Appendix A

The Early Years of Life

A Strategy to ensure children, young people and their families are safe, healthy and achieve their full potential in Lancashire

2020 - 2023

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Lancashire County Council

CONTENTS

Appendices:

FOREWORD

We are delighted to introduce the Lancashire Early Years Strategy 2020-2023. Our vision for the strategy is that all our Children, young people and their families feel safe, healthy and achieve their full potential. Hence we have taken a real partnership approach in identifying the priority areas which we believe will get the best outcomes and reduce inequalities for our children, young people and families across Lancashire.

The Lancashire Early Years Service delivers key statutory functions for Lancashire County Council including management of funded free early education, supporting and monitoring standards and provision across early years settings, provision of early help, SEND services, support for early years provision and the Early Years Foundation Stage statutory assessment.

As a council we are committed to delivering the best possible services and recognise the significant part our service plays in the early intervention and preventative agenda. We are working with Public Health and other services to help achieve the best possible start in life recognising that development begins before birth. As Professor Sir Michael Marmot stated: 'The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years has lifelong effects on many aspects of health and well-being**.** We have therefore focussed our strategy on 4 key priority areas:

To ensure better **maternal and child outcomes** throughout **pregnancy, birth and beyond**	To ensure children families and communities are **school ready** and schools ready for children	To ensure improved health and wellbeing outcomes through the **Healthy Child programme**	To target **inequalities** and **improve outcomes** in the areas of greatest need

In Lancashire the number of our children achieving a good level of development by the end of reception has been increasing over the last 5 years. A key priority is to ensure we have robust plans in place to ensure children are school ready and our schools are ready for children so we see further increases in the number of children with a good level of development and educational attainment.

We are also keen to improve the areas where we are not doing so well through the commissioning and delivery of the Healthy Child programme and early access to our Early Help offer which we have just reviewed. We hope that by focussing on these priority areas we will see a measurable change in reducing inequalities in areas of greatest need in the longer term.

It has been a privilege to have worked with all our partners across Lancashire and other organisations to develop an Early Years Strategy which will inform the development of local plans based on evidence, need and outcomes which we will measure accordingly.

Councillor Phillippa Williamson
Cabinet Member for Children, Young People and Schools

1. INTRODUCTION

1.1 Purpose of the Early Years Strategy

Every baby and child living and growing up in Lancashire deserves the best possible start in life and the best support that allows them to fulfil their potential. Children develop quickly in their early years and a child's experiences between birth and age five has a major impact on their future life chances. We want all our children to be happy, healthy and grow into confident, capable and resilient young adults.

Our Lancashire children starting school will all have different experiences, as will their families and carers. How good and positive those experiences are by the time they start school will depend on a whole range of factors, like where they grow up, the family they grew up in, the opportunities they have to play and learn and the support they have in their own communities.

A lack of attachment and stressful experiences in the early years can impact negatively on physical and emotional development. There is capacity for healing through changing circumstances, taking nurturing approaches and supporting resilience through family support, childcare providers, schools, communities and services.

Children feeling safe is also critical to supporting them into adulthood. This strategy focuses on vulnerable families and addresses issues of child poverty to empower families to keep themselves and their children safe and well cared for; having the personal resources to cope in difficult situations; knowing where to go for help; and finding help from services that understand and respond to differences in personal circumstances for example for lone parents, parents with a disability, and teenaged and young parents.

Lancashire is committed to working in partnership to achieve the very best start for its youngest children in delivering the Early Years Foundation Stage (EYFS) Statutory Framework for children between birth and age five with fidelity and consistency. The framework is mandatory for all early years providers in England.

Lancashire's key responsibilities are outlined in the *"Early education and childcare statutory guidance for local authorities".* This guidance applies to "the free entitlements for two-, three- and four-year-olds, both the universal entitlement and the extended entitlement which secures sufficient childcare for working parents, provides information advice and assistance to parents and provides information, advice and training to childcare providers."

Lancashire's vision is for all children to be able to take up their funded hours in a high quality setting. Evidence shows that higher quality provision has greater developmental benefits for children, particularly for the most disadvantaged children leading to better outcomes. The EYFS sets the standards that all early years providers must meet to ensure that children learn and develop well and are kept healthy and safe. Lancashire's work with funded education providers is designed to help shape and secure quality provision in accordance with the EYFS and, notably, its guiding principles.

- Every child is a unique child, who is constantly learning and can be resilient, capable, confident and self-assured.
- Children learn to be strong and independent through positive relationships.

- Children learn and develop well in enabling environments, in which their experiences respond to their individual needs and there is a strong partnership between practitioners and parents and/or carers.

Children develop and learn in different ways and at different rates. The framework covers the education and care of all children in early years provision, including children with special educational needs and disabilities.

In all parts of Lancashire, sufficient, high quality early years provision is vital to ensuring all of our children receive the following:-

- Quality and consistency in the provision of all early years services so that every child makes good progress and no child gets left behind
- A secure foundation through learning and development opportunities which are planned around the needs and interests of each individual child and assessed and reviewed regularly
- Good and effective partnership working between practitioners and with parents and/or carers so that information can be shared and additional support identified and provided at the earliest opportunity

1.2 What do we mean by "early years"?

For the purposes of this strategy, early years is from pre-birth to five years old. This broad definition of early years is in recognition of the importance of a healthy pregnancy and good parenting and high quality education and childcare in influencing outcomes, and that the move into primary school is a critical period in all children's lives. Many aspects of this strategy are equally relevant to children beyond the age of five.

1.3 Why have a strategy?

We know however from looking at the information we collect on health, education and other outcome measures, such as income levels and unemployment, that there are differences in how our children are developing. These differences can be seen depending on where families live; between boys and girls; between different cultural and social groups and their experiences of family life; and between those children who are looked after and/or have special educational needs and disabilities.

The overall aim is to ensure children and families have the best start in life through reducing inequalities in health, promoting good health, and readiness to play and learn.

We take an "earliest intervention" approach in child development so that all children can thrive at each age and stage of development. Underpinning this strategy is a focus on progressive universalism, which means a core offer for all families and targeted support for those families according to the level of need.

1.4 What will the strategy do?

The strategy will ensure:

- a preventative and early intervention approach that supports children, young people and families to build resilience and take responsibility for their own health and wellbeing

- Children get the best start in life so they are able to learn and develop resilience, capability, confidence and self-assurance through positive relationships
- building of community capacity to promote health and wellbeing using local assets
- Shared leadership and a joined-up approach to commissioning which is committed to driving real action and change to reduce inequalities and improve education, health and wellbeing outcomes for babies, children and young people living in Lancashire.

2. VISION AND KEY PRIORITIES

2.1 Our vision

Children, young people and their families are safe, healthy and achieve their full potential.

2.1 Our key priorities

- We will improve outcomes for our babies, children, young people and families.
- We will focus on prevention and evidence-based practice in order to improve the environment, reduce inequalities and build resilience.
- We will provide children and young people with high quality education and learning opportunities so children and young people achieve their full potential in education, learning and future employment.
- We will support children, young people and their parents to make healthy lifestyle choices and to build strong families, friendships and healthy relationships.
- We will prevent the need for children to become looked after through Early Help, so children and young people feel safe from harm through universal and targeted services.
- We will support parents and families to influence decision-making and bring about positive change for themselves and their children.

2.3 How will we do this?

We have identified four priority areas we need to focus on in the next three years if we are to see tangible benefits and improved outcomes.

Key Priority	Objective
1) Best start in life	❖ To reduce inequalities in pregnancy and ensure better maternal and infant outcomes
2) School readiness	❖ To ensure children, families and communities are school ready and schools are ready for children
3) Health and wellbeing	❖ To ensure effective delivery and commissioning of appropriate services for children, young people and families working within the framework of the Healthy Child Programme
4) Inequalities and societal issues	❖ To target inequalities and improve education, health and wellbeing outcomes in areas of greatest priority and need

2.4 Our outcomes

- We want to reduce infant mortality by ensuring we focus on conception, birth and healthy pregnancies across the social gradient
- We want to increase school readiness at the end of the reception year (with a focus on closing the word gap).

- ❖ We want to reduce inequalities in health through the provision of mandated universal and targeted services.
- ❖ We want to ensure a broader focus on reducing child poverty and inequalities, and their impact across the social gradient.

3 NATIONAL AND LOCAL STRATEGIC CONTEXT

3.1 National drivers

3.1.1 Each day is important in a child's development, especially those first 1,000 days of life, which Unicef calls the "brain's window of opportunity" and says: : *"The time spanning roughly between conception and one's second birthday - is a unique period of opportunity when the foundations of optimum health, growth, and neurodevelopment across the lifespan are established."*

3.1.2 **The Marmot Report** on health inequalities cited evidence that development begins before birth and that the health of a baby is crucially affected by the health and well-being of the mother. Professor Sir Michael Marmot wrote: *"The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being."*

3.1.3 In January 2016 "**Better Births: a five-year forward view for maternity care**" was published, with recommendations for all sectors of health and social care to make to improve maternity outcomes.

3.1.4 A recent Department for Education (DfE) statement clearly illustrates the importance of early education in government strategy: *"The first few years of a child's life are critical to shaping their future development, and our ambition is to provide equality of opportunity for every child, regardless of background or where they live, because we know that good early years education is the cornerstone of social mobility."*

3.1.5 **School Nurseries Capital Fund, September 2018**. Improving social mobility through education - A good early years education is the cornerstone of improving social mobility

3.1.6 **0 to 19 agenda / March 2018 Best start in life and beyond child poverty**. This document is one of four supporting guides to assist local authorities in the commissioning of health visiting and school nursing services to lead and coordinate delivery of public health for children from birth up to the age of 19.

3.1.7 National agencies are increasingly focused on the school readiness of young children. It is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally and is impacted by a whole range of indicators: those related to the family (maternal mental health, homelessness, family income and parental education), the child (low birth weight, health status and immunisation rates) and services (quality and availability of funded early education) among many others. Two key specific indicators are:

- Percentage of children achieving a good level of development at the end of reception year.
- Percentage of children with free school meal status achieving a good level of development at the end of reception year.

3.1.8 In July 2018, the Secretary of State for Education announced his ambition to halve the proportion of children who do not achieve at least expected levels across all goals in the "communication and language "and "literacy" areas of learning in the Early Years Foundation Stage (EYFS) Profile at the end of reception year by 2028.

3.1.9 This ambition builds on **"Unlocking Talent, Fulfilling Potential: a plan for improving social mobility through education"** which set out the government's plans to close the word gap in the early years, which it describes as the "first life ambition".

On 14 December 2017, the Department for Education (DfE) launched Unlocking Talent, Fulfilling Potential: a plan for improving social mobility through education. The plan sets an overarching ambition: no community left behind.

Ambition 1 is to close the word gap in the early years. Children with strong foundations will start school in a position to progress, but too many children still fall behind early, and it is hard to close the gaps that emerge. We need to tackle these development gaps at the earliest opportunity, particularly focussing on the key early language and literacy skills, so that all children can begin school ready to thrive

3.1.10 **Early Years Workforce Strategy 2017.** This document sets out how the DfE plans to support the early year's sector to remove barriers to attracting, retaining and developing the early year's workforce.

3.1.11 **Legislation and statutory duties 2014 Children and Families Act**. This is a key driver for a range of recent reforms and policy development was the 2014 Children and Families Act.

3.1.12 **The Code of Practice 0-25 for children and young people with special educational needs and disabled children and young people** provides statutory guidance on duties, policies and procedures relating to Part 3 of the Children and Families Act 2014 and associated regulations and applies to England.

3.1.13 **Statutory guidance for early years and childcare.** This guidance from the DfE is for English local authorities on their duties pursuant to Section 2 of the Childcare Act 2016 and have regard to this guidance when seeking to discharge their duties.

3.2 Local drivers

3.2.1 **Lancashire Health and Wellbeing Board**. Upper tier and unitary local authorities are required to have a health and wellbeing Board. The board comprises a range of partner agencies and has a duty to decide what the main public health needs of the population are and to determine how to meet them in an integrated way.

The board has a responsibility for child health and wellbeing and key actions such as infant mortality have been identified. An infant mortality strategic action plan is being developed.

3.2.2 The local **Joint Strategic Needs Assessment** (JSNA) is used to assess the current and future healthcare and wellbeing needs of our residents. These needs can only be met by collaborative working across all local authorities, clinical commissioning groups (CCGs), the NHS and a range of other partners including the voluntary, community, faith and social enterprise (VCFSE) sector, and our communities themselves working together in partnership.

3.2.3 The **Lancashire Children and Young People's Partnership Board** provides strategic direction for Lancashire in order to promote integration and to achieve our vision. This will be done through delivering our key local priorities, policies and strategies including the Lancashire Children and Young People's Plan.

3.2.4 In January the **Healthier Lancashire and South Cumbria Integrated Care System** (ICS) published its ICS strategy that sets out how the ICS will work towards its vision that our "communities be healthy and local people will have the best start in life so they can live longer, healthier lives". There is a key focus on a better start for children and young people.

This strategy, which aims to providing support as soon as a problem emerges, at any point in a child's life – from pre-birth, the foundation years through to the teenage years.

3.2.5 **Lancashire Safeguarding Children Board** (LSCB). This board is a statutory body established under the Children Act 2004, responsible for ensuring that all agencies who work with children and young people work together to safeguard and promote the welfare of children in the local area. However the structure this is also changing in view of new legislation which has to be implemented from 2019.

3.2.6 This Lancashire Safeguarding Childrens Board also include the findings, learning and recommendations from the Child Death Overview Panel which will support the areas identified as preventable such as modifiable factors and adverse childhood experiences.

3.2.7 **Family experiences**. To help us to inform and implement this strategy, we gathered the experiences, views and ideas of mums, dads, grandparents, carers, childminders and multi-agency front-line practitioners and managers of services.

3.2.8 Lancashire Special Educational Needs and Disabilities Strategy

4 LANCASHIRE AT A GLANCE

4.1 Demographics

Information is collected on a wide range of measures throughout our lifetime and is used to help those who make decisions at government level to plan services for families and communities and what health services are needed to look after the local population. This information helps us to build up a picture of an area such as that covered by Lancashire County Council and the people and families who live here.

4.1.1 Children aged 0-5 living in Lancashire

Knowing where our families and very young children live is important in deciding how resources are allocated and how services should be commissioned and delivered across the county. Where we live is important in understanding other challenges linked to social inequalities such as poverty and being able to access services.

- As at the ONS Mid-Year Population Estimate for 2018, there are a total of 1,210,053 people living in Lancashire.
- Of these, there are 81,508 children aged between new-born and five years old.
- This represents 6.7% of the total population.
- There is a slightly higher number of boys at a count of 41,707 (51%) compared to girls at a count of 39,801 or 49%.
- Preston has the highest number with 10,952 boys and girls compared to Ribble Valley with the lowest numbers at 3,157 boys and girls.
- Trend line analysis over the five to six years leading up to 2018 shows the numbers of children born each year has been gradually decreasing.

4.1.2 Social disadvantage and poverty across Lancashire

Where they live is an important factor in shaping outcomes for our Lancashire children. Evidence tells us that very young children and their families who live in communities that are less well-off than others (looking at the Index of Multiple Deprivation) do less well than their peers living in better off areas (see Appendix I).

- One in three (32%) of our children aged up to five years old live in the top fifth of the most deprived areas nationally.
- A third of our very young children are living in our poorest neighbourhoods and communities (Burnley, Hyndburn, Pendle, Preston and West Lancashire).
- If we look at the top 40% most deprived areas nationally, we can see that just over half (51.8%) of our very young children are living in the country's poorest areas.

4.1.3 Special educational needs and disability (SEND)

Where there is disability in a family, whether that is parental or child disability, evidence tells us that disabled people have higher poverty rates than the rest of the population (**Disability and Poverty NPI, 2016**).

Additionally, children with disabilities are less likely to achieve a good level of development (GLD) at the end of the EYFS, more likely to be excluded from school,

achieve on average half a grade lower at GCSE than their peers with similar levels of prior level of attainment, and are less likely to gain employment.

- In 2018 150 children (4.7%) in Lancashire accessing 2 year offer funded early education were identified as having SEND
- In 2018 1570 children (5.8%) in Lancashire accessing 3/4 year offer universal funded education were identified as having SEND, with 270 (3.1%) children with SEND accessing the extended offer.
- Although there has been a slight improvement, fewer children with SEND in Lancashire achieve GLD compared to the national average.

4.2 Inequalities in health

Key issues identified from the **Lancashire Child Health Profile 2019** show that, comparing local indicators with England averages, the health and wellbeing of children in Lancashire is mixed, however there are some areas that are worse than England and therefore a priority for Lancashire (Appendix 2).

5.1 Priority 1 Best start in life

5.1.1 Why have we chosen this as a priority for Lancashire?

There are a number of factors that can increase the risk of harm to the unborn baby and many of these are influenced by factors such as income, having support networks, leading a healthy lifestyle, parenting experience or lack of and access to good quality health care and support services.

The health secretary announced his ambition to reduce stillbirth, neonatal death and maternal death by 50% by 2030. In January 2019, that ambition was accelerated to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

Low birth weight of term babies can be for a number of reasons, perhaps due to family history. Some risk factors can be associated with an unhealthy pregnancy and the potential harms from smoking, stress and substance misuse.

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and new-born.

5.1.2 Where are we now?

- In 2017, there were 355 low birth weight babies, representing almost 3% of all babies born that year. The picture in Lancashire remains static, with no significant change in recent trends but the two districts, Burnley and Hyndburn stand out as getting worse.
- The infant mortality rate is worse than England with an average of 62 infants dying before age one each year, although the rate has been consistently reducing over time, there has recently been 33 child deaths (one to17 year olds) each year on average.
- In 2017/18 there were 136 (1%) babies born to teenage mothers in the Lancashire County Council area, or 180 across the larger footprint of the Lancashire and South Cumbria NHS region.
- The areas of Burnley, Hyndburn, Fylde, Preston and parts of West Lancashire stand out as having higher rates of teenage mothers.
- The teenage pregnancy rate is worse than England, with 440 girls becoming pregnant in a year.
- 13.9% of women smoke while pregnant which is worse than the rate for England.
- The rate for Lancashire is 4.7 infant deaths under one year of age per 1,000 live births. This rate is higher than the statistical neighbours' average at 4.3 infant deaths per 1,000 live births, and higher than the England average at 3.9 infant deaths per 1,000 live births.
- Comparing Lancashire trends with England overall shows that Lancashire rates have remained either the same as, or worse than, England over the period between 2001 and 2017.
- We have identified a strong correlation between infant deaths and deprivation.

5.1.3 Where do we want to be?

- We want to reduce inequalities in maternal health and wellbeing.
- We want to target inequalities and reduce infant mortality rates.
- We want to ensure we target vulnerable groups such as teenage pregnancies and children with SEND so they receive the targeted support needed.
- We want to ensure Lancashire has a greater understanding of adverse childhood experiences including a local approach which includes the development of more targeted support within localities through our revised multi agency early help offer where we will be developing integrated teams.

5.1.4 How will we get there?

Priority 1: Best Start in Life	
To ensure the best start in life by reducing inequalities in pregnancy, birth and beyond	1) We will develop an integrated care pathway and an outcomes-based approach for mothers, babies and children which supports the needs and wellbeing of the whole family. 2) We will ensure midwifery services adopt a personalised approach to supporting healthy pregnancies (adopt the Better Births learning into future commissioning). 3) We will develop an infant mortality action plan for Lancashire 4) We will embed learning from child death overview panel reports and serious case reviews into ongoing service review as part of a commissioning process of continuous improvement. 5) We will ensure better information for mothers, parents and carers on where to access support and advice 6) We will ensure practitioners will work to deliver a whole system approach to supporting healthy early attachment and positive relationships in the home and education settings to support children's and mother's emotional health and wellbeing. 7) We will increase the number of parent peer champions so we reinvigorate preparation for parenthood through local parenting plans and development of a parenting Strategy 8) We will develop integrated early help locality based teams that identify and support our most vulnerable families through the implementation of our revised Multi Agency Early Help offer.

5.1.5 How will we know when we get there?

We will ensure we have a baseline in order to measure outcomes in relation to this priority area based on key health outcomes measures where local targets will be established which are ambitious for Lancashire.

- Reduce infant mortality
- Reduce low birth weight of term babies 37 weeks
- Increase breastfeeding rates
- Reduce smoking status at time of delivery
- Reduce under 18s conception rate

5.2 Priority 2 Children are school ready

5.2.1 Why have we chosen this as a priority for Lancashire?

"School readiness" is a term used to describe the development outcomes of children by the time they get to the end of the reception year at school. It is defined by Public Health England as: *"Children defined as having reached a good level of development at the end of the EYFS as a percentage of all eligible children."*
Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy. Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life, as we've already mentioned.

There is increasing concern about the numbers of children starting school with poor speech, language and communication skills with unacceptable differences in outcomes in different areas of the country. Disparities in early language development are recognisable in the second year of life and have an impact by the time children enter school. Around two-fifths of disadvantaged five-year-olds do not meet the expected literacy standard for their age.

5.2.2 Where are we now?

- Nationally, 28% of children leave reception without the literacy skills they require in order to thrive and succeed (**HM Government, 2018**). In Lancashire the number of our children achieving a good level of development by the end of reception has been increasing over the last five years, although it dropped by 0.3% this year and is below national average.
- However, it had not been increasing as quickly as it has for England and had remained relatively static for the last three years, only rising 0.3%.
- For the year 2017/18, 9,796 (69.5%) of children achieved a good level of development and 4,300 (30.5%) children did not achieve a good level of development by the end of reception.
- At 2017/18, 29.2% or 4,116 of Lancashire children did not achieve the expected goals. If we are to halve this figure, then we need to see a development gain in approximately 2,000 more children born over the next decade to 2028 (based on the reception age population as at 17/18).
- In 2018/19 there has been a reduction of 0.3% compared to last year, with 69.2% of children achieving a good level of development.
- In Lancashire, 70.8% of all children achieve the expected level of development for communication and language and literacy (combined) compared to 72.6% of all children nationally.
- In Lancashire, the gap for all children is 2.6% below the national average for all children that achieve at least the expected level of development for communication and language and literacy (combined).
- We can pinpoint gaps between social groups and between boys and girls.
- 12.8% fewer boys, compared to girls achieve the expected standard in communication and language early learning goals.
- Children born pre-term before 37 weeks of gestation are at increased risk of experiencing difficulties with speech, language and communication. Based on data

from the Office for National Statistics in 2017, 8% of live births in Lancashire were pre-term (born before 37 weeks).

- In financial year 2017/18, 99.1% of children who received a development review at two to two-and-a-half years of age in Lancashire had their development reviewed using the Ages and Stages Questionnaire (ASQ-3) compared 90.2% of children nationally.
- There is also disparity across the County in relation to GLD outcomes where for some children on free school meals (FSM), there has been a 3 year trend that is below national. (Helen tbc)

5.2.3 Where do we want to be?

- We want to target our combined efforts to reach those prospective new mothers and families living in our most deprived communities.
- We want to address the gaps we see in development, with a focus on boys, those in receipt of free school meals and children with additional needs.
- We want to focus on **Closing the Word Gap** and improve child communications outcomes. We would do this through children's speech, language and communication in the home learning environment (HLE), early education environment and through early identification and intervention.
- We want to work in partnership to achieve the very best start for our youngest children, in delivering the EYFS statutory framework for children between birth and age five, with fidelity and consistency.
- We want to ensure we deliver on the free entitlements for two, three and four year-olds, both the universal entitlement and the extended entitlement which secures sufficient childcare for working parents, provides information advice and assistance to parents and provides information, advice and training to childcare providers as highlighted in the Early Education and Childcare Statutory Guidance for local authorities (June 2018)
- We want to ensure all children take up their funded hours in a high-quality setting.
- We want to ensure we deliver a range of projects to strengthen workforce development.
- We want to deliver targeted intervention for parents who have concerns about their child's behaviour.

5.2.4 How will we get there?

The following table provides actions to be delivered in this priority area:

PRIORITY 2: Children ready to learn at age two; ready for school at age five	
To ensure children families and communities are school ready and schools ready for children	1) We will ensure a shared understanding of "school readiness" within early years services, schools and partners across Lancashire 2) We will ensure better information for mothers, parents and carers on where to access support and advice, including a social media and digital communication offer for families and practitioners. 3) We will ensure partners and education settings understand and respond to the development gaps through "warranted variation" so that we target resources to where they are most needed 4) We will ensure the two-year-old funding take-up is improved and benefits disadvantaged children and families* 5) We will ensure the home learning environment is encouraged through every contact, through good information, resources and tools. 6) We will improve pathways to support early detection of, and access to support and therapy for speech delay through the implementation of a Lancashire speech, language and communication strategy and plan. Detection is no good without access to support and therapy. 7) We will ensure affordable and high-quality childcare and early years education for children from disadvantaged communities. 8) We will support the provision of free or low-cost alternative activities and community-based support for families and parent/s of very young children as part of an asset-based community development approach. 9) We will ensure the quality of provision in early years settings and schools will be supported to ensure that children are supported to make maximum progress from their starting points 10) We will ensure we promote children's own wellbeing and resilience 11) We will ensure there is appropriate follow up of children who have been identified with additional needs through the ASQ assessments prior to starting Early Years and school.

**The statutory guidance refers to early years provision free of charge (sections 7 and 7A Childcare Act 2006) and free childcare (section 2 Childcare Act 2016) as the 'free entitlement(s)', a 'free place' or 'free hours'. This reference applies to the 15 hour entitlement for the most disadvantaged two-year-olds*

5.2.5 How will we know when we get there?

We will measure outcomes in relation to impact based on key national outcome areas.

- The proportion of children aged two to two-and-a-half years receiving ASQ-3 as part of the Healthy Child Programme or integrated review and the number of children identified as having additional needs who have been referred for relevant support
- School Readiness: the percentage of children achieving a good level of development at the end of reception (age five)
- School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (age five)
- School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (age six)
- School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (age six)
- To consider the % of children aged two, three and four who have accessed high quality childcare or nursery provision from disadvantaged communities
- The number and percentage of early years schools and settings who achieve a good or outstanding OFSTED inspection outcome

5.3 Priority 3 Improved Health and wellbeing outcomes

5.3.1 Why have we chosen this as a priority for Lancashire?

In order to support children, young people and their parents to make healthy lifestyle choices we need to ensure that we provide universal prevention, health promotion and early intervention services as early as possible. This is necessary to identify and prevent the need for children to become looked after through signposting to other services through the Early Help offer (is there a link to this?) so children, young people and families feel safe from harm through targeted services. This is important in safeguarding and identifying and signposting families and children early.

The 0-19 public health nursing deliver on the Healthy Child Programme as highlighted in the Best start in life and Beyond Commissioning Guidance, which includes the delivery of Universal Health Reviews and assessments. This includes transition from maternity services, the five mandated health reviews, and maternal mood assessment. In addition, this will include health needs assessments and reviews supporting transition for children and deliver the six high impact areas as follows:

Universal Health Reviews	**0-5 Years High Impact Areas**
1) Antenatal review (women more than 28 weeks pregnant) 2) Birth review (one day to two weeks) 3) Postnatal review (six to eight weeks) 4) 12 months review 5) 24 to 30 months review	1) Transition to parenthood and the early weeks 2) Maternal mental health 3) Breastfeeding (initiation and duration) 4) Healthy weight, healthy nutrition 5) Managing minor illnesses and reducing hospital attendance/admissions 6) Health, wellbeing and development of the child aged two: Two-year-old review and support to be 'ready for school

It is also important we consider the opportunities for non-statutory education assessments when children enter the free entitlement for nursery education at age three, and at age four in addition to the statutory EYFS profile assessment at the end of reception year. This will support early intervention and where necessary early help if the child is not achieving the age related expectation.

The Service will also support and delivery of the National Child Measurement Programme (NCMP) and comply with Public Health England's NCMP operating guidance.

5.3.2 Where are we now?

- We are not achieving 90% take up of the mandated visits within the health visiting service.
- The MMR immunisation level does not meet recommended coverage (95%). By age two, 88.9% of children have had one dose.
- Population vaccination coverage - Dtap / IPV / Hib (2 years old) in 2018/19 was 89.3% in Lancashire compared to 94.2% in England.
- Dental health is worse than England with 34.0% of 5-year olds have one or more decayed, filled or missing teeth compared to 23.3% in England.
- 10% of children in reception are obese compared to 9.7% in England.
- 19.9% of children in Year 6 are obese compared to 20.2%in England which is worse.

5.3.3 Where do we want to be?

- We want to ensure we have developed an integrated care pathway for early years services which will include maternity, health visiting and early years children services.
- We want to agree an integrated workforce development plan for all early years staff.
- We want the 0-19 Healthy Child Programme integrated with the Children and Family Wellbeing Service
- We want to ensure easy access to speech, language and communication services across Lancashire.
- We want to embed a framework for peer-to-peer and cluster working that effectively promotes quality improvement, school readiness and supports children through key transition points, both in and across education settings.
- We want to establish an effective network of communication champions (language leads) in early years settings and other relevant agencies. This will include peer support.

5.3.4 How will we get there?

The following provides key actions to be delivered for this priority area:

Priority 3: Improving Health and wellbeing outcomes	
To ensure improved health and wellbeing outcomes for children through the Healthy child programme	1) To develop an integrated care pathway for maternity and integrate the 0-19 Healthy Child Programme with the Children and Family Wellbeing Service 2) To commissioning, deliver and monitor the 0-5 health visiting service 3) To review the commissioning models for speech, language and communication services across Lancashire. 4) To establish an effective network of communication champions (language leads) in early years settings and other relevant agencies. Include peer support. 5) To review models to support parent interactions – portage and educational psychology – use of video interaction. 6) To ensure all practitioners take appropriate action on families with depression, anxiety and interpersonal violence. 7) To develop agree an integrated Workforce Development Plan for Early Years staff as part of the Early Help offer 8) To align our services with the objectives of the multi-agency Early Help Strategy by bringing together locality based integrated teams.

5.3.5 How will we know when we get there?

We will measure according to key outcome areas as identified in the Outcomes frameworks for Health and social care and public health from a baseline measure in the following areas:

- To ensure all families are offered mandated visits.
- To improve oral health of children from birth to five years old.
- To reduce hospital admissions caused by unintentional and deliberate injuries in children from birth to four years old.
- To reduce the number of children who are obese in reception.
- To increase the number of children, young people and families accessing early intervention and prevention activities and services.
- To identify children with special educational needs and disabilities early.
- To increase the number of staff accessing training and development opportunities.

5.4 Priority 4 Tackling big society Issues

5.4.1 Why have we chosen this as a priority for Lancashire?

Tackling big societal issues such as child poverty are crucial if we are going to address inequalities and improve outcomes for our children, young people and families

The early years strategy and the activity associated with this will help to raise awareness and target poverty through effective commissioning and delivery of statutory, voluntary and community services. Partnership and integrated working with a focus on the wider determinants such as economic development, including improving skills, training and employment opportunities is also essential.

There is a clear role for sectors such as housing (housing providers, homelessness teams, addressing fuel poverty and reducing energy bills). Addressing child poverty will not only be the remit of key partners but also the Local Enterprise Partnership, economic development agencies, district councils, business communities, adult learning and education as well as the statutory, voluntary and community sectors.

The level of "resilience" children and young people, and their families have, is often highly relevant in terms of how they are able to deal with poverty related issues, and how their lives are affected. Working with families to increase their 'resilience' is key to sustained improved outcomes.

Helping families to take ownership of any problems and potential solutions, and where possible providing pathways to help lift families out of the poverty cycle. This includes looking at routes to employment and training for both young people, and for parents and carers, supported by accessible and affordable good quality childcare to enable them to work, whilst their children are being given the best possible start to early learning.

There is also a key focus on the areas of inequality identified within the child health profiles such as mental health issues, tooth decay, traffic accidents, substance misuse, abuse, and community safety. Collaboration and local partnership activity are key components in tackling child poverty related issues. Therefore, strategic partnerships must work together in an integrated way to ensure that long term outcomes for children, young people and their families are improved.

5.4.2 Where are we now?

- The level of child poverty (2016) in Lancashire was better than England with 15.1% children aged under 16 years living in poverty compared to 17% in England
- The rate of child hospital admissions for mental health conditions in Lancashire is 98.8 per 100,000 which is worse than England at 84.7.
- In 2017/18 hospital admissions caused by unintentional and deliberate injuries in children aged up to 14) was 137.1 per 10,000 in Lancashire compared to 96.4 in England.
- There are 224 children (34.1 per 100,000) killed or seriously injured on the roads which is worse than the England value of 17.4 (PHE 2016-17)
- There are 79 children in care in Lancashire (per 100,000) compared to 64 in England

5.4.3 Where do we want to be?

- We want to ensure action to address the child poverty agenda is embedded at the highest strategic level.
- We want to ensure ownership and leadership for the child poverty agenda is provided through the Health and Wellbeing Board and the Children's Trust Board.
- We want to ensure the continued development of a coherent early help offer for families will be driven through the Lancashire early help strategy.
- We want a whole-family assessment in place and used effectively across all services and sectors, including information shared effectively between agencies
- We want a workforce that supports working in partnership with parents, to build resilience and enable families to find solutions to issues.
- We want to ensure that we develop place-based strategies.
- We want to ensure we reduce inequalities and develop appropriate pathways and strategies to address poor mental health and self-harm, and reduce the rate of child inpatient admissions for mental health conditions.
- We want to reduce the number of children who are killed or seriously injured on the roads.

5.4.4 How will we get there?

Priority 4: Tackling Big Society Issues	
To target **inequalities** and **improve health and wellbeing outcomes** in priority areas	1) The Health and Wellbeing Board sets clear measurable targets to tackle child poverty and disadvantage 2) To achieve year-on-year improvements in child health outcomes through a focus on reducing the risk factors associated with each outcome 3) Annual improvement across all "red" indicators in the Child Health Profile, with priority in deprived areas and the outcomes identified across all the priority areas

5.4.5 How will we know when we get there?

We will ensure we have a baseline of information in order to measure outcomes in relation to the impact on health outcomes where local targets will be established which are ambitious for Lancashire.

- Reduce children in low income families
- Reduce hospital admissions caused by unintentional and deliberate injuries
- To reduce average difficulties, score for all looked after children
- Reduce the percentage of children where there is a concern (tbc –a national indicator?)
- To reduce children who are killed or seriously injured on the roads.
- To reduce the rate for self-harm

6. MEASURING PROGRESS

Performance will be measured against the strategic outcomes identified in the early years strategy and the children and young people's plan and against the JSNA.

Early years outcomes across public health, education and all key stakeholders will be captured and reported against within the Early Help shared outcomes framework as part of the implementation of the Multi Agency Early Help Strategy ratified by the Children, Young People and families Board in Dec 2019

Public health outcomes framework (PHOF)

The **PHOF** provides all the indicators and the most recent data that is recorded.

We want to be ambitious in our targets so that we improve health outcomes overall but also target work in areas identified as deprived or achieving below the regional and national average as rated red or amber.

The service will be expected to support improvements from the baseline performance data, so we are ambitious and see an improvement in the longer term in all PHOF areas identified by introducing targets which will be measured quarterly and annually where appropriate.

The strategy will be monitored against the outcomes highlighted for children, young people and families and will submit a quarterly report demonstrating activity against these outcome areas as highlighted in the Appendix 3.

7. GOVERNANCE AND REPORTING PROGRESS

The Health and Wellbeing Board will lead and co-ordinate the oversight of the strategic plan as part of a collaborative and shared leadership approach. Delivering and measuring progress against this strategy will be through the Best Start in Life Strategic Group which will be accountable to the Children and Young People and Families Partnership Board.

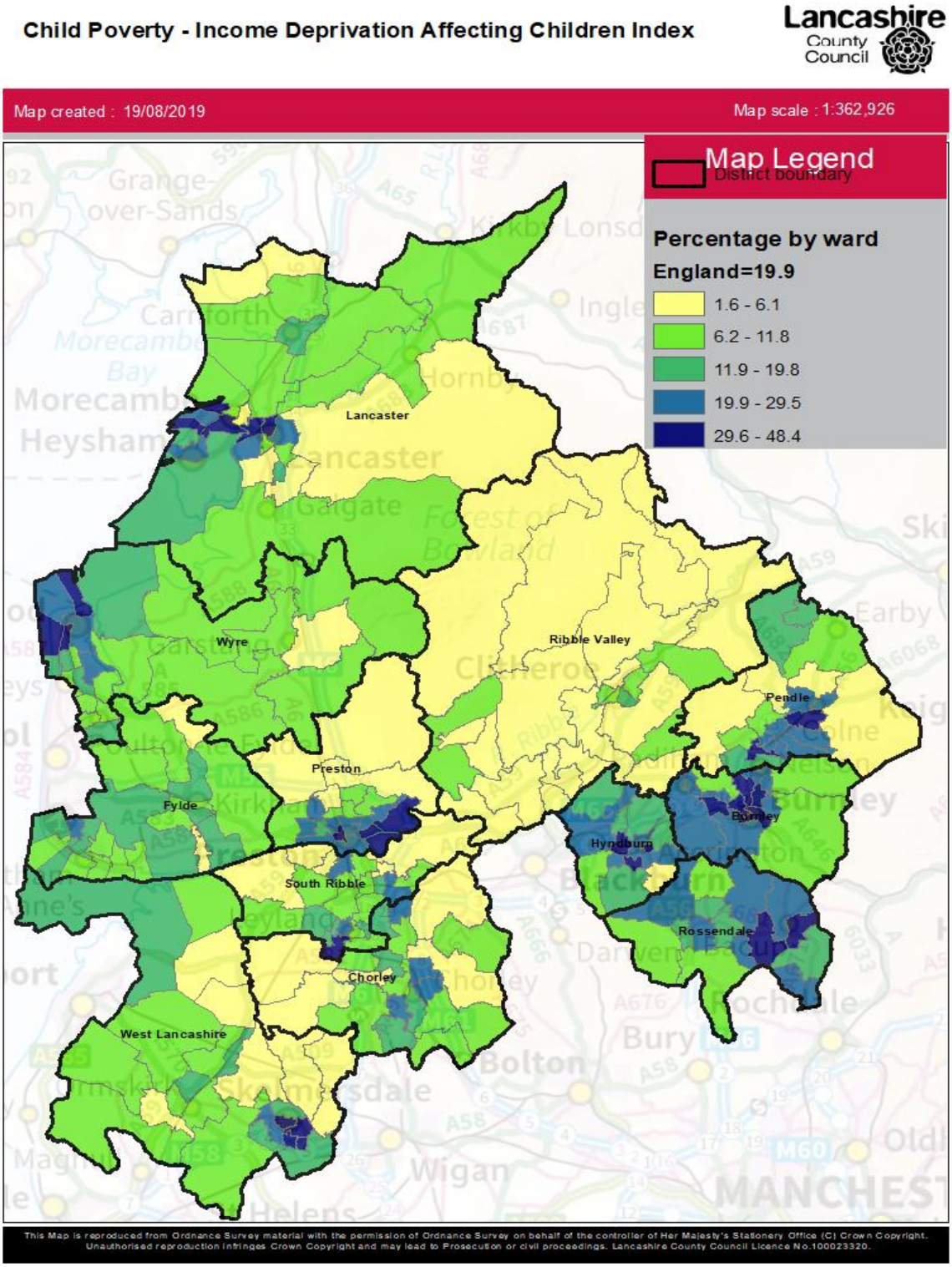
Progress towards achieving the outcomes will be reported through the Children and Young People and Families Partnership Board chaired by the executive director of education and children's services. This strategy will link into as appropriate with other plans to include early help and children with SEND.

Strategic links are therefore key to the delivery of this strategy and plan, with alignment of common actions and themes to the early help strategy; family safeguarding; SEND strategy; managing behaviour strategy and the emotional wellbeing and mental health transformation plan - and to the wider plans for the Lancashire and South Cumbria ICS.

APPENDIX I:

Map 1 –Income deprivation affecting children across Lancashire

The darker shaded areas represent those families and communities especially affected by low income and poverty



Appendix II: Child health profile for Lancashire (March 2019)

This profile shows how Lancashire children are doing against a range of health and education outcome measures, compared to the England average. The “red dots” identify key areas where we must focus our energies, especially for children up to age five.

Indicator	Period	Lancs			Neighbrs average	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Infant mortality rate	2015 - 17	–	185	4.7	4.3*	3.9	8.1		1.7
Child mortality rate (1-17 years)	2015 - 17	–	99	14.0	-	11.2	24.3		7.5
Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2017/18	↓	10,901	88.9%	92.3%*	91.2%	75.0%		96.9%
Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% 90% to 95% ≥95%	2017/18	↓	11,164	91.1%	95.2%*	95.1%	83.7%		98.5%
Children in care immunisations	2018	↑	1,245	90.1%	88.0%*	85.3%	5.7%		100%
School Readiness: the percentage of children achieving a good level of development at the end of reception	2017/18	↑	9,796	69.5%	-	71.5%	63.9%		80.5%
Average Attainment 8 score	2017/18	–	-	46.6	-	46.7	39.8		55.8
Average Attainment 8 score of children in care	2017/18	–	-	14.9	-	19.3	0.0		33.9
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2017	–	2,130	8.3%	-	6.0%	24.4%		1.9%
First time entrants to the youth justice system	2018	↓	205	190.9	-	238.5	554.3		72.3
Children in low income families (under 16s)	2016	↓	32,255	15.1%	-	17.0%	31.8%		6.4%
Family homelessness	2017/18	↓	205	0.4	-	1.7	7.7		0.1
Children in care	2018	↑	1,965	79	-	64	185		23
Children killed and seriously injured (KSI) on England's roads	2015 - 17	–	224	34.1	20.4*	17.4	41.7		2.6
Low birth weight of term babies	2017	→	355	3.07%	2.60%*	2.82%	5.30%		1.57%
Reception: Prevalence of obesity (including severe obesity) New data	2017/18	→	1,235	9.3%	9.3%*	9.5%	14.4%		4.9%
Year 6: Prevalence of obesity (including severe obesity) New data	2017/18	↑	2,388	18.8%	19.0%*	20.1%	29.7%		11.4%
Children with one or more decayed, missing or filled teeth	2016/17	–	-	34.0%	-	23.3%	47.1%		12.9%
Hospital admissions for dental caries (0-5 years)	2015/16 - 17/18	–	1,900	764.7	357.9*	325.1	10.8		1,612.1
Under 18s conception rate / 1,000	2017	↓	436	22.9	18.1*	17.8	43.8		6.1
Teenage mothers	2017/18	↓	123	1.0%	0.8%*	0.7%	2.1%		0.2%
Admission episodes for alcohol-specific conditions - Under 18s	2015/16 - 17/18	–	332	44.9	38.0*	32.9	106.5		7.4
Hospital admissions due to substance misuse (15-24 years)	2015/16 - 17/18	–	499	112.0	-	87.9	329.3		33.1
Smoking status at time of delivery	2017/18	↓	1,619	13.9%	13.9%*	10.8%	26.0%		2.0%
Breastfeeding initiation	2016/17	–	8,673	*	70.4%*	74.5%	37.9%		96.7%
Breastfeeding prevalence at 6-8 weeks after birth - current method	2017/18	–	-	*	40.2%*	42.7%*	-	*Insufficient number of values for a spine chart*	-
A&E attendances (0-4 years)	2017/18	↑	34,587	508.6	568.1*	619.0	2,011.3		321.3
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2017/18	↓	2,857	137.1	99.0*	96.4	203.7		46.5
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2017/18	↓	1,649	113.2	137.6*	132.7	284.4		69.0
Hospital admissions for asthma (under 19 years)	2017/18	↓	701	267.4	195.4*	186.4	511.7		82.5
Hospital admissions for mental health conditions	2017/18	→	245	98.8	85.0*	84.7	187.6		14.5
Hospital admissions as a result of self-harm (10-24 years)	2017/18	–	938	439.3	-	421.2	1,009.6		116.9

Source: PHE Fingertips

Appendix III: Outcomes Framework

OUTCOMES AND PERFROMANCE FRAMEWORK (Example – to be agreed)		
Priority 1: Best start in life		
Objective	**Performance Measure**	**Indicator ref**
1.1 Reduce infant mortality	1.1.1 Rate of infant mortality	
1.2 Reduce low birth weight of term babies 37 weeks	1.2.1 Low birth weight of term babies 37 weeks gestational age at birth	2.01
1.2 Increase breastfeeding rates	1.2.1. Breastfeeding initiation - all ages	2.02i
	1.2.2 Breastfeeding prevalence at 6-8 weeks after birth - current method	2.02ii
1.3 Reduce smoking status at time of delivery	1.3.1 Smoking status at time of delivery - ll ages	2.03
1.5 Reduce under 18s conception rate	1.5.1 Under 18s conception rate / 1,000 <18 yrs.	2.04
	1.5.2 Under 16s conception rate / 1,000 <16 yrs.	2.04
Priority 2: School readiness		
2.1 Increase number of ASQ-3	2.1.1 Proportion of children aged two to two-and-a-half receiving ASQ-3 as part of the Healthy Child Programme or integrated review	2.05ii
2.2 To increase the percentage of children who achieve the expected level of development for communication and language literacy at the end of reception year	2.2.1 School readiness: the percentage of children achieving a good level of development at the end of reception (age five)	1.02i
2.3 To Increase the number of children who achieve a good level of development (GLD) at the end of the reception year. (Baseline: 2017/18: 69.5% GLD)	2.3.1 School readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (age five)	1.02i
	2.3.2 School readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (age six)	1.02ii
	2.3.3 School readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (age six)	1.02ii
PRIORITY 3: Health and wellbeing		
3.1 Reduce children in low income families	3.1.1 Children in low income families (all dependent children under 20)	1.01i
	3.1.2 Children in low income families (under 16s)	1.01ii
3.2 Reduce hospital admissions caused by unintentional and deliberate injuries	3.2.1 Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14)	2.07i

	3.2.2 Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4)	2.07i
	3.2.3 Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2.07ii
3.3 To reduce the number of children who are obese	3.3.1 Reception: Prevalence of overweight (including obesity)	2.06i
	3.3.2 Year 6: Prevalence of overweight (including obesity)	2.06ii
3.4 Number of children where health needs assessment has been delivered in reception	3.4.2 Number of HNA delivered in reception (tbc – ie number of follow ups and children referred with SEND)	tbc
PRIORITY 4: Tackling big society issues (child poverty)		
4.1 Reduce children in low income families	4.1.1 Children in low income families (all dependent children under 20)	1.01i
	4.1.2 Children in low income families (under 16s)	1.01ii
4.2 Reduce hospital admissions caused by unintentional and deliberate injuries	4.2.1 Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14)	2.07i
	4.2.2 Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4)	2.07i
	4.2.3 Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2.07ii
4.3 To reduce average difficulties, score for all looked after children	4.3.1 Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	2.08i
4.4 To reduce children who are killed or seriously injured on the roads.	4.4.1 To reduce children who are killed or seriously injured on the roads. This gives a worse rate than England	
4.5 To reduce the rate for self-harm	4.5.1 To reduce the rate for self-harm	

Revised Version
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