APPENDIX 1

What we know about Children and Young People in Lincolnshire - OUR NEEDS ASSESSMENT

In shaping the priorities included within our plan, the Children and Young People's Strategic Partnership (CYPSP) have considered a wide range of information and data. This includes the Joint Strategic Needs Assessment (JSNA), Child Poverty Needs Assessment (CPNA), Child Care Sufficiency Assessment, 14 to 19 Needs Assessment and the Local Economic Needs Assessment.

Other important sources of data include; Stakeholder surveys, feedback from OFSTED inspections, Performance Monitoring reports, the Looked After Children's (LAC) Annual Report, the Placement Analysis for Looked After Children and the Lincolnshire Safeguarding Children Board (LSCB) Report.

The Partnership has also considered local and national policy changes including; changes in funding levels and the wider economic context when agreeing our priorities.

REFLECTIONS ON OUR LAST CYP PLAN - MAKING A DIFFERENCE

ATTAINMENT

We continue to see improvements in education attainment with 80% of pupils achieving 5 good GCSEs or equivalent in 2010 which is higher than our neighbouring authorities in the East Midlands.

EARLY YEARS

There has been a significant increase in the number of children who have achieved a good level of development, as measured by the Early Years Foundation Stage profile, at the end of the Reception year and we are pleased that Lincolnshire demonstrated the most improvement in this area of all the East Midlands Local Authorities. We are pleased to report that Gainsborough Children's centre has achieved 'Outstanding' by Ofsted the first in England.

SAFEGUARDING

Our Ofsted Inspection in May 2010 graded safeguarding in Children's Services as 'outstanding' and our Looked After Children services as 'good with outstanding capacity to improve'. The council and its partners were described as 'having maintained a robust, consistent and successful focus to secure the safety and well being of children and young people across such a large and diverse county'. The grading from this inspection was confirmed in January 2011 with an unannounced inspection of safeguarding services. The inspectorate remained impressed with our robust front line social work services, our delivery of a range of preventative services, the high morale of our staff and positive user feedback.

PARTNERSHIPS

We have worked hard as a Partnership and our preventative services are now fully established and our locality teams work together to share information and deliver co-ordinated plans of support for children and families through the Team Around the Child. This has led to reduced numbers of Looked After Children. As a Partnership we work hard to support children to remain at home wherever possible.

NEXT STEPS…

All Partnerships are in financially testing times and Lincolnshire is no exception. We need to continue to be strong and resolute in championing the needs of all children, young people and families, ensuring that there is equity and consistence in delivering services. There are also some high profile changes for schools. The Government's focus is diversity for schools and proposes to 'free schools' to focus on core purpose – education. Together we will draw on the strengths of all partners as we transform the Partnership to further support and improve the lives of children and young people and their families. We will put aside our organisational boundaries to ensure children and young people are at the heart of what we do. In particular, we will need to challenge and respond to evidence from monitoring and evaluation, and customer feedback.

LINCOLNSHIRE

In January 2011 Lincolnshire County Council's (LCC) population included 151,708 children and young people aged 0-18 of which 20% are aged 0 to 3. The proportion of school children entitled to free school meals (11%) is below the national average (16.7%) but has increased in recent years. Children and young people from minority ethnic groups account for 9% in primary schools and 7% in secondary schools which is below the national average of 26.5% and 22.2% respectively. The percentage of pupils who speak English as an additional language has increased from 4% in 2010 to 5% in 2011. One hundred and seventeen languages are spoken in Lincolnshire schools, an increase of fourteen since 2010. The largest increases in non-English languages have been in Polish, Lithuanian and Latvian.

District data breakdown:

	2010 Mid-Year Population Estimates	Number of Looked After Children as of 31 March 2011	Number of Children with a Child Protection Plan as of 31 March 2011	Number of active Team Around The Child cases per 10,000 aged under 19 as of March 2011	Percentage of 16-18 year olds who are NEET* (3 month average Nov 09 to Jan 10)
Boston	59,000	63	18	146	3.36%
East Lindsey	141,600	65	44	176	4.19%
Lincoln	89,700	142	51	213	8.91%
North Kesteven	106,400	33	10	99	3.29%
South Holland	84,600	23	22	89	5.55%
South Kesteven	132,300	49	45	76	3.67%
West Lindsey	89,400	42	38	126	4.83%
Out County		52	7		
Not Recorded		20	35		
Lincolnshire	703,000	489	270	131	4.7%

*NEET - not in education,employment or training - district figures are based on 2010 data.

KEY VULNERABLE GROUPS

LOOKED AFTER CHILDREN

Evidence shows that looked after children and young people share many of the same health, social and education problems as their peers, but often to a greater degree. They have frequently endured greater challenges, such as discord within their own families and physical, emotional and psychological problems during their lives. There is also a disproportionately larger number of children and young people with disabilities in care compared to the general population. Young people leaving care are a particularly vulnerable group, with their outcomes poorer than young people who have never been in care.

There are approximately 800 young people cared for within Lincolnshire each year. Over two hundred of these children are placed in Lincolnshire by other Local Authority's.

The number of Lincolnshire's Children Looked After at the 31st March 2011 decreased from 519 in 2010 to 489 in 2011, a reduction of 27 in the total looked after population. This would appear to be against the national trend, which has seen the proportion of Looked After Children in the population increasing. Based on numbers per 10,000 populations, current figures reflect 35.0 at end of year, with statistical neighbours at 44.5 and a national average at 58. The reduction in Lincolnshire is attributable to partnership working, with a strong emphasis on safeguarding children within their communities and accessing universal and targeted services wherever safe and appropriate to do so.

The Children and Young People's Strategic Partnership is effectively targeting resources and greater integrated working with partners has contributed to improved outcomes. This approach is further enhanced with Lincolnshire piloting Community Budgets with the Families Working Together project, targeting resources at those families most in need. This has ensured fewer children have lived in situations of vulnerability and as a result, fewer children have been in need of specialist services and admission to care.

CHILDREN WITH A CHILD PROTECTION PLAN

The number of children with Child Protection Plans is measured as a rate per 10,000 population aged 0 to 17. Over 2010/11 the rate in Lincolnshire has risen with the figure at the end of March 2011 at 19.37 per 10,000. At the end of March 2010 the rate was 17.69 per 10,000. Lincolnshire compares favourably to national statistics and the increase in the numbers of children subject to child protection plans is set against a reduction in the number of Looked After Children. Through robust multi-agency working, risks to children is being managed at home (where appropriate) rather than in care. For protection plans to be effective, it is essential that they are reviewed at regular intervals. This ensures that protection arrangements reflect the

family's circumstances and the level of risk the child is exposed to. This standard requires multi-agency commitment with a target of 100% of plans reviewed at the required interval set.

At the end of March 2011 there were 20 children subject to Child Protection Plan for a second or subsequent time (our target was 12). This under-performing indicator presents a challenge to all agencies. At the end of March 2011 this figure was 2.53 children ceasing to be subject to a Child Protection Plan for whom plans lasted two years or more, as a percentage of all children ceasing to be subject to a Child Protection Plan during the year. Over the course of the year performance has been consistently good and is excellent when viewed with national comparisons. Agencies work well together to ensure that there is robust and timely management of Child Protection Plans. For those children who remain subject to Plans for more than two years this is usually a reflection of complex and changing circumstances within their homes.

CHILDREN AND YOUNG PEOPLE EXCLUDED FROM SCHOOLS

The landscape of Education is significantly changing in Lincolnshire, with regard to the number of Academies being established. and this in part has lead to a change in responsibilities and accountability.

Exclusions in Lincolnshire are closely monitored by the Education Out of School team, and our colleagues in the CfBT Education Service.

Support for Lincolnshire schools for those pupils requiring early intervention, or are at risk of exclusion, is provided by the Education Out of School Team, the Specialist Teaching and Applied Psychology Service, colleagues in Additional Needs , and the Lincolnshire Teaching and Learning Centres

Provision for all permanently excluded pupils in Lincolnshire is provided by the Teaching and Learning Centres from the sixth day of any permanent exclusion, and all families of permanently excluded pupils are offered support from the Education Out of School Team Parent Liaison Officers, and the Lincolnshire Teaching and Learning centres.

All schools must have regard to the 'Special Needs Code of Practice' when considering support for pupils who may be at risk of exclusion, and parents must be given the right of appeal to the governing body.

As of March 2012 there have been a total of 64 permanent exclusions, and this is an increase on those recorded in 2011, and an area breakdown is given below

CHILDREN WITH DISABILITIES

The Family Resource Survey 2010 estimates that there are approximately 952,741 disabled children in Great Britain – 7.3% of the child population in Great Britain (Disabled Children: A Legal Handbook 2010). In the past ten years the prevalence of severe disability and complex needs has risen. This is due to a number of factors, including increased survival of pre-term babies and increased survival of children after severe trauma or illness. It is estimated that there are up to 6,000 children living at home who are dependent on assistive technology. Children and young people with life limiting conditions, such as cystic fibrosis have better life expectancy and improved quality of life due to improved treatment and support.

Children and young people with a disability, and their families, make use of a wide range of services and support. Perhaps the most valued support is provided through families and communities. Formal support services are provided by health; Lincolnshire County Council and the District Councils (in particular education, social work, leisure and housing) and through the voluntary, independent and or faith sector. Support for children and their families is therefore not the responsibility of a single organisation but is shared across a number of agencies working in partnership with families and communities.

The number of Children with a special educational need in all schools in Lincolnshire has decreased since 2008 by 22 pupils. The table below shows the latest available data is as at January 2011:

SEN Type		Number of Pupils	Percentage
ASD	Autistic Spectrum Disorder	1110	11.36%
BESD	Behaviour, Emotional & Social Difficulties	2359	24.14%
HI	Hearing Impairment	131	1.34%
MLD	Moderate Learning Difficulty	2520	25.79%
MSI	Multi- Sensory Impairment	13	0.13%
OTH	Other Difficulty/Disability	383	3.92%
PD	Physical Disability	315	3.22%
PMLD	Profound & Multiple Learning Difficulty	94	0.96%
SLCN	Speech, Language and Communication Needs	1037	10.61%
SLD	Severe Learning Difficulty	243	2.49%
SPLD	Specific Learning Difficulty	1489	15.24%
VI	Visual Impairment	78	0.80%
Total		9772	100%

TEENAGE PREGNANCY

Teenage pregnancy is a complex social problem. Having children at a young age can influence young parents health and well being, severely limit education and career prospects and result in negative health outcomes for their children, who are significantly more likely to become teenage parents themselves. In Lincolnshire the conception rates for girls living in areas of very high deprivation are over four times greater than those of girls from the most affluent areas. Table 1.3 highlights the areas where teenage pregnancy rates are highest; these areas also have the highest levels of deprivation within Lincolnshire.

Table 1.3. Teenage Conceptions by GP Cluster (18 years or under) 2006 to 2008

Cluster	Conceptions	Population	Rate per 1000
Boston	178	4386	40.58
East Lindsey	157	4917	31.93
Lincolnshire West	527	12168	43.31
Mid Kesteven	143	4235	33.77
Skegness & Coast	216	3620	59.67
Sleaford & District	79	3196	24.70
South Holland	128	3758	34.06
Welland	112	4639	24.14
NHS Lincolsnhire	1540	40921	37.63

Sources: Exeter GP Registrations, Hospital CMDS via SUS

However, there are also strong associations between high under-18 conception rates and; low educational attainment, low aspirations, poor attendance at school, being in public care, the daughter of a teenage mother, having mental health problems, sexually abused and being involved in crime. Teenage pregnancy is, therefore, a key health inequality and social exclusion issue. In Lincolnshire, there has been good progress made in reducing under-18 conception rates with a 20% reduction between 1998 and 2008; this compares favourably with the overall national reduction of 13%. In Lincolnshire the highest under 18 conception rates are found within areas of Skegness, Lincoln, East Lindsey and Boston. The Lincolnshire

Teenage Pregnancy Strategy focuses both on high rate areas and high-risk groups. While the negative consequences of teenage pregnancy are felt most by young women and their children, the Lincolnshire Strategy also has a strong focus on working with boys, young men and young fathers. Healthy Schools, School Nurses and Sexual Health Services all work closely with other agencies to ensure information and services are available to the most vulnerable groups, maximising the impact these services have on health inequalities in children.

COMMUNITY BUDGETS / FAMILIES WORKING TOGETHER

Families with complex needs can be the subject of multiple problems. Examples of these problems may include alcohol and drug misuse, mental health problems, crime and anti-social behaviour, poor parenting, child protection issues, homelessness or tenancy issues, debt, unemployment, school absence and exclusion or domestic violence. The problems faced by individuals within the family unit are often interdependent. Whilst individual agencies may provide specific packages of support for individuals within the family, a new approach is required that addresses the complex needs of the family not just the individuals within in it.

Utilising pooled budgets and aligned resources allows traditional barriers to partnership working to be overcome allowing more efficient, economic and effective use of resources. A community budget approach offers the opportunity in a step change in integrated working that will deliver improved outcomes for the family, improved social cohesion and positive financial returns on investment. Developing an integrated and holistic approach to family intervention and support will tackle the route causes of escalating problems. It will break negative problem interdependencies and the escalation of generational issues. The project will build family resilience and strengthen communities.

BULLYING

The Multi Agency Anti Bullying Working Group meets regularly and is attended by a wide range of partners with positive progress being made and reported back to the Anti Bullying Partnership Steering Group. A successful and fully co-ordinated Anti Bullying Week campaign provided a much higher profile than in previous years and this has enabled a strong, positive and consistent Anti Bullying message to be shared with over 3000 pupils in 52 schools, with free resources being issued to all schools and a range of related activities provided for children and young people across the county. Much of the work with Children and Young People is carried out in schools and colleges throughout the county and is targeting improving awareness of bullying, developing coping strategies, improving self esteem and celebrating difference. Our latest data shows that in Lincolnshire Primary schools 21.5% of pupils say they have been bullied compared to 22.1% nationally and in Secondary schools 12.3% of pupils say they have been bullied compared to 11.3% nationally. We are always striving to reduce all forms of bullying in Lincolnshire and consult regularly with Children and Young People to discuss and evaluate current strategies.

POVERTY

THE CHILD PVERTY ACT (2010) AND LINCOLNSHIRE CHILD POVERTY STRATEGY

The Child Poverty Act aims to end child poverty by 2020. This legislation compels organisations at local and national levels to take positive action to achieve this. Deprivation and poverty are persistent problems within areas of Lincolnshire. The Lincolnshire Child Poverty Strategy is currently being written in partnership with all agencies involved with both the causes and outcomes of poverty. These include; local authority education, housing, children's and adult social services, job centre plus, police, probation and youth offending teams, health services, voluntary and third sector organisations, local people along with children and young people. The priority outcomes are; Maximising Family Income and Narrowing the gap in health and education outcomes between the most disadvantaged and affluent in Lincolnshire. The children living in greatest poverty in Lincolnshire are concentrated in the Skegness coast and Lincoln City areas.

This strategy will address both the consequences and causes of poverty and will directly address the root causes of children's health inequalities at a strategic and operational level. It will work across the broad range of factors we know impact on and exacerbate deprivation and the associated health outcomes.

Lincolnshire's Child Poverty Strategy is governed by the Lincolnshire Shadow Health and Wellbeing Board.

Table 1.2 shows areas with higher deprivation levels, such as Skegness and Coast also consistently exhibit higher numbers of their population accessing benefits, experiencing higher crime rates and achieving lower school level qualifications. This is an example of the 'layering effect' deprivatic

Clinical Commissioning Group	% of Children on Role for Free School Meal Eligibility (Jan 2011)	Police recorded Crime rate/1000 Cluster Population	% of Pupils achieving >5 GCSE at Grade C or above (Inc Maths & English) (2009/10)	% of GP Cluster Population Claiming Job Seekers Allowance (Aug 2011)	Average Index of Multiple Deprivation Score
Boston	4.6	76.92	28.5	3.48	23.4
East Lindsey	11.4	46.49	59.1	2.62	17.7
Lincolnshire Southwest	10.8	79.29	61.1	2.73	14.6
Lincolnshire West	9.4	71.72	58.4	3.75	19.8
Skegness & Coast	14	89.92	52.7	3.05	33.3
South Holland	10.1	42.4	54.2	2.93	17.14
Welland	10.6	59.12	56	2.23	9.4
Lincolnshire	10	67.5	54.5	3.8	19

Average IMD: 2010

Based on the latest National data available for the National Indicator NI 116 - Percentage of children living in poverty there were 22,730 children living in poverty in Lincolnshire which equated to 15.9% of the 2008 corresponding child population. This compares to an all England rate of 20.9%. The number of children living in poverty in Lincolnshire decreased from the previous year 2007 by 295 and from 16.2% of total child population.

However the proportion of children living in poverty, in some pockets of Lincolnshire, reach levels as high as 40.7%.

Deprivation strongly influences children's health outcomes throughout all aspects of their development. Poor maternal health and lifestyle choices, premature labour, low birth weight and social/physical developmental problems are strongly associated with higher levels of poverty and poor health outcomes. Successful early emotional, physical and social developments are essential to enhance a child's future ability to form positive relationships, improve their educational attainment and achieve good health. Research shows, if children fall behind in these aspects of development during their first year they will continue to do so throughout the rest of their school education.

Deprivation also negatively impacts on a child's health through: their parents' age, level of education, whether they are unemployed and in good health, the environment they live in, housing quality, choice of nursery / schools, opportunities for social interaction and the quality of services accessed such as transport, leisure, libraries, shops, health and social care, etc. These broad social characteristics determine health outcomes by impacting directly, e.g. poor housing causing health problems, or indirectly, e.g. by making it impossible for children to study in cold damp rooms leading to poor educational attainment, reducing work choices and lowering future income, decreasing aspirations and self esteem.

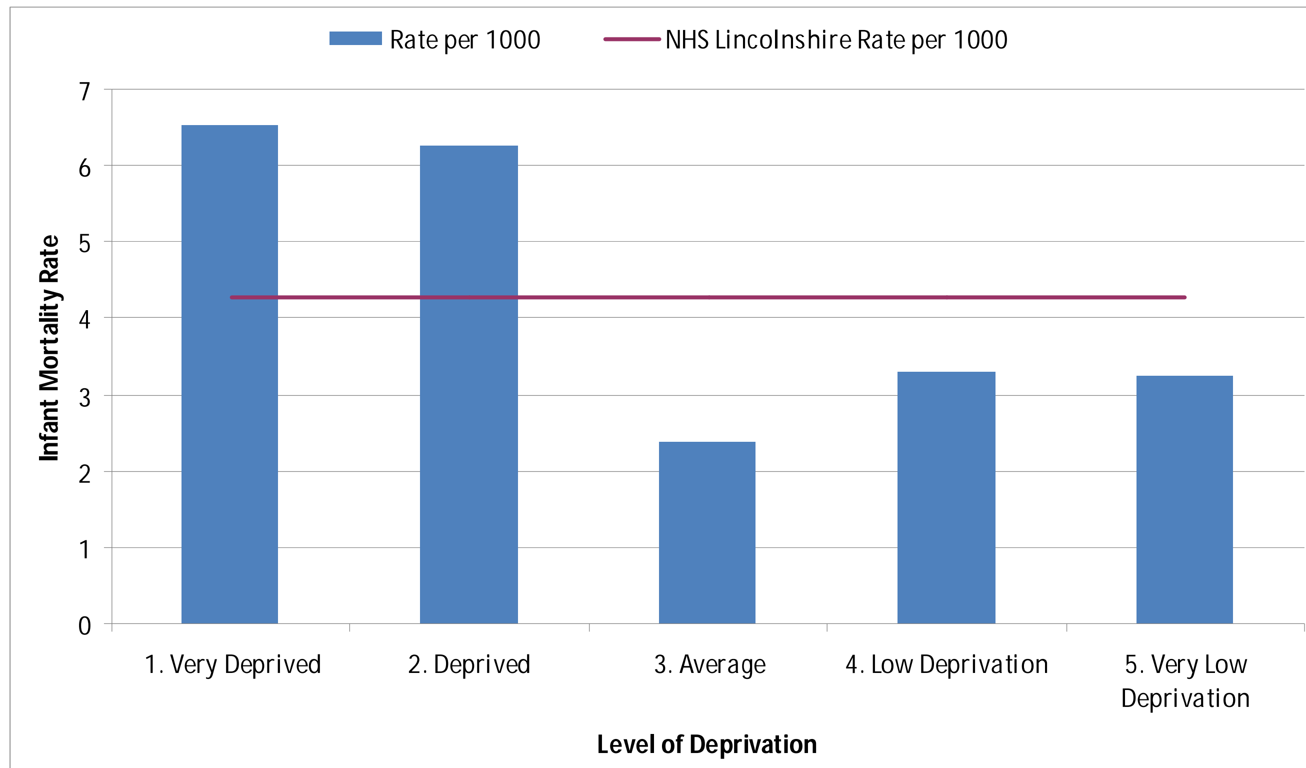
INFANT MORTALITY

Infant mortality is the term given to the number of babies who die before their first birthday. This is an important indicator of inequalities in health outcomes for children and society as a whole. A century ago the rates of children dying in early infancy were approximately 150 babies for every 1,000 births. This figure has dramatically reduced because of improved housing, welfare and access to universal health and social care. Nevertheless, although the overall infant mortality rate in England has fallen to just under five deaths per 1,000 births, there continues to be a gap in outcomes between the poorer and more affluent groups in society.

Infant mortality is closely associated with all aspects of health inequalities and deprivation. Housing quality and living environment, maternal lifestyle factors, infant feeding choice and access to services. These, in turn, are directly affected by the education level of the mother, her age, and her income. Crucially, there is no single method of tackling these wide-ranging causes. Babies born in the most deprived areas of England can be up to six times more likely to die than those from more affluent areas. This trend is also reflected in Lincolnshire, where infant mortality rates are greater within our more deprived populations (see Figure 1.1).

The reduction in the differences in health outcomes faced by deprived population compared to affluent populations remains a priority for the Government, NHS Lincolnshire and partners.

Figure 1.1
Infant Mortality Rate: Jan 2008 till Dec 2010



IMPROVING CHILDREN'S HEALTH AND SOCIAL OUTCOMES DURING PREGNANCY AND THE EARLY YEARS

Children's health outcomes are initially determined during their time in the womb and their early developmental years. Therefore, early access to maternity care is an important opportunity for healthcare professionals to interact and build relationships with women and families who, although in most need, would not otherwise access health services.

Early access allows midwives to monitor the pregnancy, the baby's growth and development and focus on the mother's health and well-being, including lifestyle factors such as diet, physical activity, smoking, drugs and alcohol. Information on benefits, housing, free vitamins available through the Healthy Start programme, along with support to breastfeed, are also vitally important at this stage to address the health inequalities experienced by children within our most vulnerable groups.

Across England approximately 16% of women delay booking into maternity care until after five months. This delay often results in 'worse' outcomes for both mother and baby. In Lincolnshire, around 90% of pregnant women book before the 12th week of pregnancy. However, information is continually being produced by our maternity units to encourage mothers to attend in early pregnancy and consultations undertaken to understand why some mothers choose not to attend until later.

In Lincolnshire we continually strive to improve children's health outcomes by offering support and information to mothers and their families during pregnancy and the child's early years. Some essential areas where we are currently influencing child health outcomes are;

Breastfeeding: There is a wealth of evidence which acknowledges breastfeeding has both short and long-term health benefits for mothers and babies. The World Health Organisation recommends that wherever possible infants should be fed exclusively on breast milk from birth until six months of age. Social inequalities in breastfeeding exist, where more affluent mothers are more likely to successfully breastfeed than mothers from deprived areas. Nevertheless, we must be aware that breastfeeding has a greater impact on the health outcomes of more vulnerable infants. Breastfeeding is a crucial element to help decrease inequalities in children's health, including lowering infant mortality rates, reducing preventable infections and unnecessary hospital admissions in infancy, halting the rise in obesity in under 11s and improving the general health and well-being of children and young people. Breastfeeding rates have been low in the UK for several generations and professionals, childbearing women, families and the general public have all been exposed to formula feeding as the norm. There are many social and psychological factors which may influence a woman's choice to breastfeed, e.g. maternal age, socio-economic status, marital status, and ethnicity along with peer, social and family pressures. The overall breastfeeding rates in Lincolnshire are between 39% to 40% of mothers continuing to breastfeed until their baby is six to eight weeks of age. In more deprived areas the rates are between 25% and 30%. In Lincolnshire, staff from a range of backgrounds, along with service users, are working together to improve breastfeeding rates through increased education for staff, support (including peer support) and information for

women. This work also includes raising the profile of breastfeeding in other areas, for example through the media, breastfeeding friendly restaurants or cafes and working with Local Authority planners.

Smoking: The time before a baby is born is often an excellent trigger point to offer support to mothers who smoke to stop during their pregnancy and beyond. Smoking during pregnancy is the single most modifiable risk factor influencing adverse health outcomes in children. Smoking during pregnancy can increase the risk of infant death by up to 40%. It also increases the risk of premature labour and is likely to cause growth restriction of the baby in the womb where the baby is starved of vital nutrients and loses weight. Low birth weight is closely associated with poor health outcomes in childhood and later in adult life. The numbers of people smoking within more disadvantaged communities is higher than affluent populations.

Smoking in pregnancy is also associated with the mother's age, level of education and whether her partner also smokes. Therefore, smoking in pregnancy is an important public health concern and a principal reason behind child health inequalities. Although only a small proportion of women continue to smoke during pregnancy these tend to be the heaviest and most addicted smokers who find it more difficult to stop. NHS Lincolnshire has committed significant resources to specialist stop smoking services for pregnant women since 2005 (Phoenix Stop Smoking Service). Every pregnant smoker in Lincolnshire is offered access to the Phoenix Programme. Since 2005 a total of 5,328 women have used the service, with 3,549 women successfully giving up cigarettes. An important aspect of stop smoking services for pregnant women is that if the quit attempt during pregnancy is not successful then women should continue to be advised to stop after their child is born.

Second Hand Smoke and the Smoke Free Homes: Children are more vulnerable to the health effects of cigarette smoke because they have higher oxygen demands, smaller airways and faster breathing rates. Small children receive a higher nicotine dose from smoke compared to adults and this can increase their risk of cot death, respiratory disorders (asthma, wheezing, chronic cough) and middle ear infections.

Lincolnshire Smoke Free Homes is a countywide initiative with 16,500 homes currently signed up to reduce the amount of cigarette smoke within rooms. The focus of this work is on the most vulnerable and deprived populations. This helps protect around 15,480 children from the effects of second hand smoke in their own homes within some of the most deprived areas in Lincolnshire. Discarded cigarettes are still the most common cause of house fires, therefore this risk is reduced for children whose families have signed up to the Smoke Free Homes promise.

SOCIAL, EMOTIONAL DEVELOPMENT AND MENTAL HEALTH WELLBEING

A child's social and emotional development and subsequent mental health outcomes have significant implications for current and later social functioning, educational and employment success. If emotional development is fostered at a young age, children are more likely to settle well into school, work co-operatively, confidently and independently. A child with poor social and emotional development is at risk of fostering 'worse' relationships with peers, academic problems, later involvement in crime, and developing physical health and adult mental-health problems. Some of the most challenging issues we face arise from young people's perception of not feeling engaged, respected, listened to or valued.

YOUNG PEOPLE NOT IN EDUCATION, EMPLOYMENT or TRAINING (NEET)

In Lincolnshire the percentage of 16 to 18 year olds who are not in education, employment or training based on an average of the figures for Nov 2010, Dec 2010 and Jan 2011 was 4.7%. The percentage of 16 to 18 year olds who were NEET decreased in 2010/11 from the 2009/10 position which was 4.8%.

Based on 2009/10 benchmarking data Lincolnshire were in the top quartile of National performance which started at a rate of 5.2%.

MINORITY GROUPS

There continues to be an increase in children from ethnic minority backgrounds most of whom have English as an additional language. As well as children moving to Lincolnshire, children born to parents of migrant communities are entering pre-schools and schools often fluent in their first language but with limited English. Language is one of the barriers to accessing services, however, others such as limited understanding of systems and lack of engagement has an impact on positive outcomes. There is an increase in the number of ethnic minority and Traveller families that are economically disadvantaged which can impact on the outcomes they achieve. Although there is evidence of an increase in access to children's services for these minority groups, they are still under represented. Achievement for Traveller children has improved but still remains low. The recently formed EMC Service supports ethnic minority and Traveller children to access education and children's services. It also acts as a voice for these groups ensuring provision and services reflect the needs of Lincolnshire's diverse communities.

CHILDHOOD OBESITY

The percentage of obese children measured in Reception and Year 6 in 2009/10 have increased from 2008/09 by around 1%: 9.9% to 10.8% in Reception and (18.5% to 19.5%) in Year 6. The England percentage has stabilised at 9.8% for Reception and 18.7% for Year 6. In Lincolnshire, the numbers of overweight children in both years have stayed the same with only a small drop observed in year 6. The numbers of children recorded as having a healthy weight for their height has reduced by 1% in reception year children and remained constant for year 6. The increase in obesity within Lincolnshire as a whole, between Reception and Year 6, is around 8%. However, there is considerable variation within different District Council areas; 5% in North Kesteven demonstrates the smallest increase and at 12% in South Holland is the greatest (closely followed by Boston). Similar results are demonstrated within GP Clinical Commissioning areas.

If we do nothing, the numbers of overweight and obese children will continue to increase year on year. This will have a negative health impact on individuals and this will be reflected on the health of the population as a whole. Obesity and sedentary lifestyles are closely linked with the increased risk of heart disease, high blood pressure, high cholesterol, type 2 diabetes, some cancers, joint problems, etc. These conditions not only shorten life expectancy; they impact negatively on the individual's quality of life and their ability to be economically active. If current and future cohorts of children continue to become overweight and obese very early in life they will potentially require substantial medical / social interventions and experience a significant reduction in their quality of life throughout adulthood.

We know that nationally there is a close relationship between deprivation and obesity. The picture in Lincolnshire is not so simple. The largest numbers of overweight children at ages 4/5 years of age are found within the most deprived populations. The numbers of overweight children measured in year 6 within this deprived group reduces significantly. More affluent groups all have lower numbers of overweight children in reception year, however only very affluent groups show a decrease in weight gain in year 6. There is a direct correlation between obesity levels and deprivation in Lincolnshire, where the most deprived groups have higher levels of obesity compared to more affluent groups.

There is little difference between males and females in reception year. However, the boys in Year 6 are more likely to be obese than girls.

Weight Management Intervention Pilot (for 4 to 7 year olds): The pilot sites will be based in our 3 worst areas: South Holland, Skegness and Coast and Gainsborough. This is being delivered by Health Visiting / School Nursing teams and supported by Home Start, Healthy Schools, Fit Kids, Food for Life, Play for Life. We plan to run flexible sessions in evenings and at weekends and will also include some home visits in our more deprived areas where we know family engagement is poor. This project will commence April 2012.

Healthy Schools: We are planning to make tackling obesity a mandatory area for every school. We are also planning for Healthy Schools to work closely with Food for Life to try to improve the food quality available in schools and encourage school meal uptake (including state funded free school meals).

Food for Life Partnership: We are in the process of commissioning Food for Life to work alongside Healthy Schools to provide the bedrock of our overall prevention strategy.

Maternal Obesity: This project will commence April 2012.

East Midlands Platform for Food, Physical Activity and Health: The Lincolnshire Childhood Obesity Partnership was accepted onto the Platform in Nov 2011. We hope that this will provide us with some excellent contacts for future and present projects.