

The School Years (5 to 19 Years)

1. Introduction

Between the ages of 5 years and 19 years old children will experience many transitions in all aspects of their lives, and their experiences will shape their future. Their start in life during the pre-birth and early years periods will influence how well they manage and cope with important transitions in their social lives, education and relationships during school years.

At age 5 children are still mostly dependent on their caregivers to provide their needs, but by age 19 young people are more independent in their choices and behaviours. Therefore the school years are important for the health and wellbeing of children young people in the short and long term.

During the primary school years (5 to 9 years old) education has an increasing influence in addition to their family and home life. Children also experience physical development, acquisition of cognitive skills and exploring environments, developing independence and experimenting with risk.

The behavioural patterns established during the early adolescent phase (10 to 14 years) help to determine young people's health status and their risk for developing chronic diseases in adulthood¹. Although early adolescence is generally a healthy time of life, several important public health and social problems either peak or start during these years.

Because adolescents are in developmental transition, early adolescents are particularly sensitive to environmental—that is, contextual or surrounding—influences². Environmental factors, including their family, peer group, school, neighbourhood, and societal cues, can either support or challenge young people's health and well-being³. Addressing the positive development of young people facilitates their adoption of healthy behaviours and helps to ensure a healthy and productive future adult population⁴.

Later adolescence (15 to 19 years) is another crucial period for children and young people as they start making important decisions in terms of their education, employment and relationships. They will also become increasingly responsible for their health behaviours and their lifestyles. All of these issues will have an impact upon their adult lives.

1 National Research Council and Institute of Medicine. Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention and Healthy Development. Adolescent health services: Missing opportunities. (2009). Lawrence, R.S., Gootman, J.A., Sim, L.J., editors. Washington: National Academies Press. Retrieved from: http://books.nap.edu/openbook.php?record_id=12063&page=1 On 2 December 2015.

2 Mulye, T.P., Park, M.J. & Nelson, C.D., et al. (2009). Trends in adolescent and young adult health in the United States. *Journal of Adolescent Health*.;45(1):8-24. Retrieved from: <http://download.journals.elsevierhealth.com/pdfs/journals/1054-139X/PIIS1054139X09001244.pdf>

3 National Research Council, Panel on High-Risk Youth, Commission on Behavioral and Social Sciences and Education. *Losing generations: Adolescents in high-risk settings*. (1993). Washington: National Academies Press. Retrieved from: http://www.nap.edu/openbook.php?record_id=2113&page=1 On 2 December 2015

4 Mc. Neely C. & Blanchard J. (2009). *The teen years explained: A guide to healthy adolescent development*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Adolescent Health; Retrieved from: <http://www.jhsph.edu/adolescenthealth> On 2 December 2015

The school years population in Leicester is larger and has higher need relative to its peer areas, the East Midlands and England. Overall, these young people experience a wide range of risk factors of poor health and well-being when compared to other areas and nationally. There has been improvement in the health and wellbeing of children and young people locally, but for many indicators gaps remain between Leicester and its peers, the East Midlands and England.

2. Who is at risk, and why

As well as risks that apply at earlier ages, there are specific factors that affect health outcomes for 5 to 19 year olds are:

Access to quality services: Timely access to appropriate care can affect the health and well-being of children and young people. This is particularly relevant for services such as dentists, GPs and school nurses and, during adolescence, services such as sexual health.

Educational achievement: Academic success and achievement are strong predictors of overall adult health outcomes. Proficient academic skills are associated with lower rates of risky behaviours and higher rates of healthy behaviours.^{5,6}

School environment: The school social environment affects students' attendance, academic achievement and behaviour. A safe and healthy school environment promotes student engagement and protects against risky behaviours and dropping out.⁷

Family socialisation: Children and young people who perceive that they have good communication and are bonded with an adult are less likely to engage in risky behaviours. Parents who provide supervision and are involved with their adolescents' activities are promoting a safe environment in which to explore opportunities.⁸

Media exposure: Adolescents who are exposed to media portrayals of violence, sexual content, smoking, and drinking are at risk for adopting these behaviours⁹.

3. Demographic Summary

3.1 Population profile

In 2015 there were an estimated 66,899 children aged 5 to 19 years old living in Leicester.

5 Sraabstein, J. & Piazza, T. (2008). Public health, safety and educational risks associated with bullying behaviours in American adolescents. *International Journal of Adolescent Medicine and Health*;20(2):223–233.

6 Public Health England (2014). The link between pupil health and wellbeing and attainment. A briefing for head teachers, governors and staff in education settings. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf on 2 December 2015

7 Public Health England (2014). The link between pupil health and wellbeing and attainment. A briefing for head teachers, governors and staff in education settings. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf on 2 December 2015

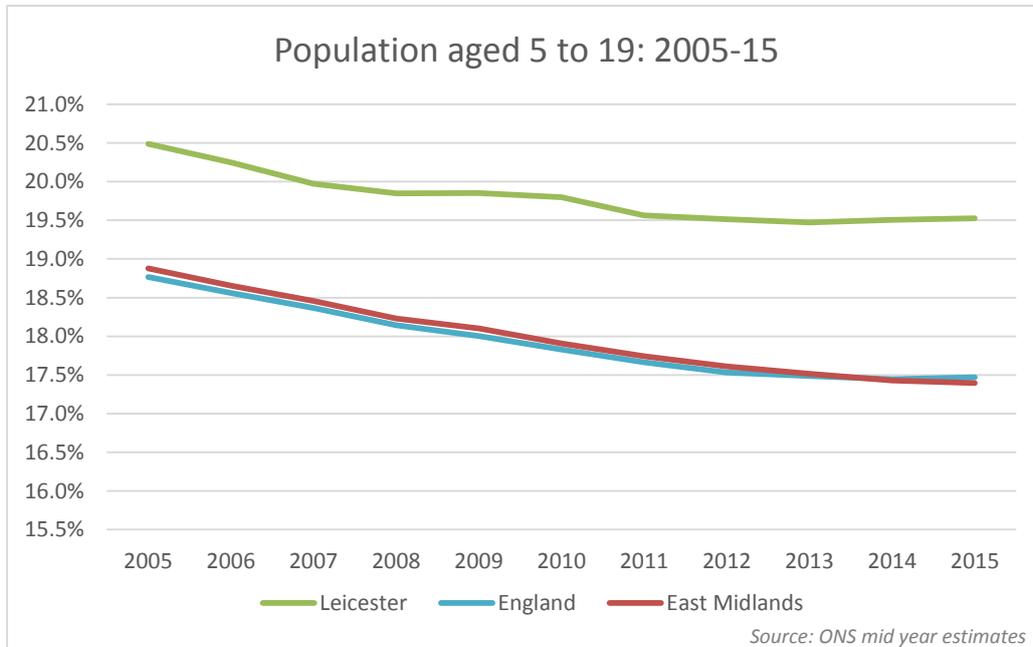
8 Roche, K. M., Ahmed, S. & Blum, R. W. (2008). Enduring consequences of parenting for risk behaviors from adolescence into early adulthood. *Social science & medicine*

9 Roberts DF, Henriksen L, Foehr UG. Adolescents and media. Chapter 16 in *Handbook of Adolescent Psychology* (pp 487-521), 2nd ed. Lerner RM, Steinberg L, editors. Hoboken, NJ: John Wiley & Sons, Inc.; 2004.

Leicester has more males (34,128, 51%) than females (32,771, 49%) in this age group.

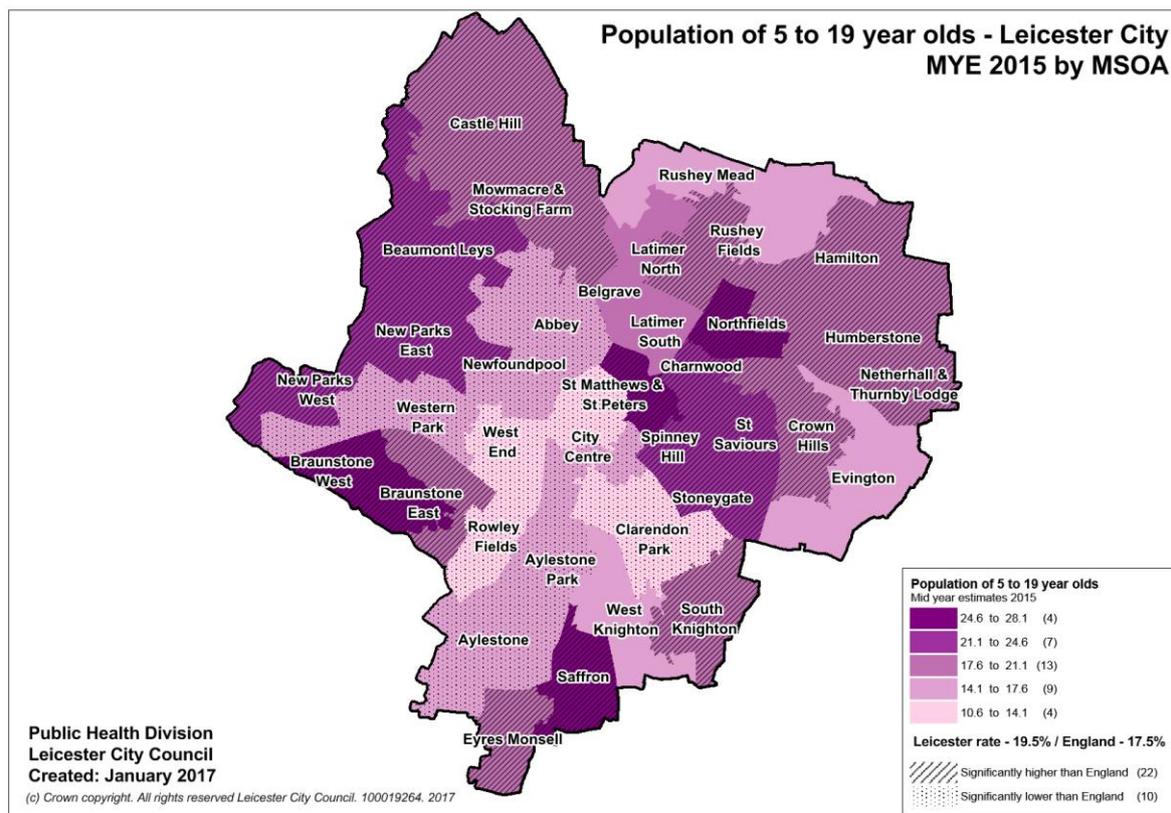
Figure 1 shows there was a decrease of 1% in the proportion of 5 to 19 year olds in Leicester from 2005 to 2015. England and the East Midlands show a similar decrease for this age group in the same time frame (1.3% and 1.5%, respectively).

Figure 1: Population trend (5-19 years old), 2005-15



The areas of Leicester with the largest proportion of children aged 5 to 19 years are primarily in the Northwest and Northeast parts of the city (Figure 2). The Central areas of Leicester have significantly smaller populations of 5 to 19 year olds compared to England.

Figure 2: Population of 10 to 14 years old by Leicester City MSOA, 2015



3.2 Ethnicity

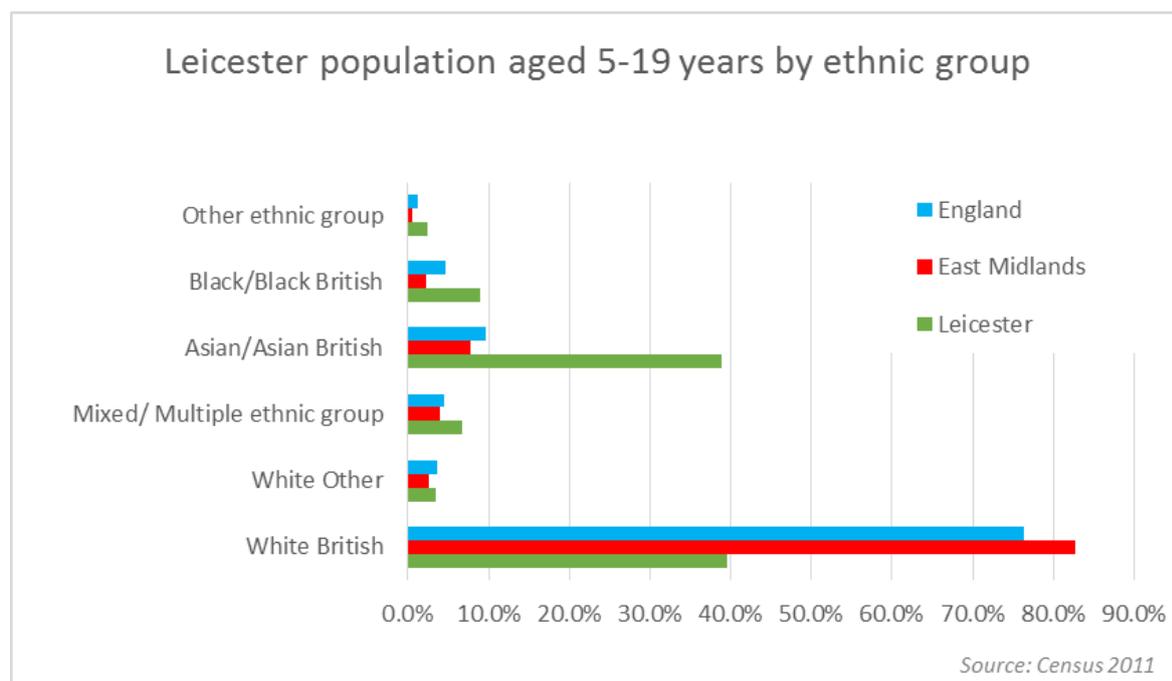
In Leicester, the ethnicities of children aged 5 to 19 years (as per census 2011) are as follows:

- 43% White¹⁰
- 39% Asian/Asian British
- 9% Black/ African/ Caribbean / Black British
- 7% Mixed/multiple ethnic group
- 2% Other ethnic group

Compared to the England and East Midland averages, Leicester has a smaller proportion of white children aged 5 to 19 years (Figure 3). For all other ethnic groups, Leicester has significantly more children in these groups compared to the England and East Midlands averages.

¹⁰ Includes 'White Other'.

Figure 3: Proportions of 5 to 19 year olds by Ethnic Group compared to England and East Midlands



4. The level of need in the population

4.1 Outcomes

4.1.1 Children with Long Term Illness or Disability

Chronic and long term illnesses and disability have a large impact on the health and wellbeing of children and young people. Care for such illnesses and disability may require regular visits to hospital, a requirement to adhere to all medical and pharmaceutical regimens, consideration of diet and what types of activities may be done. Illness and disability may limit the amount of time a child can attend school and build social relationships with peers; both of which are determinants of long term achievement and wellbeing.

Immediate and ongoing medical investigations may be invasive, uncomfortable or painful, with treatment regimens requiring medication, injections, blood measurements, brain or body scans. One in ten children will have a chronic illness that is severe enough to substantially limit their daily life and demand extended care and supervision (Yeo & Sawyer, 2005).

Long-term self-management behaviours for diabetes, asthma, epilepsy and other chronic conditions are largely initiated in adolescence. It is in early and mid-adolescence that individuals take over the management of their chronic conditions from their parents, and there is strong evidence that the self-management behaviours initiated in adolescence remain with them throughout life¹¹. Adolescence therefore provides an important window of opportunity to influence the trajectories of non-communicable diseases and physical health throughout later life.

¹¹ Sawyer S.M., Drew, S., Yeo, M.S. & Britto, M.T, (2007). Adolescents with a chronic condition: challenges living, challenges treating. *Lancet*; 369(9571): 1481–9.

4.1.1.1 Disability

It is difficult to estimate accurately the number of children with a disability. Official datasets only capture children whose disability meets the agreed criteria for extra funding and support (e.g. Disability Living Allowance). Children under 5 will not normally receive DLA because their needs may not be significantly outside the range of 'normal' compared to other children in this age group.

The 2011 Census, which relied on parental reporting, estimated there were 4,500 children aged 5 to 9 years old in Leicester with a disability. In the same year the Department for Work and Pensions reported 980 children in the age group were in receipt of Disability Living Allowance. This demonstrates that the perceived need of parents is frequently greater than those who meet the DLA thresholds for support.

The latest DLA data (May 2016) is broken down into individuals under age 16 and those 16 to 24 years old. There were 2310 children under 16 in receipt of DLA, and 640 young people aged 16 to 24 years old receiving DLA.

4.1.1.2 Diabetes

Type 1 diabetes and many other auto-immune conditions have their peak incidence in early adolescence¹². The National Paediatric Diabetes Audit showed that 70% of the childhood diabetes population is aged 12–19, and the great majority of emergency hospital admissions nationally for diabetes are in this age group¹³.

Diabetics may suffer from long term poor mental health. This is due to the overwhelming burden of their illness on their lives. Some feel like a burden, misunderstood, lonely and frustrated. Poor mental health in the school years is linked to poor achievement and lifelong wages. Over the course of their lives they may experience problems with their eye sight, circulation, and kidneys. Their life expectancy may also be cut short.

The NCMP data shows obesity is a concern for Leicester's children. The dietary and physical activity habits of children influence their weight in adulthood. Because obesity is linked to the increase in Type 2 diabetes, an increase in Type 2 diabetes for both young people and adults is expected in Leicester over the next 5 years.

Markers of diabetes control such as the HbA1c (glycated haemoglobin) level are worse in adolescence than in childhood or adulthood in type 1 diabetes¹⁴. Given poorer outcomes for diabetes in Britain than in other European countries, this places British adolescents at the bottom of the outcome leagues.

Currently the data for the 5 to 19 years age group are unavailable.

12 Patton GC, Viner R. Pubertal transitions in health. *Lancet* 2007; 369(9567): 1130–9.

13 National Paediatric Diabetes Audit Report 2010-11. London: Royal College of Paediatrics and Child Health & HQIP (Healthcare Quality Improvement Partnership) UK, 2012.

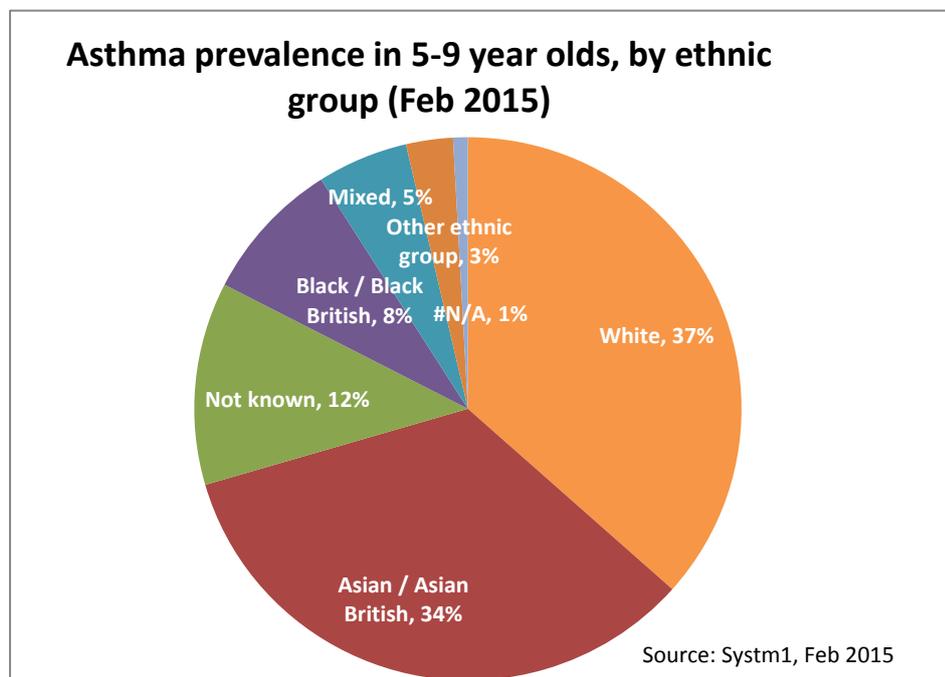
14 National Paediatric Diabetes Audit Report 2010-11. London: Royal College of Paediatrics and Child Health & HQIP (Healthcare Quality Improvement Partnership) UK, 2012.

4.1.1.3 Asthma

Asthma is the most common symptomatic long term condition in children. It can start at any age, but it is most common between ages 5 and 15. It is a respiratory condition¹⁵, which can cause breathlessness, tightness in the chest, coughing and wheezing. For most children asthma can be controlled, but at present there is no cure. Like diabetics, asthmatics may suffer from long term poor mental health which ultimately impacts their overall health and wellbeing, school performance,

In Leicester, 8% (n=1,731) of 5 to 9 year olds have been diagnosed with asthma. Prevalence is higher in males. Figure 4 shows that children in the Asian/Asian British (34%) and White (37%) ethnic groups in Leicester contribution a larger proportion of asthma cases in comparison to other ethnic groups.

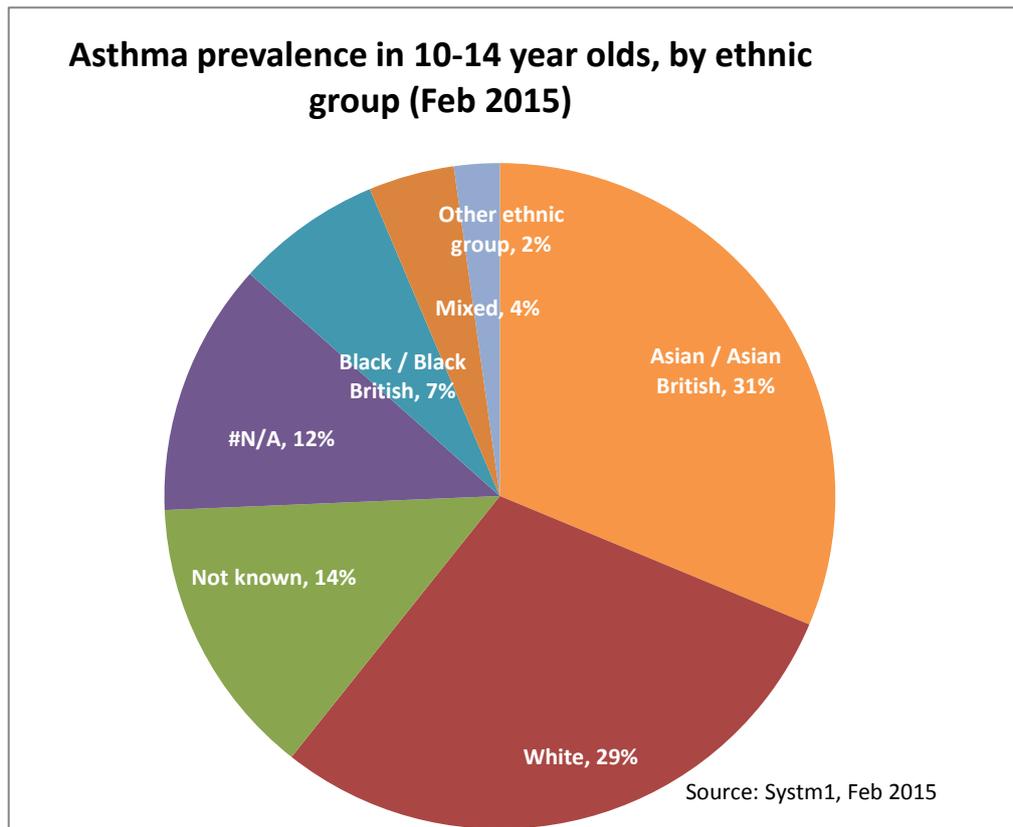
Figure 4: Ethnicity of 5 to 9 year olds in Leicester with Asthma, February 2015



Asthma is most common between 5-15 years old. The prevalence then declines until 55-64 years, when it starts to rise again. In Leicester, 12% (n=2,415) of 10 to 14 year olds have been diagnosed with asthma. The majority of these (61%) are male. Figure 5 shows Asian/Asian British children in this age group constitute 31% of those with asthma while 30% of 10 to 14 years old in Leicester are White (Source: system1).

¹⁵ British Thoracic Society (2008). BTS guidelines: British Guideline on the Management of Asthma 63:iv1-iv121 accessed from <https://www.brit-thoracic.org.uk/document-library/clinical-information/asthma/btssign-guideline-on-the-management-of-asthma/> on 5 January 2016

Figure 5: Ethnicity of 10 to 14 year olds in Leicester with Asthma, February 2015



4.1.2 Healthy weight and eating

Poor diet is responsible for over half of all coronary heart disease and also contributes to stroke, hypertension, obesity, diabetes and some cancers. It is estimated that 70,000 premature deaths in the UK could be avoided each year if UK diets matched nutritional guidelines. Healthy eating and being physically active are particularly important for children and adolescents. This is because their nutrition and lifestyle at this age influence their wellbeing, growth and development for the rest of their lives.

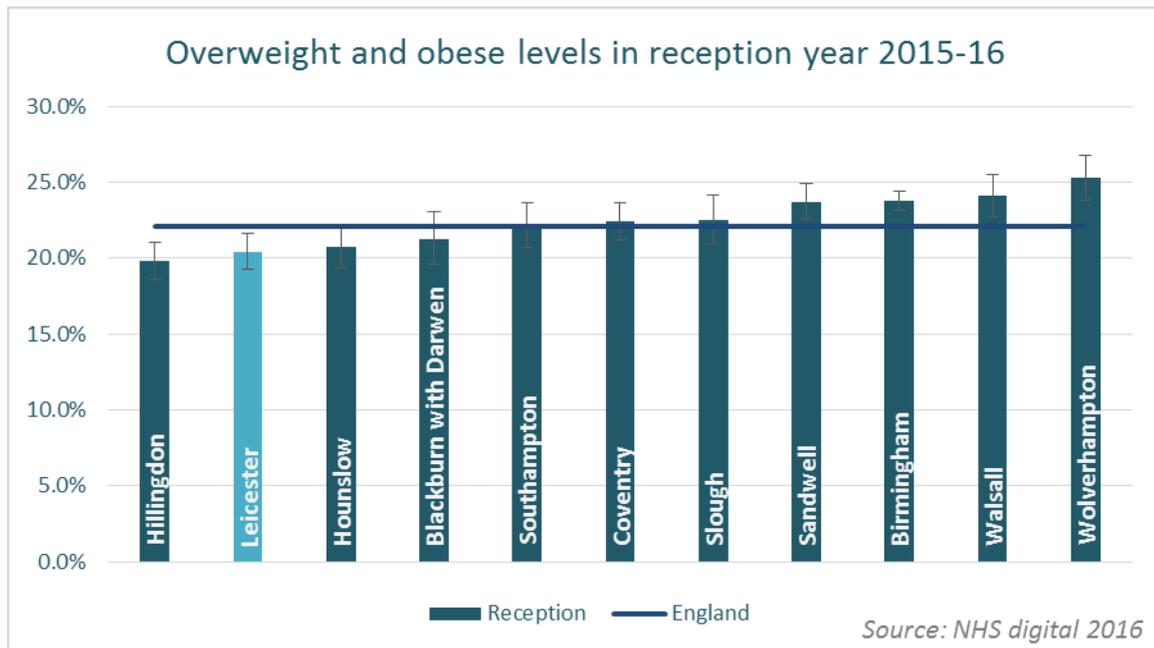
4.1.2.1 National Child Measurement Programme

The National Child Measurement Programme (NCMP) is a surveillance programme, introduced by the Department of Health in 2006 to measure obesity levels in the population. School nurses measure the height and weight of all children in reception (aged 4-5) and year 6 (aged 10-11) annually. Using these measurements the child's BMI (Body Mass Index) is calculated. The BMI provides a measure of the proportion of children who are overweight, obese or underweight in these year groups.

Obesity and overweight in Reception

The proportion of Leicester's Reception Year pupils who are obese and overweight (20.4%) is statistically lower compared to England (22.1%). Compared to its peer comparators, Leicester has a similar or smaller proportion of obesity and overweight in Reception pupils (Figure 6).

Figure 6: Prevalence of overweight and obese (combined) children in reception year, 2015/16

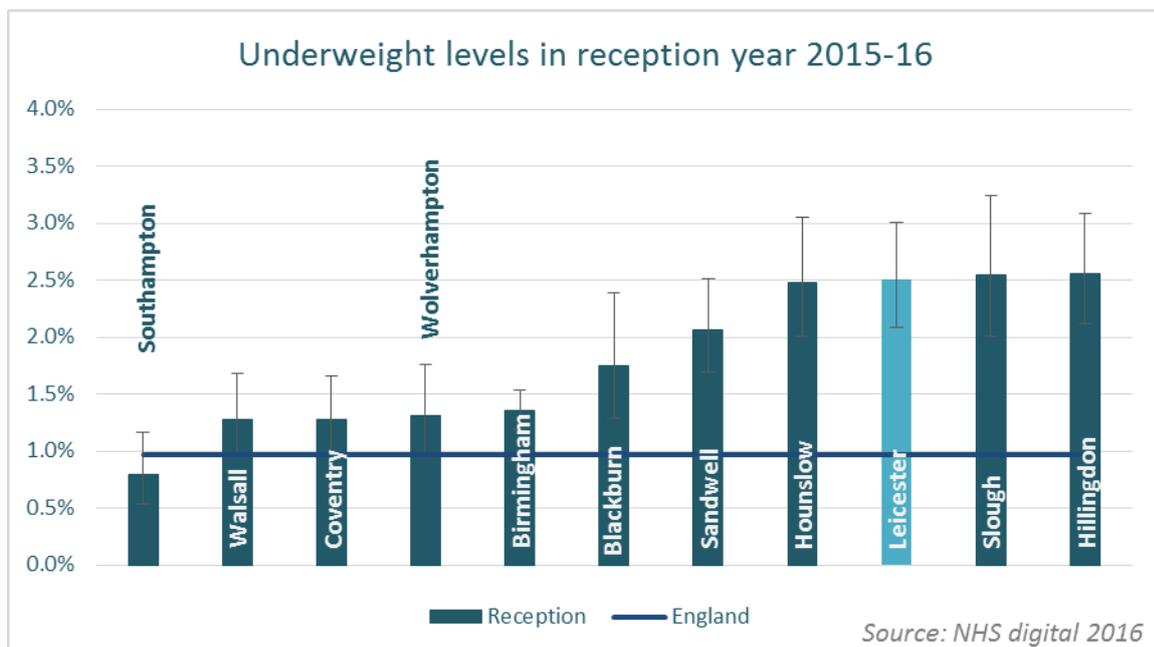


Underweight in Reception

In addition to whether or not children are overweight or obese, the NCMP measures if children are underweight. There are a variety of factors that influence whether or not a child is underweight. Some of the factors include: poor diet, malabsorption due to illness, ethnicity and neglect.

The proportion of Leicester’s Reception Year pupils who are underweight (2.5%) is statistically higher compared to England (1.0%). Compared to all but five of its peer comparators, Leicester has a statistically higher proportion of underweight reception pupils (Figure 7).

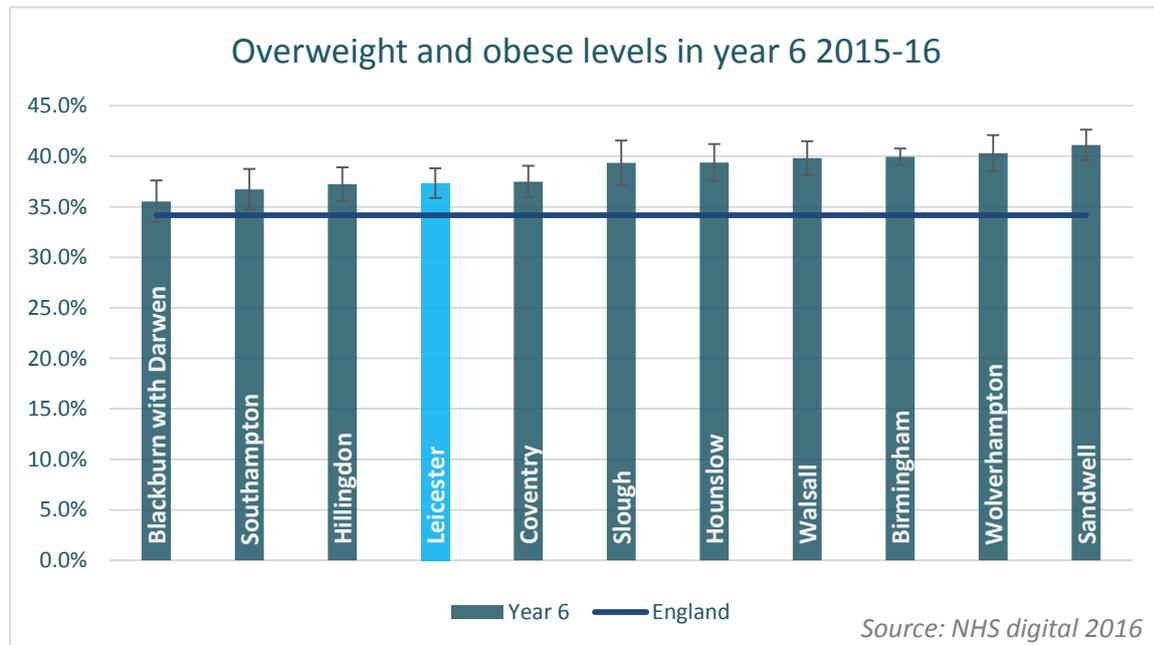
Figure 7: Underweight Levels in Reception Year, 2015/16



Obesity and overweight in Year 6

The proportion of Leicester's Year 6 pupils who are obese and overweight (37.3%) is statistically higher compared to England (34.2%). Compared to its peer comparators, Leicester has a similar proportion of obesity and overweight (Figure 8).

Figure 8: Overweight and Obese Levels in Year 6, 2015/16

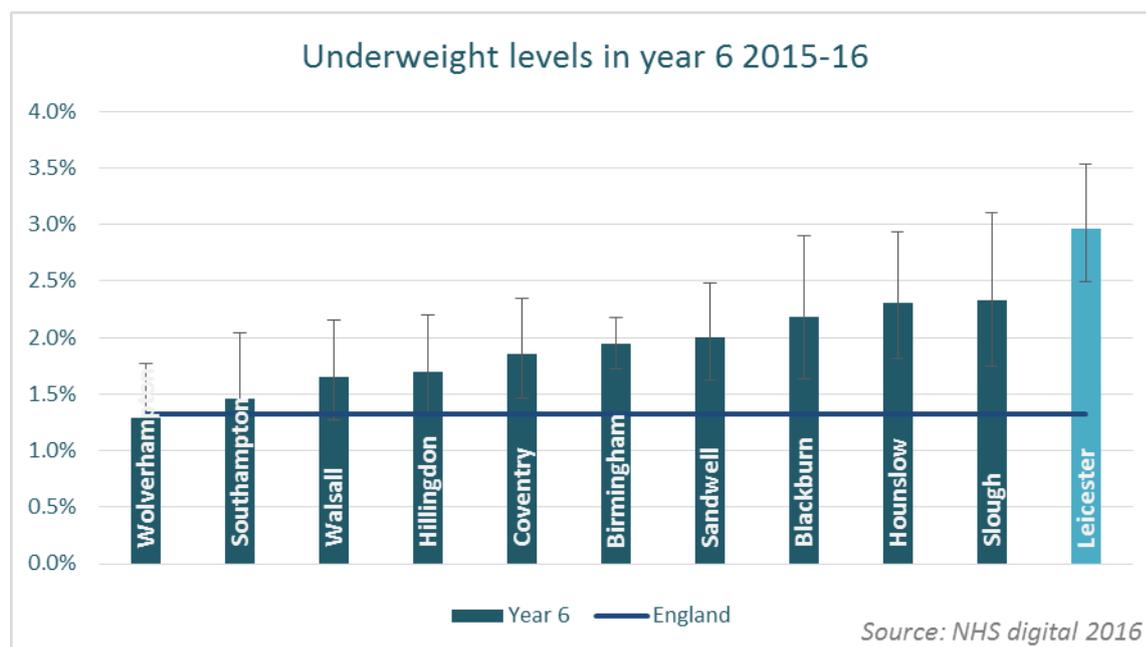


Underweight in Year 6

In addition to whether or not children are overweight or obese, the NCMP measures if children are underweight. There are a variety of factors that influence whether or not a child is underweight. Some of the factors include: poor diet, malabsorption due to illness, ethnicity and neglect.

The proportion of Leicester's Year 6 pupils who are underweight (3.0%) is statistically higher compared to England (1.3%). Compared to all but three of its peer comparators, Leicester has a statistically higher proportion of underweight Year 6 pupils (Figure 9).

Figure 9: Underweight Levels in Year 6, 2015/16



4.1.3 Oral Health

Dental decay for children in Leicester is significantly higher than the average for England. In addition to the risk of dental diseases for the general population of children, children taken into the care system are at an increased risk of poor dental health.

Long-term dental disease can result in severe acute and chronic infection. For young children whose milk teeth are affected, dental disease may also cause damage and consequential loss to the underlying permanent teeth. Additionally, older children with dental disease are also at risk of losing their permanent/adult teeth due to extensive dental decay. Treatment of extensive symptomatic disease, both with and without general anaesthesia, may distress the child and does in itself have the risk of morbidity and mortality¹⁶

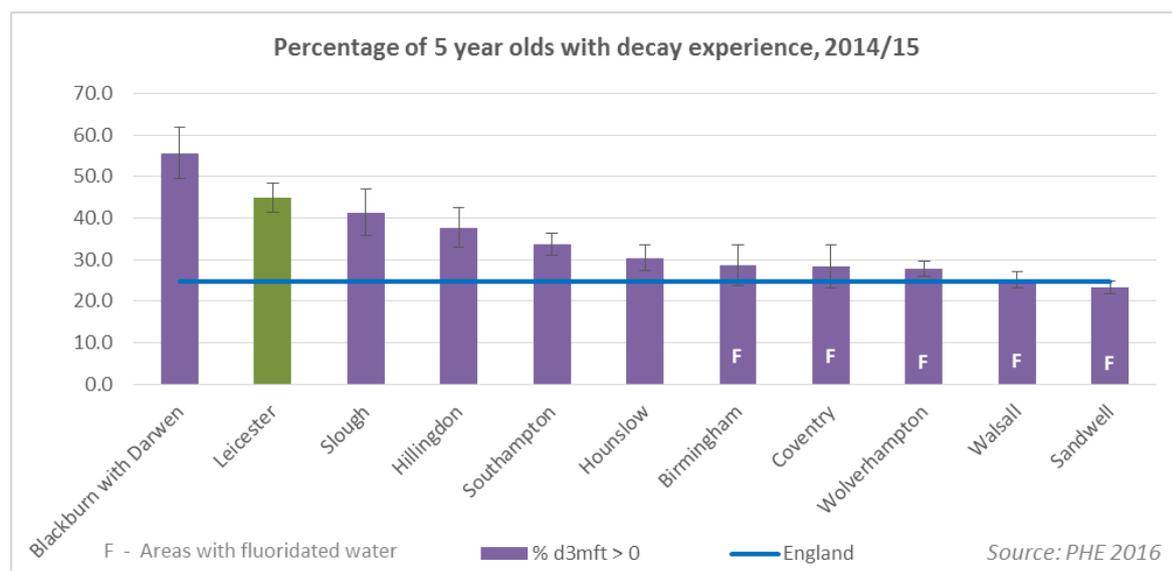
4.1.3.1 Tooth Decay

Dental caries (tooth decay) can occur at any age but can occur more frequently in earlier years of life particularly in lower socio-economic groups. Tooth decay affects physical and psychological wellbeing and quality of life; it can result in days off school or work due to the pain.

In Leicester, 48.4% of five year olds had experience of dental decay in 2014/15 (Figure 10). This proportion of decay is higher than the England average.

¹⁶ Flick RP, Katusic SK, et al (2011) Cognitive and behavioural outcomes after early exposure to anesthesia and surgery. *Pediatrics* 128(5): e1053-61.

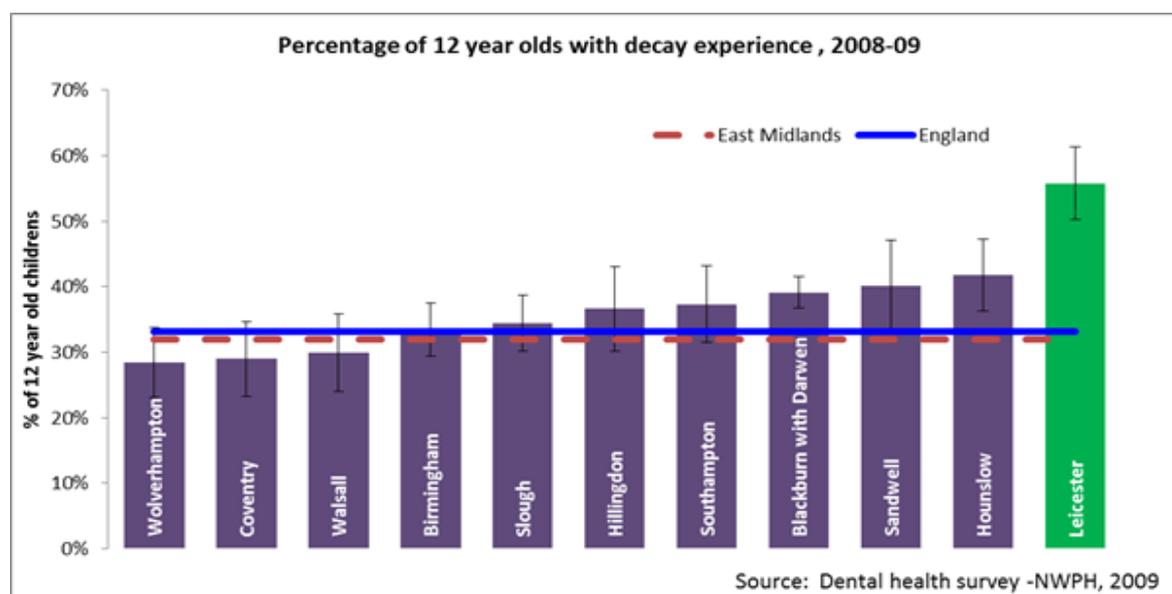
Figure 10: Percentage of children aged 5 years old experienced tooth decay in 2014/15



By age 12, children in Leicester have the highest burden of dental disease when compared against similar local authorities (Figure 11). The proportion of Leicester’s 12 year olds with dental decay experience (having one or more teeth decayed, missing or filled) is 55.7%. It should be noted that children living in Birmingham, Wolverhampton, Coventry, and Walsall all benefit from water fluoridation with much reduced levels of dental decay experience¹⁷.

These are the latest available data due to the survey cycle for oral health.

Figure 11: Proportion of 12 year olds with decay experience, 2008-09¹⁸



¹⁷ Leicester does not have an artificially fluoridated water supply.

¹⁸ Due to the survey cycle, this is the latest available local data for 12 year olds.

4.1.3.2 Fluoride Varnish

Fluoride varnish (FV) is a treatment which may be used to prevent tooth decay. It is a key public health intervention. 42,000 Leicester children aged 6 to 12 years had FV treatment in 2015. This equates to 18.4% which is significantly lower than the England figure of 38%. Children living in southern ward areas had higher FV treatment rates.

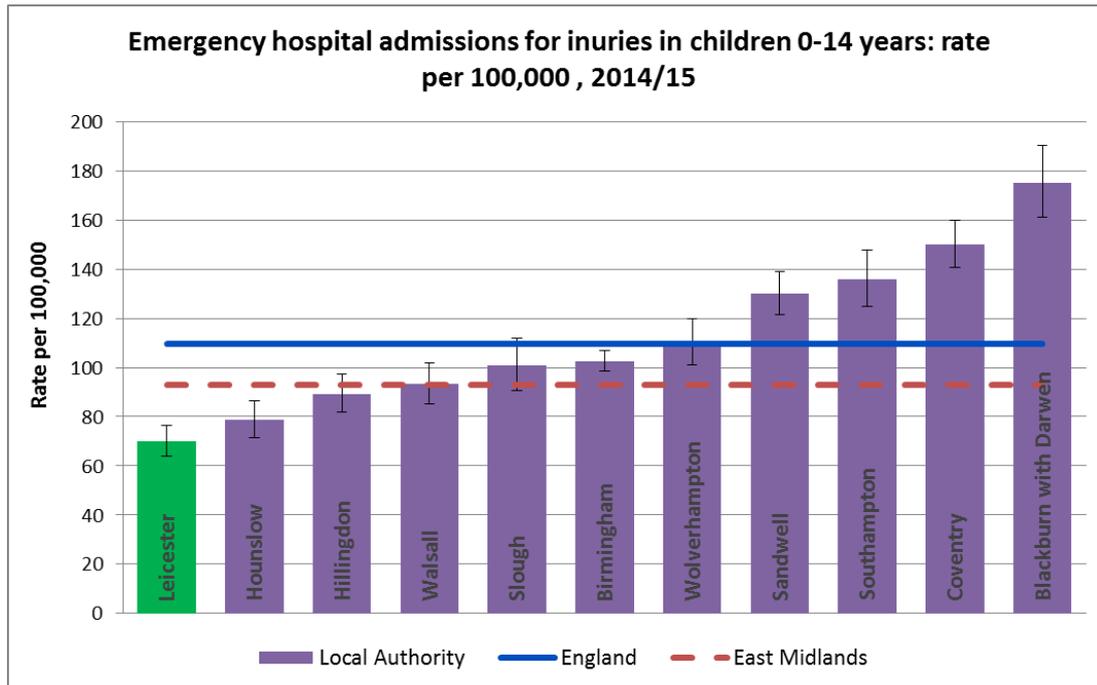
4.1.4 Unintentional and deliberate injuries

Rates of childhood injury (both unintentional and intentional) are higher among socioeconomically disadvantaged families. Based on the data below, Leicester does not fit this trend. However, it is not possible to breakdown the below data based on deprivation. There may also be factors such as a lower local threshold at which families take a child to the emergency department or the injuries may be less severe.

Income-related family factors often cited to explain differences in injuries between the least and most deprived include family functioning, family structure, parenting practices, maternal age, health and educational attainment. Families under stress due to chronic deprivation may contribute to greater risk of injury through lack of supervision and poor mental health. Inequities in injuries may also be attributed to differences in exposure to risk. There are also a number of potential neighbourhood influences, including substandard housing that lacks proper safety features, crime, violence, as well as unsuitability of the built environment for safe activities of young children.

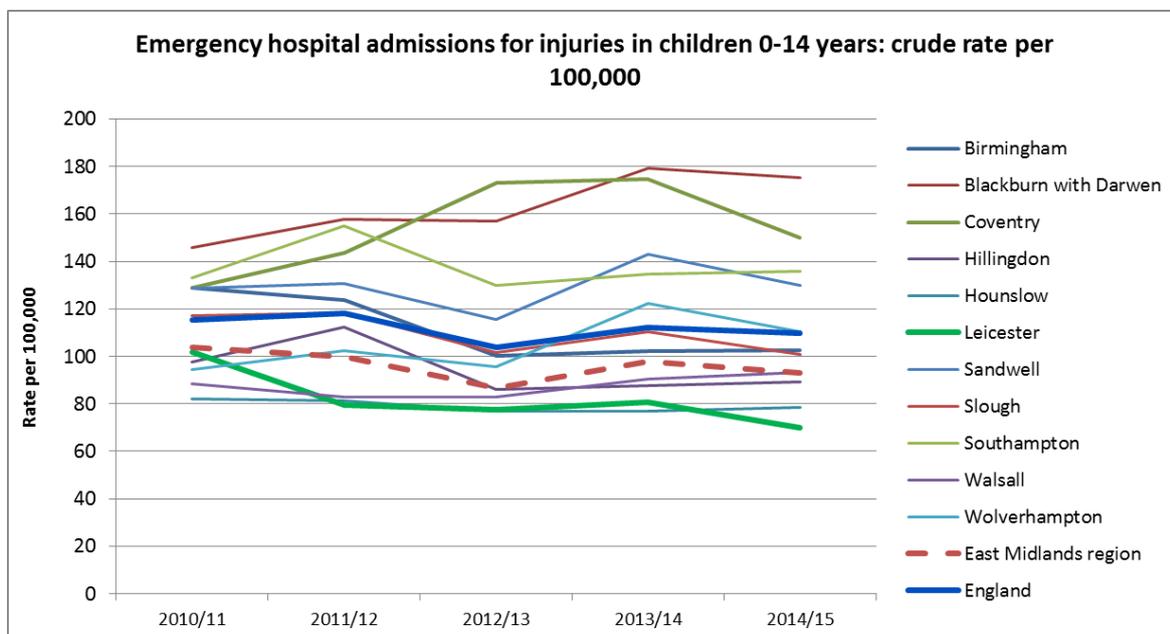
Hospital admissions caused by unintentional and deliberate injuries in the 0-14 year age group is an indicator in the Public Health Outcomes Framework for England, 2013 – 2016. Compared to its peer comparators, Leicester had a lower rate of emergency hospital admissions for injuries per 100,000 children aged 0 to 14 in 2014/15. The rate in Leicester was 70 per 100,000 compared to the England average of 109.6 per 100,000.

Figure 12: Emergency Hospital Admissions for Injuries, 2014/15



There is a decreasing trend in the rate of hospital admissions for children aged 0 to 14 years olds caused by unintentional and deliberate injury in Leicester. Between 2010 and 2015, Leicester’s rate reduced from 101.6 per 100,000 to 70.0 per 100,000. Many of Leicester’s peer comparators have either remained roughly the same or increased over the same time period.

Figure 13: Emergency hospital admissions for injuries, Trend 2010/11 to 2014/15



4.2 Determinants of health

Within this age group, in addition to the socio-economic factors that apply across all ages, there are a number of additional influences:

4.2.1 Immunisations

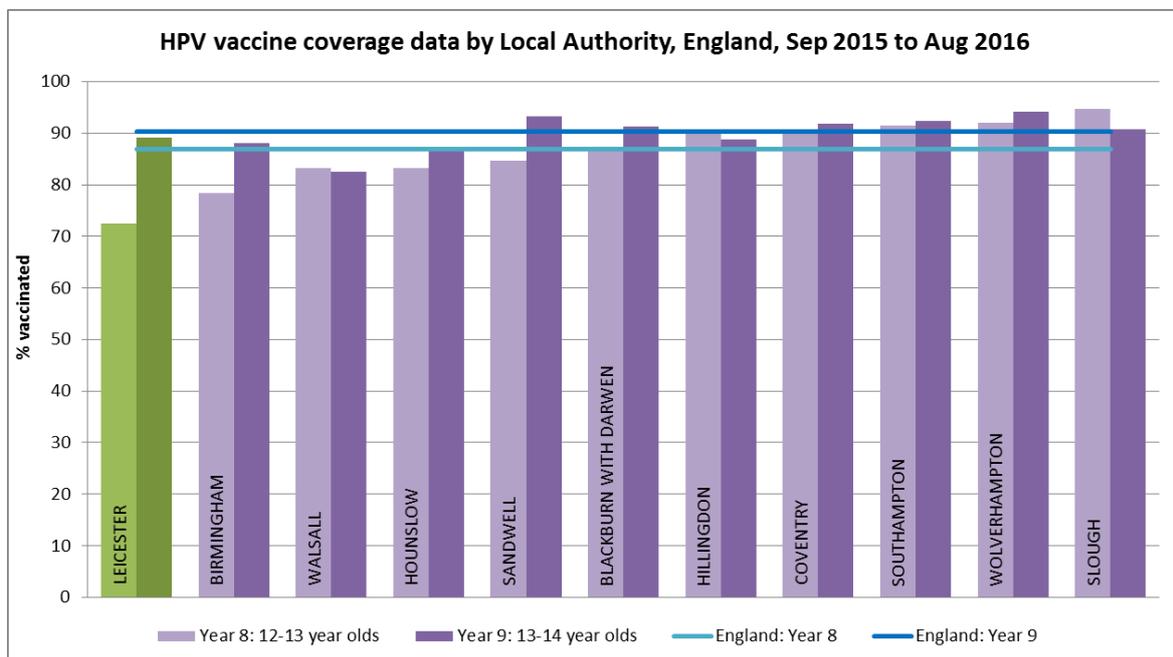
Much of the routine childhood immunisation programme is completed by age 5, but there are a number of important programmes that target adolescents:

4.2.1.1 HPV Vaccine

Human Papillomavirus (HPV) is known to be associated with an increased risk of cervical cancer. The national campaign to vaccinate girls aged 12 to 13 years was rolled out in 2008. Locally a vaccination team is responsible for delivering the vaccines, and this team is supported by the school nursing team. Leicester has achieved an uptake for 2015/16 of 72.5% in Year 8 girls and 89.1% of Year 9 girls.

Leicester has only achieved over the 90% target for one of the last five years (2012/13). However, Leicester's HPV vaccine uptake is similar to the uptake in comparator local authorities in Year 9 (Figure 14). Leicester's uptake in Year 9 is also similar to the England average, but uptake for Year 8 is low.

Figure 14: HPV Vaccine Uptake for Year 8 and 9 Girls: 2015/16



4.2.1.2 Td/IPV (Tetanus, Diphtheria, and Polio) Booster

As part of the national vaccination schedule, children aged 13 to 18 years are entitled to receive the Td/IPV booster. It is recommended that the booster is received around age 14 years, and this can be obtained from the child's General Practitioner (GP). This vaccination is a single injection into the upper arm that protects children against three separate diseases: tetanus, diphtheria and polio.

Table1 shows that of the 62 GP practices in Leicester, only 37% achieved the target of 90% of all eligible children receiving the booster. Almost 30% of Leicester’s GP practices achieved less than 80% uptake.

The data below are the latest available due to data collection for this vaccine being suspended nationally.

NHS England has implemented new data reporting mechanisms through school nurses for 2016/17. Therefore data should be available later in 2017.

Table 1: Td/IPV Booster Uptake in Leicester, 2013-14

Immunisation	Target	Number of practices achieving target	Number achieving 85-89.9 %	Number under 80 %
Td/IPV Booster 13-18 yrs	90%	23	21	18

4.2.1.3 Meningitis C and Meningitis W

Children in England are eligible to receive the MenACWY vaccine around the age of 14 years, but it is particularly important for children aged 17 to 18 years and those attending university. Recently there has been an increase in Meningitis W cases. A single injection is given into the upper arm to protect the child against meningitis C and meningitis W. This vaccine is available from the child’s GP.

Currently there are no data available nationally on the uptake of this vaccine.

4.2.2 Education

Pupils with better health and wellbeing are likely to achieve better academically.¹⁹ Effective social and emotional competencies are associated with greater health and wellbeing, and better achievement. Education is a key determinant for lifelong wellbeing, and continues to be important in this age group as they prepare to transition from primary to secondary to post-education.

School education in England is categorised into the Foundation Years followed by Key Stages (KS) 1 to 5. Expected attainment is assessed during each Key Stage. KS1 is relevant to this age group; it covers Years 1 and 2 and tests reading, writing and maths. Pupils are expected to improve by at least 2 levels for each tested topic area.

¹⁹ See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf

4.2.2.1 Educational attainment

The National Curriculum is divided into four Key Stages during children’s school life. Targets defined in the National Curriculum are assessed at the end of each Key Stage. Data are not available for Key Stage 3 data as these are no longer collected following changes nationally.

Results for Leicester’s Key Stages have continued to improve. For more detailed information, see <http://www.cabinet.leicester.gov.uk/documents/s76854/Annual%20Education%20Performance%20ReportFIN.pdf> and

<http://www.cabinet.leicester.gov.uk/documents/s73129/Early%20Years%20Foundation%20Stage%20Outcomes.pdf>

4.2.2.2 Special Education Needs (SEN)

Local data show that in 2015 there were over 7,700 children aged 5 to 19 years old with a Special Educational Need (SEN). This equates to 11.5% of all children in this age group.

Table 2: Children aged 5 to 14 years old with a SEN Stage for 2015/16

	Education Health and Care Plan	SEN Support	Statement
Totals	410	6351	942

Source: Leicester City Council, 2016

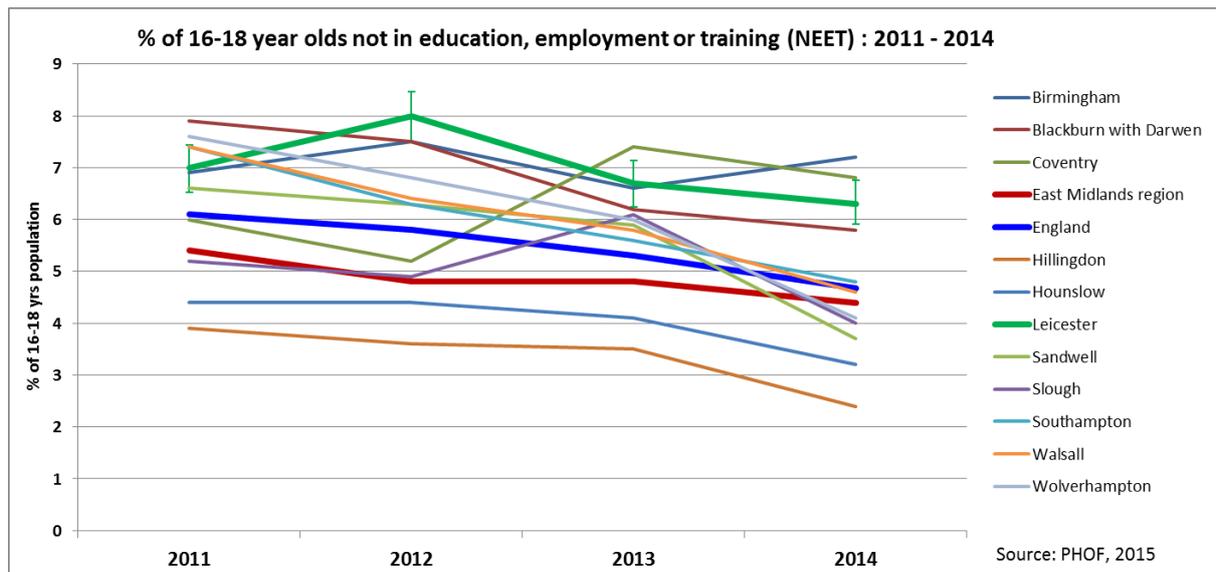
4.2.3 Not in Education, Employment or Training (NEET)

Spending time not in employment, education or training (NEET) has been shown to have a detrimental effect on physical and mental health. This effect is greater when time spent NEET is at a younger age and when a longer amount of time is spent NEET. The link between time spent NEET and poor health is partially due to an increased likelihood of unemployment, low wages, or low quality work later on in life. Being NEET can also have an impact on unhealthy behaviours and involvement in crime.

These negative health effects do not occur equally across the population. The risk of being NEET is affected by area deprivation, socio-economic position, parental factors (such as employment, education, or attitudes), growing up in care, prior academic achievement and school experiences. Being NEET therefore occurs disproportionately among those already experiencing other sources of disadvantage.

Figure 15 shows that although Leicester is currently the third highest amongst peer comparators, and significantly higher than both the East Midlands and England averages, the proportion of young people classed as NEET has fallen significantly from 2012 to 2014 in Leicester..

Figure 15: Percentage of 16-18 year olds who are NEET



4.2.4 Smoking

Smoking and its negative impact on health is a major burden on the NHS and other health services. Smoking in early adolescence is a risk factor for smoking as an adult. For children whose parents smoke, second-hand smoke can cause severe respiratory health problems such as asthma and reduced lung function.

Currently there are no local data on the levels of smoking in children and young people. More information will become available with the release of the Children and Young People’s Survey data in May 2017.

4.2.5 Teenage Pregnancy

Teenage pregnancy (under-18 conception) refers to all conceptions in females aged 15-17 years in a calendar year. This includes termination of pregnancy, still birth and miscarriage and live births. It does not include prevention by emergency contraception.

Teenage pregnancy is a complex issue with many reasons for concern. Risk factors for under-18 conceptions include being a looked after child, poor school performance and attendance, economic disadvantage, substance misuse, older male partner and single or teen parents and poor access to contraception. Teenagers as a group tend to have higher rates of complications during pregnancy and delivery; these complications may be due to factors such as biological immaturity or poor preconception health. Teenage mothers are also at greater risk of having a baby with Low Birth Weight (LBW) which can predispose the baby to increased health concerns. Ongoing maternal health can be poor and result in poor mental health and postnatal depression.

Pregnant teenagers were found to be nearly three times more likely to have insecure attachment compared with adults. They may also experience poor support from their partner. These have been

found to be associated with depression, and insecure attachment style should be addressed in prevention and intervention strategies with teenage mothers.²⁰

The data for under-18 conceptions is located in the PreBirth chapter of this JSNA. This shows a significant fall in teenage conception rates, following a national trend.

5. Current services

There are a number of additional services that are particularly relevant to this age group, particularly older adolescents, in addition to the services outlined in previous chapters.

5.1 Weight Management Services

Schools which participate in the National Child Measurement Programme weigh and measure children in Reception and Year 6 to inform local planning and delivery of children's services. Leicester is engaged in the Change4Life²¹ programme to promote healthy eating and exercise.

As part of the Food Plan for Leicester there are healthy eating projects, in schools and early years' settings. These increase awareness about the benefits of eating fresh fruit and vegetables and support schools to encourage healthy and sustainable eating behaviours, and increased cooking and growing skills.

5.2 Sexual Health Services

The Integrated Sexual Health Service (ISHS) is commissioned by the local authorities (Leicester City, Leicestershire County and Rutland County) and is provided by Staffordshire and Stoke on Trent NHS Partnership Trust (SSOTP). ISHS provides open access contraception, STI testing and treatment, outreach work, psychosexual counselling and a young people's service that includes a C card scheme.

The aim of the ISHS is to provide a range of accessible, high-quality, responsive, cost-effective, confidential services across LLR. The service provides an open access hub and spoke model of sexual health provision meeting all the sexual health needs of an individual in one visit.

In addition to the ISHS, other services which deliver elements of sexual health services in Leicester as follows:

- General Practice
- Pharmacies
- Pregnancy termination services
- HIV treatment and care
- Sexual Assault and Rape Centres
- Relationship and Sex Education

²⁰ Figueiredo, B., et al., Teenage pregnancy, attachment style, and depression: a comparison of teenage and adult pregnant women in a Portuguese series. *Attachment and Human Development*, 8(2), June 2006, pp.123-138. at <http://www.scie-socialcareonline.org.uk/teenage-pregnancy-attachment-style-and-depression-a-comparison-of-teenage-and-adult-pregnant-women-in-a-portuguese-series/r/a1CG000000GTbMMAW>

²¹ The Change4Life programme is a national scheme driven by Public Health England.

5.3 Substance Misuse

5.3.1 Smoking Cessation Services

Leicester's Stop Smoking service has played a key part in helping to lower smoking rates amongst adults and young people in Leicester. The service- adheres to national Guidance²² and as such does not have services aimed specifically at the 15-19 year old age group but rather focuses on adult smoking, as this will be the greatest influence over youth uptake. This approach is more appropriate, rather than spending a disproportionate sum on prevention, when youth smoking levels are lower than they have ever been, both nationally and locally.

However, the service acknowledges that in some communities, and in particular vulnerable groups, smoking among teens remains an issue, and so stop smoking treatment is offered to any young person who will attend appointments. Additionally, the service has helped to develop a network of pharmacies who will make extra effort with young people, and have shared the list with Leicester City schools.

Data obtained from service indicates that of those aged 18 and under (an exact 15-19 breakdown is unavailable) who set a quit date in 2013-14, 49% actually quit. In 2014-15, the equivalent figure was 27%.

5.3.2 Drugs and Alcohol

Substance misuse services for young people and adults will be changed on 1st July 2016 and are jointly commissioned across Leicester and Leicestershire. Turning Point is the provider of these services. Young Person's provision is directed towards under-21 year olds with a tailored approach to adults under 25.

5.4 Voluntary Sector

The voluntary sector offers a wide range of different services for the late teenage demographic in particular. These include groups tackling issues on sexuality and LGBT issues, youth mental health groups, and training and employability services for the most vulnerable young people furthest from the labour market. Additionally there are voluntary groups that support those who are homeless, suffering from substance misuse and young offenders.

6. Projected service use

ONS estimates suggest that there will be a significant growth in the number of 5-19 year olds in Leicester over the next few years.

6.1 Education Services

Schools are required to provide school places for every child in the City. In 2015 the School roll was 19,613 places. As the numbers of children attending schools will increase so will issues such as SEN

²² National centre for smoking cessation and training (NCST) (2015). <http://www.ncst.co.uk/usr/pub/NCST%20briefing-effectiveness%20of%20local%20cessation%20and%20prevention.pdf>. Accessed from on 11 December 2015

and the need for additional support. Furthermore from the diversity of the residents, school commissioners should infer that there will be increasing need to support children for whom English is a second language.

6.2 Health Services

The increasing numbers of children and young people will mean an increase in the need for GP registrations and the childhood immunisation programme. There will be a need to improve understanding of the health system, self-care and the need for immunisations in a culturally sensitive way. Current trends in childhood obesity and the associated impact on diabetes are also likely to have consequences for health services in the medium term.

6.3 Children's Services

Similar pressures are expected to be felt on social services in the future with the increase in the child population in Leicester City. This is predominantly expected in the west side of the City.