

CARING PLYMOUTH

Introduction to Child Health

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I. Introduction and setting the scene

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The report of this review was published in February 2010 and contained nine key messages:

- (1) Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
- (2) There is a social gradient in health – the lower a person’s social position, the worse his or her health. Action should focus on reducing the gradient in health.
- (3) Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- (4) Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism.
- (5) Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
- (6) Economic growth is not the most important measure of our country’s success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.
- (7) Reducing health inequalities will require action on six policy objectives:
 - (A) Give every child the best start in life**
 - (B) Enable all children young people and adults to maximise their capabilities and have control over their lives**
 - (C) Create fair employment and good work for all
 - (D) Ensure healthy standard of living for all
 - (E) Create and develop healthy and sustainable places and communities
 - (F) Strengthen the role and impact of ill health prevention
- (8) Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.

- (9) Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

The Marmot review is clear that tackling inequalities is something we cannot afford to neglect. Persistent inequalities across a wide range of areas provide clear examples of the wider costs to society of the impact of inequalities from early childhood development and education, employment and working conditions, housing and local neighbourhood conditions, ever increasing health and social care costs and, more generally, the freedom to participate equally in the wider benefits of society. The benefits of reducing health inequalities are economic as well as social. More than three-quarters of the population nationally do not have disability-free life expectancy up to the age of 68. If Plymouth wants to have a healthy population, working until 68 years, it is essential to take action now to raise the general level of health and flatten the social gradient in health. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society.

To reduce the steepness of the social gradient in health, action must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is known as proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem. The Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources.

However economic growth without reducing relative inequality will not reduce health inequalities. The economic growth of the last 30 years has not narrowed income inequalities. Although there is far more to inequality than just income, income is linked to life chances in a number of salient ways. A fair society would give people more equal freedom to lead flourishing lives. To achieve this, the Marmot Review contained two policy goals:

- (1) To create an enabling society that maximises individual and community potential.
- (2) To ensure social justice, health and sustainability should be at the heart of all policies.

Health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course.

The central subject of the Marmot review is that avoidable health inequalities are unfair and putting them right is a matter of social justice. Finding a way to do this in the current economic climate will not be easy. But to do nothing is not an option if the human and economic costs are too high. The health and well-being of today's children as they grow into adults depend on having the courage and imagination to rise

to the challenge of doing things differently, to put sustainability and well-being before economic growth and bring about a more equal and fair society.

Policy objective (A): Give every child the best start in life

Giving every child the best start in life is crucial to reducing health inequalities across the life course. 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 – from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children’s access to positive early experiences. Later interventions, although important, are considerably less effective if they have not had good early foundations.

- Investment in early years is vital to reducing health inequalities and needs to be sustained, otherwise its effect is lessened.
- Returns on investment in early childhood are higher than in adolescence.
- Currently, spending is higher in later childhood years and needs to be rebalanced towards the early years.
- Gaps between individuals and social groups emerge early in the life course.
- Early interventions during pregnancy and on-going support in early years are critical to the long-term health of the child and other long-term outcomes.
- Universal and proportionately targeted interventions are necessary.
- Emerging evidence shows that Sure Start Children’s Centres have a positive impact on child outcomes.
- Families have the most influence on their children.
- Adequate levels of income and material and psychological support and advice for parents across the social gradient are critical.
- Intensive home visiting is effective in improving maternal and child health.
- Good parent–child relationships in the first year of life are associated with stronger cognitive skills in young children and enhanced competence and work skills in schools.
- Good quality early childhood education has enduring effects on health and other outcomes
- These outcomes are particularly strong for those from disadvantaged backgrounds

- A good quality workforce makes a difference to health outcomes but the childcare workforce remains low paid and low status
- Pre and postnatal policy and services should be integrated.

2. The child health journey

Policy objective (A): Give every child the best start in life

2.1 Pregnancy

Pregnancy is one of the most important stages in the life cycle. This is when the foundations of future health and wellbeing are laid down, and is a time when parents are particularly receptive to learning and making changes. There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy.

The 'Healthy Child Programme pregnancy and the first five years of life' sets out the good practice framework for prevention and early interventions services for this period. It consists of a mixed approach of preventative programmes for all children and families with targeted and additional support to meet identified needs. It has a major emphasis on supporting parents, the importance of attachment and positive parenting, greater focus on pregnancy and building a progressive universal programme that responds to different risk factors of child's future chances as well as ensuring healthy development.

Pre-conception care has been defined as a set of interventions to identify and modify a woman's health or pregnancy outcome through prevention and management. Because a significant proportion of pregnancies are unintended (about half), the negative consequences of many behaviours, illnesses, and medications can affect fetal development early in pregnancy before a woman even realises that she is pregnant.

Thus, healthcare encounters during a woman's reproductive years should include counselling on medical care and healthy behaviours to optimise pregnancy outcome if it were to occur. For example, healthy women should begin folic acid supplementation ideally at least three months before conception and continue until 12 weeks' gestation.

Antenatal care is the care received from healthcare professionals during pregnancy. Children's health development begins in pregnancy and it is the responsibility of midwives to assess the health and social care needs of mothers ideally by the twelfth week of pregnancy. The midwife will co-ordinate the support of other professionals as needed to support the mother and family as required. It includes:

- a series of antenatal appointments to check on maternal and baby health (home and clinics)
- ultrasound scans
- screening checks for conditions that may affect the baby¹
 - Fetal Anomaly Screening Programme: first trimester Down's syndrome;
 - 20 week ultrasound scan checking for physical abnormalities

¹ Screening is a way of finding people at risk of a health problem before they get symptoms. This means they can get earlier, and potentially more effective, treatment or make informed decisions about their health. Within the Healthy Child Programme, there are both antenatal and newborn screening programmes:

- Infectious Diseases in Pregnancy Screening Programme: first trimester hepatitis B, HIV, syphilis and rubella susceptibility testing at booking
- Sickle Cell and Thalassaemia Screening Programme
- immunisations
- antenatal classes (Great Expectations)
- referral on for additional support
- Healthy Start scheme if eligible²

Pregnancy care is carried out by a range of professional groups depending on maternal and fetal needs. It would include midwives, ultrasonographers, health visitors, GPs, Children Centre staff and if additional needs are identified may also include obstetricians, paediatricians, smoking cessation advisors, dieticians, anaesthetists, physiotherapists to name but a few.

Key measures of outcome of healthy pregnancy are mortality (maternal and baby). Actions/interventions that could reduce the inequalities in infant mortality are reducing teenage pregnancy, smoking and obesity, reducing poverty, poor housing/overcrowding and improving infant nutrition and ensuring access and take up of healthcare services and targeted interventions aimed at reducing sudden unexpected deaths in infancy.

Low birth weight is a well-known contributor to poor outcomes in infancy and is particularly associated with prematurity and other risk factors such as smoking in pregnancy. Smoking is the major modifiable risk factor contributing to low birth weight; babies born to women who smoke weigh on average 200g less than babies born to non-smokers. The incidence of low birth weight is twice as high among smokers as non-smokers (Messecar, 2001).

Giving up smoking is one of the key steps that pregnant women and their partners can take to reduce the risks to themselves and their baby during pregnancy. Smoking in pregnancy can cause a range of serious health problems including miscarriage, premature birth, low birth weight (<2500g), sudden unexpected death in infancy.

² Healthy Start provides a nutritional safety net and encouragement for breastfeeding and healthy eating to around 600,000 women and children in over 450,000 very low income and disadvantaged families across the UK. Healthy Start vouchers can be put towards the cost of milk, fresh or plain frozen fruit and vegetables in 30,000 retail outlets (small shops as well as major supermarkets). The scheme also provides coupons that can be exchanged via the NHS locally for free Healthy Start vitamin supplements for children, pregnant women and new mothers.

Appointment	What should happen
First contact with your midwife or doctor	<p>Your midwife or doctor should give you information about:</p> <ul style="list-style-type: none"> • folic acid supplements • food hygiene, including how to reduce the risk of a food-acquired infection • lifestyle, including smoking cessation and the risks of recreational drug use and alcohol consumption • antenatal screening tests.
Booking appointment	<p>Your midwife or doctor should give you information about:</p> <ul style="list-style-type: none"> • how the baby develops during pregnancy • nutrition and diet, including vitamin D supplements • exercise, including pelvic floor exercises • antenatal screening tests • your pregnancy care pathway • where to have your baby • breastfeeding and workshops • antenatal classes • maternity benefits. <p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • see if you may need additional care or support • plan the care you will get throughout your pregnancy • ask about your job to identify any potential risks • measure your height and weight and calculate your body mass index • measure your blood pressure and test your urine for protein • find out whether you are at increased risk of gestational diabetes or pre-eclampsia • ask about mental illness and ask about any signs of depression • offer you screening tests and make sure you understand what is involved before you decide to have any of them • offer you an ultrasound scan to estimate when the baby is due • offer you an ultrasound scan at 18 to 20 weeks to check the physical development of the baby.
16 weeks	<p>Your midwife or doctor should give you information about the ultrasound scan you will be offered at 18 to 20 weeks and help with any concerns or questions you have.</p> <p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • review, discuss and record the results of any screening tests • measure your blood pressure and test your urine for protein • consider an iron supplement if you are anaemic.
18 to 20 weeks (anomaly scan)	<i>Ultrasound scan to check the physical development of the baby if you wish it.</i>

25 weeks*	<p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • check the size of your abdomen • measure your blood pressure and test your urine for protein.
28 weeks	<p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • check the size of your abdomen • measure your blood pressure and test your urine for protein • offer more blood screening tests • offer first anti-D treatment if you are rhesus D-negative.
31 weeks*	<p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • review, discuss and record the results of any screening tests from the last appointment • check the size of your abdomen • measure your blood pressure and test your urine for protein.
34 weeks	<p>Your midwife or doctor should give you information about preparing for labour and birth, including how to recognise active labour, ways of coping with pain in labour and your birth plan.</p> <p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • review, discuss and record the results of any screening tests from the last appointment • check the size of your abdomen • measure your blood pressure and test your urine for protein • offer second anti-D treatment if you are rhesus D-negative.
36 weeks	<p>Your midwife or doctor should give you information about:</p> <ul style="list-style-type: none"> • breastfeeding, including hints and tips for success • caring for your newborn baby • vitamin K and screening tests for your newborn baby • your own health after the baby is born • being aware of the 'baby blues' and postnatal depression. <p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • check the size of your abdomen • check the position of the baby and discuss options to turn the baby if he or she is bottom first (breech position) • measure your blood pressure and test your urine for protein.
38 weeks	<p>Your midwife or doctor should give you information about what happens if your pregnancy lasts longer than 41 weeks.</p> <p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • check the size of your abdomen

	<ul style="list-style-type: none"> • measure your blood pressure and test your urine for protein.
40 weeks*	<p>Your midwife or doctor should give you more information about what happens if your pregnancy lasts longer than 41 weeks.</p> <p>Your midwife or doctor should: check the size of your abdomen measure your blood pressure and test your urine for protein.</p>
41 weeks	<p>Your midwife or doctor should:</p> <ul style="list-style-type: none"> • check the size of your abdomen • measure your blood pressure and test your urine for protein • offer a membrane sweep • offer induction of labour.

2.2 First year of life

From birth, newborns undergo dramatic physical and mental changes. Babies are born with 25% of their brains developed and then there is a rapid period of development so that by three years of age their brains are 80% developed. In these first few years, the impact of neglect, poor parenting and other adverse experiences such as maternal depression can have a profound effect on how children are emotionally ‘wired’. Research shows that although the brain continues to develop, these early experiences strongly influence a child’s social and emotional development and their ability to reach their full potential. For example children of mothers who have postnatal depression are less likely to show secure attachment at 36 months and are more likely to have social, emotional and cognitive problems at five years and are more likely to experience depression at 16 years.

Prevention and intervention to address adverse experiences is therefore key in a child’s early life and therefore requires the identification of emerging problems as early as possible through assessment and then a response to the identified needs. Intervention with effective programmes to reduce risk factors and increase protective factors can de-escalate the problem and prevent individuals and families needing more intensive and costly support and treatment, leading to better outcomes.

In particular, early intervention to promote social and emotional development can significantly improve mental and physical health, educational attainment and employment opportunities. Research also shows that there are significant economic benefits of early intervention with consistently good returns on investment.

The ‘Healthy Child Programme pregnancy and the first five years of life’ sets out the good practice framework for prevention and early interventions services for this period. It has a major emphasis on supporting parents, the importance of attachment and positive parenting and building a progressive universal programme that responds to different risk factors of child’s future chances as well as ensuring healthy

development. Health visitors deliver the programme (once care has been handed over from the midwife), which is available to all families.

The government is currently introducing a new model for health visiting services which will strengthen the provision of the healthy child programme across England. The model will bring improved access and time with families, providing services where it best suits the family – at home, in health settings including GP surgeries, in Sure Start Children’s Centre as well as other non-traditional settings.

Within this programme there is a universal component which is available for all children, parents and carers. Families needing different levels of service and may need different services at different times. This is reflected in the new service model for health visiting.

2.2.1 Universal Provision

- **Checks:** New born examination ; 6-8 weeks; 1 year
- **Infant nutrition:**
 - Vitamins and Healthy Start
 - Initial feeding: breastfeeding and safe, good practice for formula feeding
 - Weaning
 - Dental health
- **Health promotion and Injury prevention**
 - Maintaining infant health: anticipatory, practical guidance on reality of early days with an infant, healthy sleep practices and bath, book, bed routine to increase parent–infant interaction
 - Reduction of risk of sudden unexplained deaths in infancy
 - Dental health
- **Promoting sensitive parenting and attachment:**
 - Introduce parents to the ‘social baby’, by providing them with information about the sensory and perceptual capabilities of their baby using a range of media
 - Promote closeness and sensitive, attuned parenting, by encouraging skin-to-skin care and the use of soft baby carriers.
- **Screening**
 - Newborn hearing screening
 - Newborn and Infant Physical Examination (NIPE) Programme: a head to toe physical examination and specific examination of eyes, heart, hips and testes in boys, within 72 hours of birth (maternity service or GP) and again at 6 to 8 weeks of age (GP)
 - Newborn Blood Spot Screening Programme: a test at age five days for phenylketonuria (PKU), congenital hypothyroidism (CHT), sickle cell disease (SCD), cystic fibrosis (CF) and medium-chain acyl-CoA dehydrogenase deficiency (MCADD)
- **Immunisations** (see diagram below)

Routine childhood immunisations from June 2013

When to immunise	Diseases protected against	Vaccine given	Immunisation site**
Two months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (Hib)	DTaP/IPV/Hib (Pediace)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Rotavirus (from July)	Rotavirus (Rotarix)	By mouth
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediace)	Thigh
	Meningococcal group C disease (MenC)	Men C (NeisVac-C or Menjugate)	Thigh
	Rotavirus (from July)	Rotavirus (Rotarix)	By mouth
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediace)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR (Priorix or MMR VaxPRO)	Upper arm/thigh
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	dTaP/IPV (Repevax) or DTaP/IPV (Infanrix-IPV)	Upper arm
	Measles, mumps and rubella	MMR (Priorix or MMR VaxPRO) (check first dose has been given)	Upper arm
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (Gardasil)	Upper arm
Around 14 years old	Tetanus, diphtheria and polio	Td/IPV (Revaxis), and check MMR status	Upper arm
	MenC†	MenC (Meningitec, Menjugate or NeisVac-C)‡	Upper arm

** Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book.

† This vaccination will be introduced during the 2013/14 academic year.

‡ The vaccine supplied will depend on the brands available at the time of ordering.

Immunisations for at-risk children

At birth, 1 month old, 2 months old and 12 months old	Hepatitis B	Hep B	Thigh
At birth	Tuberculosis	BCG	Upper arm (intra-dermal)

- Promotion of development and developmental checks
- Assessing maternal mental health

2.2.2 Progressive services based on identification of need

- **Additional support**
 - Parenting, infant feeding, maternal depression, parental relations, babies with health or developmental problems, young mothers
- **High intensity home visiting**
 - Family Nurse Partnership; Universal Plus Health Visiting
- **Referral to specialist**
 - e.g. smoking cessation, speech and language therapist, paediatric care
- **Partnership response** as part of Child In Need or Safeguarding or complex need care package

2.3 Early years (1-4/5 years)

This is a key time for speech and language, social, emotional and cognitive development. It is also a time when parents need support as children gain independence and begin to enter into early years education settings.

2.3.1 Universal Provision

- **Immunisations:** as per programme
- **Checks:** The two to two and a half year review is led by a health visitor, who will review the child's developmental progress (social, emotional, behavioural and neurodevelopmental) and health status and, with the parents, plan any future support and services to meet the needs of the child and family. The review is an important opportunity to ensure that all immunisations are up-to-date.
- **Health promotion & Injury prevention**
 - Safety advice as child becomes more mobile
 - Dental health
 - Healthy eating
 - Active play
 - Promoting child health and lifestyles
- **Monitoring of development**
- **Supporting parenting**
- **Support to early years services for key health promoting messages**
 - Promoting child health and healthy lifestyles
 - Nutrition
 - Active play
 - Accident prevention
 - Dental health
- **Transfer to school: Health questionnaire**

2.3.2 Progressive services based on identification of need

- **Additional support**
 - Parenting, children at risk of obesity / feeding problems, maternal depressions, parental relations, babies with health or developmental problems / abnormalities
- **High intensity home visiting**
 - Family Nurse Partnership; Universal Plus Health Visiting
- **Referral to specialist**
 - e.g. smoking cessation, speech and language therapist, paediatric care
- **Partnership response** as part of Child In need or Safeguarding or complex need care package

Policy Objective (B): Enable all children, young people and adults to maximise their capabilities and have control over their lives

Achieving the best possible health sets a key foundation for a child or young person to flourish, achieve and stay safe as they grow up. Health is crucially linked to education, so that a child with poor educational outcomes may experience not just educational problems in their future but also poor health outcomes, but also conversely good health and emotional wellbeing are associated with improved attendance and attainment at school. Children who thrive at school are also better placed to act on health information.

Lifestyles established through childhood and adolescence influence a person's health throughout their life. For example;

- 8 in 10 obese teenagers go on to be obese adults;
- half of life time mental illness starts at age 14
- more than 8 out of 10 adult smokers started before 19
- adolescents who binge drink are 50% more likely to be dependent on alcohol or misusing other substances by age 30

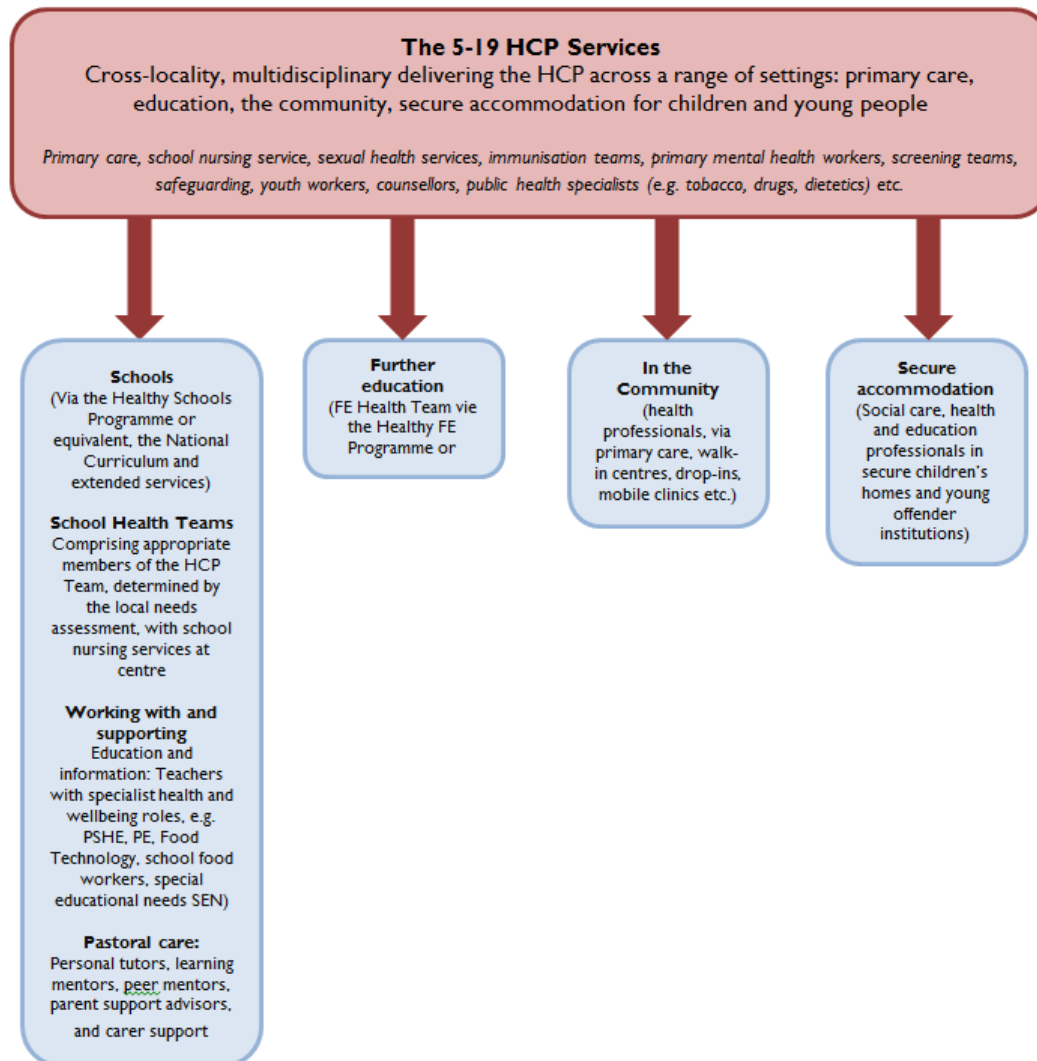
The Healthy Child Programme 5-19 sets out the good practice framework for prevention and early interventions services for children and young people age 5-19 and recommends how health, education and other partners working together across a range of settings can significantly enhance and child or young person's life chances. It focuses on providing healthy environments, building resilience, working in partnership with educational and other settings.

The Healthy Child Programme 5-19 is delivered by a wide range of agencies and disciplines across a locality in a range of settings, which can also facilitate access to more specialist services.

Key priority areas for this programme focus more on the health protecting and promoting behaviours that support children, young people and adults to maximise their capabilities and have control over their lives through:

- Emotional health, psychological wellbeing and mental health
- Promoting health weight
- Supporting children and young people with long term conditions or disability
- Teenage pregnancy and sexual health
- Drugs, alcohol and tobacco

Schools have an important role to play in the promoting of healthy lifestyles underpinned by their statutory duty to promote the wellbeing of their pupils, to provide healthy school food and provision of health promoting aspects of the curriculum e.g. Personal Social, Health and Economic Education (PHSE) and Relationship and Sex Education (RSE).



2.4 Primary School age (4/5-11)

2.4.1 Universal Provision

- **School Entry Health questionnaire:** opportunity to review immunisations, hearing screening question, parental concerns
- **Orthoptics screen for visual impairment**
- **National Child Measurement Programme:** Reception and Year 6
- **Health promotion**
 - Support for appropriate social and emotional development
 - Prevention and tackling of bullying
 - Physical activity- PE curriculum and active travel
 - Healthy Nutrition

2.4.2 Progressive services based on identification of need

- **Identification of additional needs**
 - Referral to specialist (child based or parent based) e.g. smoking cessation, speech and language therapist, paediatric care
 - Support to for children, parents and school for children with complex health problems, special educational needs or complex welfare concerns
 - Partnership response as part of Child In need or Safeguarding or complex need care package
- **Support for parents and carers**
Support to for children, parents and school for parents / carers with problems (young carers, parents with alcohol, substance misuse, mental health problems, learning difficulties or domestic violence)

2.5 Secondary school/college age (11-19)

Emerging evidence on adolescent brain development shows that in pre puberty and puberty there is a rapid and dramatic re-organisation of the brain. These changes affect behaviour and attitudes at a time when health and wellbeing choices can be challenging. Social capabilities are being developed and there is a heightened sensitivity to reward. The combination of these can lead to greater risk taking behaviours

Risk taking behaviour is considered a normal and positive part of growing up and supports the development of resilient, positive young people. However, harmful risk taking behaviours, such as smoking, drug and alcohol misuse or unprotected sex, can reduce life chances and opportunities and impact on health and well-being.

There is a close link between harmful risk taking behaviours and the most vulnerable children and young people, and similarly there are the ubiquitous links to deprivation and inequality. Risky behaviours overlap and cluster and have areas of similarity and co-dependency.

Levels of autonomy in the family, sense of belonging in schools and feeling safe in the local community can promote resilience. The fact of their youth means there is time to prevent damaging behaviours and attitude developing and time to help them establish good patterns of managing their health

2.5.1 Universal Provision

Immunisations: as per programme

Transfer to secondary school: School Entry Health questionnaire: opportunity to review immunisations, parental and young person concerns, pass on ongoing needs, follow upon NCMP results

Health promotion

- Support for appropriate social and emotional development
- Prevention and tackling of bullying
- Physical activity- PE curriculum and active travel
- Healthy Nutrition
- Sexual health

2.5.2 Progressive services based on identification of need

- **Identification of additional needs**
 - Referral to specialist (child based or parent based) e.g. smoking cessation, drugs and alcohol misuse services, smoking cessation, paediatric care, CAMHS
 - Support to for children, parents and school for children with complex health problems, special educational needs or complex welfare concerns
 - Partnership response as part of Child In need or Safeguarding or complex need care package
- **Support for parents and carers**
Support to children, parents and school for parents/carers with problems (young carers, parents with alcohol, substance misuse, mental health problems, learning difficulties or domestic violence)

3. Commissioning

With effect from April 2013, health and children’s health commissioning architecture was changed. This is explained in below:

Key LA Public Health commissioning responsibilities
Healthy Child Programme for school-age children, including school nursing
Contraception (over and above what GPs provide)
Testing and treatment of sexually transmitted infections, sexual health advice, prevention and promotion
Mental health promotion, mental illness prevention and suicide prevention
Local programmes to address physical inactivity and promote physical activity
Local programmes to prevent and address obesity, including National Child Measurement Programme and weight management services
Drug misuse services, prevention and treatment
Alcohol misuse services, prevention and treatment
Local smoking related activity, including stop smoking services and prevention activity
Locally-led initiatives on nutrition
Population level interventions to reduce and prevent birth defects (with PHE)
Dental – oral health promotion

Key CCG commissioning responsibilities
Children’s healthcare services
Maternity Services (and routine newborn services)
CAMHS
Adult mental health services
Community health services, including speech and language, continence, wheelchair services and home oxygen services (except for public health services such as health visiting and family nursing)
Elective hospital care
Urgent and emergency care, including A&E and ambulance services (for anyone present in their geographic area), out-of-hours primary medical services except where retained by practices
Services for people with learning disabilities
NHS Continuing healthcare
Infertility services

Key NHS CB commissioning responsibilities: public health
Public health services for children from pregnancy to age 5 (Healthy Child Programme 0-5), including health visiting and family nurse partnership and responsibility for Child Health Information Systems (responsibility for children’s public health 0-5 due to transfer to LAs in 2015)
Immunisation programmes
National Screening programmes
Public health services for those in prison or places of detention
Sexual assault referral services

Key NHS CB commissioning responsibilities: healthcare
Primary medical services commissioned under the GP contract, out of hours where retained by practices
Pharmaceutical services provided by community pharmacy services, dispensing doctors and appliance contractors
NHS sight tests and optical vouchers
Dental services
All health services for children, young people and adults in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure children’s homes, secure training centres, immigration removal centres, police custody suites)
Health services for families of members of the armed forces (where they are registered with Defence Medical Services) (Primary care for members of the armed forces will be commissioned by the Ministry of Defence)
Specialised and highly specialised services

Based on NHS Commissioning Board Commissioning Factsheet for CCGs (July 2012) www.commissioningboard.nhs.uk

4. Major needs assessments

4.1 The National child measurement programme (NCMP)

- The NCMP involves the annual measurement of the height and weight of children in reception year and Year 6, and the return of the data to the Health and Social Care Information Centre (HSCIC).
- The purpose of the programme is to provide robust public health surveillance data on child weight status, to understand obesity prevalence and trends at local and national levels, to inform obesity planning and commissioning and underpin the Public Health Outcomes Framework indicator on excess weight in 4-5 and 10-11 year olds.
- The NCMP provides parents with feedback on their child's weight status: to help them understand their child's health status, support and encourage behaviour change and provide a mechanism for direct engagement with families with overweight, underweight and obese children.
- Local authorities took on a duty for local delivery of the NCMP from 1st April 2013. As a mandated public health programme, provision to resource the delivery of the NCMP is made through the ring-fenced public health grant for local authorities. Nationally the programme is overseen by Public Health England.
- Being overweight or obese does not only endanger children's health. It can affect their attendance at school, their learning and their academic achievement. It may also call for extra staff training to ensure that children with health conditions can be appropriately supported during the school day.
- All of the 67 Infant, Junior, and Primary Schools in Plymouth agreed to take part in the 2012/13 NCMP and 5,021 children were weighed and measured.
- The overall participation rate (92.5%) remains well above the 85% target set by the Department of Health.
- The prevalence of obese children in 2012/13 was above the national average for Year R (9.9% compared to 9.3%) and below the national average for Year 6 (17.5% compared to 18.9%).

4.2 Survey of Health Visitor caseloads

- Health visiting teams deliver the Healthy Child Programme to all children under the age of five years registered with a Plymouth General Practice (GP). The teams are based in localities and are affiliated to the GP practices and Children's Centres within those localities. Alternatively, when a family with one or more children aged less than five years moves into the area (and prior to them registering with a GP practice) the child is allocated a health visiting team on a geographic basis.
- Surveying of health visitor caseloads was first undertaken in the Bristol and Weston area in the early 1990s. Local managers were concerned with the workload of their health visitors and therefore established a list of 26 family-related health needs indicators. Each health visitor went through their caseload and assessed each family against the 26 factors. Individual families were found to have considerable differences in need with individual family scores ranging from zero factors present to 19 factors present. The data collected in this first survey of health visitor caseloads was validated against other health-related data to confirm its robustness.
- A similar survey was first carried out in the former South & West Devon Health Authority area in 1999. The original data collection forms used in the Bristol and Weston survey were amended to include (1) the GP practice code, (2) the family postcode and (3) the number of children in specific age groups in the family. Good (reliable) information is available for Plymouth every two years from 2002 to 2012. The information collected since 2002 has been used extensively by NHS Plymouth and its partners. Most importantly perhaps, the information is used to ensure that the distribution of health visiting 'resources' across the city is equitable.
- The survey results are regarded as indicative of the health circumstances of the entire population of families with children under the age of five years usually resident in the city of Plymouth, acknowledging however that a few families may not have been included in the health visitor caseloads at the time of the survey (for instance, first-born babies to newly established families).
- Based upon their professional judgement, health visitors assess each family against a set of factors using standardised definitions and a common survey form. These factors cover observations of the health, social and lifestyle situation of the family together with details of illnesses and disabilities in the family. The association of a family with a particular health factor is therefore dependent upon the judgement of the health visitor based upon their observations of the family in question. One survey form is completed by a health visitor for each family on their caseload, a total of 13,635 records (families) in 2012.
- As the survey is based on what the health visitor knows about the family (as opposed to being based on a more traditional face-to-face survey) the information collected is subjective and there is also the risk that information about particular aspects of family life can remain 'hidden' from the health

visitor. Having said that, the information collected is more timely than traditional health indicators and is based on a large number of families (>13,000) across the whole city. The focus of the survey is on 'health' not 'healthcare' and 'need' not 'service delivery.' Most importantly perhaps, information on the wider determinants of health is collected.

Figure 1: The family health needs profile form 2013

Family Health Needs Profile 2013

Number of children in the family:	Family postcode:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Less than 3 years							
3-4 years (inclusive)							
5-15 years (inclusive)							
	Ethnic group:	<input type="text"/>					

1. One parent family	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
2. Violence within the family	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
3. Difficulties with spoken English	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
4. Separation and/or divorce in last year	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
5. Parent(s) have learning difficulties	(1 point per parent)	<input type="text"/>
6. Parent(s) have literacy problems	(1 point per parent)	<input type="text"/>
7. Parent(s) are under 18 now	(1 point per parent)	<input type="text"/>
8. Parent(s) 'in care' or abused as a child	(1 point per parent)	<input type="text"/>
9. Children at risk of significant harm (including those on the child protection register)	(1 point per child)	<input type="text"/>
10. Three or more children within the household aged under five years	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
11. In receipt of social work, probation, NSPCC or other professional support	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
12. A bereavement which is significant to the family	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
13. Major wage earner is unemployed	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
14. Low income, dependant on benefits	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
15. Poor housing having detrimental effect	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
16. In temporary accommodation	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
17. Three or more changes of address in last year	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
18. Parent(s) abuse alcohol	(1 point per parent)	<input type="text"/>
19. Parent(s) smoke	(1 point per parent)	<input type="text"/>
20. Parent(s) abuse drugs	(1 point per parent)	<input type="text"/>
21. Disabled or chronically sick adult within the household or close family	(1 point per adult)	<input type="text"/>
22. Depressed or mentally ill parents	(1 point per adult)	<input type="text"/>
23. Low birthweight (only children born in the last year)	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
24. Previous sudden infant death (S.I.D.) in the family	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
25. Centiles indicate the need for extra monitoring	(1 point per child)	<input type="text"/>
26. Children with special educational or medical needs	(1 point per child)	<input type="text"/>
27. Developmental delay	(1 point per child)	<input type="text"/>
28. Behavioural problems	(1 point per child)	<input type="text"/>
29. Family affected by social isolation	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
30. Parenting problems	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>
31. Failed to follow up professional recommendation to seek medical opinion	(<input type="checkbox"/> =no, 1=yes)	<input type="text"/>

4.3 Health and wellbeing survey in Plymouth schools

- Six of the inner-city secondary schools are currently carrying out a health and wellbeing survey.
- The survey is being completed (online) by pupils in years 8 (12-13 year olds) and 10 (14-15 year olds)
- The survey process co-ordinated by Stoke Damerel Community College. Significant advice and guidance has been provided by the Council's Public Health team.
- The Public Health Team has also provided funding to allow the survey to be expanded to cover the remaining secondary schools in the city.
- The Schools Health Education Unit (University of Exeter) has designed the survey and will be analysing the results.
- Pupils at the remaining secondary schools will complete the survey in the Summer term.
- The questionnaire covers the following issues, diet, smoking, alcohol consumption, substance misuse, stress and support, physical activity, sex and relationships, staying safe, bullying, enjoying and achieving, leisure and money, carer responsibilities.
- As the survey is being completed online the results should be available in the early Autumn.
- The information is being collected in a way that will allow the results to be made available by neighbourhood, electoral ward and locality.
- It is hoped that a modified version of the survey will be rolled out to Primary Schools although the detail of this is still to be confirmed.

5. Child health 'performance' in Plymouth

5.1 The PHE child health profile 2014

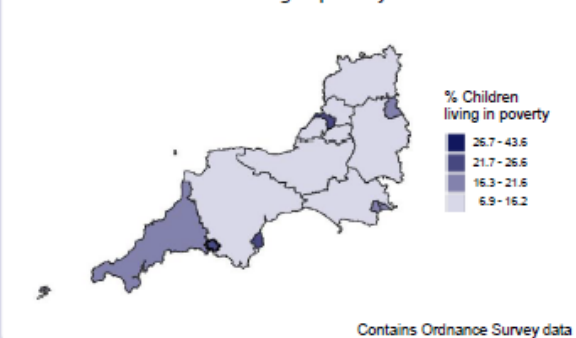
Plymouth

This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area			
	Local	South West	England
Live births in 2012			
	3,418	61,131	694,241
Children (age 0 to 4 years), 2012			
	15,700 (6.1%)	303,400 (5.7%)	3,393,400 (6.3%)
Children (age 0 to 19 years), 2012			
	60,000 (23.3%)	1,197,800 (22.4%)	12,771,100 (23.9%)
Children (age 0 to 19 years) in 2020 (projected)			
	63,200 (23.3%)	1,273,400 (22.3%)	13,575,900 (23.7%)
School children from minority ethnic groups, 2013			
	2,802 (8.6%)	66,110 (10.6%)	1,740,820 (26.7%)
Children living in poverty (age under 16 years), 2011			
	22.4%	16.2%	20.6%
Life expectancy at birth, 2010-2012			
Boys	78.3	80.0	79.2
Girls	82.1	83.9	83.0

Children living in poverty

Map of the South West, with Plymouth outlined, showing the relative levels of children living in poverty.



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Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2011-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 23.3% of the population of Plymouth. 8.6% of school children are from a minority ethnic group.

The health and wellbeing of children in Plymouth is mixed compared with the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 22.4% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average.

Children in Plymouth have average levels of obesity: 10.0% of children aged 4-5 years and 17.6% of children aged 10-11 years are classified as obese.

The teenage pregnancy rate is worse than the England average. In 2012/13, 56 teenage girls gave birth. This represents 1.7% of women giving birth which is worse than the England average.

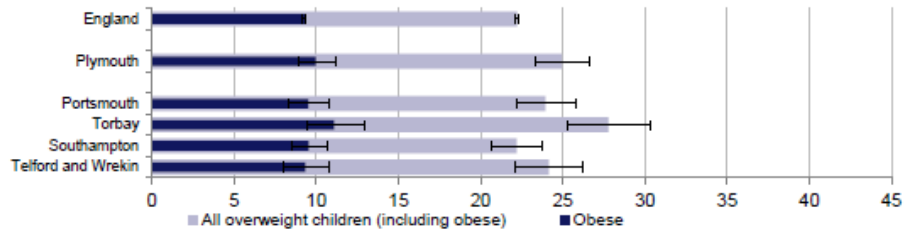
A higher than average proportion of children are judged to have achieved a good level of development at the end of the foundation stage, with 57.3% achieving this milestone. The foundation stage assessment is completed in the final term of the academic year in which a child reaches the age of five.

Any enquiries regarding this publication should be sent to info@chimat.org.uk.

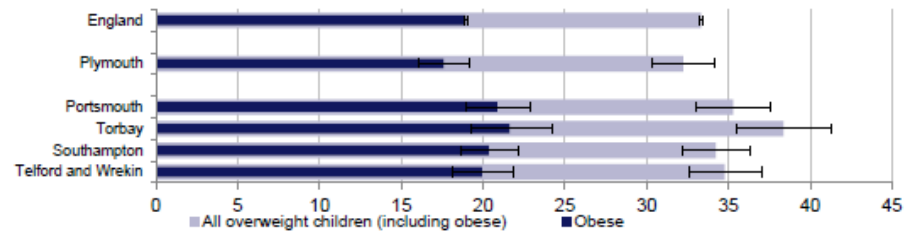
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared with their statistical neighbours. Compared with the England average, this area has a worse percentage in Reception and a similar percentage in Year 6 classified as obese or overweight.

Children aged 4-5 years classified as obese or overweight, 2012/13 (percentage)



Children aged 10-11 years classified as obese or overweight, 2012/13 (percentage)

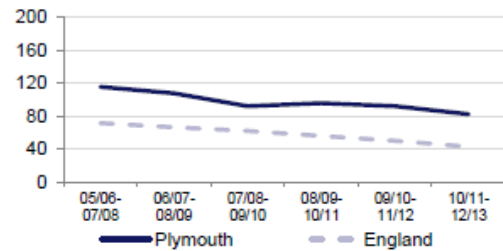


Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese. I indicates 95% confidence interval. Data source: National Child Measurement Programme (NCMP), Health and Social Care Information Centre

Young people and alcohol

In comparison with the 2005/06-2007/08 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is higher than the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

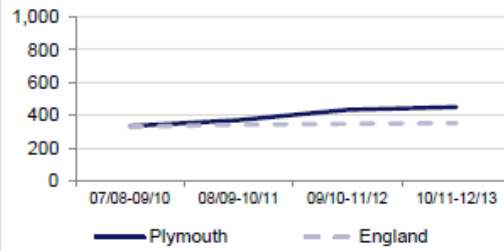


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is higher in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

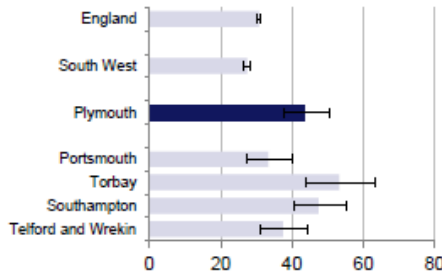
Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)



*Information about admissions in the single year 2012/13 can be found on page 4
Data source: Hospital Episode Statistics, Health and Social Care Information Centre

These charts compare Plymouth with its statistical neighbours, the England and regional average and, where available, the European average.

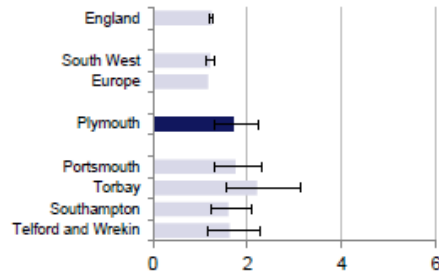
Teenage conceptions in girls aged under 18 years, 2011 (rate per 1,000 female population aged 15-17 years)



In 2011, approximately 44 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is higher than the regional average. The area has a higher teenage conception rate compared with the England average.

Data source: ONS

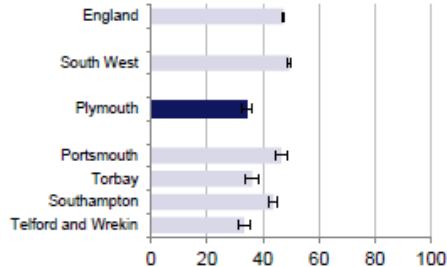
Teenage mothers aged under 18 years, 2012/13 (percentage of all deliveries)



In 2012/13, 1.7% of women giving birth in this area were aged under 18 years. This is higher than the regional average. This area has a higher percentage of births to teenage girls compared with the England average and a higher percentage compared with the European average of 1.2%*.

Data source: Hospital Episode Statistics, Health and Social Care Information Centre
* European Union 27 average, 2009. Source: Eurostat

Breastfeeding at 6 to 8 weeks, 2012/13 (percentage of infants due 6 to 8 week checks)

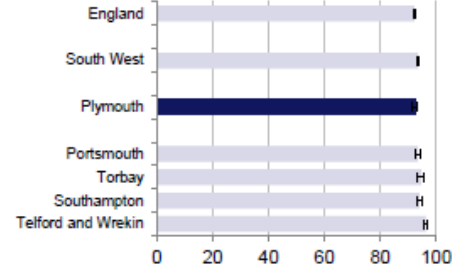


In this area, 34.2% of mothers are still breastfeeding at 6 to 8 weeks. This is lower than the England average. 69.1% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*.

* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Data source: PHE

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2012/13 (percentage of children age 2 years)



Compared with the England average, a similar percentage of children (92.6%) have received their first dose of immunisation by the age of two in this area. By the age of five, 86.0% of children have received their second dose of MMR immunisation. This is lower than the England average. In the South West, there were 80 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Data sources: Health and Social Care Information Centre, PHE

Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

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



	Indicator	Local no.	Local value	Eng. ave.	Eng. worst		Eng. best
Premature mortality	1 Infant mortality	15	4.4	4.3	7.7		1.3
	2 Child mortality rate (1-17 years)	8	11.6	12.5	21.7		4.0
Health protection	3 MMR vaccination for one dose (2 years)	3,042	92.6	92.3	77.4		98.4
	4 Dtap / IPV / Hib vaccination (2 years)	3,224	98.1	98.3	81.9		99.4
	5 Children in care immunisations	235	83.9	83.2	0.0		100.0
	6 Acute sexually transmitted infections (including chlamydia)	1,416	33.1	34.4	89.1		14.1
	7 Children achieving a good level of development at the end of reception	1,715	57.3	51.7	27.7		60.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	1,727	60.8	60.8	43.7		80.2
Wider determinants of ill health	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	5	16.7	15.3	0.0		41.7
	10 16-18 year olds not in education, employment or training	690	7.8	5.8	10.5		2.0
	11 First time entrants to the youth justice system	150	669.8	537.0	1,426.6		150.7
	12 Children in poverty (under 16 years)	10,140	22.4	20.6	43.6		6.9
	13 Family homelessness	188	1.6	1.7	9.5		0.1
	14 Children in care	370	73	60	166		20
	15 Children killed or seriously injured in road traffic accidents	8	17.8	20.7	45.6		6.3
	Health improvement	16 Low birthweight of all babies	256	7.4	7.3	10.2	
17 Obese children (4-5 years)		274	10.0	9.3	14.8		5.7
18 Obese children (10-11 years)		389	17.6	18.9	27.5		12.3
19 Children with one or more decayed, missing or filled teeth		-	24.9	27.9	53.2		12.5
20 Under 18 conceptions		186	43.6	30.7	58.1		9.4
21 Teenage mothers		56	1.7	1.2	3.1		0.2
22 Hospital admissions due to alcohol specific conditions		42	82.0	42.7	113.5		14.6
23 Hospital admissions due to substance misuse (15-24 years)		30	72.6	75.2	218.4		25.4
24 Smoking status at time of delivery		564	16.7	12.7	30.8		2.3
25 Breastfeeding initiation		2,327	69.1	73.9	40.8		94.7
Prevention of ill health	26 Breastfeeding prevalence at 6-8 weeks after birth	1,180	34.2	47.2	17.5		83.3
	27 A&E attendances (0-4 years)	5,111	332.4	510.8	1,861.3		214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	647	153.3	103.8	191.3		61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	543	127.1	130.7	277.3		63.8
	30 Hospital admissions for asthma (under 19 years)	81	148.8	221.4	591.9		63.4
	31 Hospital admissions for mental health conditions	36	70.7	87.6	434.8		28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	242	425.5	348.3	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

The spine chart shows that of the 32 indicators, there are four greens, 16 ambers and 12 reds. The 12 reds are:

- (10) 16-18 year olds NEET
- (11) First time entrants to the youth justice system
- (12) Children in poverty (under 16s)
- (14) Children in care
- (20) Under 18 conceptions
- (21) Teenage mothers
- (22) Hospital admissions due to alcohol specific conditions
- (24) Smoking status at time of delivery
- (25) Breastfeeding initiation
- (26) Breastfeeding at 6-8 weeks
- (28) Hospital admissions caused by injuries (0-14 years)
- (32) Hospital admissions self-harm (10-24 years)

5.2 Children and Young People's Health Benchmarking Tool

		Public Health Outcomes										NHS Outcomes																																																											
		Overview										Map										Trends										Compare areas										Area profiles										Definitions										Download									
Area type: County/UA		Areas grouped by: Region										Area: Plymouth		Region: South West										Benchmark: England																																															
		Compared with benchmark:										Better		Similar		Worse		Lower		Similar		Higher																																																	
Indicator	Period	England	South West	Bath and North East Som...	Bournemouth	Bristol, City of	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire																																																				
Healthy life expectancy at birth (Male)	2009 - 11	63.2	65.1	65.7	63.0	63.1	62.6	66.2	66.9	65.2	*	66.2	60.9	66.0	65.1	67.3	64.9	63.5	66.5																																																				
Healthy life expectancy at birth (Female)	2009 - 11	64.2	66.3	68.2	63.9	63.2	64.6	66.6	66.8	69.1	*	64.2	60.7	67.5	66.3	70.5	64.3	64.4	68.0																																																				
Life Expectancy at birth (Male)	2010 - 12	79.2	80.0	80.6	78.6	78.3	79.5	80.4	81.2	80.0	*	79.6	78.3	80.2	80.4	81.0	79.3	79.1	80.4																																																				
Life Expectancy at birth (Female)	2010 - 12	83.0	83.9	84.4	83.1	83.0	83.5	84.1	85.3	84.1	*	83.5	82.1	84.1	84.1	84.6	82.7	82.4	83.9																																																				
Children in poverty (all dependent children under 20)	2011	20.1	15.6	12.5	19.4	24.9	17.6	13.2	12.7	14.1	2.9	14.4	21.6	15.9	14.3	11.3	16.6	23.0	11.4																																																				
Children in poverty (under 16s)	2011	20.6	16.2	13.1	19.7	25.3	18.1	13.6	13.2	14.7	2.8	14.9	22.4	16.5	14.9	11.9	17.3	23.8	11.9																																																				
School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/13	51.7	55.6	50.7	57.5	49.5	49.4	63.8	60.9	52.0	*	63.7	57.3	48.0	53.3	67.0	55.1	*	51.9																																																				
School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	36.2	36.8	28.7	42.2	33.7	33.0	47.8	40.0	33.8	*	39.3	42.4	29.7	31.1	47.1	37.3	*	29.2																																																				

Indicator	Period	England	South West	Bath and North East Som...	Bournemouth	Bristol, City of	Comwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	36.2	36.8	28.7	42.2	33.7	33.0	47.8	40.0	33.8	*	39.3	42.4	29.7	31.1	47.1	37.3	*	29.2
School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	69.1	70.4	71.3	70.0	69.7	67.0	73.0	69.8	71.7	*	77.0	70.5	70.3	72.4	70.6	65.9	*	67.4
School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/13	55.8	55.2	55.3	57.9	58.5	53.8	56.6	53.2	52.2	*	56.7	60.3	47.8	55.5	55.3	53.0	*	48.2
Pupil absence	2011/12	5.11	5.21	5.03	5.46	5.69	5.20	5.06	5.41	5.08	4.96	5.11	5.47	4.92	5.22	5.05	5.00	5.66	5.12
First time entrants to the youth justice system	2012	537	561	705	371	936	537	483	266	466	-	807	670	357	689	774	581	728	378
16-18 year olds not in education employment or training	2012	5.8	5.5	4.8	5.4	7.9	5.1	5.3	4.9	5.2	-	3.2	7.8	6.4	4.5	4.7	6.3	5.2	6.2
Low birth weight of term babies	2011	2.8	2.5	2.6	2.6	2.3	2.4*	2.3	2.6	2.4	*	1.8	2.9	2.4	2.8	2.4	3.0	3.2	2.0
Breastfeeding - Breastfeeding initiation	2012/13	73.9	77.9	83.9	76.9	80.7	79.8	77.8	78.0	74.3	*	81.4	69.1	76.9	79.1	77.3	76.8	71.1	81.0
Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2012/13	47.2	49.3	59.7	52.3	*	46.7	50.6	52.0	50.6	*	50.7	34.2	52.3	51.4	46.3	47.6	36.0	47.6
Smoking status at time of delivery	2012/13	12.7	13.3	9.4	13.2	12.3	13.8	9.9	16.7	13.5	*	11.3	16.7	13.2	17.4	9.7	13.0	17.5	13.3
Under 18 conceptions	2011	30.7	27.3	16.2	31.7	33.2	30.3*	26.0	22.5	21.5	*	25.6	43.6	31.3	27.8	20.5	30.8	53.1	22.9
Under 18 conceptions: conceptions in those aged under 16	2011	6.1	5.1	4.1	5.1	5.4	5.4*	4.4	5.0	5.1	*	3.2	7.7	3.6	6.0	3.9	5.1	7.3	5.3
Child development at 2-2.5 years	2010	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2012/13	22.2	22.9	23.2	21.4	21.9	24.1	24.9	19.9	24.6	*	24.3	24.8	23.2	23.3	16.7	23.2	28.0	21.3
Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2012/13	33.3	30.9	26.4	31.5	33.9	31.0	29.7	29.2	32.9	*	31.2	32.1	28.3	29.4	30.3	32.8	38.5	29.4
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	103.8	103.9	120.0	116.6	104.2	105.5	103.8	116.3	80.4	*	80.6	153.3	131.3	114.2	91.8	96.8	81.2	94.0
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	130.7	144.2	133.0	169.8	137.3	166.2	132.5	162.2	126.0	*	106.1	127.1	210.0	156.4	111.7	145.2	151.1	162.5
Emotional well-being of looked after children	2011/12	13.8	15.0	15.4	13.8	14.8	14.5	16.6	14.2	14.9	-	14.6	17.3	12.5	15.5	13.8	13.2	15.4	14.1

Indicator	Period	England	South West	Bath and North East Som...	Bournemouth	Bristol, City of	Comwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
Chlamydia diagnoses (15-24 year olds) - Old NCSP data	2011	2125	2031	1475	2044	2074	1881	1934	1612	1917	-	3614	2319	1535	1786	2024	2331	3057	1861
Chlamydia diagnoses (15-24 year olds) - CTAD (Male)	2012	1368	-	545	1765	1851	1446	1480	1082	1291	*	1073	1295	998	1054	383	1553	2507	1150
Chlamydia diagnoses (15-24 year olds) - CTAD (Female)	2012	2568	-	1207	2816	4413	2966	2850	1835	2237	*	2680	2117	1942	2271	1048	3271	4852	2450
Chlamydia diagnoses (15-24 year olds) - CTAD (Persons)	2012	1979	-	874	2290	3142	2194	2141	1432	1759	-	1866	1688	1458	1646	703	2413	3644	1766
Population vaccination coverage - Hepatitis B (1 year old)	2012/13	*	-	*	*	*	*	*	*	85.7*	*	*	100*	*	*	*	100*	*	100*
Population vaccination coverage - Hepatitis B (2 years old)	2012/13	*	-	100*	*	*	*	*	*	71.4*	*	*	41.2*	*	*	*	100*	*	100*
Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2012/13	94.7*	96.1*	95.9*	94.9*	96.4*	94.9*	95.9*	97.2*	96.9*	*	97.3*	96.8*	94.9*	93.8*	97.9*	96.8*	97.3*	96.6*
Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2012/13	96.3*	97.3*	98.5*	96.6*	96.7*	96.7*	97.0*	98.1*	97.5*	*	98.1*	98.1*	96.6*	95.8*	98.7*	98.0*	98.6*	97.6*
Population vaccination coverage - MenC	2012/13	93.9*	95.5*	95.4*	93.9*	95.4*	94.4*	95.3*	96.8*	96.6*	*	97.1*	96.3*	93.9*	93.5*	96.6*	95.1*	96.8*	96.4*
Population vaccination coverage - PCV	2012/13	94.4*	96.0*	95.7*	94.4*	95.8*	94.9*	95.8*	97.2*	96.9*	*	97.4*	96.3*	94.4*	94.5*	97.5*	95.9*	97.0*	96.6*
Population vaccination coverage - Hib / MenC booster (2 years old)	2012/13	92.7*	93.0*	93.3*	92.0*	90.8*	93.1*	92.1*	94.6*	95.2*	*	94.2*	92.0*	92.0*	89.9*	95.7*	94.4*	94.6*	94.2*
Population vaccination coverage - Hib / Men C booster (5 years)	2012/13	91.5*	92.7*	93.4*	94.9*	90.5*	92.4*	92.4*	94.6*	90.9*	*	94.1*	93.2*	94.9*	90.7*	96.2*	93.7*	93.2*	92.9*
Population vaccination coverage - PCV booster	2012/13	92.5*	94.1*	95.2*	93.1*	91.9*	92.4*	92.8*	96.2*	96.5*	*	95.2*	93.2*	93.1*	93.4*	96.0*	95.4*	95.4*	95.2*
Population vaccination coverage - MMR for one dose (2 years old)	2012/13	92.3*	93.5*	93.9*	92.1*	90.7*	92.7*	92.8*	94.9*	96.1*	*	94.2*	92.6*	92.1*	92.8*	95.7*	94.9*	94.8*	94.2*
Population vaccination coverage - MMR for one dose (5 years old)	2012/13	93.9*	94.6*	94.9*	95.2*	93.1*	95.1*	93.8*	94.7*	93.8*	*	95.9*	95.4*	95.2*	94.4*	96.7*	95.9*	94.5*	94.9*
Population vaccination coverage - MMR for two doses (5 years old)	2012/13	87.7*	88.7*	88.5*	88.1*	83.1*	89.5*	87.8*	91.2*	91.4*	*	89.8*	86.0*	88.1*	88.8*	91.6*	90.2*	86.4*	89.5*
Population vaccination coverage - HPV	2012/13	86.1*	81.5*	81.8*	84.1*	68.2*	63.6*	75.7*	86.1*	86.8*	*	90.2*	79.9*	84.1*	91.3*	78.1*	96.2*	83.5*	89.6*
Infant mortality	2009 - 11	4.29	3.49	2.42	2.65	2.73	4.00	3.91	3.63	3.13	-	3.81	4.99	3.65	3.51	2.28	2.97	6.01	3.50
Tooth decay in children aged 5	2011/12	0.94	0.79	0.49	0.90	0.78	0.92	0.68	0.74	0.87	0.29	0.78	0.65	0.79	0.86	0.42	0.82	1.03	0.75

The areas where Plymouth is red (in this framework and also in the Public Health Outcomes framework (PHOF)) are:

- Healthy life expectancy at birth (male)
- Healthy life expectancy at birth (female)
- Life expectancy at birth (male)
- Life expectancy at birth (female)
- Children in poverty (all dependent children under 20)
- Children in poverty (under 16s)
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year old not in education, training or employment
- Breastfeeding initiation
- Breastfeeding at 6-8 weeks
- Smoking at time of delivery
- Under 18 conceptions
- Excess weight in 4-5 year olds
- Hospital admissions caused by unintentional and deliberate injuries in 0-14s
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage (MMR two doses, five year olds)
- Population vaccination coverage (HPV)