# Director of Public Health Annual Report 2013-14

## Foreword

My Annual Report for 2013-14 will focus on the early years of life and the health experiences and outcomes for our babies, young children and their families.

'Early childhood…is a time of rapid development and change. Although development is mutable throughout the life course, early childhood is a time when many of the foundations for subsequent development are built. Indeed, by the time children begin formal schooling significant differences and disparities are already apparent in their actions, aptitudes and behaviour'[1].

As Director of Public Health, I have chosen to focus my annual report on the early years of life because the evidence tells us that influencing the development of children to maximise their health, social and educational development is most effective when done as early as possible. There is also a strong economic case, as return on investment in the early years is higher than at any other stage of the life course.

My report will consider the variation in health status and outcome that exist across our local communities. Such harm, variation and inequity can start before birth and continue through life.

Major reports continue to highlight the importance of a system approach to early intervention and prevention, targeted support for vulnerable families and also the responsibilities of policy makers, organisations, communities and individuals.

The current financial challenges also highlight the importance of using available resources wisely. Whilst there is a risk that we may wish to focus on the short term and quick wins when it comes to efficiencies, the fact is that we cannot afford to ignore the evidence and the opportunity to improve health outcomes now as an investment in the future.

In seeking to achieve sustainable improvements in health and well-being, it is absolutely essential therefore that we work together to invest time, energy and resources in the early years of life. This challenge is not easy and requires partnership working focused 'upstream' on the determinants of health.

**Marietta Evans**
**Director of Public Health for North Tyneside**
**November 2014**

[1] Shonkoff, John P and Deborah A Phillips. From neurons to neighbourhoods: The science of early child development. Washington DC: National Academy of Sciences; 2000.

| Progress in Relation to Key Recommendations for 2012-13 | |
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| **Recommendations for Children, Young People and Families** | |
| • Commission a high-quality lifestyle survey of young people to provide a baseline for health and wellbeing improvement | This is currently on hold due to lack of available funding |
| • Review evidenced based school health improvement interventions to ensure quality and equity of access for all children and young people | This review is currently underway and will be completed before the end of March 2015 |
| • Review the School Nursing Service to identify and focus on health and wellbeing outcomes for children and young people | This review will now take place during 2015-16 |
| • Address some of the key disadvantage in the early years including child poverty and the gap in educational attainment through supporting families and identifying and addressing problems early | There is a range of on-going work with families including the Supporting Families Programme, two year old childcare offer, the early help offer, the Family Nurse Partnership Programme and parenting programmes which are working with families to improve outcomes for young children. |
| • Ensure that children with learning and/or physical disabilities are supported to be as healthy and active as possible along with their families | There is on-going work with children with disabilities and their families to provide a range of support and activities |
| • Integrate NHS, public health and/or health improvement interventions with education and social care services | Work is underway to integrate early years provision across the NHS, social care, education and public health |
| **Public Health/Health Improvement Recommendations** | |
| • Develop community based health improvement services which are developed in conjunction with local people and are able to address multiple unhealthy behaviours in a whole person and inclusive approach | The Active North Tyneside campaign will engage with local people to increase their levels of physical activity |
| • Establish a Community Health Champions Programme | A pilot Health Champions Programme has been running during 2013-14 and this will be extended and offered to a range of communities and individuals to participate in and be supported with training |
| • Remodel drug and alcohol services to place a greater emphasis | Drug and alcohol treatment services have been re-commissioned |

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| on early intervention and recovery | focusing on a recovery model |
| • Include the requirement to carry out health equity audit in all new provider contracts to ensure that health improvement and healthcare services are being accessed equitably | This process is now in place |
| • A public mental health strategy should be developed to reflect the new local authority responsibility for public mental health. | A Mental Health Needs Assessment is being developed during 2014-15 and A Public Mental Health Strategy will be developed on the basis of the needs assessment findings |
| • An evidence-based Suicide Prevention Plan should be developed reflecting local authority and clinical commission group and NHS England responsibilities | A suicide audit is taking place and a Suicide Prevention Plan will be in place by the end of March 2015 |
| • A health equity audit of screening programmes should be undertaken to establish variation in uptake of local screening programmes and make recommendations on improving uptake – particularly in relation to more vulnerable populations. | A Health Equity audit of screening programmes took place across the north East during 2013-14 and detailed analysis for North Tyneside is being used to address key issues around access to and uptake of screening programmes – working with NHS England |
| • Widen the provision of NHS Heath Checks to included appropriate community based providers and deliver health checks in innovative ways to ensure equity of access | Public Health Nurses have been widening access to health checks since April 2014 and during 2015-16 CVD health checks will be available via some pharmacies and other community locations |
| • Improve the range of falls prevention activities available to older people | This is currently under review |
| • Review sexual health services to ensure equity of access | Sexual health services have been reviewed and a detailed needs assessment undertaken. This will inform future commissioning priorities |
| • Carry out awareness raising campaigns in relation to diabetes, high blood pressure and COPD to increase the number of people being diagnosed correctly | A COPD social marketing campaign was carried out during 2013-14 in conjunction with the British Lung Foundation. There has been a subsequent increase in the number of people being diagnosed with COPD and an increase in awareness in the general public. |
| **Recommendations in relation to Working with Communities** | |
| ▪ Key front line staff need to be based within most vulnerable communities | This work is underway across partner agencies in terms of the review of service provision and property in the borough. |
| ▪ More focus is required on place based approaches to address a range of issues in a more intensive or co-ordinated way | This work forms part of the Creating Brighter Future review of local assets and provision |

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| ▪ Provide funding and/or support for community led initiatives to improve health | Locality/community budgets to improve uptake of physical activity in communities will be available via Active North Tyneside. |
| ▪ Work with local people to improve cooking skills and access to healthy food through community based schemes | Healthy cooking is delivered via Children's Centres and further initiatives will be developed during 2015-216 to extend provision to wider community groups. |
| ▪ Improve access to free and/or low cost physical activity opportunities for people on low incomes and/or people with disabilities or mental health problems | Active North Tyneside is working to engage more vulnerable individuals and support them to become more active. |
| ▪ Strengthen community based approaches to improving mental health and wellbeing – particularly in more vulnerable and low income populations | The Social Prescribing Service is increasing the numbers of vulnerable clients it engages with and supporting them to access community based activities |
| **Local Authority Recommendations** | |
| ▪ Work within communities to build resilience and capacity and empower local people | The Asset Based Community Development approach is being implemented in key local communities. |
| ▪ Carry out Health Impact Assessments and/or Equality Impact Assessments to ensure that strategic decisions and commissioning decisions do not impact adversely on health inequalities | Equality impact Assessments are carried out in relation to service commissioning. |
| ▪ Develop an approach across the Council in relation to reducing inequalities | A Health Inequalities Strategy is under development for the Council and will be completed before the end of March 2015 |
| ▪ Carry out a health impact assessment in relation to the Local Plan | A sustainability assessment is being carried out in relation to the Local Plana and health impact considerations are being built in to the assessment |
| ▪ Ensure that health at work initiatives reach staff most in need | The Better Health at Work Award scheme has been re-focused to target workplaces which employ routine and manual workers |
| **Integrated Health Service and Social Care Recommendations** | |
| ▪ Integrate and co-locate key health and social care services particularly for more vulnerable children & adults and the elderly | A specific work stream in relation to vulnerable older people is being developed as part of the Integration Programme |
| ▪ Move to a single assessment process for health and social care | This is under development for people aged 0-25 years |

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| services | |
| ▪ Continue to shift investment into more upstream preventative interventions to reduce the demand on hospitals and nursing homes | There are continuing efforts to move funding upstream in terms of public health and early years for example. |
| **Primary Care Recommendations** | |
| ▪ Improve access to health living and self care advice and support through pharmacies | A Healthy Living Pharmacy Scheme has been launched in North Tyneside and just under a third of pharmacies have signed up so far |
| ▪ Raise awareness and promote early diagnosis in relation to symptoms and risk factors for key conditions including diabetes, lung cancer, Chronic Obstructive Pulmonary Disease and high blood pressure | Comprehensive social marketing and community testing for Chronic Obstructive Pulmonary Disease was carried out in November – December 2013. |
| ▪ Ensure that once diagnosed patients have access to the right treatment when they need it, including drugs and treatments recommended by the National Institute for Health and Care Excellence (NICE) | This work in on-going with GP practices, working in conjunction with secondary care clinicians. |
| ▪ Integrate mental health support with primary care and chronic disease management programmes | The Social Prescribing Service in North Tyneside now accepts referrals for people with long term conditions and supports them to access a range of activities in the community to improve their mental and physical wellbeing. People with long term conditions may also be referred to psychological therapies |
| ▪ Support more appropriate use of A&E through primary care and community services access | This work is being taken forward via the work streams identified within the Better Care Fund |
| ▪ Implement effective self care programmes for people with long terms conditions so that they are empowered with the personal skills and confidence to manage their own condition | Work is on-going in relation to self care for example in relation to diabetes and respiratory disease. |
| ▪ Ensure that rehabilitation programmes are of sufficient scale and quality to help people with long term conditions to maximise their health, wellbeing and independence | The provision of rehabilitation programmes for range of conditions is currently under review. |
| ▪ Improve the uptake of seasonal influenza and pneumococcal | Proactive promotion of these immunisation programmes is taking |

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| immunisation in older people and at risk groups | place within local communities with key target groups. Further progress in relation to uptake is required. |
| ▪ Identify people at risk of falling and refer into falls prevention services | A Falls Service has been commissioned from Northumbria Healthcare NHS Foundation Trust |
| **Secondary Care Recommendations** | |
| ▪ Ensure that 'Making Every Contact Count' is embedded in hospital policy and practice so opportunities to engage with patients to help them stay in good health are maximised | A Healthy Living Board has been established to lead on 'Making Every Contact Count' across key partner organisations |
| ▪ Hospitals should make every effort through its policies, campaigns and incentive schemes to promote the mental and physical health and wellbeing of its own workforce | Northumbria Healthcare NHS Foundation Trust, Northumberland, Tyne and Wear NHS Foundation Trust and Newcastle Hospitals NHS Foundation Trust have all achieved the Better Health at Work Award |
| ▪ Commissioners of hospital services need to ensure that interventions to engage with patients around maintaining good health are embedded into contracts | Work is underway as part of the Healthy Living Board to develop health improvement approaches in hospital settings |
| ▪ Reduce avoidable deaths through improvements in quality of care, medicines management and a reduction in hospital acquired infections | This work is being undertaken via the Cumbria, Northumberland, Tyne and Wear Quality Surveillance Group and also the Clinical Commissioning Group Quality and Safety Committee |
| **Housing, Environment and Transport Recommendations** | |
| ▪ Continue to support housing and environmental improvements in most economically deprived areas | This work is on-going and requires a place-based approach |
| ▪ Improve the standard of non decent houses to prevent falls and reduce hospital admissions | Housing Assessment Officers have been recruited within the Council to work within the private rented sector – focusing on non-decent property and working with landlords and other agencies to facilitate improvements |
| ▪ Influence transport co-ordination and coverage to improve access to services | This work is being carried out via the Local Transport Plan (LTP3) for Tyne and Wear |
| **Poverty and Income Related Recommendations** | |
| ▪ Ensure that clear information is available to all partners and the public around welfare reform, the impacts and the support that is | This work is being undertaken by the Welfare Reform Task Group |

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| available | |
| ▪ Support people on low income and people who are vulnerable with budget management with appropriate encouragement to reduce expenditure on cigarettes and alcohol and increase expenditure on 'healthy' food | This work is being undertaken by the Welfare Reform Task Group and also via a number of community and voluntary sector organisations including Citizens Advice Bureau, Meadowell Connected, Justice Prince and Cedarwood |
| **Community Safety Recommendations** | |
| ▪ Commission community based violence/domestic violence prevention and perpetrator programmes. | A procurement exercise is taking place during 2014-15 to commission an integrated domestic violence service to ensure provision for victims, children and perpetrators |

# 1. Background and Evidence Base

The UK has some of the worst indicators for child health and well-being of any high-income country. In 2007 a UNICEF study[2] found that the UK had the worst levels of child well-being of any developed country and a recent study found that it had the second worst child mortality rate in Western Europe. Within England, the health of children is generally worse in the North, reflecting the higher levels of child poverty.

There have been substantial reductions in child mortality in the UK over the last 150 years. 6 out of 10 infants born at this time didn't survive their first year of life and often died of severe infections and malnutrition. Now 99.5% survive their first year of life and the vast majority of young children reach adulthood. Many physical illnesses have been prevented through improved nutrition, sanitation, immunisation and education; many are curable because of the considerable advances in health technology. Quality-of-life, emotional well-being and lifestyle issues have generally become the predominant issues when considering children's health.

There is a large body of evidence demonstrating that early disadvantage influences health and development in later life, and that children who start behind tend to stay behind. For example; children living in poverty and experiencing disadvantage in the UK are more likely to: die in the first year of life; be born small; be bottle fed; breathe second-hand smoke; become overweight; perform poorly at school; die in an accident; become a young parent; and as adults they are more likely to die earlier, be out of work, living in poor housing, receive inadequate wages, and report poor health[3].

To address health inequalities we need to consistently focus on evidence based prevention and early intervention programmes and develop a more proactive and responsive approach to working with disadvantaged or more vulnerable families. If we do not tackle the root causes of the issues outlined above, we will continue to be required to address the problems that arise from poverty and disadvantage and to fund the often high cost services and interventions which are required because of this failure to act.

It has been long known that healthy children make healthy learners and subsequently healthy (and economically productive) adults and parents. However children's health is good relative to adults, so the vast majority of NHS funding (96%) is spent on the adult and elderly population. Comparatively smaller amounts are allocated to promote and sustain health in children and young people.
Education is one of the most important predictors of health. A recent study in the USA, has demonstrated that if everyone had a comparable standard of education i.e. all had mean levels, 1,369,335 lives could be saved. This compares with 178,193 lives saved

[2] Report Card 7 UNICEF 2007
[3] Due North: Executive summary report of the Inquiry on Health Equity for the North. Inquiry Panel on Health Equity for the North of England 2014

by medical advances over the same time period[4]. Those working with young children can be highly instrumental in supporting parents to break cycles of disadvantage, which might have occurred for many generations before.

## Investment in early years

There is a strong economic case for investing in the early years of life. The rate of economic return on investment is significantly higher in the pre-school stage than at any other stage of the education system. Despite this, investment in services for children and young people is often at its lowest in the very early years which are the most crucial in the development of the brain. Investment only increases at the point when development slows[5].

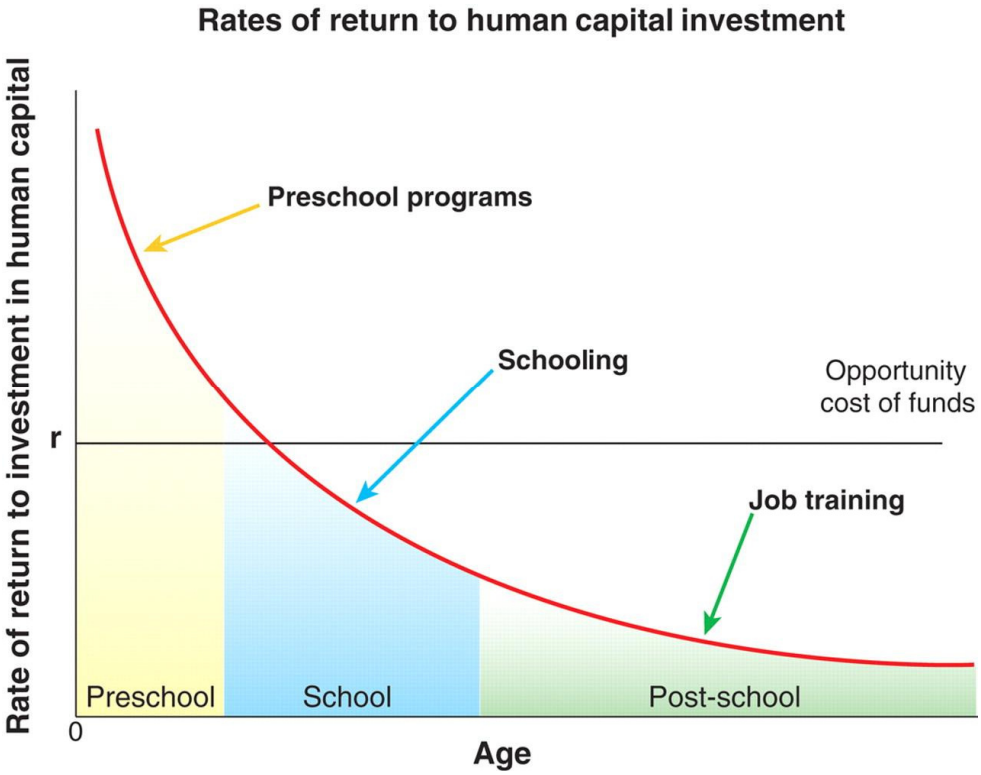



**Figure 1: Source:** Knudsen E I et al. PNAS 2006; 103:10155–10162

The figure above shows that, at current levels of funding, we overinvest nationally in most schooling and post-schooling programs and under invest in preschool programmes for children from low income families.

Children's overall wellbeing is defined in law as being about five key areas; physical, mental and emotional health; protection from harm and neglect; play and education; contribution to society; social and economic wellbeing.

[4] Optimising Health in the Early Years, M Blair, British Association for Community Child Health 2010
[5] Early Intervention: The Next Steps, Graham Allen 2010

Investment in early years is essential in terms of valuing children at all stages of their development. This is enshrined in the UNICEF Convention on the Rights of the Child[6]. Several articles are relevant in this context but especially;

- Article 6: Every child has the right to life. Governments must do all they can to ensure that children survive and grow up healthy.

- Article 18: Both parents share responsibility for bringing up their children, and should always consider what is best for each child

- Article 19: Governments must do all they can to ensure that children are protected from all forms of violence, abuse, neglect and mistreatment by their parents or anyone else who looks after them

- Article 23: which states that children who have any kind of disability should have special care and support, so that they can lead full and independent lives

- Article 24: Every child has the right to the best possible health. Governments must provide good quality health care, clean water, nutritious food and a clean environment so that children can stay healthy

- Article 27: Every child has the right to a standard of living that is good enough to meet their physical, social and mental needs.

- Article 31: Every child has the right to relax and play, and to join in a wide range of activities

### Pregnancy & Maternal Wellbeing

Pregnancy and the first years of life are 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 and the first years of life[7].

Health inequalities in the antenatal period arise from the experience of adverse and complex social factors. These can potentially:

- Increase the risk of illness, complications or death in the mother
- Increase the risk of illness, complications or death in the baby and result in poor long-term maternal and child health outcomes.

Women who experience complex social factors include those who:

[6] United Nations Children's Fund 1989
[7] Healthy Child Programme Pregnancy and the first five years of life DH 2009

- Misuse substances; (alcohol and/or drugs)
- Are recent immigrants and those who have difficulty reading or speaking English
- Experience domestic abuse
- Are young, (i.e. under the age of 20)
- Are known to social services / child protection services
- Are unemployed or experience socio-economic deprivation.
- Experience mental health problems.

Maternal health is critical to the short and long term health and wellbeing of mothers and babies. Improving maternal health requires a multidimensional approach by staff working in a range of settings, with a focus on prevention and early intervention. Maternity services for North Tyneside women are provided by two NHS foundation trusts:

- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust.

Both trusts are rated highly in relation to quality of maternity care and risk management.

### The Importance of the Early Years and the Family

There is a strong body of evidence on the importance of the early years[8]. In his recent report on health inequalities[9], Professor Sir Michael Marmot stresses that in order to give every child the best start in life, addressing inequalities and intervening early to prevent health problems must be prioritised. The early years are the most important period of development for children and are the best stage to combat poverty and promote life chances.

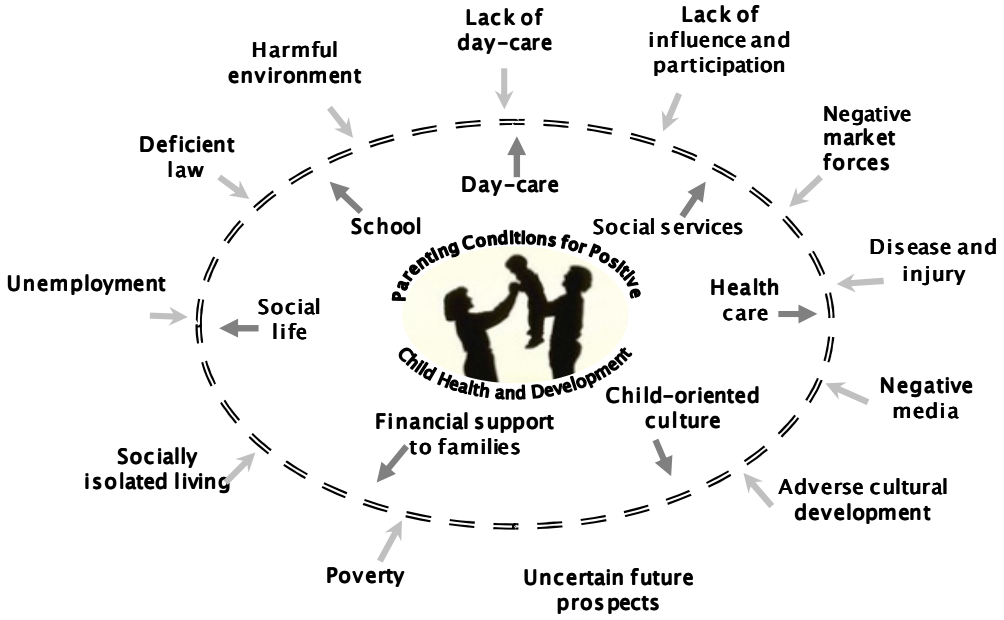
Strong evidence shows that the most important years for a child, the formative years, are from pre-birth to aged 3. It is in these first few crucial years that a child develops at a startlingly fast pace, with brain cells developing and key learning skills gained. The brain will double in size in the first year on the baby's life. It is vital for families to be supported to give their child a stable, stimulating and nurturing start[10].

There is a growing body of evidence showing that pregnancy and the first three years of life are critical in terms of later public health outcomes and emotional health[11].

[8] Early intervention the Next Steps Graham Allen, HM Government; 2011
[9] Fair Society, Healthy Lives Michael Marmot 2010
[10] Early Intervention: The Next Steps, Graham Allen 2010
[11] From Neurons to Neighbourhoods: The Science of Early Childhood J Shonkoff, D Phillips - 2000 - New York: National Academies Press

Research following groups of children over many years has demonstrated very clearly that we need to intervene at an early stage if we are to optimise health.
Children's health and development should be considered within a holistic framework, which includes economic, social and psychological determinants of health and well-being.

There are threats to the physical health of children such as malnutrition, infection, accidents and illnesses. There are also threats from economic and social circumstances e.g. low income or increased levels of violence. Families and children need to be supported to become resilient in relation to threats to wellbeing. This is demonstrated in the diagram below;




*Adapted by Gunnlaugsson G and Rigby M from Skolhälsovården 1998. Underlag för egen kontroll och tillsyn. Stockholm: Socialstyrelsen, 1998.*

Interventions do not necessarily have to be health service specific in order to have a positive impact on health inequalities. The links between health inequalities and wider social inequalities are complex and both their causes and solutions are connected. Programmes that improve learning abilities, behaviour and parental relationships early in childhood can help to break the cycle of poverty and inequality and therefore reduce health inequalities. Similarly, ensuring families benefit from timely and effective health care in pregnancy and infancy will have a positive impact on the child's future attainment and wellbeing[12].

[12] Early years interventions to address health inequalities in London: The Economic Case GLA 2011

## Key risk factors

Adverse factors relating to a young child's family and environment cause poorer outcomes for the child, both to their safety, and to their development and behaviour[13]. Parental mental health issues, substance misuse, domestic violence, financial stress and teenage motherhood are themes which are frequently identified as indicating poorer outcomes for children.

Factors rarely occur in isolation, with certain combinations being more common than others. The children within these households are at a higher risk of poorer development and physical harm. While the risk factors discussed below are intended to give an idea of the range of problems experienced within North Tyneside it should be noted that many parents who face challenging circumstances go on to successfully raise healthy and happy children.

Research[14] has identified a number of key risk factors which strongly hinder successful development. The research found that the higher the number of risk factors affecting the child, the more subsequent short- and long-term problems that child encounters.

The risk factors included:

- parental depression
- parental illness or disability
- smoking in pregnancy
- parent at risk of alcoholism
- domestic violence
- financial stress
- parental worklessness
- teenage mother
- parental lack of basic skills, which limits their daily activities
- household overcrowding

Researchers found a significant correlation between many of these factors, indicating that they are likely to occur jointly. Looking specifically at combinations of three risk factors, teenage motherhood, smoking in pregnancy and parental depression commonly occurred together. The impact of these risk factors on six the cognitive and behavioural outcomes (cognitive, emotional, conduct, hyperactivity, peer and pro-social) was examined at age five years, and found that parental depression, smoking in pregnancy and financial stress were associated with worse outcomes for all or almost all of the six outcomes.

[13] National Institute for Health and Clinical Excellence 2010
[14] Sabates, R. and Dex, S. (2013) The impact of multiple risk factors on young children's cognitive and behavioural development. Children and Society

There is evidence across a range of health and developmental outcomes that a social gradient in health exists; with health inequalities apparent from the very start of life. The impact of these inequalities is enduring and the opportunity to reduce this impact declines as children age. The early years provide a vitally important opportunity to reduce the potential impact of risk factors and enhance the protective factors for children[15].

## Family Poverty

The UK uses a relative poverty measure, wherein families are considered to be living in poverty if their household incomes, after deducting housing costs, are below 60 percent of the median UK income. Growing up in poverty affects children's development from birth and has lasting impacts throughout the life course.

Recent data from the first three sweeps of the UK Millennium Cohort Study when children were 9 months to 5 years of age reveal persistent health inequalities between poor children and their non-poor peers Findings from the Avon Longitudinal Survey of Parents and Children[16] revealed that economic deprivation was the strongest predictor of the probability that children were investigated or placed on the local child protection register: the odds that deprived children were on the register were 11 times that of non-deprived children. There is also significant evidence in relation to the impact of poverty on children's delayed cognitive development and
school readiness.

Studies have found that family income measured during the early childhood years is linked to later educational attainment and risk of school exclusion[17]. Early childhood poverty has also been associated with depression that persists until late childhood, and may also impact young people's antisocial behaviour, anxiety, and hyperactivity[18]. Across the board, the evidence suggests that the influence of poverty on children's physical well-being begins before birth and continues across the early childhood years[19].

North Tyneside currently has a child poverty level of 20% which is just below the national average. This means that 1 child in 5 is living in poverty in the borough. The child poverty rate has been fairly static in recent years and is the second lowest percentage of child poverty compared to other local authorities in the North East region.

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[15] Guidance about Effective Interventions to Support Parents, Their Infants and Children in the Early Years. NHS Health Scotland 2012
[16] Avon Longitudinal Survey of Parents and Children University of Bristol 2006
[17] Duncan, Greg J, et al; "School readiness and later achievement." Developmental Psychology 23:1428–1446, 2007.
[18] McLeod, J D and M J Shanahan. 1993. "Poverty, parenting, and children's mental health." American Sociological Review 58:351-366.
[19] Young Children's Well-being National Children's Bureau 2009

## Family Housing

Access to a secure, stable home has to be the first building block in ensuring that children have positive life chances[20]. Every child has a right to a happy and fulfilled life and a right not to have this undermined by the effects of bad housing and homelessness.

Reviews have shown that[21] overcrowded living spaces can cause children to feel stressed from an early age. Many low income families struggle to afford adequate housing which in turn impacts on the emotional wellbeing and physical health of young children. These parents struggle to provide a stable and nurturing environment in which their children can develop and thrive.

Studies looking at the impact of living persistently in bad housing have shown the following[22];

- Children in unfit and overcrowded homes are more likely to experience illnesses and infections including asthma, bronchitis and meningitis
- Homeless children are more likely to show signs of behavioural problems such as aggression, hyperactivity and impulsivity
- The high costs of temporary accommodation can make it difficult to make working worthwhile financially, trapping homeless families in unemployment, which is strongly associated with poverty and reduced life chances
- Children living in acutely bad housing are more likely to attend the hospital's Accident and Emergency department (A&E) than other children

In North Tyneside families with young children that become homeless are classed as being in priority need unless they are assessed as being intentionally homeless or ineligible. This means they would be given appropriate accommodation to suit their needs. The Council does not use bed and breakfast establishments as temporary accommodation. Bed and breakfast establishments are only used overnight so that arrangements can be made to place them in temporary accommodation, where they will remain whilst undertaking relevant assessments and until suitable accommodation is made available. The New Beginnings service provides accommodation and support to vulnerable young parents.

## Social and Emotional Wellbeing

Family relationships strongly determine outcomes for children. What happens to a child early in life determines how they progress into the future. If a child does not get

[20] Improving Outcomes For Children And Young People In Housing Need Shelter 2011
[21] The Foundation Years: Preventing Poor Children Becoming Poor Adults, Frank Field 2010
[22] Chance of a Lifetime, Shelter 2006.

the emotional love and care from its earliest days and does not form strong attachments with its main carers, the protective factors required to develop emotional resilience are not firmly established. Attachment theory is central to understanding how children grow and develop and of what skills parents need in order to form strong secure attachments with their children.

Disadvantage before birth and in a child's early years can have life-long, negative effects on health and wellbeing. Both universal and more targeted services need to provide the additional support all vulnerable children need to ensure their mental and physical health and wellbeing. Children living in disadvantaged circumstances are more likely to experience social, emotional and behavioural difficulties, and as a result, poor health, education and employment outcomes. For example, measures of 'school readiness' show that the poorest 20% of children are more likely to display conduct problems at age 5, compared to children from more affluent backgrounds.

Despite the increasing recognition of the importance of the early years as a focus for early intervention, there has been less research on the profile and rates of problems in the under-5s and they are not included in national Child and Adolescent Mental Health needs assessments. Differentiating normal from abnormal behaviour in younger children can be difficult and evidence suggests that a substantial proportion of children will 'grow out of' early childhood problems, particularly among the under-3s[23].

However, longitudinal studies suggest that 50–60% of children showing high levels of disruptive behaviour at 3–4 years will continue to show these problems at school age 8. Moreover, neuro-developmental problems including language delay, Attention Deficit Hyperactivity Disorder and autism spectrum disorders can first manifest in the pre-school years[24]. Local early interventions that support and protect vulnerable children's social and emotional wellbeing are crucial to ensure their healthy development, capacity to learn and achieve at school[25].

## 2. Key Developments in Relation to Prevention and Early Intervention

Achieving a sustainable improvement in health and well-being requires a systematic approach, with partners working together to implement and target interventions that are known to work. In bringing together the evidence base and health need data on maternal and child health outcomes in North Tyneside, this report highlights some key areas for action.

[23] Annual Report of the Chief Medical Officer, Our Children Deserve Better: Prevention Pays 2012
[24] Campbell SB: Behaviour problems in preschool children: a review of recent research. J Child Psychol Psychiatry 1995, 36: 113-149
[25] National Institute of Clinical Excellence 2014

Public health is about working in partnership for the benefit of the population. In this first stage of the life course our collective aim is to ensure that babies are born healthy in North Tyneside and that pre-school children remain healthy, safe and develop to their full potential.

In North Tyneside a Prevention and Early Intervention Strategy was developed during 2013. The strategy had a key vision; Families will be offered preventative universal services which will identify children and young people who are vulnerable to poor outcomes at the earliest opportunity and they will be supported to manage and reduce risk factors. The most vulnerable families will receive targeted, personalised support for each family member, designed to build their resilience and capacity to provide a caring and nurturing home environment. Fundamental to this development is the Early Help Assessment which all agencies working with families now use to identify any problems early on.

North Tyneside is developing its 'Ready for School' programme working closely with partner agencies. An entitlement for 0-4 year olds has been drawn up to provide clarity and guidance around what a child starting school should be able to achieve in terms of skills, physical development and emotional wellbeing.

### Supporting Families

The Supporting Families Service, which assists vulnerable families with children aged 0-19 years, through a programme of assertive family support and challenge, which is delivered by Family Partners. Families with more complex issues including poor housing condition, domestic violence, alcohol and drug problems and mental health problems will be supported by the Family Partner Team. A Family Partner will work with a family, to understand their circumstances and deliver practical hands on support. They will also co-ordinate and shape the family's integrated support package, to maximise its effectiveness. Where families are not meeting their commitments, the Family Partner will provide assertive challenge, with recourse to a sliding scale of sanctions where appropriate.

### The Healthy Child Programme

The Healthy Child Programme is available to all families during pregnancy and the first five years of life and aims to:

- help parents develop a strong bond with children
- encourage care that keeps children healthy and safe
- protect children from serious diseases, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- encourage mothers to breastfeed
- identify problems in children's health and development (for example learning difficulties) and safety (for example parental neglect), so that they can get help with their problems as early as possible
- make sure children are prepared for school

- identify and help children with problems that might affect their chances later in life

The full Healthy Child Programme is delivered within North Tyneside via the Midwifery and Health Visiting Services. Health visitors play an absolutely key role in terms of identifying problems early and ensuring that children and families receive appropriate support. In addition to the Healthy Child Programme, the Family Nurse Partnership Programme intensively supports a first time mothers under the age of 20 years who are having their first child to improve outcomes for the mother and child.

### The Front Door Service

The Front Door Service is a single dedicated service that connects users into North Tyneside Council services for children and families, as well as those provided by Northumbria Police, the NHS, Education, Early Years and Learning Providers. Members of the public and professionals can use one number to access any services for children and families in North Tyneside.

### Childcare

Childcare provision is currently being reviewed in North Tyneside. Children from low income families are being supported to access high quality childcare in the borough. North Tyneside has successfully extended the 2 year old offer, enabling around 80% of those children eligible, to take up the offer of 15 hours of free childcare in a good or outstanding setting. The childcare offer includes assertive family engagement and promotes good parenting practice.

### Parenting Support

The quality of a child's relationship with their family has a significant influence on their wellbeing and outcomes. During the early years of a child's life, good parenting and a positive home learning environment support the development of important cognitive and non cognitive skills, which shape a child's life chances. Good parenting can also mitigate the impact of deprivation upon a child's life chances. High quality parenting programmes have demonstrated that they can deliver better outcomes for vulnerable children and their families.

The overwhelming majority of parents in North Tyneside provide appropriate care for their children, however a small number require additional assistance. A range of support is available to aid families, including:

- A programme of evidence based parenting courses which are part of the wider children's centre offer to families.
- The 'Ready 2 Go' course, targeted at parents whose children receive the 2 year offer to help them understand how they can support their children with their learning and development.

# 3. What Progress are we making in North Tyneside?

## Life expectancy at birth, 2010-2012

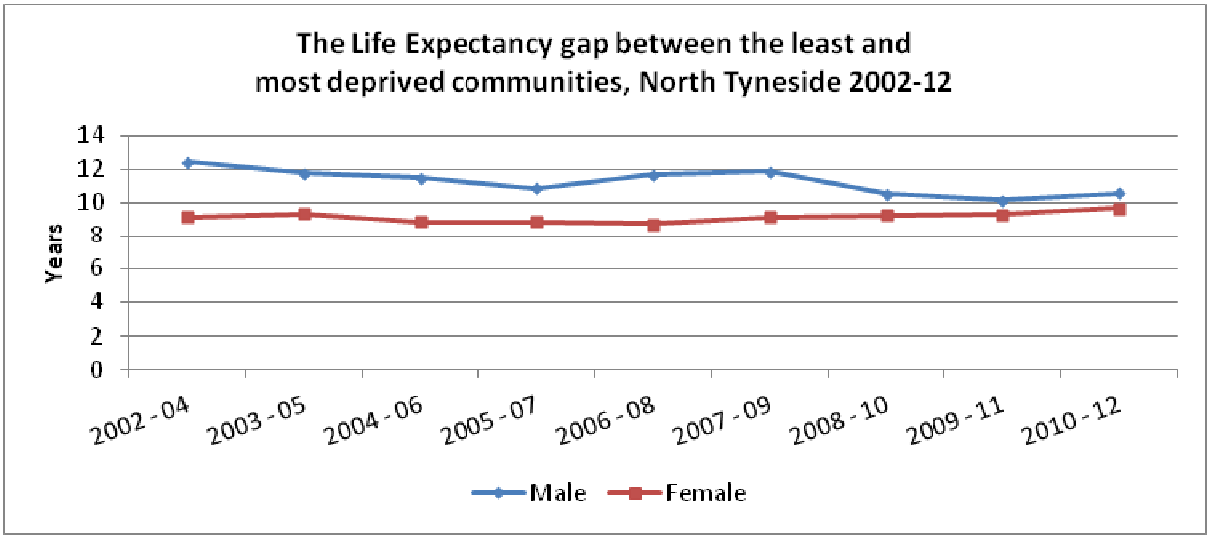
Life expectancy refers to the average length of time people can expect to live when they are born. People are living longer in North Tyneside with the average life expectancy currently being 79 years (for men it is 77 and for women is 81). There has been an upward trend in North Tyneside over the last 2 decades

## How do we perform?

As can be seen in the table below, men consistently have poorer life expectancy than women. There is approximately a 4 year difference in life expectancy between men and women in North Tyneside.

| | Local Value | North East | England |
|---|---|---|---|
| Boys | 78.1 | 77.8 | 79.2 |
| Girls | 82.0 | 81.6 | 83.0 |

The difference in life expectancy within North Tyneside between the most deprived and least deprived areas is much wider than the gap between North Tyneside and England. There is a clear social gradient for Life Expectancy across the Borough. Between the most and least deprived sections of the population, there is a life expectancy gap of 11.6 years for men and 9.2 years for women. This is illustrated in the graph below;




## Live Births and Early Years Population

The estimated number of births in North Tyneside was 2315 in 2012. This is projected to rise by 4.9% by 2015 before falling back to the current number by 2021. The number of children aged 0-4 years in North Tyneside in 2012 was 11,800 which is

equivalent to 5.8% of the population. Between 2011 and 2021 the 0-4 year old population is predicted to increase by 6.7%.

## Infant Mortality

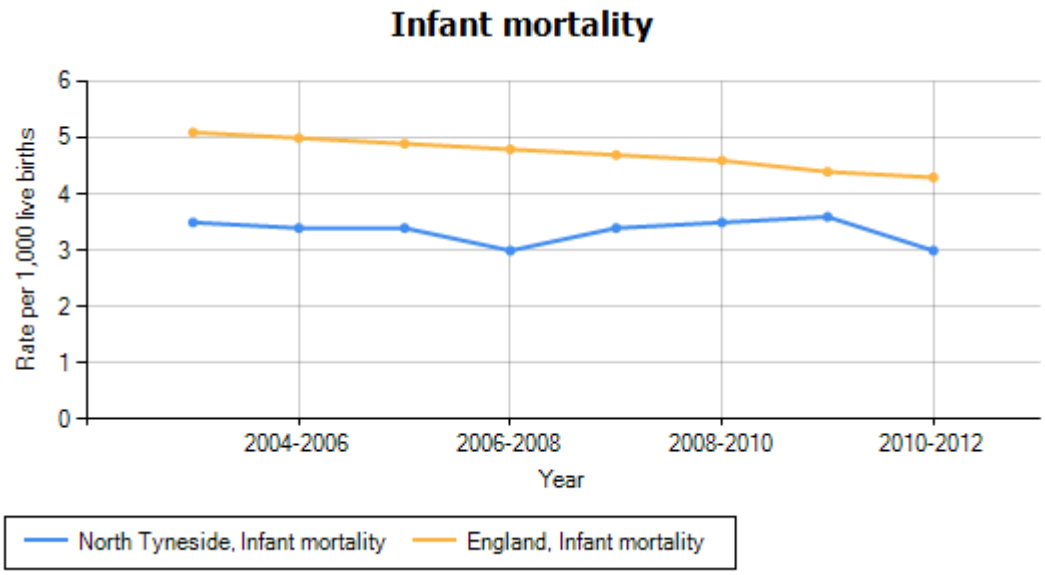
### Why is it important?

The infant mortality rate (IMR) is the number of children who die aged less than 1 year old per 1,000 live births. The IMR is widely regarded as one of the best single indicators of population health, as well as providing an indication of the wellbeing of infants, children and pregnant women. It is also considered an indicator of progress towards addressing inequalities.

Most causes of infant deaths show a socio-economic gradient. Deprivation, births outside marriage, non-white ethnicity of the infant and maternal age under the age of 20 are independently associated with an increased risk of infant mortality. The health of a baby is affected by the health of the mother. What a child experiences during the early years lays down a foundation for the whole of his or her life. Giving every child the best start in life is essential to reducing health inequalities across the life course.

### How do we perform?

The graph below shows the trend for infant mortality between 2004-06 and 2010-12.




Source: National Child and Maternal Health Intelligence Network

The table below shows that the infant mortality rate in North Tyneside is lower than the England average.

| Local Value | North East | England |
|---|---|---|
| 3.0 | N/A | 4.3 |

Mortality rate per 1,000 live births age under 1 year 2010-2012

Interventions to reduce infant mortality have been identified by the Department of Health and these are categorised into three groups:

- Interventions that have a demonstrable impact on reducing health inequalities;
- Interventions that are likely to impact on the infant mortality gap; and
- Interventions that will reduce infant mortality overall.

## Maternal Mental Health

### Why is it important?

Studies estimate[26] that approximately 10% of women who give birth experience mental health problems including depression, but also anxiety, and postnatal psychotic disorders. This equates to around 230 women in North Tyneside.
These illnesses suffered by the mother increase the likelihood that:

- the baby will be premature or have a low birth weight;
- the baby may not develop a secure attachment relationship with the mother;
- the child will experience behavioural, social or learning difficulties and
- the child faces higher risk of depression in adolescence.

In extreme cases, parental mental illnesses increase the risk that the child will be abused or neglected.

The NSPCC found that symptoms of anxiety and depression are more likely to occur in late pregnancy than after birth, and so can be identified antenatally. Early identification, support and treatment can prevent the onset and escalation of perinatal mental illnesses, or can help to prevent the effect on the family, to improve the wellbeing, health and achievement of the children.

In terms of North Tyneside Health visitors and GPs will provide support to new mothers who are experiencing low level mental health problems. There is also a Perinatal Community Mental Health Team which provides a community service to support women. For more severe diagnosed post natal depression there is a specialist in patient unit operated by Northumberland Tyne and Wear NHS Foundation Trust

## Low Birth Weight

### Why is it important?

Low birth weight is a major determinant of mortality, morbidity and disability in infancy and childhood and also has a long-term impact on health outcomes in childhood and adult life 57.6% of infant deaths in England and Wales in 2003 were of babies weighing less than 2,500g (low birth weight).

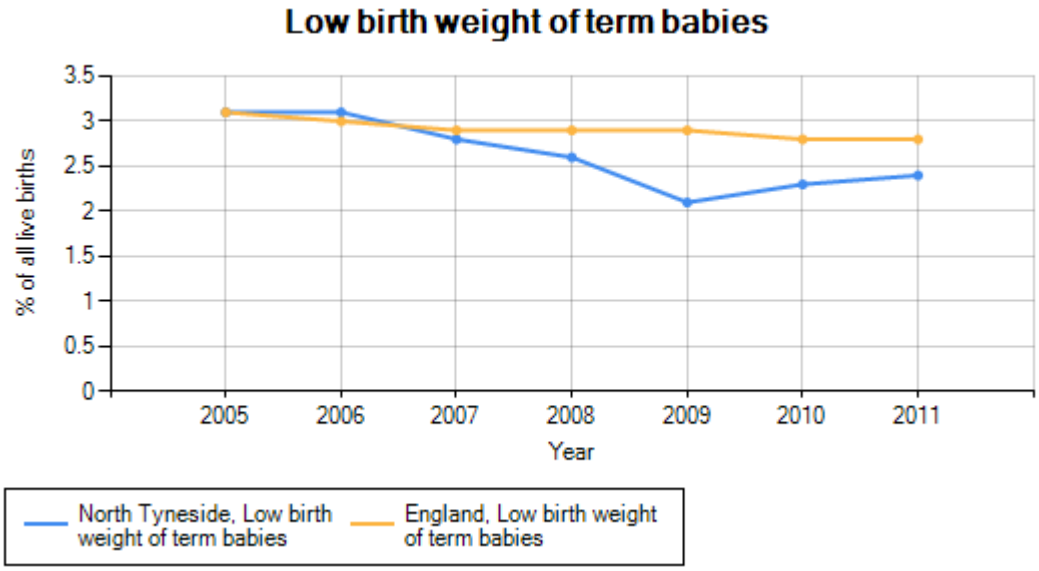
[26] Prevention in Mind NSPCC 2013

Low birth weight in particular is associated with poorer long-term health outcomes and evidence also suggests that maternal health is related to socio-economic status. Mothers living in the most deprived areas had an increased risk of having a low birth weight baby compared with mothers living in the least deprived area (39% in the 1980s and 29% in the 1990s), after taking account of their age at the time of the birth, ethnicity and limiting long-term illness.

Low birth weight in particular is associated with poorer long-term health and educational outcomes. Mothers from non-white ethnic groups had a 62% increased risk of having a low birth weight baby when compared with white mothers, after taking account of their age at the time of the birth, household and area characteristics.

## How do we perform?

The graph below shows the trend in terms of low birth weight in North Tyneside.




Source: National Child and Maternal Health Intelligence Network

The table below shows that the percentage of low birth weight babies in North Tyneside is similar to the England average.

| Local Value | North East | England |
|---|---|---|
| 6.4 | 7.6 | 7.3 |

Percentage of live and stillbirths weighing less than 2,500 grams, 2012

Birth weight is affected to a great extent by the mother's own foetal growth and her diet from birth to pregnancy. Women of short stature and young women have smaller babies.

Once pregnant, the mother's nutrition and diet, lifestyle (e.g. alcohol, tobacco or drug misuse) and other exposures (e.g. malaria, HIV or syphilis), or complications such as hypertension can affect foetal growth and development, as well as the duration of pregnancy.

## Under 18 conceptions

### Why is it important?

Most teenage pregnancies are unplanned. In England 27.7 in every 1,000 young women aged under 18 years became pregnant in 2012 and just under half (49%) of these pregnancies ended in an abortion.

While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is difficult.

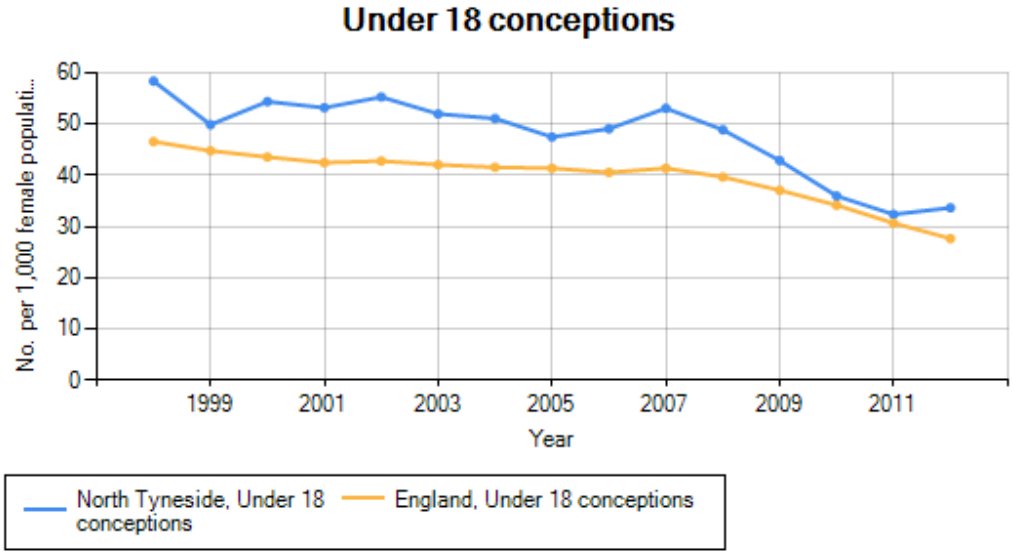
Teenage pregnancy often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and wellbeing and the likelihood of both the parent and child living in long-term poverty. As an alternative, abortions represent an emotional cost to the parent and an avoidable cost to the NHS.

Outcomes are also worse for children:

- Teenage mothers are three times more likely to smoke throughout their pregnancy;
- Babies born to teenage mothers are at an increased risk of prematurity, congenital abnormality and low birth weight;
- Teenage mothers are 50% less likely to breastfeed, with negative health consequences for the child
- Children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems.

### How do we perform?

The graph below shows that there has been a downward trend in terms of under 18 conceptions since 2007 with a slight increase in 2011-12, although numbers of conceptions are relatively small.




Source: National Child and Maternal Health Intelligence Network

The table below shows that North Tyneside is still above the England average but has made significant progress from the baseline rate of 58.4 per 1,000 in 1998.

| Local Value | North East | England |
|---|---|---|
| 33.7 | 36.3 | 27.7 |

Rate of conceptions in 15 – 17 year olds per 1,000 female population 2012

Continuing to reduce under-18 pregnancies is a high priority for both health and local authority children and young people's services. There are a number of services in place both to prevent teenage conceptions wherever possible and appropriate and also to support young parents in terms of parenting, housing and independent living for example.

### Antenatal Assessment by 12 weeks

#### Why is it important?

All women should access maternity services for a full health and social care assessment of needs, risks and choices by 12 weeks and 6 days of their pregnancy to give them the full benefit of personalised maternity care and improve outcomes and experience for mother and baby. Reducing the percentage of women who access maternity services late through targeted outreach work for vulnerable and socially excluded groups will provide a focus on reducing the health inequalities these groups face whilst also guaranteeing choice to all pregnant women.

#### How do we perform?

| Local Value | North East | England |
|---|---|---|
| 94.3 | N/A | 87.5 |

The percentage of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy 2012

### Safeguarding Children

"It is crucial to intervene early to promote infant mental health and to reduce the risk of children's development being hampered by abuse, neglect or other early parent-child relationship difficulties, thereby reducing the risk of longer term poor outcomes which incur higher longer term costs"[27].

Wherever children and cared for – in their own homes, by a childminder, or in any nursery or other setting, they have a right to feel safe and to be looked after well[28]. The 2011 Munro Review of Child Protection found domestic abuse to be a significant

[27] Conception to age 2 – the age of opportunity. Wave Trust 2013
[28] National Children's Bureau 2010

factor in child protection with up to three quarters of cases linked to domestic abuse, substance misuse and/or mental health problems in parents/carers.

In North Tyneside the Local Safeguarding Children's Board has overall responsibility for ensuring that appropriate arrangements and services are in place to safeguard children.

### How do we perform?

In terms of performance the table below shows our position in relation to the rate of children with a child protection plan and the rate of looked after children;

**Rate of children subject to a child protection plan per 10,000 2013-14**

It can be seen below that in 2013-14 the rate of children subject to a child protection plan in North Tyneside was just above the national average but significantly below the North East average.

| Local Value | North East | England |
|---|---|---|
| 38.9 | 51.1 | 37.9 |

**Rate of looked after children per 10,000**

In terms of looked after children the rate in North Tyneside is significantly higher than the England average but below the north East average

| Local Value | North East | England |
|---|---|---|
| 75.9 | 80 | 60 |

## Breastfeeding

### Why is it important?

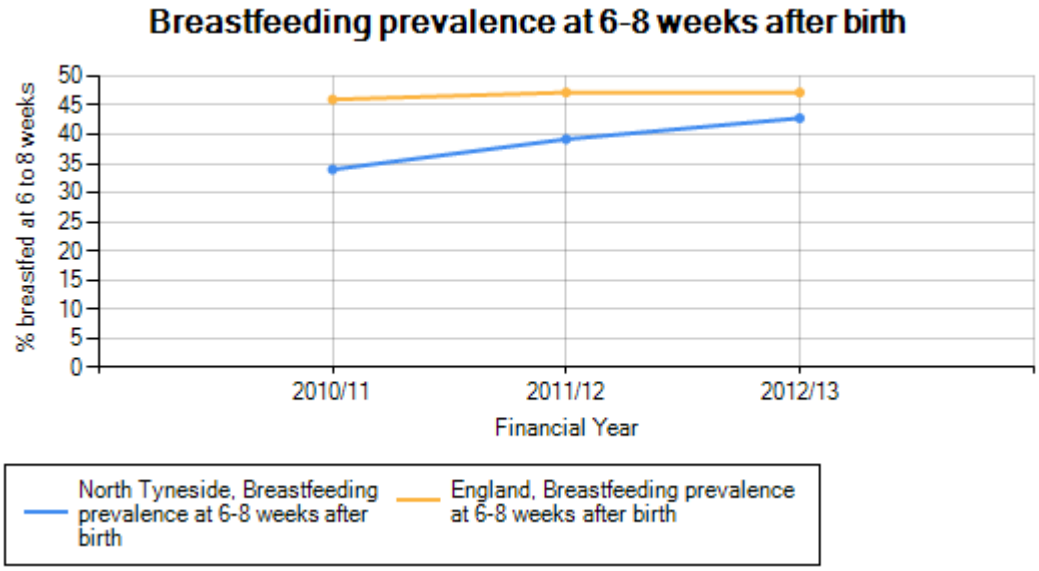
The World Health Organisation (WHO) and the Department of Health recommend exclusive breastfeeding of infants up to the age of six months. In fact a third of women stop breastfeeding soon after birth.

Although a minority of infants cannot be breastfed due to maternal health or other reasons, the benefits of breastfeeding are well established:

- Reduced hospital admissions of infants for diarrhoea and vomiting and respiratory infections;
- Reduced middle ear infections, enterocolitis and marginal improvement in cognitive outcomes;
- Reduced risk of sudden infant death;
- Improved attachment and bonding between mother and baby; and
- Reduced lifetime risk of obesity and diabetes.

In addition, women who breastfeed have a reduced risk of ovarian and breast cancer throughout their lifetime. Increases in breastfeeding prevalence are expected to reduce illness in young children. This will in turn reduce hospital admissions of children aged under 12 months and the associated avoidable costs to commissioners.

## How do we perform?




Source: National Child and Maternal Health Intelligence Network

**Breastfeeding initiation rate 2012-13**

| Local Value | North East | England |
|---|---|---|
| 63.7 | 59.3 | 73.9 |

The breastfeeding initiation rate for North Tyneside is 63.7% which is significantly below the England average of 73.9%, but better than the average for the North East of 59.3%. (2012/13)

**Breastfeeding rate at 6-8 weeks 2012-13**

| Local Value | North East | England |
|---|---|---|
| 42.8 | 31.2 | 47.2 |

The breastfeeding rate at 6-8 weeks is 42.8% in the borough, which is below the England average of 47.2% but better than the average for the North East of 31.2% (2012/13)

A Breastfeeding Needs Assessment was undertaken during 2013-14 and the recommendations are being implemented in relation to changing cultural attitudes to breastfeeding and actively supporting women who chose to breastfeed.

## Smoking in Pregnancy

### Why is it important?

Smoking in pregnancy has detrimental effects for the growth and development of the baby and health of the mother. Smoking in pregnancy leads to: a 60% increase in the risk of infertility compared with non-smokers; 3,000 to 5,000 miscarriages in the UK each year; 14,000 to 19,000 babies in the UK born with low birth weight; and 2,200 premature births per year in the UK. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes.

Encouraging pregnant women to stop smoking during pregnancy may also help them stop smoking for good, and thus provide health benefits for the mother and reduce exposure to second hand smoke for the infant. The National Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth).

### How do we perform?


Source: National Child and Maternal Health Intelligence Network

| Local Value | North East | England |
|---|---|---|
| 13.4 | | 12.0 |

% of women smoking at time of delivery 2013-14

## Childcare

### Why is it important?

Good quality childcare and early education supports the social, physical, emotional and behavioural development of children during the critical early years and is

particularly beneficial for disadvantaged children. Childcare and early education settings can help establish positive behaviours, such as healthy eating and regular physical exercise. Affordable childcare can also enable parents and carers to work, increasing household incomes and reducing disadvantage.

### How do we perform?

North Tyneside offers high quality childcare, as demonstrated by Ofsted's ratings of childminders and childcare settings.

**Childminders**

| | % Inadequate | % Good or Outstanding | % Outstanding |
|---|---|---|---|
| North Tyneside | 0.0% | 83.7% | 28.6% |
| Stat Neighbours | 0.6% | 63.7% | 8.2% |
| England | 0.8% | 71.3% | 10.1% |

None of the childminders in North Tyneside are rated as "inadequate". The percentage rated as at least "good" is 83.7%, which outstrips all of our statistical neighbours and the national average. 28.6% of North Tyneside childminders were rated "outstanding". This result is the 4th best for any local authority area in the country.

**Childcare Settings**

| | Number Inspected | % Inadequate | % Good or Outstanding | % Outstanding |
|---|---|---|---|---|
| North Tyneside | 56 | 0.0% | 80.4% | 12.5% |
| Stat Neighbours | 1056 | 0.3% | 74.0% | 10.2% |
| England | 23325 | 0.5% | 78.9% | 14.5% |

None of North Tyneside's childcare settings are rated as "inadequate". The percentage rated as at least "good" is 80.4% which is above the averages for our statistical neighbours and England. The percentage of North Tyneside childcare settings that rated "outstanding" is lower than the national average (although we are above the statistical neighbour result).

## Domestic Violence

### Why is it important?

It has been estimated that 1.8% of children in England live in households where there is a known high risk case of domestic abuse and violence[29].

In addition to the obvious increased risk of injury from any physical attack, the child is potentially at further risk due to the impacts domestic violence has on parenting. The

[29] Laming, H. (2009) The Protection of Children in England: a progress report. London: The Stationery Office.

victim (most commonly the mother) may prioritise their partner's needs, suffer from mental health issues and have his or her authority undermined, all of which will have an effect on his or her capacity to provide the child with a safe and secure environment.

Domestic violence often begins in pregnancy and evidence suggests having experienced partner violence during pregnancy results in a three-fold increase in the odds of high levels of depressive symptoms in the postnatal period. Early intervention and support for pre-school children experiencing domestic violence is currently neither recognised, nor is there adequate provision to help them overcome the effects of trauma[30]. Research suggests that these children may experience a range of responses including speech and language delay, toileting problems, separation anxiety and persistent crying.

### How do we perform?

In 2013/14 there were 3875 reported domestic abuse incidents, on average 323 domestic abuse incidents a month,

In 1898 of these incidents (49%) there were children involved. Out of these it is estimated that around 210 children aged under five years in North Tyneside are at high risk of being affected by domestic violence.

There are a number of services in place within North Tyneside to support female victims of domestic violence and a proportion of these will have children under five years of age. There are no specific services or interventions for under fives in North Tyneside who witness or experience domestic violence, however work is underway during 2014-15 through the Troubled Families Programme to identify and work with families with children where there is domestic violence.

## Immunisations

### Why is it important?

Immunisation can prevent children from getting serious diseases that can kill or cause long-term health problems. Immunised children are much less likely to suffer the devastating consequences of these diseases. Immunisation also helps to prevent outbreaks and epidemics of these infectious diseases.

Nationally, the childhood immunisation programme is offered routinely through primary care and other services. However, in England, differences in immunisation uptake persist. A range of social, demographic, maternal and infant related factors have been identified as barriers to full immunisation.

[30] Refuge 2005

Evidence shows that the following groups of children and young people are at risk of not being fully immunised: children and young people who have missed previous vaccinations (whether as a result of parental intent or otherwise); looked after children; children with physical or learning difficulties; children of teenage or lone parents; children not registered with a general practitioner; younger children from large families; children who are hospitalised; minority ethnic groups; vulnerable children, such as those whose families are travellers, asylum seekers or homeless[31].

### How do we perform?

Currently, North Tyneside performs well with regard to childhood immunisations exceeding all national targets in 2012-13. The table below shows the uptake for North Tyneside for 2012-13 compared with the uptake across England.

| Immunisation | Target | 2012-13 performance |
|---|---|---|
| Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) immunisation rate for children aged 1 | 95% | 98.3% |
| Pneumococcal infection (PCV) immunisation rate for children aged 2 | 95% | 96.1% |
| Haemophilus influenza type b (Hib), meningitis C immunisation rate for children aged 2 | 95% | 98.2% |
| Measles, mumps and rubella (MMR) immunisation rate for children aged 2 | 95% | 92.9% |

## Children achieving a good level of development at the end of reception

### Why is it important?

School readiness is used as measure in relation to closing the learning gap and improving equity in achieving lifelong learning and full developmental potential among young children. It does so by considering all children, especially the vulnerable and disadvantaged, including children with disabilities, ethnic minorities and those living in rural areas.

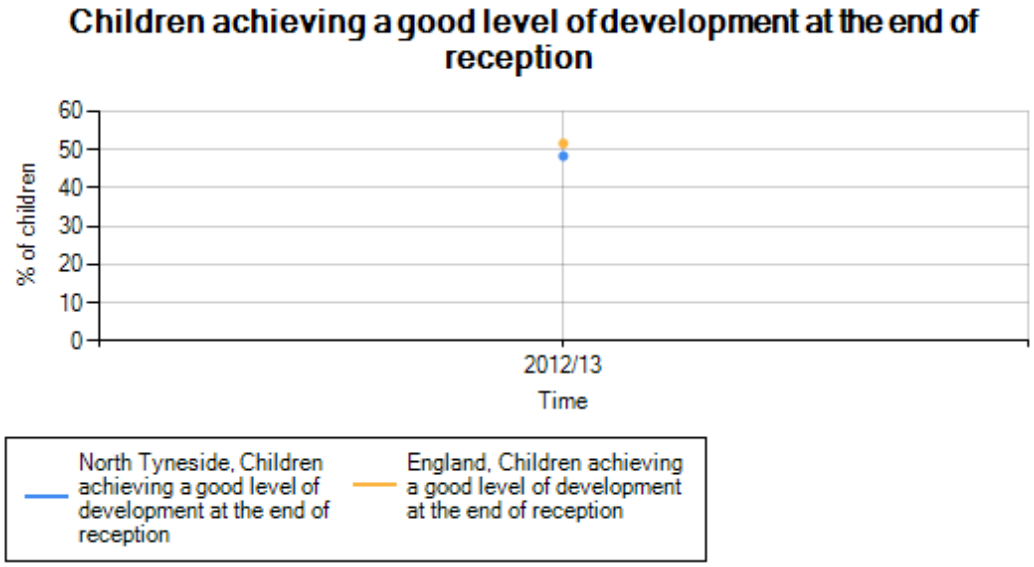
Readiness for school requires much more than a child simply reaching the chronological age required for school entry. Growth and physical development are as important to education as they are to the field of developmental medicine but have been largely overlooked by the educational system since the phasing out of routine developmental tests for all children.

At a National Level, 52% of children achieved a Good Level of Development in 2012/13 (those achieving at least the expected level within the three prime areas of learning: communication and language, physical development and personal, social

[31] NICE 2009

and emotional development and in the early learning goals within the literacy and mathematics areas of learning).

As illustrated in the graph below North Tyneside children achieve a good level of development in line with the England average.




Source: National Child and Maternal Health Intelligence Network

| Local Value | North East | England |
|---|---|---|
| 48.4 | N/A | 51.7 |

% children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13

## Childhood Accidents

### Why is it important?

Accidental injuries are a major health problem throughout the United Kingdom. They are the leading cause of preventable death and ill health among children. They are also the most common cause of death in children over one year of age. Every year they leave many thousands permanently disabled or disfigured.

Younger children have a higher percentage of burns and scalds as well as poisoning and ingestion accidents. Those most at risk from a home accident are the 0-4 year age group. Most of these accidents are preventable through increased awareness, improvements in the home environment and greater product safety.

The five main causes of serious unintentional injury for the under-fives in England which need to be prioritised in terms of prevention are;

- Choking, suffocation and strangulation
- Falls

- Poisoning
- Burns and scalds
- Drowning

Childhood injuries are closely linked with social deprivation. Children from poorer backgrounds are five times more likely to die as a result of an accident than children from better off families - and the gap is widening[32].

**How do we perform?**
For North Tyneside the rates of emergency hospital admissions (per 100,000) for the five priority areas outlined above were as follows in 2008-9[33];

| Accident Category | North Tyneside | England |
|---|---|---|
| Emergency hospital admissions due to suffocation and strangulation (including hanging) | <10.3 | 0.5 |
| Emergency hospital admissions due to falls from furniture | 168.7 | 149.2 |
| Emergency hospital admissions due to poisoning from medicines | 151.5 | 99.4 |
| Emergency hospital admissions due to hot water burns | 41.3 | 38.4 |
| Emergency hospital admissions due to drowning in the bath | <10.3 | 1.1 |

It can be seen from the table above that falls and poisoning are the main reasons for children under five years being admitted to hospital as an emergency. For these two reasons North Tyneside is also significantly above the average rate for England.

## Dental Health

### Why is it important?
Good oral health is an integral part of overall health. Poor oral health has a significant impact on quality of life causing pain and sepsis; affecting appearance and leading to a lack of confidence; loss of nights' sleep; missed school and affecting the ability to eat a healthy diet.

Despite an overall improvement in oral health over the past 30 years, over 27% of 5 year olds have tooth decay. Tooth decay (dental caries) is the decalcification of the tooth surface, which can lead to tooth decay. The cause of tooth decay is frequent sugar consumption in foods or drinks. It can be prevented by reducing the frequency of sugar consumption and by strengthening the tooth surface with fluoride, most commonly through brushing with fluoride toothpaste.

[32] Royal Society for the Prevention of Accidents
[33] Most recent data available

Interventions to improve oral health should not be carried out in isolation but in conjunction with interventions on healthy weight, in the context of healthy lifestyles, following a common risk factor approach.

### How do we perform?

The table below shows the percentage of children aged five years with one or more decayed, missing or filled teeth;

| Local Value | North East | England |
|---|---|---|
| 29.3 | 29.7 | 27.9 |

% children aged 5 years with one or more decayed, missing or filled teeth, 2011/12

It can be seen that North Tyneside is close to the average for the North East but above the England average.

## Childhood Obesity

### Why is it important?

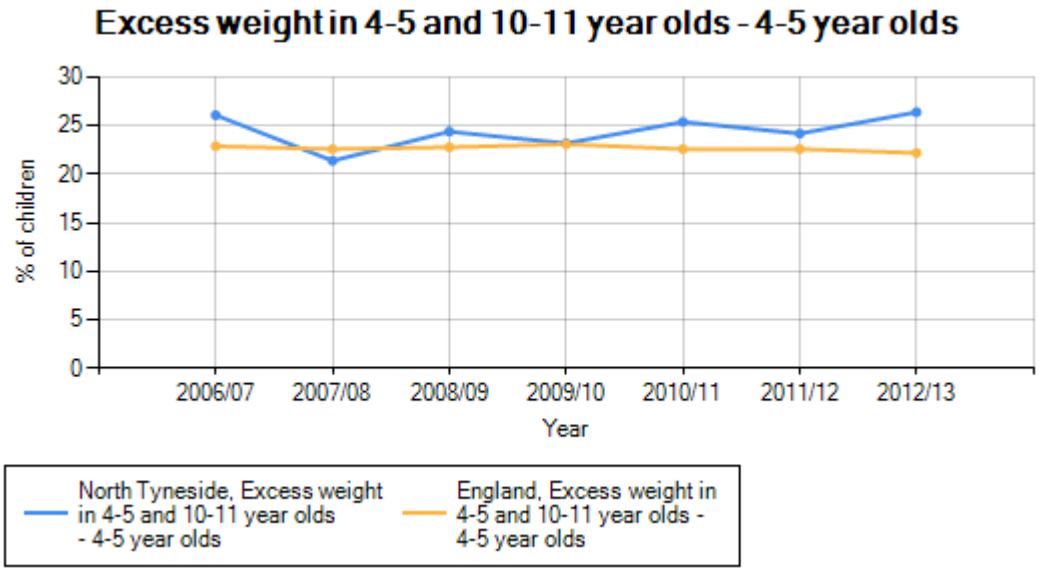
Childhood obesity is an outcome of a combination of risk factors, including biological and lifestyle factors, environment, culture and social practices. It is well recognised that children who are obese are likely to have obese parents. Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the accumulation of excess body fat.

The National Child Measurement Programme (NCMP) (now collected via local authorities) measures the height and weight of around one million school children in England every year, providing a detailed picture of the prevalence of childhood obesity.

All actions aimed at preventing excess weight gain and improving diet (including reducing energy intake) and activity levels in children and young people should actively involve parents and carers;

### How do we perform?

The graph below shows the percentage of children who are classed as having excess weight at ages 4-5 years and ages 10-111 years;




Source: National Child and Maternal Health Intelligence Network

**Percentage of children aged 4-5 years with excess weight in 2012-13**

| Local Value | North East | England |
|---|---|---|
| 26.5 | 24.16 | 22.23 |

**Percentage of children aged 10-11 years with excess weight in 2012-13**

| Local Value | North East | England |
|---|---|---|
| 35.3 | 35.65 | 33.32 |

## Children with Disabilities

### Why is it important?

Children with long-term disability are a diverse group. Some will have highly complex needs requiring multi-agency support across health, social services and education – the most extreme example perhaps being those who are technology-dependent. Other children will require substantially less support, although nevertheless have a long-term disability. Disabled children and young people currently face multiple barriers which make it more difficult for them to achieve their potential, to achieve the outcomes their peers expect and to succeed in education. 29% of disabled children nationally live in poverty and the educational attainment of disabled children is unacceptably lower than that of non-disabled children.

The prevalence rates of children and adolescents with mild disabilities were found to be higher for those from semi-skilled manual and unskilled manual family

backgrounds. The prevalence of children with mild disabilities from professional family backgrounds was lower in comparison to the other socio-economic groups.
The rate of severe disability was found to be greatest amongst children from semi-skilled manual family backgrounds, whilst the lowest rates were for children from professional and managerial family backgrounds.

Estimated number of children aged 0-4 living with a long term illness or disability

| | Local Value | North East | England |
|---|---|---|---|
| Boys | 869 | N/A | N/A |
| Girls | 728 | N/A | N/A |

Estimated number of children aged 0-4 who are severely disabled

| | Local Value | North East | England |
|---|---|---|---|
| Boys | 9 | N/A | N/A |
| Girls | 4 | N/A | N/A |

## Accidents and Emergency Hospital Attendances (0-4 years)

### Why is it important?

Illnesses such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are the leading causes of attendances at Accident & Emergency and hospitalisation amongst the under 5s. Out of all children and young people aged up to 18 years, 0-4 year olds are most likely to attend an A&E service or be admitted following an attendance.

| Local Value | North East | England |
|---|---|---|
| 485.5 | N/A | 510.8 |

Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12

In North Tyneside the main reason for A&E attendance in the 0-4 age range is respiratory condition followed by laceration. Gastrointestinal conditions are the third highest condition and North Tyneside is a known outlier for admissions for young children due to gastro-intestinal conditions.

Main reasons for attendance are:

| | |
|---|---|
| Respiratory conditions | (10.9%) |
| Laceration | (7.0%) |
| Gastrointestinal | (6.0%) |
| Contusion / abrasion | (5.7%) |

## Emergency Hospital Admissions

North Tyneside has the third highest rate of emergency admissions in England. The rate of emergency admissions, per 1,000 population, identifies that young children aged 0-4years have high admission rates

The number of emergency admissions of children fell slightly in 2012-13

| Local Value | North East | England |
|---|---|---|
| 250.3 | N/A | 149.7 |

Emergency admission rate per 1,000 for children aged 0-4 2012-13

## Hospital admissions caused by unintentional and deliberate injuries

We know that, nationally, hospital admissions due to unintentional injuries are far higher than hospital admissions due to deliberate injuries.

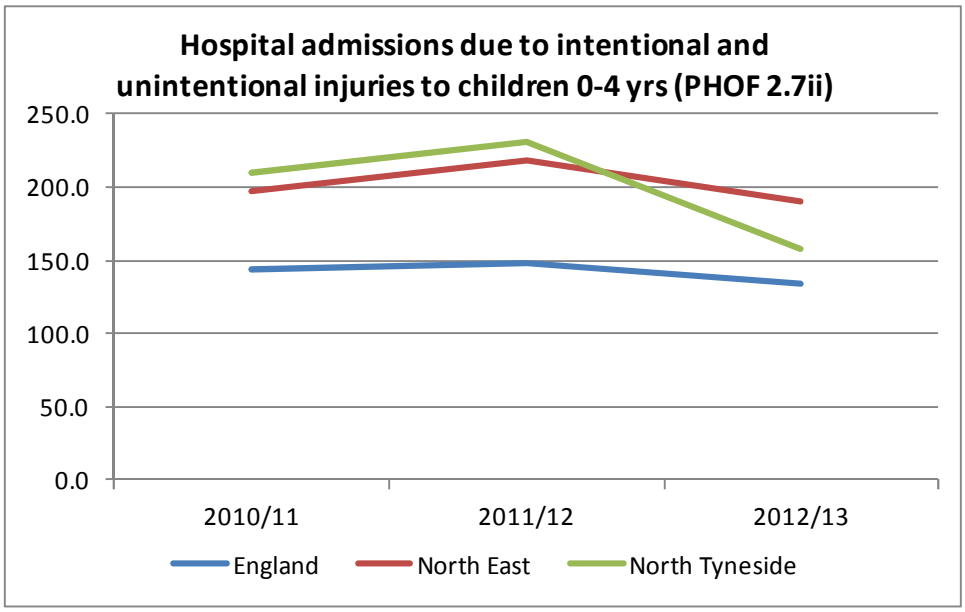
Given that some hospital admissions with an external cause of injury will be elective admissions, including some for follow-up treatment after an earlier emergency admission, the indicator is restricted to counting only emergency admissions. Some children and young people may have more than one emergency admission with an external cause of injury within a time period.

'Unintentional' injury is used here to mean accidental external causes of harm e.g. traffic accidents, falls, trips, accidental contact with tools/machinery etc, drowning, exposure, burns and scalds etc. Unintentional injury continues to be a major cause of death, ill health and long-term disability in childhood. Current evidence suggests that children in the most deprived households are more likely to be injured or die from an accidental injury.

'Deliberate' injury refers to the codes for assault, covering different types of assaults e.g. bodily force, sexual assault by bodily force, sharp/blunt objects etc. unintentional injuries account for around 90% of all child deaths due to violence and injury each year[34].

The graph below shows that hospital admissions caused by unintentional and deliberate injuries have reduced between 2010 and 2013;

[34] The *World Report on Child Injury Prevention*




| Local Value | North East | England |
|---|---|---|
| 157.4 | 189.5 | 134.7 |

Rate per 10,000 in children under 5 years 2012-13

## 4. Key Conclusions

There are a number of areas where North Tyneside performs worse than the England average;

- Under 18 conceptions
- Breastfeeding
- Smoking at time of delivery
- Children achieving a good level of development at the end of reception
- Childhood accidents
- Oral Health
- Childhood obesity
- Looked after children
- Emergency hospital admissions

It has been demonstrated throughout my report that these variations between North Tyneside and England can all be linked back to factors associated with poverty and deprivation.

- North Tyneside residents have access to high quality maternity care including accessible antenatal and postnatal provision. The low infant mortality rate in the borough is largely due to the quality of care women receive. Children in North Tyneside generally have a good start in life. However, there are pockets of health

inequalities, and some risks and harms are more hidden such as parental substance misuse, domestic violence or mental health problems

- The early year's period is critical in a child's development, and has an impact well into adult life. Investment needs to be increased and maintained in relation to evidence based preventative interventions to improve outcomes for families and reduce demand on high cost services

- Services for young children and their parents are often not sufficiently connected around the family as a whole. A family-focused approach is particularly important ineffectively tackling lifestyle issues such as obesity, and in addressing risks that might be hidden such as parental drug misuse, domestic violence or mental health problems

- The need for integrated care co-ordinated around and tailored to the needs of the child or young person and their family is clear and fundamental to improving their health outcomes.

- Affordable and appropriate housing is essential for young children to enable them to grow up in a safe, stable environment

- Accident and Emergency attendances and hospital admissions are high in the 0-4 year age group. More innovative and pro-active approaches are required to reduce these where they are avoidable.

## 5. Key Recommendations

**Pregnancy and Maternal Health**

- Develop a clear maternity care pathway that includes smoking cessation, alcohol and substance misuse, obesity, promotion of healthy eating, with clear links to a wider continuum of lifestyle programmes in early years
- Improve early identification and pathways for maternal mental health needs through implementation and promotion of a local model accessible to all women
- Extend the promotion of the Baby Friendly initiative and strengthen the focus on breastfeeding

**Early Years Education and Childcare**

- Ensure that the most vulnerable families are supported to access appropriate childcare to improve children's outcomes and parental employment and training opportunities
- Ensure that information on family circumstances is shared between education, social care and health so that children can be given additional support where required

- Ensure that families most in need are given intensive support to improve the learning and development of their children

**Advice and Information**

- Ensure that vulnerable families in particular have access to high quality, comprehensive and independent information and support covering all aspects of need, including childcare

**Service Integration**

- Where possible fully integrate early education and childcare services for children up to age 4
- Expand family support and/or the family partner approach for parents with young children, including parenting, early intervention and swift referral to more specialist help where appropriate
- Ensure access to more intensive health visiting support for the most vulnerable families (in addition to the universal offer) at home and in community settings
- Continue to transform Health Visiting Services in line with the Health Visitor Implementation Plan
- Facilitate joint or multi agency staff training where possible to avoid conflicting advice and to deliver a more integrated service across professionals and key workers involved in early years services.

**Safeguarding**

- Develop one set of records for each child shared between the NHS (including midwives, heath visitors, GPs) and children's services
- Carry out joint visits to families with health visitors and children's centre staff
- Implement best practice and evidence based approaches in relation to working with families whose children are on the edge of going into care

**Health Improvement**

- Support families to improve their own health, including smoking cessation, alcohol and drug misuse, sexual health, oral health, healthy eating and physical activity
- Skill up parents and carers with cook and eat projects, and improve access to fruit and vegetables at local level
- Engage low income and more vulnerable families in leisure activities
- Incorporate physical activity into early years education and childcare provision and outdoor play policy
- Ensure access to local, age appropriate play, leisure, and recreation opportunities that are freely chosen and done for their own sake

**Funding**

- Increase the proportion of overall expenditure allocated to the early years and ensure funding is allocated according to need;

**Social and Emotional wellbeing**

- Health professionals in antenatal and postnatal services should identify factors that may pose a risk to a child's social and emotional wellbeing.
- Health visitors or midwives should offer a series of intensive home visits to parents assessed to be in need of additional support.
- Health visitors or midwives should consider evidence-based interventions such as baby massage and video interaction guidance to improve maternal sensitivity and mother-infant attachment.
- Explore opportunities to expand the Family Nurse Partnership to meet the needs of more vulnerable young families.

**Children with Disabilities**

- Increased access to services and activities at home, children's centres and in community settings for children with disabilities
- Ensure that young children with disabilities and their families receive access to health promoting activities and interventions

**Vulnerable or isolated families**

- Outreach to support vulnerable and / or isolated families and assist them to engage with appropriate community resources
- Extend the Family Partner approach through training a range of front line staff across partner agencies
- Continue to provide access to support and training to assist families with work readiness and employment issues

**Housing**

- Ensure that families with young children are not living in or are not placed in temporary or poor standard accommodation
- When pursuing eviction proceedings, Housing Teams need to take into account the children's need for a secure home and establish effective joint-working practices to ensure their support needs are met
- Wherever possible co-locate staff from Housing and Children's Services to support making joint assessments
- Ensure families can access specialist housing advice in Children's Centres or Customer First Centres
- Carry out an Early Help Assessment with families who present to Housing
- Ensure the provision of home safety equipment – particularly in more deprived areas of the borough and in properties in a poor state of disrepair

**Reducing Hospital Attendances and Admissions**

- Focus on the main causes of admissions and provide targeted, evidence based interventions families who are most vulnerable and/or most at risk
- Explore opportunities to provide access to minor illness and injury advice in children centres