Children and Young People Select Committee Overview Meeting 2016

30th November 2016

Report from Interim Director of Public Health

Public Health Service

1. Context

Members are well aware that as a Council we have had to adapt to funding reductions of £52 million over the last five years and that we are still confronted with having to find further savings. In relation to Public Health services this has meant delivering efficiencies and savings through a programme of service reviews to ensure value for money whilst securing improved health and wellbeing outcomes.

Whilst we acknowledge that we have a strong track record of sound financial management and we have been dealing with these problems successfully for many years, it will not be easy to address the additional loss of government funding of over £20 million by 2019/20. Moving forward, expectations will need to be realistic as many more difficult decisions will need to be made.

It is both acknowledged and accepted that we can't continue to do all the things we currently do and that we won't be able to work in the same way. For Public Health services this may mean the requirement to make further savings through service reviews and the commissioning process, tailoring services according to population need.

The challenge for all Members is to ensure that decisions about the basis on which services will be delivered are within the resources available, taking account of a number of factors such as reduced budget allocation, changing demographics, increasing demand, new national legislation and policy direction. Members are reminded of the four policy principles that support our decision-making:

- **Protecting the vulnerable through targeted intervention,** particularly those people in our communities who are subject to, or at risk of harm, people who are homeless or at risk of becoming homeless and those who are financially excluded or whose circumstances make them vulnerable.

- **Promoting equality of opportunity through targeted intervention,** specifically in relation to tackling health inequalities, meeting the skills gap and improving access to job opportunities, tackling fuel poverty, improving education and training opportunities, access to affordable housing and financial and digital inclusion.

- **Developing strong and healthy communities** through the provision of mainstream and preventive services that are available to all those who choose to access them.

- **Creating economic prosperity** across the Borough

It is within this context that the select committee is invited to undertake their overview duties.

Cont'd..

2. What has been achieved?

Mandated functions

There are 5 mandated Public Health functions that the Council is required to deliver under the Health and Social Care Act 2012. These are:

1. Community Sexual Health Services
2. Health checks
3. The National Child Measurement Programme for Children in Reception and Yr6
4. Ensuring arrangements are in place to protect the health of the population
5. Providing Public Health support for the local CCG

Further detail is provided on those relevant to children and young people (all except Health Checks) as follows:

Community Sexual Health Services: a health needs assessment was carried out, together with an evaluation of delivery against the current contract in 2014/15. This information was used to inform the recommissioning of the service in 2015/16, with Stockton leading on the procurement process on behalf of the 4 Tees Local Authorities. The 5-year contract was awarded to the previous provider, Virgin Healthcare, on a Tees-wide contract valued at approx. £4m. The new contract will focus on a more developed outreach model in the community, to increase access to services and help address inequality.

National Child Measurement Programme (NCMP) is a programme to measure the height and weight of all children in reception and year 6 on an annual basis. The measurement programme is mandated but support or intervention for children who are identified as significantly overweight is not mandatory. The family weight management service delivered by MoreLife provides this service, commissioned by Public Health and working with the school nursing service.

Ensuring Arrangements are in Place to Protect the Health of the Population is fulfilled through close working with Public Health England and NHS England. NHS England commissions and delivers screening and immunisation programmes and the role of the DPH is to ensure their plans and arrangements are appropriate and robust. Our childhood immunisation rates continue to perform well. Public Health England provides excellent support for dealing with outbreaks of any nature together with our Environmental Health team; and in support of our preparation for the health aspects of emergency plans which we regularly exercise with other agencies.

Providing Public Health support for the local CCG - We work very closely with our CCG colleagues and support their work through our Public Health team led by a Public Health Consultant. This constitutes offering Public Health advice on the CCG's commissioning plans and working together to identify joint commissioning opportunities where possible. We also offer advice and support around reducing variability of primary care. The CCG also has a role in prevention and we often have common agendas around the key causes of illness and death, such as heart disease and lung disease.

There are further Public Health services which have mandatory aspects, described as follows:

Oral health improvement

Under the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, Part 4, Local Authorities are also responsible for oral health improvement (epidemiological surveys and oral health promotion programmes). Work is underway to scope the implications of this, as it transfers to us in the Local Authority. Public Health is already undertaking a significant oral health programme in the Borough working with Public Health England, through delivering toothbrushing and fluoride varnish schemes in schools. The toothbrushing scheme has been widely adopted and the fluoride varnish scheme is soon to be rolled out. Dental surgery is the main reason for children needing a general anaesthetic and we know that improved oral health results in less pain, improved school attendance and improved self-esteem in children.

Drug and alcohol

The 2015/16 Public Health grant included a new condition that a Local Authority must, in using the grant, "…have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services…". To effectively discharge this responsibility, the wider determinants of health (as set out in the grant conditions) should also be addressed e.g. child poverty, smoking prevalence. This year, we have effectively responded to the closing of the Birchtree Practice by securing the services of our existing provider, CGL. CGL provide high quality substance misuse services and responded quickly and effectively to meet the needs of Birchtree clients.

Children and young people: 0-19 services

For health visiting services, five universal health reviews are mandated by Parliamentary regulation until April 2017. Robust evidence points to the importance of health, wellbeing and resilience in early life and the impact of this on life chances into adulthood. Local Authorities have the opportunity to bring together services for children in the early years and to join up 0-19 commissioning. We are working closely with children's services colleagues to develop and implement our vision for these services. The success of the *A Fairer Start* programme has meant that much of the approach used by this work focusing on 0-3yr olds will be mainstreamed, particularly the emphasis on outreach into the community based on community peer champions and on professional training and culture.

Further Public Health activity

The mandated functions are only a small part of the activity of the Public Health department. Indeed, a range of further functions have a significant impact on the population's health and wellbeing and are also inter-related with the mandated elements of our provision. We have maintained a focus on health inequalities this year, with a range of activities across the life course (as illustrated in the DPH Annual Report for 2015/16). Important activity for the team includes:

- Drug and alcohol treatment services
- Tobacco control
- Oral health in children
- Diet and obesity
- Sexual Health
- Mental health including self-harm and suicide
- Warm homes
- Risk taking behaviours
- Domestic abuse

For example we, together with the CCG, have lead the development of a Mental Health and Wellbeing Strategy in 2015/16. Our team undertook a comprehensive health needs assessment on the mental health and wellbeing of children and young people, to underpin policy and strategy work and inform service development. We are currently undertaking a similar piece of work for the adult population. Public Health also undertook a detailed piece of work on self-harm this year, reporting to the Health and Wellbeing Board, as we know self-harm is an issue in our local young people. We are working with education improvement service colleagues to build emotional resilience in young people through a risk-taking behaviour toolkit in primary and secondary schools. A risk and resilience approach helps to prevent and address issues such as smoking, poor sexual health, emotional and mental health issues and drug and alcohol use and misuse.

In addition, we continue to help fund and support the Warm Homes, Healthy People agenda, addressing the illness and mortality that can be caused by cold, damp homes – particularly for older people, young children and those with long term conditions.

We are working closely with partners – particularly Local Authority children's services – to develop and implement our vision for 0-19yr olds. This includes reviewing our current services and linking with work such as the Children's Centre review. Public Health commissions a range of services for and supporting children and young people including health visiting, school nursing, domestic abuse, young people's substance misuse and weight management.

In addition to our commissioning work, we ensure we carry out the full range of Public Health activity which can help ensure a broad impact at population-level, for example influencing partners to deliver Public Health outcomes and developing joint plans around shared agendas that can benefit health and social care e.g. our input to the work on the Children's Hub. Public Health is also working closely with children's services and other partners on the Domestic Abuse Steering Group, to review the Public Health-commissioned Domestic Abuse service and the Domestic Abuse Strategy.

Public Health data and performance information

The appendices comprise:

- The current Child Health profile for the Borough
- The summary performance report from the Health and Wellbeing Board

These appendices will be useful in illustrating some of the key data and figures behind the issues outlined in this report. It is helpful to note that analysing longer term patterns can be more useful in identifying trends and assessing impact of work. Therefore the figures are often a 'snap shot' in time and though they are not always this year's data, they are the most recently available and are still helpful in the context of broader trends.

3. Challenges

- Continuing to ensure services operate in the most efficient and effective manner to address the needs of the population, in a climate of financial challenge

- Ensuring that services are appropriately targeted to the level of need, whilst improving and protecting the health of the population as a whole, in accordance with the duties of the Local Authority

- The Tees Valley Public Health Shared Service is to be disbanded at the end of December 2016, following a reluctant decision by Tees Valley Chief Executives.

Work is ongoing to maintain business continuity and to continue to secure scarce specialist skills as far as possible

- Continuing to input to the developing STP, across a broad footprint, particularly to inform the plans around prevention

- Work with partners through the Health and Wellbeing Board to realise the potential of the health and social care integration agenda in the most appropriate manner

4. Emerging Issues

- There is the opportunity to build further on our close strategic working with other areas e.g. children's services

- Greater integration of health and social care services, driven by national policy

5. **Possible Areas for In Depth Review** (This should be line with Council policy priorities)

- The developing plan regarding the prevention, diagnosis and treatment of diabetes through physical activity may highlight some areas where review would be valuable

- Mental and emotional wellbeing in children and young people

Appendix 1

PERFORMANCE UPDATE – NOVEMBER 2016

SUMMARY

Health improvement

HW100 Obesity in 4-5 year olds (reception) % of children measured through the National Childhood Measurement Programme:

- The latest published data was released in November 2016 and is for the period 2015/16.
- This data indicated that 9.6% of the reception year age group are considered obese.
- We have missed the target of 9.5%. However this figure is better than 10.5% in 2014/15. We are worse than the national average of 9.3% but better than the regional average of 10.7%.
- Nationally the prevalence of obesity in Reception aged children has increased since 2014/15. Stockton-on-Tees rates have decreased since 2014/15.

HW101 Obesity in 10 – 11 year olds (year six) % of children measured through the National Childhood Measurement Programme:

- The latest published data was released in November 2016 and is for the period 2015/16.
- This data indicated that 21.3% of the year 6 group are considered obese. This figure is worse than the rate of 19.6% seen in 2014/15 but better than the rate seen in 2013/14 (21.5%)
- We have achieved the target of 21.5%.
- In year 6 obesity rates are consistently higher than the England average of 19.8% but are lower than the regional average of 22.4%.
- Nationally the prevalence of obesity has increased since 2014/15 in year 6.

Context

Obesity remains a significant issue for Stockton-on-Tees. National data has shown that the deprivation gap as measured by the differences in obesity prevalence between the most and least deprived areas has increased over time. This reflects the local trend in Stockton-on-Tees.

The Children and Young Peoples Public Health School Nursing Service continue to achieve a high coverage rate delivering the National Child Measurement (NCMP) which ensures high quality data for service planning and analysis. The School Nursing Service is now providing pro-active follow-up to families when a child is identified as obese through the NCMP. This has resulted in more referrals to the Family Weight Management Service (Morelife).

The Phunky Foods programme continues to engage with primary and secondary schools to support a whole school approach to healthy eating and physical activity. The programme is currently being delivered in 35 primary schools.

HW201 % of smoking population accessing the stop smoking service commissioned by Stockton-On-Tees Public Health

- Q4 cumulative total (2015/16) showed that 2304 smokers set a quit date.
- This equates to 7.8% of the smoking population accessing the service compared with the NE figure of 6.3%.
- This is below the target of 10%, though Stockton is in the top 3 for performance in the region.

Context

Secondhand smoke causes numerous health problems in infants and children, including more frequent and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome. Stockton Public Health commissions smoking cessation services, which are regarded as an example of best practice nationally. National guidance suggests that we should access a minimum of 5% of the smoking population. Work continues with partners from the Adults Health and Wellbeing and Children and Young People's Partnerships**.**

HW202 % Smoking Quitters (number of four week quitters in the smoking cessation service commissioned by Stockton-On-Tees Public Health) and % of total population who access the stop smoking service who are residents from the ten most deprived wards of the borough.

- There were 944 quitters in 2015/16 against a target of 1400, this is 33% below target.
- There were 71 fewer quitters compared with 2014/15. This equates to a 7.1% reduction, which is lower than NE (8.9%).
- Percentage of individuals accessing the stop smoking services who are resident in our ten most deprived wards who have quit at four weeks is 40.4%.
- Percentage of the total population who access the stop smoking service who are residents from the ten most deprived wards of the borough is 63.8%.

Context

The national and local downturn in smoking quitters shown above is believed to be a result of the impact of electronic cigarettes and other alternatives to the use of the smoking cessation service. Work continues nationally to understand the impact of these alternatives. Recent work includes an intensive promotion of the local stop smoking service including a leaflet drop in all wards and advertising in a local newspaper. We also continue to work with schools and youth settings to reduce and prevent risk-taking behaviour among young people, including smoking, through a resilience-building approach.

HW300 Rate of emergency hospital admissions for alcohol related harm per 100,000 population

- There were 806 admissions per 100,000 for Q4 2015/16 giving a final figure of 2720 against a proposed target of 2560. This is a 1.3% increase compared to the same period in 2014/15.
- This is now just above the official whole year 2014/15 figure of 2684 and 2% above the North East average of 2666. It is 24% above the England average of 2189.

Context

Alcohol misuse can have a significant impact on families (including links to domestic abuse). To reduce alcohol related risk and harm across the Borough, Alcohol Screening and delivery of Brief Interventions (BI) Training is being delivered through 'Have a Word' Alcohol Training. Alcohol brief interventions/advice are an evidence based method of reducing alcohol harm. Both adult and children's workforce teams are currently taking part in the programme, with both Adult and Children & Young People's Partnership Boards giving their support to the programme. Training so far has received a positive response, with over 75% of participants strongly agreeing that training has improved their understanding of BI, confidence in delivery and anticipation that they will carry out BIs in the future.

The Public Health team are also working with the partners to develop a map which depicts alcohol related harm. The purpose of the map is to support targeting of work from partners and to highlight areas which require additional alcohol control measures via the local authority licensing policy. The partnership currently has representation from Public Health, Trading Standards, Licensing, the CCG, Police and Community Safety. This partnership approach is an excellent opportunity to support the reduction of alcohol related harms within the Borough.

HW301 Number of opiate drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment

- In Q1 performance was 4.9% against a target of 5.5%.
- This is better than the previous reported figure of 4.5% for time period Q4 2015/16.

Context

Like alcohol, substance misuse can have a significant impact on families. Work continues to manage and address the complex issues experienced by these individuals. Stockton performance remains low in comparison with comparator authorities (top quartile performance is between 8.6% and 16%). The performance indicator has a six month lag in order to measure re-presentation rates in the six months following exit. Therefore Q1 performance reflects numbers leaving treatment in the 12 months up to the end of December 2015. We can therefore anticipate likely performance in Q2 and beyond based on the number exiting treatment in Q4 2015/16 and Q1 2016/17. In these two quarters, exit rates increased significantly due to an increase in the use of community based detox. We achieved 6.3% in Q4 and 6.6% in Q1 2016/17. The Q4 improvement in exits will be reported in September 2016, once six month re-presentation rates are available. We are anticipating an increase in performance to around 6%. Currently only two individuals have relapsed and returned to treatment since October 2015.

The national trend shows continuous and significant decline falling from 7.6% in 2014/15 to 6.8% in 2015/16. Q1 2016/17 has seen a further decline to 6.7%. Prevention work in Stockton includes work through schools and youth settings to implement a risk-and resilience-based approach, aiming to prevent and reduce risk-taking behaviour.

HW302 Number of non-opiate drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment:

- In Q1 performance was 43.3% against a target of 35%. This is better than the previous reported figure of 43% for time period Q4 2015/16.

Context

Numbers in treatment are now fairly stable with referral rates consistent despite significant fluctuations in the number of arrests and drug tests taking place in arrest referrals. Re-presentation rates remain low at 3.9% (2 out of 51 exits) therefore we expect numbers in treatment to begin to decline if exit rates remain above target. We are working with partners to improve offender management for those with substance misuse issues with the aim of increasing the level of meaningful treatment for those where substance misuse remains a factor in driving offending behaviour.

Health protection

HW102 Under 18 conceptions (3 year rolling average rate per 15-17 year olds per 1,000 population)

Annual Data

- 3 year annual rolling average rate for 2012 – 2014 is 35.96 per 1000 of the 15 – 17 year old population
- Stockton Rates for 2012 = 40, 2013 = 33.5, 2014 = 34.4
- North East 2014 average rate is 30.2
- England 2014 average rate is 22.8

Under 18 conception data for 2015 will be available at end of Q4 2016-17.

Quarterly Data

The latest quarterly data available is for Q2 2015-16.

- Stockton rate is 29.5 per 1000 of the 15 – 17 year old population. This is a 5.4% reduction when compared to the same quarter in 2014-15.
- North East Q2 2015-16 average rate is 29
- England Q2 2015-16 average rate is 21.6

Context

Whilst the latest quarterly and annual under 18 conception data for Stockton indicates a decline in conception rates in the Borough, the rate of this decline is not as rapid as in the majority of North East local authority areas.

A Tees-wide Integrated Sexual Health Service (provided by Virgincare) is commissioned to provide Level 1, 2 and 3 sexual health services including provision of contraception, screening and treatment for sexually transmitted infections and provision of advice and information on sexual health and relationships.

A new service model has been in operation since August 2016 and continues to offer a hub and spoke approach but places a greater emphasis on outreach provision, preventative approaches and working with those from the most vulnerable communities. The model includes the delivery of services specifically for young people and this work is being delivered by Brook, a national young people's sexual health and wellbeing charity. Brook will be providing specific focused work to increase access to outreach services, chlamydia screening and C Card (condom distribution) alongside the delivery of evidence based

education and training packages to groups of young people and targeted support for the most vulnerable. In addition, Brook will deliver workforce development programmes for the children and young people's workforce to upskill them in the delivery of sexual health and relationship advice and information.

HW103 Chlamydia diagnosis (crude rate 15-24 year olds)

- Chlamydia Diagnosis rate for 15-24 year olds (inclusive) - 1, 512 per 100,000 in 2015. This equates to 341 cases in the Stockton on Tees population.
- Chlamydia Diagnosis rate for 15-24 year olds (inclusive) - 1, 101 per 100,000 in Q1 2016/17. This equates to 67 cases in the Stockton on Tees population.

Context

The number of chlamydia diagnoses in Stockton on Tees residents was significantly lower in 2015 (-20%) than seen in 2014. No Local Authority area across Tees or the North East achieved the diagnosis rate target of 2,300 per 100,000 across the year.

The diagnosis rate for Stockton has dropped further within the first quarter of 2016/17. Only Middlesbrough within the North East region achieved the diagnosis rate target in this quarter.

The new contract to deliver integrated sexual health services across Tees has a specific focus on increasing diagnosis and treatment of all sexually transmitted infections including chlamydia and will utilise assertive outreach to engage with the most vulnerable communities. Stockton in particular will benefit from increased outreach within this model. Sexual Health Teesside will also work closely with schools, colleges and young people's services to deliver a range of preventative services including sex and relationships education and an accessible condom distribution scheme.

Appendix 2: **Child Health Profile (2016) (www.chimat.org.uk)**

Public Health England

Child Health Profile
March 2016

Stockton-on-Tees

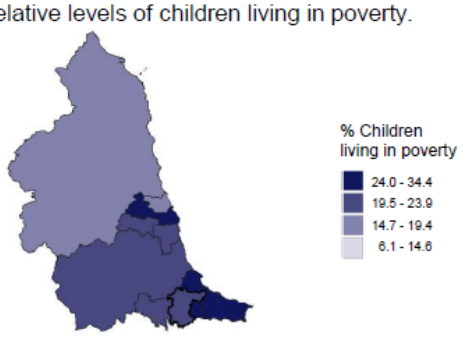
This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

	Local	North East	England
Live births in 2014			
	2,329	28,456	661,496
Children (age 0 to 4 years), 2014			
	12,400 (6.4%)	151,600 (5.8%)	3,431,000 (6.3%)
Children (age 0 to 19 years), 2014			
	47,200 (24.3%)	593,200 (22.7%)	12,907,300 (23.8%)
Children (age 0 to 19 years) in 2025 (projected)			
	50,900 (24.6%)	608,800 (22.5%)	13,865,500 (23.7%)
School children from minority ethnic groups, 2015			
	2,488 (10.3%)	29,842 (9.5%)	1,931,855 (28.9%)
Children living in poverty (age under 16 years), 2013			
	21.8%	23.3%	18.6%
Life expectancy at birth, 2012-2014			
Boys	78.4	78.0	79.5
Girls	82.3	81.7	83.2

Children living in poverty

Map of the North East, with Stockton-on-Tees outlined, showing the relative levels of children living in poverty.



Contains Ordnance Survey data

Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2012-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 24.3% of the population of Stockton-on-Tees. 10.3% of school children are from a minority ethnic group.

The health and wellbeing of children in Stockton-on-Tees is generally worse than the England average. The infant mortality rate is similar to and the child mortality rate is worse than the England average.

The level of child poverty is worse than the England average with 21.8% of children aged under 16 years living in poverty.

10.4% of children aged 4-5 years and 19.8% of children aged 10-11 years are classified as obese.

Local areas should aim to have at least 90% of children immunised in order to give protection both to the individual child and the overall population. The MMR immunisation rate is higher than 90%. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib in children aged two is higher than 90%.

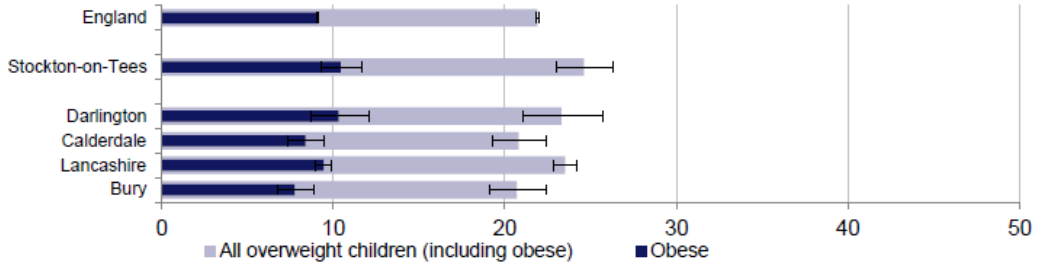
There were 375 children in care at 31 March 2015, which equates to a higher rate than the England average. A higher percentage of children in care are up-to-date with their immunisations compared with the England average for this group of children.

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

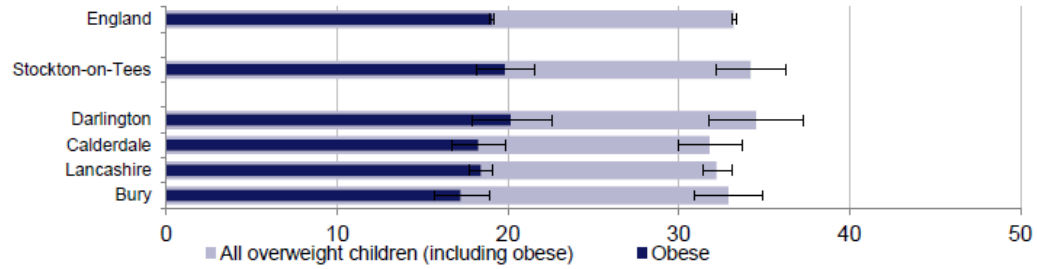
Childhood obesity

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

Children aged 4-5 years classified as obese or overweight, 2014/15 (percentage)



Children aged 10-11 years classified as obese or overweight, 2014/15 (percentage)

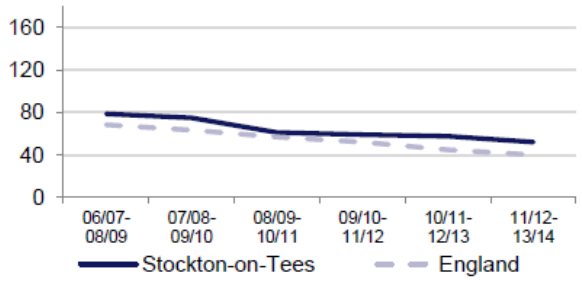


Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.
I indicates 95% confidence interval. Data source: Public Health Outcomes Framework

Young people and alcohol

In comparison with the 2006/07-2008/09 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is similar in the 2011/12-2013/14 period. The admission rate in the 2011/12-2013/14 period is higher than the England average.

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

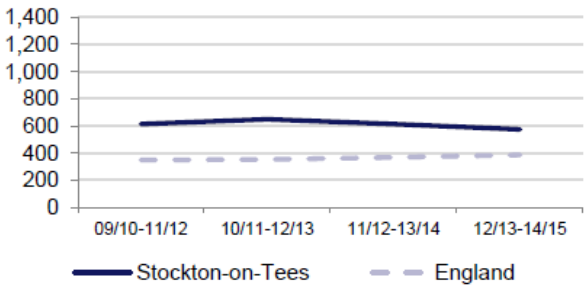


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2009/10-2011/12 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2012/13-2014/15 period. The admission rate in the 2012/13-2014/15 period is higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

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



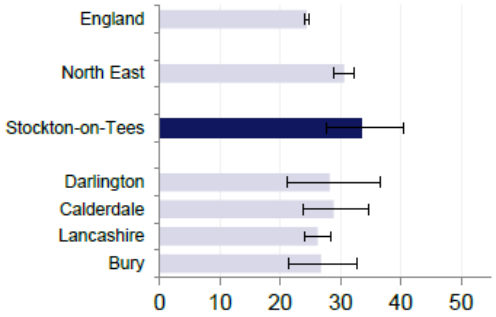
*Information about admissions in the single year 2014/15 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

Stockton-on-Tees Child Health Profile — March 2016

These charts compare Stockton-on-Tees with its statistical neighbours, the England and regional average and, where available, the European average.

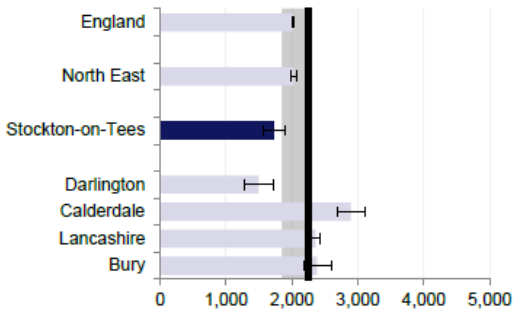
Teenage conceptions in girls aged under 18 years, 2013 (rate per 1,000 female population aged 15-17 years)



In 2013, approximately 33 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is similar to the regional average. The area has a higher teenage conception rate compared with the England average.

Source: Conceptions in England and Wales, ONS

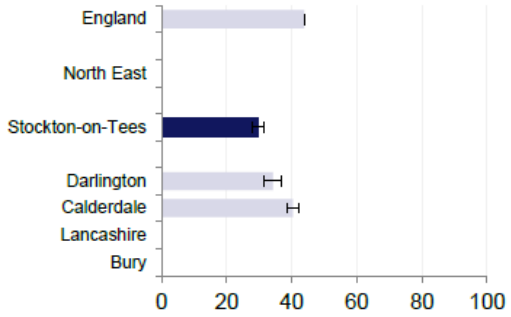
Chlamydia detection, 2014 (rate per 100,000 young people aged 15 - 24 years)



Chlamydia screening is recommended for all sexually active 15-24 year olds. Increasing detection rates indicates better targeting of screening activity; it is not a measure of prevalence. Areas should work towards a detection rate of at least 2,300 per 100,000 population. In 2014, the detection rate in this area was 1,731 which is lower than the minimum recommended rate.

Source: Public Health Outcomes Framework. The shaded area from 1,900 shows the range of values approaching the minimum recommended rate of 2,300 (the black line).

Breastfeeding at 6 to 8 weeks, 2014/15 (percentage of infants due 6 to 8 week checks)

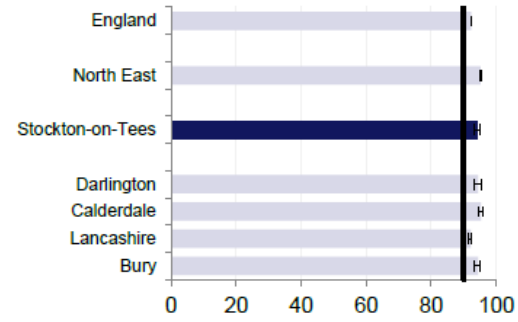


In this area, 29.6% of mothers are still breastfeeding at 6 to 8 weeks. 58.2% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*.

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

Source: Public Health Outcomes Framework

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2014/15 (percentage of children age 2 years)



More than 90% (the minimum recommended coverage level, shown as a vertical black line on the chart above) of children have received their first dose of immunisation by the age of two in this area (94.2%). By the age of five, 91.5% of children have received their second dose of MMR immunisation. In the North East, there were 3 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Sources: Public Health Outcomes Framework; Public Health England

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

Stockton-on-Tees Child Health Profile — March 2016

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

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

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	1 Infant mortality	9	3.9	4.0	7.2	1.6
	2 Child mortality rate (1-17 years)	8	19.3	12.0	19.3	5.0
Health protection	3 MMR vaccination for one dose (2 years) >=90% <90%	2,290	94.2	92.3	73.8	98.1
	4 Dtap / IPV / Hib vaccination (2 years) >=90% <90%	2,357	97.0	95.7	79.2	99.2
	5 Children in care immunisations	265	94.6	87.8	64.9	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	1,492	58.8	66.3	50.7	77.5
	7 GCSEs achieved (5 A*-C inc. English and maths)	1,282	59.2	57.3	42.0	71.4
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	9 16-18 year olds not in education, employment or training	610	9.0	4.7	9.0	1.5
	10 First time entrants to the youth justice system	72	405.5	409.1	808.6	132.9
	11 Children in poverty (under 16 years)	7,990	21.8	18.6	34.4	6.1
	12 Family homelessness	-	-	1.8	8.9	0.2
	13 Children in care	375	88	60	158	20
	14 Children killed or seriously injured in road traffic accidents	8	20.4	17.9	51.5	5.5
Health improvement	15 Low birthweight of term babies	61	2.9	2.9	5.8	1.6
	16 Obese children (4-5 years)	257	10.4	9.1	13.6	4.2
	17 Obese children (10-11 years)	406	19.8	19.1	27.8	10.5
	18 Children with one or more decayed, missing or filled teeth	-	31.9	27.9	53.2	12.5
	19 Hospital admissions for dental caries (1-4 years)	43	430.7	322.0	1,406.8	11.7
	20 Under 18 conceptions	111	33.5	24.3	43.9	9.2
	21 Teenage mothers	34	1.5	0.9	2.2	0.2
	22 Hospital admissions due to alcohol specific conditions	22	52.1	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	27	109.7	88.8	278.2	24.7
Prevention of ill health	24 Smoking status at time of delivery	412	18.1	11.4	27.2	2.1
	25 Breastfeeding initiation	1,326	58.2	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	682	29.6	43.8	19.1	81.5
	27 A&E attendances (0-4 years)	6,600	530.2	540.5	1,761.8	263.6
	28 Hospital admissions caused by injuries in children (0-14 years)	469	132.2	109.6	199.7	61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	355	145.9	131.7	287.1	67.1
	30 Hospital admissions for asthma (under 19 years)	85	189.7	216.1	553.2	73.4
	31 Hospital admissions for mental health conditions	44	103.6	87.4	226.5	28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	179	504.7	398.8	1,388.4	105.2

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

1 Mortality rate per 1,000 live births (age under 1 year), 2012-2014
2 Directly standardised rate per 100,000 children age 1-17 years, 2012-2014
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2014/15
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2014/15
5 % children in care with up-to-date immunisations, 2015
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2014/15
7 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2014/15
8 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2014 (provisional)
9 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2014
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2014
11 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2013
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2014/15
13 Rate of children looked after at 31 March per 10,000 population aged under 18, 2015
14 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2012-2014
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2014
16 % school children in Reception year classified as obese, 2014/15
17 % school children in Year 6 classified as obese, 2014/15
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
19 Crude rate per 100,000 (age 1-4 years) for hospital admissions for dental caries, 2012/13-2014/15
20 Under 18 conception rate per 1,000 females age 15-17 years, 2013
21 % of delivery episodes where the mother is aged less than 18 years, 2014/15
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2011/12-2013/14
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2012/13-2014/15
24 % of mothers smoking at time of delivery, 2014/15
25 % of mothers initiating breastfeeding, 2014/15
26 % of mothers breastfeeding at 6-8 weeks, 2014/15
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2014/15
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2014/15
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2014/15
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2014/15
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2014/15
32 Directly standardised rate per 100,000 (age 10-24 years) for emergency hospital admissions for self-harm, 2014/15