Public Health Annual Report 2014

Introduction

Welcome to Sefton's Health 2014, my annual report on the health of people in Sefton. Under the Health and Social Care Act, I have a statutory responsibility to produce an annual report and Sefton Council has the statutory duty to publish it. The report does not aim to be comprehensive as a regularly updated overview of needs is provided by the Sefton Strategic Needs Assessment. Instead each year I aim to focus on a key issue, reviewing progress and highlighting future challenges.

This year, my report focuses on one of our Joint Health and Wellbeing Strategy's key objectives - giving every child the best possible start in life. From October 2015, we will take on a new role for commissioning children's public health services from 0-5, as well as those we already commission for 5-19 year olds. By doing this role well we can make a big difference to long-term health and long-standing health inequalities. We know that good health and wellbeing, from pregnancy to five years old, has a massive impact on later life. We also know a lot can be done to improve it.

Many people have contributed to this report and have a part to play in making the improvements necessary to ensure our children really do get the best start in life. I would particularly like to take this opportunity to thank elected members, my public health team, staff from across all council departments and partner organisations and the public for all they are doing to improve health and wellbeing in Sefton. I hope that you find the report informative and that you use it to take action to improve children's lives.

This will be my final annual report as Director of Public Health for Sefton, after thirteen years as DPH in the borough. It has been a great privilege to serve the people of Sefton and to play a small part in the big improvements in people's health that we have seen over that time. People can now expect to live three years longer on average, heart disease death rates have halved, teenage pregnancy rates are at their lowest and immunisation rates at their highest. But there is much more to do, especially to tackle health inequalities in the borough which will need a concerted sustained focus over many years to shift. This is inevitably even more difficult to achieve in financially challenging times for local communities and their public services but it is vital that we have a continued focus on keeping people healthy despite the challenges.

I have been fortunate to work with some really committed people during my time in Sefton and I would like to take this opportunity to thank them for their support and to wish everyone well for the future.

Examining the evidence: why should we act?

The evidence that early health and wellbeing is vital for life-long health is clearly set out in a succession of reports including *Health for All Children* (2006), the Marmot report (2010) and the Allen report (2011). The science is clear and the economic case even more compelling. As shown in recent Chief Medical Officer for England's reports we can no longer afford the huge cost resulting from preventable disease and injury. We must refocus on prevention.

“Women are less likely to have a pre-term baby if they don’t smoke: if a pre-term baby is breastfed, they have fewer complications.” & “Every pre-term birth costs the public-sector around £25,000 and society another £52,000”

“Reducing speed limits can help prevent childhood injuries” [20-MPH sign] & “A single traumatic brain injury can cost society £1.4 to £5 million over the long term”

Commissioning: New Roles for Sefton Council

From October 2015, Sefton Council will take over responsibility for commissioning children’s public health programmes for 0 to 5 year olds from NHS England. We will be responsible for commissioning the Healthy Child Programme that provides universal programmes like immunisation and screening to all families and additional targeted support for those with the greatest need. The programme is delivered by Health Visitors and the Family Nurse Partnership and aims to prevent illness through immunisation and picks up problems with child development early through screening programmes and health checks. Catching problems early.

Healthy Places: Thriving in Sefton

Children do best when they have safe places to play, be active, learn and grow. They need safe homes and neighbourhoods to live in, families and communities that help them thrive, and high quality health care. We need to build health into the way we do things that impact on children's everyday lives to make healthy living the norm rather than a struggle.

“We’re supporting residential 20 mph zones for safer play”

The Directors of Public Health for Cheshire and Merseyside are working together through the champs public health collaboration to promote the healthy places approach with a wide range of organisations who can have a positive impact on the places where children are starting their journey in life.

Top 10 for Number 10: Keeping Health on the Agenda

There is a lot that we can do to improve children's lives through work in Sefton, but national policy also has a major role to play. That is why the North West Directors of Public Health published our “Top Ten for Number Ten” - ten evidence-based public health policy priorities. All ten affect child health, but five are especially important:

- Taxing sugar sweetened beverages: to help the fight against child obesity
- Banning unhealthy food adverts before 9pm: to reduce unhealthy food choices
- Getting schools to provide at least one hour of physical activity a day
- A commitment to eradicate child poverty: a preventable cause of physical and emotional problems
- Acting on the “1001 critical days” report: to give all babies the best possible start during a key period for brain development.

Targeted Support: Improving health where it is most needed

Sefton has big health inequalities between richer and poorer areas. We need to ensure that public health services give most support to those with the greatest need. These families will be concentrated in areas with high levels of child poverty, but it is important that we use the Healthy Child Programme effectively to identify families in need of support wherever they live. The Maternity Services Liaison Committee and the local breastfeeding programme have had a clear focus on reducing health inequalities in young children while helping all mothers and babies in Sefton.

Stronger Communities: Working together for health

Strong communities and strong families are vital for health. Organisations like Children's Centres, Healthy Living Centres and a diverse network of voluntary organisations have an important role to play in local communities. Developing community resilience is about communities having the things they need to withstand unexpected problems. It includes things like knowing where to go to get health advice and treatment, having good support networks available for times of individual need, and being prepared for emergencies.

FIND OUT MORE...

Sefton's joint health and wellbeing strategy [hyperlink http://modgov.sefton.gov.uk/moderngov/documents/s44151/Summary%20Health%20and%20Wellbeing%20Strategy%20-%202013-18.pdf]

The Public Health Outcomes Framework [hyperlink http://www.phoutcomes.info/]

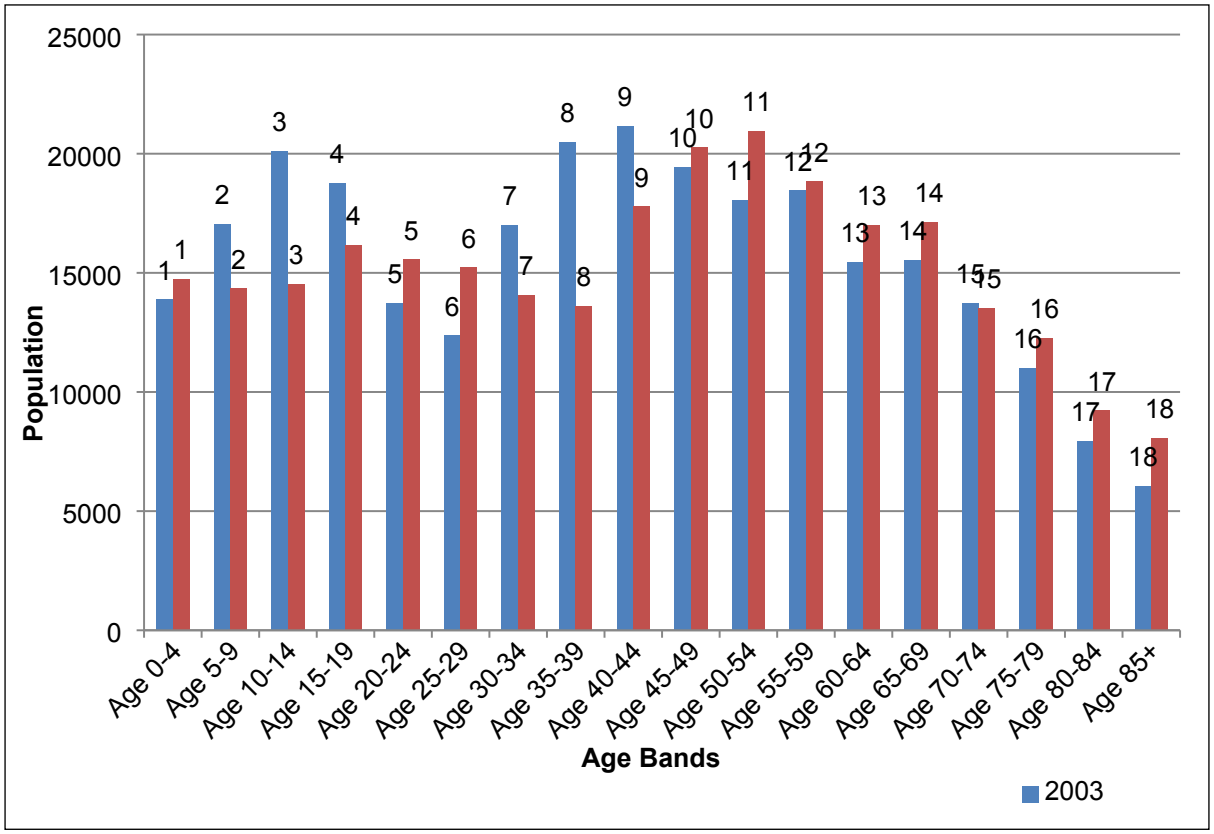
The Champs public health collaborative [hyperlink http://www.champspublichealth.com/]

The Northwest directors of public health group's 'Top Ten for Number Ten' [hyperlink http://phlive.org.uk/wp-content/uploads/Manifesto.pdf]

Chapter 1 - Health Needs in Sefton

Population

Sefton's population has changed markedly over the last ten years, with a growing older population and fewer children. However, whilst the numbers of older children have fallen, the number of 0 to 5s living in Sefton today is about the same as ten years ago: 17,000 children.



Source: Office of National Statistics

The Office for National Statistics has forecast that Sefton's population will grow by about 1% between 2011 and 2021, and that there will be fewer secondary school age children, more primary school age children, and around 450 more 0 to 5 year olds.

Life expectancy for both men and women in Sefton continues to improve. On average, Sefton men can expect to live for 77.5 years, and women 82.8 years. Over the past 10 years, life expectancy has increased by 2.6 years for men and 2.9 years for women. In terms of living a healthy life, Sefton men can expect to live an average of 62.5 years in good health, and women 63.9 years. Over the past 10 years, healthy life expectancy has increased by 1.8 years for men and 1.5 years for women. This means that whilst people are living longer, the time they spend in poor health has increased over this time.

Life expectancy varies a lot between different areas in Sefton. The most recent ward level life expectancy data for period 2009-13 shows that in the ward with the highest life expectancy (Ainsdale) men live, on average, 12.2 years longer and women 13.1 years longer than those in the lowest scoring ward (Linacre). The inequalities in health within Sefton were highlighted in Due North: the report of the Inquiry for Health Equity in the North published in 2014.

Table – Life expectancy at birth for men and women across Sefton wards by Deprivation			
Ward	Male Life Expectancy (Years)	Female Life Expectancy (Years)	Deprivation Quintiles
Linacre	70.5	76.6	Most Deprived Wards
Derby	74.1	80.7	
St Oswald	73.8	78.7	
Litherland	75.7	81.9	
Ford	77.1	84.1	
Church	73.6	79.3	Second Most Deprived Wards
Netherton and Orrell	76.5	82.2	
Dukes	75.1	81.5	
Manor	78.2	83.3	
Cambridge	75.4	80.6	Third Most Deprived Wards
Kew	78.2	80.1	
Norwood	76.1	83.4	
Molyneux	81.7	87.4	
Victoria	81.8	83.1	
Ainsdale	82.7	89.7	Fourth Most Deprived Wards
Sudell	81.0	86.7	
Birkdale	82.6	84.1	
Park	80.7	85.5	Least Deprived Wards
Meols	80.4	85.1	
Ravenmeols	81.6	84.8	
Blundellsands	81.8	85.3	
Harington	80.3	87.3	

Public Health Outcomes Framework - Sefton's Position

- In England there is a national public health outcomes framework that enables local areas to check their progress across four groups of outcomes: Wider determinants of health
- Health improvement
- Health protection
- Healthcare and premature mortality

Public Health England also produces a child health profile for every Local Authority area. An overview of Sefton's latest position against the public health outcomes framework and the child health profile is included in the appendix.

Improving the Wider Determinants of Health

The wider determinants of health are all those things in society that affect health - like poverty, the work environment, education, housing and being able to access healthy food easily.

Living in poverty can have a significant impact on early child development and health. One in five Sefton children lives in a low-income household. Children living in poverty are more likely to have slower development and poorer health than those who are better off. The proportion of Sefton children living in low income households is similar to the national average, but varies considerably across the borough.

In Linacre ward, about half of children live in low income families, yet in Harrington ward, the figure is only 1 in 20.

Children from poorer backgrounds are less likely to thrive and develop as quickly as other children in their first years of school. Across Sefton, just over half of all children achieve the minimum expected level of development by the end of reception year, which is worse than the England average. Among children receiving a free school meal, however, only 40% achieve the minimum. This is significantly worse than the England average of 45%.

Health Improvement

In 2013/14, 57% of Sefton babies were breastfed at birth. This is about the same as the last three years, and is still significantly lower than the England average of 75%. By 6 to 8 weeks, only 27% of are breastfed. This has improved slightly over the last three years, but remains significantly worse than the England average of 47%. The breastfeeding chapter explains how this will be targeted in coming years.

More women in Sefton smoke during pregnancy than the England average. Over the last three years, 15.3% of mothers were smoking at the time of delivery, compared with 12% nationally.

Recent information from the National Child Measurement Programme (2013/14) shows that fewer Sefton children aged 4 to 5 are overweight or obese compared with previous years. Across Sefton, 14.3% of 4 to 5 year-olds are overweight and 10.4% obese. These figures are higher than the national averages for England, but not significantly so, where 13.1% are overweight and 9.5% obese.

In 2013, the rate of hospital admission for accidental and deliberate injury for 0 to 4 year olds in Sefton was 117 per 10,000 children. This rate has decreased over the past three years and is now lower than the England average (135 per 10,000).

Health Protection

The proportion of Sefton children receiving their routine immunisations on time is better than the national average, with uptake of most vaccinations over 95%. In 2013/14, around 9 out of every 10 Sefton 5 year-olds received both doses of the measles, mumps and rubella (MMR) vaccine. This rate has improved over the past three years.

During winter 2013/14, all Sefton children aged 2 and 3 years old were offered the new nasal flu vaccine for the first time. Uptake of this was higher amongst children living in the Southport and Formby area (51.9% for 2 year olds and 46.4% for 3 year olds) than South Sefton area (36.8% for 2 year olds and 36.8% for 3 year olds).

Health Care

Between 2010 and 2012, fewer Sefton babies died before their first birthday than between 2008 and 2010. This infant mortality rate is currently 4.8 per 1,000 live births, which is not statistically significantly different to the England rate (4.1 per 1,000).

Childhood tooth decay in Sefton is similar to the England average. In 2011/12, the average number of teeth per child that were actively decayed, filled or had been extracted at 5 years old was 0.9, similar to the England average of 0.94.

Further resources & Useful Information

National Obesity Observatory, Public Health, England: http://www.noo.org.uk/

National Child Measurement Programme: http://www.hscic.gov.uk/ncmp

The Due North Report

http://www.cles.org.uk/wp-content/uploads/2014/09/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final1.pdf

Chapter 2 - Sefton as a place to thrive

Creating the right environment in which children can thrive is really important. Good education, excellent public planning and support for healthy living all contribute to healthier places and people. All children in Sefton should have access to good education and live in a decent and safe home, near to a park or open space, with opportunities to explore, play and have fun. These things make a huge difference to the short and long term health of developing children.

Places where children spend most of their time are a vital part of healthy child development. These places include the child's home, early years' settings (like nurseries and playgroups), and outside with parents or carers in the built and natural environment. Communities that have good quality open and green space, accessible public transport and opportunities for active travel e.g. walking and cycling, as well as access to affordable and healthy food enjoy better health than those who do not. Similarly, a safe and warm home is crucial to health and happiness especially for young children who spend a lot of their time at home. A home that is damp, mouldy, too cold, or over-crowded, can seriously affect their health and development. Being part of a homeless family can have an even greater effect. Improved housing conditions and support for households who struggle financially to heat their homes will enhance the health of children in Sefton.

Several chapters in this report describe the far reaching impact of living and growing up in poverty as a child. Over the last few years there have been a number of changes to the welfare and benefits system and a recent analysis of austerity policy in the UK suggests that children are amongst the groups most affected. Increasing family income through employment or maximising benefits reduces the negative impact of child poverty on lifelong health.

What is happening in Sefton

Sefton Council is working with our partners to make Sefton a place where more children can thrive and have a better start in life. Examples of this include:

- Sefton's Local Plan promotes accessible open and green space so children and families can enjoy the outdoors. This should improve child physical development and mental wellbeing.
- The roll out of 20 miles per hour speed limit areas will make residential areas safer for children to play.
- 'Healthy homes, Healthy people' is a pilot scheme to improve housing focusing on households with children vulnerable to poor health outcomes through their home environment.
- Over sixty parks and greenspaces in Sefton have signed up to the voluntary code for smokefree play areas. A survey of residents conducted in local parks (a quarter of them smokers), showed that 94% supported not smoking in playground areas.

- Volunteers and Sefton Council staff have been worked together over the last few years to get local organisations to sign up to be a breastfeeding-friendly venue. This scheme will get a welcome boost following the Council resolution to encourage local organisations to become breastfeeding friendly.

What more could we do in Sefton?

Local authorities, alongside health and community partners, have a key contribution to make in ensuring housing, education, environment, planning, transport and regulatory services promote good health. The following actions from local partners would support children and families in Sefton to thrive:

- All public sector organisations adopting a Health in All Policies approach - building health and wellbeing in all new plans and policies, including the Local Plan and Neighbourhood Plans.
- Reducing the number of children living in poverty by maximising incomes, job creation with a focus on young people and boosting the local economy.
- Improve the quality of housing in the private rented sector and addressing fuel poverty.
- Develop transport infrastructure to make physically active travel the norm and minimise injury and death.
- Ensure access to universal early years services including health and education provision.

Find out more...

Sefton's local plan http://www.sefton.gov.uk/localplan

Breastfeeding in Sefton http://www.healthysefton.nhs.uk/Breastfeeding.htm

Austerity Policy – link to doc

Chapter 3 - School Readiness: Getting the best start in education

Getting the best possible education can have a profound impact throughout a person's life, health, and emotional wellbeing. Early education has a huge impact on later life chances, income, and health. In England, children at the end of reception year (aged 5 years old) are assessed against the government standard "good level of development". This looks at child development, a marker of school readiness.

We know that gaps in educational attainment between poor children and other children of the same age already exist at school entry age. As noted in the health needs chapter just over half of all children in Sefton achieve the minimum expected level of development by the end of reception year, which is worse than the England average. Among children receiving a free school meal, however, only 40% achieve the minimum. This is significantly worse than the England average of 45%. These figures have improved from the previous year.

By understanding what works in improving school readiness, we can prioritise what we can do to improve it most effectively.

School readiness depends on every child achieving the best possible early physical health, development, and mental wellbeing. This can be supported through things like the national Healthy Child Programme and through targeted work to improve school readiness. The Healthy Child Programme helps through;

- Early identification of need and risk
    - Identifying those at risk of poor development and outcomes because of child, family, and environmental factors
- Universal health and development reviews
    - Identifying and addressing difficulties early in life
- Supporting the family unit
    - An important part of early child development
- Supporting parenting
- Preventing obesity
- Promoting breastfeeding and good nutrition

Improving school readiness means working to improve all of those things that impact on a child's early health, wellbeing, and development. This includes;

- The child's nutrition
- The home environment
- The family environment, parenting, and the home environment
- Early language development
- Recognising developmental delay
- Screening for visual and hearing impairments, and other medical problems
- Creating opportunities for safe play, and health promoting physical environments
- Improving dental health
- Reducing exposure to hazards like passive smoke, home accidents, and road collisions.

In Sefton Council, the school readiness team works with schools, nurseries, children's centres, child minders and families to improve partnership between organisations and improve school readiness. This team especially targets their approach to those children and families who are most vulnerable.

What more could be done?

The scope for closer working between early years services and the delivery of the Healthy Child Programme should be reviewed as the Council takes on responsibility for commissioning the HCP in 2015. Improving school readiness should be a key aim of this closer working.

Find out more

Health for All Children
(http://www.dhsspsni.gov.uk/guidance_and_principles_of_practice_for_professional_staff__health_for_all_children.pdf)

The Healthy Child Programme

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Chapter 4 - Pregnancy in Sefton

Local picture

The Maternity Services Liaison Committee – known as the MSLC - works to ensure a healthy start and healthy future for all new-born babies and their families living in Sefton. The MSLC is made up of parents, health professionals and representatives from Sefton Council, Sefton Clinical Commissioning Groups and the local Community and Voluntary Sector (CVS).

Almost 3000 babies are born in Sefton each year. Sefton's maternity services are there to support all mothers through a healthier pregnancy and birth. Support is needed throughout pregnancy as we know that some women find it difficult getting to appointments or antenatal classes, while some vulnerable families are more likely to have premature babies and need extra help. The focus of the MSLC is on promoting a healthy pregnancy and reducing health inequalities by making sure everyone can get the care and support they need. This involves:

- Engaging parents to promote healthy eating, and to support them to quit smoking and book early at maternity services to prevent problems like low birth-weight.
- Promoting choice in antenatal care and place of birth. We know that home birth is a safe option for women with low risk pregnancies. Women who plan a home birth are half as likely to have a caesarean section or forceps delivery, yet fewer than 2% of women in Sefton have a home birth.

We know that more women would choose this option if they were fully aware and supported in planning the birth.

- Developing better working together across health services, social care, children's centre's and the voluntary sector to that we all work to meet the needs of Sefton families. This includes those who may have extra needs for example young or single parents, or parents with disabilities.

Sefton midwives work together with health visitors and others to deliver the Healthy Child Programme. At the booking appointment between 8 and 12 weeks of pregnancy they give mothers information about screening tests, immunisations, healthy eating, breastfeeding support, and help with stopping smoking. At this and future appointments they also help prepare mothers and partners for parenthood, including preparing for the birth, and safe care of their baby. This includes a discussion on safe sleep to help prevent sudden infant death. Midwives also support mum's emotional wellbeing and mental health, and improve parent and baby attachment which improves the baby's mental wellbeing.

This year the MSLC supported Liverpool Women's NHS Foundation Trust's successful bid to the Department of Health to refurbish the midwifery led unit and low risk postnatal area. The bid focused on improving choice for women and encouraged normal birth and will provide additional birthing pools and improved rooms to let partners stay. This will help to make birth a more normal and less medical experience.

We also recognise the importance of joined up services between maternity services, health visiting, general practice and our children centre colleagues. Later chapters will describe some of the positive examples of this work.

Looking forward

The MSLC recognises that involving parents is essential in shaping services that are responsive to Sefton communities. Year on year, they have worked on increasing parent participation and engagement. Over the last few years the MSLC has supported Southport and Ormskirk baby day. This has led to more parents contacting and joining the parent task group of the MSLC. The challenge going forward is to maintain the enthusiasm and commitment of all, but in particular the parents. This will allow them to create a sustainable group for improving Sefton's high quality maternity services. The MSLC will develop a strategy to ensure new parents join the MSLC and maintain its vibrancy.

The MSLC parent task-group recently surveyed local parents to find out what really mattered to them during their pregnancy: this will directly inform future commissioning and improvements to maternity services. A number of challenges for maternity providers and commissioners were identified by the survey. They include:

- The need for sensitive healthy lifestyle advice and support for women who are overweight or obese
- A need for increased support in completing and implementing birth plans
- The need for more breastfeeding peer support whilst on the maternity unit

- The need to increase the offer and uptake of antenatal classes

In response to these and other findings from the survey, the parents have decided to develop a parent charter, setting out what mothers and their partners can expect from all the statutory services during pregnancy. This has the support of the CCG who commission maternity services and the maternity services themselves. It will also involve those partner services mentioned earlier.

MSLC recommendations for Sefton based on feedback from parents in the survey

- All partners must endorse the parent charter and ensure services provide the level of care agreed within it.
- Providers and commissioners should improve the choice and uptake of antenatal classes, particularly amongst those groups who have experienced difficulty attending.
- Maternity providers should develop a more robust system to ensure consistent and maintained birth plans.
- Providers and commissioners should increase the level of breastfeeding peer support in maternity units
- Sensitive support should be provided to those women who need to achieve a healthier weight.

In July 2014 a number of parents from the MSLC attended the Faculty of Public Health Annual Conference in Manchester. They presented a poster showcasing how local parents got involved with the MSLC.

Sefton MSLC now has growing, creative and inclusive parent participation. A dynamic and positive relationship exists between parents, local government, voluntary sector, health commissioners and maternity providers. The impact can be seen in:

- Parents taking the lead, e.g. chairing the committee
- The creation of a parent task-group, with work plan directed by the parents
- Parent attendance and contribution at related events, e.g. the launch of 'Cheshire and Merseyside Children, Young People and Maternity Clinical Network'
- Parents challenging providers and raising issues relevant to families
- The task-group completion of a parent survey and commitment from providers to respond to findings.
- Active parent Twitter and Facebook account.
- Fund raising activities

Chapter 5 - Emotional Wellbeing

Pregnancy and childbirth should be a happy time for both mother and baby. But it is not without its stresses and strains. Having good mental wellbeing gives mothers and carers the skills and strength they need to cope with the physical and emotional changes they go through. It also helps them cope with the normal fears and excitement about having a baby and of course the sleepless nights. However, around 1 in 7 mothers experience mental health problems. These range from low mood to clinical depression. This can happen any time before, during, or after the baby is born. Left untreated, they can lead to serious consequences, such as neglect of the baby, behavioural problems in older children and at its most tragic a mother attempting to take their own life. However, it is important to remember that with the right support this does not need to happen.

The evidence for supporting mothers

The National Institute for Health and Care Excellence (NICE) has produced guidance that sets out the care mothers and their families should receive. This starts with support from the Health Visitor and where appropriate goes onto include more specialist mental health support. It is widely accepted that effective and timely prevention, detection and treatment can have a positive impact on mothers and their families and reduce long-term difficulties. Health Visitors are trained to assess mental wellbeing and have an extensive knowledge of local support. All mothers receive a patient information leaflet called ‘Your emotional wellbeing in pregnancy and beyond’. This provides the health visitor with an opportunity to help mums talk

about how they have been feeling. If the health visitor thinks the mum needs additional help, they will refer mothers for psychological therapy and or other support services, for example, an exercise programme.

At the moment, the mental wellbeing assessment happens after the birth. But from early 2015 all pregnant women in Sefton will be offered a visit from the health visitor by 28 weeks of pregnancy. This will help health visitors identify and provide appropriate support earlier if it is needed.

Sefton's Health Visitors have developed resources to support maternal mental wellbeing and these are available in thirteen languages spoken in Sefton. This ensures that mums who do not speak English as their first language have equal access to mental wellbeing support.

Some of Sefton's Children's Centres now offer short 'Think differently, cope differently' courses to support mums with mild to moderate depression and anxiety. These provide a great resource for health visitors to refer parents to. Some of the Children's Centres also offer a 'Positive Thoughts' Course which has proven popular with mums.

Case Study

Jane is a made-up person, but her story is typical of some of the clients our health visitors support.

The Health Visitor visited first-time-mum Jane, with her 3 month old baby Dylan. She has been Jane's Health Visitor since Dylan's birth and has visited them at home a couple of times, and has also seen Jane and Dylan in clinic. Sefton Health Visitors routinely assess maternal mental health when the baby is 3 to 4 months old. During the assessment, Jane was tearful and said that her partner had left her. She said there had been some domestic violence and that she felt depressed and anxious. Jane was isolated, had little family-support locally and had low confidence. Jane said that Dylan was difficult to settle and cried a lot. The assessment tools identified mild clinical depression and moderate levels of anxiety. For the next few weeks the Health Visitor visited Jane at home to undertake 'Listening Visits' and she also accompanied her to her local Children's Centre, where Jane enrolled on the 'Positive Thoughts' Course which really helped to lift her mood and lessen her anxiety. She continued to attend the Children's Centre and became involved in the Community Garden there. A year on, her confidence has increased and she has now started a part time job. Dylan is settled in a local nursery. The support for Jane outlined in this case study will have provided long term benefits to Dylan in relation to his educational outcomes, his behaviour and his long term wellbeing.

What more could be done?

Health Visitors will soon be able to measure the level of maternal emotional wellbeing across Sefton. This will help to identify areas of greatest need in Sefton and enable health visitors to target their support during pregnancy and the early years to those who need it most.

Find out more

FIND OUT MORE

Guidance from NICE on care after birth - https://www.nice.org.uk/Guidance/QS37

Sefton Children's Centres - http://www.sefton.gov.uk/schools-learning/early-years-and-childcare/childrens-centres.aspx

Chapter 6 - Protecting mothers and babies: antenatal and newborn screening

The NHS provides world class health screening for health problems in pregnancy and for newborn children. This is part of the routine, free, and universal care offered to women who are pregnant and to their children. Pregnant women are asked for permission by their midwife, and then they are offered blood tests, ultra sound scans, and a questionnaire.

For newborn babies, the heel prick blood spot test, a hearing test, and a physical examination are offered to every baby.

There is lots of information about these screening programmes on the internet – links to useful information can be found at the end of this chapter.

Six screening tests offered:

Pregnant women are offered screening for:

- infectious diseases that could harm the mother or baby, such as syphilis and HIV;
- inherited blood-disorders related to family origin, such as sickle cell disease;
- abnormalities such as spina-bifida or chromosome disorders (the commonest being Down's syndrome);

Babies are offered screening for:

- the heel-prick blood spot test for rare diseases that can be treated if picked up early - they are phenylketonuria, MCADD, thyroid underactivity, cystic fibrosis, and sickle cell/ thalassemia and from January 2015 this has been expanded to include four more inherited metabolic diseases.
- inherited hearing impairment (deafness)
- congenital problems at birth such as hip or heart problems

Over 97% of pregnant women cared for by Liverpool Women's Hospital and Southport and Ormskirk Hospital have screening blood tests. Approximately 46% of women are screened for Down's syndrome at Liverpool Women's and 42% are screened at Southport and Ormskirk.

Pregnant women are screened for sickle cell disease if they have a family origin from certain African or Mediterranean countries. It's important for women to book early with their midwife so that this can be done in good time.

Just over 98 per cent of babies get their hearing tested, and more than nine out of ten have the heel prick blood spot test in good time after birth. Almost three in every hundred babies need a second heel prick test because the first sample was too small. Local midwives are working hard to get this figure down to one in two hundred.

We don't yet have good data on how many children get their full physical examination, but local hospitals are starting to collect this.

An example: the heel prick test (new born blood spot)

At about a week old, the midwife gets a drop of blood from the baby's heel and soaks it onto a special piece of blotting paper. This paper strip is sent to Alder Hey Hospital where a sophisticated laboratory runs a series of tests for the five diseases: phenylketonuria, MCADD, thyroid underactivity, cystic fibrosis, and sickle cell/ thalassemia.

If any of the tests is positive, then the result is checked further, and parents are contacted for a specialist opinion. For each of the diseases, picking them up early makes a huge difference to the baby as they grow up. In the case of thyroid underactivity, for example, a simple daily treatment means that the baby develops completely normally. In contrast, if it wasn't picked up early, the baby's mental and physical development are affected.

What could be improved?

- More women could benefit from screening if local maternity teams improve the uptake of infectious disease and Down's syndrome screening tests.
- Women should be booked with their midwife early enough in their pregnancy so that sickle cell tests can be offered quickly when needed.

- The heel prick test should be given in good time and without delay to almost every baby, not just nine out of ten babies.
- The sample should be “right first time” so that babies do not need to have it repeated.
- Local hospitals should collect and report data on the newborn physical examination.

Childhood vaccinations in Sefton

The NHS infant vaccination programme protects children from more than 20 common and serious infectious diseases, such as tetanus, polio, diphtheria, some forms of meningitis, mumps, measles, rubella (german measles), rotavirus diarrhoea, and pneumonia. Teenage girls also get the HPV vaccine in school year 8, which protects them against the genital warts virus – a major cause of cervical cancer. Next to clean drinking water, good nutrition and good parenting, vaccinations are one of the most important things that keep children healthy.

Most children in Sefton complete their recommended course of vaccines, and uptake of routine vaccinations has improved over the last few years. The number of 5 year olds getting their second dose of MMR still needs to be improved, however, as two doses are needed to ensure immunity. The good uptake in Sefton is down to parents ensuring they bring their children for vaccination, hard work by local doctors and nurses, and good organisation of the immunisation programme by Public Health England to make sure the vaccines are available. The table shows how well Sefton did in 2013/14.

2013/14 was the first year that children were offered immunisation against flu. The uptake rate for Sefton as a whole was similar to the national rate but further work is needed to improve this for future years.

FIND OUT MORE...

Sefton's joint health and wellbeing strategy [hyperlink http://modgov.sefton.gov.uk/moderngov/documents/s44151/Summary%20Health%20and%20Wellbeing%20Strategy%20-%202013-18.pdf]

The Public Health Outcomes Framework [hyperlink http://www.phoutcomes.info/]

The Champs public health collaborative [hyperlink http://www.champspublichealth.com/]

The Northwest directors of public health group's 'Top Ten for Number Ten' [hyperlink

http://www.screening.nhs.uk/annbpublications . There is information in other languages at www.screening.nhs.uk/languages.

Childhood Vaccinations April 2013 to March 2014: uptake as % of all invited infants. Sefton children are some of the best protected in the North of England.

For best protection, 95% (nineteen out of twenty) children need to be up to date with their vaccinations

	England	North West	Sefton
Diphtheria, tetanus, polio and Hib meningitis at 12 months old	94.3%	95.7%	96.3%
Pneumococcal vaccine at 12 months old	94.1%	95.3%	96.0%
Diphtheria, tetanus, polio and Hib meningitis at 2 years old	96.1%	97.3%	97.2%
Pneumococcal vaccine at 2 years old	92.4%	94.2%	95.0%
Hib meningitis at 2 years old	92.5%	94.3%	94.9%
MMR (mumps, measles, rubella vaccine) at 2 years old	92.7%	94.9%	94.7%
MMR (mumps, measles, rubella vaccine) at 5 years old	88.3%	92.0%	90.3%
Note: Source is NHS England data analysis, collated by Merseyside Screening and Immunisation Team			

Flu Vaccination Uptake: 2013/14

	England	South Sefton CCG	Southport & Formby CCG
Flu vaccination coverage in ALL 2 year olds combined	42.6%	38.1%	54.1%
Flu vaccination coverage in ALL 3 year olds combined	39.5%	34.8%	50.7%

Chapter 7 - Health Visiting and the Family Nurse Partnership

Health Visiting and Family Nurse Partnership

Local picture

Every family with a new baby or a child under the age of five will have a health visitor. Health visitors are qualified nurses or midwives who have specialist training in child health and health promotion. The health visitor can provide practical support and confidential health advice.

In Sefton, health visitors take over from midwives and deliver the Healthy Child Programme (HCP) for ages 0 to 5. Health visitors are supported in delivering the HCP by child health practitioners and nursery nurses. They also work closely with midwives, Family Nurse Partnership, school health, children's centres, social care and the voluntary sector. The Healthy Child Programme is a series of reviews, screening tests, vaccinations and information to support parents and help them give their child the best chance of staying healthy and well. The HCP is based on a model of 'progressive universalism'. In other words, there are standard services available to everyone (universal), and additional services available to those who need them most or are at risk (progressively more services provided according to need). The programme is offered in GP surgeries, local clinics, and Children's Centres. Some reviews can be done at home which enables the health visitor to assess the child in the family environment.

Because health visitors have specialised knowledge of community health, health promotion and child health they are able to provide specialist care from birth through to starting school. Health visitors play a pivotal role in safeguarding children and addressing issues like neglect. As part of the Healthy Child Programme, health visitors have recently started contacting families shortly before the birth to offer early support and advice, and set out the support families can expect once their baby is born.

During child development reviews, the health visitor asks how the child is doing and about any concerns parents may have. The first home visit will usually take place when babies are 10 to 15 days old. During the check-up the health visitor examines the baby and records the details in the baby's red book (Personal Child Heath Record). After the first visit, a development review takes place at 6 to 8 weeks old. Further routine reviews are at three months, four months, one year, between two and two and a half years, and at school entry (four to five years). Once the child reaches school age, the school nursing team and school staff help support the child's ongoing health and development.

Looking forward

From 2015, some of Sefton's most vulnerable families will be supported by the more intensive Family Nurse Partnership support programme. This is a targeted programme offered to first time mothers aged 19 or under. Unlike the regular health visiting service, it begins in early pregnancy; with the Family Nurse offering weekly and fortnightly visits right up until the child is two years old. The aim is to work with

young parents, helping them to understand about their pregnancy and how to care for themselves and their baby. The focus is on partnership, nurses do not tell parents what they should do, but work with them to help them make decisions about giving birth, looking after their baby and toddler and deciding what is best for them.

The programme has three major goals

- To improve antenatal health
- To improve child health and development
- To improve economic self-sufficiency

The programme is aspirational, helping young parents become the best parents they can be, and in turn helping their baby to grow, develop and learn. Nurses will also help parents explore childcare options, education and training and provide support to help parents manage household finances and setting up home.

Work is underway to recruit and train the Family Nurse Partnership Team that will work in Sefton. Liverpool Community Health already provides this service in Liverpool where it has shown positive health outcomes. The programme originated in the United States where it has been shown to provide the following benefits.

- Reduction in smoking whilst pregnant
- Fewer subsequent births and greater intervals between births
- Fewer accidents
- Increase in employment

- Reduction in child abuse and neglect
- Improved child language development
- Increased access to education and training
- Greater involvement of fathers

From October 2015, Local Authorities will take over responsibility for commissioning health visiting and FNP services from NHS England. The staff that provide the services will remain in the NHS provider services. This is the final component of transferring responsibility for public health to the council and it provides a real opportunity to align these core services along with its other key early years staff, e.g. children's centres, staff working in social care, disabilities team, and to ensure good links with public health programmes for older children.

The 2010 'Fair Society, Healthy Lives' review by Professor Sir Michael Marmot showed that investing in early years is vital to reducing health inequalities and that the returns on investment in early childhood are higher than in older age groups. The Healthy Child programme provides a blend of services, some of which are universal, with an ability to scale-up the service where need is highest. By having a universal service like this, we can support the most disadvantaged in Sefton and prevent families who might have "hidden" problems, e.g. post natal depression falling through the net. This approach has potentially huge benefits for the long-term health of Sefton's children.

What more should we do?

The local authority should work with the NHS to ensure a safe transfer of commissioning responsibility and the quality of the Health Visiting service and Family Nurse Partnership is maintained or improved post transfer.

Opportunities for building stronger links with early years services and with 5-19 public health programmes should be created.

FIND OUT MORE

The Healthy Child Programme - https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

Fair Society Healthy Lives Report (The Marmot Review) - http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Chapter 8 - Healthy Lifestyle Choices

The earlier healthy lifestyle choices are started, the more of a habit they become throughout childhood and into later life. This chapter describes what we are doing locally to give children a healthy start in life.

Smoking & Pregnancy

The Local Picture

Smoking during pregnancy is a serious public health concern because it damages the health of both mother and baby. A Royal College of Physicians' Report (2010) said that in the UK each year, maternal smoking during pregnancy impairs the growth and development of the unborn child and leads to miscarriages, perinatal deaths, premature births and low birth weight babies.

Smoking during pregnancy is measured nationally through Smoking At Time of Delivery data (SATOD). Sefton's rate for 2013/14 was 15.3%, with higher rates in South Sefton CCG at 17.1% than in Southport and Formby at 12.2%. Overall Smoking At Time of Delivery has seen only a slight decrease from 15.6 % to 15.3% between 2012/13 and 2013/14.

During 2013/14 there were 292 pregnant women who set a quit date with the Sefton stop smoking service, an increase of 28 pregnant women compared to the previous year. 47% of the women who set a quite date went on to successfully stop smoking, an increase of 3 percentage points on the previous year.

What is being done to address these issues

We are using the latest scientific evidence and recommendations to reduce smoking in pregnancy with the aim of:

- Improving the health of mothers who smoke
- Reducing the risk of harm to her unborn child

Following NICE guidance: the Merseyside 'stop smoking in pregnancy pathway'

We know from NICE guidance that midwives play a key role in identifying, referring and supporting pregnant smokers. The NICE recommendations have been applied by organisations working together across Merseyside. This includes organisations like local councils and NHS maternity services. This partnership approach has been crucial to ensure there is a consistent approach to help pregnant women to quit smoking across Merseyside.

The Merseyside 'stop smoking in pregnancy pathway' helps ensure that NHS maternity services have an evidence-based comprehensive approach to stop smoking. This means that pregnant smokers in Sefton are identified and supported to quit smoking wherever they choose to give birth.

Specialist stop smoking support

Pregnant women in Sefton can access a specialist stop smoking service through SUPPORT, Sefton's local NHS stop smoking service. They provide one-to-one quit support, including the option of home visits for pregnant women. During 2013/14, 138 pregnant women went on to successfully stop smoking.

Incentive scheme for vulnerable pregnant quitters

Pregnant women at risk of relapse can be offered rewards to continue on their quit attempt for at least four weeks. Once on this incentive programme clients can be rewarded if they sustain their quit attempt throughout the pregnancy and for at least 8 weeks after birth. Women take a carbon monoxide breath test to demonstrate they are smokefree.

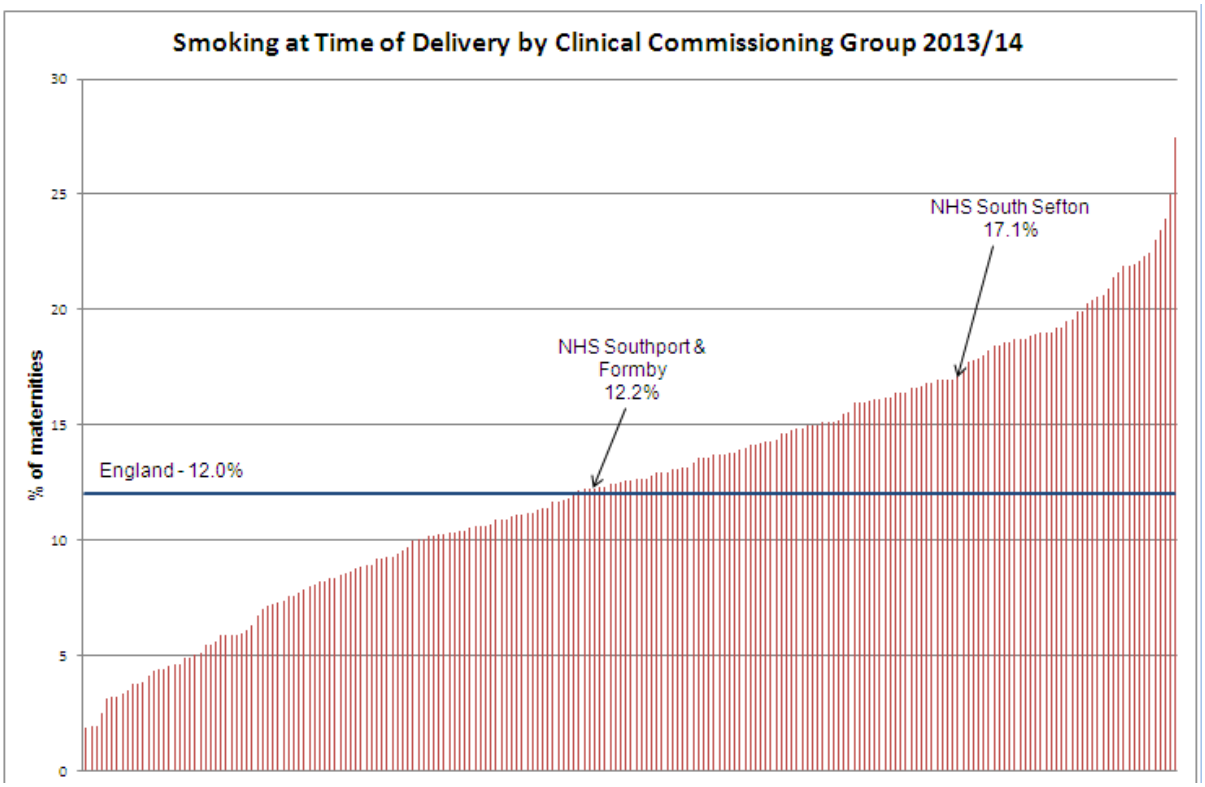
<u>What more could be done in Sefton?</u>

- We should work with partners to support young women to quit smoking before they have children. More importantly, work should be done to prevent young women from starting to smoke.

- Sefton Council should work in partnership with maternity service commissioners, to audit current practice against national smoking in pregnancy guidance and take action to improve compliance where needed in Sefton.

- We need to understand better why some women in Sefton opt out of using specialist stop smoking services to support them to stop smoking during pregnancy, and use this information to tailor the service better to their needs.

- We should identify new ideas that can support pregnant women to quit smoking, such as finding examples of good practice and innovative delivery in other areas.



Breastfeeding

Local picture

Breastfeeding is the healthiest way to feed a baby. Breastfeeding contributes to the health of mother and child in both the short and long term and provides all the nutrients a baby needs. The current UK policy is to promote exclusive breastfeeding (feeding only breast milk) for the first 6 months, and then continuing for as long as the mother and baby wish while gradually introducing a more varied diet.

The percentage of Sefton mothers deciding to breastfeed (the breastfeeding initiation rate) increased from 54% to 57% between 2012/13 and 2013/14. The percentage still breastfeeding at 6 to 8 weeks did not change over the same period remaining at 27%. This compares to national rates of 74% and 47% respectively so although we have seen improvement in breastfeeding initiation over the last year there is more to be done to improve rates further.

What are we doing to address these issues?

Sefton's Baby Friendly Initiative

Sefton achieved international recognition from the United Nations Children's Fund (UNICEF) in 2014, by successfully passing the accreditation process for Stage 3 of the Baby Friendly Initiative (BFI). Stage 3 is the final stage of the BFI award and acknowledges the commitment, support and dedication that staff and volunteers in Sefton offer to mum's and families. The BFI award process involved professionals being interviewed and assessed: pregnant women and new mothers were asked about their experience and the care they had received in over thirty different aspects

of breastfeeding. More than 80% of mothers reported positive feedback in each of the areas.

Southport & Ormskirk hospital have achieved their certificate of commitment for BFI status and are currently working to achieve the next stage of this award through the delivery of training programmes to staff in the hospital and ensuring that hospital policies and procedures promote the most supportive environment to encourage breastfeeding. Improvements may take time to be reflected in the statistics.

Breast Start

Sefton's breastfeeding peer support programme called Breast Start, is made up of paid staff and volunteers. Sefton women have found this service valuable - during 2013/14, 68% of mum's supported by Breast Start were still breastfeeding at 6 weeks. The service provides antenatal workshops, support on post natal wards, postnatal support groups, home visits and telephone support.

Breastfeeding Friendly Venues

Sefton runs a programme to encourage businesses in Sefton to actively welcome breastfeeding on their premises. 43 venues in Sefton have so far committed to providing a welcoming and supportive environment to breastfeeding mothers. Further work is underway to build on increasing the number of breastfeeding friendly venues, and to highlight to all Sefton organisations how important it is to provide a welcoming and supportive breastfeeding environment.

Breast milk – it's amazing

The 'Breast milk- it's amazing' campaign was launched in 2009 across Sefton, Knowsley, Liverpool and Wirral. It is a high profile health promotion campaign that aims to improve breastfeeding uptake in the region. The campaign was later adopted by Champs – Cheshire and Merseyside's public health collaborative service. Champs have since developed the campaign with a relaunch and a series of related events that link parents into support groups.

The Healthy Start Scheme: Providing access to free fruit, vegetables, and vitamins

Good nutrition is vitally important for early child development. The Department of Health's 'Healthy Start' scheme provides free weekly vouchers for fruit, vegetables, milk, and infant formula. It also offers free vitamin tablets for pregnant mothers and free vitamin drops for children at around 6 months old (when they are weaning onto solid foods and need vitamin supplements). The vitamins offered are tailored to the needs of pregnant mothers (providing folic acid, Vitamins C & D) and (Vitamins A, C & D) to young children, to help prevent birth defects and rickets. Vitamins are distributed via children's centres and nurseries – this helps introduce mothers to the other health improving services available at children's centres.

The fruit and vegetable voucher element of Healthy Start can assist with establishing healthier eating habits to help with maintaining a healthy weight.

The Healthy Start scheme is a statutory duty for the local authority, and is offered to families on specific benefits and all mothers under 18 years old.

In Sefton, the scheme has been supplemented by a local offer since 2009; so that all of Sefton's pregnant mothers and children under two have access to free vitamin supplements. This local offer has improved the uptake of the national Healthy Start programme in Sefton. Sefton's supplementary local offer has been shared as a model of good practice with other local public health teams and with the NHS England.

Future plans are for Sefton Council to work in partnership with food banks to improve the opportunity for eligible young families to access the necessary vitamins and food options to maintain a healthy diet.

Future Challenges

- The first few hours after delivery is a crucial time for breastfeeding support to be provided. Given the loss of Council funding for a comprehensive service, it will be important to work with Sefton Clinical Commissioning Groups, maternity and health visiting services and Breast Start to find ways of supporting breastfeeding effectively. Any voluntary activity or service supported by mainstream NHS services would have most impact if focussed in the immediate post natal period.

- Maintaining the BFI status in Sefton's community settings and ensuring that the guidance is being adhered to and new staff are trained.

- Achieving BFI status at Southport and Ormskirk hospital to ensre consistent support for new mothers wishing to breastfeed.

- Maintenance and expansion of breastfeeding friendly venues across Sefton to ensure that women feel comfortable to breastfeed and know that they will get a positive welcome when they do.

FIND OUT MORE

Healthy Sefton: Stop Smoking Service -

http://www.healthysefton.nhs.uk/Stop_Smoking.htm

Healthy Sefton: Breastfeeding Support -

http://www.healthysefton.nhs.uk/Breastfeeding/Local_Breastfeeding_Support.htm

Chapter 9 - Keeping Children Safe

When a child dies in Sefton: lessons for the future

Government legislation requires every Local safeguarding Children Board (LSCB) to review the death of each child or young person who lived in their area. By doing this, we can find ways of preventing future deaths and help support families. Each child death is a personal tragedy for the individual family, but looking at deaths collectively across Merseyside helps agencies identify interventions that may prevent further deaths or injury.

Sefton is part of the 'Mersey Child Death Overview Panel'. This panel receives a short report about each child and how they died. The information comes from records held by hospitals, local health services, schools, police, children's services or other agencies whose staff knew the child. The panel, which includes public health specialists, medical doctors, other health specialists, children's services staff, education staff, and police, meets monthly to review the reports.

The panel is not concerned with blame but focuses on finding out if anything can be changed to prevent similar deaths in the future. They also look at what support was offered to the child and their family before and after the death. The panel can recommend changes to these arrangements if needed.

The process is confidential and information about the panel should be given to parents by the registrar when they register the death of a child. Parents can contact the panel if they wish to receive individual feedback about their child, or want to contribute extra information that they feel may help to improve the care of children.

During 2013/14, the deaths of 14 Sefton children were considered by the Mersey Panel. Twelve of the deaths occurred in babies less than one year old, and of those six were neonates, that is babies less than 28 days old. For Merseyside as a whole, deaths in the neonatal and infant age groups continue to be much greater than in any other age group. Across Mersey, the commonest causes of death at this age are:

- complications associated with prematurity,
- genetic and congenital anomalies,
- and in older babies - sudden unexpected, death in infancy (also known as SUDI)

Other chapters in this year's report highlight the importance of women booking early in pregnancy. This ensures that all women get early offered pregnancy screening to identify medical conditions during pregnancy. Supportive midwifery and health visiting care can also help mothers improve their chance of a healthy pregnancy and birth through quitting smoking, healthy eating, and starting and continuing to breastfeed. Smoking and poor maternal diet is connected to low birthweight babies.

And we know that breastfeeding offers positive protection to babies from infection and allergy.

Sadly, sudden infant death often remains unexplained. But we know that the risk is greatly reduced if parents do not smoke, if babies are breastfed, and if they are placed to sleep in a safe environment. Sudden unexpected death is, thankfully, rare but it can happen. To help prevent it, all Sefton health staff advise the following:

Things to do

- Always place your baby on their back to sleep
- Keep your baby smoke free during pregnancy and after
- Place your baby to sleep in a separate cot or Moses basket in the same room as you for the first six months
- Breastfeed your baby
- Use a firm, flat waterproof mattress in good condition

Things to avoid

- Never sleep on a sofa or armchair with your baby
- Don’t sleep in the same bed as your baby
- Avoid letting your baby get too hot
- Don’t cover your baby’s face or head while sleeping or use loose bedding

Domestic violence: preventing harm to children

There are national and local strategies and programmes designed to support families and looked after children in their living and social environments. These include programmes to reduce the impact of domestic abuse on children, the government's 'Troubled Families' programme, and local programmes that support community social networks. Although only very rarely implicated in the death of children, panel reviews have identified a significant number of domestic violence incidents. In response, Sefton Council is researching the experience and impact of domestic violence on the health and wellbeing of people, including children who are affected by domestic violence.

Looking Forward

The Mersey panel is planning a series of training sessions for all front line staff who support parents and carers of babies. This will ensure they are able to discuss safe sleeping arrangements with families and give clear advice. The training will use a common protocol currently being developed across Merseyside NHS Trusts.

Sefton also plan to work with panel partners across Cheshire and Merseyside to develop a media campaign promoting safe sleeping practice.

Members of the panel are also delivering updates on the work and findings of the panel across Merseyside. Feedback from staff working in Sefton has been positive. Sharing learning will hopefully help protect children from potential harm and avoidable risks to health.

Find out more

Merseyside Child Death Overview Panel (including annual reports) - http://www.liverpoolscb.org/sub_child_death_overview_panel.html

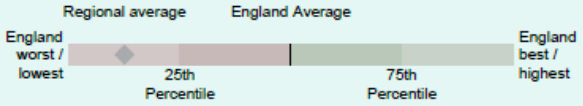
Vulnerable Victims Advocacy Team - http://www.sefton.gov.uk/advice-benefits/crime-and-emergencies/domestic-violence.aspx

Appendix 1

Spine Charts

Key
Significance compared to goal / England average:

- Significantly worse
- Not significantly different
- Significantly better
- Significantly lower
- Significantly higher
- Significance not tested



Overarching indicators

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
0.1i - Healthy life expectancy at birth (Male)	2010 - 12	62.5	63.4	52.5		70.0
0.1i - Healthy life expectancy at birth (Female)	2010 - 12	63.9	64.1	55.5		71.0
0.1ii - Life Expectancy at birth (Male)	2011 - 13	78.1	79.4	74.3		82.6
0.1ii - Life Expectancy at birth (Female)	2011 - 13	82.5	83.1	80.0		86.2
0.1ii - Life Expectancy at 65 (Male)	2011 - 13	18.2	18.7	16.0		21.1
0.1ii - Life Expectancy at 65 (Female)	2011 - 13	21.1	21.1	18.8		24.0
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Male)	2011 - 13		9.1			
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Female)	2011 - 13		6.9			
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Male)	2011 - 13		80			
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Female)	2011 - 13		73			
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	2011 - 13	12.2	-	2.4		17.3
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	2011 - 13	10.4	-	0.6		11.4
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)	2011 - 13	-1.3	0.0	-5.1		3.2
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female)	2011 - 13	-0.6	0.0	-3.1		3.1
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Male)	2010 - 12		19.4			
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Female)	2010 - 12		19.8			
0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Male)	2011 - 13		-			
0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Female)	2011 - 13		-			

Wider determinants of health

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
1.01i - Children in poverty (all dependent children under 20)	2012	19.2	18.6	39.0		6.4
1.01ii - Children in poverty (under 16s)	2012	20.1	19.2	37.9		6.6
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	2013/14	57.8	60.4	41.2		75.3
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2013/14	39.5	44.8	31.7		68.1
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2013/14	72.3	74.2	64.3		82.5
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2013/14	58.7	61.3	31.8		76.9
1.03 - Pupil absence	2012/13	5.65	5.26	6.31		4.36
1.04 - First time entrants to the youth justice system	2013	413	441	847		171
1.05 - 16-18 year olds not in education employment or training	2013	5.7	5.3	9.8		1.8
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Persons)	2013/14	83.5	74.8	47.7		94.5
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Male)	2013/14	88.0	74.5	46.2		94.9
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Female)	2013/14	76.1	75.3	50.0		94.0
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)	2013/14	62.7	60.9	12.6		93.3
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male)	2013/14	60.7	59.5	10.7		92.8
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female)	2013/14	65.1	62.5	15.2		94.2
1.07 - People in prison who have a mental illness or a significant mental illness	2012/13		4.35			
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2013/14	12.9	8.7	-2.5		24.2
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2013/14	71.0	65.1	46.7		79.1
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2013/14	69.4	64.8	55.3		75.0
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week	2010 - 12	2.0	2.5	4.6		0.8
1.09ii - Sickness absence - The percent of working days lost due to sickness absence	2010 - 12	1.5	1.6	3.1		0.4
1.10 - Killed and seriously injured (KSI) casualties on England's roads	2011 - 13	32.6	39.7	78.9		16.6
1.11 - Domestic Abuse	2012/13	30.2	18.8	5.6		30.2
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2010/11 - 12/13	92.3	57.6	167.8		9.3
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2013/14	6.6	11.1	4.6		27.8
1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	2013/14	0.64	1.01	0.38		2.43
1.13i - Re-offending levels - percentage of offenders who re-offend	2012	28.8	25.9	19.9		35.6
1.13ii - Re-offending levels - average number of re-offences per offender	2012	0.82	0.77	0.52		1.27
1.14i - The rate of complaints about noise	2012/13	3.3	7.5	80.4		2.5
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	4.2	5.2	0.8		20.8
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2011	6.2	8.0	1.2		42.4

Wider determinants of health continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
1.15i - Statutory homelessness - homelessness acceptances	2013/14	0.4	2.3	0.1		12.5
1.15ii - Statutory homelessness - households in temporary accommodation	2013/14	0.1	2.6	29.7		0.0
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2013 - Feb 2014	13.0	17.1	0.3		30.8
1.17 - Fuel Poverty	2012	11.4	10.4	21.3		4.9
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	2013/14	48.5	44.5	35.4		54.4
1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like	2012/13	40.1	41.3	23.9		58.5
1.19i - Older people's perception of community safety - safe in local area during the day	2012/13		97.5			
1.19ii - Older people's perception of community safety - safe in local area after dark	2012/13		61.9			
1.19iii - Older people's perception of community safety - safe in own home at night	2012/13		94.3			

Health improvement

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
2.01 - Low birth weight of term babies	2012	2.4	2.8	5.0		1.5
2.02i - Breastfeeding - Breastfeeding initiation	2013/14	56.8	73.9	36.6		93.0
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2013/14	27.2	-	19.4		77.4
2.03 - Smoking status at time of delivery	2013/14	15.3	12.0	27.5		1.9
2.04 - Under 18 conceptions	2012	28.0	27.7	52.0		14.2
2.04 - Under 18 conceptions: conceptions in those aged under 16	2012	5.2	5.6	15.8		2.0
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2013/14	24.8	22.5	29.5		15.9
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2013/14	35.0	33.5	43.8		24.4
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	100.9	103.8	191.3		61.7
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2012/13	117.4	134.7	282.4		76.0
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	150.3	130.7	277.3		63.8
2.08 - Emotional well-being of looked after children	2013/14	10.8	13.9	10.5		22.3
2.09ii - Smoking prevalence age 15 years - regular smokers	2013		8			
2.09iii - Smoking prevalence age 15 years - occasional smokers	2013		10			
2.12 - Excess Weight in Adults	2012	68.7	63.8	74.4		45.9
2.13i - Percentage of physically active and inactive adults - active adults	2013	54.4	55.6	43.4		66.3
2.13ii - Percentage of active and inactive adults - inactive adults	2013	31.5	28.9	39.2		16.3
2.14 - Smoking Prevalence	2013	18.7	18.4	29.4		10.5
2.14 - Smoking prevalence - routine & manual	2013	29.3	28.6	47.5		16.5
2.15i - Successful completion of drug treatment - opiate users	2013	7.3	7.8	3.5		15.8
2.15ii - Successful completion of drug treatment - non-opiate users	2013	48.4	37.7	7.6		60.2
2.16 - People entering prison with substance dependence issues who are previously not known to community treatment	2012/13	41.4	46.9	69.8		19.7
2.17 - Recorded diabetes	2013/14	6.39	6.21	3.69		8.66

Health improvement continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
2.18 - Alcohol related admissions to hospital - narrow definition (Persons)	2012/13	731	637	1121		365
2.18 - Alcohol related admissions to hospital - narrow definition (Male)	2012/13	989	829	1425		454
2.18 - Alcohol related admissions to hospital - narrow definition (Female)	2012/13	511	465	839		269
2.19 - Cancer diagnosed at early stage (Experimental Statistics)	2012	46.1	41.6	34.4		60.3
2.20i - Cancer screening coverage - breast cancer	2014	73.2	75.9	57.4		83.7
2.20ii - Cancer screening coverage - cervical cancer	2014	71.6	74.2	59.5		79.7
2.21i - Antenatal infectious disease screening – HIV coverage	2013/14		98.9			
2.21iii - Antenatal Sickle Cell and Thalassaemia Screening - coverage	2013/14		98.9			
2.21iv - Newborn bloodspot screening - coverage	2013/14	98.4 ^	93.5	81.9		99.9
2.21v - Newborn Hearing screening - Coverage	2013/14	98.8	98.5	92.7		99.9
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2012/13	- x	79.1	66.0		94.8
2.21viii - Abdominal Aortic Aneurysm Screening	2013/14	50.1	95.9	39.3		100
2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check	2013/14	20.7	18.4	0.8		44.4
2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14	44.4	49.0	14.6		100
2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health check	2013/14	9.2	9.0	0.9		29.1
2.23i - Self-reported well-being - people with a low satisfaction score	2013/14	8.4	5.6	12.7		3.3
2.23ii - Self-reported well-being - people with a low worthwhile score	2013/14	5.4	4.2	7.7		2.9
2.23iii - Self-reported well-being - people with a low happiness score	2013/14	10.6	9.7	15.0		5.8
2.23iv - Self-reported well-being - people with a high anxiety score	2013/14	24.9	20.0	29.3		9.3
2.23v - Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score	2010 - 12		37.7			
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2012/13	2119	2011	3508		1178
2.24i - Injuries due to falls in people aged 65 and over (males/females) (Male)	2012/13	1860	1602	2975		903
2.24i - Injuries due to falls in people aged 65 and over (males/females) (Female)	2012/13	2377	2420	4041		1452
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	2012/13	1118	975	1826		544
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+	2012/13	5021	5015	9119		2876

Health protection

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
3.01 - Fraction of mortality attributable to particulate air pollution	2012	4.0	5.1	3.0		7.7
3.02i - Chlamydia detection rate (15-24 year olds) - Old NCSP data < 2000 2000 to 2400 ≥ 2400	2011	1994	2092	948		4911
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD < 1900 1900 to 2300 ≥ 2300	2013	1770	2016	840		5758
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD (Male)	2013	1023	1387	599		4262
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD (Female)	2013	2505	2634	1094		6358
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2013/14	- *	-	13.6		100
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2013/14	- ^	-	-100.0		100
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) < 90 ≥ 90	2013/14	96.3 ^	94.3	78.6		98.4

Health protection continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) < 90 ≥ 90	2013/14	97.2 ^	96.1	81.6		99.1
3.03iv - Population vaccination coverage - MenC < 90 ≥ 90	2012/13	95.5 ^	93.9	75.9		98.8
3.03v - Population vaccination coverage - PCV < 90 ≥ 90	2013/14	96.0 ^	94.1	78.2		98.3
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) < 90 ≥ 90	2013/14	94.9	92.5	76.6		98.1
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years) < 90 ≥ 90	2013/14	91.7 ^	91.9	72.7		98.1
3.03vii - Population vaccination coverage - PCV booster < 90 ≥ 90	2013/14	95.0 ^	92.4	76.4		98.5
3.03viii - Population vaccination coverage - MMR for one dose (2 years old) < 90 ≥ 90	2013/14	94.7 ^	92.7	78.3		98.3
3.03ix - Population vaccination coverage - MMR for one dose (5 years old) < 90 ≥ 90	2013/14	96.3 ^	94.1	74.8		98.6
3.03x - Population vaccination coverage - MMR for two doses (5 years old) < 90 ≥ 90	2013/14	90.3 ^	88.3	63.8		97.4
3.03xii - Population vaccination coverage - HPV < previous years England average ≥ previous years England average	2013/14	90.6	86.7	51.1		96.6
3.03xiii - Population vaccination coverage - PPV < previous years England average ≥ previous years England average	2012/13	69.6 ^	69.1	55.3		77.0
3.03xiv - Population vaccination coverage - Flu (aged 65+) < 75 ≥ 75	2013/14	75.8	73.2	62.9		80.5
3.03xv - Population vaccination coverage - Flu (at risk individuals) < 75 ≥ 75	2013/14	53.2	52.3	38.9		68.6
3.04 - People presenting with HIV at a late stage of infection < 25 25 to 50 ≥ 50	2011 - 13	39.1	45.0	77.3		25.9
3.05i - Treatment completion for TB < 85 ≥ 85	2012	- x	82.8	22.6		100
3.05ii - Incidence of TB	2010 - 12	4.0	15.1	112.3		0.0
3.06 - NHS organisations with a board approved sustainable development management plan	2013/14	50.0	41.6	0.0		83.3
3.07 - Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	2014/15	100	95.2	0.0		100

Healthcare and premature mortality

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
4.01 - Infant mortality	2010 - 12	4.8	4.1	7.5		1.1
4.02 - Tooth decay in children aged 5	2011/12	0.90	0.94	2.10		0.35
4.03 - Mortality rate from causes considered preventable (Persons)	2011 - 13	216.6	183.9	319.7		130.3
4.03 - Mortality rate from causes considered preventable (Male)	2011 - 13	273.9	233.1	409.1		166.5
4.03 - Mortality rate from causes considered preventable (Female)	2011 - 13	164.8	138.0	235.2		93.7
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2011 - 13	80.8	78.2	137.0		52.1
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2011 - 13	112.7	109.5	184.9		75.0
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2011 - 13	52.7	48.6	91.2		29.9

Healthcare and premature mortality continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2011 - 13	52.2	50.9	89.0		30.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2011 - 13	79.6	76.7	130.9		46.2
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2011 - 13	27.9	26.5	57.1		14.5
4.05i - Under 75 mortality rate from cancer (Persons)	2011 - 13	161.9	144.4	198.9		104.0
4.05i - Under 75 mortality rate from cancer (Male)	2011 - 13	181.1	160.9	230.7		113.8
4.05i - Under 75 mortality rate from cancer (Female)	2011 - 13	145.3	129.2	182.3		95.5
4.05ii - Under 75 mortality rate from cancer considered preventable (Persons)	2011 - 13	98.6	83.8	126.9		52.7
4.05ii - Under 75 mortality rate from cancer considered preventable (Male)	2011 - 13	107.5	91.3	148.1		46.9
4.05ii - Under 75 mortality rate from cancer considered preventable (Female)	2011 - 13	90.9	76.9	118.2		55.6
4.06i - Under 75 mortality rate from liver disease (Persons)	2011 - 13	26.9	17.9	43.4		11.3
4.06i - Under 75 mortality rate from liver disease (Male)	2011 - 13	38.7	23.6	58.9		14.3
4.06i - Under 75 mortality rate from liver disease (Female)	2011 - 13	16.1	12.5	27.7		7.4
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons)	2011 - 13	24.5	15.7	39.5		9.6
4.06ii - Under 75 mortality rate from liver disease considered preventable (Male)	2011 - 13	35.3	21.1	54.4		12.4
4.06ii - Under 75 mortality rate from liver disease considered preventable (Female)	2011 - 13	14.7	10.5	24.5		6.4
4.07i - Under 75 mortality rate from respiratory disease (Persons)	2011 - 13	35.4	33.2	78.1		19.5
4.07i - Under 75 mortality rate from respiratory disease (Male)	2011 - 13	38.7	39.1	94.6		23.0
4.07i - Under 75 mortality rate from respiratory disease (Female)	2011 - 13	32.4	27.6	67.1		14.2
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Persons)	2011 - 13	18.7	17.9	46.6		7.6
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Male)	2011 - 13	19.6	20.4	52.9		10.6
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Female)	2011 - 13	17.9	15.5	41.4		7.6
4.08 - Mortality from communicable diseases (Persons)	2011 - 13	56.3	62.2	93.8		36.0
4.08 - Mortality from communicable diseases (Male)	2011 - 13	67.0	72.1	117.0		46.9
4.08 - Mortality from communicable diseases (Female)	2011 - 13	50.8	56.2	91.4		30.9
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2012/13	368.6	347.2	564.2		139.4
4.10 - Suicide rate (Persons)	2011 - 13	9.7	8.8	13.6		4.5
4.10 - Suicide rate (Male)	2011 - 13	16.2	13.8	21.9		8.0
4.10 - Suicide rate (Female)	2011 - 13	- x	4.0	6.6		2.2
4.11 - Emergency readmissions within 30 days of discharge from hospital (Persons)	2011/12	11.9	11.8	14.5		8.8
4.11 - Emergency readmissions within 30 days of discharge from hospital (Male)	2011/12	12.2	12.1	14.9		8.7
4.11 - Emergency readmissions within 30 days of discharge from hospital (Female)	2011/12	11.7	11.5	14.7		8.3
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2012/13	125.1	104.4	31.7		221.3
4.12ii - Preventable sight loss - glaucoma	2012/13	11.6	12.5	2.8		29.3
4.12iii - Preventable sight loss - diabetic eye disease	2012/13	2.9	3.5	1.1		14.0
4.12iv - Preventable sight loss - sight loss certifications	2012/13	54.1	42.3	13.5		79.8

Appendix 2

Sefton Child Health Profile — March 2014

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	**1** Infant mortality	14	5.0	4.3	7.7	1.3
	2 Child mortality rate (1-17 years)	3	5.5	12.5	21.7	4.0
Health protection	**3** MMR vaccination for one dose (2 years)	2,757	95.8	92.3	77.4	98.4
	4 Dtap / IPV / Hib vaccination (2 years)	2,822	98.1	96.3	81.9	99.4
	5 Children in care immunisations	275	84.6	83.2	0.0	100.0
	6 Acute sexually transmitted infections (including chlamydia)	1,124	34.8	34.4	89.1	14.1
Wider determinants of ill health	**7** Children achieving a good level of development at the end of reception	1,488	51.1	51.7	27.7	69.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	2,121	60.9	60.8	43.7	80.2
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	5	18.4	15.3	0.0	41.7
	10 16-18 year olds not in education, employment or training	630	6.7	5.8	10.5	2.0
	11 First time entrants to the youth justice system	142	550.7	537.0	1,426.6	150.7
	12 Children in poverty (under 16 years)	9,770	20.9	20.6	43.6	6.9
	13 Family homelessness	35	0.3	1.7	9.5	0.1
	14 Children in care	420	78	60	166	20
	15 Children killed or seriously injured in road traffic accidents	12	26.1	20.7	45.6	6.3
Health improvement	**16** Low birthweight of all babies	196	7.0	7.3	10.2	4.2
	17 Obese children (4-5 years)	276	10.2	9.3	14.8	5.7
	18 Obese children (10-11 years)	516	20.0	18.9	27.5	12.3
	19 Children with one or more decayed, missing or filled teeth	-	26.5	27.9	53.2	12.5
	20 Under 18 conceptions	153	30.3	30.7	58.1	9.4
	21 Teenage mothers	35	1.2	1.2	3.1	0.2
	22 Hospital admissions due to alcohol specific conditions	40	73.2	42.7	113.5	14.6
	23 Hospital admissions due to substance misuse (15-24 years)	24	72.9	75.2	218.4	25.4
Prevention of ill health	**24** Smoking status at time of delivery	426	15.6	12.7	30.8	2.3
	25 Breastfeeding initiation	1,479	54.0	73.9	40.8	94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	760	27.5	47.2	17.5	83.3
	27 A&E attendances (0-4 years)	16,179	1,106.9	510.8	1,861.3	214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	440	100.9	103.8	191.3	61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	485	150.3	130.7	277.3	63.8
	30 Hospital admissions for asthma (under 19 years)	197	344.4	221.4	591.9	63.4
	31 Hospital admissions for mental health conditions	53	98.5	87.6	434.8	28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	172	355.8	346.3	1,152.4	82.4

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2010-2012
2 Directly standardised rate per 100,000 children age 1-17 years, 2010-2012
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2012/13
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2012/13
5 % children in care with up-to-date immunisations, 2013
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2012
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2012/13
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2013 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2012
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2012
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2012/13
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2013
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2010-2012
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2012
17 % school children in Reception year classified as obese, 2012/13
18 % school children in Year 6 classified as obese, 2012/13
19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
20 Under 18 conception rate per 1,000 females age 15-17 years, 2011
21 % of delivery episodes where the mother is aged less than 18 years, 2012/13
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2010/11-2012/13
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2010/11-2012/13
24 % of mothers smoking at time of delivery, 2012/13
25 % of mothers initiating breastfeeding, 2012/13
26 % of mothers breastfeeding at 6-8 weeks, 2012/13
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2012/13
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2012/13
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2012/13
32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2012/13