
Children and young people in Lancashire

March 2011

Intelligence for Healthy Lancashire (JSNA)



**Children's Trusts
in Lancashire**

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Foreword from the Lancashire Children's Trust

The information within this document represents a huge step forward in understanding the needs of the children and young people across Lancashire. Never before have we collated in one place such detailed intelligence from such a range of partners.

Already this intelligence has helped to identify priorities for improving the outcomes for children and young people, which have shaped Lancashire's Children and Young People Plan 2011-2014. This has ensured there is a sound evidence base for the priorities we have established and in turn how we will determine what resources go where. We would ask that partners consider how they can use this JSNA to contribute to improving the lives of Lancashire's children and young people.

Moving forward, we now have a platform to inform decisions about how we deliver services for children and young people. This is both at a Countywide and a local District level. However, just as importantly there is a need to ensure we build on this evidence base through talking to children, young people and their families and considering this feedback alongside the data and statistics. Using intelligence from agencies, without interpretation from children, young people and families and subsequent action is purely an activity not an outcome.

This will enable the partners within the Children's Trust to continue to work together and deliver our new vision for service delivery through:-

- helping our children and young people to be the best they can be;
- being confident that the services we are commissioning are the right services delivered in the right way and in the right place; and
- working collaboratively in overcoming future challenges by being clear about what we are trying to achieve and why.

Finally, I think it is quite right that this document highlights the very real and specific needs of children and young people across Lancashire. We must address these, but we must also never lose sight of what a wonderful asset our children and young people are. We must lead the way in having the highest expectations on their behalf and truly believe that the future of every child and young person matters and that we can and will help them on this journey.

Helen Denton

Chair of Lancashire's Children's Trust Board

Introduction

Inequalities in the health and wellbeing of children and young people were identified as one of the top ten health inequalities in Lancashire (Lancashire JSNA 2009). The development of the Children and Young People's Plan (CYPP) for 2011-14 required a needs assessment to identify priorities for Lancashire and it was requested that this should be completed under the JSNA programme for 2010/11.

The JSNA has been completed during a challenging financial climate. Throughout the process this has been explicitly recognised and the duty of the analysis has been not only to identify what the evidence tells us about the current areas of need within the county but also to consider what the impacts for children and young people might be as the financial effects take hold.

The JSNA has been delivered by a multi-agency project team with input from a broad and extensive list of stakeholders. By engaging a variety of agencies in the assessment of priorities for Lancashire it is believed that this has ensured the priorities are owned by these agencies working across Lancashire to ensure the best outcomes possible for children and young people.

A full list of acknowledgements are contained in the appendices, but at this stage the project team would like to acknowledge two reports which have been used extensively to shape the content of this JSNA, particularly with regards to the literature review:

- Kent JSNA, Joint Strategic Needs Assessment for Children in Kent: Health, wellbeing and healthy public policy, 2010; and
- NHS Bolton Director of Public Health report 2005, the Health of Children and Young People.

Objectives

The purpose of the JSNA is:

1. To identify the priority strategic needs of children and young people in Lancashire at each point in the life cycle
2. To provide intelligence on the needs of groups of particular interest, including looked after children, children with disabilities and children with special educational needs.
3. To impact upon the deployment of resources across Lancashire County
4. To provide intelligence to support commissioning at a variety of levels:

- a. County level, through Lancashire County Council and the Children's Trust Board
 - b. Area level, through the PCTs
 - c. Locality based, through the district Local Children's Trust Partnerships and GP commissioning consortia
 - d. At local level, through GPs and schools
5. To set a baseline to monitor progress going forward

The JSNA has been influenced by the 2010 Review of Health Inequalities by Professor Marmot, which identified giving every child the best start in life as the first of six policy objectives to reduce health inequalities. The specific priority objectives listed under this policy objectives are:

1. Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
2. Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
3. Build the resilience and well-being of young children across the social gradient.

With specific policy recommendations:

1. Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.
2. Support families to achieve progressive improvements in early child development, including:
 - a. Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
 - b. Providing paid parental leave in the first year of life with a minimum income for healthy living
 - c. Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families
 - d. Developing programmes for the transition to school.

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

Other principles from the review are referenced extensively throughout this report. One such principle is that there is not one solution to reducing health inequalities but rather that a multitude of interventions is required to have an effect. Another principle is the importance of proportionate universalism, that is, that services should be delivered universally but targeted in proportion to need. Although the recommendations are for health inequalities the principles clearly apply to all sectors and areas of need.

Methodology

This JSNA was embarked upon as a true partnership piece of work. A multi-agency project team was assembled who were responsible for driving and delivering the JSNA. In addition, a wider reference group were identified, with membership to reflect the membership of the Lancashire Children's Trust. A workshop was held with the reference group in June 2010 to scope the requirements from the project – ensuring that the JSNA meets not only the requirements of the Children's Trust for the CYPP (i.e. identifying the strategic priorities), but also that it provides the intelligence needed by those responsible for making decisions which affect services for children and young people across Lancashire over the next three years.

The JSNA has followed a life cycle approach to identify the differing needs of children and young people at particular stages of their life. The life cycle provides a powerful framework for understanding the vulnerabilities and opportunities for investing in children and young people. Development during childhood and youth is not a uniform process and critical periods exist during the life cycle. These periods represent great opportunities to intervene to improve outcomes for children and young people. The advantages of a life cycle approach are several. It recognises that:

- Interventions are cumulative;
- Early intervention and prevention are the best ways to intervene as maximum benefit in one age group can be derived from interventions in an earlier age group;

- Intervening at one point or a few points is not enough for sustainable improvement of outcomes - a single intervention at one stage in life is unlikely to have a significant positive impact but instead requires a series of interventions throughout life
- Interventions in one generation will bring benefits to successive generations such as breaking the cycle of poverty or preventing unplanned and unwanted teenage pregnancies.

The life course approach emphasises that those who are vulnerable at any stage are so because of past disadvantage. Interventions required are therefore not simply of the 'safety net' variety, which put individuals back up to the original level, but rather 'spring board' interventions which seek to repair previous damage caused by the accumulation of past disadvantages. This should be borne in mind when designing responses to any of the identified needs.

The project team was very clear from the start that the JSNA should be focused upon the importance of prevention and early intervention and taking a family approach and it is hoped that the contents reflect this.

For the CYP JSNA the key stages of the life cycle used are:

- Prenatal and birth
- Early years (0 to 4 years)
- Primary years (5 to 10 years)
- Secondary years (11 to 15 years)
- Young people (16 to 19 years)

Topics have been assigned to the key stage chapters primarily based upon the ages at which any data is collected. However, in line with the focus on prevention and early intervention, it is recognised that many topics would require interventions earlier than the stage in which they are identified. Including a topic in the secondary years chapter does not imply that it is only relevant for interventions in that age group, as early intervention is usually the most cost effective way of dealing with these issues. A good example of this may be smoking, which is included in the secondary chapter. Many children may try smoking in younger years but it is likely that the majority of young people may try smoking in secondary years and therefore the topic is discussed primarily there. A similar justification is given for including sexual health in the young people chapter and alcohol and drugs in the secondary chapter.

Special consideration was given to children and young people who were identified as having particular needs. A separate chapter was created which considers all ages for the following list of groups, which is not intended to be exhaustive:

- Safeguarding
- Children who are looked after
- Children with disabilities and learning difficulties and disabilities
- Emotional wellbeing and mental health
- Young carers.

The social and economic conditions faced by children and young people of all ages in Lancashire are considered in the chapter on the social determinants of wellbeing. Again, this is an all age chapter and the sorts of topics dealt with here are the kind of big issues that would probably have the greatest impact on all children and young people if resolved – for example, issues related to the environment, community safety, employment and poverty.

At the end of each chapter recommendations are made as to what are the key needs for children and young people which should be included in the new Lancashire Children and Young People's Plan. These needs were identified by the project team on the basis of satisfaction of the following criteria:

- That the Children's Trust would be able to directly or indirectly impact upon the meeting of the need;
- That tackling the need would require cross partnership intervention rather than single agency intervention; and
- That data or intelligence was available to ensure that this is an evidence based need for Lancashire.

The last criteria was relaxed somewhat by the group as there were some areas of need suggested by national evidence that partners argued strongly should be included where there was not robust local data. Examples included maternal healthy weight and child sexual exploitation.

The identified needs of children and young people in Lancashire have been summarised as a series of six overarching priorities. The project team made the decision not to use the Every Child Matters outcomes as the overarching priorities due to the uncertainty at the time of the project

team agreeing the priorities of the new government's view of the ECM framework. However, the intention was that it would be possible to map the identified needs back to the ECM framework if required for the CYPP.

The priorities were included in the CYPP document and circulated to stakeholders for feedback on the recommended priorities. Some of the feedback has been incorporated in this final version of this JSNA report. More specific recommendations for action that should take place around the identified needs are highlighted at the end of each chapter. Summaries of the current evidence base for interventions and guidance is provided in the [appendix](#) for a number of topics.

Data

The JSNA is based predominantly upon a wide range of secondary data sources including officially published datasets, locally available datasets and previous research conducted in the local area.

The report aims to be systematic in the presentation of data to include:

- The current position in Lancashire compared to the North West and national (England) position
- The trend over time in Lancashire as compared to the North West and national (England) trends
- Variations within the three PCT areas and 12 districts within Lancashire (as appropriate)
- Variations within each of the 12 districts (at ward or lower super output area level)
- Variations within Lancashire by sociodemographic indicators

It should be noted that data gaps do not always allow for this level of analysis.

Literature reviews from other documents (such as the Kent JSNA 2010 and the NHS Bolton Director of Public Health Report 2005)) were used primarily as the basis for the document and the project team expanded the content to include issues and areas that were viewed as gaps given the primarily health focused nature of these documents. Local contributors were identified for each topic within the report who included their own evidence.

Limitations

By its very nature a JSNA is deficit based as it focuses on "needs" rather than assets. It would be advantageous to adopt a strategic asset based approach to inform the next CYPP and hopefully by this time the methodologies for using such approaches will be more developed.

Although every attempt has been made to ensure that the JSNA is comprehensive, feedback from stakeholders through the CYPP consultation process has highlighted some gaps. These should be filled when the exercise is repeated for the next CYPP.

Data is not always available for all areas of Lancashire and any gaps have been highlighted within the document.

The analysis in the document is primarily based upon secondary data and it would be useful to incorporate more systematically the views of children and young people in the next JSNA.

Report structure

The remainder of the report is structured as follows:

- The following chapter sets the scene for the JSNA by providing the national and local policy context.
- A profile of Lancashire's children and young people follows highlighting the size and ethnicity of the cohort, how it is changing, the number of families and where they live.
- The context within which children and young people live their lives has probably the greatest influence on their outcomes and this is examined by the section on the social determinants of family wellbeing.
- Ensuring positive outcomes for children begins prior to conception. The prenatal and birth chapter examines a range of indicators for pregnant women and infants at birth.
- There is overwhelming agreement that the early years of a child's life are the crucial foundation for their development and achievement of outcomes and this is the focus of the early years chapter.
- Educational achievement is the primary concern for young children once they start school and the components for success are examined in the primary years chapter alongside indicators of health and wellbeing.
- Adolescence is a formative time for children and young people where experimentation with new behaviours can cause negative consequences where individuals do not demonstrate resilience. The secondary years chapter provides a full discussion of these issues.

- The chapter on young people covers the difficult transition from child to adult a transition which is made even more difficult by the current financial climate with the resulting increased risk of not being able to access employment, education or training (NEET).
- Children and young people with particular needs will face all of the same opportunities as other children and young people but are likely to need more support to take up these opportunities as outlined in this chapter.
- The conclusions and recommended priorities chapter summarises the whole picture for children and young people in Lancashire and identifies a series of recommended priorities to include in the Lancashire Children and Young People's Plan for 2011-14.
- A number of appendices are included in the document: an appendix containing additional data; an appendix containing summaries of the evidence base and guidance on interventions for some of the needs identified; an appendix of references; and last, but by no means least, an appendix of acknowledgements containing the names of the wide range of contributors to this document.

Setting the scene

Introduction

The following section provides an overview of the national policy strategically governing and influencing services for children and young people at the present time and how this is being adopted and delivered locally in Lancashire.

National context

Over the last few years there have been numerous policy drivers concentrating on the children and young people's agenda. A chronology of which can be seen below.

A Brief History

- **2003 – Laming Inquiry into Victoria Climbié’s death**
- **2003 – Every Child Matters Green Paper**
- **2004 – Children Act 2004 (Duty to Cooperate)**
- **2007 – Review of Every Child Matters**
- **2008 – All local areas have a Children’s Trust**
- **2008 – Children’s Trust Guidance**
- **2009 – Apprenticeships, Skills, Children and Learning Bill**
- **2010 – Children's Trust Statutory Guidance on Cooperation Arrangements including the Children's Trust Board and the Children and Young Peoples Plan**

Every Child Matters

Every Child Matters (ECM) was the last government's approach to improving the well-being of children and young people from birth to age 19. Although it is not supported by the current government, stakeholders in Lancashire have made it clear that they value the clarity of the framework in Children's Plans and as such it is likely that the new Children and Young People's Plan will still use the framework.

The aim of ECM is for every child, whatever their background or their circumstances, to have the support they need to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

The ECM change programme called for **all** services to work with each other, as well as with children and young people, to achieve the above outcomes and produced performance indicators through the outcomes framework to measure this.

Children's Trusts and the Children and Young People's Plan (CYPP) were tools to enable local areas to achieve these outcomes.

Children's Trusts

The Children's Trust is the sum total of co-operation arrangements and partnerships between organisations with a role in improving outcomes for children and young people.

The Children's Trust Board was a statutory body which provided interagency governance of the co operation arrangements as a whole (through the CYPP process). Whilst the Children's Trust Board is no longer statutory it will continue in Lancashire as agreed by stakeholders.

Children and Young People's Plan

The statutory guidance described the CYPP as 'the joint strategy of the Children's Trust partners which sets out in detail how they will co-operate to improve well being for children and young people'

The CYPP should be based on a robust needs assessment, covering the full range of a child's experience and linked to the five outcomes.

To meet the guidance the plan must address the following themes:

- **Consultation and participation**

- **Needs Assessment** - must assess the needs of children and young people against the 5 ECM outcomes
- **Key Actions for Children with SEN and/ or a disability and Children Looked After** - actions must be developed following a specific needs assessment for these groups of children and young people
- **Resourcing the plan** - ensuring, where appropriate, the sharing of resources to increase efficiencies and effectiveness of services
- **Safeguarding and promoting welfare**
- **Early Intervention**
- **Families** - shaping services around the whole family
- **Reducing Child Poverty**
- **Local Workforce Strategy**
- **Performance management and target setting**

Current Political Context

There are significant changes proposed to the various national outcome frameworks currently in use e.g. Every Child Matters, National Indicator Set and Vital Signs Operating Framework. Whilst school targets have diminished, new children's health targets are being developed to support the change in focus of the NHS and Public Health. Proposed measures include:

- Perinatal and Infant mortality
- Unplanned hospitalisation for asthma, diabetes and epilepsy
- Emergency admissions for children with respiratory tract infections
- Experiences of maternity services
- Children and young people's experience of health care
- Admission of full term babies to neonatal care
- Incidence of harm to children due to 'failure to monitor'

The specific proposals are detailed key headings below.

Health

NHS White Paper: Equity and Excellence: liberating the NHS

Will transform how health care is commissioned, with around £80 billion pounds being transferred to new GP consortia. The Government is seeking to increase productivity and quality by cutting bureaucracy and improving efficiency in the context of marked financial constraints.

The Health Bill

Will support the creation of a new Public Health Service, to integrate and streamline existing health improvement and protection bodies and functions. Partnership structures will change as the SHA and PCTs are abolished and joint working will need to be developed with GP consortia. The responsibility for health improvement will be transferred to the LA and councils will have responsibility for promoting integration and joint working in this area.

GP consortia will be statutorily responsible for commissioning the great majority of NHS services, including elective hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services and mental health and learning disability services.

The NHS Commissioning Board will commission the other family health services of dentistry, community pharmacy and primary ophthalmic services, as well as national and regional specialised services, maternity services and prison health services, but with the influence and involvement of consortia.

The NHS Commissioning Board will calculate practice-level budgets and allocate these resources directly to consortia. Consortia will be responsible for managing these combined budgets, which will be kept separate from GP practice income, and deciding how best to use resources to meet the healthcare needs of their patients. They will have a duty to ensure that expenditure does not exceed their allocated resources.

The proposed new Local Authority Health and Wellbeing Boards would enable consortia, alongside other partners, to contribute to effective joint action to promote the health and wellbeing of local communities, including combined action on health improvement, more integrated delivery of adult health and social care, early years' services and safeguarding of children and vulnerable adults.

Children's social care

Munroe Review (Safeguarding and Child Protection)

It is likely to propose changes to "Working Together to Safeguard Children and Young People" government guidance. Indications so far for where there will be an impact on:

- Social work teams dealing with assessment and child protection,
- ICT systems used by these staff, performance management, inspections,
- The Safeguarding Children's Board, serious case reviews and related policy/procedures.

Updated Fostering Regulations

This will impact within the Fostering Service and also Children's Social Care (teams which place and supervise children in placement). Policies will need to be updated.

Updated Fostering National Minimum Standards

This will impact on Fostering Teams, placing social work teams, independent fostering agencies, commissioning and contracts. There may be some increased financial commitments and some changes to Human Resources recording. Policies will need to be updated.

New statutory guidance on family and friends care (unsure if the draft will change given the change of government following consultation)

This will impact within the Fostering Service and also Children's Social Care (The Director of Children's Services must identify a senior manager who is accountable for monitoring the guidance) also teams which place and supervise children in placement. There will also be an impact on financial systems/budgets and requirement to develop a policy within prescribed guidelines. Other policies will need to be updated.

National government review of Special Educational Needs (SEN) due to report in late autumn following publication of Green Paper

This will impact on service areas supporting children and young people with SEN and their parents and carers:

- Inclusion and Disability Support Services
- Health service providers
- Quality and Continuous Improvement

Education

The Schools System: Structural Reform Plan, Department for Education - Business Plan 2011-2015 and Academies Bill

The Academies Bill will “enable more schools to become Academies and give them the freedoms and flexibilities they need to continue to drive up standards”. The Bill was introduced into the House of Lords on 26 May 2010.

Current Coalition Education priorities:

- We will fund a significant premium for disadvantaged pupils from outside the schools budget by reductions in spending elsewhere.
- We will give parents, teachers, charities and local communities the chance to set up new free schools, as part of our plans to allow new providers to enter the state school system in response to parental demand.
- We will reform the existing rigid national pay and conditions rules to give schools greater freedoms to pay good teachers more and deal with poor performance.
- We will help schools tackle bullying in schools, especially homophobic bullying.
- We will simplify the regulation of standards in education and target inspection on areas of failure.
- We will give anonymity to teachers accused by pupils and take other measures to protect against false accusations.
- We will seek to attract more top science and maths graduates to be teachers.
- We will publish performance data on educational providers, as well as past exam papers.
- We will create more flexibility in the exams systems so that state schools can offer qualifications like the IGCSE.
- We will reform league tables so that schools are able to focus on, and demonstrate, the progress of children of all abilities.
- We will give heads and teachers the powers they need to ensure discipline in the classroom and promote good behaviour.

- We believe the most vulnerable children deserve the very highest quality of care. We will improve diagnostic assessment for school children, prevent the unnecessary closure of special schools, and remove the bias towards inclusion.
- We will improve the quality of vocational education, including increasing flexibility for 14–19 year olds and creating new Technical Academies as part of our plans to diversify schools provision.
- We will keep external assessment, but will review how Key Stage 2 tests operate in future.
- We will ensure that all new Academies follow an inclusive admissions policy. We will work with faith groups to enable more faith schools and facilitate inclusive admissions policies in as many of these schools as possible.

Early years

Sure Start Children's Centres – Policy Drivers

Sure Start services will be maintained in cash terms including new investment in Sure Start health visitors.

Introduction of a new and simplified Early Intervention grant – will include funding for Sure Start and other preventative services for children, young people and families (loss of ring fencing of grant). Sure Start will be refocused on its original purpose, targeting early intervention on families who need the most support and improving the life chances of disadvantaged children.

Early Years provision – Policy Drivers

- Extension of Early Years entitlement to all disadvantaged two year old children.
- An independent review of the Early Years Foundation Stage.
- The introduction of an Early Years single funding formula.

Welfare Reform – Policy Drivers

Child benefit is to be withdrawn from families with a higher rate tax payer from January 2013.

There will also be a reduction from 80% to 70% in the childcare costs parents can claim through the childcare element of Working Tax Credit tax credits from April 2011. Working hours are to be increased to a minimum of 24 hours for couples claiming Working Tax Credits. Child Tax Credit will go up by a further £30 above indexation in 2011-12, although fewer families will be eligible as there will be a sharper tail off as an individual's income rises.

The single Universal Credit will be introduced to replace existing working age benefits

Young people

Youth justice reform

Youth justice reform, including the future of the Youth Justice Board and devolved custody budgets, will be unveiled in the government's autumn green paper. Features will include:

- Reviewing sentencing policy and providing more effective community sentences, such as more robust community payback.
- Reassessing the effectiveness of indeterminate sentences (IPPs), bearing in mind the growing IPP prison population.
- Empowering local agencies (including criminal justice, health and Jobcentre Plus) to work together in tackling social issues faced by many offenders.
- Devolving funding and decision-making to local groups with more emphasis on voluntary and third-sector led services.

All-age careers guidance service

Leaving Connexions are facing an uncertain future. In the future councils "will no longer be expected to make available a universal careers advice and guidance offer to young people". Councils will be expected to offer a targeted careers guidance service for vulnerable young people, although authorities will not be required to use the Connexions brand

Welfare reforms

The White Paper “Universal Credit: welfare that works

The White Paper sets out the Coalition Government's plans to introduce legislation to reform the welfare system by creating a new Universal Credit. The Universal Credit will radically simplify the system to make work pay and combat worklessness and poverty. The White Paper outlines:

- The need for change
- How Universal Credit will work
- How it will affect benefit recipients, and
- Its broader impact.

Universal Credit is an integrated working-age credit that will provide a basic allowance with additional elements for children, disability, housing and caring. It will support people both in and out of work, replacing Working Tax Credit, Child Tax Credit, Housing Benefit, Income Support, income-based Jobseeker's Allowance and income-related Employment and Support Allowance.

Growth of the economy

The White Paper Local Growth: Realising Every Place's Potential on sub-national economic growth.

Published on 28 October, the White Paper builds on announcements made in the June Budget, and follows the direction of the recent Spending Review. It sets out the primary strategy of radically rebalancing local economic development towards private sector-led growth.

As announced in June, the previous government's Regional Development Agencies (RDAs) are to be abolished and replaced by Local Economic Partnerships (LEPs). These are meant to be self-selecting partnerships between councils and businesses, but are subject to government approval before they can be formally constituted.

The National Infrastructure Plan

The National Infrastructure Plan 2010, published on the Treasury website on 25 October gives information both on the government's plans for public expenditure on infrastructure and a blueprint for encouraging as much investment from the private sector as possible. Key infrastructure functions are divided into five sectors: energy, transport, digital communications, water and waste, and science, research and innovation.

E-accessibility action plan

This aims to empower people who are excluded from participating fully in today's digital economy. This plan will help "to ensure accessibility, affordability and equal participation for disabled users in the digital economy".

Communities and localities

National Citizens Service and VCFS

The Challenge Network will be the lead provider for the government's National Citizen Service (NCS) alongside 11 other voluntary sector organisations. The Prince's Trust and V will also help to deliver the first pilot projects in summer 2011, which will see more than 11,000 young people aged 16 years spend six to eight weeks taking part in Community Volunteering activities.

Child poverty – (Frank Field review - action to tackle the underlying causes of poverty and enhance life chances)

The major points include:

- The Child Poverty Act, which became statute in March 2010, requires each top tier Local Authority to produce a child poverty needs assessment and a child poverty strategy by 31 March 2011.
- The Coalition Government, whilst still committed to eradicating child poverty, has issued non-statutory guidance, which leaves Local Authorities to decide for themselves how they address this issue
- The Child Poverty Strategy does not necessarily need to be a 'stand-alone' strategy, but could be part of a wider strategy if the Local Authority wishes
- There are unlikely to be any government targets specifically around reduction of child poverty.
- Local Authorities and partners will need to identify actions which will seek to address child poverty, both in terms of its impact on outcomes for children and young people, and on the causes of poverty.

Major new piece of legislation enforced from the Equality Act 2010: Safeguarding priority for equality and diversity

There is a corporate drive on equality initiated by the Equality Act. Due to this, there are many obligations that public sector organisations have to adhere to, including:

- Enforced use of equality impact assessments.
- Enforced inclusion of equality and diversity actions in Business Planning cycle.
- Introduction of equality characteristics, not strands- new characteristics include transgender and a socio- economic duty.
- No individual equality schemes- overriding single equality scheme and strategy for the authority, Narrowing the Gaps.
- New employment law- removal of enforced retirement age at 65, removal of pre-employment questions relating to disability, sickness and absence in line with the Equality Act 2010.

Housing

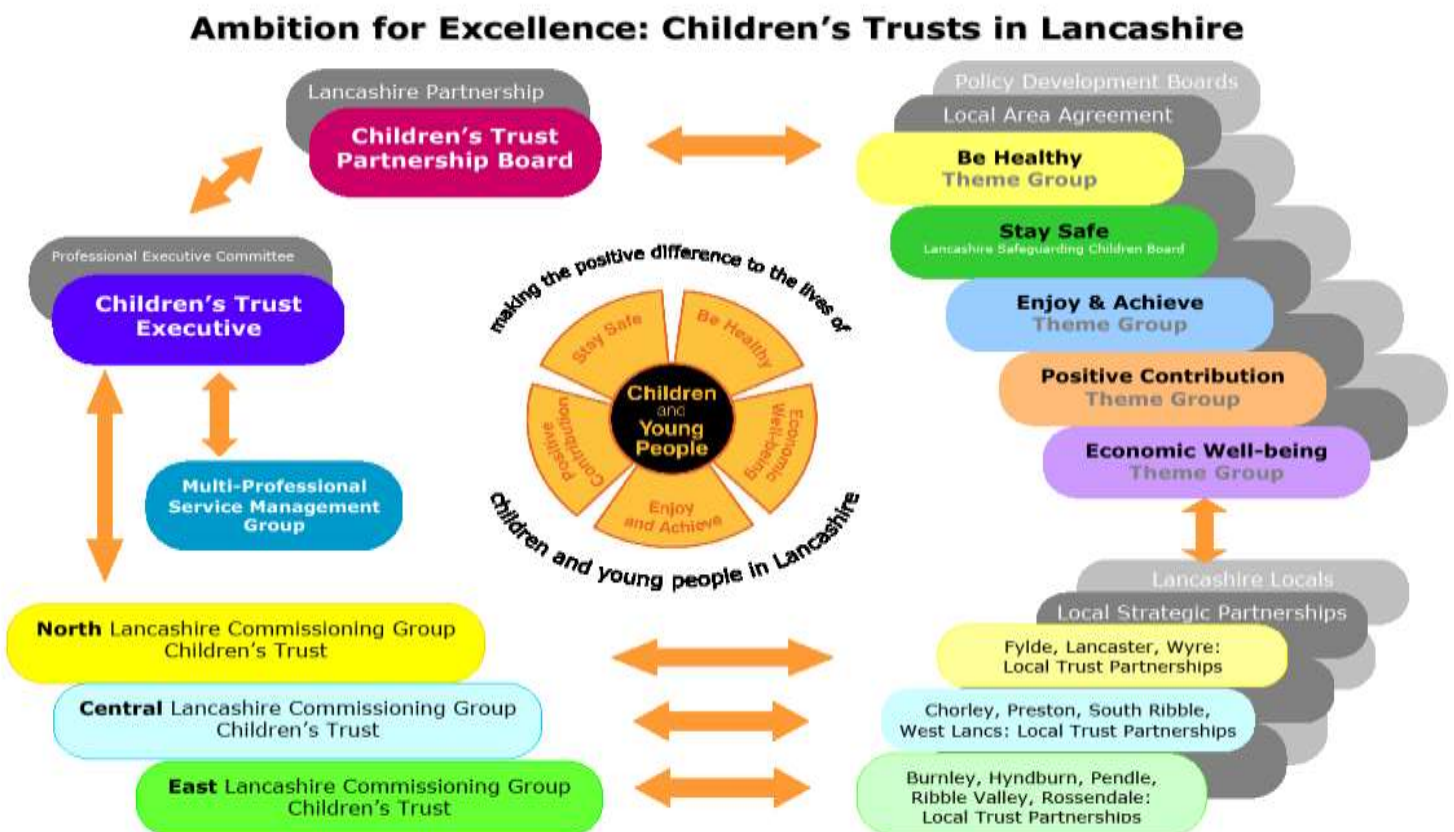
The 'Southwark Ruling' in 2009

This ruling confirmed responsibilities lie with local authorities under Section 20 of the Children Act 1989 to provide accommodation for the majority of 16 and 17 year olds who are homeless (with some exceptions).

Local Context

In response to the Every Child Matters programme of change, Lancashire established a Children's Trust which is currently delivering against its second Children and Young people's plan.

The model for Lancashire Children's Trust is as follows:



Lancashire's Children's Trust Arrangements

The Children's Trust structure in Lancashire is the key partnership that ensures delivery of the outcomes and aspirations identified in the Children and Young People's Plan.

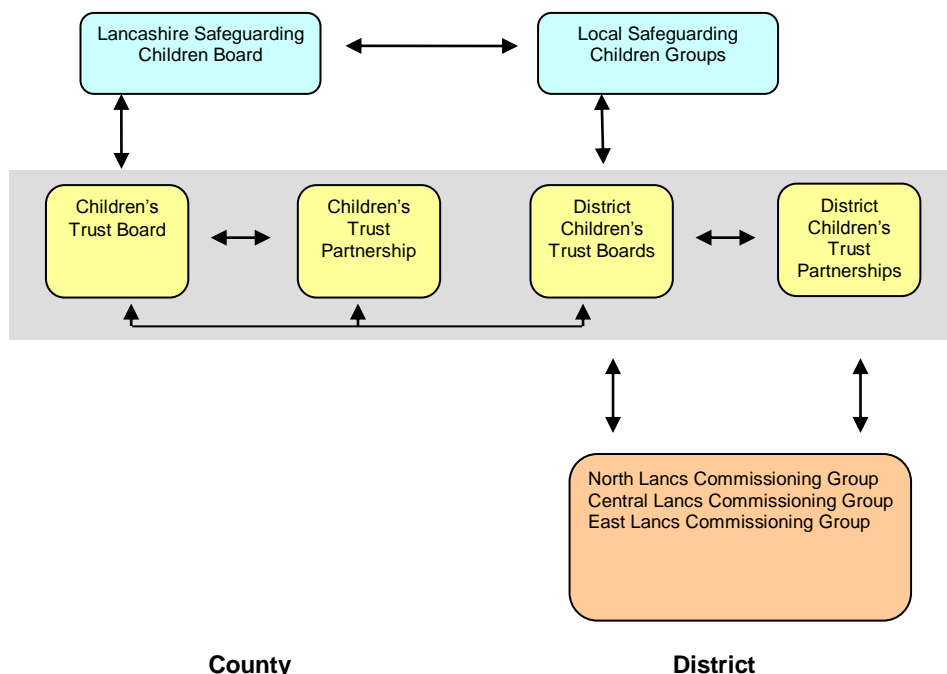
Lancashire Children's Trust is based around a countywide Board and Partnership and this is supported through a similar model within the twelve districts. These District Children's Trusts ensure that services for children and young people are tailored to the needs of the local community and that these communities are engaged in the decisions about how services will be delivered.

The agreed approach to governance across the structure helps to ensure a consistency in building a partnership that ensures better outcomes for children and young people across the county.

Children's Trusts will make a difference to the lives of children and young people by:

- listening to the views of children and young people - as well as their parents and carers - about what services they need and what are available and involving them in delivering those services;
- promoting joint working between all professionals working with children and young people;
- ensuring effective commissioning of services, based on a robust analysis of need and using resources flexibly and creatively;

Lancashire Children's Trust – Governance Structure



At the heart of the Children's Trust partnership work is an acceptance that outcomes for children and young people cannot be effectively improved by one organisation alone. Great progress has been made in bringing partners together and we already have many excellent examples of joint working and integrated delivery. But there is more we can do and changes to central grant funding

arrangements mean that further new and innovative practices are urgently required. The Children's Trust is committed to using joint commissioning and shared delivery as the vehicles for improving both outcomes and efficiencies.

The Vision for Children and Young People

The Children's Trust is committed to doing everything we can to help and support children and young people in Lancashire to have a positive future.

To do this they have adopted as the core belief;

A moral commitment to work in the best interests of children and young people and their families at all times and make a positive difference to their lives

We will ensure that:

- the views of children and young people and their carers are sought, listened to, taken into account, and acted upon at every stage;
- comprehensive information and advice on services available is swiftly and easily accessible to children, young people, families and all professionals;
- our approach is one of enabling children and young people and their families to identify, manage and seek out help to meet their own needs;
- services we all provide are generally accessible within everyday community settings such as children's centres, schools and GP surgeries etc;
- we systematically review and remove duplication across our services and make the most effective use of the total resource available to us – people, buildings, equipment or money;
- those children and young people and families who have higher levels of need will receive their support from 1 or 2 lead individuals not multiple professionals;
- children and young people will always be separately consulted and involved in decisions which affect them;
- we focus on improved outcomes rather than activity and processes, and monitor and hold each other to account for our progress towards them;
- we stop delivering or commissioning those services that do not demonstrably improve outcomes for children, young people and their families;
- we continue and enhance our investment in early intervention;
- information will always be shared between all professionals with permission and/or whenever any level of risk to a child or young person is present.

To deliver the Vision all the partners of the Children's Trust are committed to pursuing a number of important developments in the way they plan and deliver services. These include the following:-

Shared Locations

- To review the total capital resources, and identify and agree a network of local hubs of multi-professional, public, community and voluntary services. Wherever possible, these local hubs will involve staff being based together and operating out of a universal provision such as a children's centre, school, health centre/GP surgery or Youth Zone. There will be differences in different parts of the county according to availability of accommodation, rurality, population size and needs.

Shared Information

- To create one comprehensive shared one-stop shop information and advice service that is available to all children and young people and their families, and professionals. This service will be owned by all and will enable children and young people, families and those who work with them to identify organisations that can give them help and support, and set out how to access them.
- To enforce information governance policies in a way that will leave no professional in any doubt as to their duty to share information and their organisation's commitment and backing to do so. To work rapidly towards bringing together electronic information databases, through information hubs across the County and eventually one shared data access portal.

Shared ownership

- To overcome any professional barriers that might get in the way of the vision – to work in the best interests of children and young people at all times.
- To demonstrate a shared ownership of support for children young people and their families by changing service delivery to fit the vision – moving people, places and processes to plan and deliver together.
- To build consultation, engagement and involvement of children and young people, families, and staff into everything done to deliver services and the vision.

Shared Pathways

- To join up assessment processes and live by the rule of 'tell us once'.
- To develop agreed pathways to focus our support for vulnerable children and young people and their families. This will reflect a revised continuum of need and set out clear and shared roles and responsibilities at every stage.

- To ensure pathways maintain a focus on; minimising the number of staff involved with a family, listening to children and young people and their families, and helping them to greater resilience and management of their problems for better outcomes.

Shared Commissioning and Delivery

- To remove duplication in planning and delivering of services to children, young people and families, and trust that the lead professionals will be able to speak and lead on behalf of all.
- To combine resources in an area to deliver in the most effective and cost efficient way.
- In any new venture, commission or service the starting point will be integrated delivery. There will be a need to be convinced by any plan to deliver through separate services.
- To identify and share what works and leads to measurable improvements in the outcomes for children, young people and their families.
- To not refuse advice to any child, young person or family as there will always be some way in which we can make a positive difference.

Specific actions relating to these commitments are included in the separate detailed Action Plans which can be found on the Children's Trust Website at www.lancashire.gov.uk/childrenstrusts.

A profile of Lancashire: demographics

The population

There are more than 280,000 children and young people aged 0 to 19 living in the county of Lancashire. If Lancashire were made up of 100 children and young people, 12 would live in Lancaster and 12 in Preston; 9 would live in Chorley, South Ribble and West Lancashire, respectively; 8 would live in Burnley, Hyndburn, Pendle and Wyre, respectively; 6 would live in Rossendale; whilst there would only be 5 living in both Fylde and Ribble Valley.

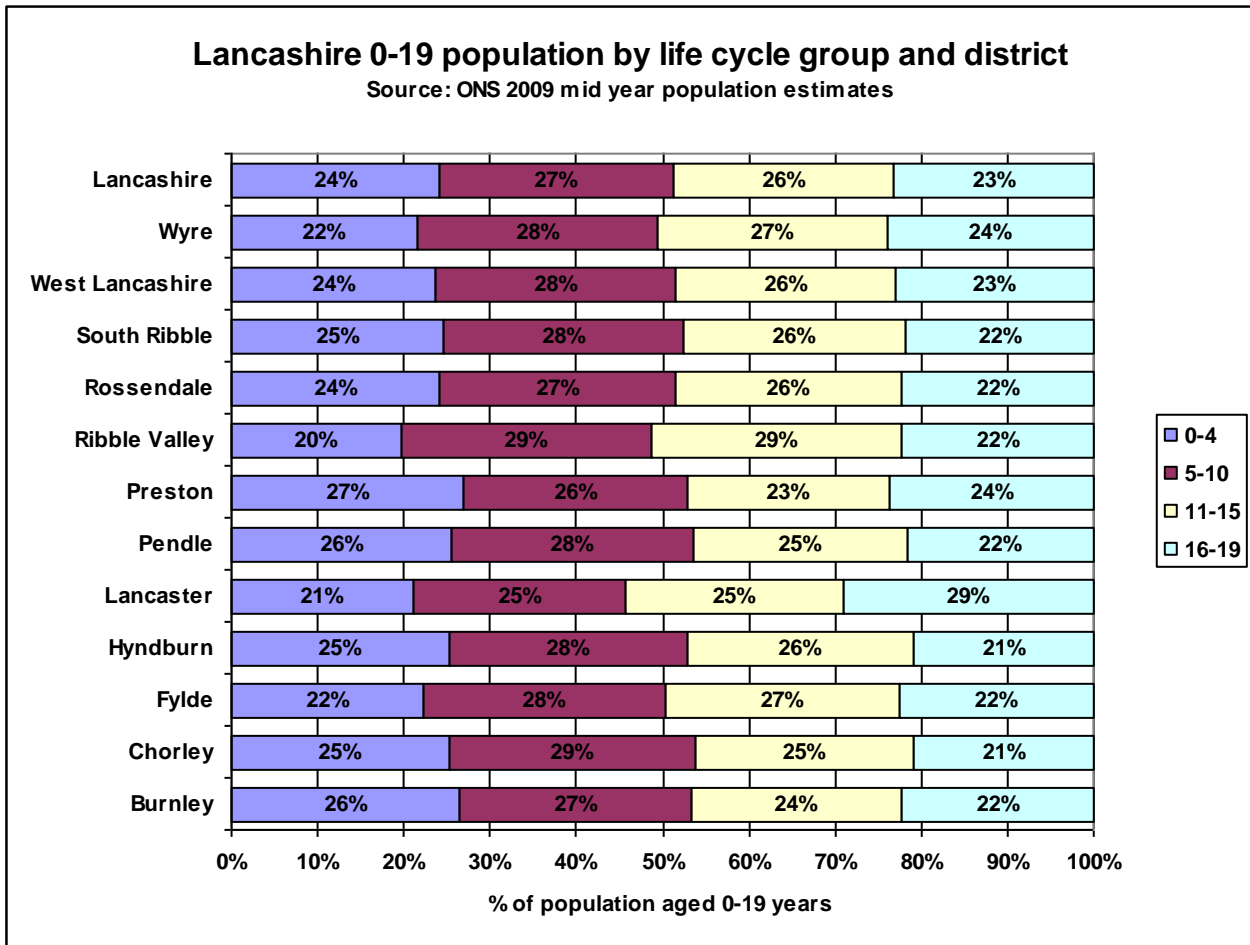
Table 1: Lancashire 0-19 population by life cycle group and district, 2009

	0-4	5-10	11-15	16-19	0-19
Burnley	5,965	6,052	5,494	5,019	22,530
Chorley	6,091	6,875	6,071	5,002	24,039
Fylde	3,419	4,283	4,144	3,430	15,276
Hyndburn	5,552	6,068	5,750	4,593	21,963
Lancaster	6,996	8,189	8,464	9,608	33,257
Pendle	5,966	6,532	5,786	5,008	23,292
Preston	8,895	8,599	7,751	7,871	33,116
Ribble Valley	2,694	3,972	3,966	3,048	13,680
Rossendale	4,216	4,749	4,596	3,878	17,439
South Ribble	6,199	7,030	6,442	5,507	25,178
West Lancashire	6,295	7,371	6,789	6,083	26,538
Wyre	5,124	6,601	6,389	5,664	23,778
Lancashire	67,412	76,321	71,642	64,711	280,086

Source: ONS mid-2009 population estimates

Although similar numbers of children and young people live in the districts of Lancaster and Preston, the makeup of the populations is very different. Lancaster has an older population with a greater proportion aged 10 to 19 years compared to the Lancashire average. Preston, on the other hand, has a higher proportion of children aged less than eleven years, and particularly those aged between 0 and 4 years of age. The needs of these different groups will be very different and services must be delivered appropriate to the age structure of the population and varying levels of need.

Figure 1: Lancashire 0-19 population by life cycle group and district, 2009



Children and young people make up more than a quarter of the total population of the East Lancashire districts of Burnley, Hyndburn, Pendle and Rossendale. They are a smaller minority in Fylde, accounting for only a fifth of the total population.

Table 2: Lancashire and district 0-19 population as a share of the total population – mid 2009 estimates

	0-19 numbers	0-19 as a percentage of the total population	All Ages numbers	Aged over 19 as a percentage of the total population
Burnley	22,530	26.3%	85,575	73.7%
Chorley	24,039	22.9%	104,785	77.1%
Fylde	15,276	20.0%	76,348	80.0%
Hyndburn	21,963	27.1%	81,111	72.9%
Lancaster	33,257	23.8%	139,757	76.2%
Pendle	23,292	26.1%	89,312	73.9%
Preston	33,116	24.6%	134,641	75.4%
Ribble Valley	13,680	23.7%	57,676	76.3%
Rosendale	17,439	26.0%	67,119	74.0%
South Ribble	25,178	23.3%	108,166	76.7%
West Lancashire	26,538	24.1%	110,244	75.9%
Wyre	23,778	21.4%	111,069	78.6%
Lancashire	280,086	24.0%	1,165,803	76.0%
North West	1,673,000	24.3%	6,897,900	75.7%
England	12,387,500	23.9%	51,809,700	76.1%

Source: ONS mid-2009 population estimates

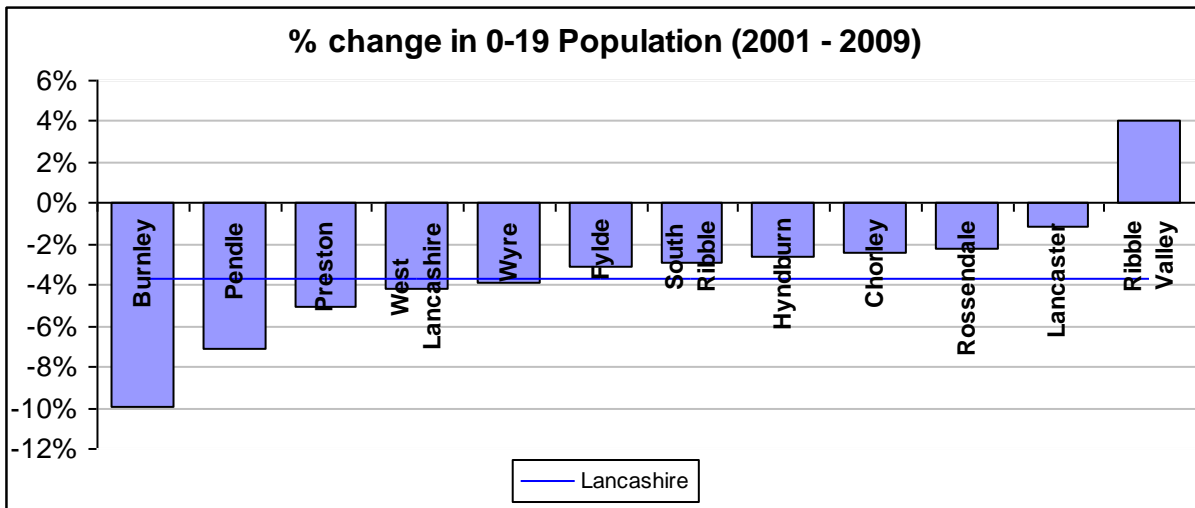
Over recent years the number of children and young people in Lancashire has fallen and there are now almost 11,000 fewer children than there were ten years ago. This is against the national pattern of a slight increase in children and young people, but in line with the North West average. Rates of fertility are lower in Lancashire than nationally, which results in a reducing number of children and young people over time and an ageing population structure.

Table 3: Change in 0-19 population by district, 2001 census – mid-2009 estimates

Change in 0-19 population by district, 2001 census – mid-2009 estimates				
	2001 Census	2009 Population Estimates	Change	% change
Burnley	25,021	22,530	-2,491	-10.0%
Chorley	24,624	24,039	-585	-2.4%
Fylde	15,765	15,276	-489	-3.1%
Hyndburn	22,551	21,963	-588	-2.6%
Lancaster	33,652	33,257	-395	-1.2%
Pendle	25,067	23,292	-1,775	-7.1%
Preston	34,866	33,116	-1,750	-5.0%
Ribble Valley	13,150	13,680	530	4.0%
Rosendale	17,835	17,439	-396	-2.2%
South Ribble	25,940	25,178	-762	-2.9%
West Lancashire	27,690	26,538	-1,152	-4.2%
Wyre	24,749	23,778	-971	-3.9%
Lancashire	290,910	280,086	-10,824	-3.7%
North West	1,736,803	1,673,400	- 63,403	-3.7%
England	12,310,418	12,387,500	77,082	+0.6%

However, this shift in demographics is not shared equally across the districts: both Burnley and Pendle have experienced the greatest reductions in their children and young people population. Only in Ribble Valley has there been an increase in the number of children and young people.

Figure 2: Percentage change in 0-19 population by district, 2001 census – mid-2009 estimates



Source: Lancashire Profile / ONS mid-2009 population estimates

Looking ahead, population projections suggest that the numbers of children and young people in Lancashire will decline over the next 25 years, with the exception of the 5 to 9 age group, which is expected to grow. Full district projections are provided in the [appendix](#).

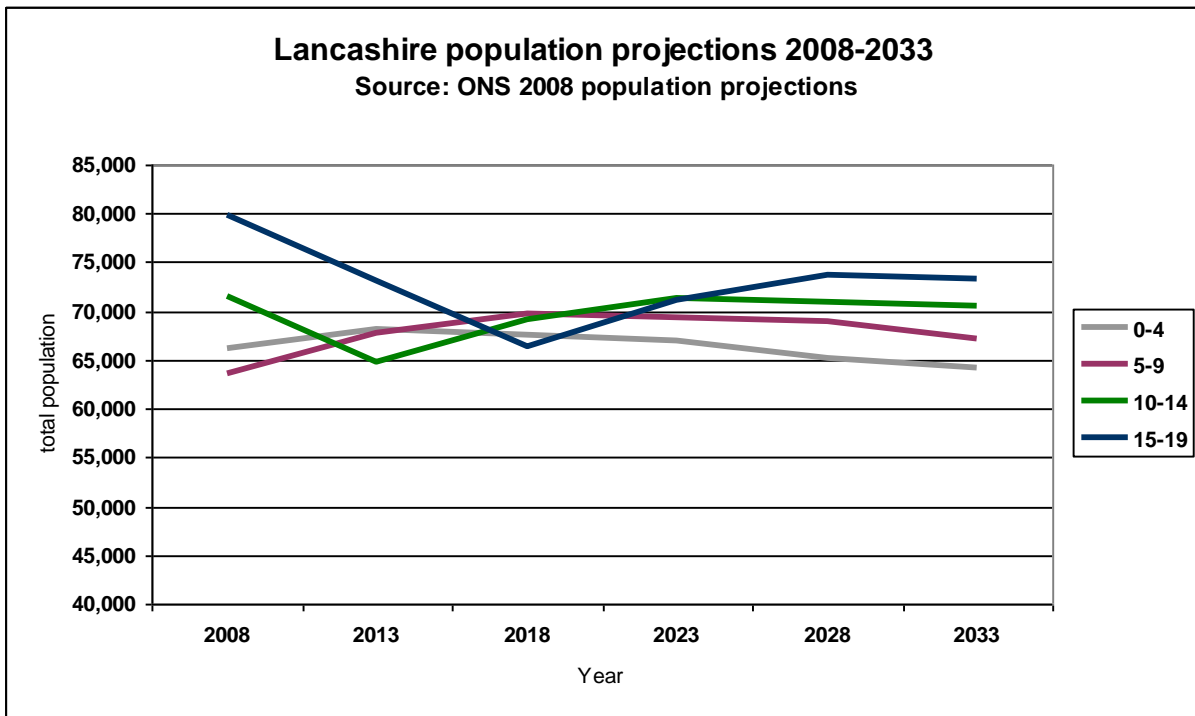
Table 4: Lancashire population projections, 2008 to 2033

Age Group	2008	2013	2018	2023	2028	2033	2008-2033 Change
0-4	66,200	68,200	67,500	67,000	65,200	64,100	-2,100
5-9	63,600	67,700	69,800	69,300	68,900	67,100	3,500
10-15	71,500	64,700	69,200	71,400	70,900	70,600	-900
15-19	79,900	73,200	66,400	71,200	73,700	73,300	-6,600
0-19	281,200	273,800	272,900	278,900	278,700	275,100	-6,100
All ages	1,165,100	1,185,200	1,206,200	1,228,700	1,249,200	1,265,000	99,900

ONS Mid 2008 population projections

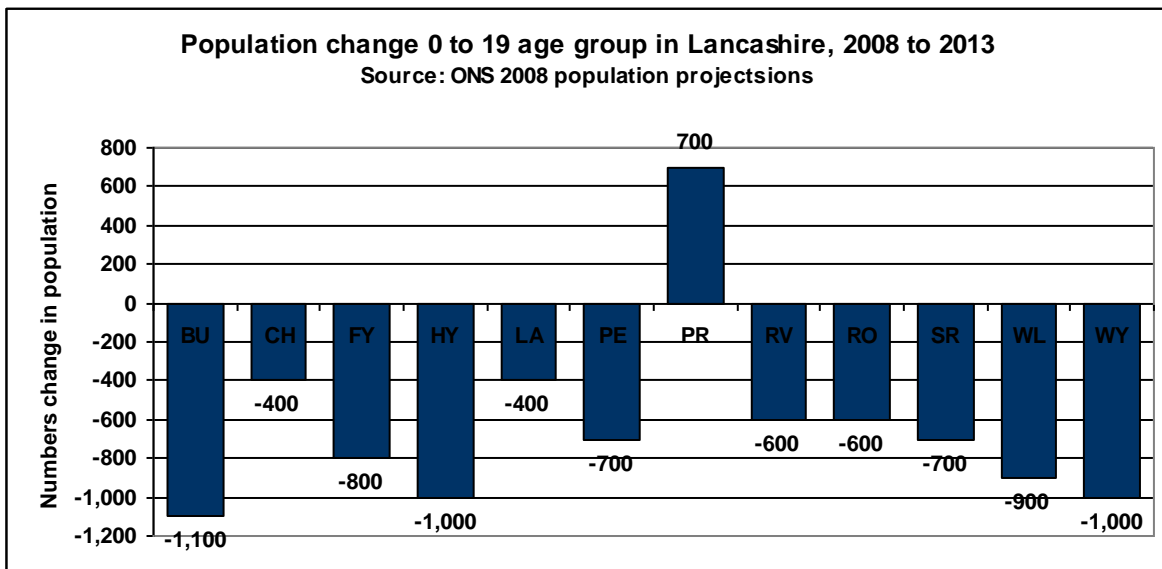
Between 2008 and 2013 there are large differences projected by age group. The younger age groups are expected to increase with an additional 2,000 children aged 0 to 4 and an additional 4,100 children aged 5 to 9 years in the Lancashire county area. Even greater reductions in the 10-15 and 16-19 age groups however, will mean an overall reduction in the 0 to 19 population with 7,400 fewer children and young people in 2013 than there are now. Universal services targeted at the younger age groups will therefore need to ensure that they are able to grow in line with the population. Under a different economic climate, universal services aimed at older age groups might be presented with the opportunity to improve quality of the services, but given the current economic climate, these services are more likely to reduce to provide savings.

Figure 3: Lancashire population projections, 2008 to 2033



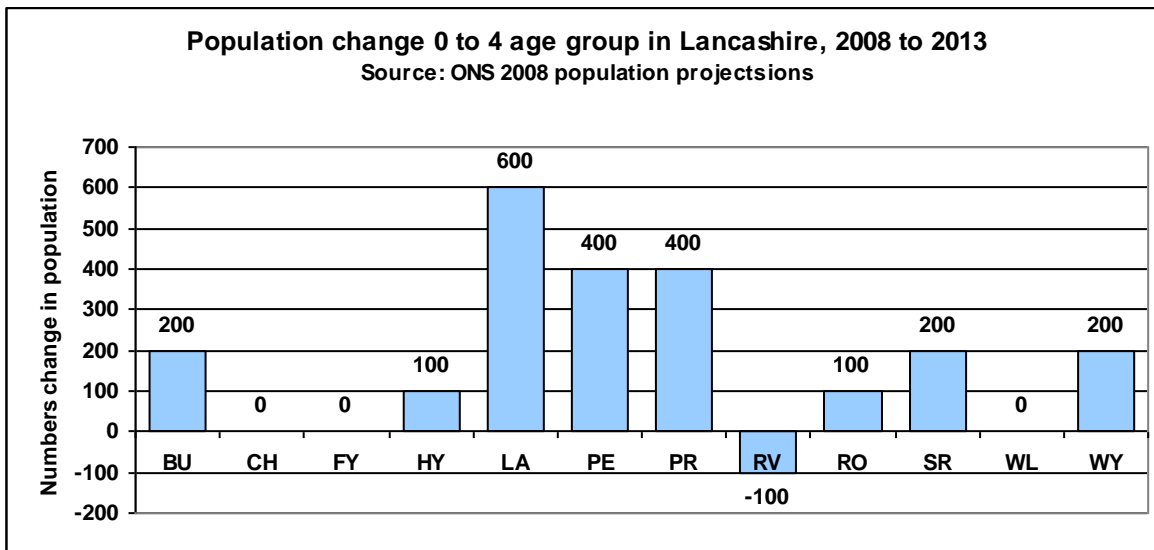
The district picture mirrors the Lancashire picture in all cases, except Preston, where the children and young people population is expected to increase by 700 children in total by 2013.

Figure 4: Lancashire population projections by district, 2008 to 2013



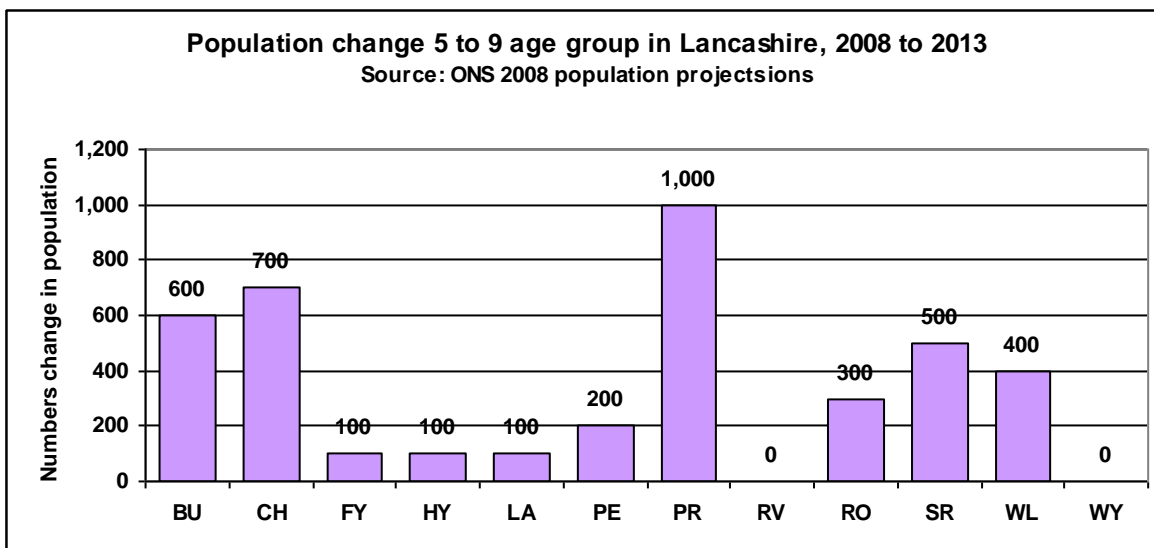
At district level, the picture remains largely in line with the Lancashire average. Between 2008 and 2013, increases in the population aged 0 to 4 years are projected in all districts with the exception of Ribble Valley. The largest population increases will be in Lancaster, Pendle and Preston.

Figure 5: Lancashire population projections by district, 0 to 4 age group, 2008 to 2013



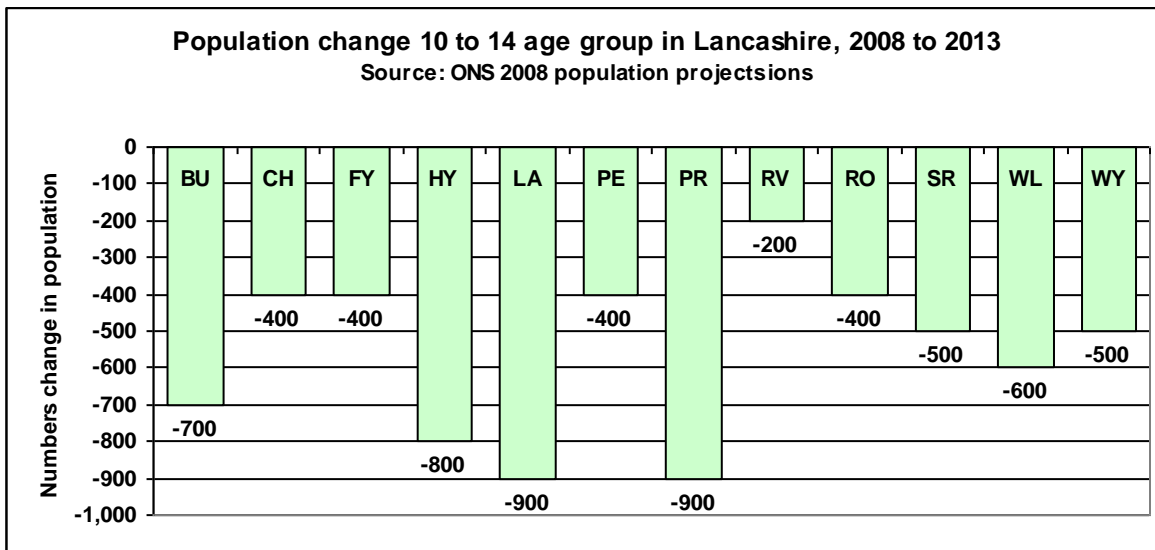
The numbers in the 5 to 9 age group will increase across most districts with largest increases in the districts of Burnley, Chorley and Preston.

Figure 6: Lancashire population projections by district, 5 to 9 age group, 2008 to 2013



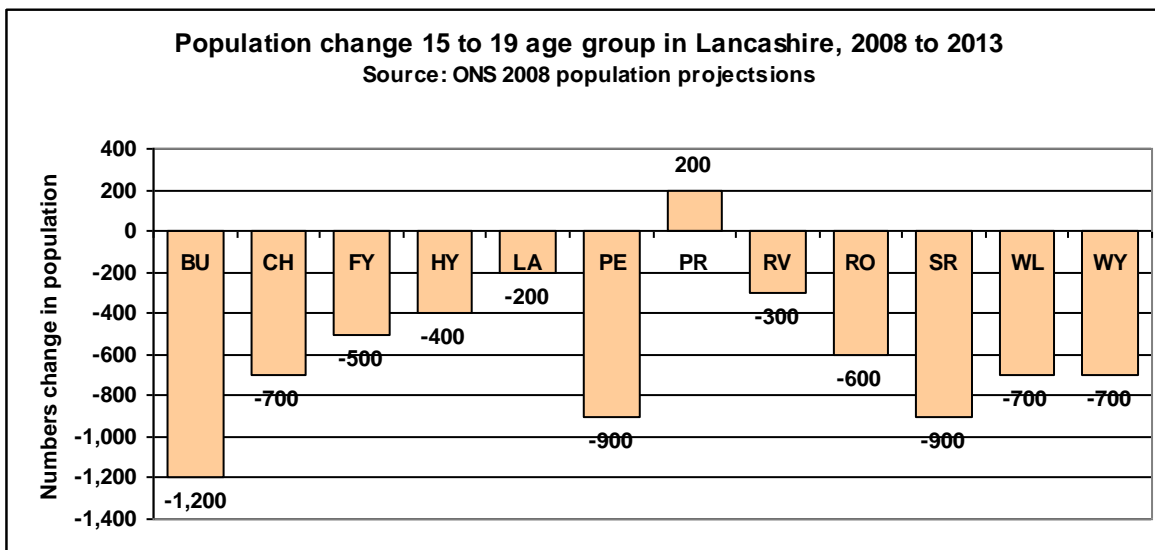
The population aged 10 to 14 is projected to fall in all districts, with the largest changes in Hyndburn, Lancaster and Preston.

Figure 7: Lancashire population projections by district, 10 to 14 age group, 2008 to 2013



Population changes in the 15 to 19 group will mean reductions in this cohort in all districts except Preston. The largest projected reductions are in Burnley, Pendle and South Ribble.

Figure 8: Lancashire population projections by district, 15 to 19 age group, 2008 to 2013



In summary:

- There are more than 280,000 children and young people living in Lancashire.
- Due to low fertility rates, the number of children and young people in Lancashire has fallen and there are now 11,000 fewer children than there were ten years ago.
- Population projections suggest the numbers of children and young people will continue to fall over the next years to 2033.

- Between 2008 and 2013 the numbers of children and young people are expected to reduce by 7,400. There are large differences projected by age group: the younger age groups, 0 to 4 and 5 to 9 years, are expected to increase, with large reductions in the numbers of older children aged 10 to 19.
- The district picture mirrors the Lancashire picture, with the exception of Preston where the numbers of children are projected to increase to 2013.
- The largest population increases in the 0 to 4 years cohort between 2008 and 2013 will be in Lancaster, Pendle and Preston. Only in Ribble Valley will the size of this cohort reduce.
- The largest population increases in the 5 to 9 years cohort between 2008 and 2013 will be in Burnley, Chorley and Preston.
- The population aged 10 to 14 is projected to fall in all districts between 2008 and 2013, with the largest changes in Hyndburn, Lancaster and Preston.
- The population aged 15 to 19 is projected to fall in all districts except Preston between 2008 and 2013, with the largest reductions in Burnley, Pendle and South Ribble.

Families

There are no comprehensive and up to date data sets which give estimates of the numbers of families in Lancashire. The most comprehensive data set is the Census, but this is now 10 years out of date and will not represent a true picture. Another potential source is data from HM Revenue and Customs (HMR&C) showing the number of families claiming child benefit.

Child Benefit is currently a universal benefit paid to those responsible for children aged less than 16 years and qualifying young people, although the coalition is planning changes which will prevent claims from high tax rate earners. The qualifying young people include:

- those in full-time non-advanced education or on certain approved vocational training courses and who are 19 and under;
- those entered for future external examinations, or are in the period between leaving education (or exams finishing) and the week containing the first Monday in September (or similar dates after Easter and in early January, if earlier), and are not in work;
- those aged under 18 who have moved directly from full-time education to being registered for work or training with the Careers service or with Connexions.

Therefore not all 16 to 19 year olds are included in this dataset. The data shows benefit claims for 252,915 children aged 0 to 19 years, meaning that the benefit is only claimed for 90% of children and young people in the Lancashire. The table below shows the number of families in Lancashire. According to the HM Revenues and Customs figures, there are almost 150,000 families in Lancashire. Families make up a higher than average proportion of the population in Chorley, Lancaster, Preston, South Ribble and West Lancashire. The children and young people population is greatest in the districts of Burnley, Hyndburn, Pendle and Rossendale, demonstrating that the families in these districts tend to be larger. This is likely to be related to the larger minority ethnic populations. The suitability of housing in these areas will be an important issue as overcrowded and unsuitable houses are linked with poorer outcomes including increased risk of accidents and limited space to complete homework, which affects educational attainment (see section on [housing](#) below).

Table 5: Child Benefit claimants in Lancashire, number of families by size, August 2009

	Total claimant families	% of Lancs total	Number of families by size (number of children)							
			One child	% of Lancs total	Two children	% of Lancs total	Three children	% of Lancs total	Four or more children	% of Lancs total
Burnley	12,005	8%	5,830	8%	4,180	8%	1,390	8%	605	10%
Chorley	13,180	9%	6,365	9%	5,135	9%	1,300	8%	380	6%
Fylde	8,255	6%	3,965	6%	3,240	6%	840	5%	210	4%
Hyndburn	11,400	8%	5,540	8%	3,865	7%	1,305	8%	690	12%
Lancaster	15,720	11%	7,620	11%	5,745	11%	1,755	11%	600	10%
Pendle	11,720	8%	5,475	8%	3,895	7%	1,520	9%	825	14%
Preston	17,495	12%	8,120	12%	6,265	12%	2,230	14%	880	15%
R. Valley	6,820	5%	2,930	4%	2,920	5%	785	5%	185	3%
Rossendale	9,045	6%	4,335	6%	3,340	6%	1,015	6%	355	6%
S. Ribble	13,905	10%	6,815	10%	5,315	10%	1,430	9%	345	6%
West Lancs	14,040	10%	6,375	9%	5,585	10%	1,570	10%	510	9%
Wyre	12,200	8%	5,825	8%	4,665	9%	1,345	8%	365	6%
Lancashire	145,780	100%	69,195	100%	54,155	100%	16,485	100%	5,945	100%
North West	892,240		426,950		326,400		101,225		37,665	
England	6,492,290		2,992,450		2,464,080		761,420		274,335	

The figures have been rounded to the nearest 5; therefore some of the totals do not sum exactly.

Source HM Revenue and Customs

Ethnicity

Lancashire has a less ethnically diverse population than the national average, although the proportion belonging to the Asian group is larger than that seen nationally. The 2007 ONS population estimates show that 11% of the population aged 0-15 is from a non white group, which means almost 25,000 children who are from a non white ethnic background. There is wide district variation, with Burnley, Hyndburn, Pendle and Preston populations displaying the greatest ethnic diversity.

Table 6: Ethnicity of resident children aged 0-15, 2007

Area	All People	White		Black		Asian		Chinese and Other		Mixed race		Total ethnic component	
		Nos	%	Nos	%	Nos	%	Nos	%	Nos	%	Nos	%
Burnley	17,900	14,700	82	400	2	2,600	15	100	1	100	1	3,200	18
Chorley	19,200	18,000	94	500	3	500	3	100	1	100	1	1,200	6
Fylde	12,100	11,500	95	300	2	300	2	100	1	100	1	800	7
Hyndburn	17,800	14,700	83	400	2	2,600	15		0		0	3,000	17
Lancaster	24,100	22,600	94	600	2	600	2	100	0	200	1	1,500	6
Pendle	18,600	13,800	74	500	3	4,200	23	100	1	0	0	4,800	26
Preston	25,500	19,900	78	1,000	4	4,200	16	200	1	200	1	5,600	22
Ribble Valley	10,900	10,100	93	200	2	500	5		0	100	1	800	7
Rossendale	13,800	12,500	91	200	1	900	7		0		0	1,100	8
South Ribble	19,700	18,600	94	500	3	500	3	100	1	100	1	1,200	6
West Lancashire	20,900	20,100	96	400	2	200	1	100	0	100	0	800	4
Wyre	18,500	17,600	95	300	2	400	2	100	1	100	1	900	5
Lancashire	218,800	194,100	89	5,300	2	17,400	8	1,000	0	1,000	1	24,700	11
North West	1,308,800	1,162,400	89	38,000	3	83,800	6	14,000	1	10,500	0	146,300	11
England	9,655,800	8,133,700	84	391,500	4	699,400	7	326,200	3	105,000	1	1,522,100	16

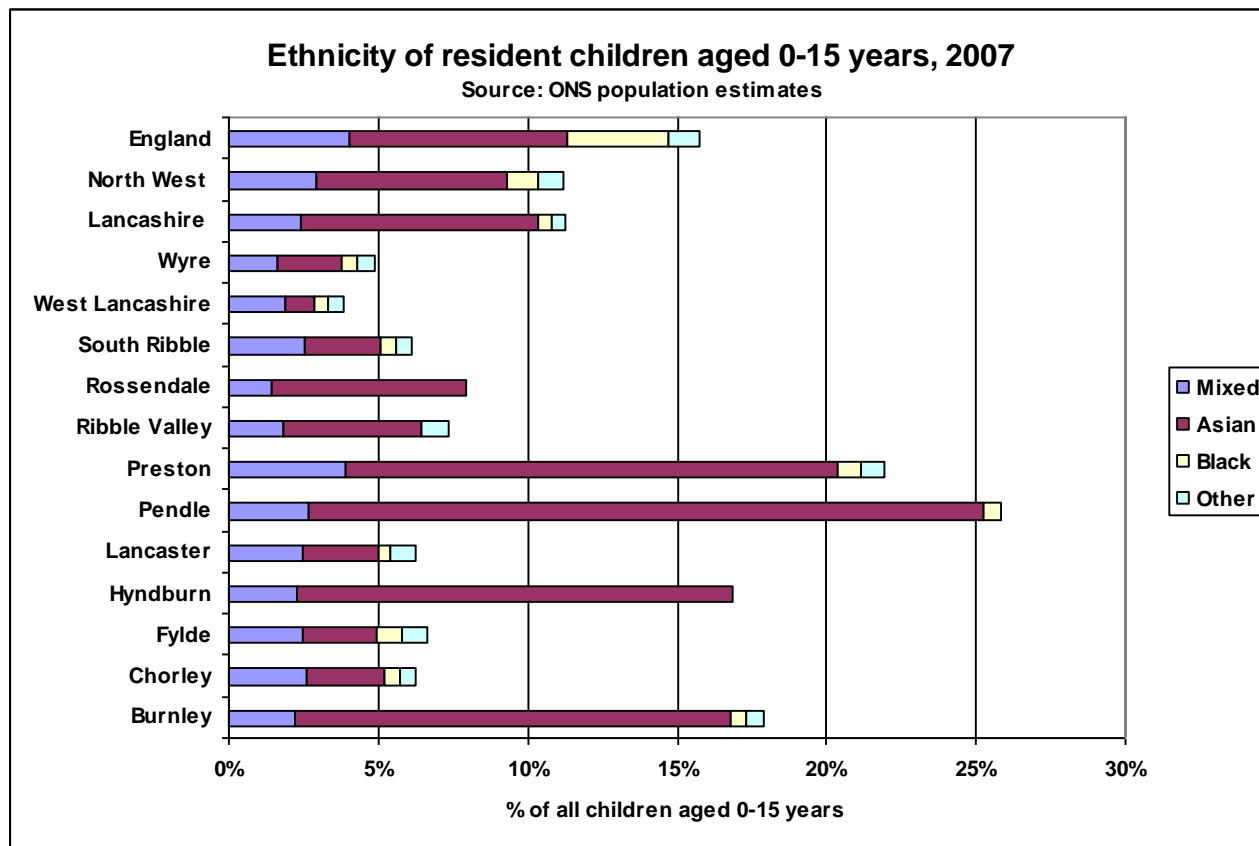
Source: ONS, Estimated resident population by broad ethnic group and sex, mid-2007 (experimental statistics)

The vast majority of the black or minority ethnic population are in the broad group of Asian. They make up 8% of the total population (more than 17,000) of children aged 0 to 15 years across Lancashire. In both Burnley and Hyndburn 15% (2,600) of young people aged 0 to 15 years are Asian and predominantly Pakistani (1,800 and 2,100 respectively).

In Pendle almost 23% (4,200) of young people are Asian (predominantly Pakistani, 3,900). In Preston 16.5% (4,200) are Asian (predominantly Indian, 2,900).

Other minority ethnic communities are Bangladeshi young people in Burnley (500) and Rossendale (400); and 500 mixed white and black Caribbean young people in Preston in addition to a 100 black Caribbean young people.

Figure 9: Ethnicity of resident children aged 0-15, 2007



The school census, undertaken each year with the sample of pupils in school that day, collects information about the ethnicity of pupils and should give a more accurate picture. District level numbers are provided in the [appendix](#). The codes are given in the table below. The proportion of children who are not classed as White British is smaller in primary than secondary schools (84% and 89%, respectively), indicating the changing ethnic diversity within the population of Lancashire. The largest black and minority ethnic group in Lancashire is

Children and young people in Lancashire

Pakistani and this group is much larger in the primary than secondary years, 7% of the primary population are of Pakistani origin and 4% of the secondary population are of Pakistani origin.

The BME populations are concentrated in a small number of education districts and the pattern of greater ethnic diversity in primary and secondary years continues. In Preston, 15% of primary school children and 9% of secondary school children are of Indian origin, whilst 6% of primary school children and 3% of secondary school children are of Pakistani origin. Large Pakistani populations are also present in the education districts of Burnley and Hyndburn / Ribble Valley, although it is likely that the majority of this population is in Hyndburn. Pendle shows the highest proportion of Pakistani children, accounting for a quarter of secondary school pupils and a third of primary school pupils.

Table 7: Primary school census percentage of pupils by ethnic group, 2010

District	Total	ABAN	AIND	AOTH	APKN	BAFR	BCRB	BOTH	CHNE	MOTH	MWAS	MWBA	MWBC	REFU, NOBT or not rec	OOTH	WBRI	WIRI	WIRT	WOTH	WROM
Burnley	100%	5%	0%	0%	13%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	77%	0%	0%	1%	0%
Chorley	100%	0%	1%	0%	1%	0%	0%	0%	0%	1%	1%	0%	1%	0%	0%	94%	0%	0%	1%	0%
Fylde	100%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	0%	1%	0%	0%	94%	0%	0%	2%	0%
Hyndburn / Ribble Valley	100%	0%	1%	0%	14%	0%	0%	0%	0%	0%	1%	0%	0%	1%	0%	80%	0%	0%	1%	0%
Lancaster	100%	0%	1%	1%	0%	0%	0%	0%	0%	1%	0%	0%	0%	1%	0%	91%	0%	0%	3%	1%
Pendle	100%	0%	0%	1%	34%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	60%	0%	0%	1%	0%
Preston	100%	0%	15%	2%	6%	0%	0%	0%	0%	1%	1%	0%	2%	1%	1%	68%	0%	0%	2%	0%
Rossendale	100%	4%	0%	0%	4%	0%	0%	0%	0%	0%	1%	0%	1%	1%	0%	87%	0%	0%	0%	0%
South Ribble	100%	0%	1%	0%	0%	0%	0%	0%	0%	1%	1%	0%	1%	1%	0%	93%	0%	0%	1%	0%
West Lancashire	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	95%	0%	0%	2%	0%
Wyre	100%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%	96%	0%	0%	1%	0%
Lancashire	100%	1%	2%	1%	7%	0%	0%	0%	0%	1%	1%	0%	1%	1%	0%	84%	0%	0%	1%	0%

Table 8: Secondary school census percentage of pupils by ethnic group, 2010

District	Total	ABAN	AIND	AOTH	APKN	BAFR	BCRB	BOTH	CHNE	MOTH	MWAS	MWBA	MWBC	REFU, NOBT or not rec	OOTH	WBRI	WIRI	WIRT	WOTH	WROM
Burnley	100%	4%	0%	1%	12%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	79%	0%	0%	1%	0%
Chorley	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	95%	0%	0%	1%	0%
Fylde	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	96%	0%	0%	1%	0%
Hyndburn / Ribble Valley	100%	0%	1%	0%	8%	0%	0%	0%	0%	1%	1%	0%	0%	0%	0%	87%	0%	0%	1%	0%
Lancaster	100%	0%	1%	0%	0%	1%	0%	0%	1%	0%	1%	0%	0%	0%	0%	91%	0%	0%	3%	0%
Pendle	100%	0%	0%	0%	25%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	71%	0%	0%	1%	0%
Preston	100%	0%	9%	1%	2%	0%	0%	0%	0%	1%	1%	0%	2%	0%	0%	80%	0%	0%	2%	0%
Rossendale	100%	3%	0%	0%	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	90%	0%	0%	0%	0%
South Ribble	100%	0%	4%	1%	1%	0%	0%	0%	0%	1%	1%	0%	1%	0%	0%	90%	0%	0%	1%	0%
West Lancashire	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	97%	0%	0%	1%	0%
Wyre	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	97%	0%	0%	1%	0%
Lancashire	100%	1%	2%	0%	4%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	89%	0%	0%	1%	0%

Table 9: DfES ethnic group codes

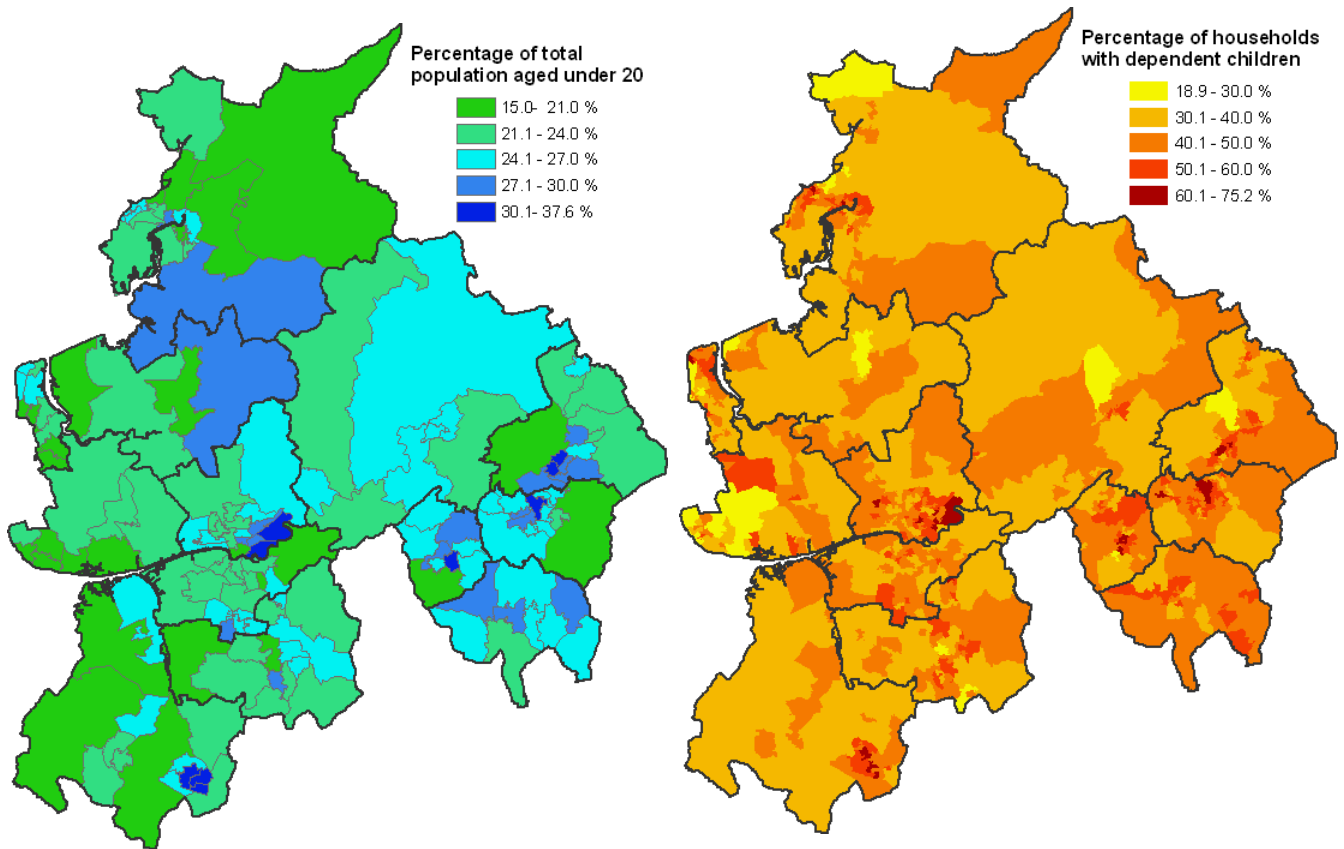
DfES Main Code	Sub- Category	Main Category
WBRI	White - British	White
WIRI	White - Irish	White
WIRT	Traveller of Irish Heritage	White
WOTH	Any Other White Background	White
WROM	Gypsy / Roma	White
MWBC	White and Black Caribbean	Mixed / Dual Background
MWBA	White and Black African	Mixed / Dual Background
MWAS	White and Asian	Mixed / Dual Background
MOTH	Any Other Mixed Background	Mixed / Dual Background
AIND	Indian	Asian or Asian British
APKN	Pakistani	Asian or Asian British
ABAN	Bangladeshi	Asian or Asian British
AOTH	Any Other Asian Background	Asian or Asian British
BCRB	Black Caribbean	Black or Black British
BAFR	Black - African	Black or Black British
BOTH	Any Other Black Background	Black or Black British
CHNE	Chinese	Chinese
OOTh	Any Other Ethnic Group	Any Other Ethnic Group
REFU	Refused	Refused
NOBT	Information Not Yet Obtained	Information Not Yet Obtained

Geography

The map below shows concentrations of young people across Lancashire. The highest concentrations, where more than a quarter of the population is aged 0 to 19 years old are in the urban areas.

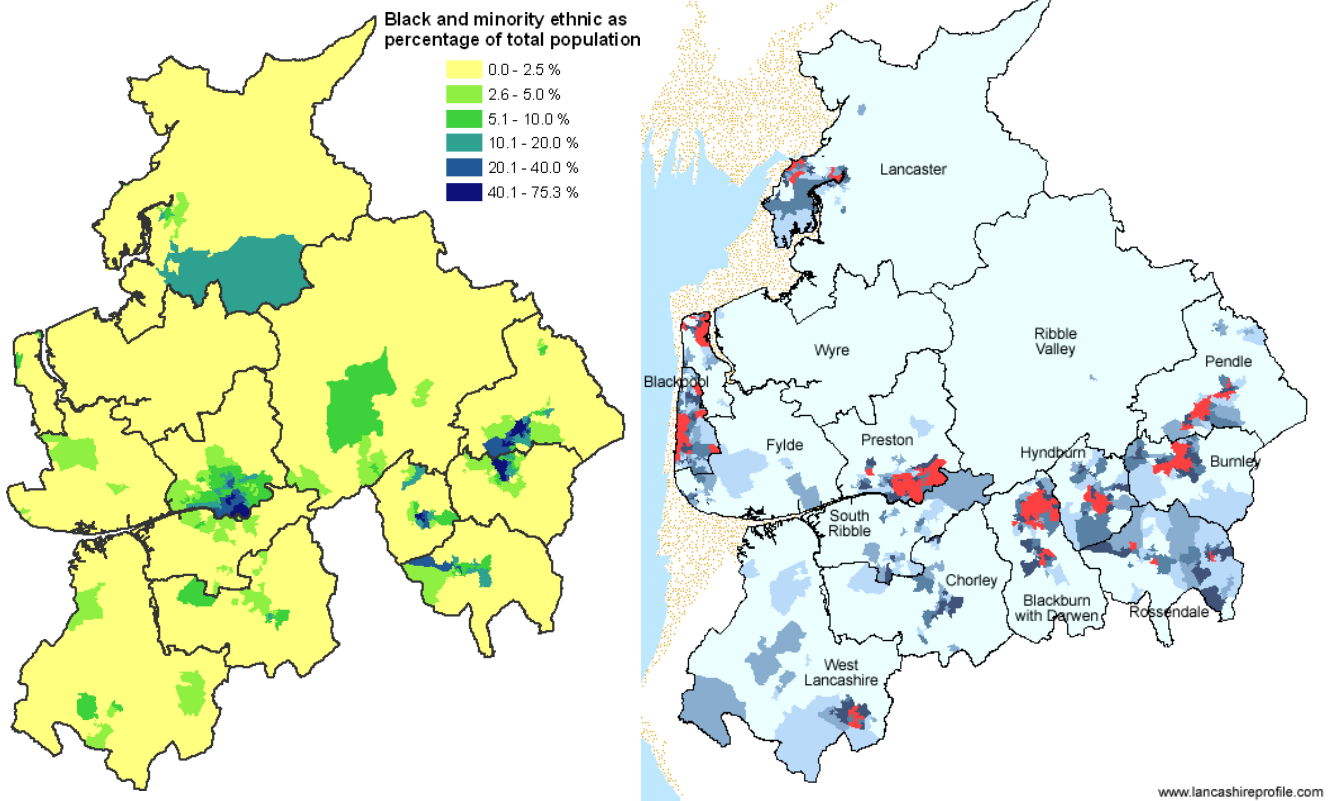
A similar picture is found for the density of households with dependent children. The areas where more than half of households have dependent children are centred on urban locations, which correspond with areas of deprivation as shown in the maps below. These maps highlight that the areas with highest density of children and families tend to be areas of higher deprivation. Children are largely powerless to influence where they live, but this is a powerful determinant of their outcomes.

Maps 1 and 2: Percentage of total population aged under 20 in Lancashire, 2008 ONS midyear population estimates, against the percentage of households with dependent children, 2001 Census



The map below highlights where the children and young people of black and minority ethnic heritage live in Lancashire. These children tend to be located in dense urban areas, which correspond with the areas of deprivation. This is not an uncommon finding but may indicate that these children and young people will face greater challenges throughout life.

Maps 3 and 4: Percentage of children and young people from a black and minority ethnic group against deprivation, 2007



Decile(s)	Ranks	Deprivation	
1	1 to 3,248	the most deprived	10% of LSOAs in England
2	3,249 to 6,496	the second most deprived	10%
3	6,497 to 9,745	the third most deprived	10%
4	9,746 to 12,993	the fourth most deprived	10%
5	12,994 to 16,241	the fifth most deprived	10%
6 to 10	16,242 to 32,482	the least deprived	50% of LSOAs in England

Summary and recommendations

Lancashire has a declining population of younger people as a result of lower than average fertility rates. Given the current austerity measures this could make services for 0 to 19 cohort more vulnerable. At the same time, there are concentrations of children and families in areas of high deprivation. This indicates that children and young people in Lancashire face greater hardships than the adult population and this is a circumstance over which they have little control. Children and young people therefore need a greater level of support to break out of the cycle of deprivation and reach their potential.

The demographics of the children and young people population of Lancashire differ from the national average but there are also important differences within Lancashire. The varied demography, with some districts having a higher proportion of older children and other areas being

more concentrated with younger children, means that a one size fits all approach to children and young people is not appropriate across Lancashire. The support that children and young people need to achieve the desired outcomes will vary over the life course and service providers need to understand the demographics in their area of operation.

The projected reduction in the numbers of children and young people will be an important demographic shift for organisations, particularly for those who deal with all ages as they will also be facing large increases in the older adult population. Over the next five years the reductions will be primarily in the 10 to 19 age group as the 0 to 9 age group are projected to increase slightly. Clearly there will be opportunities to redistribute investment in services from older age groups to younger age groups. Given the austerity measures being implemented by the coalition government, there is a drive to focus on prevention and early intervention to reduce the numbers of people who need to access higher tier services. The shifting demographics serve to support this early intervention focus.

Understanding the numbers of families in Lancashire, and not simply the numbers of children and young people, is important for the changing way in which services are operating. There is a greater focus on providing services and support for families as a whole, rather than simply looking at individual children and this approach is being mirrored in adult services. Think Family (DCFS, 2009) is a cross-departmental government programme from the previous administration which, since April 2009, has provided Local Authorities with increased funding to support the introduction of:

- Think Family practice – making sure that the support provided by children's, adults' and family services is coordinated and takes account of how individual problems affect the whole family.
- Targeted support for parents and families – such as Family Intervention Projects and Parenting Early Intervention Programmes designed to provide evidence-based support to families experiencing problems.

The increasing ethnic diversity in the children and young people population is likely to reflect an increasing diversity in the adult population in the future. There are challenges for service providers and agencies working with areas where there are such rapidly changing demographics, including the varying cultures that need to be understood and engaged, as well as those who speak English as an additional language. The correlation between those areas with large black and minority ethnic communities and deprivation is a cause for concern as those who are able to achieve at school and economically may move away from the area, broadening inequalities. The proposed

austerity measures leading to public sector cuts and changes to the NHS may have implications for community cohesion if it is viewed that one area is receiving more money or better services, with any demographic differences likely to fuel additional tension. At the same time, services should be able to work well with black and minority ethnic communities to develop methods to resolve issues within the community rather than rely upon services where possible. Service providers should continue work to engage with these and other communities to strengthen them through the application of approaches such as asset based community development (ABCD).

Specific recommendations

A number of specific recommendations can be drawn from the analysis in this chapter:

- Commissioners and service providers need to understand the demographics in their area of operation to ensure that the support that children and young people need to achieve the desired outcomes over the life course is appropriate.
- The changes in the age profile of the children and young people population will require a shift in funding from older to younger age groups.
- Think Family practice should be adopted by all partners working to improve the outcomes of children and young people.

The social determinants of family wellbeing

Introduction

Today's children grow into tomorrow's adults and, therefore, the wellbeing of children and adolescents is vital to achieving a healthy future adult population. Outcomes for children and young people and their families are based upon the foundations of accumulations over their life. The circumstances in which children live their lives, and their effect on factors such as crime, education, material wellbeing, environment, housing and population health, have an impact upon children and young people. The Marmot report on health inequalities (2010) estimated that 80% of the determinants of health fall outside the health service. The same could be said for any of the named factors, each is determined in the majority by other factors outside immediate control. Each needs to be tackled to improve the lives of children and young people.

This section outlines some key determinants of wellbeing for families who are living in Lancashire and highlights how these vary between different population groups of young people. There are a number of factors which may be regarded as having an important impact in determining the overall wellbeing of children and young people and their families. These factors may also affect the prospects for children and young people to achieve wellbeing in later life.

Some of the key determinants of wellbeing are included in the Child Wellbeing Index, which has been developed by the Department for Communities and Local Government. This chapter is structured around these determinants:

- Level of material wellbeing (e.g. reliance on benefits)
- Health (e.g. incidence of illness and accidents)
- Education (e.g. levels of educational attainment and access to higher education)
- Crime (e.g. exposure to burglary, theft, criminal damage and violence)
- Housing (e.g. quality of living accommodation and level of overcrowding)
- Environment (e.g. quality of local environment and access to facilities).

These factors are inter-linked. For example, the level of material wellbeing has a strong link with levels of educational attainment, exposure to crime and quality of housing, whilst the quality of housing will have a direct impact upon health and education.

Each topic is considered in turn in this chapter and some are returned to in greater detail by age cohort in later chapters. For example, an overview of the child wellbeing index domain for education is considered here but the core analysis of education will be considered in the chapters of [primary years](#) and [secondary years](#). Similarly, health indicators are considered by age group to provide a finer detail of understanding of the key risks posed for children and young people at each stage of their development. Also, crime against children and young people as a group is considered here but crime committed by young people is considered in a separate section on [children and young people who offend](#) within the chapter on young people (aged 16-19).

There are children and young people whose circumstances have a profound effect on their wellbeing. These include children looked after, children with disability, children with learning disabilities and children with caring responsibilities. The needs of these groups of children are also addressed separately in the chapter on [children and young people with particular needs](#). This list is not exhaustive; there will be other groups of children with particular needs who have not been included here. .

Wellbeing of children and young people

The Index of Child Wellbeing (CWI), published by the Department for Communities and Local Government in 2009, represented an attempt to assess the wellbeing of children and young people based on data on a number of different domains in their lives.

The CWI revealed that, based on the ranks of their average scores, Burnley, Pendle and Preston were in the 20% worst districts nationally for child wellbeing. In addition, Hyndburn and West Lancashire were also in the worst 20% of districts in one of the seven domains (housing and health/disability respectively). Burnley was ranked in the 20% worst English districts with lowest child wellbeing in all domains other than environment.

Five local districts appeared in the 50% of areas with the highest child wellbeing, namely Wyre, South Ribble, Chorley, Fylde and Ribble Valley. The latter two have the highest child wellbeing ratings in the county, with Fylde being ranked 49th and Ribble Valley ranked 2nd best in England in terms of the ranking of their overall scores.

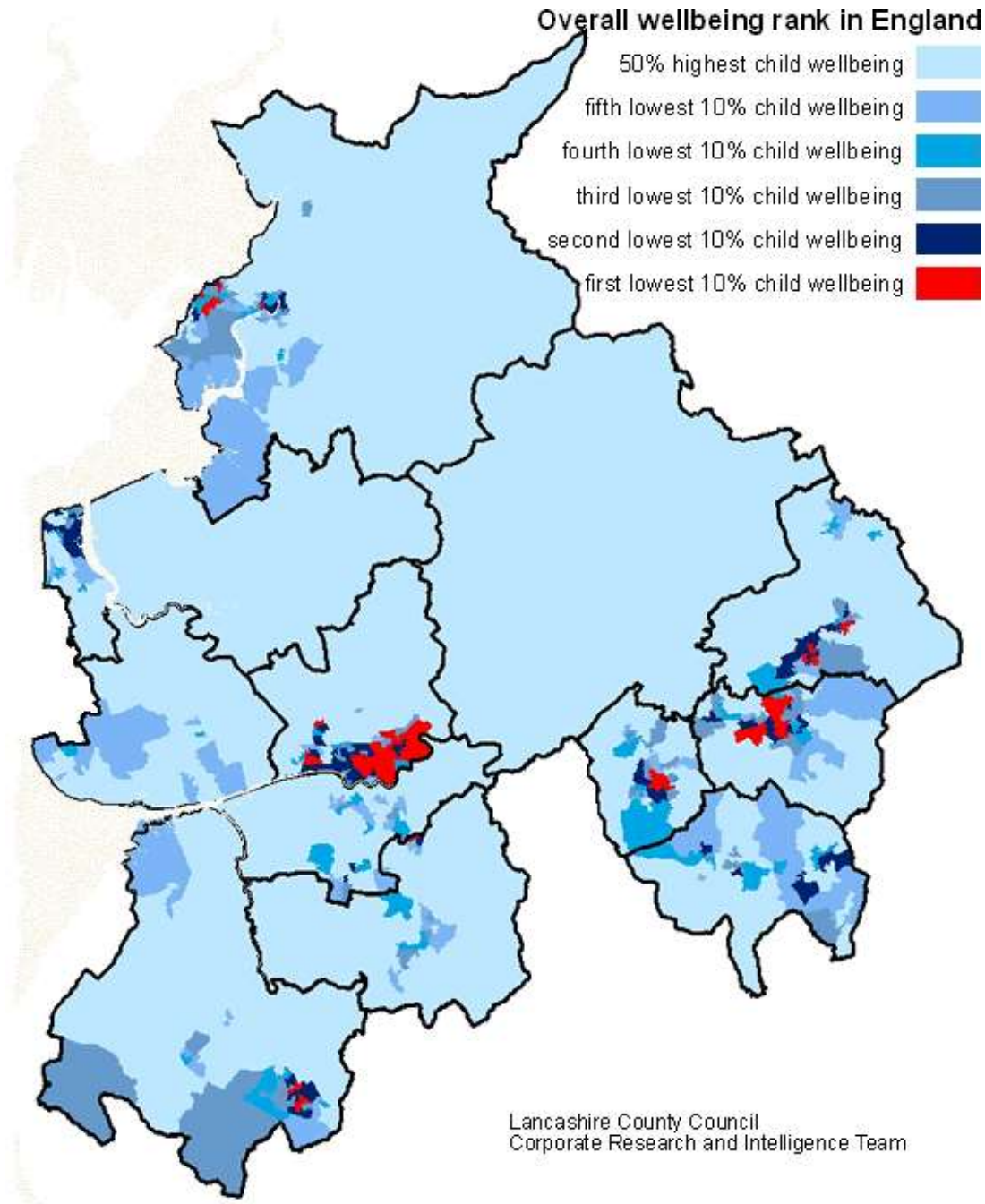
Table 10: Local index of child wellbeing rankings 2009

	CWI rank of average score*	Material wellbeing rank	Health and disability rank	Education rank	Crime rank	Housing rank	Environment rank	Children in need rank
Burnley	323	318	330	315	319	309	32	314
Chorley	132	123	113	135	185	150	241	131
Fylde	49	78	53	50	22	196	145	83
Hyndburn	264	290	205	299	263	312	3	272
Lancaster	227	223	257	221	180	280	66	225
Pendle	300	299	333	284	287	303	9	260
Preston	313	293	296	270	285	292	323	285
Ribble Valley	2	5	3	2	13	128	100	9
Rosendale	193	206	263	174	281	199	41	194
South Ribble	133	89	170	128	134	164	257	123
West Lancs	225	212	326	150	162	159	253	189
Wyre	148	160	48	203	65	230	248	173
Lancashire	64	60	76	73	52	83	51	59

*District ranks are out of 354 and the county's rank is out of 149
 Source: Communities and Local Government

The map below highlights areas with the lowest levels of wellbeing in red and dark blue. These areas have child wellbeing ranked in the worst 20% of areas nationally. The areas with the lowest levels of child wellbeing are concentrated in the most urban areas, which are also those facing the greater levels of deprivation.

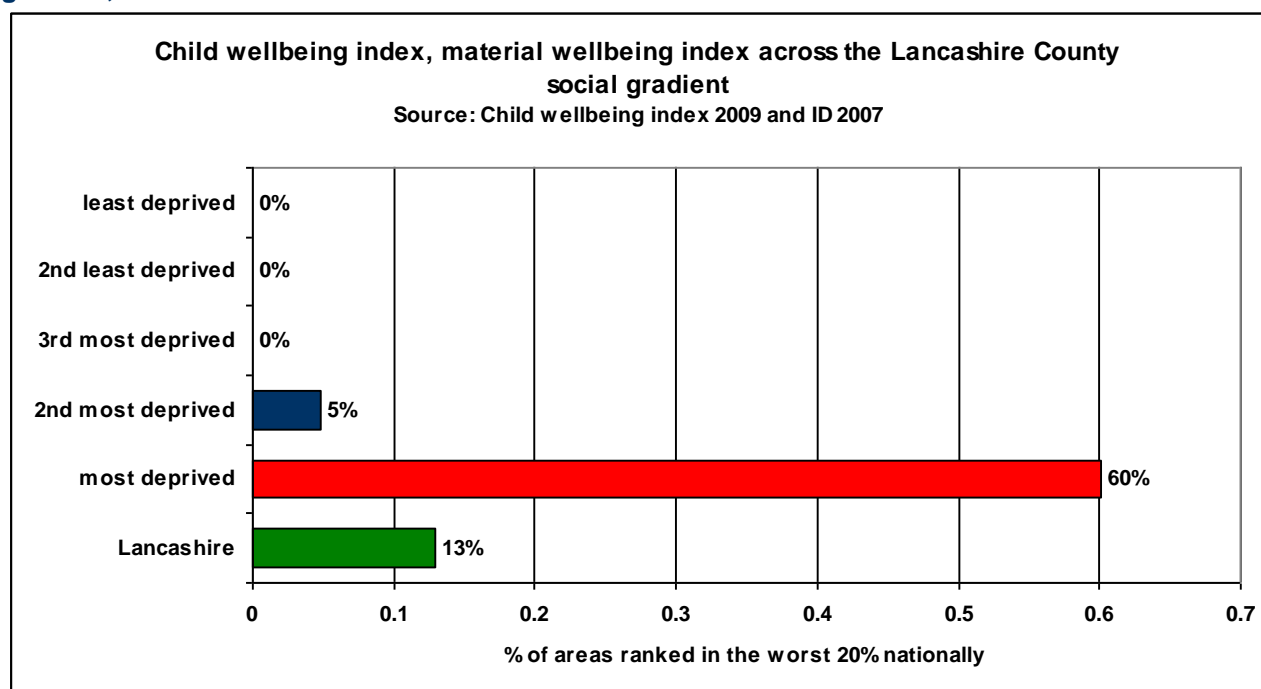
Map 5: Child wellbeing rank in Lancashire, 2009



Material wellbeing

Overall, the material wellbeing domain of the CWI shows a favourable picture for Lancashire as the areas of the county are under-represented in the bottom quintile. On average 13% of areas were ranked in the bottom 20% nationally. However, there is a stark picture of inequity across the county as while no areas in the least deprived 60% were ranked in the bottom quintile nationally, 60% of the most deprived parts of the county were. This shows an unsurprising picture of children in the most deprived parts of Lancashire experiencing the greater levels of poor material wellbeing.

Figure 10: Child wellbeing index, material wellbeing index across the Lancashire County social gradient, 2009



Child poverty

A quarter of Lancashire's children live in areas ranked within the most deprived 20% nationally.

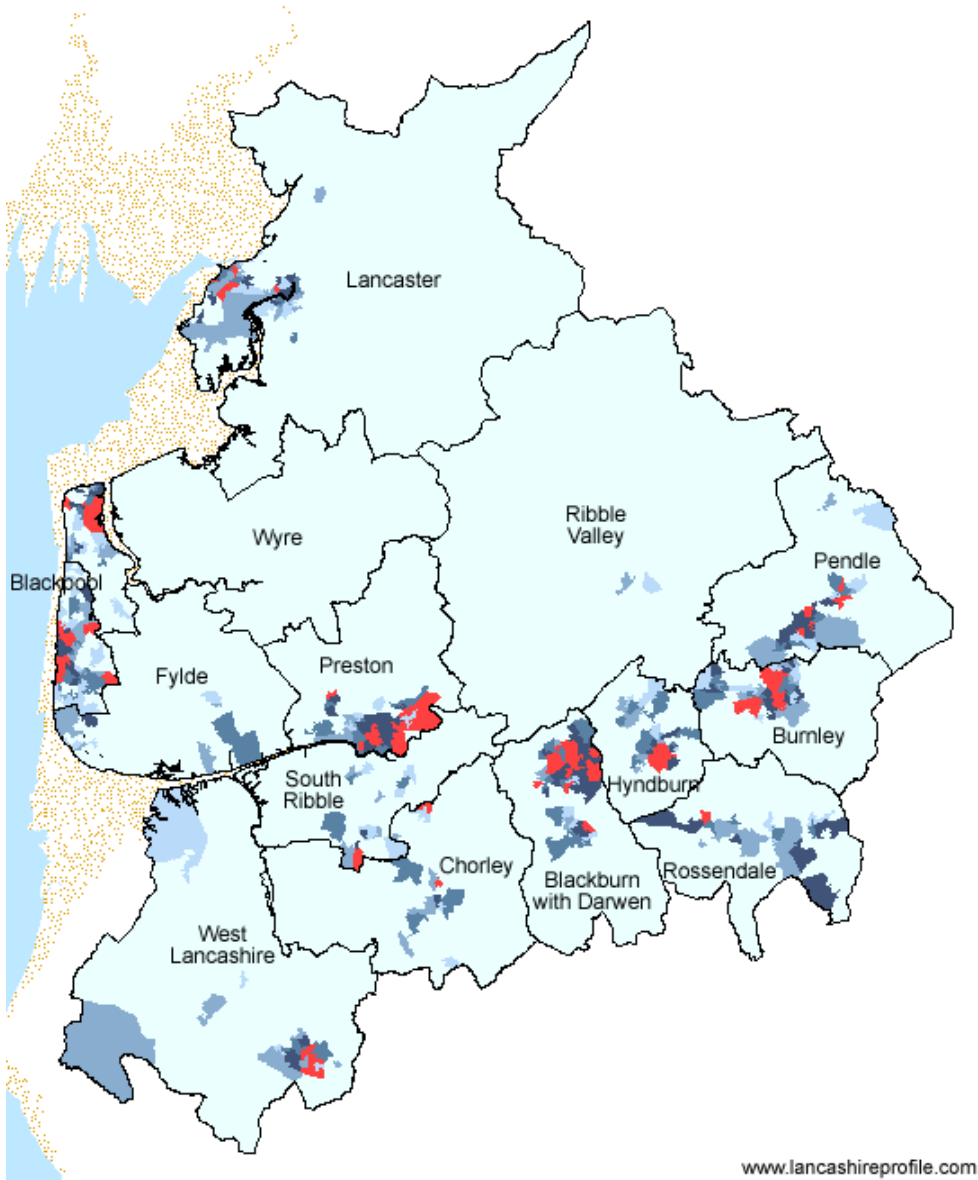
This confirms that children and young people are unequally affected by deprivation.

Table 11: Proportion and numbers of the Lancashire CYP population living in the most deprived areas of England (by age group)

	10% most deprived			20% most deprived			50% most deprived		
	Nos. of areas	0-15 yr olds in deprived areas	% of 0-15 yr olds in deprived areas	Nos. of areas	0-15 yr olds in deprived areas	% of 0-15 yr olds in deprived areas	Nos. of areas	0-15 yr olds in deprived areas	% of 0-15 yr olds in deprived areas
Burnley	14	4,770	26.9%	25	8,450	47.6%	47	14,590	82.3%
Chorley	0	0	0	8	2,590	13.5%	25	8,020	41.8%
Fylde	0	0	0	1	195	1.6%	13	2,847	23.7%
Hyndburn	10	4,331	24.8%	18	6,928	39.7%	39	13,232	75.8%
Lancaster	9	3,384	14.2%	17	5,621	23.6%	43	12,520	52.6%
Pendle	16	6,779	37%	20	8,028	43.8%	39	13,661	74.6%
Preston	20	7,691	30.3%	32	11,206	44.2%	56	17,223	68%
R. Valley	0	0	0	0	0	0	1	230	2.1%
Rosendale	3	890	6.5%	8	2,635	19.3%	32	9,879	72.3%
S. Ribble	0	0	0	3	1,036	5.3%	23	6,991	35.8%
West Lancs	6	2,333	11.3%	14	5,143	24.8%	32	9,794	47.3%
Wyre	5	1,473	8%	10	2,900	15.9%	23	6,256	34.3%
Lancashire	83	31651	15%	156	54732	25%	373	115243	54%

Source: Indices of Deprivation 2007

Map 6: Income deprivation affecting children



Decile(s)	Ranks	Deprivation	
1	1 to 3,248	the most deprived	10% of LSOAs in England
2	3,249 to 6,496	the second most deprived	10%
3	6,497 to 9,745	the third most deprived	10%
4	9,746 to 12,993	the fourth most deprived	10%
5	12,994 to 16,241	the fifth most deprived	10%
6 to 10	16,242 to 32,482	the least deprived	50% of LSOAs in England

Child Poverty Data

The Government has a target to end child poverty by 2020. The national PSA target to half the number of children in poverty is measured by the number of dependent children who live households whose equivalised income is below 60% of the national median.

A data set has been made available to measure child poverty and is based upon a snapshot of data recorded by HMR&C in August 2007. The revised proxy indicator for the national indicator 116 is intended to measure the proportion of children in poverty, using the following definition:

The proportion of children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income.

The denominator for this indicator is based on Child Benefit data held by HMR&C which covers around 96% of all children. Child Benefit data has been used as it provides the most comprehensive assessment of the number of children available.

Four districts (Burnley, Pendle, Hyndburn and Preston) recorded a child poverty rate higher than the Lancashire and national averages. Unsurprisingly, these are the districts with the highest proportion of deprivation, as outlined in the Income Deprivation Affecting Children Indices (IDACI) from 2004 and 2007.

The table below outlines the numbers of children in families in receipt of Child Tax Credits (CTC) (<60% median income) or Income Support / Job Seekers Allowance (IS/JSA), together with the proportion on children deemed to be living in poverty. This measure indicates that there are almost 48,000 children in Lancashire estimated to be living in poverty. This figure is in line with the number of children who are estimated to be living in the 20% most deprived parts of the county, 54,732.

Table 12: Child poverty data by district, 2007

Area	Children in families in receipt of CTC (<60% median income) or IS/JSA		% of Children in "Poverty"	
	Under 16	All Children (0-19)	Under 16	All Children (0-19)
Burnley	5,700	6,460	31.9%	31.0%
Pendle	5,115	5,910	28.1%	27.9%
Hyndburn	4,635	5,245	26.7%	26.2%
Preston	6,545	7,355	24.9%	24.1%
Lancaster	4,435	4,940	19.4%	18.5%
Rosendale	2,455	2,795	18.6%	18.1%
West Lancashire	3,710	4,225	17.9%	17.3%
Wyre	2,800	3,195	15.8%	15.2%
Chorley	2,530	2,780	13.4%	12.6%
South Ribble	2,305	2,560	11.7%	11.1%
Fylde	1,275	1,495	11.0%	10.8%
Ribble Valley	675	785	6.7%	6.5%
Lancashire	42,185	47,745	19.7%	19.0%
England	2,141,690	2,397,645	22.4%	21.6%

Source: HMR&C

Income deprivation amongst children in Lancashire and its districts correlates strongly with a number of other potential indicators of child poverty: free school meals eligibility, teenage conceptions, educational attainment (at all ages), and the number of 16-19 year olds not in education, employment or training (NEETs).

Ward level analysis highlights:

- in 82 wards the proportion of children in poverty was above the Lancashire average (children aged 0-19), with rates of children in poverty above the national average in 69 wards.
- Burnley had the highest percentage of wards where child poverty was more prevalent than the Lancashire and national average. In 80% of the wards in Burnley, children were disproportionately affected by child poverty.

The following table summarises the number of wards in each district where the proportion of children in poverty was above the Lancashire and national averages.

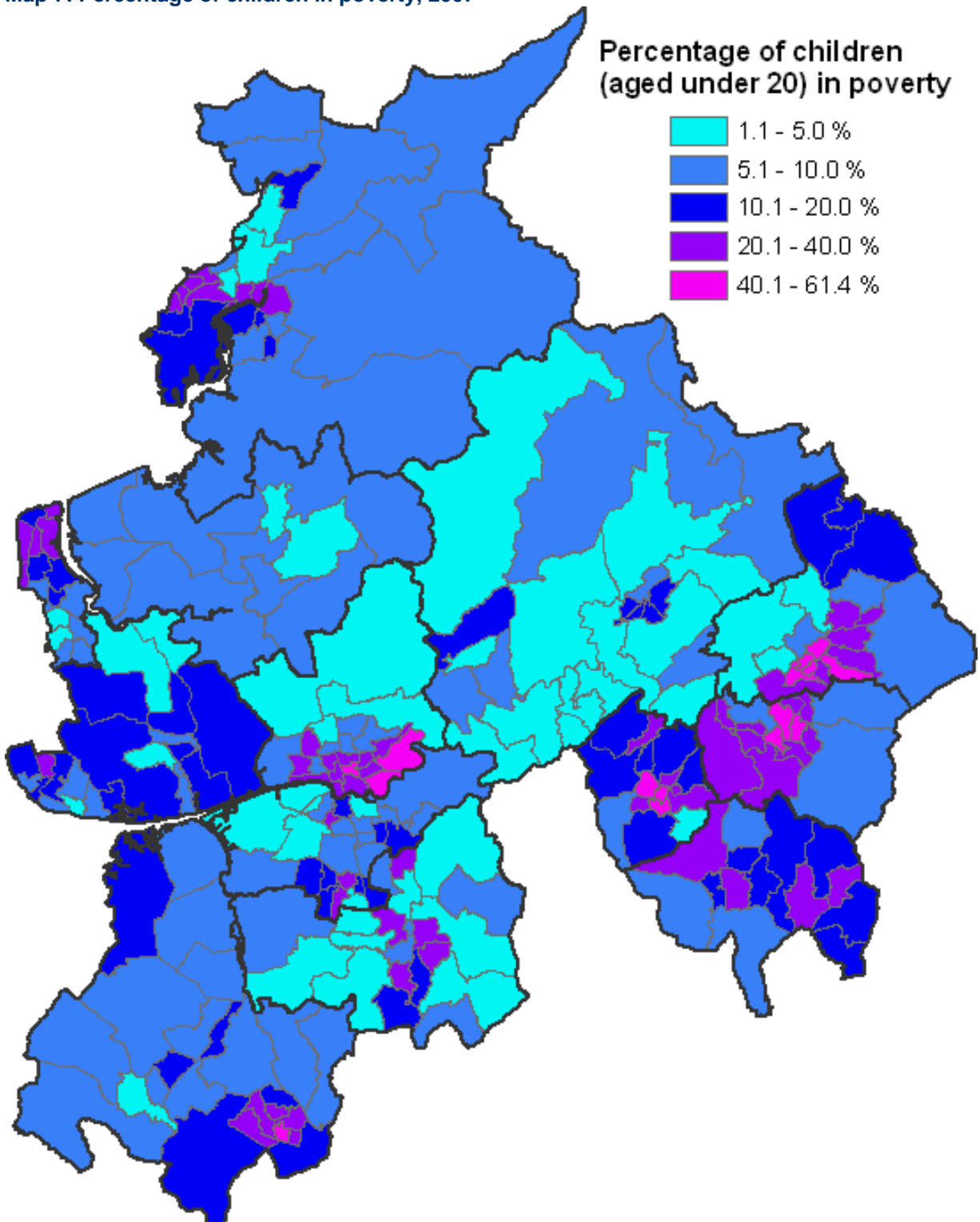
Table 13: Child poverty data, number of wards above Lancashire average, 2007

Area	Wards above the Lancashire ave (children aged 0-19)		Wards above the National ave (children aged 0-19)		% of Children in "Poverty"
	No	% of wards	No	% of wards	
Burnley	12	80%	12	80%	31.0%
Pendle	11	55%	11	55%	27.9%
Hyndburn	10	63%	7	44%	26.2%
Preston	13	59%	11	50%	24.1%
Lancaster	10	36%	8	29%	18.5%
Rosendale	4	29%	4	29%	18.1%
West Lancashire	6	24%	5	20%	17.3%
Wyre	7	27%	5	19%	15.2%
Chorley	5	25%	3	15%	12.6%
South Ribble	3	11%	3	11%	11.1%
Fylde	1	5%	0	0%	10.8%
Ribble Valley	0	0%	0	0%	6.5%
Lancashire	82	31%	69	27%	19.0%
England	-	-	-	-	21.6%

The map below shows the locations of those areas with highest levels of child poverty. In the most extreme areas, centred on the urban areas of Preston, West Lancashire, Pendle, Hyndburn and Burnley, more than 40% of children aged under 20 are deemed to be living in poverty using this

measure. This rate is almost double the national average and highlights extreme material deprivation.

Map 7: Percentage of children in poverty, 2007



Material deprivation and poverty are out of the control of children and young people. Whether a child lives in poverty or not is determined by whether they are raised in a family living in poverty. The next sections consider some of the determinants of family poverty.

Unemployment

Unemployment in families affects children and young people as it creates conditions of material deprivation due to low income. Not working is known to have an impact on mental wellbeing of adults and this will also impact upon children in the family. A lack of exposure to working role models can mean that work is not "normalised" in areas of high unemployment. Young people who live in areas of high unemployment may have low aspirations with the prospect of pursuing education and accessing paid employment far removed from the experience of their daily lives.

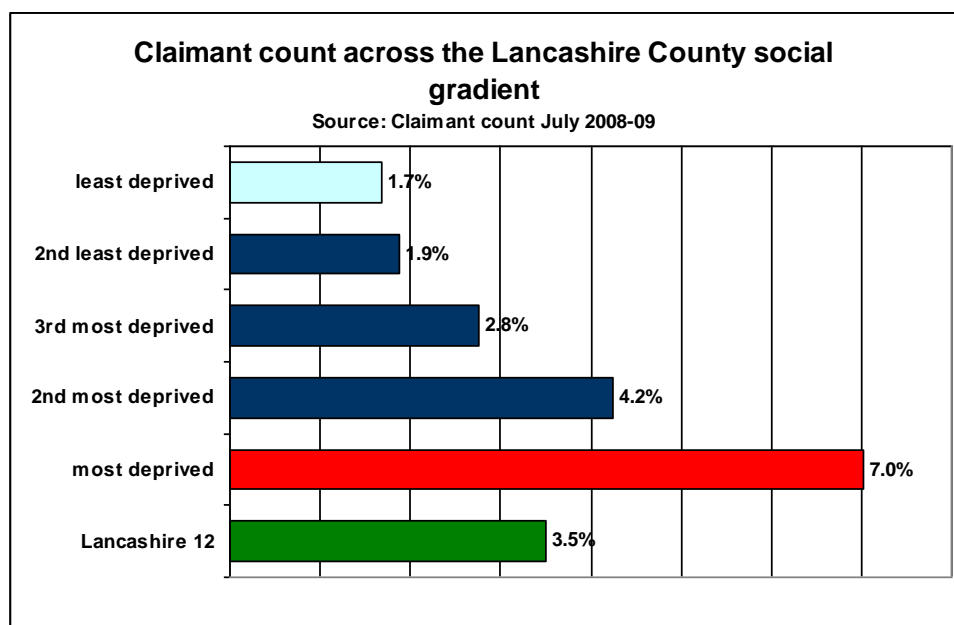
The official unemployment claimant count has for a number of years highlighted the fact that the overall rate for the county has been consistently below the national average. Lancashire is an area where the overriding problem is low wages rather than high unemployment however conditions do vary dramatically across the county council area. The claimant count represents the number of persons claiming JSA and National Insurance credits and is used as a proxy for unemployment.

Analysis of the claimant count rates down to ward level reveals that a number of wards in Skelmersdale, central Preston and inner Burnley have unemployment rates double the national average rate.

Table 14: Lancashire Wards Ranked by Claimant Count Proportions, October 2010

District/unitary	Ward name	Claimant count proportion (% of working age population)	Total claimant count	% change over year
West Lancashire	Digmoor (Skelmersdale)	9.8%	279	-18.7
West Lancashire	Tanhouse (Skelmersdale)	8.8%	251	-11.9
Preston	Ribbleton	8.3%	372	-10.4
West Lancashire	Birch Green (Skelmersdale)	8.2%	224	-11.8
West Lancashire	Moorside (Skelmersdale)	7.6%	195	-11.0
Burnley	Trinity	7.1%	240	0.8
Wards with more than double the UK average claimant count proportion of 3.5%				
Source Office for National Statistics via the National Online Manpower Information System (NOMIS)				

Figure 12: Claimant count across the Lancashire County social gradient, July 2008 to July 2009



The Department for Work and Pensions releases figures for the Job Seekers Allowance total by the age of the youngest child dependent and the district level results are listed below. The data show that there were more than 3,000 children recorded as dependent upon claimants of JSA, providing a potential indicator of children in poverty. Almost 1,300 of these children were aged under five years. The largest numbers of children dependent upon JSA claimants are found in the districts of Burnley, Lancaster, Pendle and West Lancashire. This dataset has limitations due to the numbers of unknowns and will therefore underestimate the true picture.

Table 15: Job Seeker's Allowance and dependent children, November 2009

	Total	Age of youngest child dependent				
		Unknown child age or no children	Under 5	5 to under 11	11 to under 16	16 or over
Burnley	2,420	2,070	150	50	90	60
Chorley	1,860	1,630	110	40	60	30
Fylde	930	820	50	20	30	10
Hyndburn	1,970	1,710	120	40	70	30
Lancaster	2,750	2,410	130	50	110	50
Pendle	2,040	1,740	140	50	80	30
Preston	3,270	2,850	20	60	10	60
Ribble Valley	530	480	20	10	20	-
Rossendale	1,540	1,350	80	40	60	30
South Ribble	1,600	1,390	80	40	60	30
West Lancashire	2,750	2,360	130	60	120	70
Wyre	1,380	1,200	80	30	50	30
Lancashire	23,030	20,010	1,270	480	850	410
North West	189,090	165,820	9,240	3,820	6,810	3,400
Great Britain	1,469.92	1,268.46	80.28	35.06	58.4	27.74

Source: Department for Work and Pensions Tabulation Tool

Young people can face a greater risk of unemployment. This is particularly so during times of economic downturn where employers may prefer to take on staff with greater experience. Young people who are not in education, employment or training are referred to as NEET. Discussion of this group is provided in the chapter on [young people](#) (aged 16-19).

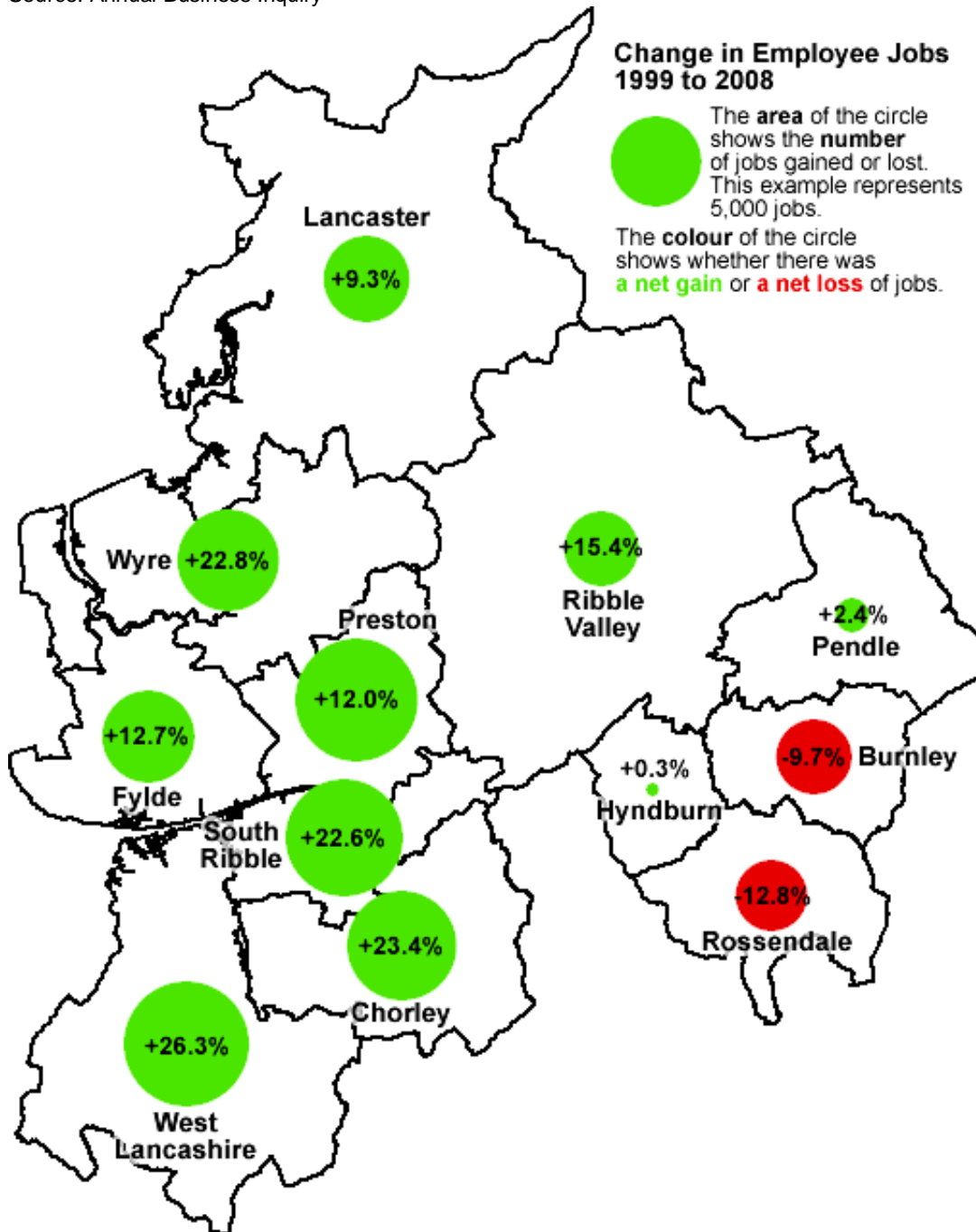
Employment and access to jobs

Access to employment is a key determinant of material wellbeing. If there are no jobs available or there are barriers to employment, it is highly likely that families will be affected by poverty. For young people leaving education with the aim of accessing employment a lack of availability of jobs may lead to a continuance of the cycle of poverty. Employee numbers in Lancashire grew by 11.1% between 1999 and 2008 to reach 491,900 and surpassed a 7.5% increase seen across Great Britain. The map below, however, emphasises the fact that employment growth rates varied dramatically between districts. Employee job numbers fell over the period in question in Burnley and Rossendale, whilst South Ribble, Chorley and West Lancashire recorded growth rates of more than 20%.

Authorities in the East of the county have a well-established history of high levels of manufacturing employment. The long-term decline of employment in this broad sector, and the rise of service sector job opportunities, underpins the employment change disparities highlighted below.

Map 9: Change in employee job numbers by District (1999-2008)

Source: Annual Business Inquiry



Lancashire continues to have a proportionately large number of manufacturing employees in comparison to the rest of the country. In 2008, they accounted for 15.1% of employees, whilst at the national level manufacturing employee job numbers represented only 9.5% of the total.

Wholesale and retail was the largest employment sector in the county with 16.9% of all employees. This is very similar to the national figure.

In the service sector, education is an important employment area for Lancashire with a high proportion of jobs in this sector in comparison to the national picture. However, the county is under-represented in a number of sub-sectors that are associated with high value job opportunities. These include financial and insurance activities, information and communication and professional, scientific and technical activities. This potentially limits the income available to families in the county and the opportunities for children and young people.

The current financial climate and the pending budget cuts pose a significant risk for employment in Lancashire as a large proportion of jobs are found in sectors which are historically dominated by the public sector. 28,000 jobs are currently in the public administration and defence sector, 57,200 in the education sector and 60,700 in the human health and social work activities, accounting for almost 30% of jobs in Lancashire. Although not all of these will be public sector funded, a significant proportion of health and social care may be private sector for example, any significant cuts to public sector funding may have a large impact on the number of jobs in the county.

Table 16: Employee jobs by industrial sector, 2008

	Lancashire (12 districts)		North West	Great Britain
	No.	%	%	%
Agriculture, forestry and fishing	5,500	1.1	0.6	0.8
Mining and quarrying	600	0.1	0.1	0.2
Manufacturing	74,300	15.1	11.1	9.5
Electricity, gas, steam and air conditioning supply	1,500	0.3	0.2	0.3
Water supply; sewerage, waste management and remediation activities	4,100	0.8	0.6	0.6
Construction	28,100	5.7	5.5	5.1
Wholesale and retail trade; repair of motor vehicles and motorcycles	82,800	16.9	16.7	16.5
Transportation and storage	17,800	3.6	4.7	4.7
Accommodation and food service activities	32,300	6.6	6.7	6.8
Information and communication	11,200	2.3	2.7	3.7
Financial and insurance activities	10,300	2.1	3.6	4.0
Real estate activities	5,200	1.1	1.3	1.4
Professional, scientific and technical activities	20,900	4.3	6.0	6.8
Administrative and support service activities	30,600	6.2	7.8	8.2
Public administration and defence; compulsory social security	28,000	5.7	5.6	5.4
Education	57,200	11.6	9.6	9.4
Human health and social work activities	60,700	12.3	13.0	12.2
Arts, entertainment and recreation	9,200	1.9	2.2	2.4
Other service activities	11,100	2.2	2.1	2.1
All industries and services	491,500	100.0	100.0	100.0

Source ONS: Annual Business Inquiry

Statistics on employment from the Annual Business Inquiry relate the pay point of persons employed rather than where they reside, which leads to some unusual results. When examining employment over the social gradient it appears that 90% of the working age population in the most deprived areas are employed, whilst less than 60% are employed in the least deprived areas. Such results are due to the locations of industrial and business estates within less affluent areas where rates are lower and the high employment within town centres, which tend to be areas of deprivation.

What this appears to demonstrate is that there are employment opportunities available even in the most deprived areas but that the people living in these areas are "crowded out" from this employment. Barriers to gaining employment within a family's area of residence should be fully understood and overcome to support families to break the cycle of deprivation which unemployment sustains.

Income and earnings

Being able to obtain employment should help a family out of poverty. However, this may not be the case if the work available is poorly paid. The Annual Survey of Hours and Earnings (ASHE) provides information about the levels, distribution and make-up of earnings for employees. For the county council area as a whole, average median weekly earnings for all employees is consistently below the national average, where median value is the middle value of incomes if all incomes were placed in order. Between 2006 and 2008, the county was closing the gap with the national figure, but the 2009 results reversed this trend and showed that the county's median figure of £367.10 was 9.2 percentage points lower than the Great Britain result.

The district level figures are subject to wide margins of error so only broad conclusions can be derived. In general terms, the results reveal consistently high average earnings in Fylde and Ribble Valley and much lower earnings in Burnley, Hyndburn and Pendle. Fylde and Ribble Valley contain important high value employers such as British Aerospace and have rural locations that are popular with well-paid commuters.

Table 17: Weekly earnings, 2002 to 2009, All Workers, Resident Analysis (Median results)

Area	2002	2003	2004	2005	2006	2007	2008	2009	2009 results as % of GB Average
	£	£	£	£	£	£	£	£	
Burnley	296.9	266.5	284.0	300.6	333.5	328.7	343.8	353.6	88.5%
Chorley	332.2	311.6	325.5	345.7	344.9	357.1	380.2	384.2	96.1%
Fylde	346.2	385.8	365.0	381.7	370.1	415.5	435.6	395.4	98.9%
Hyndburn	278.8	277.0	282.2	288.2	287.9	303.7	346.0	332.9	83.3%
Lancaster	298.4	306.4	355.8	342.0	343.0	373.8	371.4	384.5	96.2%
Pendle	265.8	289.1	288.0	293.4	301.2	350.9	373.3	356.6	89.2%
Preston	274.9	325.4	307.7	330.7	305.7	320.2	353.9	342.1	85.6%
Ribble Valley	335.8	343.3	356.1	400.0	395.2	415.8	413.6	415.7	104.0%
Rosendale	284.0	312.9	348.0	360.1	350.2	352.8	373.3	356.3	89.1%
South Ribble	326.3	335.5	345.2	357.2	330.9	389.0	405.9	364.3	91.1%
West Lancashire	330.6	307.1	316.4	341.1	371.3	409.1	412.3	415.0	103.8%
Wyre	292.2	315.1	326.4	311.4	326.9	318.6	325.6	336.3	84.1%
Lancashire	304.7	315.8	321.4	335.4	336.5	359.8	377.3	367.1	91.8%
Percentage of GB average	93.4%	93.6%	92.4%	95.2%	92.2%	95.2%	96.4%	91.8%	----
North West	307.7	316.7	328.5	334.5	344.5	357.0	371.2	373.8	93.5%
Great Britain	326.3	337.3	347.7	352.4	364.8	378.1	391.4	399.7	100%

Source: Annual Survey of Hours and Earnings

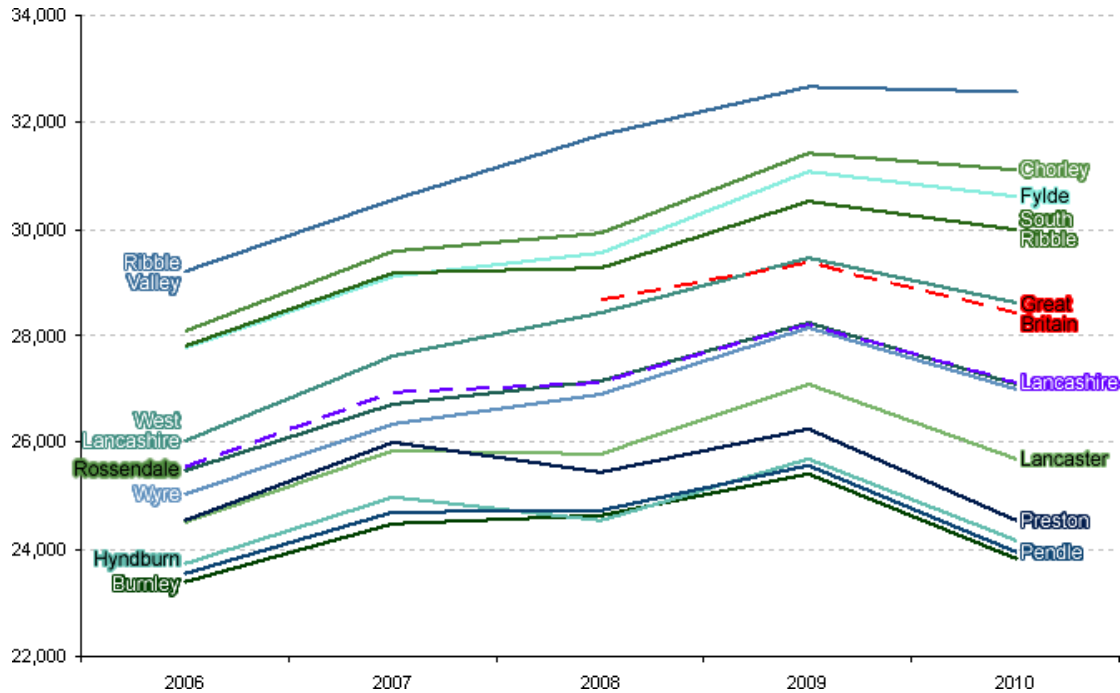
Note: The results at district authority level are subject to wide margins of error. Confidence intervals for the districts range from 4.5% up to a high of 14%.

Earnings form the major income source for many households, but investment income, pensions and various other welfare payments are also important additional sources of income. Figures for gross household income levels down to the ward level are available from the private research firm CACI.

For the Lancashire County Council area, the median household income figure for 2010 was £27,100. This was around 4.6% less than the Great Britain average of £28,400. When taking in to account other sources of revenue in addition to earning, it is normally seen to be the case that the gap between the county and national average does narrow.

The table below shows how median income levels have changed over the past five years for each Lancashire district. Comparable GB results are unfortunately only available for the past three years. Five of the 12 Lancashire authorities recorded results above or on a par with the GB average. In contrast, Burnley, Pendle, Hyndburn and Preston recorded median income levels well below the national average. The data confirms that the relative positions for each authority have changed relatively little over the five-year period apart from Preston.

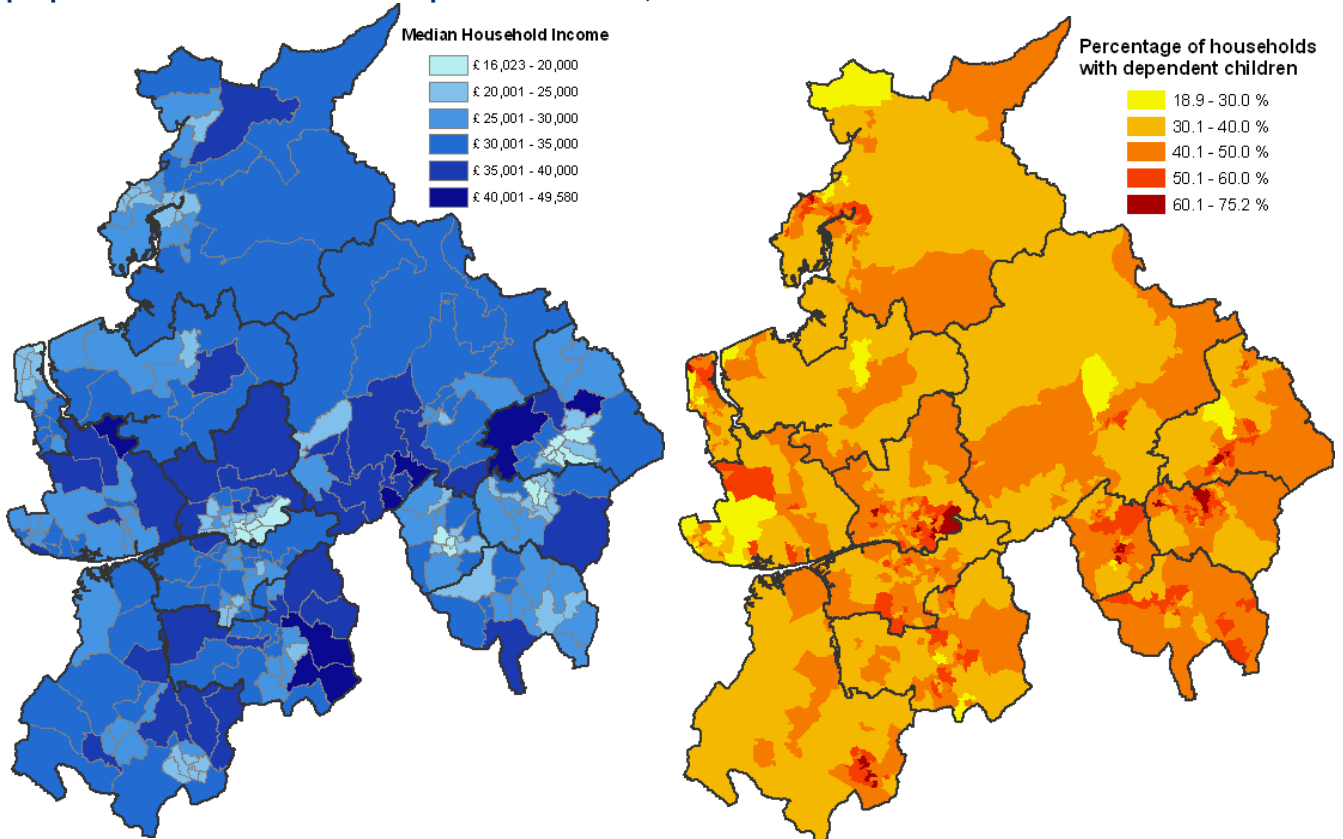
Figure 13: Median Household Income 2006-2010 (Lancashire Districts)



Source: CACI

The 2010 ward results indicate that Pennine ward in Chorley district, with a median income of £50,000 easily recorded the highest average figure. In general terms, the majority of the most affluent wards in the county are in rural areas close to the major urban centres. These are popular localities from which to commute to other parts of Lancashire and to Manchester and Liverpool. Other rural wards, such as those in the north of the county around Lancaster and in remote parts of the Ribble Valley, are somewhat more isolated and do not benefit to such a large extent from affluent commuters. The maps below show that the areas with the lowest household income tend to correlate with the areas where there are a high proportion of families with dependent children.

Maps 10 and 11: Ward median Income Levels in Lancashire by Broad Groups, 2010 against the proportion of households with dependent children, 2001

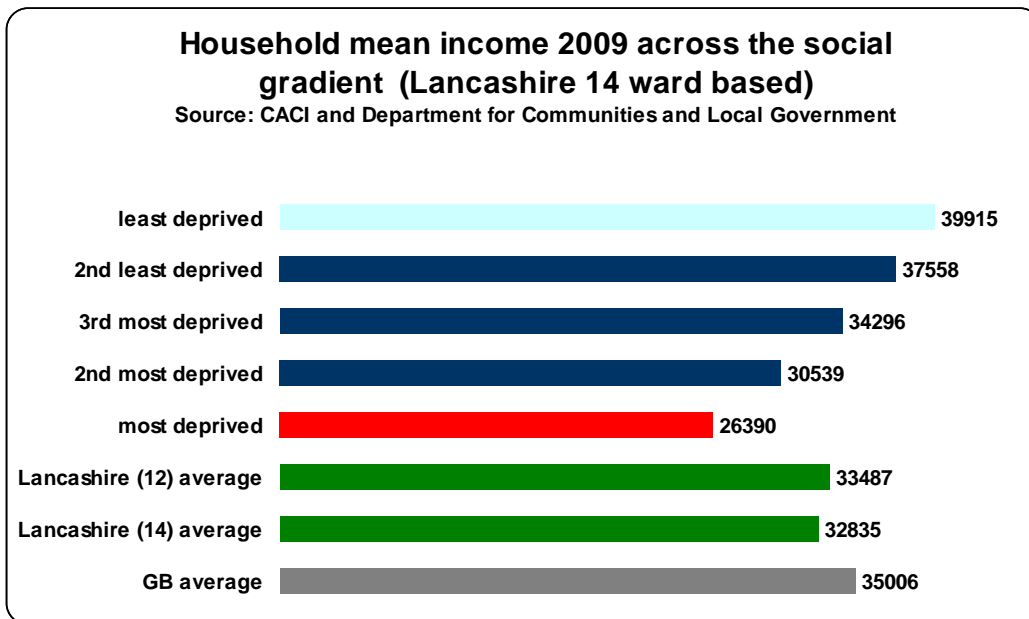


Source: CACI

Analysis of the ward level results identifies the unfortunate trend of widening inequalities in income within the county. The 20 wards with the highest median income recorded yearly changes well in excess of the national increase of 0.8%. In contrast, all 20 of the least affluent authorities recorded yearly decreases of 9.7% or more. Given the links between economic inequality and outcomes, the increasing levels of inequality are of concern.

Household income displays a clear social gradient and those in the least deprived areas are likely to have 50% more income than those in the least deprived areas.

Figure 14: Household mean income across the Lancashire 14 social gradient, 2009



There are clear inequalities in earnings between women and men. In Lancashire, the average weekly pay is £291.70 for women and £458.90 for men. In part, this reflects the fact that a higher proportion of women work part time than men. However, there are also gaps between the wages of women working full time and men working full time (£408 versus £498, respectively). Perhaps more worryingly, there are increasing inequalities in the wages of different groups of women: whilst the wages of women working full time increased by 5% between 2008 and 2009, the wages of part time women reduced slightly (a reduction of 0.5%). It is likely that mothers account for a greater proportion of part time workers than full time workers and such inequalities are therefore borne to a greater extent by children and young people.

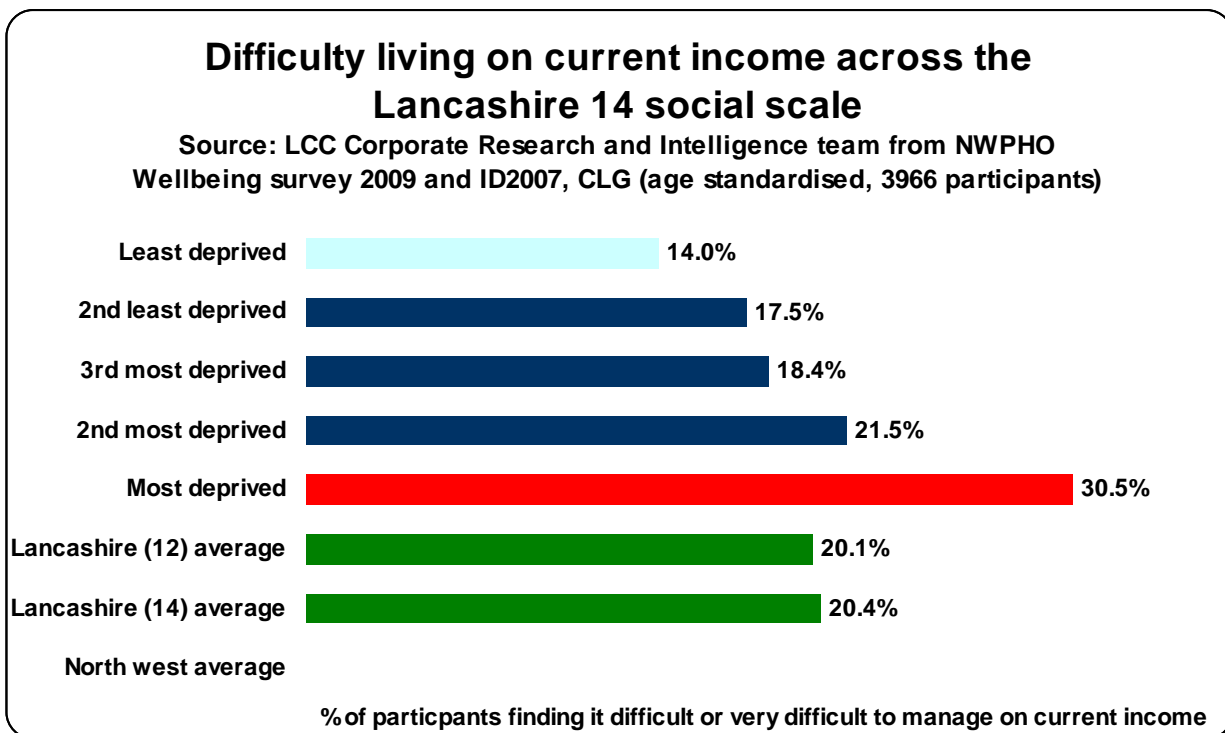
Inequalities in income are bad for children and young people due to the impact that they can have upon adults. There is a wealth of evidence highlighting that levels of wellbeing of adults are lower in areas of high inequality, which stems from the understanding of one's social position being below others (Wilkinson and Pickett 2009). Low wellbeing of adults will impact upon the lives of children in the family.

Table 18: Median Gross Weekly Earnings by Place of Residence and Place of Work, April 2009

	Lancashire (12 districts)				North West		Great Britain	
	Workplace-based [1]		Residence-based		Residence-based		Residence-based	
	Weekly pay (£)	% change 2008-2009	Weekly pay (£)	% change 2008-2009	Weekly pay (£)	% change 2008-2009	Weekly pay (£)	% change 2008-2009
Full-time males	482.9	0.3	498.0	2.0	498.3	0.7	534.4	1.7
Part-time males	136.5	7.3	130.1	2.9	144.9	11.3	144.3	4.7
All males	449.5	-1.3	458.9	0.1	460.3	0.1	494.2	1.3
Full-time females	391.9	4.8	408.6	5.2	408.3	4.7	426.6	3.1
Part-time females	148.8	-1.7	151.2	-0.5	152.2	3.1	155.8	3.8
All females	279.8	0.1	291.7	0.7	297.2	2.0	311.1	3.6
All full-time employees	454.3	2.4	460.0	1.8	460.2	2.0	491.0	2.3
All part-time employees	146.3	-0.9	148.7	0.9	150.5	4.3	153.1	3.8
All employees	362.9	-1.9	367.1	-2.7	373.8	0.7	399.7	2.1
Figures are for all employees on adult rates of pay not affected by absence.								
[1] The workplace figures correspond with National Indicator NI 166.								
Source ONS: Annual Survey of Hours and Earnings								

Results from the North West Wellbeing Survey highlight a strong social gradient in reporting difficulty living on current income. More than 30% of those in the most deprived parts of the sub-region of Lancashire (including Blackburn with Darwen and Blackpool) reported difficulty living on current income. This difficulty is likely to be felt more by families than households without children.

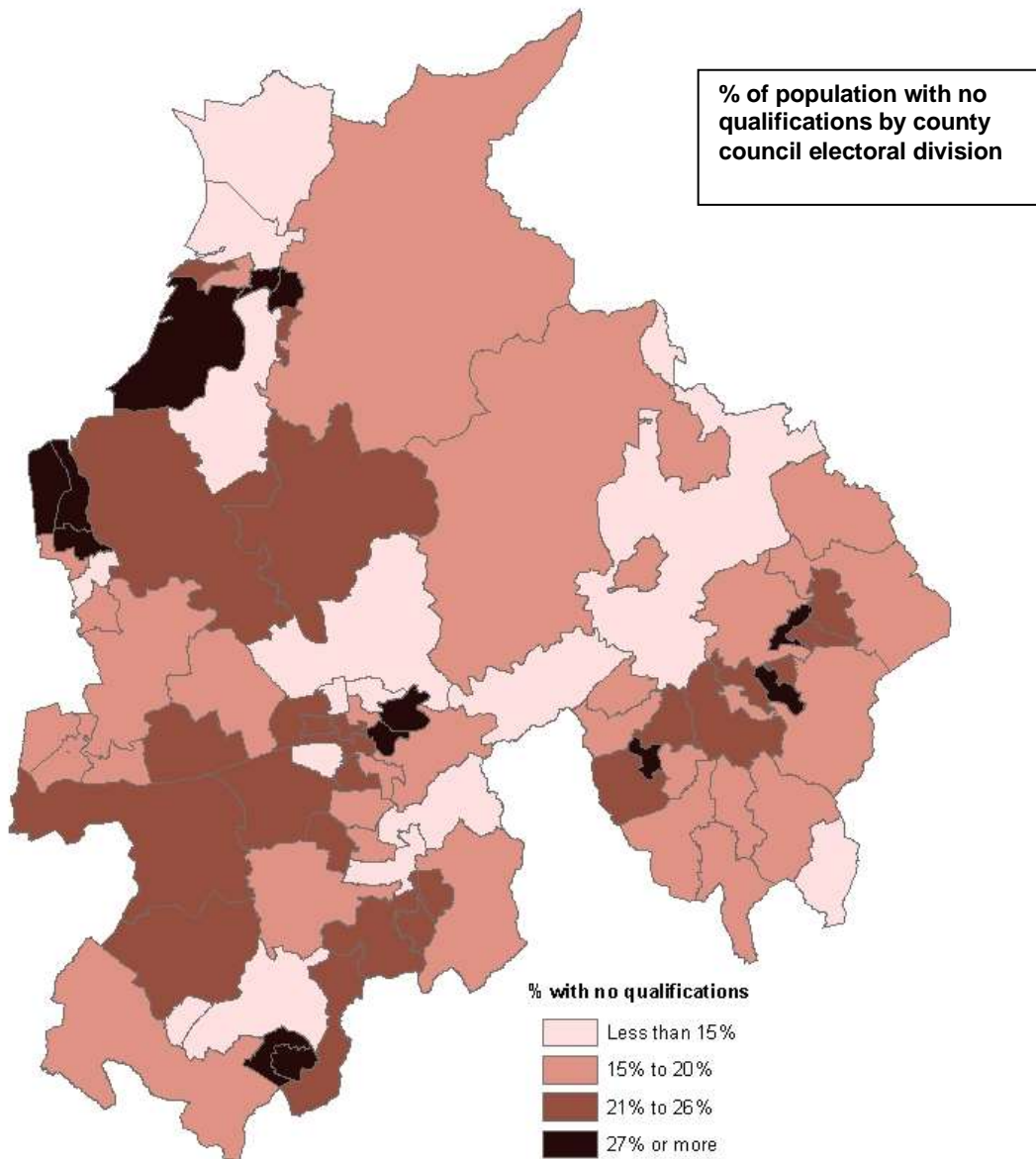
Figure 15: Difficulty living on current income across the Lancashire 14 social gradient, 2009



Adult skills

One important barrier to employment is the level of skills held by the individual seeking employment. Parents who have lower levels of skills may be less likely to engage with school and support children with their school work, which can lead to poor education outcomes for the children. The 2008 Place Survey asked respondents about their qualifications (Lancashire Profile 2009). Mapping the proportions answering that they have no qualifications gives the picture below. The proportions with no qualifications are particularly high in the towns of Fleetwood, Heysham and Skelmersdale. There are also areas of Lancaster, Preston, Accrington, Burnley and Nelson that have more than a quarter of respondents with none of the listed qualifications.

Map 12: proportion of population with no qualifications by county council electoral division

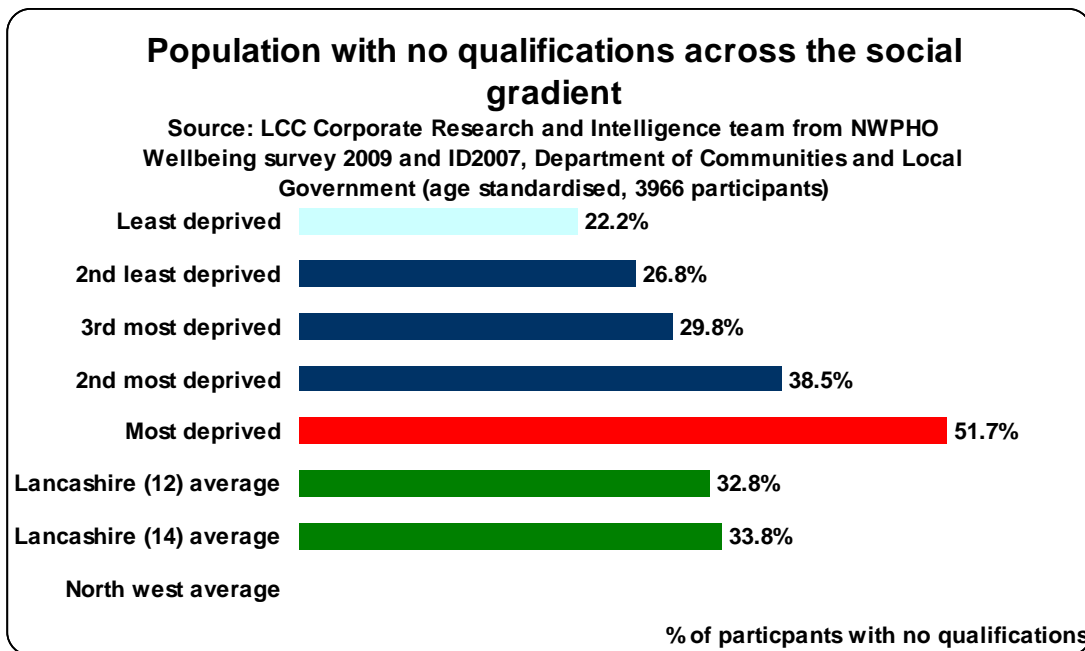


Base: 16,604 respondents, September 2008 – January 2009

Source: Place Survey 2008, Lancashire County Council - Corporate Research and Intelligence Team

The results of the North West Wellbeing Survey highlight a strong social gradient in terms of the population who do not hold any qualifications. More than half of the population living in the most deprived parts of Lancashire (in this case, the sub region of Lancashire, which includes Blackburn with Darwen and Blackpool) do not hold any qualifications. In times of increased competition, these people will face additional greater barriers to employment.

Figure 16: population with no qualifications across the social gradient, 2009

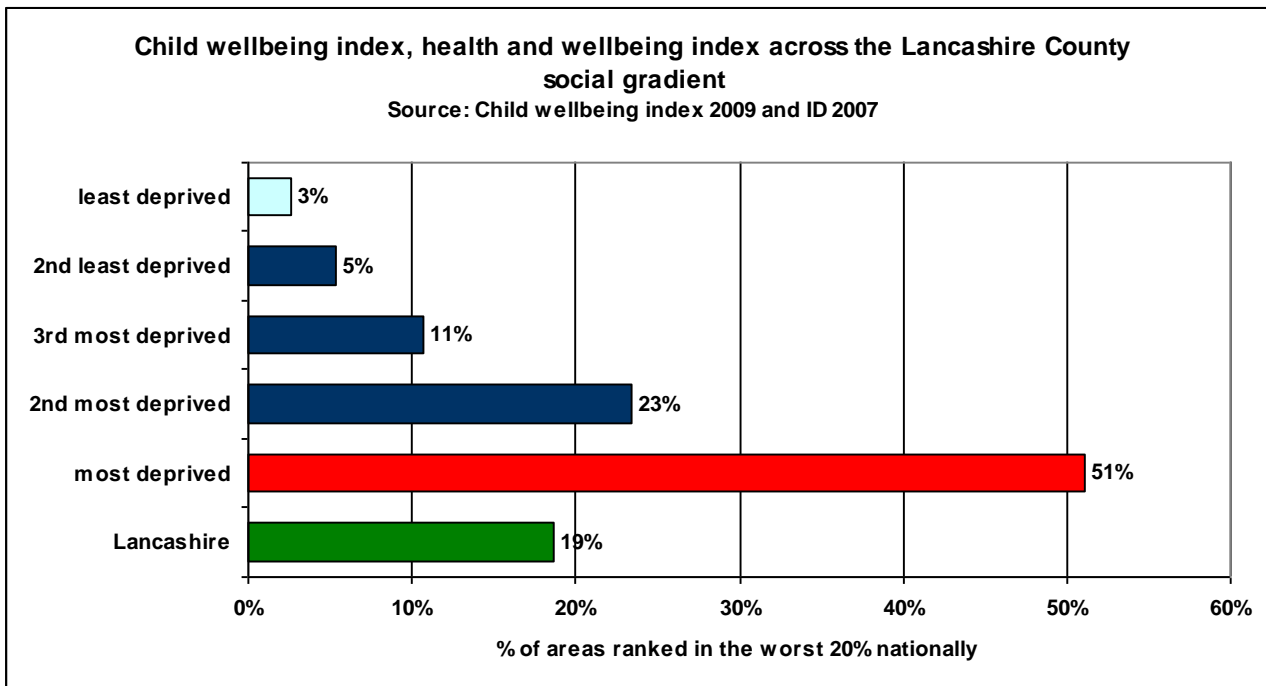


Health

Poor adult health is likely to be a barrier to employment, which may lead to family poverty. Parents who experience poor health may be less likely to be able to offer full support to children during their development and educational attainment and may thereby reduce the potential of children and young people. Physical health is strongly linked to mental health and wellbeing and the direction of causality runs both ways. Those who are in poor physical health are much more likely to develop poor mental health and vice versa. The causation is complex but can include increased propensity to live in areas of high deprivation with poor environmental quality and low incomes leading to a poor standard of living. There are also strong links between health and poverty. This section provides an overall view of the general health of the population of Lancashire. Health risks will vary at each stage of the lifecycle and in each chapter we consider hospital admissions, mortality and accidents along with other important risks.

The health domain of the Child Wellbeing Index shows that Lancashire is in line with the national average – 19% of the areas of Lancashire were ranked in the bottom 20% nationally. However, there is not a picture of equity when looking at the picture within Lancashire. More than 50% of the most deprived areas are ranked in the bottom quintile nationally for child health and 23% in the second most deprived areas. It is clear that the burden of ill health is borne most by those children living in the most deprived parts of the county.

Figure 17: Child wellbeing index, health and wellbeing index across the Lancashire social gradient, 2009

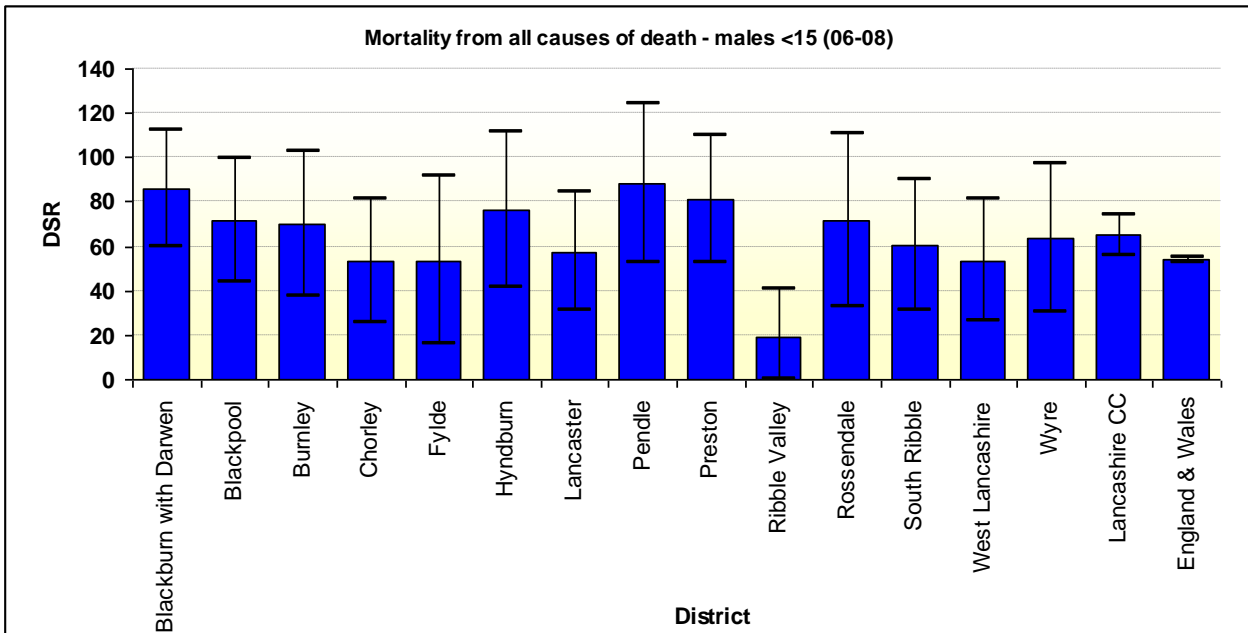


Life expectancy is a widely used indicator of the state of the nation's health. Life expectancy is hugely influenced by child deaths, in particular infant deaths so protecting the health and wellbeing of children and young people is an important issue for the nation's health. Over the period 1991-1993 to 2006-2008, there have been improvements in male and female life expectancy in all Lancashire districts. However, overall life expectancy in Lancashire males and females remains lower than the England average. A baby boy born in Lancashire today can expect to live 77 years, whilst a baby girl can expect to live 81 years. Further discussion of life expectancy and the causes of reduced life expectancy can be found in the Lancashire Health Inequalities Report, which is available at www.lancashire.gov.uk/jsna.

Mortality in under 15s

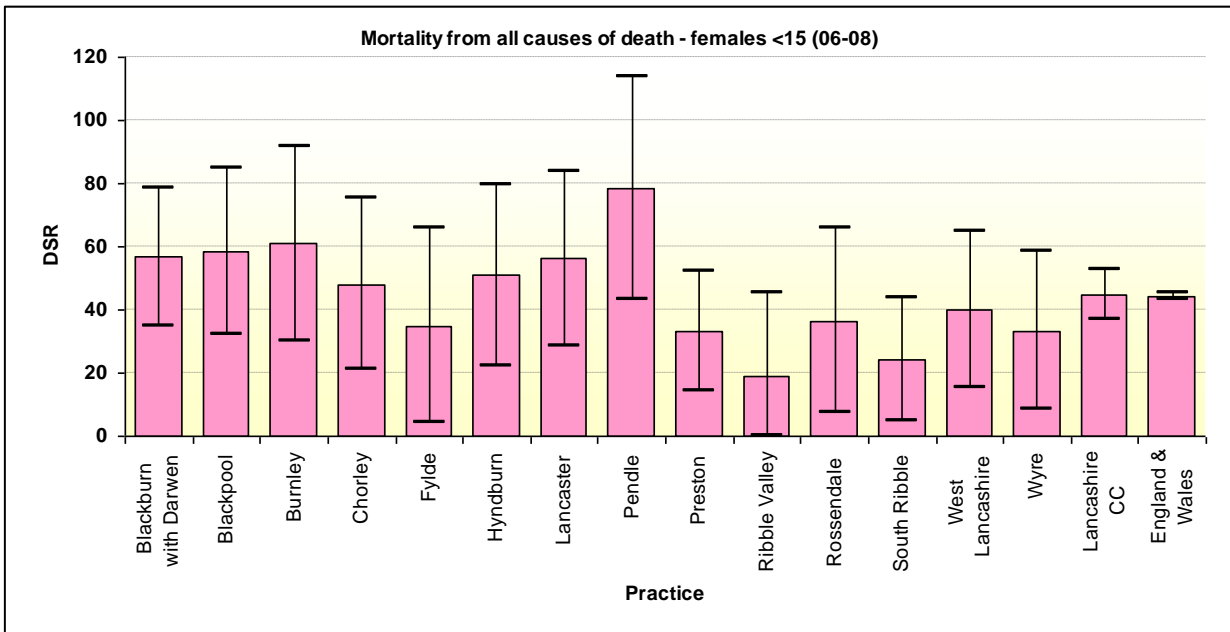
In Lancashire mortality from all causes of death amongst males and females is not significantly different from the England average. In all Lancashire districts mortality from all causes of death, amongst the under 15s, is not significantly different from Lancashire average. Due to the small sample used it is not possible to understand whether rates are higher because of systematic differences in the lives of children or random fluctuation.

Figure 18: Male mortality from all causes, directly age-standardised rates (DSR), Less than 15 years, 2006-08 (Pooled) per 100,000 European Standard population



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base

Figure 19: Female mortality from all causes, Directly age-standardised rates (DSR), Less than 15 years, 2006-08 (Pooled) per 100,000 European Standard population



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base

Limiting long term illness

Data from the 2001 Census show that within Lancashire County, overall, approximately 4.3% of all children (0-15 years) have a limiting long-term illness. The percentage of children with limiting long-term illness in Lancashire is slightly lower than that of North West (4.5%) and slightly higher than that of England (4.2%).

Rates of limiting long-term illness vary by housing tenure, children living in socially rented accommodation being nearly twice as likely to have limiting long-term illnesses as those in owner-occupied housing; this pattern is observed for all Lancashire districts. Children of families in private rented accommodation comprise a higher percentage than those residents in owner-occupation. This latter pattern is also consistent in all Lancashire districts.

Table 19: Children aged 0 to 15 with limiting long-term illness (LLTI) by tenure type, 2001

Area	Number of resident children (0-15) with LLTI	% of resident children (0-15) with LLTI	Owned - aged 0 - 15 - % LLTI	Rented Council - aged 0 - 15 - % LLTI	Other Social Rented - aged 0 - 15 - % LLTI	Private Rented or Living Rent Free - aged 0 - 15 - % LLTI
Burnley	971	4.8	4.0	7.2	8.0	5.2
Chorley	707	3.6	2.9	5.2	7.1	4.0
Fylde	478	3.7	3.1	6.3	7.2	5.1
Hyndburn	936	5.0	4.2	7.1	7.5	7.1
Lancaster	1,079	4.4	3.5	7.2	7.8	5.2
Pendle	961	4.7	4.2	6.1	7.1	6.0
Preston	1,241	4.6	3.6	6.8	8.4	5.5
Ribble Valley	363	3.5	3.2	6.6	5.5	3.4
Rossendale	684	4.7	3.8	7.1	5.2	6.4
South Ribble	785	3.8	3.3	5.4	6.2	4.2
West Lancashire	896	4.0	3.3	6.1	7.1	5.5
Wyre	814	4.2	3.5	8.7	6.6	5.4
North West	62,901	4.5	3.5	6.9	6.9	5.7
Lancashire	9,903	4.3	3.6	6.6	7.2	5.4
England	418,828	4.2	3.3	6.6	6.5	4.8

Source: Nomis official labour market statistics

Accidents and injury

Injury is not only the most important cause of child death in the UK, but also has a steeper social class gradient than any other cause of death for this cohort. Accidents in childhood primarily take place in the home or are transport related. Safety inside the home is of paramount importance in early life with a large proportion of these injuries being potentially preventable.

A summary of the evidence base in relation to accidents is provided in the [appendix](#).

Fire Safety

Young people can be both victims and perpetrators of fire related incidents. Young people in deprived households are particularly vulnerable to death and injury by fire. Children and young people are also involved in fire-related crime – including deliberate fire-setting, hoax calls and attacks on fire-fighters.

Between the period: 1st April 2009 and 31st March 2010 there have been 75 instances where a child or young person (aged 0 – 19) was either a casualty or, was rescued from fire. In the year 2008/9 there were 72. There were no child fatalities. The peak ages are 16 to 19. These incidents are distributed evenly throughout the year, with little evidence of any seasonal peaks.

Table 20: Age of injured or rescued victim from primary fire, 0-19 years, 2008-10

Age	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	Total
Male	1	3	1	1	1	2	1	1	1	2	1	3		1	3	1	1	2	5	8	39
Female		3		1	1	1	1	1	1		1				2		6	9	8	1	36
Total	1	6	1	2	2	3	2	2	2	2	2	3	0	1	5	1	7	11	13	9	75

Figure 20: Age of injured or rescued victim from primary fire, 0-19 years 2008-10

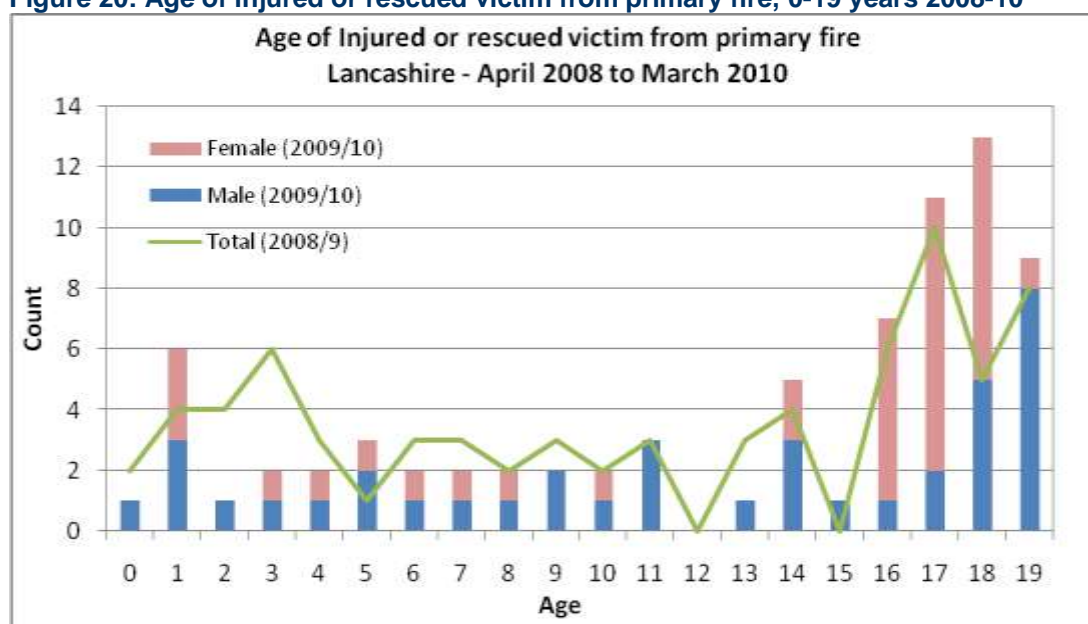
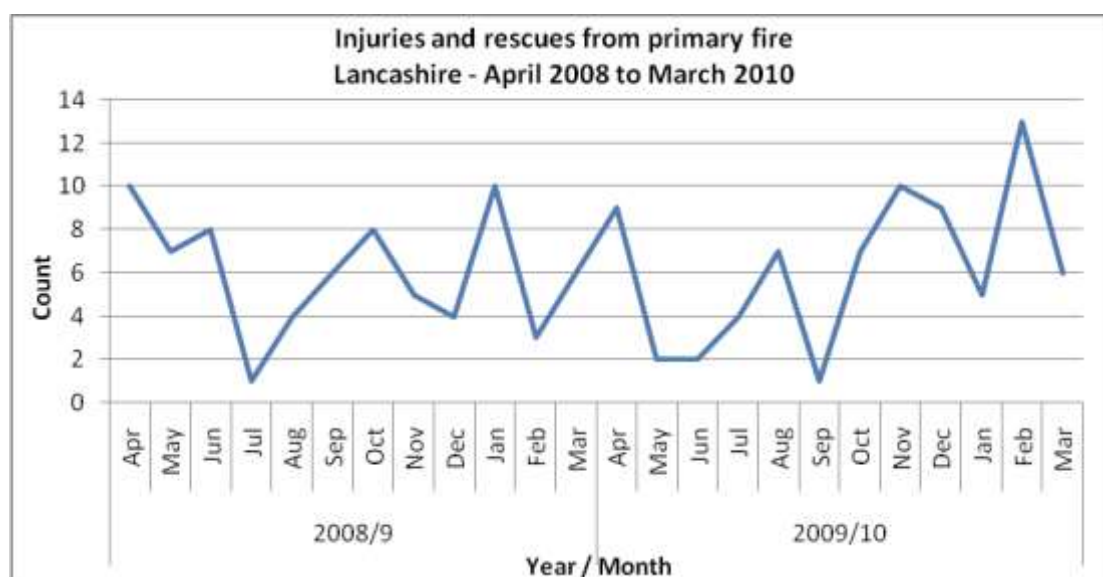


Table 21: Month of casualty/rescue occurrence, aged 0-19 years, 2008-10

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2008/9	10	7	8	1	4	6	8	5	4	10	3	6	72
2009/10	9	2	2	4	7	1	7	10	9	5	13	6	75
Total	19	9	10	5	11	7	15	15	13	15	16	12	147

Source: Lancashire Fire & Rescue Service

Figure 21: Month of casualty/rescue occurrence, aged 0-19 years, 2008-10



Fires are the second most important cause of injury to children, with smokers’ houses posing a particular risk. One contributory factor is likely to be the significance of deprivation. A child from the lowest social class is nine times more likely to die in a house fire than a child from a well off home (Roberts 2002). There were 73 non-fatal casualties amongst under-17s in Lancashire between 2006 and 2010. In addition, there were four fatalities in Hyndburn in 2006/07.

Table 22: Number of fire casualties aged under 17, 2006-10

Number of casualties aged under 17 (2006-10)	
District	Number of Casualties
Burnley	5
Chorley	7
Fylde	1
Hyndburn	7*
Lancaster	4
Pendle	10
Preston	19
Ribble Valley	5
Rossendale	2
South Ribble	3
West Lancashire	11
Wyre	3
Lancashire	77
* - includes 4 fatalities in 2006/07	
Source: Lancashire Fire and Rescue Service	

The difficulty in intervening in the home is the inability to regulate. Single issue campaigns are believed to be effective as interventions, particularly those focusing on safety equipment such as smoke detectors. It is also notable that multi-modal interventions (i.e. legislation, education, safety equipment, environmental modification) are most likely to yield positive results. The latter approach demands a change in the culture of communities. Lancashire Fire and Rescue Service already target areas with potentially vulnerable families to offer free home safety checks. They promote

safety in particular by installing smoke detectors but also through innovative methods such as providing modern deep fat fryers in exchange for chip pans, which are a well documented risk for home fires.

Road traffic accidents

The wider horizons of older children place greater risks in the immediate environment and from roads than for the youngest children. Roads provide different forms of risk across the age spectrum and therefore road traffic accidents are also considered in each age cohort chapter.

Road accidents involving children are more scattered than those involving adults with an obvious relationship to the roads near home. There is good evidence that area-wide engineering schemes and traffic calming measures reduce accidents to this age group, decreasing traffic injuries on average by between 11% and 15% (Bunn et al 2003). Such schemes also have the potential to increase cycling and walking at neighbourhood level, together with the potential for children to play outdoors with concomitant benefits to both health and environment (Morrison et al 2004).

Casualty rates for child pedestrians are estimated to be five times higher in the most affluent than least affluent wards (Social Exclusion Unit 2003).

For cyclists there is some evidence that cycle training can improve safe riding behaviour and good evidence that cycle helmets offer protection from head and brain injuries, particularly at low speeds. Education campaigns may also be important (Towner and Ward 1998). The leisure environment, like roads, is similarly in the public domain and hence a legitimate target for legislation and prevention.

Since the late 1990's, there has been a welcome overall reduction in child road casualties in Lancashire. There is evidence suggesting that the reduction in casualty rates is a result of the changing denominator, with fewer children being on the streets due to the changing nature of leisure time in childhood, which in turn means fewer children are at risk. Even despite this improvement, Lancashire's performance does not compare well with the national average: the rate in Lancashire is almost double the national rate.

Rates of children killed or seriously injured (KSI) in road traffic accidents in the county tend to be much higher than that reported by the other large shire authorities – Essex, Hertfordshire, Kent, Hampshire and Sussex. This high casualty rate may be linked to levels of deprivation in the county as it is known that the injury rate for child pedestrians is four (or possibly five) times higher in the most deprived wards than in the least deprived. However, Lancashire doesn't perform as well as

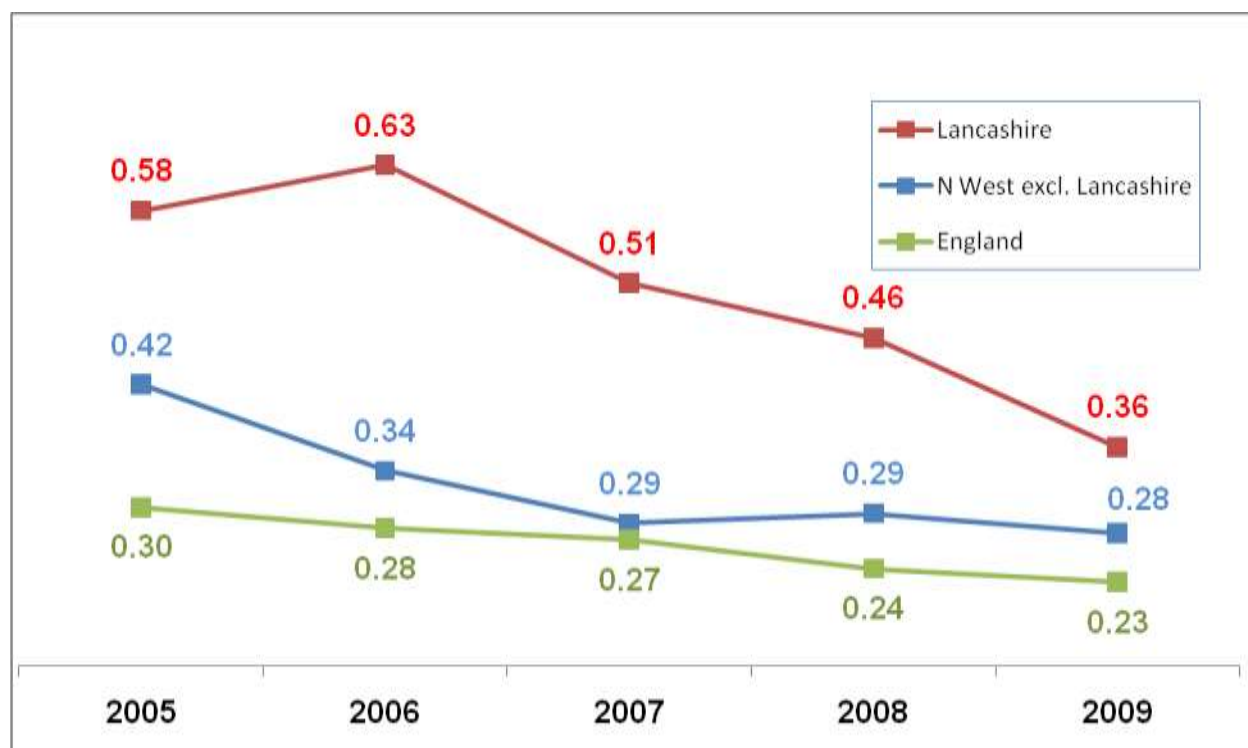
many other authorities in the North West region, many of which also experience significant levels of deprivation.

Table 23: Children aged 0-15 killed and seriously injured road accident casualties, 2005-09

	Child KSI total				KSI rate per child 1,000 population			
	England	North West	North West Excl. Lancs	Lancashire	England	North West	North West Excl. Lancs	Lancashire
2005	2,977	619	484	135	0.30	0.44	0.42	0.58
2006	2,779	534	389	145	0.28	0.38	0.34	0.63
2007	2,671	450	331	119	0.27	0.32	0.29	0.51
2008	2,402	449	342	107	0.24	0.32	0.29	0.46
2009	2,278	403	320	83	0.23	0.29	0.28	0.36
5 years	13,107	2,455	1,866	589	1.32	1.76	1.61	2.54

Source: Lancashire County Council road accidents database, Department for Transport annual road casualties reports, Office for National Statistics (2001 census populations)

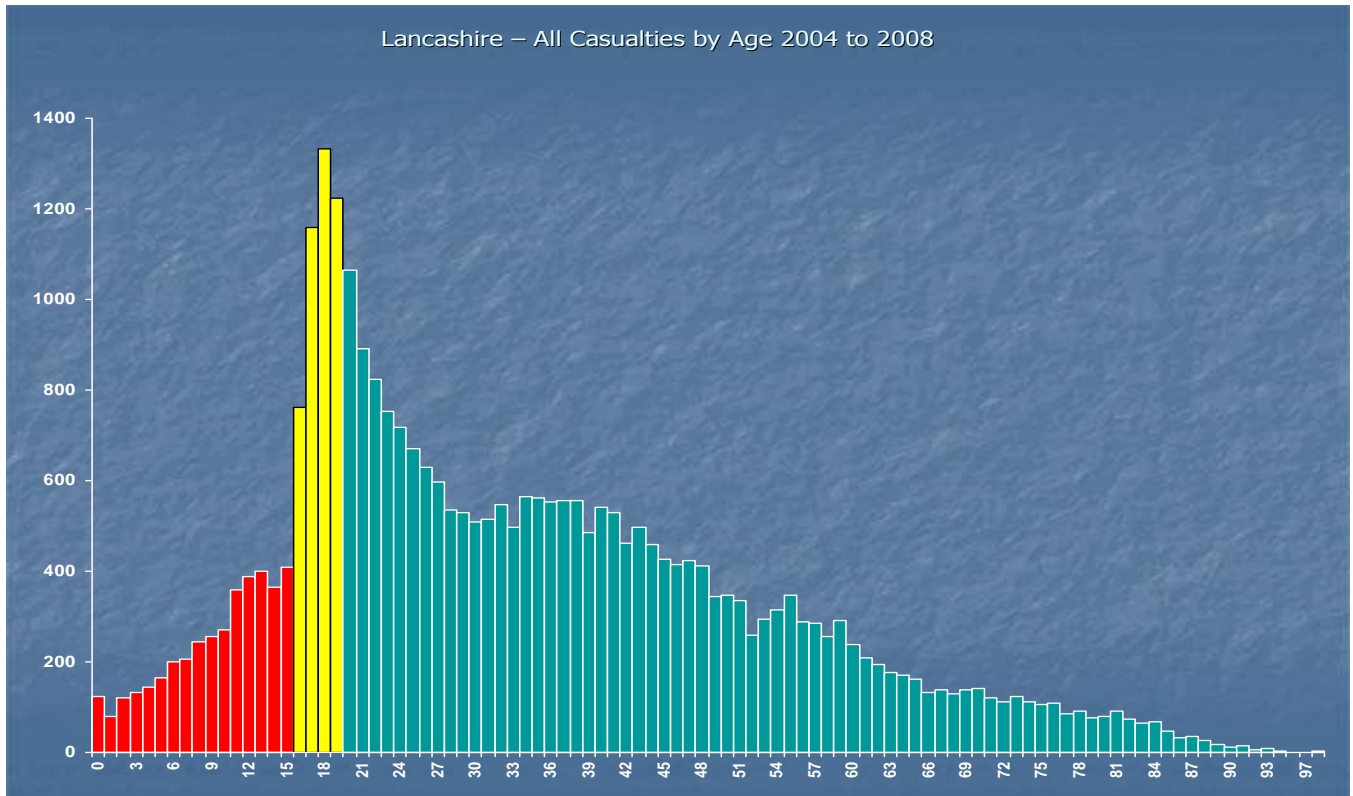
Figure 22: Children aged 0-15 killed and seriously injured road accident casualties, 2005-09



The poor performance in Lancashire has been highlighted recently in the Child Casualties Report 2010 (Road Safety Analysis Ltd (2010)). Preston ranked highest for resident child road casualty risk out of 408 authorities nationally. All Lancashire districts performed poorly: Wyre ranked fifth, Pendle 10th, Hyndburn 16th, Rossendale 29th, Lancaster 36th, West Lancashire 46th, Burnley 52nd, South Ribble 55th, Chorley 65th, Fylde 113th and even Ribble Valley, in 184th ranking, was in the top 50% for highest risk.

Child casualties (aged 0 to 15 years) account for some 12% of all road traffic casualties in Lancashire, with 16-19 year old casualties adding a further 14%, meaning that over a quarter of all road casualties in the county involve those under 20 as illustrated in the graph below. Children aged 0 to 15 are less likely to be a casualty than the population as a whole whilst young people aged 16 to 19 are almost three times as likely.

Figure 23: All road casualties by age in Lancashire, 2004 to 2008



The table below highlights that in the five years from 2005-09 there were 3585 casualties aged 0-15 in Lancashire and of those 1772 (49%) were injured as pedestrians or cyclists. There were 589 children killed and seriously injured, 474 (80%) of which were pedestrians and pedal cyclists.

The rate of children aged 0 to 15 years killed and seriously injured in Lancashire is 2.5 per 1,000 of the population. District variations are present with far higher rates experienced in Pendle, Burnley, Preston and Hyndburn. Particularly low rates are seen in the districts of Ribble Valley and Fylde.

Table 24: Lancashire 0-15 year old casualties 2005-09

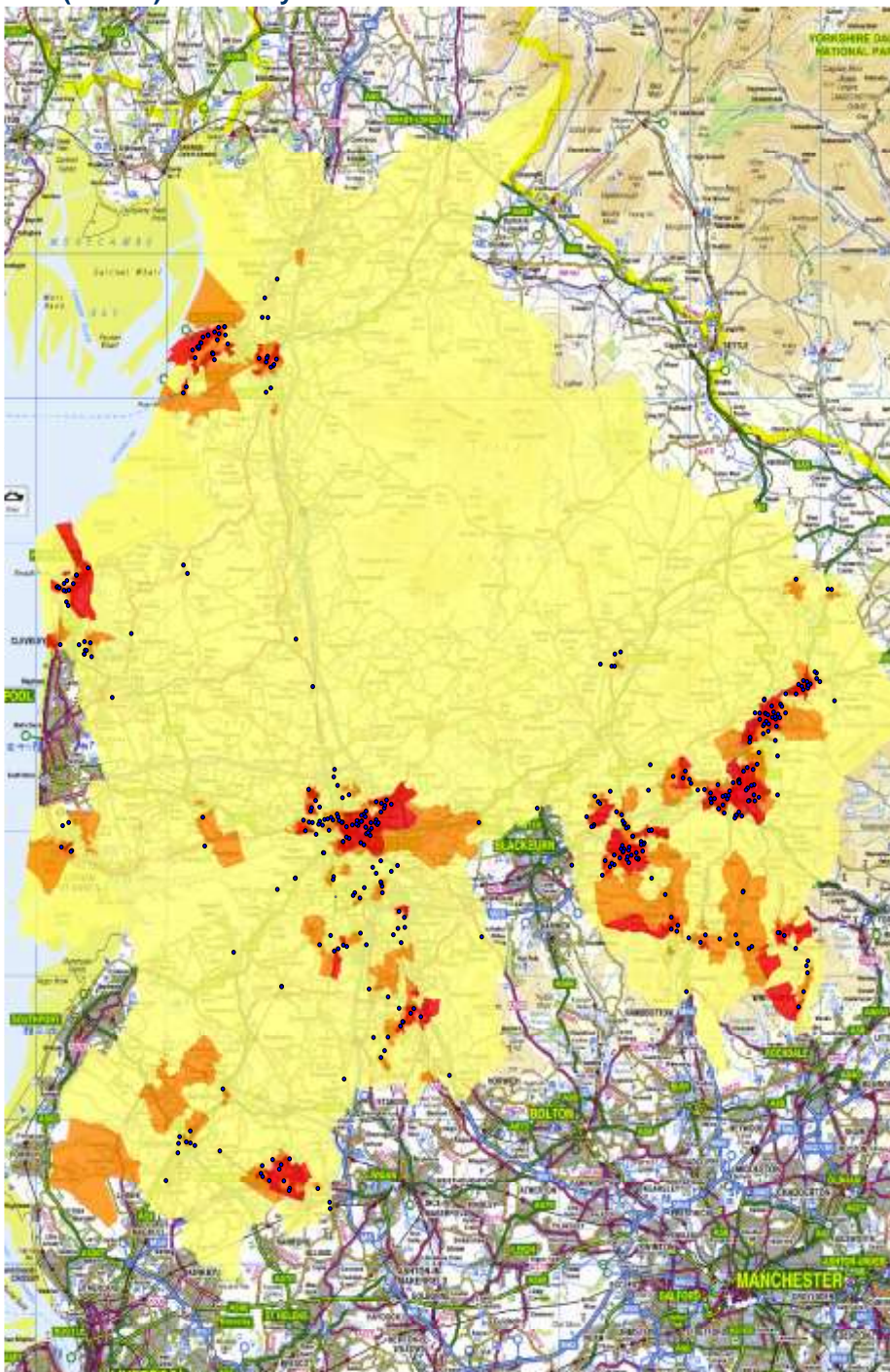
	Numbers and rates
Population (0 to15 years)	231999
Child casualties	
All child casualties	3585
All child Pedestrians	1300
All child Pedal cyclists	472
Rate of casualty / 1000 population	15.5
Killed and seriously injured	
Killed and serious casualties	589
KSI Pedestrians	385
KSI Pedal cyclists	89
Rate of KSI per 1,000 population	
Lancashire	2.5
Hyndburn	3.6
Preston	3.3
Burnley	3.1
Pendle	3.0
Rosendale	2.5
South Ribble	2.4
Lancaster	2.3
West Lancashire	2.2
Wyre	2.2
Chorley	2.1
Ribble Valley	1.5
Fylde	1.2

The following table gives details of the proportion of children living in the most deprived parts of the county, together with the numbers and rates of child KSI casualties. It shows that the incidence of pedestrian KSIs and pedal cyclist KSIs, defined collectively as vulnerable road users, is highest in the most deprived wards. When vulnerable road user KSIs (i.e. pedestrians and pedal cyclists) are expressed as a rate per child population, the rate in the most deprived parts of the county is more than double that encountered in the least deprived parts indicating that children in the most deprived parts of the county face two and a half times greater risk of being killed or seriously injured on the roads.

Table 25: Vulnerable road users KSI per 1,000 child population across the social gradient, 2005-09

Quintile	Child Population aged 0 to 15	Child KSI pedestrian	Child KSI Pedal Cyclists	Vulnerable road users KSI per child pop
20% (most deprived)	52105	156	21	3.4
21 - 40%	57178	111	24	2.4
41 - 60%	43430	52	18	1.6
61 - 80%	60830	46	19	1.1
81 - 100%	18456	19	7	1.4
Lancashire	231999	384	89	2.0

Map 13: Child Pedestrian KSI Casualties 2004 to 2008 & SOAs in most deprived 20% (Red) and 21%-40% (Amber) Nationally



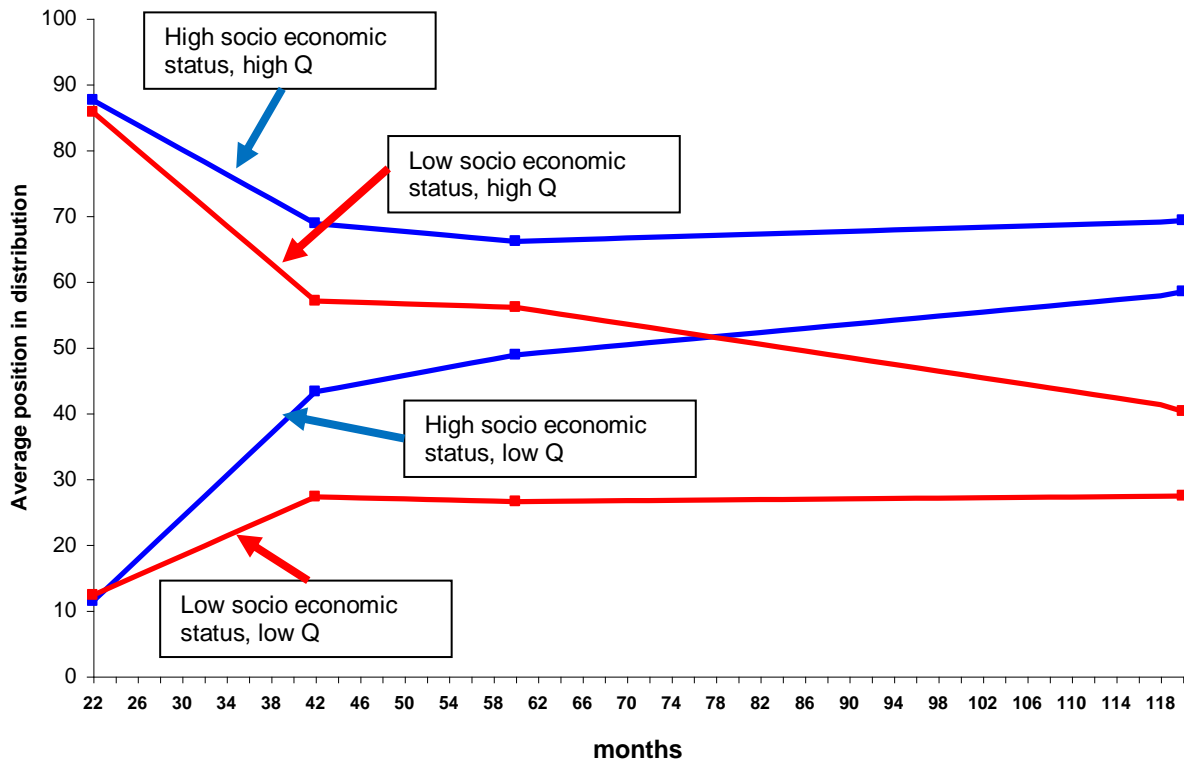
Education

Education is linked to improved wellbeing as it allows individuals to obtain better jobs, which are linked to a better standard of living. For children, education is an important part of social and cognitive development. However, education and learning throughout life are also known to be beneficial for their own sake. The five ways to wellbeing (new economics foundation, 2009) include keep learning as the evidence shows that this is one key determinant of mental capital and wellbeing.

Education plays a critical role in the link between childhood disadvantage and adult disadvantage as parental background is a significant determinant of educational performance which in turn determines access to key opportunities in adult life. The well educated are at lower risk of unemployment and more likely to obtain better paid jobs. It allows individuals to live in better conditions, consume more nutritious food and so on. By the age of 37, one third of those with very low skills do not own their own home compared to less than 10% of men and women with good skills. Those with higher educational qualifications tend to enjoy more control over their working lives, more variety and challenge with greater job satisfaction – factors that may be associated with improved psycho-social health.

Feinstein (2003) has compared the relative cognitive development of children from different socio-economic status backgrounds (based on parental occupation) between the ages of 22 months and 10 years. The commonly quoted graph shows the changes by the age of 10 between children born to parents of high socio-economic status contrasted with children born into low socio-economic status who started with similarly high (top quartile) and low (bottom quartile) levels of cognitive development (Q) at 22 months. By the age of 6 or 7 the more socially advantaged, initially bottom quartile group, had overhauled their socially disadvantaged but initially top quartile peers. Feinstein also found that large social effects continue to influence children's development after they have started school. The evidence suggests that family background and social class are still the major determinants of future success.

Figure 43: Relative cognitive shifts 22 months to 10 years

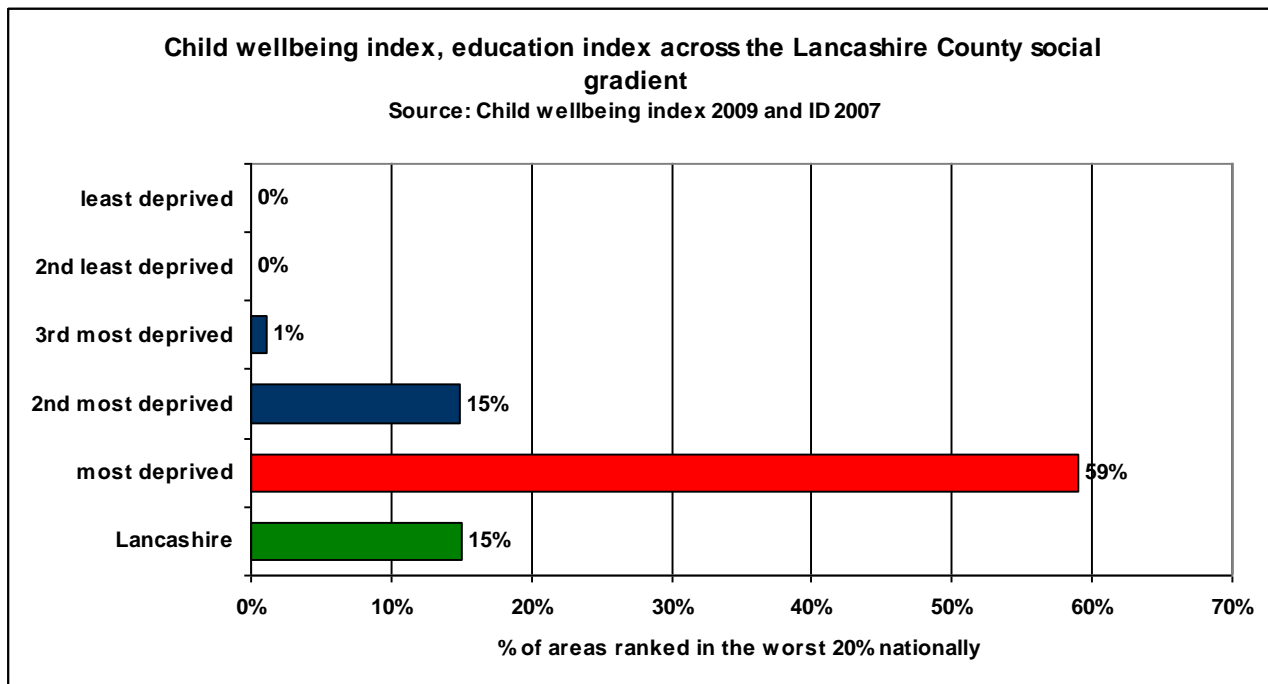


Source: Feinstein, L. (2003) 'Inequality in the Early Cognitive Development of British Children in the 1970 Cohort', *Economica* (70) 277, 73-97

Evans (2006), describing the experience of living and bringing up children in social housing in London, states “my own experience suggests that middle class mothers take it for granted that formal-learning-type skills, such as those associated with literacy (speaking, listening, reading and writing), numeracy (counting, calculating and problem-solving with numbers), arts and crafts (colour and shape recognition, hand-to-eye co-ordination, fine motor skills such as those necessary for drawing, painting and cutting) and science (developed sense of curiosity about the world and some understanding of the forces that are at work in it) as well as sport (physical co-ordination and physical competence in particular activities such as swimming) should be incorporated, in an informal, playful way into the caring relationship with the child at home. In this way middle class children often come, early on in their lives, to love formal learning because formal-learning-type tasks are what the loving relationship with the mother largely consists of. It is no surprise, then, that even by the age of two children whose mothers are educated are likely to be doing better in pre-school learning tasks than their peers whose mothers are relatively uneducated.”

According to the education domain of the child wellbeing index, only 15% of the areas of Lancashire are ranked in the bottom fifth, which indicates that the children in the county experience better wellbeing than their national counterparts. However, those children in the most deprived areas experience particularly low levels of wellbeing in relation to their education as almost 60% of these areas are ranked in the bottom 20% nationally.

Figure 24: Child wellbeing index, education index across the Lancashire social gradient, 2009



Education is a vital part of the development of children and young people. Education has been considered in stages across the life course and further discussion is provided in the [primary years](#) and [secondary years](#) chapters.

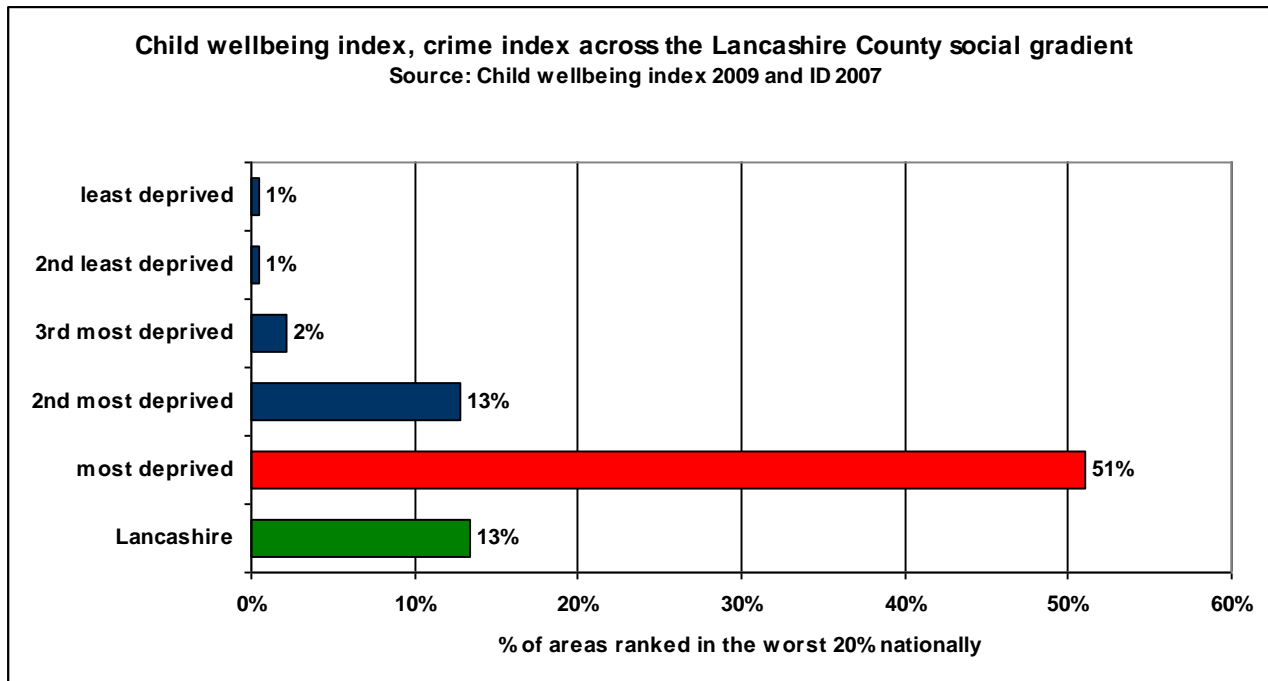
Crime and safety

This sub-section considers the impact of crime upon children as victims. Discussion of children and young people as the perpetrators of crime takes place in the chapter on [young people](#).

Crime and fear of crime has a considerable impact on the wellbeing of young people. People who have been repeat victims of crime and anti-social behaviour are more likely to suffer from depression and other mental health problems and consequently have a lower quality of life (Turner et al 2006). Young people aged 19 and under are both disproportionately victims and offenders of crime. Fear of becoming a victim of crime can also have strong impacts on mental health and wellbeing and the results of consultation in Hyndburn schools highlighted "people hanging around on the streets – it's frightening" one of the matters most concerning young people.

As with the other domains, Lancashire is under-represented in the areas of lower child wellbeing in the crime domain. However, children in the most deprived parts of the county are over-represented. Children living in half of the most deprived areas of Lancashire are ranked as experiencing the lowest levels of wellbeing nationally with regards to crime.

Figure 25: Child wellbeing index, crime index across the Lancashire social gradient, 2009



Young victims of crime

The British Crime Survey of 10-15 year olds (2009) and the MORI youth survey (2008) show that children are at more risk of being a victim of crime than adults. These surveys include crimes which might not have been reported to the police. The risk is highest for violent crime.

18,193 children and young people were victims of crime in Lancashire during 2009/10. In the Lancashire County area nearly 13% of recorded victims of crime were aged 19 or under between April 2009 and March 2010, with 10% of all victims aged between 10 and 19. In South Ribble recorded victims of crime were a higher percentage than the population norm and in Burnley a much lower percentage. This suggests that there is some under-reporting of the number of young victims of crime in some parts of the county, such as Burnley.

Table 26: Percentage of all victims aged 10-19 by district, 2009/10

Local Authority	Percentage of victims aged 10-19	Percentage of population aged 10-19
Burnley	8%	13%
Chorley	11%	12%
Fylde	10%	11%
Hyndburn	9%	14%
Lancaster	9%	14%
Pendle	9%	13%
Preston	10%	13%
Ribble Valley	10%	13%
Rossendale	7%	14%
South Ribble	13%	12%
West Lancashire	10%	13%
Wyre	12%	12%

Source: Lancashire Constabulary/MADE/ONS Mid-2009 Population Estimates

Preston has the highest rate of young victims, twice the County average. Ribble Valley has the lowest. As crime levels have fallen over the last 5 years, the risk of becoming a victim of crime has fallen according (Lancashire Profile, 2010).

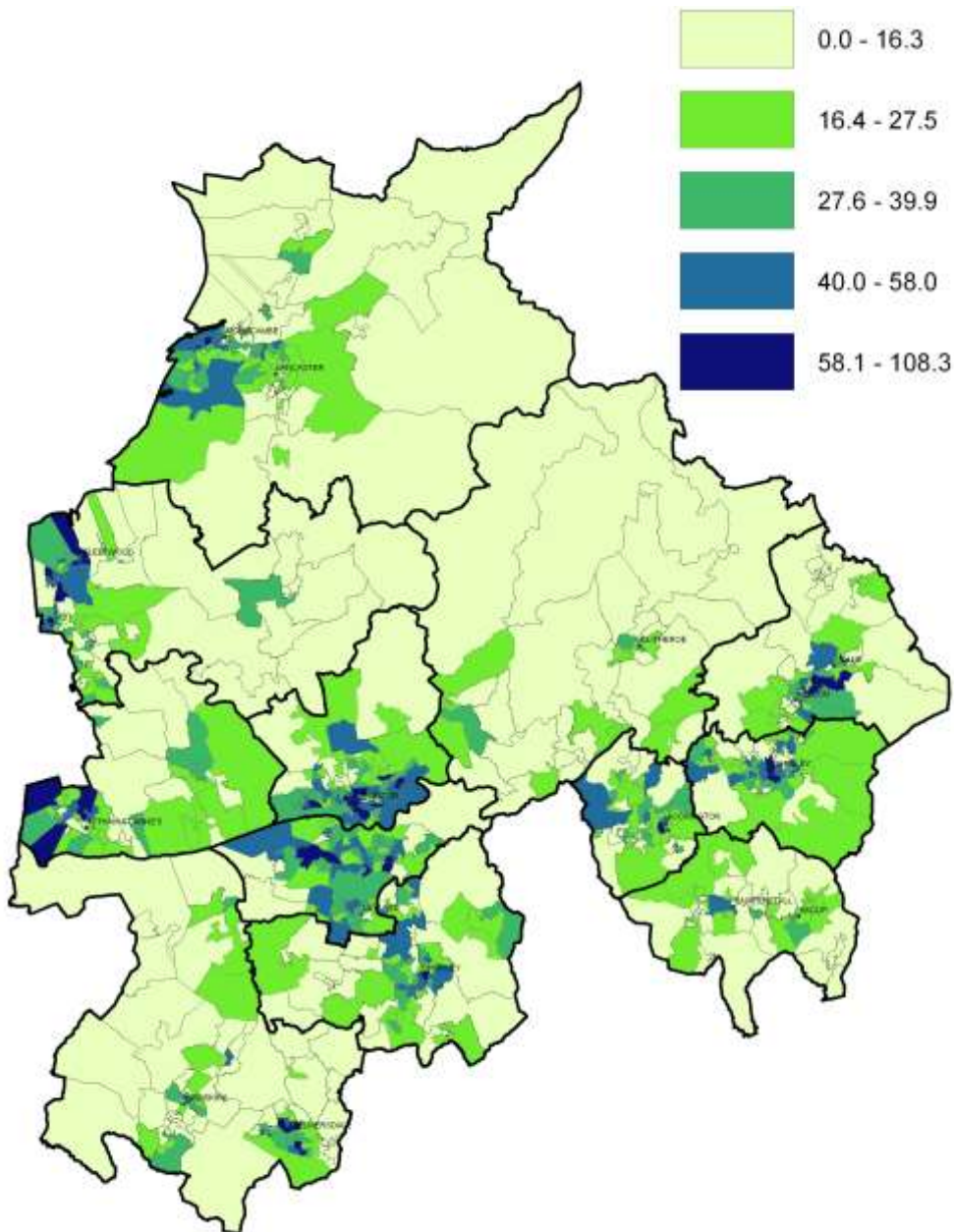
Table 27: Rate of victimisation of young people (0-19) per thousand 0-19 year olds, 2007/08 to 2009/10

Local Authority	2007/8	2008/9	2009/10
Preston	62.4	64.5	52.3
South Ribble	51.4	54.4	46.8
Lancaster	42.6	50.2	40.3
Hyndburn	39.5	42.1	36.7
Burnley	36.9	39.4	29.7
Chorley	30.4	29.6	27.3
Lancashire (12)	29.3	31.6	26.6
Wyre	24.9	27.9	24.9
West Lancashire	24.2	24.4	23.8
Rossendale	23.9	32.7	19.3
Pendle	18.5	20.9	17.6
Fylde	16.5	17.1	15.6
Ribble Valley	5.5	6.2	5.8

Source: Lancashire Constabulary/MADE

The map below shows the variation of young victimisation across the county, with concentrations broadly following the urban areas. 9% of victims aged 0-19 were a victim more than once between April 2009 and March 2010.

Map 14: Young victims of crime (rate per thousand 0-19 year olds), 2009/10



Source: MADE / Lancashire Constabulary

Violent assault can result in the young person requiring hospital support. In 32% of ambulance call outs due to assault or rape between April 2009 and March 2010, the patient was a young person aged 0-20. For callouts to stabbing or gunshot wounds the proportion was 27%.

Attendance at emergency departments shows a similar picture to the police data with the highest attendances from residents in Preston, Burnley and South Ribble. Assaults requiring attendance at an accident and emergency department are more common amongst males than females, highlighting an increased pattern of violence amongst males.

Table 28: Number of assault attendances to emergency departments by age and gender, 2009

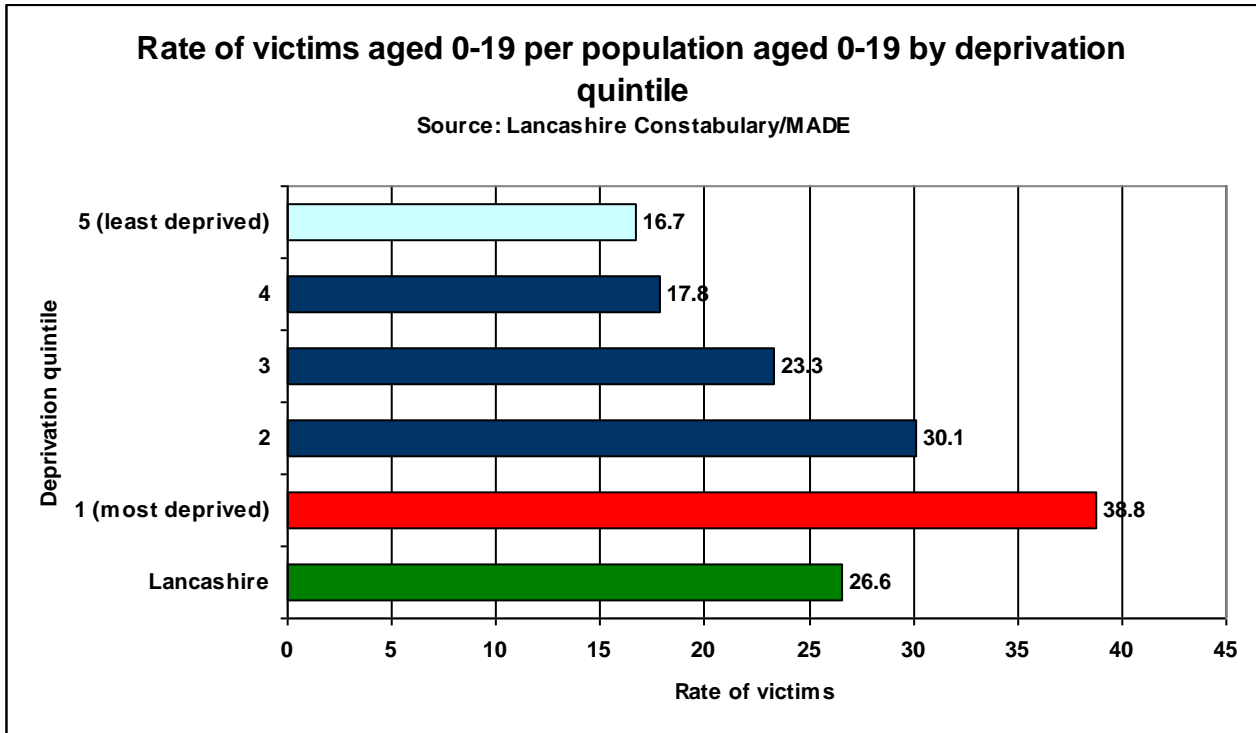
Local Authority	0-9		10-17			18-24		
	F	M	F	M	Total	F	M	Total
Burnley	***	7	35	90	125	65	144	209
Chorley	***	***	21	57	78	39	141	180
Fylde	***	***	16	27	43	17	88	105
Hyndburn	***	5	26	47	73	25	107	132
Lancaster	***	***	18	51	69	42	108	150
Pendle	***	***	14	64	78	36	109	145
Preston	***	5	48	129	177	100	319	419
Ribble Valley	***	***	7	23	30	10	35	45
Rosendale	***	***	2	13	15	7	36	43
South Ribble	***	***	29	84	113	46	124	170
West Lancashire	***	***	24	68	92	46	144	190
Wyre	***	***	23	47	70	21	120	141
Lancashire (12)			263	700	963	454	1475	1520
Source: Trauma Intelligence and Injury Group (www.tiig.info) *** numbers suppressed as below 5								

Crime and deprivation

Crime is strongly related to deprivation. Rates of crime are much higher in the most deprived areas of the county than the least deprived areas and consequently, young people living in the most deprived areas have a much greater risk of becoming a victim of crime than young people in the least deprived areas.

Young people in the most deprived areas are twice as likely as those in the least deprived areas to be a victim of crime, according to recorded statistics. However, it is not just those in the most deprived areas who are most likely to be a victim of crime. There is a strong social gradient and the risk of becoming a victim of crime increases at a greater rate as we move along the social scale.

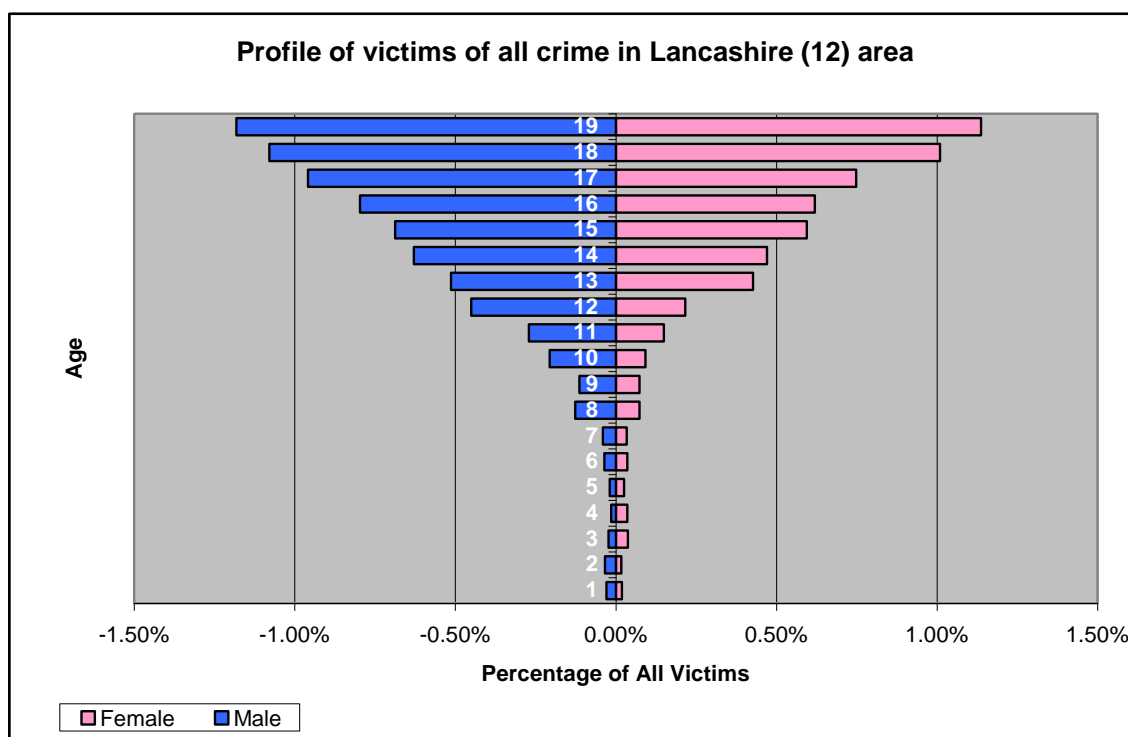
Figure 26: Rate of victims aged 0-19 across the Lancashire social gradient, 2009/10



Demographics of victims

Victimisation increases with age, with children at secondary school and college more likely to be a victim of crime than primary age children. Increasing vulnerability of young people continues until late 20s. Boys are more likely to be victims of crime than girls (7.2% versus 5.8% respectively).

Figure 27: Demographic profile of victims of all crime in Lancashire, 2009/10



Source: Lancashire Constabulary/MADE

Types of crime

Children and young people are most likely to be victims of violent crimes than of non-violent crimes. During 2009/10 almost half of offences against children and young people (47%) were violent crimes and 8% sexual offences. 21% of crimes against young people were theft, 9% criminal damage and 5% vehicle crime.

Table 29: Types of crime committed against 0-19 year olds, 2009/10

Crime Type	Number of crimes	Percentage
Violent offences	3711	47%
Theft	1653	21%
Criminal Damage	726	9%
Sexual offences	629	8%
Vehicle	378	5%
Other	811	10%

Source: Lancashire Constabulary/MADE

Child sexual exploitation

Child sexual exploitation is one area which is of particular concern because it can have long lasting implications for the health and wellbeing of the victims. Victims often turn to alcohol or drugs as comfort, with resulting mental health issues and aggressive behaviour. Victims are also more likely to engage in risky sexual behaviour, leading to increased rates of unwanted pregnancies,

abortion and sexually transmitted infections. It is less well recognised that a number of health problems such as obesity and dental neglect due to dental phobia can also be caused by abuse. (DH 2010)

Analysis of child sexual exploitation in Lancashire shows that many cases originate from deprived areas with a significant number of victims appearing as a result of 'missing from home'. The Lancashire Constabulary child sexual exploitation teams have identified a minimum number of 346 victims across the county (July to September 09). In addition there has been a 12% increase in reported 'missing from homes' to the police (Lancashire Community Safety Strategic Partnership 2010) – research by Harris and Robinson (2007) has evidenced a link between vulnerable people who are 'missing from home' and those being sexually exploited.

The number of victims of child sexual exploitation is expected to increase as awareness of cases increases through proactive work. As more cases are identified there will be an increasing strain on resources to deal with the growing problem. While national research shows that young people who are resident within the care system are more at risk of becoming involved in child sexual exploitation, in Lancashire only 10% of victims were identified as within this group (DCFS 2009 and Lancashire Community Safety Partnership 2010). It is believed that this is due to underreporting of cases rather than Lancashire bucking the national trend and the suggestion is that more Lancashire cases will be identified from this group. Furthermore, 80% of cases in Lancashire were considered 'medium risk'. This is an indication that victims are being identified by services, and interventions taking place, when the victims are already entrenched in exploitative relationships. Although Lancashire research has not specifically identified disabled children, national research has identified that this group is more than three times more at risk than able bodied children to experiencing abuse (Sullivan and Knutson 2000).

Domestic violence

The Refuge website (<http://refuge.org.uk>) defines domestic violence as *"the abuse of one partner within an intimate or family relationship. It is the repeated, random and habitual use of intimidation to control a partner. The abuse can be physical, emotional, psychological, financial or sexual. Anyone forced to alter their behaviour because they are frightened of their partner's reaction is being abused."*

Evidence on the prevalence of domestic violence has shown that it is associated with an increased risk of all forms of abuse and (when witnessed by children) increasingly is seen as a form of emotional abuse in itself (DH 2002). National trends suggest a slight decline in domestic violence

notwithstanding that it remains a significant problem. There is growing recognition that such violence does not stop when parents separate. A British crime survey has reported that when victims continue to see a violent ex-partner after separating (usually in order to maintain relationships with children), contact visits have often involved threats, abuse or violence, in over a third of cases.

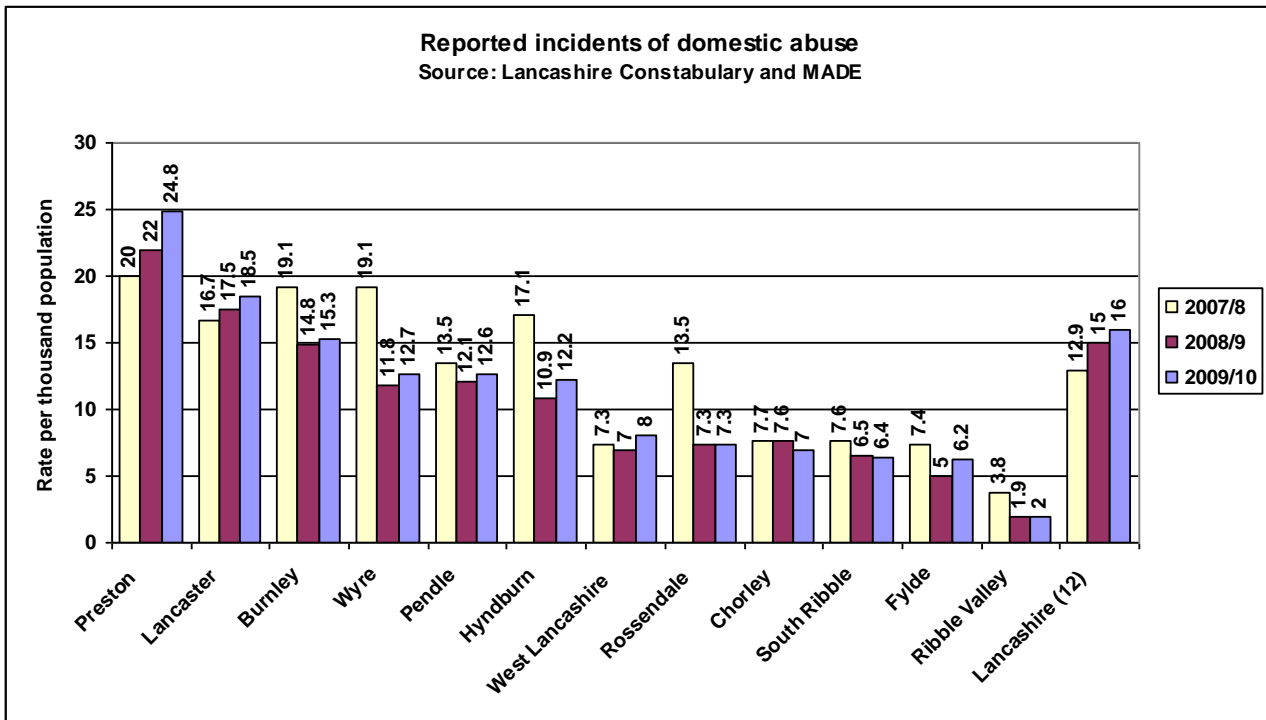
An analysis of 10 separate domestic violence prevalence studies by the Council of Europe showed consistent findings: 1 in 4 women experience domestic violence over their lifetimes, and between 6-10% of women suffer domestic violence in a given year (Council of Europe, 2002). Domestic violence is known to escalate during pregnancy and has been identified as a prime cause of miscarriage or still birth (Mezey and Gillian, 1997) and of maternal deaths during childbirth (Lewis et al, 2001).

The Department of Health (2002) estimates that every year 750,000 children experience domestic violence and such violence is frequently a factor in cases where children have been killed or seriously injured. Evidence shows that domestic violence is present in two thirds of cases of child deaths and serious injury (Brandon et al 2008). It also has other damaging effects on the health and development of children. Children living in families where there is domestic violence have been shown to be at risk of behavioural, emotional, physical, cognitive functioning, attitude and long term developmental problems (Mullender A et al 2002). Negative associations may manifest themselves in absenteeism from school, ill health, bullying, anti social behaviour, drug and alcohol misuse and self-harm, leading to continued issues in adult life.

Lancashire's domestic violence refuges reported that they have been in contact with an average of 500 children per quarter, over the last 18 months.

The table below highlights reported incidents to the police during the last three financial years in Lancashire. Preston and Lancaster are the areas with the highest rate per thousand of the population, followed by Burnley. The rate of reported incidents has increased over the last three years, partly as a result of work under taken by the Police and Crime and Disorder Reduction Partnerships to increase confidence of victims to report the abuse.

Figure 28: Reported incidents of domestic abuse in Lancashire, 2007/08 to 2009/10



Lancashire County Council received 1,703 referrals to social care services for children in December 2010. 457 or 31% of these were referred for reasons of domestic violence. The levels of referrals for reasons of domestic violence vary significantly by district in both number and proportion – from 1 referral (accounting for 0.8% of the total referrals) in Burnley to 317 referrals (accounting for 47.6% of the total referrals) in Preston. Such variations in referrals to social care could indicate underreporting in some areas and further analysis should take place to understand where levels of referrals are artificially low.

Young people aged 16-19 accounted for approximately 8% of all women accommodated in the county's refuges over the last three years.

The home accounts for 9% of assault locations for female 10 to 17 year olds and 5% for males aged 10 to 17 year olds. These numbers increase for the 18-24 year olds. A third of all assaults occur in a public place.

Table 30: Locations of assaults presenting at Emergency Departments for Lancashire residents, 2007 to 2009

Location	0-9		10-17		18-24	
	F	M	F	M	F	M
Education establishment	****	10%	6%	8%	0%	0%
Home	20%	26%	9%	5%	18%	7%
Other	****	****	14%	13%	14%	14%
Public place	22%	14%	34%	36%	32%	44%
Work	0%	****	0%	0%	2%	1%
Unknown	45%	45%	37%	38%	33%	34%
Total number	51	117	1364	3280	1991	6381

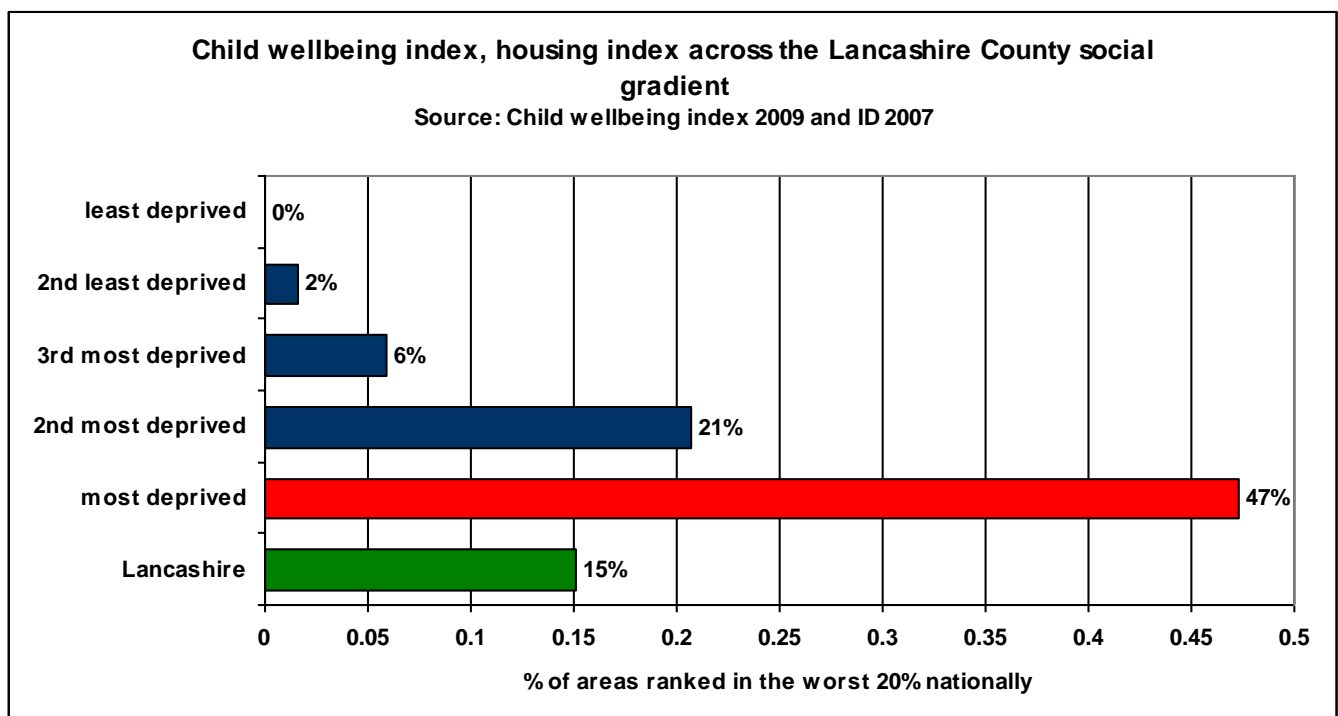
Source: Trauma Intelligence and Injury Group (www.tiig.info)

Housing

Housing can have serious impacts upon the wellbeing of families. Impacts can range from physical, mental and financial. Housing can impact not only on physical health if damp or poorly maintained, but can also impact upon mental health. Warm, secure and financially manageable homes are vital to the wellbeing of families.

Overall, 15% of the areas of the county fall within the worst quintile nationally for housing wellbeing, which means that Lancashire fares better against this domain than the national average. However, this is not shared across the social gradient and those in the most and 2nd most deprived parts of the County are over-represented in the bottom 20%. Almost half of Lancashire's most deprived areas are ranked in the bottom 20% nationally, indicating that housing conditions are disproportionately inadequate for children and young people in these areas.

Figure 29: Child wellbeing index, housing index across the Lancashire social gradient, 2009



As part of the post-war settlement, housing was a sector in which the case for strong state involvement was generally accepted. The introduction of right to buy policy together with the dearth in re-provision saw a significant decline in the local authority housing sector. As this sector has shrunk, it has come to play a residual role, primarily for the poorest of households.

From 1997 some funds were released from council house sales to address the problems of poor housing stock and further changes were facilitated through regeneration measures, particularly neighbourhood renewal as in the East of Lancashire. Alongside these developments however, there has been a continued reliance upon the housing market. Such social housing that is being built is currently insufficient to meet demand.

Trends in housing provision have taken place within the broader context of growing inequalities in housing wealth. Between 1971 and 2002 the value of homes held by the UK population had risen fifty fold. Thomas and Dorling (2004) estimate that the wealthiest 10% of households possess over five times the housing wealth of the 10% of households with least wealth by area. However it is important to note that these figures exclude those who rent whether in the private or social sectors. Therefore they have no housing wealth and are excluded from what has become the greatest single repository for wealth held by individuals within the country.

Thus children from the poorest backgrounds will be significantly more disadvantaged with respect to their relative access to resources than those of previous generations, further widening the gap between rich and poor.

Tenure

2001 census data suggests that around three quarters of households in Lancashire own their own homes and this was slightly above the national average. Ownership rates were at 80% or higher in Fylde, Ribble Valley, South Ribble and Wyre. Around 13% of Lancashire households were in the social rented sector, which is lower than national and regional average rates. There was considerable variation between districts with only 7% of households in Fylde in the social rented sector compared with 20% in Preston. The proportions of households in private rented accommodation or living rent free were similar to the national average.

Table 31: Housing tenure in Lancashire, 2001

LA NAME	Owned	Social rented	Private rented	Living rent free	All Households (number)
Burnley	72%	15%	11%	2%	36,796
Chorley	79%	14%	5%	2%	41,027
Fylde	80%	7%	12%	2%	32,369
Hyndburn	75%	14%	9%	2%	32,976
Lancaster	73%	10%	15%	2%	55,839
Pendle	75%	13%	10%	2%	35,960
Preston	69%	20%	9%	2%	52,970
Ribble Valley	81%	8%	9%	2%	22,210
Rossendale	72%	18%	8%	2%	27,112
South Ribble	84%	11%	4%	1%	42,728
West Lancashire	74%	18%	6%	2%	43,586
Wyre	83%	7%	8%	2%	45,295
Lancashire	76%	13%	9%	2%	468,868
North West	69%	20%	9%	2%	2,812,789
England	69%	19%	10%	2%	20,451,427

Source: 2001 Census Data

More recent data taken from the Department for Communities and Local Government Table 100 on the dwelling stock by tenure, 2008/09, shows a shift in tenure from social rented to privately owned properties. At the time of the Census approximately 85% of the stock was reported to be privately owned (both owned and rented). Data for 2008/09 shows that this has increased to 88%, which is not unexpected given increasing patterns of home ownership and the growth of the buy to let market pre-recession. With increased private ownership comes an increased likelihood of poor standard homes (particularly in the difficult to regulate buy to let market), but also, for those who own homes, given the financial climate, there is an increased risk of mortgage default, both of which can have wide ranging detrimental impacts for families.

Housing quality

Inadequate housing can have strong implications for children, their achievement and their health and wellbeing. Damp, cold or crowded homes pose particular health risks for children and increase the rate of acute respiratory infections, poor mental health and accidents (Liddell 2008). There are risks to wider wellbeing of children, some of which will affect a young person's ability to succeed in the long term. For example, for some families in inadequate or overcrowded households there may not be the space available to provide a young person with somewhere quiet to do their homework, a basic requirement which many families would take for granted.

Some indication of the quality of housing in the county is provided by its value and its condition. The table below provides details of the proportion of the housing stock in each district that falls within the lowest council tax band which includes properties up to £40,000 (band 'A'). This shows

that the proportion of band 'A' properties in Lancashire was above the England and Wales average. The East Lancashire authorities of Burnley, Hyndburn and Pendle all had more than 59% of their dwellings classified in band 'A'.

Properties were traditionally classified as unfit if they failed to meet one or more of a number of fitness criteria relating to issues such as structural stability, state of disrepair and satisfactory facilities. Data from 2006 showed that the proportions of unfit property in Pendle and Hyndburn were the 2nd and 3rd worst in the country (Blackburn with Darwen was the worst). Burnley and Rossendale also had rates well above average. More recently, the categorisation of properties as being fit or unfit has been replaced by assessments of hazards associated with poor housing conditions and the harm attributable to these conditions. The housing assessment is against 29 categories of housing hazards and each hazard identified is scored based upon the severity of the hazard and its potential to cause injury to a person who is most vulnerable to that hazard. The greater the likelihood of harm occurring or the more severe the outcome, the higher the score for the hazard will be. The scores are divided into hazard bands with the highest bands termed as 'category 1' hazards, which the local authority has a legal duty to take enforcement action to deal with these hazards.

This approach reveals that Burnley, Hyndburn, Pendle and Rossendale all have proportions of property with category 1 hazards more than twice the county and national average rates. There were 59,341 properties in the county with category 1 hazards and Local Authority and Registered Social Landlord housing stock only accounted for about 2,140 (3.6%) of these.

Using the tenure figures from the Census and the latest population estimates allows for estimation of the numbers of children living in each type of tenure. Applying the district level rates of unfit and category 1 hazard homes suggests that as many as 26,188 children could be living in poor quality housing. Although these figures are unlikely to reflect the accurate number they provide an indication of the scale of the problem.

The issue of unfit housing in East Lancashire was being addressed by Regenerate Pennine Lancashire, which was receiving funding through the previous government's housing market renewal programme. However, this funding is no longer available under the coalition government and it remains to be seen if and how the redevelopment of the housing stock will take place.

Table 32: Housing stock information

	% of houses in council tax band 'A' (2008)	% of unfit dwellings (2006)	% of properties with Category 1 hazards (2009)
Burnley	62.15	8.1	25%
Chorley	31.38	3.8 (2005)	5%
Fylde	18.12	5.0	14%
Hyndburn	59.30	15.9	22%
Lancaster	35.22	4.6	4%
Pendle	62.64	16.6	22%
Preston	45.75	5.3	8%
Ribble Valley	13.73	4.3	5%
Rosendale	51.82	9.1	27%
South Ribble	20.84	3.6	7%
West Lancashire	30.34	3.0	8%
Wyre	21.88	4.4	3%
Lancashire	37.74	7.0 (2005)	11%
England and Wales	24.47	4.2	9% (England only)

Source: Valuation Office Agency: Dwelling Stock by Council Tax Band and Department for Communities and Local Government: Dwelling Stock by Tenure and Condition and Category 1 Hazards

Homelessness

Homelessness can have great impacts upon outcomes for children and young people. Being homeless can leave families in chaos, causing stress and depression for both parents and children. Local authorities are obliged to provide temporary housing for homeless households, but this can be of poor condition leading to poorer health. The long term effects on children could be particularly damaging as they are found to experience poorer health and emotional wellbeing, and education and life chances are negatively impacted upon (Shelter 2009). Further discussion of the impact of [youth homelessness](#) is contained in the young people chapter.

Some 426 households were accepted as being homeless and in priority need in Lancashire in 2009/10. Those in priority need include pregnant women, people with dependent children, certain 16 and 17 year olds and certain care leavers. The numbers had reduced from 598 in the previous year following a generally reducing trend. The focus for several years has been on homelessness prevention, which explains in large part the reduction in the numbers of statutory homeless households. In this way the statistics can be taken as a measure of success in preventing homelessness. The trend towards increased levels of home ownership over recent years, combined with the economic recession is likely to have put more families at risk of homelessness. This risk is likely to increase further with the severe financial climate.

Lancaster and West Lancashire reported the highest figures of statutory homelessness in priority households. The number of people in temporary accommodation, as at 31 March 2010, was relatively low but three authorities, namely Burnley, Preston and South Ribble, accounted for nearly three quarters of the total.

Table 33: Homelessness and use of temporary accommodation, 2009/10

	Numbers accepted as being homeless and in priority need	Total in temporary accommodation at 31 March 2010
Burnley	45	14
Chorley	34	6
Fylde	12	3
Hyndburn	6	0
Lancaster	130	3
Pendle	21	0
Preston	46	21
Ribble Valley	5	3
Rossendale	30	2
South Ribble	35	21
West Lancashire	56	4
Wyre	6	1
Lancashire	426	78

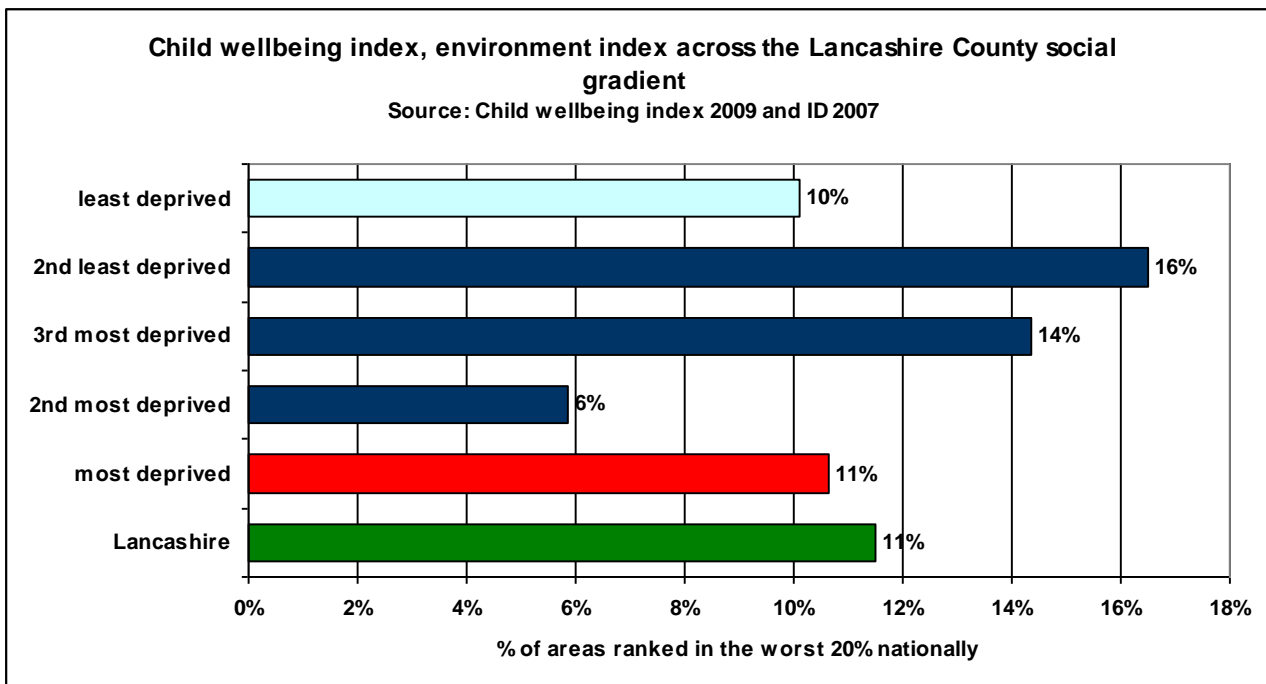
Source: Communities and Local Government

Environment

The quality of the environment has a large impact on the wellbeing of families. The design of the built environment is a determinant of community safety, with closed in estates with dark areas increasing fear of crime and the dominance of cars reducing physical activity and leading to road traffic accidents. Having access to green space is linked to wellbeing and good quality air reduces the risk of respiratory conditions in children (Bradshaw et al 2009). The importance of the environment for the wellbeing of children and young people cannot be overstated.

Lancashire, and all parts of the social gradient, is under-represented in the areas with worst environment wellbeing nationally. However, the areas with greatest representation in the worst quintile nationally are areas of middle to low levels of deprivation. This may be due to the way in which the domain is constructed. There are two sets of variables – one set on environmental quality where the most deprived areas are likely to fare badly due to their inherent urban locations, and one set on access where the less deprived areas are likely to fare badly due to more rural settings. This results in the mixed picture below.

Figure 30: Child wellbeing index, environment index across the Lancashire social gradient, 2009



Access to green space

Access to safe green spaces such as parks and playgrounds and recreational facilities is particularly important for children and young people. Evidence clearly shows that children who have better access to such safe places are more likely to be physically active and less likely to be overweight, compared to those living in neighbourhoods (usually poorer neighbourhoods) with reduced access to such facilities (Gordon-Larsen et al 2006).

Children and young people’s perceptions of neighbourhood are also likely to be associated with levels of physical activity. Thus positive aspects of neighbourhood facilities, the social environment and the aesthetics of an area are also associated with increased levels of activity (Hume et al 2005). Parents’ perceptions are an important determinant of levels of activity. Where parents perceive a neighbourhood to be safe for walking and cycling, children are more likely to undertake these activities; however, girls of all ages are less likely to walk or cycle than boys (Timperio et al 2003).

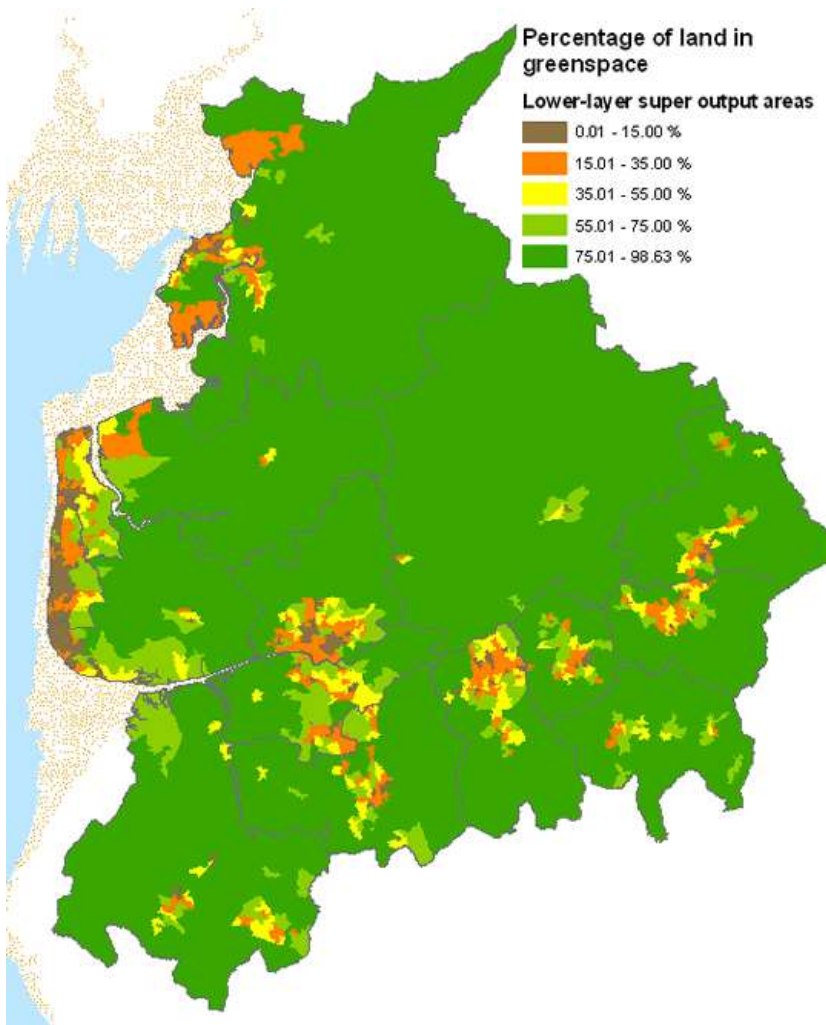
Children and young people living in greener neighbourhoods had lower body mass index, attributed to increased physical activity or time spent outdoors (Bell et al 2008). Access and contact with nature improves attention among children with ADHD among inner city girls (Faber et al 2001, 2002) and enhances emotional and values related development in school children (Kellert 2002). Studies examining children’s contact with natural environments have shown:

- views on to trees and grass are associated with reduced stress (Wells and Evans 2003);

- increasing levels of accessible green urban space promotes increased amounts of play for local children (Sallis et al 1995);
- natural features can create enclosed areas to promote play between different groups and create varied activities suitable to different age groups leading to better overall concentration and motor skills (Power et al 2009).

Access to green space is lowest in the most deprived parts of the county, which is unsurprising given the link with highly urban areas.

Map 15: Proportion of land which is green space



Source: Land use statistics

Air quality

Recent studies indicate that children living close to busy roads have an approximate 50% increased risk of experiencing respiratory illness including asthma (Royal Commission on Environmental Pollution, 2007). A recent international study of asthma and allergy in children has

shown that the UK has the highest asthma prevalence in the world with 21% and 25% of 6-7 and 13-14 year olds respectively having reported asthma symptoms within the previous 12 months. This is compounded in urban areas (Royal Commission on Environmental Pollution 2007).

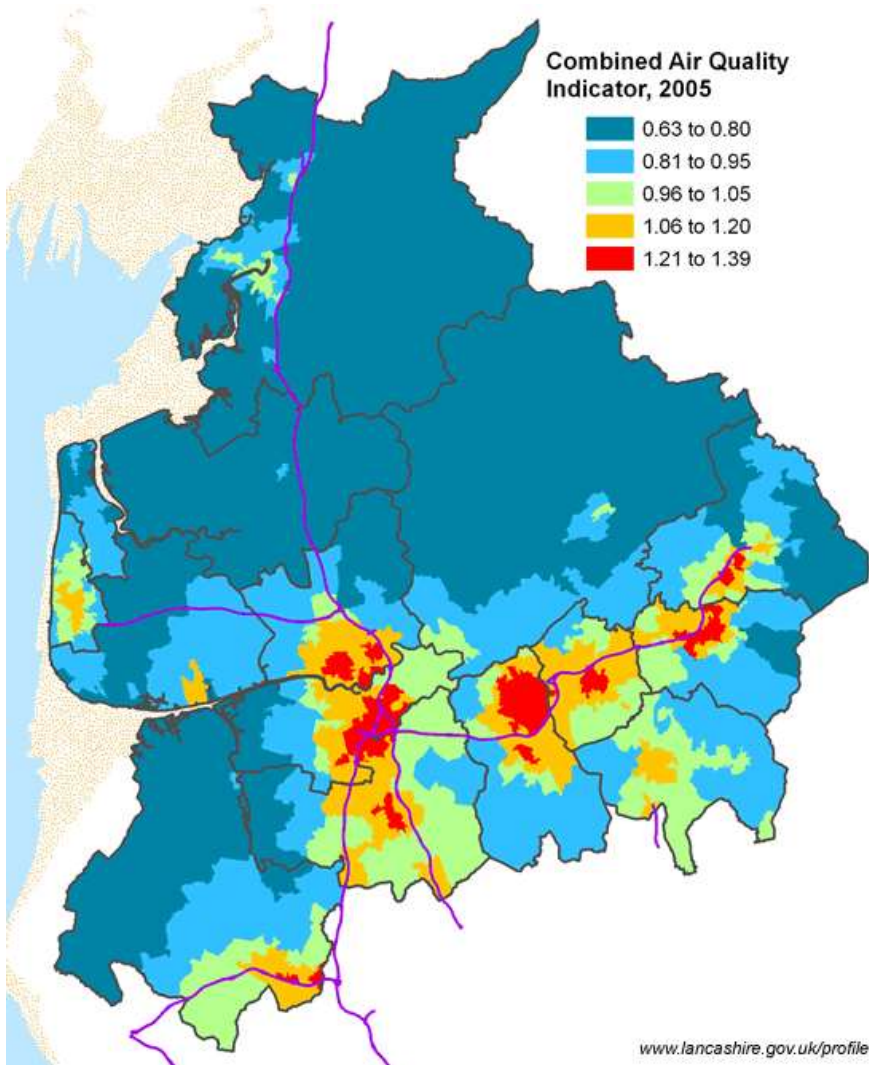
Data on air quality is available from the National Atmospheric Emissions Inventory (NAEI) which compiles estimates of emissions to the atmosphere. The data is provided at lower super output area (LSOA), which is a geographic area covering approximately 1,500 people. LSOAs are constructed so that the populations contained within them are as similar as possible to allow for valid comparisons to be made between them.

According to the latest 2005 estimates, across the whole of England combined air quality scores for LSOAs vary within a range of 0.52 (best) and 2.54 (poorest) – a difference of more than five-fold. The average Lancashire LSOA has an air quality indicator of 1.01 which is notably better than the figure for England, whilst the highest recorded score in Lancashire (1.39) is significantly below the worst level recorded in the country. No areas of Lancashire experience air pollution levels on anything like those recorded in the centres of the major conurbations and other larger cities. There are some parts of the county where the figures are not encouraging but the Combined Air Quality Indicator reveals no Lancashire LSOA in the worst 15% of results for the whole of England. Indeed, nearly nine in every ten of the LSOAs in the Lancashire sub-region (which includes Blackburn with Darwen and Blackpool) are ranked within the best 50% of England for air quality and 260 of the sub-region's LSOAs (27% of the total) sit within the best 10% in England.

The areas in Lancashire with the very best air quality are based largely within the Bowland and Lune Valley areas of the county but this is largely a matter of degree as additionally air quality across coastal parts of the sub-region in Lancaster, Wyre and West Lancashire together with upland parts of Pendle also score highly. Not unexpectedly, in the main, rural areas enjoy higher air quality than urban areas

Most urban areas in Lancashire suffer to some degree from relatively poor air quality though it is much less of an issue in the coastal towns of Lancaster/Morecambe, Fleetwood and Lytham St Annes, presumably due in part to the direction of the prevailing winds. The worst air quality figures are to be found in a number of LSOAs in South Ribble and Chorley within the Bamber Bridge and Clayton-le-Wood North wards. The urbanised nature of much of this area together with industrial development, motorway through-traffic and the intersections of the M6/M61/M65 appear to combine to produce a significant local concentration of poor air quality

Map 16: combined air quality indicator, 2005



Fuel poverty

Living in cold, damp homes is known to affect the development of children, leading to respiratory conditions but also to wider impacts on educational attainment as this can affect the availability of somewhere suitable to do homework. Fuel poverty is defined as the requirement to spend more than 10% of household income to maintain an adequate level of warmth and includes non-heating fuel use. Data on fuel poverty is limited - the most recent and widely available data on fuel poverty is the 2003 indicator from the Centre for Sustainable Energy, which is available only for small areas. Fuel poverty has, at the very least, doubled since 2003, largely due to the substantial rise in fuel prices and this should be taken into account when interpreting this data.

Around 42,000 children in Lancashire could be living in fuel poverty according to estimates developed for this JSNA. The breakdown by district is shown in the table below. These estimates use data which applies to households in Lancashire and applies the same proportions to the children and young people population. They are unlikely to be accurate for many reasons

including that only a proportion of households will contain children and children and young people may be more likely to live in social housing which due to modern building standards, are less likely to lead to fuel poverty.

Table 34: Estimated numbers of children living in fuel poverty in Lancashire

Fuel poverty	% of households living in fuel poverty	Numbers of children aged 0-19 estimated to be living in fuel poverty
Burnley	17.9%	4032
Chorley	11.5%	2764
Fylde	15.1%	2307
Hyndburn	16.2%	3558
Lancaster	20.0%	6651
Pendle	17.8%	4146
Preston	13.6%	4505
Ribble Valley	16.7%	2285
Rosendale	14.2%	2476
South Ribble	9.9%	2493
West Lancashire	12.3%	3264
Wyre	16.4%	3900
Lancashire (12)	15.1%	42293
Source: estimates calculated by Lancashire JSNA team using Department for Energy and Climate change data on fuel poverty, 2006, and ONS population estimates, 2009. Assumes the household percentages apply directly to the children and young people population aged 0 to 19 years.		

Children's time and space

Autonomy and being responsible and in control of life is important for wellbeing. Studies of workplaces have demonstrated that those who have no control over their own work are most likely to suffer from depression and stress. Children have limited control over their own lives – their parents choose where they live and what they eat. They have limited, if any, choice, over where they go to school and whilst at school they have almost no control over their time.

It is important to understand the contexts within which children live their lives and the differing pressures and experiences they face. This will be beneficial when developing interventions, policy or support services for children. Further, it is important to consider areas where children might have the ability to extend some control as these are the areas that will allow them to maintain their own wellbeing, a skill which is vital throughout life. Ensuring children and young people are able to participate in decision making is important for wellbeing. Interventions, policy and services should aim to support and compliment these areas to improve a child's ability to maintain their own wellbeing.

Home

Besides school, the home and family are the main physical and social spaces in which most children spend their childhood. Over recent decades family breakdown has resulted in significant changes to the home and family environments. For children with divorced parents, “family life no longer happens in one place but is scattered between different locations” (Beck and Gernsheim 2002). Indeed the geography of divorce for these children is one of punctuated movement as the children travel from one home space to another and back again (Mayhew et al 2005).

Children’s bedrooms

Bedroom space for a child has become symbolic of the growing child centeredness in the modern family and household arrangements (Whitehead 1997). The quality and quantity of home space is linked to socio-economic factors. Overcrowding is endemic among low income families.

Public outdoor space

Public outdoor spaces form an important part of the lives of many children, being spaces where they can meet with peers and be away from adult gaze (Matthews and Limb 2000). Parental fears about safety, specifically traffic, are increasing influences on children’s independent spatial mobility and there is an increasing tendency to escort children to and from more structured and supervised leisure activities. Increasingly letting children roam or play out unaccompanied is becoming a marker of neglectful or irresponsible parenthood (O’Brien et al 2000). Concerns about gangs and activities associated with substance misuse were greatest among children living in deprived or troubled areas and are a barrier to playing out – imposed both by children and their parents (Matthews 2001).

Spaces for teenagers

Research with teenagers and parents suggest that the lack of local, non-commercial spaces where teenagers can spend time together off the streets, contributes to the reported levels of boredom and for some, subsequent trouble among teenagers (NACRO 2000). Matthews and Limb (2000) found that the main reason for playing on the street amongst 9-16 year olds was the lack of anywhere else to go, certainly for less affluent children, the street being their only social forum through a lack of affordability of other leisure or recreational opportunities. Older teenagers frequently use shopping malls on the basis that they provide free, warm and safe places. The Government’s campaign of “no tolerance” of crime and anti-social behaviour contributes to the narrowing of public spaces where teenagers can congregate, by imposing the threat of bans and curfews on “trouble-making youth” (New Policy Institute 2002, Sutton 2008).

Virtual space

The nature and extent of children's access to virtual space is determined by where they access it, e.g. at home or school and when. School access to the internet is near universal. The majority of children also have access to a computer at home, many of whom may also have access to the internet. There remain significant inequalities in home access of the internet based on socio-economic class. Internet safety is a concern for many with the growth in popularity of social networking sites.

Children's play

Play is important for children's mental, physical and emotional development and their wellbeing. It provides an opportunity to consolidate and absorb information and helps to acquire a general mindset towards solving problems. The physical activity involved in most play provides exercise, encourages co-ordination and develops skills of the growing child. It reduces symptoms of depression and anxiety, contributing to increased self-esteem. Research by the Mental Health Foundation (1999) highlights the importance of children being able to play, take risks and use their own initiative, thereby acquiring the basic skills to become emotionally literate.

Outdoor venues are important for meeting friends and retaining some social autonomy away from adult supervision. Some urban geographers have raised concerns that children and young people have been conceptualised as "problems" in urban planning and the result has been their increasing exclusion from a hostile urban environment (Woolley 1999 and Jones et al 2000). In recent times there has been a tendency towards commercialisation of play space and the commodification of childhood (McKendrick et al, 2000).

Children's time use

According to the UK 2000 Time Use Survey (ONS 2002) children aged 16 only spend 2% of their time on their own. For the rest, children are either in the company of their parents, siblings, friends, classmates and/or teachers.

Table 35: Time use of children and young people in the UK (average minutes per person per day spent on activity)

Main activity	8-15 year olds	16-25 year olds
Sleep	607	549
Eating and drinking	67	72
Person care (e.g. washing and dressing)	48	50
Employment	5	180
Study	229	84
Housework (excluding childcare)	45	74
Childcare (of own household members)	1	14
Voluntary work and meetings	9	9
Social life and resting	52	90
Entertainment and culture	9	8
Sport and outdoor activities	29	20
Hobbies and games	94	26
Reading	10	10
Watching TV and video	139	141
Listening to radio/music	8	11
Travel	76	96
Other	12	6
Total	1,440	1,440
<i>Sample size</i>	2,925	2,372

Places to go and things to do

Feedback from young people suggests that they want an environment that provides them with places to go and things to do. A survey of how young people in Lancashire spend their weekends revealed that meeting friends was the most popular activity (Lancashire Youth Survey 2007).

When young people were asked to list three things that would make their lives better, the most popular choice was the provision of more places where they can go to spend time with their friends with nearly half (46%) of young people choosing this option (2009 Tellus4 Survey). Around half of young people (52%) were satisfied with parks and open spaces in their area but less than one quarter (23%) felt that there were enough activities for them to go out and do on Friday and Saturday nights. Access to facilities and activities may be a problem, particularly for young people in rural areas, but only 16% of those surveyed reported that they did not participate in activities because they were unable to get there.

In the absence of places to go and activities to engage in there is a tendency for young people to simply "hang around" in residential areas. Adult attitudes to this were explored in the 2008 Place Survey. The proportion of adults who perceived teenagers hanging around the streets to be a problem varied considerably across the county ranging from 26.5% in Ribble Valley to 59.7% in Burnley. Adults in Burnley were also more likely to regard the provision of activities for teenagers to be one of the most important things for making somewhere a good place to live and more likely to identify it as an area most in need of improvement. More than half of those surveyed across the county felt that activities for teenagers were in need of improvement.

Figure 31: Residents who think teenagers hanging around the streets of their local area are a problem, 2008

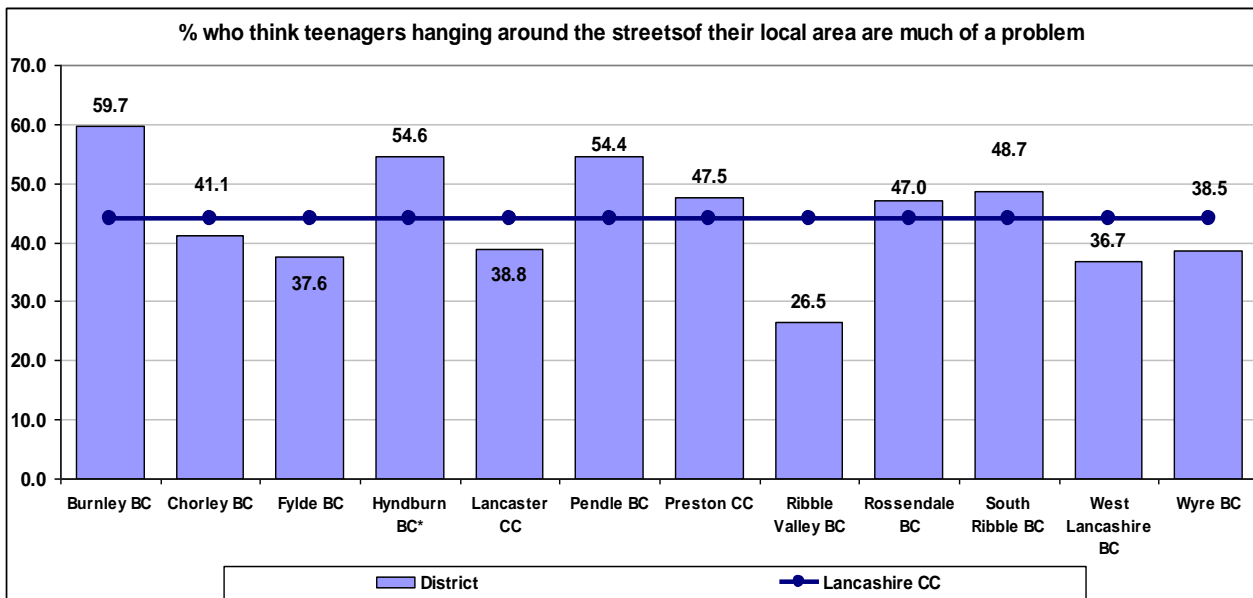


Figure 32: Residents who think activities for teenagers are important to improve their local area, 2008

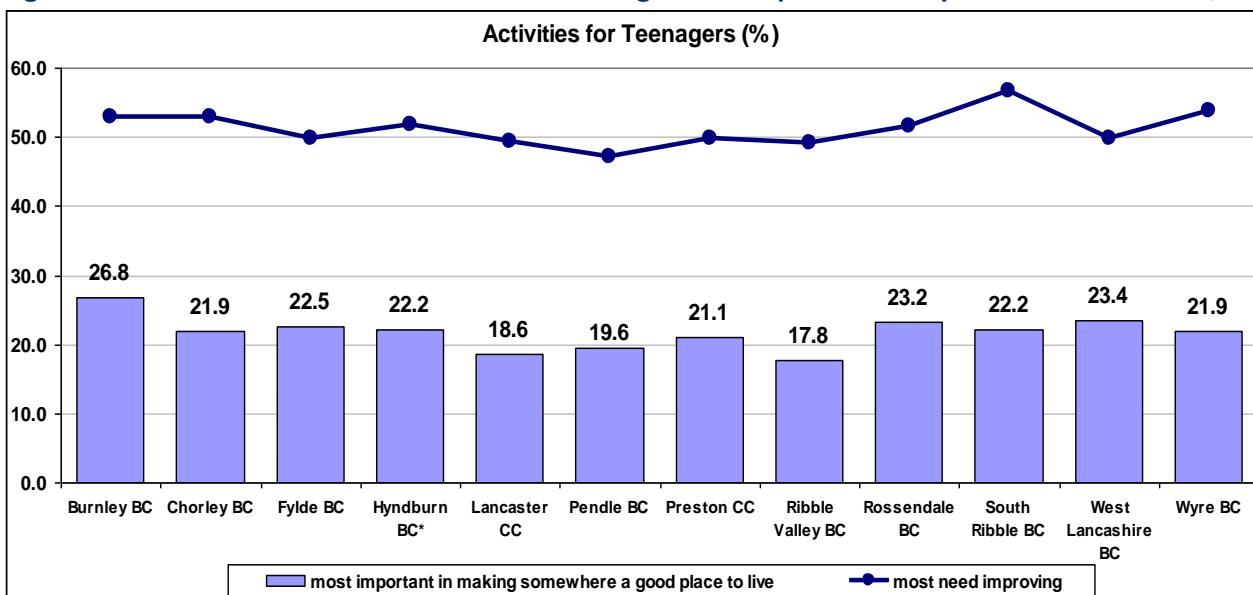


Table 36: Place survey attitudes towards teenagers in the local area, 2008

	% who believe teenagers hanging around the streets is a problem	% who believe activities for teenagers are important in an area	% who think that activities for teenagers need improving
Burnley	59.7	26.8	52.8
Chorley	41.1	21.9	52.9
Fylde	37.6	22.5	49.7
Hyndburn	54.6	22.2	51.8
Lancaster	38.8	18.6	49.3
Pendle	54.4	19.6	47.2
Preston	47.5	21.1	49.9
Ribble Valley	26.5	17.8	49.0
Rosendale	47.0	23.2	51.5
South Ribble	48.7	22.2	56.6
West Lancashire	36.7	23.4	49.8
Wyre	38.5	21.9	53.7
Lancashire	44.0	21.6	51.3
North West	48.1	24.2	51.3
ENGLAND	43.0	21.2	46.5

Source: 2008/09 Place Survey

Summary, identification of key areas of need and recommendations

Protecting and promoting the wellbeing of children is an important way to strengthen resilience and the resources of children and young people to be able to cope with difficulties in life. Some children experience poor levels of wellbeing due to the area in which they live, particularly those in Burnley, Pendle and Preston. The major causes of reduced wellbeing are structural and authorities have the potential to intervene and make significant changes, such as developing planning policies that support the creation of safe and healthy environments and creating environments which support inward investment and, in turn, the creation of jobs, wealth and economic development. However, simply by ensuring that children and young people are involved in decision making processes will make children feel in control and able to influence the things that shape their lives, promoting wellbeing.

Children have very little control over their lives and their time is dominated by school where they are likely to have very little control at all. However this has started to change as Lancashire schools have engaged with the Healthy Schools Programme (see [early years](#) chapter for further details). One of the criteria for meeting National Healthy School Status is to 'consult and encourage participation of all within the school community' such as 'putting mechanisms in place to ensure all pupils' views are reflected in curriculum planning, teaching and learning, and the whole school environment, including those with special educational needs and specific health conditions, as well as disaffected pupils, young carers and teenage parents'. Most schools have set up School Councils, but other models are Eco Committees, and Pupil Forums.

Outside of school children and young people can often be viewed as a nuisance, with groups of young people hanging around on the streets classed as behaving anti-socially, even if their intentions are simply to socialise with peers. The Place survey posed a question asking whether teenagers hanging around were a problem, indicating that teenagers hanging around could not be anything but a problem. Children and young people are the future of society and should be viewed as an asset. Although it is important to ensure that there are activities for children and young people to be involved to "keep them off the streets", it is also important to ensure that there are interventions with older generations to improve their views of children and young people.

Living in poverty has a clear link to reduced wellbeing with the influence on a range of other outcomes such as educational attainment, crime and poor health. A quarter of Lancashire's children live in areas ranked within the most deprived parts of the country and a fifth of children are classed as living in poverty. The poverty and deprivation is not experienced equally across the County but the greatest burden is born by children in the districts of Burnley, Hyndburn, Pendle, Preston and Rossendale. Children are unable to get themselves out of poverty and rely on their

parents, which they are unable to do without the right social and economic conditions. Providing the conditions to enable families to get out of poverty should be a focus of organisations in Lancashire, but it is just as important to put in place measures to mitigate some of the effects of poverty and deprivation. A Child Poverty strategy is currently being developed and this should shape this work within the County.

The well established decline of the manufacturing sector and the upcoming public sector cuts could well mean further reductions in the availability of well paid work with opportunities for progression, and at this stage it remains unclear whether the private sector will be able to step in and provide the jobs required to meet the cuts. Access to employment is a problem in the most deprived parts of the county, highlighted by the discrepancy in the high number of jobs located in such areas and the high rates of unemployment. Ensuring that adults have the skills to meet the requirements of employers is an important role for local government and the education sector. A well skilled and qualified workforce will support the broader aims of economic development by making the area a more attractive option for investment.

In general, rates of unemployment are low in Lancashire, with low wages the main issue. This is particularly of concern as the areas with low wages correspond with those areas with high proportions of dependent children. This is further compounded by the wages gap between women and men. This reflects the increased likelihood of women working part time than men. Inequalities in wages are also found between women working part time and full time, with the wages of the former increasing over recent years, whilst the wages of the latter have reduced. As mothers are more likely to make up a greater proportion of part time workers children are likely to face a greater burden of these inequalities.

The economic downturn in 2007 led to numbers of people defaulting on their mortgages and the upcoming cuts may once again lead to people losing their jobs and being unable to sustain their mortgage payments potentially leading to homelessness and the associated poor outcomes. Support for those who are to be made redundant is of paramount importance during such a turbulent period and projects such as the *Timely Information for Citizens* project run by Lancashire County Council should be promoted. The public sector organisations in Lancashire are likely to reduce their employees and should ensure that appropriate support mechanisms are in place for affected staff.

The quality of the environment has a large impact on the wellbeing of children and young people with air quality impacting upon the health of children and young people and access to green space affecting levels of physical activity and obesity. Urban areas within Lancashire have poor access to green space and low levels of air quality, providing a double negative impact upon the children

and young people living in these areas. The quality of housing also has long term risks and the areas in the east of the county have particularly poor quality housing. This issue was being tackled under the now defunct housing market renewal programme and it is currently unclear how the improvements will not be made. A related issue is that of fuel poverty, which is likely to be increase due to the combination of budget cuts leading to job losses, the restructuring of the benefits system which may leave those on the lowest incomes with even less, and cold winters experienced recently combined with rising fuel prices.

Safety of children is an important determinant of wellbeing, particularly abuse. Child sexual exploitation has lifelong implications for victims including the increased likelihood of engaging in risky sexual behaviours later in life. Similarly, living in a home as a victim or witness of domestic violence can have serious impacts upon children. Children and young people are more likely to be a victim of crime than any other age group in society and are most likely to be victims of violent crimes. With more than 18,000 children and young people victims of crime within one year, this is clearly a particular issue for this section of society. Similarly, children face great risks of injury in and around the home.

To identify needs that should be prioritised it is necessary to consider what the scale of the need, that is how many children are affected, the risk of the need occurring and the impact if it does occur and what the intelligence tells us about trends, external inequalities against the national average and internal inequalities within the County. Based upon this analysis, the key needs within socio-economic determinants of wellbeing are:

- Access to jobs
- Accidents and road traffic accidents
- Adult qualifications
- Child sexual exploitation
- Domestic violence
- Fuel poverty
- Private sector housing quality
- Victims of crime
- Wages

Specific recommendations

A number of specific recommendations can be drawn from the analysis in this chapter:

- There is a need to explicitly include children and young people in broader policies affecting the whole of society to integrate strategic work affecting children and young people.
- Barriers to gaining employment within a family's area of residence should be fully understood and overcome to support families to break the cycle of deprivation which unemployment sustains. This work should involve research with families themselves.
 - The Child Poverty Strategy should be co-produced, co-owned and co-delivered.
 - The Children's Trust should engage with partners responsible for economic development in the county to ensure that the needs of children and young people and their families are reflected within their programmes.
- Further analysis should be undertaken to understand the picture of accidents for children and young people (aside from road traffic accidents).
- Injury surveillance should be undertaken to monitor unintentional and intentional injuries among children and young people.
- Variations in referrals to social care for reasons of domestic violence could indicate underreporting in some areas and further analysis should take place to understand where levels of referrals are artificially low.

Prenatal and Birth

Protecting children from risk begins in utero, where exposure to maternal infections, nutrition, weight gain and behaviours such as smoking, alcohol and substance misuse increase premature birth, infant mortality, birth defects and low birth weight. These factors are strongly influenced by the living conditions of the mother: her income, wellbeing, housing and relationships. At the same time, this period presents extraordinary opportunities for interventions. Social support and appropriate nutrition and care during pregnancy and at birth improve children's prospects. Changing the outcomes for women at this stage would have the greatest impact upon the outcomes for children and young people, interrupting the cycle of deprivation.

Some key vulnerabilities at this stage include:

- Immediate vulnerability: In utero exposure to maternal infections, nutritional deficiencies, maternal obesity, and environmental toxins, as well as poor care around birth, may lead to severe and irreversible damage to the brain and other organs. The failure of mother and child to bond is an important determinant of the wellbeing of children.
- Leading to short term outcomes: Increased risk of maternal mortality, premature births, birth defects, low birth weight, and neonatal death. Low birth weight is the single most important determinant of infant mortality.
- Leading to long term outcomes: Severe, potentially irreversible consequences for physical and cognitive growth and development. The majority of permanent disabilities have their origin in neonatal disease. Poor emotional and mental wellbeing will have long term impacts on the ability of children and young people to succeed in life.

The following are examples of interventions that, in principle, respond to the selection criteria described above and, if properly designed, can meet the additional requisites needed to maximize benefits at the county level. It is important to recognise in each of these interventions that a partnership approach can improve the likelihood of positive outcomes. This does not necessarily mean that a given intervention must be delivered by a group of partners, but rather that partners should work together to ensure that **enabling policies** are undertaken in other areas to provide greatest synergy. The Children's Trusts provide the ideal framework for this to take place.

Beginning in utero, priority interventions could include:

- Ensuring appropriate nutrition and health for pregnant mothers;

- Ensuring access and uptake of family planning and essential prenatal, delivery, and neonatal care; and
- Providing screening for the most important diseases and conditions.

Enabling policies that can assist interventions designed to improve mothers' health and economic circumstances include investments to ensure high quality delivery of school PSHE and using existing resources such as children's centres and community centres to provide information about prenatal care.

Background information

Number of Births in Lancashire

The table below shows the number of births in Lancashire from 2004 to 2008. Over the period there has been a 6.8% increase in the numbers of births and in 2008 more than 14,000 births were recorded. The highest number of births was in the districts of Burnley, Lancaster and Preston. Between 2004 and 2008, the greatest increase in births were in the districts of Burnley, Lancaster and Pendle whilst numbers of births in the districts of Chorley, Ribble Valley and Wyre, which may reflect an increasingly ageing population.

Between 2006 and 2008, live births to all age mothers increased by just under 7% in Lancashire compared to almost 11% nationally

Table 37: Total births by local authority 2004 to 2008

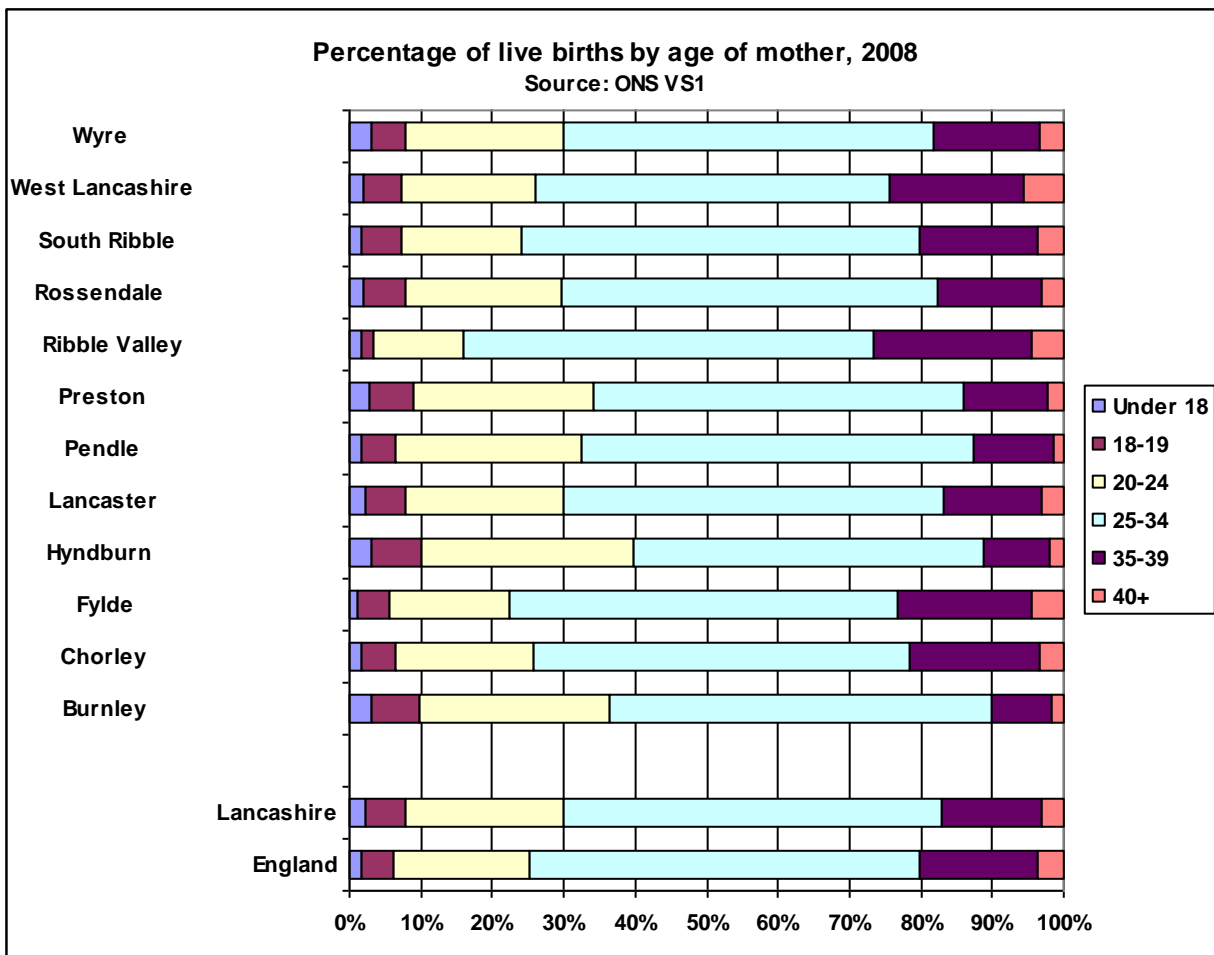
	2004	2005	2006	2007	2008	% change 2004 to 2008
Lancashire	13,145	13,149	13,325	13,589	14,035	6.8%
Burnley	1,158	1,175	1,180	1,281	1,323	14.2%
Chorley	1,252	1,182	1,209	1,214	1,248	-0.3%
Fylde	601	662	582	637	643	7.0%
Hyndburn	1,109	1,125	1,130	1,096	1,165	5.0%
Lancaster	1,334	1,414	1,387	1,469	1,493	11.9%
Pendle	1,169	1,249	1,232	1,276	1,335	14.2%
Preston	1,772	1,810	1,910	1,856	1,947	9.9%
Ribble Valley	523	477	489	533	505	-3.4%
Rossendale	818	805	841	801	883	7.9%
South Ribble	1,201	1,116	1,193	1,183	1,259	4.8%
West Lancashire	1,184	1,197	1,140	1,270	1,251	5.7%
Wyre	1,024	937	1,032	973	983	-4.0%

Source: ONS VS2

Maternal Age

In Lancashire, mothers tend to be younger than their national counterparts with 30% of live births to mothers aged under 25 compared with 25% nationally. At the opposite end of the scale there are fewer mothers aged 35 or over than nationally. However the numbers of older mothers in growing at a faster rate than nationally. At a district level there are some extremes: a large proportion of births in Hyndburn, Pendle and Preston are to mothers aged under 25 (39.9%, 32.3%; and 34.1%, respectively) whilst in Chorley, Fylde, Ribble Valley and West Lancashire the proportion of births to women aged over 35 years exceeds the national average (21.5%, 23.4%, 26.8% and 24.3%). Full numbers and percentages by district for 2008 can be found in the [appendix](#).

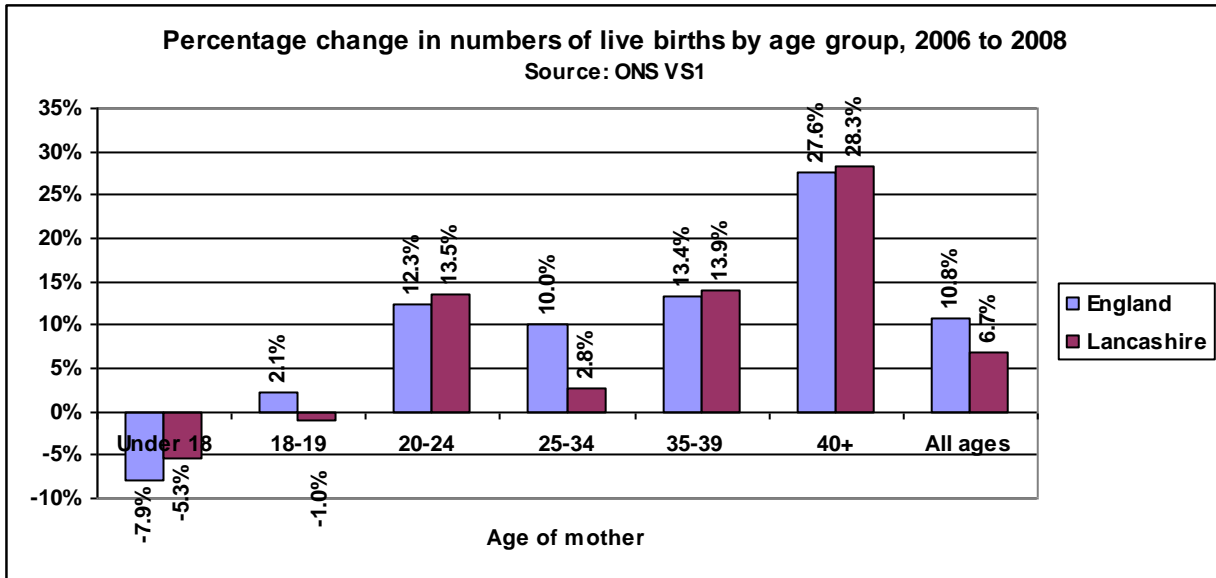
Figure 33: percentage of live births by age of mother, 2008



The numbers of births to the youngest age groups fell over the period. Young maternal age, particularly teenage pregnancy, can be associated with poorer outcomes, which is often linked to deprivation (see section on [teenage pregnancy](#) in Young People chapter). Maternal age is

increasing as more women delay having children, staying in education longer and establishing careers. Parents of higher social grades with higher incomes are linked to positive outcomes for children. However, there are also risks for the child; older women have a higher chance of having a baby with a genetic abnormality such as Down's syndrome.

Figure 34: Percentage change in numbers of live births by age group, 2006 to 2008



Types of Birth

The types of births performed by Lancashire Maternity Units are shown below. In general, Lancashire has a higher rate of spontaneous, unassisted deliveries: 64% compared to 61% nationally. Assisted deliveries and caesarean procedures are used less frequently than the national pattern would predict though Blackpool, Fylde & Wyre hospitals and Southport & Ormskirk hospitals do have higher rates which are the result of higher caesarean rates than the Lancashire and national averages.

Across Lancashire emergency caesarean rates are generally lower than national rates (13.2% compared to 14.4% of all births) with the exception being in Blackburn hospitals where rates are higher: 15%. This could be explained by the high ethnic population in this area as women from ethnic minority groups have increased odds of caesarean section in labour (Parenjothy S et al, 2005).

Additional birth statistics by trust are available in the [appendix](#).

Table 38: Births by method of delivery by NHS trust and site, 2009-10

			England	University Hospitals of Morecambe Bay	Southport & Ormskirk Hospitals	Blackpool, Fylde & Wyre Hospitals	Lancashire Teaching Hospitals	East Lancashire Hospitals - Blackburn	East Lancashire Hospitals - Burnley
Total			652,377	3,391	3,132	2,990	4,675	3,859	2,714
Total excl. unknown			635,741	*	*	2,937	4,361	*	2,702
Spontaneous	Total	Count	399,562	2,205	1,916	1,803	3,028	2,483	1,808
		%	61.2%	65.0%	61.2%	60.3%	64.8%	64.3%	66.6%
Forceps	Low	Count	15,902	120	*	*	22	120	111
		%	2.4%	3.5%	*	*	0.5%	3.1%	4.1%
	Other	Count	22,220	*	153	234	176	*	*
		%	3.4%	*	4.9%	7.8%	3.8%	*	*
Ventouse		Count	40,164	163	175	*	204	292	109
		%	6.2%	4.8%	5.6%	*	4.4%	7.6%	4.0%
Caesarean	Elective	Count	63,386	351	407	314	418	317	290
		%	9.7%	10.4%	13.0%	10.5%	8.9%	8.2%	10.7%
	Emergency / Other	Count	93,970	430	424	437	513	579	358
		%	14.4%	12.7%	13.5%	14.6%	11.0%	15.0%	13.2%
	Total	Count	157,356	781	831	751	931	896	648
		%	24.1%	23.0%	26.5%	25.1%	19.9%	23.2%	23.9%
Source: HES online Maternity data, The Information Centre for Health & Social Care									
*Due to reasons of confidentiality, figures between 1 and 5 have been suppressed									

The World Health Organisation recommends that no hospital should have a Caesarean rate higher than 10-15% (WHO 1985). The average rate in England in 2009/10 was 24%. Some hospitals (for example, large teaching hospitals) have a high proportion of women with complications which can increase the Caesarean rate. Caesarean operations are usually not available at midwifery-led units and GP units and women needing this intervention are transferred to a consultant unit. Possible reasons for high rates could be the lack of an option of midwife-led care or a low ethos of “normality” of birth, for example the unavailability of a Consultant midwife as a normality, no water birth service, no complementary therapies, high epidural rates or insufficient number of midwives to achieve one-to-one care in labour.

Although Lancashire's level of caesarean sections is lower than the national average the rate exceeds the WHO recommendation. The percentage of deliveries at home or in a midwife unit are much lower than the national average, appearing to confirm that the maternity system is following a medical rather than midwifery model. Even in Central Lancashire, which has the highest rate of the three Lancashire PCTs, the rate of home birth deliveries is half the England average. Home and midwife led deliveries may provide a more positive birth experience for women and babies and should be an option where appropriate.

Vaginal birth after Caesarean section (VBAC) should be considered as an option for all women who present for prenatal care with a history of previous caesarean birth. Where contraindications

exist, a repeat caesarean section should be advised, but in the majority of cases successful vaginal birth can be achieved safely for both mother and baby. Such deliveries are low in North Lancashire.

The proportion of home births, or those which take place in a midwife unit, are far below the national average. Even in Central Lancashire, which has the highest rate of the three Lancashire PCTs, the rate of home birth deliveries is half the England average.

Table 39: Maternity comparators by PCT, 2009/10

	England	SHA	Central Lancs PCT	East Lancs PCT	North Lancs PCT
% caesarean deliveries	24.1%	22.5%	20.5%	23.9%	22.3%
% vaginal deliveries following prior caesarean	31.1%	31.5%	29.9%	34.1%	21.1%
% of deliveries at home or in a midwife unit	10.6%	2.1%	4.3%	1.1%	2.7%

Source: NHS Comparators, 2009/10

Sole registered births

Both parents are normally registered on a baby's birth certificate. Sole registration of a birth (where only the mother and not the father is registered) is usually considered to be an indication of the social exclusion status of the mother, i.e. that she is single and unsupported. Research undertaken by the London Health Observatory (2001) has shown that babies born to women who registered their baby without a partner experience higher infant mortality than those babies born to women who registered their baby with a partner.

Approximately 7% of births are sole registered in Lancashire, which is in line with the national average. This may indicate 936 infants who face immediate disadvantage. The districts with higher rates of sole registration appear to highlight a link with socio-economic deprivation: Burnley, Preston and Rossendale. Ribble Valley has the lowest rate of sole registrations, supporting this pattern linked with deprivation. Pendle is the only notable exception as it is a deprived district but only 5% of births are sole registered. In this case, the large ethnic minority community may be a mitigating factor for deprivation and its link with sole registered births.

Table 40: Sole registered births, 2004 to 2008

	2004		2006		2008	
	No.	%	No.	%	No.	%
ENGLAND	44232	7.2%	44488	7.0%	44404	6.6%
Lancashire	961	7.3%	887	6.7%	936	6.7%
Burnley	120	10.4%	94	8.0%	103	7.8%
Chorley	78	6.2%	58	4.8%	66	5.3%
Fylde	31	5.2%	34	5.8%	32	5.0%
Hyndburn	72	6.5%	75	6.6%	82	7.0%
Lancaster	106	7.9%	89	6.4%	114	7.6%
Pendle	76	6.5%	75	6.1%	68	5.1%
Preston	160	9.0%	168	8.8%	153	7.9%
Ribble Valley	18	3.4%	17	3.5%	19	3.8%
Rossendale	57	7.0%	53	6.3%	69	7.8%
South Ribble	51	4.2%	62	5.2%	72	5.7%
West Lancashire	107	9.0%	91	8.0%	93	7.4%
Wyre	85	8.3%	71	6.9%	65	6.6%

Source: ONS VS2

Low Birth Weight

Low birth weight is the single largest determinant of infant mortality. However, a higher risk of infant mortality is not the only consequence of low birth weight. It is thought that it can also cause childhood asthma and lead to deficits in growth and cognitive development. In addition, it possibly contributes to diseases in adult life including diabetes and heart disease. The current UK policy context, with its emphasis on combating health inequalities at an intergenerational level, seeks to give every child a healthy start in life. As low birth weight is a leading cause of infant mortality, (discussed in the [early years](#) chapter) preventing or reducing the impact of it is an important policy objective (Lancashire Profile 2010).

Low birth weight varies widely according to socio-economic status and is more prevalent among lower socio-economic groups. The social gradient is also paralleled, and often confounded by, marked ethnic differences in low birth weight prevalence. The main risk factors for the social gradient in low birth weight are nutritional status of the mother, smoking in pregnancy, substance misuse, low uptake of prenatal care and psycho-social factors causing stress and depression (NICE 2003).

The numbers and proportions of low birth weight live births have fallen across Lancashire between 2001 and 2008, bringing Lancashire in line with the national average. There were 1,021 low birth weight live births in 2001, a number which had reduced to 989 in 2008. These reductions have been experienced in each district but Pendle and Preston continue to have rates above the national and Lancashire averages. Both districts also have high rates of infant mortality, although the rate is highest in Pendle (see [infant mortality](#) section in early years chapter).

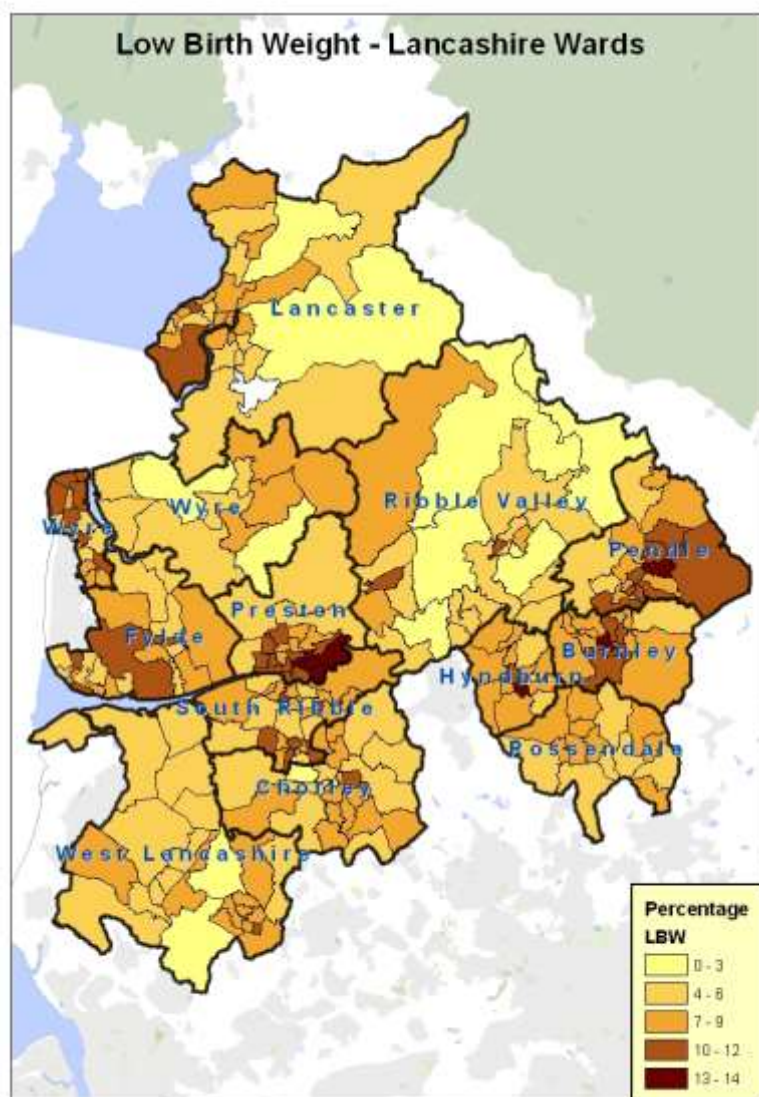
Full numbers of low birth weight live births by district are in the data [appendix](#).

Table 41: Percent of low birth weight (<2500g) live births, 2001-2008

	2001	2002	2003	2004	2005	2006	2007	2008
England and Wales	7.6	7.7	7.7	7.6	7.5	7.6	7.2	7.2
Lancashire	8.4	8.2	8.3	7.7	8.4	8.4	7.3	7.1
Burnley	9.3	9	10	10	11.9	9.8	7.5	7.5
Chorley	7.5	7	7	6.2	6.6	7.9	7.2	5.4
Fylde	6.5	7.2	5.6	5	7.6	8	6.1	5.8
Hyndburn	10.4	10.1	8.9	10	8.8	9	6.3	7.2
Lancaster	6.8	7.3	8.1	6.9	6.8	6.7	6	6
Pendle	10.2	8.5	10.3	8.5	9.7	9.2	10.1	8.5
Preston	10.3	9.6	10	8.8	10.6	11.2	9.4	10
Ribble Valley	5.8	6.6	7.3	5.9	5.9	2.9	6	5
Rosendale	7.6	8	7.9	7.1	7.5	6.8	7.3	6.2
South Ribble	7.9	7.3	7.1	6.4	7.9	8.6	5.9	7.3
West Lancashire	7.8	8	6.6	7.2	5.8	7	6.2	6.4
Wyre	7.7	8.2	7.4	7.5	9	8.6	7.3	6.2
Source: ONS VS1								

The figure below shows the geographical distribution of low birth weight according to electoral ward of residence of mother.

Map 17: Distribution of low birthweight births by electoral wards in Lancashire County, 2004-08



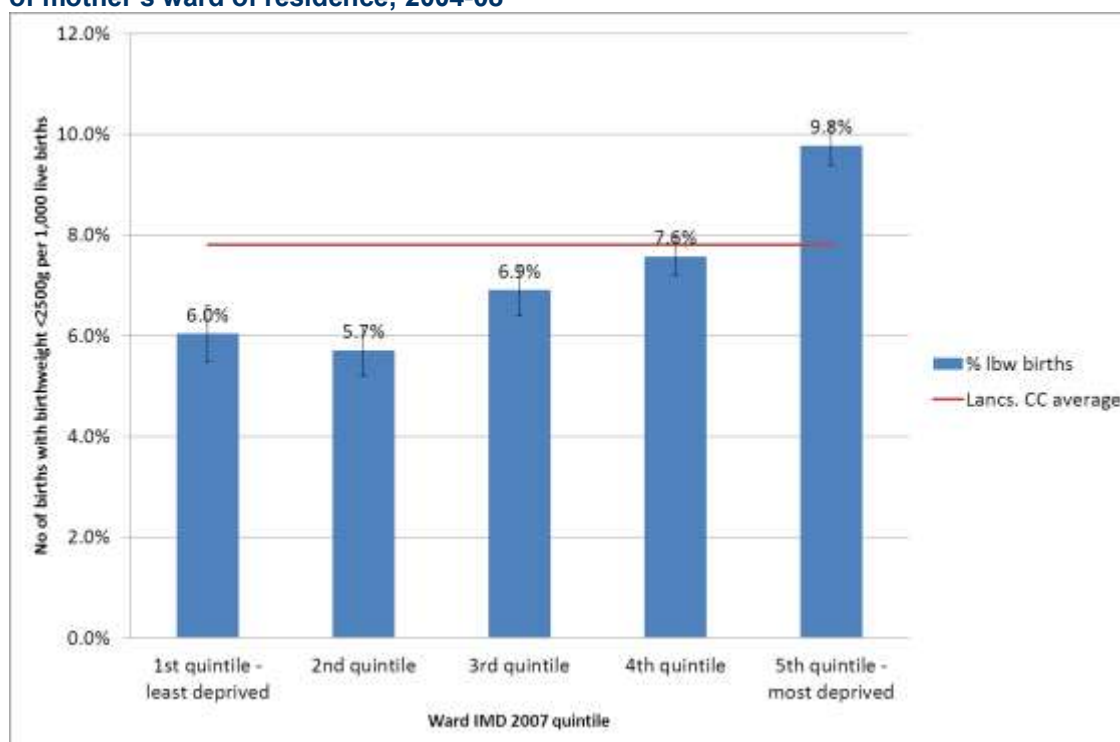
Fourteen electoral wards in Lancashire County experience statistically significantly higher percentage of low birthweight births relative to the County as a whole. These are listed below.

Table 42: Electoral wards in Lancashire with a statistically significantly higher proportion of low birthweight (<2500g) births compared to the County average; 2004-08

Ward	District
Daneshouse with Stoneyholme	Burnley
Rosehill with Burnley Wood	Burnley
Trinity	Hyndburn
Church	Hyndburn
Spring Hill	Hyndburn
Bradley	Pendle
Southfield	Pendle
Waterside	Pendle
Deepdale	Preston
Fishwick	Preston
Ribbleton	Preston
St George's	Preston
St Matthew's	Preston
Town Centre	Preston

The figure below shows the percentage of low birth weight births according to the deprivation quintile of the electoral ward of residence of the mother, confirming the link between socio-economic status and low birth weight.

Figure 35: Percentage of low birthweight births (<2500g) according to deprivation (IMD 2007) quintile of mother's ward of residence; 2004-08



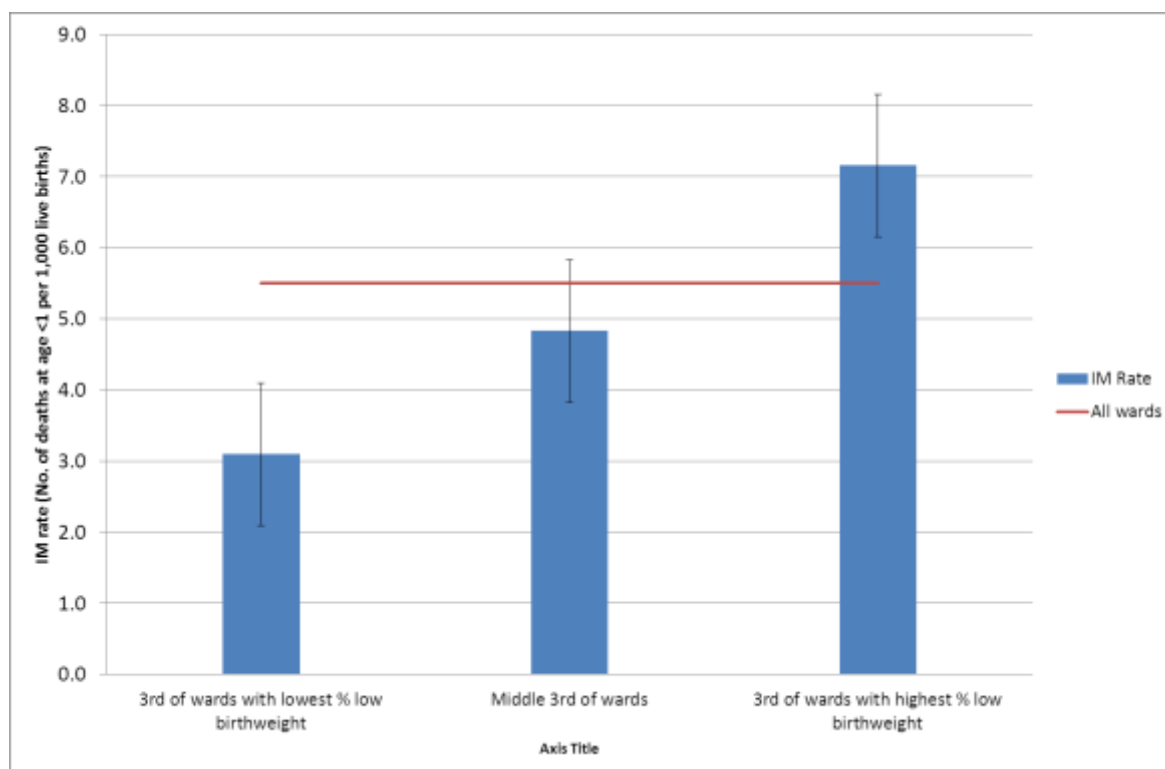
The trend is towards an increase in the proportion of low birth weight births as deprivation increases. The percentage of low birthweight births among the most deprived quintile is 60% higher than that of the least deprived quintile and this difference is statistically significant.

It is notable that the percentage of low birthweight births in the least deprived quintile is higher than in the 2nd most deprived. However, this difference is not statistically significant and could therefore simply be the result of chance variance.

As noted above, in addition to being associated with socio-economic status, low birthweight is an important risk factor associated with infant deaths. In the figure below wards have been divided into thirds on the basis of the percent of births classified as low birth weight and an infant mortality rate has been calculated for each third.

The infant mortality rate for the third of wards with the highest rate of low birthweight births is twice as high than among the third of wards with the lowest rate of low birthweight births and this difference is statistically significant.

Figure 36: Infant mortality rate according to high, medium and low percentage of low birthweight (<2500g) births; Wards in Lancashire County; 2004-08



Antenatal and screening

Ante natal care

All women should access maternity services for a full health and social care assessment of needs, risks and choices by 12 weeks and 6 days of their pregnancy to give them the full benefit of personalised maternity care and improve outcomes and experiences for mothers and babies. Reducing the percentage of women who access maternity services late through targeted outreach work with vulnerable and socially excluded groups will contribute to reducing the health inequalities faced by these groups, whilst also promoting personalised care for all pregnant women.

Low rates of early access could be caused by women not presenting, ineffective referral or booking systems or insufficient numbers of midwives to carry out the assessments. Those who do not access services early are likely to be the most vulnerable women and an increased focus on engaging these women would have benefits for reducing inequalities faced by their children.

It has been difficult to be able to assess the proportion of women receiving prenatal care by 12 weeks of gestation in Lancashire as the national data sources have proved to be unreliable. NHS comparator data was obtained in August 2010 as is shown in the first table below. According to this data NHS Central Lancashire appear to have a low rate of early booking to maternity services, which was questioned. The data was checked from the same source in January 2011 and was

found to be different as shown in the second table. The data now shows a low rate of early access to maternity services in North Lancashire, which was again questioned. It was then suggested that perhaps another data source should be used: data from the Care Quality Commission. This is shown in the third table below and suggests that more than 100% of women in both East and North Lancashire access maternity services by 12 weeks and six days, suggesting that this source is also not valid. It is recommended that these differences be understood and it may be necessary for PCTs to locally measure accurately the levels of non access so that proportionate action can be taken to target these missing women.

The ratio of antenatal admissions not related to delivery is another indicator that local trusts can use to monitor the effectiveness of services. However, the data is again subject to variability. The Department of Health (DH) wants to encourage commissioners and providers to work together to determine what level of antenatal admissions not related to delivery events might be appropriate to meet the needs of their local population.

Table 43: NHS Comparators: maternity comparators by PCT: version 1, 2009/10

	England	SHA	Central Lancashire PCT	East Lancashire PCT	North Lancashire PCT
% seen by midwife by 12 weeks of gestation*	61.9%	55.1%	47.1%	68%	68%
Ratio of antenatal admissions not related to a delivery event	1.04	1.06	0.64	1.36	0.52
Source: NHS Comparators, 2009/10 *based on approx 50% of delivery records with a valid coding					

Table 44: NHS Comparators: maternity comparators by PCT: version 2, 2009/10

	England	SHA	Central Lancashire PCT	East Lancashire PCT	North Lancashire PCT
% seen by midwife by 12 weeks of gestation*	63.0%	55.4%	68.1%	69%	49.2%
Ratio of antenatal admissions not related to a delivery event	1.03	1.05	1.39	0.50	0.66
Source: NHS Comparators, 2009/10 *based on approx 50% of delivery records with a valid coding					

Table 45: Care Quality Commission: 12 week maternity appointments, 2009/10

	Central Lancashire PCT	East Lancashire PCT	North Lancashire PCT
12 week maternity appointments indicator 1	85.2%	102.1%	100.1%

Screening

The UK National Screening Committee (UK NSC) defines screening as “a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition”.

The UK NSC reports that whilst screening has the potential to save lives or improve quality of life through early diagnosis of serious conditions, it is not a foolproof process. Screening can reduce the risk of developing a condition or its complications but it cannot offer a guarantee of protection. In any screening programme, there is a minimum of false positive results (wrongly reported as having the condition) and false negative results (wrongly reported as not having the condition). The UK NSC is increasingly presenting screening as risk reduction to emphasise this point. In addition to in utero screening, further screening takes place after birth, alongside other infection control measures. These are discussed in the chapter on [early years](#).

Down's syndrome

Down's syndrome is a genetic disorder occurring when a baby inherits an extra chromosome and is the most common identifiable cause of learning disability. Approximately one in every 1,000 babies are affected. This figure is similar in all populations and is an overall population risk. The birth prevalence of Down's syndrome increases with maternal age from about 1 in 1,500 under age 25 to about 1 in 100 at age 40. Some of the increase may be accounted for by increased decision to terminate by women of younger age.

The risk is also given as a percentage. A woman with a risk of 1:270 has a 0.37% chance of having a child with Down syndrome or another way is to say that she has a 99.63% chance of not having a child with Down's syndrome.

This means that about 600 babies with Down's syndrome are born each year in the UK. The condition tends to affect male and females equally. It is estimated that there are approximately 60,000 people with Down's syndrome currently living in the UK. In the 1950s, many people with Down's syndrome did not live past the age of 15. However due to a better understanding of the condition and advancements in treatment and care, the average life expectancy of someone with Down's Syndrome is now 60-65 years of age. Most children with Down's syndrome are healthy and there have also been great improvements in the quality of life experienced by people born with the condition. The severity of Down's syndrome symptoms can vary from person to person. Health care treatments and social care services offer a range of support which enables many people with Down's syndrome to live happy and independent lives.

In the NW there were 292 (11.5 per 10,000) Down's syndrome births in 2005-07, of which approximately 46 would be in Lancashire. The annual average number of births with Down's syndrome in Lancashire is likely to be about 14 (given the 1 per 1,000 rate quoted above and the 14,000 annual births). Given the younger age profile of mothers in Lancashire, there may be a reduced risk of Down's syndrome at a population level compared to the national average.

Screening for infectious diseases

In August 2003 the DH released the standards *Screening for Infectious Diseases in Pregnancy* for the four infections that are currently included in the UK antenatal screening programmes: Hepatitis B, HIV, Syphilis and Rubella.

There are generic standards at "Trust/Strategic Health Authority" level, at clinic level and at laboratory level. Some data is available to help monitor testing activity and the numbers of infections detected. However nationally it is recognised that further data items are required, in particular to promote a population perspective, as data currently is available only by provider trust and without a true denominator of eligible women.

Hepatitis B

This is a viral infection of the liver which in many cases does not cause any symptoms. The purpose of screening is to identify women who carry the virus so that babies at risk of infection can receive a course of vaccine following birth.

HIV

This is the virus which causes AIDS. Identification and treatment of pregnant women with HIV can significantly reduce the risk of the virus affecting the baby and can also benefit the mother's health.

Rubella

Rubella (German measles) is an airborne virus which usually causes a very mild infection. However if the mother is infected in the first 12 weeks of pregnancy it can have serious consequences for the baby's health. The measles, mumps and rubella (MMR) vaccination protects against the virus. The purpose of screening is to identify women who are not protected so that they can be offered the MMR following the baby's birth. This will protect future pregnancies from the virus.

Syphilis

This is a bacterial infection which is usually transmitted during unprotected sex with an affected individual. When acquired in pregnancy syphilis can adversely affect the baby. The condition is rare in the UK and can be cured with antibiotics. This can also treat the infection in the unborn baby if it has been transmitted.

The numbers and coverage rates of those screened for infectious diseases are shown below as are the results of those screenings. The numbers are presented for the hospitals in the wider Lancashire area, which includes Blackburn with Darwen, Blackpool and Southport & Ormskirk, as women from within the county may well attend these hospitals. From those booked into the maternity units based within the wider Lancashire area and tested during 2009 there were 32 cases of hepatitis B, six cases of HIV, 10 cases of syphilis and 408 cases of rubella.

Of those booked into the maternity units the coverage for testing varied. Across all tests coverage was lowest at Burnley General Hospital. The only exception was Rubella testing where coverage was 100%. There may be cultural issues at work in relation to the high ethnic minority population who may not consider screening for the other diseases appropriate. Given the risks involved for infants and the numbers identified by other hospitals, this in an area that merits further investigation.

Table 46: Antenatal screening for infectious diseases – uptake rates by maternity unit, 2009

		Blackpool Victoria Hospital	Burnley General Hospital	Southport & Ormskirk Hospitals	Royal Blackburn Hospital	Royal Lancaster Infirmary	Sharoe Green and Chorley Hospitals	Lancashire
Bookings		2538	2,800	1,604	4,019	1,679	2,798	15,438
Hepatitis B	Tested	2538	2,567	1,557	3,956	1,669	2,750	15,037
	Positive	7	8	0	10	1	6	32
	% positive	0.3%	0.3%	0.0%	0.3%	0.1%	0.2%	0.2%
	Coverage	100.0%	91.7%	97.1%	98.4%	99.4%	98.3%	97.4%
HIV	Tested	2488	2,495	1,566	3,945	1,669	2,729	14,892
	Positive	1	0	0	4	0	1	6
	% positive	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
	Coverage	98.0%	89.1%	97.6%	98.2%	99.4%	97.5%	96.5%
Syphilis	Tested	2538	2,706	1,604	4,002	1,669	2,771	15,290
	Positive	0	4	0	4	1	1	10
	% positive	0.0%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%
	Coverage	100.0%	96.6%	100.0%	99.6%	99.4%	99.0%	99.0%
Rubella	Tested	2538	2,800	1,604	4,019	1,669	2,797	15,427
	AB Negative	160	105	6	98	8	31	408
	% AB Neg.	6.3%	3.8%	0.4%	2.4%	0.5%	1.1%	2.6%
	Coverage	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%	99.9%

Source: Health Protection Agency

Smoking in pregnancy

There is strong evidence that smoking in pregnancy causes complications and creates risks for babies. These risks are shown in the table below. As such, there is a strong drive to support women to stop smoking during pregnancy. There is also a drive to encourage women not to start again once they have become mothers as second hand smoke is linked both to cot death and reduced lung function in infancy. Smoking is linked into the life cycle and is intergenerational – those who live in areas where smoking is "normal" behaviour are more likely to smoke. Mothers who are smoking at the time of pregnancy are likely to smoke following the birth and children are more likely to smoke if their parents smoke, continuing the cycle.

Table 47: Risks from smoking in pregnancy

There is conclusive evidence that smoking in pregnancy causes:	There is substantial evidence that smoking in pregnancy causes:	There is suggestive evidence that smoking in pregnancy causes:
<ul style="list-style-type: none"> • Placental complications • Premature rupture of the membranes • Premature birth • Perinatal death • Reduced foetal growth (low birthweight baby) • Cot death* • Reduced lung function in infancy* 	<ul style="list-style-type: none"> • Ectopic pregnancy • Miscarriage • Reduced rates of breast feeding • Shorter duration of breast feeding • Asthma* • Respiratory symptoms* 	<ul style="list-style-type: none"> • Specific foetal malformations • Predisposition to smoke in later life • ADHD
<p>* These are also caused by exposure to second hand smoke in childhood.</p>		
<p>Source: BMA 2007</p>		

In terms of interventions, the evidence suggests that advice and support tailored for pregnant women have been shown to have only a modest effect on cessation rates and a tendency not to reach those at highest risk. Any universal interventions are unlikely to account for the context within which the woman lives. Those whose lives are troubled and chaotic are likely to use smoking as a coping mechanism and basic messages to quit smoking are unlikely to be effective.

A systematic review suggested that 10% of women still smoking at the time of their first ante-natal visit are likely to stop with usual care but that formal interventions can result in an additional 6-7% quitting (Lumley et al 2001). The frequency of contact with health professionals in the pre-natal period obviously offers increased opportunities for such interventions. Historically this potential, in areas such as GP surgeries, has been under-utilised.

There is consensus that the transition from pregnancy to the post partum period is critical in preventing a relapse as is the absence of a partner who continues to smoke. It is estimated that half of all mothers who ceased smoking during pregnancy resumed within six weeks with over 70%

returning within six months (Dolan–Mullen 1999). Despite this, less emphasis has been given either to the continuation of cessation or cessation by other family members.

Research also suggests that increasing support for smoking cessation during pregnancy and its subsequent maintenance could affect breast feeding rates and suggests a legitimate component of breast feeding support programmes. (Amir and Donath 2002). Women who smoke are less likely to breast feed, which has wider implications for the nutrition of infants (see section on [nutrition](#) in early years chapter).

A synthesis of published interventions designed to reduce children’s exposure to passive smoking suggested that the most effective strategies concentrate on strengthening the parents’ faith in their ability to create a smoke-free environment and on behavioural strategies to achieve this goal (such as smoking outside) rather than focusing merely on stopping smoking altogether (Arborelius et al 2000). This is supported by a recent meta-review (a review which combines the results of several studies with similar research hypotheses), which also finds evidence in favour of interventions delivered by clinicians in both the home and the clinic including information, advice and counselling. A summary of interventions from the literature is provided in the [appendix](#).

In Lancashire during 2009/10, one in five mothers was recorded as smokers at the time of delivery (20.5%), potentially exposing 2,691 infants to the risks outlined above (based upon the total numbers of births). This is far in excess of the national smoking rates of 14.1%. Mothers are most likely to smoke during pregnancy in east Lancashire. Smoking patterns are increasingly socio-economically related with those in the more deprived areas more likely to smoke during pregnancy. The pattern in Lancashire therefore reflects the broad socio-economic differences across the county.

Table 48: Proportion of mothers smoking at the time of delivery, 2004/05 to 2009/10

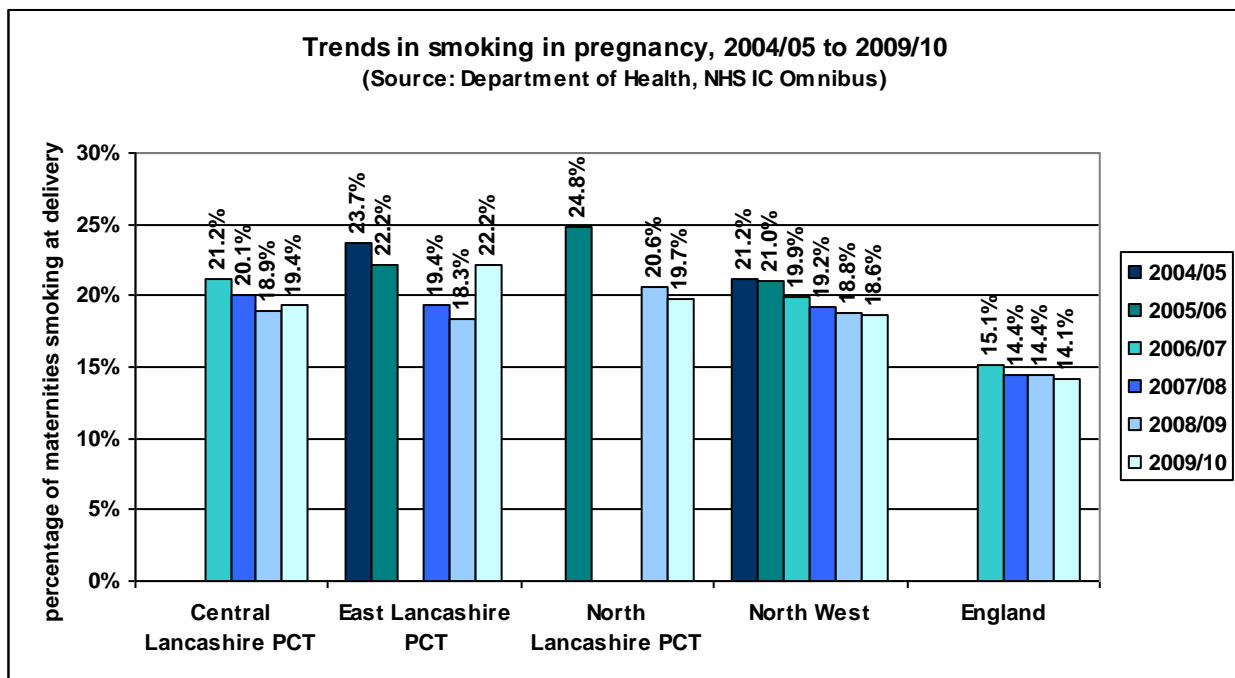
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Central Lancashire PCT			21.20%	20.10%	18.90%	19.40%
East Lancashire PCT	23.70%	22.20%		19.40%	18.30%	22.20%
North Lancashire PCT		24.80%			20.60%	19.70%
North West	21.20%	21.00%	19.90%	19.20%	18.80%	18.60%
England			15.10%	14.40%	14.40%	14.10%
Source: Department of Health, NHS IC Omnibus Missing data is due to quality issues.						

Trend data highlights success in reducing the numbers of women smoking in pregnancy in line with national and regional trends:

- Central Lancashire experienced greater reductions in the proportion smoking at time of delivery between 2006/07 and 2009/10 than experienced at a regional or national level, although the prevalence remains higher than the wider geographies.

- East Lancashire experienced large reductions in the rate until 2008/09 where it fell below the North West average. However, this trend has reversed substantially in 2009/10
- North Lancashire appears to have achieved and sustained large reductions in the rate of smoking in pregnancy from one in four women to one in five between 2005/06 and 2009/10. The rate of change was more than double that experienced at a regional level.

Figure 37: trends in smoking in pregnancy, 2004/05 to 2009/10



Nutrition

Proper nutrition to support the development of infants starts with the proper nutrition of women during and even before pregnancy. Inadequate nutrition can affect the in-utero development of infants. In addition to the balanced diet providing all required nutrients recommended for all people, pregnant women are recommended to take folic acid and vitamin D supplements. To support mothers from low income households, the government offers the Healthy Start programme, which provides expectant mums (and those with children aged under 4) with free vitamins and vouchers for milk, fruit and vegetables (this programme is currently under review by the coalition government).

Overweight and obesity in pregnancy

Improper nutrition leading to maternal overweight and obesity leads to numerous risks for both mother and baby. Women who are obese when they become pregnant face an increased risk of complications during pregnancy and child birth, including the risk of impaired glucose tolerance and gestational diabetes, miscarriage, pre-eclampsia, thromboembolism, and maternal death

(NICE 2010). They are likely to be faced with fewer choices about where and how they give birth, may have a longer or an induced labour, and are more likely to spend time in hospital during their pregnancy because of morbidity during pregnancy and labour related to their weight.

Overweight and obese women are at increased risk of premature births and recent research suggests that they are not protected from having a low birth weight baby, despite widespread belief to the contrary (McDonald et al 2010). Moreover, babies born to obese women face additional health risks including a higher risk of fetal death, still birth, infant mortality, congenital abnormality and macrosomia (Ramachenderan et al. 2008). Babies who are born to obese mothers are born into an obesogenic home, which is linked to increased chance of childhood obesity and obesity in adult life (see the primary chapter for further discussion of [child obesity](#)).

Pre-pregnancy BMI is found to be a greater determinant of healthy outcomes for mothers and babies than any weight that may be gained during pregnancy and it is therefore important to support women to maintain a healthy weight prior to getting pregnant.

Statistics on the prevalence of maternal obesity are not collected routinely in the UK and are unavailable for Lancashire, but trend data from the Health Survey for England show that the prevalence of obesity amongst women of child bearing age in England increased during the period 1997-2007. Women who are obese are significantly more likely to be older in pregnancy, to have had more children, and to live in areas of high deprivation, compared with women who are not obese.

The additional energy requirements of breastfeeding, combined with a healthy diet and moderate exercise may help new mothers to maintain a healthy body weight following giving birth. Women should be encouraged to reach a healthy weight following child birth to prevent additional pregnancies whilst overweight or obese and to protect against the outlined risks for both mother and baby. As with all areas related to mothers and babies, there are a range of partners with a role to play; from doctors to midwives, health visitors to children's centre managers, Public Health professionals to NHS commissioners and local authority leisure services through to slimming and weight management clubs. A summary of the guidance for [healthy weight and nutrition during pregnancy](#) is provided in the appendix.

Summary, identification of key areas of need and recommendations

The prenatal and birth period presents unrivalled opportunities to intervene to improve the life chances of Lancashire's children and young people. The opportunities to support mothers in behaviour change are great and will have profound effects on the development of the infant in utero, but also for the life cycle of the child as a whole into their adult life. Inequalities are passed intergenerationally and the opportunities to engage with women during their pregnancy should be maximised to support them in breaking the cycles of deprivation.

There are some key messages to come out of this chapter. The importance of early access to antenatal care is well understood but the levels of access are not clear across Lancashire's PCTs. If the more favourable data from the Care Quality Commission is to be believed which shows that the PCTs in Lancashire are doing an excellent job in ensuring early access to maternity services, there is still a need to maintain focus on this area as it is such an important phase for the development of children and the opportunities to intervene in the lives of mothers to be.

Low birth weights are overall in line with the national average but there are strong variations across the social gradient and between districts. Low birth weight continues to be an issue in Pendle and Preston. Low birth weight increases with the level of deprivation and there are pockets with high levels of low birth weight. 14 wards are identified in Burnley, Hyndburn, Pendle and Preston with significantly higher rates of low birth rates than the Lancashire average.

Smoking in pregnancy has known detrimental effects for both mother and baby and rates continue to be high in Lancashire with one in five women smoking at the time of birth. Providing support for pregnant women to stop smoking and not restart following the birth should continue to be a priority in Lancashire. This would impact upon the rates of low birth weight and infant mortality as there are established links with smoking. Research suggests that success in reducing smoking amongst pregnant women and new mothers should also have a positive impact upon breastfeeding rates, which provides a range of protective effects for both mother and baby.

Obesity during pregnancy is a current and key topic for public health concern. Mothers who are overweight and obese during pregnancy face complications during pregnancy and child birth, which put their lives at risk. As such, this was identified as a key issue for children and young people during the consultation period for the Children and Young People's Plan. There is currently no data available to be able to monitor the prevalence of maternal obesity in Lancashire and it is recommended that action be taken to ensure it is possible to monitor the rates going forward.

As such, the key issues for children and young people identified in the prenatal and birth period are:

- Early access to maternity services
- Low birth weight babies
- Smoking in pregnancy
- Maternal healthy weight

Specific recommendations

A number of specific recommendations can be drawn from the analysis in this chapter:

- A multi-agency strategy for preconception should be developed so that women and men of child bearing age have the information they need to make informed choices about preparing for pregnancy
- Interventions and services should be tailored to those at greatest risk of adverse pregnancy outcomes (such as low birth weight or infant mortality).
- Further investigation is needed on potential cultural barriers for uptake of ante natal screening.
- Further work is required to ensure support for smoking cessation and smoke free homes during and following pregnancy meets the needs of all communities and family members.
- PCTs should initiate systems for the surveillance of risk during pregnancy such as maternal obesity. Socio-economic status should also be collected to enable the identification of priority groups

Early years – 0 to 4 years

Rapid physical and neurological development takes place in the first months and years of life. During this stage, various risks cumulate and consequences are likely to be severe and irreversible. For example, the risk of death and permanent disability are highest during the first months of life, while the risk of irreversible cognitive impairment is higher in the first years. The environment has a big impact on early years as young children are more impacted by poor air quality and are particularly at risk of accidents in the home if housing is unsuitable. Bonding of mother and child and good parent child relationships are crucial at this stage for healthy development for the ability of children and young people to form relationships throughout life.

Once again, the opportunities to intervene are great. Appropriate nutrition at birth, complemented with psychosocial stimulation and nutrition in early childhood, improve children's subsequent prospects for physical and cognitive development. The Marmot review made giving every child the best start in life the highest priority recommendation. Specific policy recommendations were to increase the proportion of overall expenditure allocated to the early years, support families to achieve progressive improvements in early child development and provide good quality early years education and childcare proportionately across the social gradient.

Key vulnerabilities for this group:

- Since development of the basic cognitive and social abilities takes place in the first few years of life, adverse factors - especially poor diets, infections, and lack of cognitive stimulation - have great potential for causing poor physical and intellectual growth.
- Environmental issues have a great impact including poor air quality which can lead to increased hospital admissions for respiratory conditions and the risk of accidents if housing is unsuitable.
- Difficulties in the bonding of mother and child which can have significant effects on a child's emotional development through to adulthood.

With potential short term outcomes:

- Increased risk of infant and child morbidity and mortality.
- Stunting, slow physical growth, and other manifestations of early childhood malnutrition.
- Lack of socialisation or acquisition of psychosocial skills.

With potential long term outcomes:

- Irreversible effects on physical, emotional and cognitive growth and development.
- Increased likelihood of learning disabilities, poorer school performance, and lower grade attainment.
- Inability to form and maintain personal relationships.

Priority interventions at this stage could include:

- Interventions that support breastfeeding, and introduction to solid foods at six months;
- Interventions that provide prevention and case management of the most important diseases in early childhood; and
- Starting as early as possible during the first two years of life, parenting programme interventions that support parents and communities to provide positive parenting and provide adequate cognitive stimulation to young children, including both community outreach programmes and provision of informal preschool education.

Enabling policies can assist interventions designed to support the optimum development of children and young people. Where issues over safety and difficulty in access act as barriers to children receiving their vaccinations, enabling policies could include the provision of time for parents to discuss their concerns with GPs, ensuring vaccination checks are completed at all appropriate stages and the utilisation of schools or children's centres as vaccination locations to improve access. Where barriers are found to the initiation and continuance of breastfeeding enabling policies may include to target interventions at relevant points, particularly during pregnancy whilst in ante-natal care and to target messages at key influencers, particularly grandmothers and fathers of the baby.

Background information

In terms of robust data, this is the age group about which least is known. Population estimates from the demographics chapter show that this cohort is projected to increase over the next five years. Birth files provide a wealth of information about the 14,000 or so babies born each year, their birth weight and method of birth and the characteristics of their mothers such as their age and whether they were smoking at birth and chose to breastfeed. By the time children reach school the School Census provides a range of information including the level of deprivation where they live and whether they are entitled to free school meals, their ethnicity, first language and whether they

have any special educational needs. However, in between these two sets of comprehensive data there is a lack of information. The Office for National Statistics provides population estimates which provide the best source of information but this is limited to the number of children estimated to be in the age group, which are 67,412. This group accounts for almost a quarter of the entire children and young people population aged 0 to 19 years and there are data gaps that prevent full understanding of the characteristics of this cohort as a whole.

Nutrition

Between the ages of 0 and 4 years old, children grow rapidly and require a broad and balanced diet. This age sets the foundations for the rest of a child's life and, with the exception of the prenatal period, is probably the most important for long term development. A summary of the evidence base, guidance and interventions on [breast feeding and introducing solid foods](#) is available in the appendix.

Breastfeeding

Breast feeding delivers a range of protection for both mother and baby. Babies who are breastfed for a minimum of six months are significantly less likely than other babies to experience colic, constipation, sickness or vomiting, diarrhoea, chest infections and thrush. Propensity to develop these conditions decreases with breastfeeding duration, with babies breastfed for two weeks having a higher than average propensity (WHO 2000).

Babies formula-fed from birth have the highest rate of chest infections and thrush. In addition to providing all the energy and nutrition that a child needs in their first few months of life, breast milk promotes sensory and cognitive development and also promotes bonding between mother and baby, which is vitally important for emotional development. It leads to slower, healthier weight gain, reducing the chance of later obesity. In this way, supporting breast feeding can act as an early intervention to address rising levels of obesity (WHO 2000). Further discussion of [childhood obesity](#) is provided in the chapter on the primary age cohort.

Table 49: Advantages of breastfeeding for baby and mother

For the baby	For the mother
Lower risk of gastrointestinal infections	Cheap
Lower risk of respiratory infections	Convenient, no sterilizing or bottle preparation
Lower risk of atopic disorders	No risk of error in composition
Possibly, higher IQ in preterms	Promotes postpartum weight loss
Lower risk of cot death	Lower risk of breast cancer
Lower risk of heart disease in later life	May promote mother-infant relationship
Source: Blair et al 2003	

Breast feeding rates in England and Wales are lower than those in many other European countries. In particular, Scandinavian countries show very high rates of breast feeding initiation and women in those countries continue breast feeding for much longer than here.

The National Infant Feeding Survey 2005 (Bolling et al 2007) found that rates of breastfeeding have increased nationally over recent years with approximately 80% of women initiate breastfeeding, just under half continuing at six weeks and a quarter breastfeed for the recommended six months, 1% of which are still breastfeeding exclusively by this time. Those most likely to breastfeed are women from managerial and professional occupations, those with the highest educational levels, those aged over 30 and first time mothers. As shown above, the rates in Lancashire are lower than the national rates; approximately 70% initiate breastfeeding and 35% are breastfeeding at six to eight weeks. It stands to reason that the proportion breastfeeding for the recommended six months may be even lower.

The same survey found that 84% of mothers were aware of the benefits of breastfeeding and were able to name at least one. In short, they were aware that "breast is best". Differences in breast feeding behaviour may therefore be less indicative of a lack of knowledge (although this also applies) than of cultural attitudes. The lack of a breastfeeding culture is commonly cited as one of the most significant contributory barriers to women's decisions to breastfeed (DH 2010).

Exclusive breastfeeding drops off significantly after one week and Change4Life (www.nhs.uk/change4life) identifies this as a key time to influence women and to change the trend.

As shown in the tables below, the rates in Lancashire are lower than the national rates. Almost a third of mothers are recorded as not breastfeeding at the time of delivery, which may indicate that a third of babies born, approximately 4,000 each year, are never breastfed. Rates of breastfeeding initiation across Lancashire drop off with fewer mothers continuing with breastfeeding than seen nationally. In 2009/10 35% of mothers continued breastfeeding by the 6-8 week check. This compares with 45% nationally. It stands to reason that the proportion breastfeeding for the recommended six months may be even lower. These figures indicate that in Lancashire, bottle feeding is the 'norm'.

Table 50: Breast feeding initiation at time of delivery across Lancashire, 2009/10

	England	Lancashire	Central Lancashire	East Lancashire	North Lancashire
Number of Maternities	647,372	13,131	5,378	4,797	2,956
Number known to be breast feeding	471,088	8,982	3,597	3,360	2,025
% breast feeding	73%	68.4%	67%	70%	69%
Number known not to be breast feeding	167,828	4,114	1,781	1,430	903
% not breast feeding	26%	31.3%	33%	30%	31%
Breast feeding status unknown	8,456	35	0	7	28
% unknown breast feeding	1.30%	0.3%	0%	0.10%	0.90%

Source: Department of Health, Vital Signs Monitoring Return

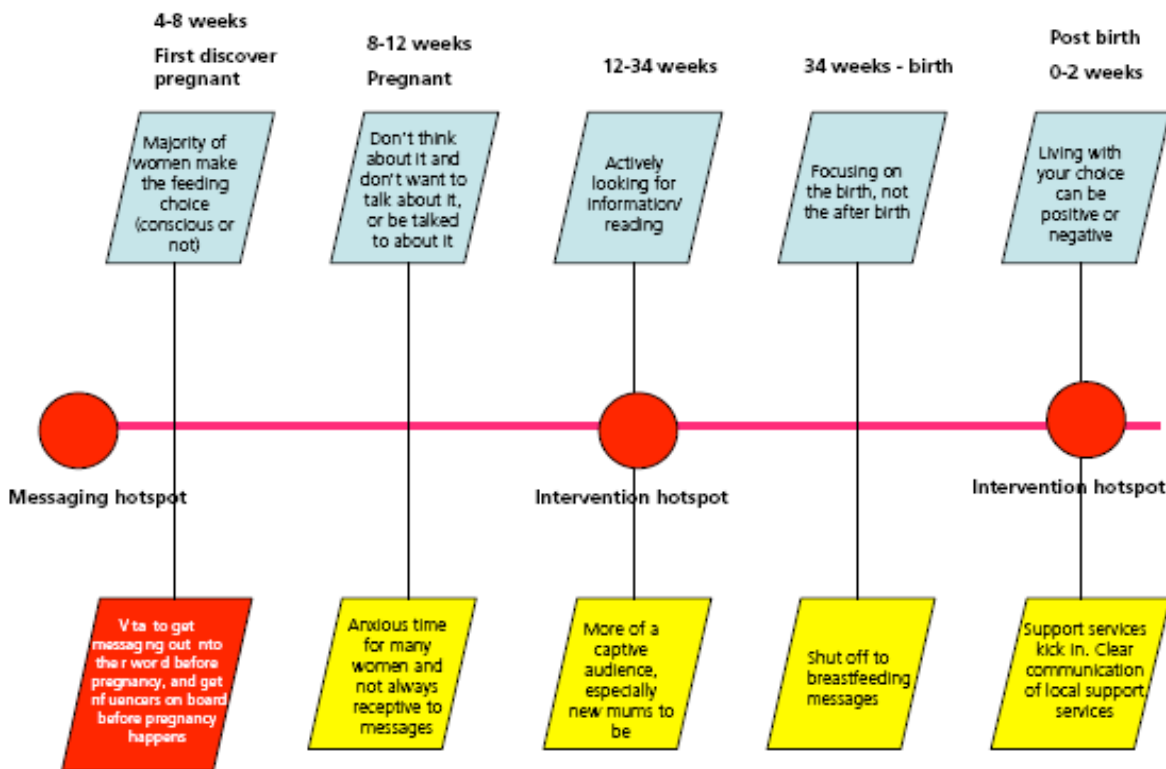
Table 51: Breast feeding continuation at 6-8 weeks, 2009/10

Health area	Number of infants due for 6-8 week check	Children being totally breastfed at 6-8 weeks	Children not being breastfed at 6-8 weeks	Children receiving both breast milk and infant formula	Children whose breast feeding status is unknown	Prevalence: % of children being breastfed (with or without complement) at 6-8 week check	Coverage: % of children with a breast feeding status recorded
Central Lancashire	5,360	1,257	3,076	1,722	562	32.1%	90%
East Lancashire	4,954	1,431	2,889	1,957	108	39.5%	98%
North Lancashire	3,187	854	1,940	1,083	164	34.0%	95%
Lancashire	13,501	3,542	7,905	4,762	834	35.3%	94%
England	655,208	205,235	303,152	294,082	57,964	44.9%	91%

Source: Department of Health, Vital Signs Monitoring Return

It is essential to educate and build awareness in mothers, and those who support them, so that they are equipped to maintain exclusive breastfeeding through the first week – and beyond. The chart below highlights the feeding decision timeline for women and indicates key times for intervention.

Figure 38: Feeding decision timeline

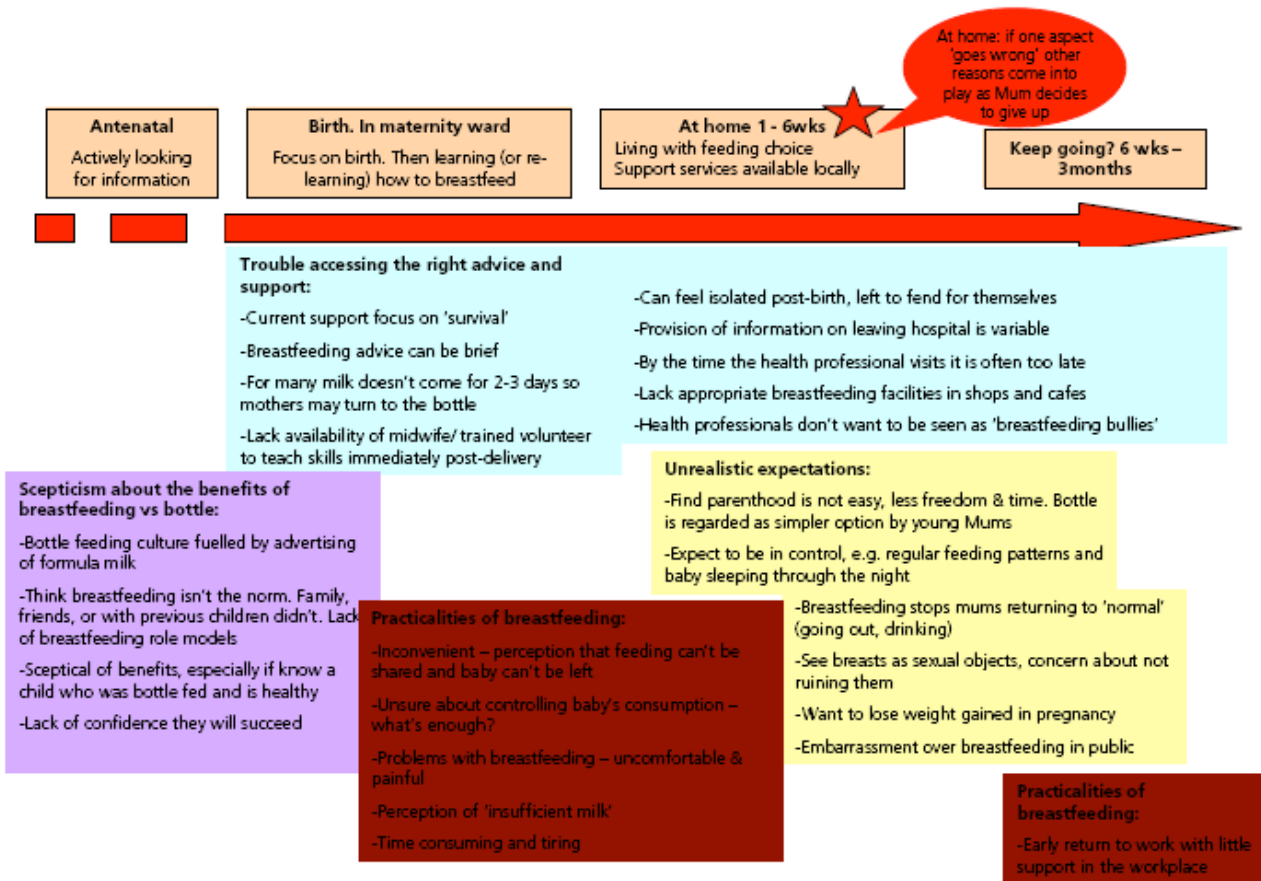


Source: Breastfeeding Research Insight, Great Yarmouth and Waveney Corporate Culture, 2009.

Research has shown that if a mother feels supported and encouraged to continue breastfeeding by all her family and health professionals then she is considerably more likely to still be feeding at six weeks (DH 2010). Qualitative evidence suggests that the lack of a supportive environment is the primary factor why young women from lower socio-economic groups decide not to breastfeed (DH 2010). It is this group who, in the absence of role models, will depend most upon professional services. However, research has found that these services are delivered inconsistently and in some cases offer outdated advice. The Consumer Insight Summary 'Breastfeeding and introducing solid foods' report (DH 2010) states:

"Of all the actions that could be taken to increase breastfeeding continuation, the one most likely to yield positive results is to ensure that mothers, especially unconfident, younger mothers, feel supported, empathised with, able to ask for help and aware of where they can find it".

Figure 39: summary of barriers to breastfeeding



Source: Wandsworth PCT breastfeeding COI and full insight report

Introducing solid foods

The Department for Health recommends that weaning, which is the introduction of solid food, should be delayed until six months. Breast milk should be the sole source of nutrition until then. The 2005 Infant Feeding Survey found a trend towards introducing solid foods later in line with the recommendations: In 2000 85% of mothers had introduced solid foods by four months, but by 2005 this had reduced to approximately half. The survey found that solid foods were introduced earlier by mothers in lower social classes and those with lower educational levels. Their children are at greater risk both of 'growth faltering' (that is they gain weight too slowly) in infancy and obesity in later childhood (NICE 2008).

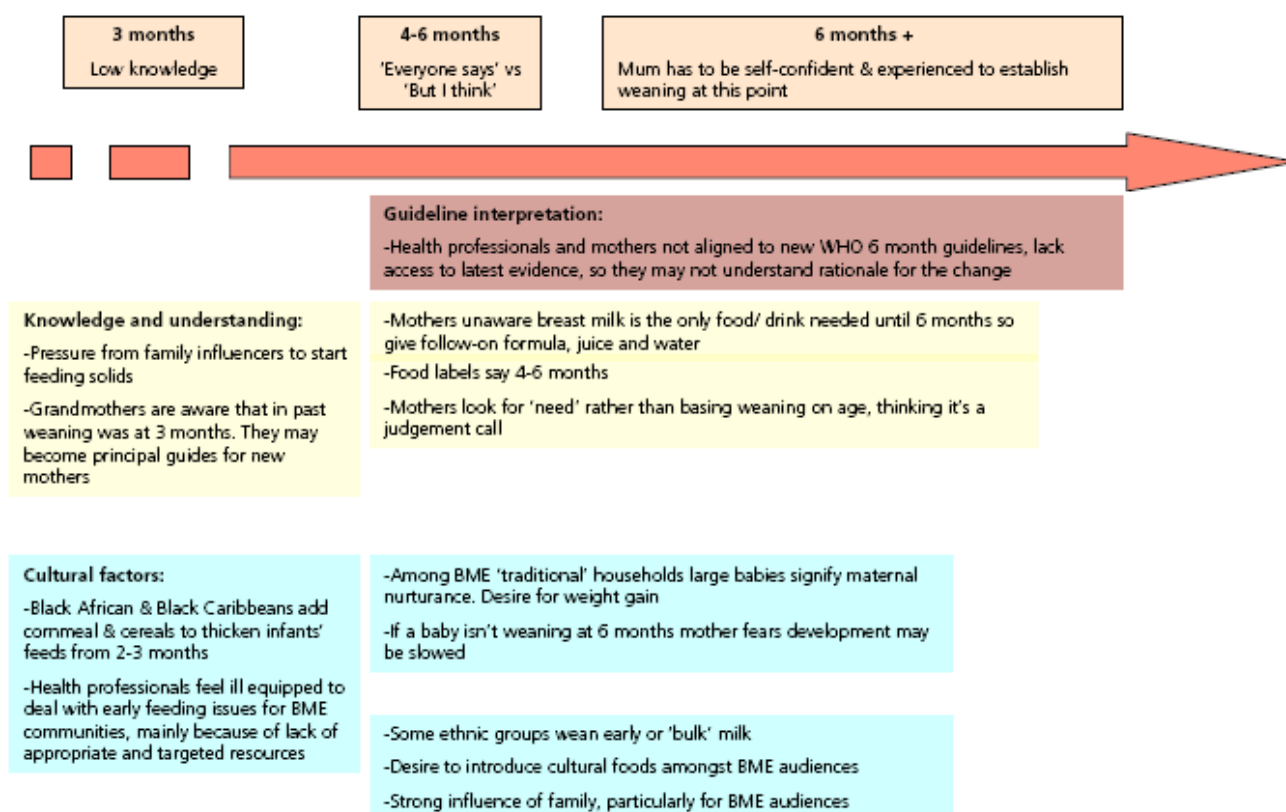
As children progress onto solid food during weaning, their diet needs to include all food groups in appropriate amounts, so that by the end of the first year of life, with help, they are feeding themselves from a suitable range of family foods. Poor nutrition and feeding patterns, developed early in life, may be contributory factors in the development of a range of health problems including diabetes, iron deficiency, anaemia and obesity. These conditions can have adverse consequences for a child's long-term health and development. The previous Government set targets for increasing

fruit and vegetable consumption through the 5 a day campaign and targets for halting the rise in childhood obesity. Childhood obesity is included in the draft public health outcomes framework indicating that it is to continue as a priority for the Government. The Public Health White Paper has outlined a responsibility deal to allow businesses and other organisations to shape the environment and encourage individuals to make better choices.

Insight work from the Start4Life (www.nhs.uk/start4life) campaign highlights that mothers gather their information on introducing solid food from a number of sources and currently this information is inconsistent. Health professionals have been found to view the six month threshold as an ideal and do not promote it vigorously. This may be further complicated by the recent publication in the British Medical Journal of an article stating that babies should be weaned earlier than six months. The Department for Health has commissioned a review of infant feeding which should publish later this year, but advised that the current recommendations of breastfeeding exclusively to six months stand.

Family views and, particularly in ethnic minority families, the perceived health status of bigger babies means that solids can be introduced into milk very early, in some cases as early as two months. Further confusion is added in the supermarket where solid foods are advertised as appropriate for ages younger than six months. Health professionals therefore have a difficult role in providing clear and authoritative messages to support delaying the introduction of solid foods.

Figure 40: Influences of early introduction of solid foods



Source: Define 'Revisiting early feeding research' for COI & DH, Nov 08

Immunisations

Immunisation is an essential part of protecting children's health and that of the community. Low vaccine uptake puts children at risk, particularly in view of high rates of migration from countries that are experiencing a resurgence of certain diseases. Polio has started to re-emerge in Nigeria and diphtheria is increasing in Eastern Europe.

The percentage of children in Lancashire being immunised in accordance with the national vaccination and immunisation schedule by the age of one, is in line or higher than the national and SHA figures.

Table 52: Percentage of children immunised by their 1st birthday, by PCT 2008/09

Health Area	Number of children aged 1	Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib)	Meningitis C
Central Lancashire	5,400	94%	94%
East Lancashire	4,900	93%	91%
North Lancashire	3,200	95%	95%
Lancashire County	13,500	94%	93%
North West SHA	85,700	94%	93%
England	654,200	92%	91%

Source: NHS Immunisation Statistics, England: 2008/09, The Information Centre

By the second birthday, the overall percentage of children immunised in Lancashire is generally better than the England average and the SHA average. The only rates below the national average is the take up of the Diphtheria combined vaccine in central Lancashire and the take up of the MMR vaccine in East Lancashire.

Table 53: Percentage of children immunised by their 2nd birthday, by PCT 2008/09

Health Area	Number of children aged 2	Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib)	MMR	Meningitis C
Central Lancashire	5,300	92%	89%	96%
East Lancashire	4,600	94%	83%	92%
North Lancashire	3,200	97%	89%	96%
Lancashire County	13,100	94%	87%	95%
North West SHA	83,100	95%	87%	94%
England	631,300	94%	85%	92%

Source: NHS Immunisation Statistics, England, 2008/09 The Information Centre

By the fifth birthday, the overall Lancashire position is better than the England average. However, the first and second dose uptake of MMR remains low in East Lancashire, although in line with the national average.

Table 54: Percentage of children immunised by their 5th birthday, by PCT 2008/09

Health Area	Number of children aged 5	Diphtheria, Tetanus, Polio	Hib	Diphtheria, Tetanus, Polio, Pertussis	MMR	
		Primary	Primary	Booster	First Dose	First and second Dose
Central Lancashire	5,100	96%	94%	87%	93%	85%
East Lancashire	4,400	96%	96%	80%	94%	78%
North Lancashire	3,000	97%	97%	89%	94%	87%
Lancashire County	12,500	96%	95%	85%	94%	83%
North West SHA	77,500	95%	94%	85%	93%	83%
England	598,800	93%	91%	80%	89%	78%

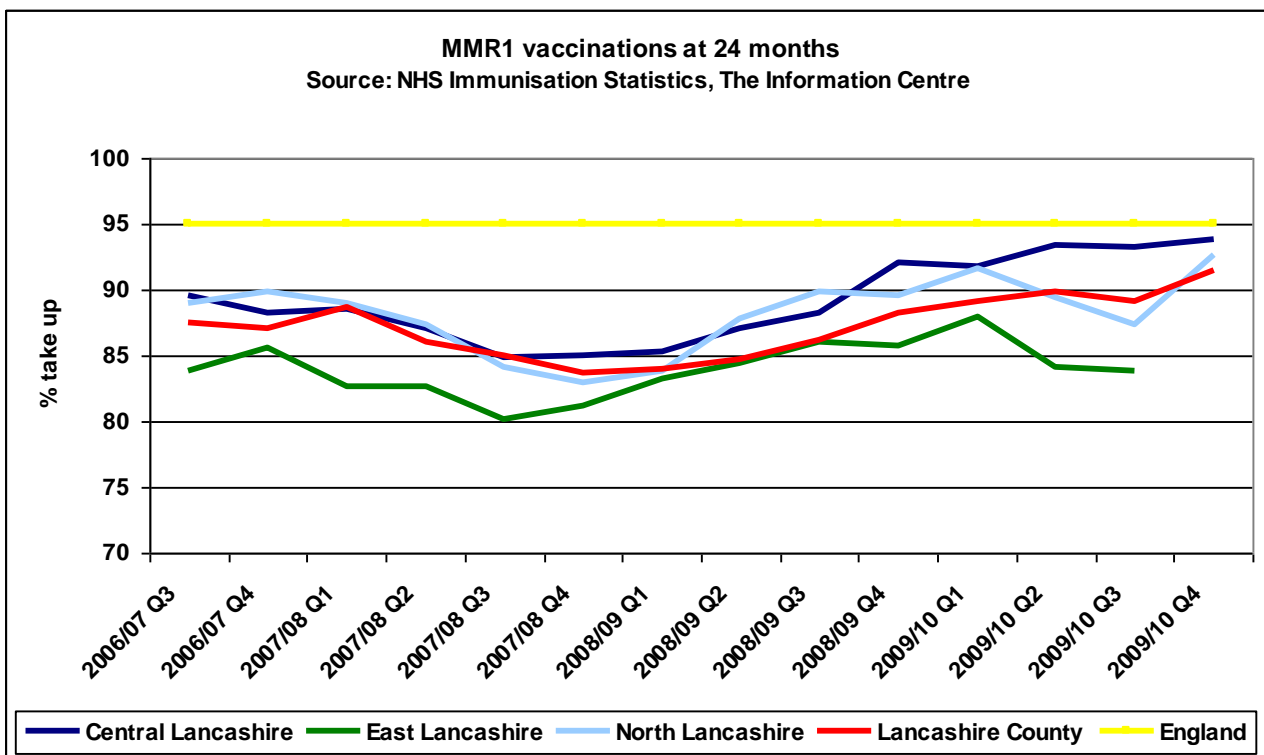
Source: NHS Immunisation Statistics, England, 2008/09 The Information Centre

Outbreaks of measles are increasing in the UK because take-up of the MMR vaccine dropped following a paper published in The Lancet in 1998 asserting a link between the vaccine and autism (which has been disproved by other international studies. Ten co-authors of the 1998 paper issued a retraction in 2004). The rate in Lancashire, whilst recovering, is not at the 95% level recorded by the World Health Organisation (WHO) as being necessary to prevent an outbreak, known as herd immunity.

Table 55: MMR1 Vaccinations at 24 Months

	2006/07 Q3	2006/07 Q4	2007/08 Q1	2007/08 Q2	2007/08 Q3	2007/08 Q4	2008/09 Q1	2008/09 Q2	2008/09 Q3	2008/09 Q4	2009/10 Q1	2009/10 Q2	2009/10 Q3	2009/10 Q4
Central Lancashire	89.5	88.2	88.5	87	84.9	85	85.3	87	88.2	92.1	91.8	93.4	93.2	93.8
East Lancashire	84.1	83.8	-	83.8	85.6	82.7	82.6	80.2	81.2	83.2	84.4	86.1	85.7	88.0
North Lancashire	89	89.9	89	87.4	84.1	82.9	83.8	87.8	89.9	89.5	91.6	89.4	87.4	92.6
Lancashire County	87.5	87.1	88.7	86	85	83.7	84	84.7	86.2	88.3	89.1	89.9	89.1	91.4

Figure 41: MMR1 vaccinations at 24 months



As the figure above demonstrates, rates of up-take of vaccine across Lancashire are variable as regards the MMR vaccination. From the first quarter of 2008/09, the take-up has been lower (and decreasing) in east Lancashire relative to north and central Lancashire. All are below the required level to prevent an outbreak.

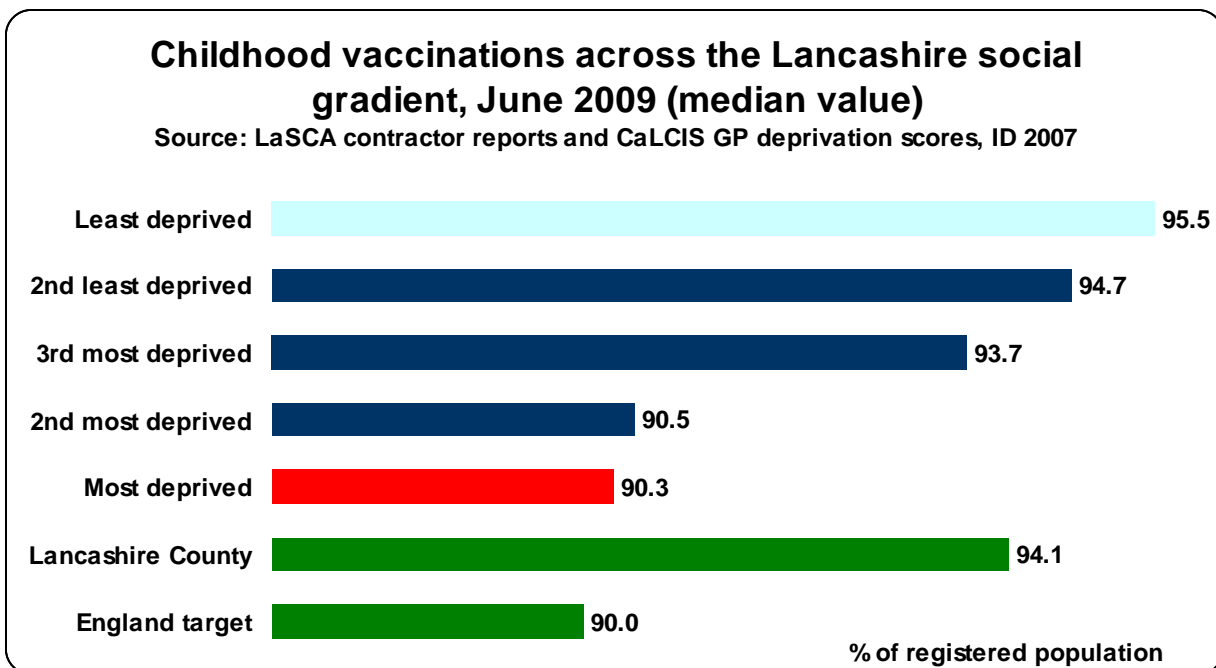
NICE Public Health guidance 21 (2009) has been published advising on practice to reduce differences in the up-take of immunisation, including targeted vaccinations among children and young people aged under 19 years. A summary of the guidance is provided in the [appendix](#). Those at risk have been identified as including:

Table 56: Those at risk of low up-take of immunisation

- └ Those who have missed previous vaccinations (whether as a result of parental choice or otherwise)
- └ Children who are looked after
- └ Those with physical or learning difficulties
- └ Children of teenage or lone parents
- └ Those not registered with a GP
- └ Younger children from large families
- └ Children who are hospitalised
- └ Those from a minority ethnic group
- └ Those from non-English speaking families
- └ Vulnerable children, such as those whose families are travellers, asylum seekers or are homeless

Analysis undertaken for the joint strategic needs assessment of health inequalities in Lancashire (Lancashire JSNA 2009) examined the proportion of children receiving the recommended package of vaccinations and immunisations. Lancashire exceeds the national recommended target for childhood vaccinations and immunisations of 90% indicating a high take up within the registered population. However, there remains a social gradient with rates lowest in the most deprived areas. If a child is not receiving their vaccinations and immunisations it is likely they will be missing other services which could be important for maintaining their wellbeing.

Figure 42: Childhood vaccinations across the Lancashire social gradient, June 2009



In addition, there is a social gradient to the numbers of GP surgeries who are not reaching the national target. With every step down the social gradient from least deprived to most deprived there is an increasing number of practices not achieving the national target. .

Table 57: GP practices not achieving the national target of 90% across the social gradient, 2009

Numbers of GP practices not achieving the national target of 90% across Lancashire's social gradient, June 2009	
least deprived	3
2nd least deprived	4
3rd most deprived	8
2nd most deprived	9
most deprived	10
Total	34

Newborn screening

NHS Newborn Blood Spot Screening Programme

This programme provides routine screening for all newborn babies for five conditions, as outlined in the table below. All newborn babies should be screened within the first week of birth, although the blood spot test can be undertaken up to one year of age. Cystic fibrosis is the only exception as the condition cannot be tested for beyond 8 weeks. The test is usually carried out 5 to 8 days after birth when a heel prick test is undertaken in order to collect drops of blood onto a blood spot card, which is then assessed at a laboratory.

Table 58: Conditions routinely screened for in all newborn babies

Condition	Occurrence	Health Problems	Treatment
Phenylketonuria (PKU)	Affects 1 in 10,000 babies (potentially 1 or 2 babies per year in Lancashire)	Inability to breakdown phenylalanine (an amino acid in protein). Untreated babies can develop serious, irreversible mental disability.	Early treatment (within 21 days of age) with strictly controlled diet prevents disability
Congenital Hypothyroidism (CHT)	Affects 1 in 4,000 babies (potentially 3 or 4 babies per year in Lancashire)	Babies with condition do not have enough thyroxine. Untreated babies develop serious, permanent mental and physical disability	Early treatment (within 21 days of age) with thyroxine tablets prevents disability
Sickle cell disorders(SCD)	Affects 1 in 2,500 babies (potentially 5 or 6 babies in Lancashire per year)	Red blood cells become sickle shaped. Causes pain, tissue damage, infection and even death.	Early treatment (within 2 months of age) through immunisations and antibiotics, and parental education improves health and prevents deaths.
Cystic Fibrosis (CF)	Affects 1 in 2,500 babies (potentially 5 or 6 babies in Lancashire per year)	Affects digestion an lungs, babies fail to thrive	Early treatment with diet, medication and physiotherapy –improves health but does not prevent progression of condition
Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)	Affects 1 in 10-20,000 babies (potentially 1 baby in Lancashire per year)	Cannot breakdown fat to make energy for body. Serious and life-threatening if baby not feeding or unwell.	Treatment to prevent metabolic crisis: avoid fasting and monitor frequency of meals. Emergency glucose regime.

Midwifery services are generally responsible for collecting the blood spots from newborn babies. Health Visitors also collect some of the blood spots and some repeat samples. The Newborn Screening Laboratory at Manchester Children's Hospital analyses blood spots from Lancashire born babies, and results are sent to the midwifery services and PCTs' Child Health Records Department (CHRD). The screening programme relies on robust communication systems between the Screening Laboratory, Child Health Records Department, midwifery and health visiting services, as well as primary care.

In August 2008, The UKNSP revised its standards relating to newborn screening which provides a quality assurance and performance management framework. The core standards set out the expected level of performance to deliver an acceptable level of quality; these cover issues from timescales for collecting blood spots through to performance monitoring. PCTs are responsible for ensuring the quality of the screening programme and must take action where a core standard is not being met.

NHS Newborn Hearing Screening Programme

1 to 2 babies per 1,000 in the UK are born with a permanent hearing loss, affecting between 14 and 29 babies per year in Lancashire based upon the annual number of births. NHS Newborn Hearing Screening Programme (NHSP) achieved national coverage in 2006 and targets all babies from birth to 5 weeks of age.

There are two tests available: the Automated Otoacoustic Emission (AOAE) test, where a computer monitors the reactions in the cochlea when an ear piece on the baby's ears produces a clicking sound; or the Automated Auditory Brainstem Response (AABR), where sensors are placed on the baby's head and a computer monitors the response from a baby's brain when clicking sounds are made from headphones on the baby's ears.

There are two different Newborn Hearing Screening Programmes currently being commissioned in Lancashire: one is hospital-based and one is community-based, where tests are undertaken at home by a health visitor or hearing screener. The NHSP has a QA framework for the programme. The NHSP have published Core Requirements which local screening programmes should meet.

NHS Newborn and Infant Physical Examination Screening Programme (NIPE)

This programme aims to identify any health concerns at an early age and all babies are targeted within 72 hours of birth and again at 6 to 8 weeks of age. Whilst physical examinations of babies have been carried out by health professionals for many decades, it was only in 2008 that clear standards were set by the UK Newborn Screening Programme (UKNSP).

This examination, carried out by a health professional (e.g. doctor, nurse, health visitor, midwife) looks at the:

- heart – to pick up heart problems
- hips – to check whether hip joints have formed properly
- eyes – checking the movement and appearance of the baby's eyes to help identify conditions such as cataract
- testes –to see if testes are in the right place
- the baby as a whole

The service is usually provided within maternity services with the 6 to 8 week checks also being undertaken within primary care by GPs and health visitors. PCTs are currently responsible for ensuring the quality of the programme. Standards relating to the physical examination were published in March 2008 which relate to the provision of physical examinations and the timelines for further investigations/referrals where an abnormality is detected. However, due to the standards only recently being produced, it is expected that quality assurance checks will be rolled out.

Maternal mental health

Maternal mental health is an important challenge for commissioners, not least because psychiatric disorders are the leading cause of maternal deaths in the UK. The World Health Organisation states that maternal mental health problems are a significant public health issues as they pose a significant human, social and economic burden to women, their infants and families. Mental health problems can occur during pregnancy but are more common following birth; in fact, suicide is one of the most common causes of maternal death in the year following delivery in developed countries.

Virtually all women are at risk of mental health problems but poverty, migration, exposure to violence, extreme stress and lack of social support are risk factors. During pregnancy, mental health problems may mean a woman is less likely to care for herself or attend ante-natal appointments and may be more likely to engage in risky behaviours. The stress hormones that can be released may have effects for the development of the baby and can lead to low birth weight.

Following the birth, mothers may again not care for themselves properly and this altered mood is likely to affect infants, who are highly attuned to their environment. Mental health problems in the

mother can affect bonding, breastfeeding and infant care and research has highlighted that infants of depressed mothers are less sociable and do not perform as well on intelligence tests at 18 months of age. Maternal mental health problems may also affect older children as they may be neglected, and have slower social, emotional and cognitive development, including higher rates of school and behavioural problems.

The most common form of postnatal disturbance is often referred to as the “baby blues” which is said to be experienced by at least half of western mothers. This usually lasts between 12-24 hours generally occurring between the third and tenth day after the birth but if untreated can last for months (Royal College of Psychiatrists 2010). Depression and anxiety can be measured during pregnancy as well as postnatally. NICE guidance recommends psychological treatment or social support for pregnant women whose lives are significantly affected by depression and anxiety, and the costing guideline estimates prevalence at 2.6 per cent. An incidence figure of 10 per cent of all new mothers is most often quoted for postnatal depression, although studies vary between 3 per cent and 22 per cent. However, it is argued that about half of these cases will never come to medical attention.

Puerperal psychosis (i.e. in the early postnatal period, up to three months after delivery) is a severe and relatively rare form of postnatal mental illness affecting between 0.1 and 0.2 percent of all new mothers. If 10 percent of new mothers experience post natal deprivation and 0.1 per cent of new mothers experience psychosis, the current numbers per district would be as shown in the following table.

Table 59: Maternal mental health

	Births 2008	Post natal depression	Puerperal psychosis
Lancashire	14,035	1,404	13
Burnley	1,323	132	1
Chorley	1,248	125	1
Fylde	643	64	1
Hyndburn	1,165	117	1
Lancaster	1,493	149	1
Pendle	1,335	134	1
Preston	1,947	195	2
Ribble Valley	505	51	1
Rossendale	883	88	1
South Ribble	1,259	126	1
West Lancashire	1,251	125	1
Wyre	983	98	1
Source: ONS VS2			

Parental support programmes can provide mothers with the psychosocial support needed to protect mental wellbeing and can also help to ameliorate any damage caused by maternal mental health problems. A summary of the evidence base on [parental support and education programmes](#) is provided in the appendix.

Infant mortality

Like low birthweight the infant mortality rate, defined as the proportion of children who die in the first year of life, has traditionally been used as an indicator of population health. The effectiveness of health systems is clearly an important factor but infant mortality is known to vary by a wide range of social and biological factors including mothers' age, birth multiplicity, ethnicity and/or country of birth, birthweight, socio-economic position, individual lifestyles and attitudes as well as area deprivation. Consequently these factors may all contribute to geographical variations.

All developed countries have seen considerable progress in reducing infant mortality rates from the level of 1970 when the average was approaching 30 deaths per 1,000 live births. The average today is less than 6 deaths per 1,000 live births, which equates to an overall reduction of over 75%. Around two-thirds of the deaths that occur during the first year of life are neonatal deaths (i.e. during the first four weeks). Congenital malformations, low birth weight of pre-term infants and other conditions arising during pregnancy are thought to be the principal factors contributing to neonatal mortality in developed countries. The large decrease in the rate of infant deaths over recent decades was dominated by the decline in neonatal mortality (in England and Wales for example, from 9.6 deaths per 1,000 live births in 1976 to 3.8 deaths per 1,000 live births in 2000).

With an increasing number of women deferring childbearing and the rise in multiple births linked with fertility treatments, the number of pre-term births has tended to increase. These factors may have contributed to a levelling off or reversal of the downward trend in infant mortality rates in some countries over the past few years. For infant deaths beyond a month (post neonatal mortality), there tends to be a greater range of causes – the most common being birth defects, SIDS (sudden infant death syndrome), infections and accidents.

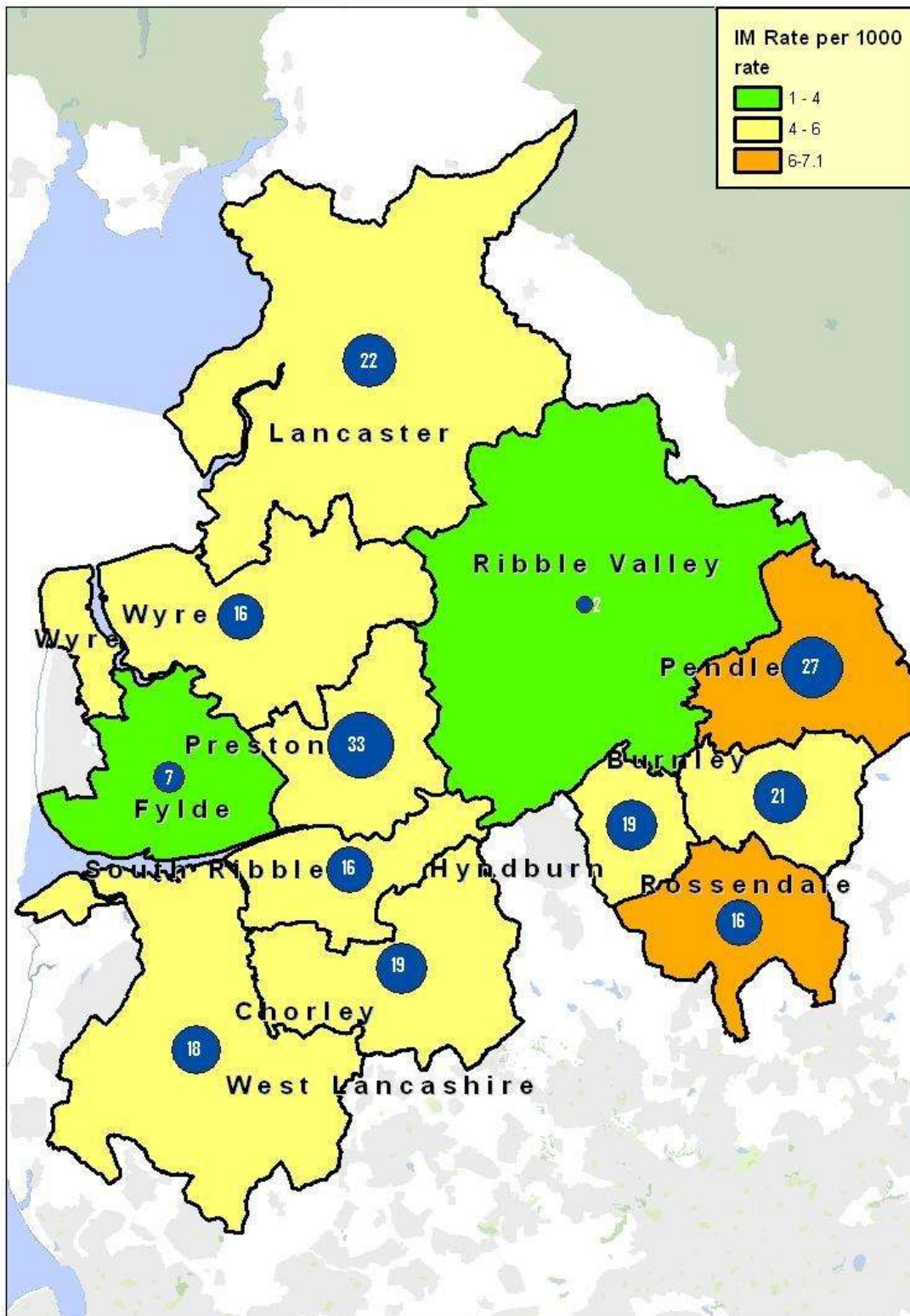
In the latest 3 year period (2006-08) there were 216 infant deaths in Lancashire County. This represented about 16% of the North West total or 2.3% of the England total. According to district, the largest number of deaths was recorded in Preston followed by Pendle. Nationally published data show that infant mortality rates have been falling both locally and nationally, but that many districts in Lancashire County remain higher than the average for England. Most recent published data (2006-08) show that the highest rates in Lancashire occur in the districts of Pendle and Rossendale, and the lowest in Ribble Valley and Fylde.

Table 60: Infant Mortality rates (number of infant deaths per 1,000 live births), 2000-02 to 2006-08

	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	Rank (1) 06-08	% change 00-02 to 06-08
ENGLAND	5.4	5.4	5.2	5.1	5.0	4.9	4.8		-11%
NORTH WEST	5.8	5.7	5.6	5.7	5.6	5.5	5.3		-9%
Burnley CD	4.8	6.9	6.4	7.3	4.9	5.5	5.6	65	17%
Hyndburn CD	7.1	5.4	6.8	7.7	8.4	8.1	5.6	65	-21%
Pendle CD	10.4	10.4	8.1	9.9	9.4	7.8	7.1	12	-32%
Ribble Valley CD	4.6	3.3	4.6	5.3	4.7	2.0	1.3	324	-72%
Rossendale CD	7.2	6.9	4.0	3.4	2.8	4.9	6.4	25	-11%
East Lancs. PCT				7.2	6.5	6.2	5.7	35	
Chorley CD	5.5	4.4	4.7	3.4	4.1	4.5	5.2	97	-5%
Preston CD	7.3	8.6	8.8	8.6	6.4	6.0	5.8	52	-21%
South Ribble CD	4.4	3.7	2.7	4.1	5.4	5.2	4.4	164	0%
West Lancs. CD	5.2	4.8	5.3	5.1	5.7	5.0	5.0	109	-4%
Central Lancs. PCT				5.7	5.5	5.2	5.2	55	
Fylde CD	3.3	3.9	5.2	4.4	4.4	3.8	3.8	212	15%
Lancaster CD	7.1	7.6	5.7	6.4	6.1	5.2	5.1	103	-28%
Wyre CD	5.4	3.9	4.1	4.1	6.0	7.2	5.4	78	0%
North Lancs. PCT				5.2	5.7	5.5	4.9	66	
Lancs. County				6.1	5.9	5.7	5.3	6	
(1) Ranking out of 326 local authorities in England when sorted in descending order of the infant mortality rate. PCT ranking out of 152 PCTs. Lancashire County ranking out of 34 county councils. A ranking of 1 indicates the highest rate of infant mortality.									
Source: NCHOD									

The geographical distribution of the district level numbers of infant deaths and infant mortality rates are represented on the map below.

Map 18: Distribution of Infant Mortality (Numbers and Rates) according to districts in Lancashire County; 2006-08 pooled data.



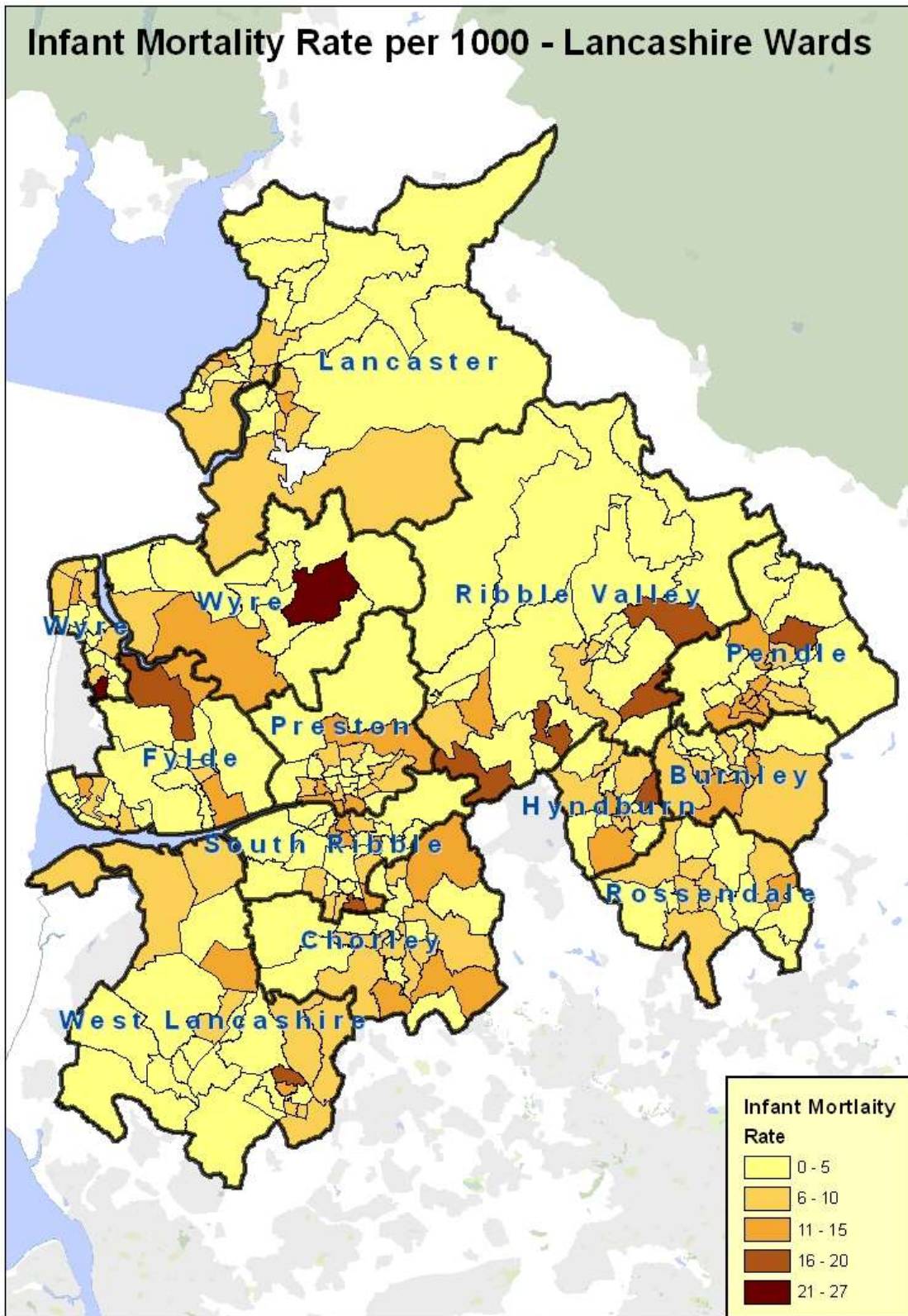
Source: NCHOD

(The size of the circle represents the number of infant deaths, also given by the number inside the circle. The colour of a district gives the rate of infant deaths per 1,000 live births)

A more detailed local analysis of infant deaths (aged less than 1 year) and live births occurring in the 12 districts of Lancashire County over the five year period 2004-08 found that:

- The majority (49%) of infant deaths occurred during the early neonatal period (i.e. between birth and 6 completed days of life)
- The infant death rate in male infants was significantly higher compared to females (6.2 per 1,000 compared with 4.7 per 1,000 respectively)
- Extreme immaturity was the most common cause of death in infants (23.8% of all deaths). This was closely followed by congenital malformations (22.0%) and then by respiratory disorders (14.3%).
- The vast majority of infant deaths occurred in the hospital setting, with only 1.9% recorded as having occurred at home.
- There was wide variation between electoral wards in infant mortality rates due, in part, to the small number of deaths per ward. Only Central ward in Hyndburn had a statistically significantly higher rate than the Lancashire average.

Map 19: Infant mortality rate according to electoral ward of residence of mother; wards in Lancashire County, 2004-08 pooled data



- The infant mortality rate at electoral ward level had a tendency to increase with:

- increasing deprivation (as measured by the 2007 Index of Multiple Deprivation score)
- an increase in the proportion of low birth weight births
- an increase in the proportion of people of Pakistani ethnic origin in the population, and,
- an increase in the rate of teenage pregnancy

However, all these ward level factors are closely interlinked and so warrant further statistical investigation. The ward level comparisons are also subject to the risk of ecological fallacy. This occurs when a relationship between two variables is found in group data which does not exist at an individual level. If this relationship is not present at the individual level it cannot be said to be causal. The use of individual rather than area level data on ethnicity, socio-economic status, birthweight and maternal age would have been preferable but was not available.

Modelling has been undertaken by the Department of Health and identifies specific actions to reduce the gap in infant mortality at a local level. The results of this work are included in the appendix.

A full analysis of infant mortality across Lancashire is provided in the Lancashire Profile infant mortality article:

http://www.lancashire.gov.uk/office_of_the_chief_executive/lancashireprofile/monitors/infantmortality.asp

Child mortality

During 2005/06 to 2009/10 there were 183 deaths recorded of children aged between ages one and four years. The largest number of these was in Pendle, where 41 deaths accounted for more than a fifth of the Lancashire total.

Table 61: number of child deaths aged 1 to 4 years in Lancashire, 2005/06 to 2009/10

Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Grand Total
Burnley	<5	<5	5	7	5	21
Chorley	<5	5	<5	<5	<5	10
Fylde	<5	<5			<5	6
Hyndburn	10	<5	<5	<5	<5	22
Lancaster	<5	7	6	6	5	28
Pendle	13	8	9	9	<5	41
Preston	<5	<5	<5	5	5	17
Ribble Valley		<5		<5		<5
Rosendale		<5	5	<5		9
South Ribble		<5	<5		<5	6
West Lancashire	5	<5	<5	<5	<5	13
Wyre	4	<5	<5		<5	8
Lancashire	45	37	36	38	27	183

Source: Public Health mortality data provided by CLCBS
Numbers fewer than 5 suppressed for reasons of confidentiality

A large number of the causes of death are listed as symptoms not elsewhere classified and other causes of death, both of which represent deficiencies in coding. Excluding these causes, the largest causes of child mortality in the 0 to 4 years age group are diseases of the nervous system and diseases of the respiratory system.

Table 62: mortality by cause in Lancashire aged 0 to 4 years, 2005/06 to 2009/10

ICD10 Code	ICD10 Description	Nos	%
A00-B99	Certain infectious and parasitic diseases	11	6.0%
C00-C97	Malignant neoplasms	6	3.3%
C81-C96	Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	<5	<5
D37-D48	Neoplasms of uncertain or unknown behaviour	<5	<5
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	<5	<5
E00-E90	Endocrine, nutritional and metabolic diseases	8	4.4%
G00-G99	Diseases of the nervous system	20	10.9%
G40-G41	Epilepsy	<5	<5
I00-I99	Diseases of the circulatory system	9	4.9%
J00-J99	Diseases of the respiratory system	20	10.9%
J10-J18	Influenza and pneumonia	6	3.3%
J20-J22	Other acute and lower respiratory infections	<5	<5
K00-K93	Diseases of the digestive system	<5	<5
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	<5	<5
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	30	16.4%
ZZZ	Other causes of death	53	29.0%
(blank)	Not recorded	<5	<5
Total deaths		183	

Source: Public Health mortality data provided by CLCBS
Numbers fewer than 5 suppressed for reasons of confidentiality

Hospital admissions

Hospital admissions provide a useful source of data for children and young people in Lancashire. Analysis of hospital admissions can inform us about the types of illnesses and injuries affecting children and young people, but it can also provide useful intelligence about the quality of services available to children and young people in the County. This is particularly the case for emergency department attendance rates; it is generally understood that high rates of attendance at emergency departments can indicate that the primary care services are not meeting the needs of the local population, rather than simply indicating a population at higher risk of injury or accident.

Total hospital admissions

Total hospital admissions for children aged less than one year are higher than for any other age group, indicating children at this age have the highest level of need. Children aged less than one year who are resident in Burnley, Hyndburn, Lancaster, Pendle, Rossendale and Wyre are admitted to hospital more frequently than children in other districts, highlighting an inequality within the County.

Rates of hospital admissions have reduced over recent years in Lancashire and according to figures from 2009/10 eleven hospital admissions are expected for every ten children. The picture is not uniform across Lancashire however. There have been large reductions in the rates of hospital admissions in the central Lancashire PCT districts, whilst admissions in most other districts have increased. This suggests some changes to practice in central Lancashire.

Table 63: Total hospital admissions rates per 1,000 population for those aged less than 1 year

Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	1220	1315	1399	1325	1137	-6.8%
Burnley	1585	1264	1458	1644	1696	7.0%
Chorley	823	1234	1388	958	624	-24.2%
Fylde	964	1223	1450	1143	1133	17.5%
Hyndburn	1485	1546	1476	1621	1524	2.7%
Lancaster	1427	1296	914	1301	1556	9.0%
Pendle	1570	1304	1543	1538	1568	-0.1%
Preston	964	1409	1513	1138	701	-27.3%
Ribble Valley	1064	1282	1448	1360	1158	8.8%
Rossendale	1285	1354	1338	1293	1385	7.8%
South Ribble	844	1243	1415	1152	567	-32.8%
West Lancashire	1473	1429	1648	1445	1016	-31.0%
Wyre	1167	1203	1234	1210	1206	3.3%

Source: SUS data provided by CLCBS and ONS midyear population estimates 2005 to 2009

Rates of hospital admission for children aged 1 to 4 years in Lancashire are less than a fifth of those for children aged under one year highlighting a reduction in need as children age. In

Lancashire, rates of admission for this cohort have increased between 2005/06 and 2009/10. Approximately two admissions can be expected for every ten children in this age group. Rates of admission are high but decreasing in Burnley, Pendle and Preston and are high and increasing in Hyndburn.

Table 64: Total hospital admissions rates per 1,000 population for those aged 1 to four years

Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	199	195	202	206	203	2.0%
Burnley	241	195	200	241	224	-7.0%
Chorley	166	179	180	183	183	10.3%
Fylde	143	139	172	149	136	-5.0%
Hyndburn	246	249	231	245	277	12.5%
Lancaster	179	193	208	230	199	11.0%
Pendle	307	252	252	208	226	-26.5%
Preston	225	215	218	226	220	-2.4%
Ribble Valley	153	143	155	161	169	10.5%
Rosendale	184	167	193	202	181	-1.2%
South Ribble	184	203	190	207	218	17.9%
West Lancashire	187	204	197	194	185	-1.2%
Wyre	122	139	181	156	163	33.1%

Source: SUS data provided by CLCBS and ONS midyear population estimates 2005 to 2009

Total hospital admissions by cause

The table below shows the numbers of admissions to hospital by children aged 0 to 4 years resident in Lancashire County by age group and primary diagnosis, 2009/10. There were approximately 14,000 hospital admissions for babies aged less than 1 year and another 14,000 admissions for those aged 1 to 4 years.

District level tables are provided in the data [appendix](#). In children under the age of 1 year the largest admissions are due to factors influencing health status and contact with health services, which needs further exploration as it is not a specific disease and highlights possible coding issues by provider. However, when admissions relating to factors influencing health status and contact with health services are excluded, the highest number of hospital admissions in children under the age of 1 year is due to diseases of the respiratory system.

In children between the ages of 1 and 4 years, diseases of the respiratory systems are responsible for the highest number of admissions and certain infectious and parasitic diseases responsible for the second highest number of admissions.

Table 65: Numbers and percentage of admissions to hospital by children aged 0-4 years resident in Lancashire County by age group and primary diagnosis, 2009/10

ICD10 Code	ICD 10 Description	Aged under 1 year		Aged 1 to 4 years	
		Nos.	%	Nos.	%
A00-B99	Certain infectious and parasitic diseases	1015	8.8%	1368	13.8%
	A00-A09 Intestinal infectious diseases	476	4.1%	616	6.2%
C00-C97	Malignant neoplasms	-	-	265	2.7%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	-	-	212	2.1%
D10-D36	Benign neoplasms	29	0.3%	40	0.4%
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	15	0.2%
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	54	0.5%	98	1.0%
E00-E90	Endocrine, nutritional and metabolic diseases	43	0.4%	119	1.2%
	E10-E14 Diabetes mellitus	-	-	14	0.1%
F00-F99	Mental and behavioural disorders	-	-	-	-
G00-G99	Diseases of the nervous system	56	0.5%	130	1.3%
	G40-G41 Epilepsy	15	0.1%	59	0.6%
H00-H59	Diseases of the eye and adnexa	20	0.2%	202	2.0%
H60-H95	Diseases of the ear and mastoid process	44	0.4%	419	4.2%
I00-I99	Diseases of the circulatory system	21	0.2%	35	0.4%
J00-J99	Diseases of the respiratory system	1855	16.1%	3086	31.2%
	J00-J06 Acute upper respiratory infections	868	7.5%	1739	17.6%
	J10-J18 Influenza and pneumonia	55	0.5%	193	1.9%
	J20-J22 Other acute lower respiratory infections	886	7.7%	484	4.9%
	J45-J46 Asthma	22	0.2%	429	4.3%
K00-K93	Diseases of the digestive system	560	4.9%	833	8.4%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	7	0.1%	335	3.4%
	K35-K38 Diseases of appendix	-	-	7	0.1%
	K40-K46 Hernia	77	0.7%	75	0.8%
	K50-K52 Noninfective enteritis and colitis	144	1.2%	196	2.0%
L00-L99	Diseases of the skin and subcutaneous tissue	110	1.0%	242	2.4%
M00-M99	Diseases of the musculoskeletal system and connective tissue	17	0.1%	150	1.5%
N00-N99	Diseases of the genitourinary system	206	1.8%	350	3.5%
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	19	0.2%	27	0.3%
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1065	9.2%	1149	11.6%
S00-T98	Injury, poisoning and certain other consequences of external causes	212	1.8%	1012	10.2%
Z00-Z99	Factors influencing health status and contact with health services	6206	53.8%	356	3.6%
Total Admissions		14082		14255	

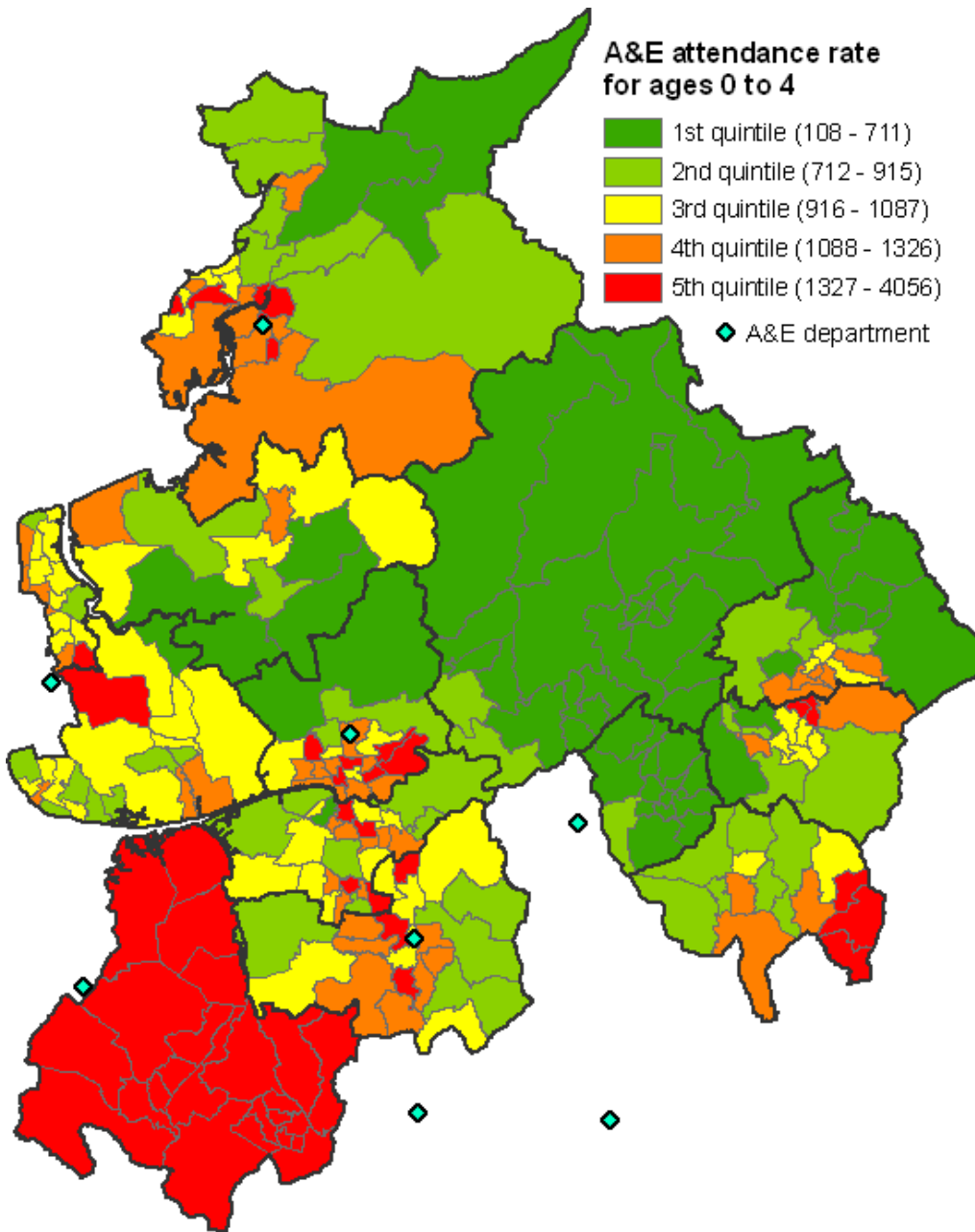
Source: SUS provided by CLCBS (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth) (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth)

Emergency hospital admissions

Rates of attendances at accident and emergency departments are shown in the map below. There is a clear east and west split with extremely high rates of attendance in West Lancashire against very low rates in East Lancashire. In West Lancashire in every ward there were between one and four presentations at emergency departments per child compared to between one and seven per ten children in Burnley and Ribble Valley between 2005/06 and 2009/10.

The proximity to hospitals would seem an obvious explanation for this but there are hospitals in other parts of the county without such high presentation rates at ward level. Other explanations may relate to the primary care system – there may be problems accessing out of hours primary care; or in the more deprived areas there may be populations who do not access health care electively but instead present at hospitals when a perceived emergency arises.

Map 20: Emergency department attendance rate for ages 0 to 4, 2005/06 to 2009/10



Emergency hospital admissions for those aged under one do not appear to be particularly high for West Lancashire, which suggests that there is not an inherent higher level of risk facing children and young people in the area. Emergency hospital admissions in Lancashire have increased between 2005/06 and 2009/10 by almost 15%. Particularly large increases have been experienced in Fylde and Wyre, whilst reductions in the rate of emergency admissions have occurred in Pendle. Similarly for the one to four age group, the admissions rate in West Lancashire is in line with the Lancashire average. Emergency admissions have increased over the period from 2005/06 to 2009/10 by almost 6%. Whilst emergency admissions reduced over the time period in Burnley, Pendle and Rossendale, they increased by more than a third in South Ribble and Wyre.

Table 66: Total hospital emergency admissions rates per 1,000 population for those aged less than 1 year, 2005/06 to 2009/10

Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	402	383	431	441	461	14.5%
Burnley	527	467	503	539	602	14.1%
Chorley	328	301	363	308	409	24.9%
Fylde	201	253	380	331	378	87.8%
Hyndburn	405	457	389	483	496	22.6%
Lancaster	442	422	505	489	499	12.8%
Pendle	532	460	517	485	496	-6.7%
Preston	494	435	447	491	501	1.4%
Ribble Valley	304	306	328	440	418	37.5%
Rossendale	343	353	373	351	399	16.4%
South Ribble	379	357	383	428	425	12.2%
West Lancashire	457	420	533	482	492	7.7%
Wyre	224	221	307	304	356	58.9%

Source: SUS data provided by CLCBS and ONS midyear population estimates 2005 to 2009

Table 67: Total hospital emergency admissions rates per 1,000 population for those aged 1 to 4 years

Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	136	134	136	143	143	5.7%
Burnley	185	144	148	188	171	-7.4%
Chorley	110	122	116	124	127	15.1%
Fylde	82	92	106	101	85	3.2%
Hyndburn	163	175	153	169	173	6.1%
Lancaster	126	140	147	174	148	17.7%
Pendle	220	169	175	160	167	-23.7%
Preston	145	149	144	150	159	10.0%
Ribble Valley	100	102	100	106	120	20.0%
Rossendale	135	108	123	123	126	-6.3%
South Ribble	116	135	129	133	156	34.8%
West Lancashire	136	150	148	146	138	1.5%
Wyre	69	76	98	86	92	34.4%

Source: SUS data provided by CLCBS and ONS midyear population estimates 2005 to 2009

Emergency hospital admissions by cause

The table below highlights the number and percentage of emergency admissions in 0 to 4 year olds by cause. District level tables are provided in the data [appendix](#). In Lancashire during 2009/10, there were 7,514 emergency hospital admissions for babies aged less than one year and 11,046 for children aged 1 to 4 years. In 0 to 4 year olds, diseases of the respiratory system are the responsible for the highest number of emergency admissions, accounting for more than a third of the total. Certain infectious and parasitic diseases are responsible for the second highest number of emergency admissions in this age group, accounting for approximately a fifth of the total.

Table 68: Numbers and percentages of emergency admissions to hospital by children aged 0-4 by primary diagnosis, 2009-10

ICD10 Code	ICD 10 Description	Aged under 1		Aged 1 to 4	
		No.	%	No.	%
A00-B99	Certain infectious and parasitic diseases	1006	19.9%	1346	18.1%
	A00-A09 Intestinal infectious diseases	475	9.4%	609	8.2%
C00-C97	Malignant neoplasms	-	-	21	0.3%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	-	-	15	0.2%
D10-D36	Benign neoplasms	21	0.4%	-	0.0%
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	15	0.3%	73	1.0%
E00-E90	Endocrine, nutritional and metabolic diseases	18	0.4%	47	0.6%
	E10-E14 Diabetes mellitus	-	-	14	0.2%
F00-F99	Mental and behavioural disorders	-	-	-	-
G00-G99	Diseases of the nervous system	36	0.7%	72	1.0%
	G40-G41 Epilepsy	11	0.2%	42	0.6%
H00-H59	Diseases of the eye and adnexa	11	0.2%	55	0.7%
H60-H95	Diseases of the ear and mastoid process	40	0.8%	121	1.6%
I00-I99	Diseases of the circulatory system	16	0.3%	21	0.3%
J00-J99	Diseases of the respiratory system	1833	36.3%	2746	37.0%
	J00-J06 Acute upper respiratory infections	864	17.1%	1611	21.7%
	J10-J18 Influenza and pneumonia	54	1.1%	191	2.6%
	J20-J22 Other acute lower respiratory infections	878	17.4%	478	6.4%
	J45-J46 Asthma	22	0.4%	425	5.7%
K00-K93	Diseases of the digestive system	468	9.3%	411	5.5%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	-	-	26	0.4%
	K35-K38 Diseases of appendix	-	-	7	0.1%
	K40-K46 Hernia	30	0.6%	14	0.2%
	K50-K52 Noninfective enteritis and colitis	141	2.8%	189	2.5%
L00-L99	Diseases of the skin and subcutaneous tissue	93	1.8%	184	2.5%
M00-M99	Diseases of the musculoskeletal system and connective tissue	14	0.3%	104	1.4%
N00-N99	Diseases of the genitourinary system	145	2.9%	191	2.6%
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-	6	0.1%
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	935	18.5%	1025	13.8%
S00-T98	Injury, poisoning and certain other consequences of external causes	204	4.0%	887	11.9%
Z00-Z99	Factors influencing health status and contact with health services	183	3.6%	115	1.5%
Total Admissions		7,513		11,046	

Source: SUS provided by CLCBS (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth) (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth). Groups of less than five have been suppressed and excluded from the total

Road traffic accidents

The age range of birth to five years covers the stage of life in which the child has the lowest level of independent mobility i.e. mainly pre-school. However, of the 708 casualties in the 0-5 years age range between 2005 and 2009, 248 (35%) were injured as pedestrians, 29% of which were killed or seriously injured. Of the others, the vast majority were injured as passengers in vehicles

Table 69: Lancashire 0-5 year old casualties 2005-09

	Numbers and rates
Population (0 to 5 years)	78959
Child casualties	
All child casualties	708
All child Pedestrians	248
Rate of casualty / 1000 population	9.0
Killed and seriously injured	
Killed and serious casualties	89
KSI Pedestrians	72
Rate of KSI per 1,000 population	
Lancashire	1.1
Hyndburn	2.3
Pendle	2.2
Burnley	1.8
Chorley	1.0
Lancaster	1.0
Rosendale	1.0
Preston	1.0
West Lancashire	0.8
South Ribble	0.7
Wyre	0.6
Fylde	0.2
Ribble Valley	0.0

15% of the total number of children and young people killed or seriously injured on the roads were five years old or younger. A fifth of all casualties were for those aged 0 to five, indicating that children in this age group are more likely to experience accidents causing slight injury rather than those which result in death or serious injury.

Research has published in the British Medical Journal (Grundy et al 2009) demonstrates that the introduction of 20 mph traffic speed zones reduced all types of road casualties. The introduction of 20 mph was associated with a 41.9% reduction in road casualties. The reduction was greatest in younger children and greater for the category of killed or seriously injured than for slight injuries. The research found no evidence of casualty migration as casualties also fell in neighbouring areas,

and the researchers were able to conclude that 20mph zones are effective measures for reducing road injuries and deaths. This is already being pursued in residential areas across Lancashire.

See the appendix for a summary of evidence based interventions to reduce [road traffic accidents](#).

Enjoying and achieving

Childcare transition

The majority of women now return to work within 12 months of giving birth. There are numerous drivers for this change. From the side of families this includes delayed motherhood meaning well established carers to return to, but also a large number of families will need the mother to return to work to protect household income. Child care is also promoted by the Government for several reasons. Firstly, they wish women to return to the labour market to boost GDP, secondly, the competitive global economy provides a strong argument for the benefits of early education and finally, child care services are seen as a prop for falling birth rates.

Whilst women returning to the labour market must be seen as a positive in terms of equality, there are risks for children. Evidence shows that what happens in a child's early life is crucial for its development. Research on brain development shows that its structure is formed by experience in the first few days and months of life. Early interactions between babies and their carers have implications for brain development. The quality of these relationships has profound implications for a child's emotional and cognitive development as well as for future mental health.

The secure child is one who is more likely to do well at school, form satisfying relationships, develop a capacity for compassion and empathy and have inherent resilience in the face of adversity. Children who experience poor relationships in their early years with adults who care for them, have a greater likelihood of developing significant mental health problems, conduct disorder and educational difficulties. Once again, this highlights the importance of parental skill and bonding and promotes the use of parenting programmes to support families.

Children's Centres

Children's centres play a pivotal role in the achieving the goal to ensure that every child and young person should have the opportunity to fulfil their potential. Local partners are working together in new ways to deliver services tailored to individual needs and offering ever greater choice and flexibility. Sure Start Children's centres are at the forefront of this work as they transform services for very young children and their families. Children's centres offer universal provision across the country to ensure that every child gets the best start in life. Working with parents from before a child's birth, Sure Start Children's Centres provide services for families including health and family

support services, integrated early learning, full day or sessional care for children from 0–5 years, and advice and information for parents on a range of issues from effective parenting to training and employment opportunities.

Sure Start Children's Centres, along with extended schools, are at the heart of the Every Child Matters (ECM) programme, which was promoted under the previous government, for improving the five ECM outcomes for children and families. Local authorities and their NHS and Jobcentre Plus partners have been working together to improve the five ECM outcomes for all children up to five and reduce inequalities between the most disadvantaged and the rest by ensuring that early childhood services:

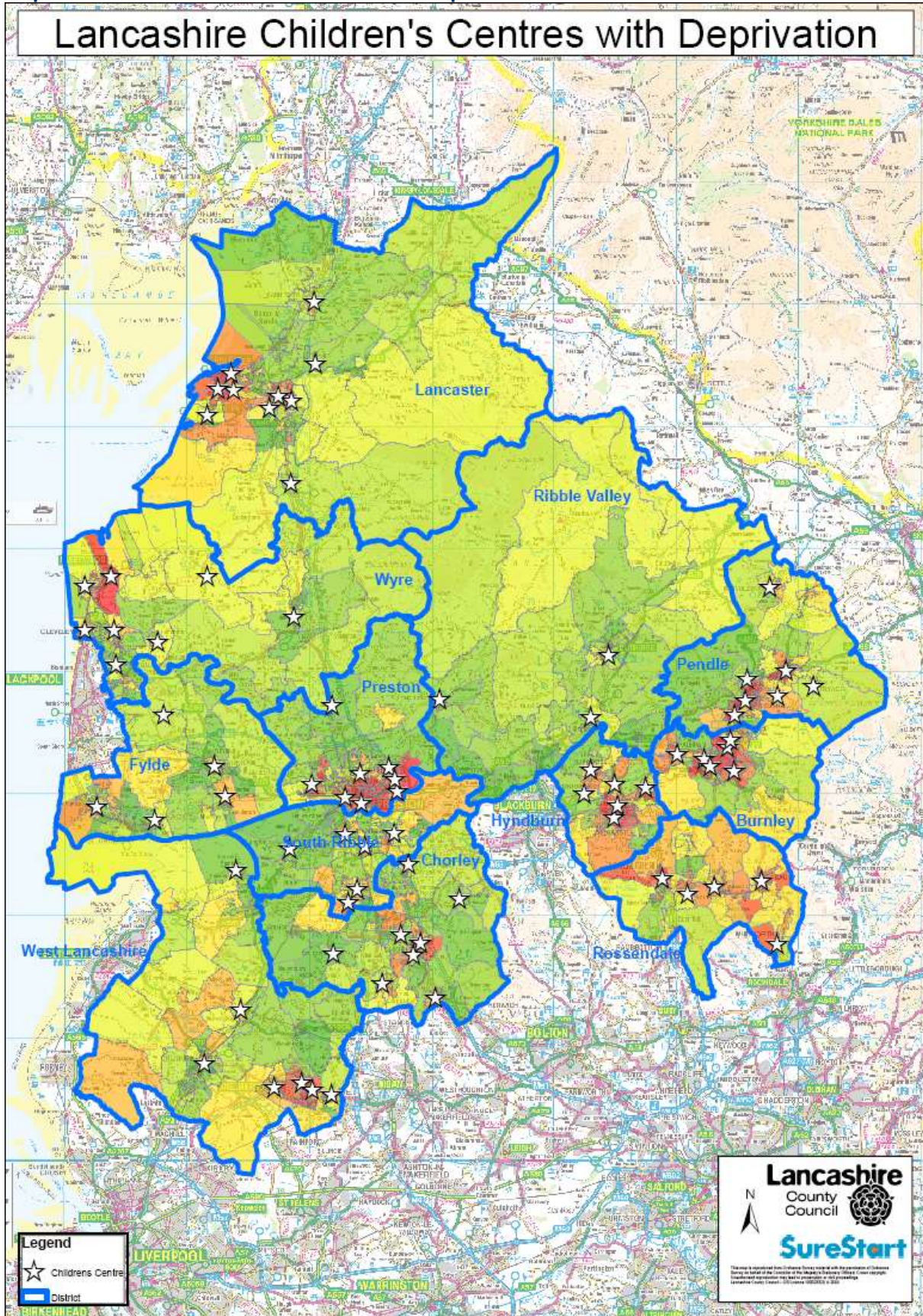
- Are integrated to maximise access and benefits to families
- Reach out to identify and support excluded families

The aim of Sure Start Children's Centres is to improve outcomes for all children but with a particular focus on reducing the inequalities between the most disadvantaged and the rest. They achieve this through:

- Prevention of the factors that limit children's life chances
- Early support, wherever possible before the problems arise
- Ongoing support for those with longer term needs.

As such, Sure Start Children's Centres are a key player in more systematically implementing prevention and early intervention.

Map 21: Lancashire Children's Centres and deprivation



In the most disadvantaged areas centres provide integrated childcare and early education, information and advice, and a range of family and parenting support, outreach, health and

employment services. Elsewhere the range of support they provide varies according to local need. But wherever they are based, children's centres act as a service hub within the community, linking parents and providers of services. They work closely with neighbouring schools, linking with the expanding range of extended services on offer.

Table 70: Children's Centres in Lancashire

District	Children's Centres within Lancashire
Burnley	Burnley Wood
	Ightenhill
	Reedley Hallows Nursery and
	South West Burnley
	The Chai Centre
	Whitegate
Chorley	Adlington
	Astley and Buckshaw
	Brinscall
	Clayton Brook
	Coppull
	Duke Street
	Eccleston
	Highfield
Fylde	Lytham
	Oak Tree
	Pear Tree
	The Orchard
	Weeton
Hyndburn	Copperhouse
	Fairfield
	Great Harwood
	Huncoat
	Mount Pleasant
	Sure Start Hyndburn
Lancaster	Appletree
	Balmoral
	Carnforth
	Firbank
	Galgate
	Heysham
	Lune Park
	Lune Valley
	Poulton
	Westgate
	Pendle
Colne	
Family Tree Centre	
Gisburn Road	

District	Children's Centres within Lancashire
	Pendleside
	Riverside
	Walton Lane
Preston	Cherry Tree
	Preston East
	Preston West
	Ribbleton
	Rural Preston
	Stoneygate
	Sunshine
	Sure Start Riverbank
Rossendale	Balladen
	Haslingden Community Link
	Staghills
	The Maden Centre
	Whitworth
Ribble Valley	Ribblesdale
	Spring Wood
	Willows Park
South Ribble	Bamber Bridge
	Kingsfold
	Longton
	Lostock Hall
	Wade Hall
	Wellfield
West Lancashire	First Steps
	Moorgate
	Park
	St. John's
	Tarleton
	The Grove Youth and Community Centre
	Up Holland
Wyre	Cleveleys
	Fleetwood
	Over Wyre
	Poulton le Fylde
	Rural Wyre
	Thornton
	West View

Monitoring and evaluation of Sure Start Children's Centres

Monitoring and evaluation of Sure Start Children's Centres has been aided by the implementation of the Children's Centres Management Information System (CCMIS). This system collects data at

children's centre level about individual children and adults and what outcomes each of these groups have achieved by accessing the services offered by each centre. The data is formally submitted via the system by each centre every 6 months and from this data, a monitoring outcomes report is produced detailing how each centre is meeting the needs of their reach area and the wider district.

The centres use this data to ensure that services are targeted effectively and Lancashire County Council Early Years Service uses the data as part of the performance management cycle for centres. The monitoring and evaluation data collected is also provided to centres to aid the completion of their self evaluation form and also to help provide quantitative evidence for Ofsted inspections.

Children's centres are a valuable resource for all children and families, particularly those parents, children and families who may require a greater level of support to be able to thrive. Children's centres should be available according to Marmot's principle of progressive universalism so that the greatest level of service provision is available to those who would benefit most from the greater level of support. To confirm this is the picture of provision in Lancashire, it would be appropriate to conduct an equity audit on children's centres across Lancashire. This would allow for analysis of access to children's centres by different groups across the social gradient and whether different groups are meeting the desired outcomes.

Early Years Foundation Stage Statutory Framework

The statutory framework for the Early Years foundation stage is mandatory for all schools and Early Years Providers in Lancashire. Providers have a duty to ensure their provision complies with the learning and development requirements, and the welfare requirements. There is a statutory requirement for Early Years providers to record each child's learning and development and at the end of the EYFS to sum up these achievements in the EYFS profile. The National Indicator target is that each child attains 78 points across the EYFS profile with at least 6 in Personal, Social and Emotional development and Communication Language and Literacy.

Lancashire meets the national average and has done so since 2005/06. Rates of achievement are variable across the districts of Lancashire: the rates of achievement across the EYFS profile are particularly low in Burnley, Hyndburn and Preston. Understanding the gaps in achievement between different groups will aid actions to improve overall achievement.

Table 71: Lancashire children achieving 'a good level of development' in early Years Foundation Stage Profile Teacher Assessments, 2005/06 to 2009/10

	2006	2007	2008	2009	2010
Burnley	38%	37%	41%	37%	43%
Chorley	48%	57%	62%	58%	65%
Fylde	55%	55%	54%	61%	61%
Hyndburn	39%	42%	45%	44%	48%
Lancaster	40%	54%	54%	57%	55%
Pendle	38%	45%	44%	45%	45%
Preston	46%	55%	55%	56%	55%
Ribble Valley	53%	60%	65%	65%	68%
Rosendale	53%	49%	58%	55%	58%
South Ribble	49%	53%	61%	60%	59%
West Lancashire	53%	56%	54%	61%	61%
Wyre	49%	62%	56%	57%	65%
Lancashire	46%	52%	54%	54%	56%
England	45%	46%	51%	52%	56%

The delivery of the core offer within children's centres provides an integrated approach to front line service delivery. Children's centres, schools and other services work together to improve outcomes and narrow the gap. Some examples of how this is achieved are as follows;

- Integrated childcare within centres and the provision of good quality childcare in areas of high deprivation ensure that parents who wish to return to work are supported. Families are supported and individual needs are met at key times including transition. Individual records are kept and transferred to ensure continuity in the child's learning and development
- Family stay and play sessions within the centres and targeted outreach support ensures that children and young people at risk of or already under-achieving are identified and assessed and supported to meet individual need. These sessions and support services adhere to the principles of the EYFS and support early identification.
- Cluster arrangements with local schools and children's centres offer referral pathways to family support and other children's centre services.
- Parental support programmes can be individually tailored and increase parents knowledge of child development.

Healthy Child Programme

Healthy Lives, Brighter futures (DH 2009) and the most recent national child health strategies, the Healthy Child Programme (DH 2009) and Maternity and Early Years (DH 2010) are an integrated approach supporting children and families from early pregnancy through to adulthood. These national strategies make an important contribution to achieving the Every Child Matters outcomes as well as to the National Service Framework for Children, Young People and Maternity Services and feeding directly into The Children's Plan. The aim is to provide strengthened support during

the early years of children's lives and to help parents ensure their children are ready for early year's education, school and later life (DH 2008).

The Maternity and Early Years vision is that the family will be able to make choices about their care during pregnancy and beyond and local services will join up so that families have continuous care and support following birth with a named children's centre contact. Families will be offered more help to prepare for parenthood so they can give their baby the best start in life with new antenatal education opportunities and improved opportunities for fathers to be more involved.

The Childcare Act 2006 places a duty on local authorities to make arrangements to provide integrated early childhood services and on PCTs and others to work with the local authority in carrying out that duty (DH 2009). This is crucial to delivering the Healthy Child Programme.

The delivery of the Healthy Child Programme is intended to promote the health and wellbeing of all children in Lancashire, identifying needs and early intervention. Improvements in outcomes for the most disadvantaged children and families will require the targeting of services, services being co-ordinated around their needs. The focus on early years is intended to ensure that children are given the opportunity to reach their full potential and on entry to school are well prepared for this next stage in the life course.

Healthy Child Programme in Lancashire

Sure Start Early Years and Childcare Service, in partnership with health colleagues, have developed active, practical and innovative early interventions aimed at reducing inequalities in infant mortality rates across Lancashire. All these initiatives are in line with the Healthy Child Programme which is structured on the principle of progressive universalism. Universal services enable early identification of problems triggering interventions to support families and their children. A progressive universal Healthy Child Programme offers a range of preventive and early intervention services for different levels of risk, need and protective factors.

The early interventions include:

- the implementation of the Early Notification System where all children's centres are notified of all local pregnancies;
- an increase in booking clinics and ante natal drop in sessions delivered from the children's centres providing accessible and visible services for pregnant mothers;
- the development of perinatal mental health pathways with children's centres supporting sessions to promote the mental health of mothers in the postnatal period; and

- the creation of a new education and preparation for parenthood programme 'From Bump to Birth and Beyond'.

The Early Notification scheme is the result of looking at how professionals can work together with expectant parents (especially the most vulnerable in the early stages of pregnancy). The midwives complete a notification form at the initial antenatal booking appointment (typically 8 to 12 weeks in to the pregnancy) and with parents' consent the details are shared with local children's centres. Sharing information in this way promotes the work of the children's centres to parents and has helped the staff working from children's centres to make contact with parents and introduce them to the wide range of services and support on offer throughout the pregnancy and beyond in to the child's early years.

An important aspect of the Early Notification has been working with other professionals. The development of the system has promoted the sharing of information. General Practitioners in one area also receive the notifications and it is intended that this practice will be extended across the County. This process is important in the strengthening of partnership working especially in light of future developments and Government initiatives.

The development of perinatal pathways in conjunction with NHS partners has included early, additional support from children's centres for families struggling to cope with a variety of challenges including perinatal mental health issues, isolation and the demands of parenting young children, to prevent these difficulties escalating. This project was developed as evidence based practice, which demonstrates the importance of parent-child attachment and that positive parenting results in better social and emotional wellbeing among children.

'From Bump to Birth and Beyond' is the programme that supports mothers and fathers by providing information at the opportune period, pregnancy, when parents are particularly receptive to learning and making changes. The programme also gives opportunities to engage fathers and strong evidence shows that early involvement of fathers has significant benefits for children's social, emotional and intellectual wellbeing.

Through joint working, sessions have been developed to be delivered in children's centres. The programme is designed to lead to better outcomes for both parent and child in terms of parents' understanding of child development, parenting, breastfeeding and nutrition, the impact on of a new baby in the family, safety aspects, the involvement of fathers and various health aspects of both the child and parent.

Targeted approaches to child development and parental education

Targeted approaches are increasingly recognising the importance of the social context and its influence on child development and parental support. Thus whilst in some instances the immediate beneficiaries are parents and children, the focus is on enhancing professional/support skills so that families as a whole can benefit. Many programmes include a central role for volunteers (mostly volunteer mothers) and draw on parents in various guises (from befrienders, home visitors, trained co-ordinators, project workers) to provide information, support, play and early learning and also deliver community health and social care. Throughout the reviews undertaken of such interventions, there is an emphasis on the family as a whole and parental wellbeing, rather than just a child's behaviour; the development of the role of "interested friends" rather than experts; enhanced training for practitioners in new roles; and the identification of a positive correlation between sustained involvement and functional improvement.

Home visiting has been identified as an important intervention from an inter-generational perspective, capable of producing improvements in parenting, child behavioural problems, cognitive development in high risk groups, a reduction in accidental injuries to children and improved detection and management of post-natal depression (Bull et al 2004). Its potential is further reinforced by evidence from a number of health based programmes aimed at improving ante-natal and post-natal health and child rearing strategies that have also proved capable of empowering families (Butz et al 2001: El Mohandes et al 2003).

A wide ranging evaluation of the Home Start programme extending across three years found volunteer support in the home could usefully extend and complement statutory provision, assisting with parenting difficulties, health problems, isolation and the problems of coping under stress (Frost et al 1996). However there is also a significant problem of non-use, which means that many families may fall through the statutory/voluntary gap (Oakley et al 1998). Not all evaluations are positive (see for example Goodson et al 2000: Gray et al 2001).

The potential for parenting education means that it is subject to a number of policy drivers. Support for parents is recognised as a key element of public health policy. It has been recognised as one of the four key strands of government's policy to tackle child poverty (HM Treasury 2001) and is one of the four main precepts of Every Child Matters where the aim is to reform service delivery for children and protect children at risk. Other imperatives include mental health, anti-social behaviour and social exclusion, particularly in high risk areas. One of the main delivery mechanisms is Sure Start.

Table 72: Targeted approaches case studies

Community Childminding

Sure Start Early Years and Childcare Service via Lancashire Children's Centres are working in partnership

with Children's Social Care Services to provide a community childminding scheme to support children and families across Lancashire. The service is for children with additional needs or children and families who, following a Children's Social Care Service assessment, have been identified as children in need or children in need of protection.

Guidelines for childminders and agencies have been produced outlining the Lancashire Community Childminding Scheme to support the process for placements of referred children onto the scheme. The placement process involves completing a request for service form; the information provided on the form enables the childminder network co-ordinator to match with a community childminder on the scheme. Funding for the scheme needs to be identified and secured via the Agency Panel process or the Aiming High funding and meet the eligibility criteria. Parents can also refer to the scheme and fund the placement themselves.

The period of support for referred children/families onto the scheme is dependent on individual needs. The length and requirements of the placement will be agreed at the initial placement meeting and detailed in the National Childminding Association, (NCMA), and Community Childminding Contract. Reviews will be held on a regular basis, at least every twelve weeks, and a new NCMA Community Childminding Contract agreed by all parties as appropriate. A placement comes to an end when all parties agree that the period of support has achieved the aims for the referred families and children or the funding for the placement is no longer available.

The Lancashire Community Childminding Scheme benefits families of children with additional needs by allowing families to spend time with their other children, accessing activities or building confidence towards work experience knowing their referred child is in a safe, good quality childcare setting, benefiting from the childminders experience and activities they provide.

Mum 2 Mum

Mum2Mum is a support network of volunteers that are trained to deliver information, to families during the antenatal, postnatal, and early years period, around key health messages and to offer support and advice on services available locally through children's centres and partner agencies, signposting accordingly.

The volunteers are from a wide variety of backgrounds and differing skills and experiences. They commit to a 6 week training plan, covering all aspects of early intervention messages, with additional sessions covering for example further safeguarding training or brief intervention training. Once trained, the volunteers from across the Borough of Rossendale support families through the five children's centres, breastfeeding groups, clinics, baby massage groups and any other activities where parents -to -be attend.

The intention is for relationships to blossom, in turn encouraging continued engagement through the child's formative years and aiding a truly preventative approach to improving the all round health and well being of the child and its family.

Early Support Panel

Early Support Panels aim to provide access to services and funding, as appropriate, to meet the needs of disabled children or identified as having additional needs. The Early Support Panel considers referrals for educational needs, Enhanced Early Years Action Plus, (EEYAP), and Portage Services, therapy services, transition periods and involving other agencies that include; Children's Integrated Services, educational psychologist, health colleagues, child development centre, and children's centres.

Currently there are five Early Support Panels across Lancashire, North, South (West Lancashire, South Ribble & Chorley), South (Preston), East (Burnley, Pendle & Rossendale), and East (Hyndburn & Ribble Valley) although there are developments and changes in the offing. Currently the panels are held on a monthly basis and generally have from 15 – 50 new children referred at each panel meeting.

The panel membership can include partners from; Early Years Special Education Needs Service, Educational Psychologist Service, therapy services- including speech and language, paediatricians, universal health visiting and school nursing services, Children with Disabilities Social Work Team, Special Education Needs Assessment team, Portage Service, Sure Start Early Years and Childcare Service and Children's Centres representatives. Although not all the area panels have a full selection of partners in their membership at each meeting.

Sure Start Early Years and Childcare Service attended the North Early Support Panel meetings to provide links with children's centres and partnership working. It was recognised that there was a lack of referrals from children's centres and a minimal number of children referred to the panel that are actively accessing children's centre services. It was also noted that early years providers needed support to complete Common Assessment Framework's and compile evidence to support referred children to the Early Support Panels. It was evident that children's centre staff could provide that support.

To establish children's centre links and partnership working at the Early Support Panels, children's centres representatives from the locality were invited to join the panel membership for the North, East (Burnley Pendle & Rossendale), Preston South areas and will be extended out to South and East (Hyndburn & Ribble Valley) shortly although Sure Start Early Years and Childcare Services representative attends on the children's centres behalf. This provides the panel with information as to the registration of referred children at a children's centre, services and support accessed in the centres and the types of activities available for referred children and their families at their local children's centres.

Following the decisions of the panel the parents and referrers will be informed via an outcomes letter identifying the support/funding that has been allocated or requesting that further information is needed in order to support the referral. A generic children's centre leaflet is added to the outcomes letter containing contact details as to nearest children's centre to referred child and family. This provides families with another opportunity to access and register at a local centre. The Portage Service also provides an opportunity for families of disabled children via a notification form for children's centres to contact the families.

Sure Start Early Years and Childcare Services has worked in partnership with the Early Years Special Education Needs Service and North Area Early Support Panel to provide guidance for children's centres that may require advice, funding or support for individual children from the panel. Guidelines for the East and South areas are in the process of being developed. The guidelines for North Lancashire 'children's centres, Pathways to the Early Support Panel' have been completed and were launched in June. Children's centre teachers, extended service co-ordinators,

managers, Special Education Needs Inclusion staff and Sure Start Early Years and Childcare Service staff attended the launch.

Following the launch, it was identified via action planning and discussions that took place, is to review ways for early identification and procedures to facilitate stay and play, crèches and other sessional activities provided in children's centres. This is to be taken forward later in the year. The links with the Early Years Special Education Needs Inclusion team are helping to develop a set of guidelines to support early year's childcare providers and ways to cascade this information to the private providers is to be discussed at the working group.

A further development for referred children to the panels has come from Aiming High who supports services for disabled children and is providing funding for the Lancashire Community Childminding Service for respite care and has recently agreed to provide funding for referred children at the Early Support Panels as part of holistic packages. A leaflet will be sent out with the outcomes letter advising families of this opportunity for respite care and allow them to contact the scheme if they wish to take advantage of the support.

The guidelines and documents used by the children's centre representatives are now available on line on the Lancashire website - Integrated Services and Partnership Team click on children's centre documents and then early intervention/ early support. The guidelines for the Lancashire Community Childminding Scheme can be found on the Lancashire website- Integrated Services and Partnership Team, on left hand side click on guidelines childminders and agencies.

Health Visitors

Among all health professionals, health visitors have a particularly crucial role in delivering child development and parental education. They should have a focus on early intervention, prevention and health promotion for young children and families – in settings where their nursing and public health skills and knowledge can have great impact. The important role that health visitors play has been recognised by the coalition government who have pledged to increase the number of health visitors by 4,200, an increase of almost 50%. Using their key role working in young families' homes, the government sees health visitors as being in a unique position to help prevent illness and injury, give children the best start in life and ensure wider community support is at hand for families who need it.

Future priorities as to practice should be on the prevention of social exclusion in children and families, the reduction of health inequalities, tackling key child public health issues, promoting infant, child and family mental health and supporting the capacity for better parenting. Specifically as regards the latter, this should include improving pregnancy outcomes, child health and

development, parents' economic self-sufficiency, safeguarding children, addressing domestic violence, supporting parental relationships and fathers in their parenting role.

The core elements of health visiting practice should therefore comprise public health and nursing for the whole family, focusing on early interventions and prevention. Health Visitors should have a detailed knowledge of the communities they work in and be seen to be 'local'. Accordingly they should be organised on a locality basis and not primarily be attached to a general practice. This requires health visitor practice to be focused upon the pro-active promotion of health and wellbeing through progressive universalism, the prevention of ill health and through home visiting where appropriate. An obligation towards the safeguarding of children requires a capacity to deliver intensive programmes for the most vulnerable children and families; managing risk/decision making in conditions of uncertainty and seeking to build therapeutic relationships to address difficult issues in families with complex needs.

It is critical that health visitor practice works across sectors, putting health into multi-agency and multi-sector working. Where necessary qualified health visitors will supervise teams of less qualified assistants who give practical support to children and families.

Summary, identification of key areas of need and recommendations

The low rates of breastfeeding initiation and continuance in Lancashire highlight that there are clearly cultural factors at work. This appears to be confirmed by the higher than national average proportion of younger mothers. There have been successful breastfeeding campaigns such as the "She's a Star" campaign run by NHS Central Lancashire and there is a need for further campaigns to target young mothers and those from low socio-economic backgrounds. The evidence clearly suggests that it is not just the mothers but their support system (fathers and grandmothers) who need to be targeted. Breastfeeding needs to be normalised and opportunities to intervene at appropriate points by appropriate health professionals should be maximised.

Similarly, the delaying of the introduction of solid foods should be promoted by all health professionals as this is still the current recommendation from the Department for Health. Opportunities for these messages to be spread through children's centres should be taken to target the most socially excluded groups. Messages for minority ethnic communities need to be devised as the national evidence highlights particular groups who introduce foods early for various cultural reasons.

The promotion of vaccinations is crucial to prevent outbreaks and is particularly important given the inward migration of families from countries where infectious diseases are still prevalent. The vaccination rate for the MMR is not sufficient according to the guidelines of the World Health

Organisation and it is important that this be corrected to safeguard the health of Lancashire's young children. Understanding who is not taking up the MMR vaccine and why is vital to promoting it and boosting uptake. Primary Care Trusts should support GP practices to achieve vaccination and immunisation targets where they are not currently doing so, a total of 34 practices across the county of Lancashire. This is particularly important given the social patterning of those GP practices who are not meeting the target.

The importance of the promotion and protection of maternal mental health cannot be understated given the links to long term development of infants and children. This has been identified as a key issue particularly as this can be considered a hidden harm – it may not be immediately apparent that anything is wrong or that damage is being done and it may be difficult to ameliorate any damage once it has been done. Parental support programmes and the role of professionals in identifying any early mental health problems will be key interventions here.

The reduction of infant mortality remains a key target for organisations across Lancashire. This is particularly important in the districts of Pendle and Rossendale where rates remain high. Infant mortality is strongly related to factors which lie predominantly outside of the control of the NHS; in Lancashire infant mortality rates are found to increase with increasing levels of deprivation, increasing rates of low birth weight (which is largely determined by socio-economic and environmental factors), increasing proportion of the population of Pakistani heritage and increasing rates of teenage pregnancy. A number of socio-economic and environmental determinants of infant mortality are priorities in themselves but it was agreed by the project team that it is important to include infant mortality as a priority rather than simply as an outcome measure.

The key areas of need identified for this early years age group and suggested for inclusion in the Lancashire Children and Young People's Plan are:

- Breastfeeding
- Infant mortality
- Maternal mental health

Specific recommendations

A number of specific recommendations can be drawn from the analysis in this chapter:

- Review Child Health Information Systems to ensure they meet the reporting requirements of the national standards for newborn screening.

- All stakeholders to work collaboratively at a strategic commissioning level and across the screening pathway for delivery and performance management of robust, quality assured Antenatal and Newborn Screening Programmes in Lancashire.
- Further application of social marketing behavioural insight approaches to support young mothers and those from low socio-economic backgrounds to breastfeed.
- Develop more authoritative messages to support delaying the introduction of solid foods.
- Conduct an equity audit on children's centres across Lancashire to check whether they are meeting the needs of those most in need. This would allow for analysis of access to children's centres by different groups across the social gradient and whether different groups are meeting the desired outcomes.

Primary years – 5 to 10 years

During the ages 5 to 10 years, the principal risk relates to not achieving in school. Children from disadvantaged backgrounds are more likely to begin primary school with lower personal, social and emotional development and communication, language and literacy skills than their peers. These children are also at significantly increased risk of developing conduct disorders that could lead to difficulties in all areas of their lives, including educational attainment, relationships and longer-term mental health. There are clear socioeconomic gradients in all these factors.

Not achieving in school can result from low levels of family aspiration, failure on the part of services to identify and support children with additional needs, cultural and social barriers, and poor prior health and nutrition. Achieving in primary school is associated with the long-term gain of human capital and capacities and with a reduced chance of social exclusion. Achieving at this level will also enable children and young people to perform at subsequent levels and will prevent adolescents and youth from being left at the margin, reducing the likelihood of their involvement in risk taking behaviours or youth offending, and drastically improving their chances of social inclusion.

Key vulnerabilities for this group include:

- Family and social structure may not place a value on education and failure of education to identify additional support needs which may prevent school attendance or participation.

With potential short term outcomes:

- Failure to attend school, reduced school performance.
- Inability to achieve at later stages of the education system.

With potential long term outcomes

- Loss of human capital and capacities.
- Social exclusion.

For primary school-aged children, nutrition and health remain a priority coupled with key investments to ensure enrolment and successful completion of primary school, particularly for disadvantaged children. These include interventions that:

- Promote healthy eating and exercise to stem the increase in levels of overweight and obesity;

- Promote dental hygiene to reduce the incidence of tooth decay;
- Promote emotional health and wellbeing;
- Building resilience to reduce the chances of engaging in risk taking behaviours; and
- Promote road safety and encourage active travel.

Background information

The School Census shows that there are nearly 87,000 primary school aged pupils living within in Lancashire. Of these:

- Approximately 17% or 14,400 receive free school meals.
- The majority of pupils are either white British (73,000 or 84%), Pakistani (6,000 or 7%), Indian (2000 or 2%) or Bangladeshi (700 Or 1%).
- Approximately 1,400 or 2% have a special educational needs statement.

Child Mortality

Between 2005/06 and 2009/10, 41 children aged 5 to 9 years died in Lancashire. Deaths of children in the 5 to 9 years cohort appear to be more common in Burnley, Lancaster and Rossendale, but this may reflect the age structure of the population rather than an increased risk. That is, if there is a larger population of people aged 5 to 9 years old we may expect that there would be a greater number of deaths in that population.

Table 73: Number of child deaths aged 5 to 9 years in Lancashire

Childhood mortality aged 5-9 years (numbers)						
Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Grand Total
Burnley	<5	<5	<5	<5	<5	6
Chorley					<5	<5
Fylde				<5		<5
Hyndburn		<5		<5		<5
Lancaster	<5	<5	<5	<5	<5	7
Pendle			<5	<5		<5
Preston	<5		<5	<5		<5
Rosendale	<5	<5		<5		6
South Ribble		<5		<5	<5	<5
West Lancashire	<5	<5				<5
Wyre		<5			<5	<5
Grand Total	11	10	6	9	5	41

Source: Public Health mortality data provided by CLCBS
Numbers fewer than 5 suppressed for reasons of confidentiality

The table below highlights the causes of death for children aged between 5 and 9 years old. The largest proportion of deaths, 37%, is due to malignant neoplasms (cancers).

Table 74: child deaths in Lancashire aged 5 to 9 years by cause, 2005/06 to 2009/10

ICD10 Code	ICD10 Description	Nos.	%
A00-B99	Certain infectious and parasitic diseases	<5	
C00-C97	Malignant neoplasms	10	37.0%
C81-C96	Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	<5	
E00-E90	Endocrine, nutritional and metabolic diseases	<5	
G00-G99	Diseases of the nervous system	7	25.9%
G40-G41	Epilepsy	<5	
I00-I99	Diseases of the circulatory system	<5	
J00-J99	Diseases of the respiratory system	<5	
J45-J46	Asthma	<5	
K00-K93	Diseases of the digestive system	0	0.0%
N00-N99	Diseases of the genitourinary system	<5	
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	<5	
ZZZ	Other causes of death	9	33.3%
Total deaths		41	100.0%

Source: Public Health mortality data provided by CLCBS
Numbers fewer than 5 suppressed for reasons of confidentiality

Total hospital admissions

Hospital admission rates are such that for every 10 children aged 5 to 9 years one admission can be expected in a year. Rates are highest in Hyndburn and Preston and lowest in Fylde and West Lancashire. Compared to the period 2005/06 in 2009/10 the rate has increased in Lancashire overall. The largest increase has been in Chorley which has resulted in Chorley moving from

having the fifth lowest rate to having the third highest rate in Lancashire. The second largest increase has been in Ribble Valley. The largest decrease has been in Burnley which means that for the 2009/10 rate of hospital admissions Burnley now ranks the 6th highest in Lancashire whereas in 2005/06 it was the 3rd highest.

Table 75: total admissions rate per 1,000 of the population aged 5 to 9 years, 2005/06 to 2009/10

Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	106	100	110	109	110	3.7%
Burnley	135	101	114	114	109	-19.5%
Chorley	92	89	97	110	126	37.5%
Fylde	68	84	95	85	76	11.1%
Hyndburn	155	122	124	123	147	-5.3%
Lancaster	91	96	98	93	91	-0.2%
Pendle	114	121	130	134	117	2.3%
Preston	130	129	147	128	141	8.1%
Ribble Valley	74	72	79	90	94	27.8%
Rossendale	104	89	97	99	97	-6.4%
South Ribble	100	97	103	122	117	17.0%
West Lancashire	93	89	94	89	83	-10.2%
Wyre	85	90	114	105	91	6.7%

Source: SUS data provided by CLCBS and midyear population estimates 2005 to 2009

Hospital admissions by cause

There were 8,435 hospital admissions for children aged 5 to 9 years in Lancashire. District level data is presented in the data [appendix](#). The greatest proportion of admissions in this age group is for:

- Diseases of the respiratory system, which account for 1,162 (18.8%) of elective admissions.
- Diseases of the digestive system and specifically diseases of oral cavity, salivary glands and jaws, which account for 858 (13.9%) admissions and could be related to poor dental health.

Table 76: Numbers and percentages of admissions to hospital by children aged 5-9 years resident in Lancashire County by age group and primary diagnosis, 2009/10

ICD10 Code	ICD 10 Description	Nos.	%
A00-B99	Certain infectious and parasitic diseases	290	4.7%
	A00-A09 Intestinal infectious diseases	125	2.0%
C00-C97	Malignant neoplasms	184	3.0%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	169	2.7%
D10-D36	Benign neoplasms	66	1.1%
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	89	1.4%
E00-E90	Endocrine, nutritional and metabolic diseases	130	2.1%
	E10-E14 Diabetes mellitus	37	0.6%
F00-F99	Mental and behavioural disorders	-	-
G00-G99	Diseases of the nervous system	150	2.4%
	G40-G41 Epilepsy	90	1.5%
H00-H59	Diseases of the eye and adnexa	127	2.1%
H60-H95	Diseases of the ear and mastoid process	397	6.4%
I00-I99	Diseases of the circulatory system	53	0.9%
J00-J99	Diseases of the respiratory system	1162	18.8%
	J00-J06 Acute upper respiratory infections	395	6.4%
	J10-J18 Influenza and pneumonia	81	1.3%
	J20-J22 Other acute lower respiratory infections	92	1.5%
	J45-J46 Asthma	274	4.4%
K00-K93	Diseases of the digestive system	1179	19.1%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	858	13.9%
	K35-K38 Diseases of appendix	49	0.8%
	K40-K46 Hernia	42	0.7%
	K50-K52 Noninfective enteritis and colitis	58	0.9%
L00-L99	Diseases of the skin and subcutaneous tissue	147	2.4%
M00-M99	Diseases of the musculoskeletal system and connective tissue	131	2.1%
N00-N99	Diseases of the genitourinary system	354	5.7%
O00-O99	Pregnancy, childbirth and the puerperium	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	33	0.5%
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	664	10.8%
S00-T98	Injury, poisoning and certain other consequences of external causes	767	12.4%
Z00-Z99	Factors influencing health status and contact with health services	242	3.9%
Total Admissions		8435	100%

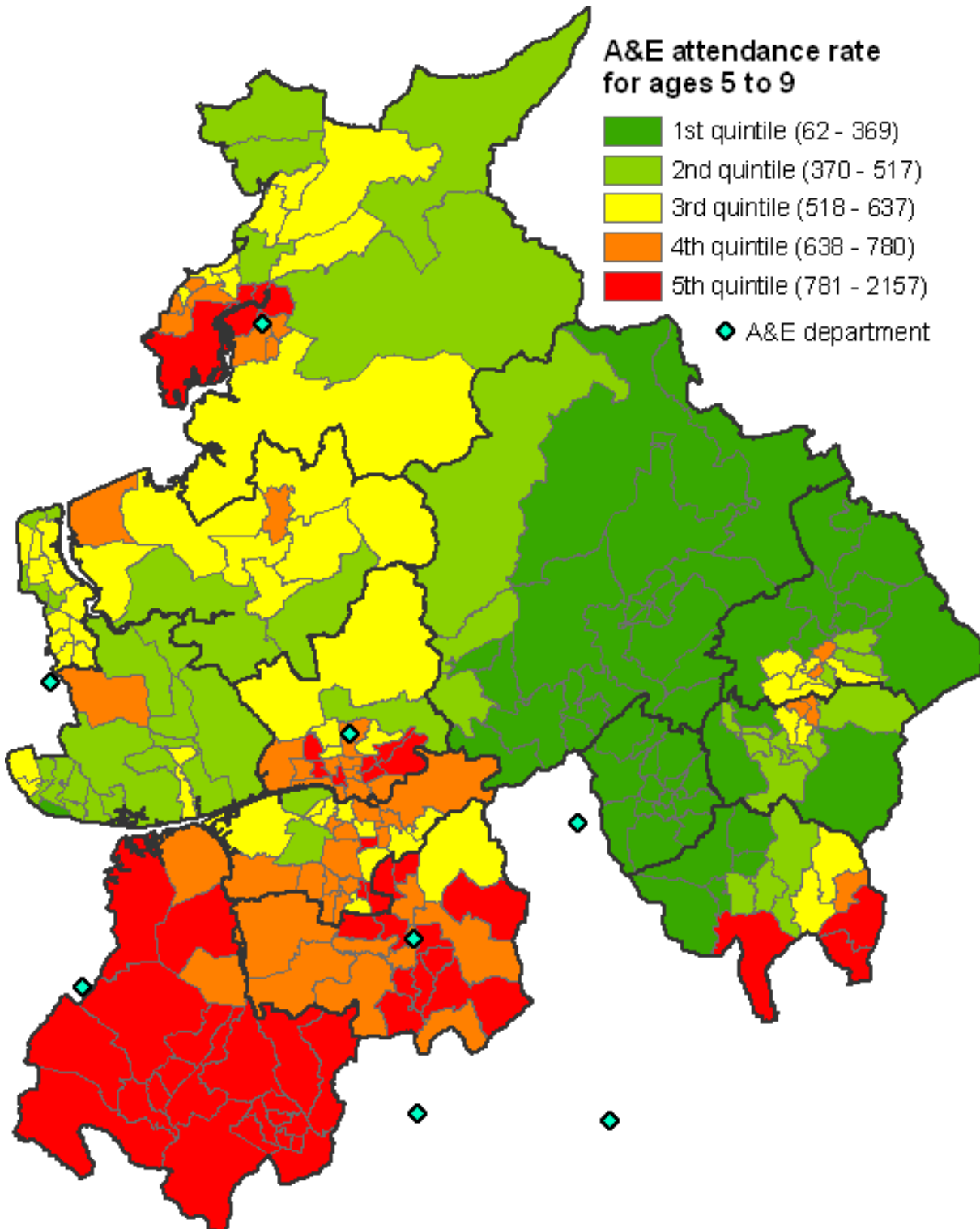
Source: SUS provided by CLCBS (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth) (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth)

Emergency hospital admissions

The overall Emergency Department attendance rate is lower for children aged 5 to 9 years than the early years age group. However, as with the early years age group, attendances at Emergency Departments are high across all of West Lancashire, whilst being relatively low in East Lancashire, which may indicate issues with the primary care offering or difficulties in accessing those services

directly. Once again, it is not clear why the rates of admissions in West Lancashire are so high and it is recommended that this be investigated. There appears to be a correlation between high attendance rates and the locations of emergency departments in some parts of the County but not in others. The rates of attendance in areas near to Blackpool and Blackburn emergency departments do not present with high rates of attendance.

Map 22: Emergency Department attendance rate per 1,000 population aged 5 to 9, 2007/08 to 2009/10



The table below confirms a levelling out of the numbers of emergency admissions by the time children are attending primary school. Out of every twenty children, one would be expected to have an emergency hospital admission in Lancashire in a year. Compared to 2005/06 in 2009/10 there was a 2.9% increase in emergency admissions in Lancashire. The greatest increase in emergency hospital admissions in 5 to 9 year olds was in Wyre and the largest reduction was in Rossendale. Preston, Burnley, Pendle and Hyndburn have the highest rate of emergency admissions in 5 to 9 year olds.

Table 77: emergency admissions rate per 1,000 of the population aged 5 to 9 years

Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	51	49	52	52	52	2.9%
Burnley	73	60	64	57	62	-14.9%
Chorley	42	40	45	49	44	3.4%
Fylde	31	31	38	37	35	12.2%
Hyndburn	66	55	53	63	61	-7.3%
Lancaster	49	51	53	56	56	14.9%
Pendle	65	65	67	67	62	-3.6%
Preston	56	57	63	57	63	11.7%
Ribble Valley	41	41	36	35	43	4.5%
Rossendale	55	40	42	46	47	-15.1%
South Ribble	42	45	42	48	52	22.2%
West Lancashire	51	57	57	53	52	1.7%
Wyre	29	31	42	39	37	24.0%

Source: SUS data provided by CLCBS and midyear population estimates 2005 to 2009

Emergency hospital admissions by cause

There were more than 4,000 emergency hospital admissions for children aged 5 to 9 years in Lancashire during 2009/10. The highest numbers of hospital admissions on an emergency basis in the 5 to 9 years age group are for diseases of the respiratory system (715 admissions and 23% of the total) and injury, poisoning and other consequences of external categories (659 admissions and 21% of the total). This includes accidents. District level data is shown in the data [appendix](#).

Table 78: Numbers and percentages of emergency admissions to hospital by children aged 5-9 by primary diagnosis, 2009-10

ICD10 Code	ICD 10 Description	Nos	%
A00-B99	Certain infectious and parasitic diseases	281	9.0%
	A00-A09 Intestinal infectious diseases	123	4.0%
C00-C97	Malignant neoplasms	12	0.4%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	9	0.3%
D10-D36	Benign neoplasms	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	48	1.5%
E00-E90	Endocrine, nutritional and metabolic diseases	58	1.9%
	E10-E14 Diabetes mellitus	34	1.1%
F00-F99	Mental and behavioural disorders	-	-
G00-G99	Diseases of the nervous system	97	3.1%
	G40-G41 Epilepsy	70	2.3%
H00-H59	Diseases of the eye and adnexa	23	0.7%
H60-H95	Diseases of the ear and mastoid process	33	1.1%
I00-I99	Diseases of the circulatory system	32	1.0%
J00-J99	Diseases of the respiratory system	715	23.0%
	J00-J06 Acute upper respiratory infections	255	8.2%
	J10-J18 Influenza and pneumonia	76	2.4%
	J20-J22 Other acute lower respiratory infections	84	2.7%
	J45-J46 Asthma	264	8.5%
K00-K93	Diseases of the digestive system	244	7.9%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	13	0.4%
	K35-K38 Diseases of appendix	48	1.5%
	K40-K46 Hernia	-	-
	K50-K52 Noninfective enteritis and colitis	54	1.7%
L00-L99	Diseases of the skin and subcutaneous tissue	77	2.5%
M00-M99	Diseases of the musculoskeletal system and connective tissue	69	2.2%
N00-N99	Diseases of the genitourinary system	122	3.9%
O00-O99	Pregnancy, childbirth and the puerperium	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	565	18.2%
S00-T98	Injury, poisoning and certain other consequences of external causes	659	21.2%
Z00-Z99	Factors influencing health status and contact with health services	66	2.1%
Total Admissions		4131	100%
Source: SUS provided by CLCBS (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth) (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth)			

Road traffic accidents

Between 2005 and 2009, road traffic casualties in children aged six to ten made up 30% of the total casualties in young people aged 0 to 19. The number of children killed or seriously injured (KSI) almost doubles from the 0 to 5 age group to the 6 to 10 age group which makes up 29% of the total KSI casualties for children and young people. Most of these were pedestrians, which is due to the increased level of mobility as children progress through primary school. At this age group 568 (52%) casualties occur to children travelling as either pedestrians or cyclists and of these 27% were killed or seriously injured.

Table 79: Lancashire 6 -10 year old road traffic casualties 2005-09

	Rates and numbers
Population (6 to 10 years)	75440
All child casualties	
All child casualties	1083
All child Pedestrians	429
All child Pedal cyclists	139
Rate of casualty / 1000 population	14.4
Killed and seriously injured casualties	
Killed and serious casualties	168
KSI Pedestrians	133
KSI Pedal cyclists	19
Rate of KSI per 1,000 population	
Lancashire	2.2
Preston	4.2
Burnley	3.0
Pendle	2.9
Hyndburn	2.7
Rosendale	2.3
South Ribble	1.9
Lancaster	1.9
Wyre	1.6
West Lancashire	1.5
Ribble Valley	1.5
Chorley	4.2
Fylde	0.2

See the appendix for a summary of evidence based interventions to reduce [road traffic accidents](#).

Educational achievement

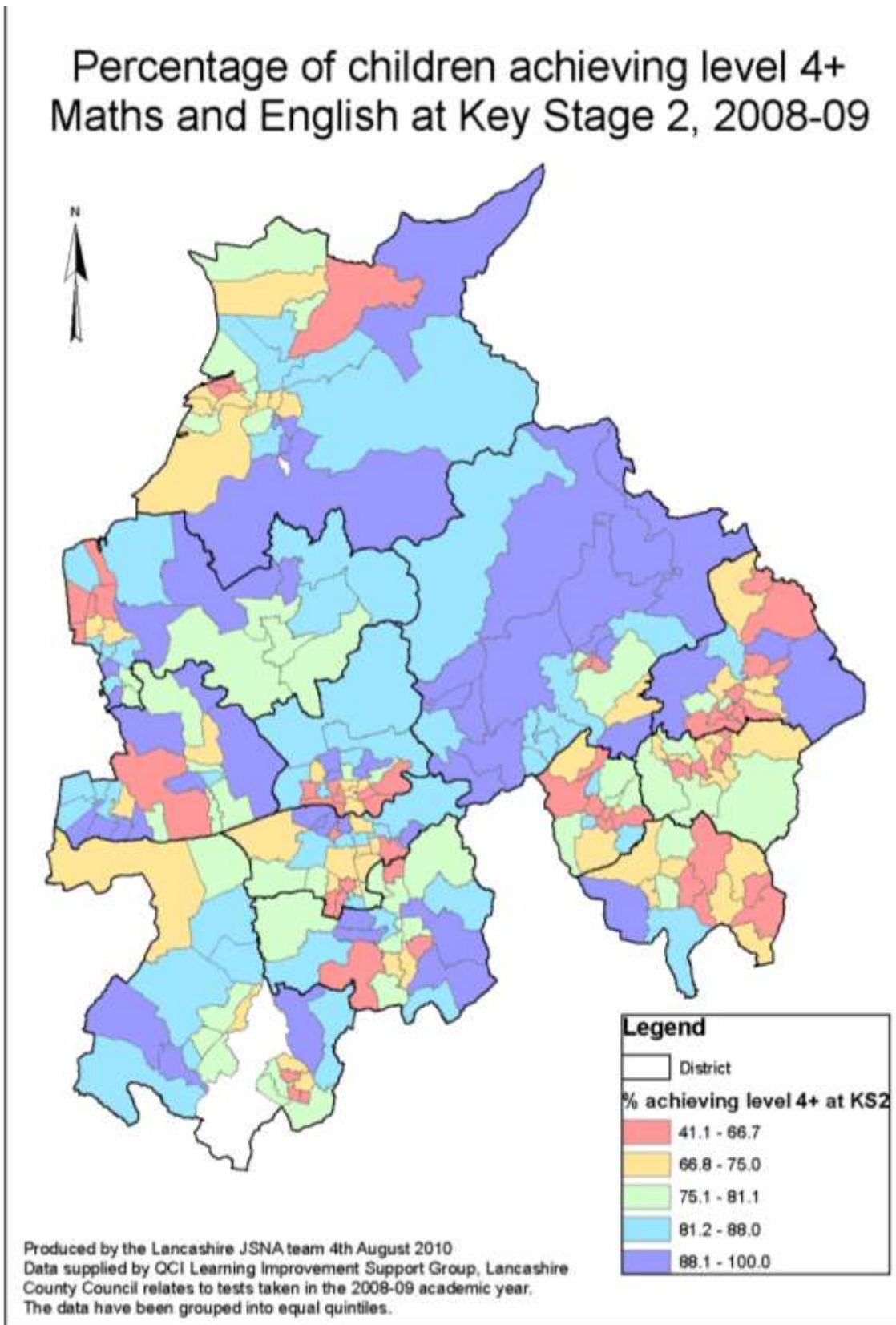
Rates of educational attainment at key stage 2 in Lancashire tend to be above the national average. The level of attainment varies between districts with consistently higher rates of attainment in the districts of Fylde and Ribble Valley. The rates in Burnley, Hyndburn and Pendle tend to be lower reflecting the higher numbers of children who suffer disadvantage in those districts. It should be noted that the figures below do not include Lancashire children in private education.

Table 80: Lancashire children achieving Level 4 or above at Key Stage 2, 2005/06 to 2008/09

Pupil District	2005/06	2006/07	2007/08	2008/09
Burnley	65.3%	63.0%	63.9%	69.9%
Chorley	77.0%	79.1%	79.7%	77.9%
Fylde	76.7%	80.4%	78.4%	82.7%
Hyndburn	61.2%	69.0%	69.0%	67.6%
Lancaster	71.6%	73.7%	72.8%	75.4%
Pendle	64.8%	64.2%	66.7%	64.8%
Preston	75.0%	72.4%	72.7%	72.7%
Ribble Valley	84.6%	80.5%	84.5%	85.4%
Rossendale	71.3%	75.4%	75.2%	72.2%
South Ribble	75.0%	74.9%	79.3%	76.1%
West Lancs	72.7%	74.7%	77.2%	76.8%
Wyre	75.0%	75.8%	79.5%	77.9%
Lancashire	72.0%	73.0%	75.0%	74.0%
England	70.0%	71.0%	73.0%	72.0%

The most recent ward level data shows very low rates of achievement at this key stage for children living in Central ward in Hyndburn, University ward in Preston and Bradley ward in Pendle, where less than half of the primary pupils achieved the standard. However, it should be borne in mind that data for one academic year does not necessarily give a truly representative picture as the relatively low numbers involved can result in considerable fluctuations.

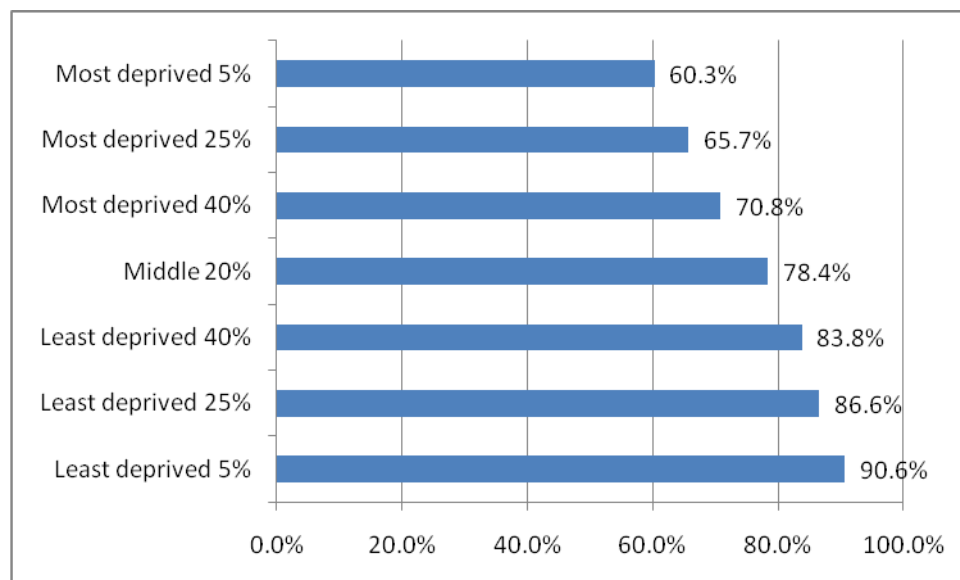
Map 23: Children achieving level 4+ maths and English at Key Stage 2, 2008/09



Attainment and deprivation

Although overall Lancashire's children perform well at key stage 2, there are clearly some areas that underperform. The chart below plots achievement of level 4 at key stage 2 across the Lancashire social gradient, as measured by the indices of deprivation.

Figure 44: 2009/10 Key Stage 2 achievement of level 4+ in English and maths across the social gradient



Source: QCI Learning Improvement Support Group, Lancashire County Council

The overall pattern demonstrates a clear relationship with pupils from more prosperous areas able to achieve higher results. Conversely, pupils from areas with significant concentrations of relative deprivation struggle to maximise their potential. These pupils are likely to perform worse than their peers at subsequent key stages and are less likely to access university places and secure good quality jobs.

Attainment and free school meals

The link between educational attainment and deprivation is also evident in the results achieved by pupils eligible for free school meals (FSM). Eligibility for FSM gives an indication that a pupil is from a low income background. The provision of free school meals has traditionally been a reliable indicator of the extent and degree of child poverty in the UK. A smaller proportion of primary age pupils are eligible for free school meals than the national average. The following districts had one in five pupils eligible for FSM: Burnley, Hyndburn, Pendle and Preston. These areas correlate exactly with those with the highest levels of deprivation. The district council area with the lowest percentage in Lancashire is Ribble Valley (4.2%). All districts have seen a rise in FSM eligibility in the last two years.

Table 81: Percentage of primary age pupils in Lancashire who are eligible for free school meals, 2005-2010

Area	2005/06	2006/07	2007/08	2008/09	2009/10
Burnley	22.0%	21.2%	20.0%	22.3%	26.0%
Chorley	9.7%	9.4%	9.4%	10.4%	12.3%
Fylde	8.6%	8.1%	7.5%	8.9%	10.8%
Hyndburn	18.6%	17.3%	17.3%	19.0%	21.5%
Lancaster	15.4%	14.8%	14.6%	15.9%	17.9%
Pendle	18.6%	17.2%	16.4%	16.8%	19.7%
Preston	18.1%	17.4%	17.4%	18.4%	20.5%
Ribble Valley	3.5%	3.2%	3.0%	3.4%	4.2%
Rossendale	13.5%	13.3%	12.5%	14.2%	16.8%
South Ribble	9.5%	9.0%	8.5%	9.7%	11.4%
West Lancashire	14.7%	14.6%	13.5%	14.2%	16.5%
Wyre	12.0%	11.5%	10.8%	12.4%	14.2%
Lancashire	13.6%	13.0%	12.5%	13.6%	15.7%
England	16.0%	15.9%	15.5%	16.0%	17.3%

The attainment of both FSM and non-FSM groups in Lancashire is higher than the national averages, but the gap is larger demonstrating an area where improvements could be achieved. The attainment gap at Key Stage 2 between pupils eligible for FSM and their peers is around 20% in most districts. The gap is lowest in Pendle (17.4%) and highest in South Ribble (28.6%). There is considerable variation in the performance of pupils eligible for free school meals between districts. The lowest performing group of pupils who are eligible for free school meals were in Hyndburn (49.3%) and the best performing is in West Lancashire (63.9%). There are clearly factors other than low income which lead to the variance in educational achievement across Lancashire.

Table 82: Pupils achieving Level 4 in English and maths at Key Stage 2 by FSM eligibility, 2009/10

District	FSM No.	Non-FSM no	FSM %	Non-FSM %	Gap (Non FSM - FSM) %
Burnley	130	585	51.6%	73.0%	21.4%
Chorley	74	822	58.3%	85.0%	26.7%
Fylde	33	483	54.1%	80.4%	26.3%
Hyndburn	99	566	49.3%	74.1%	24.8%
Lancaster	139	986	57.7%	83.1%	25.4%
Pendle	119	596	54.6%	72.0%	17.4%
Preston	152	929	51.9%	78.3%	26.4%
Ribble Valley	<10	<10	<10	<10	<10
Rossendale	67	516	58.8%	79.6%	20.9%
South Ribble	68	922	53.1%	81.7%	28.6%
West Lancashire	124	834	63.9%	83.6%	19.6%
Wyre	82	684	61.2%	81.0%	19.8%
Lancashire	-	-	56.9%	81.2%	24.4%
England			55.8%	77.1%	21.3%

Source: Lancashire County Council CYP Directorate, DFE

Note: England averages do not take into account the data from approximately 30 LAs due to unrepresentative samples sizes

Data for Ribble Valley is excluded for reasons of confidentiality as fewer than 10 pupils were eligible for FSM.

The substantive effects of social origin on educational outcomes have long been recognised. Evidence suggests that non-school factors are a more important source of variation in educational attainment than differences in the quality of education that students receive (Thomas and Mortimor 1996). This does not mean that children from socially disadvantaged backgrounds cannot achieve educationally. Schools can, and do, make a difference.

Attainment and gender

There are also significant differences in attainment according to gender. Lancashire follows a regional and national pattern with girls performing better than boys in subjects other than maths at Key Stage 2.

Table 83: Proportion of pupils achieving level 4 in Key Stage 2 subjects by gender, 2009/10

	English		Maths		Science	
	Boys	Girls	Boys	Girls	Boys	Girls
Lancashire	77%	85%	82%	80%	89%	90%
North West	77%	86%	81%	80%	89%	90%
National	75%	85%	79%	78%	87%	89%

Source: Department for Education

There is a larger attainment gap by gender in Lancashire than at national level. At a district level, the gap between girls and boys achieving the expected standard at Key Stage 2 ranges from 2.1% in Wyre and Fylde to 11.5% in Rossendale. The best performance by boys was in Lancaster (82.0%) and the worst was in South Ribble and Burnley (both 66.1%). The best performance by girls was also in Lancaster (87.7%) and the worst was in Fylde (69.5%).

Table 84: Pupils achieving Level 4 in English and Maths at Key Stage 2 by gender, 2009/10

Secondary Pupil District	Male No	Female No	Male %	Female%	Gap (F-M)
Burnley	308	357	66.1%	71.5%	5.4%
Chorley	540	585	74.4%	83.3%	9.0%
Fylde	376	339	67.4%	69.5%	2.1%
Hyndburn	552	529	71.7%	74.5%	2.8%
Lancaster	259	270	82.0%	87.7%	5.7%
Pendle	286	297	74.5%	78.6%	4.1%
Preston	496	494	77.1%	80.6%	3.4%
Ribble Valley	514	444	78.2%	83.0%	4.8%
Rossendale	365	401	72.7%	84.2%	11.5%
South Ribble	308	357	66.1%	71.5%	5.4%
West Lancashire	540	585	74.4%	83.3%	9.0%
Wyre	376	339	67.4%	69.5%	2.1%
Lancashire			74.5%	80.5%	6.0%
England			74.7%	79.6%	4.9%

Source: Lancashire County Council CYP Directorate, DFE
 Note: England averages do not take into account the data from approximately 30 LAs due to unrepresentative samples sizes

Attainment and ethnicity

There are differences in attainment by ethnic group, particularly within the Asian community. Pupils in Lancashire from an Indian background generally do better than average and pupils from Pakistani and Bangladeshi communities generally perform worse. In Lancashire and nationally, children from Gypsy, Roma and Traveller backgrounds tend to have the poorest outcomes. The numbers of children from minority ethnic backgrounds or from the Gypsy, Roma and Traveller communities tend to be too small at district level to allow meaningful analysis.

Table 85: Pupils achieving Level 4 in English and Maths at Key Stage 2 by ethnic group, 2009

Pupils	2008	2009
All pupils	74.6%	74.3%
Pakistani	61.1%	58.3%
Indian	78.1%	82.1%
Bangladeshi	53.0%	62.9%
Gypsy, Roma, Traveller	33.3%	17.2%
<i>Source: Department for Education</i>		

Attainment and special educational needs

Education is key to a more fulfilling future for children, but for those with special educational needs (SEN), too many barriers can stand in the way of the right education and support. Attainment at Key Stage 2 has risen at a faster rate for those children with a category of SEN compared with that of children and young people without a category of SEN. There has therefore been a narrowing of the SEN and non-SEN gap (measured by National indicator 104) since 2005/06. However the gap remains significant at more than 50 percentage points and is even more for those children with a statement of special educational needs.

Table 86: Pupils achieving Key Stage 2 English and Maths threshold with SEN, 2005/06 to 2008/09

SEN Description	2005/06	2006/07	2007/08	2008/09
Pupils without SEN	85.0%	85.1%	86.4%	86.1%
Pupils with SEN	26.1%	29.3%	31.2%	30.8%
SEN to non-SEN gap	58.9%	55.8%	55.2%	55.3%
Pupils with Statements	16.7%	16.9%	22.5%	17.2%
Pupils at School Action Plus	26.5%	28.5%	28.3%	28.0%

Further discussion of children with special educational needs is provided in the chapter on [children and young people with particular needs](#).

Attainment and children looked after

Before coming into local authority care, young people will have experienced trauma and disturbance in their lives, often giving rise to a range of social and emotional difficulties. Many will also have had a disrupted education. It is unsurprising then that the educational attainment of

children looked after is much lower than that of their peers. There are a number of factors that contribute to this. For example, there tends to be a higher prevalence of children with statements of special educational needs in the looked after population (around 27% in the looked after population compared to around 3% in the general school age population). Another factor is that many of these children may have come from disadvantaged backgrounds and as shown previously attainment has strong links to deprivation. Despite this there has been national recognition that the attainment of this group is unacceptably low and Section 25 of the Children Act 2004 placed a statutory duty on local authorities to promote the educational achievement of children looked after.

The proportion of children in care achieving level 4 in English at Key Stage 2 in Lancashire has improved to move closer to the national average. The proportion achieving level 4 in maths has been more erratic and was well below national and statistical averages in 2008/09.

Table 87: Children looked after achieving level 4 in English at key stage 2, 2006/07 to 2008/09

	2006/07	2007/08	2008/09
Lancashire	36.2%	40.0%	45.0%
Statistical Neighbours	42.6%	48.6%	42.3%
England	43.0%	46.0%	46.0%

Source: DCSF/Lancashire County Council – School Effectiveness Service

Table 88: Children looked after achieving level 4 in maths at key stage 2, 2006/07 to 2008/09

	2006/07	2007/08	2008/09
Lancashire	31.0%	42.0%	32.0%
Statistical Neighbours	37.1%	47.9%	41.0%
England	41.0%	43.0%	44.0%

Source: DCSF/Lancashire County Council – School Effectiveness Service

Further discussion of children who are looked after by the local authority in Lancashire is contained in the chapter on [children and young people with particular needs](#).

Educational attendance

Attendance at school is linked directly with better performance in examinations and an increased likelihood of securing quality employment. Those who are absent from school are have an increased likelihood of becoming involved in youth offending. They are also more likely to be involved in risk taking behaviours such as alcohol and drug use (see section on [alcohol and drugs](#) for further information). They miss out on the benefit from the social interaction and opportunities available to make a positive contribution. School is an ideal setting to engage with all children who attend; however, young people who are absent from school, such as travellers and those who are home educated, are potentially more vulnerable as they may not be accessing services and could be effectively unknown.

The level of authorised absence in primary schools in Lancashire is slightly higher than national and regional averages but unauthorised absence and total absence are lower. The level of

persistent absenteeism (i.e. the proportion of pupils whose absence exceeds a threshold level) is slightly above the national rate, which may indicate that the continued absence of a few is more of a concern than general absence levels amongst the entire cohort.

Figure 45: primary school absence statistics (%), 2008-09

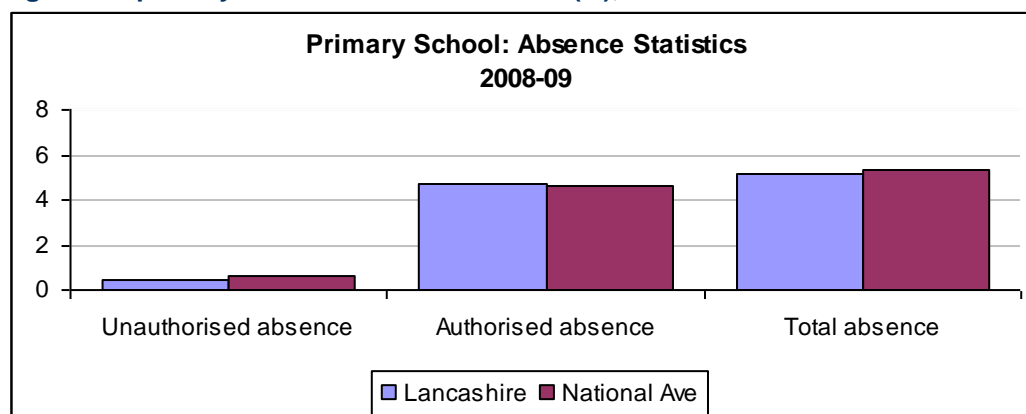


Table 89: Primary school absence statistics (%), 2008-09

	Lancashire	North West	National
Authorised absence	4.75%	4.65%	4.66%
Unauthorised absence	0.42%	0.62%	0.64%
Total absence	5.17%	5.27%	5.30%
Persistent absentees	1.7%	1.7%	1.5%

Source: Department for Children, Schools and Families

School attendance is linked to deprivation and analysis of district level data reveals that Pendle, Preston and Burnley have the highest levels of overall primary school absence in the county. Pendle, Hyndburn, Preston and Burnley have the highest rates of persistent absence in the county.

Table 90: Primary school absence levels (%) by district, 2008/09

District	Authorised Absence	Unauthorised Absence	Persistent Absence	Overall Absence	2007/08 Overall Abs.
Burnley	5.30%	0.58%	2.2%	5.88%	5.27%
Chorley	4.18%	0.19%	1.2%	4.36%	4.44%
Fylde	4.09%	0.24%	1.1%	4.34%	4.39%
Hyndburn	5.09%	0.81%	2.7%	5.90%	-
Lancaster	4.59%	0.36%	1.5%	4.95%	4.91%
Pendle	5.70%	0.94%	3.1%	6.64%	5.59%
Preston	5.30%	0.48%	2.4%	5.78%	5.57%
Ribble Valley	3.79%	0.12%	0.6%	3.91%	-
Rosendale	4.74%	0.42%	1.5%	5.16%	4.86%
South Ribble	4.00%	0.19%	0.8%	4.19%	4.2%
West Lancs	5.01%	0.33%	1.6%	5.34%	5.04%
Wyre	4.49%	0.29%	1.3%	4.78%	4.72%
Lancashire	4.75%	0.42%	1.7%	5.17%	4.93%

Source: DCSF Information Gateway

Exclusions

A Youth Justice Board survey showed that, when compared with other school children, pupils who were excluded from school were more than twice as likely to become involved in youth offending. Consequently, it is argued that reducing the number of exclusions can have a preventative effect on offending behaviour in young people. See the chapter on young people for further discussion of [children and young people who offend](#).

The rate of permanent exclusions of primary school children is very low at 0.03% and is in line with statistical neighbour and national averages. Statistical neighbours are other LAs deemed to have similar characteristics and are used for benchmarking purposes. Lancashire's statistical neighbours are Nottinghamshire, Bury, Calderdale, Sefton, Derbyshire, Stockton-on-Tees, Kent, Staffordshire, Northamptonshire and Dudley. Although the proportion is low, on average 30 primary age children are excluded from school each year in Lancashire.

Figure 46: proportion of pupils permanently excluded in primary schools, 2006/07 to 2008/09

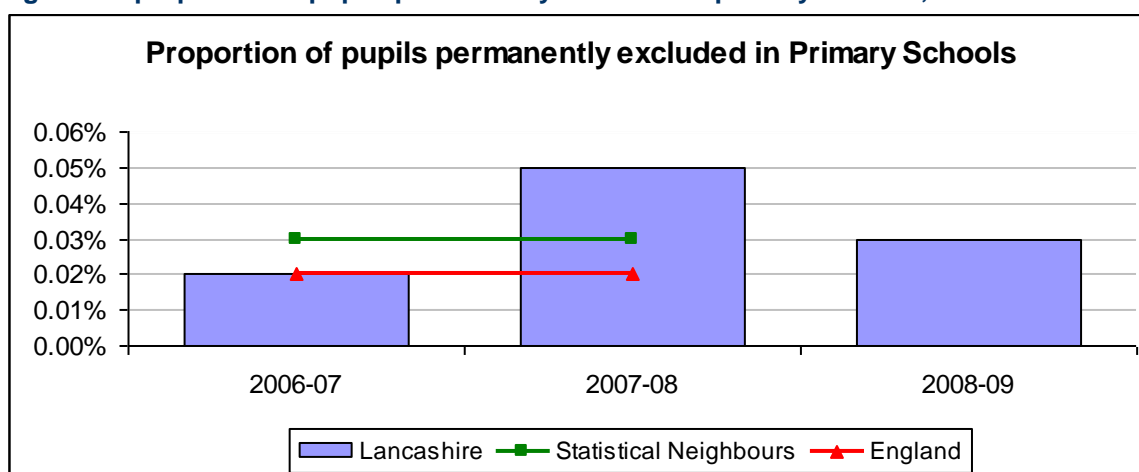


Table 91: proportion of pupils permanently excluded in primary schools, 2006/07 to 2008/09

	2006-07	2007-08	2008-09
Lancashire	0.02%	0.05%	0.03%
Statistical Neighbours	0.03%	0.03%	-
England	0.02%	0.02%	-
Source: Department for Children, Schools and Families			

Many districts saw a reduction in the number of permanent exclusions from primary school in 2008/09. Chorley, Preston and Lancaster accounted for nearly two thirds of the exclusions in the county.

Figure 47: number of permanent exclusions in primary schools by district, 2007/08 to 2008/09

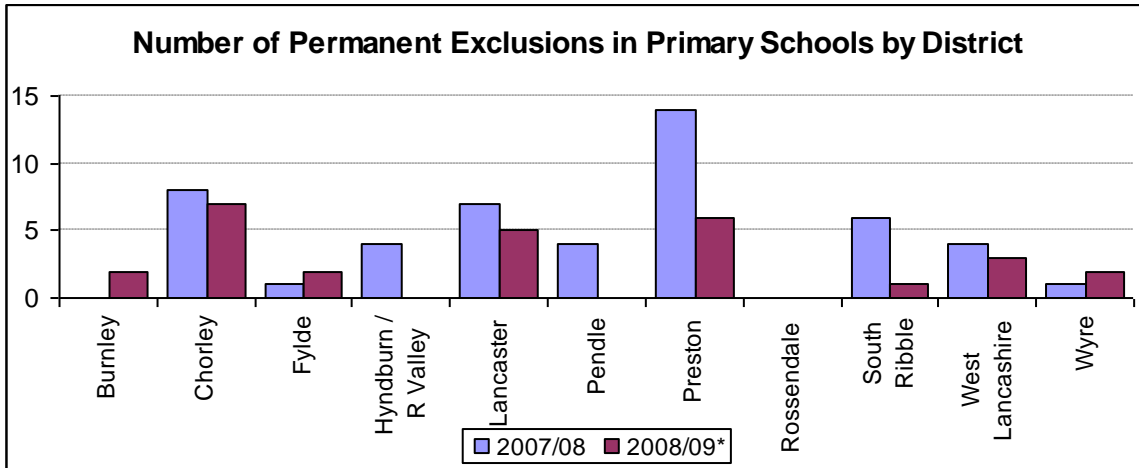


Table 92: number of permanent exclusions in primary schools by district, 2005/06 to 2008/09

	2005/06	2006/07	2007/08	2008/09*
Burnley	1	0	0	2
Chorley	2	3	8	7
Fylde	1	0	1	2
Hyndburn / Ribble Valley	6	6	4	0
Lancaster	2	3	7	5
Pendle	1	1	4	0
Preston	6	2	14	6
Rossendale	1	0	0	0
South Ribble	6	2	6	1
West Lancashire	2	1	4	3
Wyre	0	1	1	2
Lancashire	28	19	48	28

The proportion of fixed-term exclusions in primary schools is also quite low. In 2008-09 Lancashire did see a slight increase in the rate; however it remained below the national average.

Figure 48: proportion of pupils subject to fixed term exclusions in primary schools, 2005/06 to 2008/09

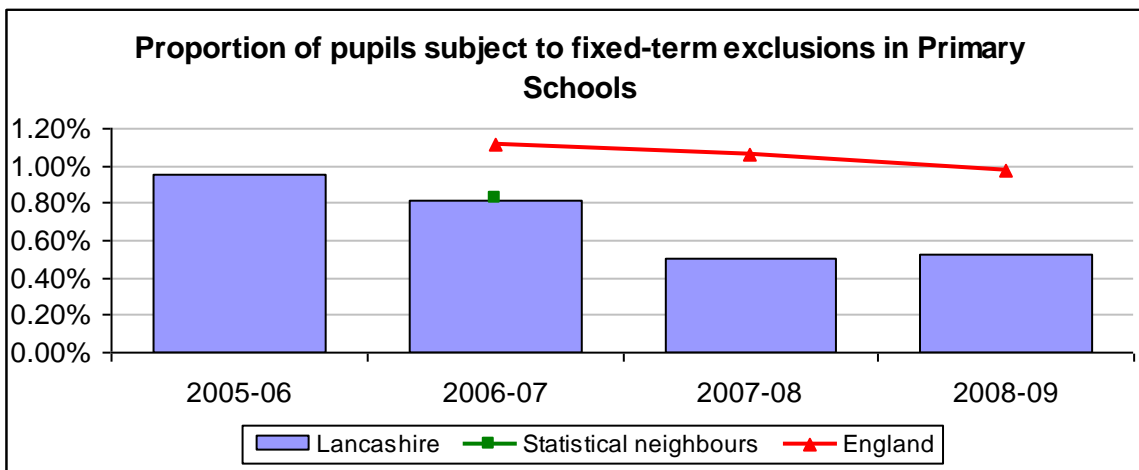


Table 93: proportion of pupils subject to fixed term exclusions in primary schools, 2005/06 to 2008/09

Proportion of pupils subject to fixed-term exclusions in Primary Schools				
	2005-06	2006-07	2007-08	2008-09
Lancashire	0.95%	0.81%	0.50%	0.52%
Statistical neighbours	-	0.82%	-	
England	-	1.11%	1.06%	0.97%
Source: Lancashire County Council – Pupil Access Team / DCSF Information Gateway				

Healthy schools

While parental circumstances and decisions influence the provision of resources that can lead to heightened risk to health or conversely to greater resilience, children’s everyday lives are also highly institutionalised (Nasman 1994). Children in the UK spend much of their waking hours in formal education.

Knowledge about health behaviours remains a key instrument for change within the primary preventative agenda notwithstanding that it tends to be most effective with those at lowest risk. Schools increasingly provide an excellent setting for engaging young people and have become a key focus for health promotion interventions such as improved nutrition and physical activity, sexual health, drug, alcohol and tobacco education and emotional health and wellbeing.

The role of schools in inclusion is also exemplified in the extended schools strategy. This expects all schools to provide a core offer of extended services including study support, parental support, family learning and improved referral to multi-agency support alongside a child care component as established by the ten year child care strategy.

Table 94: Healthy Schools in Lancashire

During academic year 2009/10, the Lancashire Healthy Schools Team began to roll out the annual review and the new Healthy Schools Enhancement Model (HSEM) across the county. Members of the school workforce have been attending twilight sessions in each district, to complete the annual review which is an on-line tool for schools to demonstrate that they are maintaining the foundation of National Healthy Schools Status (NHSS). 99% of Lancashire schools have achieved NHSS, with the remaining few working towards it. Over 200 schools that have held NHSS for 3 years or more have started the annual review and a rising number have completed it since November 2009.

The annual review contains Ofsted self-evaluation form (SEF) references. Since the introduction of NHSS in 2005, significant numbers of schools have been addressing this agenda and can use their healthy schools work to help provide evidence for the SEF. The annual review contains the original 41 criteria of the NHSS audit in a different format. They have been synthesised, turned into questions and organised under whole school approach headings instead of the four themes of healthy eating, physical activity, emotional health and well-being and PSHE. Completion of the annual review or achievement of NHSS since January 2009 is the requirement for a school to move on to the HSEM. This will be delivered in 3 distinct phases, and within each phase, there are a number of stages that schools need to complete. The phases schools work through concentrate on:

- Phase 1 – Planning our change
- Phase 2 – Delivering our change
- Phase 3 – Understanding what has changed.

While Healthy Schools maintains the original aims to:

- support children and young people in developing healthy behaviours
- help raise the achievement of children and young people
- help reduce health inequalities
- help promote social inclusion.

The emphasis is on continual improvement to schools' provision for the health and well-being, and the personal learning and development needs of their children and young people. The HSEM is designed to enable schools to identify and realise meaningful outcomes based on individual school data within the context of available health and socio-economic data.

Schools select two priorities linked to the local ones which contribute to National Indicators, based on a detailed needs analysis. Each priority has three meaningful outcomes – quantitative, qualitative/perception and targeted for children and young people in challenging circumstances. Schools identify early success indicators which are milestones to plan and monitor progress towards achieving the meaningful outcomes.

These indicators include processes to instigate the change such as involvement of children, young people and their families, policy review, workforce training, modifications to the curriculum and the added value of partnership working. The early success indicators have a number of impact measures of the change that is happening.

Once the required change has been planned, it is at this stage that universal and targeted interventions are selected and implemented to ensure evidence informed approaches are adopted. Over time this will be more refined and reduce the risk of ad hoc activities and one off events that can absorb and even divert resources but have little or no impact. It also provides the opportunity to develop an asset based approach to build upon existing success to strengthen rather than duplicate. This requires a different way of working.

The HSEM should be delivered in line with existing school improvement plans. It is not a standalone model and it has been designed to be integrated across existing school planning and reporting systems. The Health and Well-being Improvement Tool (HWIT) is the second on-line tool designed to manage progression through the stages of the HSEM and includes the facility to export to the SEF.

The original Lancashire Healthy Schools model was phased out at the end of academic year 2009/10. With the success of over 1,500 Quality Marks awarded, 162 schools achieving Lancashire Healthy Schools Status of 5 Quality Marks and 26 achieving Flagship Status of all 12 Quality Marks, the Lancashire Healthy Schools Programme is maintaining a local framework. The updated version is to help guide practice in schools and to offer local recognition for success. It has been developed with the HSEM and is not a separate model. The new up to date 13 Quality Standards are available to help schools complete the Annual review and use within the HSEM. They have been written using the same whole

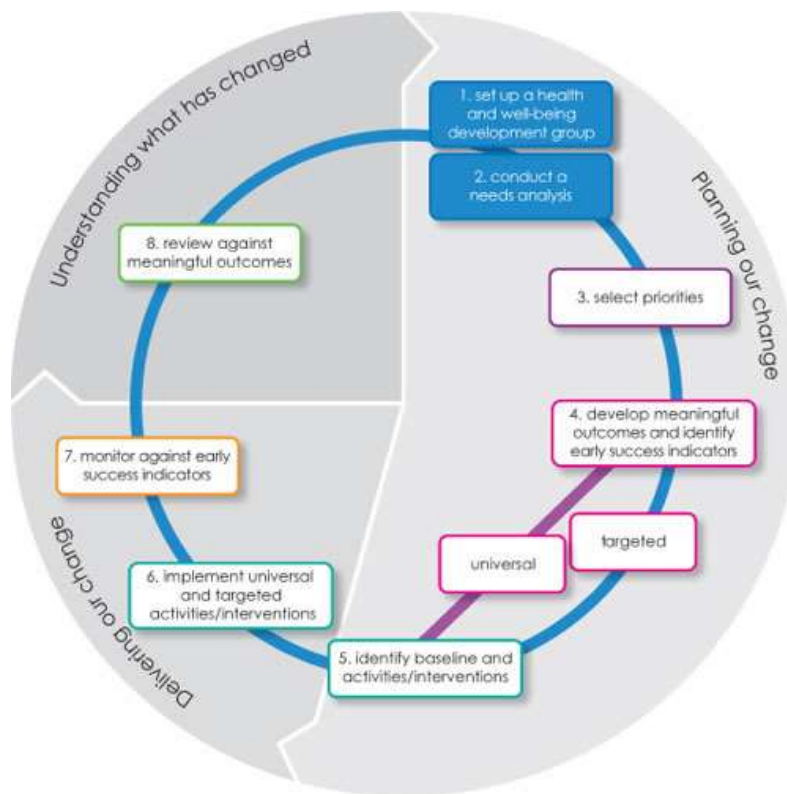
school approach headings contained in the Annual review and have been cross referenced to the SEF. The Quality Standards are available to contribute to the needs analysis, to identify early success indicators and to assist with the selection and implementation of interventions. They will enable schools to be accredited when change begins to happen and when early success indicators or milestones have been achieved but before meaningful outcomes have been realised. This will give local recognition of impact where there will not be, nationally.

For this new way of working, Senior Leadership and Governor involvement is vital to facilitate the needs analysis, the whole school approach and that the HSEM is an integral part of the planning and reporting systems. It provides a framework and consistent language for school improvement plans to inform and be influenced by local strategic needs analysis and planning.

Following the success of events for schools in the summer term, in each of the three PCT footprints, schools across the county are ready to begin using the HSEM in the academic year 2010/11.

For more information about the Annual review and the HSEM along with the on-line tools, please go to www.healthyschools.gov.uk. For information about the annual review Clusters, the new Quality Standards and how the Lancashire Programme works with schools, including the Chairman's Challenge, please go to www.lhsp.org.uk

Figure 49: Healthy Schools Enhancement Model



Emotional wellbeing

A full discussion of mental health and emotional wellbeing is included in the chapter on [children and young people with particular needs](#).

Emotional wellbeing is difficult to assess but factors such as friendships, levels of confidence, participation and access to adults to talk to when worried may be regarded as being indicative of good emotional health. Some of these factors are explored through the Lancashire Pupil Attitude Survey and data from the 2008/09 survey is shown in the tables below. The data suggests that the majority of pupils in years 4 and 6 enjoy good emotional health. These results appear quite positive and echo the findings of the national Tellus Surveys which suggested that young people in Lancashire were emotionally healthier than the national average. However, whilst the proportions of primary school children giving negative responses are small, it is evident that there are hundreds of primary age children in Lancashire who find it hard to make friends and get on with other children, feel left out of things and don't have anyone to talk to when they are worried.

Table 95: Lancashire Pupil Attitude Survey 2009, If worried I would probably talk to

Yr	No.	Adult at school	Adult at home	Friend or sibling	No one
4	6668	34.8%	44.5%	13.2%	7.1%
6	7254	25.6%	51.3%	16.5%	6.4%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 96: Lancashire Pupil Attitude Survey 2009, feeling left out of things

Yr	No.	Never	Hardly ever	Often	Always
4	6668	34.6%	40.3%	20.2%	4.4%
6	7254	31.4%	52.1%	14.3%	2.0%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 97: Lancashire Pupil Attitude Survey 2009, enjoy taking part in after school activities

Yr	No.	Always	Usually	Hardly ever	Never	
4	All	6668	55.1%	30.7%	5.7%	7.3%
6	All	7254	47.5%	38.5%	8.1%	5.5%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 98: Lancashire Pupil Attitude Survey 2009, getting on with other children

Yr	No.	Always	Usually	Hardly ever	Never
4	6668	40.3%	52.5%	5.5%	1.5%
6	7254	36.6%	58.2%	4.4%	0.7%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 99: Lancashire Pupil Attitude Survey 2009, finding it easy to make friends

Yr	No.	Always easy	Usually easy	Hardly ever easy	Never easy
4	6668	43.7%	39.9%	10.0%	5.8%
6	7254	43.1%	45.2%	8.3%	3.2%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Analysis of the data around who young people would talk to if they were worried reveals a social gradient. Pupils from the most deprived backgrounds are much more likely than those from the least deprived backgrounds to talk to an adult at school if they were worried. Conversely, they are much less likely than those from the least deprived backgrounds to talk to an adult at home. Pupils from the most deprived backgrounds are also more likely to worry alone without talking to anyone.

Table 100: Lancashire Pupil Attitude Survey 2009, If worried I would probably talk to across the social gradient

	Adult at school	Adult at home	Friend, brother or sister	No one
Least deprived 5%	27.5%	58.2%	11.2%	2.8%
Least deprived 25%	30.2%	51.3%	13.4%	4.7%
Least deprived 40%	32.1%	49.6%	13.9%	3.9%
Middle 20%	32.0%	47.6%	14.1%	5.6%
Most deprived 40%	37.8%	43.2%	13.0%	5.2%
Most deprived 25%	37.9%	40.2%	13.9%	6.8%
Most deprived 5%	41.3%	36.6%	13.2%	7.7%

Bullying

Research has consistently shown that the consequences of bullying are severe and range from impaired academic performance to increased risk of suicide (Brunstein Klomek et al 2007). A smaller, but not less influential, line of research has examined the association between severe psychotic disorders (for example schizophrenia) and history of abuse. This research has shown that adults who experience psychotic disorder are more likely than non-affected adults to have a history of childhood trauma, including peer victimization. It also showed that being victimized during middle childhood doubled the risk of experiencing definite psychotic symptoms in early adolescence (Schreier et al, 2009).

Data from the Lancashire Pupil Attitude Survey suggests that around half of primary school children have some experience of being bullied at school. Primary school children in Lancashire are more likely to experience bullying at school than on the way to or from school. Only a small proportion of children have reported that they are often or frequently bullied at school but this proportion still represents a substantial number of children. Around 8% of children have reported that they would not talk to anyone if they were worried about being bullied.

Table 101: Lancashire Pupil Attitude Survey 2009, being bullied at school

Being bullied at school						
Yr	No.	Never	Hardly ever	Often	Most of the time	
4	All	6668	48.7%	32.8%	13.9%	4.4%
6	All	7254	56.9%	33.4%	7.8%	1.7%
Source: Lancashire Pupil Attitude Questionnaire 2008/09						

Table 102: Lancashire Pupil Attitude Survey 2009, being bullied on the way to or from school

Being bullied on the way to or from school						
Yr		No.	Never	Hardly ever	Often	Almost always
4	All	6668	82.5%	10.0%	4.1%	3.0%
6	All	7254	84.3%	10.7%	3.5%	1.3%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 103: Lancashire Pupil Attitude Survey 2009, if I were worried about being bullied I would probably talk to...

If worried about being bullied I would probably talk to						
Yr		No.	Adult at school	Adult at home	Friend or sibling	No one
4	All	6668	45.1%	33.6%	12.2%	8.1%
6	All	7254	34.2%	40.9%	16.2%	8.2%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Child obesity

The World Health Organisation highlights childhood obesity as one of the most serious public health challenges of the 21st century. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, psychological problems – social isolation, low self-esteem, teasing and bullying, exacerbation of conditions such as asthma. The obesogenic environment we now live in is a product of technological advances with the life course of obesity prior to conception and parental obesity being the most significant predictor of childhood obesity. The most recent guidance from the National Institute of Clinical Excellence highlights maternal obesity as being linked to an increased risk of child obesity (see [early years](#) chapter for further discussion).

Figures have suggested that the national prevalence of obesity has trebled since the 1980s and that the population of England has the highest prevalence of obesity among the EU15 countries. Healthy Weight/Healthy Lives: A Cross Government Strategy for England was launched in January 2008 (DH), with a focus on children. The aim is to reduce the proportion of overweight and obese children to 2000 levels. The key themes of the strategy include:

- Children: healthy growth and healthy weight – early prevention of weight problems to avoid the ‘conveyor-belt’ effect into adulthood.
- Presenting healthier food choices – reducing the consumption of foods that are high in fat, sugar and salt and increasing the consumption of fruit and vegetables.
- Bringing physical activity into everyone’s life - getting people moving as a normal part of their day.

- Creating incentives for better health – increasing the understanding and value people place on long term input of decisions.
- Personalised advice and support – complementing preventive care with treatment for those who already have weight problems.

Supporting a much broader response to reducing obesity, Healthy Weight/Healthy Lives (op cit) launched a three-year social marketing campaign, Change4Life, in 2008 to urge the public to eat well, move more and live longer. This campaign has broken new ground and has drawn on academic and commercial sector expertise, behaviour change theory and evidence from other successful behaviour change campaigns, in particular tobacco control. Based on six typologies, Change 4 Life is intended to stimulate a movement, which people can join and in which everyone can play their part in creating change. The outward signs of this are a brand, a website, helpline, literature and PR activity in conjunction with major non-governmental organisations. A further campaign called Start4Life has been launched recently which focuses on pregnancy and Early Years and provides the most up-to-date advice on breastfeeding, introducing solid foods and active play, and tips on how to use them to give infants a better start in life. The Government has pledged to create a Responsibility Deal in the Public Health White Paper where industry will be asked to take a lead in providing an environment which supports people to make healthy lifestyle choices. It is unclear how, if at all, this will affect the delivery of these current social marketing campaigns.

Table 104: Summary of strength of evidence of factors that might promote or protect against weight gain and obesity (adopted from WHO, 2003)

Evidence	Decreases risk	Increases risk
Convincing	Regular physical activity High dietary non-starch polysaccharides/fibre intake	Sedentary lifestyles. High intake of energy-dense foods
Probable	Home and school environment that support healthy food choices for children Breast feeding	Heavy marketing of energy-dense foods and fast-food outlets Adverse social and economic conditions (in developed countries, especially for women). High intake of sugar-rich drinks
Possible	Low glycaemic index foods	Large portion sizes High proportion of food prepared outside the home (developed countries) 'Rigid restraint/periodic disinhibition' eating patterns.
Insufficient	Increased eating frequency	Alcohol
Source: WHO 2003		

Evidence on specific interventions to tackle obesity is limited and the evidence base is in development. However, there is evidence that factors in early years including in-utero, may be key

determinants of later obesity and ill health. This is supported by NICE guidance (2010). Lifestyle habits are resistant to change and the early years period (generally 0-2 years of age) therefore represents an important opportunity for the infant to start on a healthy trajectory; parents being particularly receptive to information at this stage. See section on [overweight and obesity in pregnancy](#) for further discussion.

The UK diet and activity facts for children are as below.

Table 105: UK diet and physical activity objectives for children

Nutrient/foods	Dietary targets (% of total energy intake, excluding alcohol) Children
Total fat	Reduce to a population average of 35%
Saturated fatty acids	Reduce to a population average of 11%
Trans-fatty acids	Reduce to a population average of 2%
Non-milk extrinsic sugars (added sugars in foods such as baked goods and table sugar)	Population average intake should not exceed 11%.
Salt	Reduce to a population average of: 3g per day for children aged 4-6 years 5g per day for children aged 7-10 years
Fruit and vegetables	As adults, with proportionally smaller portion size.
Dietary fibre	Young children require proportionally less (no specific targets have been set).
Physical activity	At least 60 minutes of moderate physical activity every day.
NB: These dietary targets do not apply to children under 5 years; those aged 2-5 years should progress towards these objectives. Exceptionally, specific recommendations exist for salt intake in children (0-6 months: less than 1g per day, 7-12 months 1g per day. 1-3 years no more than 2g per day).	

The obesity PSA target (acute), whilst based primarily on children less than 11 years, demands a response that addresses the population as a whole. A recent study sought to explore the potential of social marketing to build empowerment amongst families and healthy weight. Evidence from this study points to a number of issues that act as barriers to lifestyle change within families (Change4Life). National studies on the prevalence of obesity in children show a relationship between parental obesity and the probability of a child also being obese.

Table 106: Barriers to healthy living and healthy weight – summarised

- └ People have poor perception of their own weight status.
- └ Public perception of the link between obesity and ill health is poor.
- └ Concerns about diet and activity may not be a priority, especially in communities of low socio-economic status.
- └ Time spent on preparing meals has been reduced from two hours in 1980 to 20 minutes in 2000.
- └ Nutritional goals are secondary to maintaining a pleasant atmosphere at meal times.
- └ Ensuring that food is available predominates over the nutritional quality of the food.
- └ The built environment is an important determinant of physical activity.
- └ Parents are important gate-keepers in the provision of food to children.
- └ External influences (child peer pressure) can contribute to a vicious cycle of poor food habits.
- └ Foods previously considered a 'treat' have been everyday options.
- └ There is a low level of parental awareness of habits that predispose to excessive intake.
- └ Parents need education and support to develop highly refined parenting skills in relation to food.
- └ Parents are important role models for attitudes and participation in physical activity.
- └ Active play is an undervalued component of physical activity.
- └ There has been a marked decline in walking and cycling over the last 20 years.
- └ Computer games and videos are among the most highly valued and preferred activities for children.
- └ Increases in television viewing are associated with developed weight gain.

Source: Kent JSNA 2010

Since 2006 children entering reception year have been assessed for obesity or being overweight as part of the health checks routinely undertaken by the school health teams during that year. Year six children are also measured for body mass index (BMI).

In adults BMI is used to define overweight and obesity. A BMI measurement is obtained by dividing weight in kilograms by height in meters squared (kg/M²). Boys and girls experience different growth patterns at different rates and a single definition of overweight and obesity as in adults cannot be used. Therefore the UK National BMI percentile classification describes childhood overweight and obesity as greater than the 85th and 95th percentile respectively based on population values in 1990.

Child obesity in Lancashire

Analysis of the 2008/09 highlights that 9.1% of reception children were obese, rising to 17.1% of children in year 6. Boys are more likely to be obese in Lancashire in both years. These findings are in line with the national averages. Lancashire's levels of obesity are not significantly different;

any differences in the proportions are more likely to be a result of random variation than systematic differences in the populations.

Figure 50: prevalence of underweight, overweight and obese children in reception year by sex, 2008/09

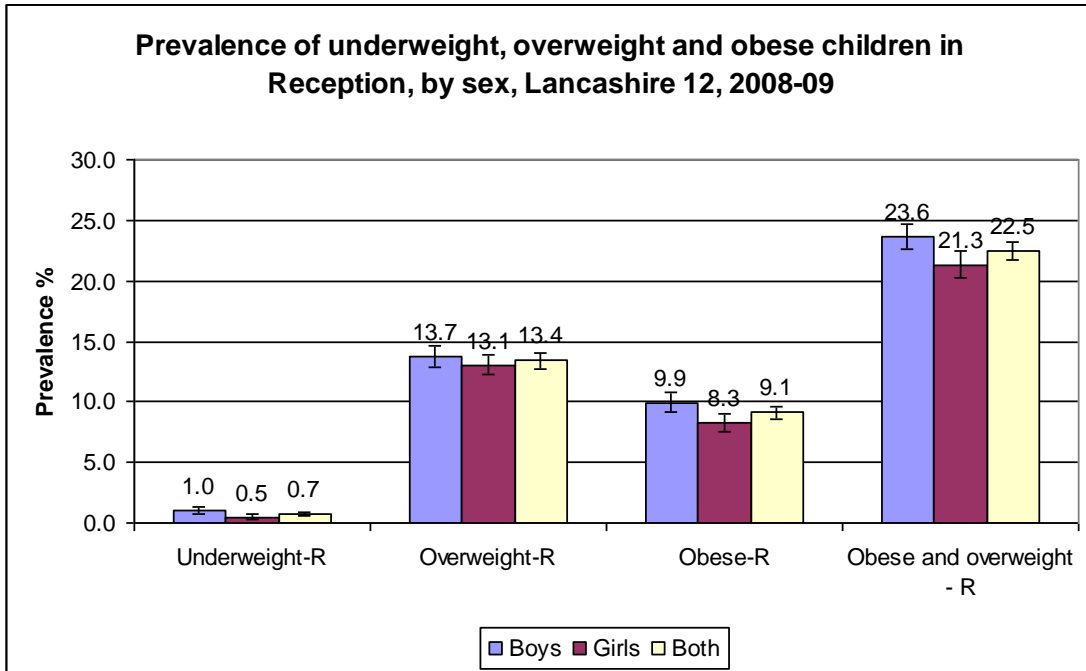
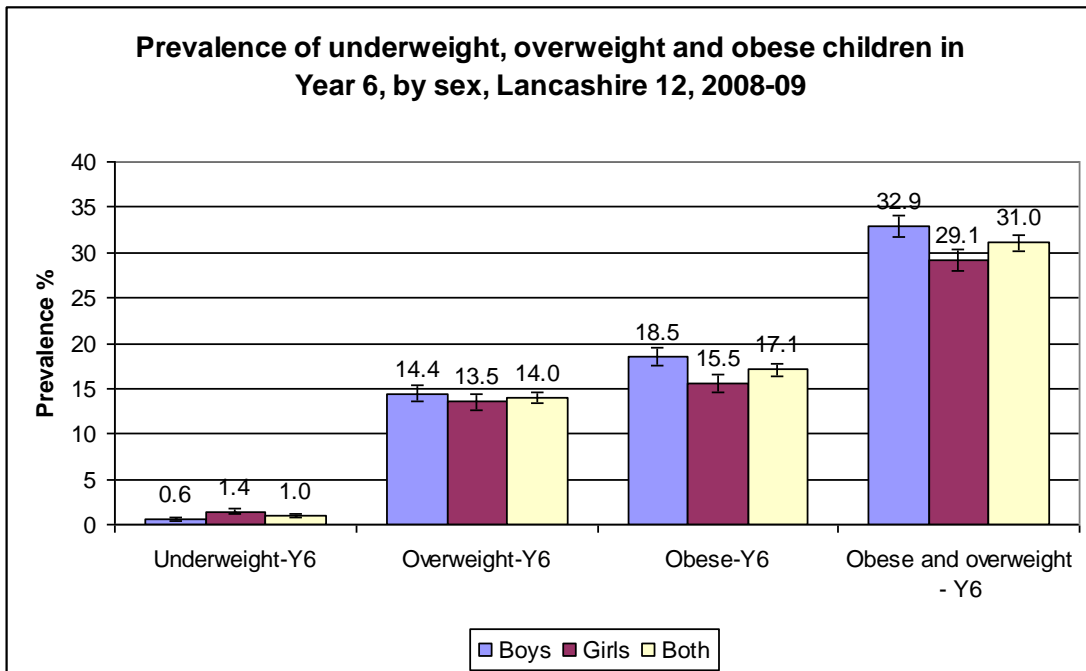


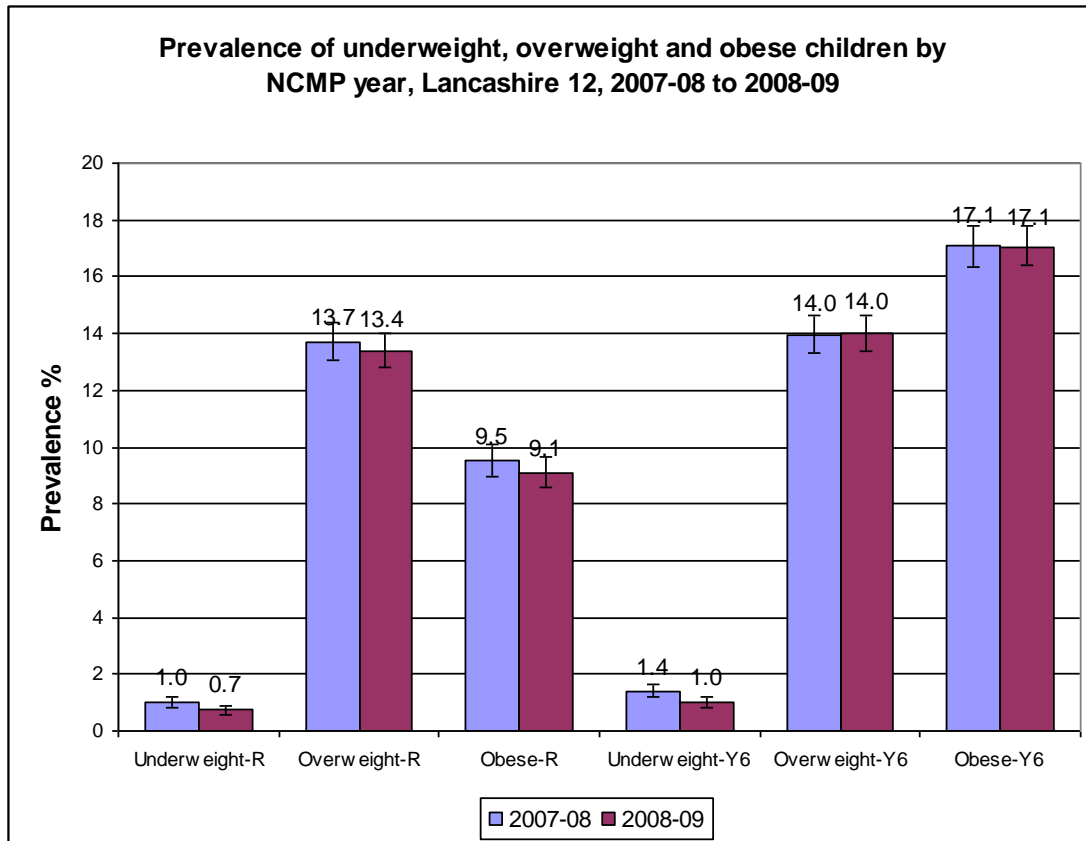
Figure 51: prevalence of underweight, overweight and obese children in year 6 by sex, 2008/09



There have been three years of NCMP data but the returns from the level of participation in the first year of the study were low so that the data is not of very good quality. As such, only the second two years are considered in the time series analysis. The next data set will be available by January 2011 which will enable a more comprehensive analysis of changes over time.

The prevalence rates of overweight and obesity (and underweight as this is also an issue) have remained the same between 2007/08 and 2009/10 for both school years. This suggests that the historic rise in prevalence has slowed.

Figure 52: prevalence of underweight, overweight and obese children by NCMP year, 2007/08 to 2008/09

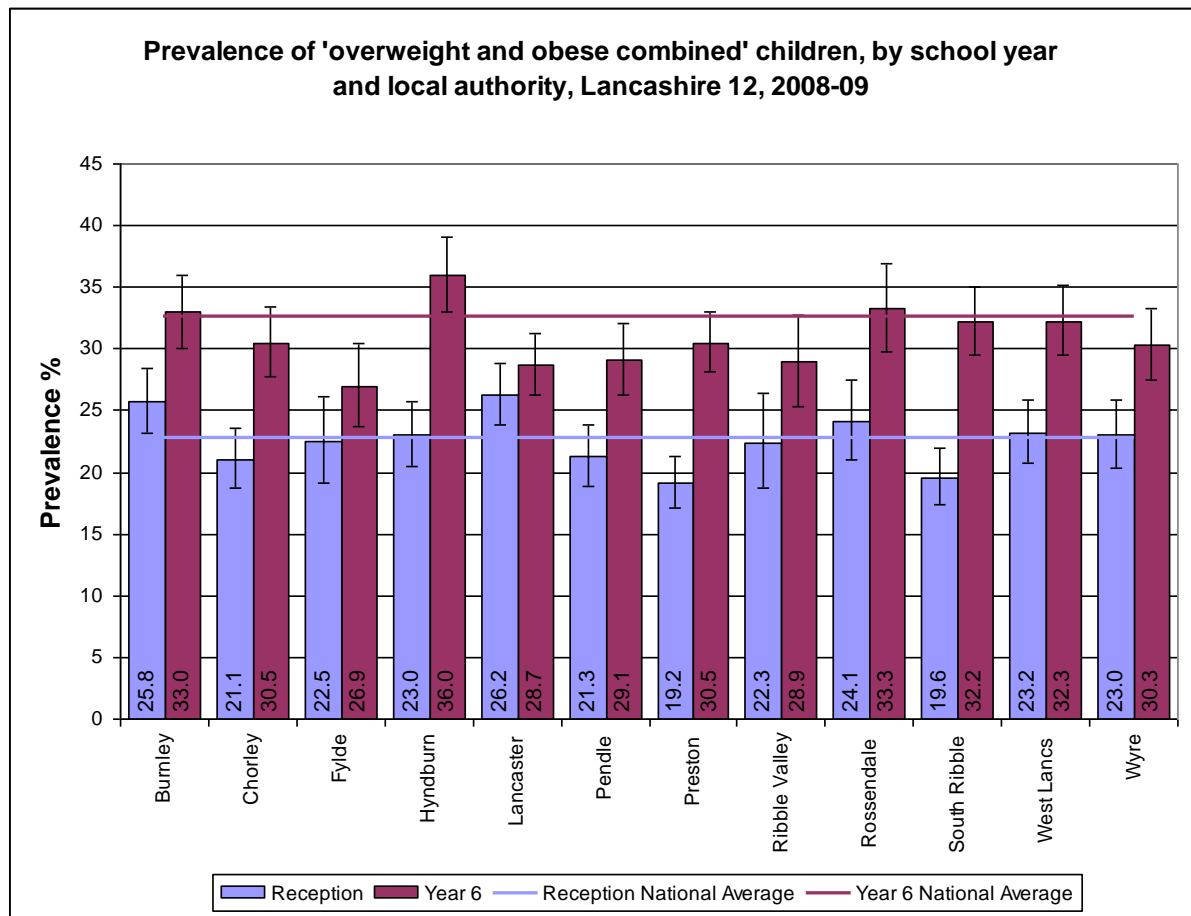


At a district level the prevalence of overweight and obesity combined is lower than the national average (in statistically significant terms) in Preston and South Ribble for reception year children, but the prevalence for year six children is the same as the national average. Although these are not the same cohort of children, this is an interesting shift at a population level and suggests there is an opportunity to intervene between reception and year six to stem the levels of obesity.

Both Burnley and Lancaster have higher than national overweight and obesity prevalence in reception year. Whilst the prevalence at year six has caught up with the national average in Burnley, in Lancaster the overweight and obesity prevalence is lower than the national average. This should be understood as it could provide a model for other areas to follow if related to successful intervention. Fylde and Pendle also had prevalence of overweight and obesity in line with the national average at reception year but lower than the national average at year 6 and these patterns should be understood further. At the other end of the spectrum, Hyndburn had prevalence

in line with the national average at reception year but prevalence above the national average in year 6 children.

Figure 53: prevalence of overweight and obese children by school year, 2008/09



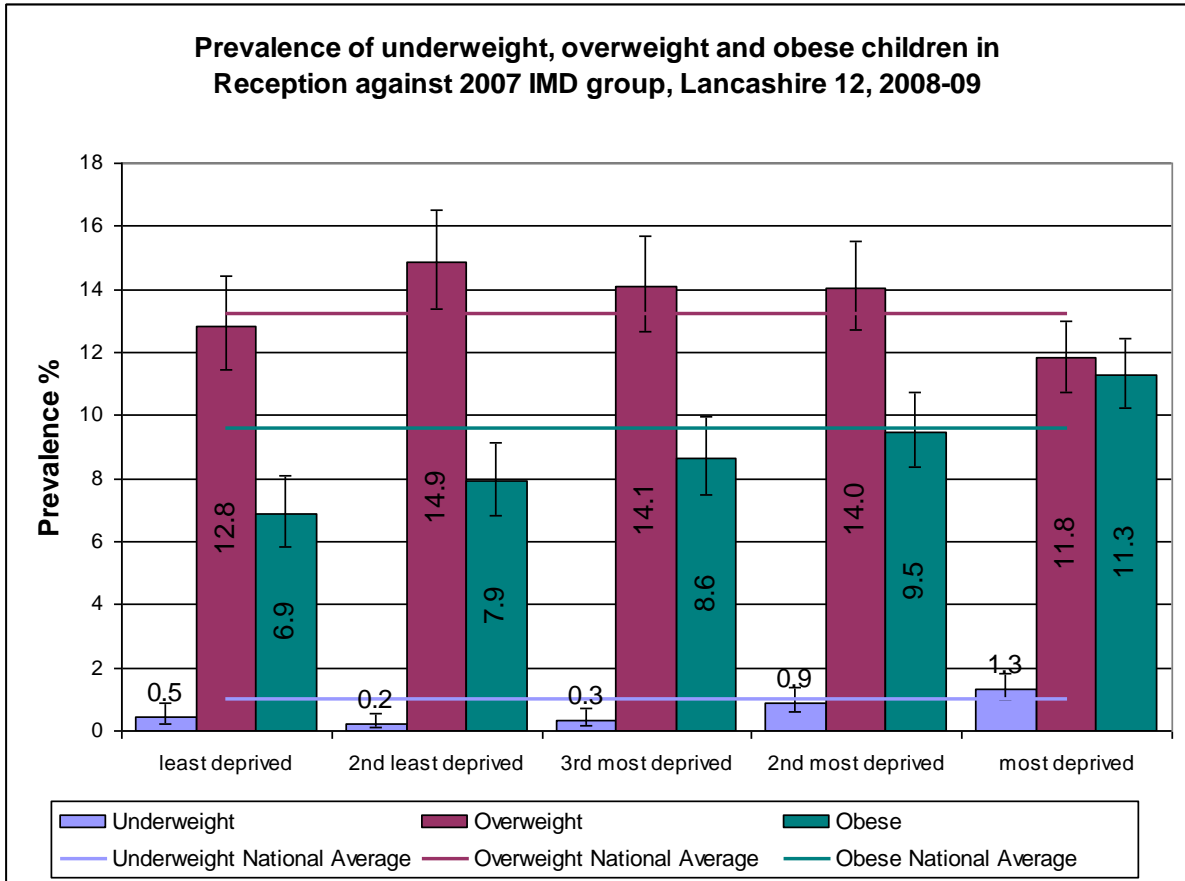
The chart below measures the prevalence of underweight, overweight and obesity in children by levels of deprivation. The chart shows clear inequalities and a strong social gradient with two polar extremes at either end of the gradient. Those children who live in the most deprived parts of Lancashire have the highest rates of obesity and underweight, both higher prevalence than the national averages, but lower prevalence of overweight than the national average.

At the other end of the scale, those in the least deprived areas are the most likely to be overweight but less likely to be underweight and obese. These prevalence rates are all significantly different from the national averages for all children. These differences across the social scale highlight that an approach based on progressive universalism is key as achieving a healthy weight is still a challenge in more affluent areas.

The Department for Health has released segmentation clusters which will help to understand the reasons behind these variations and provide interventions appropriate to different groups. This

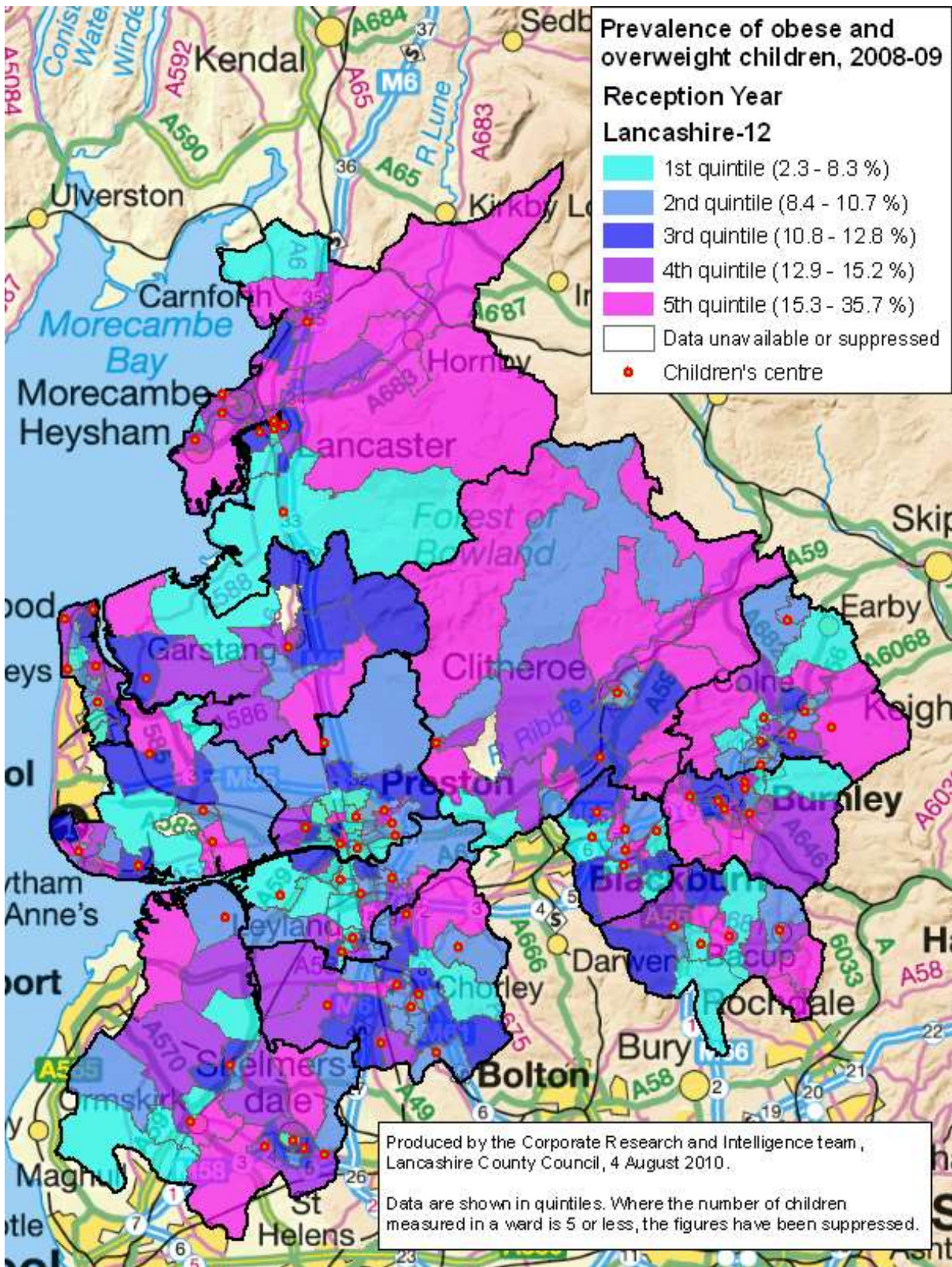
analysis will be part of the child and family needs assessment which is due following publication of the 2009/10 data set.

Figure 54: prevalence of underweight, overweight and obese children in reception year by IMD group, 2008/09



The maps below show ward level analysis of the prevalence of overweight and obesity across Lancashire in reception and year six with the locations of children's centres and primary schools. There are some interesting patterns, particularly for reception year children. In almost all cases, the areas with the highest prevalence of overweight and obesity are not directly served by children's centres.

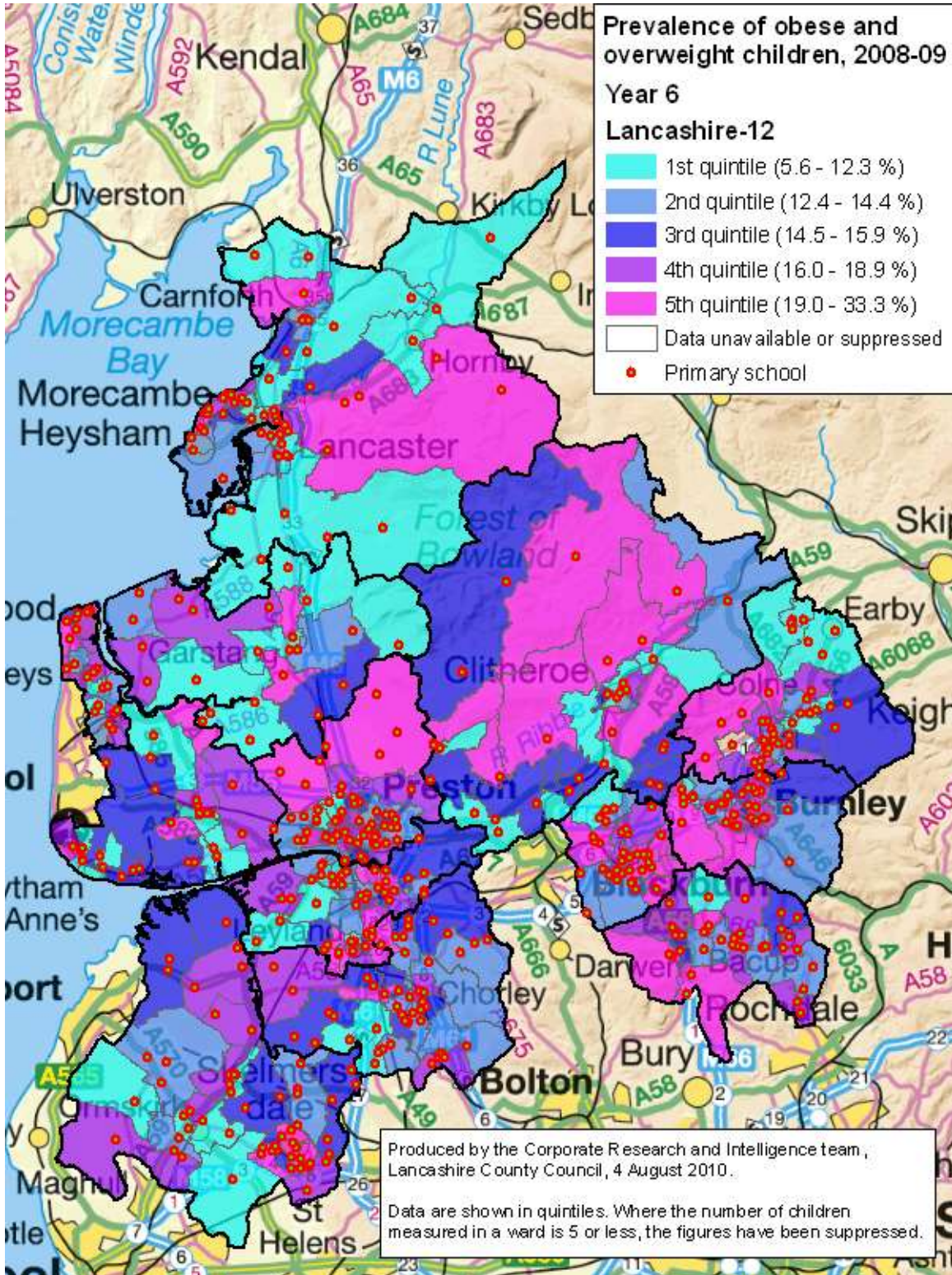
Map 24: prevalence of overweight and obese children in reception year, 2008/09



For primary years, high prevalence of overweight and obesity appear to coincide with areas not immediately served by primary schools. This may be related to levels of car transportation in these

areas with limited levels of active travel. The child and family obesity needs assessment will seek to understand these patterns to provide intelligence to support the design of appropriate interventions.

Map 25: prevalence of overweight and obese children in year 6, 2008/09



Healthy Eating

It has been suggested that the Government's National Diet and Nutrition Survey (NDNS) exposes a pattern of modern malnutrition especially in low income families (Gregory et al 2000). There is a social class and income gradient, with households in the lowest income brackets consuming less fruit and vegetables, skimmed milk, fish, fruit juices and breakfast cereals than average, despite spending a greater proportion of their income on food than those in better off households.

A lack of knowledge and skills for preparing meals from fresh ingredients is believed to be a reason for poor diet in low income families. Evidence suggests that socioeconomic status and education are associated with the sources of people's knowledge about cooking (Caraher et al 1999). Since home economics gave way to food technology on the education curriculum, practical cooking skills are rarely taught in schools. In primary schools much depends upon the enthusiasm of teachers to run after-school clubs. Even then, children usually have to provide their own ingredients, which can exclude children from poorer homes.

A generation has grown up that lacks the confidence to try out new foods or recipes and is more likely to buy convenience foods, which tend to be higher in fat and sodium than home cooked foods. This is true in all income brackets but especially in low income households, where convenience foods are seen as relatively cheap and acceptable to all the family, with no waste. As this trend continues, health workers are seeing more and more people who are obese and undernourished at the same time – a phenomenon of modern malnutrition (Hosker 2003).

Another contributory factor is believed to be food poverty as those living in the poorest areas having reduced access (although the reasons for this are debated) to good quality affordable food. Despite suggestions that adults in poverty protect their children's diets at the expense of their own it has been suggested that one in 50 children do not get three meals a day (Dowler et al 2001). Social and cultural norms, knowledge and health motivation are important in this regard. Skipping breakfast for example is particularly common among adolescent girls.

The home environment is regarded as the most important place where health behaviours are learned and maintained (Swinburn et al 1999). Therefore, it follows that it is also the place where efforts need to be concentrated in order to effect change. It is essential that research rises to the challenge and considers the best way to approach ordering of eating within the family context, not least for researchers and practitioners involved in promoting health within the family, but most importantly, for the health of the family members themselves. Evidence suggests that families with an obese child have less ordered family eating compared to families with healthy weight children (Kime 2007):

Table 107: Levels of ordered family eating

Low order	High order
Rarely ate together as a family: - Different time - Different location - Different food Eating behaviours LOW priority	Usually eat together as a family: - Same time - Same location - Same food Eating behaviours HIGH priority

Source: Kime (2007)

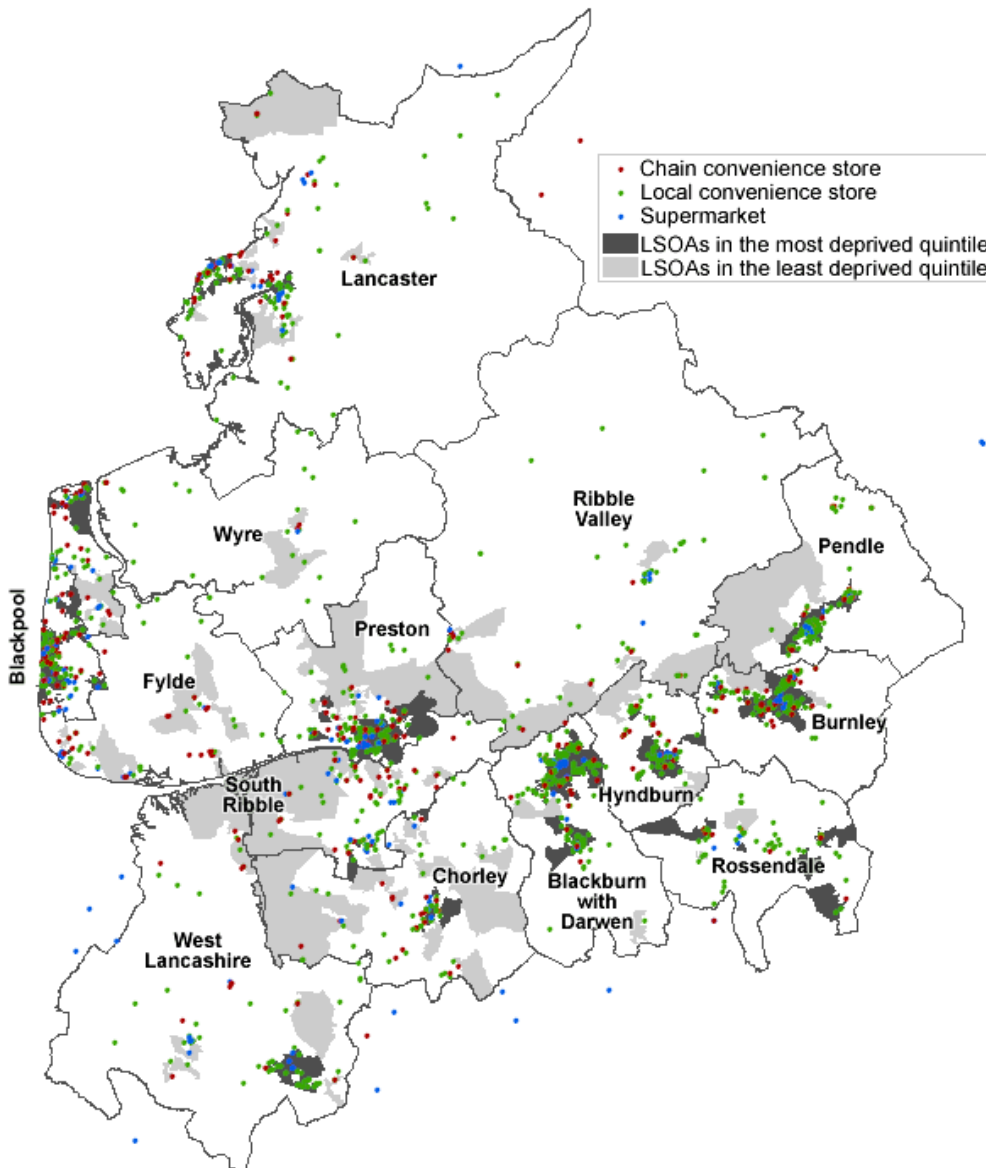
Research by Brown et al (2008) suggests the following recommendations to support more ordered family eating:

- Set a time to eat together and let the family know in advance.
- Eat as a family as much as possible (try for most nights and breakfasts).
- Describes mealtimes as a family tradition.
- Encourage children to sit down with parents to share a meal (at a table, or in a designated eating space facing eat other – not in front of the TV).

Healthy diet is an important public health issue. Studies have shown that fresh, nutritious food is less likely to be available in the most deprived areas. The increase in supermarkets in out of town locations and the granting of planning permission for fast food takeaways often means it is cheaper and easier to buy something convenient and local rather than take a trip to the supermarket to buy fresh and then cook. If meals are not cooked in the home it is difficult for children to learn how or what they should be eating, adding to a cycle of poor nutrition. A summary of the evidence on interventions to support [good nutrition and healthy eating](#) is provided in the evidence base.

The map below shows the location of all convenience stores and supermarkets which may provide access to nutritious food across Lancashire. The shaded dark grey areas are the most deprived 20% of the sub-region. There are several dark grey areas covered by many multi coloured dots and these are the urban centres of the districts. The areas of particular concern, where there is likely to be poor access to affordable food, are those with dark grey without coloured dots overlaid. Parts of Rossendale, Skelmersdale, Fleetwood and east Preston seem to have areas of high deprivation without close access to shops.

Map 26: Location of convenience stores and supermarkets across Lancashire



Source: Lancashire County Council Strategic Planning Team

The 2008/09 Pupil Attitude Survey revealed that almost one in five primary school pupils in Lancashire either "weren't keen on" or "didn't like" fruit and vegetables, and a slightly higher proportion "rarely" or "never" chose healthy food options.

Table 108: Pupils eating fruit and vegetables

Eating fruit and vegetables					
Yr	No.	Really like	Quite like	Not keen	Don't like
4	6668	44.0%	36.0%	12.3%	7.0%
6	7254	34.2%	46.3%	13.9%	5.3%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 109: Pupils choosing healthy food options

Choosing healthy food options					
Yr	No.	Always	Usually	Hardly ever	Never
4	6668	24.5%	53.0%	14.4%	7.5%
6	7254	13.1%	61.7%	20.1%	4.7%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Those children in the least deprived areas are must less likely to report that they usually make healthy choices; less than 50% compared with almost two thirds in the least deprived areas. Children in the most deprived 5% also report being more likely to never make healthy choices; 8% versus 2% of children in the least deprived 5%. There are conflicting results however, particularly for the very positive response of always making healthy choices where a quarter of pupils in the most deprived 5% claim to do so, which is almost double that in the least deprived 5%.

Table 110: Pupils making healthy choices where they have an option

	Very positive	Positive	Negative	Very negative	All Positive responses	All Negative Responses
	I always make healthy choices	I usually make healthy choices	I hardly ever make healthy choices	I never make healthy choices		
Least deprived 5%	13.1%	63.7%	19.9%	2.4%	76.9%	22.3%
Least deprived 25%	14.8%	64.9%	16.5%	3.4%	79.7%	19.9%
Least deprived 40%	15.9%	64.3%	15.9%	3.6%	80.2%	19.5%
Middle 20%	16.7%	60.9%	17.8%	4.0%	77.6%	21.8%
Most deprived 40%	19.4%	58.8%	16.8%	4.3%	78.2%	21.1%
Most deprived 25%	22.5%	53.1%	16.8%	6.5%	75.6%	23.4%
Most deprived 5%	25.9%	47.3%	17.1%	8.4%	73.2%	25.5%

Table 111: Case study: Community food growing schemes in central Lancashire

Growing your own produce not only offers a good source of nutritious food but is also linked to health benefits such as physical activity and wellbeing. Food growing schemes provide the potential for communities to take an active role in growing locally fresh fruit and vegetables, reduces the carbon footprint as well as promoting a healthy environment and promote social inclusion.

NHS Central Lancashire is working in collaboration with partnership agencies to deliver community food growing programmes (2009-12) in the four local authority districts of Chorley, Preston, South Ribble and West Lancashire, driven by multi-agency action plans. Training and development for people and communities is a key component to the sustainability of this scheme with a strong focus on the promotion of healthy lifestyles and social inclusion. As part of developing skills locally, the programme is also implementing this work within school settings which provide a captive audience for learning and developing skills, taking classroom education into real life experiences. However, the schools programme is the least developed and requires further input to meet the demand from schools to be involved within the programme. One possible solution is to obtain more engagement from PTAs to help resource and utilise the assets that exist.

Key highlights for the first year include community allotment sites established across central Lancashire, a successful schools project involving 18 local schools in West Lancashire, rollout of training programmes, and provision of support and advice to existing and new allotment holders.

Oral Health

Tooth decay, which is a preventable disease, remains one of the most common diseases of childhood affecting physical and psychological wellbeing and quality of life.

Although oral health has improved dramatically over the last 40 years and 12 year old children in England now have the lowest levels of tooth decay (dental caries) in Europe (DH, 2005). Rates of tooth decay in Lancashire are above the national average and there are a high proportion of planned admissions for children in this age group are for diseases of the oral cavity (see earlier [hospital admissions](#) section).

In common with other chronic diseases, high levels of tooth decay are associated with deprivation, with people from higher socio-economic groups having better oral health than people from lower socio-economic groups (Watt and Sheiham, 1999; Locker, 2000). Additionally, people from higher socio-economic groups are more likely to access regular oral healthcare (Kelly et al 2000). Opportunities to improve oral health and prevent tooth decay are present from birth and should be maximised to prevent the development of dental decay by primary school age.

Tooth decay is caused by the frequent consumption of sugary foods and drinks. Sugars are metabolised by bacteria in the mouth resulting in the production of acids. These acids dissolve the substance of the tooth and over time, can eventually lead to the formation of cavities. The primary prevention of tooth decay should focus on controlling the amount and frequency of consumption of sugars in the diet and protecting the tooth surface through application of fluoride or fissure sealants. A summary of the evidence base on interventions to [prevent tooth decay](#) is provided in the appendix.

In 2007/08 there were inequalities across the county of Lancashire in terms of the proportion of school children who had experienced tooth decay and in the severity of the disease experienced; the worst areas being Hyndburn, Pendle and Preston.

Table 112: Oral health of schoolchildren in Lancashire

Area	Mean dmft ¹	Percentage of Schoolchildren with Tooth Decay Experience	dmft>0 ²	Care Index ³
Central Lancashire	1.53	40%	3.68	11
East Lancashire	1.78	41%	4.13	15
North Lancashire	0.93	26%	3.49	18
Lancashire County	1.48	37%	3.83	9
North West Region	1.52	38%	3.80	11
England	1.11	31%	3.45	14
Source: NHS Dental Epidemiology Programme, Oral Health Survey of 5-year-old children in England 2007/08, c/o The Dental Observatory				

1Mean dmft = average number of decayed, missing or filled teeth in all schoolchildren

2Mean dmft>0 = average number of decayed, missing or filled teeth in those schoolchildren with decay experience

3Care Index = proportion of teeth with decay experience that have been restored (filled)

NB. The requirement for positive consent has introduced bias into these data which means that they cannot be used for backwards comparison. These results should be viewed and interpreted in conjunction with the "NHS Dental Epidemiology Programme for England; Oral Health Survey of five year old children 2007 / 2008" report and the "Explanation of caveats for 2007/08 five-year-olds survey data" document.

http://www.nwph.info/dentalhealth/reports/NHS_DEP_for_England_OH_Survey_5yr_2007-08_Report.pdf
http://www.nwph.info/dentalhealth/reports/Statements_re_NHS_DEP_5_yr_olds_2007_08.pdf

Table 113: Caries experience in 5 year-old children across Lancashire

Local Authority	Mean Decayed teeth (d)	Mean Missing teeth (m)	Mean Filled teeth (f)	Mean dmft	% of children with tooth decay experience	Mean dmft (dmft >0)	% Caries free
Burnley	1.53	0.26	0.14	1.93	44%	4.28	56
Chorley	1.06	0.14	0.10	1.30	36%	3.47	64
Fylde	0.67	0.13	0.08	0.89	25%	3.30	75
Hyndburn	1.59	0.30	0.22	2.11	46%	4.46	54
Lancaster	0.59	0.19	0.14	0.92	25%	3.51	75
Pendle	1.49	0.35	0.16	2.00	47%	4.08	53
Preston	1.70	0.18	0.15	2.03	46%	4.12	54
Ribble Valley	0.54	0.16	0.15	0.85	25%	3.36	75
Rossendale	1.30	0.12	0.12	1.55	36%	4.03	64
South Ribble	1.01	0.16	0.10	1.28	36%	3.48	64
West Lancashire	1.14	0.10	0.15	1.39	39%	3.49	61
Wyre	0.96	0.22	0.13	1.30	33%	3.78	67
Source: NHS Dental Epidemiology Programme, Oral Health Survey of 5-year-old children in England 2007/08, c/o The Dental Observatory							

1Mean dmft = average number of decayed, missing or filled teeth in 5 year olds

2Mean dmft>0 = average number of decayed, missing or filled teeth in those 5 year olds with decay experience

Table 114: Oral health case study, Smile4Life

The need for a consistent, equitable, evidence based approach to oral health prevention had been recognised through the Local Area Agreement. The Smile4Life Programme, launched in October 2010, supports co-ordinated oral health improvement activity across Lancashire with the aim of reducing dental caries and laying solid foundations for good oral health throughout life. The Smile4Life Programme focuses upon 4 key areas:

- Encouraging healthy eating and drinking
- Encouraging regular tooth brushing
- The promotion of a healthier lifestyle
- Visiting the dentist regularly

The programme consists of a suite of resources and a Smile4Life programme workbook. Electronic versions are also being made available along with an interactive website which will provide statistical information allowing settings to plan activities according to identified need.

Early years settings will be targeted initially. Oral health training will be made available, and expert support will be provided to each setting in the implementation of the Smile4Life programme.

Implementation of the Smile4Life programme will ensure that early years settings:

- Are supported in providing an environment which will minimise the risk of children getting tooth decay
- Support behaviour which will promote good oral health
- Ensure evidence based, self care behaviours are adopted which will prevent tooth decay

Smoking

People who smoke are more susceptible to certain illnesses including lung cancer, heart disease and emphysema. In Great Britain it is recognised that about 450 children start smoking every day and by the age of 15 around 20% of them are regular smokers (Royal College of Physicians 1992). The earlier children become regular smokers and persist in the habit into adulthood the greater the risk that they will develop lung cancer or heart disease (Royal College of Physicians 1992). Around half of today's young smokers will die early from smoking related diseases.

The issue of **young smokers** is dealt with in more detail in the next chapter. However, in order to prevent young people from starting smoking it is important that young children are informed of the dangers of taking up the habit and families are worked with to reduce the overall prevalence of smoking amongst the adult population.

Data gathered through the annual Pupil Attitude Survey in Lancashire has revealed that the majority of primary school children believe that they will never take up smoking and only a very small proportion believe that they definitely will smoke.

Table 115: Pupil attitudes to smoking, 2008/09

Yr	No.	Never	Probably never	Probably will	Definitely will
4	6668	84.3%	9.9%	2.7%	1.9%
6	7254	82.8%	12.9%	2.4%	1.0%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Further analysis of the data reveals a social gradient in the responses. Pupils from the 5% most deprived backgrounds are almost twenty times more likely to report that they will probably or definitely smoke than those from the 5% least deprived.

Table 116: Pupil attitudes to smoking across the social gradient, 2008/09

	Very positive	Positive	Negative	Very negative	All Positive responses	All Negative Responses
	I definitely will never smoke	I probably will never smoke	I probably will smoke	I definitely will smoke		
Least deprived 5%	90.4%	8.8%	0.0%	0.4%	99.2%	0.4%
Least deprived 25%	88.2%	8.8%	1.5%	0.9%	97.0%	2.4%
Least deprived 40%	87.2%	9.9%	1.4%	0.8%	97.1%	2.2%
Middle 20%	83.1%	12.8%	2.5%	0.8%	95.9%	3.3%
Most deprived 40%	82.3%	11.9%	3.3%	1.5%	94.2%	4.8%
Most deprived 25%	80.5%	12.9%	3.9%	1.3%	93.5%	5.2%
Most deprived 5%	79.9%	11.1%	4.7%	3.2%	91.1%	7.9%

Table 117: Smoking case studies

Lancashire Trading Standards has undertaken a young person's alcohol and tobacco project aimed at preventing children from starting smoking. The main focus of the project is on primary age pupils but developments are in place to extend the project to target secondary school pupils. A summary of elements of the project are provided below:

- A tobacco website has been constructed and is in operation (www.lookouttobacco.co.uk) that aims to address key health and wellbeing priorities and to increase the awareness around tobacco issues with primary aged children. The website supports teachers by introducing tobacco education through a cross-curricular approach and assists parents in raising their awareness of the issues surrounding tobacco and their children. Posters and promotional material have been produced regarding the website for and distributed to 165 primary schools across East Lancashire.
- On the 5th March 2009 a World of Alcohol and Tobacco Conference for east Lancashire primary school pupils and their teachers was held at Turf Moor, Burnley. 41 children, aged between 9 and 11, from 12 Lancashire schools attended. The aim of the conference was to educate children as to the issues surrounding alcohol misuse and tobacco use and the personal, social and health problems that can occur. The conference was hosted and organised by The Young Persons Alcohol Project and a partner organisation, the School and Communities Partnership Team. School children participated in a series of workshops with the aim of:
 - Increasing their knowledge of alcohol and tobacco and the related effects;
 - Address and clarify their attitudes to alcohol and tobacco use; and
 - Help enhance and develop the skills required to deal with difficult situations around alcohol and tobacco use.
- The conference also provided information to attending teachers to enable them to deliver alcohol and tobacco education lessons in the classroom. The conference was structured around the Tacade resources 'World of Alcohol' and 'World of Tobacco' which contain key lessons, classroom materials, workshop materials for teaching staff and parents' background papers. The purpose of the material is to provide a comprehensive approach to dealing with a sensitive area of health education. Each school attending the conference received their own copy of the resource.
- Supply of 10 World of Tobacco school teaching packs to be distributed to target schools by the Stop Smoking Service. The schools are being targeted on the basis of need.
- A Tobacco and Young Person Group has been established with various partners, including Smoke Free Homes and East Lancashire PCT, to develop and coordinate a children's education approach across East Lancashire. There are plans to develop a 'Teachers' brief intervention pack' providing relevant information for teachers to use in tobacco education.
- A tobacco awareness leaflet aimed at young people has been designed. The leaflet outlines the law

in relation to tobacco products including underage sales, illicit tobacco and niche tobacco. Design students from a 6th form college developed the artwork for the leaflet. The leaflet will go into production in the coming months and will be distributed to schools during the autumn term.

- Focus group work has been undertaken with young people in East Lancashire schools to gauge their views of tobacco use, including how much they smoke, where they obtain tobacco and how it impacts on school performance. 35 young people were interviewed. The results are currently being collated. The results will then be used to make recommendations and identify areas for further work.
- In partnership with East Lancashire PCT, work has commenced to produce a tobacco education resource box which will be made available to East Lancashire secondary schools which provides a variety of education material such as carbon monoxide indicators and website materials which can be used by teachers as part of their tobacco awareness education activities.

Physical activity

Encouraging children to be physically active can help combat childhood obesity. In addition, physical education and sport can help promote team-building, improve interpersonal skills, foster motivation and encourage perseverance. Physical activity is also linked to improved wellbeing and mental health. The quality of the local environment is strongly linked to levels of physical activity. See the section in the [socio-economic determinants](#) chapter for further discussion.

Data gathered through the Lancashire Pupil Attitude Survey shows that the vast majority of primary school children in Lancashire enjoy sporting activities and physical exercise.

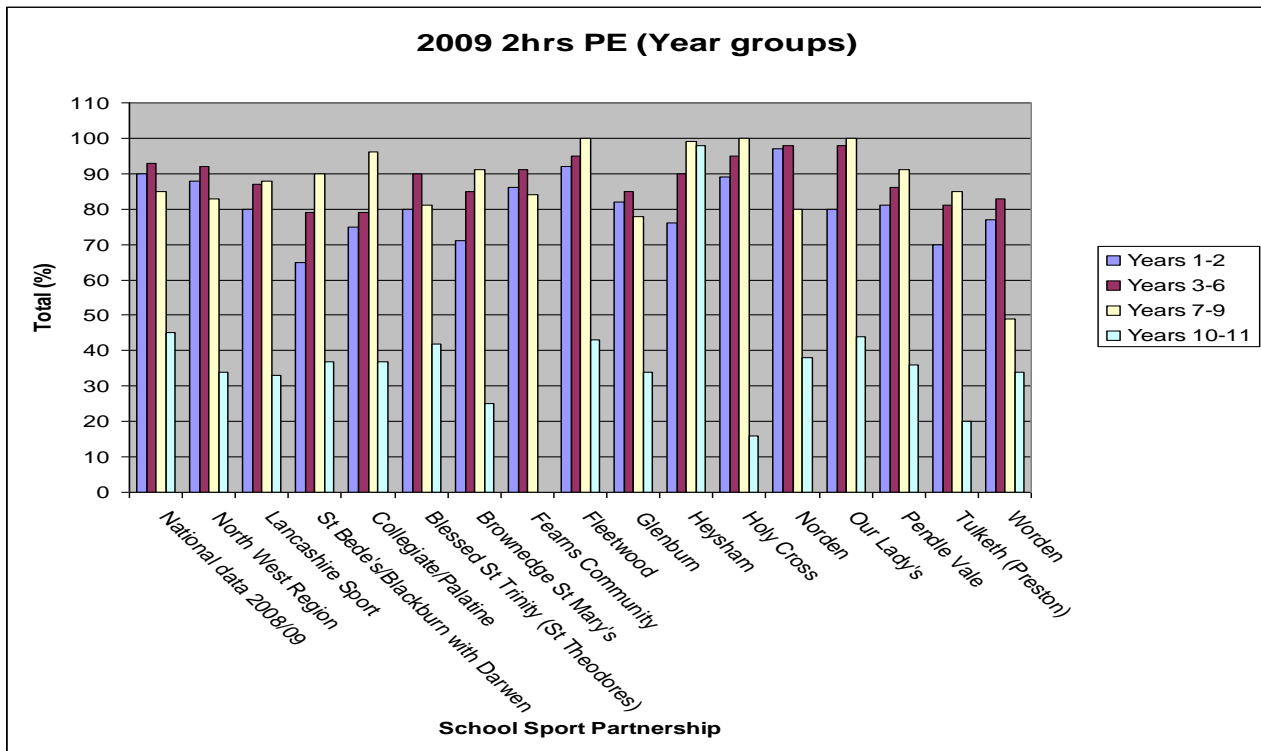
Table 118: Pupils enjoying sporting activities and physical exercise, 2008/09

Yr	No.	Always	Usually	Hardly ever	Never
4	6668	74.3%	20.8%	2.9%	1.5%
6	7254	66.2%	29.3%	4.0%	1.2%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

The proportion of primary school children in Lancashire participating in at least 2 hours a week of high quality physical education and sport in schools is shown below. Participation is variable across the School Sport Partnerships and children in years 3 to 6 are more likely to have 2 hours physical education than those in years 1 to 2. Within the Lancashire County partnerships, the lowest rates of achievement of two hours physical education are seen in Brownedge St Mary, Tulketh and Worden.

Figure 55: Two hours physical education by year groups, 2009



Views of Primary Schools

Children and young people of school age spend a large proportion of their time in school and schools are well placed to comment on children's services. The Audit Commission Survey of Schools was a national survey exploring schools' opinions on services and support for schools and for children and young people. 145 out of 484 primary schools in Lancashire took part in the 2009 survey and their responses were generally favourable. All areas were rated 'adequate' or better.

The responses in Lancashire also compared well with those achieved by other children's service authorities. There were only three areas where Lancashire's ratings were in the bottom 25% and these were as follows:

- Lancashire County Council's co-ordination of services to support the education of looked after children.
- Lancashire County Council's support for improving school attendance.
- Lancashire County Council's educational psychology support.

Summary, identification of key areas of need and recommendations

During the primary years, the main risk for children relates to not achieving at school. Being able to achieve at this level supports a child to go on and achieve at subsequent levels, supporting success in later life. Whilst schools are clearly an important area, with a role to provide good education, identify and support children with additional needs and help children to overcome cultural and social barriers, the influence of home cannot be overlooked as this is where the prerequisites for achievement are instilled. Low levels of family aspiration, the view of not working as a "norm" and poor health and nutrition are all factors.

Childhood obesity is clearly a key need for this age group but, as with many needs identified through the JSNA, the best way to tackle is through early intervention. Recent feedback from the NST visit to NHS North Lancashire confirms that national evidence suggests that priority needs to be given to early intervention from preconception to children up to 2 years to address the rising levels of obesity. This confirms the importance of tackling maternal obesity and the value of children's centres in tackling this need.

The same early intervention approach should be taken to the clear need for improved oral health. Lancashire has a high proportion of children experiencing tooth decay compared with the national average, and the rates of decayed, missing and filled teeth are particularly troubling in Burnley, Hyndburn and Pendle, confirming a link with deprivation. For the primary age group, a high proportion of planned admissions to hospital are for treatments for diseases of the oral cavity, salivary glands and jaws confirming oral health is an important need for this age group.

Educational achievement in primary years is crucial for young people to be able to achieve in later stages of life. Lancashire has an excellent record of overall achievement but there are notable gaps related to some groups of children including those with special educational needs, those who are eligible for school meals and those who are looked after. Variance in achievement is still found by ethnic group and gender. Ensuring that all children, regardless of background and circumstances, have the appropriate support to be able to achieve should remain a priority for Lancashire.

Although the rate of persistent absence from school and exclusions from school are below the national averages, there remain significant numbers of children involved. This will affect their chances of succeeding at school and is particularly of concern for groups such as travellers, who may not be known at all to services. Schools provide an excellent setting for engaging with children to ensure they receive all the support they need throughout their time in compulsory education and the exclusion or absence of particular groups could mean they are not receiving all the support they would ideally receive with consequences for their development during life.

Results from the Audit Commission survey of schools highlights that Lancashire schools are concerned with the support available for improving school attendance.

In summary, the key areas of need identified for children and young people of primary age in Lancashire are:

- Absence from school, including exclusions
- Childhood obesity
- Educational attainment gaps
- Oral health

Specific recommendations

A number of specific recommendations can be drawn from the analysis in this chapter:

- Time series analysis of educational attainment in Lancashire overall, by district, and by various groups such as by gender, ethnic group, FSM eligibility, children who are looked after, children with special educational needs, etc, should be made available through the JSNA pages.
- Investigation of the characteristics of those pupils who are persistent absentees would assist in developing better support for schools to improve school attendance.
- The intelligence from the JSNA child and family obesity needs assessment, due summer 2011, should be used to develop comprehensive and multi-agency approaches to the prevention and reduction of child obesity rates.
- Opportunities to improve oral health are present from birth and should be maximised to prevent the development of dental decay by primary school age.

Secondary years –11 to 16 years

Adolescence is a crucial time for developing life and livelihood skills, accessing new information and knowledge, and experimenting with cultural, artistic, and physical expression with peers. However, some young people will face barriers to their taking part fully in education with the result that some young people will often not be in the position to acquire marketable knowledge and skills, including key information technology skills. For many young people there will be a draw towards risk taking behaviours such as alcohol and drug use, which for those young people who are not equipped with the skills to be resilient will be linked to poor mental health.

Key vulnerabilities for this group include:

- Lack of development of life and livelihood skills
- Lack of participation in decisions and policies that affect the lives of young people

With potential short term outcomes:

- Exposure to risky behaviours: alcohol and drug abuse, early unprotected sex, smoking, and premature death

With potential long term outcomes:

- High economic costs of negative consequences of risky behaviours
- Intra- and inter-generational transmission of poor health and its consequences
- Lost opportunities for involving young people as agents of better governance, accountability and democracy

For children of secondary school age, priority should be given to interventions that:

- Improve the quality of education at the secondary level with particular emphasis on building skills – including information technology skills – to compete effectively in the job market;
- Promote emotional health and wellbeing;
- Build resilience to reduce negative consequences of risk taking behaviours;
- Improve access to community-based opportunities for life and livelihood skills development, with direct participation of youth organisations;

- Develop an inclusive local youth policy to promote youth participation in decisions and policies that affect their lives.

Background

There are nearly 63,000 secondary school aged pupils living within Lancashire. Of these:

- Approximately 8,000 or 13% receive free school meals.
- The majority of pupils are white British (56,000 or 89%)
- 2,500 or 4% are Pakistani, 2% or 1,000 are Indian and 1% or 400 are Bangladeshi.
- Approximately 1,500 secondary school pupils have a statement of special educational needs.

Child mortality

In Lancashire there were 63 deaths of children aged 10-14 years old over the period 2005/06 to 2009/10. During this 5 year period there were 8 deaths in Preston, 7 deaths in Lancaster and 6 deaths in both Hyndburn and Pendle.

Table 119: Childhood deaths in Lancashire, aged 10-14, 2005/07 to 2009/10

Childhood mortality aged 10-14 years						
Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Grand Total
Burnley		<5	<5			<5
Chorley	<5	<5		<5		<5
Fylde	<5	<5		<5		5
Hyndburn	<5	<5		<5	<5	6
Lancaster	<5	<5		<5	<5	7
Pendle	<5	<5	<5			6
Preston	<5	<5		<5		8
Ribble Valley	<5			<5		<5
Rossendale	<5					<5
South Ribble		<5				<5
West Lancashire			<5			<5
Wyre	<5			<5	<5	<5
Lancashire	15	19	7	10	12	63

Source: Public Health mortality data provided by CLCBS
Numbers fewer than 5 suppressed for reasons of confidentiality

The table below highlights the causes of death for young people aged between 10 and 14 years in Lancashire. More than a third of deaths in this age group are within the category of other causes of death, which suggests further work is required on coding of the data. Excluding this cause, the

largest cause of death is again malignant neoplasms (cancers), followed by diseases of the circulatory system, which accounted for 9 and 7 deaths respectively.

Table 120: Childhood deaths aged 10 to 14 years in Lancashire by cause, 2005/06 to 2009/10

ICD10 Code	ICD10 Description	Nos.	%
A00-B99	Certain infectious and parasitic diseases	<5	
C00-C97	Malignant neoplasms	9	14.3%
C81-C96	Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	<5	
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	<5	
E00-E90	Endocrine, nutritional and metabolic diseases	<5	
G00-G99	Diseases of the nervous system	<5	
I00-I99	Diseases of the circulatory system	7	11.1%
J00-J99	Diseases of the respiratory system	<5	
J45-J46	Asthma	<5	
K00-K93	Diseases of the digestive system	<5	
K40-K46	Hernia	<5	
M00-M99	Diseases of the musculoskeletal system and connective tissue	<5	
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	<5	
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	<5	
ZZZ	Other causes of death	22	34.9%
Total deaths		63	
Source: Public Health mortality data provided by CLCBS Numbers fewer than 5 suppressed for reasons of confidentiality			

Hospital admissions

Rates of hospital admissions in the age group 10 to 14 years are once again lower than the rates of the previous age group (5 to 9) showing the reducing risk as children develop. Across Lancashire as a whole a single admission could be expected per every ten people aged 10 to 14 in one year. There are slight variations in the rates with the highest in West Lancashire and the lowest in Ribble Valley. Over recent years there have been reductions in the rates of hospital admissions across East Lancashire, with the exception of Rossendale. Fylde and Wyre have experienced quite large increases in admissions and further investigation is needed for these changes to be understood.

Table 121: Total hospital admissions rate per 1,000 of the population aged 10-14 years, 2005/06 to 2009/10

Total admissions rate per 1,000 of the population aged 10-14 years						
Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	92	88	89	93	94	2.1%
Burnley	104	90	89	87	95	-8.9%
Chorley	92	93	110	100	94	2.1%
Fylde	80	89	77	101	104	29.4%
Hyndburn	102	90	101	110	104	2.1%
Lancaster	78	83	81	87	80	3.3%
Pendle	106	91	82	91	91	-14.2%
Preston	101	110	116	102	103	1.6%
Ribble Valley	78	62	70	83	72	-8.2%
Rosendale	102	74	66	70	77	-24.1%
South Ribble	97	87	92	89	92	-4.5%
West Lancashire	96	94	81	111	109	12.7%
Wyre	61	75	82	77	98	61.2%

Source: SUS data provided by CLCBS and midyear population estimates 2005 to 2009

Causes of hospital admissions

There were almost 7,500 planned hospital admissions for young people aged 10 to 15 years old in Lancashire during 2009/10. The causes of admissions are beginning to shift away from respiratory disease as diseases of the digestive system and external causes become a much more important cause of elective admissions for older children. There are also a large number (800+) classes as symptoms, signs or abnormal clinical or laboratory findings not classified elsewhere. District level data is presented in the [appendix](#).

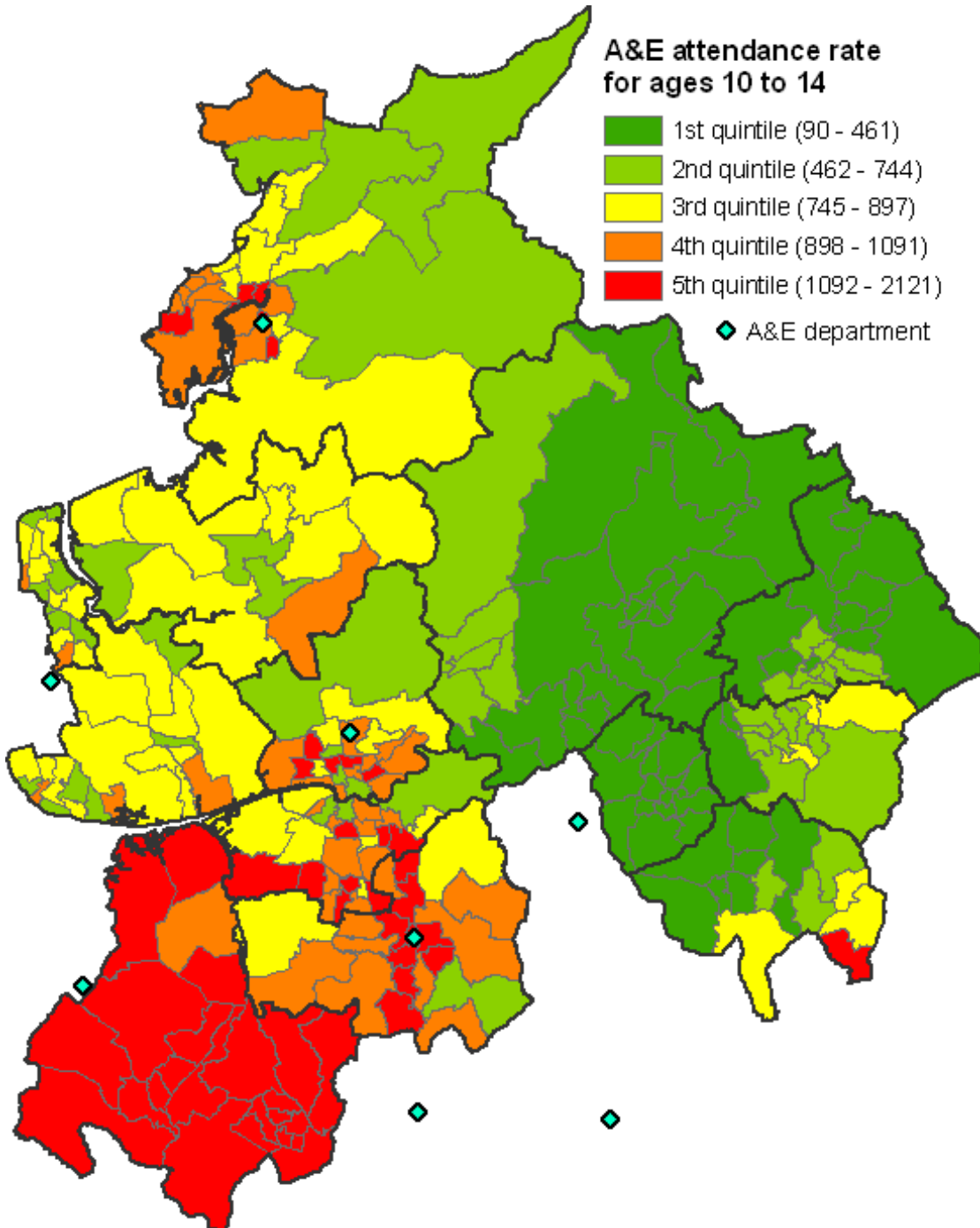
Table 122: Numbers and percentages of admissions to hospital by children aged 10-14 years resident in Lancashire County by age group and primary diagnosis, 2009/10

ICD10 Code	ICD 10 Description	Nos.	%
A00-B99	Certain infectious and parasitic diseases	166	2.9%
	A00-A09 Intestinal infectious diseases	44	0.8%
C00-C97	Malignant neoplasms	196	3.4%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	137	2.4%
D10-D36	Benign neoplasms	105	1.8%
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	55	0.9%
E00-E90	Endocrine, nutritional and metabolic diseases	210	3.6%
	E10-E14 Diabetes mellitus	68	1.2%
F00-F99	Mental and behavioural disorders	113	1.9%
G00-G99	Diseases of the nervous system	133	2.3%
	G40-G41 Epilepsy	58	1.0%
H00-H59	Diseases of the eye and adnexa	88	1.5%
H60-H95	Diseases of the ear and mastoid process	141	2.4%
I00-I99	Diseases of the circulatory system	103	1.8%
J00-J99	Diseases of the respiratory system	666	11.5%
	J00-J06 Acute upper respiratory infections	249	4.3%
	J10-J18 Influenza and pneumonia	45	0.8%
	J20-J22 Other acute lower respiratory infections	52	0.9%
	J45-J46 Asthma	148	2.5%
K00-K93	Diseases of the digestive system	1029	17.7%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	574	9.9%
	K35-K38 Diseases of appendix	123	2.1%
	K40-K46 Hernia	21	0.4%
	K50-K52 Noninfective enteritis and colitis	131	2.3%
L00-L99	Diseases of the skin and subcutaneous tissue	159	2.7%
M00-M99	Diseases of the musculoskeletal system and connective tissue	326	5.6%
N00-N99	Diseases of the genitourinary system	333	5.7%
O00-O99	Pregnancy, childbirth and the puerperium	22	0.4%
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	46	0.8%
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	840	14.5%
S00-T98	Injury, poisoning and certain other consequences of external causes	872	15.0%
Z00-Z99	Factors influencing health status and contact with health services	204	3.5%
Total Admissions		7457	100%
Source: SUS provided by CLCBS (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth) (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth)			

Emergency Hospital Admissions

Attendances to emergency departments are shown in the map below. Having reduced in frequency for children aged 5 to 9, the rates of attendance increase again for older children and an even greater east and west split is apparent. For every ten children there are an expected seven or more attendances at emergency departments across most of central and north Lancashire. Once again there are high rates AED attendances in West Lancashire.

Map 27: Ward level emergency department attendance rate per 1,000 population, 2007/08 to 2009/10



The rate of emergency admissions was 48 per 1,000 in 2009/10, which represented a reduction in attendances of 7.4% since 2005/06. However, in Wyre this rate increased by 43.2% (the largest increase in Lancashire districts) and the second highest increase was seen in Preston; Chorley had the third highest increase. The largest decrease in rate was seen in Rosendale and Pendle. In 2009/10 the highest rate was in West Lancashire, though compared to 2005/06 the rate in West Lancashire had reduced. In 2005/06 West Lancashire had the second highest rate but the considerable reduction in Pendle's rate resulted in West Lancashire rate being highest in 2009/10.

Table 123: Emergency admissions rate per 1,000 of the population aged 10-14 years, 2005/06 to 2009/10

Emergency admissions rate per 1,000 of the population aged 10-14 years						
Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	52	48	47	47	48	-7.4%
Burnley	60	54	51	49	49	-18.0%
Chorley	47	46	51	43	48	2.2%
Fylde	38	38	36	40	35	-6.7%
Hyndburn	57	51	54	55	57	0.0%
Lancaster	50	50	44	48	46	-7.9%
Pendle	69	57	48	49	51	-26.7%
Preston	53	55	58	52	56	7.1%
Ribble Valley	42	37	39	44	34	-18.7%
Rosendale	52	37	37	36	41	-20.6%
South Ribble	58	46	47	42	49	-16.4%
West Lancashire	62	59	50	59	58	-6.9%
Wyre	30	37	37	42	43	43.2%

Source: SUS data provided by CLCBS and midyear population estimates 2005 to 2009

Causes of emergency hospital admissions

There were 3,871 emergency hospital admissions in Lancashire during 2009/10. As with elective hospital admissions, respiratory diseases are increasingly less important causes of emergency admissions for older children, whilst external causes such as injuries and poisonings, and symptoms not elsewhere classified become more important. District level data is provided in the [appendix](#).

Table 124: Numbers and percentages of emergency admissions to hospital by children aged 10-14 by primary diagnosis, 2009-10

ICD10 Code	ICD 10 Description	Nos.	%
A00-B99	Certain infectious and parasitic diseases	157	5.0%
	A00-A09 Intestinal infectious diseases	44	1.4%
C00-C97	Malignant neoplasms	15	0.5%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	10	0.3%
D10-D36	Benign neoplasms	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	19	0.6%
E00-E90	Endocrine, nutritional and metabolic diseases	110	3.5%
	E10-E14 Diabetes mellitus	65	2.1%
F00-F99	Mental and behavioural disorders	105	3.3%
G00-G99	Diseases of the nervous system	79	2.5%
	G40-G41 Epilepsy	42	1.3%
H00-H59	Diseases of the eye and adnexa	24	0.8%
H60-H95	Diseases of the ear and mastoid process	17	0.5%
I00-I99	Diseases of the circulatory system	48	1.5%
J00-J99	Diseases of the respiratory system	396	12.6%
	J00-J06 Acute upper respiratory infections	137	4.3%
	J10-J18 Influenza and pneumonia	44	1.4%
	J20-J22 Other acute lower respiratory infections	48	1.5%
	J45-J46 Asthma	141	4.5%
K00-K93	Diseases of the digestive system	325	10.3%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	16	0.5%
	K35-K38 Diseases of appendix	121	3.8%
	K40-K46 Hernia	-	-
	K50-K52 Noninfective enteritis and colitis	55	1.7%
L00-L99	Diseases of the skin and subcutaneous tissue	66	2.1%
M00-M99	Diseases of the musculoskeletal system and connective tissue	93	2.9%
N00-N99	Diseases of the genitourinary system	143	4.5%
O00-O99	Pregnancy, childbirth and the puerperium	8	0.3%
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	766	24.3%
S00-T98	Injury, poisoning and certain other consequences of external causes	735	23.3%
Z00-Z99	Factors influencing health status and contact with health services	42	1.3%
Total Admissions		3871	100%
Source: SUS provided by CLCBS (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth) (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth)			

Road traffic accidents

Road traffic accidents continue to be a high risk for this age group. The table below shows the casualty information covering the secondary school years during which mobility, especially

independent mobility, increases again. This is reflected in the increase in pedestrian and cyclist casualties in this age range to a total of 938 (52% of all casualties in this age range). 26% of the pedestrian and cyclist casualties were killed or seriously injured. The number of children killed or seriously injured almost doubles again in the 11 to 15 age group to 56.3% of the total casualties for children and young people (compared with 28.5% for 6 to 10 year olds).

Table 125: Lancashire 11-15 year old road traffic casualties 2005-09

	Lancashire
Population (11 to 15 years)	77600
All child casualties	
All child casualties	1794
All child Pedestrians	623
All child Pedal cyclists	315
Rate of casualty / 1000 population	23.1
Killed and seriously injured casualties	
Killed and serious casualties	332
KSI Pedestrians	180
KSI Pedal cyclists	67
Rate of KSI per 1,000 population	
Lancashire	4.3
Hyndburn	6.1
Preston	5.0
Burnley	4.5
South Ribble	4.4
Wyre	4.2
West Lancashire	4.2
Rosendale	4.1
Lancaster	4.1
Chorley	3.9
Pendle	3.7
Fylde	3.2
Ribble Valley	3.0

See the appendix for a summary of evidence based interventions to reduce [road traffic accidents](#).

Educational achievement

The proportion of pupils in Lancashire achieving 5 GCSEs grades A* to C, including English and mathematics, is well above the national average despite relatively high levels of deprivation in parts of the county. Attainment levels vary widely between districts with almost seven out of ten pupils achieving the expected standard in Ribble Valley compared with less than four out of ten in Burnley.

Table 126: Achievement of 5+ A*-C grades at GCSE including English and maths, 2006/07 to 2008/09

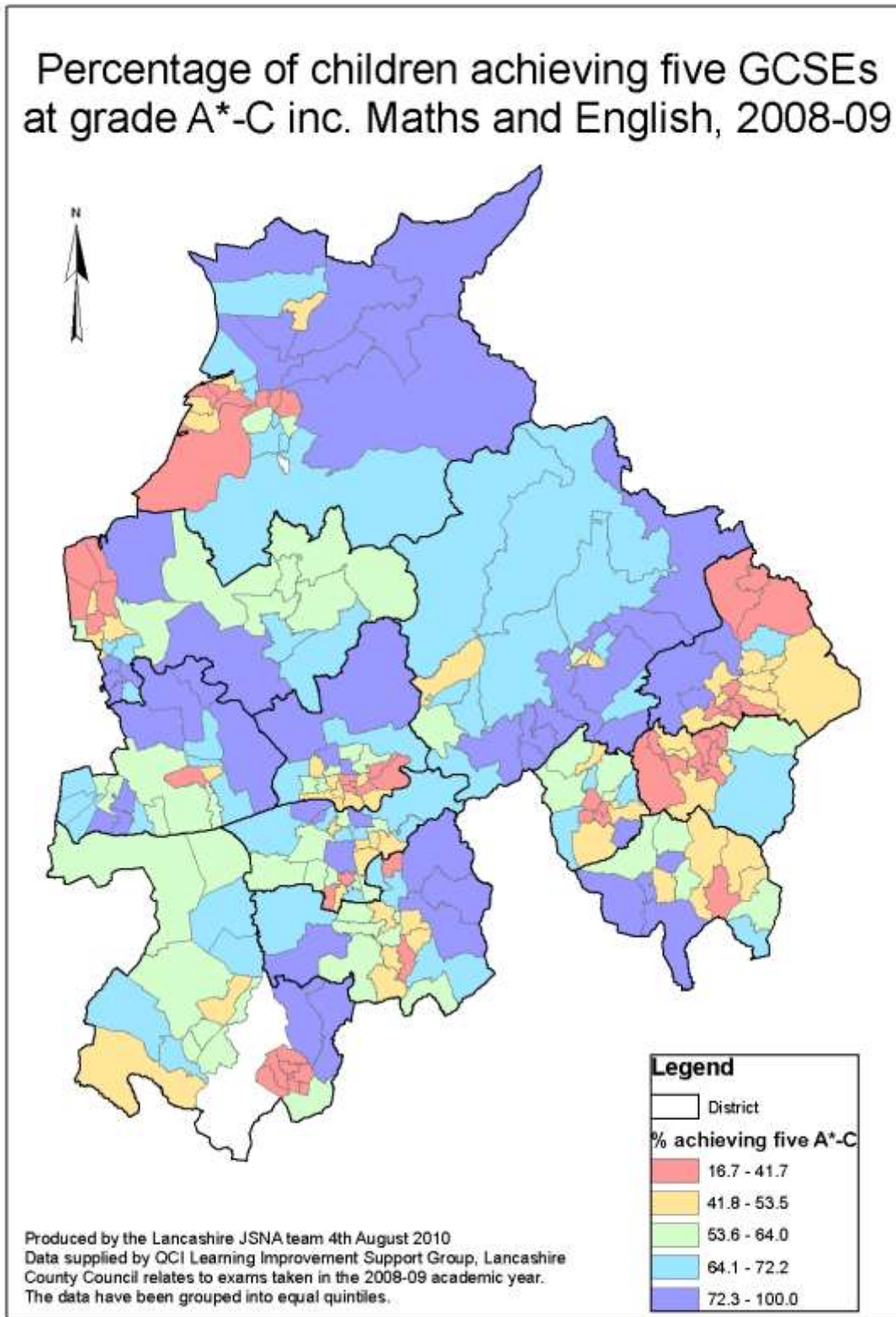
District	2006/07	2007/08	2008/09	2009/10*
Burnley	34.6%	34.2%	37.9%	39.1%
Chorley	54.9%	57.9%	56.9%	60.2%
Fylde	60.5%	56.9%	68.8%	62.1%
Hyndburn	39.9%	43.6%	51.3%	55.2%
Lancaster	47.3%	52.5%	52.6%	57.4%
Pendle	38.5%	41.9%	42.6%	49.0%
Preston	46.8%	49.9%	50.9%	60.9%
Ribble Valley	66.1%	72.0%	71.5%	67.2%
Rosendale	50.7%	54.8%	58.6%	57.9%
South Ribble	55.3%	59.0%	59.1%	62.3%
West Lancashire	47.5%	46.5%	48.9%	54.8%
Wyre	51.8%	53.6%	55.5%	60.9%
Lancashire	48.3%	50.8%	53.5%	57.2%*
England	46.3%	47.6%	49.8%	54.9%

*Lancashire and District figures for 2009/10 do not include Academies. Lancashire figure including Academies was 56.5%.

The map of ward level attainment, based upon the pupil's residence, highlights a wide range of attainment with some clear areas of low achievement at key stage 4. Rates of achievement are particularly low in the following 15 wards, where fewer than 30% of children achieved the standard of 5 or more A*-C grades at GCSE or equivalent including English and maths:

- Trinity, Bank Hall and Lanehead in Burnley
- Ribby with Wrea in Fylde
- Skerton West in Lancaster
- Earby and Bradley in Pendle
- Ribbleton and Brookfield in Preston
- Moorside, Digmoor and Birch Green in West Lancashire
- Mount, Rossall and Pharos in Wyre

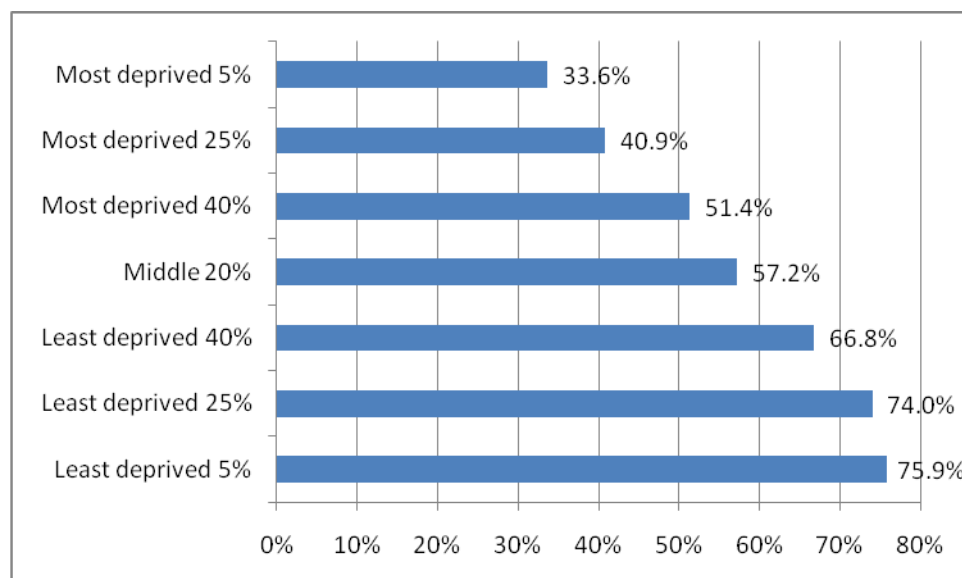
Map 28: Ward level percentage of children achieving five GCSEs at grade A*-C including maths and English, 2008/09



Attainment and deprivation

As was found for key stage 2, there is a strong social gradient at key stage 4 with young people with those in the least deprived 5% of Lancashire more than twice as likely to achieve the required 5 or more GCSEs graded A* to C as those in the least deprived 5%. In fact, fewer than half of children in those areas ranked in the most deprived quartile nationally achieve the key stage 4 standard.

Figure 56: 2009/10 Key Stage 4 achievement of 5+ GCSEs graded A*-C across the social gradient



The overall pattern demonstrates a strong relationship with those children from more prosperous areas achieving higher results and with the greatest chance to maximise the potential of life.

Attainment and free school meals

The proportion of pupils eligible for school meals (FSM), which is used as a proxy for lower socio-economic status, is lower than in the primary age group but most districts have seen a rising trend over the last couple of years. Overall, the rate of FSM eligibility is lower in Lancashire than nationally. Rates are particularly high in Burnley, where one in five children are eligible, and Hyndburn, Pendle and Preston also have rates above the national average.

Table 127: Percentage of secondary age pupils in Lancashire who are eligible for free school meals, 2005/06 to 2009/10

Area	05/06	06/07	07/08	08/09	09/10
Burnley	20.8%	19.7%	19.1%	19.6%	21.9%
Chorley	10.9%	7.4%	7.6%	7.6%	8.8%
Fylde	7.3%	7.0%	6.8%	7.3%	8.5%
Hyndburn	19.3%	20.0%	18.9%	18.0%	15.9%
Lancaster	12.5%	12.7%	10.3%	11.0%	12.5%
Pendle	18.0%	16.5%	15.6%	16.5%	18.6%
Preston	17.2%	15.8%	15.2%	16.2%	16.2%
Ribble Valley	5.0%	4.6%	4.5%	4.6%	5.4%
Rossendale	11.6%	10.4%	9.7%	10.6%	12.7%
South Ribble	9.1%	8.2%	7.9%	9.0%	9.9%
West Lancashire	14.1%	12.6%	11.8%	12.0%	13.5%
Wyre	10.7%	9.3%	8.9%	9.8%	10.6%
Lancashire	12.6%	11.6%	10.8%	11.3%	12.5%
England	13.7%	13.4%	13.1%	13.4%	14.2%

Burnley and Pendle have the highest rates of FSM eligibility and the lowest levels of GCSE attainment whilst Fylde and Ribble Valley have the lowest rates of FSM eligibility and the highest levels of GCSE attainment. However, GCSE performance does not directly correlate with FSM eligibility for all districts.

Analysis of the attainment of pupils eligible for FSM and their peers in GCSE examinations reveals substantial gaps in performance across the county. The gaps are generally wider than at Key Stage 2. All districts have gaps of more than 20% and seven of them have gaps of more than 30%. The gap is smallest in Burnley (20.6%), despite the fact that pupils eligible for FSM in Burnley have the worst pass rate in the county, and the highest gap is in Rossendale (38.5%).

Table 128: FSM gap: pupils achieving 5 GCSEs graded A*-C including English and maths, 2009/10

District	FSM No.	Non-FSM no	FSM %	Non-FSM %	Gap (F-T)
Burnley	39	361	22.0%	42.7%	20.6%
Chorley	22	669	25.9%	62.9%	37.1%
Fylde	16	408	32.7%	64.4%	31.7%
Hyndburn	50	416	38.2%	58.3%	20.2%
Lancaster	46	744	26.7%	61.8%	35.0%
Pendle	51	451	28.3%	53.4%	25.1%
Preston	64	753	32.0%	65.9%	33.9%
Ribble Valley	<10	<10	<10	<10	<10
Rossendale	23	440	24.0%	62.5%	38.5%
South Ribble	35	751	34.0%	64.8%	30.8%
West Lancashire	32	616	23.0%	59.0%	36.0%
Wyre	36	616	39.1%	63.0%	23.9%
Lancashire	414	6225	29.4%	61.5%	32.1%
England			30.9%	58.5%	27.6%

Source: Lancashire County Council CYP Directorate, DFE

Note: Data for Ribble Valley is excluded for reasons of confidentiality as fewer than 10 pupils were eligible for FSM.

Attainment and gender

As at other key stages, girls tend to perform better than boys in GCSE examinations. In fact, girls outperform boys at GCSE in every district. The gender gap in Lancashire is wider than should be expected given the national gap, indicating an area where further work is needed. The gender gap is smallest in Preston (0.2%) whilst Fylde, Lancaster, Pendle, Rossendale and West Lancashire all had gaps of more than 10% 2009/10.

Table 129: Gender gap in attainment of 5 GCSEs A*-C including English and maths, 2009/10

Gap in attainment of 5 GCSEs A*-C including English and Maths					
Secondary Pupil District	Male No	Female No	Male %	Female%	Gap (F-M)
Burnley	185	215	35.5%	42.8%	7.3%
Chorley	310	381	55.9%	64.2%	8.4%
Fylde	178	246	55.5%	68.0%	12.5%
Hyndburn	234	232	53.5%	57.0%	3.5%
Lancaster	349	441	50.9%	63.9%	13.0%
Pendle	243	259	44.0%	54.9%	10.9%
Preston	434	383	60.8%	61.0%	0.2%
Ribble Valley	218	215	64.9%	69.8%	4.9%
Rossendale	205	258	51.6%	64.0%	12.4%
South Ribble	373	413	57.7%	67.0%	9.3%
West Lancashire	301	347	49.6%	60.2%	10.7%
Wyre	313	339	57.0%	65.1%	8.1%
Lancashire	3343	3729	53.2%	61.5%	8.5%
England			51.1%	58.6%	7.5%

Source: Lancashire County Council CYP Directorate, DFE

Attainment and ethnicity

As at other key stages, there is some variation in GCSE attainment between ethnic groups. In many districts within the county the numbers of young people from minority ethnic groups are so small that they do not allow meaningful analysis. The table below provides data on the attainment of some ethnic groups (based on populations of 10 or more pupils) and gives a mixed picture.

For Lancashire as a whole, Bangladeshi-heritage and Pakistani-heritage pupils perform below the county average. Conversely, Indian-heritage pupils perform at a level about the Lancashire key stage 4 average. District level results are difficult to present accurately due to low numbers. The gaps for all three groups are wider in Lancashire than nationally.

Table 130: Ethnicity gap: proportion of pupils achieving 5 GCSEs A*-C including English and maths, 2009/10

Secondary Pupil District	Proportion of pupils achieving 5 GCSEs A*-C including English and Maths						
	All Pupils %	Bangladeshi Pupils		Pakistani Pupils		Indian Pupils	
		%	Gap	%	Gap	%	Gap
Lancashire	57.2%	43.5%	- 13.7%	48.7%	- 8.5%	75.7%	+18.5%
England	54.8%	53.7%	-1.1%	49.1%	-5.7%	71.3%	+16.5%

Attainment and special educational needs

Over recent years in Lancashire there has been a continued decrease in the number of statements of special educational needs (SEN) issued for pupils of secondary school age due to the impact of Enhanced Early Years Action Plus (EEYAP) and Enhanced School Action Plus (ESAP) funding. A full description of this support is provided in the chapter on [children and young people with particular needs](#). This funding provides intervention so that children and young people can have their needs met at an earlier stage, without the need for the statutory assessment process. Children and young people whose needs cannot be met through ESAP funding can still request a statutory assessment, which may lead to the issuing of a statement.

Table 131: Number of secondary age children with a statement of special educational needs, 2003 to 2010

	2003	2004	2005	2006	2007	2008	2009	2010
Number of Children with a statement of SEN - Aged 11 to 15	4130	4058	4014	3941	3801	3543	3429	3251

The percentage point gap between young people with SEN and those without SEN (measured by National Indicator 105) had previously remained fairly static but has increased in the last 2 years, and is now the highest gap for 6 years at. Attainment of 5 A*-C including mathematics and English has risen for all young people, but the rise amongst pupils with a category of SEN has been exceeded by the rise in the attainment of pupils without SEN. Having said this, there has still been a significant increase in the attainment of children with SEN, with the rate more than doubling in six years from 7.3% to almost 19%.

Table 132: SEN gap: of pupils achieving 5 GCSEs A*-C including English and maths, 2004/05 to 2009/10

National Indicator 105	The Special Educational Needs (SEN)/Non-SEN gap - achieving 5 A*-C inc. English and Maths					
	Actual					
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Pupils with SEN	7.3%	9.6%	10.3%	13.9%	19.1%	18.7%
Pupils without SEN	51.2%	52.2%	54.7%	57.8%	61.0%	65.8%
Gap	43.9%	42.6%	44.5%	44.0%	41.9%	47.1%

Further discussion of children with [special educational needs](#) is provided in the chapter on children and young people with particular needs.

Attainment and children looked after

The average academic attainment of those in care at the age of 16 is significantly lower, compared to the same-age population as a whole. For Lancashire as a whole, 53% of pupils achieved 5 or more GCSEs graded A*-C including English and maths, compared with only 12% of those pupils who were looked after by the authority.

Table 133: Educational attainment of children looked after at key stage 4, 2009

GCSE Attainment	Year 11 students in care	Year 11 cohort	Gap
1 or more GCSEs Grades A* - G	78%	99%	21%
5 or more GCSEs Grades A* - G	49%	90%	41%
5 or more GCSEs Grades A* - C	20%	62%	42%
5 or more GCSEs Grades A* - C including English and Maths	12%	53%	41%
Source Virtual School			

Further discussion of [children looked after](#) is contained in the chapter on children and young people with particular needs.

Attendance

Attendance at school is considered important for more reasons than to improve education: attendance is known to reduce the chances of young people becoming involved in youth offending; it offers an opportunity for services to engage with young people; and schools provide a wealth of opportunities for young people to engage in positive activities and contributing to promoting health and wellbeing. It is also known that non-attendance at school is a risk factor for risk taking behaviour in the form of substance misuse (see section on [alcohol and drugs](#) for further information).

The level of authorised absence in secondary schools in Lancashire is slightly higher than national and regional averages but unauthorised absence and total absence are lower. The level of persistent absence (i.e. the proportion of pupils whose absence exceeds the threshold level) is slightly above the national average.

Figure 57: Secondary school absence statistics, 2008/09

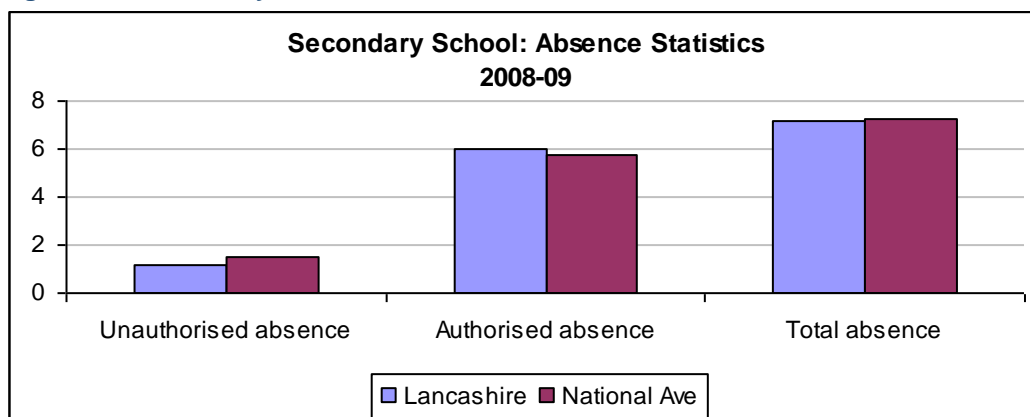


Table 134: Secondary school absence statistics, 2008/09

	Lancashire	North West	National
Authorised absence	6.0%	5.8%	5.7%
Unauthorised absence	1.2%	1.6%	1.5%
Total absence	7.2%	7.4%	7.2%
Persistent absentees	5.1%	5.4%	4.9%

Source: Department for Children, Schools and Families

Reflecting the link between school attendance and deprivation, overall absence is highest in Burnley, Pendle and Hyndburn, where levels of relative deprivation are highest, and lowest in Ribble Valley, South Ribble and Fylde. Levels of persistent absenteeism are highest in Pendle and Burnley and lowest in South Ribble.

Table 135: Absence levels in secondary schools by district, 2008/09

Absence Levels – All Maintained Secondary Schools – 2008/09 (Percentage of half days missed)					
District	Authorised Absence	Unauthorised Absence	Overall Absence	Persistent Absence	2007/08 Overall Abs.
Burnley	6.99%	1.66%	8.65%	7.6%	8.96%
Chorley	5.88%	0.77%	6.64%	4.3%	6.41%
Fylde	5.77%	0.75%	6.51%	4.4%	6.91%
Hyndburn	6.04%	1.60%	7.65%	5.7%	-
Lancaster	5.65%	1.38%	7.04%	4.9%	7.01%
Pendle	7.18%	1.37%	8.55%	6.2%	8.18%
Preston	5.49%	1.78%	7.27%	5.6%	7.58%
Ribble Valley	5.52%	0.35%	5.87%	3.4%	-
Rossendale	6.14%	1.03%	7.17%	5.2%	6.77%
South Ribble	5.39%	1.02%	6.41%	4.3%	6.23%
West Lancs	6.31%	0.97%	7.28%	5.2%	6.87%
Wyre	6.16%	1.15%	7.30%	5.4%	7.22%
Lancashire	6.00%	1.17%	7.16%	5.1%	7.11%

Source: DCSF Information Gateway

Exclusions

Research has suggested that there is a direct link between being excluded from school and involvement in criminal activity with excluded pupils being more than twice as likely to get involved in crime. (See discussion of [children and young people who offend](#) in chapter on young people).

The proportion of permanently excluded pupils is much higher in secondary schools than in primary schools, although it remains low, at less than half a percent. The rate in Lancashire increased in 2007/08 and was above the national average and the average for our statistical neighbours. Data for 2008/09 showed that the rate of permanent exclusions from secondary schools (0.31%) had moved much closer to the 2007/08 statistical neighbour average but remained above the 2007/08 national average.

Figure 58: Proportion of pupils permanently excluded in Secondary schools, 2006/07 to 2008/09

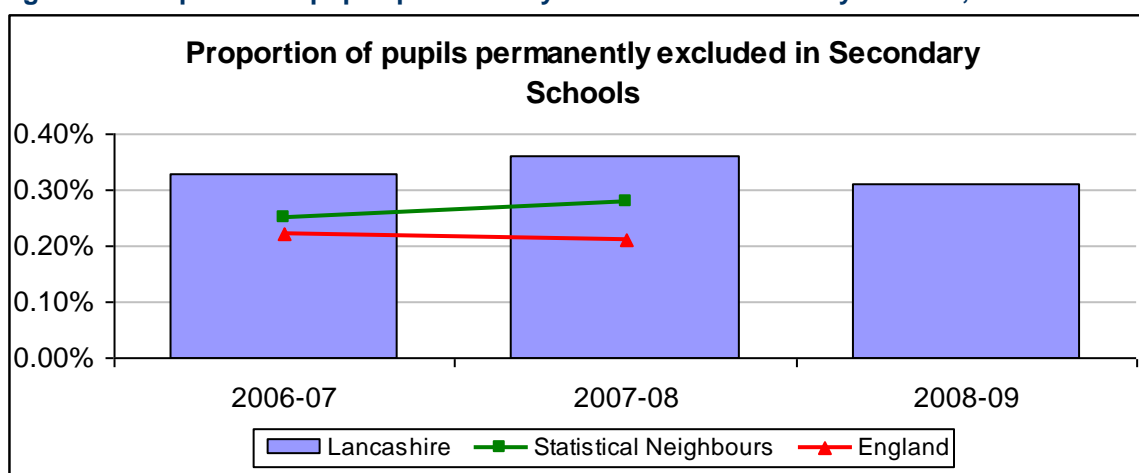


Table 136: Proportion of pupils permanently excluded in Secondary schools, 2006/07 to 2008/09

Proportion of pupils permanently excluded in Secondary Schools				
	2005-06	2006-07	2007-08	2008-09
Lancashire	0.32%	0.33%	0.36%	0.31%
Statistical Neighbours	0.24%	0.25%	0.28%	-
England	0.24%	0.22%	0.21%	-

Source: Department for Children, Schools and Families

All districts, with the exception of South Ribble, West Lancashire and Wyre, saw a reduction in the number of permanent exclusions from secondary schools in 2008/09. Preston had the highest number of permanent exclusions in three out of the last four years whilst the number in Burnley had fallen to match the lowest in the county. Proportionally, Preston and Pendle were the highest excluders with rates more than double the national average.

Figure 59: Number of permanent exclusions in secondary schools by district, 2007/08 to 2008/09

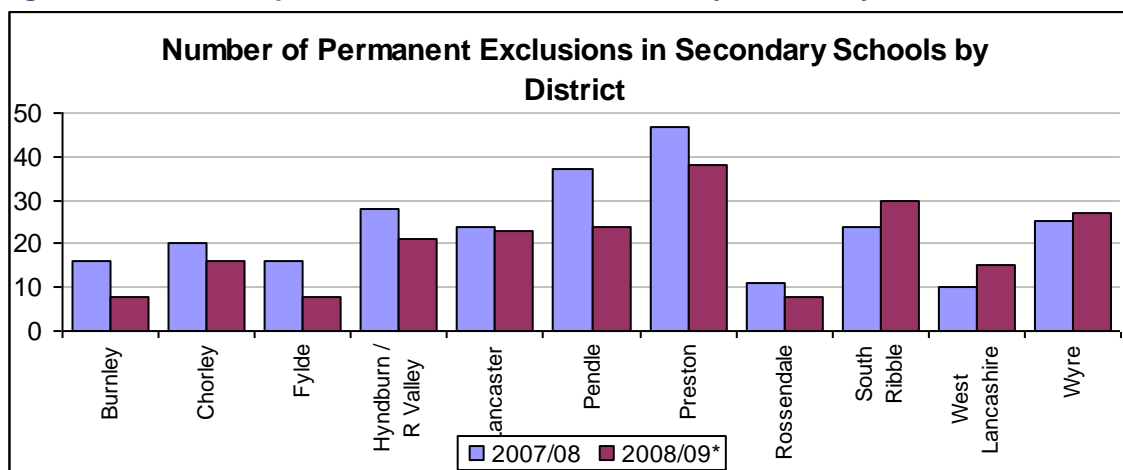


Figure 60: Number of permanent exclusions in secondary schools by district, 2008/09

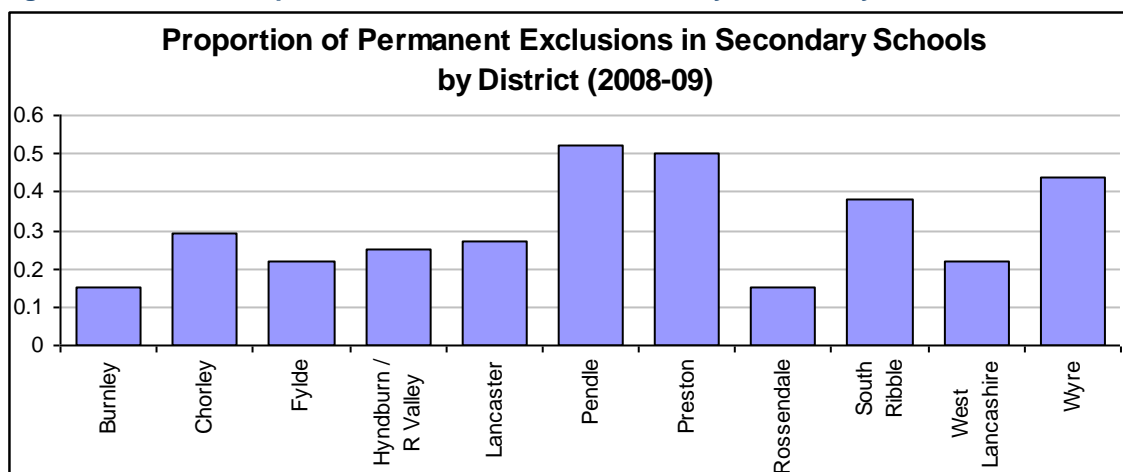


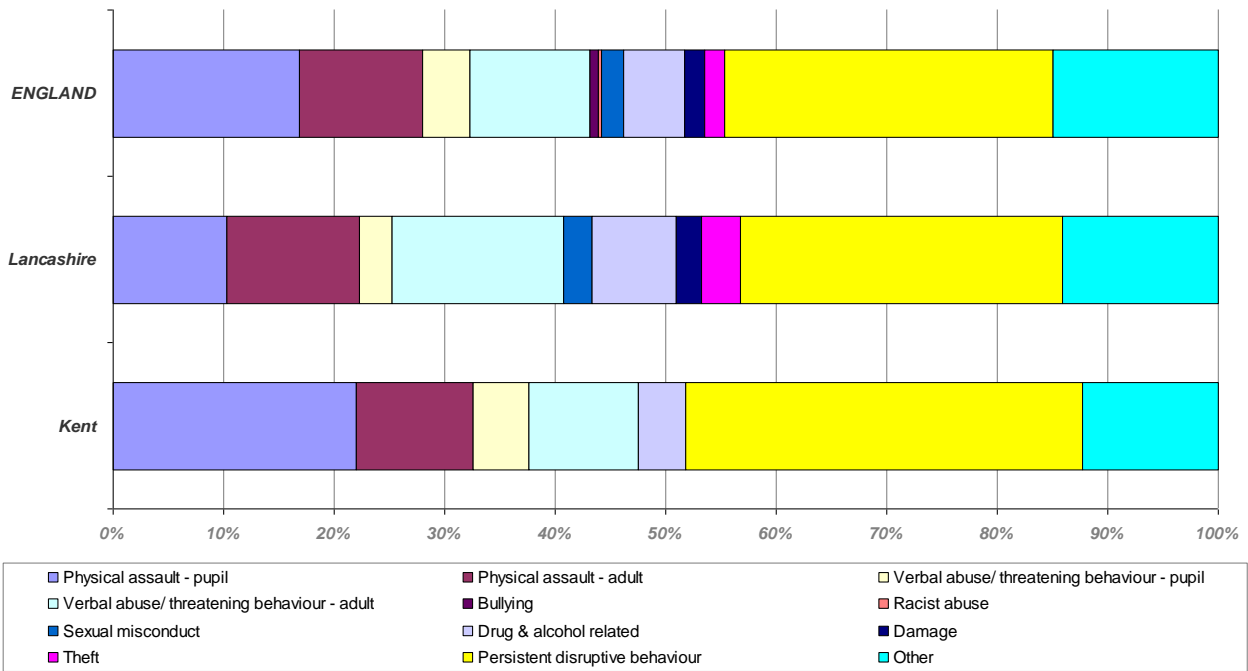
Table 137: Permanent exclusions in secondary schools by district, 2005/06 to 2008/09

Pupils permanently excluded in Secondary Schools					
	Numbers				% 2008/09*
	2005/06	2006/07	2007/08	2008/09*	
Burnley	33	30	16	8	0.15%
Chorley	15	13	20	16	0.29%
Fylde	8	13	16	8	0.22%
Hyndburn / Ribble Valley	25	29	28	21	0.25%
Lancaster	24	13	24	23	0.27%
Pendle	30	40	37	24	0.52%
Preston	43	29	47	38	0.50%
Rossendale	18	17	11	8	0.15%
South Ribble	31	23	24	30	0.38%
West Lancashire	15	12	10	15	0.22%
Wyre	23	22	25	27	0.44%
Lancashire	264	241	258	218	0.31%

*Provisional data and Accrington Academy data not available
Source: Lancashire County Council – Pupil Access Team

The following graph gives an analysis of the reasons for permanent exclusions. It compares exclusions from all of Lancashire's schools (including a proportion of primary exclusions) with those across England and in Kent (a county council similar authority to Lancashire in terms of size, demographic make-up, and numbers of permanent exclusions). It suggests that the proportions of permanent exclusions for verbal abuse/threatening behaviour to adults, drug and alcohol related incidents and theft were higher in Lancashire than in England or the comparator authority.

Figure 61: Breakdown of permanent exclusions by reason, 2008/09



The proportion of fixed term exclusions in secondary schools is much higher than in primary schools. The rate in Lancashire increased slightly in 2008/09 but remained below the national average.

Figure 62: Proportion of pupils subject to fixed-term exclusions in secondary schools, 2005/06 to 2008/09

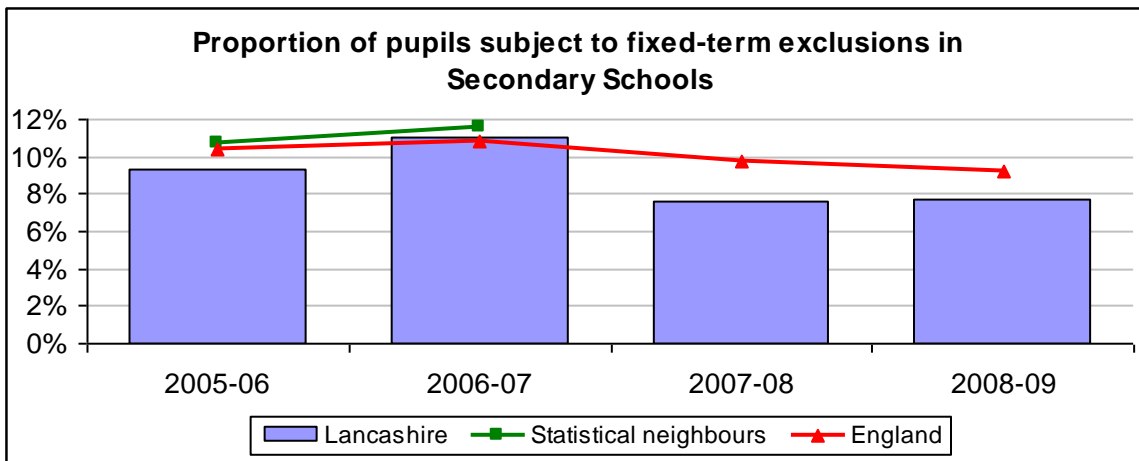


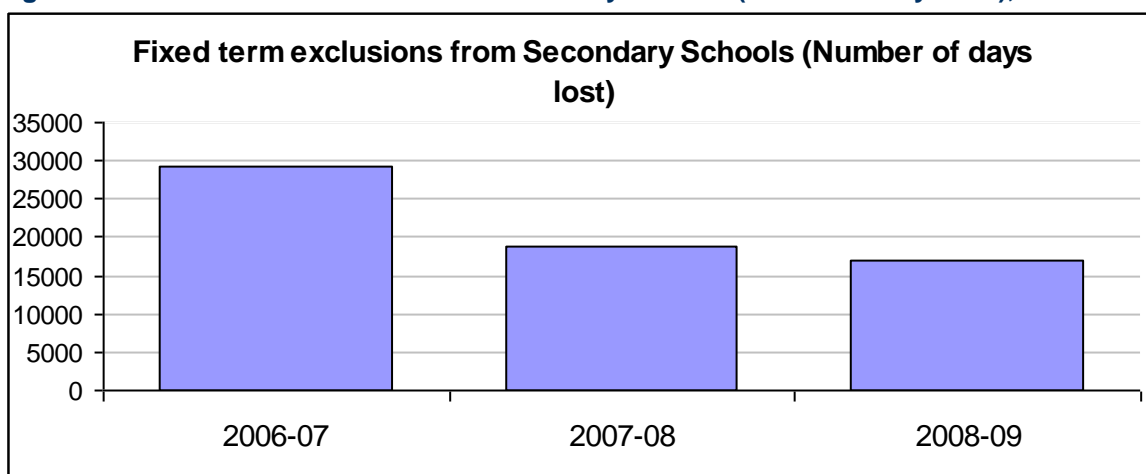
Table 138: proportion of pupils subject to fixed-term exclusions in secondary schools, 2005/06 to 2008/09

Proportion of pupils subject to fixed-term exclusions in Secondary Schools				
	2005-06	2006-07	2007-08	2008-09
Lancashire	9.37%	11.03%	7.62%	7.72%
Statistical neighbours	10.69%	11.54%	-	-
England	10.40%	10.83%	9.78%	9.26%

Source: Lancashire County Council – Pupil Access Team/DCSF Information Gateway

Alongside reductions in fixed term exclusions there has been an emerging reduction in the average length of exclusion and substantial reductions in the numbers of days lost through exclusion.

Figure 63: Fixed term exclusions from secondary schools (number of days lost), 2006/07 to 2008/09



At a district level, Burnley and Pendle have achieved significant reductions in the numbers of pupils excluded for fixed term periods in secondary schools with Pendle having more than halved its rate in the last couple of years. The rates of fixed term exclusions are highest in secondary schools in Preston and Wyre.

Figure 64: Fixed term exclusions from secondary schools by district, 2006/07 to 2008/09

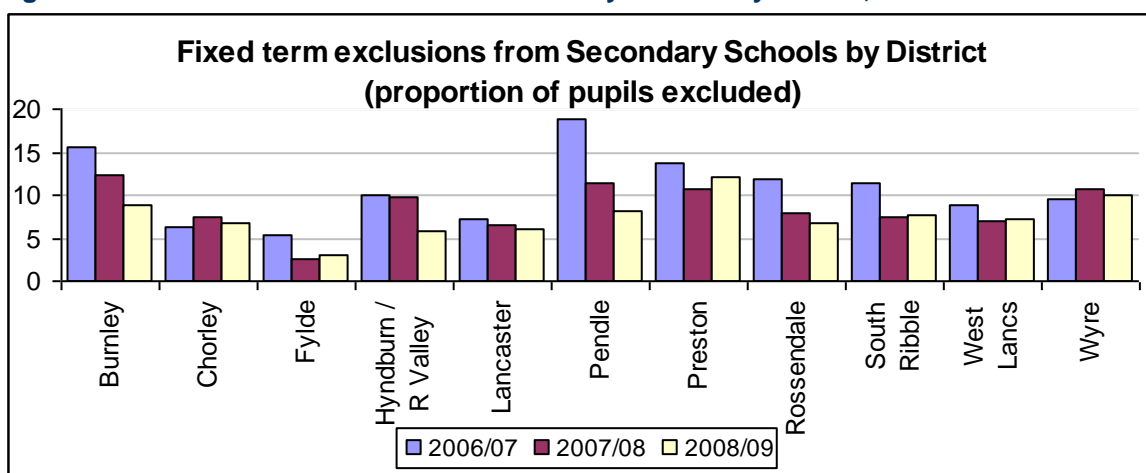


Figure 65: Fixed term exclusions from secondary schools by districts (number of days lost), 2006/07 to 2008/09

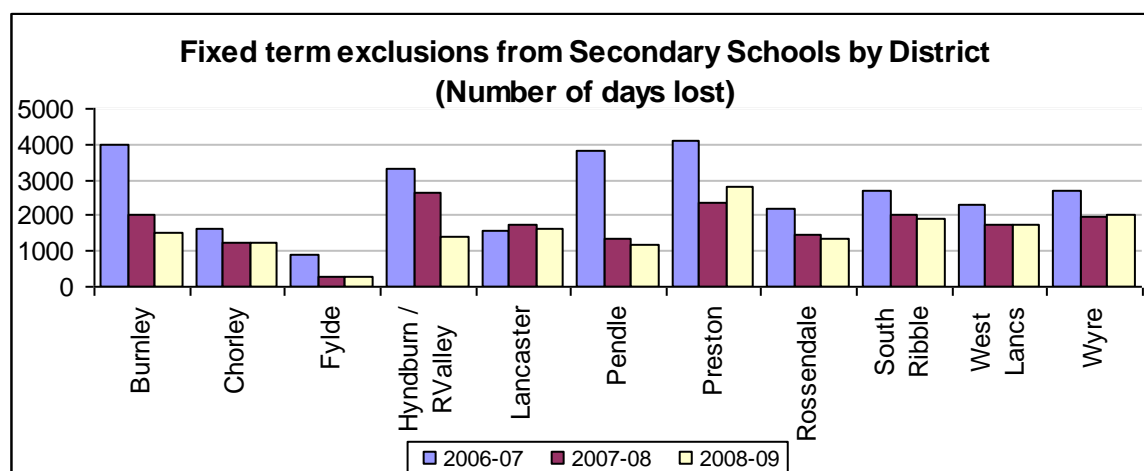


Table 139: Fixed term exclusions from Secondary Schools (proportion of pupils excluded and days lost), 2006/07 to 2008/09

Fixed term exclusions from Secondary Schools (proportion of pupils excluded and days lost)						
District	2006/07		2007/08		2008/09	
	% excluded	Days lost	% excluded	Days lost	% excluded	Days lost
Burnley	15.5%	3961	12.43%	2048	8.79%	1489
Chorley	6.39%	1605	7.43%	1249	6.77%	1232
Fylde	5.38%	880	2.52%	285	2.94%	277
Hyndburn/Ribble Valley	10.02%	3312	9.66%	2667	5.74%	1393
Lancaster	7.27%	1596	6.54%	1759	6.10%	1639
Pendle	18.85%	3803	11.34%	1371	8.08%	1200
Preston	13.79%	4106	10.79%	2351	12.19%	2797
Rossendale	11.97%	2178	7.86%	1447	6.66%	1358
South Ribble	11.38%	2703	7.37%	2007	7.63%	1893
West Lancs	8.89%	2304	6.94%	1745	7.29%	1714
Wyre	9.61%	2675	10.63%	1978	10.04%	2016
Total	10.76%	29186	8.64%	18909	7.62%	17,010
National	10.83%		9.78%		n/a	

Source: Lancashire County Council – Pupil Access Team

Emotional wellbeing

A full discussion of **mental health and emotional wellbeing** is included in the chapter on children and young people with particular needs.

Adolescence is a time of great change and transition, when young people start to make decisions about career paths, further education and living on their own. These stressors, coupled with changing peer and family interactions, may lead in some cases to mental health problems, such as depression, suicidal thoughts, and anxiety disorders, particularly if the adolescent has a family history of mental illness.

The Pupil Attitude Survey explores some aspects of emotional health such as friendships, involvement, confidence levels and how young people deal with their worries. The responses

suggest that the majority of secondary age pupils in the county get on well with other pupils, feel involved, enjoy after school activities and feel like valued members of their schools. Most of them usually or always feel confident and they believe that their confidence has increased in the last couple of years. However, whilst the proportions of pupils giving negative responses on these issues are low it needs to be borne in mind that they still represent hundreds (and in some cases over a thousand) of secondary age pupils in the county.

Table 140: Lancashire Pupil Attitude Survey 2009, getting on with other pupils

Yr	No.	Always	Usually	Hardly ever	Never
7	6915	37.9%	56.8%	4.6%	0.5%
9	6309	33.5%	61.5%	3.9%	0.8%
11	4937	41.7%	54.1%	3.1%	0.8%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 141: Lancashire Pupil Attitude Survey 2009, feeling left out of things

Yr	No.	Never	Hardly ever	Sometimes	A lot
7	6915	35.0%	51.1%	12.0%	1.5%
9	6309	33.4%	54.1%	10.5%	1.7%
11	4937	35.2%	53.5%	9.3%	1.6%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 142: Lancashire Pupil Attitude Survey 2009, feeling like a valued member of the school

Yr	No.	Always	Usually	Hardly ever	Never
7	6915	32.0%	52.9%	11.9%	2.6%
9	6309	21.8%	53.9%	19.0%	4.7%
11	4937	24.1%	50.8%	19.9%	4.7%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 143: Lancashire Pupil Attitude Survey 2009, having confidence in myself

Yr	No.	Always	Usually	Hardly ever	Never
7	6915	29.4%	48.7%	16.7%	3.7%
9	6309	25.3%	45.2%	22.2%	6.1%
11	4937	26.3%	43.9%	21.6%	6.7%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 144: Lancashire Pupil Attitude Survey 2009, my confidence in the last two years

Yr	No.	Much more	Bit more	Bit less	Much less
7	6915	43.9%	42.3%	7.0%	2.5%
9	6309	42.1%	48.6%	6.9%	4.2%
11	4937	45.1%	41.2%	7.0%	4.3%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 145: Lancashire Pupil Attitude Survey 2009, worrying about changes in my life

Yr	No.	Never	Little and talk about it	A little and alone	A lot and alone
7	6915	22.4%	50.3%	20.5%	6.1%
9	6309	21.9%	43.1%	27.0%	7.4%
11	4937	22.1%	43.1%	26.2%	7.5%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Secondary school children are much less likely than primary school children to talk to an adult if they are not able to deal with their issues alone. The proportions that would be willing to speak to an adult either at school or home decreases as children move up through secondary school years. 17% of children in year 7 said they would speak to an adult at school compared with fewer than 13% of those in years 9 and 11. More than half of children in year 7 reported they would talk to an adult at home if they could not deal with issues on their own, but this had reduced to less than 35% of children in year 11. Young people were more likely to speak to others who are not adults at school and home as they grow up and this preference almost doubles between years 7 and 9.

Table 146: Lancashire Pupil Attitude Survey 2009, if I were worried I would probably talk to

Yr	No.	Adult in school	Adult at home	Someone else	No one
7	6915	17.0%	51.5%	22.7%	7.9%
9	6309	11.0%	42.2%	36.2%	10.0%
11	4937	12.4%	33.9%	42.2%	10.4%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Analysis of the data around who young people would talk to if they were worried reveals some differences linked to deprivation. Pupils from the most deprived backgrounds are much more likely than those from the least deprived backgrounds to talk to an adult at school if they were worried. Conversely, they are less likely than those from the least deprived backgrounds to talk to an adult at home. Pupils from the most deprived backgrounds are also slightly more likely to talk to no one about their worries.

Table 147: If I were worried I would probably talk to...across the Lancashire social gradient

	Adult at school	Adult at home	Friend, brother or sister	No one
Least deprived 5%	11.1%	45.8%	34.4%	7.7%
Least deprived 25%	11.1%	46.0%	33.3%	8.4%
Least deprived 40%	13.0%	46.3%	31.8%	8.0%
Middle 20%	13.1%	43.4%	32.7%	9.4%
Most deprived 40%	14.7%	42.6%	32.0%	9.3%
Most deprived 25%	18.7%	41.3%	29.7%	8.9%
Most deprived 5%	22.6%	35.3%	31.4%	9.3%

Bullying

As with primary school pupils, secondary school pupils are more likely to experience bullying in school rather than on the way to or from school. The majority of pupils are never or rarely bullied either in school or on journeys to or from school. It is also worth noting that the proportion of pupils reporting that they are never bullied in school shows a marked improvement as children progress from years 9 to year 11. Conversely, the proportion who is often or frequently bullied declines over the same period.

Table 148: Lancashire Pupil Attitude Survey 2009, being bullied at school

Yr	No.	Never	Hardly ever	Often	Most of the time
7	6915	55.4%	32.7%	8.9%	2.2%
9	6309	58.8%	32.0%	6.8%	1.9%
11	4937	70.4%	24.0%	4.1%	1.1%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Table 149: Lancashire Pupil Attitude Survey 2009, being bullied on the way to or from school

Yr	No.	Never	Hardly ever	Often	Most days
7	6915	75.6%	17.6%	4.3%	1.5%
9	6309	77.8%	16.7%	3.2%	1.4%
11	4937	82.4%	12.6%	2.3%	1.5%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Views of Secondary Schools

31 out of 84 secondary schools in Lancashire responded to the 2009 Audit Commission Survey of Schools. Whilst the responses from primary schools were mostly positive, the views of secondary schools were generally less favourable. Secondary schools rated 15 areas as being between 'poor' and 'satisfactory'. They were as follows:

- Effectiveness of local services in meeting the mental health needs of children and young people
- Effectiveness of local services' work to prevent children and young people becoming victims of crime
- Effectiveness of support from local services to help families in danger of harming or neglecting their own children
- Effectiveness of multi-agency early intervention for children in need
- The accessibility of the social workers responsible for the looked-after children in schools
- How statutory assessments are made for children and young people with learning difficulties and/or disabilities
- Local services' provision of appropriate formal and informal play areas
- Local services provision of appropriate family learning opportunities
- Lancashire County Council's school place planning
- Lancashire County Council's behaviour support programmes

- Lancashire County Council's support for promoting pupil attendance
- Lancashire County Council's provision for pupils out of mainstream schools, including pupils who have been excluded
- Lancashire County Council's educational psychology support
- The extent to which schools influence policies/plans/procedures of the Children's Trust/Partnership
- Effectiveness of the Children's Trust/Partnership in combating the impact of child poverty

Results of the survey were communicated with school staff and Governors, via a series of briefing sessions and respective services have based their future planning arrangements on the issues raised by Lancashire secondary schools.

Sport and physical activity

The Department for Children, Schools and Families (DCSF) commissioned an independent research company to conduct the sixth survey among schools in the School Sport Partnership (SSP) Programme to collect information about levels of participation in physical education and school sport. This survey provided the basis of measurement towards a Public Service Agreement target. The last survey took place from May to July 2009 and collected data for the academic year 2008/09.

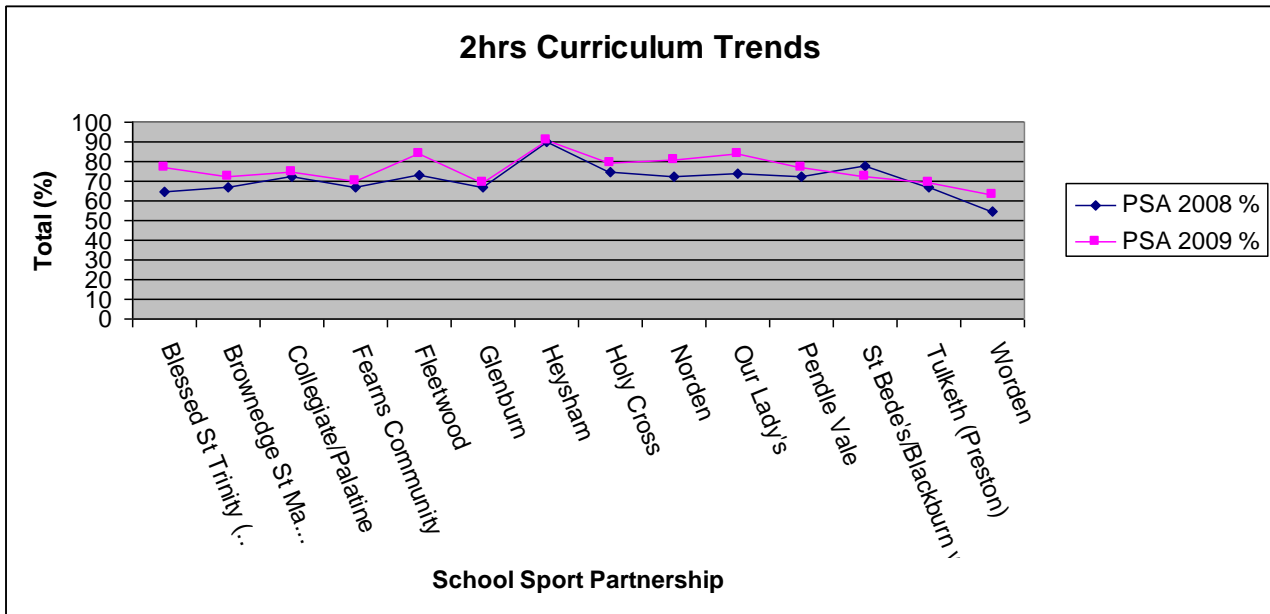
The data relates to all School Sport Partnerships in Lancashire, a guide to where these are found is below:

- Blessed St Trinity – Burnley
- Brownedge St Mary – South Ribble
- Collegiate / Palantine – Blackpool (outside of the JSNA study area)
- Fearn Community – Rossendale
- Fleetwood – Wyre
- Glenburn – West Lancashire
- Heysham – Lancaster
- Holy Cross – Chorley

- Norden – Hyndburn
- Our Lady’s – Lancaster
- Pendle Vale – Pendle
- St. Bedes / Blackburn (outside of the JSNA study area)
- Tulketh – Preston
- Worden – South Ribble

The figure below shows that in most Lancashire SSPs, the percentage of young people participating in 2 hours of high quality curriculum sport has increased from the previous year.

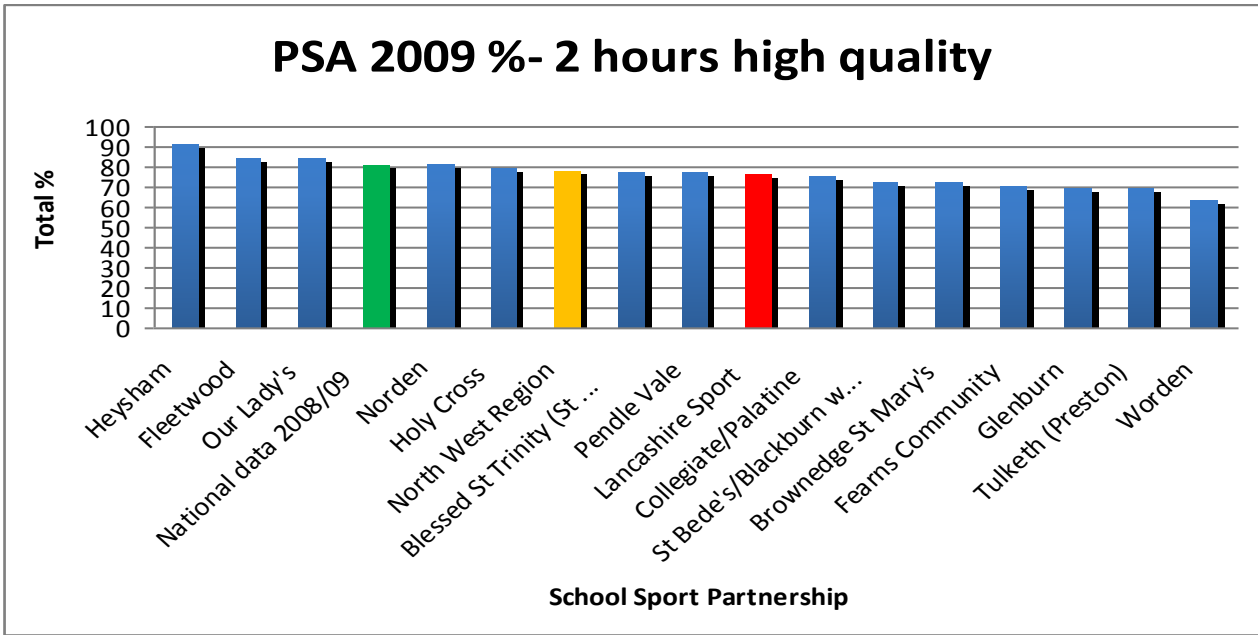
Figure 66: Physical education, 2hrs curriculum trends, 2008 and 2009



Source: School PE & Sport Survey 2008/2009

The following chart shows the percentage of high quality PE & sport for each SSP in relation to the national (in green), the North West Region (in yellow) and the County average (in red). The highest levels of participation are found in Heysham and Our Lady's, both in Lancaster and Fleetwood in Wyre, which were the only SSPs to exceed the national average. Participation in two hours high quality PE and sport was particularly low in Worden in South Ribble, Tulketh in Preston and Glenburn in West Lancashire.

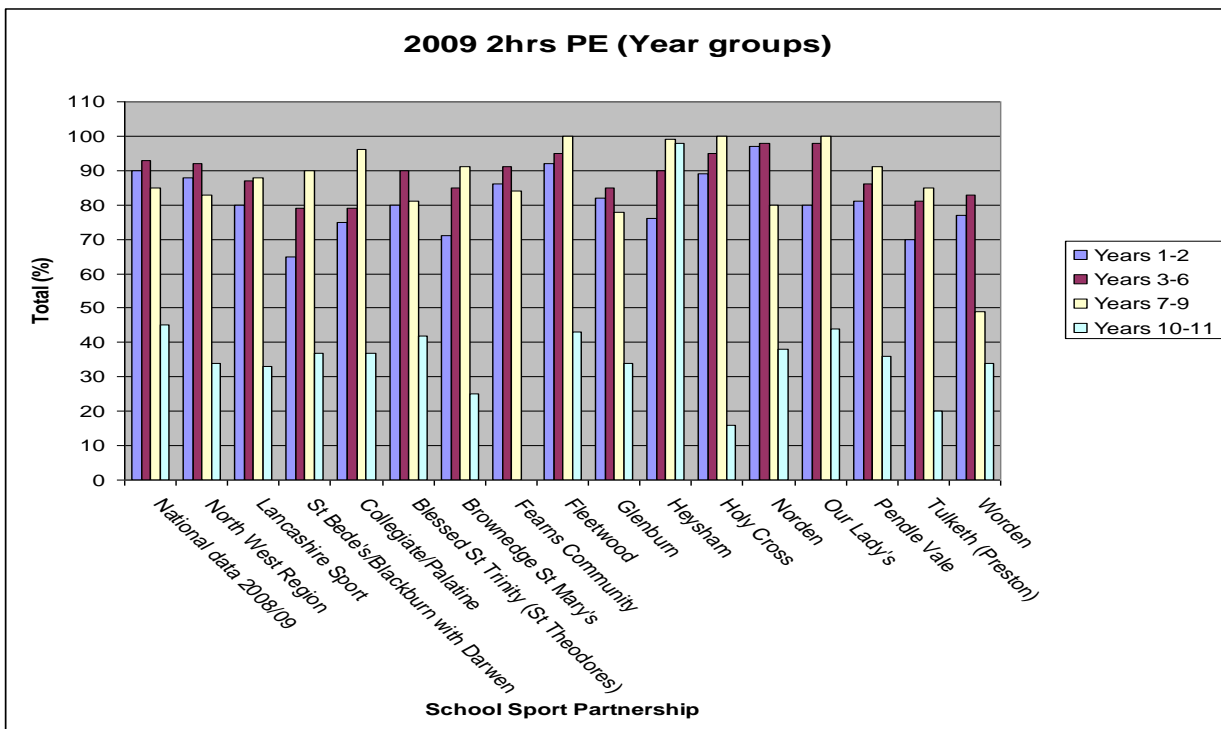
Figure 67: High quality physical education, 2 hours, 2009



Source: Lancashire School Sport Survey 2008/2009

The total figures above can be broken down by year groups as follows. For many of the SSPs, the participation in two hours of PE is highest in years seven to nine. For all SSPs there is a significant drop off in the participation rate in years 10 and 11, with participation rates of 40% or below common. The only exception to this is Heysham SSP in Lancaster who maintains a high rate of participation in two hours of quality PE – almost 100% participation during years 10 and 11.

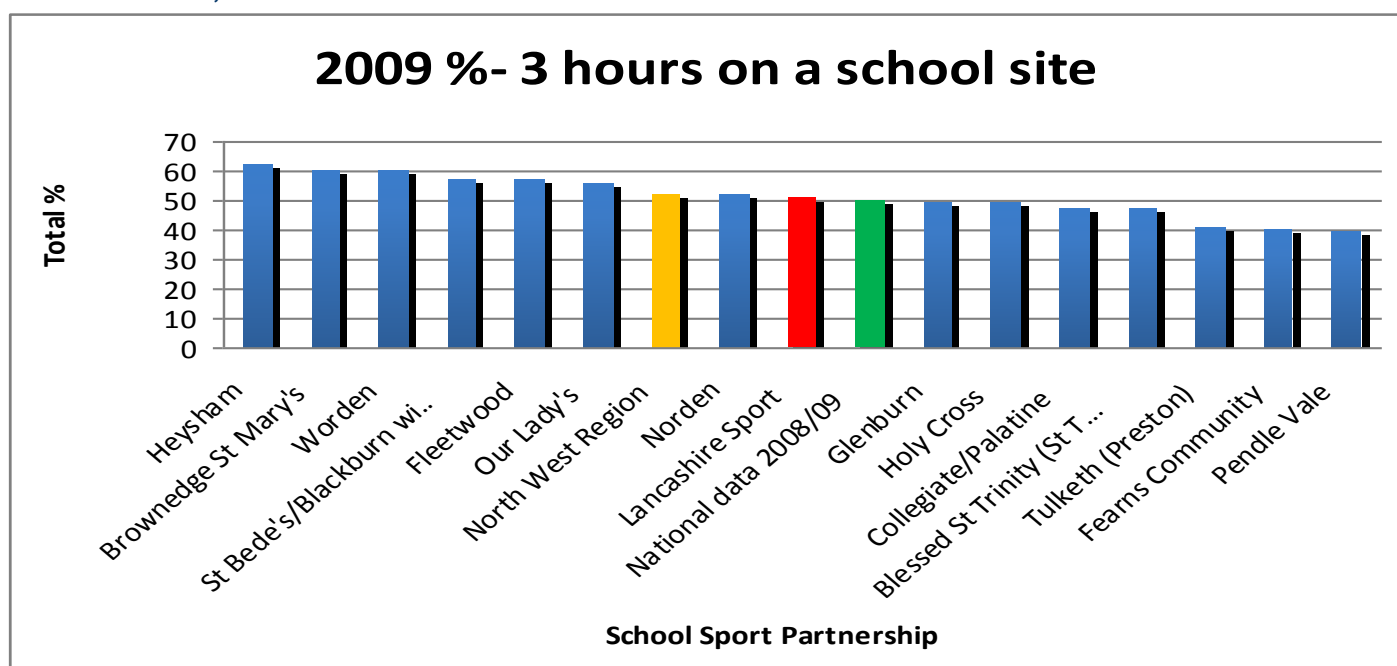
Figure 68: Physical education, 2hrs by year groups, 2009



Source: Lancashire School Sport Survey 2008/2009

In addition to curriculum provision the survey provides an insight into the percentage of young people participating in an additional hour of sport and physical activity on a school site. This additional hour may be within a school sports club held on site for example. Lancashire on average has a slightly higher rate of young people participating in three hours on a school site than the national and regional averages, although there are variations at SSP level.

Figure 69: Percentage of young people participating in an additional hour of physical activity on a school site, 2009



Source: Lancashire School Sport Survey 2008/2009

Results from the Lancashire Pupil Attitude questionnaire highlight a weakening in positive attitude towards sport and children with age. In year 7, a majority of children, 56%, report that they always enjoy sport and exercise and a further 35% report they usually enjoy it, indicating 91% percent of children in year 7 have a positive interest in physical activity. By year 11 this has fallen to 77% of young people with an interest in physical activity and less than half of these, 35% of the total, report that they always enjoy sport.

Table 150: Pupils who enjoy sport and exercise in and out of school, 2008/09

Enjoying sport and exercise in & out of school						
Yr	No.	Always	Usually	Hardly ever	Never	
7	All	6762	55.8%	35.4%	5.4%	1.4%
9	All	6875	42.4%	42.9%	10.1%	3.0%
11	All	5208	35.2%	42.2%	14.2%	5.6%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Healthy Lifestyle

Healthy behaviours are patterns which start to be learned in childhood. Those who grow up in communities and families who do not make healthy choices are less likely to make healthy choices in childhood and youth and are less likely to make healthy choices in adulthood. Given that we know health is determined by an accumulation of factors over the course of life, healthy behaviours whilst young are important for the long term.

When asked about living a healthy life the majority of secondary school pupils in Lancashire report that they always or usually make healthy choices. However, as they grow older their responses become less positive. Year 11 pupils were far less likely than those in year 9 to always make healthy choices and far more likely than those in year 9 to never or rarely make healthy choices.

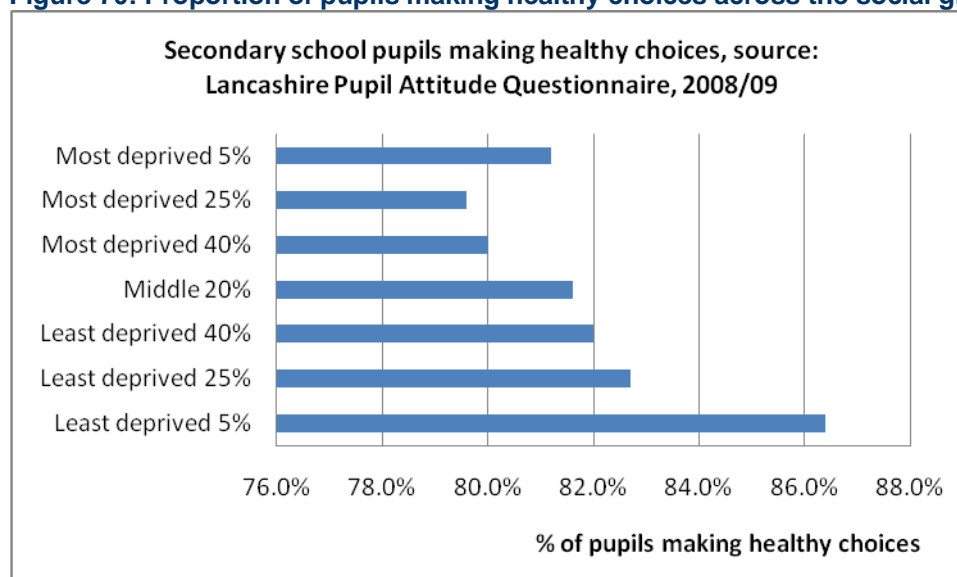
Table 151: Proportion of pupils making healthy choices, 2008/09

Making healthy choices					
Yr	No.	Always make healthy choices	Usually make healthy choices	Hardly ever make healthy choices	Never make healthy choices
7	6915	26.6%	59.4%	9.0%	2.1%
9	6309	18.4%	61.4%	14.8%	3.5%
11	4937	16.4%	57.3%	19.3%	5.0%

Source: Lancashire Pupil Attitude Questionnaire 2008/09

Analysis of the data by social gradient highlights variations. Pupils in the 25% most deprived parts of the county are less likely to report that they make healthy choices as those in the 25% least deprived parts.

Figure 70: Proportion of pupils making healthy choices across the social gradient, 2008/09



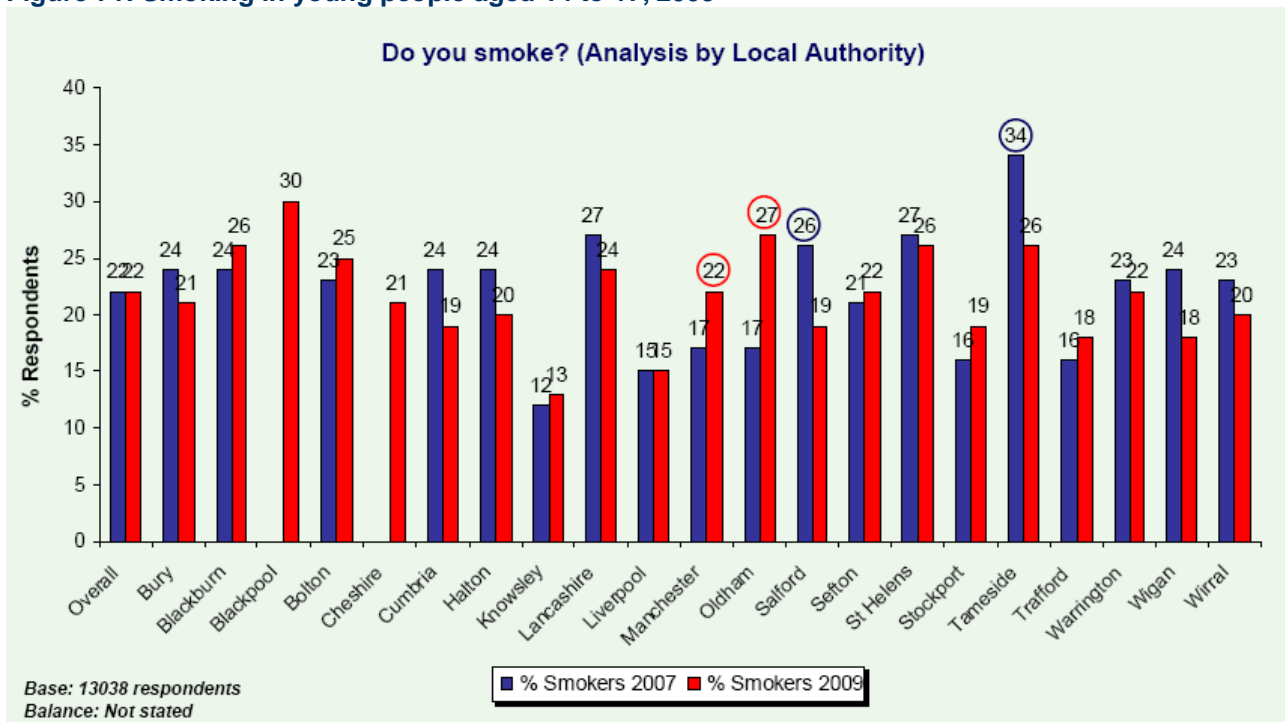
Smoking

The degree to which smoking is an addiction from childhood, rather than an adult choice is illustrated by the fact that over eight in ten current smokers say that they started smoking before the age of 19 (Goddard, 2006). Evidence shows that the younger you start smoking, the more you smoke in adulthood, the more harm is done to your health and the harder it is to quit (ASH, 2009).

The national prevalence of smoking amongst 11 to 15 year olds is reported to have decreased from 13% in 1996 to 9% in 2007 (DH, 2008), even though there is some evidence to suggest that young people who smoke may under-report their smoking behaviour (National Statistics and NHS Information Centre 2006).

Research by Trading Standards North West (2009), which does not provide comparable figures to the above, shows In Lancashire, youth uptake of smoking is a very serious public health concern with almost a quarter of 14 to 17 year olds (24%) reported to smoke.

Figure 71: Smoking in young people aged 14 to 17, 2009



Source: Trading Standards North West (2009)

It should be noted that between the ages of 11 to 19 there are distinct differences in smoking between particular ages as well as distinct differences between the smoking rates of males and females. For example, females are now more likely than males to have ever smoked (ASH, 2009), a pattern that has reversed since males were more likely to smoke in the 1970's (Amos, 2007).

Long and short-term impacts of smoking on young people

Child and adolescent smoking causes serious risks to respiratory health both in the short and long term. Children who smoke are two to six times more susceptible to coughs and increased phlegm, wheeziness and shortness of breath than those who do not smoke.

Therefore, it is not surprising that children and young people who smoke are more likely to be absent from school, both as a result of smoking-related ailments as well as for truancy and suspension, which helps to explain why youth smoking is linked to lower educational attainment (Charlton et al, 2010). This pattern of absence also continues into adulthood, where adults who smoke are more likely to take more sick days from work than those who do not smoke (Laaksonen et al, 2009), therefore impacting on employment in later life.

In the medium term, young people who smoke can also expect to suffer from more wrinkles than non-smokers when they begin to age in their mid-twenties (Yolanda et al, 2007; Daven et al, 2007) and for men who smoke, the risk of erectile dysfunction is doubled (Tengs & Osgood, 2001).

In regard to longer-term health concerns, smoking impairs lung growth and initiates premature lung function decline which may lead to an increased risk of chronic obstructive lung disease later in life. The earlier children become regular smokers and persist in the habit as adults, the greater the risk of developing lung cancer or heart disease. Smokers are also less fit than non-smokers: the performance in a half marathon of a smoker of 20 cigarettes a day is that of a non-smoker 12 years older (ASH, 2009).

Smoking is not the only concern for young people. Second hand smoke is an unavoidable consequence of living in a home with parents who smoke. Second hand smoke is linked to an increase in infant mortality ([infant mortality](#) is discussed in the early years chapter). Exposure to second hand smoke has immediate health effects. It can reduce lung function; exacerbate respiratory conditions; trigger asthma attacks; reduce coronary blood flow; irritate eyes; and cause headaches, coughs, sore throats, dizziness and nausea. There is no safe level of exposure to tobacco smoke and there are long-term health effects, especially with continued exposure over time. (ASH).

Table 152: Smoking case study, Take 7 steps out

Smokefree Northwest has launched a campaign to encourage parents to smoke outdoors and to help keep their children safe from second hand smoke. Take 7 Steps out stresses the benefits as:

- It can help to improve the health of your children.
- Your children won't see you smoking, so might not be tempted to start.
- It might cut down on the number of cigarettes you smoke.
- It keeps your home smelling and looking fresh.

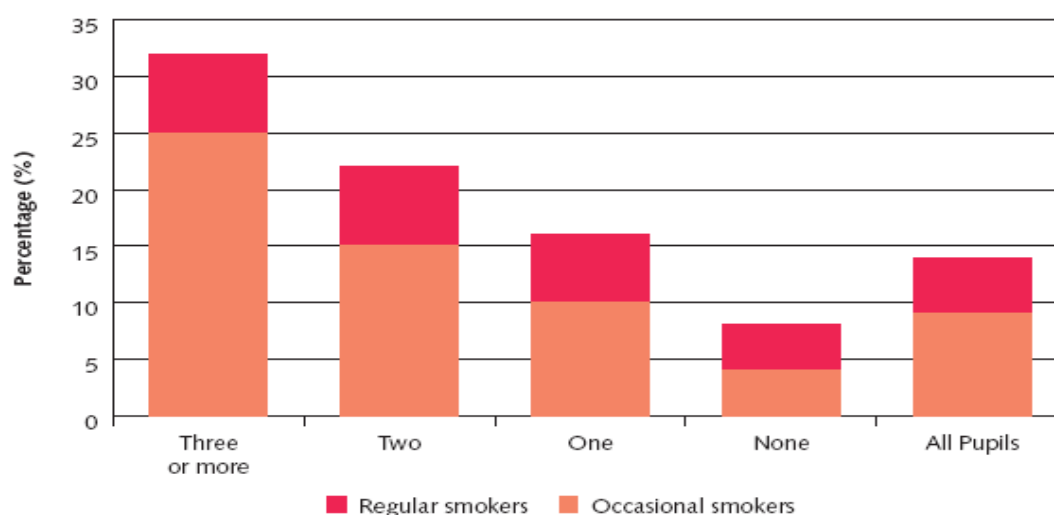
The campaign includes a website (www.take7stepsout.co.uk), a TV advert and support packs for parents.

Risk factors

One of the most critical factors in determining the likelihood of a young person's uptake of tobacco is whether they live with other people who smoke. For example, an 11 to 15 year old who lives with at least one other person who smokes is more than twice as likely to be a regular smoker as someone who does not live with anyone who smokes (DH 2008).

Parental attitude to smoking has also been established as a major risk factor for smoking initiation, with permissive attitudes towards smoking increasing the risk. In England, 10% of children who smoke regularly report that they have been given cigarettes by their parents (DH 2008).

Figure 72: Smoking among children in England, aged 11-15 years old, by number of smokers they live with (DH, 2008)



Other factors associated with youth smoking include (Amos 2007):

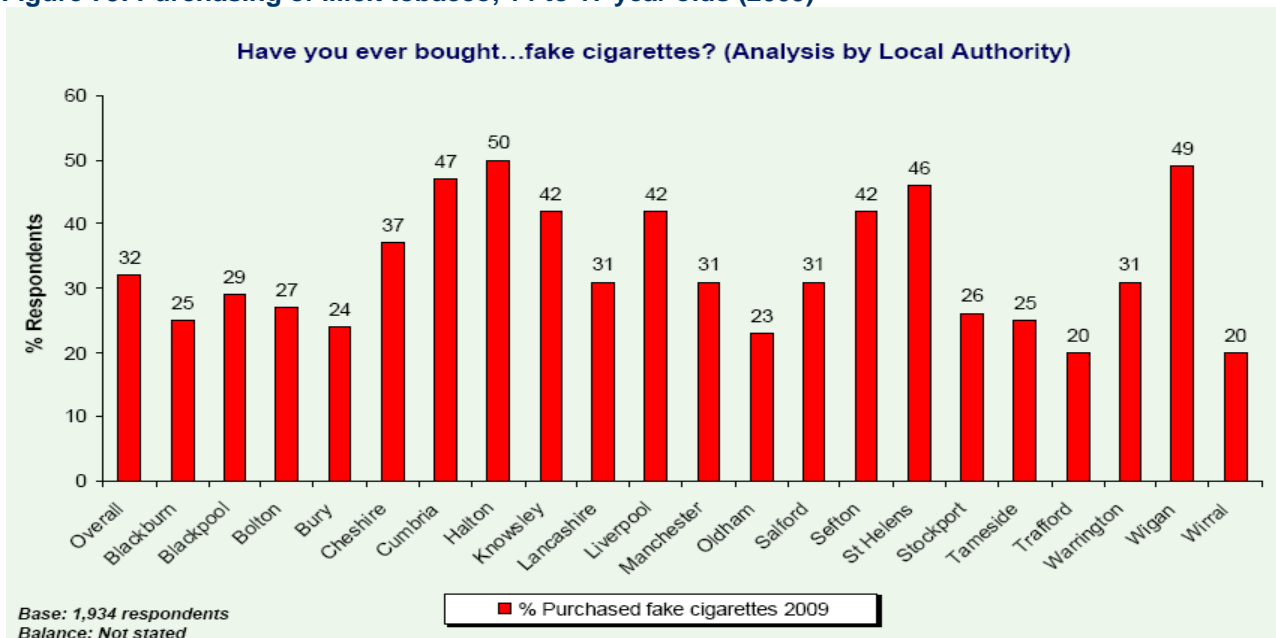
- Availability of cheaply priced tobacco (including illicit tobacco)
- Parental and peer smoking
- Low socioeconomic status
- Low educational attainment
- Live in areas of deprivation
- Exposure to tobacco marketing activities
- Television and films

- Mental illness

Personal influences are also important when considering smoking amongst young people. These may include belief systems about what smoking will do for them: for example, control weight, calm nerves, give confidence, look adult and cool, or be fun, enjoyable and sociable. Young people with low perceptions of their academic achievement and behaviour are at increased risk of becoming smokers, and girls who are unhappy about their appearance often take up smoking because they believe it makes them more attractive. Even if these beliefs are not founded on evidence, images in films, television and advertising often serve to reinforce them (Charlton et al, 2010).

In terms of cheaply priced tobacco, a survey which took place across Lancashire and the rest of the North West last year showed that one in five smokers admitted to buying illegal / illicit tobacco, but amongst 14-17 year old smokers the figure rose to one in three (Trading Standards, 2009). For Lancashire, the trading standards survey which was conducted last year confirms this to be the case, with 31% of 14 – 17 year olds admitting to buying illegal /illicit tobacco products. This backs up other evidence which shows that younger people are more influenced by the price of cigarettes and tobacco than their adult counterparts (Amos 2007). Reducing availability of illicit tobacco, enforcing the current age of sale legislation and undertaking tobacco test purchases is therefore an important responsibility of trading standards departments.

Figure 73: Purchasing of illicit tobacco, 14 to 17 year olds (2009)



Tobacco marketing in all its forms is also a central influence on the initiation and continuance of youth smoking. In particular, evocative tobacco brands appeal to young people. The entertainment media also projects images that normalise smoking, making it appear both more common and acceptable than it is. It can influence how young people perceive and attribute

meaning to their own and others smoking and reinforces the idea that cigarettes have social and cultural significance (BMA 2008).

Table 153: Different forms of tobacco marketing

- Sponsorship of sport and the arts
- Point-of-sale: promotional material in shops such as branded gantries, clocks, signage, staff clothing and product display
- Merchandising: giving away or discounting low cost items such as T-shirts, baseball hats and key rings
- Free samples: the distribution of free product
- Loyalty schemes: promotional mail and coupons designed to encourage continued purchase
- Brand stretching: non-tobacco products with tobacco branding such as Marlboro Classic Clothes
- Pack designed to communicate brand image and to add value
- Internet sites: websites promoting tobacco companies, cigarette brands or smoking
- Product placement: paid-for placement of cigarette brands in films or television

Source: Based on MacFadyen et al (2001)

A fully comprehensive approach to preventing tobacco initiation needs to be taken as no single solution will be effective on its own. Continuing to address the adult smoking prevalence, reducing the availability of cheap illicit tobacco as well as decreasing the amount of media and marketing exposure that glamorise tobacco use should help to reduce tobacco consumption in young people. A summary of the evidence base relating to interventions to **prevent and reduce smoking** is shown in the appendix.

Whilst nicotine replacement therapy (NRT) is now licensed for use for young people over the age of 12 years, recent research raises questions as to whether NRT will be effective in this age group (Platt et al 2006, Grimshaw and Stanton 2006) and Amos et al (2006) found that although many young people often express a desire to give up, their views are often characterised by ambivalence. Many young see quitting as a project for the future rather than short term. It is therefore imperative that local strategies attempt to 'turn off the tap' of young people who start to smoke, given that cessation with young people will have limited success.

In terms of having more robust youth tobacco data, the future use of the World Health Organisation's Global Youth Tobacco Survey (1998) should be considered. This would provide a standard methodology and would allow us to make international comparisons with local data.

Lancashire County Council Trading Standards Service

Irrespective of the health dangers associated with tobacco, it is a legal product to buy and consume. However, there are strict controls enforced by Trading Standards over how it can be sold. For example, it can't be sold to people under the age of 18; general advertising is banned and point of sale information restricted; and tobacco products have to be labelled with appropriate health warnings. Trading Standards complete test purchases and compliance visits to ensure tobacco is controlled.

Test purchases

Below is a summary of tobacco activity relating to test purchasing across the County, highlighting an increasing rate of compliance.

Table 154: Tobacco test purchasing activity, 2005/06 to 2009/10

Year	Number of test purchase attempts	Retail compliance rate
05/06	74	84%
06/07	301	87%
07/08	300	92%
08/09	330	92%
09/10	212	87%

Source: Lancashire County Council Trading Standards

Vending machines are a particular area of vulnerability in terms of children accessing tobacco. Below is a summary of tobacco activity relating to test purchasing at vending machines across the County.

Table 155: Tobacco vending machine test purchasing activity, 2005/06 to 2009/10

Year	Number of test purchase attempts	Retail compliance rate
05/06	14	57%
06/07	50	56%
07/08	50	82%
08/09	50	80%
09/10	20	60%

Source: Lancashire County Council Trading Standards

On the whole the trend line is up, i.e. there has generally been an increase in retail compliance rates albeit for vending machines. The rate appears to have fallen in 2009/10 but this may reflect the reduced number of test purchase attempts rather than reduce compliance. The increase in test purchasing activity can be attributed mainly to specific targets under the previous Local Area Agreement from 06/07 to 08/09. The Local Area Agreement targets were, in effect, two-tier targets - firstly to increase enforcement activity in this discipline by conducting more test purchase visits and, secondly, to increase retail compliance rates. Other drivers (regional Department of Health funding allocated to Trading Standards) have also assisted in increasing activity regarding tobacco control activity on a regional and national footprint.

Funding streams received from partner organisations also assisted in 'pump priming' enforcement activity particularly in the east of the County via East Lancashire PCT and a programme has been developed to support this.

Tobacco advertising

Tobacco advertising compliance visits are undertaken to tobacco retailers to ensure that they are complying with the restrictions on tobacco advertising; that the required 'underage sales' notice was being correctly displayed; to establish whether the trader operated a check 21/25 policy and to establish whether they used an underage sales refusals book. The table below highlights the results of visits conducted in East Lancashire.

Table 156: Tobacco advertising compliance visits Oct 09 to March 10 (Target: 50 compliance visits)

DISTRICTS	No. of compliance visits	Tobacco advertising being displayed and correct	Tobacco advertising being displayed but incorrect	Tobacco notice not present	Tobacco notice present but not in prominent position	No refusals book in operation	No age check policy in operation
Burnley	10	3	1	2	4	5	6
Hyndburn	10	9	0	2	1	6	7
Pendle	10	5	0	2	2	4	2
Ribble Valley	10	9	0	3	0	4	4
Rosendale	10	5	0	4	1	7	8
TOTALS	50	31 (62%)	1 (2%)	13 (26%)	8 (16%)	26 (52%)	27 (54%)

Source: Lancashire County Council Trading Standards

Only one trader was found not to comply with the tobacco advertising requirements (this related to an old adhesive advertisement which was partially visible above the doorway to a shop). 42% of traders were found not to be complying with the tobacco age notice requirement, corrective action being taken. Over 50% of traders were found not to operate a 21/25 age-check policy or a refusals book. It is hoped that the updated Age Check Pack when distributed to retailers will increase the uptake of these activities.

Niche tobacco products

Traditional enforcement work involving tobacco products has focused on cigarettes and hand rolling tobacco. However, there are a variety of other 'niche' tobacco products that are widely available and consumed across Lancashire, particularly in the BME communities of Preston and East Lancashire, which have not been subject to the Trading Standards measures. Niche tobacco is comprised of:

- **smokeless tobacco products** such as chewing tobacco (including paan, gutkha, zarda and khaini) and nasal snuff; and
- **smoked tobacco products** such as water pipe/shisah/hookah.

Smokeless tobacco products have been in existence for thousands of years among populations in South America and Southeast Asia. Smokeless tobacco is consumed without burning the product, and can be used orally or nasally. There is sufficient evidence that the use of smokeless tobacco causes cancer in humans (International Agency for Research on Cancer 2007). Smokeless tobacco contains carcinogens, which contribute to cancers of the oral cavity and the risk of other head and neck cancers. Smokeless tobacco use also causes a number of noncancerous oral conditions and can lead to nicotine addiction similar to that produced by cigarette smoking.

Smoked tobacco products have also been around for many years, with water pipe/shisha/hookah smoking being common practice in North African, Middle Eastern and South Asian countries. It has been claimed that more than 100 million people worldwide smoke shisha daily. Shisha tobacco is usually a combination of plain tobacco mixed with flavours (typically fruit) and aromatic substances.

Scientific studies to establish the adverse health consequences of shisha smoking point to dangers that are similar to those associated with cigarette smoking (WHO Study Group on Tobacco Product Regulation 2005). The research conducted on shisha use has clearly shown that it has particularly serious health consequences on the lungs and heart. Lung cancer, cancers of the oesophagus, precipitation of asthma attacks and pneumonia are some of the health hazards associated with shisha smoking.

Trading Standards have found that there is a general lack of awareness amongst both users and sellers of niche tobacco products that they do, in fact, contain tobacco and are unaware of the health consequences from their use. There is also evidence that such products have, for cultural reasons, been given to children by their parents. The products often come in brightly coloured packaging and are available at low cost compared to a traditional packet of cigarettes and so are particularly attractive to children. Legal selling requirements, including the minimum age for purchase and the correct labelling of the products, are often not complied with.

A variety of activity aimed at niche tobacco has been undertaken over the past 12 months with the aim of increasing awareness amongst sellers and users. This has included the inspection of traders' premises from which niche tobacco products may be sold to ensure products are labelled correctly and that the seller is aware that such products must not be sold to children; the distribution of a business advice leaflet to traders advising of selling and labelling requirements;

awareness training to traders and health professionals; and the production of a consumer awareness leaflet explaining that such products contain tobacco.

Alcohol and drugs

The NHS Information Centre's Smoking Drinking and Drug use among young people in England 2008, (2010) includes estimates of illegal drug use among 11 to 15 year olds. The findings show that 22% of school pupils reported having ever used drugs, a decrease from 29% in 2001. Meanwhile 15% of pupils reported having taken drugs in the past year (21% in 2003) and 8% reported having taken drugs in the last month (12% in 2008). Among 15 year olds 40% report having ever taken drugs (49% in 2003); 30% have taken drugs in the past year (38% in 2003) and 17% in the past month (23% in 2003). The survey also found that 22.8% of 15 year olds have used cannabis in the past year.

The school survey shows an encouraging downward trend in overall levels of drug taking, smoking and drinking by school children countering some of the more alarmist claims, but the figures do have limitations. Headline statistics cannot show the harm that drug use causes to many children – it is a concern for example that almost a quarter of 15 year olds have used cannabis and one in four of those have used it more than 10 times in the past year. While general levels of drug use among young people may be declining and many who do experiment with drugs may do so without long term harm to their potential, there is a significant minority who run into problems with their drug and alcohol use and are in need of support. It is important to emphasise that there is still a significant job to do in tackling drug and alcohol use and harms, there can be absolutely no room for complacency. (Drugscope 2010)

Key trends in the use of individual drugs

Nationally, 9% of school pupils aged 11-15 told the NHS Information Centre in 2008 that they had used cannabis in the last year, compared with 3.6% who said that they had tried Class A drugs. The use of volatile substances such as glue, gas, aerosols and other solvents was more common than Class A drug use among this age group with 5% reporting use in the last year.

Alcohol remains a particular concern. For 90% of under 18s in treatment the primary substance causing them problems is either alcohol or cannabis although the number of under 18's seeking treatment for powder cocaine use has increased by more than a half between 2005/06 and 2008/09.

Some young people are mixing and matching a range of drugs often in combination with cheap, strong alcohol. Poly drug use (mixing a number of substances in any one time) is common amongst young people. The rise of the AACCE profile has been recognised nationally and locally

in Lancashire. AACCE stands for Amphetamines, Alcohol, Cannabis, Cocaine and Ecstasy. More recently it has become the MAACCE profile to include Mephedrone.

Nationally, the number of young people taking illicit substances seems to be decreasing however the number of referrals to specialist substance misuse services appears to be increasing. It is believed that this is a result of the improvement in children's policy and pathway into accessible services.

Alcohol consumption amongst young people in Lancashire

The consumption of alcohol during childhood has been directly linked to changes in brain development (DH 2009). It can also lead to negative outcomes for young people arising from accidents, violence, early and unprotected sex ([sexual health](#) and [teenage pregnancy](#) are discussed in the chapter on young people) and poor school performance. Hospital admissions have been the focus of a recent report (Quigg et al 2010) which estimated that in Lancashire hospitals (including Blackpool Victoria and Royal Blackburn) during 2009 there were 1,091 alcohol related attendances to emergency departments for young people aged 12 to 17. Of these, 736 are believed to be unintentional injuries and 355 intentional injuries.

Trading Standards North West (2009) undertook major surveys amongst 15 and 16 year olds in 2005 and 2007 to investigate levels of drinking among school children. The 2007 survey found that, compared with the earlier survey in 2005, there had been a decrease in the population of 15 and 16 year olds who were drinking alcohol in the North West, but those who were drinking were drinking more heavily and more frequently. Females were continuing to drink more than males and school children in the wealthiest quintile had a higher proportion of drinkers than those in the poorest.

The 2007 survey explored risky drinking behaviour which was defined as follows:

- **Binge drinking:** drinking five or more alcoholic drinks on one occasion once a week or more
- **Frequent drinking:** drinking twice a week or more
- **Drinking in public places:** drinking at pubs/ members clubs/ nightclubs/ discos or outside (street, parks, shops).

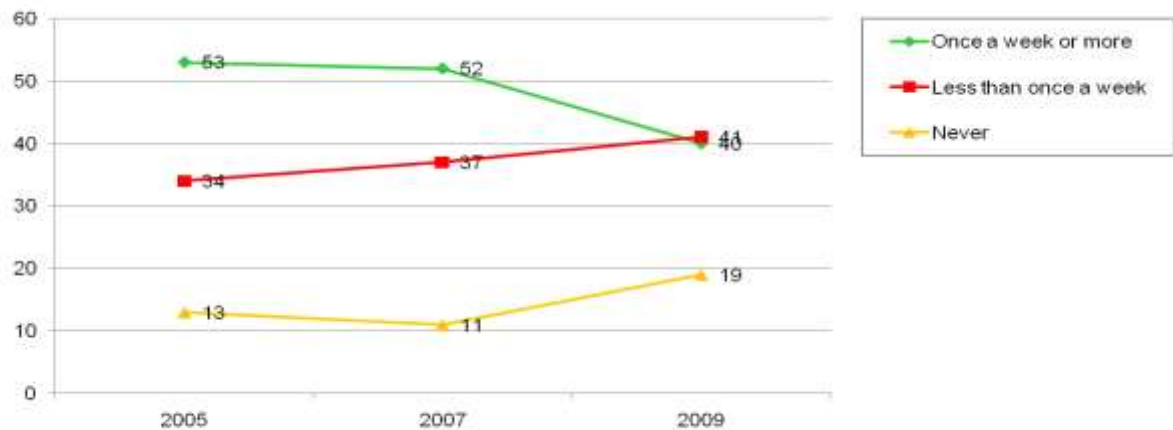
The survey found that for young people in the North West:

- 34.1% of drinkers stated that they bought their own alcohol and these individuals were more likely to engage in risky drinking behaviour.

- Those who have alcohol provided to them by parents (48.5%) were 1.6 less likely to binge drink and 1.3 times less likely to drink in public places.
- Respondents who had a hobby or were involved in sport were 1.6 times less likely to binge drink.
- Among those that drank once a week or more, 39.7% of females and 42.0% of males had been involved in violence following alcohol use.
- Those binge drinking three or more times a week were over 5 times more likely to have been involved in alcohol related violence than those who did not.
- Among those that drank once a week or more, 20.7% of females and 15.4% of males reported regretting sex following alcohol.

The Trading Standards North West Survey 2009 findings indicate an 8% decline in the percentage of 14-17 year olds in Lancashire claiming to drink alcohol since 2007 (89% in 2007 – 81% in 2009). Analysis at a more detailed level reveals a 9% fall in the proportion of 14-17 year olds in Lancashire claiming to drink alcohol twice a week or more. The graph below illustrates participants' response to how often they drink alcohol.

Figure 74: Participants' response to the question: How often do you drink alcohol?



40% of 14-17 year olds report drinking alcohol once a week or more in Lancashire.

The results indicate:

- Alcohol consumption amongst males in Lancashire is more polarised, with slightly higher percentages claiming not to drink and drink alcohol frequently compared to females.

- The percentage of 14-17 year olds in Lancashire identified as binge drinkers has fallen 12% since 2007 (83% in 2007 – 71% in 2009).
- The proportion claiming to binge drink regularly has fallen by 9%.
- An 8% fall in the proportion of 14-17 year olds in Lancashire claiming to binge drink at least once a week.
- There has been a fall in the proportion of 14-17 year olds binge drinking regularly in Lancashire since 2007

The majority of young people involved with the young people's treatment services already consume alcohol as part of their using behaviour. However, LDAAT are receiving increasing reports of a younger age range (primary school age) who are involved with high levels of consumption of alcohol on a regular basis. This is particularly evident within the East Lancashire population involved with Early Break Service. Throughout the county however it is felt that more young females are becoming involved with chaotic levels of alcohol consumption.

Table 157: Alcohol case studies

Countywide alcohol project research - 'Girls just wanna have fun'

In 2007, Alcohol and Tobacco Team in partnership with the Schools and Community Partnership Team undertook a research project into the levels of alcohol consumption for young women in Lancashire. The research identified some of the motivations and influences for alcohol consumption amongst young females (aged 11-16):

- Social facilitation: This motivation links alcohol consumption with increased enjoyment and comfort in social situations.
- Individual benefits: These include escapism, getting a buzz or something to do.
- Social norms and influences: This motivation links alcohol consumption to peer influences and ones image amongst peers.
- Other influencing factors:
 - Parental attitudes and behaviour
 - Advertising
 - Drinks retailing and marketing
 - Price and availability
 - Improvement in household income

The relationship between drinking behaviour and other risk behaviours, such as smoking, drug and solvent experimentation and sexual behaviour is significant. Today young women have more disposable income and are more independent, there is also a growing acceptance for women to consume alcohol and to get drunk. Being drunk can lead to females putting themselves at risk through unprotected sex, accidents or seriously damaging their health.

Evidence from the survey showed that young women in Lancashire were drinking well above the limits that define 'binge drinking' which is 5 or more units of alcohol in one session. The young females were asked to consider the consequences of their drinking behaviours. None of the consequences either emotional or physical would deter them from drinking. The general consensus amongst the girls was that being caught by the police would not act as a deterrent to stop them drinking alcohol. It was only important to them in choosing a place to drink where they would not be hassled by the police and they could drink without being disturbed.

Through these informal discussions with young females it was apparent that they regularly put their own safety at risk and they were not aware that they were doing so. All of the girls were very clear that they 'looked out for each other' and felt that they kept their mates safe. They all claimed that if a mate were unconscious through drink they would not worry about getting themselves into trouble. They would all know how to react to help their friends in an emergency situation.

Youth alcohol action plan 2009 – East Lancashire

In 2009 The Young Persons Alcohol Project, School and Communities Partnership Team and East Lancashire Healthy Schools consulted with young people across the five districts of East Lancashire regarding the Youth Alcohol Action Plan of the Government at that time and the Chief Medical Officers guidance.

Impacts of young people's drinking on communities:

All the young people were aware of how their own or young people's drinking was viewed within the community. Young people thought that they were often unfairly labelled, stereotyped as 'anti-social wreck-heads', and 'not all young people want to be viewed as a threat to their community'. They thought that it was unfair on those that only drank occasionally or didn't cause any trouble. They commented that it's not just teenagers who are drinking too much. Several of the young people lived near pubs and were often woken up during the early hours in the morning by drunken adults causing trouble.

However there were certain communities where the young people felt the stereotype labels were right - 'there are ten year olds wobbling up and down my streets'. They also mentioned incidents of anti-social behaviour where car wing mirrors had been kicked off, bottles smashed and 'sat nav systems taken from cars'.

Some young people drinking alcohol on the streets commented about the impact on police time. They felt that the police could be out dealing with more important issues such as 'robberies and drugs raids' and that there was 'no point taking young people home when caught drinking as they would be back out on the streets the following night doing the same thing'. It was suggested that 'young people between 14 and 16 should have places where they can go to have a drink where they won't cause trouble for the community or police'.

Access to alcohol / drinking behaviours:

There was a general consensus that young people had no problems getting access to alcohol. They got access to alcohol through older friends, sisters, brothers or buying it themselves. The young girls in particular had very few problems getting served, as they dressed themselves up to look older, especially if it was young men or older males serving.

The majority were drinking mainly at the weekends as 'hangovers weren't a problem on Saturday / Sunday'. At the weekend 'your mission is to get as drunk as humanly possible.....you sacrifice the taste to get drunk... spirits on Saturday and cheap cider'. Another young person commented that: 'I drink alcohol cos I have more fun..... I drink more heavily when something is on my mind or I have a problem. Young people think that no-one has ever gone through anything that they are going through, alcohol is a way of coping,drinking alcohol means acceptance with the in-crowd and at 15 we all want to be popular'.

Chief Medical Officer's guidelines:

The majority of young people felt that the CMO guidance of an alcohol free childhood under 15 was unrealistic. They agreed with it in relation to impacts upon health but felt having the guidelines would not alter young people's drinking behaviours. There was a definite difference in views of the older college students that were consulted compared to the views of the younger school pupils. There was a view that if a young person was over 15 the CMO guidance gave them permission to drink. A number of the younger pupils had more negative view towards drinking alcohol whilst the older pupils had more positive views of alcohol.

'Legal Highs'

The emergence and rapid increase in use of 'Legal High' substances in the UK in the last 18 months has evidenced users' desire for intoxication constrained by concerns about availability, purity, legality and price of the more established drugs of choice such as amphetamine, cocaine and ecstasy.

A recent article in Drugs and Alcohol Today 'Tweaking, bombing, dabbing and stockpiling: the emergence of mephedrone and the perversity of prohibition' Measham et al, March 2010, reported that 'within the last 18 months an unexpected and unprecedented shift has occurred in British recreational drug use.' We have seen the emergence and rapid growth in the use of a group of psychoactive drugs 'legal highs' including substituted cathinones or 'M-Cats', most notably mephedrone, but also naphyrone and methylenedioxypropylvalerone (MDPV).

On the 16th April 2010, Mephedrone was made a class B drug under the Misuse of Drugs Act 1971. Since then other legal highs such as Naphyrone (NRG-1) have been made a Class B drug under the Misuse of Drugs Act (23rd July 2010).

Recent sample batch analysis of substances sold as 'legal highs' has shown the presence of mephedrone and other banned substances (Ramsey et al 2010). Users are unaware of the content of their purchases, and it appears existing stocks are still being sold after they have been classified. It seems likely that until the possibilities for chemically 'tweaking' molecules are exhausted the emergence of psychoactive substances and their classification under the Misuse of Drugs Act will continue. In the meantime, young people in Lancashire continue to put themselves at risk in terms of their health and the legalities of their use of these substances. This has been seen in the increase of referrals to the treatment services across Lancashire since December 2009.

Table 158: Legal highs case study

Lancashire Drug and Alcohol Action Team (LDAAT) are currently working with a research team at Lancaster University to investigate the growth and use of such substances. The research will support the work of LDAAT in being proactive in developing a wider treatment system that truly meets the needs of the Lancashire population. In particular the research will:

- Build a greater understanding of the patterns of use of these substances within Lancashire in terms of the range of substances used, how they are mixed and a profile of who uses what.
- An understanding of the risks faced by those using such substances.
- Explore what harm reduction / treatment / educational needs this group may have now and in the future.
- Support partnership mapping of trends and aid strategic planning around the future developments of substance misuse services.

Substance misuse services in Lancashire

LDAAT is a public sector partnership with responsibility of delivering the National Drug Strategy (2008 – 2018) and elements of the National Alcohol Strategy. It comprises of health and criminal justice agencies and commissions services and interventions across the county of Lancashire in response to different levels of need.

The core aim for LDAAT is for children and young people and their parents to avoid substance misuse and achieve their full potential. To achieve this LDAAT commissions a range of early intervention and prevention services, and specialist substance misuse treatment and support services for young people across Lancashire.

LDAAT commissions treatment services for children and young people who have significant issues with substance misuse and who need individual help to overcome the problem. These services work with young people up to the age of 21 years and offer early intervention and targeted support to vulnerable groups.

The three service providers, operating in central, east and north Lancashire, offer a comprehensive assessment and a subsequent care plan, one to one support, harm reduction, information and advice. Alongside these, a variety of complementary therapies and focused interventions may be offered including; motivational therapy, counselling, family support, access to other structured activities and prescribing services and signposting / referral into other services.

Service use

In 2009/10 there were over 900 young people who accessed support via specialist substance misuse treatment services in Lancashire.

The majority of young people entering treatment for substance misuse in Lancashire ranges between the age of 14 and 17 years of age however services have also reported having a number of clients between the ages of 10 and 13 years old. This suggests that substance misuse has become a problem for some minors and more prevention work should be done at an early stage.

In 2009/10 62% of clients in treatment were male with 38% female. This percentage split is reflected in each locality although in East Lancashire it is 55% male, 45% female. Generally, alcohol and cannabis remain predominantly the main substances of choice of young people throughout Lancashire. Services have reported a significant increase in the number of young people presenting with 'legal highs' as their main drug of choice between 2009/10 and 2010/11. The numbers in treatment are ever increasing, and providers adapt their services to respond quickly when new trends emerge.

Table 159: All active LDAAT Tier 3 clients breakdown by gender, 2009/10

	Early Break	Young Addaction North	Young Addaction Central
Male	55%	69%	66%
Female	45%	31%	34%

Source: Q4 NDTMS data

Analysis of service use by provider is provided in the data [appendix](#).

Caseload and referrals

The young people treatment services have delivered significant change in terms of quality and access to substance misuse services in Lancashire over the past three years. The data below demonstrates the increase in children and young people accessing and achieving positive outcomes through addressing their (and in some cases their families) substance misuse.

The year to date (YTD) new presentations of under 18s to treatment in 2009/10 represented a remarkable **825% increase** since 2006-07. Similarly, numbers in treatment YTD have increased significantly since the start of the contracts in 2006. Annual referrals have increased from 481 in

2006/07 to 505 in 2008/09 to 599 in 2009/10, driven by criminal justice and looked after children sources.

The percentage of 15 year olds in treatment as a proportion of the overall under 18 caseload has increased from 15% in quarter 2 2006, to 27% in quarter 4 2009/10. Smaller increases are noted for 14 and 17 year olds. The number of clients aged 10 and under in treatment has remained low (between 2 and 3). The number of young people declaring heroin as their main substance of choice appears to be decreasing. Despite an increase in overall numbers in treatment, the number of primary heroin users has decreased from 17 in quarter 2 2006, to just 5 in 2009.

Conversely, alcohol misuse has increased significantly, with primary alcohol users representing 37% of all YTD clients at the end of September 2009, against 19% in September 2006. This is at odds with the overall picture of a reduction in alcohol consumption in children and young people in Lancashire. It may be that there is variance present by groups and a potential widening of the gap in drinking behaviour. This is certainly true for adult alcohol consumption in Lancashire and is related to areas of deprivation: those in the most deprived parts of Lancashire are less likely to drink but of those who do drink, they drink alcohol at levels which are harmful to health. (Lancashire JSNA 2009).

Table 160: LDAAT number of under 18s in treatment

	<u>2007/08</u>	<u>2008/09</u>	<u>2009/10</u>
Early Break	327	270	319
Young Addaction North	174	183	257
Young Addaction Central	157	205	222

Table 161: LDAAT referrals and numbers in treatment 1st April 2009 – 31st March 2010

YP (up to 21) referrals full year 09/10			Treatment	Number of young people in treatment full year 09/ 10	Number of young people under 18 in treatment 09/10	Average number of Young Offenders up to 21 on the quarterly caseload 09/10
Referrals	Number	%				
East	540	40%	East	436	319	51
North	284	21%	North	306	257	53
Central	525	39%	Central	330	222	68
Lancs	1,349	100%	Lancashire	1,072	798	172

Main referral sources: Youth Offending Service (20%), School (13%), Self (10%) and Children's Social Care (8%).

- 40% of young people in Lancashire (up to age 21) entering treatment are referred via the Youth Offending Team (YOT) or criminal justice system (09/10).
- The second highest level of access to treatment remains through the education pathway whereby 121 (20%) of Lancashire's clients were referred. This includes referrals from primary and secondary schools, colleges and other education to employment initiatives.

However, for Lancashire this figure is predominantly referrals for young people of secondary school ages.

- The third highest source of referral for access to treatment is self, family or friends, which accounted for 69 (12%) of Lancashire clients in 2009/10. This referral level is reflective of the services maintaining their profile within their local communities and constant promotion of their services through visiting local community centres, family centres etc and providing information, advice, service leaflets, advertisements within other locality services and agencies.

Table 162: LDAAT referrals by source, 2009/10

Agency	Figure	%
Youth Offending Team & Criminal Justice	234	40%
Health - GP and Primary Care	9	1%
Health – A&E and Hospital	15	2%
Health – School Nurse	4	1%
Mental Health	5	1%
Non Child Mental Health	5	1%
Education	121	20%
Looked After Children	22	4%
Substance Misuse Services	6	1%
Children & Family Services	48	8%
Self/ Family/ Friends	69	12%
Targeted Youth Support	11	2%
Other	47	8%

(Source: National Treatment Agency 09-10)

Vulnerable Groups

Substance misuse is common amongst groups of vulnerable young people. These groups include [looked after young people](#), [young offenders](#), young people who are not in mainstream school, young people who are truanting, children of substance misusing parents, [young homeless people](#) and young people who are sexually exploited and further discussion of some of these groups is provided in the other sections of this report. The close correlation between substance misuse and unplanned teenage pregnancy has been highlighted in many studies as risk taking behaviour in that one may easily lead to experimentation in the other. Use of substances may lead young people to intimate sexual contacts, having unprotected sex, have sex with someone they do not know or become victim of a sexual act (Independent Advisory Group on Sexual Health and HIV, 2007).

Hidden Harm - young people who are affected by family substance misuse

The negative impact of problems arising from parental substance misuse on children has been well documented and acknowledged in two key government publications (Advisory Council on the

Misuse of Drugs, 2003 and Prime Minister's Strategy Unit, 2003). Negative experiences of children and young people living with parental substance misuse include:

- High levels of violence.
- Experiencing or witnessing neglect or abuse (physical, sexual or verbal).
- Poor and/or neglectful parenting.
- Inconsistency from one or both parents.
- Having to adopt responsible or parenting roles at an early age.
- Feeling negative emotions such as shame, anger, guilt, fear and embarrassment.
- Possible neurodevelopmental consequences of substance misuse in pregnancy that may contribute to developmental delays or intellectual disability.

It should also be added that another potential consequence of parental substance misuse occurs in adolescents, and follows two common patterns (Velleman and Templeton 2007):

- participation in peer relationships that themselves may lead to early involvement in drug and alcohol use, alongside other risk taking behaviours.
- increasing introspection and social isolation, with friendship difficulties, anxiety and depression, and attempts to leave the family home at an early age.

There is very little reliable data around hidden harm figures. There are steps being taken to improve the recording. There is now recording of some data by the comprehensive implementation of the Common Assessment Framework (CAF) across Lancashire and the Adult and Young People Performance Monitoring Framework (PMF) now records local and county wide CAF data, although this does not specifically identify when a young person uses substances.

Across all areas of the DAAT, around one third of those entering substance misuse treatment (674 in a full year) have children. Current data is summarised below.

Table 163: LDAAT service users with children, 2009/10

	Individuals with children (% of new treatment journeys YTD)	
	1st Oct– 31st Dec 09/10 (Q3)	1st Jan – 31st March 09/10 (Q4)
Lancashire	32%	34%
East	29%	28%
North	39%	48%
Central	34%	34%
Source: National Drug Treatment Monitoring System (NDTMS)		

LDAAT supports and developed the multi-agency County (Lancashire) Hidden Harm Group and four Locality Hidden Harm groups in line with Locality Safeguarding groups. They implement and recognise the respective action plans, raise awareness and accountability of the issues within mainstream adult and children and young people’s services. The Lancashire Hidden Harm action plan was revised in September 2009 in line with the recommendations of Hidden Harm Three Years On: Realities, Challenges and Opportunities (Advisory Council on the Misuse of Drugs, 2007). Improved levels of data from locality to county level are required as part of the on-going developments identified within the County (Lancashire) and Locality Hidden Harm Action Plans.

Young people who offend

Substance misuse is particularly prevalent amongst young people entering the criminal justice system. In Lancashire, the Youth Offending Team (YOT) generate on average 45% of referrals into treatment services. It is important that young offenders are assessed so that any drug misuse problems are identified and addressed. In Lancashire, the aim is to promptly provide every young person referred to them with a substance misuse assessment and an appropriate intervention where necessary. Further discussion of [children and young people who offend](#) is contained in the chapter on young people

A protocol was developed for a joint working arrangement with Young Addaction (North and South), Early Break and Lancashire Youth Offending Team (YOT) to enable partnership working. It ensures consistency and clarity of roles and responsibilities in order to provide effective substance misuse treatment services to young people.

Young people who are looked after

As an identified vulnerable group young people who are looked after are statistically at greater risk of becoming involved with risky behaviour which may include misusing substances. The young people’s treatment services have specifically identified and worked with those young people and staff within local authority children’s homes in each locality and have provided education, advice, and harm reduction and prevention messages. There is a high proportion of local authority and

privately run children's homes within the East of the County in which more Tier 2 targeted work can be undertaken. However, there are low levels of referrals for children who are looked after received by young people's treatment services throughout the County and we are aware that there is much more work is required in this area. Further discussion of [children who are looked after](#) is contained in the chapter on young people with particular needs.

School non-attendeess, truants, temporary and permanent excludes

Young people excluded from school are at greater risk of becoming involved in misusing substances. Schools should ensure that pupils vulnerable to drug misuse are identified and receive appropriate support either from within the school or through referral to other services.

Whilst Lancashire County Council monitors the numbers of young people non-attending, truanting, temporarily or permanently excluded, the reasons behind such responses, by adults and young people, have not been fully explored. There is a need to monitor the level of exclusions for drugs/alcohol related incidents and identify the impact of such responses on young people in achieving the five ECM outcomes.

Sexual health

The main discussion of [sexual health](#) is presented in the young people chapter. However, this issue is also important in the 11 to 15 age group and interventions here are likely to support a reduction in negative outcomes.

Even though under 18 conceptions in England are currently at the lowest rate since the launch of the Teenage Pregnancy Strategy in 1999, we still have the highest rates in Western Europe. Evidence identifies the delivery of comprehensive Sex and Relationships programmes and provision of quality, accessible young people –centred contraceptive and sexual health services as the two factors for which the evidence on the impact on teenage pregnancy rate reductions is the strongest (DCFS 2010).

Work is currently taking place to produce a teenage pregnancy needs assessment for the sub-region of Lancashire. This will be published in the near future on the JSNA website:

jsna@lancashire.gov.uk.

Making a positive contribution amongst children and young people

The following information refers to young people in aged 11-19, and up to 25 where there are specific needs.

Young people's priorities

Young people involved in the Lancashire County Youth Council have evaluated their priority campaigns for 2010 to 2011, determined through an annual consultation exercise. The identified priorities are:

- Sex and relationships education
- Transport
- Political education of young people
- Positive images of young people in the media

The aim is that the County Youth Council may gain the support from services and agencies involved in Lancashire Children's Trust Partnerships, to make progress in these key areas.

Encouraging a culture of active participation

The Lancashire Children's Trust Partnerships in each District (LCTPs) aim to ensure that young people have a range of opportunities to become active participants in their communities. This approach is supported through actions identified in the Children and Young People's Plan and in service-specific planning, for example, in the Young People's Service, Libraries and Information Service as well as in the voluntary, community and faith sectors.

Young people have been encouraged to participate in discussion, research and consultation with Children's Trusts in every district, promoting the Lancashire Children and Young People's Charter, as well as local and Lancashire wide campaigns, (see young people's priorities above).

The Lancashire Youth Strategy, which was approved by the Positive Contribution Theme Group in September 2010, is in the final stages of consultation. In the development of a Youth Offer in Lancashire, it seeks commitment to 'develop and co-ordinate the voice and influence of young people across partnership organisations'

Involving children and young people

Involving young people in decision making may take place at any stage of their contact with services, whether through evaluating choices around activities on offer or about next steps in their learning, career and general wellbeing.

Additionally, there are established mechanisms for the strategic and formal involvement of young people, in making decisions about services that effect them and resources or facilities that are available to all.

In 2009 to 2010, more than 4,000 individual young people were involved either directly in their District Youth Councils or in electing other young people to represent them on the County Youth Council and the National Youth Parliament.

In the same period, 390 young people were directly involved in Youth Banks – the mechanism for making decisions around the distribution of Youth Capital and Youth Opportunities funding. Through this process, many more young people have directly benefited as a result of new and enhanced youth facilities and increased access to positive activities – 2043 young people by being involved in applying for the grants, and an estimated 14,906 benefiting from activities and facilities made available through the funds.

Where there has been any refurbishment or development of venues for young people's use, the Young People's Service (YPS) has actively sought young people's involvement at each stage.

Involving young people in volunteering

Young people's engagement in communities through volunteering has been a feature of many existing programmes and services for young people, through Youth Action Groups and forums; senior member/helper opportunities in youth clubs and projects; the service element of the Duke of Edinburgh Award scheme; and through Youth Council campaigns and actions. The following examples demonstrate additional initiatives which have been recently developed through targeted resources and partnerships:

Table 164: Involving young people in volunteering case studies

<p>VTalent</p> <p>V was created in 2006 as a result of the Russell Commission Report, 'A National Framework for Youth Action and Engagement'. VTalent is a programme currently being piloted with 33 local authorities and 28 Further Education colleges offering 44 week long placements in Children's and Young People's Services. The aim is to give 2,000 volunteers aged 16-25 the opportunity to directly influence and enhance public sector services and gain skills to improve their employability. At least 40% of the places are given to young people who are not in employment, education or training (NEET). An evaluation of the first year of the national programme is available at: http://vinspired.com/uploads/admin_assets/datas/782/original/vtalent_year_impact_2010_FINAL.pdf</p> <p>Lancashire is one of the pilot Authorities for VTalent; the programme is half-way through its second year. This year, 95 young people have shown an interest in this structured volunteering programme: 15 volunteer places were available and were secured by a diverse group of young people, including some who had previously been looked after by the Local Authority, disabled young people, young mothers and young carers.</p> <p>Participating services offering placements in the children and young people's sector are the Young People's Service, Outdoor Education Service, Youth Offending Service, primary and secondary schools and children's</p>

centres. The young volunteers are aiming for three 'Level 2' qualifications within an apprenticeship framework, in teaching assistance, child care and youth work.

The positive outcomes achieved by 9 of the 10 participants in the first year have been in undertaking a Level 3 qualification; completing a Level 2 qualification and in securing full-time or part-time posts.

Step into Sport Leadership and Volunteering Programme

Through the Step into Sport Leadership and Volunteering Programme, which is delivered through schools, young people aged 11-19 engage in leadership and volunteering opportunities within and outside the curriculum.

Publicising positive activities

Young people's engagement in positive activities in their community is dependent on them being informed about the extent and content of activities on offer to them. The publication of positive activities continues to be a statutory requirement of the Young People's Service, but is also a priority at the heart of the Lancashire Youth Strategy, 'to co-ordinate publicity and marketing so that young people have attractive and up-to-date information about what is available and how to access it'.

Although paper-based promotions are still relevant, the primary means of publicising is through the Go4It website: <http://www.lancashire.gov.uk/yps>. Increasing numbers of partnership organisations – 136 organisations at September 20210 - are publicising their activities on this site, since its launch in September 2010.

The involvement of young people and parents in design, development and feedback about the marketing of activities, as well as about the activities themselves, will be vital to their success.

Summary, identification of key areas of need and recommendations

Secondary years are formative years for young people and are a natural time when experimentation and trying new things is common. At the same time it is an incredibly important time in terms of sowing the seeds for future success in life with achievement in education opening up options for young people to pursue beyond compulsory education. Although the overall levels of attainment across the county are very good, there remain strong inequalities between different groups of young people. Attainment gaps are present between children from different ethnic groups, genders, those who are looked after and those with special educational needs.

These options are restricted for those who are persistently absent or who are permanently excluded from school. Rates of permanent exclusion are above average and are particularly high in Pendle and Preston. Exclusions for reasons of verbal abuse or threatening behaviour towards adults, drug and alcohol related incidents and theft all occur more frequently in Lancashire than

nationally. On the other hand, fixed term exclusions appear to be used less frequently on the Lancashire average which may indicate a zero tolerance approach taken in some schools. Schools have reported that poor support is offered for promoting pupil attendance and the provision for pupils out of mainstream schools, including pupils who have been excluded.

Smoking is a major public health concern and is linked to both short and long term health problems. The increased risk of respiratory conditions can lead to absence from school and smoking is linked with increased truancy, impacting upon educational attainment. It is clear that the best approach to smoking is prevention and this necessitates a family approach as children and young people are most influenced by their family and what is considered "normal" within their community. The availability of illicit and illegal tobacco products is an area where an impact may be felt on children and young people by restricting supply and trading standards in Lancashire continue to work to do this. Niche tobacco products may be a particular issue in some parts of Lancashire, particularly in the BME community where smokeless tobacco products such as sweets and foods are given to children. This often happens as parents and retailers are unaware they contain tobacco or are unaware of the risks involved in providing them to children. Niche smoked tobacco products include water pipes, known as hookahs, which are used by young people who may not consider themselves to be smokers.

Substance misuse, both alcohol and drug use, is of concern due to the impact it can have on the lives of young people who may be involved in accidents or engage in early and unprotected sex. There are also concerns over the link with sexual exploitation and teenage pregnancy and it is important that the relationship between these agendas is recognised and exploited. Links with lower educational attainment have also been identified. 40% of young people in Lancashire report drinking alcohol at least once a week. Almost half of young people who drink get alcohol from their parents, which provides support for total family approaches to reduce consumption. Having said this, young people who get alcohol from their parents are less likely either to binge drink or drink in public places. There are reports of primary school age children starting to consume alcohol, particularly in East Lancashire, but the main risk group is considered to be young women who research in Lancashire has shown regularly put their own safety at risk, without realising it. Research with young people in Lancashire highlights strong views that alcohol free youth is unrealistic despite the known damage to health. This suggests approaches need to be tailored to not only try to discourage the behaviour but to help young people be resilient from potential negative consequences from this form of risk taking behaviour.

The use of legal highs is believed to be increasing in Lancashire and LDAAT are involved in a research project with the University of Lancaster which should provide valuable intelligence on the needs of young people who engage in these behaviours in the county. The increasingly young age

profile of service users of LDAAT again strengthen the need for early intervention at younger ages to prevent (or at the very least delay) drug use. There is a need to continue focus on vulnerable young people who face greater risk of negative outcomes from experimenting with substances. The children and young people participants in the Children's Trust local democracy week also highlighted drugs and alcohol services as a priority for health funding, indicating this to be a key priority area for them.

In summary, the key areas of need highlighted for children and young people aged 11 to 15 years are:

- Educational attainment gaps
- Missing from education
- Smoking
- Substance misuse (alcohol and drugs)

Specific recommendations

A number of specific recommendations can be drawn from the analysis in this chapter:

- Time series analysis of educational attainment in Lancashire overall, by district, and by various groups such as by gender, ethnic group, FSM eligibility, children who are looked after, children with special educational needs, etc, should be made available through the JSNA pages.
- Investigation of the characteristics of those pupils who are persistent absentees would assist in developing better support for schools to improve school attendance.
 - Reinforce the schools and exclusion teams to develop better links and support mechanisms for young people at risk of being temporarily or permanently excluded from school.
- It is recognised that there is a lot of excellent work already taking place around the smoking agenda for young people. Reducing adult smoking is the most effective way of preventing smoking in young people and protecting children from second hand smoke. A Lancashire wide tobacco control strategy should be developed in line with the coalition governments' 5 –Year Tobacco Control Action Plan, due to be published this year.

The following recommendations have been suggested to tackle substance misuse by young people:

- Better integrated family support services - this should be developed as an 'integrated' part of the holistic treatment service interventions across Lancashire. The holistic treatment system for Lancashire should incorporate interventions to address the wider family needs including parenting skills, parental use and parental education.
- Those young people that drink alcohol are consuming more and they would benefit from basic harm reduction and health advice around alcohol misuse, educational input to local primary and secondary schools around alcohol misuse and to educational and supportive input for parents. Specific interventions could include:
 - Social marketing campaigns aimed at targeted groups of young people with their involvement. Messages around alcohol consumption and its' wider social and health consequences including sexual health and teenage pregnancy.
 - Statutory and voluntary agencies should agree clear, consistent and accurate messages about the impact of alcohol consumption on young people. These must include short-term health effects, the impact on relationships, risk taking behaviour and issues of personal safety.
 - Schools should audit their PSHE (personal, social and health education) and science curriculum and make explicit links between alcohol education and sex and relationships education.
- Hidden harm: ensure that the needs of children and young people of substance misusing parents / carers are known, acknowledged and appropriately addressed within all mainstream, targeted and young people and adult services as part of the Every Child Matters agenda.
- Workforce development: continue to increase the opportunities for substance misuse training and resources for personnel working within mainstream and targeted services within both the statutory and voluntary sector.
- Vulnerable groups are often hard to engage with and may need targeted support. An effective integrated workforce and consistent working patterns will ensure a partnership approach.

- Identify a consistent approach to substance misuse education and highlight young people at risk both outside and within the school environment.

Young people – 16 to 19 years

Nationally youth unemployment is rising and the recent recession and current financial climate may mean a reduction in the numbers of jobs available (see socio-economic determinants of wellbeing chapter for further discussion). Employers may favour older and more experienced adults over new entrants to the jobs market during tough times. As a consequence, young people actively seeking work are two to three times more likely than older generations to find themselves unemployed. The worst affected by this will be those who have not achieved within the education system. The most vulnerable youth are those who are not in employment, education or training (known as NEET). Unemployment and a lack of other positive activities are often linked to offending behaviours, a negative outcome particularly affecting young males, but also to early parenthood.

The exclusion of a key component of society such as young people from decision-making, even on issues that directly affect their lives, creates an enormous problem of political legitimacy and equity and leads to key opportunities to involve youth as agents of better governance, accountability, and democratic development being missed. This is discussed in the secondary chapter and is therefore not covered again here, although it remains an important issue for this age group.

Key vulnerabilities for this group include:

- Poor job market opportunities magnified by specific barriers posed by employers to hiring first time job seekers.
- Lack of participation in decisions and policies that affect the lives of young people

With potential short term impacts:

- Exposure to risky behaviours: early unplanned or unwanted pregnancies, drug abuse, sexually transmitted infections including HIV/AIDS, violence, and premature death.
- Unemployment, hazardous or exploitative labour.
- Exclusion from decision making of key component of civil society

With potential long term impacts:

- Intra- and inter-generational transmission of poor health and its consequences (low birth weight, vertical transmission of HIV/AIDS).
- Reduced productivity.

- Inter-generational transmission of household and community violence.
- High economic costs of risky behaviours and forgone assets for development.
- Lost opportunities for involving young people as agents of better governance, accountability, and democracy.

For young people, priority should be given to interventions to:

- Promote full access to sexual health services with a particular focus on pregnancy prevention and STIs.
- Improve access to community-based opportunities for life and livelihood skills development, with direct participation of youth organisations;
- Establish and support links between youth organisations and employers to offer information about existing opportunities, including flexible paths to employment, internships, apprenticeships, and hands-on experience; and
- Develop an inclusive local youth policy to promote youth participation in decisions and policies that affect their lives.

Background information

Within Lancashire there are almost 65,000 young people aged 16-19, accounting for 23% of the total children and young people population aged 0 to 19. This age cohort is expected to reduce over the next few years. There is limited information available about the general characteristics of these children as, like those in Early Years, they fall outside the remit of the School Census where a lot of detailed information is collated. The Connexions dataset provides a range of information but this is by no means complete.

Mortality

During the period from 2005/06 to 2009/10 there were 138 deaths in 15 to 19 year olds in Lancashire. The highest number of deaths was found in Burnley and Preston (18), closely followed by South Ribble (17).

Table 165: number of deaths aged 15 to 19 years in Lancashire, 2005/06 to 2009/10

Childhood deaths aged 15-19 years						
District	2005/06	2006/07	2007/08	2008/09	2009/10	Grand Total
Burnley	6		<5	6	<5	18
Chorley	5	<5	<5	<5	<5	12
Fylde		<5		<5	<5	5
Hyndburn	<5	<5	<5	<5		7
Lancaster	4	<5	<5	<5	<5	11
Pendle	5	<5	<5	<5	<5	12
Preston	<5	11	<5	<5	<5	18
Ribble Valley	<5	<5	<5	<5	<5	9
Rossendale	<5	<5	<5	<5		7
South Ribble	5	7	<5	<5	<5	17
West Lancashire	<5		<5	7	<5	12
Wyre	<5	<5	<5	<5		10
Lancashire	36	31	24	31	16	138

Source: Public Health Mortality File held by Lancashire CBS
Numbers less than five suppressed to ensure confidentiality

The greatest numbers of deaths in the 15-19 age group are classified as other causes of death. The largest known causes of death are diseases of the nervous system and cancers, which account for more than a quarter of total deaths over the period.

Table 166: mortality by cause in Lancashire aged 15 to 19 years, 2005/06 to 2009/10

ICD10 Code	ICD10 Description	Nos	%
A00-B99	Certain infectious and parasitic diseases	<5	
C00-C97	Malignant neoplasms	18	13.0%
C81-C96	Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	<5	
E00-E90	Endocrine, nutritional and metabolic diseases	<5	
F00-F99	Mental and behavioural disorders	<5	
G00-G99	Diseases of the nervous system	18	13.0%
G40-G41	Epilepsy	<5	
I00-I99	Diseases of the circulatory system	5	3.6%
J00-J99	Diseases of the respiratory system	5	3.6%
J10-J18	Influenza and pneumonia	<5	
J45-J46	Asthma	<5	
K00-K93	Diseases of the digestive system	5	3.6%
K35-K38	Diseases of appendix	<5	
M00-M99	Diseases of the musculoskeletal system and connective tissue	<5	
O00-O99	Pregnancy, childbirth and the puerperium	0	0.0%
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	<5	
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	<5	
ZZZ	Other causes of death	54	39.1%
(blank)	Not recorded	5	3.6%
Total deaths		138	100%

Source: Public Health Mortality File held by Lancashire CBS
Numbers less than five suppressed to ensure confidentiality

Hospital admissions

The total hospital admissions rate for the 15-19 age group is approximately triple that of the 10-14 age group. Across Lancashire there are variations with the highest admissions rates in the districts of Chorley, Preston, South Ribble and West Lancashire.

The table below shows that from 2005/06 to 2009/10 the hospital admission rate in 15 to 19 year olds in Lancashire increased by 1.1%. The districts with the three highest increases were Fylde, Preston and West Lancashire. Hyndburn, Rossendale and Pendle had the three largest reductions, respectively. The increase in hospital admissions in Preston resulted in Preston having the highest rate in 2009/10 followed by Chorley, which also had an increase over the same period.

Table 167: Total admissions rate per 1,000 of the population aged 15 to 19 years, 2005/06 to 2009/10

Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	149	147	149	151	151	1.1%
Burnley	168	155	170	155	161	-3.7%
Chorley	159	170	167	168	183	15.4%
Fylde	102	115	146	152	127	24.6%
Hyndburn	227	210	185	183	161	-29.1%
Lancaster	105	96	110	108	109	4.6%
Pendle	171	140	142	146	148	-13.5%
Preston	177	181	175	203	213	20.2%
Ribble Valley	98	105	99	94	97	-0.9%
Rossendale	148	155	146	143	117	-21.1%
South Ribble	174	171	159	166	170	-2.1%
West Lancashire	139	150	139	154	165	18.7%
Wyre	111	120	145	129	123	11.1%

Source: SUS data provided by CLCBS and midyear population estimates 2005 to 2009

Causes of hospital admissions

There were more than 12,000 hospital admissions for the 15 to 19 cohort in Lancashire during 2009/10. The greatest numbers of admissions in Lancashire were for pregnancy and child birth (2,419), injuries, poisonings and other external causes (1,506) and diseases of the digestive system (1,142). District level data is available in the data [appendix](#).

Table 168: Numbers and percentage of admissions to hospital for those aged 15-19 years resident in Lancashire County by age group and primary diagnosis, 2009/10

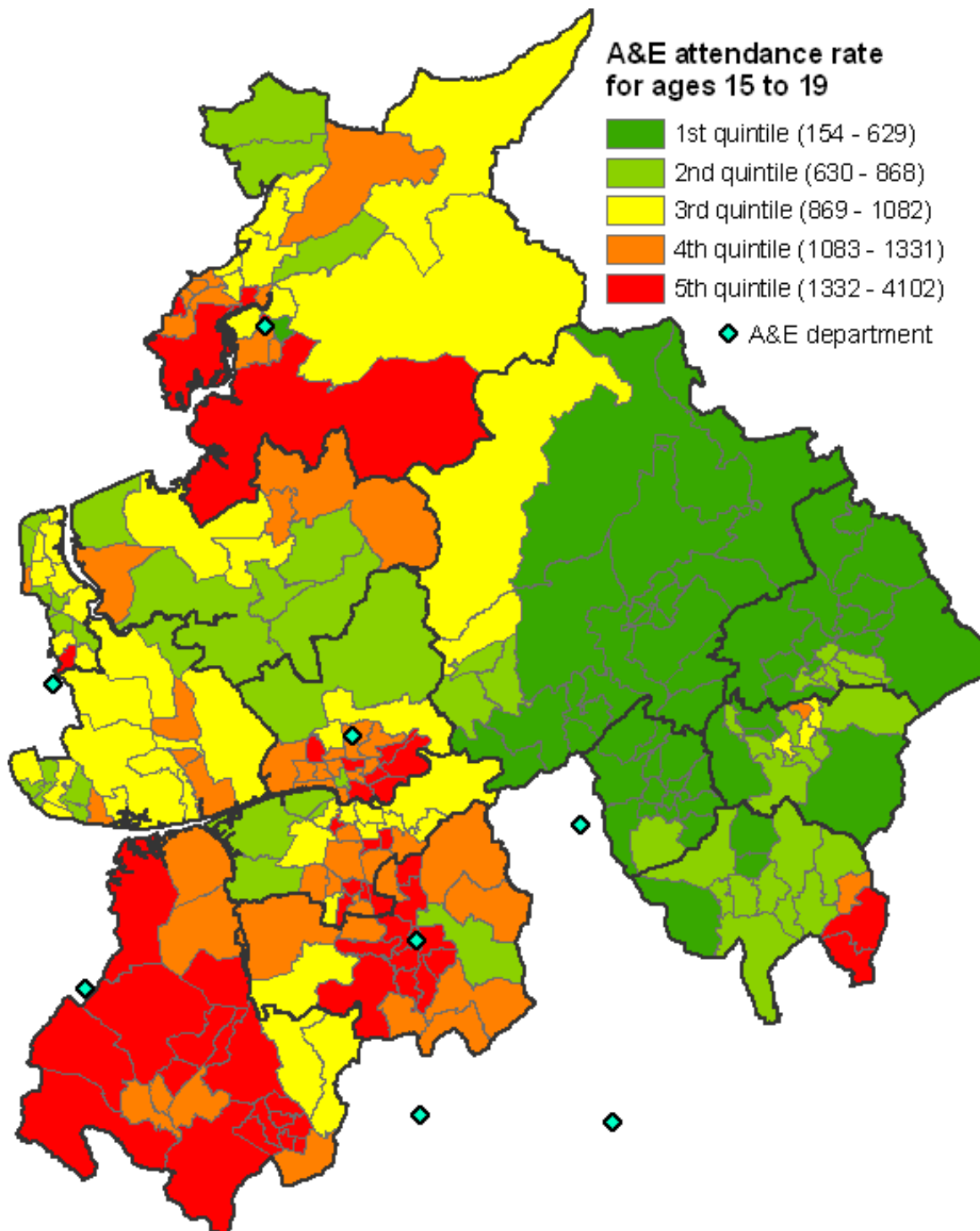
ICD10 Code	ICD 10 Description	Nos.	%
A00-B99	Certain infectious and parasitic diseases	134	1.2%
	A00-A09 Intestinal infectious diseases	25	0.2%
C00-C97	Malignant neoplasms	229	2.1%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	111	1.0%
D10-D36	Benign neoplasms	183	1.7%
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	84	0.8%
E00-E90	Endocrine, nutritional and metabolic diseases	224	2.0%
	E10-E14 Diabetes mellitus	113	1.0%
F00-F99	Mental and behavioural disorders	203	1.8%
G00-G99	Diseases of the nervous system	187	1.7%
	G40-G41 Epilepsy	89	0.8%
H00-H59	Diseases of the eye and adnexa	112	1.0%
H60-H95	Diseases of the ear and mastoid process	87	0.8%
I00-I99	Diseases of the circulatory system	187	1.7%
J00-J99	Diseases of the respiratory system	762	6.9%
	J00-J06 Acute upper respiratory infections	248	2.3%
	J10-J18 Influenza and pneumonia	32	0.3%
	J20-J22 Other acute lower respiratory infections	48	0.4%
	J45-J46 Asthma	94	0.9%
K00-K93	Diseases of the digestive system	1142	10.4%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	455	4.1%
	K35-K38 Diseases of appendix	155	1.4%
	K40-K46 Hernia	37	0.3%
	K50-K52 Noninfective enteritis and colitis	183	1.7%
L00-L99	Diseases of the skin and subcutaneous tissue	371	3.4%
M00-M99	Diseases of the musculoskeletal system and connective tissue	578	5.3%
N00-N99	Diseases of the genitourinary system	747	6.8%
O00-O99	Pregnancy, childbirth and the puerperium	2419	22.0%
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	23	0.2%
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1231	11.2%
S00-T98	Injury, poisoning and certain other consequences of external causes	1506	13.7%
Z00-Z99	Factors influencing health status and contact with health services	580	5.3%
Total Admissions		12,579	100%
Source: SUS provided by CLCBS (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth)			

Emergency hospital admissions

The pattern of an east west split remains in emergency department attendance rates of the 15 to 19 cohort. The rate of emergency hospital admissions in Lancashire is such that for every ten

young people, six will be expected to be admitted as an emergency in a year. Rates are particularly high in Chorley and Preston, whilst very low in Ribble Valley and Wyre.

Map 29: Emergency department attendance rate for ages 15 to 19, 2005/06 to 2009/10



Between the period 2005/06 and 2009/10, overall, in Lancashire there was a slight fall in the rate of emergency admissions of 15 to 19 year olds. However, the rate of emergency admissions increased in a number of districts with the largest increases being in Preston and Fylde. The largest decrease was in Hyndburn and the second largest in Rossendale. In 2009/10 the three highest rates of emergency admissions were in Preston, Chorley and South Ribble and the three lowest rates in Ribble Valley, Wyre and Fylde.

Table 169: Emergency admissions rate per 1,000 of the population aged 15 to 19 years, 2005/06 to 2009/10

Financial Year	2005/06	2006/07	2007/08	2008/09	2009/10	Change
Lancashire	64	62	60	64	64	-1.2%
Burnley	77	69	64	68	68	-11.6%
Chorley	71	66	59	67	74	3.6%
Fylde	43	50	60	60	53	25.1%
Hyndburn	83	74	62	67	65	-21.6%
Lancaster	54	50	55	56	59	8.5%
Pendle	70	62	60	60	61	-12.2%
Preston	71	70	72	86	89	25.1%
Ribble Valley	38	39	40	46	46	20.3%
Rossendale	64	57	60	63	54	-16.0%
South Ribble	73	74	64	65	69	-5.3%
West Lancashire	68	72	63	63	61	-10.3%
Wyre	49	48	56	53	47	-4.1%

Source: SUS data provided by CLCBS and midyear population estimates 2005 to 2009

Causes of emergency hospital admissions

During 2009/10 there were almost 5,500 emergency admissions for the 15 to 19 cohort. There is a strong shift in the emergency admissions from elective with by far the largest numbers due to injuries, poisonings and external causes and other symptoms not elsewhere classified (1,268 admissions). It is likely that a proportion of these will be due to alcohol related admissions. District level data is available in the [appendix](#).

Table 170: Numbers and percentage of emergency admissions to hospital by children aged 15-19 by primary diagnosis, 2009-10

ICD10 Code	ICD 10 Description	Nos.	%
A00-B99	Certain infectious and parasitic diseases	113	2.4%
	A00-A09 Intestinal infectious diseases	23	0.5%
C00-C97	Malignant neoplasms	17	0.4%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	13	0.3%
D10-D36	Benign neoplasms	6	0.1%
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	28	0.6%
E00-E90	Endocrine, nutritional and metabolic diseases	141	3.0%
	E10-E14 Diabetes mellitus	107	2.2%
F00-F99	Mental and behavioural disorders	194	4.1%
G00-G99	Diseases of the nervous system	131	2.7%
	G40-G41 Epilepsy	80	1.7%
H00-H59	Diseases of the eye and adnexa	-	-
H60-H95	Diseases of the ear and mastoid process	15	0.3%
I00-I99	Diseases of the circulatory system	47	1.0%
J00-J99	Diseases of the respiratory system	346	7.2%
	J00-J06 Acute upper respiratory infections	108	2.3%
	J10-J18 Influenza and pneumonia	32	0.7%
	J20-J22 Other acute lower respiratory infections	45	0.9%
	J45-J46 Asthma	85	1.8%
K00-K93	Diseases of the digestive system	420	8.8%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	22	0.5%
	K35-K38 Diseases of appendix	152	3.2%
	K40-K46 Hernia	-	-
	K50-K52 Noninfective enteritis and colitis	59	1.2%
L00-L99	Diseases of the skin and subcutaneous tissue	107	2.2%
M00-M99	Diseases of the musculoskeletal system and connective tissue	98	2.1%
N00-N99	Diseases of the genitourinary system	287	6.0%
O00-O99	Pregnancy, childbirth and the puerperium	471	9.9%
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1020	21.4%
S00-T98	Injury, poisoning and certain other consequences of external causes	1268	26.5%
Z00-Z99	Factors influencing health status and contact with health services	60	1.3%
Total Admissions		5495	100%
Source: SUS provided by CLCBS (Groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality but included in the total. This dataset excludes admissions for conditions originating at birth)			

Road traffic accidents

There were 4,370 casualties of young people aged 16-19 in the period 2005-09; 628 young people were killed or seriously injured (KSI). Whilst the children and young people rate (aged 0 – 19 years) was 2.5 per 1,000 population, for the age 16-19 age range the figure was 10.7 per 1,000

population, demonstrating that young people aged 16-19 experience almost quadruple the risk of being killed or seriously injured on Lancashire roads as the general children and young people population.

For the 16-19 age range the travel characteristics are perhaps becoming dominated by independent trips. Also the pedestrian and cyclist casualties of 430 (10% of all casualties) become less significant. Car occupant casualties become dominant and the 3,144 of these make up 72% of all casualties in this age range. The pattern in Ribble Valley is of particular interest as the rate of young people killed or seriously injured is highest in this district, which is a complete reversal of the pattern for other age groups where the rates for the Ribble Valley were usually the lowest.

Table 171: Lancashire 16-19 year old road traffic casualties, 2005-09

	Lancashire
Population (16 to 19 years)	58894
All young people casualties	
All young people casualties	4370
All young people Pedestrians & cyclists	430
All young people car occupant casualties	3,144
Rate of casualty / 1000 population	74.2
Killed and seriously injured casualties	
Killed and serious casualties	628
KSI Pedestrians & cyclists	101
KSI car occupants	339
Rate of KSI per 1,000 population	
Lancashire	10.7
Ribble Valley	19.1
Chorley	14.4
Preston	12.1
West Lancashire	11.6
Wyre	10.4
Burnley	10.2
Rosendale	10.1
South Ribble	9.9
Lancaster	9.8
Hyndburn	9.1
Fylde	7.8
Pendle	5.6

See the appendix for a summary of evidence based interventions to reduce [road traffic accidents](#).

Sport and physical activity

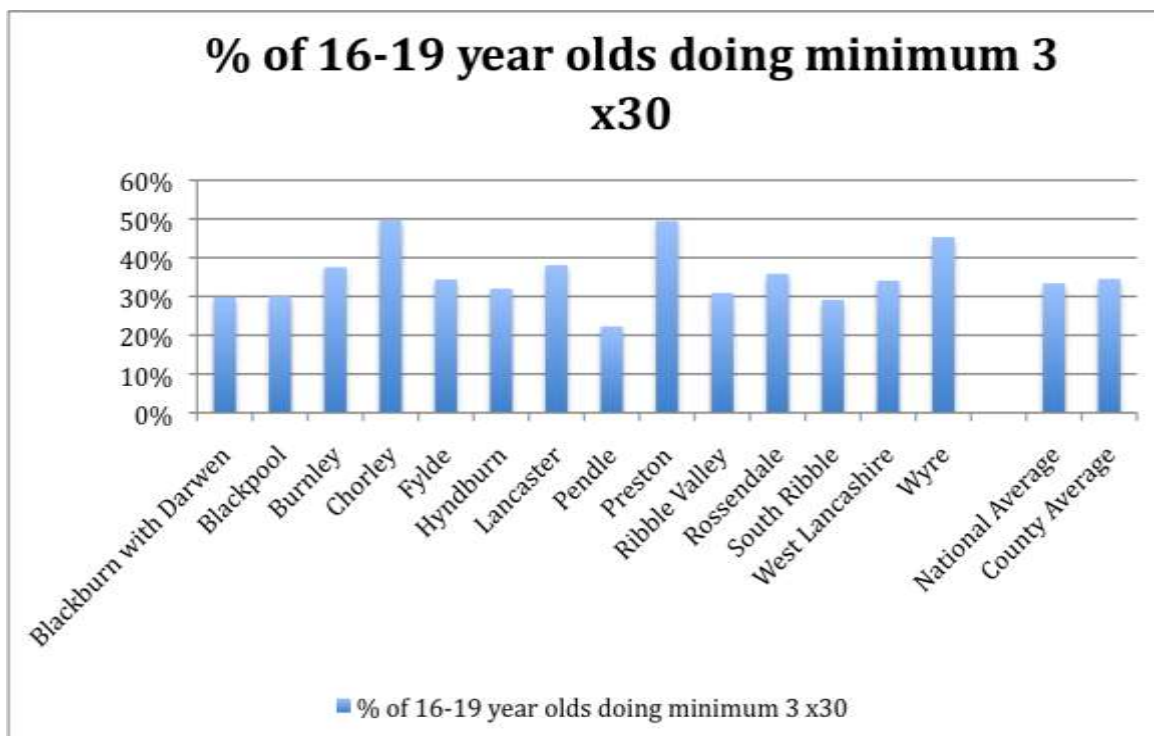
Physical activity is an important determinant of physical health and there is a wealth of evidence which highlights the importance of keeping active for mental health and wellbeing. Children and

young people of school age are required to undertake a number of physical education sessions per week and it is when they leave school that there is likely to be a drop off in the proportion of young people undertaking physical activity. For some this may represent a change in behaviour that they maintain throughout their adult life with implications for their long term health.

The Active People Survey, carried out by Sport England, is the largest survey for measuring levels of sport and physical activity in England. The survey is repeated every year and is based upon measuring key statistics around sports participation of adults aged 16+. One of their key statistics is the amount of people doing 3 or more sessions of moderate sport and physical activity a week (also referred to as NI 8 or 3 x 30), where 'moderate' is defined as raising the heart-rate or breaking a sweat. The figure below shows the 3x30 participation levels of teenagers aged 16 to 19 across Lancashire based upon the last survey's data of 2008-2009 (called APS3).

The highest levels of participation are found in Chorley, Preston and Wyre whilst rates of young people participating in sport and physical activity are low in Pendle, the Ribble Valley and South Ribble. Overall, young people in Lancashire are more physically active than their national counterparts, although there remain more than 60% of young people who do not participate in a minimum of three thirty minute sessions a week of physical activity

Figure 75: Proportion of 16 to 19 year olds doing 3 or more sessions of moderate sport per week, 2008/09



Source: Sport England's Active People Survey 3

Education, training and employment

The content of this section has been sourced from the Lancashire Profile article "The Impact of the Recession on Young People (16-18 years) Not in Employment, Education or Training (NEET)" (Lancashire Profile, 2010).

NEET in Lancashire

The table below shows Lancashire's NEET and 'in-learning' performance as at February 2010 in comparison to 10 'statistical neighbours', as well as regional and national averages. The NEET rate in Lancashire is higher than the national average and in line with the regional average. Lancashire is in the upper half of the rates of the statistical neighbours.

Table 172: Comparison with Statistical Neighbours, February 2010

	NEET %	In Learning %
Bury	5.3	87.0
Calderdale	9.1	81.6
Derbyshire	7.7	79.8
Dudley	4.7	88.1
Kent	5.1	82.8
Northamptonshire	5.1	82.8
Nottinghamshire	4.8	84.0
Sefton	6.5	86.0
Staffordshire	5.1	86.3
Stockton-on-Tees	11.0	79.4
England	6.4	83.4
North West	7.4	83.1
Lancashire	7.2	82.3

Source National Connexions Customer Information System (NCCIS)

The Young People's Service (YPS) works intensively with young people to help them to identify and address their barriers to progression and to minimise the length of time that an individual remains NEET. But whilst YPS takes a lead on NEET among 16-18 year olds, tackling NEET across the county requires the involvement of network of partners whose commitment to the task has previously been embodied in:

- the Children and Young People's Partnership Plan
- the Lancashire Local Area Agreement

Effective partnership working has helped to produce year-on-year reductions in the overall number and percentage of 16 to 18 year old NEETs in Lancashire. However, in the same way that

concentrations of deprivation occur across the county, there are corresponding variations in NEET when factors such as geography, age, gender, ethnicity and levels of qualification are considered.

NEET by geography

There has been an overall reduction of 270 (10.8%) in 16-18 year old NEETs between two 'snapshot' dates in March 2009 and March 2010.

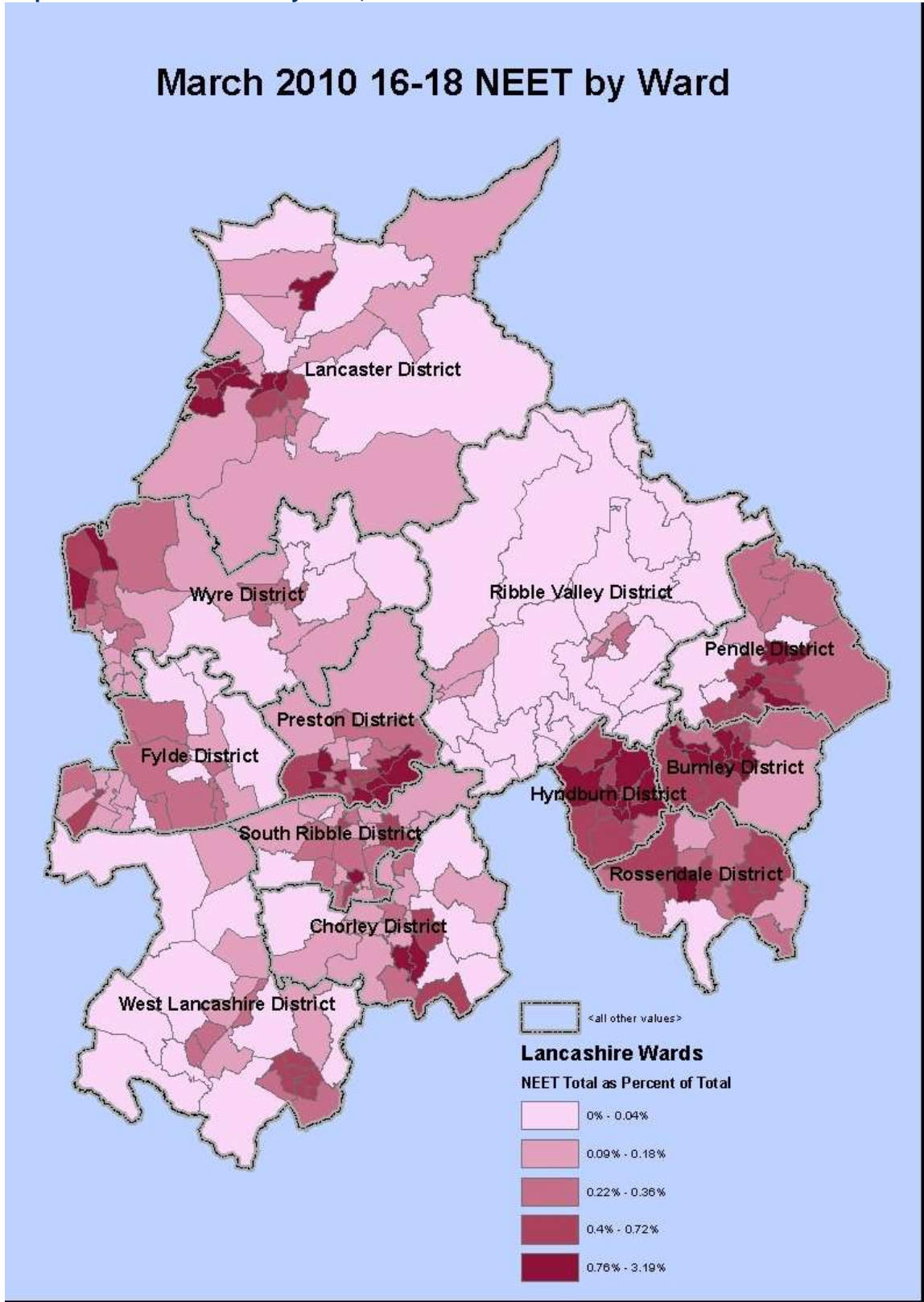
Table 173: Analysis by district and gender, March 2009 and March 2010

	NEET 16-18					
	March 2009			March 2010		
	Female	Male	Total	Female	Male	Total
Burnley	140	141	281	134	133	267
Chorley	74	75	149	63	60	123
Fylde	32	41	73	33	46	79
Hyndburn	159	143	302	150	154	304
Lancaster	128	162	290	142	152	294
Pendle	133	123	256	107	101	208
Preston	211	244	455	168	210	378
Ribble Valley	22	22	44	9	23	32
Rossendale	57	63	120	63	60	123
South Ribble	74	106	180	72	77	149
West Lancashire	75	87	162	58	60	118
Wyre	83	100	183	84	66	150
Lancashire	1,188	1,307	2,495	1,083	1,142	2,225

Source Lancashire Young People's Service <http://yps.lancashire.gov.uk/>

With the exception of a small number of (semi-rural) locations, the distribution of NEET in Lancashire closely matches that of other deprivation indices. Concentrations of NEET can be found in Nelson and Colne, Rossendale, Burnley, Hyndburn, Chorley, South Ribble, Skelmersdale, Preston, Fleetwood, Lancaster and Morecambe.

Map 30: NEET distribution by ward, March 2010



Source Lancashire Young People's Service <http://yps.lancashire.gov.uk/>

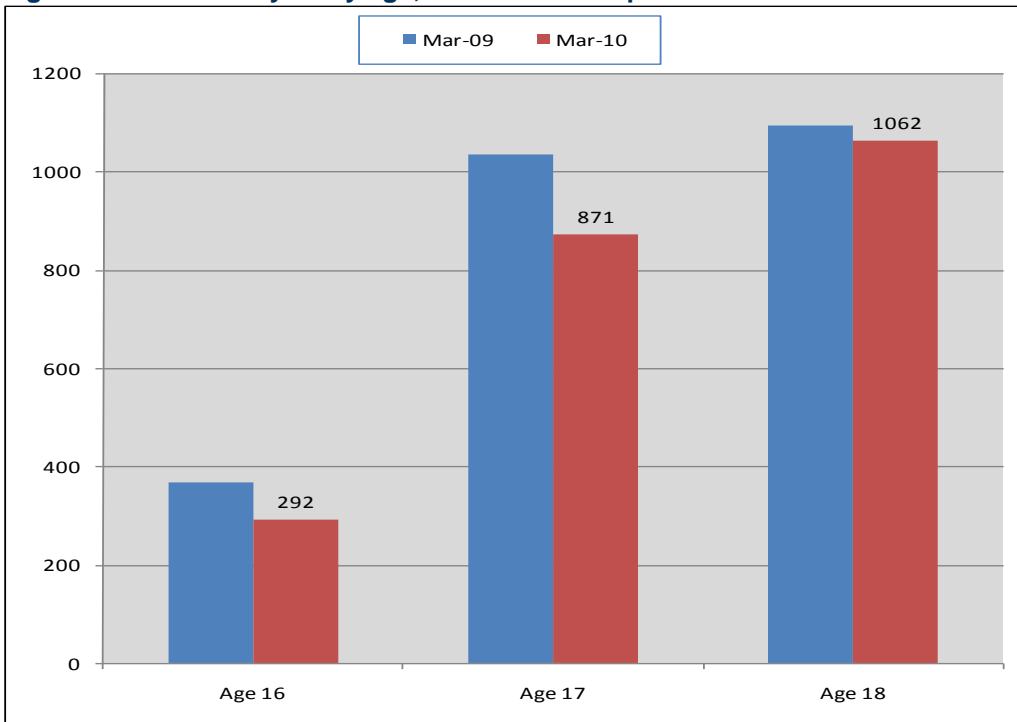
NEET by age group

The age profile of NEETs shows year-on-year decreases among sixteen to eighteen year olds, though with concentrations of NEET among 17 and 18 year olds. This reflects the national trend towards older NEETs and has been the subject of central government appeals to local authorities, Jobcentre Plus and Connexions Service providers for 'a much sharper focus on the older age group in the current rapidly changing labour market' (DCSF 2009).

For Lancashire, the age profile should be viewed in the context of:

- a decrease of 6% in the 16-18 cohort in 2009, compared to 2008
- a steady increase in recent years in participation in post-16 learning (82.5% of school leavers were in learning at March 2010, compared to 80.0% in March 2009 and 77.8% in March 2008)
- the positive impact of government NEET targets and strategies that have focused resources on younger NEETs.

Figure 76: NEET analysis by age, March 2010 snapshot

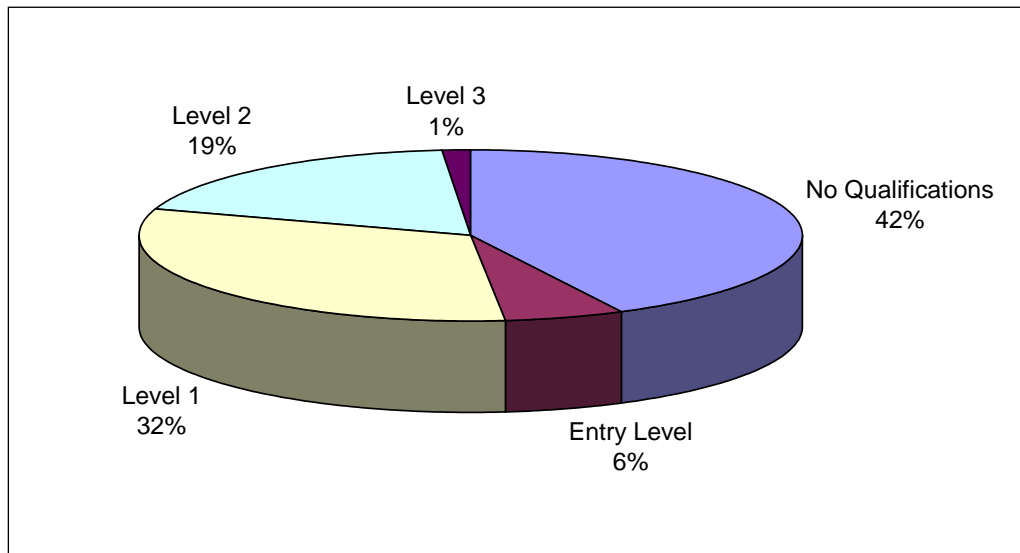


Source Lancashire Young People's Service <http://yps.lancashire.gov.uk/>

NEET by academic level

Figure 77: NEET analysis by academic level, 2010

NEET by academic level - March 2010



Source Lancashire Young People's Service <http://yps.lancashire.gov.uk/>

In recent years there has been a slight increase in the qualifications profile of the NEET group across the county. This might be expected, given the increase in attainment of the school leaver population as a whole. However, the average rate of improvement in the attainment of NEETs lags well behind that of the age group as a whole and, as the chart above indicates a NEET young person is still typically unqualified or poorly qualified and those with a learning difficulty or disability are over-represented within NEET, particularly at age 18 and over (see chapter on children and young people with particular needs for further discussion of [learning difficulties and disabilities](#)). Those with no or low qualifications are also more likely to remain NEET for longer periods.

Nevertheless, at any given time there are significant numbers of young people who are well qualified. In March 2010, for example, 412 (18.5%) held, or were assessed as being capable of achieving, a Level 2 qualification (equivalent to five good GCSEs). A further 30 (1.3%) held, or were assessed as being capable of achieving, a Level 3 qualification (equivalent to 2 A levels). As one eighteen year old states:

'It's hard to get a job, [I've] tried everywhere – NVQ2 in fitness and 10 GCSEs at A-C and I still can't get one...Told I've not enough experience.'

Support during NEET

Young people who become NEET typically refer themselves to the Young People's Service, or are referred to YPS by other support agencies. An assessment of needs is undertaken and priorities for action agreed. This action plan is regularly reviewed and can be amended as circumstances change. Robust tracking procedures ensure that contact is maintained with the young person, for example to address specific barriers to progression, to help with applications, or to discuss participation in a range of positive activities that may help to build self-esteem and self-confidence and so aid the young person's return to work, training or study.

Where necessary, formal assessment procedures are used, such as the Common Assessment Framework, or an Assessment Relating to Learning Difficulties (known as a 'Section 139A Assessment'). These ensure that statutory responsibilities are met and that complex needs can be identified and addressed through multi-agency working.

Barriers to progress

Targeted support from qualified staff ensures that NEET young people receive the appropriate information, advice and guidance to help them to assess their options and to make informed choices. The vast majority of young people in this situation are keen to 'get fixed up' as soon as possible with appropriate work or learning; most have a strong desire to move on in their lives and most have the maturity to learn from previous experience or poor decisions. But many also face barriers in their personal and family lives that cannot be resolved quickly or easily. Some, for example, may come from homes where there is no family experience of work, training or further education. Others may have left home due to abuse or neglect, some becoming 'sofa surfers' who move between the homes of friends or extended family members. They are likely to find it impossible to 'fit in' with the discipline of a regular work routine, however keen they might be to work and learn. For them even the basics of daily life, such as staying clean, warm and fed can be a major challenge and moving out of NEET can seem a long and difficult journey.

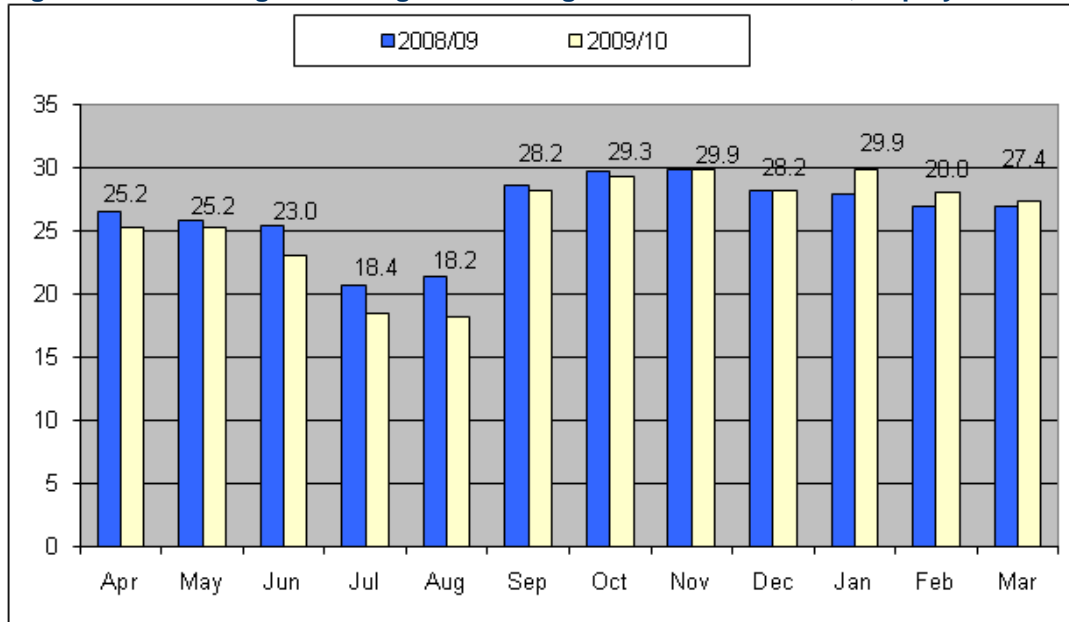
Vulnerable groups

National as well as local data clearly indicate that certain groups are at higher risk than others of becoming and remaining NEET. In addition to the issue of vulnerability due to low attainment, risk of NEET is also associated with teenage pregnancy and young parenthood, with young people in public care and care leavers, those with a learning difficulty or disability and young people who offend. The following statistics illustrate the point:

Teenage mothers

A national target is that 60% of teenage mothers aged 16-19 will be in some form of learning by 2010. The figure below illustrates performance in relation to this goal and clearly highlights the need for further progress. Evidence suggests that the same issues are faced by young fathers, who are also more likely to be unemployed compared with their peers (Hendessi and Dodwell 2002).

Figure 78: Percentage of teenage mothers aged 16-19 in education, employment and training (EET)



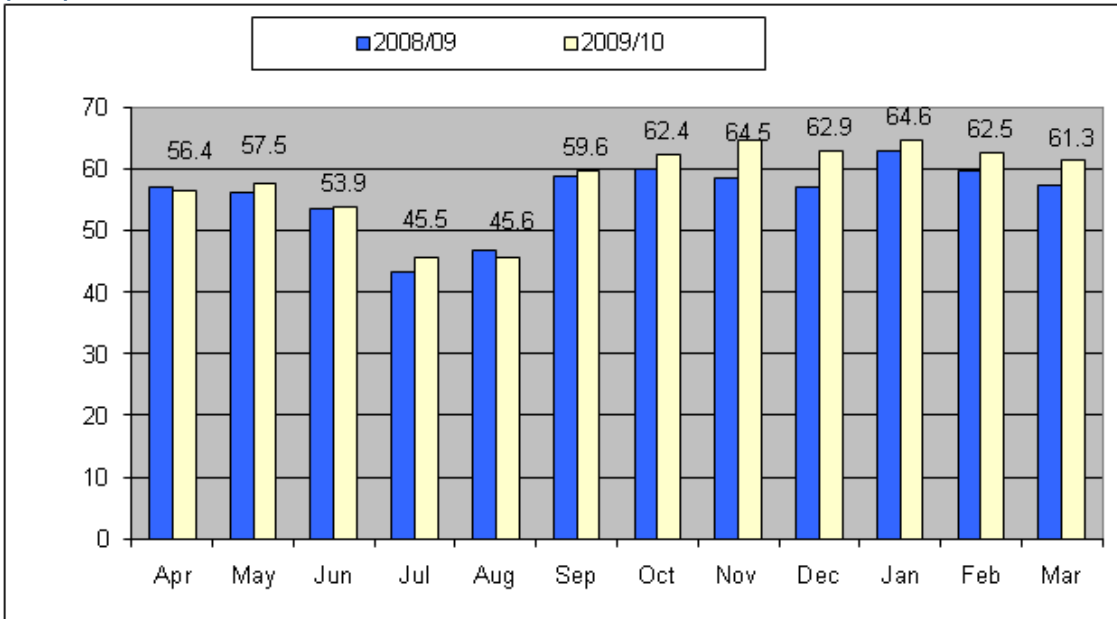
Source Lancashire Young People's Service <http://yps.lancashire.gov.uk/>

Further consideration of the difficulties related to teenage pregnancy is discussed in the [sexual health](#) sub-section in this chapter.

Those in care and care leavers

Young people in care are likely to have experienced disruption to their education and may experience other difficulties which lead to reduced qualification levels compared to the general population. Further discussion is provided on [children looked after](#) in provided in the chapter on children and young people with particular needs. Discussion of the educational attainment gaps is provided in the primary and secondary chapters. Similarly, the post-16 progression rate of those in care into further education, jobs or training is approximately 20 percentage points below that of the same-age population as a whole, although improving steadily.

Figure 79: Percentage of 16-19 year olds 'known to after care' in education, employment or training (EET)



Source Lancashire Young People's Service <http://yps.lancashire.gov.uk/>

Supporting those in public care to achieve and progress in their lives is a high priority for Lancashire County Council and its partners. The above statistics point to an incremental increase in the 'in-learning' rate among this group over the past two years, but clearly there is more to do if they are to achieve parity with their peers. Nevertheless major steps forward have been made, with actions focused by the findings of the Joint Area Review undertaken in 2008. Examples of progress include:

- improved data sharing protocols between support services (such as a new partnership agreement between the Young People's Service and Children's Social Care)
- improved monitoring and individual support, including the establishment of a 'virtual school', the provision of computers and free internet access to those in Years 6-13 and additional financial support for those progressing to further or higher education.
- a renewed focus by post-16 learning providers on this group, particularly regarding retention strategies
- the targeting of those from a care background in projects addressing NEET

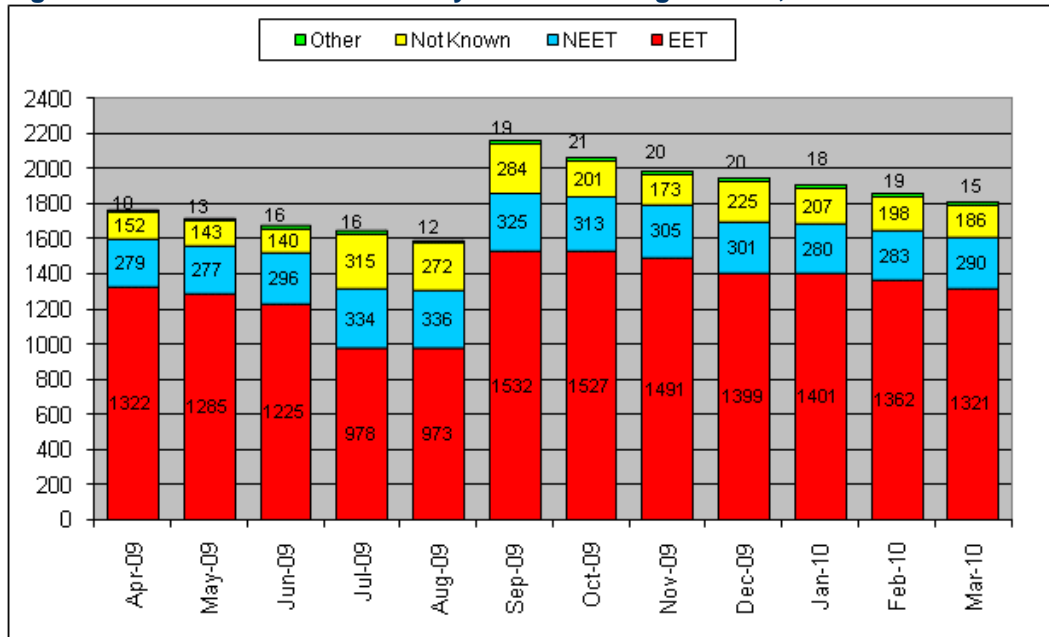
Those with learning difficulties and/or disabilities

Nationally, young people with a learning difficulty or disability (LDD) are twice as likely to be NEET as their non-disabled peers (DCSF 2008). In Lancashire they are similarly vulnerable, though here the difference is slightly less, with LDD young people being approximately twice as likely to be NEET as their non-disabled counterparts. These statistics belie the progress towards inclusion that has been made in recent years, for example in providing:

- improved assessment processes, such as the Statement of Special Educational Needs, the Assessment in Relation to Learning Difficulties ('Section 139A') and the Common Assessment Framework
- improved transition planning and information sharing, to facilitate the smooth progression of LDD young people from school to college or training
- improved access to further education and work-based learning
- changes in funding structures that give some disabled young people greater control of their situation through direct payments
- additional funding for learning providers to meet specific learner needs

However, the statistics show that significant barriers still exist. Local research is needed to analyse the situation in more detail, but anecdotal evidence suggests that the underlying factors include: transport and access problems; low aspirations and low expectations of disabled young people and/or their families; and sometimes a poorly-integrated response by agencies and learning providers to the complex needs of individuals, resulting in a 'patchwork' of provision that fails fully to meet the needs or expectations of the learner, leading to impaired progress or early drop-out from a course.

Figure 80: Number of LDD clients by NEET status aged 16-19, 2009/10



Source Lancashire Young People's Service <http://yps.lancashire.gov.uk/>

There is currently no firm evidence of the impact of the recession on disabled young people across the county. However, the statistics show an average 1.8% increase in the NEET rate among those with a learning difficulty or disability during 2009, corresponding to the height of the recession.

Further discussion of the issues facing children with [learning difficulties or disabilities](#) is provided in the chapter on children and young people with particular needs. Discussion of educational attainment gaps is provided in the [primary](#) and [secondary](#) chapters.

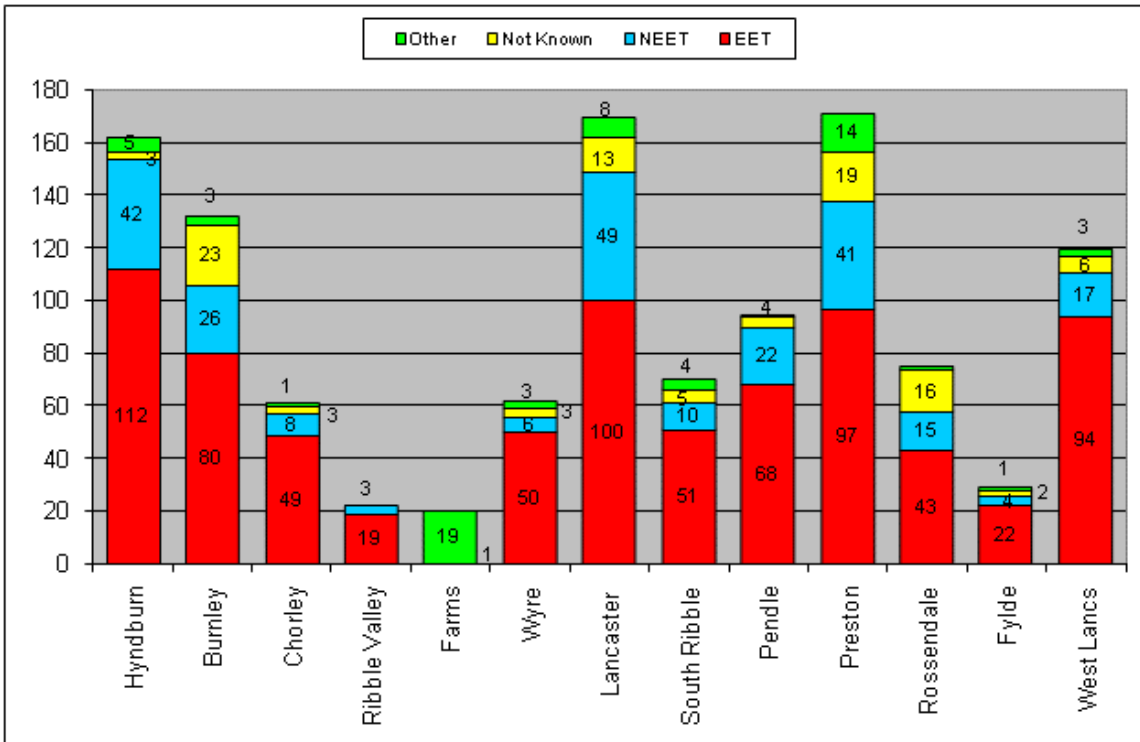
Young people who offend

A large majority of young people who offend are males aged 15 to 17, many of whom have been involved in what are classified as minor crimes involving, for example, theft or criminal damage. A Lancashire County Council brief guide to the Young Offending Team highlights that many offenders who become the subject of a community order will have associated difficulties concerning relationships, housing, alcohol or drug misuse or poor mental health; approximately one fifth will be NEET. Further discussion of [children and young people](#) who offend is provided in the young people chapter.

A range of agencies contribute to working with young offenders to help them to address the consequences of their actions, reduce re-offending, stay safe and achieve positive outcomes. In many cases, interventions are undertaken or co-ordinated by Lancashire Youth Offending Team (YOT), working with partners such as schools, the police, Primary Care Trusts, the Young People's Service or voluntary agencies. The charts below provide geographical and status analyses for

those known to YOT for the 'snapshot' period of March 2010. (Note, however, that the age range is wider than for other analyses cited in this report).

Figure 81: Number of young people aged 13-19 known to youth offending teams by NEET status, March 2010



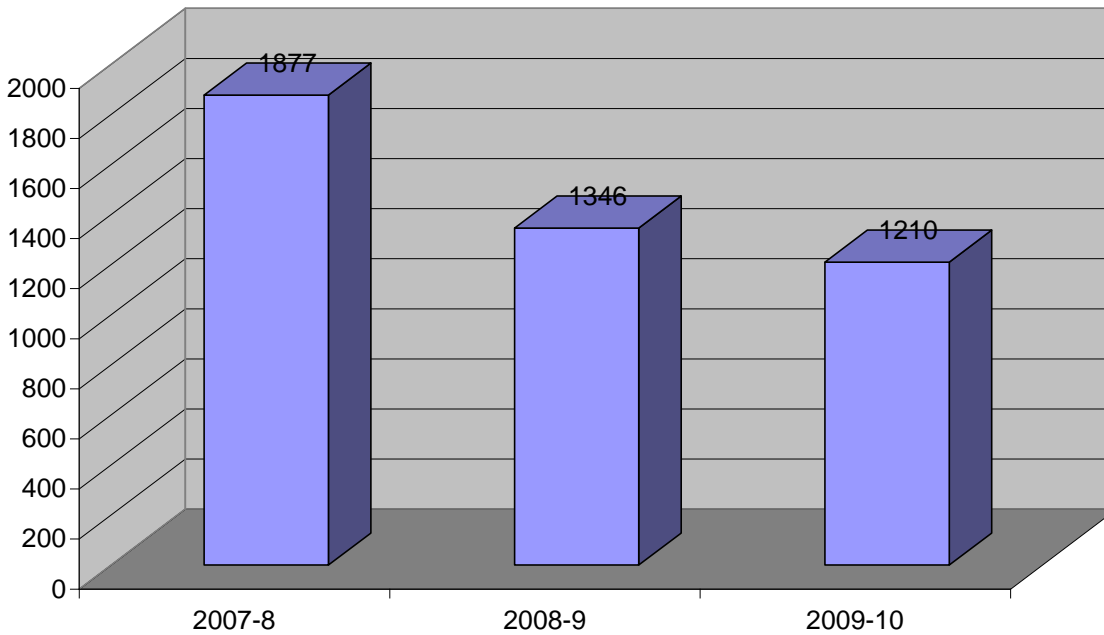
'Farms' relates to HMYOI Lancaster Farms. Although previously accommodating 'juveniles' as well as young adults, this institution was re-designated in 2008-9 to accept only those aged over 18.

Source Lancashire Young People's Service <http://yps.lancashire.gov.uk/>

The impact of the recession

For Lancashire's young jobseekers, the impact of the economic downturn in 2009-10 is evident in the reduction in the number of vacancies received by CXL (who operate a vacancy and matching service for young people on behalf of the Young People's Service)

Figure 82: Comparison of vacancies taken by CXL, Lancashire, 2007/08 to 2009/10
Vacancies notified



Source CXL

These statistics represent a three-year reduction in vacancy volumes of 35.5%. Significantly, three of the occupational areas experiencing the biggest decline in vacancy numbers in the year to 31st October 2009 (construction, motor vehicle work and general labouring) also featured in the top five most popular occupations sought by young people. This fact has implications for the provision and timing of appropriate careers education, information, advice and guidance (CEIAG) to young people. Effective CEIAG not only helps young people to make informed career choices based on their abilities and interests; it also provides them with access to relevant and up to date labour market information, helping them to test their choices against the reality of the opportunities available locally, regionally and nationally.

Table 174: Occupations with the largest reduction in available vacancies, year to 31 October 2009

Occupational area	% fall
Electrical	79
Construction	64
Unskilled Service Sector	50
Motor Vehicle	49
Labouring	48
'Unskilled Service Sector' refers to catering assistants/porters/car valets etc.	
Source: CXL	

The decline in the number of vacancies is exacerbated by the frequent mismatch between the skills and qualifications of those who are NEET, and those required by employers. This is more evident at certain times of the year, typically following periods when better qualified young people have progressed into skilled employment or returned to full-time education.

In response to the reduction in vacancy numbers during the past year, CXL Ltd carried out a series of employer engagement visits, targeting localities across Lancashire. A total of 899 employers were visited in the year to March 2010. These visits provided an opportunity to reinforce to employers the benefits of employing young people, and to gauge the state of the youth labour market in the light of the recession. The response from most employers has been that they are just able to maintain output and retain their existing staff, but that they do not envisage being able to recruit new workers until the economy improves.

The voice of young people

Comments were invited for inclusion in this report from NEET young people in various locations across the county. They capture the frustrations, regrets and ideas of a diverse group of individuals, trying to make sense of their situation:

On Being NEET...

It's rubbish! You have no money, nothing to do. You have less experience than everyone else, so you can't get work!

I've missed out by not going to school, getting no education

I'm fed up not being able to get a job

The only jobs are for those people with loads of GCSEs

I want to be a fork lift driver and there's no training for that unless you pay, but I've got no money, 'cos I can't get a job.

I'm fed up – I have a really good CV and have taken it to all the shops in Chorley and none get back to me – that's worse than being told they've no jobs

I have done lots of things and look in the paper all the time but don't have any luck

Every time I come in there seem to be fewer jobs

I can't find nowhere that I can work in a garage...I'm good at mechanics and I want to work, but I can't get someone to take me on

I left college because I thought there would be more jobs out there. I wish I hadn't now

On the support they receive...

It's good to get support

Good! It's been excellent

Had a lot of help from Connexions and the Jobcentre

Young People's Service do everything they can, but there aren't any jobs for me

On the recession...

It affects everyone you know, it affects your future

Our parents are financially less stable

The credit crunch hasn't had much impact because things were bad anyway

It's meant there aren't any jobs for me

Someone I know has been made redundant and they are struggling to keep their house running

Parents have less money – we're shopping on a budget

There isn't enough money coming in to pay the bills and mum and dad are fighting a lot

Would love to be back at work

On what should be done...

Get as much education as you can in school

NEETs could talk to others about how hard it is being unemployed - to stop it happening to them

Provide more activities and trips

Fill the 18-19 gap, for those who have done two years at college but can't access free Adult college courses

Give us things to look forward to, like a day out or something

NEET conclusion

Even before the effects of the recession began to be felt, the imperative to respond to the NEET agenda, brought into focus by national and local targets, led to the development of new approaches among key partners across the county. These included a broader, shared ownership of NEET 'problem' through the framework of the Local Area Agreement, through better systems for the exchange of information using formal data sharing protocols and partnership agreements, and through the introduction of new ways of working designed to target resources more effectively to meet local needs.

Work has also progressed in the area of NEET prevention, with new strategies being employed in schools, colleges and work-based learning to monitor the risk factors that may lead to NEET and to work with students before they drop out, or fail to reach their full academic potential. Young people's access to high quality information, advice and guidance information continues to improve through developments such as Lancashire's Area-wide Prospectus (www.steps4me.co.uk) and the new Young People's Service website (<http://yps.lancashire.gov.uk/>).

For the longer term, NEET prevention is further aided by the statutory requirement for secondary schools to provide a careers education programme for all students from Year 7. Also, the ongoing 14-19 education reforms, including the introduction of 17 Diplomas and new Foundation Learning arrangements, mean that there is a widening range of options for young people who are unmotivated by the traditional academic progression routes offered by GCSEs and A levels.

Further proposals to increase the quality and flexibility of vocational education were announced in the new administration's programme for government, published in May 2010.

For those who do become NEET, there is an increasing range of flexible learning opportunities and positive activities that can help to provide mentoring support, positive role models, new skills and a stepping-stone to a job, training place or college course. Feedback from the NEET client group is often that they want 'real jobs' not training. Work opportunities for young people need to be created and the large public sector organisations within Lancashire have responsibilities to do this but the private and voluntary, community and faith sectors should also be encouraged to provide such opportunities.

Despite these advances, the reality of declining vacancy numbers and the rising age profile of NEETs means that further action is likely to be needed if the trend is to be reversed. And while only a buoyant economy can deliver sustained levels of high employment, past experience suggests that much can be done to mitigate the impact of recession on young people and to give them the skills and experience they will need to take advantage of economic recovery.

Developments in these areas would help in addressing many of the immediate challenges of NEET, would help to grow the talents of the county's young people and would build economic and social resilience for the longer term.

Smoking, drug and alcohol use

The main discussion of [smoking](#), [alcohol](#) and [drug use](#) are presented in the secondary chapter. These behaviours continue to be important in the 16 to 19 age group, where they are likely to cause immediate concern for services such as hospitals and the police.

Smoking

Smoking is a key public health concern and early intervention measures tend to be favoured to prevent young people from starting smoking. However, there is a strong evidence base which demonstrates that the sooner a person stops smoking the more reduced the impact will be on their health so encouraging young people to stop smoking should also be a priority. Smoking prevalence statistics for this age group are not available in Lancashire. However, the 2008 Department of Health consultation document on tobacco control reported that smoking by young people has declined over the last decade but 1 in 5 16-19 year olds smoke.

Drug use

According to the 2009/10 British Crime Survey, the numbers of 16 to 24 year olds reporting having used a drug in the last year dropped to 20%, down from 22.6% in 2008/09. It was found that

among 16 to 24 year olds nationally, there were falls in 'last year' use of cannabis (from 18.7% in 08/09 down to 16.1%) and amyl nitrate (4.4% to 3.2%). In this age group there were 'statistically significant' increases in use of crack cocaine (from 0.2% in 08/09 to 0.5% in 09/10);

The percentage of 16-24 year olds who report using cannabis in the past year has fallen from 28.2% in 1998 to 16.1% in 2009/10. For 16-59 year olds use in the past year has fallen from 10.3 in 1998 to 6.6%

It is encouraging that there has been a decline in overall levels of drug use, including some significant reductions in reported use of cocaine powder and cannabis. Although cocaine use remains much higher than in the late 1990s, the worrying increase we saw last year does appear to have been reversed. Drug use among 16 to 24 year olds has declined and is at its lowest level since 1996. It is significant that reported cannabis use among young adults has halved since 1998. There are understandable concerns about the use and availability of stronger types of cannabis, but it is possible that a decrease in the availability of less potent forms of the drug could in part be contributing to the decline in cannabis use. Drug related offending remains an issue for the Community Safety Partnership in Lancashire and further discussion is presented in the section on young people who offend later in this chapter.

Alcohol use

Statistics on alcohol consumption are not routinely available for this cohort. From 18 it is legal for young people to purchase alcohol but there remain community safety and public health concerns linked with accidents and injury. Statistics on the prevalence of alcohol use and hospital admissions related to those aged under 17 are provided in the [secondary](#) chapter.

Sexual Health

In 1986 the World Health Organisation (WHO) presented for discussion a definition for sexual health:

'A state of physical, emotional, mental and social well being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'

For many young people the onset of adolescence is a difficult and challenging time, a time for pushing at the boundaries and trying to make sense of the world. Accompanying this is an intense period of physical and emotional change. Sex and relationships issues are an integral part of this.

If we are to support young people in the transition to adulthood we need to see a positive approach to sex, sexual health and relationships.

Positive sexual health needs to raise awareness with young people of their choices in relation to lifestyle and risk taking behaviour, enabling them to identify and overcome blocks to their personal development both physically and emotionally. Local strategies seek to empower young people to make informed decisions and choices around relationships and sexual health matters, thereby reducing the effects and likelihood of unplanned and unwanted teenage conception and the transmission of sexually transmitted infections. It is also important that young people should be able to access a wide range of services from a variety of settings.

Risk taking behaviour

Young people in the UK, according to a UNICEF report (2009) are more likely to take part in certain “risky” behaviours than their peers in over 20 other industrialised nations, including the US and Canada. UK adolescents are reported to have among the highest prevalence rates in their use of alcohol and cannabis, sexual behaviour, unprotected sexual activity and violence. It is also worthy of note that young people rarely engage in just one risky behaviour; unprotected sexual activity, for example, may be preceded by use of alcohol.

In the UK, the primary policy focus on young people and risk is in relation to drug, alcohol and tobacco use, underage sex and unprotected sexual activity. These are complemented, from time to time, by other concerns including anti-social behaviour and criminal activity, gang membership, carrying weapons, sedentary lifestyle, over-eating, under-eating and “yo-yo” dieting.

There has been much discussion around young people and risk and what are adult perceptions and what are young people’s perceptions. The issue is complex but common understandings can be stated much more succinctly as young people do not engage in risky behaviour: they experiment and explore. They have different priorities and want to try something new. It can be said, therefore, that “risk” is a concept that adults ascribe to young people and their activities.

Sexually transmitted infections

Young people generally have a higher number of sexual partners, a greater number of concurrent partnerships and change partners more often than older age groups (HPA et al, 2003). They are therefore more vulnerable to acquiring a sexually transmitted infection (STI). Sexual health has deteriorated in recent years – surveillance data has indicates a rise in the prevalence of acute STIs

since 1999, with a particularly steep increase being noted for those aged 24 years and under. Between 1997 and 2002, diagnoses of Chlamydia, gonorrhoea and new HIV infections have doubled and new diagnoses of syphilis have increased nine fold (Kent JSNA 2010). However, the main sexually transmitted infection of concern is Chlamydia. It should be noted that the rise coincides with the introduction of a national screening campaign and rises in rates are therefore to be expected.

Young people under 25 years of age are disproportionately affected by sexually transmitted infections. In 2008; 56% of men and 80% of women diagnosed with Chlamydia infection in GUM clinics were under 25 years old; 42% of men and 70% of women diagnosed with gonorrhoea and 47% of men and 67% of women diagnosed with genital warts were under-25. In the North West, there have been large increases in the number of new cases of Chlamydia since 1999: cases have increased by 157% for males and 80% for females. However, the data for 2007 and 2008 suggest that the rise is halting as the growth in male cases was only 2% between the two years and the numbers of new cases fell by 1% for females (HPA 2009).

The apparent halt of the rapidly rising Chlamydia rates is likely to be related to the large scale campaigns aimed at encouraging young people to be tested. In Lancashire (and Cumbria), the Public Health Network was commissioned to run a non NHS branded campaign called Best2Know. This campaign offers a web page and a test service where young people can access free Chlamydia test kits and advice and guidance on healthy sexual relationships.

During 2009/10 21,791 Chlamydia tests were issued, with a coverage rate of 27.4% of all young people aged 15-19. This exceeds the national coverage rate. Coverage rates vary by PCT and gender, but all are above the national average. Central Lancashire has the highest rates of uptake of the screening service. Across Lancashire, males are less likely to access screening than females.

Results of the tests show that, of those tested, Lancashire had a higher percentage of positive test results compared to the national average for the total population and female population. Percentages of positive results appear particularly high for females in East Lancashire and males in central Lancashire.

Table 175: Percentage of population aged 15-19 screened for Chlamydia and outcomes, 2009/10

Area Name	Total number of tests*			Percentage of Index cases testing positive		
	Total	Male	Female	Total	Male	Female
Central Lancashire PCT	9,036	2,891	6,142	6.6%	5.0%	7.4%
<i>Coverage rates</i>	30.1%	18.9%	41.8%			
East Lancashire PCT	6,606	2,305	4,269	6.5%	3.7%	8.0%
<i>Coverage rates</i>	24.6%	16.8%	32.3%			
North Lancashire PCT	6,149	2,784	3,364	4.7%	2.7%	6.4%
<i>Coverage rates</i>	27.1%	24.4%	30.0%			
Lancashire**	21,791	7,980	13,775	6.0%	3.8%	7.3%
<i>Coverage rates</i>	27.4%	19.8%	35.2%			
England	801,913	278,900	517,021	5.9%	4.1%	6.9%
<i>Coverage rates</i>	24.2%	16.4%	32.1%			
* includes all index, partner/contact and laboratory reports						
** figures not in original data and calculated from the three Lancashire trust results						
Source: NHS National Screening Programme. NHS Local Delivery Plan data monitoring line (PSA11d) Primary Care Trust (PCT) and Strategic Health Authority (SHA) specific tables						

The HPA released STI data for 2009 by PCT in August 2010, which was the first time this data has been available. This data is shown in the table below. For young people (aged 15-24), Chlamydia rates in all three PCTs are higher than the national averages. The rate is also higher than the regional average in central Lancashire. For the population as a whole, rates of Gonorrhoea and Syphilis are below the national and regional averages. High rates of herpes are recorded in central and East Lancashire and higher than national rates of warts and acute STIs are recorded across Lancashire as a whole.

Table 176: Rates of selected STI diagnoses per 100,000 population, by patient PCT: 2009

	Chlamydia (by age group)		Gonorrhoea	Syphilis	Herpes	Warts	Acute STIs
	15-24	25+					
North West SHA	2639.4	103.1	26.8	5.7	55.1	170.0	848.9
England	2180.6	94.4	28.5	5.2	49.6	141.2	774.6
Central Lancashire	2662.1	98.1	18.1	2.2	55.4	174.9	874.7
East Lancashire	2531.9	75.4	19.8	4.2	44.2	159.7	789.6
North Lancashire	2193.3	75.5	8.8	2.7	58.6	160.4	752.4
Ashton, Leigh & Wigan	2540.0	63.4	20.2	1.0	29.0	141.5	626.5
Blackburn with Darwen	2395.4	92.0	13.5	2.8	44.1	151.4	824.6
Blackpool	4357.7	176.2	57.1	17.6	84.6	235.4	1328.3
Bolton	2883.5	101.9	15.2	4.9	55.2	159.8	797.6
Bury	3015.0	109.8	27.3	3.3	57.9	140.3	827.2
Central & Eastern Cheshire	2041.1	68.4	16.7	1.8	63.1	141.5	585.9
Cumbria	2168.8	58.1	11.9	1.0	36.4	143.4	616.8
Halton & St Helens	3412.7	107.0	28.9	3.4	44.4	185.3	954.9
Heywood, Middleton & Rochdale	2833.0	149.1	31.0	8.2	63.0	177.4	914.5
Knowsley	2001.3	92.1	20.6	1.3	38.5	180.3	782.3
Liverpool	2279.5	111.2	29.2	3.7	68.8	248.8	1126.1
Manchester	2539.8	242.6	92.8	26.9	73.0	214.6	1350.1
Oldham	2453.2	130.9	25.5	4.6	54.2	148.4	778.7
Salford	2717.8	160.9	43.8	25.8	72.8	176.3	1000.2
Sefton	2308.7	79.6	14.2	1.1	53.8	149.0	761.1
Stockport	2093.4	90.7	18.9	3.2	37.7	143.4	616.0
Tameside & Glossop	3616.4	113.1	32.4	5.2	42.1	147.4	923.7
Trafford	2970.4	93.9	40.4	6.6	48.9	131.6	818.6
Warrington	3204.8	96.9	13.3	3.1	44.3	206.9	825.2
Western Cheshire	2463.0	75.8	23.3	3.4	71.3	160.9	712.6
Wirral	3398.5	67.7	11.6	1.9	72.7	165.1	778.1
Source: HPA							

The Public Health Outcomes Framework proposes a shift from a Chlamydia indicator focusing on screening volume to one focused on achieving positive results in young people. That is, finding those with Chlamydia and treating them so that the overall prevalence and incidence fall over time. The rationale for this is that "annual testing and testing at partner change in this age group is expected to reduce the transmission rate, leading to a fall in prevalence and a secondary reduction in the incidence of new infections. Early diagnosis and treatment will reduce the severe effects of Chlamydia in women, such as pelvic inflammatory disease and infertility." (DH 2010). Research suggests that screening could reduce prevalence by 30% after one year if there is 26% coverage and 40% if there is 46% coverage (Kalwijn et al, 2010).

Teenage pregnancy

Teenage pregnancy is strongly associated with the most deprived and socially excluded young people. Difficulties in young people's lives such as poor family relationships, low self-esteem and unhappiness at school also put them at greater risk. Evidence clearly shows that having children

at a young age is associated with poorer health outcomes for mother and child and can limit their future education and career prospects (see section on [NEET](#)). Teenage mothers are less likely to breast feed or be in work or a stable relationship. Children of teenage parents are more likely to become teenage parents themselves, continuing the cycle of poor outcomes. The facts are stark (DfES 2006):

- At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner
- Teenage mothers are 20% more likely to have no qualification at age 30 than mothers giving birth at age 24 or over.
- Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment
- Teenage mothers have three times the rate of post natal depression of older mothers and a higher risk of poor mental health for three years after the birth;
- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers;
- Teenage mothers are three times more likely to smoke throughout their pregnancy and 50% less likely to breastfeed, than other mothers – with negative health consequences for the child;
- Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties, have higher mortality rates under 8 and are more likely to have accidents and behavioural problems
- Among the most vulnerable girls, the risk of becoming a teenage mother before the age of 20 is nearly one in three.

The most recent data from 2006-08 highlights that the rate for Lancashire is in line with the national average in that it is not different in statistically significant terms. However, there are variations at PCT and district level. Rates of teenage conceptions exceed the national average in Burnley, Hyndburn and Preston but are lower in Fylde, Ribble Valley and Wyre. Overall during the period 2006-08 there were almost 3,000 teenage conceptions. Approximately 40% of these will have ended in abortion meaning that 1,800 children were born to teenage mothers over the period in Lancashire.

Table 177: Teenage conceptions rate per 1,000 females aged 15-17 in Lancashire, 2006-08 provisional data

LA Area	Number of conceptions	Rate per 1,000 females aged 15-17	95% Confidence Interval		Statistically significant difference from England?
			lower	Upper	
ENGLAND	118,319	41.0	40.7	41.2	--
Lancashire County	2,991	42.2	40.7	43.7	In line
Central Lancashire	1,116	41.8	39.3	44.3	In line
East Lancashire	1,164	46.1	43.5	48.8	High
North Lancashire	711	37.6	34.9	40.5	Low
Burnley	340	57.6	51.6	64.1	High
Chorley	232	39.5	34.6	44.9	In line
Fylde	124	29.4	24.5	35.1	Low
Hyndburn	287	54.8	48.7	61.5	High
Lancaster	356	43.6	39.2	48.4	In line
Pendle	255	44.1	38.8	49.9	In line
Preston	404	51.2	46.3	56.4	High
Ribble Valley	93	24.7	19.9	30.3	Low
Rosendale	189	41.2	35.6	47.6	In line
South Ribble	244	38.0	33.4	43.1	In line
West Lancashire	236	36.0	31.6	40.9	In line
Wyre	231	35.4	31.0	40.3	Low

Source: Teenage Pregnancy Unit

Recent research into the activities and experience of 18 year olds in England suggests that one in five sexually active girls has been pregnant at least once by the age of 18 (Department for Education, 2010). Teenage pregnancy is most prevalent in deprived areas (50% of conceptions occur in just 20% of wards which link closely to the most deprived wards in England). Evidence is also clear that teenage mothers are more likely to be NEET (see [EET section](#) for further discussion) and their children will have poorer outcomes. Risk factors for teenage pregnancy are well known and, where possible, the correlations at ward level were examined. Strong associations were found between teenage pregnancy and the following factors in Lancashire:

- Deprivation
- Child wellbeing
- Rate of children and young people offending
- Young people not in education, employment or training
- Educational attainment
- Anti-social behaviour rates

- Vulnerable adults

Local action to reduce teenage pregnancy and improve teenage parents' outcomes is a key contribution to reducing child poverty and should be clearly identified within the Child Poverty Strategy.

There are strong economic and social justifications for intervening to reduce teenage pregnancy. Reducing teenage pregnancy rates cuts abortion and maternity expenses as well as costs associated with supporting vulnerable teenage parents, including work to improve outcomes for them and their children, payments of income support, housing and child benefit. Every £1 invested in contraception saves the NHS an estimated £11 (TPIAG 2010).

The table below provides an estimate of the potential cost to the NHS of the 1,013 conceptions across Lancashire in 2008 as outlined by the National Support Team during their visit in 2010. This indicates a strong economic rationale for continuing prevention work around teenage pregnancy and also for supporting young parents to prevent them being not in education, employment or training (NEET).

Table 178: Estimate costs to the NHS of teenage conceptions in Lancashire, 2008

Unit Cost	Conceptions	Total Cost
Per termination – approx. - £500	466 terminations	£233,000
Per delivery – approx. £1,500	547 live births	£820,500
Average cost per conception - £1,000	1013 conceptions	£1,013,000

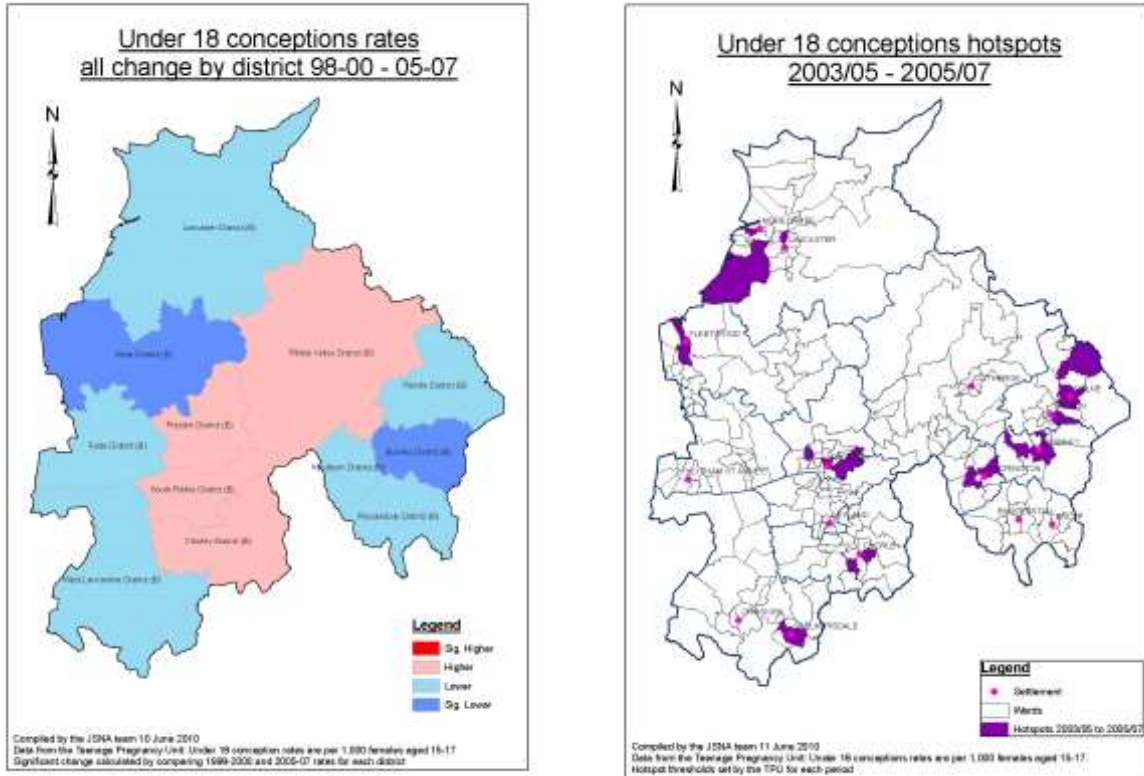
It also emphasises the continued need for commitment to the teenage pregnancy strategy as a key priority for the County Council and its partners, particularly in identifying and taking action on the factors that will counteract the cycles of deprivation that result in repeat pregnancies from generation to generation.

Partnership working across the county is strong and there has been much successful and innovative work from key partners. This focus and a targeted approach in those geographical areas and with those young people most at risk is crucial in accelerating progress in this agenda.

Since the start of the Teenage Pregnancy strategies in 1998, only two districts (Burnley and Wyre) have experienced real change in the measured rates of teenage conceptions as shown by statistically significant reductions in the rates of teenage conceptions between 1998-00 and 2005-07. A number of other districts experienced increases or decreases in the rates of teenage conceptions, which were not statistically significant. As such, it is possible to say that all districts stemmed the rise in rates of teenage pregnancy over the period. The final data for 2006/08 shows

a slight reversal in trend with slight increases in the rates meaning that the data does not show any significant change in the teenage conception rates since 1998-00 for any district.

Maps 31 and 32: Under 18 conception rate changes by district, 1998-00 to 2005-07, and under 18 conception hotspots, 2003/05 to 2005/07



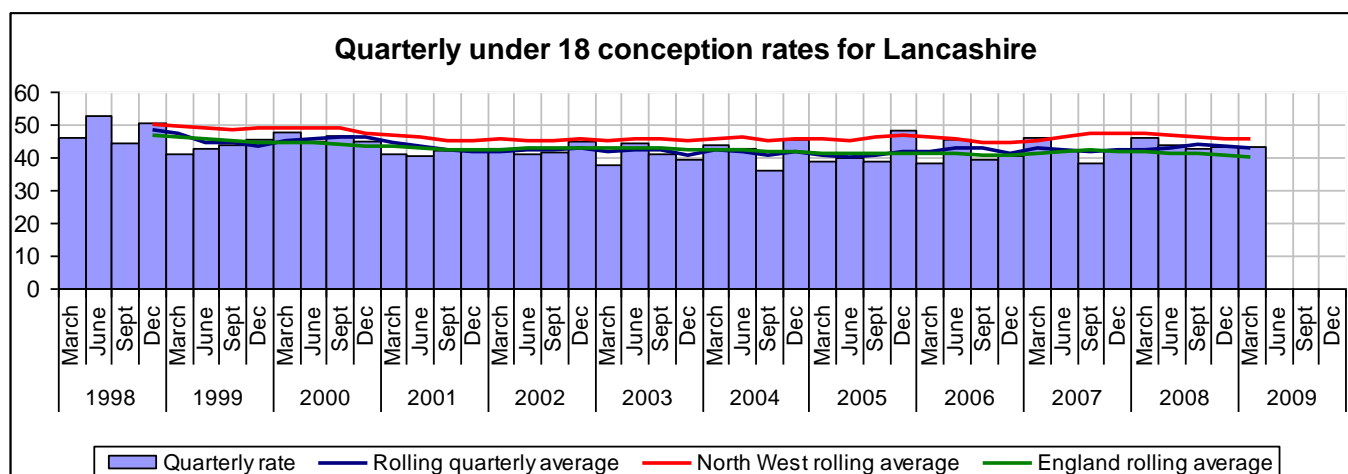
Each year the Teenage Pregnancy Unit publishes the rate of teenage conceptions over which an area is said to have a rate among the highest 20% in England. Each ward with a higher rate is therefore considered a "hotspot" for teenage conceptions. 38 wards in Lancashire County have been "hotspot" wards from 2003/05 to 2005/07 as shown in the table below. This indicates a multitude of areas in Lancashire where outcomes are consistently poor for children and young people. The same analysis looking at whether the ward rates were significantly higher than the national rates over the period from 2003/05 to 2005/07 (in statistical terms), indicates that 14 wards were statistically significant hotspots, meaning we can be certain that they have high rates of teenage pregnancy, which are not simply the result of chance variation.

Table 179: Teenage pregnancy "hot spot" wards during 2003/05 to 2005/07

District	Ward	Significantly higher than England average?
Burnley	Bank Hall	
Burnley	Brunshaw	
Burnley	Gannow	Yes
Burnley	Gawthorpe	
Burnley	Queensgate	
Burnley	Rosegrove with Lowerhouse	
Burnley	Rosehill with Burnley Wood	
Burnley	Trinity	
Chorley	Chorley East	Yes
Chorley	Chorley South West	
Hyndburn	Church	Yes
Hyndburn	Huncoat	
Hyndburn	Milnshaw	
Hyndburn	Peel	Yes
Hyndburn	Spring Hill	Yes
Hyndburn	St Andrew's	
Lancaster	Harbour	
Lancaster	Overton	
Lancaster	Skerton East	
Pendle	Clover Hill	
Pendle	Earby	
Pendle	Horsfield	
Pendle	Southfield	Yes
Pendle	Vivary Bridge	
Pendle	Waterside	Yes
Preston	Fishwick	
Preston	Ingol	Yes
Preston	Moor Park	
Preston	Ribbleton	Yes
Preston	St George's	Yes
Preston	St Matthew's	Yes
West Lancashire	Birch Green	Yes
West Lancashire	Digmoor	Yes
West Lancashire	Moorside	
West Lancashire	Skelmersdale North	
West Lancashire	Tanhouse	Yes
Wyre	Mount	
Wyre	Pharos	

Monitoring of teenage conceptions data takes place using the quarterly rates issued by the Teenage Pregnancy Unit. The general pattern of conceptions shows a downward trend but there continue to be difficulties in closing the gap with England.

Figure 83: Quarterly under 18 conception rates for Lancashire, 1998 to 2009



A summary of the evidence base of interventions to improve sexual health and reduce teenage conceptions is provided in the appendix. A needs assessment for teenage pregnancy is currently being delivered by partners working through the Intelligence for Healthy Lancashire group. This work will draw together comprehensive evidence on the trends of conceptions, the importance of risk factors, the views of young people and the patterns of provision pan-Lancashire (the needs assessment in being completed in partnership with Blackburn with Darwen and Blackpool). It will support the development of a local performance monitoring framework and will provide important intelligence and recommendations to support interventions to reduce teenage conception rates. The final report is due to be published by Spring 2011 and will be available from the JSNA web platform (www.lancashire.gov.uk/jsna).

Children and young people who offend

The collective responsibility to prevent and reduce youth offending is shared between a range of public, voluntary agencies and the wider community, established through national policy. Youth Offending Teams (YOTs) are responsible for preventing offending and re-offending by children and young people. Community Safety Partnerships (CSPs) are responsible for reducing overall crime levels, a significant proportion of which involve young people either as victims or offenders.

Children and young people who offend are referred to the YOT via the police or court, dependant on receiving a pre court disposal of a final warning or subject to a court order. CSPs focus on prevention, situational measures and civil orders such as Anti Social Behaviour Orders (ASBOs).

Preventing and reducing further offending requires a partnership approach. The work of the CSPs focuses on areas such as influencing interventions with prolific offenders. YOTs undertake a holistic assessment of each young person including identifying risks and needs. Targeted interventions are applied to each young person to address and manage their offending behaviour.

Key universal services which make a difference to offending patterns in the long term are health, education, employment and housing.

Health and mental health services have crucial roles to play in meeting the wide range of needs of young offenders and need to involve schools directly (Audit Commission 2004). It may be the case that young people who offend 'slip through the net' in terms of being monitored by health professionals, for example, school nurses, GPs and dentists. Every Child Matters argued for the co-location of front line staff in children's centres, extended schools and health settings to increase the opportunities for the early identification of risk.

It is well established that young offenders are a vulnerable group, with complex psychosocial, physical and mental health needs. Over a third of young offenders have a diagnosable mental health disorder (HM Government 2009) and 60% have speech, language and communication needs (Bryan and McKenzie 2009). Substance misuse is particularly prevalent amongst young people entering the criminal justice system (see section on [alcohol and drug misuse](#) in secondary chapter). Young people who offend are also particularly at risk of becoming NEET (see [NEET](#) section above).

Many of these young people suffer from conduct disorders, problems with social understanding and disorders on the autistic spectrum. Conduct disorders often develop into personality disorders which are resistant to treatment in adults and are very expensive to treat. Further discussion on these disorders is provided in the chapter on children and young People with particular needs (sub-sections on [children with disabilities and learning difficulties](#) and [emotional health and wellbeing](#)).

Generally, research suggests detection of problems in this population is imprecise and tends towards under-estimation, particularly of internalising disorders (i.e. disorders of emotion such as depression) (Kent JSNA 2010). There are no widely used screening instruments for detecting mental health problems within the youth justice system in England, although the Youth Justice Board standard general assessment tool (ASSET) contains a brief rating of mental health status as linked to the offending behaviour. There are no statistics on reliability and validity of the ASSET.

Despite the high incidence of mental health problems in this group, only a small proportion of young people who offend with mental health problems are receiving help from specialist child and adolescent mental health services (CAMHS). The National CAMHS Mapping Exercise in 2004 showed of the total caseload of CAMHS, only 5% were young offenders. The YOT has recently developed a health screening tool to further identify young people's need and this has identified that a health needs assessment is required for this group as there is little information on the health needs of this group. The potential for undertaking a Lancashire wide health needs assessment for

young people who offend is currently being assessed. Further discussion of [mental health](#) is provided in the chapter on children and young people with particular needs.

A summary of recommendations for children and young people who offend is provided in the [appendix](#).

Rates of children and young people who offend

The detection rate for all crime in Lancashire was 35% in 2009/10, which is one of the highest detection rates in the country. This analysis looks at the detected crimes that have an offender or offenders associated to them. Between April 2009 and March 2010, 22% of all offenders were aged 19 or under and were responsible for 33% of all detected offences. Preston has the highest rate of youth offending, with 52 per thousand young people aged 10-19 offending.

Table 180: Rate per thousand 10-19 population of offenders by district of residence, 2008/09 and 2009/10

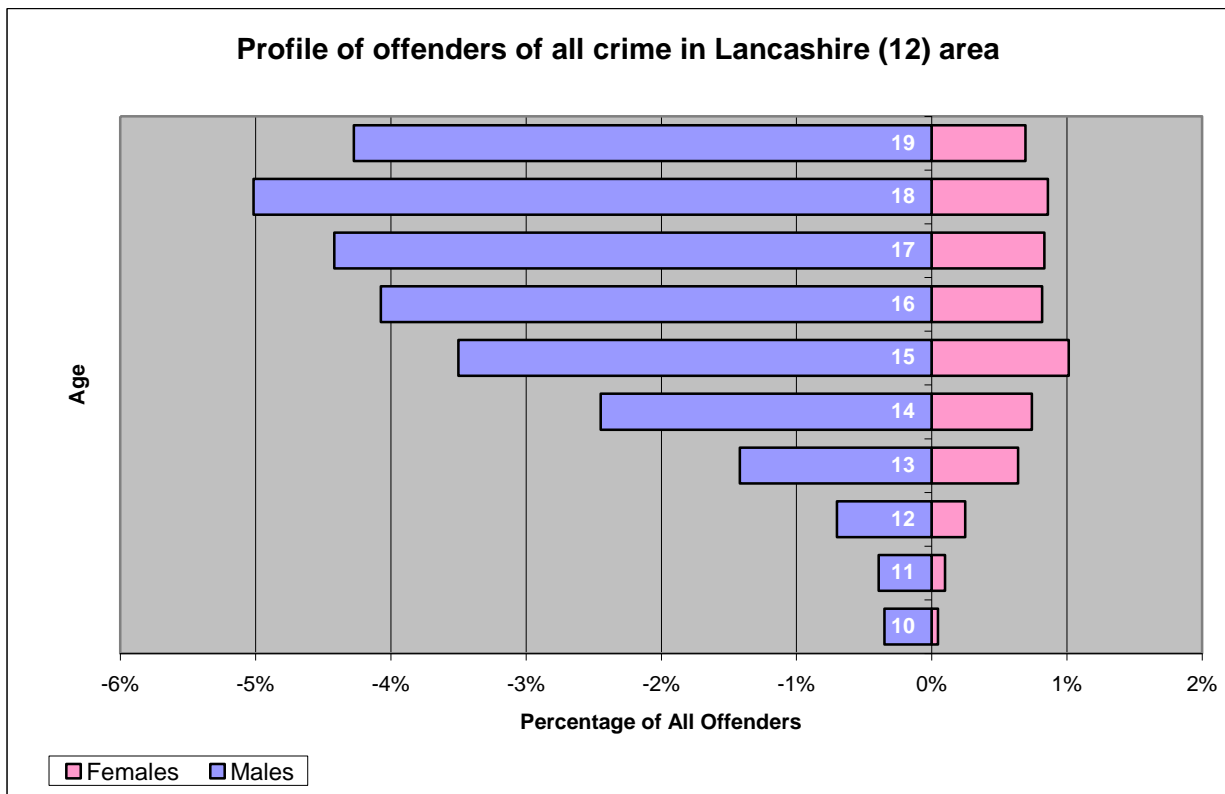
Local Authority	2008/9	2009/10
Preston	52.1	52.3
Hyndburn	44.6	42.0
Burnley	48.5	40.3
Pendle	39.1	38.2
South Ribble	39.8	37.7
Lancashire	37.0	36.2
Fylde	28.6	35.8
Wyre	34.5	35.4
Chorley	38.0	33.2
West Lancashire	28.5	33.0
Lancaster	32.0	31.7
Rosendale	27.2	21.6
Ribble Valley	18.3	20.9

Source: Lancashire Constabulary/MADE/ONS 2009 mid-year estimates

Demographics of young people who offend

The table below gives the age and gender breakdown for offending in Lancashire. 27% of all offenders were males aged 10 to 17 and 6% were females aged 10 to 19.

Figure 84: Demographic profile of young people who offend in Lancashire



Types of crime

Violent crimes by young people, often against their peers, are the top crime type for children and young people who offend. Criminal damage and drug offences are the next two most common crime types.

Table 181: Types of crime committed by 10-19 year olds, 2009/10

Crime Type	Percentage
All Violent Crime	28%
All Criminal Damage (incl. Arson)	18%
All Drugs Offences	16%
Shoplifting	12%
All Violent Crime	28%
All Vehicle Crime	6%
Domestic Burglary	4%

Source: Lancashire Constabulary/MADE

The proportion of young people entering the Youth Offending Service is small relative to the overall youth population, averaging 9 per thousand 10-17 population. 60% receive a reprimand from the Police, 23% a final warning and 18% a referral to the youth offending panel. A referral order is given to a young person who pleads guilty to an offence when it is their first time in court.

Table 182: First time entrants to Youth Offending Service, 2009/10

Local Authority	Number of new entrants	Rate per thousand 10-17 population	Intervention Type		
			Police Reprimand	Final Warning	Referral Order
Burnley	92	10.2	69%	13%	19%
Chorley	81	8.3	51%	37%	12%
Fylde	48	7.3	89%	9%	2%
Hyndburn	121	13.3	51%	29%	20%
Lancaster	151	10.1	56%	28%	17%
Pendle	87	9.1	59%	11%	30%
Preston	140	10.5	65%	17%	18%
Ribble Valley	23	3.7	52%	35%	13%
Rossendale	35	4.7	59%	21%	21%
South Ribble	100	9.6	57%	29%	14%
West Lancashire	112	10.1	52%	25%	23%
Wyre	111	10.7	66%	18%	16%
Lancashire (12)	1101	9.3	60%	23%	18%

Source: Lancashire Youth Offending Team/MADE

Mosaic has been used to conduct analysis of the children and young people who offend. Mosaic is a geodemographic profiling tool, which allows the postcodes of any group of people to be assigned to household "types" which provide intelligence on their likely socio-economic characteristics. The analysis reveals that 23% of Lancashire children and young people who offend are in group I – lower income workers. In particular they fall into types I43 and I44, typified by young people renting poor quality accommodation. Because of the young age profile of the population the Experian Mosaic profiles (2009) suggest that overall demand on the health service may be moderate, but the demands on specific services such as tobacco, drug and alcohol treatment, sexual health and mental health services will be above average. This is a transient population.

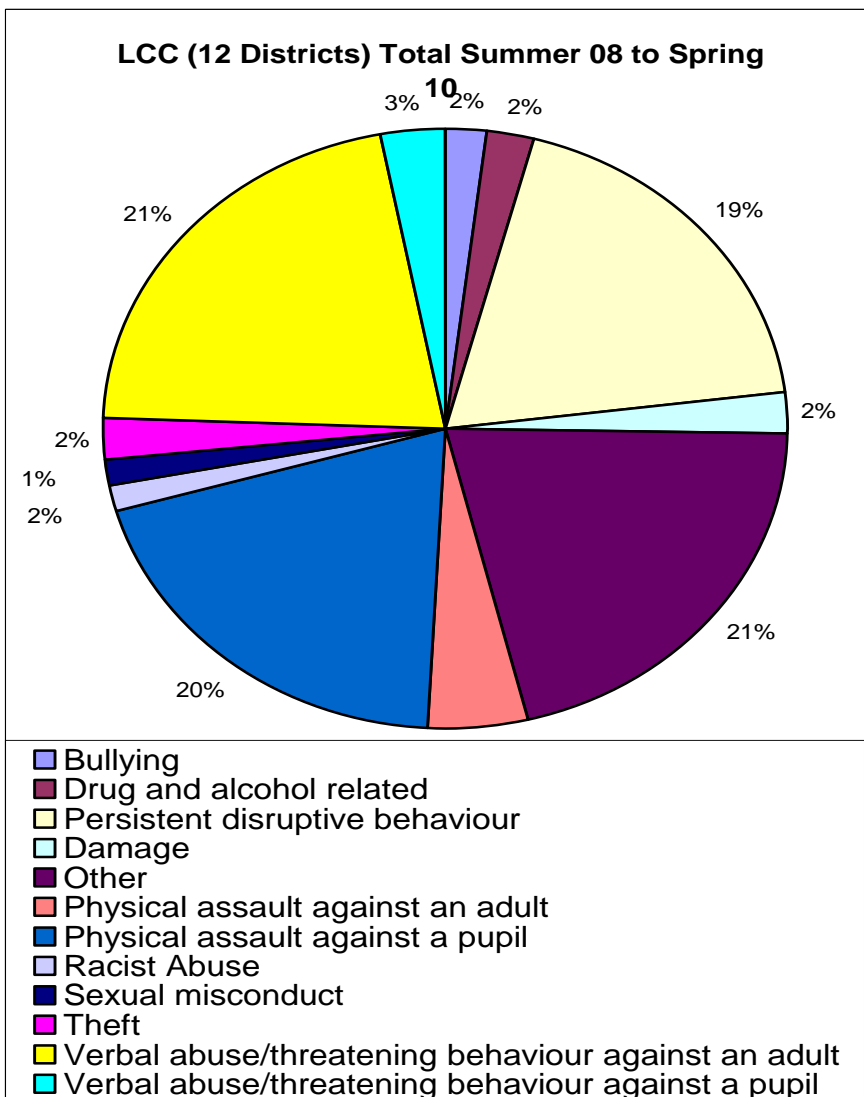
Table 183: Socio-economic profile of children and young people who offend by place of residence

Mosaic Public Sector Group 2009	Percentage of children and young people who offend by place of residence
I Lower income workers in urban terraces in often diverse areas	23%
O Families in low-rise social housing with high levels of benefit need	19%
K Residents with sufficient incomes in right-to-buy social housing	14%
J Owner occupiers in older-style housing in ex-industrial areas	10%
E Middle income families living in moderate suburban semis	9%
B Residents of small and mid-sized towns with strong local roots	6%
G Young, well-educated city dwellers	3%
N Young people renting flats in high density social housing	3%
F Couples with young children in comfortable modern housing	3%
D Successful professionals living in suburban or semi-rural homes	3%
M Elderly people reliant on state support	2%
H Couples and young singles in small modern starter homes	2%
A Residents of isolated rural communities	2%
L Active elderly people living in pleasant retirement locations	0%
C Wealthy people living in the most sought after neighbourhoods	0%
Source: Experian - Mosaic Public Sector	Base = 2,668 offenders

Drug and alcohol related offending is a particular problem for young people. According to data from the National Drug Treatment Monitoring Service, during 2009/10 759 young people under the age of 18 went through drug treatment services in Lancashire.

Being excluded from school is a known risk factor for youth offending. Lancashire schools excluded pupils 12,157 times in the six terms, summer 2008 to spring 2010. The chart below shows the reasons for these exclusions. Most were fixed term exclusions, but 264 were permanent. 20% of these exclusions were bullying related and 19% persistent disruptive behaviour. For further discussion of exclusions see [primary](#) and [secondary](#) chapters.

Figure 85: Reasons for exclusion from schools in Lancashire (12) area



Railway offences

Up to 30 children and young adults are killed on the railway every year in England and Wales by crossing the tracks, taking short cuts or playing "chicken". Children who trespass are at risk of death or serious burns through electrocution, as well as being hit by a train.

Data from the British Transport Police highlight that since 1st August 2009 there have been approximately 194 offences in Lancashire which state the involvement of youths, juveniles, kids, etc, either as victims or offenders. The majority of these offences are route crime offences, mainly trespass and stone throwing. Route crime offences account for around 53% of all offences involving young people. There are several hotspots which include Blackburn, Preston, Blackpool North, Layton, Lancaster, Chorley, Leyland and Accrington. These offences are recorded against the nearest station location, but could, in fact, be at a line side location several miles away. The analysis shows:

- Approximately 12% of offences are low level disorder, i.e. unacceptable behaviour, which occur mainly at the stations. Preston, Lancaster and Blackburn were recorded locations which suffered on several occasions.
- The majority of all offences occur between 12:00 and 22:59 hours, with a peak period running from 15:00 to 20:59 hours.
- There were 89 children and young people listed as having offended whose ages range from 9 to 18, with the average age being 15 years old. There were 22 juvenile victims shown, whose ages again ranged 9 to 18 and the average age was 15 years old.
- Alcohol was recorded as a contributing factor in just 6 offences and there were only 4 drugs offences recorded for possession of cannabis.

British Transport Police have strong links with other local agencies, including visiting schools, and create Problem Solving Profiles in conjunction with local forces, rail operators, local councils, etc to target specific problems at locations or on train services.

Youth Homelessness

Young people are unlikely to leave home without finding a safe alternative but many may be forced out of their homes due to domestic, sexual or racial abuse, poverty and family conflict. There are a number of reasons why young people become homeless. Family and relationship breakdowns are the most common factor. Key risks for young people becoming homeless are:

- Unemployment;
- Drug and alcohol problems;
- Mental health problems;
- Young offenders struggling to get work;
- Young people leaving care; and
- Low self esteem.

The Big Issue's 2004 Audit revealed that a third of its vendors were homeless before the age of 20, highlighting the importance of early intervention (Pearlman 2010). Young people experiencing disruption or trauma during childhood and / or from poor socio-economic backgrounds are at increased risk of homelessness. The main 'trigger' for youth homelessness is relationship breakdown (Quilgars et al 2008). For many, this is a consequence of long-term conflict within the home and often involves violence.

Young homeless people have much poorer health than other young people. Depression and other mental health problems are prevalent, as are substance misuse issues (Quilgars et al 2008). A significant minority of young homeless people have multiple needs. It is not clear whether the prevalence of complex needs is on the increase or whether agencies are now better at recognising a range of needs.

Homelessness compounds a number of the problems faced by young people. This is particularly evident with mental health problems and / or the onset of (or exacerbation of existing) substance misuse problems. There is particularly strong evidence that homelessness impedes young people's participation in employment, education or training as outlined in the earlier [section](#) on this topic.

Other impacts are more mixed. For some young people, social networks are fractured, but many gain increased support from friends and support from new sources (particularly support workers). Homelessness can be associated with experiences of violence and / or involvement in 'risky behaviour' but may also lead to increased feelings of safety and an overall improvement in quality of life.

Statutory Homelessness

The focus of interventions for homelessness of young people for several years has been on homelessness prevention. Therefore DCLG statistics available will generally show a reduction in the number of statutory homeless applicants and a rise in the number of cases where homelessness has been prevented. This is highlighted by the sharp drop off in the numbers accepted as statutorily homeless in 2009/10.

Individual applicants are accepted as statutorily homeless and are thus owed a housing duty, if they are proven to be unintentionally homeless and in priority need due to particular vulnerabilities. Priority categories are households with dependent children or containing a pregnant woman, those aged 16 and 17, and care leavers aged 18-20.

Table 184: Statutory homelessness acceptances 2005-06 to 2009-10

	2005-06		2006-07		2007-08		2008-09		2009-10	
	Priority Categories		Priority Categories		Priority Categories		Priority Categories		Priority Categories	
	Aged 16/17	Aged 18-20 (having been in care)	Aged 16/17	Aged 18-20 (having been in care)	Aged 16/17	Aged 18-20 (having been in care)	Aged 16/17	Aged 18-20 (having been in care)	Aged 16/17	Aged 18-20 (having been in care)
Burnley	9	3	17	5	23	2	29	6	3	3
Chorley	28	3	17	0	29	2	18	2	0	1
Fylde	#	#	7	0	0	0	0	0	0	0
Hyndburn	2	0	0	0	0	0	0	0	0	1
Lancaster	11	8	8	5	8	2	3	2	2	0
Pendle	9	0	0	0	1	0	1	0	2	1
Preston	8	1	21	5	19	3	15	0	9	4
Ribble Valley	1	0	1	0	0	0	0	0	2	0
Rossendale	5	0	3	0	1	0	1	0	0	0
South Ribble	18	3	9	3	3	1	3	1	1	0
West Lancashire	3	3	1	0	3	0	2	0	0	0
Wyre	4	2	11	1	11	1	1	0	0	0
Lancashire	98	23	95	19	98	11	73	11	19	10

Source: Department for Communities and Local Government

Supporting People funded services for youth homelessness

Supporting People is a central government funded programme to improve housing-related support services. The support is offered with the aim of enabling people to live independently so it includes a wider remit of services than traditional housing support including support and training for life skills, social skills, and personal budgeting, for example. During 2009-10, 1,024 new service users aged between 16 and 21 accessed Supporting People services in Lancashire. Of those new

clients, 64% were female and included young women with dependent children and those at risk of domestic violence. More than 370 (or 36%) of the total new clients were aged under 18.

Figure 86: New Supporting People clients by gender and age groups, 2009/10

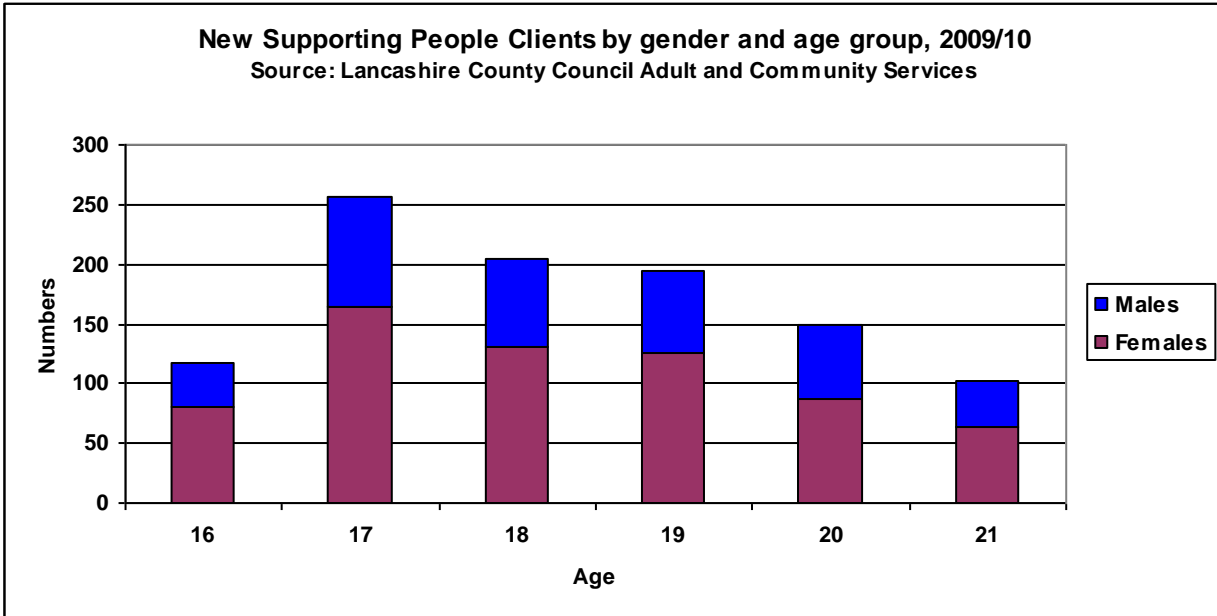


Table 185: Supporting People Client Group Classification of New Clients aged 16-21, 2009-10

Primary Client Group		Age of Client						Total
		16	17	18	19	20	21	
Mental health problems	Count	0	4	1	9	6	7	27
	%	0.0%	1.6%	0.5%	4.6%	4.0%	6.9%	2.6%
Learning disabilities	Count	0	0	3	1	2	2	8
	%	0.0%	0.0%	1.5%	0.5%	1.3%	2.0%	0.8%
Physical or sensory disability	Count	0	0	0	1	0	0	1
	%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.1%
Single homeless with support	Count	41	91	72	44	36	26	310
	%	35.0%	35.5%	35.1%	22.6%	24.2%	25.5%	30.3%
Alcohol problems	Count	0	0	0	2	1	0	3
	%	0.0%	0.0%	0.0%	1.0%	0.7%	0.0%	0.3%
Drug problems	Count	0	0	0	0	0	3	3
	%	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%	0.3%
Offenders or at risk of offending	Count	2	2	1	2	8	5	20
	%	1.7%	0.8%	0.5%	1.0%	5.4%	4.9%	2.0%
Mentally disordered offenders	Count	0	0	1	0	0	0	1
	%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.1%
Young people at risk	Count	48	96	64	56	47	30	341
	%	41.0%	37.5%	31.2%	28.7%	31.5%	29.4%	33.3%
Young people leaving care	Count	3	5	11	3	1	0	23
	%	2.6%	2.0%	5.4%	1.5%	0.7%	0.0%	2.2%
People with HIV/AIDS	Count	1	0	0	0	0	1	2
	%	0.9%	0.0%	0.0%	0.0%	0.0%	1.0%	0.2%
Homeless families with support	Count	5	15	10	18	15	12	75
	%	4.3%	5.9%	4.9%	9.2%	10.1%	11.8%	7.3%
Teenage parents	Count	4	24	22	19	2	0	71
	%	3.4%	9.4%	10.7%	9.7%	1.3%	0.0%	6.9%
Rough sleeper	Count	0	1	1	4	1	0	7
	%	0.0%	0.4%	0.5%	2.1%	0.7%	0.0%	0.7%
Traveller	Count	1	0	1	1	0	0	3
	%	0.9%	0.0%	0.5%	0.5%	0.0%	0.0%	0.3%
People at risk of domestic violence	Count	12	17	18	34	25	16	122
	%	10.3%	6.6%	8.8%	17.4%	16.8%	15.7%	11.9%
Generic/Complex needs	Count	0	1	0	1	5	0	7
	%	0.0%	0.4%	0.0%	0.5%	3.4%	0.0%	0.7%
Total	Count	117	256	205	195	149	102	1024
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Lancashire County Council Adult and Community Services

There were 2,970 new clients of all ages for Supporting People during 2009/10, indicating that young people aged 16 to 21 accounted for 34% of all new clients. Young people aged 16 to 19 accounted for more than one in four new clients (26% of the total).

As the table above shows a large proportion of new clients aged 16-21 were classified as client groups other than 'young people at risk'. Overall, 30% of all new service users identified as 'single homeless' are aged 16-21. Exactly a third were identified as 'young people at risk'

Despite their youth and being legally under age, 35% of 16 and 17 year old new clients are not identified primarily as ‘young people at risk’ but as ‘single homeless’. 39% of under 18s are identified as ‘young people at risk’. Of those aged 16 (117 service users):

- 55 (47%) accessed dedicated supported housing for Young People
- 20 accessed direct access services
- 11 accessed supported lodgings, women's refuges and foyer
- 8 accessed floating support
- 9 accessed other supported housing

Table 186: Service accessed by New Clients aged 16-21, 2009-10

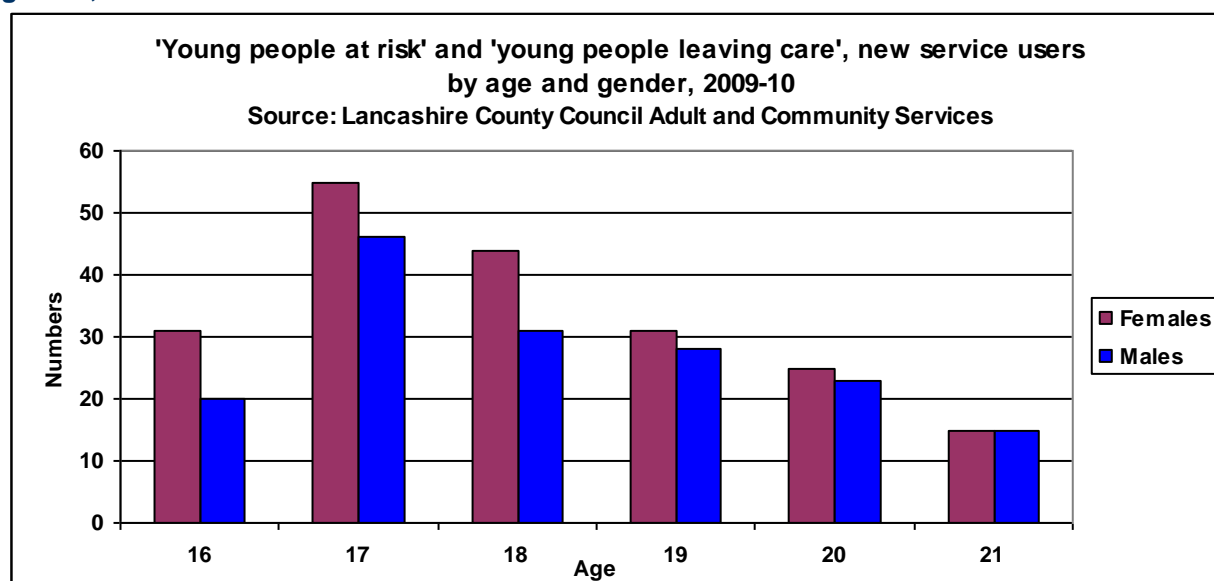
Type of service		Age of Client						Total
		16	17	18	19	20	21	
Supported housing	Count	55	137	73	50	39	28	382
	%	47.0%	53.5%	35.6%	25.6%	26.2%	27.5%	37.3%
Supported lodgings	Count	11	10	8	9	4	2	44
	%	9.4%	3.9%	3.9%	4.6%	2.7%	2.0%	4.3%
Women's refuge	Count	11	15	15	26	13	9	89
	%	9.4%	5.9%	7.3%	13.3%	8.7%	8.8%	8.7%
Foyer	Count	11	17	10	5	7	1	51
	%	9.4%	6.6%	4.9%	2.6%	4.7%	1.0%	5.0%
Teenage parent accommodation	Count	1	4	6	5	2	0	18
	%	0.9%	1.6%	2.9%	2.6%	1.3%	0.0%	1.8%
Direct access	Count	20	14	23	11	14	7	89
	%	17.1%	5.5%	11.2%	5.6%	9.4%	6.9%	8.7%
Floating support	Count	8	59	69	87	69	55	347
	%	6.8%	23.0%	33.7%	44.6%	46.3%	53.9%	33.9%
Resettlement service	Count	0	0	1	2	1	0	4
	%	0.0%	0.0%	0.5%	1.0%	0.7%	0.0%	0.4%
Total new service user	Count	117	256	205	195	149	102	1024
	%	1.0	1.0	1.0	1.0	1.0	1.0	1.0

Source: Lancashire County Council Adult and Community Services

A number of young people, 178, accessed supported housing not specific to young people such as homeless hostels and women's refuges.

Looking specifically at the two client groups of ‘young people at risk’ and ‘young people leaving care’, 55% of new clients were female. The graph below demonstrates that, when only considering those particular two clients groups, the ratio between males and females is in favour of females, particularly for the younger ages between 16 and 18 years old:

Figure 87: 'Young people at risk' and 'young people leaving care', new service users by age and gender, 2009/10



Young People's Service

The Young People's Service collects a range of data about the young people with whom they come into contact. Included in the data collected is a field about homelessness. As with the other sources used, this data will not be perfect but provides another way to attempt to triangulate the scale of the problem of homelessness facing young people.

The snapshot of data showed 869 young people to be homeless in August 2010, 348 of whom were aged under 18 years, accounting for 40% of the total. This is higher than the numbers of people accessing the Supported People service at 773.

Table 187: Snapshot of homeless young people by age, August 2010

Homeless Young People by Age as at 3rd August 2010					
	16	17	18	19	Total
Burnley	4	41	25	30	100
Chorley	5	17	23	16	61
Fylde	1	4	8	6	19
Hyndburn	12	20	19	19	70
Lancaster	16	31	41	37	125
Pendle	9	26	25	22	82
Preston	20	26	32	39	117
Ribble Valley	5	5	2	2	14
Rosendale	6	8	18	10	42
South Ribble	7	14	23	20	64
West Lancs	11	28	31	41	111
Wyre	11	21	18	14	64
Lancashire total	107	241	265	256	869
Source: Lancashire Young People's Service					

Females were more likely to be homeless than males across Lancashire, a picture which is replicated across all districts. 57% of the young people recorded as homeless were female.

Table 188: Snapshot of homeless young people by gender, August 2010

Homeless young people by gender			
	F	M	Total
Burnley	57	43	100
Chorley	39	22	61
Fylde	13	6	19
Hyndburn	39	31	70
Lancaster	74	51	125
Pendle	50	32	82
Preston	65	52	117
Ribble Valley	8	6	14
Rossendale	24	18	42
South Ribble	33	31	64
West Lancs	61	50	111
Wyre	32	32	64
Total	495	374	869

Source: Lancashire Young People's Service

Analysis of destination of young people highlights the following. The full table is available in the data [appendix](#):

- One in five were in education, either compulsory or full time
- 22% were either in training or employment
- Almost half were not in education, employment or training.

Local authority housing departments

District councils are another significant source of data on youth homelessness. The North West Homelessness Service, Moving on, is working with Preston City Council and the Lancashire Young People's Service to identify homeless young people in Preston. They collected data on the presentations at a number of services, which identified 274 young people who were homeless or at risk of homelessness. These figures exceed the numbers from the previous sources and highlight the complexity of measuring homelessness. Anyone who is interested in measuring youth homelessness is encouraged to contact local authority housing departments. For further county wide pieces of work it is recommended that data from local authority housing departments is collected.

A summary of the evidence base on interventions for [young people at risk of, or currently homeless](#), is provided in the appendix.

Summary, identification of key areas of need and recommendations

Young people aged 16-19 are at a very sensitive period of transition from childhood to adulthood and they face a multitude of challenges as well as the positive new experiences that are inherent during this age. The overriding area of concern for young people must be the lasting impact of the recession and the outcome of the current financial climate, which will reduce the level of support being offered to them from public services.

NEET is clearly a priority area of need for young people, especially given the current likelihood of young people facing unemployment. The Government has urged a focus on older young people as they are most likely to become NEET. Some groups will be particularly at risk such as those who have not succeeded at school but also vulnerable groups such as teenage parents, children who are looked after, those with learning difficulties and disabilities and those young people who offend. Given the cumulative effect of events over the life course, this has implications for long term inequalities. Young people who are NEET are clear that it is "real jobs" that they want and not simply training. Public, private and voluntary, community and faith sectors should all consider what potential they have to provide work opportunities for young people.

Sexual health is an important area of need for young people as high rates of some sexually transmitted diseases, such as Chlamydia and herpes, are found in Lancashire. The importance of this issue is compounded with young people who are engaging in sexual activity but also other "risk taking behaviours" such as using alcohol and drugs and it is important that these agendas are linked. When dealing with this agenda, however, we must appreciate that young people do not view their behaviour as "risk taking" but rather as experimentation and trying new things, all of which is viewed as normal within their cohort.

Teenage pregnancy continues to put children in Lancashire at risk of poorer outcomes. It is important to focus on actions to reduce teenage pregnancy and improve teenage parents' outcomes in all strategies related to children and young people and families. The demographic makeup of teenage parents suggests that this is a group who are particularly at risk of being or becoming part of a vicious cycle of dysfunction. Consequently promoting 'child readiness' to those most at risk of teenage pregnancy could both assist in reducing the overall number of teenage parents and improving the outcomes for those who do become parents at a relatively young age.

Young people who offend are a group of particular concern during the current economic situation. Such young people often require frequent support from other services such as tobacco, drug and alcohol treatment, sexual health and mental health services. Drug related offending is a crucial issue as highlighted by the high numbers of re-offenders who have been through drug counselling.

Youth homelessness affects a limited number of young people, but has huge consequences for those it does affect. A survey of Big Issue vendors found that a third were homeless before the age of 20, highlighting the need for early intervention. Homelessness can lead to increased propensity for drug misuse and sexual abuse and physical harm. However, there is evidence that the experience may also be more positive for some young people, providing them with a strengthened social network and increased safety (where abuse at home was the reason for leaving in the first place). It is a complex issue but there is certainly evidence that being homeless impedes young people's progress in employment, education and training.

The wider horizons of young people coupled with an increased mobility due to the opportunities to drive or ride motorbikes brings safety issues to the fore. Evidence from the Lancashire Road Safety Team highlights that over a five year period one in a hundred young people aged 16-19 was killed or seriously injured in a road traffic accident. The issue appears to be particularly of concern in Ribble Valley where road traffic accidents in other age groups are noticeably low.

The analysis in this chapter highlights some key areas of need for Lancashire's young people. These have been identified for a number of reasons: because Lancashire is underperforming against targets; because the current economic conditions are likely to exacerbate a problem; and because the consequences of not acting are severe for the young people involved and their offspring. In summary, the following are identified as key needs for this age group:

- Not in education, employment and training (NEET)
- Road traffic accidents
- Sexual health
- Teenage pregnancy
- Youth homelessness
- Youth offending

Specific recommendations

A number of specific recommendations can be drawn in relation to young people:

- The focus for the sexual health agenda should move from Chlamydia screening volume to attempting to find Chlamydia, thereby treating more cases and reducing overall incidence over time.

- A health needs assessment should be conducted to inform multi-agency action to ensure young people who offend have access to the health services they need.
- Further work is required to understand the full picture of road traffic accidents for young people and develop appropriate evidence based interventions.
- Further work should be undertaken to gather together district level youth homeless data to provide a full picture of the issue for the county.

A number of recommendations have been identified in relation to NEET:

- Local research is needed to understand the barriers faced by young people with learning difficulties and/or disabilities in terms of accessing employment, education and training to prevent them from becoming NEET.
- Identify what scope there may be for increasing further the flexibility of further education provision, to facilitate access to courses throughout the year, rather than at the traditional intake point of September.
- Foster closer collaboration with partners, including Jobcentre Plus, for example to facilitate more effective tracking of young people, the fast-tracking to New Deal of Jobseekers Allowance claimants as they reach the age of 18, and the sharing of local labour market information.
- Reduce the tendency towards an artificial 'watershed' at age 18 in the delivery of some support services, due to current funding structures. Despite many examples of good practice, in some circumstances this can act as a barrier to the continuity of support to young people at crucial time.
- Investigate the potential to develop an overarching Lancashire strategy for EET, capturing the commitment of all key partners to work together to deliver a coherent programme of high quality education, employment and training opportunities for all young people.
- Reinforce activities designed to support those in vulnerable groups, such as care leavers, teenage mothers, young offenders, and those with a learning difficulty or disability.
- Implement measures to address specific barriers to participation – e.g. affordable transport.

A number of recommendations have been identified in relation to teenage pregnancy:

- the Children's Trust should urgently develop a robust performance management framework for the Teenage Pregnancy Strategy, holding partners to account
- the County Council and PCT partners should work together to ensure local relevant data is being effectively captured, collated, analysed and disseminated to inform commissioning and to better performance manage the Teenage Pregnancy Strategy
- Intelligence from the JSNA teenage pregnancy needs assessment should be used to inform future action to reduce unplanned and unwanted teenage pregnancies.
- Embed teenage pregnancy across commissioning activity at county, PCT and locality level
- Future commissioning of contraceptive and sexual health services should use a collaborative approach between NHS (including GP commissioning consortia) and Local Authority to form an effective sexual health system to minimise the potential fragmentation of services proposed in the Public Health White Paper
- *Work on the development of a core Sex and Relationships Education (SRE) offer is prioritised to outline:*
 - what pupils can expect from their school SRE
 - what schools can expect from health, local authority and voluntary sector providers
 - the responsibilities of schools to their pupils, including giving information about and supporting access to local Contraception and Sexual Health (CASH) services.
- Local action to reduce teenage pregnancy and improve teenage parents' outcomes is a key contribution to reducing child poverty and should be clearly identified within the Child Poverty Strategy.
- Targeted prevention and early intervention work with teenage parents should be upscaled in order to address the inequalities that exist in health outcomes for mothers and babies.

Children and young people with particular needs

All children have needs which must be met in order to achieve their true potential. However, the circumstances into which some children are born and live will mean that they have more complex needs that require additional or alternative methods of support if they are to achieve the outcomes desired by the Every Child Matters framework. This chapter focuses on particular issues facing some children and young people as well as specific groups of children and young people who face additional challenges. These groups were decided upon by the JSNA project team and this is not intended to be an exhaustive list. The chapter covers:

- Safeguarding;
- Children who are looked after;
- Children with disabilities and learning difficulties and disabilities;
- Emotional wellbeing and mental health; and
- Young carers.

Safeguarding

Children are inherently vulnerable as they rely on a range of adults in their everyday lives. Some children may face harm and there is a duty on all services to keep children safe and promote their wellbeing. The harms children face come in varying degrees from the most extreme forms of emotional, sexual and physical abuse, as well as the inherent risks of growing up in a household where there is domestic violence (covered in the [crime section](#) of the socio-economic determinants chapter) to issues of neglect. Other risks include those of living in a household with parents who misuse substances (discussion of this is included in the [alcohol and drugs section](#) of the secondary chapter) and sexual exploitation (covered in the crime section of the [socio-economic determinants](#) chapter). However, there are also risks posed by general life, including those posed by the environment or by local traffic (both covered in the [socio-economic determinants](#) chapter with further breakdown of [road traffic accidents](#) in the age chapters). This section focuses on the most extreme types of harm.

Referrals to Lancashire Children's Social Services

The number of children and young people referred to Lancashire Children's Social Care during the year (1 April – 31 March) is illustrated below. Between 2003/04 and 2008/09 there was a steady

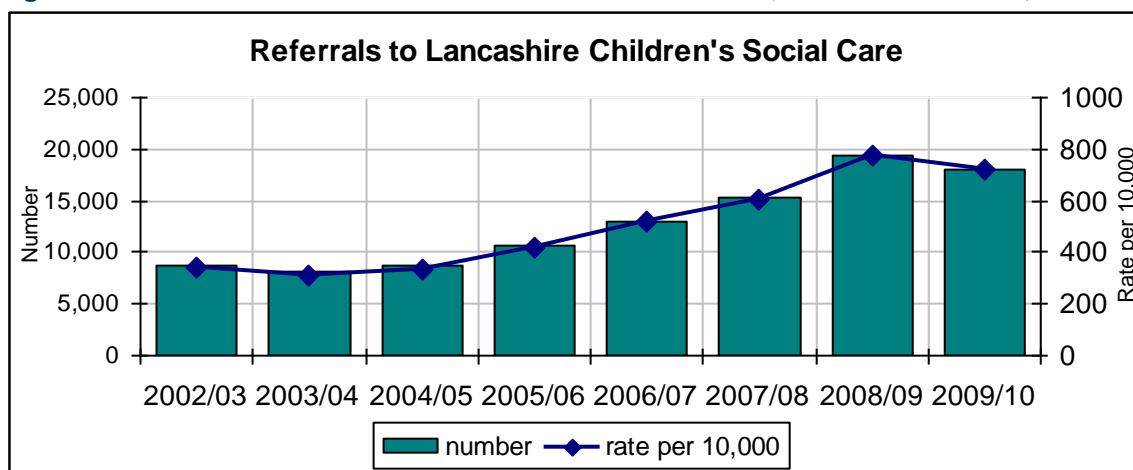
year-on-year increase in the number of referrals, with the 2008/09 number being more than double that seen in 2003/04. The rate in recent years has been higher than national rates.

2009/10 however saw a reduction in the number of referrals. This is mainly due to the introduction of the 'contact record' which differentiates between a 'contact' and a 'referral' whereas previously this difference in recording was not available.

Table 189: Referrals to Lancashire Children’s Social Services, numbers and rates, 2002/03 to 2009/10

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Number of referrals	8,800	8,085	8,665	10,590	13,070	15,225	19,390	18,022*
Rate per 10,000 population aged 0-18	338	313	337	415	516	606	778	724*
National rate			499	515	496	490	497	
*Provisional								
Source: DCSF Information Gateway / LCC CYP Commissioning Team								

Figure 88: Referrals to Lancashire Children’s Social Services, numbers and rates, 2002/03 to 2009/10



Source: DCSF Information Gateway / LCC CYP Commissioning Team

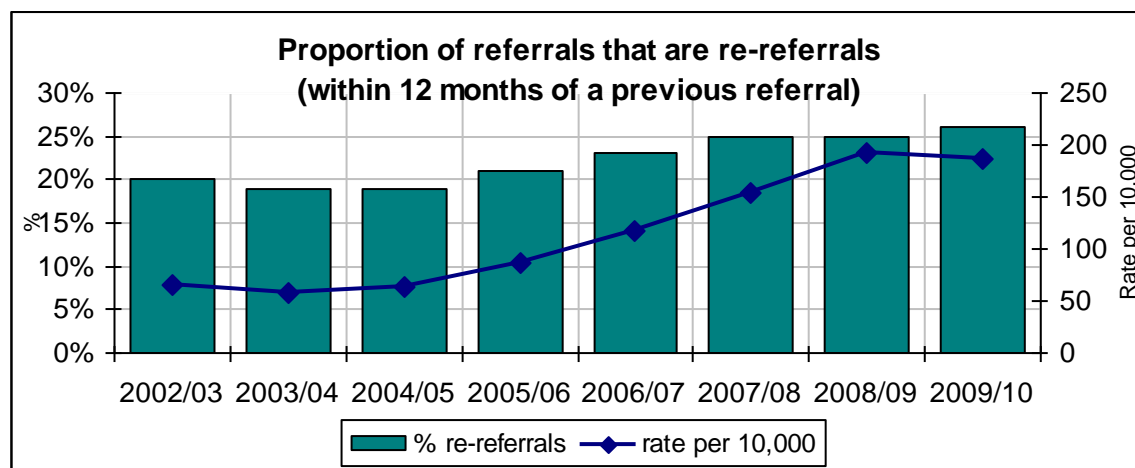
More than a quarter of safeguarding referrals are those that have been re-referred within a 12 month period. The proportion of re-referrals has increased since 2002/03, in line with the increase in overall referrals. The proportion of re-referrals (within 12 months of a previous referral) to Lancashire children's social care increased slightly in 2009/10 from 25% to 26%, although the rate per 10,000 population aged 0-18 has shown a reduction over this same period. Re-referrals for safeguarding could be taken as a measure of the success of interventions to support children and their families and effort should be made to reducing the proportions of re-referrals. Understanding the characteristics of those who are re-referred would be beneficial to this process.

Table 190: Re-referrals to Lancashire children's social care within 12 months, 2002/03 to 2009/10, rate and numbers

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Proportion of referrals that are a re-referral within 12 months of a previous referral	20%	19%	19%	21%	23%	25%	25%	26%
Rate per 10,000 population aged 0-18	66	58	64	86	117	153	193	186

Source: DCSF Information Gateway / LCC CYP Commissioning Team

Figure 89: Re-referrals to Lancashire children's social care within 12 months, 2002/03 to 2009/10, rate and numbers



Source: DCSF Information Gateway / LCC CYP Commissioning Team

Child protection plans

A child protection plan is a working tool for those children who are deemed to be at risk that should enable the family and professionals to understand what is expected of each other. All children who were formerly on the child protection register will have a plan. The aims of the plan are to keep the child safe, to promote their welfare and to support their wider family to care for them (if this can be done safely).

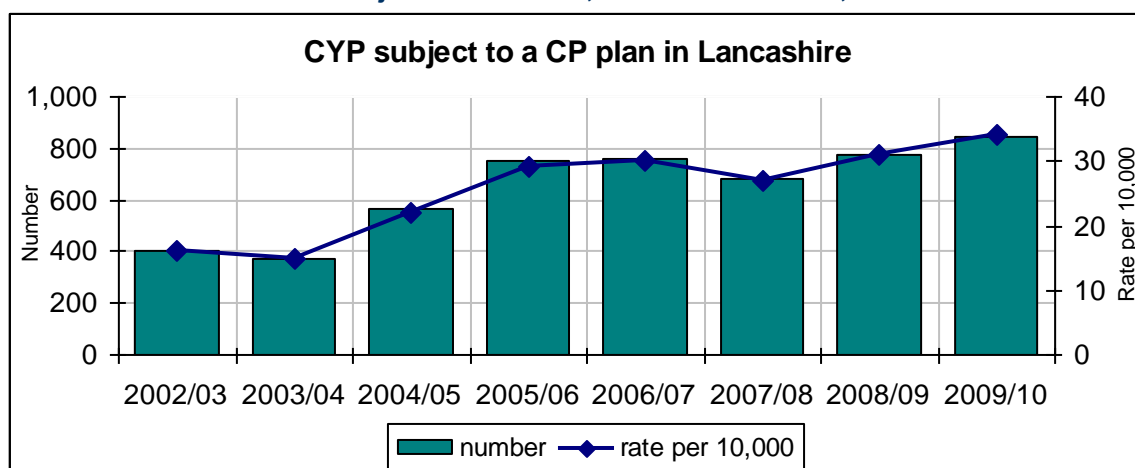
During 2009/10 more than 800 children in Lancashire had a child protection plan. The number of children and young people aged under 18 and subject to a child protection (CP) plan increased between 2002/3 and 2009/10. This has been matched by an increase in the rate of children subject to plans, but remains in line with national trends.

Table 191: Lancashire children subject to a CP Plan, numbers and rates, 2002/03 to 2009/10

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Number subject to a plan during the year	405	375	565	750	760	685	775	844*
Rate per 10,000 population aged 0-18	16	15	22	29	30	27	31	34*
National rate					30	31	34	

Source: DCSF Information Gateway / LCC CYP Commissioning Team
*Provisional data

Figure 90: Lancashire children subject to a CP Plan, numbers and rates, 2002/03 to 2009/10



Source: DCSF Information Gateway / LCC CYP Commissioning Team
 *Provisional data

Preston has the highest proportion of children subject to a child protection plan, at 45.3 per 10,000 under 18s. Ribble Valley has the lowest at 5.6 per 10,000 under 18s. National data for the year ending 31 March 2010 is yet to be published, however the national average for the same period in 2009 was 34 per 10,000. The rate of children under 18 subject to a child protection plan is higher than the national average in Hyndburn, Pendle and Preston. It is not clear whether this represents a different level of need or different levels of identification. Local safeguarding boards should make the determination of what is an appropriate rate to enable effective monitoring and measuring the success of interventions.

Table 192: Children subject to a child protection plan on 31st March 2010 by district, numbers and rates

	0-18 Population (mid 2008)	Deprivation IMD 2007 Score	subject to a CP plan	
			number	per 10,000
Burnley	20,413	34.6	52	25.5
Chorley	21,877	16.6	46	21.0
Fylde	13,862	12.9	18	13.0
Hyndburn	19,876	30.9	76	38.2
Lancaster	27,438	21.9	76	27.7
Pendle	21,011	30.2	84	40.0
Preston	28,904	29.8	131	45.3
Ribble Valley	12,614	10.1	7	5.6
Rosendale	15,738	24.2	52	33.0
South Ribble	22,472	14.1	35	15.6
West Lancashire	23,678	20.4	57	24.1
Wyre	21,213	17.7	37	17.4
Lancashire	249,096	22.3	671	26.9

Source: LCC CYP Commissioning Team

The largest proportion of children subject to a plan in Lancashire fall into the 1-4 age group, however there are also a significant proportion in the 5-9 and 10-15 age groups. This pattern is generally reflected across the districts.

Table 193: Age of children subject to a child protection plan on 31st March 2010 by district

	Under 1	1 to 4	5 to 9	10 to 15	16 and Over	Total
Burnley	6	14	11	21		52
Chorley	9	17	12	7	1	46
Fylde	3	6	7	2		18
Hyndburn	8	17	22	27	2	76
Lancaster	7	27	25	17		76
Pendle	6	25	24	28	1	84
Preston	22	46	38	22	3	131
Ribble Valley	1		2	4		7
Rossendale	7	17	13	14	1	52
South Ribble	4	13	8	8	2	35
West Lancashire	5	23	12	14	3	57
Wyre	4	11	8	13	1	37
Lancashire	82	216	182	177	14	671

Source: LCC CYP Commissioning Team

Nearly 90% of children subject to a child protection plan in Lancashire fall into the White British category. It is unclear whether this reflects levels of need or simply population numbers.

Table 194: Ethnicity of children subject to a child protection plan on 31 March 2010 by district

	White British	Any other ethnic group	Bangladeshi	Indian	Unknown	Other Asian background	Other Black background	Other mixed background	Other White background	Pakistani	White and Asian	White and Black Caribbean	Total
Burnley	47		1					1		2	1		52
Chorley	44						1					1	46
Fylde	17											1	18
Hyndburn	64			2		1				8	1		76
Lancaster	74										2		76
Pendle	56	4	2		1			7	1	5	8		84
Preston	113	1		3	1	1	1	4	1		6		131
Ribble Valley	7												7
Rossendale	49				2						1		52
South Ribble	34								1				35
West Lancashire	51	1			1			1			3		57
Wyre	37												37
Lancashire	593	6	3	5	5	2	2	13	3	15	22	2	671

Source: LCC CYP Commissioning Team

13% of children in Lancashire are subject to a child protection plan for a second or subsequent time, which indicates that the support needs of the family to maintain the wellbeing of these children are not being met. Almost a quarter of children subject to a child protection plan in Rossendale are subject to a plan for a second or subsequent time. South Ribble also has a figure of over 20%. This varies across the districts, with Pendle, West Lancashire and Wyre all having fewer than 10% of children with a second or subsequent plan.

Table 195: Proportion of children subject to a child protection plan for a second or subsequent time as at 31st March 2010, by district

District	% of all children subject to a CP plan
Burnley	12.1%
Chorley	17.7%
Fylde	17.2%
Hyndburn	12.0%
Lancaster	15.8%
Pendle	5.7%
Preston	14.0%
Ribble Valley	0.0%
Rossendale	23.9%
South Ribble	22.5%
West Lancashire	6.3%
Wyre	7.9%
Lancashire	13.3%

Source: LCC CYP Commissioning Team

Child protection plans by category

Child protection plans may be issued for a number of reasons related to the wellbeing of the child.

Table 196: Child protection plan categories

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age of developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Sexual abuse involved forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women also commit acts of sexual abuse, as can other children.

Neglect is the persistent failure to meet a child's basic physical and / or physiological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm and danger;
- Ensure adequate supervision (including the use of inadequate care-givers); or
- Ensure access to appropriate medical care and treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

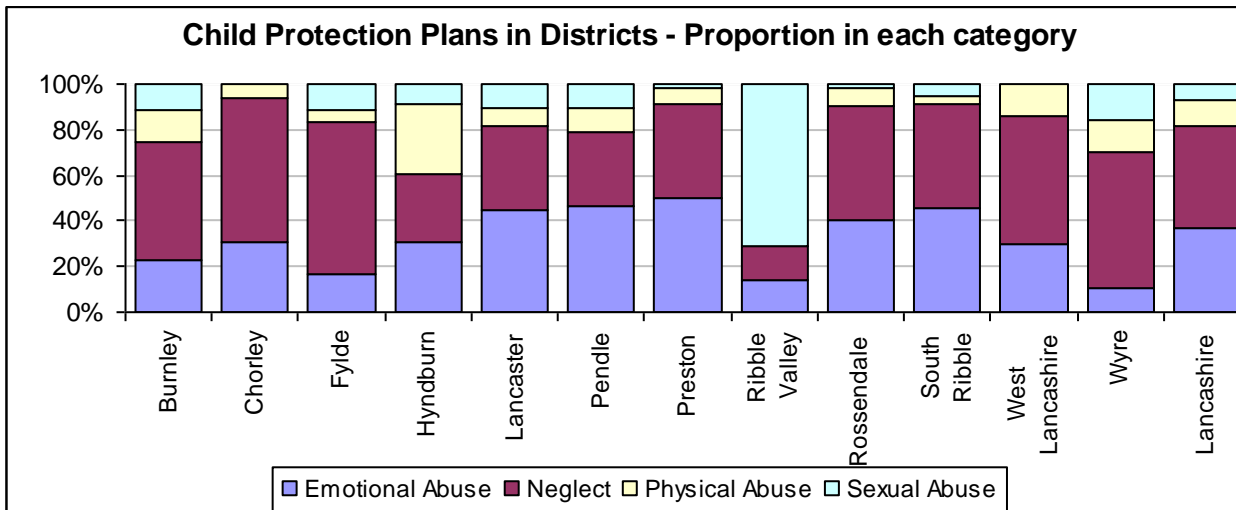
The vast majority of child protection plans in Lancashire are ordered because of emotional abuse (37% of all plans) and neglect (44% of all plans). A minority of plans are put in place because of physical abuse (11%) and sexual abuse (7%). Variations are present at district level although the general Lancashire pattern is followed. The only exception is Ribble Valley where over 70% of the plans in place are for reasons of sexual abuse. However, this is more likely to be a reflection of the small number of plans overall (seven) than a greater risk faced by children in the district.

Table 197: Child protection plans by category, at 31st March 2010, by district

	Emotional Abuse		Neglect		Physical Abuse		Sexual Abuse	
	Num	%	Num	%	Num	%	Num	%
Burnley	12	23.1%	27	51.9%	7	13.5%	6	11.5%
Chorley	14	30.4%	29	63.0%	3	6.5%	0	0.0%
Fylde	3	16.7%	12	66.7%	1	5.6%	2	11.1%
Hyndburn	23	30.3%	23	30.3%	23	30.3%	7	9.2%
Lancaster	34	44.7%	28	36.8%	6	7.9%	8	10.5%
Pendle	39	46.4%	27	32.1%	9	10.7%	9	10.7%
Preston	65	49.6%	55	42.0%	9	6.9%	2	1.5%
Ribble Valley	1	14.3%	1	14.3%	0	0.0%	5	71.4%
Rossendale	21	40.4%	26	50.0%	4	7.7%	1	1.9%
South Ribble	16	45.7%	16	45.7%	1	2.9%	2	5.7%
West Lancashire	17	29.8%	32	56.1%	8	14.0%	0	0.0%
Wyre	4	10.8%	22	59.5%	5	13.5%	6	16.2%
Lancashire	249	37.1%	298	44.4%	76	11.3%	48	7.2%

Source: LCC CYP Commissioning Team

Figure 91: Child protection plans by category, at 31st March 2010, by district



Source: LCC CYP Commissioning Team

Emotional abuse

There is variation at district level with regard to children being subject to a child protection plan due to emotional abuse, although some of this is a result of the small numbers involved in some of the districts. Over 40% of the child protection plans in the districts of Lancaster, Pendle, Preston, Rossendale and South Ribble are recorded as resulting from emotional abuse, compared with just over 10% of Wyre's child protection plans.

Neglect

Again, there is significant variation across the districts with regard to the proportions of children with a child protection plan recorded as being due to neglect. Over 60% of the children with a plan in Chorley and Fylde fall into this category. The distinction between emotional abuse and the abusive impact of neglect is complex. Thus districts with higher averages in neglect often have lower averages in emotional abuse.

Physical abuse

The proportion of children with a child protection plan due to physical abuse in Hyndburn is double that of any other district within Lancashire. This appears to reflect a reduction elsewhere in the numbers in this category rather an increase in Hyndburn's figures.

Sexual abuse

In Ribble Valley, 71.4% (5 out of 7) of the children with a child protection plan have a plan due to sexual abuse. None of those subject to a plan in Chorley or West Lancashire fall into this category.

Children looked after

While education plays a key role in the transmission of advantage and disadvantage across generations, one of the most powerful predictors of social exclusion in adult life is the experience of being in care. There is a well established link between deprivation and children coming into care such as unemployment, low income, inadequate accommodation and lone parent status; factors in other words that threaten the stability of family life. (Kent JSNA 2010)

The poor educational participation and performance of many children who are looked after has become a national concern not least because educational disadvantage leads to disadvantage in other areas. Frequent movement within the care system, school exclusion and non-attendance have been linked to educational under achievement. Some estimates suggest that children who are looked after are ten times more likely to be excluded than those outside the care system (Brodie 2000: Goddard 2000). As an illustration, nationally in 2009, only one in ten of children looked after obtained at least five GCSEs grades A*-C including English and Maths compared to over half of all children (DfES 2004). Children who are looked after in Lancashire are also shown to be more likely to be NEET than their peers (see [NEET](#) section).

There is a high incidence of mental health problems and psychiatric disorders among looked after children (DfES 2004). The poor mental health of children living in residential homes in part reflects placement decision and patterns in response to children and young people's needs. Teenagers with severe behavioural difficulties are more likely to be placed in residential care than in foster homes. Young people who are looked after are at greater risk of becoming involved in risky behaviour which may include abusing substances (see section on [alcohol and drug misuse](#) in secondary chapter).

Higher than average rates of poor mental health and anti-social behaviour combined with low educational attainment significantly increase the likelihood that looked after children will experience social exclusion in later life. 2009 national data suggests that around 7% of young people were not in education, employment or training, where as in care leavers, this is nearer 40%. (Source: DCSF LAIT / LCC Young People's Service)

Research and experience shows that unemployment and insufficient support from care to adult life, place care leavers at additional risk of homelessness (see young people chapter for further discussion of [youth homelessness](#)). 20% of care leavers will experience some form of homelessness within two years of leaving care. Over a quarter of prisoners were in care at some point during their childhood. Young people who have been in care are two and a half times more likely to become teenage parents and the children of women who have spent time in care are

themselves two and a half times more likely to go into care than their peers (see young people chapter for further discussion of [teenage pregnancy](#)).

Residential care in Britain continues to be seen as a last resort. Young people living in residential homes will remain one of the most vulnerable groups in respect to both social exclusion and health inequalities. In Lancashire, the aim of policy and strategy remains to prevent the need for children to become looked after. Despite upward pressures in activity within the social care service, numbers of children looked after have remained quite stable.

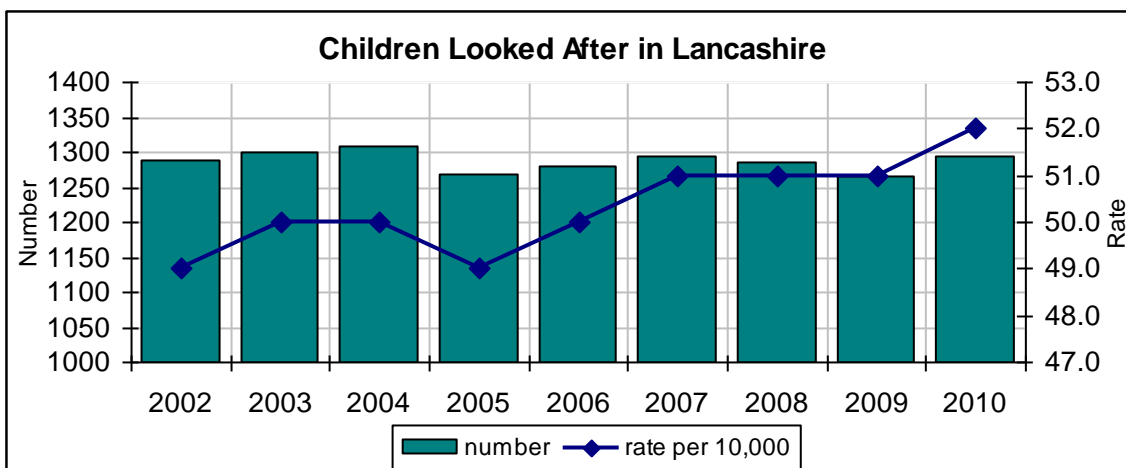
The number of children looked after aged 0-18 years in Lancashire is illustrated in the figure below. The number of children looked after in Lancashire has remained relatively stable, fluctuating between 1265 and 1310 since 2002. There has been an increase in the rate of children looked after, which reflects the reducing population aged 0 to 17 years whilst the numbers of children looked after have remained stable. In recent years the rate has remained around 51 per 10,000 under 18s. This is slightly below the national rate which has also remained stable at around 55 per 10,000.

Table 198: CLA aged 0-17 years in Lancashire per 10,000 population, 2002 to 2010

	2002	2003	2004	2005	2006	2007	2008	2009	2010
number	1290	1300	1310	1270	1280	1295	1285	1265	1293*
rate per 10,000	49	50	50	49	50	51	51	51	52*
England rate	52	54	55	55	55	55	54	55	n/a

*Provisional data
Source: CYP Commissioning Team / DCSF Information Gateway

Figure 92: CLA aged 0-17 years in Lancashire per 10,000 population, 2002 to 2010



Source: CYP Commissioning Team / DCSF Information Gateway

At district level, Preston has the highest number of children looked after, with Ribble Valley having the fewest. However, rates are a more meaningful way of analysing such data due to differences in the size of the populations of interest. When expressed as a rate per 10,000 under 18s, both

Pendle and Hyndburn have rates above that of Preston (84 per 1,000 and 76 per 1,000 compared to 74 per 1,000), whilst Ribble Valley is again the lowest.

Table 199: CLA aged 0-17 years by district per 10,000 population, March 2010

	Number	Rate per 10,000
Burnley	147	72.0
Chorley	87	39.8
Fylde	31	22.4
Hyndburn	151	76.0
Lancaster	118	43.0
Pendle	177	84.2
Preston	213	73.7
Ribble Valley	21	16.7
Rossendale	101	64.2
South Ribble	63	28.0
West Lancashire	130	54.9
Wyre	54	25.5

Source: LCC CYP Commissioning Team

Nearly three quarters of the children looked after in Lancashire are in a foster placement. This includes foster placements both within the authority and outside the authority along with placements through external fostering agencies. This large proportion of placements being foster placements is consistent across all parts of the county. There is currently a large recruitment drive taking place across the county to increase the number of foster carers.

Table 200: Children looked after in Lancashire by placement type, March 2010

	East Lancs		Central Lancs		North Lancs		County	
	#	%	#	%	#	%	#	%
Foster Placement	437	73%	344	69%	140	69%	921	71%
Residential (Children's Homes)	51	9%	68	14%	24	12%	143	4%
Residential (Other)	10	2%	21	4%	4	2%	35	3%
Placed with parents	56	9%	47	9%	14	7%	117	9%
Placed for adoption	23	4%	11	2%	16	8%	50	4%
Other	20	3%	6	1%	5	2%	31	2%

Source: LCC CYP Commissioning Team

The majority of children who are looked after are looked after due to abuse or neglect, with the next highest number due to family dysfunction.

Table 201: Children looked after in Lancashire by primary category of need, March 2010

	Not stated	Abuse or neglect	Child illness / disability	Parental illness / disability	Family in acute stress	Family dysfunction	Socially unacceptable behaviour	Absent parenting	Other	Unallocated	Total
Burnley	<5	114	<5	<5	<5	8	5	5		<5	147
Chorley	<5	62	5	<5	<5	7	<5	<5	<5	<5	87
Fylde		24	<5			<5	<5	<5			31
Hyndburn		130	<5	<5	7	6	<5			<5	151
Lancaster		84	7	<5	5	12	<5	5	<5		118
Pendle	<5	133	<5	8	16	12	<5	<5	<5	<5	177
Preston	<5	126	8	10	18	31	5	<5	7	5	215
Ribble Valley		14			6	<5					21
Rosendale		67	<5	<5	9	10		<5		<5	101
South Ribble		41	<5	<5	7	9	<5			<5	64
West Lancashire	<5	79	<5	10	8	25	<5	<5		<5	131
Wyre		42	<5	<5	<5	7					54
Lancashire	7	916	37	44	86	131	25	22	10	19	1297

Source: LCC CYP Commissioning Team
Numbers less than 5 are suppressed to protect confidentiality

The majority of children looked after in Lancashire are white (93%), with the next highest proportion being of mixed race (5%).

Table 202: Children looked after in Lancashire by ethnicity, March 2010

	White	Mixed	Asian or Asian British	Black or Black British	Chinese or other ethnic	Unknown
Burnley	139	<5	<5			
Chorley	79	<5		<5	<5	
Fylde	30	<5				
Hyndburn	137	7	7			
Lancaster	115	<5	<5			
Pendle	157	12	7		<5	
Preston	194	15	<5		<5	<5
Ribble Valley	21					
Rosendale	96	5				
South Ribble	59	5				
West Lancashire	123	5		<5	<5	
Wyre	52	<5				
Lancashire	1202	61	21	5	7	<5

Source: LCC CYP Commissioning Team
Numbers less than 5 are suppressed to protect confidentiality

The majority of children looked after in Lancashire are subject to a care order (47% have a full care order and 28% have an interim care order).

Table 203: Children looked after in Lancashire by legal status, March 2010

	Care Orders: interim	Care Orders: full	Voluntary agreements under S20	Freed for adoption	On remand, committed for trial or detained	Emergency orders or police protection	Placement order
Burnley	28	85	19				15
Chorley	31	31	20			<5	<5
Fylde	9	15	<5				<5
Hyndburn	35	85	16	<5	<5		10
Lancaster	36	42	17	<5	<5	<5	19
Pendle	50	95	16				16
Preston	63	72	65				15
Ribble Valley	<5	15	<5				<5
Rossendale	23	55	17	<5			5
South Ribble	22	27	15				
West Lancashire	37	64	26				<5
Wyre	20	27	<5				<5
Lancashire	358	613	218	6	<5	<5	96
Source: LCC CYP Commissioning Team							
Numbers less than 5 are suppressed to protect confidentiality							

Care leavers

Children who are looked after by the local authority have a lower level of educational attainment than the average as shown in the primary and secondary chapters. For this, and other reasons related to their being in care, care leavers experience high levels of unemployment and are at risk of homelessness and social exclusion. Although Lancashire's performance around care leavers in education, employment or training has improved significantly, from 42.9% in 2007-08 to 57.7% in 2009-10, performance is still below both national and statistical neighbour averages. Further discussion of care leavers and those in [education, employment or training \(EET\)](#) is provided in the young people chapter.

Table 204: Care leavers in education, employment or training (NI148)

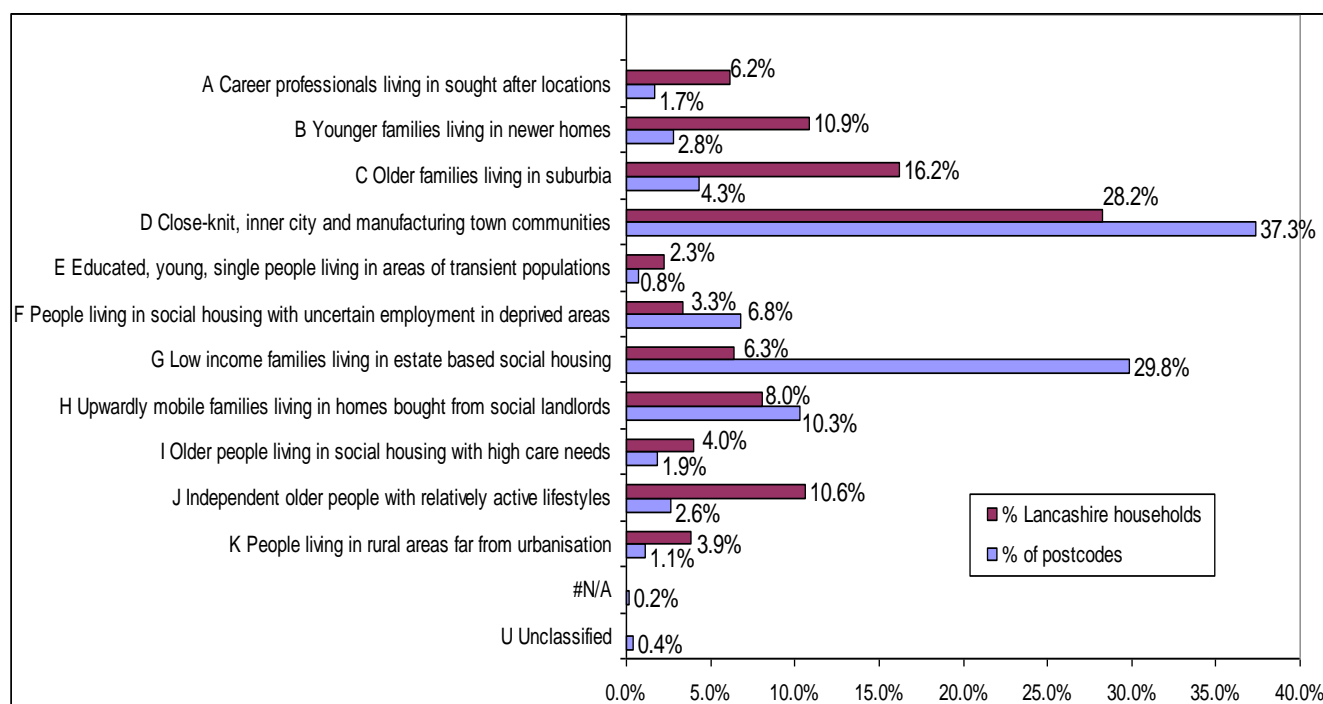
	2006/07	2007/08	2008/09	2009/10
Lancashire	50.0%	42.9%	52.0%	57.7%
Statistical Neighbours	66.6%	59.0%	58.4%	62.1%
England	63.0%	64.9%	63.0%	62.1%
Source: Department for Children, Schools and Families				

MOSAIC profiling of looked after children

Mosaic profiling the origins of looked after children

Geodemographic profiling of the looked after children in terms of the address from their original home (in many cases their family home) has been conducted using Mosaic profiling data. Using MOSAIC categorisations (an older version than that which is currently used) provides a breakdown of Lancashire households by type and shows a great over-representation of looked after children from low income families living in estate based social housing (social group G). Almost 30% of children who were looked after by the authority came from this group whereas only 6% of households in Lancashire are in this group. To a lesser extent there was over-representation of children from families in close-knit inner city and manufacturing town communities (group D) and people living in social housing with uncertain employment in deprived areas (group F).

Figure 93: Origins of children who are looked after by social group, using Mosaic (pre 2009 version)



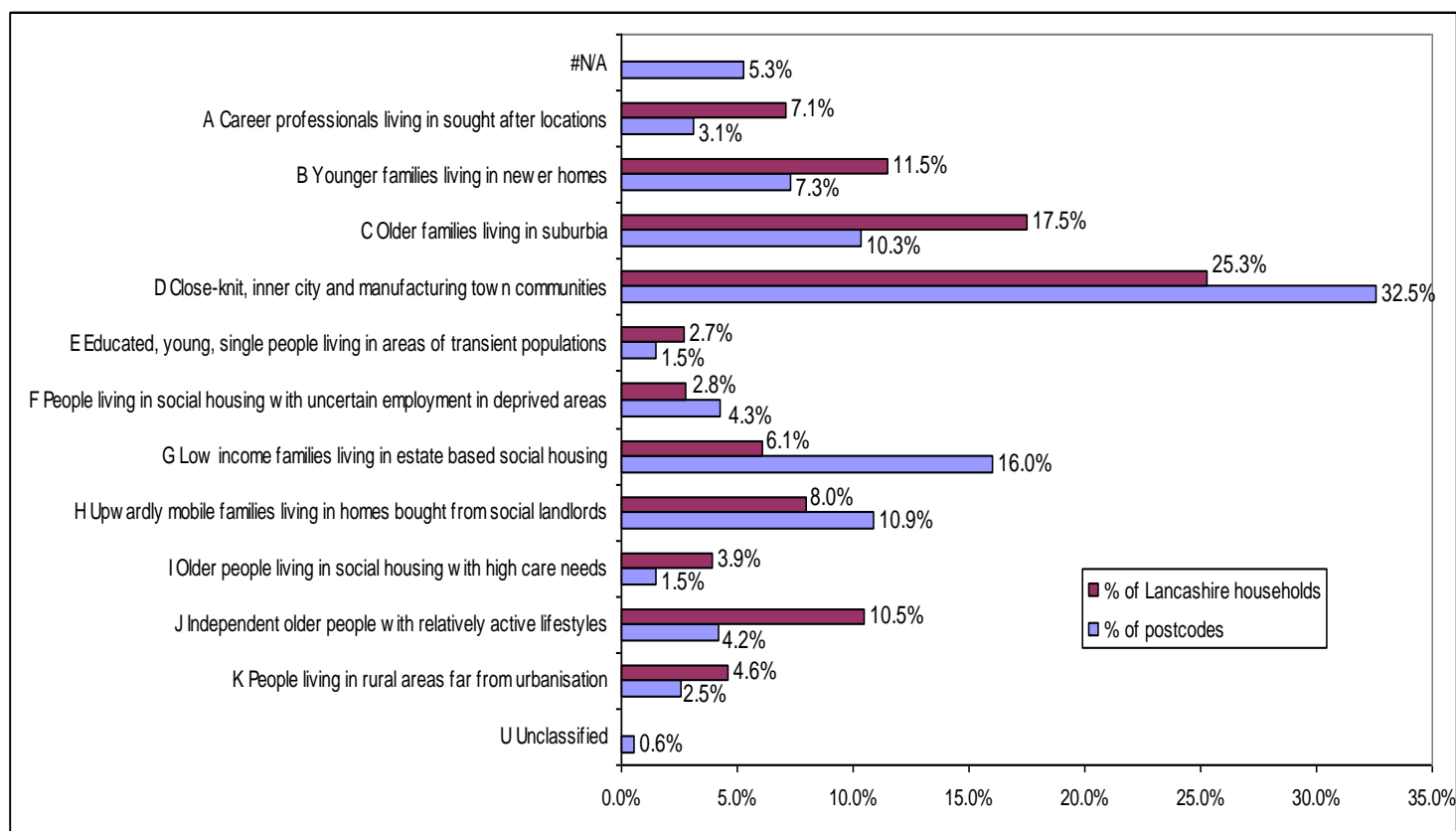
Mosaic profiling of children in care placements

Mosaic profiling was also used to profile children who were in care placements at the end of January 2010. Profiling was conducted based on the location of the child in placement, mainly foster care and residential establishments. The looked after children profiled were aged up to 22 years as social services remain responsible for providing a service to care leavers. These young people, aged in the main between 18 and 21, were living in a range of settings including lodging with previous foster carers, with birth family or independently.

The groups most over-represented were low income families living in estate based social housing (G) by 10% and close-knit inner city and manufacturing town communities (D) by 7%. Others over-represented were upwardly mobile families living in homes bought from social landlords (H) by 3% and people living in social housing with uncertain employment prospects (F).

The groups most under-represented were older families living in suburbia (C) and older people with relatively active lifestyles (J).

Figure 94: Socio-demographic profiling of the children in care placements by Mosaic category, Jan 2010

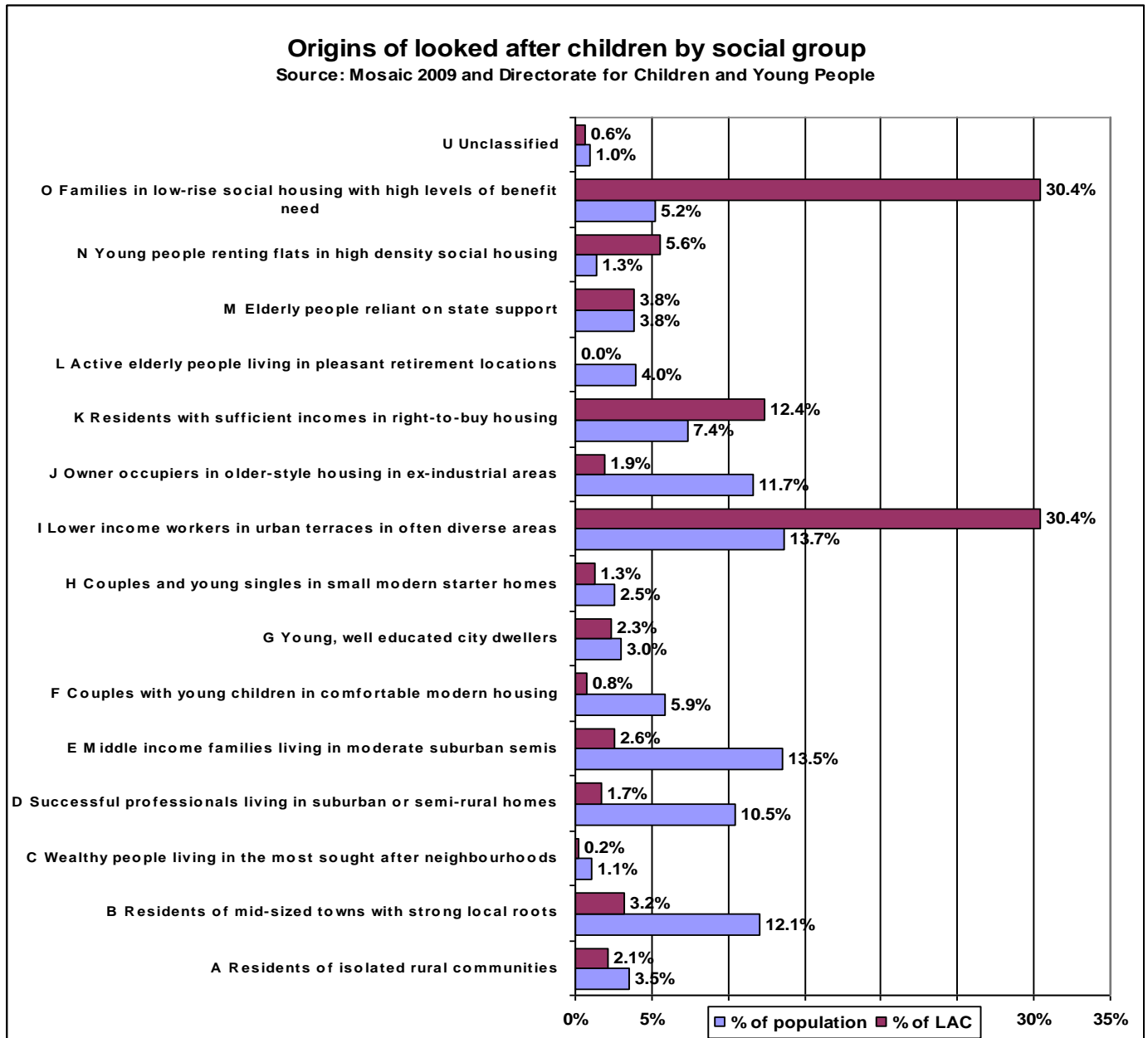


An interesting pattern emerges from this analysis. The same patterns are found in the social groups of both the origins of looked area children and their placements. This may well be the policy to house children in similar areas. However, the life cycle model argues that it is the accumulation of factors over a child's life that determines their outcomes. Although they have been removed from their original home, they are being moved to a new home where a lot of the same conditions will apply in terms of the broader social determinants of wellbeing and therefore the desired impact on outcomes might not be realised.

Since the initial analysis was complete, a new version of Mosaic has been released which benefits from updated profiles to reflect changes in how the population live. There are more groups and types which allows a greater degree of differentiation of households. Using the new Mosaic profiling, children who were looked after predominantly came from families in low-rise social

housing with high levels of benefit need and lower income workers in urban terraces often in diverse areas (groups O and I). Together over 60% of children who were looked after came from these two groups. 12% of children who were looked after were from households of residents with sufficient incomes in right to buy social housing (group K).

Figure 95: Origins of children who are looked after by social group using Mosaic 2009, Jan 2010



Source: Lancashire County Council. Based on a snapshot of LAC at September 2008. Base is 533 records with home postcodes.

It would be worthwhile repeating the analysis for the placements of looked after children to check whether the patterns once again are reflected. Another issue of concern for looked after children relates to situations where children are looked after considerable distances from their homes, in particular when they are looked after outside of the county. Further work is needed to understand

the distances from home involved in placements for looked after children and the impacts that this has.

Children with disabilities and learning difficulties and disabilities

Disability

Disabilities have become a more significant aspect of child health as acute illnesses have become less common. Due to advances in medical science more children are surviving with very complex medical conditions and significant disabilities. This places a challenge on children's services. Quality of life is a major consideration for both parents and children. Expectations of health, children's social care and education services are high and treatments available are costly. The demands on professionals are great especially in the context of resources that must have some limitations. This can result in family frustrations and stress as parents feel they have to fight for what their children need.

Children with long-term disability are a diverse group. Some will have highly complex needs requiring multi-agency support across health, social services and education – the most extreme example perhaps being those who are technology-dependent. Other children will require substantially less support, although they may have a long-term need which services are required to address.

The Department for Children's, Schools and Families (DCSF) which operated under the previous government stated that:

- Disabled children and young people currently face multiple barriers which make it more difficult for them to achieve their potential, to achieve the outcomes their peers expect and to succeed in education.
- 29% of disabled children nationally live in poverty.
- The educational attainment of disabled children is unacceptably lower than that of non-disabled children and fewer than 50% of schools have accessibility plans.
- Disabled young people aged 16-24 are less satisfied with their lives than their peers and there is a tendency for support to fall away at key transition points as young people move from child to adult services.
- Families with disabled children report particularly high levels of unmet needs, isolation and stress.

- Only 4% of disabled children are supported by social services. A report by the Audit Commission in 2003 found that there was a lottery of provision, inadequate strategic planning, confusing eligibility criteria, and that families were subject to long waits and had to jump through hoops to get support.
- The prevalence of severe disability is increasing.

Prevalence of disability

Measurement of prevalence remains a challenge. A major series of Office of National Statistics (ONS) studies in the late 1980s showed that behavioural problems represent the most common category of functional disability. There have been many attempts to provide accurate estimates of disability in children and young people. Some of these have provided condition based estimates based on the literature and others have utilised specific survey data. Information on self-reported (by the parent) long-standing illness or disability is provided from the General Household Survey. Routine data are collected by local authorities on children with statements of Special Educational Needs, but this does not reflect the spectrum of disability and is only a weak proxy measure for severity. Local authorities develop their own criteria for initiating statutory assessment and providing funding to address additional need.

Defining disabled children is not straightforward as there are several definitions and systems used. The definition from the section 17 Children Act 1989 is the most restrictive as it only includes children with severe impairments and is based upon the medical model of disability. From Government estimates, there are approximately 2,000 children with a severe disability in Lancashire.

However, estimates calculated for the Aiming High for disabled children initiative put the number closer to 2,300 children. The Children in Need Census provides a further source of information on children classed as having a disability. This source reports the number of children who are recorded as receiving "social care services" and puts the number at almost 2,500 in Lancashire. This will obviously be an underrepresentation of the number of children with disabilities as not all will be receiving social care support.

Table 205: Numbers of disabled children reported in the Children in Need Census, 2009/10

Disabilities	Nos.
AUT - Diagnosed with autism or Asperger's syndrome	240
BEH - Behaviour	178
COMM - Communication	415
CON - Consciousness	95
DDA - Disabled under DDA but not in above categories	49
HAND - Hand function	57
HEAR - Hearing	57
INC - Incontinence	78
LD - Learning	644
MOB - Mobility	380
PC - Personal care	215
VIS - Vision	88
Total	2496
Source: Children in Need (CiN) Census 2009-10	

The Disability Discrimination Act (1995) provides a further definition, which is considered more in line with a social model of disability as it includes those who have a condition which prevents their full access to work, education, social activities and so on. Children in Lancashire who fall into this definition are said to have “additional needs” and includes children with emotional or behavioural disorders and specific learning disabilities such as dyslexia, who wouldn’t normally be considered disabled. The size of this cohort is measured at approximately 16,000 and is by far the largest estimate (Lancashire JSNA 2009). Further discussion of [learning difficulties and special educational needs](#) follows in the next section.

The Thomas Coram Research Unit estimates national prevalence rates of between 3% and 5.4%. Applying these figures to Lancashire's population suggests between 8.4 and 15.1 thousand children and young people (aged 0-19) experience some form of disability. The figures by district are provided in the [appendix](#).

The broad range of estimates, from a low of 2,000 up to 16,000 highlights how broad the term disability is and therefore how difficult it is to understand the numbers of disabled children in Lancashire. However, what is known for certain is that they experience poorer outcomes than non-disabled children and services should be in place to support them and close the gap.

[Learning disability](#)

The Department of Health suggests that the number of people with severe learning disabilities may increase by 1% per annum for the next 15 years. This is a result of:

- increased life expectancy among children with Down’s Syndrome;

- Growing numbers of children and young people with complex and multiple disabilities who now survive into adulthood;
- A sharp rise in the reported numbers of school age children with Autistic Spectrum Disorders, some of whom have learning difficulties.;
- Greater prevalence of certain conditions among some minority ethnic populations of South Asian origin.

As with physical disabilities, measurement of learning disabilities is also challenging, particularly as the definitions applied by different services vary within children's services. Educational services are focused as much on learning difficulties as learning disabilities and consequently differing definitions are used between education and social care services for children.

Valuing people, the 2001 White paper on the health and social care of people with learning disabilities provides a working definition of learning disabilities, although it appears this is developed primarily with adults in mind:

"Learning disability includes the presence of:

- *A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;*
- *A reduced ability to cope independently (impaired social functioning);*
- *Which started before adulthood, with a lasting impact on development."*

Learning difficulties is a term often used interchangeably with learning disabilities when discussing adults. However, for children's educational services, the term 'learning difficulty' also includes people who have specific learning difficulties such as dyslexia but do not have a significant impairment to intelligence and would therefore not be considered to have a learning disability. The special educational needs (SEN) codes of 'moderate learning difficulty', 'severe learning difficulty' and 'profound multiple learning difficulty' taken together are considered interchangeable with the adult and social care term 'learning disability' by the Learning Disabilities Observatory: Improving health and lives (Emerson and Heslop 2010).

The observatory provides guidance on identifying children with learning disabilities, suggesting that children will be considered to have a learning disability if they meet any of the following criteria:

- They have been identified within education services as having a Special Educational Need (SEN) associated with 'moderate learning difficulty', 'severe learning difficulty' or 'profound

multiple learning difficulty'. Children aged 7 or older should be at the School Action Plus stage of assessment or have a Statement of SEN. Younger children should also be included if they are at the School Action stage of assessment of SEN.

- They score lower than two standard deviations below the mean on a validated test of general cognitive functioning (equivalent to an IQ score of less than 70) or general development. Care should, however, be taken when considering the results of tests, especially tests carried out in English on children below the age of 7 living in bi-lingual households or households where English is not spoken.
- They have been identified as having learning disabilities on locally held disability registers (including registers held by GP practices or Primary Care Trusts).

There are no national data sets of autistic children, or for those with a learning disability. Using the guidance above it is possible to consider national estimates and compare them with the local results of the school survey to understand how appropriate and useful national estimates would be, but also to understand if we are failing to identify children with learning disabilities.

Emerson & Hatton (2008) estimated that 2% of the total population has a learning disability. They provide estimates of prevalence in children and young people by age group. Applying these prevalence rates to the mid-year 2008 population estimates suggests that almost 4,360 children aged 5-19 are likely to have a learning disability in Lancashire. The categories of 'moderate learning difficulty', 'severe learning difficulty' and 'profound multiple learning difficulty', which together are taken to measure learning disability, add up to a total of 4,246 children in Lancashire (see the section below on [special educational needs](#)).

The close matching of these numbers show that Lancashire is in line with the national estimates for learning disabilities, which may be taken as a measure of success on the part of services involved in identifying such children. This also suggests that the use of national estimates may be appropriate for the planning of services in Lancashire. Full estimates by district and age groups are included in the data [appendix](#). These estimates and projections do not account for any increasing prevalence.

Table 206: Learning disability prevalence in children and young people aged 5-19 years

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	4360	4322	4259	4187	4110	4067
Central Lancashire	1659	1662	1641	1611	1589	1574
East Lancashire	1525	1490	1464	1432	1405	1389
North Lancashire	1177	1168	1154	1138	1115	1101
Burnley	343	333	324	312	304	301
Chorley	363	358	353	349	345	341
Fylde	244	236	232	230	227	223
Hyndburn	335	329	326	319	312	307
Lancaster	548	556	550	544	532	523
Pendle	352	344	338	331	324	321
Preston	496	514	514	502	494	491
Ribble Valley	224	219	216	215	211	211
Rossendale	271	265	260	256	253	248
South Ribble	385	380	370	364	360	354
West Lancashire	416	410	404	397	391	388
Wyre	385	376	372	364	356	355

Source: Chimat, Emerson and Hatton 2008

Children with learning disabilities are known to experience poorer mental health and wellbeing. A 40% prevalence of mental health problems is associated with learning disability as reported in the Foundation for People with Learning Disabilities publication "Count Us In" (2002). Applying this to population estimates for children and young people with Learning Disabilities suggests that there could be 1,744 in Lancashire with emotional wellbeing and mental health needs. Full district estimates by age group are provided in the [appendix](#).

Table 207: Learning disability and mental health problem prevalence in children and young people aged 5-19 years

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	1744	1729	1704	1675	1644	1627
Central Lancashire	664	665	656	644	636	630
East Lancashire	610	596	585	573	562	556
North Lancashire	471	467	462	455	446	440
Burnley	137	133	129	125	122	120
Chorley	145	143	141	140	138	137
Fylde	98	94	93	92	91	89
Hyndburn	134	132	130	127	125	123
Lancaster	219	222	220	218	213	209
Pendle	141	137	135	132	130	128
Preston	198	206	206	201	197	196
Ribble Valley	90	88	87	86	85	85
Rossendale	108	106	104	102	101	99
South Ribble	154	152	148	145	144	142
West Lancashire	166	164	161	159	156	155
Wyre	154	150	149	145	143	142

Source: Chimat, The Foundation for People with Learning Disabilities "Count Us In" 2002)

Learning difficulties and special educational needs (SEN)

The SEN code of practice defines children as having special educational needs if they have a learning difficulty which calls for special educational provision to be made for them. Children may have a learning difficulty if they:

- Have a significantly greater difficulty in learning than the majority of children of the same age; or
- Have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for children of the same age in schools within the area of a local education authority
- Are under compulsory school age and fall within the definition of either of the two points above or would do so if special educational provision was not made for them.

Children with special educational needs generally perform less well at the various key stages. A discussion of the educational attainment of children with special educational needs can be found in the chapters on [primary](#) and [secondary](#) years. Young people with special educational needs (and disabilities and learning disabilities) are also more likely to become NEET than their peers (see section on [NEET](#)).

The school census is conducted in each academic year and provides a comprehensive data set on the children present in school on that day. In January 2010, 14,689 children in Lancashire were recorded by schools as having a special educational need. Almost a quarter of these, 3,478 children, were recorded as having a moderate learning difficulty. A further 20%, 2,905, were recorded as having behavioural, emotional and social difficulty (see the section on children and young people with [emotional wellbeing and mental health](#) needs for further discussion). Approximately a further 2,000 children also have speech, language and communication difficulty and specific learning difficulty.

Table 208: Lancashire school census results by SEN category, January 2010

Phase	Nursery	Primary	Secondary	Special	Sixth Form	Total
Autistic spectrum disorder	7	398	316	374	8	1,103
Behavioural, emotional and social difficulty	2	1,272	1,266	359	6	2,905
Hearing impairment	3	189	186	32	9	419
Moderate learning difficulty	4	1,866	1,026	576	6	3,478
Multi-sensory impairment	1	4	4	6	0	15
Other	5	397	544	13	8	967
Physical disability	10	347	248	97	17	719
Profound and multiple learning difficulty	1	17	2	233	1	254
Speech, language and communication difficulty	30	1,672	384	118	8	2,212
Severe learning difficulty	0	66	20	428	0	514
Specific learning difficulty	1	864	991	33	16	1,905
Visual impairment	4	102	76	9	7	198
Total	68	7,194	5,063	2,278	86	14,689

Source: Lancashire School Census January 2010

The table below outlines the numbers of statements of special educational need within Lancashire. Over recent years in Lancashire there has been a continued decrease in the number of statements of special educational needs (SEN) issued for pupils of secondary school age due to the impact of Enhanced Early Years Action Plus (EEYAP) and Enhanced School Action Plus (ESAP) funding. This funding provides intervention so that children and young people can have their needs met at an earlier stage, without the need for the statutory assessment process. Children and young people whose needs cannot be met through ESAP funding can still request a statutory assessment, which may lead to the issuing of a statement. A description of the levels of special educational need support is provided below:

Early Years Action: *When an education practitioner who works day-to-day with the child identifies a child with special educational needs they should devise interventions that are 'additional to' or 'different from' those provided as part of the school or setting's usual curriculum offer and strategies. This is classed as Early Years Action.*

Early Years Action Plus *If the intervention does not enable the child to make satisfactory progress the setting or school Special Educational Needs Co-ordinator (SENCO) may need to seek advice and support from external agencies. These forms of intervention are characterised by the involvement of external support services who can help education settings with advice on new Individual Education Programmes (IEP) and targets, provide more specialist assessments, give advice on the use of new or specialist strategies or materials, and in some cases provide support for particular activities.*

For a few children the help given through Early years Action Plus is not be sufficiently effective to enable the child to progress satisfactorily. It will then be necessary for the setting, in consultation

with the parents and any external agencies already involved, to consider whether a statutory multi-disciplinary assessment may be appropriate.

Statutory Assessment and Statement of SEN: If the statutory assessment confirms that the assessment and provision made by the school or PVI setting is appropriate but the child is nonetheless not progressing sufficiently well, the LEA should consider what further provision may be needed and whether that provision can be made within the school's or setting's resources or whether a statement is necessary. Where it is necessary for the LEA to determine the special educational provision which the child's learning difficulty calls for, the LA shall make and maintain a 'Statement of Special Educational Needs'. The 'Statement' will then specify clearly the provision necessary to meet each identified need.

Table 209: Numbers provided with support for special educational needs, 2006/07 to 2008/09

District: Lancashire	2006/07	2006/07	2007/08	2007/08	2008/9	2008/9
Pupils with Statements	6459	3.8%	6017	3.6%	5623	3.4%
Pupils at School Action Plus	7169	4.2%	8186	4.9%	8770	5.4%
Pupils at School Action	15384	9.1%	15612	9.4%	15292	9.3%
Pupils with no SEN	140341	82.9%	136882	82.1%	133939	81.9%

The table below highlights the primary type of special educational need for which the statement is issued. Some of these figures are out of line with those reported by the school census. For example, 514 children are reported to have a severe learning difficulty according to the school census, but the table below shows that 650 children have a statement due to severe learning difficulty. The data reported below is taken from Impulse, which is the system used by Lancashire Council for the recording of information on children educated in Lancashire. The data is entered by the SEN teams who are responsible for administering the children's statements. The data from the school census returns represents the schools' views of the special educational need. Ideally, these should align but may result in differences such as highlighted for severe learning difficulties.

More than a fifth of these statements are issued for moderate learning difficulty, which is below the overall prevalence of this type of SEN in the population as measured by the School Census. When compared against the numbers reported in each SEN type in the school census it is clear that children with severe learning difficulties, autistic spectrum disorder, physical disabilities, visual impairment and multi-sensory impairment are most likely to have a statement of special educational need.

Table 210: Special educational needs statements by primary SEN category, January 2010

LCC Statements by Primary SEN Type		
Primary SEN Type	Numbers	% of total
Autistic spectrum disorder	1,018	17.1%
Behavioural, emotional and social difficulty	821	13.8%
Hearing impairment	199	3.3%
Moderate learning difficulty	1,269	21.3%
Multi-sensory impairment	9	0.2%
Physical disability	634	10.6%
Profound and multiple learning difficulty	78	1.3%
Speech, language and communication difficulty	779	13.0%
Severe learning difficulty	650	10.9%
Specific learning difficulty	381	6.4%
Visual impairment	132	2.2%
Total	5,970	100%

Source: Impulse, January 2010

Autism

Autism spectrum disorders are on a continuum and the most widely accepted definition of autism was formulated by Wing and Gould (1978) when they identified the triad of impairments: impairment of social interaction; social communication; and imagination. The spectrum includes children and adults across the range of severity and intellectual ability, from severely impaired to high functioning (Aspergers Syndrome) and therefore not all will be considered to have a learning disability. Autistic spectrum disorders affect many more males than females.

The exact causes of autism are unknown. Autistic Spectrum Disorder (ASD) describes a range of lifelong disorders which can come under the definition of learning disabilities. They are characterised by difficulties in social interaction, communication and imagination. Those living with ASD may appear to be indifferent or aloof, insensitive to others needs and have difficulty with co-operating with other people. They may have language problems both understanding and normal verbal communication. They can have problems with inter-personal play and imaginative activities, preferring instead familiar routines and resisting change.

The European Union Commission highlights the problems associated with establishing prevalence rates for Autistic Spectrum Disorders. These include the absence of a long-term study of psychiatric case registers and inconsistencies of definition over time and between locations.

Nonetheless the Commission estimates that according to the existing information, the age-specific prevalence rates for 'classical autism' in the EU could be estimated as varying from 3.3 to 16.0 per 10,000. These rates could however increase to a range estimated between 30 and 63 per 10,000 when all forms of autism spectrum disorders are included. Debate remains about the validity and usefulness of a broad definition of autism.

A study in South East London identified a 1% prevalence rate of Autistic Spectrum Disorder in children aged between five and 16 years. Applying this to ONS mid-year 2008 population estimates suggests that there may be more than 1,600 children on the Autistic Spectrum across Lancashire. Considering the figures supplied by the school census, which reports 1,100 children on the autistics spectrum, this suggests that there could be a number of children who have not been identified and are therefore not receiving the support that would enable them to achieve their true potential.

Table 211: Estimates and projections of Autistic Spectrum Disorders in children aged 5-16 years

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	1671	1652	1640	1628	1615	1617
Central Lancashire	641	639	637	635	632	634
East Lancashire	594	582	577	570	567	567
North Lancashire	437	430	427	422	415	415
Burnley	131	128	127	125	124	125
Chorley	143	143	142	142	142	143
Fylde	95	92	92	92	91	90
Hyndburn	132	129	128	126	124	124
Lancaster	195	194	191	190	187	187
Pendle	138	135	135	133	132	133
Preston	188	190	191	190	189	190
Ribble Valley	88	86	86	85	84	84
Rossendale	105	103	101	101	102	102
South Ribble	150	148	147	146	146	146
West Lancashire	160	159	157	156	155	156
Wyre	146	144	143	140	138	139

Sources: SNAP prevalence estimates and ONS survey mid-year population estimates and projections

Emotional wellbeing and mental health

The emotional wellbeing and mental health needs of children and young people are as important as their physical health and are a vital safeguard to their future. The level of importance is highlighted by the fact that emotional wellbeing is central to each of the five Every Child Matters Outcomes.

The emotional wellbeing and mental health of our children and young people is vital – to them as individuals and to all of us. Failing to tackle emotional problems and mental disorders as early as possible creates significant social and economic costs. The presence of mental illness during childhood has been shown to lead to costs which are up to ten times higher during adulthood (National Advisory Council 2010).

Emotional wellbeing and mental health problems in children are associated with educational failure, family disruption, disability, offending and anti-social behaviour, placing demands on social

services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, continuing into adult life and affecting the next generation. Supporting children and young people with emotional wellbeing and mental health needs is not solely the responsibility of specialist child and adolescent mental health services (CAMHS). In many cases, the intervention that makes a difference will come from another service and early intervention is always preferable. As stated by the National CAMHS Support Service (<http://learning.camhs.org.uk>), tier one CAMHS services should be everybody's business. For example, a child presenting with behavioural problems may make better progress if his or her literacy problems are also addressed, in which case an input is required from education (DH 2004). Whilst it is a requirement to provide comprehensive CAMHS and we should clearly be providing interventions and treatment for those children with mental health problems, the focus should be on early intervention and prevention for all the population and creating the conditions to support positive mental health and wellbeing – that is, "everybody's business". A summary of the evidence base around mental health and wellbeing is provided in the [appendix](#).

There is strong consensus about what needs to be done, coming from many sources including the Marmot review of health inequalities (Marmot 2010), the CAMHS review (2008) and the Foresight report on mental capital and wellbeing (2008). The recent publication by NHS North West (2010) "Living Well across Local Communities, prioritising wellbeing to reduce inequalities" further promotes the importance of positive mental health and asset based approaches. It represents a call to action and sets out six statements of direction, one of which focuses on children and young people. Taken from the report:

Statement of direction 3: Children in all communities get the best start in life and young people are supported to become successful adults:

- This statement reflects the importance of early years and the transition to adulthood in achieving lifelong health and wellbeing (the Marmot review concludes this is the first national priority). The importance of strong intervention on early years at school, at home and in the community is echoed in other evidence too.
- It responds to the need to combat the cultural, social and environmental obstacles to health and wellbeing that particularly affect young people, including commercialism, peer pressure, poor transport systems, discrimination and exclusion, unemployment, low educational attainment, learning and development, family breakdown and unsafe

environments. It also responds to the need to create intergenerational trust and reciprocal relationships.

- This statement also recognises the need to integrate strategic work affecting children and young people in broader policies affecting the whole of society by including them explicitly.

Emotional wellbeing and mental health risk factors

Child poverty increases the risk of emotional wellbeing and mental problems in children and young people. Evidence shows that children at the lowest parental income levels experience triple the risk of emotional wellbeing and mental health difficulties compared to children and young people at the higher end of income levels. Children and young people living with a single parent have twice the risk of an emotional wellbeing and mental health problem of those living with two parents. (Kent JSNA 2010).

Adverse childhood experiences are clearly associated with higher incidence of childhood emotional wellbeing and mental problems. Growing up in households where there is a parent mis-using alcohol or drugs, experiencing mental illness, perpetrating domestic violence, committing sexual abuse, or undergoing divorce and separation are all risk significant factors and the higher the numbers of adverse events, the stronger the risk.

Vulnerable population groups include:

- Children who are looked after;
- Children and young people who offend;
- Young homeless;
- Those with learning disabilities and special educational needs;
- Young carers;
- Young carers living with parents with mental health problems;
- Young carers living with parents with substance misuse problems;
- Young people who are abused; and
- Young people in transition to adult services.

In any locality there should be clarity about how the full range of users' needs are to be met, whether it be the provision of advice for minor problems or the arrangements for admitting a young person with serious mental illness to hospital.

Clear pathways should be set out to show how the range of emotional wellbeing and mental health needs of children and young people will be met, whether from within services whose prime purpose is to deliver mental health care or from other services with a different primary function, particularly those focused on early intervention and prevention.

Identifying the opportunities to promote positive mental health, particularly focused on the roles that children and young people, their families, communities and schools can take should also be clear in localities. Children's trusts are particularly well placed to identify and support these arrangements. Opportunities for young people to get involved in designing services and solutions and in supporting each other are desirable as this focuses on the promotion of positive mental health and moves away from the idea of services intervening to solve "problems".

It is important to understand that parents whose children have emotional wellbeing and mental health problems may seek help from a variety of professionals and often from more than one service. Teachers are most likely to be the first professionals approached, followed by primary care professionals, highlighting the importance and opportunities available to promote positive mental health within communities.

Table 212: Professionals most commonly approached by parents whose children have emotional wellbeing and mental health needs

Professionals most commonly approached are:

- └ Teachers (40%)
- └ Primary health care professionals (30%)
- └ Specialist educational professionals, such as educational psychologists (25%)
- └ Specialist CAMHS (25%) who are seeing the most impaired young people (those with more than one diagnosis)
- └ Paediatrics (13%)
- └ Social Services (13%)

Positive events such as success at school (not necessarily academic) can increase self-efficiency, self-esteem and hence self-control over key life events, all of which promote resilience and personal wellbeing. Negative life events are risk factors for mental health and particular events that could take place at school include bullying, social isolation, conflicts with staff and exclusion. Schools therefore represent a key setting to reduce the chances of negative life events and increase positive life events.

Positive mental health and wellbeing

The Child Wellbeing Index provides an attempt by Government to measure this important issue. The index measures indicators over the topics of material wellbeing, health and disability, education, crime, housing, environment and children in need to provide a holistic picture of wellbeing. Child wellbeing in Lancashire is strongly correlated with deprivation ($R^2 = 93.6\%$) as is highlighted by the fact that the most deprived districts of Burnley, Pendle and Preston, all feature in the bottom quintile nationally for child wellbeing whilst the Ribble Valley not only features in the top quintile nationally but is in fact ranked as having the 2nd highest child wellbeing of all authorities in the country.

Table 213: Child wellbeing rank by district

District	Rank of average score	Percentile rank	Quintile
Burnley	323	91	Lowest 20% nationally
Chorley	132	37	2nd highest nationally
Fylde	49	14	Highest 20% nationally
Hyndburn	264	75	2nd lowest nationally
Lancaster	227	64	2nd lowest nationally
Pendle	300	85	Lowest 20% nationally
Preston	313	88	Lowest 20% nationally
Ribble Valley	2	1	Highest 20% nationally
Rossendale	193	55	Middle 20% nationally
South Ribble	133	38	2nd highest nationally
West Lancashire	225	64	2nd lowest nationally
Wyre	148	42	Middle 20% nationally

Source: Child Wellbeing Index, 2009

The Child Wellbeing Index provides a national rank for small areas. As a measure of poor wellbeing it is possible to consider the number of children in Lancashire who are resident in areas ranked as having wellbeing in the lowest 20% nationally. Across Lancashire 44,000 children, a fifth of all children aged 0 to 15 years in Lancashire, are living in such areas of low wellbeing. Children in Preston are the most affected as almost half live in areas with low levels of wellbeing. Burnley and Pendle are not far behind as more than 40% of children live in areas ranked as having some of the lowest levels of child wellbeing in the country.

Table 214: Numbers of children aged 0-15 living in areas ranked in the bottom quintile nationally for wellbeing

LA NAME	Children living in the areas of low wellbeing	Numbers of children aged 0-15	Proportion of children aged 0-15
Burnley	7,312	17,511	41.8%
Chorley	642	19,037	3.4%
Fylde	0	11,846	0.0%
Hyndburn	4,368	17,370	25.1%
Lancaster	3,978	23,649	16.8%
Pendle	7,696	18,284	42.1%
Preston	12,149	25,245	48.1%
Ribble Valley	0	10,632	0.0%
Rosendale	1,589	13,561	11.7%
South Ribble	635	19,671	3.2%
West Lancashire	3,962	20,455	19.4%
Wyre	2,076	18,114	11.5%
Lancashire	44,407	215,375	20.6%

Source: Child Wellbeing Index, Communities and Local Government

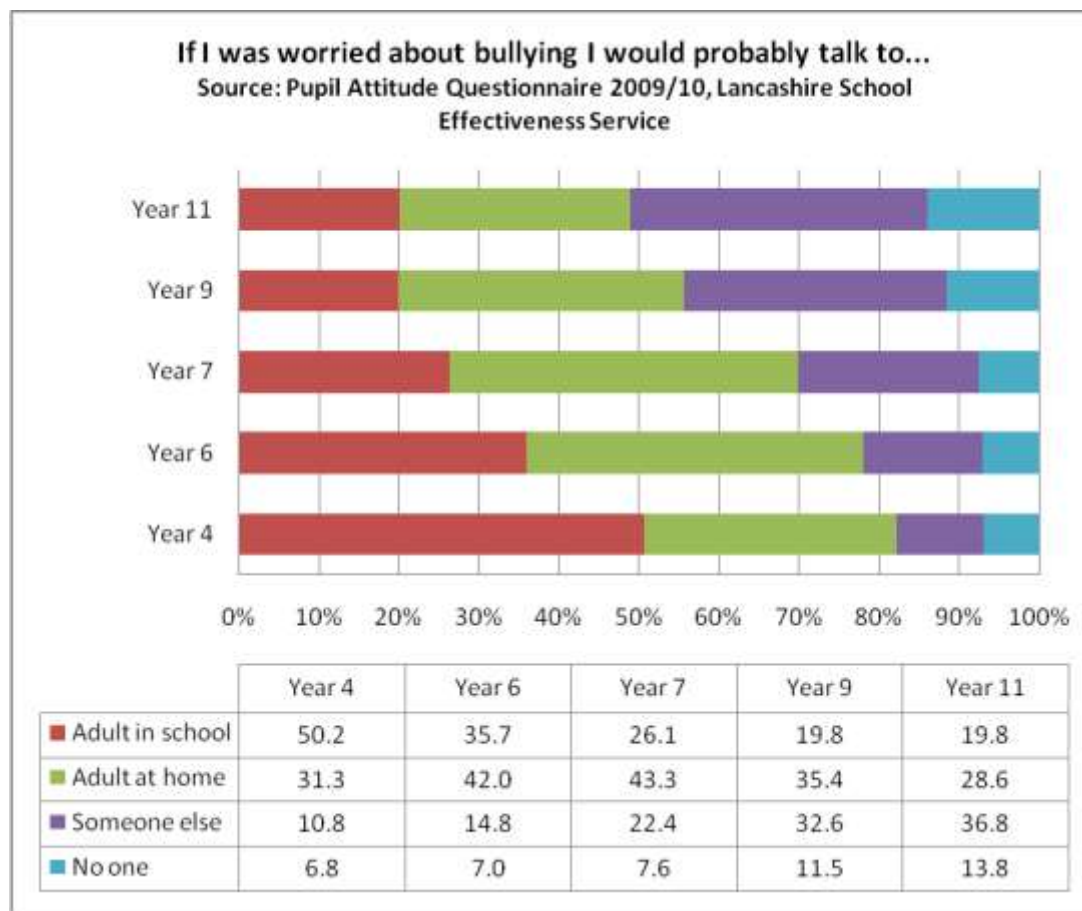
Bullying and racism

To promote positive mental health and wellbeing in the school setting important issues to tackle are bullying and racism. Bullying can have strong negative impacts upon the lives of children and young people and the growth in the use of mobile phones, email and social networking websites have created a new outlet for bullying in the form of cyber bullying.

Analysis from the 2009/10 Lancashire Pupil Attitude Questionnaire highlights that those in younger years of school experience the most bullying with rates reducing as school year increases. Bullying on the way to or from school is much less common than at school. Bullying on the way to or from school is most common in year 7 and year 9 children, which is likely to reflect the accompanied journey to school of young children. Further discussion of bullying is included in the [primary](#) and [secondary](#) chapters.

The experience of bullying is linked to the age of children, as is their response to it. There appears to be an increasing mistrust or reduction in confidence in adults as children age. This break down of intergenerational relations is reflective of a common theme in society as a whole. During year 4, more than 80% of children reported they would speak to an adult either at home or in school if they were concerned about bullying. This reduces to 77% in year 6, 69% in year 7, 55% in year 9 and fewer than half in year 11 who would confide in an adult. The majority of the shift is reflected in the numbers who report they would speak to someone else (the primary school children were given the examples of siblings or friends). A worrying pattern is seen in the proportions who would not speak to anyone, which doubles from 7% of children in year 4 to 14% in year 11.

Figure 96: If I was worried about bullying I would probably talk to, 2009/10



Schools in Lancashire have a duty to report racist incidents and the tables below highlight the numbers of racist incidents are reducing. However, there were still 485 racist incidents reported during 2008/09. These incidents were equally split between primary and secondary schools, which is a changing pattern as racist incidents were more commonly reported by secondary schools during 2006/07. It should be understood whether this reflects a greater level of success in tackling racism in secondary schools, an increasing reluctance of pupils to report racist incidents or something else entirely such as inaccuracies in data recording.

Table 215: Racist incidents across Lancashire by schools, 2006/07 to 2008/09

	August 06-July 07	August 07-July 08	August 08-July 09
Nursery	2	5	0
Infant	3	4	0
Junior	5	6	8
Primary	261	229	191
Short Stay	21	9	25
Special	79	57	79
Secondary	322	228	182
Other	3	0	0
Totals	696	538	485

Source: Lancashire County Council, Schools Effectiveness Service

In general the reduction in racist incidents at the county level has been mirrored across the districts. Particular reductions in the reporting of racist incidents were experienced in Preston as they fell from 122 incidents during 2006/07 to 62 in 2008/09. It is important to understand this pattern to be able to share best practice or tackle any issues which are leading to underreporting. Burnley is the noticeable exception to the general rule as there has been an increase in reported racist incidents between 2006/07 and 2008/09 (although with a reduced number of incidents in between).

Table 216: Racist incidents across Lancashire by education district, 2006/07 to 2008/09

	August 06-July 07	August 07-July 08	August 08-July 09
Lancaster & Morecambe	58	53	52
Wyre	38	36	26
Fylde	16	9	11
Preston	122	103	62
South Ribble	66	48	41
West Lancashire	46	27	40
Chorley	29	28	19
Hyndburn & Ribble Valley	94	54	63
Burnley	106	89	114
Pendle	75	63	43
Rossendale	37	21	14
Out County*	9	7	0
Totals	696	538	485

Source: Lancashire County Council, Schools Effectiveness Service

Measuring emotional wellbeing and mental health needs

The Child and Maternity Observatory, Chimat, offers a range of data to support CAMHS partnerships in assessing need. This prevalence data has been summarised here. It should be noted that the School Census provides measures of some overlapping conditions, particularly behavioural, emotional and social difficulties. These are presented in the section on children with [disabilities and learning difficulties and disabilities](#). The numbers there relate to the Special Educational Needs Code of Practice and do not tally with the estimates provided here. It is therefore necessary for the reader to make a judgement about which statistics they place greater value upon.

Emotional Disorders

Emotional disorders are the most common emotional wellbeing and mental health problem in children and include anxieties, phobias and depression. Anxieties and phobias are related to fear, which can be generalised or specific to a situation or object; for example school or separation from a parent. For a problem to be classified as a disorder, behaviour needs to present as an exaggeration of normal developmental trends.

The latest ONS survey provides prevalence of 4.3% for ages 5-16 (10% for girls aged 11 to 16 and 13% for boys). Estimates and projections for emotional disorders in children aged 5-16 years are in the table below.

Table 217: Estimates and projections of emotional disorders in children aged 5-16 years

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	7184	7104	7053	7001	6946	6952
Central Lancashire	2755	2749	2741	2730	2717	2728
East Lancashire	2553	2503	2482	2451	2436	2439
North Lancashire	1879	1851	1834	1813	1786	1786
Burnley	562	552	547	538	534	537
Chorley	613	614	612	611	609	614
Fylde	409	397	396	394	390	388
Hyndburn	568	556	551	541	535	531
Lancaster	840	836	823	815	803	802
Pendle	594	582	579	571	568	570
Preston	809	816	820	818	814	817
Ribble Valley	377	371	369	367	363	363
Rossendale	452	442	436	434	437	438
South Ribble	643	637	632	629	627	628
West Lancashire	690	682	676	673	667	669
Wyre	630	617	616	604	593	596
Sources: ONS survey prevalence 4.3% and 2008 population projections						

It is estimated nationally that 1% of children and 3% of adolescents suffer from depression in any one year. Symptoms include sadness, irritability and loss of interest in activities. Associated features include changes in appetite; sleep disturbance and tiredness, difficulty concentrating, feelings of guilt, worthlessness and suicidal thoughts.

Conduct Disorders

Typical behaviour includes unusually frequent and severe temper tantrums beyond the age that this is normally seen, severe and persistent disobedience, defiant provocative behaviour, excessive levels of fighting and bullying, cruelty to others or animals, running away from home and some criminal behaviour.

These children and adolescents typically have low self-esteem, often showing marked misery and unhappiness as a result of a high incidence of depression. Some of these children lack the social skills to maintain friendships and may become isolated from peer groups.

Harsh and inconsistent parenting is the major cause of conduct disorder, but hyperactivity and a low IQ may also contribute (Johnston C and Jassy JS 2007). Family dysfunction, low income and parental mental illness are other factors which contribute to the risk of adult problems.

A conduct disorder can affect a child's development and interfere with their ability to lead a normal life. In children and young people with conduct disorders there is a high correlation with youth offending, anti-social personality disorder and increased risk of abusing and becoming dependent on alcohol and to a lesser extent, illicit drugs.

The latest ONS estimates suggest that the prevalence of conduct disorders is 5.3% of people aged 5-16 years. Across Lancashire it is estimated there are more than 11,000 people age between five and 16 years with a conduct disorder.

Table 218: Estimates and projections of conduct disorders in children aged 5-16 years

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	8854	8757	8693	8629	8562	8569
Central Lancashire	3396	3389	3378	3364	3349	3362
East Lancashire	3147	3085	3059	3021	3003	3006
North Lancashire	2316	2281	2261	2234	2202	2202
Burnley	692	681	674	663	658	661
Chorley	756	757	755	753	750	757
Fylde	505	490	488	485	480	478
Hyndburn	701	685	679	667	659	655
Lancaster	1036	1030	1014	1005	990	989
Pendle	732	718	713	704	700	703
Preston	997	1006	1011	1008	1004	1007
Ribble Valley	464	457	455	453	447	447
Rosendale	558	545	537	535	538	540
South Ribble	793	785	779	775	773	774
West Lancashire	850	841	833	829	822	825
Wyre	776	761	759	744	731	735

Sources: ONS survey prevalence 5.3% and 2008 population projections

Attention Deficit Hyperactivity Disorder (ADHD)

Hyperkinetic disorder is the official term in the UK for describing children who are consistently over-active and inattentive. ADHD and Attention Deficit Disorder (ADD) are now more commonly used terms. ADHD is a neuro-biological disorder and there is more medical evidence for this than any other such disorder. It is primarily genetically inherited; however non-genetic factors have been linked to ADHD including exposure to lead, complications during pregnancy and delivery, premature birth, foetal exposure to alcohol or tobacco. The disorder is diagnosed many times more in boys than girls, however as differences in presentation may lead to referral bias, the existence in the overall difference of prevalence of ADHD in boys versus girls is debatable.

Children with hyperkinetic disorder may find it difficult to interact with other children and their inability to concentrate and restlessness at school impacts on their education and can be extremely disruptive to other pupils. Their behaviour can also put significant strains on family life. These

problems can persist into adult life. Children with hyperkinetic disorder are at greater risk of academic and occupational failure, self esteem issues, relationship problems, injury/accidents and substance abuse.

NICE guidelines (2008) demand that specialist ADHD teams for children and young people should develop age-appropriate training programmes for the diagnosis and management of ADHD for mental health, paediatric, social care, education, forensic and primary care providers; as well as for other professionals who have contact with people with ADHD. Parents or carers of pre-school children should be offered a referral to a parent training/education programme as the first line of treatment. School age children and young people with severe ADHD could be offered drug treatment. Such treatment should always form part of a comprehensive treatment plan to include psychological, behavioural and educational advice and intervention.

Medication such as methylphenidate can help treat hyperkinetic disorder, reducing the hyperactivity and improving concentration, although this is only a temporary effect. NICE (2008) guidelines state that medication should initially only be prescribed by a specialist after confirmed diagnosis. It can however be continued and monitored by a GP.

The latest ONS survey suggests hyperactivity prevalence of 1.4% of children aged 5-16 years. Applying this rate to population estimates suggest that more than 2,000 children are hyperactive in Lancashire.

Table 219: Estimates and projections of hyperactivity in children aged 5-16 years

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	2339	2313	2296	2279	2262	2264
Central Lancashire	897	895	892	889	885	888
East Lancashire	831	815	808	798	793	794
North Lancashire	612	603	597	590	582	582
Burnley	183	180	178	175	174	175
Chorley	200	200	199	199	198	200
Fylde	133	129	129	128	127	126
Hyndburn	185	181	179	176	174	173
Lancaster	274	272	268	265	262	261
Pendle	193	190	188	186	185	186
Preston	263	266	267	266	265	266
Ribble Valley	123	121	120	120	118	118
Rossendale	147	144	142	141	142	143
South Ribble	209	207	206	205	204	204
West Lancashire	225	222	220	219	217	218
Wyre	205	201	200	197	193	194
Sources: ONS survey prevalence 1.4% and 2008 population projections						

Self-harm and Suicide

Self-harm and suicide can be a symptom of underlying unhappiness or emotional disorder. Self-harm can include self-cutting, burning, hair-pulling or self-poisoning. It may be linked to suicidal thoughts and is a way of coping with problems, a means of taking control, or a form of release from painful feelings.

Depression, serious mental health problems and the misuse of drugs are all factors related to suicide attempts. Young people who have already tried to kill themselves, or know someone who has tried to kill themselves are also at greater risk of attempting suicide.

Suicide rates are very low in children, but start to increase from the age of 11. Boys and young men aged 15-24 are most at risk. A conservative estimate is that there are 24,000 cases of attempted suicide by adolescents (of 10-19 years) each year in England and Wales, which is one attempt every 20 minutes (Hawton et al, 1999). A Samaritans study found that four times more adolescent females self-harmed than adolescent males (Centre for Suicide Research, 2003).

The most recent data from the Office for National Statistics (ONS) suggest a national prevalence rate of 3.6 deaths per 100,000 population aged 15 to 19 years. If applied to the pan Lancashire population this equates to approximately four per year.

Table 220: Characteristics of those who self harm

The following information is taken from Hawley and James:

- Common characteristics of adolescents who self harm are similar to the characteristics of those who commit suicide.
- Young South Asian females in the United Kingdom seem to have a raised risk of self harm. Intercultural stresses and consequent family conflicts may be relevant factors.
- As many as 30% of adolescents who self harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self harm during the following year, with repeats being especially likely in the first two or three months.
- The risk of suicide after deliberate self harm varies between 0.24% and 4.30%. Our knowledge of risk factors is limited and can be used only as an adjunct to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a risk: being an older teenage male; violent method of self harm; multiple previous episodes of self harm; apathy, hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital.

Eating Disorders

These are more common in young women. Up to 1% of women are affected by anorexia nervosa, where the person eats very little, effectively starving themselves and between 1-2% bulimia nervosa which involves bingeing on food followed by induced vomiting or use of laxatives. The average age of onset of anorexia is 15 and of bulimia 18. Some eating disorders are associated with other underlying mental health conditions. Data is not available for Lancashire.

Alcohol and substance misuse

The use of alcohol and drugs can both exacerbate and trigger mental health problems: those with emotional wellbeing and mental health needs may be at greater risk of misusing drugs. For example, alcohol can be attractive to those suffering from depression because it increases confidence and may produce a feeling of wellbeing, drowning out problems in the short term. It is however, also a depressive and worsens the symptoms of depression, such as increasing the risk of suicidal thoughts. Further discussion of [alcohol and substance misuse](#) is provided in the secondary years chapter.

Comprehensive CAMHS

The 1999 ONS survey on the mental health of children and adolescents in Britain (Meltzer et al 2000) reports high rates of service use amongst those with emotional wellbeing and mental health problems including health, education, social services and the police. However, only a small (unknown) proportion receives treatment from CAMHS. In common with other countries, most children who need mental health services are not receiving specialised care.

To support children and young people with emotional wellbeing and mental health needs, however, a specialist service is not necessary or often appropriate. It is necessary that a full range of effective services are available including services for all groups of children and young people vulnerable to poor outcomes, ensuring the right balance between early intervention and more specialist services and agreeing complex pathways across many agencies. In short, there should be a graduated response to need where all services respond to emotional wellbeing issues meaning that only the children and young people with the higher end needs are accessing specialist services.

An appropriate model has three types of interventions focused on universal, targeted and specialist CAMHS:

- **Universal** services are focused on prevention, identification and early intervention of emotional wellbeing and mental health problems and are mainstreamed across health workers, local authority children's services, education and the voluntary sector.
- **Targeted services** are focused on those vulnerable children and young people and necessitate multi-agency working.
- **Specialist CAMHS** are focused on high level mental disorders and are delivered by staff with additional training and multidisciplinary CAMHS teams.

This is a comprehensive CAMHS and there is a national requirement for this to be in place in all areas by 2013. A key element of this model is the need for interventions in early years. The National Standards Framework standard 9 states that the early years are fundamental and conditions during this time can lead to emotional and behavioural disorders. Particular support may be needed for parents who are ill (including mental illness) or who have a disability. Partnership working with adult social services, primary care services and early years support is therefore crucial. Being able to identify who is a parent is a crucial first step and it is uncertain whether this is currently recorded for all services (see [young carers](#) section for further discussion).

Lancashire has developed a strategy for prevention and early intervention for children, young people and their families, which was published in April 2010. It identifies both:

- Preventative interventions, which focuses on reducing risk and promoting protective factors in the child as well as their cultural contexts (family, classroom, school, peer group, neighbourhood, etc), thereby promoting resilience. This activity should be delivered in universal services and settings.
- An early intervention approach which offers children, young people and families more than a solution to a specific problem; it offers them the skills to deal with a similar problem if it arises in the future. This is a targeted response to identified needs.

The Lancashire strategy aims to secure a county-wide approach providing a framework which enables all partners to co-ordinate their efforts, re-shape services and work together to utilise resources in a more integrated way to improve the resilience and outcomes for children, parents and families. The need for an early intervention and prevention strategy is made clear in the requirement for a comprehensive CAMHS. Early intervention and prevention will help improve outcomes for children and young people. However, it also makes clear sense in economic terms as *Backing the Future*, a report by the new economics foundation and Action for Children (2009), has estimated that for every £1 invested in early intervention, there is a financial benefit to society of between £7.60 and £9.20.

Levels of need by CAMHS Tiers

The requirement for a Comprehensive CAMHS is a standard which highlights the need to improve service provision at all levels from universal services, promoting mental health and providing early interventions, to highly specialised services. This is the standard which all areas are expected to achieve by 2013.

Over recent years a four tier model of provision has been used to guide the commissioning and planning of services:

- **Tier 1:** a primary level of care
- **Tier 2:** a service provided by specialist individual professionals relating to workers in primary care
- **Tier 3:** A specialised multi-disciplinary service for more severe, complex or persistent disorders
- **Tier 4:** Essential tertiary levels services such as day units, highly specialised out-patient teams and in-patient units.

This four tier model does not capture the range of prevention and early intervention activity which a comprehensive CAMHS provides. However, it is useful to consider this model as there has been research to identify numbers in need using it. The report 'Treating Children Well' (Kurtz, Mental Health Foundation, 1996) provides an estimate of the number of children / young people who may experience emotional wellbeing and mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4. Applying these rates in Lancashire provides an estimate of the numbers in need, as provided in the table below. It should be possible to measure this against the numbers actually accessing services. This will enable an equity audit whereby we can check whether current services are being accessed equitably across the county.

Table 221: Children and young people aged 0 to 17 years experiencing mental health problems appropriate to a response from CAMHS tiers

AREA	Tier 1	Tier 2	Tier 3	Tier 4
Lancashire	37386	18693	4611	1171
Central Lancashire	14568	7284	1797	456
East Lancashire	13323	6662	1643	417
North Lancashire	9510	4755	1173	298
Burnley	3036	1518	374	95
Chorley	3246	1623	400	102
Fylde	2052	1026	253	64
Hyndburn	2967	1484	366	93
Lancaster	4284	2142	528	134
Pendle	3132	1566	386	98
Preston	4392	2196	542	138
Ribble Valley	1851	926	228	58
Rossendale	2337	1169	288	73
South Ribble	3351	1676	413	105
West Lancashire	3579	1790	441	112
Wyre	3174	1587	391	99

Source: 'Treating Children Well' and ONS 2008 mid-year population estimates

Young carers

The impact of the caring role can have significant effects for a young person. Many young carers report a sense of isolation and of feeling 'different'. They will often shy away from social contact to avoid being exposed. Educational difficulties are common resulting in under achievement and consequently fewer opportunities are available career wise.

Self esteem is often poor and young carers may lack confidence, they may be affected adversely by the nature of the illness of the cared for person (e.g. mental illness) and depression and poor physical health may follow. Bullying in schools is not uncommon, creating a barrier to young people in disclosing their role or seeking advice or assistance.

Conversely, it is important to recognise the positive aspects of being a young carer, for example, increased maturity and sensitivity towards others. They may also develop increased resilience and a more responsible attitude than is usually consistent with their age.

A Scottish study (Armstrong 2004) found that young carers tended to live in more deprived areas than the general population, have higher rates of utilisation of health services compared to a control group of the same age, gender and deprivation category. Specifically they had high rates of admissions to A&E and high rates of mental health outpatient appointments.

Young carers often need to cope with competing demands from those who need care as well as from wider family and formal organisations, specifically schools, which have expectations of them. These challenges are frequently confronted at a time when identity, social awareness and social and educational competencies are at a formative stage (Grant 2004). The most serious disadvantages are:

- Isolation from peers of the same age and from other family members;
- Lack of time to play sport and leisure activities;
- Conflict between the needs of the person they are helping and their own needs, leading to feelings of guilt and resentment;
- Feeling that there is nobody there for them, that professionals do not listen to them and are only working with the adult;
- Lack of recognition, praise or respect;

- Feeling they are different from other children and unable to be part of a group;
- Problems of transition into adulthood, finding work, their own home and establishing relationships.

Schools, young carers projects and any agencies involved with young carers have a responsibility to seek to identify and diminish the negative effects of caring, recognise the positive effects and celebrate the role of the young carer. Many schools demonstrate their awareness of young carer's issues and strive to accommodate additional needs as there is a great deal of scope to identify the young carer within this setting.

Once identified, young carers benefit from a holistic approach to family issues and effective joint partnership working between adults and children's services and any other agencies involved. The national carers strategy 'Carers at the Heart of the 21st Century Families and Communities' (DH 2008) states that 'children and young people will be protected from inappropriate caring and have the support they need to learn, develop, thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters Outcomes'

The Princes Royal Trust (2006) has identified a number of potential barriers to delivering the five outcomes for young carers, including:

- Interrupted sleep due to night time caring
- Stress or constant worry about another's safety or health
- Most young carers are hidden from children's and adult's services
- Reliance on young carers for adult tasks at an early age
- Missing school days, falling behind on homework and dropping out of school; and behavioural problems whilst in school
- Lack of awareness of young carers services among young people

Young carers in Lancashire

In Lancashire, there is a very strong commitment to improving the lives of young carers and to promoting their health, wellbeing and life chances in accordance with the Every Child Matters Agenda, the National Carers Strategy and the Lancashire Multi Agency Carers Strategy.

Table 222: Young carers case study, Young Carers' Projects

Young Carers' Projects aim to provide relief from isolation faced by children as carers. They typically provide three kinds of intervention: group activities and discussions, individual counselling or befriending and advocacy on behalf of the child or family. The majority concentrate on providing opportunities for enjoyable interaction with peers (Banks et al 2002).

There are a total of seven young carers' projects that are largely funded by Lancashire County Council from the Children and Young People's allocation of the Carers Grant. The projects cover a large geographical area across a wide social and economic spectrum, providing services in Preston, Chorley and South Ribble, Burnley Pendle and Rossendale, Hyndburn and Ribble Valley, Fylde and Wyre and Lancaster and Morecambe districts.

The projects offer some or all of the following – one to one support, group activities and outings, drop-in service, home visits, telephone support, information advice and guidance to young people and their families. Project staff also seek to raise awareness in schools and within other partner agencies. All projects strive to deliver the Every Child Matters outcomes for young carers within the framework of their service. The projects' policies and procedures relating to safeguarding children are consistent with the Local Safeguarding Children Board's. Referrals to the projects can come from anyone and children and young people can refer themselves. Contact details are available in many public places and on the LCC Young Carers Website.

In Lancashire a Young Carers Forum operates, which is held four times a year. Representative young carers from all the projects attend the forums where they have the opportunity to express their views on a wide range of issues affecting young carers and to influence the development and delivery of relevant services. It is intended that the forum will link into other related events.

The definition of young carers that has been adopted in Lancashire is:

' A Young Carer is a person under 18 years of age who is significantly affected by caring for a person with a long term illness or disability including mental health issues and substance misuse '.

It is estimated that there are 3,700 young people in Lancashire providing some level of care to another person (Lancashire JSNA 2009). This amounts to 2% of all young people in Lancashire and 3% of all carers in Lancashire.

It is estimated that there could be an additional 348 young people providing care at any level by 2011 all of which are likely to require additional support. Of these, 53 are forecast to be providing care for someone of 20 or more hours per week. The greatest number of additional young carers is predicted in Chorley, Lancaster and West Lancashire.

Table 223: 2008 estimates of the numbers and location of young carers aged 5-17 (by hours of care)

Area	Young people (aged 5-17)		Provides 1-19 hours of care		Provides 20+ hours of care					
					Total		Provides 20-49 hours of care		Provides 50+ hours of care	
	Nos (1000s)	Share of Lancs total	Nos	Share of Lancs total	Nos	Share of Lancs total	Nos	Share of Lancs total	Nos	Share of Lancs total
Lancashire	184.7	100.0%	3165	100.0%	567	100.0%	323	100.0%	243	100.0%
Burnley	14.6	7.9%	263	8.3%	47	8.3%	29	9.0%	18	7.4%
Chorley	15.5	8.4%	249	7.9%	64	11.3%	41	12.8%	23	9.3%
Fylde	10.4	5.7%	128	4.0%	6	1.1%	0	0.0%	6	2.6%
Hyndburn	14.5	7.9%	231	7.3%	37	6.4%	27	8.5%	9	3.8%
Lancaster	22.0	11.9%	340	10.7%	61	10.8%	25	7.8%	36	14.7%
Pendle	15.3	8.3%	370	11.7%	69	12.2%	42	12.8%	27	11.2%
Preston	20.9	11.3%	391	12.3%	59	10.4%	39	11.9%	20	8.3%
Ribble Valley	9.7	5.3%	122	3.9%	9	1.7%	3	1.0%	6	2.6%
Rossendale	11.4	6.2%	246	7.8%	37	6.5%	21	6.6%	15	6.3%
South Ribble	16.3	8.8%	230	7.3%	40	7.0%	25	7.6%	15	6.3%
West Lancashire	17.5	9.5%	312	9.9%	61	10.7%	34	10.5%	27	11.0%
Wyre	16.4	8.9%	269	8.5%	39	7.0%	16	4.8%	24	9.8%

Taken from Lancashire Carer's Needs assessment by the Lancashire JSNA using Lancashire Profile; Census 2001, Department for Work and Pensions, ONS Population Projections 2006

Currently, approximately 600 young carers access services delivered specifically to provide them with support in Lancashire, confirming the picture that most carers are unknown to services. The number being supported aligns with the estimates of those who are providing high levels of carer support (in excess of 20 hours per week), however, it is not known whether it is this group who are accessing support. There is potentially a hidden cohort providing significant levels of care without support, a burden which will undoubtedly impact upon the outcomes for these children and young people.

The project team attempted to gather numbers of the dependent children of adults receiving support from Adult Social Care services. Although it could not be directly assumed that these children and young people are carers, it is likely that they would be young people in greater need of support to achieve the Every Child Matters Outcomes. The current version of ISSIS, which is the system used by Lancashire County Council's social services, does not provide any way of recording whether someone in receipt of services has dependent children. If they are specifically identified as being a carer they will be offered a carer assessment, otherwise any additional needs are not identified and supported.

Identifying young people providing care is a crucial step to providing them with the support required to achieve the Every Child Matters Outcomes. Children's centres and schools offer an ideal opportunity to identify those who may be taking on caring responsibilities and it is recommended

that the pathways for doing so are reviewed. However, are there opportunities for the earliest of interventions through midwives and children's centres? Also, there are clearly some links which are being under-utilised with adult social care services and the opportunities for establishing pathways for support for child carers should be investigated. A clear first step would seem to be the inclusion of a field to monitor dependent children in the ISSIS system.

Summary, identification of key areas of need and recommendations

All the groups of children and young people identified in this chapter have particular needs that require a particular response from the services that they come into contact with. Often the difficulty in providing this support is being able to identify children and young people as having a particular need. For some, such as those who are looked after, or those with a physical disability it is not as difficult to identify and offer support although the scale of the challenge in helping these young people to achieve in terms of the Every Child Matters agenda remains significant.

For children and young people who are at risk, have a learning disability or difficulty including a special educational need, have an emotional wellbeing or mental health need or are providing care for an adult in their lives, the action of identification can be a difficult challenge to overcome. For those who are caring for an adult in their lives, this difficulty could be compounded by active secrecy on the part of the child as they fear what will happen if authorities discover they are providing care.

Schools provide the ultimate setting to be able to identify young people and for partner services to be able to engage not only with the individuals but with the families as a whole. Many of the issues identified in the previous chapters will be magnified for these young people and as such all are identified as key areas of need:

- Children looked after
- Emotional wellbeing and mental health
- Learning disabilities and disabilities
- Safeguard vulnerable children and young people
- Young carers

Specific recommendations

A number of specific recommendations can be drawn in relation to children and young people with particular needs:

- Further work should be undertaken to provide a full understanding of the impact of distances from home on looked after children placements
- Analysis of the characteristics of those who are re-referred for social care within 12 months would be beneficial to the process of reducing the proportions of re-referrals received by Lancashire County Council's social services.
- Further work is needed to understand the extent of which the outcomes for disabled children in Lancashire differ from their peers.
 - Further work is needed to understand the needs of children and young people with learning difficulties and disabilities. The JSNA on learning disabilities being delivered as part of the 2011/12 Lancashire JSNA work programme will follow a life cycle approach and therefore include children and young people. It is recommended that partners in the Children's Trust consider how they would like to be involved in that piece of work.

A number of recommendations arise for young carers:

- A field should be included in ISSIS to monitor dependent children of those receiving social care as a proxy for young carers.
- Children's centres and schools offer an ideal opportunity to identify those who may be taking on caring responsibilities and it is recommended that the pathways for doing so are reviewed. However, there may be opportunities for the earliest of interventions through midwives and children's centres.
 - Links with adult social care services could be strengthened and the opportunities for establishing pathways for support for child carers should be investigated.

A number of recommendations arise for emotional wellbeing and mental health:

- Clear pathways should set out how the range of emotional wellbeing and mental health needs of children and young people will be met, including those services that deliver mental health care and other services with a different primary function, particularly those focused on early intervention and prevention.
- Opportunities should be identified to promote positive mental health, particularly focused on the roles that children and young people, their families, communities and

schools can take. Children's trusts are particularly well placed to identify and support these arrangements.

- Opportunities for young people to get involved in designing services and solutions and in supporting each other are essential, as this focuses on the promotion of positive mental health and moves away from the idea of services intervening to solve "problems".
- Use estimates within the JSNA to conduct an equity audit and confirm whether current services are being accessed equitably across the County.

Summary, priorities and specific recommendations

Summary

There are more than 280,000 children and young people in Lancashire, making up almost a quarter of the total population of the County. Changes in fertility rates in Lancashire over recent years mean that the children and young people population is reducing and there are to be demographic shifts over the coming years as the numbers of older children reduce whilst the numbers of younger children increase. Resources will need to shift between the age groups as a result. The pattern is not uniform across the districts of Lancashire, however, and understanding the demographics of different areas will prevent an unsuitable one size fits all approach. The children and young people population is becoming increasingly ethnicity diverse and this also requires changes in service provision to ensure appropriateness for use.

Children and young people are more likely to live in poverty than other age groups, a situation over which they have little control: a quarter of Lancashire's children live in some of the most deprived parts of the Country. Intervening in the lives of children to break the cycle of deprivation is therefore vitally important and could represent the most cost effective way of intervening to break the cycle or mitigate its effects, as opposed to later in life. Having said this, intervening in the lives of adults is crucial to influence the outcomes of children – if children are trapped in poverty it may be because their parents do not have the skills to be able to access employment or a lack of jobs available which are skilled and well paid. Without strategic interventions to support the development of adult skills and improve access to well paid jobs, it is unlikely that the workless culture in certain areas will change in a way that will support children to achieve their potential. This would not only support children and young people and their families, but also the development of the Lancashire economy. The Lancashire Child Poverty Strategy is currently in development and it should promote action in these and related areas.

The environment has a significant effect upon the lives of children and young people. Access to good quality green space and the natural environment has positive effects for children and young people, including promoting wellbeing and encouraging activity, which in turn helps to stem the rise of child obesity. Living in inappropriate, cold or damp homes can affect the health of children. Limited space can mean children do not have space to complete their homework and that families do not have a dining table around which to sit and eat, negatively affecting family cohesion. The rapid increases in domestic fuel prices over recent years has tipped many families into fuel poverty, a situation which may be felt more keenly in private sector housing of poor standard.

Keeping children safe is important in Lancashire. Children and young people are more likely to be victims of crime than any other age group, with more than 18,000 children and young people victims of reported crime in Lancashire in any one year. Child sexual exploitation is a particular area of concern for partners due to the long term impact it has on the lives of victims. Children and young people in Lancashire are at risk of being involved in accidents including road traffic accidents. Whilst young children face higher risk of accidents in the home, with increased age comes a higher risk of accidents further and further away from the home. Independent mobility is linked with road traffic accidents and the risk is so high for young people that, over a five year period, one in one hundred young people was killed or seriously injured in a road traffic accident in Lancashire.

Early intervention is the best policy for supporting better outcomes for children and young people and working with parents during the prenatal and birth period provides significant opportunities to improve the life chances of Lancashire's children and young people. Lancashire does a good job in ensuring early access to maternity services and partners should ensure the focus is maintained in this area. However, too many mothers continue to smoke in pregnancy - one in five in Lancashire, which greatly exceeds the national average. Low birth weight and infant mortality continue to be of concern in some districts and low rates of breastfeeding are found across Lancashire, as initiation and continuance of breastfeeding continues to be below the national averages. Smoking during pregnancy and following birth is known to be linked to low birth weights and infant mortality, and is believed to play a part in preventing mothers from breastfeeding.

The national concern over maternal obesity highlights the need to support mothers to ensure they are living as healthily as possible whilst pregnant and following birth to give children the best start possible. Children of obese parents are born into homes which are obesogenic, meaning that the way of life supports and promotes obesity. This is clearly linked to childhood obesity. National evidence suggests that priority should be given to early intervention from preconception to children up to 2 years to address the rising levels of obesity, confirming the importance and value of children's centres in tackling this need. The importance of the health of women during pregnancy should include consideration of mental health, as early identification of any problems will reduce the potential hidden harm that can be caused for infants, which can go on to have implications throughout their lives for their ability to form relationships.

The rates of children experiencing tooth decay are high in Lancashire and in some districts almost half of five year old children have decayed, missing or filled teeth. A high proportion of planned admissions to hospital for children of primary school age are for treatments for diseases of the oral cavity, salivary glands and jaws, indicating that oral health of children is not as good as it could be.

Poor oral health causes pain for children and young people and is linked with low levels of mental wellbeing. Having decayed and missing teeth is associated with low self-esteem in children.

Education takes up the majority of the lives of children and young people and overall Lancashire has an excellent record at key stages 2 and 4. However, there are gaps in attainment, particularly for children with special educational needs, those who are eligible for school meals and those who are looked after. Variance in achievement is still found by ethnic group and gender. Ensuring that all children, regardless of background and circumstances, have the appropriate support to be able to achieve should remain a priority for Lancashire.

Schools provide an excellent setting for engaging with children to ensure they receive all the support they need throughout their time in education. The exclusion or absence of particular groups can mean they are not receiving all the support they could with consequences for their further development throughout the life course. Schools do an excellent job of identifying children who have particular needs such as learning disabilities or mental health needs. It should be ensured that schools are supported to perform this role and that pathways are in place so that they are able to refer children to appropriate services for support. This will enable groups with particular needs to achieve their potential. Identifying children with particular needs is a challenge and young carers as a group can be especially difficult to identify as they can try to prevent their role being discovered for fear of what will happen if statutory services become involved. However, once young carers are identified there is multitude of support that can be offered to them, and it should be a priority to ensure all organisations, and not just schools, are equipped to identify these young people.

A school's physical and social environment can provide a positive context for promoting children's health and wellbeing. Access to the green space within the school setting encourages physical activity, positive wellbeing and respect for the natural environment. Opportunities to be involved in decisions about the daily life of the school, such as through school councils, can provide primary school age children with their first experience of civic participation and local democracy that can be carried into later childhood and adult life.

Throughout childhood, but particularly as children enter secondary school, the temptation to experiment with new behaviours is natural but can be of concern as these behaviours can lead to negative outcomes. Smoking is a major public health concern and is linked to many problems including poor short term health which can result in absence from school. The evidence shows that the best approaches to tackling smoking are preventative and involve the family as a whole and wider community – children and young people will adopt behaviours that they see as "normal". School based smoking policies can also ensure that where tobacco issues are covered in the

curriculum, this is not undermined by staff tobacco use. The availability of illicit and illegal tobacco, including niche tobacco products, has been highlighted as a concern in the JSNA. Niche tobacco products are an issue in some Asian communities where there is a level of misunderstanding that products being given to children as part of cultural behaviour are tobacco products.

40% of young people in Lancashire report drinking alcohol at least once a week and intelligence from LDAAT suggests that the use of legal highs is increasing. Use of alcohol and drugs can lead to young people being involved in accidents or early and unprotected sex. The links with sexual exploitation and teenage pregnancy are clear and it is important that the agendas are aligned and opportunities are identified and exploited. Research with young people in Lancashire highlights strong views that alcohol free youth is unrealistic despite the known damage to health. This suggests approaches need to be tailored to not only try to discourage the behaviour but to help young people be resilient from potential negative consequences from this form of risk taking behaviour. The same is true of the sexual health agenda and, whilst Lancashire has high rates of some sexually transmitted infections in young people, it is important to recognise that the interpretation of behaviour as "risk taking" is an interpretation by adults and services, which is unlikely to engage young people. Teenage pregnancy rates continue to be of concern and opportunities to focus actions to reduce teenage pregnancy and improve teenage parents' outcomes should be taken in all strategies related to children and young people.

Young people aged 16 to 19 are potentially going to face the greatest hardships as a result of the economic context and associated austerity measures. Young people entering the job market for the first time are doing so during a very difficult period and the risk of becoming NEET is high – young people are many times more likely to face unemployment than more experienced workers. Some groups will be even more vulnerable, including teenage parents, children leaving care, those with learning disabilities and physical disabilities and those young people who have become involved in offending. Young people who are NEET are clear that they want real job opportunities and not simply training and the organisations involved in the Children's Trust should ensure they are providing work opportunities for young people to prevent a lost generation of workers.

Young people who are at risk of becoming homeless or who are already homeless are a further vulnerable group due to service cuts. Evidence shows that being homeless impedes young people's progress in employment, education and training. Surveys have shown that people become homeless at an early age so the need to intervene early is all important.

Recommended priorities for the Lancashire CYPP 2011-14

Based upon the evidence collected for this assessment a number of needs of children and young people in Lancashire have been identified. Based upon these needs six priorities are recommended for inclusion in the CYPP:

1. Poverty (focused on employment and education)
2. Housing and homelessness
3. Parents and parenting
4. Resilience to risk taking behaviours
5. Staying safe
6. Children and young people with particular needs

Using a life cycle approach highlights the causal pathways in the lives of children and young people. Priorities should ensure a mix of interventions to prevent poor outcomes in the first place, such as ensuring a robust economy with adequate employment opportunities or ensuring that pregnant women attend maternity services. At the same time they should deal with outcomes that have already occurred (consequences) such as young people who have started smoking.

The six priorities are therefore split; some are considered determinants of outcomes for children and young people, others relate to social support and behaviour, which affect outcomes and consequences (or the outcomes themselves). The focus of the determinants and social support priorities is, on the whole, the economic and social structure and targets parents and carers, rather than being on children and young people themselves. Whilst the consequence priorities are focused on the children and young people themselves. It is necessary to prioritise each stage so that interventions take place at all points to minimise the negative impact on the lives of children and young people and reduce any cumulative effects and intergenerational patterns.

Table 224: Priorities for Lancashire's children and young people and the underlying needs

Priority	Identified need	Stage of causal pathway
Poverty (focused on employment and education)	Access to jobs Adult qualification levels Educational attainment gaps NEET Wages	Determinants
Housing and homelessness	Fuel poverty Private sector housing quality Youth homelessness	Determinants
Parents and parenting	Breastfeeding Child obesity Early access to maternity services Infant mortality Low birth weight babies Maternal healthy weight Maternal mental health Oral health Smoking in pregnancy	Social support and behaviour
Resilience to risk taking behaviours	Smoking Substance misuse (alcohol and drugs) Sexual health Teenage pregnancy Youth offending	Consequences
Staying safe	Accidents and road traffic accidents Child sexual exploitation Domestic violence Victims of crime	Consequences
Children and young people with particular needs	Children looked after Emotional wellbeing and mental health Learning disabilities and disabilities Safeguard vulnerable children and young people Young carers	Consequences

Clearly it will not be possible for these priorities to be delivered by the Children's Trust alone. The identified needs in relation to adult qualifications, access to jobs, wages, private sector housing and fuel poverty are clearly under the primary control of authorities responsible for adult services, housing strategies and economic development. The priorities related to these needs highlight areas where there is already action taking place and the Trust's role should be to link in and provide the children and young people perspective.

Additional themes for delivering against the priorities

A number of themes arose from the meetings of the reference group and project teams, through responses to the CYPP consultation exercise and from meetings where the results of the JSNA have been presented. Many of these themes related to perceived missed needs. These themes are acknowledged as important ways of tackling the identified needs and so discussion of them is included here.

Focus on families

It is well recognised that an inter-generation cycle of disadvantage exists. Those children who grow up in dysfunctional families are more likely to create such families themselves (Graham Allen, 2011). The shift needed to create a virtuous cycle, and thus functional families requires early intervention at three stages: school ready (age 3-5); life ready (age 5-11) and child ready (age 11-18). Child ready means having an understanding of what it is like to build and sustain a relationship, to have a family and look after a small child, of how babies grow and develop and how parents can best promote this development (Graham Allen, 2011). These skills are not automatically developed and will depend largely on the experience of one's own upbringing (hence the development of virtuous or vicious cycles). The provision of support to develop 'child readiness' could play an important role in building the emotional foundation on which an environment for pre and post natal care can be established.

A focus on families, rather than children as individuals is supported by programmes such as Think Family.

Focus on parenting skills

The role of parenting remains important throughout a child's development and not only during early years and primary school. The need for positive parenting is throughout children's lives and impacts will be recognised at secondary age and as they grow into young people. Support for parents and a family is an important element of successful early intervention. Many of the needs of children and young people which may be created by poor parenting could be reduced or eliminated by improving parenting skills, enhancing parental self confidence and self efficacy, and improved communication skills.

Focus on inequalities

A focus on tackling inequalities is vitally important. Focusing on raising the overall average is known to polarise outcomes with those who are more affluent and better resourced experiencing improved outcomes at the expense of those who are already relatively deprived. The overall picture will show success but the real experience of those living in the county will be one where some parts of society benefit greatly, whilst others experience no benefit at all. There are important implications for inequalities which should be considered when any policy, budget or service decisions are being taken. The difficult choices to be taken in the current financial climate are likely to impact most upon the most vulnerable groups and decision makers need to be aware of these impacts and take steps to mitigate them.

Focus on hidden harm

Hidden harm is an issue raised by several contributors to the report and during consultations for the priorities. Hidden harm takes a range of forms. It can include children of substance misusing parents, or those with a disability or special educational need that children have to provide care for. Maternal mental health is an important area of hidden harm. The key difficulty currently in Lancashire is identifying these children and young people and actions need to focus on better identification to enable successful intervention.

Specific recommendations

A number of specific recommendations can be drawn from the analysis in this report and these are summarised here:

Table 225: Specific recommendations for action from the Children and young people in Lancashire JSNA

Chapter	Specific recommendations
General	<p>On a countywide level investment should focus on early intervention and prevention, positive outcomes and improved efficiency.</p> <p>Develop a single model of integrated 'high street service' across the county- for young people to address multiple needs under one roof, potentially including a wide range of services such as housing, employment, sexual health, mental health, etc. Greater integration with a focus on early intervention and prevention and positive outcomes will improve efficacy, particularly for children and young people with complex needs, efficiency and stop duplication of services.</p> <p>Commissioners and service providers need to understand the demographics in their area of operation to ensure that the support that children and young people need to achieve the desired outcomes over the life course is appropriate.</p> <p>The changes in the age profile of the children and young people population will require a shift in funding from older to younger age groups.</p> <p>Think Family practice should be adopted by all partners working to improve the outcomes of children and young people.</p>
Social determinants of family wellbeing	<p>There is a need to explicitly include children and young people in broader policies affecting the whole of society to integrate strategic work affecting children and young people.</p> <p>Barriers to gaining employment within a family's area of residence should be fully understood and overcome to support families to break the cycle of deprivation which unemployment sustains, ideally ask families themselves.</p> <p>The Child Poverty Strategy should be co-produced, co-owned and co-delivered.</p> <p>The Children's Trust should engage with partners responsible for economic development in the county to ensure that the needs of children and young people and their families are reflected within their programmes.</p> <p>Further analysis should be undertaken to understand the picture of accidents for children and young people.</p> <p>Injury surveillance should be undertaken to monitor unintentional and intentional injuries among children and young people.</p> <p>Variations in referrals to social care for reasons of domestic violence could indicate underreporting in some areas and further analysis should take place to understand where levels of referrals are artificially low.</p>
Prenatal and birth	<p>A multi-agency strategy for preconception should be developed so that women and men of child bearing age have the information they need to make informed choices about preparing for pregnancy</p>

Chapter	Specific recommendations
	<p>Interventions and services should be tailored to those at greatest risk of adverse pregnancy outcomes (such as low birth weight or infant mortality).</p> <p>Further investigation is needed on potential cultural barriers for uptake of ante natal screening.</p> <p>Further work is required to ensure support for smoking cessation and smoke free homes during and following pregnancy meets the needs of all communities and family members.</p> <p>PCTs should initiate systems for the surveillance of risk during pregnancy such as maternal obesity. Socio-economic status should also be collected to enable the identification of priority groups</p>
Early years	<p>Review Child Health Information Systems to ensure they meet the reporting requirements of the national standards for newborn screening.</p> <p>All stakeholders to work collaboratively at a strategic commissioning level and across the screening pathway for delivery and performance management of robust, quality assured Antenatal and Newborn Screening Programmes in Lancashire.</p> <p>Further application of social marketing behavioural insight approaches to support young mothers and those from low socio-economic backgrounds to breastfeed.</p> <p>Develop more authoritative messages to support delaying the introduction of solid foods.</p> <p>Conduct an equity audit on children's centres across Lancashire to check whether they are meeting the needs of those most in need. This would allow for analysis of access to children's centres by different groups across the social gradient and whether different groups are meeting the desired outcomes.</p>
Primary and secondary years	<p>Time series analysis of educational attainment in Lancashire overall, by district, and by various groups such as by gender, ethnic group, FSM eligibility, children who are looked after, children with special educational needs, etc, should be made available through the JSNA pages.</p> <p>Investigation of the characteristics of those pupils who are persistent absentees would assist in developing better support for schools to improve school attendance.</p> <p>The intelligence from the JSNA child and family obesity needs assessment, due summer 2011, should be used to develop comprehensive and multi-agency approaches to the prevention and reduction of child obesity rates.</p> <p>Opportunities to improve oral health are present from birth and should be maximised to prevent the development of dental decay by primary school age.</p> <p>Reinforce the schools and exclusion teams to develop better links and support mechanisms for young people at risk of being temporarily or permanently excluded from school.</p> <p>It is recognised that there is a lot of excellent work already taking place around the smoking agenda for young people. Reducing adult smoking is</p>

Chapter	Specific recommendations
	<p>the most effective way of preventing smoking in young people and protecting children from second hand smoke. A Lancashire wide tobacco control strategy should be developed in line with the coalition governments' 5 –Year Tobacco Control Action Plan, due to be published this year.</p> <p>The following recommendations have been suggested to tackle substance misuse:</p> <p>Better integrated family support services - this should be developed as an 'integrated' part of the holistic treatment service interventions across Lancashire. The holistic treatment system for Lancashire should incorporate interventions to address the wider family needs including parenting skills, parental use and parental education.</p> <p>Those young people that drink alcohol are consuming more and they would benefit from basic harm reduction and health advice around alcohol misuse, educational input to local primary and secondary schools around alcohol misuse and to educational and supportive input for parents. Specific interventions could include:</p> <ul style="list-style-type: none"> • Social marketing campaigns aimed at targeted groups of young people with their involvement. Messages around alcohol consumption and its' wider social and health consequences including sexual health and teenage pregnancy. • Statutory and voluntary agencies should agree clear, consistent and accurate messages about the impact of alcohol consumption on young people. These must include short-term health effects, the impact on relationships, risk taking behaviour and issues of personal safety. • Schools should audit their PSHE (personal, social and health education) and science curriculum and make explicit links between alcohol education and sex and relationships education. <p>Hidden harm: ensure that the needs of children and young people of substance misusing parents / carers are known, acknowledged and appropriately addressed within all mainstream, targeted and young people and adult services as part of the Every Child Matters agenda.</p> <p>Workforce development: continue to increase the opportunities for substance misuse training and resources for personnel working within mainstream and targeted services within both the statutory and voluntary sector.</p> <p>Vulnerable groups are often hard to engage with and may need targeted support. An effective integrated workforce and consistent working patterns will ensure a partnership approach.</p> <p>Identify a consistent approach to substance misuse education and highlight young people at risk both outside and within the school environment.</p>
<p>Young people</p>	<p>The focus for the sexual health agenda should move from Chlamydia screening volume to attempting to find Chlamydia, thereby treating more cases and reducing overall incidence over time.</p> <p>A health needs assessment should be conducted to inform multi-agency action to ensure young people who offend have access to the health services they need.</p> <p>Further work is required to understand the full picture of road traffic accidents for young people and develop appropriate evidence based interventions.</p> <p>Further work should be undertaken to gather together district level youth homeless data to provide a full picture of the issue for the county.</p>

Chapter	Specific recommendations
	<p>A number of recommendations have been identified in relation to NEET:</p> <p>Local research is needed to understand the barriers faced by young people with learning difficulties and/or disabilities in terms of accessing employment, education and training to prevent them from becoming NEET.</p> <p>Identify what scope there may be for increasing further the flexibility of further education provision, to facilitate access to courses throughout the year, rather than at the traditional intake point of September.</p> <p>Foster closer collaboration with partners, including Jobcentre Plus, for example to facilitate more effective tracking of young people, the fast-tracking to New Deal of Jobseekers Allowance claimants as they reach the age of 18, and the sharing of local labour market information.</p> <p>Reduce the tendency towards an artificial 'watershed' at age 18 in the delivery of some support services, due to current funding structures. Despite many examples of good practice, in some circumstances this can act as a barrier to the continuity of support to young people at crucial time.</p> <p>Investigate the potential to develop an overarching Lancashire strategy for EET, capturing the commitment of all key partners to work together to deliver a coherent programme of high quality education, employment and training opportunities for all young people.</p> <p>Reinforce activities designed to support those in vulnerable groups, such as care leavers, teenage mothers, young offenders, and those with a learning difficulty or disability. Implement measures to address specific barriers to participation – e.g. affordable transport.</p> <p>A number of recommendations have been identified in relation to teenage pregnancy:</p> <p>The Children's Trust should urgently develop a robust performance management framework for the Teenage Pregnancy Strategy, holding partners to account</p> <p>The County Council and PCT partners should work together to ensure local relevant data is being effectively captured, collated, analysed and disseminated to inform commissioning and to better performance manage the Teenage Pregnancy Strategy</p> <p>Intelligence from the JSNA teenage pregnancy needs assessment should be used to inform future action to reduce unplanned and unwanted teenage pregnancies.</p> <p>Embed teenage pregnancy across commissioning activity at county, PCT and locality level</p> <p>Future commissioning of contraceptive and sexual health services should use a collaborative approach between NHS (including GP commissioning consortia) and Local Authority to form an effective sexual health system to minimise the potential fragmentation of services proposed in the Public Health White Paper</p> <p>Work on the development of a core Sex and Relationships Education (SRE) offer is prioritised to outline:</p>

Chapter	Specific recommendations
	<ul style="list-style-type: none"> • what pupils can expect from their school SRE • what schools can expect from health, local authority and voluntary sector providers • the responsibilities of schools to their pupils, including giving information about and supporting access to local Contraception and Sexual Health (CASH) services. <p>Local action to reduce teenage pregnancy and improve teenage parents' outcomes is a key contribution to reducing child poverty and should be clearly identified within the Child Poverty Strategy.</p> <p>Targeted prevention and early intervention work with teenage parents should be upscaled in order to address the inequalities that exist in health outcomes for mothers and babies.</p>
<p>Children and young people with particular needs</p>	<p>Further work should be undertaken to provide a full understanding of the impact of distances from home on looked after children placements</p> <p>Analysis of the characteristics of those who are re-referred for social care within 12 months would be beneficial to the process of reducing the proportions of re-referrals received by Lancashire County Council's social services.</p> <p>Further work is needed to understand the extent of which the outcomes for disabled children in Lancashire differ from their peers.</p> <p>Further work is needed to understand the needs of children and young people with learning difficulties and disabilities. The JSNA on learning disabilities being delivered as part of the 2011/12 Lancashire JSNA work programme will follow a life cycle approach and therefore include children and young people. It is recommended that partners in the Children's Trust consider how they would like to be involved in that piece of work.</p> <p>A number of recommendations arise for young carers:</p> <p>A field should be included in ISSIS to monitor dependent children of those receiving social care as a proxy for young carers.</p> <p>Children's centres and schools offer an ideal opportunity to identify those who may be taking on caring responsibilities and it is recommended that the pathways for doing so are reviewed. However, there may be opportunities for the earliest of interventions through midwives and children's centres.</p> <p>Links with adult social care services could be strengthened and the opportunities for establishing pathways for support for child carers should be investigated.</p> <p>A number of recommendations arise for emotional wellbeing and mental health:</p> <p>Clear pathways should set out how the range of emotional wellbeing and mental health needs of children and young people will be met, including those services that deliver mental health care and other services with a different primary function, particularly those focused on early intervention and prevention.</p> <p>Opportunities should be identified to promote positive mental health, particularly focused on the roles that children and young people, their families,</p>

Chapter	Specific recommendations
	<p>communities and schools can take. Children's trusts are particularly well placed to identify and support these arrangements.</p> <p>Opportunities for young people to get involved in designing services and solutions and in supporting each other are essential, as this focuses on the promotion of positive mental health and moves away from the idea of services intervening to solve "problems".</p> <p>Use estimates within the JSNA to conduct an equity audit and confirm whether current services are being accessed equitably across the County.</p>

Appendix: data

Population projections data

Table 226: District population projections, 2008 to 2033

	Age Group	2008	2013	2018	2023	2028	2033	2008-2033 Change
Burnley	0-4	5,900	6,100	5,800	5,600	5,300	5,300	-600
Burnley	5-9	5,000	5,600	5,800	5,600	5,400	5,200	200
Burnley	10-14	5,500	4,800	5,300	5,500	5,400	5,200	-300
Burnley	15-19	6,400	5,200	4,500	5,000	5,200	5,100	-1,300
Burnley	All ages	86,000	84,800	84,300	84,100	83,800	83,700	-2,300
Chorley	0-4	6,100	6,100	6,100	6,100	6,000	5,900	-200
Chorley	5-9	5,600	6,300	6,300	6,300	6,300	6,200	600
Chorley	10-14	6,100	5,700	6,400	6,500	6,400	6,500	400
Chorley	15-19	6,400	5,700	5,300	6,000	6,100	6,100	-300
Chorley	All ages	104,700	107,200	110,000	112,800	114,900	116,500	11,800
Fylde	0-4	3,300	3,300	3,200	3,200	3,100	3,000	-300
Fylde	5-9	3,600	3,700	3,700	3,600	3,600	3,600	0
Fylde	10-14	4,200	3,800	4,000	4,000	3,900	3,900	-300
Fylde	15-19	4,300	3,800	3,500	3,700	3,700	3,700	-600
Fylde	All ages	76,100	76,900	78,200	80,000	81,700	83,100	7,000
Hyndburn	0-4	5,400	5,500	5,400	5,300	5,100	5,000	-400
Hyndburn	5-9	5,100	5,200	5,400	5,300	5,200	5,000	-100
Hyndburn	10-14	5,800	5,000	5,200	5,300	5,300	5,200	-600
Hyndburn	15-19	5,800	5,400	4,700	4,900	5,100	5,000	-800
Hyndburn	All ages	81,200	81,200	81,500	82,100	82,400	82,800	1,600
Lancaster	0-4	6,800	7,400	7,400	7,400	7,300	7,200	400
Lancaster	5-9	6,900	7,000	7,500	7,500	7,500	7,400	500
Lancaster	10-14	8,200	7,300	7,500	8,000	8,000	8,000	-200
Lancaster	15-19	11,100	10,900	9,900	10,200	10,900	10,900	-200
Lancaster	All ages	139,500	143,900	147,200	150,900	155,400	158,700	19,200
Pendle	0-4	5,800	6,200	6,100	6,000	5,700	5,700	-100
Pendle	5-9	5,500	5,700	6,100	6,000	5,800	5,600	100
Pendle	10-14	5,800	5,400	5,600	6,000	5,900	5,800	0
Pendle	15-19	6,300	5,400	5,000	5,300	5,600	5,500	-800
Pendle	All ages	89,100	90,100	91,500	92,800	93,800	94,600	5,500
Preston	0-4	8,600	9,000	8,900	8,900	8,700	8,700	100

Children and young people in Lancashire

	Age Group	2008	2013	2018	2023	2028	2033	2008-2033 Change
Preston	5-9	7,200	8,200	8,600	8,500	8,500	8,300	1,100
Preston	10-14	7,900	7,000	8,000	8,300	8,300	8,300	400
Preston	15-19	9,300	9,500	8,600	9,500	9,900	9,900	600
Preston	All ages	135,300	138,900	141,100	143,100	145,600	147,600	12,300
Ribble Valley	0-4	2,800	2,700	2,700	2,700	2,600	2,500	-300
Ribble Valley	5-9	3,300	3,300	3,300	3,200	3,200	3,100	-200
Ribble Valley	10-14	3,900	3,700	3,800	3,800	3,700	3,700	-200
Ribble Valley	15-19	3,900	3,600	3,400	3,500	3,500	3,500	-400
Ribble Valley	All ages	57,800	59,000	60,400	61,900	63,100	64,000	6,200
Rossendale	0-4	4,100	4,200	4,200	4,100	4,000	3,900	-200
Rossendale	5-9	4,000	4,300	4,400	4,400	4,300	4,200	200
Rossendale	10-14	4,600	4,200	4,500	4,600	4,600	4,500	-100
Rossendale	15-19	4,800	4,200	3,900	4,200	4,400	4,300	-500
Rossendale	All ages	66,700	67,700	69,000	70,500	71,700	72,600	
South Ribble	0-4	6,000	6,200	6,200	6,200	6,000	5,900	-100
South Ribble	5-9	5,800	6,300	6,400	6,400	6,500	6,300	500
South Ribble	10-14	6,400	5,900	6,400	6,600	6,600	6,600	200
South Ribble	15-19	6,900	6,000	5,600	6,100	6,200	6,300	-600
South Ribble	All ages	107,500	110,000	113,100	116,100	118,400	120,200	12,700
West Lancs	0-4	6,300	6,300	6,300	6,300	6,100	6,000	-300
West Lancs	5-9	6,200	6,600	6,700	6,600	6,700	6,500	300
West Lancs	10-14	6,800	6,200	6,600	6,700	6,700	6,700	-100
West Lancs	15-19	7,600	6,900	6,300	6,700	6,800	6,800	-800
West Lancs	All ages	110,400	111,700	113,000	114,300	115,400	116,000	5,600
Wyre	0-4	5,100	5,300	5,300	5,300	5,100	5,000	-100
Wyre	5-9	5,500	5,500	5,700	5,700	5,700	5,600	100
Wyre	10-14	6,300	5,800	5,900	6,100	6,100	6,100	-200
Wyre	15-19	7,100	6,400	5,800	6,100	6,300	6,300	-800
Wyre	All ages	110,800	113,700	116,800	120,100	123,000	125,300	14,500

Source: ONS population projections

Ethnicity data

Table 227: Primary school census numbers of pupils by ethnic group, 2010

District	Total	ABAN	AIND	AOTH	APKN	BAFR	BCRB	BOTH	CHNE	MOTH	MWAS	MWBA	MWBC	REFU, NOBT or not rec	OOth	WBRI	WIRI	WIRT	WOTH	WROM
Burnley	7389	376	20	26	982	6	4	9	14	25	79	12	21	7	25	5717	4		61	1
Chorley	8224	19	64	26	62	7	9	3	12	59	52	17	74	24	9	7692	9	1	77	8
Fylde	4355	4	17	14	9	3		2	11	43	22	11	25	20	12	4087	9		66	
Hyndburn / Ribble Valley	11317	51	59	40	1628	6	1	3	21	44	104	15	26	59	15	9042	8	30	128	37
Lancaster	9711	15	81	58	21	29		10	45	77	47	18	33	51	43	8793	7	46	254	83
Pendle	7453	37	10	45	2567	2	1	1	8	30	90	12	14	16	21	4488	4	2	101	4
Preston	11657	58	1713	189	746	47	23	17	25	129	150	37	190	78	61	7877	23	13	275	6
Rossendale	5597	241	12	14	197	1	3	2	12	26	54	5	28	65	5	4888	10	7	27	
South Ribble	8101	5	46	33	15	5	4	5	21	78	65	15	75	67	19	7549	12	3	84	
West Lancashire	9009	1	28	17	2	13		10	13	30	31	16	13	89	40	8536	7	7	152	4
Wyre	7408	10	12	16	9	5	2	2	18	44	34	13	30	30	11	7115	7	1	49	
Lancashire	90221	817	2062	478	6238	124	47	64	200	585	728	171	529	506	261	75784	100	110	1274	143

Table 228: Secondary school census numbers of pupils by ethnic group, 2010

District	Total	ABAN	AIND	AOTH	APKN	BAFR	BCRB	BOTH	CHNE	MOTH	MWAS	MWBA	MWBC	REFU, NOBT or not rec	OOTH	WBRI	WIRI	WIRT	WOTH	WROM
Burnley	5069	216	12	44	607	6	2	1	8	20	30	9	8	25	11	4017	5	1	47	
Chorley	5395	10	18	9	18	7	10	5	16	26	13	5	33	7	17	5152	5		44	
Fylde	3581	4	7	5	3		2		12	14	17		16	26	8	3422	5		38	2
Hyndburn / Ribble Valley	8311	28	65	39	670	9		2	20	42	59	14	13	22	5	7233	11	1	76	2
Lancaster	8507	9	120	27	22	54		3	45	31	58	15	26	39	23	7759	11	11	230	24
Pendle	4538	7	6	16	1122	2	1	2	7	20	55	4	10	9	9	3216	3		49	
Preston	6388	11	587	50	151	24	27	6	12	39	73	14	108	25	18	5130	11	1	100	1
Rossendale	5257	168	14	21	171	2	1	1	22	16	21	7	12	17	17	4734	7		26	
South Ribble	7737	20	290	53	54	7	16	2	25	40	66	9	67	33	18	6950	11		76	
West Lancashire	6560	1	5	11	1	12		1	8	24	14	7	12	15	5	6367	8		69	
Wyre	5989	4	5	7	5	7		3	17	25	13	4	6	26	4	5816	8		39	
Lancashire	67332	478	1129	282	2824	130	59	26	192	297	419	88	311	244	135	59796	85	14	794	29

Births data

Table 229: Numbers of live births by age of mother, 2008

2008	All ages	Under 18	18-19	20-24	25-34	35-39	40+
England	672,809	11,755	29,845	127,762	366,922	111,140	25,385
Lancashire	13,963	323	756	3,122	7,365	1,975	422
Burnley	1,315	41	89	349	702	113	21
Chorley	1,239	22	58	238	655	223	43
Fylde	642	8	28	108	348	122	28
Hyndburn	1,159	36	81	345	566	107	24
Lancaster	1,487	34	81	332	790	205	45
Pendle	1,322	24	60	344	726	148	20
Preston	1,940	55	121	486	1,004	228	46
Ribble Valley	505	8	9	63	290	112	23
Rossendale	876	16	52	191	462	129	26
South Ribble	1,255	22	68	214	698	209	44
West Lancashire	1,243	26	64	233	618	232	70
Wyre	980	31	45	219	506	147	32

Source: ONS VS2

Table 230: Percentage of live births by age of mother, 2008

2008	All ages	Under 18	18-19	20-24	25-34	35-39	40+
England	672,809	1.70%	4.40%	19.00%	54.50%	16.50%	3.80%
Lancashire	13,963	2.30%	5.40%	22.40%	52.70%	14.10%	3.00%
Burnley	1,315	3.1%	6.8%	26.5%	53.4%	8.6%	1.6%
Chorley	1,239	1.8%	4.7%	19.2%	52.9%	18.0%	3.5%
Fylde	642	1.2%	4.4%	16.8%	54.2%	19.0%	4.4%
Hyndburn	1,159	3.1%	7.0%	29.8%	48.8%	9.2%	2.1%
Lancaster	1,487	2.3%	5.4%	22.3%	53.1%	13.8%	3.0%
Pendle	1,322	1.8%	4.5%	26.0%	54.9%	11.2%	1.5%
Preston	1,940	2.8%	6.2%	25.1%	51.8%	11.8%	2.4%
Ribble Valley	505	1.6%	1.8%	12.5%	57.4%	22.2%	4.6%
Rossendale	876	1.8%	5.9%	21.8%	52.7%	14.7%	3.0%
South Ribble	1,255	1.8%	5.4%	17.1%	55.6%	16.7%	3.5%
West Lancashire	1,243	2.1%	5.1%	18.7%	49.7%	18.7%	5.6%
Wyre	980	3.2%	4.6%	22.3%	51.6%	15.0%	3.3%

Source: ONS VS2

Table 231: Number of low birth weight (<2500g) live births, 2001-08

	2001	2002	2003	2004	2005	2006	2007	2008
England and Wales	45,059	45,962	47,522	48,574	48,335	50,121	49,305	50,581
Lancashire	1,021	963	1,029	1,004	1,100	1,116	988	989
Burnley	98	94	109	115	138	115	96	98
Chorley	76	72	77	77	77	95	87	67
Fylde	41	41	32	30	50	46	38	37
Hyndburn	106	103	101	110	99	101	69	83
Lancaster	86	89	107	91	95	93	87	89
Pendle	110	90	115	99	121	113	128	112
Preston	170	150	169	155	191	212	174	193
Ribble Valley	29	32	37	31	28	14	32	25
Rosendale	58	57	56	58	60	57	58	54
South Ribble	88	77	78	77	88	102	70	91
West Lancashire	88	85	75	85	69	80	78	79
Wyre	71	73	73	76	84	88	71	61

Source: ONS VS1

Table 232: Additional selected birth statistics by NHS trust and site, 2009-10

	England	University Hospitals Of Morecambe Bay	Southport & Ormskirk Hospitals	Wyre Hospitals	Blackpool, Fylde & Wyre Hospitals	Lancashire Teaching Hospitals	East Lancashire Hospitals - Blackburn	East Lancashire Hospitals - Burnley
Method of Onset of Labour	Spontaneous	392,510	1,987	1,663	1,860	2,374	2,830	1,686
	Caesarean	66,378	488	405	383	418	399	390
	Surgical Induction	27,802	0	74	153	146	64	110
	Medical Induction	61,763	95	631	429	446	530	286
	Surgical & Medical Induction	31,092	339	124	78	246	28	100
	Not Known	72,832	482	235	87	1,045	8	142
	Total	652,377	3,391	3,132	2,990	4,675	3,859	2,714
Spontaneous deliveries with an episiotomy	33,073	161	129	99	224	227	107	
% excluding unknowns	8.3%	7.3%	6.7%	5.5%	7.4%	9.1%	5.9%	
Caesarean with postnatal stay 0-3 days	111,536	502	620	568	555	634	498	
% excluding unknowns	79.6%	68.6%	78.3%	79.2%	63.5%	71.2%	77.1%	
Method of Onset - Spontaneous	392,510	1,987	1,663	1,860	2,374	2,830	1,686	
Method of delivery: Spontaneous vertex/ cephalic	397,018	2,200	1,909	1,790	3,006	2,462	1,802	
Deliveries without Episiotomy	557,697	2,927	2,718	2,568	4,136	3,261	2,439	
Unassisted deliveries	264,307	1,479	1,177	1,286	1,737	1,912	1,246	
% Unassisted deliveries	46.7%	51.2%	41.1%	45.1%	48.9%	29.9%	19.5%	

Source: HES online Maternity data, The Information Centre for Health & Social Care
 *Due to reasons of confidentiality, figures between 1 and 5 have been suppressed

Total hospital admissions data

Hospital admissions for those aged under 1 year

Table 233: Hospital admissions for those aged less than 1 year – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	1015	138	62	29	106	111	118	120	38	72	89	88	44
	A00-A09 Intestinal infectious diseases	476	77	31	13	66	44	67	44	15	37	37	25	20
C00-C97	Malignant neoplasms	-	-	-	-	-	-	-	-	-	-	-	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	-	-	-	-	-	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	29	-	-	-	-	7	-	6	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	54	-	-	-	-	-	34	6	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	43	13	-	-	8	-	-	7	-	-	-	-	-
	E10-E14 Diabetes mellitus	-	-	-	-	-	-	-	-	-	-	-	-	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	56	12	-	-	-	14	-	16	-	-	-	-	-
	G40-G41 Epilepsy	15	-	-	-	-	8	-	-	-	-	-	-	-
H00-H59	Diseases of the eye and adnexa	20	-	-	-	-	-	-	-	-	-	-	-	-
H60-H95	Diseases of the ear and mastoid process	44	-	-	-	-	-	-	13	-	-	-	-	-
I00-I99	Diseases of the circulatory system	21	-	12	-	-	-	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	1855	235	126	36	187	220	176	293	58	94	154	208	68
	J00-J06 Acute upper respiratory infections	868	104	62	14	75	113	87	149	31	39	68	105	21
	J10-J18 Influenza and pneumonia	55	-	-	-	-	11	7	9	-	-	8	-	-
	J20-J22 Other acute lower respiratory infections	886	123	55	21	106	89	78	129	24	51	72	95	43
	J45-J46 Asthma	22	-	-	-	-	-	-	-	-	-	-	-	-
K00-K93	Diseases of the digestive system	560	40	53	16	63	51	33	89	14	30	59	78	34
	K00-K14 Diseases of oral cavity, salivary glands and jaws	7	-	-	-	-	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	-	-	-	-	-	-	-	-	-	-	-	-	-
	K40-K46 Hernia	77	6	10	-	16	-	-	13	-	-	6	-	7

Children and young people in Lancashire

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
	K50-K52 Noninfective enteritis and colitis	144	-	15	10	10	13	-	29	-	7	22	17	13
L00-L99	Diseases of the skin and subcutaneous tissue	110	15	9	6	7	11	22	13	-	-	9	-	7
M00-M99	Diseases of the musculoskeletal system and connective tissue	17	-	-	-	-	-	-	-	-	-	-	-	-
N00-N99	Diseases of the genitourinary system	206	20	11	-	14	17	30	27	7	9	39	16	11
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	19	6	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1065	111	80	43	75	162	114	153	28	48	106	63	82
S00-T98	Injury, poisoning and certain other consequences of external causes	212	34	16	-	17	25	13	41	6	6	16	26	8
Z00-Z99	Factors influencing health status and contact with health services	6206	951	88	288	877	1001	1019	106	267	572	53	402	582
Total Admissions		14082	1885	630	476	1627	1897	1798	1263	488	965	738	1123	940

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 234: Hospital admissions for those aged less than 1 year – percentage of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	8.8%	8.7%	13.1%	6.6%	7.8%	6.8%	7.5%	13.3%	8.8%	8.6%	16.5%	9.8%	5.2%
	A00-A09 Intestinal infectious diseases	4.1%	4.8%	6.5%	2.9%	4.8%	2.7%	4.3%	4.9%	3.5%	4.4%	6.9%	2.8%	2.4%
C00-C97	Malignant neoplasms	-	-	-	-	-	-	-	-	-	-	-	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	-	-	-	-	-	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	0.3%	-	-	-	-	0.4%	-	0.7%	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	0.5%	-	-	-	-	-	2.2%	0.7%	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	0.4%	0.8%	-	-	0.6%	-	-	0.8%	-	-	-	-	-
	E10-E14 Diabetes mellitus	-	-	-	-	-	-	-	-	-	-	-	-	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	0.5%	0.8%	-	-	-	0.9%	-	1.8%	-	-	-	-	-

Children and young people in Lancashire

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
	G40-G41 Epilepsy	0.1%	-	-	-	-	0.5%	-	-	-	-	-	-	-
H00-H59	Diseases of the eye and adnexa	0.2%	-	-	-	-	-	-	-	-	-	-	-	-
H60-H95	Diseases of the ear and mastoid process	0.4%	-	-	-	-	-	-	1.4%	-	-	-	-	-
I00-I99	Diseases of the circulatory system	0.2%	-	2.5%	-	-	-	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	16.1%	14.8%	26.5%	8.2%	13.7%	13.4%	11.2%	32.5%	13.4%	11.2%	28.6%	23.2%	8.1%
	J00-J06 Acute upper respiratory infections	7.5%	6.5%	13.1%	3.2%	5.5%	6.9%	5.5%	16.5%	7.2%	4.6%	12.6%	11.7%	2.5%
	J10-J18 Influenza and pneumonia	0.5%	-	-	-	-	0.7%	0.4%	1.0%	-	-	1.5%	-	-
	J20-J22 Other acute lower respiratory infections	7.7%	7.7%	11.6%	4.8%	7.8%	5.4%	5.0%	14.3%	5.6%	6.1%	13.4%	10.6%	5.1%
	J45-J46 Asthma	0.2%	-	-	-	-	-	-	-	-	-	-	-	-
K00-K93	Diseases of the digestive system	4.9%	2.5%	11.2%	3.6%	4.6%	3.1%	2.1%	9.9%	3.2%	3.6%	10.9%	8.7%	4.0%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	0.1%	-	-	-	-	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	-	-	-	-	-	-	-	-	-	-	-	-	-
	K40-K46 Hernia	0.7%	0.4%	2.1%	-	1.2%	-	-	1.4%	-	-	1.1%	-	0.8%
	K50-K52 Noninfective enteritis and colitis	1.2%	-	3.2%	2.3%	0.7%	0.8%	-	3.2%	-	0.8%	4.1%	1.9%	1.5%
L00-L99	Diseases of the skin and subcutaneous tissue	1.0%	0.9%	1.9%	1.4%	0.5%	0.7%	1.4%	1.4%	-	-	1.7%	-	0.8%
M00-M99	Diseases of the musculoskeletal system and connective tissue	0.1%	-	-	-	-	-	-	-	-	-	-	-	-
N00-N99	Diseases of the genitourinary system	1.8%	1.3%	2.3%	-	1.0%	1.0%	1.9%	3.0%	1.6%	1.1%	7.2%	1.8%	1.3%
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	0.2%	0.4%	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	9.2%	7.0%	16.8%	9.8%	5.5%	9.9%	7.3%	17.0%	6.5%	5.7%	19.7%	7.0%	9.7%
S00-T98	Injury, poisoning and certain other consequences of external causes	1.8%	2.1%	3.4%	-	1.2%	1.5%	0.8%	4.5%	1.4%	0.7%	3.0%	2.9%	0.9%
Z00-Z99	Factors influencing health status and contact with health services	53.8%	59.9%	18.5%	65.3%	64.2%	61.0%	64.9%	11.8%	61.8%	68.0%	9.8%	44.8%	69.0%

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Hospital admissions for those aged under 1 to 4 years

Table 235: Hospital admissions for those aged 1 to 4 years – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	1368	190	99	47	147	161	157	162	56	83	92	116	58
	A00-A09 Intestinal infectious diseases	616	101	39	12	88	58	83	75	19	44	30	50	17
C00-C97	Malignant neoplasms	265	-	26	-	86	20	36	-	-	-	8	28	56
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	212	-	26	-	86	-	36	-	-	-	8	23	30
D10-D36	Benign neoplasms	40	-	-	-	-	-	-	6	-	-	6	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	15	-	-	-	-	-	-	-	-	-	-	13	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	98	11	8	-	11	-	15	27	-	-	-	6	6
E00-E90	Endocrine, nutritional and metabolic diseases	119	-	-	-	47	-	6	14	12	6	17	-	-
	E10-E14 Diabetes mellitus	14	-	-	-	-	-	-	-	-	-	-	-	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	130	9	10	8	14	14	15	29	-	6	11	-	9
	G40-G41 Epilepsy	59	-	7	-	6	8	6	10	-	-	7	-	-
H00-H59	Diseases of the eye and adnexa	202	20	17	10	21	19	15	19	-	13	26	17	20
H60-H95	Diseases of the ear and mastoid process	419	32	46	22	30	39	45	59	13	25	48	29	31
I00-I99	Diseases of the circulatory system	35	-	-	-	-	7	-	-	-	6	-	-	-
J00-J99	Diseases of the respiratory system	3086	344	246	81	310	332	298	428	101	166	315	318	147
	J00-J06 Acute upper respiratory infections	1739	207	146	46	175	199	167	240	58	73	168	184	76
	J10-J18 Influenza and pneumonia	193	21	18	6	14	13	19	31	7	11	30	15	8
	J20-J22 Other acute lower respiratory infections	484	45	30	8	56	54	45	68	15	32	62	53	16
	J45-J46 Asthma	429	46	36	9	37	30	46	61	18	33	31	53	29
K00-K93	Diseases of the digestive system	833	64	86	39	90	60	36	163	23	38	109	69	56
	K00-K14 Diseases of oral cavity, salivary glands and jaws	335	24	37	20	57	-	13	77	11	14	40	12	27
	K35-K38 Diseases of appendix	7	-	-	-	-	-	-	-	-	-	-	-	-
	K40-K46 Hernia	75	-	9	-	-	16	-	10	-	-	11	-	-
	K50-K52 Noninfective enteritis and colitis	196	8	24	11	13	12	-	48	-	-	38	21	9
L00-L99	Diseases of the skin and subcutaneous tissue	242	27	18	7	21	22	43	34	-	9	20	28	12
M00-M99	Diseases of the musculoskeletal system and connective tissue	150	12	15	-	18	11	16	16	9	14	14	10	11

Children and young people in Lancashire

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
N00-N99	Diseases of the genitourinary system	350	33	34	17	31	35	35	45	8	33	28	21	30
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	27	8	-	-	-	-	-	-	-	-	-	-	6
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1149	125	91	54	92	97	102	194	35	61	133	80	85
S00-T98	Injury, poisoning and certain other consequences of external causes	1012	103	80	25	100	111	109	139	36	65	108	89	47
Z00-Z99	Factors influencing health status and contact with health services	356	43	22	13	29	44	21	48	19	27	42	17	31
Total Admissions		14255	1473	1170	435	1579	1362	1364	2003	440	759	1402	1252	817

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 236: Hospital admissions for those aged 1 to 4 years – percentage of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	13.8%	18.4%	12.2%	14.0%	13.9%	16.3%	16.4%	11.6%	17.2%	14.9%	9.3%	13.6%	9.5%
	A00-A09 Intestinal infectious diseases	6.2%	9.8%	4.8%	3.6%	8.3%	5.9%	8.7%	5.4%	5.8%	7.9%	3.0%	5.9%	2.8%
C00-C97	Malignant neoplasms	2.7%	-	3.2%	-	8.2%	2.0%	3.8%	-	-	-	0.8%	3.3%	9.2%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	2.1%	-	3.2%	-	8.2%	-	3.8%	-	-	-	0.8%	2.7%	4.9%
D10-D36	Benign neoplasms	0.4%	-	-	-	-	-	-	0.4%	-	-	0.6%	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	0.2%	-	-	-	-	-	-	-	-	-	-	1.5%	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1.0%	1.1%	1.0%	-	1.0%	-	1.6%	1.9%	-	-	-	0.7%	1.0%
E00-E90	Endocrine, nutritional and metabolic diseases	1.2%	-	-	-	4.5%	-	0.6%	1.0%	3.7%	1.1%	1.7%	-	-
	E10-E14 Diabetes mellitus	0.1%	-	-	-	-	-	-	-	-	-	-	-	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	1.3%	0.9%	1.2%	2.4%	1.3%	1.4%	1.6%	2.1%	-	1.1%	1.1%	-	1.5%
	G40-G41 Epilepsy	0.6%	-	0.9%	-	0.6%	0.8%	0.6%	0.7%	-	-	0.7%	-	-
H00-H59	Diseases of the eye and adnexa	2.0%	1.9%	2.1%	3.0%	2.0%	1.9%	1.6%	1.4%	-	2.3%	2.6%	2.0%	3.3%
H60-H95	Diseases of the ear and mastoid process	4.2%	3.1%	5.7%	6.5%	2.8%	4.0%	4.7%	4.2%	4.0%	4.5%	4.8%	3.4%	5.1%
I00-I99	Diseases of the circulatory system	0.4%	-	-	-	-	0.7%	-	-	-	1.1%	-	-	-
J00-J99	Diseases of the respiratory system	31.2%	33.3%	30.4%	24.1%	29.4%	33.7%	31.2%	30.8%	31.0%	29.8%	31.8%	37.3%	24.1%
	J00-J06 Acute upper respiratory infections	17.6%	20.0%	18.0%	13.7%	16.6%	20.2%	17.5%	17.3%	17.8%	13.1%	17.0%	21.6%	12.4%

Children and young people in Lancashire

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
	J10-J18 Influenza and pneumonia	1.9%	2.0%	2.2%	1.8%	1.3%	1.3%	2.0%	2.2%	2.1%	2.0%	3.0%	1.8%	1.3%
	J20-J22 Other acute lower respiratory infections	4.9%	4.4%	3.7%	2.4%	5.3%	5.5%	4.7%	4.9%	4.6%	5.7%	6.3%	6.2%	2.6%
	J45-J46 Asthma	4.3%	4.5%	4.4%	2.7%	3.5%	3.0%	4.8%	4.4%	5.5%	5.9%	3.1%	6.2%	4.7%
K00-K93	Diseases of the digestive system	8.4%	6.2%	10.6%	11.6%	8.5%	6.1%	3.8%	11.7%	7.1%	6.8%	11.0%	8.1%	9.2%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	3.4%	2.3%	4.6%	6.0%	5.4%	-	1.4%	5.5%	3.4%	2.5%	4.0%	1.4%	4.4%
	K35-K38 Diseases of appendix	0.1%	-	-	-	-	-	-	-	-	-	-	-	-
	K40-K46 Hernia	0.8%	-	1.1%	-	-	1.6%	-	0.7%	-	-	1.1%	-	-
	K50-K52 Noninfective enteritis and colitis	2.0%	0.8%	3.0%	3.3%	1.2%	1.2%	-	3.5%	-	-	3.8%	2.5%	1.5%
L00-L99	Diseases of the skin and subcutaneous tissue	2.4%	2.6%	2.2%	2.1%	2.0%	2.2%	4.5%	2.4%	-	1.6%	2.0%	3.3%	2.0%
M00-M99	Diseases of the musculoskeletal system and connective tissue	1.5%	1.2%	1.9%	-	1.7%	1.1%	1.7%	1.2%	2.8%	2.5%	1.4%	1.2%	1.8%
N00-N99	Diseases of the genitourinary system	3.5%	3.2%	4.2%	5.1%	2.9%	3.6%	3.7%	3.2%	2.5%	5.9%	2.8%	2.5%	4.9%
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	0.3%	0.8%	-	-	-	-	-	-	-	-	-	-	1.0%
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	11.6%	12.1%	11.2%	16.1%	8.7%	9.8%	10.7%	13.9%	10.7%	11.0%	13.4%	9.4%	13.9%
S00-T98	Injury, poisoning and certain other consequences of external causes	10.2%	10.0%	9.9%	7.4%	9.5%	11.3%	11.4%	10.0%	11.0%	11.7%	10.9%	10.4%	7.7%
Z00-Z99	Factors influencing health status and contact with health services	3.6%	4.2%	2.7%	3.9%	2.8%	4.5%	2.2%	3.5%	5.8%	4.8%	4.2%	2.0%	5.1%
Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers														

Hospital admissions for those aged 5 to 9 years

Table 237: Hospital admissions for those aged 5 to 9 years – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	290	26	26	12	29	38	29	35	8	16	18	37	16
	A00-A09 Intestinal infectious diseases	125	17	10	-	15	11	17	11	6	8	7	19	-
C00-C97	Malignant neoplasms	184	-	8	8	18	9	38	31	35	-	37	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	169	-	6	8	18	9	38	31	29	-	30	-	-
D10-D36	Benign neoplasms	66	8	10	-	6	8	-	-	-	-	-	8	13
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	89	-	6	-	7	10	23	20	-	7	7	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	130	10	-	-	-	10	9	15	13	25	12	13	13
	E10-E14 Diabetes mellitus	37	-	-	-	-	-	-	-	-	6	8	-	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	150	6	22	-	7	26	14	28	14	-	9	6	13
	G40-G41 Epilepsy	90	-	10	-	-	18	9	21	11	-	-	-	6
H00-H59	Diseases of the eye and adnexa	127	23	8	-	9	9	19	9	-	-	9	14	14
H60-H95	Diseases of the ear and mastoid process	397	51	33	25	28	26	37	56	18	24	43	20	36
I00-I99	Diseases of the circulatory system	53	-	16	-	-	8	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	1162	100	62	33	157	137	128	141	73	52	111	100	68
	J00-J06 Acute upper respiratory infections	395	31	28	14	32	43	39	72	12	11	42	36	35
	J10-J18 Influenza and pneumonia	81	9	-	-	6	10	12	12	7	-	9	9	-
	J20-J22 Other acute lower respiratory infections	92	10	6	-	7	11	10	-	7	-	9	18	7
	J45-J46 Asthma	274	23	16	7	33	29	39	35	13	16	26	24	13
K00-K93	Diseases of the digestive system	1179	61	142	39	167	41	50	259	36	38	148	71	127
	K00-K14 Diseases of oral cavity, salivary glands and jaws	858	25	123	24	146	12	23	205	27	27	111	35	100
	K35-K38 Diseases of appendix	49	6	-	-	-	-	-	9	-	-	-	-	6
	K40-K46 Hernia	42	6	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	58	-	6	-	-	-	-	11	-	-	12	8	6
L00-L99	Diseases of the skin and subcutaneous tissue	147	13	6	9	22	11	20	28	-	10	6	10	10
M00-M99	Diseases of the musculoskeletal system and connective tissue	131	11	23	14	9	11	8	13	-	7	18	8	-

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ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
N00-N99	Diseases of the genitourinary system	354	31	83	14	21	31	17	35	9	14	33	37	29
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	33	-	-	-	-	7	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	664	84	46	24	74	53	74	100	17	37	68	54	33
S00-T98	Injury, poisoning and certain other consequences of external causes	767	74	81	35	66	78	63	111	34	46	65	65	49
Z00-Z99	Factors influencing health status and contact with health services	242	19	14	10	26	33	18	34	13	21	27	12	15
Total Admissions		8435	644	791	276	903	689	734	1322	382	365	865	604	609

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 238: Hospital admissions for those aged 5 to 9 years – percentage of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	4.7%	4.9%	4.4%	5.1%	4.4%	7.0%	5.2%	3.8%	2.8%	5.2%	2.9%	8.0%	3.5%
	A00-A09 Intestinal infectious diseases	2.0%	3.2%	1.7%	-	2.3%	2.0%	3.1%	1.2%	2.1%	2.6%	1.1%	4.1%	-
C00-C97	Malignant neoplasms	3.0%	-	1.3%	3.4%	2.7%	1.6%	6.9%	3.4%	12.2%	-	5.9%	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	2.7%	-	1.0%	3.4%	2.7%	1.6%	6.9%	3.4%	10.1%	-	4.8%	-	-
D10-D36	Benign neoplasms	1.1%	1.5%	1.7%	-	0.9%	1.5%	-	-	-	-	-	1.7%	2.9%
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1.4%	-	1.0%	-	1.1%	1.8%	4.2%	2.2%	-	2.3%	1.1%	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	2.1%	1.9%	-	-	-	1.8%	1.6%	1.6%	4.5%	8.1%	1.9%	2.8%	2.9%
	E10-E14 Diabetes mellitus	0.6%	-	-	-	-	-	-	-	-	1.9%	1.3%	-	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	2.4%	1.1%	3.7%	-	1.1%	4.8%	2.5%	3.0%	4.9%	-	1.4%	1.3%	2.9%
	G40-G41 Epilepsy	1.5%	-	1.7%	-	-	3.3%	1.6%	2.3%	3.8%	-	-	-	1.3%
H00-H59	Diseases of the eye and adnexa	2.1%	4.4%	1.3%	-	1.4%	1.6%	3.4%	1.0%	-	-	1.4%	3.0%	3.1%
H60-H95	Diseases of the ear and mastoid process	6.4%	9.7%	5.6%	10.6%	4.3%	4.8%	6.7%	6.1%	6.3%	7.8%	6.9%	4.3%	8.0%

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ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
I00-I99	Diseases of the circulatory system	0.9%	-	2.7%	-	-	1.5%	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	18.8%	19.0%	10.5%	14.0%	23.9%	25.1%	23.1%	15.2%	25.3%	16.9%	17.8%	21.6%	15.1%
	J00-J06 Acute upper respiratory infections	6.4%	5.9%	4.7%	5.9%	4.9%	7.9%	7.1%	7.8%	4.2%	3.6%	6.7%	7.8%	7.8%
	J10-J18 Influenza and pneumonia	1.3%	1.7%	-	-	0.9%	1.8%	2.2%	1.3%	2.4%	-	1.4%	1.9%	-
	J20-J22 Other acute lower respiratory infections	1.5%	1.9%	1.0%	-	1.1%	2.0%	1.8%	-	2.4%	-	1.4%	3.9%	1.6%
	J45-J46 Asthma	4.4%	4.4%	2.7%	3.0%	5.0%	5.3%	7.1%	3.8%	4.5%	5.2%	4.2%	5.2%	2.9%
K00-K93	Diseases of the digestive system	19.1%	11.6%	23.9%	16.5%	25.4%	7.5%	9.0%	28.0%	12.5%	12.3%	23.8%	15.3%	28.2%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	13.9%	4.8%	20.7%	10.2%	22.2%	2.2%	4.2%	22.2%	9.4%	8.8%	17.8%	7.6%	22.2%
	K35-K38 Diseases of appendix	0.8%	1.1%	-	-	-	-	-	1.0%	-	-	-	-	1.3%
	K40-K46 Hernia	0.7%	1.1%	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	0.9%	-	1.0%	-	-	-	-	1.2%	-	-	1.9%	1.7%	1.3%
L00-L99	Diseases of the skin and subcutaneous tissue	2.4%	2.5%	1.0%	3.8%	3.3%	2.0%	3.6%	3.0%	-	3.2%	1.0%	2.2%	2.2%
M00-M99	Diseases of the musculoskeletal system and connective tissue	2.1%	2.1%	3.9%	5.9%	1.4%	2.0%	1.4%	1.4%	-	2.3%	2.9%	1.7%	-
N00-N99	Diseases of the genitourinary system	5.7%	5.9%	14.0%	5.9%	3.2%	5.7%	3.1%	3.8%	3.1%	4.5%	5.3%	8.0%	6.4%
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	0.5%	-	-	-	-	1.3%	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	10.8%	16.0%	7.8%	10.2%	11.2%	9.7%	13.4%	10.8%	5.9%	12.0%	10.9%	11.7%	7.3%
S00-T98	Injury, poisoning and certain other consequences of external causes	12.4%	14.1%	13.7%	14.8%	10.0%	14.3%	11.4%	12.0%	11.8%	14.9%	10.4%	14.0%	10.9%
Z00-Z99	Factors influencing health status and contact with health services	3.9%	3.6%	2.4%	4.2%	4.0%	6.0%	3.3%	3.7%	4.5%	6.8%	4.3%	2.6%	3.3%

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Hospital admissions for those aged 10 to 14 years

Table 239: hospital admissions for those aged 10 to 14 years – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	166	17	18	8	16	27	17	15	-	14	6	15	12
	A00-A09 Intestinal infectious diseases	44	7	-	-	6	7	8	-	-	-	-	-	-
C00-C97	Malignant neoplasms	196	24	-	12	-	11	-	14	10	-	-	36	88
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	137	20	-	12	-	9	-	14	6	-	-	35	40
D10-D36	Benign neoplasms	105	6	11	11	-	22	-	6	-	-	7	15	17
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	55	9	-	-	17	-	-	10	-	-	-	-	8
E00-E90	Endocrine, nutritional and metabolic diseases	210	23	20	6	30	15	15	26	16	14	20	16	9
	E10-E14 Diabetes mellitus	68	11	7	-	10	-	-	9	-	-	8	-	-
F00-F99	Mental and behavioural disorders	113	14	11	8	7	10	8	17	-	7	8	15	6
G00-G99	Diseases of the nervous system	133	8	15	-	-	15	11	12	-	11	12	25	15
	G40-G41 Epilepsy	58	-	-	-	-	8	8	-	-	7	9	6	9
H00-H59	Diseases of the eye and adnexa	88	7	-	7	-	-	11	7	-	8	10	11	13
H60-H95	Diseases of the ear and mastoid process	141	13	13	10	13	10	12	16	8	13	17	6	10
I00-I99	Diseases of the circulatory system	103	6	10	31	6	7	7	10	-	-	11	-	7
J00-J99	Diseases of the respiratory system	666	44	36	22	82	84	60	105	28	35	64	64	42
	J00-J06 Acute upper respiratory infections	249	15	21	18	16	23	17	43	10	11	32	22	21
	J10-J18 Influenza and pneumonia	45	-	-	-	-	-	-	12	-	-	8	-	-
	J20-J22 Other acute lower respiratory infections	52	-	-	-	8	-	8	9	-	-	-	10	-
	J45-J46 Asthma	148	-	7	-	35	14	18	23	-	-	12	20	6
K00-K93	Diseases of the digestive system	1029	93	110	62	93	76	82	116	53	59	93	112	80
	K00-K14 Diseases of oral cavity, salivary glands and jaws	574	51	57	31	63	30	41	69	34	39	61	49	49
	K35-K38 Diseases of appendix	123	17	9	14	12	11	9	11	8	-	9	12	6
	K40-K46 Hernia	21	-	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	131	-	30	12	-	11	14	11	-	-	-	30	12
L00-L99	Diseases of the skin and subcutaneous tissue	159	10	14	6	10	16	17	16	-	12	17	18	18
M00-M99	Diseases of the musculoskeletal system and connective tissue	326	33	22	11	25	38	13	44	18	14	29	53	26

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ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
N00-N99	Diseases of the genitourinary system	333	21	25	82	23	36	33	30	9	10	30	17	17
O00-O99	Pregnancy, childbirth and the puerperium	22	-	-	-	-	6	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	46	7	6	-	-	-	6	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	840	74	86	32	86	92	74	97	35	40	75	80	69
S00-T98	Injury, poisoning and certain other consequences of external causes	872	74	79	36	63	86	66	133	35	56	77	98	69
Z00-Z99	Factors influencing health status and contact with health services	204	17	16	12	18	22	10	33	6	12	31	13	14
Total Admissions		7457	621	623	443	639	686	565	908	276	362	646	778	663

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 240: Hospital admissions for those aged 10 to 14 years - % of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	2.9%	3.4%	3.6%	2.2%	3.2%	4.6%	3.8%	2.1%	-	4.5%	1.2%	2.5%	2.3%
	A00-A09 Intestinal infectious diseases	0.8%	1.4%	-	-	1.2%	1.2%	1.8%	-	-	-	-	-	-
C00-C97	Malignant neoplasms	3.4%	4.8%	-	3.3%	-	1.9%	-	2.0%	4.1%	-	-	5.9%	16.8%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	2.4%	4.0%	-	3.3%	-	1.5%	-	2.0%	2.5%	-	-	5.8%	7.6%
D10-D36	Benign neoplasms	1.8%	1.2%	2.2%	3.0%	-	3.8%	-	0.8%	-	-	1.4%	2.5%	3.3%
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	0.9%	1.8%	-	-	3.4%	-	-	1.4%	-	-	-	-	1.5%
E00-E90	Endocrine, nutritional and metabolic diseases	3.6%	4.6%	4.0%	1.6%	6.0%	2.6%	3.3%	3.7%	6.6%	4.5%	3.9%	2.6%	1.7%
	E10-E14 Diabetes mellitus	1.2%	2.2%	1.4%	-	2.0%	-	-	1.3%	-	-	1.6%	-	-
F00-F99	Mental and behavioural disorders	1.9%	2.8%	2.2%	2.2%	1.4%	1.7%	1.8%	2.4%	-	2.2%	1.6%	2.5%	1.1%
G00-G99	Diseases of the nervous system	2.3%	1.6%	3.0%	-	-	2.6%	2.4%	1.7%	-	3.5%	2.3%	4.1%	2.9%
	G40-G41 Epilepsy	1.0%	-	-	-	-	1.4%	1.8%	-	-	2.2%	1.8%	1.0%	1.7%
H00-H59	Diseases of the eye and adnexa	1.5%	1.4%	-	1.9%	-	-	2.4%	1.0%	-	2.6%	1.9%	1.8%	2.5%
H60-H95	Diseases of the ear and mastoid process	2.4%	2.6%	2.6%	2.7%	2.6%	1.7%	2.7%	2.3%	3.3%	4.2%	3.3%	1.0%	1.9%
I00-I99	Diseases of the circulatory system	1.8%	1.2%	2.0%	8.5%	1.2%	1.2%	1.6%	1.4%	-	-	2.1%	-	1.3%

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ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
J00-J99	Diseases of the respiratory system	11.5%	8.7%	7.2%	6.0%	16.3%	14.4%	13.4%	14.8%	11.5%	11.2%	12.5%	10.5%	8.0%
	J00-J06 Acute upper respiratory infections	4.3%	3.0%	4.2%	4.9%	3.2%	3.9%	3.8%	6.1%	4.1%	3.5%	6.2%	3.6%	4.0%
	J10-J18 Influenza and pneumonia	0.8%	-	-	-	-	-	-	1.7%	-	-	1.6%	-	-
	J20-J22 Other acute lower respiratory infections	0.9%	-	-	-	1.6%	-	1.8%	1.3%	-	-	-	1.6%	-
	J45-J46 Asthma	2.5%	-	1.4%	-	7.0%	2.4%	4.0%	3.2%	-	-	2.3%	3.3%	1.1%
K00-K93	Diseases of the digestive system	17.7%	18.5%	22.0%	17.0%	18.5%	13.0%	18.3%	16.3%	21.8%	18.9%	18.1%	18.4%	15.3%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	9.9%	10.1%	11.4%	8.5%	12.5%	5.1%	9.1%	9.7%	14.0%	12.5%	11.9%	8.1%	9.4%
	K35-K38 Diseases of appendix	2.1%	3.4%	1.8%	3.8%	2.4%	1.9%	2.0%	1.5%	3.3%	-	1.8%	2.0%	1.1%
	K40-K46 Hernia	0.4%	-	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	2.3%	-	6.0%	3.3%	-	1.9%	3.1%	1.5%	-	-	-	4.9%	2.3%
L00-L99	Diseases of the skin and subcutaneous tissue	2.7%	2.0%	2.8%	1.6%	2.0%	2.7%	3.8%	2.3%	-	3.8%	3.3%	3.0%	3.4%
M00-M99	Diseases of the musculoskeletal system and connective tissue	5.6%	6.5%	4.4%	3.0%	5.0%	6.5%	2.9%	6.2%	7.4%	4.5%	5.7%	8.7%	5.0%
N00-N99	Diseases of the genitourinary system	5.7%	4.2%	5.0%	22.5%	4.6%	6.2%	7.3%	4.2%	3.7%	3.2%	5.8%	2.8%	3.3%
O00-O99	Pregnancy, childbirth and the puerperium	0.4%	-	-	-	-	1.0%	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	0.8%	1.4%	1.2%	-	-	-	1.3%	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	14.5%	14.7%	17.2%	8.8%	17.1%	15.8%	16.5%	13.7%	14.4%	12.8%	14.6%	13.2%	13.2%
S00-T98	Injury, poisoning and certain other consequences of external causes	15.0%	14.7%	15.8%	9.9%	12.5%	14.7%	14.7%	18.7%	14.4%	17.9%	15.0%	16.1%	13.2%
Z00-Z99	Factors influencing health status and contact with health services	3.5%	3.4%	3.2%	3.3%	3.6%	3.8%	2.2%	4.6%	2.5%	3.8%	6.0%	2.1%	2.7%

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Hospital admissions for those aged 15 to 19 years

Table 241: Hospital admissions for those aged 15 to 19 years by district – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	134	10	18	-	6	10	13	33	8	8	12	10	-
	A00-A09 Intestinal infectious diseases	25	-	-	-	-	-	-	-	-	-	-	-	-
C00-C97	Malignant neoplasms	229	57	11	6	7	16	27	6	-	-	21	46	32
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	111	10	9	-	6	16	-	-	-	-	17	38	11
D10-D36	Benign neoplasms	183	-	16	20	11	27	10	23	8	7	17	19	20
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	84	18	6	-	-	-	18	16	-	-	-	6	6
E00-E90	Endocrine, nutritional and metabolic diseases	224	22	17	13	15	33	10	28	6	11	24	25	20
	E10-E14 Diabetes mellitus	113	12	12	6	5	24	-	17	-	7	9	7	8
F00-F99	Mental and behavioural disorders	203	30	21	9	12	20	19	27	-	13	12	24	12
G00-G99	Diseases of the nervous system	187	18	10	10	13	17	18	27	7	18	20	22	7
	G40-G41 Epilepsy	89	11	-	-	6	-	14	18	-	7	15	-	-
H00-H59	Diseases of the eye and adnexa	112	12	10	-	12	18	8	8	-	6	9	12	11
H60-H95	Diseases of the ear and mastoid process	87	9	6	-	9	11	-	12	-	8	6	10	6
I00-I99	Diseases of the circulatory system	187	9	12	-	10	25	8	11	-	6	11	79	8
J00-J99	Diseases of the respiratory system	762	62	77	27	60	94	87	120	27	47	73	49	39
	J00-J06 Acute upper respiratory infections	248	16	31	11	12	26	14	40	-	15	36	28	15
	J10-J18 Influenza and pneumonia	32	-	-	-	-	-	-	-	-	-	-	-	-
	J20-J22 Other acute lower respiratory infections	48	7	-	-	-	6	-	-	-	-	-	-	-
	J45-J46 Asthma	94	-	12	-	15	18	8	12	-	10	10	-	-
K00-K93	Diseases of the digestive system	1142	145	93	51	114	105	64	118	46	86	101	118	101
	K00-K14 Diseases of oral cavity, salivary glands and jaws	455	59	35	20	67	18	36	43	14	47	37	32	47
	K35-K38 Diseases of appendix	155	23	10	10	10	21	9	18	10	7	11	13	13
	K40-K46 Hernia	37	-	6	-	-	6	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	183	31	11	11	12	8	7	17	8	11	19	35	13
L00-L99	Diseases of the skin and subcutaneous tissue	371	41	27	23	18	35	29	56	12	27	39	26	38
M00-M99	Diseases of the musculoskeletal system and connective tissue	578	57	60	38	45	56	33	88	26	23	47	45	60

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ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
N00-N99	Diseases of the genitourinary system	747	42	52	23	101	78	42	84	25	30	49	183	38
O00-O99	Pregnancy, childbirth and the puerperium	2419	166	242	91	200	220	169	608	50	78	263	188	144
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	23	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1231	95	91	69	90	171	102	195	33	65	119	107	94
S00-T98	Injury, poisoning and certain other consequences of external causes	1506	146	121	69	114	174	123	263	55	87	130	135	89
Z00-Z99	Factors influencing health status and contact with health services	580	31	104	28	36	34	33	116	13	14	73	43	55
Total Admissions		12579	1139	1120	535	1006	1287	901	2004	348	638	1180	1300	887

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 242: Hospital admissions for those aged 15 to 19 years by district – percentage of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	1.2%	1.0%	1.8%	-	0.7%	0.9%	1.6%	1.8%	2.4%	1.5%	1.2%	0.9%	-
	A00-A09 Intestinal infectious diseases	0.2%	-	-	-	-	-	-	-	-	-	-	-	-
C00-C97	Malignant neoplasms	2.1%	5.8%	1.1%	1.2%	0.8%	1.4%	3.3%	0.3%	-	-	2.0%	4.0%	4.1%
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	1.0%	1.0%	0.9%	-	0.7%	1.4%	-	-	-	-	1.6%	3.3%	1.4%
D10-D36	Benign neoplasms	1.7%	-	1.6%	4.0%	1.3%	2.3%	1.2%	1.2%	2.4%	1.3%	1.6%	1.7%	2.5%
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	0.8%	1.8%	0.6%	-	-	-	2.2%	0.9%	-	-	-	0.5%	0.8%
E00-E90	Endocrine, nutritional and metabolic diseases	2.0%	2.3%	1.7%	2.6%	1.7%	2.9%	1.2%	1.5%	1.8%	2.0%	2.3%	2.2%	2.5%
	E10-E14 Diabetes mellitus	1.0%	1.2%	1.2%	1.2%	0.6%	2.1%	-	0.9%	-	1.3%	0.9%	0.6%	1.0%
F00-F99	Mental and behavioural disorders	1.8%	3.1%	2.1%	1.8%	1.4%	1.7%	2.3%	1.5%	-	2.4%	1.2%	2.1%	1.5%
G00-G99	Diseases of the nervous system	1.7%	1.8%	1.0%	2.0%	1.5%	1.5%	2.2%	1.5%	2.1%	3.4%	1.9%	1.9%	0.9%
	G40-G41 Epilepsy	0.8%	1.1%	-	-	0.7%	-	1.7%	1.0%	-	1.3%	1.5%	-	-
H00-H59	Diseases of the eye and adnexa	1.0%	1.2%	1.0%	-	1.4%	1.6%	1.0%	0.4%	-	1.1%	0.9%	1.0%	1.4%
H60-H95	Diseases of the ear and mastoid process	0.8%	0.9%	0.6%	-	1.0%	1.0%	-	0.7%	-	1.5%	0.6%	0.9%	0.8%
I00-I99	Diseases of the circulatory system	1.7%	0.9%	1.2%	-	1.1%	2.2%	1.0%	0.6%	-	1.1%	1.1%	6.9%	1.0%

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ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
J00-J99	Diseases of the respiratory system	6.9%	6.3%	7.7%	5.4%	6.8%	8.2%	10.6%	6.5%	8.2%	8.8%	7.1%	4.3%	5.0%
	J00-J06 Acute upper respiratory infections	2.3%	1.6%	3.1%	2.2%	1.4%	2.3%	1.7%	2.2%	-	2.8%	3.5%	2.4%	1.9%
	J10-J18 Influenza and pneumonia	0.3%	-	-	-	-	-	-	-	-	-	-	-	-
	J20-J22 Other acute lower respiratory infections	0.4%	0.7%	-	-	-	0.5%	-	-	-	-	-	-	-
	J45-J46 Asthma	0.9%	-	1.2%	-	1.7%	1.6%	1.0%	0.7%	-	1.9%	1.0%	-	-
K00-K93	Diseases of the digestive system	10.4%	14.8%	9.3%	10.3%	13.0%	9.1%	7.8%	6.4%	14.0%	16.0%	9.8%	10.3%	12.9%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	4.1%	6.0%	3.5%	4.0%	7.6%	1.6%	4.4%	2.3%	4.3%	8.8%	3.6%	2.8%	6.0%
	K35-K38 Diseases of appendix	1.4%	2.4%	1.0%	2.0%	1.1%	1.8%	1.1%	1.0%	3.0%	1.3%	1.1%	1.1%	1.7%
	K40-K46 Hernia	0.3%	-	0.6%	-	-	0.5%	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	1.7%	3.2%	1.1%	2.2%	1.4%	0.7%	0.9%	0.9%	2.4%	2.0%	1.8%	3.1%	1.7%
L00-L99	Diseases of the skin and subcutaneous tissue	3.4%	4.2%	2.7%	4.6%	2.1%	3.0%	3.5%	3.0%	3.6%	5.0%	3.8%	2.3%	4.8%
M00-M99	Diseases of the musculoskeletal system and connective tissue	5.3%	5.8%	6.0%	7.7%	5.1%	4.9%	4.0%	4.8%	7.9%	4.3%	4.6%	3.9%	7.6%
N00-N99	Diseases of the genitourinary system	6.8%	4.3%	5.2%	4.6%	11.5%	6.8%	5.1%	4.6%	7.6%	5.6%	4.7%	16.0%	4.8%
O00-O99	Pregnancy, childbirth and the puerperium	22.0%	17.0%	24.3%	18.3%	22.8%	19.1%	20.5%	33.0%	15.2%	14.5%	25.5%	16.4%	18.3%
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	0.2%	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	11.2%	9.7%	9.1%	13.9%	10.3%	14.8%	12.4%	10.6%	10.0%	12.1%	11.5%	9.3%	12.0%
S00-T98	Injury, poisoning and certain other consequences of external causes	13.7%	14.9%	12.2%	13.9%	13.0%	15.1%	14.9%	14.3%	16.7%	16.2%	12.6%	11.8%	11.3%
Z00-Z99	Factors influencing health status and contact with health services	5.3%	3.2%	10.5%	5.6%	4.1%	3.0%	4.0%	6.3%	4.0%	2.6%	7.1%	3.7%	7.0%

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Emergency hospital admissions

Emergency hospital admissions for those aged under 1 year

Table 243: Emergency hospital admissions for those aged less than 1 year – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	1006	138	60	29	105	111	117	117	38	72	87	88	44
	A00-A09 Intestinal infectious diseases	475	77	31	13	66	44	67	44	15	37	36	25	20
C00-C97	Malignant neoplasms	-	-	-	-	0	-	-	-	-	-	-	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	-	-	-	-	0	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	21	-	-	-	1	7	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	0	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	15	-	-	-	1	-	-	-	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	18	-	-	-	5	-	-	-	-	-	-	-	-
	E10-E14 Diabetes mellitus	0	-	-	-	0	-	-	-	-	-	-	-	-
F00-F99	Mental and behavioural disorders	0	-	-	-	0	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	36	7	-	-	0	9	-	12	-	-	-	-	-
	G40-G41 Epilepsy	11	-	-	-	0	8	-	-	-	-	-	-	-
H00-H59	Diseases of the eye and adnexa	11	-	-	-	0	-	-	-	-	-	-	-	-
H60-H95	Diseases of the ear and mastoid process	40	-	-	-	1	-	-	12	-	-	-	-	-
I00-I99	Diseases of the circulatory system	16	-	10	-	0	-	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	1833	230	124	36	186	215	174	288	57	94	153	208	68
	J00-J06 Acute upper respiratory infections	864	103	61	14	75	113	87	147	31	39	68	105	21
	J10-J18 Influenza and pneumonia	54	-	-	-	2	10	7	9	-	-	8	-	-
	J20-J22 Other acute lower respiratory infections	878	119	55	21	106	89	76	127	24	51	72	95	43
	J45-J46 Asthma	22	-	-	-	2	-	-	-	-	-	-	-	-
K00-K93	Diseases of the digestive system	468	30	41	14	50	48	24	74	12	24	52	70	29
	K00-K14 Diseases of oral cavity, salivary glands and jaws	-	-	-	-	0	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	0	-	-	-	0	-	-	-	-	-	-	-	-
	K40-K46 Hernia	30	-	-	-	9	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	141	-	15	10	9	13	-	29	-	7	20	17	13
L00-L99	Diseases of the skin and subcutaneous tissue	93	14	8	-	7	10	21	11	-	-	7	-	-

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
M00-M99	Diseases of the musculoskeletal system and connective tissue	14	-	-	-	3	-	-	-	-	-	-	-	-
N00-N99	Diseases of the genitourinary system	145	14	7	-	9	9	20	18	7	-	30	16	7
O00-O99	Pregnancy, childbirth and the puerperium	0	-	-	-	0	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-	-	-	0	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	935	97	80	38	72	114	102	140	24	43	96	56	73
S00-T98	Injury, poisoning and certain other consequences of external causes	204	34	13	-	17	25	13	36	6	6	16	26	8
Z00-Z99	Factors influencing health status and contact with health services	183	20	11	12	13	12	19	36	-	9	11	13	23
Total Admissions		7513	883	516	187	739	837	727	1100	214	382	656	719	349

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 243: Emergency hospital admissions for those aged less than 1 year – percentage of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	19.9%	23.1%	16.4%	6.6%	22.3%	19.3%	23.7%	15.4%	24.1%	27.7%	18.8%	17.9%	5.2%
	A00-A09 Intestinal infectious diseases	9.4%	12.9%	8.5%	8.7%	14.0%	7.7%	13.6%	5.8%	9.5%	14.2%	7.8%	5.1%	7.7%
C00-C97	Malignant neoplasms	-	-	-	-	-	-	-	-	-	-	-	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	-	-	-	-	-	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	0.4%	-	-	-	-	1.2%	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	0.3%	-	-	-	-	-	-	-	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	0.4%	-	-	-	-	-	-	-	-	-	-	-	-
	E10-E14 Diabetes mellitus	-	-	-	-	-	-	-	-	-	-	-	-	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-	Diseases of the nervous system	0.7%	1.2%	-	-	-	1.6%	-	1.6%	-	-	-	-	-

Children and young people in Lancashire

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
G99	G40-G41 Epilepsy	0.2%	-	-	-	-	1.4%	-	-	-	-	-	-	-
H00-H59	Diseases of the eye and adnexa	0.2%	-	-	-	-	-	-	-	-	-	-	-	-
H60-H95	Diseases of the ear and mastoid process	0.8%	-	0.5%	-	-	-	-	1.6%	-	-	-	-	-
I00-I99	Diseases of the circulatory system	0.3%	-	2.7%	-	-	-	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	36.3%	38.5%	33.9%	8.2%	39.6%	37.5%	35.2%	37.9%	36.1%	36.2%	33.1%	42.4%	8.1%
	J00-J06 Acute upper respiratory infections	17.1%	17.2%	16.7%	9.4%	16.0%	19.7%	17.6%	19.3%	19.6%	15.0%	14.7%	21.4%	8.0%
	J10-J18 Influenza and pneumonia	1.1%	0.8%	-	-	-	1.7%	1.4%	1.2%	-	-	1.7%	-	-
	J20-J22 Other acute lower respiratory infections	17.4%	19.9%	15.0%	14.1%	22.6%	15.5%	15.4%	16.7%	15.2%	19.6%	15.6%	19.3%	16.5%
	J45-J46 Asthma	0.4%	-	-	-	-	-	0.6%	-	-	-	-	-	-
K00-K93	Diseases of the digestive system	9.3%	5.0%	11.2%	9.4%	10.6%	8.4%	4.9%	9.7%	7.6%	9.2%	11.3%	14.3%	11.1%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	-	-	-	-	-	-	0.0%	-	-	-	-	-	-
	K35-K38 Diseases of appendix	-	-	-	-	-	-	0.0%	-	-	-	-	-	-
	K40-K46 Hernia	0.6%	-	-	-	1.9%	-	0.0%	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	2.8%	-	4.1%	6.7%	1.9%	2.3%	0.2%	3.8%	-	2.7%	4.3%	3.5%	5.0%
L00-L99	Diseases of the skin and subcutaneous tissue	1.8%	2.3%	2.2%	-	1.5%	1.7%	4.3%	1.4%	-	-	1.5%	-	-
M00-M99	Diseases of the musculoskeletal system and connective tissue	0.3%	-	-	-	-	-	-	-	-	-	-	-	-
N00-N99	Diseases of the genitourinary system	2.9%	2.3%	1.9%	-	1.9%	1.6%	4.0%	2.4%	4.4%	-	6.5%	3.3%	2.7%
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	18.5%	16.2%	21.9%	25.5%	15.3%	19.9%	20.6%	18.4%	15.2%	16.5%	20.8%	11.4%	28.0%
S00-T98	Injury, poisoning and certain other consequences of external causes	4.0%	5.7%	3.6%	-	3.6%	4.4%	2.6%	4.7%	3.8%	2.3%	3.5%	5.3%	3.1%
Z00-Z99	Factors influencing health status and contact with health services	3.6%	3.3%	3.0%	8.1%	2.8%	2.1%	3.8%	4.7%	-	3.5%	2.4%	2.6%	8.8%

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Emergency hospital admissions for those aged 1 to 4 years

Table 245: Emergency hospital admissions for those aged 1 to 4 years – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	1346	189	98	47	144	159	155	158	53	82	89	114	58
	A00-A09 Intestinal infectious diseases	609	100	38	12	88	58	83	74	19	43	29	48	17
C00-C97	Malignant neoplasms	21	-	-	-	7	-	-	-	-	-	-	6	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	15	-	-	-	7	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	0	-	-	-	-	-	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	73	10	-	-	10	-	15	12	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	47	-	-	-	17	-	-	7	6	-	-	-	-
	E10-E14 Diabetes mellitus	14	-	-	-	-	-	-	-	-	-	-	-	-
F00-F99	Mental and behavioural disorders	0	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	72	-	-	-	9	9	10	17	-	-	8	-	-
	G40-G41 Epilepsy	42	-	-	-	-	6	-	6	-	-	6	-	-
H00-H59	Diseases of the eye and adnexa	55	-	-	-	-	11	-	-	-	-	7	12	-
H60-H95	Diseases of the ear and mastoid process	121	-	20	-	-	18	11	22	-	7	20	6	-
I00-I99	Diseases of the circulatory system	21	-	-	-	-	-	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	2746	307	222	63	275	295	266	390	94	146	273	296	119
	J00-J06 Acute upper respiratory infections	1611	193	137	39	166	197	157	217	55	69	149	172	60
	J10-J18 Influenza and pneumonia	191	20	18	6	13	13	19	31	7	11	30	15	8
	J20-J22 Other acute lower respiratory infections	478	45	30	8	52	54	44	68	14	32	62	53	16
	J45-J46 Asthma	425	46	35	9	37	30	45	61	18	33	30	52	29
K00-K93	Diseases of the digestive system	411	35	40	15	26	40	23	78	8	20	60	45	21
	K00-K14 Diseases of oral cavity, salivary glands and jaws	26	-	-	-	-	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	7	-	-	-	-	-	-	-	-	-	-	-	-
	K40-K46 Hernia	14	-	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	189	8	23	11	11	11	-	46	-	-	37	21	9
L00-L99	Diseases of the skin and subcutaneous tissue	184	23	12	6	11	19	38	26	-	8	17	16	7
M00-M99	Diseases of the musculoskeletal system and connective tissue	104	9	11	-	10	7	12	13	8	10	11	6	-

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ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
N00-N99	Diseases of the genitourinary system	191	14	22	8	20	23	15	29	-	17	17	13	9
O00-O99	Pregnancy, childbirth and the puerperium	0	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	6	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1025	107	85	47	83	87	95	168	33	54	118	70	78
S00-T98	Injury, poisoning and certain other consequences of external causes	887	86	64	25	84	101	99	119	33	59	96	82	39
Z00-Z99	Factors influencing health status and contact with health services	115	16	-	7	10	17	-	15	-	-	17	8	10
Total Admissions		11046	1208	855	303	1080	1155	1087	1557	348	591	1076	1035	480

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 246: Emergency hospital admissions for those aged 1 to 4 years – percentage of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	18.1%	23.1%	16.4%	20.3%	20.3%	19.9%	20.6%	14.9%	21.2%	19.9%	11.9%	16.7%	15.9%
	A00-A09 Intestinal infectious diseases	8.2%	12.2%	6.3%	5.2%	12.4%	7.3%	11.0%	7.0%	7.6%	10.4%	3.9%	7.0%	4.7%
C00-C97	Malignant neoplasms	0.3%	-	-	-	1.0%	-	-	-	-	-	-	0.9%	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	0.2%	-	-	-	1.0%	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	0.0%	-	-	-	-	-	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1.0%	1.2%	-	-	1.4%	-	2.0%	1.1%	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	0.6%	-	-	-	2.4%	-	-	0.7%	2.4%	-	-	-	-
	E10-E14 Diabetes mellitus	0.2%	-	-	-	-	-	-	-	-	-	-	-	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	1.0%	-	-	-	1.3%	1.1%	1.3%	1.6%	-	-	1.1%	-	-
	G40-G41 Epilepsy	0.6%	-	-	-	-	0.8%	-	0.6%	-	-	0.8%	-	-
H00-H59	Diseases of the eye and adnexa	0.7%	-	-	-	-	1.4%	-	-	-	-	0.9%	1.8%	-
H60-H95	Diseases of the ear and mastoid process	1.6%	-	3.3%	-	-	2.3%	1.5%	2.1%	-	1.7%	2.7%	0.9%	-
I00-I99	Diseases of the circulatory system	0.3%	-	-	-	-	-	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	37.0%	37.5%	37.1%	27.3%	38.7%	37.0%	35.3%	36.8%	37.6%	35.4%	36.6%	43.5%	32.6%

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ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
	J00-J06 Acute upper respiratory infections	21.7%	23.6%	22.9%	16.9%	23.3%	24.7%	20.8%	20.5%	22.0%	16.7%	20.0%	25.3%	16.4%
	J10-J18 Influenza and pneumonia	2.6%	2.4%	3.0%	2.6%	1.8%	1.6%	2.5%	2.9%	2.8%	2.7%	4.0%	2.2%	2.2%
	J20-J22 Other acute lower respiratory infections	6.4%	5.5%	5.0%	3.5%	7.3%	6.8%	5.8%	6.4%	5.6%	7.7%	8.3%	7.8%	4.4%
	J45-J46 Asthma	5.7%	5.6%	5.8%	3.9%	5.2%	3.8%	6.0%	5.7%	7.2%	8.0%	4.0%	7.6%	7.9%
K00-K93	Diseases of the digestive system	5.5%	4.3%	6.7%	6.5%	3.7%	5.0%	3.1%	7.4%	3.2%	4.8%	8.1%	6.6%	5.8%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	0.4%	-	-	-	-	-	0.5%	-	-	-	-	-	-
	K35-K38 Diseases of appendix	0.1%	-	-	-	-	-	0.3%	-	-	-	-	-	-
	K40-K46 Hernia	0.2%	-	-	-	-	-	0.0%	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	2.5%	1.0%	3.8%	4.8%	1.5%	1.4%	0.5%	4.3%	-	-	5.0%	3.1%	2.5%
L00-L99	Diseases of the skin and subcutaneous tissue	2.5%	2.8%	2.0%	2.6%	1.5%	2.4%	5.0%	2.5%	-	1.9%	2.3%	2.3%	1.9%
M00-M99	Diseases of the musculoskeletal system and connective tissue	1.4%	1.1%	1.8%	-	1.4%	0.9%	1.6%	1.2%	3.2%	2.4%	1.5%	0.9%	-
N00-N99	Diseases of the genitourinary system	2.6%	1.7%	3.7%	3.5%	2.8%	2.9%	2.0%	2.7%	-	4.1%	2.3%	1.9%	2.5%
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	0.1%	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	13.8%	13.1%	14.2%	20.3%	11.7%	10.9%	12.6%	15.8%	13.2%	13.1%	15.8%	10.3%	21.4%
S00-T98	Injury, poisoning and certain other consequences of external causes	11.9%	10.5%	10.7%	10.8%	11.8%	12.7%	13.1%	11.2%	13.2%	14.3%	12.9%	12.0%	10.7%
Z00-Z99	Factors influencing health status and contact with health services	1.5%	2.0%	-	3.0%	1.4%	2.1%	-	1.4%	-	-	2.3%	1.2%	2.7%

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Emergency hospital admissions for those aged 5 to 9 years

Table 247: Emergency hospital admissions for those aged 5 to 9 years – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	281	26	26	11	26	38	29	32	8	16	18	18	16
	A00-A09 Intestinal infectious diseases	123	17	10	-	14	11	17	11	6	8	7	7	-
C00-C97	Malignant neoplasms	12	-	-	-	-	-	-	-	-	-	-	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	9	-	-	-	-	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	-	-	-	-	-	-	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	48	-	6	-	6	9	6	9	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	58	-	-	-	-	7	-	-	-	6	8	8	7
	E10-E14 Diabetes mellitus	34	-	-	-	-	-	-	-	-	-	7	7	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	97	-	13	-	-	20	10	16	8	-	6	6	8
	G40-G41 Epilepsy	70	-	7	-	-	17	8	13	8	-	-	-	-
H00-H59	Diseases of the eye and adnexa	23	-	-	-	-	-	-	-	-	-	-	-	-
H60-H95	Diseases of the ear and mastoid process	33	-	-	-	-	-	-	-	-	-	-	-	-
I00-I99	Diseases of the circulatory system	32	-	-	-	-	-	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	715	67	39	16	83	87	99	87	44	33	58	58	34
	J00-J06 Acute upper respiratory infections	255	26	16	6	27	40	34	37	10	7	19	19	13
	J10-J18 Influenza and pneumonia	76	7	-	-	6	10	12	12	-	-	8	8	-
	J20-J22 Other acute lower respiratory infections	84	9	6	-	7	10	10	-	7	-	9	9	6
	J45-J46 Asthma	264	23	16	7	33	26	39	34	12	16	21	21	13
K00-K93	Diseases of the digestive system	244	23	18	8	17	21	18	43	8	7	30	30	22
	K00-K14 Diseases of oral cavity, salivary glands and jaws	13	-	-	-	-	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	48	6	-	-	-	-	-	9	-	-	-	-	6
	K40-K46 Hernia	-	-	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	54	-	6	-	-	-	-	10	-	-	11	11	6
L00-L99	Diseases of the skin and subcutaneous tissue	77	12	-	-	-	9	14	13	-	-	-	-	-
M00-M99	Diseases of the musculoskeletal system and connective tissue	69	8	7	6	-	10	6	6	-	-	6	6	-

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ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
N00-N99	Diseases of the genitourinary system	122	12	6	-	8	14	8	21	-	6	17	17	6
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	565	70	40	23	62	49	62	83	15	33	55	55	30
S00-T98	Injury, poisoning and certain other consequences of external causes	659	66	69	28	57	69	51	91	32	37	57	57	41
Z00-Z99	Factors influencing health status and contact with health services	66	-	-	-	8	7	6	9	-	6	-	-	-
Total Admissions		4131	372	285	105	354	454	429	536	158	175	337	337	208

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 248: Emergency hospital admissions for those aged 5 to 9 years – percentage of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	9.0%	8.4%	10.7%	10.1%	9.0%	10.8%	9.1%	7.5%	5.9%	9.6%	6.4%	12.0%	8.7%
	A00-A09 Intestinal infectious diseases	4.0%	5.5%	4.1%	-	4.8%	3.1%	5.3%	2.6%	4.4%	4.8%	2.5%	6.2%	-
C00-C97	Malignant neoplasms	0.4%	-	-	-	-	-	-	-	-	-	-	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	0.3%	-	-	-	-	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	-	-	-	-	-	-	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1.5%	-	2.5%	-	2.1%	2.6%	1.9%	2.1%	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	1.9%	-	-	-	-	2.0%	-	-	-	3.6%	2.8%	3.1%	3.8%
	E10-E14 Diabetes mellitus	1.1%	-	-	-	-	-	-	-	-	-	2.5%	-	-
F00-F99	Mental and behavioural disorders	-	-	-	-	-	-	-	-	-	-	-	-	-
G00-G99	Diseases of the nervous system	3.1%	-	5.3%	-	-	5.7%	3.1%	3.8%	5.9%	-	2.1%	-	4.3%
	G40-G41 Epilepsy	2.3%	-	2.9%	-	-	4.8%	2.5%	3.1%	5.9%	-	-	-	-
H00-H59	Diseases of the eye and adnexa	0.7%	-	-	-	-	-	-	-	-	-	-	2.4%	-
H60-H95	Diseases of the ear and mastoid process	1.1%	-	-	-	-	-	-	-	-	-	-	-	-
I00-I99	Diseases of the circulatory system	1.0%	-	-	-	-	-	-	-	-	-	-	-	-

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ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
J00-J99	Diseases of the respiratory system	23.0%	21.8%	16.0%	14.7%	28.6%	24.7%	31.0%	20.4%	32.4%	19.9%	20.6%	23.3%	18.5%
	J00-J06 Acute upper respiratory infections	8.2%	8.4%	6.6%	5.5%	9.3%	11.4%	10.7%	8.7%	7.4%	4.2%	6.7%	6.8%	7.1%
	J10-J18 Influenza and pneumonia	2.4%	2.3%	-	-	2.1%	2.8%	3.8%	2.8%	-	-	2.8%	3.1%	-
	J20-J22 Other acute lower respiratory infections	2.7%	2.9%	2.5%	-	2.4%	2.8%	3.1%	-	5.1%	-	3.2%	4.5%	3.3%
	J45-J46 Asthma	8.5%	7.5%	6.6%	6.4%	11.4%	7.4%	12.2%	8.0%	8.8%	9.6%	7.4%	8.2%	7.1%
K00-K93	Diseases of the digestive system	7.9%	7.5%	7.4%	7.3%	5.9%	6.0%	5.6%	10.1%	5.9%	4.2%	10.6%	9.9%	12.0%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	0.4%	-	-	-	-	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	1.5%	1.9%	-	-	-	-	-	2.1%	-	-	-	-	3.3%
	K40-K46 Hernia	-	-	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	1.7%	-	2.5%	-	-	-	-	2.3%	-	-	3.9%	2.7%	3.3%
L00-L99	Diseases of the skin and subcutaneous tissue	2.5%	3.9%	-	-	-	2.6%	4.4%	3.1%	-	-	-	-	-
M00-M99	Diseases of the musculoskeletal system and connective tissue	2.2%	2.6%	2.9%	5.5%	-	2.8%	1.9%	1.4%	-	-	2.1%	-	-
N00-N99	Diseases of the genitourinary system	3.9%	3.9%	2.5%	-	2.8%	4.0%	2.5%	4.9%	-	3.6%	6.0%	6.2%	3.3%
O00-O99	Pregnancy, childbirth and the puerperium	-	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	18.2%	22.7%	16.5%	21.1%	21.4%	13.9%	19.4%	19.5%	11.0%	19.9%	19.5%	14.7%	16.3%
S00-T98	Injury, poisoning and certain other consequences of external causes	21.2%	21.4%	28.4%	25.7%	19.7%	19.6%	16.0%	21.4%	23.5%	22.3%	20.2%	20.9%	22.3%
Z00-Z99	Factors influencing health status and contact with health services	2.1%	-	-	-	2.8%	2.0%	1.9%	2.1%	-	3.6%	-	-	-

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Emergency hospital admissions for those aged 10 to 14 years

Table 249: Emergency hospital admissions for those aged 10 to 14 years – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	157	16	17	7	13	26	17	15	-	14	-	15	11
	A00-A09 Intestinal infectious diseases	44	7	-	-	6	7	8	-	-	-	-	-	-
C00-C97	Malignant neoplasms	15	-	-	-	-	-	-	-	-	-	-	6	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	10	-	-	-	-	-	-	-	-	-	-	6	-
D10-D36	Benign neoplasms	-	-	-	-	-	-	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	19	-	-	-	-	-	-	-	-	-	-	-	8
E00-E90	Endocrine, nutritional and metabolic diseases	110	14	10	-	17	8	-	15	-	-	12	6	9
	E10-E14 Diabetes mellitus	65	11	7	-	10	-	-	9	-	-	6	-	-
F00-F99	Mental and behavioural disorders	105	13	10	7	7	9	7	16	-	7	8	13	6
G00-G99	Diseases of the nervous system	79	-	8	-	-	13	7	7	-	7	8	13	9
	G40-G41 Epilepsy	42	-	-	-	-	7	-	-	-	-	6	6	-
H00-H59	Diseases of the eye and adnexa	24	-	-	-	-	-	-	-	-	-	-	7	-
H60-H95	Diseases of the ear and mastoid process	17	-	7	-	-	-	-	-	-	-	-	-	-
I00-I99	Diseases of the circulatory system	48	6	8	-	-	-	-	-	-	-	-	-	6
J00-J99	Diseases of the respiratory system	396	25	18	8	58	38	44	71	16	15	41	44	18
	J00-J06 Acute upper respiratory infections	137	12	7	-	13	19	14	25	6	-	13	13	7
	J10-J18 Influenza and pneumonia	44	-	-	-	-	-	-	12	-	-	8	-	-
	J20-J22 Other acute lower respiratory infections	48	-	-	-	8	-	8	7	-	-	-	8	-
	J45-J46 Asthma	141	-	7	-	33	12	18	22	-	-	12	18	6
K00-K93	Diseases of the digestive system	325	37	24	23	22	37	31	36	17	15	25	38	20
	K00-K14 Diseases of oral cavity, salivary glands and jaws	16	-	-	-	-	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	121	17	8	14	11	11	9	11	8	-	9	12	6
	K40-K46 Hernia	-	-	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	55	-	10	6	-	6	7	6	-	-	-	8	-
L00-L99	Diseases of the skin and subcutaneous tissue	66	6	-	-	-	6	8	-	-	6	7	11	6
M00-M99	Diseases of the musculoskeletal system and connective tissue	93	6	8	-	8	16	-	10	10	6	9	14	-

Children and young people in Lancashire

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
N00-N99	Diseases of the genitourinary system	143	-	11	-	14	24	20	22	-	-	18	11	7
O00-O99	Pregnancy, childbirth and the puerperium	8	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	766	69	78	29	77	87	70	85	31	35	67	73	65
S00-T98	Injury, poisoning and certain other consequences of external causes	735	57	60	34	52	78	48	109	28	50	65	92	62
Z00-Z99	Factors influencing health status and contact with health services	42	-	-	-	6	-	-	-	-	-	8	-	-
Total Admissions		3871	296	298	128	355	404	316	478	116	155	322	414	246

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 250: Emergency hospital admissions for those aged 10 to 14 years - % of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	5.0%	6.1%	6.3%	5.4%	4.5%	7.3%	6.3%	3.7%	-	8.3%	-	4.2%	4.6%
	A00-A09 Intestinal infectious diseases	1.4%	2.7%	-	-	2.1%	2.0%	3.0%	-	-	-	-	-	-
C00-C97	Malignant neoplasms	0.5%	-	-	-	-	-	-	-	-	-	-	1.7%	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	0.3%	-	-	-	-	-	-	-	-	-	-	1.7%	-
D10-D36	Benign neoplasms	-	-	-	-	-	-	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	0.6%	-	-	-	-	-	-	-	-	-	-	-	3.3%
E00-E90	Endocrine, nutritional and metabolic diseases	3.5%	5.3%	3.7%	-	5.9%	2.2%	-	3.7%	-	-	4.2%	1.7%	3.7%
	E10-E14 Diabetes mellitus	2.1%	4.2%	2.6%	-	3.5%	-	-	2.2%	-	-	2.1%	-	-
F00-F99	Mental and behavioural disorders	3.3%	4.9%	3.7%	5.4%	2.4%	2.5%	2.6%	3.9%	-	4.1%	2.8%	3.7%	2.5%
G00-G99	Diseases of the nervous system	2.5%	-	3.0%	-	-	3.7%	2.6%	1.7%	-	4.1%	2.8%	3.7%	3.7%
	G40-G41 Epilepsy	1.3%	-	-	-	-	2.0%	-	-	-	-	2.1%	1.7%	-
H00-H59	Diseases of the eye and adnexa	0.8%	-	-	-	-	-	-	-	-	-	-	2.0%	-
H60-H95	Diseases of the ear and mastoid process	0.5%	-	2.6%	-	-	-	-	-	-	-	-	-	-
I00-I99	Diseases of the circulatory system	1.5%	2.3%	3.0%	-	-	-	-	-	-	-	-	-	2.5%

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ICD10 Code	ICD 10 Description	LCC	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
J00-J99	Diseases of the respiratory system	12.6%	9.5%	6.6%	6.2%	20.1%	10.7%	16.2%	17.5%	13.4%	8.9%	14.4%	12.5%	7.5%
	J00-J06 Acute upper respiratory infections	4.3%	4.5%	2.6%	-	4.5%	5.3%	5.2%	6.2%	5.0%	-	4.6%	3.7%	2.9%
	J10-J18 Influenza and pneumonia	1.4%	-	-	-	-	-	-	3.0%	-	-	2.8%	-	-
	J20-J22 Other acute lower respiratory infections	1.5%	-	-	-	2.8%	-	3.0%	1.7%	-	-	-	2.3%	-
	J45-J46 Asthma	4.5%	-	2.6%	-	11.4%	3.4%	6.6%	5.4%	-	-	4.2%	5.1%	2.5%
K00-K93	Diseases of the digestive system	10.3%	14.0%	8.9%	17.7%	7.6%	10.4%	11.4%	8.9%	14.3%	8.9%	8.8%	10.8%	8.3%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	0.5%	-	-	-	-	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	3.8%	6.4%	3.0%	10.8%	3.8%	3.1%	3.3%	2.7%	6.7%	-	3.2%	3.4%	2.5%
	K40-K46 Hernia	-	-	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	1.7%	-	3.7%	4.6%	-	1.7%	2.6%	1.5%	-	-	-	2.3%	-
L00-L99	Diseases of the skin and subcutaneous tissue	2.1%	2.3%	-	-	-	1.7%	3.0%	-	-	3.6%	2.5%	3.1%	2.5%
M00-M99	Diseases of the musculoskeletal system and connective tissue	2.9%	2.3%	3.0%	-	2.8%	4.5%	-	2.5%	8.4%	3.6%	3.2%	4.0%	-
N00-N99	Diseases of the genitourinary system	4.5%	-	4.1%	-	4.8%	6.7%	7.4%	5.4%	-	-	6.3%	3.1%	2.9%
O00-O99	Pregnancy, childbirth and the puerperium	0.3%	-	-	-	-	-	-	-	-	-	-	-	-
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	24.3%	26.1%	28.8%	22.3%	26.6%	24.4%	25.8%	20.9%	26.1%	20.7%	23.6%	20.7%	27.0%
S00-T98	Injury, poisoning and certain other consequences of external causes	23.3%	21.6%	22.1%	26.2%	18.0%	21.9%	17.7%	26.8%	23.5%	29.6%	22.9%	26.1%	25.7%
Z00-Z99	Factors influencing health status and contact with health services	1.3%	-	-	-	2.1%	-	-	-	-	-	2.8%	-	-

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Emergency hospital admissions for those aged 15 to 19 years

Table 251: Emergency hospital admissions for those aged 15 to 19 years by district – number of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	113	9	17	-	6	9	8	25	-	8	11	10	-
	A00-A09 Intestinal infectious diseases	23	-	-	-	-	-	-	-	-	-	-	-	-
C00-C97	Malignant neoplasms	17	-	-	-	-	-	-	-	-	-	-	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	13	-	-	-	-	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	6	-	-	-	-	-	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	28	-	-	-	-	-	-	-	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	141	15	12	10	7	28	-	22	-	6	12	7	16
	E10-E14 Diabetes mellitus	107	11	10	6	-	24	-	17	-	-	9	7	7
F00-F99	Mental and behavioural disorders	194	29	21	9	11	19	18	25	-	12	12	23	12
G00-G99	Diseases of the nervous system	131	13	10	-	10	14	15	20	-	8	15	18	-
	G40-G41 Epilepsy	80	11	-	-	6	-	14	16	-	-	13	-	-
H00-H59	Diseases of the eye and adnexa	-	-	-	-	-	-	-	-	-	-	-	-	-
H60-H95	Diseases of the ear and mastoid process	15	-	-	-	-	-	-	-	-	-	-	-	-
I00-I99	Diseases of the circulatory system	47	-	9	-	-	12	-	-	-	-	-	-	-
J00-J99	Diseases of the respiratory system	346	28	40	8	33	53	35	45	10	20	31	25	18
	J00-J06 Acute upper respiratory infections	108	7	12	-	6	15	8	18	-	-	13	14	-
	J10-J18 Influenza and pneumonia	32	-	-	-	-	-	-	-	-	-	-	-	-
	J20-J22 Other acute lower respiratory infections	45	7	-	-	-	6	-	-	-	-	-	-	-
	J45-J46 Asthma	85	-	12	-	15	17	8	9	-	6	9	-	-
K00-K93	Diseases of the digestive system	420	47	29	21	35	60	17	47	27	23	40	42	32
	K00-K14 Diseases of oral cavity, salivary glands and jaws	22	-	-	-	-	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	152	23	9	10	10	21	8	18	10	6	11	13	13
	K40-K46 Hernia	-	-	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	59	-	-	-	-	6	-	-	7	-	-	8	7
L00-L99	Diseases of the skin and subcutaneous tissue	107	12	10	7	-	13	10	15	-	11	10	7	-
M00-M99	Diseases of the musculoskeletal system and connective tissue	98	-	8	9	-	17	-	12	8	-	7	11	10

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
N00-N99	Diseases of the genitourinary system	287	22	18	9	19	46	26	50	13	15	23	30	16
O00-O99	Pregnancy, childbirth and the puerperium	471	23	61	23	50	42	19	118	13	7	68	22	25
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1020	75	77	48	74	144	90	171	27	57	99	85	73
S00-T98	Injury, poisoning and certain other consequences of external causes	1268	123	95	58	90	152	100	223	46	77	103	121	80
Z00-Z99	Factors influencing health status and contact with health services	60	-	16	-	-	-	-	7	-	-	-	10	-
Total Admissions		5495	455	466	218	372	698	376	858	161	256	486	453	309

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Table 252: Emergency hospital admissions for those aged 15 to 19 years by district – percentage of admissions during 2009/10 by selected ICD10 codes

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
A00-B99	Certain infectious and parasitic diseases	2.4%	2.2%	4.0%	-	1.7%	1.4%	2.2%	3.2%	-	3.2%	2.5%	2.4%	-
	A00-A09 Intestinal infectious diseases	0.5%	-	-	-	-	-	-	-	-	-	-	-	-
C00-C97	Malignant neoplasms	0.4%	-	-	-	-	-	-	-	-	-	-	-	-
	C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue	0.3%	-	-	-	-	-	-	-	-	-	-	-	-
D10-D36	Benign neoplasms	0.1%	-	-	-	-	-	-	-	-	-	-	-	-
D37-D48	Neoplasms of uncertain or unknown behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	0.6%	-	-	-	-	-	-	-	-	-	-	-	-
E00-E90	Endocrine, nutritional and metabolic diseases	3.0%	3.6%	2.8%	4.6%	2.0%	4.5%	-	2.8%	-	2.4%	2.7%	1.7%	5.2%
	E10-E14 Diabetes mellitus	2.2%	2.7%	2.3%	2.8%	-	3.8%	-	2.1%	-	-	2.0%	1.7%	2.3%
F00-F99	Mental and behavioural disorders	4.1%	7.0%	4.9%	4.1%	3.1%	3.0%	5.1%	3.2%	-	4.8%	2.7%	5.4%	3.9%
G00-G99	Diseases of the nervous system	2.7%	3.2%	2.3%	-	2.8%	2.2%	4.2%	2.5%	-	3.2%	3.4%	4.3%	-
	G40-G41 Epilepsy	1.7%	2.7%	-	-	1.7%	-	3.9%	2.0%	-	-	2.9%	-	-
H00-H59	Diseases of the eye and adnexa	-	-	-	-	-	-	-	-	-	-	-	-	-
H60-H95	Diseases of the ear and mastoid process	0.3%	-	-	-	-	-	-	-	-	-	-	-	-
I00-I99	Diseases of the circulatory system	1.0%	-	2.1%	-	-	1.9%	-	-	-	-	-	-	-

Children and young people in Lancashire

ICD10 Code	ICD 10 Description	L12	Bu	Ch	Fy	Hy	La	Pe	Pr	RV	Ro	SR	WL	Wy
J00-J99	Diseases of the respiratory system	7.2%	6.8%	9.3%	3.7%	9.3%	8.5%	9.8%	5.7%	6.1%	7.9%	7.0%	5.9%	5.8%
	J00-J06 Acute upper respiratory infections	2.3%	1.7%	2.8%	-	1.7%	2.4%	2.2%	2.3%	-	-	2.9%	3.3%	-
	J10-J18 Influenza and pneumonia	0.7%	-	-	-	-	-	-	-	-	-	-	-	-
	J20-J22 Other acute lower respiratory infections	0.9%	1.7%	-	-	-	1.0%	-	-	-	-	-	-	-
	J45-J46 Asthma	1.8%	-	2.8%	-	4.2%	2.7%	2.2%	1.1%	-	2.4%	2.0%	-	-
K00-K93	Diseases of the digestive system	8.8%	11.4%	6.8%	9.7%	9.8%	9.6%	4.8%	5.9%	16.5%	9.1%	9.0%	9.9%	10.4%
	K00-K14 Diseases of oral cavity, salivary glands and jaws	0.5%	-	-	-	-	-	-	-	-	-	-	-	-
	K35-K38 Diseases of appendix	3.2%	5.6%	2.1%	4.6%	2.8%	3.4%	2.2%	2.3%	6.1%	2.4%	2.5%	3.1%	4.2%
	K40-K46 Hernia	-	-	-	-	-	-	-	-	-	-	-	-	-
	K50-K52 Noninfective enteritis and colitis	1.2%	-	-	-	-	1.0%	-	-	4.3%	-	-	1.9%	2.3%
L00-L99	Diseases of the skin and subcutaneous tissue	2.2%	2.9%	2.3%	3.2%	-	2.1%	2.8%	1.9%	-	4.4%	2.3%	1.7%	-
M00-M99	Diseases of the musculoskeletal system and connective tissue	2.1%	-	1.9%	4.1%	-	2.7%	-	1.5%	4.9%	-	1.6%	2.6%	3.2%
N00-N99	Diseases of the genitourinary system	6.0%	5.3%	4.2%	4.1%	5.3%	7.3%	7.3%	6.3%	7.9%	6.0%	5.2%	7.1%	5.2%
O00-O99	Pregnancy, childbirth and the puerperium	9.9%	5.6%	14.2%	10.6%	14.0%	6.7%	5.3%	14.9%	7.9%	2.8%	15.4%	5.2%	8.1%
Q00-Q18	Congenital malformations, deformations and chromosomal abnormalities	-	-	-	-	-	-	-	-	-	-	-	-	-
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	21.4%	18.2%	17.9%	22.1%	20.8%	23.0%	25.3%	21.6%	16.5%	22.6%	22.4%	20.1%	23.7%
S00-T98	Injury, poisoning and certain other consequences of external causes	26.5%	29.9%	22.1%	26.7%	25.3%	24.3%	28.1%	28.2%	28.0%	30.6%	23.3%	28.6%	26.0%
Z00-Z99	Factors influencing health status and contact with health services	1.3%	-	3.7%	-	-	-	-	0.9%	-	-	-	2.4%	-

Source: SUS provided by CLCBS. Numbers lower than 5 have been suppressed. Totals exclude suppressed numbers

Alcohol and drugs: LDAAT provider service use statistics

East Lancashire

Figure 97: Early Break East Lancashire (LDAAT), active client age breakdown, 2010/11

**Early Break - Active Client Age Breakdown
Quarter 2010 - 2011**

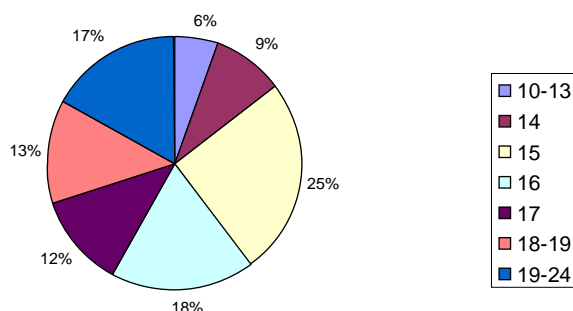


Table 253: Early Break East Lancashire (LDAAT), main substance of choice breakdown, 2009/10 to 2010/11

Main Substance of Choice 2009/10 – Q1		Main Substance of Choice 2010/11 – Q1	
Cannabis	133	Cannabis	106
Alcohol	56	Alcohol	66
Cocaine	21	Cocaine	9
Heroin	7	Heroin	3
Ecstasy	6	Ecstasy	2
Amphetamine	4	Amphetamine	1
Solvents	1	Solvents	3
Crack	1	Mephedrone	23
Hallucinogens	1	Other	0

Cannabis and alcohol still remain the prominent substances of choice of young people in treatment in East Lancashire. The number of young people using more problematic substances heroin and crack cocaine has reduced since 2009/10 with no young people reporting crack as their substance of choice in quarter 1 of 2010/11. Solvent use appears to have increased. The data for Q1 2010 highlights a decrease in the number of young people using cocaine, ecstasy and amphetamines although there are 23 young people presenting with mephedrone as their main substance of choice. A further 32 young people reported it as their 'other substance of choice' in quarter 1 of 2010/11.

North Lancashire

Figure 98: Young Addaction North Lancashire (LDAAT), active client age breakdown, Q1 2010/11

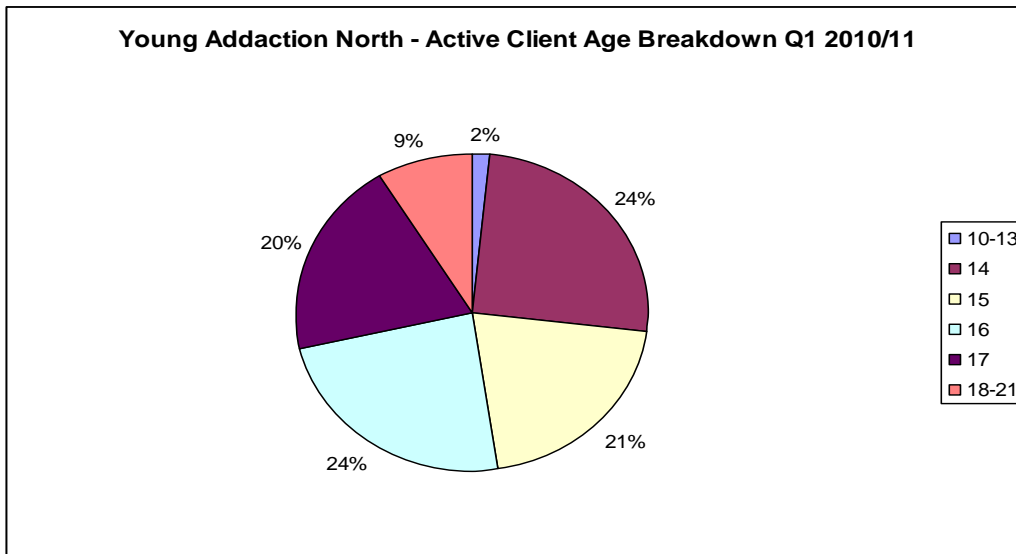


Table 254: Young Addaction North Lancashire (LDAAT), main substance of choice breakdown, 2009/10 to 2010/11

Main Substance of Choice 2009/10 – Q1		Main Substance of Choice 2010/11 – Q1	
Cannabis	49	Cannabis	54
Alcohol	57	Alcohol	53
Cocaine	4	Cocaine	3
Ecstasy	2	Ecstasy	2
Amphetamine	3	Amphetamine	3
Solvents	5		
Heroin	1	Mephedrone	31
Poly Drug User (No specific main drug of choice)	12	Poly Drug User (No specific main drug of choice)	29

Alcohol and cannabis are the most common main substance of choice for young people in North Lancashire. Q1 2010/11 has seen an increase in the number of young people presenting as a Poly Drug User (the client has no specific main drug of choice and will use more than one drug at any time i.e. cocaine and ecstasy.) The number of young people presenting with amphetamine, cocaine and ecstasy remains similar in both years. This year we have seen 31 young people presenting with Mephedrone as their main substance of choice.

Central Lancashire

Figure 99: Young Addaction Central Lancashire (LDAAT), active client age breakdown, Q1 2010/11

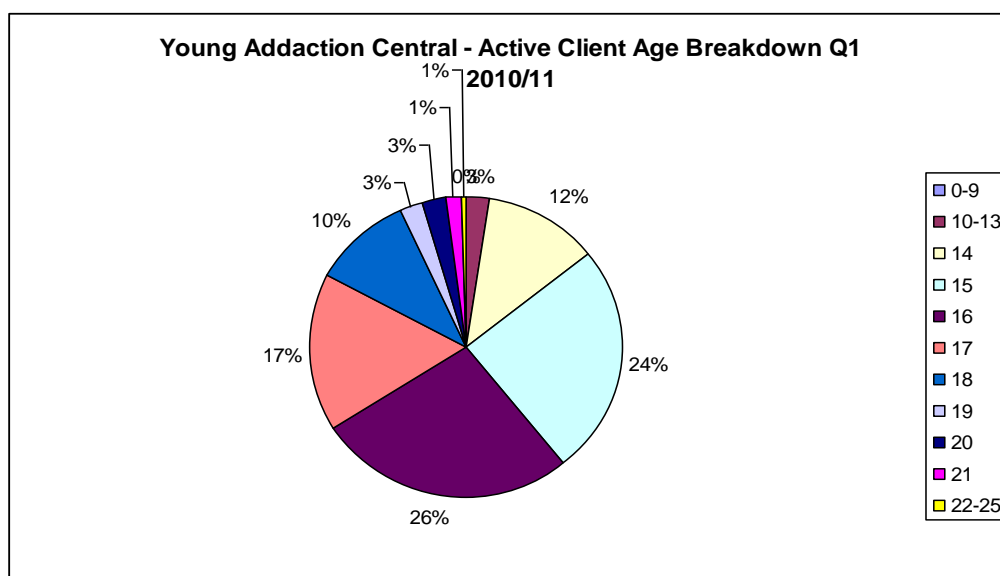


Table 255: Young Addaction Central Lancashire (LDAAT), main substance of choice breakdown, 2009/10 to 2010/11

Main Substance of Choice 2009/10 – Q1		Main Substance of Choice 2010/11 – Q1	
Cannabis	85	Cannabis	89
Alcohol	64	Alcohol	60
Cocaine	6	Cocaine	3
Heroin	5	Heroin	2
Amphetamine	2	Amphetamine	1
Solvents	1	Solvents	1
Crack	1	Mephedrone	2
Hallucinogens	1	Other	
Benzodiazepine	1		

Alcohol and cannabis remain the main substance of choice amongst young people in Central Lancashire. Only 2 young people have presented this quarter with Mephedrone as their ‘main’ substance of choice however, 10 young people reported Mephedrone as their ‘other’ substance of choice in Q1 2010/11. In 2009/10 5 young people reported using heroin as their main substance of choice compared to 2 in 2010/11 which supports the suggestion that young people’s substance misuse trends are changing.

Young people: Homeless young people by prior destination

Table 256: Homeless young people by prior destination

Homeless Young People by Destination										
	Compulsory Education	Employment	NEET Available	NEET Not Available	Other	Not Known	Full Time Education	Education outside of Lancashire	Training	Total
Burnley	2	5	51	12	2	10	11	0	7	100
Chorley	5	11	12	13	1	2	9	1	7	61
Fylde	1	3	3	3	0	2	5	0	2	19
Hyndburn	6	4	35	10	2	3	3	0	7	70
Lancaster	7	18	48	13	1	7	14	0	17	125
Pendle	4	6	36	14	1	6	9	1	5	82
Preston	14	13	41	12	1	8	16	0	12	117
Ribble Valley	5	0	5	0	0	2	2	0	0	14
Rossendale	4	3	17	7	0	1	3	1	6	42
South Ribble	6	8	20	7	0	10	7	1	5	64
West Lancs	7	20	26	13	0	5	17	8	15	111
Wyre	5	5	12	8	0	4	14	0	16	64
Total	66	96	306	112	8	60	110	12	99	869

Source: Young people's service

Disability data

Table 257: Disability estimates by district, 2009

	Lower	Upper
	(thousands aged 0 to 19 years)	
Lancashire	8.4	15.1
Central Lancashire PCT	3.3	5.9
East Lancashire PCT	3.0	5.4
North Lancashire PCT	2.2	3.9
Burnley	0.7	1.2
Chorley	0.7	1.3
Fylde	0.5	0.8
Hyndburn	0.7	1.2
Lancaster	1.0	1.8
Pendle	0.7	1.3
Preston	1.0	1.8
Ribble Valley	0.4	0.7
Rossendale	0.5	0.9
South Ribble	0.8	1.4
West Lancashire	0.8	1.4
Wyre	0.7	1.3
Source: Thomas Coram Research Unit estimates between 3% and 5.4% prevalence of disability, www.chimat.org . Applied to 2009 population estimates.		

Learning disability data

Table 258: Learning disability prevalence aged 5 to 9 years by district

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	611	607	613	620	634	650
Central Lancashire	238	239	245	251	255	263
East Lancashire	220	217	219	220	227	231
North Lancashire	154	151	152	149	152	156
Burnley	48	48	49	50	52	54
Chorley	54	55	57	58	59	60
Fylde	35	34	35	34	35	36
Hyndburn	49	48	49	49	50	50
Lancaster	66	65	64	63	65	67
Pendle	53	52	52	52	53	55
Preston	69	70	72	75	77	79
Ribble Valley	32	32	32	31	32	32
Rossendale	38	37	37	38	40	41
South Ribble	56	56	57	58	59	60
West Lancashire	60	59	60	60	61	63
Wyre	53	52	53	52	52	53
Source: Emerson & Hatton (2004), 0.96% prevalence for those aged 5 to 9 applied to ONS population projections						

Table 259: Learning disability prevalence aged 10 to 14 years by district

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	1616	1584	1555	1530	1485	1462
Central Lancashire	615	606	592	581	567	560
East Lancashire	579	565	556	545	527	522
North Lancashire	423	414	405	405	386	382
Burnley	124	122	120	115	111	108
Chorley	138	138	133	131	129	129
Fylde	95	93	90	93	88	86
Hyndburn	131	127	122	118	113	113
Lancaster	185	181	176	176	167	165
Pendle	131	129	129	127	124	122
Preston	179	172	170	165	160	158
Ribble Valley	88	86	86	88	84	84
Rossendale	104	102	99	97	95	95
South Ribble	145	142	140	138	136	133
West Lancashire	154	154	149	147	142	140
Wyre	142	140	138	136	131	131
Source: Emerson & Hatton (2004), 2.26% prevalence for those aged 10 to 14 applied to ONS population projections						

Table 260: Learning disability prevalence aged 15 to 19 years by district

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	2133	2131	2091	2037	1992	1954
Central Lancashire	806	817	804	780	766	750
East Lancashire	726	708	689	668	651	635
North Lancashire	601	603	598	585	577	563
Burnley	171	163	155	147	142	139
Chorley	171	166	163	160	158	152
Fylde	115	109	107	104	104	101
Hyndburn	155	155	155	152	150	144
Lancaster	296	310	310	304	299	291
Pendle	168	163	158	152	147	144
Preston	248	272	272	262	256	254
Ribble Valley	104	101	99	96	96	96
Rosendale	128	125	123	120	117	112
South Ribble	184	182	174	168	166	160
West Lancashire	203	198	195	190	187	184
Wyre	190	184	182	176	174	171
Source: Emerson & Hatton (2004), 2.67% prevalence for those aged 15 to 19 applied to ONS population projections						

Learning disability and mental health data

Table 261: Learning disability and mental health need prevalence aged 5 to 9 years by district

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	244	243	245	248	253	260
Central Lancashire	95	96	98	100	102	105
East Lancashire	88	87	88	88	91	93
North Lancashire	61	60	61	60	61	62
Burnley	19	19	20	20	21	22
Chorley	22	22	23	23	23	24
Fylde	14	13	14	13	14	14
Hyndburn	20	19	20	20	20	20
Lancaster	26	26	26	25	26	27
Pendle	21	21	21	21	21	22
Preston	28	28	29	30	31	31
Ribble Valley	13	13	13	12	13	13
Rosendale	15	15	15	15	16	17
South Ribble	22	22	23	23	23	24
West Lancashire	24	23	24	24	25	25
Wyre	21	21	21	21	21	21

Source: A 40% prevalence of mental health problems are associated with learning disability, "Count Us In", Foundation for People with Learning Disabilities publication

Table 262: Learning disability and mental health need prevalence aged 10 to 14 years by district

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	646	634	622	612	594	585
Central Lancashire	246	242	237	232	227	224
East Lancashire	231	226	222	218	211	209
North Lancashire	169	165	162	162	155	153
Burnley	50	49	48	46	44	43
Chorley	55	55	53	52	52	52
Fylde	38	37	36	37	35	34
Hyndburn	52	51	49	47	45	45
Lancaster	74	72	71	71	67	66
Pendle	52	52	52	51	50	49
Preston	71	69	68	66	64	63
Ribble Valley	35	34	34	35	33	33
Rosendale	42	41	40	39	38	38
South Ribble	58	57	56	55	54	53
West Lancashire	61	61	60	59	57	56
Wyre	57	56	55	54	52	52

Source: A 40% prevalence of mental health problems are associated with learning disability, "Count Us In", Foundation for People with Learning Disabilities publication

Table 263: Learning disability and mental health need prevalence aged 15 to 19 years by district

AREA	2008	2009	2010	2011	2012	2013
Lancashire County	853	852	836	815	797	782
Central Lancashire	323	327	321	312	307	300
East Lancashire	290	283	276	267	261	254
North Lancashire	240	241	239	234	231	225
Burnley	68	65	62	59	57	56
Chorley	68	66	65	64	63	61
Fylde	46	44	43	42	42	41
Hyndburn	62	62	62	61	60	58
Lancaster	119	124	124	122	120	116
Pendle	67	65	63	61	59	58
Preston	99	109	109	105	103	101
Ribble Valley	42	41	40	38	38	38
Rossendale	51	50	49	48	47	45
South Ribble	74	73	69	67	66	64
West Lancashire	81	79	78	76	75	74
Wyre	76	74	73	70	69	68
Source: A 40% prevalence of mental health problems are associated with learning disability, "Count Us In", Foundation for People with Learning Disabilities publication						

Appendix: Summary of the evidence base, guidance on interventions and recommendations from the JSNA

Accidents

Table 264: Interventions during early life: summary of the evidence base – Accidents

Accidents	Source
Local authority children's services and their partnerships, in consultation with local safeguarding children's boards should ensure that local plans for children's health and wellbeing include a commitment to preventing unintentional injuries. In particular, plans should aim to prevent unintentional injuries amongst the most vulnerable	NICE PH guidance 29
Partners should ensure that unintentional injury prevention activity is co-ordinated	NICE PH guidance 29
Partners should provide the wider childcare workforce with access to injury prevention training	NICE PH guidance 29
Partners should provide access to appropriate education and training in how to prevent unintentional injuries for everyone who works with children, young people and their families	NICE PH guidance 29
Commissioners of health services should ensure high quality injury data is gathered from emergency departments	NICE PH guidance 29
Roads	
Area-wide engineering schemes and traffic calming measures decrease traffic injuries	Systematic review
Child restraint loan schemes and legislation produce behavioural change	Systematic review
Cycle helmets offer protection from head and brain injuries, particularly at lower speeds	Overview
Educational campaigns and legislation can increase their use	Systematic review
There is reasonable evidence that cycle training can improve safe riding behaviour	Systematic review
Further guidance is provided in the NICE PH guidance 31: Preventing unintentional road injuries among under-15s – road design	
Leisure	
Improvements to playground design can reduce both the frequency and severity of injuries	Overview
Environmental engineering changes to the sports environment and prophylactic injury prevention programmes reduce injuries to adolescents	Overview
Legislation is effective for 15-24 year olds whether in sports, road or workplace settings	Overview
Home	
There is good evidence that smoke detectors and child-resistant containers reduce injury particularly if high-risk households are targeted	Systematic review/Overview
Less evidence attaches to window bars and the design of domestic products	Systematic review
Home visiting can substantially reduce rates of accidental injury	Overview
The role of education only reaches reasonable levels with respect to child/parent education to reduce pedestrian injuries and the use of car restraints	Overview
Multimodal interventions are the most likely to yield positive results	Systematic review
Further guidance is provided in the NICE PH guidance 30: Preventing unintentional road injuries among under-15s in the home	
Lack of review-level evidence	
<i>Leisure environment</i>	
<i>Older children</i>	

Smoking in early life

Table 265: Interventions during early life: summary of the evidence base - Smoking

Smoking cessation in pregnancy	Source
Advice and support tailored for pregnant women has a modest effect on cessation rates, increasing mean birth weight and reducing low birth weight. It tends not to reach those at highest risk.	Cochrane Review
Ten per cent of women still smoking at the time of their first ante-natal visit will stop with usual care. Formal interventions typically result in an additional 6% to 7% quitting.	Cochrane Review
Pre-natal counselling, combined with at least ten minutes person-to-person contact and written material tailored to pregnancy can double cessation rates.	Overview
Even reducing smoking in pregnancy can increase health outcomes	Systematic review
Exposure to passive smoking in early life	
Both home-based and clinic-based interventions by a clinician (for example information, advice and counselling) can be effective in reducing children's exposure to second-hand smoke. But studies tend to rely on self-reported health rather than biochemical measures	Review of reviews
Intensive counselling increases knowledge but few studies show a statistically significant intervention effect in terms of attitudes and behaviour (and hence exposure to environmental tobacco smoke)	Cochrane Review
Lack of review-level evidence	
<i>Safety and efficacy of Nicotine Replacement Therapy (NRT) for smoking cessation during pregnancy</i>	
<i>Strategies that are effective against relapse in the postpartum period</i>	
<i>Interventions that include the family as a whole</i>	
<i>Holistic interventions that address poverty, disadvantage and increase smoking control and support in the wider community</i>	

Healthy weight and nutrition in pregnancy

Table 266: Guidance for healthy weight and nutrition during pregnancy

Pre-pregnancy healthy weight	
Women should be supported to maintain a healthy weight prior to pregnancy. Local education initiatives should stress the risks of being obese, including during pregnancy.	NICE PH guidance 27
Nutrition during pregnancy	Source
All women should be advised to take 400 micrograms (µg) of Folic Acid daily before pregnancy and throughout the first 12 weeks, even if they are already eating foods fortified with folic acid or rich in folate.	NICE PH guidance 11
All women should be advised to take a vitamin D supplement during pregnancy and breastfeeding	NICE PH guidance 11
The Healthy Start scheme should be promoted to pregnant women and mothers of children aged less than 4 years who may be eligible. This should include Healthy Start vitamin supplements	NICE PH guidance 11
Women should be advised that a healthy diet and being physically active will benefit both the woman and her unborn child during pregnancy and help her to achieve a healthy weight after child birth.	NICE PH guidance 27
Dispel any myths about the need to 'eat for two'. Explain that energy needs do not increase in the first six months and only by 200 calories in the last three months.	NICE PH guidance 27
Advice that moderate-intensity physical activity will not harm her or her baby. At least 30 minutes per day is advised. Specific and practical advice about being physically active during pregnancy should be offered.	NICE PH guidance 27
Midwives and other health professionals should encourage women to breastfeed and reassure them that a healthy diet and regular, moderate-intensity physical activity and gradual weight loss will not adversely affect the ability to breastfeed or the quantity or quality of breast milk	NICE PH guidance 27
Explain the increased risks that being obese poses to them and, if they become pregnant again, their unborn child. Encourage them to lose weight.	NICE PH guidance 27
Local authority leisure and community services should offer women with babies and children the opportunity to take part in a range of physical or recreational activities. Where possible, affordable childcare (for example, a crèche) should be provided and provision made for women who wish to breastfeed.	NICE PH guidance 27
NHS and other commissioners and managers, local authority leisure services and slimming clubs should work together to offer women who wish to lose weight after childbirth the opportunity to join a weight management group or slimming club.	NICE PH guidance 27

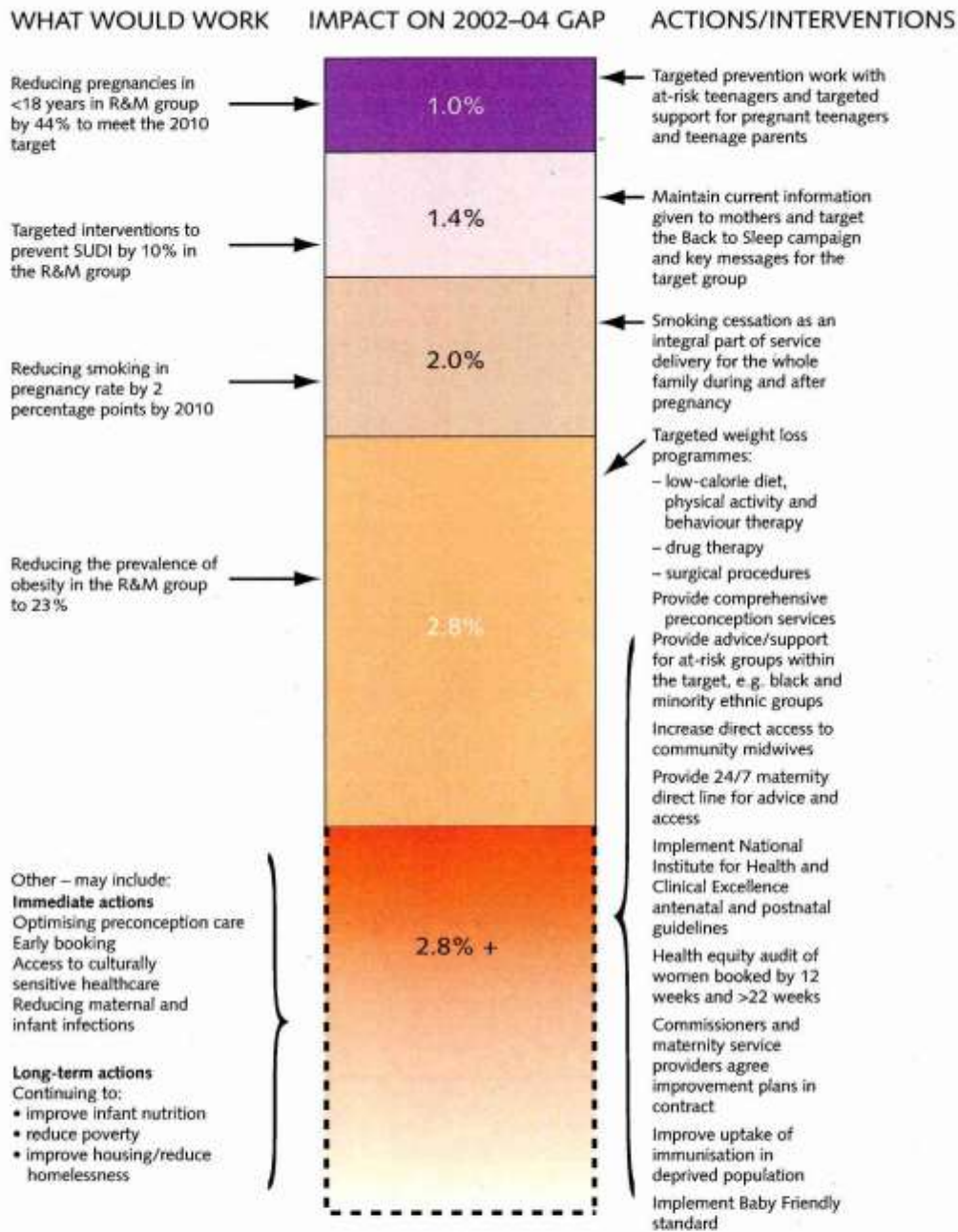
Breastfeeding and the introduction of solid foods

Table 267: Interventions during early life: summary of the evidence base – Nutrition

Breast feeding and the introduction of solid foods	
<ul style="list-style-type: none"> ▪ Action should create a mainstream view that breastfeeding is normal ▪ The "solid foods are introduced at six months" message should be communicated and explained clearly, including explanation of the reasons why. ▪ There is a need to provide and tailor appropriate information for different stages of pregnancy ▪ Information alone is insufficient – personal support and advice from health professionals are required to ensure that knowledge is embedded and transformed into behaviour ▪ Early influence is crucial, even during pre-pregnancy ▪ Ongoing support needs to continue from birth, with mothers able to access timely help and support easily ▪ Fathers and other family influencers, especially grandmothers, are key audiences. They may be highly influential when targeting harder to reach mothers, especially mothers who are younger, of lower educational achievement, or disadvantaged. ▪ Healthcare professionals are central deliverers of information and guidance to parents-to-be and parents. Communications campaigns targeting healthcare professionals with consistent information will ensure that they understand and support the evidence and approach. ▪ Cohesive and imaginative communications, in which fathers, peers and professionals as well as mothers are targeted under a single promotional campaign, have been shown to deliver significant improvements in both breastfeeding initiation and continuation. 	Start4Life, Breastfeeding and introducing solid foods, Customer Insight Summary
<ul style="list-style-type: none"> ▪ Midwives and other health professionals should encourage women to breastfeed and reassure them that a healthy diet and regular, moderate-intensity physical activity and gradual weight loss will not adversely affect the ability to breastfeed or the quantity or quality of breast milk 	NICE PH guidance 27
<ul style="list-style-type: none"> ▪ Initiation rates can be increased by: Multi-faceted interventions, including for example, health education, changes to maternity ward practice, such as unrestricted mother-baby contact and feeding and the prevention of discharge packs containing formula feeding information and samples, the use of peer facilitators and advocates 	Systematic review
<ul style="list-style-type: none"> ▪ Education – small, informal discussion classes led by health professionals that emphasise the benefits of breast feeding and provide practical advice. But one-to-one education sessions may be necessary to persuade women who have decided to feed infant formula to breast feed 	Other review
<ul style="list-style-type: none"> ▪ Training – intensive targeted lactation training for health professionals (particularly if accorded mandatory status) 	Review of Reviews
<ul style="list-style-type: none"> ▪ A peer support component (particularly important for low-income women). But only effective as a standalone component with women intending to breast feed ▪ Professional support increases the duration of (any) breast feeding ▪ Lay support is effective in promoting exclusive breast feeding 	Cochrane review

Infant mortality

Figure 100: Identifiable actions to reduce the 2002-04 gap in Infant mortality



This illustrates a set of interventions, that could make a significant contribution towards narrowing the infant mortality gap by 10%.

There is a need to commission research to improve the evidence base on modelling interventions and outcomes and good practice.

Improving vaccination uptake

Table 268: Guidance to improve vaccination uptake

NICE Public Health guidance 21 summary of recommended actions:

- Ensure there is an identified healthcare professional in the PCT and every GP practice who is responsible – and provides leadership – for the local childhood immunisation programme
- Improve access to immunisation services, particularly for those with transport, language or communication difficulties of physical disabilities. This could be achieved by extending clinic times, ensuring children and young people are seen promptly, making sure clinics and child and family friendly and offering mobile or outreach services.
- Send tailored invitations for immunisation. When a child does not attend, send tailored reminders and recall invitations and follow them up by telephone or text message
- Ensure parents and young people have the opportunity to discuss any concerns they might have about immunisation. This could either be in person or by telephone and could involve a GP, community paediatrician, health visitor, school nurse or practice nurse.
- Consider using pharmacies, retail outlets, libraries and community venues to promote and disseminate accurate, up to date information on childhood immunisation.
- Head Teachers, school governors, managers of children's services and PCT immunisation coordinators, should work with parents to encourage schools to become venues for vaccinating local children. This would form part of the extended school role.

Checking immunisation status:

- Check the immunisation status of children and young people at every appropriate opportunity. Checks should take place during appointments in primary care, hospital in- or out-patient and accident and emergency departments, walk-in centres or minor injuries units. Use the personal child health record as appropriate.
- Health professionals should check the immunisation history of new migrants, including asylum seekers when they arrive in the country.
- Prison health services should check the immunisation history of young offenders.
- The immunisation status of looked after children should be checked during their initial health assessment, the annual review health assessment and statutory reviews.
- The Healthy Child Team should check the immunisation record of each child aged up to 5 years. This should be done when a child joins a day nursery, nursery school, playgroup, children's centre or when they start primary school.
- School nursing teams should check the vaccination status of children and young people when they start a new school or college. Working with the PCT, they should advise young people and their parents about the vaccinations recommended at secondary school age.
- Where vaccinations are missing, discuss the appropriate vaccination with the young person and their parents and offer the vaccination or referral to vaccination services as appropriate.

Information systems and training:

- Ensure PCTs and GPs have a structured, systematic method for recording, maintaining and transferring accurate information on the vaccination status of all children and young people.
- Encourage and enable private providers to give the relevant GP or PCT details of all administered vaccinations so they can be recorded.
- Record any factors which make it less likely that a child or young person will be up-to-date with vaccinations. E.g. record if they are looked after, have special needs or have any contraindications to vaccination.
- Use recorded information together with surveillance data on the incidence of infection to inform needs assessments and joint strategic needs assessments and health equity audit.
- Monitor the age composition of the practice population to ensure the service is appropriately sized. Waiting lists are not acceptable.
- Ensure all staff involved in immunisation services are appropriately trained. Training should be regularly updated.
- Ensure staff are appropriately trained to document vaccinations accurately in the correct records.

Parenting education and support

Table 269: Interventions during early life: summary of the evidence base – Parenting Education and Support

Parenting Education and Support	Source
Group based behavioural interventions can improve the emotional and behavioural adjustment of children under the age of three	Cochrane Review
Parenting programmes can improve behavioural problems in children aged 3-10	Systematic review
Parenting programmes can make a significant contribution to the short-term psychosocial health of mothers	Cochrane Review
Home visiting can produce improvements in parenting, child behavioural problems, cognitive development in high-risk groups, a reduction in accidental injuries to children and improved detection and management of post-natal depression	Review of reviews
The involvement of both parents and direct work with the child increases efficacy	Overview
<i>Lack of review-level evidence</i>	
<i>Role of parenting programmes in primary prevention as opposed to treatment</i>	
<i>Long-term effectiveness on both maternal mental health and children's adjustment</i>	
<i>Efficacy of relational interventions</i>	
<i>Ability to isolate the effective components</i>	

Childhood obesity and healthy eating

Table 270: Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – nutritional status and healthy eating

Nutritional Status	Source
Obesity	
Two key reviews (one on treatment and one on prevention) suggest no direct conclusions can be drawn with confidence	Cochrane Review
There is some evidence that multifaceted school-based programmes that promote physical activity, modify diet and target sedentary behaviour can reduce the prevalence of obesity among school children	Review of reviews
There is less evidence that preventative efficacy attaches to any of these elements alone or to a multifaceted focus on the family	Review of reviews
Multifaceted family behaviour modification programmes can be effective in the targeted treatment of obesity	Review of reviews
Healthy eating	
Healthy eating interventions can prompt behavioural change and reduce fat intake and blood cholesterol but such reductions tend to be minimal (approximately -3% total fat intake)	Other review
Support more ordered family eating: <ul style="list-style-type: none"> - Set a time to eat together and let the family know in advance. - Eat as a family as much as possible (try for most nights and breakfasts). - Describes mealtimes as a family tradition. - Encourage children to sit down with parents to share a meal (at a table, or in a designated eating space facing eat other – not in front of the TV). 	Brown et al (2006)
Lack of review-level evidence	
<i>Information on adolescents</i>	
<i>Studies from the UK</i>	
<i>Sustainable weight-loss treatments</i>	
<i>Interventions for preventing eating disorders</i>	
<i>Upstream interventions</i>	

Oral health

Table 271: Interventions for the prevention of tooth decay: summary of the evidence base

All ages	Source
Water fluoridation is the most cost effective method of reaching the whole population, particularly children with a high risk of tooth decay	Medical Research Council Review
Children 0-3 years	
Breast feeding is best for babies.	Cochrane Review
<ul style="list-style-type: none"> • From six months of age infants should be introduced to drinking from a cup and from the age of one years feeding from a bottle should be discouraged • Sugar should not be added to weaning foods • Parents should brush or supervise tooth brushing • Use only a smear of toothpaste containing no less than 1,000 ppm fluoride • As soon as teeth erupt brush them twice a day • Sugars should not be consumed more than four times per day • Sugar-free medicines should be recommended • Brush last thing at night and on one other occasion, this should be supervised by an adult 	Delivering Better Oral Health – An Evidence Toolkit for Prevention
Children 3-6 years	
<ul style="list-style-type: none"> • Brush last thing at night and on one other occasion this should be supervised by an adult • Use a pea-sized amount of toothpaste containing 1,350–1,500 ppm fluoride • Spit out after brushing and do not rinse • Sugars should not be consumed more than four times per day • Sugar-free medicines should be recommended • Fluoride varnish should be applied to teeth twice yearly (2.2% F–) 	Delivering Better Oral Health – An Evidence Toolkit for Prevention
Children aged from 7 years and young people	
<ul style="list-style-type: none"> • Brush twice daily • Brush last thing at night and on one other occasion • Use fluoridated toothpaste (1,350 ppm fluoride or above) • Spit out after brushing and do not rinse • Sugars should not be consumed more than four times per day • Fluoride varnish should be applied to teeth twice yearly (2.2% F–). 	Delivering Better Oral Health – An Evidence Toolkit for Prevention

Tobacco and smoking

Table 272: Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – Tobacco

Tobacco and Smoking	Source
There is a lack of high-quality evidence about the effectiveness of combinations of social influences and social competence approaches in school	Cochrane Review
Enforcement of the law relating to cigarette sales to under-age youth can have an effect on retailer behaviour, but the impact on smoking behaviour is likely to be small	Cochrane Review
There is some support for the effectiveness of community-wide interventions in helping to prevent the uptake of smoking in young people based again on social learning theory/the social influences approach	Cochrane Review
There is some evidence that the mass media can be effective in preventing the uptake of smoking in young people in conjunction with other interventions	Cochrane Review
There is review-level evidence that increasing the price of cigarettes reduces tobacco use among both adolescents and young adults	Review of reviews
Research suggests that knowledge about smoking (such as school based education) is a necessary component of anti-smoking campaigns but by itself does not affect smoking rates. It may, however, result in a postponement of initiation	Reid D. et. al. Reducing the prevalence of smoking in youth in Western countries: an international review. Tobacco Control 1995; 4 (3): 266 – 277
Legislation alone is not sufficient to prevent tobacco sales to minors. Both enforcement and community policies may improve compliance by retailers but the impact on underage smoking prevalence using these approaches alone may still be small. Successful efforts to limit underage access to tobacco require a combination of approaches that tackle the problem comprehensively.	Lancaster T, Stead LF, Interventions for preventing tobacco sales to minors. The Cochrane Library, Issue 4, 1999
Smoking cessation in the form of NHS Stop Smoking Services has been proved to be effective in treating adult smokers; however the effectiveness when treating young people does decrease.	Department of Health (March 2009). NHS Stop Smoking Services: Service and Monitoring Guidance 2009 / 2010).

Sexual health and teenage pregnancy

Table 273: Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – sexual health and teenage pregnancy

Sexual health	Source
<ul style="list-style-type: none"> • There is good evidence to support school-based sex education; education linked to contraceptive services alongside the community-based delivery education, development and contraceptive services; youth development programmes; and family outreach (but this is not supported by randomised control trials) • STI campaigns increase condom use and can delay initiation and reduce the frequency of sex, potentially reducing unintended pregnancy as well 	Review of reviews
Programmes that offer educational support or improve job prospects may motivate young people to avoid pregnancy	Overview/Cochrane Review
Parenting programmes and ante-natal care programmes may be effective in improving outcomes for both teenage mothers and their infants	Cochrane Review
It is appropriate to encourage post-natal health education and the promotion of contraception for teenage mothers to prevent second teenage pregnancies with potentially higher risks of adverse outcomes	Khashan, Baker and Kenny, Preterm birth and reduced birthweight in first and second teenage pregnancies: a register-based cohort study. BMC Pregnancy and Childbirth
Teenage pregnancy	Source
<ul style="list-style-type: none"> - All schools, FE colleges and work-based learning providers need to be providing high quality SRE, that focuses on relationships and skills development as well as biological facts - Parents need to be better supported so that they are confident to take on the role of providing advice and support for their children on relationships and sexual health - All members of the children's workforce need opportunities to develop at least a basic level of competence in talking to children and young people about sex and relationships; and those working with young people need to be aware of who is most at risk or early pregnancy. - Young people need to be able to access reliable information via websites and help lines, which includes information on where to go for one to one advice (and treatment) on contraception and sexual health. - Young people are supported to develop positive attitudes about relationships, including: acceptance of diversity; respect and tolerance of other people's views and choices the importance of strong and stable relationships for bringing up young children. 	Teenage pregnancy strategy: Beyond 2010
<ul style="list-style-type: none"> - Preventions of teenage pregnancy and support for teenage parents should be a key consideration for Children's Trusts when commissioning Information Advice & Guidance (IAG) services, Targeted Youth support and positive activities. - Children's Trusts should consider what specific services and activities they need to provide to support this agenda as well as considering how teenage pregnancy and sexual health issues might be addressed in delivery of more generic universal or targeted provision. - The children and young people's workforce should be adequately trained in these issues and know how to identify risk and where to signpost young people to more specialist support. 	Teenage pregnancy strategy: Beyond 2010
Lack of review-level evidence	
Early fatherhood	
Upstream interventions versus poverty and disadvantage	
Interventions related to the UK	

Youth offending

Table 274: Recommendations for interventions for the health of young offenders

Youth offending

Primary care trusts, YOT managers, court services, drug and alcohol teams and mental health trusts working with YOTs should ensure that:

- Preventative services are improved so that children and young people's health needs are accurately assessed and appropriate interventions are provided
- Health services, in conjunctions with YOTs, carry out through assessments of generic health needs within youth offending services
- YOT staff, who have been trained well, carry out initial assessments of health needs, using recognised assessment tools. Referrals to specialist health workers need to be carried out consistently where required.
- Court services are encouraged to consider health needs more consistently by receiving training and also through health needs more consistently by receiving training and also through health information being included in packages of support for people on bail and in pre-sentence reports where required.
- Health services have appropriate and sufficiently senior, representatives on youth offending management boards. These should include people from all health agencies involved in the YOT, including substance misuse services.

PCTs working with YOTs should ensure that:

- Sufficient resources are provided to identify and meet specific health needs, including the provision of health workers in YOTs as appropriate to the size of the YOT.

PCTs, mental health trusts, the Youth Justice Board and YOTs should ensure that:

- YOT health workers and staff in secure establishments communicate with each other effectively to ensure that children and young people experience positive health transitions between different environments.

Children and adolescent mental health services (CAMHS) working with YOTs should ensure that:

- All children and young people up to the age of 18 who require appropriate intervention can receive access and support from CAMHS, including clear pathways for referrals.
- Transitions from child-centred to adult-orientated mental health services take place with care and sensitivity

Management boards of YOTs and PCTs should ensure that:

- Service level agreements and relevant protocols are in place between health services and YOTs
- Protocols for sharing information between health services and YOTs are introduced as a matter of urgency where these do not exist.
- The contribution of health services to the aims and objectives of YOTs is consistently monitored and evaluated.

Source: Actions speak louder: A second review of healthcare in the community for young people who offend, 2009. Commission for Healthcare Audit and Inspection and Her Majesty's Inspectorate of Probation.

Homelessness

Table 275: Recommendations for interventions for young people at risk of, or currently homeless

Homelessness
<ul style="list-style-type: none">▪ Practical support: while specific clinical help is essential, many emotional problems may be alleviated by the simple and reliable provision of practical help.▪ Listen to young people: it is critical that young people's voices are heard, not just to map their routes into homelessness and its impact on their mental health, but also to help workers assess the availability and appropriateness of supportive provision.▪ Active intervention: early and pro-active, rather than reactive services are essential as are multiple and intensive support services. More assertive outreach work is needed to reach young people with the most pressing problems▪ Improve access: access to services has to be negotiated, paying attention to such factors as physical proximity and timing to ensure continued access to benefits, day centres and other essential services.▪ Improved inter-agency working: there is a need to increase services' capacity to deal with young people's varied and multiple needs▪ Preventative housing measures: these include improved housing quality and availability to those at the lower end of the housing market, increases in housing benefit, more secure tenancies and better regulated private and social landlords.▪ Accommodation provision: a range of secure and flexible accommodation will have both preventative and healing effects on psychiatric morbidity. Supported accommodation and half-way houses can be crucial resources for young people▪ Definition: the acceptance of a common definition of homelessness would make referrals easier and service provision more consistent.▪ Preventative familial measures: these include family mediation and respite services▪ Preventative health measures: more education and active health promotion around mental health issues is required, in different settings and styles. Preventative and primary care services need to be more accessible to young homeless people and provide continuity▪ Support care leavers: care leavers independence needs to be promoted at a time when the young person is receptive and looking to move on <p>Source: The mental health needs of homeless young people, Bright futures: working with vulnerable young people, 2002.</p>

Mental health

Table 276: Interventions during childhood and adolescence: summary of the evidence base – Mental Health

Mental Health	Source
Parenting programmes with a preventative emphasis increase the social competence of children under ten years and the management skills of their parents	Overview
Family and parenting interventions can reduce the time juvenile delinquents (aged 10-17) spend in institutions	Cochrane Review
Cognitive Behavioural Therapy can be effective in the treatment of anxiety disorders, phobias and depression and (in combination with parent training) conduct disorders	Cochrane Review/Overview
Functional Family Therapy can reduce both delinquent behaviour and sibling delinquency	Overview
MST can prove effective with severe emotional and behavioural problems	Other review
Pharmacological treatments are effective for ADHD, particularly if supported by diet and psychosocial treatments (for example, parent training or behavioural therapy). Psychopharmacological treatments are also supported in the treatment of obsessive-compulsive disorder and depression and may be appropriate in the treatment of conduct problems and delinquency	Overview
Specialist ADHD teams for children developing appropriate training programmes for the diagnosis and management of ADHD	Overview
General management and advice to family and patient for management of conduct disorder	Overview
Non-pharmacological and pharmacological strategies for the management of Tourette's syndrome	Overview
<i>Lack of review-level evidence</i>	
<i>A specific focus on adolescents</i>	
<i>Evaluation of community-based programmes for young offenders in the UK</i>	
<i>The underlying causes and diagnostic criteria for dyspraxia</i>	
<i>Prevention programmes for oppositional defiant and conduct disorders</i>	
<i>Non-pharmacological, pharmacological and combined therapy for the management of ADHD</i>	
<i>Parent involvement in ADHD</i>	
<i>Interventions for pre-school age children with ADHD</i>	
<i>Family therapy without medication for ADHD</i>	
<i>Cognitive behaviour therapy to prevent depressive disorder in adolescent offspring of depressed parents</i>	

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