



# Reducing health inequalities among children and young people in East Sussex

**Director of Public Health  
Report 2012/13**



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## Foreword

Reducing health inequalities among all residents is a main priority for East Sussex County Council and NHS Sussex. This report aims to present the key factors that contribute to health inequalities in children and young people. The report acknowledges the significance of wider influences on health including education, housing, transport, the environment and leisure.

The report takes a life-course approach, considering pregnancy and the postnatal period; the health of pre-school children; and lifestyle factors in school age children; as well as children and young people with additional needs. We introduce the main findings from the 2012 Health Related Behaviour Survey, which surveyed 14-15 year olds across the county.

There are marked inequalities in preventable health outcomes for children in East Sussex including infant mortality, low birth weight, children on child protection plans, school achievement, teenage pregnancy and a range of risky lifestyle behaviours. This report makes recommendations for the NHS and Local Authority, working with a range of partners, to reduce these health gaps and improve the health and wellbeing of our most vulnerable children, young people and families.

### **Changes to the NHS and their impact on children's services**

The NHS is currently undergoing a great deal of change. From April 2013, Clinical Commissioning Groups will commission the majority of current NHS services as Primary Care Trusts (NHS Sussex) dissolve. The NHS Commissioning Board is being created and will commission some specialist services including screening and vaccination. The Commissioning Board will have local offices, with Surrey Sussex being our local team. Public Health England is being created as a specialist Public Health organisation of the Department of Health and will be responsible for functions previously discharged by the Health Protection Agency and the National Treatment Agency and the provision of specialist expertise around screening and vaccinations.

Local authorities will undertake new leadership duties for Public Health and will be the new commissioners of sexual health services and NHS services for 5-19 year olds (including school nursing). This heralds opportunities for even greater integration of sexual health commissioning with other council services including education, targeted youth services, under-19 substance misuse services, services for looked after children, domestic violence services and adult social care. Similarly, taking the lead for commissioning health services for 5-19 year olds will support a more integrated approach for the school nursing service. The NHS Commissioning Board will commission health services for 0-5 year olds for two years from April 2013 after which these services will also be commissioned by the Local Authority.

### **The Health and Wellbeing Strategy and priorities for children and young people**

Integral to the changes is the development of a new statutory partnership - the Health and Wellbeing Board - which includes membership from local authorities, the local NHS, the new public involvement group, Healthwatch, and the voluntary sector. This will be the vehicle for coordinating commissioning of healthcare, social care and public health services to increase the health and wellbeing of the residents of East Sussex. A Health and Wellbeing Strategy - Healthy Lives, Healthy People 2013-16 - is in development to frame the priorities for the next three years. Seven priority areas have been suggested for the Strategy:

- The best possible start for all babies and young children
- Safe, resilient, secure parenting for all children and young people
- Reducing the harm caused by alcohol and tobacco
- Preventing and reducing falls, accidents and injuries
- Enabling people to manage and maintain their mental health and wellbeing
- Supporting those with special educational needs, disabilities and long-term conditions
- High quality and choice of end of life care

The findings of this report have contributed to the current consultation on the Strategy.

#### **Looking ahead**

Improving the health of children and young people increases the likelihood of them leading healthier lives as adults. In a time of immense change in the way NHS services are commissioned and in the context of a major economic recession, it is crucial to prioritise the needs of children as an investment in the health of the population of the future.

It is my belief that the joint expertise of local authorities - including public health - and the wider NHS will offer a greater opportunity to engage with local children, families and communities and work together with them to build a healthier future.



**Dr Diana Grice**  
**Director of Public Health and Wellbeing**  
**NHS East Sussex and East Sussex County Council**

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# Chapter 1.

# Summary

The recent integration of the public health function in local authorities offers exciting opportunities for improving health and reducing health inequalities among children and young people in East Sussex.

East Sussex County Council has many years' experience of commissioning and providing services for children, young people and families, as well as responsibility for the wider determinants of health - including education and economic regeneration - which have such a crucial role to play in the health and wellbeing of communities.

This report outlines the key factors contributing to health inequalities among children and young people in East Sussex; describes the services that are currently in place to improve health and prevent disease; and recommends future priorities for improving the health and wellbeing of the youngest members of our community.

**Chapters 1 and 2** introduce the strategic context and outline key statistics relating to children's health and child poverty.

**Chapter 3** focuses on the antenatal and postnatal period, describing the impact of maternal smoking, obesity and emotional wellbeing on the health of mothers and babies. This chapter also considers protective factors, such as screening and breastfeeding, and describes local trends in infant mortality.

**Chapter 4** outlines issues relating to childhood immunisation and oral health for pre-school children and describes some local initiatives to improve the health of children from vulnerable families, including the Family Nurse Partnership and the Good Start Programme.

**Chapter 5** focuses on children and young people with additional needs, including looked after children and young carers. This chapter also provides information about the Thrive Programme, which aims to reduce the number of children subject to child protection plans.

**Chapter 6** summarises data from the 2012 Health Related Behaviour Survey of 4,500 Year 10 pupils across East Sussex and makes recommendations for supporting local young people to lead healthier lives. This chapter also outlines key education issues and their impact on health inequalities.

**Chapter 7** provides a snapshot of hospital admissions for children and young people, and outlines issues which may require further investigation.

This report highlights many encouraging signs that efforts to improve health and prevent disease among local babies, children and young people are having an impact.

However there are also indications that health inequalities persist in our county, perpetuated by continued deprivation and unhealthy lifestyles. A recurring theme throughout the report is the geographical variation in levels of health and wellbeing and health-promoting behaviour in children and young people.

Data presented in the report reinforces the relationship between deprivation, unhealthy lifestyles and poor health. One fifth of children in East Sussex are living in poverty. East Sussex has seen a continued rise in child protection and safeguarding activity over the last four years.



Hastings is a particular area of concern. The infant mortality rate in Hastings Borough Council is statistically higher than the rate for South East Coast. Rates of emergency hospital admissions due to unintentional and deliberate injuries for 0-17 year olds are higher than the rates for England. Almost a quarter of pregnant women in Hastings are smokers at the time of booking antenatal care.

These are all major challenges for service providers, and it is crucial that the NHS, local authorities and the voluntary sector continue to work closely with local communities to explore innovative ways to promote health, prevent disease and halt the cycle of deprivation. The recommendations in this report provide some guidance on evidence-based actions to improve the health and life chances of the children in our county, and are written to reflect current responsibilities, some of which will change from April 2013.

Health inequalities are unacceptable and many are avoidable, and tackling them will require commitment, resources and energy from a broad range of organisations and individuals. However, this input should be seen as an investment, because improving the health of the youngest members of our community will not only have benefits for those individuals in adulthood, but will also increase the likelihood of better health and wellbeing for future generations.



# Chapter 2.

# Setting the scene

East Sussex has a generally older population profile compared with England, with a lower proportion of children and young people, especially children aged under 10 years. There were 88,000 children in East Sussex in 2010.

There were around 5,400 births in East Sussex in 2010. The birth rate varies between districts and boroughs in East Sussex with the highest rates in Hastings (68.9 per 1,000 females aged 15-44) and Eastbourne (66.0 per 1,000 females aged 15-44).

## **Child poverty**

Almost one in five (18.7%) children are living in poverty across the county. There is variation across the county in terms of numbers of children affected and the proportion living in poverty. There is almost a six-fold difference in the number of children living in poverty in urban areas compared with those living in rural areas. The area with the highest percentage of children living in poverty is Central St Leonards (50%), the areas with the highest numbers of children living in poverty are Hampden Park and Langney (795).

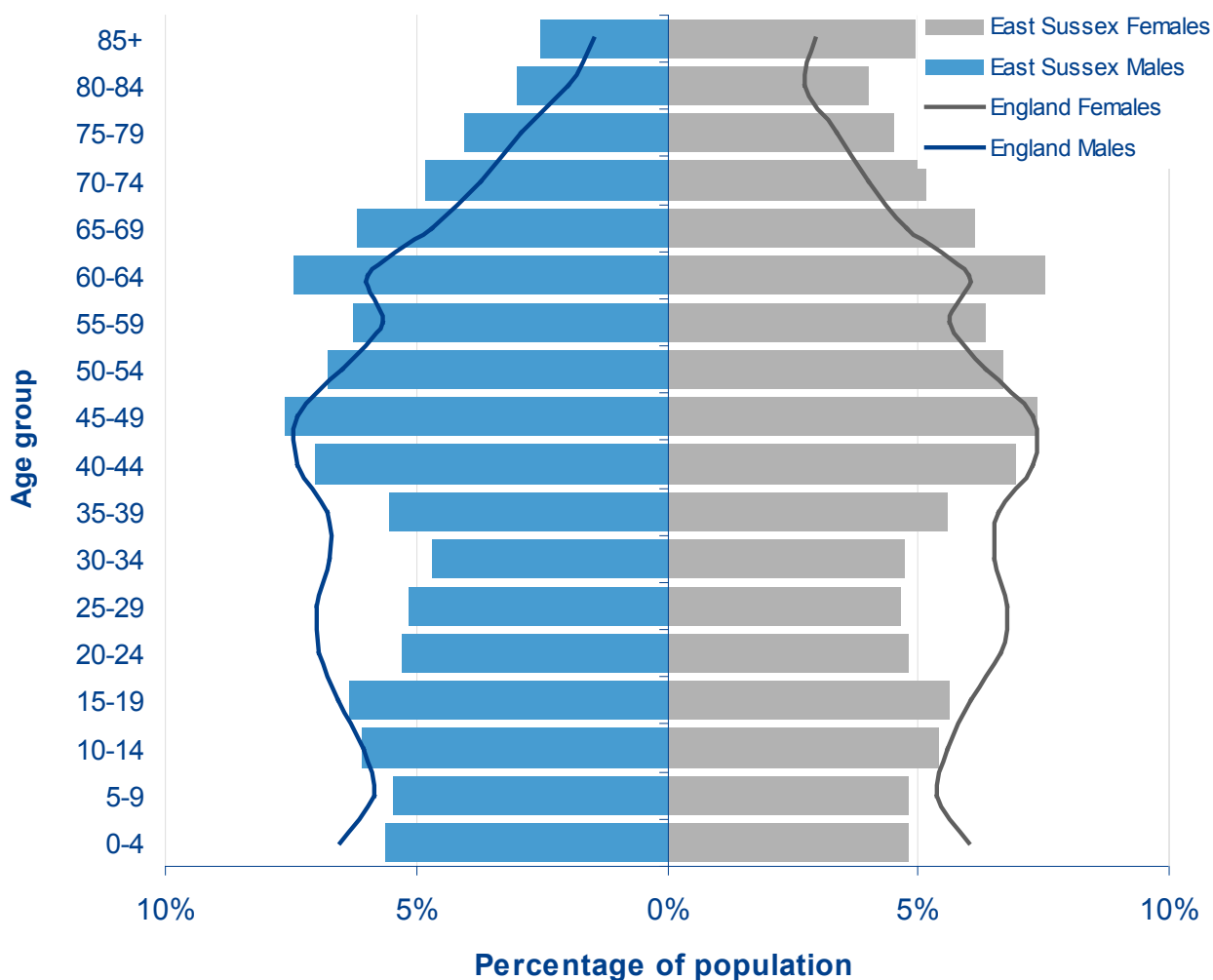


## Key statistics

East Sussex has a generally older population profile compared with England, with a lower proportion of children and young people, especially children aged under 10 years.

Figure 2.1 shows that East Sussex has a lower proportion of children aged 0-4 years and 5-9 years compared with the England average.

**Figure 2.1: East Sussex population compared with England, 2011**



**Source: Office for National Statistics**

Table 2.1 shows that there were around 5,400 births in East Sussex in 2010. The birth rate varies between districts and boroughs in East Sussex with the highest rates in Hastings (68.9 per 1,000 females aged 15-44) and Eastbourne (66.0 per 1,000 females aged 15-44).

Table 2.1: East Sussex births and child population

Area	Registered live births 2010	Birth rate	Mid-2011 population estimates by age group				
			0-4	5-9	10-14	15-19	Total 0-19
Eastbourne	1,163	66.0	5,347	4,861	5,349	6,152	21,709
Hastings	1,147	68.9	5,570	4,782	5,249	5,732	21,333
Lewes	980	63.6	5,062	5,218	5,517	5,617	21,414
Rother	752	62.0	4,050	4,082	5,066	5,147	18,345
Wealden	1,322	61.9	7,529	8,138	9,043	8,963	33,673
East Sussex	5,364	64.5	27,558	27,081	30,224	31,611	116,474
England	687,007	65.5	3,328,746	2,990,135	3,067,411	3,324,270	12,710,562

Source: Office for National Statistics

Figure 2.2 shows that birth rates have been increasing over the last 10 years both nationally and locally. The indication is that rates have now peaked and that levels are likely to stabilise or reduce. The East Sussex birth rate (64.5 per 1,000 females aged 15-44) in 2010 is slightly below the national rate of 65.4 per 1,000. Hastings has had consistently higher birth rates than England. The birth rates in Lewes, Rother and Wealden District Councils are all below the county average.

Figure 2.2: Trend in fertility rates



Source: Office for National Statistics

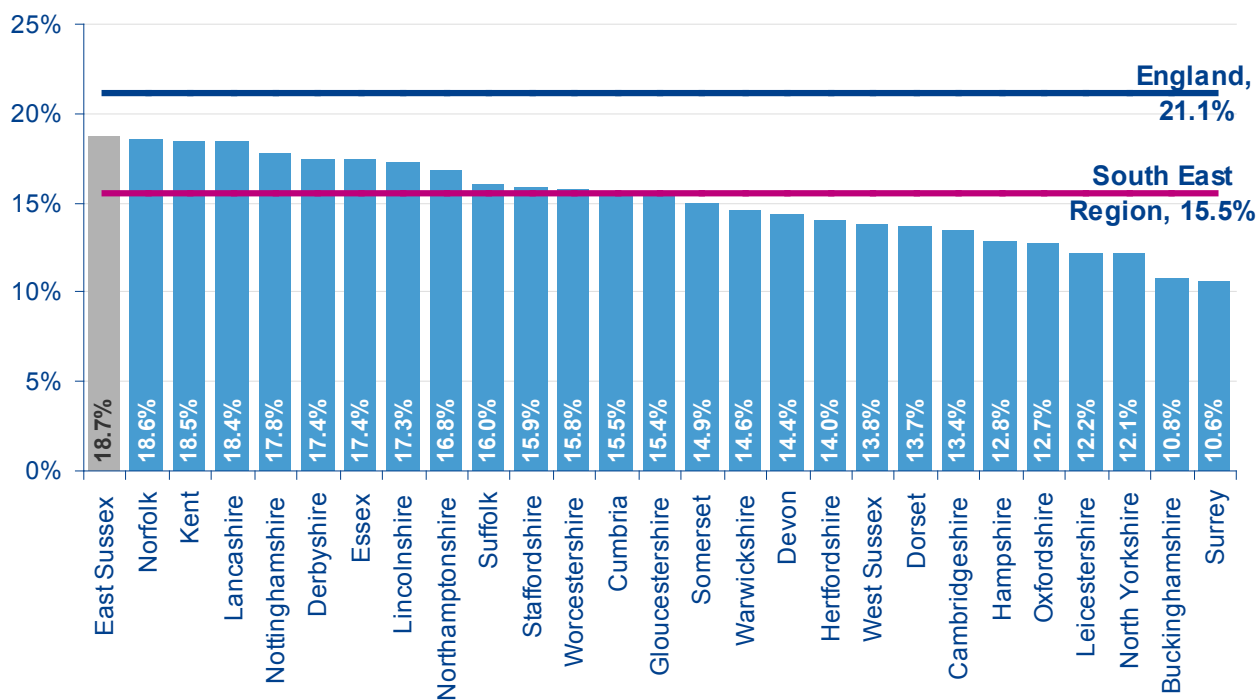
## Child poverty

Research has shown that low income has a negative impact on health and that this is not just confined to those on the lowest incomes.

Income inequality is not solely about material deprivation, but people on low incomes are more likely to live in more deprived neighbourhoods. 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.

In terms of children living in poverty, East Sussex is ranked 95th out of 152 top tier local authorities in England. However, when compared with the other 26 two-tier counties in England it is ranked the highest. This means that East Sussex has the highest percentage of children living in poverty by two-tier county in England.

**Figure 2.3: Percentage of children aged under 16 living in poverty, 2010, counties in England**



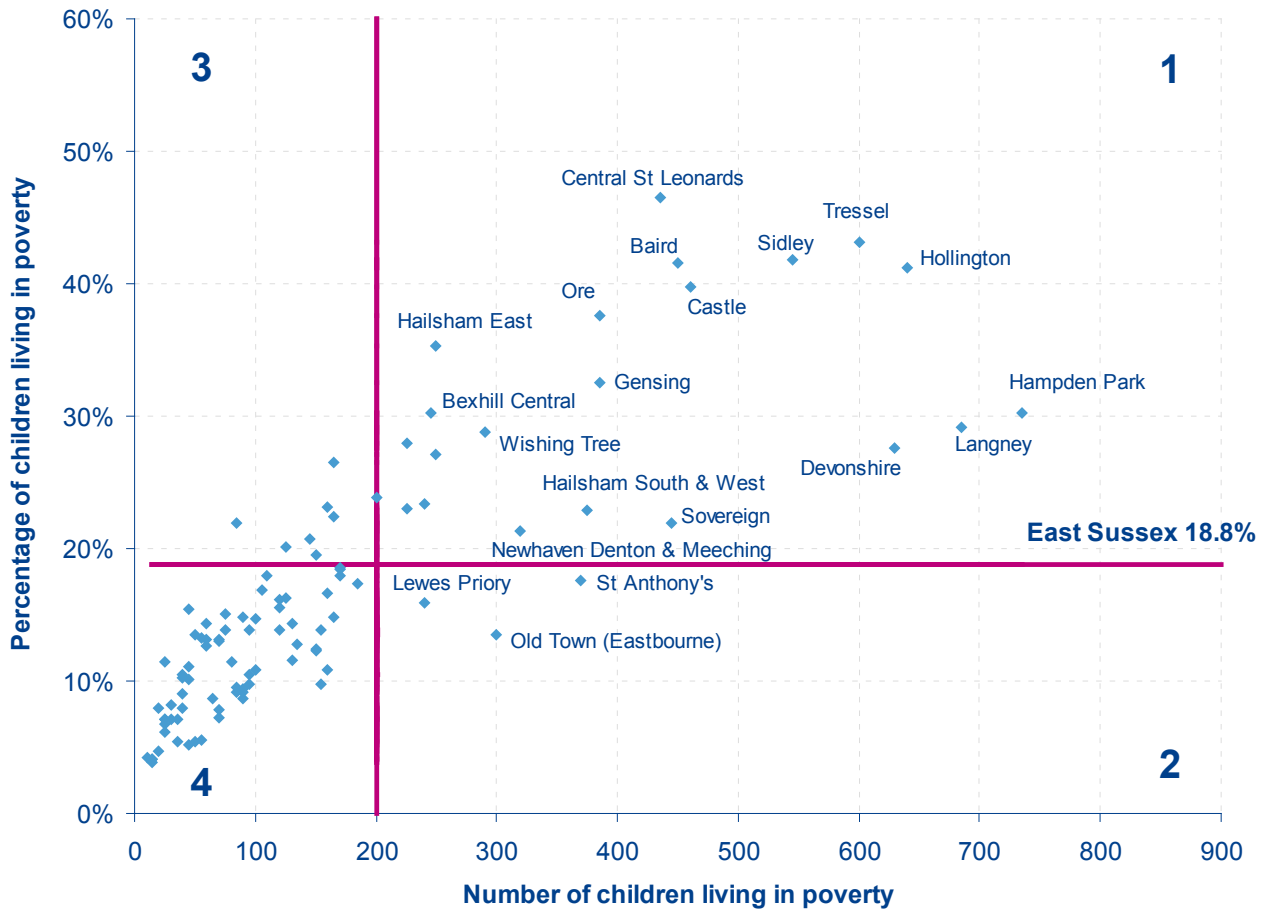
**Source: HM Revenue and Customs, Child Poverty Statistics, October 2012**

The Index of Multiple Deprivation (2010) includes a sub-domain entitled the Income Deprivation Affecting Children Index. This indicates that 19% of children living in East Sussex are income deprived. Using this figure it can be estimated that there are approximately 16,400 children aged under 16 years in East Sussex who are income deprived. The Clinical Commissioning Group (CCG) with the highest rate of income-deprived children is Hastings and Rother CCG (23%), followed by Eastbourne, Hailsham and Seaford CCG (18%) and Havens and Lewes CCG (15%). The CCG localities with the highest levels of income deprivation affecting children are West Hastings (30%), St Leonards (28%) and East Hastings (26%).

When considering where to target efforts to reduce child poverty it is important to consider not just those areas where a high percentage of the child population live in poverty, but also those areas where high numbers of children are living in poverty. Figure 2.4 plots the number of children living in poverty and the percentage of children living in poverty in each of the electoral wards in East Sussex. Those wards which

sit within the top right quadrant (quadrant 1) of the graph can be considered the areas where the greatest effort to reduce child poverty should be targeted. These are areas that are above the East Sussex average of 18.7% for the percentage of children living in poverty and the East Sussex average of 200 children living in poverty. The areas in quadrant 2 should also be considered because although the percentage of children living in poverty in these areas is below the East Sussex average, they contain more than 200 children living in poverty.

**Figure 2.4: Number and percentage of children living in poverty by ward, East Sussex, 2010**



Source: HM Revenue and Customs, Child Poverty Statistics, October 2012

Table 2.2 lists the electoral wards that appear in quadrants 1, 2 and 3 in Figure 2.4.

**Table 2.2: Number and percentage of children living in poverty by ward, East Sussex, 2010**

Quadrant in chart	Ward Name	District/ Borough	Number of children living in poverty	% of children living in poverty
1	Central St Leonards	Hastings	435	47%
	Tressell	Hastings	600	43%
	Bexhill Sidley	Rother	545	42%
	Baird	Hastings	450	42%
	Hollington	Hastings	640	41%
	Castle	Hastings	460	40%
	Ore	Hastings	385	38%
	Hailsham East	Wealden	250	35%
	Gensing	Hastings	385	33%
	Hampden Park	Eastbourne	735	30%
	Bexhill Central	Rother	245	30%
	Langney	Eastbourne	685	29%
	Wishing Tree	Hastings	290	29%
	Newhaven Valley	Lewes	225	28%
	Devonshire	Eastbourne	630	28%
	Braybrooke	Hastings	250	27%
	Bexhill St Stephens	Rother	200	24%
	West St Leonards	Hastings	240	23%
	Old Hastings	Hastings	225	23%
	Hailsham South & West	Wealden	375	23%
Sovereign	Eastbourne	445	22%	
Newhaven Denton & Meeching	Lewes	320	21%	
2	St Anthony's	Eastbourne	370	18%
	Lewes Priory	Lewes	240	16%
	Old Town (Eastbourne)	Eastbourne	300	14%
3	Rye	Rother	165	27%
	Eastern Rother	Rother	160	23%
	Peacehaven East	Lewes	165	22%
	Bexhill Sackville	Rother	85	22%
	Bexhill St Michaels	Rother	145	21%
	Old Town (Bexhill)	Rother	125	20%
	Maze Hill	Hastings	150	20%

**Source: HM Revenue and Customs, Child Poverty Statistics, October 2012**

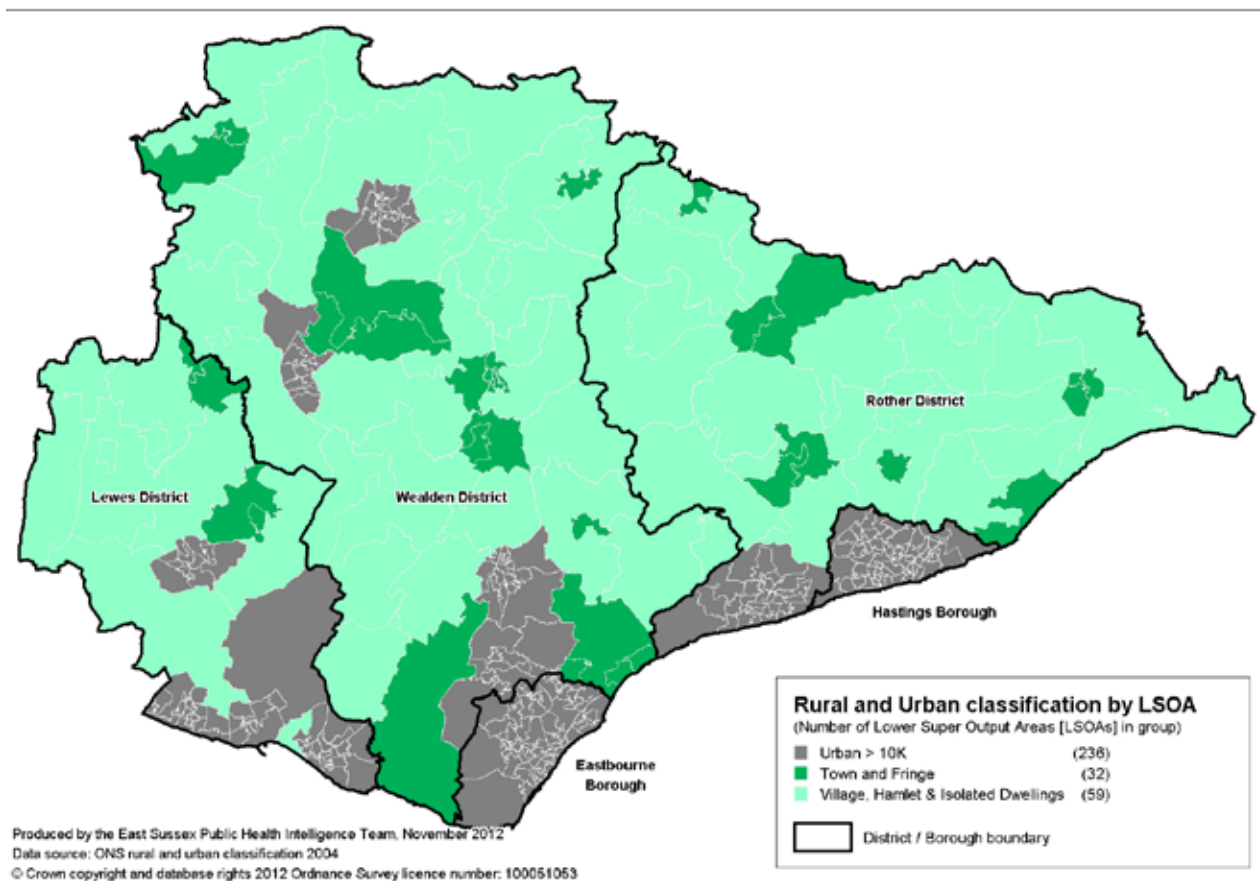
Looking at the data within East Sussex by rural and urban classification (see Figure 2.5 for classification) there is clearly both a higher percentage and a higher number living in the urban areas of East Sussex. When the two rural classification types are combined in the table below there are 2,420 children living in poverty, compared with the 14,055 children in urban areas. This translates to an almost six-fold variation in the number of children living in poverty in urban compared with rural areas, and more than a two-fold difference in the percentage of children living in poverty in urban areas compared with rural areas.



**Table 2.3: Percentage of children aged under 16 living in poverty, 2010, urban and rural classification in East Sussex**

Classification type	Number	Percentage
Urban	14,055	21.6%
Rural	2,420	10.5%
of which Town and Fringe	1,120	13.3%
Village, Hamlet & Isolated Dwellings	1,300	8.8%
<b>Grand Total</b>	<b>16,475</b>	<b>18.7%</b>

Source: HM Revenue and Customs, Child Poverty Statistics, October 2012

**Figure 2.5: Rural and urban areas within East Sussex**

The Rural/Urban definition, an official National Statistic introduced in 2004, defines the rurality of very small census based geographies. Lower Super Output Areas (LSOAs) forming settlements with populations of over 10,000 are urban, while the remainder are defined as one of three rural types: town and fringe, village or hamlet and dispersed.

There is already a range of work being undertaken across East Sussex to tackle child poverty. This includes housing policies, employment policies and welfare benefits.

The Commission for Rural Communities commissioned some research to compare the needs and costs of households in urban and rural areas<sup>1</sup>. The research, based on 15 focus groups in nine Local Authority areas, considered what rural households need to achieve the same minimum living standards as their urban counterparts. The research found that although some things could be cheaper for rural households than for urban households this was unusual and that overall rural households faced additional costs. There is a need for high quality published evidence to support this.

In addition, a Child Poverty Strategy is being developed, overseen by the Children and Young People's Trust Executive Group.

### **Recommendation**

**East Sussex County Council and local district and borough councils need to ensure that their partnerships, strategies, policies and services to support reduction in child poverty and its health impact are informed by this analysis which shows areas where there are children living in poverty.**

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<sup>1</sup> A minimum income standard for rural households, N. Smith, A. Davis, D. Hirsch, Joseph Rowntree Foundation, 2010

# Chapter 3. The antenatal and postnatal period

## Infant mortality

The infant mortality rate for East Sussex 2008-10 was 4.6 per 1,000 live births (which equates to 26 deaths in children under 1 each year in East Sussex). The rate is equal to the England average, though is higher than the South East Coast (SEC) rate of 3.6. The rate in Hastings is significantly higher than the SEC rate (6.1). Reducing maternal obesity, reducing smoking in pregnancy, reducing under 18 conceptions and increasing breastfeeding are some of the measures that will reduce infant mortality.

## Maternal smoking

Smoking in pregnancy is the single most modifiable risk factor for adverse outcomes in pregnancy and is estimated to contribute to 40% of all infant deaths. Women who live in the most deprived 20% of areas are almost four times more likely to smoke during pregnancy than those who live in the least deprived 20% of areas. Across the county 17% of mothers are known to be smoking at delivery and this varies from 10% in Lewes to 22% in Hastings. At ward level, rates are highest in Hailsham East (36%).

## Breastfeeding

The latest available data shows a 5% improvement in the breastfeeding rate at 6-8 weeks in Hastings and Rother (48% in April-June 12), although the rate remains below that of East Sussex Downs and Weald (49%). Breastfeeding initiation and maintenance rates are lowest in women aged under 20 (20%) and highest in older women (72% in women aged 40 and over).



Health inequalities for children and young people start prior to birth. During the antenatal period, several factors can adversely affect the developing fetus. These include maternal smoking, alcohol and drug use, domestic violence, mental health problems, and maternal diet. These factors tend to be more common in less affluent areas and households. Access to high quality antenatal care is also an important factor. It is the responsibility of local authorities and the NHS to focus support on more deprived groups in order to reverse the incidence of perinatal mortality and ill health.

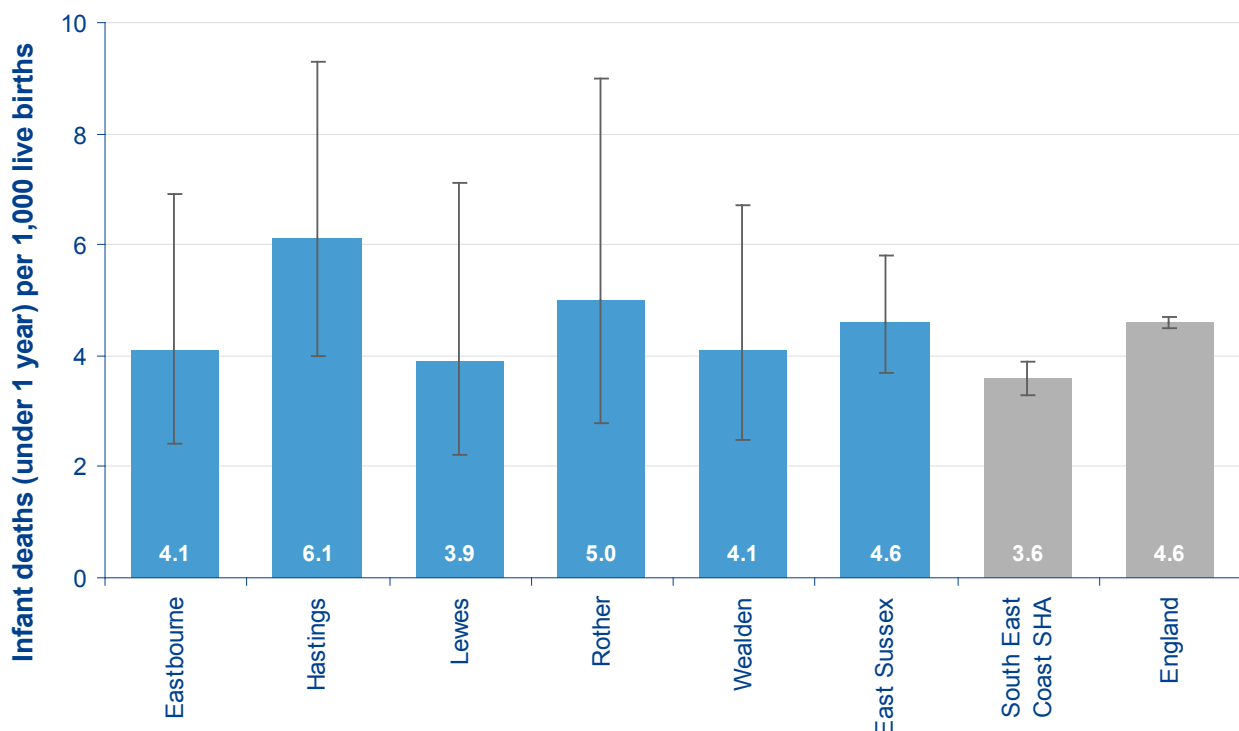
This chapter sets out to describe the variations in factors affecting child health and what action we need to take to contribute to reducing health inequalities.

## Infant mortality

Infant mortality is an important indicator of the health of pregnant women, infants and children. Nationally, infant mortality is at an all-time low and rates continue to fall. However, significant inequalities persist.

The infant mortality rate for 2008-10 in East Sussex was 4.6 per 1,000 live births, equal to the England average. This is equivalent to 26 deaths in children under one year of age each year in East Sussex. For the same period, while rates of infant mortality appear to vary across the county, the difference in infant mortality rates between districts and boroughs is not statistically significant. Although the East Sussex infant mortality rate is not significantly different from the South East Coast region as a whole, the rate in Hastings Borough Council is statistically higher than the South East Coast rate.

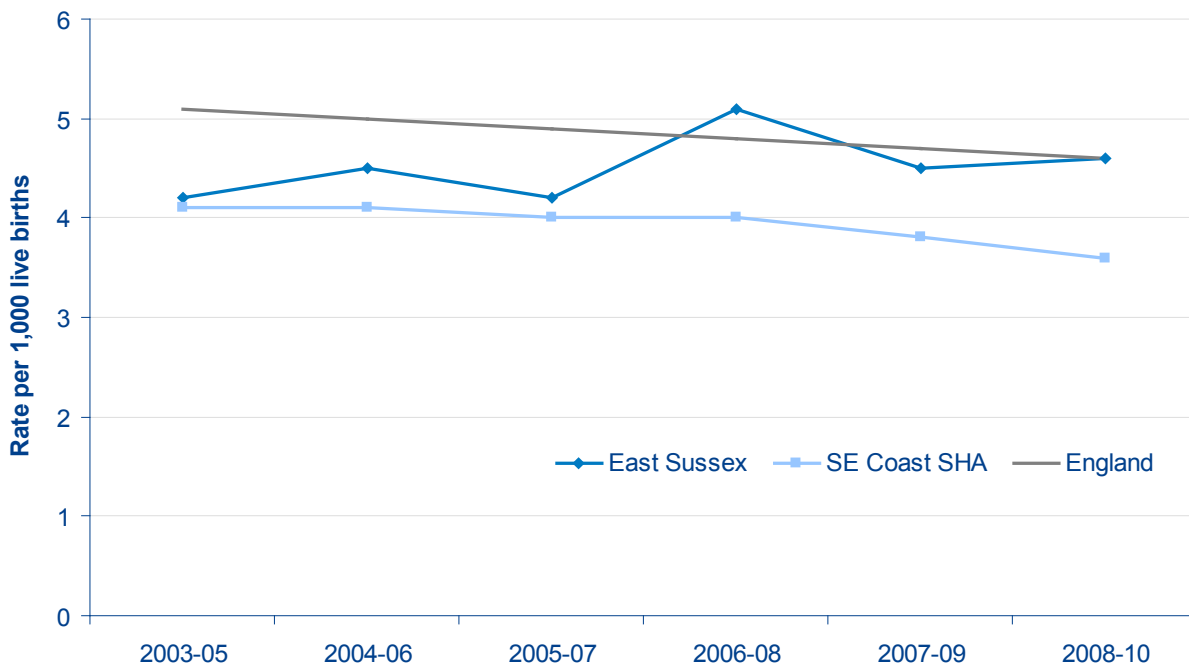
**Figure 3.1: Infant mortality rate: East Sussex local authorities, South East Coast Strategic Health Authority and England, 2008-10**



**Source:** The NHS Information Centre for health and social care. <http://www.indicators.ic.nhs.uk/webview/> (accessed 08/08/2012)

Trends in infant mortality fluctuate locally due to the relatively small number of deaths each year. However, there appears to be a general upward trend across the county, which is counter to the improvements seen over the last seven years across the South East Coast and England.

**Figure 3.2: Trends in infant mortality rate per 1,000 live births: East Sussex, South East Coast and England, 2003-05 to 2008-10**



**Source: The NHS Information Centre for health and social care. <http://www.indicators.ic.nhs.uk/webview/> (accessed 08/08/2012)**

There are a number of factors that have been identified which would reduce the risk of infant death if tackled effectively.<sup>2</sup>

These are:

- reducing under-18 conceptions
- reducing rates of smoking in pregnancy
- reducing prevalence of obesity
- increasing breastfeeding
- ensuring interventions for preventing sudden infant deaths are in place
- reducing household overcrowding
- reducing child poverty

Improving educational attainment, reducing maternal and infant infections and improving access to and the quality of antenatal services are also likely to have a positive impact on infant mortality rates. The prevalence of many of these risk factors and the steps required to tackle them are discussed in separate chapters of this report. However, their interplay highlights the importance of a joined-up partnership approach across organisations if infant mortality is to be tackled effectively.

<sup>2</sup> Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide. Department of Health, December 2007

## Maternal smoking

Smoking in pregnancy is the single most modifiable risk factor for adverse outcomes in pregnancy, and is estimated to contribute to 40% of all infant deaths.<sup>3</sup> Women who smoke in pregnancy are at higher risk of miscarriage, premature birth, low birth weight babies and stillbirth. Prematurity and low birth weight are associated with an increased risk of various health problems including impaired cognitive development and chronic conditions later in life.<sup>4</sup>

Because of the implications for mother and baby of smoking in pregnancy, NHS maternity services record the smoking status of women both prior to having their baby (when booking antenatal care) and at birth. This data indicates that there is a strong relationship between smoking during pregnancy and deprivation, with higher rates seen in more deprived groups. Figure 3.3 shows the variation across the county; in Hastings almost a quarter of women indicated that they were smokers at booking and a similar rate is recorded at birth. In Lewes, whilst around one sixth of women indicated they smoked at booking, this had fallen to just over a tenth at birth. At a Primary Care Trust level, Hastings and Rother has the highest prevalence of mothers smoking at time of delivery in the South East Coast Region.<sup>5</sup> At district and borough level, Hastings Borough Council has one of the highest rates nationally. Addressing the harm caused by tobacco use has been identified as a priority by the East Sussex Public Health Systems Partnership, and a multi-agency Tobacco Control Partnership has been established to bring together partners to address this. Reducing the proportion of women who smoke in pregnancy is a key outcome for this group.

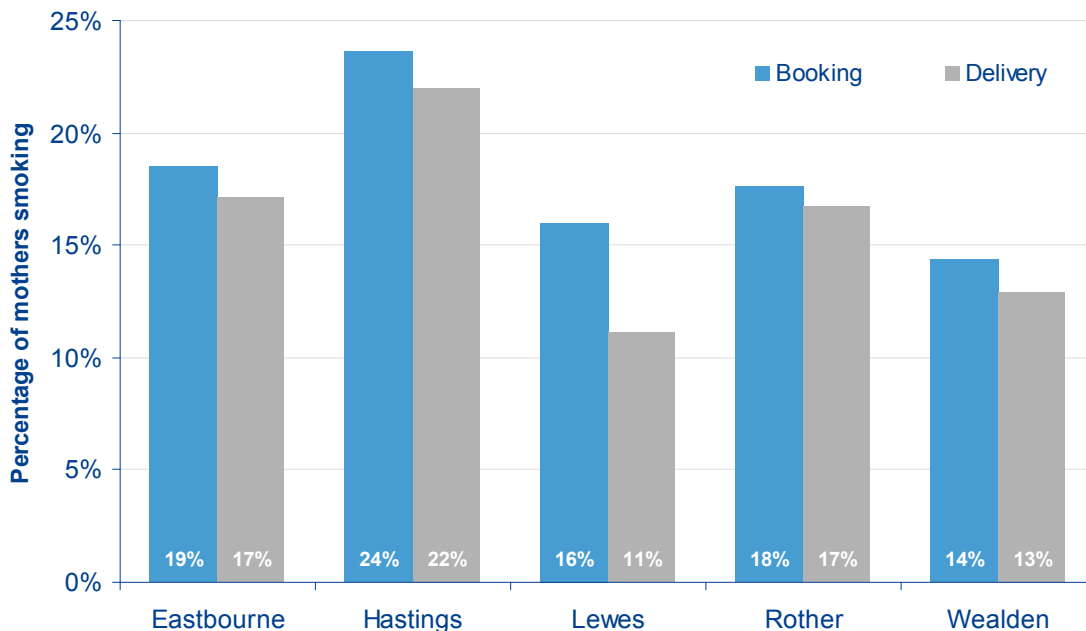


<sup>3</sup> <http://www.ncsct.co.uk/Content/FileManager/ncsct-smoking-in-pregnancy-final-report.pdf> [Accessed on 28/09/12]

<sup>4</sup> <http://www.ncsct.co.uk/Content/FileManager/ncsct-smoking-in-pregnancy-final-report.pdf> [Accessed on 28/09/12]

<sup>5</sup> Statistics on Women's Smoking Status at Time of Delivery: England Quarter 4, 2011/12. The Health and Social Care Information Centre, 2012

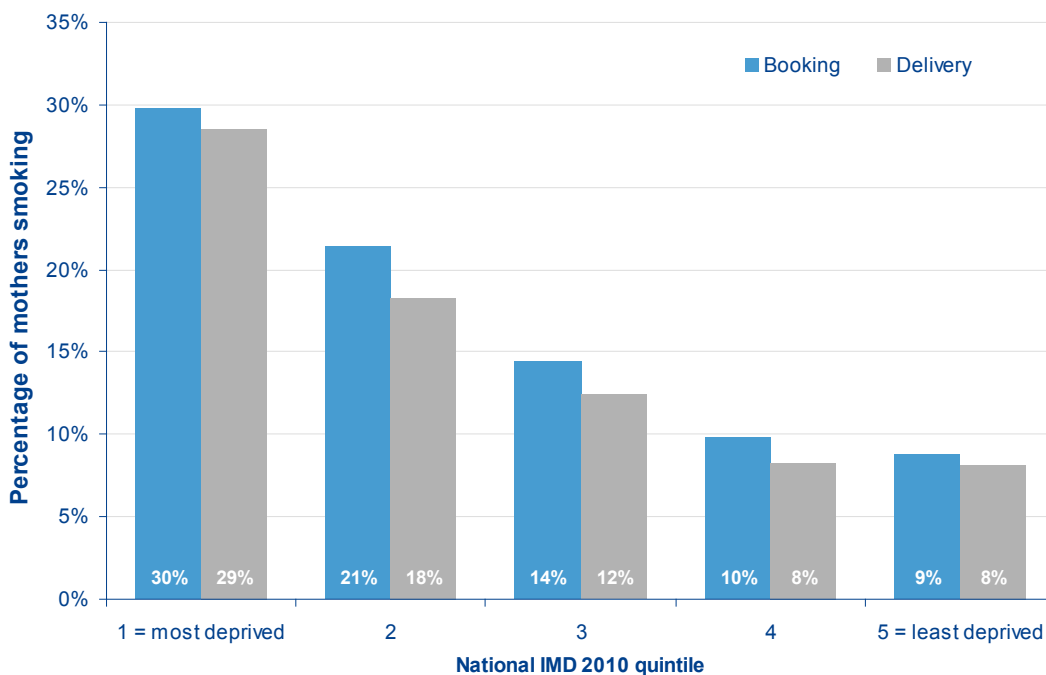
**Figure 3.3: Smoking at booking and delivery by district/borough, 2011/12**



**Source: Local maternity unit data (ESHT, BSUH and MTW)**

Figure 3.4 indicates that in East Sussex, women who live in the most deprived 20% of areas in England are almost four times more likely to smoke during pregnancy than those who live in the least deprived 20% of areas in England. For all deprivation quintiles, the proportion of women smoking at birth is only slightly lower than the proportion smoking at booking.

**Figure 3.4: Smoking at booking and delivery, by Index of Multiple Deprivation (IMD) quintile, 2011/12**



**Source: Local maternity unit data (ESHT, BSUH and MTW)**



Across East Sussex, 17% of mothers are known to be smoking at delivery. At district and borough level, the figure varies from one in 10 (11%) in Lewes to nearly one in four (22%) in Hastings. At ward level, the rate varies from none or less than five mothers in many wards across the county to 43% in Hailsham East. Other wards with high rates include Bexhill Sidley (40%) and Baird (34%).

Across East Sussex, 16% of mothers are current smokers at their baby's 6-8 week check. At district and borough level, the figure varies from 13% in Wealden to 20% in Hastings. At ward level, the rate varies from none or less than five mothers in several wards across the county to 36% in Hailsham East. Other wards with high rates include Tressell (33%), Baird and Central St Leonards wards (32%) and Hollington (30%).

Smoking during pregnancy increases the likelihood of babies being born at a low birth weight. Low birth weight is a major cause of infant mortality and has implications for child and adult health. Across the county, 7% of babies are born at low birth rate (under 2,500 grams). At ward level, the rate varies from none to 12% in Heathfield East. Other wards with high rates of low birth rate include Tressell and Baird wards (11%), Central St Leonards, Castle, Langney, Meads, Bexhill Sidley and Cross-in-Hand/ Five Ashes wards (10%).<sup>6</sup>

### Local action to tackle health inequalities in maternal smoking

Research indicates that by using NHS Stop Smoking Services, people who smoke are more likely to quit and remain smoke free. Routine recording of smoking status at booking is enhanced by carbon monoxide testing of all women and 'opt out' referral of all smokers to Stop Smoking Services, in line with NICE guidance.<sup>7</sup>

Maternity service providers in East Sussex are working with the East Sussex Specialist Stop Smoking Service to ensure that all staff are trained and confident to discuss with pregnant women the impact of smoking on their own and their baby's health and support them to access Stop Smoking Services. The Stop Smoking Service provides specialist pregnancy advisers and flexible appointments and support for pregnant women and their families in line with the evidence-base for effective interventions to help pregnant women to stop smoking.

Because only a very small proportion of smokers from all deprivation quintiles stop smoking during pregnancy, staff from a range of agencies who work with pregnant women and families are trained to provide brief advice on the health harms of smoking. Smoking prevalence at conception for women aged 16-19 years and 20-24 years using maternity services at East Sussex Healthcare NHS Trust (ESHT) is significantly higher than that of the general population in this age group, with 60% of 16-19 year olds smoking at conception (compared with around 22% of all women in this age group)<sup>8</sup>. Because of this, reducing smoking prevalence in young women is particularly important in addressing smoking in pregnancy. A range of services are in place to support young people to understand the impact of smoking on their health and lifestyle and to choose not to take up smoking. This includes support to schools to provide high quality Personal, Social, Health and Economic education (PSHEe) and a pilot smoking prevention peer support programme delivered by the Target Youth Service (TYS) in some schools in East Sussex.

<sup>6</sup> Source: JSNA Scorecards Local Authority View 2011/12 [www.eastsussexjsna.org.uk/scorecards/authorityview.aspx](http://www.eastsussexjsna.org.uk/scorecards/authorityview.aspx) [Accessed on 28/09/12]

<sup>7</sup> How to stop smoking during pregnancy and after childbirth June 2010. <http://guidance.nice.org.uk/PH26> [Accessed on 28/09/12]

<sup>8</sup> Smoking in Pregnancy and following childbirth, East Sussex 2010/11. [www.eastsussexjsna.org.uk/briefing](http://www.eastsussexjsna.org.uk/briefing) [Accessed on 28/09/12]

## Maternal obesity

Maternal obesity is associated with greater health risks both to the mother and the baby. These include a higher risk of maternal death and miscarriage and maternal illness including cardiac disease, gestational diabetes and post-caesarean wound infection. For the baby, there is a higher rate of stillbirth, congenital abnormality and prematurity. Maternal obesity is also associated with higher caesarean section rates, admission to hospital for complications, longer length of stay in hospital post-delivery, and a need for specialist equipment in hospital. There are technical issues, too, including difficulties performing ultrasound examination and fetal monitoring and implications for anaesthesia.<sup>9</sup> Women who are obese are more than twice as likely to live in areas with high deprivation as women who are not obese.

Currently, data on maternal obesity is not routinely collected in the UK. However, we have access to local data from ESHT, and there are some national surveys. From our local data, it would appear that, year on year, there is a slight increase in maternal obesity rates (women with a Body Mass Index (BMI) of over 35) for women who deliver their babies at ESHT, with the rate rising from 6.5% in 2009/10 to 8.0% in 2011/12.

The 2010 Maternal Obesity report of the Centre for Maternal and Child Enquiries notes a national maternal obesity rate of 4.99% for 2009. The South East Coast Strategic Health Authority (SHA) rate from the report is 4.38%. This suggests that the rate for women who deliver their babies at ESHT is higher than both the national and SHA rates.



<sup>9</sup> The National Obesity Observatory [www.noo.org.uk](http://www.noo.org.uk) [Accessed on 14 August 2012]

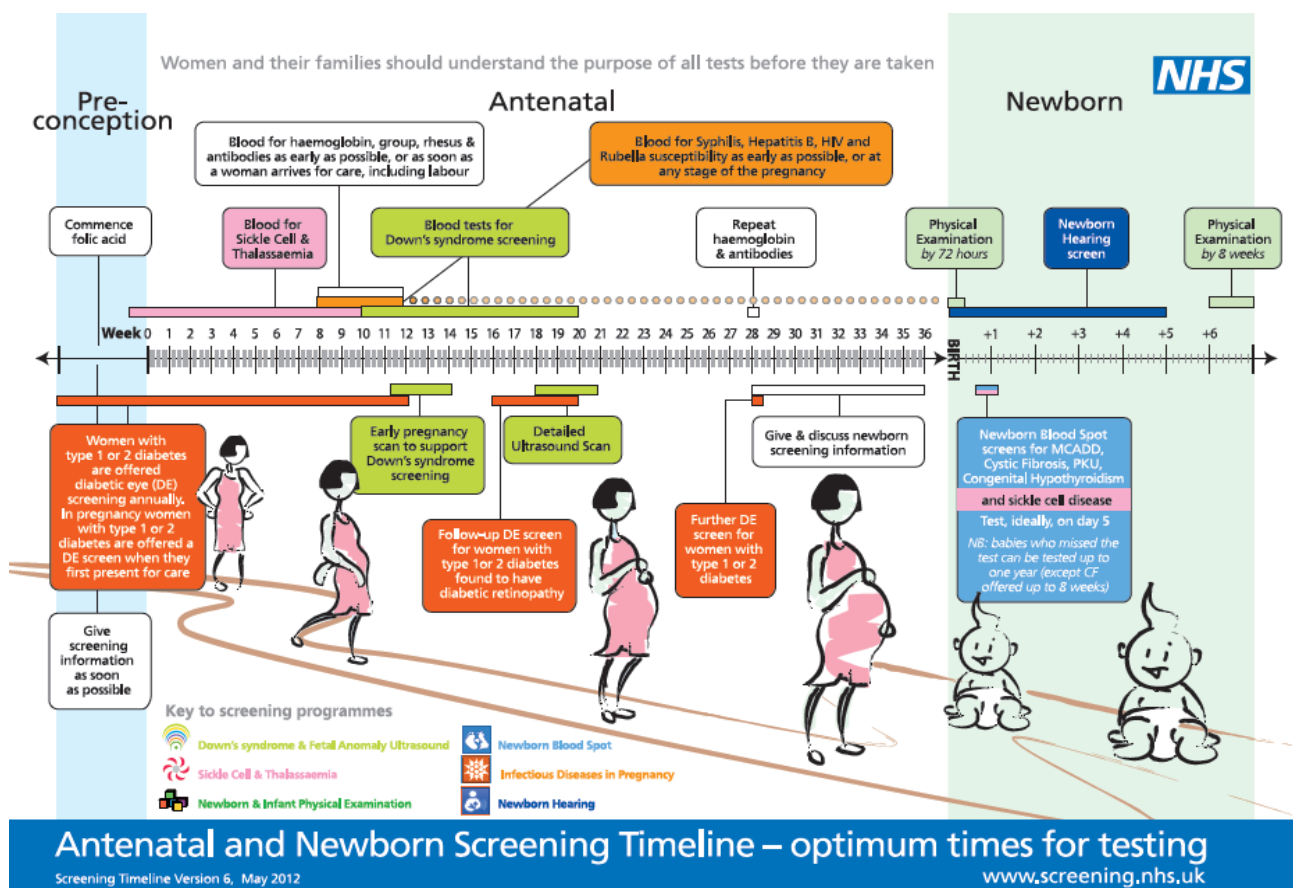
## Antenatal and newborn screening

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. Once identified, these individuals can then be offered information, further diagnostic tests and appropriate treatment as required to reduce complications arising from the disease or condition.

The Antenatal and Newborn Screening Programme brings together six screening programmes that are offered to pregnant women and their babies. Antenatal Screening includes a combination of scans and blood tests to screen for Sickle Cell and Thassaemia, Fetal Anomaly (Down's syndrome & fetal anomaly ultrasound) and infectious diseases (Hepatitis B, HIV, Syphilis and Rubella). Newborn screening includes a combination of blood tests and physical examinations to screen for rare but serious conditions (Phenylketonuria, Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD), Cystic Fibrosis, Congenital Hypothyroidism and Sickle Cell) and any indications of problems with eyes, heart, hips or hearing.

Figure 3.5 shows the detailed pathway for antenatal and newborn screening, including the optimum time for receiving tests.

**Figure 3.5: The Antenatal and Newborn Screening Pathway, 2012**



Source: <http://cpd.screening.nhs.uk/timeline> (accessed 06/08/2012) © 2012 UK National Screening Committee

In 2010/11 in East Sussex, the majority of antenatal screening was provided by ESHT but it is also provided by the Brighton and Sussex University Hospitals NHS Trust (BSUH) and Maidstone and Tunbridge Wells NHS Trust (MTW). Women can choose to have their antenatal care locally in East Sussex and have their delivery at another hospital, and vice versa. In 2010/11 in East Sussex, 75% of women delivered their babies at ESHT, 18% delivered at BSUH, 4% at MTW and 5% elsewhere.

From 2010/11, the quality of the services was assessed by a Key Performance Indicator dataset including quarterly screening data and an additional dataset on infectious diseases in pregnancy. The latest available quarterly data (Q4 2011/12) shows that ESHT are meeting all of the Key Performance Indicator standards.

During 2010/11, ESHT reported a total of 4,881 women booked for antenatal care who were eligible for antenatal screening. All women are offered screening, but not all women take up the offer and some women choose to be screened for some conditions but not others. In 2010/11, 85% of women were tested for all conditions.

The proportion of women accepting HIV testing is one of the key measures for the antenatal screening programme. In 2010/11, 92% of women under the care of ESHT received an HIV test as part of their antenatal care (compared with a national target of 90%).

In 2013, these screening services will be commissioned by the National Commissioning Board with advice from Public Health England staff, and East Sussex County Council will have a duty to protect the health of East Sussex residents and be assured that screening services are commissioned in line with local needs.



## Breastfeeding

Increasing the rate of breastfeeding is a key priority that will support reducing health inequalities. There are well-researched benefits both to the baby and the mother of exclusive breastfeeding for up to six months. These include lower rates of gastrointestinal, respiratory and ear infections for the baby, as well as a lower risk of childhood obesity; lower risk of breast and ovarian cancer for the mother; and stronger mother and child bonding. There are joint targets for both East Sussex County Council and the NHS locally to improve breastfeeding initiation rates and the breastfeeding maintenance rate at 6-8 weeks.

The latest available data for quarter 1 (April – June 2012) shows that there has been a 5% improvement in breastfeeding rates in the Hastings and Rother area compared with 2011/12. During 2011/12, Hastings and Rother achieved 43% of mothers breastfeeding at 6-8 weeks compared with 48% in April-June 2012. This is an encouraging sign and should be closely monitored along with an assessment of the service changes that have brought this about. The overall rate for the county was 47% in 2011/12 and 49% during April-June 2012. The county target for 2012/13 is 48.3%.

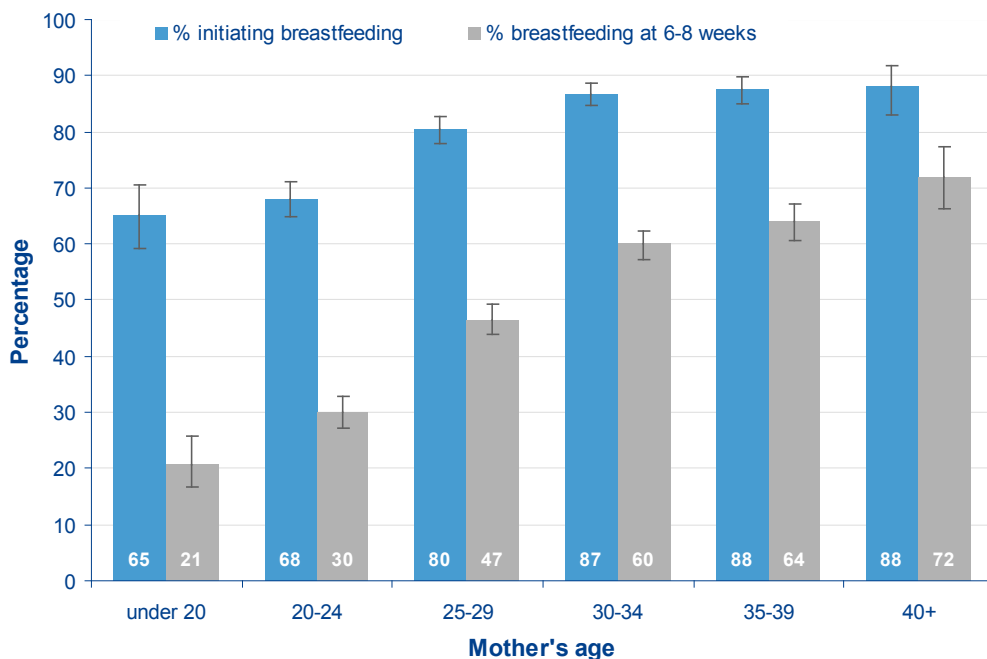
**Table 3.1: Recording and breastfeeding rates at 6-8 weeks, East Sussex Downs and Weald PCT, Hastings and Rother PCT and East Sussex, 2011/12 and 2012/13 (Q1)**

		ESDW PCT		H&R PCT		East Sussex	
		% recorded	% breastfed	% recorded	% breastfed	% recorded	% breastfed
2011/12	Q1	95.2	50.1	95.0	42.4	95.1	47.2
	Q2	97.3	51.5	96.8	44.5	97.1	49.0
	Q3	95.4	48.0	96.5	42.3	95.7	46.1
	Q4	92.1	47.8	96.6	43.6	93.6	46.4
2012/13	Q1	95.3	48.8	95.4	48.3	95.3	48.6

**Source: East Sussex Child Health Systems 2011-2013**

The targets for 2011/12 for the percentage of babies breastfed at 6-8 weeks was 49.6% for East Sussex Downs and Weald PCT, 45.9% for Hastings and Rother PCT and 48.3% for East Sussex. None of these targets were met. Rates of breastfeeding in East Sussex appear to be strongly related to age. Figures 3.6 and 3.7 show that breastfeeding initiation and maintenance rates are lowest in women aged under 20 and highest among older women. In particular, there are marked differences in the maintenance rates, with about 20% of women aged under 20 still breastfeeding at 6-8 weeks compared with about 72% of women aged 40 and over.

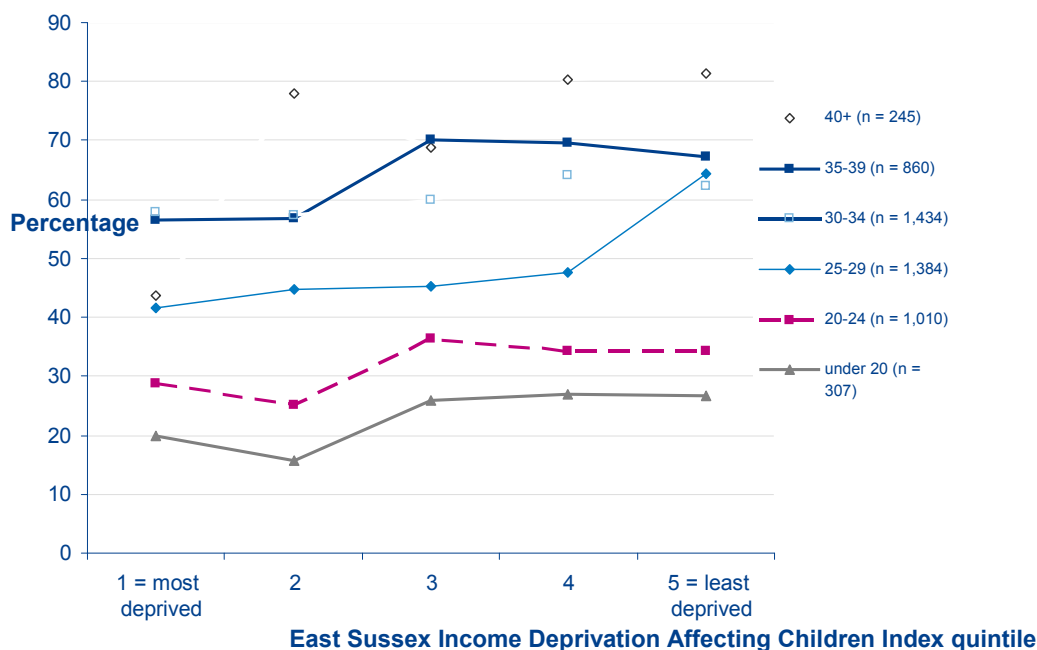
**Figure 3.6: Prevalence of breastfeeding initiation and breastfeeding at 6-8 weeks by maternal age, 2011/12**



Source: [www.eastsussexjsna.org.uk/briefings](http://www.eastsussexjsna.org.uk/briefings)

Figure 3.7 shows that age is a stronger predictor of whether a woman breastfeeds than deprivation. This means that efforts to support improving breastfeeding rates should also focus on younger women in order to have the potential to derive the greatest health gain.

**Figure 3.7: Prevalence of breastfeeding at 6-8 weeks by maternal age and deprivation quintile**



Source: [www.eastsussexjsna.org.uk/briefings](http://www.eastsussexjsna.org.uk/briefings)

## Emotional health and wellbeing

The majority of women have good mental health during pregnancy. Some women may already have a mental illness when they get pregnant. Others worry about mental health problems they have had in the past. Seven out of 10 women who stop antidepressants in early pregnancy become unwell again. Some women have mental health problems for the first time in pregnancy.

Depression and anxiety are the most common mental health problems in pregnancy, affecting about 10 to 15 out of every 100 pregnant women. Women also experience many other mental health problems during pregnancy, just like at other times.<sup>10</sup>

Mental health problems increase the likelihood of parenting problems. Untreated mental health problems in pregnancy and the postnatal period will contribute to health inequalities in children and young people.

Poor mental health is more common in less affluent groups and may be linked to poor housing, unemployment, low income and domestic violence. It is also more common in people who misuse alcohol and drugs. There is additionally a hereditary factor for some types of mental ill health.

In July 2011, a new perinatal mental health service was launched in East Sussex. This specialist service focuses on early intervention and is a comprehensive service for women who are pregnant and who have recently had babies. Women can be referred to the service by a range of healthcare professionals including midwives, health visitors and obstetricians. The service, which has a current caseload of 130 women (as at August 2012), offers clinics and outreach across the county, as well as advice, guidance and signposting.

### Recommendations

#### 1 Public Health commissioners need to:

- ensure improved performance of local Stop Smoking Services;
- continue to work with partners through the Tobacco Control Partnership to ensure that women are supported to stop smoking before or during pregnancy;
- ensure that effective tobacco prevention services for young people are prioritised.

#### 2 NHS maternity service commissioners should ensure that:

- BMI monitoring is in place and that women are offered information and support to manage their weight in pregnancy.
- services to improve breastfeeding are targeted to meet the needs of younger women and those in deprived areas.

#### 3 East Sussex County Council needs to establish an assurance process to ensure that safe and effective antenatal and newborn screening and immunisation programmes are in place commissioned by the NHS Commissioning Board.

#### 4 NHS maternity service commissioners need to work with adult mental health commissioners to evaluate the new perinatal mental health service to ensure it is cost-effective and achieving successful outcomes.

<sup>10</sup> The Royal College of Psychiatrists <http://www.rcpsych.ac.uk/mentalhealthinfo/problems/mentalhealthinpregnancy.aspx>. [Accessed on 31 August 2012]





# Chapter 4. Children of pre-school age

The pre-school period is a time when children can be nourished emotionally and physically in preparation for achieving their potential at school. It can also be a time when a range of factors including poor parenting, missing or incomplete vaccination, tooth decay, excess weight, ill health and accidents, and child protection issues can mean that certain children have poorer chances of reaping the benefits of our education system. This chapter aims to describe these key issues and what we are doing about them, and outline what more needs to be done to improve the emotional and physical health of young children.

It is important that appropriate early support is provided to pregnant women who are at risk of not being able to parent safely or well. In a small number of cases, safeguarding action is necessary and pre-birth assessments lead to statutory social care intervention. In other cases, a range of support may be necessary to ensure the best start for children. Support is available for families from midwives, health visitors and the Children's Centre Family Outreach Support. The Family Nurse Partnership Programme is currently available across the county, offering support to vulnerable young women under the age of 20 years, and their partners, from the 16<sup>th</sup> week of pregnancy to the second birthday of their child.

## **Immunisation**

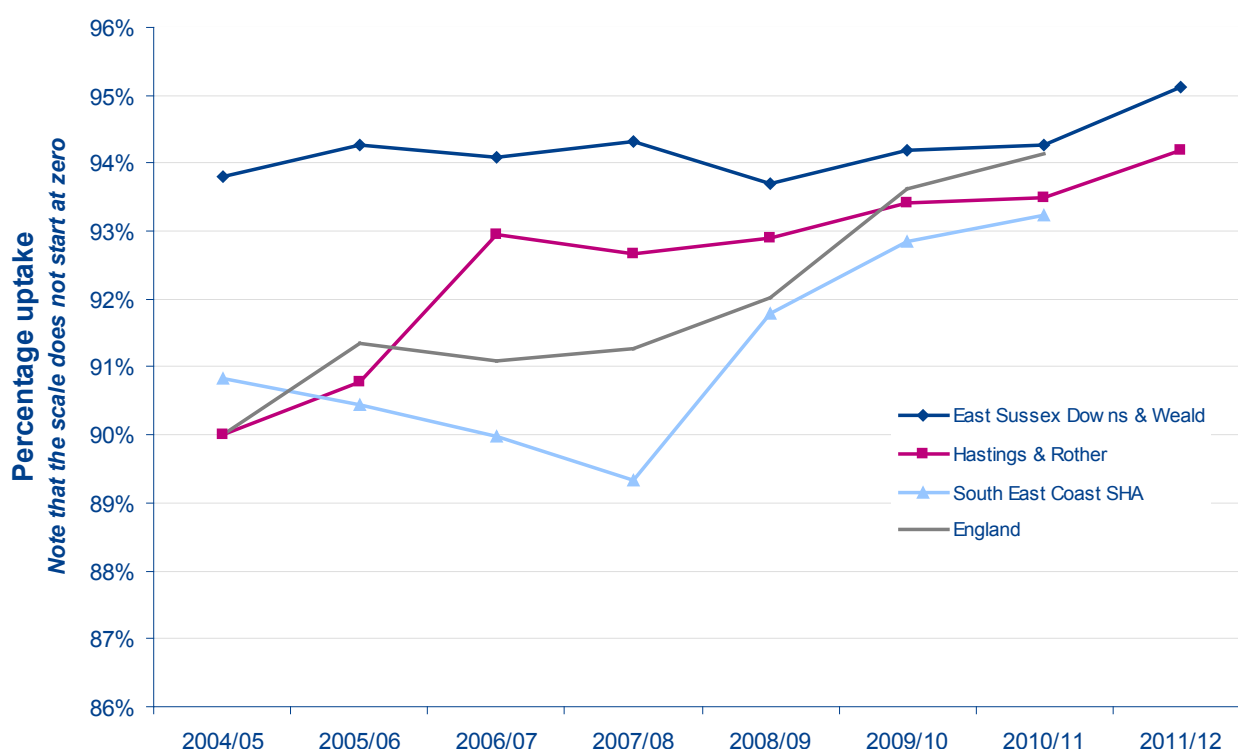
Although there has been an improvement in the first vaccine uptake to 95% we do not achieve this level across all childhood vaccinations. In particular our rate of measles mumps and rubella vaccination is low at around 85%. We have seen more cases of measles and whooping cough which can cause severe health complications. There is a new vaccination programme against whooping cough for pregnant women.

## Childhood immunisation

In the UK, children routinely receive a course of scheduled vaccinations between the ages of 2 months and 18 years. However, the viruses and bacteria that cause vaccine-preventable disease and death still exist and can be passed on to people who are not protected by vaccines.

We have a target to achieve 95% vaccination uptake across all childhood vaccines in order to achieve herd immunity. This means vaccination rates are high enough to avoid outbreaks and to protect those who cannot be vaccinated due to their age or underlying health conditions.

**Figure 4.1: Children aged one who have been immunised for Diphtheria, Tetanus, Polio, Pertussis and Haemophilus influenza type b (Hib)**



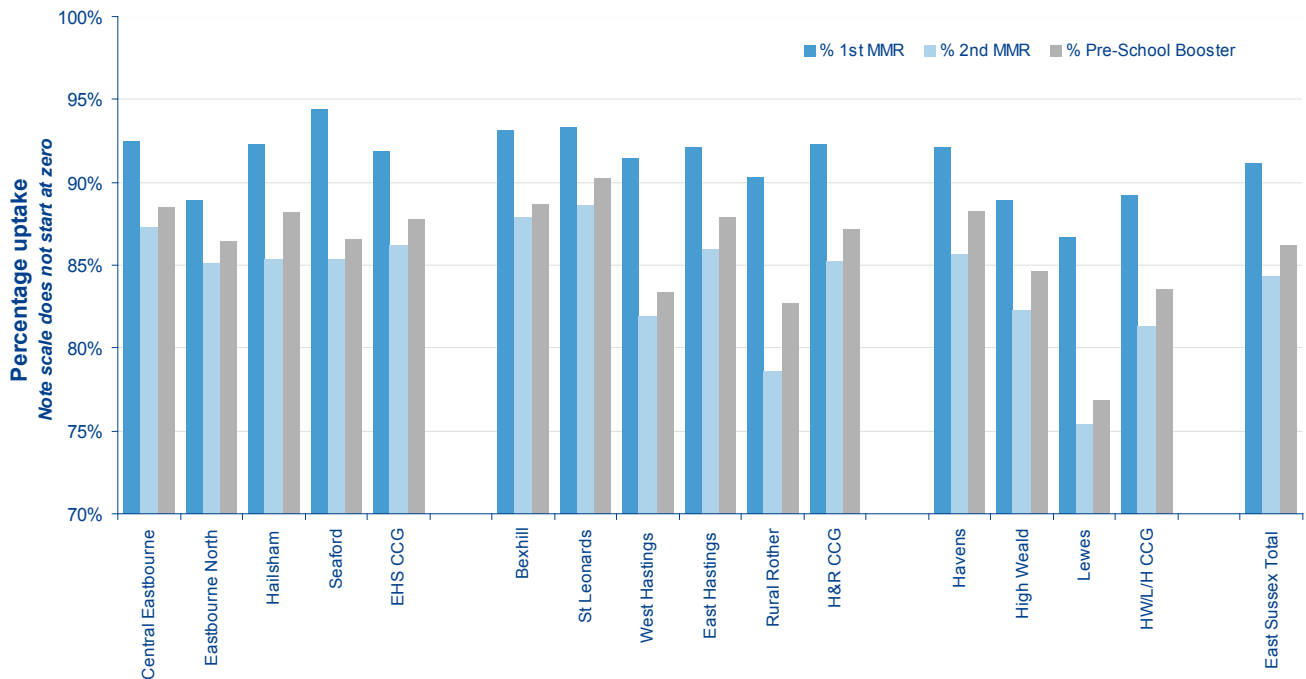
Source: COVER data 2011/12

Figure 4.1 indicates that primary vaccinations (those given at 2 months, 3 months and 4 months) have increased in East Sussex since 2004/05. It also indicates that our rate of vaccination in East Sussex Downs & Weald PCT is higher than the England rate.

Though uptake of the majority of childhood immunisations is good, levels of measles, mumps and rubella (MMR) vaccination have been lower than required for a number of years. We are currently experiencing a sustained rise in measles cases across the South East Coast. Within East Sussex we have had clusters of cases in certain communities. Cases of measles pose a real risk to people who are unvaccinated, including young babies, and to those who are immuno-compromised, have chronic health conditions, or are pregnant and not immunised.

Across East Sussex, uptake of MMR vaccination remains below target levels in all Clinical Commissioning Groups (CCGs) and their localities. For the first dose of MMR, uptake ranges from 87% in Lewes to 94% in Seaford, while for the second dose rates drop to between 75% in Lewes and 89% in St Leonards.

Figure 4.2: Childhood immunisation coverage for selected vaccines, 2011/12



Source: COVER data 2011/12

In addition to measles, the number of whooping cough (pertussis) cases is also increasing across England and Wales. Locally, there have been 514 cases reported in the first six months of 2012 across the South East Health Protection Agency (HPA) region. The HPA are working closely with the Department of Health's Joint Committee on Vaccination and Immunisation (JCVI) to resolve the ongoing outbreak. One outcome of this is the introduction, in October 2012, of a new temporary vaccination programme against whooping cough for pregnant women, to protect their babies. Pregnant women will be offered the vaccine between 28 and 38 weeks of pregnancy in order to protect their babies from whooping cough in the first eight weeks of their life before they are offered whooping cough vaccine as part of the routine vaccination programme.

Currently, the NHS commissions services to support GP practices to increase vaccination rates. We are also undertaking a social media campaign designed to increase our MMR vaccination rates. We are reinstating the MMR Locally Enhanced Service which means that practices will be reimbursed for providing MMR to older children who have missed one or both doses. From April 2013, East Sussex County Council has a new duty of supporting, reviewing and challenging delivery of key public health funded and NHS delivered services including immunisation and screening programmes.

## Recommendations

- 1 Public Health commissioners should work with Primary Care to improve the current immunisation uptake and to make recommendations to the NHS Commissioning Board for future immunisation commissioning in East Sussex.
- 2 East Sussex County Council needs to set up an assurance process to ensure that safe and effective vaccination and immunisation programmes are in place.

## Oral health

Child oral health has been improving and far fewer children experience tooth decay than in the past. Older children in England now have the best oral health in Europe. However, in spite of this overall improvement, national surveys still highlight inequalities, which are strongly associated with social background. Tooth decay is a predominantly preventable disease, but significant levels remain, resulting in pain and the need for treatment.

Data is collected on oral health through a survey of five year olds undertaken every four years. The latest local information on the average number of decayed missing and filled teeth (dmft) per child is from 2007/08 at PCT level. This data indicates that rates of dmft in Hastings and Rother (1.17) are significantly higher than in East Sussex Downs and Weald (0.70) and the South East Coast (0.72) but similar to the national average (1.11). Rates of dmft in East Sussex Downs and Weald are statistically significantly lower than the England average.

The key steps to take to reduce the risk of poor oral health are:

- brush teeth twice a day using a family fluoride toothpaste as soon as children have their first tooth
- supervise brushing until children are 7 or 8 years old
- try to eat sugary food and drinks at meal times only
- children should visit the dentist at least once before they are two years old, and as frequently as the dentist recommends thereafter<sup>11</sup>

In East Sussex, all young families are offered oral health promotion sessions as part of the routine postnatal programme and through the Healthy Child Programme. Targeted support is also offered to primary schools in the most deprived parts of East Sussex.

### Recommendation

**NHS commissioners should continue the current oral health promotion programme and increase targeting of preventative services in deprived areas.**

<sup>11</sup> NHS Choices <http://www.nhs.uk/livewell/dentalhealth/Pages/Dentalhome.aspx> [Accessed on 28/09/12]

## Family Nurse Partnership

The Family Nurse Partnership (FNP) aims to support young first-time mothers under the age of twenty years. It offers intensive, structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is two. In a review by *The Lancet* in 2008, the FNP was named as one of only two programmes shown to prevent child maltreatment.<sup>12</sup>

FNP aims to improve pregnancy outcomes; improve child health and development; and improve parents' economic self-sufficiency. The methods are based on theories of human ecology, self-efficacy and attachment. Much of the work is focused on building strong relationships between the client and nurse to facilitate behaviour change and tackle the emotional problems that prevent some parents from caring well for their child.

Research has shown significant benefits for vulnerable young families in the short, medium and long term across a wide range of outcomes including: improvements in antenatal health, parenting behaviour, early language development, school readiness and academic achievement; increases in maternal employment and paternal involvement; reductions in children's injuries, neglect and abuse, arrests and criminal behaviour; reduced welfare use; fewer subsequent pregnancies; and greater intervals between births.

### East Sussex Family Nurse Partnership

The FNP Programme, jointly funded by East Sussex County Council and the PCTs, has run successfully in East Sussex since 2008.

The East Sussex Programme covers two distinct areas: Hastings and St Leonards (established in 2008 and expanded to Rother in 2010) and Eastbourne (which covers the west of the county including the rural areas). The programme has supported 284 women, with 55 women graduating from the programme. The latest review indicates that the rate of repeat pregnancies has reduced; the use of Long Acting Reversible Contraception (LARC) has increased; the involvement of fathers/partners has improved; and the number of cigarettes smoked per day has reduced (although the maternal smoking rate has remained the same). There are four areas where East Sussex performs below the national Programme average: smoking during pregnancy; low birth weight; A&E attendances; and use of LARC.

### Recommendation

**Local Authority and NHS commissioners\* need to ensure that the Family Nurse Partnership in East Sussex continues to be evaluated, and has an increased focus on achieving improved performance in smoking during pregnancy; low birth weight; Accident & Emergency attendances; and use of Long Acting Reversible Contraception.**

<sup>12</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_118530](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118530)  
[Accessed on 31/08/12]

\* Currently the Primary Care Trust but from April 2013 will be the NHS Commissioning Board Local Area Team

## The Good Start Programme – a new model for early years and health visiting

In February 2011, the Department of Health issued a new national plan for health visiting – *A Call to Action*. The plan calls for new health visiting services to include health promotion support for families. The national plan also commits to increased investment in the workforce.

As well as ensuring the delivery of the new model, the desire to work more in partnership and in an integrated way has led to a pilot scheme in Bexhill which has been named the Good Start Programme.

### The Good Start Programme

The aim of this scheme is to improve the outcomes for vulnerable families by delivering better-targeted early intervention and prevention services as well as delivering an effective universal service. The Programme encourages team working between staff from different services.

### Key issues and priorities

The two main priorities for the Good Start Programme are:

- identifying the appropriate families who can most benefit from this approach
- increasing antenatal health visitor contact and enhancing breastfeeding support

The Good Start pilot scheme has just been evaluated and there are a number of key findings from this, including:

- the measures of success for Good Start need to be further considered and linked to proven outcome measures
- local parent engagement must be further developed to ensure views and feedback on experiences are taken into account in plans
- the telephone line, open for local parents since January 2012, has had mixed reviews and needs to be further considered

### Recommendation

The Local Authority and NHS commissioners should use the findings from the ongoing evaluation of the Good Start Programme to ensure that the new integrated model meets needs in East Sussex and improves care for vulnerable families.

## Children's Centres

Children's Centres are available to every family with a child under five. They work with other agencies to deliver a range of services aiming to improve outcomes for all children, but with a particular focus on the most disadvantaged. All new parents are encouraged to register with their local Children's Centre by their health visitor. There are currently 31 Centres in East Sussex which have performed well at inspection by Ofsted.

Children's Centres provide a range of activities including play sessions that are open to all parents and their children; targeted sessions, for example for dads and young mums; and specially tailored courses on issues such as parenting, healthy eating, play and activities. Some Children's Centres host other services, for example mental health support and counselling services and provide a supervised crèche to enable parents to take part.

### Recommendation

East Sussex County Council commissioners need to assess the effectiveness of their Children's Centres in improving the health of the most vulnerable and deprived communities.



# Chapter 5. Children and young people with additional needs

There has been an increase in numbers of children and young people coming into care, leading to considerable additional demands on all aspects of related service delivery across education, health and social care. East Sussex County Council has invested in the THRIVE programme to reduce the number of children subject to child protection plans by concentrating on early help services and family assessment. Public Health have a role in ensuring that health improvement services are targeted at the most vulnerable families through the Thrive Programme.





## The health of looked after children

East Sussex services for looked after children (LAC) have seen a rise in numbers of children and young people coming into care from 585 in March 2011 to 635 in August 2012. This has led to considerable additional demands on all aspects of service delivery across education, health and social care, and a large increase in cost to the health and care economy.

### Issues and key priorities

The following areas have been identified as those where either the risk of inequalities is highest or where the outcomes for children and young people in public care can be improved most:

- Timely medical assessments across the whole area, met through a new model of GP initial assessment supported by a nurse with Health Care Plans put in place more quickly, have delivered better outcomes and improved responses to LAC needs, and will remain a priority for the future.
- School-age children require an annual health review and there is a need to ensure capacity in school health services to undertake this.
- It is a statutory requirement to have a designated doctor for LAC, and ensuring capacity to meet needs across all areas as outlined in the guidance remains a priority.
- The increase in numbers of foster carers being recruited and children going forward for adoption within the THRIVE targets, coupled with changes introduced by the Family Justice Review and in adoption regulations, will need a faster response from the NHS that is in line with the new timescales.
- The LAC Child and Adolescent Mental Health Service (CAMHS) specialist team provide mental health care that helps maintain placement stability and meet the attachment needs as identified in the assessment process. The service also provides therapeutic consultation, supervision and advice to residential settings in East Sussex.

### Recommendations

- 1 Local Authority and NHS commissioners need to prioritise the needs of looked after children through school-age services.
- 2 NHS commissioners need to ensure that the health needs of looked after children are prioritised including provision of timely medical assessments and appropriate CAMHS input.

## Child protection, safeguarding and the THRIVE Programme

Major factors contributing to the health and wellbeing of children are the extent to which their parents and carers are able to provide a safe environment and the level of care they need in order to thrive.

East Sussex has experienced a continued rise in child protection and safeguarding activity over the past four years. Nearly 18,000 children were referred into the system for assessment in the year 2011/12, with 2,785 children being the subject of a child protection investigation and 675 children being subject to child protection plans as of 31/03/12. Due to the statutory requirement for this work to be a multi-agency responsibility, this has significantly increased the demand on social care, health, police and education services.

Although this rise in activity has been seen nationally, East Sussex has a higher rate of referral, assessment, investigation and number of children subject to child protection plans than the national average, and higher rates than comparable statistical neighbours. The introduction of the THRIVE Programme by the local authority is designed to reduce this activity and reduce the number of children subject to child protection plans by redirecting resources from downstream child protection referrals and assessments to more upstream early interventions; concentrating on early help services; and targeting proportionate family assessment in line with the Munro Review of Child Protection in 2012.

Children aged 5-11 make up a significant proportion of children who are referred to children's social care and are the subject of a child protection plan. Assessing the level of need for early help for families with children in this age range, and how best to provide that help, is a key element within the THRIVE Programme. The current level of investment in this age range is lower than that for young children or for teenagers and this is being reviewed as part of the Programme.

The numbers of referrals to East Sussex services for looked after children are now beginning to decline as a result of actions taken through the THRIVE Programme – for example, developing a more appropriate response to the needs of children who do not require social care intervention. Promoting and ensuring safe, effective parenting remains a priority, and is reflected in the proposed Health and Wellbeing Strategy.

### Issues and key priorities

- During the period of implementation of the NHS reforms, a key task for NHS Sussex and the Clinical Commissioning Groups (CCGs) is to ensure that professional leadership and expertise in safeguarding are retained in the NHS system and that the CCGs are ready to undertake the statutory safeguarding responsibilities of a commissioning organisation.
- A key priority is to ensure that there is ongoing recruitment to any vacancy of designated or named professional Child Protection health roles in East Sussex.
- The early help agenda requires support and workforce development to manage risk at an earlier stage (particularly through the development of the common assessment framework and the team around the child/family approach).
- Every child who needs one should be given a child protection medical examination in consultation with the Consultant Paediatrician during a child protection investigation.

### Recommendations

- 1 **Public Health commissioners need to ensure that health improvement interventions are targeted at the most vulnerable families through the THRIVE Programme.**
- 2 **Local authority commissioners need to evaluate the parenting groupwork and early help services as part of the THRIVE programme.**

# Chapter 6. School age children and young people

This chapter sets out key issues that impact on health inequalities in school age children and young people. Starting with an introduction to educational issues relating to health inequalities, the chapter then highlights the main findings from the Health Related Behaviour Survey on sex, diet, exercise, emotional and mental wellbeing, smoking, alcohol, drugs, and safety among Year 10 pupils. We also present the evidence-base for effective services in these areas.

## **Educational achievement**

Educational achievement is a key determinant of health. Rates of educational achievement vary across the county and some indicators are below the regional and national levels. There is a 32% difference in GCSE attainment between those eligible for free school meals and other pupils. In 2011/12 there were 387 (3.5%) 16 and 17 years olds who were Not in Education, Employment or Training (NEET) and of these 46% had special educational needs. Young people who are NEET are of particular concern due to the impact of their current and future employment on their long-term economic wellbeing and health.

## **Health-related behaviour**

A schools health-related behaviour survey was undertaken in the Spring of 2012 with over 4,500 14 and 15 year olds taking part. Key priorities for improving children and young people's lifestyles are reducing rates of smoking, increasing levels of physical activity, and promoting healthy eating.



## Educational achievement

Educational achievement influences employment and household income. These factors have a positive effect on health. Inequalities in educational attainment influence health inequalities.

Over the last five years there has been some improvement in educational achievement among pupils leaving Reception Year in East Sussex. However, attainment is below regional and national levels, and there is variation across the county. Hastings and Eastbourne achieve below the county average, and Rother achieves above it.

Educational attainment among pupils aged 16 shows a similar picture. The proportion of pupils in East Sussex achieving five or more GCSEs has increased from 43% in 2006/07 to 58% in 2011/12. But there is variation at district and borough level, with the lowest rate in Hastings (46%) and the highest rate in Rother (64%).

There are targets for narrowing the gap in educational achievement between vulnerable groups and the rest of the population, including those with special educational needs and those in receipt of free school meals. Again, there have been some improvements in narrowing the gap, however the attainment gap remains wide. There is a 32% difference in attainment at GCSE between those eligible for free school meals and other pupils.

Efforts will continue to ensure that pupils in vulnerable groups, including those with special educational needs and those in receipt of free school meals, are supported to reach the same educational attainment as other pupils. This will support reducing health inequalities.

### Pupil absence and school exclusions

Regular absence and exclusion from school affects educational attainment. The rate of persistent absence in secondary schools in East Sussex was 10.5% in 2011/12. This is higher than the national rate of 9.5% and is also higher than the rates of similar statistical neighbours, including West Sussex at 9%.

In 2011/12 there were 314 fixed-term exclusions in primary schools and 2,133 in secondary schools. The rate has reduced very slightly (by around 0.2%) in the last two years since 2009/10. In 2011/12, there were 87 permanent exclusions.

Efforts should continue to reduce pupil absence and school exclusions in order to improve educational achievement and reduce health inequalities.

### Young people who are not in employment, education or training (NEETs)

This group of young people are of particular concern nationally due to the impact of current and future unemployment on their long-term economic wellbeing and health. In 2011/12, there were 387 (3.5%) 16 and 17 year olds not in employment, education or training in East Sussex. There were a further 859 (7.8%) where their current situation was not known. Of the known NEETs, 54% had no learning difficulties and/or disabilities, while the remainder had special educational needs.

The characteristics of those who were NEET in 2011/12 include: having been in receipt of free school meals (190; 37%); identified at school as being at risk of NEET (79; 16%); attendance issues (46; 10%); history of exclusion (23; 5%); offending background (50; 10%); mental and emotional health issues (41; 8%); and teenage parent or pregnant (35; 7%).

In terms of reducing health inequalities, it is important to reduce the number of young people who are not in employment, education or training.

### **The Special Educational Needs and Disabilities (SEND) Programme**

Children and young people with special educational needs (SEN) and disability are a potentially vulnerable and marginalised group. East Sussex has joined other councils in the South East to pilot a new approach to providing services to such families.

The 2012 SEN Census indicates that there are 14,229 East Sussex children in education who have a statement of Special Educational Needs. Currently (September 2012) there are 71 young people (68 families) involved in a new approach within a national pathfinder scheme. This new approach involves including parents, children and young people in assessment, planning and commissioning health, care and education. This includes offering families the opportunity to hold personal budgets from 2014 and introduces a single plan arrangement.

### **Recommendations**

- 1 Schools and academies should increase efforts to improve educational attainment in vulnerable groups.**
- 2 Local Authority and NHS commissioners need to ensure that the health needs of children and young people with Special Educational Needs and disabilities are met.**



## Health-related behaviour

During the Spring term of 2012, we commissioned the Schools Health Education Unit (SHEU) to undertake a Health Related Behaviour Survey. The Survey had taken place previously in 2004 and 2007. In 2012, over 4,500 14 and 15 year olds from Year 10 from all secondary schools and the Pupil Referral Unit in East Sussex took part, completing the questionnaire during their lesson time at school. This represents a participation rate of 85% of pupils on the school roll (January 2012 School Census).

The Survey included questions about smoking, drugs, sex, diet, exercise, emotional wellbeing and safety. Local District and Borough summary reports are available as well as a summary report for the County Council. In addition, a more detailed full report is also available on the JSNA website.

This section presents the key findings of the Survey; other sources of information on the lifestyles of local children and young people in East Sussex; and a summary of evidence-based interventions to support young people to lead healthy lifestyles.

### Survey results: a summary of the good news

- Alcohol use has reduced
- Drug use has reduced and fewer young people start taking drugs at an early age (aged 13 or under)
- Bullying has reduced
- The proportion of young people who know where to get free condoms has increased
- The proportion of young people who know about the local sexual health services for young people has increased
- The proportion of pupils who claim that they have been the victim of violence or aggression in the area where they live in the last 12 months has reduced

### Survey results: a summary of areas of concern

- Smoking rates have not reduced and there has been an increase in Hastings
- There has been an increase in the proportion of pupils saying they are quite or very unhappy with their lives at the moment
- Exercise levels have not improved
- Eating habits have got worse
- Fewer young people are eating the recommended five portions of fruit and vegetables per day and fewer young people are eating breakfast compared with 2007
- One in 10 pupils state that they never or rarely eat fresh fruit
- The rate of young people in sexual relationships has increased
- Fewer young people know about drug and alcohol treatment services for young people



## Smoking

Smoking in young people is of particular concern because of the immediate health impact and also because the majority of adult smokers start when they are children. The earlier smokers start smoking, the less likely they are to give up in adulthood.

There has been no significant change overall in the proportion of pupils describing themselves as occasional or regular smokers. In 2012, 18% of pupils who responded described themselves as occasional or regular smokers compared with 17% in 2007. However, there is reported to be a significant increase in Hastings, from 17% in 2007 to 25% in 2012. Overall, 50% of those who smoke regularly say they would like to give up.

**Figure 6.1: Percentage of pupils who describe themselves as occasional or regular smokers in 2012 compared with 2007**

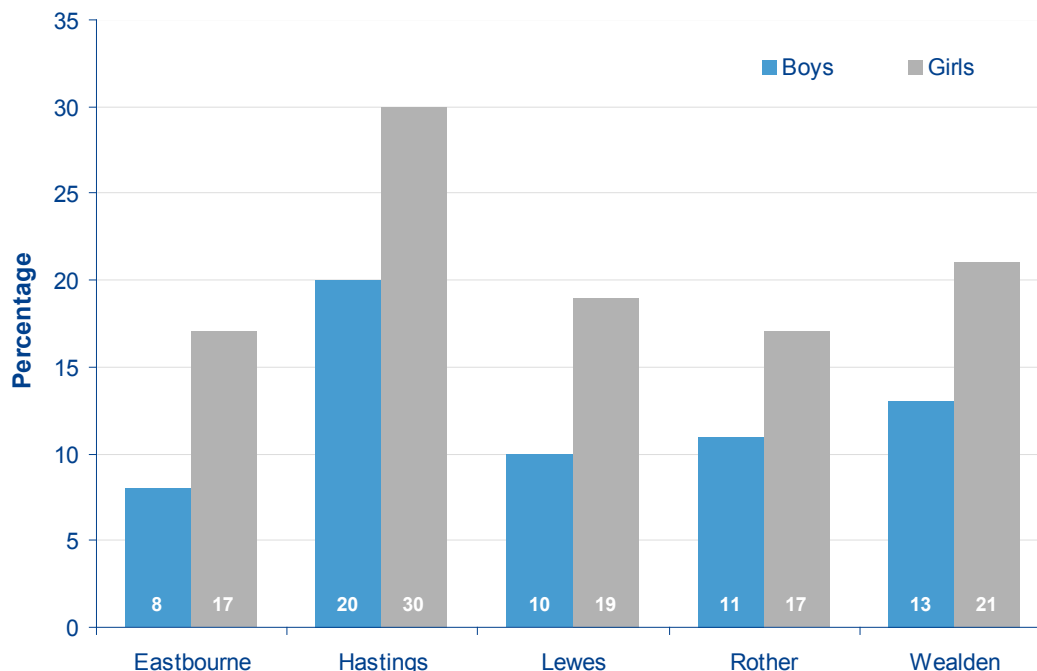


**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

Rates of smoking vary by sex. In 2012, 12% of boys and 21% of girls said that they had smoked at least one cigarette in the last seven days. Almost twice as many girls as boys claim to have smoked at least one cigarette in the last week.

Rates also vary geographically (see Figure 6.2), with Hastings having the highest smoking rate at one in four (nearly one in three girls).

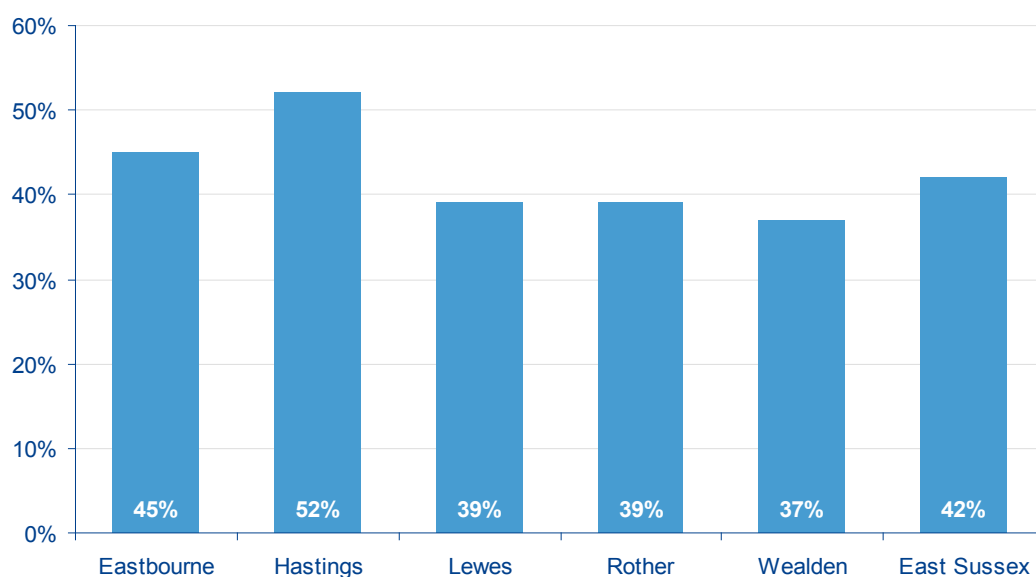
**Figure 6.2: Percentage of boys and girls who describe themselves as occasional or regular smokers in 2012**



**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

Figure 6.3 shows the percentage of young people indicating that at least one person smokes on most days indoors at home. On average, around two fifths of pupils are likely to be exposed to tobacco smoke at home. This rises to over half of all young people in Hastings.

**Figure 6.3: Percentage responding that at least one person smokes on most days indoors at home**



**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

Living in a smoky home is associated with a range of negative health outcomes such as asthma and respiratory disease in children. Children whose parents smoke are significantly more likely to smoke themselves than those from non-smoking households. Reducing exposure to second-hand smoke is likely to have both short- and long-term health benefits for young people.<sup>13</sup>

### **What works in reducing smoking**

ASSIST is a smoking prevention programme which aims to reduce adolescent smoking prevalence. The programme encourages new norms of smoking behaviour by training Year 8 students to work as 'peer educators', advising other students about the risks of smoking and the benefits of being smoke-free. ASSIST has been evaluated by a randomised controlled trial and found to be effective in reducing smoking prevalence over a two year period of follow-up, with the trial results published in *The Lancet*.

The World Bank has made a range of recommendations on tobacco control, known as the 'six strand' approach. These six strands can be used to prevent young people from taking up smoking:

1. Reducing exposure to secondhand smoke
2. Communication and education
3. Reducing the availability and supply of cheap tobacco
4. Supporting stop smoking services
5. Reducing tobacco promotion
6. Tobacco regulation

The provision of consistent advice to parents, for example from health visitors, school nurses and social care workers, can support efforts to reduce young people's exposure to second-hand smoke in the home.

### **What we are doing**

In East Sussex, we are encouraging a schools-based approach to tackling tobacco use.

Evidence-based peer education approaches to tobacco control are being piloted and Targeted Youth Support (TYS) staff are all trained to deliver brief health promotion interventions.

Health promotion training is delivered to all people with a potential role in promoting the health of children and young people such as nurses, voluntary sector staff, volunteers, youth workers and teachers, covering topics such as sexual health, delivering brief health promotion interventions and smoking.

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<sup>13</sup> Smoking: Children. Action on Smoking and Health. October 2011. <http://www.ash.org.uk/localtoolkit/docs/cllr-briefings/Children.pdf>

## Physical activity, healthy eating and excess weight

### Physical activity

There has been no significant change in the proportion of pupils exercising in the last five years. The rate of pupils stating that they exercised five times or more in the last week in 2012 is 28%, which is the same as the 2007 rate. There is a gender difference, with 39% of boys and 18% of girls exercising five times or more in the last week. A total of 80% of boys say that they enjoy physical activities quite a lot or a lot compared with 58% of girls.

Physical activity is associated with a range of positive physical and emotional health benefits. These include maintaining a healthy body weight which leads to a lower risk of heart disease, diabetes and cancer in later life. To stay healthy or to improve health, young people aged 5-18 need to do at least 60 minutes of physical activity every day and this should include three types of physical activity each week: moderate (such as playing in a playground or cycling), vigorous (such as fast running, swimming or football) and muscle-strengthening and bone-strengthening activity (such as skipping, gymnastics or tennis).

### Healthy eating

There has been a significant increase in the proportion of pupils who say that they 'never' consider their health when choosing what to eat. One in five (20%) pupils stated that they never consider their health, compared with 12% in 2007. Similarly, the proportion who said that they 'very often' or 'always' think about their health when choosing what to eat has halved from 21% in 2007 to 11% in 2012.

There has also been a significant reduction in the proportion of pupils who claim to eat five portions of fruit and vegetables per day, from 20% in 2007 to 16% in 2012. A total of 11% of pupils stated that they had eaten no fruit or vegetables on the previous day and one in 10 (10%) stated that they rarely or never eat fresh fruit.

Ideally, all young people and adults should eat at least five portions of fruit and vegetables per day. There is evidence that healthy eating can reduce rates of heart disease, stroke and some cancers in later life.<sup>14</sup> Fresh, frozen, tinned or dried fruit and vegetables all count towards the recommended five portions a day.

Eating habits are formed early in life and so it is important to encourage healthy eating habits from an early age. Understanding how to eat the right quantities and variety of different foods is an essential part of leading a healthy lifestyle. It may be that the current economic situation is contributing in part to negative changes in eating habits for some households across the county. Additionally it would appear that young people are not aware of the importance of healthy eating, are not taking on board advice, or are unable to address the barriers they face to eating a healthy diet.

### Excess weight in 4-5 and 11-12 year olds

Although the rise in obesity levels appears to be levelling off, obesity remains a significant threat to the health of young people. Obesity in children is defined as an 'accumulation of excess body fat, which occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity.'<sup>15</sup> Children who are overweight or obese are more likely to go on to develop diabetes and cardiovascular disease.<sup>16</sup> Overweight babies and toddlers are more than five times as likely to be overweight at the age of 12 as those who were a healthy weight in infancy.<sup>17</sup>

<sup>14</sup> Prevention of cardiovascular disease at population level. NICE public health guidance 25

<sup>15</sup> Department of Health, 2010. Healthy Weight, Healthy Lives: Two years on.

<sup>16</sup> Magnusson, J. 2005. Childhood obesity: diagnosis, prevalence and implications for health. *Community Practitioner*, Vol. 78, No. 2. 29-30

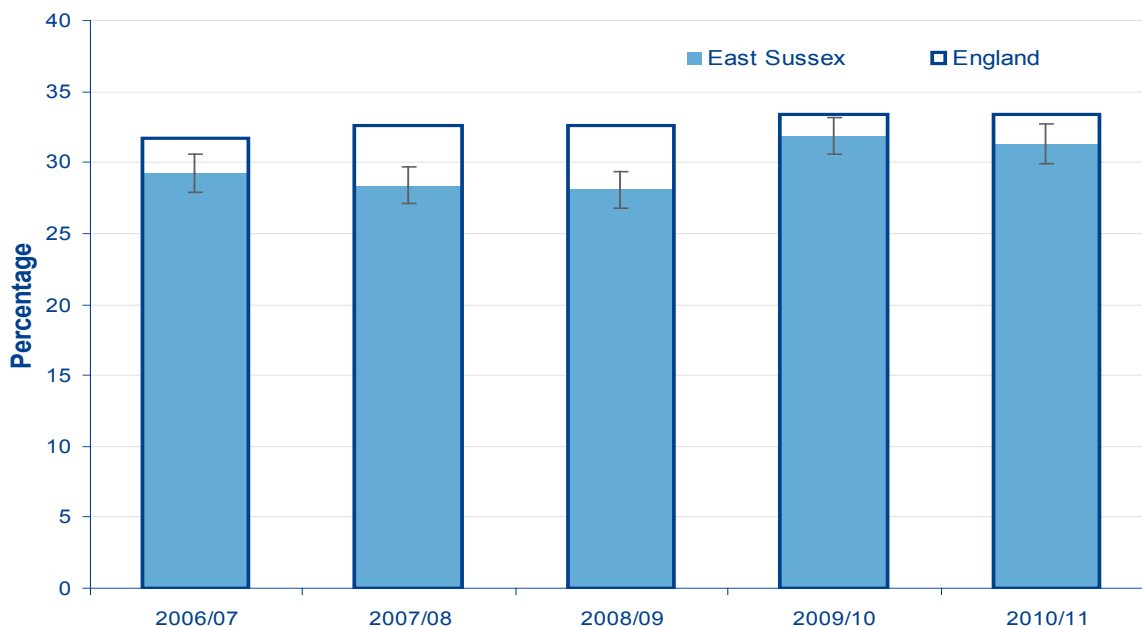
<sup>17</sup> Baird J, Fisher D, Lucas P, Kleijnen J, Roberts H, Law C. Being big or growing fast: systematic review of size and growth in infancy and later obesity. *BMJ*. 2005 October 22; 331(7522): 929

Guidelines for the management of obesity in children and young adults have been developed by the Child Growth Foundation. These use age and gender specific BMI centile charts, adjusted for growth, to identify overweight and obesity in children. Since 2005/06 the height and weight of all school children in the Reception Year (ages 4-5 years) and Year 6 (ages 10-11 years) have been measured through the National Child Measurement Programme in order to understand the prevalence of overweight and obesity.

### Prevalence of overweight and obesity in Reception Year and Year 6

In 2010/11, 20.5% of Reception Year and 31.4% of Year 6 pupils measured were recorded as overweight or obese across East Sussex. This compares with England where 22.6% of Reception Year and 33.4% of Year 6 pupils were overweight or obese. In East Sussex, boys in Year 6 had a significantly higher prevalence of obesity than girls in Year 6. For both year groups, there was a strong positive relationship between deprivation and obesity prevalence.

**Figure 6.4: Prevalence of overweight and obesity, Year 6, East Sussex**



**Source: East Sussex National Child Measurement Programme 2010/11, March 2012, [eastsussex.jsna.org.uk](http://eastsussex.jsna.org.uk)**

### What works in reducing childhood obesity, increasing physical activity and promoting healthy eating?

A range of dietary factors as well as changes in patterns of physical activity and the adoption of more sedentary lifestyles are likely to be important factors contributing to the rise of obesity in children. Evidence suggests that comprehensive strategies to improve diet and physical activity, together with psychosocial support and environmental change, may help prevent obesity.<sup>18</sup> The Childhood Obesity National Support Team has identified strategic high impact changes to reduce childhood obesity.<sup>19</sup> For example, at-risk families should be identified as early as possible and offered support; breastfeeding should be promoted as the norm for mothers; pre-schools, schools and colleges should contribute to developing life-long healthy eating and physical activity practices; children should have access to green spaces and safe play areas; and weight management services should be made available.

<sup>18</sup> Summerbell CD, Waters E, Edmunds L, Kelly SAM, Brown T, Campbell KJ. Interventions for preventing obesity in children. Cochrane Database of Systematic Reviews 2005, Issue 3.

<sup>19</sup> Strategic High Impact Changes - Childhood Obesity. Department of Health 2011

All schools should ensure that improving the diet and activity levels of children and young people is a priority for action, for example by including healthy eating in the Personal Social Health and Economic education (PSHEe) curriculum; by promoting small changes such as healthy lunchtime meals; by making links with parents and community organisations; and by ensuring that all food and drink provided or made available in schools supports young people to make healthy choices. The evidence that is available suggests that school-based obesity prevention programmes which focus on decreasing television viewing, decreasing the consumption of high-fat foods, increasing fruit and vegetable intake, and increasing moderate and vigorous physical activity may be cost-effective.<sup>20</sup>

Specific weight management interventions for obese children and young people, where commissioned, should include a whole family approach and aim to increase knowledge and skills in families to eat a healthy diet. Family-based group behavioural therapies that focus on diet, activity, behavioural change techniques, parenting, and coping with psychosocial problems are effective.<sup>21</sup>

NICE guidance for promoting physical activity in children and young people suggests that combining the following elements is effective: promoting the benefits of physical activity and encouraging participation; ensuring high-level strategic policy planning for children and young people supports the physical activity agenda; consultation with, and the active involvement of, children and young people; planning and provision of spaces, facilities and opportunities; and a skilled workforce promoting physically active and sustainable travel.<sup>22</sup>

### What we are doing

A multi-component approach is used in East Sussex to prevent overweight and obesity. For example, the specialist health improvement service provides training to staff and volunteers in pre-school settings, schools and colleges to enhance their skills, knowledge and confidence so that they can develop and deliver diet and physical activity interventions for children and young people. Specific services have been commissioned to increase physical activity and access to fresh fruit and vegetables in people of all ages, such as Active Hastings, Active Rother, Active Women and the Community Fruit and Vegetable project. Towns, districts and boroughs across East Sussex are developing physical activity plans to bring together partners to increase access to and uptake of physical activity opportunities including physical activity in green space. A cookery club leader training programme is enhancing the skills of people who work with vulnerable communities to improve their knowledge and skills for healthy eating. Projects such as East Sussex County Council's Targeted Youth Support Service's Positive Futures programme provide open access and targeted community-based physical activity sessions. Statutory, voluntary and community sector organisations have also widely publicised the Department of Health's national Change4Life and Games4Life campaigns. Schools have been supported to incorporate physical activity into the PSHEe agenda and most schools have a school travel plan which promotes active travel. The Sussex County Sports Partnership supports a range of initiatives to help young people (and adults) become more physically active.

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<sup>20</sup> Department of Health. South East QIPP Report 1. Overweight and Obesity. Department of Health 2010

<sup>21</sup> Department of Health. South East QIPP Report 1. Overweight and Obesity. Department of Health 2010

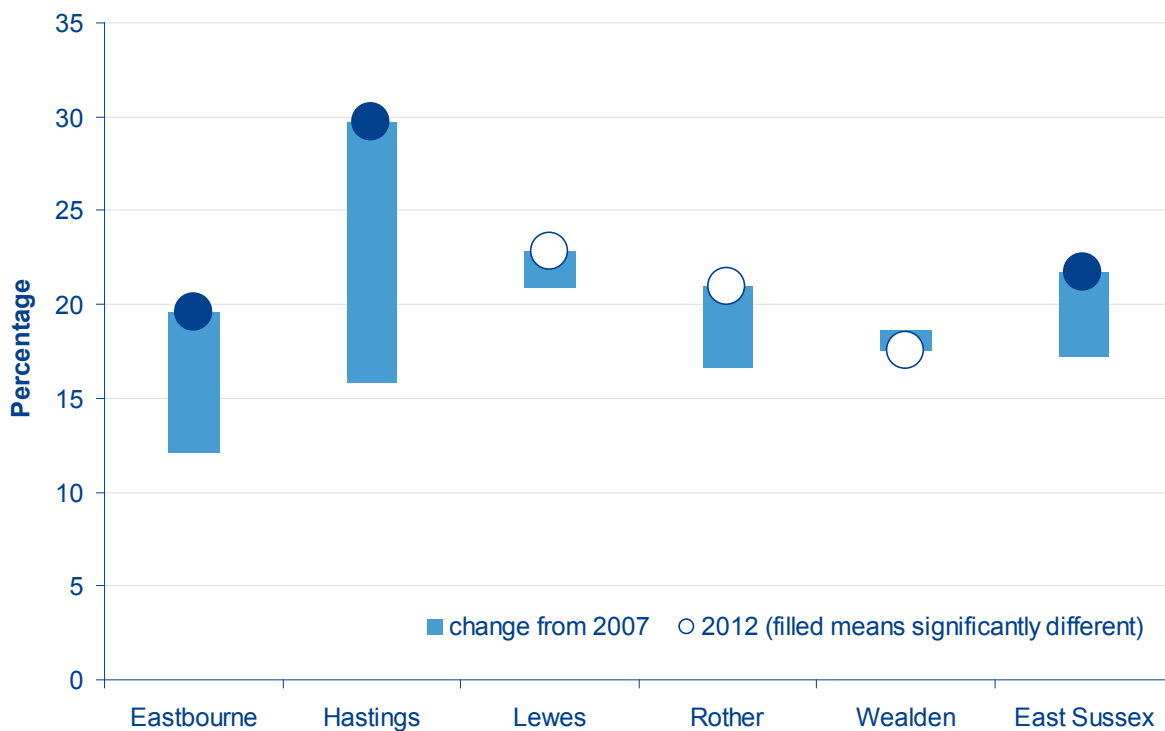
<sup>22</sup> Promoting physical activity for children and young people. National Institute for Health and Clinical Excellence. 2009

## Sexual health and teenage pregnancy

A total of 88% of pupils described themselves as heterosexual; 3% said that they are bisexual; 1% said that they are gay/lesbian; 3% stated that they were unsure; and 2% preferred not to say.

There has been a statistically significant increase in the proportion of pupils who are or have been sexually active – 22% in 2012 compared with 17% in 2007. Within East Sussex, only Wealden does not show an increase. Both Eastbourne and Hastings show statistically significant increases. There is a gender difference, with 24% of girls and 19% of boys claiming to be in a sexual relationship or to have had one in the past. The rate is highest in Hastings, where 33% of girls and 26% of boys claim to be in or to have previously had a sexual relationship. This compares with 19% and 16% respectively in Wealden.

**Figure 6.5: Percentage of pupils who are currently in or who have previously had a sexual relationship, comparing 2012 with 2007**



**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012.**

There has been an increase in the proportion of pupils who know where to get condoms free of charge, from 50% in 2007 to 63% in 2012. There has also been an improvement in the proportion of pupils who know about the local specialist contraception and advice centres for young people. A total of 33% of boys and 40% of girls have knowledge of these compared with 22% of boys and 27% of girls claiming to be aware of these services in 2007.

The majority of respondents (72%) reported that their main sources of information on relationships and sexual health were schools, parents and friends. Relatively few young people reported getting information from the internet (9%), with rates slightly higher for boys (13%) than girls (9%).

### Teenage pregnancy

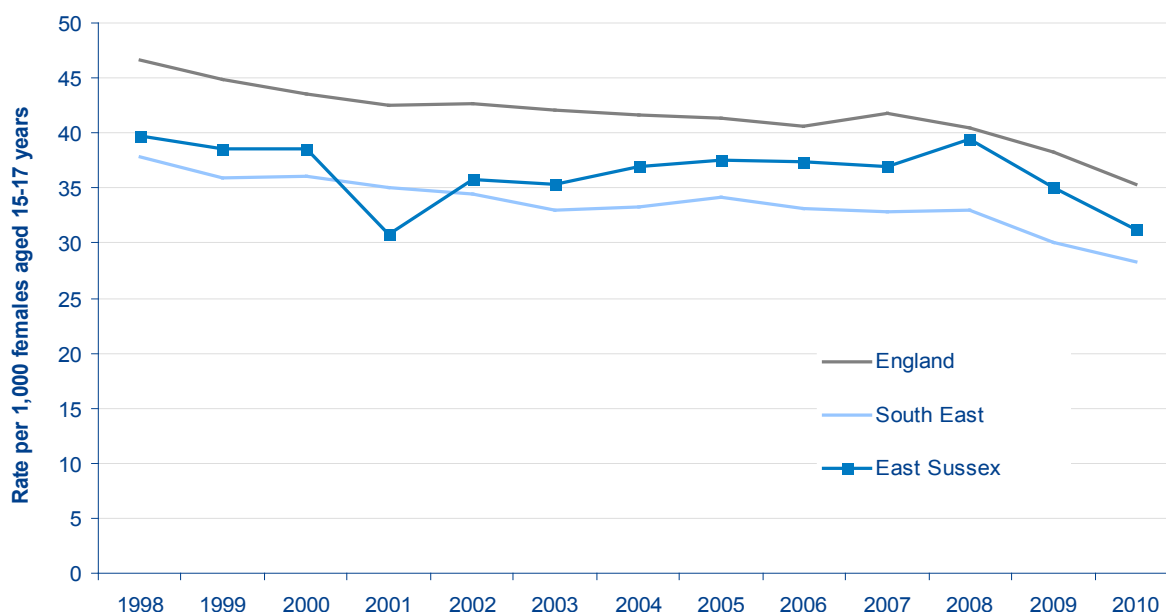
Teenage pregnancy is an important health issue, with poorer health outcomes and health inequalities both for teenage parents themselves and for their children.

Some groups of young people are at higher risk of becoming teenage parents. Teenage pregnancy is strongly linked to the aspirations that young people have. There is an inverse relationship between educational achievement and rates of teenage pregnancy. In areas where educational attainment is low, teenage pregnancy rates tend to be higher. Groups at increased risk of becoming a teenage parent include: those not in education, employment or training (NEET); children and young people who are looked after either in care or in foster placements; those who misuse alcohol and/or drugs; those in contact with youth offending services; and those whose mothers were teenage parents.

The factors leading to teenage pregnancy are complex, and partnership working across key agencies including education, youth services, sexual health services, housing and local voluntary and community groups is essential in reducing rates.

Figure 6.6 shows that teenage pregnancy rates have been reducing nationally, regionally and locally since 1998. Although East Sussex is below the national rate, we are above the regional rate. The reduction in East Sussex between 2008 and 2010 from 39.4 per 1,000 15-17 year olds to 31.3 per 1,000 15-17 year olds is encouraging.

**Figure 6.6: Rate of under-18 conceptions (per 1,000 females aged 15-17 years), 1998 to 2010**



Source: Office for National Statistics



Table 6.1 shows that rates of teenage pregnancy vary by district and borough, with Hastings having the highest rate and Wealden the lowest. This largely reflects the higher rates of deprivation in Hastings.

**Table 6.1: Rate of under-18 conceptions per 1,000 females aged 15-17 years, 2010**

Area	Teenage pregnancy rate per 1,000
England	35.4
South East	28.3
East Sussex	31.3
Eastbourne	37.6
Hastings	45.0
Lewes	31.5
Rother	28.2
Wealden	21.0

**Source: Office for National Statistics**

Organisations across East Sussex have worked together to address the causes of teenage pregnancy and support young women who are pregnant to have better health outcomes. We have focused on the following evidence-based actions:

- improving access to contraception for young people
- improving the quality of Sex and Relationship Education delivery in schools
- improving access to advice and information across a range of settings

Future developments include ensuring good quality advice and information for young people; reviewing commissioning intentions for sexual health; and prioritising the needs of the most vulnerable first, including young people, those who find it difficult to access services and those in rural areas.

We need to ensure that we continue to provide high quality advice and information for young people, for example using evidence-based social marketing techniques. We also need to ensure that sexual health services meet the needs of young people, including those at risk of teenage pregnancy, and that those most at risk are able to access services easily and quickly.

Levels of teenage pregnancy in East Sussex are reducing overall. Although delaying sexual relationships might be preferable, it is encouraging that knowledge about how to access contraception and sexual health advice appears to have improved.

### What we are doing

- A condom distribution scheme is in place across the county
- Schools are supported to deliver high quality PSHEe
- Outreach health promotion drop-ins have been piloted (although uptake in some areas is low)
- Outreach sexual health services and access to emergency hormonal contraception are available in key places such as GP surgeries, pharmacies and community locations
- Targeted Youth Support (TYS) staff are all trained to deliver brief health promotion interventions
- Health promotion training is available to all people with a potential role in promoting the health of children and young people such as nurses, voluntary sector staff, volunteers, youth workers and teachers, covering topics such as sexual health, delivering brief health promotion interventions and smoking

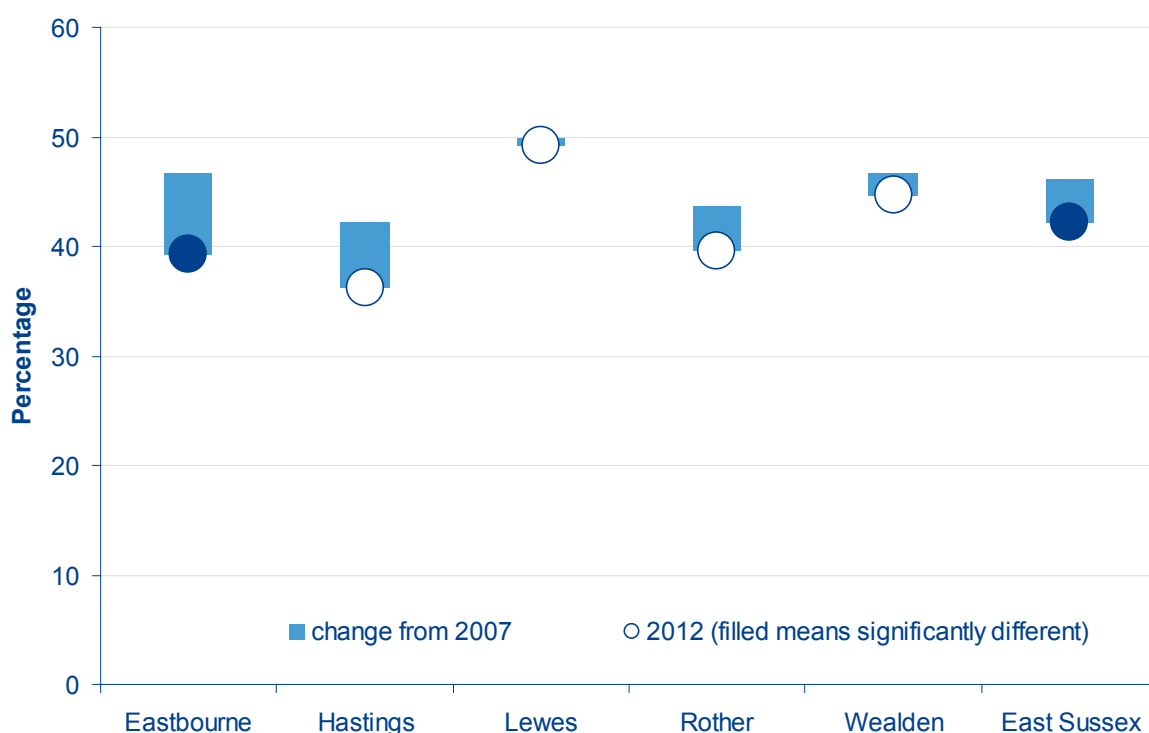
## Emotional and mental wellbeing and safety

There has been an increase in the proportion of pupils who state that they are quite or very unhappy with their lives. Overall, in the 2012 survey, 13% of boys and 20% of girls said they were quite or very unhappy with their life at the moment. This has increased from 9% of boys and 12% of girls in 2007. The top two worries for girls are exams and tests (66%) and their looks (38%). The top two worries for boys are exams and tests (42%) and career (23%).

Body image is closely linked to emotional and mental wellbeing. The proportion of girls who state that they would like to lose weight appears to have increased from 58% in 2007 to 66% in 2012. This means that two out of every three girls claim that they would like to lose weight. It is interesting to note that 25% of pupils (31% of girls) regard themselves as being a little or very overweight. Over twice as many girls who regard themselves as being a little or very overweight claim that they would like to lose weight.

There has been a statistically significant decrease overall and also in Eastbourne in the proportion of pupils scoring levels of high self-esteem. In 2012, 42% of pupils were in the high self-esteem bracket compared with 46% in 2007.

**Figure 6.7: Percentage of pupils scoring levels of 'high self-esteem' in 2012 compared with 2007**



**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

Rates of bullying have reduced. A total of 16% of boys and 18% of girls said they had been bullied at school in the last 12 months. This is lower than the 21% of boys and 22% of girls who said this in 2007. There has been a statistically significant reduction overall and in all the districts and boroughs except Eastbourne and Hastings.

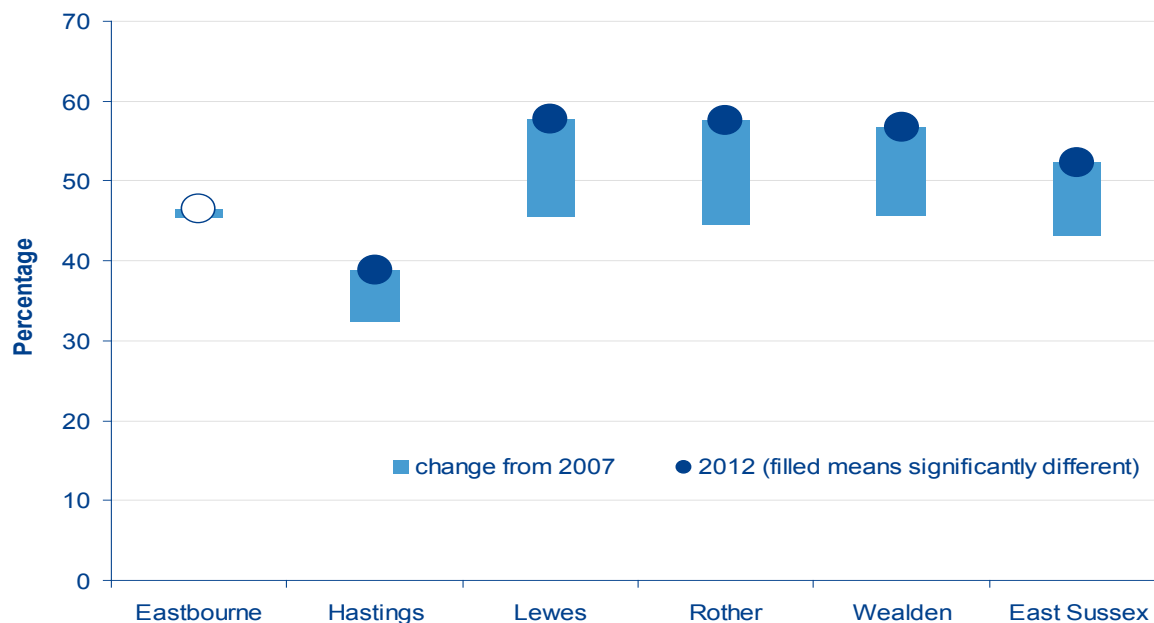
**Figure 6.8: Percentage of pupils who said they had been bullied in the past 12 months in 2012 compared with 2007**



**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

There has been a statistically significant increase in the proportion of pupils saying that they think their school takes bullying seriously overall and in all the districts and boroughs except Eastbourne. A total of 52% of pupils stated this in 2012 compared with 43% in 2007. In Hastings, although there has been a statistically significant increase in the percentage of pupils saying that their school takes bullying seriously, it still has the lowest percentage in East Sussex.

**Figure 6.9: Percentage of pupils who think their school takes bullying seriously in 2012 compared with 2007**



**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

19% of boys and 26% of girls claim that the amount of sleep they get is not enough to stay alert and concentrate at school.

### Safety

12% of boys and 8% of girls state that they have been the victim of violence or aggression in the area where they live in the last 12 months. This appears to be lower than in 2007 when the reported rates were 18% for boys and 13% for girls.

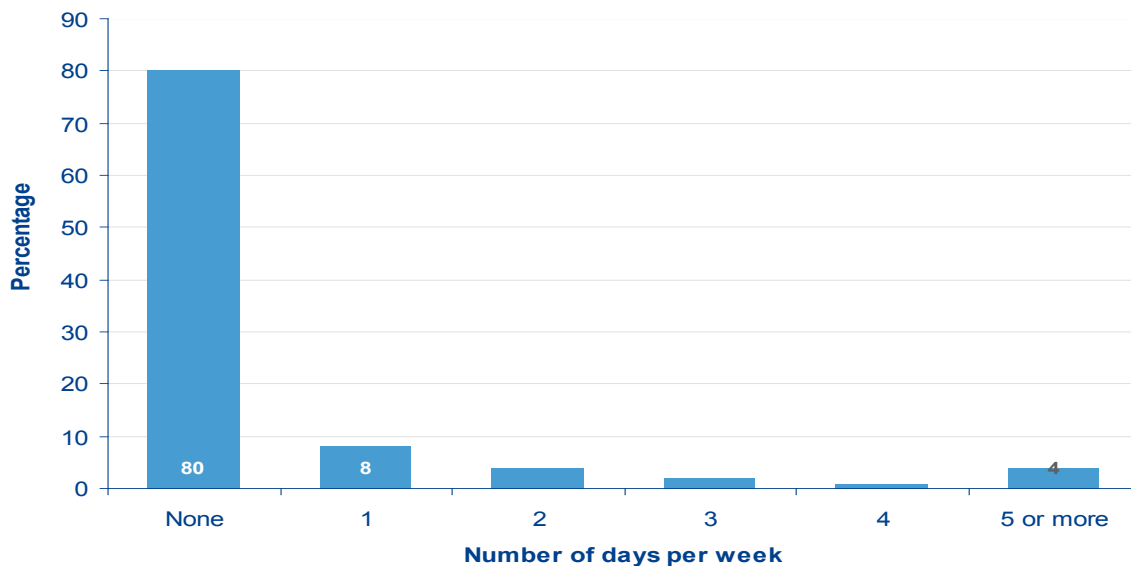
### What we are doing

A range of support interventions for young people with mental health support needs is commissioned through the CAMHS pathway. This includes psychological interventions and support to families. In addition, wider services support young people with mental health needs, for example pastoral support in schools and Targeted Youth Support. Supporting young people to maintain good mental health and prevent the development of mental health problems requires a whole systems approach including supporting good parenting and healthy schools, and developing resilience in vulnerable young people.

## Young carers

Pupils were asked to indicate how many days in the past week they had looked after someone in their family with an illness or disability. 20% of respondents reported that they had looked after someone for at least one day, with 4% indicating that they had looked after someone for five or more days. It is difficult to produce an estimate of the numbers of young carers in East Sussex because this information is not routinely collected. Although this is a crude method for estimating the prevalence of young carers, applying the percentage of young people caring for five or more days in the past week indicated in the survey to 2011 mid-year estimates of the 15-19 population suggests that there may be around 1,000 young carers in this age group in East Sussex. A needs assessment for carers of all ages has been commissioned and this will provide further information on the number of young people undertaking a caring role in the county.

**Figure 6.10: Percentage of pupils looking after someone in their family, by number of days per week**



**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

Young carers may not be familiar with the term 'carer' and may not identify themselves as such. Unlike adult carers, young carers are not routinely offered an assessment of their needs. Caring for an adult or sibling can impact on the health and life chances of young people. Young carers, and organisations working with them, report that their caring role can impact on their school work, school attendance and ability to socialise with friends, and can cause stress and anxiety. Consequently, identifying young people who have a caring role and ensuring that their caring role is appropriate are important factors in improving the health of young people who have a caring role.

## Alcohol and drugs

### Alcohol

The Survey indicated that alcohol consumption appears to have reduced since both 2007 and 2004. There is a significant reduction overall and (in Lewes) in the proportion of pupils saying that they drank alcohol in the previous week. A total of 35% of pupils said that they drank alcohol on at least one day in the last week in 2012 compared with 39% who said this in 2007 and 48% in 2004.

**Figure 6.11: Percentage of pupils who said they did not drink alcohol in the last 7 days, 2012 compared with 2007**



**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

The rates vary by district and borough with Hastings and Wealden having the highest percentage of pupils drinking alcohol in the last seven days and Eastbourne and Rother the lowest.

**Table 6.2: The percentage of pupils who said that they drank alcohol on at least one day in the last week, 2012**

District/Borough	Percentage
Eastbourne	28%
Hastings	39%
Lewes	36%
Rother	32%
Wealden	38%

**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

Overall, 8% of pupils claim to drink alcohol at least once per week.

**Table 6.3: The percentage of pupils who said they drink alcohol at least once per week, 2012**

District/Borough	Percentage
Eastbourne	6%
Hastings	13%
Lewes	7%
Rother	5%
Wealden	10%

**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

### Evidence-base

Drinking at an early age is associated with having more sexual partners, pregnancy, using drugs, employment problems, and risky driving behaviours.<sup>23</sup>

Parental use of alcohol increases the likelihood that children will also consume alcohol. Supportive parent–adolescent relationships are associated with lower levels of adolescent alcohol use, as well as lower rates of problematic alcohol use and misuse.

Family-focused interventions including brief interventions focused on parenting skills are effective in the longer term in reducing alcohol use in young people. Professionals from health, education, social care and criminal justice agencies should be able to identify, assess and, where necessary, appropriately refer young people experiencing alcohol-related problems.

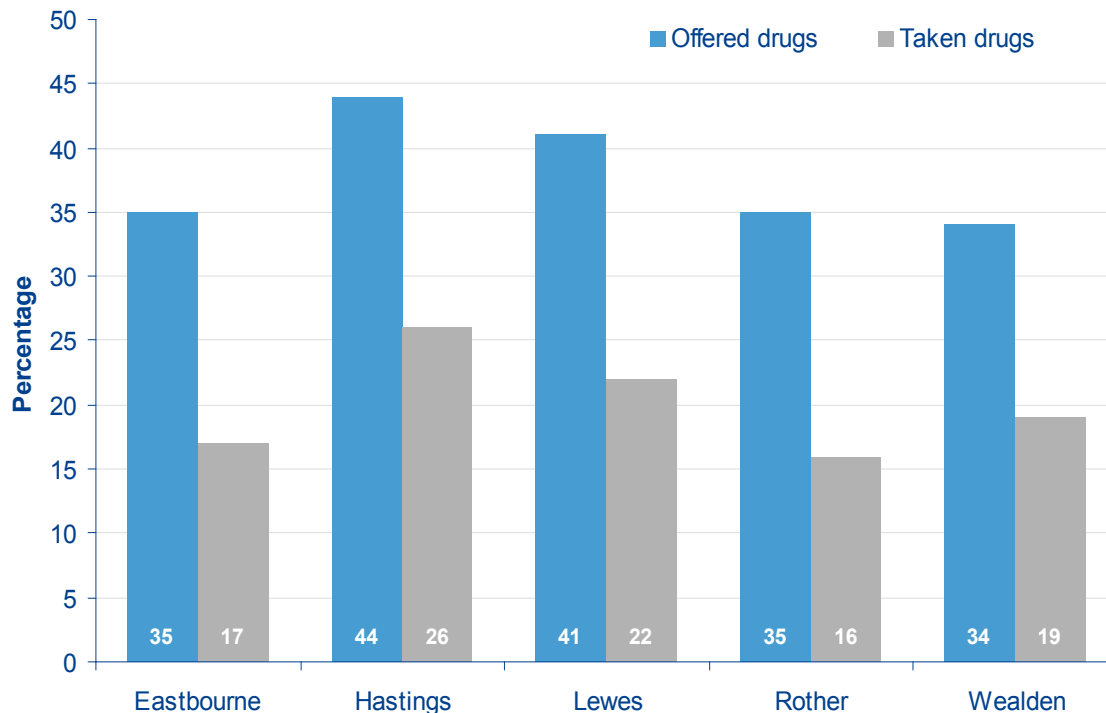
Brief, one-to-one advice on the harmful effects of alcohol use, how to reduce the risks and how to find sources of support is an effective approach for tackling harmful drinking among children and young people.

### Drugs

Rates of drug use are reported to have reduced since 2004. In 2012, a total of 38% of 14-15 year olds claim to have been offered drugs and 20% claim to have taken drugs (17% claim to have used cannabis). This compares with 18% claiming to have taken drugs in 2007 and 31% in 2004. In particular, cannabis use appears to have reduced by half from 33% in 2004 to 17% in 2012. Percentages vary by district and borough, with the highest percentages in Hastings.

<sup>23</sup> Guidance on the Consumption of Alcohol by Children and Young People. Chief Medical Officer. Department of Health. 2009

**Figure 6.12: Percentage of pupils who were offered drugs compared with those who confirmed they took drugs, 2012**



**Source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012**

For those taking drugs, 35% stated they first tried a drug when they were 13 or younger. This compares with 54% in 2004 and 59% in 2007. Only 17% of young people said that they knew about the special drug and alcohol advice and support service for young people, compared with 23% in 2007.

**What we are doing**

- Targeted Youth Support (TYS) staff are all trained to deliver brief health promotion interventions
- Health promotion training is available to all people with a potential role in promoting the health of children and young people such as nurses, voluntary sector staff, volunteers, youth workers and teachers, covering topics such as sexual health, delivering brief health promotion interventions and smoking



## Recommendations

- 1 Local Authority commissioners and schools and academies should ensure a whole school approach to promoting and supporting healthy lifestyles in young people. The priority areas for action are reducing smoking, increasing physical activity and healthy eating and promoting good mental health, with a focus on deprived areas and the needs of girls.
- 2 Schools and academies, and public health commissioners need to ensure that young people are informed about how to maintain good sexual health and how to access the range of sexual health services available for them by providing high quality information on relationships and sexual health and using the communication methods preferred by young people (namely parents and schools).
- 3 Public Health commissioners should commission evidence-based services for obese children and young people and their families.

# Chapter 7. Children and young people and healthcare

The largest single cause of emergency hospital admissions in children and young people aged 18 and under is respiratory conditions, which account for 20% of emergency admissions. Children aged under 5 years account for 78% of all emergency admissions for children and young people across the county. East Sussex has the highest rate of under 18s admissions for unintentional and deliberate injuries than England for the last nine years. The highest rates were in children aged four and under.



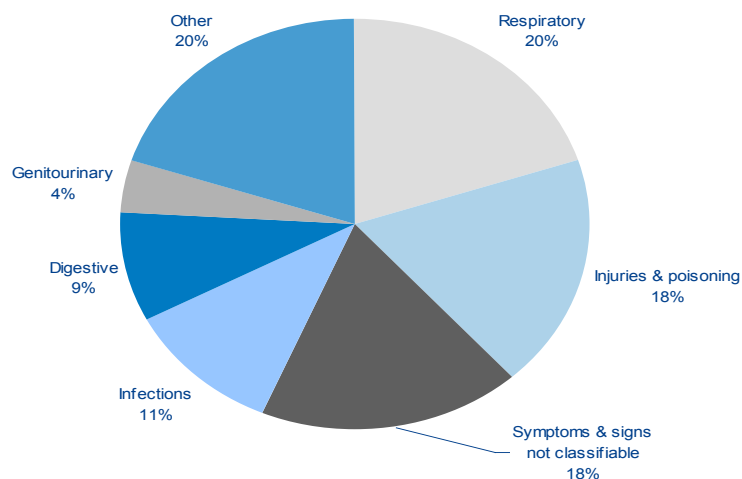
## Emergency admissions to hospital

Rates of admission to hospital are affected by many factors including variation in clinical practice, proximity to a hospital, presence of alternative healthcare provision (for example, minor injuries units), and quality of and access to primary care including out of hours services. Rates of accidents are generally higher in more deprived communities. Contributing factors include generally larger families (often with relatively more babies and children), higher likelihood of single parent families which may lead to less supervision, higher rates of alcohol/ drug use among parents, and lower likelihood of adopting safety prevention precautions including the use of stair gates.

Between 1<sup>st</sup> April 2010 and 31<sup>st</sup> March 2012, 14,987 children aged 18 years and under were admitted to hospital as an emergency admission. The largest single cause of these admissions was respiratory conditions, representing 20% of all admissions (Figure 7.1). The second largest cause of emergency admissions was unintentional and deliberate injuries and poisonings (18%). The third largest cause was symptoms and signs not classifiable. In general, this category includes the less well-defined conditions and symptoms where a final diagnosis may not have been established or symptoms are transient. The category 'other' includes a range of conditions with small numbers (each representing less than 4% of the cause of admissions) including congenital abnormalities and endocrine, nutritional and metabolic diseases.

Children under the age of five account for 78% of all emergency admissions for children in East Sussex. Of the remaining admissions, children aged between five and nine years account for 12%, and those aged 10-14 and 15-17 both account for a further 5% each.

**Figure 7.1: Primary diagnosis of emergency admissions for East Sussex patients aged under 18 years, 2010/11 - 2011/12**



### Source: Hospital admissions data from local SUS extracts

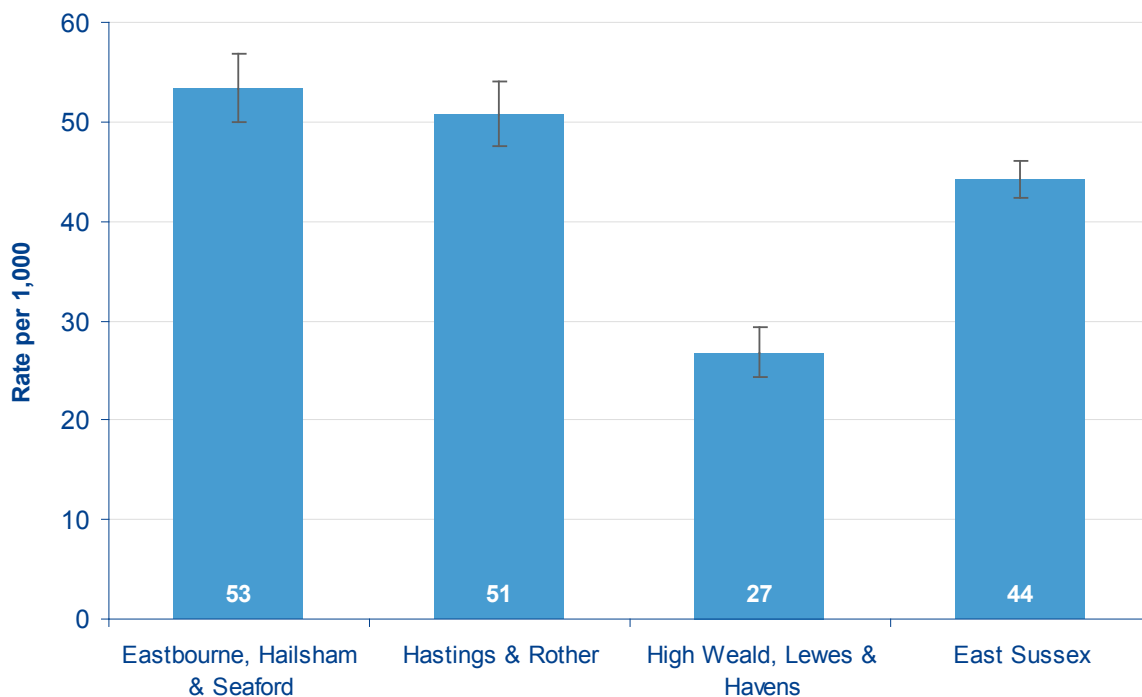
Across the county, the rate of Accident & Emergency (A&E) attendances for 0-4 year olds is 323 per 100,000 population. At ward level, the rate varies from 99 per 100,000 in Kingston to 778 per 100,000 in Peacehaven West. Other wards with high rates include Peacehaven East (734 per 100,000), Devonshire (524 per 100,000), Gensing (516 per 100,000) and Baird (503 per 100,000).

## Respiratory admissions

Between April 2010 and March 2012 there were 3,014 admissions for respiratory illnesses. Of these, 75% were acute respiratory infections, 10% were asthma and 10% influenza and pneumonia.

As with admissions overall, the 0-4 year age group accounts for the majority of emergency respiratory admissions with an admission rate nearly three times higher than the average for all under-18s (44.2 per 1,000 and 14.8 per 1,000 respectively).

**Figure 7.2: Rate of emergency respiratory admissions (primary diagnosis) for East Sussex patients aged 0-4 years (rate per 1,000), by Clinical Commissioning Group, 2010/11 - 2011/12**

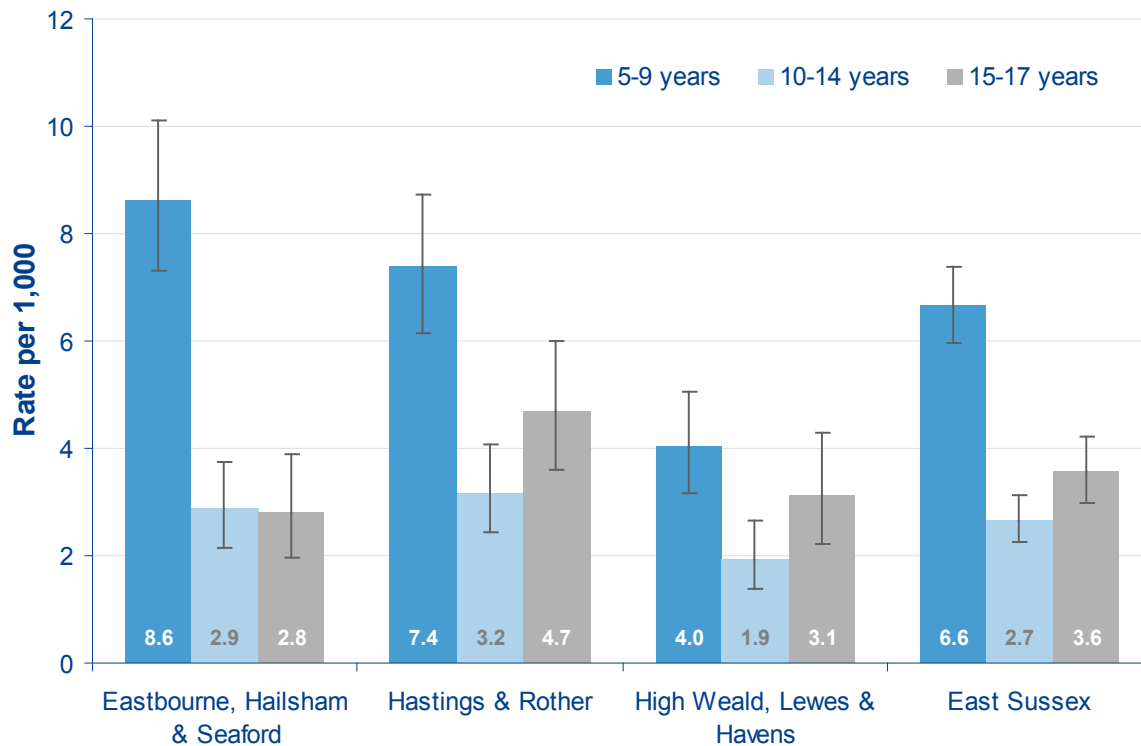


### Source: Hospital admissions data from local SUS extracts

Rates of emergency admissions due to respiratory illnesses were statistically significantly lower in High Weald, Lewes and Havens Clinical Commissioning Group (CCG) than the East Sussex average and the other CCGs. Admission rates in both Eastbourne, Hailsham & Seaford CCG and Hastings & Rother CCG areas were statistically significantly higher than the East Sussex average (Figure 7.2).

Though rates of emergency admissions due to respiratory illnesses drop significantly after the age of four years, the rate of admissions in 5-9 year olds remains statistically significantly higher than in older age groups in Eastbourne, Hailsham & Seaford and in Hastings & Rother (Figure 7.3). Across all of the CCGs, the admission rate for 5-9 year olds is significantly higher than for the 10-14 year age group. There are no significant differences between the 10-14 year olds and 15-17 year olds.

**Figure 7.3: Rate of emergency respiratory admissions (primary diagnosis) for East Sussex patients aged 5-17 years (rate per 1,000), by CCG, 2010/11 - 2011/12**



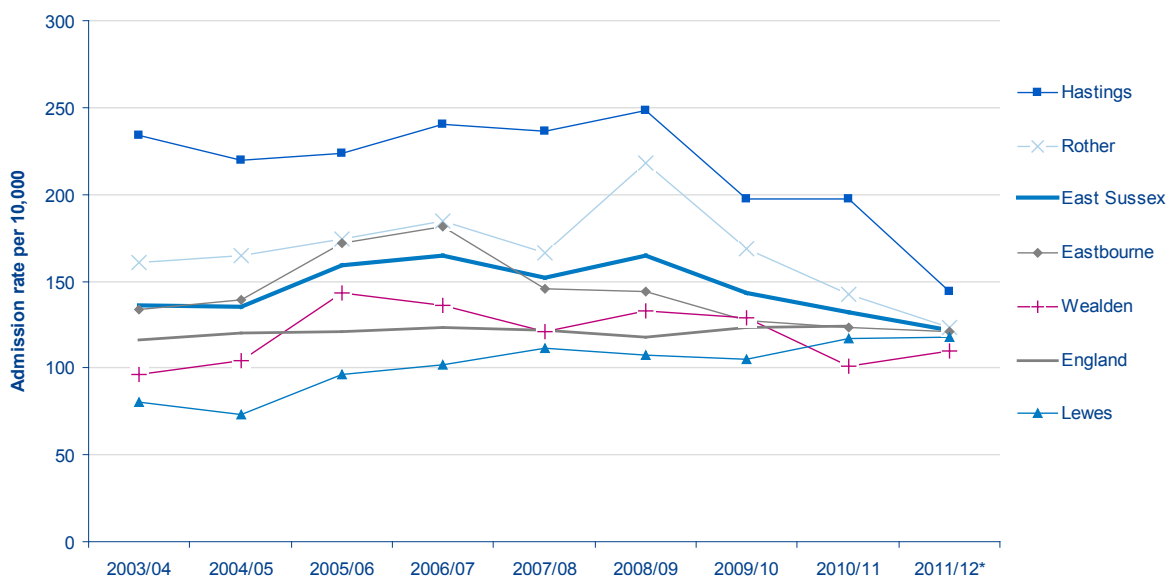
Source: Hospital admissions data from local SUS extracts

## Under-18s admissions to hospital as a result of an accident or deliberate injury

East Sussex has had a higher rate of under-18 admissions for unintentional and deliberate injuries than for England as a whole over the last nine years. Hastings consistently had the highest rate of any district/borough in England between 2003/04 and 2008/09, and had the sixth highest rate in 2010/11 (data is not yet available for other areas for 2011/12). Local data suggests that there has been a significant decrease in the rate for Hastings from 2010/11 to 2011/12. Rother has also had a decrease in the rate, but not significantly so (Figure 7.4).

Previous analysis of admissions data highlighted that there had been a different process for paediatric patients passing through A&E at the Conquest hospital in Hastings than at the District General Hospital (DGH) at Eastbourne. At the Conquest, paediatric patients were assessed in a 'paediatric assessment unit' and were more likely to be coded as admissions than paediatric patients being assessed at the DGH. From January 2009, East Sussex Healthcare NHS Trust has ensured that the pathway for children attending A&E at the Conquest matches the pathway at Eastbourne DGH, and therefore this should not be reflected in the data for Hastings and Rother from 2009/10 onwards.

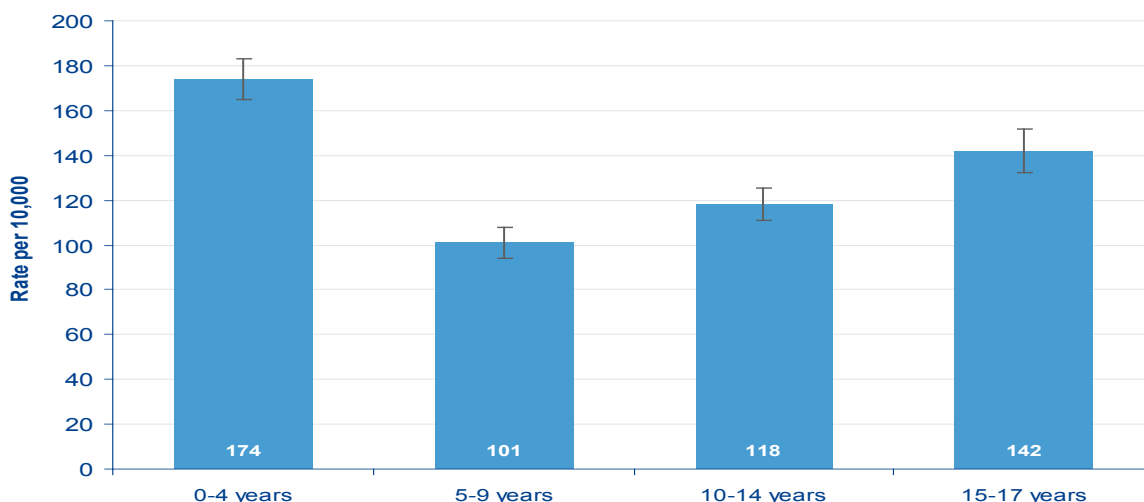
**Figure 7.4: Emergency hospital admissions caused by unintentional and deliberate injuries to under-18s per 10,000 population by local authority, 2003/04 – 2011/12**



**Source: Hospital Episode Statistics. The Information Centre for Health and Social Care.**

Unintentional and deliberate injuries represent the second largest cause of emergency admissions in East Sussex. Analysis of admissions by age group indicates that the highest rates of admission are within the 0-4 year age group and are statistically significantly higher than in any other age group. The lowest emergency admission rates for accidents and injuries were seen in the 5-9 year age group, with an admission rate statistically significantly lower than for any other age group.

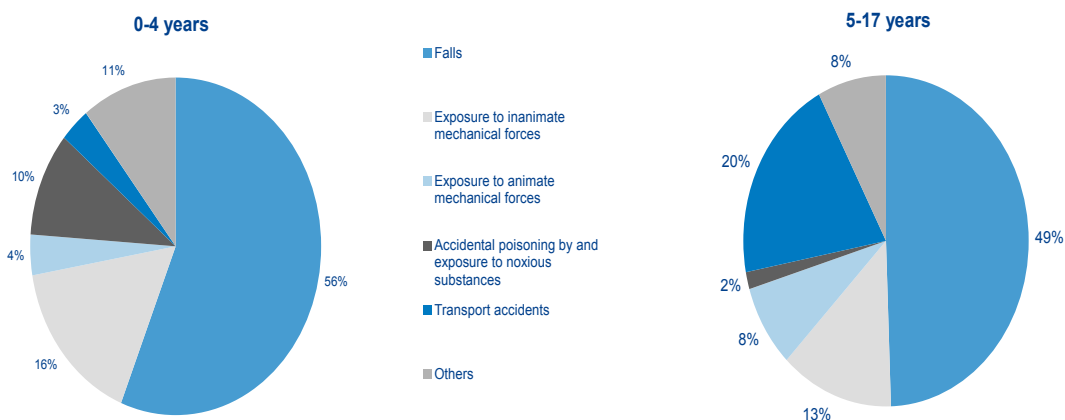
**Figure 7.5: Rate of emergency admissions due to unintentional and deliberate injuries for East Sussex children aged 0-17 years (per 10,000 population), 2009/10 - 2011/12**



**Source: Hospital admissions data from local SUS extracts**

Analysis of admissions for unintentional and deliberate injuries by cause indicates that among both the 0-4 and 5-17 year age group, falls represent the largest single cause of admissions. The second largest reason for admission was exposure to inanimate mechanical force in the 0-4 age group and transport accidents in the 5-17 year age group.

**Figure 7.6: Admissions due to unintentional and deliberate injuries by cause of injury for 0-4 year olds and 5-17 year olds, East Sussex, 2009/10 - 2011/12**



**Source: Hospital admissions data from local SUS extracts**



Across the county, the rate of emergency hospital admissions caused by unintentional and deliberate injuries for persons aged under 18 years is 140 per 100,000 population. At ward level, the rate varies from none or less than five admissions in Alfriston and Plumpton, Streat, East Chiltington and St John wards to 414 per 100,000 in Tressel. Other wards with high rates include Baird (289 per 100,000), and Braybrooke (269 per 100,000).

Geographical analysis of emergency hospital admissions due to unintentional and deliberate injuries indicates that rates are highest in Hastings and Rother where they are significantly higher than for England in both the 0-4 and 5-17 year age groups.

Rates of under-18 emergency hospital admissions for unintentional and deliberate injuries appear to have reduced since 2003/04 to be in line with or below the 2011/12 England average, for East Sussex and for all districts and boroughs apart from Hastings.



## The NHS Atlas of Variation in Healthcare for Children and Young People

The NHS Atlas of Variation in Healthcare for Children and Young People is an interactive mapping tool produced by the Child and Maternal Health Observatory in partnership with the South East Public Health Observatory. The aim of the Atlas is to highlight unwarranted variations in children's healthcare services, acting as a catalyst for commissioners and clinicians to review local performance and reasons for variation. Every population and each individual may have different needs, values and priorities.

The tool presents data on 27 indicators ranging from very high-level measures (such as the rate of expenditure on community child health services per head of population aged 0-17 years) to more detailed indicators (such as immunisation uptake and average length of stay for certain conditions). Table 7.1 shows the indicators in the Atlas where the East Sussex PCTs are amongst those nationally with the highest rates (amongst the highest 20% in England).

**Table 7.1: Indicators where the East Sussex PCTs are amongst the 20% nationally with the highest rates/percentage/length of stay**

PCT	Amongst the 20% nationally with the highest rates/percentage/length of stay
East Sussex Downs and Weald	<p>Rate of aural ventilation tube (grommet) insertion in children per population aged 0-17 years, 2007/08 - 2009/10</p> <p>Emergency admission rate for inflammatory bowel disease (IBD) in children per population aged 0-17 years, 2007/08-2009/10</p> <p>Rate of elective tonsillectomy in children per population aged 0-17 years, 2007/08 - 2009/10</p>
Hastings and Rother	<p>Admission rate for children for upper and/or lower gastro-intestinal endoscopy per population aged 0-17 years, 2007/08 - 2009/10</p> <p>Percentage of children aged 0-15 years with previously diagnosed diabetes in the National Diabetes Audit (NDA) admitted to hospital for diabetic ketoacidosis, 1 January 2009 to 31 March 2010</p> <p>Rate of perinatal mortality per all live births, 2007 - 2009</p>

**Source: NHS Atlas of Variation in Healthcare for Children and Young People**

Table 7.1 indicates that in East Sussex Downs and Weald we are among those nationally with the highest rates of grommets, tonsillectomy and emergency admissions for inflammatory bowel disease. In Hastings and Rother we are among those nationally with the highest rates of admission for gastrointestinal endoscopy and diabetic ketoacidosis in children with previously diagnosed diabetes; and perinatal mortality (stillbirths plus neonatal deaths at under seven days of life).

### What's happening in East Sussex

All first time parents and some second time parents receive child safety education from ESHT's health visiting team. Home safety equipment is supplied to vulnerable families and this service is to be enhanced, so that vulnerable families identified by ESHT will receive further home safety advice as part of a home safety equipment supply and fitting service. Within schools, the Police and East Sussex Fire and Rescue Service support the delivery of accident prevention work so that children are better informed of situations of potential danger in the home and community and have the knowledge and skills to avoid danger and seek help when necessary. The Safer Sussex Roads Partnership coordinates initiatives to prevent and reduce road injuries with a focus on road safety, pedestrian safety and safe driving by young drivers.

### Recommendations

- 1 Public Health commissioners need to prioritise households at greatest risk and support them to take action to reduce the risk of accidents at home including through accident prevention education, providing home safety assessments and the provision and fitting of safety gates.**
- 2 Clinical Commissioning Groups need to review the areas where the use of hospital services by children in their locality is high, to ensure that their service commissioning is cost effective.**

