THE HEALTH OF SCHOOL AGED ADOLESCENTS IN LUTON

ANNUAL PUBLIC HEALTH REPORT 2016

The Health of School Aged Adolescents in Luton

Foreword

Welcome to my Public Health annual report 2016. Last time my report focussed on the wider social determinants of health and in that year we included many of the areas we had recommended as priorities in the Joint Strategic Needs Assessment (2015)\(^1\).

A summary of the recommendations we made in the last report and the actions that have been taken can be found in Section 6. I am pleased with the progress made, and with the Luton Investment Framework firmly setting out a strategic direction for Luton’s economic and healthy future, there is further opportunity to ensure that health and wellbeing is central to what we do.

For this year’s report I turn the spotlight on the health of young people studying in secondary schools in the town. In the last few years, similar to other areas, Luton has invested time and resource to improve the health of children. Luton’s Flying Start Early Years Strategy, a ten year programme to improve the health of children, is strategically led through a partnership of organisations.

There has been successful engagement with many statutory and voluntary organisations across Luton to deliver our ambition to give every child the best start in life. We are starting to realise the positive impact that joint working, system redesign and a shared vision can have, and the early signs that these changes are having an impact is seen in the new evidence based parenting programme offer. By working together, our community 0-5 healthy child programme providers have integrated with the newly restructured Children Centres, and the roll out of the school oral health programme as part of the 1 year check and National Child Measurement Programme working in co-terminus teams and sharing the care of families, especially those requiring additional support. Additionally, we are seeing improvement in levels of childhood obesity in reception year and this year there has been an increase from 60% of 5 years olds in 2015 achieving ‘Good Level of Development’ school readiness, to 66% of children this year, starting to close the gap between Luton and the national performance of 69%.

Whilst the Flying Start Strategy has a primary focus on the early years (0-5 year olds), we recognise that to make the improvement over an individual’s life course. The focus must extend to and include supporting the health of Luton’s ‘parents of the future’; enabling them to maximise their health, wellbeing and educational attainment to allow them to gain good employment and the means by which they can live in good homes, eat well, have a healthy lifestyle and plan for a healthy family.

This report presents what we know on the health of Luton’s secondary school aged young people, the next generation of adults and parents who will support Luton’s children of the future. It presents a picture of what issues affect their health, and brings attention to the priorities that professionals in health, social care and education organisations should focus on through support of young people and their families to improve the health and wellbeing of this community in Luton.

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\(^1\) Luton JSNA 2015
This report also includes what secondary school aged young people have told us are their views, what they believe is positive and what are their challenges, and I have included the information from the second year of the School Health Education Unit survey of secondary schools.

We are committed to being active partners, to support and prepare our children and young people for the future, and that means providing opportunities for them to be involved.

This report shares my recommendations for action where we need to do better and calls for all partners and communities to contribute. I make no excuse for the focus I have placed on mental health and emotional wellbeing as these are the health and wellbeing issues that my colleagues in health, social care, education and youth services tell me cause them greatest concern.

Improving the health and wellbeing of young people requires a collaborative effort and response through our existing strong partnerships; we have started to demonstrate what a combined effort can achieve through the work we are doing for the conception to 5 years community, our next step is to turn our attention to this group.

**Gerry Taylor, Corporate Director of Public Health, Commissioning & Procurement**
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Executive Summary

Adolescence is a life stage of significant neural, emotional and physical development from ages 10-19 and represents one of the critical transitions in the life span, characterised by a significant increase in growth and change in an individual, second only to infancy.

Behaviour patterns established during this period can have a lasting effect on future health and wellbeing. Therefore embedding health and healthy behaviours for young people of this age, and better preparing and protecting them from health risks is critical to prevent adult life health problems. It is important for young people to understand the relationship between behaviour and consequences and the control they can have over their own health and wellbeing decisions. This leads to increased vulnerability leading to a range of adjustment and mental health problems which can have an impact on educational attainment, and subsequent life opportunities.

Adolescents depend on networks in their lives that include their families, communities, schools, and contact with services to learn the life skills required to transition from child to adult. These networks all have a role in promoting development and supporting young people as they adjust to their new independence.

The same relationship exists for children ‘in care’; looked after children. Their vulnerability is often greater because of their past experience and while one in ten children and young people have a diagnosable mental health need, for looked after children the risk is considerably greater. Almost 50% of children in care have a diagnosable mental health disorder and two-thirds have special educational needs which can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading a happy and healthy adult life.

The health and wellbeing of Luton adolescents for some outcomes is comparable to the national average, for many health and wellbeing needs there is significant inequality. Much of this inequality reflects the demography of Luton; higher rates of poverty, greater ethnic diversity, higher rates of children in care and greater ill-health associated with mental health and emotional wellbeing compared to the national picture. Other headlines for Luton are:

- 48% of pupils do not speak English as a first language compared to 15% nationally.
- 27% of pupils in Luton are white British compared to 73% nationally.
- Nationally, 19.9% of children are living in poverty compared to 23.1%, in Luton.
- Rates of emergency admissions due to unintentional or deliberate injuries in children aged up to 17 years is 1,130 per 100,000 child population compared to 1,180 nationally.
- Rates of overweight and obese for children in reception year; children aged 4/5, are 20.7% compared to 22.1 for England, however by year 6, 40.8% of Luton children are overweight and obese compared to 34.2% nationally.
- 14% of boys and 8% of girls aged 13-15 meet recommended physical activity levels.

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2 Public Health England/ Mental Health Foundation
3 Fingertips: 2014/15 data.
• 10% of 5-16 year olds have a diagnosable mental health disorder, and for boys between the ages of 11-16 this increases to 13%\(^4\).

• Teenage pregnancy rates have reduced by 51% nationally over the last 10 years; 22.8 conceptions per 1000 young women in 2014 compared with 46.6 per 1000 in 1998.

• While the screening uptake is still low, 17.4% in Luton and 22.5% for England, there are rising rates of diagnosed sexually transmitted infections, particularly Chlamydia, which has doubled nationally; the diagnosis rate is 804 per 100,000 young people in Luton and 815 nationally.

• Luton has the highest rate of looked after children (LAC) in the region, 73.1 per 10,000 child population compared to 60 per 10,000 nationally.

• Achievement of five or more A*-C passes including English and Maths increased from 49% to 52% nationally, but for children in Luton academic achievement is showing a downward trend. Although in line with statistical neighbours Luton children are below the national average with the position for boys at national, statistical neighbour and local levels being poorer than girls.

• 84.6% of Luton secondary schools are graded good or better and 91.8% of pupils in Luton attend a good or better school.

It is clear that investing in adolescents and focusing on improving their health has social and economic benefit. As professional we need to build on the strengths and assets that young people in Luton have and offering opportunity to young people and making their opinions matter is an important part of developing aspiration and ambition. However, many young people are not maximising their opportunities, accessing services or information they need to manage their health effectively. The ten reasons presented for investing in adolescents should assist commissioners and providers with an evidence base to support young people more effectively.

Recommendations:

1. The use of information and data needs to drive services and be the measure by which we evaluate service impact and the outcomes for young people. Therefore the first recommendation must be to tackle the lack of access to up-to-date data to inform business planning and outcomes. Given that health needs assessment should be the starting point of commissioning and the basis upon which change is planned, implemented and measured if we are to get the outcomes we need from services, without access to data the health and social care commissioners will be challenged to make the service changes that are required to drive the improvement needed.

2. Local organisations should consider a partnership and shared strategic focus not only on adolescents but include all school aged children.

3. Young People in schools are a captive audience and the PHSE programme is the ideal conduit to really focus on what the school health profiles have identified as priorities. There are many quality providers keen to engage with schools. The objective now is to match the health and wellbeing need with the provider, and engage all schools, not only the informed few to appreciate the synergy between health and wellbeing and academic attainment. This

\(^{4}\) ONS report 2004 Mental health of children and young people in Great Britain
should include the development of sex and relationship education which the school survey identifies as needing clear investment of resource.

4. No health without mental health should be reflected in what we commission to make young people more resilient and independent. The following actions are recommended:

- Carry out a mental health needs assessment for children and young people in Luton and agree a shared strategy that recognises inequality and therefore targets vulnerable groups such as looked after children.
- Develop a strategic approach should view mental health as a continuum of need, ensuring appropriate attention is given to emotional wellbeing and resilience, prevention and early intervention to reduce demand on tier 3 and 4 services which is currently increasing to an unsustainable level.
- Develop a pathway for ASD children to establish compliance with NICE guidance and address the delay through improved commissioning and provision of services to reduce time from assessment to diagnosis.

5. Luton Council should use the assessments on the Toxic Trio and Adverse Child Experiences and take the lead and:

- Commission and provide services which recognises ACE impact and ensure assessments include an understanding of ACE, identify exposure, and risk.
- Develop a broader and more integrated approach to children at risk from a range of adverse circumstances.
- Implement the recommendations from the Toxic Trio Health Needs Assessment:
  - Review the thresholds for accessing specialist services in the light of concerns that earlier access could improve outcomes, and potentially reduce costs in the medium and longer term). This is particularly the case for child and adolescent mental health services.
  - Equalities monitoring should be improved and reported regularly and a regular programme of audit of key services in relation to agreed standards should be undertaken and reported.

6. School Nurses, PHSE providers, parents and schools need to work together to prioritise health and wellbeing need, build resilience while young people are at a stage in life when they form life-long lifestyle behaviours.

7. In line with Luton’s emerging Strategic Vision for Sport and Physical Activity 2017-21 there should be greater participation encouraged in healthy exercise and support schools to:

- Engage with the ME TIME women and girls participation programme, in order to address the decline in girl’s enjoyment and participation levels in sport and physical activity between Year 8 and Year 10.
- Provide local communities with access to their facilities for the purpose of sport and physical activity via the ‘Community Access to Schools Programme’. This programme supports schools through a range of business planning, networking and marketing tools to enable greater levels of community access to their facilities, in recognition
that schools are often viewed as the safest, most suitable and high quality facilities locally available.

8. Improving policy development for children and young people’s commissioning and putting this into practice should start with a gap analysis against six principles that include the development of child and young people’s commissioning forum to ensure that children and young people are making decisions about services that are being commissioned for them.
Introduction

“The effects of poor health during the teenage years can last a lifetime. Keeping adolescents healthy is a valuable investment in the nation’s future” (Dame Sally Davies 2007).

Adolescence is a life stage of significant neural, emotional and physical development after childhood and before adulthood, from ages 10-19. It represents one of the critical transitions in the life span and is characterised by a tremendous pace of growth and change in an individual that is second only to infancy.

Behaviour patterns that are established during this period can have a lasting and negative effect on future health and wellbeing. Therefore embedding health and healthy behaviours for young people of this age, and taking steps to better protect them from health risks is critical for the prevention of health problems in adulthood and for future health and social infrastructure.

Many adolescents are not able to understand the relationship between behaviour and consequences, or the degree of control they can have over their own health and wellbeing decisions. This makes them a particularly vulnerable group and can lead to a range of adjustment and mental health problems.

Many adolescents face pressures to engage in risky lifestyle behaviour:

- Use of alcohol, cigarettes and other drugs
- Initiate sexual relationships at an earlier age
- High risk for intentional and unintentional injuries
- Unintended pregnancies and
- Infection from sexually transmitted diseases.

There are close links between education and health which are central to child and adolescent development. Educational attainment is directly linked to life chances. Action for Children report found that only 58% of children and young people living in the most deprived areas reach a positive level of development, compared to 77% in the least deprived areas. Children who start primary school in the bottom range of ability tend to stay there; 55% of seven year olds in the bottom 20% of attainment at key stage 1 are still at this level when they reach key stage 4 at 16 years of age.

Evidence tells us that:

- Pupils with better health and wellbeing are likely to achieve better academically.
- Effective social and environmental competencies are associated with greater health and wellbeing, and better achievement
- The culture, ethos and environment of a school have significant influence on the health and wellbeing of pupils and their readiness to learn
- A positive association exists between academic attainment and the physical activity levels of pupils.

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5 Improving Young People’s Health and Wellbeing: A Framework for Public Health. PHE/ Association for Young People’s Health. 2015.
6 Public Health England, 2014
7
Adolescents depend on their families, communities, schools, health services and their workplaces to learn the important life skills they need to transition from child to adult. Parents, members of the community, social institutions and service providers are in a position of responsibility to promote adolescent development and support young people to adjust to their new independence.

The same relationships exist for looked after children, but the extent of health problems is often greater because of their past experience. Almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs which can have far-reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults.

Inequalities in social and economic circumstances have a profound impact on health with poverty the main contributor to poor health. Addressing disadvantage and family poverty is essential for improving child and young people’s health.

The health and wellbeing needs of young people have in the past been given a lower priority than the pre-school and elderly population by policy makers. Yet good health in adolescence is central to wellbeing in later life and we do not invest enough in prevention and early intervention for young people. This is an important group to target as the appropriate management of adolescent health will pay long term dividends for individuals and for society, increasing employment prospects, economic viability and reducing health and social care need and demand on services.

Promoting health and healthy behaviours for young people of this age, and taking steps to better protect them from health risks is critical for the prevention of health problems in adulthood and for future health and social infrastructure.

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SECTION 1

The Health of Adolescents: The National Picture

During their adolescent stage some young people will engage in behaviours that carry long term risks to their health. While this is not the case for all young people, and some do make sensible decisions, nonetheless during this stage of life there are some who take risks with their health, either because they lack knowledge, or that they are aware but lack the personal skills and strategies to avoid them. Lifestyle risks include the use of alcohol, use of drugs, poor eating and nutrition, with increased risk of obesity, and increased rates of sexually transmitted infections. Death amongst adolescents (10–19 years) is now higher than for any other period of childhood except the new-born period, with injuries the main cause of death.

One child in three in the UK is living in poverty (2013/14) and the 9.9 million young people in the UK have poorer health outcomes than those in many comparable developed countries. Notably more than a third of 11-15 year olds in England are obese or overweight. On average, 11-18 year old young women only eat 2.8 portions of fruit and vegetables each day, and young men only eat 3 (5 is recommended). Adults report average consumption of 4.1. As many as 17% of British secondary school children report daily consumption of food high in fat, salt or sugar and low in nutritional value.

Only 14% of boys and 8% of girls aged 13-15 meet recommended physical activity levels and almost two-thirds of adult smokers begin smoking before they are 18 years of age. For cigarette smoking and the use of cannabis, the proportion of 16-19 year olds who smoke has reduced from 33% to 20% over a 25 year period, and a reduction in the use of cannabis with decreased levels of use by 11-15 year olds by an estimated 20%. However, Shisha use is also increasing. In addition:

- 13% of boys and 10% of girls aged 11-15 have emotional, behavioural or hyperactivity disorders.
- 10% of 5-16 year olds have a diagnosable mental health disorder. 18,349 young people saw specialist substance misuse services in 2014-15, some 777 fewer than the previous year.
- There has been an improvement in the rate of teenage conception with significant reduction over the last 10 years. Figures for 2014 (published March 2016) show the rate of under 18 conceptions has declined by 51%; 22.8 conceptions per 1000 young women in 2014 compared with 46.6 per 1000 in 1998. In real terms the number is a reduction in conceptions from 41,089 to 21,282.

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10 HMRC. Children in low income families
14 Children and Young Peoples Outcomes Forum 2012
However there are rising rates of diagnosed sexually transmitted infections, particularly Chlamydia, which has doubled; this is as a result of better access to screening and diagnostic tests although continued unsafe sexual behaviour is also a contributory factor.

Encouragingly, in recent years there has been a reduction in the proportions of young people aged between 10-24 who drink, smoke and use drugs and a significant reduction in the suicide rates for young men aged 15-24 years from 17 per 100,000 to 10 per 100,000 over the last 15 years. However, there has been little change in rates for young women. Rates of self-harm are increasing and it is estimated that one in ten young people have diagnosable mental ill-health.16

Social factors affecting health include family assets, housing, social exclusion, lack of education during adolescence and unemployment17. Without equal access to resources and support, some young people are put at a disadvantage:

- 20% of children in the UK are living in poverty; measured as those children living in families earning less than 60% of the median wage18.
- In all families with dependent children, 20% have a gross weekly income of £300 or less. In lone parent families, this rises to 51%19.
- 15% of children and young people in the UK live in a household where there is no parent at work20.
- Parents of adolescents are more likely to work than any other age group, with over three quarters of mothers of teenagers are in work. But lone mothers with 11-15 year olds are less likely to work than their peers in couple families (68% versus 80%)21.
- There are 70,440 children looked after by Local Authorities in England (data recorded at 31 March 2016) of which 27,220 young people are aged 10-15 years (39%), and 16,460 young people aged 16 and over (23%). 75% of all looked after children are of white British background22.
- Although in the last 10 years there has been a steady reduction in looked after children, there have been increases in those aged 16 and over. This may be partly because of a growing recognition that this age group tend to have greater needs and require considerable support23.
- National statistics for 2014/2015 show that there were 13.8% of children looked after achieving 5+ GCSE’s at grades A*-C including English and Maths24.

Overall examination attainment has been rising in the UK, however there is a significant inequity for gender, looked after children and children eligible for free school meals; a measure used as a proxy of deprivation. Between 2010 and 2015:

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16 PHE
17 Wilkinson and Marmot, 2003
18 HMRC. Children in low income families.
19 ONS General Lifestyle Survey year?
20 ONS Working and workless households 2012
21 ONS Labour Force Survey dates?
22 Department for Education, Children looked after in England
23 Department for Education, Children looked after in England
Boys achievement of five or more A*-C passes including English and Maths increased from 49 to 52%, with a peak of 56% in 2013 whereas girls increased from 58% to 61% with a peak of 66% in 2013. Only 14.5% of looked after young people achieve five GCSEs grades A*-C including English and Maths. Among the 16% of young people at state funded secondary schools who are eligible to receive free school meals, 36.9% achieve five A*-C grades GCSEs including English and Maths.

Why invest in maintaining and improving adolescent health and wellbeing:

“We need to stop thinking of spend on healthcare for children and young people and instead think of investing in the health of children and young people as a route to improving the economic health of our nation.”

Dame Sally Davies, Chief Medical Officer, 2013

The long term benefits of focusing on improving the health of adolescents has both social and economic value, and it is clear that many young people are not getting the services or information they need to manage their health effectively.

Table 1: 10 reasons to invest in adolescent health:

<table>
<thead>
<tr>
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<th>Reason</th>
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<tbody>
<tr>
<td>1</td>
<td>Adolescence is a critical time for health. The first signs of many serious long-term conditions emerge. It is a time when risk-taking behaviours begin, including sexual activity, and when life-long health behaviours are set in place.</td>
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<td>2</td>
<td>Adolescent health is not improving enough. There have been fewer health improvements or reductions in mortality amongst adolescents compared to other age groups. Accidents and suicide are the leading cause of death in this age group and are both preventable.</td>
</tr>
<tr>
<td>3</td>
<td>Young people are not getting the health services or information they require. They are regular users of primary care, but the age group least satisfied with their consultations. They also get the shortest time with a GP. Services need to be designed and commissioned with young people involved from the outset.</td>
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<tr>
<td>4</td>
<td>Good sexual health services and testing are critical. In 2014, 1.6 million chlamydia tests were carried out in England among 15 to 24 year olds, with over 138,000 diagnoses. But this is 500,000 fewer tests than in 2011. Young people are still vulnerable to sexually transmitted infections and are the most affected age group.</td>
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<td>5</td>
<td>Teenage pregnancy reduction must continue. Under-18 conception rates for 2014 were the lowest ever recorded in England, at 22.8 per 1,000 females aged 15-17. This is a fall of 51% since 1998 as a result of the Teenage Pregnancy Strategy. Work must continue in all local areas or rates will start to rise again.</td>
</tr>
<tr>
<td>6</td>
<td>Ignoring chronic adolescent disease costs money. This leads to more emergency hospital admissions. Conditions including diabetes, eating disorders, asthma and epilepsy in the 10-24 age groups resulted in 32,219 hospitalisations in England in 2013-14.</td>
</tr>
<tr>
<td>7</td>
<td>Effects of poor healthcare in adolescence can last a lifetime. One fifth of 11-15 year olds in the UK are obese. One third of 16-24 year olds smoke cigarettes regularly. These behaviours have long-term health impacts and costs to the NHS unless they are addressed.</td>
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<tr>
<td>8</td>
<td>Investing in adolescent wellbeing has benefits beyond health. 25% of 15 year olds in England have experimented with illegal drugs and over 70% have consumed alcohol. These actions impact on antisocial behaviour and crime levels as well as resulting in accidents and A&amp;E attendance.</td>
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<tr>
<td>9</td>
<td>Mental health issues are diagnosed. Half of all psychiatric disorders start by age 14 and three quarters by age 24.</td>
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25 Department for Education, GCSE and equivalent attainment by pupil characteristics, England 2014/15
27 Department for Education, GCSE and equivalent attainment by pupil characteristics. 2014/15
28 The Association of Young People’s Health:
at this age

Investment is needed in young people’s mental health services which are overstretched and have long waiting lists and high thresholds.

10 Research has brought new insights.

We know more about the development of the teenage brain and the importance of sleep. New insights bring new challenges and new reasons to invest in different aspects of young people’s health.

A Health and wellbeing offer for children and young people ages 10-19 years:

The report ‘Improving Young People and Children Health and Wellbeing: A framework for ages 10-19’ sets out a recommended offer for young people to promote good health, prevent poor health and provide targeted services when they are needed. The focus is as much on building resilience as it does on addressing specific health concerns and includes;

- A holistic health and wellbeing offer which addresses all factors affecting the young person rather than single health issues.
- A focus on prevention as well as intervention.
- Support to help build their resilience and life skills, working with others including schools, families and communities.
- Provision of appropriate levels of support across universal, targeted and specialist services.
- A ‘no wrong door’ service approach that young people may access or be referred to the service they need regardless of which organisation/service they initially contact.
- That frontline staff are trained to deliver age appropriate services for young people in the right settings.

Children and young people do need greater awareness of the role of primary care, their GP and pharmacy services. It is clear that young people need and want to access their GP, however they need to be more informed and assured of issues of confidentiality, and that their GP understands their needs as a teenager.

Schools and colleges have an important role in health promotion. There are growing numbers of children with long term conditions and the school has a responsibility to work with health services to ensure they receive the support and medication required to attend school, however the role of the school in improving health and wellbeing has changed. How schools choose to address the health need of their students is now a decision for the governors and this has led to inconsistency.

To improve access to services, listening to the voice of adolescent patients is essential. The increasing use of digital technology for this group should not be underestimated as a means to inform and engage. Social networking can encourage increasing engagement of young people in health-related activities, and is a key medium for facilitating increased participation, particularly for targeting the vulnerable and disenfranchised.

30 Achieving equity and excellence for children’ (2010)
SECTION 2:

The Health of Adolescents in Luton:

We now focus on the health and wellbeing needs of young people in Luton by looking at health and wellbeing in each secondary school population. Adolescent health in Luton is better than the national average for some health and wellbeing issues, but worse for others. This section provides a practical approach to inform schools, education teams and commissioners about the health and wellbeing of students in each Luton secondary school population and recommends where to focus and prioritise efforts to make the most difference to improve their student’s health, thereby optimising their learning and future potential.

The reports use varied data sources to present the picture of health and wellbeing of secondary students in Luton. The data from the Luton School Health Education Unit (SHEU) annual survey of secondary schools takes account of the views from over 1,800 children in years 8, 9 and 10 (children aged 12-15 years old) on what they consider their health needs to be.

Secondary Schools Profile

The profile for each secondary school shows the picture for each of their student populations and compares their health and wellbeing to other schools, Luton overall and England.

Presented below is an ‘All School Profile’. Individual school profiles are available as appendices to this report. These profiles show differences in demography, health and wellbeing between schools for example:

- Luton Indices of Multiple Deprivation (2015) is 27.6 compared to England 21.8. Variation between school areas; the highest Challney Girls at 32.1 and Stopsley at 20.8. For the index of child deprivation (2015) all schools are more deprived than the England average of 0.18, with Lea Manor being the most deprived at 0.27. 8 schools have an IDACI of 0.26 whilst Stopsley is at 0.18.
- The ethnicity of school aged children: 27% of children in Luton secondary schools are white British, 24% Pakistani, 11% Bangladeshi and 9% white other which includes children of eastern European origin.
- Rates of dependent children living in homes with no employed adults is generally greater across Luton ranging from 8.58% to 3.72% compared to Luton and England average of 5.86% and 4.20% respectively.
- Accidents and injuries are the commonest cause of death and injury for young people nationally and are more likely amongst children from more deprived families and areas; road traffic accidents are the main cause. The rate is lower in Luton than England.
- Variation in immunisation uptake for school delivered immunisations, with HPV vaccination rates reducing in 2015/16 compared to 14/15. Uptake is below 80% for all schools apart from Challney Girls and Denbigh and similar variation for school leaver booster is unexplained.
- Child Obesity levels are not recorded routinely in secondary schools with the final National Child Measurement Programme delivered in year 6. It is however clear that obesity levels in secondary schools is a concern and using adult obesity as a proxy measure, all school areas, with
the exception of Stopsley, have adult obesity recorded above the national average of 24.2%, the highest is the Lealands area at 28.5%.

### All secondary School – School Profile

This profile uses the 2016 School census data and compares the demographics specifically ethnicity, deprivation, gender make up and free school meal eligibility. Selected health indicators and the wider determinants of health are presented and compared to national figures. Further information taken from the school survey in 2015 and 2016 is looked at in order to give a fuller view of the opinions and behaviours of pupils within the school.

**Profile Summary:**
- 48% of pupils do not speak English as a first language compared to 15% nationally.
- 27% of pupils are white British in Luton compared to 73% nationally.
- 24% are Pakistani and 11% are Bangladeshi in Luton compared to 4% and 2% nationally.
- 27% (n=3,108) live in the 20% most deprived areas nationally.
- Using Income Deprivation Affecting Children (IDACI) 21% (n=2,239) live in the 20% most deprived areas nationally.
- Adult obesity in Luton (25.9%) compared to 24.2% nationally.
- Adult binge drinking in Luton (13.5%) compared to 20.1%.
- % children living in poverty in Luton (23.7%) compared to 19.9% nationally.
- % working age unemployed in Luton (4.5%) compared to 3.8% nationally
- % number of adults unemployed with dependent children in Luton (5.9%) compared to 4.2% nationally.
- Rate of emergency admissions due to unintentional or deliberate injuries in children aged up to 17 years in Ashcroft school area (1,130 per 100,000 population) compared to 1,180 per 100,000 population nationally.

**Figure 1: Location of Secondary Schools in Luton**
The map above shows the location of all the mainstream secondary schools within the borough. There are 12 mainstream secondary schools, four are maintained schools; Ashcroft, Lea Manor, Lealands and Stopsley and 8 are academies, Cardinal Newman, Challney Boys, Challney Girls, Denbigh High, Icknield, Putteridge, Chalk Hill and Stockwood Park.

Table 2 below compares a number of variables for all Luton schools against the Luton and England average. The data is sourced from local health profiles at Medium sized Output Area level and this has been extrapolated to pupils within schools. Deprivation figures come from the Indices of Multiple Deprivation 2015 similarly extrapolated to pupils in schools.

### Table 2: Summary of indicators for secondary schools in Luton

<table>
<thead>
<tr>
<th>Secondary school</th>
<th>IMD 2015</th>
<th>IDACI 2015</th>
<th>Adult obesity (%)</th>
<th>Unintentional and deliberate injury per 100,000</th>
<th>Adult binge drinking (%)</th>
<th>No adults in unemployment in household with dependent children (%)</th>
<th>% of children living in poverty 2015</th>
<th>% of working age unemployed 16-64</th>
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<tbody>
<tr>
<td>Challney High School for Girls</td>
<td>22.10</td>
<td>0.24</td>
<td>25.95</td>
<td>1497.26</td>
<td>7.84</td>
<td>8.33</td>
<td>24.00</td>
<td>4.93</td>
</tr>
<tr>
<td>Barnfield South Academy</td>
<td>21.42</td>
<td>0.16</td>
<td>25.50</td>
<td>1556.90</td>
<td>11.20</td>
<td>6.90</td>
<td>27.44</td>
<td>4.63</td>
</tr>
<tr>
<td>Barnfield West Academy</td>
<td>21.45</td>
<td>0.26</td>
<td>28.56</td>
<td>1577.70</td>
<td>11.15</td>
<td>6.37</td>
<td>23.77</td>
<td>4.31</td>
</tr>
<tr>
<td>Challney High School for Boys</td>
<td>21.50</td>
<td>0.16</td>
<td>26.61</td>
<td>1500.00</td>
<td>11.26</td>
<td>6.90</td>
<td>23.03</td>
<td>4.45</td>
</tr>
<tr>
<td>Icknield High School</td>
<td>21.55</td>
<td>0.26</td>
<td>26.63</td>
<td>1506.81</td>
<td>11.27</td>
<td>6.90</td>
<td>22.88</td>
<td>4.45</td>
</tr>
<tr>
<td>Denbigh High School</td>
<td>22.56</td>
<td>0.26</td>
<td>26.64</td>
<td>1191.28</td>
<td>12.27</td>
<td>6.93</td>
<td>22.84</td>
<td>4.45</td>
</tr>
<tr>
<td>Cardinal Newman</td>
<td>20.63</td>
<td>0.26</td>
<td>26.67</td>
<td>1531.95</td>
<td>13.30</td>
<td>6.31</td>
<td>23.94</td>
<td>4.40</td>
</tr>
<tr>
<td>Lea Manor High School</td>
<td>30.89</td>
<td>0.27</td>
<td>27.63</td>
<td>1217.13</td>
<td>12.84</td>
<td>7.03</td>
<td>26.79</td>
<td>5.12</td>
</tr>
<tr>
<td>Lealands High School</td>
<td>28.20</td>
<td>0.26</td>
<td>28.49</td>
<td>1087.37</td>
<td>13.27</td>
<td>7.12</td>
<td>27.34</td>
<td>5.04</td>
</tr>
<tr>
<td>Putteridge High School</td>
<td>27.16</td>
<td>0.30</td>
<td>28.48</td>
<td>1084.34</td>
<td>18.26</td>
<td>4.98</td>
<td>30.12</td>
<td>5.06</td>
</tr>
<tr>
<td>Stopsley High School</td>
<td>20.81</td>
<td>0.18</td>
<td>25.96</td>
<td>1224.47</td>
<td>13.55</td>
<td>3.12</td>
<td>21.07</td>
<td>4.30</td>
</tr>
<tr>
<td>Ashcroft High School</td>
<td>27.67</td>
<td>0.16</td>
<td>25.90</td>
<td>1572.99</td>
<td>16.46</td>
<td>5.24</td>
<td>24.62</td>
<td>4.37</td>
</tr>
<tr>
<td>Luton</td>
<td>27.60</td>
<td>0.24</td>
<td>25.90</td>
<td>1130.30</td>
<td>13.50</td>
<td>5.58</td>
<td>23.70</td>
<td>4.50</td>
</tr>
<tr>
<td>England</td>
<td>21.80</td>
<td>0.18</td>
<td>24.20</td>
<td>1380.90</td>
<td>20.10</td>
<td>4.20</td>
<td>19.50</td>
<td>3.80</td>
</tr>
</tbody>
</table>

Whilst the profiles\(^{31}\) focus on health and wellbeing across the secondary school age population, schools also need to consider the challenges associated with other factors that contribute to health and wellbeing and educational attainment, including the children and young people who require additional support.

### Table 3: All High School Health Profile Spine Chart

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Luton Average</th>
<th>National Average</th>
<th>Luton Highest</th>
<th>Luton Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of pupils where English is not their first language</td>
<td>48</td>
<td>15.0</td>
<td>94.6</td>
<td>15.8</td>
</tr>
<tr>
<td>% of SEN pupils with a statement or EHC plan</td>
<td>2.1</td>
<td>1.8</td>
<td>5.1</td>
<td>1.0</td>
</tr>
<tr>
<td>% of eligible pupils with SEN support</td>
<td>13.1</td>
<td>12.4</td>
<td>28.5</td>
<td>5.2</td>
</tr>
</tbody>
</table>

---

   Income Deprivation Affecting Children Index (IDACI). LSOA-level data interpolated to school catchment area.
   Table KS106EW-Adults not in employment and dependent children and persons with long-term health problems or disability for all households. MSOA-level data interpolated to school catchment area. Census 2011 data in NOMIS.
<table>
<thead>
<tr>
<th>Percentage</th>
<th>21.1</th>
<th>13.2</th>
<th>35.2</th>
<th>13.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of pupils eligible for free school meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of pupils eligible for free school meals at any time during the last 6 years</td>
<td>36.6</td>
<td>29.4</td>
<td>53.7</td>
<td>21.6</td>
</tr>
<tr>
<td>% of pupils absent</td>
<td>5.2</td>
<td>5.3</td>
<td>15.3</td>
<td>3.6</td>
</tr>
<tr>
<td>% persistent absence</td>
<td>5.1</td>
<td>5.4</td>
<td>28.1</td>
<td>1.4</td>
</tr>
</tbody>
</table>

**Ethnicity**

**Figure 1:**

Source: School Survey data 2016

Figure 1 shows the ethnicity of young people attending secondary schools in Luton. The proportion of students attending Luton secondary schools is:

- White British, 27% compared to 73% nationally;
- 24% are of Pakistani origin compared to 4% nationally;
- Bangladeshi students account for 11% compared to 2% nationally;
- 6% are black African compared to 4% nationally.

According to the 2011 Census there are 158 languages spoken by young people in Luton. The percentage of children whose first language is either not English or listed as “Other than English” or “Believed not to be English” or “Other Language” is 51%. The Census is not specific about a child’s language; it might say “Other Language” or “Other than English”, therefore it is possible that the real figure of children whose first language is not English is higher.
Figure 2:

Proportion of Luton School pupils within national deciles of deprivation, IMD 2015

Source: School Census 2016

Figure 2 shows that of the 11,667 pupils in Luton Secondary Schools, 8% (n=937) live in the most deprived decile nationally with a further 26.6% (n=3,108) living in the 2nd most deprived decile. This means that a total of 35% of Luton pupils live in the 20% most deprived areas in the country.

Figure 3:

Proportion of Luton School pupils within national deciles of income deprivation, Affecting Children, IDACI 2015

Source: School Census 2016
Figure 4 shows that the highest proportion of children and young people aged 0-15 years who are in poverty are living in the north of the borough and in the catchment areas for Lea Manor School and Lealands School.

**School immunisations**

Immunisation in schools is offered to all children in secondary schools as part of the national vaccination programme. These programmes are the Human Papilloma Virus (HPV) and the school leaver’s boosters which follow on from the early years vaccinations.

**HPV Vaccination:**

This vaccination is offered to girls when they are in year 8 as part of a school vaccination programme, and protects against cervical cancer and certain sexually transmitted infections. For protection two doses must be administered.

Figure 5 presents the uptake of HPV vaccine in Luton secondary schools in 2015/16 was 89.4% compared to 85.1% in England. The range of uptake in Luton schools was from 76% to 94%.
The school leaver booster immunisation programme is another school delivered vaccination and is the last child vaccination, boosting the protection for lifetime of those vaccinations given in infancy. This vaccination protects against Diphtheria, Tetanus, Pertussis and Meningitis C. The uptake rates of these within secondary schools in Luton are shown below with vaccine uptake in 2015/16 being 73.5%, and a range across schools from 58% to 99.6% uptake.

**Figure 6:**

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Note: Stopsley school had no pupils vaccinated in 2015/16.
Alcohol Use:

The map below shows the percentage of adult binge drinking in Luton. Rates are highest in the town centre area of Luton. Alcohol consumption is associated with chronic health problems including psychiatric, liver, neurological, gastrointestinal and cardiovascular conditions and several types of cancer. It is also linked to accidents, injuries and poisoning. Excessive alcohol use may result in poor parenting, and children living in houses where this occurs may experience worry, anxiety, anger and neglect which can have a life-long impact.

Figure 7: Adult binge drinking by Luton ward: 2016

Child Obesity:

The National Child Measurement Programme is carried out annually in primary schools targeting Reception class (children aged 4-5 years) and Year 6 (aged 10-11 years) students. The level of participation in the programme is higher in Luton than nationally and this provides an accurate picture of overweight and obesity levels at school level. Whilst this is carried out at primary and junior school age, it is important that secondary schools are aware of the levels of children who are overweight and obese, particularly for year 6 students being educated in schools within the same partnership (often referred to as feeder schools) and who are likely to transition to the secondary school in their area. Figure 8 shows obesity levels in different areas of the town for children in year 6, and identifies a priority that schools need to support addressing; 40.8% of children at this age in Luton are overweight and obese, compared to 34.2% nationally, and these rates are a significant
increase from the records for children in reception class, 20.7% in Luton compared to 22.1 for England\textsuperscript{32}. There are no further routine measurements after this age, and we know that as children become young adults their physical activity reduces and they are increasingly likely to eat a poorer diet.

**Figure 8: Child obesity measured in year 6 cohort in Luton by ward: 2012/13 to 2014/16**

A further indicator of obesity risk is the estimated prevalence of obesity in adults. In Luton, the level of adult obesity is 25.9%, slightly higher than the England average (24.2%). This information is a proxy indicator of eating and physical activity behaviours in families with children whose parents are overweight and obese at greater risk of being overweight and obese themselves.

**Figure 9: Adult obesity by Luton Ward 2016**

\textsuperscript{32} Fingertips: 2014/15 data.
Figure 9 shows that the greater prevalence of obesity is concentrated in the north of the Borough, particularly in Lewsey, Sundon Park and Northwell wards which cover Lealands, Barnfield West, and Lea Manor school areas. Promoting a family centred approach to healthy weight management is a must if to reduce the risk of family obesity, promote healthy weight management and through that, child obesity levels.

**Mental Wellbeing:**

It is estimated that 1 in 10 young people in Luton are likely to have a diagnosable mental ill-health condition. This means that around 1,100 young people in Luton secondary schools may require an intervention to support a level of psychological and psychiatric need above the level that they receive as part of general health and wellbeing. If unmanaged some of these affected children will not achieve their academic potential, decreasing their chances of living a full and healthy life and increasing the risk of unemployment and lifelong mental ill-health.

**Figure 10: School-based mental health and wellbeing indicators, Luton compared to England average**

![Mental Health and Wellbeing Indicators](source)

Unemployment in Luton is high and accounts for 4.5% of the working age population; higher than the national average of 3.8%. The map below shows the wards with the highest rates of unemployment are Biscot, Farley, Dallow, High Town and Northwell.
Parental unemployment is associated with a wide range of negative social, health and lifestyle behaviour’s, and mental health outcomes for children and adolescents. It is also associated with poorer school performance and education outcomes. Schools can work to reduce the negative consequences of parent unemployment, working with children to raise aspirations and build self-esteem.

Figure 11: Adult employment: households with dependent children by Luton ward 2016

Figure 12: Unemployment of working age adults by Luton ward 2016
Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and especially young people. They can also increase the risk of long-term health issues, including mental health related to experience(s). Rates of injuries are lower in Luton compared to national rates. The map below shows where the injuries and accidents affecting children and young people occur.

**Figure 13: Unintentional and Deliberate Injuries per 100,000 child population: Luton, 2016**
In 2015 and again in 2016 the Health Related Behaviour Survey was distributed among Luton schools (both primary and secondary) and an annual sample of children and young people perceptions of their health and wellbeing was recorded.

The survey developed by the Schools Health Education Unit (SHEU) is designed for young people of primary and secondary school age to tell us about what they know about health and wellbeing, and their experience of different issues that affect how they feel in their school, home and community environment. The survey was first used in Luton schools in 2015, and this formed a baseline, and identified where commissioners and service providers needed to focus efforts to ensure children and young people were better informed and able to make the right decision about their health and wellbeing choices.

This survey provides a snapshot of young people’s views of their own health and focused on:

- Healthy eating
- Physical activity
- Sexual Health
- Use of illegal and ‘legal’ drugs
- Emotional health and wellbeing
- Staying safe
- School lessons
- Values and beliefs

Not all schools took part in the survey and some of those who did participate in the survey chose not to share their results and contribute to this overview of Luton Secondary Schools. The following are headlines from the survey in 2016 and where significantly different from the 2015 recorded information, the change is stated.

The total number who undertook the 2016 secondary school survey was 1934 young people (880 boys, 1054 girls). The headline results are shown below from 2016 survey data with the 2015 data provided where available in brackets.

### Table 4: Headline Information from school health survey 2016

<table>
<thead>
<tr>
<th>Background</th>
<th>Illegal Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>21% of pupils described themselves as White British (28% in 2015).</td>
<td>5% of pupils responded that they have taken at least one of the drugs listed during the last month (3% in 2015).</td>
</tr>
<tr>
<td>30% of girls and 12% of boys described themselves as Asian British.</td>
<td>Of the 107 (2015) and 96 (2016) pupils who have ever taken drugs, they were on average 12 years old when they first tried them.</td>
</tr>
<tr>
<td>49% of pupils responded that they live in a home where at least 2 more people live than there are bedrooms (46% in 2015).</td>
<td>38% of pupils responded that they know where they would go for support if they wanted help or advice about drugs (39% in 2015), while 28% said they don’t know where they would go (27% 2015).</td>
</tr>
<tr>
<td>74% of pupils responded that they live with their mother and father together (71% in 2015).</td>
<td></td>
</tr>
</tbody>
</table>

### Healthy Eating

- 37% of pupils responded that they would like to lose...
**Physical Activity:**
Currently there is limited data that accurately represents the level of participation in sport and physical activity of those aged 11-16 years. Sport England’s new Active Lives reports on people aged 16 years and over in England. However, in line with Sport England’s new remit, they are currently working on ways to extend their measurement and reporting to include the younger age group of 5-15 year olds, with a view to reporting on the activity levels of 14 to 15 year olds as part of this wider picture of young people’s engagement in sport and physical activity.

The SHUE Survey data(2016) indicates a decline in several of their key ‘physical activity’ indicators for boys including: the percentage answering that they enjoy physical activities ‘quite a lot’ or ‘a lot’ with Year 8 boys down from 90% (2015) to 82% (2016). Similarly, the percentage answering that they did physical activity on at least three days in the week before the survey demonstrates some significant decreases with Year 8 boys down from 77% (2015) to 68% (2016) and Year 10 boys down from 70% (2015) to 62% (2016).

For girls, significant ‘year on year’ changes included the percentage answering that they enjoy physical activities ‘quite a lot’ or ‘a lot’ with Year 10 girls down from 63% (2015) to 54% (2016), however the key shifts in behaviour change remain between Year 8 and Year 10 whereby there is a significant change in both girls enjoyment and participation levels, as demonstrated below:

<table>
<thead>
<tr>
<th>Year 8 (girls)</th>
<th>Year 10 (girls)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage answering that they enjoy physical activities ‘quite a lot’ or ‘a lot’</td>
<td>71%</td>
</tr>
<tr>
<td>Percentage answering that they did physical activity on at least three days in the week before the survey.</td>
<td>65%</td>
</tr>
<tr>
<td>Percentage answering that they got out of breath and/ or sweaty while doing physical activity for an hour or more on at least three days in the week before the survey.</td>
<td>30%</td>
</tr>
</tbody>
</table>
Improving participation in sports is important not only to improve healthy weight but also to improve mental health. The recommendations to achieve this are in line with Luton’s emerging Strategic Vision for Sport and Physical Activity 2017-21 and promote targeted activity towards girls, using school facilities as community sports venues and recognising the need to encourage family units to create and embed positive habits and motivations towards sport and physical activity.

The Toxic Trio: “Domestic abuse, mental ill-health and substance misuse”:

The 'Toxic Trio' has been identified as common features of families where harm to children has occurred, and are considered as indicators of increased likelihood of risk of harm to children and young people.

Many children experience adverse circumstances that can have an immediate and longer-term effect on their health and wellbeing. This is when children are living with a parent or carer who experience drug or alcohol misuse issues and/or mental illness and/or domestic abuse. Children affected by one or more of the toxic trio are more likely to experience worse outcomes in later life including higher rates of smoking, obesity, drug and alcohol use, low self-esteem, crime and mental health problems.

A needs assessment for Luton, carried out in 2015 suggested that at least 21,000 children in Luton are affected by at least one of the toxic trio, with some 4,200 children affected by more than one of these factors; exposure to more than one increases risk and vulnerability.

Although all groups of children are affected, toxic trio factors are more commonly recorded in deprived areas and among the white British ethnic group. Around a third of child social care assessments in Luton noted one or more of the toxic trio factors, with 25.3% recording parental alcohol misuse, 6.8% parental drug misuse, 16.5% mental illness and 26.6% domestic violence.

The diagram below presents national prevalence of the factors that contribute to the toxic trio based on NICE estimates.

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33 [www.luton.gov.uk/Community_and_living/Lists/LutonDocuments/PDF/JSNA/Toxic%20trio%202015.pdf](http://www.luton.gov.uk/Community_and_living/Lists/LutonDocuments/PDF/JSNA/Toxic%20trio%202015.pdf)
Figure 14: Percentage of children (within the last year) who have parents with mental health, and/or, who are problem drinkers, and/or who are using illicit drugs, and/or who are experiencing domestic abuse:

The table below applies these estimates to Luton data to indicate an estimated scale of children affected by the toxic trio factors.

Figure 15: Estimated number of children in Luton who have parents with mental illness and/or who are problem drinkers and/or who are using illicit drugs and/or are experiencing domestic abuse:

<table>
<thead>
<tr>
<th>Number of children (age range)</th>
<th>&lt;1</th>
<th>1-5 years</th>
<th>6-10</th>
<th>11-15</th>
<th>16-17</th>
<th>&lt;18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total in age group</td>
<td>3,498</td>
<td>17,002</td>
<td>14,638</td>
<td>13,141</td>
<td>5,400</td>
<td>53,679</td>
</tr>
<tr>
<td>Parent has any mental illness (within last year) – 17.8%</td>
<td>623</td>
<td>3,026</td>
<td>2,606</td>
<td>2,339</td>
<td>961</td>
<td>9,555</td>
</tr>
<tr>
<td>Moderate severity – requires psychological therapy</td>
<td>93</td>
<td>454</td>
<td>391</td>
<td>351</td>
<td>144</td>
<td>1,433</td>
</tr>
<tr>
<td>Severe or complex – requires specialist support</td>
<td>31</td>
<td>151</td>
<td>130</td>
<td>117</td>
<td>48</td>
<td>478</td>
</tr>
</tbody>
</table>

Parent is a problem drinker or a drug user (within last year)

| Problem drinker (22.1%) | 773 | 3,757 | 3,235 | 2,904 | 1,193 | 11,863 |
| Dependent drinker (5.9%) | 206 | 1,003 | 864 | 775 | 319 | 3,167 |
| Drug user (8%) | 280 | 1,360 | 1,171 | 1,051 | 432 | 4,294 |
| Drug dependent (2.8%) | 98 | 476 | 410 | 368 | 151 | 1,503 |

Domestic abuse in household (within the last year)

| Have experienced domestic violence (3%) | 105 | 510 | 439 | 394 | 162 | 1,610 |

Affected by more than one factor:

| Parent misusing substances (problem drinker or drug user AND any mental illness (5.8%)) | 201 | 986 | 849 | 762 | 313 | 3,113 |
| Parent misusing substances (problem drinker or drug user AND domestic abuse (1%)) | 35 | 170 | 146 | 131 | 54 | 537 |
Parent has mental illness AND domestic abuse (1%) | 35 | 170 | 146 | 131 | 54 | 537

Affected by any factor (40%) | 1,399 | 6,801 | 5,855 | 5,256 | 2,160 | 21,472

Note: Prevalence estimates applied to 2013 data. Source: Based on NICE estimates

Adolescent Mental Health

Mental health problems affect about 1 in 10 children, however only 25% of children who need treatment receive it. These problems include depression, anxiety and conduct disorder, and are often a direct response to what is happening in their lives. Mental illness is a leading cause of health related disability in children and young people and can have adverse long-lasting effects, such as reducing educational attainment and employment prospects, and making smoking, alcohol misuse and drug misuse more likely.

Luton has a high proportion of young people in the population, high deprivation, and a relatively high percentage of young people in vulnerable groups such as looked after children and young people in the youth justice system. These factors contribute to a high level of mental health need.

Estimated overall prevalence of mental health issues in young people in Luton is 9.8%, and estimates of prevalence of emotional, conduct, and hyperkinetic (attention deficit hyperactivity disorders) disorders for Luton in 2014 as 3.7, 6.1, and 1.7% respectively. Self-harm is an increasingly challenging mental health issue locally. Issues such as anxiety are seen frequently in schools, care and other settings. Estimates are presented in the diagrams below.

Conduct disorders and hyperkinetic disorders are more common in boys in both age groups presented in the CHiMAT data, whereas emotional disorders are more common in girls. Overall, conduct disorders are the most common of the three disorders.

Figure 16: Estimated number of Luton children aged 5-16 with common mental health disorders by sex (2014)

Source: CHIMAT needs assessment: Local authority mid-year resident population estimates for 2014 from ONS. CCG population estimates aggregated from GP registered populations (Oct 2014).

35 CHIMAT “Child Health Profile,” 2016.
Headline information that should inform mental health provision for Luton is:

Public Health England estimate\(^36\) that there are 3670 young people aged 16-24 with ADHD living in Luton in 2013.

Neurotic disorders, such as anxiety, depression and obsessive compulsive disorders and more likely to be diagnosed in girls compared to boys. Figure 17 shows ChiMat applied prevalence rates (2014) to the population of Luton to give estimates of numbers with neurotic disorders.

**Figure 17: Estimated number of people aged 16 to 19 with neurotic disorders (2014)**

Source: ChiMat Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014).

**Self-harm:** Awareness and detection of this mental health need is increasing. ChiMat report that:

- In 2014 there were 476 deaths of 15 to 24 year olds from intentional self-harm or undetermined intent in England and Wales; this equates to a rate of 6.6 deaths per 100,000 populations (aged 15 to 24 years).
- Levels of self-harm are higher among young women than young men, 302 per 100,000 in 10 to 14 year olds and 1,423 per 100,000 in 15 to 18 year olds girls compared to 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year old boys.
- Young South Asian women are at increased risk of self-harm; intercultural stresses and consequent family conflicts are considered relevant factors.
- Up to 30% of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10% of young people repeat self-harm during the following year with highest risk of repeats being in the first two or three months post the first episode.
- The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%. Risk factors include:
  - being an older teenage boy;
  - previous violent method of self-harm;

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o multiple previous episodes of self-harm;
  o apathy, hopelessness, and insomnia;
  o substance misuse;
  o previous admission for psychiatric care.

**Autistic Spectrum Disorder (ASD):**

Evidence suggests that 1% of the child population has ASD. Table 5 presents the estimated overall prevalence of ASD is 157 children per 10,000/population and applied these to the Luton population to obtain estimates of the numbers of children in different age groups with autism-spectrum disorders in Luton in 201437.

In Luton the pathway for referral to diagnosis is not sufficiently responsive to the number of children and young people referred for assessment due to resourcing, and this means that many families are waiting for years to be diagnosed. Current pathway for diagnosis and treatment is not NICE compliant. The data presented is limited by the current delays in diagnosis and therefore accuracy is unclear and likely to be under-reported.

**Table 5 - Estimated number of children with autistic spectrum disorders aged 9-10 in Luton (2014)**

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Autism in children aged 9-10 years</th>
<th>25</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other ASDs in children aged 9-10 years</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Total of all ASDs in children aged 9-10 years</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Autism-spectrum conditions disorders in children aged 5-9 years</td>
<td>250</td>
</tr>
</tbody>
</table>

Source: ChiMat service snapshot - Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014).

**Eating disorders:**

Public Health England estimates that there were 3470 young people aged 16-24 with eating disorders living in Luton in 2013. However, this estimate should be treated with caution, and is based on applying a prevalence estimate from the literature to the local population of 16-24 year olds, without taking into account any other local factors.

In 2016 as part of the Local Transformation Plan for Child and Adolescent Mental Health a specialist service was established for Bedfordshire and Luton to support and treat children and young people. This service is in its infancy and therefore supporting data is not available.

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37 A study of 56,946 children in South East London by Baird et al (2006) [11] estimated the prevalence of autism in children aged 9 to 10 years at 38.9 per 10,000 and that of other ASDs at 77.2 per 10,000, making the total prevalence of all ASDs 116.1 per 10,000.

A survey by Baron-Cohen et al (2009) [12] of autism-spectrum conditions using the Special Educational Needs (SEN) register alongside a survey of children in schools aged 5 to 9 years produced prevalence estimates of autism-spectrum conditions of 94 per 10,000 and 99 per 10,000 respectively. The ratio of known to unknown cases is about 3:2. Taken together, a prevalence of 157 per 10,000 has been estimated, including previously undiagnosed cases.
Mental health needs in different risk groups and settings

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is formed of 14 statements covering a range of feelings and attitudes towards life. Each participant is given a single score based on their responses to the 14 statements which ranges from 14 – 70 (a sum of their scores to the individual statements). In Luton the mean score is 47.1; similar to the England mean score of 47.6.

Compared to regional and England estimates Luton has a:

- Higher percentage of young people reporting low life satisfaction,
- Lower percentage who have been bullied,
- Higher percentage who have bullied others.

The ‘What about YOUth’ survey in 2014 showed comparable results for the same indicators between Luton, regional and national data.

**Figure 18: What About YOUth? Survey results 2014, wellbeing and bullying: Luton compared to East of England region and England**

PHE has estimated a number of indicators relating to mental health in a school setting (Figure 19). Luton is estimated to have 6.66% of pupils with a learning disability, which is statistically higher than the England average estimate of 4.97%. Luton also has a higher prevalence than the England average estimate of pupils with social, emotional, and mental health needs – 2.45% in Luton compared with 2% in England.
The 2016 Schools Health Education Unit (SHEU) carried out in Luton identified increasing levels of anxiety particularly related to exams. All schools surveyed reported an increase in anxiety in students in recent years. Anxiety was seen across all year groups but peaked in year 11, in line with examination periods with one school reporting that in year 11 nearly 20% of the year group had above normal levels of anxiety which had required medical advice to be sought. Similar to the data on anxiety girls appear to present with anxiety more than boys, and the triggers are reported as exam pressure, family problems, including housing evictions, and peer relationships.

Youth offending: Young People known to the Criminal Justice System

Nationally more than 6,000 young people under the age of 18 pass through the criminal justice system every year and at any one time, approximately 1,800 are in custody. The issue of unmet mental health support provision for those young people entering the criminal system has been well researched and documented. Estimates state that:

- 85% of those known to the criminal justice system have personality disorders. This figure is eight times higher than the social norm.
- 60% also have speech or language problems.
- 25% have learning difficulties; this figure increases to 50% for youngsters in custody.
- Cases of depression, anxiety, psychosis and self-harm are significantly higher than population levels.

In 2013/14, the rate of Luton children entering the youth justice system were higher than the regional and England rates for young people aged 15 and 17 year olds. The numbers are given in table 6.
Figure 20: Children and young people formally entered the youth justice system: 2013/14: rate per 1,000 population

![Graph showing the rate of children and young people formally entered the youth justice system by age group for 2013/14, with rates per 1,000 population.](image)

Source: ChiMat snapshot, Ministry of Justice, Office for National Statistics

### Table 6: Number of children formally entered the youth justice system (2013/14)

<table>
<thead>
<tr>
<th>Age at entry to YOS</th>
<th>Number of young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14 years</td>
<td>32</td>
</tr>
<tr>
<td>15 years</td>
<td>37</td>
</tr>
<tr>
<td>16 years</td>
<td>34</td>
</tr>
<tr>
<td>17 years</td>
<td>56</td>
</tr>
</tbody>
</table>

Source: ChiMat snapshot, Ministry of Justice

The Luton Youth Offending Service data for 2014/15 – 15/16 reports that:

- 33% of children and young people who received an intervention had an identified emotional or mental health need. This increased to 41% in 2015/16.
- 24% of the overall number of children and young people who received an intervention had a referral to the YOS Mental Health specialist. For 15/16, 22% were referred for specialist support.

**Looked after children and care leavers:**

This group has a significantly increased risk of mental, behavioural and emotional problems, and are often diagnosed with at least one physical health need.

It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such as anxiety or depression, and 7% were hyperkinetic.\(^{38}\)

Variation in mental health need has been shown to reflect the type of care placement with up to 66% of children living in residential care found to have a mental health disorder compared with 40% placed with foster-carers or their birth parents.

Luton had 73.1 per 10,000 children who are looked after in 2014/15, which is the highest rate in the East of England and statistically higher than both England and the East of England region overall [7]. Compared to Luton’s statistical neighbours the Luton rate is similar.

Figure 21: looked after children rate per 10,000, 2014/15 - Luton compared to East of England and to CIPFA statistical neighbours.

![Figure 21](image)

Source: PHE, Children and Young People’s mental health and wellbeing profile

Figure 22: Luton looked after children rate per 10,000 child population compared to statistical neighbour areas:

![Figure 22](image)

The rate of looked after children in Luton has remained relatively constant in recent years, although the actual numbers increased between 2009 and 2015 and between then and December 2016 have reduced from 400 to 357.

While it is estimated 10% of children have a diagnosable mental illness, for children and young people in care this figure increases to 60%. Of the 357 looked after children in Luton; based on modelled data this would suggest that 214 are likely to have mental ill-health that could affect their well-being.
Data is collected by local authorities through a strengths and difficulties questionnaire (SDQ) and a summary figure for each child in care (the total difficulties score) is submitted to the Department for Education. Scores may range from 0 to 40, and a higher score on the SDQ indicates more emotional difficulties. The definitions are:

- A score of 0 to 13 is considered normal
- A score of 14 to 16 is considered borderline cause for concern
- A score of 17 and over is a cause for concern.

In 2013/14 scores in Luton were similar to those in the East of England and slightly higher than for England (Figure 23).

**Figure 23 - Emotional and behavioural health of looked after children: Average score per child**

Sources: ChiMat snapshot, Department for Education

PHE estimates for 2014/15 indicate that Luton has a statistically higher rate of children in need than England (838 per 10,000 compared to 674 per 10,000 children aged <18), as well as a higher proportion of those in need that have been in need for more than two years (33.3% compared to 31.1%). Of those children in need, a higher proportion has completed an initial assessment compared to the England average.

A higher proportion of looked after children (83% compared to 74.8%) are in foster placements, and a lower proportion in secure units, children’s homes or hostels (5.3% compared to 9.4%).

The percentage of looked after children who had both a development assessment or health assessment is statistically lower than the England value; 50% compared to 86.8% for development assessments, 78.6% compared to 88.4% for annual health assessments. Similarly, the percentage of children who have had an emotional and behavioural health assessment is lower than for England overall – 57% compared to 68% of the eligible population.

**Estimated need for services at each intervention tier**

Children and adolescent mental health services are organised into a tier structure, with 4 tiers indicating the level of specialist mental health support required, one a universal low need and 4 being severe need, often requiring inpatient care.
ChiMat has estimated the number of children and young people who may experience mental health problems at any time during their childhood appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 (see diagram above for explanation of tiers in the mental health service) for the population aged 17 and under in Luton. These estimates are based on a Mental Health Foundation report from 1996.³⁹

Table 7 - Estimated number of children / young people who may experience mental health problems appropriate to a response from CAMHS (2014)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Number of children/young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>8,210</td>
</tr>
<tr>
<td>Tier 2</td>
<td>3,835</td>
</tr>
<tr>
<td>Tier 3</td>
<td>1,015</td>
</tr>
<tr>
<td>Tier 4</td>
<td>45</td>
</tr>
</tbody>
</table>


Children and young people who are experiencing difficulties that could be related to their mental health are usually first identified within Tier 1 services, for example by a teacher, GP, health visitor or school nurse. Similarly, parents/carers who identify that their child is experiencing difficulties will usually initially seek help from services at that level. Children and young people with an identified need may be subsequently referred into specialist CAMH services (falling within Tiers 2–4) for assessment and intervention if necessary.

Hospital admissions

Compared to the England average, Luton had a higher rate of child admissions for mental health (95 per 100,000 compared to 87.4 per 100,000 in 2014/15); there are lower rate of reported self-harm, alcohol and drug misuse and injuries (Figure 24).

The level of funding and resources in mental health is considerably lower than investment in physical health services despite the recognition that there is no health without mental health. Commissioners need to recognise that without mental health and emotional wellbeing young people will struggle to achieve their potential, maximise their education and life opportunities and their ability to achieve resilience and independence.

Over the past few years there has been a growing recognition for the need to make dramatic improvements to mental health services for children and young people. Nationally, this has resulted in significant new investment in these services, and the development of local transformation plans. These outline how clinical commissioning groups (CCGs) working with partner agencies will use the new funding to improve children’s health and wellbeing and improve services for children and young people with mental health illness across the care pathway. New investment comes at a time of savings being required across health and social care, and this will have impact on how services are commissioned and whether new investment can achieve the outcomes required.

There has been a tightening of the eligibility criteria for young people needing to access CAMH service, and the level of need will not be reduced unless there is increasing focus and investment on tier 1 and 2, prevention and early intervention services. For young people with very profound mental health need whilst numbers of tier 4 in-patient care is very small there continues to be a challenge and delay in accessing tier 4 beds when required.

A strategic approach to improving the mental health of young people is required across Luton and across settings and providers. The evidence needs to be collated to inform decision making and completing a needs assessment to understand where the gaps is between need and service provision should be a starting point in evaluating where health resource should be targeted.

Further work will be undertaken to inform a system-wide approach to mental health in children and young people: to understand the evidence of what works in terms of early intervention and prevention; gather best practice from elsewhere; mapping service provision and outcomes in other areas.

**Adverse Childhood Experiences (ACE)**

Having a trusting relationship with at least one adult was one of the significant protective factors for a young person to have resilience to deal with adversity.
The evidence of the studies that have been undertaken in the UK is that outcomes for children are worse with the greater the number of ACEs the child has experienced, and those children and young people with four or more ACEs faring worst.

Compared to those with no ACEs, children and young people with four or more ACEs were significantly more likely to have poor outcomes in adulthood, including:

- 3.9 times more likely to be current daily smokers
- 3.7 times more likely to be heavy drinkers
- 8.8 times more likely to have spent at least one night in a police station or prison.
- 3.0 times more likely to be morbidly obese.

Children also had greater risk of poor educational and employment outcomes, using cannabis, heroin or crack cocaine, having low mental wellbeing and life satisfaction, recent involvement with violence, recent inpatient hospital care having chronic health conditions, and having caused/been unintentionally pregnant aged under 18 years.

An adverse child experience survey Luton was carried out by Liverpool John Moore University in 2015 on a sample of approximately 1500 Luton residents aged between 18 and 80 from all community and ethnic backgrounds. The info graphics presented overleaf show the study outcomes and reported adverse experiences in childhood.

Building from the ACE survey, the SHEU school surveys have included questions regarding relationships with trusted adults and perceived safety. The study found:

- 65% of young people sampled had three or more adults they trusted,
- 8% stated that there are no adults they trust.

Young people were also presented with a list of life issues that could cause them ‘worry’ from which:

- 74% said they worry about at least one of the issues listed ‘quite a lot’ or ‘a lot’.

When asked about their perceived safety in the area where they live and where they go to school, 72% rated their safety as ‘good’ or ‘very good’ at school but 28% rated their safety as ‘poor’ or ‘very poor’ when going out after dark in the area where they live. Other important safety issues were:

- 17% were ‘fairly sure’ or ‘certain’ they or their friends carry weapons or other things for protection.
- 20% felt afraid ‘sometimes’ going to school because of bullying and 4% ‘often’ or ‘very often’ feel afraid of going to school because of bullying.
- 54% stated that their school takes bullying seriously, while 19% said they think it doesn’t take bullying seriously.

Adverse Childhood Experiences (ACEs) in Luton

ACEs are stressful events occurring during childhood that directly affect a child (e.g. child maltreatment) or affect the environment in which they live (e.g. growing up in a house where there is domestic violence).

How many adults in Luton have suffered each ACE?

**CHILD MALTREATMENT**
- Verbal abuse: 18%
- Physical abuse: 11%
- Sexual abuse: 6%

**CHILDHOOD HOUSEHOLD INCLUDED**
- Parental separation: 15%
- Domestic violence: 15%
- Mental illness: 5%
- Alcohol abuse: 5%
- Drug use: 3%
- Incarceration: 4%

For every 100 adults in Luton, 36 have suffered at least one ACE during their childhood and 8 have suffered 4 or more.

0 ACEs: 64%
1 ACEs: 15%
2-3 ACEs: 13%
4+ ACEs: 8%

Figures based on population-adjusted prevalence in adults aged 18-65 years in Luton. Some caution should be taken when interpreting the rates of ACEs identified in Luton. Previous studies have found associations between ACE prevalence and deprivation, thus a higher ACE prevalence for Luton may have been anticipated. The population in Luton is ethnically diverse, with almost a third of residents being of Asian ethnicity. This and other studies have found a much lower prevalence of ACEs reported among this population which may be due to cultural variations in reporting.
ACEs increase individuals’ risks of developing health-harming behaviours

Compared with people with no ACEs, those with 4+ ACEs are:

- 2 times more likely to currently binge drink or have a poor diet
- 3 times more likely to be a current smoker
- 4 times more likely to have had sex while under 16 years old or to have smoked cannabis
- 4 times more likely to have had or caused unintended teenage pregnancy
- 8 times more likely to have been a victim of violence in the last year or ever been incarcerated
- 10 times more likely to have been a perpetrator of violence in the last year

In Luton preventing ACEs in future generations could reduce levels of:

- Early sex (before age 15) by 32%
- Unintended teen pregnancy by 35%
- Smoking (current) by 20%
- Binge drinking (current) by 13%
- Cannabis use (current) by 33%
- Heroin/crack use (current) by 50%
- Incarceration by 45%
- Violence perpetration (past year) by 56%
- Violence victimisation (past year) by 51%
- Poor diet (current: <5 fruit & veg portions daily) by 11%

*These figures relate to the full study sample.

The Northamptonshire, Hertfordshire and Luton ACE study interviewed nearly 5,500 residents (aged 18-69) in 2015. Around six in ten people asked to participate agreed to do so and we are grateful to all those who freely gave up their time. A report presenting the full methodology and results is available at www.cph.org.uk. Ford K, Butler N, Hughes K, Quigg Z, Bells M. (2016) Adverse Childhood Experiences (ACEs) in Northamptonshire, Hertfordshire and Luton. Liverpool: Centre for Public Health.

We would like to acknowledge the following contributors to this research: Public Health England, Luton Borough Council, Hertfordshire County Council and Northamptonshire County Council. April 2016.

Centre for Public Health, Faculty of Education, Health and Community, Liverpool John Moores University, Henry Cotton Campus, 15-21 Webster Street, Liverpool, L3 2ET | 0151 231 4542 | www.cph.org.uk
Educational Attainment:

Ofsted has rated 84.6% of secondary schools in Luton as good or outstanding. The percentage of pupils in Luton attending a good or outstanding school is 91.8%. Academic attainment as qualified by achievement of 5 or more GCSE grades A*-C is a measure of school achievement. Healthy and resilient children and young people are more able to focus on their education attainment and take a step towards higher education, training, employment and a standard of living that increases the likelihood of a healthy life.

The figure below shows the education attainment of Luton boys and girls compared to statistical neighbours and the national average.

Figure 25: Key Stage 4: Achievement of 5 or more GCSEs including English and Maths: Luton compared to England and Statistical Neighbours 2010-15

The data shows that Luton children, whilst achieving comparable education attainment with similar areas are for both genders below the national average. Boys achieve poorer results at local, statistical neighbour and national level than girls, and achievement is currently showing a downward trend.

Figure 26: Key Stage 4: Achievement of 5 or more GCSEs including English and Maths: Luton compared to England 2016.
SECTION 3: Discussion and Conclusions

If we are to make the difference to young people’s lives, improve their health and wellbeing so that we optimise their academic attainment and future life opportunities we need to have a shared understanding and picture of local needs which makes the connections between health, wellbeing and future prospects and agree a shared future strategy. Luton partners have the experience of the Early Years Flying Start Strategy as a benchmark for what can be achieved by working together in the same strategic direction. This is an opportunity to not only address the needs of adolescents and include all school-aged children, aged 5-19 years.

Working together at a time when all organisations have no choice but to economise means that evidence to inform needs assessment to make the commissioning decisions about where to target resources is particularly important. For needs assessments and evidence reviews to be consistently the starting point of decision making through we can understand the impact of efficiencies we have to be ever more data informed. This is core business for Luton Public Health and Commissioning Teams, with a business intelligence function that is sufficiently mature to shape the choices.

Data must not be the only information that drives commissioning decisions. It is time that we go back to the level of engagement and inclusion of young people as commissioners to shape the services they use.

Luton’s Investment Framework sets a strategic direction for an improved economic basis for the town built on developing employment opportunities, developing young people’s education, training and apprenticeship opportunities and aligning them with local business demand. Developing a workforce that will support the planned business environment for Luton in the next 20 years is predicated on health and wellbeing and young people being resilient, independent and able and gaining from the new investment; local jobs for Luton young people.

As services make efficiencies they need to start making bold plans to integrate. The 0-19 healthy child programme and children centres have been a starting point, but there is opportunity to further integrate, bring together a wider 0-19 universal service to include mental health and social care services and then extend to children with complex needs.

SECTION 4: Recommendations

The following recommendations reflect the actions that are considered a priority for Luton if we are to make the significant improvement in health and wellbeing of our young people.

1. The use of information and data needs to drive services and be the measure by which we evaluate service impact and the outcomes for young people therefore the first recommendation must be to tackle the lack of access to up-to-date data to inform business planning and outcomes. Given that health needs assessment should be the starting point of commissioning and the basis upon which change is planned, implemented and measured if we are to get the outcomes we need from services, without access to data the health and social care commissioners will be challenged to make the service changes that are required to drive the improvement needed.
2. Local organisations should consider a partnership and shared strategic focus not only on adolescents but include all school aged children.

3. Young People in schools are a captive audience and the PHSE programme is the ideal conduit to really focus on what the school health profiles have identified as priorities. There are many quality providers keen to engage with schools and the objective now is to match the health and wellbeing need with the provider, and engage all schools, not only the informed few to appreciate the synergy between health and wellbeing and academic attainment. This should include the development of sex and relationship education which the school survey identifies as needing clear investment of resource.

4. No health without mental health should be reflected in what we commission to make young people more resilient and independent. The following actions are recommended:
   - Carry out a mental health needs assessment for children and young people in Luton and agree a shared strategy that recognises inequality and therefore targets vulnerable groups such as looked after children.
   - Develop a strategic approach should view mental health as a continuum of need, ensuring appropriate attention is given to emotional wellbeing and resilience, prevention and early intervention to reduce demand on tier 3 and 4 services which is currently increasing to an unsustainable level.
   - Develop a pathway for ASD children to establish compliance with NICE guidance and address the delay through improved commissioning and provision of services to reduce time from assessment to diagnosis.

5. Luton Council should use the assessments on the Toxic Trio and Adverse Child Experiences and take the lead and:
   - Commission and provide services which recognises ACE impact and ensure assessments include an understanding of ACE, identify exposure, and risk.
   - Develop a broader and more integrated approach to children at risk from a range of adverse circumstances.
   - Implement the recommendations from the Toxic Trio Health Needs Assessment:
     - Review the thresholds for accessing specialist services in the light of concerns that earlier access could improve outcomes, and potentially reduce costs in the medium and longer term). This is particularly the case for child and adolescent mental health services.
     - Equalities monitoring should be improved and reported regularly and a regular programme of audit of key services in relation to agreed standards should be undertaken and reported.

6. School Nurses, PHSE providers, parents and schools need to work together to prioritise health and wellbeing need, build resilience while young people are at a stage in life when they form life-long lifestyle behaviours.

7. In line with Luton’s emerging Strategic Vision for Sport and Physical Activity 2017-21 there should be greater participation encouraged in healthy exercise and support schools to:
Engage with the ME TIME women and girls participation programme, in order to address the decline in girl’s enjoyment and participation levels in sport and physical activity between Year 8 and Year 10.

Provide local communities with access to their facilities for the purpose of sport and physical activity via the ‘Community Access to Schools Programme’. This programme supports schools through a range of business planning, networking and marketing tools to enable greater levels of community access to their facilities, in recognition that schools are often viewed as the safest, most suitable and high quality facilities locally available.

8. Improving policy development for children and young people’s commissioning and putting this into practice should start with a gap analysis against the six principles stated in the diagram below and include the development of child and young people’s commissioning forum to ensure that children and young people are making decisions about services that are being commissioned for them.

The six Principles: Putting Policy into Practice:

9. No health without mental health needs to be more than words and therefore policies and services need to ensure that the impact of poor mental health is understood, that resilient teenagers need to be psychologically competent and that mental ill-health increases the risk of poor physical health, and reduces the ability for independence. It is recommended that the CAMH needs assessment is used as a catalyst to address the difference in service provision, resources, access to services, and funding between mental and physical health.

This section provides an update on the progress that has been made to implement the recommendations made in the previous report.

**Recommendation 1: Health Inequalities Strategy**

| I. Refresh the Health Inequalities Strategy with a specific focus on the wider determinants of health. | The Health Inequalities strategic plan covers the six policy areas as set out in Fair Society, Health Lives. Each policy area has a designated responsible Service Director lead and reflects the Luton Investment Framework priorities. Delivery of action against the plan is overseen by the Health Inequalities Board which reports to the Health and Wellbeing Board. ([https://www.luton.gov.uk/Health_and_social_care/Lists/LutonDocuments/PDF/Health%20inequalities%20strategic%20plan.pdf](https://www.luton.gov.uk/Health_and_social_care/Lists/LutonDocuments/PDF/Health%20inequalities%20strategic%20plan.pdf)) |

**Recommendation 2: Family Poverty and Welfare Reform**

| I. Develop and support initiatives to ensure Luton residents in work have a sufficient income to fund a healthy lifestyle. | Luton Access is an ongoing process for integration and improvement which has led to more people getting a ‘right first time service’, for example, by putting debt specialist access as a priority. The number of people using Luton Access is increasing with people needing advice to improve their income; debt, benefits and employment advice. |
| II. Model the impact of welfare reform on health and mental wellbeing and identify actions to mitigate negative impacts. | As one of the main employers of people who live in Luton, the Council has committed to, and ensures that all staff are paid a living wage. Employment advice is delivered through Luton Access and Stronger Families. More resources are being sought for Luton residents through Luton Access. |
| III. Ensure all front line staff have the | The Council runs a programme to continually increase staff familiarisation with welfare reform changes and |

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knowledge and skills to signpost individuals to the help and support that is available based on the Making Every Contact Count principle.

IV. Ensure that advice, support and advocacy are joined up and there is consistency in the advice given. This will prevent the duplication of support, allow case management of the individual/household and ensure a positive outcome for all concerned.

Information, advice and guidance available through Luton Access cover debt, benefits, housing and immigration. The integration of Adult Social Care, currently in the planning process, will add a Housing IAG.

Advocacy services are being retendered in 2016/17 and this will join up children’s and adult’s advocacy and link this to Luton Access.

### Recommendation 3: Mental Health

<table>
<thead>
<tr>
<th>I.</th>
<th>Ensure new mental health provider supports people with mental health problems into employment or volunteering.</th>
</tr>
</thead>
<tbody>
<tr>
<td>II.</td>
<td>Increase awareness of mental health issues in the workplace to reduce stigma and discrimination through Mental Health First Aid (MHFA) training.</td>
</tr>
</tbody>
</table>

Being employed promotes mental wellbeing, and using our psychological wellbeing and mental health services to support people into training and employment is part of the specified requirements of commissioned services in Luton.

MHFA is being delivered as part of the Luton workplace wellness plan which supports employees in the Council, and is offered to local employers which through the Luton Investment Framework there is increasing engagement.

### Recommendation 4: Education

<table>
<thead>
<tr>
<th>I.</th>
<th>Work with schools to implement the recommendations of the PSHE review.</th>
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</thead>
</table>

A PSHE Support Network (PSN) has been established. This allows schools to access continuous professional development through locality updates, training, briefings, workshops and access to resources. Network meetings allow sharing of good practice of effective initiatives.
| II. | Prioritise early years by increasing support for families to achieve improvements in early child development and continuing to improve the quality of pre-school education to ensure a healthy start in life. |
| III. | Maintain a focus on reducing the inequalities gap in educational attainment between girls and boys and between those eligible and those not eligible for free school meal by reporting on outcomes and key performance indicators. |

The School Health and Well-Being award, a 3 tiered award allows for the auditing of PHSE curriculum provision, identifying gaps and offering support and guidance to schools.

The health and behaviour related SHEU survey has been rolled out in 2015 and 2016 and used to support a focused, targeted PSHE curriculum which is bespoke to Luton Schools. This has led to the development of a standardised SRE programme, now implemented into primary schools and a model being developed for secondary schools.

An evidence based drug education programme is also in place.

The school health profiles are being used more widely and have identified health priorities for schools to focus on when undertaking the School Health & Well-Being Award accreditation.

A Directory of quality-assured agencies to support PSHE has been developed and distributed to schools. The School Health Education Directory signposts schools to services that meet the required standard of education; a trusted provider for students and staff. For entry in the directory providers are required to agree and sign up to the School Health and Well-being SRE pledge, which supports the values and principles of the Sex Education Forum of which Luton Council is a core member.

Flying Start Parenting Programmes are now available in children’s centres with a range of targeted and universal programme that are responsive to the assessed need of parents. A range of training courses such as Five To Thrive have been available for the early year’s staff through Flying Start. Access to evidence based parenting courses such as the Peep Learning Together Programme are being offered for delivery in nurseries and primary school that will enable staff to further strengthen the town wide standardised approach to improving parenting.

The integration of 0-19 services provides an opportunity to work together, pool resources and target additional support towards families with the greatest need. We anticipate that this will be the start of further service integration, as we work in the best interests of families.

We maintain a focus on reducing the inequalities gap in educational attainment between girls and boys and between those eligible and those not eligible for free school meal by reporting on outcomes and key performance indicators.
<table>
<thead>
<tr>
<th><strong>Recommendation 5: Training and employment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I.</strong> Continue to improve links with major employers in the town to better understand their needs as employers and how best the schools, adult education and apprenticeship providers can up-skill young people for future employment.</td>
</tr>
<tr>
<td>The Council Education and Economic Development departments have increased engagement with local employers through the implementation of the Investment Framework, and schools working with employers to identify training and apprenticeship opportunities locally. This has been achieved through Business Breakfasts, pilots for engaging employers in education, bringing together employers and those who develop curriculum programmes for 14-19 year olds to optimise alignment between skill development and local business need. Planning for the Government Area Based Review has made employability outcomes that reflect employer and learner need central to the review and is part of delivery of the Luton Investment Framework. In addition, with increased focus on careers activity to support young people’s understanding and knowledge of the local labour market offer supports raising aspiration for training and employment.</td>
</tr>
<tr>
<td><strong>II.</strong> Use research tools to monitor qualifications and skills looked for in job adverts and use this data to inform Job Centre Plus, education and training providers in the town to better identify future skills needs.</td>
</tr>
<tr>
<td>Labour Insight software is being used to monitor job adverts and companies hiring in the area. Data is shared monthly with Job Centre Plus and other organisations. In addition NOMIS web data on employment rates, claimant counts and qualifications are shared monthly with strategic leads for welfare reform and health inequalities. The Council’s jobs and training website pages have been upgraded and expanded to give links to local company jobs pages and free access to Careers Explorer, software that provides detailed information about careers, training opportunities, apprenticeships and jobs in the local area.</td>
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<tr>
<td><strong>III.</strong> Promote the value of apprenticeships with young people, their parents, carers and advisers and Luton’s employer base as a route into employment and a credible and viable alternative to ‘A’ Level and University study.</td>
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<tr>
<td>Luton Council Apprenticeship Strategy was approved in 2016. The LIF revision of the Skills and Employability Strategy is now consistent with the Apprenticeship Strategy and both are aligned to prioritise the promotion of skills acquisition as a viable alternative to academic education and training routes. Promoting apprenticeships to young people, parents and school based staff continues to be part of the offer, and the new Apprenticeship Levy and Duty also heightens awareness of the benefits of apprenticeships. The 16-19 Team restructure brings resource for greater activity on Skills, Employability and Apprenticeships.</td>
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</tbody>
</table>
**IV. Continue to support people into employment through skills and employability programmes with a particular focus on people with mental health issues and disabilities.**

We know that some groups need greater support and therefore focus has been on assisting vulnerable people. To do this the Council has taken the following actions:

- College and Post 16 providers are now developing an understanding of the golden thread and review process.
- Creative packages are being developed that are individualised and personalised to meet individual need.
- There are stronger links between health and adult social care which are leading to improved outcomes for young people with special educational needs (SEND)
- The SEND Reform grant has been used to extend the brokerage capacity
- LDA’s have been converted to education and health care plans (EHC) within statutory timescales to be implemented (April 2016)

There are areas that are in development which include support and bespoke training for college staff and ensuring those with mental health issues, particularly those with SEN but without an EHC plan do not fall through the gap between school, college and training.

**Recommendation 6: General housing conditions**

<table>
<thead>
<tr>
<th>I. Update the Housing Conditions Survey in 2014 in partnership with the Building Research Establishment (BRE) to identify where areas of housing improvements should take place and potential cost savings</th>
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<tr>
<td>A review of housing conditions is being undertaken as part of the development of the council’s housing Investment strategy.</td>
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**Recommendation 7: Fuel poverty**

<table>
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<tr>
<th>I. Develop a coordinated action plan with the aim of targeting fuel poor households and improving knowledge</th>
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<tr>
<td>Addressing fuel poverty and reducing excess winter deaths are outcome measures in the refreshed Health and Wellbeing Strategy. An audit of current action against NICE guidance was undertaken in the summer 2016. An action plan has been developed to act on the audit findings.</td>
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</table>
and understanding amongst key partners on the issues and extent of fuel poverty in Luton. The implementation of the new energy strategy for Luton will start to address fuel poverty and take action to reduce fuel poverty.

**Recommendation 8: Homelessness**

| I. | Ensure the new Homeless Strategy recognises the importance of prevention and addresses the health needs of homeless people. Homelessness Prevention Strategy includes analysis and action on the structural drivers to homelessness. The strategy is the first joint homelessness strategy between the Council and NHS (CCG) |
| II. | Maintain and improve access to Primary Care services for homeless people in Luton. The Homelessness Prevention Strategy recommends undertaking a Health Needs Assessment of homeless people and rough sleepers, to inform future developments in primary care access for this very vulnerable group of people with considerable health need. |

**Recommendation 9: Unintentional injuries**

| I. | Review NICE Guidance ‘Preventing unintentional injuries among the under-15s in the home’ (PH30) to ensure the recommendations are being implemented locally. Luton Safe at Home Scheme has operated a child safety in the home programme for four years. Originally working with RoSPA, the programme brings together a partnership of funding and supporting organisations with the primary aim of reducing accidents for children aged 0-5 through at home assessments, access to safety equipment, and promoting education and awareness of risk, from fire safety, burns and scalds, trading standards and ingestion. |
| II. | Explore the options for collecting appropriate data specifically on under 5’s accidents and falls in the over 65’s in order to plan interventions based on local trends and highest risks. Access to up to date data to inform action plans has proven a continuous challenge. There are action plans in place for both the under 5’s programme and the falls agenda, the impact of which it remains too early to assess. |
| III. | Develop formal referral pathways between the falls service and exercise programmes designed to improve mobility. The Falls Task and Finish Group is reviewing the effectiveness of the current falls pathway and associated services and is developing strength and balance exercise support for those at risk of falling. Falls prevention is part of the STP Prevention work stream and will be developed across commissioner and provider organisations. |
### Recommendation 10: Planning and Health

<table>
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<tr>
<th>I.</th>
<th>Development of local areas should ensure that the health and wellbeing of residents are improved by:</th>
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<tr>
<td><img src="https://via.placeholder.com/150" alt="image" /></td>
<td>• Designing future plans that promote active travel such as walking and cycling</td>
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Within the draft Local Plan, supplementary planning policies advocate for design to support health and wellbeing, including access to support services where required. A local sports strategy and work between the Council, Active Luton, the physical activity provider and Sport England means that local residents have access to high quality physical activity programmes. The Council has embedded the importance of health in all decisions, and planning decisions are not an exception.

### Recommendation 11: Green spaces

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<th>II.</th>
<th>Continue improvement of the play area stock and outdoor fitness equipment in appropriate locations within the town.</th>
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<tr>
<td>III.</td>
<td>Continue to develop links with organisations to support people with mental health issues to develop skills through active involvement in environmental projects in local parks and green spaces.</td>
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<tr>
<td>IV.</td>
<td>Work with General Practice to explore options to increase social prescribing such as Green Prescriptions.</td>
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As development of areas occur across the Borough the Council is making best use of green spaces and public access areas, looking at opportunities for walking and cycling, and building in additional outdoor exercise equipment, Wardown Park and Marsh Farm are currently being developed. Previous installations have been well used by local residents.

There are a series of walks i.e. Let’s Do This programme in partnership with BHF, Tesco’s and Diabetes UK, Nordic Walking and condition specific walks for Pulmonary Disease, Cancer and Palliative Care, but not specifically for MH.

In partnership with Macmillan and Groundworks a Health Garden is being developed to be ready in April 2017.

Social Prescription is a key project working with 4 GP practices engaged and referring to the programme. It is expected that coverage of all GP practices in Luton with be reached by 2018.

### Recommendation 12: Air quality

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</table>
I. Develop a business case to extend the current Air Quality Management Area (AQMA) to include the monitoring of small particulates as well as nitrogen dioxide.

The most recent Air Quality Management Area, declared in April 2016, covers area to the West of the Town Centre. The boundaries were set by modelling air quality monitoring data along with other information such as traffic volumes and proximity of residential accommodation. The modelling only included Nitrogen Dioxide as insufficient data on particulates (PM10) was available. An action plan is currently being drawn up to address the Nitrogen Dioxide levels in the AQMA and will link closely with the local transport strategy. A business case for further modelling will be developed once the action plan has been approved by Defra (Summer 2017) following which the data relating to particulates will be reviewed. Vehicular traffic is the main source of Nitrogen Dioxide and particulates so any actions to reduce traffic volume encourage less pollutant-emitting vehicles and maintain smooth traffic flow will assist in improving air quality.

II. Review the health impact assessment (HIA) submitted as part of the airport planning application with a view to developing a health management plan.

The Council is working with local Universities to have in place a health plan in line with the wider developments planned for Luton as detailed in the Investment Framework which sets out the ambitions for the town.

Recommendation 13 Road safety

I. Prepare a child safety audit report by March 2014 and develop a plan to implement the recommendations.

A child road safety report was completed in 2014 and the results included in the Borough Road Safety Plan 2015-2020. The road safety agenda is being overseen by the Child Accident Prevention Steering Group led by Public Health.

Recommendation 14: Illegal drug use

I. Improve the access to safe housing, education, training and employment for alcohol and drug users seeking to re-establish alcohol and or drug free lifestyles.

Drug and alcohol services are being re-procured during 2016/17 with a new provider(s) starting April 2017. Within the specification safe housing, education training and employment are key outcomes measures.

II. Continue the development of local licensing policies concerning the availability of alcohol.

A joint local licensing group in Luton will be established by the end of March 2017 to identify and set criteria for responding to applications. This will include engaging with elected members to gain intelligence surrounding potential alcohol related issues in their areas. It will also review and implement information.
### Recommendation 15: Community safety

<table>
<thead>
<tr>
<th>I. Ensure strategies to tackle community safety issues such as violence and sexual exploitation incorporate evidence-based, preventative interventions.</th>
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<tr>
<td>Each of the Community Safety Partnership priorities has its own Strategy and implementation plan, which is overseen by the Community Safety Partnership Executive. The strategies include key priorities and desired, measurable outcomes. The implementation plans incorporate evidence-based, preventative interventions which are implemented by services across the Partnership.</td>
</tr>
<tr>
<td>The Community Safety Partnership Executive oversees the Partnership Delivery, which feeds action updates and any concerns up to the CSPE. Each of the priorities has a delivery group, who oversee the relevant strategy and implementation plan. The delivery groups are made up of the relevant services for the priority, with other services invited if and when required. Having the delivery groups has strengthened joint working to improve services. The core Community Safety Team has been expanded to include members of staff from Victim Support, Stronger Families, MARAC Co-coordinator and Public Health who all contribute to victim and offender risk assessments.</td>
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### III. Ensure Making Every Contact Count (MECC) is widely promoted in all agencies to ensure that alcohol and drug use is considered alongside other health information.

Sharing protocols as required with particular attention on L&D emergency department and East of England Ambulance Service

Having contact with the public provides an opportunity to not only assist with the primary reason for that contact but to recognize where wider use of services can support greater resilience, independence and self-care. Luton Access leads this work, signposting individuals and families to supportive services.

This principle is widely used by health services and commissioners and providers alike recognize how important it is to maximize each contact opportunity. Live Well Luton is commissioned to provide MECC training to agencies in Luton. The specification for the new drug and alcohol service embeds MECC into service provision.