APPENDIX B

The tool

Programme or project being assessed	Teen Health 11-19 Programme
Date completed	10.11.22
Contact person (name, Directorate, email, phone)	Imran Mahomed
Name of strategic leader	Kelly-Marie Evans

Steps to take	Your response – remember to consider multiple dimensions of inequalities, including protected characteristics and socio-economic differences
A. Prepare – agree the scope of work and assemble the information you need	
1. Your programme of work What are the main aims of your work? How do you expect your work to reduce health inequalities?	The national Healthy Child Programme framework sets out the suggested universal services for children and young people to promote optimal health and wellbeing. The Teen Health 11-19 service will provide support for health needs by providing evidence-based interventions for universal services for secondary aged young people. The service is integrated with LCC Children's and Families Wellbeing service to provide a holistic approach to prevention. The six high impact areas for school aged children identified following the national review are: 1. Supporting resilience and wellbeing 2. Improving health behaviours and reducing risk taking 3. Supporting healthy lifestyles 4. Supporting vulnerable young people and improving health inequalities 5. Supporting complex and additional health and wellbeing needs 6. Promoting self-care and improving health literacy prevention Alongside these three Local priorities were identified, these priorities are; • Emotional health and wellbeing including body image and self esteem • Healthy relationships • Substance misuse including alcohol

	The service will focus on the six high impact areas and local priorities to support and enable children and young people to achieve their full potential and be physically and emotionally healthy leading to a productive adulthood. The key objectives of the service as per the service spec are focussed on reducing health inequalities: - to improve the health and wellbeing of children and young people and reduce inequalities in outcomes as part of an integrated multi-agency approach to supporting and empowering children and families. - to ensure a strong focus on prevention, health improvement, early identification of needs, early intervention, and clear packages of support. - to identify and support those who need additional support and targeted interventions, for example, young people suffering from low self-esteem, anxiety, low mood who need support with managing their emotions in accordance with NICE guidance. - to provide expert advice to help lay the foundations for emotional resilience and good physical and mental health - to ensure early help and additional evidence-based preventive programmes to promote and protect health - reducing the risk of poor future health and wellbeing - to promote positive health messages and behaviour change using evidence-based approaches. - to promote national campaigns such as Rise Above - to work with children and young people and their families to support behaviour change leading to positive lifestyle choices through working with individuals or as a family or a wider group. - to support families and young people to engage with their local community through education, training, and employment opportunities to support young people, and families to navigate the health and social care services to ensure timely access and support - to safeguard children and young people through safe and effective practice in safeguarding and child protection. This will include working with other agencies to intervene effectively in families where there are concerns about parenting capacity, adult mental health, alcohol or substance misuse, domestic abuse or child abuse. - to develop on-going relationships and support; universal reach for all children and offering services which are personalised to meet individual need and the early identification of additional and/or complex needs - to deliver services in partnership to with CFS and will include embedding Healthy schools and be 'lead professional' or 'key worker' for a child or family where and where appropriate

2. Data and evidence What are the key sources of data, indicators, and evidence that allow you to identify HI in your topic? • Consider nationally available data such as health profiles and RightCare • Consider local data such as that available in JSNA, contract performance data, and qualitative data from local research	Health-Related Behaviour Questionnaire results: Consultation with and feedback from a Focus Group: (local priorities) Leicestershire JSNA https://www.lsr-online.org/leicestershire-2018-2021-jsna.html (currently being updated) LSOA in Leicestershire 10% most deprived (2019) https://imd-by-geo.opendatacommunities.org/ - Charnwood - North West Leics Public Health Outcomes Framework: https://www.lsr-online.org/public-health-outcomes-framework.html Public Health Fingertips data: District Level School Health Profiles: https://www.lsr-online.org/childrenyoungpeople.html
B. Assess – examine the evidence and intelligence	
3. Distribution of health Which populations face the biggest health inequalities for your topic, according to the data and evidence above?	Socio-economic status or geographic deprivation: Leicestershire is within the 10% least derived decile in the country. However, it has significant health and wellbeing challenges and variation between communities. Add updated JSNA data Areas of deprivation - According to IMD 2019, most of Leicestershire's towns have pockets of deprivation and clear inequalities. Coalville and Loughborough have communities considered the 'most deprived' in the country – both towns also have communities considered the 'least deprived' - Childhood obesity is higher in areas of deprivation in Leicestershire - The most deprived communities have lower life expectancy

	- School readiness is lower than the Leicestershire average in localities with increased income inequalities – these are often sustained to school leaving age (or the gap widens further) South Asian communities - Increased prevalence of DMFT in areas with higher BAME populations, e.g. O&W Rural communities - A significant proportion of the population live in rural areas with reduced access to services, such as sexual health clinics, GP practices, unemployment support etc LSOAs in the most deprived areas - Charnwood - North West Leicestershire
	Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care): - Children and young people not attending mainstream school settings - Children and young people living in homes with domestic violence present/chaotic lifestyles frequently absent from schools - Children and young people who may by asylum seekers or refugees - Children and young people experience gender identity or difference - Children and young people with ongoing illness who may be frequently absence from education - Children and young people with alcohol/substance dependant parents or dependant themselves missing schools regularly - Families with no fixed abode/frequent moving - Informal young carers, caring for family members
	Experience related to protected characteristics: - Age - Sex - Race - religion or belief - disability - sexual orientation - gender reassignment - pregnancy and maternity - marriage and civil partnership

4. Causes of inequalities	
What does the data and evidence tell you are the potential drivers for these inequalities? • Which wider determinants are influential? E.g. income, education, employment, housing, community life, racism and discrimination. • What aspects of mental wellbeing are affected? Consider risk and protective factors. • Which health behaviours play a role? • Does service quality, access and take up increase the chance of health inequalities in your work area? Which of these can you directly control? Which can you influence? Which are out of your control?	• Which wider determinants are influential? E.g. income, education, employment, housing, community life, racism and discrimination. - Income and job prospects - Educational attainment - Neighbourhood/area effects- concentrated pockets of deprivation, role modelling effects, concentration of disadvantaged people - Lack of social/community cohesion of the area, higher rates of crime/antisocial behaviour - Racial, religious or other discrimination • Causes of inequalities :what aspects of mental wellbeing are affected? Consider risk and protective factors. - Life chances affected – poorer education attainment in areas with higher deprivation leading to limited job options less chance of social mobility - Mental wellbeing affected leading to comfort seeking behaviours that may lead to unhealthy habits going forward – self harm, drug use, alcohol dependency - Low provision of support within the wider system for CYP with ASD/ND without presenting MH need • Which health behaviours play a role? - Health harming behaviours such as drinking, drug use, comfort eating - Limitations due to area/school attended for example areas with higher crime risk children may be less likely to engage in active travel to and from school due to safety concerns. Ait quality of area, road safety etc. • Does service quality, access and take up increase the chance of health inequalities in your work area? - Somewhat Which of these can you directly control? - Adopting Proportionate Universalism approach to targeted offers to those schools in the most deprived areas and ensuring thematic focus/support based on local needs Which can you influence?

	- Delivering evidence based early intervention support to children and young people to improve emotional health and wellbeing, positive relationships and informed decisions regarding sexual health and substance use. - Supporting schools to adopt evidence-based approaches to improving health and wellbeing within the school setting, e.g. policies that facilitate good health, - Supporting schools to work with wider PH programmes - Improving partnership links with wider system and VCSE Which are out of your control? - Schools that may not yet see the benefits of the approach - CYP that are home schooled, that are NEET, attending Special/SEND schools, - Young people that are in FE/HE - Support within system for CYP with ASD/ND without a MH need
C. Refine and apply – make changes to your work plans that will have the greatest impact	
5. Potential effects In light of the above, how is your work likely to affect health inequalities? (positively or negatively) Could your work widen inequalities by: • requiring self-directed action which is more likely to be done by affluent groups? • not tackling the wider and full spectrum of causes? • not being designed with communities themselves. • relying on professional-led interventions? • not tackling the root causes of health inequalities?	• Could this work widen inequalities by not tackling the wider and full spectrum of causes/ not tackling the root causes of health inequalities? Although the Teen Health service cannot directly affect wider underpinning causes of inequalities such as poverty or educational attainment and wider social injustices, it can be effective in reducing inequalities by supporting the health and wellbeing of students to promote better outcomes. School settings will receive input from a Health and Wellbeing Officer with links into wider PH activity. This will promote awareness of and improve access to physical and emotional health and wellbeing. This embedded approach will ensure that children, and by extension parents/families and school staff benefit from healthy behaviours and choices. As the Teen Health service will initially be based in and with mainstream secondary schools, children not routinely attending school settings, children attending SEND/Specialist schools, or those in Further and Higher Education will miss out on this support. As such a digital offer is being created to allow access to information and advice, along with signposting to more specialist support

	Larger schools/those part of Academy chains/those in more affluent areas may be financially better resourced and therefore already have more capacity to deliver similar support within their school setting. Use of the schools wellbeing audit will support the Teen health team to ensure services in schools are not being duplicated, and this could allow additional targeted work at those schools that may require it in more deprived areas.
6. Action plan What specific actions can your work programme or project take to maximise the potential for positive impacts and/or to mitigate the negative impacts on health inequalities? • How can you act on the specific causes of inequalities identified above? • Could you consider targeting action on populations who face the biggest inequalities? • Could you design the work with communities who face the biggest health inequalities to maximise the chance of it working for them? • Could you seek to increase people's control over their health and lives (if appropriate)? • Could you use civic, service and community-centred interventions to tackle the problem – to maximise the chance of reaching large populations at scale? • Who else can help?	Following programme launch, the Teen Health service will complete a brief 'Schools Wellbeing' audit to inform the focus of programme delivery in each school. PHE, Ofsted and local data could also be used to understand where there may be significant areas of concern within a school and/or community. • How can you act on the specific causes of inequalities identified above? While the programme will have little control on key wider determinants of health for CYP, such as household income, housing status, it can support children and young people directly through information and intervention sessions, and indirectly by encouraging and supporting schools to ensure the environment and the schools' practices are supportive of positive health and wellbeing. • Could you consider targeting action on populations who face the biggest inequalities? The initial allocation of resource will be based on school population to ensure equity of access, following collation of data and needs analysis the programme can adopt a more targeted approach to programme delivery and will actively focus on particular needs such as high teenage pregnancy rates etc • Could you design the work with communities who face the biggest health inequalities to maximise the chance of it working for them? Initial planning includes identifying and developing Youth Voice in schools with Wellbeing Officer support, this could support development of focus groups in schools to coproduce programme design and delivery methods alongside a Neighbourhood network. • Could you seek to increase people's control over their health and lives (if appropriate)? The Teen Health service will work across the National and Local priorities, as such the focus is on a preventative approach to improving and maintaining good health and wellbeing. The service will also facilitate earlier uptake of services and improved service promotion, e.g. sexual health service to increase CYP control over their health. • Could you use civic, service and community-centred interventions to tackle the problem – to maximise the chance of reaching large populations at scale? There is ongoing work to develop a digital offer which could support community health promotion/campaigns, and there is a commitment to working with wider PH campaigns • Who else can help?

	Partnerships with Youth Engagement Activators, Healthy Schools Programme, MHST teams, SEN/Inclusion services, wider CFWS, Youth Services, District Councils; CAMHS; ICB
7. Evaluation and monitoring How will you quantitatively or qualitatively monitor and evaluate the effect of your work on different population groups at risk of health inequalities? What output or process measures could you consider?	• School Wellbeing Audit • Development of KPI framework which will support monitoring of outcomes and mapped to Health In All Policies approach • Delivery of Teen Health programme in schools • Additional training delivered to schools (e.g. asthma or c-card) • Annual reports from Team Leads and Wellbeing Officers working with schools, reporting on targeted engagement activity • Evaluation of service (to be commissioned)
Set a health equity assessment review date, recommended for between 6 and 12 months from initial completion. Review date:	

D. Review – identify lessons learned and drive continuous improvement	
Date completed (should be 6-12 months after initial completion):	20.02.23 (early review, scheduled to be reviewed fully in May 2023 and Aug 2023)
Contact person (name, directorate, email, phone)	Imran Mahomed
1. Lessons learned Have you achieved the actions you set? How has your work: a) supported reductions in health inequalities associated with physical and mental health? b) promoted equality, diversity and inclusion across communities and groups that share protected characteristics? What will you do differently to drive improvements in your programme? What actions and changes can you identify?	The service is now beginning to embed within the mainstream secondary schools in Leicestershire. The initial phase includes completing a schools wellbeing audit (attached below) to identify existing additional services and gaps in relation to the local priority areas. In addition direct feedback has been obtained from schools advising a need for services providing support regarding sexual health and for vaping. Planning is underway to provide sexual health drop-in sessions which will be accessible for all CYP. The service is supporting the local Youth Parliament programme to develop a health and wellbeing day across all secondary schools in October. This will be complemented by a focus on supporting and developing Youth Voice opportunities within each school population, to allow meaningful co-production and promote health equity. Specialist training from Stonewall has been procured in response to feedback from Health and Wellbeing officer's regarding identified need for support for students identifying as LGBTQI+, or with queries regarding sexuality and identity. Data from the schools audit, and wider information from local partners, such as the FSM data will inform further developments of service delivery. While the above early outcomes are positive, there could be a risk that while the service focusses on delivering a standardised service across the County, it could miss opportunities to support reductions in health inequalities within local populations. As such there remains a need to ensure links with local networks and partners, as well as regular reviews of the audit and local data to inform service development  School Audit v2.4.docx .

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