LEEDS CHILDREN AND FAMILIES HEALTH NEEDS ASSESSMENT 2022

Leeds CITY COUNCIL

Foreword

Children are our future. It makes moral and financial sense to invest in the best start in life for all children in Leeds. As we emerge from the COVID-19 pandemic, the Leeds ambition to be the best city for all children and families is stronger than ever. Our focus on children and families within the city is based soundly within the evidence base, starting with the findings of the economist James Heckman who demonstrated that the highest rate of economic return comes from investments early in the life course. As such we are aiming for all children in Leeds to have the best start in life and enjoy a happy and healthy childhood. Achievement of this vision requires a coordinated effort from all partners in Leeds.

There are so many assets in Leeds from antenatal education to support in children's centres. However, this report demonstrates that children in Leeds face persistent and worsening health inequalities and that there remains work to achieve the ambitions set out in the Leeds Children and Young People's Plan. There is also a need to focus on reversing the negative impact of the COVID-19 pandemic on children which was often invisible and indirect.

This health needs assessment uses up to date evidence to tell the story of children and families in Leeds. The content of this needs assessment is drawn from data collated using published datasets. In addition, children's voices have been prioritised at the heart of this report. It is hoped that this needs assessment can be used as a resource for all those interested in improving the health of children in Leeds and reduce the inequality gap.

Councillor Salma Arif
Executive Member for Public Health and Active Lifestyles

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Executive Summary

Leeds has an ambition to be the best city for children and young people to grow up in[1]. To achieve this Leeds aims to be a child friendly city that provides the best start in life[2]. There are a number of strategies in Leeds that help the city achieve these goals including the Best City Ambition, which has a key focus on children as well as improving the health of the poorest the fastest.

The aim of this Health Needs Assessment (HNA) is to provide a wide range of data that partners can use to build on when they are developing and leading other more focused and specific pieces of work. This HNA therefore provides a snapshot of information that describes life for children and families in Leeds in 2022. It has been developed in partnership with colleagues from across the city and brings together existing knowledge and data from a national, regional and local level into a single document. The structure of the document follows the life course of children, while retaining focus on key determinants of child health and key health factors. Throughout this structure there is an emphasis on children's voices, as well as a focus on the assets present in Leeds.

Presented below are the headlines from each of the chapters. These headlines provide extracts of information, some difficult to interpret in isolation, it is therefore recommended these are read in conjunction with further reading of each of the chapters. References for all information can be sourced within the main chapter.

Children and Young People Population Summary

- 194,280 children and young people aged 0-19 years in Leeds.
- 24% of the LSOAs in Leeds were in the 10% most deprived nationally, however 33% of Leeds school-aged pupils (43,210) children and young people live in the most 10% deprived areas.
- 30% of children are from Other White Background, Black African, Pakistani or British Pakistani, Indian or British Indian, Other Ethnic Background, Other Asian Background, Chinese, Other Black background, Mixed White and Black African, Other Mixed Background, Mixed White and Black Caribbean, Black Caribbean, Mixed White and Asian, Bangladeshi or British Bangladeshi, White Irish.
- 1,278 children looked after in Leeds.
- 4.5% of children under 18 have at least one long term condition.
- 13% of all pupils were reported as having Special Educational Needs support (2021).
- 19.8% of the Leeds population of 0-17-year-olds are estimated to live in households with **any one** of the 'toxic trio' (i.e., domestic violence or parental mental health or parental substance abuse).
- 1.2% (1,994 children) of the Leeds population of 0-17-year-olds estimated to live in households with **all three** of the 'toxic trio'.

Organisational assets in Leeds for Children

- There are 219 primary schools, 41 secondary schools, 3 through schools, 2 infant schools, 2 junior schools, 1 14-19 provision (provision starting in Key stage 4), 11 Special schools and 2 alternative provisions.

[1] Leeds Children and Young Peoples Plan 2018-2023
[2] Child Friendly Leeds | Leeds for Learning

- Ofsted judgements of schools demonstrate that the majority of schools in Leeds are judged either 'Good' (67%) or 'Outstanding' (16%). There were 11% of schools judged as 'Requires Improvement' and 6% 'Inadequate'.
- There are 28 colleges in Leeds.
- Leeds has four universities and one of the highest student populations in the UK with over around 70,000 students.

What are children telling us?

- Supporting children and young people with their mental health is **the top issue from the last three years –** identified as the biggest issues in manifestos written by children and young people and also in the Make Your Mark Ballot where 5546 young people in Leeds aged 11-18 voted.
- The 2022 Child Friendly Leeds 12 Wishes are developed from priorities identified from analysis of data collected from citywide elections, ballots, and consultation work over the last three years.
- The 12 wishes relate to: 1) mental health, 2) play, 3) having views heard, 4) being accepted, 5) protecting the environment, 6) travel, 7) better promotion of activities to do in the city, 8) reducing the impact of poverty, 9) getting support to make healthy decisions, 10) having learning settings to meet needs of children, 11) access to employment and training opportunities, 12) being an inclusive city for children with special educational needs and disabilities.

Life course

The First 1001 Days: Conception to age 2

- Pregnancy, birth and the first 2 years of a child's life - the first 1001 days - set the foundations for an individual's cognitive, emotional, and physical development.
- The infant mortality rate is used as a marker 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.
    - The infant mortality rate for Leeds between 2019-21 was 5.0 per 1,000 live births, compared to a national rate of 3.6 deaths per 1,000 live births in England and Wales in 2020.

Early Years (Age 2 to 5)

- Ages 2 to 5 years are a crucial period for children where they rapidly grow, learn and develop.
- Children growing up in Harehills (part of Gipton and Harehills Ward) have the poorest outcomes in Leeds in terms of communication and language at age 5 (27.1% not achieving expected speech and language outcomes compared to the Leeds average of 18.9%.).
- Notably these are also the areas with the lowest take-up of early education age 2. Research[3] demonstrates positive impacts of early education for this age group on social, cognitive and language development.

[3] About - PISA (oecd.org), reference sourced from Take-up of free early education entitlements (publishing.service.gov.uk)

- In Leeds the average take-up of funded early education (FEE) is 67% compared to an England rate of 68%. The areas with the lowest take up are Harehills (26%), Shepherds Lane (49%) and Chapeltown (54%).

Primary and Secondary Aged Children

- This is a wide age group in which children mature into young adults. It is during this time they learn skills that set the foundations of adult life.
- The issues facing children within these age groups are captured within other chapters of this document. In particular, the education and key health factors chapters.

Transition to Adulthood

- The transition to adulthood is a period of change for young people in which they generally leave school and begin to experience independence. Young people who are in care and with long term health conditions experience disproportionate levels of challenge during the transition to adulthood.
- Leeds is a university city, and there is therefore a larger population of 17-24-year-olds compared to other areas.
- In March 2022 in Leeds 7.8% of all 19-year-olds were either "Not in Education or Training" or their status was 'Not Known'. This compares to a national proportion of 5.5%.
- In 2019/20 51.1% of young people aged 19 in Leeds achieved Level 3 qualifications*[4]. This compares 57.4% nationally.

Key Determinants of Child Health

Child Poverty

- "Child poverty is not inevitable. ***In the past***, child poverty levels in the UK have been significantly lower than they are today and are currently lower in many comparable countries. Making sure every child gets a good start in life is the right thing to do and the smartest investment we can make as a country." Child Poverty Action Group, 2022
- 24.6% of children in Leeds are living in living in families in relative low income (2020/21). This is a 7.9% increase in the percentage of children under 16, in relative low-income families between 2014/15 and 2020/21 (16.7%, 24.6%). The gap between the Leeds and England rate continues to widen from 1.5% in 2014/15 to 6.1% in 2020/21.
- The Leeds child population is growing faster in the localities considered most deprived. Between 2012 and 2018 the overall Leeds population grew by 4% and the child population (aged 0-17) grew by 7%. However, in the 10% most deprived areas the child population grew by 13%, and in the 3% most deprived it grew by 17%.

Housing

- Where children live, the condition, location and stability of their accommodation has a wide-ranging impact on their early health and development[5].

*[4] A full level 3 qualification is equivalent to an advanced technical certificate or diploma, or 2 A levels
[5] Fuel poverty and human health: A review of recent evidence - ScienceDirect

- In Leeds there are very few families classified as homeless due to being in temporary accommodation (15 families at time of writing - April 2022).
- According to Leeds Housing Options:
    - 11,300 people living in families with dependent children are on the register seeking social housing.
    - 23% of **all** those on the social housing register have needs that have been assessed as urgent.

Education

- Education is vital and there are direct links between education and health, with schools playing an important role in the wider safeguarding system for children.
- According to the 2020-21 Leeds My Health My School Survey 83% of primary pupils and 63% of secondary pupils agreed that their school was a caring place.
- The majority of schools in Leeds are judged by Ofsted as either 'Good' (67%) or 'Outstanding' (16%). There were 11% of schools judged as 'Requires Improvement' and 6% 'Inadequate'.
- 42% of Leeds pupils achieve a strong pass in English and Maths GCSE (grade five of higher) in 2019, very slightly higher than the 2018 figure. The national figure for 2019 was 43% (Figure 52).

Transport

- There are clear and established links between transport and children and young people's health[6].
- Wish number 6 in the Child Friendly Leeds 12 wishes is that "children and young people can travel around the city safely and easily".
- An annual mode of transport to school survey is conducted in Leeds. Data from 2021-22 shows that for primary school children, walking is the most common mode of transport for primary (60.2%) and secondary (44.7%) school aged children. For those attending SEND schools, the school bus (51.1%) was the most common mode of transport followed by taxi (22.5%).

Ethnicity and Racism

- Racism and discrimination have a direct impact on children and communities' wellbeing. This is a form of trauma which we know increases risk for poor health and drives, in part, the structural inequalities which are also risk factors for poor health (poverty, poor housing etc)[7].
- Youthwatch produced a powerful video in 2020 describing children's experiences of being black in Leeds.
- In Leeds the school clusters with the highest proportion of Black and Ethnic Minority pupils are those with the highest levels of deprivation.

[6] Transport, health and wellbeing (publishing.service.gov.uk)
[7] How systemic racism affects young people in the UK | Barnardo's (barnardos.org.uk)

Play

- Play is a fundamental part of childhood which is essential for children's growth and development[8,9].
- Nationally:
    - 92% of children experienced negative impacts on their play due to the pandemic.
    - 22% of children in most deprived neighbourhoods were unhappy with the choice of things to do in their area, compared to 15% of children in the least deprived neighbourhoods.
- In Leeds:
    - 76.5% of children rated their play experiences positively.
    - Children who were allowed to play independently reported greater satisfaction with their play experience.
    - 70% of children in Pupil Referral Units (PRUs) and 50% of children in Specialist Inclusive Learning Centres (SILCs) did not play outside at all.
    - 20% of children say they don't have enough friends to play with.

Priority Groups

- According to estimated figures in 2019 produced by the Children's Commissioner, 19.8% of the Leeds population of 0-17 year-olds live in households with **any** of the so called 'toxic trio' (domestic abuse or mental ill health or substance misuse).
    - This is 33,580 children and young people in Leeds.
- According to estimated figures in 2019 produced by the Children's Commissioner, 1.2% of the Leeds population of 0-17 year-olds live in households with **all** of the so called 'toxic trio' (domestic abuse and mental ill health and substance misuse).
    - This is 1,994 children and young people in Leeds.
- Deprivation is a key factor for priority groups:
    - In March 2020 in Leeds 57.6% of children subject to a child protection plan lived in the most deprived 10% areas nationally (based on Index of Multiple deprivation).
    - The same pattern in seen in terms of the number of children looked after with 59% living in the most deprived decile.

Key Health Factors

Children's Healthy Weight

- In Leeds in 2021/22 9.9% of children in reception living with obesity.
    - This is below regional (11.0%) and national (10.1%) figures.
    - This is lower than 2020-21 (14.9%) and 2019-20 (10.1%) rates but in general remains an increase when compared with previous years
- In Leeds in 2021/22 25.1% of children in Year 6 were living with obesity
    - This is much higher compared to 20.8% (2019-20) and compared to 2021-22 regional (24.9%) and national (23.4%) rates

[8] Playing Out | Children's Commissioner for England (childrenscommissioner.gov.uk)
[9] The-power-of-play-for-childrens-positive-mental-health - Play Scotland Research Briefing May 2020

- Stark inequalities in children living with obesity levels exist across Leeds.
    - In 2020, 32.4% of 10-11-year-old children living in Gipton and Harehills were living with obesity, compared to 11% in Horsforth.
- Food insecurity is a growing problem both nationally and locally. In 2020/21 the number of people in Leeds accessing foodbanks increased by 47% compared to the previous year. This is important because food security impacts the ability to provide healthy food for children.

Mental Health and Emotional Wellbeing

- Nationally in 2021, one in six (17.4%) children aged 6 to 16 years were identified as having a probable mental health disorder, increasing from one in 9 (11.6%) in 2017. When modelled to the Leeds 6-16 year-old population, this equates to around 20,000 children.
- Nationally in 17-23-year-olds, 27% of young women and 13% of young men are likely to have a mental health disorder. When modelled to the Leeds 17-23 year-old population, this equates to 11,500 young women and 5,000 young men.
- The relationship between poor mental health and deprivation is clear. In Leeds, mental health service use, crisis service use and drop-out rates are higher for young people from deprived areas.
- In Leeds there are wide inequalities in self-reported (via My Health My School Survey) emotional wellbeing, with girls, those eligible for Free School Meals and those identifying as LGBTQ+ reporting poorer emotional wellbeing[10].
- In Leeds children and young people from Minority Ethnic communities experience inequalities in terms of access to mental health support.

Alcohol, Smoking and Drugs

- Self-reporting of drug and alcohol use by children shows usage has dropped over the past few years both nationally and in Leeds
- However national level data demonstrates that the proportion of pupils classified as current e-cigarette users has increased from 6% in 2018, to 9% in 2021. Usage increases with age from 1% of 11 year-olds, to 11% of 14 year-olds and 18% of 15 year-olds[11].
- According to the 2019/20 My Health My Schools Survey in Leeds 26% of pupils felt they needed better information or were unsure if they needed better information on learning material in school on smoking, 27% on alcohol and 27% on drugs.

Oral Health

- Tooth decay is the most common reason for hospital admissions in the 6-10 year-old age group.
- Dental health is worse in Leeds than England with more than a quarter (26%) of Leeds 5-year-olds having experienced dental decay compared to 24% in England in 2018/2019. The severity of dental decay in children in Leeds is the same as that of Yorkshire and Humber but higher than the England average.

[10] To note, this analysis was not assessed for statistical significance, however the patterns demonstrate reflect national research.

[11] Part 4: Electronic cigarette use (vaping) - NHS Digital

- In 2018/19 63% of secondary school pupils eligible for a Free School Meal (FSM) were brushing their teeth twice daily or more, compared with 75% who are not eligible for FSM's. Rates of teeth brushing are higher in secondary than primary school children in Leeds.
- COVID-19 has had a significant impact on dental access for children and young people, however this is now starting to improve.

Sexual and Reproductive Health

- The teenage pregnancy rate is declining at a national, regional and local level. However the Leeds rate in 2020 (20 girls aged under 18 conceived, for every 1,000 girls) is higher than the national (13.0 per 1000) and regional rate (16.5 per 1000).
- According to My Health My School Survey data over the last 10 years progressively fewer year 11 pupils have ever had sexual intercourse. However of those who have had sex, there is an increasing proportion not using any form of contraception.
- When comparing experiences of pupils with differing sexualities in year 11 pupils in 2020-21 in Leeds, those identifying as gay/lesbian are most likely to self report via the My Health My School Survey that they have hurt themselves on purpose (70%) and are also most likely to feel unsafe or very unsafe at home (10%).

Health Protection

- Children will be disproportionately impacted by climate change and our actions now. Leeds reduction in carbon emissions since 2005 is slightly below average when compared to the other UK core cities.
- Leeds vaccination rates for children have declined more than national figures since the start of the COVID-19 pandemic.
- Yorkshire and the Humber has the highest regional rates of lead exposure in children (2015-2020).

List of Figures

Acknowledgements

This HNA has been conducted with the help of a wide range of individuals working in Leeds. This section acknowledges those that have had major input to the document, however there are countless others whose work has contributed either directly or indirectly to this Health Needs Assessment and without whom the report would not have been possible. Therefore, the first thanks are to all those working with children and families in Leeds.

The second acknowledgement is to the steering group. The steering group have provided a discussion forum within which the contents and focus of the Health Needs Assessment were decided collectively. As well as this they have reviewed drafts and sense checked the document. The members of the steering group are listed in Appendix 1.

Thirdly this report was co-authored by various professionals. A detailed list of the co-authors and contributors to each section is provided in Appendix 2.

Finally, thanks to the Children and Families Public Health Team at Leeds City Council, led by Kathryn Ingold for hosting and supporting the production of this Health Needs Assessment.

1. Introduction

1.1. Purpose

A health needs assessment (HNA) is an integral step in planning services. It creates an evidence base to understand the health needs of the population and therefore enables consideration of the distribution of health and care resources to bring the greatest benefit.

In this HNA health is defined broadly using the definition described in the World Health Organisation (WHO) constitution[12]:

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Health is therefore considered a positive concept comprising of personal and social resources, as well as a person's subjective and objective capabilities.

With this definition in mind, this HNA aims to provide a broad and reliable source of data and analysis related to the health of children and families in Leeds. It aims to create a broad understanding of need for children and families in Leeds and identify areas that require further analysis. Whilst this HNA describes need it also documents assets to promote strengths on which we can build. The scope of the HNA was shaped by partners and intelligence about what is important to children in Leeds, provided by the Leeds Voice and Influence Team.

This health needs assessment aims to lead to identification of gaps in understanding and to influence key strategies and partnerships, including the refreshed Children and Young People's Plan, The Children and Young People's Partnership and the Children's Population Board.

1.2. Context

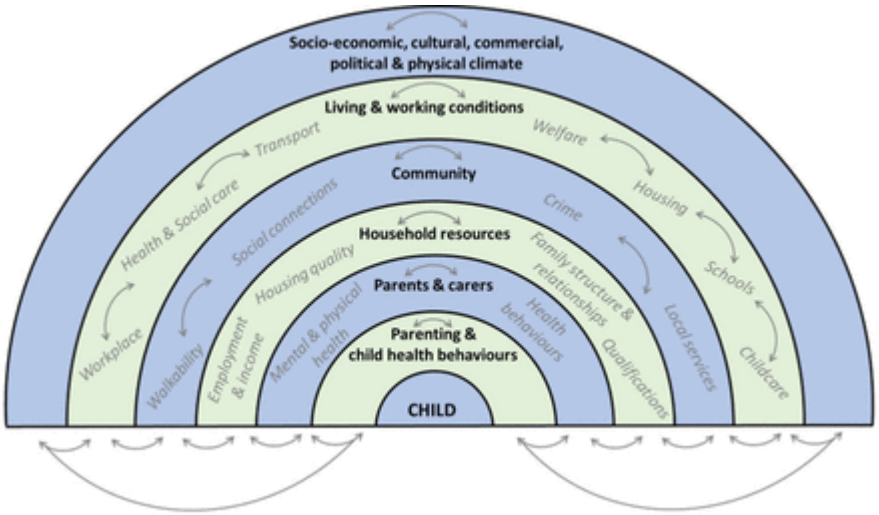
The Children and Young People's Plan states the ambition for Leeds to be the best city for children and young people to grow up in. To achieve this Leeds has a coordinated ambition to be a child friendly city that provides the best start in life. This is worked towards through children being a key priority in the health and wellbeing strand of the Leeds City Ambition. Partners in Leeds have demonstrated a strategic and practical commitment to invest in children. The Heckman curve[13] shows us that the highest rate of economic returns comes from the earliest investments in the life course and supports our focus on investment in children to build an increasingly successful city.

Our ambition is to improve the health of the poorest children the fastest[14]. To do this Leeds has a relentless focus on identifying and addressing health inequality. This HNA evidences the health impact of the broader determinants of health which often have a disproportionate impact, depending on the relative deprivation or affluence of the community children live in. The social determinants of health for children are represented in the 'rainbow' which is derived from Bronfenbrenner's Ecological systems theory of development and social model of health by Dahlgren and Whitehead (Figure 1). The child or young person lies at the centre of this model, having fixed

[12] Constitution of the World Health Organization (who.int)
[13] The Heckman Curve - The Heckman Equation
[14] Best City Ambition (leeds.gov.uk)

characteristics such as age, sex, and ethnicity. Surrounding the child there are concentric layers of influence or social determinants that are potentially modifiable.

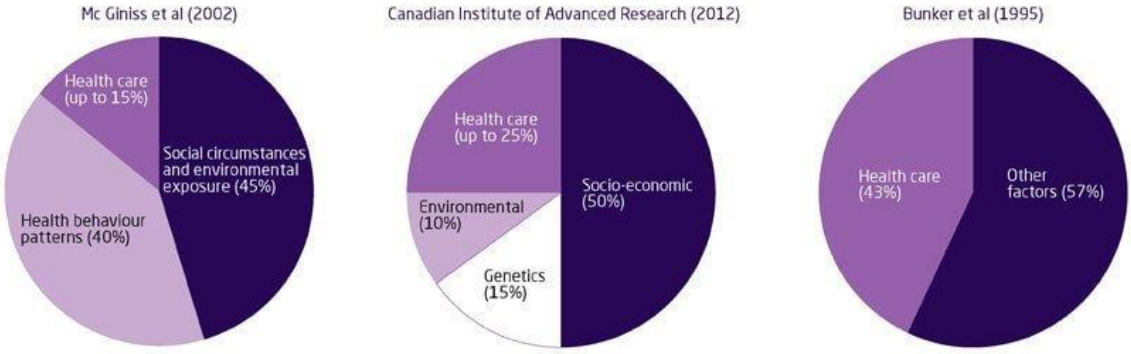
Figure 1 – The social determinants of health for children



Source: Dahlgren & Whitehead (2007); Bronfenbrenner (1979)

Several studies have attempted to quantify the impact of the wider determinants on health, with estimates ranging from 57% - 85% (Figure 2). This highlights the importance of the consideration of these factors in assessing people's health and for people to have a broad view of health to appropriately drive improvement.

Figure 2 -- Broader determinants of health



Source: Broader determinants of health | The King's Fund (kingsfund.org.uk)

This HNA was conducted between September 2021 and October 2022. At the time of writing the UK is emerging from the COVID-19 pandemic, with associated uncertainty of its impact in the medium and long term. This makes it a challenging time to appropriately highlight health trends due to patchy availability of up-to-date data and areas where the data is yet to show the true effects of the COVID-19 pandemic. Therefore, throughout this report we have highlighted areas where there should be further lines of inquiry over the coming months. However, what is already clear and has

been highlighted by the Joint Strategic Assessment (JSA) is that COVID-19 has not impacted all populations equally. The Leeds JSA "is an assessment of the current and future health and social care needs of the people of Leeds. It is the responsibility of the Health and Wellbeing Board and its purpose is to inform and guide the planning and commissioning of health, well-being and social care services enabling them to plan for the future" (Leeds JSA, 2021). Further to this the recently published document 'Build Back Fairer: The COVID-19 Marmot Review' highlighted that it is imperative that we do not allow a return to the status quo but instead strive to use the circumstances created because of and in response to the COVID-19 pandemic as an opportunity to address the stagnation of health improvement that we have seen over the past decade. The review highlights an urgent need to do things differently to reduce health inequalities and rebuild a society based on the principles of social justice and proportionate universalism[15]*.

[15] *Proportionate universalism = "the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need" – Public Health Scotland, 2014

2. Methods

This HNA aims to tell the story of life in Leeds for children and families. It has been developed in partnership with colleagues from across Leeds and the chosen areas of focus were guided by the HNA steering group (Appendix 1). The structure below has been used for the report. Throughout this structure there is a focus on children's voices, as well as a focus on the assets present in Leeds.

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    - Sexual and Reproductive Health
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Children's voices have been at the centre of this work through close engagement with the Voice and Influence Team at Leeds City Council and utilisation of analysis of My Health My School Pupil survey data. No primary research was carried out when writing this HNA but existing knowledge about what children in Leeds are experiencing was collated, synthesised and was central in directing the focus of the HNA.

The document is underpinned by robust national and local data sets and the data sources used are clearly indicated within the chapters as well as in Chapter 1 - Data sources. Where possible and relevant, data has been disaggregated to draw comparisons between population groups. Additionally, to enable contextualisation of results, comparisons have been drawn between regional and national data where possible.

Each chapter is co-authored by the lead author (Kerry Badger), under the supervision of a Consultant in Public Health (Kathryn Ingold) and supported by the Head of Service for Children and Families Public Health and Advanced Health Improvement Specialists, members of the steering group and other relevant colleagues. Following this a final draft of the HNA was shared with key partners including the Children and Families Public Health team, the HNA steering group and the Children's Population Board for comment, addition, or correction. This process enabled sense checking of data interpretations and drew together expertise to identify and explain trends.

In addition to the steering group role in identifying areas of focus for the HNA and reviewing chapters where appropriate, to individuals' areas of expertise, their input has been vital in creating the narrative of this document and ensuring it appropriately matches their experiences of working with children and families in Leeds.

This HNA will be presented to the Children's Population Board, the Children and Young People's Partnership, Future in Mind Board, and Want to Know More Sessions between November 2022 and March 2023 and will be available online at the Leeds Observatory. It will also be published online on the Leeds Observatory website.

3. Children and Young People Population Summary

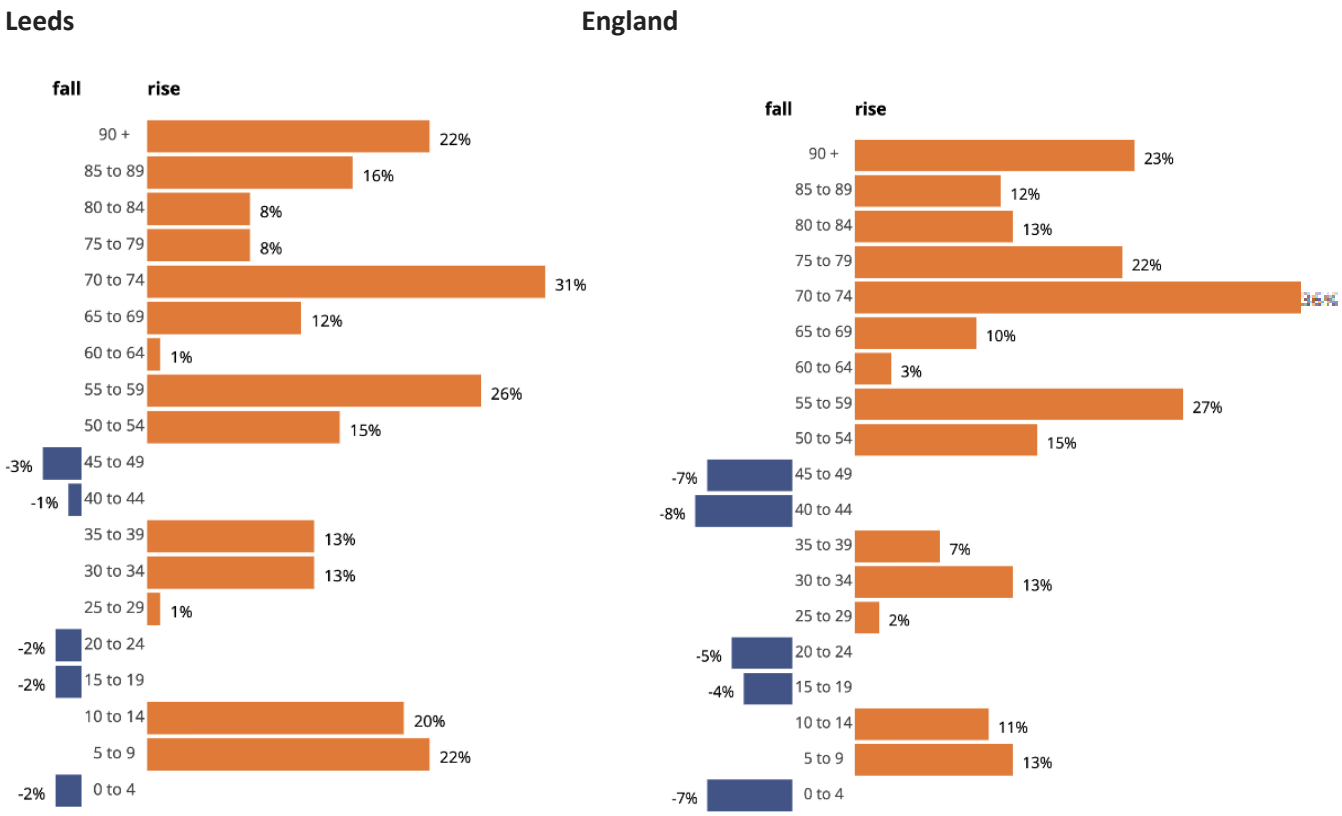
2021 Census Data

Full 2021 Census data will be released in October 2022. Initial results are summarised in this section.

Leeds is the second largest local authority out of a total of 309. According to the 2021 census there are 812 000 people in Leeds, which is an 8.1% increase, from around 751,500 in 2011. This is higher than the overall increase for England of 6.6%.

When reviewing this for the under 19 age group there have similarly been increases in Leeds above the England average (Figure 3). In particular there has been growth in the 5-14-year-old age ranges.

Figure 3 - Population change (%) by age group in Leeds and England, 2011 to 2021



Source: Census 2021

ONS Mid-Year Estimates Data

There are currently approximately 194,280 children and young people aged 0-19 years in Leeds (ONS mid-year estimate 2020). Of the core cities in England, Leeds has the seconds largest number of residents aged 0-19 behind Birmingham. This is around a quarter of Leeds residents, slightly above the rate in England (23.6%), and mid pack among core cities.

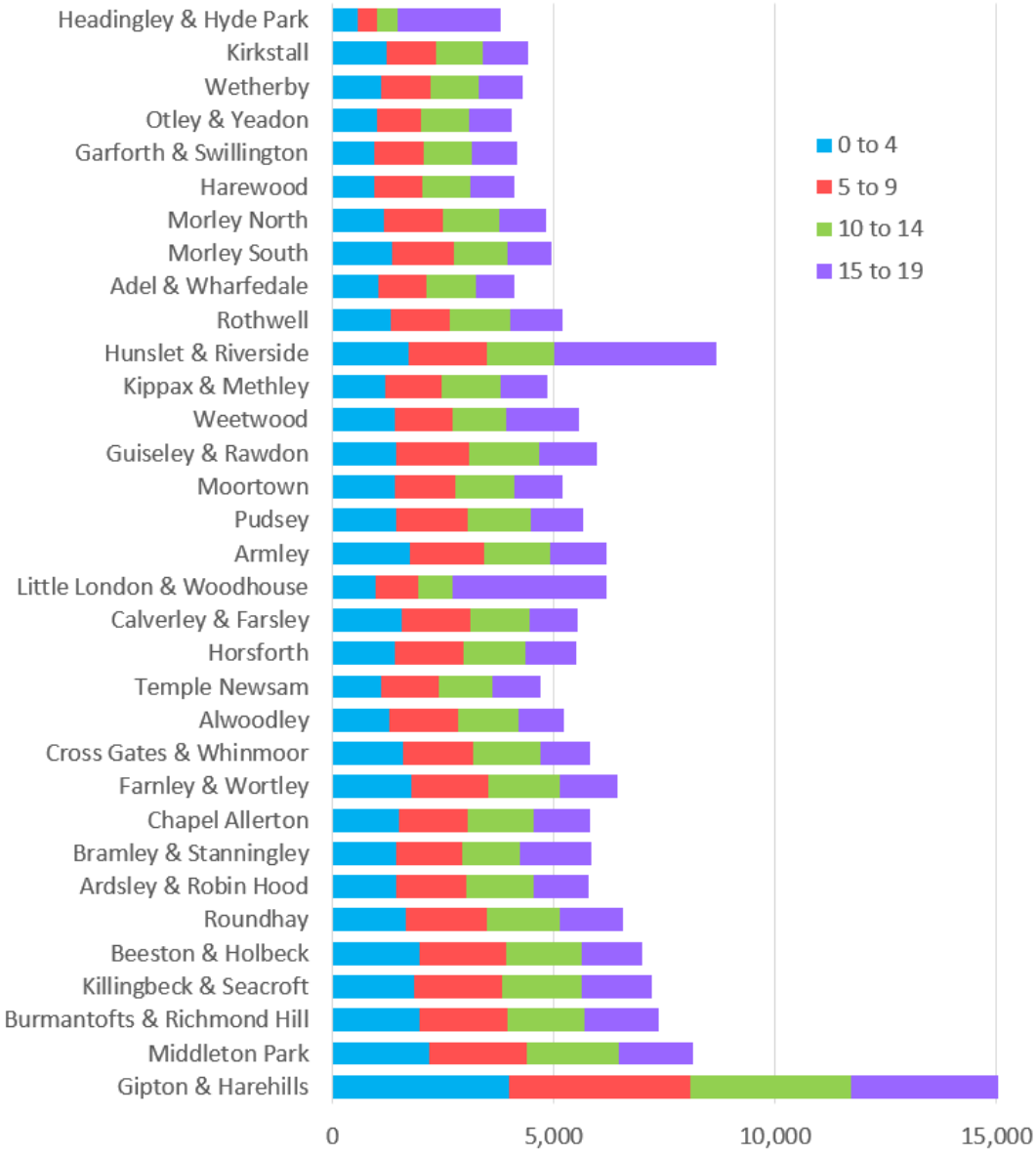
The Children and Young People (CYP) population of Leeds increased by 9% between 2010 and 2020 (ONS mid-year estimates). This growth is expected to slow as an overall change to 2.9% between 2021 and 2030 (ONS population projections). However, the 15-19-year-old age group is the only group expected to increase and that projection is for it to grow by 19.6%.

Geography

The child population in Leeds is not “uniformly distributed” at ward level it can be seen that CYP make up a much larger proportion of the population in certain parts of the city (Figure 4).

The highest proportions of CYP are found in 'Gipton and Harehills' (36.1%) and 'Middleton Park' (29.5%). In total in Leeds there are 8 wards where greater than 25% of the population are CYP. Note that the 0-19 age band excludes the student ages and 'Headingly & Hyde Park' ward for example has the lowest rate (12.0%) of CYP in Leeds. Further detailed information available on the Leeds demographic dashboard.

Figure 4 - The number of CYP in each Leeds ward, showing 5-year age bands.



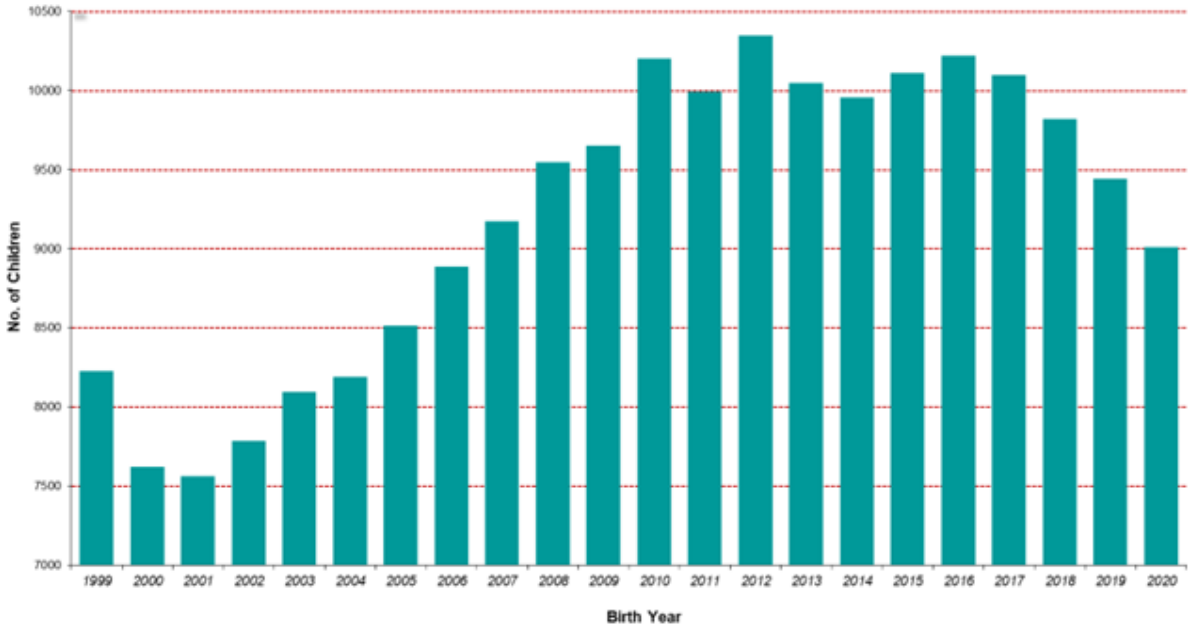
Note: Wards are ordered by the overall proportion of CYP in the wards, with Gipton and Harehills having the highest proportion.

Source: Source: GP recorded data, data available via the following tool.

Birth Rate

The Leeds birth rate increased rapidly from the early 2000s and plateaued at around 10,000 per annum for eight years until 2016. However, the number of births has now fallen consecutively for four years and was 12% lower than 2016 in 2020[3] as shown in Figure 5.

Figure 5 - Births within Leeds boundary between 1999 and 2020



Source: NHS Health Leeds / Wakefield / Bradford, contains data within the Leeds boundary only (2021)

Figure used with permission from Leeds Joint Strategic Assessment 2021

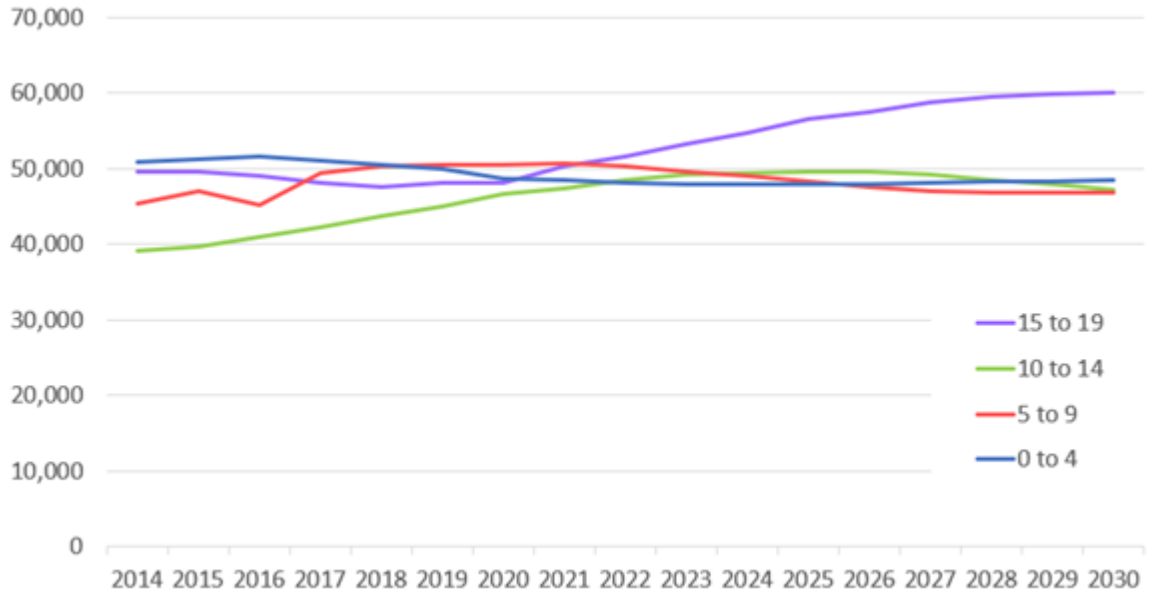
A third of births are to people residing in deprived areas of Leeds. In Leeds, the majority of ethnic minority groups are over-represented in deprived areas of Leeds – with almost 80% of babies born to mothers of Bangladeshi ethnicity and approximately 70% of babies born to mothers of African ethnicity born in deprived areas of Leeds[4].

Since 2009 there has also been an increase in the proportion of births to ethnic minority and non-British born people. For example, between 2007 and 2017 births to non-British born people in Leeds rose from 1,847 to 2,738[5].

Age distribution

Although the CYP population has been increasing, that rate is expected to slow overall with just the 15-19 age band showing large growth for the next few years before tailing off into 2030. Figure 6 shows ONS mid-year estimates from 2014 to 2020 and then ONS population projections from 2021 to 2030. The slow reduction in all age groups except 15-19 can be seen.

Figure 6 - ONS Mid-Year Estimates from 2014-2020 and ONS population projections from 2021 to 2030

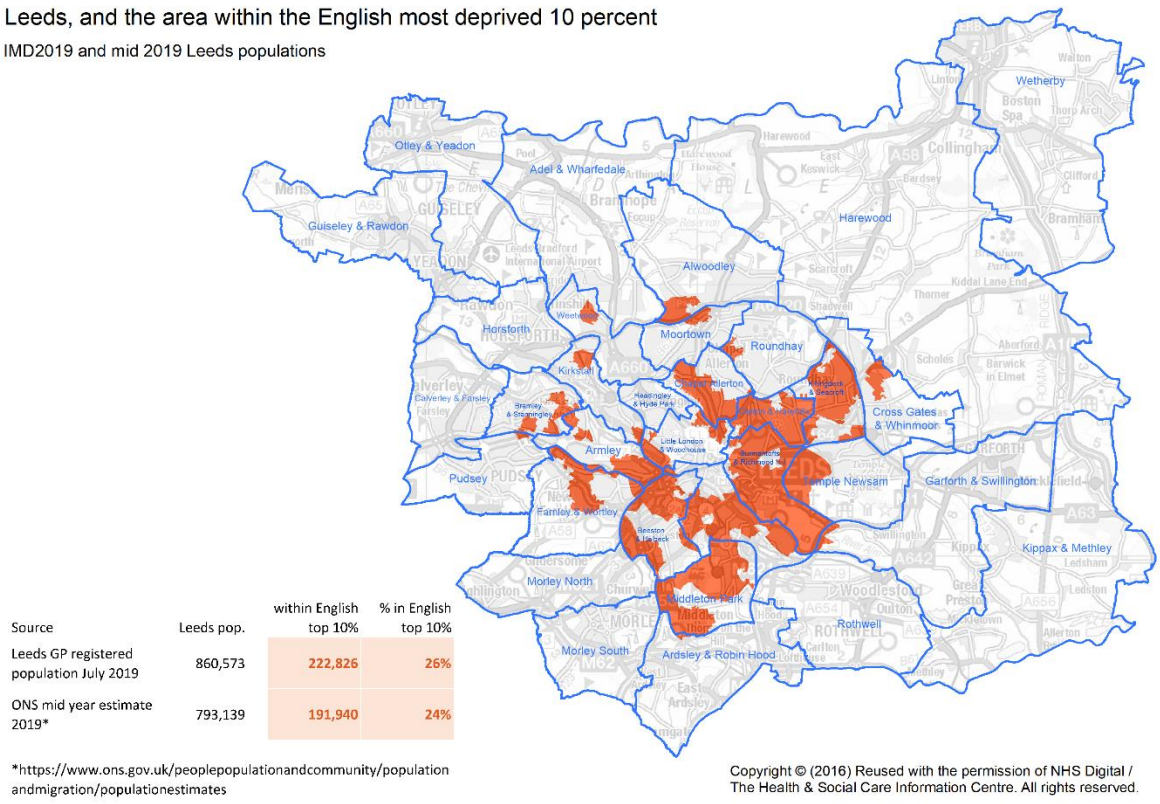


Source: ONS Population Estimates by Local Authority and ONS Population Projections by Local Authority

Overall Levels of Deprivation

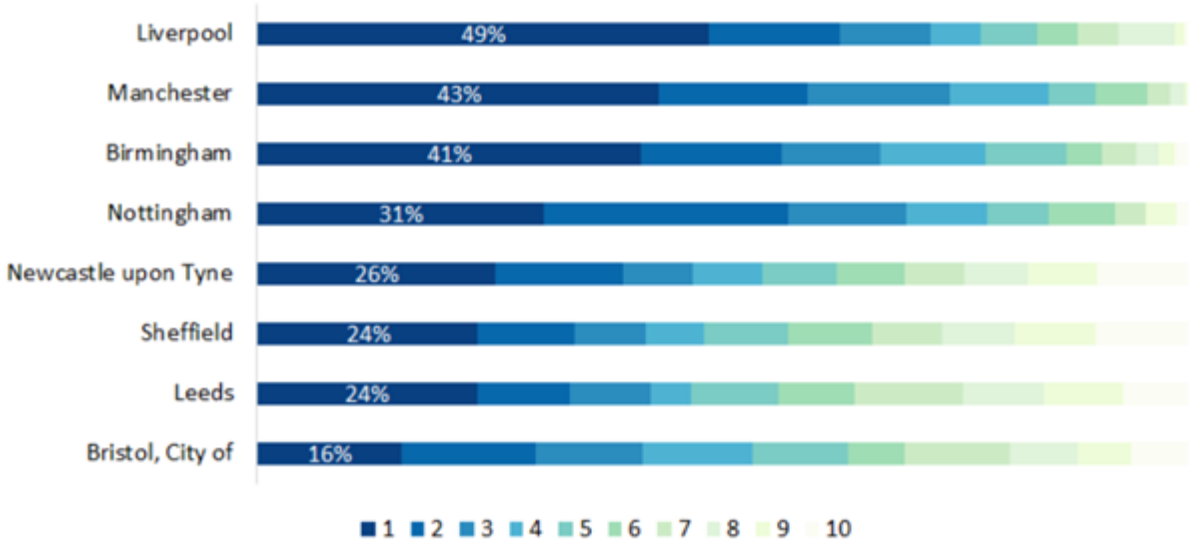
Deprivation varies across the city. This is demonstrated in this linked interactive map of the Index of Multiple Deprivation (2019). 24% of Leeds Lower layer Super Output Areas (LSOAs)[6]* are in the most deprived 10% nationally (Figure 7).

Figure 7 - Leeds and the areas in the English most deprived 10%



Leeds ranks 33 out of 317 local authorities on the proportion of LSOAs in the most deprived 10% nationally[7]. When compared to core cities based on the proportion of LSOAs in the most deprived 10% nationally Leeds ranks joint sixth out of the eight English core cities (Figure 8).

Figure 8 - Proportion of Core City LSOAs by IMD 2019 decile

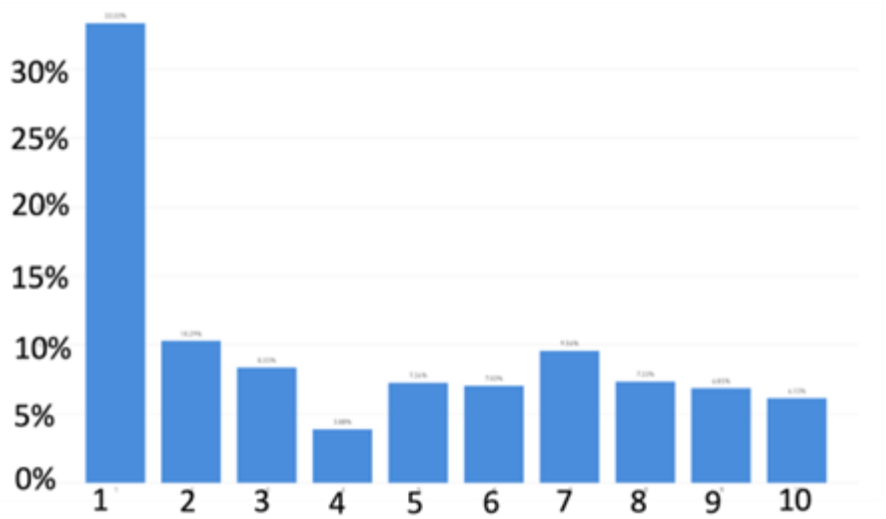


Source: [Leeds Index of Multiple Deprivation (IMD) 2019 (arcgis.com)]

However, based on the number of LSOAs in the most deprived 10% nationally Leeds ranks fourth out of the eight English core cities[8]. So, although a smaller proportion of LSOAs in Leeds are affected by higher levels of deprivation, the number of LSOAs is high. This is in part due to the diversity of the city, with its boundary encompassing a larger rural hinterland than most other core cities whose boundaries are more closely drawn around their urban core, as well as an urban core with high concentrations of deprivation[9].

Generally, the greatest proportion of 0-19-year-olds live in IMD Decile 1. School census data from 2022 shows that whilst 24% of the LSOAs in Leeds were in the 10% most deprived nationally, this equates to 33% of Leeds school-aged pupils or 43,210 children and young people (Figure 9). Decile 1 alone therefore contains more than three times the percentage in any other decile. There are very similar proportions of Primary and Secondary pupils living in the 10% most deprived communities, though numerically there are more primary aged pupils (23,524) than secondary (16,002).

Figure 9 - Proportion of Leeds pupils by Index of Multiple Deprivation Decile (1 is most deprived; 10 is least deprived)



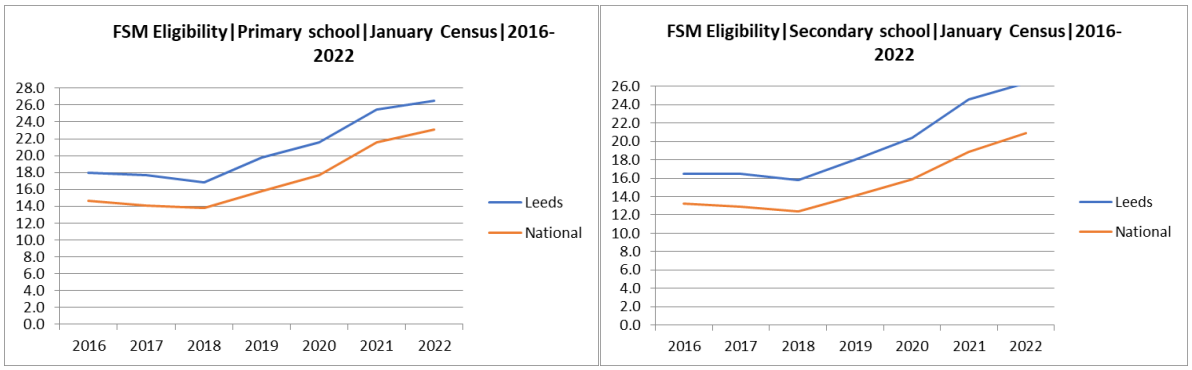
Source: Office for National Statistics/Leeds January School Census 2021

Free school meal (FSM) eligibility is often used as a key deprivation indicator. Children in state-funded schools in England are entitled to receive free school meals if a parent or carer are in receipt of certain benefits. Children in nursery schools are eligible if they meet the criteria and attend for full days. Pupils are still eligible for free school meals in school in sixth form, but not sixth form college or further education. In Leeds, there were 29,350 pupils of statutory school age eligible for FSM in the January Census 2021. In 2022 this increased to 31,393 (27%). By stage of education there were 18,779 primary-age pupils (27%) and 12,614 secondary pupils (27%) eligible for FSM. There is a higher rate of eligibility within special establishments and alternative provision. Please note that despite the way it sounds, FSM eligibility refers to the number of children that have actually claimed free school meals in the past, not just the number that are eligible to claim.

As Figure 10 shows, the proportion of those children and young people who are FSM eligible in Leeds follows a similar trajectory to national FSM eligibility and had been steadily decreasing since

2013, however as stated above the eligibility criteria has now changed. Leeds still has a higher proportion of children and young people who are eligible for FSM compared to national (England only).

Figure 10 - Percentage of primary and secondary phase pupils eligible for free school meals, Leeds v National



Source: January school census 2022

Ethnicity

Data categorising children's ethnic group are available from GP records. The overall counts of CYP vary between GP records and ONS data, and data on ethnicity from the Census is now almost ten years old (although data from the 2021 census will be released between October – December 2022). GP data is very recent (October 2021) and has been used here.

Rates of children categorised as ethnic minorities vary according to the methods used to create category and the level of ethnicity categorisation used. We have classed the following ethnic groups as 'ethnic minority' which give an overall average ethnic minority rate for children and young people in Leeds of 30%:

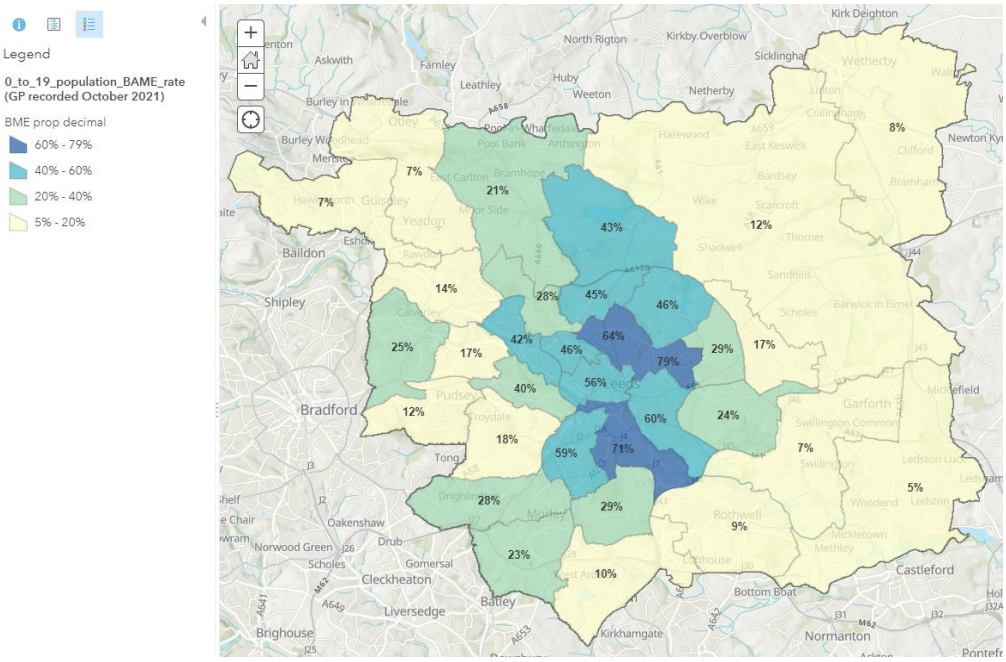
> Other White Background, Black African, Pakistani or British Pakistani, Indian or British Indian, Other Ethnic Background, Other Asian Background, Chinese, Other Black background, Mixed White and Black African, Other Mixed Background, Mixed White and Black Caribbean, Black Caribbean, Mixed White and Asian, Bangladeshi or British Bangladeshi, White Irish.

These groups are classed as "not ethnic minority":

> White British, Unknown ethnicity.

Ethnic minority rates within the 0-19-year-old population vary greatly at ward level in Leeds, from 79% in Gipton & Harehills to 5% in Kippax & Methley (Figure 11). There is a positive correlation between higher ethnic minority rates and deprivation in the 0-19 population of Leeds. This can be seen when comparing Figure 11 below to the linked deprivation interactive map.

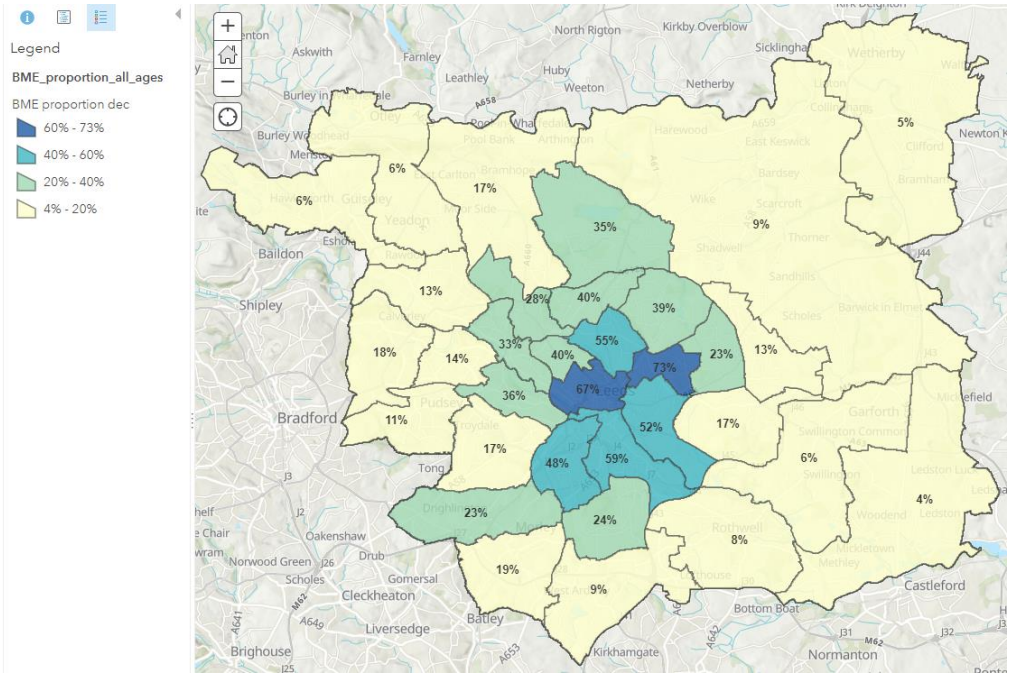
Figure 11 - Ethnic minority (referred to as BAME within chart) proportions at ward level in 0-19 age range.



Source: GP recorded data October 2021

Ethnic minority rates in Leeds for all ages (i.e., including the adult population) are generally lower but the overall pattern is very similar with higher ethnic minority rates in more central parts of the city.

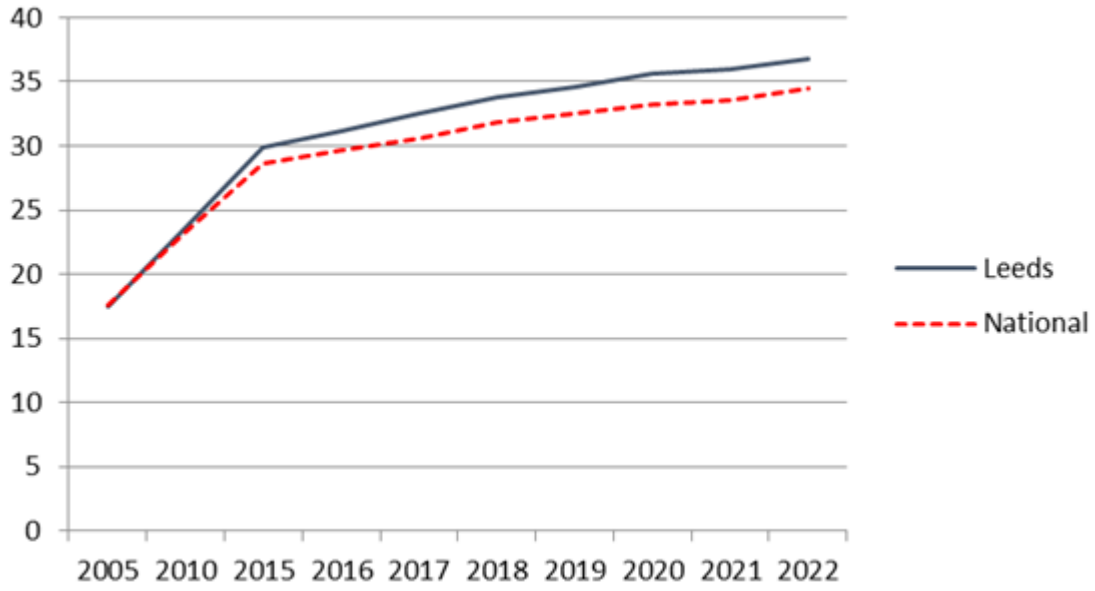
Figure 12 - Ethnic minority (referred to as BAME within chart) proportions at ward level in all ages.



Source: GP recorded data October 2021

While the school census only refers to children of school age (Nursery to Year 14) and only to children within schools in Leeds this data is collected annually and so provides insight into trends in the proportion of ethnic minority pupils in Leeds. As shown in Figure 13 according to the school census data the proportion of ethnic minority groups in Leeds continues to increase and this pattern is relatively consistent with national trends. There remains a slightly higher proportion of ethnic minority pupils in primary school (37.6%) compared to secondary schools (35.1%).

Figure 13 - Percentage of ethnic minority groups, Leeds v National, 2005, 2010, and 2015 - 2022.



Source: January school census 2022

Note: Due to significant changes to some categories since 2005, some caution should be used with some of the following comparisons.

According to this school census data the proportion of the total Leeds school population from ethnic minority backgrounds has doubled since 2005 (from 17.4% to 36.7%). The primary school stage has seen steady increases in Asian, Black, and Mixed ethnicities. White Other grew steadily until 2020 but has since decreased. In secondary school stages there were steady increases across all high-level groupings, with White Other having plateaued since 2020.

Gypsy, Roma, and Traveller Children

Children from Gypsy, Roma and Traveller communities experience poorer health outcomes compared to the rest of the population. Determining the size of the population in Leeds is challenging, due to nomadic lifestyles, lack of monitoring and some community members choosing not to disclose their ethnicity due to discrimination faced. Leeds GATE is the major third sector organisation supporting Gypsy, Roma, and Traveller communities in Leeds. Leeds GATE estimate there are 3,000 Gypsies and Travellers in Leeds, but the proportion of which are children is not stated.

According to school census data in 2022 there are 925 children in the Gypsy/Roma ethnicity group, which is a 11% decrease compared with 2021. However, this group have experienced significant growth since 2015 where there were 763 recorded on the school census. This figure is likely to

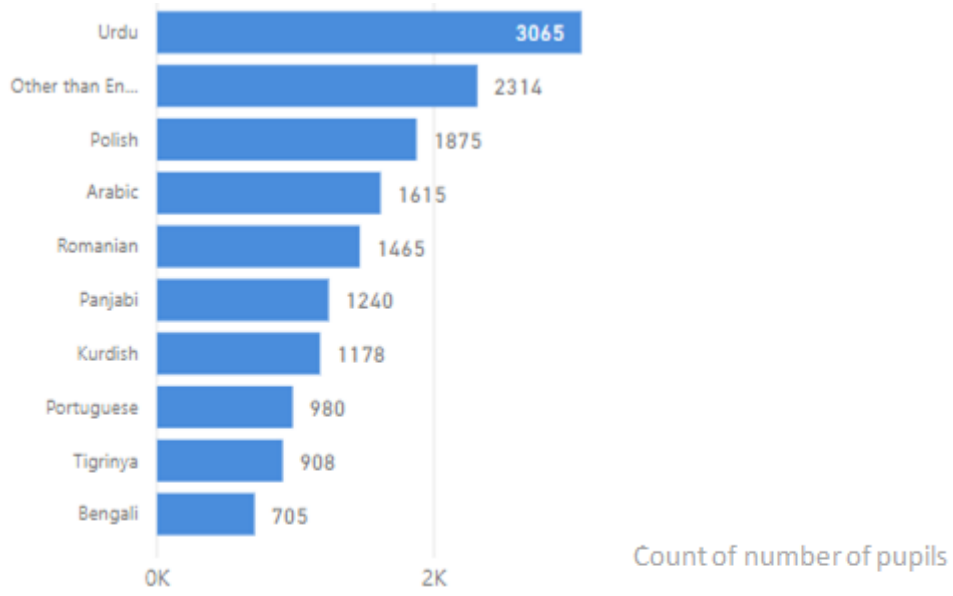
underrepresent the true number in Leeds as it only represents the number of children within the education system and Gypsy and Roma children are less likely to engage in education than any other group.

In 2019 a Health Needs Assessment was produced for the Gypsy Roma Traveller population in Leeds. This highlighted two main findings: 1) the important role of the wider determinants of health including financial exclusion, and prejudice and discrimination for this group 2) the need to increase opportunities for healthy living for this group for example through community development approaches.

Language

The most spoken language other than English by pupils in Leeds is Urdu (Figure 14).

Figure 14 - Top 10 Languages other than English spoken by pupils in Leeds



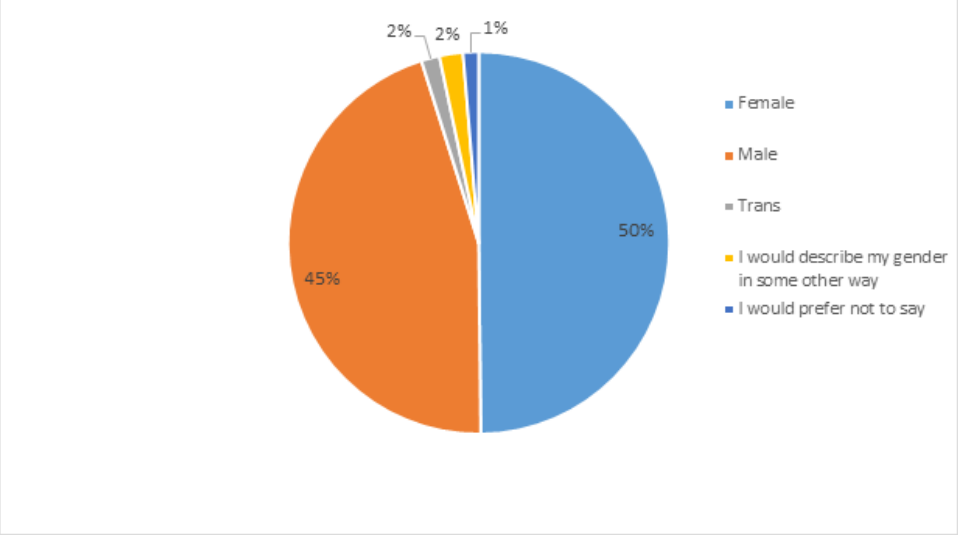
Source: School Census 2022

Gender

2022 School census data states that across all year groups 48.8% of pupils are female and 51.2% are male. However, this likely more accurately reflects sex. The My Health My School Survey asks year 9 and year 11 pupils only to self-report their gender. In 2020-21 50% of respondents were female, 45% were female, 2% were trans, 2% would describe their gender in some other way (which notably would include non-binary) and 1% preferred not to say (Figure 15).

However, we must be cautious with this data as children are self-reporting their identity while at school and as such there may be some who incorrectly fill out their forms.

Figure 15 - Gender of Year 9 and Year 11 School Pupils

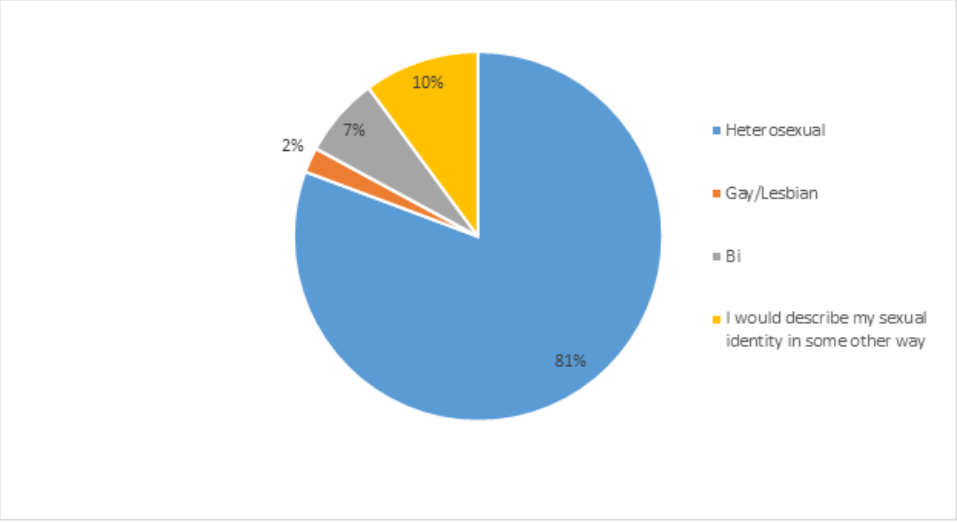


Source: My Health My School Survey 2020-21

Sexual Identity

The My Health My Schools Survey asks pupils to self-report their sexuality. According to this data 81% of year 9 and year 11 pupils are heterosexual, with 19% of pupils being either gay/lesbian, bisexual or 'would describe their sexual identity in some other way' (Figure 16).

Figure 16 - Sexual Identity of Year 9 and Year 11 Leeds School Pupils



Source: My Health My School Survey 2020-21

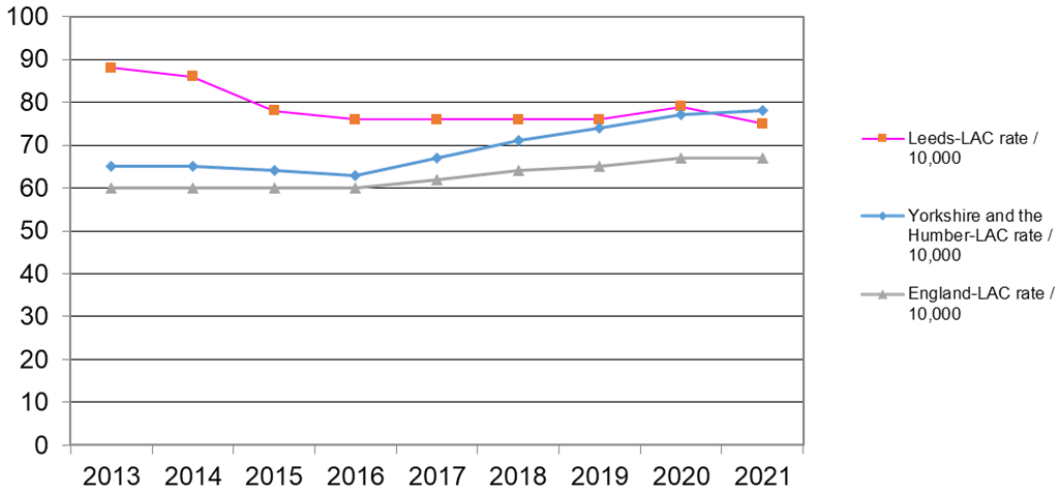
Children looked after

See Priority Groups Chapter for more detailed information.

In 2021 in Leeds there were 1,278 children looked after in Leeds (75 per 100,000). This includes all children being looked after by a local authority; those subject to a care order under section 31 of the Children Act 1989; and those looked after on a voluntary basis through an agreement with their parents under section 20 of that Act. Between 2011 and 2021 there was an 11% reduction in the

number of children looked after in Leeds (Figure 17). Across the same period the number of children looked after in England rose by 22%. In 2021, 49 of these children were unaccompanied Asylum Seekers.

Figure 17 - Looked After Children (LAC) rate/10,000 in Leeds, Yorkshire and the Humber, and England



Source: Office for Health Improvements and Disparities, Fingertips, Public Health Data

Children in Need (CIN)

Under Section 17 Children Act 1989, a child will be considered 'in need' if:

- they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the local authority.
- their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the local authority.
- they have a disability.

In Leeds there were 8,544 children in need during the financial year 2020/21, a decrease since the previous period when there were 8,680 such children. 3,866 children started an episode of need during the period and 3,416 ended an episode[16]. There were 5,128 children in need at 31 March for the financial year 2020/21, a rate of 300.6 per 10,000 children. This compares to the current rate for All English metropolitan boroughs 376.9 per 10,000 children[17].

Within 2019/20 most children in need were aged 16 years plus (31.4%), with 27.1% being aged 10-15 years, whilst the lowest number were aged one year or below (4.3%)[18].

Children with Long Term Conditions

Many long-term conditions develop in childhood.

[16] Children in Need and Care in Leeds | LG Inform (local.gov.uk)
[17] Children in Need and Care in Leeds | LG Inform (local.gov.uk)
[18] Leeds Safeguarding Children Partnership | Annual report (leedsscp.org.uk)

Using data from the national NHS England and NHS Improvement (NHS E&I) Population and Person Insight (PAPI) dashboard in Leeds in June 2021, 4.5% of those under 18 have at least one long term condition. Of these, 91.9% have just one long term condition. Data on individual long-term conditions are available from the Leeds data model which draws on data from GP systems. This data can be used to estimate prevalence of various long-term conditions however they may underestimate the true prevalence of some conditions as it relies on a diagnosis being made and recorded by a GP. The data also enables the analysis of differences in prevalence by ethnicity and deprivation however it should be noted that ethnicity data in GP systems are often incomplete, and conclusions are therefore interpreted with caution.

3.1.1. Asthma

Asthma is the most common long-term condition suffered by children. The UK has one of the highest asthma death rates for 10-24-year-olds in Europe[19] and asthma is among the top reasons for emergency admission to hospital in the UK for children. Importantly, many of these admissions and mortality associated with asthma is largely avoidable with improved asthma management. Further, in 2015 the most deprived children in England (aged 5-14) were 2.5 times more likely to have an emergency asthma admission compared to their least deprived counterparts[20]. This is perhaps related to children living in deprived areas being more likely to be exposed to high levels of tobacco smoke and air pollution. The rate of emergency hospital admissions for asthma and the estimated prevalence are shown below.

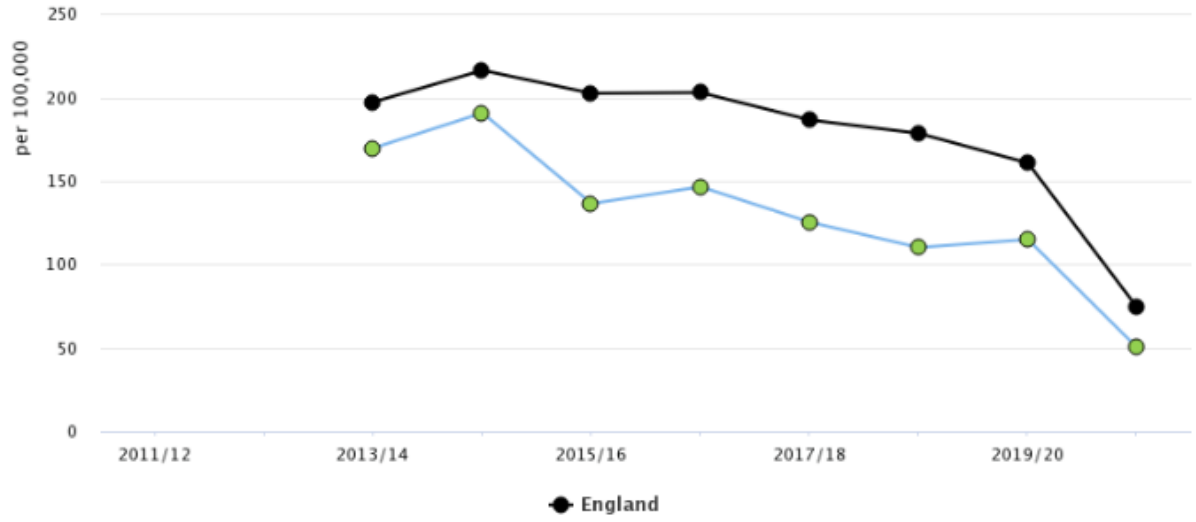
Figure 18 shows that emergency admissions for asthma in Leeds are consistently below the national average and have been falling in recent years. Data from the Leeds data model show that 11,627 children and young people aged up to 19 have a diagnosis of asthma, giving a prevalence of 55.63 cases per 1,000 population. There is no strong relationship between prevalence of asthma and deprivation (as measured by IMD). No data on the effect of deprivation on emergency admissions for asthma in Leeds were identified.

Analysis of prevalence of asthma by ethnicity shows that there is variation in prevalence between ethnic groups. The lowest prevalence is amongst those whose ethnicity is recorded as Chinese and Other at 29.00 per 1,000. Children and young people from a Black background also had a lower-than-average prevalence of asthma at 41.69 per 1,000. The highest prevalence of asthma was for those from an Asian background with a prevalence of 66.30 per 1,000. It should be noted that these differences are not necessarily statistically significant as no testing was carried out.

[19] Asthma – RCPCH – State of Child Health

[20] Admissions of inequality: emergency hospital use for children and young people | The Nuffield Trust

Figure 18 - Hospital admissions for asthma (under 19 years) for Leeds compared to England



Source: Office for Health Improvement and Disparities, Fingertips Child and Maternal Health Data

3.1.2. Diabetes

The prevalence of diabetes among children and young people is rising. 90% of cases in children and young people are Type 1 diabetes[21]. Type 1 diabetes occurs when the immune system attacks insulin producing cells in the pancreas, resulting in the body being unable to produce any insulin. There is currently no way to prevent type 1 diabetes. Type 2 diabetes results from the body producing an insufficient amount of insulin or from the body having a resistance to insulin. This type of diabetes is more common in people who are overweight and those of South Asian and Afro-Caribbean ethnicity. There is a strong association between type 2 diabetes and deprivation, there is no association with type 1 diabetes and deprivation[22]. Importantly, type 2 diabetes can largely be prevented.

Diabetes (both type 1 and type 2) is associated with a range of long-term complications including eye, kidney, and heart problems. These issues are exacerbated by poor control of diabetes and subsequent high blood sugars. There remain inequalities in outcomes for children with both type 1 and type 2 diabetes according to socioeconomic status. Those living in the least deprived areas tend to have better control over their blood sugars and are less likely to be admitted to hospital[23].

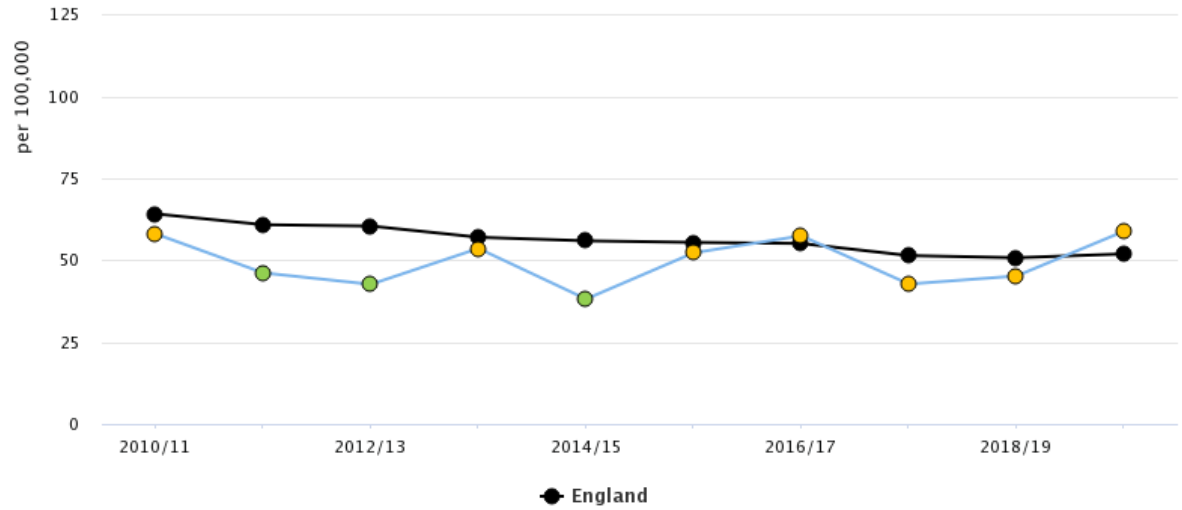
Data for Leeds show that admissions for diabetes in children and young people are similar to the national average however the rate has risen slightly in recent years (Figure 19). The estimated prevalence of diabetes in children and young people is 1.59 per 1,000, representing 326 people with a diagnosis of diabetes. It is not possible from the data to identify whether these are type 1 diabetes or type 2 diabetes diagnoses. As we might expect, the prevalence of diabetes in children and young people in Leeds rises with age. The prevalence is lowest in the 0-4 age group at 0.28 per 1,000 and highest in the 15-19 age group at 3.30 per 1,000. Analysis by deprivation shows that prevalence is highest in those living in the least deprived areas of Leeds (2.36 per 1,000 in IMD 10) and is generally

[21] Diabetes – RCPCH – State of Child Health
[22] National Paediatric Diabetes Audit (NPDA) annual reports | RCPCH
[23] Admissions of inequality: emergency hospital use for children and young people | The Nuffield Trust

lower in those from more deprived areas (1.44 per 1,000 in IMD1). It should however be noted that there are only small numbers of cases so no firm conclusions can be drawn from this finding.

Data on ethnicity show that prevalence is highest in those from a White background (1.75 per 1,000) and lowest in those from a Chinese background (0.79 per 1,000) although again the small number of cases limits the ability to draw conclusions.

Figure 19 - Admissions for diabetes for children and young people aged under 19 years for Leeds



Source: Office for Health Improvement and Disparities, Fingertips Child and Maternal Health Data

3.1.3. Epilepsy

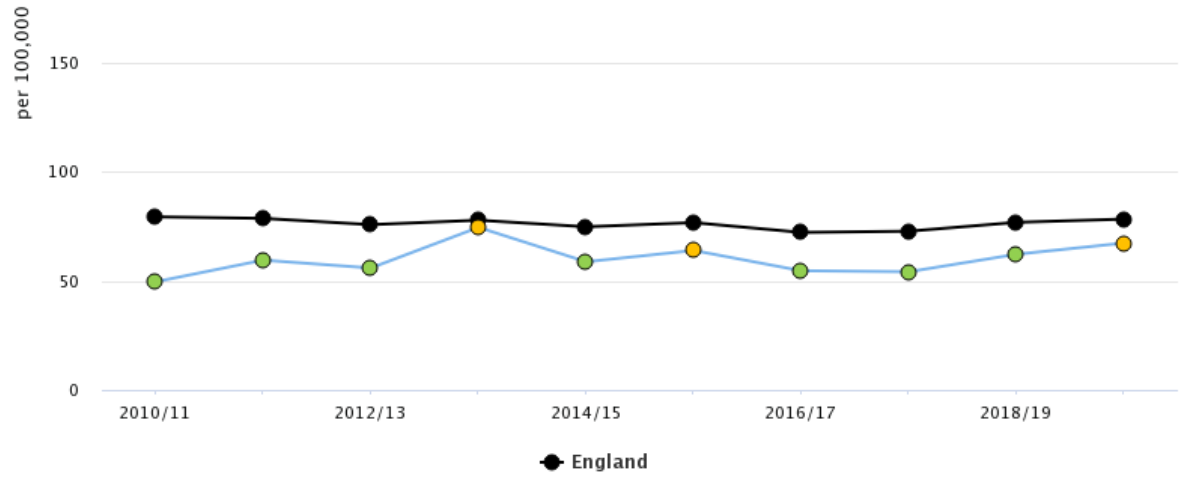
Nationally 112,000 children and young people have epilepsy. Despite many emergency admissions with epilepsy being unavoidable there remains an association with deprivation[24]. This may result from differences in education and support related to epilepsy medications and emergency seizure management plans.

Data for emergency admissions for epilepsy in children and young people in Leeds show that the rate in Leeds is similar to the national average, having recently been lower than the national average. Prevalence data show that there are 3.18 cases per 1,000 in Leeds. Analysis by deprivation decile shows that rates are higher in more deprived areas (4.26 per 1,000 in IMD 1, 4.39 per 1,000 in IMD2 and 4.34 per 1,000 in IMD3) and lowest in those living in IMD 9 (2.26 per 1,000). Interestingly the rates are higher in those living in the least deprived areas (3.70 in IMD10) however again there are relatively few children and young people living with epilepsy in the city, limiting the ability to draw conclusions.

Ethnicity data show that there is some variation between ethnic groups from 1.85 per 1,000 in children and young people from a Chinese background to 4.19 per 1,000 in those from an Asian background.

[24] Admissions of inequality: emergency hospital use for children and young people | The Nuffield Trust

Figure 20 - Admissions for epilepsy for children and young people aged under 19 years for Leeds



Source: Office for Health Improvement and Disparities, Fingertips Child and Maternal Health Data

3.1.4. Cancer

Cancer is a leading cause of death among children and young people. The incidence of childhood cancer has risen by 15% in the UK since the 1990s. There is no local data recording the prevalence of cancer in children in Leeds.

The childhood survival cancer rate in Yorkshire is world leading with 86 out of 100 children diagnosed with cancer under the age of 15 living for at least 5 years.

Prevalence data for childhood cancer in Leeds show that there are 173 children and young people in the city with a diagnosis of cancer (0.84 per 1,000). There is no strong relationship between childhood cancer and deprivation in Leeds. There is some variation between ethnic groups however the small numbers (less than 5 in some groups) limit the ability to make any meaningful conclusions.

Children Who Are Carers

A young carer is someone under the age of 18 who looks after someone who has a disability, illness, mental health condition, or drug or alcohol problem[25]. As well as those caring for parents, they may also support brothers, sisters, elderly relatives or even friends too.

Information from Leeds Young Carers Service explains that young carers may be performing the following roles and that this may be inappropriate or excessive:

- Collecting/dispensing medication
- Caring for younger siblings – inc. taking them to and from school, completing homework, implementing boundaries/discipline
- Personal hygiene tasks such as bathing, toileting
- Managing and paying bills
- Emotional support when cared for person is distressed/low mood
- Arranging/organising health care appointments

[25] Being a young carer: your rights - NHS (www.nhs.uk)

For the young carer these roles may have knock on effects including:

- Lateness and absence at School/College leading to poorer attainment/achievements
- Poor mental health due to worries about cared for person/siblings and lack of social opportunities due to caring tasks at home.
- Poor living conditions leading to social isolation, poor health, and hygiene.
- Poor physical health due to lack of adult influence and responsibility to eat well, attend health appointments and lack of opportunities to be active.
- Less opportunities to spend time with peers impacting on social emotional and behavioural well-being.

In Leeds, young carers may also be supported by the Leeds Young Carers Support Service . Leeds Young Carers Support Service, delivered by Family Action, has been commissioned to co-ordinate awareness raising, early identification and support for young carers and their families across Leeds. LYCSS works in partnership with a range of organisations to support practitioners to recognise a young carer, identify at an early stage what support they and their family might need, and then co-ordinate that support to ensure it is making a positive difference to the lives of the young carer and their family. LYCSS also work directly with those young carers who are undertaking inappropriate and excessive caring tasks and their families to look at ways to reduce any tasks which might be having a detrimental impact on the child's life.

In addition to this, young carers have legal rights to assessments and support:

- A Young Carers Needs Assessment under s17ZA of the Children Act 1989 is designed to ensure that young carers are not taking on inappropriate or excessive caring responsibilities. They are available to any young carer who requests one, no matter who they care for or how much care they provide.
- Young Adult Carers (young carers approaching adulthood) are also entitled to an assessment under s63 of the Care Act 2014 to help ensure that any barriers to them making successful transitions into adulthood are removed.

Up until now there has not been a system in Leeds for accurately identifying number of young carers. However, from Spring 2023, young carers are for the first time going to be included on the school census return. This will enable a much clearer picture of the number of young carers in schools, but also provides opportunities to use this data to monitor attendance and attainment of young carers. In addition, it will increase the visibility of this group of children and will enable better reflection of the impacts of caring on children.

Current data on young carers is collected from the Leeds Young Carers Service. This data shows that:

- The majority of carers are caring for their mother (183/255).
- The highest numbers of referrals to the service occurred at age 11 (38), 12 (41) and 13 (39) (Figure 21).

Figure 21 - Age at Referral to Leeds Young Carers Service

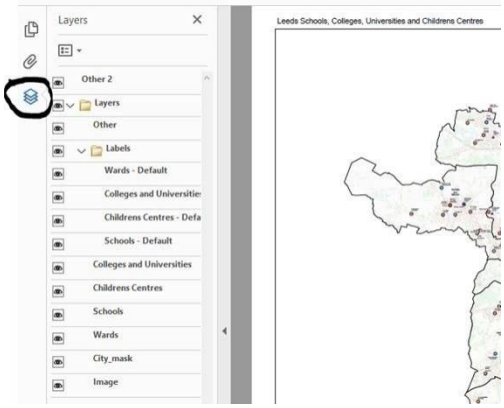
Age at Referral	Number
<10	35
10	23
11	38
12	41
13	39
14	30
15	24
16	29
17	26
18	*
Unknown	*

Source: Leeds Young Carers Support Service Data

4. Organisational assets in Leeds for Children

The city's Children's centres, schools, colleges and universities are mapped on the following link. The map is shaded according to IMD decline.

You can view individual 'layers' (i.e., just the children's centres) by clicking the symbol circled below on the left-hand side of the PDF, then the drop down next to layers and you can turn off different layers and labels by clicking on the 'eye' symbol next to the respective layer.



Other services in Leeds are listed on the Synergy website via this link. This website outlines information and services available specifically for Children and Families in Leeds. It provides details of the services, as well as their contact details.

Children's Centres

There are 58 children centres Children's centres in Leeds. Information about children's centres can be found here: Children's Centres | Family Information Service Leeds

Schools

There are 219 primary schools, 41 secondary schools, 3 through schools, 2 infant schools, 2 junior schools, 1 14-19 provision (provision starting in Key stage 4), 11 Special schools and 2 alternative provisions.

Of these, 92 are academies, 13 are free schools and 171 are maintained, that is overseen, or 'maintained', by the local authority. There are also 5 LA maintained special schools.

Ofsted judgements of schools demonstrate that the majority of schools in Leeds are judged either 'Good' (67%) or 'Outstanding' (16%). There were 11% of schools judged as 'Requires Improvement' and 6% 'Inadequate'.

Definitions:

Academy Schools: Academies receive funding directly from the government and are run by an academy trust. They have more control over how they do things than community schools. Academies do not charge fees. They can be Primary, Secondary, Special or Further education establishments.

Free schools: Free schools are funded by the government but are not run by the local authority. They have more control over how they do things. Unlike academies they are not run by an academy trust.

Leeds Colleges

There are 28 colleges in Leeds.

Leeds Universities

Leeds has one of the highest student populations in the UK with over around 70,000 students attending the city's universities, with students heavily concentrated in the city centre and Inner West areas.[26] There are four universities in Leeds: Leeds Arts University, Leeds Beckett University, Leeds Trinity University and University of Leeds.

[26] HESA Student Population

5. What are children telling us?

Children and young people have a right to be involved in decisions that affect their lives[27]. In Leeds investment has been made into ensuring the voice of children and young people is systematically included in all work to ensure that children are listened to, valued, and can influence decisions and actions that impact them. This is prioritised in Outcome 5 of the Children and Young People's Plan:

> *"Children and young people should feel they can express their views and have their voices heard in all aspects of their lives including their home, schools, services they use, places of work, local communities and their city".*

This chapter outlines major national mechanisms for incorporating children and young people's voices as well as the work going on locally in Leeds.

5.1. National Children and Young People's Voice

The Children's Commissioner reported the findings of the Big Ask Survey in October 2021.

The National Study of Health and Wellbeing: Children and Young People 2022 is published annually.

At a national level sport England produces the Active Lives Children's survey annually.

5.2. Children and Young People's Voices in Leeds

5.2.1. Voice Influence and Change team

The Voice Influence and Change Team champion the voice of children and young people and provide advice and guidance to teams and services to help improve practice and build confidence and skills of staff. The team also facilitate meaningful engagement between decision makers and children and young people – enabling children and young people to share their issues, priorities, views, and ideas. The team run citywide youth voice groups and programmes including Leeds Youth Council, Leeds Children's Mayor, UK Youth parliament, SEND Youth Forum, Children in care Council (Have a Voice) and the Care Leavers Council. The team support young people to participate in recruitment panels, commissioning panels and training sessions. The team have also developed links with youth groups and youth voice groups and have a network of over 1500 VIC leads in different settings across the city. The team promote the key issues raised by children and young people, voice and influence opportunities and good practice of VIC leads via a quarterly newsletter, social media (@leedsyouthvoice) and via six monthly voice and influence reports that are shared with strategic boards, elected members, and decision makers.

Further information about the role of the team is provided in this one-minute guide - One minute guide: Voice and influence (leeds.gov.uk)

5.2.2. Annual youth voice ballots and surveys

Leeds Children's Mayor - Year 5 children are invited via their schools to produce manifestos outlining what they would want to change or improve if they were the Leeds Children's Mayor and 12 are shortlisted. Children from across the city then vote on their favourite manifestos and the candidate with the highest number of votes becomes Leeds Children's Mayor and is supported by the team and partners to develop their campaign based on their manifesto aims. The 2021-22 Mayor is

[27] UN Convention on the Rights of the Child

Zulaykha from Bardsey Primary. Her manifesto focuses on togetherness following the COVID-19 pandemic.

UK youth parliament - Biannually, young people aged 11-18 are invited to submit a manifesto to become Leeds members. 6 candidates are shortlisted and then campaign to become a member of youth parliament and represent their city both locally, regionally, and nationally at events run by the British Youth Council. Three young people with the highest number of votes are elected by young people across the city aged 11-18. Youth parliament members then work with the Leeds Youth Council on the Make Your Mark Campaign. The 2022three members for Leeds are: 1) Blessing, Elliott Hudson College 2) Amelia, Mount St Mary's School and 3) Tian, Cockburn High School. Their identified priority is 'health and wellbeing'.

Make Your Mark ballot – Leeds takes part in this the biggest youth ballot in the UK. Young people aged 11-18 are invited to vote on their top issue that they want the youth parliament to campaign on. Traditionally this has been an annual campaign but in 2022 it will be a two-year campaign. Young people can vote individually or via their school or youth group.

MHMS survey – This is a pupil perception survey that asks questions under 8 themes: About Me, Healthy Eating, Physical Activity and Sport, PE in School, Drugs Alcohol & Tobacco, Sexual Health, Social, Emotional & Mental Health (SEMH) and My School/College. Results from this pupil perception data to are used to influence strategic priorities and plans.

5.2.3.Child Friendly Leeds 12 Wishes

The 2022 Child Friendly Leeds Wishes are developed from priorities identified from analysis of data collected from citywide elections, ballots, and consultation work over the last three years (Figure 22). The thematic results of this were then reported to and discussed with youth groups and schools as part of a member checking phase to ensure the wish list aligns with those of children and young people in the city.

A summary of the consultation data and key findings 2019-22 is available by contacting vic@leeds.gov.uk

Figure 22 - Child Friendly Leeds 12 wishes

Wish 1. Children and young people know how and where to get support for their mental health and wellbeing if they need it.

Children and young people have a greater understanding of their mental health and emotional wellbeing. They know where to get information and advice and who to speak to, to help them find services and support and it is available to them when they need it.

Wish 2. Children and young people have safe spaces to play, hang out and have fun.

Children and young people have time and opportunities to play, hang out and have fun across the city. They feel safer as there is less crime, vandalism and litter.

Wish 3. Children and young people express their views, feel heard and are involved in decisions that affect their lives.

Children and young people have a greater awareness of the different ways they can share their views and ideas. They know how to influence change within their school and community. They have access to support and training to develop their skills and confidence to enable them to have a voice and influence.

Wish 4. Differences are celebrated in Leeds so children and young people feel accepted for who they are. They do not experience bullying and discrimination.

People in Leeds have a better understanding of diversity and therefore celebrate differences in abilities, ethnicity, family background, language, religion, sex and opinions. Children and young people feel accepted, included and valued. They have a greater awareness of their rights not to be bullied or discriminated against and know what to do if it happens.

Wish 5. Everyone takes more action to protect the environment from climate change.

Children and young people have a greater awareness and understanding of what actions are being taken in Leeds to address the climate emergency and protect the environment. They know how they can get involved and make a difference.

Wish 6. Children and young people can travel around the city safely and easily.

Children and young people feel that public transport is safe, reliable, and accessible. They will not experience rising costs.

Wish 7. Children and young people know about different things to do and places to go across the city. They enjoy different cultural experiences including art, music, sport and film.

Children, young people and families feel there is better promotion and communication of fun and particularly free things to do and places to go within the city including events, activities, groups, cultural experiences and days out.

Wish 8. Leeds is a city that reduces the impact of poverty and helps families who need it.

Children, young people and families experiencing the impact of poverty feel they are supported and receive the help they need. They have their basic rights and needs met.

Wish 9. Children and young people have the support and information needed to make healthy choices. They have opportunities for regular physical activity.

Children and young people know about different opportunities to take part in physical activity and are supported and encouraged to join in. They have access to the information they need to make healthy choices and have healthy and safe relationships.

Wish 10. All children and young people are in learning settings that meet their needs.

Early years settings, schools and post 16 settings identify and address the barriers that prevent children and young people, particularly those with additional needs, engaging in and enjoying learning.

Wish 11. Young people have access to a wide range of work experience, employment and volunteering opportunities.

Young people know where to get information and advice and are supported to access a wide range of opportunities that meet their needs and aspirations. This includes work experience, employment, training and volunteering.

Wish 12. Leeds is an inclusive city for children and young people with special educational needs and disabilities.

Children and young people feel there is more awareness and understanding of different disabilities and that there are more activities and places to go that are accessible to all.

5.2.4.Children's views on the Key factors influencing health

Poverty

Supporting children and young people living in poverty and tacking poverty is highlighted as in issue in children and young people's manifestos.

One of the elected 2022 UKYP Amelia's manifesto aim:

> *"Tackling poverty by providing equipment and uniform for those students whose families can't afford it to enable future academic success".*

Play

In addition to the findings of the play sufficiency survey which are reported in the play chapter a key finding from the Leeds Big Chat 2021

> *"Children, young people and families told us they wanted to see more for young people and children to do in the city. There was a widespread feeling that fun activities, spaces and facilities would help our youngest residents to stay healthy and well, especially at a time when many have missed out on school and spent long periods away from their peers."*

Education

Themes from manifestos of children and young people focused on reviewing the curriculum, support with wellbeing and mental health, better careers advice, work experience and employment opportunities and tackling barriers to engaging and enjoying learning – particularly for children and young people with additional needs.

One of the elected 2022 UKYP Blessing's manifesto included:

> *"I surveyed to see what were the main issues that young people were facing in Leeds...One of the main problems that young people voted on was lack of opportunity career-wise. They Highlighted that it was quite difficult for them to gain any sort of work experience in the medical field, legal system, political system, financial system, and many more"*

One of the elected 2022 UKYP Tian's manifesto included:

> *"I don't believe schools are covering enough on diversity and present-day issues (climate change and Human Rights, equality, etc.) as many young people are oblivious to what problems we may face in future or guidance on life"*

Transport

Cost, reliability, bus routes and accessibility issues are frequently raised by young people. These barriers impact on young people and families being able to travel easily and safely to different parts of the city to meet friends and family, and access different activities, places or spaces.

Housing

One of the elected 2022 UKYP Tian's manifesto included housing as a priority:

> *"Living in a good place is crucial for self-development as it fulfils deep-seated psychological needs for privacy and personal space. Youth can shape what type of adult you will become. Living in poor conditions can result from the child feeling a lack of safety and trust in government, school struggles, and stress for parents."*

Care leavers have shared their views with decision makers about what need to improve around housing and these are being incorporated into future plans to make improvements. The key messages included there being a generally low understanding, awareness and confidence in the group in relation to various aspects of care leaver housing and accommodation – rights and entitlements, bidding and other processes, and where to go for information and support. Interestingly they described that 'Good' accommodation is not just about the building itself. Around half of the group put factors such as the area, people and surrounding infrastructure as their top priority. – More information available on request from the Voice & Influence team (vic@leeds.gov.uk)

Family context

Please see priority groups chapter.

5.2.5.Children's Views on Key Health Factors

Mental health

Engagement is a key thread throughout all work in Leeds to improve the mental health of children and young people, including MindMate Ambassadors, who are employed to draw on personal experiences to help develop work.

Supporting children and young people with their mental health is **the top issue from the last three years –** identified as the biggest issues in manifestos written by children and young people but also in the Make Your Mark Ballot where 5546 young people in Leeds aged 11-18 voted.

Nationally the Royal College of Paediatrics and Child Health Youth Authors Group identified "Improving Mental Health Support" as one of four things that could make a difference to children and young people's health. They concluded this, following conversations with over 630 children and young people.

Also covered within the My Health My Schools survey. The findings of this are reported within the epidemiology section of mental health chapter.

Children's healthy weight, Smoking drinking and alcohol use, Oral Health, Sexual health and teenage pregnancy and Health protection

All covered within the My Health My Schools survey. The findings of this are reported within the epidemiology section of individual chapters.

6. Life course

6.1. The First 1001 Days: Conception to age 2

Headlines

- Pregnancy, birth and the first 2 years of a child's life - the first 1001 days - set the foundations for an individual's cognitive, emotional, and physical development.
- The infant mortality rate is used as a marker 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.
    - The infant mortality rate for Leeds between 2019-2021 was 5.0 per 1,000 live births, compared to a national rate of 3.6 deaths per 1,000 live births in England and Wales in 2020.

Population Summary

There are a total of 15,813 children aged 0-2 living in Leeds, 4,384 of these children live in the most deprived fifth of Leeds (27.7%). Figure 23 outlines the age distribution according to population factors. Notably there are more children aged 1-2 than aged 0-1 due to declining birth rates.

Figure 23 - Population of children aged 0-2 years in Leeds in 2022

		Total Number of Children in Leeds					Proportion of Children In Leeds				
Age band	Total	Males	Females	No of Children living in most deprived fifth	BME Back-ground	Non-English Language as first language	Males	Females	No of Children living in most deprived fifth	BME Back-ground	Non-English Language as first language
0-1	7,270	3,735	3,535	1,939	2,013	771	51.4%	48.6%	26.7%	27.7%	10.6%
1-2	8,543	4,393	4,150	2,445	2,453	953	51.4%	48.6%	28.6%	28.7%	11.2%
Total	15,813	8,128	7,685	4,384	4,466	1,724	51.4%	48.6%	27.7%	28.2%	10.9%

"Most deprived fifth" refers to the number of children living in the 20% most deprived areas of Leeds. It is a within Leeds comparison and is not a national comparison as seen in the IMD deciles. "BME background" refers to those recorded as Asian, Black, Mixed, Chinese and Other. Those not included in this figure are those recorded as White or unknown or not recorded.

Source: GP recorded data, data available via the following tool

Introduction

Pregnancy, birth and the first 2 years of a child's life - the first 1001 days - set the foundations for an individual's cognitive, emotional, and physical development[28]. This can be a challenging time for expectant and new parents and some parents may find it difficult to provide their child with the best start. Studies demonstrate that when a baby's development falls behind the norm during this period,

[28] The best start for life: a vision for the 1,001 critical days - GOV.UK (www.gov.uk)

it is more likely to fall even further behind than to catch up with those who have had a better start[29]. This is therefore a critical time during a person's life and the best time to turn this around lies within the first 1001 critical days.

For the best outcomes babies need a healthy pregnancy, sensitive care and a safe and stimulating environment[30]. However, many families face pressures that can affect their ability to provide this care. For example, nationally around 79,000 babies under one live with a parent classified as a 'harmful' or 'hazardous' drinker, 33,000 babies under one in England live in homes affected by domestic abuse and perinatal mental illness affects more than 1 in 10 women[31]. To address issues faced during this period the Early Years Healthy Development Review[32] was launched in July 2020. Led by Andrea Leadsom MP, it aims to set out a vision for the First 1001 days of life, to implement best practice across the health system and improve outcomes for babies and infants from conception to age 2. This review published "*The best start for life: a vision for the 1,001 critical days*".

The Leeds Best Start Plan underpins delivery of a broad preventative programme from conception to age 2 years which aims to ensure the best start in life for every baby, with early identification and targeted support for vulnerable families early in the life of the child. This is a progressive universal approach. In the longer term, this will promote social and emotional capacity and cognitive growth and will aim to break inter-generational cycles of neglect, abuse and violence.

The overall outcomes for the programme will be:

- Healthy mothers and healthy babies at population and individual level
- Parents experiencing stress will be identified early and supported
- Well prepared parents
- Good attachment and bonding
- Development of early language and communication

Additionally The Leeds Maternity Strategy 2021 – 2025 is a five year plan for the city outlining how people will work together to improve the health and care services we offer to parents-to-be and new parents, to give babies the best start in life. This strategy has five key priorities: personalised care, emotional wellbeing, reconfigurations, reducing health inequalities and preparation for parenthood.

Epidemiology

The Leeds Maternity Health Needs Assessment (2020) provides detailed analysis of health needs related to pregnancy and birth in Leeds. It provides a comprehensive review of trends and the inequalities that exist in health outcomes for parents and babies amongst the different groups living in Leeds. The Leeds Joint Strategic Assessment presents data related to infant mortality, breastfeeding, and vaccinations. The State of Women's Health in Leeds report contains really useful data related to maternal and perinatal health. The Fairer Start Local Report Leeds outlines research

[29] 1001 Days - Parent-Infant Foundation (parentinfantfoundation.org.uk)
[30] 1001-days_oct16_1st.pdf (parentinfantfoundation.org.uk)
[31] 1001-days_oct16_1st.pdf (parentinfantfoundation.org.uk)
[32] The Best Start for Life - The Early Years Healthy Development Review Report (publishing.service.gov.uk)

completed by NESTA that summarises findings looking into how innovation could help to transform early years services in each area. The report also maps out services in Leeds age 0-5.

The Leeds Best Start Dashboard provides the most up to date data for this age group. It provides statistical comparisons across time and location. Access is available upon request from the Leeds City Council Public Health Intelligence team (phi.requests@leeds.gov.uk). A snapshot of the dashboard in shown in Appendix 3. Additionally, the Early Years High Impact Summary dataset shown in Appendix 4 is also produced and regularly updated.

The national Maternity Dashboard publishes a series of maternity data points for each hospital trust each month.

Birth Rate

See Population Summary Chapter. For Under 18s conception rate see Sexual Health Chapter.

Infant mortality

Infant mortality rate is the number of infants dying before their first birthday per 1,000 births and is a sensitive indicator of the changing overall health of societies, acting as an early warning sign for future adverse trends. One factor linked with increased risk of infant mortality is poverty and there is strong evidence that increased child poverty leads to an increase in infant deaths. On average, there was a relative 10% increase in risk of death between each decile of increasing deprivation. It is estimated that each 1% increase in child poverty is significantly associated with an extra 5.8 infant deaths per 100,000 live births[33].

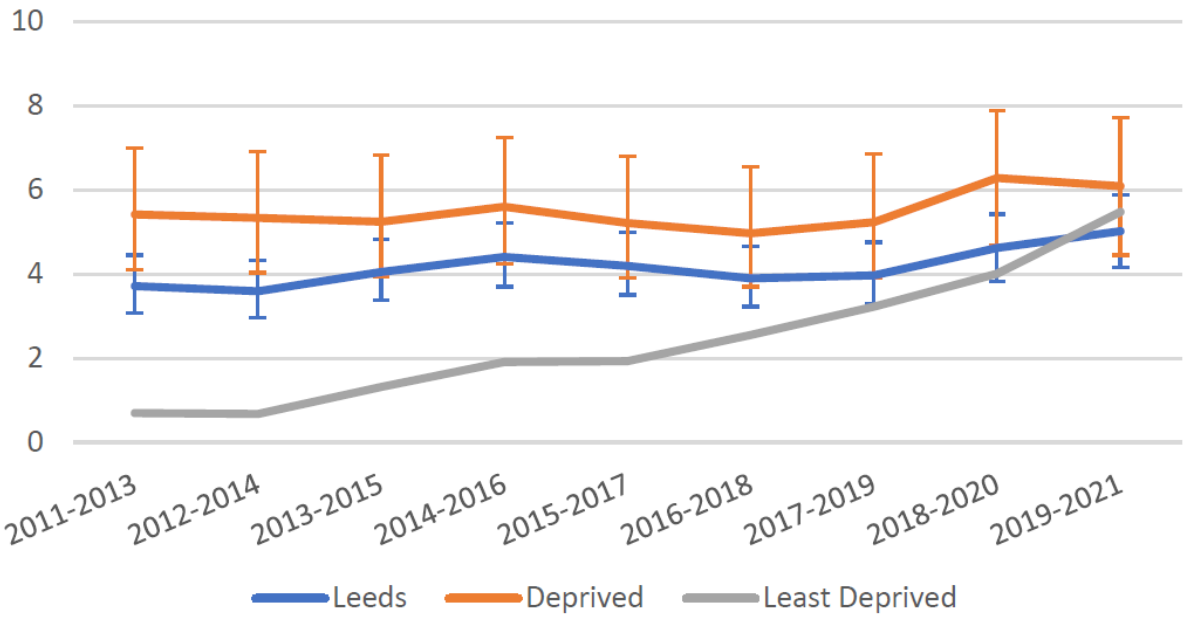
In 2020 the infant mortality rate for England and Wales was 3.6 deaths per 1,000 live births. This marker has shown a general decline since 1980, but rates have remained fairly stable since 2014[34].

Leeds generally has a higher infant mortality than the figure for England and Wales. The infant mortality rate for Leeds between 2019-21 was 5.0 per 1,000 live births, which is a non-statistically significant increase from the previous period (4.6 per 1,000 in 2018-20) (Figure 24).

The overall trend for Leeds shows the inequality gap has narrowed, however again this change is not a statistically significant. Importantly the infant mortality rate for deprived areas of Leeds and least deprived areas are not statistically different to the Leeds average. This lack of statistical significance largely results from the extremely small number of deaths occurring. This is particularly true in the least deprived areas of Leeds where birth rates are some of the lowest in the city. For example, the apparent rise in infant mortality rates for least deprived areas between 2018-20 and 2019-21 results from there being two additional deaths in the least deprived areas during (2019-2021) compared to the previous period (2018-2020), however there were also 34 fewer births.

[33] Assessing the impact of rising child poverty on the unprecedented rise in infant mortality in England, 2000-2017: time trend analysis (Taylor-Robinson et al 2019)
[34] Child and infant mortality in England and Wales - Office for National Statistics (ons.gov.uk)

Figure 24 - Infant Mortality 3 Year Aggregate Rates in Deprived and Non-Deprived Leeds – 2011-13 to 2019-21. All changes seen are not statistically significant.



Confidence Intervals for least deprived not available.

Source: ONS Births, ONS Deaths, via Civil Registrations Data NHS Digital

Low birth weight of term babies

Low birth weight is one of the major factors affecting child morbidity, mortality, and disability, having a lasting impact on health throughout the life course. Being born at a low birth weight can in turn predict a range of negative outcomes wider than health issues, which include lower education, attainment, and earnings[35].

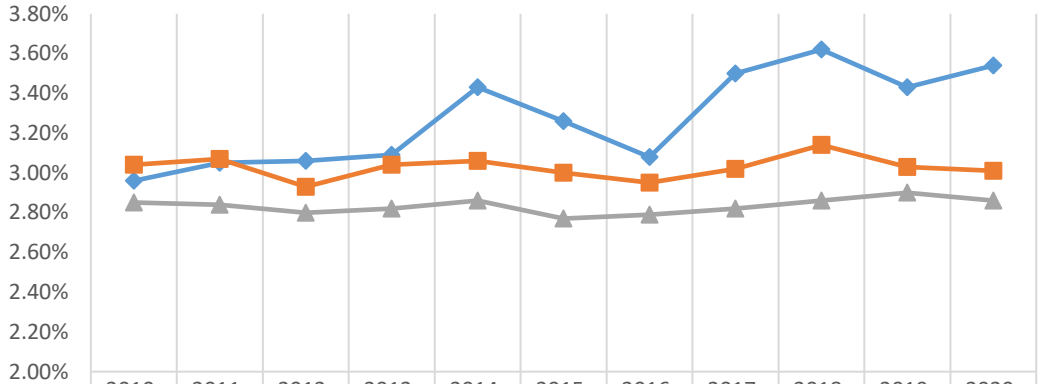
The ONS defines a full-term birth as having a gestation length of greater than or equal to 37 weeks, and a low birth weight is defined as being lower than 2,500g[36]. Low birth weight is associated with several health issues and has a higher prevalence in more deprived communities[37]. Babies born below normal birth weight are more vulnerable to infection, developmental problems and even death in infancy as well as longer term consequences such as cardiovascular disease and diabetes in later life[38]. Low birth weight can be caused by a variety of factors but there is particular concern to eliminate smoking and substance use in pregnancy as a cause[39].

Analysis of low birth weights in Leeds show a relatively stable picture. There has been a slight increase in the Leeds percentage per live births over the last year with 3.54% in 2020 compared with

[35] Social inequality and infant health in the UK: systematic review and meta-analyses (Weightman et al, 2012)
[36] Birth characteristics in England and Wales - Office for National Statistics (ons.gov.uk)
[37] Area deprivation, individual factors and low birth weight in England: is there evidence of an "area effect"? - PMC (nih.gov)
[38] A life course approach to chronic disease epidemiology: conceptual models, empirical challenges and interdisciplinary perspectives - PubMed (nih.gov)
[39] Smoking During Pregnancy | Smoking and Tobacco Use | CDC

3.43% in 2019. This remains above both the Yorkshire and Humber and England 2020 rate of 3.01% and 2.86% respectively (Figure 25).

Figure 25 - Low Birth Weight of Term Babies in Leeds, Yorkshire & Humber, and England - 2010 to 2020

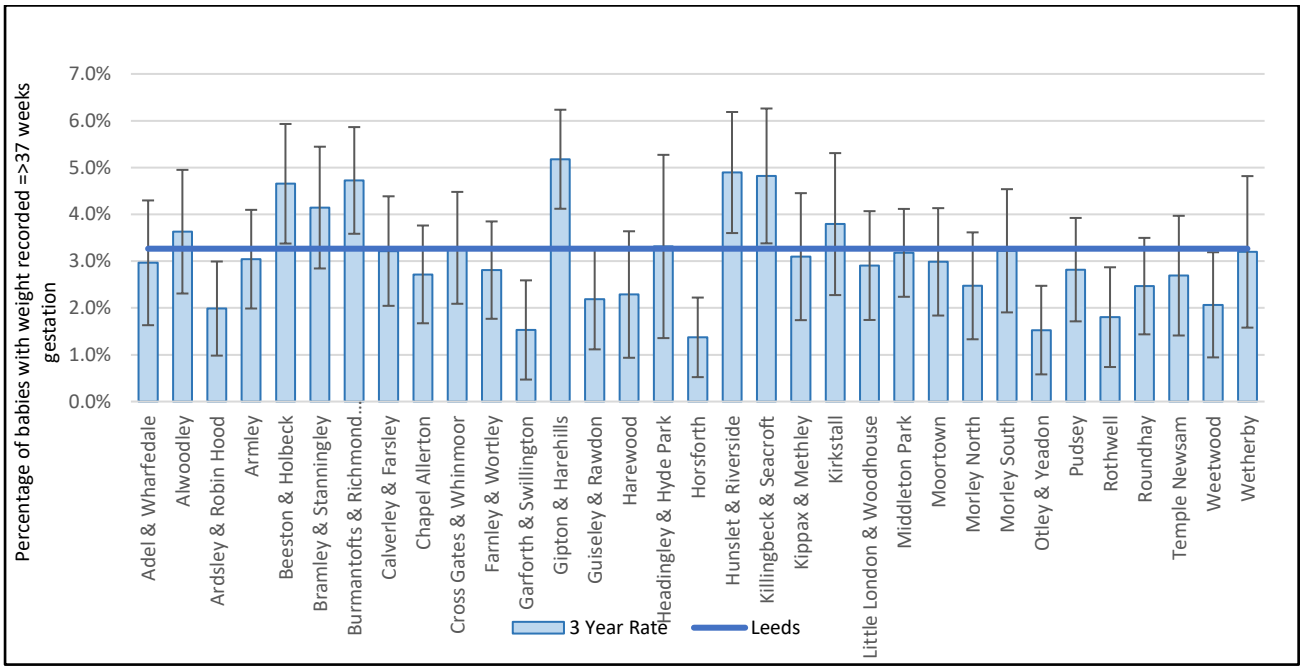


	2010-	2011-	2012-	2013-	2014-	2015-	2016-	2017-	2018-	2019-	2020-
Leeds	2.96%	3.05%	3.06%	3.09%	3.43%	3.26%	3.08%	3.50%	3.62%	3.43%	3.54%
Yorkshire & Humber	3.04%	3.07%	2.93%	3.04%	3.06%	3.00%	2.95%	3.02%	3.14%	3.03%	3.01%
England	2.85%	2.84%	2.80%	2.82%	2.86%	2.77%	2.79%	2.82%	2.86%	2.90%	2.86%

Source: Low birth weight data, Public Health England Fingertips

Using a 3-year aggregate rate of low-birth-weight (LBW) babies it is possible to look at the ward level prevalence and spot some significant contributors to the Leeds rate (Figure 26). Most of the more deprived wards are significantly higher than the Leeds rate for LBW; Gipton and Harehills (5.2%), Hunslet and Riverside (4.9%), Killingbeck and Seacroft (4.8%), Burmantofts and Richmond Hill (4.7%), and Beeston and Holbeck (4.7%).

Figure 26 - Low Birth Weight of Term Babies in Leeds by Ward (2015-2017)



Source: ONS Births via Civil Registration Data, NHS Digital

Breastfeeding

A new breastfeeding dashboard is currently being developed and will contain all data related to breastfeeding in Leeds.

Breastfeeding is a public health priority. Breast milk provides the ideal nutrition for infants in the first stages of life and current national and international guidance recommends exclusive breastfeeding from birth and for the first six months of life - with ongoing breastfeeding for two years and beyond. In both the short and long-term, breastfeeding protects parents and babies against both acute and chronic diseases. Breastfeeding reduces the risk of babies developing many illnesses, provides protection against later childhood diseases, has a positive effect upon infant and maternal health and wellbeing, it also promotes bonding between parent and baby[40]. No other health behaviour has such a broad-spectrum and long-lasting impact on public health.

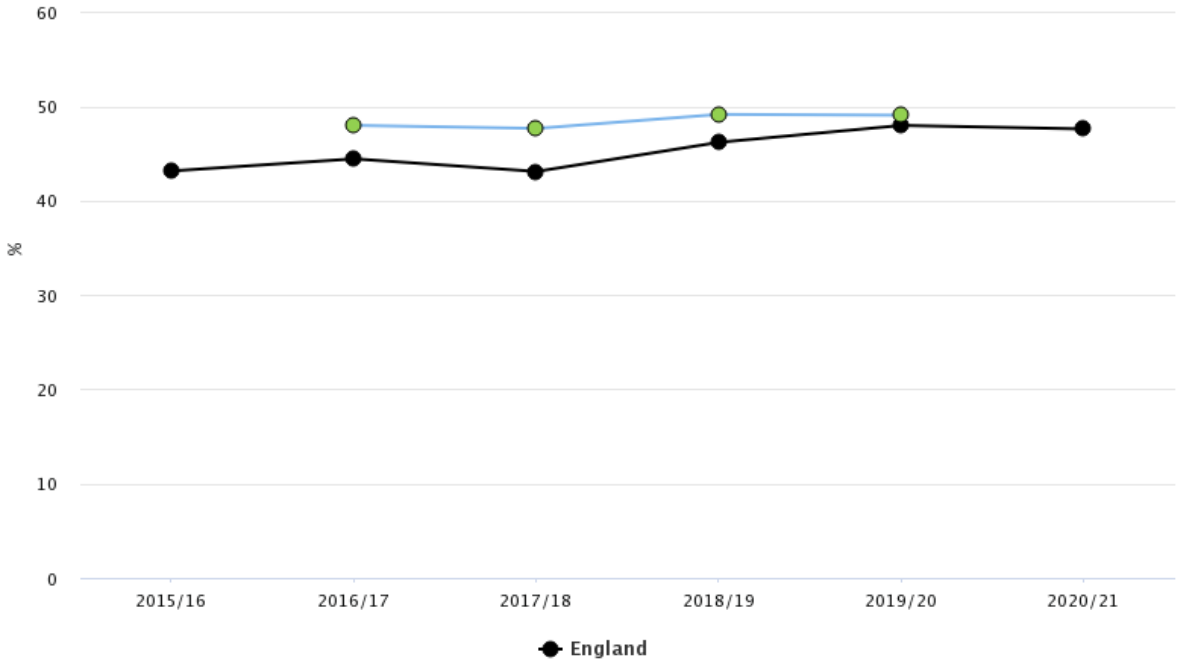
The influences on breastfeeding rates are complex and a parent's decision to breastfeed is influenced by many factors including their own experiences, friends and family, culture, the media as well as through health advice[41].

In Leeds a report in 2018 provided a mid-term update and information about successes and progress that has been made in delivering the Leeds Breastfeeding Plan (2016-2021). The revised Leeds Breastfeeding Plan (2022-2027) has considered the impact of COVID-19, and recognised that the ways families are supported will continue to look different for some time and that strategies must be in place to ensure breastfeeding support is maintained even during unprecedented times. It has also highlighted that breastfeeding support, as with all other support services, must be accessible and inclusive and the Breastfeeding Plan clearly sets out the aim to support all people with breastfeeding.

Breastfeeding initiation rates in Leeds in 2021-22 was 73.3% according to maternity services data. This compares to a national rate of 68% in the UK. Breastfeeding continuation rates (6-8 weeks) are better in Leeds (49.1% in 2019/20) compared to national rates (48%), although have dropped a little since 2013/14 and no improvement in deprived Leeds (Figure 27).

[40] Benefits of breastfeeding - NHS (www.nhs.uk)
[41] Infant Feeding Survey - UK, 2010 - NHS Digital

Figure 27 - Breastfeeding prevalence at 6-8 weeks after birth Leeds vs England

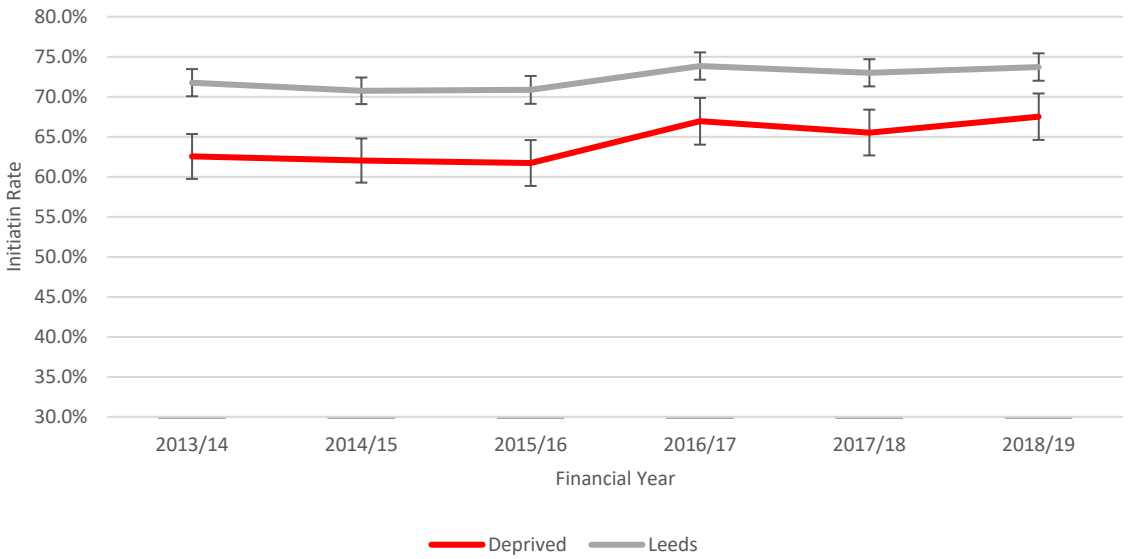


Source: Public Health England Child and Maternal Health Profiles

Since the recording of breastfeeding statistics began in the UK through the National Infant Feeding Surveys, breastfeeding initiation rates have risen steadily. However, the socio-demographic profiles of parents who breastfeed remain the same, and young, non-professional, low-income parents who leave school early continue to be those who are least likely to initiate breastfeeding[42]. As deprivation levels rise, parents are less likely to initiate breastfeeding; only three-quarters of parents (73%) living in the most deprived areas in England initiated breastfeeding, compared to nine out of ten (89%) of parents living in the most affluent areas – a difference of 13%[43]. Breastfeeding initiation rates in deprived Leeds have improved during the period 2013/14 to 2018/19 – rising from 62.5% in 2013/14 to 67.5% in 2018/19; yet rates remained significantly lower than Leeds overall rate of 73.7% (Figure 28). This HNA did not find Leeds breastfeeding data broken down by age range.

[42] Factors associated with breastfeeding in England: an analysis by primary care trust (Oakley et al, 2013)
[43] Factors associated with breastfeeding in England: an analysis by primary care trust (Oakley et al, 2013)

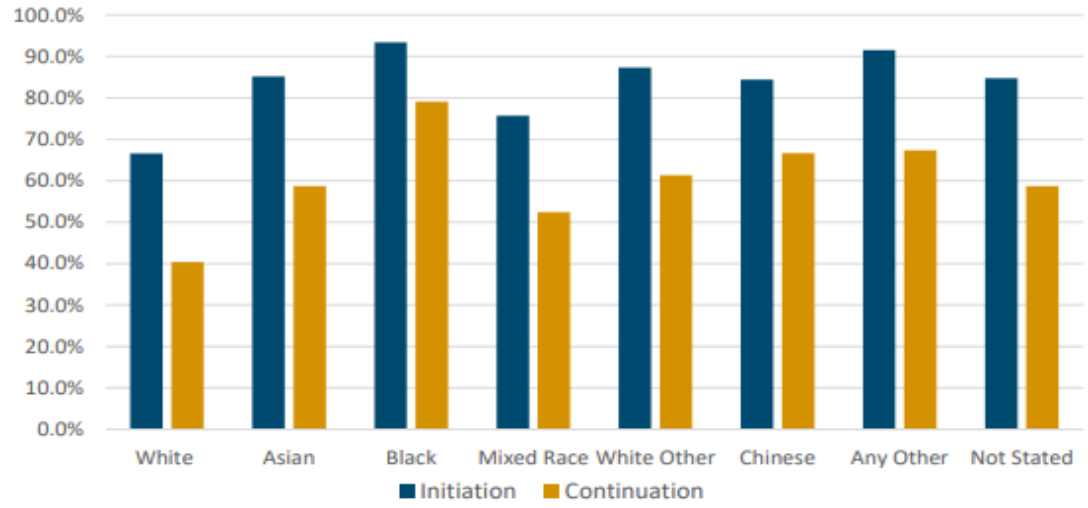
Figure 28 - Breastfeeding Initiation Rates in Leeds Overall and Deprived Leeds - 2013/14 to 2018/19



Source: Breastfeeding Data, LCH and Public Health England Fingertips

The white population in Leeds has the lowest breastfeeding initiation and continuation rates of all ethnicities. Figure 29 demonstrates the relationship between breastfeeding initiation, continuation rates and ethnicity. As described previously, the white population has the lowest initiation and continuation rates compared to other ethnic groups with an initiation rate of 66.58% and continuation rate of 40.39%. The highest initiation and continuation rates can be seen for Black women: 93.42% and 79.11% respectively.

Figure 29 - Breastfeeding initiation and continuation (6-8 weeks) Rates by Ethnicity in Leeds (2018/19).



Source: Used with permission from Maternity Health Needs Assessment 2020, original source Breastfeeding data, LTHT.

Maternal Health

Smoking, Drugs and Alcohol

A national report in 2019 analysed the maternity services dataset antenatal booking data to identify the health of women before and during pregnancy: health behaviours, risk factors and inequalities[44].

Use of alcohol, illicit drugs and other psychoactive substances during pregnancy can lead to multiple health and social problems for both mother and child, including miscarriage, stillbirth, low birthweight, prematurity, physical malformations, and neurological damage. In particular, smoking in pregnancy is strongly associated with a higher rate of still birth[45,46].

The latest data for 2018/19 indicate that smoking status at time of delivery in Leeds is 12.3%, which is worse than the national rate of 10.6%; although better than the Yorkshire and Humber rate which is 14.4%. This is significantly higher amongst mothers who are under 18 years old at the time of delivery. This figure has not improved since 2014. There is an acknowledgment that smoking rates are associated with deprivation and the Office for National Statistics highlights that people living in England's most deprived areas are four times more likely to smoke than in the least deprived[47]. One of the four key ambitions of the national Tobacco Control Plan (2017-22) is to reduce smoking in pregnancy (as recorded at time of delivery) to 6% or less.

Maternal Healthy weight

Being both under- or over- weight is associated with numerous health risks for both woman and baby. For women who are overweight, this includes an increased risk for gestational diabetes, pre-eclampsia, gestational hypertension, instrumental and caesarean birth, and surgical site infection[48]. For children of overweight mothers risks include: preterm birth, small-for-gestational-age, large-for gestational-age, foetal defects, congenital anomalies and perinatal death[49]. As weight increases, so too do these risks[50]. Similarly, being underweight is associated with increased risk of miscarriage, premature birth, and low birth weight[51]. As such, supporting healthy weight before and between pregnancies is one of 6 maternity high impact areas.

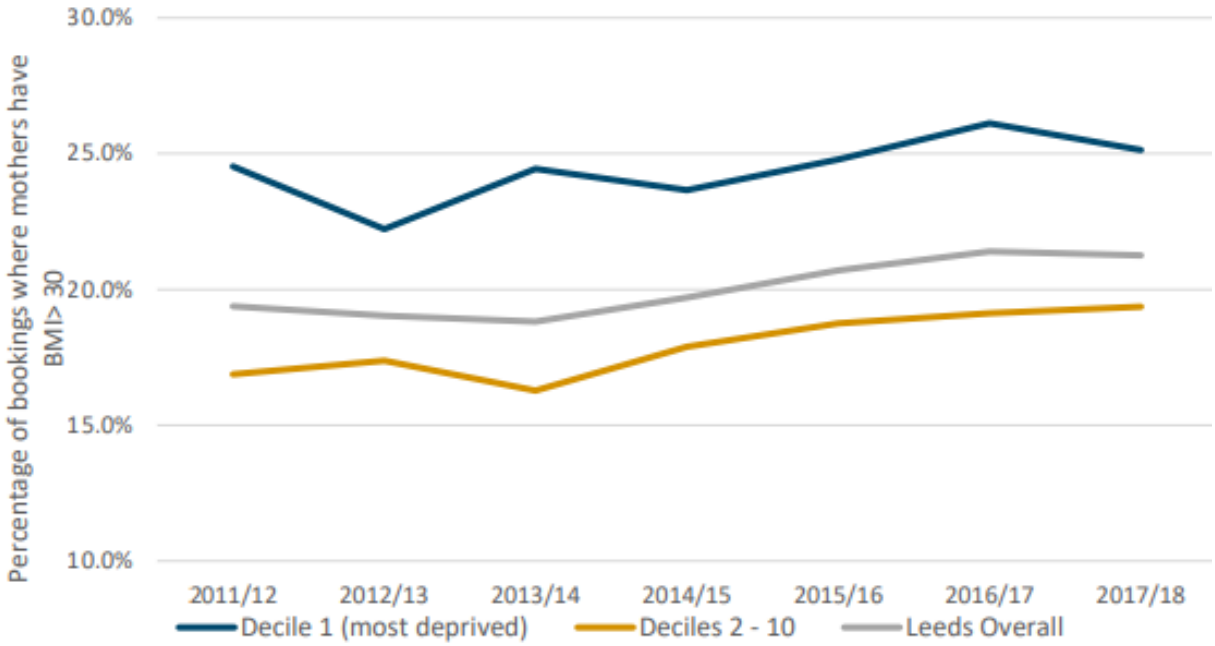
In the financial year 2020/21 there were 7,788 deliveries in Leeds and of these: 3,438 in healthy BMI range, 166 underweight, 2,173 overweight, 1,028 class 1 obese, 456 class II obese, 258 class III obese. In the financial year 2021/22 there were 7,953 deliveries and of these: 3,283 healthy weight BMI, 139 underweight, 2,310 overweight, 1,191 class 1 obese, 506 class II obese, 250 class III. This data is from the Patient Level Information and Costing Systems (PLICS) database and only shows

[44] Health of women before and during pregnancy: health behaviours, risk factors and inequalities (publishing.service.gov.uk)
[45] Preconception care: making the case - GOV.UK (www.gov.uk)
[46] Smoking: stopping in pregnancy and after childbirth | Guidance | NICE
[47] Likelihood of smoking four times higher in England's most deprived areas than least deprived - Office for National Statistics (ons.gov.uk)
[48] Overweight and pregnant | Tommy's (tommys.org)
[49] Overweight and pregnant | Tommy's (tommys.org)
[50] Being overweight in pregnancy and after birth patient information leaflet | RCOG
[51] Underweight during pregnancy | Tommy's (tommys.org)

delivered women that have had antenatal care in Leeds and delivered in Leeds, so does not include out of area women.

There are clear links between deprivation and maternal obesity in Leeds. This was reviewed in the Leeds Maternity Health Needs Assessment (2020) which showed that In 2017/2018 the Leeds average of bookings where mothers had a BMI>30 was 21.3%, with a greater percentage of mothers residing in deprived Leeds having a BMI>30 (25.1%) compared with IMD deciles 2-10 (19.4%) (Figure 30).

Figure 30 - Percentage of Maternity Bookings by IMD Decile and Leeds Overall where Mothers have a BMI>30 – 2010/11 to 2017/18



Source: Source: Used with permission from Maternity Health Needs Assessment 2020, original source Maternity Booking Data, LTHT.

Maternal Mental Health

Supporting parental mental health is one of the national 6 maternity high impact areas[52]. These are national areas identified for support to assist local maternity systems delivering preventative approaches before, during and after pregnancy. Nationally mental health problems during the perinatal period (that is, from conception to 1 year after birth) affect up to 27% of new and expecting mothers[53]. If left unresolved, parental mental health problems can have a negative impact on how parents interact with their children and their ability to bond with their baby including being sensitive to their baby's emotions and needs[54]. This can have long-term health consequences for the child. This includes poor mental health, physical health, social and educational outcomes. The effects

[52] Maternity high impact area 2: Supporting good parental mental health (publishing.service.gov.uk)
[53] NHS England » Perinatal mental health
[54] Parental mental health problems | NSPCC Learning

can be of particular concern in the absence of other carers able to provide the quality emotional contact an infant's needs.

Public Health England produced the following estimates of numbers of women in Leeds who may experience different types of mental health disorders in the perinatal period, over the course of one year (Figure 31). The analysis applies population estimates of mental health disorders to the local birth rate in Leeds. Women may have more than one illness, so may be counted twice.

Figure 31 - Public Health England Perinatal Mental Health Estimates Leeds (2016)

Estimated number of women with postpartum psychosis	20
Estimated number of women with chronic SMI	20
Estimated number of women with severe depressive illness	290
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate)	955
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate)	1,430
Estimated number of women with PTSD	290
Estimated number of women with adjustment disorders and distress (lower estimate)	1,430
Estimated number of women with adjustment disorders and distress (upper estimate)	2,860

Source: Table used with permission from Maternity Health Needs Assessment 2020, original source Breastfeeding data, LTHT.

However, it is likely that these nationally derived estimates for perinatal mental ill health underestimate levels of need in Leeds as they are not adjusted for deprivation and Leeds experiences a disproportionate amount of deprivation[55].

Leeds Teaching Hospital Trust K2 Maternity Booking Data indicate that of the 10,184 women booking onto maternity services in Leeds in 2019, 285 (2.8%) were noted to require a mental health referral. Looking at the Public Health England estimates this would appear to represent women with more severe mental illness and not mild to moderate anxiety and depression or adjustment disorders.

Speech, language and communication

See Early Years Chapter.

Family Dynamics

See Priority Groups Chapter

[55] 14_Maternal-health-and-motherhood.pdf (leeds.gov.uk)

Identified gaps in knowledge about current need

- Infant mortality is one of the most important indicators reflecting health trends across the population. Reasons behind increases in rate in least deprived areas aren't clear.
- Perinatal mental health estimates are from 2016, COVID-19 likely to impact and so it would be worthwhile reviewing these figures again.
- There are some gaps in data collection related to breast feeding. The new breast-feeding dashboard being developed will be useful in monitoring data collection.

6.2. Early Years (Age 2-5 years)

Headlines

- Ages 2 to 5 years are a crucial period for children where they rapidly grow, learn and develop.
- Children growing up in Harehills (part of Gipton and Harehills Ward) have the poorest outcomes in Leeds in terms of communication and language at age 5 (27.1% not achieving expected speech and language outcomes compared to the Leeds average of 18.9%.).
- Notably these are also the areas with the lowest take-up of early education age 2.
    - In Leeds the average take-up of funded early education (FEE) is 67% compared to an England rate of 68%. The areas with the lowest take up are Harehills (26%), Shepherds Lane (49%) and Chapeltown (54%).

Population Summary

There are a total of 28,780 children aged 2-5 living in Leeds, 8,021 of these children live in the most deprived fifth of Leeds (27.9%). Figure 32 outlines the age distribution according to population factors. Notably there are more children aged 4-5 than aged 2-3 due to declining birth rates.

Figure 32 - Age distribution of Children in Leeds Aged 2-5 according to different population attributes (2022).

		Total Number of Children in Leeds					% of children in Leeds				
Age band	Total	Males	Females	No of Children living in most deprived	BME Background	Non-English Language as first language	Males	Females	No of Children living in most deprived	BME Background	Non-English Language as first language
2-3	9116	4617	4499	2532	2479	2713	50.6%	49.4%	27.8%	27.2%	29.8%
3-4	9777	4958	4819	2735	2705	3082	50.7%	49.3%	28.0%	27.7%	31.5%
4-5	10039	5187	4852	2766	2919	3604	51.7%	48.3%	27.6%	29.1%	35.9%
Total	28932	14762	14170	8033	8103	9399	51.0%	49.0%	27.8%	28.0%	32.5%

"Most deprived fifth" refers to the number of children living in the 20% most deprived areas of Leeds. It is a within Leeds comparison and is not a national comparison as seen in the IMD deciles. "BME background" refers to those recorded as Asian, Black, Mixed, Chinese and Other. Those not included in this figure are those recorded as White or unknown or not recorded.

GP recorded data, data available via the following tool

Introduction

Ages 2 to 5 years is a crucial period for children where they rapidly grow, learn, and develop. It is during this time where a child's need for additional support from health and education systems may be recognised. While the first 1001 days have lifelong impacts on many aspects of health and wellbeing, the early years are another important time for children where planned contact with all children and their parents can help to make a real difference to a child's future outcomes. Factors

affecting health in the early years are multifaceted and similar to those in the first 1001 days: family environment; learning environment, community environment and socioeconomic context.

Nationally there are many policies that are relevant to this age group, including the provision of 30 hours funded early years childcare as well as national level monitoring of the age group via the 2 to 2-and-a-half years health and development review. The Advancing our health: prevention in the 2020s consultation green paper in 2019 included detailed actions to support families in the early years including 'modernising' the Healthy Child Programme and the Hungry Little Minds campaign to support parents to help their children to develop their communication, language and literacy skills. Further, in the March 2020 Budget, the Government announced that it would provide "£2.5 million for research and developing best practice around the integration of services for families, including family hubs, and how best to support vulnerable children". However, there are many challenges affecting the early years healthcare workforce as a result of funding cuts and lack of skilled workforce. For example health visitor numbers in August 2022 are at an all time low.

The early years age group falls between the first 1001 days and starting primary school and as such there is no specific Leeds based policy related to how best to serve this age group . However, there are numerous services supporting families during this period, notably the Healthy Eating and Nutrition for the Really Young (HENRY) training programme has been extremely beneficial. Leeds has partnered up with NESTA as part of Fairer Start Local. This organisation is supporting Leeds, alongside Stockport and York, to explore how innovation could help to transform early years services in the area. NESTA have completed their discovery phase and have reported some very interesting initial findings.

Epidemiology

Nationally the Children's Commissioner produced a report entitled 'Best beginnings in the early years' which describes key factors influencing children's lives in the early years and their impact.

OHID produce a series of indicators relevant to early years.

A regularly updated dataset for this age group is the Leeds Early Years High Impact Summary dataset shown in Appendix 4. The Leeds Best Start Dashboard provides up to date data for this age group. It provides statistical comparisons across time and location. Access is available upon request from the Leeds City Council Public Health Intelligence team (phi.requests@leeds.gov.uk). A snapshot from October 2022 of the dashboard in shown in Appendix 3.

Education

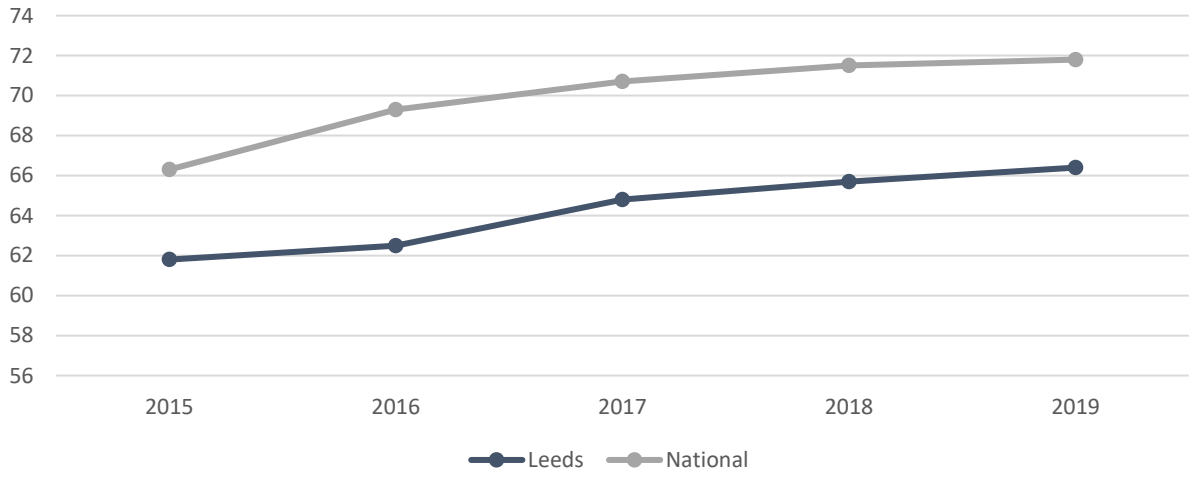
Speech and language develop fastest in the first 4 years of life and provide a foundation for learning through school, into adult literacy and potential employment opportunities. Leeds has a longstanding gap between children living in deprived and non-deprived areas of the city achieving their potential; particularly at pre-school and primary age[56]. There have been some encouraging improvements in the proportion of children achieving the expected level in the early learning goals

[56] Fairer Start Local: closing the disadvantage gap | Nesta

(measured at age 5), and the mean average total point score for the lowest attaining 20% of learners is improving consistently and is now above national rates[57].

In 2019 the overall Leeds percentage of children achieving a good level of development in the Early Years Foundation Stage (EYFS) profile was 66.4% compared to the England rate of 71.8% (Figure 33). This marker is worse in Leeds than its statistical neighbours, the Yorkshire and Humber and National rates. Despite improving slightly on the previous year, Leeds is in the lowest 10% of local authorities in England. In the Early Years Foundation Stage profile, children are measured across 17 early learning goals (ELGs) and it is determined whether their skills are 'emerging', 'expected standard', or 'exceeding'. In Leeds, the percentage of children 'exceeding' is consistently above national across all ELGs (except one, which is in line). However, there are more pupils in Leeds than national in the 'emerging' category for 'reading', 'writing', 'numbers' and 'shapes, space and measures'. This indicates that, despite Leeds children having some of the highest attainment nationally, there is also a significantly high level of low attainers.

Figure 33 - Early Years Foundation Stage Profile – children achieving a good level of development (2015 to 2019)



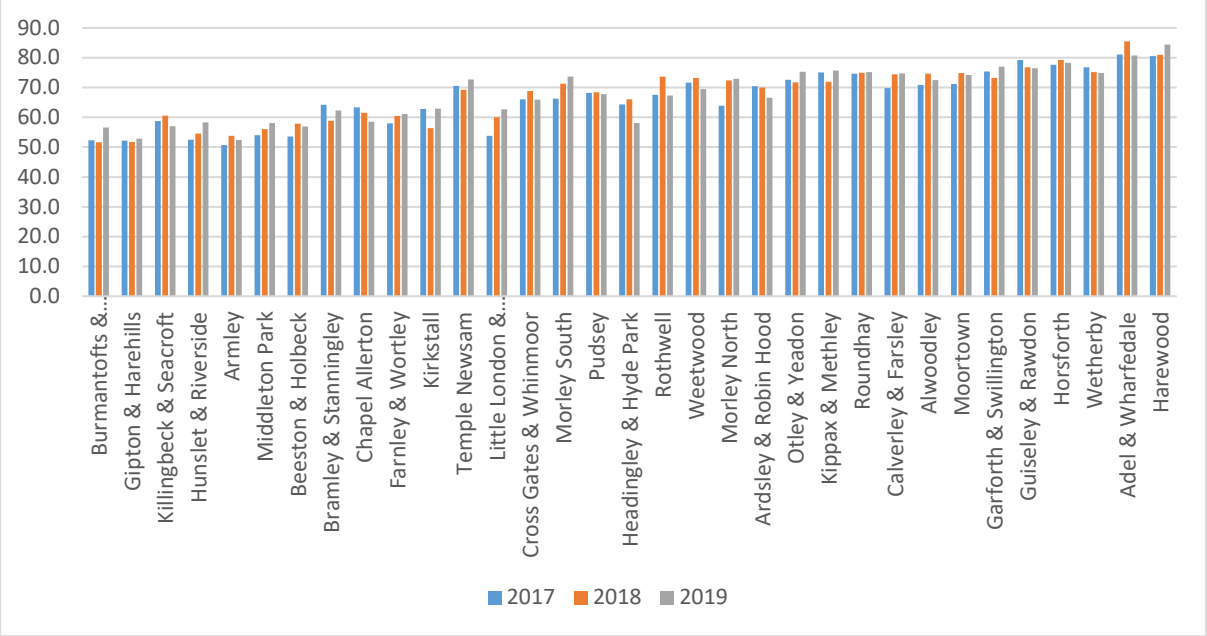
	2015	2016	2017	2018	2019	Change
Leeds	61.8	62.5	64.8	65.7	66.4	▲ 0.7
National[1]	66.3	69.3	70.7	71.5	71.8	▲ 0.3
Stat. Neighbours	63.0	67.7	69.2	70.4	70.8	▲ 0.4
Core Cities	61.0	64.7	66.7	68.0	67.9	▼ -0.1
Yorkshire & Humber	64.6	67.4	68.8	69.4	70.0	▲ 0.6

Source: Department for Education and Leeds City Council

Deprivation is associated with lower levels of development and Figure 34 shows EYFS good level of development, for 2017 to 2019, by Leeds wards in order of deprivation from most to least deprived. The gap between most and least deprived is stark, with 2019 data showing a 27.9% difference in the rate of achieving a good level of development at the end of the Reception year (56.6%, 84.5%).

[57] Starting Well - Child Friendly Leeds (arcgis.com)

Figure 34 - EYFS Good Level of Development



Source: Early years pupils GLD, LCC Intelligence and Policy and Department for Education

There are gender differences too. In 2018/19 73.4% of girls achieved at least the expected level at foundation stage, compared to 59.6% of boys. The England average in this year was 76.3% for girls and 62.8% for boys.

Data reported here is until 2019 and there are gaps in the data resulting from COVID-19. The issues highlighted here are very likely to have been exacerbated further by COVID-19 and the impact of this will need to be closely monitored. A summary of the impact of COVID-19 on early childhood and care in the UK was published in 2021[58]. Initial reports show that school disruption due to COVID-19 meant that in 2020, children in Reception made less progress than expected during this time. A recent study involving primary schools in Leeds and compiled by the Economic and Social Research Council with the University of Leeds shows reduced progress against the EYFSP goals in Mathematics, Literacy, Personal Social and Emotional Development (PSED) and Communication & Language; with 64% making either no progress or less progress than normal in maths and literacy[59]. In addition, when children started Year 1 the report found that a significantly lower proportion of the cohort reached the expected levels for the EYFSP goals in Mathematics, Literacy, PSED and Communication & Language, when compared to the levels attained by children in England in the previous year with home learning factors such as the amount of home learning resources provided attributed to having had an impact on these results[60].

[58] Impact of COVID-19 on Early Childhood Education & Care - POST (parliament.uk)
[59] _Progress of reception children during the Spring 2020 lockdown in Early Years Foundation Stage curriculum areas_-compressed.pdf (leeds.ac.uk)
[60] Progress of reception children during the Spring 2020 lockdown in Early Years Foundation Stage curriculum areas_-compressed.pdf (leeds.ac.uk)

Take up rate of funded early education age 2

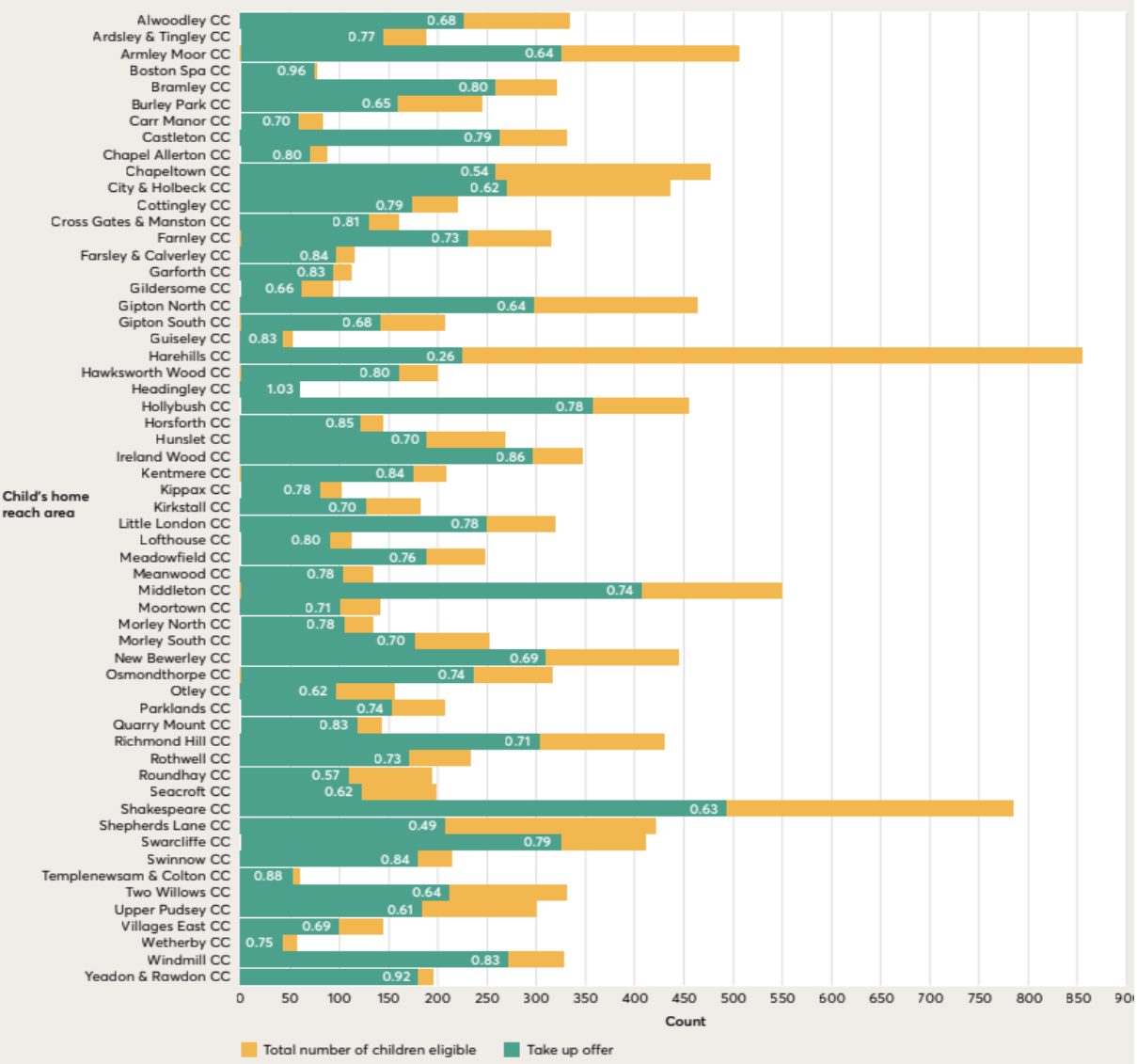
Nationally there are wide differences in the take up and provision of early education. This is reviewed in a report by The Nuffield Foundation in 2021.

High quality early years provision makes a difference to young children. It has been shown to help to break the cycle of disadvantage and improve social mobility through offering a good start in life[61]. There are wide inequalities in those accessing funded early education (FEE) at age 2. In England in 2019, average take up of FEE was 68% and it was 67% in Leeds. The areas with the lowest take up are Harehills (26%), Shepherds Lane (49%) and Chapeltown (54%).

Figure 35 below shows the total count of eligible children living within each children's centre area (yellow bar) and the number of children within each area that are taking up funded early education (green bar), with the proportion of children in each area taking up funded early education presented as a number within the green bar.

[61] Costs and benefits of free childcare, House of Commons, 19 February 2019 (local.gov.uk)

Figure 35 - Take up rate of funded early education age 2 - by Children's Centre reach area



Source: [Fairer Start Local Report: Leeds - NESTA]

Speech, language, and communication

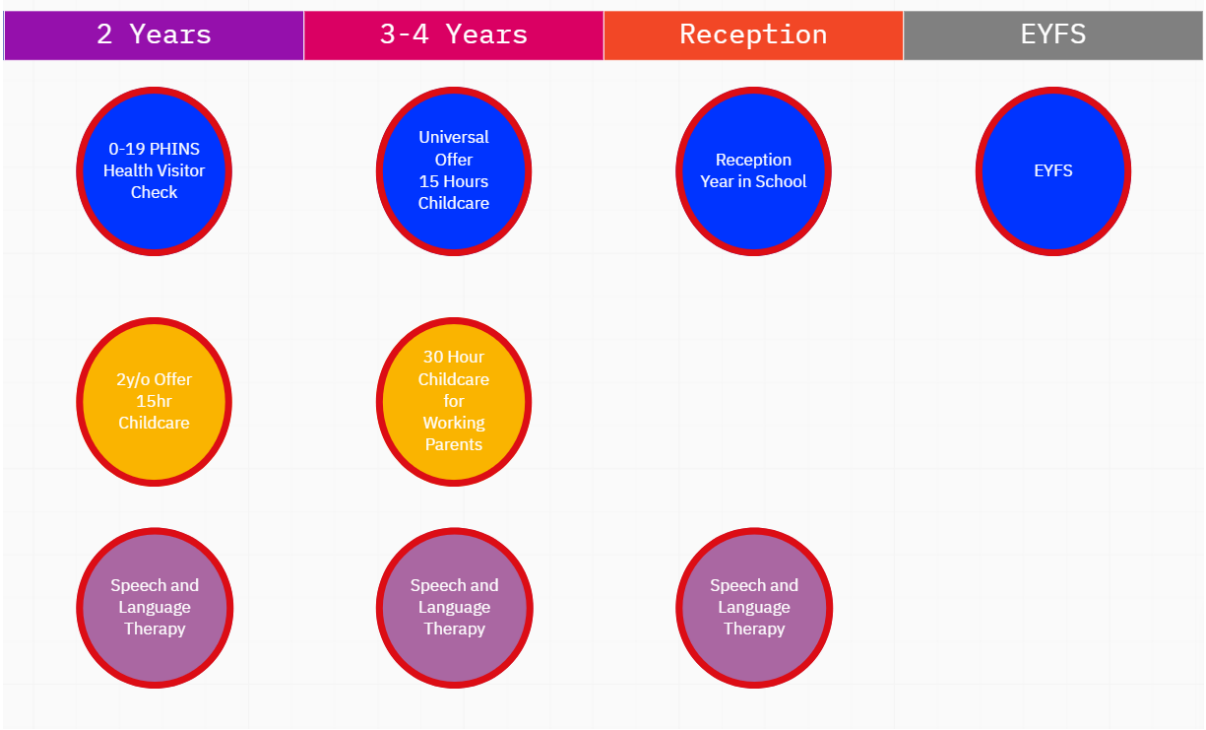
Children growing up in Harehills (part of Gipton and Harehills Ward) have the poorest outcomes in Leeds in terms of Communication & Language at (27.1% not achieving expected speech and language outcomes - Leeds average 18.9% - EYFS 2019). Notably these are also the areas with the lowest take-up of early education age 2 (Harehills 26% - Leeds 67% - EYFS 2019) which was highlighted in the recent Leeds City Council/NESTA research project.

OHID regularly report on Speech Language and Communication indicators in Leeds.

Leeds City Council worked with NESTA to improve speech, language and communication skills for children aged 3 – 5 years in Leeds. This work aimed to understand the current offer of speech, language and communication support for families in the early years in Leeds and created a detailed

map of services in Leeds (Figure 36), of which the key milestones relevant to early years are displayed below.

Figure 36 - Map of speech, language and communication support for families in the early years available in Leeds



Source: NESTA Learning from Rapid Discovery Projects report

Following this, colleagues from NESTA interviewed parents and carers in Harehills and Shepherd's Lane (two areas where a lower proportion of children are currently reaching expected language and communication development in reception year) and identified parents' understanding of speech, language, and communication (SLC) and their experiences with services and their community:

- Parents recognised the importance of supporting their child's SLC learning at home. Some actively promoted enriching activities, but others faced financial and time constraints limiting their ability to do so.
- The importance of social networks and being well-connected to the community in determining whether parents accessed support.
- Parents' first port of call for advice was usually their child's nursery or the GP. Other trusted figures included health visitors, support workers and family and friends.
- Most families had heard of the local Children's Centre and the local library - but the majority had not accessed them.

Emotional health and wellbeing

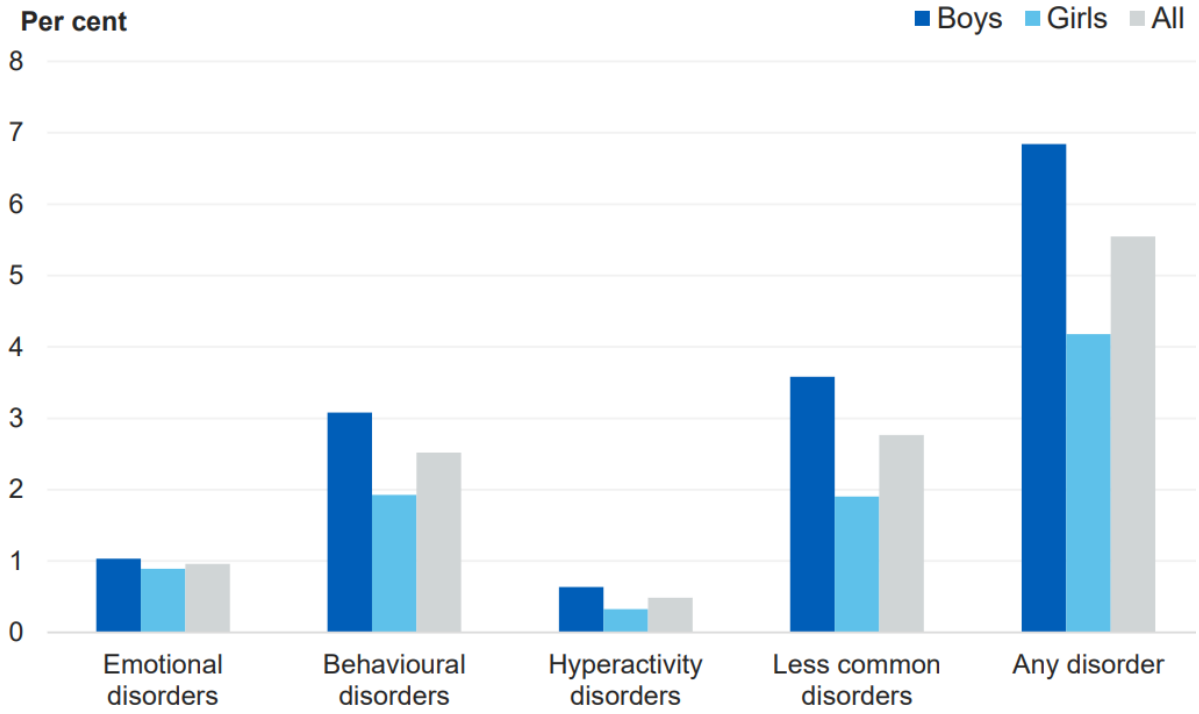
Mental health problems do occur in preschool children, but the prevalence is much lower than in older age groups.

According to experimental statistics reported by NHS Digital in 2017 5.5% of 2 to 4 year-old children experienced a mental disorder. This equates to 1 in 18 children in this age group. Data for this study were collected using a validated screening questionnaire with parents of children within this age

range only. As the methods used in the study were novel the statistics reported are described as 'experimental statistics'. The study found that behavioural disorders were evident in 2.5% of preschool children, with 1.4% of children being identified with Autism Spectrum disorder. Other disorders included sleeping disorders (1.3%) and feeding disorders (0.8%) (Figure 37).

2 to 4 years olds were not surveyed in the 2021 NHS Digital Follow Up Mental Health of Children and Young People in England Survey.

Figure 37 - Prevalence of mental disorders in preschool children by sex, 2017



Source: NHS Digital Mental Health of Children and Young People in England, 2017 – Preschool Children Report

There are no Leeds estimates for these figures.

Identified gaps in knowledge about current need

- As we look towards the introduction of family hubs, there is a requirement to better understand how to introduce the service to best meet the needs of children in this age-group and their families in Leeds. This will take an asset-based approach to build on the strengths existing in Leeds.
- Indicators described in this chapter are largely measured as children reach school in reception. Understanding of children in this pre-school age group is limited as, for many, contact with services is limited to the 2-2.5-year integrated review or private childcare providers such as childminders and nurseries, if these services are taken up.
- This chapter has reviewed inequalities related to deprivation and geographical variation in the city. Focus on other drivers of inequality is required.

6.3. Primary and Secondary Aged Children

Children aged 5 to 16 are considered in this section. The issues facing children within these age groups are captured within other chapters within this document. In particular the education and key health factors chapters.

This chapter therefore presents a brief population summary only.

Population Summary

There are 62,192 primary school and 50,774 secondary school aged children in Leeds (Figure 38 and Figure 39).

Figure 38 - Age distribution of Children in Leeds Aged 5-10 according to different population attributes.

		Total Number of Children in Leeds					% of children in Leeds				
Age band	Total	Males	Females	No of Children living in most deprived	BME Background	Non-English Language as first language	Males	Females	No of Children living in most deprived	BME Background	Non-English Language as first language
5 to 6	10417	5355	5062	2847	2939	1404	51.4%	48.6%	27.3%	28.2%	13.5%
6 to 7	10369	5298	5071	2894	2967	1442	51.1%	48.9%	27.9%	28.6%	13.9%
7 to 8	10337	5307	5030	2840	2839	1386	51.3%	48.7%	27.5%	27.5%	13.4%
8 to 9	10390	5324	5066	2845	2821	1345	51.2%	48.8%	27.4%	27.2%	12.9%
9 to 10	10863	5601	5262	3070	2943	1508	51.6%	48.4%	28.3%	27.1%	13.9%
Total	**52376**	**26885**	**25491**	**14496**	**14509**	**7085**	**51.3%**	**48.7%**	**27.7%**	**27.7%**	**13.5%**

"Most deprived fifth" refers to the number of children living in the 20% most deprived areas of Leeds. It is a within Leeds comparison and is not a national comparison as seen in the IMD deciles. "BME background" refers to those recorded as Asian, Black, Mixed, Chinese and Other. Those not included in this figure are those recorded as White or unknown or not recorded.

GP recorded data, data available via the following tool

Figure 39 - Secondary School Aged Children in Leeds

		Total Number of Children in Leeds					% of children in Leeds				
Age band	Total	Males	Females	No of Children living in most deprived	BME Background	Non-English Language as first language	Males	Females	No of Children living in most deprived	BME Background	Non-English Language as first language
11-12	10866	5518	5348	2989	2874	1488	50.8%	49.2%	27.5%	26.4%	13.7%
12-13	10559	5388	5171	2988	2735	1445	51.0%	49.0%	28.3%	25.9%	13.7%
13-14	10198	5252	4946	2849	2660	1434	51.5%	48.5%	27.9%	26.1%	14.1%
14-15	9642	4937	4705	2606	2479	1194	51.2%	48.8%	27.0%	25.7%	12.4%
15-16	9646	4979	4667	2634	2449	1161	51.6%	48.4%	27.3%	25.4%	12.0%

16-17	9164	4633	4531	2434	2236	1080	50.6%	49.4%	26.6%	24.4%	11.8%
Total	**50911**	**26074**	**24837**	**14066**	**13197**	**6722**	**51.2%**	**48.8%**	**27.6%**	**25.9%**	**13.2%**

"Most deprived fifth" refers to the number of children living in the 20% most deprived areas of Leeds. It is a within Leeds comparison and is not a national comparison as seen in the IMD deciles. "BME background" refers to those recorded as Asian, Black, Mixed, Chinese and Other. Those not included in this figure are those recorded as White or unknown or not recorded.

Source: GP recorded data, data available via the following tool

6.4. Transition to adulthood

Headlines

- The transition to adulthood is a period of change for young people in which they generally leave school and begin to experience independence. Young people who are in care and with long term health conditions experience disproportionate levels of challenge during the transition to adulthood.
- Leeds is a university city, and there is therefore a larger population of 17-24-year-olds compared to other areas.
- In March 2022 in Leeds 7.8% of all 19-year-olds were either "Not in Education or Training" or their status was 'Not Known'. This compares to a national proportion of 5.5%.
- In 2019/20 51.1% of young people aged 19 in Leeds achieved Level 3 qualifications*[62]. This compares 57.4% nationally.

Introduction

The title 'transition to adulthood' is used in this chapter to focus on the age group of 18-24-year-olds. However due to the range of topics covered themes may span a broader age range and where this occurs it will be clearly indicated in the text.

The transition to adulthood is a period of change for young people in which they generally leave school and begin to experience independence. This period has become increasingly challenging for young people living in areas of higher deprivation as evidence shows social mobility has stalled in the UK, for example the Marmot Review 10 Years On paper. Social mobility has stalled for many reasons including increasing levels of poverty (including in-work poverty), limited increase in wages and increasing inequality in wealth[63]. It means that those children born to the poorer families in the UK will take an average of five generations to reach the average income, compared to other countries such as Denmark where only takes two[64]. However, it is an age group often overlooked within systems and data sets, as it lies between adulthood and childhood. Therefore, this chapter is important as it highlights this age group and their unique health needs.

In Leeds the major of strategy for young people, the Leeds Children and Young People's Plan, is inclusive of those aged 0-19 or 0-25 for children with special educational needs and disabilities. However, as a result of growing awareness of the gap this creates in services for those transitioning to adulthood there are other strategies including Future in mind: Leeds which covers children and young people up to the age of 25.

*[62] A full level 3 qualification is equivalent to an advanced technical certificate or diploma, or 2 A levels

[63] State of the Nation 2022: A fresh approach to social mobility (publishing.service.gov.uk)

[64] A Broken Social Elevator? How to Promote Social Mobility - en - OCDE (oecd.org)

Epidemiology

Population Profile

According to the Leeds GP registered population in 2022 in Leeds there are 90,011 young people aged 17-24 (Figure 40).

Figure 40 - Age distribution of Children in Leeds Aged 17-24 according to different population attributes.

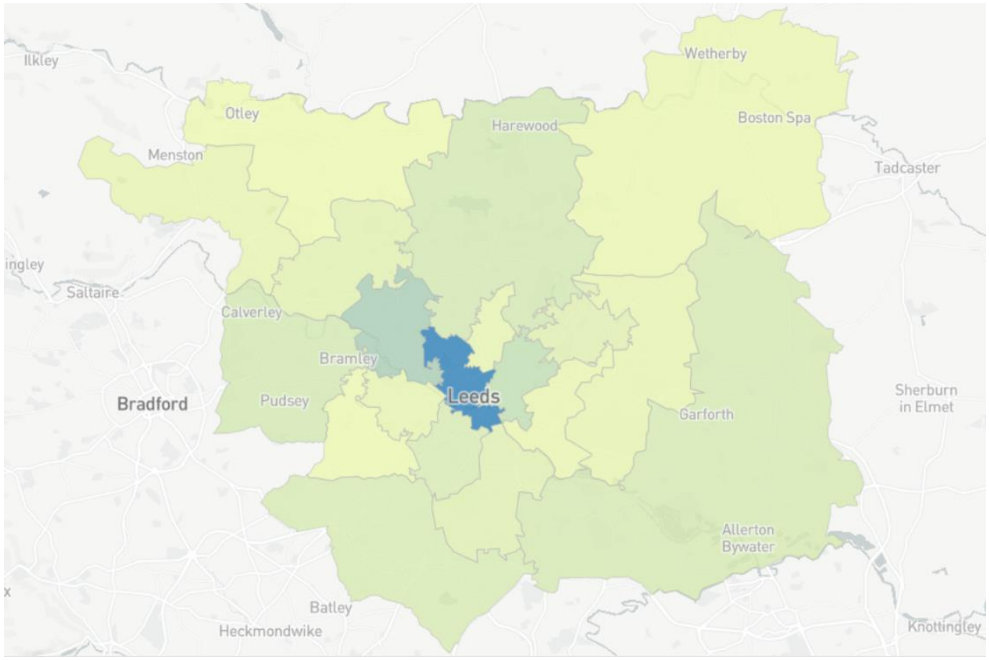
		Total Number of Children in Leeds					% of children in Leeds				
Age band	Total	Males	Females	No of Children living in most deprived	BME Background	Non-English Language as first language	Males	Females	No of Children living in most deprived	BME Background	Non-English Language as first language
17-18	9016	4593	4423	2514	2355	1106	50.9%	49.1%	27.9%	26.1%	12.3%
18-19	10840	5125	5715	2461	2556	1386	47.3%	52.7%	22.7%	23.6%	12.8%
19-20	12686	5726	6960	2394	3066	1665	45.1%	54.9%	18.9%	24.2%	13.1%
20-21	13710	6274	7436	2362	3481	2139	45.8%	54.2%	17.2%	25.4%	15.6%
21-22	14445	6659	7786	2511	3630	2470	46.1%	53.9%	17.4%	25.1%	17.1%
22-23	15565	7082	8483	2617	4415	3038	45.5%	54.5%	16.8%	28.4%	19.5%
23-24	16047	7280	8767	2864	5159	3713	45.4%	54.6%	17.8%	32.1%	23.1%
24-25	16235	7375	8860	2922	5539	3975	45.4%	54.6%	18.0%	34.1%	24.5%
Total	**55416**	**26351**	**29065**	**12165**	**13694**	**7376**	**47.6%**	**52.4%**	**22.0%**	**24.7%**	**13.3%**

"Most deprived fifth" refers to the number of children living in the 20% most deprived areas of Leeds. It is a within Leeds comparison and is not a national comparison as seen in the IMD deciles. "BME background" refers to those recorded as Asian, Black, Mixed, Chinese and Other. Those not included in this figure are those recorded as White or unknown or not recorded.

Source: GP recorded data, data available via the following tool

Leeds has one of the biggest student populations in the UK with around 70,000 students attending the city's three universities. This inflates the number of people in the 17-24-year-old age group in the city because a large proportion of people in the age group have moved to Leeds to study. One implication of a large group of young people moving to Leeds is an interruption from their usual health and care services and a need to access health and care services in Leeds. Geographically students are concentrated in the city centre and inner west of the city (Figure 41).

Figure 41 - Map of GP registered population of 17-24-year-olds in Leeds

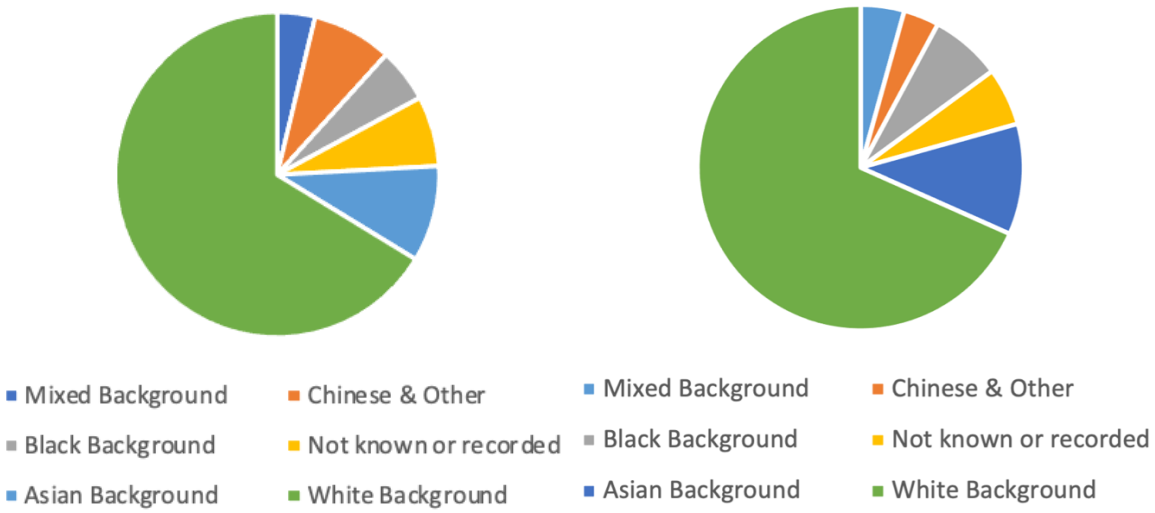


Source: GP recorded data, data available via the following tool

Leeds is an ethnically diverse city and the ethnic background of young people aged 17-24 in Leeds is shown below in Figure 42. From this chart the increase in diversity between the secondary school aged population and the university aged population can be seen. This is likely due to the influx of students to the city from other areas of the UK and abroad leading to changes.

Figure 42 - Ethnic Background of young people aged 17-24 (chart on left) and secondary school aged children (chart on right) in Leeds in 2022

University Aged Population (17-24 years) **Secondary School Aged Children (11 to 16 years)**



Source: GP recorded data, data available via the following tool

Education, Employment and Training Status

The education and employment status of young people is an important determinant of health. Those not in employment, education, or training (NEET) during the transition to adulthood are more likely to continue in unemployment and low paid jobs later in life and they are at higher risk of adverse mental and physical health conditions[65].

At age 19 when young people are moving into adulthood, marginally over half of Leeds young people achieved a level 3 qualification in 2019, 7% lower than nationally (Figure 43). For level 2 marginally over three quarters achieved this level of qualification, 5.5% below national rates[66]. For young people who were eligible for free school meals at 16, 50.7% attained a level 2 qualification in 2019 and 24.5% Level 3[67]. For Leeds, this reflects a wider gap for our less advantaged pupils as measured by FSM eligibility, evident at all ages.

The Department for Education monitors those not participating in Education, Employment and Training (NEET) through regular data submissions.

- The number of young people (aged 16-24 years old) in Leeds who are NEET or whose status is 'Not Known' in March '22 was 1,356 young people, which is 7.8% of people in that age range (Figure 43)[68].
    - This is composed of 429 who are NEET (2.5%) and 927 whose status is 'Not Known' (5.3%).
    - This is marginally lower than the previous year's figure of 7.9%.

[65] Review3_NEETs_health_inequalities.pdf (publishing.service.gov.uk)
[66] Level 2 and 3 attainment age 16 to 25, Academic Year 2019/20 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)
[67] Level 2 and 3 attainment age 16 to 25, Academic Year 2019/20 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)
[68] NEET age 16 to 24: 2021 - GOV.UK (www.gov.uk)

- The gap between Leeds and national has however increased from 2.4 percentage points to 3.1 percentage points in 2022. This is due to national NEET/Not Known figures since November being lower than the corresponding months in the previous year.
- A statistical first release is still awaited, so we await to see how this ranks Leeds compared to other comparable areas.

NEET and Not Known National guidance for this year emphasises the impact of COVID-19 on young people's learning with less emphasis on the national performance indicator. Additionally recent changes to the tracking system used by most Local Authorities and the national monitoring body has strengthened relationships with Post 16 learning providers and especially with schools in supporting young people through the transition from statutory education into post-16 learning.

Figure 43 – Level 3 qualifications at 19, Young people who are NEET or whose status is 'not known'

Measure	National	Stat neighbour	Result for same period last year	Result June 2021	Result September 2021	Result December 2021	Result March 2022	Direction of Travel
Level 3 Qualifications at 19	57.4% (2019/20)	55.3% (2019/20)	50.1% (2018/19)			51.1% (2019/20)		↑
Young people who are NEET	2.8% (2021 SFR)	3.0% (2021 SFR) Yorks and Humber	395 (2.4%)	453 (2.7%)	213 (1.3%)	332 (2.0%)	501 (3.07%)	↑
Young People whose status is 'not known'	2.7% (2021 SFR)	3.3% (2021 SFR) Yorks and Humber	854 (5.2%)	646 (3.9%)	2009 (12.7%)	1007 (6.2%)	819 (5.02%)	↓

DOT = direction of travel

Source: NEET age 16 to 24: 2021 - GOV.UK (www.gov.uk)

It is worth noting that even those in employment may face additional adversity within this age group because the national minimum wage is significantly lower for those aged under 23[69] (changed in April 2021 as minimum wage previously set aged 25) and employed 16-24-year-olds are three times more likely to be on zero-hour contracts[70].

[69] Gov.uk: National Minimum Wage and National Living Wage rates

[70] Office for National Statistics: Contracts that do not guarantee a minimum number of hours: April 2018

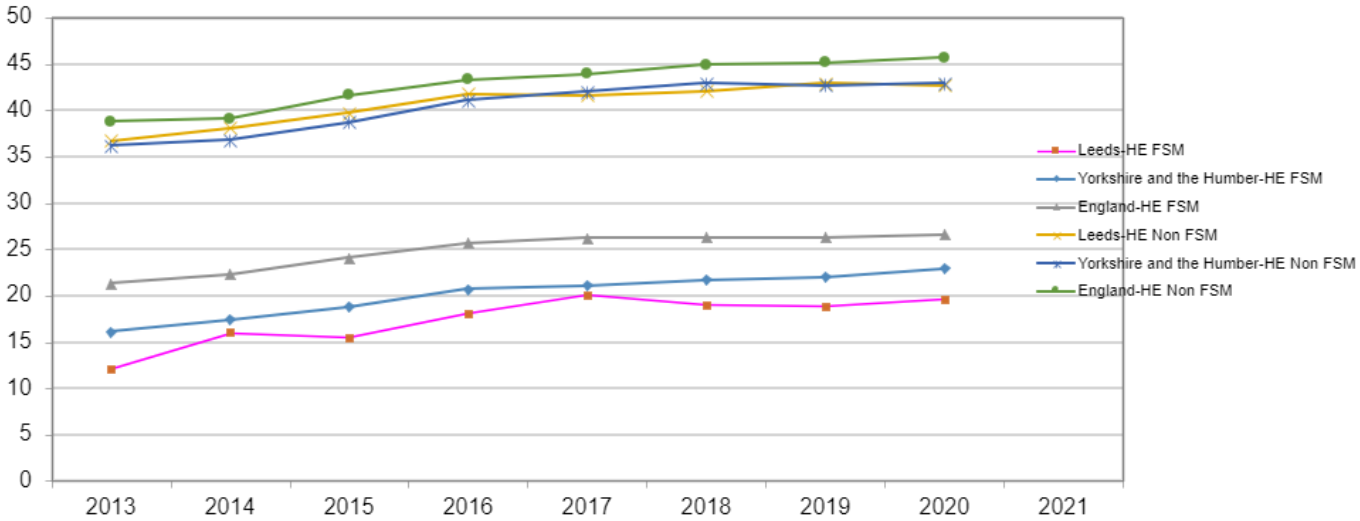
September Guarantee

Every young person of school Year 11 and Year 12 age is entitled to have an appropriate offer of education, employment, or training. This offer needs to be in place by the end of the September when they would enter Year 12 or Year 13. This is called the September Guarantee[71]. This may be full time education in a college, apprenticeships or employment with part time education or training. The local authority is required to lead the September Guarantee process for 16-year-olds who are educated in their area, and for 17-year-olds who are resident in their area. Data collated via the school census showed that using the combined data the proportion of young people in Year 11 and 12 who had an appropriate 'offer' remained in 2021 was 16,058 out of 17,230 young people (93.2%). This is against a backdrop of an increasing cohort, with 2,071 more young people being part of the September Guarantee cohort in 2021 compared to 2018; in 2021, there were 689 more young people than there were in 2020. Nationally, performance improved by just over one percentage point to 95.5%, increasing the gap between Leeds and national to 2.3 percentage points in 2021. Leeds ranked equal 131 out of 152 local authorities and was in the fifth quintile for performance. Therefore, across both indicators Leeds is underperforming compared to the UK average.

Progression to higher education

In 2020 in Leeds 41.3% of those attending state funded schools entered higher education by age 19. When broken down according to free school meals status when aged 15, 19.6% of those receiving free school meals went on to higher education, compared to 42.7% of those who do not receive free school meals. Across both groups (those eligible and not eligible for free school meals) Leeds performed worse than regional and national figures (Figure 44).

Figure 44 - Proportion of pupils attending state funded schools going on to higher education by age 19 according to Free School Meal status at aged 15 (Leeds, Yorkshire and the Humber and England) (2019/2020)



Source: Statistics: widening participation in higher education - GOV.UK (www.gov.uk), accessed via LAIT tool

[71] Leeds.gov.uk One Minute Guides – September Guarantee

Housing

Please also see housing chapter

Young adults often have their first experiences of independent living. As housing has an important impact on quality of life, mental and physical health it is crucial that appropriate support is given to young adults as they transition into independent living.

It is widely known that housing is an increasing problem for young adults, with house prices rising faster than average UK earnings and increased demand on social and affordable housing[72]. In Leeds there is a service called Our Way Leeds. This service is commissioned by children and adult social services and aims to support vulnerable people during the transition to adulthood, particularly those at risk of homelessness.

Care Leavers

Care leavers can leave care from the age of 16 and they must leave local authority by the age of 18[73]. This is inequitable as on average in the UK young people now live in their family home until the age of 23[74]. National research into care leavers views of leaving care published in January 2022 showed that more than a third of care leavers felt they left care too early. While for many the level of support received from the local authority tapers away between the age of 16 and 21, recent research shows that many children in care did not begin discussions about leaving care until they had reached 18[75]. The requirements of the local authority in terms of care during this period are outlined here and simply explained by the charity Shelter here.

For care leavers the transition to adulthood is often more challenging compared to others of their age. In addition to less support to transition to independence, children in local authority care have a disproportionately high experience of abuse or neglect compared to children growing up in family homes. Those in care also experience poorer outcomes across a range of measures including mental health and educational attainment. The national Big Ask Survey by the Children's Commissioner showed that the ambitions of care leavers are exactly the same as their peers. However in 2019 care leavers were less likely to be in education, training or employment compared to their peers, with national data showing that in 2019 35% of care leavers aged 19 were not in education, training or employment, compared to 11% of 18 year-olds in 2019. Further nationally just 6% of care leavers aged 19-21 go on to higher education compared to 34% of all 19-21-year-olds[76]. These findings along with other primary research have been compiled in a report by Barnardo's. The charity St Christopher summarise the below on their website:

"Statistically, care leavers achieve poorer outcomes than the general population:

- *46% of care leavers have some form of mental health issue compared to just 10% of their peers*
- *41% of 19-year-old care leavers are not in education*

[72] Social housing deficit - Shelter England
[73] Leaving foster or local authority care - GOV.UK (www.gov.uk)
[74] No-Place-Like-Home-Report-IKEA.pdf (barnardos.org.uk)
[75] 'Ready or not': care leavers' views of preparing to leave care - GOV.UK (www.gov.uk)
[76] 12by24-Publication.pdf (centreforsocialjustice.org.uk)

- *Only 6% of care leavers go to university*
- *25% of people who are homeless have been in care at some point in their lives*
- *22% of female care leavers become teenage parents*
- *More than 25% of the adult prison population have previously been in care"*

In Leeds there is a Care Leavers Council. This a group of young people who have experienced care and aims *"to improve the services care leavers receive from Leeds City Council, and to help make the difficult transition from care to adulthood a better experience for all young people."*

In Leeds the percentage of 19 to 21 year-old care leavers in education, employment or training in 2020/21 was 47% compared to an England average of 50% for the same metric[77]. The proportion of Care leavers in suitable accommodation aged 19, 20 or 21 in Leeds in 2020/21 is 80% compared to the England average of 90%[78].

See Priority Groups chapter for further information.

Substance Misuse

This age group are known to trial risk taking behaviours such as smoking, drinking and substance use. Some of this risk-taking behaviour may be attributed to the biological phenomenon of the 'teenage brain'. During teenage years there is massive change that occurs within the brain and as such there are impacts on behaviours during this period. An example of this is that areas of the brain associated with reward develop faster than the areas of the brain linked with self-control. This may lead to increased impulsive behaviour seen in teenagers[79]. As with all stages of children's lives there is a mix between the biological factors described via the changes in the brain structure but there is also very strong influence from the environment in which children live. This is even more so during adolescence as the brain has high levels of plasticity meaning there is the possibility for environmental influence to have particularly strong impacts during this time[80].

The majority of the data related to substance misuse in Leeds children and young people comes from the My Health My School Survey, but this data does not relate to the age group referred to in this chapter.

Forward Leeds produces annual data (available from Forward Leeds on request) on the numbers of young people aged 18-24 accessing services. These data show that in 2020/21 83 referrals were received with 65 young adults entering treatment. In line with their younger counterparts the primary substances for which treatment was sought were cannabis and alcohol. However, within this group, higher levels of use were noted and there is a wider range of substances being used. Again, much of these data are reported within adult datasets and it is estimated that the cohort of people aged 18-24 makes up 30-40% of the workload of Forward Leeds.

[77] Children in Need and Care in Leeds | LG Inform (local.gov.uk)
[78] Children in Need and Care in Leeds | LG Inform (local.gov.uk)
[79] Konrad K, Firk C, Uhlhaas PJ. Brain development during adolescence: neuroscientific insights into this developmental period. Dtsch Arztebl Int. 2013 Jun;110(25):425-31. doi: 10.3238/arztebl.2013.0425. Epub 2013 Jun 21. PMID: 23840287; PMCID: PMC3705203.
[80] Same as previous footnote

The local Leeds Drug and Alcohol Strategy and action plan take a life course approach and incorporates the transition to adulthood.

See alcohol, smoking and drugs chapter for further information related to children and young people's usage.

Young People with Long Term Conditions

Information related to the number of children with certain long-term conditions is contained in the population summary chapter.

For those in contact with healthcare services the transition to adulthood is intertwined with the transition from children's healthcare services to adults. Until the age of 18, services are provided by child health but between the ages of 16 and 18 planning will commence to transition across to adult services.

In Leeds this is supported by the LTHT Youth Service and there are dedicated youth workers to support young people through the process of transition. The keywords associated with this transition are displayed in Figure 45.

Figure 45 – LTHT Youth Service Keywords Associated with transition to adult healthcare services

Source: Leeds Children's Hospital Twitter

Mental Health

The transition from adolescence to adulthood is an important phase of life for both short and long term happiness (Mental Health Foundation, 2017) and as such is key window of opportunity for intervention. This Health Needs Assessment has not identified any Leeds level data related to mental health within this age group. Therefore, the below section is a summary of national level data.

According to the NHS Digital Mental Health of Children and Young People in England, nationally in 2021 the rate of probable mental disorder among 17-23 year-olds was 16.9%. This compares to 17.4% of 6 to 16 year-olds. There is a wide difference between genders with 10.7% of young men having a probable mental disorder compared to 23.5% of young women.

A concern in this age group is a rise in eating disorders. National level data from NHS Digital used the Eating Disorders Development and Well-Being Assessment model to identify those with possible problems associated with eating. This demonstrated that around three quarters (76.4%) of young women aged 17 to 23 screened positive. While this does not mean that this number have an eating disorder, as the tool is a simplistic screening questionnaire, it is indicative of an increased likelihood of problems with eating in the large majority of women in this age group.

Identified Gaps in Understanding

- Aside from data related to education, employment and training Leeds level data for this age group is relatively sparse within this Health Needs Assessment. Therefore, to better understand the local population further insight and identification of data is warranted.

7. Key Determinants of Child Health

7.1. Child Poverty

Headlines

- "***In the past***, child poverty levels in the UK have been significantly lower than they are today. They are lower today in many other comparable countries. Making sure every child gets a good start in life is the right thing to do and the smartest investment we can make as a country." Child Poverty Action Group, 2022
- 24.6% of children in Leeds are living in living in families in relative low income (2020/21). This is a 7.9% increase in the percentage of children under 16 living in families in relative low income between 2014/15 and 2020/21 (16.7%, 24.6%). The gap between the Leeds and England rate continues to widen from 1.5% in 2014/15 to 6.1% in 2020/21.
- The Leeds child population is growing faster in the localities considered most deprived. Between 2012 and 2018 the overall Leeds population grew by 4% and the child population (aged 0-17) grew by 7%. However, in the 10% most deprived areas the child population grew by 13%, and in the 3% most deprived it grew by 17%.

Introduction

Poverty is a complex issue with much debate over measures and definition. The definition of poverty used in the Leeds Thriving: The Child Poverty Strategy for Leeds 2019-2022 is Townsend's definition. This is one of the most used definitions of poverty as it describes a wider understanding of poverty*: "Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities, and have the living conditions and amenities which are customary, or at least widely encouraged or approved, in the societies to which they belong. Their resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary patterns, customs and activities*"[81].

Health and wealth are inextricably linked, and this is especially the case for children. Children living in poverty experience cumulative impacts of the intersections between poverty, exclusion, and discrimination[82]. They are more likely to experience adverse development, adverse childhood events, poorer health, and poorer long term social outcomes[83]. Additionally, a growing body of evidence indicates that effects of poverty on physiologic and neurobiological development are likely central to poverty-related gaps in academic achievement.

Children are more likely to be living in poverty than adults. After housing costs in the UK in 2020/21 3.9 million children were living in poverty, which equates to 27% of children, or 8 in a classroom of

[81] Poverty, participation and choice: the legacy of Peter Townsend (jrf.org.uk)
[82] Effects Of Child Poverty | The Children's Society (childrenssociety.org.uk)
[83] Child poverty: the crisis we can't keep ignoring – Children's Commissioner

30[84,85]. While COVID-19 significantly impacted the economy, even prior to the COVID-19 pandemic the levels of child poverty in the UK had been rising for the past 5 years. The highest rates of poverty (around 50%) are experienced by children of lone parents and children in households headed by someone of Bangladeshi or Pakistani ethnicity[86]. Other factors associated with a higher risk of poverty include being in a family in which someone is disabled, is from a minority ethnic background or being from a family where no one is in paid employment. However, it must be recognised that 75% of children living in poverty live in families where someone is working[87].

The UK government have implemented numerous policies which deeply affect children living in poverty. Recently welfare reforms in the UK, including the change to Universal Credit have negatively impacted low-income families[88]. Alongside this there has been a reduction in the level of support available to children and families living in poverty, for example through the reduction of number of Children's centres at a national level[89].

Leeds aims to be a compassionate city and to be the best city for children and young people to grow up in. Central to this is addressing poverty and this is highlighted in the City Ambition, which is an umbrella including the health and wellbeing strategy and inclusive growth strategy and the Children and Young People's plan. Specifically Thriving: The Child Poverty Strategy for Leeds outlines how poverty is addressed in the city and regular reports outline the impacts of this.

Epidemiology

The Children's commissioner produced a national report entitled "Child poverty: the crisis we can't keep ignoring" in January 2021. This report outlines the extent of the impact of poverty on children in the UK.

The Leeds Observatory publishes regularly updated information related to poverty in the Leeds Poverty Factbook. This contains information related to statistics on poverty in the city, child poverty, wages, welfare benefits and universal credit, in work poverty, food poverty, fuel poverty, debt and the Index of multiple deprivation.

In March 2022 a report was written by Leeds City Council – Update on Thriving: The Child Poverty Strategy for Leeds.

Appendix 6 provides detailed analysis of My Health My School survey data according to Free School Meal Status.

The Institute of Health Equity produced a report in 2022 outlining the impacts of fuel poverty in the UK - Fuel Poverty, Cold Homes and Health Inequalities in the UK

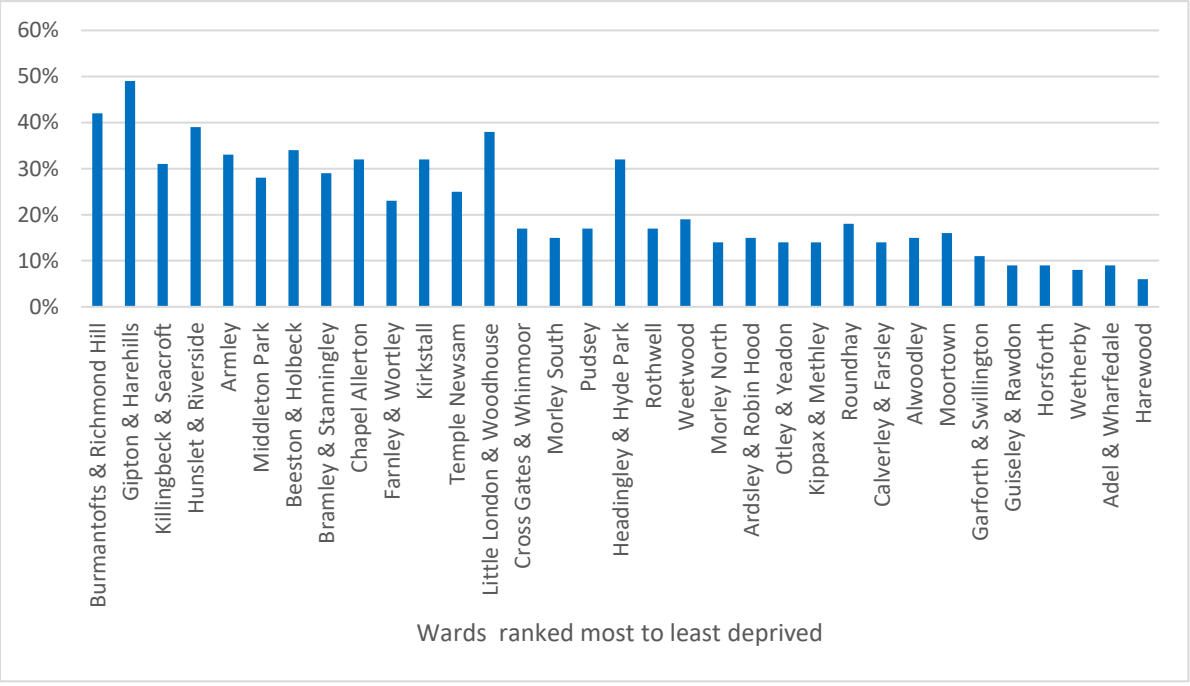
[84] Child poverty facts and figures | CPAG
[85] Households Below Average Income, Statistics on the number and percentage of people living in low income households for financial years 1994/95 to 2020/21, Table 1.4b and Table 1.4a. Department for Work and Pensions, 2022
[86] Households Below Average Income, Statistics on the number and percentage of people living in low income households for financial years 1994/95 to 2019/20
[87] Households Below Average Income, Statistics on the number and percentage of people living in low income households for financial years 1994/95 to 2019/20
[88] universal_credit_report-lr.pdf (peabody.org.uk)
[89] How budget cuts have impacted children's centres | Policy report | Action For Children

Children in low-income families

Leeds has seen a 7.9% increase in the percentage of children under 16, in relative low-income families between 2014/15 and 2020/21 (16.7%, 24.6%). The gap between the Leeds and England rate continues to widen from 1.5% in 2014/15 to 6.1% in 2020/21.

The percentage of children living in relative poverty across Leeds wards ranges from 49% in Gipton & Harehills to 6% in Harewood. Figure 46 shows a predictable pattern of the highest rates of child poverty in the most deprived wards, with a couple of noticeable outliers, i.e., Little London and Woodhouse, and Headingley and Hyde Park. In both areas much of the poverty is masked at the level of reporting but is highly existent in small pockets within the community. For example, in Headingley much of the poverty in the area is masked by the transient and relatively affluent student population in the area. Additionally in Little London and Woodhouse there is diversity in the population with over 63 different languages spoken between the Children's Centres in Woodhouse (Quarry Mount), Burley and Little London and 33 languages at Little London Primary School. In addition to this the area is a magnet for newly arrived families from other countries and there are many relatively cheap private rented accommodations in the area. Notably there is some extremely positive work happening within these areas targeted at those impacted by poverty. For example, the Communities Teams have recently conducted some cost-of-living crisis workshops with practical actions.

Figure 46 - Percentage of children living in relative poverty by ward 2020



Source: Children in low-income families: local areas statistics. Department for Work and Pensions

Fuel Poverty

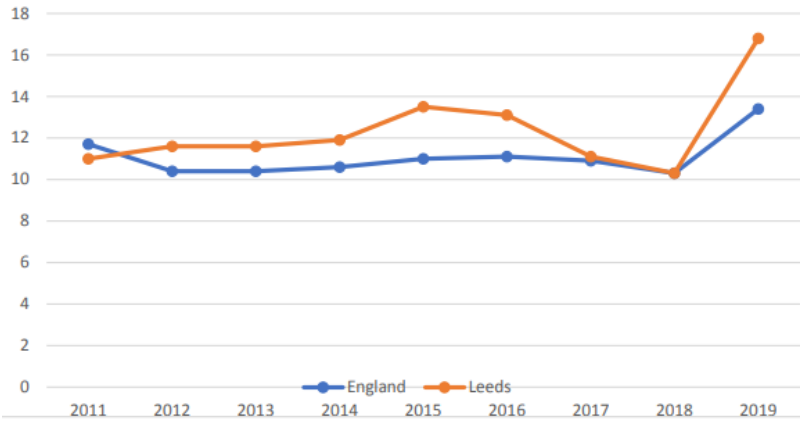
In the UK 55% of households are predicted to experience fuel poverty in January 2023[90]. Fuel poverty in England is measured using the Low-Income Low Energy Efficiency (LILEE) indicator. Under this indicator, a household is considered to be fuel poor if the household's fuel poverty energy efficiency rating is Band D or below, and their disposable income, after housing and fuel costs, is below the official poverty line[91]. Fuel poverty impacts on households with children hardest, unsurprisingly, as this demographic is especially susceptible to socioeconomic difficulty. Long-term exposure to a cold home can affect weight gain in babies and young children, increase hospital admission rates for children, and increase the severity and frequency of asthmatic symptoms. Children in cold homes are more than twice as likely to suffer from breathing problems, they are also more likely to experience depression, anxiety and slower physical growth and cognitive development. Cold houses generally suffer from poor ventilation, damp and mould as windows and doors stay closed in an attempt to keep any heat in, thus resulting in children being up to three times more likely to suffer from coughing, wheezing and respiratory illness, compared with those with warm, dry homes. This is a problem set to worsen with the current soaring energy prices[92].

Children in cold homes are more than twice as likely to suffer from respiratory problems such as asthma and bronchitis. Cold increases the likelihood of what are normally considered minor illnesses such as cold and flu, but from which young children, in particular, are vulnerable to becoming more seriously ill[93]. Evidence also indicates a link between home temperature and mental health. Findings from a study undertaken by the National Centre for Social Research found that young people living in cold homes were more likely to be at risk of multiple negative mental health symptoms, experiencing four or more. 28% of young people in cold homes were at risk of multiple mental health symptoms, compared with 4% living in suitably warm homes[94].

The most recent fuel poverty figures were published in April 2021 and are compiled with data from 2019. In West Yorkshire, there are 169,097 (17.2%) households living in fuel poverty compared to the England average of 13.4%. This data shows Leeds having experienced a sharp increase in the proportion of households experiencing fuel poverty, rising from 10.3% in 2018 to 16.8% in 2019 (Figure 47 and Figure 48). This equates to an increase of 22,772 households in the last year to a figure of 57,429. While the fuel poverty rate for England has also increased abruptly, this has not been to the same extent seen in Leeds (Figure 47 and Figure 48).

[90] Fuel Poverty, Cold Homes and Health Inequalities in the UK - IHE (instituteofhealthequity.org)
[91] Fuel poverty statistics methodology handbooks - GOV.UK (www.gov.uk)
[92] Fuel Poverty, Cold Homes and Health Inequalities in the UK - IHE (instituteofhealthequity.org)
[93] Fuel poverty and human health: A review of recent evidence (2010)
[94] Fuel poverty and human health: A review of recent evidence (2010)

Figure 47 - Fuel poverty rate in Leeds and England



Source: Fuel Poverty sub-regional statistics. Department for Business, Energy & Industrial Strategy

Figure 48 - Households in fuel poverty

Fuel Poverty LIHC	2019	2018	2017	Change 2018-19
Leeds households	57,429	34,657	36,926	+22,772
Leeds % of households	16.8	10.3	11.1	+6.5
England households	3,176,000	2,400,000	2,532,000	+776,000
England % of households	13.4	10.3	11.0	+3.1

Source: Leeds Observatory Data Explorer, Department for Business, Energy and Industrial Strategy, June 2021

With the increases in energy implemented across 2022, it is expected that this figure will continue to rise sharply.

Food Poverty

In April 2022 research conducted by the food foundation found that 15.5% of all UK households were food insecure. This is defined within the research as having eaten less or went a day without eating because they could not access or afford food.

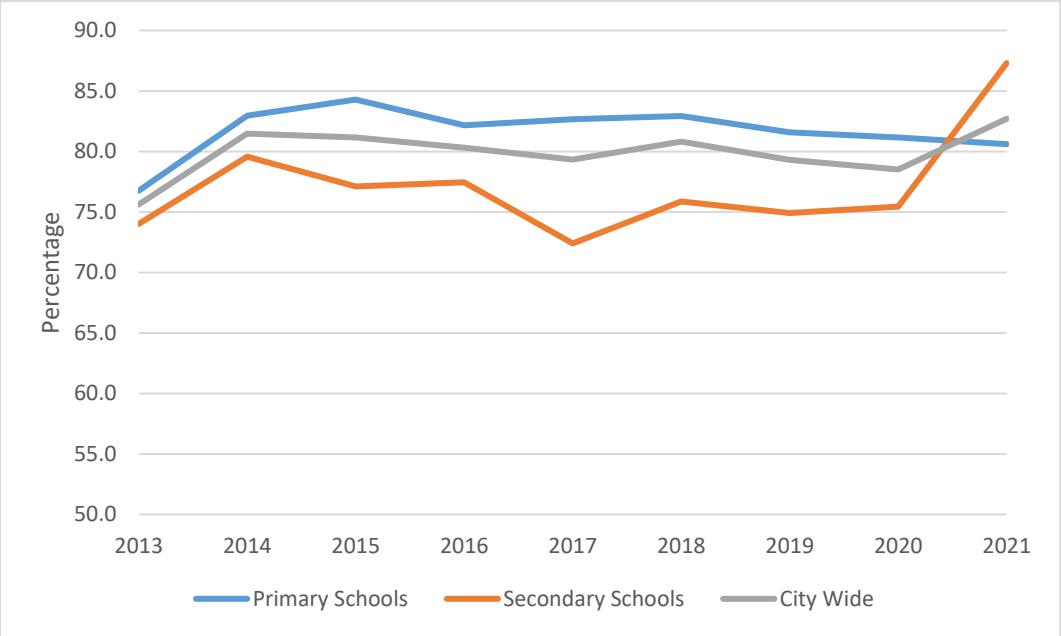
Between 1ST April 2020 and 31ST March 2021, 153,335 food parcels were given out informally in Leeds via Community Care Hubs, Emergency Food Provisions, which equates to an 860% increase since 2019/20. 61,137 people accessed a foodbank in 2020/21, which is a 47% increase on 2019/20. These large increases are likely due to the COVID-19 pandemic. National data however shows us that while 2020/21 is likely to represent a peak year for food bank usage, there is a general trend of increasing usage. Data from the Trussell Trust (a charity operating around 1300 food banks across the UK) shows that the charity supplied 2.2 million three-day emergency food parcels in 2021/22 which is an increase of 14% compared to 2019/20.

It is unclear how many of these food parcels are given to families and children and young people in the city. However, with children disproportionately affected by poverty and the increasing cost of living, food insecurity is concerning.

Free School Meals

24.1% of Leeds pupils were eligible for FSM in 2020/21 (Figure 49), higher than both the Yorkshire & Humber eligibility rate of 21.9% and England rate of 19.7%. Of those eligible for FSM in Leeds during 2021, uptake was 82.7% compared to 78.5% in 2020 and is the highest take up rate recorded since 2013. The increase in secondary school uptake was most noticeable rising to 87.3% in 2021 compared to 75.4% in 2020.

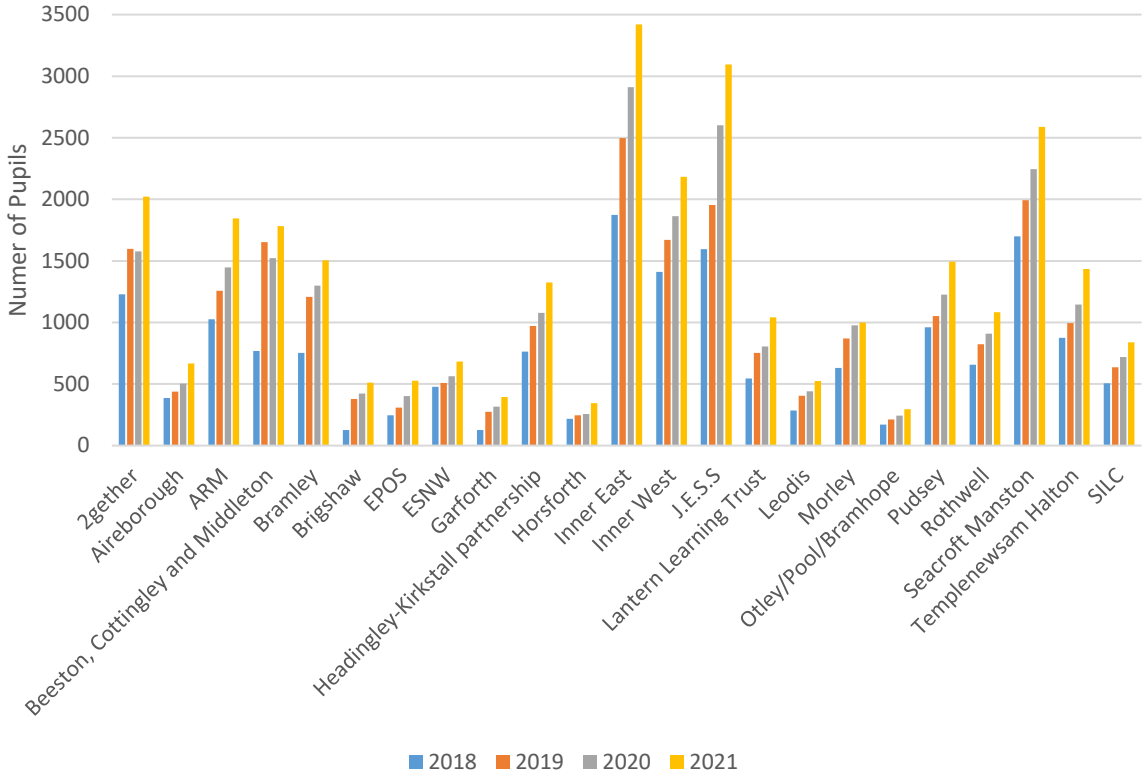
Figure 49 - Leeds Free School Meal Uptake (2013-2021)



Source: Free School Meal Take up, Department for Education 2013-2021

2021 data shows an increase in FSM eligibility across all Leeds clusters (Figure 50). More noticeable eligibility increases can be seen in those clusters with the highest rates, i.e. Inner East and Jess clusters.

Figure 50 - Free School Meal Eligibility by Cluster



Source: Free School Meal Take up by Cluster, January School Census and Department for Education

Identified gaps in understanding of need

- Poverty impacts across indicators and a continued focus on differences between advantaged and less advantaged children is required.
- As we know, poverty is a determinant of poorer outcomes for children comparing areas within Leeds produces a relatively predictable pattern of health impacts. Therefore, to compare findings across similar areas according to IMD in core cities and a national level would be useful in providing meaningful benchmarking.
- Further understanding of assets improving outcomes for children living in poverty is required. While this may be known this chapter does not include extensive information.

7.2. Housing

Headlines

- Where children live, the condition, location and stability of their accommodation has a wide-ranging impact on their early health and development[95].
- In Leeds there are very few families classified as homeless due to being in temporary accommodation (15 families at time of writing - April 2022).
- According to Leeds Housing Options:
    - 11,300 people living in families with dependent children are on the register seeking social housing.
    - 23% of **all** those on the social housing register have needs that have been assessed as urgent.

Introduction

Where children live, the condition, location and stability of their accommodation has a wide-ranging impact on their early health and development[96]. Households with dependent children are more likely than those without to live in private or social rented accommodation[97]. While over half of households with dependent children are owner occupiers, the proportion in private rented accommodation is rising[98]. Changes to housing benefits and rising house prices and rent are likely to mean that more families of young children struggle with the cost of accommodation. A report by the Royal College of Paediatrics and Child Health called Poverty and Child Health: Views from the frontline in 2017 included a survey of 266 paediatricians and found more than two thirds reported homelessness or poor housing contributes to the ill health of the children they work[99].

In Leeds, as elsewhere, the local authority has a legal duty to house children which means that children should never have to sleep rough. Leeds has both an overarching Housing Strategy and a Homelessness and Rough Sleepers Strategy, both of which are currently under review and include actions to improve housing for local families. The local authority employs Leeds Housing Options team who support those at risk of being homeless or seeking social housing. The team have established good relationships with Children and Families Directorate colleagues and at the time of writing in July 2022 were reviewing existing protocols to improve housing support for families with Children in Need or on a Child Protection Plan, 16 -17-year-olds and Care Leavers. A member of the Homelessness team attends the Corporate Parenting Board.

While action at the local level is vital, the Housing sector are also calling on the government to take more long-term measures to tackle debt, rent arrears associated with COVID-19, protect families from eviction and invest in a new generation of social homes. To lift children and their families out of bad housing and homelessness, the national charity Shelter is calling on the government to:

- Strengthen our welfare safety net, by removing the benefit cap and ensuring housing benefit is fit for purpose.

[95] Fuel poverty and human health: A review of recent evidence - ScienceDirect
[96] Fuel poverty and human health: A review of recent evidence - ScienceDirect
[97] EHS_19-20_PRS_report_FINAL.pdf (publishing.service.gov.uk)
[98] Poverty in the UK: statistics - House of Commons Library (parliament.uk)/
[99] Poverty and child health: views from the frontline | CPAG

- Bring forward urgent legislation to end Section 21 “no fault” evictions, which remains one of the leading causes of homelessness.
- Tackle the root cause of the housing emergency, by investing in a new generation of social homes.

Epidemiology

Below is a detailed analysis of housing in relation to child health in Leeds. Within the housing sector in Leeds, it is acknowledged that the high cost of the private rental sector, and lack of social housing mean some of our most vulnerable families live in homes that are having a detrimental impact on their health, and limit children’s life chances. The recent cost of living increases have magnified the issue by reducing the proportion of family income available for rent.

Information about housing in Leeds is published and regularly updated on the Leeds Observatory Housing page.

Temporary Housing and Homelessness

In Leeds, as elsewhere, the local authority has a legal duty to house children which means that children should never have to sleep rough. Given the lack of available social housing homeless families may need to be housed in temporary accommodation. Because they do not have a permanent home and they can be moved on at very short notice they are officially classified as homeless.

In Leeds there are very few families classified as homeless due to being in temporary accommodation (15 families at time of writing - April 2022).

The Authority recognises that while Leeds homeless figures are relatively very low compared to other core cities, they do not truly reflect the level of unmet housing need as many families choose to remain in existing housing or move into the private rented sector until a council or social housing alternative can be found.

Social Housing

The demand for social housing far outstrips the number of houses available and while in 2018 the government made its first commitment in ten years to building homes for social rent, research by the National Housing Federation shows that there is a need for over 17 times the number of social houses currently being built in England[100].

Leeds, like other areas, is required to sell council housing via the right to buy scheme and currently sells off almost 3 times as many houses as it is currently funded to build.

Leeds Housing Options Service within Leeds City Council report that at the time of writing in 2022:

- There are around 26,000 people in Leeds on the Leeds Homes register seeking access to social housing
- Of these around 11, 300 are families with dependent children.

[100] New homeless families outnumber new social homes by 8 to 1 (National Housing Federation, 2019)

- Of the current 26,000 seeking social housing round 6,000 have been assessed as in urgent need.

Private Rental Market

Like elsewhere Leeds private rental market has doubled in size in the last 20 years, has higher rental costs than social housing, and families are overrepresented within this sector and particularly in Inner East and Inner South of the city. Private rented homes are more likely to be non-decent than any other housing type (as detailed in bullet points below). The cost of private rents in less deprived areas outstrips welfare benefits leading to the poorest families only being able to afford housing in the most deprived areas of the city placing their children at multiple disadvantages. The Housing Stock Condition Survey (2017) highlighted Inner east and Inner South areas have the poorest standards of accommodation of anywhere in the city[101]. Unfortunately there is currently no data available that can provide an indication of the number of children and young people who live in non-decent private rented homes.

Leeds Private Rental team oversee and work with the sector to improve the quality of private rented housing in Leeds and manage any rogue landlords. The team undertake the Housing Stock Condition Survey. The key findings from the most recent Leeds survey in 2017 are summarised below:

- 46,044 dwellings in the private sector have category 1 Housing Health and Safety Rating System (HHSRS) hazards. Category 1 hazards are the most serious hazards[102]. This equates to 17% of properties.
- 16,948 dwellings in the private rented sector have category 1 HHSRS hazards. This equates to 25% of properties in the private rented sector.
- The highest concentrations of all HHSRS hazards in the private sector are found in the wards of City and Hunslet, Gipton and Harehills and Headingley.
- The total cost of mitigating category 1 hazards in Leeds's private sector stock is estimated to be £103.1 million.
- The highest concentrations of fuel poverty (Low Income High Costs definition) in the private sector are found in the wards of Headingley, Gipton and Harehills and Hyde Park and Woodhouse and for excess cold the highest concentrations are in City and Hunslet, Hyde Park and Woodhouse and Burmantofts and Richmond Hill.
- A SAP rating is a measure of the energy efficiency of a dwelling. Scores range from 0-100, with higher scores representing improving energy efficiency. The average Simple SAP[103] rating for all private sector dwellings in Leeds is 57, which is better than both England (55) and Yorkshire and The Humber (56).

[101] English Housing Survey 2017: stock condition - GOV.UK (www.gov.uk)

[102] Dwellings are assessed using the HHSRS to determine if any defects or deficiencies associated with the dwelling could contribute towards a hazard which has the potential to cause harm. The seriousness of the hazard is then scored and dependent upon that score rated as either a Category 1 or Category 2 hazard. Local Housing Authorities (LHA) have a legal duty to address the most serious Category 1 hazards and discretionary powers to address Category 2 hazards

[103] Standard Assessment Procedure - GOV.UK (www.gov.uk)

- Energy efficiency of homes can also be reviewed by looking at the Energy Performance Certificate (EPC) rating. 8.6% (23,488) of *private sector* dwellings and 15.2% (10,214) of *private rented* dwellings in Leeds are estimated to have an EPC rating below band E.

The team have developed and promote the Leeds Rental Standard, a self-accreditation scheme that awards Landlords that meet higher than minimum standards. The team have also introduced selective licensing in areas of greatest need to drive up the quality of the private rented market.

In the rental market, housing costs in Leeds are also considerably higher than in our neighbouring authorities. Figure 51 demonstrates that for an average family seeking to rent a two-bedroom property today, they're facing roughly 23% higher costs compared to Wakefield, 25% higher than in Bradford, 30% higher than in Calderdale and 31% higher than in Kirklees.

Figure 51 - Median monthly rents (2020/21) for two-bedroom properties in West Yorkshire

Source: Private rental market summary statistics in England (ONS, June 2021)

Housing Benefits

Leeds City Council operate a system whereby residents can apply for housing benefit if they are in temporary accommodation provided by the council or discretionary housing payments that can be used to support vulnerable families and young people to secure private rented accommodation when they do not have access to the necessary funds, for example paying for bonds and rental fees in advance. Most families are not eligible for these payments as an allowance for housing is included in the universal credit they receive.

Identified Gaps in Understanding

- Further analysis of the data within the Leeds Homes register will enable better understanding Leeds children housing needs.
- Better understanding of the landscape of interaction between staff in child health, early years and social care and housing support services would be useful to facilitate high quality and timely referral for support.
- Further economic analysis of the impacts of the shortfalls in social housing in the city will enable better understanding of potential health impacts.

7.3. Education

Headlines

- Education is vital and there are direct links between education and health, with schools playing an important role in the wider safeguarding system for children.
- According to the 2020-21 Leeds My Health My School Survey 83% of primary pupils and 63% of secondary pupils agreed that their school was a caring place.
- The majority of schools in Leeds are judged by Ofsted as either 'Good' (67%) or 'Outstanding' (16%). There were 11% of schools judged as 'Requires Improvement' and 6% 'Inadequate'.
- 42% of Leeds pupils achieve a strong pass in English and Maths GCSE (grade five of higher) in 2019, very slightly higher than the 2018 figure. The national figure for 2019 was 43% (Figure 52).

Introduction

Education is vital and there are direct links between education and health[104]. Higher levels of education are associated with a range of health benefits, including improved educational attainment, greater social mobility, fewer co-morbidities, and longer life expectancy[105]. For children securing a good quality education shapes life opportunities and therefore has an important role in reducing health inequalities[106]. Further to educational outcomes school provides safe and supportive spaces for children in which they are supported by teachers to learn and develop[107]. For some children school therefore provides a safe respite from challenging home situations.

Leeds has a longstanding gap between more and less advantaged children achieving their potential, particularly at pre-school and primary, and particularly for our poorest children. These issues are very likely to have been exacerbated further by COVID-19[108]. The councils 'Three As' strategy sets out the city's direction and approach to change. The Three As are:

- Attendance because it is recognised that being in schools means children are not just more likely to learn but be safe and build friendships.
- Attainment to focus on exam results and academic progress.
- Achievement, here defined in its widest sense to include not just exams but personal and social development and wider growth and success.

Additionally learning fundamentally underpins wellbeing and the Leeds Children and Young People's Plan (2019-2023) places strong focus on learning, and readiness for learning, to narrow the gap and enable all children and young people - particularly those learners who are vulnerable to poor outcomes to realise their potential.

[104] The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015
[105] Education, schooling and health summary - GOV.UK (www.gov.uk)
[106] The role of education in reducing health inequalities - Health Action Campaign
[107] Importance Of Schools | The Children's Society (childrenssociety.org.uk)
[108] Learning during the pandemic: review of research from England - GOV.UK (www.gov.uk)

Epidemiology

Detailed information on all schools and colleges performance at the end of Key Stage 2, Key Stage 4, Ofsted ratings, absence and finance data is available via the gov.uk compare school performance website.

Appendix 4 contains a snapshot from the Leeds Children and Young People's Plan Key Indicator Dashboard. This is a regularly updated source of data related to education (and other indicators) for children in Leeds.

Schools Provision

In terms of education provision in Leeds, there are currently 58 Children's Centres, 222 primary schools (including infant and 1 junior school), 44 secondary schools, 28 colleges and 3 universities. There are also 5 schools specifically catering for children and young people with additional needs.

At the time of writing in 2022 Ofsted judgements of schools demonstrate that the vast majority of schools in Leeds are judged either 'Good' (67%) or 'Outstanding' (16%)[109]. There were 11% of schools judged as 'Requires Improvement' and 6% 'Inadequate'[110]. Those schools where Ofsted identify improvements are required can access support through the local authority Education Safeguarding Team or the LSCP Education Reference Group.

Early Years

Please see Early Years Chapter.

Key Stage 2

Results at the end of Key Stage 2 focus on a child's attainment and progress in maths, reading and writing. Writing is based on teacher assessment, reading and maths on end of key stage tests.

Results reported below are from 2018/19 academic year. This is because this was not recorded during 2019/20 or 2020/21.

- 62% of Leeds year 6 children achieved the expected standard in reading, writing and maths, compared to 64% of children nationally.
- There was a 6% increase between 2016/17 and 2017/18 in the proportion of disadvantaged pupils gaining the expected standard in reading, writing and maths. However, this figure remained at 45% in 2018/19, still 6% points below the national level for disadvantaged pupils.
- There remains a gap of 26% in attainment between disadvantaged and non-disadvantaged pupils in Leeds, six points greater than the national gap between these cohorts.

Initial results from 2021/22 academic year show 57% of Leeds year 6 pupils achieved the expected standard in reading, writing and maths, which is the same as the national average. This is suggestive that COVID-19 has negatively impacted this cohort.

[109] All schools and colleges in Leeds - GOV.UK - Find and compare schools in England (compare-school-performance.service.gov.uk)
[110] All schools and colleges in Leeds - GOV.UK - Find and compare schools in England (compare-school-performance.service.gov.uk)

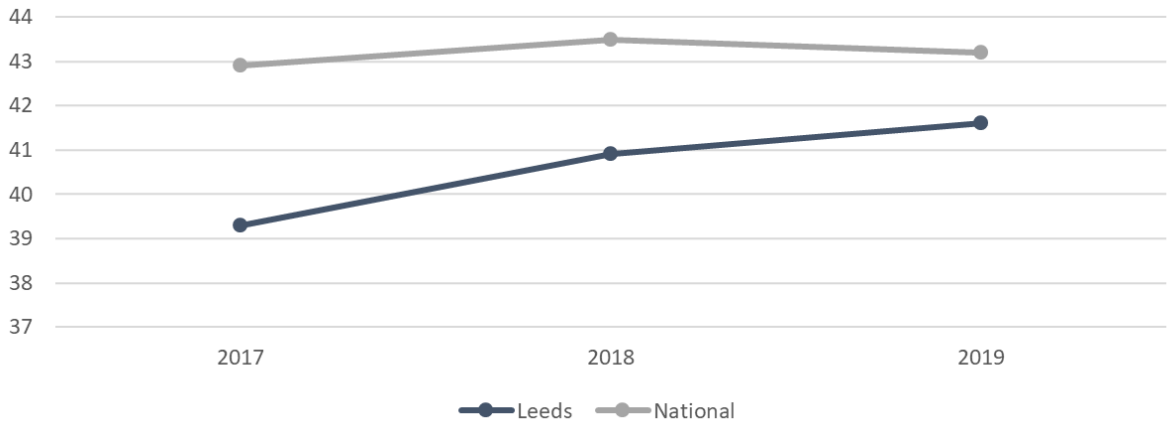
Key Stage 4 and beyond

For data related to progression to higher education, including comparison between those eligible for free school meals and those who are not. Please see Transition to Adulthood chapter.

Headline measures at key stage 4 are based on the results of eight GCSEs or equivalent, including English and Maths. The overall achievement is known as Attainment 8.

- In 2019, the average Attainment 8 score per pupil in Leeds was 45.1, which is slightly higher than the 2018 figure of 44.8. The gap to national narrowed slightly, from 1.8 points in 2018 to 1.6 points.
- Disadvantaged children in Leeds perform less well than their non-disadvantaged peers, gaining an average point score of 35.4, compared to 49.4. This is also below the national figure for disadvantaged pupils which stands at 36.8.
- 42% of Leeds pupils achieve a strong pass in English and Maths (grade five of higher) in 2019, very slightly higher than the 2018 figure. The national figure for 2019 was 43% (Figure 52).

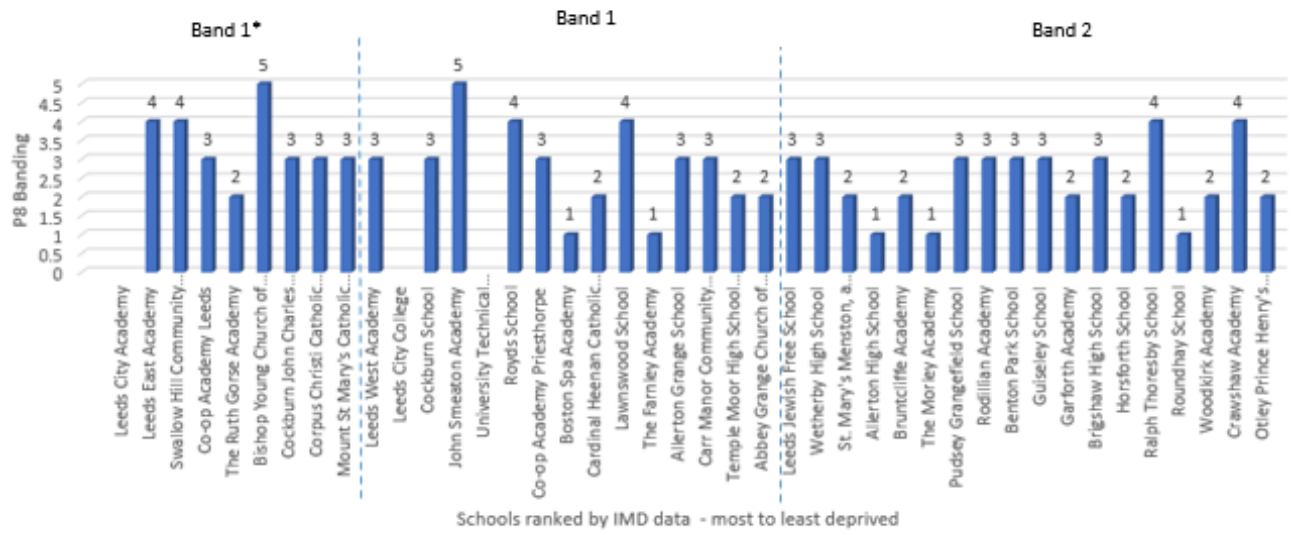
Figure 52 - Key Stage 4: pupils achieving a strong pass in English and Maths (2017 to 2019)



Source: Department for Education and Leeds City Council

Progress 8 is a measure that indicates how much pupils have improved during secondary school when compared to pupils in the same year group who were at the same academic level when they finished Key Stage 2. Figure 53 show Leeds P8 achievement and ranked using the Healthy Schools Programme Banding criteria in order from least to most deprived. Making a comparison or assumptions between child poverty and a school's P8 score is unhelpful as not all pupils will attend a school in the ward they live. Nevertheless, it is notable that more schools with 'well above average' and 'above average' scores are in the Band 2 (least deprived) category.

Figure 53 - Leeds Progress 8 scores 2018-2019 by ward



P8 Banding – 1= well above average, 2= above average, 3= average, 4= below average, 5= well below average. Where schools are blank data is suppressed or they were not open/using a different name.

Source: School progress data, LCC Intelligence and Policy and Department for Education

School Attendance

At a national level the Children's Commissioner published the findings of an attendance audit in June 2022. This reported that the number of children persistently absent from school in Autumn 2021 (1 in 4) was more than double that in 2018/19 (1 in 9). The report outlines detailed information from research conducted in 10 local authorities to better understand the experiences of children missing from education.

Children's and young people's education has significantly been disrupted during the COVID-19 pandemic. Throughout this period, monitoring of numbers of pupils attending school has occurred which has been reliant on regular reporting from schools to the DfE, with data then being made available to local authorities.

During this time school attendance rates have varied significantly in line with national regulations. The below bullet points are sourced directly from the Leeds Joint Strategic Assessment.

- Attendance was just 1.7% from March to May 2020 as school was open to only children of key workers and vulnerable children.
- Attendance rose to 16.7% in June and July 2020 with school open to a small number of additional year groups.
- With school open as normal, attendance at the start of the 2020/21 academic year was 83%, affected by the collapse of 'bubbles'.
- Attendance fell again to 20% in January 2021 when lockdown was reimposed.

In the autumn term 2020/21 the number of school enrolments in Leeds that missed at least one session due to a COVID-19 related absence was 66.8%[111]. DfE analysis suggests an overall Leeds school absence rate of 4.6% plus an additional 8.6% due to COVID-19. For England, it was 4.6% and lower COVID-19 additionality of 7%. Leeds overall absence rate inclusive of COVID-19 was in line with the region. For autumn 2019 the Leeds absence rate was 5.2%.

The January school census saw a return to the submission of pupil level information for the autumn term 2020/21. Attendance data has been further analysed in line with the DfE methodology, which removes the impact of COVID-19. This means that any COVID-19 related absence is removed from the overall statistics and, with some caveats, enables some comparison of attendance for the same period in previous years. In normal years, autumn term attendance considered in isolation can be volatile with the impact of flu season and weather; data for autumn and spring terms or for the full year are a more reliable basis for assessing performance.[112]

- In 2020-21, Primary attendance for the autumn term remained stable at 96.3%; secondary attendance decreased from 94.8% in 2019/20 to 93.3%.
- Absence in secondary schools (excluding COVID-19) was the highest it has been in the last four autumn terms, at 6.69%, driven by an increase in illness (other than COVID-19) and unauthorised absence.
- Overall, persistent absence also increased from 14.2% in 2019/20 to 14.9% in 2020/21, equating to an additional 819 pupils being persistent absentees.
- Secondary attendance saw a drop between 2018/19 and 2019/20, but unlike primary, the decrease continued into 2020/21 (from 94.8% in 2018/19 to 93.3% in 2020/21).
- In the autumn term 2020/21, just under two thirds of secondary schools saw a decrease in their attendance and in some cases, this was marked.

Support for children with Special Educational Needs

The information within this section is sourced directly from the Leeds Joint Strategic Assessment.

Leeds has an inclusive model[113], reflected in how funding is directed to schools, which contributes to lower rate of children having Education and Health Care Plans (EHC plans) relative to other local authorities, especially in the primary years.

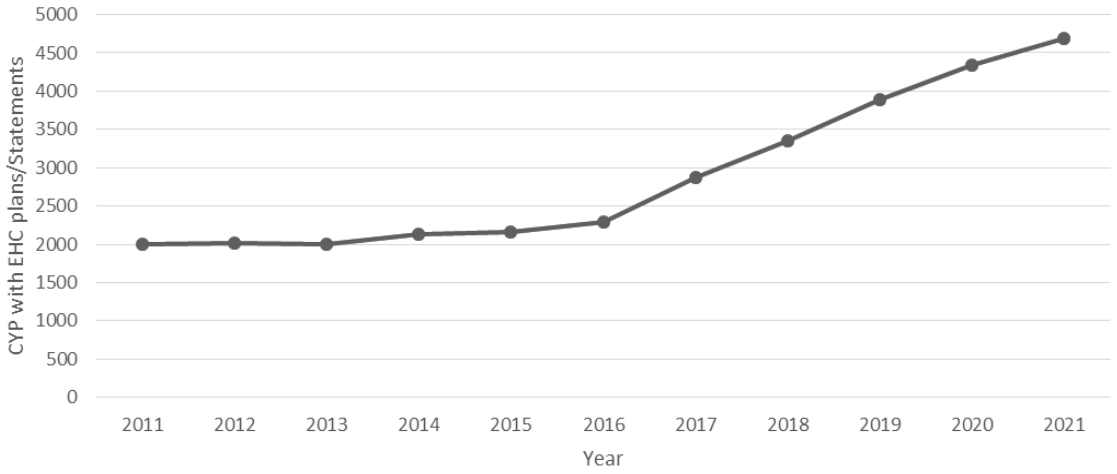
- 2.4% of the school age population attending school has an EHC plan, compared to 3.1% in Core Cities and 3.7% across England.

Leeds like England is seeing significant increases in EHC plans.

- In January 2021, the number of plans maintained by Leeds City Council was 4,689, an increase of 350 on the previous year (or 8.1%). Growth is continuing and by June 2021 numbers had risen to 4,952 (Figure 54).

[111] School Census
[112] School Census
[113] Item 9 - Appendix 1 - Draft SEND and Inclusion Strategy for Leeds.pdf

Figure 54 - EHC plans maintained by Leeds City Council, 2011 to 2021



Source: Department for Education SEN2 returns, January 2021

- Leeds maintains a lower proportion of EHC plans in younger age groups than national averages and comparators – 2.4% for under-5s and 24.4% for ages 5-10.
- The reverse is true for older young people, with the 24.7% for 16-19 old and 14% for 20-25 both higher than national and comparators.
- The largest proportion of EHC plans in Leeds are within the 11-15 age group in 2021 (34.6%).
- 15.9% of all pupils who attend a primary school in Leeds are recorded as having a special educational need, 1% of whom have an EHC Plan.
- For secondary schools in Leeds 1.4% of secondary school pupils have an EHC plan and 11.9% are recorded as SEN support, 13.3% in total. The overall number of secondary school pupils with SEND has grown by 25.9% since 2016.
- In Leeds maintained schools, the most common type of need for those with an EHC plan is Autistic Spectrum Disorders and for those with SEN support Speech, Language and Communication needs.
- In Leeds primary schools, the most prevalent SEN primary need is speech, language and communication at 41.4 percent, an increase in proportion for the past four years and greater than national and comparators.
- Social, emotional and mental health is the most prevalent SEN primary need in Leeds secondary schools at 25.1 percent of the cohort, this includes being the most common need for those with an EHC plan followed closely by autism.
- Considering SEND primary needs against deprivation some needs such as speech and language and moderate learning difficulties are weighted to more disadvantaged areas, other needs like autism spectrum disorder are reflected more evenly in all communities.

Elective Home Education

A Leeds Elective Home Education report was written on 3rd November 2021 and provides detailed information related to children who are educated at home.

All children are entitled to an education under United Nations Law[114]. It is the legal responsibility of parents, as outlined in section 7 of the Education Act 1996, to ensure that their children receive access to a full-time education suitable to their age and aptitude either through being on school roll or otherwise through elective home education. Parents who choose to electively home educate also take full responsibility for providing a suitable full-time education themselves and must comply with the Department for Education Elective Home Education guidance. Full-time education is broadly outlined as 25 hours per week for 39 weeks per school year. If a young person is not receiving or attending this entitlement at school/ alternative educational provision, they are 'missing out' on education and may be vulnerable to less positive outcomes.

There may be times in a child or young person's life when they cannot access 25 hours of education per week due to illness or specific circumstance to the individual young person. Schools may offer a reduced timetable or organise alternative arrangements such as access to remote learning or specific services in these circumstances. It is the responsibility of those working with children and young people to check that any such arrangements are planned in accordance with an assessment of the child's educational, social, emotional and health needs and are time limited or regularly reviewed to ensure that they continue to meet the needs of the child or young person, which may change over time. More information can be found in the councils one minute guide: elective home education.

The Association of Directors of Children and Families survey in 2021 estimated that 115,542 children were electively home education in 2020/21. This was a 35% increased on the previous year, suggesting the pandemic had a significant impact. However nationally the precise figures are unknown due to parents not having to register children that are home educated, resulting in councils using various sources to estimate the numbers

In the 2020-21 academic year Leeds City Council received 651 elective home education notifications. 377 of the new notifications were received in the autumn term and this is more than the total for the whole of the 2019/20 academic year when there were 330 new notifications. This represents a 97% increase in notifications in the 2020/21 academic year.

At the end of the 2020-21 academic year, there were 907 children and young people recorded as being electively home educated. This is a 47% increase compared to the end of the 2019-20 academic year when there were 618 children and young people recorded as electively home educated. The reasons for parents choosing to home educate changed throughout the last year. A third of all new notifications received in 2020/21 were recorded as 'prefer not to say/unknown', followed by 22% stating 'COVID-19' and 12% citing a 'belief in home education'.

35% of all electively home educated children and young people are from a Black or Minority Ethnic Group[115]. This is an increase from 32 percent in 2019/20. Whilst this is not disproportionate to the school population of pupils of whom 35.8 percent are from a Black or Minority Ethnic Group, it does represent a 60% increase (121 pupils) in the number of children and young people from BAME heritage choosing to electively home educate.

[114] UNCRC Full Text - The Children and Young People's Commissioner Scotland (cypcs.org.uk)
[115] Item 7 - Appendix B - Report on Elective Home Education.pdf (leeds.gov.uk)

Additional analysis of data from previous years found some emerging trends[116], with:

- 27% of those receiving Elective Home Education also being eligible for Free School Meals
- More cases having had previous social care involvement at some point prior to Elective Home Education
- Many children had previous low attendance
- Some children are below expected level of attainment for their years.

Children Missing Education

There are many reasons why children and young people do not routinely access school provision and recorded as missing from education.

In Leeds, cases are designated either:

- 'Missing from Education' (where the whereabouts of the child at the point of referral is unknown). These children could either be in another part of the UK or have left the UK
  OR
- 'Out of Education' (children known to be in the city but who are without a school place). These are almost entirely children new to Leeds or the UK, or the very small cohort of children who have previously lived in Leeds and have returned.

Data reported below is taken from the Annual Report Leeds Safeguarding Children Partnership (leedsscp.org.uk).

The Children Missing Education team received a total of:

- 2552 referrals in the academic year 2019/20
- 1339 (52.5%) were referred as missing from education (Whereabouts Unknown - WUK) at the point of referral
- 1213 (47.5%) as Out of Education (Whereabouts Known - WK).

This is the first year that there has been a significant fall in the numbers of referrals since 2007 when CME came into being, with a total of 434 fewer cases, a 14.5% fall, compared to the previous year.

The numbers of Missing Child (WUK) referrals were 82 (5.7%) less than the previous year whilst the Out of Education (WK) referrals fell by 350 (22.5%).

This represents a significant shift in the split between Missing Child (WUK) referrals from 47.6% in 2018/19 to 52.5% and Out of Education (WK) referrals from 52.4% in 2018/19 to 47.5%. A shift of 5% from WK referrals to WUK referrals[117].

The link between school exclusion, reduced timetables and alternative educational settings and an increased risk of exploitation is an issue that has been identified by the Leeds Child Safeguarding

[116] Report on Elective Home Education.pdf (leeds.gov.uk) Item 7 - Appendix B
[117] Annual Report | Leeds Safeguarding Children Partnership (leedsscp.org.uk)

Partnership (LSCP). Further to this the link between children not in education, employment or training and other vulnerabilities is well known, but the LSCP reports following their analysis that further assurance is required that these children have a particular focus in Leeds.

Not In Education, Employment or Training (NEET)

Please see transition to adulthood chapter.

Safe Supportive Schools

Whilst learning outcomes are crucial to children and young people's development and future life chances, education settings also play an important role in the wider safeguarding system for children. The Keeping Children Safe in Education statutory guidance highlights the role education staff have in identifying concerns early, providing help for children, promoting children's welfare and preventing concerns from escalating.

Pastoral support is the provision a school or education setting has in place to ensure the physical and emotional welfare of pupils, and which is an essential foundation upon which learning can take place and therefore enable children and young people to meet their potential.

As part of the 'School/College' section of the 2020-21 Leeds My Health My School survey (MHMS), young people in both primary and secondary were asked if they agreed or disagreed with a range of statements about their school.

- 83% of primary pupils and 63% of secondary pupils agreed that their school was a caring place
- 75% of primary and 49% of secondary pupils agreed that their school helps them if they are worried or have a problem
- 77% of primary and 66% of secondary pupils said there are staff in their school that they trust

There is a disparity between the percentage of primary school children and secondary school children who view their school as a caring place, and a place that helps if children are worried or have a problem. Less than half of secondary age pupils agree that their school helps if they are worried or have a problem. Although it is acknowledged that the transition to a much larger high school from primary can be a challenging transition for most young people, it would seem there is scope to improve the pastoral care and supportive mechanisms for children within secondary education.

In September 2020 the government introduced statutory guidance for Relationships and Sex Education and Health Education which covers broad areas of relevance and concern to young people today. It ensures that every child is guaranteed a Personal, Social, Health and Economic (PSHE) education that covers mental health and wellbeing, physical health and learning about safe, healthy relationships, including understanding consent and negotiating life online. The impacts of these sessions are wide reaching.

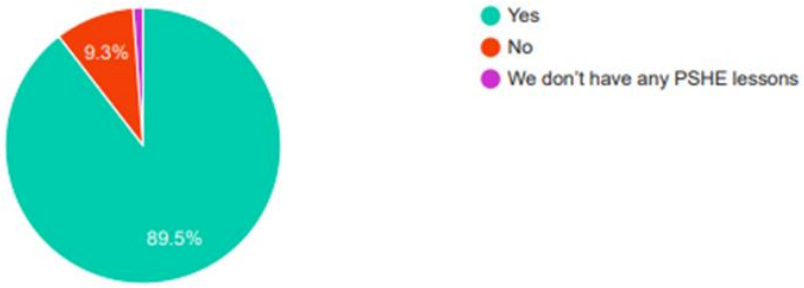
To reach their potential, children and young people need to feel safe and supported within the school environment as well as be encouraged to value their own and other's strengths, values, and contributions. The PHSE and relationships and sex education (RSE) curriculum provides children and

young people with the foundations they require to play a positive role within the education setting and wider community. RSE is integral to children's development and wellbeing and is of vital importance to ensure that children and young people are taught the fundamental building blocks and characteristics of positive relationships.

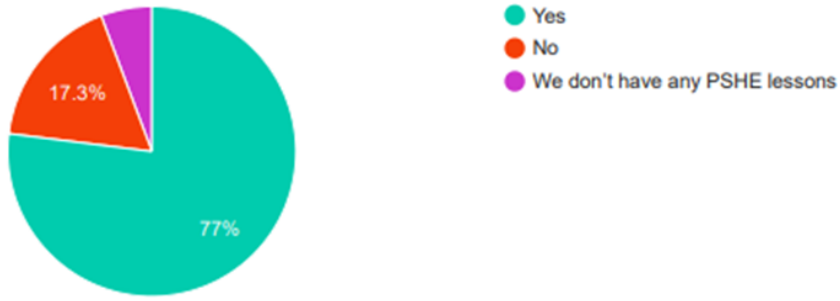
The MHMS survey asked pupils the following question: Do you find your Personal, Social, Health and Economic (PSHE) education lessons useful? Figure 55 outlines their responses to this question at primary and secondary school age groups.

Figure 55 – Primary and Secondary School pupil responses to the following question in the My Health My School Survey: 'Do you find your Personal, Social, Health and Economic (PSHE) education lessons useful?'

Primary pupils



Secondary pupils



Source: My Health My School Survey (MHMS) 2020-21

A further question asks how much useful information and learning young people think they have had on specific topics, a selection of which has been identified below (Figure 56).

Figure 56 - Percentage of pupils reporting they had enough useful information on the listed things

Topic	Primary	Secondary
Staying safe on the internet	85%	81%
Radicalisation/extremism	N/A	69%
Gangs	44%	67%
Pressure/encouragement to commit a crime	N/A	69%
Knife/weapon awareness	50%	70%
Safe and Unsafe relationships	61%	68%
Domestic violence and abusive relationships	N/A	70%
Child Sexual Exploitation	N/A	68%
Female Genital Mutilation (FGM)	N/A	62%

Source: My Health My School Survey 2020-21

A high proportion of both primary and secondary pupils reported they had enough useful information regarding staying safe on the internet. Whilst it is encouraging to see that a large percentage of pupils had enough information around other emerging topics affecting young people, such as domestic violence, weapon awareness, gangs and radicalisation. There is still approximately between 30-40 % of pupils who require more information on these topics.

Impact of COVID-19 on education

COVID-19 has had a significant impact on children's education[118]. The governments national enforcement of lockdown restrictions and rising COVID-19 infection rates resulted in reduced staffing in nursery/education settings and missed school days, which were often replaced with remote, online learning. Whilst nurseries and schools remained open for children of key workers and those identified as most vulnerable uptake among these groups was low, national data found an average of just 8% of the eligible cohort attended before schools partially opened in June. The majority of children had no right to attend school for most, if not all, of lockdown. As a result, approximately 575 million school days were missed since between March and June 2020[119].

[118] Impact of COVID-19 on Learning: A review of the evidence – Education Endowment Foundation
[119] cco-briefing-on-school-attendance-since-september.pdf (childrenscommissioner.gov.uk)

Before the pandemic, disadvantaged children were estimated to be 18 months behind their wealthier peers[120]. In the first month of lockdown, private school children were twice as likely to take part in daily online lessons as those in state schools[121]. The school offer during the pandemic varied, with some pupils receiving good quality remote education and others not. National research showed that nearly 40% of children in low-income families were living without enough desk space during lockdown[122].

Furthermore, research from Ofcom highlighted a digital divide, estimating that between 1.14million and 1.78 million children in the UK had no home access to a laptop, desktop, or table[123]. In addition to the disruption to education provision, there was no national assessment prior to key stage 4 (GCSE) and national examinations were replaced with teacher-assessed grades. Cancelling examinations had a profound impact on all children and young people, however more so for children who were electively home educated, who were unable to receive centre assessed grades.

Identified Current Gaps in Understanding

- The developing impacts of COVID-19 within education require close monitoring and analysis.
- Ongoing focus on information related to children who are not in formal education, such as those who are missing education or electively home educated, is required to ensure these groups are not lost.
- Overall education is an area in which there are robust processes for data collection and analysis across population groups in Leeds

[120] Education in England: Annual Report 2020 - Education Policy Institute (epi.org.uk)
[121] Learning-in-Lockdown.pdf (suttontrust.com)
[122] How lockdown has affected children's lives at home | Children's Commissioner for England (childrenscommissioner.gov.uk)
[123] Children without internet access during lockdown | Children's Commissioner for England (childrenscommissioner.gov.uk)

7.4. Transport

Headlines

- There are clear and established links between transport and children and young people's health.
- Wish number 6 in the Child Friendly Leeds 12 wishes is that "children and young people can travel around the city safely and easily"
- An annual mode of transport to school survey is conducted in Leeds. Data from 2021-22 shows that for primary school children walking is the most common mode of transport for primary (60.2%) and secondary (44.7%) school aged children. For those attending SEND schools, school bus (51.1%) was the most common mode of transport followed by taxi (22.5%).

Introduction

The Young People's Future Health Inquiry showed the clear and established links between transport and children and young people's health. Transport influences the life course of children through impacting education, training and employment options, physical and mental wellbeing as well as supporting independence[124]. Transport has the propensity to widen socio-economic inequalities by limiting access for some to education and employment opportunities, as well as limiting their ability to visit family and friends[125]. Furthermore, an evidence review in 2019 for the Department of Transport outlines that there are three ways in which health and transport are linked[126].

1. Access to transport: Essential to accessing health and education services
2. Mode of transport: The mode of transport affects physical and mental health as a result of impact on activity level and time spent commuting
3. Wider effects of transport and its infrastructure: Transport can promote social inclusion

It is widely known that the differences in the impact of transport vary according to population group, with older people, younger people, economically disadvantaged people, and people with disabilities more likely to experience the negative health impacts of transport[127]. Investing in transport is one way to help address widening health inequalities and regional disparities in public health but this requires a connected working process which incorporates a holistic view of health. In Leeds transport is persistently highlighted by children as an area of importance, for example it is listed in Leeds Children and Young Peoples plan with a focus on improving access to affordable, safe, and reliable connected transport for young people.

Epidemiology

The Leeds Joint Strategic Assessment provides a detailed chapter related to transport in Leeds.

Access to transport

Transport is essential to our daily lives and particularly for children who may need to access health and education services. There are differences in access to transport according to socioeconomic

[124] Children's travel behaviour and its health implications - ScienceDirect
[125] Children's travel behaviour and its health implications - ScienceDirect
[126] Transport, health and wellbeing (publishing.service.gov.uk)
[127] Transport and inequality (publishing.service.gov.uk)

status. Transport can therefore mean those living in poverty experience its impacts more acutely[128] due to impacts on ability to access employment and education.

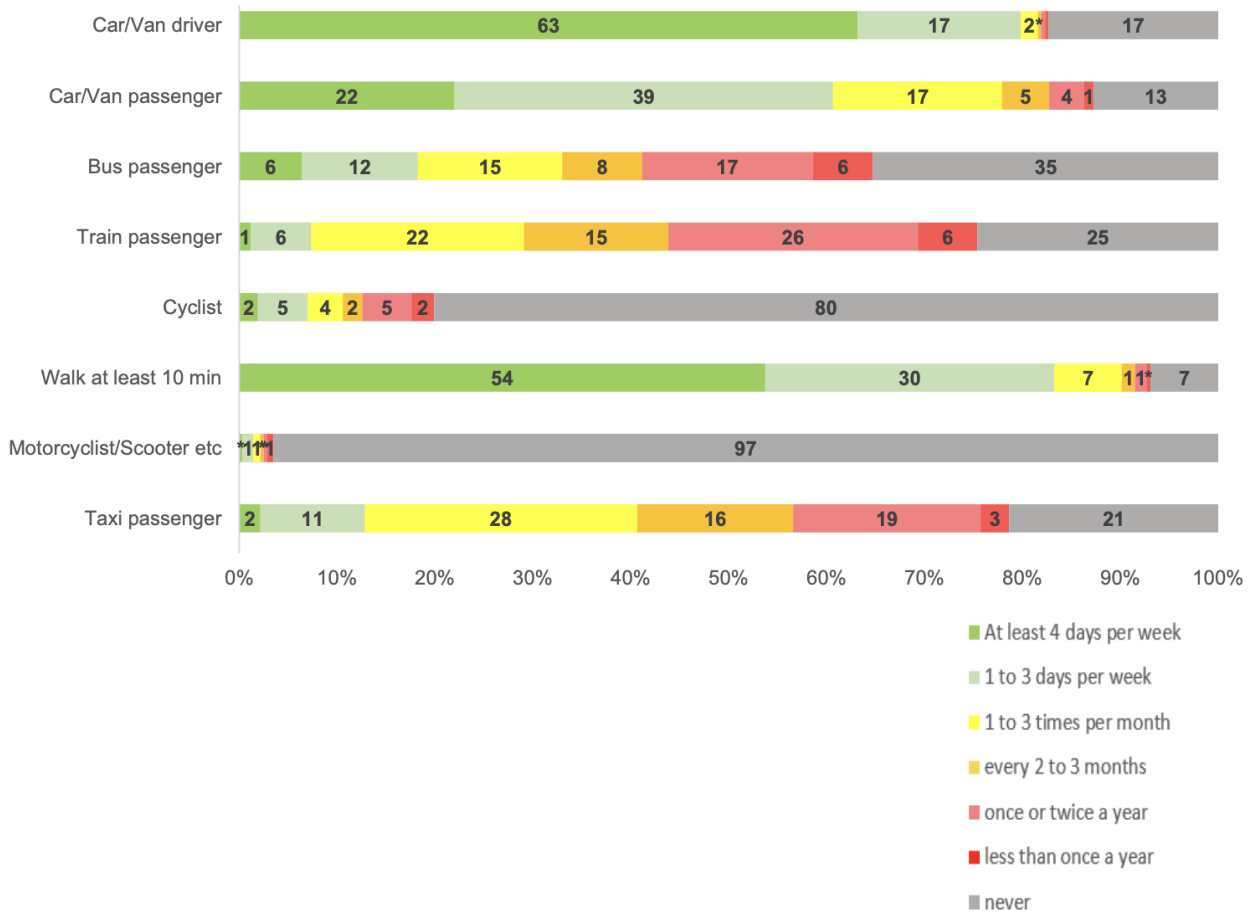
For many children transport choice is limited by affordability. Nationally between 2005 and 2017, local bus fares in England rose by 66% on average. In 2022 according to the First Bus Website the single fare for those under 19s is £0.60 if under 1 mile journey, £1.20 1-5 miles and £1.80 if over 5 miles. However currently young people are facing challenges accessing this fare as they are required to provide proof of their age via an app or providing ID at the bus station. This is leading to digital inclusion issues and discriminatory practices according to those who have relevant ID documents. West Yorkshire Combined Authority (WYCA) and Leeds City Council are working to improve this barrier to accessing transport.

Mode of Transport

The West Yorkshire Combined Authority Residents Perceptions of Transport Survey does not record data for those under the age of 16 but provides detailed analysis of adult transport use in Leeds. This data showed that in 2021/22 80% of West Yorkshire residents drove a car at least 1 day per week, compared to 18% using the bus and 7% using the train (Figure 57). Leeds residents are more likely to use a bus at least monthly (40%) than those in Bradford (28%) and Wakefield (25%). Therefore, most journeys in West Yorkshire are taken in a car. However, for many young people who are unable to drive public transport and active travel provides higher proportions of their travel.

[128] Child Poverty and Transport Research - Final Report - May 2021 (002) (povertyalliance.org)

Figure 57 - Frequency of use different modes of transport in West Yorkshire 2021/22 (%)



Source: West Yorkshire Combined Authority Residents Perceptions of Transport Survey (2021/22)

The annual Travel to School Survey helps Leeds City Council to understand how children travel to school. Figure 58 is a summary of academic years 2017/18 to 2021/22 and the data collection forms part of the statutory duty for local authorities to monitor the success of promoting sustainable travel to school. The ITB team strongly encourages all schools to provide the data. Although, not all of them, participate, and some are unable to provide data for every pupil/student on roll.

Data from 2021-22 shows that for primary school children walking is the most common mode of transport (60.2%), followed by car/van (34.4%) and bus (1.7%) (Figure 58). Similarly for secondary school aged children walking was most common (44.7%), followed by car/van (19.1%) and bus (15.1%) or school bus (14.8%). For those attending SEND schools school bus (51.1%) was the most common mode of transport followed by taxi (22.5%).

Figure 58 - School Mode of Travel 2017-18, 2019-20 and 2021-22

Establishment type	Academic Year	Bus	School Bus	Car/Van	Car Share	Cycle	Taxi	Train	Walk	Other
Primary	2017-18	1.9%	0.4%	33.7%	2.4%	0.4%	0.4%	0.0%	60.8%	0.1%
	2019-20	2.7%	0.6%	33.0%	2.4%	0.4%	0.3%	0.0%	60.5%	0.2%
	2021-22	1.7%	0.4%	34.4%	1.9%	0.2%	0.4%	0.0%	60.2%	0.7%
Secondary	2017-18	15.6%	20.1%	19.8%	1.7%	1.0%	0.5%	0.5%	40.0%	0.9%
	2019-20	12.6%	21.9%	19.2%	1.8%	1.2%	0.4%	0.1%	42.6%	0.2%
	2021-22	15.1%	14.8%	19.1%	1.7%	1.1%	0.4%	1.1%	44.7%	1.9%
All-through school	2017-18	16.8%	5.3%	27.7%	2.5%	1.1%	0.7%	0.0%	45.6%	0.2%
	2019-20	14.8%	2.2%	29.7%	2.9%	1.7%	1.0%	0.0%	47.5%	0.1%
	2021-22	10.1%	2.2%	39.6%	5.2%	1.3%	0.5%	0.9%	39.7%	0.4%
Special Educational Needs (SEN)	2017-18	0.0%	53.8%	14.1%	4.6%	0.0%	22.6%	0.0%	4.7%	0.2%
	2019-20	0.1%	51.2%	16.7%	4.3%	0.0%	24.1%	0.0%	3.6%	0.0%
	2021-22	0.0%	51.1%	21.0%	1.0%	0.2%	22.5%	0.0%	4.0%	0.0%

Source: Leeds City Council – School Mode of Travel

The Influencing Travel Behaviour Team (ITB) team at Leeds City Council delivers programmes and events that promote safe and sustainable travel. These include School Streets, Leeds City Bikes, Bike Register, road safety training and the Leeds Safe Roads Vision Zero strategy. They also support schools and businesses to develop and implement travel plans that promote safe, sustainable and less car-dependent patterns of travel. You can find out more about some of the work they do on their blog or follow them on Twittter @ConnectingLeeds, sign up to the Connecting Leeds newsletter or subscribe to The Commuter newsletter.

In addition to this there is ongoing research being conducted by Leeds University trialling different methods of travel with young people to identify facilitators and barriers to different modes of transport.

Wider effects of transport and its infrastructure

Noise

Research in relation to the impact of noise on adults' health demonstrates clear links between higher exposure to noise and negative health outcomes such as high blood pressures[129]. However, research in relation to children is inconclusive, with some suggesting that children are less vulnerable to the impacts of noise[130].

Air Pollution

[129] Noise EURO (who.int)
[130] Noise and health in vulnerable groups: a review - PubMed (nih.gov)

See health protection chapter

Climate Change and Health

See health protection chapter

Road Traffic Injuries

The number of children killed or seriously injured in road traffic collisions in Leeds according to age and road user status are shown below in Figure 59. This data shows that for those aged <16 the majority of deaths are to pedestrians, but in the 16-19 age group (when young people begin to drive) there are higher numbers of deaths of those in motor vehicles.

Figure 59 - Fatal and serious injury casualties by road user and age, 2017-2021

Road user	0-4	5-15	16-19
Pedestrian	8	101	35
Pedal cyclist / passenger	1	30	14
Powered two-wheeler / passenger	0	11	46
Other motor vehicle occupant	5	21	62
Horse Rider	0	0	0
Unknown vehicle	0	0	0
Total	14	163	157

Source: Leeds City Council Collision Studies Team

Connecting Leeds deliver road safety training in schools to children across Leeds including bike ability training, pedestrian skills and scooter training. Demand from schools for pedestrian training continues to be high. For 2021-2022, road casualty data were used to identify the following priority wards for education initiatives with children:

- Gipton & Harehills
- Hunslet & Riverside
- Burmantofts & Richmond Hill
- Beeston & Holbeck, Killingbeck & Seacroft
- Middleton Park and Armley

Each year more than 10,000 children and young people in Leeds receive ‘Bikeability’ training. Data around child cycling casualties showed that priority schools for Bikeability are in Killingbeck and Seacroft, and Armley.

Identified gaps in current understanding

- Within this chapter there is limited data related to children's viewpoints in relation to transport. For example, there are no transport related questions in the My Health My School Survey. This limits understanding of the impacts of transport for children in Leeds.
- Within this chapter data is mostly related to school journeys only and not wider transport issues related to leisure travelling to/from activities, social use.
- This chapter does not analyse public transport usage, nor the impacts of planned future models of public transport in the city.

7.5. Ethnicity and Racism

Headlines

- Racism and discrimination have a direct impact on children and communities' wellbeing. This is a form of trauma which we know increases risk for poor health and drives, in part, the structural inequalities which are also risk factors for poor health (poverty, poor housing etc)[131].
- Youthwatch produced a powerful video in 2020 describing children's experiences of being black in Leeds.
- In Leeds the school clusters with the highest proportion of Black and Ethnic Minority pupils are those with the highest levels of deprivation.

Introduction

Racism and discrimination have a direct impact on children and communities' wellbeing[132]. Experiencing racism is a form of trauma which we know increases risk for poor health and drives, in part, the structural inequalities which are also risk factors for poor health (poverty, poor housing etc)[133]. Following this racism and discrimination patterns the way in which services are provided/what services are provided which then amplifies the existing inequalities[134]. Racism takes many forms and extends far beyond individual examples of physical and verbal abuse and into more difficult to identify pervasive discrimination, known as systemic racism[135]. Numerous data points can be used to exemplify the institutional and structural racism faced by children in the UK and raising the profile of the reality of life experienced by Black and Minority ethnic children in Leeds is imperative to hold the system to account and drive forward positive change.

The impact of racism is evident in data including statistics that show families from ethnic minority backgrounds are 2-3 times more likely to live in persistent poverty than white families, are more likely to live in crowded housing and to be unemployed[136]. There are links between these findings and systemic racial discrimination in education, employment, criminal justice and housing. Importantly these factors shape and restrict the opportunities for ethnic minority families to be healthy.

In recent years there have been significant events that have starkly highlighted existent racism, including the murder of George Floyd in the US, the strip search of a black schoolgirl in Hackney (Child Q), as well as high level media coverage of racial disparities in the impacts of COVID-19. This has bought a sharp focus to racism in the UK. In response the Commission on Race and Ethnic Disparities produced a report in 2021, which examines the national data related to ethnicity and race to understand disparities and why they exist. In Leeds we are working alongside the West Yorkshire Health partnership and over 40 organisations and civic leaders have signed a pledge to 'Root Out Racism'.

[131] How systemic racism affects young people in the UK | Barnardo's (barnardos.org.uk)
[132] A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people - PubMed (nih.gov)
[133] BME statistics on poverty and housing and employment - Institute of Race Relations (irr.org.uk)
[134] Ethnic inequalities in health: the impact of racism. Briefing 3 (raceequalityfoundation.org.uk)
[135] How systemic racism affects young people in the UK | Barnardo's (barnardos.org.uk)
[136] BME statistics on poverty and housing and employment - Institute of Race Relations (irr.org.uk)

Epidemiology

Data related to racism is complex and must be used in a responsible and informed way. There is a drive to disaggregate the term BAME (black, Asian and minority ethnic), as grouping all ethnic minorities together hides existent differences between ethnic groups and presents a reductionist viewpoint. This is reflected in the government advice on 'Writing about ethnicity'. Therefore, where possible this term is avoided in below analysis; however, this is sometimes not possible as the source of the data does not provide detailed ethnicity data analysis.

The impacts of racism on health are wide reaching and all chapters have where possible included analysis of ethnicity data. Data presented in this chapter will therefore focus on poverty, education, infant mortality and maternal deaths. These are key indicators as measures of population health and while they cannot represent the entire story - they are useful in developing understanding.

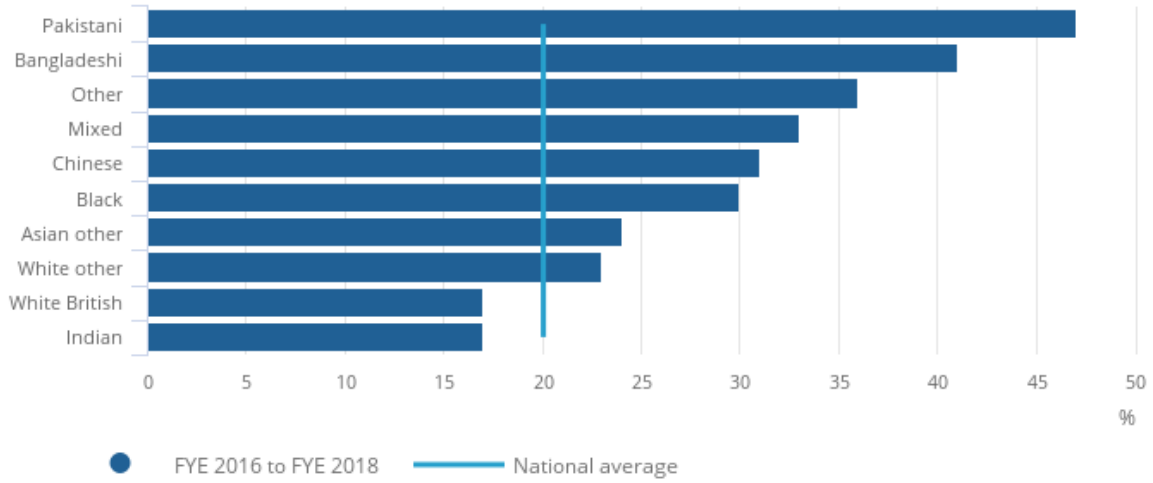
A detailed analysis of the impact of ethnicity on children and young people's mental health is provided in the 2019 Social, Emotional and Mental Health Needs Assessment: Children and young people from Black, Asian and Ethnic Minority Communities in Leeds.

A powerful video produced by Youthwatch describes Children's experiences of being black in Leeds.

Poverty

Nationally a report by the Office for National Statistics reviewed the proportion of children from different ethnicities living in low-income families (Figure 60). Consistently Pakistani and Bangladeshi households have been found to be the most likely to live in low-income households.

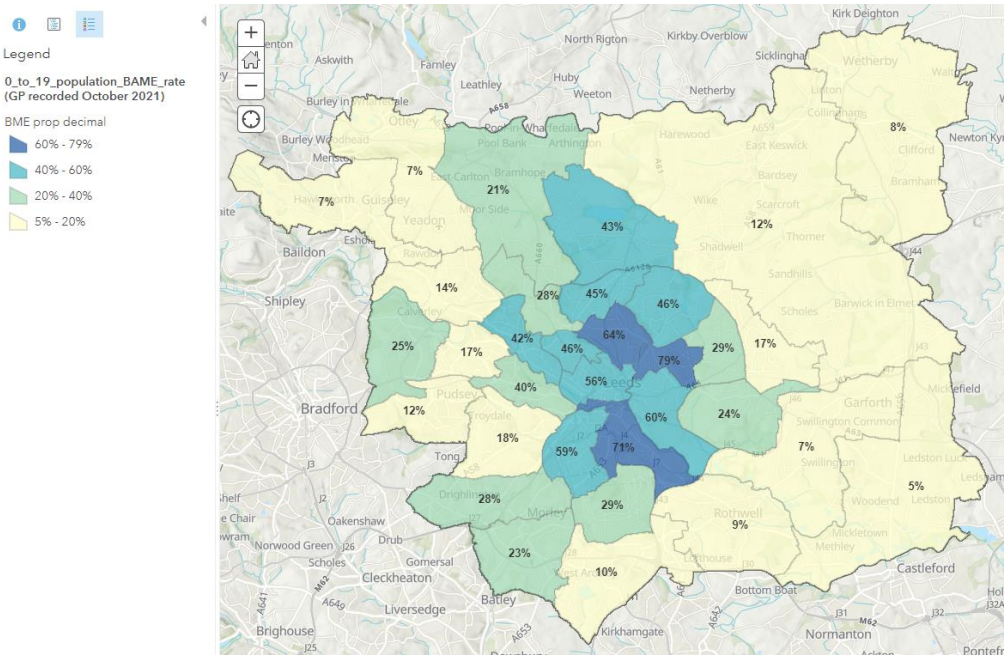
Figure 60 - Proportion of children living in low income families according to ethnicity



Source: Department for Work and Pensions – Households Below Average Income 1994/95 to 2017/18

In Leeds BAME populations are concentrated in areas experiencing the highest levels of deprivation as mapped in Figure 61. The overall pattern of BAME rates in the 0-19 population is focused in inner areas of Leeds.

Figure 61 - BAME Proportions at ward level in 0-19 age range.



Source: GP recorded data

Further school census data demonstrates that generally the school clusters with the highest proportion of BAME pupils are those with the highest levels of deprivation (Figure 62). Families of all ethnicities should have equal opportunities to thrive economically, however in Leeds deprivation is not equally distributed.

Figure 62 – IMD Rank and % BME pupils of school clusters in Leeds

Cluster	IMD Av Rank Perc	IMD Rank	No. of Pupils	% BME
Inner East	6.07%	1	9304	70.98%
J.E.S.S.	10.45%	2	7986	58.21%
Bramley	15.30%	3	5310	22.54%
Beeston, Cottingley and Middleton	16.67%	4	6195	44.60%
Seacroft Manston	17.33%	5	7349	24.07%
Inner West	18.54%	6	6112	34.29%
2gether	19.64%	7	8168	76.42%
Lantern Learning Trust	24.13%	8	2537	86.13%
Templenewsam Halton	31.50%	9	3968	26.11%
Headingley - Kirkstall Partnership	38.10%	10	3971	48.45%
Morley	44.71%	11	5761	17.57%
Pudsey	48.61%	12	6922	20.80%
Rothwell	49.82%	13	4194	10.85%
Brigshaw	54.70%	14	3562	7.19%
Leodis	55.10%	15	2184	10.81%
ESNW	56.18%	16	3315	33.36%
ARM	61.19%	17	8901	50.81%
Garforth	67.53%	18	2436	10.06%
Aireborough	68.66%	19	4854	10.92%
Horsforth	71.34%	20	2947	19.10%
Otley/Pool/Bramhope	72.93%	21	2566	8.61%
EPOS	77.80%	22	3587	11.04%

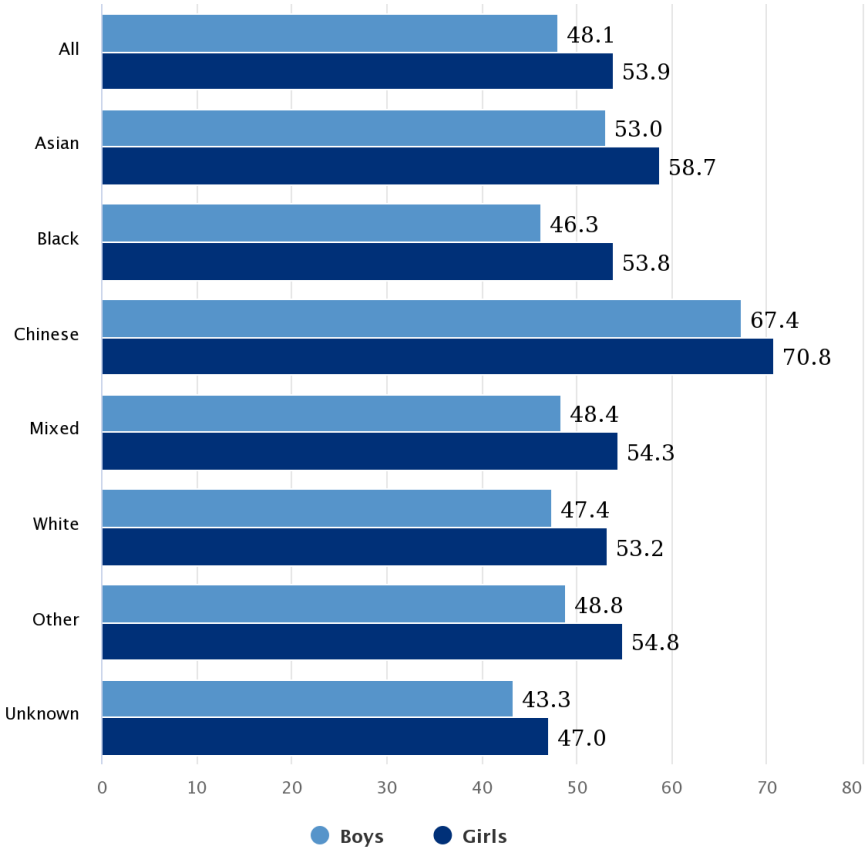
Source: School Census Data 2021

Education

All children should have equal opportunity to achieve at school and therefore differences in attainment result from multiple factors, including structural racism.

The 'Attainment 8' score is a measure that summarises the results of pupils at state funded mainstream schools in England in 8 GCSE subjects. In 2020/21 nationally the average attainment 8 score for pupils was 50.90 out of 90.0, with pupils from Chinese ethnicity having the highest score of 69.2 and Gypsy and Roma pupils having the lowest of 22.7 (Figure 63).

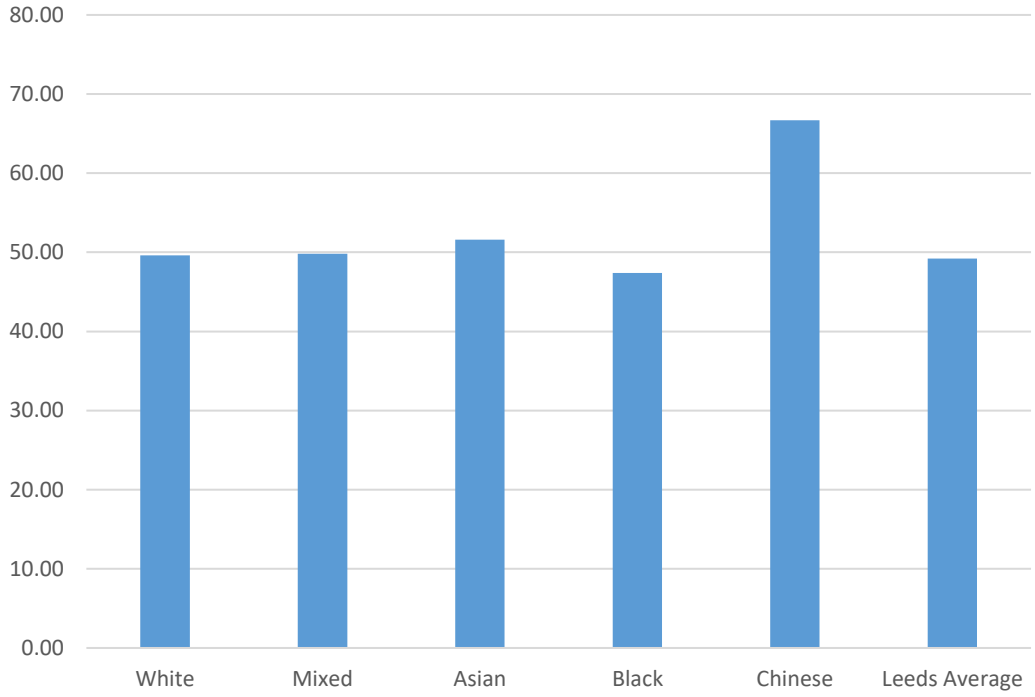
Figure 63 - National average attainment 8 by ethnicity and gender (2020/21)



Source: [GCSE results (Attainment 8) - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)]

In Leeds, data is grouped into 5 ethnic groups: White, Mixed, Asian, Black and Chinese. This perhaps masks the true picture for some ethnic groups. Trends seen in Leeds are similar to those shown at a national level (Figure 64).

Figure 64 - Leeds Average Attainment 8 score per pupil according to ethnicity



Source: Key stage 4 performance, Academic Year 2020/21 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

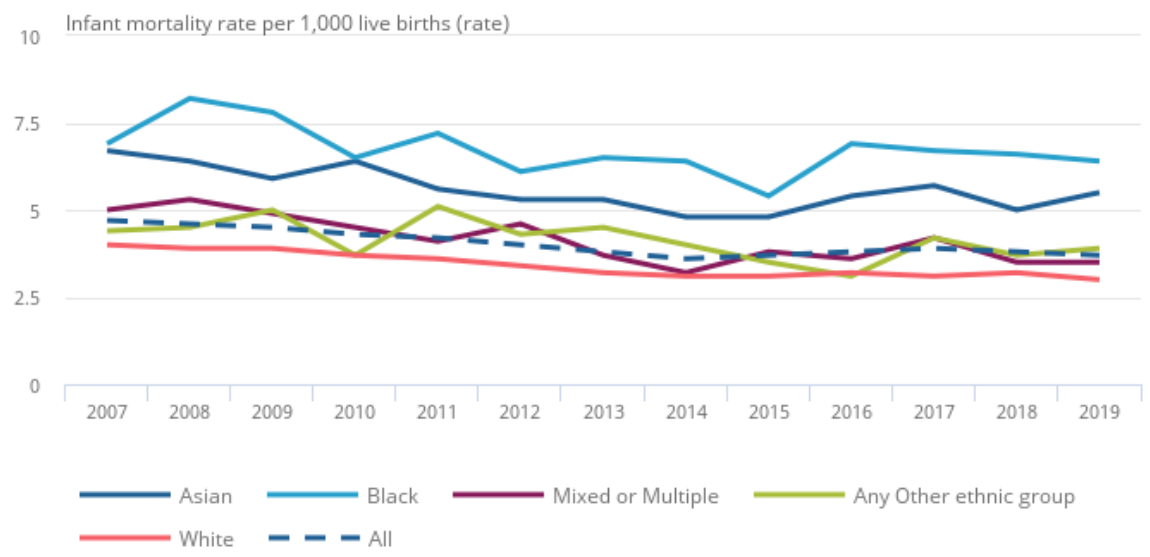
Infant Mortality

See 1001 days chapter for Leeds specific data.

National level data demonstrates that the highest infant mortality rate is in the Black ethnic group (Figure 65)[137]. The reasons for this are unclear. However, there are known links between infant mortality and deprivation and the black ethnic group also has the highest proportion of live births in the 5 most deprived deciles, with 82.9% of live babies from the Black ethnic group being born in these deciles in 2019. The White ethnic group had the lowest percentage of live births in the 5 most deprived deciles, with 53.1% of babies from the White ethnic group born in these areas in 2019. However, for the Black ethnic minority group the stillbirth and infant mortality rate is similar across all levels of deprivation, suggesting that not all difference is accounted for by socioeconomic factors and that ethnicity is an important factor in infant mortality.

[137] Births and infant mortality by ethnicity in England and Wales - Office for National Statistics (ons.gov.uk)

Figure 65 - Infant Mortality rate by ethnicity of the baby, England and Wales 2007 to 2019



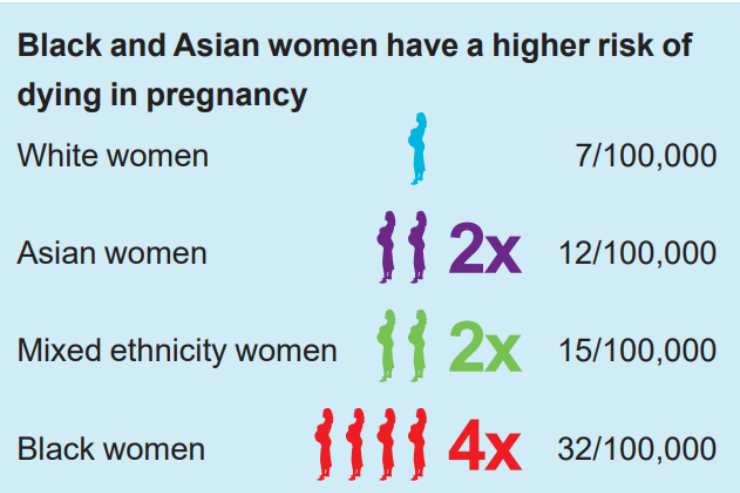
Source: Births and infant mortality by ethnicity in England and Wales - Office for National Statistics (ons.gov.uk)

Maternal Deaths

A maternal death is a death either during or up to 6 weeks after pregnancy.

At a national level the Mothers and babies: Reducing Risk Through Audits and Confidential Enquiries (MBRRACE) reports have year on year demonstrated inequalities related to ethnicity in maternal deaths. Black women are five times more likely to die as a result of pregnancy than white women, women with mixed ethnicity are three times as likely to die as white women and Asian women twice as likely to die (Figure 66).

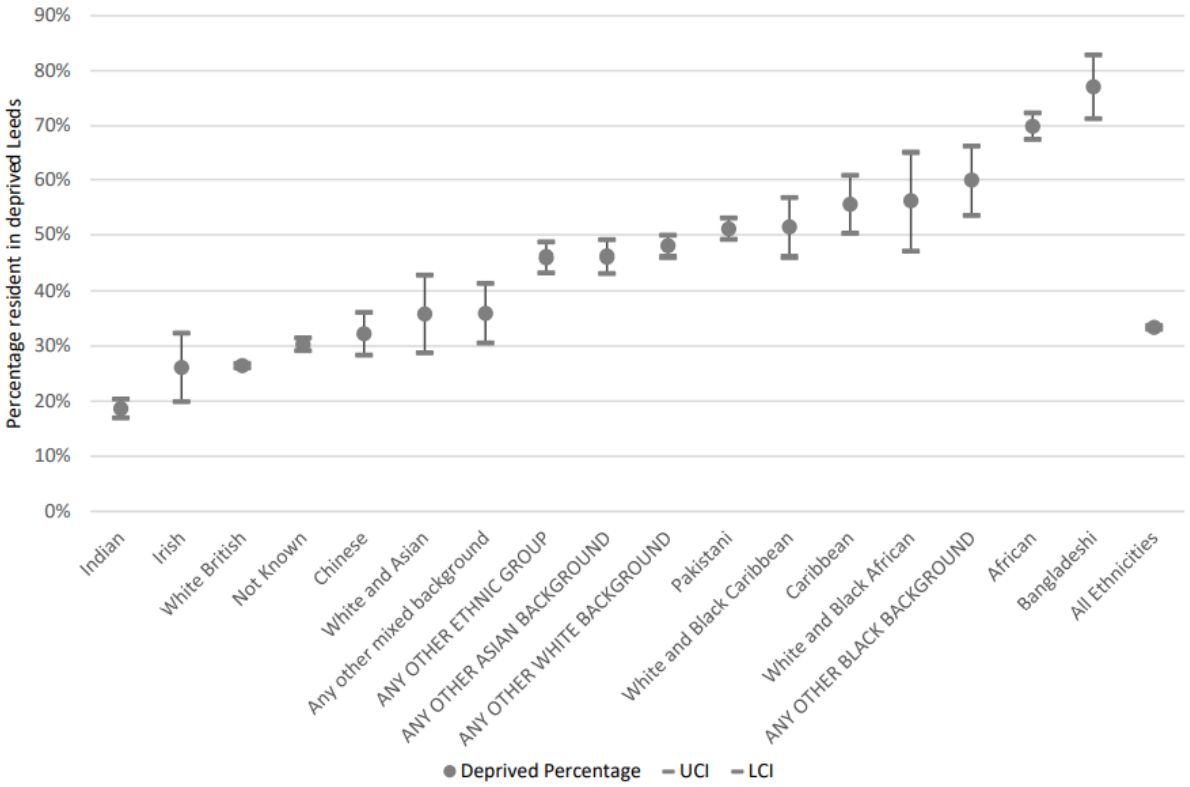
Figure 66 - National Differences in Maternal Deaths according to ethnicity



Source: [Findings from MBRRACE: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19]

Again, the impact of deprivation must be considered. MMBRACE data demonstrates that in 2017-19 at a national level, those living in the 20% most deprived areas had a maternal mortality rate almost twice as high as those living in the least deprived 20%[138]. This is important because most of the ethnic minority groups are over-represented in deprived Leeds – the exceptions being Indian and Irish. The maternity booking data clearly shows the picture for Leeds (Figure 67). This shows that the highest proportion of mothers living in deprived Leeds is within the Bangladeshi and African ethnicity groups, with the lowest proportion of mothers living in deprived Leeds within the Indian, Irish and White British ethnicity groups.

Figure 67 - Percentage of Maternity Bookings in Deprived Leeds by Ethnicity – 2009/10 to 2017/18.



Source [Leeds-Maternity-Health-Needs-Assessment-April-2020-FINAL.pdf]. Original Source LTHT Maternity Booking Data.

However, the national data is clear, even when deprivation and age are adjusted for stark differences in maternal mortality rates between different ethnic groups persist[139]. The reasons for this are unclear, however one factor may be the treatment women receive from health care professionals during their pregnancy[140]. The charity Birthrights held a yearlong inquiry into racial injustice and human rights in UK maternity care. They found key themes across their research that

[138] MBRRACE-UK_Maternal_Report_2021_-_Lay_Summary_v10.pdf (ox.ac.uk)
[139] MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf (ox.ac.uk)
[140] Black people, racism and human rights (parliament.uk)

include: issues with workforce representation and culture; lack of choice, consent and coercion; structural barriers; racism by caregivers; being ignored and disbelieved; lack of physical and psychological safety.

Identified Gaps in Current Understanding

- Further insight work to build on the positive example of the “Being Black and Being Me” video produced by youthwatch
- This chapter provides only surface level analysis of the impacts of ethnicity. There are countless examples of ways this can be built upon.

7.6. Play

Headlines

- Play is a fundamental part of childhood which is essential for children's growth and development[141,142].
- Nationally
    - 92% of children experienced negative impacts on their play due to the pandemic.
    - 22% of children in most deprived neighbourhoods are unhappy with the choice of things to do in their area, compared to 15% of children in the least deprived neighbourhoods.
- In Leeds
    - 76.5% rate their play experiences positively
    - Children who are allowed to play independently report greater satisfaction with their play experience.
    - 70% of children in Pupil Referral Units (PRUs) and 50% of children in Specialist Inclusive Learning Centres (SILCs) do not play outside at all.
    - Some children can only identify rooms in their home as places they play independently.
    - 20% say they don't have enough friends to play with.

Introduction

Play is a fundamental part of childhood which is essential for children's growth and development. To play freely is an inherent pleasure, as well as an essential component of physical, educational, social, cognitive, emotional and spiritual development [143]. Regular active play is associated with improved mental health, better physical health (including reduced disease burden in adulthood) and greater resilience and pro-social behaviours in adolescence [144].

Leeds has formally recognised spontaneous and independent play as a necessary and vital daily experience for children. As part of the 2018 Leeds Commitment to Children's Play[145], the city pledged to realise article 31 of the United Nations Convention on the Rights of the Child (UNCRC)[146], which enshrines a child's right to play. The Leeds Commitment to Children's Play focused on increasing opportunities to play, creating time and space for play, and ensuring recognition and understanding of children's play. As defined by the UNCRC, children's play is any behaviour, activity or process initiated, controlled and structured by children themselves; it takes place whenever and wherever opportunities arise (2013). As a fundamentally child-led experience, play is referenced in 3 of the 12 wishes identified by thousands of children as the building blocks of Child Friendly Leeds.

Epidemiology

National Data

[141] Playing Out | Children's Commissioner for England (childrenscommissioner.gov.uk)
[142] The-power-of-play-for-childrens-positive-mental-health - Play Scotland Research Briefing May 2020
[143] Playing Out | Children's Commissioner for England (childrenscommissioner.gov.uk)
[144] The-power-of-play-for-childrens-positive-mental-health - Play Scotland Research Briefing May 2020
[145] Play Strategy Report Appendix, Leeds City Council, 2018.
[146] United Nations/(Unicef, (1992), United Nations Convention on the Rights of the Child.

The British Children's Play Survey[147], conducted in 2020 with 1919 parents/caregivers of children aged 5-11, showed that children now spend half the time their parents did playing outside, and the average age for children being allowed to play out unsupervised is 11 (compared to 9 for the parents/carers).

Prior to the pandemic, the Children's Commissioner report, Playing Out, had already expressed fears about children's denuded play experiences, citing habitual use of screen time as the dominant mode of play (up to 3 hours on average at weekends, 2 hours on weekdays), and consequentially low levels of physical activity. Multiple barriers to play outside the home were identified, including traffic dangers, issues with accessing green spaces, and a culture shift away from 'playing out' as a normalised activity[148].

As children's independent play experiences have eroded, the necessity of parental facilitation for play has increased. Yet the State of Play Back to Basics report concluded that play is becoming a "lost art" for British families, with 21% of parents stating they didn't feel confident enabling their children's play[149].

The impact of the pandemic has exacerbated this further. A rapid evidence review identified that lockdown measures led to widespread disruption and adaptation of children's play (Graber *et al*, 2020), while research conducted in 2021 on behalf of Save the Children indicated that 92% of children experienced a negative impact on their play during the pandemic. According to the survey, over half (51%) of children said they were playing outside less than before the pandemic, while a third (34%) of children said they played alone more than they used to.

The disproportionality of the pandemic's impact on families coping with poverty and living in urban areas with little access to green spaces is well evidenced. In Bradford, 30% of 949 9-13-year-olds interviewed in 2021 had not left the house in the previous seven days. This was also reflected in The Big Ask, a survey of 557,077 children led by the Children's Commissioner in 2021. One of the most frequently used words in survey responses was 'play', with children from the most deprived neighbourhoods more likely to report a negative experience of play. The survey found 22% of children in most deprived neighbourhoods were unhappy with the choice of things to do in their area, compared to 15% of children in the least deprived neighbourhoods.

Leeds Play Data

In Leeds a large-scale research project to investigate children's play experiences commenced in 2021.

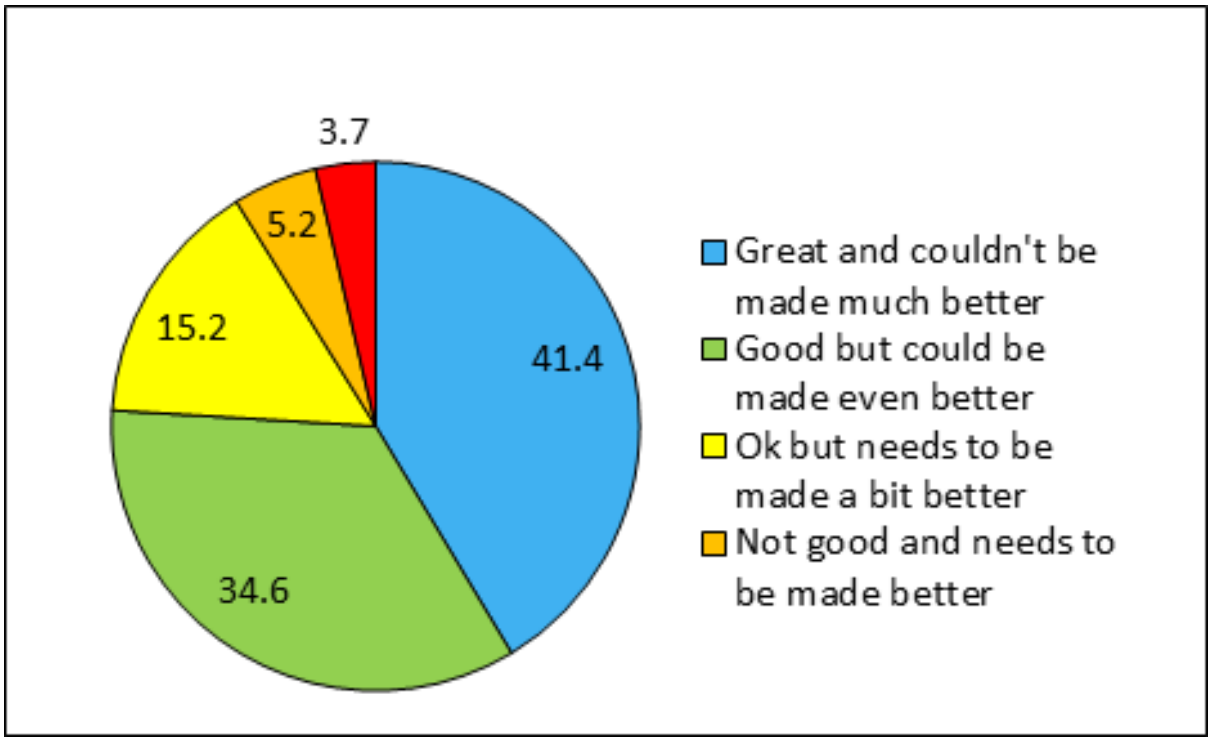
This has been conducted using a Play Sufficiency framework, establishing three lines of inquiry around space, time, and attitudes to play. The project is due to be completed in late 2022. Interim findings are based on 595 Play Satisfaction surveys completed by 9-10-year-olds living in the 1% most deprived LSOAs, together with workshops representing 50 hours of time exploring children's lived experiences. In addition, the study involves focus groups with children and parents, semi-

[147] Children's Play and Independent Mobility in 2020: Results from the British Children's Play Survey
[148] Playing Out | Children's Commissioner for England (childrenscommissioner.gov.uk)
[149] Byron, T. (2010), State of Play: Back to Basics. As cited in The Guardian, (2010).

structured interviews with professionals, policy analysis, spatial analyses in case study communities, and multi-agency workshops.

In the survey, a combined 76.5% of children reported their opportunities for play were great or good, which is positive and indicates there is much that needs to be protected and maintained. However, as outlined by Figure 68, 23.5% rated their opportunities for play as 'OK, 'not good' or 'rubbish', which equates to almost 1 in 4 children.

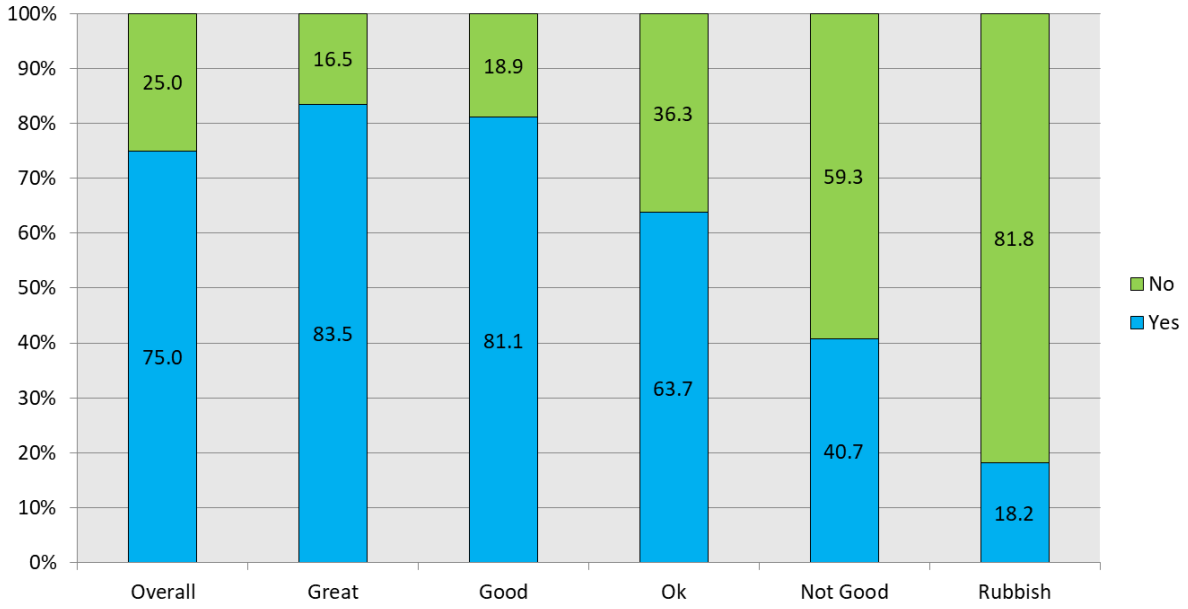
Figure 68 - How good are your opportunities for playing and hanging out?



Source: Leeds Play Satisfaction Survey 2021

Where children rated their experiences positively, there was a strong correlation with permission for independent play. As Figure 69 indicates, when children were not allowed to play out without adult supervision, they were more likely to rate their play experiences as 'rubbish' or 'not good'.

Figure 69 - Are you allowed to play out on your own or with friends?



Source: Leeds Play Satisfaction Survey 2021

One in four respondents said they were not allowed to play without adult supervision, while 30% identified they didn't play out at all. This rose to 70% of children in Pupil Referral Units (PRUs) and 50% of children in Specialist Inclusive Learning Centres (SILCs).

A mapping exercise was also carried out to identify geographies of play. The home was the primary setting – indeed some children only cited rooms in their house as spaces they played independently. Gardens (their own or a friend's) were also cited by 58% of children. Outside the domestic space, parks and playgrounds were cited by 41-47% of children. 'Streets near my home' also featured as important sites for play, with 44% saying they play on local streets.

In terms of opportunities for play, children at 5 of the 7 school-based workshops identified little or no opportunity to play during their school day, and after-school clubs were rarely identified as 'playful' experiences. More than 20% of children also felt they didn't have enough friends to play or hang out with.

Identified Gaps in Current Understanding

- Once complete, the Play Sufficiency research will fill gaps in current understanding about play in Leeds and establish clear recommendations for maintaining and improving play experiences in the city. These recommendations should be considered as priority areas for implementation in strategy and policy.
- If the Play Sufficiency research doesn't specifically gather data on parental confidence around play, this would be a gap to explore further. Parental confidence, motivation and skills to support play are key, especially for pre-school-age children, whose play experiences are not being investigated within the parameters of the Play Sufficiency research.
- Evaluation of programmes to encourage and enable play in lunchtimes and playtimes during the school day would be beneficial.

7.7. Priority Groups

Headlines

- According to estimated figures in 2019 produced by the Children's Commissioner, 19.8% of the Leeds population of 0-17 year-olds live in households with **any** of the so called 'toxic trio' (domestic abuse or mental ill health or substance misuse).
    - This is 33,580 children and young people in Leeds.
- According to estimated figures in 2019 produced by the Children's Commissioner, 1.2% of the Leeds population of 0-17 year-olds live in households with **all** of the so called 'toxic trio' (domestic abuse and mental ill health and substance misuse).
    - This is 1,994 children and young people in Leeds.
- Deprivation is a key factor for priority groups:
    - In March 2020 in Leeds 57.6% of children subject to a child protection plan lived in the most deprived 10% areas nationally (based on Index of Multiple deprivation).
    - The same pattern in seen in terms of the number of children looked after with 59% living in the most deprived decile.

Introduction

This chapter utilises the term 'Priority Groups'. Priority groups in this chapter are defined using a definition of 'vulnerable children' utilised in the PHE Vulnerable Children and Young People's report Leeds: "taken to be any children at greater risk of experiencing physical and/or emotional harm and experiencing poor outcomes because of one or more factors in their lives"[150].

The term priority group is preferred to vulnerable children to highlight that there are numerous factors that may make a child vulnerable, but there are also protective factors that make a child less likely to experience adverse outcomes even when risk factors are present. Due to the constraints of this document protective factors will not be reviewed, but they are extremely important in recognising that a child's life is not determined by the risk factors they experience and as such simply because a child experiences factors that increase their risk of adverse outcomes it does not mean that this will occur. This chapter will review children in the care of social services, in need of help, as well as children who have experienced adverse childhood experiences (ACEs) including those who are in the justice system, unaccompanied asylum seekers and those who have lost their parents.

In Leeds there is a drive towards recognition of the impact of family and vulnerability and Leeds aims to be a Trauma Informed City. This 'Trauma Informed' strategy has a focus on preventing, raising awareness of and responding to trauma. It aims to build a public health approach to improve outcomes for children which is guided by evidence from the 'Adverse childhood experiences: What we know, what we don't know, and what should happen next' report produced by Early Intervention Foundation. As much work with children focuses on trauma, vulnerability and family there are numerous additional strategies in Leeds that draw focus to the area. In particular, The Leeds Best Start Strategy 2015 - 25, the Future in Mind: Leeds Strategy (2021-26) and The Early Help Strategy (2020-23).

[150] Report for Leeds produced by Public Health England, amended with additional local data January 2021

Epidemiology

The Leeds Safeguarding Children Partnership report annually on the effectiveness of child safeguarding and promoting of child wellbeing. This provides detailed information about numbers of children in care, in need and subject to a child protection plan, alongside further details surrounding child safeguarding.

The Children's commissioner produces a series of local area profiles of child vulnerability, which provides a comprehensive dataset of children experiencing vulnerability.

The Children's commissioner conducted the Big Ask Survey in 2021 and produced a report based on the 5936 responses from children in care, including 3800 in foster care and almost 2000 in residential care.

Leeds has a Student Safeguarding Children's report and they produced an annual report on YouTube in 2020-21.

The Office for Health Improvement and Disparities produces data on a number of indicators specific to vulnerable children and young people. Local Government Inform produces an annually updated summary report on Children in Need and in Care in Leeds.

Appendix 4 contains a snapshot from the Leeds Children and Young People's Plan Key Indicator Dashboard.

The Leeds Support Model

Clusters

In Leeds there are over 20 Clusters. Clusters are groups of schools and key partners in small geographical areas who have come together and pooled funding to provide holistic early help to achieve the best possible outcomes for children and families. Clusters aim to identify those families, children and young people most in need of help and to ensure they are offered the right intervention at the right time, by the right people as early as possible in the life of a problem.

Restorative Early Support (RES) teams

In addition to clusters there are also 7 Restorative Early Support (RES) teams. Restorative Early Support (RES) teams bring together social work and family support staff locally, with the aim of trying a more flexible, multi-disciplinary approach to working with families to help them solve their problems within their own communities. RES teams are additional to and not instead of cluster and early help resources, responding to the various levels of complexity in the presenting needs of children, young people and families which may exceed the early help or cluster offer but would not require a child protection response from social work fieldwork teams. The teams have been established in those clusters with the highest levels of social work and family support needs, e.g. high numbers of referrals to social work services. The seven RES teams are aligned to the following clusters: 2gether; Seacroft & Manston; Inner East; JESS; BCM; Bramley and Inner North West; and Armley & Farnley.

Early Help Hubs

The Early Help Hubs are multi-disciplinary teams in the East, West and South of Leeds. The 3 hubs were established in the summer of 2019 as a key part of the Leeds early help offer. As of April 2021, they are based in the Compton Centre (East), Albion House (West) and Cottingley Children's Centre (South).

In each team there is a Hub Manager, early help practitioners and project support, alongside an Alcohol and Substance Use Coordinator, a Domestic Violence and Abuse Coordinator, and a Mental Health Coordinator. In addition, there are police officers in each hub and strong links with the Families First employment co-ordinators from the Department of Work and Pensions. The teams are also co-located with other partners including (but not restricted to) the clusters and Family Action (commissioned service for family support).

The Early Help Hubs provide advice and support to clusters and partners working in the three localities to ensure seamless, co-ordinated and effective early help support and a 'getting it right first time' response.

Children in contact with social services

The reasons for children requiring social care input are broad. Early help hubs in Leeds combine Local Authority, Police, Health and Voluntary Sector organisations to co-ordinate early help services for families. This service also provides specialist roles in relation to domestic violence, drug and alcohol use and emotional and mental health support. Below are the number of contacts made to the service in 2020-21 and this demonstrates that abuse and neglect is by far the most common cause for referral (Figure 70). While this is only an example of a single service and does not represent all children in contact with social services, it provides interesting insight.

Figure 70 - Family Action – early help contacts child's primary need

Child Primary Need	No. of contacts	
Abuse or Neglect	171	71.8%
Emotional wellbeing/Mental health	98	34.6%
Missing education	4	1.4%
Domestic abuse	4	1.4%
Socially unacceptable behaviour	3	1.0%
Learning disability	2	0.7%
Problematic/harmful sexual behaviour	1	0.3%
Grand Total		**283**

Source: Appendix 2 - Data | Leeds Safeguarding Children Partnership (leedsscp.org.uk)

1365 children were looked after in Leeds at the end of March 2022[151]. This is a rate of 80.0 children per ten thousand (RPTT) in Leeds. This includes all children being looked after by a local authority;

[151] Leeds Children and Young People's Plan Key Indicator Dashboard

those subject to a care order under section 31 of the Children Act 1989; and those looked after on a voluntary basis through an agreement with their parents under section 20 of that Act[152]. While there was a dip in this number during the pandemic, the figures have now returned to their pre-pandemic levels. This increase in demand has led to an increase in the number of children looked after.

In March 2022 the number of open child in need cases in Leeds was 3349 (a rate of 199.1 per ten thousand children in Leeds) and the number of children subject to a child protection plan was 619 (a rate of 36.8). Under Section 17 Children Act 1989, a child will be considered 'in need' if[153]:

- they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the local authority
- their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the local authority
- they have a disability.

Within 2019/20 the majority of children in need were aged 16 years plus (31.4%), with 27.1% being aged 10-15 years, whilst the lowest number were aged one year or below (4.3%)[154].

When considering this geographically and according to deprivation there is a clear link between school clusters experiencing the most deprivation having the higher number of children in need cases, number of children subject to a child protection plan and looked after. This is summarised below in Figure 71.

[152] DfE external document template (publishing.service.gov.uk)
[153] Child in need - childlawadvice.org.uk
[154] Appendix 2 - Data | Leeds Safeguarding Children Partnership (leedsscp.org.uk)

Figure 71 - Number of children in need cases, number of children subject to a child protection plan and looked after – according to school cluster and ranked according to the level of deprivation in the cluster

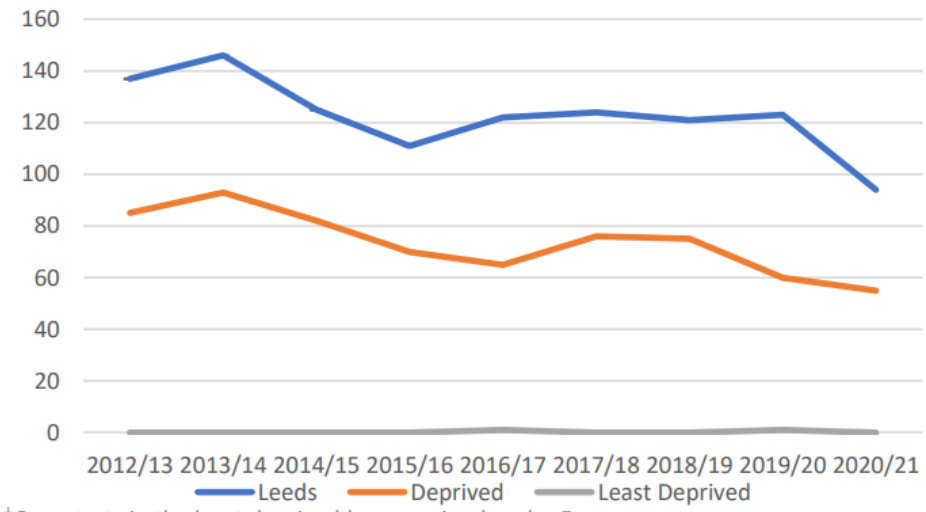
	Deprivation Rank	Children in Need [1 2]		Children subject to a child protection plan [1 2]		Children looked after [1 2]	
Time Period	**IMD 2019**	**As at 31/03/2022**		**As at 31/03/2022**		**As at 31/03/2022**	
Leeds		**3,349 (196.3)**		**619 (36.3)**		**1,365 (80.0)**	
Cluster	**1= most deprived; 22= least deprived**	**No.**	**RPTT**	**No.**	**RPTT**	**RPTT**	**%**
Aireborough	19	89	119.8	12	16.1	31	41.7
ARM	17	132	97.5	19	14.0	35	25.8
Beeston, Cottingley and Middleton	4	194	215.8	45	50.1	115	127.9
Bramley	3	185	248.9	9	12.1	73	98.2
Brigshaw	14	49	96.2	11	21.6	16	31.4
EPOS	22	51	69.7	9	12.3	7	9.6
ESNW	16	69	135.2	13	25.5	22	43.1
Garforth	18	16	46.7	<5	-	6	17.5
Headingley - Kirkstall partnership	10	117	177.2	20	30.3	45	68.2
Horsforth	20	46	111.3	<5	-	<5	-
Inner East	1	353	236.4	70	46.9	220	147.3
Inner North East	7	295	226.3	58	44.5	91	69.8
Inner West (ACES + Farnley)	6	275	305.3	70	77.7	87	96.6
J.E.S.S	2	323	273.8	67	56.8	165	139.8
Lantern Learning Trust	8	68	163.4	21	50.5	49	117.8
Leodis	15	44	136.1	5	15.5	15	46.4
Morley	11	129	152.9	19	22.5	51	60.5
Otley/Pool/Bramhope	21	52	128.2	<5	-	<5	-
Pudsey	12	116	110.0	6	5.7	23	21.8
Rothwell	13	81	125.9	34	52.8	33	51.3
Seacroft Manston	5	319	307.3	36	34.7	140	134.9
Templenewsam Halton	9	99	180.4	28	51.0	36	65.6

Source: Children and Young People's Plan Key Indicator Dashboard

There were 94 care starts for children under 2 in 2020/21, this is a reduction from the previous period 2019/20 which saw 123 care starts (Figure 72). For the latest period, 55 of the care starts

were in the deprived areas. There were 0 care starts in the least deprived areas during the latest period, prior to this, care starts have remained under 5.

Figure 72 - Number of under 2s taken into Care between 2012/13 – 2020/21 according to deprivation



‡Care starts in the least deprived has remained under 5

Source: Local Data via Best Start Dashboard

In 2021 there were 49 unaccompanied asylum seekers, which is a figure that has declined since 2020[155]. The most recent data that draws national and regional comparison is from March 2021. This is 0.03% of the 0-17 age population in Leeds. This compares to 0.02% in Yorkshire and the Humber. The number of accepted referrals to the Children's Social Work service was 12,606 in 2021/22.

The potential impact of care status on health are broad. Below are three examples of impacts:

- Impacts on educational attainment
  - At a national level educational outcomes for children in care are dramatically lower than their non looked after peers. Using the 2019 Attainment 8 score to assess children's progress between primary school and Key Stage 4, children looked after average attainment 8 score was 19.1 compared to 44.6 for non-looked after children and 19.2 for children in need. These differences are massive. They may in part be explained by the fact that Children with SEN have been recorded to have lower average attainment compared to the overall population. As such, the higher prevalence of SEN amongst looked after children (CLA) and children in need in part explains the difference in attainment compared to the overall pupil population.
- Impacts on mental health
  - The Strengths and Difficulties Questionnaire measures emotional and behavioural health of looked after children. It is a requirement for a child looked after continuously for at least twelve months at the 31 March. A higher score indicates more emotional difficulties. A score of 0-13 is considered normal, a score of 14-16 is considered borderline cause for concern and a score of 17 and over is a cause for concern.

[155] Unaccompanied asylum-seeking children (arcgis.com)

- In 2020/21 the average score of looked after children in Leeds is 14.1[156]. In comparison, the overall average for England is 13.7[157].

- Impacts on risk taking behaviours
  - In 2020/21 4% of children who are looked after for at least 12 months in Leeds are identified as having a substance misuse problem[158].
  - In 2020/21 2% of looked after children aged 10-17 have been convicted, subject to youth cautions, or youth conditional cautions in Leeds during the year[159]. This compares to 3% and 2% respectively for this group in England.

Children in households experiencing the toxic trio

'The Toxic Trio' refers to children living in households experiencing domestic violence, parental mental health issues and parental substance abuse.

A key resource used for this is the Local Vulnerably profile for Leeds, produced by the Children's Commissioner. As there is no consistent available data this uses modelling to generate estimated figures, which is explained in this report. While there are therefore caveats to this data it enables us to begin to understand the picture in Leeds.

In Leeds

- 19.8% of the Leeds population of 0-17 year-olds *estimated* to live in in households with **any** of the so called 'toxic trio'. This is 33,580 children/young people
- 1.2% of the Leeds population of 0-17 year-olds *estimated* to live in in households with **all 3** of the so called 'toxic trio'. This is 1,994 children/young people

The estimated prevalence of each of the trio is outlined in Figure 73 below. Leeds ranks poorly across all groups indicating high prevalence of underlying needs in children in Leeds due to Children in households suffering domestic abuse, mental health problems, drug/alcohol problems and a combination of needs.

[156] Children Looked After by Local Authorities in England (including adoption and care leavers) published by Department for Education, referenced within Emotional and behavioural health of looked after children - average score in Leeds | LG Inform (local.gov.uk) .
[157] See previous footnote
[158] Percentage of children looked after - Substance misuse in Leeds | LG Inform (local.gov.uk)
[159] Percentage of looked after children offending aged 10-17 in Leeds | LG Inform (local.gov.uk)

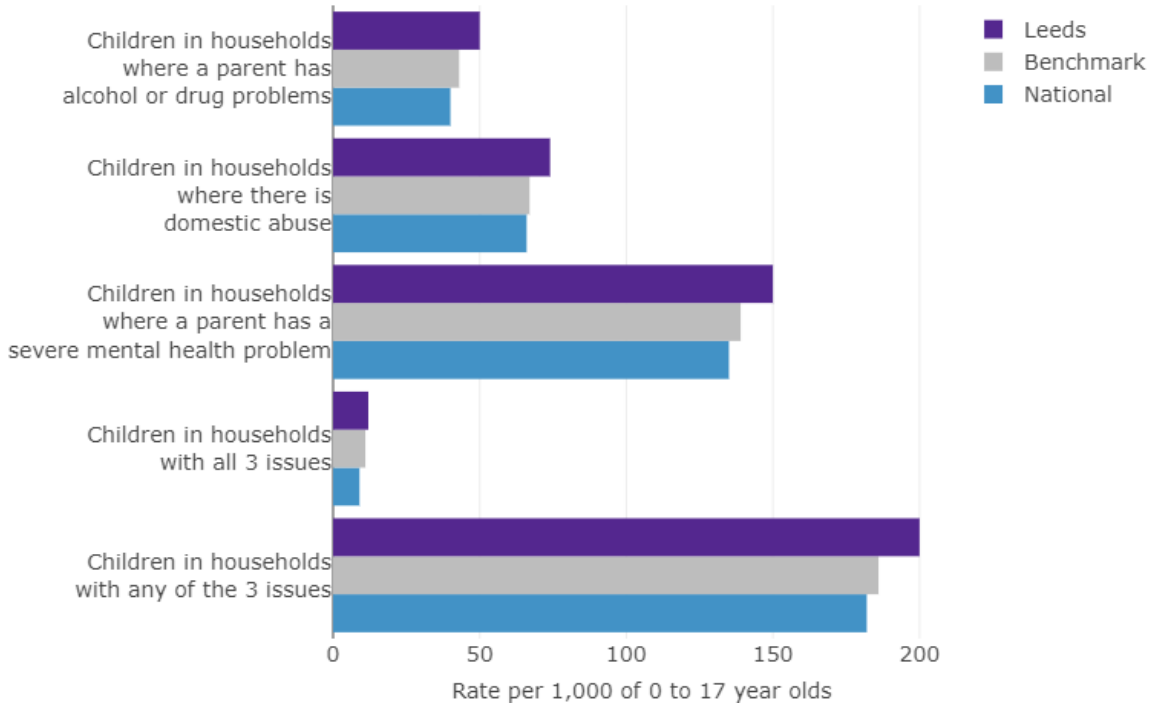
Figure 73 - Estimated prevalence of underlying needs among children in Leeds

Group	Indicator	Estimate	Rate	Percentile rank amongst LAs (0 = Lowest rate, 100 = Highest rate)	Source
Children in at risk households with multiple vulnerabilities	Modelled prevalence of children in households with any of so called 'toxic trio'	33,580	199.7 per 1000 0-17 yr olds	82	CCO prevalence estimates
	Modelled prevalence of children in households with all 3 of so called 'toxic trio'	1,994	11.9 per 1000 0-17 yr olds	80	CCO prevalence estimates
Children in households suffering domestic abuse	Modelled prevalence of children in households where parent suffering domestic abuse	12,432	73.9 per 1000 0-17 yr olds	82	CCO prevalence estimates
Children in households suffering from mental health problems	Modelled prevalence of children in households where parent suffering severe mental health problem	25,274	150.3 per 1000 0-17 yr olds	78	CCO prevalence estimates
Children in households suffering from drug/alcohol problems	Modelled prevalence of children in households where parent suffering alcohol/drug dependency	8,477	50.4 per 1000 0-17 yr olds	95	CCO prevalence estimates

Source - Local vulnerability profiles | Children's Commissioner for England (childrenscommissioner.gov.uk)

When displayed graphically it is clear that Leeds children are exposed to higher rates of the toxic trio than the England rate (Figure 74). This chart also compares to a 'benchmark' - "These are the areas identified as the nearest neighbours for Leeds using the Chartered Institute of Public Finance & Accountancy (CIPFA) 2018 Model: Salford, Bolton, Wigan, Kirklees, Wakefield, Sheffield, Bradford, Derby, Birmingham, Coventry, Dudley, Medway, Bristol, Plymouth, Swindon. Please see the appendix for a table of these benchmark areas including upper tier local authority codes."

Figure 74 - Children in households experiencing the toxic trio, Leeds, Benchmark and England (2019-2020)



Source: Chart used from [Parents with problem alcohol and drug use: Data for England and Leeds, 2019 to 2020 (ndtms.net)], original source [Local vulnerability profiles | Children's Commissioner for England (childrenscommissioner.gov.uk)]

The estimates provided above give an insight into the issues at a population level. However, when compared to the data collected about children who are known to services in Leeds (Figure 75), Leeds appears to rank more highly compared to other local authorities than was the case in Figure 73 above. The cause for this is unclear and warrants further investigation.

Figure 75 -Profile of vulnerable children known to services in Leeds

Group	Indicator	Estimate	Rate	Percentile rank amongst LAs (1 = Lowest rate, 100 = Highest rate)	Source
Children in households suffering domestic abuse	CIN episodes where a child has domestic abuse identified as a factor at CIN assessment (excluding looked after children)	3,270	19.4 per 1000 0-17 yr olds	82	CCO prevalence estimates
Children in households suffering from mental health problems	CIN episodes where a child has mental health of parent/someone else in household identified as a factor at CIN assessment (excluding looked after children)	898	5.3 per 1000 0-17 yr olds	10	CCO prevalence estimates
	CIN episodes where a child has self-harm identified as a factor at CIN assessment (excluding looked after children)	92	0.5 per 1000 0-17 yr olds	11	CCO prevalence estimates
Children in households suffering from drug/alcohol problems	CIN episodes where a child has substance misuse by a parent/someone else in household identified as a factor at CIN assessment (excluding looked after children)	928	5.5 per 1000 0-17 yr olds	15	DfE statistics

CIN = Children in Need

Source - Local vulnerability profiles | Children's Commissioner for England (childrenscommissioner.gov.uk).

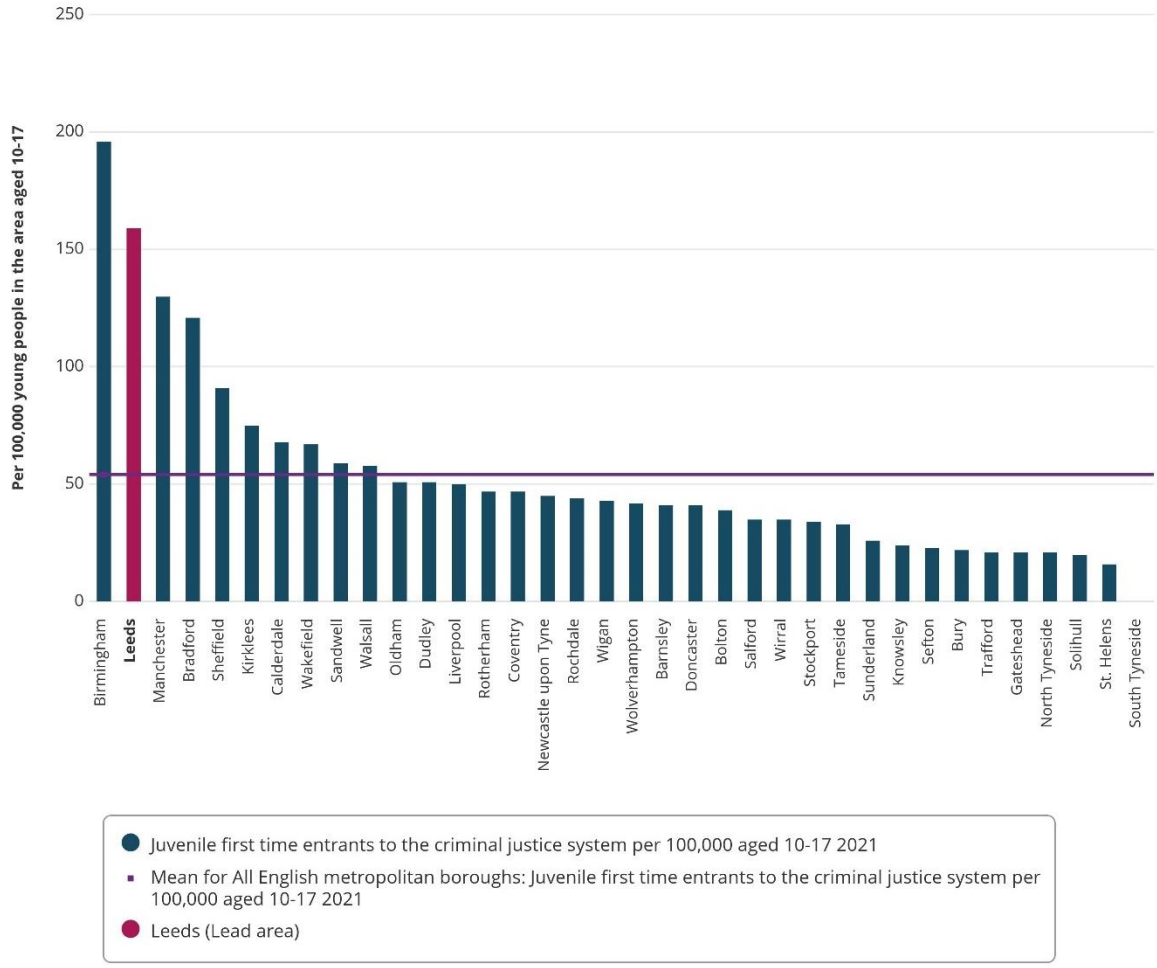
Children experiencing poverty

See Child Poverty chapter

Children in the Justice System

Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. In 2021 the rate of first time entrants to the criminal justice system among young people (aged 10 – 17) in Leeds is 198 per 100,000. The national average is 169 (Figure 76).

Figure 76 - Juvenile first time entrants to the criminal justice system per 100,000 of 10-17 year-olds (2021) for All English metropolitan boroughs



Source: Ministry of Justice, chart downloaded from [Juvenile first time entrants to the criminal justice system per 100,000 of 10-17 year-olds in Leeds | LG Inform (local.gov.uk)]

In 2018, the Leeds City Council Youth Justice Service carried out in internal review of the prevalence of ACES that their service users experienced[160].

A total of 237 cases with information completed. The cases were a snapshot of open cases from mid-July.

- 4 young people had experienced 9 out of 10 areas of trauma
- 36% of the cohort had experienced 4 or more traumatic events
- 43.5% of the 10-14 year-olds had experienced 4 or more traumatic events whereas 35.1% of those over 15 years had experienced 4 or more.
- Three quarters of the young people had parents who were separated or divorced (75.1%)

[160] Report for Leeds produced by Public Health England, amended with additional local data January 2021 (Appendix 1)

- 22% of young people had experienced someone in their home being sent to prison during their lifetime

Children who have experienced bereavement

In the 2021 My Health My School Survey 'Within the last 12 months, has anyone close to you died?',

- 2.6% of pupils responded 'yes, someone who lives in my house (e.g. parent, brother or sister)'
- 4.8% responded 'yes, a friend'
- 36.8% reported 'Yes, someone who is in my family but does not live in the same house as me (e.g. grandparent, aunt or uncle)'
- 55.8% of children had not experienced death in the last 12 months.

Children's experiences of Family Life

Family environments have significant effects on health, in both negative and positive ways[161]. Children experiencing supportive and loving family life can expect improved wellbeing and lifelong outcomes, but when this is reversed and family life is chaotic and stressful, wellbeing is negatively affected.

At a national level children tell us they care about their families and for those not living with their family they too care about having a happy home environment in whatever form this may be. Family life is increasingly becoming an area of interest and focus. The Children's Commissioner has launched a review into contemporary family life in Britain as a result of a recommendation from the Commission on Race and Ethnic Disparities which identified family life as a key factor in childhood disparities. As part of this review a Big Ask survey was conducted in September 2021 and the report describes children's responses around family, community, health and wellbeing, schools, work and life in care. This showed that 80% of children aged 9-17 were happy with their family life compared to 95% of those aged 6-8; evidencing lower levels of satisfaction as children get older. Satisfaction with family life is lower for children who are young carers and children looked after. Only 57% of 9-17 year-old carers were happy with family life. Only 68% of children looked after were happy with family life. However, while most children are happy at home according to a report by the Early Intervention Foundation in England 2.5% of Children in England are experiencing some form of family dysfunction or maltreatment. This figure is the tip of the iceberg as often this is hidden and underreported.

While at a local level there is no data related to children's satisfaction with their family life, there is data collected about safety and home life within the My Health My Schools Survey. In the 2021 Leeds the My Health My School Survey when asked 'How safe do you feel at home?', 3.2% of respondents felt unsafe, 28.0% safe and 68.7% very safe.

Identified Gaps In Understanding

- The datasets from the Children's Commissioner are really positive. They provide insight into a range of issues a child might be living with, from physical or mental illness, to going

[161] Commission from Government: Children's Commissioner Family Review | Children's Commissioner for England (childrenscommissioner.gov.uk)

hungry; being homeless or excluded from school; being at risk of neglect; or living with parents with health problems. These datasets must be used effectively to guide work in the city.

- Within this chapter adult services are not reviewed. However improved understanding of how adult services impact children through the impacts on families will enable informed service management. There are positive examples which could be built upon within alcohol and drug service use data, which collect data on the parental status of service users and model potential unmet need[162].

[162] Parents with problem alcohol and drug use: Data for England and Leeds, 2019 to 2020 (ndtms.net)

8. Key Health Factors

8.1. Children's Healthy Weight

Headlines:

- In Leeds in 2021/22 9.9% of children in reception living with obesity.
    - This is below regional (11.0%) and national (10.1%) figures.
    - This is lower than 2020-21 (14.9%) and 2019-20 (10.1%) rates but in general remains an increase when compared with previous years
- In Leeds in 2021/22 25.1% of children in Year 6 were living with obesity
    - This is much higher compared to 20.8% (2019-20) and compared to 2021-22 regional (24.9%) and national (23.4%) rates
- Stark inequalities in children living with obesity levels exist across Leeds.
    - In 2020, 32.4% of 10-11-year-old children living in Gipton and Harehills were living with obesity, compared to 11% in Horsforth.
- Food insecurity is a growing problem both nationally and locally. In 2020/21 the number of people in Leeds accessing foodbanks increased by 47% compared to the previous year. This is important because food security impacts the ability to provide healthy food for children.

Introduction:

Living with obesity in childhood profoundly impacts children's physical health, social and emotional well-being and self-esteem. It is a complex issue and childhood obesity is one of the biggest public health issues facing the UK[163]. Children living with obesity are more likely to become adults living with obesity and this has serious implications for both physical and mental health[164]. In children, obesity is defined as a BMI greater than or equal to the 95th centile. Obesity doubles the risk of dying prematurely and increases the risks of numerous health conditions including stroke, heart disease, some cancers, hypertension, diabetes and depression. The economic costs are great too. It is estimated that the cost of obesity to the NHS is £6.1 billion and £27 billion to wider society annually[165].

The rates of children living with obesity are rising and there are widening disparities. For example, children in the most deprived areas are more than twice as likely to be living with obesity as those living in the richest areas and while just over 9% of white children were living with obesity in 2018/19 at age 4 to 5, 15% of black children were[166]. With 34% of Leeds pupils (42,768) living in the 10% most deprived areas, this represents a significant additional challenge for Leeds[167]. The factors influencing weight in children are similar to those in adults, including behaviour and genetics, as well as a significant impact of a child's community and family setting on their ability to make healthy choices. The complexity of the issue therefore demands a whole systems approach to give children a healthy start in life.

The government policy "Childhood Obesity: A Plan for Action" set out a plan to halve childhood obesity by 2030 and the more recent policy document "Tackling obesity: empowering adults and

[163] Healthy weight – RCPCH – State of Child Health
[164] Predicting adult obesity from childhood obesity: a systematic review and meta-analysis - PubMed (nih.gov)
[165] Health matters: obesity and the food environment - GOV.UK (www.gov.uk)
[166] Healthy weight – RCPCH – State of Child Health
[167] School Census

children to live healthier lives" set out further changes to drive forward this change. In 2022 the Better Health Healthier Families campaign brings renewed focus to the importance of nutrition. The United Nations Children's Fund (UNICEF) has noted that although much remains to be done to tackle childhood obesity, the UK is paving the way to ensure that all children grow up in a healthy food environment. Locally, Leeds City Council has adopted the healthy weight declaration which focuses on creating a healthier environment to help people achieve a healthy weight and through the Leeds Child Healthy Weight plan and the Pledge for a Healthy and Active Future has set out a vision for every child in Leeds to be a healthy weight.

Epidemiology

Local Authority Inform also produces an annually updated summary report - National Child Measurement Programme (NCMP) data for Leeds | LG Inform (local.gov.uk).

The healthier weight intelligence tool also has detailed and regularly updated Leeds and West Yorkshire level data related to childhood obesity and activity levels, as well as an interesting review of inequalities at a national level.

The Leeds joint strategic needs assessment reports the percentage of children classified as a healthy weight with comparison between IMD quintiles.

National Child Measurement Data

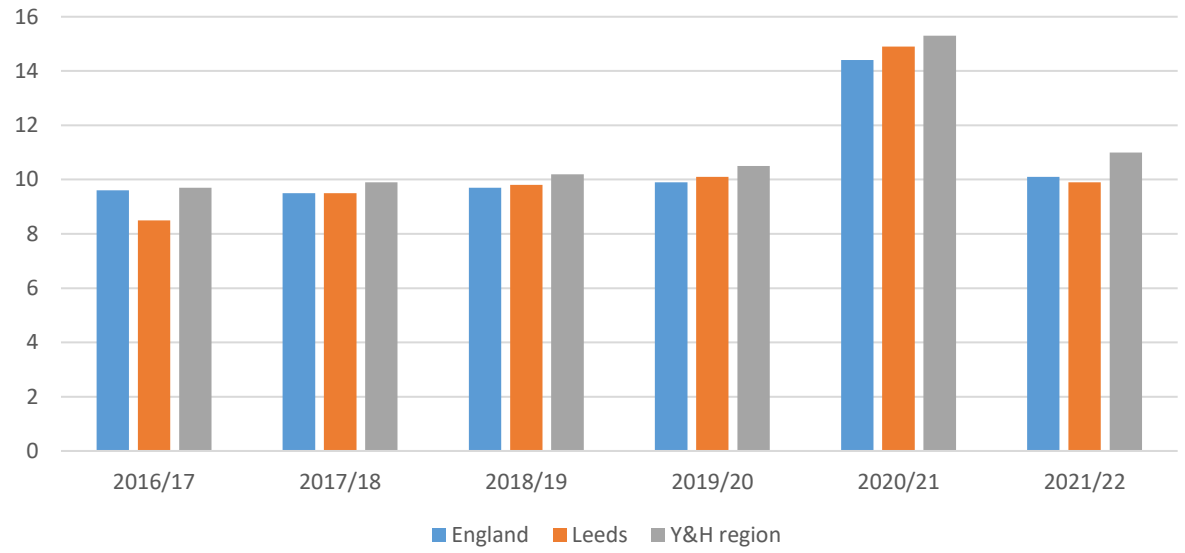
In the UK there is a National Child Measurement Programme (NCMP) that measures the height and weight of children in reception class and year 6 to monitor changes in children's weight over time. This provides a robust national and local dataset to monitor trends, however in recent years the dataset has been challenged by school closures and a subsequent inability to measure the required number of children to produce reliable data.

According to the 2020/21 NCMP data in Leeds in the reception age group 14.9% of children were living with obesity. This represented a 4.8% increase on the previous year, which was the biggest annual increase in the data (Figure 77). Analysis of Leeds deprivation in single years showed that the number of children living with obesity in the most deprived quintile during this time period rose significantly from 12.5% to 19.6%.

In Leeds in 2020/21 the 0-19 service managed to weigh and measure more than 75% of eligible reception age children, meaning a reliable dataset for this age group. However, this was not possible for the year 6 age group and as such there were no Leeds estimates produced for this age group in this year.

However recently published national data from 2021/22 has shown in Reception, the prevalence of children living with obesity has decreased from 14.4% in 2020/21 to 10.1% in 2021/22 (Figure 77). In Leeds in 2021/22 9.9% of children in reception were living with obesity. This is below regional (11.0%) and national (10.1%). Despite the decrease compared to last year there remains an increase generally over time.

Figure 77 - Proportion of children in the reception year group living with obesity in Leeds, Yorkshire and the Humber and England between 2016/17-2021/22.

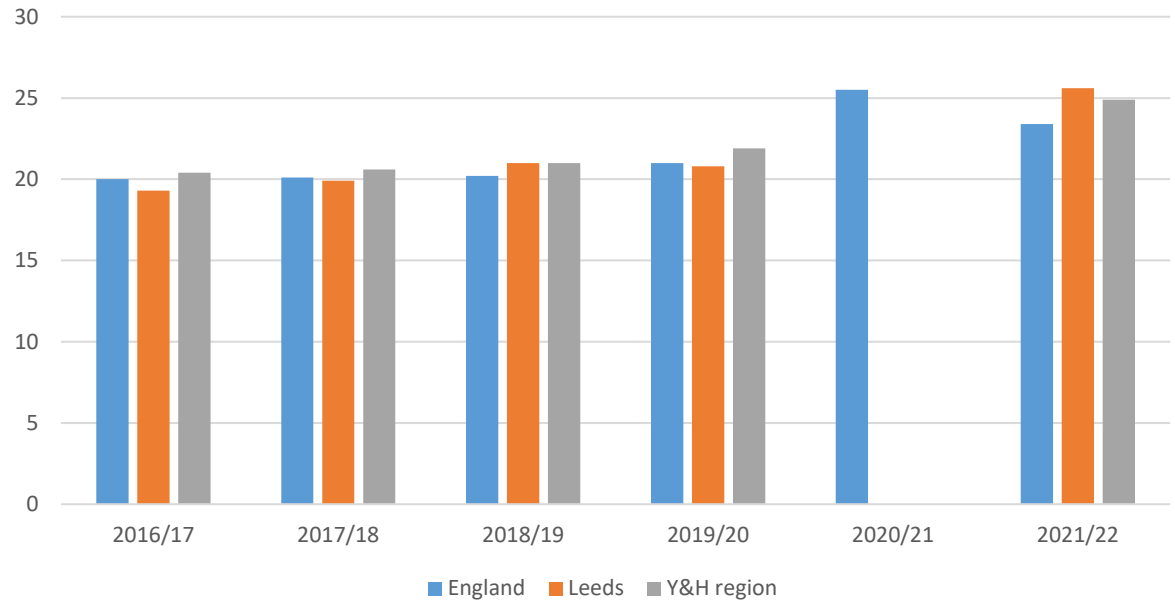


Source: NCMP Data

Nationally in Year 6, the prevalence of children living with obesity increased from 21.0% in 2019/20 to 25.5% in 2020/21 (Figure 78). As described, due to the pandemic interrupting data collection there was no Leeds estimates for 2020/21 for this age group. However, in the previous year's data collection the Leeds obesity rate was not statistically significantly different to England in either Reception or Year 6 suggesting that the same trend is likely to have been observed this year.

However recently published national data from 2021/22 the proportion of year 6 pupils living with obesity at a national level is 23.4%. Therefore, similar to the reception age group at a national level there has been a decline in the rate of children living with obesity compared to last year, but still an increase when compared to 2019/20 and the years prior to this. At a Leeds level the percentage of Leeds children living with obesity in 2021/22 in Year 6 is 25.6% which is much higher compared to 2019-20 rates of 20.8% and compared to regional (24.9%) and national (23.4%) rates. Additionally in this single year, the rate of Leeds children living with obesity in Year 6 have increased.

Figure 78 - Proportion of children in Year 6 living with obesity in Leeds, Yorkshire and the Humber and England between 2016/17-2021/22.



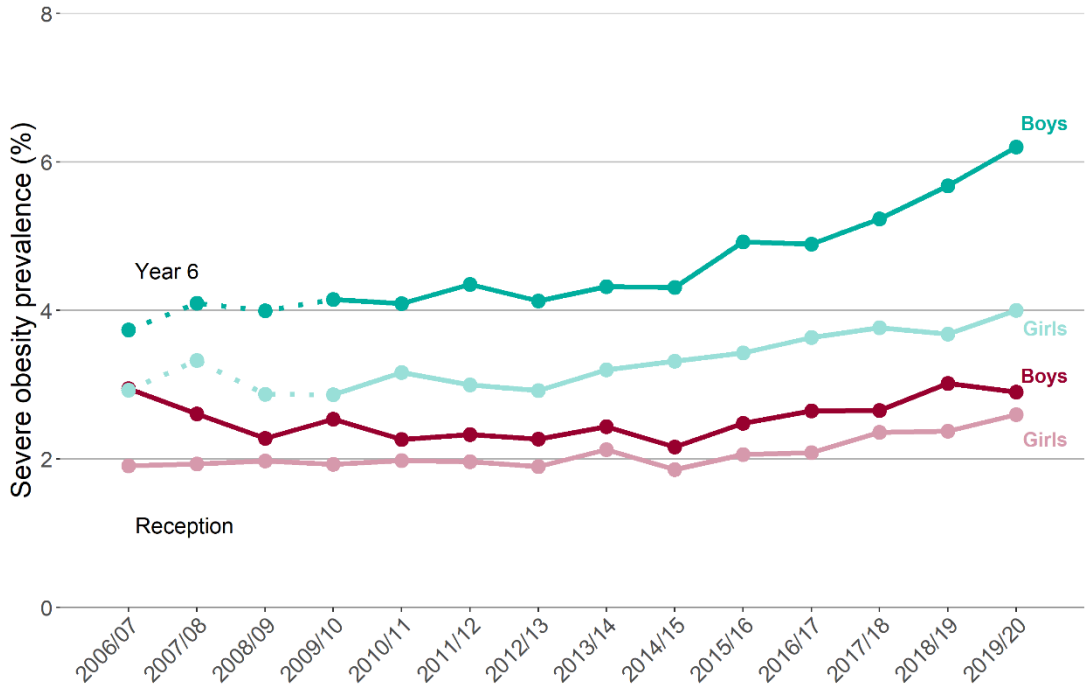
Source: NCMP Data

It is likely that these unprecedented fluctuations and increases are related to the COVID-19 lockdown which reduced children's access to healthy affordable food, physical activity and impacted negatively on child and family emotional wellbeing all evidence-based risk factors for obesity. During the pandemic school closures, increased screen time, and marketing of fast foods increased many children's exposure to the environmental drivers of weight gain[168,169]. Access to green space and regular physical activity opportunities both at or outside school were reduced and despite restrictions allowing 60 minutes of exercise in a local area, nearly 30% of children reported not leaving the house on a typical lockdown day. This was more pronounced among ethnic minority communities. The pandemic made it harder for families, and especially those living in deprived areas to access and buy fresh food. Food insecurity among families increased with 2.3 million children experiencing food insecurity between August 2020 and January 2021. making families more likely to buy cheaper and more calorie-dense foods[170]. Emotional wellbeing was also negatively affected[171] reducing children and family's resilience and ability to manage the very many challenges our obesogenic environment presents.

An emerging area of interest is the rise in severe obesity, particularly among year 6 boys. Data related to severe obesity is available at a regional level and the latest available data is from 2019/20 (i.e. prior to the increase in obesity rates seen in 2020/21) and is shown in Figure 79.

[168] Children's Media Lives: Life in Lockdown (ofcom.org.uk)
[169] Peer Reviewed: Accelerated Weight Gain Among Children During Summer Versus School Year and Related Racial/Ethnic Disparities: A Systematic Review - PMC (nih.gov)
[170] A Crisis Within a Crisis: The Impact of Covid-19 on Household Food Security | Food Foundation
[171] Mental health and wellbeing of children and adolescents during the covid-19 pandemic | The BMJ

Figure 79 - Trend in the prevalence of severe obesity by age and sex in Yorkshire and the Humber. Reception (aged 4-5 years) and Year 6 (aged 10-11 years)



Source: NCMP Data reported in 'Patterns and trends in child obesity in Yorkshire and the Humber' presentation by Public Health England.

Inequalities and Healthy Weight

The prevalence of children living with obesity in England follows a socioeconomic gradient, and poverty plays a key role in diving obesity. The gap in children living with obesity prevalence between children from the most deprived and least deprived areas is stark. England level data from 2020/21 reported by NHS Digital suggest that between 2006/07 and 2020/21 the gap between the prevalence of children living with obesity for children attending schools in the most and least deprived areas increased from 4.5 to 10.7 percentage points, with the steepest increase shown between the latest two academic years[172]. Research shows that unhealthy food, high in fat, sugar and salt is cheaper and more often subjected to promotions in supermarkets than healthy foods. For example, more healthy foods are almost three times more expensive per calorie than less healthy foods[173]. Price is therefore undoubtedly an important lever in what food and drink children in low income families have access to. For example, for those living in families in the lowest income quintile they would need to spend 47% of their disposable income to be able to meet the HYPERLINK "https://www.nhs.uk/live-well/eat-well/food-guidelines-and-food-labels/the-eatwell-guide/"Eatwell Guide recommendations, compared to just 11% of the top quintile, compared to just 11% of the top quintile[174]. In addition to this children living in poorer areas are exposed to up to five times more fast

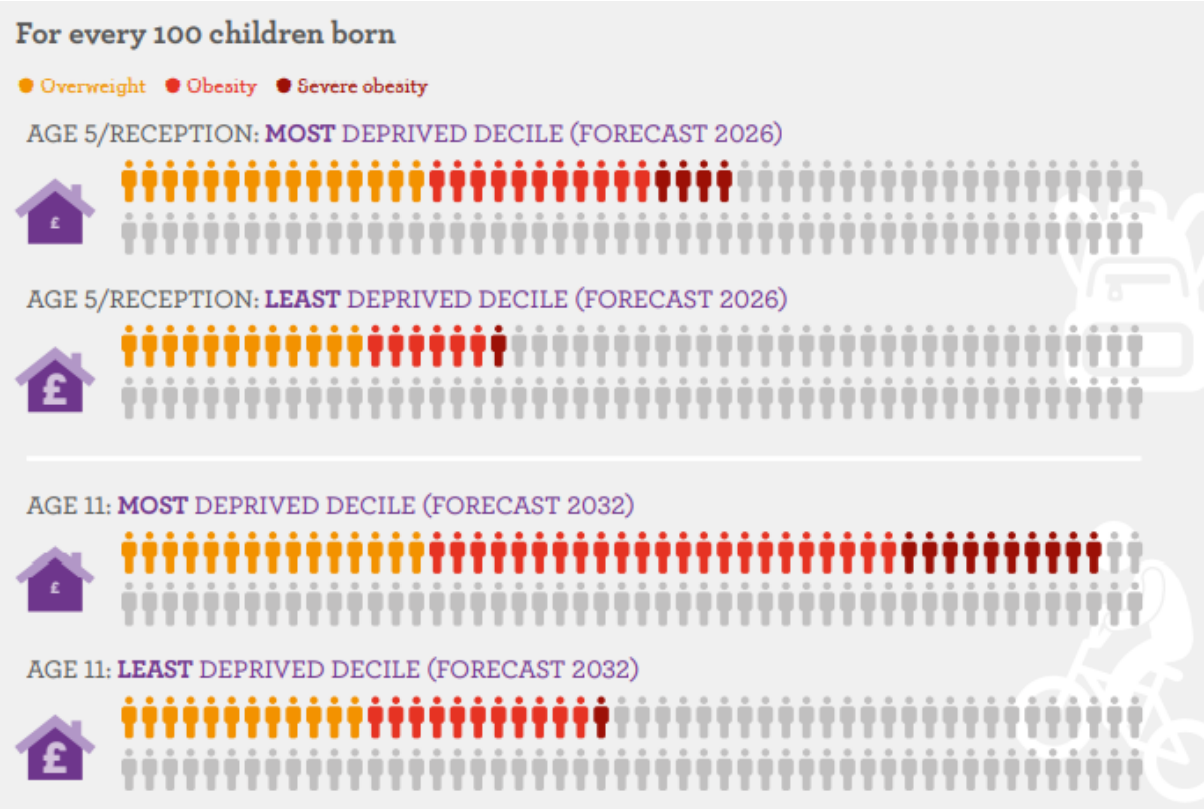
[172] NCMP – Part 4 Deprivation
[173] The Broken Plate 2022 | Food Foundation
[174] The Broken Plate 2022 | Food Foundation

food takeaways and concentrations of these outlets are greatest in deprived areas[175]This is further compounded by children living in more deprived areas facing barriers to participation in sports and access to green space. [176], children living in poorer areas are exposed to up to five times more fast food takeaways and concentrations of these outlets are greatest in deprived areas[OBJ]. [177]children living in more deprived areas facing barriers to participation in sports and access to green space[OBJ]. [178].

The Food Foundation calculated the projected health implications of current diets for children born in England in 2021[179]. The trajectory was modelled using projected figures based on current trends, thus showing what the rates of overweight, obesity and diet-related disease will be for children born into the poorest 10% of households compared to those in the richest 10% of households if things continue as they are. Figure 80 below demonstrates the stark gap in outcomes between the most and least deprived communities.

[177] The Broken Plate 2022 | Food Foundation – annual report
[178] Child Poverty Action Group - Sport and Poverty
[179] The Broken Plate 2021 | Food Foundation

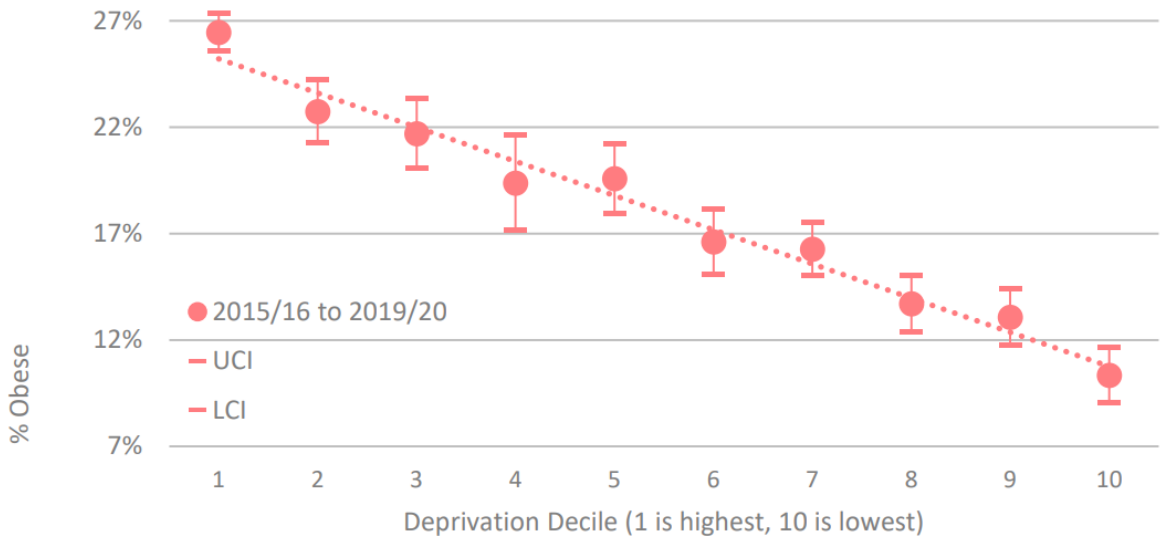
Figure 80 - Proportion of children who are overweight, obese and severely obese according to deprivation



Source: [The Broken Plate 2021 | Food Foundation]

Geographically across Leeds the association between obesity and deprivation can be seen. The range of percentage obesity in Year 6 children is from 32.4% in Gipton and Harehills to 11% in Horsforth. The graph below (Figure 81) shows the association between deprivation and obesity in Leeds.

Figure 81 – Prevalence of children living with obesity in Year 6 by Leeds school area 2019 IMD using 5 year aggregated data 2015/16 to 2019/20



Source: Leeds NCMP Report 2019/20

There are inequalities according to ethnicity too. In comparison to the Leeds overall rate, the "African", "Any other black background", and "White and Black African" groups are all significantly above the Leeds average. Statistically these findings are in line with national trend[180]. However this must be treated with caution as there are known associations between ethnicity and area deprivation, as well as wide debate of the appropriateness of BMI as a measure across all ethnicities.

There are small differences in prevalence of obesity by gender with boys generally having a higher prevalence. The difference between the genders increases from reception to year 6.

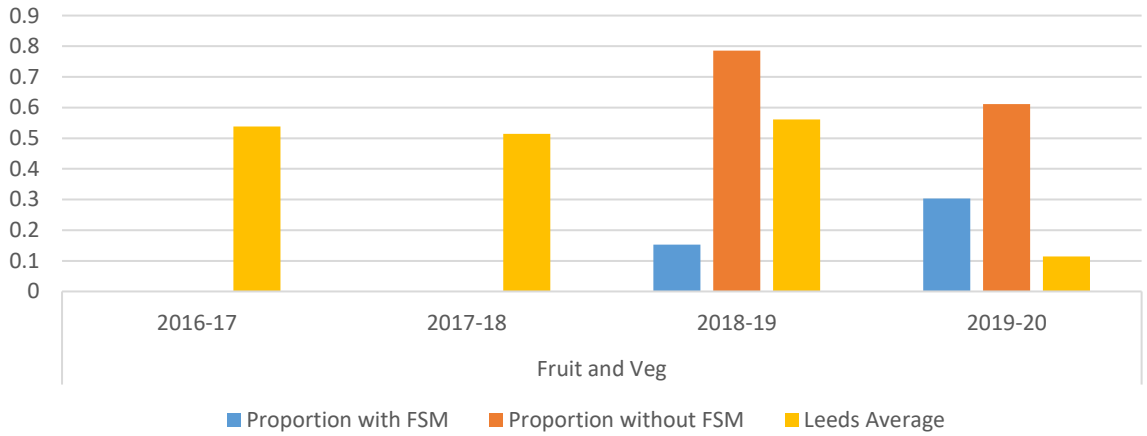
Epidemiology of factors affecting Children's Healthy Weight

Nutrition

The majority of children (92.3% of boys and 90.7% of girls) do not eat the recommended minimum of 5 portions of a variety of fruit and vegetables per day and children's consumption of added or processed sugars (non-milk extrinsic) significantly exceeds the maximum recommended level[181]. The National Diet and Nutrition Survey 2020, which analysed the physical activity and diet of around 1000 children and adults and compared to their previously reported data averagely 2 years and 7 months earlier, concluded that habits were broadly similar to the previous study and therefore concluded that the impact of COVID-19 on dietary habits is uncertain[182].

In Leeds there are wide inequalities in the consumption of fruit and vegetables between those receiving free school meals and those not eligible for free school meals (Figure 82). While this does not attempt to describe the nutritional picture for Leeds children, it is an example of the differences in nutrition that exist for children in Leeds.

Figure 82 - Self reported proportion of year 7,9 and 11 children who eat three or more portions of fruit and vegetables according to self-reported eligibility for free school meals.



[180] NCMP Data - Part 3: Ethnicity - NHS Digital
[181] National Diet and Nutrition Survey: Diet and physical activity – a follow-up study during COVID-19 - GOV.UK (www.gov.uk)
[182] See previous footnote

Years 7,9 and 11 data are analysed here as they were the only year groups asked about their eligibility for free school meals. Children who were unsure about their eligibility for free school meals were included in the leeds average figure, and excluded from further analysis.

Source: My Health My School questionairre

Food insecurity

Food insecurity has varying definitions between sources. The Food Foundation defines food insecurity as:

"experiencing one or more of the following:

1. having smaller meals than usual or skipping meals due to being unable to afford or get access to food
2. being hungry but not eating because due to being unable to afford or get access to food
3. not eating for a whole day due to being unable to afford or get access to food"

Not having access or being able to consume sufficient quality food has significant consequences. A National Institute for Health Research (NIHR) review found that food-insecure children had poorer physical health across a wide range of indicators, from greater levels of asthma and dental caries, to higher levels of hospitalisations, as well as lower wellbeing and quality of life and higher levels of homelessness and substance use[183]. The review notes that poor nutrition through food insecurity is associated with both poor growth of deprived babies and children on the one hand, and rising child obesity on the other[184]. Food insecurity is generally associated with poverty and deprivation, yet the relationship is complex and multidimensional with a combination of factors such as income, food access, food knowledge parenting potentially ameliorating or exacerbating the problem.

Food affordability – the household cost of the diet relative to income – is an objective way of assessing if people theoretically have the financial ability to eat sufficiently. According to the latest Office for National Statistics (ONS) CPI figures for March 2022, food was 5.9% more expensive on average than it was last year, with the price of key items - like milk, cheese and eggs (8.6% up), pasta (10.1% up) and lamb (16.9% up) - all increasing. The price of more healthy foods continues to remain much higher than less healthy foods, with little change in the cost of different food groups between 2019 and 2021. The FSA's nutrient profiling model reveals striking differences, with more healthy foods almost three times more expensive than less healthy foods for the equivalent number of calories. The mean cost of more healthy foods in 2020 per 1,000 kilocalories was £7.00, compared to £2.41 for less heathy foods. The Broken Plate report 2022 assesses the affordability of a healthy diet as one of its ten metrics. The report states that the poorest fifth of UK households would need to spend 47% of their disposable income on food to meet Eatwell Guide costs. This compares to just 7% for the richest fifth[185].

[183] Child food insecurity in the UK: a rapid review (Martins et al, 2018)
[184] See footnote above
[185] The Broken Plate 2021 | Food Foundation

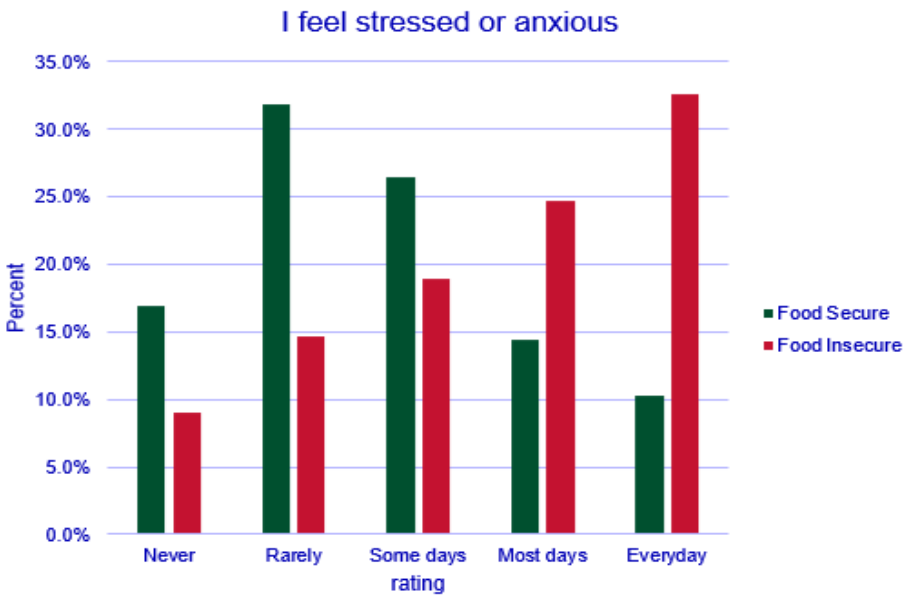
Between 1st April 2020 and 31st March 2021, 153,335 food parcels were given out informally in Leeds via Community Care Hubs, Emergency Food Provisions, which equates to an 860% increase since 2019/20. 61,137 people have accessed a foodbank in 2020/21, which is a 47% increase on 2019/20. In addition, 100,707 meals were given out through a drop in or through Street Outreach. While this is a 7% reduction on the previous year it is almost certainly due to the COVID-19 pandemic which prevented provision during lockdown periods.

Previous research has shown that children growing up in families that are food insecure demonstrate high levels of symptoms of anxiety and depression[186]. Secondary analyses of the 2018-19 My Health My School data was carried out by University of Leeds in order to examine the relationship between food insecurity and children's psychological wellbeing. The survey asked one question related to food insecurity: "*over the last 12 months have you worried about not having enough to eat because your family didn't have enough money for food?*'' Figure 83 below shows children and young people who are food secure (green bars) report rarely or never feeling stressed or anxious, whereas the opposite pattern is clear in children and young people who are food insecure (red bars) and much more likely to report being stressed or anxious most days or everyday. This association between food insecurity and poorer mental health is well established[187].

[186] COVID-19 partial school closures and mental health problems: A cross-sectional survey of 11,000 adolescents to determine those most at risk - Mansfield - 2021

[187] The association between food insecurity and mental health during the COVID-19 pandemic

Figure 83 - Leeds My Health My School 2018-19 – Wellbeing in children who report worrying about not have enough food at home



Source: Secondary analyses of the 2018-19 My Health My School data by University of Leeds

Activity

The UK Chief Medical Officer physical activity guidelines 2019 recommend that all children and young people accumulate an average of at least 60 minutes physical activity per day across the week. As well as physical benefits physical activity promotes social interaction amongst children leading to increased confidence and peer acceptance[188].

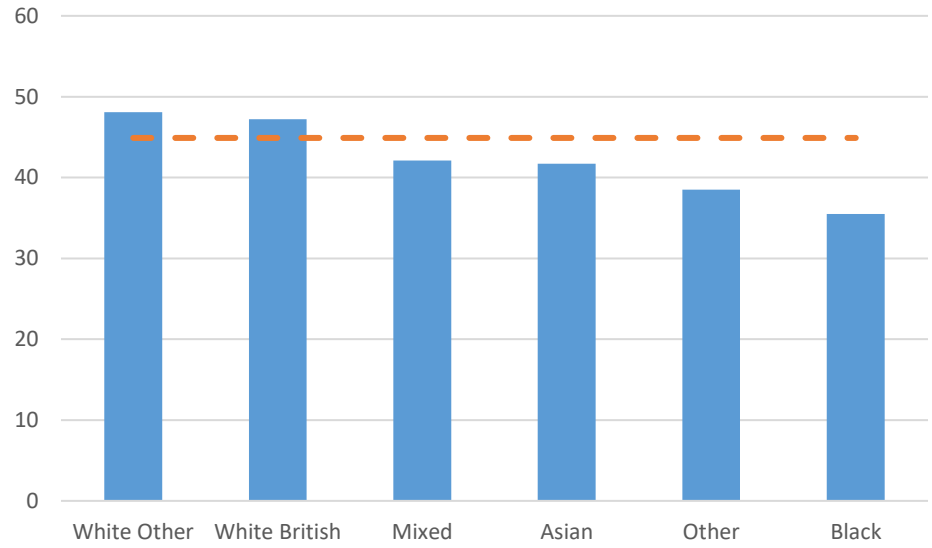
Nationally the Active Lives Children and Young People Survey 2020 demonstrated that 44.9% of children and young people met this target (a 1.9% decrease from previous year but remaining higher than 2017/18). This survey did not collect data during school closures due to COVID-19 (March – May 2020). These results therefore reflect the picture in the summer of 2020.

The latest Leeds level data from the Active Lives Children and Young People Survey is from 2019/20, where 42.7% of children were meeting the target compared to the national average of 44.9%. In Leeds there are differences in the proportion meeting the recommended activity levels between ethnic groups with black children least likely to be reaching the target (Figure 84). There are also differences between genders, with 47.1% of males meeting the target and 42.7% of females.

[188] Physical Activity Statistics 2015 | BHF Oxford University

Figure 84 - Proportion of children in Leeds meeting the recommended UK Chief Medical Officer physical activity guidelines according to ethnic group.

(Dotted line represents the England average).



Source: Active Lives Children and Young People Survey 2020. Graph recreated from Healthier Weight Intelligence Tool

Identified gaps in understanding

- The impact of COVID-19 on the prevalence of children living with obesity in Leeds is yet to be fully revealed as we await the 2021/22 dataset
- There is limited information about children's experiences related to weight including living with challenges related to body image and living with obesity.
- This chapter has focused on living with obesity, however increasingly there is need to understand access to food, food poverty and food deserts in Leeds and the interaction of this with children's healthy weight.
- This report has not focused on children living with underweight. This is reported in the healthier weight intelligence tool which has regularly updated Leeds and West Yorkshire level data. Therefore, better understanding of the impacts and contributing factors of this at a Leeds level is warranted.

8.2. Mental Health and Emotional Wellbeing

Headlines

- Nationally in 2021, one in six (17.4%) children aged 6 to 16 years were identified as having a probable mental health disorder, increasing from one in 9 (11.6%) in 2017. When modelled to the Leeds 6-16 year-old population, this equates to around 20,000 children.
- Nationally in 17-23-year-olds, 27% of young women and 13% of young men are likely to have a mental health disorder. When modelled to the Leeds 17-23 year-old population, this equates to 11,500 young women and 5,000 young men.
- The relationship between poor mental health and deprivation is clear. In Leeds, mental health service use, crisis service use and drop-out rates are higher for young people from deprived areas.
- In Leeds there are wide inequalities in self-reported (via My Health My School Survey) emotional wellbeing, with girls, those eligible for Free School Meals and those identifying as LGBTQ+ reporting poorer emotional wellbeing[189].
- In Leeds children and young people from Minority Ethnic communities experience inequalities in terms of access to mental health support.

Mental Health Terminology

Language used to talk about mental health changes over time due to the social constructions associated with different terminology.

Mental health is more than the absence of mental illness; it is a positive sense of well-being. For children and young people this includes the ability to play, learn, enjoy friendships and relationships, as well as deal with the difficulties experienced during childhood, adolescence and early adulthood.

Mental disorder is a term used in the Mental Health of Children and Young People Surveys - NHS Digital (key research cited in this chapter) as they applied diagnostic criteria from classification systems ICD-10 and DSM-5. It is *not* a term utilized in Leeds due to its negative connotations but has been used throughout this chapter when citing this report.

Self-reported emotional wellbeing has been used when presenting the findings from the My Health My School survey. This term acknowledges that there are no formal diagnostic criteria used in this survey.

Social, Emotional and Mental Health (SEMH) is a category utilised in Education settings, which replaced the terms BESD (Behaviour Emotional Social Development) and EBD (Emotional & Behaviour Difficulties) in the Special Educational Need and Disabilities Code of Practice in 2014. Dropping the word 'behaviour' aimed to encourage practitioners to focus on the needs behind the behaviour, rather than the behaviour itself.

Introduction

Nationally the proportion of children with mental health disorders is rising. In 2021, one in six (16%) of children aged 5-16 are likely to have a mental health problem. In Leeds, this equates to around: 19,608 children. COVID-19 has negatively impacted on the mental health of all groups, but

[189] To note, this analysis was not assessed for statistical significance, however the patterns demonstrate reflect national research.

particularly young people as they have experienced loss of education and routine as well as disruption of support services[190].

There are wide inequalities in experiences of mental health issues; children and young people who are most likely to develop problems with their mental health are those who: are excluded from school, are living in poverty, have experienced trauma, are in the justice system, are looked after children in the care system, are new to the country and asylum seekers or have special educational needs[191]. While there are factors that make someone more likely to experience mental health problems, there are also protective factors. Protective factors can be within the individual, in the family, or in the school or community – and they all link together[192]. For example, a strong attachment relationship as a baby with your parent or carer develops your ability to self-regulate your emotions and make friends in childhood[193]. This means that all parts of the system that work around the child and family have a part to play in promoting their mental health and supporting them when they are experiencing difficulties.

National policy has an emphasis on prevention and promotion, early intervention and timely access to specialist services, with intervention and support being evidence-based and focused on achieving measurable outcomes. Future in Mind (2015) set out numerous recommendations, which were re-iterated by the Five Year Forward View for Mental Health (2016).

The local strategic direction for Leeds reflects national policy and emphasises early help, resilience-building, better support for the most vulnerable children, and service transformation. The all age Leeds Mental Health Strategy 2020-2025 outlines children and young people as a priority, with Future in Mind: Leeds 2021-2026 as the strategy driving forward these improvements. This covers children and young people from birth up to age 25.

Epidemiology

The Mental Health of Children and Young People in England Survey, 2017 provides England's best source of data on trends in child mental health as it used robust methodology to assess for mental health problems. This survey was followed up in 2020 and 2021 with a smaller sample size and explored the Mental Health of Children and Young People in England 2021, during the pandemic and changes since 2017. A follow up wave 3 survey is due to be published in the coming months - Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey.

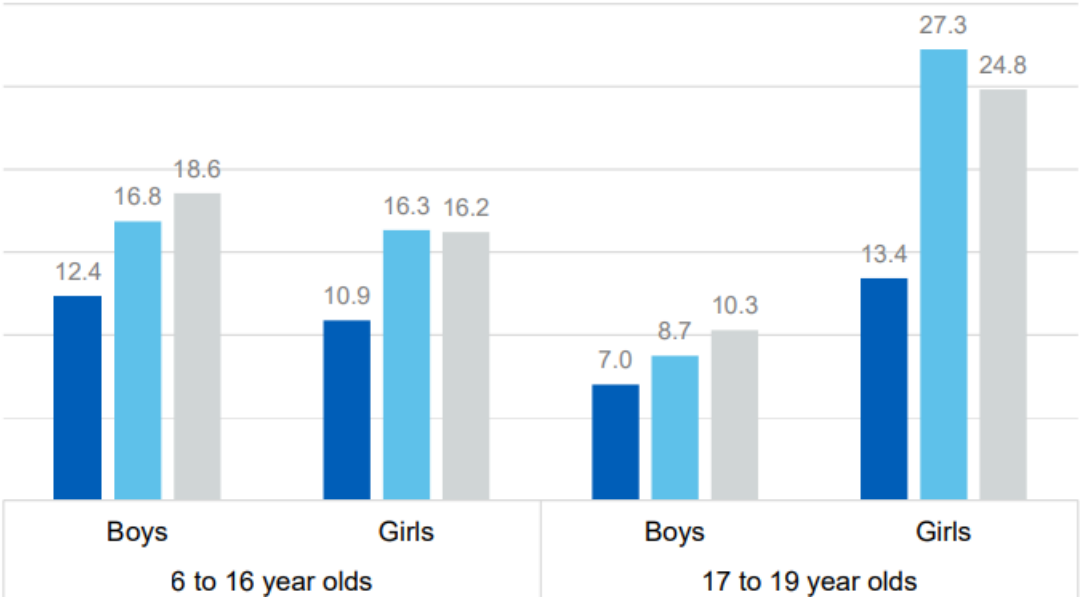
In 2021, data from NHS Digital showed that nationally one in six (17.4%) of children aged 6-16 were likely to have a mental health disorder. If modelled onto the Leeds population, this equates to around: 19,608 children. This compares to one in 9 (10.8%) in 2017.

The graph in Figure 85 using NHS Digital shows the percentage of children or young people in England with a probable mental disorder, by sex in 2017, 2020 and 2021. It demonstrates that rates

[190] COVID-19 mental health and wellbeing surveillance: report - 4. Children and young people - GOV.UK (www.gov.uk)
[191] Future in Mind Strategy: Leeds 2021 – 26 Future in Mind strategy: Leeds 2021-26 - NHS Leeds Clinical Commissioning Group (leedsccg.nhs.uk)
[192] Risk and Protective Factors for Youth | Youth.gov
[193] Attachment and child development | NSPCC Learning

are generally worsening over time. It also shows that rates of mental disorders worsen with age in girls, but improve in boys.

Figure 85 - Percentage of children or young people in England with a probable mental disorder, by sex,2017, 2020 and 2021

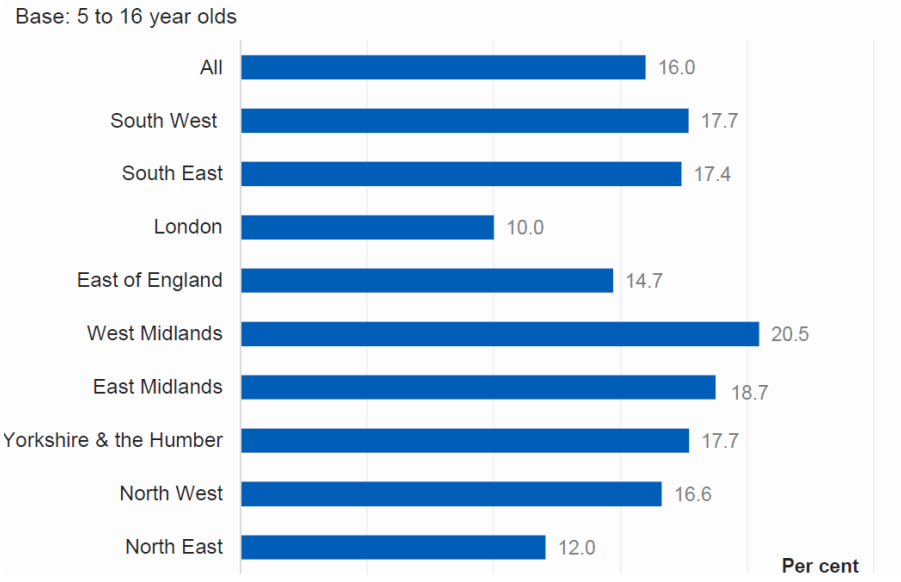


Key: Dark blue – 2017. Light Blue – 2020. Grey – 2021.

Source: NHS Digital

When reviewed at a local level in 2020, rates of probable mental disorder in children aged 5 to 16 years was 17.7% in Yorkshire and the Humber, compared to the national 17% (Figure 86). This data is not available at a Leeds level.

Figure 86 - Proportion of children aged 5 to 16 with a probable mental health disorder.



Source: Mental Health of Children and Young People in England, 2020, Data tables

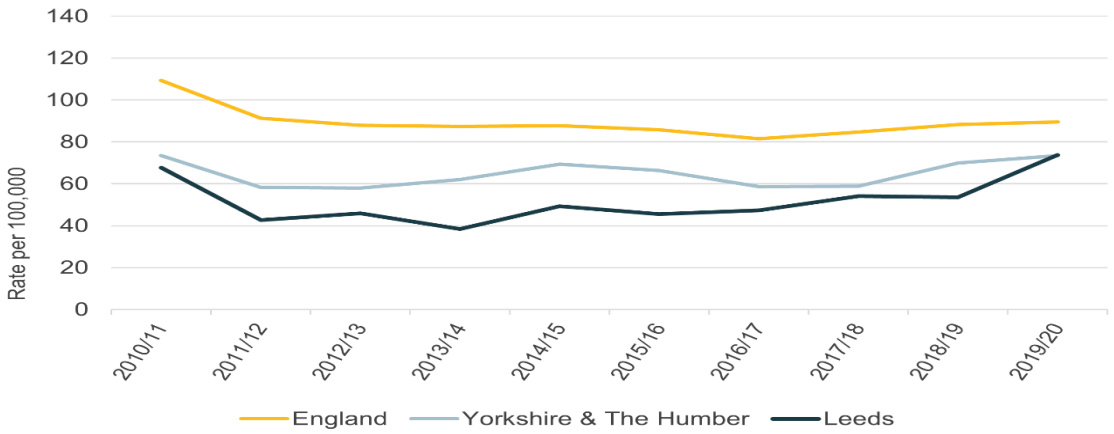
In 17-23 year-olds, 27% of young women and 13% of young men are likely to have a mental health problem. In Leeds if modelled onto the population, this equates to around: 11,400 young women and 4,573 young men.

The prevalence of different disorders in 2017 is outlined in the Summary of Data Pack to inform the refresh of the Future in Mind Leeds Strategy. These have increased since then as a result of the COVID-19 pandemic.

Hospital Admissions for mental health conditions under 18s

The Leeds rate of child inpatient admissions for mental health conditions at 73.8 per 100,000 is better than the England average, although it has risen more sharply in recent years (Figure 87).

Figure 87 - Hospital admissions for mental health conditions under 18s



Source: Public Health England Child and Maternal Health Profiles, graph used with permission from Leeds Joint Strategic Assessment 2021

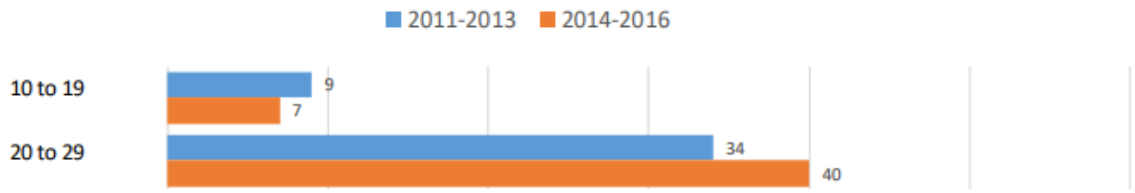
Suicide

Suicide amongst children and young people is rare, though rates increase with age.

Locally the numbers of suicides are too small to report annually. Figure 88 is taken from the most recent Leeds Suicide Audit[194] which assessed deaths occurring between 2014 to 2016 and shows the age distribution along with a comparison to the last audit (2011-13). The criteria of the audit meant that deaths under age 10 were not reviewed and it is therefore unclear if there were any deaths by suicide in children under the age of 10. A new suicide audit is currently being conducted and this will be reported in mid 2023.

[194] Leeds-Suicide-Audit-2014-2016-Full-Report.pdf

Figure 88 - Deaths from Suicide in 10-19 and 20-29 year-old age groups 2014-2016 vs 2011-2013 in Leeds City Residents by Age



Source: [Leeds City Council Audit of Suicides in Leeds (2014-2016)]

In Leeds during the audit across all age groups there were five male suicides for every one female suicide. For those under 26 the ratio is 7.7 to 1.

Data from the Child Death Overview Panel shows that there were 17 deaths by suicide in children from 2008-2022. This is 0-3 deaths per year. The age range of children who died by suicide was 12-17 year in this time period. Of these deaths 15 were male and 2 female. 6 had experienced suicidal ideation, 8 had self harmed, 4 experienced suicide, 4 experienced bullying and 9 were in touch with mental health services.

National research analysed suicides amongst children and young people which took place between April 2019 to March 2020 in order to identify common risk factors. This highlighted the following as significant risk factors: problems with household functioning (69%) loss such as bereavement (62%) and non-suicidal self-harm (36%)[195].

Research looking at rates of suicide during the COVID-19 pandemic showed no consistent evidence that child suicide deaths increased during the COVID-19 pandemic although there was a concerning signal that they may have increased during the first UK lockdown[196]. A similar peak was not seen during the following months, or the second lockdown. It will be interesting to review data emerging from the upcoming Leeds suicide audit that will cover the period of COVID-19.

6803 young people in Leeds (aged between 11 and 16) completed the My Health My School Survey in 2021/ 22. For the first time they were asked the following question in relation to suicide.

Have you ever thought about ending your life (this is known as having suicidal thoughts)?	Total	Percentage
No	4142	60.88
Yes	1706	25.08
Don't Know	955	14.04

[195] Suicide in Children & Young People | National Child Mortality Database (ncmd.info)
[196] Child Suicide Rates During the COVID-19 pandemic in England | medRxiv

Those that responded either 'yes' or 'don't know' were subsequently asked:

Have you ever tried to end your life?	Total	Percentage
No	2016	75.85
Yes	642	24.15

This equates to 9.4% of the total respondents. This number is exceptionally high, especially when correlated with the number of deaths by suicide reported by CDOP. The reasons for this are unclear and warrant further investigations. One such reason may be children's differing interpretation of the question. As this is the first year these questions have been included in the survey there is no previous data for comparison, however this will be an important question to monitor across the coming years.

Self-Harm

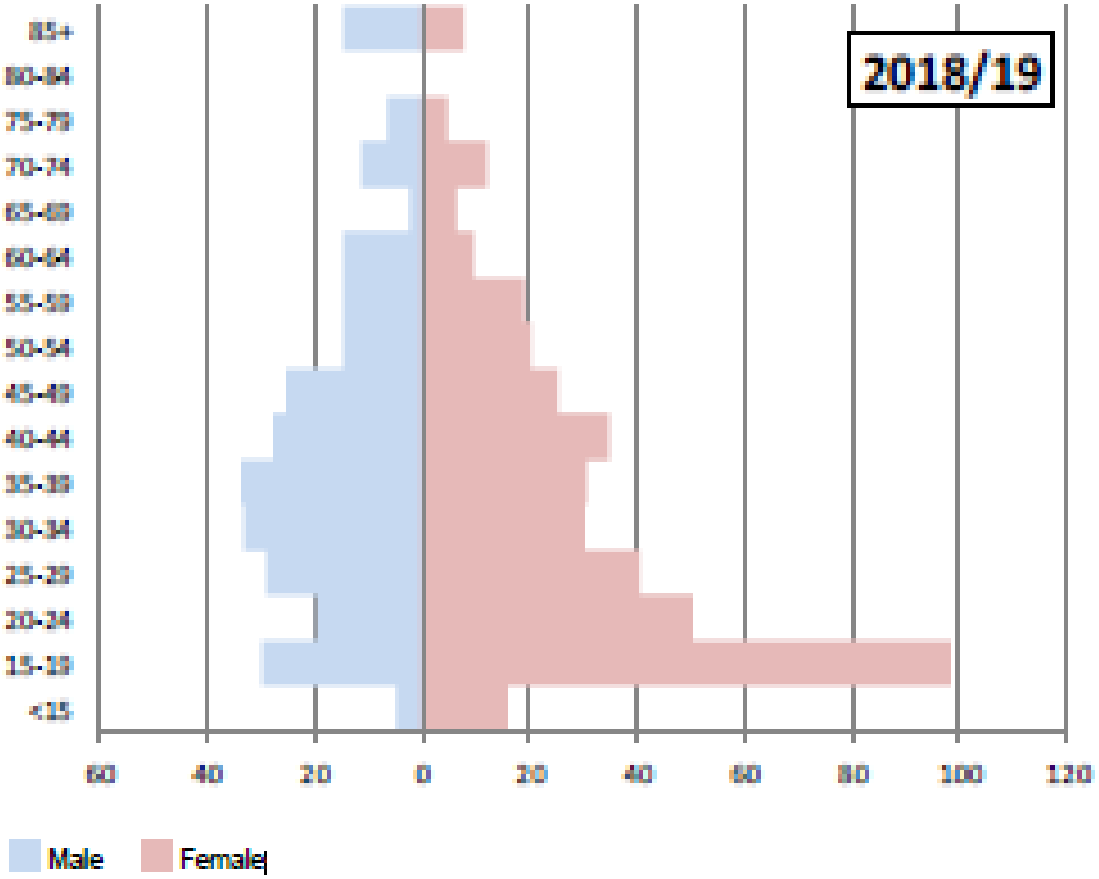
Nationally, the rate of young people (10-24 years) being admitted to hospital as a result of self-harm is increasing. This is not the case in Leeds, where there is no significant trend. The hospital admissions as a result of self-harm (201-24 years) in the latest period (2020/21) of 345.5 per 100,000 (previously 482.4 in 2019/20) is better than the English rate of 421.9. Nationally, levels of self-harm are higher among young women than young men[197].

In depth analysis of self-harm admission data in Leeds from 2018/19 showed that Females aged 15-19 continue to have a higher rate of self-harm related spells than any other

Figure 89 shows the profile of Leeds PCT/CCG patients who have had a self-harm related spell in 2018/19, expressed as a rate per 10,000 population, split by gender and five year age band.

[197] Admissions for mental health and self harm, by gender and age - NHS Digital

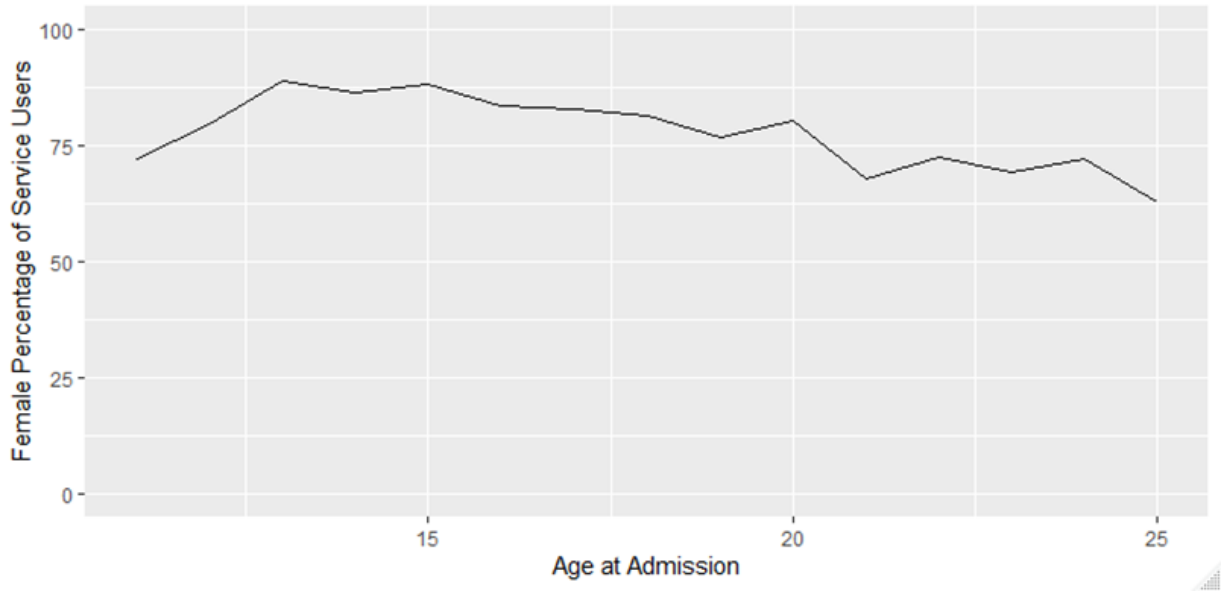
Figure 89 - Leeds PCT/CCG patients who have had a self-harm related spell in 2018/19, expressed as a rate per 10,000 population, split by gender and five year age band.



Source: Murphy (2018) Self Harm Admissions in Leeds

Recent analysis shows that at age 13-15 around 88% of people admitted to hospital are young women) (Figure 90).

Figure 90 - Self harm admissions by age and gender



Source: Alcock, B, email communication July 2022; additional analysis of data collected as part of this project - NHS Leeds CCG & City Council Satellite Analysis (wypartnership.co.uk)

Roughly 40% of admissions for self-harm are from people living in the most deprived 20%, and only 7% of admissions from those living in the least deprived 20% areas. However some preliminary analysis suggests that when admission data is turned into rates the pattern changes; with around 6 admissions per thousand for people in both the *most* and *least* deprived deciles. This drops to around 3 admissions per thousand people for the middle deciles[198]. Further analysis is planned to explore this.

Mental Health Services Data

4770 children and young people aged 0-18 received two or more contacts with mental health services in Leeds during April 2020 and March 2021. This figure expressed as a percentage of the estimated number of children and young people with a diagnosable mental health condition in Leeds is 30.7%, with variations across key factors such as sexual identity and social and family circumstances unknown.

As part of the Leeds Networked Data Lab project, in depth analysis of patient data from the Mental Health Services Data Set (MHSDS) was carried out in 2022[199]. The aim was to understand demographics of children and young people (aged 11 to 25) using mental health services and explore transition to adult services and impact of COVID-19.

Clear differences in those using mental health services were seen by looking across demographic variables, including[200]:

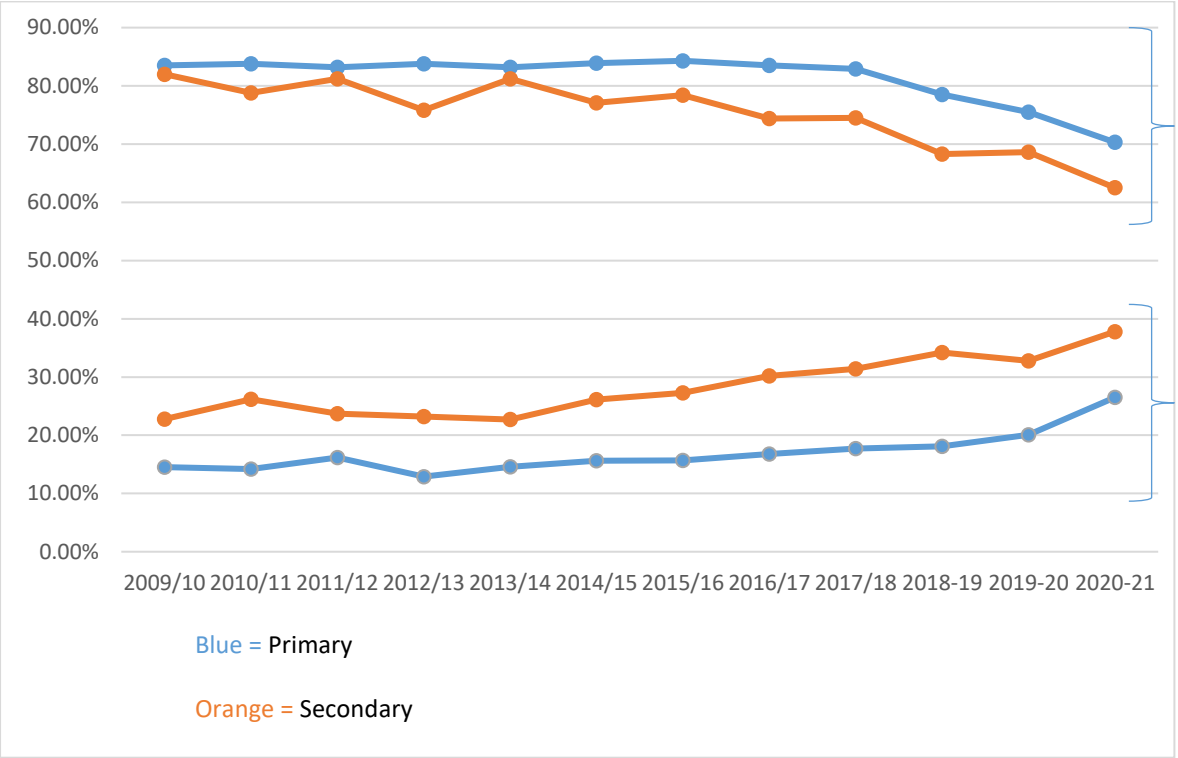
[198] Alcock, B, email communication July 2022; additional analysis of data collected as part of this project - NHS Leeds CCG & City Council Satellite Analysis (wypartnership.co.uk)
[199] NHS Leeds CCG & City Council Satellite Analysis (wypartnership.co.uk)
[200] NHS Leeds CCG & City Council Satellite Analysis (wypartnership.co.uk)

- Significant variations in the gender split of patients occur across the age range, peaking at mid-adolescence where around 70% of all patients are female.
- When standardised to the Leeds population, around 1 in 3 more people in the 10% most deprived areas had access to mental health services than those in the 10% least deprived areas.
- Patients from the 10% most deprived areas experience around twice the number of crises than patients from the 10% least deprived areas.
- Increased deprivation level is correlated with increased dropout rate
- Transition: where 17-19 year-olds are transferred from childhood and adolescent services (CAMHS) to adult services (AMHS)
    - Sustained drop in patient retention around this transition age, with around one in five fewer AMHS patients remaining in contact with the mental health service one year past a referral.
    - There was a significant drop in transition likelihood with increasing deprivation, and female patients were less likely to successfully transition than male patients.
- COVID-19 impact on service use:
    - Across all variables, there was a relatively stable level of service usage pre-COVID-19, significant increases in referrals and discharges during the "COVID-19" time-period, followed by general decreases in service use.
    - Generally, during the COVID-19 peak substantially more referrals per person were made by people living in the most deprived areas than those living in the least deprived areas. There were similarly stark increases in crisis service use during the peak, which correlates well with the finding that people from more deprived areas are significantly more likely to require crisis services than those from less deprived areas.
    - Younger people (11-16) experienced a much smaller increase in service use than older people (17+), although while service usage decreased post-COVID-19 for older people, there is an increase in the number of service requests for younger people.

My Health My Schools (MHMS) Data

Data from the MHMS survey indicates that in 2020/21 70.3% of primary school children and 62.5% of secondary school children reported that they felt happy every or most days. As shown in Figure 91 these are figures that are worsening.

Figure 91 - Proportion of children in primary (blue) and secondary (orange) school feeling 'happy every or most days' and 'stressed or anxious every or most days'



Source: My Health My Schools Survey Data

Factors influencing emotional health and wellbeing

A detailed analysis of the My Health My School Survey 2018/19 completed by 21,769 pupils Leeds is published in Section 3.2 of the Summary of Data Pack to inform the refresh of the Future in Mind Leeds Strategy. This is a survey that asks children and young people in school age-appropriate questions about their health and wellbeing. Analysis of relevant questions was carried out with the findings then grouped into a new category entitled 'self-reported emotional wellbeing' with the following conclusions:

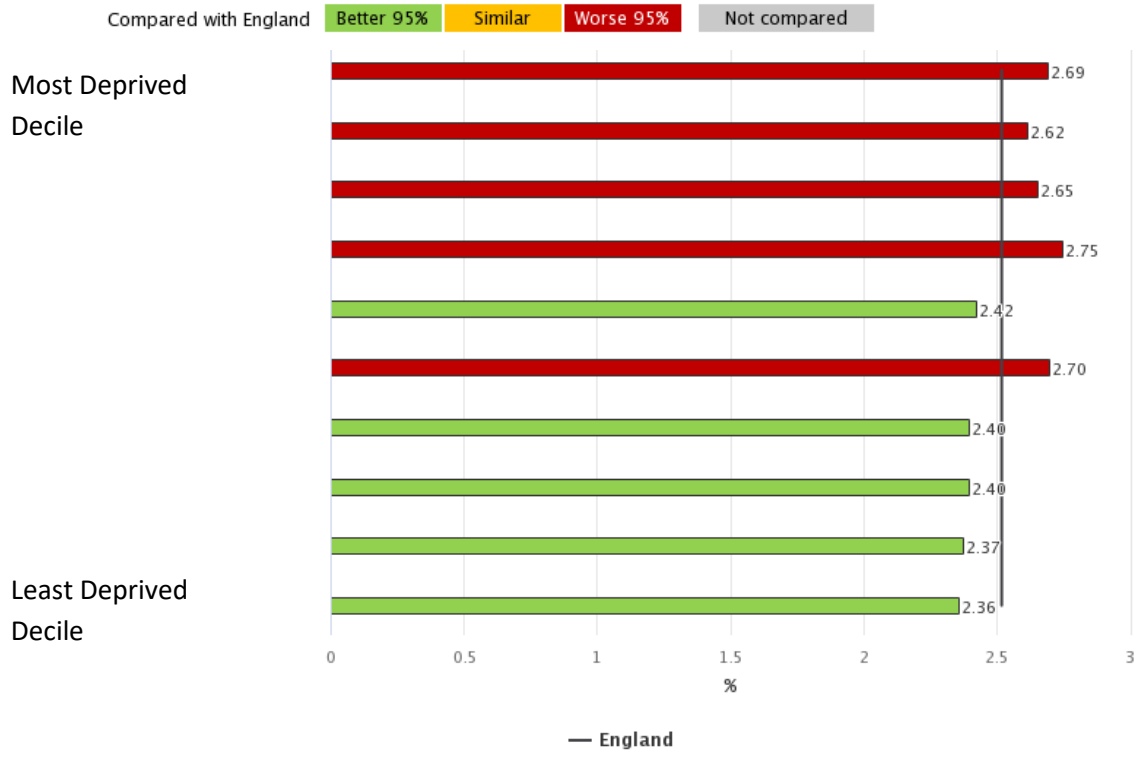
- Self-reported emotional wellbeing worsens with age, with girls reporting worse rates than boys. The difference between genders becomes more pronounced amongst secondary pupils.
- Trans and 'other' gender young people report worse emotional wellbeing than Male or Female young people. For example, 18.1% of secondary aged boys, 22.4% of girls, 46.4% of Trans young people and 58.2% young people who selected other gender, reported having hurt themselves on purpose.
- Lesbian/Gay/Bisexual young people report poorer emotional wellbeing than Heterosexual young people. For example, 15.3% of Gay/Lesbian young people report 'never' feeling happy compared to 2.29% of Heterosexual young people.
- Children and young people who are eligible for Free School Meals (i.e. an indicator for deprivation) report poorer emotional wellbeing than those who are not.

These findings were not analysed to see if they were statistically significant, however all the findings reflect trends shown in national figures.

Deprivation

Poverty and deprivation are key determinants of children's cognitive, social and behavioural development and children living in poverty are five times more likely to be unhappy than children from wealthier families[201]. Data for Yorkshire and Humber shows that the highest proportion of school pupils with social, emotional and mental health needs are in the most deprived deciles (Figure 92).

Figure 92 - % of school pupils in Yorkshire and the Humber with social, emotional and mental health needs according to deprivation decile



Source: Child and Maternal Health Profiles

Research suggests children experiencing food insecurity report feeling stressed, anxious and less able to cope with life[202]. The Leeds My Health My School survey indicates that secondary school aged young people experiencing food insecurity report higher levels of self-harm compared to their food secure peers (Figure 93).

[201] Effects Of Child Poverty | The Children's Society (childrenssociety.org.uk)
[202] Food Insecurity and Children's Mental Health: A Prospective Birth Cohort Study (Melchior et al, 2012)

Figure 93 - Self-harm in food insecure secondary school young people

Self harm	2018	2019	2020
Prevalence (%) FI FS	 54% 20%	 38.5% 21%	 69% 28%
Odds ratio	4.78	2.33	5.7

*FI – Food insecure FS – Food secure

Source: LCC My Health My School survey data

Ethnicity

The Social, Emotional and Mental Health Needs Assessment: Children and young people from Black, Asian and Ethnic Minority Communities in Leeds (2019) demonstrated that the mental health of those in minority ethnic communities is similar or better to White British (drawing on variety of evidence including national prevalence data and MHMS survey data)

However, children from BAME communities experience inequalities in terms of access to support services. The report considers these findings in terms of the life course, with adults from minority ethnic communities more likely to experience severe mental health problems and more likely to access support via crisis routes.

In Leeds minority groups are under-represented in mental health support services (including CAMHS, Cluster based support and voluntary sector led support) but overrepresented in other services such as Youth Justice, Social Emotional Mental Health data in schools, exclusion data and the Care System[203]. Robust national research shows that minority ethnic children and young people are less likely to be referred to CAMHS by a GP, and more likely to be referred from Education or Social Care, therefore mirroring the pattern with adults[204]. Local data showed White British young people slightly more likely to be referred to child and adolescent mental health services from a GP however the difference was not significant[205].

Analysis of My Health My School data demonstrated that White British, Mixed and Chinese groups report the poorest mental health[206]. The sample size of the Chinese group was small however some differences were statistically significant.

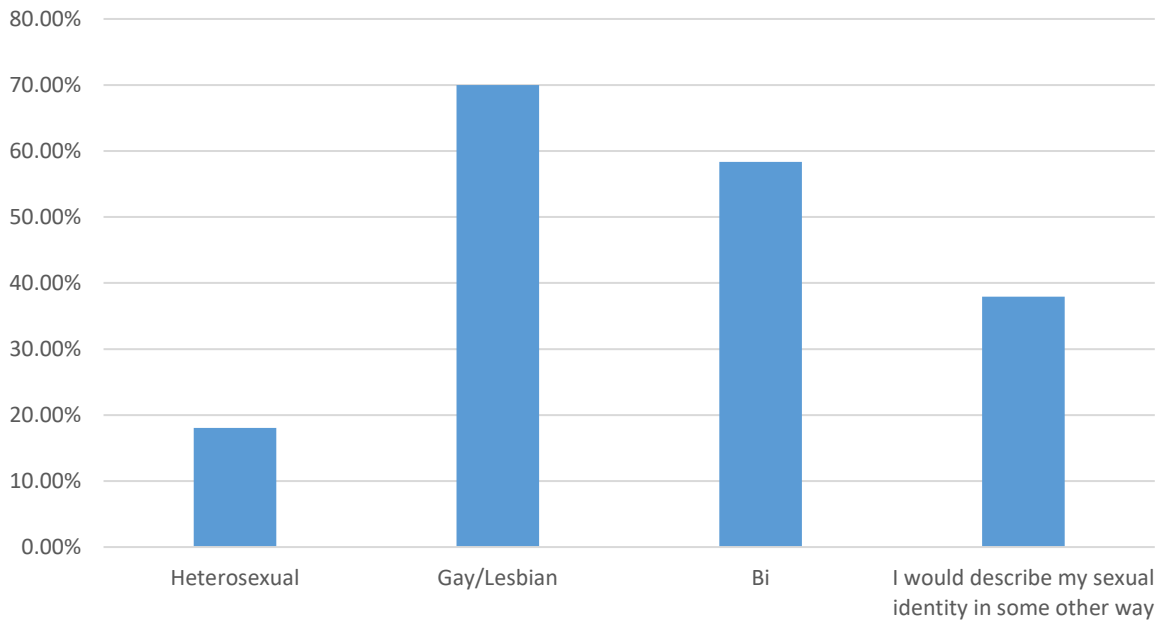
[203] Social, Emotional and Mental Health Needs Assessment: Children and young people from Black, Asian and Ethnic Minority Communities in Leeds (2019)
[204] Ethnic Differences in Referral Routes to Youth Mental Health Services - PubMed (nih.gov)
[205] Social, Emotional and Mental Health Needs Assessment: Children and young people from Black, Asian and Ethnic Minority Communities in Leeds (2019)
[206] Social, Emotional and Mental Health Needs Assessment: Children and young people from Black, Asian and Ethnic Minority Communities in Leeds (2019)

Sexuality

Due to stigma and discrimination, LGBTQ+ youth are more likely to experience mental health issues. For example, national independent report from the charity Just Like Us in 2021 found that LGBT+ young people are twice as likely to have depression, anxiety and panic attacks[207].

Figure 94 demonstrates in Leeds there are distinct differences in rates of self-harm reported via MHMS survey between those classifying themselves as LGBT+ and heterosexual pupils in Year 11. The regularity of self-harm was also much higher within these groups.

Figure 94 - Proportion of pupils in Year 11 responding yes when asked in the My Health My Schools Survey 'Have you ever hurt yourself on purpose? (Often referred to as self-harm)' according to sexual identity.



Source: MHMS Data 2020-21

Looked after children

Because of their experiences both before and during care, looked-after children are at much greater risk of poor mental health than their peers. The rate of mental health disorders in those who are looked after, is 45%, and 72% for those in residential care. This compares to one in ten children outside the care system.

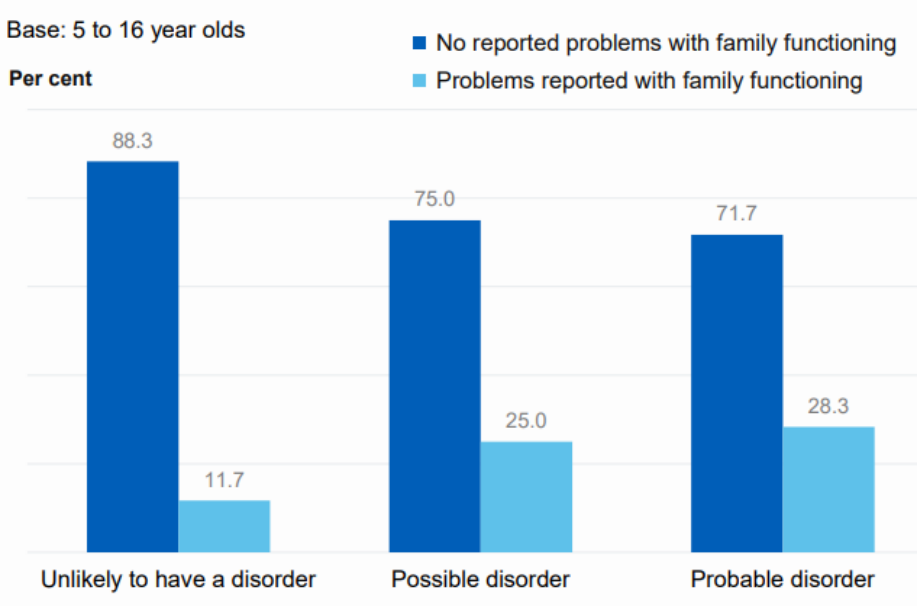
Family Dynamics

In 2020 data from NHS digital showed that children (aged 5 to 16 years in England) with a probable mental disorder were more likely to be living in a family who reported problems with family functioning (28.3%), compared to children who were unlikely to have a mental disorder (11.7%) (Figure 95).

[207] Just Like Us releases Growing up LGBT+ report on bullying, schools and mental health - Just Like Us

As a type of cross-sectional analysis, these associations cannot explain causality. While problems with family functioning may contribute to the onset of a probable mental disorder, the presence of a probable mental disorder could also lead to problems with family functioning.

Figure 95 - Family functioning by mental health of child 2020.



Source: Mental Health of Children and Young People Surveys - NHS Digital

Children living in families with the 'toxic trio' (which refers to domestic violence, parental substance misuse and parental mental health problems) are particularly at risk. Please see Priority Groups chapter for further information.

Identified gaps in knowledge and Recommendations

- Identifying need has been based on national prevalence modelling and could also be expanded on by bringing in local knowledge about rates/areas of deprivation and how this impacts on prevalence.
- Insight work done in the 2018 Leeds Social, Emotional and Mental Health Needs Assessment: Children and young people from Black, Asian and Ethnic Minority Communities in Leeds is extremely positive. This kind of meaningful listening and responding to the voices and experiences of children and young people should be continued.
- Further insight is required to ensure service development is in response to evidence, for example, a key focus on young women aged 17 to 19/22 is key with 1 in 4 likely to experience a mental health problem.

8.3. Alcohol, Smoking and Drugs

Headlines

- Self-reporting of drug and alcohol use by children shows usage has dropped over the past few years both nationally and in Leeds
- However national level data demonstrates that the proportion of pupils classified as current e-cigarette users has increased from 6% in 2018, to 9% in 2021. Usage increases with age from 1% of 11 year-olds, to 11% of 14 year-olds and 18% of 15 year-olds[208].
- According to the 2019/20 My Health My Schools Survey in Leeds 26% of pupils felt they needed better information or were unsure if they needed better information on learning material in school on smoking, 27% on alcohol and 27% on drugs.

Introduction

Whilst the majority of young people do not use alcohol or drugs and most of those that do are not dependent, drug and alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life[209].

Alcohol and drugs are among the leading risk factors for the overall burden of disease in the UK[210]. Those who drink alcohol regularly from an early age are more likely to develop later alcohol misuse or abuse and a range of other negative health and social outcomes when they reach adulthood[211]. In 2009, the Chief Medical Officer of England published the first official guidance on alcohol aimed specifically at children and young people and the 2012 Alcohol Strategy had a particular focus on excessive drinking by adults, but also included the ambition to achieve 'a sustained reduction in both the numbers of 11 to 15 year-olds drinking alcohol and the amounts consumed'. Tobacco use remains one of the most significant public health challenges in the UK and one of the national ambitions in the government's tobacco control plan published in 2017, is to reduce the number of 15 year-olds who regularly smoke to 3% or less by 2022. This ambition will be measured via the Smoking, Drinking and Drugs survey. Finally research clearly shows that the use of both legal and illegal drugs has both immediate and long term risks to young people's health, which vary with the type of drugs taken[212].

In Leeds there is commitment across partners to ensure that children and young people are protected from the harmful effects of substance misuse and aim to achieve this by an effective prevention and treatment approach that is bespoke to children's and young people's needs. The Leeds Drug and Alcohol Strategy outlines a key outcome to reduce the impact of harm from drugs and alcohol on children, young people and families.

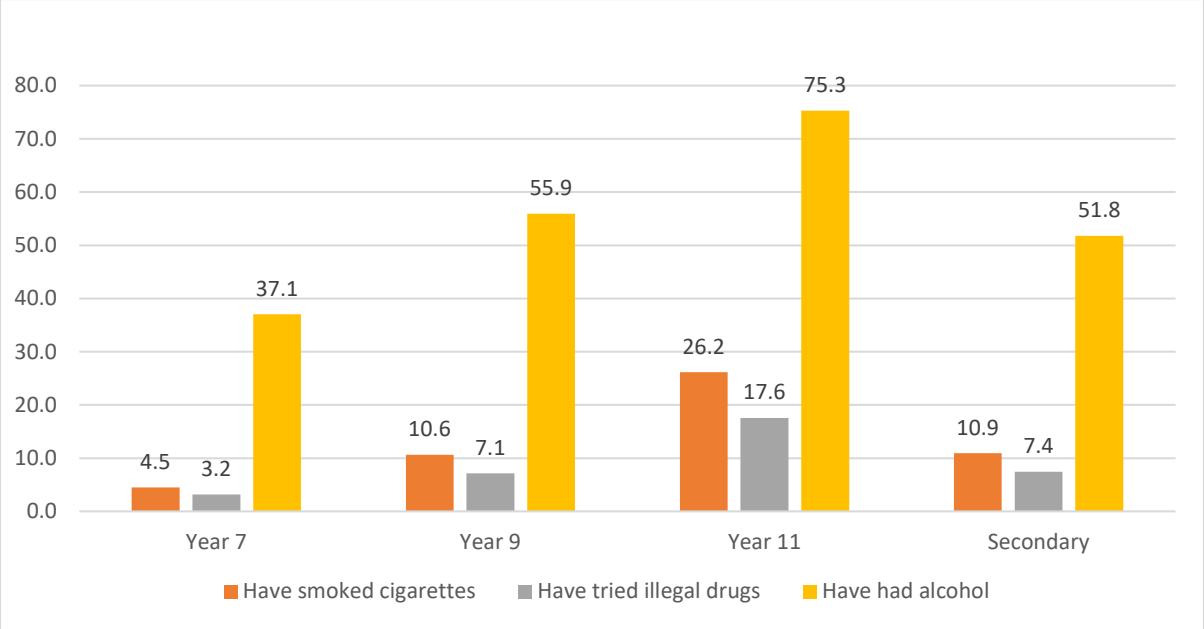
[208] Part 4: Electronic cigarette use (vaping) - NHS Digital
[209] (PDF) Impact of Alcohol Consumption on Young People: A systematic review of published reviews (researchgate.net)
[210] UK health performance: findings of the Global Burden of Disease Study 2010 - PubMed (nih.gov)
[211] Impact of alcohol consumption on young people - A systematic review of published reviews — Teesside University's Research Portal
[212] Teen Substance Use & Risks | CDC

Epidemiology

Nationally NHS Digital Complete a 2 yearly survey of Smoking, Drinking and Drug Use among Young People in England. This surveys children in years 7 to 11 and provides detailed analysis with comparison between different population groups.

Figure 96 demonstrates the proportions of respondents to the MHMS survey who had tried cigarettes, illegal drugs and alcohol. Clearly the numbers of pupils that have tried each increase with age.

Figure 96 - Percentage of pupils responding to the MHMS survey that have tried cigarettes/illegal drugs/alcohol (%).



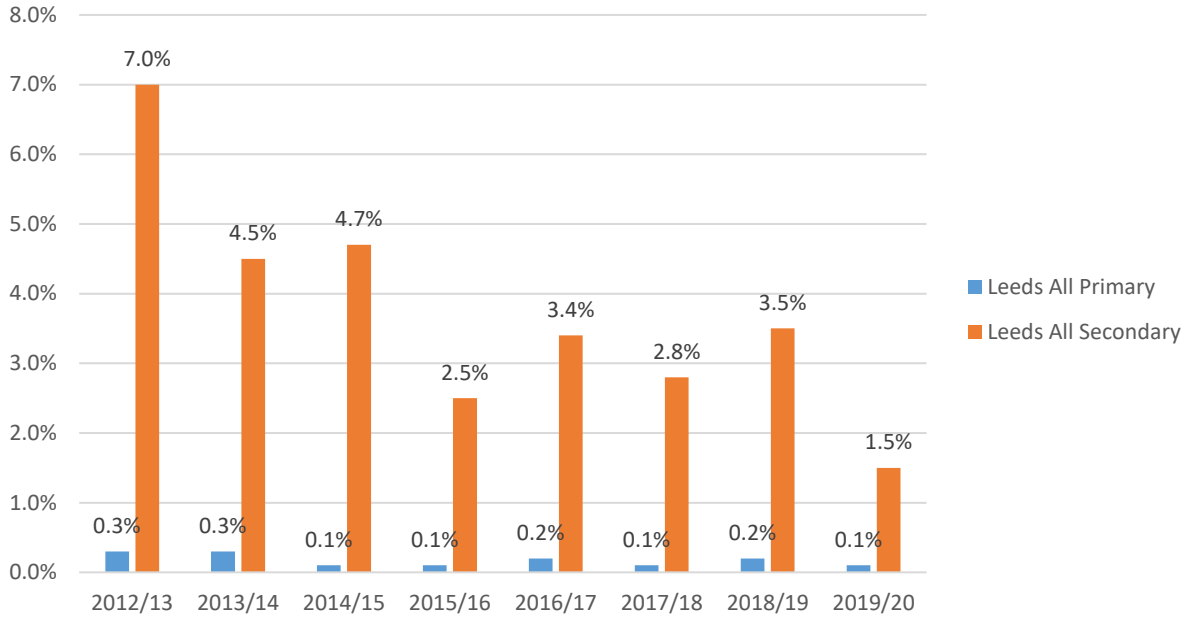
Source: MHMS survey data on young people and gambling 2019/20 report

Smoking

National trends show that rates of smoking among young people have been steadily falling since the 1990s. Data is collected for England via the NHS Digital - National survey 'Smoking, Drinking and Drug Use among Young People in England'. In 2021 this data showed that 12% of pupils had ever smoked (16% in 2018), 3% were current smokers (5% in 2018), and 1% were regular smokers (2% in 2018). This survey does not provide a breakdown at local authority level.

In Leeds, data is collected via the 'My Health My School survey' which mirror national trends in showing a reduction in rates of smoking in young people (Figure 97). Both data sources should be treated with slight caution for various reasons including gaps in national data, varying sample size and self-reporting issues however they do illustrate trends.

Figure 97 - Smoking Prevalence in Leeds – Primary and Secondary Schools.



Source: My Health My School Survey

This decline in prevalence amongst young people mirrors the decline in smoking prevalence in the population and is a result of the comprehensive approach that has been taken to tackle tobacco control particularly over the last 20 years. It will be interesting to see what impact the COVID-19 pandemic has on smoking among young people. As smoking initiation is associated with a wide range of risk factors including: parental smoking, the ease of obtaining cigarettes, smoking by friends and peer group members we might reasonably expect numbers to decline more steeply[213].

However e-cigarette use (vaping) is increasing sharply. Data related to e cigarette use was not found locally. However national data showed the proportion of pupils classified as current e-cigarette users has increased from 6% in 2018, to 9% in 2021. The same data set showed that the prevalence of current e-cigarette use rose as children got older, from 1% of 11 year-olds, to 11% of 14 year-olds and 18% of 15 year-olds[214].

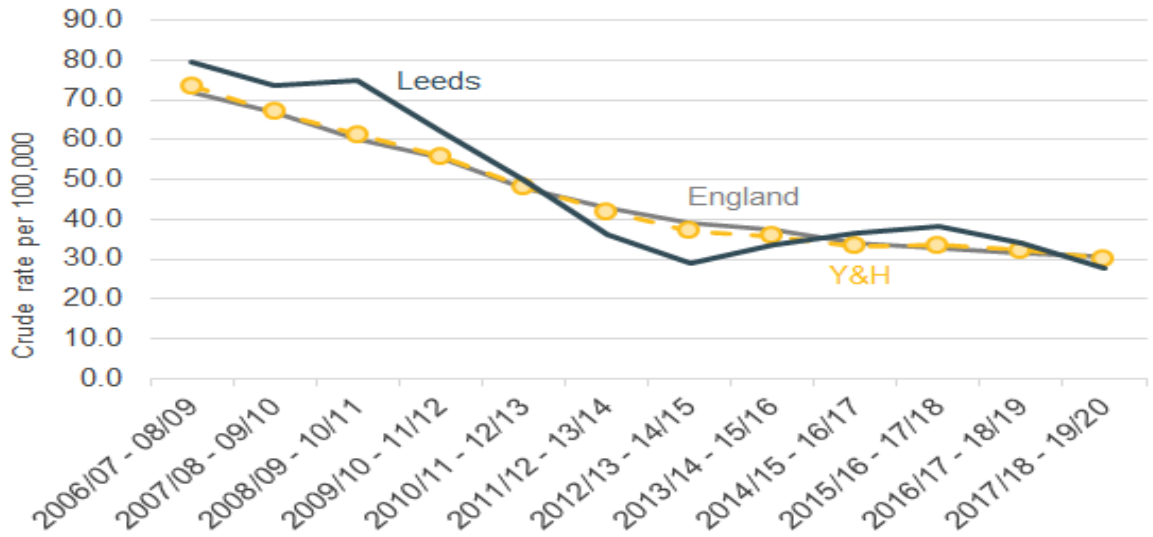
Although these devices are significantly less harmful than smoking and there is no evidence currently that they act as a route to smoking for children or non-smokers[215], this is concerning as the evidence related to e-cigarette use is uncertain.

Alcohol

Nationally, the rate of hospital admissions of children and young people for conditions wholly related to alcohol is decreasing and this is also the case in Leeds. The admission rate in the latest period is similar to the England average (Figure 98).

[213] Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis - PubMed (nih.gov)
[214] Part 4: Electronic cigarette use (vaping) - NHS Digital
[215] E-cigarettes: an evidence update - GOV.UK (www.gov.uk)

Figure 98 - Admission episodes for alcohol-specific conditions under 18s



Source: Public Health England Child and Maternal Health Profiles

According to the analysis of MHMS survey data on young people and gambling 2019/20 report, 62% of all pupils are abstinent from drinking alcohol. This rate has been stable for the last 5 years. 73% of primary school pupils have never had a drink of alcohol. In addition 0.4% of pupils in year 11 reported drinking every day, a 4% decrease on last year.

National data from 2021 shows that 6% of all pupils said they usually drank alcohol at least once per week, the same as in 2018[216]. The proportion increases with age, from 1% of 11 year-olds to 14% of 15 year-olds.

Drugs

Nationally, 18% of pupils reported they had ever taken drugs (this compares to 24% in 2018) with 6% having taken drugs in the last month (compared to 9% in 2018)[217].

Drug use data in Leeds is drawn from the My Health My School data set.

Illegal drug use has dropped significantly since 2007-8 in secondary pupils overall, reducing consistently from a peak of 17%. An increase in 2016-17 has remained consistent the last three years at 7%. Year 11 pupils' reporting 'ever using an illegal drug, glue, gas or solvent as a drug', has fluctuated over the years, peaking at 28% in 2007-8 and a low of 15% in 2015-16. Over the last 3 years we have seen this gradually increase to 22%. In 2020/21 there was a 4% decrease to 18%. The most commonly used illegal drug nationally[218] and in Leeds is cannabis with Leeds having higher than

[216] Smoking, Drinking and Drug Use among Young People in England, 2021 - NHS Digital
[217] Smoking, Drinking and Drug Use among Young People in England, 2021 - NHS Digital
[218] Drug misuse in England and Wales - Office for National Statistics (ons.gov.uk)

average number of young people in treatment for cannabis use[219]. Class A drug use such as heroin, crack cocaine etc has declined in young people over the last few decades and is minimal[220].

Information

According to the analysis of MHMS survey data on young people and gambling 2019/20 report, 26% of pupils felt they needed better information or were unsure if they needed better information on learning material in school on smoking, 27% on alcohol and 27% on drugs. In terms on knowing where to access support 30% did not know where to access support for drugs, 30% didn't know about access to support on alcohol and 30% didn't know where to access support on smoking.

Factors affecting alcohol, drugs and smoking

The Smoking, Drinking and Drug Use among Young People in England Survey 2021 highlighted that:

"Pupils who have recently smoked, drank alcohol and taken drugs* are more likely to report low levels of life satisfaction (57%) compared to pupils who have only done one of these (35%), and those who have done none of these (18%). * 'recently' refers to smoking in the last week, drinking alcohol in the last week, and taking drugs in the last month"

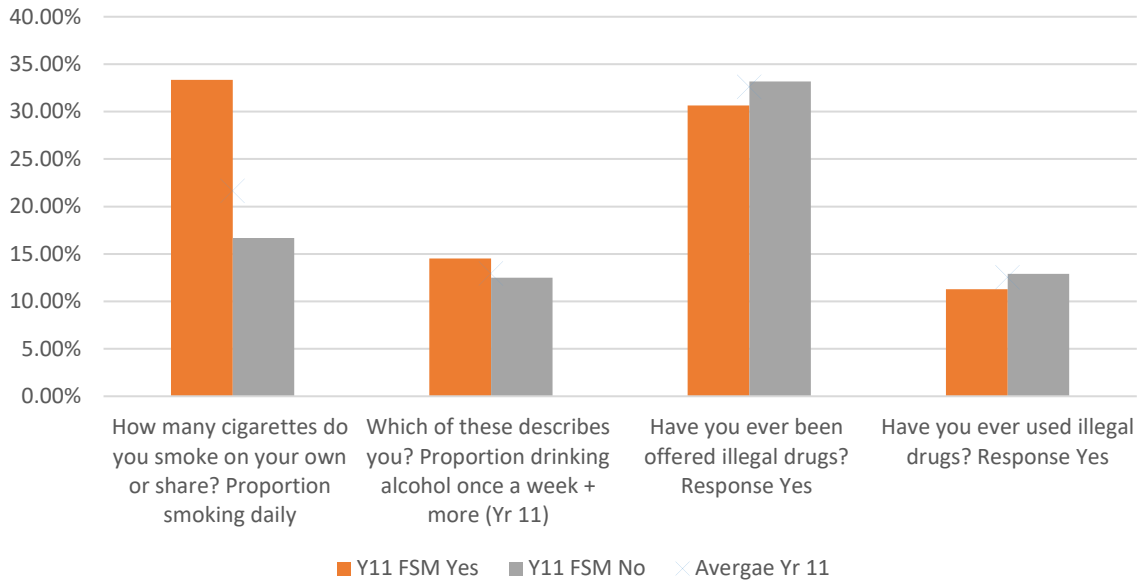
Although it is not clear the directionality of this relationship this pattern is clear.

According to the MHMS survey for year 11 pupils in 2020/21, a higher proportion of pupils eligible for free school meals smoke daily and drink alcohol once a week or more than pupils who are not eligible for free school meals. This trend is reversed when considering drugs, where those who are not eligible for free school meals are more likely to have ever used or been offered illegal drugs. This is shown below in Figure 99.

[219] Forward Leeds Data

[220] Drug misuse in England and Wales - Office for National Statistics (ons.gov.uk) and Forward Leeds Data

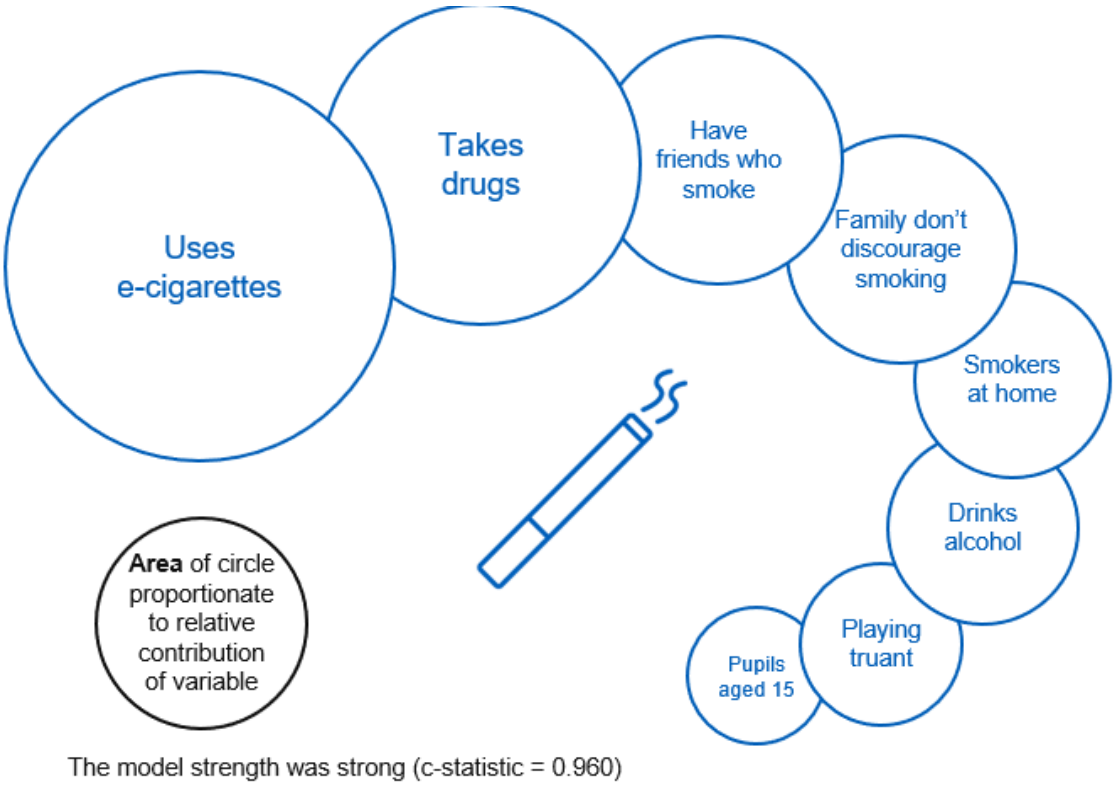
Figure 99 - Responses to questions in My Health My School survey related to alcohol, drugs and smoking according to free school meal status.



Source: My Health My School Survey Data

At a national level white pupils have a higher prevalence of smoking. The national survey in 2018 also identified 8 factors that had a significant association with smoking (Figure 100).

Figure 100 - Factors associated with smoking



Source: Smoking, Drinking and Drug Use in Children and Young People in England, 2018

Young people's attitudes towards smoking, drinking and drugs

Nationally the smoking drinking and drugs survey measures young people's acceptability of certain behaviours. In 2018 it found that pupils were much more likely to think that drinking alcohol was OK (52% to try, 27% to do every week), than smoking (24% and 9% respectively). Acceptance of e-cigarette use was higher than that of smoking, with 36% saying it was OK to try an e-cigarette, and 24% saying it was OK to use them once a week. Drug use was the least likely activity to be seen as acceptable; 13% thought it was OK for someone of their age to try cannabis and 7% thought it OK to take once a week.

Interestingly after a longer-term decline, acceptance of both drinking and drug use have increased in recent years. This does not apply to smoking.

Identified gaps in understanding

- This chapter has not reported the outputs from services supporting young people with drugs, alcohol and smoking. These datasets are worthy of analysis to identify any inequalities.
- The My Health My School Data Set is extremely positive and tracks trends in young people's smoking, drug and alcohol use. This dataset must continue to be built upon to reflect current need, for example this chapter did not identify data related to e-cigarette use for Leeds.
- Further insight work into the impact of social marketing campaigns in Leeds, which are positively prevention focused.
- This chapter has not considered the impact of parental alcohol, smoking and drug use. This is partially covered in the priority groups chapter. Although there are further datasets including Parents with problem alcohol and drug use: Data for England and Leeds, 2019 to 2020 (ndtms.net) that warrant analysis.

8.4. Oral Health

Headlines

- Tooth decay is the most common reason for hospital admissions in the 6-10 year-old age group.
- Dental health is worse in Leeds than England with more than a quarter (26%) of Leeds 5-year-olds having experienced dental decay compared to 24% in England in 2018/2019. The severity of dental decay in children in Leeds is below that of Yorkshire and Humber (29%) but higher than the England average.
- In 2018/19 63% of secondary school pupils eligible for a Free School Meal (FSM) were brushing their teeth twice daily or more, compared with 75% who are not eligible for FSM's. Rates of teeth brushing are higher in secondary than primary school children in Leeds.
- COVID-19 has had a significant impact on dental access for children and young people, however this is now starting to improve.

Introduction

Poor oral health in children can lead to infection, pain, sleep problems, absence from school and dental extraction[221]. Oral health problems in children are preventable through establishing good eating habits by limiting sugary snacks and drinks, regular attendance at the dentist from an early age and regular toothbrushing with a fluoride toothpaste[222]. Although dental caries (tooth decay) are preventable, they are still the most common oral disease in children. Tooth decay is also the most common cause for admission to hospital in the 2–5-year-old age group, as extractions in children require a general anaesthetic, which not only poses a risk to the child but also places a financial burden on the NHS[223].

There has been some success over the last decade with the prevalence of visually obvious tooth decay among 5-year-olds, in England falling from 30.9% in 2008 to 23.3% in 2017 (7.6 percentage point reduction). However, there are wide inequalities in oral health, with children in the most deprived areas having more than twice the level of decay when compared to those from the least deprived and Asian children in 2018/19 most likely than other ethnic group to experience visible tooth decay[224]. A report by Public Health England in 2021 describes the current picture of oral health inequalities and oral health service inequalities in England by socioeconomic position, geographic area, protected characteristics and vulnerable (disadvantaged) groups[225]. It further describes that this is an issue that is worsening with relative inequalities in the prevalence of dental decay in 5-year-old children in England increasing from 2008 to 2019.

The Office for Health Improvement and Disparities (OHID) established the Children's Oral Health Improvement Programme Board in 2016 and released an action plan in 2016 which set out a vision that every child grows up free from tooth decay as part of having the best start in life. This board last reported in 2020. A key indicator on the Public Health Outcomes Framework measures the number of children with experience of visually obvious dental decay (5 years). This is monitored through the

[221] Oral health – RCPCH – State of Child Health
[222] Children's Oral Health | Basics | Children's Oral Health | Division of Oral Health | CDC
[223] Treatment of dental caries under general anaesthetic in children | BDJ Team (nature.com)
[224] Tooth decay in 5 year olds - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)
[225] Inequalities in oral health in England - GOV.UK (www.gov.uk)

National Dental Epidemiology Programme (NDEP), which runs bi-annually and involves standard examinations of a random sample of 5-year-old children from individual authorities.

In 2021 the Health and Care Bill brought renewed focus to fluoridisation of water and there is now a statutory duty for schools to include oral health teaching as part of their wider Health Education/PSHE programme. COVID-19 has had a profound and direct impact on children's oral health. Whilst dental practices have prioritised the dental needs of children, they have had long periods with limited access to routine dental care and preventative advice due to COVID-19.

Leeds has a focus on improving the oral health of children through the Children and Young Peoples Oral Health strategy.

The strategy has four key objectives, which are:

- Children and young people (CYP), parents and carers are supported to care for oral health
- Children and young people's intake of sugar is reduced
- All children's teeth are exposed to adequate amounts of fluoride
- Children and young people access preventative services from their dentist

The strategy outlines a co-ordinated response, which includes:

- promotion of training and resources including the Leeds Smiles website.
- policy intervention through the Leeds Food Strategy and partnership work with the Leeds Healthy Schools (Health and Wellbeing Service).
- preventative services including those provided by the Leeds 0-19 service. These include the supervised tooth brushing scheme, which supports children in schools and early years settings to brush their teeth correctly and the Brushing for Life scheme which provides toothbrushing packs alongside key oral health messages.
- partnership work between Leeds City Council and Leeds University, which is currently focusing on the Choose the Cup research, which is exploring the acceptability and feasibility of the Baby Cup. The SOAP research which focuses on exploring the feasibility of online oral health training for Early Years staff.

Epidemiology

National Dental Epidemiology Programme for England: oral health survey of 5-year-olds 2019

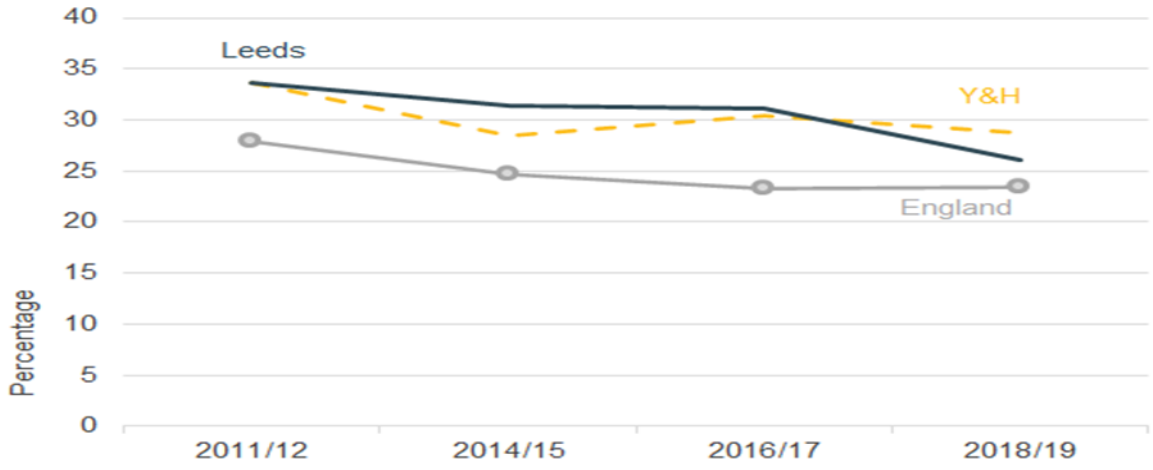
Since 1985, standardised and coordinated surveys of child dental health have been conducted across the United Kingdom (UK). These have produced robust, comparable information for use at regional and local government level and for varying health geographies. As part of Public Health England's co-ordinated National Dental Epidemiology Programme (NDEP), standard examinations of a random sample of 5-year-old children were undertaken in the academic year 2018 to 2019.

Due to COVID-19 many authorities, including Leeds were unable to conduct the 5-year-olds epidemiology survey for the 20/21 academic year. The latest Leeds data for this age group is therefore from the 2018/2019 survey, which is detailed below.

Prevalence of decay experience

Data from the 2018/2019 survey show dental health is worse in Leeds than England, with more than a quarter (26%) of Leeds 5-year-olds having experienced dental decay compared to 24% in England. This has however improved in line with national trends where the prevalence of tooth decay has fallen from 30.9% in 2008 to 24% in 2019. Figure 101 shows that Leeds figures have also seen a significant decline reducing from 40.7% in 2008 to 26% in 2019.

Figure 101 - Percentage of 5-year-olds with experience of visually obvious dental decay



Source: Public Health England Child and Maternal Health Profiles

Severity of Dental Decay

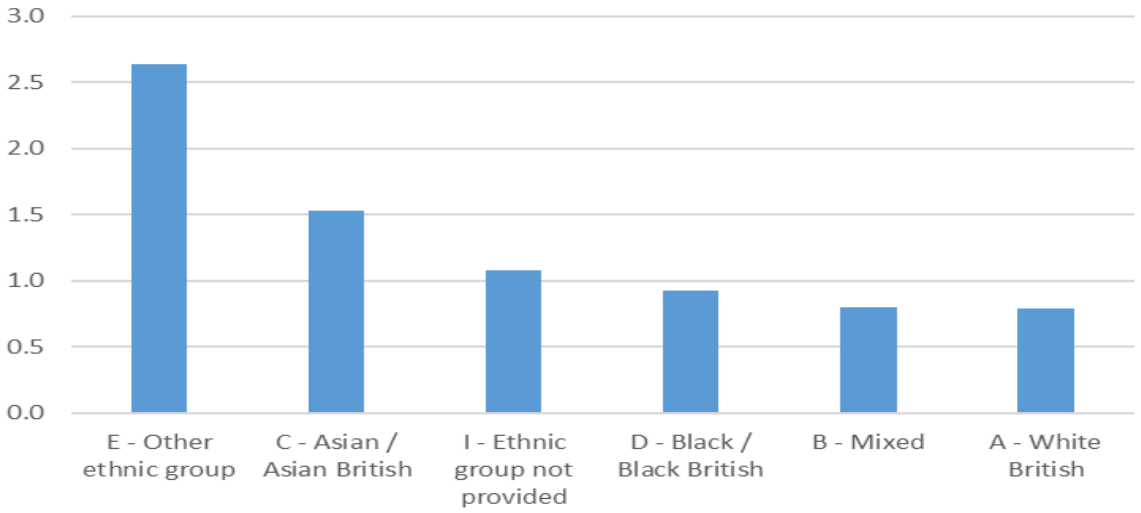
The number of teeth affected by decay is a measure of severity. The average number of teeth affected by decay (decayed, missing or filled teeth or dmft) per child in Leeds was 1.0, compared to an England average of 0.8. and a Yorkshire and Humber average of 1.1.

It is also important to look at the severity of disease in only those children who have experienced dental decay. Among these children, the mean number of teeth with experience of dental decay in England was 3.4 (a child at this age normally has 20 primary teeth) compared with 3.8 for both Yorkshire and Humber and Leeds. Evidence shows that these are the children who are more likely to develop more dental decay later in their childhood.

Inequalities in Children's Oral Health

The 2018/19 data for Leeds indicated inequalities with regards to levels of decayed, missing and filled teeth (dmft) seen in terms of both ethnicity (Figure 102) and the ward of Leeds in which children live (Figure 103).

Figure 102 - Leeds data: Average number of decayed, missing and filled teeth (dmft) per child at age 5, according to ethnicity



Source: PHI, Leeds City Council, 2021

Of those Leeds children surveyed who experienced dental decay, the highest average of decayed, missing and filled teeth (dmft) was seen in those children who were identified as being in the "Other ethnic group" (2.6 teeth). In comparison this was nearly **three times** the levels of decay found in those identifying as "Black/Black British" (0.9 teeth) ,"White British" and "Mixed" groups (both 0.8 teeth). The "Asian/Asian British" group had **almost twice** the level of decay as the "White British" and "Mixed" groups with an average of 1.5 teeth affected. Nationally the prevalence of experience of dental decay is highest in these two groups (Other and Asian/Asian British).

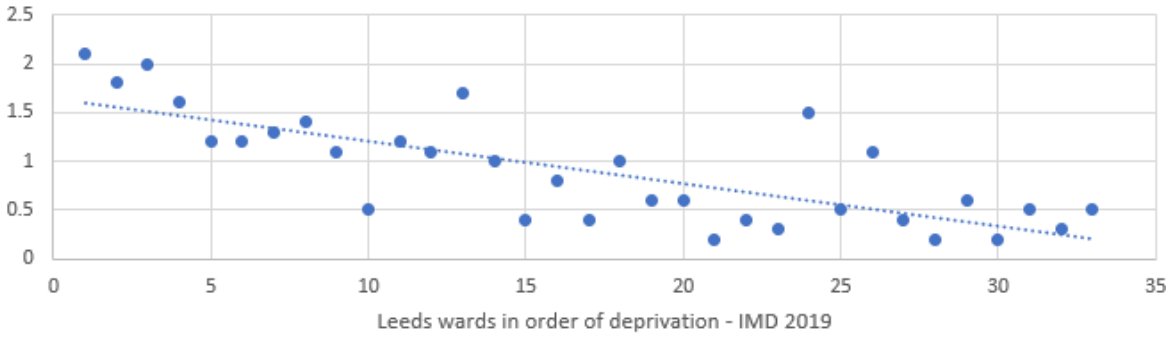
Figure 103 demonstrates the average number of decayed, missing and filled teeth (dmft) of those 5 year-old children surveyed, who had experienced dental decay, by Leeds ward. Ward results demonstrating high averages of decay are consistent with those from the previous 2016 survey. Figure 104 demonstrates that generally speaking wards with higher levels of deprivation experienced the highest average number of dfmt.

Figure 103 - Leeds data: Average number of decayed, missing and filled teeth (dfmt) at age 5, according to ward.

Ward	Average of Decayed, missing and filled (dmft)
Burmantofts & Richmond Hill	2.1
Killingbeck & Seacroft	2.0
Gipton & Harehills	1.8
Little London & Woodhouse	1.7
Hunslet & Riverside	1.6
Roundhay	1.5
Bramley & Stanningley	1.4
Beeston & Holbeck	1.3
Armley	1.2
Middleton Park	1.2
Kirkstall	1.2
Temple Newsam	1.1
Chapel Allerton	1.1
Alwoodley	1.1
Cross Gates & Whinmoor	1.0
Rothwell	1.0
Pudsey	0.8
Guiseley & Rawdon	0.6
Weetwood	0.6
Morley North	0.6
Farnley & Wortley	0.5
Harewood	0.5
Calverley & Farsley	0.5
Wetherby	0.5
Morley South	0.4
Otley & Yeadon	0.4
Moortown	0.4
Headingley & Hyde Park	0.4
Adel & Wharfedale	0.3
Kippax & Methley	0.3
Ardsley & Robin Hood	0.2
Garforth & Swillington	0.2
Horsforth	0.2
Grand Total	0.9

Source: PHI, Leeds City Council, 2021

Figure 104 - Average Decayed, Missing and Filled Teeth at Age 5 by Ward, ordered by deprivation



Source: PHI, Leeds City Council, 2021

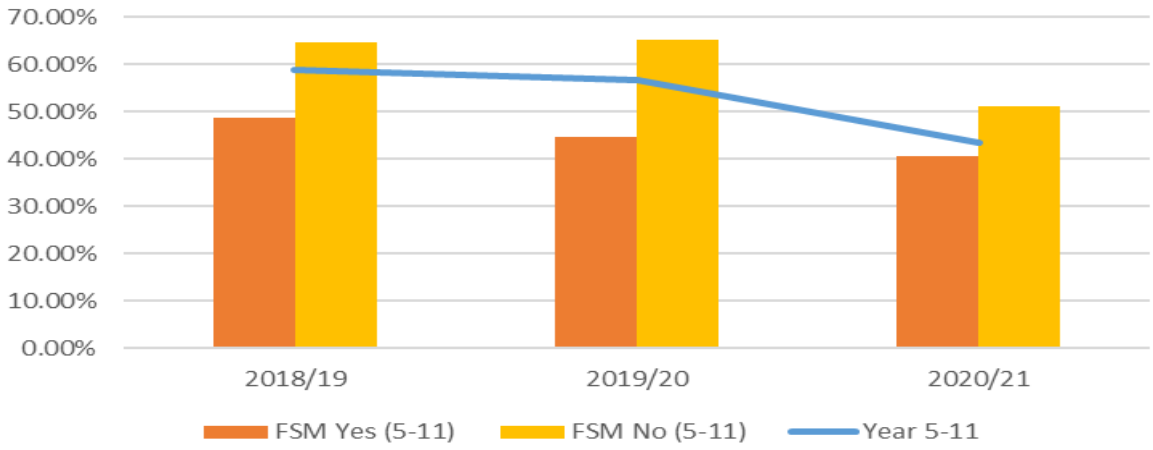
Incisor Decay

Incisor decay is decay affecting the front teeth, usually associated with long term bottle use with sugar-sweetened drinks. In Leeds, 6.7% of children examined had visible signs of dentinal decay affecting the incisors, compared with an average of 5.2 % in England.

Access to dental care for children

Data from the My Health My School survey indicates that in 2018/19 59% of respondents visited a dentist twice a year or more, which compares to 43.42% in 2020/21. Inequalities related to free school meal (FSM) eligibility are also seen, with 41% of those eligible for a free school meal visiting a dentist twice or more in 2020/21 compared to 51% of those who are not eligible for a free school meal (Figure 105).

Figure 105 - Proportion of pupils (primary and secondary) visiting the dentist twice a year or more, by eligibility of FSM.



Source: My Health My School Survey Data, 2021

In common with healthcare in general, the dental sector has faced challenges since the start of the pandemic (March 2020) due to the reliance of care delivery on of aerosol generating procedures (AGPs). Initially dental practices were asked to close and urgent dental centres (UDCs) were established for patients in pain. Practices reopened for the provision of face-to-face care in June 2020 and have steadily increased the activity provided as infection prevention guidance has evolved.

Due to the reduced capacity, the Chief Dental Officer asked primary dental care to prioritise patients according to their clinical need[226]. The starting point was a requirement to deliver at least 20% of normal activity volumes and this has gradually increased to a current minimum of 85% of pre-COVID activity until March 2022. This is reflected in the proportion of children accessing dental services (Figure 106). Whilst restoration of NHS dental activity continues, it will be some time before dental services return to providing care at previous activity levels, with many dental practices still catching up on a backlog of treatment.

Figure 106 - Proportion of children accessing NHS dental services 2019 to 2021.

LA name	% 0-17 accessing dental services quarter ending			
	Dec 2019	Dec 2020	Jul 2021	Dec 2021
Leeds	49	11	35	47
West Yorkshire ICS*	**51**	**10**	**na**	**na**

Source: NHS BSA *includes Craven

Hospital admissions for dental extractions

Tooth decay is still the most common reason for hospital admissions in the 6-10 year-old age group. For the financial year 2019 to 2020 the estimated costs of hospital admissions in 0 to 19 year-olds for all tooth extractions was £54.6 million and for extractions due to tooth decay was £33.0 million[227].

Children have extractions carried out in hospital mainly because they need general anaesthetic for the procedure.

During 2019/20 there was a 5.9% reduction in the number of episodes of decay-related tooth extractions in hospital for 0 to 19 year-olds compared to the previous year[228]. The reduction is mainly due to the significant drop in the number of admissions for tooth extractions in March 2020 and is consistent with the reduction for all admissions to hospital during this month because of the COVID-19 outbreak.

Yorkshire and the Humber (YH) has the highest proportion of children aged 0-19 admitted for extractions (0.7%) (Figure 107). Across YH, and the local authorities within, the proportion of children receiving such care has remained relatively stable over time.

Access to these services like other dental services was initially prevented by the COVID-19 pandemic. Although services are starting to recover, many have yet to achieve pre-pandemic levels of activity and have a back log of care to manage.

[226] NHS England » Dental recall priorities for children
[227] Hospital tooth extractions of 0 to 19 year olds - GOV.UK (www.gov.uk)
[228] Hospital tooth extractions of 0 to 19 year olds 2021 - GOV.UK (www.gov.uk)

Figure 107 - Summary of Finished Consultant Episodes (FCE) for all extractions and extractions with caries as the primary diagnosis for 0-19 years 2019/20.

	FCE's for extractions as a % of the total population (all diagnoses)	FCE's for extractions as % of population with caries as the primary diagnosis			Number of FCE's for extractions with caries as the primary diagnosis
Local Authority of residence	**(0-19 years)**	**(0-5 years)**	**(6-10 years)**	**(0-19 years)**	**(0-19 years)**
Leeds	0.5%	0.4%	0.8%	0.4%	295
Yorkshire and the Humber	**0.7%**	**0.6%**	**1.3%**	**0.6%**	**7,755**
ENGLAND	**0.4%**	**0.3%**	**0.5%**	**0.3%**	**19,947**

Source: Hospital tooth extractions of 0 to 19 year-olds 2021 - GOV.UK (www.gov.uk)

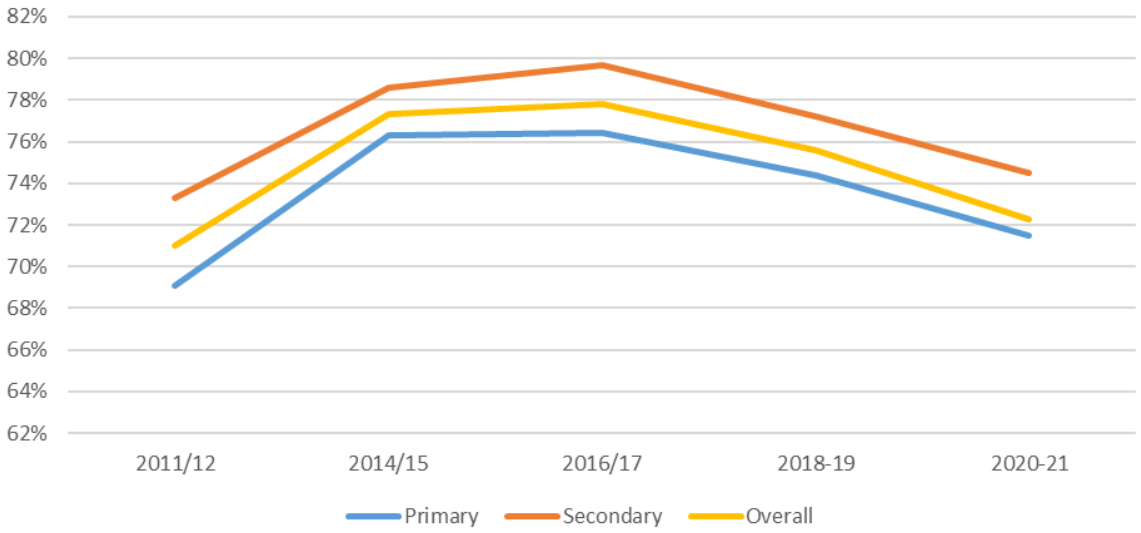
Health Behaviours

Toothbrushing

Figure 108 demonstrates results from the My Health My School survey relating to the trends in tooth brushing practice amongst primary and secondary school children in Leeds. It is evident that primary school children are less likely to brush their teeth twice a day or more compared to secondary school children. However, it can also be seen that since 2016/7 the proportions of pupils brushing their teeth twice daily has been decreasing across both primary and secondary. It is important to consider these data when planning interventions for these cohorts of children and young people.

When analysing the 2018/19 data according to eligibility for free school meals (FSM), 63% of those eligible were brushing their teeth twice daily, compared to 75% of young people who were not eligible. As FSM is an indicator of deprivation there is a clear association between deprivation and teeth brushing.

Figure 108 - Proportion of pupils (primary and secondary) brushing their teeth twice daily or more.



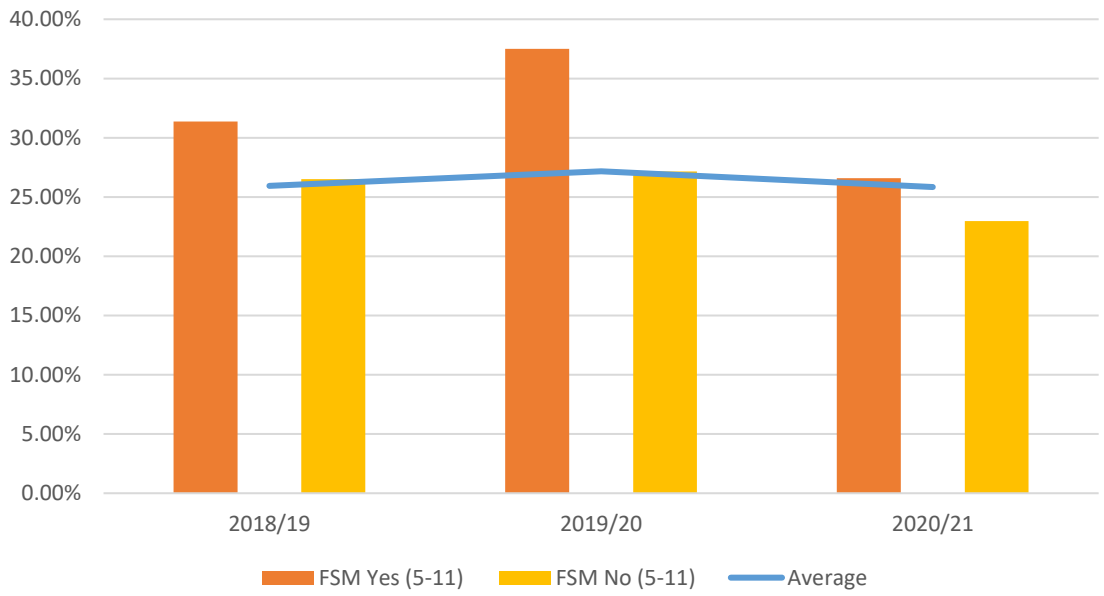
Source: My Health My School Survey Data

Nutrition and sugar consumption

See Children's Healthy Weight Chapter for detailed review.

Consumption of foods high in sugar can lead to tooth decay. Children may consume sugar through both food and drinks. Figure 109 shows the inequality in self-reported "unhealthy snack" consumption between children eligible for free school meals and those who are not eligible for free school meals.

Figure 109 - Proportion of children having 3+ snacks a day (crisps, chocolate bar, packet of sweets, biscuits) according to eligibility for Free School Meals (FSM) for pupils in Year 7,9 and 11.



Source: My Health My School Survey Data

Identified Current Gaps in Understanding

- The impact of the pandemic is still being felt in children's oral health and so this requires monitoring.
- There are schemes in Leeds including the Leeds Tooth brushing scheme in targeted primaries and the Brushing for Life scheme. Detailed evaluation of these schemes was not found for this Health Needs Assessment, however it would be useful in understanding the impact of the services and directing future support.
- The links between oral health and nutrition, particularly sugar consumption, have been briefly reviewed in this chapter. Better understanding of these factors at a local level will strengthen strategy and policy development.

8.5. Sexual and Reproductive Health

Headlines

- The teenage pregnancy rate is declining at a national, regional and local level. However the Leeds rate in 2020 (20 girls aged under 18 conceived, for every 1,000 girls) is higher than the national (13.0 per 1000) and regional rate (16.5 per 1000).
- According to My Health My School Survey data over the last 10 years progressively fewer year 11 pupils have ever had sexual intercourse. However of those who have had sex, there is an increasing proportion not using any form of contraception.
- When comparing experiences of pupils with differing sexualities in year 11 pupils in 2020-21 in Leeds, those identifying as gay/lesbian are most likely to self report via the My Health My School Survey that they have hurt themselves on purpose (70%) and are also most likely to feel unsafe or very unsafe at home (10%).

Introduction

Good sexual health is essential to adolescent wellbeing. Adolescence is a period of change in which young people experience changes in their body, develop intimate relationships and as such are exposed to sexual risks[229]. Children's lives and sexual and reproductive health are increasingly complex, with both online and offline pressures impacting behaviours. Encouragingly at a national level the rates of teenage pregnancy have continued to decline over the past decade and rates of sexually transmitted infections have also improved[230]. Increasingly young people identify as part of the LGBT+ community with 4.2% of 16-24 year-olds identify as gay, lesbian or bisexual compared to 2% of the UK population[231].

Epidemiology

Key indicators related to sexual and reproductive health in Leeds are available from OHID. These indicators are not specific to children and young people.

A Leeds Sexual Health Needs Assessment was published in 2018/19, while not focused on children and young people this contains useful and detailed analysis particularly related to the 16-24 year-old age group.

Sexual Identity

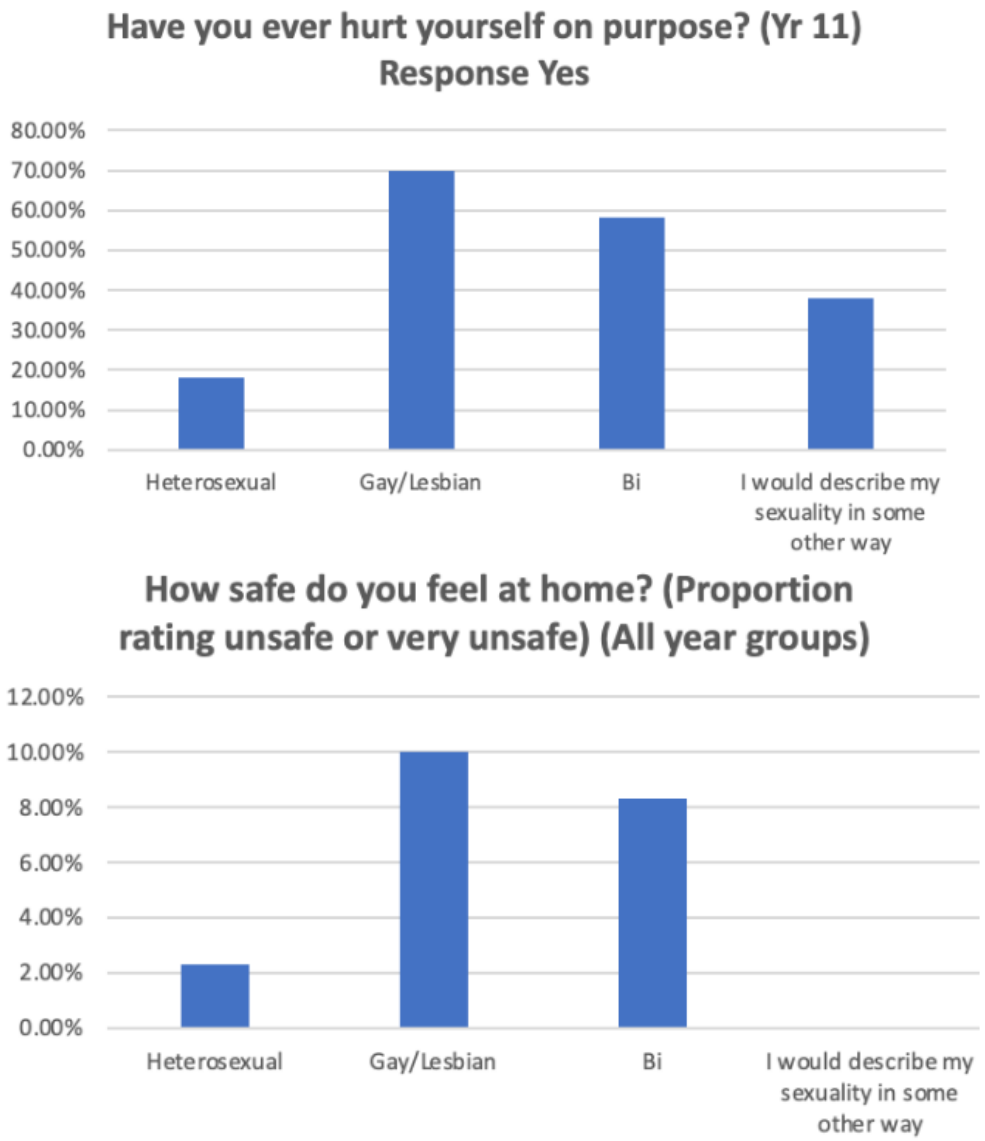
LGBT+ pupils are twice as likely to be bullied as their non-LGBT+ peers, half as likely to be 'very close' to their family, three times more likely to experience sexual harassment and twice as likely to have depression, anxiety and panic attacks. This demonstrates the distinct needs of LGBT+ young people.

In Leeds the My Health My Schools Survey asks pupils to self-report their sexuality. According to this data 81% of year 9 and year 11 pupils are heterosexual, with 19% of pupils being either gay/lesbian, bisexual or 'would describe their sexual identity in some other way'. Similar to the data related to gender, this data must be interpreted cautiously.

[229] Sexual development and behaviour in children | NSPCC Learning
[230] Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)
[231] Sexual orientation, UK - Office for National Statistics (ons.gov.uk)

What is clear however is that those identifying as LGBT+ are experiencing more challenges in Leeds than their non-LGBT+ counterparts. When comparing experiences of pupils with differing sexualities in year 11 pupils, those identifying as gay/lesbian are most likely to have hurt themselves on purpose (70%) and are also most likely to feel unsafe or very unsafe at home (10%) (Figure 110).

Figure 110 - My Health My School Survey responses according to sexuality



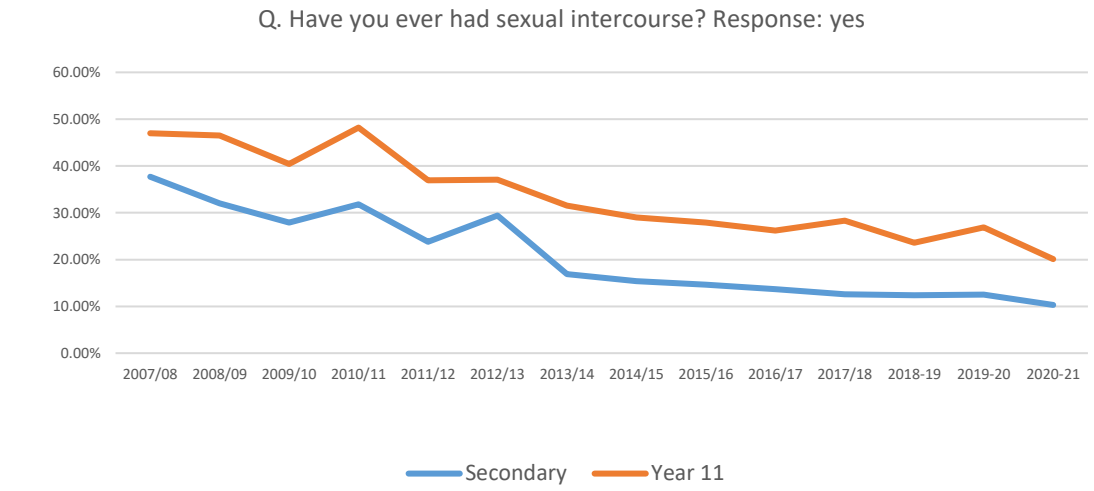
Source: My Health My Schools Data 2020-21

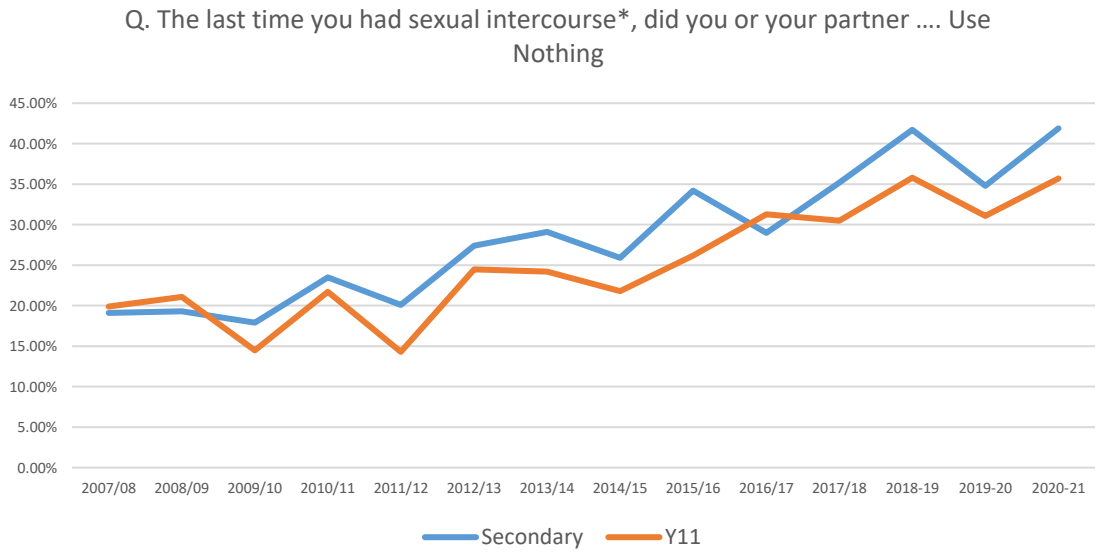
Sexual Behaviours

Adolescence is a period where children may begin experiencing their first intimate relationships.

In Leeds the My Health My Schools survey asks year 9 and year 11 pupils about their sexual behaviour. The trend data (Figure 111) shows a decline in the number of pupils that had ever had sexual intercourse. However of those who have had sex, there is an increasing proportion not using any form of contraception (Figure 111).

Figure 111 - Proportion of secondary (year 9 and 11 combined) and year 11 pupils who have ever had sexual intercourse. Proportion of secondary (year 9 and 11 combined) and year 11 pupils that have had sexual intercourse who did not use any form of contraception





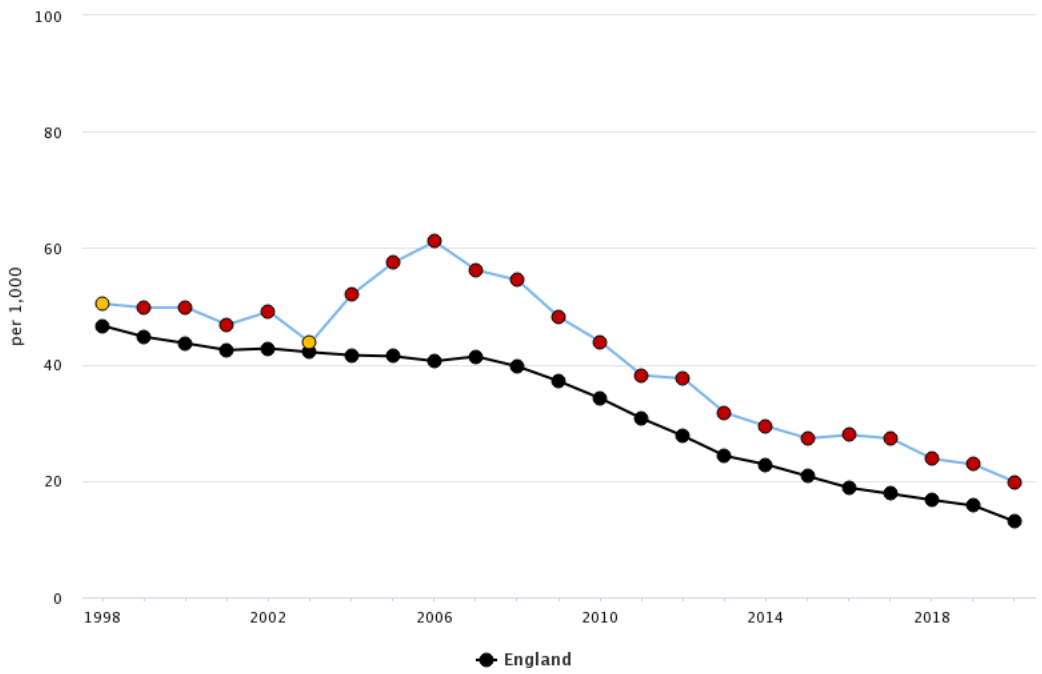
Source: My Health My School Survey

Data from the 2021/22 My Health My School survey show that 6% of secondary school pupils stated they felt they had been pressured into sex. This percentage was the same for year 11 and year 9. Of the 905 pupils surveyed in years 9 and 11, 41 pupils said they did not understand what was meant by the term consent and 42 said they had not heard of the term.

Under 18 conception rate

In 2020, approximately 20 girls aged under 18 conceived, for every 1,000 girls aged 15-17 years living in Leeds. This is higher than the national (13.0 per 1000) and regional rate (16.5 per 1000). However overall there is a declining trend in the under 18s conception rate (Figure 112).

Figure 112 - Under 18s conception rate / 1,000 for Leeds

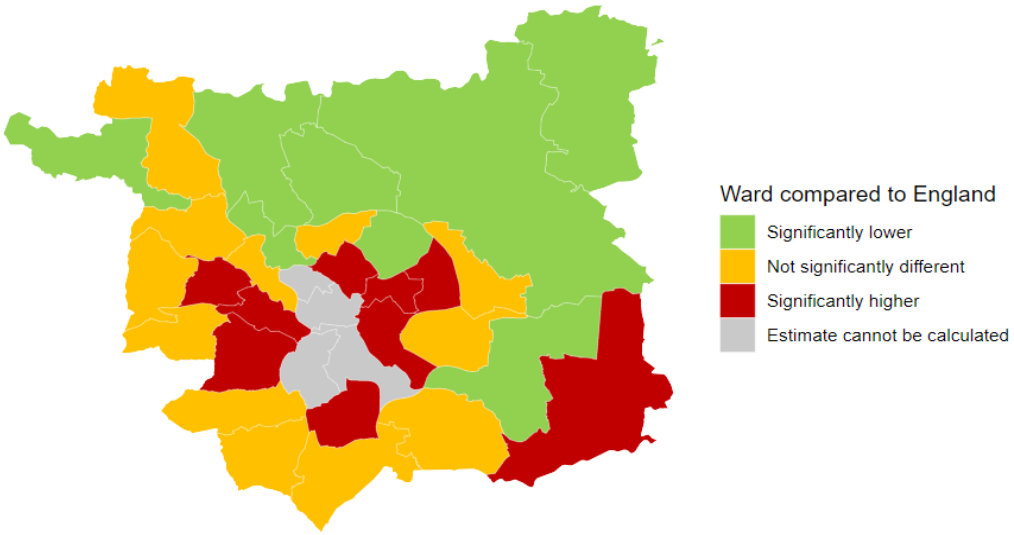


Source: Office for Health Improvement and Disparities, Fingertips Child and Maternal Health Data

Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Figure 113 demonstrates the Under 18s conception rate by ward. Babies born to mothers under 20 years consistently have a higher rate of stillbirth, infant mortality and low birthweight than average[232]. At an individual level, the strongest associated factors for pregnancy before 18 years are free school meal eligibility, persistent school absence by age 14 years, poorer than expected academic progress between ages 11-14 years, and being looked after or a care leaver[233]. Children born to teenage mothers have a 63% higher risk of living in poverty. Teenage mothers are more likely than other young people to not be in education, employment or training; and by the age of 30 years, are 22% more likely to be living in poverty than mothers giving birth aged 24 years or over[234]

[232] Teenage pregnancy | The Nuffield Trust
[233] Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)
[234] [ARCHIVED CONTENT] Teenage conception rates highest in the most deprived areas - ONS (nationalarchives.gov.uk)

Figure 113 - Under 18s conception in Leeds by ward, compared to England: three-year period between 2017-2019



Source: Sexual and Reproductive Health, PHE Fingertips

Despite the falling number of conceptions to teenage people. National figures in 2018 demonstrate that 53% of under 18 conceptions ended in abortion[235]. This is suggestive that there is work remaining to help young women prevent unwanted pregnancy through effective sex education and promotion of access to effective contraception.

Emergency Contraception

Emergency contraception is used to try to prevent pregnancy following unprotected sex. There are two forms: 1) the emergency contraceptive pill (also known as the morning after pill) and 2) the Intrauterine Device (or coil)[236]. To enable young women to avoid unwanted or unplanned pregnancy there is a need to have free and easy to access emergency contraception.

There are numerous routes available for emergency hormonal contraception in Leeds, including general practice and sexual health clinics. A further method for hormonal contraception access are sexual health pharmacies in which free emergency hormonal contraception (EHC) can be provided to any woman without a prescription or appointment. Notably at other pharmacies you can buy EHC without a prescription, but it's expensive. The pharmacies are located across Leeds and have been planned to be accessible to women living in the areas of highest deprivation and where teenage conceptions are highest. These pharmacies also provide free chlamydia and gonorrhoea self-screening kits. They are generally open during evenings and weekends to increase accessibility. A full consultation takes place in private before the drug is given.

3292 young people aged from 13-19 accessed a pharmacy for EHC over the 3 years (Figure 114). This represents 13% of all women (i.e. women of all ages) using the scheme. Notably this doesn't include

[235] Teenage pregnancy | The Nuffield Trust
[236] Emergency contraception (morning after pill, IUD) - NHS (www.nhs.uk)

EHC accessed via GPs or at a sexual health clinic. Therefore the majority of people accessing EHC are over 16, however there is a significant number of people aged 13-16.

Figure 114 - Young people aged from 13-19 who accessed a pharmacy for EHC in Leeds over the 3 years

Age	N
Age 13	10
Age 14	42
Age 15	89
Age 16-19	3151

Source: Sexual Health Pharmacy Data

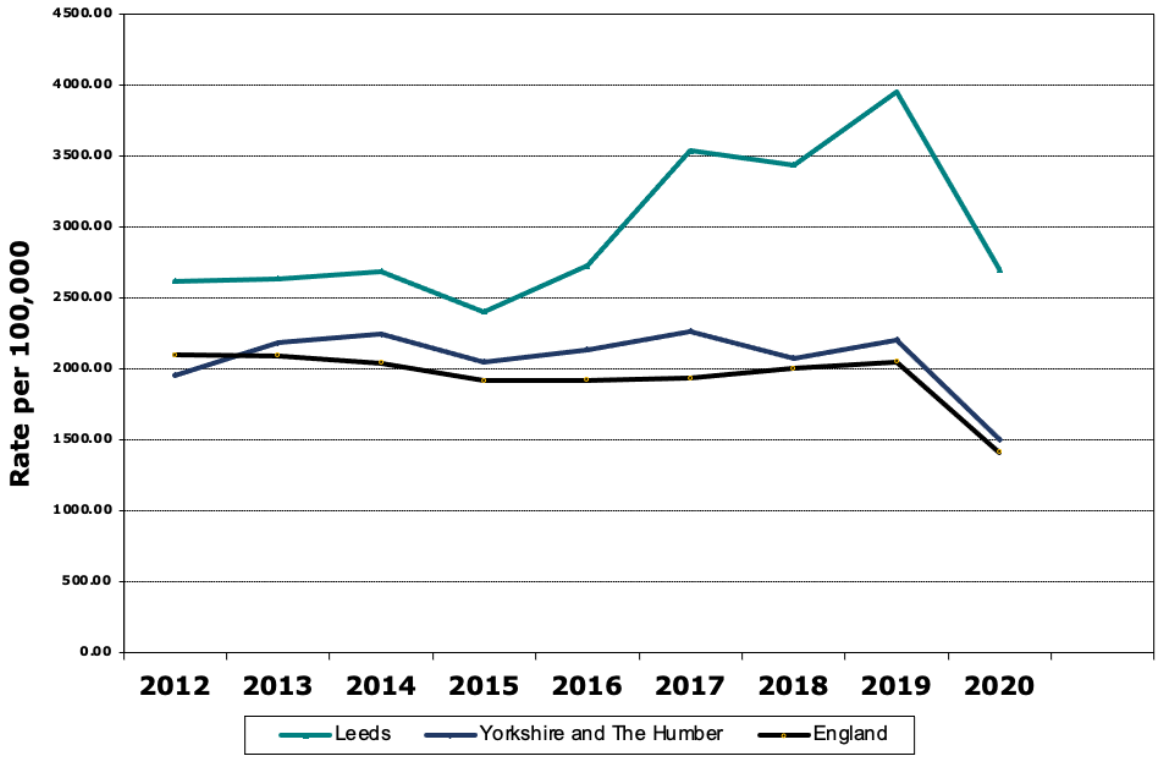
Sexual Health Screening

Asymptomatic screening in Leeds is operated by Preventx. STI testing kits are available through this service by ordering a kit online to be posted home or can be accessed from a sexual health pharmacy. Both options are for 16-24 year-olds only. Under 16s can pick up a kit from a 3 in 1 service (3 in 1 sites offer sexual health services including STI screening, pregnancy testing and free condom pick ups to under 25s). Once they have a kit urine sample/swab sample collected by the young person themselves, posted off to be screened and the result is generally sent via phone call or text. In the instance the test is positive they are invited to Leeds Sexual Health for treatment

Between 1st Jan 2019 – 31st Dec 2021 227 young people aged 19 and under returned a kit – the majority were 19 year-olds (179). There were 1334 tests returned for all ages in that period – so 19% went to 19s and under. Positivity was good for u19s at 9.7% (n=22). This suggests the right people were screening and plenty of unknown infections were able to be treated. Most tests are returned by females (88%) and almost all positives are chlamydia (only 0.7% of all tests yielded a positive gonorrhoea result). These figures are encouraging and demonstrate that those who are sexually active are accessing asymptomatic screening to promote early diagnosis of unknown infection. These figures are taken from pre-COVID-19. The impact of COVID-19 and more up to date figures may provide an interesting update to that described here.

The Chlamydia diagnosis rate in Leeds amongst 15-24 year-olds was rising prior to the COVID-19 pandemic and was significantly higher than the national and regional figure (Figure 115). This is not seen as a measure of morbidity but rather as a measure of prevention success, as all diagnoses can be treated and infection transmission prevented which will lead to reduced infection rates. However there was an evident decrease in 2020, in line with the start of the pandemic experienced in Leeds, Yorkshire and the Humber and England.

Figure 115 - Chlamydia diagnosis rate per 100,000 aged 15-24



Source: Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk) – accessed via LAIT tool

Sexual Health And Relationships Education

Relationships and Sex Education (RSE) is now compulsory in UK primary and secondary schools. There is no parental right to withdraw from relationships education, but parents have the 'right of excusal' from sex education with pupils being able to opt in from age 15. In Leeds this is supported via the Health & Wellbeing Service who are able to deliver sessions to schools and support schools in their delivery.

Identified Gaps in Current Knowledge

- This Health Needs Assessment did not review any insight work done with teenage mothers. With Leeds having a higher than regional and national rate of under 18s conception this insight would be helpful.
- The impact of changing educational practice (i.e. mandatory RSE in UK primary and secondary schools) requires ongoing monitoring and evaluation.

8.6. Health Protection

Headlines

- Children will be disproportionately impacted by climate change and our actions now. Leeds reduction in carbon emissions since 2005 is slightly below average when compared to the other UK core cities (Figure 120).
- Leeds vaccination rates for children have declined more than national figures since the start of the COVID-19 pandemic.
- Yorkshire and the Humber has the highest regional rates of lead exposure in children (2015-2020).

Introduction

Health protection is defined by the UK Health Security Agency (UKSHA) as: "*The protection of individuals, groups and populations through expert advice and effective collaboration to prevent and mitigate the impact of infectious disease, environmental, chemical and radiological threats.*"[237]. In Leeds Health protection work is led by the Health protection board, who work closely with a number of organisations including directorates within Leeds City Council, UKSHA, the NHS, social care and third sector organisations. The 'Golden Thread' and current main priorities for health protection in Leeds are: communicable disease and infection control; tackling antibiotic resistance; tackling tuberculosis; emergency preparedness, response and resilience; air quality; vaccination and screening programmes[238].

Children are more vulnerable to these threats than adults for multiple reasons. For example, they are exposed to proportionally more pollutants than adults as a result of higher breathing rates and for some being pushed in pushchairs which are at the same level as car exhausts[239]. Additionally, they are affected disproportionately by infectious diseases as their immune and other bodily systems are still developing which means they are less able to protect themselves[240]. Therefore, a focus on children's health protection is integral to protecting the health of the population.

Epidemiology

This report focuses solely on areas of Health Protection that impact on children specifically. The Leeds Health Protection Board annual report provides further detailed information related to: antibiotic resistance, air quality and health, winter wellbeing, reducing TB, childhood immunisation and influenza vaccination.

Childhood immunisations

The most effective way to prevent many infectious diseases is through vaccination[241]. The schedule for routine childhood immunisations is set out by NHS England and regularly updated as the

[237] What is health protection? - Oxford Medicine
[238] Leeds Health Protection Board Report 2022
[239] New air quality measurements by Deutsche Umwelthilfe: 115 cities and municipalities exceed NO2 limit value – Deutsche Umwelthilfe e.V. (duh.de)
[240] Children's environmental health (who.int)
[241] Vaccines and immunization (who.int)

evidence base changes[242]. Immunisations (for those below school age) are delivered in general practice and commissioned by the Screening and Immunisations team within NHS England.

At a national level the Cover of vaccination evaluated rapidly (COVER) programme provides data on childhood vaccination rates for children aged 1, 2 and 5 in England[243]. There is an expectation that the UK coverage for all routine childhood immunisations evaluated up to 5 years of age achieve 95%. This is in line with the World Health Organisation's target needed to achieve and sustain elimination.

Results from COVER data for Leeds in the fourth quarter of 2021/22 are shown below in Figure 116. This demonstrates that the current coverage for **all** vaccines are below the target of 95%, which is also the case at a national level. However the data shows that Leeds is generally performing less well than the national average and the NHS West Yorkshire Integrated Care Board average. It also shows that there has been a significant reduction in vaccine coverage since pre-COVID.

Figure 116 - Vaccine coverage (Data from COVER)

12 months:

Programme	Values	LEEDS CITY COUNCIL	NHS WEST YORKSHIRE INTEGRATED CARE BOARD	ENGLAND
12m DTaP/IPV/Hib3	Current Coverage (Q4 2021/22)	89.71%	91.70%	91.89%
	Difference from Pre-Covid levels (Q3 2019-20)	-2.36%	-1.53%	-0.87%
	Coverage Pre-Covid (Q3 2019-20)	92.07%	93.23%	92.76%
12m MenB2	Current Coverage (Q4 2021/22)	90.14%	91.65%	91.98%
	Difference from Pre-Covid levels (Q3 2019-20)	-2.65%	-2.17%	-0.90%
	Coverage Pre-Covid (Q3 2019-20)	92.79%	93.82%	92.88%
12m PCV1	Current Coverage (Q4 2021/22)	93.04%	94.34%	94.14%
	Difference from Pre-Covid levels (Q3 2019-20)			
	Coverage Pre-Covid (Q3 2019-20)			
12m Rota2	Current Coverage (Q4 2021/22)	88.09%	89.15%	90.50%
	Difference from Pre-Covid levels (Q3 2019-20)	-2.20%	-1.58%	-0.04%
	Coverage Pre-Covid (Q3 2019-20)	90.29%	90.73%	90.55%

[242] NHS vaccinations and when to have them - NHS (www.nhs.uk)
[243] Vaccine uptake guidance and the latest coverage data - GOV.UK (www.gov.uk)

24 months:

Programme	Values	LEEDS CITY COUNCIL	NHS WEST YORKSHIRE INTEGRATED CARE BOARD	ENGLAND
24m DTaP/IPV/Hib3	Current Coverage (Q4 2021/22)	91.18%	92.81%	93.04%
	Difference from Pre-Covid levels (Q3 2019-20)	-3.29%	-1.98%	-0.75%
	Coverage Pre-Covid (Q3 2019-20)	94.47%	94.80%	93.78%
24m Hib/MenC	Current Coverage (Q4 2021/22)	88.44%	90.01%	89.68%
	Difference from Pre-Covid levels (Q3 2019-20)	-2.98%	-1.93%	-0.83%
	Coverage Pre-Covid (Q3 2019-20)	91.43%	91.93%	90.51%
24m MenB-booster	Current Coverage (Q4 2021/22)	86.98%	88.73%	88.61%
	Difference from Pre-Covid levels (Q3 2019-20)	-4.69%	-2.44%	-0.35%
	Coverage Pre-Covid (Q3 2019-20)	91.67%	91.17%	88.96%
24m PCV-booster	Current Coverage (Q4 2021/22)	87.89%	89.63%	89.06%
	Difference from Pre-Covid levels (Q3 2019-20)	-3.69%	-2.51%	-1.33%
	Coverage Pre-Covid (Q3 2019-20)	91.59%	92.14%	90.39%

5 years:

Programme	Values	LEEDS CITY COUNCIL	NHS WEST YORKSHIRE INTEGRATED CARE BOARD	ENGLAND
5yr DTaP/IPV-booster	Current Coverage (Q4 2021/22)	84.57%	86.53%	84.59%
	Difference from Pre-Covid levels (Q3 2019-20)	-1.77%	-2.76%	-0.95%
	Coverage Pre-Covid (Q3 2019-20)	86.33%	89.29%	85.54%
5yr DTaP/IPV/Hib3	Current Coverage (Q4 2021/22)	93.61%	94.69%	94.51%
	Difference from Pre-Covid levels (Q3 2019-20)	-0.99%	-1.54%	-0.91%
	Coverage Pre-Covid (Q3 2019-20)	94.60%	96.24%	95.42%
5yr Hib/MenC	Current Coverage (Q4 2021/22)	90.50%	92.22%	92.05%
	Difference from Pre-Covid levels (Q3 2019-20)	-1.23%	-1.79%	-0.74%
	Coverage Pre-Covid (Q3 2019-20)	91.73%	94.02%	92.79%

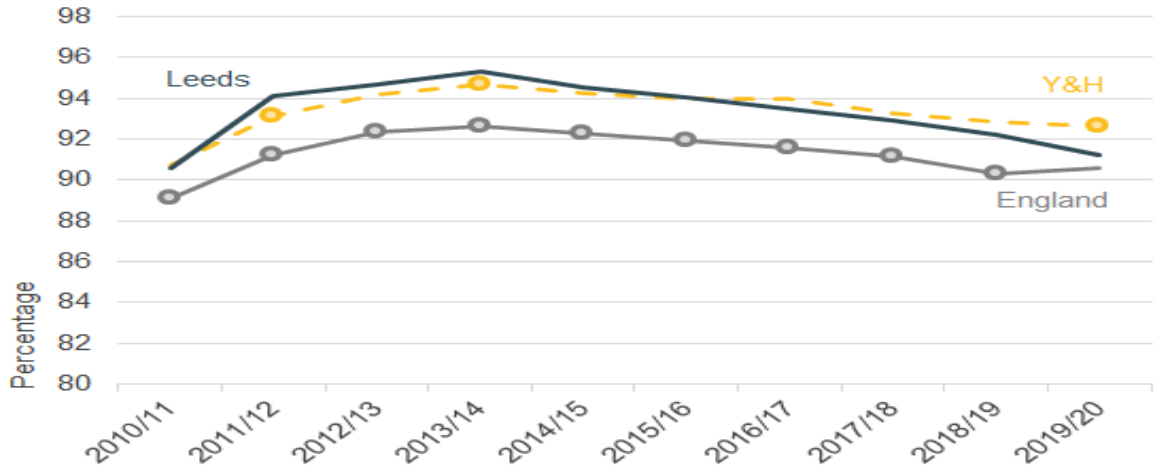
The Measles Mumps and Rubella (MMR) immunisation is given in two doses at 12 months and 3 years 4 months. Due to the highly infectious nature of these infection (particularly measles) the target for coverage of the MMR vaccine is 95% as suggested by World Health Organisation. In Leeds, data from Q4 2021/22 shows that coverage for the first MMR dose (at 24 months of age) is 88.35%, down from 91.59% pre-pandemic in Q3 2019/20. Coverage of the second MMR dose (at 5 years of age) is lower still at 85.43%, down from 87.50% pre-pandemic. Coverage at both 24 months and 5 years is now lower than the England average having previously been higher. Coverage in Leeds has fallen more than both regional and national coverage for both ages. This is on a background of falling rates in recent years as shown in Figure 117. Notably the MMR vaccine schedule guidance has been changed following guidance in August 2022 from the Joint Committee on Vaccination and Immunisation (JCVI).

Figure 117 - MMR coverage with 1 dose at 24 months and 2 doses at 5 years (Data from COVER)

Programme	Values	LEEDS CITY COUNCIL	NHS WEST YORKSHIRE INTEGRATED CARE BOARD	ENGLAND
24m MMR1	Current Coverage (Q4 2021/22)	88.35%	89.93%	89.67%
	Difference from Pre-Covid levels (Q3 2019-20)	-3.24%	-2.03%	-0.77%
	Coverage Pre-Covid (Q3 2019-20)	91.59%	91.96%	90.44%
5yr MMR2	Current Coverage (Q4 2021/22)	85.43%	87.35%	85.92%
	Difference from Pre-Covid levels (Q3 2019-20)	-2.08%	-2.66%	-0.99%
	Coverage Pre-Covid (Q3 2019-20)	87.50%	90.01%	86.92%

Source: COVER data

Figure 118 - MMR vaccination coverage – one dose for 2 year-olds



Source: Public Health England Child and Maternal Health Profiles, chart used with permission from JSA Leeds 2021

Additional data from COVER (Figure 116) show that coverage of all immunisations in the schedule for children has fallen from pre-pandemic levels. Whilst some of the changes are small (less than 1% change) others are more significant including a 4.69% reduction in coverage of the Meningitis B booster at 24 months of age.

Vaccination against polio meant that the UK was declared polio free in 2003, with the last case of wild polio (as opposed to vaccine derived polio) contracted in 1984. Recent monitoring of sewage samples in London has identified closely related wild-type polio viruses, suggesting there may have been person to person transmission. Whilst at the time of writing in August 2022 there is nothing to suggest there has been any transmission in Leeds, the data show that vaccination against polio (IPV in **Error! Reference source not found.**, **Error! Reference source not found.** and **Error! Reference source not found.**) has fallen from pre-pandemic levels. Coverage at 12 months is now 89.71% (down 2.36%), coverage at 24 months is 91.18% (down 3.29%) and coverage at 5 years is 84.57% (down 1.77%). This is on a background of slowly falling rates since peaks of 96.8% at 12 months and 98.0% at 24 months in 2012/12.

These reductions in vaccination coverage increase the risk of outbreaks of infectious disease. In particular when considering the decline in MMR vaccine uptake, even a small decline in rates can lead to a rise in case numbers of measles due to the extremely infectious nature of the infection[244].

In order to prevent the morbidity (and mortality) associated with these childhood infections it is necessary to understand the reasons behind the reduction in immunisation coverage and work to reverse the pattern seen in recent years. Recently published national research examining the decline has demonstrated that there is widespread misunderstanding amongst parents and guardians about the risks of measles. Additional research, carried out by the Royal College of Paediatrics and Child Health as part of the State of Child Health, demonstrated that 96.5% of children agree that children should have all their vaccinations as they grow up and that children want more formal education on immunisations.

Leeds is part of an extended access pilot that has national support to run a new childhood vaccine delivery model in Leeds. Initially this will start in Crossgates Primary Care Network and successful delivery of this model will result in this being rolled out City Wide by the end of 2022.

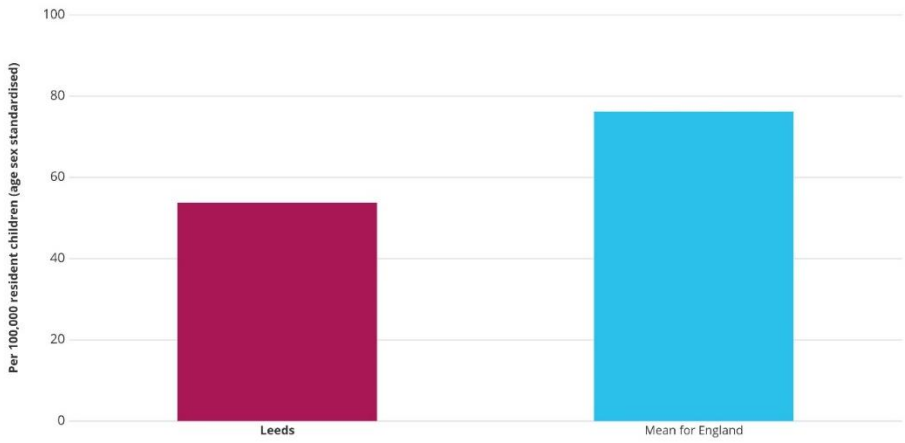
Infectious Diseases

Respiratory conditions

Children are more likely to contract respiratory conditions than adults. This is because they have not yet built immunity to the range of infections that commonly cause disease. Respiratory infections form one of the most common causes for hospital admission and sadly mortality in childhood. Data from NHS Digital uses indirect standardisation methods to show that in Leeds there are 53.9[245] admissions to hospital of children under the age of 16 with lower respiratory tract infections per 100,000 resident children. Nationally this figure is 76.30[246] (Figure 119).

[244] What do I need to know about the MMR vaccine? - UK Health Security Agency (blog.gov.uk)
[245] Rate of emergency admissions for children with lower respiratory infections per 100,000 population in Leeds | LG Inform (local.gov.uk)
[246] Rate of emergency admissions for children with lower respiratory infections per 100,000 population in England | LG Inform (local.gov.uk)

Figure 119 - Rate of emergency admissions for children with lower respiratory infections per 100,000 population (2020/21) for Leeds



Source: Chart used from LG Inform, original data source NHS Digital, Emergency hospital admissions: children with lower respiratory tract infections.

Tuberculosis (TB)

The Tuberculosis in England 2021 Report by the UK Health Security Agency gives detailed characteristics of national level data for children diagnosed with TB. Further the Leeds Health Protection Board Report gives detailed data.

The incidence of TB among children in Leeds has not been established for this HNA. However among the whole population of Leeds (i.e. all age groups) the number of Active TB cases recorded in 2021 is 62 ; an average rate of 7.8 per 100,000, comparable to the 2020 England average of 7.3 per 100,000[247]. Regions nearest to Leeds are seeing higher rates per 100,000 population (Bradford 13.2 and Kirklees 9.5 per 100,000 population)[248].

Meningitis

There were higher incidences of meningococcal disease across Yorkshire in 2017/18 (2.51 per 100,000) than the England average (1.36 per 100,000), particularly in Leeds (2.68 per 100,000) and Wakefield (2.93 per 100,000).

Environmental Hazards

Lead

Yorkshire and Humber has the highest detection rate of lead exposure in children from 2015 to 2020 in England[249].

[247] Leeds Health Protection Board Report 2022
[248] Leeds Health Protection Board Report 2022
[249] Lead Exposure in Children Surveillance System (LEICSS) annual report, 2021 (publishing.service.gov.uk)

In 2018 sadly one toddler in Leeds died of Lead poisoning after compulsive urges to eat painted woodwork.

Air Quality

There is currently a Health Needs Assessment related to Air Quality being written by the Health Protection Public Health Team at Leeds City Council. This will be reviewing factors across the life course and identifying high risk groups. When finalised this will be available via the Leeds Observatory.

The Leeds Joint Strategic Assessment has a detailed analysis of air quality in Leeds and its impacts. Additionally air quality is continually monitored in the city and a report is produced annually. Leeds also has an air quality strategy 2021 – 2030 and there a campaign entitled Clean Air Leeds. Additionally Leeds is currently consulting on being the first city in West Yorkshire to adopt Vision Zero. This focuses on the impact of traffic on health. It focuses on the greater threat of traffic to groups of people such as children than to others and helps Leeds to address this inequity in relation to exposure to road danger and opportunities to travel safely. The vision, in removing more cars from the roads, will improve air quality and cut congestion for all and help the city meet its carbon reduction commitments.

Children are differently affected by poor air quality as a result of differences in underlying health and levels of exposure to poor air quality as a result of where they live or go to school. In the UK 1 in 3 children are living in areas with dangerously high levels of air pollution[250] and many more are living in poorly maintained homes with high levels of indoor air pollutants[251]. The impact of air pollution is worse for children than it is for adults and exposure to such pollutants is associated with stunted lung growth, and increased risk of asthma and pneumonia[252]. This is because children's airways are smaller and are still developing. Further their height and transport in pushchairs and prams puts them at the level of car exhausts[253]. In addition to this there are some children who are at an even higher risk, including those with existing medical conditions and those that live in areas with particularly high levels of pollution[254].

For example, increased air pollution is associated with higher rates of admission for children living with asthma[255]. The UK has the highest rates of children suffering lung conditions in Europe and every 20 minutes a child suffering an asthma attack is admitted to hospital. There were higher rates of hospital admissions for asthma in under 19 year-olds in West Yorkshire (172.5 per 100,000) in 2019/20 than the England average (160.7 per 100,000) with the highest rates in Bradford, Calderdale and Kirklees, and lower than England average rates in Leeds. Although not entirely related to air pollution, this may have been a factor.

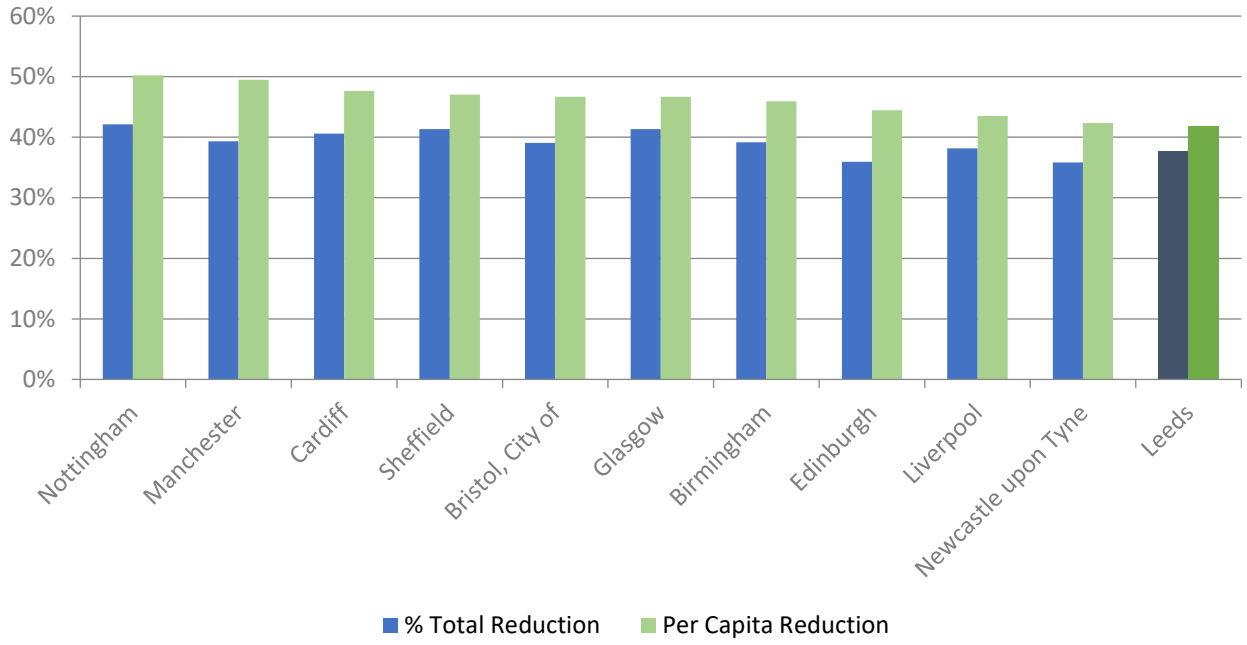
Climate Change

[250] Healthy Air for Every Child - Unicef UK Healthy Air for Every Child
[251] Indoor air pollution | Asthma + Lung UK (blf.org.uk)
[252] How does air pollution affect children's lungs? | Asthma + Lung UK (blf.org.uk)
[253] More than 90% of the world's children breathe toxic air every day (who.int)
[254] More than 90% of the world's children breathe toxic air every day (who.int)
[255] https://www.asthma.org.uk/advice/triggers/pollution/

As the 2021 JSA in Leeds has highlighted, climate change remains the single greatest threat to global health and Leeds is not immune from its impacts. Leeds City Council has declared a climate emergency. The impact of climate change is felt more acutely for children than adults as its impacts will be felt greater by future generations. We know the impacts of climate change are unevenly distributed and that the impacts will be worse for societies with fewer resources and infrastructure to adapt.

Leeds reduction in carbon emissions since 2005 is slightly below average when compared to the other UK core cities (Figure 120).

Figure 120 - Reduction in carbon emission for UK Core Cities, 2005 to 2018



Source: Department for Business, Energy and Industrial Strategy. Chart Used from Leeds Joint Strategic Assessment 2021

Identified Gaps in Understanding

- Data related to infectious diseases that are reported by schools and early years settings are not reported here. These may be useful to analyse to monitor trends.
- Data related to meningitis included in this HNA is from 2017/18. There may be more up to date information available that would be helpful in understanding the burden of meningitis in Leeds, however it was not found in time for publication of this HNA.
- There is a dataset related to vaccine uptake of children for COVID-19. This has not been included within this Health Needs Assessment but analysis of this is helpful in considering the differential impact of COVID-19 on children.

9. Appendices

Appendix 1 – Steering Group Members

Name	Role	Organisation
Kerry Badger	Public Health Registrar	Leeds City Council
Kathryn Ingold	Consultant in Public Health / Chief Officer	Leeds City Council
Hannah Lamplugh	Voice Influence and Change Lead Children and Families Directorate	Leeds City Council
Nick Grudgings	Head of Population Health Planning	Leeds Office of the NHS West Yorkshire Integrated Care Board
Suresh Perisetla	Public Health Intelligence Manager	Leeds City Council
Martin Earnshaw	Leeds Head of Commissioning – Vulnerable Groups	Leeds Office of the NHS West Yorkshire Integrated Care Board
Emily Griffiths	Associate Director of Pathway Integration (Children, Families and Healthy Populations)	Leeds Office of the NHS West Yorkshire Integrated Care Board
Andrew Irvine	Senior Public Health Registrar	Leeds City Council
Pip Goff	Director, Volition	Forum Central
Chris Dickinson	Head of Service, Commissioning and Market Management, Children and Families	Leeds City Council
Ann Crossland	Project Worker	Voluntary Action Leeds
Janice Burberry	Head of Public Health (Children and Families) Adults and Health Directorate	Leeds City Council
Michelle Kane	Health Improvement Principal - Young People	Leeds City Council
Jane Mischenko	Children's Partnership Development Lead	Leeds Office of the NHS West Yorkshire Integrated Care Board

Mark Law	CEO	BARCA
Jayne Bathgate-Roche	Pathway Integration Leader – Children and Maternity	Leeds Office of the NHS West Yorkshire Integrated Care Board

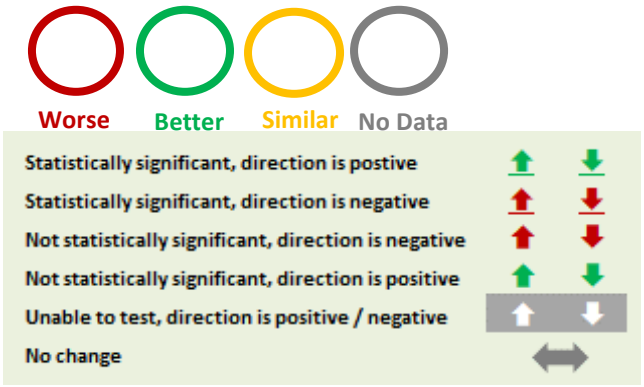
Appendix 2 – Co-authors (Bold) and Contributors to Each Chapter

Section	Name(s)	Role
Children and Young People Population Summary	**Adam Taylor** **Suresh Perisetla** **Tom Ellis** Maria White	Senior Information Analyst (Leeds City Council) Public Health Intelligence Manager (Leeds City Council) Intelligence and Policy Senior Support Officer (Leeds City Council) Public Health Information Analyst (Leeds City Council)
What Are Children Telling Us?	**Hannah Lamplugh** Maria White Kerrie Burton Siobhan Jennings	Voice Influence and Change Lead (Leeds City Council) Public Health Information Analyst (Leeds City Council) Behaviour Change Specialist (Leeds City Council) Healthy Eating Adviser- Schls & Henry (Leeds City Council)
The First 1001 Days: Conception to age 2	**Nicola Goldsborough** Sally Goodwin-Mills	Advanced Health Improvement Specialist – Maternity and Infants (Leeds City Council) Adv. Health Improvement Specialist – Infant Feeding and Maternity (Leeds City Council)
Early Years (Age 2-5 years)	**Zoe White** Nicola Goldsborough Sally Goodwin-Mills	Advanced Health Improvement Specialist (Early Years) (Leeds City Council) Advanced Health Improvement Specialist – Maternity and Infants (Leeds City Council) Adv. Health Improvement Specialist – Infant Feeding and Maternity (Leeds City Council)
Primary and Secondary Aged Children		
Transition to adulthood		

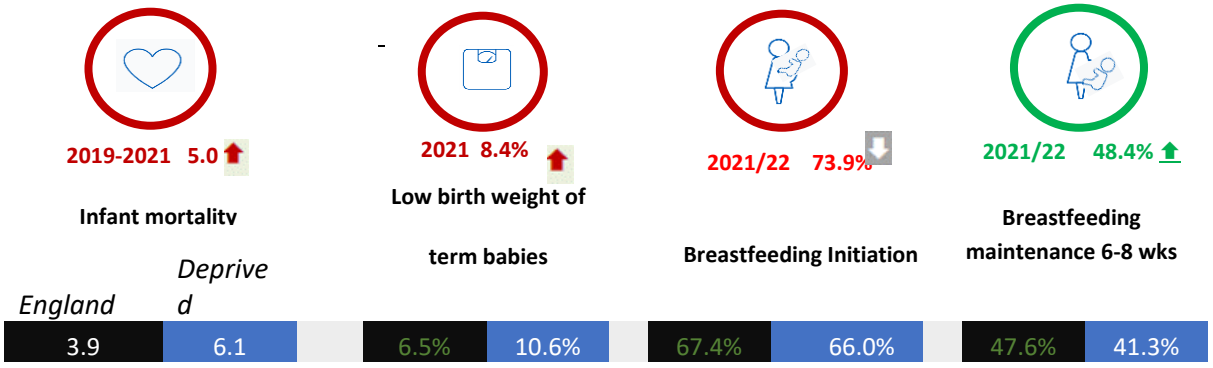
Child Poverty	**Michelle Kane**	Health Improvement Principal - Young People (Leeds City Council)
Housing	**Janice Burberry**	Head of Public Health (Children and Families) (Leeds City Council)
Education	**Emma Newton** **Zoe White**	Advanced Health Improvement Specialist (Children & Families Team) Advanced Health Improvement Specialist (Early Years) (Leeds City Council)
Transport	**Lynsey McGarvey**	Principal Transport Planner (Leeds City Council)
Ethnicity and Racism	Sarah Erskine	Head of Public Health (Mental Health) (Leeds City Council)
Play	**Sally Hall**	Advanced Health Improvement Specialist (Leeds City Council)
Priority Groups	Charlotte Hanson	Advanced Health Improvement Specialist (Leeds City Council)
Children's Healthy Weight	**Deb Lowe**	Advanced Health Improvement Specialist (Leeds City Council)
Mental Health and Emotional Wellbeing	**Charlotte Hanson**	Advanced Health Improvement Specialist (Leeds City Council)
Alcohol, Smoking and Drugs	**Sally Hall** Heather Thompson	Advanced Health Improvement Specialist (Leeds City Council) Head of Public Health (Health Improvement) (Leeds City Council)
Oral Health	**Emma Newton**	Advanced Health Improvement Specialist (Leeds City Council)
Sexual and Reproductive Health	Kerry Swift	Advanced Health Improvement Specialist (Sexual Health) Leeds City Council
Health Protection	Jackie Moores Lisa Hammond	Advanced Health Improvement Specialist – Health Protection (Leeds City Council) Advanced Health Improvement Specialist – Health Protection

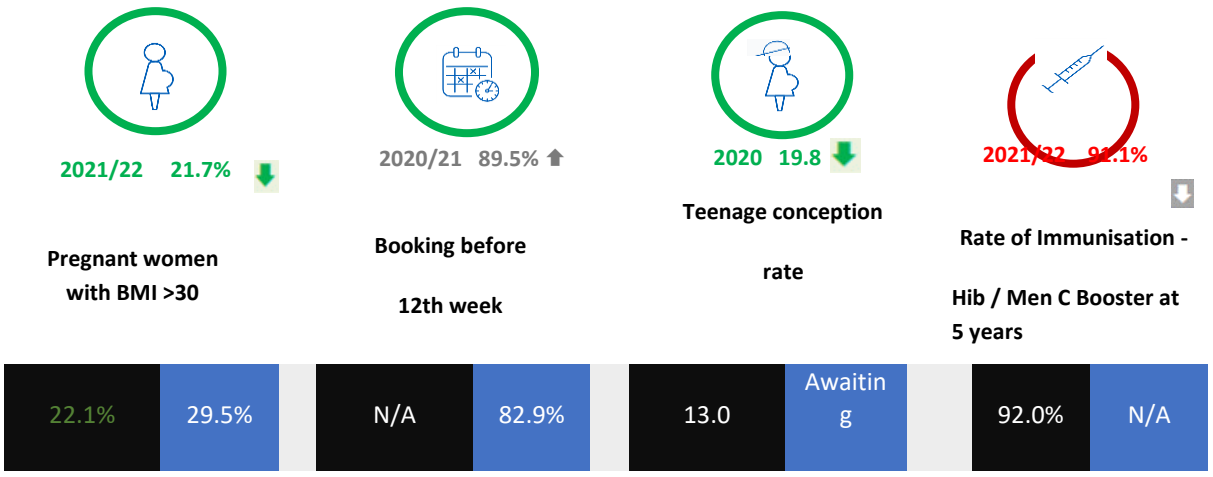
		(Leeds City Council)
	Martyn Cutts	Advanced Health Improvement Specialist (Leeds City Council)
	Vineeta Sehmbi	Advanced Health Improvement Specialist (Leeds City Council)
	Donna Whitlock	Health Improvement Specialist (Leeds City Council)
	Chloe Rankin	Advanced Health Improvement Specialist (Leeds City Council)
Proofreading	Hannah McGurk	Health Improvement Specialist (Leeds City Council)
	Lisa Jennings	Health Improvement Resource Assistant (Leeds City Council)
	Laura Overfield	Advanced Health Improvement Specialist (Leeds City Council)

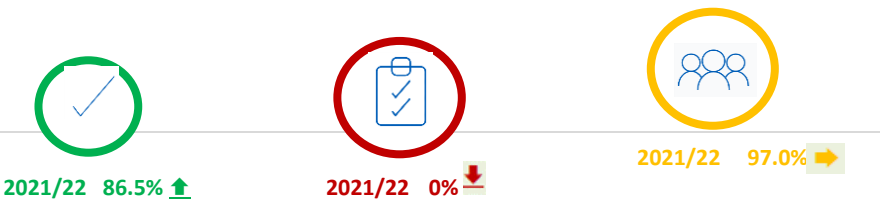
Appendix 3 – Best Start Dashboard Snapshot October 2022



England	Deprived	England - Most recent period available
N/A	Data not available for indicator	







Appendix 4 – Early Years High Impact Summary

The Early Years High Impact Figures are a nationally reported set of figures developed to maximise and focus the health visiting services. They support the delivery of the national Healthy Child Programme.

High impact area	Key performance indicator	Leeds Current performance	National Current performance	Leeds Current trend

Transition to parenthood and the early weeks	Teenage pregnancy, 15 - 17 years	22.8 per 1,000 -2019	15.7 per 1,000 -2019	No significant change
	Smoking at time of delivery	Not available (2020/21)	9.60% (2020/21)	Cannot be calculated (missing data)
	Smoking at booking	Not available (2018/19)	12.80% (2018/19)	Too early to say (new indicator)
	Maternal obesity at booking	Not available (2018/19)	22.10% (2018/19)	Too early to say (new indicator)
	Low birth weight of term babies	3.40% -2019	2.90% -2019	No significant change
	Infant mortality rate	4.6 per 1,000 (2018 - 20)	3.9 per 1,000 (2018 - 20)	No significant trend
Maternal mental health (perinatal)	Maternal mental health	Metric in development	Metric in development	Not applicable
Breastfeeding	Breastfeeding at 6 - 8 weeks	Not available (2020/21)	47.60% (2020/21)	Cannot be calculated (missing data)
Healthy weight	Excess weight 4 - 5 years	24.00% (2019/20)	23.00% (2019/20)	Increasing and getting worse
Managing minor illnesses and reducing accidents	A&E attendance rates, under 5 years	479.1 per 1,000 (2018/19)	655.3 per 1,000 (2018/19)	Increasing and getting worse
	Emergency hospital admissions, under 5 years	96.6 per 1,000 (2019/20)	162.0 per 1,000 (2019/20)	Increasing and getting worse
	Hospital admissions for injuries, under 5 years	104.2 per 10,000 (2019/20)	117.0 per 10,000 (2019/20)	Decreasing and getting better
	Tooth decay, at 5 years	26.00%	23.40%	

Health, wellbeing and development		(2018/19)	(2018/19)	Cannot be calculated (missing data)
	MMR immunisation coverage, 2 doses at 5 years	86.80% (2020/21)	86.60% (2020/21)	Decreasing and getting worse
	Child development outcomes at 2 - 2½ years, all areas	85.00% (2020/21)	82.90% (2020/21)	Too early to say (new indicator)
	Child development outcomes at 2 - 2½ years, communication skills	88.70% (2020/21)	86.80% (2020/21)	Too early to say (new indicator)
	Child development outcomes at 2 - 2½ years, gross motor skills	92.10% (2020/21)	91.80% (2020/21)	Too early to say (new indicator)
	Child development outcomes at 2 - 2½ years, fine motor skills	93.10% (2020/21)	92.00% (2020/21)	Too early to say (new indicator)
	Child development outcomes at 2 - 2½ years, problem solving skills	91.50% (2020/21)	91.90% (2020/21)	Too early to say (new indicator)
	Child development outcomes at 2 - 2½ years, personal-social skills	91.10% (2020/21)	90.20% (2020/21)	Too early to say (new indicator)
	School readiness, good level of development at end of reception, all areas	66.40% (2018/19)	71.80% (2018/19)	Increasing and getting better
	School readiness, good level of development at end of reception, communication and language skills	81.10% (2018/19)	82.20% (2018/19)	Increasing and getting better

Appendix 5 – Children and Young People's Plan Key Indicator Dashboard

	Deprivation Rank	Children in Need [1 2]		Children subject to a child protection plan [1 2]		Children looked after [1 2]	
Time Period	**IMD 2019**	**As at 31/03/2022**		**As at 31/03/2022**		**As at 31/03/2022**	
Leeds		**3,349 (196.3)**		**619 (36.3)**		**1,365 (80.0)**	
Cluster	**1= most deprived; 22= least deprived**	**No.**	**RPTT**	**No.**	**RPTT**	**RPTT**	**%**
Aireborough	19	89	119.8	12	16.1	31	41.7
ARM	17	132	97.5	19	14.0	35	25.8
Beeston, Cottingley and Middleton	4	194	215.8	45	50.1	115	127.9
Bramley	3	185	248.9	9	12.1	73	98.2
Brigshaw	14	49	96.2	11	21.6	16	31.4
EPOS	22	51	69.7	9	12.3	7	9.6
ESNW	16	69	135.2	13	25.5	22	43.1
Garforth	18	16	46.7	<5	-	6	17.5
Headingley - Kirkstall partnership	10	117	177.2	20	30.3	45	68.2
Horsforth	20	46	111.3	<5	-	<5	-
Inner East	1	353	236.4	70	46.9	220	147.3
Inner North East	7	295	226.3	58	44.5	91	69.8
Inner West (ACES + Farnley)	6	275	305.3	70	77.7	87	96.6
J.E.S.S	2	323	273.8	67	56.8	165	139.8
Lantern Learning Trust	8	68	163.4	21	50.5	49	117.8
Leodis	15	44	136.1	5	15.5	15	46.4
Morley	11	129	152.9	19	22.5	51	60.5
Otley/Pool/Bramhope	21	52	128.2	<5	-	<5	-
Pudsey	12	116	110.0	6	5.7	23	21.8
Rothwell	13	81	125.9	34	52.8	33	51.3
Seacroft Manston	5	319	307.3	36	34.7	140	134.9
Templenewsam Halton	9	99	180.4	28	51.0	36	65.6

PARTICIPATION & WELLBEING	**Healthy Weight (No update for 20/21)**

	Deprivation Rank	Young People who are NEET [1 2]		Young People whose status is 'not known'[1 2]		Prevalence of children at age 11 who are a healthy weight[1]	Primary Attendance[3]	Secondary Attendance[3]
Time Period	**IMD 2019**	**As at 31/03/2022**		**As at 31/03/2022**		**2018/19 AY**	**2020/21 HT1-6**	**2020/21 HT1-6**
Leeds		**501 (3.07%)**		**819 (5.02%)**		**63.2%**	**96.4%**	**94.3%**
Cluster	**1= most deprived; 22= least deprived**	**No.**	**%**	**No.**	**%**			
Aireborough	19	13	1.7%	24	3.2%	70.9%	96.9%	93.7%
ARM	17	14	1.1%	14	1.1%	67.7%	96.3%	93.3%
Beeston, Cottingley and Middleton	4	48	5.7%	39	4.6%	58.3%	95.5%	91.1%
Bramley	3	50	6.5%	31	4.1%	61.1%	95.3%	90.9%
Brigshaw	14	7	1.4%	18	3.5%	62.8%	96.6%	93.1%
EPOS	22	4	0.7%	15	2.6%	72.8%	97.4%	92.7%
ESNW	16	9	1.9%	10	2.1%	71.2%	96.3%	90.9%
Garforth	18	8	2.0%	14	3.6%	69.2%	97.0%	94.2%
Headingley - Kirkstall partnership	10	19	3.6%	18	3.4%	60.3%	95.7%	93.8%
Horsforth	20	2	0.5%	12	3.1%	75.7%	96.6%	94.5%
Inner East	1	47	3.7%	76	5.9%	58.1%	93.9%	90.3%
Inner North East	7	32	2.7%	61	5.2%	61.1%	93.6%	92.9%
Inner West (ACES + Farnley)	6	43	4.7%	36	3.9%	57.6%	94.6%	91.5%

J.E.S.S	2	68	6.0%	58	5.1%	52.9%	94.6%	92.7%
Lantern Learning Trust	8	4	1.5%	14	5.3%	55.0%	92.9%	85.9%
Leodis	15	5	1.4%	12	3.3%	63.2%	97.4%	94.2%
Morley	11	17	2.1%	43	5.3%	64.9%	96.2%	93.7%
Otley/Pool/Bramhope	21	6	1.4%	12	2.7%	68.4%	96.3%	94.4%
Pudsey	12	19	1.9%	25	2.5%	66.6%	95.8%	91.6%
Rothwell	13	8	1.3%	29	4.6%	68.8%	96.5%	91.0%
Seacroft Manston	5	52	5.2%	48	4.8%	60.1%	95.1%	89.3%
Templenewsam Halton	9	23	3.8%	23	3.8%	61.1%	94.8%	88.4%

ATTAINMENT (due to COVID-19 there will be no update for 2019/20 or 2020/21)

	Deprivation Rank	Early Years Foundation Stage: % GLD [3 4]	Reaching the expected standard in RWM at the end of KS2 [3]	Average Progress 8 Score [3]	Level 3 Quals at age 19 [5]
Time Period	**IMD 2019**	**2018/19 AY**	**2018/19 AY**	**2018/19 AY**	**2018/19 AY**
Leeds		**66.4%**	**62%**	**+0.03**	**49.9%**
Cluster	**1= most deprived; 22= least deprived**	**Confirmed**	**Confirmed**	**Confirmed**	**Confirmed**
Aireborough	19	76.6%	70%	+0.12	68.7%
ARM	17	72.6%	73%	+0.02	60.9%
Beeston, Cottingley and Middleton	4	56.7%	51%	+0.12	33.6%
Bramley	3	59.5%	58%	-0.05	34.4%
Brigshaw	14	75.9%	60%	-0.10	46.2%
EPOS	22	78.6%	76%	+0.22	55.6%
ESNW	16	72.1%	68%	-0.33	59.1%
Garforth	18	78.3%	68%	+0.49	51.5%
Headingley - Kirkstall partnership	10	66.7%	68%	+0.04	59.8%
Horsforth	20	77.2%	76%	+0.38	67.6%
Inner East	1	57.8%	48%	-0.09	38.3%
Inner North East	7	59.0%	55%	+0.16	48.9%
Inner West (ACES + Farnley)	6	56.0%	56%	+0.33	41.6%
J.E.S.S	2	56.7%	50%	+0.00	31.6%
Lantern Learning Trust	8	60.6%	54%	+0.16	36.1%
Leodis	15	64.1%	69%	+0.32	59.9%
Morley	11	74.5%	70%	+0.59	49.3%
Otley/Pool/Bramhope	21	80.1%	72%	+0.36	71.6%
Pudsey	12	72.1%	67%	-0.10	45.9%
Rothwell	13	68.2%	68%	-0.10	47.9%
Seacroft Manston	5	61.0%	62%	-0.69	28.8%
Templenewsam Halton	9	70.1%	56%	+0.12	44.3%

Key: AY - academic year
(P) - Provisional data

Notes
CYPP indicators reported at a cluster level are not comparable with citywide results, as the data used are not always from the same period.

1 - Data for this indicator show children and young people living in the cluster area, not attending schools in the cluster
2 - Data suppressed for instances of fewer than 5.
3 - Data for this indicator are by schools within the cluster, not by pupils living in the cluster area.
4 - GLD is Good Level of Development
5 - Based on the location of the school the young person attended when they were in Year 11; not where they gained the Level 3 qualification.

Appendix 6: My Health My School Report for Thriving