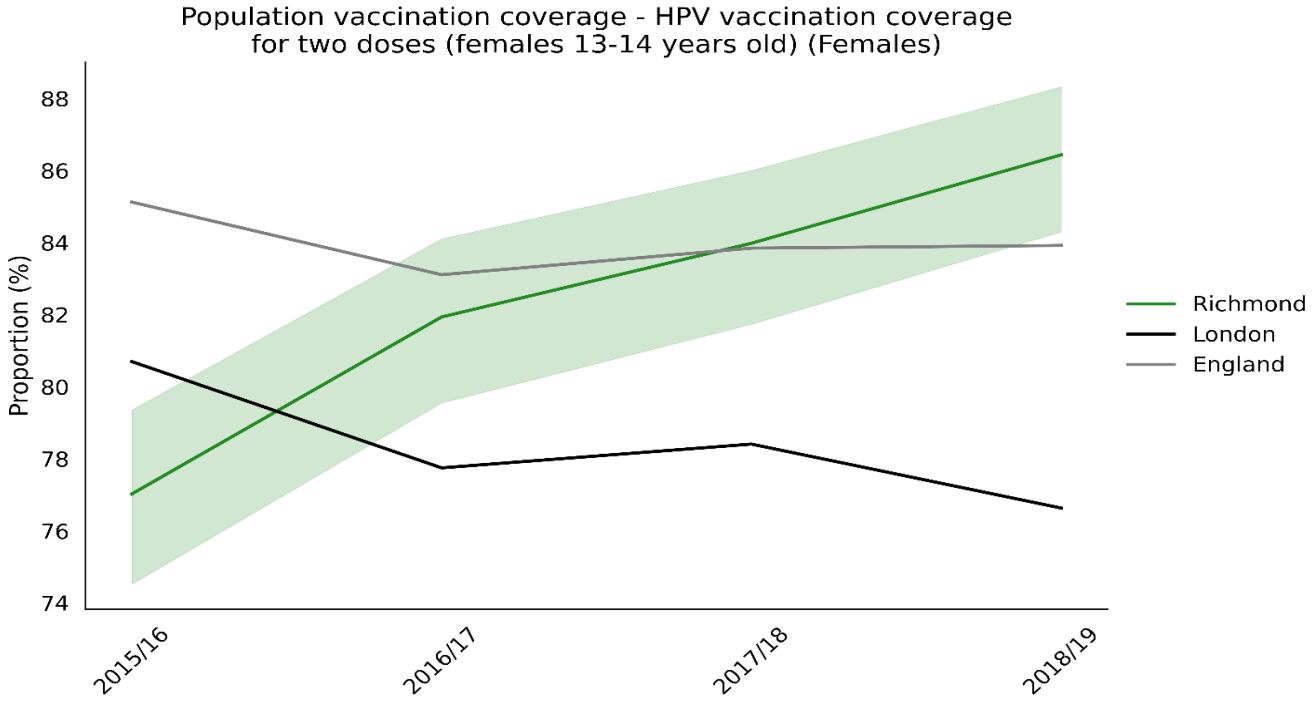
[38] NHS. HPV vaccine overview. 2021.

Figure 28: HPV Vaccination Coverage for Two Required Doses by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

Figure 29: HPV Vaccination Coverage for Two Required Doses, 2015–2019

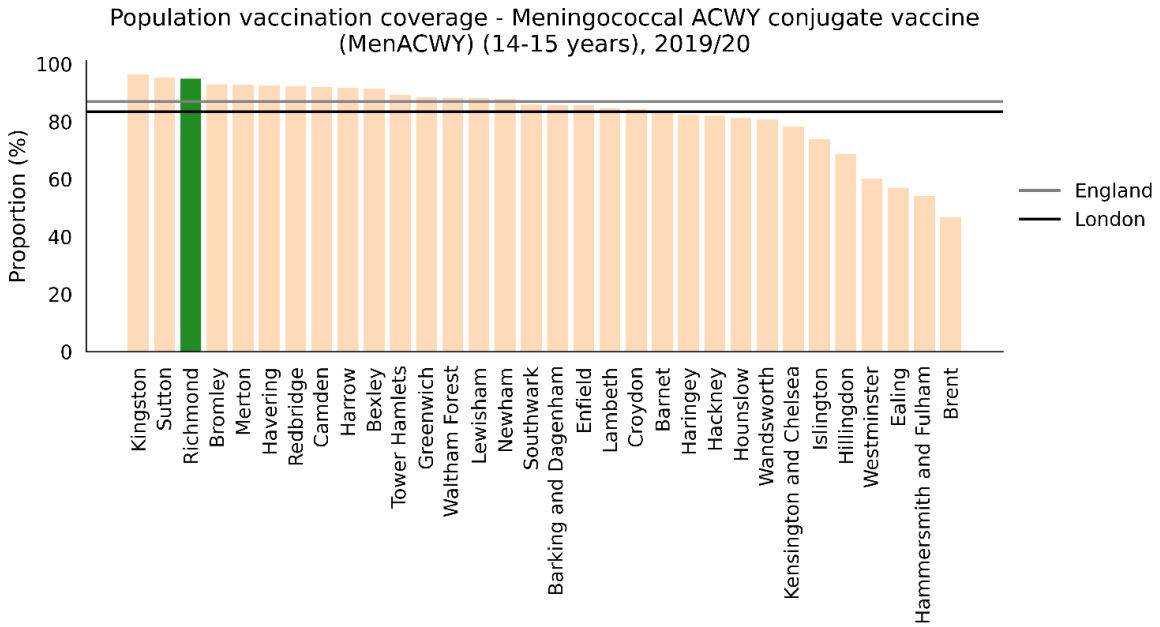


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Meningococcal (MenACWY) Vaccinations

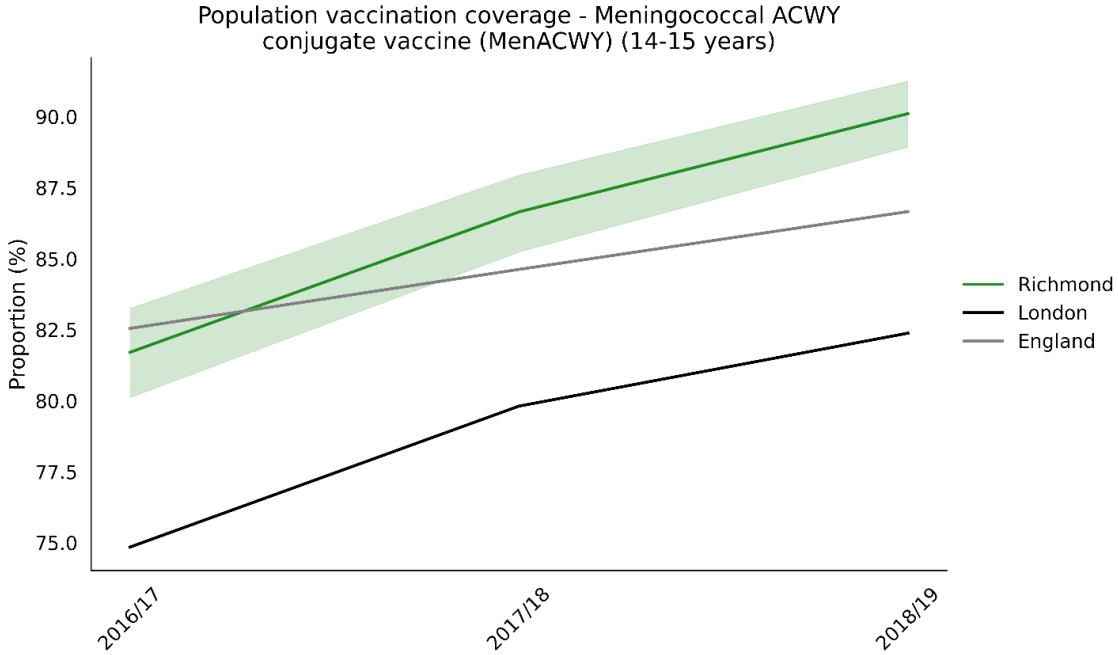
MenACWY vaccine against 4 strains of the Meningococcal Bacteria – A, C, W, Y – which cause Meningitis and Blood Poisoning (Septicaemia). Children aged 13-15 years are routinely offered the MenACWY vaccine in schools[39]. In 2018/19 Richmond's coverage was 90.1%, 6th highest in London (**Figure 30**), which was significantly higher than England and London averages of 87.0% and 83.4%. The latest Borough figure was also 10.3% higher from year 2016/17, in comparison with a 5.0% relative increase in England's rate in the equivalent time period (**Figure 31**).

Figure 30: Meningococcal ACWY Conjugate Vaccine Coverage by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

Figure 31: Meningococcal ACWY Conjugate Vaccine, 2016–2019



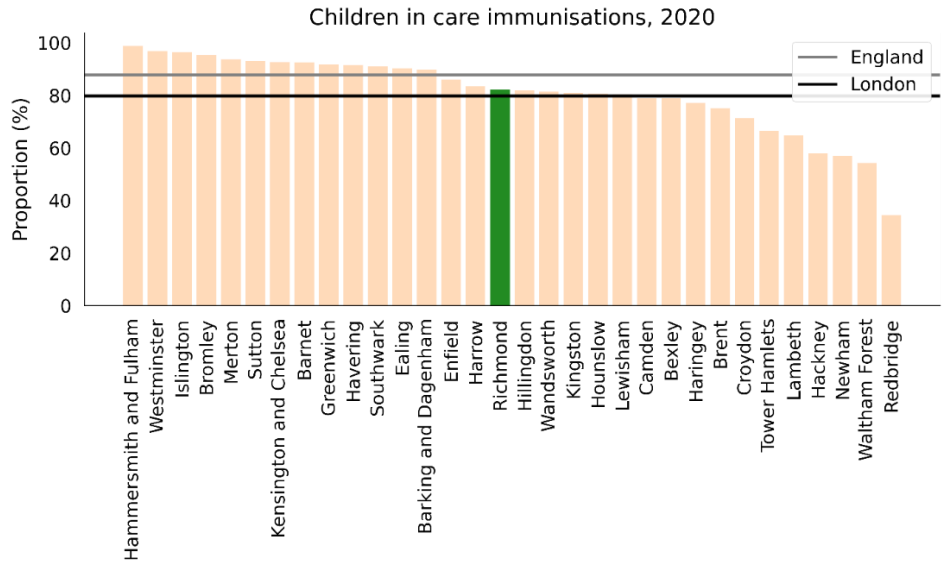
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

[39] MenACWY vaccine NHS overview: https://www.nhs.uk/conditions/vaccinations/men-acwy-vaccine/

.3 Immunisation Rates of Looked After Children

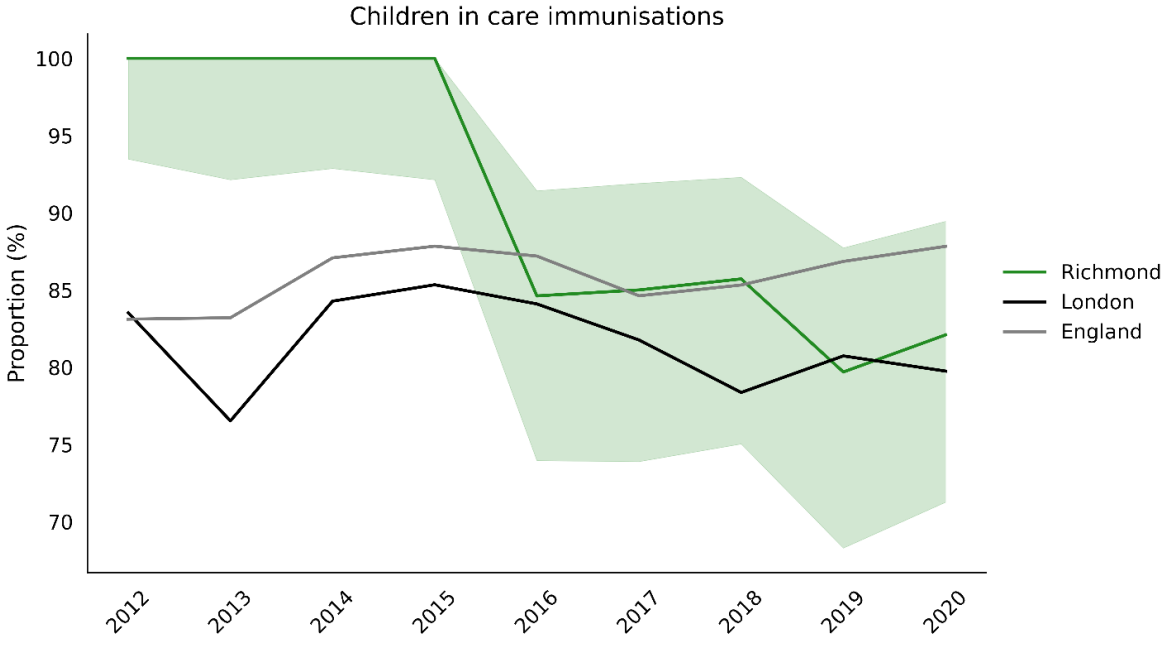
Immunisation coverage for looked after children in Richmond for 2020 was 82.1% (16th lowest in London, **Figure 32**); this is above the London average of 79.7% but below the England average of 87.8%. The latest Borough figure was also 17.9% lower from year 2012, in comparison with a 5.7% increase in England's rate in the equivalent time period (**Figure 33**).

Figure 32: Proportion of LAC who are up to date with the Vaccinations in the NHS Routine List by Local Authority, 2020



Source: PHE Public Health Outcomes Framework

Figure 33: Proportion of LAC who are up to date with the Vaccinations in the NHS Routine List, 2012–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

6.Health Visiting (Ages and Stages)

A range of multi-agency services exist for children and young people that promote and encourage positive health and well-being outcomes. Many are referenced in other parts of this JSNA, but for the purpose of this chapter the key health related service to be focussed on is the 0–19 years Health Visiting and School Nursing Service.

The 0–19 years Health Visiting and School Nursing Service is commissioned to undertake interventions which result in the overall improvement of child health across Richmond contributes to the achievement of the Child Health Measures as set out by the Department of Health and presented in **Table 5**.

Table 5: National Measures of Child Health[40]

Domain	Measures
Mortality and Morbidity	Reducing infant mortality
	Reducing low birth weight of term babies
	Reducing smoking at delivery
	Reducing under 18 conceptions
	Promotion of effective parenting including parental involvement, positive parental expectations, parental supervision and authoritative attachment
Maternal Mental Health (Perinatal Depression)	Improving numbers of women asked about their emotional well-being at each routine antenatal and postnatal contact
	Improving adherence to the NICE pathway
Breastfeeding (Initiation and Duration)	Improving breastfeeding initiation
	Increasing breastfeeding prevalence at 6–8 weeks.
Healthy Weight, Healthy Nutrition (to include Physical Activity)	Reducing excess weight in 4–5-year-olds
	Reducing tooth decay in children aged 5
Managing Minor Illness and Reducing Accidents	Reducing hospital admissions caused by unintentional injuries in children and young people aged 0–14 years
	Parents are more confident to manage their children's illnesses and use services appropriately.
Health, well-being & development at 2 years & support to be ready for school	Health visiting teams will need to report on results of the Ages and Stages Questionnaire ASQ-3 including the social emotional screening tool as part of HCP 2-year reviews
	Improving school readiness;
	Improving life expectancy and healthy life expectancy; and reducing the number of children in poverty
Safeguarding	Reducing hospital admissions caused by deliberate injuries in children and young people aged 0–14 years;
	Children are protected from harm and their welfare is promoted at every opportunity.

40 PHOF, Guide to Early Years Profile (2014); NHSOF; Early Intervention Foundation - The Best Start at Home (March 2015); NICE QS115 (2016); and Working Together to Safeguard Children (2015).

This is achieved through adherence to all components of the Department of Health 2009 Healthy Child Programme (HCP)[41]. A core universal service offer is balanced with effective and targeted responses to varying family needs, and accounts for the specific requirements of those with greater needs.

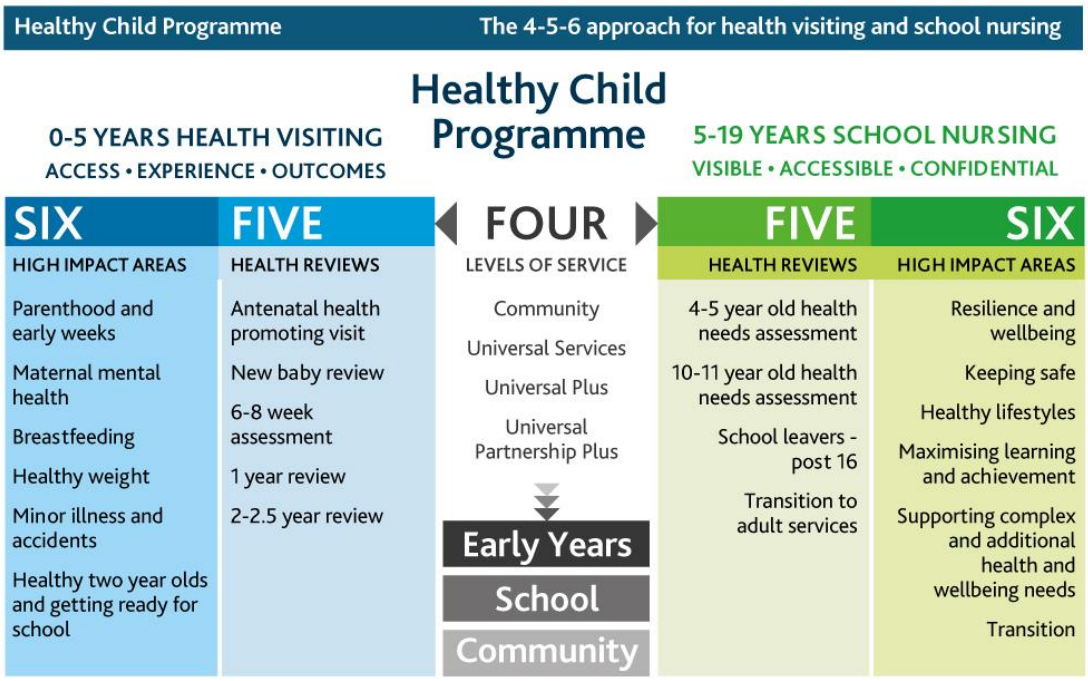
The HCP provides an evidence-based framework which outlines the necessary screening tests, immunisations, developmental reviews, information and support that enable children to secure optimum health and well-being. Evidence shows that the HCP yields a good return on investment and interventions are highly effective in securing healthy child development and positive future health and educational outcomes. A successful HCP reduces the costs associated with dealing with problems such as mental health difficulties and delayed learning, as well as child protection issues[42].

The 0–19 years' service is currently provided by Central London Community Health (CLCH) and has the following objectives to:

- Improve the health and well-being of babies and children under five years and reduce inequalities in outcomes as part of an integrated multi-agency approach to supporting and empowering children and families.
- Ensure a strong focus on prevention, health promotion, early identification of needs and early intervention with clear, effective plans.
- Ensure the delivery of the Healthy Child Programme to all children and families, including at each of the 5 mandated contacts (5 touch points).
- Consider all adults with legal parental responsibility for the child as equal parents and fully include them wherever this is practical and possible when working with families.

The service model is based on the 4-5-6 Model (DoH, 2015) as shown in **Figure 34**.

Figure 34: 4-5-6 Model



Source: PHE Overview of the 6 early years and school aged years high impact areas (redesigned)

41 Department of Health and Social Care. Healthy Child Programme: Pregnancy and the First 5 Years of Life. 2009
42 As above

Four levels of support are offered to account for differing family needs including:

- **Community**: Health visitors work to promote, develop and maintain community resources available for children and their families e.g., children's centres and self-help groups
- **Universal**: Every family and child has contact with a health visitor at five touch points during the child's development
  They include evidence-based development checks, and information on topics such as parenting, breastfeeding and immunisations. Interventions include individual and group programmes that will motivate and support parents to adopt health enhancing behaviours, understand and support their child's development, and promote positive parenting.
- **Universal Plus**: Proactive and systematic identification and support for families who are at risk of poor health and social outcomes. Specific issues may include mental health and postnatal depression, domestic violence, child poverty, social isolation or disadvantage, and poor educational attainment. Universal Plus families receive timely, structured, expert advice drawing on agreed evidence-based programme such as the Maternal Early Childhood Sustained Home Visiting Programme (MESCH), Parenting Programmes, and NICE-recommended Perinatal Mental Health Support. The Health Visiting Service plays a key role in undertaking Early Help Assessments and leading the coordination of support for these families.
- **Universal Partnership Plus:** Families identified as having continued complex needs such as long-term medical conditions, a disability, child protection, children in need, looked after children and parents with long term mental health problems and/or substance misuse are supported through with close partnership working with relevant local services.

Additionally, in Richmond CLCH is commissioned to deliver the Family Nurse Partnership (FNP) which works with parents aged 24 years and younger, partnering them with a specially trained family nurse who visits them regularly, from early pregnancy until their child is two years old.

The five contact points for the service: an antenatal contact, a home visit at 10–14 days, a home visit at 6–8 weeks, a home visit at 1 year (between 9–12 months) and a contact at 2- 2.5 years are presented in **Table 6**[43]**.**

[43] Cowley, S (2013) "Why health visiting? A review of the literature about key health visitor interventions, processes and outcome for children and families. Department of Health Policy Research Programme" (12th February 2013)

Table 6: Five Health Visiting Touch Points

Touch point	Interventions specific to each touch point	Interventions at ALL touch points
Antenatal visit from 28 weeks	Feeding intentions, experiences and support	Growth and development (social, emotional, behavioural & language) Parenting capacity Safeguarding Nutrition, family diets & lifestyles Mental health Family Support Maternal mental health Child safety and minor illness management Immunisations and screening Parental smoking, alcohol or drug use Play promotion, including info on local groups Involvement of both parents and/or significant carers Respond to expressed needs with advice and guidance Observe and respond to unexpressed needs Provide anticipatory guidance Narrative listening interviews
	Parenting experiences and expectations	
	Maternal weight	
	Any other aspect covered in the Healthy Start Programme	
New baby visit by 14 days	Parental transitions and sensitive parenting	
	Infant feeding	
	Safe sleeping	
	Hygiene	
	Monitoring mothers to have newborn blood spot test, NIPE examinations and hearing screening outcomes	
	Encourage registration with a children's centre	
6–8-week visit	Encourage the use of children's centres and health clinic	
	Safe sleeping	
	Record breastfeeding status	
	Check immunisations	
One-year visit at 9–12 months	Oral health	
	Encourage registration with a children's centre	
2–2½ year check	Routines including sleep, feeding and toileting	
	Oral health	
	Child behaviour	
	Childcare and transition to early education	

6.1 Six High Impact Areas of Intervention

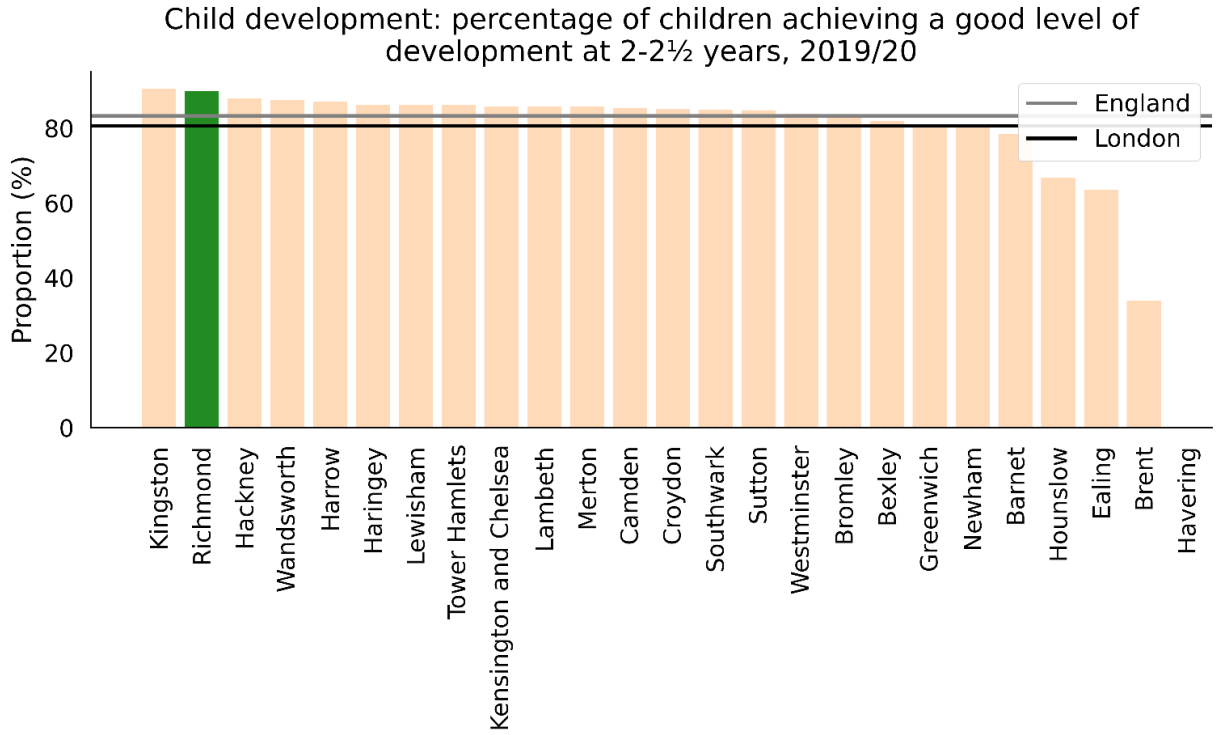
The 0–19 years' Service identifies and delivers clear evidenced pathways for delivering each of the high impact areas to all levels of family need across the four different levels of service at the five touch points **Table 7**.

Table 7: Six High Impact Areas, Richmond

High Impact Area	Interventions Specific to each High Impact Area
Transition to parenthood	Lead delivery of antenatal and post-natal groups to promote attachment e.g., parenting classes
	Evidence based parenting programmes such as Family Partnership Model and Solihull approach
Maternal mental health	Assess for maternal mental health using evidence-based tools and ensure appropriate support is provided early
Breastfeeding	Lead the implementation and delivery of evidence-based public health programmes for breastfeeding in the community
	Support a whole system approach to promoting breastfeeding by developing a high level of expertise in the workforce
	Implement the UNICEF Baby Friendly Standards working to level 3
	Support other settings such as children's centres to become baby friendly including training for early year's staff
Healthy weight, healthy nutrition and physical activity	Undertake measures to contribute to the assessment, recording and behaviour change approach to obesity
	Work with partners on the early identification and prevention of obesity in children through an emphasis on breastfeeding, good nutrition at weaning and beyond and encouraging an active lifestyle
	Use evidence- based techniques such as promotional and motivational interviewing to support health promotion and behaviour change in group and community settings
Managing minor illness & Accident Prevention	Support parents to know what to do when their child is ill, providing information about managing childhood conditions
	Lead delivery of home safety schemes undertaking home safety assessments and provision of low-cost safety equipment to target families
	Signpost to NHS Choices, 111, community pharmacies or other appropriate minor illness services
	Raise awareness of accident prevention in the local community particularly at children's centres
	Lead and support health promotion campaigns in the community
School Readiness	Work with partners to develop evidence-based prevention interventions in early life that can make a difference to life-long health and well-being, education achievement, economic productivity and responsible citizenship throughout life
	Promotion of play and the use of community groups in particular Children Centres
	Promote uptake of 2-year-old Early Education Offer to eligible families
	Promote the preparation for effective transitions to childcare and nursery education

Figure 35 shows the latest available data from the last in a series of health visiting contact points at 2–2.5 years. In Richmond the percentage of children achieving a good level of development was 89.9%, which was higher than England and London average and the 2nd highest in London.

Figure 35: Proportion of 2 Years Old Children Achieving a Good Level of Development by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

The latest available published data reveals that in Quarter 2 2019/20:

- 95% of all new births received a new birth visit within 14 days (of 537 new births in the quarter)
- 93% received of infants received a 6–8 week by the time they were 8 weeks (of 540 infants in the quarter)
- 76% of children received a 12-month review by the time they turned 12 months (of 606 infants turning one in the quarter) and 88% had received the review by the time they reached 15 months
- 66% of 2-2½ year olds received a 2-2½ year review in the quarter (of 606 infants), 100% of which used the ASQ 3 questionnaire
- Of these 86.8% of all children who had completed their Ages and Stages Questionnaire ,(ASQ-3)were above the threshold for all five domains of development.

6.2 School Nursing Service

The overarching aim of the School Nursing Element of the 0–19 years' Service is to develop and improve the emotional, physical and mental well-being of children and young people. Reducing the health inequalities across their life course and closing the health gap for children and young people identified as vulnerable or disadvantaged is a high priority.

The School Nursing Service includes these key components:

- universal and Specialist Public Health Services for children that promotes the health and well-being of all children and reduces inequalities through targeted interventions for vulnerable and disadvantaged children aged 5–19 years and their families

- delivery of the Healthy Child Programme using holistic health assessment skills to establish where early intervention is needed and where preventive public health skills should be deployed
- an important conduit between Education and Health Services to ensure that children and their parents access appropriate medical and health support to enable children and young people to maximise their educational achievements
- maintaining and developing a diverse set of clinical skills and/or specialities within the School Nursing Team to ensure the service can address a wide range of health needs, including meeting the mental health and well-being needs of children and young people.

The School Nursing Service helps children and young people to develop the skills they need to manage the challenges they face in school, at home, in their personal lives or online. In Richmond, the service is provided by CLCH and focuses on:

- the assessment and identification of the health and well-being needs of children and young people
- offering advice, support and care that meets the needs of children and young people with the involvement of their parents and carers
- building emotional well-being and resilience and identifying mental health concerns at an early stage
- preventing risky behaviours including smoking, alcohol and drug misuse
- providing sexual health and relationship education
- delivering the National Child Measurement Programme in Reception and Year 6, statutory requirement within the Health and Social Care Act 2012
- reducing childhood obesity
- eeting additional and complex needs with respect to mental health and disabilities, including vulnerable groups: (children with an education and health care plan, a child protection plan, looked after children, children in YOT, young carers, children in need and children on schools' SEND registers).

In Richmond the School Nursing Service also provides the Family Start Programme for children who are:

- Identified as overweight or obese at Reception through the National Child Measurement Programme (NCMP)
- Identified as obese at Year 6 through the NCMP
- Identified as obese through other processes with school nurse involvement (e.g., Child Protection).
- If a child's weight is on or above the 98th centile they are referred to their GP for medical management

The School Nursing Service builds on the evidence within cross-cutting policy and guidance, namely, but not exhaustively:

- best start in life and beyond: Improving public health outcomes for young people and families (PHE March 2018)
- maximising the School Nursing Team Contribution to the Public Health of School Age Children (DOH PHE 2014).
- Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency, (DoH, 2010 and updates 2011, 2012), provides the outcomes framework for public health and recognise the importance of School Nursing in the promotion and delivery of the public health agenda as it includes children and young people.
- 'Getting it right for children, young people and families' (DoH, 2012), sets out the vision and best practice model framework for the delivery by a School Nursing Service, of the Health Child Programme (HCP)
- 'The Children and Young People's Health Outcome Forum' (DoH, 2012), describes what children and young people consider to be the most important attributes of an effective school health service

- New Relationships and Health Education in schools (DfE July 2018) draft guidance on the duty to provide relationships and sex education in schools
- Transforming Children and Young People's Mental Health – a Green Paper and Next Steps DHSC and DfE July 2018 which sets out proposals to increase the support for children's mental health in schools.

Prior to the pandemic, work had commenced to ensure the outcomes for the school nursing services were captured within key performance data to ensure enhanced monitoring of the service. This work was put on hold during the pandemic following NHS COVID-19 directives. Some school nursing teams were re-deployed on an interim basis. Our local provider, however, retained a key focus on safeguarding while schools were closed. In March 2021 the government re-launched the Healthy Child Programme (replacing the 4,5,6 model) in order to focus on personalised assessments of need and provide interventions which are suitable for the children and families' needs.

The new model aims to capture the full extent of both the health visitor and school nurse offer in recognition that local services were offering so much more than the 5 mandated contacts. It enables increased opportunities for further contacts to provide additional support, especially during the early years. The model includes two additional universal contacts at 3-4 months and 6 months. These will provide important opportunities to address key public health priorities including perinatal mental health, child development, breastfeeding, childhood obesity prevention, immunisation uptake, and safe sleep.

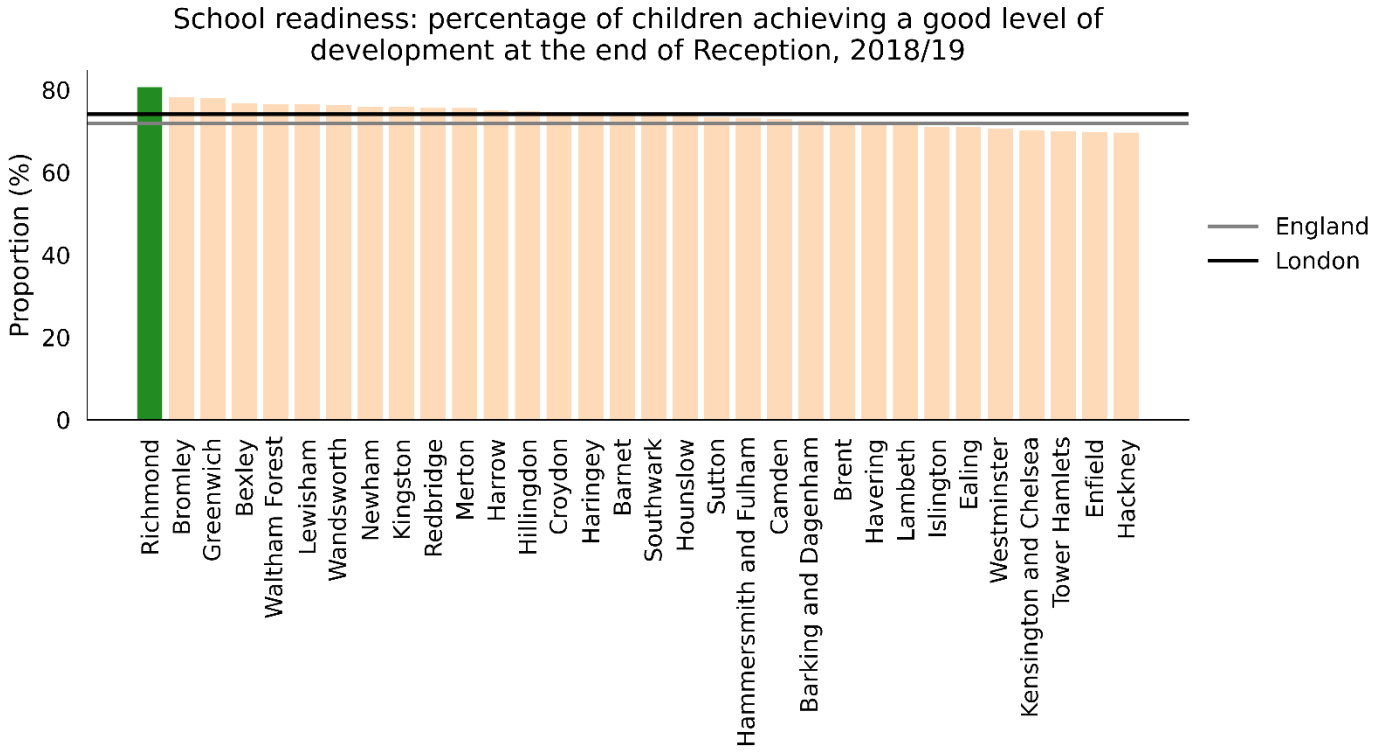
Commissioners and Public Health are currently working with the provider to ensure the service meets both universal and targeted needs of children, young people and families, re-starting contract variation and KPI discussions whilst embedding changes to the Healthy Child Model.

7.School Readiness

7.1 Children Achieving a Good Level of Development

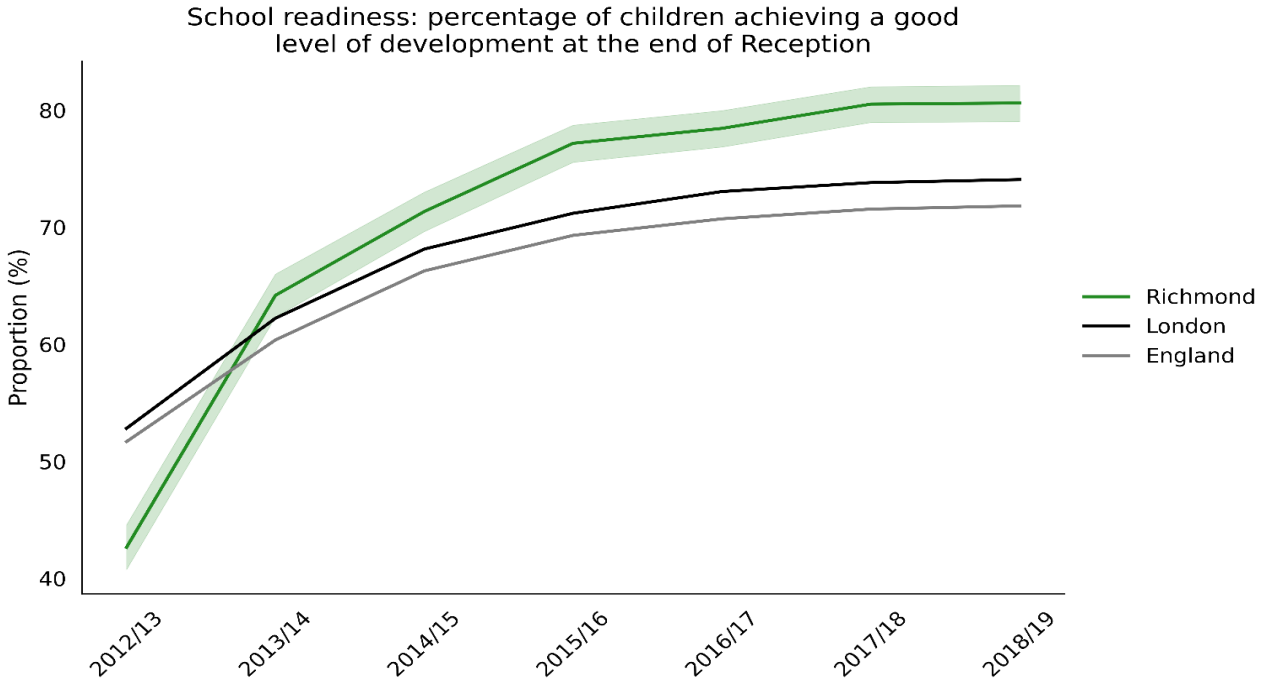
Children are assessed at various points, data from which can help inform both the education of individual children as well as planning services which bring benefit to larger groups in the community. As children come to the end of Reception, their readiness for school is assessed. School readiness indicators in Richmond are consistently above both London and England averages. For example, by the time a child ends the first year of Reception, 80.6% achieve a good level of development (London 74.1%, England 71.8%). Richmond's percentage is the highest in London, (**Figure 36**). The latest Borough figure was also 89% higher from year 2012/13, in comparison with a 39.0% increase in England's rate in the equivalent time period (**Figure 37**).

Figure 36: Reception Year Children Achieving a Good Level of Development by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

Figure 37: Reception Year Children Achieving a Good Level of Development, 2012–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

In 2019 Richmond's Good Level of Development was the second highest in London at 80.6% with only the City of London (which is very small) coming higher. Nationally, 71.8% of children achieved a good level of development in

2019 so Richmond is performing well above the national average. However, there is local recognition that scores are beginning to plateau. Early Years teams are in the early stages of developing a cross borough Early Language Strategy in partnership with SALT services. In Richmond, plans are being developed to restructure the Early Years' Service with a view to focusing on the gap in outcomes between disadvantaged children and their peers. Plans are under way to provide consistent support for children with SEND across the early years sector. The Borough is also working towards implementing the new Early Years Foundation Stage reforms that became statutory in September 2021.

Two of the key aims of these reforms are to:

- place greater focus on language and communication
- support disadvantaged children and vulnerable groups.

Those working in Early Years and Childcare settings, headteachers and teachers have received briefings and will continue to have training and professional development to support these key aims.

Throughout the pandemic Health Visiting Services have been key to ensuring all children reach a good level of development. Health Visiting Services were reduced during the pandemic following NHS National Directives. The service was temporarily re-fined to focus attention on those with higher needs with the temporary suspension of some universal services. In response to the return to business as usual, the updated Healthy Child Programme and a significant national and local shortage of health visitors, CLCH worked in partnership with commissioners and public health teams to re-structuring their services across London. This review programme 'Reimagining Health Visiting', has been developed through consultation with staff, clients and commissioners, benchmarking with other 0-19 services, reviewing of commonalities across existing service specifications, and demand /capacity case modelling. It has also been informed by the NHS Long Term Plan for England, CQC inspection feedback, a review of caseload sizes, and improved and different ways of working as a response to COVID-19. Health visitors utilise Ages and Stages Questionnaires (ASQs) and 1 year checks to identify that children's social-emotional development is on schedule, identifying cohorts most likely to fall behind. Health visitors have completed specialist speech and language training as part of a London wide initiative.

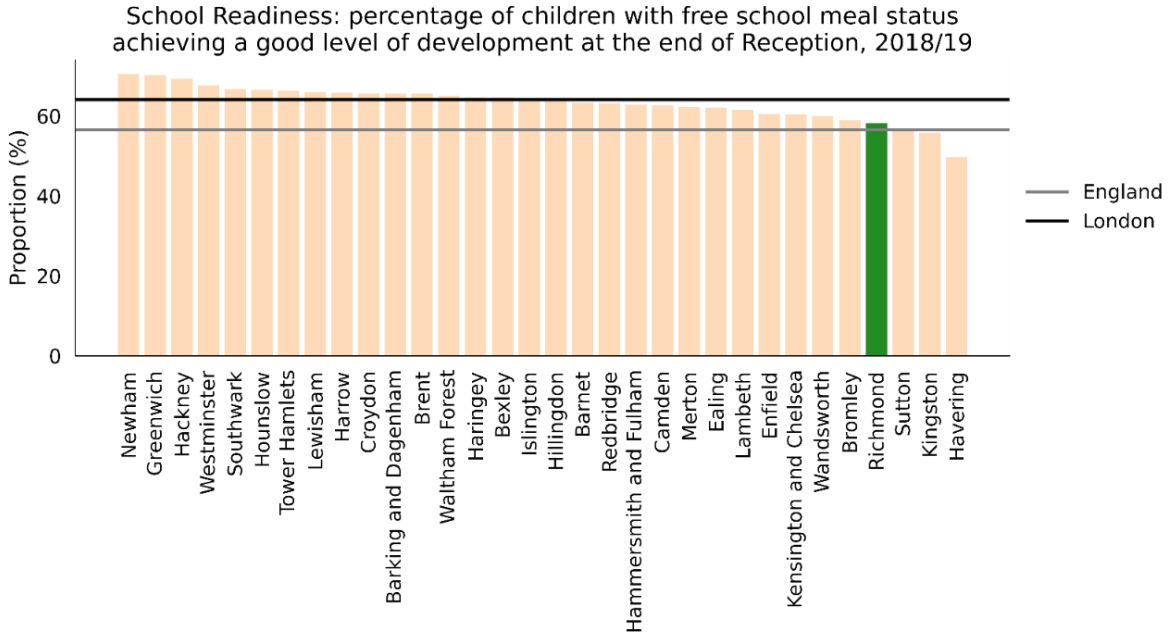
As has been found nationally, the current clinical model for health visiting has been inflexible and the data set does not reflect the totality of what is done across the service. The Re-imagining Programme essentially seeks to move toward utilising an 'active' and 'inactive' caseload model to increase capacity for those identified as the most in need or at risk. Health visitors will be supported by an increase in the recruitment and deployment of staff nurses to support families assessed as requiring universal services. The initial antenatal and new birth visits will continue to be carried out by health visitors as will support for vulnerable families assessed as requiring a universal plus or universal partnership plus services. Achieving for Children, with support from public health, have continued to progress the HEYL Awards for the Early Years' setting, all be it at a lower profile given the temporary closure of some services.

Social Communication Intensive Packages (SCIPs) are run in Richmond for children going into Reception and continued for some children in Year 1. There will be 20 running from September 2021. Schools receive additional funding, outreach support and training for identified children in Early Years with social communication difficulties who are on the autism spectrum. Support continued virtually through COVID-19, but it is hoped that there will be a return to more face to face contact.

7.2 Good Level of Development for Children on Free School Meals

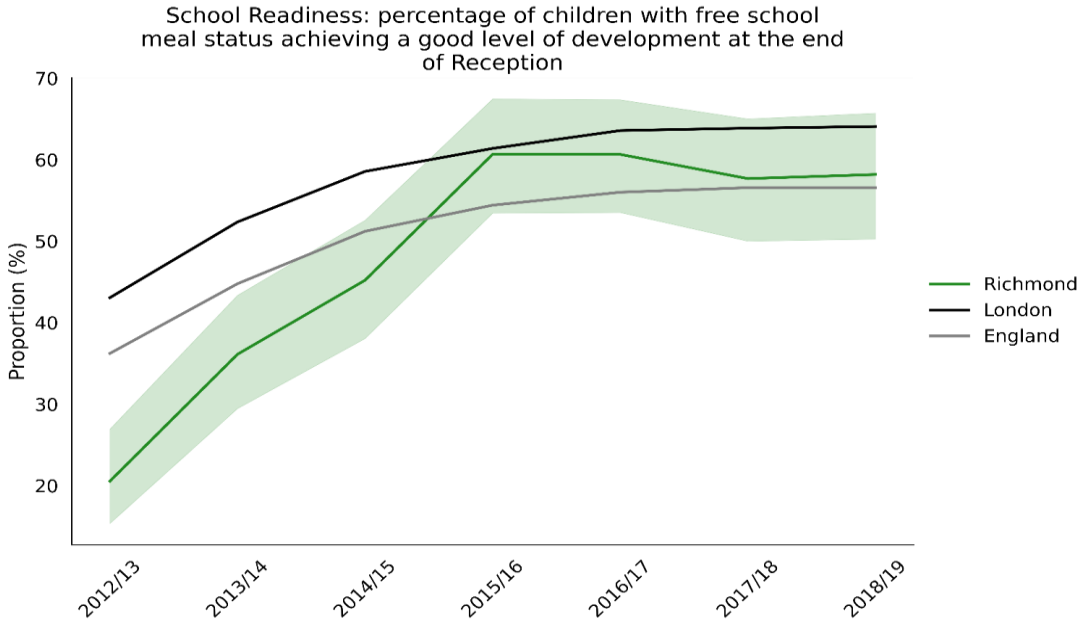
Despite Richmond's highest ranking in London for overall school readiness Reception Year children, the Borough ranks the same indicator for children on FMS and is 4th lowest in London (**Figure 38**).
The latest percentage was 58.2%, which was lower than the London average but higher than the England average. The pace of improvement in achieving a good level of development in Reception Year among the poorest children has stagnated in the last 4 years (**Figure 39**).

Figure 38: Reception Year Children with Free School Meals Achieving a Good Level of Development by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

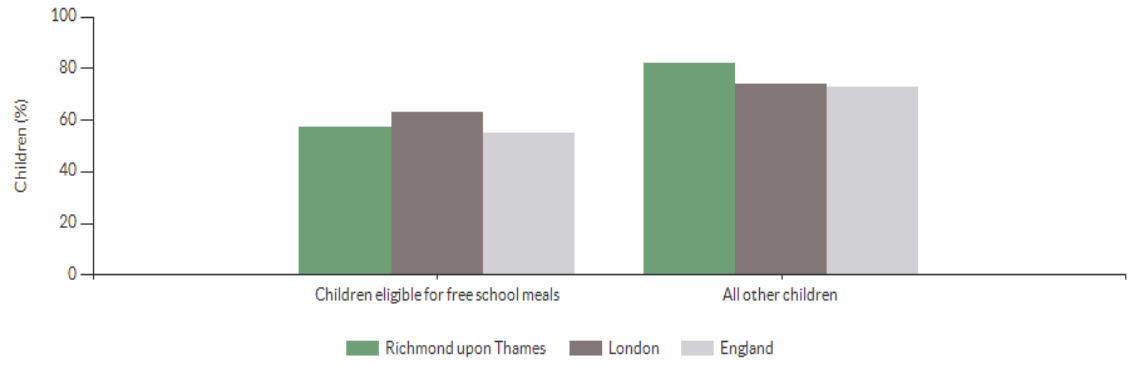
Figure 39: Reception Year Children with Free School Meals Achieving a Good Level of Development, 2012–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

There has been no discernible downward trend in the percentage of children receiving FSM achieving the expected level in the Phonics Screening Check in Year 1 since 2015/16. The level has remained around 71% in comparison to 87% for those not receiving FSM. Richmond ranks within the bottom quintile of all London Boroughs for those on FSM (**Figure 40**).

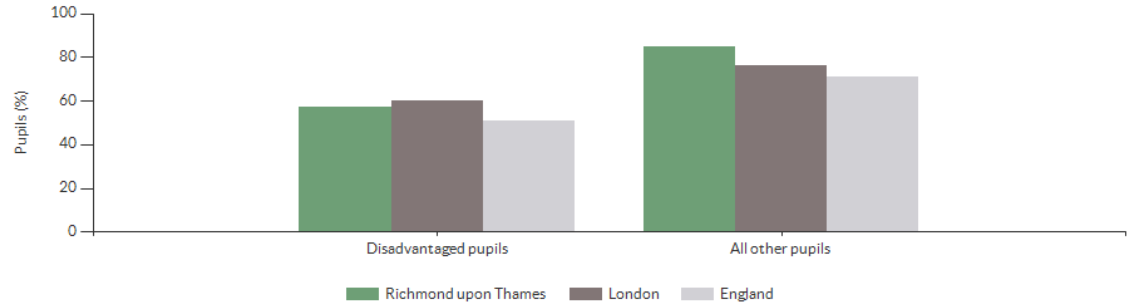
Figure 40: Proportion of Children Achieving a Good Level of Development (by end of Reception), 2017/18



Date: 2018 Source: DfE

By the end of Year 6, however, the percentage of disadvantaged children reaching the expected standard drops to 57% compared to other children at 85%. The inequality in Richmond is greater than that seen in both London and England (**Figure 41**).

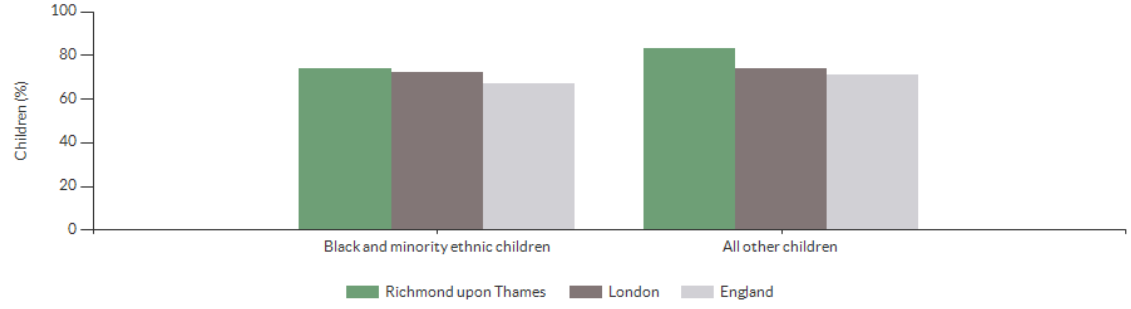
Figure 41: Proportion of Children Achieving the Expected Educational Standards by End of Year 6, 2017/18



Date: 2018 Source: DfE

Achievement for those in Black, Asian and Minority Ethnic Groups (74%), is almost 10% lower than in all other children (83%) and will perpetuate health inequalities through the life-course (**Figure 42**).

Figure 42: Proportion of BACK, ASIAN AND MINORITY ETHNIC GROUPS Children Achieving the Expected Educational Standards by End of Year 6



Date: 2018 Source: DfE

7.3 Communication and Language Development

Children who do not develop good oral language skills in early life are at greater risk of experiencing problems with literacy later in life, potentially impairing their ability to reach their full academic potential. As the National Institute for Health and Care Excellence (NICE) explains: "Children and young people with communication difficulties are at increased risk of social, emotional and behavioural difficulties and mental health problems. So, identifying their speech and language needs early is crucial for their health and well-being. Many young children whose needs are identified early do catch up with their peers".

Early identification and intervention to support communication development ensures that children start school in a position to flourish and minimises the development of gaps which can have a lasting detrimental impact on social mobility. Research has shown that children who had poor language skills at age five were about six times less likely to reach the expected standard in English and about 11 times less likely to reach the expected standard in Maths at age 11[44]. In addition, 15% of pupils with identified speech, language and communication needs achieve the expected standard in reading, writing and numeracy at the end of primary school, compared with 61% of all pupils. As the government's national plan to improve social mobility through education states: "Children who arrive at school in a strong position will find it easier to learn, while those already behind will face a growing challenge: early advantage accumulates, but so too does early disadvantage"[45].

Since 2011/12 there has been a steady increase in:

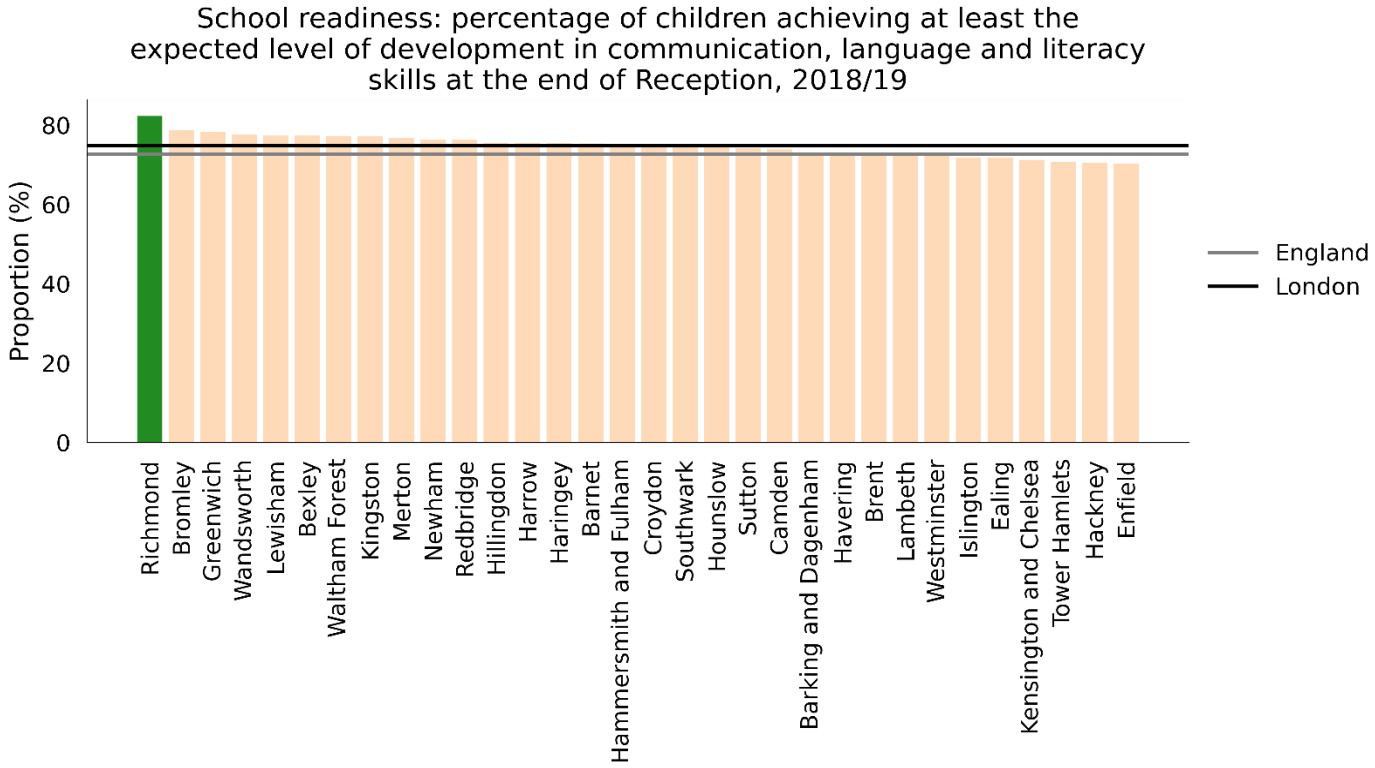
- the percentage of children achieving the expected level in the Phonics Screening Check in Year 1; a 20% increase to 85.5% by 2018/19
- in 2018/19, Richmond's percentage of children achieving at least the expected level in communication and language skills at the end of Reception was 82.2% (n=2046), which is the highest rate in London (**Figure 43**), 13.2% higher than the England average and 9.9% higher than the London average
- the latest Borough figure for 2018/19 was also 60.8% higher than in 2012/13, in comparison with a 27.5% increase in England's rate in the equivalent time period (**Figure 44**)
- the exact same metric is not available according to eligibility for Free School Meals In 2018/19 58.2% of children on free school meals in Richmond were school ready, similar to that in London (64.1%) and England (56.5%)[46].

[44] National Literacy Trust. Language unlocks reading: supporting early language and reading for every child. 2018

[45] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/667690/Social_Mobility_Action_Plan_-_for_printing.pdf

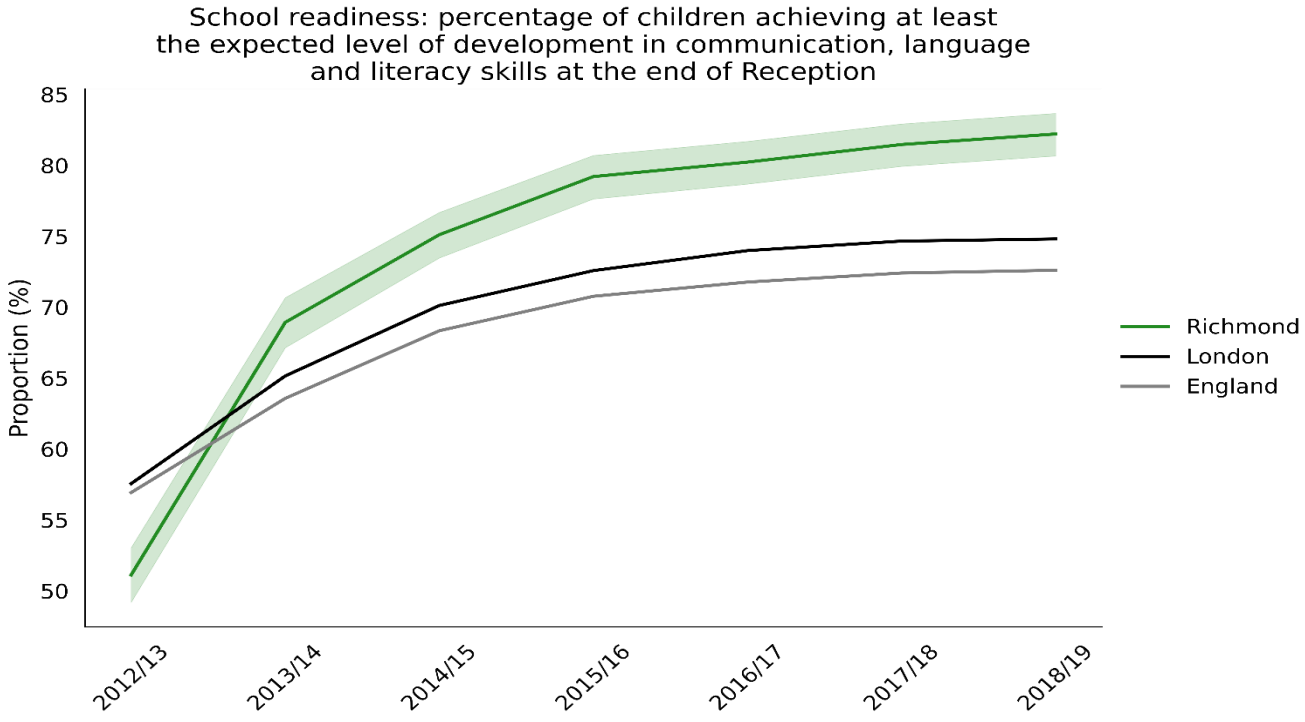
[46] https://fingertips.phe.org.uk/search/free%20school%20meals#page/1/gid/1/pat/6/par/E12000007/ati/102/are/E09000027/iid/90632/age/34/sex/4/cid/4/tbm/1/page-options/car-do-0

Figure 43: Proportion of Reception Year Children Achieving at Least the Expected Level of Development in Communication, Language and Literacy Skills by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

Figure 44: Proportion of Reception Year Children Achieving at Least the Expected Level of Development in Communication, Language and Literacy Skills, 2012–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

8.Hospital Admissions for Injuries and Long-Term Conditions

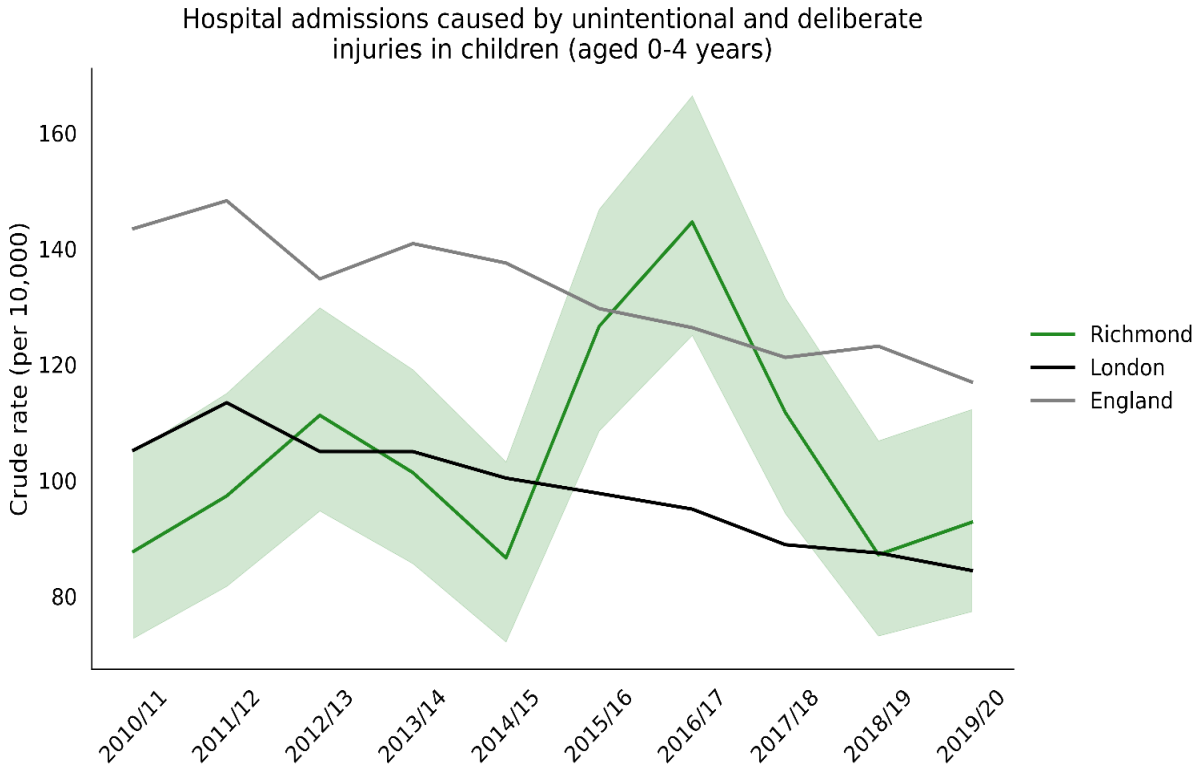
8.1 Injuries and Accidents

Unintentional injuries form a major burden of disease in children and young people and are a major cause of inequality. In 2014/15, there were 19.6 million Accident and Emergency (A&E) attendances recorded at major A&E departments, single specialty A&E Departments, Walk-in Centres and Minor Injury Units in England. More than one quarter (25.9%) of attendances were made by children and young people aged0–19 years. A&E admissions in Richmond have seen a worrying upward trend across all age groups in 0–19 year olds and are statistically worse than the England averages. Furthermore, Richmond has the third highest emergency admissions for falls in children aged 0–4 years of all London Boroughs.The inclusion of this indicator within Public Health Profiles as one of the five most common causes of childhood injury admissions is key for cross-sectoral and partnership working to reduce injuries and improve child safeguarding. Local Authorities and CCGs can use this indicator to inform child safety campaigns and service provision which may be evidence of the hidden safeguarding concerns prevalent within more affluent areas.

Under 5 Year Olds

Richmond's 2019/20 rate of admissions of children under 5 years for injuries was 92.7 per 10,000 population, which was 20.7% lower than the England average and 9.9% higher than the London average. The latest Borough figure was also 5.7% higher from year 2010/11, in comparison with an 18.5% decrease in England's rate in the equivalent time period (**Figure 45).** The rate was 9th highest in London (**Figure 46**).

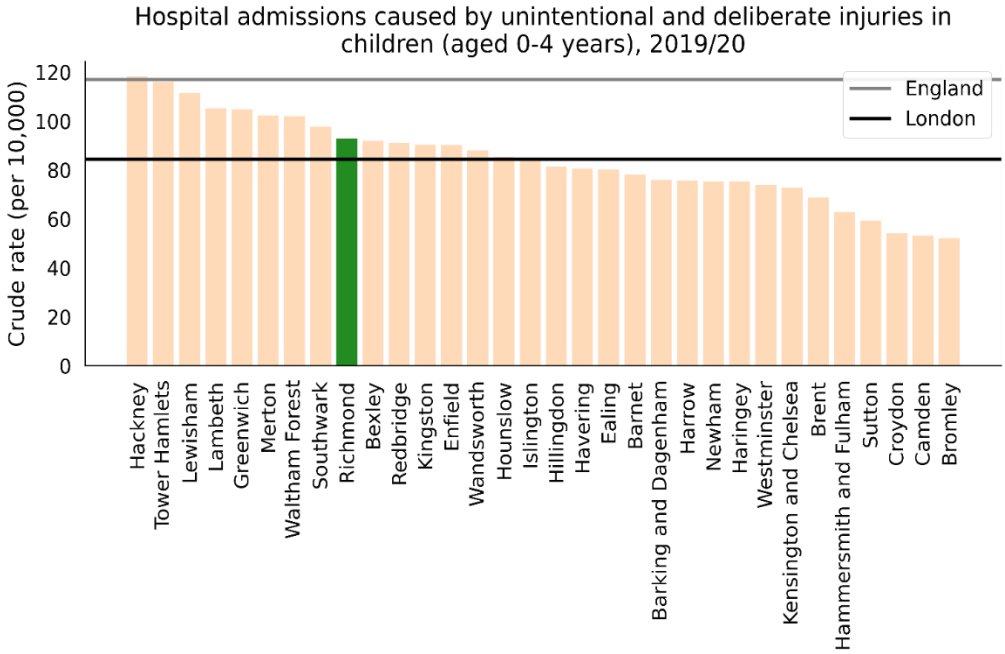
Figure 45: Hospital Admissions of Children Under 5 for Unintentional and Deliberate Injuries, 2010–2020.



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

Figure 46: Hospital Admissions of Children Under 5 for Unintentional and Deliberate Injuries by Local Authority, 2019/20

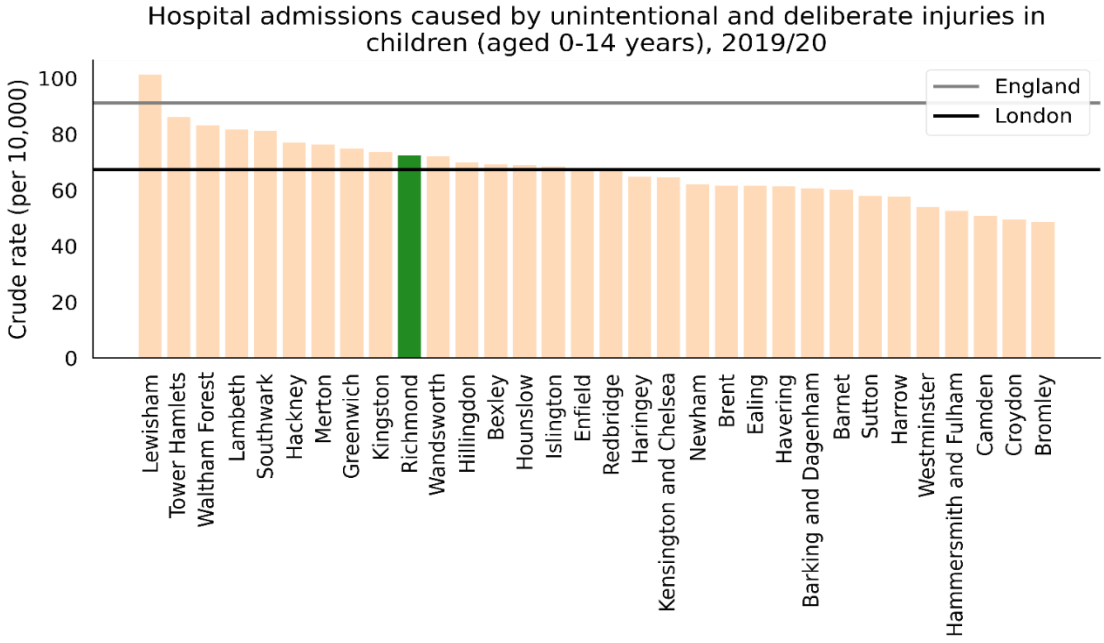


Source: PHE Public Health Outcomes Framework

0–14 year olds

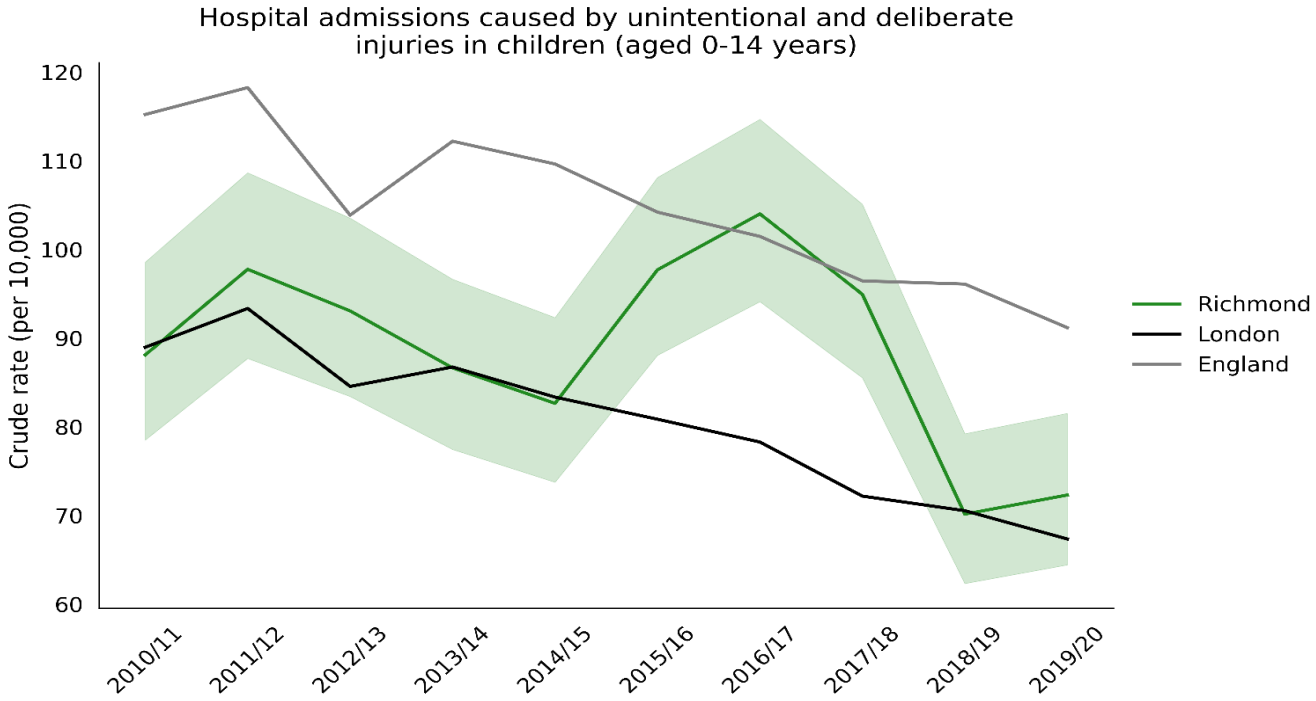
In 2019/20 Richmond's rate of admissions of children aged 0–14 for injuries was 72.3 per 10,000 population, 10th highest in London, (**Figure 47**), which was 20.7% lower than the England average and 7.4% higher than the London average. The latest Borough figure was also 17.9% lower from year 2010/11, in comparison with a 20.9% decrease in England's rate in the equivalent time period (**Figure 48**).

Figure 47: Hospital Admissions of Children Aged Under 15 for Unintentional and Deliberate Injuries by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Figure 48: Hospital admissions of Children Aged Under 15 for Unintentional and Deliberate Injuries, 2010–2020

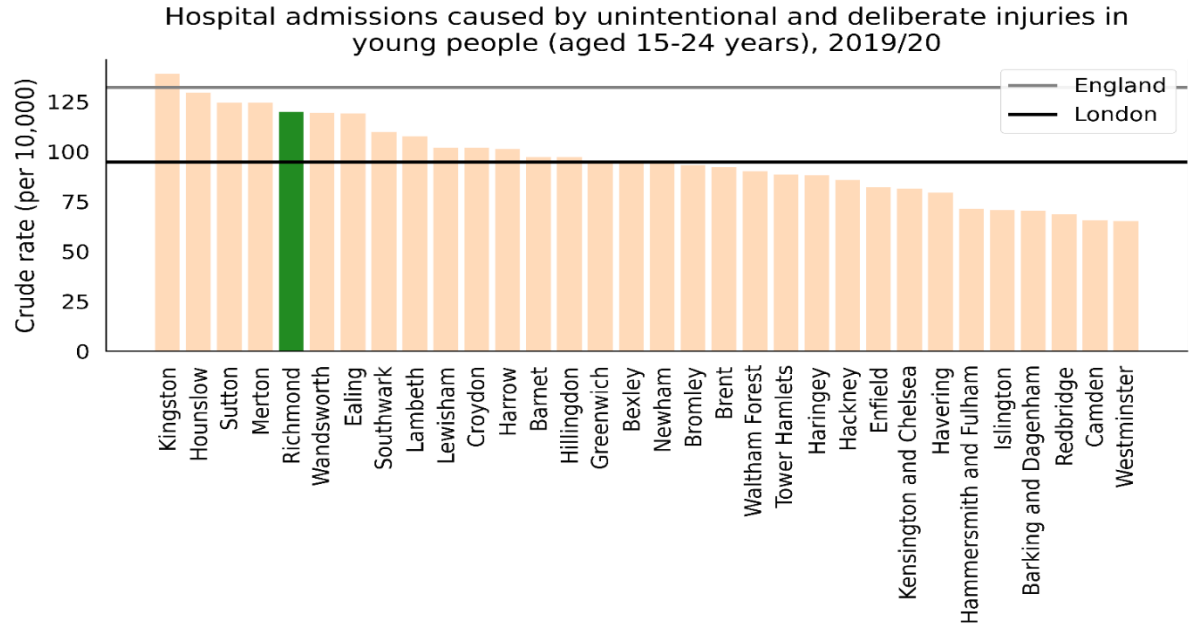


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

15–24 Year Olds

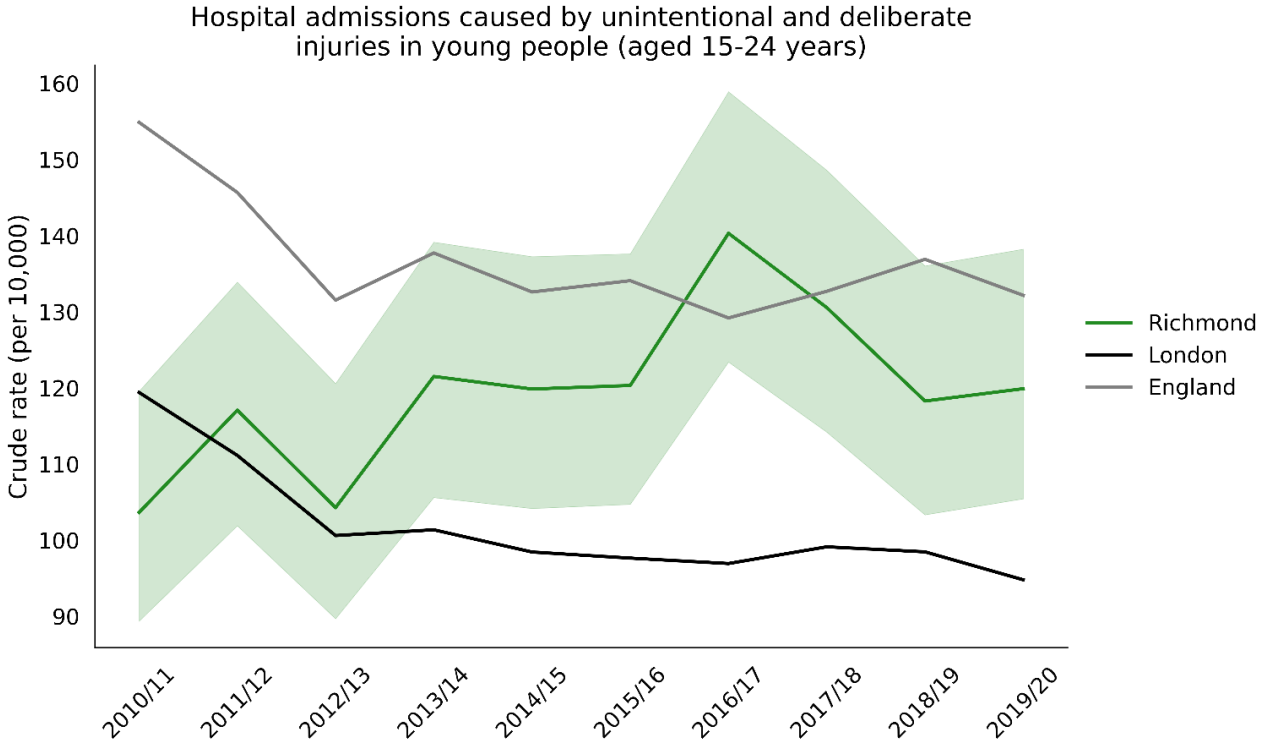
Richmond's 2019/20 rate of hospital admissions for injuries of young people aged 15–24 was 119.9 per 10,000 population, 5th highest in London, (**Figure 49**), which was 9.3% lower than the England average and 26.5% higher than the London average. The latest Borough figure was also 15.7% higher from year 2010/11, in comparison with a 14.7% decrease in England's rate in the equivalent time period (**Figure 50**).

Figure 49: Hospital Admissions of Young People Aged 15–24 for Unintentional and Deliberate Injuries by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Figure 50: Hospital Admissions of Young People Aged 15–24 for Unintentional and Deliberate Injuries, 2010–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

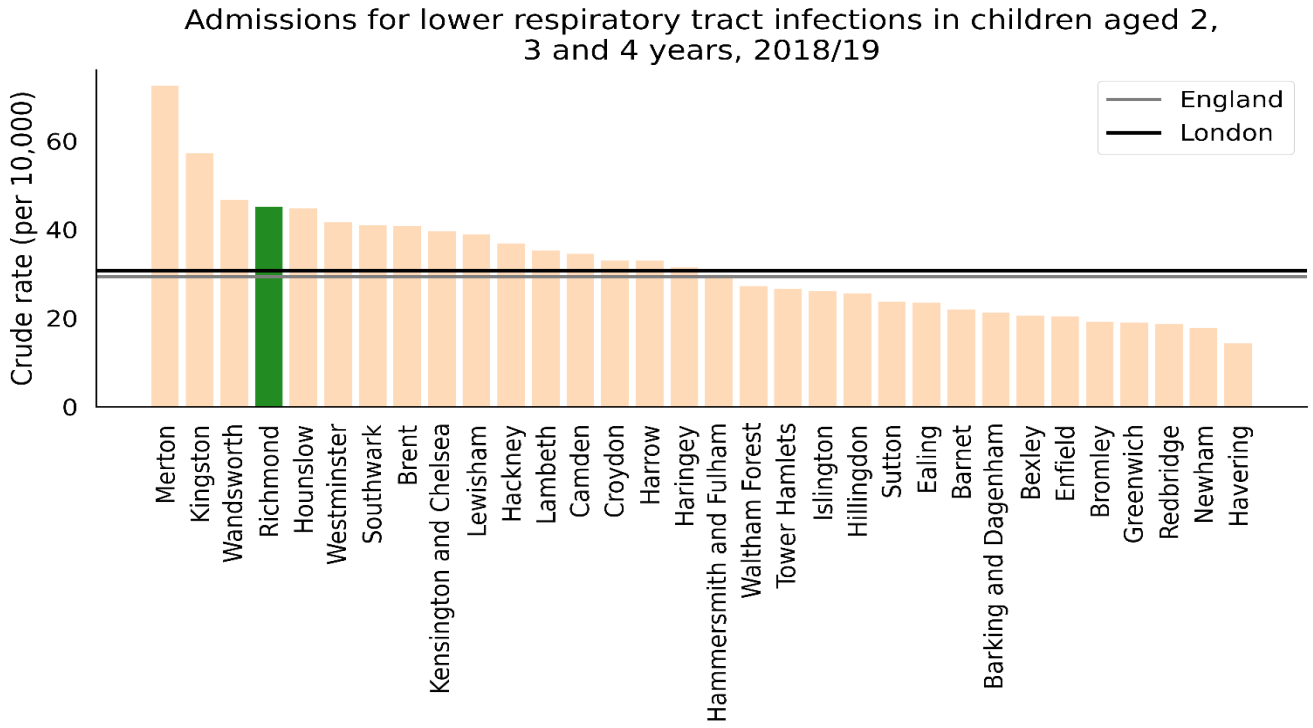
8.2 Lower Respiratory Admissions in Pre-School Children

PHE expects that most of the lower respiratory tract Infections in toddlers should be managed outside of hospital. Primary care has an important role in advising and managing infections at home, as well as encouraging a healthy diet and high levels of hygiene. High rate of hospitalisation might indicate that the system for supporting predominantly young parents with managing child's lower respiratory infections has been inefficient[47].

In 2018/19 Richmond's hospitalisation rate for young children with lower respiratory infections was 45.1 per 10,000 population, 4th highest in London (**Figure 51**), which was 53.5% higher than the England average and 46.7% higher than the London average. The latest Borough figure was also 150.2% higher from year 2014/15, in comparison with a 44.9% increase in England's rate in the equivalent time period (**Figure 52**).

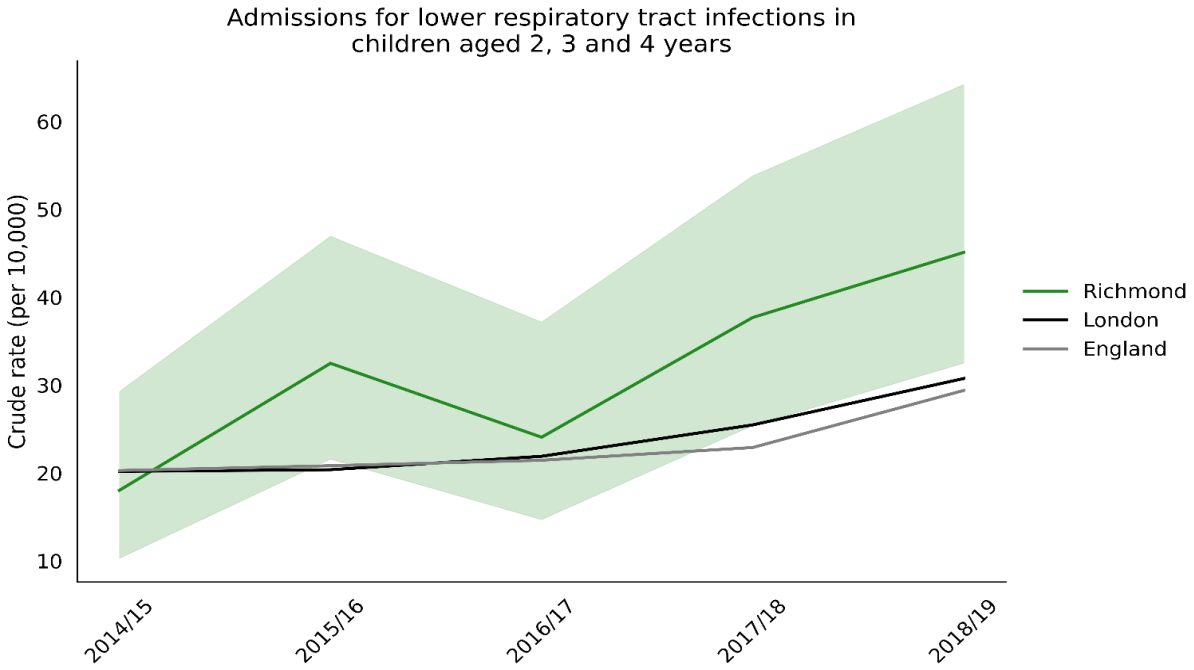
[47] PHE. Public Health Profiles – indicator definition. 2021.

Figure 51: Admissions for Lower Respiratory Tract Infections in Children Aged 2 to 4 By Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

Figure 52: Admissions for Lower Respiratory Tract Infections in Children Aged 2 to 4, 2010–2019



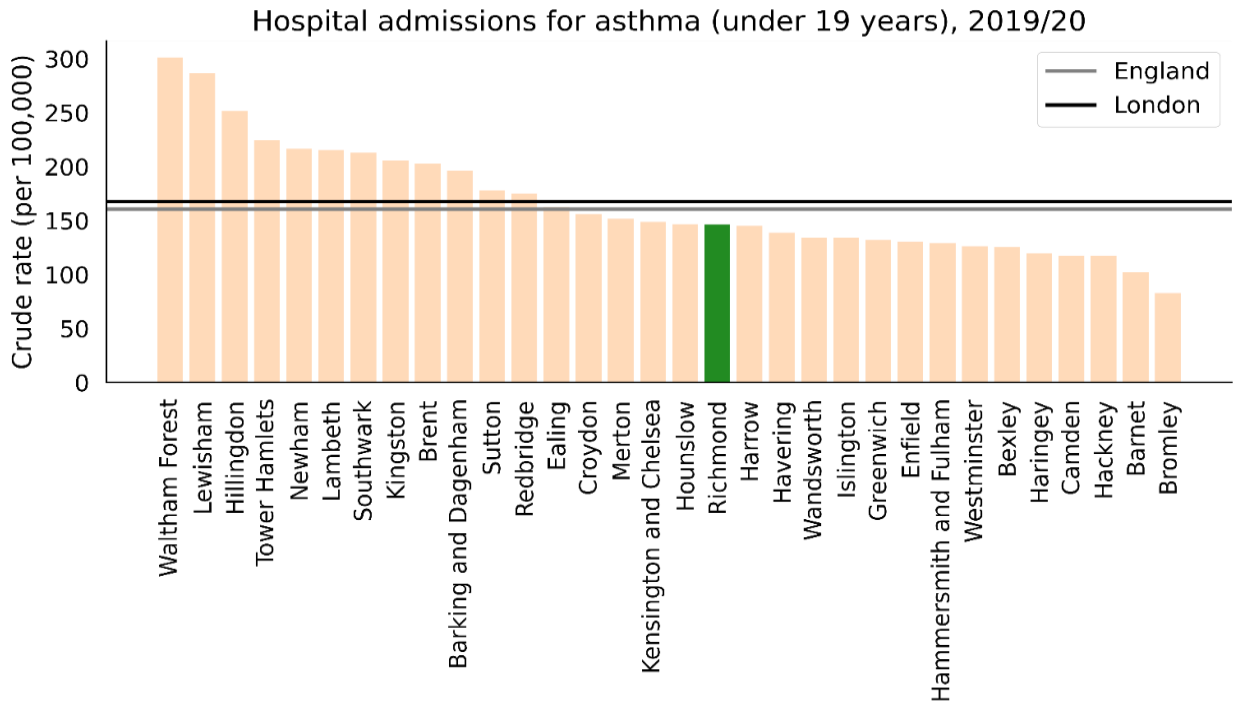
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

8.3 Asthma admissions

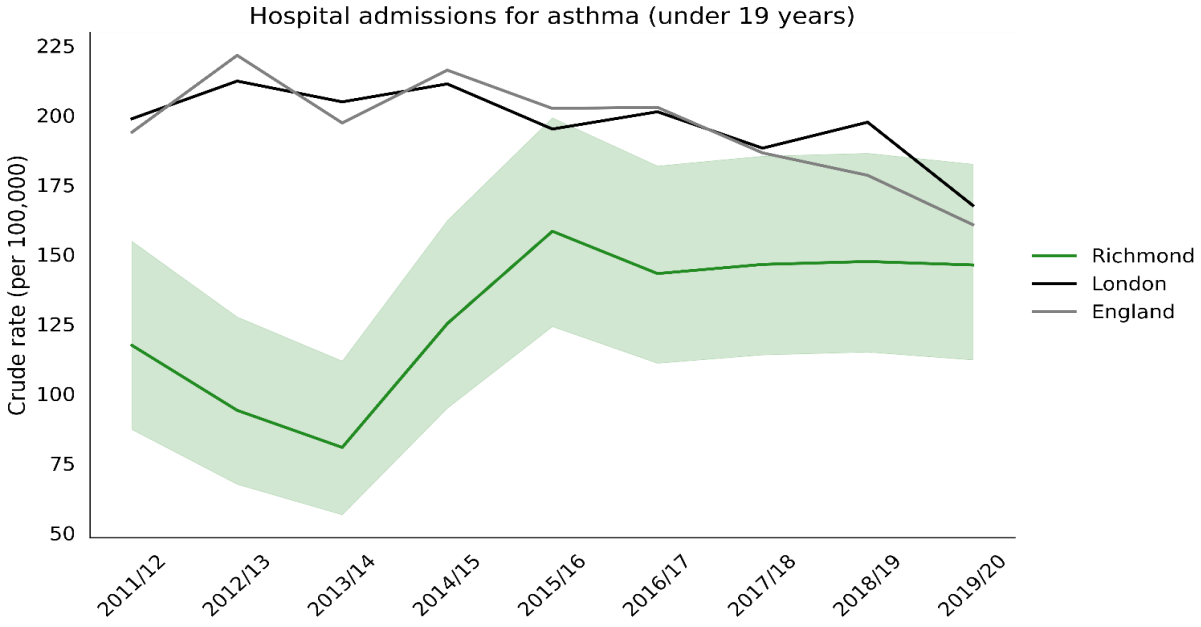
In 2018/19 Richmond's asthma-related hospitalisation rate for children and young people aged under 19 years was 146.2 per 100,000 population, 15th lowest in London (**Figure 53**), which was 9.0% lower than the England average and 12.8% lower than the London average. The latest Borough figure was also 24.6% higher from year 2011/12, in comparison with a 17.1% decrease in England's rate in the equivalent time period (**Figure 54**).

Figure 53: Admissions for Asthma for Children aged 0 to 18 by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

Figure 54: Admissions for Asthma for Children Aged 0 to 18, 2010–2019



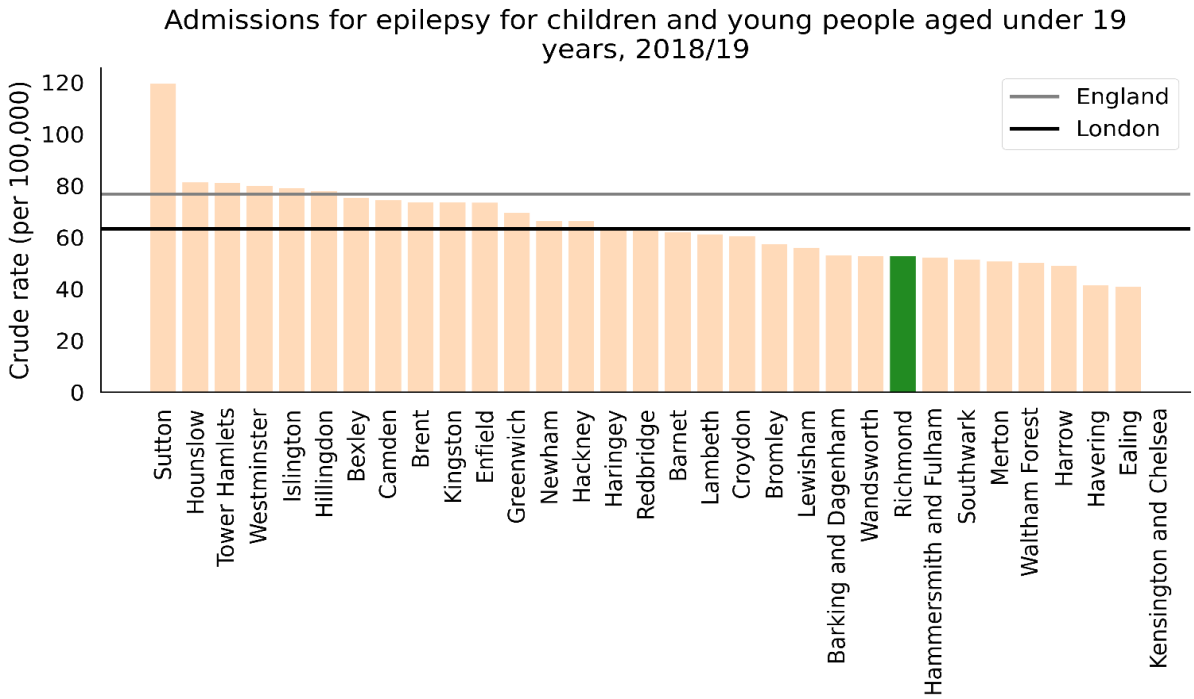
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

8.4 Epilepsy Admissions

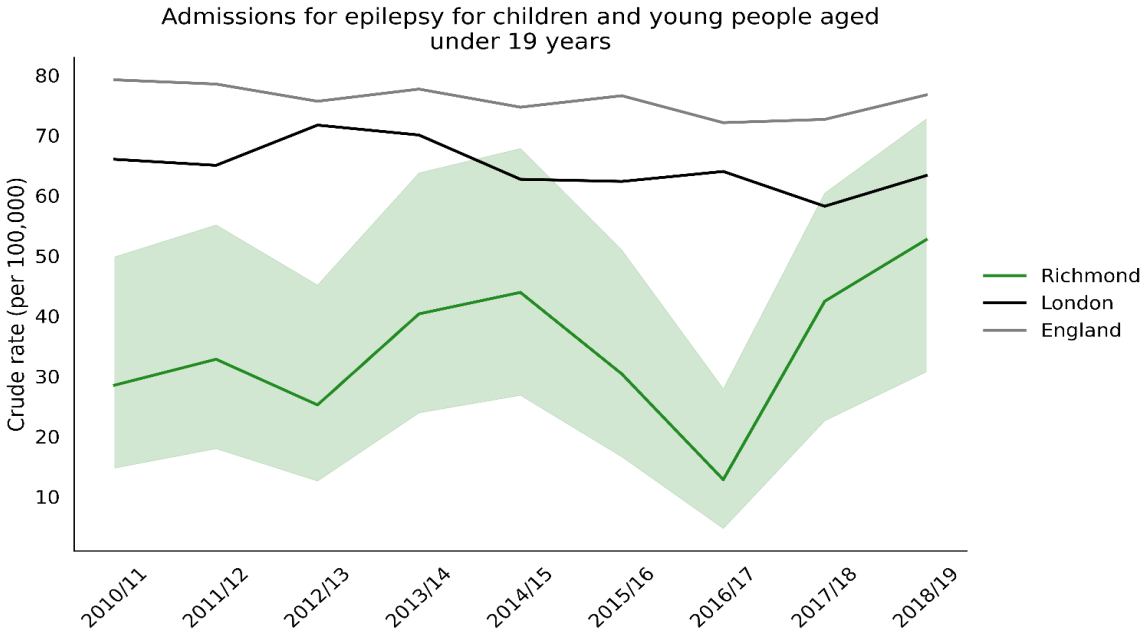
In 2018/19 Richmond's hospitalisations for epilepsy in children under 19 was 52.6 per 100,000 population, 9th lowest in London **(Figure 55)**, which was 31.3% lower than the England average and 16.8% lower than the London average. The latest Borough figure was also 84.7% higher from year 2010/11, in comparison with a 3.2% decrease in England's rate in the equivalent time period (**Figure 56**).

Figure 55: Admissions for Epilepsy for Children Aged 0 to 18 by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

Figure 56: Admissions for Epilepsy for Children Aged 0 to 18, 2010–2019



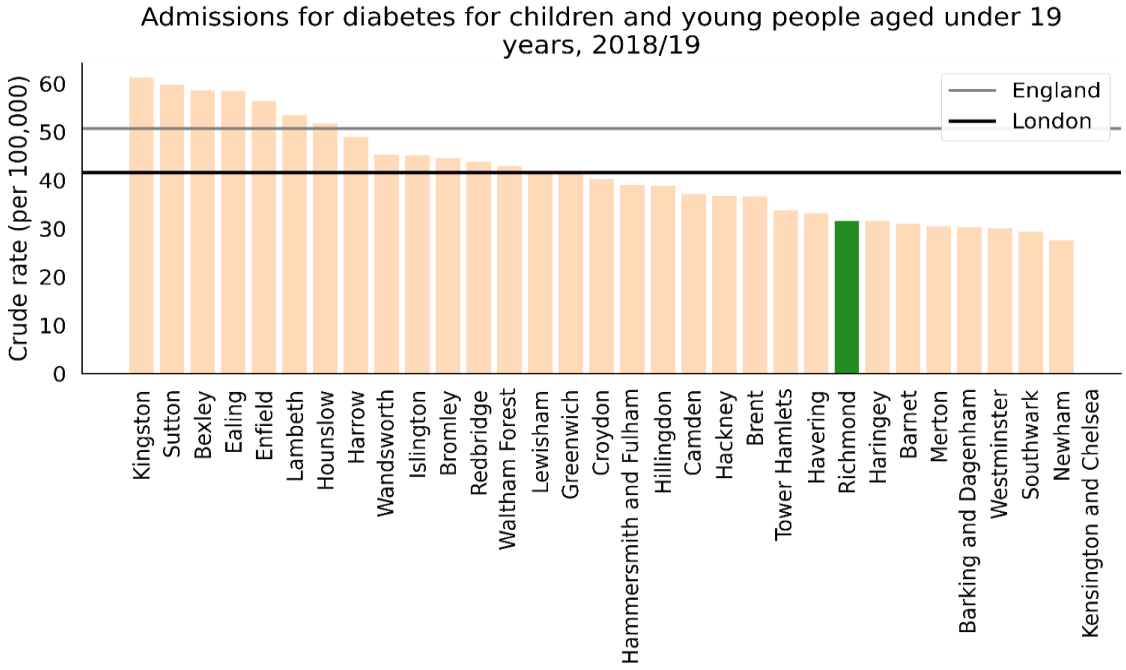
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

8.5 Diabetes Admissions

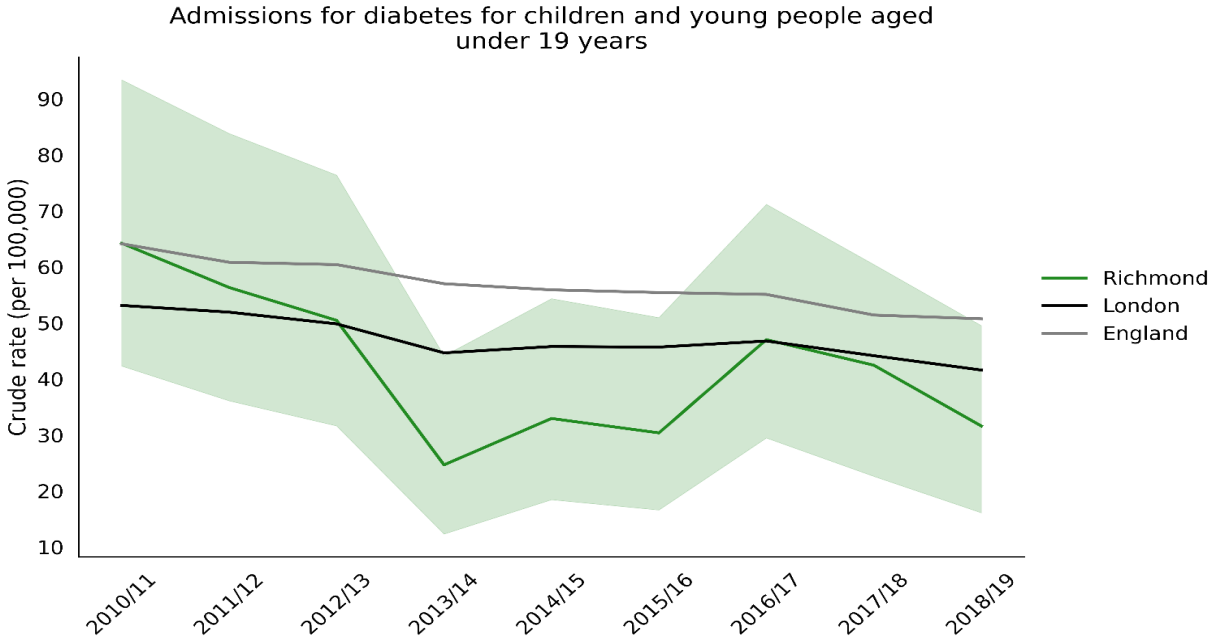
Richmond's latest rate of diabetes admissions in under 19 year olds was 31.6 per 100,000 population, 9th lowest in London (**Figure 57**), which was 37.7% lower than the England average and 24.0% lower than the London average. The latest Borough figure was also 50.8% lower from year 2010/11, in comparison with a 20.9% decrease in England's rate in the equivalent time period (**Figure 58**).

Figure 57: Admissions for Diabetes for Under 19s, 2018/19



Source: PHE Public Health Outcomes Framework

Figure 58: Admissions for Diabetes for Under 19s, 2010–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

9.Healthy Weight in Children

9.1 Overweight and Obesity

Childhood obesity is defined as abnormal or excessive fat accumulation that presents a risk to health and is one of the most serious public health challenges of the 21st century[48]. However, it is a complex issue and there is no singular solution.

The UK is now ranked among the worst in Western Europe for childhood obesity rates and it is one of the biggest health problems the country faces. Nationally, two thirds of adults, a third of 11–15 year olds and a quarter of 2–10 year olds are overweight or obese.

Overweight and obesity disproportionately affects those from more deprived areas, and this association is seen most strongly in children, with obesity prevalence in the most deprived decile being approximately twice that of the least deprived. Prevalence of obesity is also higher amongst children from Black, Asian and Minority Ethnic groups with boys in Year 6 more likely to be obese than White British boys, and girls in Year 6 are more likely to be obese if they are from Black or Black African ethnic groups. Children with learning disabilities are also more likely to be overweight or obese.

In childhood, obesity is associated with several health risks, such as the development of eating disorders, musculoskeletal problems, respiratory problems and Type 2 Diabetes, which until recently was considered a health issue that only effected adults. Excess weight also has a significant impact on psychological well-being, with many children developing negative self-image and low self-esteem issues[49].

Childhood obesity is most likely to be a result of diet and eating patterns and research indicates that 40% to 60% of obese school-age children become obese adults [50]. Dietary behaviours established in childhood are found to continue into adolescence and adulthood[51]. Moreover, if healthy dietary behaviours have not been adequately introduced at a young age, the likelihood of a child having a lower quality of life and an increased risk of illnesses such as cancer, heart disease and obesity in adulthood is greater.

A roundtable event by LSE entitled, “Tackling Obesity in London and Beyond – Nudge and Trade” identified the importance of locally-led solutions in relation to tackling public health challenges such as obesity. Learning from France and the Netherlands shows that Local Authorities, working with local stakeholders, such as parents, schools, community groups, businesses and the media, can have a modest effect on stopping childhood obesity. There is evidence of intergenerational transmission of obesity which highlights the importance of considering the whole family when tackling child obesity. Parental obesity increases obesity in adolescence. This link is even stronger when both parents are obese and is stronger for school age girls. It is recommended that consideration is given to how to improve access to and encourage use of green space; as well as an increased focus on cooking to improve health[52].

[48] WHO. Noncommunicable diseases: Childhood overweight and Obesity. 2020.
[49] https://www.datarich.info/staying-healthy/Obesity-in-children/#_edn7
[50] Office for Standards in Education. Children's Services and Skills – Obesity, healthy eating and physical activity in primary schools. 2018.
[51] Northstone K & Emmett PM. Are dietary patterns stable throughout early and mid-childhood? A birth cohort study. The British Journal of Nutrition, 100(5), 1069–1076. 2018
[52] Tackling Obesity in London and Beyond – Nudge and Trade LSE Policy Roundtable Write-Up: 29th June 2021. The Obesity Challenge and the Need for Locally Led Solutions (and Funding)

We must put our children's health first and act now to improve child health and well-being. In working together across society, we can improve our children's health and several strategies to achieve this are recommended and have been incorporated into the government's action plan to counteract the rise in childhood obesity[53]. The plan includes improving the nutritional content of the food and drink our children consume, strengthening the information available to parents and the general public about nutritional content of foods and drinks (and those that should be limited). Changing the way that unhealthy food and sugary drinks are promoted, for example, removing offers for 'Buy One Get One Free' on foods high in sugar must be challenged.

These actions are important to reduce the increasing financial burden that the obesity epidemic is having on the NHS; obesity-related health conditions are estimated to cost the NHS (and therefore UK taxpayers) £6.1 billion per year[54].

9.2 Reception Year Children Classified as Obese and Overweight

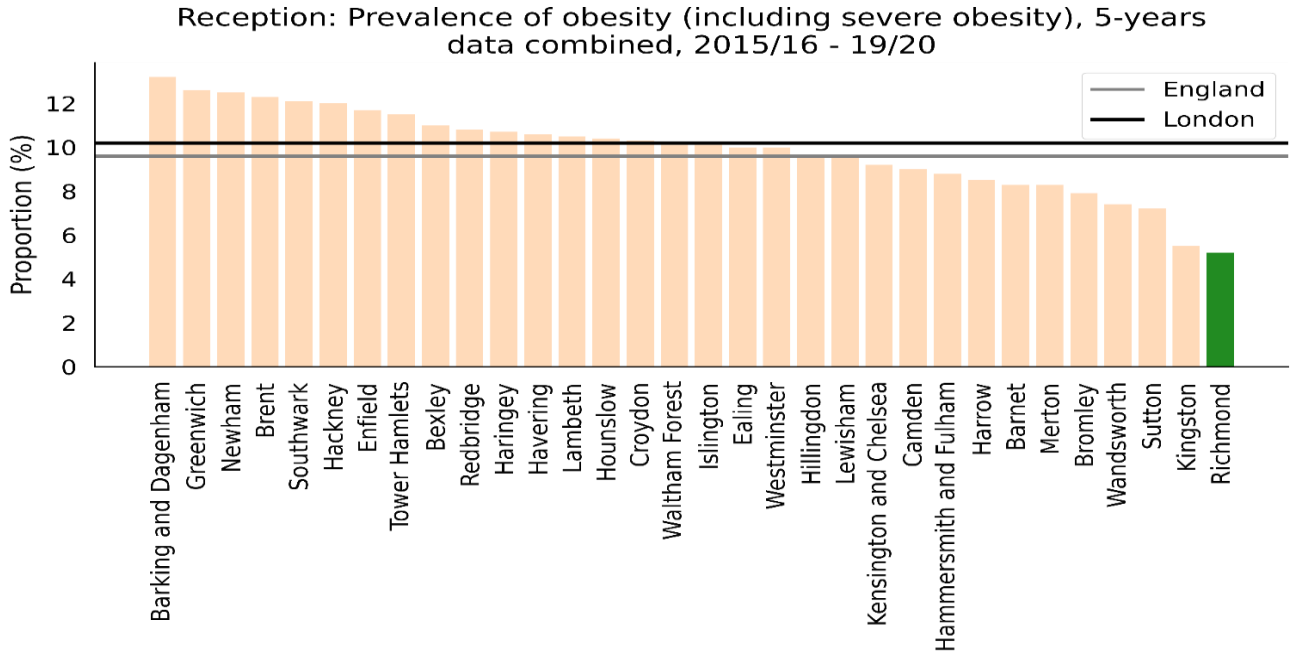
More than 1 in 5 children in England are obese or overweight by the time they start primary school, and this rises to one third by the time they are 11 years old[55]. In England, the National Child Measurement Programme (NCMP) measures the weight and height of children within state maintained Primary Schools in Reception Class (aged 4 to 5 years) and Year 6 (aged 10 to 11 years). Their figures are based on large numbers of measurements and provide a robust assessment of obesity in children[56]. However, the NMCP does not include children in the independent sector so the overall measurement of school children in Reception and Year 6 aged 4–5 years is incomplete.

Obesity

In 2019/20 Richmond's obesity prevalence in Reception Year was 4.7 per 100, the lowest in London, **(Figure 59**), which was 52.5% lower than the England average and 53.0% lower than the London average. The latest Borough figure was also 14.9% lower from year 2008/09, in comparison with a 3.1% increase in England's rate in the equivalent time period (**Figure 60**).

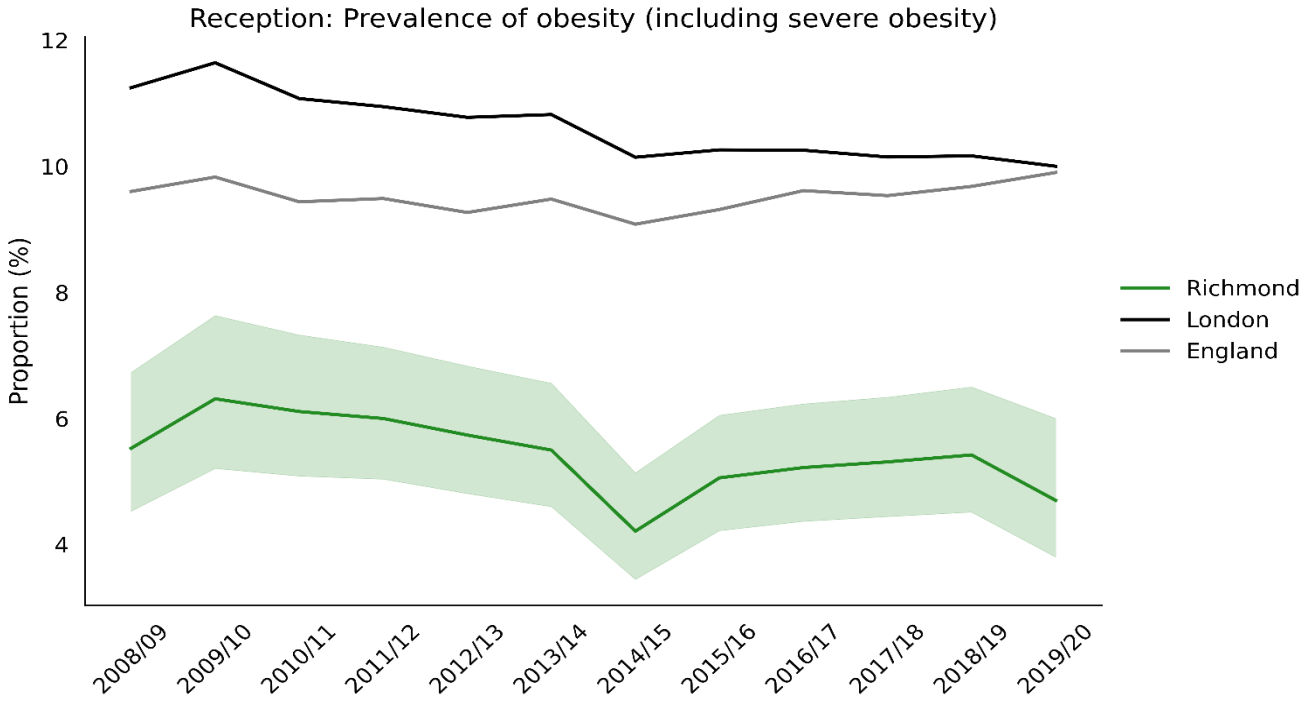
[53]Department of Health. Childhood Obesity: a plan for action. 2018.
[54] Public Health England. Health Matters: Obesity and the food environment. 2018.
[55] NHS Digital. National Child Measurement Programme 2016/17. 2017
[56] https://www.datarich.info/staying-healthy/Obesity-in-children/#_edn14

Figure 59: Prevalence of Obesity in Reception Year by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Figure 60: Prevalence of Obesity in Reception Year, 2006–2020

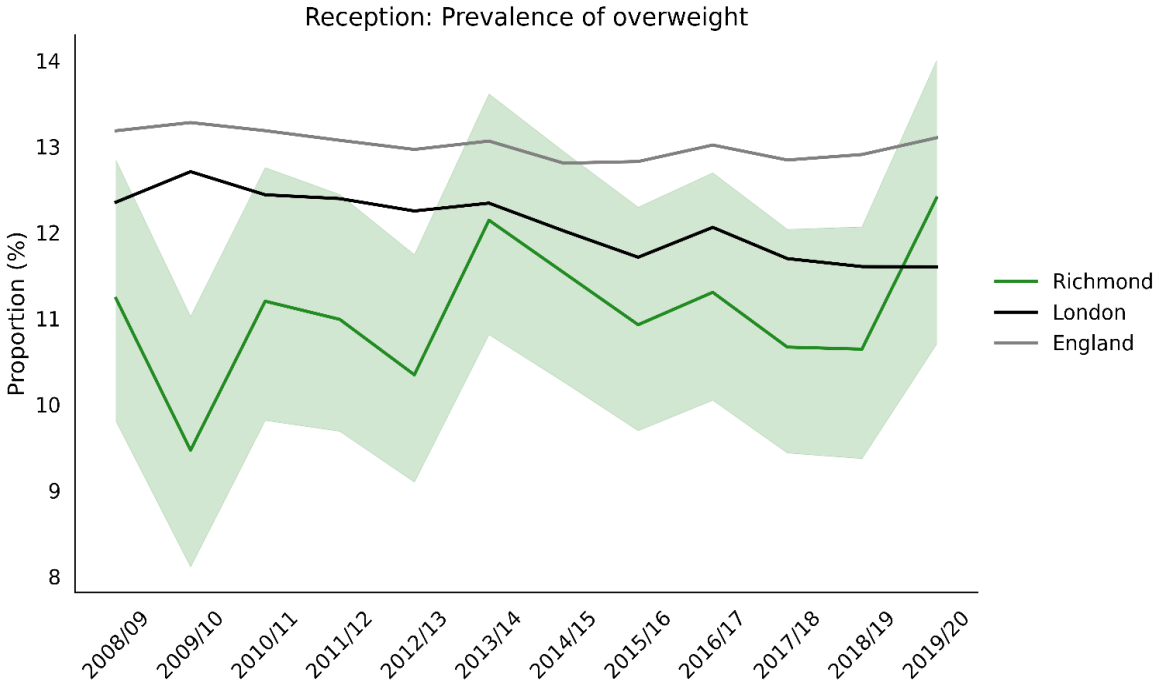


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Overweight

Prevalence of overweight children in Richmond's Reception Year in 2019/20 was 12.4%, significantly lower than the national average of 12.9% for that year. The latest Borough figure was also 10.4% higher from year 2008/09, in comparison with a 0.6% decrease in England's rate in the equivalent time period (**Figure 61**). The latest rate was 9th highest in London (**Figure 62**).

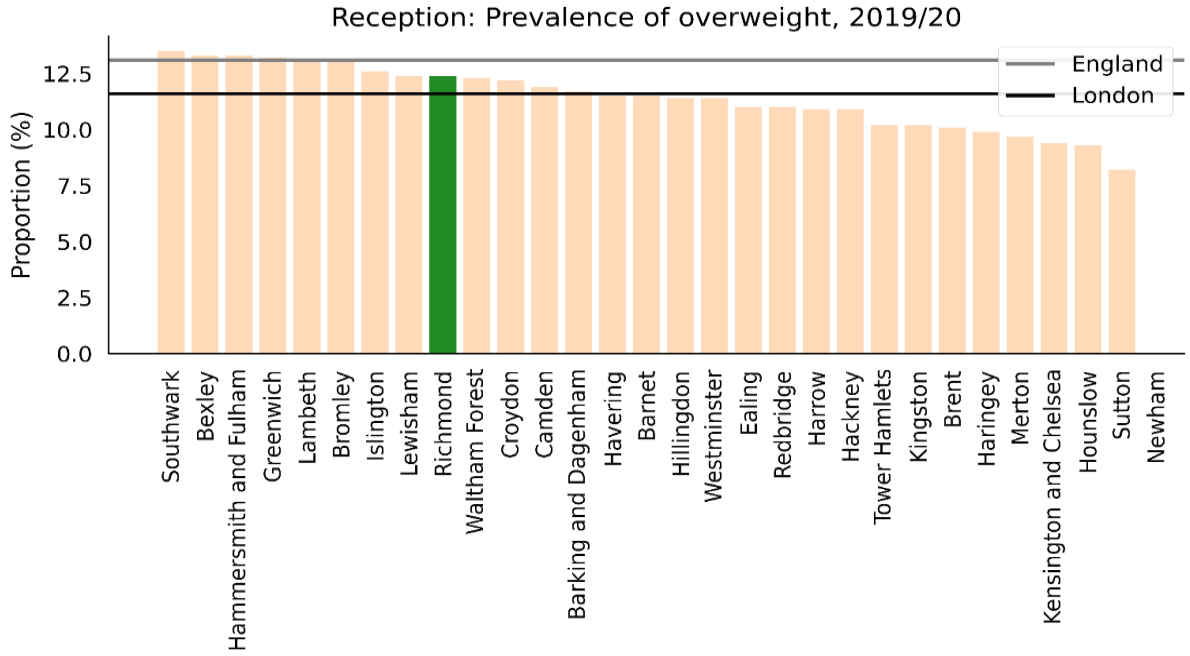
Figure 61: Prevalence of Overweight in Reception, 2006–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

Figure 62: Prevalence of Overweight in Reception by Local Authority, 2019/20



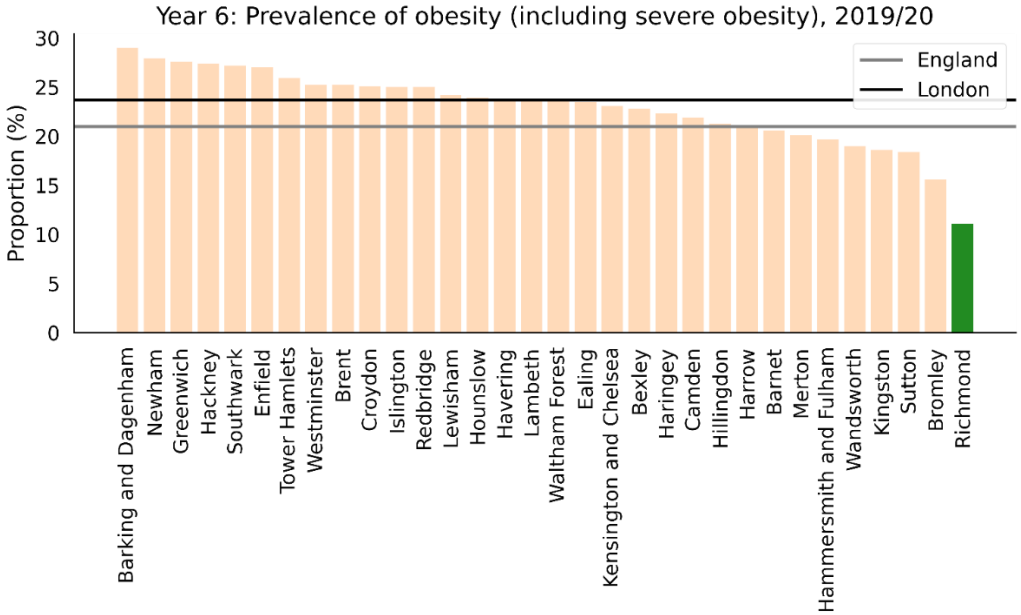
Source: PHE Public Health Outcomes Framework

9.3 Children in Year 6 Classified as Obese or Overweight

Obesity

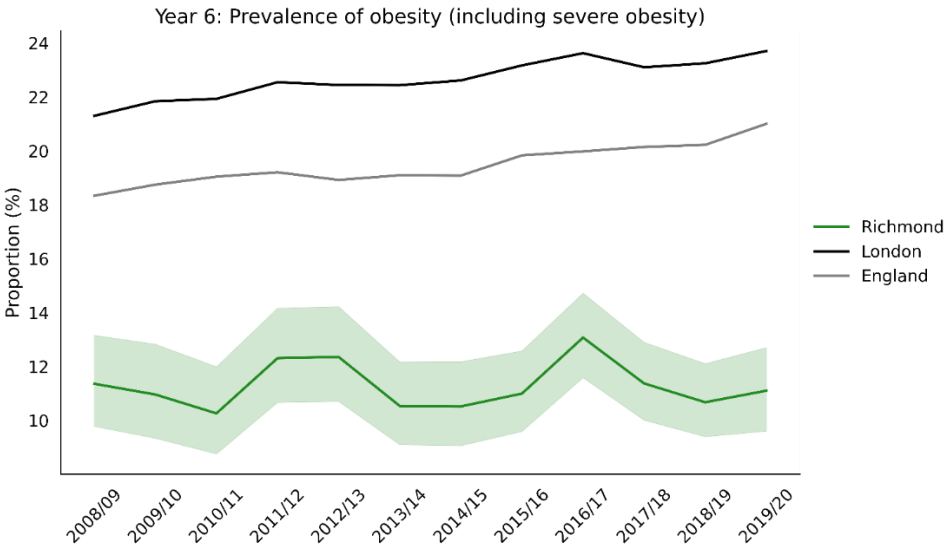
By the time a child reaches Year 6, the percentage of obese children has increased two-fold to 11.1% in 2019/20. Richmond ranks the lowest of all London Boroughs for prevalence of obesity at Year 6 and while these rates are still lower than both London (23.2%) and England (20.2%), the doubling of obesity rates from Reception to Year 6 in concerning (**Figure 63**). The latest Borough figure was also 2.3% lower from year 2008/09, in comparison with a 14.6% increase in England's rate in the equivalent time period. Richmond's obesity levels in Year 6 remained stable in the last 3 years (**Figure 64**), indicating further need to increase both physical activity and instil healthy eating habits in the Primary School phase.

Figure 63: Obese Children in Year 6 by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Figure 64: Obese Children in Year 6, 2006–2020

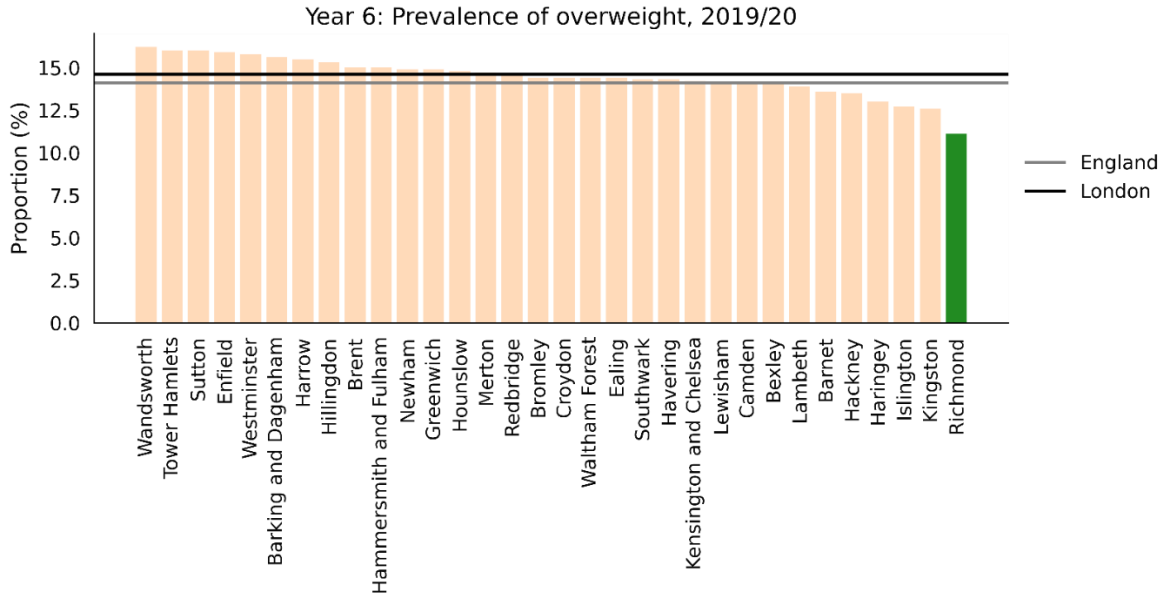


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Overweight

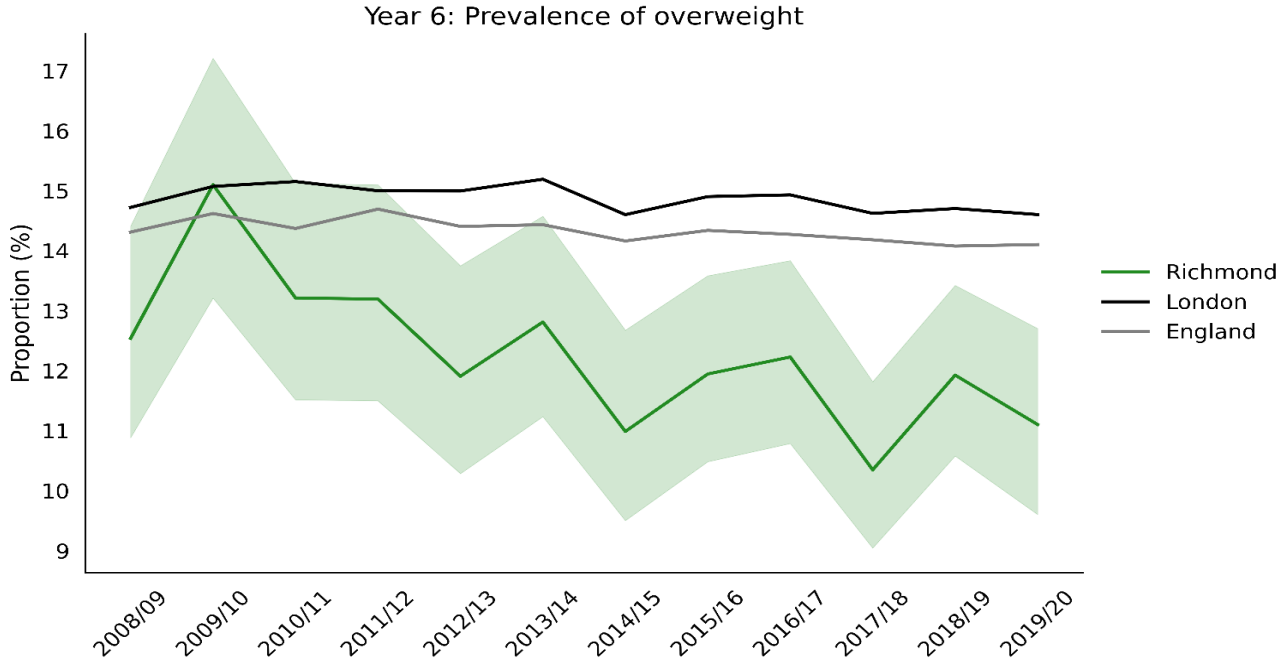
Obesity prevalence in Year 6 remains level, in contrast to the latest substantial increase in the percentage of overweight children. In 2019/20 Richmond's prevalence of overweight in Year 6 was 11.1%, lowest in London (**Figure 65**), which was 21.3% lower than the England average and 24.0% lower than the London average. The latest Borough figure was also 11.5% lower from year 2008/09, in comparison with a 1.5% decrease in England's rate in the equivalent time period. (**Figure 66**)

Figure 65: Prevalence of Overweight Children in Year 6 by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Figure 66: Prevalence of overweight children in Year 6, 2007–2020

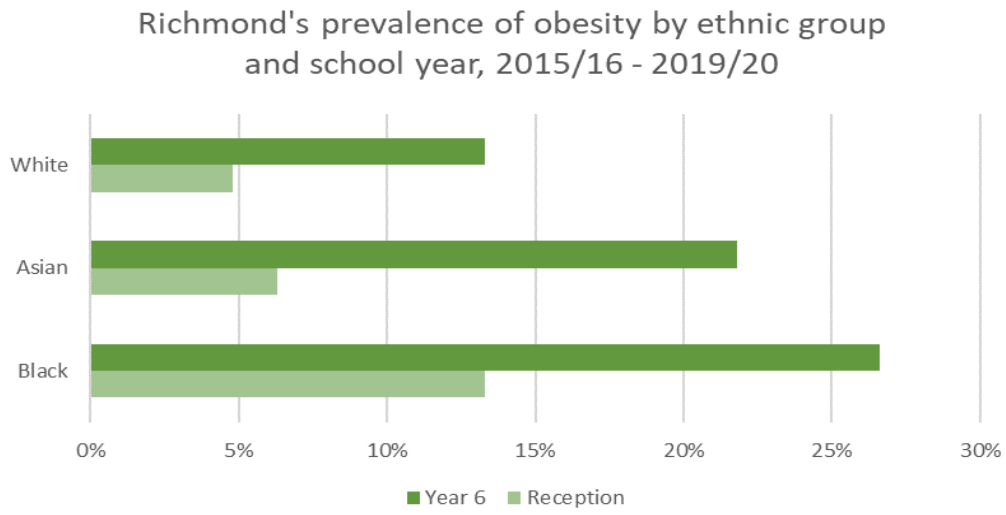


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

9.4 Obesity Prevalence by Ethnic Group

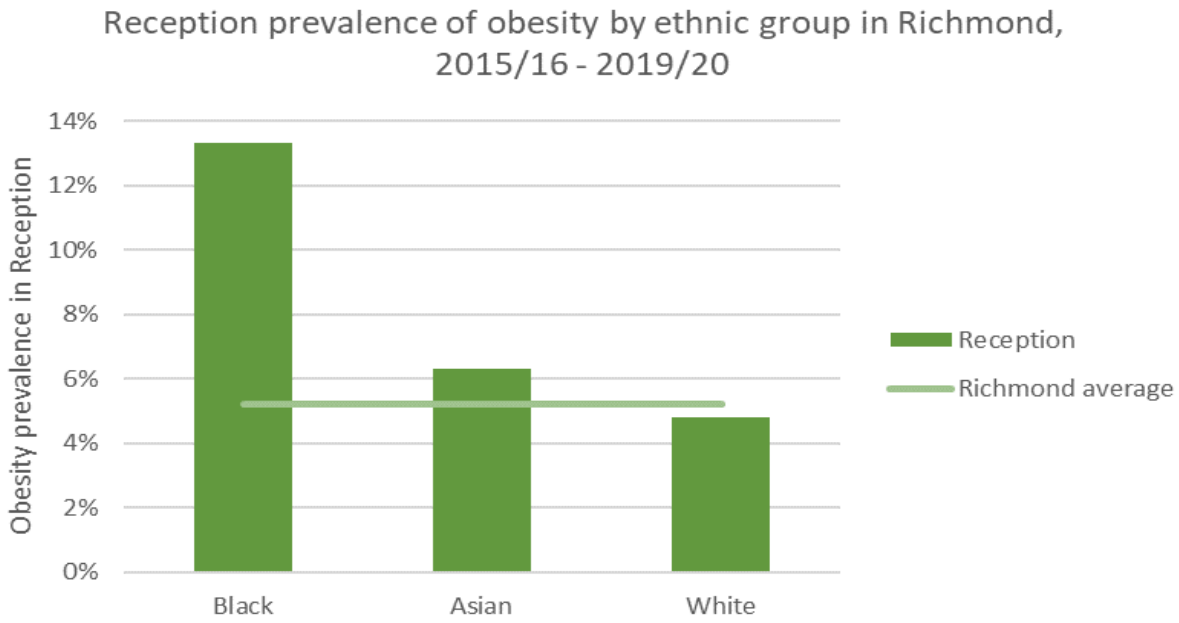
Childhood obesity prevalence changes with age and ethnic group. In Richmond (and nationally) the prevalence of obesity is the highest in Black Ethnic groups and the lowest in White Ethnic groups; the prevalence in Asian Ethnic groups was somewhere in the middle. Interestingly, the pace of increase in obesity prevalence between Reception and Year 6 varies even more substantially. for Black ethnicities, the prevalence in Year 6 is 181% higher than in Reception, in comparison with a 261% increase in White ethnicities and 316% increase in Asian ethnicities (**Figure 67 - Figure 69**).

Figure 67: Prevalence of Obesity by Ethnicity and School Year in Richmond, September 2015 - July 2020



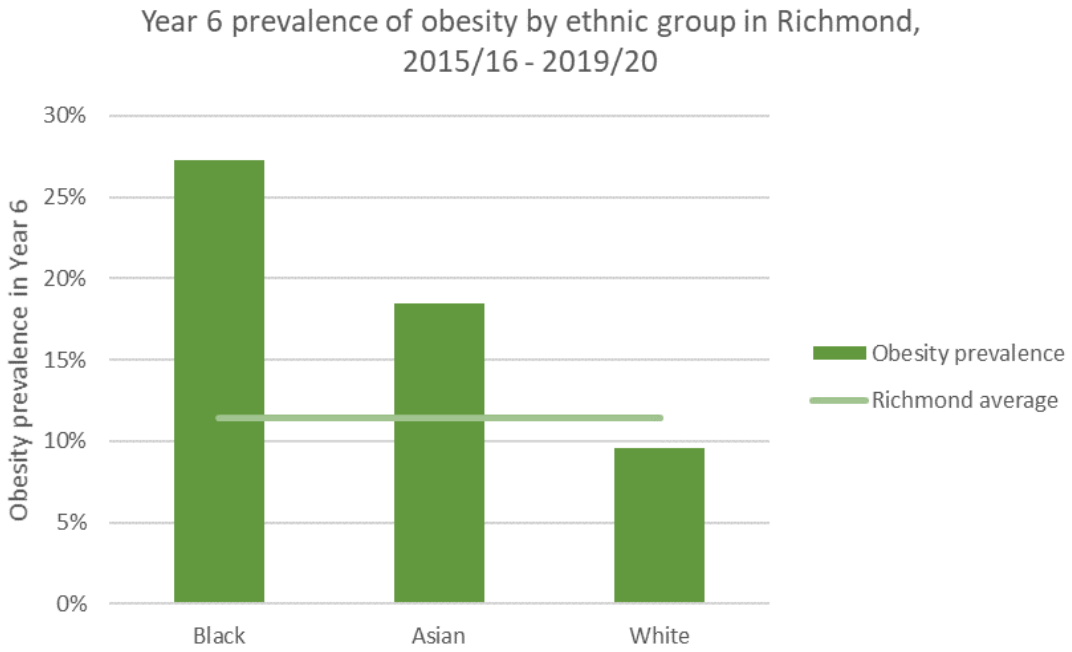
Source: PHE Public Health Outcomes Framework

Figure 68: Prevalence of Obesity by Ethnicity in Richmond's Reception Year Children, September 2015 - July 2020



Source: PHE Public Health Outcomes Framework

Figure 69: Prevalence of Obesity by Ethnicity in Richmond's Year 6 Children, September 2015 - July 2020



Source: PHE Public Health Outcomes Framework

9.5 Protective Factors Reducing the Risk of Childhood Obesity

The causes of obesity and being overweight are multi-factorial as no one single factor can be attributed to it. The Obesity Systems Map outlines the main areas that contain variables which are considered to affect the outcome of obesity directly or indirectly: environmental, societal and individual themes[57]. These include variables such as an individual's psychology and physiology, and their food and activity environment.

A growing body of evidence suggests that a whole systems approach could help tackle complex problems, such as obesity. The recent Public Health England document 'Whole Systems Approach to Obesity: A Guide to Support Local Approaches to Promoting a Healthy Weight' is a professional resource that is designed to support local action to address Obesity. The guide describes a how to process, which can enable Local Authorities, and their partners, to create their own local whole systems approaches to reducing obesity and promoting a healthy weight, as it is understood that there is no one singular solution; causes of obesity exist in the places where we live, work and play. The guide does not specify which specific policies, interventions or actions local areas should include in a whole systems approach; this is an important part of the approach, which needs to be agreed collectively by local stakeholders to reflect the local context[58].

In 2019 the London Child Obesity Taskforce launched their 'Every Child a Healthy Weight' campaign, which outlines 10 ambitions on areas that are understood to reduce the risk of lifelong ill health for children. These ambitions have been chosen to reflect the circumstances in which children may live which makes it difficult for them to eat healthy food, drink water and be physically active[59]. Some examples of these ambitions include, ending child poverty, supporting women to breastfeed for longer, ensuring all nurseries and schools are enabling health for life, making free water

[57] PHE. Obesity map. 2021.
[58] Public Health England (PHE). Health matters: whole systems approach to Obesity. 2019.
[59] The London Child Obesity Taskforce. Every Child A Healthy Weight. Ten Ambitions for London. 2019.

available everywhere, creating more active, playful streets and public spaces, and stopping unhealthy marketing which influences what children eat.

Healthy Eating

At its simplest, excess weight in children is caused by an energy (calorie) imbalance and consuming too much energy compared to expenditure. Children in the UK have diets that are too high in energy-dense foods, saturated fat and 'free' sugars (sugars that are added to our food), all of which contribute to this imbalance. Children also consume too little fibre, fruit and vegetables[60] which counteract overconsumption of calorie-dense foods by filling us up more than the processed foods.

The adoption of a healthy diet from as young an age as possible is recommended[61]. In general, a healthy diet is rich in fruit and vegetables, wholegrains, legumes and nuts, and low in foods high in saturated fat, salt and sugar. It is recommended that at least 400 grams (equivalent to approximately five portions of 80 grams) of fruit and vegetables per day (excluding starchy root vegetables) are consumed from two years of age[62].

The Public Health England Eatwell Guide [63] and the Department of Health Campaign '5 A Day' aim to improve diet and nutrition in the general population and have been promoted widely. Nevertheless, reportedly, only 18% of 5-15-year olds eat the recommended '5 A Day'[64] and research has indicated that over the last 20 years there has been a dramatic reduction of intake in key nutrients in children, such as vitamin A, folate, calcium, zinc, iron and iodine[65], all of which are available in a healthy, nutrient-rich diet[66].

The implications of this are that children from a young age do not have the required nutrients to support growth and development, including the formation of healthy teeth, bones, body tissues and normal nerve function[67]. Ultimately a poor diet is putting children's future health at risk.

Breastfeeding

Risk factors begin from birth, starting with an increased risk of obesity for children who are not breastfed[68]. In Richmond the number of children being breastfed continues to increase. Richmond has seen an overall improvement

[60] PHE and Food Standards Agency. National Diet and Nutrition Survey. 2020.
[61] Delgado-Noguera, M., Tort, S., Martínez-Zapata, M. J., & Bonfill, M. J. (2011). Primary school interventions to promote fruit and vegetable consumption: a systematic review and meta-analysis. Preventative Medicine, 53(1-2), 3-9; Bull, C. J., & Northstone, K. (2016). Childhood dietary patterns and cardiovascular risk factors in adolescence: results from the Avon Longitudinal Study of Parents and Children (ALSPAC) cohort. Public Health Nutrition19(18), 3369-3377; Holley, C. E., Farrow, C., & Haycraft, E. (2017). A Systematic Review of Methods for Increasing Vegetable Consumption in Early Childhood. Current Nutrition Reports, 6, 157-170
[62] World Health Organization. Healthy Diet. 2018.
[63] PHE. The Eatwell Guide: Helping you eat a healthy, balanced diet. 2018.
[64] NHS. Health Survey for England 2018 [NS]. 2018.
[65] Roberts, C., Steer, T., Maplethorpe, N., Cox, L., Meadows, S., Nicholson, S., … Swan, G. National Diet and Nutrition Survey. 2018.
[66] Roberts, C., Steer, T., Maplethorpe, N., Cox, L., Meadows, S., Nicholson, S., … Swan, G. National Diet and Nutrition Survey. 2018.
[67] British Nutrition Foundation. Minerals and trace elements. 2021.
[68] Victora CG, Bahl R, Barros AJD, Franca GVA, Horton S, Krasevec J, Murch S, Sankar MJ, Walker N, Rollins NC (2016) Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. The Lancet Series: Breastfeeding 1. Volume 387, No. 10017, p475–490, 30 January

in 6–8 weeks prevalence rates between 2018 to 2019 from 26% in Q1 to 79% in Q4. The overall total for the year is 56% which is higher than the England average of 42.7%[69]. For more information on breastfeeding, see Section 3.4.

Physical Activity

To stay healthy or to improve health, young people aged 5–18 years need to do three types of physical activity each week: aerobic exercise, exercises to strengthen bones and exercises to strengthen muscles[70].

This age group should be encouraged to do at least 60 minutes of physical activity every day and up to several hours a week. This should range from moderate activities such as walking, cycling and playground activities, to vigorous activities causing heavier and faster breathing and an increase in heart rate, such as football, rugby or tennis. It is recommended that on three days a week, these activities should involve exercises to strengthen muscles and exercises to strengthen bones. Examples would be a child lifting their own body weight or working against a resistance, such as push-ups, rope climbing, and sports like gymnastics and rugby. Bone strengthening activities could include running, dancing, or martial arts which promote bone growth and strength by producing an impact or tension force on the bones.

Children and young people should reduce the amount of time they spend on sedentary activities, for example watching TV and playing computer games. It is encouraged to travel by foot or bicycle as opposed to being a passenger in a car where possible.

School nurses conduct the NCMP and measure all children at Reception and Year 6. Children who are identified as overweight or obese are provided with appropriate support and advice and referred to the Health4Life Child Weight Management Service. This is run by CLCH and provides a family-based approach covering nutrition and physical activity. Children are followed up and referred to this service.

The Family Weight Management Service is also available for children aged 2–5 years (pre-school) with weight more than 2 centiles above height centile (using the UK-WHO: 0–4 Growth Charts in the Red Book); and women who have given birth in the previous 2 years who are obese (BMI ≥30), also run by CLCH as part of the 0–19 service.

Richmond is also part of the Healthy Early Years London (HEYL) Award Scheme. It is funded by the Mayor of London for all Early Years settings and child minders. It supports and recognizes achievements in child health, well-being, and development in early years settings. The HEYL Award builds on from the success of Healthy Schools London and compliments the statutory Early Years Foundation Stage Framework adding to the focus on children, families and staff health and well-being. The award is focused on a whole setting approach by involving children, parents, and the local community to create a healthy learning environment across 12 themes which are:

- Healthy eating
- Breastfeeding and starting solid foods
- Oral health
- Physical activity
- Physical development
- Reducing sedentary behaviour

[69] Richmond has seen an overall improvement in 6–8 weeks prevalence rates between 2018 to 2019 from 26% in Q1 to 79% in Q4 . The overall total for the year is 56% which is higher than the England average

[70] PHE. Everybody active, every day: framework for physical activity. 2019.

- Speech language and communication
- Early cognitive development
- Social and emotional well-being
- Parenting and home learning
- Home safety
- Accident prevention & reducing injuries.

There are 4 levels of the HEYL award: First Steps, Bronze, Silver and Gold. At present 57 settings have registered, 41 settings are on First Steps, 5 settings have achieved Bronze, 1 setting has achieved Silver and no school is yet on Gold.

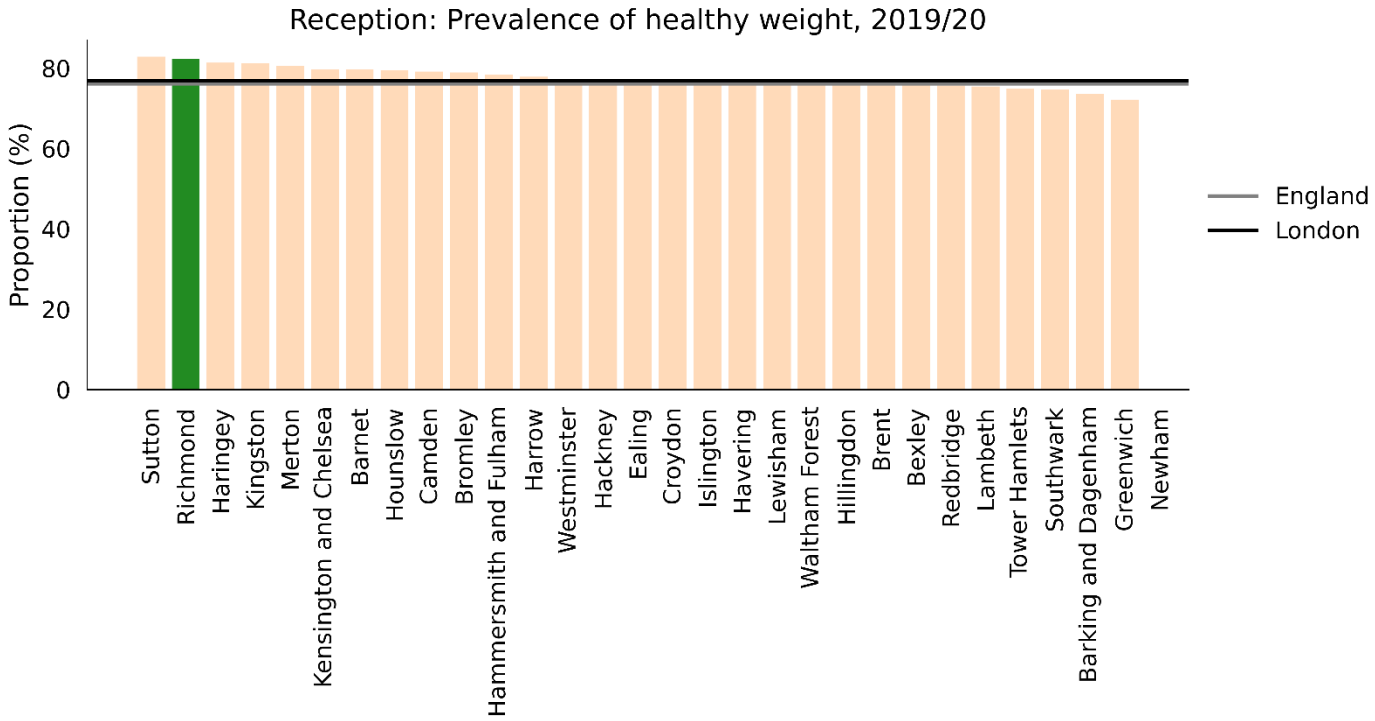
- Daily mile: offer support to all primary schools to deliver the Daily Mile, a 15-minute intervention of physical activity.
- Fast food exclusion zones: schools have a 400m exclusion zone around them to limit to 4 existing A5 licences (this covers take-aways). Please note this can only apply to new premises and not existing premises.
- Healthy Start**:** pregnant women and women with children up to 5 years old on certain benefits can get free milk, fruit and vegetables, and vitamins with Healthy Start vouchers. Currently, only 51% of eligible families in Richmond take up this offer.

There is local recognition that the impact of the response to COVID-19 further restricted children and young people's level of physical activity, both in the respect of lockdown and due to the closure of schools, and disproportionately affecting those already disadvantaged. While Child Weight Management services are run by the School Health Services in Richmond there is acknowledgment that further support is required to increase physical activity for targeted groups least likely to access extra-curricular sporting activities. Public health is currently planning to conduct a validated Health and Related Behaviour Survey across all schools. This will gather comparative data in respect of physical activity and inform multi-agency partnership responses.

9.6 Healthy Weight

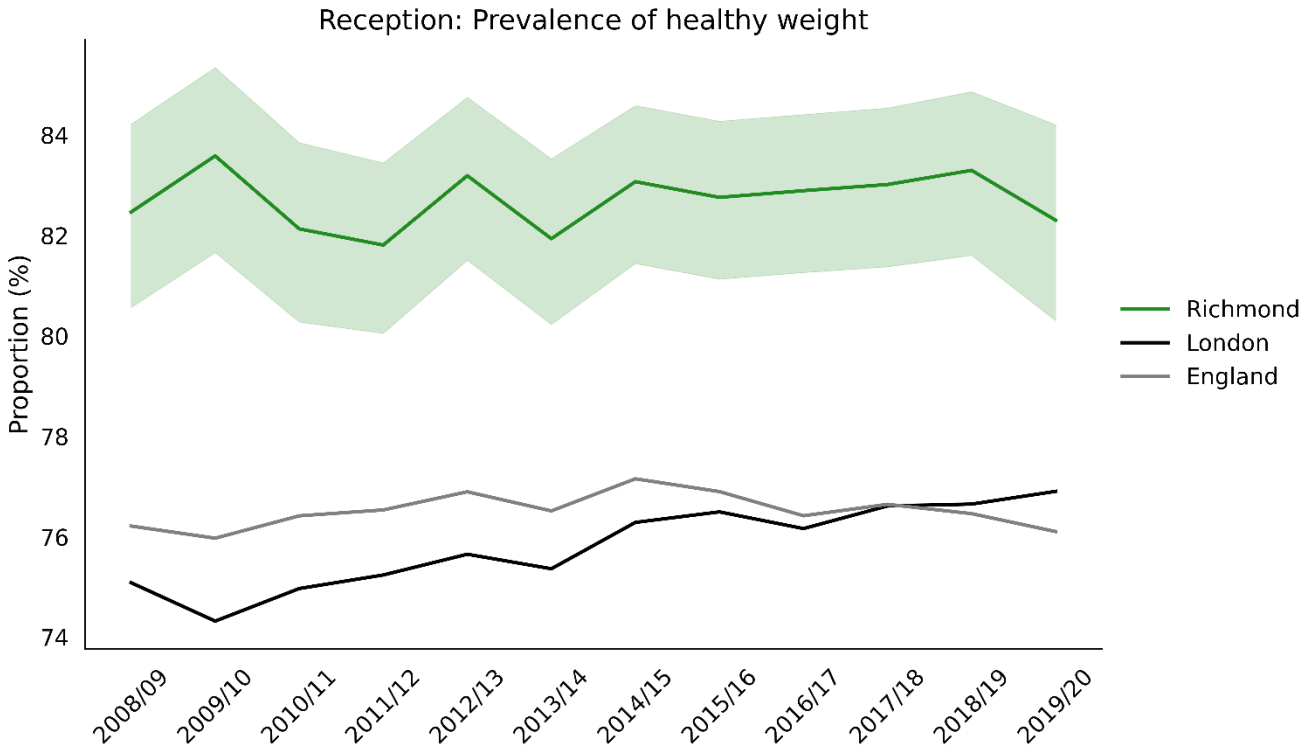
The percentage of Richmond's Reception Year children that are a healthy weight has remained relatively stable in the last decade. In 2019/20 Richmond's rate was 82.3 per 100, the 2nd highest in London **(Figure 70**), which was 8.1% higher than the England average and 7.0% higher than the London average. The latest Borough figure was also 0.2% lower from year 2008/09, in comparison with a 0.1% decrease in England's rate in the equivalent time period (**Figure 71**).

Figure 70: Prevalence of Healthy Weight in Reception Year Children by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

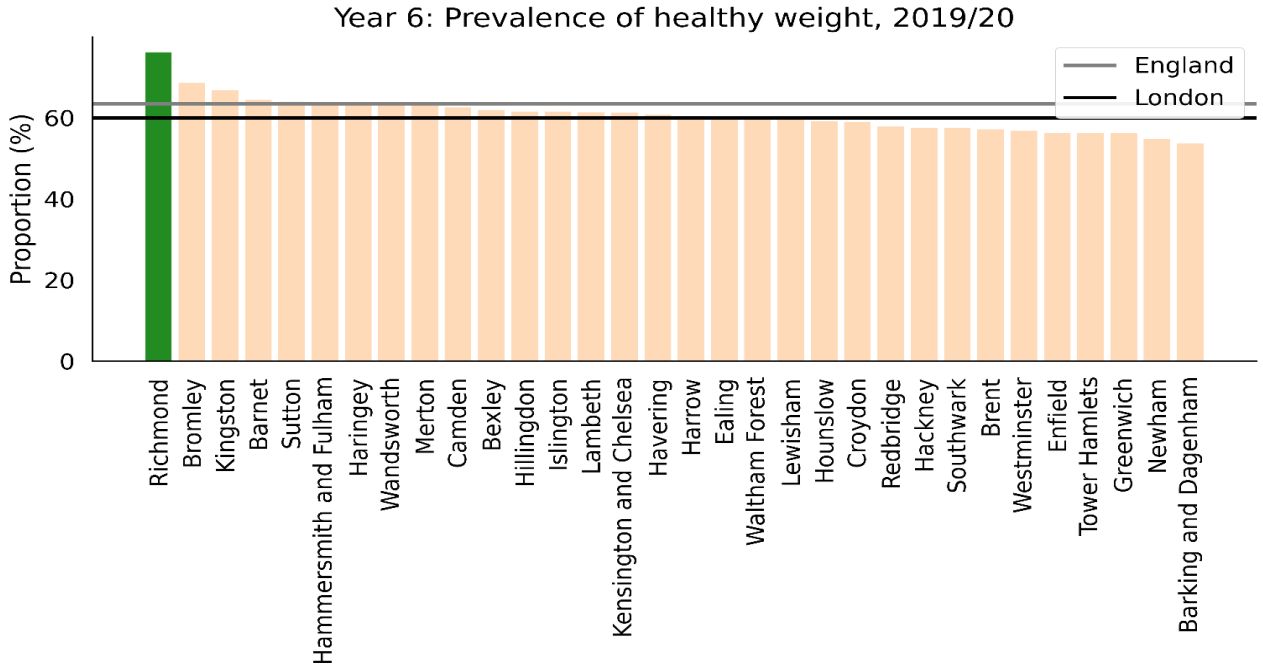
Figure 71: Prevalence of Healthy Weight in Reception Year Children, 2006–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

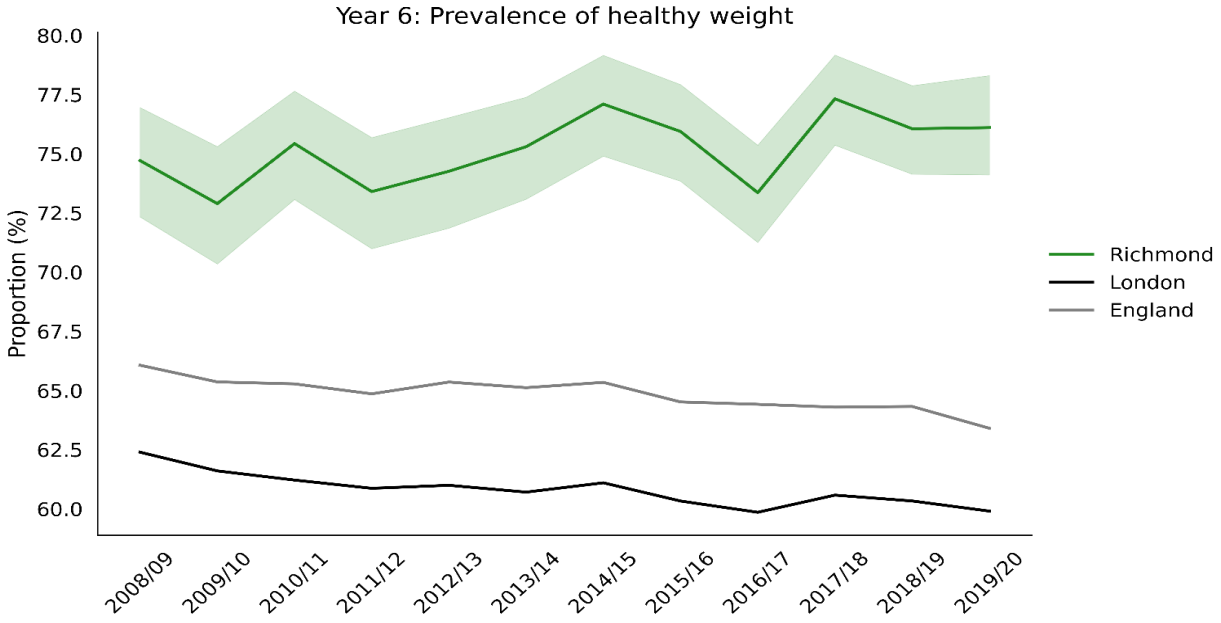
In 2019/20, Richmond's percentage of healthy weight children in Year 6 was 76.1%, the highest in London (**Figure 72**), which was 20.0% higher than the England average and 27.0% higher than the London average. The latest Borough figure was also 1.9% higher from year 2008/09, in comparison with a 4.0% decrease in England's rate in the equivalent time period (**Figure 73**).

Figure 72: Prevalence of Healthy Weight in Year 6 Children by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Figure 73: Prevalence of Healthy Weight in Year 6 Children, 2006–2020

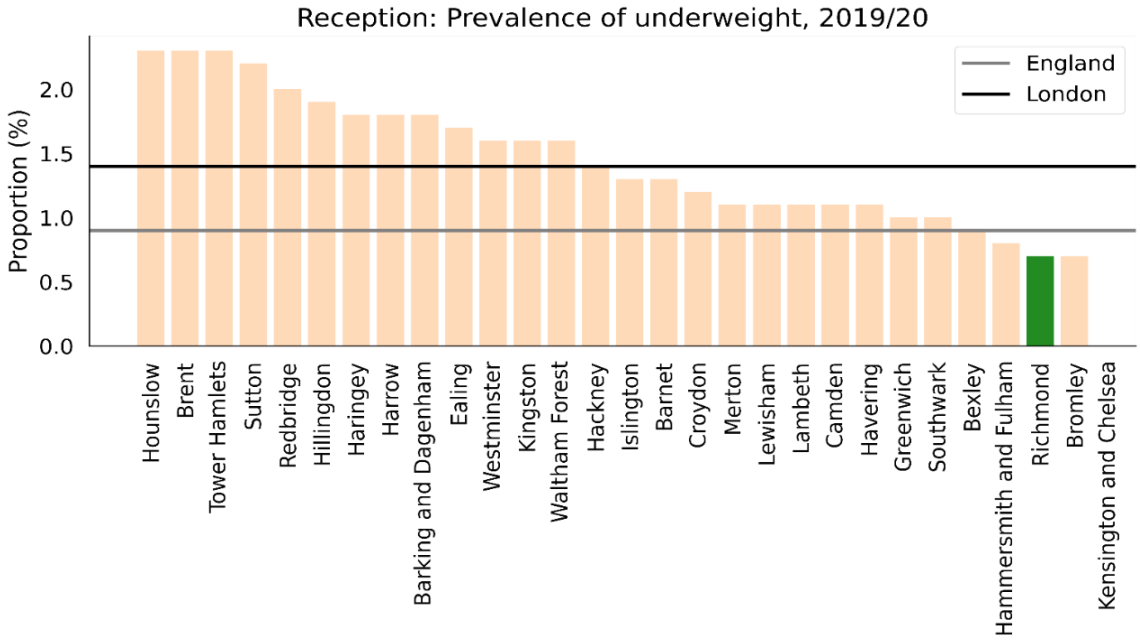


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

9.6 Underweight Children

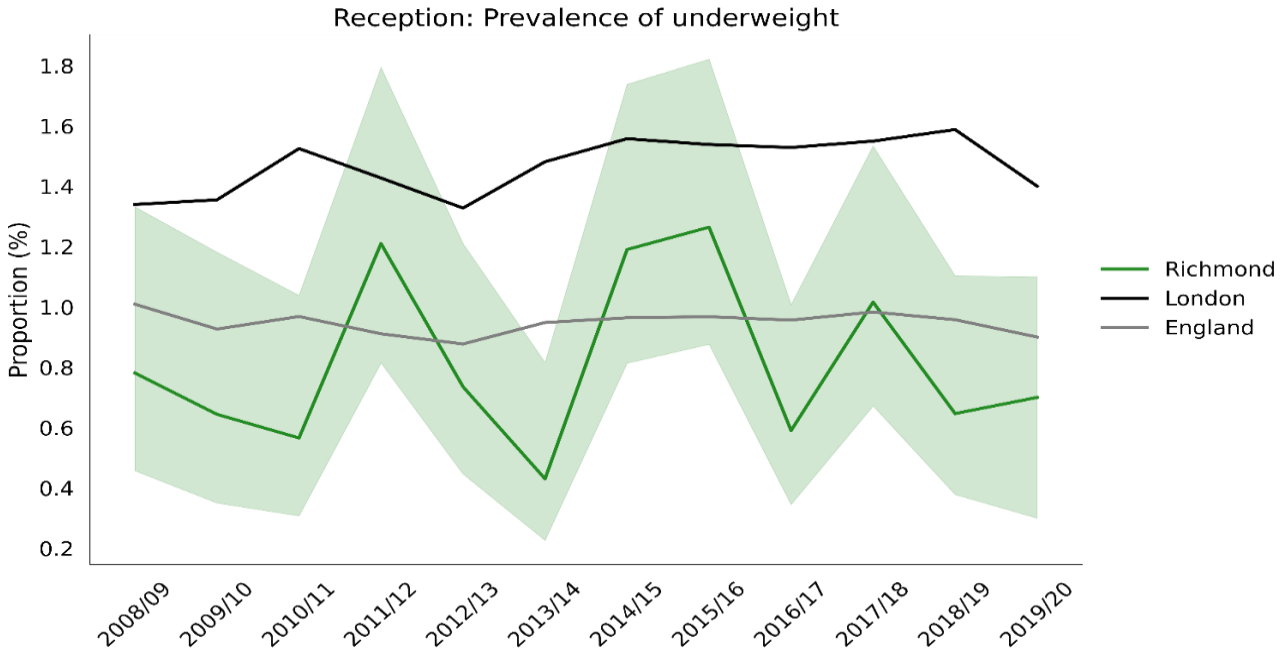
Richmond's prevalence of underweight in 2019/20 (BMI less than 2nd centile of the UK90 growth reference) among children in Reception Year was 0.7%. This is lower than both the London and England averages and the 3rd lowest in London (**Figure 74**). The latest Borough figure was also 10.3% lower from year 2008/09, in comparison with a 10.8% decrease in England's rate in the equivalent time period (**Figure 75**).

Figure 74: Prevalence of Underweight in Reception Year by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

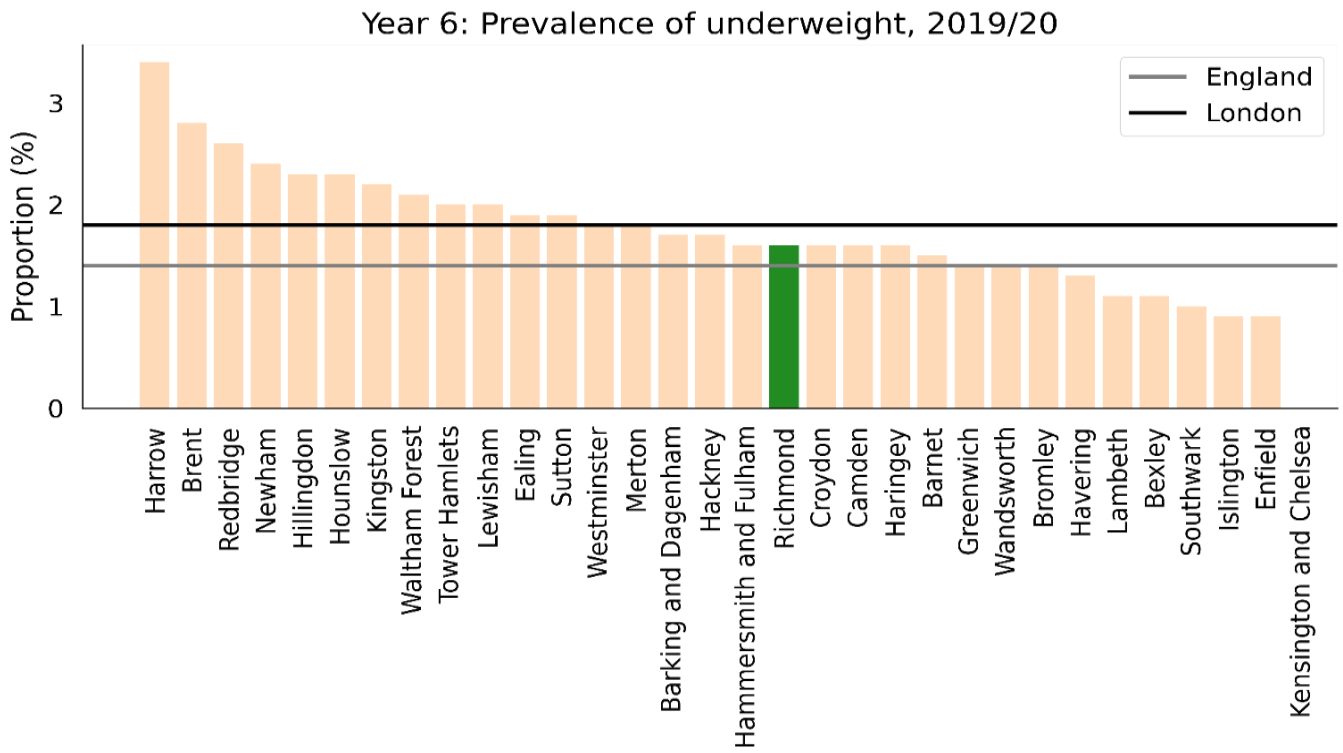
Figure 75: Prevalence of Underweight in Reception, 2006–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

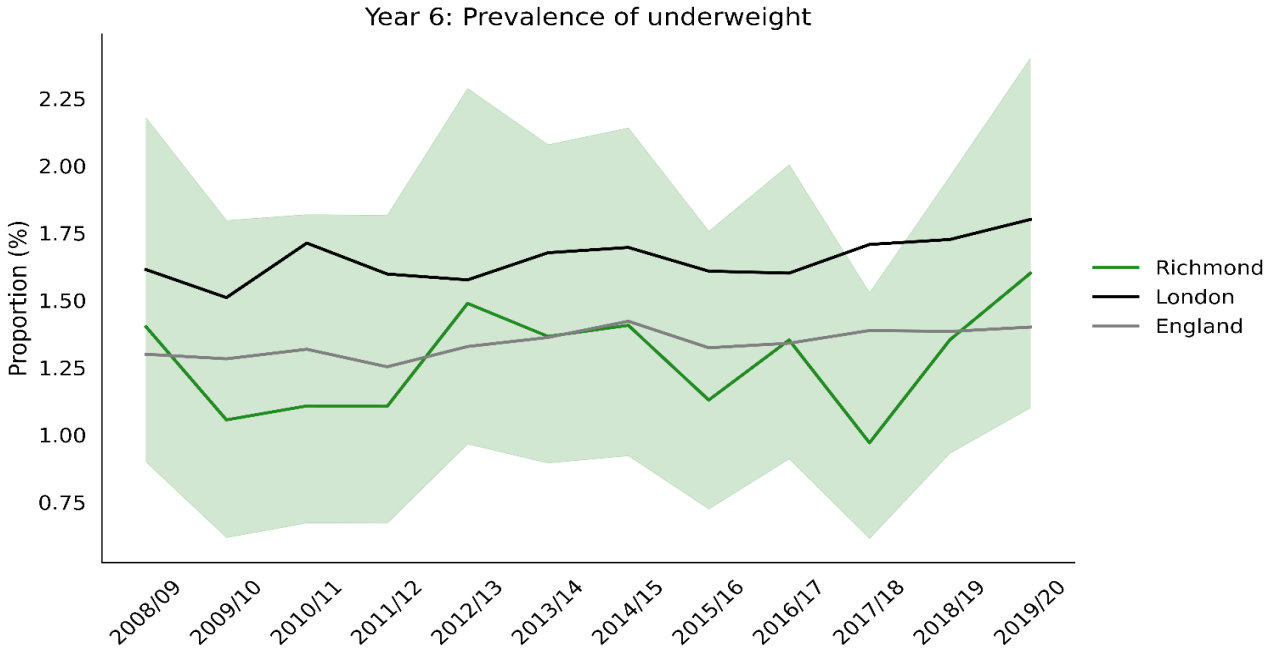
In 2019/20 there were 25 Year 6 pupils in Richmond that were classified as underweight which is 1.6% and the 15th lowest in London (**Figure 76**). This is higher than the England average but lower than the London average. The latest Borough figure was also 14.2% higher from year 2008/09, in comparison with a 7.8% increase in England's rate in the equivalent time period (**Figure 77**).

Figure 76: Prevalence of Underweight in Year 6 by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Figure 77: Prevalence of Underweight in Year 6, 2006–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

Eating disorders

The data in **Table 8** below have been obtained from the North East London Commissioning Support Unit. They show the number of child eating disorder contacts at CAMHS for the months of April to July 2021/22.

Table 8: CAMHS child eating disorder contacts in England, Apr-Jul 2021

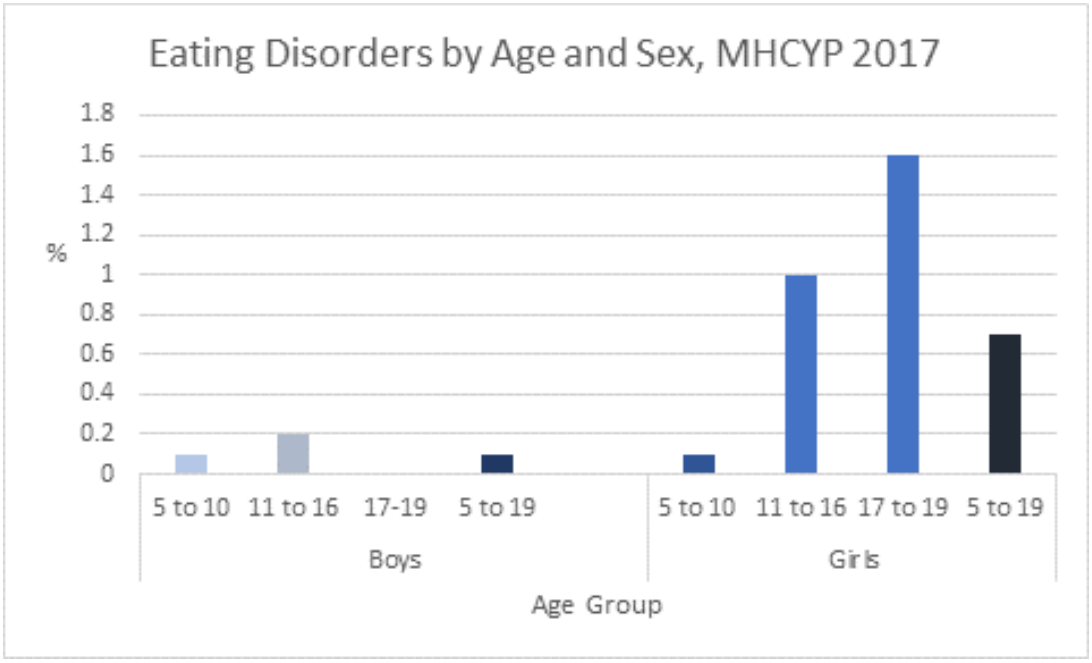
Service Line	April	May	June	July	Activity Total
Child ED contacts	150	164	178	167	659
CAMHS Activity Total	**1,029**	**1,116**	**1,127**	**1,029**	**4,301**

Source: North East London Commissioning Support Unit. 2021.

Currently, there are no available data to fully explore the impact of eating disorders on Richmond's children and young people.

Data reported in (**Figure 78)** are taken from the most recent national study carried out by NHS Digital. The 2017 Mental Health in Children and Young People Survey identified that 0.4% of 5-19 year olds surveyed had an eating disorder[71]. The figure below shows that they were more common in girls (0.7%) than boys (0.1%); and in older age groups than younger ones (0.1% of 5-10 year olds; 0.6% of 11-16 year olds; 0.8% of 17-19 year olds). Rates of eating disorder were higher in girls aged 17-19 year olds (1.6%) than in other demographic groups. While the pattern of association between presence of eating disorder and age group looks different between girls and boys, this was not statistically significant.

Figure 78: Child eating disorders by age and sex, 2017



Source: NHS Digital. Mental Health in Children and Young People Survey. 2017

This survey confirms an expected profile for eating disorders that while it can affect boys, it is primarily a disorder experienced by girls. The findings also confirm the established pattern that vulnerability to eating disorder increases with age. The survey found a prevalence of 1 in 60 girls aged 17 to 19 years old equivalent to one case in every two classes. However, eating disorders in younger girls aged 11-16 years old were evident in 1 in 100. These figures

[71] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

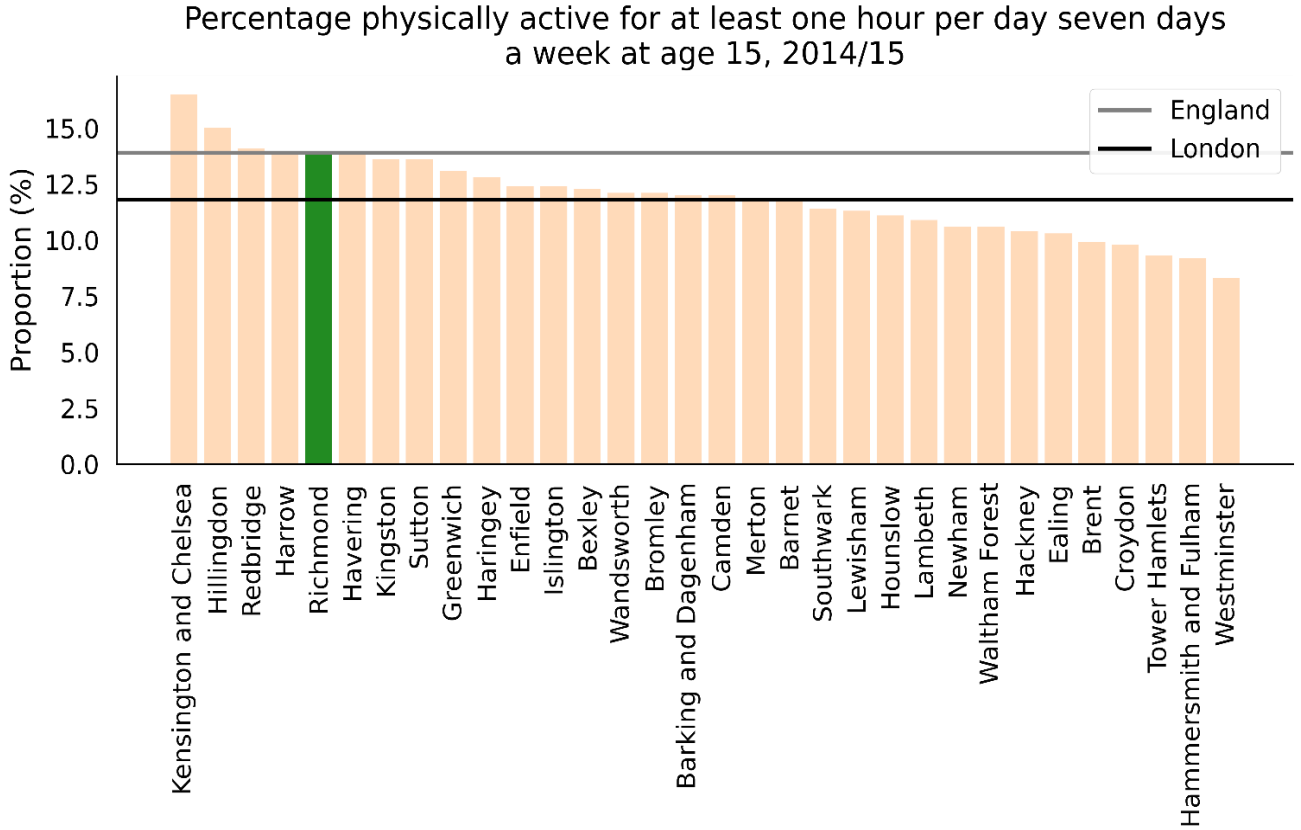
should be viewed as estimates, due to the few positive cases identified in the sample. They should be considered underestimates.

Public Health is conducting a comprehensive Mental Health Needs Assessment (MHNA) in 2021/2022. This needs assessment will incorporate an in-depth review of the latest data available to identify the estimated prevalence of mental disorder in Richmond and includes eating disorders. The MHNA will use the NHS Digital national study Mental Health in Children and Young People 2017 (MHCYP, 2017) to estimate the number of girls and boys that we would expect to have an eating disorder. The MHNA will also examine service demand and utilisation for a more complete picture of need.

9.7 Physical Activity

The data on physical activity in children and young people in Richmond is scarce. The latest available data comes from the What About YOUth (WAY) Survey that took place in 2014/15[72]. The percentage of physically active young people aged 15 years was 13.9%, which is identical to the England average (13.9%) but lower than the London average of 11.8%. Richmond's percentage was 4th highest in London (**Figure 79**). Unfortunately, no time trend data is available for this indicator.

Figure 79: Young People Aged 15 that are Physically Active for at Least 1 hour per Day by Local Authority, 2014/15



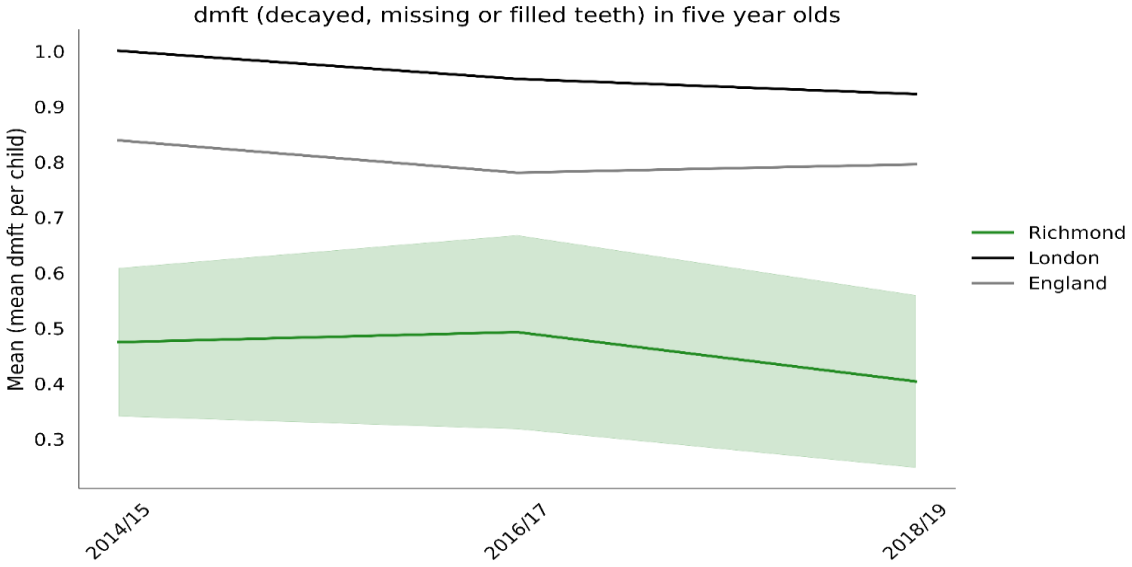
Source: PHE [Public Health Outcomes Framework](#)

[72] There is more recent physical activity survey data published in 2020 by PHE and Sport England: Active Lives Children and Young People Survey but the data for Richmond (and for 10 other London Boroughs) are not available

10. Oral and Dental Health (Cavities)

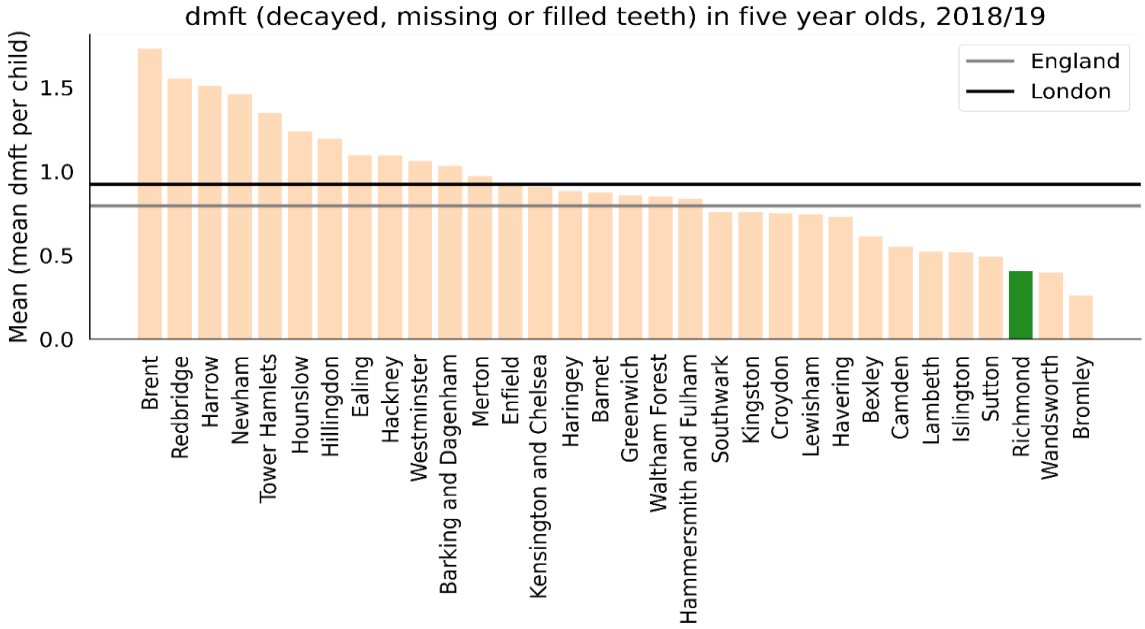
In 2018/19, the mean number of decayed, missing or filled teeth (DMFT) in 5-year olds in Richmond was 0.4. Tooth decay has become less common over the past two decades and levels in Richmond are now significantly lower than both the London, 0.92 and England 0.8 averages. The indicator is a good direct measure of dental health and an indirect, proxy measure of child health and diet. Dental disease is more common in deprived communities than those that are more affluent. The latest Borough figure was 52.3% lower from year 2014/15, in comparison with a 5.2% decrease in England's DMFT average in the equivalent time period (**Figure 80**). Richmond's 2018/19 DMFT average number is the 3rd lowest in London (**Figure 81**).

Figure 80: Mean Number of Decayed, Missing or Filled Teeth in 5-Year-Old Children, 2014–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

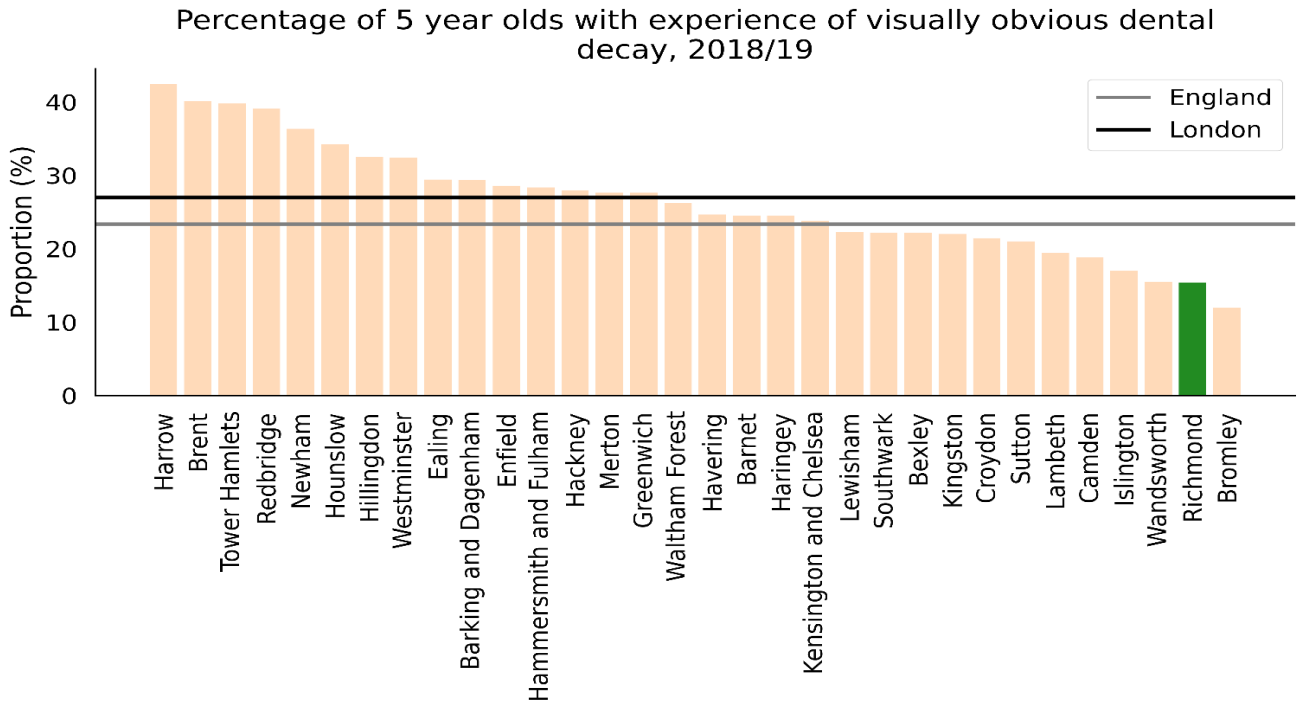
Figure 81: Mean number of decayed, missing or filled teeth in 5-year-old children by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

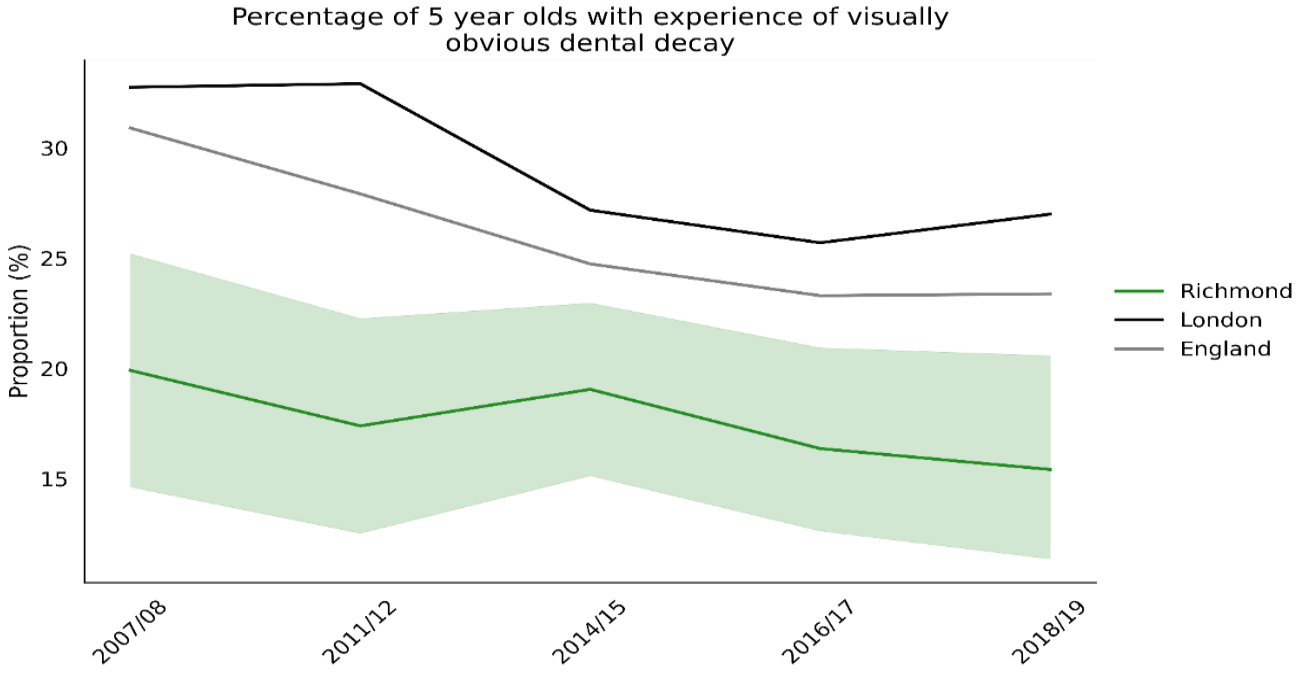
In 2018/19 Richmond's percentage of children aged 5 years with visually obvious dental decay was 15.4%, the 2nd lowest in London (**Figure 82**) and significantly lower than both the England and London averages. The latest Borough figure was also 22.6% lower from year 2007/08, in comparison with a 24.3% decrease in England's rate in the equivalent time period (**Figure 83**).

Figure 82: Children Aged 5 with Visually Obvious Dental Decay by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework

Figure 83: Children Aged 5 with Visually Obvious Dental Decay, 2007/08 and 2011–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

11.School aged Children with Significant Social, Emotional and Mental Health Needs

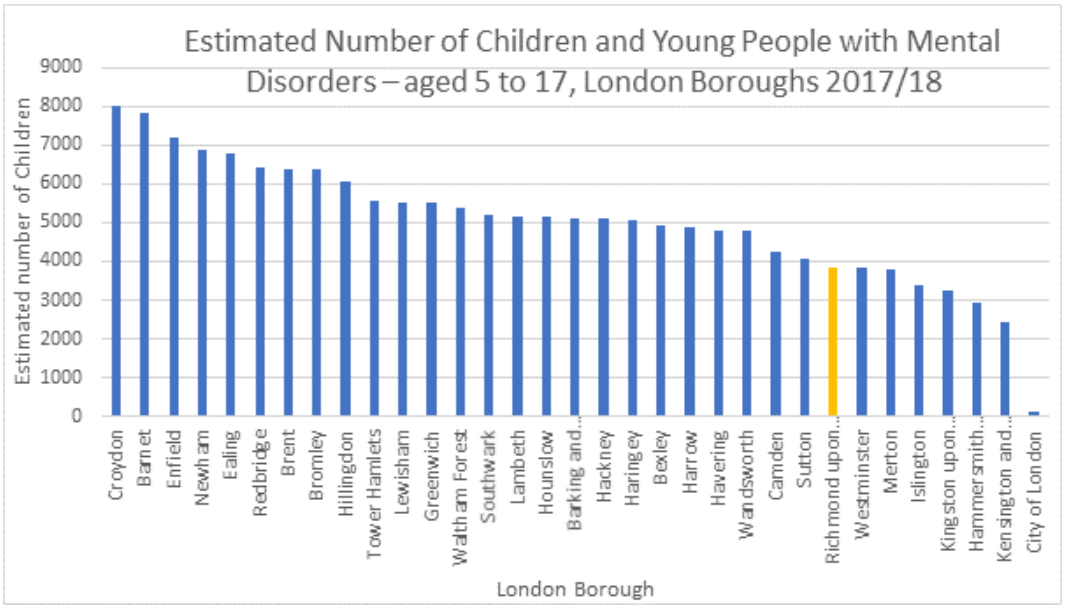
The percentage of all school pupils with social, emotional and mental health needs in Richmond is 1.91% which is significantly lower than both the London and England Levels at 2.41% and 2.39% respectively[73]. This masks the disparity in outcomes and the challenges felt by secondary school aged pupils in Richmond with the percentage of secondary school aged pupils with social, emotional and mental health needs rising to 2.67% and is significantly higher than levels seen across England.

School aged Children with Significant Social, Emotional and Mental Health Needs is an indicator from PHE Public Health Profiles. The data represents the number of school children with Special Education Needs (SEN) who are identified as having social, emotional and mental health as the primary type of need, expressed as a percentage of all school pupils.

The most recent data available using the Mental Health in Children and Young People Survey 2017 identifies an estimated 3,849 children and young people in aged 5-17 years with a mental disorder. This includes emotional disorders, behavioural disorders, hyperactivity disorders, and autism spectrum, eating and other less common disorders.

Figure 84 below provide a comparison across the 32 London Boroughs of estimated number of children and young people with mental disorders in Richmond.

Figure 84: Estimated number of children and young people with mental disorders by local authority, 2017/18



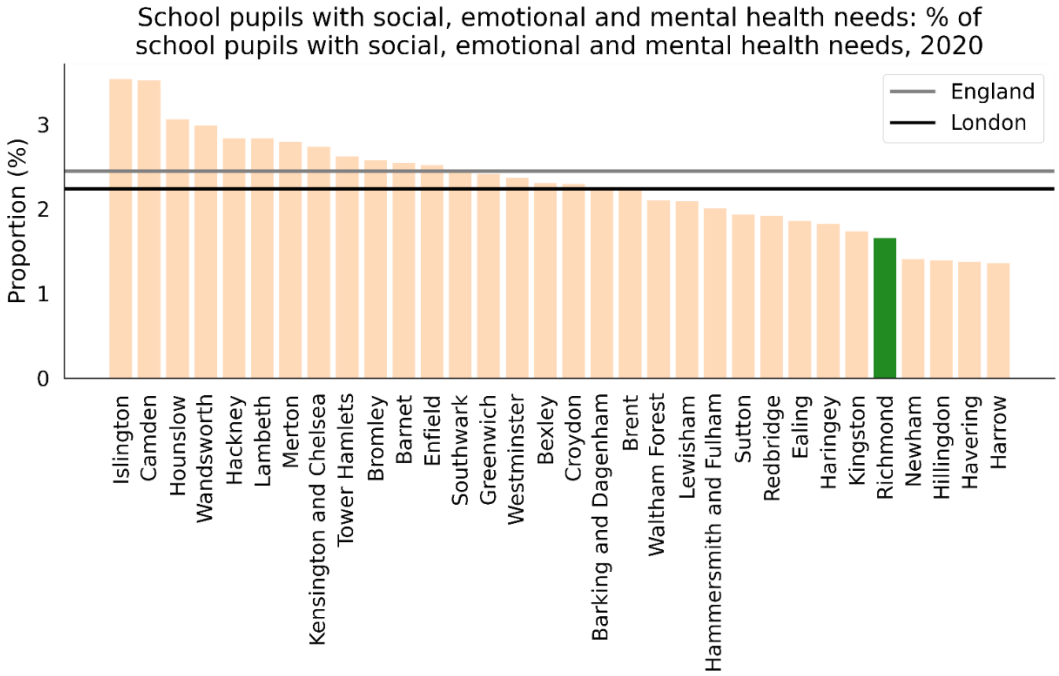
Source: Mental Health in Children and Young People Survey 2017

[73] Department for Education. SEN statistics. 2020.

11.1 Primary School Children

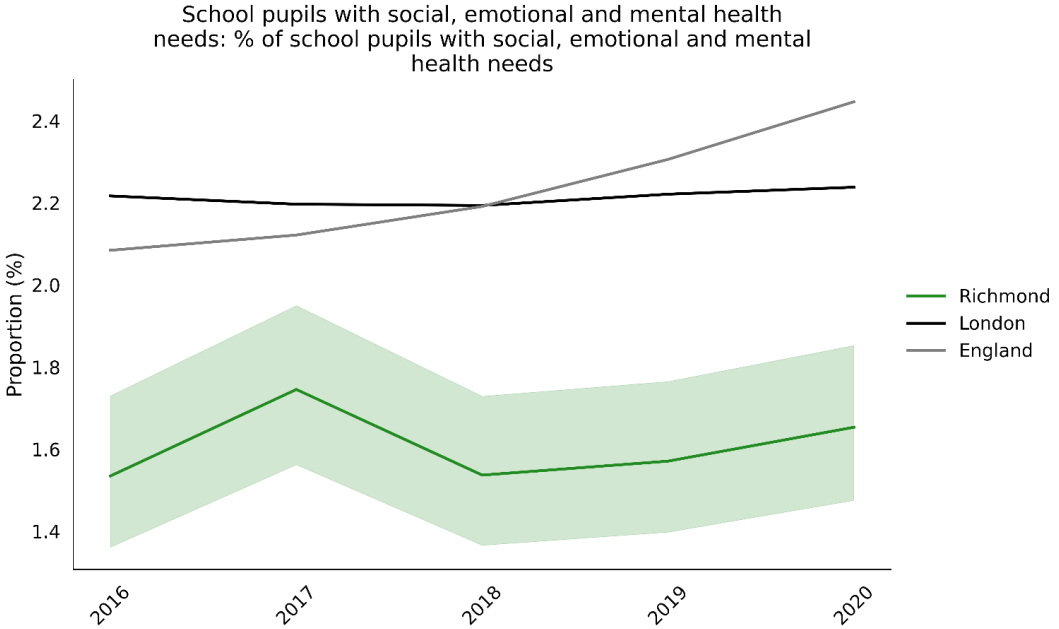
In 2018, 1.7% of Richmond's Primary School children were identified as having social, emotional and mental health needs, the 5th lowest percentage in London (**Figure 85**). This is significantly lower value than both the England and London averages. The latest Borough figure was also 7.7% higher from the year, 2016, in comparison with a 17.4% increase in England's rate in the equivalent time period (**Figure 86**).

Figure 85: Primary School Children Identified as Having Emotional, Social and Mental Health Needs by Local Authority, 2018



Source: PHE Public Health Outcomes Framework

Figure 86: Primary School Children Identified as Having Emotional, Social and Mental Health Needs, 2016–2018



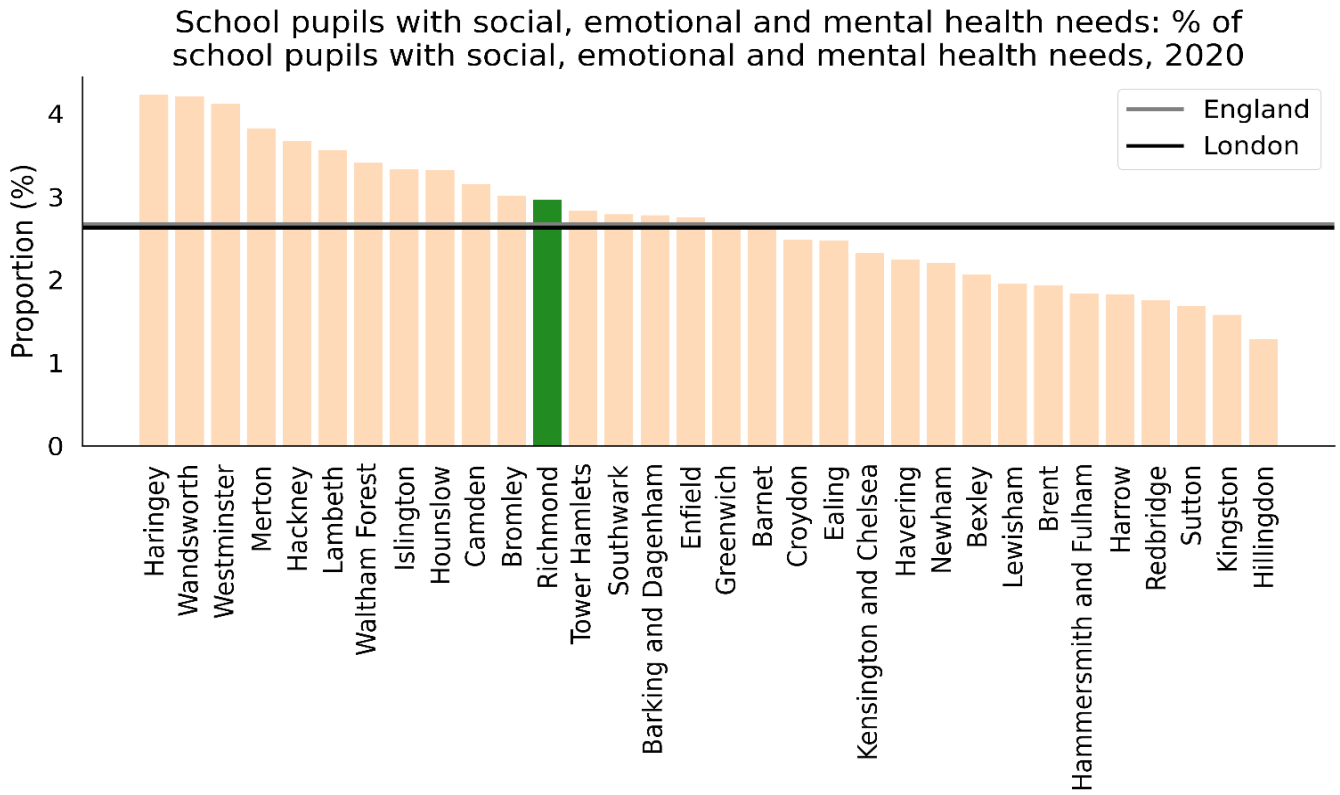
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

11.2 Secondary School Children

In 2020 Richmond had 3.0 per 100 secondary school pupils with substantial emotional, social and mental health needs and was the 12th highest in London (**Figure 87**). This is 11.1% higher than the England average and 12.8% higher than the London average. The latest Borough figure was also 17.1% lower from the year, 2016, in comparison with a 13.2% increase in England's rate in the equivalent time period. The Borough's percentage of children with mental health needs in secondary schools was also 43% higher than in the primary schools; the equivalent figure for England was just 16%. The Borough figures have started to increase since 2018 (**Figure 88**).

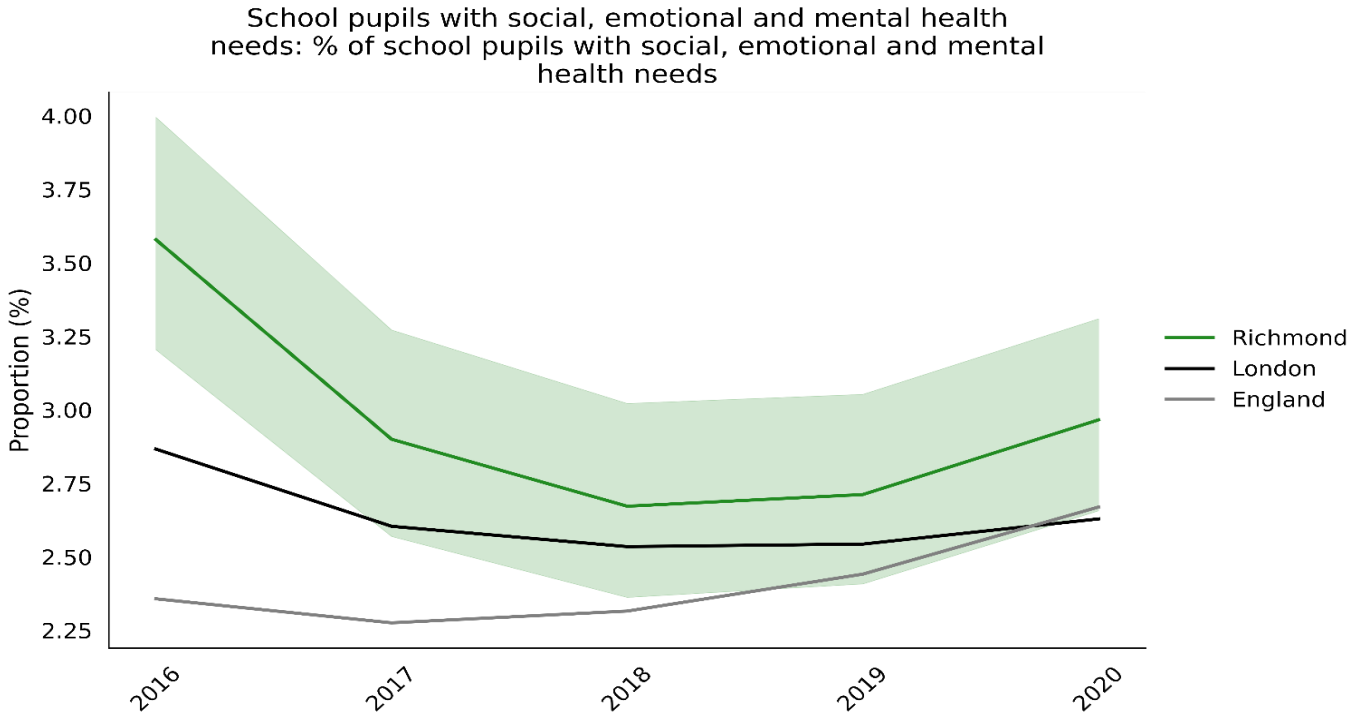
Looking at presentations to accident and emergency, 125 children and young people attended Accident and Emergency requiring a Mental Health Assessment in 2017/18. This was up from 19 children and young people in 2015/16. Of the 125 children, 71 (57%) were aged 11–15 years and 88 (70%) were female.

Figure 87: Secondary School Children Identified as Having Emotional, Social and Mental Health Needs by Local Authority, 2020



Source: PHE Public Health Outcomes Framework

Figure 88: Secondary School Children Identified as Having Emotional, Social and Mental Health Needs, 2016–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

11.3 Types of Services

There is an estimated 2008 children and young people in Richmond with a mental health disorder (**Table 9**).

Table 9: Mental Health of Children and Young People, Prevalence Estimates for Richmond

	% of population aged 5–16	Estimated total
Estimated prevalence of mental health disorders in children and young people	7.0%	2,008
Estimated prevalence of emotional disorders	2.8%	797
Estimated prevalence of conduct disorders	4.0%	1,136
Estimated prevalence of hyperkinetic disorders	1.1%	305

Source: Children and Young People Needs Assessment (CYPNA)

Support for children with mental health concerns is offered through a Tiered Service:

- Tier 1 includes prevention via schools and GPs
- Tier 2 includes counselling through Early Help Services and Community Organisations
- Tier 3 includes Specialist Children and Adolescent Mental Health Services (CAMHS)
- Tier 4 includes specialised day and inpatient units.

Tier 2 & Tier 3: Emotional and Mental Health Referrals

- In 2017/18 1,697 children and young people were referred to Mental Health Services
- In 2017/18 649 referrals were made to the Borough's Tier 2 Emotional Health Service, with an 8 week wait from referral to assessment and 15 week wait from assessment to treatment
- Of these, 532 were Tier 3 CAMHS referrals to the South West London St George's Mental Health NHS Trust, an increase from 426 in 2016/17
- Waiting times from referral to assessment were 5.7 weeks and from assessment to treatment 5.3 weeks. In 2017/18 there were 241 young people in treatment in CAMHS
- 49.8% of those referred to the Tier 3 Service were aged 11–15 in 2017/18. In 2017/8 a further 516 referrals were made to other Mental Health Services (Relate/Off the Record).

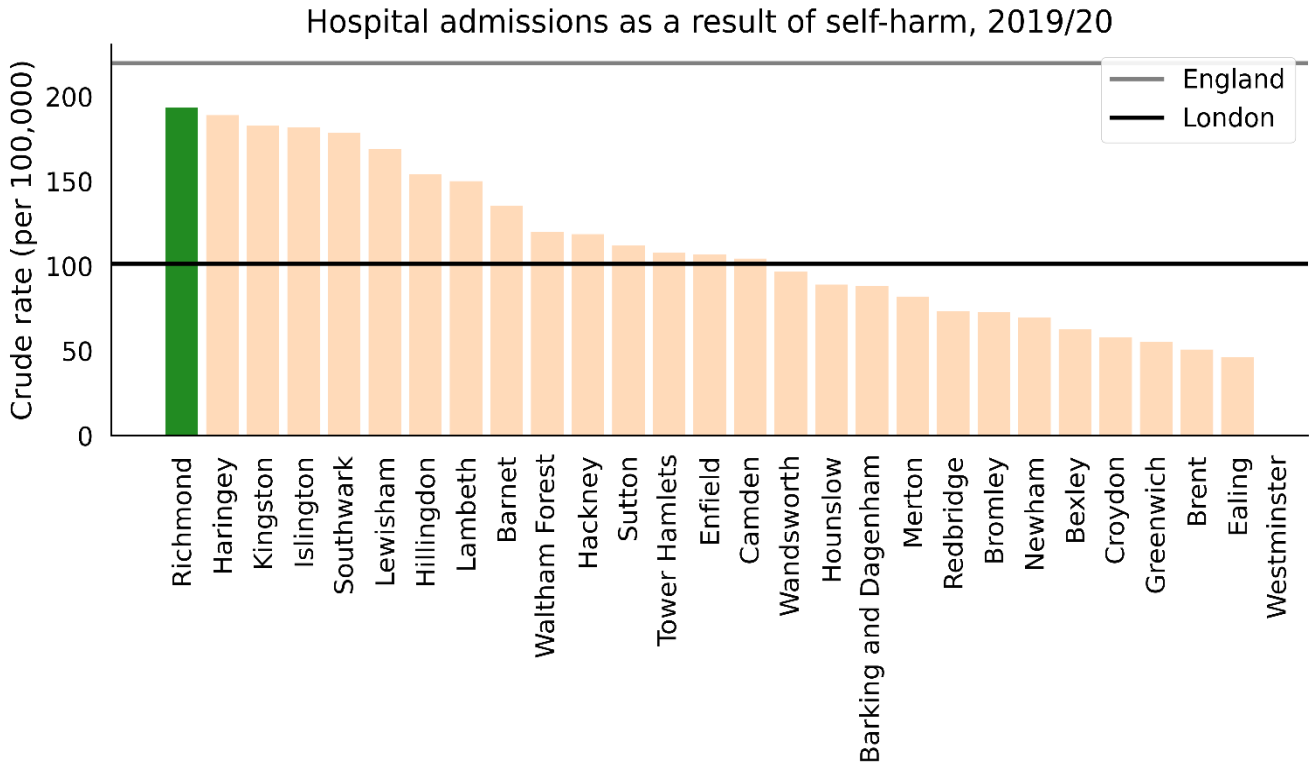
Tier 4: Hospital Admissions

44 young people were in treatment for eating disorders in 2017/8, which has been a steady trend since 2015/6. 95% of those in treatment were female, while 71% were between 11–15 years of age.

11.4 Hospitalisations for Self-Harm in Children and Young People

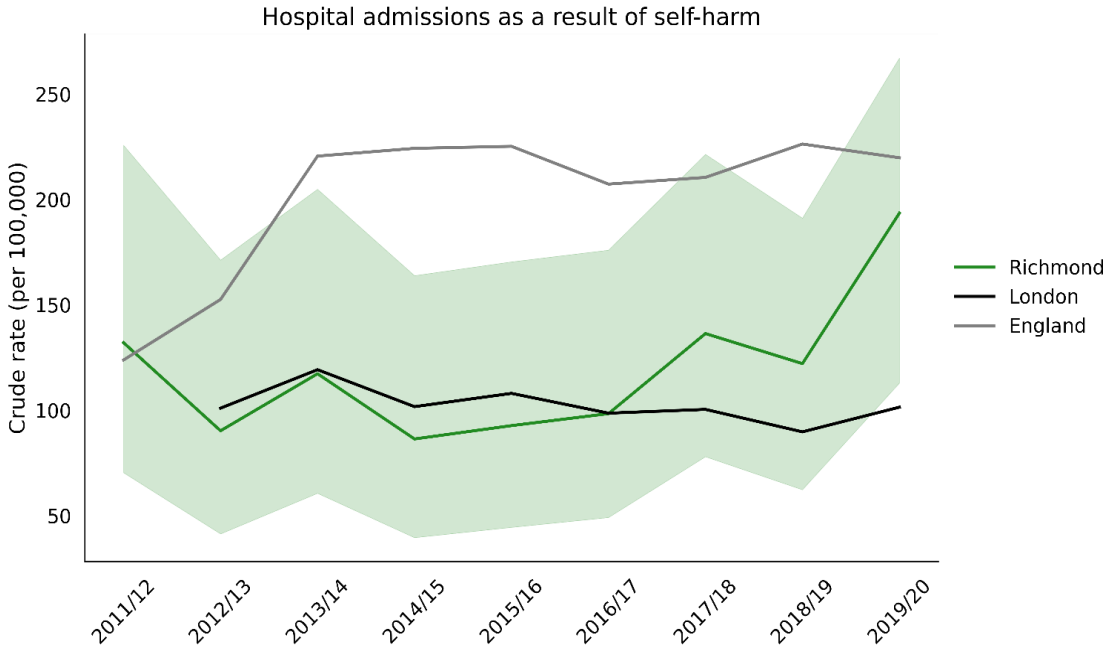
In 2018/19 Richmond's rate of hospital admissions for self-harm in children aged 10-14 years was 193.5 per 100,000 and the highest rate in London (**Figure 89**). This is 12.0% lower than the England average and 90.8% higher than the London average. For the last 4 years the rate for the Borough is increasing. For the first time the annual rate is significantly higher than the London average (**Figure 90**).

Figure 89: Hospitalisations as a Result of Self-harm in Children Aged 10–14 by Local Authority, 2019/20



Source: PHE [Public Health Outcomes Framework]

Figure 90: Hospitalisations as a result of Self-Harm in Children Aged 10–14, 2011–2020

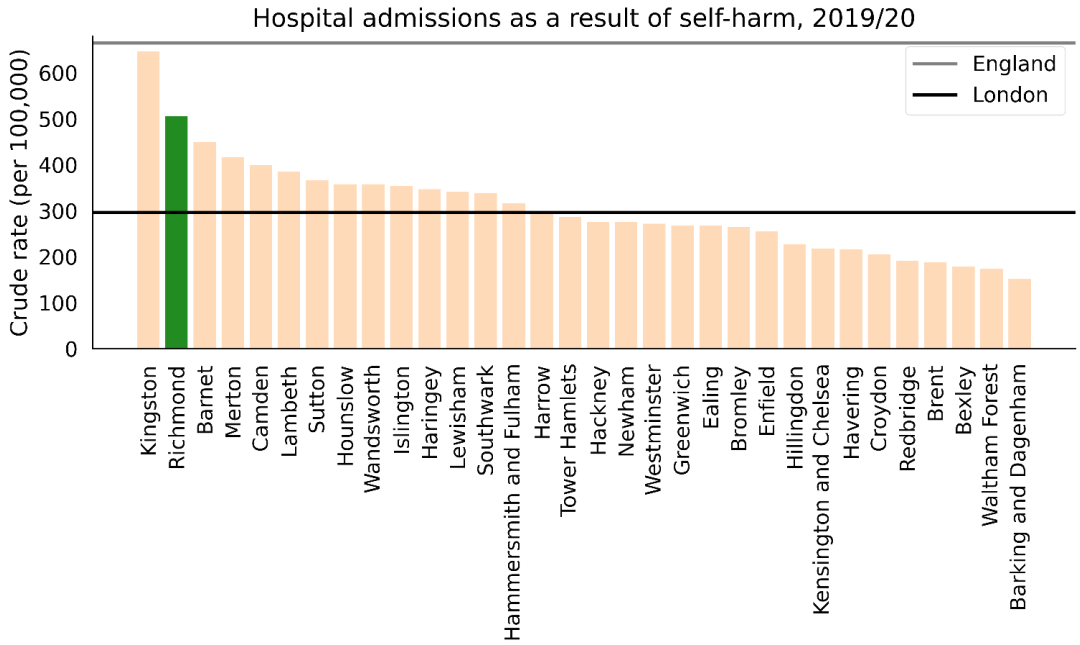


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

11.5 Hospital Admissions for Self-Harm in Teenagers

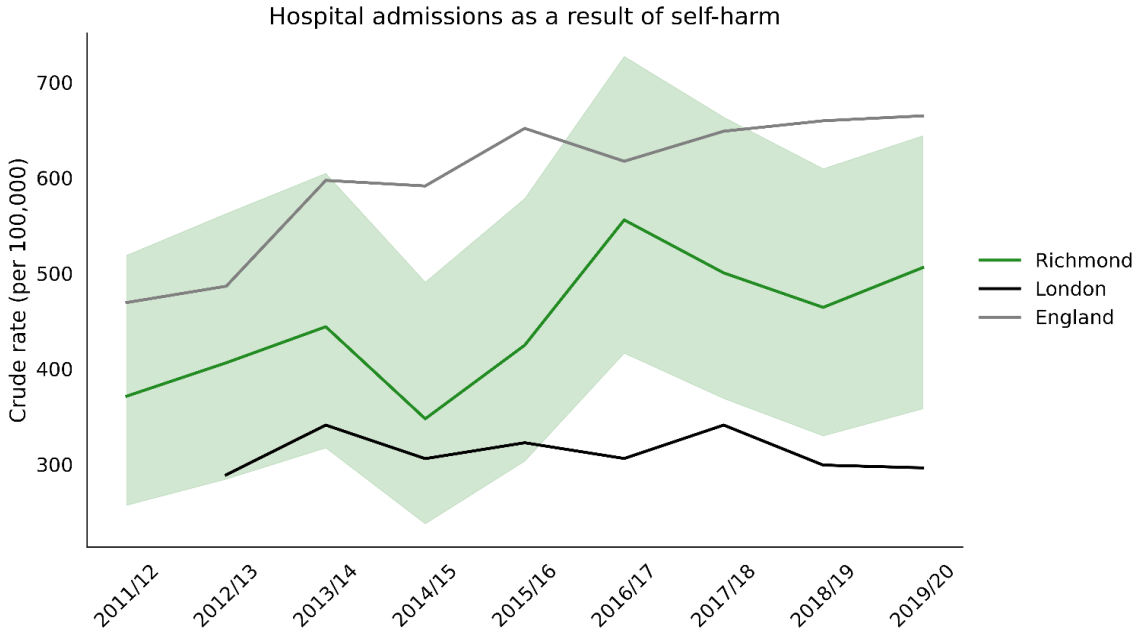
In 2018/19 Richmond's rate of hospital admissions for self-harm in teenagers aged 15–19 years was 505.8 per 100,000 the 2nd highest rate in London (**Figure 91**), second only to Richmond's neighbouring Borough of Kingston, whose Children's Services are also provided by Achieving for Children. This is 23.9% lower than the England average and 70.8% higher than the London average. The latest Borough figure was also 36.2% higher from year 2011/12, in comparison with a 41.6% increase in England's rate in the equivalent time period (**Figure 92**).

Figure 91: Hospitalisations as a Result of Self-Harm in Young People Aged 15–19 by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Figure 92: Hospitalisations as a Result of Self-Harm in Young People Aged 15–19 , 2011–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

12. Risky Behaviours

Adolescence is a critical time. It is a period when life-long behaviours are set, long term conditions emerge, and risk-taking behaviours begin including sexual activity and experimentation with alcohol and drugs.

Nationally, recent trends have seen improvements in some areas of adolescent health including young people's health risk-taking behaviour[74]. Young people's rates of smoking, alcohol consumption and teenage pregnancy rates have been on the decline over the past decade.

National evidence demonstrates that young people's substance misuse is a causal factor of and contributor to a wide range of other serious problems experienced by adolescents and young adults. Substance misuse can both exacerbate and be a consequence of failing or falling behind in school, involvement in crime and anti-social behaviour, and becoming a victim of crime. Alcohol and substance misuse can contribute to teenage pregnancy and sexually transmitted infections[75]. Substance misuse is also a response to or a causal factor of mental health problems, a contributing factor to missing from home episodes, and is strongly linked to the exploitation of young people such as through county lines and/or CSE[76]. Furthermore, it can exacerbate problems relating to employment, housing and family life.

[74] Hagell A and Shah R (2019) Key Data on Young People 2019. London: Association for Young People's Health.
[75] Alcohol consumption leads to an increased likelihood of sex at a younger age, a greater number of sexual partners and more regretted or coerced sex (Bellis M et al, 2009)
[76] Alcohol also increases the risk of sexual aggression, sexual violence and sexual victimisation of women.

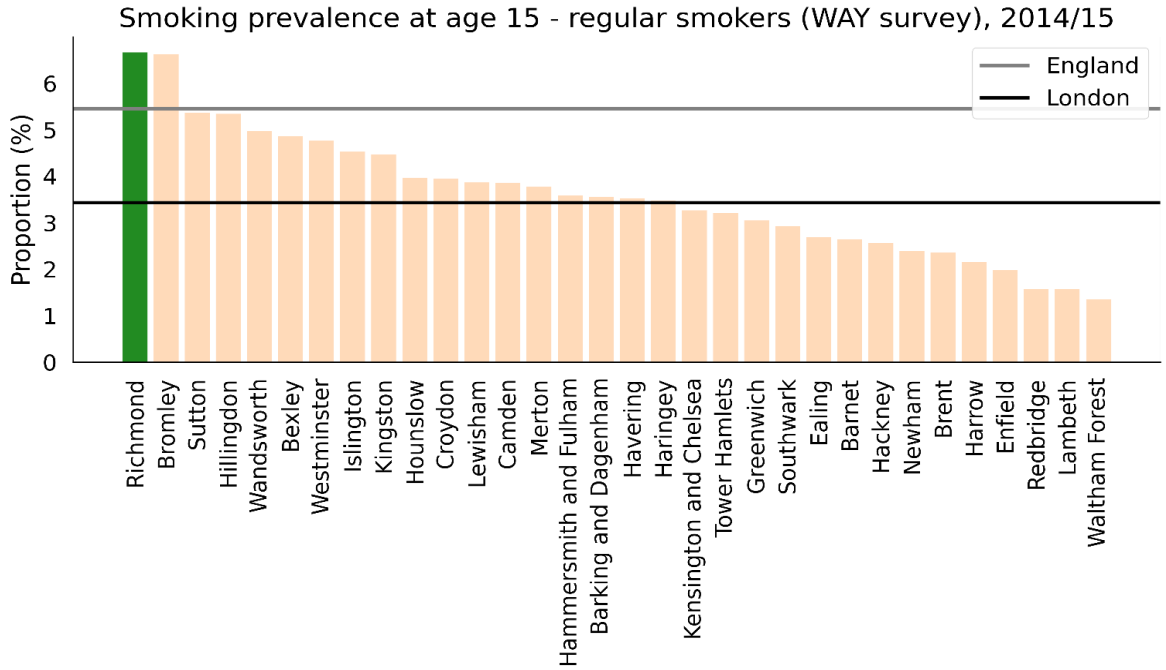
Nationally, recent trends have seen improvements in some areas of adolescent health including young people's health risk-taking behaviour[77]. Young people's rates of smoking, alcohol consumptions and teenage pregnancy rates have been on the decline over the past decade.

12.1 Smoking

According to the WAY Survey (2014/15) the percentage of regular smokers among 15 year old children in Richmond is the highest in London. The prevalence in Richmond was 6.7%, which is higher than the England average of 5.5%, almost doubling the London average prevalence of 3.4% (**Figure 93**).

Please note, information gathered from the national Tell-Us survey is now 6 years out of date and should be read with an element of caution as the cohort of children surveyed is not clearly understood for Richmond. The plan to conduct a borough wide Healthy Related Behaviour Questionnaire will provide a much needed greater level of understanding of the health of our primary and secondary cohorts.

Figure 93: Self-reported Regular Smokers Among Children Aged 15 by Local Authority, 2014/15



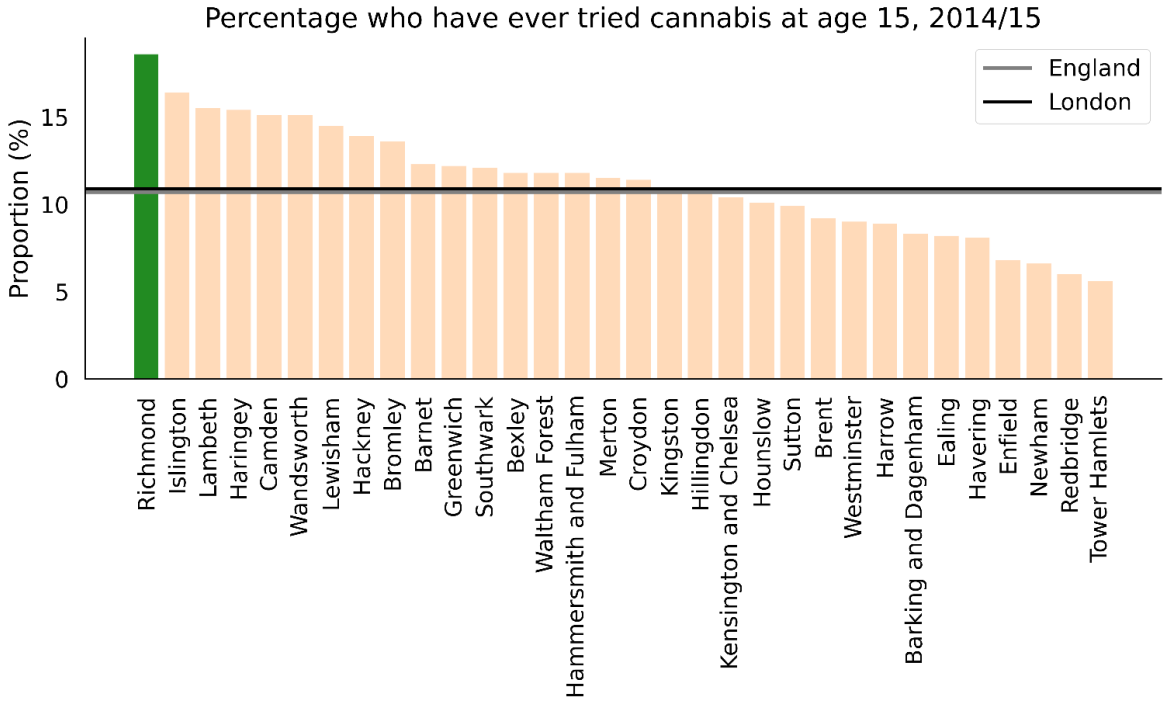
Source: PHE [Public Health Outcomes Framework](#)

12.2 Substance Misuse

The National What About Youth (WAY) Survey conducted in 2014/15 with young people showed that Richmond ranked the highest of all London Boroughs in relation to the percentage of 15 year olds who have ever tried cannabis (18.6%) or who had reported taking cannabis (8.5%) in the last month compared to London levels of (10.9% who had ever tried cannabis and 5.0% who had reported use in the last month), (**Figure 94)**.

[77] Hagell A and Shah R (2019) Key Data on Young People 2019. London: Association for Young People's Health.

Figure 94: Proportion of 15-Year-Olds who Tried Cannabis by Local Authority, 2014/15



Source: PHE Public Health Outcomes Framework

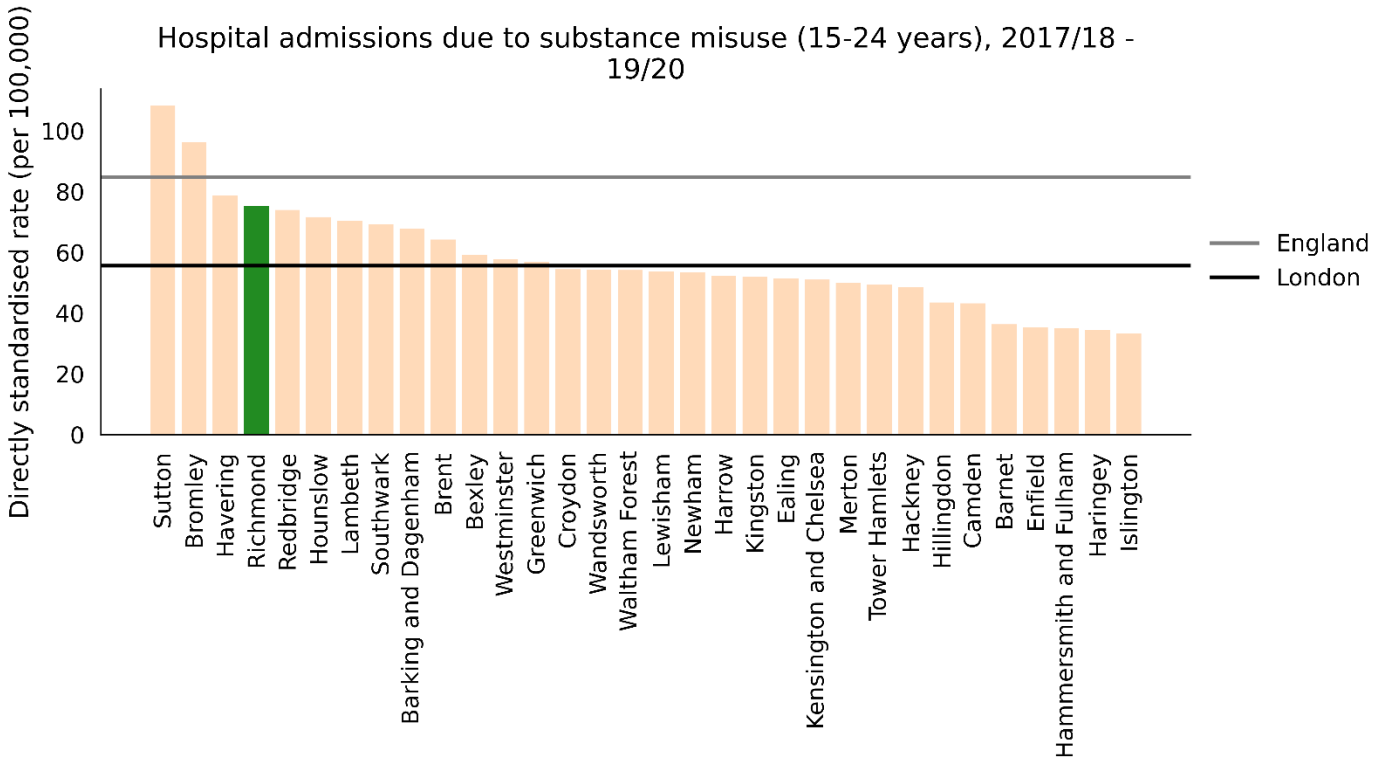
Smoking behaviour in individuals aged 15+ has also seen a recent downward trend and now stands at 11.8% of the population which is below both the London and England levels. The 2014/15 WAY Survey amongst 15 year olds found that Richmond ranked the highest of all London Boroughs in all three areas of the survey domains: Current smokers (14.3%), regular smokers (6.7%) and occasional smokers (7.6%). Richmond young people report regular smoking at age 15 years (6.7% compared to 3.4% for London). Survey data shows that 15 year olds in Richmond are more than twice as likely to smoke than their peers across London (WAY Survey 2014/15).

For 2018/19 there were 144 new referrals into the Young Persons Substance Misuse Service, a reduction from 226 in 2017/18. The top three referral routes were via Children's Services, followed by A&E and Education Providers. Primary substance use reported during 2018/19 was linked to cannabis 33%, followed by alcohol 12%, others such as Benzodiazepines and MDMA were less than 2%. The ages of those referred to the service were mainly 15-16 years (40%), followed by those who were 17-18 years (27%) and 13-14 years (21%). In terms of gender, 40% were female and 60% male. With regards to ethnicity 37% were White, 6% Mixed, 3% Black, and 1% Asian with 51% did not state their ethnicity.

Hospital Admissions for Substance Misuse

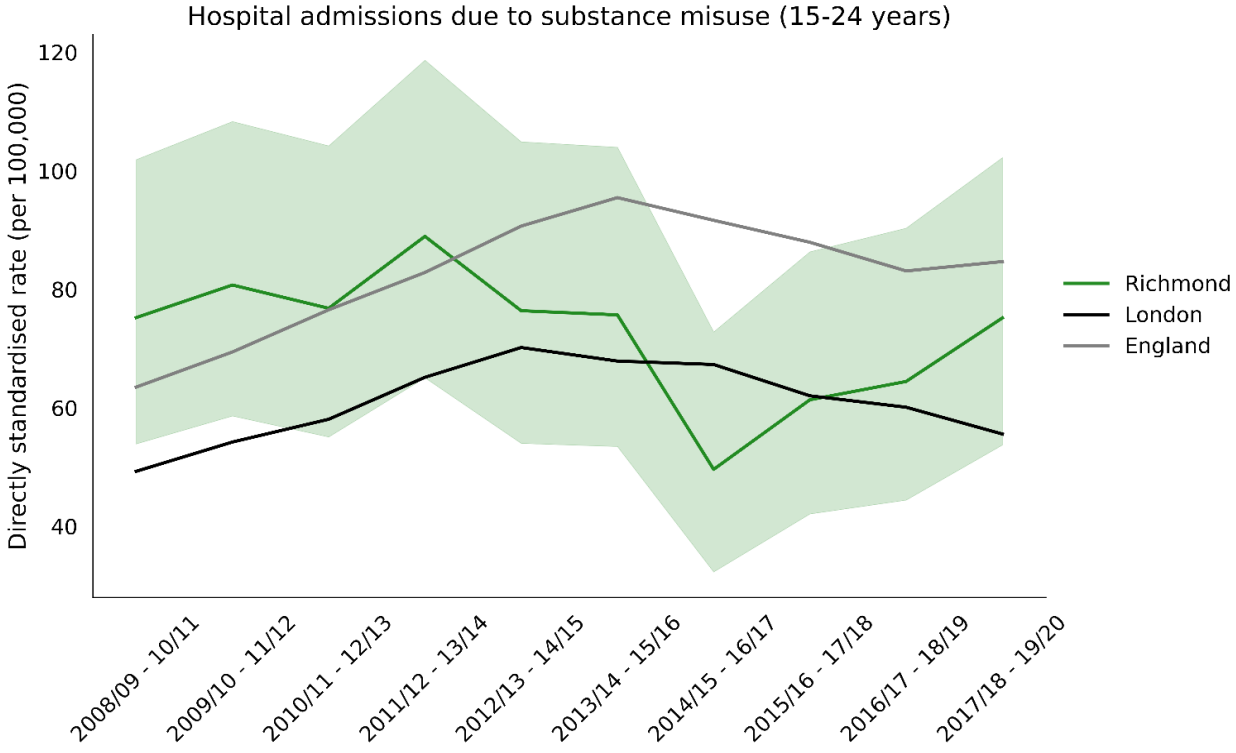
Richmond hospital admissions for substance misuse amongst 15-24-year olds was 75.1 per 100,000, the 4th highest in London (**Figure 95**). This is 11.2% lower than the England average and 35.3% higher than the London average. The latest Borough figure was also 0.1% lower from year 2008/09–10/11, in comparison with a 33.4% increase in England's rate in the equivalent time period (**Figure 96**). The rates in Richmond have been rising over the last 3 years.

Figure 95: Hospital Admissions Due to Substance Misuse (15–24 years) by Local Authority, Apr 2017–Mar 2020



Source: PHE Public Health Outcomes Framework

Figure 96: Hospital Admissions due to Substance Misuse (15–24 years), 3-yearly Rates per 100,000, 2008–2012



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

Children and Young People Substance Misuse Treatment

National Trends

Adolescence is a crucial time for physical, emotional and social development. It is also a time of intense learning, both in terms of formal education and informally from family and peers. Alcohol and drug use affects, impairs, interrupts or hinders young people and is harmful to their physical, emotional, social or academic development.

The Smoking, Drinking and Drug use among young people in England survey of pupils in secondary schools across England provides national estimates and information on the smoking, drinking and drug use behaviours of young people aged 11–15 years. The results are published every two years. The latest publications, Statistics on Drug Misuse (England, 2019)[78] and Statistics on Alcohol (England, 2018)[79] show that 44% of 11-15 year old pupils have had an alcoholic drink, 19% have smoked cigarettes, and 24% have taken drugs.

The most recent national treatment data (2019–2021)[80] shows the most common substances young people seek help for are cannabis and alcohol. However, young people also attend treatment services who are using a range of substances including ecstasy (MDMA), new psychoactive substances and cocaine. A very small minority will present using heroin. Use of Benzodiazepines has also doubled since 2016–2017 but reduced when compared to previous year's estimates.

The latest Crime Survey for England and Wales (2018–2019)[81] shows that a higher proportion of younger adults aged 16 to 24 years have taken a drug in the last year (20.3%) as compared to a wider age group of adults aged 16 to 59 years (9.4%).

Young adults aged 16 to 24 years were more likely to be frequent drug users and consume higher proportion of Class A drugs (8.7%) than the wider age group (3.7%).

The Sexual Health Framework (2013)[82] highlights that alcohol consumption and being drunk can result in lower inhibitions and poor judgements regarding sexual activity and vulnerability.

Local Prevalence Data

Young people who use recreational drugs run the risk of damage to mental health including suicide, depression and disruptive behaviour disorders. Regular use of cannabis or other drugs can also lead to dependence.

Admission episodes for alcohol specific conditions in Richmond for under 18-year-olds between 2017/18 and 2019/20 is 33.0 per 100,000 and has been on an upward trend since 2015/16[83]. This is equivalent to 45 admissions,

[78] NHS Digital (2019). Statistics on Drug Misuse: Part 4- Drug use among young people. Available at https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-drug-misuse/2019/part-4-drug-use-among-young-people. Last accessed April, 2021.
[79] NHS Digital (2018). Statistics on Alcohol: Part 5- Drinking behaviours among children. Available at https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2018/part-5. Last accessed April 4, 2021.
[80] Public Health England (2021). National Statistics - Young people's substance misuse treatment statistics 2019 to 2020: report. Available at: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-statistics-2019-to-2020/young-peoples-substance-misuse-treatment-statistics-2019-to-2020-report. Last accessed April 4, 2021.
[81] Home Office (2019). National Statistics – Drug misuse: findings from the 2018 to 2019 CSEW. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832533/drug-misuse-2019-hosb2119.pdf. Last accessed April 4, 2021.
[82] A Framework for Sexual Health Improvement in England (publishing.service.gov.uk)
[83] Local Authority Health Profiles (LAPE – 2021). Available at https://fingertips.phe.org.uk/profile/health-profiles. Last accessed August, 2021

10 of which were males and 35 females. Richmond has the highest amongst all of London boroughs and has a higher rate than London (15.4) and England (30.7)[84]

In 2017/18, there were 40 hospital admissions due to substance misuse in 15–24 year olds in Richmond, a rate of 75.1 per 100,000. This rate is higher than London (55.6 per 100,000) but lower than England (84.7 per 100,000).

The rate of hospital admissions caused by unintentional and deliberate injuries in young people aged between 15–24 is 119.9 per 10,000, which is equivalent to 215 admissions in 2019/20. This rate is higher than London (94.8 per 10,000) but lower than England (132.1 per 10,000).Unintentional and deliberate Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health related to experiences. This can put young people at risk of turning to substances as a coping mechanism.

Local Treatment Data

This section highlights key performance information about young people (under the age of 18 years) accessing specialist substance misuse interventions provided by the YPSMS. The data is taken from the National Drug Treatment Monitoring System (NDTMS) which reflects specialist treatment activity reported for young people with problems around alcohol and drug misuse. For the purposes of this report and to uphold the confidentiality of all young people's data being used, the specific age and gender categories of young people in treatment have not been outlined. A more generalised trend analysis has been provided.

Among 10–15 year olds, an increased likelihood of drug use is linked to a range of adverse experiences and behaviour, including truancy, exclusion from school, homelessness, time in care, and serious or frequent offending.

Table 10 shows the totals for the number of young people in treatment in Richmond each year since 2016/17 Q4 up until 2020/21 Q2. Data from 2020/21 Q2 was the most recent data available at the time when this review was being conducted.

The data highlights a marked increase in young people accessing specialist substance misuse interventions over the last two years when compared to previous years.

Table 10: Total numbers of Young People in treatment over the years in Richmond

Borough	2016/17	2017/18	2018/19	2019/20	2020/21 (Q2)
Richmond	26	32	20	39	38

Source: NDTMS

In Richmond, the most common age of young people accessing treatment with most referrals coming through amongst young people were aged 15–16. In 2019/20, the highest age group was 15 and in Q2 202/21, the highest was 16. This could mean that there is a specific cohort of users that are ageing and are clients in service. Across both years, there were significantly more males than females accessing treatment, with more than 60% males in treatment in both years.

[84] The Government has said that everyone has a role to play in reducing the harmful use of alcohol - this indicator is one of the key contributions by the Government (and the Department of Health) to promote measurable, evidence-based prevention activities at a local level, and supports the national ambitions to reduce harm set out in the Government's Alcohol Strategy. Alcohol-related admissions can be reduced through local interventions to reduce alcohol misuse and harm.

The most used substance amongst young people accessing treatment was cannabis. This was followed by alcohol, and in 2019/20 this was followed by nicotine. All other substances were used at a frequency less than 5 or not at all (**Table 11**).

Table 11: Substances used by young people in treatment in 2019/20 Q4 and 2020/21 Q2 across Richmond

Substances Used by YP in Treatment Service	Richmond	
	2019/20 (Q4) Apr - Mar	2020/21 (Q2) Apr - Sep
Cannabis	35	20
Alcohol	23	9
Amphetamines	0	0
Cocaine	<5*	0
Ecstasy	<5*	<5*
Solvents	<5*	0
Opiates	<5*	0
Crack	<5*	
Nicotine	8	0
Other	*<5**	*<5**

** Numbers smaller than 5 are suppressed to protect confidentiality of service users*
Source: NDTMS

Referral pathways into young people's substance misuse services in Richmond, across both years (to date), come predominantly via Children and Family services, followed by Youth Justice Services, Education Services, Health & Mental Health Services, and Accident and Emergency. No referrals have been made via other sources (**Table 12**).

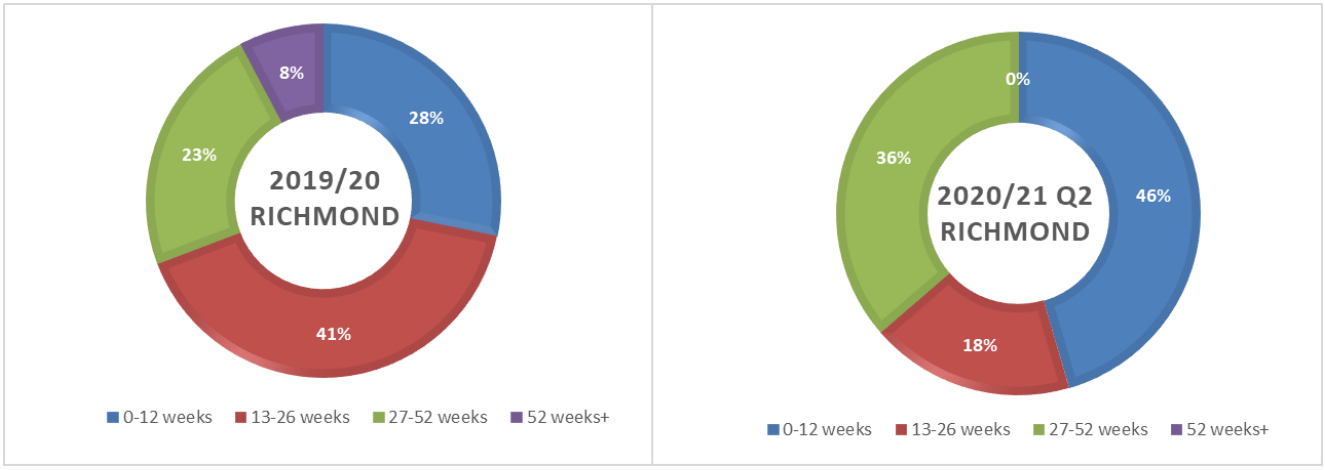
Table 12: Referral sources for young people entering local treatment in 2019/20 and 2020/21 (Q2) for Richmond

Referral source	Richmond	
	2019/20 Apr - Mar	2020/21 (Q2) Apr - Sep
Children & Family Services	14	6
Education services	5	0
Health & Mental Health Services	<5*	<5*
Accident and Emergency	<5*	0
Substance Misuses Services	0	0
Youth Justice Services	5	<5*
Family, Friends and Self	0	0
Other Referral Source	0	0
No Source recorded	0	0

** Numbers smaller than 5 are suppressed to protect confidentiality of service users*
Source: NDTMS

- During 2020/21 (to date), a greater proportion of treatments delivered fell into the 0–12 weeks and 13–26 weeks treatment window compared to the year before, with the largest rise observed in treatments lasting on average between 0–12 weeks (now 46% compared to 28%). The overall average length of time in services in 2019/20 was 22.62 weeks, compared to 19.82 in 2020/21 (a decrease of 2.8 weeks).
- The proportion of treatments lasting 13–26 weeks has decreased from 41% in 2019/20 to 18% by Q2 of 2020/21, (**Figure 97).**
- Those with treatment length greater than 52 weeks also decreased from 8% to 0%.

Figure 97:Treatment length (in weeks) spent in services in 2019/20 Q4 and 2020/21 Q2 in Richmond



Source: NDTMS

An individual may receive more than one intervention during their time in treatment so percentages may add up to more than 100%. In Richmond during the full year of 2019/20 and mid-year of 2020/, psychosocial interventions are the most commonly used in treatment. Young People Harm Reduction and Young People Multi Agency interventions are the second and third most commonly used interventions, respectively **Table 13**.

Table 13: Interventions delivered to young people in treatment in 2019/20 Q4 and 2020/21 Q2 across Richmond

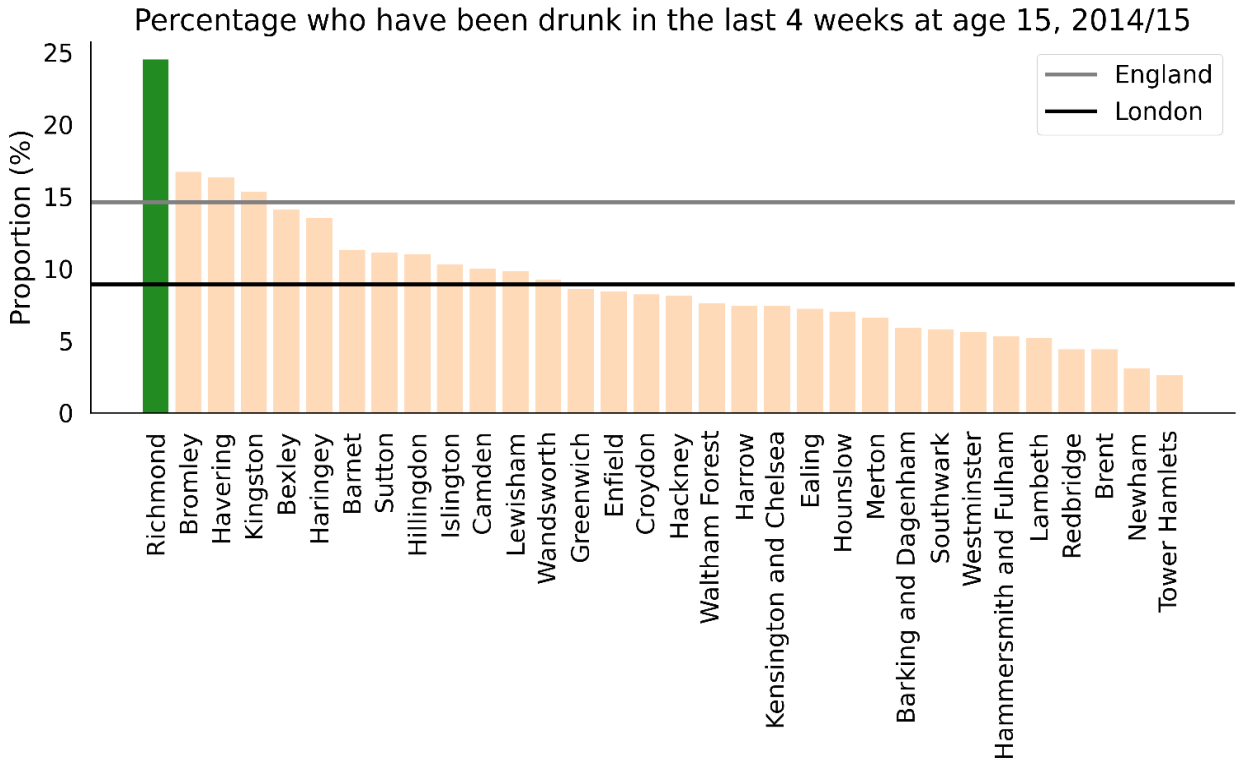
Intervention Type	Richmond	
	2019/20 (Q4) Apr–Mar	2020/21 (Q2) Apr - Sep
YP Harm Reduction	25 (64%)	20 (91%)
Pharmacological	0 (0%)	0 (0%)
Psychosocial	36 (92%)	20 (91%)
YP Multi Agency Working	23 (59%)	13 (59%)
No intervention recorded	3 (8%)	1 (5%)

Source: NDTMS

12.3 Alcohol Misuse

The WAY Survey (2014/15) showed that Richmond has by far the highest percentage of children aged 15 years who reported being drunk in the last 4 weeks. 24.5% of Richmond's respondents were drunk in the last 4 weeks which is significantly higher than both the England (14.6%) and London (8.9%) averages (**Figure 98**).

Figure 98: Children Aged 15 Reported Being Drunk in the Last 4 Weeks by Local Authority, 2014/15

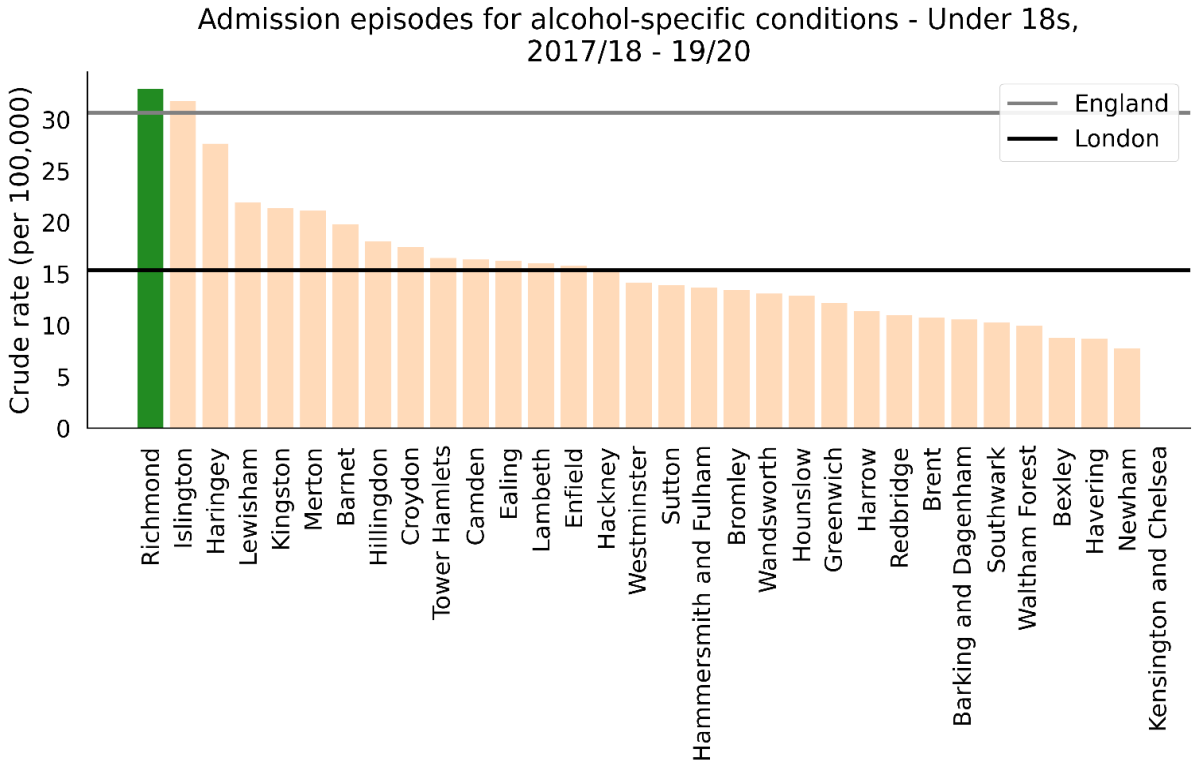


Source: PHE Public Health Outcomes Framework

Alcohol Attributable Admissions

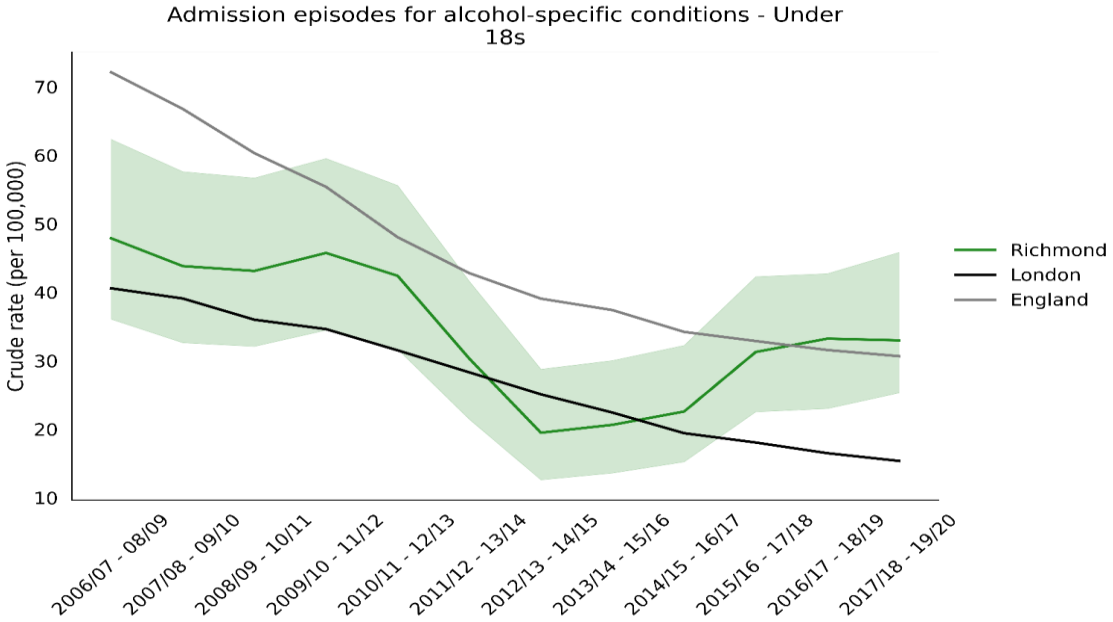
Excess alcohol is attributable to a diverse range of conditions. Alcohol misuse is estimated to cost the NHS £3.5 billion per year and society £21 billion annually. In Richmond, trends in hospital admissions for alcohol-specific conditions in the under 18 year olds, where the primary diagnosis or any of the secondary diagnoses are an alcohol-specific condition, have seen an upward turn in recent years with episodes rising to 33 per 100,000. This is the highest in London (**Figure 99**) which was 7.5% higher than the England average and 114.6% higher than the London average. The latest Borough figure was also 31.1% lower from year 2006/07–08/09) in comparison with a 57.5% decrease in England's rate in the equivalent time period (**Figure 94**). The alcohol-related hospitalisation in Richmond's children and young people has been steadily rising for the last 6 years.

Figure 99: Under 18 Hospital Admissions Wholly Attributable to Alcohol Consumption by Local Authority, Apr-2017–Mar-2020



Source: PHE Public Health Outcomes Framework

Figure 100: Under 18 Hospital Admissions Wholly Attributable to Alcohol Consumption by Local Authority, 2006–2020



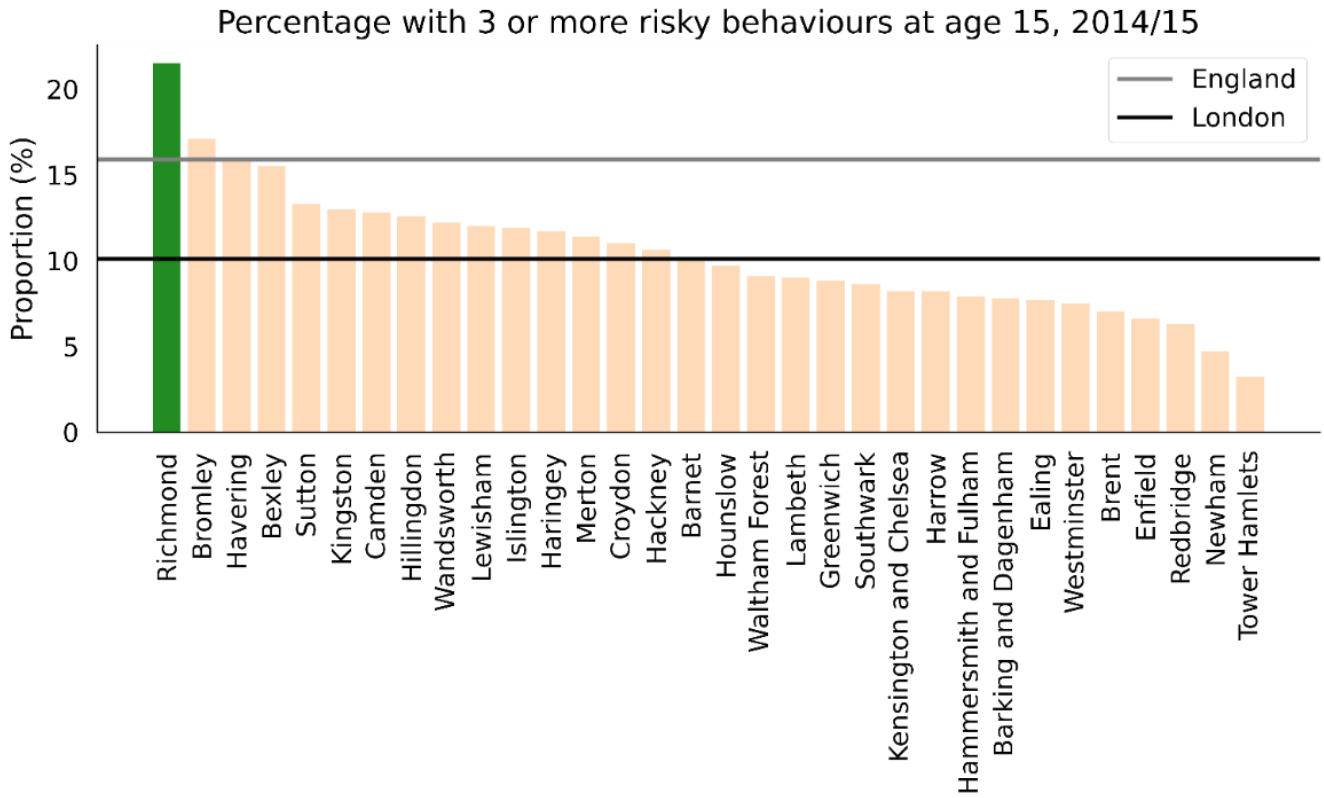
**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

12.4 Three or More Risky Behaviours in Children Aged 15 Years

The WAY Survey shows that Richmond ranks the highest of all London Boroughs for reporting three or more risky behaviours at 21.5% of all surveyed 15 year olds. This was significantly worse than both the England level of 15.9% and London level of 10.1% (**Figure 101**). In response to this finding Richmond developed a Risky Behaviour Review and Plan that has been actioned over the past two years. It is too early to tell whether this Risky Behaviour Review and Plan has made a difference to young people in Richmond. It is not yet clear when or if the WAY Survey will be recommissioned.

Figure 101: Proportion of Children Aged 15 Reporting 3 or More Risky Behaviours by Local Authority, 2014/15



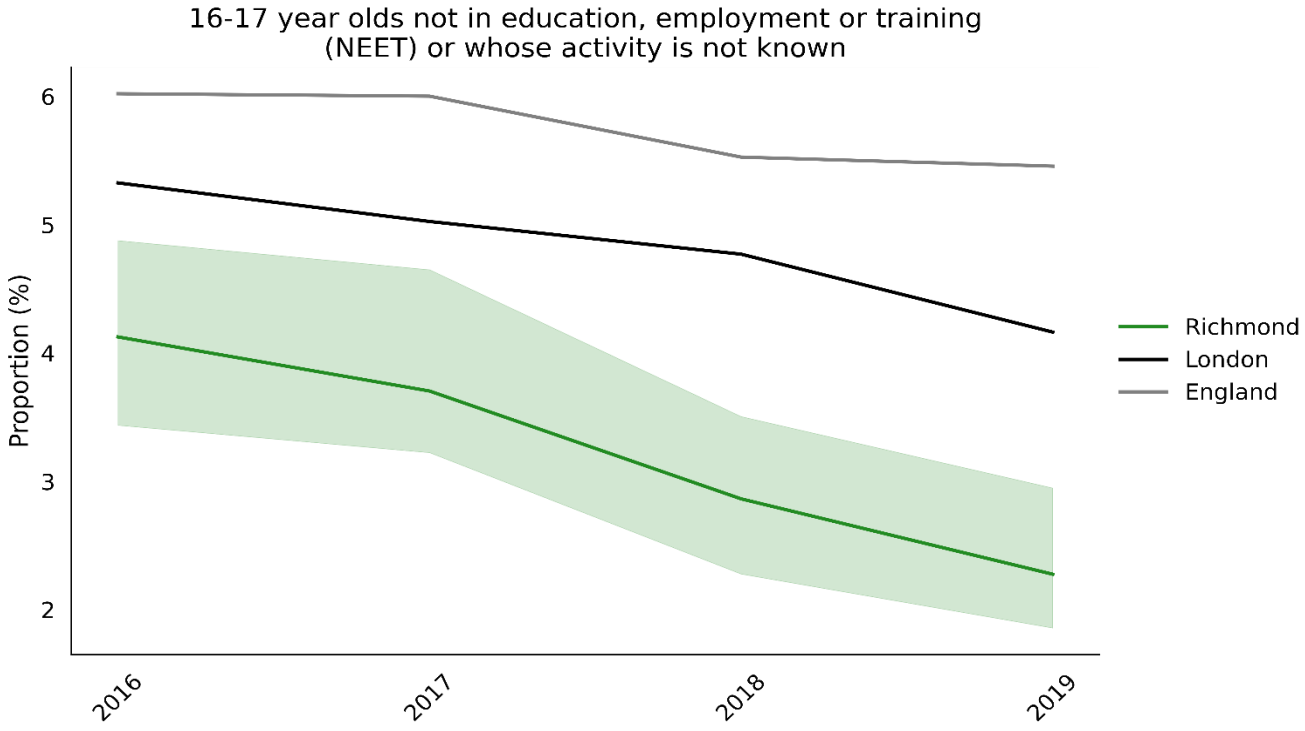
Source: PHE Public Health Outcomes Framework

13. Young People – Education, Employment and Attainment

Richmond has seen a steady decrease in numbers of young people who are classified as Not in Education, Employment, Training or Unknown (NEET). The data shows the number and proportion of 16 and 17 year olds recorded as in education, employment or training in each local authority area and an estimate of the proportion and number of 16 and 17 year olds who are recorded as NEET or whose activity is 'not known'.

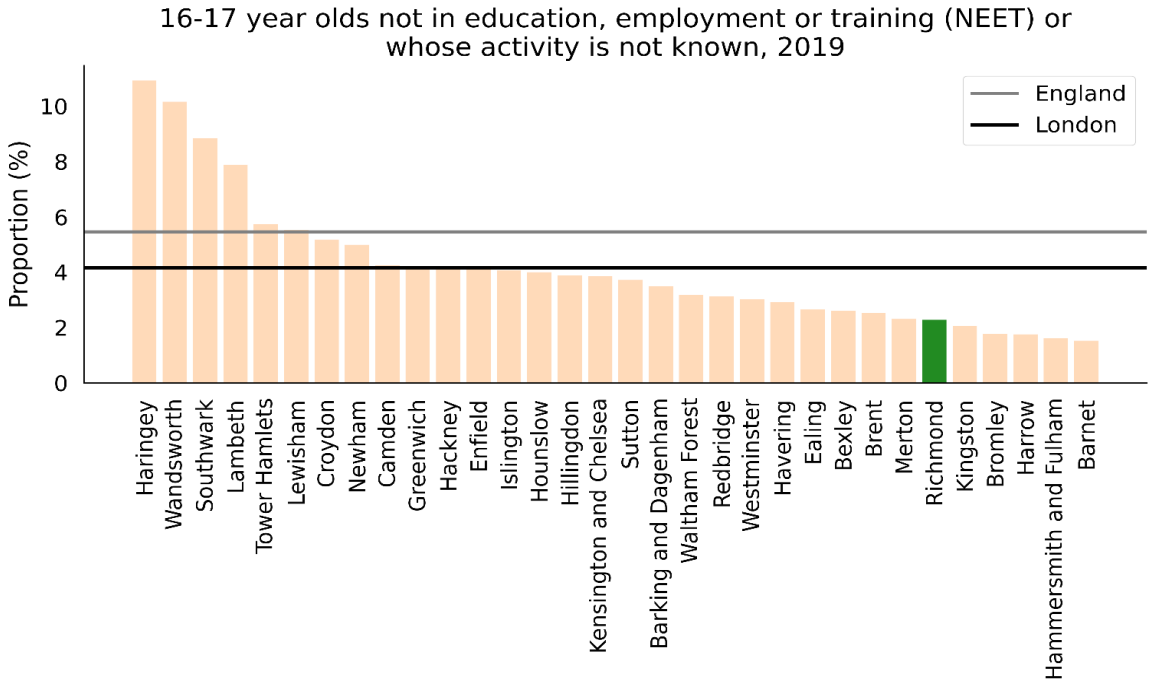
Richmond's latest NEET rate for 2019/20 was 2.3 per 100, which is 58.3% lower than the England average and 45.3% lower than the London average. The latest Borough figure was also 44.8% lower from year 2016, in comparison with aa 9.4% decrease in England's rate in the equivalent time period. The 2019/20 NEET figure for the Borough was the 5th lowest in London (**Figure 102** and **Figure 103**).

Figure 102: Young People Aged 16–17 not in Education, Employment or Training, 2016/17–2019/20



**- blue ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Figure 103: 16–17-year-olds not in Education, Employment or Training by Local Authority, 2019/20



Source: PHE Public Health Outcomes Framework

Fifty percent of Richmond care leavers aged 19–21 years were in education, employment or training in 2018/19, this was slightly lower than the averages for England at 52% and London at 54%.

14. Serious Youth Violence and Crime

Youth Offending (YO) and Serious Youth Violence (SYV) affect us all and particularly affects the most disadvantaged groups in society. It is a complex and challenging issue, however, can be preventable. Taking a public health approach to tackling youth offending and serious youth offending examines the root causes of crime and uses a whole-system approach informed by data and intelligence. Collaboration and leadership across the system is critical. To reduce youth offending and serious youth offending one must, in partnership, tackle drugs, the criminal and sexual exploitation of children, and gang related violence. Shifting the narrative from one of criminality to vulnerability and a 'child first' approach is important if we are to understand and tackle the root causes of crime.
Early identification and consideration of needs include:

- emotional well-being and mental health
- speech, language and communication
- family and home-life circumstances including exposure to violence
- domestic abuse
- Substance misuse
- Other adverse childhood experiences
- Wider determinants of health including, education, employment, housing.

14.1 Key Messages from Practice and Research

- Risk factors for offending do not exist in isolation, can be cumulative, and children commonly experience multiple risk factors.
- Many of the risk factors for offending are also prevalent in people who have complex health and/or social care needs.
- Education is protective of children's health.
- Poverty and low socioeconomic status during childhood is a risk factor for subsequent Substance Misuse and Criminal Behaviour.
- Adverse childhood experiences (ACEs) can cause several poor health outcomes in adulthood, for example increasing the risk of mental illness, violence and becoming a victim of violence.
- Skills-based programmes such as sports and arts can be an effective part of diversionary and rehabilitative approaches of intervention.
- Black Ethnic, Asian Ethnic or Minority boys are disproportionately represented in the youth offending cohort in Richmond and other London Boroughs
- With some exceptions, crime hotspots across the Borough largely correlate with areas of multiple deprivation.

Serious youth violence is a multi-faceted complex issue. To address this, innovative action is taking place in Richmond including the work of the Evolve Adolescent Exploitation Team, the Multi-Agency Risk Vulnerability Exploitation (MARVE) Panel, the Community Safety Local Knife Crime Forum, and the targeted detached work being delivered by the Youth Service. These are local examples of collaboration, active intelligence gathering, partnership and community engagement, working to intervene and support some of the most vulnerable children and communities.

Children's Services are also working towards further integration of Vulnerable Adolescent Services to improve coordination of partnership support and to develop effective early responses to further reduce and prevent risk.

Further work is required to improve and embed the needs and experiences of local children into the development of services if we want to say we are truly child centred and put children first.

In addition to this, three specific areas of partnership working are identified for development that will improve the support and offer available for those at risk of encountering the Youth Justice System:

1. Contextual Safeguarding – embed a whole system contextual safeguarding approach across the Councils and Partners: recognising, understanding, and responding to, children's experiences of significant harm beyond their families
2. Improving Data and Intelligence – using intelligence systems across partnerships to fully understand needs, predict risk cohorts & areas, embed predictive analytics and be able to coordinate appropriate and timely responses
3. Disproportionality – seek to understand and respond to this, particularly in relation to male BACK, ASIAN AND MINORITY ETHNIC GROUPS children and the emerging inequalities for all vulnerable children resulting from the Covid-19 Pandemic

Richmond is a safe place to live. In 2018/19 it had the third lowest crime rate in London and in 2017/18. The rate of children cautioned or sentenced was the lowest in London. However, total crime has risen by 20% since 2014, similar to the London increase of 23%. Since 2016/17, there has also been a 20% rise in crimes with a victim aged 1–17 years, compared to an 11% increase in all other ages. Knife crime is now more likely to involve a victim or suspect under the age of 18 years. These changes have been influenced by a rise in knife-related robberies involving young people.

Young people are more likely victims of assault (37%), robbery (16%) or sexual offences (11%) than victims of any age (17%, 3% and 3%, respectively). Young people are more likely to be suspects of robbery (14.5%) than suspects of any age (4.1%).

Of all crimes recorded and where age data was captured, 6.7% of victims and 12.8% of suspects during 2018/19 were 10–17 years old **Table 14**. Though they can be affected, crimes that occur in higher volumes, such as burglary and vehicle crime rarely count a young person as a victim. Conversely, young people are disproportionally affected by crimes that occur in lower volumes but pose a higher risk to safety, such as knife and gang grime, or sexual exploitation. As a result, the 6.7% is not fully reflective of the impact crime may have on the development and well-being of young people.

Table 14: Young people by role in crime, 2018/19

Role in Crime	Incidents (unique crime events)	Age 1–17 (% of all incidents)	% change in ages 1–17 since 2016/17 (% change all other ages)
Victim	10,237	772 (7.5%)	+20% (+11%)
Suspect	4,660	599 (12.9%)	-8% (-4%)

Source: Metropolitan Police Crime Data, June 2019

Since 2016/17, the percentage of male victims has increased from 48% to 60%, whilst the percentage of suspects from Black Ethnic, Asian Ethnic or Minority groups has increased from 22% to 28% **Table 15**.

Table 15: Demographics of young people 0–17 and crime, 2018/19

	Victims	Suspects
Male	60%	80%
Female	40%	20%
White	80%	73%
Ethnic Minority Groups	20%	28%

Source: Metropolitan Police Crime Data, June 2019

Compared to other areas in London and across England, fewer local young people enter the Criminal Justice System. There were 19 First Time Entrants (FTEs) in 2017/18, a reduction from 37 in 2016/17. The rate was 90 per 100,000 population in 2017/18 and this has been decreasing over the past several years. This is lower than our statistical neighbour's rate of 169.1 per 100,000 and the England rate of 238.5 per 100,000 population.

36% of 15–17 year old offenders in 2015/16 went onto re-offend over the following 12 months, a reduction from 45.7% for the 2014/15 cohort. Less than 5 young people were sentenced to custody for each of the last two years. The use of custody rate for 10–17 year olds in 2016/17 fell to 0.03 per 1,000, from 0.16 per 1,000 population in 2014/15. This is lower than the national rate of 0.41 per 1,000 population.

14.2 Knife Crime

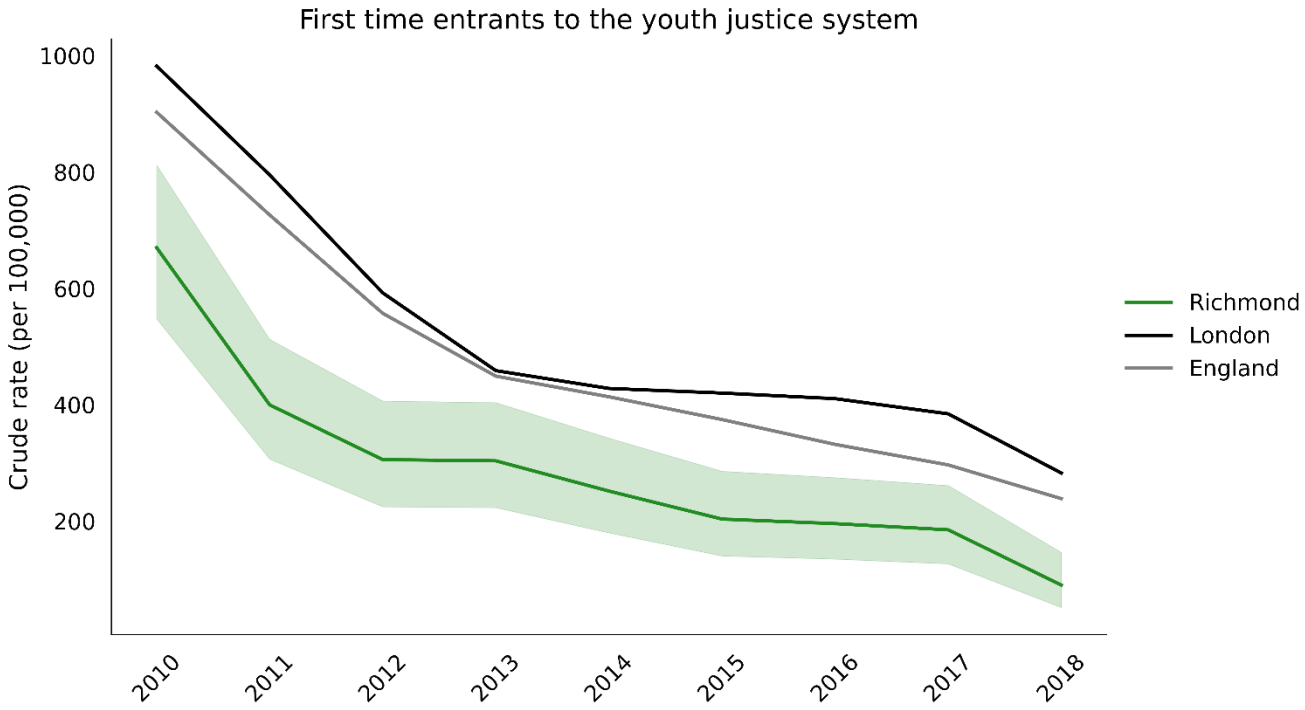
Reported levels of knife crime have been increasing over the past 2–3 years, with young people increasingly affected, whether as victims or perpetrators. In Richmond, recorded knife crime offences affecting all ages has increased from 81 offences in 2016/17 to 158 offences in 2018/19 (+95%). However, the rate is the 4th lowest in London. The percentage of knife crime events with a victim or suspect under the age of 18 years has increased from 31% (2016/17) to 55% (2018/19). This is an increase from 20 to 58 events and is closely linked to a rise in robberies where the suspect(s) are in possession of a knife. However, violent crime (assaults) involving knives remains very low in Richmond.

- During 2018/19, 94% of young victims and 96% of described young suspects of knife crime were male. 92% of young victims and 65% of young suspects were White.
- More than 80% of knife crime events with a young victim and/or suspect were robbery offences, with suspects often described, rather than formally identified.

14.3 First Time Entrants to the Youth Justice System

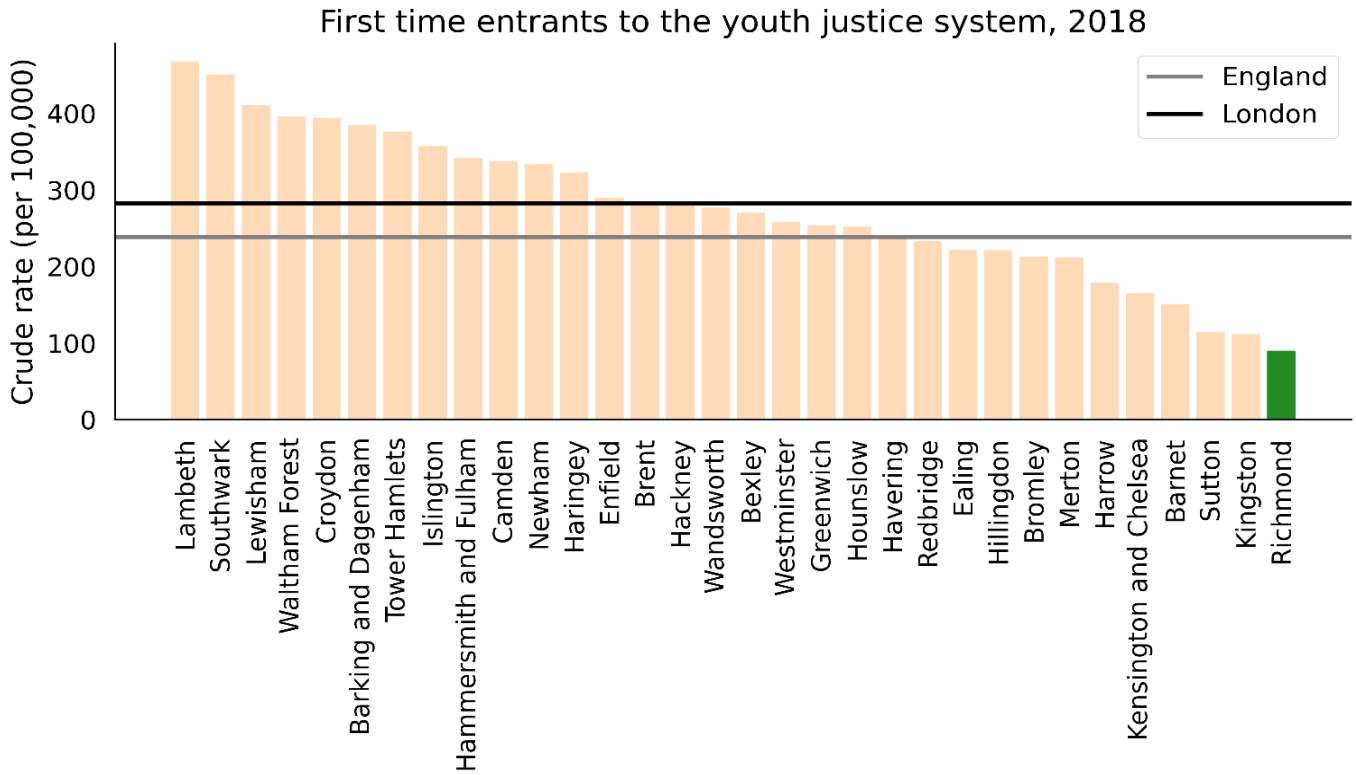
In 2018, there were 16 First Time Entrants (FTES) to the Youth Justice System, a 50% decline compared to the year before and a continuation of the steady decline over the last 10 years (**Figure 104**). The rate per 100,000 10–17 year olds was 90.0, the lowest in London (**Figure 105**). This is much lower than the London average of 282.5 and the England average of 238.5. The latest Borough figure was also 86.6% lower from year 2010, in comparison with a 73.6% decrease in England's rate in the equivalent time period.

Figure 104: First Time Entrants to the Youth Justice System, 2010–2018



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Figure 105: First Time Entrants to the Youth Justice System by Local Authority, 2018



Source: PHE Public Health Outcomes Framework

15. Young People's Sexual Health

15.1 Teenage Pregnancy

Teenage parents and their children experience poorer health, educational and economic outcomes and inequality[85]. There is a strong relationship between teenage conceptions and deprivation, and poor education and economic outcomes. High rates of teenage pregnancy are most often associated with low educational attainment, disengagement from school, economic deprivation, and poor mental health. Young people at increased risk of early parenthood and teenage pregnancy include:

- children of teenage mothers
- looked after children
- those partaking in substance misuse
- those involved in crime
- those at risk of or experiencing child sexual exploitation
- children who may go missing from home or care.

Other significant risk factors include:

- early onset of sexual activity
- poor contraceptive use
- repeat abortions.

Nationally, recent trends have seen improvements in some areas of adolescent health including young people's health risk-taking behaviour[86]. Teenage Pregnancy rates have been on the decline over the past decade.

Under-18 Conceptions

The 2018 Conception Rate for under 16 year olds fell by 7% from 2017. Both rates are at the lowest level since records began in 1969. In comparison, in Richmond, rates have fallen by 55.1% since 1998 but saw an increase of 54.5% between 2017 to 2018.

This brings the overall under 18 years conception rate to just 10.2/1000 in the age group which is now lower than the outer London average at 13.4 per1,000 females aged 15–17. In Richmond 62.5% of these conceptions led to abortion which is lower than the London average of 64.9%. The percentage of conceptions leading to abortions, however, have decreased since 1998 by 9.3% ,and by 16.7% since 2017. Conception rates for the under 16 year olds have also fallen both nationally. In Richmond they now stand at just 1.8/1000 women in the age group (3-year aggregate rate 2015 to 2018) with 58.8% leading to abortion, compared to 68.2% at a London level. Most teenage conceptions are unintended, and the data suggests that access to conception for young women in Richmond must continue to be strengthened.

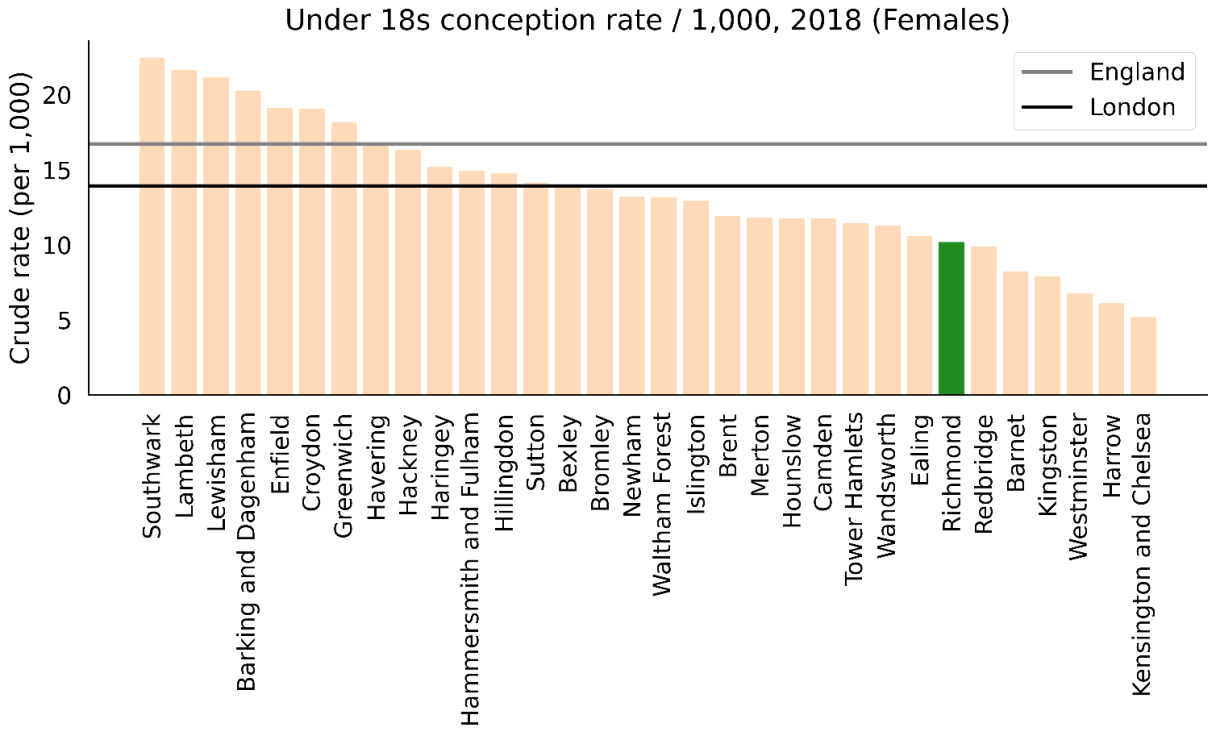
[85] Public Health England. A framework for supporting teenage mother & young fathers. 2019

[86] Hagell A and Shah R. Key Data on Young People 2019. London: Association for Young People's Health. 2019.

The rate of under 18 years conceptions in Richmond have seen a substantial reduction over the last decade[87]. The latest data for 2018 shows that in England 16.7/1,000 young women under-18 became pregnant, a 6.2% decrease compared with 2017, and a 58% decline compared with 2008.

Richmond's latest rate was 10.2/1,000 population (n=32), 7th lowest rate in London (**Figure 106**), which is 39.1% lower than the England average and 26.9% lower than the London average. The latest Borough figure was also 55.9% lower from year 1998, in comparison with a 64.2% decrease in England's rate in the equivalent time period (**Figure 107**). In 2018 the rate for Richmond had increased from the previous year by 55% (from 6.6/1,000 in 2017).

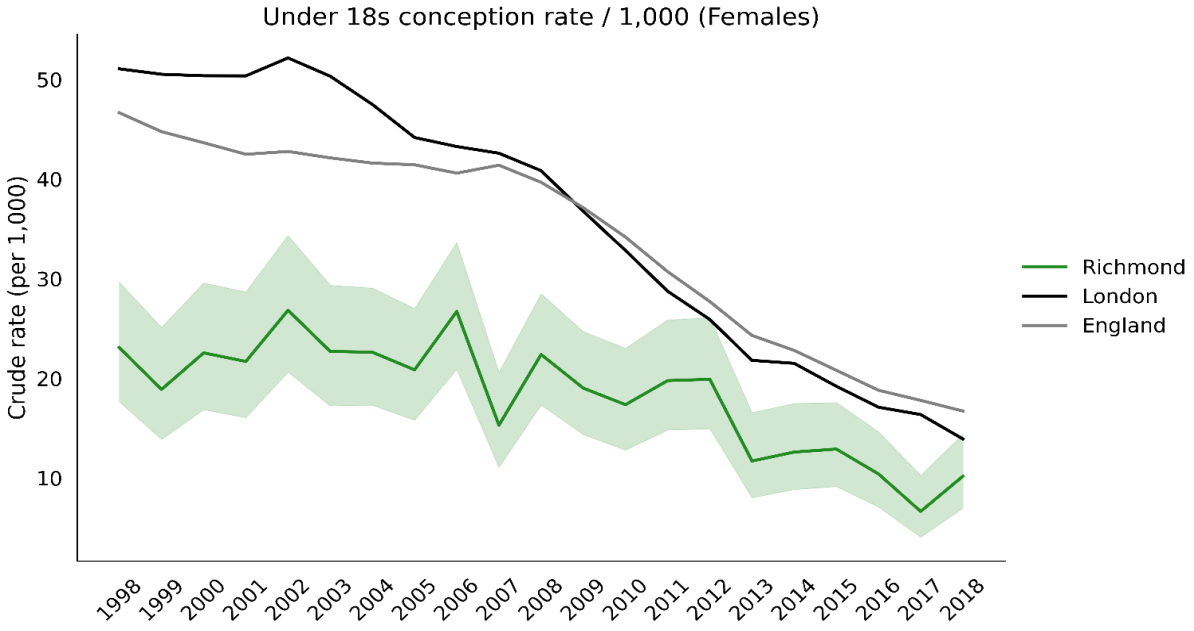
Figure 106: Under-18 conception rates per 1,000 females aged 15–17 by local authority, 2018



Source: PHE Public Health Outcomes Framework

[87] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/datasets/conceptionstatisticsenglandandwalesreferencetables

Figure 107: Under-18 Conception Rate per 1,000 females aged 15–17, 1998–2018

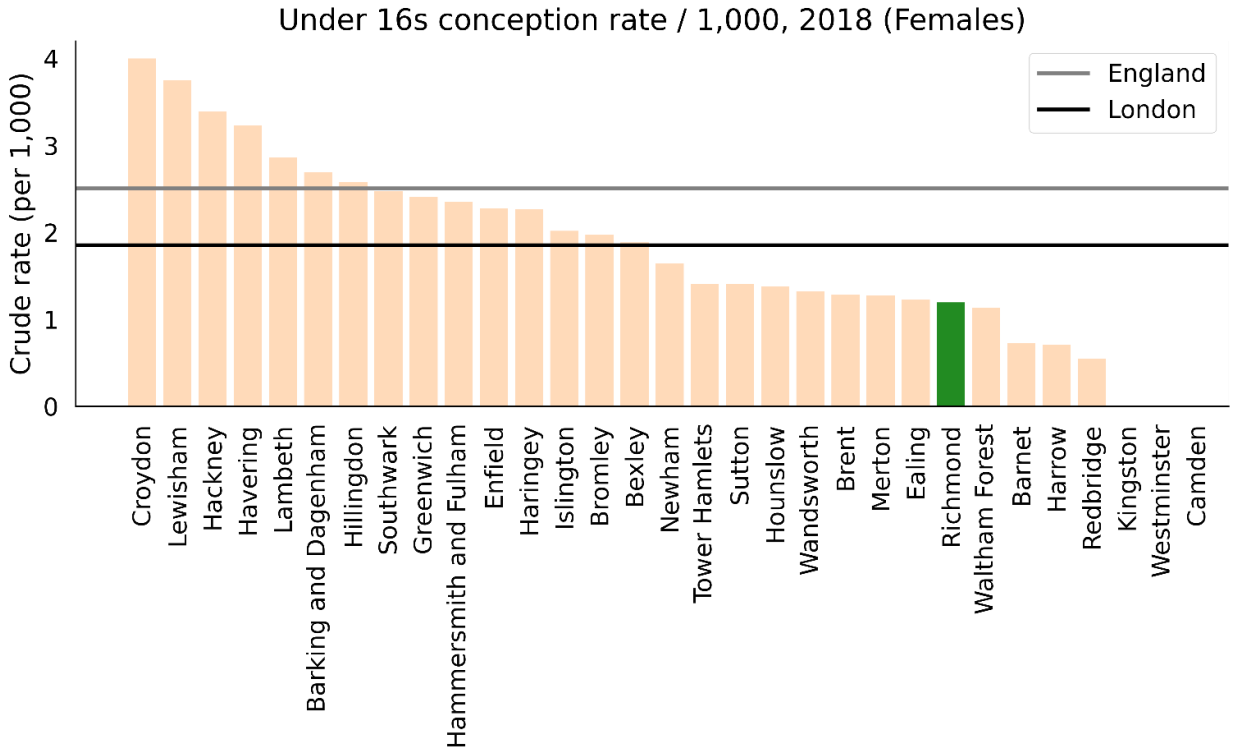


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Under-16 Years Conceptions

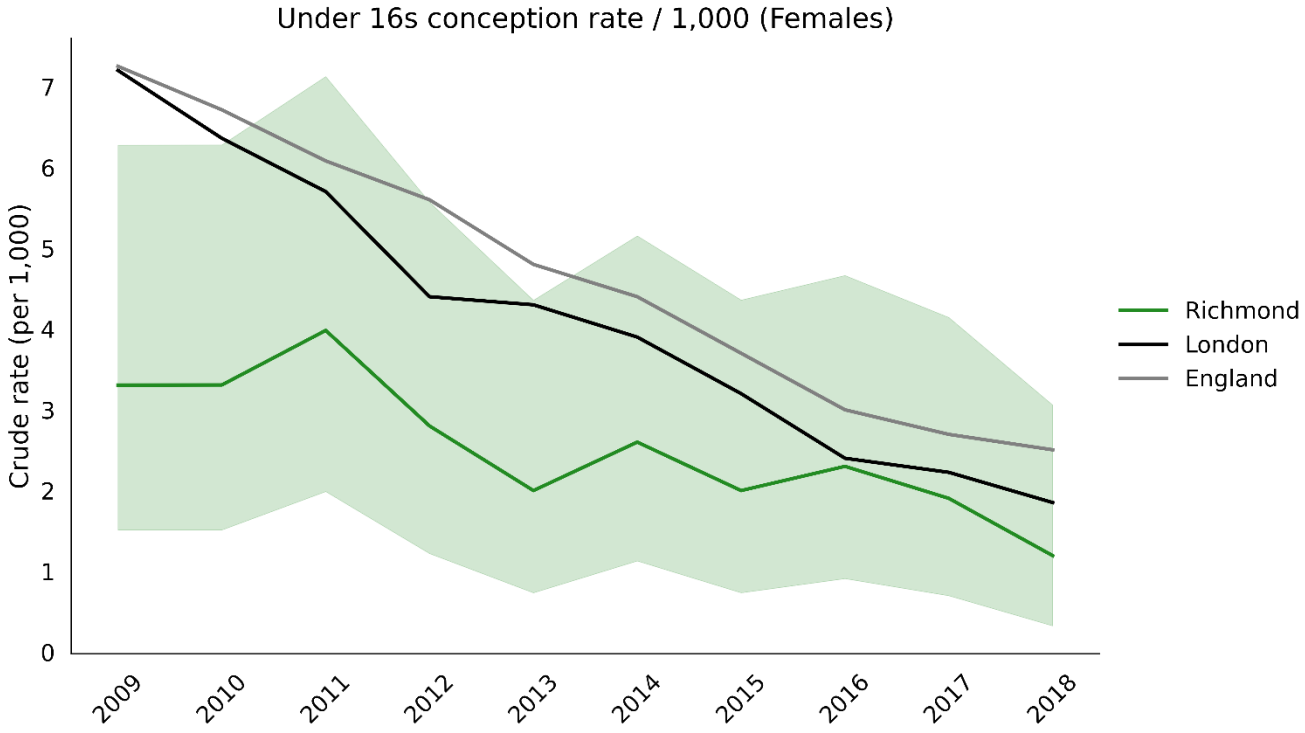
Conception rates for the under 16 year olds has also fallen both nationally and in Richmond now stands at 1.2 per 1,000 females aged 13–15 which is the 8th lowest in London (**Figure 108**). This is 52.3% lower than the England average and 35.5% lower than the London average. The latest Borough figure was also 63.9% lower from year 2009, in comparison with a 65.5% decrease in England's rate in the equivalent time period (**Figure 109**).

Figure 108: Conceptions in women aged under 16 per 1,000 females aged 13–15 by local authority, 2018



Source: PHE Public Health Outcomes Framework

Figure 109: Conceptions in women aged under 16 per 1,000 females aged 13–15, 2018



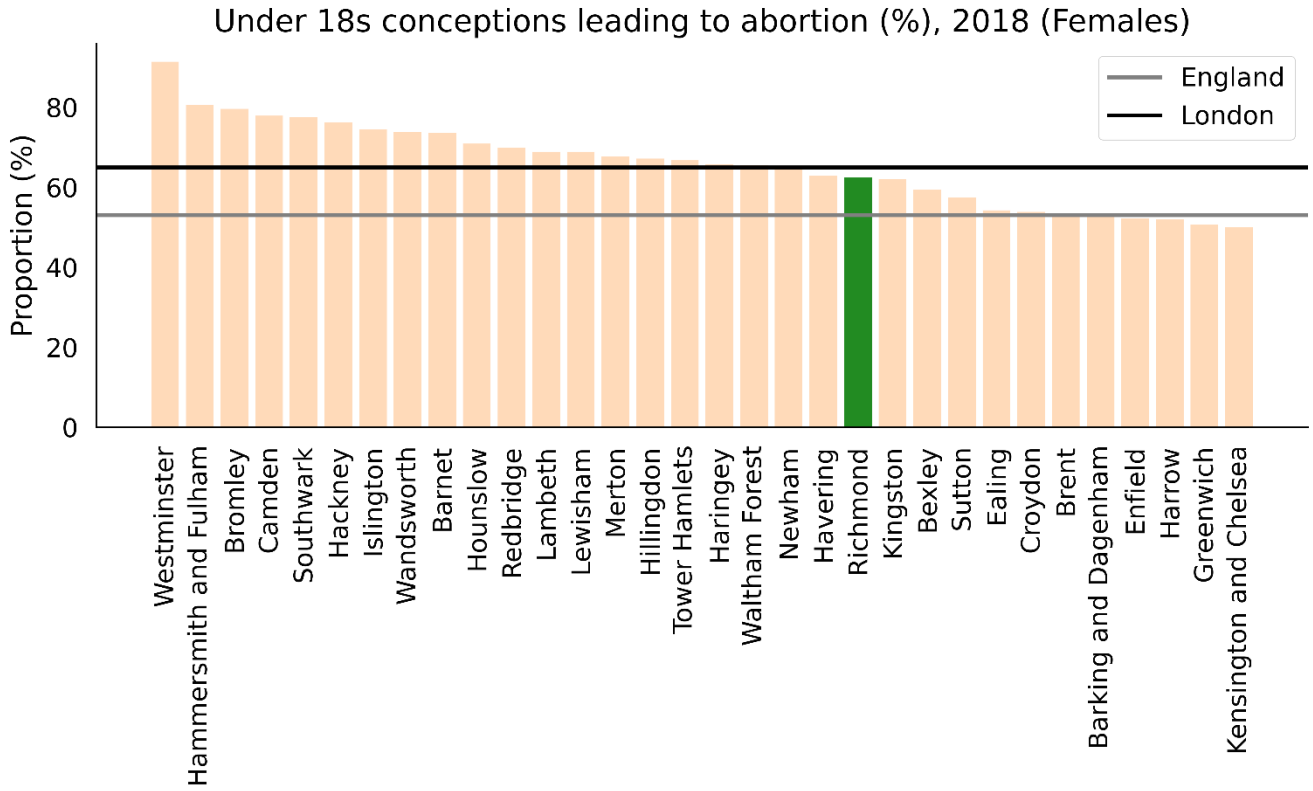
**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

15.2 Termination of Pregnancies in Under 18 Year Olds

In 2018 62.5% of under-18 years conceptions in Richmond led to abortion, the 12th lowest percentage in London (**Figure 110**), which is higher than the England average (53%) but lower than the London average of 64.9%. The latest Borough figure was also 9.2% lower from year 1998, in comparison with a 25.0% increase in England's rate in the equivalent time period (**Figure 111**).

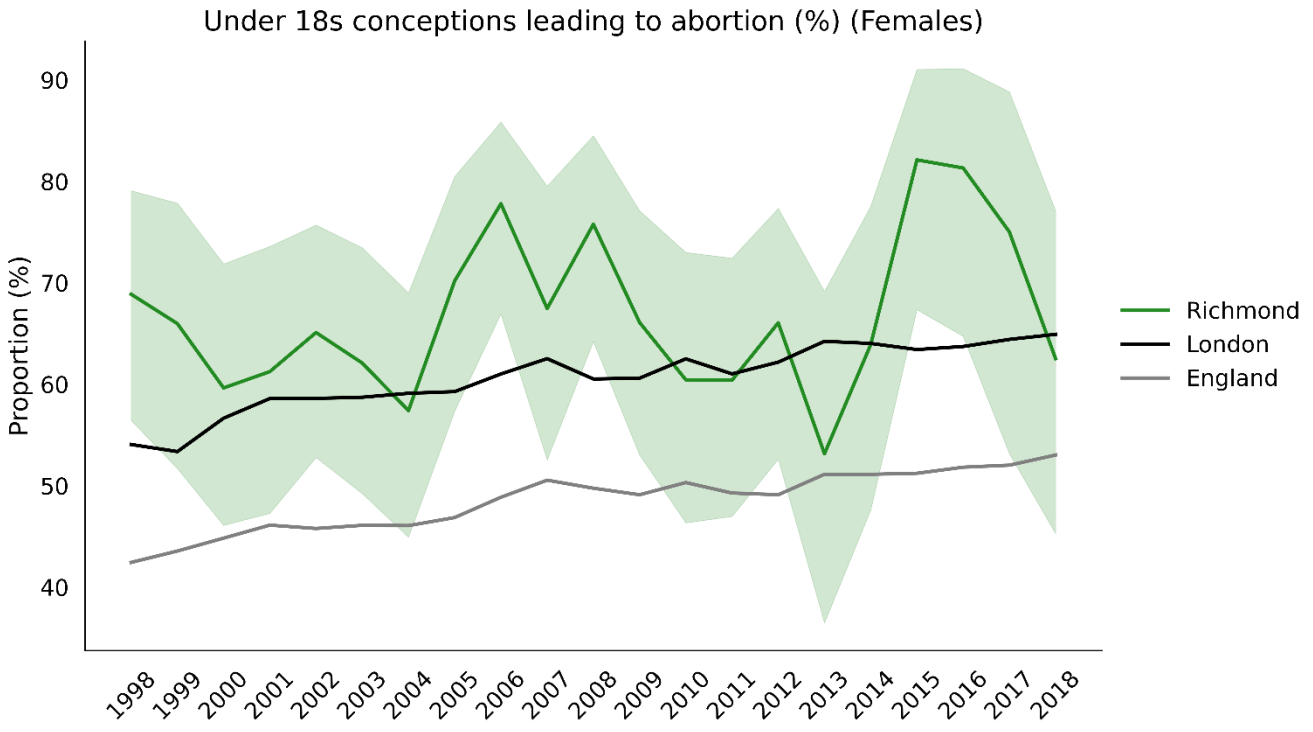
Most teenage conceptions are unintended, and the data suggests that access to contraception for young women in Richmond must continue to be strengthened to reduce abortion rates.

Figure 110: Proportion of Pregnancies Leading to Abortion in Under 18s by Local Authority, 2018



Source: PHE Public Health Outcomes Framework

Figure 111: Proportion of Pregnancies Leading to Abortion in Under 18s, 1998–2018

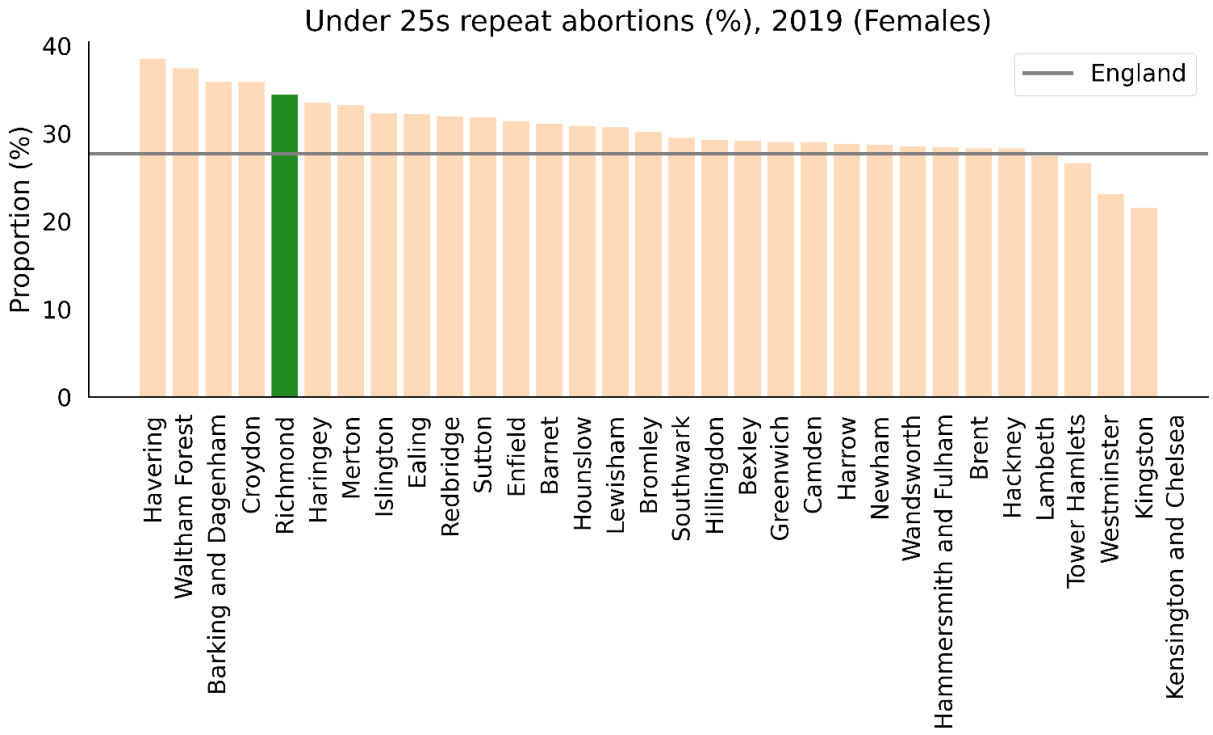


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Terminations in Under 25 Year Olds

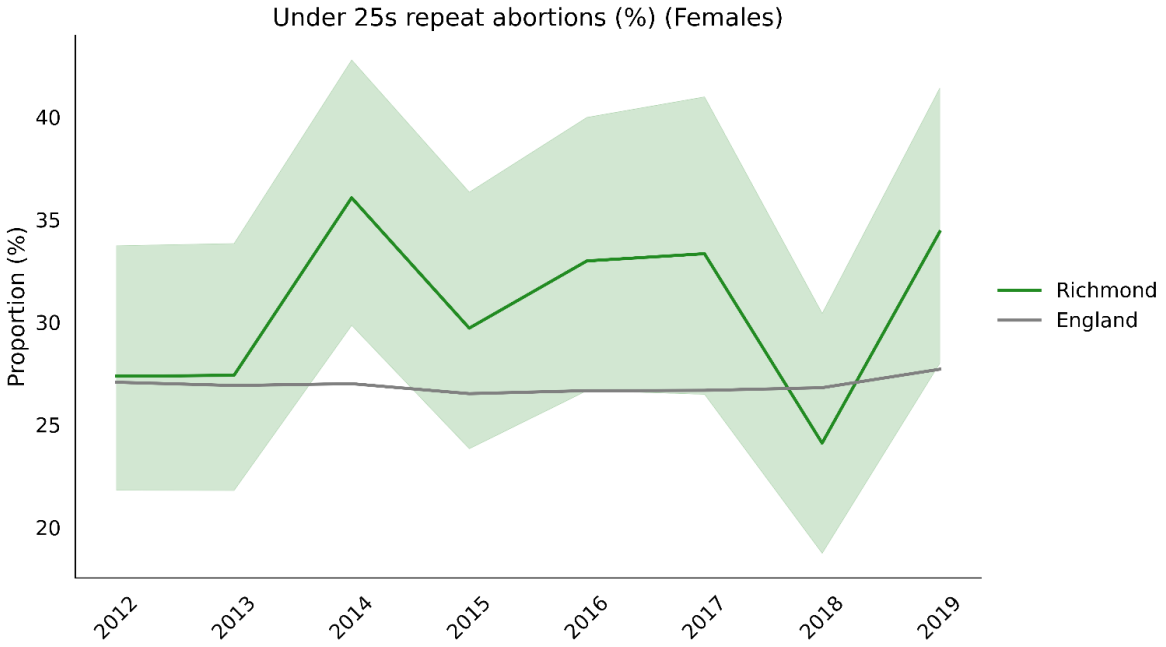
Richmond's 2019 repeat abortions rate in females aged under 25 years was 34.4 per 100 abortions, the 5th highest in London (**Figure 112**). This is 24.2% higher than the England average. The latest Borough figure is also 25.7% higher from year 2012, in comparison with a 2.3% increase in England's percentage in the equivalent time period (**Figure 113**). There has been a substantial increase in the percentage of repeat abortions from 2018 (24.1 per 100).

Figure 112: Repeat Abortions in Females Aged Under 25 Years by Local Authority, 2019



Source: PHE Public Health Outcomes Framework

Figure 113: Repeat Abortions in Females Aged Under 25, 2012–2019

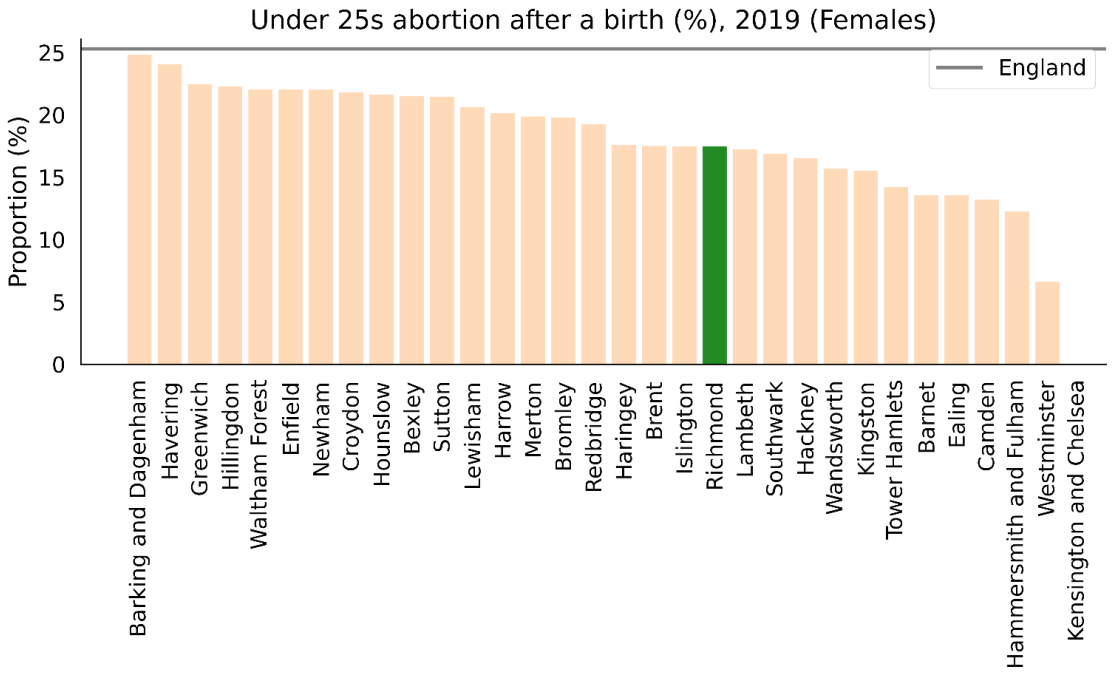


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

Termination After a Birth in Under 25 year olds

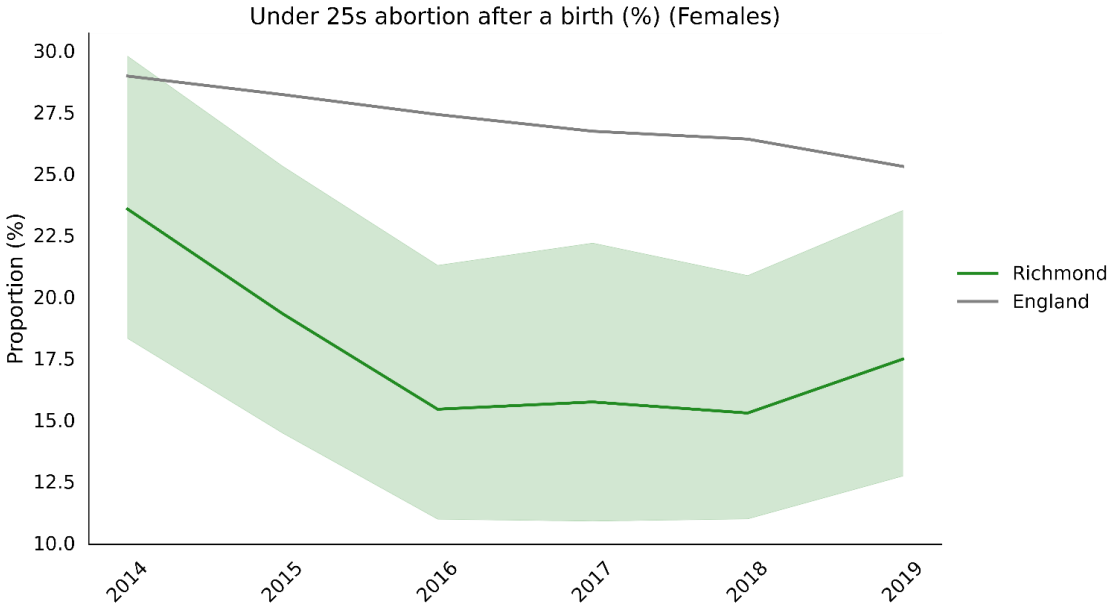
In 2019 in Richmond there were 33 females aged under 25 years having an abortion who have had a previous birth. This indicator can help to monitor the awareness of available postpartum contraception at the local level. Richmond's latest percentage of abortions after birth in females aged under 25 was 17.5 per 100, the 13th lowest in London (**Figure 114**). This is 31.0% lower than England the average. The latest Borough figure was also 25.9% lower from year 2014, in comparison with a 12.7% decrease in England's rate in the equivalent time period (**Figure 115**). The 2019 percentage has slightly increased from 2018 figure (15.3%).

Figure 114: Abortion After a Birth in Under 25s by Local Authority, 2019



Source: PHE Public Health Outcomes Framework

Figure 115: Abortion After a Birth in Under 25s, 2014–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

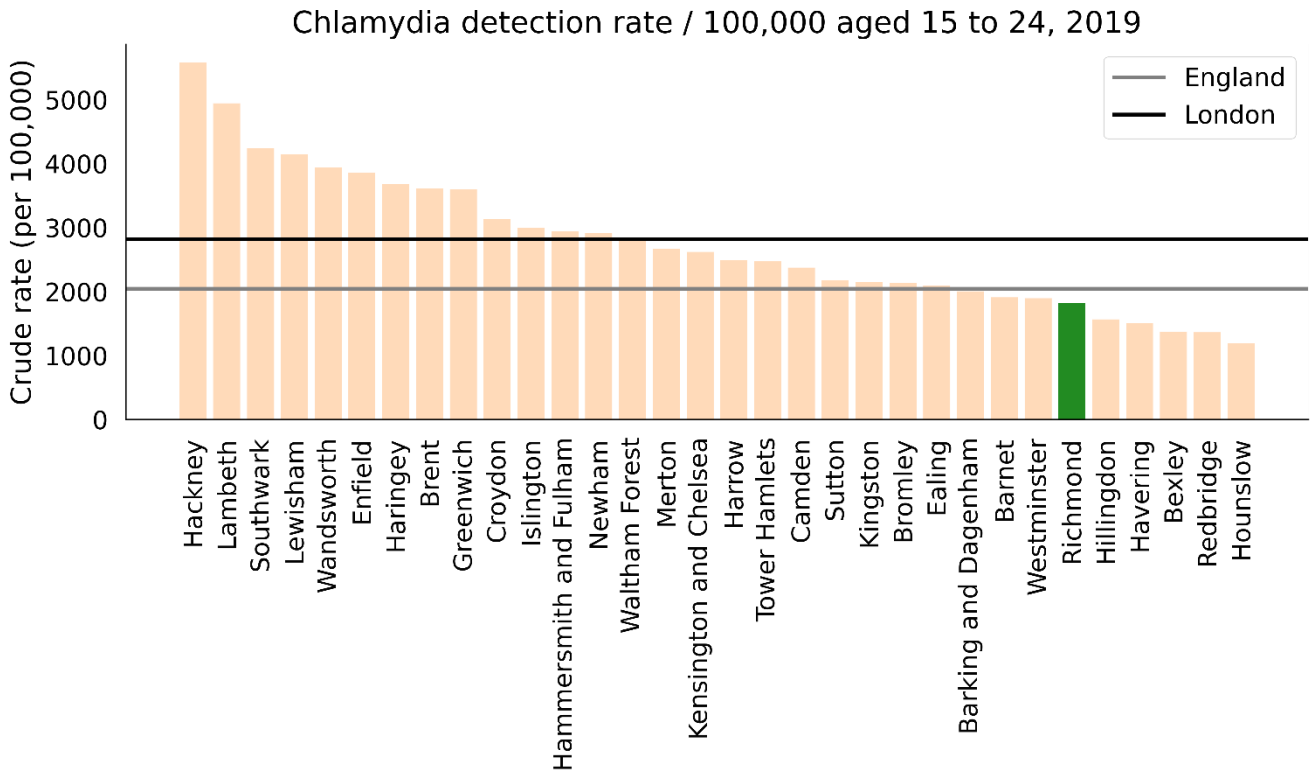
16. Sexually Transmitted Infections (STI)

16.1 Chlamydia Detection Rate

PHE recommends that Local Authorities work towards achieving a Chlamydia Detection Rate of above 2,300 per 100,000 population aged 15- 24 years. The recommended level was set high to encourage an increase in the volume of screening and diagnoses. The PHE expectation is that an increased level of screening is likely to result in a continued chlamydia prevalence reduction.

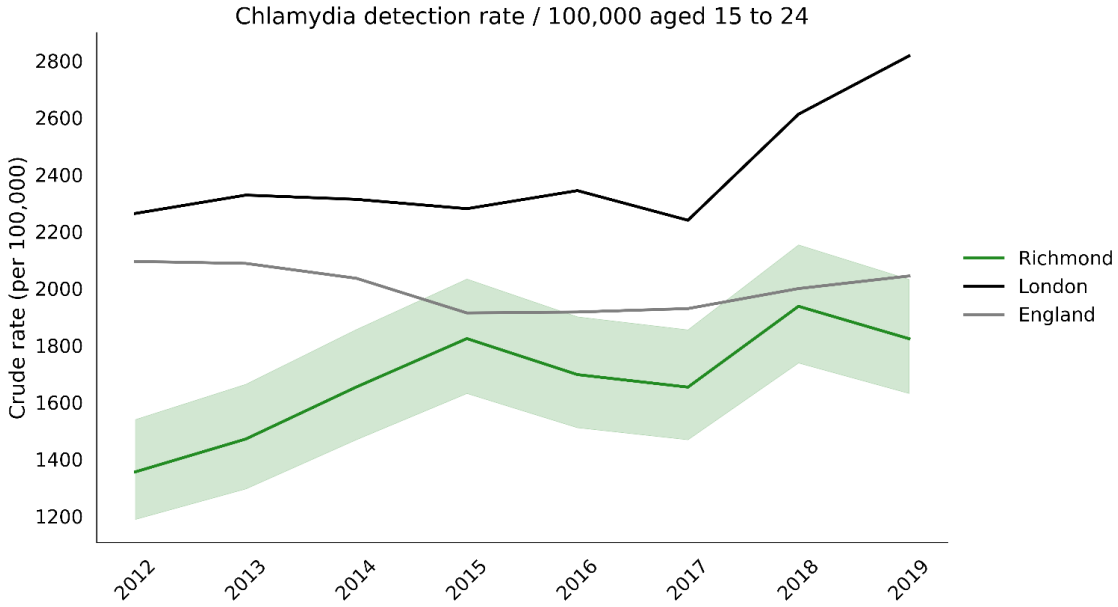
Richmond's latest chlamydia detection rate was 1823.1 per 100,000 (n=327), 6th lowest rate in London (**Figure 116**), which was 10.8% lower than the England average and 35.3% lower than the London average. The latest Borough figure was 34.5% higher from 2012 in comparison with a 2.4% decrease in England's rate in the equivalent time period (**Figure 117**). The 2019 Chlamydia Detection Rate in the Borough was also slightly lower than in 2018 (1937.0 per 100,000 population).

Figure 116: Chlamydia Detection Rate / 100,000 Aged 15 to 24 by Local Authority, 2019



Source: PHE Public Health Outcomes Framework

Figure 117: Chlamydia Detection Rate / 100,000 Aged 15 to 24, 2012–2019

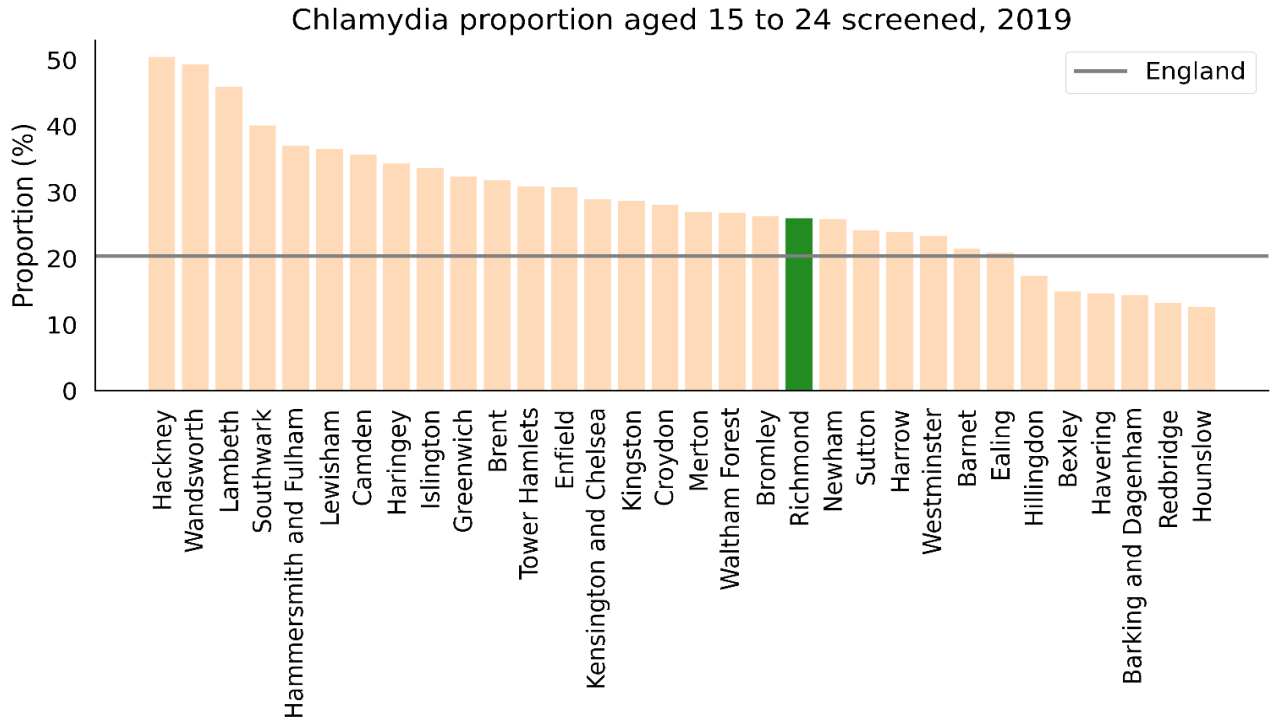


**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

16.2 Percentage of Young People Aged 15–24 Years Partitioned for Chlamydia

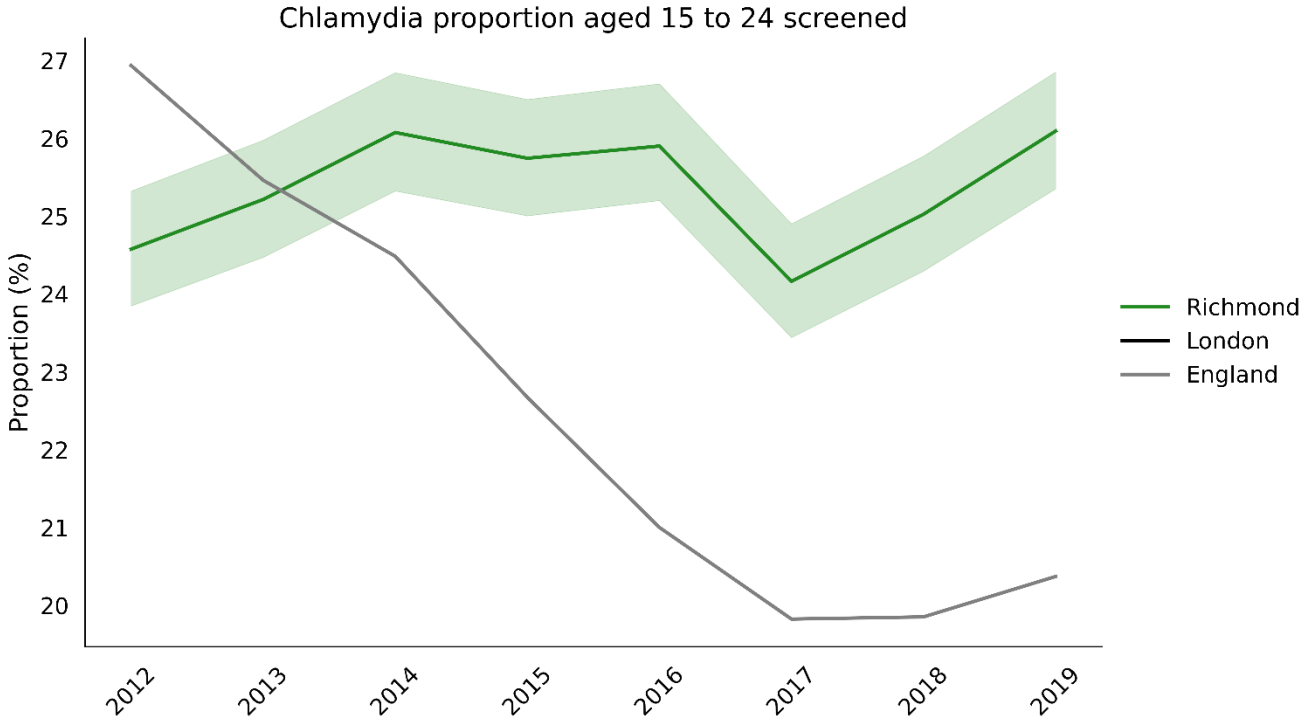
In 2019, Richmond's percentage of 15–24 year olds screened for Chlamydia was 26.1 per 100, the 2nd highest in London (**Figure 118**). This is 28.1% higher than the England average and 9% lower than the London average. The latest Borough figure was also 6.2% higher from year 2012, in comparison with a 24.4% decrease in England's rate in the equivalent time period (**Figure 119**).

Figure 118: Proportion of Population Aged 15–24 Screened for Chlamydia by Local Authority, 2019



Source: PHE Public Health Outcomes Framework

Figure 119: Proportion of Population Aged 15–24 Screened for Chlamydia, 2012–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

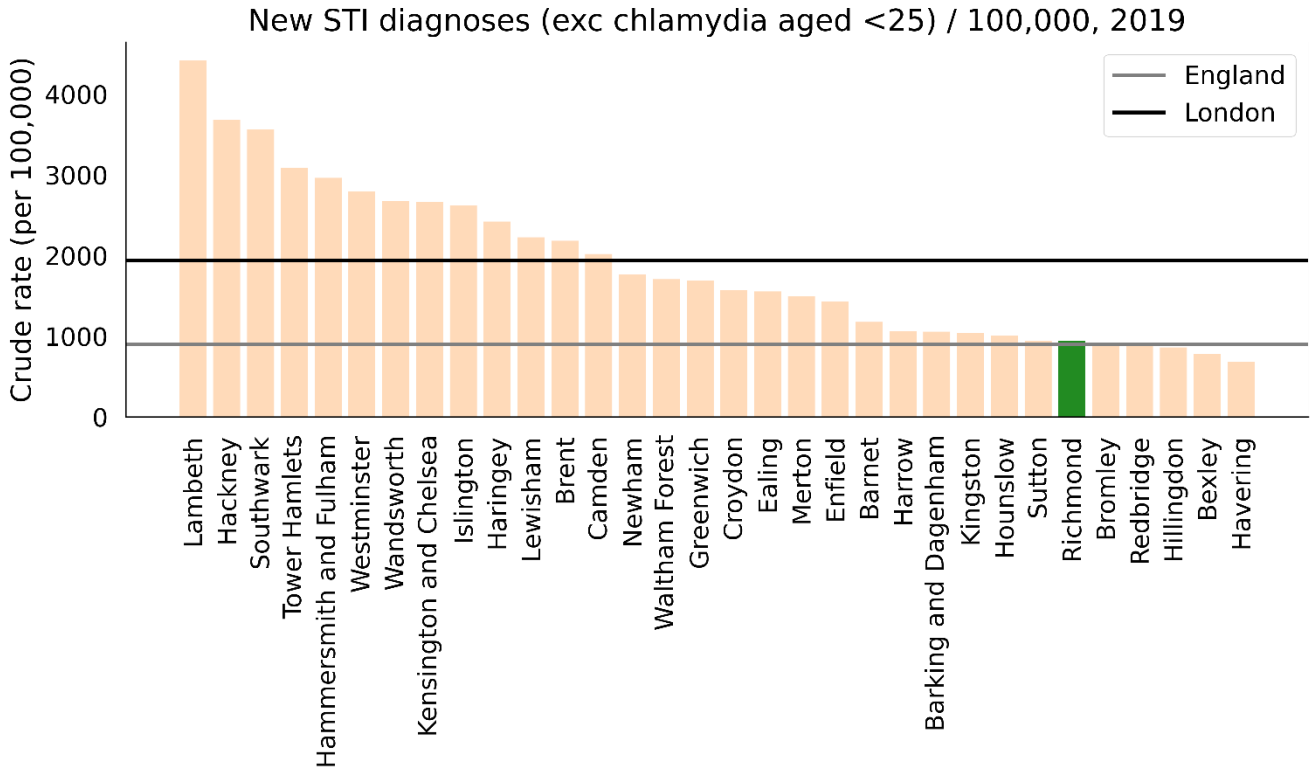
16.3 Other Sexually Transmitted Infections

There are no published non-Chlamydia STI indicators for young people aged 15–24 years. The only non-chlamydia STI indicator is available for 15–64 years age group only. Based on the national data, the impact of STIs remains greatest in young people aged 15-24 years, with most of STIs diagnosed in people aged under 35[88]. The rates of STIs are the highest in under 25 year olds, hence it is fitting to report on this indicator here.

In 2019 Richmond's rate of STIs other than chlamydia was 942.6 per 100,000 people aged 15–64 years, 6th lowest in London (**Figure 120**). This is 4.7% higher than the England average and 51.4% lower than the London average. The latest Borough figure was also 11.7% higher from 2012, in comparison with a 07.7% increase in England's rate in the equivalent time period (**Figure 121**).

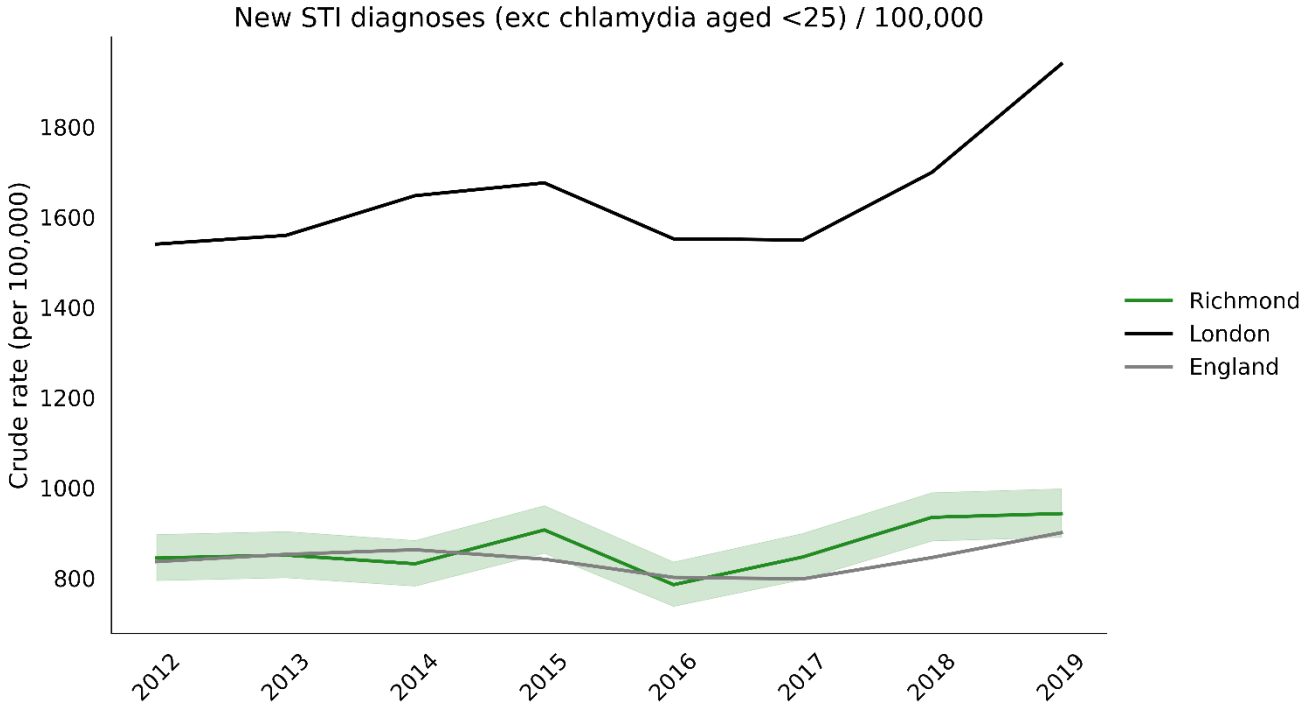
[88] PHE: Sexually transmitted infections and screening for chlamydia in England, 2019

Figure 120: Non-Chlamydia STI Diagnoses in People Aged 15–64 by Local Authority, 2019



Source: PHE Public Health Outcomes Framework

Figure 121: Non-Chlamydia STI Diagnoses in People Aged` 15–64, 2012–2019



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: PHE Public Health Outcomes Framework

17. Looked After Children

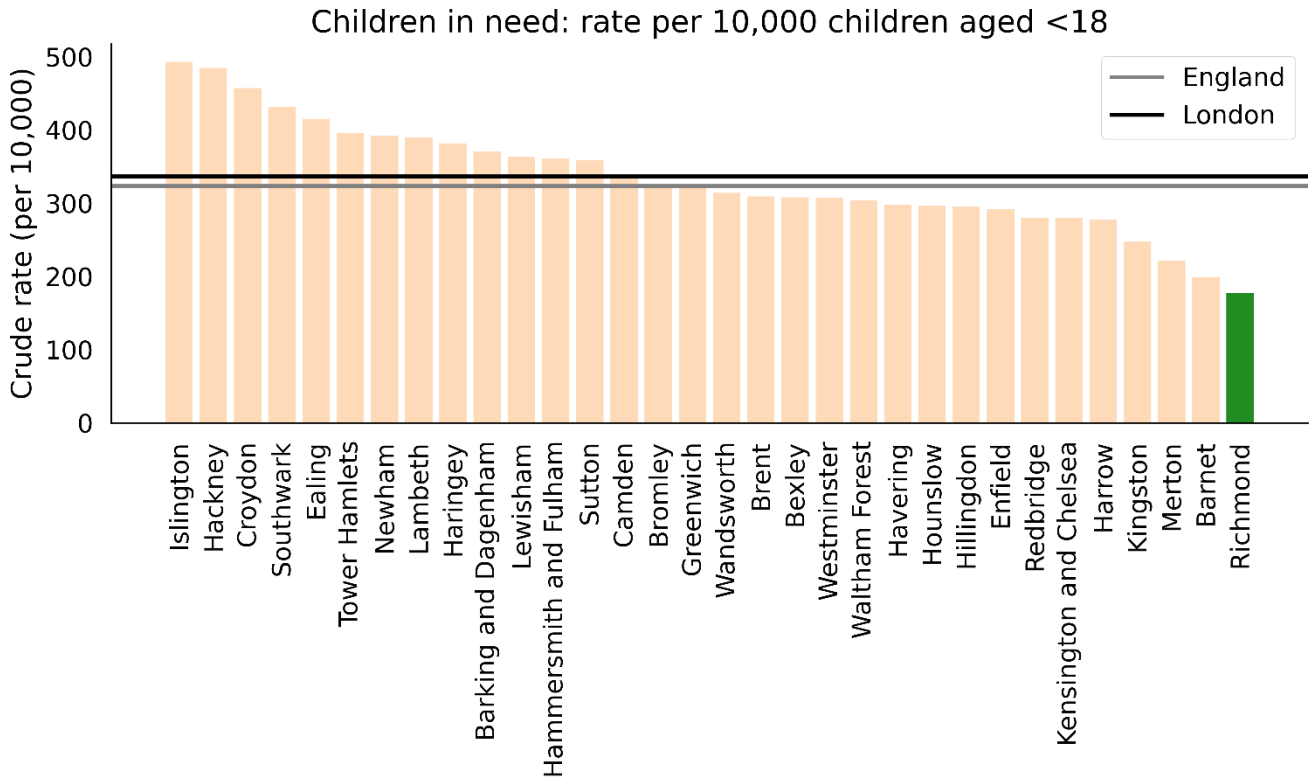
16.1 Looked After Children, Children in Need, Children on a Child Protection Plan

When family relationships breakdown or circumstances are concerning, it may be necessary for children to become 'looked after' by the local authority to ensure they are safeguarded and protected. A decision to take a child into care is not one that is made lightly. Key factors such as risk of harm, the child's health and well-being are all considered holistically before a decision to provide statutory care is taken. This is because evidence shows that longer term outcomes (including education, health and employability) for children who do not remain at home are usually poor. This makes looked after children (LAC) one of the most vulnerable groups in society.

The journey of a child into becoming looked after by the Local Authority starts with a referral to Children's Social Care Services. Following the referral, an initial assessment can identify the child as needing Social Care Services input.

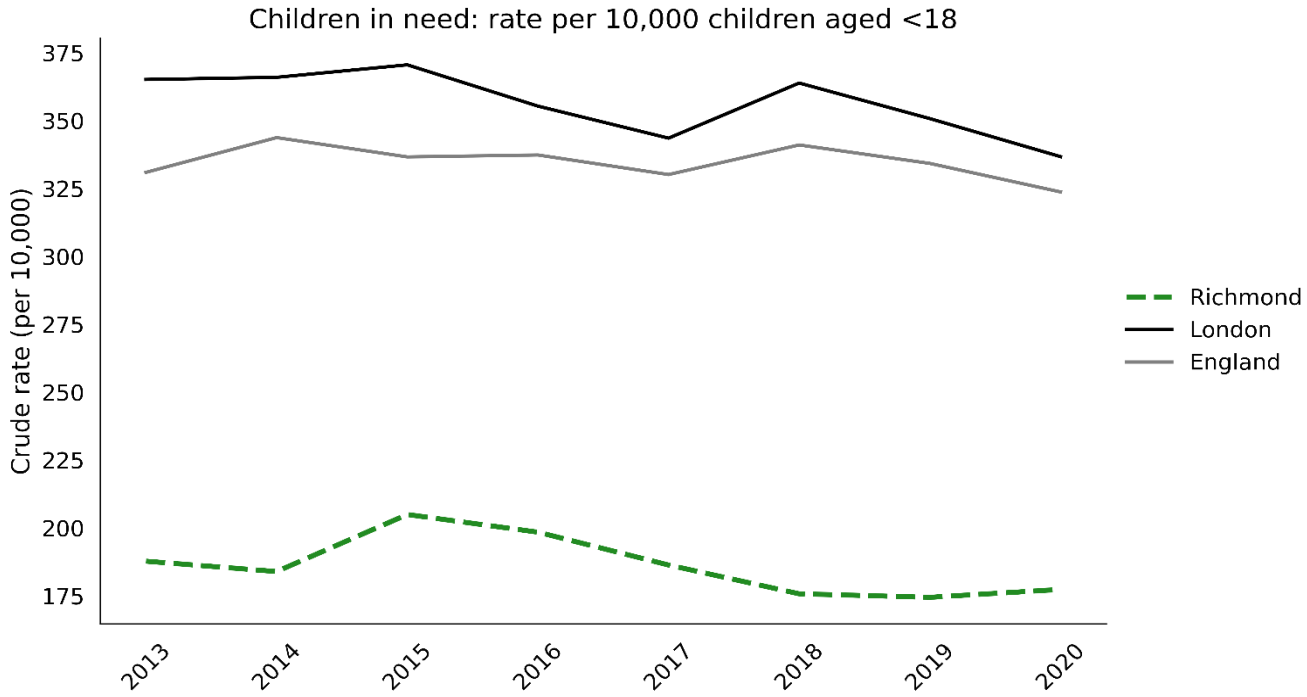
In 2020, Richmond's rate of children in need (CIN) was 464.2 per 10,000 children, the lowest rate in London (**Figure 122**). This which was 45.2% lower than the England average and 47.3% lower than the London average. The latest Borough figure was also 5.5% lower from year 2013, in comparison with a 2.2% decrease in England's rate in the equivalent time period (**Figure 123**).

Figure 122: Children in Need per 10,000 Children aged 0–17 by Local Authority, 2020



Source: ONS Children in need statistics, 2020

Figure 123: Children Identified as 'In Need' per 10,000 Children Aged 0–17, 2013–2020



Source: ONS Children in need statistics, 2020

A looked after child can be aged between 0–18 years. A child stops being looked after when they are adopted, return home or turn 18 years old. However, Local Authorities are required to support children leaving care at 18 years until they are 21 years old.

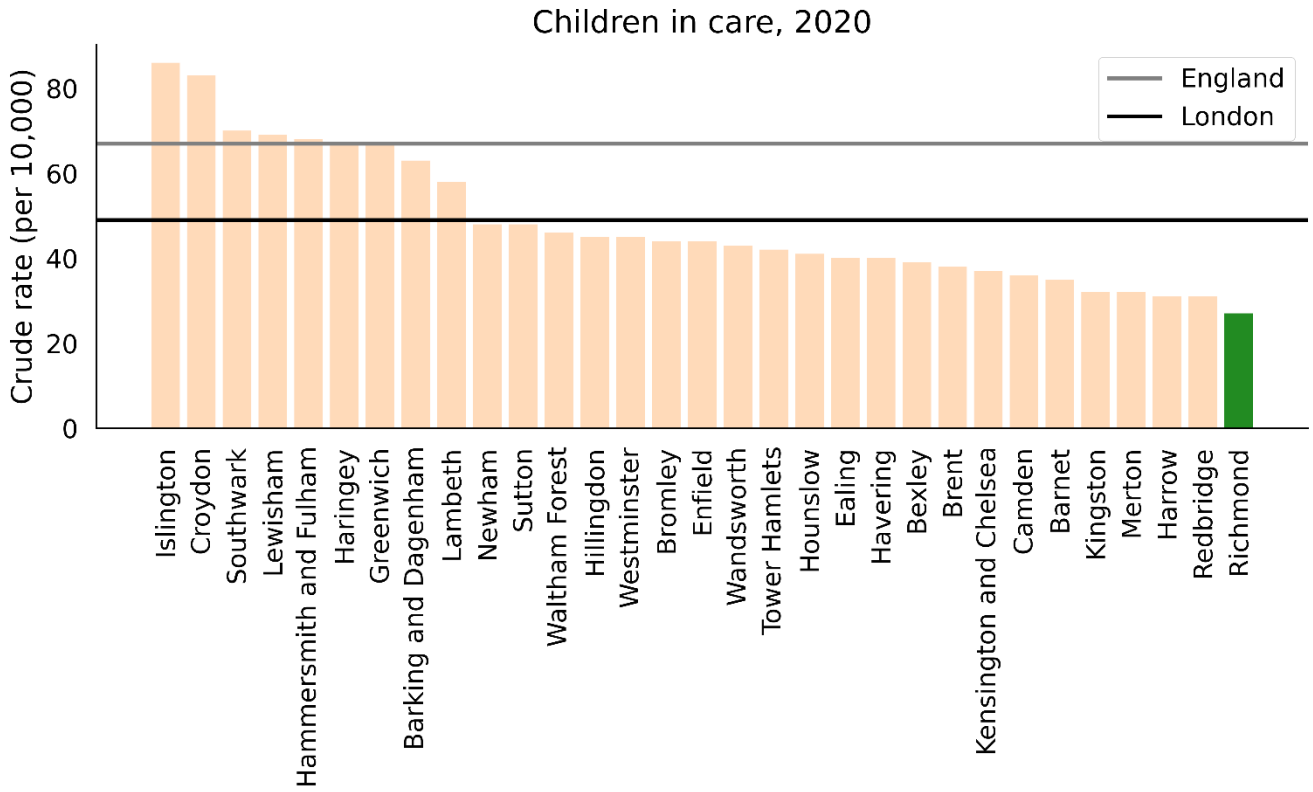
The definition of looked after children and duties of the local authority towards them are set out in the Children Act 1989. Local Authorities also have duties towards young people leaving care or care leavers, governed by the Children (Leaving Care) Act 2000.

Children considered looked after can be broken down into three main groups:

- Looked after children
- Unaccompanied asylum-seeking children
- Care leavers

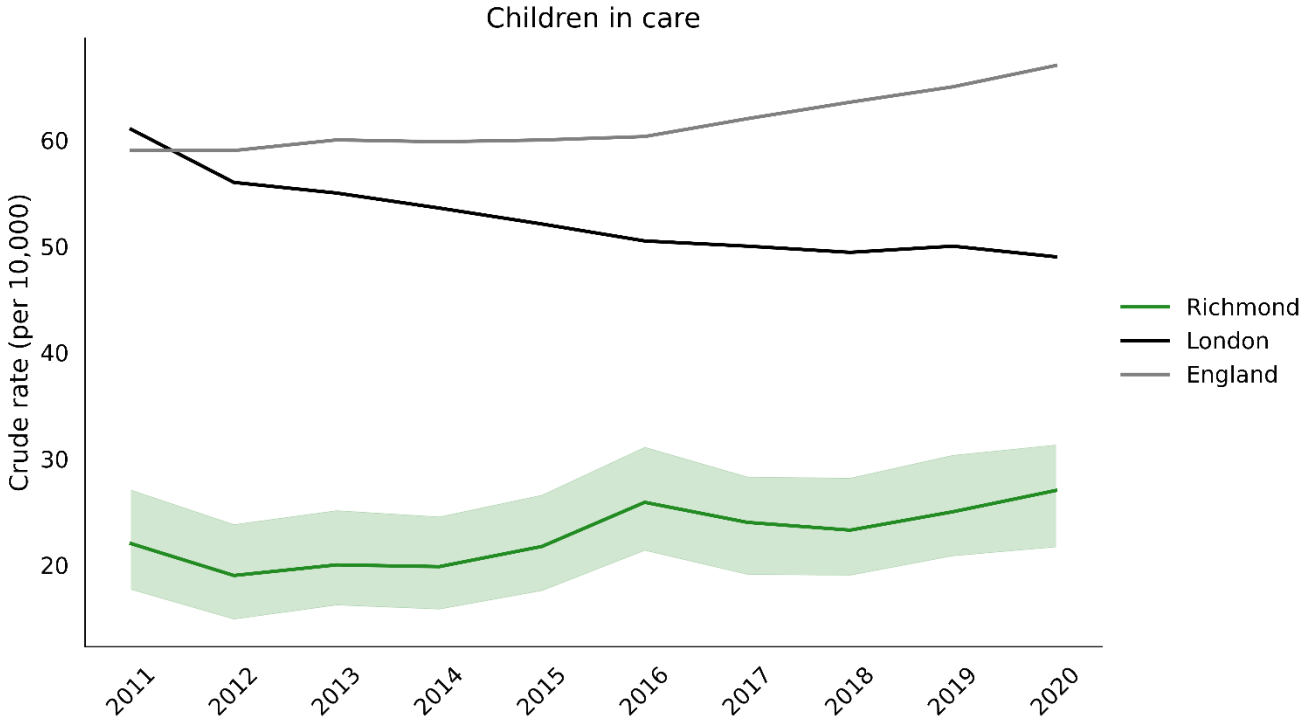
Children and young people come into the care of the local authority when it is necessary. Decisions are based on clear, effective, comprehensive and risk-based assessments that include input from the professionals working with the family. At the end of March 2020, 277 children and young people were being looked after by the local authority, this equates to a rate of 27.0 per 10,000 of the child population. This is lower than statistical neighbours and the London average, in fact it's the lowest in London (**Figure 124**). The latest Borough figure is 22.7% higher from year 2011, in comparison with a 13.6% increase in England's rate in the equivalent time period (**Figure 125**).

Figure 124: Looked After Children on 31 March (rate per 10,000 Population Aged Under 18 years) by Local Authority, 2020



Source: ONS Looked after children in England including adoptions, 2021

Figure 125: Looked After Children on 31 March (Rate Per 10,000 Population Aged Under 18 Years) by Local Authority, 2011–2020



**- green ribbon shows 95% confidence interval around Richmond's indicator values*
Source: ONS Looked after children in England including adoptions, 2021

There were 115 looked after children on 31st March 2019, this was taken as a snapshot. Of this group approximately 60% were male, while 51% were White and 49% were from a Black, Asian and Minority Ethnic group. Most looked after children were over the age of 16 years (approximately 44%), 28% were aged 13–15 years and 15% were aged 0–4 years old. The number of looked after children is projected to reduce slightly by 2022 to 111, with a consistent projected rate of 24 per 10,000 of the under-18 population. This is notably less than the 2018 rate in Kingston of 33 and the 2018 national rate of 64 per 10,000 of under-18 population. In 2018 47% of looked after children have an EHCP for SEND compared to 26.5% nationally. Conversely 17.6% of looked after children have SEND but are without an EHCP compared to 29% nationally.

In 2019 32% of looked after children were living in 38 in-house foster placements, and 24% in independent foster placements (Kingston 45%).

16% of looked after children went missing from care in Richmond compared to 11% nationally. Local data shows there were 99 episodes of children missing from care between October to December 2018. There were 27 episodes of children missing from home during the same period.

There were 794 children in need as measured on 31st March 2019, a rate of 174 per 10,000 under-18 population. This compares to 907 in Kingston, a rate of 233 per 10,000 under-18 population. The national rate in 2019 was 334 per 10,000 under 18 population. Locally, there is projected to be an increase of children in need to 840 by 2022.

There were 96 children subject to Child Protection Plans in 2019. This equates to a rate of 21.1 children for every 10,000 within Richmond and is notably less than the outer London rate of 37 and national rate of 43.7. Children and young people in Richmond have a lower likelihood of becoming subject to a plan for a second time at 15.9% compared to Kingston at 25% and nationally at 20%.

In 2018, 47.1% of looked after children had an EHCP, more than the national average of 26.5%. In 2018 17.6% of looked after children have SEND support (but not an EHCP) compared with 29% nationally. In 2017, 27.8% of school age children in need received SEND support compared with 25.3% nationally.

Data from services treating dependent adults in 2018/19 suggest that there were 24 households where children were living with alcohol misusing adults and 32 households with children living with substance misusing adults. In 2018/19 there were 220 households with children living with adults with mental health problems.

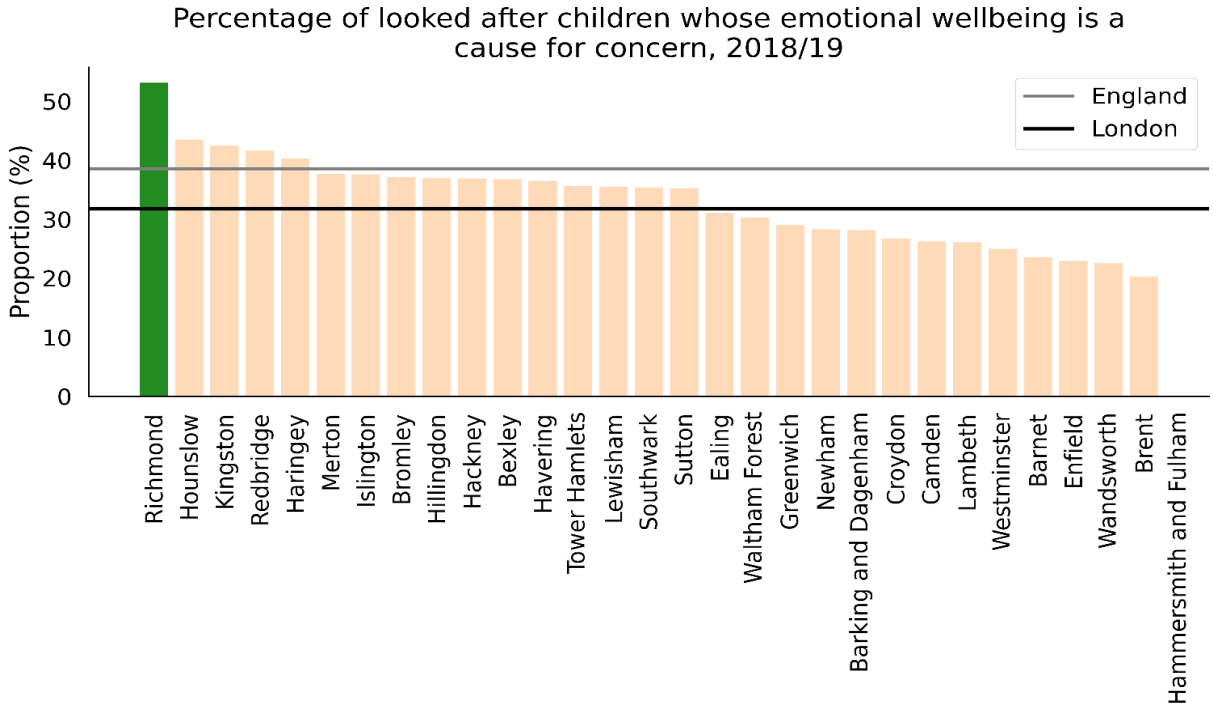
Below are the estimated prevalence rates of children living with adults with mental health concerns:

- there are 488 mothers with a mental disorder
- 20% of births are to women with mental disorders with varying degrees of severity
- there are 98 mothers with severe mental disorder
- 4% of births are to women who have severe mental disorders
- Around 3,290 children under 16 years (8% of children under 16 years) live with an adult who had recently used illicit drugs
- Around 12,320 children under 16 years (30% of children aged under 16 years) live with one binge drinking parent.

In 2018/19 there were 17 looked after children in Richmond that scored 17 or over on the Strength and Difficulties Questionnaire (SDQ).

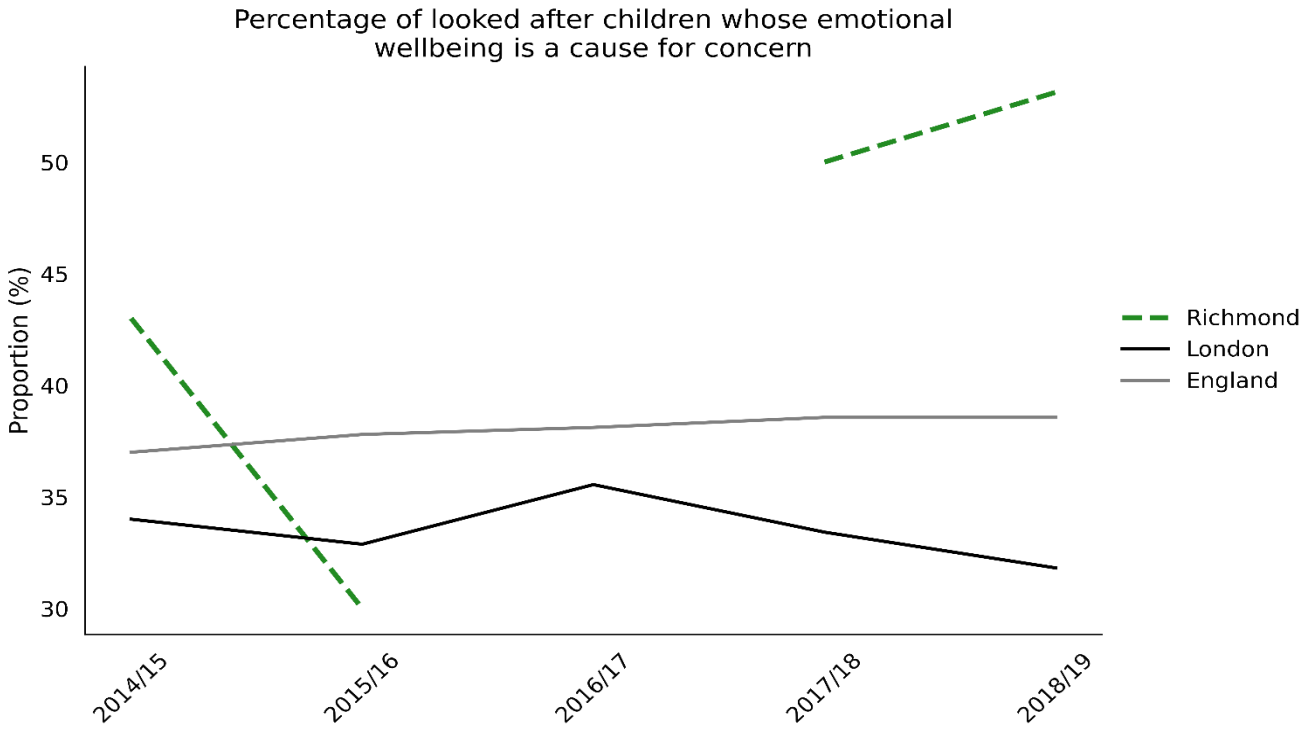
Such high scores indicate a substantial cause of concern for the emotional well-being of those children. The percentage of children with an SDQ score that is a cause for concern was 53.1%. This is much higher than the England average of 38.6% and the London average of 31.8%. Richmond's percentage of looked after children reporting substantial emotional difficulties is the highest in London (**Figure 126**). The 2018/19 figure was also 23.5% higher from 2014/15, in comparison with a 4.2% increase in England's rate in the equivalent time period (**Figure 127**). For 2016/17 the data for Richmond was suppressed for disclosure control reasons.

Figure 126: Proportion of Looked After Children in the Area who are Affected by Poor Emotional Well-being by Local Authority, 2018/19



Source: PHE Public Health Outcomes Framework, 2021

Figure 127: Proportion of Looked After Children in the Area who are Affected by Poor Emotional Well-being, 2014–2019



Source: PHE Public Health Outcomes Framework, 2021

In 2018, 17.6% of looked after children had SEND support, but not an EHCP, compared with 29% nationally.

18. Children with Special Educational Needs and Disabilities (SEND)

18.1 Prevalence of Need

A child or young person has Special Educational Needs and Disabilities (SEND) if they have a learning difficulty or disability which calls for special educational provision to be made for him/her. According to the 2019 School Census, 12.4% of the pupil population (3,442) with SEND live or were educated in the Borough. Of the 0–19 year old population, Hampton North ward had the highest percentage of pupils with SEND at 17.3% (203) followed by Heathfield ward, 16% (224). In March 2019, there were 1381 children and young people with an Education and Health Care Plan (EHCP) in the Borough; it is estimated that this number will increase to at least 1,596 in 2022.

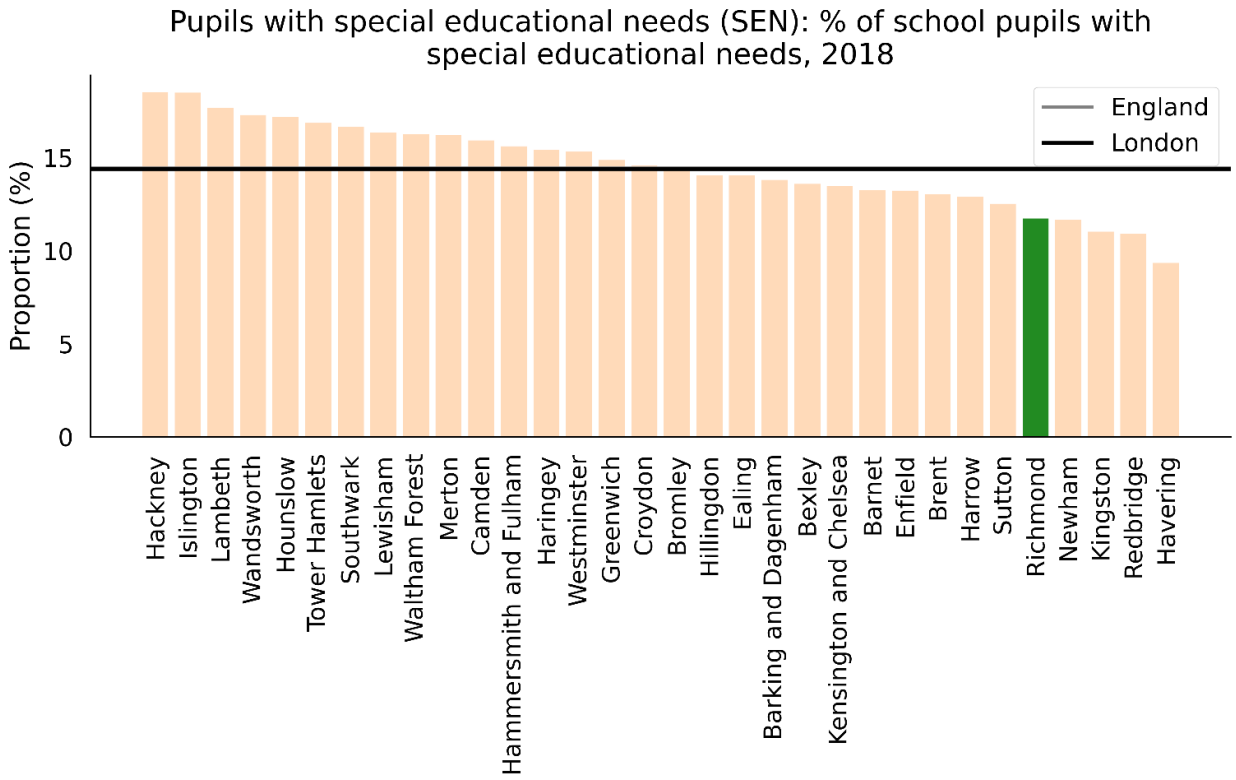
The largest percentage of children with EHCPs are 9–11 year olds followed by 15–17 year olds, with higher percentages seen amongst boys than girls. Generally, there are more children living in Richmond wards with SEND compared to those with an EHCP[89].

In 2018 in Richmond there were 3,183 children identified as having SEND, 11.7 per 100 (5th lowest percentage in London (**Figure 128**). This is 18.7% lower than the England average and 18.5% lower than the London average.

[89] Richmond's Children and Young People Needs Assessment.

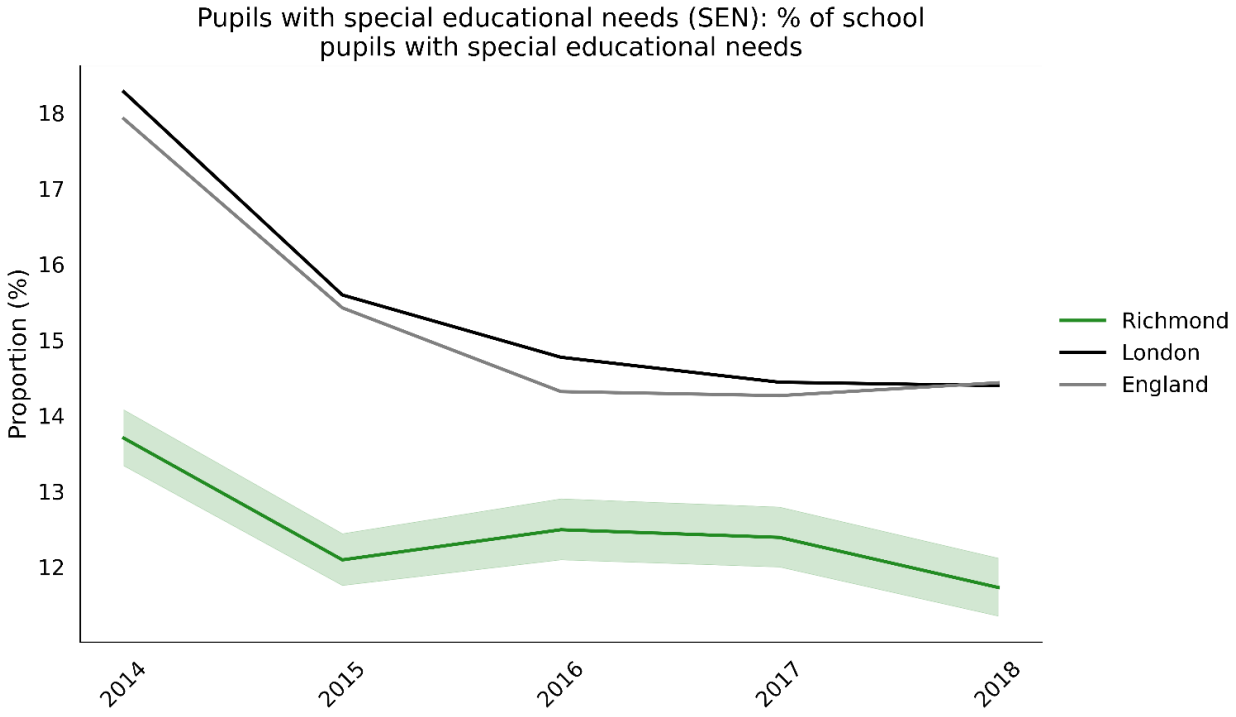
The latest Borough's percentage of children with SEND was also 14.4% lower from year 2014, in comparison with a 19.4% decrease in England's rate in the equivalent time period (**Figure 129**).

Figure 128: School Age Children with SEND by Local Authority, 2018



Source: PHE Public Health Outcomes Framework

Figure 129: School Age Children with SEND, 2014–2018



**- green ribbon shows 95% confidence interval around Richmond's indicator values*

Source: PHE Public Health Outcomes Framework

18.2 Demand-SEND Support, Education Health Care Plans, Residential

12.4% of the pupil population, 3,442 pupils with SEND live in or are educated in the Borough[90]. In all Richmond wards in 2018 more children have SEND support than an EHCP:

- 2.6% of pupils at Richmond schools have an EHCP
- 16% of pupils who live in in Heathfield, 15.8% of pupils living out of Borough and 17.3% of pupils living in Hampton North have SEND.

In 2018 47.1% of looked after children had an EHCP, more than the national average of 26.5%. In 2018 17.6% of looked after children had SEND support but not an EHCP compared with 29% nationally. In 2017, 27.8% of school age children in need receive SEND support compared with 25.3% nationally.

On 31 March 2019, 1,381 children and young people had EHCPs, an increase from 1040 in 2014. It is estimated that this will increase to at least 1,596 in 2022. The largest percentage of children with EHCPS are 9-11 year olds (286 individuals) followed by 15–17 year olds (275). In all age groups more boys than girls have EHCPs.

The main needs addressed in local EHCPs are:

- autistic spectrum conditions at 28%
- speech, language and communication needs at 18%
- social, emotional and mental health needs at 12%[91].

Learning disabilities at 44.2% and autism spectrum conditions at 32.5% are the most prevalent disabilities in children in need. This is in line with national averages.

In March 2019, 71.2% of EHCPs were issued within 20 weeks compared to 60.2% nationally. The rate of SEND registered appeals per 10,000 school population in 2017 was 8.14%, which was almost twice the national rate at 5.45%. On March 2019, 48 children and young people with SEND were in residential placements.

Of the 1381 children with EHCPs in 2019, 45% children and young people with SEND were in mainstream Schools (626 children), followed by special maintained and academies at 17% (231 children). 13% of 16 years + were in College (178) with 13% (174) in independent and non-maintained placements. 323 pupils access SEND transport, 271 of these were of statutory school age (aged 5–16 years).

18.3 Transition to Adult Services: Children Leaving Care

97% of children over 16 years remained looked after until their 18th birthday, compared with 71% nationally. 170 young people were supported by Leaving Care Services at March 2019. This is an increase from 131 in 2014 and has been impacted by the extended duty to provide services until 25 years of age.
In 2019 92% of children leaving care lived in suitable accommodation and 52% were in education, training or employment. This is the same or better than the national average.

[90] School CENSUS 2019
[91] *AfC SEND futures Plan*

19. Kingston and Richmond Safeguarding Partnership (KRSCP) Priorities 2020–22

The KRSCP priorities for 2020–2022 are:

- mental Health
- contextual safeguarding
- parental vulnerabilities and early help.

There are strong links between poverty, children living at risk of significant harm, and those being taken into local authority Care. 268 children aged under 16 years were living in temporary accommodation compared to 347 in 2018/19.

In Richmond, there are several Indices of Deprivation which affect our local children in some areas of need. 15% of Richmond children were living in low-income families in 2016. The Children's Commissioner highlighted the following local vulnerabilities, which often affect those who live in poverty:

- 2019/20, schools in Richmond made 24% more referrals to the Sigle Point of Access than the previous year
- 13% more Local Authority Designated Officer (LADO) referrals were made in Richmond, with an increase seen in those from sports organisations, early years' settings and Schools
- a higher need for child protection.

19.1 Mental Health

- In Richmond in Q3 20/21, 789 contacts for help due to child mental health were received at the Single Point of Access, a rise from Q2 of 579
- Contacts received by the Single Point of Access due to parental ill health (including mental health) continues to rise. In Q3 20/21 there were 235 contacts up from 223 in Q2 20/21 and 124 in Q1 20/21
- Contacts received by the SPA due to parental substance misuse was 169 in Q3 20/21, a rise from 133 in Q2 20/21.

The Children's Commissioner estimates there are 18,220 children aged under 18 years old living in Kingston and Richmond where an adult in their household has one of the three serious vulnerabilities, putting the child at greater risk of harm **Table 16**.

Table 16: Parental Vulnerabilities, Richmond

Parental vulnerability	Number of Children Aged 0–17 years
Alcohol / drug dependency	1420
Domestic Abuse	2620
Symptoms of mental ill-health	10,420
All 3 combined	790

Source: Richmond Council

There are other hidden harms that affect children and young people, many of which have been exacerbated by the Covid-19 Pandemic, including:

- poverty
- clinical vulnerability to COVID-19
- separation/relationship breakdown
- stress
- job loss and threat of job loss
- bereavement
- illness/worry.

All these factors put children at greater risk of hidden harm because there are no obvious physical signs of harm.

Table 17: MARAC Referrals, Richmond 2017–20

	2017/18	2018/19	2019/20
Number of children	259	252	154
Repeat cases	31%	29%	26%
BACK, ASIAN AND MINORITY ETHNIC GROUPS cases	22%	25%	28%
Disability	12%	12%	9%
LGBT cases	2%	1%	1.2%
Males	4%	6%	6%
16–17-year-olds	1.2%	2%	1%
Total cases discussed	251	230	246

Source: MARAC

Approximately 51% of children and young people accessing the Youth Resilience Services (YRS) are from Black, Asian and Minority Ethnic groups in Kingston and Richmond. This is an inequality within the Youth Justice cohort for Richmond and it has been agreed as a strategic priority for the next 3 years for the Youth Offending Service (YOS) Management Board and Partnership. There are small numbers of young people and young people from a Black, Asian and Minority Ethnic Groups across the Youth Justice cohort, however the outcomes within this cohort are often poor and require a specific focus going forward. Achieving for Children (AfC),a recent thematic audit into knife crime offences in 2019/20 further highlighted concerns regarding disproportionality. In Richmond, 7 in 10 knife crime offences involved young people from a Black, Asian and Minority Ethnic groups.

In 2021, Kingston and Richmond Safeguarding Children Partnership (KRSCP) will be completing a Local Child Safeguarding Practice Review with learning around perinatal mental health for all agencies including supervision, pre-birth risk assessments, staff confidence in working with families, and information sharing.

19.2 Child in Need and Pre-birth Child Protection Planning

Table 18 shows the category of abuse for child protection plans in Richmond 2016 onwards.

Table 18: Child protection plans in Richmond by category of abuse, 2016/17–2020/21

Category of Abuse	2016-17	2017/18	2018-19	2019-20	2020-21
Emotional	81	46	37	56	66
Neglect		29	26	48	46
Physical	7	17	28	51	34
Sexual	4	5	7	10	9

Source: AfC

Table 19 shows annual numbers of unborn children and children under the age of 1 that are on Child Protection Plan.

Table 19: Child Protection Planning Snapshots, Richmond, 2016–20

	2016/17	2017/18	2018/19	2019/20	2020/21
Richmond children unborn and under 1 year old	10	13	14	12	15

Source: AfC

- One local indicator of risk for unborn babies and infants is child protection planning. A Child Protection Plan is made if the child is considered by the multi-agency group to be at risk of significant harm. Plans can be made during pregnancy.

Other Indicators include:

- in 2020, numbers of pre-birth Child Protection Plans in Richmond had fallen to 29 in total up until October. Children in need plans pre-birth have increased during this year. Whilst these numbers are relatively small, there is a significant amount of pre-birth assessment work being undertaken with 49 assessments in total in Richmond. Attendance at A&E for children aged 0–4 years old is high on a London wide basis, which indicates infants are at significant risk of accidents, injuries and illness
- the KRSCP provides local learning to encourage further engagement of those practitioners working with adults to identify the children at potential risk in those families. This model is called Think Family and has a multi-agency protocol called See the Adult, See the Child protocol
- young carers may have difficulty accessing school and other support services or not being identified by those working with the adults in the home.
- In July 2021 here were 481 young carers supported by the Richmond Carers Centre[92]
- in 2013 in the UK there were between 10,000 and 13,000 potential victims of modern slavery. In 2019, there were four referrals for Modern Slavery in Richmond, which were all for young people aged 13–17 years.

[92] Source: Richmond Carers Centre

Acronyms

Acronym	Meaning
A&E	Accident & Emergency
ACE	Adverse Childhood Experiences
ADPHR	Annual Director of Public Health Report
AfC	Achieving for Children
ASQ-3	Ages and Stages Questionnaire
BFI	Baby Friendly Initiative
CAMHS	Child and Adolescent Mental Health Services
CHIS	Child Health Information Service
CIN	Children in Need
CLCHT	Central London Community Health Trust
CPP	Child Protection Plan
CYP	Children and Young People
CYPNA	Children and Young People Needs Assessment
DA	Domestic Abuse
DFE	Department for Education
DHSC	Department of Health and Social Care
DMFT	Decayed, Missing or Filled Teeth
DOH	Department of Health
EAL	English Aditional Language
EHCP	Education and Health Care Plan
FNP	Family Nurse Partnership
FTE	First Time Entrant
GLA	Greater London Authority
HCP	Healthy Child Programme
HEYL	Healthy Early Years London
HFHS	High Fat High Sugar
HPV	Human Papilloma Virus
IADCI	Income affecting Deprivation in Children Index
IMD	Indices of Multiple Deprivation
KRSCP	Kingston and Richmond Safeguarding Partnership
LADO	Local Authority Designated Officer
LGBTQ+	Lesbian, Gay, Bisexual, trans or questioning
LSOA	Lower Super Output Areas
MARVE	Multi Agency Risk Vulnerability and Exploitation
MESCH	Maternal Early Childhood Sustained Home Visiting Service
NCMP	National Child Measurement Program
NCT	National Childbirth Trust
NEET	Not in Education, Employment or Training
NICE	National Institute of Clinical Excellence
OECD	Organisation for Economic Cooperation and Development
ONS	Office of National Statistics
PHE	Public Health England
SEND	Special Educational Needs and Disabilities

SYV	Serious Youth Violence
TFL	Transport for London
UNICEF	United Nations International Children's Emergency Fund
WAY	What About YOUth
WHO	World Health Organisation
YO	Youth Offending
YOS	Youth Offending Service
YOT	Youth Offending Team
YP	Young People
YRS	Youth Resilience Services

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Image credits	Beans grown in Kew 2021 by Leona Patel, Public Health Lead, Richmond Council
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