JSNA Topic Summary

Children & Families

November 2015

Contents

1. Key Issues & Gaps

There are many children and young people's health and wellbeing measures for which Cumbria performs better than the national average; these are identified later in this chapter. However, evidence provided within this chapter also suggests that the county performs less well than the national average in relation to the areas identified below.

58.6% of Cumbrian children achieve a good level of development at the end of reception (school readiness); lower than the national average (60.4%). Furthermore, when compared to the national average: Barrow-in-Furness and Carlisle have lower proportions of pupils achieving 5+ GCSEs at grades A*-C including English & Maths (50.5% and 47% respectively vs. 56.8% nationally); Carlisle has worse absence rates (4.9% of school sessions missed due to overall absence vs. 4.5% nationally and 4.6% of pupils classed as persistent absentees vs. 3.6% nationally); and Cumbria has a higher rate of fixed period exclusions (368 vs. 350 per 10,000 pupils nationally). The youth unemployment rate in Cumbria is higher than the national rate (3.4% v 2.9%), with particularly high rates found in Barrow, Copeland and Allerdale (5.8%, 5.3% and 4.9% respectively).

NHS Cumbria CCG had 385 observed unplanned hospitalisations for asthma, diabetes and epilepsy in under 19s in 2013/14; this equates to a rate of 381.4 per 100,000 registered patients under 19 (higher than the national average of 311.4), with under 19s admissions for epilepsy in the area being in the highest quartile of all CCG areas nationally.

Cumbria has worse rates than the national average in relation to mothers smoking at time of delivery (13.8% vs. 12% nationally) and breastfeeding initiation (66.4% vs. 73.9% nationally). Amongst Cumbria's districts, rates of breastfeeding initiation are worse than the national average in Allerdale, Barrow-in-Furness, Carlisle and Copeland. Breastfeeding continuation data is inconsistently recorded throughout the county.

25.1% of Cumbria's 4-5 year olds have excess weight; worse than the national average of 22.5%. Allerdale, Barrow-in-Furness and Copeland all have worse rates than the national average for this measure, with Barrow being rating worst out of all local authorities in England (30.6%). Additionally, compared to the national average, Year 10 females in Cumbria are less likely to say they enjoy physical activity (53% vs. 61% nationally) and secondary pupils in Cumbria are less likely to say they walked to school (35% vs. 40% nationally).

Carlisle has significantly higher rates of tooth decay in 3 year olds than the national average. In addition, Cumbria's 5 year olds have higher rates of tooth decay than the national average (1.16 vs. 0.94 mean decayed missing or filled teeth per child nationally), with Barrow-in-Furness, Carlisle and Copeland all having significantly higher rates than the national average for this measure.

Cumbria's rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years is worse than the national average (133.7 vs. 112.2 per 10,000 population nationally) and an increase the previous year (119 per 10,000). Barrow-in-Furness, Carlisle and Copeland all have significantly higher rates than the national average for this measure. Cumbria's rate of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 years also worse than the national average (160.1 vs. 136.7 per 10,000 population nationally) and an increase from the previous year (155.3 per 10,000). Barrow-in-Furness, Copeland and South Lakeland have significantly higher rates than the national average for this measure.

Cumbria's rate of under 18s alcohol-specific hospital admissions is significantly worse than the national average (68 vs 40.1 per 100,000 population nationally). Allerdale, Barrow, Copeland and South Lakeland all have rates that are worse than the national average for this measure, with Copeland having the highest rate of all local authorities in England. Cumbria's rate of hospital admissions due to substance misuse for 15-24 year olds is significantly higher than the national average (118.1 vs 81.3 per 100,000 population nationally).

Cumbria's rate of new Sexually Transmitted Infections, including chlamydia, in 15 to 24 year olds was lower than the national average (2,575 vs. 3,433 per 100,000 population nationally). Cumbria has not reached the target Chlamydia detection rate (1,526 detections per 100,000 vs. national target of 2,300). Of Cumbria's districts, only Carlisle has a detection rate above the national target. Surveys suggest that, of those sexually active, just over 40% of young people use condoms and there is low awareness of the Sexual Healthline.

Cumbria's rate of killed or seriously injured road casualties is significantly worse than the national average (45.7 vs 39.7 per 100,000 population nationally). Eden, South Lakeland and Allerdale have significantly worse rates than the national average for this measure.

Cumbria's rate of 10-17 year olds receiving their first reprimand, warning or conviction (known as first time entrants) increased in the most recent year (438 per 100,000 population up from 329 per 100,000).

Surveys suggest that Cumbria's secondary school pupils are less likely to have a self-esteem score in the highest bracket than the national average (33% vs. 44% nationally). The fear of bullying amongst Year 6 pupils has increased in Cumbria since 2003 and is 5% higher than the national average. Cumbria's rate of child admissions for mental health is significantly higher than the national average (110.6 vs. 87.2 admissions per 100,000) and has increased from the previous year (70.9 admissions per 100,000). Cumbria's rate of young person hospital admissions for self-harm is also significantly higher than the national rate (467.8 vs. 412.1 per 100,000 nationally) and has increased from the previous year (458.7 per 100,000). Cumbria's rate of mortality from suicide and injury undetermined in those aged 15-44 years is significantly higher than the national average (14.3 vs. 10.1 per 100,000 nationally).

There are a number of groups of children and young people identified within this chapter as being particularly vulnerable to poor health and wellbeing outcomes. These groups include:

- Children Living in Poverty and Deprivation;
- Children in Need;
- Children Subject to a Child Protection Plan;
- Children Looked After;
- Children with Special Educational Needs or Disability;
- Gypsy and Irish Travellers;
- Young Carers;
- Children Living with Domestic Violence;
- Children Living with Parental Drug & Alcohol Misuse;
- Children Missing from Home;
- Children who are Homelessness or Not in Suitable Accommodation; and
- Children at Risk of Sexual Exploitation.

Barrow-in-Furness has a greater proportion of children living in poverty than the national average (20.4% vs. 18.6% nationally) and there are 10 wards in Cumbria which fall within the bottom 10% nationally for levels of child poverty. Cumbria has 29 LSOAs that rank within the 10% most deprived nationally, with 8.3% of the county's population living these LSOAs.

In Cumbria there are 3,421 children in need (363.9 per 10,000 population), 325 children with a child protection plan (34.6 per 10,000 population), and 681 children are looked after by CCC (72.4 per 10,000). Cumbria had higher rates of these three groups than the national average in 2014. 11,203 pupils in Cumbria have SENs (15.6%) and 2,141 pupils have a Statement/ EHC plan (3%); similar to the national average (15.4% and 2.8% respectively).

In Cumbria 1,123 children aged under 15 (1.3%) are reported to provide unpaid care, with 90 (0.1%) providing 50+ hours unpaid care a week. Cumbria's rate is slightly higher than the national average for this measure (1.1% nationally). Of Cumbria's districts, Eden has the greatest proportion of children providing unpaid care (1.7%).

Cumbria has a lower rate of incidents of recorded domestic abuse than the national average (16.6 vs. 19.4 per 1,000 population nationally). However, Cumbria's rate has increased from the previous year (15.7 per 1,000). In 2011/12, 92 parents in Cumbria were attending treatment for substance misuse (110.4 per 100,000 children aged 0-15), which was the same as the national average rate.

In the last year there were 1,017 cases of people missing from home for more than 24 hours in Cumbria, with under 18s accounting for 58% of these cases. Cumbria had a total of 63 applicant households with dependent children or pregnant woman accepted as unintentionally homeless and eligible for assistance in the last year (0.3 per 1,000 households); significantly better than the national average (1.7 per 1,000 households). In the last year 147 contacts have been made through Cumbria's Safeguarding Hub for 16-17 year olds with a presenting issue of homelessness. There were 9,644 vulnerable child reports in Cumbria in the most recent year, of which 139 were relating to child sexual exploitation.

The Cumbria Intelligence Observatory found that children in need, children on child protection plans and children looked after are much more likely to originate from the areas of the county with the highest levels of deprivation and child poverty, while young carers in Cumbria are more likely live in areas belonging to the most deprived socio-economic categories *(© 1979 – 2015 CACI Limited. This data shall be used solely for academic, personal and/ or non-commercial purposes)*.

2. Recommendations for Consideration by Commissioners

This chapter identifies many factors which influence the health and wellbeing outcomes of children and young people. In particular, the chapter highlights importance of the early years in giving all children the best start to enable them to stay healthy, as well as the detrimental impact that risk taking behaviours and mental health issues can have on outcomes.

Although each factor has been addressed in separate sections within the chapter, evidence shows that factors are clearly interlinked and should therefore not to be viewed in isolation. Furthermore, evidence also illustrates that there are a number of groups of children and young people who are especially vulnerable to poor health and wellbeing outcomes across many of the factors identified.

It is recommended that commissioners fully investigating the evidence base and consider all factors identified within this chapter holistically when developing services to support health and wellbeing outcomes of Cumbria's children and young people, in order to provide a universal offer alongside targeted intervention for those vulnerable groups who are most in need.

3. Chapter Approach

This chapter will begin by providing the national and local policy context relating to the health and wellbeing of children and young people, followed by an overview of the structure of Cumbria's 0-19 year old population. The chapter will then review evidence relating to issues affecting the health and wellbeing of children and young people in the county. This evidence review has been divided into the following four sections:

- Best Start and Staying Healthy;
- Risk Taking Behaviours;
- Mental Health and Emotional Wellbeing; and
- Vulnerable Groups.

Each section contains a number of topics. For each topic the following segments of information will be provided:

- Topic Introduction;
- Who is at Risk and Why;
- What Local Data Tells Us; and
- Evidence of What Works.

The chapter then concludes by considering:

- Projections relating to the county's children and young people;
- The views of children, young people and their families regarding health and wellbeing;
- The key services and assets currently provided across the county to support children and young people's health and wellbeing needs.

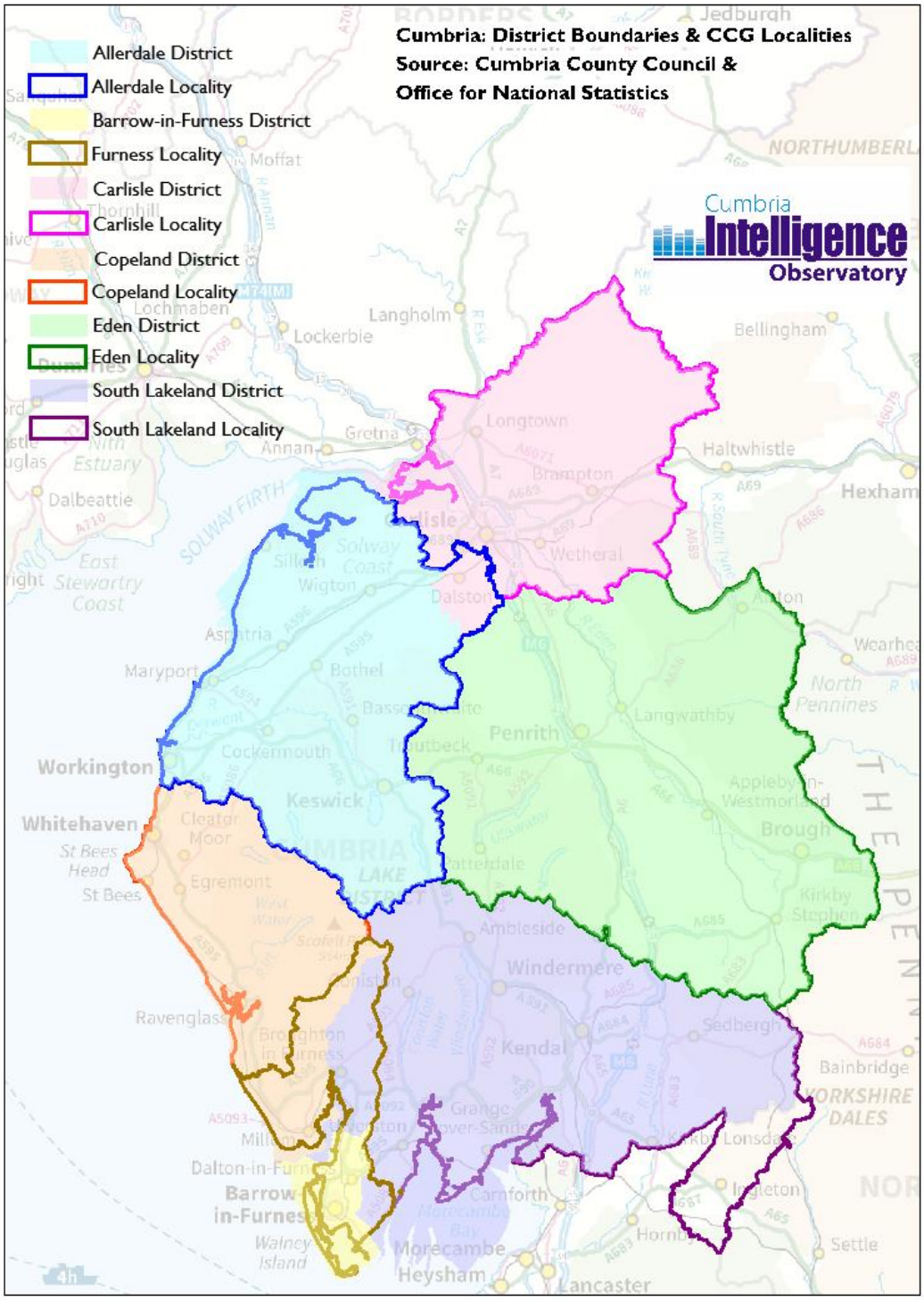
Unless otherwise stated 'Who is at Risk and Why' and 'Evidence of What Works' segments consider national and/or international research findings.

'Who is at Risk and Why' segments identify that many topics are relate to each other. In cases where one topic is referred to within another topic, hyperlinks are provided to enable readers to navigate easily between related topics. Hyperlinks are also provided to allow for navigation to a glossary of key terms and acronyms.

'What Local Data Tells Us' segments will compare Cumbria to national figures. Local Authority District, ward and Lower Super Output Area (LSOA) figures are referred to only where information is available and where the district/ward/LSOA varies significantly from the national or county averages. Explanations of the above geographies and definition of their boundaries within Cumbria are provided in the Geography & Maps section of the Cumbria Intelligence Observatory website; to access this page, please click here.

It should be noted that NHS Cumbria's Clinical Commissioning Group (CCG) work across six geographical localities which differ from Cumbria's Local Authority District boundaries. The key difference between the area covered by NHS Cumbria's CCG and Cumbria's county boundary is that South Lakeland Locality extends beyond the county boundary to include Bentham Medical Practice. Due to data availability, unless otherwise stated, any reference to districts within this chapter refers to Cumbria's Local Authority Districts. Figure 1 plots Cumbria's Local Authority Districts with CCG localities overlaid.

Figure 1: Local Authority District & CCG Locality Boundaries:



4. Context

4.1 National Policy Context

Department of Health (DoH): 0-19 Healthy Child Programme (HCP): 2009:

This evidence based early intervention and prevention public health programme provides the framework to ensure a universal reach and to identify families that are in need of additional support and children who are at risk of poor outcomes. The 0-5 HCP, for the early life stages, focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. The 5-19 HCP sets out the good practice framework for prevention and early intervention services for children and young people, recommending how health, education and other partners working together across a range of settings can significantly enhance a child's or young person's life chances. The responsibility for commissioning of the 5-19 HCP (school aged nursing) lies with Cumbria County Council (CCC). In 2012, the DoH published 'Getting it Right for Children, Young People and Families. Maximising the contribution of the school nursing team: vision and call to action'. The model in this document joins up best evidence of what should be done. On 1st October 2015 local authorities have taken on the commissioning of the 0-5 HCP (Health Visiting and Family Nurse Partnership).

DoH: Healthy Lives, Healthy People: 2010:

This document outlines the health and wellbeing challenges, across the life course, to improving health, and in particular the importance of ensuring that children and young people get the best start in life.

NHS: Five Year Forward View: 2014:

This document highlights issues in the current health care systems and a plan of how to overcome these issues. It is identified within the report that "the future health of millions of children's health….is dependent on a radical upgrade in prevention and public health". As well as a focus on prevention the vision involves new models of care and efficiency.

The Marmot Review: Fair Society, Healthy Lives: 2010:

This report proposed an evidence based strategy to address the social determinants of health which lead to health inequalities. It drew further attention to the evidence that most people in England aren't living as long as the better off in society and spend longer in states of ill health. Marmot identified 6 key policy objectives, two of which related to children and young people: Give every child the best start in life; and enable all children, young people and adults to maximise their capabilities and have control over their lives.

The Public Health Outcomes Framework (PHOF):

PHOF, produced by Public Health England (PHE), sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. The framework groups indicators into four 'domains' that cover the full spectrum of public health for all stages of life.

The following indicators within each of the following domains of the PHOF relate to children and young people:

PHOF Domain: Improving the Wider Determinants of Health
Objective: Improvements in wider factors that affect health, wellbeing & health inequalities.
Indicators: • Children in poverty; • School readiness; • Pupil absences; • First time entrants of the youth justice system; • 16-18 year olds NEET.
PHOF Domain: Health Improvement
Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities.
Indicators: • Low birth weight of term babies; • Breastfeeding; • Smoking status at time of delivery; • Under 18 conceptions; • Child development at 2 - 2 ½ years; • Excess weight in 4/5 and 10/11 year olds; • Hospital admissions caused by unintentional and deliberate injuries in under 18's; • Emotional wellbeing of looked after children; • Smoking prevalence – 15 year olds; • Hospital admissions as a result of self-harm; • Diet.
PHOF Domain: Health Protection
Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities.
Indicators: • Chlamydia diagnoses (15-24 year olds); • Population vaccination coverage.
PHOF Domain: Healthcare Public Health and Preventing Premature Mortality
Objective: Reduce numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities
Indicators: • Infant mortality; • Tooth decay in children aged 5.

4.2 Local Policy Context

Cumbria Children's Trust Board (CTB) Children & Young Peoples Plan 2016-19

- To be finalised Dec 2015:

The CTB has a shared vision and through working together aims to give all children and young people the best opportunities. Priorities are as follows:

- Outcome 1: Children and young people are healthy;
  - Priority 1: Emotional wellbeing;
  - Priority 2: Obesity;
  - Priority 3: Breastfeeding;
- Outcome 2: Child and young people are safe;
  - Priority 1: Safeguarding and feeling safe;
  - Priority 2: Neglect;
  - Priority 3: Community safety;
  - Priority 4: Criminal justice;
- Outcome 3: Children and young people are achieving;
  - Priority 1: Child poverty;
  - Priority 2: Educational attainment;
  - Priority 3: Access to post-16 employment, education and training.

Cumbria Health & Wellbeing Strategy: 2012 – 2015:

The strategy identifies children and young people as a key challenge with priorities including:

1. Ensure children get the best start in life:
2. Prioritise lifestyle improvement, particularly around obesity:
3. Integrated services and partnership working:
4. Promote mental and emotional wellbeing:

Cumbria Local Health Economy Strategic Plan: 2014 – 2019:

This strategy sets out the collective five year plan for the Cumbrian Local Health Economy to make sure that Cumbria's population have the best possible chance to live healthy lives and that if they do become ill or have an accident that they consistently receive the high quality services they deserve. The plan aims to: Ensure a sustainable NHS for future generations; Improve outcomes; and, Reduce health inequalities. The plan provides information about a wide range of initiatives to achieve the above aims, including initiatives specifically relating to children's services covering the following: Developing a strategy for children and young people (the Child Health Strategy 2014 -2019: Building Health with Children and Young People); Prevention and early help; Primary Care; Unscheduled care; Children with complex needs; Integrated children's nursing; Child and adolescent mental health services; and Transition from adolescent to adult services.

Children Looked After Strategy: 2015-18:

This strategy sets out the vision for every child in care to achieve their potential and have best life chances possible. It acknowledges the risks that children looked after and care leavers face in relation to safeguarding and emotional well-being challenges. The following links to health and wellbeing are made in the strategy in relation to children in care:

- Every child should have a healthy start and a healthy life;
- The importance of physical and emotional health being promoted;
- A commitment to the introduction of fast-track access to Child and Adolescent Mental Health Services (CAMHS);
- A commitment to monitoring numbers of health assessments and dental checks.

Local Safeguarding Children Board (LSCB): Business Plan: 2015-18:

The LSCB's vision is that 'we are working together to keep children and young people safe in Cumbria.' To achieve this, the LSCB provides the strategies and operational direction of safeguarding and continued monitoring of performance in Cumbria. The LSCB has introduced a new priority: Emotional Health and Wellbeing of Children, and in April 2015 set up a new Health subgroup. Under the priority of Domestic Abuse, the LSCB will implement recommendation 1 arising from the Ofsted's 'Inspection of Services for Children in Need of Help and Protection, Children Looked After and Care Leavers', published in May 2015.

Cumbria County Council (CCC): Council Plan: 2014-17:

Through public engagement, analysis of the limited resources available and evidence of need, the Council has developed the following priorities to safeguard children and ensure that Cumbria is a great place to be a child and grow up:

- Improve our safeguarding practice and services to ensure all children and young people in Cumbria are safe;
- Work with our partners focusing on early intervention and developing the role of children's centres in delivering early help;
- Maximise capital investment opportunities for our schools, focusing on those in greatest need;
- Support schools to improve where necessary as identified by Ofsted.

Cumbria County Council (CCC): Early Help and Learning Services Service Plan: 2015:

This service is responsible working with partners address a range of children and young people's emotional health and wellbeing needs. The 2015 Service Plan includes the priority working collaboratively within the council and with partners to improve integrated working. This includes the following whole systems approaches:

Programmes and Projects	Description
1-LSCB	Develop and deliver the LSCB Business Plan 2015-18 in line with current priorities to deliver the requirements identified through the Annual Report 2014-15.
2 – Early Help	Ensuring the ongoing engagement and ownership of Early Help across directorate and partner landscape with particular focus on the transition around commissioned services and the challenges that step down and providing of robust evidence of framework.
3 – Emotional Well-being	Support the whole system approach being taken across, in particular local authority children's services and Children's services in health with particular focus on head start and the development and delivery of a PMHEIS (Primary Mental Health & Early Intervention Services)
4 - Homeless	To respond in particular to the Ofsted report in respect of consistent and robust services for all 16-17 year olds who are homeless or at risk of becoming homeless in the County.
5 – Focus Families	To put in place a robust delivery framework for the expanded programme.
6 –Systems Development	Continued development of key management information systems to support the Directorate and Corporate strategic priorities, including the Ofsted Improvement Plan.

4.3 The Importance of Early Years

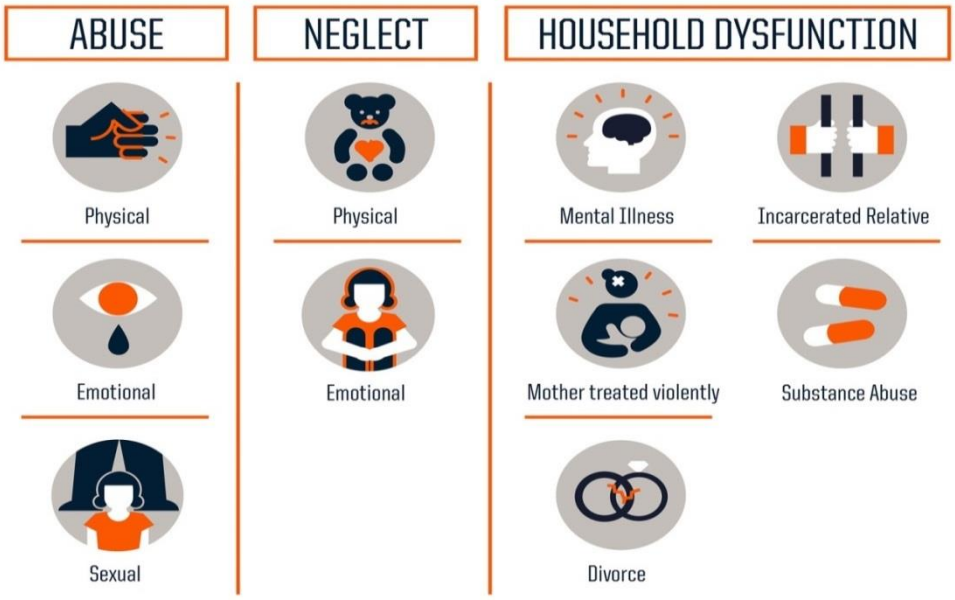
The foundations of good health and wellbeing are laid at the start of pregnancy, childhood, and adolescence especially in teenage years. Evidence demonstrating the impact of positive and negative experiences during pregnancy and the early years of life on a child's and well-being throughout childhood and into adult life continue to mount.

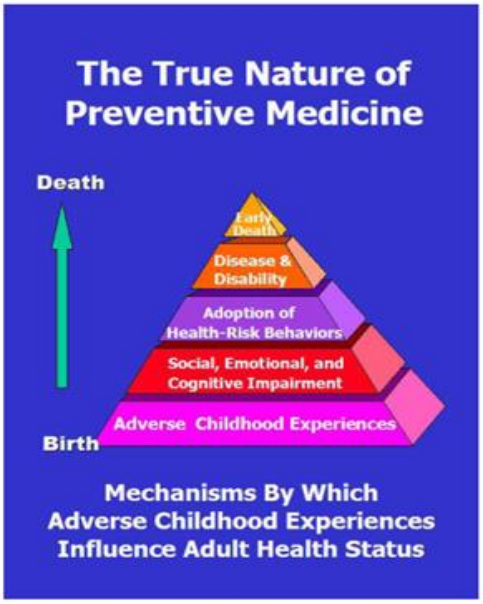
The 1001 Critical Days Manifesto (2013) sets out a vision for the provision of services in the UK for the early year's period, putting forward the moral, scientific and economic case for the importance of the conception to age two period. The Manifesto highlights the importance of acting early to enhance outcomes for children. Too many children and young people do not have the start in life they need, leading to high costs for society, and too many affected lives.

Further evidence on early intervention also comes from the Early Years High Impact Areas which have been developed to help inform commissioning of the 0-5 HCP and integrated children's early year's services.

4.4 Adverse Childhood Experiences (ACE)

Studies in the USA suggest strong links between ACE and poor adult health and social outcomes. A retrospective cross-section survey of 1,500 UK residents (including 67 substance users aged 18-70) (Bellis, et al, 2014) found that an increased number of ACEs were strongly related to: adverse behavioural, health, social, educational and employment outcomes; low mental wellbeing and life satisfaction; recent violence involvement; recent inpatient hospital care; chronic health conditions; and early unplanned pregnancy. Furthermore, those with higher ACE counts have higher risks of exposing their own children to ACEs.





Source: The Robert Wood Johnson Foundation

5. Population Overview

5.1 Population Estimates

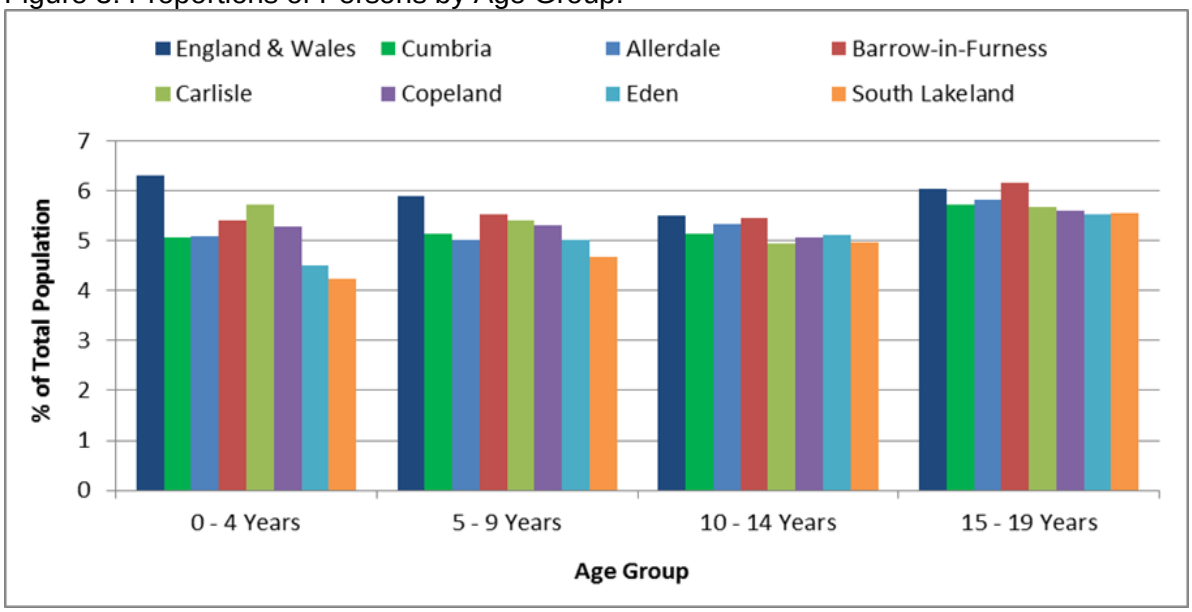
The Office for National Statistics (ONS) report that Cumbria is home to 104,900 0-19 year olds; equating to 21.1% of the county's total population; lower than the national average of 23.8%. Across Cumbria's six districts the proportion of 0-19 year olds ranges from 19.4% in South Lakeland to 22.6% in Barrow-in-Furness. The proportion of residents aged 0-19 years varies more considerably across Cumbria's 166 electoral wards; ranging from just 12% in Grange North ward (South Lakeland) to 28.3% in Kendal Kirkland ward (South Lakeland). 25 wards in Cumbria have greater proportions of 0-19 year olds than the national average.

Figure 2: Numbers of Persons by Age Group:

			Age Group (Years)			
	All Ages	0-19	0 - 4	5 - 9	10 - 14	15 - 19
England & Wales	56,948,200	13,543,900	3,592,900	3,360,500	3,143,800	3,446,700
Cumbria	498,100	104,900	25,200	25,600	25,600	28,500
Allerdale	96,200	20,500	4,900	4,800	5,100	5,600
Barrow-in-Furness	67,800	15,300	3,700	3,800	3,700	4,200
Carlisle	107,900	23,500	6,200	5,800	5,400	6,100
Copeland	70,000	14,900	3,700	3,700	3,500	3,900
Eden	52,600	10,600	2,400	2,600	2,700	2,900
South Lakeland	103,500	20,100	4,400	4,800	5,100	5,700

Source: ONS, Mid-2013 Population Estimates

Figure 3: Proportions of Persons by Age Group:



Source: ONS, Mid-2013 Population Estimates

Figure 4:

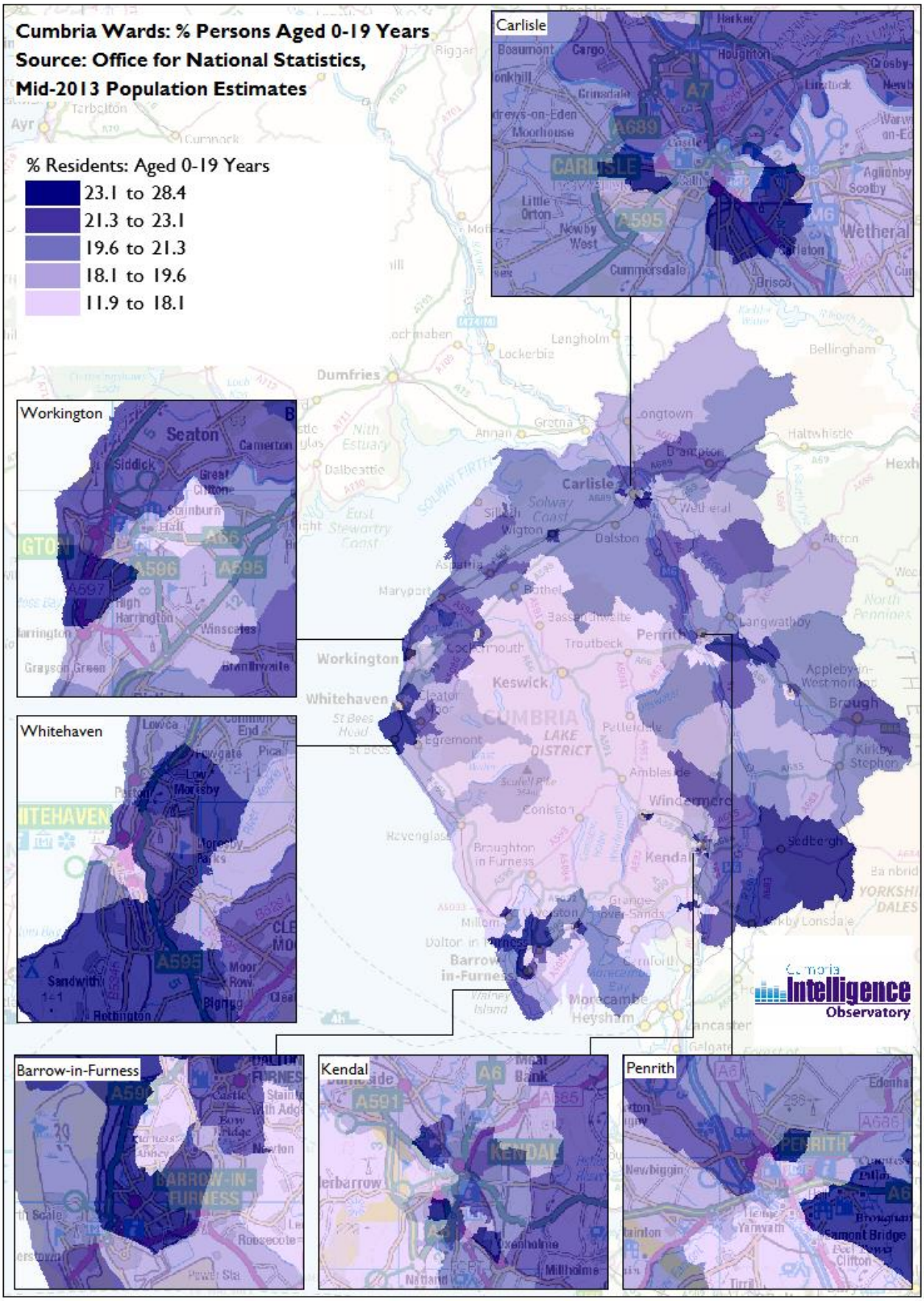


Figure 5 presents the GP registered 0-19 year old populations of NHS Cumbria's localities without figures for Bentham Medical Practice included. It should be noted that Cumbria's GP registered population includes those living outside Cumbria (but within England & Wales) who are registered with a Cumbrian GP and excludes anyone who lives in Cumbria but who is registered with an English or Welsh GP outside Cumbria.

Figure 5: GP Registered 0-19 Year Old Population:

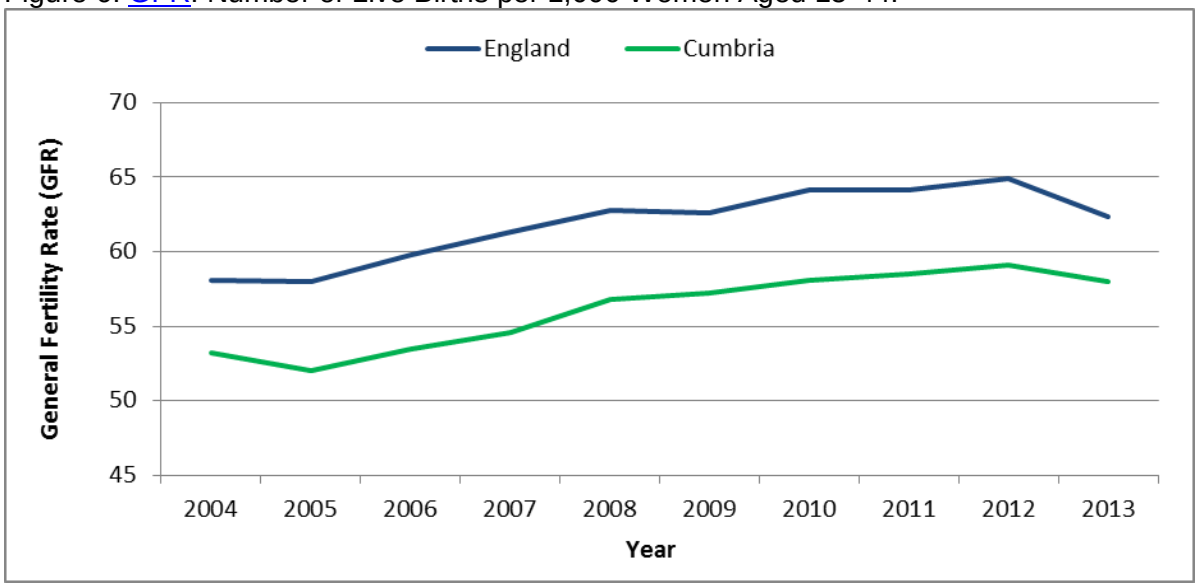
	All Ages	0-19 Year Olds	
	No. Registered	No. Registered	% of Registered Population
NHS Cumbria CCG (without Bentham included)	513,500	105,700	20.6
Allerdale	104,600	21,600	20.7
Carlisle	103,600	22,200	21.4
Copeland	61,900	13,100	21.2
Furness	83,800	18,000	21.5
Eden	52,000	10,300	19.9
South Lakes (without Bentham included)	107,600	20,400	18.9

Source: NHS Cumbria CCG, July 2014 GP Registered List

5.2 Fertility Rates

The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15-44. The ONS report that over the last ten years Cumbria's GFR has increased from 53.2 in 2004 to 58 in 2013. The county's increase in birth rates follows national trends. However, Cumbria's birth rates have remained slightly lower than the national average throughout the decade. Figure 6 plots GFRs for Cumbria and England.

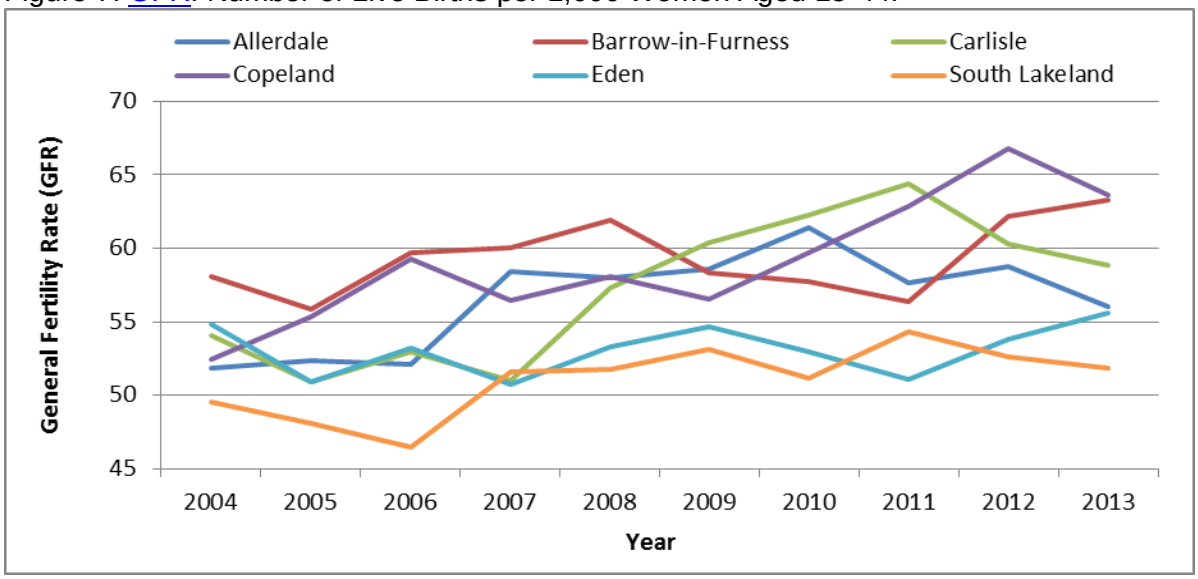
Figure 6: GFR: Number of Live Births per 1,000 Women Aged 15-44:



Source: ONS, Live Births

Two of Cumbria's districts, Copeland and Barrow-in-Furness, have higher GFRs than the national average; 63.7 and 63.3 live births per 1,000 women aged 15-44 respectively. GFRs have risen in all six of the county's districts over the last decade, with Copeland having experienced a particularly large rise. Figure 7 plots GFRs for Cumbria's districts.

Figure 7: GFR: Number of Live Births per 1,000 Women Aged 15-44:



Source: ONS, Live Births

5.3 Ethnicity

The January 2015 School Census reported that 3,083 statutory school aged pupils in Cumbria (4.4%) were from Non-White British ethnic groups, known as Black and Minority Ethnic (BME) groups. This was lower than the national average (28.6%), with Carlisle and South Lakeland having the greatest proportions of pupils from BME groups (6.8% and 5.2% respectively). The January 2010 School Census reported that 2,186 pupils in Cumbria (3%) were from BME groups; suggesting that numbers of pupils from BME groups have increased by 41% over the last five years. All of Cumbria's districts have experienced large increases in numbers of pupils from BME groups in this time, with Carlisle, Barrow and Eden experiencing the greatest proportional increases (+60.3%, +45.2% and +42% respectively).

The 2011 National Census reported that while none of Cumbria's wards had greater proportions of 0-19 year olds from BME groups than the national average, six wards had proportions more than three times the county average: Windermere Applethwaite and Troutbeck in South Lakeland (21.7%); St Bees in Copeland (15.8%); St Aidans in Carlisle (15%); Windermere Bowness South in South Lakeland (13.6%); Milnthorpe in South Lakeland (13.1%); and Sedbergh and Kirkby Lonsdale in South Lakeland (12%).

5.4 English as an Additional Language (EAL)

The January 2015 School Census reported that 1,482 statutory school aged pupils in Cumbria (2.4%) had a first language known or believed to be other than English. This was much lower than the national average (17.3%) but has proportionally increased by 65% since January 2010 (England +31%).

5.5 Refugee Children

Under Section 95 of the Immigration and Asylum Act 1999, destitute individuals who submit an asylum application "as soon as reasonably practicable" after arriving in the UK can apply for accommodation and/or financial support from UK Visas and Immigration (UKVI, a Home Office directorate) whilst their claim is being decided. Home Office statistics report that there have been less than five asylum seekers of all ages in receipt of Section 95 support across Cumbria over the last five years.

However, the government recently announced that the UK will resettle 20,000 Syrian refugees over the next 5 years. It is not yet known whether any of these 20,000 refugees will be placed in Cumbria but it is possible that the county may receive a small number. Discussions are taking place between Cumbrian organisations including Cumbria County Council, the six district councils, health, emergency services and voluntary and charity organisations to make sure that robust plans are in place, ready for any refugees that may be resettled in the County and it is anticipated that more clarification over likely numbers will be provided in the coming months.

5.6 Child Poverty

The national definitions of Child Poverty are set out in the Child Poverty Act (2010), in which all households with children that earn less than 60% of mean income are in poverty (there are several sub-definitions based on relative and absolute poverty). However, poverty is not just financial; there is also poverty of opportunity, and of ambition, and those elements point to solutions as well as to problems. The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. For more information about the link between poverty and health inequalities, please see the Health Inequalities Chapter of Cumbria's JSNA.

HMRC report there are currently 13,585 children aged 0-19 years in Cumbria living in poverty (14.1% of all children). Levels of child poverty in Cumbria and all of the county's districts, with the exception of Barrow, are below national levels (18.6%). In Barrow 20.4% of all children are living in poverty.

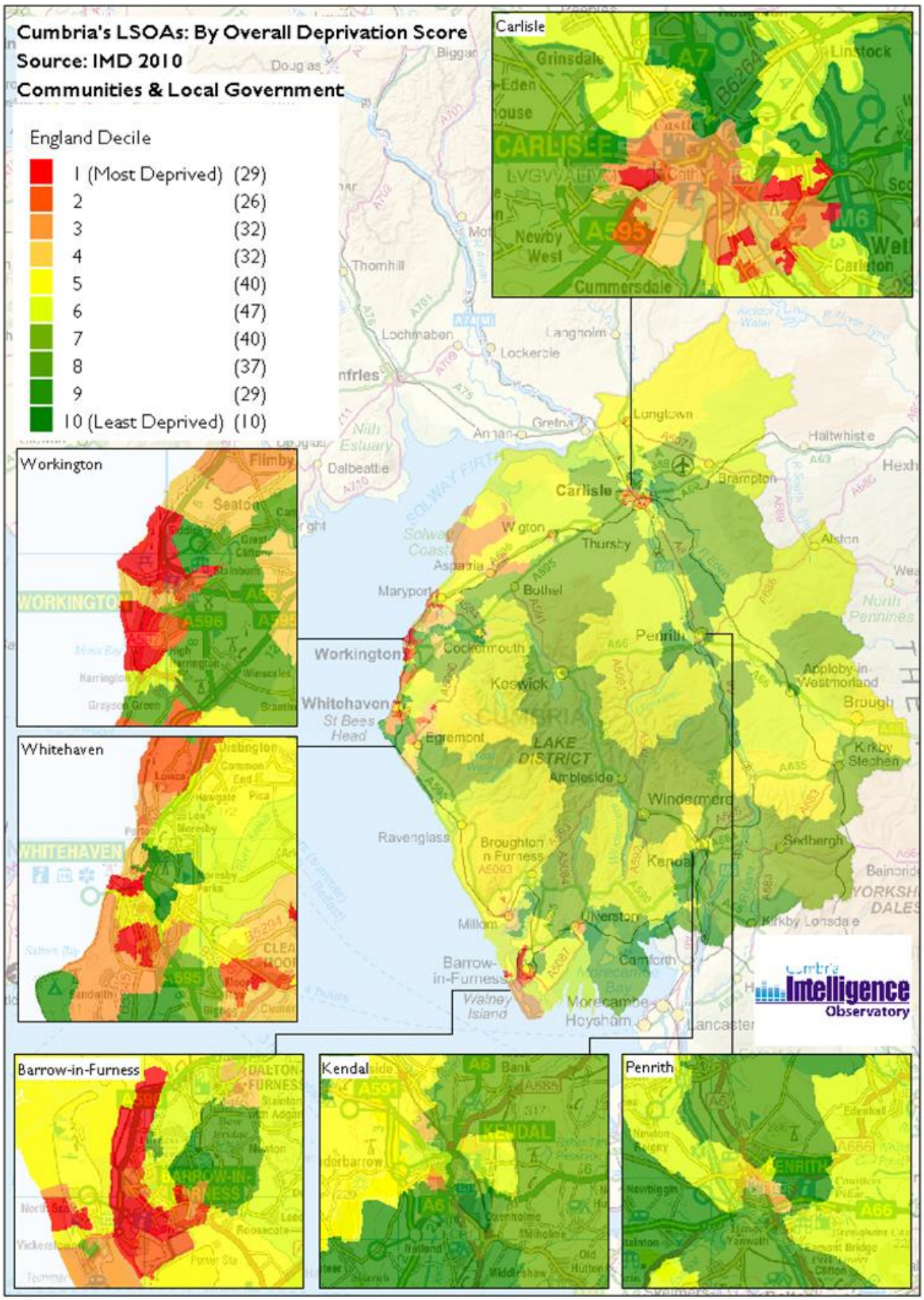
In Cumbria, Central ward (Barrow) has the greatest proportion of children living in poverty at 48.4%, followed by Sandwith ward (Copeland) at 41.0%. There are 10 wards in Cumbria which fall within the bottom 10% nationally for levels of child poverty, these wards are: Central (Barrow); Sandwith (Copeland); Moss Bay (Allerdale); Hindpool (Barrow); Upperby (Carlisle); Barrow Island (Barrow); Mirehouse (Copeland); Ewanrigg (Allerdale); Moorclose (Allerdale); Ridedale (Barrow).

5.7 Deprivation

The Indices of Multiple Deprivation (IMD) were produced by the Department for Communities and Local Government (DCLG) to consider the unmet needs of areas caused by a lack of resources of relating to the following seven domains: Income; Employment; Health and Disability; Education Skills and Training; Barriers to Housing and Services; Living Environment; and Crime. As well as providing scores for communities in relation to each individual domain, the IMD also provides an overall score for communities indicating overall levels of deprivation across all seven domains.

Cumbria has 29 communities (aka LSOAs) that rank within the 10% most overall deprived in England, with 41,450 (8.3%) of the county's residents living in 29 these LSOAs. Furthermore, eight of Cumbria's LSOAs are classified as being within the 3% most overall deprived nationally, with 11,300 (2.3%) of the county's residents living within these eight LSOAs (which are located in parts of: Moss Bay (Allerdale); Barrow Island (Barrow-in-Furness); Central (Barrow-in-Furness); Hindpool (Barrow-in-Furness); Ormsgill (Barrow-in-Furness); and Sandwith (Copeland) wards. Figure 8 plots each LSOA in Cumbria shaded according to the national decile that their overall deprivation score falls in. A decile of one represents LSOAs in the 10% most deprived of areas in England, while a decile of 10 represent LSOAs in the 10% least deprived of areas in England.

Figure 8:



5.8 School Readiness and Educational Attainment

PHE (source PHOF) state that educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. These are related to health and health inequalities.

School readiness refers to children assessed to have reached a good level of development at the end of the Early Years Foundation Stage (EYFS). The Department for Education (DfE) EYFS Profile Attainment by Pupil Characteristics 2014 release reports that nationally the proportion of children reaching a good level of development by the age of five can vary considerably; with girls outperforming boys; children eligible for Free School Meals (FSM) lagging 19 percentage points behind their peers; the gap between children with a Special Educational Need (SEN) and those with no identified SEN being 47 percentage points; and the proportions of Gypsy/Roma pupils and travellers of Irish heritage being 41 and 30 percentage points below the national average respectively.

The DfE reported that in 2013/14 58.6% of Cumbrian children achieved a good level of development at the end of reception; this was lower than the national average of 60.4% but an increase from the county average for the previous year (49.7%). 40.5% of Cumbrian children eligible for FSM achieved a good level of development at the end of reception; this was lower than the national average of 44.8% but an increase from the county average for the previous year (30%).

Those who start school behind their peers may struggle to catch up. The latest DfE GCSE and Equivalent Attainment by Pupil Characteristics Statistical First Release (SFR) reported that nationally the proportion of pupils achieving at least 5 A*- C GCSEs (or equivalent) grades including English and mathematics was lower for: boys; pupils from black, traveller of Irish heritage and Gypsy/Roma ethnic backgrounds; pupils eligible for FSM; pupils with SEN; and pupils living in deprived areas. The DfE Outcomes for Children Looked After release (2014) also reported that children looked after are more likely have lower attainment nationally.

The DfE reported that in 2013/14 56.8% of Cumbrian pupils achieved 5+ GCSEs at grades A*-C (including English & Maths) at Key Stage 4; this proportion is the same as the national average (56.8%). However, of Cumbria's districts, Barrow-in-Furness and Carlisle had lower proportions of pupils achieving the above levels of attainment (50.5% and 47%).

5.9 School Absenteeism and Exclusions

PHE (source PHOF) state that improving attendance (i.e. tackling absenteeism and reducing exclusions) in schools is crucial to the Government's commitment to increase social mobility and ensure every child can meet their potential.

The Pupil Absence in Schools 2013/14 SFR from the DfE reported that at a national level pupil absence rates are higher amongst: pupils who are known to be eligible for and claiming FSM; pupils with a statement of SEN; pupils in older year groups; Traveller of Irish Heritage and Gypsy/Roma pupils; pupils living in the most deprived areas. The Outcomes for Children Looked After 2014 SFR from the DfE also reports that nationally, while rates of overall absence for children looked after are better than the average for all children, rates of overall absence for children in need are more than double those for all children.

The 2013/14 SFR reports that 4.5% of school sessions (half days) were missed by Cumbrian pupils due to overall absence (including authorised and unauthorised absence); this was similar to the national average absence rate (4.5%). However, at a district level, Carlisle had a worse absence rate than the national average (4.9). Cumbria had a lower rate of unauthorised absences than the national average (0.7% compared to 1.1%). 2,070 pupils in Cumbria were classified as persistent absentees (3.6%); similar to the national average (3.6%). However, again, Carlisle had a higher proportion of persistent absentees than the national average (4.6%).

The most common reason for pupil absence in Cumbria was illness (not medical or dental appointments) with 2.8% of all possible school sessions missed due to this reason in the county; similar to the national average of 2.6%.

The Permanent and Fixed Period Exclusions 2013/14 SFR from the DfE reported that nationally exclusion rates are higher amongst: boys; SEN pupils; pupils who are FSM eligible; 14 year olds; pupils of Gypsy/Roma and Traveller of Irish Heritage ethnic groups; and pupils of Black Caribbean and White and Black Caribbean ethnic groups. The Outcomes for Children Looked After 2014 SFR from the DfE also reports that nationally rates of exclusions for children looked after are above the rates seen for all children.

The 2013/14 SFR reports that there were 2,530 fixed period exclusions in Cumbria during the 2013/14 academic year; this equates to 368 fixed period exclusions per 10,000 pupils, which is higher than the national average (350 per 10,000). 1,300 Cumbrian pupils (1.9%) received 1 or more episodes of fixed period exclusion; this is similar to the national average (1.9%). Furthermore, in Cumbria there were 30 permanent exclusions; this equates to 4 permanent exclusions per 10,000 pupils, which is lower than the national average (6 per 10,000).

The greatest proportion of fixed period exclusions in Cumbria (32%) were due to "persistent disruptive behaviour"; this reason also accounted for the greatest proportion of fixed period exclusions nationally, however Cumbria's proportion was higher than the national average (England 25%).

5.10 16-18 Year Olds Not in Education, Employment or Training (NEET)

The Department for Work and Pensions (DWP) and DfE define NEET as young people who are not in any form of:

- Education: Any formal course of education (full or part-time);
- Employment: Any paid work (including part time or temporary work) or self-employment;
- Training: Any formal employment-related training course (full or part- time) and including traineeships, 'Basic Skills' and engagement programmes for the most disengaged.

PHE (source PHOF) state that unemployment has negative effects on health. It is linked to poor physical health, poor mental health and premature death while spending more time in education and achieving higher qualification tends to improve physical and mental health. Therefore, young people who are NEET are of particular concern to local and national government, due to the high and often long term financial and social costs to individuals, local communities and wider society.

In July 2015 the DWP reported that there were 1,274 young people aged 18-24 claiming unemployment benefit in Cumbria (Jobseekers Allowance or out of work Universal Credit). This equates to 3.4% of the population aged 18-24 years, more than double the rate for the working age population as a whole (1.5%). Rates of youth unemployment are particularly high in Barrow (5.8%), Copeland (5.3%) and Allerdale (4.9%), with parts of Harbour (Copeland), St. Michael's (Allerdale), Barrow Island (Barrow-in-Furness), Ewanrigg (Allerdale) and Moss Bay (Allerdale) wards having youth unemployment rates more than five times the national average.

The DfE reported that in 2014 the proportion of NEET young people in Cumbria was 4.3% compared to a national average of 4.7%. Rates are highest in Cumbria among 18 years olds (7.1%), with the rate for 17 year olds being 3.9% and for 16 year olds 1.6%. All these rates are below the national average. Locally sourced data from Inspira suggests that Copeland has some of the highest NEET rates in Cumbria in all three age groups whilst young people in Allerdale, Barrow and Carlisle also face particular challenges compared to those in Eden and South Lakeland.

5.11 Children with Long-Term Conditions

The 2011 Census reported that the day to day activities of 2,926 0-15 year olds in Cumbria (3.5%) were limited by a long-term health problem or disability, with 1,262 of the county's 0-15 year olds (1.5%) having their day to day activities limited 'a lot'; these proportions were similar to the national average (3.8% and 1.6% respectively). Of Cumbria's districts, only Barrow-in-Furness had rates that were higher than the national average in relation to the above measures (4.7% and 2% respectively). The following eight Cumbrian wards had rates that were more than 1.5 times the national average in relation to 0-15 year olds with day to day activities limited by a long-term health problem or disability: Kendal Fell (South Lakeland); Central (Barrow-in-Furness); Holme (Allerdale); Ormsgill (Barrow-in-Furness); Ulverston South (South Lakeland); Hawkshead (South Lakeland); Brough (Eden); and Kendal Mintsfeet (South Lakeland).

The NHS Outcomes Framework is grouped into five domains which include 'Enhancing Quality of Life for People with Long-Term Conditions'. Within this domain the framework includes an indicator for reducing unplanned hospital admissions in under-19s for asthma, diabetes and epilepsy. The Health & Social Care Information Centre (HSCIC) report that NHS Cumbria CCG had 385 observed unplanned hospitalisations for asthma, diabetes and epilepsy in under 19s in 2013/14; this equates to a rate of 381.4 per 100,000 registered patients under 19 (higher than the national average of 311.4).

Rates of hospital admissions for under 19s in relation to asthma, diabetes and epilepsy individually are available via the National Child & Maternal Health Intelligence Team (CHIMAT). In 2013/14 CHIMAT report NHS Cumbria CCG had:

- 209.1 under 19s emergency hospital admissions for asthma per 100,000 population (placing the area in the second highest quartile of all CCGs nationally);
- 67.4 under 19s admissions for diabetes per 100,000 population (placing the area in the second highest quartile of all CCGs nationally);
- 103.6 under 19s admissions for epilepsy per 100,000 population (placing the area in the highest quartile of all CCGs nationally).

6. Section One: Best Start and Staying Healthy

6.1 Infant Mortality

Introduction: One of the key objectives of the PHOF is to reduce infant mortality. PHE (source PHOF) state that infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

Who is at Risk & Why: Child mortality statistics produced by the ONS suggest that the follow groups are more likely to be at risk: Low birth weight babies; Babies born to teenage mothers and older women; babies born to mothers in the routine and manual occupations.

What Local Data Tells Us: PHOF reports that Cumbria's infant mortality rate (deaths in infants aged under one year) were 3.4 per 1,000 live births in 2011/13; this was similar to the England average (4 per 1,000 live births).

Evidence of What Works: There are a number of broad public health interventions likely to have an impact on infant mortality including the development of strategies to: reduce child poverty; increase access to timely antenatal care (especially for teenage parents); reduce rates of smoking in pregnancy; improve maternal and infant nutrition; reduce the number of sudden unexpected death in infancy; and improve the uptake of childhood vaccinations.

6.2 Low Birth Weight

Introduction: Low Birth Weight has been defined by the World Health Organisation (WHO) as weight at birth of less than 2,500 grams (5.5 pounds) based on epidemiological observations that infants who weigh less than 2,500 grams are approximately 20 times more likely to die than heavier babies.

PHE (source PHOF) state that low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services.

Who is at Risk & Why: The risk of low birth weight is highest among: Young mothers and older mothers; Mothers living in deprived areas; Mothers with hypertension; An interval of 6 months or less between first delivery and second conception; Mothers who have already had a low birth weight baby; and Multiple births (source: NHS Lothian).

What Local Data Tells Us: The ONS reported that between 2008 and 2012 the proportion of all live and still births (including premature births) with a low birth weight was 6.9% in Cumbria; this was better than the national average of 7.4%. Furthermore, PHOF reports that 2.2% of live births at term (not including premature births) in Cumbria had a low birth weight in 2012; this was also better than the England average of 2.8%.

Evidence of What Works: Smoking is one of the most important preventable determinants of low birth weight babies, for evidence of what works to reduce smoking in pregnancy please refer to the smoking in pregnancy topic within this chapter. Further evidence of what works suggests ensuring that mothers receive timely antenatal care to identify potential risks earlier, while the DoH recommends the use of folic acid (vitamin B9) pre-pregnancy and for first 12 weeks of pregnancy, as it can significantly reduce the risk of neural tube defects (NTDs), such as spina bifida.

6.3 Smoking in Pregnancy

Introduction: Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, placental complications and perinatal mortality.

Who is at Risk & Why: PHE (source PHOF) state that smoking during pregnancy can cause serious pregnancy-related health problems including an increased risk of: complications during labour; miscarriage; premature birth; stillbirth; low birth-weight; and sudden unexpected death in infancy. Second hand smoke is dangerous for anyone exposed to it, but children are especially vulnerable as they have less well-developed airways, lungs and immune systems. Up to five million children across the UK are regularly exposed to second hand smoke in the home, which puts them at risk of: bronchitis; pneumonia; asthma attacks; meningitis; and ear infections. Babies exposed to second-hand smoke are more at risk of cot death. Breathing second-hand smoke increases the risk of lung cancer by 24% and heart disease by 25%. It is estimated that children breathing in other people's cigarette smoke resulted in 300,000 GP visits and 9,500 hospital admissions for children every year.

What Local Data Tells Us: PHOF reports that in 2013/14, 13.8% of mothers in Cumbria were smoking at time of delivery, this is worse than the national average of 12%.

Evidence of What Works: National Institute for Health and Care Excellence (NICE) guidelines (2010) provide a number of recommendations regarding how to support pregnant women who smoke, and those who are planning a pregnancy, to quit smoking, as well as how to reduce the danger that second-hand smoke poses to them and to their baby.

6.4 Breastfeeding

Introduction: The positive impact of breastfeeding on lowering the risk of death from infectious diseases in the first two years of life is now well-established (WHO, 2014). A mounting body of evidence suggests that breastfeeding may also play a role in reducing non communicable disease risk later in life including protection against excess weight and obesity in childhood (WHO, 2014). Emerging evidence suggests breastfeeding has a positive impact on mother-baby relationships by releasing certain hormones which promote maternal feelings and behaviour. Strong early relationships and a stable and loving environment are all conducive to babies' healthy emotional, social and physical development, through production of the hormone oxytocin (UNICEF 2015).

Who is at Risk & Why: The 2010 Infant Feeding Survey conducted by HSCIC reported that across the UK, breastfeeding rates were lowest among the following mothers: those under the age of 20; those from white ethnic groups; those in routine and manual occupations or who had never worked; those aged 16 or under when they left full-time education; those living in the most deprived areas; mothers of second or later babies; those who had breastfed a previous child for less than six weeks or not at all.

What Local Data Tells Us: PHOF reports that in 2013/14 nationally 73.9% of maternities had breastfeeding initiated, however, in Cumbria this rate was 66.4%. Rates of breastfeeding initiation were worse than the national average in Allerdale, Barrow-in-Furness, Carlisle and Copeland. Breastfeeding continuation data is inconsistently recorded throughout the county.

Evidence of What Works: Effective strategies to promote breastfeeding include peer support, either one-to-one or as part of a group, and structured support from professionals. These strategies are significantly more likely to begin and sustain breastfeeding than advice offered from a distance (PHE, 2015). UNICEF's Baby Friendly Initiative is a set of evidence based standards which are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development.

6.5 Immunisations

Introduction: All children in the UK are offered vaccinations against key diseases, as part of the national childhood immunisation schedule. Vaccination is an important step in protecting children and young people against a range of serious and potentially fatal diseases. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease.

Who is at Risk & Why: Evidence has shown that the following groups of children and young people are at risk of not being fully immunised: Those who have missed previous vaccinations; Looked after children; Those with physical or learning disabilities; Children of teenage or lone parents; Those not registered with a GP; Younger children from large families; Children who are hospitalised or have a chronic illness; Those from some minority ethnic groups; Those from non-English speaking families; Vulnerable children, such as travellers, asylum seekers and those who are homeless. Source: DH 2005; Hill et al. 2003; Peckham et al. 1989; Samad et al. 2006.

What Local Data Tells Us: Cover of Vaccination Evaluated Rapidly (COVER) data is collected by PHE and published by HSCIC. The most recent annual HSCIC figures are provided below.

The percentage of children in Cumbria immunised by their **1st birthday** was as follows:

- **DTaP/IPV/Hib:** 97.3% received 3 doses of diphtheria, tetanus, polio, pertussis (whooping cough) and Haemophilus influenzae type b vaccine (2013/14); better than the England average of 94.3%;
- **PCV:** 97.3% received the complete course of pneumococcal disease vaccine (2013/14); better than the England average of 94.1%;
- **Rotavirus** (introduced July 2014): No annual data published yet. In the last quarter (to March 2015) that 93.8% received rotavirus vaccine. However, Barrow & South Lakes locality had a lower rate 89.8%);
- **Men C:** 96.5% received the completed course of meningitis C (MenC) vaccine (2012/13); better than the England average of 93.9%.

The percentage of children in Cumbria immunised by their **2nd birthday** was as follows:

- **Hib/MenC:** 96.7% received one booster dose of Hib/Men C vaccine (2013/14); better than the England average of 92.5%;
- **PCV:** 95.2% received one booster dose of PCV vaccine (2013/14); better than the England average of 92.4%;
- **MMR:** 96.7% received one dose of measles, mumps, and rubella (MMR) vaccine (2013/14); better than the England average of 92.7%;

The percentage of children in Cumbria immunised by their **5th birthday** was as follows:

- **DTaP/IPV:** 94.3% had received the first booster for diphtheria, tetanus, polio and pertussis (2013/14) better than the England average of 88.8%;
- **MMR:** 93.7% received two doses of MMR vaccine (2013/14); better than the England average of 88.3%.

Human Papillomavirus (HPV):

- 91.2% girls aged 12 to 13 years old in Cumbria received all 3 doses of the routine HPV vaccine (2013/14); better than the England average of 86.7%.

Evidence of What Works: PHE (source PHOF) state that monitoring coverage identifies possible drops in immunity before levels of disease rise and that previous evidence shows that highlighting vaccination programmes encourages improvements in uptake levels.

NICE (2009) suggests it is important to ensure DoH guidance and updates on immunisations (including official letters from the Chief Medical Officer, Chief Nursing Officer and Chief Pharmaceutical Officer) are disseminated to relevant professionals and implemented. This includes nurseries, school and Further Education (FE) colleges. Furthermore, NICE (2009) provides details of a multifaceted, coordinated programme that should be adopted across different settings to increase timely immunisation among groups with low or partial uptake. The programme should form part of the local child health strategy.

6.6 Excess Weight

Introduction: The WHO regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults. Obese children are more likely to be ill, be absent from school due to illness, experience health-related limitations and require more medical care than normal weight children. There is strong evidence to suggest that by adolescence, there is increased risk of low self-esteem and impaired quality of life in obese individuals (Griffiths et al, 2010). Recent findings from the Millennium Cohort Study (Griffiths, 2011) suggest that childhood obesity may be associated with emotional and behavioural problems from a very young age, with obese boys at particular risk.

The UK government is committed to tackling childhood obesity. The National Child Measurement Programme (NCMP) is a nationally mandated public health programme which is crucial in monitoring the progress of this work. The programme has an important role for health and wellbeing boards in bringing together a range of local partners and informing local action to promote healthy weight. Additionally it provides the opportunity for direct engagement with families through the provision of results to parents along with follow up advice and support.

Who is at Risk & Why: The NCMP and the Health Survey for England suggest that obesity is associated with: Deprivation; Low household income; Households where the main income earner works a manual occupation.

What Local Data Tells Us: The NCMP reports that in Cumbria 25.1% of 4-5 year olds had excess weight in 2013/14; worse than the national average (22.5%) and an increase from the county's figure for the previous year (22.9%). Rates of 4-5 year olds with excess weight were worse than the national average in Allerdale, Barrow-in-Furness and Copeland. Allerdale and Barrow-in-Furness also experienced increases in this measure over the last year, with Barrow currently being rating worst out of all local authorities in England (30.6%). Between 2011/12 and 2013/14, the following wards had significantly higher rates of 4-5 year olds with excess weight than the national average: Hindpool (Barrow-in-Furness); Kirkby Stephen (Eden); Risedale (Barrow-in-Furness); Sandwith (Copeland); Ormsgill (Barrow-in-Furness); Newtown (Copeland); Upperby (Carlisle); Silloth (Allerdale); Mirehouse (Copeland); Ulverston East (South Lakeland); and Newbarns (Barrow-in-Furness).

In Cumbria 33.4% of 10-11 year olds had excess weight in 2013/14; this is similar to the national average (33.5%). However, there are a number of wards within the county that had worse rates of 10-11 year olds with excess weight than the national average between 2011/12 and 2013/14, these wards were: Netherhall (Allerdale); Ewanrigg (Allerdale); Ellenborough (Allerdale); Hindpool (Barrow-in-Furness); Moss Bay (Allerdale); Egremont North (Copeland); and Central (Barrow-in-Furness).

It should be noted that data regarding excess weight is not available for all wards in Cumbria as data is supressed for a number of areas due to small counts. For ward level data and information about the wards with supressed data, see: http://www.noo.org.uk/visualisation .

Evidence of What Works: The most effective interventions for the prevention and treatment of obesity involve a multi-component and holistic approach that aims simultaneously to improve diet, physical activity and behaviour change (NICE, 2006). Specifically, they involve parents/the whole family, physical activity, nutritional education, and, for children in school/preschool, support from teachers (PHE, 2015). A Cochrane Review in 2011 highlighted a number of policies and strategies that may be beneficial in decreasing rates of childhood obesity. NICE (2013) recommends that all lifestyle weight management programmes for overweight and obese children and young people are multi-component. The programmes should focus on: diet and healthy eating habits; physical activity; reducing the amount of time spent being sedentary; strategies for changing the behaviour of the child or young person and all close family members. NICE (2013) also recommends a number of core components be developed with the input of a multidisciplinary team. The EPODE (Ensemble Prevenons l'Obesité Des Enfants/Together Let's Prevent Childhood Obesity) is a coordinated, capacity – building approach for communities to implement effective and sustainable strategies to promote healthier lifestyles and prevent childhood obesity.

6.7 Physical Activity

Introduction: There is a need to establish healthy patterns of behaviour during the early years to protect against possible health detriments in the future. There is emerging evidence that sedentary behaviour in the early years is associated with excess weight and obesity, as well as lower cognitive development. PHE (source PHOF) state that people who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle and that regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health.

Who is at Risk & Why: The Health Survey for England 2012 found that, based on self-reporting, 21% of boys and 16% of girls aged 5–15 years met the UK physical activity guidelines for children and young people. Among both sexes, the proportion meeting the recommendations in the guidelines was lower in older children.

What Local Data Tells Us: 3,845 young people took part in Cumbria's 2012 Health-Related Behaviour Survey. 62% of males and 44% of females in Year 6 reported that they exercised enough to breathe harder and faster three times or more in the previous week. These percentages rose to 84% for males and 73% for females in Year 8, before falling to 74% for males and 52% for females in Year 10. Survey findings suggested enjoyment of physical activity declined with age, most noticeably for girls. Those reporting they are physically 'fit' or 'very fit' also followed the same trend. Year 10 females in Cumbria were less likely to say they enjoy physical activity than the national average (53% vs. 61%). Furthermore, secondary pupils in Cumbria were less likely to say they walked to school on the day of the survey compared to the national average (35% vs. 40%); this result may be expected due to the county's rural nature meaning that the distances travelled between home and school for many pupils are not 'walkable' distances.

Evidence of What Works: The Chief Medical Officer provided guidelines in 2011 for recommended levels of physical activity in children and young people. NICE (2009) provides guidance for all those who are involved in promoting physical activity among children and young people, including parents and carers. PHE have co-produced the 'Physical Activity Framework: Everybody Active Every Day' in partnership with stakeholders, this is a culmination of evidence on 'what works' across all sectors and levels for increasing physical activity. PHE have also published 'What works in schools and colleges to increase physical activity' which provides evidence for staff working in education settings, directors of public health and wider partners. Further information about physical activity can be found in the Healthy Living and Lifestyles Chapter of Cumbria's JSNA.

6.8 Healthy Nutrition

Introduction: The importance of diet as a major contributor to chronic disease and premature death in England is recognised in the White Paper 'Healthy Lives, Healthy People'. The Foresight Report (2007) suggests that the promotion of healthy eating has a potentially positive role in social inclusion by helping individuals and families improve their food preparation skills, and their nutritional intake, with potential benefits on child development and behaviour.

Who is at Risk & Why: For information about groups at risk please see the Healthy Living and Lifestyles Chapter of Cumbria's JSNA.

What Local Data Tells Us: 7% of primary pupils and 11% of secondary pupils responding to Cumbria's 2012 Health-Related Behaviour Survey said they had no fruit or vegetables on the day before the survey, while 25% of primary pupils and 17% of secondary pupils said they had 5 or more portions. 45% of primary pupils and 52% of secondary pupils reported that they consume vegetables 'on most days', while 48% of primary pupils and 38% of secondary pupils reported that they consume fresh fruit 'on most days'. Secondary school pupils in Cumbria were more likely to eat vegetables on most days than the national average (52% vs. 42%).The proportion of Cumbrian pupils who say they eat fresh fruit and vegetables on most days has also increased since a low point in 1995.

21% of primary pupils and 24% of secondary pupils said they consider their health when choosing food. Secondary school pupils in Cumbria were more likely to consider health often when choosing food than the national average (55% vs. 41%).The proportion of pupils who said they thought about their health 'very often' when choosing what to eat has increased for all groups (more so the girls than the boys), to the highest level seen to date.

Evidence of What Works: Please see the Healthy Living and Lifestyles Chapter of Cumbria's JSNA.

6.9 Tooth Decay

Introduction: First teeth are important developmentally for a child's speech, eating and facial appearance. They establish a space in the mouth for adult teeth, allowing the permanent teeth to grow and develop normally. Early loss of first teeth can lead to overcrowding in adult teeth, which may require orthodontic treatment (braces). Dental caries (tooth decay) can cause toothache, distress and discomfort to toddlers, stop them sleeping and eating, and lead to reduced food intake, behavioural disturbances and parental concerns about appearance.

Who is at Risk & Why: The British Dental Health Foundation (2010) report that there are many risk factors for developing dental caries including: Excess and frequent dietary sugar intake; Low socioeconomic status; Poor parental education; and Low levels of fluoride in the drinking water. In addition, the National Dental Epidemiology Programme for England (2013) reported that deprivation explains 44% of the variation in the severity of tooth decay.

What Local Data Tells Us: The 2013 Oral Health Survey of 3 year olds, undertaken by the Dental Public Health Epidemiology Programme (DPHEP) for England, reported that 4.5% of 3 year olds in Cumbria had early childhood caries; this is similar to the national rate of 3.9%. Amongst Cumbria's 3 year olds, the mean number of teeth per child which were decayed, missing or filled (d3mft) was 0.4; again, this was similar to the national average (England 0.36). Of Cumbria's districts, Carlisle had a significantly higher rate of 3 year olds with early childhood caries than the national average and a significantly higher mean number of d3mft amongst 3 year olds than the national average.

The DPHEP 2012 Oral Health Survey of 5 year olds reported that amongst Cumbria's 5 year olds, the mean number of d3mft was 1.16; this was worse the national average (England 0.94). Of Cumbria's districts, Barrow-in-Furness, Carlisle and Copeland had significantly higher mean numbers of d3mft amongst 5 year olds than the national average.

Evidence of What Works: British Dental Health Foundation (2010) makes a series of recommendations to reduce tooth decay.

6.10 Unintentional Injuries

Introduction: Unintentional injury is a leading cause of death among children and young people aged 1-14 (Audit Commission and Healthcare Commission, 2007). In the UK unintentional injury (in all environments) results in more than two million visits to Accident & Emergency (A&E) departments by children every year. Half of these injuries occur in the home. Falls are the most common cause of injury for children aged 0-15 years, while transport accidents are the most common cause of injury for young people aged 16-17 years. The term 'unintentional injury' is more widely used rather than 'accidents' since most injuries and their precipitating events are predictable and preventable.

Who is at Risk & Why: Epidemiological data indicates that the risk of an unintentional injury is greatest among households with: Deprived circumstances; Lower socioeconomic status; Parents that have never worked or are long-term unemployed. Source: Edwards et al, 2006.

What Local Data Tells Us: HSCIC using Hospital Episode Statistics (HES) report that Cumbria's rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years in 2013/14 was 133.7 per 10,000 population; this was worse than the national average of 112.2 per 10,000 and an increase from county's 2012/13 figure of 119 per 10,000. The following districts had worse rates than the national average for this measure: Barrow-in-Furness (175.1 per 10,000, up from 166.1 in 2012/13); Carlisle (139.9 per 10,000, up from 106.9 in 2012/13); and Copeland (143.2 per 10,000, up from 139.9 in 2012/13).

HSCIC also report that Cumbria's rate of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 years in 2013/14 was 160.1 per 10,000 population; worse than the national average of 136.7 per 10,000 and an increase from the county's 2012/13 figure of 155.3 per 10,000. The following districts had worse rates than the national average for this measure: Barrow-in-Furness (181.8 per 10,000); Copeland (188.1 per 10,000, up from 175.1 in 2012/13); and South Lakeland (172.6 per 10,000, up from 160.8 in 2012/13).

In May 2014 the Centre for Public Health Trauma and Injury Intelligence Group (TIIG) produced a themed report which provided more detailed analysis of unintentional and deliberate injuries in children and young people across Cumbria in the 2012/13 year. Key findings from this report were as follows:

- In 2012/13 Cumbria had 6,881 Emergency Department (ED) attendances made by children (0-14 years) and 6,806 attendances made by young people (15 and 24 years);
- 6,770 attendances (98%) made by children were due to unintentional injuries;
- 5,687 attendances (84%) made by young people were due to unintentional injuries;
- Unintentional injuries were classified as being due to a Road Traffic Collision (RTC), sports or 'other' causes. 83% of unintentional injuries in children were recorded as 'other' causes, followed by 15% sustained by sport and 3% due to road traffic collisions;
- 63% of unintentional injuries in young people were categorised as 'other' causes, with 26% sustained by sport and 11% due to an RTC;
- Deliberate injuries were classified as being due to assault or deliberate self-harm. 74% of deliberate injuries in children were due to assault, 26% were due to deliberate self-harm;
- 53% of deliberate injuries in young people we due to assault, 47% were due to deliberate self-harm;
- Males accounted for 58% of children's and 62% of young people's attendances;
- The primary incident location for children's injuries was the home (49%);
- 46% of injuries in young people were recorded as taking place in an 'other' location, followed by the home (28%).

Evidence of What Works: NICE Guidance (2010) suggests that households at greatest risk should be prioritised. Data and evidence on who these households are should come from the relevant statutory and voluntary organisations e.g. local children's safeguarding board, children's centres etc. Good practice should ensure that home safety issues are integrated with other home visits e.g. those conducted by midwives, health visitors, social workers. Where home safety equipment is supplied and installed it should be tailored to meet the household's specific needs and circumstances.

7. Section Two: Risk Taking Behaviours

7.1 Smoking

Introduction: Smoking and tobacco use continues to be one of the most significant health challenges in England. In 2007 the legal age for the purchase of tobacco in England and Wales was raised from 16 to 18 years. Legislation which banned the sale of cigarettes from vending machines in 2011, the display of tobacco products in supermarkets in 2012 and in smaller shops from this year was also intended to deter young people from buying cigarettes. The minimum age to smoke in public is 16 years and cigarettes can be confiscated from those under 16 caught smoking in public.

Who is at Risk and Why: Action on Smoking and Health (2015) reports that smoking initiation is associated with a wide range of risk factors including: Parental, sibling and peer smoking; The ease of obtaining cigarettes; Socio-economic status; Other substance use (i.e. alcohol). Additionally, the What About YOUth? (WAY) 2014 survey carried out by HSCIC found that: girls were more likely than boys to have ever smoked (28% vs. 21%); 27% of young people in the most deprived areas had ever smoked compared to 21% in the least deprived areas; 17% of young people from a BME background had ever smoked compared to 26% of young people from a white background.

What Does Local Data Tell Us: Local Tobacco Profiles produced by PHE estimate that in 2009-12, 3.6% of 11-15 year olds in Cumbria were regular smokers, with this figure rising to 16.7% in 16-17 year olds. Cumbria's rates were similar to the national averages of 3.1% and 14.7% respectively. Furthermore, the WAY 2014 survey reported that amongst Cumbria's 15 year olds, 7.3% were current smokers, 5.1% were regular smokers and 2.2% were occasional smokers. Again, Cumbria's rates were similar to the national averages of 8.2%, 5.5% and 2.7% respectively. The WAY 2014 survey also reported that amongst Cumbria's 15 year olds, 3.2% were current users of E-cigarettes, 1.4% were regular users of E-cigarettes and 1.8% were occasional users of E-cigarettes; similar to the national averages of 2.7%, 1% and 1.7% respectively.

Evidence of What works: NICE (2010) guidance for schools, Pupil Referral Unit (PRUs), secure training, local authority secure units and FE colleges makes recommendations. Further evidence of effective work suggests developing national, regional or local mass-media campaigns to prevent the uptake of smoking among young people under 18; the targeting of illegal sales; work with retailers to ensure they are aware of legislation prohibiting under-age tobacco sales.

7.2 Alcohol Misuse

Introduction: Alcohol use has health and social consequences borne by individuals, their families, and the wider community. The Chief Medical Officer for England's Guidance (2009) states that young people under 15 should not drink alcohol at all, based on the fact that young people who start drinking at an early age tend to drink more frequently and more than those who start drinking later; as a result they are more likely to develop alcohol problems in adolescence and adulthood (Government, 2012).

Who is at Risk and Why: PHE (source PHOF) state that alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions, and is a major risk factor for mental health disorders, injuries due to road traffic accidents and violence. The Sexual Health Framework (2013) highlights that there is evidence that alcohol consumption and being drunk can result in lower inhibitions and poor judgements regarding sexual activity, vulnerability and risky sexual behaviour, such as not using contraception or condoms; alcohol consumption by young people leads to an increased likelihood that they will have sex at a younger age, and alcohol misuse is linked to a greater number of sexual partners and more regretted or coerced sex; alcohol also increases the risk of sexual aggression, sexual violence and sexual victimisation of women.

What Does Local Data Tell Us: Local Alcohol Profiles for England (LAPE) produced by PHE report that in 2011/12 - 13/14, the rate of under 18s alcohol-specific hospital admissions in Cumbria was 68.0 per 100,000 population, this is significantly worse than the national average of 40.1 per 100,000 population. Of Cumbria's districts, Allerdale, Barrow, Copeland and South Lakeland all have under 18s alcohol-specific hospital admissions rates that are worse than the national average, with Copeland having the highest rate of all local authorities in England.

Evidence of What works: There are no national guidelines on what constitutes safe and sensible alcohol consumption for children and young people. However, NICE (2007) have issued recommendations that focus on: encouraging children not to drink, delaying the age at which young people start drinking and reducing the harm it can cause among those who do drink. NICE also recommends a partnership approach to tackling alcohol use for children and young people in schools. More specialist support may be required for those young people who are drinking harmful amounts of alcohol and who may be at an increased risk of alcohol-related harm. This includes those: who have had an accident or a minor injury; who regularly attend genito-urinary medicine (GUM) clinics or repeatedly seek emergency contraception; involved in crime or other antisocial behaviour; that truant on a regular basis; at risk of self-harm; who are looked after; involved with child safeguarding agencies.

7.3 Substance Misuse

Introduction: There is a perception that substance misuse is a widespread problem among under 18's in England. While any substance misuse among this age group is concerning, figures released in 2012/13 (PHE) show that overall, secondary school pupils are far less likely to use drugs than their counterparts were a decade ago. Cannabis remains the drug for which young people are most likely to seek help**.**

Who is at Risk and Why: Becker and Roe (2005) define five groups of young people who may be vulnerable to substance misuse: Those who have ever been in care; Those who have ever been homeless; Truants; Those excluded from school; and Serious or frequent offenders.

Factors that influence substance misuse among children and young people include: environment (e.g. availability of drugs); family (e.g. sibling and/or parental substance misuse and lack of discipline); individual experience (e.g. early sexual encounters and peer group pressure to misuse substances); mental health (e.g. low self-esteem, depression) and education (e.g. parental expectations); using a range of drugs at an early age; drinking on a daily basis; and self-harm.

What Does Local Data Tell Us: HSCIC report that, between 2011/12 and 2013/14, there were 64 hospital admissions due to substance misuse for 15-24 year olds in Cumbria; equivalent to a rate of 118.1 per 100,000 population; significantly higher than the national average (81.3 per 100,000). Cumbria's 2012 Health Related Behaviour Survey found that for Cumbrian Year 10 pupils:

- 14% had ever tried drugs (national average 11%);
- 16% had taken an illegal drug, 8% had taken one in the last month;
- 10% had taken an illegal drug and alcohol on the same occasion;
- 31% of boys and 28% of girls had been offered cannabis;
- Cannabis was the most popular drug;
- 44% were concerned about other people's drug use and 1% about their own use;
- 12% of those who had never used cannabis believed cannabis was safe if used properly, this increased to 75% in those who had used cannabis in the last month;
- Experience of illegal drugs in males was linked with, playing rugby, greater anxiety about money (and other worries), use of internet (e.g. for chatting), higher weekly income and caring for family members.

A review of the previously commissioned young people's substance misuse service (DASH) reported that in December 2013 there were 30 open cases and 37 discharged. The primary areas of misuse were alcohol followed by cannabis; there was no heroin or crack usage and other drugs were minimal in numbers. The main areas adding complexity to cases were: criminal justice involvement; mental health problems; housing issues; child protection; and education.

Evidence of What works: NICE guidance to reduce substance misuse among vulnerable young people focuses on community-based activities taking place in, for example, schools and youth services (NICE, 2007). However, there are some protective factors which can be key sources of stability and support, and may play vital roles in ensuring young people overcome their drug problems. These protective factors include being in mainstream or alternative education, training or employment.

7.4 Sexual Health

Introduction: The essential elements of good sexual health are equitable relationships, with access to information and services to avoid the risk of unintended pregnancy, illness or disease. Sexual health is influenced by complex factors ranging from sexual behaviour, attitudes and societal factors, to biological risk and genetic predisposition. It includes the problems of HIV and Sexually Transmitted Infections (STIs), unintended pregnancy and abortion, infertility and cancer results from STI's. Although sexual health has been implicitly understood to be part of the reproductive health agenda, the emergence of HIV and STI's, as key public health issues, has highlighted the need to focus more explicitly on the promotion of good sexual health.

Who is at Risk and Why: There is a clear link between sexual ill-health, deprivation and social exclusion (source: DoH, 2013, A Framework for Sexual Health in England). Vonstanis, P. (2002) reported that homeless adolescents and street youth are vulnerable to STIs. The Sexual Health Framework (2013) reported that influences on sexual health outcomes include: personal beliefs, the understanding and perception of risk associated with certain sexual behaviours; attitudes; social norms and peer pressure; religion; self-esteem and confidence; past behaviour; relationships within families; stigma and discrimination and behavioural willingness.

What Does Local Data Tell Us: PHE reported that in 2013, there were 1,431 new STIs (including chlamydia) diagnosed in Cumbria for 15 to 24 year olds; equivalent to a rate of 2,575 per 100,000 population aged 15-24. Cumbria's rate was lower than the national average of 3,433 per 100,000 population.

PHE (source PHOF) state that Chlamydia is the most commonly diagnosed STI. It causes avoidable sexual and reproductive ill-health. The chlamydia diagnosis rate is a measure of chlamydia control activities as positive detections are highly dependent on screening services offered. It represents infections identified (reducing risk of sequelae in those patients and interrupting transmission onto others). The target is to reach 2,300 detections per 100,000 of 15-24 year old population. This target aims to encourage high volume screening and diagnoses.

In 2013, Cumbria did not reach the target with a detection rate of 1,526 per 100,000 (a decrease from 2012). Within the districts only Carlisle had a detection rate above the national target of 2,300 per 100,000.

PharmOutcomes, which collates information on pharmacy services, reported that in 2013/14, around 2,300 people accessed Emergency Hormonal Contraception (EHC) services at pharmacies in Cumbria. More than half of those (57.8%) were young people aged between 16-25 years, with the greatest number of service users aged 20 years. Unprotected sex was the main reason for young people accessing EHC services (54.1%) in Cumbria. The greatest proportion of young people accessing EHC were from Barrow-in-Furness (26%). However, more than 200 young people accessing EHC were resident outside of the county.

In 2013 Journey of Youth and Cumbria Youth Alliance carried out research into young people's experiences and knowledge of sexual health services in Cumbria. A total of 2,506 questionnaires were returned, with the majority of respondents aged 14-16 years. Key research findings included:

- 29% reported they were in a relationship and 32% reported they were sexually active;
- Proportions in a relationship and/or sexually active increased with age;
- Higher proportions of females stated being in a relationship, particularly in Barrow;
- Of those sexually active, just over 40% of respondents answered yes to using condoms;
- Knowledge and awareness of the C-Card scheme (free condoms) was greater in Copeland and Carlisle and less apparent in Barrow;
- There were low levels of awareness of the Sexual Healthline;
- 62% of females were aware of where to access emergency contraception, recognising Drs and chemists as the two primary sources;
- More females were aware of where to get checked for STI's, with greater proportions in Carlisle (females 64%, males 48%). Drs were recognised as the primary location;
- Preference for help with concerns about STIs or possible pregnancy would be Drs or sexual health clinics;
- 12% had used a sexual health clinic, Barrow had the greatest proportion (20%);
- Most would prefer a service in their youth centre, school or GP surgery to speak to someone about sexual health or contraception with significant demand for a service just for young people;
- The best time to visit a sexual health clinic was after school, evenings and weekends;
- 41% indicated that they would benefit from more education on sexual health, with a preference for receiving sexual health information via schools (40%).

Cumbria's 2012 Health-Related Behaviour Survey reported that the majority of secondary school pupils reported that they would contact friends and family for help or information about sex and relationships. Specifically in relation to Year 10 pupils the survey found:

- 72% stated that they had never had sex;
- 8% were in a relationship and thinking about having sex;
- 12% have had sex; 8% were currently in a sexual relationship;
- 7% had had unprotected sex;
- More girls reported that they have had sex;
- 5% reported that they had unprotected sex after using alcohol;
- 2% reported that they had unprotected sex after using drugs;
- 59% of boys and 65% of girls believed there was a special contraception and advice service for young people available locally;
- 69% of boys and 74% of girls said they knew where to get free condoms; and
- 51% identified that chlamydia is a treatable STI.

Evidence of What works: The recommended standards for sexual health services suggest that people should have access to accurate information about, and free provision of, all contraceptive methods. Where appropriate, one to one sexual health advice for vulnerable young people (disadvantaged backgrounds, in or leaving care, low educational attainment) aged under 18 should also be provided (Medical Foundation for AIDS and Sexual Health 2005). Both young people and parents want high quality education about sex and relationships. The provision of sex education is a statutory requirement for maintained secondary schools. What schools include in their sex education programme is a matter for local determination; however all schools must have regard to the Secretary of State for Education's Sex and Relationship Guidance. Academies do not have to teach sex education, but are required through their funding agreements to provide a broad and balanced curriculum (Framework for Sexual Health Improvement, 2013).

7.5 Teenage Pregnancy

Introduction: PHE (source PHOF) state that most teenage pregnancies are unplanned and around half end in an abortion. For some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.

Who is at Risk and Why: The ONS report that the infant mortality rate is 41% higher for babies born to women under 20, while Botting B, Rosato M and Wood R (1998) reported that the incidence of low birth weight of term babies is 25% higher for babies born to women under 20. The Infant Feeding Survey (2010) reported that mothers under 20 are: twice as likely to smoke before and during pregnancy; a third less likely to initiate breastfeeding; and half as likely to be breastfeeding at 6-8 weeks. The DoH (2004) reported that mothers under 20 had 30% higher level of mental illness two years after the birth.

The risk of teenage parenthood is greatest for young people who have grown up in poverty and those with poor educational attainment. The Teenage Pregnancy Strategy 2010 reported that children of teenage mothers are generally at increased risk of: poverty, low educational attainment, poor housing, poor health, lower rates of economic activity in adult life; and becoming teenage parents themselves, perpetuating disadvantage from one generation to the next. Furthermore, the DfE reported in 2014 that 21% of females who are NEET and aged 16-18 are teenage mothers.

What Does Local Data Tell Us: In Cumbria in 2013 there were 20.2 under 18s conceptions per 1,000 females aged 15-17 and 5.0 under 16s conceptions per 1,000 females aged 13-15. Cumbria's rate of under 18s conceptions is better than the national average of 24.3, while the county's rate of under 16s conceptions is similar to national average of 4.8.

Evidence of What works: Following the implementation of the Teenage Pregnancy Strategy (1999) and subsequent Phase 2 an extensive review of the evidence has identified Sex and Relationships Education (SRE) and contraception as being effective. Further reviews from areas with significant reductions in teenage pregnancy suggest other factors critical to reducing teenage pregnancy are:

- Having local champions and senior engagement in the local authority and CCG;
- Training for the children's workforce to talk to young people about sex and relationships;
- The collection, sharing and effective use of local data to inform targeted work and provide a more timely assessment of progress;
- Giving young people knowledge and skills to experience positive relationships and good sexual health;
- Improving young people's access to / use of effective contraception when they need it;
- Intervening early with those most at risk; and
- Improving outcomes for teenage parents and their children.

7.6 Road Accidents

Introduction: Unintentional injury is still a leading cause of death among children and young people aged 1–14 (Audit Commission and Healthcare Commission 2007) and nearly half (44%) of those deaths in England & Wales are transport-related (ONS 2009). Furthermore, the WHO (2013) reported RTCs are the leading cause of death among 15-19 year olds.

Who is at Risk and Why: It has been suggested that high rates of death due to RTCs in young people is due to their lack of experience of driving at high speed, distractions from passengers, driving at night and the tendency to drive older, smaller and less well-protected cars (Neary et al., 2011). The number of people killed or seriously injured (KSI) on the road increases with age. There is a noticeable increase between ages 10 and 11, coinciding with the move to secondary school and probably with increasingly unsupervised travel. In 2008, 65% of children or young people KSI were boys. This higher rate in boys is seen in all modes of transport (except for car passengers, where girls account for 54% KSI casualties). Fosdick (2013) found that young rural drivers are 44% more likely to be involved in an RTC which resulted in injury.

Greyling et al. (2002) reported that among young people aged under 15, the likelihood of dying as a result of an RTC is higher for those whose parents are unemployed and those living in the most deprived areas. Edwards et al. (2006) reported the largest factor resulting in this difference in death rate is exposure to danger rather than behaviour; people from lower socioeconomic groups are more likely, for example, to live in neighbourhoods with on-street parking, high-speed traffic and few or no off-street play areas.

What Does Local Data Tell Us: The Department for Transport (DfT) reported that Cumbria had a rate of 45.7 per 100,000 resident population KSI casualties on England's roads in 2011-13; this was significantly worse than the national average of 39.7 per 100,000. Of Cumbria's districts, Eden, South Lakeland and Allerdale had rates that were significantly worse than the national average (89.9, 55.4 and 48.5 per 100,000). During the above timeframe the DfT reported that Cumbria had a rate of 18.1 child KSI casualties per 100,000 population aged 0-15 years; this was similar to the national average of 19.1 per 100,000 population. Furthermore, the DfT reported that throughout 2014, there were 226 KSI casualties on Cumbria's roads, a decrease of 13 incidents (-5.4%) from the previous year. Numbers of KSI incidents increased in Allerdale (+1), Barrow-in-Furness (+5), and Copeland (+4); whilst numbers decreased in Carlisle (-2), Eden (-8) and South Lakeland (-13).

There were a total of 12 child KSI incidents in Cumbria in 2014; a decrease of 2 incidents from the previous year. The greatest number of child KSI incidents took place in the districts of Carlisle (3) and Barrow-in-Furness (3); in Allerdale and Copeland there were 2 incidents respectively; and in Eden and South Lakeland there was 1 incident respectively.

Figure 9: KSIs by user group category, Cumbria, 2014

	2012	2013	2014	Numerical Change 2013-14	% Change 2013-14
All KSIs	196	239	226	-13	-5.4%
Child KSIs	10	15	12	-3	-20.0%
All fatal	30	27	25	-2	-7.4%
Slights (Non KSI Casualties)	1,511	1,437	1625	188	13.1%
Total Casualties	1,707	1,676	1851	175	10.4%

Source: DfT

In February 2015 the TIIG produced a themed report providing detailed analysis of RTCs in Cumbria between 2011/12 and 2013/14. Key findings were as follows:

- There were 6,966 attendances to EDs in Cumbria due to injuries caused by an RTC between April 2011 and March 2014, of which, 87% were Cumbrian residents;
- Across the three years there has been a 16% reduction in the number of RTC-related injury attendances to the EDs in Cumbria;
- For Cumbrian residents only, 20-24 year olds made up the largest proportion of attendances (17% / 1,037 attendances), followed by 15 -19 year olds (14% / 871 attendances);
- Males accounted for 57% of the above 1,037 attendances for 20-24 year olds and 55% of the above 871 attendances for 15 -19 year olds.

Figure 10 presents numbers of ED attendances for RTC injuries by gender and five-year age groups for Cumbrian residents aged up to 24 years old between 2011/12 to 2013/14.

Figure 10: ED Attendances: RTC Injuries: Cumbrian Residents: 2011/12 to 2013/14:

	Female	Male	Total
Age Group	Count	Count	Count
0-4	84	69	153
5-9	68	84	152
10-14	95	92	187
15-19	391	480	871
20-24	450	587	1,037
All Ages (0-90+)	2,677	3,365	6,042

Source: TIIG

Evidence of What Works: In line with DfT guidelines engineering measures can be introduced to reduce speed in streets that are primarily residential or where pedestrian and cyclist movements are high or on rural roads where the risk of injury is relatively high. Additionally, engineering measures can be developed to provide safer routes commonly used by children and young people, including to school and other destinations (such as parks, colleges and recreational sites). This should be done as part of the development of a broad package of measures to address travel, for instance when developing school travel plans and should include discussions with school governors and head teachers about changes relating to school travel.

7.7 Youth Offending

Introduction: Young offenders are offenders under the age of 18, or in some cases aged 18 but remaining in the under 18 estate, and will be held in either a Secure Children's Home (SCH), a Secure Training Centre (STC) or a Young Offender Institution (YOI). The Youth Justice Board is responsible for placing young people in custody and typically those aged under 15 will be held in an SCH and those over 15 will be held in either a YOI or STC. Only 17 year old female young people are normally placed in a YOI. Young people can be sentenced to either a Detention and Training Order (DTO), imprisonment under section 90 or 91 of the Powers of Criminal Courts (Sentencing) Act 2000 or imprisonment under section 226 or 228 of the Criminal Justice Act 2003.

Who is at Risk & Why: First time entrants to the youth justice system have far more unmet health needs than other children of their age. These include poor communication skills, mental health problems, learning difficulties and both self-harm and risk of harm to others. First time entrants to the youth justice system face a range of other, often entrenched, difficulties including school exclusion, substance misuse, fragmented family relationships and unstable living conditions and parental poverty, and social exclusion. It is the combination of overlapping facts that gives these children multiple and complex needs and heightens the risk of their being drawn into anti-social activity. The Outcomes for Children Looked After 2014 SFR from the DfE reports that, rates of offending amongst children who are looked after are more than five times higher than those reported for all children.

Contact with the Youth Justice system can bring extra problems for some children and young people including those with learning difficulties, communication needs and mental health problems. This makes it more difficult for them to cope with police interviews after arrest, understand court proceedings or comply with the requirements of a community sentence. For those placed in custody there is the added anxiety of being away from home, maintaining contact when placed at a distance, staying safe in unfamiliar surroundings and worrying about the welfare of siblings and parents left behind. Once they have completed their sentence, they face the challenges of settling back into the community.

Organisational and attitude problems can be barriers to progress. Children and their parents have often missed out on early attention to their health, mental health and well-being needs. They may not have qualified for help because each different problem they had was not in itself serious enough to attract attention, even though the combination of problems put them at high risk. Help offered to them later may not be enough to make up for early failings.

What Does Local Data Tell Us: The Ministry of Justice reported that Cumbria's rate of 10-17 year olds receiving their first reprimand, warning or conviction (known as first time entrants) in 2014 was 438 per 100,000 population; this was similar to the national average of 409 per 100,000 but an increase from the county's rate of 329 per 100,000 in 2013 (nationally rates fell during the last year from 448 per 100,000 in 2013).

Cumbria Youth Offending Service (YOS) reported that in the 2013-14 year there were 340 young offenders (aged 10-17 years) in Cumbria, a fall of 102 (-23.1%) from the previous year. Furthermore, there were 32 custodial sentences in the county for young offenders, down from 33 in the previous year. The greatest proportion of Cumbria's young offenders (36.3%) were aged 17+ years, while 81.4% were male. The greatest proportion of offences amongst Cumbria's young offenders were for 'Violence Against the Person' (20%).

Evidence of What Works: Health and well-being can be addressed throughout the youth justice system by (source: HM Government (2009) Healthy Children, Safer Communities):

- Appropriately diverting children and young people from the formal Youth Justice System;
- Improving primary and specialist healthcare services to young offenders in the community;
- Providing courts and sentencers with accurate information about health and well-being needs and the service available to meet them;
- Promoting health and well-being in the secure estate; and
- Providing continuity of care and improve support when children and young people complete a community or custodial sentence.

8. Section Three: Mental Health and Emotional Well-being

Introduction: Mental health has been defined as “A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”

Emotional wellbeing has been defined as “a positive state of mind and body, feel safe and able to cope, with a sense of connection with people, communities and the wider environment” It is increasing used alongside mental health and is often favoured by schools and others whose main contribution is around prevention and health promotion.

Who is at Risk and Why: Prevalence estimates for mental health disorders in children aged 5 to 16 years have been estimated in a report by Green et al (2004) based on the ICD-10 Classification of Mental and Behavioural Disorders; disorder causing distress to the child or having a considerable impact on the child’s day to day life. Boys are more likely to experience mental health problems than girls, and children aged 11 to 16 years olds are also more likely to experience mental health problems than 5 to 10 year olds.

Emerson, E. et al, (2008) reported that people with learning disabilities are more likely to experience mental health problems, while Ford, T. et al, (2007) reported that children who are looked-after after by local authorities are more likely to experience mental health problems. Additionally, Vonstanis, P. (2002) reported that homeless adolescents and street youth are likely to present with depression and attempted suicide.

Windfuhr, K. (2008) reported that: three times as many young men than young women aged 15-19 committed suicide; only 14% of young people who committed suicide were in contact with mental health services in the year prior to their death; and 20% of young women were in contact with mental health services compared to only 12% of young men.

Hawton, K. (2012) reported that levels of self-harm are higher among young women than young men and that repetition of self-harm was frequent. In 2005 Hawton, K. reported that young South Asian women in the UK seem to have a raised risk of self-harm.

Hawton, K. also reported in 2005 that common characteristics of adolescents who self-harm are similar to the characteristics of those who commit suicide and that the following factors seem to indicate a risk of suicide after deliberate self-harm: being an older teenage boy; violent method of self-harm; multiple previous episodes of self-harm; apathy, hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital.

What Does Local Data Tell Us:

8.1 Emotional Health and Wellbeing

Cumbria's 2012 Health-Related Behaviour Survey found the following for Cumbria's pupils:

- Boys generally appear in the highest self-esteem brackets more often than girls do;
- The top three worries for boys of primary school age were crime (24%), family (24%) and SATs/tests (18%);
- The top three worries for girls of primary school age were SATs/tests (37%), family (33%) and friends (31%);
- The top three worries for boys of secondary school age were exams & tests (41%), family problems (26%) and career (25%);
- The top three worries for girls of secondary school age were exams & tests (60%), the way you look (58%) and family problems (38%);
- Girls worry more than boys about several topics, e.g. tests, looks, family and friends;
- Family is the most popular source of support for boys and girls;
- 68% of primary pupils and 67% of secondary pupils reported that, in general, they were satisfied with their life;
- Primary school pupils in Cumbria are more likely to score in the highest bracket of self-esteem (35%) the national average (33%). However, secondary school pupils in Cumbria are less likely to have a self-esteem score in the highest bracket (33%) than the national average (44%);
- Secondary school pupils in Cumbria are more likely to say they can say no if a friend wanted them to do something they didn't want to do (58%) than the national average (66%).

8.2 Bullying

Cumbria's 2012 Health-Related Behaviour Survey found that for Cumbrian pupils:

- Fear of going to school because of bullying was reported by both primary pupils (35%) and secondary pupils (24%);
- 31% of primary pupils (31%) and 23% of secondary pupils reported that they had been bullied at, or near, school in the last 12 months;
- The fear of bullying amongst Year 6 pupils has increased since 2003 and is 5% higher than the national average;
- However, more primary pupils in Cumbria believe their school takes bullying seriously (74% compared to 68% nationally);
- For Year 8 and Year 10 pupils, the fear of bullying has fluctuated since 1995;
- 51% of secondary pupils believe their school takes bullying seriously (51%);
- Results indicate a strong link between experiences of bullying and self-esteem. However, it is unclear whether bullying itself leads to lowered self-esteem, or whether low self-esteem makes a child more of a target for bullies;
- As stated above, secondary school pupils in Cumbria have lower self-esteem scores compared to the national average.
- Other children were not only perpetrators of bullying incidents, 27% of pupils indicated that they had been approached by and either scared, or upset, by an adult, in 13% of cases, the child indicated that they knew the adult.

8.3 Mental Health Disorder Prevalence

CHIMAT reported that the average prevalence rate of any mental health disorder in children aged 2 to 5 years was 19.6% (Egger, H et al, 2006). In July 2015 CHIMAT applied this prevalence rate to Cumbria's population to estimate that 4,030 children aged 2 to 5 years living in the county have a mental health disorder.

CHIMAT also applied the rates of mental health disorders in children aged 5 to 16 years (Green et al, 2004) to the Cumbrian population to estimate that 2,340 5-10 year olds and 3,530 11-16 year olds in the county have mental health disorders. Furthermore, CHIMAT applied prevalence rates of mental health disorders by type (Green, H. et al, 2004) to the Cumbrian population to estimate numbers of children in the county with mental health disorders by type in the county. These figures are provided in figure 11.

Figure 11: Cumbria: Estimated No. Children with Mental Health Disorders by Type:

	Aged 5-10 Years	Aged 11-16 Years
Conduct Disorders	1,525	2,040
Emotional Disorders	715	1,555
Hyperkinetic Disorders	515	445
Less Common Disorders	385	380

Source: ONS Mid-2014 estimates with Green, H. et al (2004) prevalence rates applied. Numbers do not add as some children have more than one disorder.

Singleton et al (2001) estimated prevalence rates for neurotic disorders in young people aged 16 to 19 inclusive living in private households. The table below provides CHIMAT estimates for Cumbria with the above rates applied.

Figure 12: Cumbria: Estimated No. 16 to 19 Year Olds: Neurotic Disorders:

	Males	Females	Persons
Mixed anxiety & depressive disorder	595	1,330	1,925
Generalised anxiety disorder	190	120	310
Depressive episode	105	290	395
All phobias	70	225	295
Obsessive compulsive disorder	105	100	205
Panic disorder	60	65	125
Any neurotic disorder	1,000	2,055	3,055

Source: ONS Mid-2014 estimates, with Singleton et al (2001) prevalence rates applied. Numbers do not add as some young people have more than one disorder.

CHIMAT applied the prevalence rates for children with autistic spectrum disorders found by Baird et al (2006) and by Baron-Cohen et al (2009) to the population of Cumbria to estimate that 410 children aged 5-9 years in the county have autism-spectrum conditions disorders.

8.4 Mental Health Disorder Hospital Episodes

HSCIC report that in 2013/14 there were a total of 104 child hospital admissions for mental health in Cumbria; equivalent to a rate of 110.6 admissions per 100,000 population aged 0 - 17 years, which is significantly higher than the national rate (87.2 admissions per 100,000) and an increase from the county's rate for the previous year (70.9 admissions per 100,000).

HSCIC also report that in 2013/14 there were 379 young person hospital admissions for self-harm in Cumbria; equivalent to a rate of 467.8 per 100,000 aged 10 – 24; this is significantly higher than the national rate (412.1 per 100,000) and an increase from the county's rate for the previous year (458.7 per 100,000).

The TIIG Themed Report into Deliberate Self-Harm across Cumbria reported that in 2013, there were 279 ED attendances for deliberate self-harm injuries in Cumbrian residents aged 10-19 years old, with a higher proportion of attendances for females.

8.5 Suicide

The ONS report national level annual suicide rates for those aged 15 and over by five-year age group. In 2013 the ONS reported that across the UK suicide rates were greatest amongst those aged 45-49 years, followed by those aged 40-44 years (17.1 and 16.7 per 100,000 population respectively). The rate of suicide in 15-19 year olds was 4.4 per 100,000; the lowest rate amongst all age groups (please note, only those aged 15+ are reported on). Across all age groups male suicide rates were much higher than female rates; with the overall rate for males being more than three times higher than the female rate. The rate of suicide in 15-19 year old males was 7 per 100,000 compared to just 1.6 per 100,000 in 15-19 year old females.

Local level suicide rates are provided by HSCIC, however, these rates are only available for broad age bands. HSCIC report that during 2011/13 mortality from suicide and injury undetermined in those aged 15-44 years in Cumbria was significantly higher than the national average (14.3 vs. England 10.1 per 100,000 population). Cumbria's rate was also significantly higher than the national average in males (24.07 vs. England 16.12 per 100,000). Of Cumbria's districts, Copeland had a significantly higher rate of mortality from suicide and injury undetermined in those aged 15-44 years than the national average both in relation to all persons and males (13.08 and 19.70 per 100,000 respectively).

HSCIC also provide 2011/13 figures for mortality from suicide in relation to those aged 15-34 years. Cumbria's rate for this measure was 11.21 per 100,000 population; higher than the national average of 5.94 per 100,000. Furthermore, all of the county's districts had higher rates than the national average, with Copeland having especially high rates (19.17 per 100,000). Male rates were higher than female rates for all districts, with Copeland and Barrow-in-Furness having the highest male rates (32.7 and 20.66 respectively vs. Cumbria 18.92 and national 9.55 per 100,000). However, it is important to note that no confidence intervals are available for this dataset so it is not possible to conclude whether the county and district figures are significantly higher than the national average.

8.6 Child and Adolescent Mental Health Services (CAMHS)

CAMHS range from mental health promotion and primary prevention to specialist care. Services are separated into 4 tiers:

- Tier 1 CAMHS is provided by professionals whose main role and training is not in mental health (i.e. GPs, health visitors, school nurses, social services, voluntary agencies, teachers, residential social workers and juvenile justice workers);
- Tier 2 CAMHS is provided by specialist trained mental health professionals. They work primarily on their own but may provide specialist input to multiagency teams (i.e. clinical child psychologists, paediatricians (especially community), educational psychologists, child psychiatrists and community child psychiatric nurses/ nurse specialists);
- Tier 3 CAMHS is aimed at young people with more complex mental health problems than those seen at Tier 2. Many of the professionals working at Tier 2 will work in this area, however the service is provided by a multidisciplinary team. Roles include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists and art, music and drama therapists;
- Tier 4 services are aimed at children and adolescents with severe and/or complex problems. These specialised services may be offered in residential, day patient or out-patient settings. These services include adolescent in-patient units, secure forensic adolescent units, eating disorder units, specialist teams for sexual abuse and specialist teams for neuro-psychiatric problems (York, A. et al, 2006, Kurtz, Z., 1996).

Kurtz (1996) calculated rates of children and young people (aged 0-17 years) who may experience mental health problems appropriate to a response from CAMHS by tier. CHIMAT applied these rates to Cumbria's population to provide the estimates reported in figure 13.

Figure 13: Estimated No. 0-17 Year Olds: May Experience Mental Health Problems: Appropriate to a Response from CAMHS:

	Tier 1 (2014)	Tier 2 (2014)	Tier 3 (2014)	Tier 4 (2014)
Cumbria	13,995	6,535	1,730	70

Source: ONS Mid-2014 estimates with Kurtz, Z. (1996) prevalence rates applied.

The 2014 Children and Young People Emotional Health and Wellbeing in Cumbria: Joint Strategic Needs Assessment [Refresh] reported the following numbers of CAMHS referrals in Cumbria for 2012/13.

Figure 14: Cumbria: Referrals to CAMHS: 2012-2013:

Indicator	Period	Cumbria
		Current Period
Number of referral to CAMHS Tier 3 for mental health conditions	2012/13	2380
Number of CAMHS Tier 4 referrals	2012/13	17
Number of children diagnosed with a mental health condition	2012/13	943

Source: 2014 Children and Young People Emotional Health and Wellbeing in Cumbria: Joint Strategic Needs Assessment [Refresh]

Evidence of What Works: An independent review of Tier 4 CAMHS commissioned by NHS England (CAMHS Tier 4 Report Steering Group, 2014) and evidence presented at the House of Commons Health Committee's inquiry (2014) into children and young people's mental health have shown that many children and young people with mental health and emotional difficulties do not receive timely, high quality, accessible or evidence-based support.

The Children and Young People's Mental Health and Wellbeing Taskforce was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided. The Taskforce published its report Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing in March 2015. This report made key recommendations to schools, commissioners, and early years staff. It emphasised the need to improve services for children and young people from vulnerable backgrounds, to improve access to services and to improve data and standards. For more information about the above taskforce, including a link to the report see: www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce

In October 2015 PHE published 'Measuring Mental Wellbeing in Children and Young People'. This guide supports the commissioning of interventions to improve the mental wellbeing of local children and young people with links to evidence based practice.

9. Section Four: Vulnerable Groups

There are a number of groups of children and young people identified within this chapter as being particularly vulnerable to poor health and wellbeing outcomes. The following sections provide further information about these groups in Cumbria.

9.1 Children Living in Poverty and Deprivation

Introduction: The national definitions of Child Poverty are set out in the Child Poverty Act (2010), in which all households with children that earn less than 60% of mean income are in poverty (there are several sub-definitions based on relative and absolute poverty). However, poverty is not just financial; there is also poverty of opportunity, and of ambition, and those elements point to solutions as well as to problems.

Who is at Risk and Why: The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy. Barnardos report that other risk factors for living in poverty include: Living in a lone parent family; Living in a larger family with 3 or more children; Living in social housing; and Living in a household where someone is disabled.

What Does Local Data Tell Us: For data regarding levels of child poverty and deprivation in Cumbria, please see the Population Overview section within this chapter.

Evidence of What Works: Under the Child Poverty Act local authorities have a duty to produce a child poverty needs assessment and strategy that sets out their plans to work with partners to address child poverty. Although local authorities have limited powers to reduce numbers in poverty based on the national definition, there is a body of emerging best practice in terms of how to tackle the effects of poverty. Particular areas of emphasis include: children in poverty's readiness for entering primary school; addressing equality in attainment at Key Stages 2 and 4; provision of support for families at an early stage through children's centres, and provision of a range of support services including money advice, food banks, credit unions and advocacy services. The Child Poverty Action Group campaigns to raise awareness of child poverty and have developed policy guides and best practice.

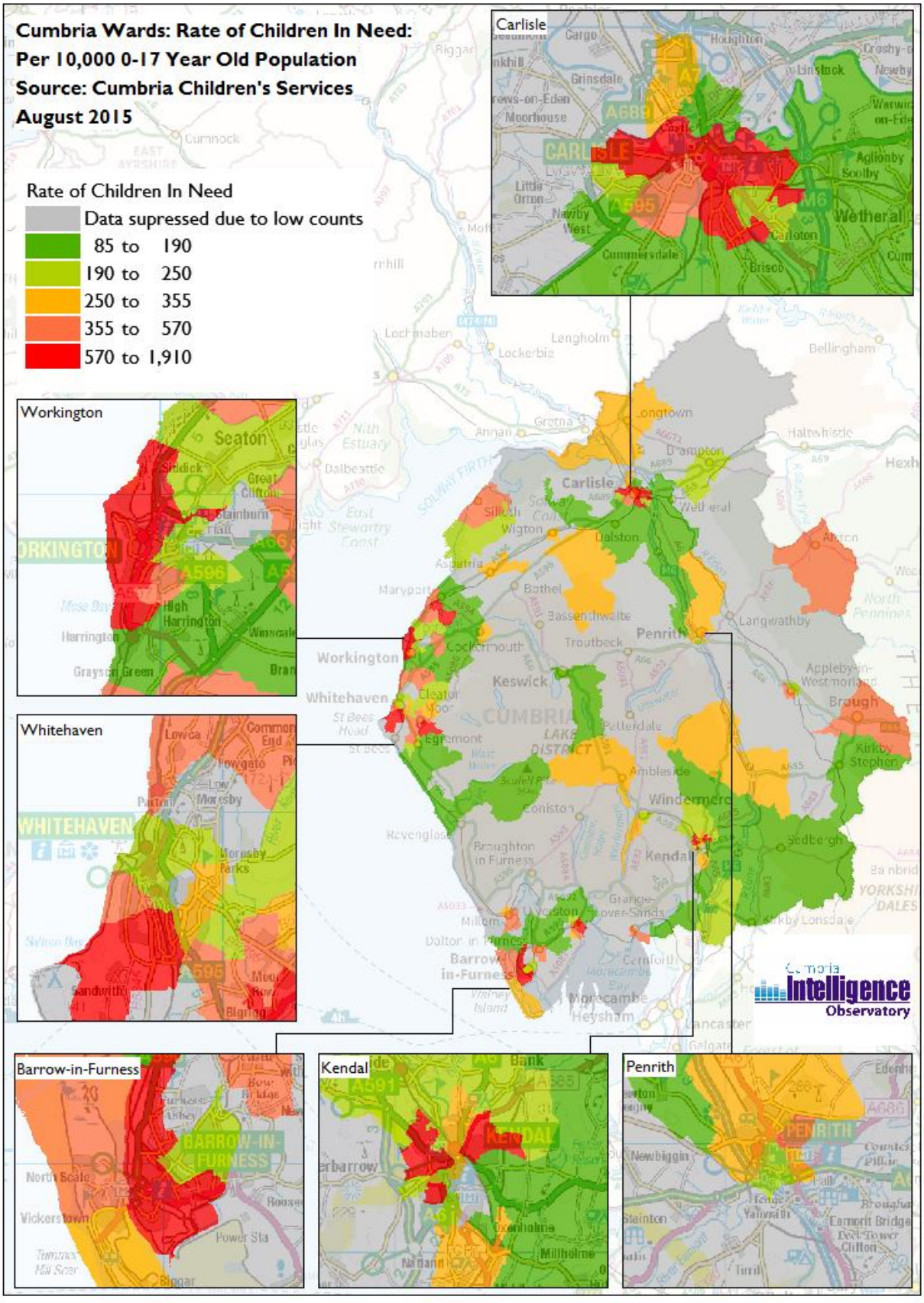
9.2 Children in Need and Children Subject to a Child Protection Plan

Introduction: When a child is referred to children's social care, an assessment is carried out to identify if the ***child is in need of services***, which local authorities have an obligation to provide (i.e. family support or disabled children's services). When a child is assessed, the practitioner determines the child's primary category of need. The list of primary needs is hierarchical, so in cases where multiple needs are identified, the need highest in the list is reported.

If the local authority identifies there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, it will carry out an assessment under section 47 of the Children Act 1989 to determine if it needs to take steps to safeguard and promote the welfare of the child. If concerns are substantiated and the child is judged to be at continuing risk of harm then an initial child protection conference should be convened. At the initial child protection conference, the decision will be made as to whether the child needs to become the ***subject of a child protection plan***. When a child becomes the subject of a plan, the initial category of abuse is recorded.

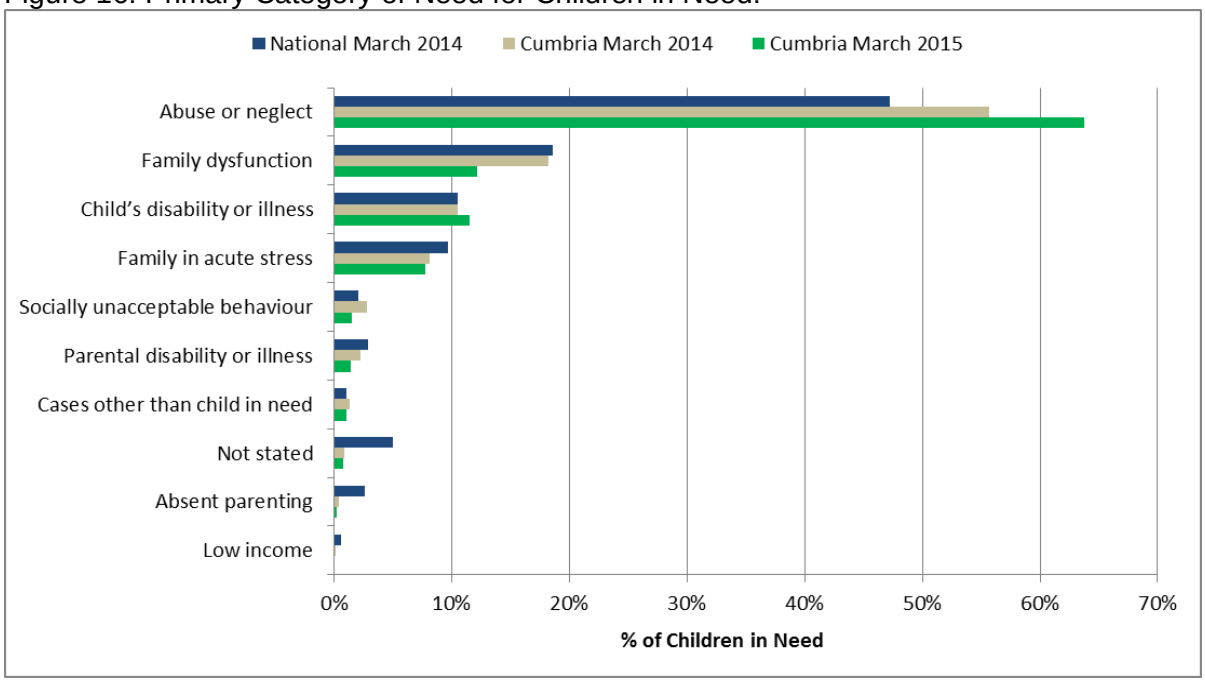
What Data Tells Us: The March 2015 Children in Need (CiN) census, collected by the DfE, reported that there were 3,421 children in need in Cumbria; this equated to a rate of 363.9 children in need per 10,000 population aged 0 – 17 years. Rates of children in need varied across the county's localities, with Allerdale & Copeland and Barrow & South Lakeland having higher rates than Carlisle & Eden (376.4 and 379.5 compared to 334.8 per 10,000 respectively). The latest data from Cumbria's Children's Services (August 2015) identifies a number of wards within the county as having particularly high rates of children in need, with rates in the following wards being three or more times the county average: Barrow Island (Barrow-in-Furness); Kendal Far Cross (South Lakeland); Central (Barrow-in-Furness); Hindpool (Barrow-in-Furness); and Sandwith (Copeland). Figure 15 plots rates of children in need across Cumbria's wards.

Figure 15:



At the time of writing national data is not yet available for the March 2015 CiN Census, but data from the March 2014 CiN Census suggested that Cumbria had a higher rate of children in need than the national average (413.9 compared to 346.4 per 10,000). However, Cumbria's rate of children in need did fall between March 2014 and March 2015 (from 413.9 to 363.9 per 10,000). Figure 16 plots the primary category of need for children in need.

Figure 16: Primary Category of Need for Children in Need:



Source: CiN Census, DfE.

The greatest proportion of Cumbria's children in need cases in 2015 recorded abuse or neglect as the child's primary need (64%). The profile of primary need across Cumbria's localities was very similar to the county profile, although Allerdale & Copeland had a higher proportion of cases recording abuse or neglect as the child's primary need (72%). In 2014 abuse or neglect also accounted for the greatest proportion of children in need cases both at county and national level, however, Cumbria had a greater proportion of cases with this primary category of need; 56% compared to a national figure of 47%. It should also be noted that the proportion of Cumbria's children in need cases recording abuse or neglect as the child's primary need increased between 2014 and 2015; rising from 56% to 64%.

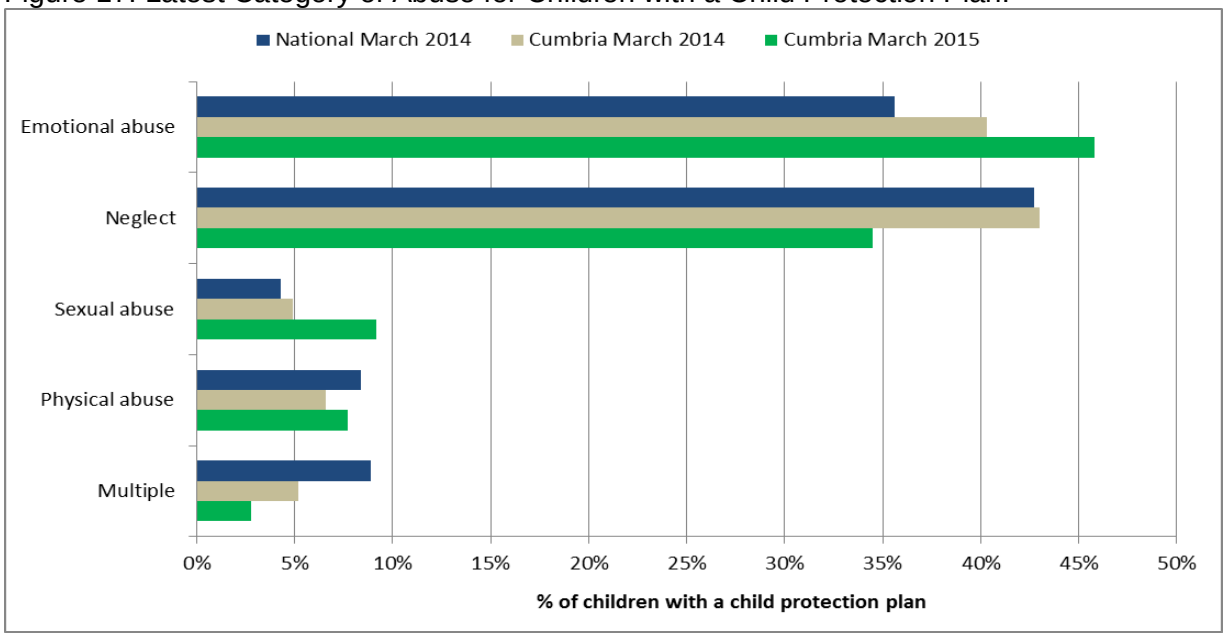
At March 2015 the CiN census reported that there were 174 children in need assessments where drug misuse was a factor, 136 assessments where alcohol misuse was a factor, and 254 assessments where the mental health of the child was a factor.

Analysis carried out by CCC's Information & Intelligence team in August 2015 found that 30% of all 0-19 year olds in Cumbria live in areas (LSOAs) that fall into the 30% most deprived of all areas nationally, however, 57% of Cumbrian children in need cases originate from these deprived areas. Inversely, 21% of all 0-19 year olds in Cumbria live in areas (LSOAs) that fall into the 30% least deprived of all areas nationally, however, just 8% of Cumbrian children in need cases originate from these affluent areas.

Furthermore, the above analysis found that 33% of all 0-19 year olds in Cumbria live in the 30% of areas (LSOAs) with the highest levels of child poverty in the county, however, 60% of Cumbrian children in need cases originate from these areas. Inversely, 28% of all 0-19 year olds in Cumbria live in the 30% of areas (LSOAs) with the lowest levels of child poverty in the county, however, just 9% of Cumbrian children in need cases originate from these areas.

The March 2015 CiN, reported that there were 325 children with a child protection plan in Cumbria; this equated to a rate of 34.6 children with a child protection plan per 10,000 population aged 0 – 17 years. Rates of children with a child protection plan varied across the county's localities, with Allerdale & Copeland having higher rates than Barrow & South Lakeland and Carlisle & Eden (43.1 compared to 32.2 and 28.2 per 10,000 respectively). The March 2014 CiN Census suggested that Cumbria had a higher rate of children with a child protection plan than the national average (63.3 compared to 42.1 per 10,000). However, Cumbria's rate fell between March 2014 and March 2015 (from 63.3 to 34.6 per 10,000). Figure 17 plots the latest category of abuse for children with a child protection plan.

Figure 17: Latest Category of Abuse for Children with a Child Protection Plan:



Source: CiN Census, DfE.

The greatest proportion of children with a child protection plan in Cumbria at March 2015 had emotional abuse recorded as the latest category of abuse (46%); this was followed by neglect (35%). The profile of Cumbria's localities in relation to the latest category of abuse for children with a child protection plan generally followed the county profile, although Allerdale & Copeland had a higher proportion of cases recording emotional abuse as the latest category of abuse (55%), while neglect accounted for the greatest proportion of cases in Carlisle & Eden (40%), closely followed by emotional abuse (38%).

In 2014 neglect accounted for the greatest proportion of child protection plan cases both at county and national level (both 43%). However, the proportion of Cumbria's child protection plan cases recording emotional abuse as the latest category of abuse increased between 2014 and 2015; rising from 40% to 46%, while, inversely, the proportion of Cumbria's child protection plan cases recording neglect as the latest category of abuse decreased between 2014 and 2015; falling from 43% to 35%.

Analysis carried out by CCC's Information & Intelligence team in August 2015 found that 30% of all 0-19 year olds in Cumbria live in areas (LSOAs) that fall into the 30% most deprived of all areas nationally, however, 57% of Cumbrian child protection plan cases originate from these deprived areas. Inversely, 21% of all 0-19 year olds in Cumbria live in areas (LSOAs) that fall into the 30% least deprived of all areas nationally, however, just 7% of Cumbrian child protection plan cases originate from these affluent areas.

Furthermore, the above analysis found that 33% of all 0-19 year olds in Cumbria live in the 30% of areas (LSOAs) with the highest levels of child poverty in the county, however, 63% of Cumbrian child protection plan cases originate from these areas. Inversely, 28% of all 0-19 year olds in Cumbria live in the 30% of areas (LSOAs) with the lowest levels of child poverty in the county, however, just 6% of Cumbrian child protection plan cases originate from these areas.

Evidence of What Works: The Working Together report (2013) states that *"Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years"*. Early Help is the response made when a professional identifies needs with a child/family and seeks advice from another agency in order to meet those needs. E.g. a midwife recognising that a young parent is experiencing relationship and housing problems and appearing socially isolated.

9.3 Children Looked After

Introduction: The term 'looked-after children' was introduced in the Children Act 1989 and describes children and young people placed into the care of local authorities by order of a court. Children often enter the care system with a poorer level of physical and mental health than their peers, and their longer-term outcomes remain worse. The importance of the health of children and young people in care cannot be overstated.

Many children in care are likely to have had their health needs neglected and unlike their peers have not been given the best start in life. Children who are looked-after are more likely to have experienced deprivation and poverty as a result of low family income or parental unemployment. A high proportion of children looked after experience poor health outcomes after leaving care.

Who is at Risk & Why: Every Child Matters (2005) identified that children and young people who are looked after are four times more likely to misuse substances. Additionally, Meltzer, H. et al, (2003) found that among children aged 5 to 17 years who are looked after by local authorities, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such as anxiety or depression, and 7% were hyperkinetic. Variation was shown depending on the type of placement with two-thirds of children living in residential care found to have a mental health disorder compared with four in ten of those placed with foster-carers or their birth parents. Furthermore, the Outcomes for Children Looked After 2014 SFR from the DfE also reports that just half of children looked after have emotional and behavioural health that is considered normal, when compared to all children, children looked are more likely have lower levels of educational attainment, SENs and receive exclusions from school.

What Data Tells Us: The Children Looked After by Local Authorities annual return (SSDA903), collected by the DfE, reported that in Cumbria at March 2015 there were 681 children and young people looked after; this equates to a rate of 72.4 per 10,000 0-17 year olds. Allerdale & Copeland has a higher rate of children looked after than Barrow & South Lakeland and Carlisle & Eden; 86.2 compared to 65.9 and 64.9 per 10,000 respectively. While national figures are not yet available in relation to children looked after for the most recent year, the SSDA903 for March 2014 suggests that Cumbria has a higher rate of children looked after than the national average; 71 compared to 60 per 10,000.

As well as providing information about the profile of children looked after and their placements, the SSDA903 return provides information about health outcomes. 94.4% of Cumbrian children looked after were up to date with immunisations for the year ending March 2015. The proportions of children looked after with up to date immunisations were close to the county average across Cumbria's localities. The proportion of Cumbrian children looked after with up to date immunisations has improved over the last year; rising from 86.9% in the year ending March 2014; which was similar to the national average of 87.1%.

80.7% of Cumbrian children looked after were up to date with dental checks for the year ending March 2015. Barrow & South Lakeland had a much higher proportion of children looked after with up to date dental checks than Allerdale & Copeland and Carlisle & Eden; 90.7% compared to 75.8% and 76.2% respectively. The proportion of Cumbrian children looked after with up to date dental checks has improved over the last year; rising from 78.9% in the year ending March 2014; which was lower than the national average of 84.4%.

In Cumbria 89.2% of children looked after had an up to date health assessment for the year ending March 2015. Barrow & South Lakeland had a much higher proportion of children looked after with an up to date health assessment than Allerdale & Copeland and Carlisle & Eden; 98.1% compared to 84% and 86.4% respectively. The proportion of Cumbrian children looked after with an up to date health assessment has improved over the last year; rising from 77.8% in the year ending March 2014; which was lower than the national average of 88.4%.

25 (5%) children and young people in Cumbria who are looked after had an identified substance misuse problem in the year ending March 2015; this was slightly higher than the proportion for the previous year (3.8%). Of Cumbria's localities, Barrow & South Lakeland had the greatest proportion of children and young people who are looked after with an identified substance misuse problem (8.7%). While national figures are not yet available in relation to the health of children looked after for the most recent year, the county's proportion of children looked after with an identified substance misuse problem in the year ending 2014 was similar to the national average (3.5%).

6.1% of children and young people in Cumbria who are looked after and aged 10 and over received a caution, conviction or final warning in the year ending March 2015; this was higher than the proportion for the previous year (3.4%). Of Cumbria's localities, Barrow & South Lakeland and Allerdale & Copeland had greater proportions of children and young people who are looked after receiving a caution, conviction or final warning than Carlisle & Eden (9.7%, 6.5% and 1.3% respectively). While national figures are not yet available for the most recent year, the county's proportion of children looked after receiving a caution, conviction or final warning in the year ending 2014 was lower than the national average (5.6%). Additionally, 24 children looked after by CCC were reported as missing or absent from their placement during the year ending March 2015.

A higher score on the Strength and Difficulties Questionnaire (SDQ) indicates more emotional difficulties, with a score of 0 to 13 being considered normal, a score of 14 to 16 considered borderline cause for concern, and 17 or more a cause for concern. In the year ending March 2015, the average SDQ score for children looked after by CCC was 13.8; this was slightly lower than the average score for the previous year (14.4). Of Cumbria's localities, Allerdale & Copeland and Carlisle & Eden had higher average SDQ scores than Barrow & South Lakeland (14.3, 14 and 13.1 respectively. While national figures are not yet available for the most recent year, the county's average SDQ score in the year ending 2014 was higher than the national average (13.9). 47% of children in Cumbria who are looked after had an SDQ score that was considered normal, while 15% had a score that was borderline cause for concern and 38% had a score that was cause for concern; these proportions were similar to the national average (50%, 13% and 37% respectively).

Analysis carried out by CCC's Information & Intelligence team in August 2015 found that 30% of all 0-19 year olds in Cumbria live in areas (LSOAs) that fall into the 30% most deprived of all areas nationally, however, 64% of Cumbrian children looked after originate from these deprived areas. Inversely, 21% of all 0-19 year olds in Cumbria live in areas (LSOAs) that fall into the 30% least deprived of all areas nationally, however, just 4% of Cumbrian children looked after originate from these affluent areas.

Furthermore, the above analysis found that 33% of all 0-19 year olds in Cumbria live in the 30% of areas (LSOAs) with the highest levels of child poverty in the county, however, 67% of Cumbrian children looked after originate from these areas. Inversely, 28% of all 0-19 year olds in Cumbria live in the 30% of areas (LSOAs) with the lowest levels of child poverty in the county, however, just 5% of Cumbrian children looked after originate from these areas.

The Outcomes for Children Looked After 2014 SFR (DfE) reported that figures regarding the proportion of Key Stage 4 children looked after by CCC achieving 5+ GCSEs at grades A*-C including English & mathematics in 2014 were not available for Cumbria due to small numbers. However, 15.7% of Key Stage 4 children looked after by CCC achieved 5+ GCSEs at grades A*-C; this was similar to the national average for children looked after (16.3%) but much lower than the county and national averages for all children (Cumbria 65.2%, England 63.2%).

In 2014 3.3% of school sessions were missed by children looked after by CCC; this was better than the national average for children looked after (3.9%) and better than the county and national average for all children (4.5%). However, in the 2012/13 academic year 9.4% of children looked after by CCC had at least one fixed exclusion; while this was similar to the national average for children looked after (9.8%), it was around five times higher than the local and national rates for all children (Cumbria 2%, England 1.9%).

64.5% of children in Cumbria who are looked after had an SEN in the year ending March 2014; this was similar to the national average (66.6%), but higher than the local and national rates for all children (Cumbria 16.9%, England 17.9%). Furthermore, 30.7% of children in Cumbria who are looked after had a Statement of SEN in the year ending March 2014; again, this was similar to the national average (29%), but higher than the local and national rates for all children (Cumbria 2.9%, England 2.8%).

49.6% of care leavers in Cumbria were NEET in the year ending March 2015; this was slightly lower than the proportion for the previous year (61%). Of Cumbria's localities, Allerdale & Copeland and Barrow & South Lakeland had higher proportions of care leavers who were NEET than Carlisle & Eden (52.5%, 52.9% and 44% respectively). While national figures are not yet available for the most recent year, the county's proportion of care leavers who were NEET in the year ending 2014 was higher than the national average (55%). The DfE reported that in 2014 the proportion of NEET young people in Cumbria was 4.3% compared to a national average of 4.7%, while these figures do not refer to exactly the same time scales, they do suggest a much higher proportion of care leavers are NEET both locally and nationally.

Evidence of What Works: Statutory guidance from DfE/DoH (2015) and NICE Guidance on Looked After children and Young People (2010) make a number of recommendations to promote the health and well-being of children looked-after.

9.4 Children with Special Educational Needs or Disability (SEND)

Introduction: The Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD), (2013) found that men with learning disabilities died on average 13 years younger than men in the general population and women 20 years younger. CIPOLD data also showed that people with learning disabilities are three times as likely as people in the general population to have a death classified as potentially avoidable through the provision of good quality healthcare.

Pupils with SEND are currently categorised as follows:

- **SEN Support:** Extra or different help is given from that provided as part of the school's usual curriculum. The class teacher and SEN Coordinator (SENCO) may receive advice or support from outside specialists. This category replaces the former 'School Action' and 'School Action Plus' categories.
- **Statement/ Education, Health and Care (EHC) plan:** From September 2014, any children or young people who are newly referred to a local authority for assessment are considered under the new EHC plan assessment process. The legal test of when a child or young person requires an EHC plan remains the same as that for a statement under the Education Act 1996. A pupil has a statement of SEN or an EHC plan when a formal assessment has been made. A document is in place that sets out the child's needs and the extra help they should receive. Transferring children with statements to EHC plans will be phased.

Who is at Risk & Why: The SEN 2015 SFR from the DfE reports that: SEN is more prevalent in boys; older age groups are more likely to have statement of SEN/ EHC plan; likelihood of having SEN support peaks around age 9 and 10; pupils with SEN are much more likely to be eligible for FSM. The Pupil Absence 2013/14 SFR from the DfE reports that pupil absence rates are higher amongst pupils with a statement of SEN, while the Permanent and Fixed Period Exclusions 2013/14 SFR from the DfE reported that SEN pupils have the highest rate of permanent exclusion. Furthermore, the Outcomes for Children Looked After 2014 SFR from the DfE also reports that, 67% of children looked after have a SEN and 29% of children looked after have a statement of SEN, these figures are much higher than those for the total population; 18% of all children have a SEN and 3% have a statement of SEN.

What Data Tells Us: The SENs 2015 SFR from the DfE reported that 11,203 pupils in Cumbria have SENs (15.6%), with 2,141 pupils having a Statement/ EHC plan (3%); similar to the national averages (15.4% and 2.8% respectively). The January 2015 School Census reported that, of Cumbria's districts, Barrow in Furness and Carlisle had higher proportions of pupils with SEN than the county average (16.3% and 17.7% respectively), while Barrow in Furness, Copeland and South Lakeland had higher proportions of pupils with a Statement/ EHC plan than the county average (3.6%, 3.3%, and 3.3% respectively).

The SENs 2015 SFR from the DfE reported that, for those pupils with a type of need provided, the greatest proportion of pupils with a SEN in Cumbria had 'Specific Learning Difficulties' recorded as their primary type of need (18.5%), followed by 'Speech, Language and Communications Needs' (16.7%) and 'Moderate Learning Difficulties' (16.1%). Nationally, 'Moderate Learning Difficulties', 'Speech, Language and Communications Needs' and 'Social, Emotional and Mental Health' account for the greatest proportions of primary needs reported for pupils with SENs (23.8%%, 18.8% and 16.7% respectively). When compared to the national average, Cumbria has higher proportions of pupils with SENs with their primary needs recorded as Specific Learning Difficulties, Severe Learning Difficulties, and Other Difficulty/Disabilities, while the county has lower proportions of pupils with SENs with their primary needs recorded as Moderate Learning Difficulties and Social, Emotional and Mental Health. Figure 18 presents the numbers and proportions of pupils with SENs by primary need for Cumbria and England.

Figure 18: SEN by Primary Need:

	No. Pupils with SEN*		% Pupils with SEN*	
Primary Type of Need	England	Cumbria	England	Cumbria
Specific Learning Difficulty	135,505	1,353	13.4%	18.5%
Moderate Learning Difficulty	241,125	1,177	23.8%	16.1%
Severe Learning Difficulty	32,090	527	3.2%	7.2%
Profound & Multiple Learning Difficulty	10,910	113	1.1%	1.5%
Social, Emotional and Mental Health	169,110	891	16.7%	12.2%
Speech, Language and Communications Needs	190,475	1,220	18.8%	16.7%
Hearing Impairment	19,350	128	1.9%	1.8%
Visual Impairment	10,840	65	1.1%	0.9%
Multi-Sensory Impairment	1,845	13	0.2%	0.2%
Physical Disability	30,790	216	3.0%	3.0%
Autistic Spectrum Disorder	90,775	607	9.0%	8.3%
Other Difficulty/Disability	50,210	680	5.0%	9.3%
SEN support but no assessment of type of need	28,495	318	2.8%	4.3%

Source: SENs 2015 SFR from the DfE. *Note table only includes figures for pupils with a type of need provided.

Evidence of What Works: The SEND code of practice: 0 to 25 provides improved guidance to help schools and others more accurately identify children with SEN. Guides are available to support education settings to understand their statutory duties and responsibilities under the reforms in the Children and Families Act 2014 in relation to children in their care who have or may have SEND. Guides are also available for children, young people, their families and carers.

9.5 Gypsy and Irish Travellers

Introduction: Gypsy and Irish Travellers are recognised under the Equality Act 2010. Friends, Families and Travellers' (FFT) reported in 2015 that a range of evidence shows that Gypsies and Travellers are more likely to develop certain conditions, less likely to access certain services and more likely to have a poorer experience of health services due to direct or indirect discrimination.

Who is at Risk & Why: 2011 Census analysis found that in England & Wales, of any ethnic group, Gypsy or Irish Travellers had: the lowest proportion of people rating their general health as 'good' or 'very good'; the highest proportions of people providing unpaid care; and the highest proportion of people with no qualifications. Additionally FFT (2015) report that Gypsies and Travellers are more likely to: be affected by a long-term condition; have higher levels of stress, anxiety and depression; have higher numbers of smokers; and have higher rates of stillbirth, infant mortality and maternal death.

Annual data collected by the DfE reports that when compared to the national average, lower proportions of Gypsy/Roma pupils and Travellers of Irish heritage reach a good level of development by the age of five or achieve at least 5 A*- C GCSEs (or equivalent) grades including English and Mathematics. Furthermore, pupil absence and exclusion rates are higher amongst Gypsy/Roma pupils and Travellers of Irish heritage. Evidence has also shown that traveller children and young people are at risk of not being fully immunised (Source: DH 2005; Hill et al. 2003; Peckham et al. 1989; Samad et al. 2006).

What Does Local Data Tell Us: The 2011 Census reported that 315 Cumbrian residents (0.1%) identified their ethnic group as Gypsy or Irish Traveller; the same as the national average (0.1%). Of the above 315 Cumbrian Gypsy or Irish Traveller residents, 81 were aged 0-19 years; this equates to 0.1% of the county's 0-19 population; lower than the national proportion (0.2%). In line with national trends, self-reported general health was worse amongst Gypsy and Irish Traveller residents in Cumbria than for other ethnic groups.

Of Cumbria's districts, Carlisle had the greatest number of Gypsy or Irish Traveller residents (196 persons, 0.2% of the district's total population), followed by Barrow-in-Furness (39 persons, 0.1%) and South Lakeland (36 persons, less than 0.1%). The county's remaining districts had less than 15 Gypsy or Irish Traveller residents each. Of Carlisle's 196 Gypsy or Irish Traveller residents, 58 were aged 0-19 years (0.2% of the 0-19 population). All other districts in the county had less than 10 Gypsy or Irish Traveller residents aged 0-19 years.

Across Cumbria's wards, Carlisle's Castle ward had the greatest number of Gypsy or Irish Traveller residents (20 persons), while Lyne ward in Carlisle had the greatest proportion (0.5% of the population).

It is important to note that 2011 Census data only includes respondents who chose to identify with the Gypsy or Irish Traveller ethnic group. However, FFT report that community estimates suggest that 2011 Census data may have undercounted by a ratio of 1:5 due to unwillingness to ascribe due to fear of discrimination and barriers to completing the census such as low literacy levels and enforced mobility.

The January 2015 School Census reported that 94 statutory school aged pupils in Cumbria (0.2%) were from Traveller of Irish Heritage or Gypsy/ Roma ethnic groups. This was lower than the national average (0.4%).

The DCLG biannual count of Gypsy and Traveller caravans on council sites, private sites, caravans on Gypsies' own land (with or without planning permission) and unauthorised sites (tolerated or not tolerated), reported that in January 2015 there were 201 traveller caravans across Cumbria. Carlisle had the greatest number amongst the county's districts (149 caravans), followed by Eden (22 caravans), and Barrow-in-Furness (21 caravans); the remaining districts had less than 10 caravans each. As this dataset counts caravans it can only be used to estimate the Gypsy Traveller population living in caravans.

In 2009 NHS Cumbria carried out a Health Needs Assessment of Gypsy Travellers in Cumbria which confirmed evidence that this group have significantly poorer health status and more self-reported symptoms of ill-health than both other UK resident English-speaking ethnic minority groups and economically disadvantaged white UK residents. The assessment's findings also included that in Cumbria:

- Prevalence of mental health and wellbeing problems within the Travelling community appears to be considerably higher than the overall population of England;
- A wide disparity between immunisation uptake in the settled wider population and the Travelling population, with particular resistance to the MMR vaccination in Travellers;
- As an ethnic group, Irish Travellers experienced the greatest health problems and were the least likely to be registered with a GP or use healthcare services;
- Barriers to healthcare access were experienced, including: reluctance of some GP surgeries to register Travellers with no permanent address or postcode; practical problems of access whilst travelling; complex and variable appointment systems; mismatch of expectations between Travellers and healthcare staff; interruption of treatment as a consequence of travelling or being moved on/evicted;
- Travellers expressed specific concerns about their health as an ethnic group, particularly in relation to high levels of anxiety and stress, smoking, alcohol and drug use.

The above assessment also included a number of other findings, for more information please refer to: http://www.cumbriaobservatory.org.uk/health/Reports.asp

Evidence of What Works: Cumbria's 2009 Health Needs Assessment of Gypsy Travellers made a series of recommendations specific to Cumbria to improve health outcomes including: Identifying appropriate health workers with dedicated time to work with local Travellers; Health Trainers on each authorised site in Cumbria; Introducing care pathways for Travellers; Immunisation programmes; Implementing mandatory cultural awareness training for all Primary Care Trust (PCT) staff that may interact or have contact with Travellers or other vulnerable groups; Ethnic monitoring; Developing patient-held records for adult Travellers; and supporting the development of a county/regional network of good practice in primary care.

The NHS Primary Care Service Framework: Gypsy and Traveller Communities (2009) also provided advice to assist PCTs to ensure that Gypsy and Traveller communities can access the same high quality, mainstream primary care services as everyone else.

Furthermore, 'Improving access to health care for Gypsies and Travellers, homeless people and sex workers: An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards' (Paramjit G et al (2013) Royal College of General Practitioners Clinical Innovation & Research Centre) also made recommendations including: Adopting a holistic approach as this vulnerable group will not be experiencing their needs in isolation e.g. mental health, substance misuse and general health issues often occur simultaneously; Access to the primary care as the system gatekeeper is crucial; The role of the 'trusted individual' is invaluable to enable 'bridge-building and navigating work carried out by health and voluntary sector organisations working with excluded, high-need clients; Outreach work is often the first and most important step in re-connecting the user with the system.

'Inclusion of Gypsy Traveller Health Needs in Joint Strategic Needs Assessments: A Review' (FFT 2015) also suggests that health inequalities in Gypsies and Travellers arise due to a range of factors including: barriers to accessing health services; poor accommodation; discrimination; poor health literacy; and lack of cultural awareness and understanding by health professionals. FFT recommend that a flexible and supportive approach must be taken to ensure that children are supported through their education.

9.6 Young carers

Introduction: A young carer is someone aged 5-18 years old who lives with and helps to care for a family member who has physical or mental health problems, learning difficulties, and drug or alcohol problems or for some other reason. The 2011 national census found that the number of young carers in England had risen substantially since 2001. Young carers may remain hidden due to the fear of being identified, not realising they are a young carer or through professionals not acknowledging their role and therefore failing to identify and support them.

Who is at Risk & Why: Research shows that young carers often fare less well than their peers in education, may be subject to bullying, suffer isolation and are more likely to experience poverty.

What Does Local Data Tell Us: The 2011 Census asked: "Do you look after, or give any help or support to family members, friends, neighbours or others because of either: a long-term physical or mental ill-health / disability or problems related to old age"? In Cumbria 1,123 residents aged under 15 years were reported to provide unpaid care in response to this question (1.3%), with 90 providing 50 or more hours unpaid care a week (0.1%). Cumbria had a slightly higher proportion of 0-15 year olds providing unpaid care than the national average (1.1%). Of Cumbria's districts, Eden had the greatest proportion of 0-15 year olds providing unpaid care (1.7%).

At March 2015, 1,060 young carers were known to CCC; this equates to 1.4% of the county's 5-18 year olds. Again, Eden had the highest rate of known young carers (2.4%). Analysis using the ACORN socio-economic profiling tool, developed by the company CACI, suggests that 68% of known young carers in Cumbria live in postcodes classified as belonging to the two most deprived socio-economic categories; this is much higher than the proportion of Cumbria's total population living in postcodes assigned to these socio-economic categories (42%).

Evidence of What Works: The views of young carers formed the development of a pathway as part of a national review of school nursing. Cumbria Children's Service Virtual School have published a Memorandum of Understanding between Children's and Health Care Services which provides a clear direction to services that they should adapt a "whole family" approach in order to support young carers and their families. The guidance reflects current national policy and is intended to promote working together between Children's Services, Health and Care Services and offers an enhanced basis for working in partnership with Health, Education and Third Sector parties. For more information see:

http://www.cumbria.gov.uk/childrensservices/schoolsandlearning/ils/vselt/youngcarers.asp

9.7 Domestic Violence

Introduction: Domestic violence is officially classified as "any incident of threatening behaviour, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality". Children who witness domestic violence may have a number of emotional, physical and behavioural responses. The children may exhibit signs of anxiety and have a short attention span which may result in poor school performance and attendance. They may experience developmental delays in speech, motor or cognitive skills. They may also use violence to express themselves or become self-injuring.

The Crime Survey for England & Wales reports that 30% of the adult female population have experienced some form of domestic abuse. HM Inspectorate of Constabulary state that: three women a fortnight are killed by a partner or former partner and a third of all assaults recorded by the police relate to domestic violence; one in four young people aged 10 to 24 report that they experienced domestic violence and abuse during their childhood; and on average, the police receive an emergency call relating to domestic abuse every 30 seconds.

Who is at Risk and Why: Cumbria's 2013/14 Crime & Community Safety Assessment (CCSA) reports there is a relationship between numbers of domestic abuse incidents and areas with high levels of: deprivation; unemployment; households with low incomes; and child poverty. However, we must be mindful of hidden and unreported abuse in more affluent areas. There is also a correlation between alcohol related crimes and domestic abuse.

What Does Local Data Tell Us: The ONS report that in the 2013/14 year, there were the 16.6 incidents of domestic abuse recorded by the police in Cumbria per 1,000 population; slightly lower than the national average of 19.4 incidents per 1,000. However, Cumbria's rate of recorded domestic abuse incidents has increased from the previous year (15.7 incidents per 1,000 in 2012/13); England's rate also increased (18.1 incidents per 1,000 in 2012/13).

Cumbria's CCSA reported that in 2013/14 there were 6,932 domestic violence incidents in Cumbria and 424 sexual offences; +5.9% and +22% respectively from 2012/13. Numbers of sexual offences almost doubled in Copeland and Barrow. The rate of domestic violence and sexual offences was greatest in Barrow. The rate of repeat incidents increased in Copeland.

Cumbria's CCSA also reported that in 2013/14, 510 cases were opened for those accessing Cumbria's Independent Domestic Violence Advisory services ("Let Go"). Of those accessing the service: 96% were female; 37% were aged 21 – 30 years; 65% had children; 46% were classed as 'high risk'; 65% experienced physical abuse; 73% experienced jealous and controlling behaviour; 17% experienced sexual abuse; 60% experienced harassment and stalking; 5% were misusing drugs; 13% were misusing alcohol; and 31% had mental health issues.

Evidence of What Works: Reducing domestic abuse, reducing the rate of repeat incidents, supporting services to increase the numbers of reports and ultimately increasing convictions for domestic abuse is a priority for Cumbria Constabulary. Over a 3 year period numbers of domestic violence incidents and sexual offences have increased in the county which may be a reflection of the investment of specialist support services as the aim of the Constabulary is to increase the number of first time reports. However, consideration still must be taken to other possible contributing factors such as financial pressures, lack of social and economic opportunities, mental health issues and drugs and alcohol misuse.

Behind Closed Doors Report (UNICEF, 2006) suggests that children can be better protected from the effects of domestic violence by them having a safe and secure home environment; knowing that there are adults who will listen to them, believe them and shelter them; sense of routine and normalcy; having support services meet their needs; having adults to speak out and break the silence and learning that domestic violence is wrong and learn non-violent methods of resolving conflicts.

9.8 Parental Drug & Alcohol Misuse

Introduction: Children in households where drugs and alcohol misuse are a problem are extremely vulnerable and are at risk of neglect and abuse. They are at risk of not achieving their full potential in life through poor educational attainment and emotional and mental health issues (source: Advisory Council on the Misuse of Drugs (2007) Hidden Harm).

Who is at Risk and why: For information about groups at risk of misusing drugs and alcohol, please see the Healthy Living and Lifestyles Chapter of Cumbria's JSNA.

What Does Local Data Tell Us: PHE reported that in 2011/12, 92 parents in Cumbria were attending treatment for substance misuse; this equates to a rate of 110.4 per 100,000 children aged 0-15, which was the same as the national average. In Cumbria throughout 2014/15 there were 3,118 service users in contact with Unity (the provider of drug and alcohol services). Of these service users: 57.7% users used the service for drugs related issues (42.3% for alcohol related issues); most were male (65.7%) and were aged 35-39 years (18.3%); 21% had a child (or children) living with them; and 33.4% had children which live with either a partner or family member.

Evidence of What Works: Please see the Healthy Living and Lifestyles Chapter of Cumbria's JSNA.

9.9 Children Missing from Home

Introduction: Safeguarding and promoting the welfare of children is a key duty on local authorities and requires effective joint working between agencies and professionals. When a child goes missing or runs away they are at risk. Safeguarding children therefore includes protecting them from this risk. There are no exact figures for the number of children who go missing or run away, but national estimates suggest that a figure around 100,000 per year.

Who is at Risk and Why: Children may run away from a problem, such as abuse or neglect at home, or to somewhere they want to be. They may be coerced to run away by someone else. Whatever the reason it is thought that approximately 25% of children and young people that go missing are at risk of serious harm. There are particular concerns about the links between children running away and the risks of sexual exploitation. Missing children may also be vulnerable to other forms of exploitation, to violent crime, gang exploitation or to drug and alcohol misuse. Children looked after missing from their placements are particularly vulnerable as are children in residential care.

What Does Local Data Tell Us: Cumbria Constabulary's Force Strategic Assessment reported that in 2013-14 there were 1,017 cases of people missing from home for more than 24 hours in the county. Under 18s made up 58% of these cases, with a relatively equal gender split (52% female, 48% male). The above assessment recognised that being missing from home is an indicator that a child may be the victim of physical and / or sexual abuse. The assessment also reported that in the west of the county more children go missing from family homes, whereas in the south of the county more children go missing from care homes. In general, children in care are three times more likely to go missing than children living at home. The children most likely to go missing are those placed in residential homes outside of their own local authority with the increased risk of emotional and physical abuse that running away can bring. Partners are currently working together to improve intelligence on what children do and where they go when they are missing.

Evidence of What Works: In 2014 the DfE published 'Statutory guidance on children who run away or go missing from home or care'. This document provides guidance for local authorities and their partners to stop children going missing and to protect those who do, including additional actions to protect looked after children.

9.10 Homelessness and Suitable Accommodation

Introduction: Quilgars et al (2011) estimated number of young people aged 16 to 24 sleeping rough in England in 2008/9 was 3200, giving a rate of 51.3 per 100,000.

Who is at Risk and Why: Two major studies of homeless adolescents in London (Craig, T. et al, 1996) and Edinburgh (Wrate, R. et al, 1999) found significant histories of residential care, family breakdown, poor educational attainment and instability of accommodation. These were associated with sexually risky behaviours, substance misuse and comorbid psychiatric disorders, particularly depression.

What Does Local Data Tell Us: DCLG reported that in 2013/14 Cumbria had a total of 63 applicant households with dependent children or pregnant woman accepted as unintentionally homeless and eligible for assistance; equivalent to a rate of 0.3 statutory homeless households with dependent children or pregnant women per 1,000 households, which was significantly better than the national average (1.7 per 1,000 households).

Cumbria Children's Services report that between July 2014 and August 2015, 147 contacts have been made through Cumbria's Safeguarding Hub for 16-17 year olds with a presenting issue of homelessness. However, figures have decreased over the year and it is suggested that this could be due to the role of the Homeless Case Officers.

The Homeless Case Officers have been operational since January 2015 and their purpose is to: work with and support young people aged 16-17 who are not already open to other statutory agencies; 'slow down' potential homelessness at point of presentation; prevent homelessness where safe to do so; and register Early Help Assessments where appropriate. The young people who are engaged with the Case Officers are unlikely to be the same young people who are referred through to the Hub. The data presented in figure 19 reflects the case load of the Homeless 16-17 year olds' Case Officers between January 2015 and August 2015.

Figure 19: Case load of the Homeless 16-17 year olds' Case Officers:

District	No. Cases
Allerdale	12
Barrow	27
Carlisle	6
Copeland	4
Eden	8
South Lakeland	19

Cumbria Children's Services, January 2015 to August 2015

SSDA903, collected by the DfE, reported that 91.5% of care leavers in Cumbria were in suitable accommodation in the year ending March 2015; this was higher than the proportion for the previous year (83.1%). Of Cumbria's localities, Carlisle & Eden had a much lower proportion of care leavers in suitable accommodation (86%). While national figures are not yet available in relation to the most recent year, the county's proportion of care leavers in suitable accommodation in the year ending 2014 was slightly higher than the national average (77.8%).

Evidence of What Works: Statutory guidance was issued on 1 April 2010 to local authorities jointly by the Secretary of State for Children, Schools and Families and the Secretary of State for Communities and Local Government. It provides revised guidance for children's services authorities and local housing authorities about their respective duties under Part 3 of the Children Act 1989 and Part 7 of the Housing Act 1996 to secure or provide accommodation for homeless 16 and 17 year old children.

9.11 Children at Risk of Sexual Exploitation

Introduction: The sexual exploitation of children and young people has been difficult to identify, but is becoming increasingly recognisable as practitioners gain more understanding of grooming and other methods of sexual exploitation. The prevalence of child sexual exploitation is unknown but it has been identified throughout the UK, in both rural and urban areas.

The UK National Working Group for Sexually Exploited Children and Young People defined the issue as: *Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.*

Child sexual exploitation is a hidden crime. Young people often trust their abuser and don't understand that they're being abused. They may depend on their abuser or be too scared to tell anyone what's happening. It can involve violent, humiliating and degrading sexual assaults.

Who is at Risk and Why: Sexual exploitation is often linked to other issues in the life of a child or young person, or in the wider community context. Sexual exploitation has links to other types of crime. This includes: child trafficking (into and out of and within the UK); domestic violence; sexual violence in intimate relationships; and grooming (both online and offline). It also has links to other factors likely to affect the welfare of children and young people including: running away from home and going missing; drug and alcohol misuse; sexual health and sexually risky behaviour; bullying; domestic servitude, neglect and violence; teenage pregnancy; long term sexual, physical psychological harm; forced marriage; self-harm and suicide; mental health issues; non-attendance at school and school phobia; learning disabilities; being in residential and foster care; forced isolation from community and family immigration status.

Sexual exploitation can have a serious impact on the life of children and young people. It can lead to difficulties in forming relationships with others, a lack of confidence or self-esteem and can affect their mental and physical health. Sexual exploitation can create feelings of worthlessness within children and young people, which can lead to acts of self-harm, including cutting themselves, overdosing and eating disorders. It can put the young person at increased risk of STIs including HIV, unwanted pregnancy and abortion, as well as long-term sexual and reproductive health problems. It can also ultimately impact on their parenting capacity in the future.

Where children or young people manage to recover to some extent from sexual exploitation they will sometimes feel unable to stay in their local area because of the associations it holds for them (or because of very real threat from networks around their abusers) leading to family break-ups and isolation from family and friends.

What Does Local Data Tell Us: Nationally and historically child sexual exploitation (CSE) has been a hidden problem, high profile investigations into current and historic cases are now significantly raising awareness of the problem. The understanding and knowledge of CSE in Cumbria is developing with the help of the Cumbria Safeguarding Hub. It is known nationally that CSE is under reported however improvements are being made locally to the reporting of CSE and action plans are in place. Cumbria Police and partners across the county are working together in order to understand the threat and allocate resources accordingly. Further work and legislation on internet usage relating to illegal images and sexual communication to a child is underway. Between September 2013 – August 2014 there were 9,644 vulnerable child reports of which 139 were relating to child sexual exploitation. Furthermore, in Cumbria at March 2015 the CiN census reported that 169 children in need assessments had child sexual exploitation recorded as a factor as part of their assessment. As previously mentioned reporting mechanisms are being developed in order to try and capture a more accurate picture.

Evidence of What Works: HM Government (2009) Safeguarding Children and Young People from Sexual Exploitation suggests the following preventative actions to reduce the risk of CSE: Awareness raising and preventative education; Targeted Prevention; Police Prevention Work; and Health Prevention Work.

In 2015 CCC's Children and Young People's Scrutiny Advisory Board carried out a review of CSE in Cumbria. The review found that overall CSE is being acknowledged and taken seriously. There was also an acknowledgement that CSE is a national challenge for public organisations, who are still in the early stages of understanding the extent of the issue and putting in place the right measures to tackle the problem.

The review found that the multi-agency CSE group which brings together police, county council, health and third sector organisations is making a difference in early identification and putting in place actions to disrupt the perpetrators, and where possible prosecute them.

The development of the Sexual Assault Referral Unit in Penrith was also identified as a positive development that would enable victims of rape and sexual violence to receive immediate specialist support within Cumbria.

10. Projections

Figure 20 presents the estimated and projected numbers of 0-19 year olds in 2012 and 2022 across England, Cumbria and districts. Two projection scenarios are provided. The ONS projection scenario is based on the 2012-Based ONS Sub-National Population Projections (SNPPs); which assume that future population growth will follow the trends observed in fertility, mortality and migration over the five years to 2012. The Experian Jobs scenario assumes that future population growth will follow the number of jobs projected by Experian for each district. For more information about these two scenarios, please see the Population Chapter of the JSNA.

Figure 20: Projected Population: 0-19 Year Olds: ONS Projection & Experian Jobs Projection:

	ONS	ONS	Experian	ONS	Experian	ONS	Experian
	Estimated Population	Projected Population		Numerical Change		Proportional Change	
	2012	2022		2012-2022		2012-2022	
England	12,771,200	13,571,600	n/a	800,400	n/a	6.3	n/a
Cumbria	105,900	100,600	110,900	-5,300	5,000	-5.0	4.7
Allerdale	20,600	19,900	21,900	-700	1,300	-3.4	6.3
Barrow-in-Furness	15,600	14,400	16,900	-1,200	1,300	-7.7	8.3
Carlisle	23,800	23,500	26,300	-300	2,500	-1.3	10.5
Copeland	15,200	13,800	13,300	-1,400	-1,900	-9.2	-12.5
Eden	10,600	10,000	10,800	-600	200	-5.7	1.9
South Lakeland	20,100	19,300	21,700	-800	1,600	-4.0	8.0

Source: ONS 2012-Based SNPPs & Cumbria Intelligence Observatory Popgroup 2013

By 2022 the ONS 2012-Based SNPPs project that numbers of 0-19 year olds in Cumbria will decrease by 5,300 persons (-5%); this is contrary to the projected national trend (England +6.3%). Numbers of 0-19 year olds are projected to decrease all of Cumbria's districts, with the greatest decrease projected for Copeland (-9.2%).

By 2022 the Experian Jobs Led Scenario projects that numbers of 0-19 year olds in Cumbria will increase by 5,000 persons (+4.7%). All districts except Copeland are projected to experience increases in numbers of 0-19 year olds, with the greatest increase projected for Carlisle (+10.5%). Contrary to the countywide trend, Copeland's 0-19 year old population is projected to decrease by 12.5%.

Figure 21 presents the estimated and projected numbers of 0-19 year olds in 2012 and 2022 for England, Cumbria and districts by five year age group.

Figure 21: Projected Population: 0-19 Year Olds: ONS Projection & Experian Jobs Projection:

		ONS	ONS	Experian	ONS	Experian	ONS	Experian
		Estimated Population	Projected Population		Numerical Change		Proportional Change	
	Age	2012	2022		2012-2022		2012-2022	
England	0-4	3,393,400	3,479,100	n/a	85,700	n/a	2.5	n/a
	5-9	3,083,600	3,483,200	n/a	399,600	n/a	13.0	n/a
	10-14	3,007,900	3,442,400	n/a	434,500	n/a	14.4	n/a
	15-19	3,286,300	3,166,900	n/a	-119,400	n/a	-3.6	n/a
Cumbria	0-4	25,300	23,800	28,300	-1,500	3,000	-5.9	11.9
	5-9	25,200	25,300	28,400	100	3,200	0.4	12.7
	10-14	26,200	26,700	27,900	500	1,700	1.9	6.5
	15-19	29,200	24,800	26,400	-4,400	-2,800	-15.1	-9.6
Allerdale	0-4	5,000	4,700	5,600	-300	600	-6.0	12.0
	5-9	4,700	5,100	5,800	400	1,100	8.5	23.4
	10-14	5,200	5,400	5,600	200	400	3.8	7.7
	15-19	5,700	4,700	4,800	-1,000	-900	-17.5	-15.8
Barrow-in-Furness	0-4	3,700	3,600	4,800	-100	1,100	-2.7	29.7
	5-9	3,700	3,600	4,200	-100	500	-2.7	13.5
	10-14	3,900	3,700	4,100	-200	200	-5.1	5.1
	15-19	4,300	3,500	3,800	-800	-500	-18.6	-11.6
Carlisle	0-4	6,200	5,700	6,700	-500	500	-8.1	8.1
	5-9	5,700	6,000	6,800	300	1,100	5.3	19.3
	10-14	5,400	6,100	6,600	700	1,200	13.0	22.2
	15-19	6,500	5,700	6,200	-800	-300	-12.3	-4.6
Copeland	0-4	3,700	3,400	3,300	-300	-400	-8.1	-10.8
	5-9	3,700	3,500	3,400	-200	-300	-5.4	-8.1
	10-14	3,700	3,600	3,400	-100	-300	-2.7	-8.1
	15-19	4,100	3,300	3,300	-800	-800	-19.5	-19.5
Eden	0-4	2,300	2,200	2,600	-100	300	-4.3	13.0
	5-9	2,600	2,500	2,700	-100	100	-3.8	3.8
	10-14	2,800	2,700	2,700	-100	-100	-3.6	-3.6
	15-19	2,900	2,600	2,800	-300	-100	-10.3	-3.4
South Lakeland	0-4	4,400	4,300	5,300	-100	900	-2.3	20.5
	5-9	4,800	4,700	5,500	-100	700	-2.1	14.6
	10-14	5,200	5,300	5,400	100	200	1.9	3.8
	15-19	5,700	5,000	5,500	-700	-200	-12.3	-3.5

Source: ONS 2012-Based SNPPs & Cumbria Intelligence Observatory Popgroup 2013

Projected changes in numbers of 0-19 year olds vary by five year age group for both projection scenarios. By 2022 the ONS 2012-Based SNPPs project that numbers of 0-4 year olds and 15-19 year olds in Cumbria will decrease (by -5.9% and 15.1% respectively), while numbers of 5-9 year olds will remain more or less the same and numbers of 10-14 year olds will increase slightly. Across Cumbria's districts numbers of children in all five year age groups are projected to decrease with a small number of exceptions; numbers of 5-9 year olds are projected to increase in Allerdale and Carlisle and numbers of 10-14 year olds are projected to increase in Allerdale, Carlisle and South Lakeland.

By 2022 the Experian Jobs Led Scenario projects that numbers of 0-4, 5-9 and 10-14 year olds in Cumbria will increase, while numbers of 15-19 year olds in the county will decrease.

Of Cumbria's districts, Allerdale, Barrow-in-Furness, Carlisle and South Lakeland follow the projected countywide trends. In Eden numbers of 0-4 and 5-9 year olds are projected to increase, while numbers of 10-14 and 15-19 year olds are projected to decrease. In Copeland numbers of children in all five year age groups are projected to decrease.

Projections for numbers of children and young people in Cumbria with specific needs and within vulnerable groups could be produced by applying current rates to the projected 0-19 population; both in relation to the ONS population led projections and the Popgroup Experian Jobs Led projections. However, the impact of factors such as welfare reform, changes to commissioning strategies and other policy decisions are likely to mean that current rates do not remain the same. Additional work is needed to understand potential future changes in rates of the above groups and apply these rates to Cumbria's 0-19 population projections to estimate potential future needs.

11. User views

In recent years a number of consultations have taken place with children and young people in the county to seek their views on issues affecting them and the services provided to support them. A summary of some key consultations is provided below.

Cumbria Children & Young People's Voluntary Sector Reference Group / Cumbria Youth Alliance: Reform of the Emotional Health & Wellbeing Service for Children & Young People (CAMHS): 2013: In a CCG commissioned consultation, children and young people reported that when they are upset and anxious they need to know where to get advice and help quickly from people who know best how to help. 91% of the 656 respondents thought that CAMHS should also support the wider family.

Inspira Consultation with 10 – 14 year olds: Informing the Cumbria HeadStart Project: 2013: Children and young people said they would want to talk to their families and friends first before talking to anyone else and whilst accessing information and support on-line could help, their preference would be to get the help they really need from talking to someone face to face. In the co-design of the Cumbria HeadStart Project, parents reported that they often feel unsupported and that there is not enough advice aimed at helping them to support the child/ adolescent in their family who is experiencing difficulties and distress. These views were corroborated in the findings of a Serious Case Review (Child J July 2014) and have resulted in a HeadStart Family Resilience project and also supported the targeted training workshops covering self-harm and suicide prevention.

Lakeland Youth Council (LYC): Mental Health Survey in Schools: 2013/14: This research worked with staff to look at how schools supported students with mental health issues and found a varying range of approaches that were not consistent. Research also took feedback from peers and recommended several improvements including: better information and more training for schools staff (e.g. Mental Health First Aid); the development of more counselling services in schools; more student consultation and the maintenance of privacy and confidentiality.

Consultation into the Emotional Wellbeing of School Pupils: 2013: This research involved 31 Primary and 17 Secondary schools and found a range of serious concerns including: poor parenting skills; family breakdown; increasing levels of parental depression; alcohol and drug use; cyber bullying; peer pressure; low self-esteem; feelings of isolation; academic stress; and "self-harming behaviour at epidemic proportions in Year 10".

Children's Services Consultation with Children and Families: 2013: This consultation collated information about key priority areas of need to inform the Early Help Commissioning Process and found that emotional mental health and wellbeing was identified by services and parents as the most pressing need and a key priority across different localities.

Focus groups on Self-Harm: November 2014: This research, with Year 12 and Year 13 students in Barrow, suggested that there is a lot of stigma about self-harm and a need for awareness-raising especially in secondary schools, along the lines of sexual health education. It was also suggested that confidential early help needs to be available, and help must also be available for parents. Participants also recognised that digital technology can be part of the solution as well as part of the problem.

Cumbria Children's Services Customer Feedback: Child & Family Support Teams: During the period 1st April – 30th June 2015, 491 service user feedback forms were sent out to families who had received a service from the Child & Family Support Team (Early Intervention). Of those, 21 were completed and returned (4.27%). 95% of parents felt that social workers explained their role to them; and 75% stated that they were treated with respect. However, only 52.4% of parents felt their emails and calls were returned promptly; and only 50% said that social workers kept in touch with them. 50% of families are reporting that their situation has got better with involvement of Children's Services, 35% report no change, while 15% report that they have got worse.

Cumbria Children's Services Customer Feedback: Child Protection Teams: During the period January – June 2015, 310 service user feedback forms were sent out to families who had received a service from the Child Protection teams. Of those, 9 were completed and returned (2.9%). 55.5% of families reported that things had got better following involvement with Children's Services, 22.2% reported there was no change, while 22.2% reported things had got worse. 62.5% of families reported that social workers explained their role to them; only 37.5% reported that their calls/emails were returned promptly; only 37.5% believed that social workers listened to their views; and less than half (42.9%) felt that decisions were explained to them.

Cumbria Children's Services Customer Feedback: Children looked after: In April 2015, 383 service user feedback forms were sent out to all Children looked after aged 8 and over. Of those, 53 were completed and returned (13.8%). 79% of children and young people felt that they have a positive relationship with their social worker. 67% felt they are able to share things with their support worker, while 89% feel that their support workers listen to them. However, survey results indicate that some improvements are required in the following areas: All children and young people in care should be provided with a copy of the notes from meetings with their support worker documenting agreed actions (survey results indicate that only one third currently receive a copy); Children and young people would like more support to enable them to have safe contact with their families; Additional support is wanted to enable children and young people to participate in hobbies and interests.

Children in Care Council: Children and young people participating in Cumbria's Children in Care Council have set priorities including:

- Mental health and well-being of young people looked after;
- Employment and educational opportunities for young people looked after;
- Social skills - developing interpersonal, independent and life skills for children and young
- people who are looked after;
- Transitions – coming into care, experience whilst in care and leaving care;
- Emotional resilience of children and young people looked after;
- Getting good quality social workers and keeping them;
- Improving placements;
- Contact with birth families; and
- Support in school for children in care.

Feedback from Young People who have Experienced Homelessness: Cumbria: May 2013: Young people reported that they would like to: Feel supported; Be accommodated in places just for young people but with support; Be listened to; Have a fair and transparent process that they can understand; Have a say in what happens; Have support whilst in temporary accommodation to develop some skills; Have no young person put in a B&B; Have quicker access to supported housing.

Healthwatch Cumbria (HWC): HWC is set up to champion the views of patients and people who use health and social care in Cumbria. HWC routinely gather views and experiences through public engagement events. During 2014-15 HWC experienced an increase in concerns raised by families relating to the challenges of accessing mental health services for children and young people. From November 2014 to January 2015 HWC was commissioned to provide a series facilitated meetings with North Cumbria University Hospitals NHS Trust (NCUHT) to provide opportunities for local communities to learn about proposed changes to hospital services in the North and West of Cumbria. Many issues were raised about the potential reconfiguration of maternity and paediatric services. Local communities were concerned about the impact upon the care received and the logistics of transporting sick babies, mothers and children, particularly in emergency situations.

12. Current Services and Assets

There are many services and assets provided across the county to support children and young people's health and wellbeing needs. A summary of some of the key services and assets is provided below.

NHS Cumbria Clinical Commissioning Group (CCG): Cumbria CCG is the main commissioner of local NHS services in the county. Cumbria CCG receives an annual NHS budget for Cumbria from the DoH and uses this to plan and deliver NHS services for all ages, including children and young people. Services include: acute hospitals, community hospitals, community based health services and mental health services. Cumbria CCG does not commission Primary Care in Cumbria (GPs, Opticians, Dentists and Pharmacies); this is commissioned by NHS England and other specialist services. Cumbria CCG do not manage hospitals or community and mental health services, but work closely with providers to oversee how they are run and work together to integrate primary, secondary and community services.

Current CCG commissioned contracts specific to children and young people are as follows: Audiology; Dietetic; Specialist safeguarding; Community paediatrics; Tier 3 CAMHS; Physiotherapy; Children's Community Nursing; Speech and Language Therapy; Occupational Therapy; Children's LD Nursing; Children Looked After specialist nursing.

Cumbria Partnership NHS Foundation Trust: Provide a range of services for children and families promote a healthy start to life and provide health care services that they might need as they grow that are responsive to the changing needs of young people and their families. The Trust works closely with other organisations such as CCC to safeguard the health and wellbeing of our children and their families. The children and families services provided by the Trust are as follows:

- **Health Visiting** - every child under five-years old and their parents have a health visitor who can visit them in their home or who they can see at their local clinic, doctor's practice or Children Centre to deliver the HCP contacts for 0-5s;
- **Specialist** CAMHS - these community teams are integrated health and social care teams who provide assessment and treatment for children, young people and their families up to the age of 18 who show signs of mental health problems;

- **School Nurses** –deliver the HCP in schools for 5-19s. Children and young people can access information about health and wellbeing from their school nurse. 4-16 year olds can go to their school nurse for facts and advice on health and lifestyle. They have information on everything from immunisations, diet, sexual health, child protection and safeguarding information. They also support schools to become healthy environments for children;
- **Children Looked After** – this team provides health coordination for children who are Looked After by the local authority. They make sure that the children's health needs are fully assessed and care plans in place to keep them healthy;
- **Children's Audiology Services** - the Community Paediatric Audiology team is open to any child aged 0 - 19 years where there are concerns or doubts about hearing. The service also provides surveillance for children with permanent hearing impairments and for those children with temporary, conductive problems;
- **TB Nursing Service** - This team provides support for patients with tuberculosis and carries out vital contact tracing for those who have been in close contact with TB patients in case they also need treatment. The nurses provide advice for patients, relatives, work colleagues and other professionals on all aspects of TB care and treatment;
- **Children's Community Nursing** - This team provides a home nursing service to children and young people aged 0-18 years old with long term conditions, including learning disability/autistic spectrum disorder, physical disability, sensory impairment, highly complex conditions and palliative care. The team also provides specialist continence advice and support for those requiring short or long term help with toileting;
- **Community Learning Disability Teams for Children** - these teams provide a county-wide service from four bases: Carlisle, Workington, Barrow and a satellite office in Kendal. They work with children and young people who have a global learning disability;
- **Children's Community Paediatrics** - This team of doctors specialise in treating children and young people aged 0-to-18 years old outside hospital;
- **Family Nurse Partnership** - for teenage mothers in the second trimester of pregnancy until her child is two years old - this team provides an intensive targeted home visiting programme for teenage parents and their babies;
- **Child Development Services** - provide services for children aged 0-18 years old with learning disability/autistic spectrum disorder, physical disability and sensory impairment. The team works with children, young people and their families to reduce the negative impact of medical conditions, developmental delay or disability on their daily life;

- **Children's Occupational Therapy** - Occupational Therapists provide assessment and advice for children and young people aged 0 -18 years (19 if attending school) who need help with skills for everyday occupations. Therapists take into account the chronological age of the child/young person, their developmental level, the environment and the readiness for working on change. The service is for: Self-Care (i.e. helping a child learn to use cutlery or dress themselves, assessment of the home environment which may include advice about improving access to the toilet or use of specialist equipment); School work (i.e. able to sit, access table top activities, developing pencil control, improving handwriting, accessing school environments); and Play & Leisure (i.e. helping a child to take part in their chosen activities such as playing with toys, taking part in sport). The service can be accessed via Health Professionals, Education, and parents;
- **Children's Physiotherapy** – The Children's Community Physiotherapy Teams provide a specialist service to babies, children and young people aged 0 to 19 within Cumbria. Physiotherapists aim to maximise movement and function when a child is affected by injury, illness, developmental delay, or other disability. Following assessment they use a combination of approaches to provide holistic physical rehabilitation, offer advice and education or provide suitable treatment programmes. They work with other professionals and care givers within a range of locations including schools, the child's home, children's centres, clinics and child development centres;
- **Speech and Language Therapy** - this service works with children with speech, language and communication difficulties, as well as children with feeding or swallowing difficulties.

Cumbria County Council's Children's Services: Cumbria Children's Services are responsible for a wide range of services for children, young people, their families and schools in Cumbria. The Directorate consists of four broad areas of activity:

- **Schools and Nurseries;**
- **Other Schools & Learning Services;**
- **Children & Families Social Care;**
- **Early Help & Partnerships.**

The schools and nurseries element of the Directorate includes school provision for 49,137 pupils in maintained schools in Cumbria. This is delivered through 18 Maintained Secondary Schools, 253 Maintained Primary Schools, 6 Nursery Schools, 5 Special Schools and 3 PRUs. The Council also ensures that 8,588 nursery places are provided to 2, 3 and 4 year olds in schools and the private, voluntary and independent sectors.

The Directorate is also responsible for providing schools and learning support including SEN provision, early years support and learning improvement both by the Council and through partnership with Cumbria Alliance of System Leaders (CASL) and 6 Local Alliances of System Leaders (LASLs).

The Children and Families service area includes early intervention and targeted support for children and families; child protection, safeguarding, fostering and adoption services, and services for children looked after. As of May 2015, 3,392 children and young people were known to the Council with 2,751 having an allocated social worker.

The Directorate provides early help and partnership services through the provision of 28 children's centres – where children under 5 years old and their families can receive integrated services and information - and youth provision across the County. It also has 3 Family centres providing targeted work with children and their parents and 2 Children's Residential Care Homes in Barrow and Whitehaven. 2 Respite Units provide short breaks for children with learning disabilities who may also have associated physical or sensory impairment. They are registered to care for children and young people from the age of 8 -18 years. Additionally, there is a Edge of Care Service provided in Kendal (and 1 in development) providing overnight respite at weekends and school holidays to young people and outreach support for families. This service area also encompasses YOS.

Specific services delivered by Cumbria Children's Services which support some of the vulnerable groups referred to in this chapter include:

- **Cumbria Local Offer:** A signposting service for parents/carers and their children with SEND, to information about provision that they expect to be available across education, health and social care for children and young people with SEND.
- **Cumbria Information, Advice & Support Service:** Offers up to date information, impartial advice and practical support to parents/carers of children with SEN or severe medical conditions (disabilities), which affect the way their child can access education. This support now includes signposting to health and social care advisory services.
- **Cumbria Access & Inclusion Team:** Offers support in accessing education. The team consists of: Children Missing Education Officers; Inclusion Officers; Re-Integration Co-Ordinators; Inclusion Support Officers; and a Child Employment & Entertainment Officer.
- **Cumbria County Council's Virtual School and Equalities Learning Team:** This team encompasses the following vulnerable groups: Looked After Children; EAL; BME; Travellers; and Young Carers. The team work to improve outcomes of each of these groups as well as promoting a better understanding of their specific needs and of equality issues.

- **Pupil Referral Units (PRUs):** PRUs are a type of school that offers education to students who are; at risk of exclusion, permanently excluded from, or are not attending school for other reasons, such as illness (physical and psychological) or pregnancy. In Cumbria, there are three PRUs – Barrow / Kendal (South), Carlisle (North) and Distington (West). Each PRU currently offers education to students aged 7-16 with the exception of the North PRU who also offer support to the 5-7 age group.
- **Cumbria Reading Intervention:** An intensive, research-based programme that is highly effective at speeding up the development of children's early literacy skills. The Cumbria Reading Intervention project has been supported by CCC since the early 1990s and has already benefited thousands of children.

Cumbria Children's Centres: There are 28 Sure Start Children`s Centres across Cumbria. They provide information and access to services and activities for children aged up to 19 and their families. Services are tailored to meets local needs and may vary between different centres. All centres are expected to provide access to, or information about how to access, the following services:

- Good quality, integrated early learning and childcare;
- Child and family services;
- Family support services, including support for parents and children with additional needs;
- Links with Jobcentre Plus to support parents and carers who are considering employment or training leading to employment;
- Drop in sessions and other activities for children and carers;
- Support for childminder networks;
- Effective links with the Children and Families Information Service, local childcare providers, out of school clubs and extended services.

Carbon Monoxide (CO) Monitoring in Pregnancy: Training has taken place for midwives so that all women are now offered a CO test at first booking with CO monitoring now taking place at 36 weeks. This was previously at delivery but this has been introduced as it is thought to be a better proxy indicator of smoking at time of delivery, and is easier to record and monitor.

Baby Friendly Initiative: An initiative set up by UNICEF and the WHO. In the UK, the initiative works with health professionals to ensure high-quality support to enable successful breastfeeding. NCUHT, with support from CCC, has been awarded a Certificate of Commitment. Baby Friendly awards are considered the 'gold standard' of training and practice to promote breastfeeding for maternity, health visiting, neonatal and children's centres services. The Certificate of Commitment recognises dedication to implementing recognised best practice standards.

Local Breastfeeding Groups and Breastfeeding Peer Supporters: There are a number of local breastfeeding groups across the county, while breastfeeding Peer Support Workers are employed mums that are currently breastfeeding or have breastfed their children and have undergone a breastfeeding training course to support other mothers to breastfeed, working in partnership with local health professionals.

National Child Measurement Programme (NCMP): Measures the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight children and obese levels within primary schools. A new service specification will develop pathway to support those children who have been identified as being overweight or very overweight.

Active Cumbria: One of 45 County Sports Partnerships (CSPs) in England and has established a successful inclusive sports delivery system through a network of providers and deliverers committed to working together to achieve active and healthy communities in Cumbria through sport and physical activity.

Change4Life: Aims is to inspire a broad coalition of people, including the NHS, local authorities, businesses, charities, schools, families, and community leaders to all play a part in improving the nation's health and well-being by encouraging everyone to eat well, move more and live longer. Change4Life uses cartoon imagery and informal, non-judgmental language to suggest easy diet and exercise swaps. In addition to TV advertising and online resources, Change4Life provides resources and branding for partners and supporters to use free of charge to support their health and well-being work.

Cooking Clubs / Courses: Provided in a variety of locations across Cumbria, including Children's Centres.

HENRY – Healthy Exercise, Nutrition for the Really Young: Provides evidence-based early years training courses for all practitioners working with families of young children to support families to develop a healthier lifestyle. Courses are aimed at health visitors, midwives, children's centre workers, nutritionists, dietician and child-minders.

Healthy Start Vitamins and Vouchers: A means tested scheme which provides pregnant women and women who have children under the age of 4 with vouchers to help buy some basic food. Women and children getting Healthy Start food vouchers also get vitamin coupons to swap for free Healthy Start vitamins; which are specifically designed for pregnant and breastfeeding women and growing children. Midwifes and health visitor can advise on where to swap coupons for vitamins.

Oral Health Promotion Training: The 0-5 HCP is developing training for health visiting service around oral health promotion.

Smile4Life: An oral health improvement programme to help adults and children improve their oral health by encouraging; healthy eating and drinking; regular tooth brushing; promotion of a healthy lifestyle; visiting the dentist regularly. Delivered in Children's Centres, currently commissioned by PHE.

Water Fluoridation: Fluoridation takes place at two water treatment works in West Cumbria (Cornhow and Ennerdale).

Reducing Exposure to Unintentional Injury: Work is being done via the 0-5 HCP to develop a training programme for health visiting service around this issue.

Integrated 2 ½ Year Reviews: The 0-5 HCP requires a health review at age 2 – 2 ½ covering: general development; growth; behaviour; teeth brushing; sleeping habits; safety; and vaccinations. From September 2012 there was a requirement for parents to be provided with a written summary at age 2 of their child's progress in the EYFS prime areas of learning. In Cumbria Early Years Providers and Health Visitors have developed an integrated review to cover both these important developmental stages. By integrating these reviews a more complete picture is provided of the child; drawing together detailed knowledge of how the child is learning and developing day to day at their educational setting, along with the expertise of the child's health visitor at the health review and parents' views and concerns about their child's progress.

Unity: A drug and alcohol recovery service, providing treatment and recovery support for individuals (aged 18 years and above) and their family members who are affected by substance misuse (including alcohol, illicit drugs and over the counter and prescribed medication).

Cumbria Alcohol and Drug Advisory Service (CADAS): Primary objective is to enhance the lives of people in Cumbria through the reduction of harm caused to them by the use or misuse of alcohol and drugs, by providing them with an opportunity to work towards living in a more satisfying and resourceful way. The organisation provides drug and alcohol service to individuals and help to families, communities and employers with training and information provision. **CADAS** has limited services for young people which vary depending on the area.

Assertive Alcohol Outreach Service (CAAO): This is an early intervention services aimed at young people in the most acute need and are at risk of harm due to alcohol misuse. The service provides a universal early intervention, targeting and delivering harm reduction with the aim of reducing vulnerability and preventing an escalation in risk taking behaviour by young people. Criteria for referral are any young person between the ages of 10 and 17 years who has been identified by the following referrers as being under the influence of alcohol: A&E Units; Children's Services Triage; Police Custody; School Nurses; Children's Services District Teams; Prevent and Deter Panels; Pub Watch; Prevention Triage; Focus Families; Early Help Assessment/CAF; Self/Parent Referral; and Voluntary Agencies.

Sexual Health Treatment and Advice in Cumbria: Provided in a variety of settings across the county including Sexual Health Clinics (combined GUM and Contraceptive services), GP surgeries, community pharmacies, and Inspira (previously Connexions). Confidential help is provided by the Sexual Healthline Cumbria signposting service.

Cumbria Youth Offending Service: The Principle aims of the Youth Offending Service are to: prevent offending and reoffending by young people; deal appropriately with those who offend including encouraging them to make amends for their crimes; and to support victims of crime. Cumbria Youth Offending Service is built on the basis of strong partnership work across both statutory and voluntary sector organisations. It works hard to balance supervision and surveillance of young people with support and advice to help them change their lifestyles. This helps drive down youth crime in Cumbria continuing to make it a safer place to live, and a place where young people are making better decisions about their behaviour which will help improve their life chances as they move into adulthood and independence.

Inspira: Deliver services to young people and adults to help them develop their personal and employability skills. The organisation works across different dimensions of people's lives – family, health services, schools, friends, leisure activities, housing, careers, FE, and specific needs relating to social and community issues, criminal justice and homelessness. The organisation offers general advice, support and education for young people to reduce risk taking behaviour.

Self-harm Awareness for All (SAFA) Cumbria: A team of qualified staff committed to making a positive difference to the lives of individuals who self-harm and to those who support them. SAFA offer counselling and trusting support, and raise awareness through training and education. SAFA may be able to provide support around alcohol and drugs misuse as these are often included in ways that young people self-harm.

HeadStart: Cumbria is one of 12 areas nationally that has been awarded funding from the Big Lottery to focus on building children and young people's emotional resilience for children and young people's Emotional Resilience. The Big Lottery Fund wants to focus on improving resilience and lives of young people by working in four areas: A child's time and experiences at school; their ability to access the community services that they need; their home life and relationship with family members; their interaction with digital technology.

Safety Net Advice and Support Centre: Works with Children, Young People and Adults who have suffered Rape, Sexual Abuse and Domestic Violence in Cumbria. Clients include Children that have suffered the trauma of Sexual Abuse, Young People in Child Protection and Adults with Mental Health difficulties.

Focus Family Programme: The Focus Family project is part of the national Troubled Families programme, a DCLG initiative to support local authorities in addressing the needs of the most challenging and hard to reach families. Nationally these are families considered to have children not attending school, family members involved in crime or anti-social behaviour and adults on out of work benefits. In Cumbria this programme works closely with over 1,000 families who meet a number of criteria including worklessness and financial hardship.

Credit Unions: Cumbria has 6 credit unions that enable families to access affordable credit.

Cumbria Money Advice Service: Provided by the Citizen's Advice Bureaux (CAB) and helps families in debt.

Cumbria Advice & Assistance Team (CAST): Provides support to families in need.

Cumbria DeafVision: Provides help and advice to families regarding extra support available. They can help with specialist social work, communication support, children and families project. There is also a local group of the National Deaf Children's Society where families can meet each other and get moral support.

Letgo: An accredited countywide service across Cumbria providing a range of services to individuals aged 16 and over, experiencing domestic abuse, regardless of age, sexual orientation or gender. A team of qualified staff co-ordinate support and interventions to enhance safety for people affected by domestic abuse, and their families.

Sexual Assault Referral Centre (SARC): A SARC is being established in Cumbria for victims of sexual assault and abuse of all ages. Currently victims have to travel out of the county for some services. It is expected that the SARC in Cumbria will begin service towards the end of 2015 and will include the facilities for conducting medical checks and taking forensic samples for victims. It will also provide a point of contact for victims to find out what services are available and refer them onto support services.

Joint Protocol for Homeless Young People in Cumbria: Organisations across the county (including all the district housing authorities and the County Council) have been working in partnership to review their response to 16-17 year olds who present as homeless. This work resulted in the Joint Protocol to address the needs of Homeless 16-17 year old Young People in Cumbria. This protocol and the way in which it is implemented is seen as an example of national best practice for 2 tier authorities. Local Commitments are developed by local operational staff in districts to set out how the protocol will be implemented. Local Commitments have been developed and are live in Barrow, Copeland Eden and Carlisle.

Nightstop: This service is commissioned by CCC and delivered by Depaul UK. Nightstop will provide emergency accommodation for young people aged 16-25, who find themselves in a crisis situation and at risk of homelessness by offering placements on a night by night basis, in the homes of trained and approved volunteer hosts.

Case Officers for Homeless 16-17 Year Olds: CCC funded posts, initially funded until 31/03/16, which will: work with and support young people aged 16-17 who are not already open to other statutory agencies; 'slow down' potential homelessness at point of presentation; prevent homelessness where safe to do so; and register Early Help Assessments where appropriate.

Healthwatch Cumbria (HWC): Set up to champion the views of patients and people who use health and social care in Cumbria, with the goal of making services better and improving health and wellbeing. HWC's main roles are to: Gather information on the quality of services in Cumbria, highlighting local issues that are raised by the public and forwarding those that require a national response to Healthwatch England; Make sure that health and social care are held responsible for their actions, and the services they provide; Promote better, and more joined-up services for people who use health and social care in Cumbria; Help people to find ways to improve their personal health and wellbeing; Provide free information to help people know about health and social care services and understand the choices available.

13. Geographical Differences:

There are a number of sources that provide district and sub-district level information relating to the health and wellbeing of children and young people. These sources include:

- **General Health Profiles:** Produced by PHE annually, these profiles include a number of measures relating to children and young people's health at local authority district level.
- **Children and Young People's Health Benchmarking Tool:** Developed CHIMAT, this tool presents a selection of indicators relevant to the health and wellbeing of children and young people at local authority district level.
- **Children and Young People's Mental Health and Wellbeing Profiling Tool:** Developed by PHE, this tool provides data on children with, or vulnerable to, mental illness at local authority district level.
- **Local Health Comparison Spreadsheets:** Spreadsheets comparing health indicators across the wards in each of Cumbria's district have been produced by the Cumbria Intelligence Observatory using data from the Local Health website.

Based on the findings of this chapter and the above sources, the following district level health and health and wellbeing summaries for children and young people are provided for each of Cumbria's districts.

13.1 Allerdale

Allerdale is home to 20,500 0-19 year olds; equating to 21.3% of the district's total population; lower than the national average of 23.8%. The proportion of residents aged 0-19 years ranges across the district's electoral wards from 16.2% in Boltons ward to 26.7% in Ewanrigg ward. The district's fertility rates have risen over the last decade (+8%). Projections of past demographic trends suggest that by 2022 Allerdale's 0-19 population will decrease by 3.4%, while projections based on Experian jobs projections suggest that by 2022 the district's 0-19 population will increase by 6.3%.

Moss Bay, Ewanrigg and Moorclose wards fall within the bottom 10% nationally for levels of child poverty and parts of Moss Bay ward fall within the 3% most deprived of areas nationally. The district's youth unemployment rate is significantly higher than the national average (4.9% vs. 2.9%), with parts of St. Michael's, Ewanrigg and Moss Bay wards having youth unemployment rates more than five times the national average. The district's Holme ward has a rate more than 1.5 times the national average in relation to 0-15 year olds with day to day activities limited by a long-term health problem or disability.

Rates of breastfeeding initiation are worse than the national average in Allerdale. Compared to the national average the district also has worse rates of excess weight in 4-5 year olds (26.2% vs. 22.5% nationally) and obese children in Year 6 (22% vs. 19.1% nationally). Silloth ward has a significantly higher rate of 4-5 year olds with excess weight than the national average, while Netherhall, Ewanrigg, Ellenborough and Moss Bay wards have worse rates of 10-11 year olds with excess weight than the national average. Furthermore, Allerdale has worse rates of hospital admissions for accidental and deliberate injuries in children aged 0-4 than the national average (179.4 vs. 140.8 per 10,000 population nationally).

Compared to the national average Allerdale has worse rates of: Alcohol-specific hospital stays for under 18s (73.8 vs. 40.1 per 100,000 population nationally); Chlamydia detection for 15-24 year olds (1,507 vs. 2,012 per 100,000 nationally); and KSI casualties on roads (48.5 vs. 39.7 per 100,000 population nationally).

Compared to the county average, Allerdale & Copeland locality has higher rates of: children in need (376.4 vs. Cumbria's 363.9 per 10,000 population); children in need cases recording abuse or neglect as the child's primary need (72% vs. 64% for Cumbria); children with a child protection plan (43.1 vs. Cumbria 34.6 per 10,000 population); and child protection cases recording emotional abuse as the latest category of abuse (55% vs. Cumbria 46%).

Allerdale & Copeland locality also has higher rates of children looked after than the county average (86.2 vs. Cumbria 72.4 per 10,000 population). Additionally, the locality has lower proportions than the county average of children looked after with up to date dental checks (75.8% vs. Cumbria 80.7%) and children looked after with an up to date health assessment (84% vs. Cumbria 89.2%). Inversely, the locality has a higher average SDQ score for children looked after (indicating more emotional difficulties) than the county average (14.3 vs. Cumbria 13.8) and higher proportions of care leavers who are NEET than the county average (52.5% vs. Cumbria 49.6%).

- Allerdale General Health Profile
- Allerdale Children and Young People's Health Benchmarking Tool
- Allerdale Children and Young People's Mental Health and Wellbeing Profiling Tool
- Allerdale Local Health Comparison Spreadsheet

13.2 Barrow-in-Furness

Barrow-in-Furness is home to 15,300 0-19 year olds; equating to 22.6% of the district's total population; lower than the national average of 23.8%. The proportion of residents aged 0-19 years ranges across the district's electoral wards from 14.8% in Hawcoat ward to 27.5% in Risedale ward. The district has higher fertility rates than the national average (63.3 vs England 62.4 live births per 1,000 women aged 15-44), with the district's fertility rates having risen over the last decade by 8.9%. Projections of past demographic trends suggest that by 2022 Barrow-in-Furness's 0-19 population will decrease by 7.7%, however, projections based on Experian jobs projections suggest that by 2022 the district's 0-19 population will increase by 8.3%.

Barrow-in-Furness has a greater proportion of children living in poverty than the national average (20.4% vs. 18.6% nationally). Central, Hindpool, Barrow Island and Risedale wards all fall within the bottom 10% nationally for levels of child poverty. 39.6% of residents in the district live in areas that fall within the 20% most deprived of areas in England compared to 20.4% nationally, with parts of Barrow Island, Central, Hindpool and Ormsgill wards falling within the 3% most deprived of areas nationally. Compared to the national average, the district has lower proportions of pupils achieving 5+ GCSEs at grades A*-C including English & Maths (50.5% vs. 56.8% nationally), while the district's youth unemployment rate is double the national average (5.8% vs. 2.9% nationally), with parts of Barrow Island ward having youth unemployment rates more than five times the national average.

Barrow-in-Furness's rates of 0-15 year olds with day to day activities limited by a long-term health problem or disability are higher than the national average (4.7% vs. 3.8% nationally). Furthermore, the district's Central and Ormsgill wards have rates that are more than 1.5 times the national average in relation to 0-15 year olds with day to day activities limited by a long-term health problem or disability.

Breastfeeding initiation rates are worse than the national average in Barrow-in-Furness, while the Barrow & South Lakes locality has a lower rate of children receiving rotavirus vaccine than the county average (89.8% v 93.8%). The district is rated worst out of all local authorities in England for rates of 4-5 year olds with excess weight (30.6% vs. 22.5% nationally), with Hindpool, Risedale, Ormsgill and Newbarns wards all having significantly higher rates than the national average for this measure. Additionally, Hindpool and Central wards have worse rates of 10-11 year olds with excess weight than the national average.

Barrow-in-Furness has significantly higher rates of tooth decay in children aged 5 (1.45 d3mft per child compared to 0.94 nationally). The district also has worse rates than the national average of hospital admissions caused by unintentional and deliberate injuries in: children aged 0-14 years (175.1 vs. 112.2 per 10,000 population nationally); children aged 0-4 (231.7 vs. 140.8 per 10,000 population nationally); and young people aged 15-24 (181.8 vs. 136.7 per 10,000 population nationally).

Compared to the national average Barrow-in-Furness has significantly higher rates of alcohol-specific hospital stays for under 18s (93.6 vs. 40.1 per 100,000 population nationally) and Chlamydia detection for 15-24 year olds (1,469 vs. 2,012 per 100,000 nationally). Surveys report that, of Cumbria's districts, knowledge and awareness of the C-Card scheme (free condoms) is less apparent in Barrow and the district has the greatest proportions of young people: who have used a sexual health clinic (20% vs. Cumbria 12%); and accessing EHC. Throughout 2014 numbers of KSI road casualties increased in Barrow-in-Furness (+5), with three child KSI occurring in the districts. The district has the greatest rate of domestic violence and sexual offences in Cumbria, with numbers of sexual offences having almost doubled in the district in the last year.

Compared to the county average Barrow & South Lakeland locality has higher rates of: children in need (379.5 vs. Cumbria 363.9 per 10,000 population), with Barrow Island, Central and Hindpool wards having rates of children in need that are three or more times the county average. The locality also has higher rates than the county average of: children and young people who are looked after with an identified substance misuse problem (8.7% vs. Cumbria 5%); children and young people who are looked after receiving a caution, conviction or final warning (9.7% vs. Cumbria 6.1%); and care leavers who are NEET (52.9% vs. Cumbria 49.6%). Compared to the national average Barrow-in-Furness has higher proportions of pupils with SEN (16.3% vs. 15.4% nationally) and pupils with a Statement/ EHC plan (3.6% vs. to 2.8% nationally).

- Barrow-in-Furness General Health Profile
- Barrow-in-Furness Children and Young People's Health Benchmarking Tool
- Barrow-in-Furness Children & Young People's Mental Health & Wellbeing Profiling Tool
- Barrow-in-Furness Local Health Comparison Spreadsheet

13.3 Carlisle

Carlisle is home to 23,500 0-19 year olds; equating to 21.8% of the district's total population; lower than the national average of 23.8%. The proportion of residents aged 0-19 years ranges across the district's wards from 18.6% in Longtown & Rockcliffe ward to 26.2% in Upperby ward. The district's fertility rates have risen over the last decade (+8.8%). Projections of past demographic trends suggest that by 2022 Carlisle's 0-19 population will decrease (-1.3%), however, projections based on Experian jobs projections suggest that by 2022 Carlisle's 0-19 population will increase (10.5%). In Cumbria, Carlisle has the greatest proportion of pupils from BME groups (6.8% vs. Cumbria 4.4%, national 28.6%). In St Aidans ward 15% of 0-19 year olds are from BME groups; three times the county average.

Upperby ward falls within the bottom 10% nationally for levels of child poverty. When compared to the national average, Carlisle has lower proportions of pupils achieving 5+ GCSEs at grades A*-C including English & Maths (47% vs. 56.8% nationally) and worse absence rates; 4.9% of school sessions missed due to overall absence vs. 4.5% nationally and 4.6% of pupils classed as persistent absentees vs. 3.6% nationally.

Rates of breastfeeding initiation are worse than the national average in Carlisle, while Upperby ward has a significantly higher rate than the national average in relation to 4-5 year olds with excess weight. When compared to the national average Carlisle has higher rates of: 3 year olds with early childhood caries; tooth decay amongst 3 year olds; and tooth decay amongst 5 year olds. The district also has worse rates hospital admissions caused by unintentional and deliberate injuries in: children aged 0-14 years (139.9 vs. 112.2 per 10,000 population nationally); and children aged 0-4 years (194 vs. 140.8 per 10,000 population nationally). In 2014 three child KSI road casualties occurred in the district.

When compared to the county average Carlisle & Eden locality has a higher proportion of child protection plan cases recording neglect as the latest category of abuse (40% vs. Cumbria 35%). When compared to the county average the locality also has: lower proportions of children looked after with up to date dental checks (76.2% vs. Cumbria 80.7%); lower proportions of children looked after with an up to date health assessment (86.4% vs. Cumbria 89.2%); and a higher mean SDQ score (indicating more emotional difficulties) for children looked after (14 vs. Cumbria 13.8). Carlisle district also has higher proportions of pupils with SEN than the national average (17.7% vs. 15.4% nationally).

The 2011 Census reported that of Cumbria's districts, Carlisle had the greatest number of Gypsy or Irish Traveller residents; 196 persons (0.2% of the population vs. county and national averages of 0.1%). Of Carlisle's 196 Gypsy or Irish Traveller residents, 58 were aged 0-19 years; (0.2% of the 0-19 population vs. Cumbria 0.1%, national 0.2%).

Across Cumbria's wards, Carlisle's Castle ward had the greatest number of Gypsy or Irish Traveller residents (20 persons), while Lyne ward in Carlisle had the greatest proportion (0.5%). The DCLG January 2015 count of Gypsy and Traveller caravans also reported Carlisle had the greatest number of caravans of the county's districts (149 caravans).

- Carlisle General Health Profile
- Carlisle Children and Young People's Health Benchmarking Tool
- Carlisle Children and Young People's Mental Health and Wellbeing Profiling Tool
- Carlisle Local Health Comparison Spreadsheet

13.4 Copeland

Copeland is home to 14,900 0-19 year olds; equating to 21.3% of the district's total population; lower than the national average of 23.8%. The proportion of residents aged 0-19 years ranges across the district's electoral wards from 12.9% in Haverigg ward to 26.9% in Sandwith ward. Copeland has higher fertility rates than the national average (63.7 vs. 62.4 live births per 1,000 women aged 15-44 nationally), with the district's fertility rates having risen over the last decade (+21.3%). Projections of past demographic trends suggest that by 2022 Copeland's 0-19 population will decrease by 9.2%, while projections based on Experian jobs projections suggest that by 2022 Copeland's 0-19 population will decrease by 12.5%. None of the district's wards have greater proportions of 0-19 year olds from BME groups than the national average, however, St Bees ward has proportions more than three times the county average (15.8%).

Sandwith and Mirehouse wards fall within the bottom 10% nationally for levels of child poverty, while parts of Sandwith ward fall within the 3% most deprived of areas nationally. Copeland's youth unemployment rate is significantly higher than the national average (5.3% vs. 2.9% nationally), with parts of Harbour ward having youth unemployment rates more than five times the national average. Locally sourced data from Inspira suggests that Copeland has some of the highest NEET rates in Cumbria.

Rates of breastfeeding initiation are worse than the national average in Copeland. The district also has worse rates of 4-5 year olds with excess weight than the national average (26.1% vs. 22.5% nationally). Sandwith, Newtown and Mirehouse wards all have significantly higher rates of 4-5 year olds with excess weight than the national average, while Egremont North ward has worse rates of 10-11 year olds with excess weight than the national average.

Furthermore, compared to the national average, Copeland has significantly higher rates of tooth decay in 5 year olds (1.27 vs. 0.94 decayed/missing/filled teeth per child nationally) and hospital admissions caused by unintentional and deliberate injuries in: children aged 0-14 years (143.2 vs. 112.2 per 10,000 population nationally); children aged 0-4 years (227.3

vs. 140.8 per 10,000 population nationally); and young people aged 15-24 years (188.1 vs. 136.7 per 10,000 population nationally).

Copeland's under 18s alcohol-specific hospital admissions rate is the highest of all local authorities in England (105.8 vs. 40.1 per 100,000 population nationally). The district also has a worse Chlamydia detection rate for 15-24 year olds than the national average (1,366 vs. 2,012 per 100,000 nationally). Throughout 2014 numbers of KSI road casualties increased in Copeland (+4). In the last year numbers of sexual offences have almost doubled in Copeland and the rate of repeat incidents has also increased.

Copeland has a significantly higher rate of mortality from suicide and injury undetermined in those aged 15-44 years than the national average both in relation to all persons and males (13.08 and 19.7 respectively vs. England 10.1 and 16.12 respectively per 100,000).

Compared to the county average, Allerdale & Copeland locality has higher rates of: children in need (376.4 vs. Cumbria's 363.9 per 10,000 population); children in need cases recording abuse or neglect as the child's primary need (72% vs. 64% for Cumbria); children with a child protection plan (43.1 vs. Cumbria 34.6 per 10,000 population); and child protection cases recording emotional abuse as the latest category of abuse (55% vs. Cumbria 46%). Sandwith ward has rates of children in need that are three or more times the county average.

Allerdale & Copeland locality also has higher rates of children looked after than the county average (86.2 vs. Cumbria 72.4 per 10,000 population). Additionally, the locality has lower proportions than the county average of children looked after with up to date dental checks (75.8% vs. Cumbria 80.7%) and children looked after with an up to date health assessment (84% vs. Cumbria 89.2%). Inversely, the locality has a higher average SDQ score for children looked after (indicating more emotional difficulties) than the county average (14.3 vs. Cumbria 13.8) and higher proportions of care leavers who are NEET than the county average (52.5% vs. Cumbria 49.6%). Copeland district also has higher proportions of pupils with a Statement/ EHC plan than the national average (3.3% vs. 2.8% nationally).

- Copeland General Health Profile
- Copeland Children and Young People's Health Benchmarking Tool
- Copeland Children and Young People's Mental Health and Wellbeing Profiling Tool
- Copeland Local Health Comparison Spreadsheet

13.5 Eden

Eden is home to 10,600 0-19 year olds; equating to 20.2% of the district's total population; lower than the national average of 23.8%. The proportion of residents aged 0-19 years ranges across the district's electoral wards from 16.2% in Ullswater ward to 23.9% in Kirkby Thore ward. The district's fertility rates have risen over the last decade (+1.3%). Projections of past demographic trends suggest that by 2022 Eden's 0-19 population will decrease by 5.7%, however, projections based on Experian jobs projections suggest that by 2022 Eden's 0-19 population will increase by 1.9%.

The district's Brough ward has a rate more than 1.5 times the national average in relation to 0-15 year olds with day to day activities limited by a long-term health problem or disability. Kirkby Stephen ward has a significantly higher rate than the national average in relation to 4-5 year olds with excess weight. When compared to the national average, Eden has worse rates of: Chlamydia detection in 15-24 year olds (1,776 vs. 2,012 per 100,000 nationally); and KSI casualties on roads (89.9 vs. 39.7 per 100,000 population nationally).

When compared to the county average Carlisle & Eden locality has a higher proportion of child protection plan cases recording neglect as the latest category of abuse (40% vs. Cumbria 35%). When compared to the county average the locality also has: lower proportions of children looked after with up to date dental checks (76.2% vs. Cumbria 80.7%); lower proportions of children looked after with an up to date health assessment (86.4% vs. Cumbria 89.2%); and a higher mean SDQ score (indicating more emotional difficulties) for children looked after (14 vs. Cumbria 13.8). Of Cumbria's districts, Eden has the greatest proportion of 0-15 year olds reported to be providing unpaid care (1.7% vs. 1.1% nationally), Eden also has the highest rate of young carers known to CCC (2.4%).

- Eden General Health Profile
- Eden Children and Young People's Health Benchmarking Tool
- Eden Children and Young People's Mental Health and Wellbeing Profiling Tool
- Eden Local Health Comparison Spreadsheet

13.6 South Lakeland

South Lakeland is home to 20,100 0-19 year olds; equating to 19.4% of the district's total population; lower than the national average of 23.8%. The proportion of residents aged 0-19 years ranges across the district's electoral wards from 12% in Grange North ward to 28.3% in Kendal Kirkland ward. The district's fertility rates have risen over the last decade (+4.7%). Projections of past demographic trends suggest that by 2022 South Lakeland's 0-19 population will decrease by 4%, however, projections based on Experian jobs projections suggest that by 2022 South Lakeland's 0-19 population will increase by 8%.

Of Cumbria's districts, South Lakeland has the second greatest proportion of pupils from BME groups (5.2% vs. Cumbria 4.4%, national 28.6%). While none of the district's wards had greater proportions of 0-19 year olds from BME groups than the national average, the following wards had proportions more than three times the county average: Windermere Applethwaite and Troutbeck (21.7%); Windermere Bowness South (13.6%); Milnthorpe (13.1%); and Sedbergh and Kirkby Lonsdale (12%).

The following wards within the district have rates that are more than 1.5 times the national average in relation to 0-15 year olds with day to day activities limited by a long-term health problem or disability: Kendal Fell; Ulverston South; Hawkshead; and Kendal Mintsfeet.

Ulverston East ward has a significantly higher rate than the national average in relation to 4-5 year olds with excess weight. Additionally, Barrow & South Lakes locality has a lower rate of children receiving rotavirus vaccine than the county average (89.8% vs. 93.8%). When compared to the national average, South Lakeland also has worse rates of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 (172.6 vs. 136.7 per 10,000 population nationally).

Furthermore, South Lakeland has worse rates than the national average in relation to: alcohol-specific hospital stays for under 18s (78.8 vs. 40.1 per 100,000 population nationally); chlamydia detection in 15-24 year olds (1,264 vs. 2,012 per 100,000 nationally); KSI casualties on roads (55.4 vs. 39.7 per 100,000 population nationally).

Compared to the county average Barrow & South Lakeland locality has higher rates of: children in need (379.5 vs. Cumbria 363.9 per 10,000 population). Kendal Far Cross ward has rates of children in need that are three or more times the county average. The locality also has higher rates than the county average of: children and young people who are looked after with an identified substance misuse problem (8.7% vs. Cumbria 5%); children and young people who are looked after receiving a caution, conviction or final warning (9.7% vs. Cumbria 6.1%); and care leavers who are NEET (52.9% vs. Cumbria 49.6%). South Lakeland district also has higher proportions of pupils with a Statement/ EHC plan than the national average (3.3% vs. 2.8% nationally).

- South Lakeland General Health Profile
- South Lakeland Children and Young People's Health Benchmarking Tool
- South Lakeland Children and Young People's Mental Health and Wellbeing Profiling Tool
- South Lakeland Local Health Comparison Spreadsheet

14. Key Contacts

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15. Related Documents

- JSNA Population Chapter
- JSNA Inequalities Chapter
- JSNA Health Living & Lifestyles Chapter
- Cumbria and Districts - Recent Population Trends
- Cumbria and Districts - 10 Year Population Trends
- ONS: 2012-Based Population Projections for England, Cumbria and Districts
- POPGROUP 2012-Based Projections (Published Spring 2014)
- 2011 Census - Key & Quick Statistics - Equality - Cumbria & Districts
- Child Poverty: Children in Low-Income Families Local Measure
- Child Poverty Needs Assessment 2014
- Cumbria Deprivation Analysis
- DfE Early Years Foundation Stage Profile Attainment by Pupil Characteristics
- DfE GCSE and Equivalent Attainment by Pupil Characteristics
- DfE Pupil Absence in Schools
- DfE Permanent and Fixed-Period Exclusions
- Monthly Unemployment Briefings
- Health Related Behaviour Survey 2012
- Community Safety Strategic Assessment
- Children and Young People Emotional Health and Wellbeing in Cumbria: Joint Strategic Needs Assessment
- DfE Characteristics of Children in Need
- DfE Outcomes for Children Looked After by Local Authorities
- DfE Statistics: Special Educational Needs (SEN)
- Cumbria Childcare Sufficiency Report

16. Data Sources

- Public Health Outcomes Framework (PHOF)
- PHE General Health Profiles
- CHIMAT Children and Young People's Health Benchmarking Tool
- PHE Children and Young People's Mental Health and Wellbeing Profiling Tool
- Local Alcohol Profiles
- Local Tobacco Profiles
- Local Health
- Local Health Comparison Spreadsheets
- Cumbria Intelligence Observatory
- Cumbria Atlas

17. Glossary

- A&E: Accident & Emergency
- ACE: Adverse Childhood Experience
- BME: Black and Minority Ethnic
- CAAO: Cumbria Assertive Alcohol Outreach Service
- CAB: Citizen's Advice Bureaux
- CADAS: Cumbria Alcohol and Drug Advisory Service
- CAMHS: Child and Adolescent Mental Health Services
- CASL: Cumbria Alliance of System Leaders
- CAST: Cumbria Advice & Assistance Team
- CCC: Cumbria County Council
- CCG: Clinical Commissioning Group
- CCSA: Crime & Community Safety Assessment
- CHIMAT: National Child and Maternal Health Intelligence Network
- CiN: Children in Need
- CIPOLD: Confidential Inquiry into Premature Deaths of People with Learning Disabilities
- CO: Carbon Monoxide
- COVER: Cover of Vaccination Evaluated Rapidly
- CSE: Child Sexual Exploitation
- CSPs: County Sports Partnerships
- CTB: Children's Trust Board
- d3mft: Mean number of teeth per child which are decayed, missing or filled
- DCLG: Department for Communities and Local Government
- DfE: Department for Education
- DfT: Department for Transport
- DoH: Department of Health
- DPHEP: Dental Public Health Epidemiology Programme
- DTO: Detention and Training Order
- DWP: Department for Work and Pensions
- EAL: English as an Additional Language
- ED: Emergency Department
- EHC Plan: Education, Health and Care Plan
- EHC: Emergency Hormonal Contraception
- EYFS: Early Years Foundation Stage
- FE: Further Education
- FFT: Friends, Families and Travellers'
- FSM: Free School Meals
- GFR: General Fertility Rate
- GUM: Genito-Urinary Medicine
- HCP: Healthy Child Programme
- HENRY: Healthy Exercise, Nutrition for the Really Young
- HES: Hospital Episode Statistics
- HSCIC: Health and Social Care Information Centre
- HWC: Healthwatch Cumbria
- ICD: International Classification of Diseases

- IMD: Indices of Multiple Deprivation
- KSI: Killed or Seriously Injured
- LAPE: Local Alcohol Profiles
- LASL: Local Alliances of System Leaders
- LSCB: Local Safeguarding Children Board
- LSOA: Lower Super Output Area
- NCMP: National Child Measurement Programme
- NCUHT: North Cumbria University Hospitals Trust
- NEET: Not in Education, Employment or Training
- NHS: National Health Service
- NICE: National Institute for Health and Care Excellence
- ONS: Office for National Statistics
- PCT: Primary Care Trust
- PHE: Public Health England
- PHOF: Public Health Outcomes Framework
- PRU: Pupil Referral Unit
- RTC: Road Traffic Collision
- SAFA: Self-harm Awareness for All
- SCH: Secure Children's Home
- SDQ: Strength and Difficulties Questionnaire
- SEN: Special Educational Need
- SEND: Special Educational Need or Disability
- SFR: Statistical First Release
- SNPP: Sub-National Population Projections
- SRE: Sex and Relationships Education
- SSDA903: Children Looked After by Local Authorities Annual Return
- STC: Secure Training Centre
- STI: Sexually Transmitted Infection
- TIIG: Trauma and Injury Intelligence Group
- WAY: What About YOUth? Survey
- WHO: World Health Organisation
- YOI: Young Offender Institution
- YOS: Youth Offending Service