

**Looking to the Future:
The Health and Wellbeing of
Children and Young People
in Cheshire East**

**The Annual Report
of the
Director of Public Health

2013-2014**

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Foreword

It is with great pleasure that I bring you this Annual Report for 2014. As Director of Public Health I am required by law to write an independent annual report on the health of the local population. This year's report focuses on the health and wellbeing of children and young people. It provides a current picture of how healthy the children and young people in Cheshire East are and what services they and their families use to support them. This report highlights areas which are performing well and also makes recommendations on ways to improve.

One Year On

It is now more than a year since some Public Health duties transferred from the NHS to Local Authorities. Cheshire East Council, in line with the requirements of the Health and Social Care Act 2012, appointed a specialist Director of Public Health to oversee and discharge their responsibilities.

A number of the Director's responsibilities and duties arise directly from Acts of Parliament - mainly the NHS Act 2006 and the Health and Social Care Act 2012 - and related regulations. In particular, Section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, makes the Director of Public Health responsible for all of the local authority's duties to take steps to improve the health of the people in its area. Improving the health of local people can be achieved in a number of ways. This includes influencing factors that determine health, both good and bad (e.g. good housing, vibrant economy), protecting people from disease (from pathogens or risky behaviour such as smoking or drinking), and ensuring that local services are delivered in the right place at the right time and are of the right quality. All of these approaches should reduce inequalities in health.

As the Director of Public Health, I also lead the commissioning of the mandated and non-mandated public health services and manage the ring-fenced public health grant that has been provided to the Council. Some of these services (such as those for alcohol and drug misuse, sexual health and smoking cessation) cover all age groups. The high level of clinical expertise required for the provision of some of these services, for example sexual health, means that it is not appropriate to have separate arrangements specifically for young people. However, all services are carefully tailored to specifically meet the needs of the young as well as older people.

In order to deliver these responsibilities, I work closely with NHS colleagues in Clinical Commissioning Groups (CCGs), in NHS England and Public Health England, as well as with local authority colleagues such as the Director of Children's Services and the Director of Adult Social Services. Together, we promote joined-up action across the whole life course.

The pivotal report, 'Fair Society, Healthy Lives – The Marmot Report' (2010), highlighted the importance of the life course model and emphasised the accumulation of effects seen on health and wellbeing starting before birth as well as during a person's life. The Marmot Report stated that its highest priority recommendation was 'giving every child the best start in life'. The report identified that disadvantages start before birth and accumulate throughout life. What happens during a child's early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational attainment and economic status.¹

The report states that action must start before birth and be followed through the life of the child. However, the report also assures the reader that there is much that can be done to improve the lives and health of people who have already reached school, working age or beyond. It is for these reasons that together with my Council and NHS colleagues, I address health differences across the

life course to improve the health and wellbeing of all the citizens of Cheshire East from the very young to the very old. This report, however, will focus on our younger members of society, their health needs are and how we can improve their health and wellbeing, and through that, their futures.

Children's Public Health Services

In October 2013, the Chief Medical Officer, Professor Dame Sally C Davies chose to focus on children and young people in her Annual Report.² She found that the health and wellbeing of children and young people is a complicated mixture of genetics, sociology and psychology, and that the evidence shows that during the life course there are still opportunities to make improvements and develop a more healthy population.

There are a wide range of public health interventions that can improve the health of children and young people. These include interventions at a whole population level, for examples, to reduce and prevent birth defects, the National Child Measurement Programme and public health services for children and young people aged 5-19 (including school health services and the Healthy Child Programme 5-19). In October 2015 a further service will be added to the Director of Public Health's portfolio; commissioning the Healthy Child Programme 0-5 (including health visiting and the Family Nurse Partnership services) will transfer from NHS England to Cheshire East Council.

In this Annual Report I will:

- Explain the critical significance of a healthy pregnancy and how it contributes to the subsequent development and outcomes experienced by the child
- Assess some of the key patterns in economic prosperity and child health in Cheshire East and their influence on health
- Draw attention to the strong relationships that exist between children's environments (whether in the home, at play, being transported, or when attending school) and their state of health
- Highlight the many opportunities that exist to keep children healthy and injury free
- Summarise the current national guidance on maximising the school health team's contribution to the public health of school-aged children, and outline a way forward for the development of school health services
- Set out the complicated commissioning environment for children and young people, together with some simple steps that commissioners can take to ensure that their plans are aligned and in the best interests of children

The Local Health and Care System

Unfortunately a silent and often unrecognised feature of the current system for children and young people is that care is not always coordinated and lacks a common agreed purpose or planned outcome. Different services do what is right for an individual child, but their actions are not always aligned with other providers or agreed between different commissioners. This can lead to pregnant women, their partners, children and young people and their families experiencing inconsistent

advice and management. This is more likely to occur at key transition points such as pregnancy, infancy and later on as a young person moves on to adult services.

This has been recognised locally and the current integration programmes in both of the Clinical Commissioning Group areas are now starting to look at children and young people.

This report looks at the main reasons for ill health in the local population, and highlights the strong evidence base that shows that actions can achieve change. I highlight areas where societal change is possible, including tackling fuel poverty, where Cheshire East Council is developing innovative approaches including sourcing low-cost energy for its residents. I will also outline the improved outcomes that can occur when families are empowered to manage their child's minor illnesses themselves at home through self-care, or by knowing which health services can support them in the community, rather than waiting and then relying on urgent care or hospitalisation. These include, but are not limited to:

- The refocusing of 'public health nursing' (health visitors, school nurses, but also the roles of midwives) to predict, prevent, plan for ill health and support parents and young people to manage minor illnesses with self-care
- Greater publicity of the role and skills of the local pharmacist in providing advice and treatment for minor childhood illnesses
- Coordinated care pathways across the different services to manage childhood illnesses or unintentional injuries in the community unless life threatening or serious enough to require specialist services (e.g. broken bones)
- Reinforced messages to parents and families about self-care and how to manage their child's illnesses at home, what key warning signs to look out for and who to go to for help or advice
- An alternative approach to out-of-hours care for children and young people which does not channel them into hospital, but instead provides treatment and support in the community

This vision for the future will take time to implement, and there may be difficulties to overcome, but it will benefit our children and young people and their families. I call upon my colleagues in the local NHS, wider council services and third sector organisations to embrace this vision and work towards it as we move ahead to improve the lives and health and wellbeing of our local children and young people.

Dr Heather Grimbaldeston
Director of Public Health

Chapter One

Applying Proportionate Universalism to Children's Health and Wellbeing

In my last Report I drew attention to proportionate universalism as an approach to reducing health inequalities across a community. In summary this means that universal action is taken but its scale and intensity is proportionate to the level of need in different areas.

A good example of why proportionate universalism is important can be taken from those children and young people experiencing limiting long-term illness (LLTI). Figure 1 and Figure 2 show the proportion and number of children aged 0-15 who were reported in the 2011 Census as having a long-term health problem or disability that limits their daily activities either “a little” or “a lot”, using ten national deprivation deciles based on the index of multiple deprivation (IMD).

There is a clear health inequality between the ten types of area. Children living in more affluent areas experience lower levels of limiting long-term illness (LLTI) than children in more deprived areas. Those in the 40% most deprived areas experience greater levels of LLTI. Although the burden of disease is disproportionately focused on this 40%, a sizeable number of children who live in the least deprived areas still have a need for services (Figure 2).

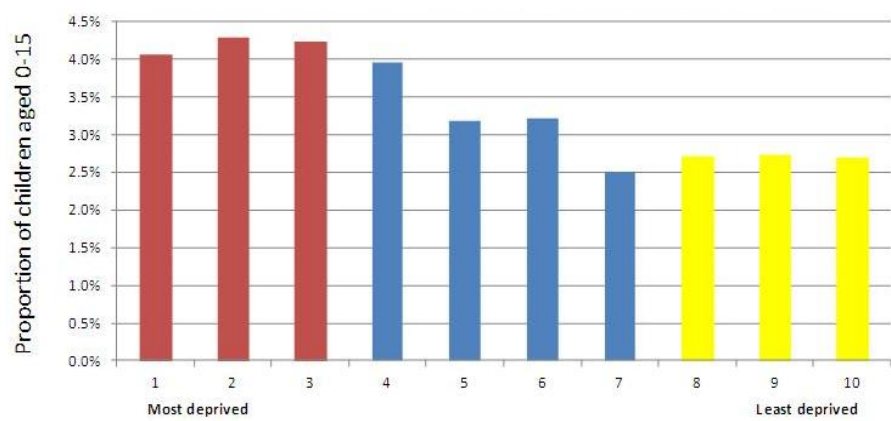


Figure 1. Proportion of 0-15 year olds with LLTI in Cheshire East areas classified by national IMD decile

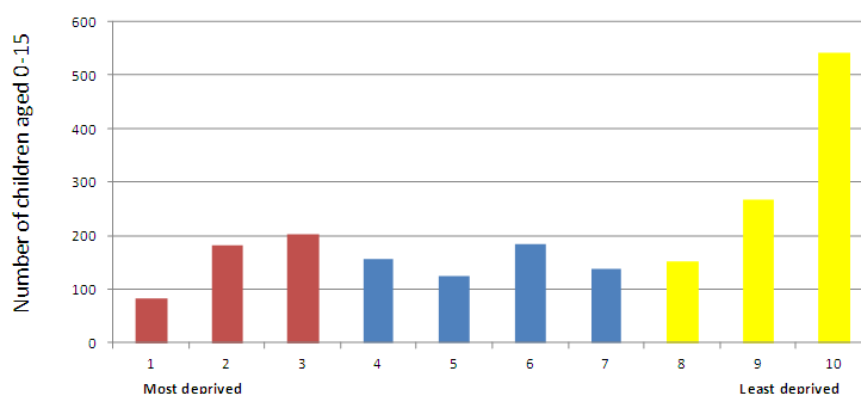


Figure 2. Children aged 0-15 with LLTI in Cheshire East areas classified by national IMD decile

There is a very easy explanation as to why this occurs. In Cheshire East only 18% of children live in the most deprived 30% of areas (illustrated in red on Figure 3). Whereas nearly 55% of children in Cheshire East live in areas that are among the 30% least deprived areas nationally (illustrated in yellow on Figure 3).

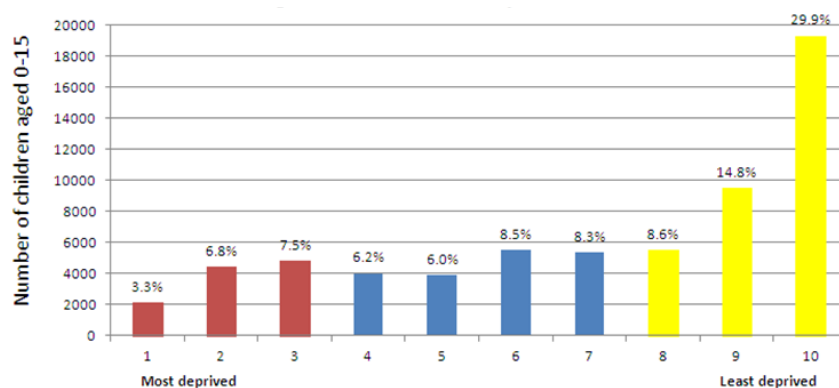


Figure 3. Number and proportion of children in Cheshire East living in areas classified by national IMD Decile

As Marmot recognised, in Cheshire East we cannot exclude any area from public health initiatives purely because of its relative national deprivation. The important requirement is to identify what the health and wellbeing needs are in each part of the Borough, and then for the commissioning process to drive improvements in the factors that underlie those individual children's needs.

Locally it has been identified that 9.5% of households in the Borough live in fuel poverty. To try to address this local need, Cheshire East Council is intending to become only the second council to offer to all its households, and local businesses, the chance to benefit from an energy deal aimed at tackling fuel poverty by enabling them to buy their supply, at a competitively low cost, through the Council.³ This is a good example of proportionate universalism. Although anyone in the borough can benefit, households in poverty have most to gain and should be supported to take part.

Not only will this scheme directly impact the household budget of those households experiencing fuel poverty, it will have a wider impact on health and wellbeing. A warm, dry and secure home is associated with better health; chapter six focuses on this issue in more detail. In addition, if less money is spent on heating the home, more is available in the household budget for the other things that will benefit a child's health including a healthier diet. By tackling the wider societal problems, such as fuel poverty, the overall health and wellbeing of local children (and their families) can be improved.

Healthy Child Programme

The Healthy Child Programme is a national public health programme that is based on the best knowledge and evidence to achieve good outcomes for all children. The Healthy Child Programme uses proportionate universalism to ensure that children and their families receive appropriate levels of care. All families receive 'your community' services and those with children aged 0-5 receive 'universal' care, but those families identified by midwives, health visitors or the Family Nurse Partnership as needing additional support receive either 'universal plus^a' or 'universal partnership plus^b' levels of care.⁴

The professional redevelopment of health visiting and school health services during recent years has given both groups the necessary skills and tools to achieve proportionate universalism. They are able to actively support parents, children, young people and families when they need extra help. Some examples of this include specific parenting issues, post natal depression, asthma, emotional

^a Universal Plus delivers a rapid response from the health visiting team when specific expert help is needed, e.g. with parental mental health, attachment, toilet training, behaviour management, domestic violence.

^b Universal partnership plus provides ongoing support from the health visiting team, bringing together a range of local services, to help families who have complex additional needs. These include services from Sure Start Children's Centres, other community services including voluntary and community organisations and, where appropriate, the Family Nurse Partnership and referral to the GP, social care or specialist services where appropriate.

difficulties and bullying. They can also coordinate additional help from a range of other local services to work together with the family and deal with more complex issues over a period of time.

The Government has recently announced that it intends to make certain universal elements of the programme 'mandatory', namely:

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment
- 2-2½ year review

These are key points during a child's early years when parents are supported to give their child the best start in life, and to identify early, those families who need extra help (early interventions). These elements are delivered by midwives, health visitors or through the Family Nurse Partnership (FNP) targeted services for teenage mothers, as part of an ongoing relationship with families and communities. A key finding from this Public Health Report is that children from every community in Cheshire East have a range of health needs. Variations and inequalities do exist, but not to the extent that *public health services* for children should only be provided in some towns and not in others.

From October 2015 the responsibility for commissioning health visiting and FNP services will move from the NHS to local authority public health departments. Clinical commissioning groups will remain responsible for commissioning midwifery and children's acute or hospital type services.

In order to fully support proportionate universalism in the Healthy Child Programme locally, the main commissioners in the Council, both Clinical Commissioning Groups (CCGs) and Police and Crime Commissioner must work together to reconfigure this local preventive work. This will be based on an understanding of need as described by the children and their families and the expert knowledge of midwives, health visitors and school nurses. The improvement in children's health that will be achieved in each area (or outcome) will be guided by an understanding of the wide range of social and environmental factors (in addition to deprivation) that affect children and their families. Some of these variations are illustrated in the Statistical Appendix to this Report. Understanding these are key to addressing need and improving outcomes for local children.

The Family's Role

Families, right from the start and even before birth, should be provided with the information they need to help keep their child safe, healthy and happy. The concept of an 'empowered' family, able to manage their child's ill health and address what is important to them and the child is described as 'family resilience' in the Annual Report of the Chief Medical Officer 2012.

The diagram below shows how families, alongside some professional services, can support the development of an emotionally and physically robust child. Although services such as health visiting play a part, the family is the first line of defence against ill health, both mental and physical, in children and young people. Often simple "personal prevention" tasks such as good hand hygiene can help protect against gastrointestinal conditions like diarrhoea and vomiting and respiratory

conditions such as cold and flu. A good diet and good oral health can have both short (healthy teeth) and longer term (reduced risk of developing diabetes) effects. Indeed the vast majority of the preventative measures that can help to keep a child healthy and happy are enacted through their family.

Alongside this, services, including the police, housing teams, Environmental Health Teams, health visitors and midwives all have a 'preventive' role to play by helping to improve the home or environment in which a child is growing up. It is well established that the wider determinants of health such as housing or transport can negatively impact on a child's health, but through a multiagency focus on achieving proportionate universalism the health and wellbeing of children and young people in Cheshire East will improve.

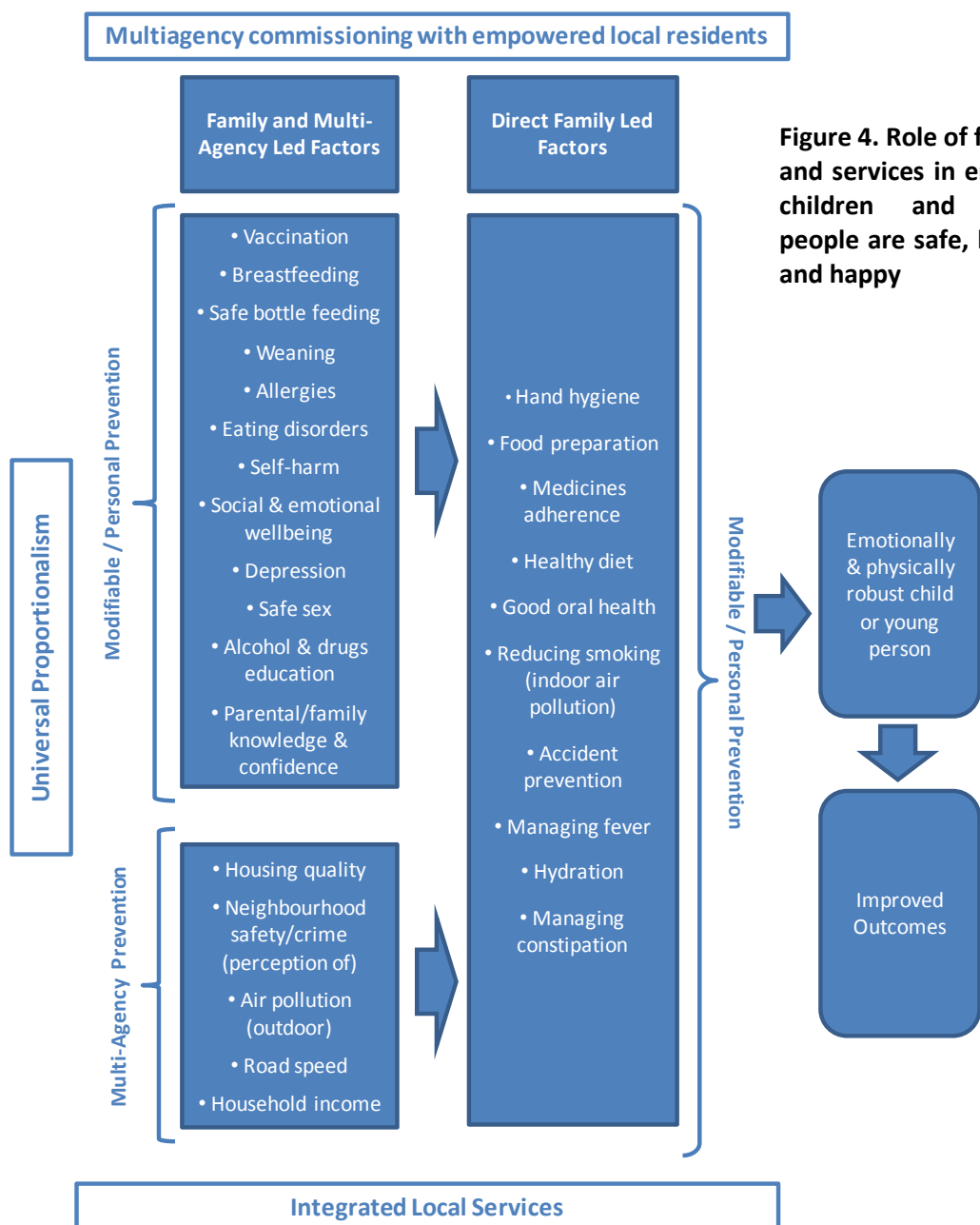


Figure 4. Role of families and services in ensuring children and young people are safe, healthy and happy

Key Points

Children from every community in Cheshire East have a range of health needs. Variations and inequalities do exist, but not to the extent that public health services for children should only be provided in some towns and not in others. Proportionate universalism, where universal action is taken but its scale and intensity is proportionate to the level of need in different areas, should be used to address the differences in need between areas and reduce the gap between them.

Cheshire East is a relatively affluent borough; nearly 55% of Cheshire East children live in areas that are among the 30% least deprived areas nationally. Yet this overall picture of affluence masks that 18% of the children in Cheshire East live in the most deprived 30% of areas and that these children experience worse health outcomes than their peers in more affluent parts of the borough. A number of examples of proportionate universalism show how Cheshire East can help to reduce the variation that exists within the borough:

- In October 2014, Cheshire East Council announced a fuel poverty initiative designed to help local residents and businesses buy their fuel at a competitively low cost. Although anyone in the borough can benefit, households in poverty have most to gain and should be supported to take part.
- The national Healthy Child Programme ensures that children and their families receive appropriate levels of care. All families receive 'your community' services and those with children aged 0-5 receive 'universal' care, but those families identified by midwives, health visitors or the Family Nurse Partnership as needing additional support receive more intensive support from these services (called 'universal plus' or 'universal partnership plus').

Families are pivotal to reducing ill health amongst children; they offer the first line of defence against ill health, both mental and physical. Further, local families need to be 'empowered' to enable them to keep their children safe, health and happy. Future developments are needed locally to support current work and continue to reduce the difference in need between local areas. This requires local commissioners to work together to reconfigure local preventative work, based on expert local understanding of need from those professionals working directly with families and children.

Chapter Two

Sure Start Children's Centres

The purpose of a Sure Start children's centre is to improve outcomes for young children and their families and reduce inequalities between families. These outcomes include child development and school readiness; parenting aspirations and parenting skills; and child and family health and life chances.⁵

Children's centres are a good example of proportionate universalism. They make available universal and targeted early childhood services either by providing the services at the centre itself or by providing advice and assistance to parents and prospective parents in accessing services provided elsewhere. The scope of the children's centre is very wide but it includes health services relating to pregnancy (and preconception care for subsequent pregnancies), as well as health services for young children up to the 31st August following their fifth birthday.

A children's centre is defined in the Childcare Act 2006 as a place or a group of places:

- which is managed by or on behalf of, or under arrangements with, the local authority with a view to securing that early childhood services in the local authority's area are made available in an integrated way
- through which early childhood services are made available (either by providing the services on site, or by providing advice and assistance on gaining access to services elsewhere), and
- at which activities for young children are provided

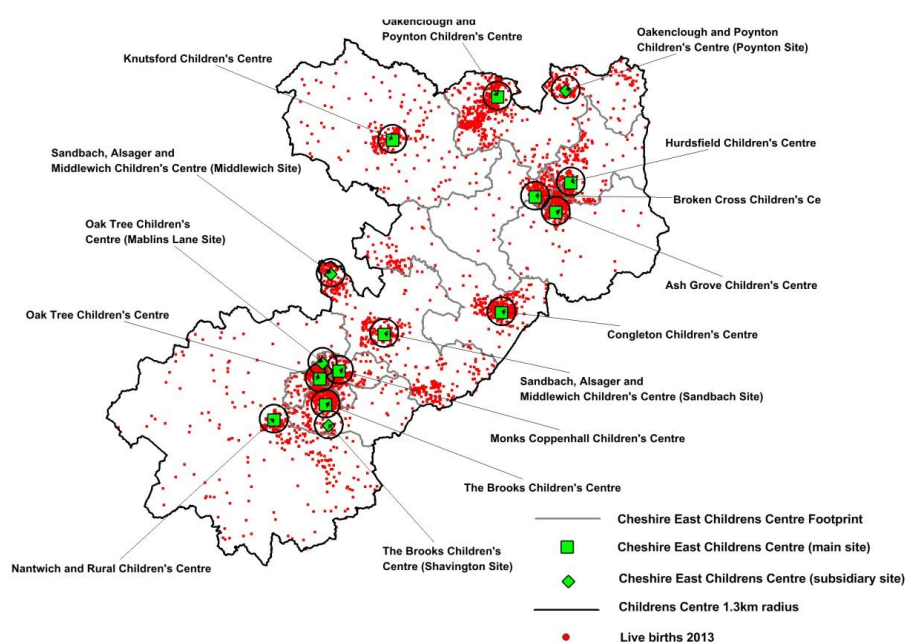
Children's centres were originally planned to be a physical building from which all services for families would be provided – a 'one stop shop' within pram-pushing distance from the family home. The model has changed due to national policy changes, reductions in national funding and the needs of the community. Many provide services at other locations, however the majority of services are still provided through the main local hub.

Cheshire East Council has eleven children's centres. They provide a range of clinical and peer support services all designed to improve health and wellbeing of parents and children. These include antenatal and postnatal care for women, well baby clinics, and support groups, for example breastfeeding groups and multiple birth groups, smoking cessation courses, baby weaning groups, support groups for new mothers with postnatal depression, eczema groups, baby massage groups, dads groups and messy play.

These activities and other services such as play sessions are spread throughout the day and week.

Map 1 illustrates that several medium-sized towns and many rural villages may be some distance away from the main children's centre's building which covers their area. These include Alderley Edge, Alsager, Bollington, Disley, Goostrey, Holmes Chapel; Wilmslow and Nantwich and surrounding rural areas. In these areas, families and babies with higher needs, and those rural families without private transport, may require extra support to be able to access their children's centre.

Map 1. Map showing the location of Cheshire East Children's Centres with a 1.3km radius, their footprint, and births in 2013



Children's Centres in Rural Areas

Deprivation is a key indicator for the positioning of a children's centre and helps them identify those families who can most benefit from their services. Whilst deprivation is usually seen as an urban issue, rural poverty is real,^{6,7} but it is often hidden and unacknowledged. Statutory guidance, published in April 2013, for Sure Start children's centres highlights that the reduction of child poverty should be a priority for local authorities, commissioners and the leaders of children's centres.⁸ It is important therefore that the needs of families in Cheshire East's rural communities are recognised in the planning of services at or from local Children's Centres.

The Commission for Rural Communities reports that for the majority of parents in rural areas who have cars, internet access, a reasonable income and friends and family close by, the disadvantages of living in a rural area are regarded as occasionally troublesome but no more than that. But for a minority, the disadvantages are very significant, causing some of them to miss out on primary health care, continuing education, the opportunity to have social relationships, childcare and employment.⁷

The Evaluation of Children's Centres in England Report (2013)⁹ looked at how far users or potential users travelled to the children's centre. Overall most centres' users live nearby with the average distance travelled being just less than 1.3km. This figure is based on the 'crow flies' distance, rather than actual travel distance or travel time but gives a general level of magnitude. Nationally 78% live less than 1.5km from the centre, 61% less than 1km and less than 5% of users are likely to live more than 3km from their children's centre. In Cheshire East, these 5% are likely to be from rural communities.

Although the majority of births in Cheshire East are to women living in urban areas, nearly a fifth of all births (18.7%, 751/4013) in 2013 were from rural areas (Map 1). The 2011 census shows that in the rural communities of Cheshire East 2% of residents aged 0-15 have no cars or vans in the household and 20% have one car or van in the household. With the latter category, it can be

assumed that the car or van would usually be used by the member of the family who was going to work, so it would not be accessible during the day to family members at home. It is therefore likely that parents in most need in rural areas in Cheshire East may not have ready access to private transport during the day.

In addition public transport in rural areas of Cheshire East is limited. The design of some buses are not suitable for prams or young children and the timetables will not necessarily coincide with the timings for sessions at children's centres. This leaves the most vulnerable rural families isolated from services that should be supporting them.

In a 2012 evaluation of children's centres services, managers of rural children's centres spoke of particular problems with transport and long distances between services. They highlighted the importance of play/outreach buses going out into rural areas which other transport did not reach; this was described as particularly important in addressing social isolation.⁹ Indeed other local authorities with similar rural geographies have tackled this issue. Cumbria has large numbers of children's centres (29) with satellite centres in village halls. Lincolnshire County Council uses mobile toy buses and clinics,⁶ and the Ilfracombe children's centre has developed a "Tiny Travellers" transport scheme using volunteer drivers who are trained and CRB checked.

Summary

Although the greatest level of need is found in urban centres such as Crewe where high numbers of children and young people live within the most deprived deciles, the needs of those families living in deprivation and isolation in rural areas should not be ignored. Coordinating activities on particular days or sessions (morning/afternoon) may help to increase access to children's centres' services by making the travel justifiable to families living in rural communities. However, some families will still be unable to attend due to lack of transport, so additional activities and infrastructure (such as play buses) are still needed to bring the services to these families. Currently there are a few examples of outreach sessions at some of the children's centres serving the rural communities, but the number of these and their locations should be reviewed. The Health Sector need to engage with the development of community hubs across Cheshire East, which includes work to address rural needs looking at maximising the potential of existing community assets and better use of mobile services to our rural communities. Using proportionate universalism as a basis will help recognise the needs of families in Cheshire East's rural communities and identify what alternative provision may need to be made to reach these isolated families.

The Role of Children's Centres in achieving Health Outcomes

Children's centres are able to provide health services from preconception advice to support for the child up to five years of age. All eleven children's centres host health visitor clinics (though not at all sites) and the majority host midwifery-led antenatal care clinics, with about half also hosting midwifery-led postnatal care clinics. However, these clinics, as alluded to earlier, are not always joined-up with the provision of other services, such as peer-led breast feeding support in the centres.

The five health outcomes that are specifically identified in "An Equal Start: Improving outcomes in children's centres"¹⁰ are:

- fewer children born with low birth weight
- fewer children with high or low Body Mass Index
- fewer mothers smoking during pregnancy

- more mothers who breastfeed
- increase in the number of parents with good mental wellbeing

However, local needs assessments and the analyses in this report suggest that in Cheshire East at least two other health outcomes should be added to this list (see chapters four and five for further information). These are:

- fewer children exposed to household cigarette smoke (chapter four)
- fewer children experiencing serious unintentional injuries during the first three years of life (chapter five)

In order to monitor the improvement on health outcomes, we need good information on children's health. Maternity, child health, general practice and hospitals already capture data on a wide range of children's health outcomes. Much of this information is published at community level in statistical indicator sets. Children's centres do not need to gather this information again.¹¹ With the mother's permission local NHS Trusts are able to share details of live births with children's centres.

Children's centres should use the information to target limited resources on children and families where there is a risk of good health outcomes not being achieved. Commissioners need to track these outcomes and monitor the services, ensuring they are available in the right places for those who need to access them, which includes a wide range of location (not all will be children's centres). Every children's centre has access to a named health visitor, who can work with the centre leader and management team to ensure that information about children is shared securely and used appropriately.

In addition, some children's centres deliver a diverse community programme, well in excess of the core role. As the centres are situated amongst the most disadvantaged communities in the Borough, there is scope to extend this role and become integral in the current planning for a community hub network for Cheshire East. The work which is currently delivered from some centres includes holiday play, adult education and self-esteem classes for parents, gardening and job clubs.

The centres are ideally placed to operate as community hubs as they already build trust and credibility within the local community through intensive family support. The extended role does not need to be delivered by family support staff but could offer an opportunity to engage the local community in contributing to a social enterprise. This model could run alongside the conventional children's centre programme but could utilise the centres on evenings and weekends for a number of community activities, thus generating income and making better use of the facilities. Other key partners who centre their work on these estates, such as neighbourhood and community development workers and Police Community Support Officers could be accommodated as part of the hub design.

This development could build stronger communities within disadvantaged neighbourhoods, offering training, support to return to work as well as social and recreational opportunities and could have a very positive effect on mental health and well-being. In addition, a vibrant local centre could also be well placed to deliver a range of additional conventional and 'out of hours' health services for adults including flu jabs, clinics, promotions and road shows and mental health support. Community pharmacies could also deliver outreach services.

An Eleven Point Plan for Improving Public Health Outcomes at Children's Centres

The planned changes to children's public health services provide a new opportunity to strengthen the role of children's centres in delivering the Healthy Child Programme. There is also some scope for children's centres to help to prevent many common childhood illnesses and injuries. This will require the main commissioners (local authority, both Clinical Commissioning Groups (CCGs) and the police) to work together to reconfigure the preventative work of the Healthy Child Programme, which can be consistently implemented across all of the children's centres in Cheshire East. It is recommended that children's centres are developed in the following ways in order to improve public health outcomes:

1. Increase the proportion of antenatal care that is carried out at children's centres.^c And develop links with midwifery, looking at the potential to share information to ensure we reach all those families we need to.
2. Cigarette smoking is particularly common among younger pregnant women aged under 30 and their partners. Specialist smoking cessation services (commissioned by public health) should be provided alongside antenatal clinics and new baby clinics.
3. Members of the Cherubs Team (Che(shire) Really Useful Breastfeeding Support) should be available at all new baby clinics to ensure all new mothers can access breastfeeding support particularly in the early days, weeks and months after birth (see Appendix A for more information on Cherubs).
4. Preconception care can reduce the number of babies who are exposed to risks during the earliest stages of their development, particularly from alcohol and smoking. There should be access to preconception advice for second and subsequent pregnancies from health visitors. Children's centres should help and support couples to receive alcohol counselling and advice, smoking cessation services and signpost to weight reduction if needed.
5. All children's centres should provide weaning advice to families which includes information on dental health for infants and children.
6. As children's centres become established as part of the antenatal pathway, they need an agreed approach to enable them to respond to midwives' and health visitors' assessment of which families and children are most able to benefit from support to improve their health, including those that have newly moved to the area. Children's centres must agree methods to track the outcomes that are achieved amongst these children.
7. As part of the development of Community hubs, children's centres should actively consider the needs of every new parent in rural areas who are not able to access the children's centre. Outreach activities in rural communities will always have to be proportionate to the level of need that exists at that time and, with advanced planning, children's centre activities should change to meet the needs of different groups of infants and young children.
8. Children's centres have a responsibility towards the health and wellbeing of all pre-school children. The evidence consistently demonstrates the positive effects of living in a safe and warm house on the health and wellbeing of children. Achieving a safe environment in every home to reduce risk of injuries and illness to young children should be a locally determined

^c By increasing the number of antenatal visits that occur at children's centres, families will be introduced to the centres and their services before the birth of their child. Families can be registered with the children's centre antenatally; thus more children and their families can benefit from the services available immediately from birth.

priority for children's centres activity. Children's centres should take ownership of the process to improve families' homes by coordinating families' access to relevant and appropriate services, based on needs identified by other partners (e.g. health visitors, midwives etc), and ensure work is completed.

9. Vitamin D supplementation has been recommended for all pre-school children, and pregnant women, to promote good bone health. The children's centres should actively promote vitamin D supplements to pregnant women and families with young children. Those families from more deprived areas should be encouraged to register for Healthy Start and make use of the free vitamins as well as the food vouchers. Alternative models of delivery may be trialled in a pilot to provide free vitamin D supplements for pregnant women and children under 4 within Cheshire East.
10. Children's centres should clearly understand the local position for all of the Public Health Outcome indicators that relate to young children, and they should be able to quantify all the actions that they take to achieve improvements in these indicators.
11. Children's centres could play a key role in engaging parents, families and the wider community in a range of health interventions and could provide a safe and trusted venue as part of a community hub.

Chapter Three

Pregnancy and Early Years

Experiences during the nine months of pregnancy can have lifelong effects on a child's growth and development. During pregnancy, due to the extremely rapid development of the baby's organs and structures of the body, the behaviours and living conditions of the pregnant woman can have profound effects on her unborn baby. Most body systems continue to develop throughout early and late childhood, so the quality of the child's environment (home, nursery and school environments) throughout its childhood will heavily influence the maturation of the child's body systems and its health as well as its social development. The impact of environments on children's health and wellbeing is discussed further in chapter seven.

Preconception Care

Preconception care describes the support available to women and their partners to enable them to optimise their health prior to pregnancy, thus providing them with the best chance of having an uncomplicated pregnancy and delivering a healthy baby.¹² As some women become pregnant through an unplanned pregnancy all women of childbearing age are encouraged to be healthy.

Antenatal care begins when pregnancy is confirmed. There are many common themes running through preconception and antenatal care.

The core themes of preconception care are:

1. Education on exposures hazardous to pregnancy – particularly avoiding alcohol and smoking, reducing excess weight, and not using illegal drugs
2. Improving the health of the mother – being vaccinated against rubella, taking folic acid and vitamin D supplements, and having regular exercise and a healthy diet
3. Improving maternal long term health conditions – including asthma, diabetes, epilepsy, heart disease, high blood pressure, mental health problems and obesity
4. Identifying couples at increased risk of having a baby with a genetic or chromosomal malformation – couples can seek advice from their General Practitioner and may be referred to a Genetics Clinician who will organise any necessary tests

An important part of preconception care is to avoid behaviours and exposures that may be hazardous to the developing baby during the earliest weeks of pregnancy. It should be possible for women to avoid their baby being exposed to alcohol or the chemicals in second hand cigarette smoke, but local data suggests that this does not always happen.

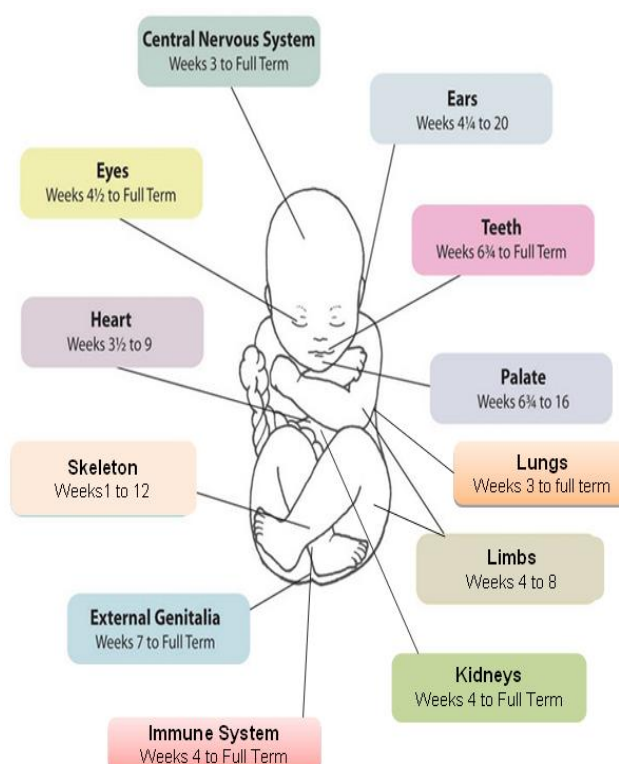
The particular windows of vulnerability are when the vital organs are developing, and these are illustrated in Figure 5. The most significant harms usually occur during very early life, which is when the major structures of the body are still being formed.

Figure 5. Fetal development during pregnancy

Folic Acid

There is strong evidence that folic acid supplementation (either alone or in combination with other vitamins) reduces the incidence of congenital malformations of the brain, spine, or spinal cord in the unborn infant. Couples who are planning a pregnancy can assess their risk of conceiving a baby with a neural tube defect. Couples are at 'high risk' if there is:

- A family history
- A relevant maternal medical history: if the mother is taking anti-epileptic drugs (which may affect folate metabolism), has diabetes at the start of her pregnancy, coeliac disease or a type of anaemia (haemolytic)
- Maternal obesity: if the mother is obese (defined as a BMI greater than 30kg/m^2), studies have shown an increased risk of 1.7 (95% CI 1.34 to 2.15) in obese women



All other women are at 'normal risk' of conceiving a child with a neural tube defect. The key message is that all women planning to conceive should take folic acid to reduce the risk of neural tube defects in their baby. Surveys of the knowledge and attitudes of low income women to folic acid supplementation have shown that many did not understand the serious nature of neural tube defects, or the role of folic acid in preventing this.

- Women at 'normal risk' are advised to take 400 micrograms of folic acid daily once they start trying to conceive and to continue this until the twelfth week of pregnancy
- Women at 'high risk' are advised to take 5 milligrams of folic acid daily once they start trying to conceive and to continue this until the twelfth week of pregnancy

Misuse of Drugs

The developing fetus is particularly vulnerable to the harmful effects of drug misuse. Women who are intending to conceive should be offered specialist support to reduce or stop their misuse, including contraceptive advice.¹² Those who have ever injected drugs should also be offered hepatitis C testing, as treatment is successful in clearing the virus in 40-60% of people and so hepatitis C treatment prior to conception can prevent the baby getting the infection.¹² Other strategies are used in pregnancy and labour to reduce the risk of transmission of HIV or hepatitis B from mother to baby and so all pregnant women are screened antenatally for these infections.

Antenatal Care

Most women will not be seen by a midwife until the twelfth week of their pregnancy. As Figure 5 shows, much of a baby's development takes place during the early weeks of pregnancy and so it is important that women take steps to protect the health of their unborn child from the moment they realise they are pregnant. For those couples planning a pregnancy it is hoped that preconception advice will have helped them change any lifestyle factors which may harm a new pregnancy and engage in protective actions such as taking folic acid and reducing alcohol intake whilst trying to conceive and once pregnant.

Overweight and Obesity

Obesity in pregnant women is linked to socioeconomic deprivation and poor access to maternity services. Being overweight or obese can reduce fertility, but if a woman becomes pregnant it can be associated with an increased risk of congenital anomalies (neural tube e.g. spina bifida, heart defects, cleft lip and palate), pregnancy complications (miscarriage, impaired glucose tolerance and pre-eclampsia) and delivery (as the baby itself may be large). Normal weight babies born to obese mothers are at increased risk of becoming obese themselves in later life.

It is estimated from national figures that about 5% of pregnant women are obese; in Cheshire East this equates to 186 women deemed to be obese during pregnancy in 2013.

The evidence recommends informing the woman of the increased health risk their weight poses to themselves and would pose to their unborn child, then supporting women who are overweight or obese to lose 5-10% of their body weight before becoming pregnant.

Smoking

Smoking whilst pregnant can increase the risk of miscarriage, stillbirth, premature birth and delivery of a low birth weight baby. Children exposed to tobacco smoke in the womb are more likely to experience respiratory illnesses in childhood.^{13, 14} The national Public Health Outcomes Framework recommends measuring if a mother smokes or not at the time of pregnancy; this is aimed at ensuring that local tobacco control activity is focused on pregnant women. The national Tobacco Control Plan contains an ambition to reduce the rate of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth).

In 2012/13, 575 mothers in Cheshire East were smokers at the time of their delivery. This represents 15.1% of all maternities, statistically worse than the England average of 12.7%. Some local authorities have smoking rates of just 2.3%, equivalent to 87 mothers in Cheshire East.

Although local data suggests that the smoking rate among mothers has reduced to 14.3% in 2013/14, there were also an additional 17.3% of maternities where another member of the household was a smoker. This means that 31.6% (approximately 1020 annually) of babies and young children are being exposed to tobacco smoke during pregnancy and from birth onwards.

In some parts of the Borough, very few infants are exposed to household cigarette smoke. In other areas over 35% of babies are exposed, including the rural areas around Sandbach, parts of Alsager, Congleton, Knutsford and Handforth, and southern parts of Macclesfield.

The most striking finding is that the highest smoking rates are concentrated in the town of Crewe, where an average of 45.5% (approximately 430 annually) of all babies are living in a household where one or both of their parents is a current smoker.

Figure 6 below shows household smoking rates decline with increasing maternal age. Three findings are of particular importance and will require significant coordinated action from midwives, health visitors and Children's Centres:

- Smoking rates are significantly higher in Crewe than the rest of the Borough in all age groups except for teenage mothers where the rates are (non-statistically) lower, possibly as a consequence of additional health initiatives in these families
- In all areas, household smoking rates are considerably higher where mothers are aged under 30 compared to those aged over 30
- Babies born in Crewe to mothers over the age of 30 are twice as likely to be exposed to household tobacco smoke than babies born elsewhere in the Borough to mothers over the age of 30

Map 2. Proportion of infants exposed to household tobacco smoke in 2013 (where either the mother or her partner smokes)

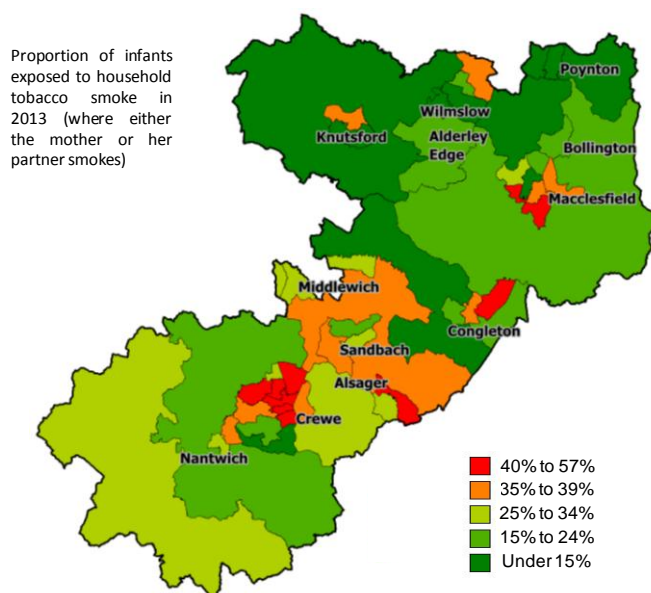
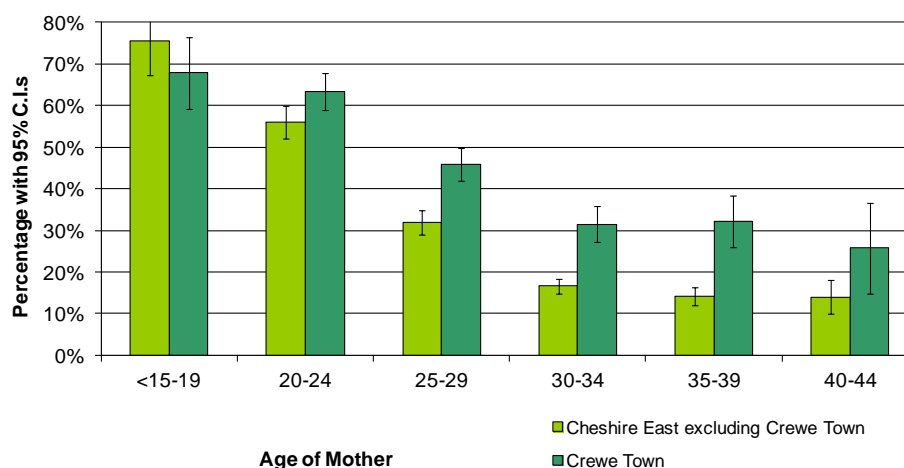


Figure 6. Proportion of infants exposed to household tobacco smoke, 2012-13 Crewe Town Area compared with the rest of Cheshire East



Alcohol

Statistics on alcohol use in pregnancy are not routinely collected, but national studies suggest that pregnant women are less likely to drink alcohol than those who are not pregnant; only one in ten pregnant women drink regularly during their pregnancy. However, there is a known association between smoking and alcohol use, and so alcohol consumption in pregnant women is also likely to be high in the areas and age groups shown above.

Alcohol crosses the placenta freely. Every time a pregnant woman consumes alcohol her unborn baby will develop similar blood alcohol levels to herself within a matter of minutes. This exposure to alcohol can have a variety of effects on the developing baby depending on the stage of gestation. Alcohol particularly disrupts the normal development of brain cells, and it can also cause physical abnormalities of the brain.

Babies are therefore at considerable risk of harm from levels of alcohol consumption that will only have a minimal effect on the long term health of their mother.¹² Women planning a pregnancy should not drink alcohol whilst trying to conceive, or during the first three months of pregnancy.^{12,14} During pregnancy, women can be highly motivated to stop drinking for the sake of their unborn child, and support and specialised advice can be offered to those who wish to reduce their drinking but feel unable to do so alone.

Prolonged and high levels of drinking during pregnancy can lead to Fetal Alcohol Syndrome (FAS), where the child has characteristic facial abnormalities, growth retardation, and brain damage that results in learning disability or behavioural problems.¹⁴ The full syndrome occurs in around 10 to 20 babies per 10,000 births – that approximates to four to eight babies in Cheshire East each year.

However, being exposed to prolonged or high levels of alcohol *in utero* does not always result in FAS. Some babies have no lasting effects, while others have partial manifestations of the disorder, most frequently lesser degrees of brain damage with little or no facial abnormality. The occurrence of any harm to the brain due to drinking alcohol during pregnancy is thought to be as high as one in every 100 births, which is equivalent to 40 babies in Cheshire East each year.

Other Exposures

Toxoplasmosis: The toxoplasmosis parasite lives in soil, raw meat and in cat faeces. Infection of the fetus causes miscarriage or congenital anomalies.¹⁵ Pregnant women should wear gloves when gardening, wash fruit and vegetables, and avoid changing cat litter (or wear gloves).^{12,15}

Vitamin A: A high intake of vitamin A (from high-dose multivitamin supplements or fish liver oil) can cause congenital anomalies.^{12,14,16} Pregnant women should be advised not to eat foods that are naturally high in vitamin A such as liver pâté, liver sausage or haggis.¹⁶

Home decorating: Pregnant women should not strip down old paint (painted pre-1970) to avoid inhaling lead in the paint dust. They should avoid using solvent based paints until after the 14th week of pregnancy, to lessen any risk of paint fumes or chemicals harming the baby.¹⁷

Over-the-counter medication: Women planning a pregnancy should check with a pharmacist that an over-the-counter medication is safe for them.

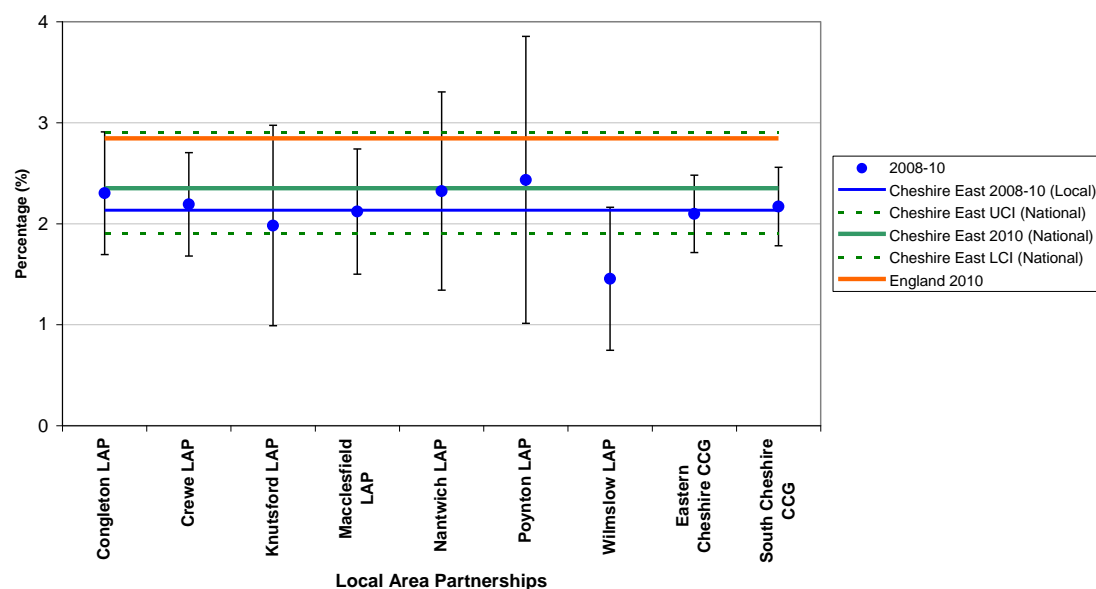
Herbal remedies: Herbal products (such as Wild Yam Root capsules or Red Clover Blossoms capsules) are not regulated, so there is little information about their safety immediately before and in the early stages of pregnancy.¹²

Low Birth Weight

A low birth weight increases the risk of developmental problems for the child and is associated with poorer health in later life. The occurrence of low birth weight (under 2,500 grams) among term births (those with 37 weeks or greater gestational age at birth) provides a way of comparing fetal growth between different populations. This is included as an indicator in the national Public Health Outcomes Framework in the context of measuring starting well through early intervention and prevention. It is also used within the context of addressing issues of premature death, avoidable ill health, and inequalities in health, particularly in relation to child poverty.

In Cheshire East, 93 babies were born with low birth weight at term in 2011. This represents 2.5% of all live births at term, which is lower than the England average of 2.8%. There is considerable scope for further improvement as low birth weight at term affected just 1.6% of babies in some Local Authorities in England. The chart below shows the locally calculated figures for Cheshire East and LAP areas for 2010. The numbers of babies are very small and there is little difference between LAP areas. Low birth weight at term is lower in the Wilmslow LAP although this is not statistically significant.

Figure 7. Low birth weight in term babies 2008-10



Optimising the Health of the Mother and Her Baby

Being a parent is a wonderful and challenging experience. Mothers care about the well being of their newborn but at the same time it is important to ensure that they are in good health themselves. First time parents often find adjustment to this new role coupled with some uncertainty about the general care of the baby an emotional and physical challenge.

Mother's Health

After delivery of the baby, the mother goes through a postpartum period which lasts about 6-8 weeks. During that time, the mother experiences physical and emotional changes, while learning how to adjust to the role of being a new mother. It is important that the mother takes good care of herself, and rests whenever possible to let her body recover and rebuild her strength. Newborn babies need to be fed, changed and comforted every 3-4 hours, which leads to disrupted sleep. Many mothers, especially first time mothers find the first weeks of motherhood particularly tiring. In many cultures and communities, families, friends and others have traditionally provided the new mother with support and help during this time.

Postnatal Depression

The experience of pregnancy, labour and delivery of the baby is overwhelming for many. Exhaustion of labour combined with hormonal changes in the body after delivery, can affect the mother's mental health. The mother may experience mood swings known as baby blues which normally lasts the first week after delivery. Baby blues is very common and affects about 8 out of 10 mothers. More distressing is postnatal depression which normally presents anytime after the second week

post delivery and affects 1 in 10 mothers. It is estimated that in Cheshire East during 2013, 374 women will have suffered with postnatal depression. The affected mother often feels tired, depressed, guilty, anxious and is unable to care for herself and her baby. A new mother should not suffer in silence and should be encouraged to talk to someone she trusts, such as her partner, family, friends, health visitor or her GP. Counselling can be offered through the GP and sometimes medications may also be helpful.

Mother's Diet

The mother's diet is key to ensuring recovery and healing after giving birth. Mothers also need to have a healthy and balanced diet to ensure adequate milk production if breastfeeding. A healthy diet for the new mother includes food rich in calcium, low-fat dairy products, vegetables, fruits and grains. It is common that mothers who breastfeed feel very thirsty while the baby is nursing. Fluid intake should be increased.

Breastfeeding

Newborn babies require good nutrition as their body grows rapidly in the first two years of life. Breastfeeding is the healthiest option for babies and has been proven to be beneficial in many ways. Breast milk contains the correct balance of nutrients needed for growth of the baby with a high concentration of fat and lower concentration of proteins. It is known that breastfed babies are less likely to have allergies or eczema than bottle fed babies. Breastfeeding also provides protection against respiratory and intestinal infections by transferring antibodies from mother to the baby.

Breastfeeding does not only benefit the baby but is also beneficial for the mother's health. Breast milk production is a natural process which occurs after delivery. The risk of developing breast and ovarian cancer later in life is reduced by breastfeeding. Breast feeding naturally uses up to 500 calories in a day and helps strengthen the bond between the mother and baby.

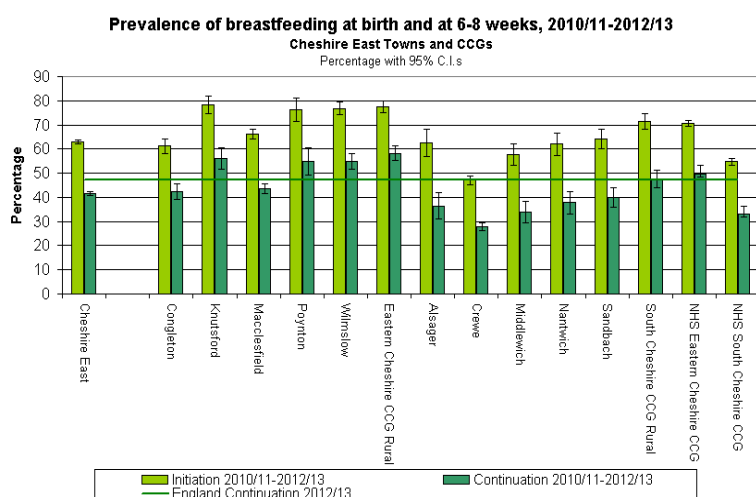


Figure 8. Prevalence of breastfeeding at birth and at 6-8 weeks, 2010/11-2012/13, Cheshire East Towns and CCGs, Percentage with 95% Confidence Intervals

Within Cheshire East, breastfeeding initiation at birth and continued breastfeeding at 6-8 weeks, differs markedly by area. Breastfeeding is less common amongst mothers in more deprived areas and amongst younger mothers. Babies who live in the least deprived areas of Cheshire East are twice as likely to be breastfed at birth as babies who live in the most deprived areas.

The difference is even more marked at 6-8 weeks when babies in the least deprived areas are three times as likely to be breastfed than those in the most deprived LAP areas (in Crewe only 29% of babies were still breastfed at 6-8 weeks compared to over 60% in Poynton and Knutsford). In the

three years 2010/11-2012/13, breastfeeding rates at 6-8 weeks were five times higher in Wilmslow Town South East (72.7%) than in East Coppenhall (14.1%).

Key Points

A healthy pregnancy should ideally start before conception. Preconception care enables women and their partners to optimise their health prior to pregnancy, thus providing them with the best chance of having an uncomplicated pregnancy and delivering a healthy baby. Women are encouraged to improve their health and avoid exposures that could be hazardous to the baby's health, such as alcohol and smoking. Preconception care is important as the most significant harms usually occur during the first few weeks of pregnancy, which is when the major structures of the body (skeleton, heart, kidneys etc) are being formed. As some women become pregnant through an unplanned pregnancy, all women of childbearing age are encouraged to be healthy.

Most women will not see a midwife until the twelfth week of pregnancy, thus it is important that women and their partners know that experiences in the womb can have lifelong impacts. It should be possible for pregnant women to avoid their baby being exposed to alcohol or the chemicals in cigarette smoke, but local data suggests that this does not always happen. Deprivation also influences the start in life that children receive in Cheshire East.

- 575 mothers in Cheshire East were smokers at the time of their delivery in 2012/13. This represents 15.1% of all maternities, statistically worse than the England average of 12.7%. Some local authorities have smoking rates of just 2.3%, equivalent to 87 mothers in Cheshire East.
- 31.6% of babies and young children in Cheshire East live in households with at least one smoker; they are being exposed to tobacco smoke during pregnancy and from birth onwards.
- In the town of Crewe an average of 45.5% of all babies are living in a household where one or both of their parents is a current smoker.
- In all areas, household smoking rates are considerably higher where mothers are aged under 30 compared to those aged over 30 (except for those with 'teenage parents').
- Approximately 4 to 8 babies each year in Cheshire East are affected by Full Fetal Alcohol Syndrome.
- Approximately 40 babies in Cheshire East each year experience some harm to the brain due to their mother drinking alcohol during pregnancy.
- Breastfeeding initiation is less common amongst mothers in more deprived areas and amongst younger mothers.
- At 6-8 weeks babies in the least deprived areas in Cheshire East are three times as likely to be breastfed compared to those in the most deprived LAP areas (in Crewe only 29% of babies were still breastfed at 6-8 weeks compared to over 60% in Poynton and Knutsford).

Chapter Four

Childhood Illness

Most children spend their childhood well, but are commonly affected by short periods of ill health. A small number of children may be disproportionately affected by ill health, and illness in the early years can affect their health and opportunities later in life. The wider determinants of health such as housing quality, poverty, indoor air pollution (smoking), poor diet and overcrowding will contribute to, or make worse ill health, particularly amongst children with long-term conditions such as asthma. Yet whilst lifestyles are of growing significance for long-term health outcomes, communicable diseases and unintentional injuries remain a major threat to the health of children.

This chapter will consider three groups of diagnoses – respiratory conditions, gastrointestinal conditions, and fever associated with viral infections. These three conditions account for 40% (5,335) of all non-injury attendances at accident and emergency departments (A&E) in Cheshire East in 2013/14 in children and young people aged 0-19. Of these attendances, 46% (2,477) relate to the 0-4 year old age group. These three conditions also account for 47% (3,485) of emergency admissions to hospital in 0-19 year olds in Cheshire East in 2013/14. Within this group 68% (2,378) relate to the 0-4 year old age group. As the youngest children are disproportionately affected by these conditions, much of the focus of this chapter will be on the 0-4 age group.

Within this chapter are examples of possible advice for families on some of the main causes for A&E attendance and hospital admissions among children and young people. These use the traffic lights key from the NHS 'Choose Well' campaign and are based on tested leaflets show-cased by the NHS Institute for Innovation and Improvement. They highlight when families should access A&E, but also illustrate when alternative management, from self-care to support from pharmacists, public health nurses or general practitioners, would be more appropriate. Such advice, if consistently and easily available and used, would help families to provide self-care to their children confidently and ensure they know where to go for help should they need it.

The majority of respiratory conditions, gastrointestinal conditions and feverish illness are preventable. Often basic prevention techniques such as good hand hygiene would help keep a child healthy.

Respiratory Conditions

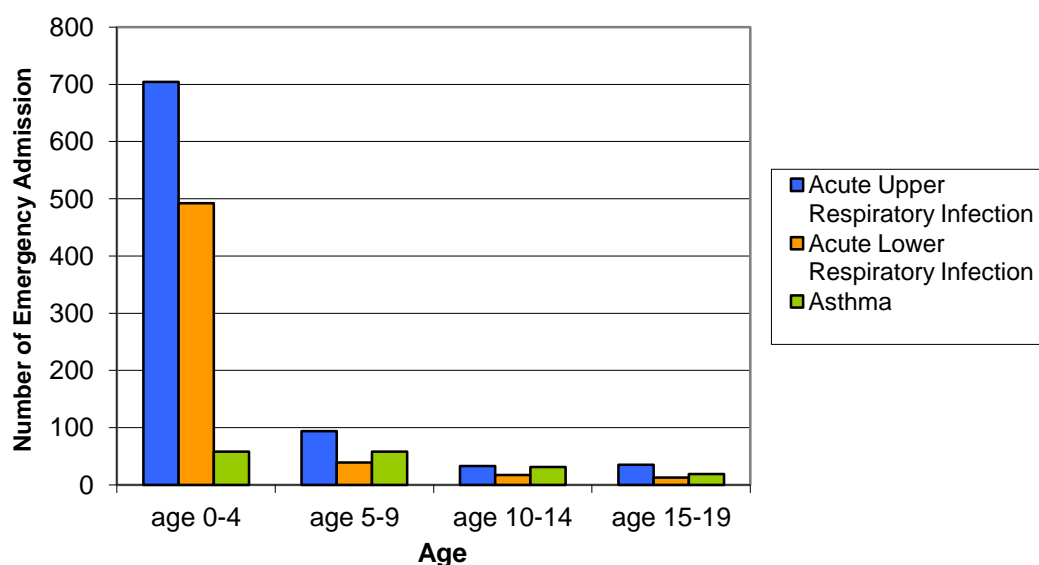
Respiratory conditions are particularly common among children, some of whom can catch between seven and ten colds each year. Most infections are due to respiratory viruses that spread easily from child to child because of their close proximity during play, social interaction and education. Young children are still learning how to use their hands or tissues to catch coughs and sneezes so this is not surprising. Environmental factors such as living in a smoky environment will also impact on the numbers of younger children experiencing poor respiratory health.

Infections of the upper respiratory tract (the nose, sinuses, ear tubes and throat) often lead to difficulties in breathing in very young children and may be very alarming to parents. In toddlers a respiratory infection may be followed by earache and fever which normally settles with medication.

Respiratory infections can also affect the lower part of the respiratory tract (the larynx, bronchial tubes and lungs) and are then associated with symptoms such as croup or wheezing. Lower respiratory conditions include asthma, bronchitis, bronchiolitis and pneumonia.

In Cheshire East, a total of 1,593 hospital admissions of children and young people aged 0 to 19 occurred during 2013/14 with conditions related to respiratory infections, including acute upper respiratory infection (866), acute lower respiratory infection (561) and asthma (166). This is equivalent to 2% of the total population of 0-19 year olds. The vast majority of those admitted for acute upper respiratory infection (81%) and acute lower respiratory infection (88%) were aged 0-4. This age group is disproportionately represented in admissions for these conditions; the equivalent of 6% of the 0-4 year old population was admitted for respiratory conditions in 2013/14.

Figure 9. Emergency admission for respiratory conditions in 0-19 year olds, 2013-14

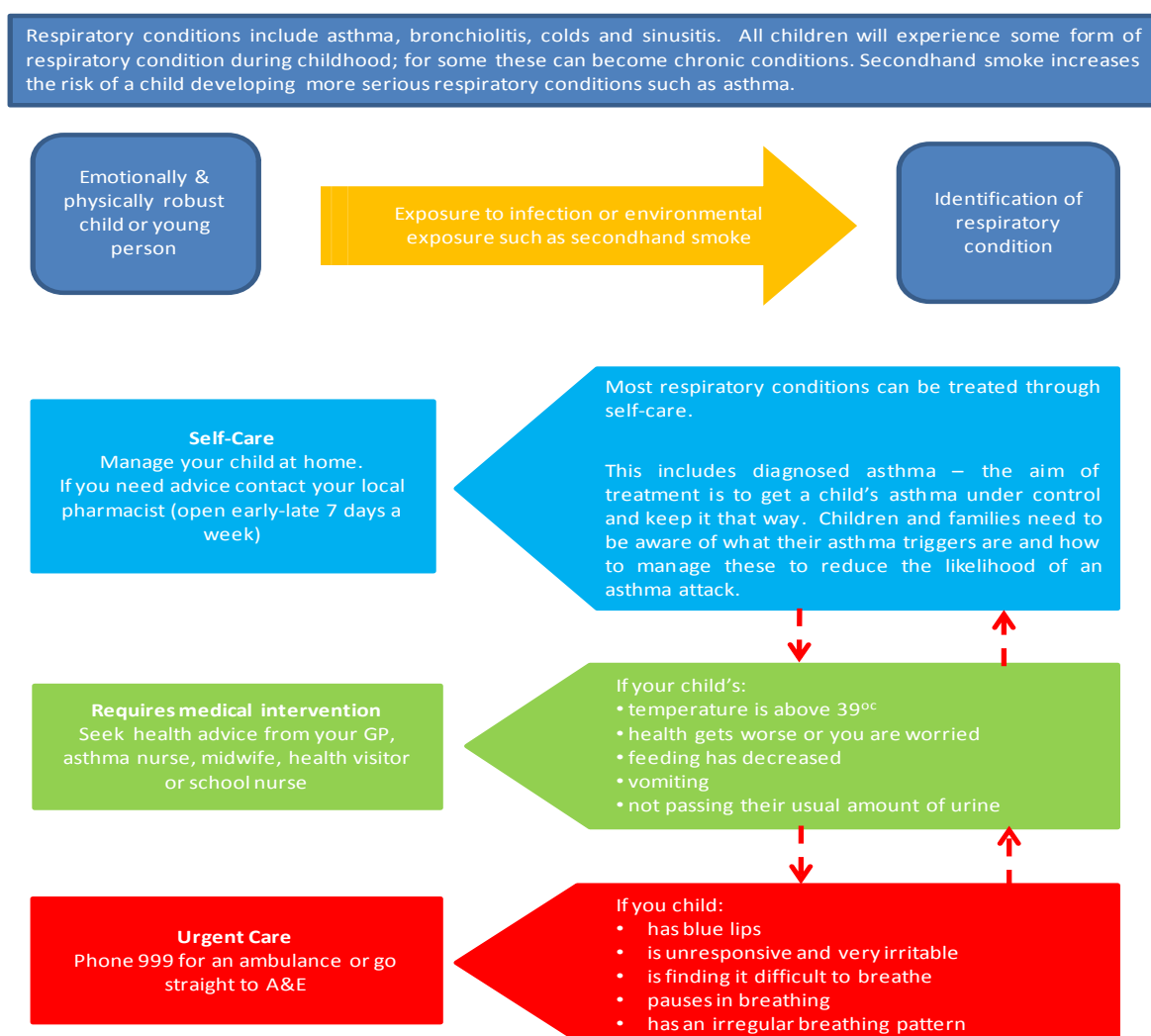


Many of these children, particularly those aged 5 upwards, presenting at A&E will have a previously diagnosed chronic respiratory condition. Ideally, children who have a pre-existing respiratory condition should not reach the stage where they are so unwell that it is necessary for them to be attending A&E. Their attendance often means that their condition was not appropriately controlled in the community. This could be due to a combination of factors including not always taking prescribed medication and a lack of knowledge and confidence around self-care.

Advice to Families

Parents, especially first time parents, will likely find the coughs and snuffled breathing of a young child or infant with a respiratory condition alarming. The illness may be relatively minor, but the symptoms can appear very serious. Providing parents with clear advice, such as the example leaflet overleaf (Figure 10), should help to reduce unnecessary attendance at hospital and increase self-care with community support if needed.

Figure 10. An Example of Possible Respiratory Conditions Advice for Parents



This advice is largely based on the leaflet ‘Bronchiolitis Discharge and Follow Up Advice Sheet for Children 0-2 years’ produced by NHS West Sussex Children & Young People’s Urgent Care Network

Chronic Respiratory Conditions

During the six years from 2008/09 to 2013/14, the number of children and young people on general practice chronic respiratory disease registers in Cheshire East increased by over 25%, and the figure currently stands at over 3,250 children which amounts to 4% of those aged 0-19 in Cheshire East. Many of them will take their respiratory problems with them into adult life.

Asthma is a common chronic respiratory condition; it is a serious condition that can lead to hospital admission if not appropriately treated. The aim of treatment is to get a child’s asthma under control and keep it that way. Asthma treatments are effective in most children and should allow them to be free from symptoms and lead a normal life. A child and their family should be shown how to recognise when their symptoms are getting worse and the appropriate steps to take. They should also be encouraged to draw up a personal asthma action plan with their GP or asthma nurse; this should be reviewed annually or more frequently if symptoms are severe or not well controlled.

It is important that children living with asthma and their families understand the specific triggers that may cause an asthma attack. These include an upper respiratory infection such as cold or flu, or exercise especially in cold weather, or coming into contact with an allergen such as dust mites or

animal fur and exposure to air pollution especially tobacco smoke. Living in poorly ventilated or damp homes can also exacerbate symptoms.

Prevention

All respiratory conditions are negatively affected by being in a smoky environment. Children growing up in homes with smokers are at greater risk of developing respiratory conditions (including chronic conditions such as asthma) than those in smoke-free homes. Second hand cigarette smoke causes damage to the protective lining of children's airways, and this makes it easier for viruses to enter and cause infection.

Exposure to second hand smoke is known to trigger the development of asthma and exacerbate symptoms; the prevalence of asthma increases with the number of smokers in the home. Parents and family members should be encouraged to stop smoking by others including by health and social care professionals. If parents or family members are unwilling or unable to stop smoking, the next best step is to at least make the indoor environment smoke free by encouraging parents to smoke outside. However, parents should be reminded that smoke remains on their clothes even if they smoke outside and so this step does not completely protect their children.

Gastrointestinal Conditions

Gastrointestinal conditions include diarrhoea and vomiting, abdominal pain and constipation. These affect children of all ages, though young children are often most at risk of becoming unwell from gastrointestinal infections due to poor hygiene practices and a lack of naturally acquired immunity.

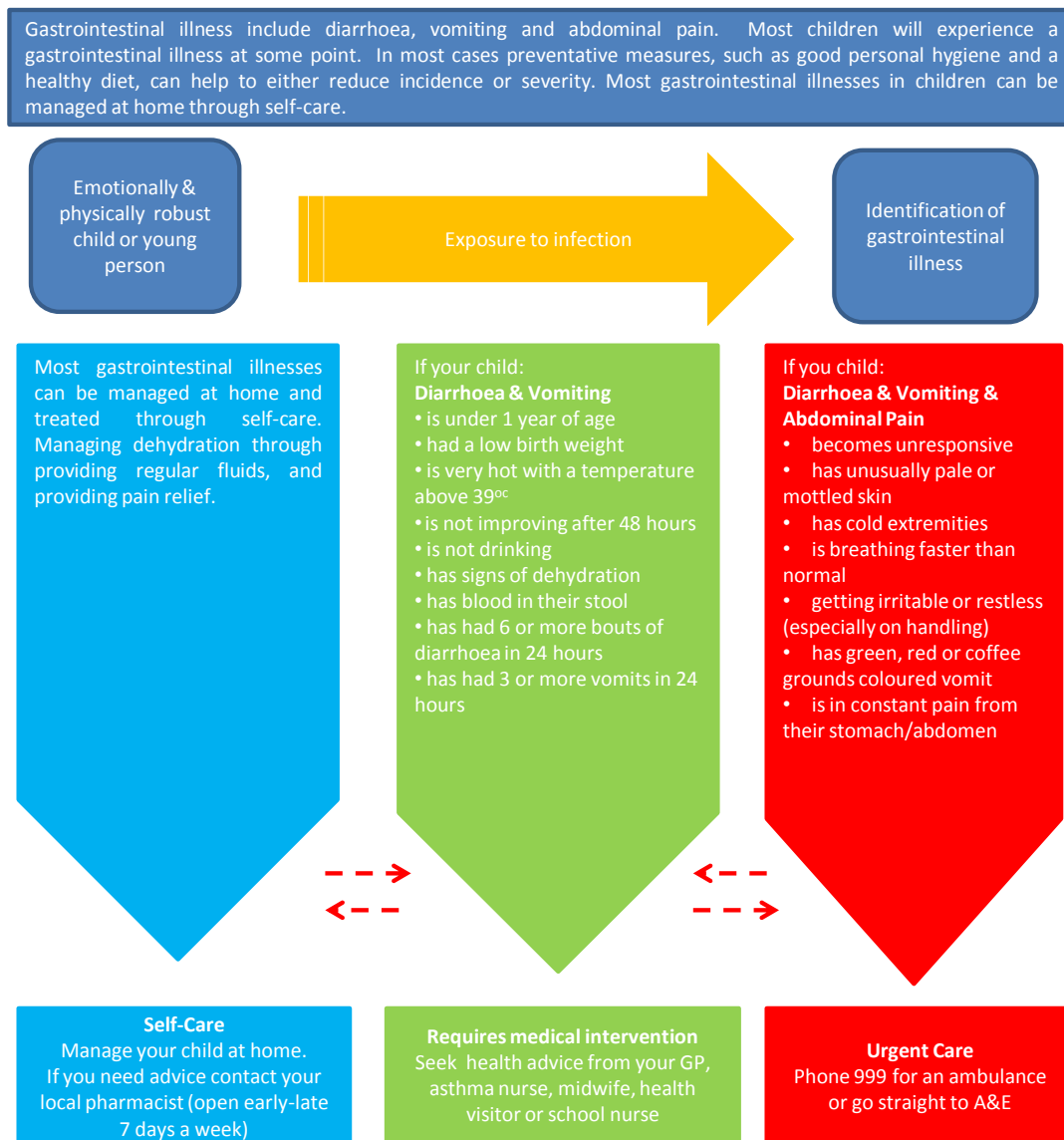
Four percent of all A&E visits (894) in children and young people aged 0-19 in 2013/14 were for gastrointestinal conditions, with 21% of this in the 0-4 age group. Whilst the overall percentage is relatively small, it contributed to nearly one in ten emergency admissions to hospital in this age group. Thirteen per cent (988) of all emergency admissions to hospital in children and young people aged 0-19 in 2013/14 were for gastrointestinal conditions. Of that number, 39% of admissions were in children aged 0-4.

Prior to 2013 around half of all gastroenteritis in children under five years was due to rotavirus infection. In 2013 a rotavirus vaccination was introduced in England for young babies, given as oral drops at age 2 months and 3 months. This highly effective vaccine is providing protection to the youngest children in Cheshire East against this extremely contagious virus.

Other causes of gastroenteritis include food poisoning. Between 2010 and 2012 there were on average 107 confirmed cases annually of food poisoning in children and young people aged 0-19 in Cheshire East. Nearly half of these (44%) were in children aged 0-4. Around a half of all confirmed cases were caused by campylobacter, and a further fifth due to salmonella.¹⁸ This will be a small proportion of the true number of cases actually experienced in the community as many episodes of diarrhoea and vomiting are either not reported to a doctor or samples are not taken to find out the cause.

Most gastrointestinal conditions will not be a serious illness and can be safely managed at home with over-the-counter medicines or oral rehydration solutions from the local pharmacy if necessary. However, some children may become more unwell and may require hospitalisation to manage serious dehydration.

Figure 11. An Example of Possible Gastrointestinal Illness Advice for Parents



This advice is largely based on the leaflet 'Diarrhoea and Vomiting Advice Sheet for Parents and Carers of Children 0-5' by NHS Nottingham and 'Gastroenteritis in children < 5 yrs – Patient information for Acute Gastroenteritis' by NHS Worcestershire Acute Hospitals NHS Trust

Prevention

Most infectious gastrointestinal diseases are transmitted via the faecal-oral route. Therefore, good hand hygiene and food hygiene practices (measures to avoid cross-contamination, appropriate storage and cooking of food) are particularly important to prevent their occurrence and spread. Families whose child is unwell should ensure potties and toilets are disinfected (including the handles and seats) after each bout of diarrhoea. Adults should wash their hands after changing nappies and younger children should be helped to wash their hands properly after using the toilet. During an episode of illness, particular attention should be paid to avoiding sharing towels and cutlery between family members.

Infants are more likely than older children to experience more serious symptoms due to gastrointestinal conditions. However, breastfed babies are less likely to experience these conditions than their bottle fed peers. Families who are bottle feeding must ensure that bottles and water are

properly sterilised to reduce the risk of infection. It is recommended that new babies should be breastfed and vaccinated against rotavirus to provide them with the best protection against gastrointestinal infections.

Feverish Illness in Children

Fever is a common presenting complaint in children and can cause anxiety for parents and carers. Between 20% and 40% of parents report their child has a feverish illness each year. Fever is an elevation in body temperature above the normal daily variation. It is typically defined as a fixed body temperature $\geq 38^{\circ}\text{C}$. Fever may be caused by a number of infections, the most common one being self-limiting viral infection such as an upper respiratory tract infection. Most children with fever will recover quickly and without any problems. As fever is a symptom of infections rather than an illness in its own right, data is not recorded for children or young people who present to A&E with a fever. We can assume that those children who presented with a 'diagnosis not classifiable' may have also had a fever as it is a common symptom of many illnesses particularly in younger children. Again, children under five account for the largest single proportion (46%) of all 0-19 years attending A&E with this diagnosis in 2013/14.

Babies less than 3-6 months of age rarely have fever and if present, fever can be a sign of a serious underlying illness. Temperature $\geq 38^{\circ}\text{C}$ in babies under 3 months of age and temperature $\geq 39^{\circ}\text{C}$ in babies between 3 and 6 months of age should be reviewed by a healthcare professional.

A high body temperature in children can be due to overheating as a consequence of being overdressed, during teething and following vaccination. Fever in these cases is rarely significant and can be easily managed with simple interventions at home.

Management of Fever

Most children with fever can be cared for at home. Over the counter medicines such as paracetamol and ibuprofen can be helpful. They help to lower the body temperature and make the child more comfortable. Paracetamol and ibuprofen should not be given at the same time and parents should only alternate these medicines if the child has not settled with the first one. Parents should check and administer only the recommended dose for their child's age at the intervals stated on the packet.

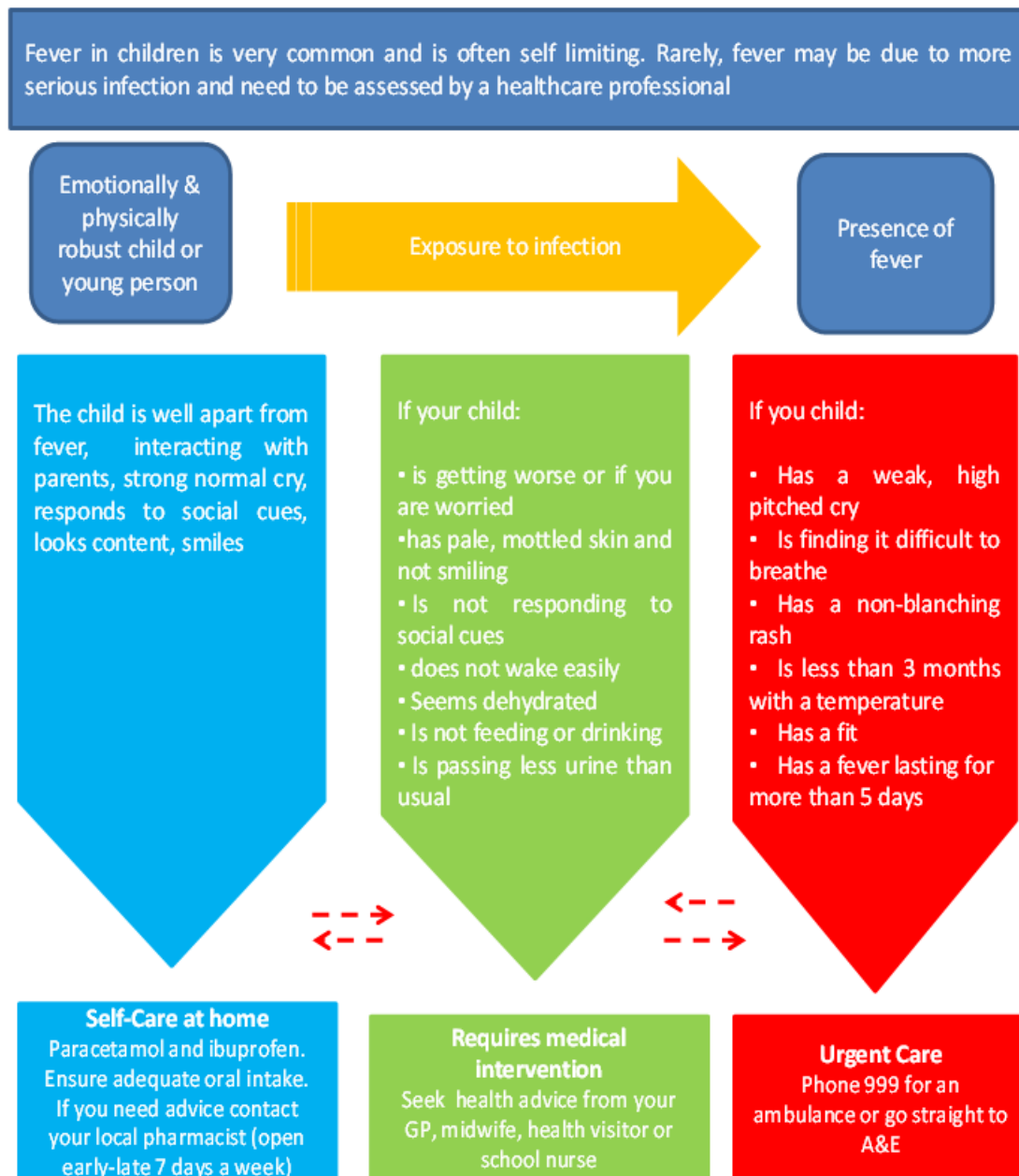
It is important to keep the child hydrated and encourage the child to drink breast milk, bottle milk or clear fluids. Parents should look out for signs of dehydration such as dry mouth, absence of tears, sunken eyes, or sunken fontanelle (soft spot on a baby's head). If parents are concerned that any of these signs are present they should seek assistance from a healthcare professional. Parents are also advised to keep the child off school or nursery if they are unwell with a fever.

Parents should be educated that fever is a natural and healthy body response to infection. By increasing the body's temperature, fever makes it more difficult for the bacteria and viruses that are causing the infection to survive. Despite the common misconception, NICE¹⁹ recommends that children with fever should not be over or under dressed. Sponging children with cold water is not advised as cold water makes the blood vessels under the skin narrower and the heat is trapped inside the body. This reduces heat loss and can make the child worse. Providing parents with advice regarding these simple measures can help decrease the number of hospital admissions.

Parents should always be advised to seek medical attention if the child develops a non-blanching rash (a rash that does not go away with pressure), or has a fever lasting for more than 5 days, or

develops a fit, or if parents are concerned that the child is not getting better and are unable to look after the child.

Figure 12. An example of feverish illness advice to parents



This advice is largely based on the NICE clinical guideline 160 'Feverish Illness in Children' and on 'Fever Discharge and Follow Up Advice Sheet for Children 0-5 years' by West Sussex Children & Young People's Urgent Care Network

Minor Illnesses

Children and young people are frequently affected by a wide range of minor illnesses and health problems. Some of these can lead to children becoming quite unwell for short periods of time. If parents are not confident about managing these illnesses, or if they cannot readily access help and support in the community, they may seek help from their general practitioner or sometimes from an

accident and emergency department. Many illnesses will get better without any specific intervention or treatment, although over-the-counter medicines can help to control symptoms such as pain, fever and itching.

The “Think Pharmacy” Minor Ailments Service

In a move towards increasing self-care and the use of community health resources, NHS Eastern Cheshire and NHS South Cheshire Clinical Commissioning Groups (CCGs) have recently commissioned a “Think Pharmacy” Minor Ailments service that can provide advice and treatment for a wide range of minor illnesses and health problems that commonly affect children and young people. Under the “Think Pharmacy” Minor Ailments service, a community pharmacist can assess the child and supply a range of medicines that would normally need a prescription. This means that if the parent is worried about the symptoms or if things are not getting better, they can go to any community pharmacy for advice rather than having to make an appointment at their surgery. In Cheshire East pharmacies are open much longer hours than GP surgeries including early morning, evenings and weekends.

How does it work?

- People can visit any pharmacy without an appointment for advice and treatment
- The consultation will always be confidential with a qualified pharmacist in a private room
- Consultations are always free, regardless of whether the pharmacist provides any treatment
- Prescriptions are free for children under age 16 and young people aged 16, 17 and 18 in full time education, but otherwise the medicine will cost no more than the prescription charge

A Pen-picture of some Minor Ailments

- **Oral Thrush**

Oral thrush affects around one in 20 newborns. Babies with oral thrush may refuse breast feeding or become quite irritable when feeding. It usually resolves within seven days without any treatment but medicines can be used if the thrush fails to resolve or the baby is unwell. Breast feeding mothers can be given advice on breast feeding hygiene.

- **Impetigo**

Impetigo affects around one in every 35 young children each year. Without treatment it usually resolves within 2-3 weeks, but medicines may be needed if it is severe, extensive or slow to resolve. As impetigo is contagious, children should wash their hands regularly and avoid scratching the crusts. They should not attend school or nursery until the crusts have healed.

- **Eczema (affects around 14,600 children and young people locally)**

Eczema may be continuously present or come in cycles (flare-ups). It can improve over time, but asthma and hay fever can also develop. Young people with eczema should know how to avoid triggers and treat flare-ups. First line therapy involves applying a moisturiser regularly and liberally on dry skin. A short course of steroid cream can bring acute symptoms under control.

- **Acne (affects around 29,500 young people locally)**

Acne is a common skin condition that usually starts in puberty and affects most young people. It can vary greatly in severity and the young person's perception of the problem usually influences whether they will seek help for it. Good skin self-care can be supplemented with medicated gels or creams, although improvement can take several months to occur.

Improving the Management of Minor Illness

It is important that the work already undertaken locally is built upon. Consistent advice must be provided to families and young people by the different services (health, education, social services, etc) to help them to recognise and manage minor illnesses when they occur.

The promotion of information and advice through mobile phone apps, web-based resources and printed materials needs to be co-ordinated and targeted towards the illnesses and injuries that the child is most at risk of experiencing, based on their age and household circumstances. The Public Health team in Cheshire East is developing this preventive advice in conjunction with both CCGs, and it is intended that Health Visitors will use such resources to educate parents of children under 5 about managing common childhood conditions. Ideally advice and information would be provided as part of a preventative approach, but in some cases it may be provided retrospectively to help a family learn what to do, and what symptoms to watch for, should they experience a similar episode again with their child.

The Cheshire and Merseyside Public Health Collaborative Service (CHaMPs) report 'Evidence Briefing: Delivering effective health services to children and young people' (March 2014) has highlighted that particularly for young people health and care services should use new cost effective technologies. The report suggests that health promotion and service delivery can utilise a variety of approaches such as websites, social networks, YouTube, email text messaging and through apps for smartphones. The services provided through these means can include service promotion, information and advice, health promotion messages or reminders. It can also be used to facilitate service user involvement and provide interaction and discussion as well as the monitoring and management of health conditions and wellbeing.

This may seem a daunting suggestion for some services, but "...something as simple as an online list of all the services that can be accessed in your area would help" (Chapter 4, page 4).² This is according to a young person from the Royal College of Paediatrics and Child Health focus group (which provided the views of young people in the Annual Report of the Chief Medical Officer 2012).

By improving the knowledge of local families and young people about the services available to them in their local community and how these can help them manage minor illnesses in either their children or themselves at home, will help to see a reduction in the number of children and young people attending A&E unnecessarily or being admitted to hospital for observation.

Future Arrangements for the Unwell Child

An emerging theme through this annual report is the need for the statutory agencies - NHS, local authority and police – along with the public, to commission integrated services which meet local need and improve local outcomes. Both South and Eastern CCGs are working with partners to deliver that vision. What would success look like for children and their families?

Here I share two stories of how families could be supported when their child becomes ill.

Imagine that it is the early evening, your three year old has a fever of 39^oC and is restless, they are coughing and you are worried about them. Or your four year old has had a few episodes of vomiting and diarrhoea and you are not sure what to do to help them. Or your teenager is complaining of bad stomach cramps. It is getting late so what do you do? Who do you call? Where do you go?

At the moment many families who call for help are advised to take their child to be assessed at their general practice or at the out-of-hours service. A home visit is no longer common practice. Despite reassurance the family is nervous about continuing to manage their child's care in their own home and may decide to take their child directly to the accident and emergency department. Many of the children and young people who arrive at hospital in the evening may be admitted to hospital for observation. The vast majority of these children are then discharged first thing in the morning because there is no need for them to be there and they can be treated and looked after perfectly well (and more suitably) in the community and at home. As a parent you have had to arrange for someone to look after the house and other dependents so you can stay with your sick child.

Moreover your fear that your child was seriously ill and needed medical intervention and an overnight stay has been confirmed, and next time your child has similar symptoms you won't hesitate to do the same thing. In fact next time you might just go straight to the hospital.

In Cheshire East, over the last ten years, there has been:

- a move away from assessment processes that are based in the community to high levels of direct access and usage of accident and emergency departments
- increased referral by general practitioners for specialist paediatric assessment
- children being admitted to hospital for what is often a very brief period of time

This has reinforced the tendency to take unwell children to emergency departments and to an overreliance on urgent care pathways, which means that too many children are being admitted to hospital for relatively minor conditions, which risks deskilling and reducing community support.

Now, imagine that an alternative community based service is available.

The worried parent calls during the evening. A primary care nurse or suitably skilled professional from the community paediatric team visits their home, examines the child, and explains to the parent that (s)he does not need to be concerned, that the symptoms they are seeing are normal for the condition the child has (a cold, diarrhoea and vomiting or constipation), and that (s)he can alleviate their child's distress by providing pain relief or oral rehydration. The nurse explains how long symptoms are likely to last, what is likely to happen next and about any warning signs that the child's condition is getting worse and that self-care in the home is not enough, which would mean that the child would need to go to hospital.

A health professional who you trust told you that you are doing a good job and can manage. You have all the information you need and know what is likely to happen next and what warning signs to look out for. Next time your child experiences something similar you will be able to cope by yourself. You are not overly alarmed as you know you can manage this episode of ill health and equally what to do should it get worse.

An Eight Point Plan for Increasing Self-Care for Minor Illnesses

Families should be able to manage common minor conditions affecting children and teenagers themselves. Many of these are self-limiting and do not normally require healthcare intervention, such as colds and other viral infections, oral thrush in babies and impetigo in younger children. Families should know how to manage a fever or diarrhoea and vomiting so that the child's condition does not worsen, or know when a bump to the head needs medical attention and when it does not.

But this change will only happen if local services and commissioners work together to improve the information provided to local families and young people and through this increase their confidence to manage minor illnesses through self-care at home. To aid this development, I am making the eight following recommendations to help bring about the changes we hope to see in the near future:

1. Midwives, health visitors and school nurses should include within routine care health promotion work to inform parents on how to manage their children's minor illnesses through self-care at home and where to go for advice within their community if they need it. Midwives, health visitors and school nurses are a trusted source of information and a vital link in helping to improve the confidence of parents and young people to manage minor illnesses themselves and with the support of community resources such as pharmacies. They should work with young people who are unwell (or families with an unwell child) to support them to manage minor illness through self-care at home.
2. General practices need to develop or improve systems that will provide quick and consistent advice and support to families with an unwell child. This may be through face-to-face consultations, leaflets or web-based/mobile communications. General practices should identify what the preferred method of communication is for their families with young children and young people (both via parents and independently of them) to ensure messages are easily accessible for these patients or their carers.
3. The CCGs, NHS England and public health team should work together to increase parental awareness of the advice and services available at community pharmacies, their locations and opening hours. It should be highlighted that community pharmacies are an appropriate 'first port of call' for families with a child unwell due to a minor illness and for young people with health concerns. It should be publicised that community pharmacies can provide private and confidential consultations on a range of health issues and can provide some prescription drugs without patients having to attend their GP.
4. The CCGs, children and families team and public health team need to work with schools to help them, and pupils, understand the importance of self-care in relation to health and wellbeing. Self-care for minor illnesses is an important part of growing up and is a key skill for later life. Empowering pupils to take control of their own health and wellbeing, will reduce absence from school and unnecessary hospital or doctor's appointments. Self-care can be about knowledge or can be very practical, for example, pupils with eczema being supported to use moisturisers at school.
5. The CCGs, children and families team and public health team should work with schools to understand the access needs of their pupils in relation to some health services. Schools need to recognise that independent access to pharmacy services (which are now providing a greater range of self-care advice and medication) after school may be difficult for young people who are brought to school on scheduled bus services from rural areas. Older teenagers should be allowed to access local community pharmacies during the school day to obtain health advice

and support for self-care, as it may not be possible for them to access these services at any other point.

6. General practices should consider the needs of children and young people in terms of accessing their services. They should be mindful that appointments during the day are disruptive to the child's education. General practices should provide early morning or late afternoon appointments for children and young people so that their education is not disadvantaged by having to leave school for appointments.^d
7. General practices should work to restore confidence amongst young people that their services are private and confidential. It was identified in the Annual Report of the Chief Medical Officer 2012 that many young people are concerned that their family's doctor (GP) not a confidential service and that their parents or family will be notified of their visit and the discussions they have with the doctor. Changing this preconception will help to encourage young people to access primary health care services rather than relying on other services, for example sexual health, which they perceive to be more 'anonymous'.
8. Services need to increase the methods and ways of communicating with young people in relation to their health and wellbeing. They should identify what technology local young people use and like, and ensure services use up-to-date technology that is compatible and liked by young people. Providers must have access to, and be familiar with, these technologies and methods of communication; training and support should be provided to staff if necessary and must include issues relating to online safety, information sharing and communication over the internet and other electronic devices.

Key Points

Whilst lifestyles are of growing significance for long-term health outcomes, communicable diseases and unintentional injuries remain a major threat to the health of children.

Most respiratory conditions, gastrointestinal conditions and feverish illness can be managed by parents. Though, in 2013/14, 40% of non-injury A&E attendances and 47% of all emergency hospital admissions amongst children and young people aged 0-19, were due to these three conditions. Often basic prevention techniques such as good hand hygiene would have helped keep a child healthy. Ensuring families can provide self-care confidently to their poorly child, and that they know where to go for help should they need it, will help to reduce the number of children and young people who attend hospital for these conditions.

To help families increase their use of self-care and community health resources, rather than relying on A&E services, the two local CCGs have commissioned a "Think Pharmacy" Minor Ailments service. This can provide advice and treatment for a wide range of minor illnesses and health problems (such as oral thrush, conjunctivitis, eczema and acne) that commonly affect children and young people. The minor ailments service enables community pharmacists to supply a range of medicines that would normally require a prescription. This means that families can access the required treatment for a minor ailment quickly and without needing a GP appointment.

In addition to the work already done by the local CCGs to help local families to increase self-care for minor illnesses, this chapter includes an eight point plan for further action. This recommends that

^d This was raised as a concern by children and young people in the Annual Report of the Chief Medical Officer 2012 (chapter 4 page 6). It also related to chronic condition clinics at hospitals as well as GP surgeries.

families should receive better information and support about managing an unwell child themselves from midwives, health visitors, GPs and school health teams. Schools should be supported to understand the importance of self-care for their pupil's health and the role that pharmacies play in promoting this. Work should be done to improve trust in, and access to, general practices by young people, including appointment times that do not disadvantage their schooling. All services should also improve their methods of communication with young people in relation to their health and wellbeing, particularly using technology used and liked by young people.

Chapter Five

Preventing Childhood Injuries

The new public health responsibilities for improving health and reducing health inequalities include two outcomes relating to childhood injury, which are:

- Reducing hospital admissions from unintentional and deliberate injuries for children and young people
- Reducing deaths from road traffic injuries

Partnership working across the public, private, voluntary and community sectors is essential in order to achieve these outcomes. The local priorities for each community need to be identified in conjunction with residents, and agreed with a wide range of services including health, education, social care, housing, police, and the fire and rescue service.

Approaches that empower parents and carers can embed home safety behaviours. For example, policies developed by parents at children's centres on where hot drinks can be consumed safely are more likely to be adopted by other parents than policies created by staff alone.

In her 2012 Annual Report on children and young people's health, the Chief Medical Officer made a powerful economic case for preventing unintentional injuries, and highlighted the need for more information about the wider costs and benefits of injury prevention to help local areas prioritise investments. She pointed out that injury prevention can be low cost, and it can provide a tremendous return for young children in terms of reducing preventable years of life lost and disability adjusted life years.

NICE guidance^{20,21} contains a range of approaches to prevent unintentional injuries among vulnerable children and young people. The guidance also uses the term 'vulnerable' to refer to the following groups of children and young people who are at greater than average risk of an unintentional injury:

- Children under the age of 5 years, in relation to unintentional injuries in the home
- Those over the age of 11, in relation to unintentional injuries on the road
- Children and young people who have a disability or impairment
- Children from some minority ethnic groups
- Those who are living in a low income family
- Those who are living in accommodation which may put them more at risk of injury, which includes multiple-occupied housing, and social and privately rented housing

Unintentional Injuries In and Around the Home

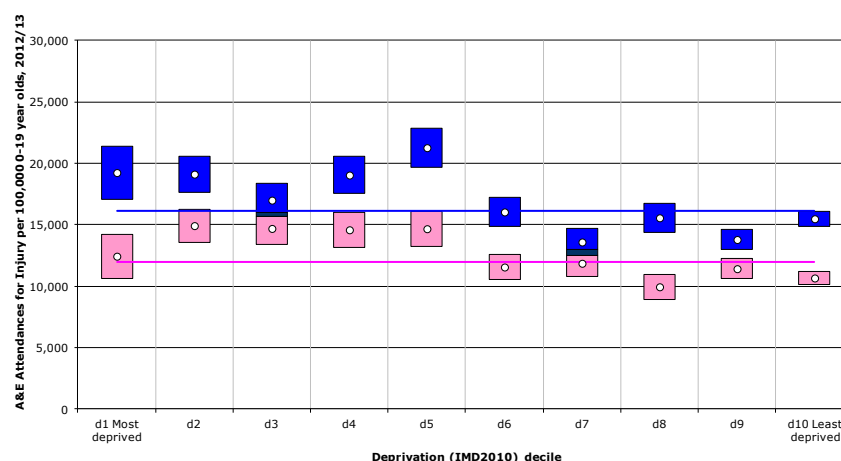
Unintentional injuries in and around the home are a major cause of ill health and serious disability for children, particularly for those aged under five.

In Cheshire East in 2013/14, a total of 2,380 children aged 0-4 years attended an accident and emergency department because of an injury. This is the equivalent of 12% of the population in this age group. Over the same period, 275 children aged 0-4 were admitted to hospital due to an unintentional injury. There is a strong relationship between the age of the child and the cause of injury, with around 65% of admissions in the under-five's resulting from falls and household knocks and a further 21% from burns and accidental poisoning.

High adult alcohol consumption, socioeconomic deprivation and maternal depression all represent important modifiable risk factors for burns and poisoning in pre-school children.²² Since these risk factors are generally known to primary care teams and health visitors, there is an opportunity to reduce injury risk by implementing effective preventive interventions.

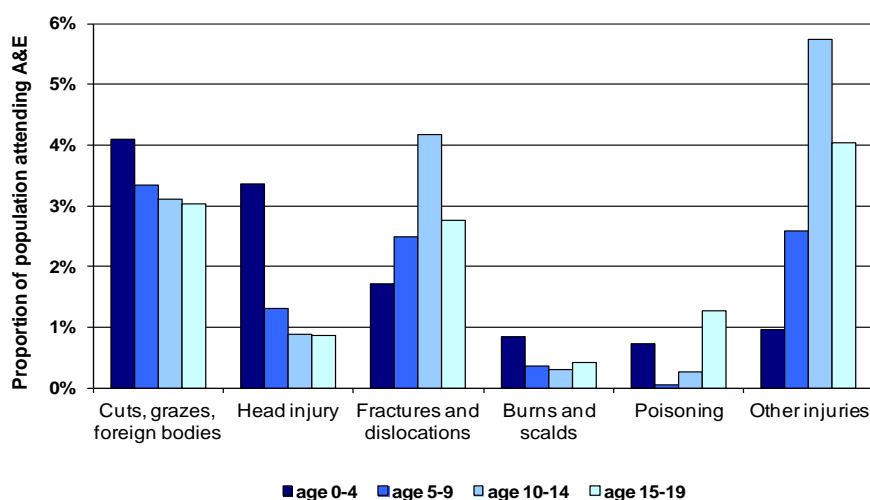
The risk of emergency admission is higher in more deprived areas in both genders, as shown in Figure 13. However, the higher than average attendance rates across the five most deprived deciles suggests that something other than the incidence of injury may be involved. The pattern may be reflective of accessibility of services and previous use of these services by the family.

Figure 13. Emergency admissions to hospital in children aged 0-4 in Cheshire East by deprivation decile, 2012/13



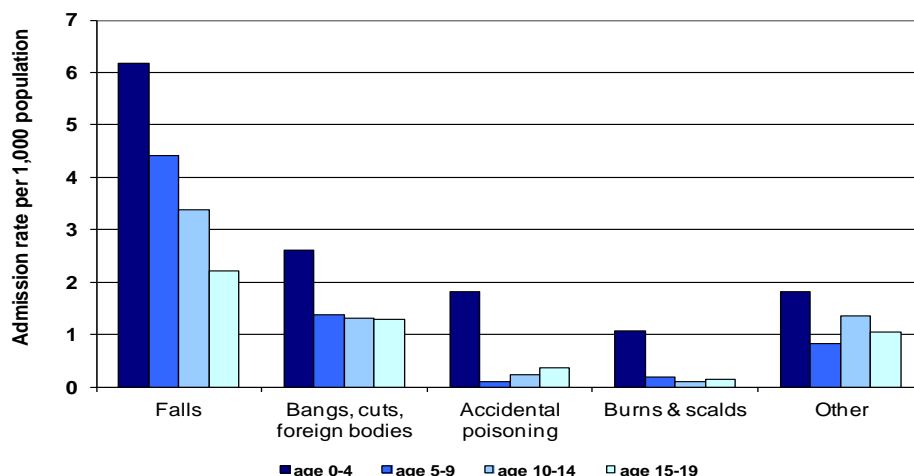
A&E attendances due to injuries in older age groups aged 10 to 19 are largely due to musculoskeletal injuries such as sprains, ligament and muscle injuries, and fractures and dislocations as Figure 14 shows.

Figure 14. A&E attendances due to injury, 2013/14



Though Figure 15 highlights that children aged 0-4 have the highest rates of emergency hospital admissions for all forms of injury.

Figure 15. Emergency hospital admissions due to injury, 2013/14



Amongst the 0-4 age range cuts, grazes, foreign bodies and head injuries account for over two thirds of all A&E attendances. These types of injuries are linked to a number of factors including child development, the physical environment in the home, the knowledge and behaviour of parents and other carers, overcrowding or homelessness, the availability of safety equipment and new consumer products in the home. Many of these injuries will have been caused by falls which account for nearly half of all emergency hospital admissions in this age group.

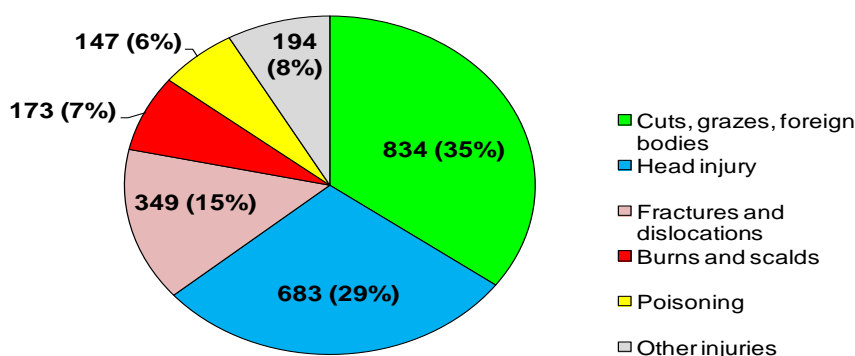


Figure 16. A&E attendances due to injury in 0-4 year olds, 2013/14

Head Injury

Some head injuries cannot be predicted or avoided – toddlers and young children are full of energy and have little sense of danger, and all children will at some point experience a bump to the head. But many head injuries can be prevented, and particularly the more serious ones.

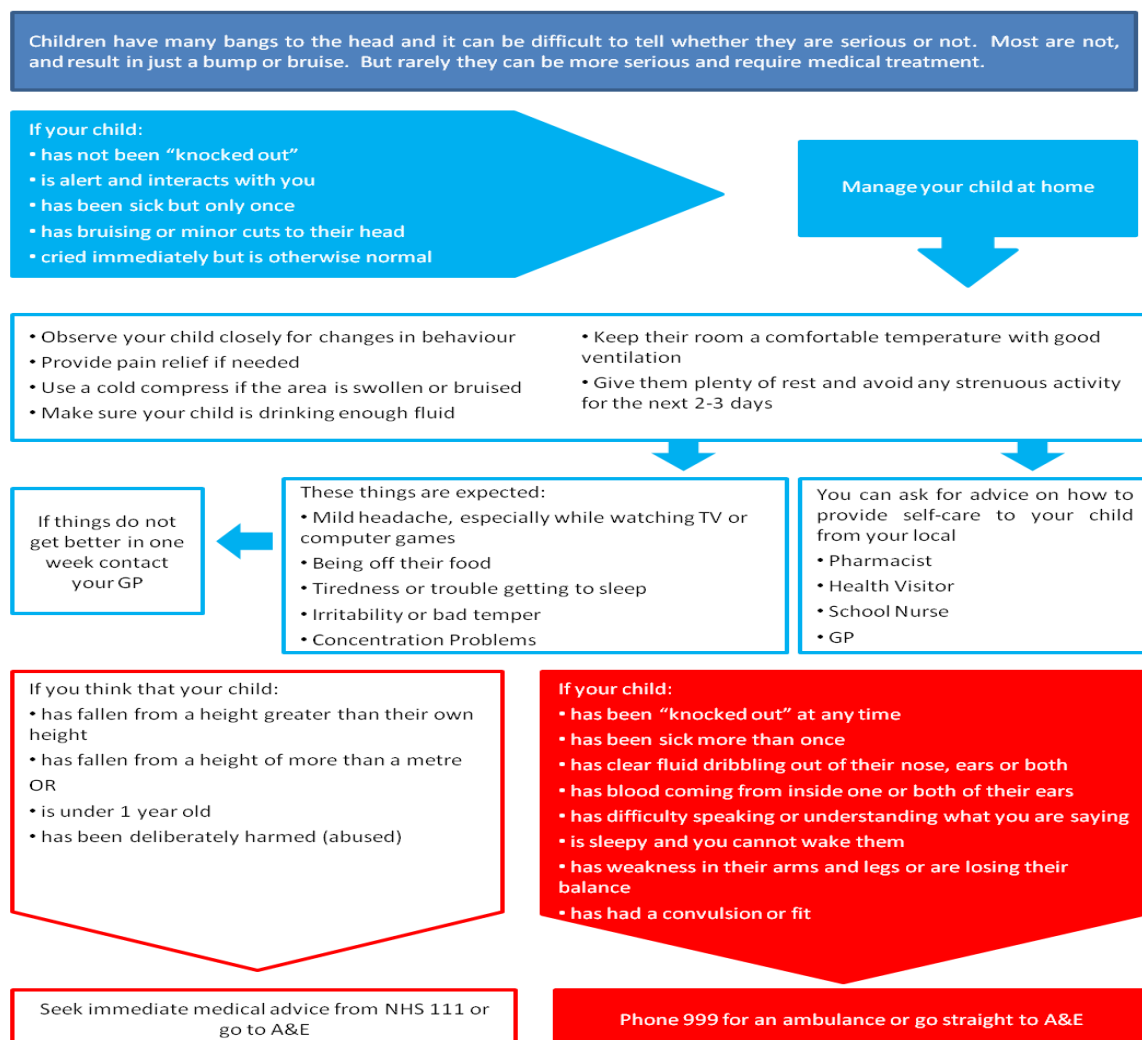
The Royal Society for the Prevention of Accidents²³ suggest that falls (a common cause of head injury) can be reduced by age appropriate ‘childproofing’ within the home including safety gates at both the top and bottom of stairs, removing trip hazards on the stairs, never leaving babies unattended on raised surfaces or placing baby bouncers on raised surfaces, or placing anything under a window which can be climbed on. Using cycle helmets for all family members and wearing

appropriate safety equipment when playing sports, particularly contact sports, will also help to reduce head injuries.

In Cheshire East, head injuries accounted for 1,323 (13%) of all the injury-related A&E attendances among children and young people aged 0-19 years in 2013/14. Over half (52%) of these head injury attendances were in children under five, particularly one-year olds. More than a third of the children who attended an accident and emergency department in Cheshire East with a head injury in 2012/13 required no investigation or treatment; they were sent home with advice and guidance. Their injury could have been successfully managed at home had their family felt confident they knew how to manage a head injury.

It is important that families are provided with the understanding as to what to expect following a minor head injury and what key signs to look out for which would indicate a deterioration in their child's condition necessitating a trip to hospital.

Figure 17. An Example of Possible Head Injury Advice for Parents



This advice is based on the leaflet 'Head injury advice for Parents' produced by NHS Brighton & Hove, Brighton & Hove Children and Young People's Trust and Brighton & Hove City Council

Figure 18 demonstrates the significantly higher level of A&E attendances in both males and females aged 0-4 in Macclesfield LAP, and males in Poynton LAP. Knutsford and Nantwich LAPs have significantly lower rates of attendance for both sexes, and Crewe LAP has significantly lower rates for males. The higher rates of attendance in Macclesfield could be a function of proximity to the A&E Department at Macclesfield District General Hospital. Rudge *et al* (2013) found a strong relationship between the rate of A&E attendance and distance from the A&E Department for children aged 0-14. For each additional kilometre from the department, attendances reduced by 2.2%²⁴. This effect was greater when deprivation was taken into account, with those in the most deprived income quintiles less likely to attend as distance from the department increased. This effect may partly explain why higher rates of attendance are seen in Macclesfield than in Crewe, where the level of deprivation, as measured by the Index of Multiple Deprivation (IMD) 2010 is greater. It is pertinent that the A&E Department at Leighton Hospital in Crewe is located some distance from the town centre, whereas the Macclesfield A&E Department is very central. Learnt behaviour and culture are also known to influence patterns of A&E Attendance.

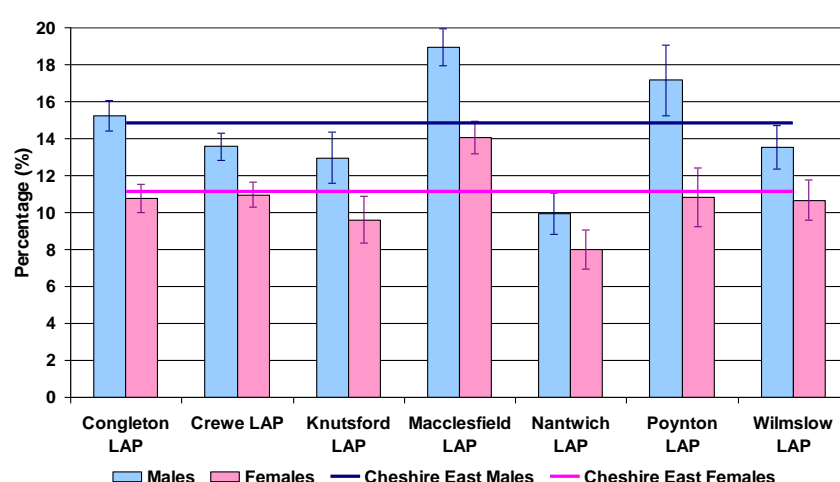


Figure 18. A&E attendances due to injury in 0-4 year olds, 2011-2014

Preventing unintentional injuries for the under-fives is an aim of targeted interventions such as the Family Nurse Partnership programme as well as of widely used parenting programmes. The work also supports the wider aims of the Troubled Families Programme and family intervention services and projects. For some families, unintentional injuries are a result of neglect which is an important aspect of child protection work. A&E departments and minor injury units also play an important role as they are able to advise families about future prevention when they see an injured child.

Community Hubs and children's centres are well placed to provide information and support to families around child accident prevention through educational input at centres and family outreach work. Training for staff and volunteers to further develop confidence and competence in this area is important. With appropriate training and supervision, voluntary and community organisations such as Home-Start are also able to support vulnerable families on injury prevention as part of customised user-led services given the trusting relationships they develop.

Focusing on Five Kinds of Injuries for the Under-fives

There is a strong argument to focus on tackling the most severe and preventable injuries, including those that result in a high risk of death and the largest number of emergency hospital admissions. Figure 19 and Figure 20 illustrate the numbers of A&E attendances and emergency admissions by single year of age from 0 to 9.

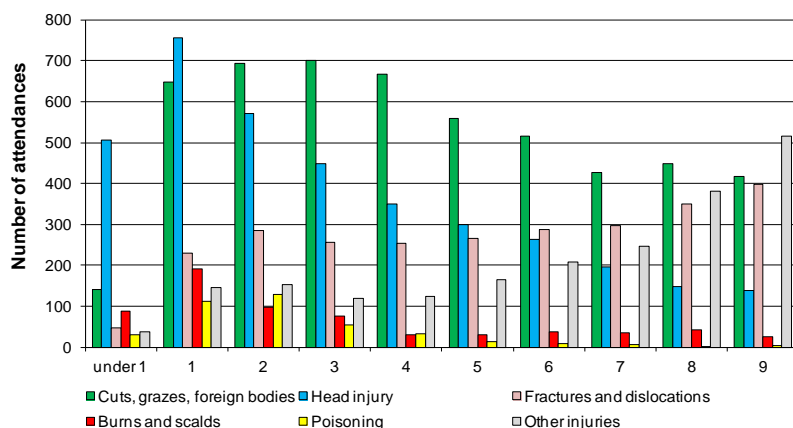


Figure 19. A&E attendances due to injury at ages 0-9, 2011/12 to 2013/14

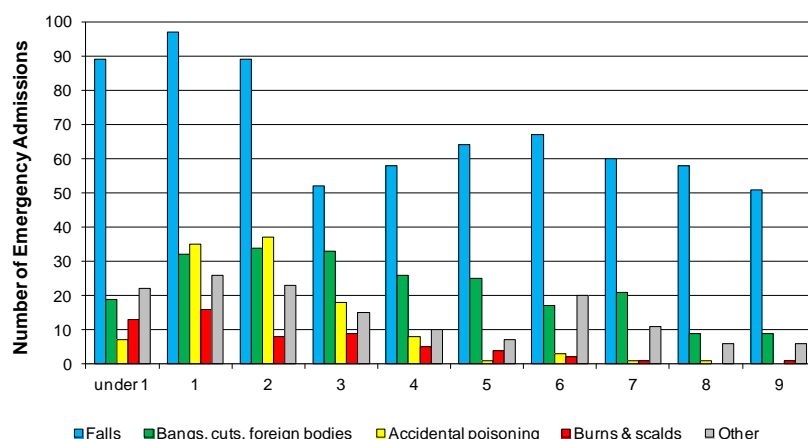


Figure 20. Emergency admissions from injury at ages 0-9, 2011/12 to 2013/14

These highlight that amongst children aged 0-4 years, five types of unintentional injury need to be prioritised, and each has its own profile and characteristics:

1. **Choking, suffocation and strangulation.** Although relatively uncommon, these injuries carry the highest risk of death among the under-fives and have already been prioritised by the Cheshire East Child Death Overview Panel. They include:
 - inhalation of food and vomit, primarily affecting children under two
 - hanging and strangulation, with window blind cords being a major hazard
 - suffocation in bed
2. **Falls.** In Cheshire East falls are the leading cause of admission to hospital from injury in children under five, with 126 admissions in 2013/14. Many parents take their child to an accident and emergency department because they are worried about the possibility of head injury. Most falls attendances and admissions are in babies and in children aged one or two, which means that robust falls prevention initiatives need to be in place from birth onwards. There are four broad groups of injuries, the first two are common but rarely result in death. The last two are less common but have a higher risk of death:
 - falls from furniture, such as beds, sofas and high chairs
 - falls on and from stairs and steps

- falls while being carried, which primarily affect children under the age of one
 - falls from or out of buildings, such as from windows or balconies
3. **Poisoning.** These injuries caused 147 A&E attendances and 37 hospital admissions in children aged 0-4 in Cheshire East in 2013/14. National data indicates that poisoning admissions caused by household chemicals peak at the age of one; and those caused by medicines at the age of two. As these products can be stored well away from very young children, all of these injuries were potentially preventable:
- medicines are the cause of over 70% of poisoning admissions nationally.
 - household chemicals account for a further 20% of admissions nationally.²⁵
4. **Burns and scalds.** This is the fourth highest reason for injury admissions in under-fives in Cheshire East, with 173 A&E attendances and 22 admissions in 2013/14. In Cheshire East most burns and scalds are in children aged one, although they are also common in babies and in children up to the age of three. Serious burns and scalds are disfiguring and disabling for young children. They arise from five main sources:
- scalds from hot drinks, which peak at the age of one
 - burns from hot household appliances, increasingly from hair straighteners
 - contact with other hot fluids, including water being heated on a stove
 - burns from hot heating appliances, including radiators and pipes
 - bath water scalds, which also peak at the age of one and cause severe injury
5. **Drowning.** The lethal nature of drowning means that it should be a core part of injury prevention. For the under-fives the main risk occurs in the bath.

Other Hazards

Although five main causes of unintentional injuries are described above, other causes of injury should not be ignored. For example, exposure to smoke, fire and flames results in a high proportion of deaths among the under-fives in and around the home. Furthermore, hazards change, especially as new products such as hair straighteners or liquid detergent capsules emerge, and as children grow up. Concerns have been raised about harm caused by swallowing powerful button batteries and more recently the dangers of nicotine poisoning from electronic cigarettes.

An Eight Point Plan for Reducing Unintentional Injuries In and Around the Home

1. Any professional working with families or children (including health care professionals, teachers, social workers, children's centre staff etc) should identify households with young children as vulnerable groups who are at greatest risk of having unintentional injuries. They should provide advice both verbally and through leaflets and work together with parents to minimise injuries in and around the home.
2. Any professional working with families or children (including health care professionals, teachers, social workers, children's centre staff etc) should provide parents and carers with advice

regarding home safety assessments, and provide advice on how to reduce risks. Assessments can be carried out by parents, carers and other householders using an appropriate checklist. Parents should be educated to systematically identify potential hazards in the home and garden. Once identified these risks should be evaluated and ways to reduce them should be sought. Home safety assessments and education should be incorporated in local plans and strategies relating to children and young people's health and wellbeing. Home safety assessments should be aimed at families with a child under five or with other children who may be particularly vulnerable to unintentional injuries. (See list of vulnerable groups on page 41).

3. Health visitors should recommend the use of appropriate safety equipment such as door guards, cupboard locks, window restrictions, safety gates both at the top and bottom of stairs to parents with young children under the age of 5. Young children starting to crawl and learning to walk are at an increased risk of falling over while doing so. These simple strategies will help prevent a number of injuries such as falls, bumps and head injuries. Community hubs supporting Life Links would be able to coordinate this with advice and issuing equipment.
4. Parents with babies should be advised never to leave them unattended on a raised surface or place baby bouncers on raised surfaces. Babies learn to roll over at a very young age and can easily fall over and suffer from significant injury.
5. Community pharmacies, general practices and health visitors should provide clear advice regarding the hazards of medicines in children. Accidental poisoning with household chemicals and medicines is very common in young children under the age of three. This can be easily prevented by keeping these products locked in cupboards out of reach from children.
6. Housing associations and landlords, working with the local Fire and Rescue Service, should ensure that permanent home safety equipment such as smoke and carbon monoxide alarms, thermostatic mixing valves and window restrictors are installed and maintained in all temporary, social and rented housing where there are children under 15, with priority given to accommodation where there are children aged under 5.
7. Accidental burns and scalds in young children due to hot drinks, heating appliances, hot fluids on stoves or other household appliances are very common. Recently there has been an increased number of burns arising from hair straighteners. Burns can cause serious harm in young children. Parents should be well educated and given advice in the form of leaflets regarding precautions to take to prevent burns and scalds in children. They should be told to always turn off any hot appliances after use, make sure that children are kept away from kitchen stoves, radiators, to avoid handling hot fluids around children and to check the temperature of bath water.
8. Local health organisations need to engage actively with, and contribute to, the Cheshire East Road Safety Partnership.

Unintentional Injuries – Road Traffic Accidents

The focus of unintentional injuries so far has been mainly on younger children particularly those under the age of five. However, accidents remain an important part of the picture of health of young people. In these older age groups accidents can be affected by behaviour.

Unlike the younger age ranges, where the greatest risks are found in the home, for older children and young people the risks are greater outside of the home, particularly on the roads. Young people locally recognise traffic as a concern; it was highlighted in the Cheshire East Good Childhood Report 2014. This showed that overall 28% of local children (both primary and secondary school ages)

wanted to see less traffic. Amongst primary school children however, it was their biggest concern with 41% wanting to see less traffic. This was statistically different from the national picture where only 26% of primary school children wanted to see less traffic. Amongst local primary school children concern was often about the speed of traffic as much as the volume of traffic. The speed of traffic was particularly of concern to those children living in rural areas.³⁶

“It’s not safe people come speeding around in cars and it’s a rough area there are scary places on the estate” – year 7 boy³⁶

Amongst secondary school aged children concern about traffic was lower, but it was still above the national figure for this age range (though not statistically significant). In Cheshire East 22% of young people wanted to see less traffic compared to 19% nationally.³⁶ It is this age group who are at greater risk from injuries on the roads whether pedestrians, cyclists, vehicle passengers or drivers. Nationally, there is a noticeable increase in injuries between ages 10 and 11, which coincides with the move to secondary school and probably with increasingly unsupervised travel.²⁶ However, less traffic was not this age group’s main area of concern about their local environment.

In my Annual Report last year I drew attention to road accidents as an important cause of early death. Of those who were fatally and seriously injured in 2013^e, 13 (6.3%) were under the age of 16 whilst 53 (25.9%) were aged 16-25. This means that nearly a third of deaths and serious injuries on the roads are in children and young adults.

National studies of reported road traffic injuries and emergency hospital admissions clearly show that some groups of young people are at greater risk of injury:

- young males are three times more likely to be killed on the roads than young females
- the highest rates of hospital admissions and police-reported serious and fatal casualties occur soon after young people start legally using cars and motorcycles
- one in every 1,250 young people aged between 15 and 24 years in 2012 suffered a serious or fatal traffic injury
- half of all deaths in young car occupants occur between 8pm and 4am
- the rate of fatal and serious injuries on the roads in 5 to 9 year olds is nine times higher for those who live in the 20% most deprived areas; for 10 to 14 year olds, it is more than three times higher. There is a gradient in the risk of fatal and serious injury among 5-15 year olds, with the risk decreasing as the level of affluence increases.
- the move from primary school to secondary school increases the risk of injury by almost two-fold in Year 7 pupils compared to Year 6 pupils²⁷

Cheshire East Council, working alongside Cheshire Constabulary and Cheshire Fire and Rescue Service, has implemented a range of initiatives to reduce the number of road casualties. It is therefore encouraging to see that there has been a steady reduction in the occurrence of deaths and serious injuries among children under 16, and in 2012 and 2013 the local rate was very similar to the

^e Fatal casualties sustain injuries which cause death less than 30 days after the collision. Injuries are categorised as severe when a casualty is detained in hospital as an “in-patient”, or any of the following injuries whether or not they are detained in hospital: fractures, concussion, internal injuries, crushing, burns (excluding friction burns), severe cuts, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident.

national rate. However the occurrence of other road traffic injuries in children continues to be higher than nationally.

Figure 21. Road traffic casualty rates for children aged 0 to 15

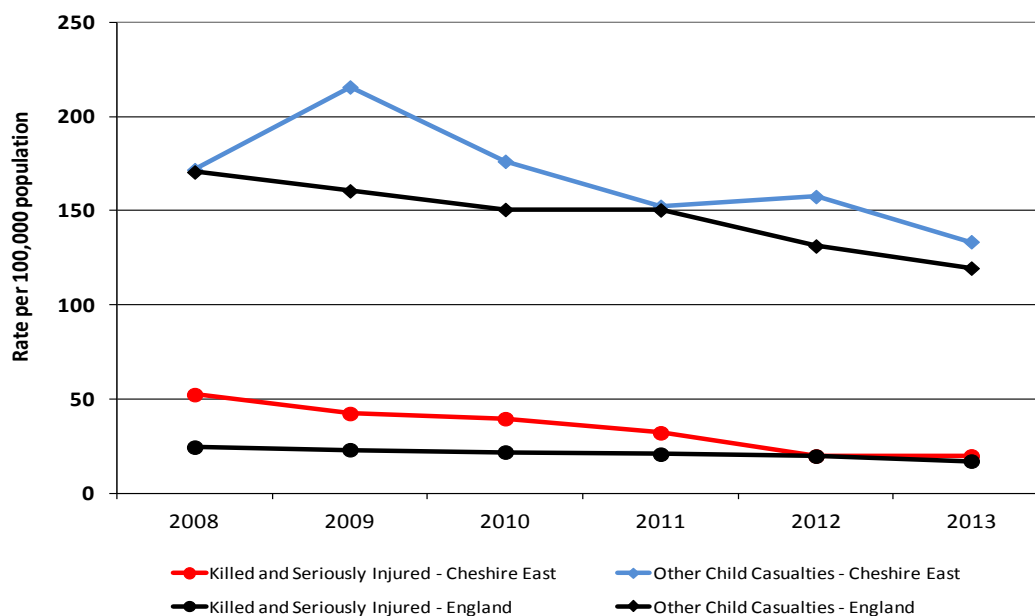
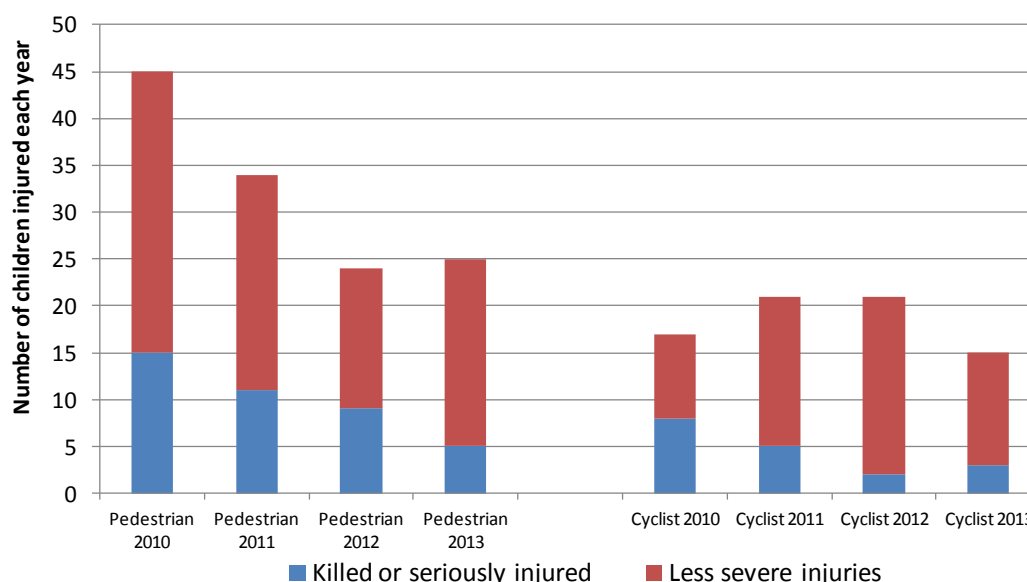


Figure 22 looks at injuries to child pedestrians and cyclists. In both groups there has been a fall in the number of deaths and serious injuries in children under 16, but it is noticeable that the overall number of injuries affecting child cyclists has not reduced significantly since 2010.

Figure 22. Trends in road traffic injuries affecting children aged 0 to 15 in Cheshire East



Young people can first get a moped licence at the age of 16, and at this age there is a sharp increase in the occurrence of fatal and serious injuries. This increases again at the age of 17 when young people can access larger motorbikes. Young car occupant injuries increase from the age of 17 and 18, and a significant proportion of fatal and serious injuries in this group occur in the evening and

early morning. On Cheshire East's large network of higher speed (60mph) roads, it is more likely that collisions will carry a risk of fatal injury.

Many young people will aspire to travel independently for work, study and leisure, although actually achieving this may result in high costs – both in affording the method of transport and from the risk of traffic injury. The Council and its partners can seek to influence these costs through developing a range of initiatives that reduce exposure of younger drivers and motorbike riders to dangerous scenarios, support their independence through the provision of age-appropriate cycling and walking facilities, and their needs for public transport.

A Three Point Plan for Reducing Road Traffic Injuries

1. Improving safety for children travelling to and from school

The largest numbers of child injuries occur between 8am to 9am and 3pm to 7pm, and safe travel for children during their first years at secondary school is of particular importance as pedestrian casualty rates for both boys and girls increase following this transition.

Every school in Cheshire East already has a School Travel Plan that is based on the specific needs of the school, community, and pupils. School Travel Plans are a good way to encourage walking and cycling on journeys to and from school, and are intended to address safety issues throughout the whole journey. Such plans need to be regularly and systematically updated, and where necessary supported by measures to:

- physically alter the road environment
- reduce vehicle speeds
- provide Bikeability cycle training (which in Cheshire East is increasing from a baseline of 3,800 in 2013/14 to 4,000 in 2014/15)
- enforce traffic laws

2. Introducing 20mph limits in priority areas as part of a safe system approach to road safety

Introducing 20mph limits and zones in priority areas can reduce vehicle speeds and thereby prevent injuries and reduce their severity. Lower vehicle speeds can also help to reduce health inequalities due to traffic injury. The introduction of 20mph speed limits should be supported with education and publicity, appropriate road engineering measures, and enforcement activities. In creating a safer road environment, the safety of pedestrians and cyclists should be considered first because of their particular vulnerability to injury. Where 20mph limits cannot be introduced, segregated walking and cycling arrangements improve safety and encourage active travel.

3. Bringing together actions to prevent traffic injury and improve health

Many actions are known to prevent traffic injuries, and these can often achieve other public policy goals or improve other areas of public health. Safe travel for children should be aligned to other agendas such as spatial planning, child safeguarding, using outdoor space for exercise and health reasons, and reducing noise and air pollution.

Cheshire East Council's Key Outcome 5 - People Live Well and for Longer – provides an appropriate focus for planning a coordinated approach to these activities across the Borough, although introducing safe travel and liveable streets into towns and neighbourhoods requires strong local partnerships that will include community leaders, schools, police, fire and rescue, health services and local businesses.

Key Points

Unintentional injuries are a major cause of ill health and serious disability for children, especially those aged under 5. All children are at risk of unintentional injuries but different risks affect different ages. At younger ages the greatest risks are found in the home, but for older children and young people the risk are far greater outside of the home, particularly on the roads.

- In Cheshire East in 2013/14, 275 children aged 0-4 years were admitted to hospital due to an unintentional injury. 65% of admissions in the under-five's result from falls and household knocks and a further 21% from burns and accidental poisoning.
- In Cheshire East, over half (52%) of head injury attendances were in children under five, particularly one-year olds. More than a third of the children who attended an A&E department with a head injury in 2012/13 required no investigation or treatment; they were sent home with advice and guidance.
- In older children other factors other than the occurrence of injury may influence decisions to attend A&E for minor injuries, for example, accessibility and previous use by the family.

Working with families/parents to develop safety behaviours can help these to become fully embedded. This chapter suggests ways in which unintentional injuries in and around the home can be reduced. This includes increasing awareness of risks around the home, supporting families to do home safety assessments and working with them to implement appropriate changes (such as safety gates on stairs, locking up household chemicals). Particular attention should be paid to reducing poisonings and burns. Permanent home safety equipment (e.g. smoke and carbon monoxide alarms and thermostatic mixing valves) should be installed and maintained in all temporary, social and rented housing where there are children under 15. Local health organisations are encouraged to contribute to the Cheshire East Road Safety Partnership.

Local children and young people have identified traffic issues as being of concern to them. Road accidents are an important cause of early death - nearly a third of deaths and serious injuries on the roads in Cheshire East are in children (under 16) and young adults (16-25 years). There are certain key times in their life when a child or young person is at increased risk of injury or death on the road. These are related to increased independence of travel at age 11 (Year 7 pupils), and at ages 16, 17 and 18 when young people are able to gain licenses to drive mopeds, motorbikes and cars.

Chapter Six

The Effects of Housing on Children's Health

It has been well reported that good quality housing has a substantial impact on health: a warm, dry and secure home is associated with better health.^{28,29,30,31} In addition, there have been numerous studies to explore the effects of poor quality housing conditions on health, which suggest the existence of a causal association.^{29,30}

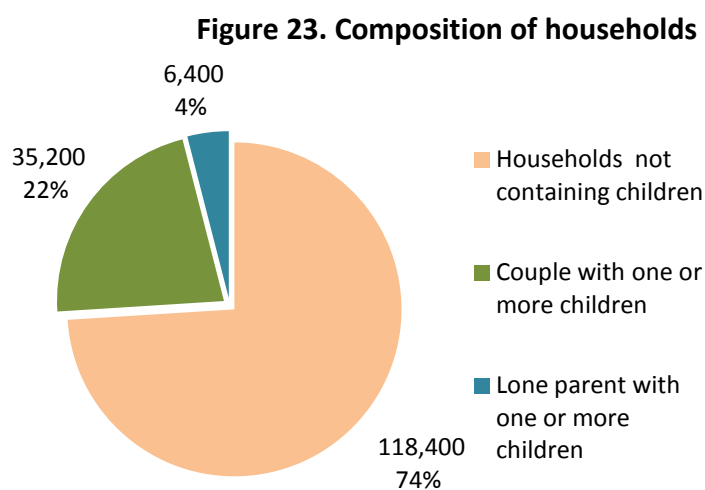
This section looks at the effects of poor housing on its occupants, particularly children and other vulnerable members of a household.

An Overview of the Housing Stock in Cheshire East

Overall there are estimated to be 165,100 dwellings^f in Cheshire East. Eighty-nine percent of the housing stock is privately owned, with 72% owner occupied and 17% privately rented; just 11% of houses are social housing.

Despite its rural geography, most of the homes in Cheshire East are in an urban or suburban neighbourhood. The large market towns of Crewe and Macclesfield constitute the 2 main urban areas, with a number of smaller market towns including Nantwich, Knutsford and Congleton. Despite the perceived rurality only 15% of residents in Cheshire East live in a rural area.³²

Like all boroughs Cheshire East has a mixed housing stock; over 90% of the stock is made up of houses or bungalows, and just 10% are flats.³² The age profile of local housing is markedly different to the national picture; fewer houses were built before 1945 (pre-1945 housing constitutes just 31% of houses compared to 42% nationally). The borough has a higher proportion of more modern houses, with 18% of the housing stock built since 1990.³² Importantly however the age profile of the stock is approximately comparable across different tenure types.³²



Source: 2010 House Condition Survey

The 2011 Census estimated there are 159,441 households living within Cheshire East, and approximately a quarter of these households contain children.

^f Dwellings are classified into two types, unshared and shared. The 2011 Census defines a dwelling as a single self-contained household space (an unshared dwelling) or two or more household spaces at the same address that are not self-contained, but combine to form a shared dwelling that is self-contained. A household space is the accommodation that a household occupies, and self-containment means that all rooms, including the kitchen, bathroom and toilet are behind a door (but not necessarily a single door) only that household can use. In most cases, a single household space will be an unshared dwelling.

What Causes Poor Quality Housing?

Based on the Decent Homes Standard, the term 'poor housing' describes a property that is experiencing one or more significant hazards such as:

- Damp
- Mould
- Excess cold
- Structural defects that increase the risk of an accident³¹

If a hazard presents a severe threat to the health or safety of a resident, it is known as a 'category 1 hazard'.³³ Exposure to significant hazards is recognised to negatively influence both mental and physical health and well being.

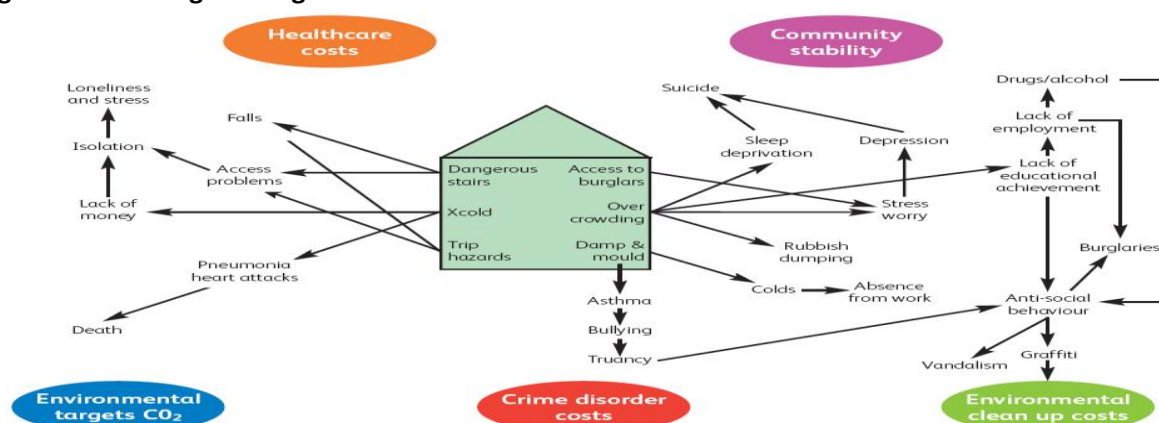
Significant hazards in the home may arise due to:

- Poor design or construction
- Failure to update or repair - whether due to choice or other constraints e.g. lack of knowledge, finance or skill
- Failure to take appropriate precautions or action to protect the household^g - whether due to choice or other constraints

What are the Effects of Poor Quality Housing?

The potential effects of poor quality housing are extensive, and illustrated in Figure 24. The key issues associated with poor housing are described below.

Figure 24. Relating housing hazards to health



(Source: Good Housing Leads to Good Health CIEH September 2008)

^g In the 2011 Census "household" is defined as 'one person living alone, or a group of people (not necessarily related) living at the same address who share cooking facilities and share a living room or sitting room or dining area. A household must contain at least one person whose place of usual residence is at the address. A group of short-term residents living together is not classified as a household, and neither is a group of people at an address where only visitors are staying.

Respiratory Illness

As we have described, cold living conditions can lead to the development of mould growth in damp houses. Moulds produce allergens (substances that can cause an allergic reaction) and substances that irritate the skin and respiratory tract.

Evidence from a number of studies looking at children of pre-school and primary school age have consistently shown that visible damp and mould growth exacerbates asthma and is associated with self-reported respiratory symptoms such as wheezing and chronic cough.^{34,35}

Mental Health and Wellbeing

Children living in poor quality properties can feel unhappy in their home and family life. Some develop a feeling of shame and embarrassment that can lead to social isolation: others may attempt to find respite elsewhere, usually away from both their home and family. Social isolation, chronic anxiety linked to feelings of shame and embarrassment, and a low mood are all risk factors for the development of poor mental health, independently, cumulatively and interactively.

The Cheshire East Good Childhood Report 2014 highlighted these negative feelings:

“The place I live has a lot of litter/mess, takeaways, rundown buildings, graffiti, and pubs. I don’t feel safe in my area because there are a lot of intimidating people who hang around” – Year 7

“There are a lot of people who smoke near where I live – they are not nice people. There is a lot of dog poo. I feel ashamed to live where I live.” – Year 8 (page 19)³⁶

Poor emotional health can then impact on school attendance which can in turn impact on other issues relating to social interaction as well as education, and possibly impact on employment possibilities later in life.

Accidents

The potential for accidents is recognised as a serious concern in the home, and it is important to acknowledge their potential seriousness, as accidents are a leading cause of death in all age groups.^{31,37} Children are a particularly vulnerable group as they often have a limited perception of the environment and fail to consider consequences of their actions (see chapter five).²³

Childhood injuries are closely linked with social deprivation, and children from poorer backgrounds, who often live in poorer quality housing, are five times more likely to die as a result of an accident than children from more affluent families.

Overcrowding

Overcrowding in a home can have a significant effect on family relationships, as well as each individual’s mental health and wellbeing.³⁸ Overcrowding is associated with an increased risk of accidents, hygiene risks, and can facilitate the spread of communicable diseases.³⁸ Overcrowding can impact on the whole family, through lack of privacy, reduction of tolerance, disrupted sleep patterns when large numbers of people are sharing a bedroom, and it can directly impact on a child’s development and progress in school.³⁸ There are also practical issues such as lack of a suitable place within an overcrowded home for children to study or do their homework and a reduction in the ability to concentrate.³⁸ There does not appear to be a particular age group that is more vulnerable than others.³⁹

Overcrowding is not recognised as a significant problem in Cheshire East with 73% of residents living in a house that averages less than one person per bedroom, and in 99.9% of settings a single family unit occupy a recognised dwelling.⁴⁰ Very few children are likely to be living in overcrowded conditions in Cheshire East. However for the small number who are it is important to acknowledge the impact that overcrowding can have on a child's mental health (e.g. due to lack of privacy, or due to disrupted sleep patterns from sharing a bedroom) and physical health (e.g. overcrowding increases the risk of accidents and facilitates the spread of communicable diseases).

Damp, Mould and Excess Cold

One of the key issues across the UK is excess cold (used to describe properties below the NHS recommended room temperature of between 18°C-21°C), which can lead to damp and mould growth within the property. Local surveys have shown that damp and mould growth are not a significant local issue. However, such surveys are unlikely to show the true extent of damp and mould growth locally, as it is very rare for it to be scored as a severe ('Category 1') hazard because it is statistically unlikely to cause extreme or severe harm. Therefore its prevalence could be (and is likely to be) a lot higher than the report indicates.

Studies have demonstrated higher rates of mortality and morbidity when living in a property that is excessively cold.¹ Excess cold occurs when households cannot afford the costs of heating their properties or fail to carry out improvements which would enable their home to be heated efficiently.

Examples of evidence, from the literature, that have demonstrated the association between cold housing and poorer health in children include evidence of the physical impact of fuel poverty.

- An American study⁴¹ compared 2 groups of low-income children, one group received a winter fuel subsidy and the other group received no payment. The study found those not in receipt of the payment were 30% more likely to be admitted to hospital or need to consult primary care clinics in their first 3 years of life. They were also 29% more likely to be underweight. Researchers believed this was attributable to the infants burning more calories to keep warm, leaving fewer available for growth and the building of a healthy immune system. Paediatricians involved in this research have speculated that longer term risks to children's cognitive development could accrue from their being underweight in the early years of life.

Although children not receiving winter fuel subsidy probably needed to burn more calories in order to stay warm, the study described how they actually consumed 10% fewer calories during winter months than children in homes that received the subsidy, and is a real life example of the "heat-or-eat" dilemma which many households in Fuel Poverty face in the cold weather. Whilst previous studies had shown parents often consumed less food as a way of affording more heating in winter, this study was the first to suggest young children are affected too.

- A UK study³⁵ inspected the homes of 193 children with a persistent wheezing illness and categorised the presence of damp in their home as very low, low, moderate or high. The occurrence of damp in the home was compared with a control group of 223 children who were well. The risk of wheezing illness was increased by 32% as the severity of damp moved up each category.
- A comparable study³⁵ in New Zealand found similar results. Researchers inspected 891 New Zealand homes, and compared the occurrence of damp and mould with the presence of

respiratory symptoms in residents of all age groups. As the occurrence of damp increased, the occurrence of respiratory symptoms also increased (dose-response). There was evidence of a higher risk of respiratory symptoms with increasing levels of damp for children under 7 years, compared to older children and adults. Using the study data the researchers predicted a 33% reduction in the number of people experiencing respiratory symptoms if those households currently living in the poorest quality homes were housed in the best performing houses.

Other studies have explored the physical impact of improved energy efficiency measures.

- A study⁴² in New Zealand followed up 2 similar groups of families, one group had had upgrades to their home to improve energy efficiency whilst the other group had not. The groups were reviewed a year after the home improvements had been made, and researchers found that children in the group whose homes had been improved had had 15% fewer days off school compared to those whose homes had not been upgraded. This may be attributable to fewer respiratory ailments after a house is made warmer and drier, as children are particularly vulnerable to respiratory problems if they live in cold, damp conditions.
- A further UK study⁴³ followed up 14,000 English children over a period of 5 years by a research team at the National Centre for Social Research (NATCEN), which looked at the effects of cold and damp independently. The evidence suggested respiratory problems were more than twice as common in children who lived for 3 years or more in cold homes (15%), compared with similar children living in energy efficient homes (7%). The research also suggested a significant reduction in the prevalence of allergies in children after homes are made more energy efficient, which is likely to be a consequence of better air quality and a reduction in dust mites.

Data from the Census shows that 98% of homes in Cheshire East are fitted with central heating, although this doesn't tell us how effectively the central heating system works or whether the household can afford to use it.⁴⁴ This does however mean 2% of dwellings do not have central heating, equating to approximately 3,600 dwellings locally (this is lower than the 3% national rate).

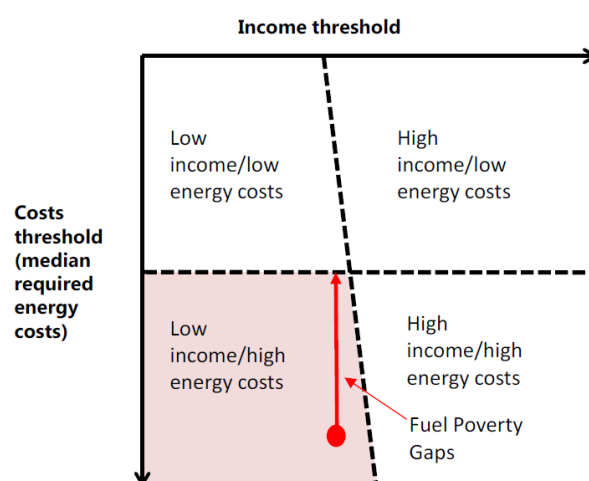
Fuel Poverty

Under the Low Income High Cost definition a household is considered to be fuel poor where:

- they have required fuel costs that are above average (the national median level)
- were they to spend that amount, they would be left with a residual income below the official poverty line⁴⁵

Figure 25 highlights an important issue - not all children who are income poor are also fuel poor. Reasons for this are many, but a primary one is that many income poor children are living in newer housing stock which is relatively energy efficient. Affordable heating then becomes achievable for

Figure 25. Fuel poverty under the low income high cost measure⁴⁵



families, no matter what their family income, provided they live in decent, well insulated and energy efficient homes.⁴¹

Tackling Fuel Poverty requires a specific strategy, distinct from what is needed to tackle income poverty. The primary determinant of Fuel Poverty is the home itself. Homes which have high quality cavity wall and loft insulation, efficient central heating systems, draught-proofing, and double-glazing are least likely to create fuel poor residents, even when the residents themselves are in income poverty.

Historically senior citizens and people with disabilities have been the primary focus of Fuel Poverty interventions, however in recent years a growing bank of evidence has demonstrated two further vulnerable groups, namely people with long term illnesses and young children. This was acknowledged nationally with the introduction of the 'Warm Home Discount Scheme'. This is a four year initiative running from April 2011 – March 2015 to help those most vulnerable to the effects of fuel poverty.

The £1.1 billion scheme is funded by energy suppliers, and the government have recently committed to additional spending of £320m on the Warm Home Discount scheme in 2015/16.⁴⁶ The initiative still acknowledges that pensioners on low incomes are the most vulnerable group, but it also recognises a broader group of 'at risk' customers which consists of people who are disabled, have a long term illness or young children under five years of age. 'Cold Weather Payments' are also available for families in receipt of benefit who have a child under five or a child of any age who is registered disabled. Under the 'Cold Weather Payment' scheme payments of £25 are made for each 7 day period of very cold weather between 1st November and 31st March. Additionally, 'Winter Fuel Payments' are available for people born on or before 5th July 1952, for winter 2014/15.

The evidence demonstrates that living in Fuel Poverty has specific and significant detrimental effects on the young. However, even amongst children and young people, the effects of Fuel Poverty differ across the age groups. For infants and young children, the effects of a cold home primarily impact on their physical health. Those children most at risk are:

- babies and children under 5 years – young children are unable to recognise and respond to feeling cold, however babies are particularly vulnerable as they cannot regulate their body temperature as well as older children or adults
- children of any age who are disabled or have a long term condition that can affect their ability to respond to temperature change

Unfortunately these are the very members of society who often spend the greatest amount of time in their homes, therefore their need for heating is greater than most because they require heating all day rather than for short intervals.⁴⁵ Many of these vulnerable groups face a dilemma over whether to "heat or eat", many choosing food over keeping warm.⁴⁵ Failing to tackle the problem however makes their living conditions worse and this can be to the detriment of their health.

Amongst adolescents by contrast, effects appear to be primarily on mental health and wellbeing.⁴¹ Within the NATCEN study, when other contributory factors were controlled for statistically, fuel poverty had highly significant effects on adolescent risk-taking (e.g. early alcohol and tobacco abuse) and truancy. Among adolescents who had lived for long periods in a home that was inadequately heated, 28% were at significant mental health risk, compared with 4% of similar children who lived in homes that were adequately heated.⁴¹

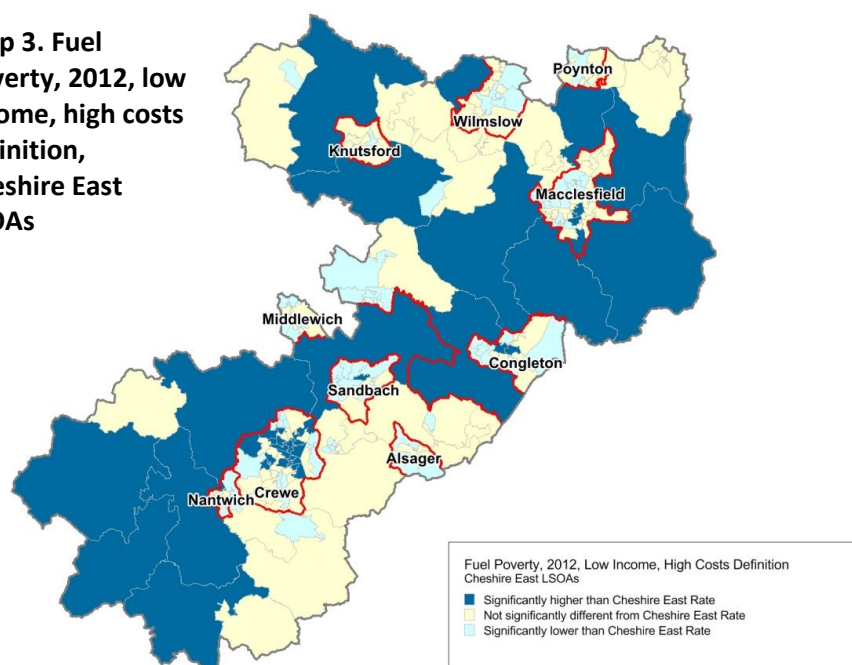
In cold homes, where heating is limited to family living rooms, and family members cluster together, problems of overcrowding may also occur. Domestic relationships often come under strain during adolescence, which could make crowding especially challenging for this age group. This is supported by the fact that 10% of the NATCEN adolescents in fuel poor homes felt unhappy in their family compared with 2% of similar teenagers living in warmer homes.⁴¹

This research also explored the effects of home improvement on wellbeing, and demonstrated children were more likely to complete homework in a separate room following home efficiency improvements, probably as a consequence of more rooms in the house being heated. Together with the finding that there were fewer days of absence from school post improvement, this evidence suggests it is possible that improving the quality of housing may have small but significant effects on children's longer term educational achievement.^{42,43}

Taken together, these findings offer a lifespan perspective on Fuel Poverty's impacts on the young, suggesting that there may be lifelong benefits from targeting Fuel Poverty strategies towards the young.

Within Cheshire East fuel poverty occurs in many of the rural areas, but it also affects many parts of the town of Crewe, which is the only urban area in the Borough that has significant levels of fuel poverty (Map 3).

Map 3. Fuel poverty, 2012, low income, high costs definition, Cheshire East LSOAs



Whilst it is important to identify the areas within the Borough with the highest levels of fuel

poverty, it's also important to acknowledge fuel poverty affects all geographies. This provides another example of how proportional universalism strategies need to be applied within the borough to improve the health of children and young people. Chapter One discusses the Cheshire East initiative to allow residents to buy their fuel through the Council at a competitively low price, which was launched in October 2014.

Locally we also know a greater proportion of lone parent households are in fuel poverty compared to any other household type. Half of lone parents are fuel poor, and are more than twice as likely to be in fuel poverty when compared with households that contain children headed by two adults.

Inadequate central heating can also lead to the use of portable heaters and open fires, which, if not managed appropriately can also pose a risk of thermal injury and burns, particularly among children in their first four years of life.

Summary

The evidence consistently demonstrates the positive effects of living in a warm home free from damp and mould, which promotes both the mental and physical health and development of children. Given that these gains have a lifetime of potential benefit, they are of prime importance in improving child health. Universal services would be well placed to identify unmet need and provide information and proactive support to families in order to tackle the problems associated with cold housing locally, and which should be a locally determined priority for Children Centre's activity.

Structural Defects

Structural defects in the home can also lead to poor quality housing and consequently impact on health. Structural defects can arise through poor construction, use of inappropriate building materials, or disrepair. For example:

- a leaking roof, poor plumbing, poorly fitted windows or inadequate ventilation could lead to indoor pollutants or mould, causing or exacerbating asthma, allergies or respiratory diseases³⁰

Poor design or construction of homes is an important and preventable cause of accidents, for example:

- an unsafe staircase or banister can be a fall hazard
- poor quality flooring or lack of adequate lighting can be a trip hazard
- a poorly maintained hot water system can pose a scalding risk³⁰

Other key factors that may impact on the health and wellbeing of the household include:

- poor security – the perception of poor security may be due to inadequacy of physical security measures (e.g. having the ability to securely lock doors and windows), but will also be influenced by any perceived threats within the neighbourhood
- overcrowding – overcrowding within the household can also make the dwelling unfit for purpose³⁸

Local Impact of the Quality of Housing on Health

The key aims of Cheshire East Council are to ensure everyone has access to a home of decent quality at a price they can afford, in good quality neighbourhoods that are safe, attractive, and have good access to schools, leisure and employment opportunities. In practice however (whilst strict legislation exists relating to the quality of social housing, and some guidance exists relating to the safety and quality of privately rented housing) it is more difficult to influence the quality of owner occupied dwellings.

In 2010, a formal survey³³ was used to inspect the quality of a sample of the privately owned housing stock (which equates to 89% of our total housing stock). It estimated 28% of the privately owned housing stock in Cheshire East contained a hazard which could significantly impact on health, with the hazards predominantly due to one or more of three issues:

- opportunity for falls (on stairs and between levels, due to unsafe stairs etc)
- excess cold
- potential for entry by intruders

The issues are being addressed through targeted actions outlined within Cheshire East's Housing Strategy, "Moving forward" 2011-2016. These include:

- **improving the quality of housing across all tenures**
 - providing a range of affordable financial options for home repairs, targeted at vulnerable low income households, including low income families with children, living in the worst housing conditions
 - providing support to older and vulnerable households to improve, repair and maintain their homes
 - exploring approaches to improving housing within our town centres
- **improving the quality of housing in the private rented sector**
 - by improving landlords' and tenants' knowledge of good management and property standards
 - working with sub-regional partners to implement and develop the Cheshire Landlord Accreditation Scheme
 - targeting inspections on an area-based approach in areas with high levels of privately rented properties
 - ensuring houses in multiple occupation are free from fire risks and other significant hazards
- **reduce the incidence of fuel poverty**
 - by working across tenures to improve health through warmth
 - targeting practical and financial support for vulnerable homeowners, including vulnerable families with children to tackle the effects of cold and damp homes
 - utilising housing legislation to effect thermal improvements in the private rented sector
- **promoting sustainability for future generations**
 - maximising the use of government-initiated carbon reduction schemes

Key Points

A poorly maintained, cold damp home can have a negative impact on a child or young person's physical and mental health. Equally, overcrowding and lack of privacy can affect a child or young person's emotional wellbeing and their educational attainment. Although strict legislation exists

relating to the quality of social housing, and some guidance exists relating to the safety and quality of privately rented housing, it is more difficult to influence the quality of owner occupied dwellings. A housing stock survey in 2010 identified 28% of privately owned houses in Cheshire East had a significant problem that could impact on health, for example increased risk of unintentional injuries, respiratory illness and mental health and wellbeing. Of the 165,100 dwellings in Cheshire East, 89% of housing stock is privately owned, with 72% owner occupied.

Fuel poverty is also a concern in Cheshire East. The primary determinant of fuel poverty is the home itself, so not all children who are income poor are also fuel poor as many will be living in newer housing stock which is relatively energy efficient. Fuel poverty, and thus living in a cold and damp home, has significant detrimental effects on children and young people due to. For infants and young children, the effects of a cold home primarily impact on their physical health, whereas among adolescents the effects appear to be primarily on mental health and wellbeing. Fuel poverty has been shown to have highly significant effects on adolescent risk-taking (e.g. early alcohol and tobacco abuse) and truancy. Among adolescents who had lived for long periods in a home that was inadequately heated, 28% were at significant mental health risk, compared with 4% of similar children who lived in homes that were adequately heated.

Certain families are more at risk of being fuel poor; half of lone parents are fuel poor, and are more than twice as likely to be in fuel poverty when compared with households that contain children headed by two adults.

Chapter Seven

Environmental Impacts on Child Health

The Marmot Review highlighted that ‘the more deprived the neighbourhood, the more likely it is to have social and environmental characteristics presenting risks to health. These include poor housing, higher rates of crime, poorer air quality, a lack of green spaces and places for children to play, and more risks to safety from traffic.’¹ Whilst this is the case in urban areas, different environmental risks exist in rural areas. These include drowning in open water, injuries on farms and exposure to agricultural pesticides and herbicides. Cheshire East has a diverse mixture of urban and rural areas with approximately 39% of the population living in rural areas and 61% in towns.⁴⁷

Ten years ago, the WHO European Region developed a Children’s Environment and Health Action Plan for Europe. This plan required countries to develop national Children’s Environment and Health Action Plans to protect the health of children and young people. In 2009 this led to the Department of Health commissioning the then Health Protection Agency (now Public Health England) to produce “A Children’s Environment and Health Strategy for the UK”. The strategy identifies a number of priority areas to reduce the burden of disease in children from environmental risk factors and promote good health and well-being.

This chapter will also consider two key settings, schools where children spend much of their lives, and farms where children and young people are at heightened risk of unintentional injury or death.

Exposure to Chemicals and Allergens

In 2002, the World Health Organisation’s Regional Office for Europe and the European Environment Agency suggested that children are the “canaries in the coalmines” – the first people to show adverse health effects resulting from environmental factors, with possible lifelong implications for adults and children.⁴⁸ The risks to a child’s health from the environment in which they live and play are wide and various. However, not all children will be equally affected; environmental inequalities – the unequal impact of environmental influences on health and wellbeing⁴⁹ – exist alongside other wider determinants of health.

Legislation and other initiatives have led to reduced exposures to many chemicals in children and young people. Nevertheless, chemical exposures in the womb and early life still do occur and can be linked to a wide range of congenital and developmental abnormalities. The main concern is that the health effects are often difficult to quantify, and may be as a result of chronic exposures to single chemicals or mixtures of chemicals.

Children have proportionately greater exposure than adults:

- they eat and drink more relative to their body weight
- they consume a different diet (particularly when very young)
- their higher respiratory rate means a proportionately greater air intake
- young children have a larger surface to volume ratio, and skin that is more permeable to chemicals than adult skin
- young children tend to explore their environments using their mouths

- children play on the floor close to dusts, chemicals and solvent vapours
- rugs and carpets are reservoirs of toxicants that may include moulds, aromatic hydrocarbons, and allergens such as pollens, pet dander and dust mite droppings^h

Children's metabolic pathways are immature and easily disrupted:

- they are less able to detoxify and excrete chemicals from the body
- synthetic chemicals are present in many common household products.
- their high metabolic rates increase their susceptibility to carbon monoxide
- many environmental exposures in early life are now known to act as triggers for chronic disease in adult life

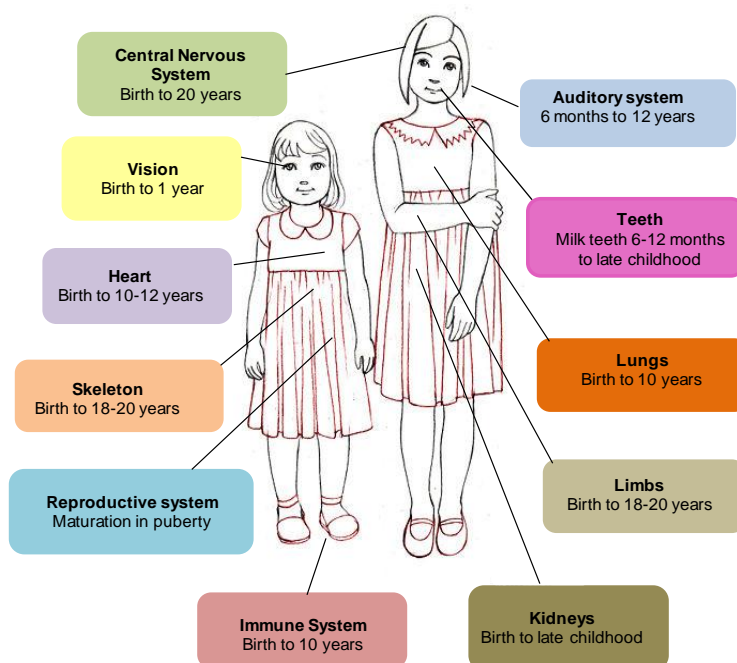
Figure 26 shows that many body systems continue to develop during childhood and into adolescence until full maturation is achieved. The purpose of this section is not to go into a discussion of the evidence, which is substantial, but to highlight the reasons why children's health is particularly at risk, and to suggest some simple steps that can be taken to reduce this risk. Some examples are given below:

Lungs: At birth the baby has about 6 to 15 percent of the full adult number of alveoli (the tiny air sacs where oxygen enters the bloodstream). The rest are formed by the age of two, although the tiny blood vessels serving the alveoli continue to develop up to the age of five years. Children who are chronically exposed to cigarette smoke will develop thicker airway walls and are at greater risk of developing asthma.

Skeleton: Limited access to sunlight or poor diets that lack vitamin D can lead to skeletal malformation, called rickets.

- This can easily be avoided if children eat vitamin D fortified foods (many cereals and margarines) and are allowed to play in sunlight for about 20 minutes a few times a week during spring and summer. Although all under-fives should receive vitamin D supplements, children in older age groups who have limited access to sunlight would benefit too.

Figure 26. Timeline of physical development through childhood from birth onwards



^h There is some evidence that regular vacuuming can lower allergen levels in carpets substantially. Carpets should be vacuumed once or twice a week. Intensive vacuum cleaning is particularly effective (4 minutes per m²). Steam cleaning can also reduce dust mites and does not use chemicals. (Jacobs, D.E., et al (July 2008) National Centre for Healthy Housing Fact Sheet – Carpets and Healthy Homes)

Central Nervous System: Chemicals in pesticides (e.g. insecticides, herbicides and fungicides) are known to be harmful to the developing brain and nervous system, with vulnerability being at its greatest during pregnancy and during the early years of life.

- Garden chemicals should not be stored inside the house, and should be used outside with particular care where there is a possibility that young children may play in treated areas. Pregnant women should avoid directly handling pesticides.

Eyes, skin and lungs: Some household chemicals, particularly bleaches, cleaning and laundry products can be highly irritant and have the potential to lead to significant respiratory, skin and eye damage in children through accidental contact.

- These products should always be stored safely out of the reach of children and where possible should be exchanged for simple soaps and detergents.

Reproductive system: Plastic is part of our way of life. Bisphenol A or BPA, is a chemical used to make plastics including protective coatings and linings for refillable drinks bottles and food storage containers. Although the Food Standards Agency states that 'the levels of BPA found in food from food contact materials are not a concern to health'⁵⁰ it notes that it is one of a number of substances known as 'endocrine disrupters' that may have the potential to interact with human reproductive health. The European Union has legislated on the amount of BPA that can migrate from plastic food containers on contact with food.

- The market, particularly producers of food containers, drinking and baby bottles, appears to have self-regulated itself. Many of these clearly state that they are BPA free and parents are encouraged to buy such products to protect the health of their children (particularly in relation to infant feeding).

Open Spaces

Living close to areas of green space such as parks, woodland and other open spaces can improve health regardless of social class. For children, the presence of parks, playgrounds and recreational areas provides space for physical activity.⁴⁹ However, the quality of the green space is important. The Marmot Report highlighted that some groups, including children, can feel excluded if spaces are not appropriately designed, and poor maintenance or cleanliness can impact more widely on perceptions of safety.

Access to a variety of unstructured play experiences is one of the best ways for children to stay both mentally and physically strong, and there are increased levels of exercise among children where there is access to open spaces⁵¹. Thus, investment in parks and green spaces should be seen as investment in public health.⁴⁷

In January 2013, Cheshire East Council published its *Green Space Strategy*. The Strategy brings together all the green space elements of Cheshire East Council (Open Space, The Countryside Service, Public Rights of Way, Landscape and Biodiversity) to feed into the Infrastructure Plan / Community Infrastructure Levy work. It is a tool to:

- promote green space across Cheshire East in the creation of sustainable communities

"There are lots of activities, I like football at the park" –Year 8 boy

"In my village there are a lot of ways to stay healthy because there are lots of jogging places and walking areas. It is also affordable to be active." –Year 7 girl

Quotes from Cheshire East Good Childhood Report 2014

- co-ordinate the various partners to make sure that resources are effectively used and benefits are maximised, and
- to make an effective case for investment

Through this plan, Cheshire East is working towards maximising the green spaces in the Borough, as 'although Cheshire East is considered a green area, significant shortages to the quantity and quality of open spaces exists, particularly within urban areas'.⁴⁷

Access to Safe Play Spaces

Cheshire East Council has recognised that all of the main towns have a shortage of open space and additional play facilities, teenage facilities and appropriate open spaces are needed for children and young people.⁴⁷

The Green Space Strategy identified that a standard was needed for children's play space which equated to the size of an international football pitch (0.8ha) per 1,000 population. This could be a single site or split between sites, but should provide a kickabout area, landscaping and equipped play, and combine formal and informal play provision. The emphasis will be on creating a network of varied open spaces for children's play (all ages).⁴⁷

Table 1. The shortage of children's play space in the key urban areas in Cheshire East.

Town/Area	Shortage of children's & teenagers play provision (hectares)	Number of international football pitches which this shortage is equivalent to
Alsager	5.61	5
Crewe	34	28
Congleton	13.11	11
Handforth	1.71	1
Knutsford	5.41	4
Macclesfield	22.28	18
Middlewich	6.5	5
Nantwich	8.97	7
Poynton	5.8	5
Sandbach	7.17	6
Wilmslow	8.8	7

Source: The Green Space Strategy

As Table 1 shows, none of the main urban areas in Cheshire East have this standard amount of children's play space. There is a shortage in every town. An example is Crewe where there is a shortage of 34ha of children's outdoor play provision, equivalent to 28 international sized football pitches. Open space provision is poorer in the north-eastern area of Crewe, the central area, the high density residential areas and parts of south western Crewe and there is a specific shortage for some types of open spaces.⁴⁷

Whilst there is a large deficit of play space for children in Crewe (and other parts of the borough), it should be recognised, that particularly within an urban environment, it may be difficult to find the additional amount of green space that is needed. It is likely that alternative provision will have to be found. The Strategy made fifteen recommendations within Crewe, three of these related specifically to facilities available to children and young people:

- try and upgrade poor quality children and teenager sites through a variety of funding mechanisms
- explore the need for additional facilities for older children
- secure appropriate sites to address the shortage of children and teenager facilities in north-eastern and southern parts of Crewe

Teenage facilities are different to those provided for younger children. Not all parks cater specifically for teenagers. Some of the parks elsewhere in England that have achieved Green Flag status in 2013/14 have identified 'teenagers' as a key park user. These parks have facilities ranging from 'teen shelters' to skateparks and/or BMX tracks to a youth service bus attending the park. These parks also encourage teenagers to make use of the open spaces, tennis courts and football pitches available. In some parks there are 'adventure playgrounds' with facilities such as zip wires and larger climbing frames which are also suitable (and designed for) teenagers.⁵²

The Cheshire East Open Space Assessment recommended that all children should live within a five to ten minute walk of a children's play area. The Green Spaces Strategy has recommended that Cheshire East Council should produce a Play, Health and Recreation Strategy.

Whilst it is preferable that children and young people have outdoor areas to play in, they equally value indoor place spaces:

"It's [the youth centre] boring, there isn't much to do there and they don't open up the hall so we can play football, and it's £2.50" – year 9 boy

Utilising appropriate indoor spaces may be a way of providing some additional space for children and young people to play in (this may be particularly relevant during the darker winter months).

Playground Safety

The opportunity to play creatively in high-quality environments is essential to the development of children. Through their play they acquire skills and abilities which can be learnt in no other way. Children cannot provide these opportunities for themselves - adults must do it for them. The quality of what we provide affects the quality of what children learn. The greater the complexity of that environment the greater the quality of learning.⁵³

Equipment should be appropriate for the age group and match their developmental needs - as well as being fun to play on. Younger children like sand-play, swinging, climbing and sliding - but they are small and items should be scaled accordingly. Older children like more exciting equipment - large group swings, cable runways, roundabouts etc. They want places where they can sit and talk - that is one of the most popular playground activities. They like planting and trees; places for skateboards and bicycles; flat areas for ball games.⁵³

The Royal Society for the Prevention of Accidents highlights that once a playground has been provided the playground requires regular inspection and maintenance and eventual replacement. They argue that unless this can be provided it is better not to start the project.

Contaminated Land

Cheshire East Council has a Contaminated Land Strategy in accordance with the requirements in Part 2A of the Environmental Protection Act 1990. This identifies any prioritised sites, such as those

contaminated by previous industrial or commercial usage, for example gasworks, fuel stations, chemical works, mining and landfilling. The presence of contamination at a site (a source) is not sufficient on its own to present a risk. For contamination to pose a risk there must also be something affected by it (a receptor) and a mechanism for their interaction (a pathway). Only if all three elements are present does contamination present a risk.

The Environmental Health Team at Cheshire East, through the planning process, proactively identify those sites that have had a previous use which may have led to contamination. As part of the prioritisation process under Part 2A, they have identified 4,440 sites which need to be inspected further. As part of this process, the most sensitive receptor is used to identify risks based on the existing land use; this is a female child aged 0-6 years. Contamination levels are also ranked by the existing use for the land; residential is highest with schools, allotments and parks ranked second.

Contamination can occur in a number of forms. It may exist in solid form in soil, as a spillage of fuel which may affect a river or stream or as a vapour risk to residents or as ground gas (methane and/or carbon dioxide) or vapours. Land can also be determined as contaminated due to its proximity to off-site contaminated areas.⁵⁴

Water

Drowning

In the UK, drowning causes 400 deaths every year, with more than 40 of these being children and young people, making it the third highest cause of death in children. It is estimated that for every death by drowning there are around 300 near misses.⁵⁵

Children can benefit from learning to swim. However, it is also important that children and young people are educated on both where it is safe, and where it is dangerous, to swim.

Open waters (rivers, canals, ponds, quarries and lakes), of which Cheshire East has a wide variety, can look particularly enticing to children and young people however they can hide a number of dangers including:

- cold temperature
- hidden currents
- difficulty getting out (steep slimy banks)
- depth (which can be difficult to estimate)
- hidden rubbish e.g. shopping trolleys, broken glass
- no lifeguards/rescue
- pollution⁵⁶

There are no open swimming sites in Cheshire East. Families who wish to enjoy open water swimming together should consult trusted sources for advice (the information included in these is not endorsed by the Council and should be treated with caution).

Drowning is a real and present danger in the worked out sand quarries (Brereton Heath Local Nature Reserve and Astbury Mere Country Park) due to the temperature of the water, and obstructions. There are no lifeguards and swimming is not allowed. The presence of green algae and the presence of wildfowl waste (campylobacter) particularly in still waters are also risks. Leptospirosis is also a low, but present concern for those by canals, ponds and riverbanks.

The canals are a significant body of water in Cheshire East. The often narrow nature of tow paths means it is vital that children are well supervised around the canals; canal water is not clean, and

there are many obstructions on the canal bottom. There is also the risk of an accident with a canal boat.

The risk of drowning is not limited to the warmer summer months. Frozen open water can be very enticing especially to children. The Royal Society for the Prevention of Accidents identifies young children and males of any age as being those of greatest risk of drowning after falling through ice into water. Children are obviously attracted to frozen lakes and canals as they present natural ice skating opportunities. It is important that children are taught of the dangers of venturing onto ice, and are reminded of these dangers during freezing weather.

Lead Pipes

Lead poisoning (when levels of lead build up in the body) is particularly dangerous for infants and children. Lead can have an adverse impact on mental development; it may also be a factor in behavioural problems.⁵⁷ Legislation has been enacted to control lead in drinking water (as well as other things such as in petrol and paint) and as a result, blood lead levels in children have significantly declined.⁵⁸

It is estimated by United Utilities that about a third of older properties in the North West still have lead pipes either within the property itself or the pipe that connects the home to the water main in the street.

In soft water areas, such as Cheshire East, there is a greater likelihood that lead from pipes will be present in the water. Where this problem exists, water companies treat the water with orthophosphate and this reduces the problem significantly. Nonetheless, particles of lead may build up in these older pipes.⁵⁷ Since 2013 a new drinking water quality standard for lead (below 10 micrograms per litre reduced from 25µg/litre) has come into force.⁵⁸

Outdoor Air Pollution

The 2009 publication 'A Children's Environment and Health Strategy for the UK'⁵⁸ called for the prevention and reduction of 'respiratory disease due to outdoor and indoor air pollution'.

Outdoor air pollution in the UK has improved greatly in the past few decades, but there are still some localised areas where people are exposed to high pollution levels.⁵⁸ Air pollution is any chemical or other material in the air which detracts from its quality. This could be smoke (which caused the smogs of the 1950's), soot particles, odours (from agriculture or hot food takeaways), or chemicals such as sulphur dioxide (linked to acid rain) and nitrogen dioxide. Some natural events also cause air pollution such as volcanoes (like the 2010 eruption of Eyjafjallajökull on Iceland), or dust storms from deserts (as experienced in southern England in spring 2014). However, by far the largest contributor to ground based levels of air pollution is the combustion of fossil fuels. The biggest contributor to air pollution within Cheshire East is from road transport.⁵⁹

Cheshire East Council, amongst other initiatives to reduce air pollution, is developing a Low Emission Strategy which will utilise the Development Control Framework to incentivise the use of low emission technologies to reduce transport emissions associated with future developments, thus helping to improve air quality from road traffic.

The UK Air Quality Strategy⁶⁰ aims to improve air quality, and sets out air quality standards and objectives for eight key pollutants, some of which (lead for example) it identifies as being particularly harmful to children. The air quality standards and objectives are acceptable concentrations of pollutants over a given time period. No specific information was included relating to children and

young people, though the strategy did identify the importance of providing funding for green sustainable transport such as walking buses to help reduce air pollution.

Nitrogen Dioxide and Particulate Matter

Exposure to particulate matter affects lung development in children including reversible deficits in lung function as well as chronically reduced lung growth rate and a deficit in long-term lung function.⁶¹

There are two types of particulate matter, the larger PM₁₀ and the smaller PM_{2.5}. The smaller particulates are of greatest concern as these can get deeper into the airways and lungs. Recently it has been recognised that particulates have no safe threshold, and health effects have been observed at very low concentrations. At present Cheshire East Council does not routinely measure for particulates. However, the Council runs a comprehensive monitoring network for nitrogen dioxide which is the main pollutant of concern locally as a result of emissions from road traffic; emissions of nitrogen dioxide (NO₂) give rise to all of the 13 Air Quality Management Areas (AQMA's) in the Borough. The monitoring locations are reviewed on an annual basis. There is no singular linear relationship due to atmospheric chemistry between NO₂ and Particulates. However, reducing emissions will reduce both.

Educational Establishment Environmental Standards

Children, particularly young children, are efficient carriers for disease. They are still learning about personal hygiene, are frequently in close personal contact with each other and therefore easily spread bacteria and viruses from one to another.

Children and young people are also likely to be much more active than adults (and it is recommended that they do more physical activity per week than adults). Whilst learning through play and physical activity they often undertake what adults would deem 'risky behaviour' as they test their boundaries and learn their limits. These can result in accidents and unintended injuries. It is therefore important that the educational establishments are safe environments and promote the health and wellbeing of the children and young people.

In the UK primary school children spend approximately 6.5 hours a day in the school environment for 190 days per year. Secondary school children, and those involved in extracurricular activities, spend up to 8 hours a day in school. Pre-school children can spend even longer (upwards of 10 hours) with many nurseries providing early to late care for working parents often for over 50 weeks a year. Both school and nursery environments are subject to considerable regulation, but may lend themselves to further improvements. Cheshire East has 172 preschool and day nurseries, and 151 schools which consist of:

- 7 secondary schools;
- 14 secondary academies;
- 110 primary schools;
- 15 primary academies;
- 3 special schools;
- 1 special academy and
- 1 pupil referral unit.

Within the boundaries of Cheshire East there are also 10 independent schools, two of which provide boarding (one mainstream school and one special school).

Schools and nurseries are important in developing children's knowledge, understanding and skills relating to healthy lifestyles, food nutrition and health. Many lifelong dietary habits are established before the age of ten.⁵⁸ It was identified in the NICE guidance on physical activity and the

environment⁶² that nurseries and other childcare providers can play a key role in minimising sedentary activities and implementing actions to reduce obesity.

Nurseries

Nurseries must adhere to specific requirements relating to the amount of space that is required per child. The regulations are very clear and require that:

- children under two years have 3.5m² per child
- two year olds have 2.5m² per child, and
- children aged three to five years have 2.3m² per child⁶³

They must also ensure that there is a separate baby room for children under the age of two. This is to ensure the safety of all children at the nursery.

Nurseries are also required to provide access to outdoor play areas. If this is not possible providers must ensure that outdoor activities are planned and taken on a daily basis (unless dangerous to do so e.g. extreme weather). Young children, who can walk on their own, should be physically active for at least 3 hours per day. By providing active play nurseries can ensure that the number of reception school children who are overweight or obese when measured as part of the national childhood measurement programme (NCMP) is reduced over time.

Hand Hygiene

An issue common to both nurseries and schools (particularly primary schools) is teaching children effective hand hygiene. Young children in particular often have poor hand hygiene and can therefore easily spread disease amongst themselves and their carers. Both nurseries and primary schools should teach children how to wash their hands after using the toilet and before eating. There have been a number of 'hand hygiene' initiatives to support teachers and early years staff to do this. This has included the UK Schools Hand Hygiene Challenge in 2012 led by the Health Protection Unit (HPA) (now Public Health England) and guidance and fact sheets.

Environmental Health Officers inspect school premises to ensure adequate facilities are available to pupils. They advise schools when there are infection control issues on their premises such as an inappropriately located water fountain (for example in the toilets).

Adequate infection control procedures are required in schools and nurseries to reduce the risk of infection. Nurseries are required to have suitable hygienic nappy changing facilities including the use of disposable gloves and plastic aprons⁶⁴ and ensure that adequate numbers of toilets and hand basins are available (though unlike for schools the numbers are not stipulated). Nurseries are also required to ensure there is an adequate supply of clean bedding, towels, spare clothes and any other necessary items so that children can be changed out of soiled or dirty clothing and the risk of cross-infection reduced.

Recently published Public Health England guidance⁶⁴ reminds childcare settings of the importance of preventing the spread of infections by ensuring:

- routine immunisation
- high standards of personal hygiene and practice, particularly hand washing

- maintaining a clean environment

Children under five are disproportionately affected by gastrointestinal disease; though the introduction of the rotavirus vaccine is helping to reduce this. More details can be found in chapter four on gastrointestinal illness and children and young people.

School Environment Standards

There are clear regulations for many aspects of the school environment. These are clearly stated in law.⁶⁵ Some refer to the structure and layout of buildings and facilities (such as washrooms for staff and visitors must be separate to facilities for pupils with the exception of disabled facilities which can be shared).

These regulations also extend to the playing fields. Minimum areas are stipulated in law based on the age and number of pupils attending the school. The required area goes up with age and number of pupils. The regulations also examine the surfaces and equipment available. These rules apply to both mainstream and special schools (with some exceptions for the latter due to historical issues). Mainstream schools are allowed to offset some of the minimum requirements for playing field space by providing alternative physical activities through regular swimming, indoor team games or outdoor team games at other venues.

The Cheshire East Green Spaces Strategy highlighted that schools often have green space resources such as playing fields. The Strategy encourages schools to open their facilities to the local community in which they are situated to encourage safe areas for people to be active and for children to play.

Every school must have a room appropriate and readily available for use for medical or dental examination and treatment, and for the caring of sick or injured pupils. It must contain a washbasin and be reasonably near a toilet. It must not be used for teaching purposes. There are additional strict rules for boarding schools around medical accommodation (the number required, the facilities it must include and that for children over 8 years of age they must be single sex).

All schools must also adhere to structural requirements which include the amount of light in rooms, exposure to sunlight, the structure and maintenance of load bearing walls, fire risks, heating including minimum and maximum temperatures, hot surfaces (dependent upon the age of children attending), ventilation, asbestos, water, drainage and noxious fumes. All of these requirements are designed to keep children and young people safe and well in their schools.

There are also strict rules for those schools that provide boarding accommodation on the provision of sleeping accommodation for pupils (floor size, single sex accommodation, room type, and washroom and toilet facilities). All pupil accommodation must be separate from sleeping accommodation for staff. There must also be appropriate places for the eating of meals and storage facilities for pupil's personal belongings.

Food in Schools

As of September 2014, The Children and Families Act 2014 places a legal duty on all state-funded schools in England, including academies, free schools, pupil referral units and alternative provision as well as mainstream schools to offer a free school lunch to all pupils in reception, year 1 and year 2.⁶⁶ In June 2014 a new set of simplified School Food Standards were introduced. These standards are designed to ensure children get the nutrition they need across the whole school day. They apply to all pupils not just those receiving free school meals. They govern all food and drink on offer within the school and apply across the whole day, including breakfast, mid-morning break, lunchtime

and food served after school. The new standards are designed to make it easier for school cooks to create imaginative, flexible and nutritious meals.⁶⁶ To ensure these standards are met it is expected that the free infant school meals will have to be hot. As of September 2014, all schools in Cheshire East with children in reception, year 1 and year 2 have kitchens on site.

The take up of free school meals for infant pupils is not mandatory and those families that wish to provide their children with a packed lunch may still do so. It is considered best practice that cold storage is available to store packed lunches as food-borne illnesses can occur if they are not stored at a safe temperature. However there is no legal requirement on schools to provide this. It is therefore up to parents to include an ice-block or similar to ensure their child's packed lunch maintains a cool temperature until lunchtime.

Risks to Children and Young People in Rural Areas and on Farms

Cheshire East is a largely rural area with 93% of the area classed as at least 'more rural than urban', while 88% is classified as green space. Cheshire East has a large farming community and is a major dairy-producing area.⁶⁷ The beauty of this rural environment hides some rather sobering facts relating to the health and wellbeing of children and young people.

Agriculture has one of the highest fatal injury rates of any industry in Great Britain and many hazards are associated with farms particularly for children and young people. Farming is the only high-risk industry that has to deal with the constant presence of children – farms are homes as well as workplaces; children may also be visitors.

There are a number of restrictions in place to try and protect children and young people from accidents and injuries on farms. These focus predominantly on farm vehicles. The law (The Prevention of Accidents to Children in Agriculture Regulations 1988) makes it illegal to allow a child under 13 to ride on or drive agricultural self-propelled machines (such as tractors and quad bikes) and certain other farm machinery. However, it is legal for them to ride on a trailer, or on a load carried by a trailer, if there are adequate means, such as edge protection, to prevent them falling from it. Restrictions remain for the 13-16 age group with only certain vehicles being allowed to be operated or ridden on by them. But from 16-18 years, young people may use larger machines and powered implements. However, the farmer must decide if they can handle these machines safely depending on their experience and competence not just their age.

Although the law focuses on farm vehicles, the risks to children and young people on farms are diverse. Nationally, the most common causes of death or major injury to children on a farm were:

- | | |
|--|-----------------------------|
| • falling from vehicles | • drowning and asphyxiation |
| • being struck by moving vehicles or objects | • poisoning |
| • contact with machinery | • fire |
| • driving vehicles | • contact with animals |
| • falls from height | |

Nationally, the children who died in recent accidents were⁶⁸:

- | | |
|--|-----------------------------------|
| • being carried as passengers on agricultural plant or machinery | • working/helping around the farm |
| • not working under proper adult supervision | • playing unsupervised |
| | • trespassing |

Key Points

The environment in which children and young people live, play and learn can have both positive and negative impacts upon their health and wellbeing. Living close to areas of green space such as parks, woodland and other open spaces can improve health regardless of social class. Access to a variety of unstructured play experiences is one of the best ways for children to stay both mentally and physically strong. All of the main towns in Cheshire East have a shortage of open space; it is difficult to find the additional amount of green space that is needed to meet the standard. Despite this, investment in parks and green spaces should be seen as investment in public health.

Whilst it is important that children and young people have access to outside spaces, it should be remembered that some sites and certain environmental features can put children at risk of harm or death. In Cheshire East, as elsewhere, drowning is a real and present danger in the open water spaces (meres, canals, ponds etc) due to the temperature of the water and obstructions. Drowning is the third highest cause of death in children nationally. It is estimated that for every death by drowning there are around 300 near misses.

Farms are also a known risk for children and young people in Cheshire East where 93% of the area is classed as at least 'more rural than urban'. Agriculture has one of the highest fatal injury rates of any industry in Great Britain. Farming is recognised as the only high-risk industry that has to deal with the constant presence of children – farms are homes as well as workplaces; children may also be visitors. Risks can include farm vehicles, contact with machinery contact with animals, falls from height, poisoning, drowning and asphyxiation and fire.

In addition to their homes, children and young people spend a large part of their lives at educational establishments. There are clear regulations for schools and pre-school educational establishments to ensure children and young people remain safe whilst on their premises. Both schools and pre-school educational establishments play a large part in promoting the health and wellbeing of children and young people.

Chapter Eight

Young People

The health and wellbeing needs of teenagers and young people differ from the needs and issues affecting younger children. The Association for Young People's Health (AYPH) and Public Health England (PHE) have highlighted that:

*'Good health in adolescence is central to wellbeing, and the bedrock for good health in later life. Yet we do not invest enough in prevention and early intervention with young people aged 10-24 and when problems do arise they can face barriers in access to appropriate care.'*⁶⁹

Particular issues affecting young people include mental health problems including anxiety and self-harm, substance misuse, managing sleep and nutrition, sexual health, and unintentional injuries such as road traffic accidents. To help improve the health and wellbeing of young people, the Association for Young People's Health and Public Health England suggest 'collaborative working between sectors, full use of youth participation, and a focus on health promotion in education settings offer some ways forward'.⁶⁹

In partnership with the Association for Young People's Health, Public Health England has developed a **Framework for Young People's Public Health**⁷⁰ (to be published Autumn 2014) which is aimed at commissioners, Directors of Public Health, lead councillors, Health and Wellbeing Boards, Local Authority service leads and private and voluntary sector partners who are providing services for young people. The Framework will describe six cross-cutting core principles to promote a more holistic approach to commissioning. It will also outline the most critical health outcomes to be focused upon for this group, and set out questions for local leaders to assess their capability to drive improvement in their areas.⁶⁹

As this Framework is currently unavailable, I am focusing on some of the key issues for adolescents and young people locally. These include health inequalities, mental health, and alcohol, tobacco and drug use. I will also consider issues about confidentiality and the need for young people to be able to trust the health services they are accessing to keep their information secure.

Health Inequalities

It is well recognised that health inequalities exist between different parts of a community, and this is no different for young people. Health inequalities normally disproportionately affect those from the poorest areas. However, there is some evidence, relating to alcohol, within Cheshire East that suggests that young people from more affluent families may be experiencing inverse health inequalities due in part to their greater affluence.

Alcohol use by young people is of particular concern in Cheshire East and the rate of admission to hospital by under 18 year olds due to alcohol-specific conditions is significantly higher than the England average. Although Cheshire East has seen improvements in recent years against this indicator, the borough still remains in the worst quartile nationally. Therefore, young people who drink regularly and excessively are of particular concern in Cheshire East. The relative affluence of the borough may in part be a cause – as young people have access to a larger disposable income, the cost of alcohol is not considered prohibitive by them.

Elsewhere in this report, I have highlighted some areas where children and young people face health inequalities based on deprivation. For young people these include increased risk of serious road traffic injuries and accidents within the home, as well as the consequences of living in a cold home which include poor mental health and wellbeing, increased risk taking such as early alcohol and tobacco abuse, and truancy. Young people also recognise that their family's relative deprivation, and the area in which they therefore live, can affect their health:

"Mostly it's very expensive to buy fruit and healthy food. In Bollington there are mainly takeaways" – year 8³⁶

Young people from more affluent homes can have more freedom and opportunities to access a wider range of activities or places to spend time with friends:

"Costa is somewhere to go" – year 7³⁶

"I can get the train to Manchester for £2.10" – year 8³⁶

"I've got my horse" – year 7 girl³⁶

Health inequalities are also evident between young people who live in urban and rural environments. Young people living in local rural communities have highlighted that they are unable to meet with their friends because of limited things to do in their local area or long distances and the lack of public transport. This can impact their mental health and wellbeing and can affect young people from both affluent and deprived families.

"There's nothing to do where I live, I live in the middle of nowhere in between Sandbach and Middlewich" – year 7 boy³⁶

"I live so far away from my friends so I can't really like see them" – year 7 girl³⁶

Mental Health

Whilst four out of five young people report high life satisfaction, and young people aged 16-19 are among the most optimistic about what the next twelve months will bring⁷¹, mental ill health is common and persistent amongst young people. Mental health problems have important implications for every part of a young person's life including their ability to engage with education, make and keep friends, engage in constructive family relationships, and make their own way in the world.⁷¹

For many, a mental health problem during adolescence will follow them into adulthood. More than 75% of adults who accessed mental health services had a diagnosable disorder prior to the age of 18.⁷² Thus diagnosis, treatment and support for young people with mental health problems are all important parts of the services provided to this age group.⁷¹

The last nationally representative data was compiled in 2004 and is now a decade out of date. That survey highlighted that around 13% of boys and 10% of girls aged 11-15 have mental health problems⁷¹, the most frequent being anxiety and depression, eating disorders, conduct disorder (serious antisocial behaviour), attention deficit hyperactivity disorder (ADHD) and self-harm. Early emergence of rarer psychotic disorders such as schizophrenia is also seen during the teenage years.⁷¹

We know relatively little about the mental health of adolescents and young people in Cheshire East. If the national figures from 2004 are applied to Cheshire East, we can estimate that around 1,400 boys and around 1,050 girls aged 11-15 may have mental health problems locally. There is evidence that mental health disorders are linked to socioeconomic status and social background.⁷¹ It has been reported that children and young people from the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes.⁷²

Eating disorders tend to start in the mid-teens⁷¹ and are most prevalent in early adulthood.⁷² Overall it is estimated that around 1 in 250 females and 1 in 2,000 males will experience anorexia nervosa, usually as an adolescent or young adult, and that around five times this number will suffer from bulimia nervosa.⁷¹ However, eating disorders may be underestimated in the general population; significant proportions will not seek help and good quality data is lacking.

The Chief Medical Officer's 2013 Report highlighted that conduct disorderⁱ predicted all adult psychiatric disorders including psychosis. The report recommends that effective intervention to reduce childhood behavioural difficulties may be a particularly important lever to improve both child and adult mental health.⁷² The report also highlighted that 'bullying worsens childhood and adult mental health and is experienced by between a third and half of British school children and young people'.⁷² ChildLine (the UK's free 24-hour helpline for children and young people) reported 315,111 counselling sessions in 2011/12, with the primary concerns being family relationships, bullying, physical abuse and self-harm.⁷¹

"I feel sad at school all the time. It is hard to fit in at school because other people make you feel bad/poo about yourself (especially the popular's). There should not be people which think they are better than you. I don't have many friends"- girl year 9³⁶

"Many girls and boys have started to think it's acceptable to call each other nasty names, but it's horrible" - girl year 8³⁶

The Cheshire East Good Childhood Report 2014 highlighted as an issue of concern that from primary school age, girls were already thinking about their looks and appearance. Those of primary school age did not necessarily have negative things to say about their appearance but would reflect on it. However, amongst secondary school aged female pupils the reflections were much more negative and largely concerned with how boys and girls commented on physical appearance. Girls felt more comments were critical and boys did not realise the impact their comments could have. Whilst some girls were able to brush off the concerns this was a major issue locally for teenage girls.

"There's a lot of pressure to look good, you get called names no matter what, people always say stuff behind your back, boys always call you ugly if you have spots, or a slag if you wear makeup" – year 8 girl³⁶

"Boys judge you and they expect perfection from you. It only started in High school because in primary they didn't really care" – year 7 girl³⁶

"Because boys only want a real life Barbie" – year 9 girl³⁶

ⁱ The term 'conduct disorder' is generally used to describe a pattern of repeated and persistent misbehaviour. This misbehaviour is much worse than would normally be expected in a child of that age. The essential feature is a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms and rules are violated (American Psychiatric Association, 2000). (Quoted from http://www.rcpsych.ac.uk/files/samplechapter/80_3.pdf, accessed 6/10/2014)

*“Girls can’t go out the house without make up looking good. Boys are mainly the ones that criticise girls for their looks, boobs or bum. Then girls feel insecure and threatened”
– year 8 girl³⁶*

Interestingly the report concludes that the worry and concern secondary school girls feel about their appearance was not driven by the media or images of skinny models, but instead is largely down to the way in which boys and girls relate to each other and the observations and criticisms they make of each other. Specifically it is the way boys talk to girls about their appearance.

The report recommends that further work is needed locally on issues of respect, understanding, self-worth, realism and confidence with young people. These all feed into public health work streams (Personal, Social, Health and Economic education (PSHE); Sex and Relationships Education (SRE); and school health) and by improving these, progress in public health outcomes may be seen.

Substance Misuse (smoking cigarettes, drinking alcohol, and the misuse of legal or illegal drugs)

Substance misuse is often a symptom rather than a cause of vulnerability among young people. Many have broader difficulties that are compounded by drugs and alcohol and that need addressing at the same time. Drugs and alcohol have been voted as one of the top three issues affecting young people in Cheshire East⁷³. Local 11-18 year olds suggested that more needs to be done to raise awareness of the problems that alcohol and drugs cause young people. This is one of the campaigns for the Cheshire Youth Parliament in 2014/15.

Some young people are more at risk than others of becoming dependent upon alcohol or drugs; this can be measured. The “Risk Harm Profile” identifies the vulnerabilities of young people entering specialist treatment. The profile consists of 10 items designed to show risk of escalation or vulnerability. The number of risk factors that the Young Person has is added together to give each young person a ‘score’ out of 10. The higher the score, the more complex the need and the more likely these young people will be to go on to misuse drugs and alcohol as adults.⁷⁴ The ten items measured in the Risk Harm Profile are:

- | | |
|--|--|
| • Opiate and/or crack user | • Not in education, employment or training |
| • Alcohol user | • Involved in self harm |
| • Using 2 or more substances | • Involved in offending |
| • Early onset (age of first use is under 15) | • Pregnant and/or a parent |
| • No Fixed Abode/unsettled housing | • Looked after child |

Schools are well placed to identify teenagers who are at risk of substance misuse, or who are already smoking or drinking. The process of identifying needs should aim to distinguish between pupils who require general information and education, those who could benefit from targeted prevention, and those who require a detailed needs assessment and more intensive support.⁷⁵ The new Substance Misuse Service commissioned by public health is able to work with schools to develop school based substance misuse programmes that may include preventive education, targeted prevention, peer-led alcohol and/or smoking reduction programmes, as well as more intensive support for addiction. Service provision and referral arrangements need to be clearly identified for every school.

Signposting Services and Appropriate Services

As adolescents mature and develop greater independence they should have their own access to information about the health and support services that are available. However, this provision should

be done in a guided way. The Annual Report of the Chief Medical Officer 2012 called attention to this issue as one of great concern to young people and their families.

Young people emphasized their concerns around confidentiality; as they got older they did not necessarily want their family or others to know all their medical details. They did not want their condition discussed in front of others on a ward. In primary care, young people did not understand their rights as patients to confidentiality between themselves and their GP. Privacy and confidentiality was a particular concern for young people living in rural areas, for cared-for children and with regard to mental and sexual health. Young people suggested that a clear explanation of their rights (e.g. seeing a GP without a parent, not having family told about their discussions with a clinician) would help to lessen these concerns and therefore increase their confidence in using these services.²

As well as age appropriate services throughout their teenage years, young people^j, particularly those with long-term disabilities or mental health problems, highlighted that the transition from children to adult services could be a very traumatic experience and was frequently badly handled by the NHS and other sectors. Specific problems included:

- lack of an integrated structured transition process
- lack of support during transition
- lack of clarity about how to navigate adult services, young people describing themselves as lost or in limbo at the time of transition
- difficulty in adjusting to the differences between adult and children's services in a short space of time, such as having to stay in hospital alone and suddenly needing to take on all responsibility of their own care
- health professionals in adult services lacking understanding of being a teenager and being able to communicate effectively with them
- the loss of relationships with trusted professionals and the loss of continuity of support²

'Moving from child services to adult services, I have felt the pivotal services I require fall away and I am helpless and almost stranded' - Young person from a Royal College of Paediatrics and Child Health focus group (Chapter 4 page 7)²

Some of these transition issues are already recognised in Cheshire East. NHS South Cheshire and NHS Eastern Cheshire CCGs are currently working on improving the transition process for young people between paediatric and adult health services. However, transition is not just about the clinical services commissioned by the CCGs; it also relates to the various public health and social care services that the Council commissions, including substance misuse and sexual health services, and in addition wider provision relating to education, employment and good housing.

^j The Chief Medical Officer chose to refer to children and young people in her 2012 report using the United Nations definition of young people, which includes all those under the age of 25.

You're Welcome

As outlined above, confidentiality is extremely important to young people. In 2005 the Department of Health launched 'You're Welcome' which laid out 'principles that will help health services – both in the community and in hospitals – to 'get it right' and become young people friendly'.⁷⁶ The You're Welcome criteria were updated in 2011 and continue to be strongly supported by the Department of Health.⁷⁷ The quality criteria are helping to provide a framework for change in how resources are allocated, and are helping to ensure better health outcomes. They are making health facilities become more youth-friendly, and help to improve the abilities of health workers to respond to adolescents effectively, appropriately and with sensitivity.

This approach is evidence-based – the You're Welcome criteria were devised as a result of work with young people to identify and address the barriers that prevent them from accessing health services⁷⁸ - and have been shown to be effective in systematic reviews undertaken by WHO.⁷⁶ The quality criteria cover ten topic areas – accessibility, publicity, confidentiality and consent, environment, staff training (skills, attitudes and values), joined-up working, young people's involvement in monitoring and evaluation of patient experience, health issues for young people, sexual and reproductive health services, and specialist child and adolescent mental health services.⁷⁶

One of these key themes is confidentiality and consent. All staff should 'routinely explain their confidentiality policy to young people and their parents or carers, in order to enable them to understand young people's right to confidentiality'.⁷⁶ Services should 'explain to young people that they have the opportunity to attend a consultation without the involvement of a parent or carer'.⁷⁶

In Cheshire East 'You're Welcome' is used in a number of different health settings including some GP practices and all of the sexual health services. However, 'You're Welcome' could be rolled out more broadly, for example in more general practices and in pharmacies to ensure young people feel welcomed, supported and able to access the necessary services for their health and wellbeing. The Department of Health would like all health services that are used regularly by young people to gain the You're Welcome quality mark by 2020.

An Eight Point Plan for Improving Young People's Public Health

1. The Public Health team should strengthen the Joint Strategic Needs Assessment (JSNA) by obtaining better information about the prevalence of mental health conditions that affect adolescents and young people. This will require a range of approaches including the use of sample surveys of young people in schools and other settings, obtaining and analysing information from child and adolescent mental health services (in conjunction with both of the Clinical Commissioning Groups), and identifying mental health conditions affecting children in need and young people in care (in conjunction with the Council's Children and Families team).
2. Increased public health involvement in local surveys of secondary school children in Cheshire East should be developed to obtain better estimates of how many teenagers smoke cigarettes, drink alcohol or take illicit drugs.
3. Schools are well placed to identify teenagers who are at risk of substance misuse, or who are already smoking or drinking. The process of identifying needs should aim to distinguish between pupils who require general information and education, those who could benefit from targeted prevention, and those who require a detailed needs assessment and more intensive support.⁷⁹ The new Substance Misuse Service commissioned by public health is

able to work with schools to develop school based substance misuse programmes that may include preventive education, targeted prevention, peer-led alcohol and/or smoking reduction programmes, as well as more intensive support for addiction. Service provision and referral arrangements need to be clearly identified for every school.

4. Children and adolescents with a mild or moderate learning disability that is not identified by their school are at higher risk of poor mental health. For these young people learning is more difficult and they often face bullying. These factors negatively influence their mental health and wellbeing. A programme should be developed to ensure that schools identify young people with a mild or moderate learning disability.
5. The expanded Troubled Families programme will be accessible to families with at least two out of a list of six problems. One of the six has a particular focus on improving poor health, and it includes parents or children with mental health problems including conduct disorder (they do not need to be receiving specialist treatment), drug or alcohol problems, and new mothers who have a mental health or substance misuse problem and other health factors associated with poor parenting.⁸⁰ Families can also be referred if they have any mental and physical health problems of equivalent concern, which may include unhealthy behaviours resulting in problems like obesity, malnutrition or diabetes. As such, the new programme has a significant potential to improve young people's public health, particularly for adolescents, and locally agreed processes will need to be established so that general practitioners, public health nurses and other health professionals can easily refer families into the programme.
6. Increase the number and range of health services who achieve 'You're Welcome' status. Develop a systematic and ongoing audit of health services against the You're Welcome criteria, led by young people.
7. Emotional and mental health problems are common among adolescents. Many schools already have their own programmes to help these young people, such as school-based counsellors or whole school approaches to mental and emotional health. However, there is sufficient need within each secondary school and college to support the development of a single, integrated, school based therapy service that provides Tier 1 and Tier 2 support for these young people, including group and peer support. There needs to be greater alignment and/or pooling of the commissioning budgets held by schools and colleges, Cheshire East Council and the two Clinical Commissioning Groups. The development of an integrated school based therapy service could most appropriately be facilitated by the Council's Children and Families team.
8. A strategy to manage the transition between children's and adult services should be drawn up for Cheshire East. This must be a joint piece of work and should enlist the guidance and input of local young people to ensure it meets their requirements.

Chapter Nine

The Development and Future of School Health Services

The importance of giving every child the best start in life and reducing health inequalities throughout life has been highlighted by both The Marmot Report and the Chief Medical Officer. The Healthy Child Programme aims to ensure that every child gets the good start they need to lay the foundations of a healthy life, and it should be available to every child and young person in the Borough. School health services are a key component of the Healthy Child Programme and these services support school-aged children (aged 5 to 19 years) to achieve the best possible health outcomes.

The Healthy Child Programme offers children and young people a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and tailored support. It aims to:

- help parents develop and sustain a strong bond with children
- encourage care that keeps children healthy and safe
- protect children from serious disease, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- identify health issues early, so support can be provided in a timely manner
- make sure children are prepared for and supported in education settings
- identify and help children, young people and families with problems that might affect their chances later in life

The Director of Public Health is the lead commissioner for school health services, and these services are funded from the public health grant. Yet, the public health responsibilities for child health are much wider than just school health services, and include:

- improving the health and wellbeing of school-aged children and young people
- bringing together holistic approaches to health and wellbeing across the full range of public health responsibilities
- optimising the ring-fenced public health budget to improve outcomes for children and young people
- leading commissioning of public health services, for example, health improvement, drug and alcohol services, and sexual health services
- emergency planning for child populations, including outbreak response in schools

School health teams lead and contribute to improving the outcomes for children and young people but they are not solely responsible for achieving these; there needs to be a partnership approach. School health works with a number of partners including health and social care teams, teachers and youth workers to deliver the evidence based public health interventions outlined in the Healthy

Child Programme, using the core principles of Making Every Contact Count for intelligent, opportunistic interventions.

The additional or targeted support that may be needed from school health services in individual schools and colleges will be determined locally according to individual and population health needs as identified in the Cheshire East Joint Strategic Needs Assessment (JSNA). This will include support to address specific health issues. Separate or additional services may need to be commissioned and funded by the responsible agencies, for example child and adolescent mental health services, domestic violence or bereavement support.

The school health team are the single biggest workforce specifically trained and skilled to deliver public health for school-aged children, and they are clinically skilled in providing holistic, individualised and population health assessment. School nurses are qualified nurses who hold an additional specialist public health qualification. The school health team co-ordinates and delivers public health interventions for school-aged children. The nature of their work requires clinical input and effective leadership, which they are equipped to provide. Because of their close working links to primary and secondary health care services, school nurses are also in a unique position to support multi-disciplinary team working within community and education settings.

The school health service is ideally placed to provide planned structured support that strengthens family relationships, with continued intervention and support to prevent deterioration as part of a multi agency team approach to meet the health needs of children and young people. In Cheshire East the service is presently based on a model of term-time delivery, and it is not currently accessible to young people from colleges and universities or those who are no longer in education. As we develop school health services in Cheshire East, there is a need to increase visibility and accessibility to children, young people and parents, in the following ways:

Developing the service in different settings that are:

- accessible for those up to and including the age of 19 years to include those no longer in school
- accessible for children who are home educated or who do not attend school
- available in the school holidays
- young people friendly and flexible to meet local needs

Using a variety of media and new technologies e.g. websites, social networks

- to raise the profile of the service and reduce any stigma associated with its use
- to provide key health messages targeted to local needs

Having portable electronic devices to access the internet and email

- to enable electronic communication methods e.g. using text messaging and email for young people and parents to request and arrange appointments, and access advice and support
- to enable referrals both into the service and on to other services as needed

- to access and signpost to relevant age appropriate information websites, for example during one-to-one consultations

Increasing involvement in health promotion activities and talks

- supporting PSHE programmes in schools including sexual health messages, personal resilience, self awareness and respect
- to encourage engagement so that young people know they can access non-judgemental support and advice
- developing links in the wider community with other services used by young people

Table 2 summarises the core elements of the Healthy Child Programme and shows how public health will commission a range of school health strategies and interventions to support the achievement of many of the above outcomes. We intend to align these plans with key providers and obtain support from other commissioners.

Table 2. The Role of School Health Teams within a Local Strategy to Improve Outcomes

Description	Suggested strategies and interventions	Delivered by
Improving access to preventative strategies and early intervention	<ul style="list-style-type: none"> • use of a school health profile to identify needs • a set of agreed priorities for each school, college and locality, matching allocation of services to meet needs • monitoring the proportion of children and young people receiving brief interventions, including vulnerable young people and hard-to-reach groups 	School Health and schools
Health development reviews	<ul style="list-style-type: none"> • handover between health visiting and school health • school entry, year 6/7, and mid-teen reviews to identify need for targeted support • identify needs of children with additional or complex health needs and assess involvement of other services • identify and plan tailored packages of care for children with additional or complex health needs • identify continence issues and their management • handover to adult services 	Health Visiting and School Health teams School Health and schools
Preventing injuries and accidents	<ul style="list-style-type: none"> • raise awareness of injury prevention and child safety • co-ordinate education programmes in schools and communities based on local injury information • brief interventions * with young people and parents • identify vulnerable families and refer into support services e.g. parenting programmes • follow-up children and young people after an A&E attendance to offer support and prevent recurrence 	School Health and Accident and Emergency services
Sexual health and contraception	<ul style="list-style-type: none"> • active participation in PHSE development & delivery • sexual health education and puberty sessions • care pathways defined with local general practices, community pharmacies and sexual health services • brief interventions * covering all related risk-taking behaviour e.g. alcohol and unprotected sex • access to Emergency Hormonal Contraception and pregnancy testing • provision of condoms and chlamydia screening • active promotion of Long Acting Reversible Contraception (LARC) and referral for provision 	School Health, Sexual Health services, General Practices and Pharmacies
Healthy weight Interventions on healthy weight and exercise National Child Measurement Programme	<ul style="list-style-type: none"> • develop a new healthy schools charter scheme with rewards for achievements • develop a whole school approach to healthy eating including the use of the eatwell plate • work with local supermarkets, shops and fast food outlets to encourage the availability of healthy food choices • support and promote family physical activity in the school and the local community, including use of engagement activities such as family fun days/family swim times/allotment schemes and active travel (walk/bike to school schemes) and more 20mph zones • promote opportunities for family physical activity in parks and green spaces, and increase the number of 	School Health, Environmental Health, Country Parks and Ranger Service and Everybody Sport and Recreation Trust

	<ul style="list-style-type: none"> safe (and maintained) places to play and be active • provide brief interventions * for healthy weight 	
Stop Smoking/ Tobacco Control	<ul style="list-style-type: none"> • development of whole school tobacco control policy • stop smoking brief interventions * and advice • nicotine replacement treatment under PGD • referrals to Stop Smoking service 	School Health and Stop Smoking services
Drug and alcohol misuse	<ul style="list-style-type: none"> • ensure delivery of drug and alcohol education within science & PHSE tailored for primary, secondary and college ages as part of a whole-school approach to alcohol and drug harm reduction, including parents • drug and alcohol brief interventions * and advice • use of age-specific screening and assessment tools to identify and support vulnerable young people • establish referral pathways with specialist young people's substance misuse treatment services 	School Health and Substance Misuse services
Emotional wellbeing	<ul style="list-style-type: none"> • support schools to adopt a comprehensive 'whole-school' approach to social and emotional wellbeing • identification and support for children and young people showing early signs of emotional distress • care pathways clearly defined with local general practices and mental health and wellbeing services • active referral and monitoring to CAMHS 	School Health and CAMHS
Safeguarding	<ul style="list-style-type: none"> • develop role of prevention and early detection • support children, young people and families through integrated working, with handover to other professionals where there are no health issues or to another health professional who is already involved 	School Health teams and Children's services
Targeted support Cared for children, young offenders, young carers, young people at risk of abuse including domestic violence and child sexual exploitation	<ul style="list-style-type: none"> • contribute to annual health assessments and support resolution of issues or concerns • contribute to in care reviews • early identification of health needs of young carers and provide support that is tailored to individual need • identification of health needs of young offenders and sign posting to appropriate services 	School Health and Children's services
Dental decay and promoting oral health	<ul style="list-style-type: none"> • brief interventions* • use of toothbrushes and toothpaste • cutting down on sugary drinks • encourage registration with a dentist • include in whole school approach to healthy eating 	Health visitors, School Health Teams and Schools
Screening	<ul style="list-style-type: none"> • hearing and vision screens in reception year 	School Health
Immunisation	<ul style="list-style-type: none"> • review immunisation status at school entry • provide diphtheria, tetanus, pertussis and polio; HPV; childhood flu • work with immunisation coordinators to achieve 90% coverage for vaccination in all schools 	School Health teams and PHE Immunisation Coordinators
<p>* A brief intervention consists of a conversation that aims to give a young person and/or parents the tools to change attitudes and handle underlying problems. It should include assessing their motivation to change, explaining the consequences of behaviours, giving advice to change behaviour, providing a range of options to change, encouraging self efficacy, agreeing steps on the journey and offering follow up</p>		

Children with Special Educational Needs

A pupil has special educational needs when their learning difficulty or disability requires special educational provision that is different from, or additional to, that which is typically available to pupils of the same age.⁸¹ Identifying these needs early and responding to them effectively will improve long-term outcomes for that child or young person.

The four broad areas below give an overview of the range of needs. The purpose of identifying children with these needs is to help the school to take the correct action to support that child, not to fit a pupil into a category. In practice, individual children or young people may have needs that cut across these areas, and their needs are likely to change over time.

1. **Speech, language and social communication needs.** These children have difficulty in communicating with others. This may be because they have difficulty saying what they want to, or understanding what is being said to them, or they may not understand or correctly use social rules of communication.
2. **Cognition and learning difficulties.** These children learn at a slower pace than their peers. They may have specific learning difficulties (like dyslexia), moderate learning difficulties, severe learning difficulties where children need support in all areas of the curriculum, or profound and multiple learning difficulties where children have severe and complex learning difficulties as well as a physical disability or sensory impairment.
3. **Social, emotional and mental health difficulties.** These children and young people may experience a wide range of social and emotional difficulties. They may be withdrawn or isolated, or display challenging, disruptive or disturbing behaviour. Their behaviours may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, eating disorders or physical symptoms that are medically unexplained. Other children may have disorders such as attention deficit hyperactive disorder or attachment disorder.
4. **Sensory and/or physical needs,** where children and young people require special educational provision because they have a disability which prevents or hinders them from making use of the usual educational facilities. This can be age related and may fluctuate over time. Many children and young people with vision, hearing or multi-sensory impairment will require specialist support and/or equipment.

Schools tend to be very aware of children who have particular difficulties in learning. The class or subject teacher works with the child on a daily basis and liaises with teaching assistants or specialist staff to plan and assess the impact of support and interventions and how they can be linked to classroom teaching. The school may also directly commission specialist services to support the early identification of special educational need and to provide effective support and interventions. These specialist services may include:

- educational psychologists
- Child and Adolescent Mental Health Services
- specialist teachers or support services

- therapists including speech and language therapists, occupational therapists and physiotherapists

Although schools determine their own approach to maintaining records about these pupils, they are required to provide information about all children with special educational needs through the School Census. The Census covers all pupils enrolled in state-funded primary, secondary or special schools, and allows the Local Authority to identify pupils who have or may have special educational needs. It also enables the Department for Education to produce nationally comparative statistics. The Cheshire East January 2014 Census included 3,395 children which is equivalent to 6.3% of children being schooled in Cheshire East. Table 3 illustrates their primary type of need.

Table 3. Pupils with statements of Special Educational Need (SEN) or at School Action Plus by their primary type of need, January 2014

	Children in Cheshire East	Cheshire East rate per 1,000	England rate per 1,000	CE compared to England
Speech, language, social communication	720	13.4 / 1,000	16.7 / 1,000	19.6% lower
Cognition and learning difficulties	1,015	18.9 / 1,000	28.7 / 1,000	34.1% lower
<i>specific learning difficulties</i>	<i>461</i>	<i>8.6 / 1,000</i>	<i>8.1 / 1,000</i>	<i>5.9% higher</i>
<i>moderate learning difficulties</i>	<i>319</i>	<i>5.9 / 1,000</i>	<i>15.6 / 1,000</i>	<i>61.9% lower</i>
<i>severe learning difficulties</i>	<i>172</i>	<i>3.2 / 1,000</i>	<i>3.7 / 1,000</i>	<i>14.0% lower</i>
<i>profound and multiple learning difficulties</i>	<i>63</i>	<i>1.2 / 1,000</i>	<i>1.3 / 1,000</i>	<i>7.7% lower</i>
Social, emotional, behavioural difficulties	746	13.9 / 1,000	16.6 / 1,000	16.5% lower
Sensory and/or physical needs	317	5.9 / 1,000	6.4 / 1,000	8.0% lower
<i>hearing impairment</i>	<i>114</i>	<i>2.1 / 1,000</i>	<i>2.0 / 1,000</i>	<i>7.4% higher</i>
<i>visual impairment</i>	<i>58</i>	<i>1.08 / 1,000</i>	<i>1.09 / 1,000</i>	<i>1.3% lower</i>
<i>multi-sensory impairment</i>	<i>6</i>	<i>0.13 / 1,000</i>	<i>0.11 / 1,000</i>	<i>16.5% lower</i>
<i>physical disability</i>	<i>139</i>	<i>2.6 / 1,000</i>	<i>3.2 / 1,000</i>	<i>19.4% lower</i>
Autistic spectrum	325	6.1 / 1,000	9.1 / 1,000	33.7% lower
Other needs	266	5.0 / 1,000	3.5 / 1,000	42.1% higher
All pupils	3,395 *	63.2 / 1,000	81.0 / 1,000	22% lower
* The row totals add up to 3,389 because of suppressed information relating to six children in secondary and special schools				

It is not easy to provide a clear interpretation of these figures. They suggest that a lower proportion of school pupils in Cheshire East have special educational needs than nationally. This is consistent with other relevant indicators that also show better outcomes in Cheshire East, such as the proportion of infants with low birth weight at term and children achieving a good level of development at the end of Reception Year.

However, three groups of children show a different pattern. The recording of pupils with “other needs” is over 42% higher than nationally, which equates to around 79 children. Autistic spectrum is over a third lower than the national rate, and this equates to around 165 children. The third group of children are those with a moderate learning disability, among whom schools are recording special educational need at around 38% of the rate seen nationally – or around 518 children fewer than expected. Even taking into account the expected lower proportion of special educational needs in Cheshire East, there may be over 500 children in the Borough who have unrecognised needs. The majority of these are likely to have moderate learning disability or an autistic spectrum disorder.

There are several reasons why this under-recording is important, including:

- schools may not yet have identified or assessed these children
- schools may not be allocating appropriate support to these children
- these children are not being reported to the Local Authority through the School Census. As the Local Authority helps to populate and validate General Practice registers of people with a learning disability, their needs are not being identified to their General Practitioners
- there is clear evidence that children and adults with any degree of learning disability have worse health than their peers, and this often starts early in life. Some children and adults may require “reasonable adjustments” to be made to the health services that they receive. If health services do not know that someone has a learning disability, these adjustments cannot be made and health inequalities will persist
- young people may need additional support to make the transition to adult life. Without a good understanding of their individual needs, including the impact of any learning difficulties or disabilities that they may have, it is more difficult to co-ordinate care around these needs, and ensure continuity and the best outcomes

Health Outcomes Associated with Learning Disability

General practices were previously only required to establish and maintain a register of patients aged 18 and over with learning disabilities. From April 2014, this age restriction has been removed so their registers now include people of any age with a learning disability. This helps general practices and other health services to make plans for any “reasonable adjustments” that may be needed for a child or young person with a learning disability. Reasonable adjustments include removing physical barriers to accessing health services, and making whatever alterations are necessary to policies, procedures, staff training and service delivery to ensure that they work equally well for people with learning disabilities.

Learning disabilities are defined by the presence of three core criteria, which are: i) a significantly reduced ability to understand new or complex information and learn new skills, ii) a reduced ability to cope independently, with impaired social functioning, and iii) the disability begins in very early childhood and has a lasting effect on development.

People with learning disabilities have poorer health than the general population, and much of this starts early in life and is avoidable.⁸² The impact is serious. As well as having a poorer quality of life, people with learning disabilities die at a younger age than their non-disabled peers. There are five determinants of health inequalities of relevance to learning disability:

1. Greater risk of exposure to the social determinants of poorer health such as poverty, poor housing, unemployment, discrimination and isolation
2. Increased risk of health problems associated with specific genetic, biological and environmental causes of learning disabilities
3. Communication difficulties and reduced understanding of health issues
4. Personal health risks and behaviours such as poor diet and lack of exercise
5. Problems with access to healthcare provision

A number of longitudinal studies are actively following up representative groups of children over their life course, and are accurately measuring their long-term health and wellbeing outcomes. As these studies include children with learning disabilities, they provide us with valuable evidence about the impact that a learning disability can have on the health and wellbeing of a child.

The Millennium Cohort Study is tracking the well-being of over 18,000 children who were born in the UK between 2000 and 2002. Test scores taken at age three, five and seven have been used to identify children with any degree of learning disability. The study has found that three year old children with developmental delay have significantly higher rates of emotional and behavioural difficulties in comparison to their typically developing peers. Recent work by the Learning Disability Observatory has shown that these differences are more apparent by age seven, with children with learning disabilities being over three times more likely to have conduct difficulties and emotional difficulties, over four times more likely to have difficulties relating to their peers and over five times more likely to have hyperactivity or attention deficit hyperactive disorder.

Another study⁸³ has suggested that children with borderline or intellectual disability were significantly more likely to exhibit persistent conduct difficulties, but only if exposed to multiple environmental risks (living in an income poor household; living in a more deprived neighbourhood; having co-morbid emotional difficulties; having poorer pro-social behaviours; poorer maternal health; greater exposure to angry/harsh parenting; and greater exposure to more inconsistent parenting). The persistence and high levels of conduct difficulties among this high risk group appears to be associated with a combination of increased risk of exposure to environmental adversity and decreased resilience when so exposed.

The Learning Disability Observatory has used the Longitudinal Study of Young People in England to look at 532 adolescents who were identified through education records as being at School Action Plus or a having a special educational need associated with a mild or moderate learning difficulty. This study is tracking adolescents as they transition from mainstream school to adult life. Boys with mild or moderate learning disabilities reported significantly poorer self-rated health and mental health than their peers. They were also more likely to have smoked in the last year, be bullied on a weekly basis at school, and to live in a poorer household. There were fewer differences between girls with and without mild or moderate learning disabilities, although these girls too were more likely to be exposed to common social determinants of poorer health, including poverty and bullying.

Mental Health

Children and young people who are emotionally healthy achieve more, participate more with their community and peers, engage in less risky behaviour and cope better with adversities they may face

from time to time. Emotional health in children has important implications for health and social outcomes in adult life.

Emotional health is not about feeling happy all the time, it is about having the resilience, self-awareness, social skills and empathy required to form relationships, enjoy one's own company and deal constructively with setbacks that everyone faces from time to time. Within the school setting, whole school approaches to emotional health e.g. through PHSE, are an important contribution to promoting emotional health in the school age population. From time to time some children and young people may develop problems which require support from others.

Schools are being encouraged to identify mental health problems in their pupils at an early stage. Many schools already have their own programmes to help children who may be experiencing mental health problems, such as school-based counsellors or whole school approaches to mental and emotional health.⁸⁴ I have discussed school based therapy services in Chapter Eight.

In addition, the new Special Educational Needs and Disability (SEND) Code of Practice provides statutory guidance for education and health services on identifying and supporting children and young people with mental health problems who have a special educational need. It will ensure a child's mental health needs are captured within any assessment of their educational, health and social care needs. It sets the expectation that there should be clear arrangements in place between local health partners, schools, colleges, early years providers and other organisations for making appropriate referrals to Child and Adolescent Mental Health Services (CAMHS).

This will require health and education professionals to work collaboratively so that the right decisions can be made to support each child, and quickly referring those who need extra support. Education services and Clinical Commissioning Groups should ensure that young people have a planned and painless transition to adult mental health services. This will lessen their chance of getting lost in transition with the attendant high risk of deterioration in their mental and physical health.

Sex and Relationships Education

Sex and relationships education (SRE) is learning about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health. Both young people and parents want high-quality education about sex and relationships.

The provision of sex education is a statutory requirement for maintained secondary schools. What schools include in their sex-education programme is a matter for local determination; however, all schools must give regard to the Secretary of State for Education's Sex and Relationship Education Guidance. This guidance, if followed, should ensure that pupils develop positive values and a strong moral framework that will guide their decisions, judgement and behaviour. It ensures that pupils are taught about the benefits of loving, healthy relationships and delaying sex, and also that pupils are aware of how to access confidential sexual health advice and support.

Academies do not have to teach sex education, but are required through their funding agreements to provide a broad and balanced curriculum. They are also required to have regard to the Sex and Relationship Education Guidance when providing sex education.

All schools delivering sex and relationship education are required to ensure that their pupils receive high-quality information on the importance of good sexual health.

Some aspects of SRE are taught in science, and others are taught as part of personal, social, health and economic education (PSHE).⁸⁵ Good PSHE is essential to support positive relationships and sexual health. Although schools are responsible for determining the content of their PSHE, the Department of Health has advised that school nurses can use the following checklist⁸⁶ to support good quality sex and relationships education in each school:

1. Are school nurses introduced in person to all pupils?
2. Do pupils learn that they can visit the school nurse and other health services 'un-invited' and that it is fine to come with a worry or a question?
3. Are younger pupils taught correct names for sexual parts of the body and about bodily privacy?
4. Do primary children learn about puberty before they experience it?
5. Is the confidentiality offered by school nurses explained to pupils in SRE?
6. Do secondary school pupils have opportunities to practice the skills for using a sexual health service by themselves, for example by using role-play conversations?
7. Does the SRE programme teach sufficient knowledge about sexual health for young people to be able to assess their own need to use a service?
8. Are school nurses documenting common questions and concerns from pupils and feeding this back anonymously to the lead SRE teacher in order to inform curriculum planning?
9. Do pupils have a way of asking the school nurse a question anonymously, for example by email or a question box, and is this facility explained in SRE?
10. Are school nurses aware of any external agencies contributing to the schools SRE, and are they confident about the medical accuracy of what they teach?
11. Are school nurses consulted when the SRE programme is reviewed or the policy updated?

Supporting Pupils with Medical Conditions at School

Parents of children with medical conditions are often concerned that their child's health will deteriorate when they attend school. This is because pupils with long-term and complex medical conditions may require on-going support, medicines or care while at school to help them manage their condition and keep them well. Others may require monitoring and interventions in emergency circumstances. The Children and Families Act 2014 requires governing bodies of maintained schools and proprietors of academies to make arrangements for supporting pupils at school with medical conditions. Schools are expected to:

- develop policies for supporting pupils with medical conditions and review them regularly
- develop individual healthcare plans for pupils with medical conditions that identify the child's medical condition, triggers, symptoms, medication needs and the level of support needed in an emergency
- have procedures in place on managing medicines on school premises

- and ensure staff are appropriately supported and trained⁸⁷

The Annual Report of the Chief Medical Officer 2012 stressed that for school-aged children the school plays an important role in supporting them with their chronic illness or disability. An individual healthcare plan can alleviate fears about how much the school staff knows about the child's condition and how best they can help and support them. They provide clarity about what needs to be done, when and by whom. However, not all children will require one. The school, healthcare professional and parent should agree, based on evidence, when a healthcare plan would be inappropriate or disproportionate.

School nurses are responsible for notifying the school when they become aware that a child has a medical condition which will require support in school. Wherever possible, they should do this before the child starts at the school. They would not usually have an extensive role in ensuring that schools are taking appropriate steps to support children with medical conditions, but may support staff on implementing a child's individual healthcare plan and provide advice and liaison, for example on training. School nurses can liaise with lead clinicians locally on appropriate support for the child and can work with local specialist nursing teams to offer training to school staff, for example on the appropriate use of inhalers, adrenalin auto injectors prescribed for children and young people with diagnosed anaphylaxis, and any specialist equipment that may be needed by the child. Community nursing teams will also be a valuable potential resource for a school that is seeking advice and support in relation to children with a medical condition. Healthcare professionals, including the school nurse, can confirm the proficiency of school staff in a medical procedure or in providing medication.

There are a very wide range of medical conditions that might justify an individual healthcare plan being put in place. Some of these may have resulted from a serious home, sporting or road traffic injury, while others may be due to disorders such as cancer, infections, gastrointestinal and skin conditions. Many of the children and young people in the following chronic disease groups are being followed up regularly by their general practitioner and may benefit from having an individual healthcare plan:

Table 4. Children and Young People in Cheshire East on Chronic Disease Registers (2013/14)

Chronic Disease Register	Numbers	Percentage
Chronic respiratory disease (the majority of these are likely to be using salbutamol inhalers)	3,252	3.9%
Chronic heart disease	837	1.0%
Chronic neurological disease	345	0.4%
Diabetes	161	0.2%
Immunosuppression	108	0.1%
Chronic kidney disease	21	-
Chronic liver disease	18	-

Governing bodies should ensure that the school's policy is explicit about actions that are not acceptable. Although school staff should use their discretion and judge each case on its merits with reference to the child's individual healthcare plan, it is not generally acceptable practice to:

- prevent children from easily accessing their inhalers and medication and administering their medication when and where necessary
- assume that every child with the same condition requires the same treatment
- ignore the views of the child or their parents, or ignore medical evidence or opinion
- send children with medical conditions home frequently or prevent them from staying for normal school activities, including lunch, unless this is specified in their individual healthcare plan
- if the child becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable
- penalise children for their attendance record if their absences are related to their medical condition, for example hospital appointments
- prevent pupils from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively
- require parents, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their child, including with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs
- prevent children from participating, or create unnecessary barriers to children participating in any aspect of school life, including school trips, e.g. by requiring parents to accompany the child

Emergency Salbutamol Inhalers in Schools

Asthma is the most common chronic condition and affects around one in eleven children. On average, there are two children with asthma in every classroom in the UK. In Cheshire East there are believed to be over 7,578 school aged (5-16 years old) children and young people with asthma, and they experience 118 emergency hospital admissions for asthma every year.

The Human Medicines (Amendment) (No. 2) Regulations 2014 allows schools to keep a salbutamol inhaler for use in emergencies (as part of an emergency asthma inhaler kit). Larger schools may have several such kits located in different buildings. The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty). It can only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication.⁸⁸

Primary and secondary schools are not required to hold an inhaler, but keeping one for emergency use could prevent an unnecessary and traumatic trip to hospital for a child, and could potentially save their life.

Key Points

School health services are a key component of the Healthy Child Programme. These services support school-aged children (5-19 years) to achieve the best possible health outcomes. School health teams lead and contribute to improving the outcomes for children and young people but they are not solely responsible for achieving these; there needs to be a partnership approach involving health and social care teams, teachers and youth workers.

- The current school health service (school-based and term-time only) needs to be remodelled. The school health services should be a key health resource for children and young people up to age 19. To ensure all young people (up to age 19) can access the service, school health services should be available to those young people at colleges and universities, and for those who are no longer in education. It should also be available during school holidays.
- The new school health service should utilise electronic devices and social media/texts as methods of communication with families and/or young people including for health promotion and service reminders (e.g. appointments).

Schools tend to be very aware of children who have particular difficulties in learning, whether due to a learning disability, a physical disability or a health condition. The class or subject teacher works with the child on a daily basis and liaises with teaching assistants or specialist staff to plan and assess the impact of support and interventions and how they can be linked to classroom teaching. However, within Cheshire East there is an under-recording by schools of children and young people with moderate learning disabilities or an autistic spectrum disorder – it is estimated that around 500 children in the Borough have unrecognised needs. This affects not only their educational attainment but also their health and wellbeing, with wider services such as health not being aware of their additional needs.

- People with learning disabilities have poorer health than the general population, and much of this starts early in life and is avoidable. Boys with mild or moderate learning disabilities report significantly poorer self-rated health and mental health than their peers. They are also more likely to have smoked in the last year, be bullied on a weekly basis at school, and to live in a poorer household.
- Recent work by the Learning Disability Observatory has shown that children with learning disabilities are over three times more likely to have conduct difficulties and emotional difficulties, over four times more likely to have difficulties relating to their peers and over five times more likely to have hyperactivity or attention deficit hyperactive disorder.
- Schools are being encouraged to identify mental health problems in their pupils at an early stage. Many schools already have their own programmes to help children who may be experiencing mental health problems, such as school-based counsellors or whole school approaches to mental and emotional health.
- An individual healthcare plan can alleviate fears about how much the school staff knows about a child's medical condition, and how best the school can help and support them. They provide clarity about what needs to be done, when and by whom.

Chapter Ten

Commissioning Services for Children and Young People

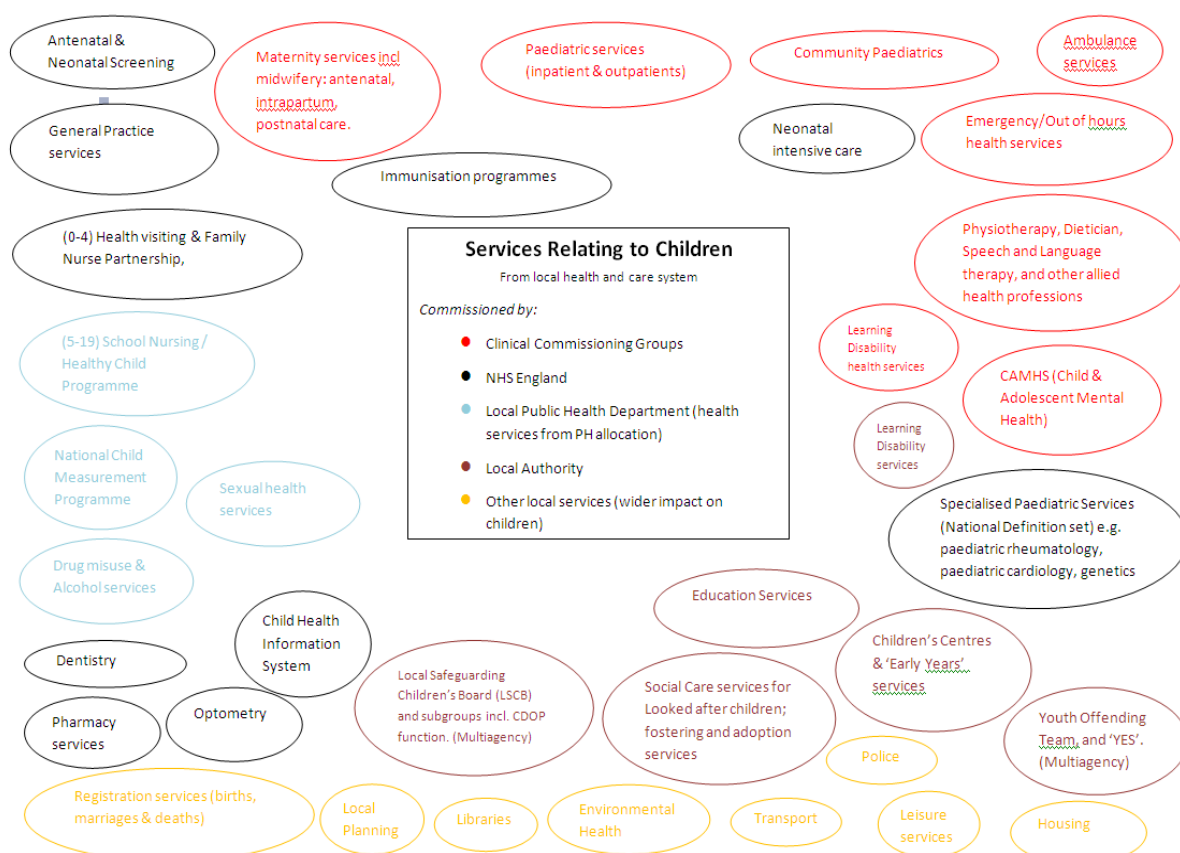
Many services are commissioned for children and young people in the local health and care system by a range of statutory commissioning organisations (see Figure 27). Some services are available on a population wide basis, for example antenatal care, health visiting, school health, accident and emergency services. Outside the health service arena, education services are an example of a population wide service for children.

In addition to all those services, some services are targeted at children in specific circumstances (for example services for cared for children).

There are also generic services serving the community that are included on the diagram because they contribute to the wider environment that children live in, for example housing, leisure and transport services.

Figure 27 also shows the local organisation with the commissioning responsibility for that service. It shows that the commissioning responsibility for services for children lies across several statutory organisations, including two Clinical Commissioning Groups, NHS England, Cheshire East Council and the police.

Figure 27. Commissioned services relating to children from the local health and care system



In relation to children and young people, the Director of Public Health has commissioning responsibilities that relate to the following statutory functions⁸⁹:

- a range of public health services that are aimed at improving the health of children and young people. These include population level interventions to reduce and prevent birth defects, the National Child Measurement Programme, public health services for children and young people aged 5-19 (including school health services and the Healthy Child Programme 5-19) and, from October 2015 the Healthy Child Programme 0-5 (including health visiting services and the Family Nurse Partnership)
- all of the local authority's duties to take steps to improve the health of children and young people in its area. This arises from section 73A(1) of the NHS Act 2006, inserted by section 30 of the Health and Social Care Act 2012
- the provision of a public health advice service to both of the Clinical Commissioning Groups in the authority's area.⁹⁰ The purpose of the public health advice service in relation to children and young people is to assist both CCGs with the following:
 - the creation of a summary of the overall health of children and young people
 - the provision of assessments of the health needs of children and young people with particular conditions or diseases
 - advice on the development of plans for the anticipated care needs of children and young people, to improve the outcomes achieved for them by the provision of health services
 - advice on how to meet the duty on each clinical commissioning group to reduce inequalities
- such other public health functions as the Secretary of State specifies in regulations, for example the commissioning of sexual health services and, from 2015, certain universal elements of the 0-5 Healthy Child Programme (antenatal health promoting visits, new baby review, 6-8 week assessment , 1 year assessment and 2-2½ review)

As Director of Public Health I work closely with my colleague the Director of Children's Services, who discharges the education and children's social services functions of the local authority, and has professional responsibility for children's services, including operational matters. This includes responsibility for children and young people receiving education or children's social care services in their area and all cared-for children or in custody (regardless of where they are placed). The Director of Children's Services has commissioning responsibilities that relate to the following statutory functions⁹¹:

- securing the provision of services which address the needs of all children and young people, including the most disadvantaged and vulnerable, and their families and carers
- ensuring that the local voluntary and community sector, charities, social enterprises, the private sector and children and young people themselves are included in the scope of local authority planning, commissioning and delivery of children's services where appropriate
- helping to join up local commissioning plans for clinical and public health services with children's social care and education, where appropriate, to address the identified local

needs through the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

- being responsible for any agreements made under section 75 of the National Health Service (NHS) Act 2006 between the local authority and NHS relating to children and young people – for example, pooled budgets for commissioning and/or delivering integrated services covering children’s health, social care and education

From a commissioning perspective, to achieve optimum outcomes for children with respect to preventive, treatment and ongoing care, multiple commissioners need to be aware not only of their own responsibilities but also those of partner organisations, and in turn of when it might be sensible to work together. It may even be sensible to consider commissioning together, known as collaborative commissioning (common vision, pooled funds, single contract). However, effective collaborative commissioning arrangements need mature understanding from all parties about the common goals, any financial risk sharing, and clarity about ultimate accountability.

This next section is about working out if a collaborative arrangement is suitable or not, and if not, then what arrangements is more suitable.

Firstly consider,

- is the *purpose* of the service to be commissioned clear? (if not, agree this with the responsible commissioner(s) first)
- is there sufficient clarity about the *service* to be commissioned? e.g. health visiting, child and adolescent mental health services, school health, or an out-of-hours service, etc

If answers to these questions are not clear, go back and clarify. When ready use the following steps to consider the most sensible commissioning model.

This next stage is about working out whether a simple commissioning-provider relationship is needed, or whether one of the collaborative approaches is suitable.

Consider the following factors:

- **how many commissioners** are involved? (commissioners hold the commissioning responsibility, can make decisions about using funds for this purpose)
- **how many providers** are involved? (including voluntary and fourth sector)
- **is there an aligned vision/ common goal** across commissioners about the service to be provided? Or are there several independent visions? (if there is no common vision then a collective commissioning arrangement is not suitable)
- **will funds be pooled?**
- which is/are the **accountable organisation(s)?** (accountable for the funds, responsible for holding the provider to account for quality)

See Table 5 and Table 6 to help decide. There is also a summary flowchart (Figure 28) to assist:

Table 5. Commissioning approaches (Table A)

	Number of Providers involved	Number of Commissioners involved	Which type of commissioning approach is suitable?
A	One or more providers of the service that is being commissioned	Single commissioner	<p>Simple commissioning relationship between commissioner and provider.</p> <p><i>Description:</i> One commissioner contracts with one provider organisation to provide a service. A commissioner may hold many of these types of contracts. Examples include:</p> <p><i>CCG commissioning of:</i> Maternity services (antenatal, intra-partum and postnatal care); Paediatric services; Emergency services; Child and adolescent mental health services</p> <p><i>NHS England commissioning of:</i> Primary care services (GP practices, optometrists, pharmacists, dentists); Immunisation programmes</p> <p><i>Local Public Health Department commissioning of:</i> School nurses, pharmacies for emergency hormonal contraception, community sexual health services</p>

When there is more than one commissioner involved in organising the service, one of the collaborative approaches below may be appropriate. These are the **Collaborative commissioning (collaborative contracting)** approach, or a ‘**Collaboration of intent**’.

With both of these models, all participating commissioners have an aligned vision of the service to be commissioned. The next matter is then whether funds are pooled into a single contract with the provider. If the answer is yes then there is a true collaborative commissioning arrangement. If the answer is no then the arrangement is probably a ‘Collaboration of intent’.

Choose carefully because using a ‘collaborative commissioning’ arrangement when it is actually a collaboration of intent can be difficult to manage and eventually unfolds.

Table 6. Commissioning approaches (Table B)

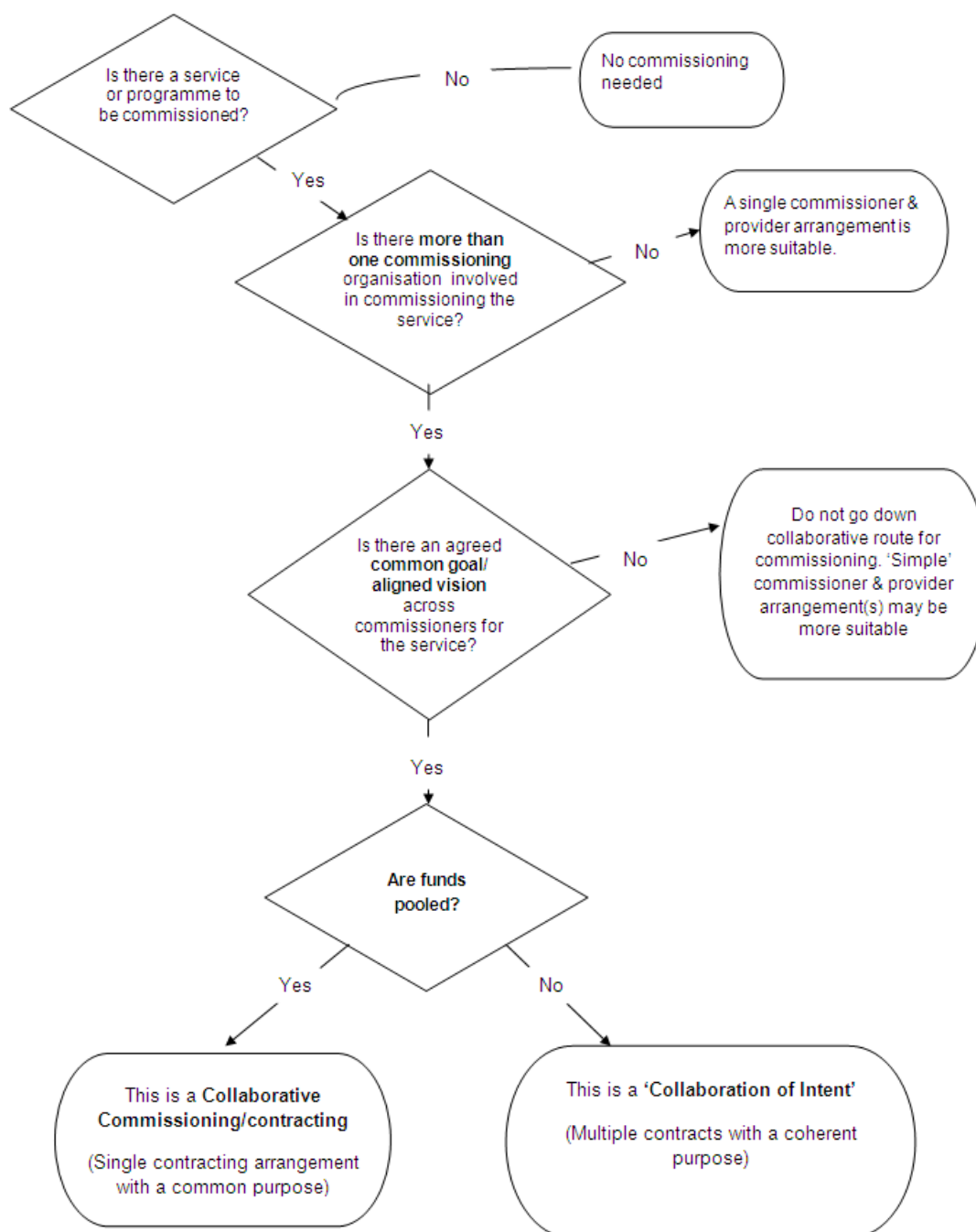
	Number of Providers involved	Number of Commissioners involved	Which type of commissioning approach is suitable?
B	Single, or very few providers	Multiple commissioners	<p>‘Collaborative commissioning’ (Collaborative contracting)</p> <p><i>Description:</i> several commissioners wish to work together with a common goal, and agree that this is best done through a single contract. Funding is pooled. There is a common commissioning process (strategically and contractually). Usually co-ordinated through a ‘Lead’ organisation with multiple ‘co-commissioners’. Each organisation remains ultimately accountable for their</p>

			<p>population.</p> <p><i>Situations suitable:</i></p> <ul style="list-style-type: none"> • Only 1 or very few providers and common quality standards are needed • Or, for high cost, low volume services and a financial risk share needs to be considered <p><i>Disadvantages:</i> All commissioners must be happy about the common standards of provision. Not suitable when each commissioner wants a bespoke service.</p> <p>Local examples include:</p> <ul style="list-style-type: none"> • North West Ambulance services • Screening services where there are a limited number of providers e.g. laboratory services • Specialised paediatric services e.g. paediatric cardiology, neonatology, genetics, paediatric rheumatology • Local medicines management team • Potential services from the Better Care Fund
C	Multiple providers	Multiple commissioners	<p>‘Collaboration of intent’</p> <p><i>Description:</i> There is an explicitly agreed aligned vision in the system, but there are multiple commissioners and providers and with many separate commissioning processes. Funding is not pooled. Each organisation is accountable for their own commissioning.</p> <p><i>Situation suitable:</i> When several commissioners wish to work together towards a common goal, but each commissioner wishes to directly commission their own services.</p> <p><i>Disadvantages:</i> Have to trust partner organisations to deliver the joint vision in this way. There is no contractual leverage over partner organisations to deliver the common vision.</p> <p>Many multiagency efforts are organised this way (or aspire to work this way) i.e. no money is pooled but they have (or aspire to have) a common purpose for working together. Examples include:</p> <ul style="list-style-type: none"> • Health & Well-Being Strategy • ‘Caring Together’ integration programme (although initially focused on the frail elderly a future stage of this programme will be to look at the children’s service pathways). • Local Safeguarding Children’s Board and subgroup work <p>N.B. Often, ventures referred to as ‘joint commissioning’ are actually arrangements that aspire to be collaborations</p>

			of intent, i.e. no money or accountability is actually pooled but there is an agreement to work together strategically.
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The term **'joint commissioning'** is best avoided as it is often not defined and can lead to unnecessary confusion. Historically it has been used to refer to many different things such as 'better joined up working at operational level', or more joined up working strategically without explicitly agreeing a common goal, or sometimes it does actually aspire to a true 'collaboration of intent'.

Figure 28. Aid to help assess whether a collaborative approach is suitable



It is very rare for the term 'joint commissioning' to be used to actually mean true collaborative commissioning with contracting. So it is better in discussions to be specific about whether we actually are exploring a collaboration of intent, or true collaborative commissioning, or whether it is none of these, just an exploratory discussion about how best for things to work together at an operational level without any change to the commissioning arrangements.

Key Points

From a commissioning perspective, to achieve optimum outcomes for children with respect to preventive, treatment and ongoing care, multiple commissioners need to be aware not only of their own responsibilities but also those of partner organisations, and when it might be sensible to work together. When organisations do work collaboratively it is best that they are clear from the start what type of commissioning or joint working arrangement they are choosing to use to avoid confusion and ensure good working relationships.

- Effective collaborative commissioning arrangements need mature understanding from all parties about the common goals, any financial risk sharing, and clarity about ultimate accountability.
- When there is more than one commissioner involved in organising the service it may be appropriate to use either a collaborative commissioning (collaborative contracting) approach, or a 'collaboration of intent'.
- Commissioners must choose carefully because using a 'collaborating commissioning approach' arrangement when it is actually a 'collaboration of intent' can be difficult to manage and eventually unfolds.
- It is less likely that true collaborative commissioning with contracting ('joint commissioning') is achieved. Therefore this term is best avoided as it is often not defined and can lead to unnecessary confusion.

Appendix A

Using Social Media to Deliver Public Health Messages

Public Health has an important role to advise and signpost other bodies such as Clinical Commissioning Groups and NHS Trusts towards accurate and reliable health information. This is to ensure that the information provided to members of the public is consistent and relevant to their needs. Partnership working is vital to achieving this.

An example is that of the Cherubs (Cheshire's Really Useful Breastfeeding Support) Project and website. The website is the base point for all information around local breastfeeding groups, peer supporter training programmes and it also provides detailed guidance to both mothers and health professionals around all aspects of breastfeeding.

Both of the acute Trusts in Cheshire East have their own supply of materials for the promotion of Cherubs including posters, pull up banners, business cards, flyers and stickers. The health visiting and maternity teams of East Cheshire NHS Trust have received the top accolade "Stage 3 Baby Friendly" from UNICEF, while the maternity team at Mid Cheshire Hospitals NHS Foundation Trust has achieved Stage 2; clearly demonstrating their commitment to Cherubs and to breastfeeding.

Cherubs is formally discussed with local parents on a regular basis. Parents receive consistent messages at different stages during pregnancy and beyond. On booking at the chosen hospital a Cherubs breastfeeding sticker is visible on the pregnancy file. Cherubs is part of the antenatal checklist – this acts as a reminder to both parents and the midwife to discuss breastfeeding. A Cherubs sticker is on the child's "Red Health Book" ensuring that breastfeeding is covered at the health visitors home check and beyond.

The Cherubs website has seen a consistent growth in the number of hits, demonstrating its increasing popularity and support. It has risen from an average of less than 100 hits per month (2011) to over 300 (2014). In its first 12 months only 19% of new mothers accessed the site, but by 2014 the website was being used by over half of new mothers locally (54%).

A web based tool is an ideal base for further information but it also has merit in directing parents to further resources. The Healthy Child Programme portrays a journey from 0-4 and 5-19 through the health visiting and school health services, and all aspects of the programme could link into a web based journey from one recognised resource to another.

Building on Cherubs as one small part of a "child's journey" would involve the design of a "brand identity" linking one set of information to another. This identity could be something as simple as a logo or sign that would appear on each of the linked web sites. A standardised home page with links to the next and previous parts of the life course would be ideal. Commitment of key health professionals such as midwives, pharmacists, general practitioners and health visitors is important in the successful growth of a project such as this.

Based on the evidence presented within this public health report, the key web resources to support improvements in health in the 0-4 age group will need to cover:

- Preconception advice
- Smoking

- Alcohol
- Breastfeeding
- Cold homes
- Safe homes
- Management of head injury
- Management of fever
- Management of respiratory conditions

In preparation for the re-tender of the health visiting and school health services in 2015, the Public Health team should work with Clinical Commissioning Groups and other commissioning partners to develop improved web-based information and health promotion resources for Children's Centres, Nurseries, Schools and General Practices. This will support the healthy childhood journey from birth up to 19 years.

Technical Appendix – Health Statistics at LAP, CCG, Children’s Centre and Town Level

Figure 29. Cheshire East: Public Health Outcomes Framework indicators

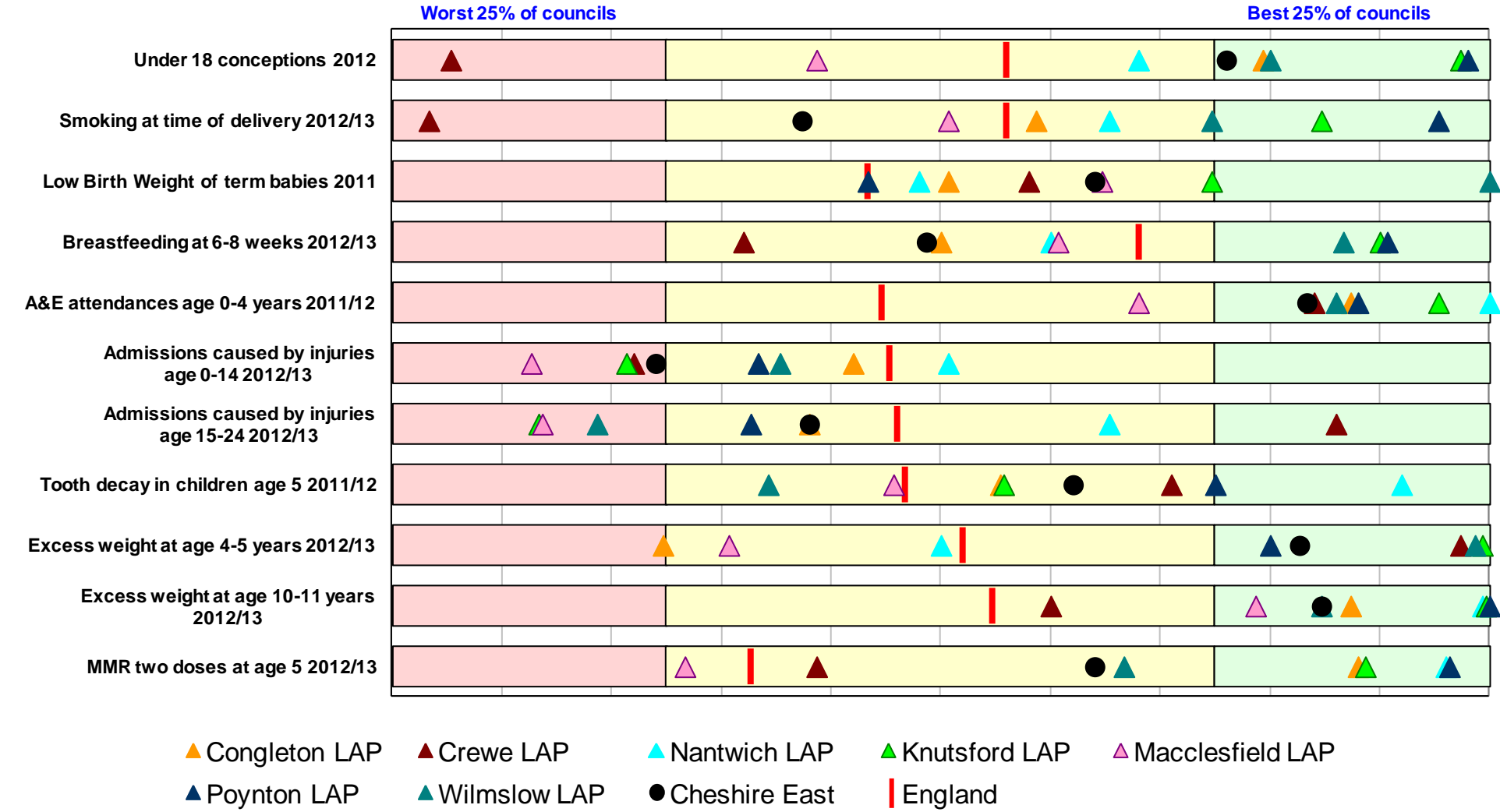
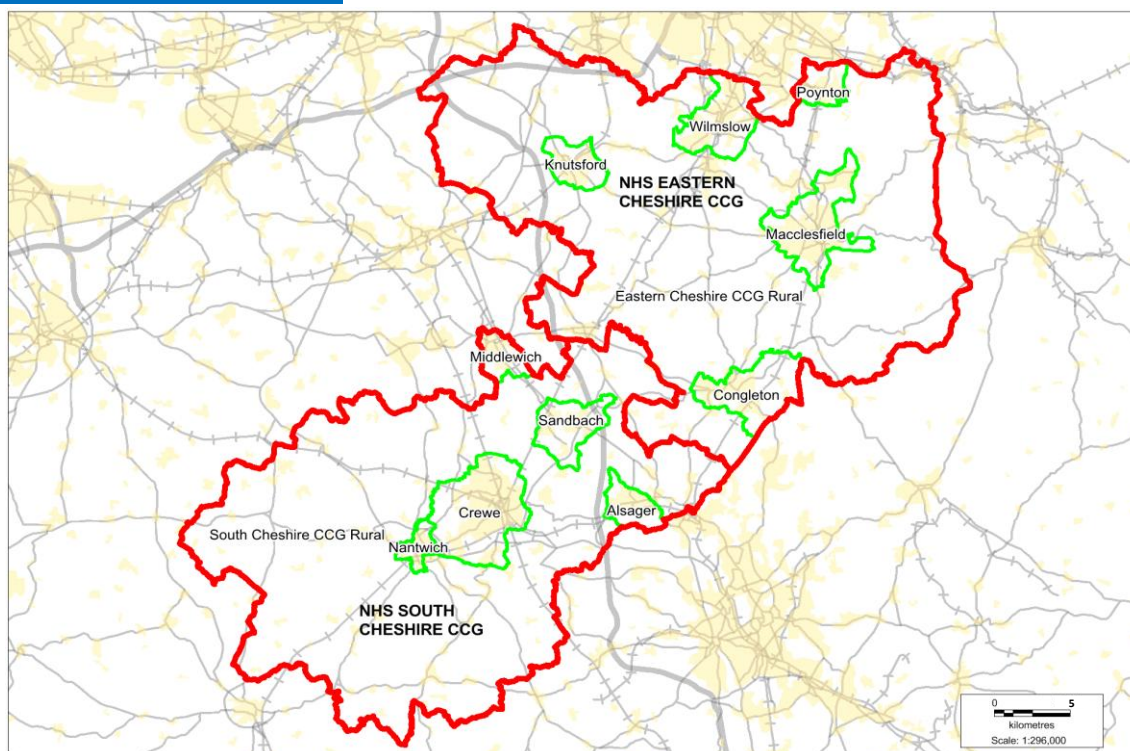


Table 7. Public Health Outcome Framework Indicators by LAP and CCG with Cheshire East and England data

Indicator	Year	Value type	Congleton LAP	Crewe LAP	Knutsford LAP	Macclesfield LAP	Nantwich LAP	Poynton LAP	Wilmslow LAP	Eastern Cheshire CCG	South Cheshire CCG	Cheshire East	England
Under 18 conceptions	2012	Crude rate per 1000	22.4	42.4	15.7	30.5	25.1	14.7	22.3	23.8	32.4	23.8	27.7
Smoking at time of delivery	2012/13	Proportion (%)	12.3	20.6	5.1	13.2	10.9	1.2	8.0	10.6	17.2	15.1	12.7
Low Birth Weight of term babies	2011	Proportion (%)	2.3	2.2	2.0	2.1	2.3	2.4	1.5	2.1	2.2	2.5	2.8
Breastfeeding at 6-8 weeks	2012/13	Proportion (%)	40.4	31.1	60.2	43.8	43.7	63.2	57.8	50.9	34.0	39.3	47.2
A&E attendances age 0-4 years	2011/12	Crude rate per 1,000	333.8	348.9	307.3	401.0	244.1	332.6	339.0	366.9	315.4	350.3	510.8
Hospital admissions caused by injuries age 0-14	2012/13	Crude rate per 10,000	106.9	128.8	130.0	140.9	101.6	114.2	113.6	128.8	112.5	122.5	103.8
Hospital admissions caused by injuries age 15-24	2012/13	Crude rate per 10,000	138.3	97.8	184.4	180.7	114.6	145.1	164.1	174.0	104.3	138.2	130.7
Tooth decay in children age 5	2011/12	Proportion (%)	23.5	20.2	23.6	25.3	12.8	19.3	28.8	25.2	19.4	22.2	27.9
Excess weight at age 4-5 years	2012/13	Proportion (%)	23.9	17.4	16.2	23.5	22.5	20.9	16.4	20.6	20.6	20.7	22.2
Excess weight at age 10-11 years	2012/13	Proportion (%)	29.3	32.9	23.5	31.1	25.6	21.3	29.7	28.1	30.9	29.5	33.3
MMR two doses at age 5	2012/13	Proportion (%)	92.7	88.2	93.0	86.6	94.4	94.6	90.8	90.5	90.3	90.5	87.7

Cheshire East Council



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This map illustrates Clinical Commissioning Group and town areas.

The "town areas" shown on the above map are constructed from MSOA's (Mid-level Super Output Areas) and are used for statistical comparison purposes. There are five "town areas" and one "rural area" in each Clinical Commissioning Group. The boundary between the two Clinical Commissioning Groups straddles the Congleton Local Area Partnership area. For certain indicators, additional information at "town" level is available in the JSNA.

Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Cheshire East Council	3734	65028	57.4

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Cheshire East Council	3770	65028	58.0

Births within & outside marriage/ civil partnership (2013)

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partnership
Cheshire East Council	1994	1776	47.1

Registrations by lone mothers (2013)

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Cheshire East Council	276	179	12.1

Low Birth Weight (under 2500g) 2009-2011

	Babies with low birth weight	Total births in 3 year period	Percentage (%)
Cheshire East Council			
Total LBW babies (2009-11)	768	11984	6.4
LBW at term (2008-10)	230	10782	2.1

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continuation %
Cheshire East Council	3774	63.0	42.6

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Cheshire East Council	3085	430	1018
Percentage infants exposed to smoke		14.0%	33.0%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

	Number of infants	Number vaccinated	Uptake
Cheshire East Council			
Full primary course aged 1	4100	3955	96.5%
MMR 1st dose aged 2	4211	4009	95.2%
MMR 2nd dose aged 5	4218	3813	90.4%

The primary immunisation course consists of three vaccines protecting against diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

	Total Maternities	Smoking Exposure	Exposure to Smoking %
Cheshire East Council			
Aged <15-19	156	218	0.7
Aged 20-24	609	1030	0.6
Aged 25-29	602	1616	0.4
Aged 30-34	396	1974	0.2
Aged 35-39	216	1246	0.2
Aged 40+	56	357	0.2
Total	2035	6441	0.3

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Cheshire East Council (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Cheshire East Council	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	20397	2656	13.0
Males aged 0-4	10500	1555	14.8
Females aged 0-4	9897	1102	11.1

Total A&E Attendances aged <1 year, 2011-2014

Cheshire East Council	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	165	34.9
Females under 1 year	450	140	31.0

A&E Attendance for injury, average per year for 2011-14

Cheshire East Council	Attended per year	Percent (%)
under 1	284	6.9
1-4	2374	14.6
5-9	2244	11.0
10-14	3231	15.6
15-19	3027	13.9
0-19	11160	13.4

Emergency admissions for injury, av'g per year for 2011-14

Cheshire East Council	Admitted per year	Percent (%)
under 1	49	1.2
1-4	170	1.0
5-9	161	0.8
10-14	167	0.8
15-19	180	0.8
0-19	727	0.9

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

Cheshire East Council	Total
Oral Thrush (aged 0-4)	204
Impetigo (aged 0-4)	1302
Headlice (aged 4-11)	4227
Acne (aged 12-19)	29492
Eczema (aged 0-19)	14582
Conjunctivitis (aged 0-19)	1167

Daily activity affected by long term illness/disability 2011

Cheshire East Council	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.2%	1.9%	96.9%
Young people aged 16-19	1.9%	2.9%	95.2%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	20397	
Aged 5-11	28229	(Primary age range)
Aged 12-16	21823	(Secondary age range)
Aged 17-19	12874	
Total aged 0-19	83323	

Emergency Admissions for Injury, aged 0-4, 2011-2014

Cheshire East Council	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	20397	261	1.3
Males aged 0-4	10500	151	1.4
Females aged 0-4	9897	110	1.1

Total Emergency Admissions aged <1 year, 2011-2014

Cheshire East Council	Aged under 1y	Admitted per year	Percent (%)
Males under 1 year	472	211	44.6
Females under 1 year	450	141	31.4

A&E Attendance non-injury, average per year for 2011-14

Cheshire East Council	Attended per year	Percent (%)
under 1	1202	29.4
1-4	3120	19.1
5-9	2021	9.9
10-14	2578	12.4
15-19	3698	17.0
0-19	12618	15.1

Emergency admissions non-injury, av'g per year for 2011-14

Cheshire East Council	Admitted per year	Percent (%)
under 1	1657	40.6
1-4	1894	11.6
5-9	734	3.6
10-14	673	3.2
15-19	1155	5.3
0-19	6112	7.3

Children aged 6m to 19y with long term conditions

Cheshire East Council	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	2510	3252	3.9%
Heart disease	661	837	1.0%
Neurological disease	268	345	0.4%
Diabetes	124	161	0.2%

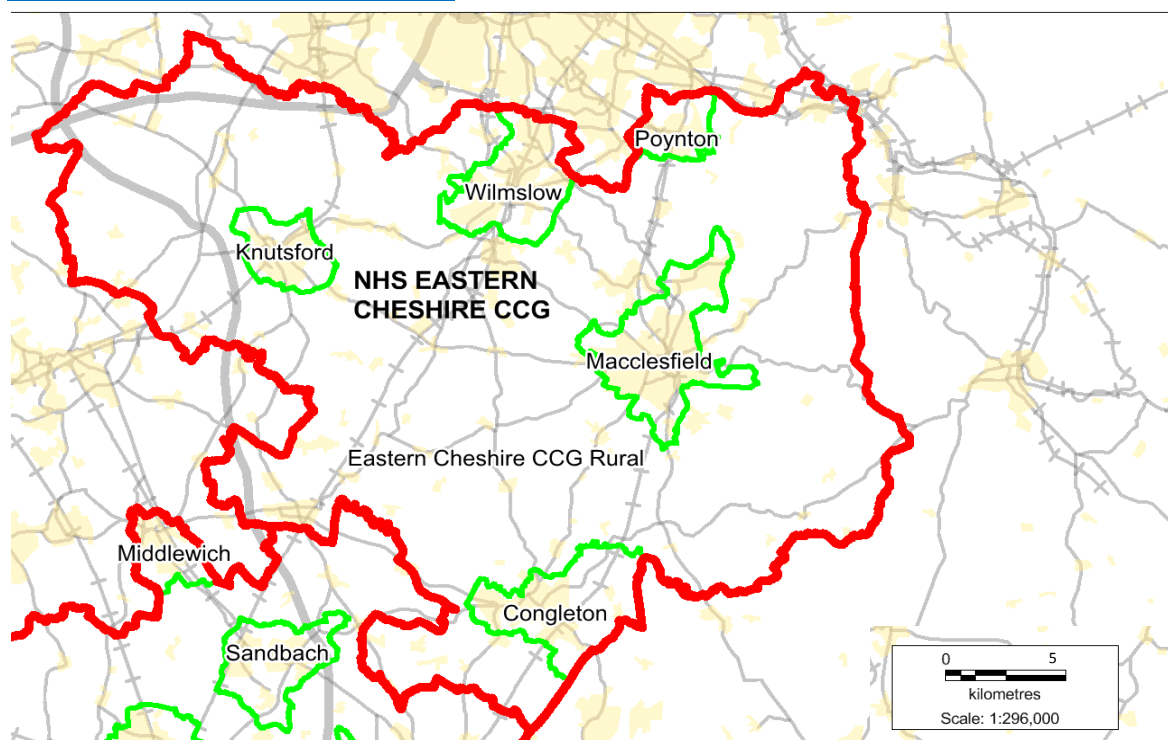
Ethnicity from Census data 2011

Cheshire East Council	Total	Percentage
White	96,770	94.9%
Asian/Asian British	2,032	2.0%
African/Carib/Black British	423	0.4%
Other ethnic group	279	0.3%
Mixed/multiple ethnic	2,511	2.5%

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	4084
Aged 1-4	16313
Aged 5-9	20370
Aged 10-14	20772
Aged 15-19	21784

NHS Eastern Cheshire CCG



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This map illustrates Clinical Commissioning Group and town areas.

The "town areas" shown on the above map are constructed from MSAO's (Mid-level Super Output Areas) and are used for statistical comparison purposes. There are five "town areas" and one "rural area" in each Clinical Commissioning Group. The boundary between the two Clinical Commissioning Groups straddles the Congleton Local Area Partnership area. For certain indicators, additional information at "town" level is available in the JSNA.

Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
NHS Eastern Cheshire CCG	1967	32474	60.6

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
NHS Eastern Cheshire CCG	1993	32474	61.4

Births within & outside marriage/ civil partnership (2013)

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partnership
NHS Eastern Cheshire CCG	1175	818	41.0

Registrations by lone mothers (2013)

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
NHS Eastern Cheshire CCG	130	89	11.0

Low Birth Weight (under 2500g) 2009-2011

	Babies with low birth weight	Total births in 3 year period	Percentage (%)
NHS Eastern Cheshire CCG	373	6076	6.1
Total LBW babies (2009-11)	373	6076	6.1
LBW at term (2008-10)	113	5389	2.1

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continuation %
NHS Eastern Cheshire CCG	1,904	71.7	50.9

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
NHS Eastern Cheshire CCG	1508	159	429
Percentage infants exposed to smoke		10.6%	28.4%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Smoking exposure by age of mother, 2012-2013

	Total Maternities	Smoking Exposure	Exposure to Smoking %
NHS Eastern Cheshire CCG			
Aged <15-19	49	13	0.7
Aged 20-24	216	118	0.6
Aged 25-29	214	327	0.3
Aged 30-34	155	646	0.1
Aged 35-39	98	473	0.1
Aged 40+	26	124	0.1
Total	758	1701	0.2

Immunisation uptake 2013/14

	Number of infants	Number vaccinated	Uptake
NHS Eastern Cheshire CCG			
Full primary course aged 1	2130	2070	97.2%
MMR 1st dose aged 2	2242	2156	96.2%
MMR 2nd dose aged 5	2219	3813	90.4%

The primary immunisation course consists of three vaccines protecting against diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

NHS Eastern Cheshire CCG (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

NHS Eastern Cheshire CCG	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	10431	1555	14.9
Males aged 0-4	5390	921	17.1
Females aged 0-4	5041	633	12.6

Total A&E Attendances aged <1 year, 2011-2014

NHS Eastern Cheshire CCG	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	165	34.9
Females under 1 year	450	140	31.0

A&E Attendance for injury, average per year for 2011-14

NHS Eastern Cheshire CCG	Attended per year	Percent (%)	Cheshire East (%)
under 1	175	8.5	6.9
1-4	1381	16.5	14.6
5-9	1274	12.2	11.0
10-14	1783	16.5	15.6
15-19	1626	15.4	13.9
0-19	6239	14.8	13.4

Emergency admissions for injury, av'g per year for 2011-14

NHS Eastern Cheshire CCG	Admitted per year	Percent (%)	Cheshire East (%)
under 1	26	1.2	1.2
1-4	94	1.1	1.0
5-9	86	0.8	0.8
10-14	90	0.8	0.8
15-19	100	0.9	0.8
0-19	396	0.9	0.9

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

NHS Eastern Cheshire CCG	Total
Oral Thrush (aged 0-4)	103
Impetigo (aged 0-4)	670
Headlice (aged 4-11)	2176
Acne (aged 12-19)	14697
Eczema (aged 0-19)	7399
Conjunctivitis (aged 0-19)	592

Daily activity affected by long term illness/disability 2011

NHS Eastern Cheshire CCG	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.1%	1.8%	97.1%
Young people aged 16-19	1.3%	2.0%	96.7%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	10431	
Aged 5-11	14561	(Primary age range)
Aged 12-16	11240	(Secondary age range)
Aged 17-19	6050	
Total aged 0-19	42282	

Emergency Admissions for Injury, aged 0-4, 2011-2014

NHS Eastern Cheshire CCG	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	10431	135	1.3
Males aged 0-4	5390	80	1.5
Females aged 0-4	5041	55	1.1

Total Emergency Admissions aged <1 year, 2011-2014

NHS Eastern Cheshire CCG	Aged under 1y	Admitted per year	Percent (%)
Males under 1 year	472	211	44.6
Females under 1 year	450	141	31.4

A&E Attendance non-injury, average per year for 2011-14

NHS Eastern Cheshire CCG	Attended per year	Percent (%)	Cheshire East (%)
under 1	655	31.7	29.4
1-4	1624	19.4	19.1
5-9	1157	11.0	9.9
10-14	1544	14.3	12.4
15-19	2032	19.3	17.0
0-19	7012	16.6	15.1

Emergency admissions non-injury, av'g per year for 2011-14

NHS Eastern Cheshire CCG	Admitted per year	Percent (%)	Cheshire East (%)
under 1	932	45.1	40.6
1-4	1040	12.4	11.6
5-9	397	3.8	3.6
10-14	370	3.4	3.2
15-19	512	4.9	5.3
0-19	3251	7.7	7.3

Children aged 6m to 19y with long term conditions

NHS Eastern Cheshire CCG	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	1317	1677	4.0%
Heart disease	308	387	0.9%
Neurological disease	123	155	0.4%
Diabetes	77	98	0.2%

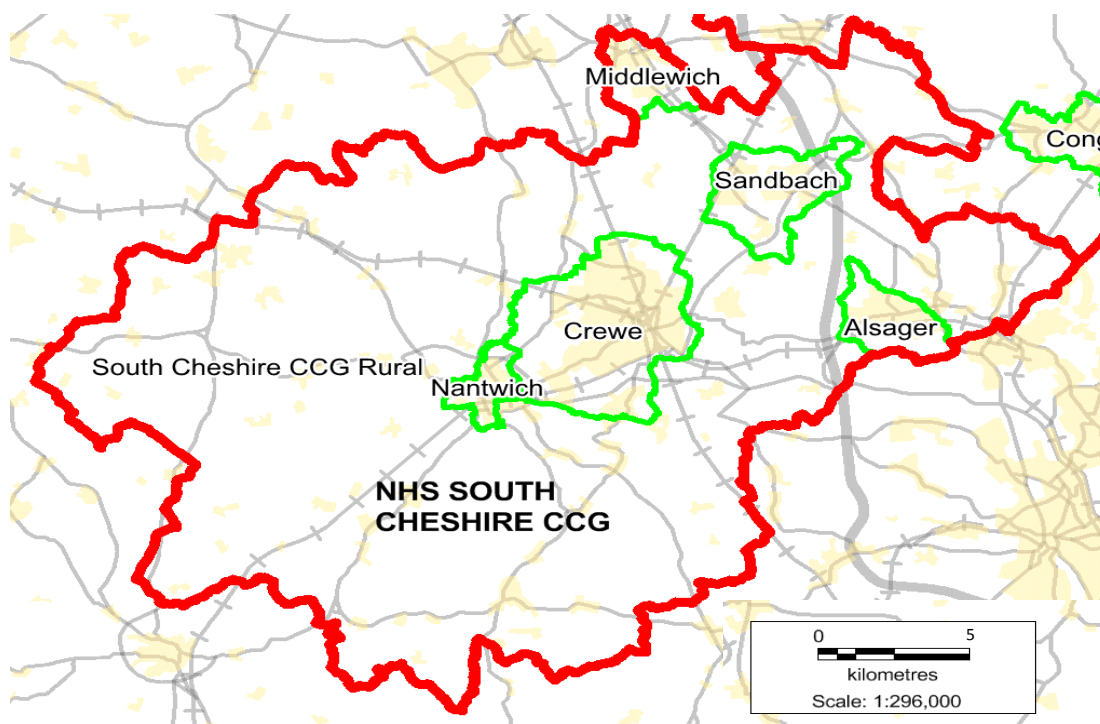
Ethnicity from Census data 2011

NHS Eastern Cheshire CCG	Total	Percentage
White	47,813	94.4%
Asian/Asian British	1,258	2.5%
African/Carib/Black British	147	0.3%
Other ethnic group	163	0.3%
Mixed/multiple ethnic	1,256	2.5%

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	2066
Aged 1-4	8365
Aged 5-9	10482
Aged 10-14	10835
Aged 15-19	10534

NHS South Cheshire CCG



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Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
NHS South Cheshire CCG	1767	32554	54.3

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
NHS South Cheshire CCG	1777	32554	54.6

Births within & outside marriage/ civil partnership (2013)

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
NHS South Cheshire CCG	819	958	53.9

Registrations by lone mothers (2013)

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
NHS South Cheshire CCG	146	90	13.3

Low Birth Weight (under 2500g) 2009-2011

	Babies with low birth weight	Total births in 3 year period	Percentage (%)
NHS South Cheshire CCG	395	5908	6.7
Total LBW babies (2009-11)	395	5908	6.7
LBW at term (2008-10)	117	5393	2.2

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continuation %
NHS South Cheshire CCG	1,870	54.2	34.0

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
NHS South Cheshire CCG	1577	271	589
Percentage infants exposed to smoke		17.2%	37.3%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Smoking exposure by age of mother, 2012-2013

	Total Maternities	Smoking Exposure	Exposure to Smoking %
NHS South Cheshire CCG			
Aged <15-19	107	31	0.7
Aged 20-24	393	200	0.6
Aged 25-29	388	449	0.4
Aged 30-34	241	538	0.3
Aged 35-39	118	308	0.2
Aged 40+	30	92	0.2
Total	1277	1618	0.4

Immunisation uptake 2013/14

	Number of infants	Number vaccinated	Uptake
NHS South Cheshire CCG			
Full primary course aged 1	1970	1885	95.7%
MMR 1st dose aged 2	1969	1853	94.1%
MMR 2nd dose aged 5	1999	1805	90.3%

The primary immunisation course consists of three vaccines protecting against diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

NHS South Cheshire CCG (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

NHS South Cheshire CCG	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	9966	1102	11.1
Males aged 0-4	5110	633	12.4
Females aged 0-4	4856	468	9.6

Total A&E Attendances aged <1 year, 2011-2014

NHS South Cheshire CCG	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	165	34.9
Females under 1 year	450	140	31.0

A&E Attendance for injury, average per year for 2011-14

NHS South Cheshire CCG	Attended per year	Percent (%)	Cheshire East (%)
under 1	109	5.4	6.9
1-4	993	12.5	14.6
5-9	970	9.8	11.0
10-14	1448	14.6	15.6
15-19	1401	12.5	13.9
0-19	4921	12.0	13.4

Emergency admissions for injury, av'g per year for 2011-14

NHS South Cheshire CCG	Admitted per year	Percent (%)	Cheshire East (%)
under 1	23	1.1	1.2
1-4	76	1.0	1.0
5-9	75	0.8	0.8
10-14	77	0.8	0.8
15-19	80	0.7	0.8
0-19	331	0.8	0.9

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

NHS South Cheshire CCG	Total
Oral Thrush (aged 0-4)	101
Impetigo (aged 0-4)	632
Headlice (aged 4-11)	2051
Acne (aged 12-19)	14796
Eczema (aged 0-19)	7182
Conjunctivitis (aged 0-19)	575

Daily activity affected by long term illness/disability 2011

NHS South Cheshire CCG	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.3%	2.0%	96.7%
Young people aged 16-19	1.8%	2.9%	95.3%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	9966	
Aged 5-11	13668	(Primary age range)
Aged 12-16	10583	(Secondary age range)
Aged 17-19	6824	
Total aged 0-19	41041	

Emergency Admissions for Injury, aged 0-4, 2011-2014

NHS South Cheshire CCG	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	9966	126	1.3
Males aged 0-4	5110	71	1.4
Females aged 0-4	4856	55	1.1

Total Emergency Admissions aged <1 year, 2011-2014

NHS South Cheshire CCG	Aged under 1y	Admitted per year	Percent (%)
Males under 1 year	472	211	44.6
Females under 1 year	450	141	31.4

A&E Attendance non-injury, average per year for 2011-14

NHS South Cheshire CCG	Attended per year	Percent (%)	Cheshire East (%)
under 1	547	27.1	29.4
1-4	1496	18.8	19.1
5-9	864	8.7	9.9
10-14	1034	10.4	12.4
15-19	1666	14.8	17.0
0-19	5606	13.7	15.1

Emergency admissions non-injury, av'g per year for 2011-14

NHS South Cheshire CCG	Admitted per year	Percent (%)	Cheshire East (%)
under 1	725	35.9	40.6
1-4	854	10.7	11.6
5-9	337	3.4	3.6
10-14	303	3.0	3.2
15-19	643	5.7	5.3
0-19	2861	7.0	7.3

Children aged 6m to 19y with long term conditions

NHS South Cheshire CCG	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	1193	1573	3.8%
Heart disease	353	450	1.1%
Neurological disease	145	190	0.5%
Diabetes	47	62	0.2%

Ethnicity from Census data 2011

NHS South Cheshire CCG	Total	Percentage
White	48,957	95.3%
Asian/Asian British	774	1.5%
African/Carib/Black British	276	0.5%
Other ethnic group	116	0.2%
Mixed/multiple ethnic	1,255	2.4%

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	2018
Aged 1-4	7948
Aged 5-9	9888
Aged 10-14	9937
Aged 15-19	11250

The map shows the Sandbach, Alsager and Middlewich area. The three centres are located at the following coordinates:

- Sandbach, Alsager and Middlewich Children's Centre (Middlewich Site): 53° 15' 30" N, 2° 28' 30" W
- Sandbach, Alsager and Middlewich Children's Centre (Sandbach Site): 53° 15' 30" N, 2° 28' 30" W
- Congleton Children's Centre: 53° 15' 30" N, 2° 28' 30" W

The map also shows the locations of the three centres: Sandbach, Alsager and Middlewich Children's Centre (Middlewich Site), Sandbach, Alsager and Middlewich Children's Centre (Sandbach Site), and Congleton Children's Centre. The map is titled 'Map of the Sandbach, Alsager and Middlewich area' and includes a scale bar indicating 0 to 1 kilometre.

	Maternities	Females (15-44)	Rate
Congleton LAP	797	15265	52.2

	Live Births	Females (15-44)	General Fertility Rate
Congleton LAP	807	15265	52.9

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partnership
Congleton LAP	508	391	43.5%

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Congleton LAP	45	38	10.3

	Babies with low birth weight	Total births in 3 year period	Percentage (%)
Congleton LAP			
Total LBW babies (2009-11)	160	2633	6.1
LBW at term (2008-10)	54	2346	2.3

	Number of births	Initiation %	Continu- ation %
Complete LAP	883	60.4	40.4

	Number of maternities	Women smoking at delivery	Household smoking exposure
Congleton LAP	656	81	214
Percentage infants exposed to smoke		12.3%	32.6%

	Number of	Number	
Congleton LAP	infants	vaccinated	Uptake
Full primary course aged 1	1010	978	96.8%
MMR 1st dose aged 2	1036	990	95.6%
MMR 2nd dose aged 5	1011	937	92.7%

	Total	Smoking	Exposure to
Congleton LAP	Maternities	Exposure	Smoking %
Aged <15-19	35	26	74.3%
Aged 20-24	216	127	58.8%
Aged 25-29	334	110	32.9%
Aged 30-34	461	99	21.5%
Aged 35-39	262	48	18.3%
Aged 40+	81	9	11.1%
Total	1389	419	30.2%

N81642 - Water's Edge
N81039 - Oaklands
N81077 - Holmes Chapel

N81027 - Readesmoor
N81052 - Lawton House
N81118 - Meadowside

N81032 - Ashfield's
N81008 - The Cedars
N81111 - Merepark

N81071 - Greenmoss

Congleton Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

	Aged 0-4	Attended per year	Percent (%)
Congleton LAP	4617	605	13.1
Children aged 0-4			
Males aged 0-4	2407	367	15.2
Females aged 0-4	2210	238	10.8

Emergency Admissions for Injury, aged 0-4, 2011-2014

	Aged 0-4	Admitted per year	Percent (%)
Congleton LAP	4617	55	1.2
Children aged 0-4			
Males aged 0-4	2407	31	1.3
Females aged 0-4	2210	24	1.1

Total A&E Attendances aged <1 year, 2011-2014

	Aged under 1y	Attended per year	Percent (%)
Congleton LAP	472	165	34.9
Males under 1 year			
Females under 1 year	450	140	31.0

Total Emergency Admissions aged <1 year, 2011-2014

	Aged under 1y	Admitted per year	Percent (%)
Congleton LAP	472	211	44.6
Males under 1 year			
Females under 1 year	450	141	31.4

A&E Attendance for injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Congleton LAP			
under 1	59	6.4	6.9
1-4	547	14.8	14.6
5-9	559	11.3	11.0
10-14	814	15.9	15.6
15-19	780	14.6	13.9
0-19	2759	13.8	13.4

A&E Attendance non-injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Congleton LAP			
under 1	247	26.8	29.4
1-4	692	18.7	19.1
5-9	530	10.7	9.9
10-14	715	14.0	12.4
15-19	979	18.3	17.0
0-19	3163	15.8	15.1

Emergency admissions for injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Congleton LAP			
under 1	8	0.9	1.2
1-4	33	0.9	1.0
5-9	39	0.8	0.8
10-14	40	0.8	0.8
15-19	49	0.9	0.8
0-19	169	0.8	0.9

Emergency admissions non-injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Congleton LAP			
under 1	344	37.3	40.6
1-4	414	11.2	11.6
5-9	158	3.2	3.6
10-14	143	2.8	3.2
15-19	293	5.5	5.3
0-19	1352	6.7	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

Congleton LAP	Total
Oral Thrush (aged 0-4)	46
Impetigo (aged 0-4)	308
Headlice (aged 4-11)	1015
Acne (aged 12-19)	7318
Eczema (aged 0-19)	3507
Conjunctivitis (aged 0-19)	281

Children aged 6m to 19y with long term conditions

	6mths- <16yrs	6mths-19yrs	Percent (%) of 6m-19y
Congleton LAP			
Respiratory disease	718	936	4.7%
Heart disease	159	205	1.0%
Neurological disease	69	88	0.4%
Diabetes	30	39	0.2%

Daily activity affected by long term illness/disability 2011

	Activity limited a lot	Activity limited a little	Activity not limited
Congleton LAP			
Children aged 0-15	1.1%	1.8%	97.2%
Young people aged 16-19	2.1%	3.0%	95.0%

Ethnicity aged 0-24 Census data 2011

Congleton LAP	Total	Percentage
White	23,547	97.0%
Asian/Asian British	237	1.0%
African/Carib/Black British	24	0.1%
Other ethnic group	38	0.2%
Mixed/multiple ethnic	422	1.7%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	4617
Aged 5-11	6815 (Primary age range)
Aged 12-16	5492 (Secondary age range)
Aged 17-19	3117
Total aged 0-19	20041

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	922
Aged 1-4	3695
Aged 5-9	4946
Aged 10-14	5120
Aged 15-19	5358

Secondary Schools

Feeder Primary Schools

Alsager Academy	Alsager Highfield's	Cranbury	Excalibur	Pikemere	Rode Heath
Congleton High School	Astbury St Mary's	Black Firs	Daven	Scholar Green	
	Smallwood CE	The Quinta	Woodcock's Well		
Eaton Bank Academy	Bosley St Mary's	Buglawton	Havannah	Marlfields	
	Marton and District	Mossley CE			
Holmes Chapel Comprehensive	Brereton CE	Chelford CE	Goostrey	Hermitage	
	Holmes Chapel	Lower Peover CE	Peover Superior		
Middlewich High School	Byley	Cledford	Middlewich	Wimboldsley	
Sandbach High and 6th Form College	Elworth CE	Haslington	Rode Heath	St John's CofE	Wheelock
Sandbach School	Elworth Hall	Offley	Sandbach	The Dingle	
	Feeder school in another LAP		Feeder school in CWAC council		

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	Maternities	Females (15-44)	Rate
Crewe LAP	985	17367	56.7

	Live Births	Females (15-44)	General Fertility Rate
Crewe LAP	991	17367	57.1

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partnership
Crewe LAP	437	686	61.1%

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Crewe LAP	102	65	16.9

	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Crewe LAP			
Total LBW babies (2009-11)	248	3436	7.2
LBW at term (2008-10)	69	3148	2.2

	Number of births	Initiation %	Continu- ation %
Crewe LAP	1102	50.5	31.1

	Number of maternities	Women smoking at delivery	Household smoking exposure
Crewe LAP	962	198	408
Percentage infants exposed to smoke		20.6%	42.4%

	Number of	Number	
Crewe LAP	infants	vaccinated	Uptake
Full primary course aged 1	1078	1030	95.5%
MMR 1st dose aged 2	1105	1027	92.9%
MMR 2nd dose aged 5	1088	960	88.2%

	Total	Smoking	Exposure to
Crewe LAP	Maternities	Exposure	Smoking %
Aged <15-19	78	115	67.8%
Aged 20-24	280	449	62.4%
Aged 25-29	290	638	45.5%
Aged 30-34	499	152	30.5%
Aged 35-39	251	74	29.5%
Aged 40+	71	17	23.9%
Total	2023	891	44.0%

N81053 - Earnswood
N81015 - Delamere
N81016 - Millcroft

N81068 - Grosvenor
N81044 - Hungerford
N81043 - Haslington

N81084 - Rope Green

Crewe Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

	Aged 0-4	Attended per year	Percent (%)
Crewe LAP	5489	674	12.3
Children aged 0-4	2784	378	13.6
Males aged 0-4	2705	297	11.0

Emergency Admissions for Injury, aged 0-4, 2011-2014

	Aged 0-4	Admitted per year	Percent (%)
Crewe LAP	5489	81	1.5
Children aged 0-4	2784	46	1.7
Males aged 0-4	2705	35	1.3

Total A&E Attendances aged <1 year, 2011-2014

	Aged under 1y	Attended per year	Percent (%)
Crewe LAP	573	239	41.7
Males under 1 year	546	181	33.2

Total Emergency Admissions aged <1 year, 2011-2014

	Aged under 1y	Admitted per year	Percent (%)
Crewe LAP	573	266	46.5
Males under 1 year	546	179	32.8

A&E Attendance for injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Crewe LAP	71	6.3	6.9
under 1	604	13.8	14.6
1-4	550	10.9	11.0
5-9	823	16.8	15.6
10-14	780	13.6	13.9
15-19	2828	13.3	13.4
0-19			

A&E Attendance non-injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Crewe LAP	350	31.2	29.4
under 1	892	20.4	19.1
1-4	493	9.8	9.9
5-9	570	11.6	12.4
10-14	922	16.0	17.0
15-19	3227	15.2	15.1
0-19			

Emergency admissions for injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Crewe LAP	16	1.5	1.2
under 1	48	1.1	1.0
1-4	45	0.9	0.8
5-9	45	0.9	0.8
10-14	38	0.7	0.8
15-19	192	0.9	0.9
0-19			

Emergency admissions non-injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Crewe LAP	429	38.4	40.6
under 1	502	11.5	11.6
1-4	189	3.7	3.6
5-9	170	3.5	3.2
10-14	342	5.9	5.3
15-19	1632	7.7	7.3
0-19			

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

Crewe LAP	Total
Oral Thrush (aged 0-4)	56
Impetigo (aged 0-4)	331
Headlice (aged 4-11)	1046
Acne (aged 12-19)	7460
Eczema (aged 0-19)	3710
Conjunctivitis (aged 0-19)	297

Children aged 6m to 19y with long term conditions

	6mths- <16yrs	6mths-19yrs	Percent (%) of 6m-19y
Crewe LAP	571	753	3.6%
Respiratory disease	197	249	1.2%
Heart disease	85	112	0.5%
Neurological disease	20	26	0.1%
Diabetes			

Daily activity affected by long term illness/disability 2011

	Activity limited a lot	Activity limited a little	Activity not limited
Crewe LAP	1.5%	2.1%	96.4%
Children aged 0-15	1.9%	3.1%	95.0%
Young people aged 16-19			

Ethnicity aged 0-24 Census data 2011

Crewe LAP	Total	Percentage
White	25,546	93.7%
Asian/Asian British	2.1%	2.1%
African/Carib/Black British	245	0.9%
Other ethnic group	83	0.3%
Mixed/multiple ethnic	804	2.9%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	5489	
Aged 5-11	6935	(Primary age range)
Aged 12-16	5232	(Secondary age range)
Aged 17-19	3545	
Total aged 0-19	21201	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	1119
Aged 1-4	4370
Aged 5-9	5058
Aged 10-14	4900
Aged 15-19	5754

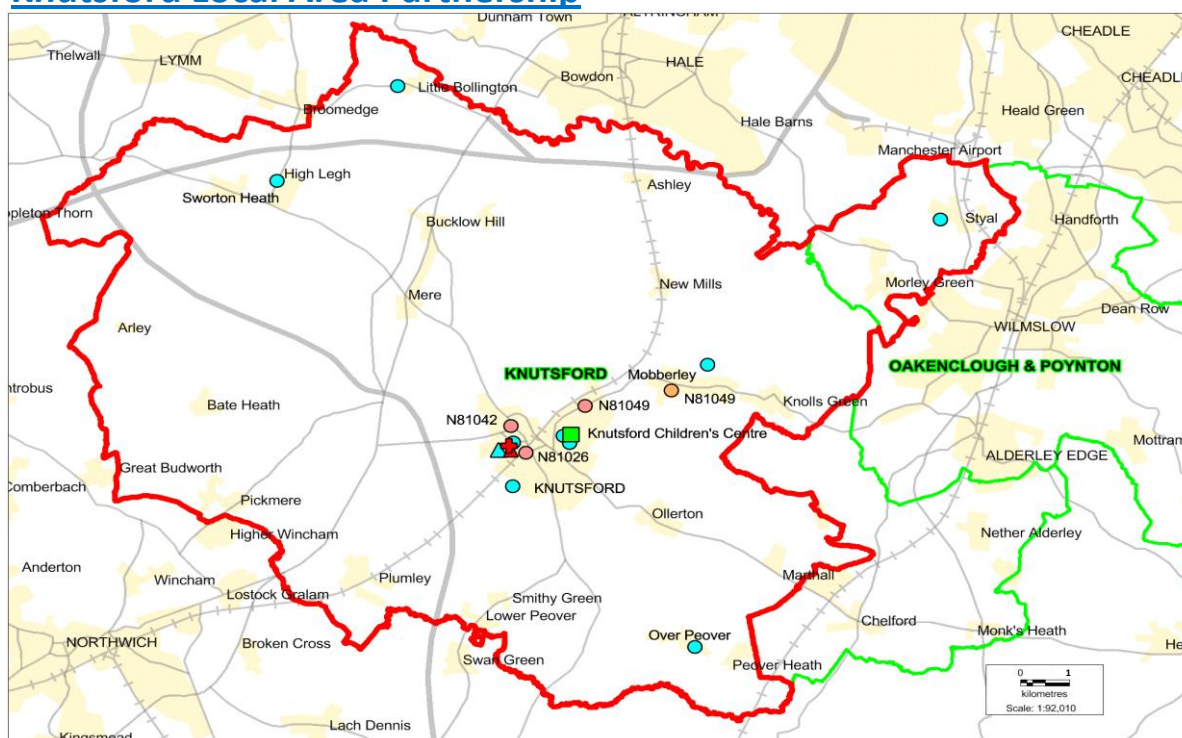
Secondary Schools

Primary Schools

Kings Grove School	Underwood West	Vine Tree	Wistaston Green
Ruskin Sports College	Edleston	Gainsborough	Pebblebrook
Shavington High School	Shavington	The Berkeley	Weston Village
	Wistaston Church Lane	Wynbunbury Delves	
Sir William Stanier Community School	Beechwood School	Brierley	Hungerford
	Mablins Lane	Monks Coppenhall	St Michael's Community
St Thomas More Catholic High School	St Mary's, Crewe	St Gabriels, Alsager	St Anne's, Nantwich
			Leighton
			Warrington

Feeder school in another LAP

Knutsford Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Knutsford LAP	265	4039	65.6

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Knutsford LAP	269	4039	66.6

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partnership
Knutsford LAP	210	100	32.3%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Knutsford LAP	13	11	8.9

Low Birth Weight (under 2500g) 2009-2011

	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Knutsford LAP			
Total LBW babies (2009-11)	56	903	6.2
LBW at term (2008-10)	15	757	2.0

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continuation %
Knutsford LAP	244	77.5	60.2

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Knutsford LAP	157	8	31
Percentage infants exposed to smoke		5.1%	19.7%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

	Number of infants	Number vaccinated	Uptake
Knutsford LAP			
Full primary course aged 1	250	247	98.8%
MMR 1st dose aged 2	282	274	97.2%
MMR 2nd dose aged 5	270	251	93.0%

The primary immunisation course consists of three vaccines protecting against diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

	Total Maternities	Smoking Exposure	Exposure to Smoking %
Knutsford LAP			
<15-24	13	23	56.5%
25-29	14	53	26.4%
30-34	15	123	12.2%
35+	6	121	5.0%
Total	48	320	15.0%

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81049 - Annandale
N81042 - Manchester Road
N81026 - Toft Road

Knutsford Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

	Aged 0-4	Attended per year	Percent (%)
Knutsford LAP	1449	164	11.3
Children aged 0-4	1449	164	11.3
Males aged 0-4	751	97	13.0
Females aged 0-4	698	67	9.6

Emergency Admissions for Injury, aged 0-4, 2011-2014

	Aged 0-4	Admitted per year	Percent (%)
Knutsford LAP	1449	17	1.2
Children aged 0-4	1449	17	1.2
Males aged 0-4	751	10	1.3
Females aged 0-4	698	7	1.0

Total A&E Attendances aged <1 year, 2011-2014

	Aged under 1y	Attended per year	Percent (%)
Knutsford LAP	140	61	43.3
Males under 1 year	140	61	43.3
Females under 1 year	146	33	22.8

Total Emergency Admissions aged <1 year, 2011-2014

	Aged under 1y	Admitted per year	Percent (%)
Knutsford LAP	140	70	50.0
Males under 1 year	140	70	50.0
Females under 1 year	146	44	29.9

A&E Attendance for injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Knutsford LAP			
under 1	15	5.4	6.9
1-4	149	12.8	14.6
5-9	134	10.4	11.0
10-14	159	12.7	15.6
15-19	139	11.0	13.9
0-19	597	11.4	13.4

A&E Attendance non-injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Knutsford LAP			
under 1	79	27.6	29.4
1-4	202	17.4	19.1
5-9	134	10.3	9.9
10-14	159	12.7	12.4
15-19	198	15.7	17.0
0-19	772	14.7	15.1

Emergency admissions for injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Knutsford LAP			
under 1	1	0.5	1.2
1-4	16	1.4	1.0
5-9	9	0.7	0.8
10-14	6	0.5	0.8
15-19	13	1.1	0.8
0-19	46	0.9	0.9

Emergency admissions non-injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Knutsford LAP			
under 1	112	39.3	40.6
1-4	134	11.6	11.6
5-9	51	4.0	3.6
10-14	40	3.2	3.2
15-19	61	4.8	5.3
0-19	399	7.6	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

Knutsford LAP	Total
Oral Thrush (aged 0-4)	14
Impetigo (aged 0-4)	86
Headlice (aged 4-11)	271
Acne (aged 12-19)	1709
Eczema (aged 0-19)	920
Conjunctivitis (aged 0-19)	74

Children aged 6m to 19y with long term conditions

	6mths- <16yrs	6mths-19yrs	Percent (%) of 6m-19y
Knutsford LAP			
Respiratory disease	145	183	3.5%
Heart disease	36	45	0.9%
Neurological disease	19	23	0.4%
Diabetes	6	8	0.1%

Daily activity affected by long term illness/disability 2011

	Activity limited a lot	Activity limited a little	Activity not limited
Knutsford LAP			
Children aged 0-15	0.9%	1.7%	97.4%
Young people aged 16-19	1.8%	3.3%	94.9%

Ethnicity aged 0-24 Census data 2011

Knutsford LAP	Total	Percentage
White	5,865	94.4%
Asian/Asian British	134	2.2%
African/Carib/Black British	22	0.4%
Other ethnic group	17	0.3%
Mixed/multiple ethnic	172	2.8%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	1449	
Aged 5-11	1798	(Primary age range)
Aged 12-16	1275	(Secondary age range)
Aged 17-19	736	
Total aged 0-19	5258	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	286
Aged 1-4	1163
Aged 5-9	1295
Aged 10-14	1256
Aged 15-19	1258

Secondary Schools

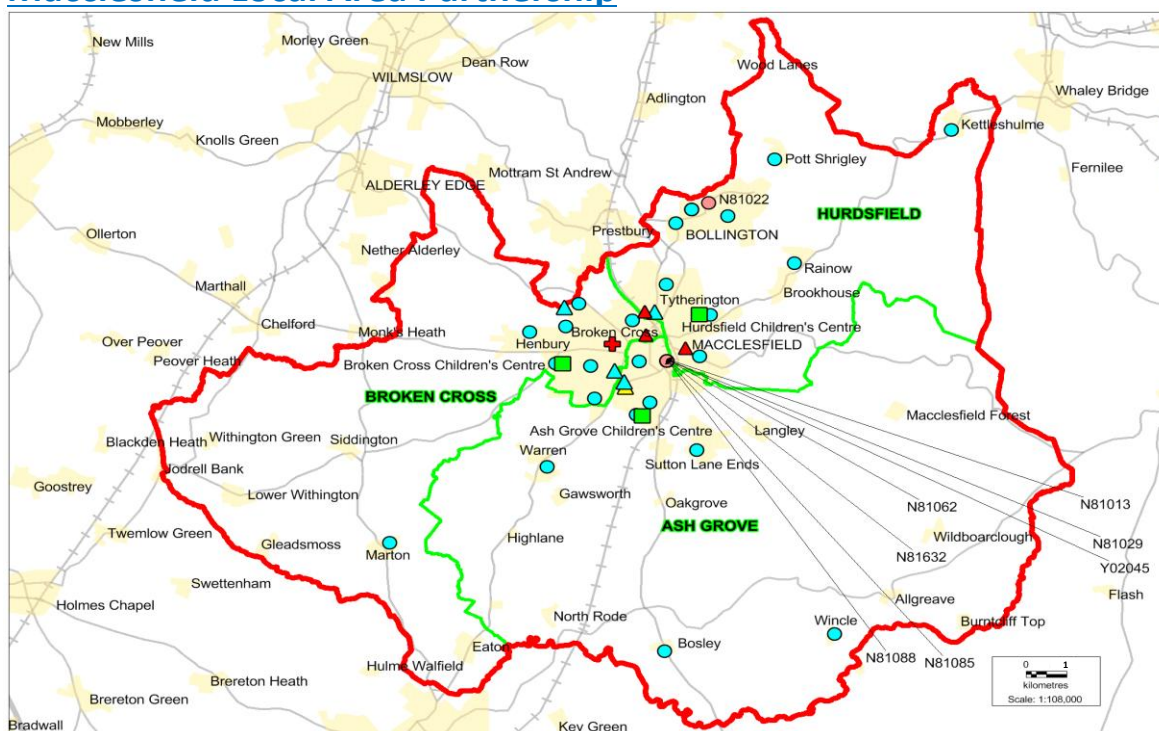
Primary Schools

Knutsford Academy	Bexton	Egerton	High Legh
	Little Bollington	Manor Park	Mobberley

St Nicholas Catholic, Northwich	St Vincent de Paul Catholic	St Mary's, Middlewich
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Secondary school in CWAC council	Feeder school in another LAP
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Macclesfield Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Macclesfield LAP	743	12498	59.4

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Macclesfield LAP	748	12498	59.8

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Macclesfield LAP	421	369	46.7%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Macclesfield LAP	56	38	12.6

Low Birth Weight (under 2500g) 2009-2011

	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Macclesfield LAP	148	2293	6.5
Total LBW babies (2009-11)	44	2075	2.1

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
Macclesfield LAP	780	67.9	43.8

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Macclesfield LAP	703	93	234
Percentage infants exposed to smoke		13.2%	33.3%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

	Number of infants	Number vaccinated	Uptake
Macclesfield LAP			
Full primary course aged 1	788	762	96.7%
MMR 1st dose aged 2	861	823	95.6%
MMR 2nd dose aged 5	799	692	86.6%

The primary immunisation course consists of three vaccines protecting against diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

	Total Maternities	Smoking Exposure	Exposure to Smoking %
Macclesfield LAP			
Aged <15-19	32	44	72.7%
Aged 20-24	132	237	55.7%
Aged 25-29	124	359	34.5%
Aged 30-34	72	454	15.9%
Aged 35-39	42	304	13.8%
Aged 40+	18	88	20.5%
Total	420	1486	28.3%

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81022 - Bollington
N81013 - High Street
N81029 - South Park

N81632 - Broken Cross
N81085 - Park Lane
N81088 - Park Green

N81062 - Cumberland House
Y02045 - Verona Health Care

Macclesfield Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

	Aged 0-4	Attended per year	Percent (%)
Macclesfield LAP			
Children aged 0-4	3976	660	16.6
Males aged 0-4	2059	390	18.9
Females aged 0-4	1917	270	14.1

Emergency Admissions for Injury, aged 0-4, 2011-2014

	Aged 0-4	Admitted per year	Percent (%)
Macclesfield LAP			
Children aged 0-4	3976	50	1.3
Males aged 0-4	2059	28	1.4
Females aged 0-4	1917	22	1.1

Total A&E Attendances aged <1 year, 2011-2014

	Aged under 1y	Attended per year	Percent (%)
Macclesfield LAP			
Males under 1 year	434	193	44.4
Females under 1 year	403	159	39.5

Total Emergency Admissions aged <1 year, 2011-2014

	Aged under 1y	Admitted per year	Percent (%)
Macclesfield LAP			
Males under 1 year	434	249	57.5
Females under 1 year	403	199	49.3

A&E Attendance for injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Macclesfield LAP			
under 1	78	9.3	6.9
1-4	582	18.6	14.6
5-9	488	13.3	11.0
10-14	707	18.4	15.6
15-19	689	18.4	13.9
0-19	2545	16.7	13.4

A&E Attendance non-injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Macclesfield LAP			
under 1	277	33.1	29.4
1-4	661	21.1	19.1
5-9	429	11.7	9.9
10-14	589	15.3	12.4
15-19	871	23.2	17.0
0-19	2827	18.5	15.1

Emergency admissions for injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Macclesfield LAP			
under 1	9	1.1	1.2
1-4	35	1.1	1.0
5-9	35	1.0	0.8
10-14	32	0.8	0.8
15-19	37	1.0	0.8
0-19	149	1.0	0.9

Emergency admissions non-injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Macclesfield LAP			
under 1	439	52.4	40.6
1-4	461	14.7	11.6
5-9	176	4.8	3.6
10-14	169	4.4	3.2
15-19	232	6.2	5.3
0-19	1477	9.7	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

	Total
Macclesfield LAP	
Oral Thrush (aged 0-4)	42
Impetigo (aged 0-4)	244
Headlice (aged 4-11)	771
Acne (aged 12-19)	5245
Eczema (aged 0-19)	2669
Conjunctivitis (aged 0-19)	214

Children aged 6m to 19y with long term conditions

	6mths- <16yrs	6mths-19yrs	Percent (%) of 6m-19y
Macclesfield LAP			
Respiratory disease	439	559	3.7%
Heart disease	82	103	0.7%
Neurological disease	37	47	0.3%
Diabetes	35	45	0.3%

Daily activity affected by long term illness/disability 2011

	Activity limited a lot	Activity limited a little	Activity not limited
Macclesfield LAP			
Children aged 0-15	1.3%	2.2%	96.5%
Young people aged 16-19	2.0%	3.3%	94.7%

Ethnicity aged 0-24 Census data 2011

	Total	Percentage
Macclesfield LAP		
White	17,715	95.1%
Asian/Asian British	422	2.3%
African/Carib/Black British	44	0.2%
Other ethnic group	31	0.2%
Mixed/multiple ethnic	411	2.2%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	3976
Aged 5-11	5106 (Primary age range)
Aged 12-16	3987 (Secondary age range)
Aged 17-19	2184
Total aged 0-19	15253

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	837
Aged 1-4	3139
Aged 5-9	3678
Aged 10-14	3844
Aged 15-19	3755

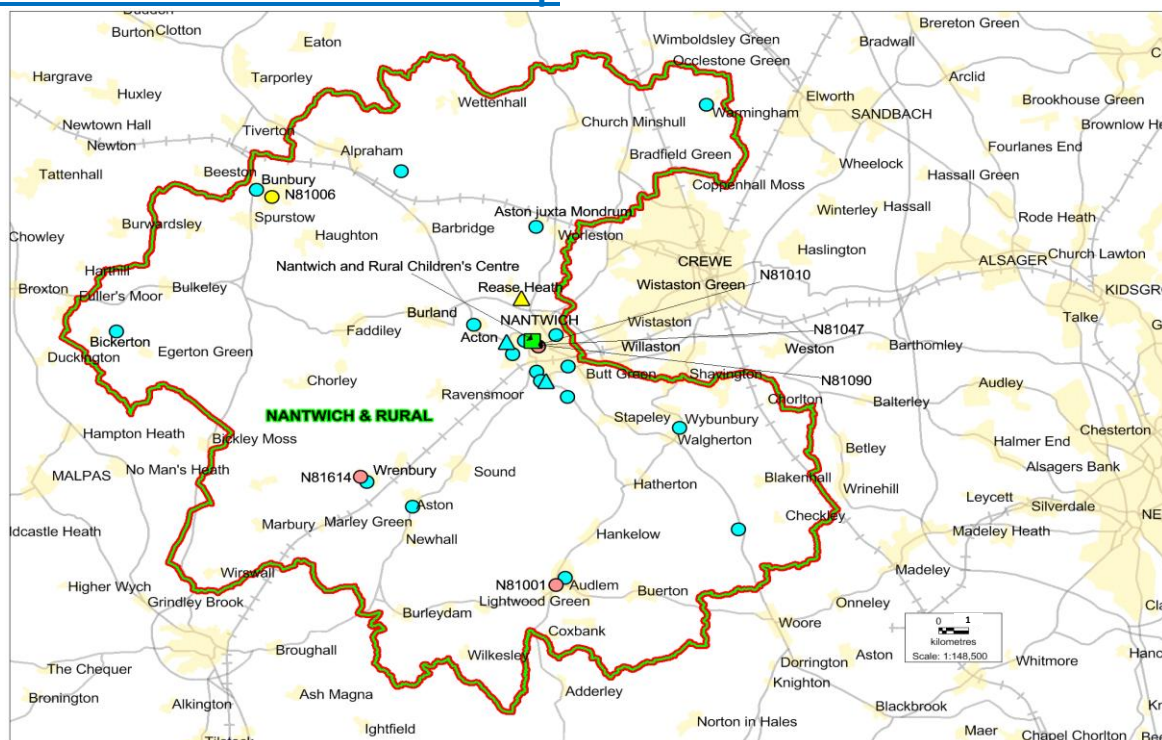
Secondary Schools

Primary Schools

All Hallows Catholic College	Christ the King Catholic/ CE	St Alban's Catholic	St Benedicts	
	St Gregory's Catholic	St John the Evangelist CE	St Mary's, Congleton	St Paul's (Poynton)
The Fallibroome Academy	Bollinbrook	Broken Cross	Mottram St Andrew	
	Nether Alderley	Prestbury CE	Upton Priory	Whirley
The Macclesfield Academy	Ash Grove	Broken Cross	Gawsworth	Hollinhey
	Ivy Bank	Parkroyal	Puss Bank	
	St John the Evangelist CE	Whirley	Wincle CE	
Tytherington High School	Bollington Cross	Bollington St John's CE	Dean Valley	Hursfield
	Kettleshulme	Parkroyal	Puss Bank	Rainow
	The Marlborough			

Feeder school in another LAP

Nantwich Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Nantwich LAP	325	5968	54.5

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Nantwich LAP	327	5968	54.8

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partnership
Nantwich LAP	207	103	33.2%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Nantwich LAP	17	6	7.0

Low Birth Weight (under 2500g) 2009-2011

	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Nantwich LAP	60	961	6.2
Total LBW babies (2009-11)	60	961	6.2
LBW at term (2008-10)	21	904	2.3

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continuation %
Nantwich LAP	238	64.3	43.7

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Nantwich LAP	274	30	70
Percentage infants exposed to smoke		10.9%	25.5%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

	Number of infants	Number vaccinated	Uptake
Nantwich LAP			
Full primary course aged 1	302	285	94.4%
MMR 1st dose aged 2	267	258	96.6%
MMR 2nd dose aged 5	323	305	94.4%

The primary immunisation course consists of three vaccines protecting against diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

	Total Maternities	Smoking Exposure	Exposure to Smoking %
Nantwich LAP			
Aged <15-19	16	19	84.2%
Aged 20-24	37	69	53.6%
Aged 25-29	40	132	30.3%
Aged 30-34	32	175	18.3%
Aged 35-39	20	115	17.4%
Aged 40+	7	37	18.9%
Total	152	547	27.8%

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81066 - Bunbury	N81010 - Nantwich
N81614 - Wrenbury	N81047 - Kiltarn
N81001 - Audlem	N81090 - Tudor

Nantwich Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

	Aged 0-4	Attended per year	Percent (%)
Nantwich LAP			
Children aged 0-4	1781	161	9.0
Males aged 0-4	927	92	10.0
Females aged 0-4	854	68	8.0

Emergency Admissions for Injury, aged 0-4, 2011-2014

	Aged 0-4	Admitted per year	Percent (%)
Nantwich LAP			
Children aged 0-4	1781	19	1.1
Males aged 0-4	927	11	1.2
Females aged 0-4	854	8	0.9

Total A&E Attendances aged <1 year, 2011-2014

	Aged under 1y	Attended per year	Percent (%)
Nantwich LAP			
Males under 1 year	175	42	24.2
Females under 1 year	172	34	20.0

Total Emergency Admissions aged <1 year, 2011-2014

	Aged under 1y	Admitted per year	Percent (%)
Nantwich LAP			
Males under 1 year	175	63	36.0
Females under 1 year	172	42	24.6

A&E Attendance for injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Nantwich LAP			
under 1	16	4.7	6.9
1-4	144	10.1	14.6
5-9	172	8.5	11.0
10-14	227	11.3	15.6
15-19	224	10.3	13.9
0-19	783	9.8	13.4

A&E Attendance non-injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Nantwich LAP			
under 1	60	17.4	29.4
1-4	214	14.9	19.1
5-9	143	7.1	9.9
10-14	165	8.2	12.4
15-19	251	11.5	17.0
0-19	833	10.4	15.1

Emergency admissions for injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Nantwich LAP			
under 1	3	0.9	1.2
1-4	14	1.0	1.0
5-9	9	0.4	0.8
10-14	13	0.7	0.8
15-19	17	0.8	0.8
0-19	56	0.7	0.9

Emergency admissions non-injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Nantwich LAP			
under 1	102	29.5	40.6
1-4	131	9.1	11.6
5-9	53	2.6	3.6
10-14	53	2.7	3.2
15-19	104	4.8	5.3
0-19	443	5.6	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

Nantwich LAP	Total
Oral Thrush (aged 0-4)	17
Impetigo (aged 0-4)	121
Headlice (aged 4-11)	421
Acne (aged 12-19)	2866
Eczema (aged 0-19)	1397
Conjunctivitis (aged 0-19)	112

Children aged 6m to 19y with long term conditions

	6mths- <16yrs	6mths-19yrs	Percent (%) of 6m-19y
Nantwich LAP			
Respiratory disease	203	267	3.3%
Heart disease	65	83	1.0%
Neurological disease	23	30	0.4%
Diabetes	6	8	0.1%

Daily activity affected by long term illness/disability 2011

Nantwich LAP	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.2%	1.8%	97.0%
Young people aged 16-19	1.7%	1.9%	96.4%

Ethnicity aged 0-24 Census data 2011

Nantwich LAP	Total	Percentage
White	9,405	97.1%
Asian/Asian British	69	0.7%
African/Carib/Black British	21	0.2%
Other ethnic group	9	0.1%
Mixed/multiple ethnic	183	1.9%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	1781
Aged 5-11	2827 (Primary age range)
Aged 12-16	2062 (Secondary age range)
Aged 17-19	1310
Total aged 0-19	7980

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	347
Aged 1-4	1434
Aged 5-9	2024
Aged 10-14	2000
Aged 15-19	2175

Secondary Schools

Brine Leas	Audlem St James	Bridgemere	Pear Tree	Sound and District
	Stapeley Broad Lane	Weaver	Wrenbury	Wyche
Malbank School and 6th Form Centre	Acton CE	Highfields	Millfields	St Oswalds
	Willaston			

Primary Schools

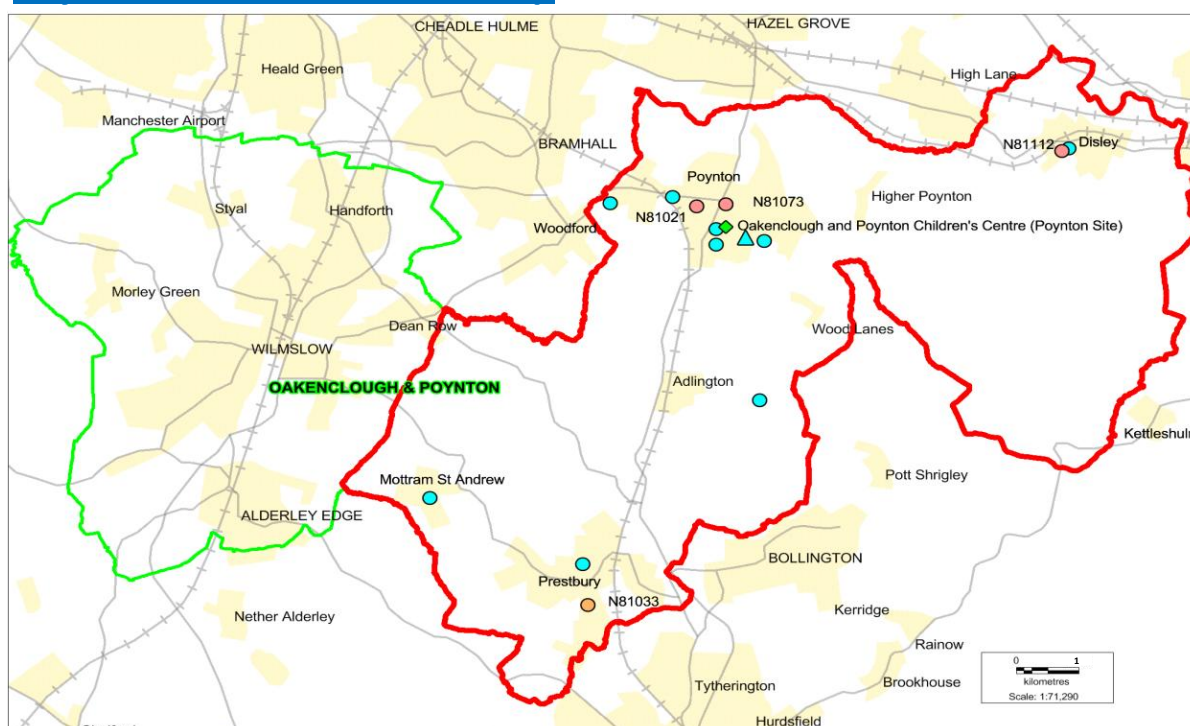
Cheshire West and Chester Secondary's

Bishop Heber High	Bickerton Holy Trinity
Tarporley High	Bunbury Aldersey Calveley

Secondary school in CWAC council

Feeder school in another LAP

Poynton Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Poynton LAP	181	3362	53.8

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Poynton LAP	182	3362	54.1

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Poynton LAP	111	60	35.1%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Poynton LAP	5	6	6.0

Low Birth Weight (under 2500g) 2009-2011

	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Poynton LAP	29	521	5.6
Total LBW babies (2009-11)	29	521	5.6
LBW at term (2008-10)	11	452	2.4

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continuation %
Poynton LAP	155	78.1	63.2

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Poynton LAP	82	s	7
Percentage infants exposed to smoke		s	8.5%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

	Number of infants	Number vaccinated	Uptake
Poynton LAP			
Full primary course aged 1	174	169	97.1%
MMR 1st dose aged 2	184	180	97.8%
MMR 2nd dose aged 5	204	193	94.6%

The primary immunisation course consists of three vaccines protecting against diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

	Total Maternities	Smoking Exposure	Exposure to Smoking %
Poynton LAP			
<15-24	s	8	s
25-29	s	24	s
30-34	s	70	s
35+	s	74	s
Total	13	176	7.4%

s = data suppressed due to small numbers

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81021 - McIlvrde	N81033 - Prestbury (George Street branch surgery)
N81073 - Priorslegh	
N81112 - Schoolhouse	

Poynton Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

	Aged 0-4	Attended per year	Percent (%)
Poynton LAP			
Children aged 0-4	965	135	14.0
Males aged 0-4	484	83	17.1
Females aged 0-4	481	52	10.8

Emergency Admissions for Injury, aged 0-4, 2011-2014

	Aged 0-4	Admitted per year	Percent (%)
Poynton LAP			
Children aged 0-4	965	11	1.1
Males aged 0-4	484	7	1.4
Females aged 0-4	481	4	0.8

Total A&E Attendances aged <1 year, 2011-2014

	Aged under 1y	Attended per year	Percent (%)
Poynton LAP			
Males under 1 year	79	44	55.3
Females under 1 year	80	28	34.6

Total Emergency Admissions aged <1 year, 2011-2014

	Aged under 1y	Admitted per year	Percent (%)
Poynton LAP			
Males under 1 year	79	45	57.4
Females under 1 year	80	27	33.8

A&E Attendance for injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Poynton LAP			
under 1	16	9.9	6.9
1-4	120	14.8	14.6
5-9	127	10.8	11.0
10-14	205	15.0	15.6
15-19	174	12.3	13.9
0-19	641	13.0	13.4

A&E Attendance non-injury, average per year for 2011-14

	Attended per year	Percent (%)	Cheshire East (%)
Poynton LAP			
under 1	56	35.0	29.4
1-4	130	16.2	19.1
5-9	74	6.3	9.9
10-14	123	9.0	12.4
15-19	193	13.6	17.0
0-19	576	11.7	15.1

Emergency admissions for injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Poynton LAP			
under 1	3	1.7	1.2
1-4	7	0.9	1.0
5-9	8	0.7	0.8
10-14	14	1.0	0.8
15-19	9	0.6	0.8
0-19	41	0.8	0.9

Emergency admissions non-injury, av'g per year for 2011-14

	Admitted per year	Percent (%)	Cheshire East (%)
Poynton LAP			
under 1	70	43.8	40.6
1-4	78	9.7	11.6
5-9	31	2.6	3.6
10-14	37	2.7	3.2
15-19	54	3.8	5.3
0-19	270	5.5	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

Poynton LAP	Total
Oral Thrush (aged 0-4)	8
Impetigo (aged 0-4)	73
Headlice (aged 4-11)	247
Acne (aged 12-19)	1928
Eczema (aged 0-19)	861
Conjunctivitis (aged 0-19)	69

Children aged 6m to 19y with long term conditions

	6mths- <16yrs	6mths-19yrs	Percent (%) of 6m-19y
Poynton LAP			
Respiratory disease	165	218	4.4%
Heart disease	32	42	0.8%
Neurological disease	14	18	0.4%
Diabetes	8	11	0.2%

Daily activity affected by long term illness/disability 2011

	Activity limited a lot	Activity limited a little	Activity not limited
Poynton LAP			
Children aged 0-15	1.3%	1.6%	97.0%
Young people aged 16-19	1.7%	2.3%	96.0%

Ethnicity aged 0-24 Census data 2011

Poynton LAP	Total	Percentage
White	5,620	96.0%
Asian/Asian British	87	1.5%
African/Carib/Black British	7	0.1%
Other ethnic group	15	0.3%
Mixed/multiple ethnic	123	2.1%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	965	
Aged 5-11	1687	(Primary age range)
Aged 12-16	1426	(Secondary age range)
Aged 17-19	842	
Total aged 0-19	4920	

Population size for 0-19 year olds in 5 year bands, 2012

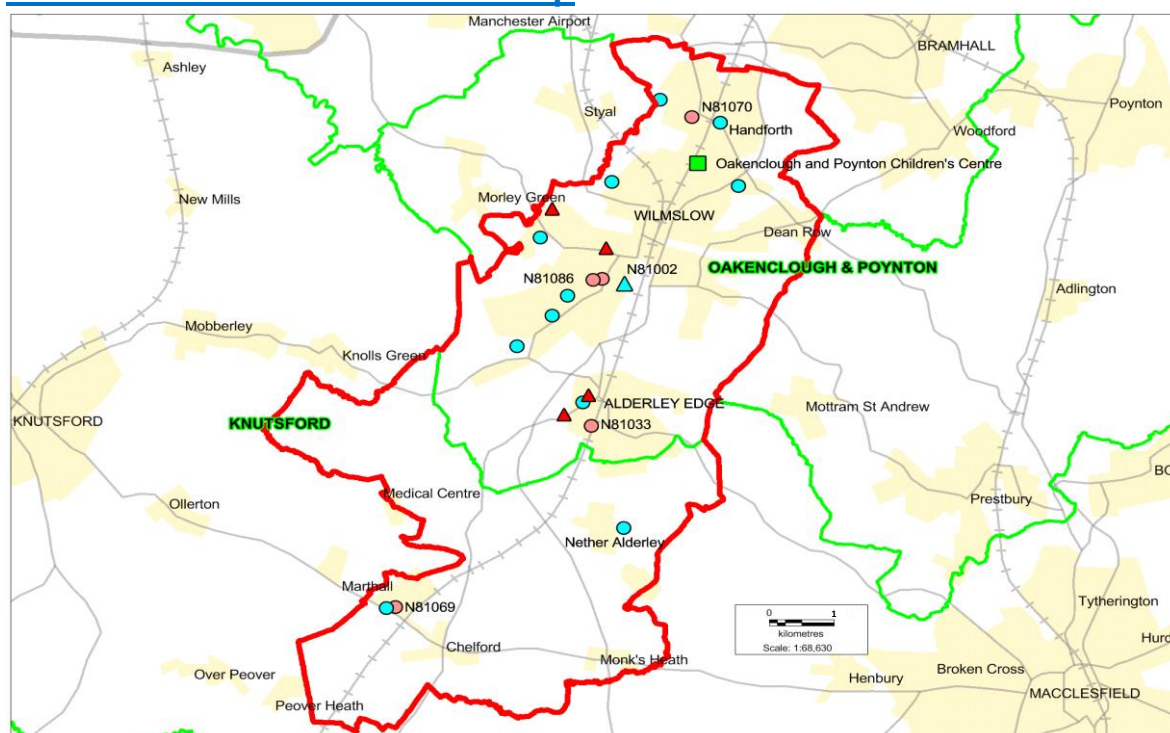
Aged <1	159
Aged 1-4	806
Aged 5-9	1174
Aged 10-14	1363
Aged 15-19	1418

Secondary Schools

Poynton	Adlington	Disley	Lostock Hall	Lower Park
	Pott Shrigley	Vernon	Worth	

Feeder school in another LAP

Wilmslow Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Wilmslow LAP	438	6529	67.1

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Wilmslow LAP	446	6529	68.3

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Wilmslow LAP	250	160	39.0%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Wilmslow LAP	38	15	11.9

Low Birth Weight (under 2500g) 2009-2011

	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Wilmslow LAP	67	1237	5.4
Total LBW babies (2009-11)	67	1237	5.4
LBW at term (2008-10)	16	1100	1.5

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continuation %
Wilmslow LAP	372	79.8	57.8

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Wilmslow LAP	251	20	54
Percentage infants exposed to smoke		8.0%	21.5%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

	Number of infants	Number vaccinated	Uptake
Wilmslow LAP			
Full primary course aged 1	498	484	97.2%
MMR 1st dose aged 2	476	457	96.0%
MMR 2nd dose aged 5	523	475	90.8%

The primary immunisation course consists of three vaccines protecting against diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012/2013

	Total Maternities	Smoking Exposure	Exposure to Smoking %
Wilmslow LAP			
<15-24	21	33	63.6%
25-29	23	76	30.3%
30-34	22	192	11.5%
35+	26	199	13.1%
Total	92	500	18.4%

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81070 - Handforth	N81033 - George Street Surgery
N81002 - Kenmore	N81069 - Chelford Surgery
N81086 - Wilmslow	

Wilmslow Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Wilmslow LAP	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	2120	257	12.1
Males aged 0-4	1088	147	13.5
Females aged 0-4	1032	110	10.7

Emergency Admissions for Injury, aged 0-4, 2011-2014

Wilmslow LAP	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	2120	28	1.3
Males aged 0-4	1088	18	1.7
Females aged 0-4	1032	10	1.0

Total A&E Attendances aged <1 year, 2011-2014

Wilmslow LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	220	93	42.4
Females under 1 year	194	69	35.4

Total Emergency Admissions aged <1 year, 2011-2014

Wilmslow LAP	Aged under 1y	Admitted per year	Percent (%)
Males under 1 year	220	90	40.8
Females under 1 year	194	78	40.2

A&E Attendance for injury, average per year for 2011-14

Wilmslow LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	29	7.1	6.9
1-4	228	13.4	14.6
5-9	214	9.7	11.0
10-14	295	12.9	15.6
15-19	240	11.6	13.9
0-19	1007	11.6	13.4

A&E Attendance non-injury, average per year for 2011-14

Wilmslow LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	134	32.3	29.4
1-4	329	19.3	19.1
5-9	216	9.9	9.9
10-14	258	11.3	12.4
15-19	284	13.7	17.0
0-19	1220	14.1	15.1

Emergency admissions for injury, av'g per year for 2011-14

Wilmslow LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	7	1.8	1.2
1-4	17	1.0	1.0
5-9	16	0.7	0.8
10-14	16	0.7	0.8
15-19	17	0.8	0.8
0-19	73	0.8	0.9

Emergency admissions non-injury, av'g per year for 2011-14

Wilmslow LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	161	38.8	40.6
1-4	172	10.1	11.6
5-9	75	3.4	3.6
10-14	62	2.7	3.2
15-19	69	3.4	5.3
0-19	539	6.2	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalence rates applied to local population to give estimated numbers.

Wilmslow LAP	Total
Oral Thrush (aged 0-4)	21
Impetigo (aged 0-4)	139
Headlice (aged 4-11)	456
Acne (aged 12-19)	2966
Eczema (aged 0-19)	1517
Conjunctivitis (aged 0-19)	121

Children aged 6m to 19y with long term conditions

Wilmslow LAP	6mths- <16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	269	337	3.9%
Heart disease	90	111	1.3%
Neurological disease	21	26	0.3%
Diabetes	19	24	0.3%

Daily activity affected by long term illness/disability 2011

Wilmslow LAP	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	0.9%	1.4%	97.7%
Young people aged 16-19	2.0%	2.3%	95.7%

Ethnicity aged 0-24 Census data 2011

Wilmslow LAP	Total	Percentage
White	9,072	89.7%
Asian/Asian British	501	5.0%
African/Carib/Black British	60	0.6%
Other ethnic group	86	0.9%
Mixed/multiple ethnic	396	3.9%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	2120	
Aged 5-11	3061	(Primary age range)
Aged 12-16	2349	(Secondary age range)
Aged 17-19	1140	
Total aged 0-19	8670	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	414
Aged 1-4	1706
Aged 5-9	2195
Aged 10-14	2289
Aged 15-19	2066

Secondary Schools

Wilmslow High

Primary Schools

Alderley Edge
Gorsey Bank
Nether Alderley

Ashdene
Lacey Green
St Anne's Fulshaw

Dean Oaks
Lindow

Styal Wilmslow Grange

Feeder school in another LAP

Key for Local Area Partnership and Children's Centre maps



	LAP Boundary		GP Practice
	Children's Centre Footprint		GP Practice (Branch Surgery)
	Road		GP Practice (Non-Cheshire East CCG)
	Motorway		Primary School
	Railway		Secondary School
	Settlement		Further or Higher Education Establishment
	Children's Centre (Main Site)		Non-Cheshire East School
	Children's Centre (Subsidiary Site)		Hospital

Table 8. Overview of Selected Indicators by Children's Centre

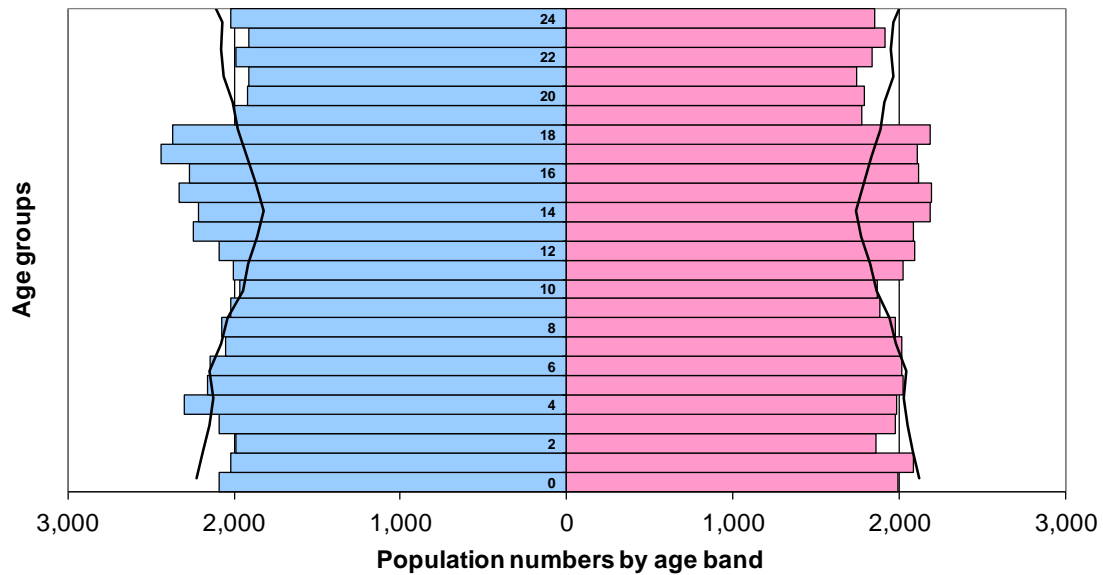
Children's Centre Footprints	Live Births 2013	Maternities 2013	GFR per 1000 2013	Maternity Rate per 1000 2013	Outside marriage or civil partnership (%) 2013	Sole registrations + Joint registrations different address 2013	Low Birth Weight <2500g (%) 2013	% Prenatal & postnatal tobacco smoke exposure 2012-2013	% Smoking at time of delivery 2013	Proportion of households fuel poor (%) 2012*	A&E attendances injury (%) 2011/12-2013/14	Breastfeeding Initiation 2010/11-2012/13**	Breastfeeding Continuation 2010/11-2012/13
Ash Grove	276	272	65.5	64.6	58.3	17.0	8.3	36.7	16.6	11.6	8.9	61.9	38.7
Broken Cross	255	256	62.5	62.8	45.5	12.5	4.3	26.7	12.3	8.1	10.8	68.2	43.5
Congleton	348	340	57.6	56.2	44.3	10.6	5.2	27.8	12.1	8.4	9.9	64.3	46.3
Hurdsfield	217	215	51.6	51.1	39.6	6.9	5.5	20.3	10.0	8.5	8.3	71.3	51.2
Knutsford	258	255	66.2	65.5	29.5	5.8	3.5	15.7	5.0	9.8	5.3	78.4	56.7
Monks Coppenhall	200	201	45.5	45.8	60.5	17.0	7.5	43.1	21.8	9.3	7.3	44.1	24.1
Nantwich & Rural	327	325	54.8	54.5	38.2	7.0	5.8	27.8	10.9	10.4	4.7	67.0	42.9
Oak Tree	397	391	71.4	70.4	66.8	19.4	8.5	50.0	24.6	11.6	5.6	41.3	25.4
Oakenclough & Poynton	639	629	63.7	62.7	35.2	11.4	7.2	15.2	6.4	8.5	7.9	76.8	55.9
Sandbach Alsager Middlewich	459	457	49.8	49.6	48.6	10.0	3.9	32.3	12.6	7.8	4.0	62.3	38.3
The Brooks	394	393	53.1	53.0	56.9	14.2	8.6	38.7	16.1	12.0	6.6	58.6	35.0
Cheshire East	3770	3734	58.0	57.4	47.1	12.1	6.3	31.6	14.0	9.5	6.9	62.9	41.6

* Fuel Poverty is calculated using the Low Income High Costs (LIHC) definition

**Local Breastfeeding initiation rates are self-reported and, therefore, not directly comparable with national rates.

Population Information

Cheshire East: Population Distribution, 2012



Cheshire East Males Cheshire East Females England Males England Females

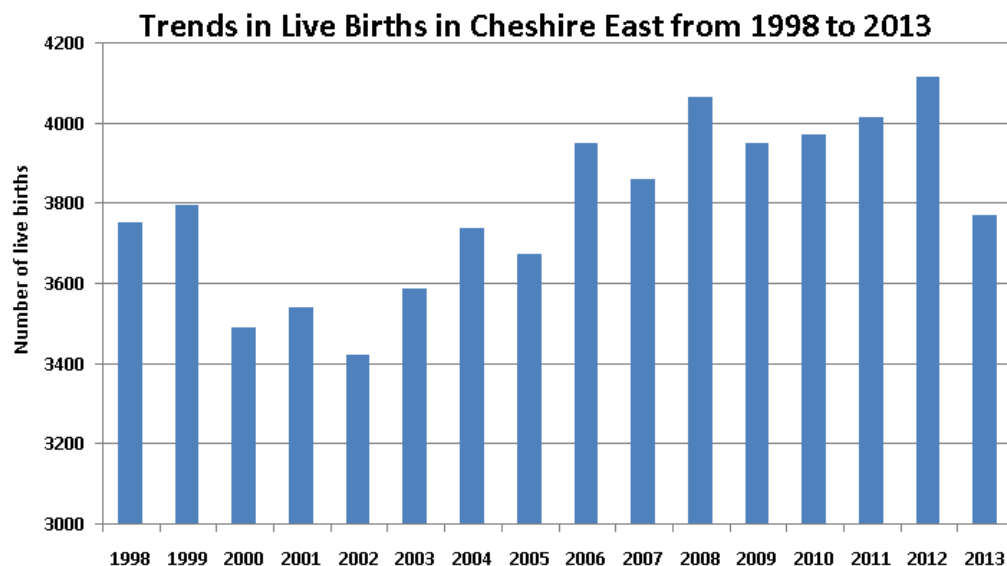
Source: ONS single year of age population estimates, mid-2012

Notes: England population comparator derived by applying England age and sex proportions to Cheshire East populations in order to scale.

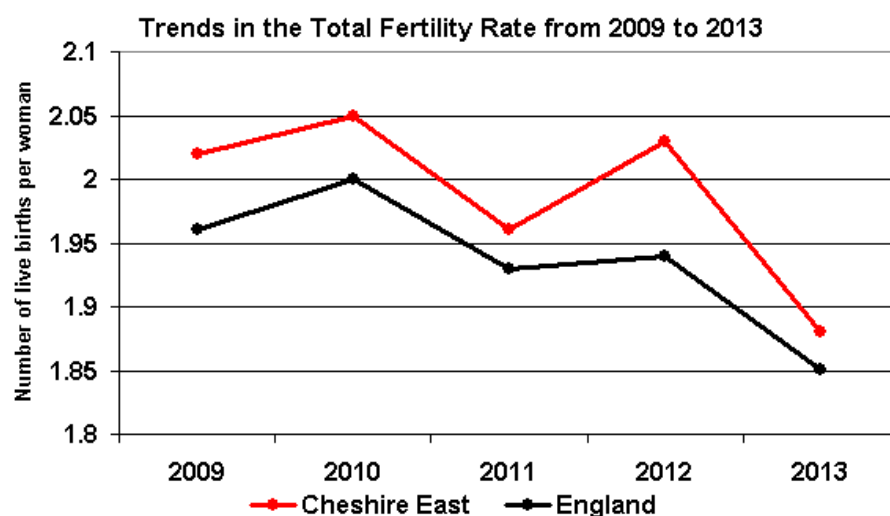
Ages	Males		Females	
	Population	Percentage of total	Population	Percentage of total
0	2093	2.05	1991	1.95
1	2022	1.98	2089	2.04
2	1991	1.95	1857	1.82
3	2093	2.05	1975	1.93
4	2301	2.25	1985	1.94
5	2162	2.12	2026	1.98
6	2143	2.10	2015	1.97
7	2048	2.00	2014	1.97
8	2074	2.03	1978	1.94
9	2024	1.98	1886	1.85
10	1968	1.93	1869	1.83
11	2001	1.96	2021	1.98
12	2092	2.05	2095	2.05
13	2244	2.20	2083	2.04
14	2211	2.16	2188	2.14
15	2331	2.28	2195	2.15
16	2267	2.22	2117	2.07
17	2437	2.38	2112	2.07
18	2370	2.32	2185	2.14
19	1995	1.95	1775	1.74
20	1917	1.88	1791	1.75
21	1913	1.87	1743	1.71
22	1990	1.95	1841	1.80
23	1908	1.87	1916	1.87
24	2018	1.97	1854	1.81

Births in Cheshire East in 2013

There were 3,770 live births in Cheshire East in 2013 compared with 4,112 in 2012 (a fall of 342 or 8.3%). This is the largest single year fall in births in recent years, and is greater than the fall of 307 births that occurred between 1999 and 2000. It is the lowest number of births since 2005 (3,672 births) and represents a marked difference from the trend of increasing numbers of births in Cheshire East since 2002 (live births rose overall by 20.2% between 2002 and 2012).



The fall in live births was not just a local phenomenon; nationally live births fell by 4.3% between 2012 and 2013. Changes in childbearing patterns from year to year can be assessed using the total fertility rate (TFR), which measures the average number of births per woman based on current patterns of fertility. In Cheshire East, the TFR has been consistently above that of England, although in 2012 it rose unexpectedly, largely due to births among women in their thirties. The TFR then decreased from an average of 2.03 births per woman in 2012 to 1.88 in 2013. Across the same period, the TFR in England fell from 1.94 to 1.85.

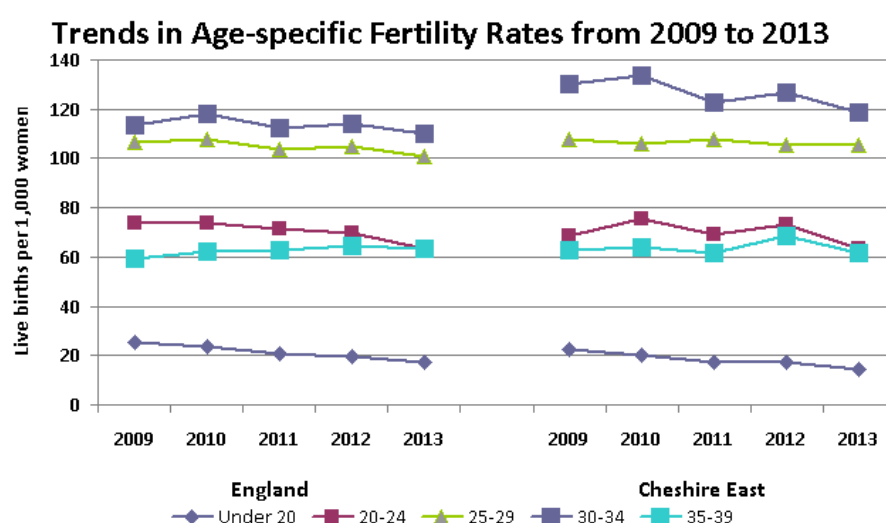


The general fertility rate (GFR) is another measure of an area's birth rate and represents the number of live births per 1,000 women aged 15 to 44. Unlike the TFR, this measure can be calculated for

local areas within Cheshire East. In 2013, the areas with the highest GFR were Wilmslow (71.8 per 1,000) and Knutsford (69.4 per 1,000); the lowest GFR occurred in the rural areas of NHS South Cheshire CCG (46.0 per 1,000), Sandbach (47.6 per 1,000) and Alsager (49.0 per 1,000). Fertility rates in NHS Eastern Cheshire CCG were 12.7% higher than those in NHS South Cheshire CCG.

Public health has not yet received information to calculate the local GFR rates for 2012, so is only able to comment on changes in GFR between 2011 (4,013 births) and 2013. Wilmslow was the only area that experienced an increase in fertility rates between these two time periods (from 63.0 to 71.8). The GFR remained stable in Macclesfield, Sandbach, Poynton and the rural areas of NHS Eastern Cheshire CCG, but fell in all other areas.

The decrease in fertility between 2012 and 2013 was seen in all age groups, with the largest percentage decreases of 17.9% and 13.4% respectively seen in women aged under 20 and 20-24. The smallest decrease in fertility (0.5%) was in women aged 25-29. Women in this and the 30-34 age group continue to have the highest fertility rates, with rates that are 4.1% and 8.2% higher than England.



In 2013, nearly half of all babies were born outside marriage or civil partnership (47.1%). This represents no change from 2012 and is consistent with the high proportion of couples cohabiting rather than entering into marriage or civil partnership.

Stillbirths

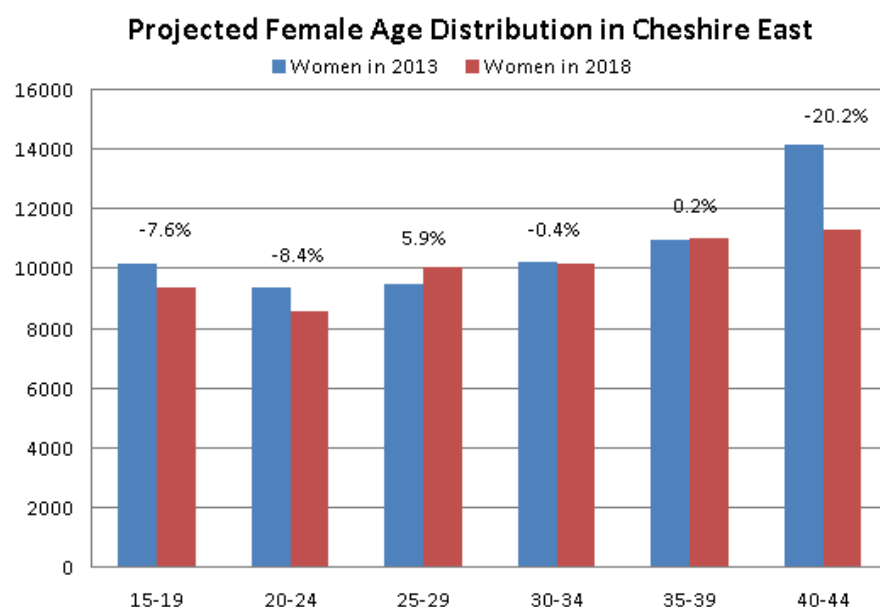
A stillbirth is defined as a baby born after 24 weeks completed gestation which did not, at any time, breathe or show signs of life. In 2013, there were 15 stillbirths from a total of 3785 births, which represents a rate of 3.96 per thousand births. In 2012, there were 19 stillbirths out of 4135 births, a rate of 4.6 per thousand births. In England, the stillbirth rate fell from 4.9 in 2012 to 4.7 in 2013.

The NHS Outcomes Framework contains an indicator aimed at reducing the number of stillbirths in England. The key risk factors for stillbirth include maternal obesity, smoking, and fetal growth restriction. The Department of Health is working on a stillbirth programme with the stillbirth and neonatal death charity (Sands) and a number of key organisations such as NHS England, Public Health England, the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. The programme aims to raise awareness and minimise these risk factors.

Birth projections

The number of births in a given year is dependent on the number of women in the key childbearing ages (15–44 years) and on fertility rates in that year. Predicting the future number of live births

therefore depends on these two main factors. The number of women in the population can be predicted with some degree of certainty, but their future decisions around childbearing are much less easy to predict.

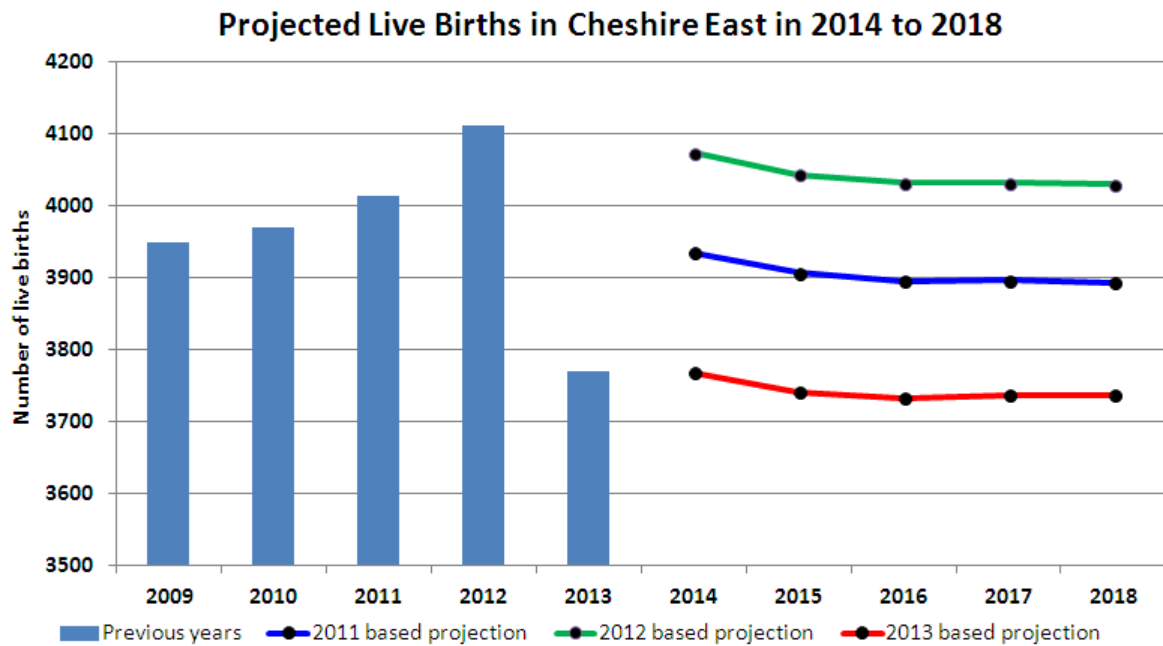


Population projections

Population projections suggest that between 2013 and 2018 the number of women in the childbearing age groups will change as shown above. The number of women aged 25 to 29 is predicted to increase by around 5.9%, but other age groups will either remain stable or reduce. If birth rates remain constant, these population changes would lead to a slight decline in live births.

It is not possible to determine at this stage whether the fall in the birth rate and the number of live births in 2013 represents an end to the increase in births since 2002. Uncertainty about employment, as well as significant changes in the benefits system announced in 2011 and 2012 may have influenced decisions around childbearing. These factors, and others, may persist into 2014 and beyond and influence birth rates to remain at the low levels seen in 2013. However, it is also possible that birth rates may return to the higher levels seen in previous years.

The diagram illustrates the number of live births that might occur over the next five years using three alternative scenarios based on the 2011, 2012 and 2013 age-specific birth rates. The birth rates in Cheshire East in 2012 were unexpectedly high, and so the 2012-based projection (green line) is considered to be the least likely of the three scenarios. For planning purposes, the blue and red lines best represent the upper and lower range of births that might occur in each of the next five years.

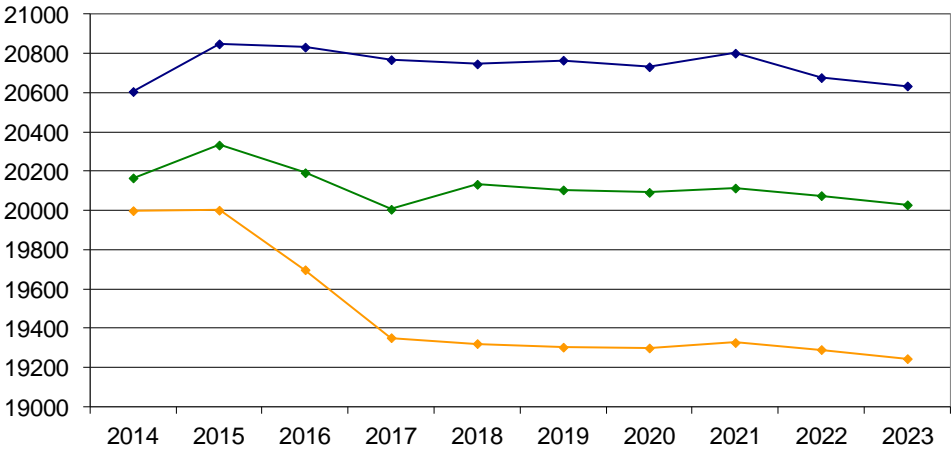


Source: Public Health Birth File 2009-2013; 2012-based population forecasts for Cheshire East, Cheshire West and Chester Council; ONS mid-2012 population estimates

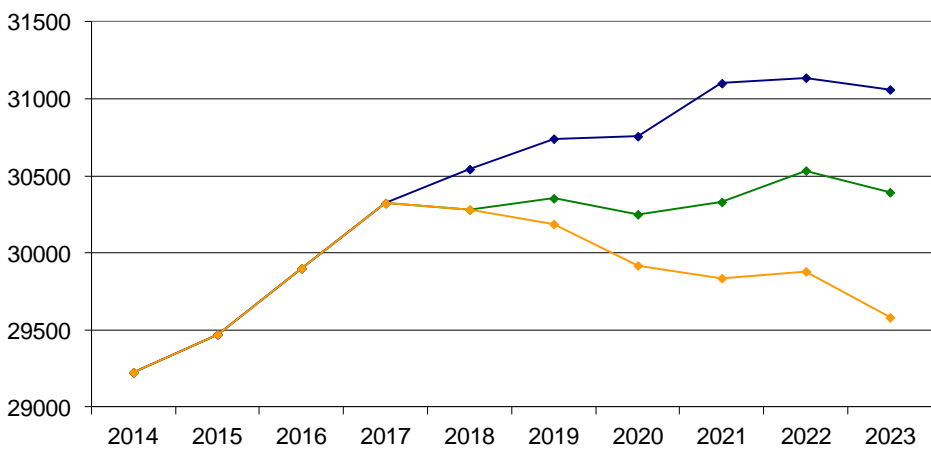
We have used these three scenarios for the number of future births in Cheshire East to create variant population projections that illustrate the possible differences in the number of 0-4 year olds and 5-11 year olds during the ten year period between 2014 and 2023.

The future size of the 0-4 year old population carries the greatest level of uncertainty. By 2017 the size of the 0-4 year old population (20,397 children in 2012) might be as few as 19,400 children or as many 20,700 children, and it may either remain stable thereafter or be somewhere between these figures. The primary school age population of 5-11 year olds (28,229 children in 2012) is projected to rise progressively to around 30,300 children in 2017, but thereafter may either increase, stay the same, or decrease depending on the three different birth scenarios.

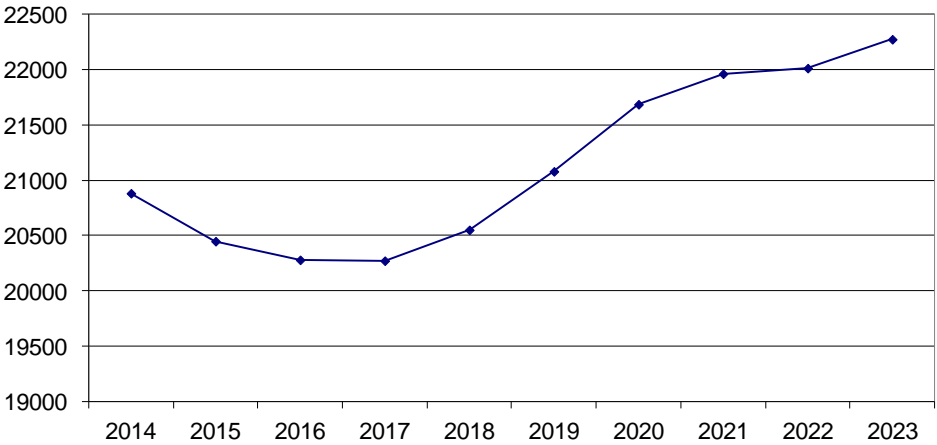
Population projections 0-19 year olds



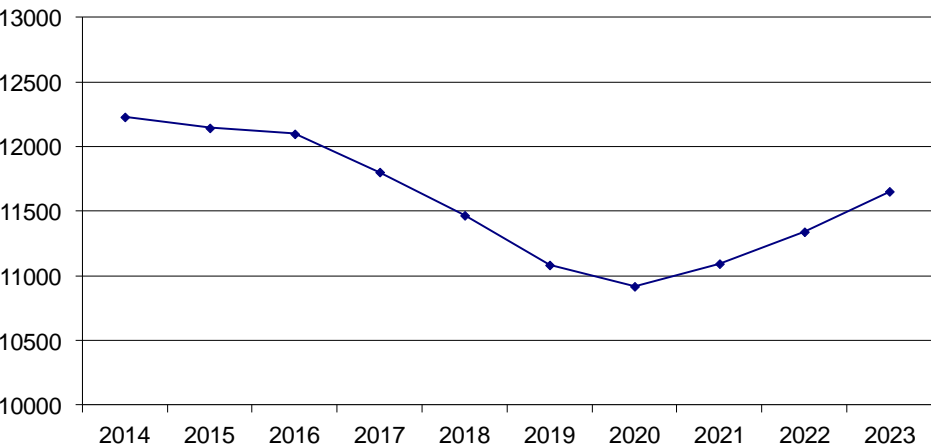
0-4 year olds



5-11 year olds



12-16 year olds



17-19 year olds

◆ Projections based on 2011 live births ◆ 2012 based population projections
◆ Projections based on 2013 live births

Analysis of hospital activity within Cheshire East's APHR2014

Pseudo-anonymised patient-level data for 3 financial years, 2011/12 – 2013/14, where the patient was aged between 0-24 years at the time of attendance or admission was provided via the two Clinical Commissioning Groups within Cheshire East.

The Hospital admissions data was analysed in two different ways:-

1. Data was initially analysed by the ICD10 groupings within the analysis presented in the PHE report 'Reducing unintentional injuries in and around the home among children under fives' and accompanying slides published in June 2014 <https://www.gov.uk/government/publications/reducing-unintentional-injuries-among-children-and-young-people>. See Table 10
2. A frequency distribution of Primary Diagnosis codes was done to identify the common reasons for admission. This was used to group relevant ICD10 codes. See Table 11

Accident and Emergency (A&E) data

A&E data was initially analysed using the A&E diagnosis 2 character codes. This was grouped further to enable comparison with the analysis presented in the PHE report 'Reducing unintentional injuries in and around the home among children under fives' and accompanying slides published in June 2014

<https://www.gov.uk/government/publications/reducing-unintentional-injuries-among-children-and-young-people>. See Table 9

Table 9. Diagnostic groupings used in A&E Attendance analysis

	A&E diagnosis code	Description	Grouping 1
A&E Injuries	1	Laceration	Cuts, grazes, foreign bodies
	2	Contusion/Abrasion	Cuts, grazes, foreign bodies
	4	Head injury	Head injury
	5	Dislocation/Fracture/Joint Injury/Amputation	Fractures and dislocations
	6	Sprain/ligament injury	Other injuries
	7	Muscle/tendon injury	Other injuries
	8	Nerve injury	Other injuries
	9	Vascular injury	Other injuries
	10	Burns and scalds	Burns and scalds
	11	Electric shock	Other injuries
	12	Foreign body	Cuts, grazes, foreign bodies
	13	Bites/stings	Other injuries
	14	Poisoning (inc overdose)	Poisoning
	15	Near drowning	Other injuries
	16	Visceral injury	Other injuries
A&E non-injuries	3	Soft tissue inflammation	Infection & inflammation
	17	Infectious disease	Infection & inflammation
	18	Local infection	Infection & inflammation
	19	Septicaemia	Infection & inflammation
	20	Cardiac conditions	Circulatory
	21	Cerebrovascular conditions	Circulatory
	22	Other vascular conditions	Circulatory
	23	Haematological conditions	Other
	24	Central nervous system conditions	Other
	25	Respiratory conditions	Respiratory
	26	Gastrointestinal conditions	Gastrointestinal
	27	Urological conditions (inc cystitis)	Genitourinary
	28	Obstetric conditions	Other
	29	Gynaecological conditions	Genitourinary
	30	Diabetes and other endocrinological	Other
	31	Dermatological conditions	Other
	32	Allergy (inc anaphylaxis)	Other
	33	Facio-maxillary conditions	Other
	34	ENT conditions	Other
	35	Psychiatric conditions	Mental Health
	36	Ophthalmological conditions	Other
	37	Social problems	Other
	38	Diagnosis not classifiable	No Diagnosis
	39	Nothing abnormal detected	No Diagnosis

Table 10. Diagnostic codes used in childhood injury admissions analysis

ICD10 codes, all diagnosis	Description	Grouping
W00-W19	Falls	Falls
W20-W49	Inanimate mechanical	Bangs, cuts, foreign bodies
W50-W64	Animate mechanical	Other
W65-W74	Drowning	Other
W75-W84	Suffocation	Other
W85-W99	Electric current etc	Other
X00-X09	Smoke Fire	Burns & scalds
X10-X19	Thermal	Burns & scalds
X20-X29	Venomous	Other
X30-X39	Forces of nature	Other
X40-X49	Poisoning	Accidental poisoning
X50-X57	Overexertion	Other
X58-X59	Other	Other
W00-X59	Unintentional injuries	Other

Table 11. Diagnostic codes used in hospital admissions analysis

ICD10 codes, Primary Diagnosis	Description	Grouping
A00-A09	Intestinal Infectious Disease	Gastrointestinal
A80-B34	Viral Infection	Fever
E10-E14	Diabetes mellitus	Other
G40-G41	Epilepsy	Other
J00-J06	Acute Upper Respiratory Infection	Acute Respiratory
J10-J22	Acute Lower Respiratory Infection	Acute Respiratory
J45-J46	Asthma	Acute Respiratory
K21	Gastro-oesophageal Reflux	Gastrointestinal
K35-K38	Appendicitis	Gastrointestinal
K59	Constipation	Gastrointestinal
L00-L08	Skin Infection	Other
N39	Urinary Tract Infection	Urinary Tract Infection
P58-P59	Neonatal Jaundice	Neonatal Jaundice
R10	Abdominal Pain	Gastrointestinal
R50	Fever of Unknown Origin	Fever
R51	Headache	Other
R56	Convulsions	Convulsions
S00-S09	Head Injury	Head Injury
S42, S52, S62, S72	Limb Fracture	Limb Fracture
S43-S51, S53-S61	Other Injury	Other injuries
T15-T19	Foreign body	Other injuries
T20-T32	Burns	Other injuries
All remaining codes not included above	Other	Other

Cheshire East: Public Health Outcomes Framework indicator

					Local LAP level data	
Indicator	Year	National data set reference	Definition	Value type	Year	Notes
Under 18 conceptions	2012	PHOF2.04	Conceptions in women aged under 18 per 1,000 females aged 15-17	Crude rate per 1000	2009-11	
Smoking at time of delivery	2012/13	PHOF2.03	Number of women who currently smoke at time of delivery per 100 maternities.	Proportion (%)	2013	
Low Birth Weight of term babies	2011	PHOF2.01	Live births with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks as a percentage of all live births with recorded birth weight and a gestational age of at least 37 complete weeks.	Proportion (%)	2008-2010	Rank positions for LAPs are calculated by scaling local 2008-10 data to match PHOF2011 data for Cheshire East to give relative rank position. Rates given in table are actual 2008-10 data.
Breastfeeding at 6-8 weeks	2012/13	PHOF2.02ii	This is the percentage of infants that are totally or partially breastfed at age 6-8 weeks. Totally breastfed is defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are not receiving formula milk, any other liquid or food.	Proportion (%)	2012/13	
A&E attendances age 0-4 years	2011/12	ChiMat EY	Crude rate of A&E attendances in children (aged 0 to 4 years), per 1,000 resident population.	Crude rate per 1,000	2011/12 - 2013/14	Local LAP data calculated from A&E extractions supplied by the Cheshire Clinical Commissioning Groups (CCGs) for the purpose of the APHR2014. National data source is the ChiMat Early Years Profiles.
Hospital admissions caused by injuries age 0-14	2012/13	PHOF2.07i	Crude rate of emergency hospital admissions (episode number = 1, admission method = 21 to 28) caused by unintentional and deliberate injuries (ICD 10: S00-T79 and/or V01-Y36 in any diagnostic field position), in children (aged 0 to 14 years), per 10,000 resident population.	Crude rate per 10,000	2012/13	
Hospital admissions caused by injuries age 15-24	2012/13	PHOF2.07ii	Crude rate of emergency hospital admissions (episode number = 1, admission method = 21 to 28) caused by unintentional and deliberate injuries (ICD 10: S00-T79 and/or V01-Y36 in any diagnostic field position), in young people (aged 15 to 24 years), per 10,000 resident population.	Crude rate per 10,000	2012/13	
Tooth decay in children age 5	2011/12	PHOF4.02	Percentage of children with decay experience (ie with one or more obviously decayed, missing (due to decay) and filled teeth (dmft)) - %of dmft>0	Proportion (%)	2007/08	The proportion of dmft is presented instead of the actual definition used in the PHOF4.02, this is because the public find this easier to understand. Local LAP data is taken from the 2007/08 survey as there was insufficient coverage in the 2011/12 survey to allow local data to be calculated. Rates for Cheshire East are statistical similar across the two years to allow comparison.
Excess weight at age 4-5 years	2012/13	PHOF2.06i	Proportion of children aged 4-5 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.	Proportion (%)	2012/13	
Excess weight at age 10-11 years	2012/13	PHOF2.06ii	Proportion of children aged 10-11 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.	Proportion (%)	2012/13	
MMR two doses at age 5	2012/13	PHOF3.03x	All children for whom the PCT is responsible who received two doses of MMR on or after their first birthday and at any time up to their fifth birthday as a percentage of all children whose fifth birthday falls within the time period.	Proportion (%)	2012/13	

Glossary

Adolescent	This is the stage of development between puberty and maturity, roughly between the ages of 12 and 19 when changing from being a child to an adult.
Better Care Fund	This is a pooled budget that shifts resources into social care and community services for the benefit of the NHS and local government.
Bikeability	This refers to cycling training for the 21st century which aims to get more people cycling, more safely and more often. Bikeability is designed to give the next generation the skills and confidence to ride their bikes on today's roads.
Birth Weight	This is the first weight of the baby taken just after he or she is born. The average birth weight in UK is between 2.5 and 4.5 Kg. A low birth weight is when a baby weighs less than 2.5 Kg (5.5 lb).
Blood Borne Viruses (BBV)	These are viruses that some people carry in their blood and can be spread from one person to another. Some people may show few or no symptoms of serious disease, but others may be severely ill. The most common types of BBV are Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C.
Body Mass Index (BMI)	This is defined as the weight in kilograms divided by the square of height in metres. For children aged two and over, BMI is interpreted by looking at the child's age in relation to their age, height and sex. All school children are routinely weighed and measured as part of the National Child Measurement Programme when the child is in reception and in year six.
Cheshire East Youth Council	<p>The Youth Council is run by young people, and provides opportunities for 11-18 year-olds (25 if they have learning difficulties or have been in care) to use their voice in creative ways to bring about social change. The aim of a youth council is to empower young people to influence and inform the decisions that affect their lives. Young people are encouraged to get involved in their communities and democracy locally, nationally and internationally. The Cheshire East Youth Council consists of 3 tiers of involvement:</p> <p><u>Leadership Group</u>: This consists of Members of UK Youth Parliament, Deputies, REP's (Representatives of other groups) and PYP's (This stands for Passionate Young People who really want to get involved). This group attends Youth Council meetings, makes decisions about campaigns and</p>

represents the Youth Council at other meetings.

Active Group: This consists of young people who are involved with other youth groups and prefer to have their say through that group. Young people are on Facebook Group and a mailing list and choose what they want to get involved with. This group are invited to meetings and to sit on task and finish groups. They also receive online survey opportunities.

Informed Group: Young people give their views and opinions through social media and join in online polls.

Chief Medical Officer	The Chief Medical Officer (CMO) acts as the Government's principal, most senior medical adviser and the professional head of all Directors of Public Health in local government.
Child And Adolescent Mental Health Services (CAMHS)	CAMHS are specialist NHS services which offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.
Commissioning	This is the process of planning, agreeing and monitoring services. Commissioning is not one action but many, ranging from the needs assessment for a population, through the design of client pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.
Conduct Disorder	This is a serious behavioural and emotional disorder that can occur in children and teenagers. A child with this disorder may display a pattern of disruptive and violent behaviour and have problems following rules.
Confidentiality	This refers to the obligation not to disclose information; the right of a person to withhold information from others.
Contraceptive Services	This offers family planning services including advice about birth control methods, emergency contraception, permanent sterilization and, where appropriate, screening for sexually transmitted infections.
Early Years Foundation Stage (EYFS)	The EYFS sets standards for the learning, development and care of children from birth to 5 years old.
Family Nurse Partnership	This is an intensive, structured, home visiting programme, which is offered to first time parents under the age of 20. A specially trained family nurse visits the mother regularly from early pregnancy until the baby is 2 years old and builds a close, supportive relationship with the family.
Fatal Casualties	This refers to people who died at the time or within 30 days of an accident.

GUM Services	A sexual health or genitourinary medicine (GUM) clinic specialises in sexual health, and gives tests and treatment for many sexually transmitted infections.
Immunisation and Vaccination	Immunisation is the most important way of protecting people from catching infections. A vaccine usually has a small dose of an active or inactive form of the germ, or the poison made by the germ. This causes the body to make antibodies against the germ or poison, and then the antibodies are ready to attack the germ if it begins to invade the body.
Infant	An infant refers to young children between birth and approximately 1 year of age. A newborn or neonate is an infant in the first 28 days after birth.
Infection	This is the invasion of the body by an infectious agent which can be a virus, bacteria, or other organisms. A bacterium is a single-celled microorganism, most are harmless, but some can cause disease such as e-coli causing urine infection, streptococci causing throat infections, campylobacter and salmonella. Viruses, e.g., rotavirus and chickenpox virus are much smaller and require a host to live in. Once they invade the body, viruses enter the cells and multiply. The most important distinction is that antibodies kill bacteria but have no effect on viruses. The overuse of antibiotics can create strains of bacteria that are resistant to some types of antibiotics, which is why antibiotics should only be given after careful assessment.
Intentional and Unintentional Injuries	Unintentional injuries include those injuries that occur without intent of harm. Intentional or deliberate injuries are injuries that are purposely inflicted with the intent to cause harm such as child abuse and neglect.
Joint Strategic Needs Assessment (JSNA)	The JSNA analyses health and social care needs to inform and guide commissioning of health, well-being and social care services within local authority areas. The main goal of a JSNA is to accurately assess the health and social needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.
Lifecourse and Lifespan	Life course is the sequence of age categories that people are expected to pass through as they progress from birth, through childhood and adulthood to death. The length of time for which a person lives is called lifespan.
Local Safeguarding Children Board	The Children Act 2004 requires all local authority areas to have a Local Safeguarding Children Board in place to oversee, monitor and scrutinise local arrangements for safeguarding children and promoting their welfare. The Cheshire East Safeguarding Children Board is the partnership body responsible for co-ordinating and ensuring the effectiveness

	of Cheshire East services to protect and promote the welfare of children.
Health and Wellbeing Boards	Health and Wellbeing boards are statutory bodies introduced in England under the Health and Social Care Act 2012. According to the Act, each upper-tier local authority in England is required to form a health and wellbeing board as a committee of that authority.
Making Every Contact Count	This is a concept which aims to improve lifestyles and reduce health inequalities. It encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), empowering healthier lifestyle choices and exploring the wider social determinants that influence all of our health.
Mental Health Disorders	These include a wide range of disorders such as anxiety disorders, bipolar disorder, mood disorders, personality disorders and psychotic disorders.
Miscarriage and Still Birth	A miscarriage is the loss of a pregnancy during the first 23 weeks whereas a stillbirth is a baby delivered with no signs of life after 24 completed weeks of pregnancy.
National Institute For Health And Care Excellence (NICE)	NICE provides national guidance and advice to improve health and social care. NICE guidance sets the standards for high quality healthcare and encourages healthy living.
Outbreak	A disease outbreak is the occurrence of cases of disease in excess of what would normally be expected in a defined community or geographical area.
Personal Child Health Record (PCHR)	This is also known as the red book and is a national standard health and development record given to parents or carers at a child's birth. It is the main record of a child's health and development. The parent/ carer retains the PCHR and the health professionals update the record each time the child is seen in a healthcare setting.
Personal, Social, Health & Economic Education (PSHE)	PSHE education is a planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives. As part of a whole school approach, PSHE develops the qualities and attributes pupils need to thrive as individuals, family members and members of society.
Postpartum or Postnatal	This is the period immediately after the birth of a child and extending for about six weeks.

Pregnancy Gestation	Gestation is how far along the foetus is, determined by the beginning of the mother's last period. Babies are usually born at 40 weeks, but considered full-term from 37 weeks to 42 weeks. A baby born before 37 weeks is a premature birth.
Proportionate Universalism	To reduce health inequalities, action should be universal but proportionate to the level of disadvantage.
Public Health Nursing	This consists of registered nurses and midwives including school nurses and health visitors who have gained an additional qualification in public health.
Road Safety Partnership	The partnership exists to reduce the number of people killed and hurt on the roads.
Rural	This term is based on population sparsity, remoteness from urban areas, access to services, land use, socio-economic characteristic of areas, local perceptions of whether home is rural or not, and whether it involves an economically active population.
School Travel Plan	This is a document put in place to encourage parents and children to consider healthy and sustainable forms of transport when travelling to and from school and provide practical measures for improving children's safety on the school journey.
Schools: Academy Schools, Free Schools, Studio Schools and Grammar Schools	<p><u>Academies</u> are publicly funded independent schools. They do not have to follow the national curriculum and can set their own term times. Academies get money directly from the government, not the local council although funding arrangements are broadly similar. There are many different types of Academies, some sponsored by other schools or organisations and some acting as a single academy or part of a Multi Academy Trust (several schools working together in a structured way).</p> <p><u>Free schools</u> are funded by the government but are not run by the local council and are a type of academy. They have more control over how they do things. They are 'all-ability' schools, so cannot use academic selection processes like a grammar school and do not have to follow the national curriculum.</p> <p>A <u>Studio school</u> is a type of secondary school that is designed to give students practical skills in workplace environments as well as traditional academic and vocational courses of study.</p> <p><u>Grammar schools</u> are run by a council, a foundation body or a trust. They select all, or most, of their pupils based on academic ability and there is often an entry exam.</p>

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Foreword

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