THE STATE OF CHILD HEALTH IN EAST SUSSEX

Annual Report of the Director of Public Health 2017/18

FOREWORD

Good health and wellbeing in childhood and adolescence is the key to good health in adult life so this report aims to develop our understanding of the health of children and young people in East Sussex. The good news is that most children and young people in East Sussex are healthy. But it's not all good news, as the report identifies where East Sussex children and young people are experiencing poor health outcomes. There are two important messages that are repeated throughout this report:

- poor outcomes are mostly preventable;
- children and young people from a more deprived background do less well than their more affluent peers.

So the bottom line is that in East Sussex we could do more to improve children's health and wellbeing.

There is a need to reinforce the importance of intervening early in life on the determinants of child health. This includes: healthy behaviour and lifestyle of the child and the parents (for example nutrition, smoking); the families' ability to care for the child; education; the broader socio-economic conditions (i.e. poverty and inequity); and the environment. Child health (both physical and mental) is largely influenced by these broader determinants rather than the health care system, so there is a need to work with a range of professionals across the different sectors and organisations with a focus on children's health and wellbeing. Greater emphasis on prevention and proactive early intervention where every contact with a child and the family is used as an opportunity, are essential.

But why is this so challenging in reality? Local government and the NHS are facing significant financial constraints and pressures on services continue to build. However, prevention is part of the solution. It's not just about doing more prevention but also about doing it differently as well, and also by investing jointly across the health, public health and social care system. The challenge is that there is limited flexibility to shift investment away from treatment and social care services when the current demands on the health and care services are so great.

It's vital that we make the case for investment in prevention and early intervention as budgets continue to tighten. Prevention and early intervention measures are cost-effective, but the return on investment is likely to be medium to long-term and they do not produce immediate cashable savings. Few people would argue that stopping children from becoming overweight is not the right thing to do, rather than treating the morbidly obese for serious diseases and health conditions and with gastric surgery, even if in the short term there were no cashable savings from doing so. However, there is a need for immediate cost savings, given the pressures on budgets. It is important that we recognise these financial pressures, on all parts of the system, and that they necessitate prioritisation and choices to be made to get the greatest value from every penny of public money spent.

The benefits of intervening early and investing in the broader determinants of child health will lead to a reduction in the disease burden and therefore benefit adult health and care services. Investing in strategies that make a significant difference in outcomes for children come at a fraction of the cost of treating and caring for adults.

Cynthia Lyons,
Acting Director of Public Health

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This report is available in hard copy and also at www.eastsussexjsna.org.uk

CONTENTS

INTRODUCTION

'A vital and productive society with a prosperous and sustainable future is built on a foundation of healthy child development'

Centre for the Developing Child, Harvard[1]

This report is based on the 'State of Child Health 2017' published by the Royal College of Paediatrics and Child Health in January 2017. The State of Child Health 2017 brought together data for the first time on a comprehensive list of 25 measures of the health of UK children. The data provides 'an across the board' snapshot of child health and wellbeing in the UK. We have reproduced it for East Sussex presenting data at an East Sussex, district and borough, local authority (LA) and Clinical Commissioning Group (CCG) level and made comparisons to national data and to trend data where these are available. In some places where it is useful, we have also included some additional measures.

Chapter one examines mortality in infants under 1 year, children aged 1-9 years and young people aged 10-19 years. It shows that infant mortality in East Sussex is very much linked to levels of deprivation.

Chapter two outlines issues relating to conception, pregnancy and infancy with a focus on smoking and pregnancy, breastfeeding and immunisation.

Early years are picked up in chapter three, including healthy weight when starting school, healthy teeth and gums, hospital admissions due to injury and school readiness.

Chapter four covers topics within school age and adolescence and includes healthy weight at Year 6, Human Papilloma Virus (HPV) vaccination, smoking in young people, alcohol and drug use, mental health and wellbeing, suicide, road traffic injuries, sexual and reproductive health, and those children who are not in employment, education or training plus school absences and exclusions.

Family and social environment are picked up in chapter 5, including child poverty, family keywork, the child protection system and looked after children.

Chapter six explores the common health conditions of childhood including asthma, cancer, diabetes, disability and additional learning needs, epilepsy, palliative care and Autistic Spectrum Disorder.

EXECUTIVE SUMMARY

The Director of Public Health Annual Report 2017/18 focusses on the state of child health in East Sussex, from pre-conception through to adolescence: comparing East Sussex with national indicators; and for Clinical Commissioning Groups (CCGs) and Districts and Boroughs comparing them with England and also with East Sussex overall. This provides us with a valuable snapshot of the state of child health in East Sussex and identifies many areas where we can make improvements.

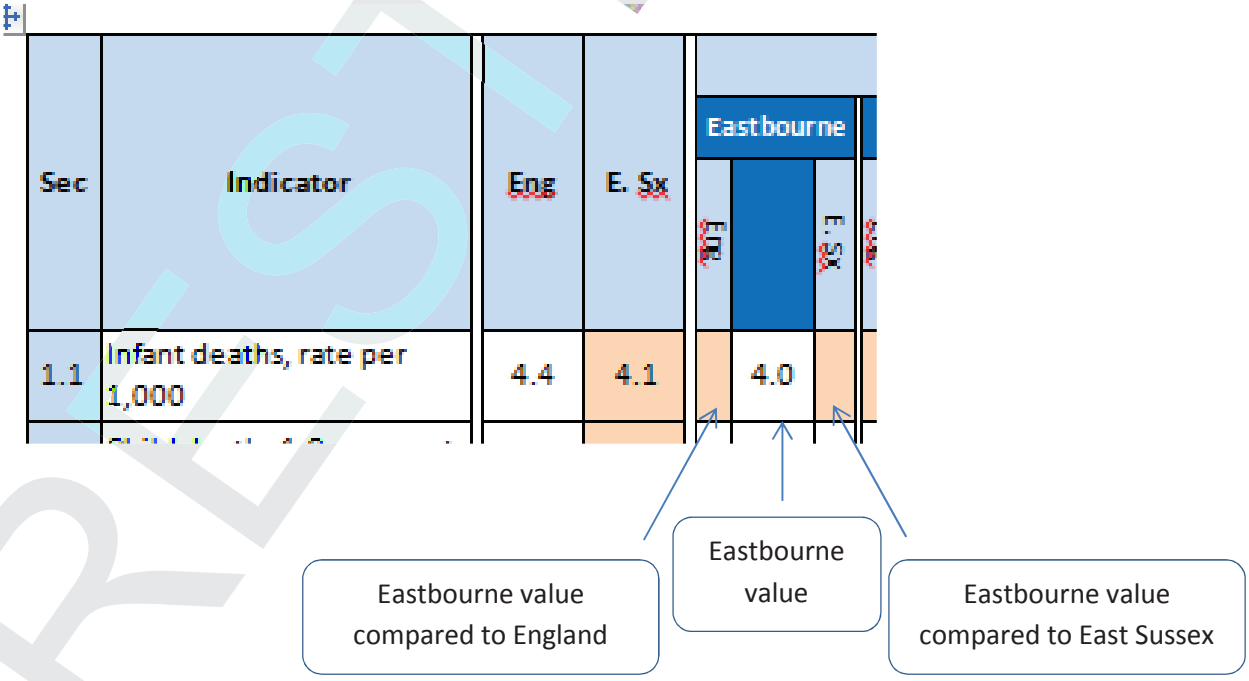
Overall the report shows that for many indicators, East Sussex performs well compared to national rates. However, there is marked variation at CCG and district and borough level, so even where indicators are similar or better than the national rate at county level, they may be worse at a more local level.

The picture is complex. The table below summarises how East Sussex compares to England and for each of the district and borough local authorities and clinical commissioning groups how they compare to England and to East Sussex.

TABLE KEY

Similar to England/East Sussex
Better than England/East Sussex
Worse than England/East Sussex
Higher than England/East Sussex
Lower than England/East Sussex

Where data are available, the value for each indicator is shown at District, Borough and CCG level. This value has been statistically compared to England and East Sussex as shown below.



Sec	Indicator	Eng	E. Sx	District/Borough														Clinical Commissioning Groups								
				Eastbourne			Hastings			Lewes			Rother			Wealden			EHS			H&R			HWLH		
				Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx
1.1	Infant deaths, rate per 1,000	4.4	4.1		4.0			5.3			3.4			4.6			3.2										
1.2	Child deaths 1-9 years, rate per 100,000	12.0	12.1																							
1.3	Child deaths 10-19 years, rate per 100,000	16.3	17.9																							
2.1	Maternal smoking, %	10.5	12.1		13.3			18.1			6.8			12.9			9.2		13.4			16.2			7.4	
2.2	Breastfeeding, %	44	48		46			38			50			42			55		49			40			54	
2.3	5 in 1 vaccine by age 1, %	93	94																96			92			95	
2.4	MMR by age 5, %	88	89																92			90			90	
3.1	Excess weight age 4-5, %	23	23		24			24			24			23			22		24			24			21	
3.2	Healthy teeth age 5, %	75	80		77			78			85			70			88										
3.3	Injury admissions age <5, rate per 10,000	130	148		158			176			105			170			135		154			180			116	
3.4	School readiness %	71	75		76			73			75			78			79		77			76			77	
4.1	Excess weight age 10-11, %	34	30		31			35			26			34			27		31			35			26	
4.2	2 doses HPV age 12-13, %	n/a	59																							
4.2	1 dose HPV age 13-14, %	89	81																							
4.2	2 doses HPV age 13-14, %	83	75																							
4.3	Smoking age 14-15, %	5.5	7.3																							

Sec	Indicator	Eng	E. Sx	District/Borough												Clinical Commissioning Groups								
				Eastbourne			Hastings			Lewes			Rother			Wealden			EHS			H&R			HWLH	
				Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx
4.4	Regular alcohol drinking age 15, %	6.2	7.8																							
4.4	Alcohol in last week age 15, %	n/a	36																							
4.4	Cannabis age 15, %	10.7	15.6																							
4.5	Positive life satisfaction age 15, %	64	62																							
4.6	Mental health admissions age <18, rate per 100,000	87	108		108			107			118			93			108			107			96			114	
4.7	Self-harm admissions age 10-24, rate per 100,000 (2015/16)	431	457																							
4.7	Self-harm admissions age 10-24, rate per 100,000 (2013/14 to 2015/16)	n/a	457		435			598			501			469			343										
4.8	Suicide age 15-19, rate per 100,000	4.8	n/a																							
4.9	KSI on roads age <16, rate per 100,000	17.1	21.5																							
4.9	KSI motorcyclists age 15-24, rate per 100,000	23	47																							
4.9	KSI car occupants age 15-24, rate per 100,000	29	54																							
4.10	Teenage conceptions, rate per 1,000	20.8	19.3		22.2			29.5			17.7			23.9			9.9										

Sec	Indicator	Eng	E. Sx	District/Borough												Clinical Commissioning Groups								
				Eastbourne			Hastings			Lewes			Rother			Wealden			EHS			H&R			HWLH	
				Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx
4.11	Overall school absence age 5-15, %	4.6	5.1																							
4.11	Persistent school absence age 5-15, %	10.5	12.4																							
4.12	NEET age 16-17, %	3.0	3.6		4.6			4.6			3.6			3.1			2.2									
5.1	Child poverty, %	20.1	18.6		21.0			28.7			15.8			19.2			11.4			19.0			25.0			12.0	
5.2	Child protection plan, rate per 10,000	43	45		32			120			22			38			24			35			84			18	
5.3	Looked after children, rate per 10,000	62	53		51			76			31			57			32			53			67			26	
6.1	Asthma admissions age <19, rate per 100,000	207	199																	249			249			98	
6.2	Cancer incidence age <20, rate per 100,000	15.1	15.4																							
6.2	Cancer mortality age <20, rate per 100,000	2.5	3.3																							
6.3	Controlled diabetes, %	7	n/a																	0			0			8	
6.4	Pupils with SEND, %*	14.4	13.3		12.3			14.4			14.2			12.7			10.6			12.0			13.7			12.3	
6.5	Epilepsy admissions age <19, rate per 100,000	74	89																	113.2			101.9			50.4	
6.6	Autism Spectrum Disorder, rate per 1,000*	12.5	13.3		19.7			14.8			12.8			14.4			12.0			18.4			14.6			10.1	

n/a = not available * Data relating to a child's residency differs between national and local data making statistical comparison inappropriate

Mortality

There were 88 deaths in children under-one year in East Sussex between 2011 and 2015. This is an average infant mortality rate of 3.34 per 1,000 births and similar to the England rate of 3.85. This is lower than the rolling 10 year average rate (2006-2015) in East Sussex of 4.1 per 1,000 and of 4.4 per 1,000 in England.

Almost all of the most common causes of infant death are associated with inequalities. Babies born to mothers experiencing greater levels of deprivation are more likely to die than the babies of better-off mothers. Promotion of healthy lifestyles in women of childbearing age including advice about healthy weight, stopping smoking and reducing alcohol use will go some way to addressing infant mortality as will providing new parents' advice about safe sleeping and accident prevention.

After infancy, the highest rates of death in children and young people are in late adolescence. The majority of deaths are preventable. Deaths specifically due to road traffic injuries and suicide account for the majority of deaths among older adolescents. Focusing on preventing the two main causes of death among older adolescents will assist in reducing the number of deaths in this age group.

Conception, pregnancy and infancy

Pre-conception, pregnancy and infancy are all stages where lifestyle factors have a major role in the future health and wellbeing of babies and children. It is well documented how smoking, alcohol and substance use and exposure to domestic violence can all have a detrimental impact on the health status of the developing fetus and the baby/ child once born.

Smoking during pregnancy is one of the most important modifiable risk factors for improving infant health. The proportion of East Sussex women smoking at the time of delivery is 2% higher than the England average which is statistically significant.

Smoking in pregnancy is highest in Hastings followed by Eastbourne and related to deprived populations and in mothers under 20 years of age. Mothers from the most deprived quintile are five times more likely to smoke in pregnancy than mothers from the least deprived quintile. In addition to monitoring smoking status, all maternity services must ensure that smoking is addressed early in all pregnancies and that all women have access to equitable and tailored smoking cessation services which are appropriate to their needs.

Breastfeeding has physical and mental health benefits for mother and baby which last beyond the period of breast-feeding.

Breastfeeding at 6-8 weeks in East Sussex is 47.6% which is slightly higher than the England average of 44.4% though the rates are not increasing. Both younger women and women in more deprived areas are less likely to breastfeed. All women should be made aware about the benefits of breastfeeding before they give birth and provided with timely and adequate support to start and continue breastfeeding.

Early Years

Vaccination in early childhood is key in protecting children against serious and potentially fatal diseases. By 12 months of age, babies should have received several vaccinations, including three doses of the 5-in-1 vaccination (from August 2017 this became the 6-in-1 vaccination). At CCG level, Eastbourne, Hailsham and Seaford CCG achieve the national target of 95% coverage which is sufficient to provide herd immunity. High Weald Lewes Havens CCG achieves 94.6% coverage, but Hastings and Rother falls short of the target at 92.1%. Coverage of vaccination also varies by deprivation quintile and by GP practice. Uptake of two doses of Measles, Mumps and Rubella (MMR) vaccination by age 5 is lower than uptake of the 5-in-1 vaccination and is slightly higher than

the national rate. Practices with the lowest vaccination rates should be identified and plans put in place to improve coverage.

Weight when a child starts primary school is an important predictor of health outcomes later in life. Nearly one in four children in East Sussex are classified as overweight or obese during their reception year of primary school, similar to the England average. There has been minimal overall improvement in the proportion of East Sussex children classified as having a healthy weight during their reception year of primary school over the past decade. The overweight and obesity prevalence for children living in the most deprived areas in East Sussex is significantly greater than it is for those living in the least deprived areas. A range of interventions is required to promote healthy weight in children, including both access to healthy food and opportunities for physical activity; and to target critical periods in the life course. A programme to transform how nurseries and schools in East Sussex embed evidence -based health improvement activity into their work is being delivered.

Good oral health is an important component of overall health and wellbeing for children. Despite tooth decay being almost entirely preventable, and decay rates being lower in East Sussex than England, just over one in five children aged 5 years across East Sussex have evidence of tooth decay. Nationally rates are higher for those in deprived populations. Supervised teeth brushing at least twice a day, reduced sugar consumption and regular access to a dentist are crucial in preventing tooth decay.

Accidents are preventable, yet unintentional injuries are a major cause of ill health and disability in children in East Sussex and England. In 2015/2016 there were 419 injury-related hospital admissions across East Sussex for children under five years. This is a rate of 148 per 10,000 population, significantly higher than the England rates of 130 per 10,000. A total of 67% of non-traffic accidents in children aged under 5 requiring hospital admission in East Sussex were recorded as happening at home, although a further 18% are coded as unspecified, so the true figure could be higher.

Despite recent decreases, Hastings still has the highest admission rates in the county.

Injury reductions can be achieved at low cost through parent education, key staff group training and local coordination including the Home Safety Equipment Scheme.

School readiness is an important measure of early years development across a wide range of learning areas and has been linked with better academic outcomes from primary and secondary education as well as positive behavioural and social outcomes in adulthood. In East Sussex 75.4% of children reach a good level of development at the end of reception, significantly above the England average of 71%. All five districts and boroughs achieve above the national average. In East Sussex, fewer children eligible for free school meals (FSM) reach the expected level of achievement in phonics compared to their non-FSM peers. Boys eligible for FSM are further behind their non-FSM peers than girls eligible for FSM are.

School age/adolescence

Like weight earlier in childhood, weight at the end of primary school is an important predictor of health outcomes both in childhood and later in life. Currently, almost one third of children in East Sussex are classified as overweight or obese during their final year of primary school, with the percentage of Year 6 children in Hastings classified as overweight or obese being significantly worse than East Sussex. There has been minimal overall improvement in the proportion of East Sussex children classified as having a healthy weight during their final year of primary school over the past decade, although there was a decrease in the proportion of obese children in East Sussex in 2016/2017. The overweight and obesity prevalence for children living in the most deprived areas in East Sussex is significantly greater than it is for those living in the least deprived areas.

The promotion of healthy weight in children needs to include a range of interventions to both reduce the obesogenic environment and target critical periods in the life course.

The Human Papilloma Virus (HPV) vaccination during adolescence is a highly effective public health measure to prevent cervical cancer and genital warts. The national HPV immunisation programme was introduced in September 2008 with all girls in school year 8 (aged 12 to 13 years) offered the vaccine against HPV infection, with a 'catch-up' campaign for girls aged from 14 years to less than 18 years. In East Sussex we are currently below both the Surrey Sussex and national uptake rates for HPV. Due to problems with service delivery the schools-based and community vaccination service for children and young people is being re-procured by NHS England. Additionally, girls from a black and ethnic minority backgrounds, and girls not in mainstream education are less likely to take up or complete the vaccination course.

Smoking continues to be the greatest single cause of avoidable mortality in the UK. Starting to smoke during adolescence increases the likelihood of being a life-long smoker. Latest figures from a national survey show that more 15-year-olds in East Sussex smoke regularly (7.3%) than the South East or England (5.8%, 5.5%). A 2017 local survey showed that 11% of girls and 8% of boys in year 10 have had a cigarette in the last week. Significant inequalities in adolescent smoking persist, with higher rates of smoking in young people from deprived populations. Smoking is rarely initiated after adolescence so prevention during this critical period is essential. Tobacco control measures across the whole population are the most effective measures for reducing smoking and smoke exposure in children and young people.

Over the last 13 years alcohol and cannabis use in young people has reduced in East Sussex. However, compared to England significantly more young people drink regularly or have tried cannabis. 2017 local survey data suggest that rates are no longer falling. Health promotion activities at school are a vital opportunity for intervention, given that alcohol and drug use among school-aged children are linked with negative social and health outcomes into adulthood.

In East Sussex just over 61.6% of young people reported positive life satisfaction in a 2014/15 national survey, although life satisfaction appears to be higher in boys than in girls. Bullying and disruptive behaviours at school are linked with lower levels of wellbeing amongst young people whilst higher levels of life satisfaction are linked to physical activity, reducing screen time, nutrition, and good mental health.

Mental health problems during childhood and adolescence are associated with a wide range of adverse outcomes in later life, including higher rates of adult mental health problems, poor educational outcomes, unemployment, low earnings, teenage parenthood, marital problems, criminal activity, and shorter life expectancy. East Sussex has a similar rate of hospital admissions for mental health disorders to England (2015/16 data). Inpatient admissions for mental health disorders are indicative of early help for emerging mental health disorders not being available in a timely way or being effective. The self-harm admission rate for those aged 10-24 years in East Sussex is around 457 per 100,000. This has risen from around 275 per 100,000 in 2011/12 and is now similar to the England rate. Within East Sussex, rates of self-harm admissions are highest in Hastings and lowest in Wealden. The focus of preventive work should be on promoting resilience, and early recognition and provision of help, particularly in schools and colleges.

In East Sussex, suicide is the second most common cause of death in young people aged 15 to 19, and accounts for 18% of deaths. In young people, suicide is strongly linked with self-harm, bereavement, poor mental health, alcohol and drug misuse, abuse, academic pressures, and bullying. Suicide is preventable: improving emotional and mental health support and limiting access to the means of suicide are essential to reduce suicide rates amongst young people.

In East Sussex, road traffic accidents are the main cause of death in young people aged 15-19 years, accounting for 26% of deaths. East Sussex rates of children aged 0 -15 who are killed or seriously injured on the road are similar to England and have slightly reduced over the last five years. East Sussex has significantly higher rates of young people aged 15-24 years killed or seriously injured on the road in both cars and motorbikes compared to national rates. There is a two year Road Safety Programme to reduce those killed or seriously injured on East Sussex roads.

The sexual and reproductive health of young people is an important indicator of population health. In East Sussex, the teenage conception rate has been reducing since 1998 and this matches the national trend. Rates of teenage conception are linked to deprivation and vary by district and borough with Hastings Borough Council having a consistently higher rate and Wealden District Council having a consistently lower rate. In East Sussex we are promoting access to high quality relationship and sex education, as well as good access to young-people friendly sexual and reproductive health services. Early and coordinated support is needed for young parents to improve outcomes for themselves and their children.

Non-attendance at school or school absence is linked to academic underachievement, anxiety, challenging behaviour and further non-attendance. Truanting and non-attendance can also place children and young people at greater risk of Child Sexual Exploitation Overall absence (OA) rates in East Sussex are 5.1% which is slightly higher than England at 4.6%.

Young People who are not in education, employment or training are at greater risk of poor physical health, depression, low skilled jobs or unemployment and early parenthood compared to their peers who are actively engaged in learning or working. In East Sussex, 3.6% of 16-17 year olds are not in employment, education or training (NEET) which is a slightly higher proportion compared to England at 3.1%. However, East Sussex has a much lower proportion of young people of unknown status (0.9%) compared to England (2.8%). In the more deprived boroughs of Hastings and Eastbourne 4.5% of 16-17 year olds are NEET. East Sussex County Council (ESCC) Standards, Learning and Effectiveness Service commission the Youth Employability Service (YES) to work closely with schools to identify young people at risk of becoming NEET and provide additional support to those vulnerable groups during transition from school to further education or training.

Family and social environment

Children growing up in poverty are likely to do less well across a range of outcomes including health, cognitive and emotional development, and education. The effects of poverty last through the life-course and also influence long term social outcomes. Although child poverty rates in East Sussex are lower than England, nearly one in five children in East Sussex are living in poverty (18%).At a district and borough level, Hastings has highest level of children in poverty and Wealden the lowest. Hastings and Eastbourne have significantly higher rates of child poverty than East Sussex overall, and Lewes and Wealden significantly lower. Improving the health outcomes of children living in poverty requires provision of good quality, effective and universal prevention and health care services.

The Troubled Families programme (TF) was set up by the government to transform the way services work with families with multiple health or social problems including absence from school and worklessness. East Sussex is in the top 10% of local authorities for engaging families in the TF2 programme and for successfully achieving progress with families (2,192 families supported as of 31st July 2017). The average length of engagement with a family is eight months. For many families the TF programme acts as early intervention and improves outcomes for families as well as preventing the need for more costly involvement of statutory services. Households with young carers account for almost 1 in 4 of families involved in the TF programme in East Sussex.

A child protection (CP) plan is put in place when a child is considered in need of protection from neglect or physical, emotional or sexual abuse. In East Sussex between 2012 and 2017, the number of children in the child protection system decreased from 64.6 to 45.0 per 10,000 and is now similar to the England average. Rates are highest in Hastings and lowest in Lewes and Wealden. Children with CP plans are a vulnerable group at greater risk of physical and mental health issues. Good data is essential to support effective service delivery and to improve the health outcomes of children and young people in the child protection system.

In 2017 there were 53 children per 10,000 aged 0-17 years who were looked after by the local authority. There has been an overall decrease in numbers of Looked After Children (LAC) from 620

in 2012 to 560 in 2017. East Sussex is now below the England average and slightly below the South East average. There are large differences in the rate of LAC between districts and boroughs, with more deprived areas having higher rates. Children who are LAC generally have worse physical and emotional and mental wellbeing than their peers. Some LAC do not achieve their academic potential, particularly if they enter the care system when they are older. In East Sussex the Virtual School works to support LAC through education and improve outcomes.

Health conditions of childhood

Asthma is a common lung condition that often starts in childhood. Emergency admission rates for asthma in children vary across East Sussex. Admissions due to asthma for children and young people (0-18 years) are similar for East Sussex compared to the England average. Evidence suggests that up to 70% of all asthma admissions are preventable through better management in primary care.

Cancer in children under the age of 15 is rare and accounts for less than 1% of all new cancer cases in England. More than 8 out of every 10 children diagnosed with cancer will live for at least 5 years, and most of these children will be cured. The number of children surviving five years following a cancer diagnosis has doubled since the 1970s. This reflects improvements in treatment and care. Cancer causes only 1 in 100 (less than1%) of all deaths in children. Children's cancers mortality rates have decreased by 66% since the early 1970s in the UK. Services need to be able to consider each case of cancer individually, taking into consideration the clinical and wider needs of each child and young person, and their families and carers.

The incidence of type-1 diabetes is increasing and accounts for 97% of all children with diabetes in England. The UK has one of the highest rates of type-1 diabetes in the world, for reasons that are currently unknown. When diabetes is not well managed, it is associated with serious complications including heart disease, stroke, blindness, kidney disease and amputations leading to disability and premature mortality. Very few children and young people in East Sussex have glycated haemoglobin (HbA1c) levels below the maximum target of 48mmol/mol. Although a higher proportion have HbA1C levels below 58mmol/mol (the pre-2015 target) than nationally. There are higher emergency admission rates for children and young people with diabetes from more deprived areas in East Sussex. Schools have an important role to play in supporting children and young people with type-1 diabetes to manage their diabetes.

Local authorities have a statutory duty to identify and support children and young people with disabilities and learning difficulties. In East Sussex there are currently 13% of children and young people identified as having a special or additional educational need, compared to 14% in England. In line with the national trend, the recorded SEN population in all CCGs and Districts and Boroughs in East Sussex has declined, most rapidly since the start of the transitional stage to Education Health and Care (EHC) Plans in 2014. Children with special educational needs or disabilities (SEND) or additional support needs (ASN) are more likely to come from low income families. This may be partially linked to caring duties preventing parents from full employment.

Epilepsy is a common neurological disorder characterised by recurring seizures. The nature of epilepsy means that it can be difficult to diagnose accurately. There is a strong relationship between emergency epilepsy admission rates for children and deprivation across East Sussex. For many children and young people diagnosed with epilepsy the seizures can be controlled through treatment with an anti-epileptic drug or other interventions. Optimal management improves health outcomes and can help to minimise other impacts on children and young people's social relationships, educational outcomes and employment.

Autism is a lifelong developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them. Children and young people with autism are also at higher risk of some physical health conditions such as epilepsy, or stroke as well as mental health problems including anxiety. Children and young people with autism

often find it hard to access health services and may have co-morbid symptoms dismissed. Children with autism are also much more likely to be formally excluded from education that their peers (27% compared to 4%). Over one in four (26%) of those who do succeed in education and graduate remain unemployed. East Sussex has a higher rate of children recognised by schools as having Autism Spectrum Disorder (ASD) compared to the national average, but is below the average for the South East. Since 2013 there has been a steady increase in the rate of children recognised as having ASD by schools in East Sussex.

Palliative care for children differs from that of adults, and by comparison, the number of children dying is relatively small. New draft National Institute for Health and Care Excellence (NICE) guidance on best practice about end of life care has recently been issued for consultation. High-quality end of life care for children and young people requires a *holistic approach which recognises the needs of the child or young person and their families and* carers.

Recommendation

Nationally, the profile of children and young people's health and wellbeing within the new models of care has been relatively low yet they provide an opportunity to improve the quality of services for children and young people, increase efficiency and improve outcomes.

Improving children and young people's health and wellbeing is a top priority in the accountable care system in East Sussex to ensure that we are not just making gains in health outcomes now but improving the long-term outcomes of future adult populations.

So there is only one recommendation in this report:

Continue to implement the key actions agreed by partners as outlined in each chapter, and in doing so ensure a focus on prevention, as almost all poor outcomes are preventable, and on reducing inequalities, as the majority of poor outcomes have a relationship to deprivation.

In making this recommendation it is important to acknowledge the unprecedented financial pressures on all parts of the system and the need to get value for every penny of public money spent. When local authorities and National Health Service (NHS) organisations are under pressure to cut costs within reduced budgets, making the case for investment in prevention of any kind can be difficult.

We have to make sure that we are using resources efficiently now. Are we allocating resources to the right activities (the ones that achieve the best outcomes within the resource envelope) and are we delivering those outcomes in the most efficient way?

Investing in prevention and early intervention to support and maintain health and wellbeing and prevent ill-health will not produce immediate cash savings. However, it is vital for the long-term sustainability of the system. The financial challenge can only be tackled by adopting a system-wide approach, rather than budgets for prevention, treatment and care operating in silos. A system-wide approach is being adopted in East Sussex through **East Sussex Better Together** (the accountable care system being developed based on an integrated Primary and Acute Care System Model). We are building an accountable care system that integrates our whole system: primary prevention, primary and community care, social care, mental health, acute and specialist care for children and young people and adults. However, a system-wide approach still necessitates prioritisation and choices to be made and all parts of the system being open and honest in the debate on future levels and sources of funding.

CHAPTER 1
Mortality
1.1 Infants (under one year)

Number of infant deaths per 1,000 live births

Key messages

- Improvements in maternity and neonatal intensive care, as well as general health care, have led to a reduction in infant mortality since the 1970s.
- There were 88 deaths in children under-one year in East Sussex between 2011 – 2015. This is an average infant mortality rate (IMR) of 3.34 per 1,000 births and similar to the England rate of 3.85.
- Deaths of children under one year of age account for over 50% of all child deaths in East Sussex, and 40% of all child deaths were children under 28 days (April 2008 - March 2017 data).
- Maternal health and health behaviours are the most frequent cause of infant mortality (56%) in East Sussex, followed by chromosomal and genetic anomalies (25%).
- There is a statistically higher rate of infant mortality in the most deprived wards compared to the least deprived.

What is this indicator showing us?

This indicator shows the number of deaths under one year of age per 1,000 live births each year, also known as the infant mortality rate (IMR). Figure 1.1.1 shows the 5 year rolling average mortality rate.

Other important indicators focus on:

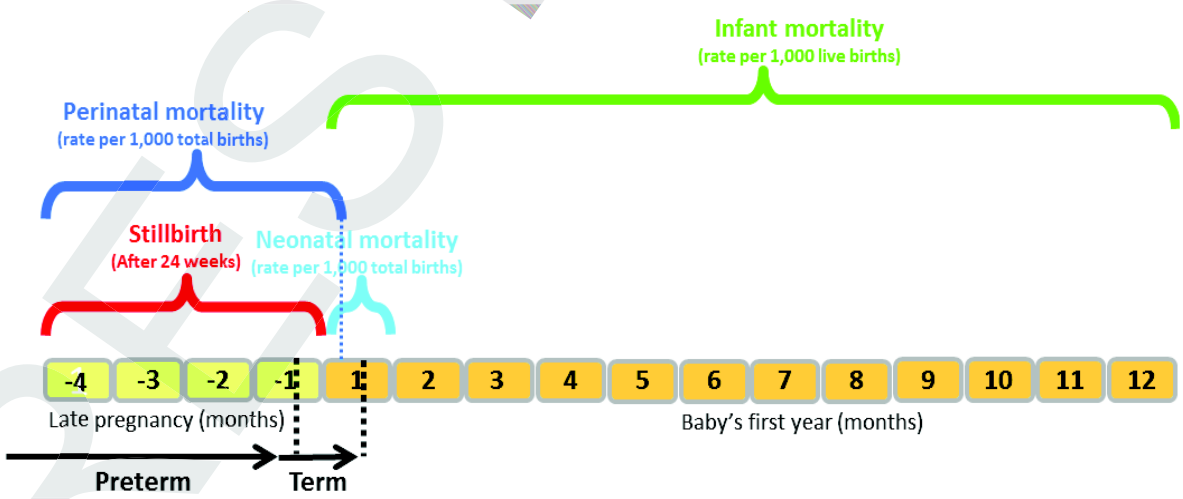
Perinatal mortality [PNMR]:

Perinatal mortality includes: stillbirths (a baby born without signs of life after 24 weeks gestation); and those babies who die within 7 days of birth. Stillbirths account for half of all perinatal deaths. Rates are calculated per 1000 total births.

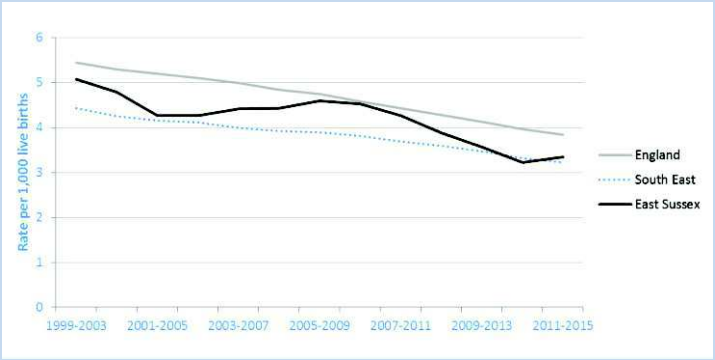
Neonatal mortality: Death before the age of 28 completed days after live birth. Rates are calculated per 1000 live births.

Infant mortality [IMR]: Deaths of infants in the period from birth to less than 1 year of age. Rates are calculated per 1000 live births.

Post neonatal mortality: Deaths of infants from 28 days to 364 days old. Rates are calculated per 1000 live births.



Infant mortality rates in East Sussex, South East and England

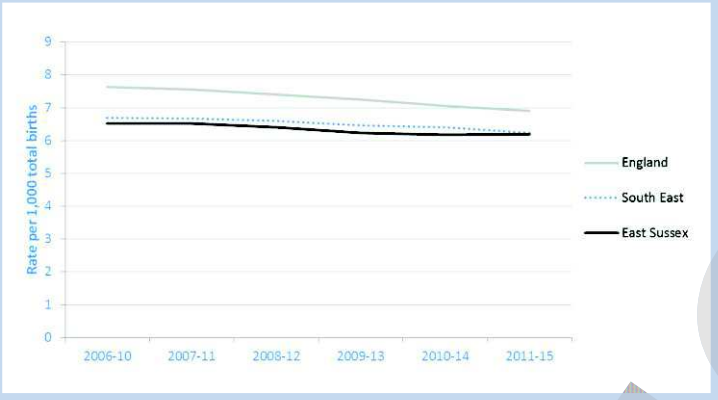


Latest data The2011- 2015 average IMR in England was 3.85 deaths per 1,000 live births compared to 3.34 deaths per 1,000 live births in East Sussex.

Trend: The IMR across the UK has been declining since 1999. However, in the year 2015 there was the first increase in the infant mortality rate in England and Wales since 2003. The rate rose to 3.7 deaths per 1,000 births from the record low of 3.6 in 2014, but remains low in historical terms.

Source: ONS, Vital Statistics

Figure 1.1.1: Infant mortality rates per 1,000 live births in East Sussex, (5 year moving average) 1999 to 2015

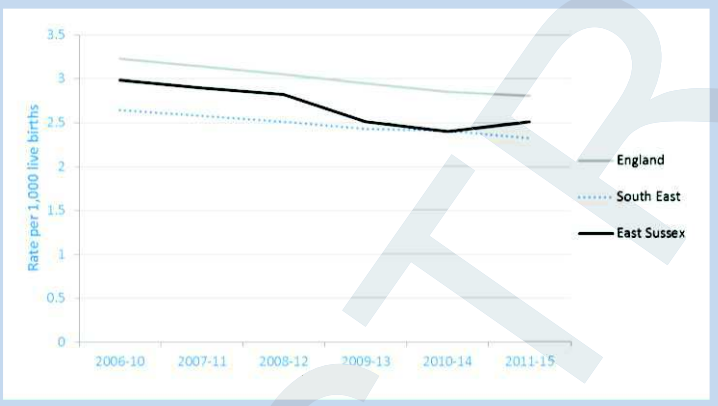


Latest data: The perinatal mortality rate [PNMR] is shown as a five year moving average rate between 2006 and 2015, in view of the small numbers. The PNMR in East Sussex for the period 2011-15 was 6.2 per 1,000 total births

Trend: The rate of perinatal deaths in the UK has declined over the past two years, largely driven by a drop in rates of stillbirth, particularly those occurring in late pregnancy. East Sussex has not seen the same decline.

Source: ONS, Vital Statistics

Figure 1.1.2: Perinatal mortality rates per 1,000 total births in East Sussex, South East Region and England (5 year moving average) 2006-2015



Latest data: The most recent published data are from 2015 and show East Sussex with a higher neonatal mortality rate than the South East but lower than England

Trend: In 2015 the neonatal mortality rate in East Sussex, increased but overall it is lower than it was in 2006-10 in parallel with the declining rate in England

Source: ONS, Vital Statistics

Figure 1.1.3: Neonatal mortality rates (deaths from 0-28 days of age) per 1,000 live births 2006-15 (5 year moving average)

Latest data: The most recent published data are from 2015.

Trend: There has been a steady decrease in the East Sussex post-neonatal mortality rate

Source: ONS, Vital Statistics

Figure 1.1.4: Post-neonatal mortality rate per 1,000 live births in East Sussex, (5 year moving average) 2006 to 2015

Why is this indicator important?

The IMR is frequently used as an indicator of wider population health and of access to, and quality of, healthcare services for children and mothers. Infant deaths account for the majority of all child deaths.

Infant deaths are categorised as neonatal (within the first 28 days of birth) or post neonatal (after 28 days but less than a year). Neonatal deaths count for between 70% and 80% of *infant* deaths, or around 50% of all child deaths nationally. The main causes of neonatal deaths are related to perinatal causes including maternal health and health behaviours e.g. smoking and obesity, followed by genetic or congenital anomalies. Premature babies tend to have a different pattern of causes of death from term babies.

Infant deaths after 28 days are due to a range of causes, including genetic anomalies and sudden infant death syndrome (SIDS). Unsafe sleeping arrangements and parental smoking are risk factors for SIDS which can be reduced through health promotion to parents.

Low birth weight (LBW, weight less than 2,500 grams) is one of the known risk factors for infant deaths. LBW babies have much higher IMR than babies of normal birth weight. In 2015 a smaller proportion of East Sussex babies were born with LBW (6%), compared to England (7.4%).

Nationally, IMR stratified according to birth weight in 2015 were:

- Very Low Birth Weight babies (under 1,500 grams) **159.6** deaths **per 1,000** live births.
- Low Birth Weight babies (under 2,500 grams) **31.6** deaths **per 1,000** live births.
- Birth weight (above 2,500 grams) **1.1** deaths **per 1,000** live births

Where are we now in East Sussex?

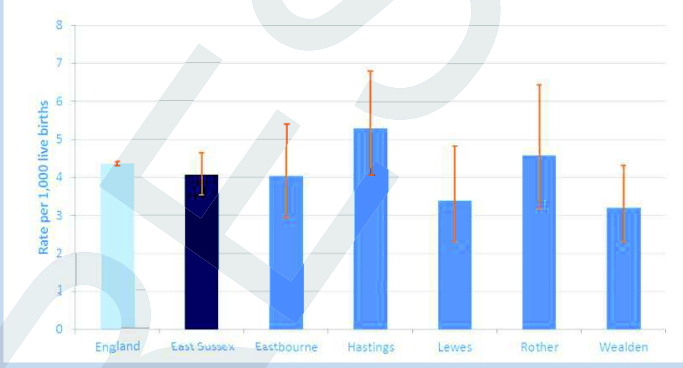
In the three East Sussex Clinical Commissioning Groups (CCGs) there were 53 infant deaths in total for the period 2013-15 which is an IMR of 3.4 per 1,000 births.

Table 1: Infant Mortality in East Sussex CCGs 2013-15

	Number of infant deaths	Rate per 1,000 live births
Eastbourne, Hailsham and Seaford CCG	18	3.3
Hastings and Rother CCG	24	4.4
High Weald Lewes Havens CCG	11	2.5
East Sussex	**53**	**3.4**

Source: PHE, Child Health Mortality Profiles

In East Sussex, the two constituents of the IMR, neonatal and post neonatal mortality, have both shown marked declines over the last ten years. However this progress cannot be taken for granted as the most recent figures (2015) show a slight increase in neonatal mortality rate. The post neonatal component of infant mortality has been declining more rapidly than the neonatal component.



Latest data: As the annual number of deaths per individual district or borough is low we use a ten year average IMR to make comparisons. Between 2006 and 2015 the East Sussex and the lower tier authority rates are not significantly different from the England rate of 4.4 per 1,000 live births. Furthermore, whilst the rate in Hastings 5.3 per 1,000 live births) is higher for the ten year period, it is not statistically significant.

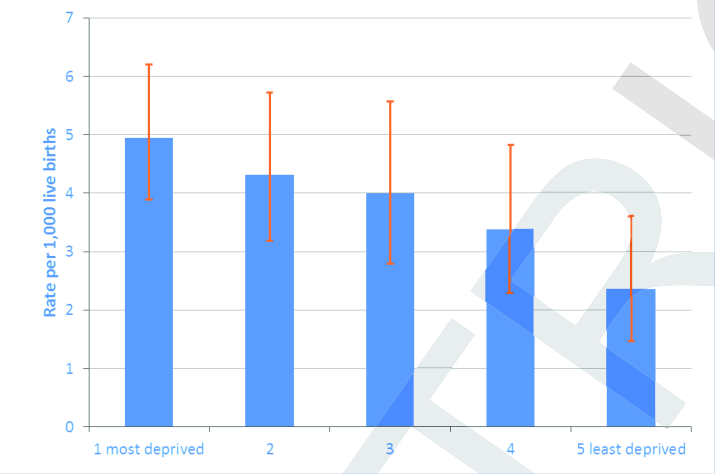
Source: ONS, Vital Statistics

Figure 1.1.5: Infant mortality rate per 1,000 live births in East Sussex by district and borough, (10 year average) 2006-15

Spotlight on inequalities

National data shows an association between higher deprivation and higher rates of infant mortality. In East Sussex this pattern can also be seen with a statistically higher rate of mortality in the most deprived wards compared to the least deprived. Almost all of the most common causes of infant death are associated with inequalities. Babies born to mothers experiencing greater levels of deprivation are more likely to die than the babies of better off mothers. Mothers from more deprived groups are more likely to experience a range of complex social factors which impact on their health and the health of their baby such as exposure to stress, smoking in pregnancy, poorer nutrition, and to substance misuse substances. These factors contribute to the increased risk of LBW for babies of mothers from more deprived groups. Being overweight or obese contributes to an increased risk of pre-term and induced pre-term birth. Rates of protective behaviours e.g. breastfeeding and recommended practices such as safe infant sleeping arrangements, including placing a baby on his or her back, are higher in more wealthy groups.[2]

There is an association between young maternal age and higher infant mortality, partially explained by very young mothers tending to come from more deprived backgrounds. The IMR for babies born to mothers under 20 is almost 80% higher than the IMR for babies born to mothers aged 25 to 29 years in England and Wales (6.1 deaths compared to 3.4 deaths per 1,000 live births). Overall the IMR across the UK has been declining. However, the rate has been rising for the poorest children since 2010, while continuing to fall for more advantaged groups, demonstrating widening inequalities.[3]



Latest data: Looking across the county of East Sussex over the past 10 years the IMR is statistically significantly higher in the most deprived wards [quintile 1] of the Income Deprivation Affecting Children Index [IDACI] compared with the least deprived wards [quintile 5].

Source: NHS Digital, Primary Care Mortality Database

Figure 1.1.6: Infant mortality rate per 1,000 live births in East Sussex by deprivation (IDACI quintiles), (10 year average) 2006-15

What does good look like?

Infant and neonatal mortality rates for East Sussex (3.4) are lower than rates for England but slightly higher than rates for the South East, whereas the perinatal mortality rate for East Sussex has been consistently lower than both the South East region and England rates. A quarter of areas in the country had an annual IMR of 3.1 or below in 2015, with the best in England being a rate of 2 per 1,000 in the London Borough of Havering.

The IMR in the UK has fallen over the last 20 years, but progress has not been as fast as in other wealthy European countries, which means that the UK is falling behind the best in Europe. One international study found that the UK was in the bottom 10% of comparable countries in 2008.

How can we improve?

There is much we can do to reduce IMR - tackling preventable risk factors and promoting exposure to protective factors will increase infant survival. Like many health improvement programmes, reducing infant mortality requires both policy changes to influence change at a population level, as well as individual and targeted changes in behaviour and practice.

Infant death rates are highest amongst the most economically and socially disadvantaged families, therefore Government actions to **reduce poverty and inequalities** are important for improving infant survival. The majority of policies which can be socially protective e.g. child care, housing, tax and welfare policies are set at a national level and not within the control of local health and social care systems.

Maximising the health and wellbeing of women before conception and both during and after pregnancy is essential. Services to promote healthy lifestyles including nutritional advice, weight management and smoking cessation are important preventative interventions. Reducing smoking during and after pregnancy is vital to reducing infant mortality as smoking is a major risk factor for poor pregnancy outcomes, including impaired foetal growth and development, increased risk of stillbirth, preterm birth, low birth weight, as well as the development of some congenital abnormalities (see Indicator 2.1 for further detail).

Underweight and overweight women are at increased risk of adverse outcomes during pregnancy. For overweight or obese mothers even a small increase in body mass index (BMI) leads to higher risk, and both obesity and gestational diabetes are strongly associated with an increased risk of stillbirth. Good pre-conceptual care includes folic acid supplements to prevent birth defects such as spina bifida, as well advice to ensure pregnant women have sufficient vitamin D, vitamin C, iron and calcium in their diets.

Implementing the recommendations of Better Births: the NHS plan to improve the choice and personalisation of local maternity services and the safety of maternity care[4].

Universal midwifery and health visiting services play an important role in supporting new mothers through advice and education about looking after their new baby**.** Health professionals **promote protective factors** such as **breastfeeding** and skin to skin care, particularly for babies born early. Not all mothers find it easy to breastfeed, or are discouraged by expectations of others, so non-judgemental infant feeding support is essential (see Section 2.2 for further detail). Working to **reduce risk factors** such as **unsafe sleeping** arrangements and **exposure to second hand smoke** also has a substantial role**.** Both are associated with Sudden Infant Death Syndrome [SIDS].

Maternal mental health has a strong influence on outcomes for both child and mother, as well as affecting the rest of the family. Raising awareness of symptoms, protective factors and how to get support are vital.

Vulnerable mothers: young mothers, first-time parents, and mothers exposed to domestic violence, substance misuse or mental health problems are all at increased risk of infant mortality (see Section 4.9 for approaches to reduce teenage pregnancy).

Research into practice: at a local level it is important to incorporate advances in knowledge of risk and protective factors into health and social care professional practice to reduce the preventable proportion of infant deaths. One recent example of research resulted in advice for women to fall asleep on their side, including daytime naps, in the last three months of pregnancy which may reduce the risk of having a stillbirth.

What are we doing in East Sussex?

Our multi-agency, partnership working across East Sussex through East Sussex Better Together (ESBT) and Connecting 4 You (C4Y) programmes includes a focus on prevention and activity to address infant and child mortality. Examples of activity include:

- We are **supporting women to lead healthy lifestyles in the pre-conception period** through targeted initiatives such as embedding preconception advice in sexual health and contraceptive clinics.
- All pregnant women who indicate they are smokers are provided **with advice and information on the importance of stopping smoking during pregnancy**, and automatically referred to stop smoking services ('opt – out' referral). Our maternal smoking pathways are being reviewed to ensure that effective ways of enabling women to stop smoking during pregnancy are embedded as part of routine maternal care.
- Health visitors and the integrated 0-5 children's service have **achieved level 2 UNICEF UK Baby Friendly Initiative (BFI) accreditation** for support of breastfeeding and healthy weaning.
- **Embedding of the Royal College approved Baby Buddy mobile phone application** for pregnant and new mums into local maternity and health visiting pathways. Baby Buddy provides accredited parent friendly information and advice for pregnant women, new mums and their partners to help women and their babies stay healthy and well. This includes breastfeeding and mental health advice and support for the healthy emotional and physical development of babies.
- **Advice on reducing risks for SIDS** are clearly communicated to new parents during routine midwife and health visitor contacts as well as through local safe sleeping campaigns.
- **Vulnerable mothers receive additional support from health visitors** with a focus on addressing identified risk factors and needs.
- In Hastings and Rother **enhanced ante-natal support for women most likely to experience health inequalities is being piloted** to support women in preparing for birth and parenthood.

Key actions going forward

- Review action to address maternal smoking **ensuring that every opportunity is taken to support women to stop smoking during pregnancy.**
- Continue to **protect and support health improvement and early intervention service**s such as universal midwifery and health visiting services for mothers, and expand provision of targeted support for younger mothers and vulnerable women.
- **Ensure that policy and strategies to improve maternal and child health are joined up locally**.
- Improve communication; **enable families to spot the signs of illness or failing health**. A recent example of this is the national campaign raising awareness of sepsis being led by Public Health England (PHE). Previous national campaigns have included raising awareness of the signs and symptoms of meningitis.
- Continue to **promote use of the Baby Buddy App** and evaluate uptake and impact.
- **Consider routinely including information on the impact of lifestyle on a healthy pregnancy** to women of childbearing age as part of routine health improvement advice.

CHAPTER 1
Mortality
1.2 Children (one to nine years)

Annual number of deaths of children aged one to nine years per 100,000 Population

Key messages

- Over the last forty years, mortality rates for 1-9 year olds have reduced, but as rates get lower the reduction gets smaller. Since 2006 national rates fell from 14 to 11.6 per 100,000, and East Sussex rates from 15.2 to 12.1.
- Cancer, injuries and poisonings, congenital conditions, and neurological and developmental disorders are the main causes of death; however the effects of preterm births continue to influence mortality rates for up to 10 years after birth.
- In East Sussex, 40 children aged 1 to 4 and 28 children aged 5-9 died over the ten year period 2006 to 2015.
- Children from more deprived areas have a higher risk of death.
- The East Sussex Child Death Overview Panel (CDOP) reviews all deaths of children in and from East Sussex to identify if there were any modifiable factors which may prevent similar deaths in the future.

What is this indicator showing us?

This indicator shows the mortality rate of children aged one to nine years per 100,000 population of that age. Five and ten year average rates have been shown. There were four more deaths in 1 to 9 year olds in the period 2010-14 than in the previous period 2009-13. This accounts for the increase in the rate in 2010-14 which is not statistically significant.

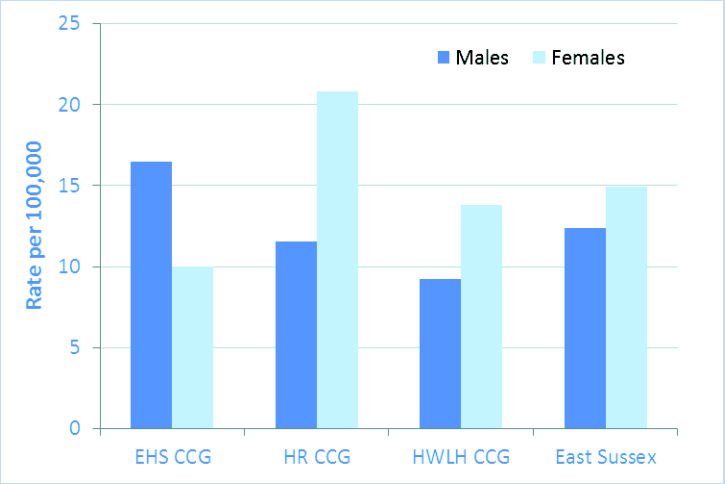
Mortality rates for children aged one to nine in East Sussex, South East Region and England

Latest data: The 2011-15 mortality rate was 12.1 per 100,000 in East Sussex and 11.6 in England.

Trend: Mortality rates [5 year moving averages] have declined over the period 2006 to 2015.

Source: ONS, Vital Statistics

Figure 1.2.1: Mortality rates per 100,000 population aged 1-9 in East Sussex, (5 year moving average) 2006 to 2015



Latest data: In East Sussex, the mortality rate for females aged one to nine is slightly higher than for males, although this is not statistically significant. By CCG, the rate for females is higher in Hastings and Rother and is lower in High Weald Lewes Havens and Eastbourne, Hailsham and Seaford CCGs. This is not statistically significant.

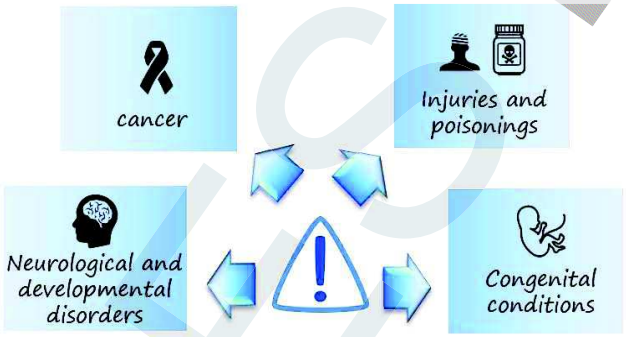
Source: NHS Digital, Primary Care Mortality Database

Figure 1.2.2: Mortality rates per 100,000 population aged 1-9 in East Sussex by CCG by sex, (10 year average) 2006-15

Why is this indicator important?

Although children's health and healthcare has improved over the last 40 years, with a corresponding reduction in the mortality rate, there are still improvements to be made. The UK's recent progress has been significantly lower than in other wealthy European countries. Monitoring the causes of death, analyzing trends and identifying common factors enables preventable causes to be recognized and changes made to practice to reduce deaths.

Factors that contribute to death during childhood differ from those which contribute to death during infancy or adolescence. The main causes of death amongst 1 to 9-year-olds are:



Nationally there are gender differences in the leading cause of death for children aged 1-4: boys die from injuries and poisonings, whereas cancer is the leading cause of death in girls of the same age.

Cancer is the leading cause of death for both boys and girls aged 5-9 years. Boys still remain more likely to die from injuries than girls.

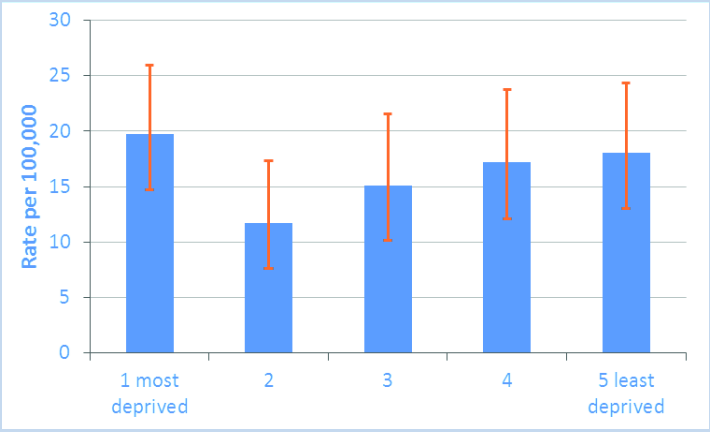
Another significant cause of mortality in children aged 1-9 is the impact of being born preterm. Preterm birth can cause breathing difficulties, difficulties in feeding, jaundice and insults to brain development. Some of these impacts can be permanent.

Where are we now in East Sussex?

Mortality rates for one to nine year olds in East Sussex have declined over the last ten years. The difference between boys and girls is not statistically significant, nor are differences between CCG areas.

Spotlight on inequalities

Nationally there is a strong association between deprivation and mortality during childhood, with social inequalities found to affect many of the leading causes of death among young children.[5] At a county level, as the numbers of deaths are relatively small, the following analysis looks at all deaths of 1-19 year olds over a ten year period. There were 68 deaths in total in 1 to 9 year olds and 97 deaths in total in 10 to 19 year olds in the period 2006 to 15. There is no clear relationship between deprivation and mortality.



Latest data: In East Sussex, when child mortality rates for one to nineteen year olds are viewed across the county over a ten year period there are no significant differences associated with deprivation, as defined by the Income Deprivation Affecting Children Index [IDACI] although there is at national level.

Source: NHS Digital, Primary Care Mortality Database

Figure 1.2.3: Mortality rates per 100 000 population aged 1-19 in East Sussex by deprivation (IDACI quintiles), (10 year average) 2006-15

What does good look like?

East Sussex has a similar mortality rate for 1-9 year olds to England.

In the 1970s the UK was in the best 25% of comparator countries for child mortality, but by 2008 UK child mortality rates were in the worst 25% of similarly economically developed countries. If the UK had the same rate of child mortality as the average of comparator countries it is likely there would be around 130 fewer deaths amongst 1-9 year olds each year.

How can we improve?

In order to reduce child mortality we need to understand the underlying influence and events leading up to the death as well as the immediate cause of death. It is important to identify those events which are **modifiable or preventable**. Some risk factors can be addressed at a local level, but others require national legislation. Healthcare services, familial, social and environmental factors as well as other services and organisations working with the child should all be considered.

Child Death Overview Panels (CDOP): These are statutory multi-disciplinary review panels which aim to understand *how* and *why* a child has died. Each local area has a CDOP and systematically considers comprehensive information about each child death for the purpose of identifying notable and potentially modifiable factors and making recommendations for system improvement. Specific local actions are taken based on local findings, and learning is shared nationally. In 2015/16 CDOPs across England identified **around one in four child deaths as having a modifiable risk factor**.[6]

How can we improve?

Medical causes accounted for 82% of all deaths reviewed by Child Death Review Panels in 2015/16 of which 16% had modifiable risk factors. Not surprisingly a much higher proportion of deaths from *non-medical causes* had modifiable risk factors (sudden unexplained death (65%), deliberately inflicted injury, abuse or neglect (60%), trauma and other external factors (56%). Only 3% of all child deaths resulted in a serious case review but over 50% of these were found to have modifiable risk factors.

Accident prevention: Many of the preventable deaths during childhood occur following accidents. Boys are at higher risk of mortality from injuries. Families should have access to information and support to **make the home safe from hazards** and to **teach their children how to manage hazards** in their community e.g. roads, railways, open water. Professionals such as healthcare workers, early years staff and teachers can also play a role in the provision of information and safety resources appropriate to a child's developmental stage. Managing safe play experiences at home and outside is important to help children learn about safety. See section 3.3 for more information

Knowledge and practice: Child death review processes could have even greater impact if there was a national database for sharing findings and using them to inform policy and practice nationally and locally.[7,8]

Looking at how a child interacts over time with their environment can help our understanding of childhood mortality. Different types of risks interact and can be described as:

- intrinsic [biological and psychological factors within the child e.g. prematurity, having a long term illness].
- the physical environment [housing, play areas, access to pools, ponds, rivers, the sea].
- the social environment [parental care, responding to health needs, parental smoking, parental age, social class, domestic abuse].
- factors relating to health and social care service delivery [unmet health needs, prevention, recognition of acute illness by health and social care professionals, follow up of those at risk, availability of support services].

Palliative care: Children with life limiting conditions should be able to access support and services and, as they reach the end of life, receive high-quality palliative care in the place of their and their family's choice (see section 6.7 for more information)

What are we doing in East Sussex?

- **East Sussex wide initiatives to improve access to advice and treatment** as part of urgent health care system improvements.
- **Promotion of "Spotting the sick child": approved web resources** and other relevant continual professional development (CPD) resources in local hospitals.
- East Sussex Healthcare NHS Trust (ESHT) use the Situation, Background, Assessment, Recommendation (SBAR) communication tool, an NHS Quality and safety initiative to **ensure relevant key information is communicated between health care teams during patient transfers and hand overs in hospital.**
- **Epilepsy individual care plans** and **asthma personal management plans** are in use.

What are we doing in East Sussex?

- **Each child with a long term condition has an individual health plan or an Education, Health and Care (EHC) plan** as appropriate for needs, produced by the school. School nurses can help with preparing individual health plans or the EHC plan in collaboration with the community paediatric team.
- **Promoting home safety via the 0-5 years integrated service** with Health Visitors.
- **Provision and fitting of targeted safety equipment and advice** to vulnerable families with young children across East Sussex.
- Have provided **accident prevention training to support early years professionals** to confidently raise the issue of home safety with families.
- As part of our Whole Systems Transformation Programmes, ESBT and C4Y, we are taking a settings approach to improving health. This includes a **whole schools transformation programme** whereby schools **develop a school health improvement plan**, and using a primary prevention and whole school approach, put in place actions to address health and wellbeing priorities (to include Road Safety) supported by a health improvement grant.
- **The Child Death Overview Panel reviews all child deaths in East Sussex**, identifies those with any modifiable factors **and ensures learning is disseminated** appropriately to parents and staff to reduce the risk of future deaths from the same factors.
- Health visitors, nurseries and other early years settings and staff ensure **weaning and healthy eating advice addresses the risk of choking from food** and advises parents on safe food preparation.

Key actions going forward

- **Further promote safety in the home**: Create safe environments, including access to information and safety equipment schemes to help the most disadvantaged parents ensure their homes are safe for children.
- **Further promote safety outside the home:** Improve safety for children travelling to and from school through driver awareness (see 4.9) and improve safety in leisure areas.
- **Ensure adequate support in schools** for children and young people **to manage their long-term conditions.**
- Ensure that clinical teams looking after children **make maximum use of tools to support improved communication, management and self-care**.
- **Ensure the maintenance of NHS England quality initiatives to improve the communication of key information between health and social care professionals** as part of the process of handing over responsibility for patients between shifts, and between staff working in primary and secondary care.
- **Continue to use setting based approaches developed through ESBT and C4Y to work with schools and early years settings** to enable them to take action to embed health improvement in their work.

CHAPTER 1
Mortality
1.3 Young People (10 to 19 years)

Annual number of deaths of young people aged 10 to 19 years per 100,000 Population

Key messages

- Young people aged 10-19 are most likely to die from injuries, violence and suicide, followed by cancer, substance misuse disorders, and nervous system and developmental disorders.
- The risk of mortality increases if deprivation or mental health problems are present.
- Death rates are much higher for 15-19 year olds, and young men are more likely to die than young women.
- In the ten year period 2006 to 2015 in East Sussex, 28 young people died aged 10 to 14, while 89 died aged 15 to 19. This is a rate of 17.9 per 100,000 10-19 year olds which is above but not statistically higher than the England rate of 16.3.
- More than 50% of adolescent deaths occur from external causes, with the potential for modifying these causes in many of the cases.
- Adolescent mortality rates in the UK have fallen in recent years, but not at the same rate as comparable wealthy countries. The difference is mostly due to higher rates of death from Non-Communicable Diseases in the UK.
- Families, communities, and schools must play a key role in promoting positive social interactions and reducing risk-taking behaviours in children and young people. This includes focusing on their behaviours and interactions when using the internet as well as in everyday life.

What is this indicator showing us?

This indicator shows the mortality rate of young people aged 10 to 19 years per 100,000 population of that age. The rate is shown as a five year moving average.

Mortality rates of 10-19 year old in East Sussex, South East and England

Latest data: The most recent published data are for 2015 and show a recent increase in East Sussex mortality rates.

Trend: Between 2006 and 2015, the mortality rate in 10 to 19 year olds decreased from 21.1 to 16.3 per 100,000 in England. The East Sussex was lowest in 2010-14. Although slightly higher in 2011-15, the East Sussex rate is not statistically significantly different from England.

Source: ONS, Vital Statistics

Figure 1.3.1: Mortality rates per 100,000 population aged 10-19 in East Sussex, (5 year moving average) 2006 to 2015

Why is this indicator important?

Mortality rates in late adolescence are higher than for younger children and adolescents (excluding infants under 1). Despite improvements in young people's health in the last 30 years, almost 1,300 young people die each year in the UK. Like younger age groups many deaths in this age group are preventable, and understanding causes and patterns of death can be used to change practice at a local level and policy at a national level.

Deaths in adolescence have different causes from those in younger children, and young men aged 15-19 have higher mortality rates than young women of the same age. Preventing avoidable deaths is key – rates of injuries, a frequent cause of mortality in 10-19 year olds and rates of suicide, more common in 15-19 year olds, can both be reduced through appropriate interventions.

Non-Communicable Diseases (NCD) risks begin to increase in adolescence as young people become more independent from their families and possibly engage in more risky behaviours. NCDs and injuries are the main causes of death in adolescence. As road traffic injuries and suicide account for the majority of deaths among older adolescents of both sexes there are sections on both these topics in this report (see sections 4.7 and 4.8).

Other common causes of death of adolescents are cancer, substance misuse, epilepsy and neurodevelopmental disorders. Cancer and epilepsy are covered in more detail in sections 6.5 and 6.2 respectively.

Where are we now in East Sussex?

The mortality rate for 10 to 19 year olds in East Sussex has declined since 2006 although it has recently increased by a non-statistically significant amount. Boys in this age group in East Sussex had higher mortality rates than girls, due to much higher rates in males aged 15-19 years.

Between 2006 and 2015 in East Sussex, the mortality rates for young people were:

Differences between CCG areas are not statistically significant.

Latest data: In East Sussex, the mortality rate for males aged 10 to 19 is higher than for females. This is statistically significant. The rates for males and females are highest in High Weald Lewes Havens CCG and lowest in Hastings and Rother CCG but not significantly so.

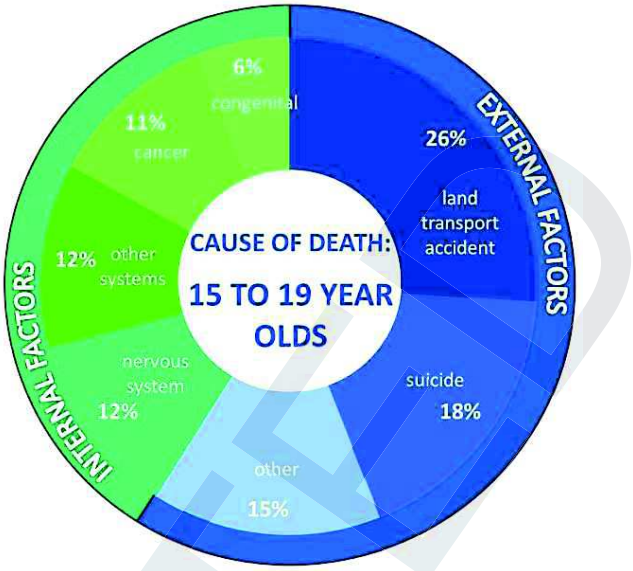
Source: NHS Digital, Primary Care Mortality Database

Figure 1.3.2: Mortality rates per 100,000 population aged 10-19 in East Sussex by CCG by sex, (10 year average) 2006-2015

For the period 2006-15 just under 60% (52/89) of deaths in 15-19 year olds in East Sussex were attributable to external causes.

East Sussex is an outlier (has higher rates than elsewhere in England) with regard to the rate of children being killed or seriously injured in road traffic accidents (see section 4.8).

Deaths due to suicide accounted for 18% (16 out of 89) of deaths of 15-19 year olds (see section 4.7)



Spotlight on inequalities

Nationally there is a strong association between increasing deprivation and increasing rates of death from injury in young people aged 15-19 years. Deaths from other causes are also related to inequality. More hazardous environments with high density housing, close proximity to high volumes of traffic, high levels of on-street parking and exposure to more hazardous and illegal driving, as well as educational level, parental mental health and low income all affect adolescents' risk of mortality.

The number of deaths in the 10 to 19 age group is too small to demonstrate an inequality relationship at county level (see section 1.2 Spotlight on inequalities for information on 0-19 mortality in East Sussex).

What does good look like?

East Sussex has a similar mortality rate to England. However, the UK has not reduced adolescent mortality rates as fast as other European countries. In 1970 the UK had one of the lowest adolescent mortality rates in Europe but by 2008 was in the middle of the group of comparable countries.[9]

The UK has low injury mortality among adolescents particularly for road traffic deaths. Rates of death by transport crashes for young people aged 10-19, for the period 2009-12, as compared with other European countries, show the UK has the sixth lowest rate (3.7 per 100,000). Lower rates in Spain, the Netherlands, Sweden, Portugal and Denmark, however, show that a considerable number of deaths can be prevented each year.

UK rates of mortality from long term conditions are in the worst quartile compared with other wealthy countries. Sections 6.1, 6.3 and 6.5 look at three common long term conditions: Asthma, Diabetes and Epilepsy.

How can we improve?

In order to reduce mortality in 10-19 year olds we need to understand the underlying influences and events leading up to the death as well as the immediate cause of death. It is important to identify events which are modifiable or preventable. Some risk factors can be addressed at a local level, but others may require national legislation. Healthcare services, familial, social and environmental factors as well as other services and organizations working with the child should all be considered.

Inequalities: Mortality rates in young people are higher in those from more deprived backgrounds, reflecting higher rates of suicide, injury and mortality from NCD. Reducing mortality rates in this age group requires national government efforts to reduce child and family poverty.[10]

Improving resilience, mental health and wellbeing (See 4.5 and 4.6)**:** young people with poor mental health are at a higher risk of substance misuse, injury and mortality from long-term conditions as well as suicide. Improving wellbeing will help reduce mortality rates.

Suicide (See 4.7): The promotion and fostering of wellbeing and positive mental health in young people can help to reduce suicide. Early access to support for emerging mental health problems is also key.

Road traffic injuries (See 4.8): These are a leading cause of death in this age group, and one of the most amenable to further prevention. East Sussex has high rates of deaths on the road compared to England.

Health: As young people with long term conditions (See 6.1, 6.3, 6.5) approach adulthood they often fall between paediatric and adult health services. It is important to plan transition or develop self-management programmes to enable teenagers to cope with less intensive support as an adult.

What are we doing in East Sussex?

- **East Sussex road safety** programme to reduce killed and seriously injured on roads (Section 4.9).
- **The East Sussex Suicide Prevention Group are working to actively prevent suicide** by better understanding the risk factors and promoting partnership working to address these.
- **The East Sussex ESBT and C4Y Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan is working to improve prevention, identification and early intervention in mental health problems.** Actions include mental health training for health, social care and education professionals and promoting adolescent mental health and wellbeing in local schools (Section 4.6)
- As part of our work to transform how the places where people spend their time (settings) play an active role in improving **health we have rolled out a whole school health improvement programme. Through this 184 schools are participating in developing and delivering plans which include identifying the steps that schools can take in improving mental health** as an essential component.
- **Personal Social Health and Economic (PSHE) education hubs have been set up** for primary and secondary schools where best practice in PSHE education can be shared.
- **There is ongoing local care pathway development through transition for people with a learning disability, and long term conditions**. For example, young people with cystic fibrosis who attend joint local clinics with Kings College Hospital, the Regional Centre of Excellence, until they are 18.

Key actions going forward

- See also Sections 4.6, 4.7, 4.8, 6.7
- **Implementing prevention and early intervention, and improving access to mental health services** is a key priority in the ESBT and C4Y Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan.
- Continue to **protect and support early intervention services and strategies**.
- **Embed activities developed through whole school health improvement programme into routine practice in schools.**
- **Continue to provide advice and support to schools and colleges to take action to improve mental health** through the School Health Service, East Sussex Behaviour and Attendance Support (ESBAS), Educational Psychology, Standards and Learning Effectiveness Service (SLES), and the Inclusion and Special Educational Needs and Disability (ISEND) service.
- **Continue to promote physical, mental and social health** through statutory, comprehensive, evidence-based PSHE in all schools.
- **Improve transition for children and young people with high needs to adult services**
- Provide **high-quality, end-of-life care** and access to appropriate palliative care.

CHAPTER 2
Conception, pregnancy and infancy
2.1 Smoking at time of delivery

Proportion of women smoking at time of delivery

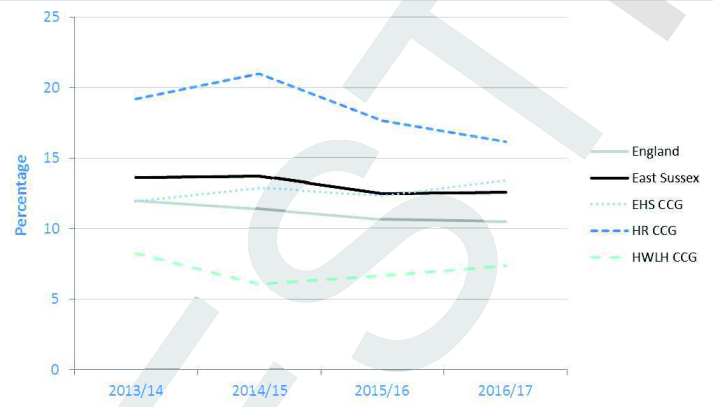
Key messages

- Smoking during pregnancy is an important and modifiable risk factor for poor birth outcomes and the future health of babies and children.
- The proportion of East Sussex women smoking at the time of delivery is 2% higher than the England average which is statistically significant.
- 18% of women from Hastings smoke at the time of delivery compared to 7% in Lewes. This is statistically significantly higher. Smoking during pregnancy is highest in deprived populations and in mothers under 20 years of age.
- Building smoking cessation support and monitoring into maternity pathways is essential to reduce the number of women smoking during pregnancy.
- Preconception and pregnancy are key opportunities to promote smoking cessation and support women to improve their own health as well as that of their baby.
- Parents who smoke are more likely to have children who smoke, not just as adults, but as children and teenagers.

What is this indicator showing us?

The indicator shows the proportion of pregnant mothers who reported smoking at the time when they delivered their baby.

East Sussex smoking at time of delivery, 2010/11 to 2016/17 - commissioner-based



Latest data: The percentage of mothers registered with a GP in East Sussex who were smoking at the time of delivery is 13%.

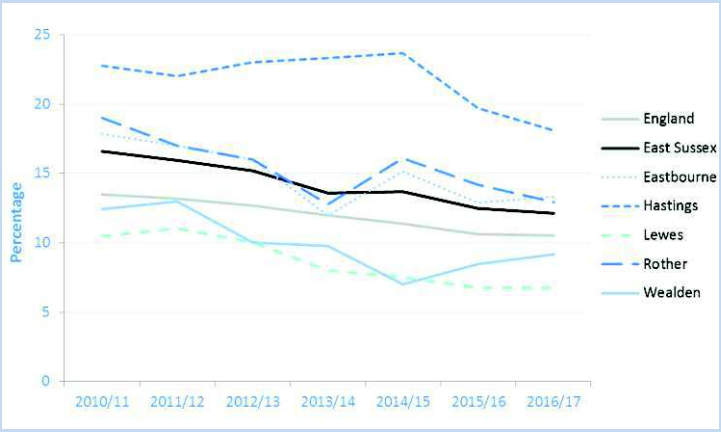
Trend: Both nationally and locally the rates are reducing and have been since 2010/11. However it would appear that since 2014/15 the rates are slightly increasing in both High Weald Lewes Havens CCG and Eastbourne, Hailsham and Seaford CCG.

Source: NHS Digital, Statistics on Women's Smoking Status at Time of Delivery

*Note that the East Sussex figures differ in this chart compared to the following chart due to different data sources and methodology used. The NHS view of the data (this chart) is commissioner-based and includes all women registered with an East Sussex GP practice (and are published figures from NHS Digital) whereas the local authority view of the data (chart below) uses local maternity unit data and are based on women who are residents of East Sussex.

Figure 2.1.1: Percentage of mothers smoking at time of delivery in East Sussex by CCG, 2010/11 to 2016/17

Resident-based



Latest data: The percentage of mothers resident in East Sussex who were smoking at the time of delivery is 12%. In Hastings a statistically significant higher proportion of women smoke compared to East Sussex, which leads to East Sussex having significantly worse rates of smoking in pregnancy compared to England.

Trend: Both nationally and locally the rates are reducing and have been since 2010/11.

Source: Data provided by East Sussex Healthcare NHS Trust, Brighton and Sussex University Hospitals NHS Trust and Maidstone and Tunbridge Wells NHS Trust

Figure 2.1.2: Percentage of mothers smoking at time of delivery in East Sussex by district and borough, 2010/11 to 2016/17

Why is this indicator important?

Smoking in pregnancy is the single most important modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health.

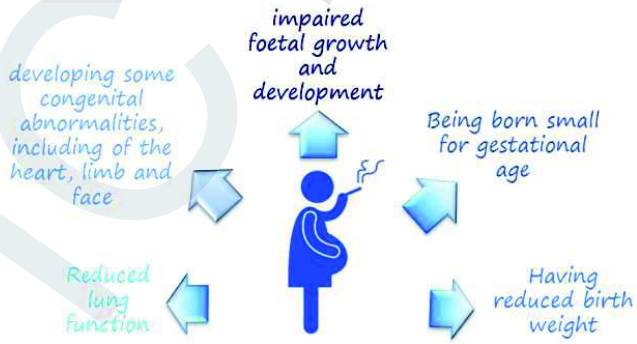
Maternal smoking during pregnancy is linked with an extremely wide range of problems during pregnancy, for the birth and for the child later in life.

Each year in the UK, Smoking during pregnancy has been suggested to cause around:

- **2,200** preterm births,
- **5,000** miscarriages and
- **300** perinatal deaths (babies who are stillborn or those who die before seven days of age)

Maternal smoking during pregnancy also places children at greater risk of mortality – e.g. Sudden Infant Death Syndrome (SIDS) and morbidity throughout their life.

Maternal smoking during pregnancy places unborn babies at an increased risk of:



Exposure to smoke in utero can affect brain development which reduces overall intelligence as well as increasing the risk of conduct disorder, attention deficit hyperactivity disorder (ADHD) and anxiety. Children of mothers who smoke are also at increased risk of asthma and obesity.

It is estimated that 57% of mothers who quit smoking during pregnancy are non- smokers six months after giving birth. This reduces the growing child's exposure to the detrimental effects of second hand smoke.

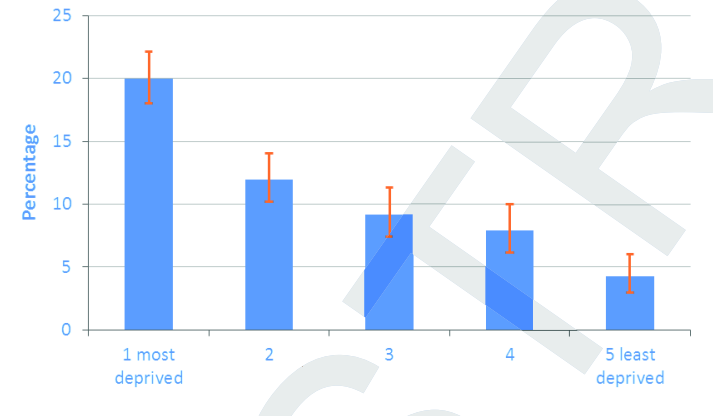
Preconception and pregnancy are key opportunities to promote smoking cessation and support women to improve their own health as well as that of their baby.

Where are we now in East Sussex?

There is no safe level of exposure to tobacco for an unborn baby. Quitting smoking before pregnancy is the ideal way to avoid any antenatal exposure to tobacco and will reduce the risk of adverse outcomes such as infant mortality. However quitting at any time brings benefits for mother and child.

Spotlight on inequalities

Smoking in pregnancy is strongly linked to deprivation, with higher rates of mothers smoking during pregnancy in more deprived areas.



Latest data: Mothers from the most deprived quintile are five times more likely to smoke in pregnancy than mothers from the least deprived quintile.

Source: Data provided by East Sussex Healthcare NHS Trust, Brighton and Sussex University Hospitals NHS Trust and Maidstone and Tunbridge Wells NHS Trust.

Figure 2.1.3: Percentage of mothers smoking at time of delivery in East Sussex by deprivation (IDACI quintiles), 2016/17

What does good look like?

Across England 10.6% of women are recorded as smoking at the time of delivery, with a quarter of areas having fewer than 7.6% women smoking at the time of delivery. The lowest rates of smoking in pregnancy are in Westminster which has an exceptionally low rate of 1.8%. In East Sussex 13% of women smoke at the time of delivery which is significantly higher than the England average.

How can we improve?

The National Institute for Health and Care Excellence (NICE) provide clear guidance on how health professionals can support women to stop smoking in pregnancy and after childbirth. NICE PH26 recommends routine **carbon monoxide (CO) monitoring from early pregnancy** in all maternity services. Routine screening for active smoking and exposure to passive smoke in pregnancy through CO monitoring (a non-invasive breath test) would improve the robustness of data on smoking during pregnancy and at time of delivery. Data is currently based on self-reporting so is likely to be an underestimate.

In addition to monitoring smoking status, all maternity services must ensure that smoking is addressed early in all pregnancies and that **all women have access to equitable and tailored smoking cessation services** which are appropriate to their needs.

What are we doing in East Sussex?

- Our whole systems transformation programmes, East Sussex Better Together (ESBT) and Connecting for You (C4Y), include a focus on addressing smoking in pregnancy. In addition to the continued efforts to reduce smoking across the population, additional targeted interventions include **actions to reduce the harm** caused by smoking in pregnancy and by exposure to second hand smoke.
    - **Local Stop Smoking Services have provided Carbon Monoxide (CO) monitors and training** to ensure midwives are correctly using them at booking and subsequent appointments and as part of routine care in pregnancy.
    - A social marketing organisation has been **working to make local services more accessible in the most deprived areas** by improving referral pathways and **engaging with pregnant women early** in their pregnancy. This has resulted in detailed insight work to better understand the target audience and the ability to **tailor support to their identified needs**, for example through amended treatment protocols.
    - Focussing on cross-agency work to **reduce access to illegal tobacco**.
    - Work has also been completed to better understand how **to reduce exposure and vulnerability to second hand smoke** in the most deprived parts of the county and inform a multi-agency action plan to protect communities and families from exposure to second hand smoke.

Key actions going forward

- **Ensure full implementation of the NICE Guideline PH26, Smoking: Stopping in pregnancy and after childbirth** across maternity services with a particular emphasis on routine CO testing, training of health care staff and the setting of local targets to monitor implementation.
- **Continue to work with midwifery** to incorporate the routine use of CO screening into maternity appointments.
- Ensure the detailed insight from social marketing is used to **ensure that smoking cessation services are accessible to pregnant women who experience health inequalities**.
- **Implement the multi-agency action plan to protect communities and families from exposure to second hand smoke**.

CHAPTER 2
Conception, pregnancy and infancy
2.2 Breastfeeding

Proportion of mothers recorded as breastfeeding at six to eight weeks post birth

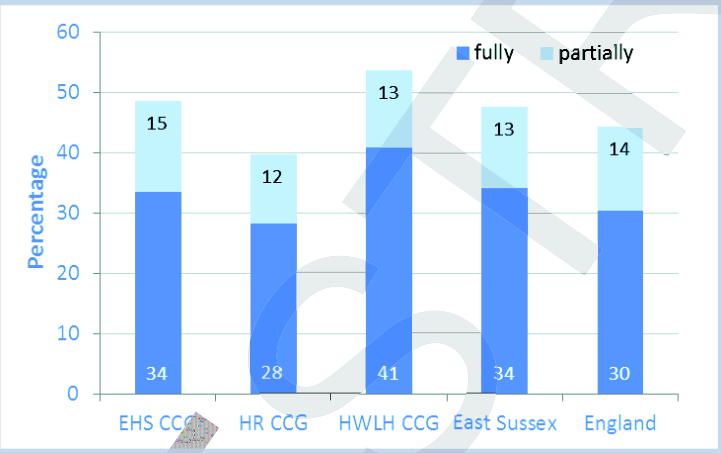
Key messages

- Breastfeeding has physical and mental health benefits for mother and baby which last beyond the period of breast-feeding.
- Breastfeeding rates in East Sussex are currently significantly higher than the England average. Latest data shows an improvement on a previously deteriorating trend. Some of this is down to improved data recording.
- Breastfeeding rates in England have not increased significantly since recording started and are lower than in many other European countries.
- Nationally new strategies for infant nutrition are needed to cover improvements in data collection, and approaches to support women to start and maintain breastfeeding of their new-born.

What is this indicator showing us?

This indicator shows the proportion of women recorded as breastfeeding at their six to eight week health visitor review following the birth of their baby. Breastfeeding is recorded as either fully (the infant is only receiving breastmilk) or partially (the infant is receiving a combination of breastmilk and infant formula).

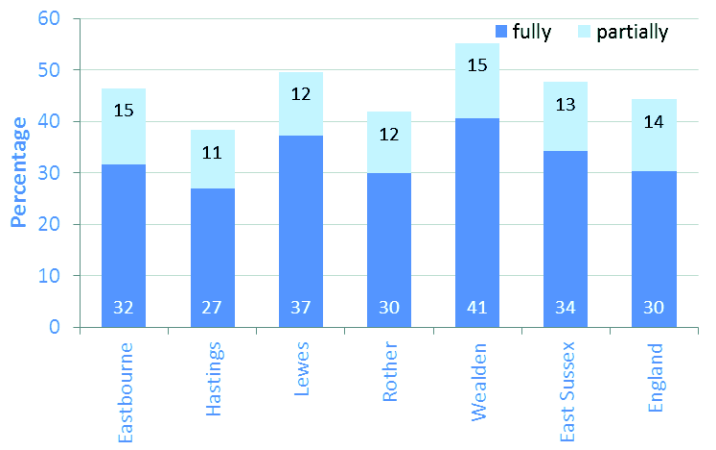
Breastfeeding in East Sussex



Latest data: 47% of women in East Sussex are recorded as fully or partially breastfeeding at the 6 to 8 week review. This is significantly better than for England (44%). Eastbourne, Hailsham and Seaford (49%) and High Weald Lewes Havens (54%) are both significantly better than England, whilst Hastings and Rother CCG (40%) is significantly worse.

Source: East Sussex Child Health Information System

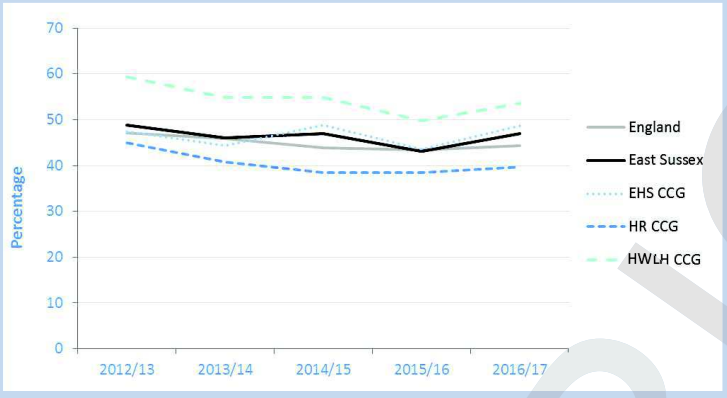
Figure 2.2.1: Percentage of infants at 6 to 8 week review who were recorded as being fully or partially breastfed in East Sussex by CCG, 2016/17



Latest data: At district and borough level Hastings (38%) is significantly worse that England, whilst Lewes (50%) and Wealden (55%) are significantly better.

Source: East Sussex Child Health Information System.

Figure 2.2.2: Percentage of infants at 6 to 8 week review who were recorded as being fully or partially breastfed in East Sussex by district and borough, 2016/17



Latest data: 47% of mothers in East Sussex were recorded as fully or partially breastfeeding at their 6 to 8 week health visitor review in 2016/17 in East Sussex.

Trend: Although East Sussex breastfeeding rates increased in 2016/17 there has been a slight overall downward trend since 2012/13.

Source: East Sussex Child Health Information System and PHE Breastfeeding Statistics.

Figure 2.2.3: Percentage of infants at 6 to 8 week review who were recorded as being fully or partially breastfed in East Sussex by CCG, 2010/11 to 2016/17

Why is this indicator important?

The benefits of breastfeeding extend beyond infancy throughout life. Fully breastfeeding is recommended for the first six months of a baby's life, in line with advice from the World Health Organisation. Breastfeeding provides protection to babies for a range of infections including gastrointestinal, respiratory and ear infections and may lead to a lower risk of being overweight in later life and developing Type 2 diabetes. There are also benefits for the mother, including protection against breast cancer and possibly ovarian cancer and Type 2 diabetes. For both baby and mother breastfeeding leads to improved bonding.

For premature babies, breastmilk is particularly important, reducing the risk of infections and potentially life-threatening conditions[11].

Some women are unable to breastfeed, and there are a small number of babies who cannot be breastfed for medical reasons, however the majority of women should be able to breastfeed with the right knowledge, encouragement and support.

Nationally, breastfeeding rates increase with maternal age, with around a quarter (24%) of women under 20 years breastfeeding at six weeks compared with around two-thirds (67%) of women aged 35 and over .

Where are we now in East Sussex?

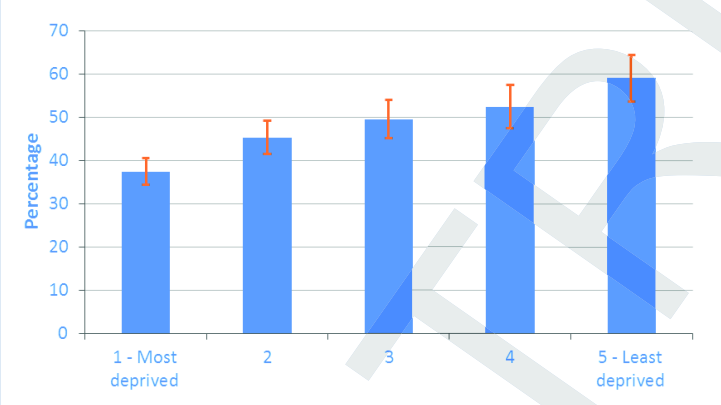
47% of new mothers were breastfeeding by the six to eight week review in East Sussex in 2016/17. This is substantially lower than the 74% of new mothers who were recorded as initiating breastfeeding during the same period following the birth of their baby.

The variation in breastfeeding rate between Clinical Commissioning Groups (CCGs) is also reflected in the districts and boroughs level data. Eastbourne has the highest rates of partial feeding (15%) which is also reflected in the CCG figures (Eastbourne, Hailsham and Seaford CCG 15%).

In East Sussex there has been slight decrease in breastfeeding rates since 2012/13.

Spotlight on inequalities

There is a strong impact of deprivation on breastfeeding (fully or partially) at six weeks across the UK. The same pattern is seen in East Sussex.



Latest data: 37% of mothers in the most deprived areas in East Sussex breastfeed compared to 59% in the least deprived areas.

Source: Data from the East Sussex Child Health Information System.

Figure 2.2.4: Percentage of infants at 6 to 8 week review who were recorded as being fully or partially breastfed in East Sussex by deprivation (IDACI quintiles), 2016/17

What does good look like?

Across England, of areas who have been able to submit validated data on breastfeeding rates at 6-8 weeks, Lewisham is the highest at 76.8%. This is unusually high compared to the England average of 44%. East Sussex breastfeeding rates at 6-8 weeks are above the England average, and we would only need to increase breastfeeding rates from the current 47% to 48.6% to be in the top quartile of areas in England. Our neighbouring area Brighton and Hove has the second highest breastfeeding rate in England at 71.5%.

There are limited data available to compare trends in breastfeeding internationally and no local data on breastfeeding at six months. An international study found that in the UK only 34% of babies are still receiving some breastmilk at six months, compared to 71% in Norway.[12]

How can we improve?

Reasons for low breastfeeding rates are complex. They include k**nowledge about the benefits of breastfeeding** and **attitudes towards breastfeeding**. Rates are particularly low in young mothers and those from deprived groups. Some women also have **difficulty in establishing breastfeeding** after birth and have concerns about whether the baby is growing adequately and receiving enough milk. The attitudes of family, peers and the public all have an impact on rates of breastfeeding.

To improve rates, local services must ensure that all women are encouraged to start breastfeeding and are **supported to fully breastfeed**, including **access to timely support** if they are experiencing difficulties.

Education should begin in the antenatal period and continue through birth and beyond. Maternity services need to be equipped to **support women to make informed choices** about breastfeeding. This can be achieved through the UNICEF Baby Friendly Initiative (BFI) accreditation which provides an evidence-based framework for best practice[13].

Universal midwifery and health visiting services must continue to be commissioned and improved to help support breastfeeding initiation soon after birth and its subsequent continuation[14].

The evidence shows that the vast majority of women who breastfed during the initial 2 weeks said they would have **liked to have breastfed** for longer. There is an association with postnatal depression for women who while pregnant wanted to breastfeed, but did not initiate after giving birth.

Primary care and paediatric services also have a role and there should be **improved education of paediatric and primary care teams to support breastfeeding**.

What are we doing in East Sussex?

- **East Sussex maternity services** are **currently working towards UNICEF BFI accreditation**.
- The **0-5 year old integrated service** of health visiting, community nursery nurses and family key workers **achieved UNICEF level 2 Baby Friendly Initiative** accreditation in March 2017 and is working towards level 3 accreditation by March 2018.
- **To reduce inequalities in breastfeeding rates** between areas in East Sussex, Hastings and Rother CCG funds **additional breastfeeding support workers in the east of the county**. There is **a dedicated breastfeeding lead within the health visiting team** and a programme of **peer supporters across East Sussex** to help support breastfeeding continuation for all mums who wish to breastfeed.
- **Baby Buddy** is an award winning free mobile phone app to support women through pregnancy and the first six months of baby's life, including **modules specifically designed to support breastfeeding**. Baby Buddy is being **embedded in maternity and early years pathways in East Sussex**.
- East Sussex Healthcare NHS Trust, like many across England, has previously struggled to record the breastfeeding status of 95% of the eligible cohort, meaning that reported data was not considered by Public Health England (PHE) as valid. **Data recording has recently improved in order to meet BFI accreditation standards**.

Key actions going forward

- **An East Sussex wide strategy for infant feeding will be developed**, bringing together the approaches from midwifery, primary care and health visiting.
- **Maternity services should achieve and maintain UNICEF BFI accreditation** (All services should provide antenatal education and health promotion regarding breastfeeding to both parents). The integrated 0-5 Service are aiming for level 3 accreditation by April 2018.
- **Robust and comparable data collection will continue to be improved**: measuring breastfeeding initiation and recording breastfeeding at six to eight weeks.
- **Ensure delivery of universal midwifery and health visiting services to all mothers**.
- **Promote the Royal College of Paediatrics and Child Health (RCPCH) recommendation that healthy infant nutrition is taught as part of Personal, social, health and economic (PSHE) education** in secondary schools.

CHAPTER 2

Conception, pregnancy and infancy

2.3 Immunisation

Proportion of children who received the full course (three doses) of the 5-in-1 vaccination by 12 months and children who received two doses of Measles, Mumps and Rubella (MMR) vaccination by 5 years of age.

Key messages

- Vaccinations in early childhood are key in protecting children against serious and potentially fatal diseases.
- By 12 months of age, babies should have received several vaccinations, including three doses of the 5-in-1 vaccination.
- Uptake of the 5-in-1 vaccine by 12 months in East Sussex (94.0%) is similar to the England rate (93.4%) and falls below the national target of 95%.
- In the last four years the uptake of the 5-in-1 vaccine in East Sussex has reduced slightly from 94.8% in 2011/12 to 94.0% in 2016/17.
- By the age of five years, children should have had two doses of MMR to ensure full immunity.
- Uptake of both doses of the MMR vaccine in East Sussex has declined since 2013/14 and at 88.7% is below the national target of 95%.
- The East Sussex health system is working with Public Health England and NHS England to address barriers and improve uptake of both vaccines.

What are these indicators showing us?

These indicators show us the proportion of babies who, by 12 months of age, have received all three doses of the 5-in-1 vaccination to protect them against five communicable diseases: diphtheria, tetanus, whooping cough (pertussis), polio and Haemophilus influenza type b (Hib); and children who have received two doses of MMR by 5 years of age. There are multiple potential vaccination indicators; and these are the best proxies for system coverage.

Immunisation: 5-in-1 vaccination and Measles Mumps and Rubella (MMR) vaccination

Latest data: In 2016/7 England's 5-in-1 immunisation rate was 93.4%, and East Sussex was 94.0%.

Trend: Since 2011/12, the uptake rate of the 5-in-1 vaccine in East Sussex has reduced slightly from 94.8% to 94.0% in 2016/17.

Source: NHS England, Child Immunisation Statistics

Figure 2.3.1: Percentage of children who have received the 5-in-1 vaccination by 12 months of age in East Sussex by CCG, 2011/12 to 2016/17

Latest data: The uptake rate for both doses of the MMR vaccine across East Sussex by age 5 years is 88.7%.

Trend: There has been a slight decrease in uptake of both doses of MMR in East Sussex from 88.9 % in 2013/4 to 88.7% in 2016/17.

Source: NHS England, Child Immunisation Statistics

Figure 2.3.2: Percentage of children who have received two doses of MMR by 5 years of age in East Sussex by CCG, 2011/12 to 2016/17

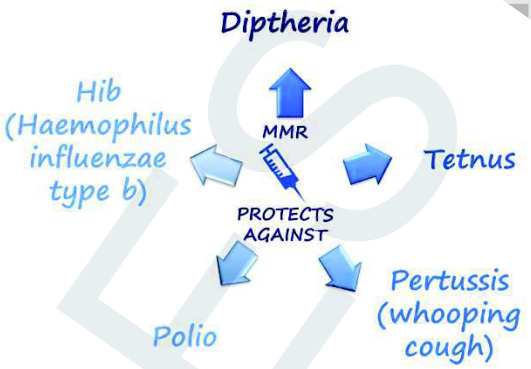
Why are these indicators important?

Immunisation is key for preventing illness and death linked to many communicable diseases.

Vaccination prevents an estimated 2.5 million deaths globally each year[15].

Achieving high rates of vaccination means that more of the population who cannot be vaccinated (either because they are too young or have particlar medical conditions) are protected (through herd immunity), and can also lead to the elimination of some diseases. Even when a disease is no longer common, without sustained high rates of vaccination it is possible for these diseases to return[16], as we have seen with measles outbreaks.

The 5-in-1 vaccine is a single injection administered on three separate occasions at 8, 12 and 16 weeks of age providing protection against five diseases[17]:

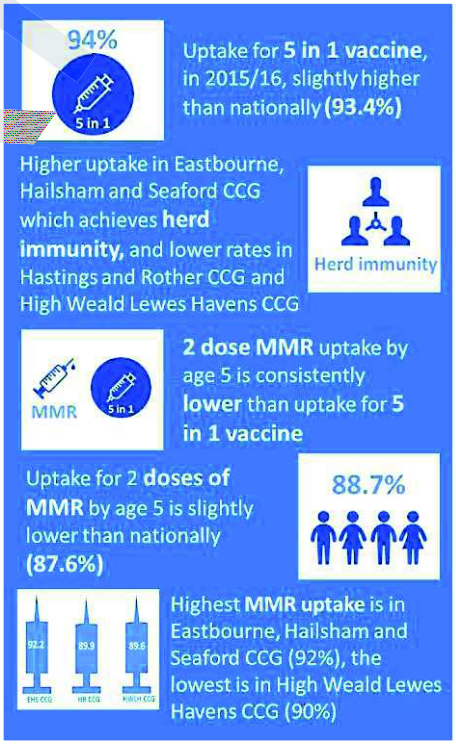


Apart from tetanus (which is not passed from person-to-person), these diseases are contagious and can cause severe illness and even death.

From August 2017 the 5-in-1 vaccine changed to the 6-in-1 vaccine, with the addition of hepatitis B, however for the purposes of this report the data relates to the 5-in-1 vaccine.

The first dose of the MMR vaccine is offered to children at one year of age with a second dose at three years four months.

Where are we now in East Sussex?

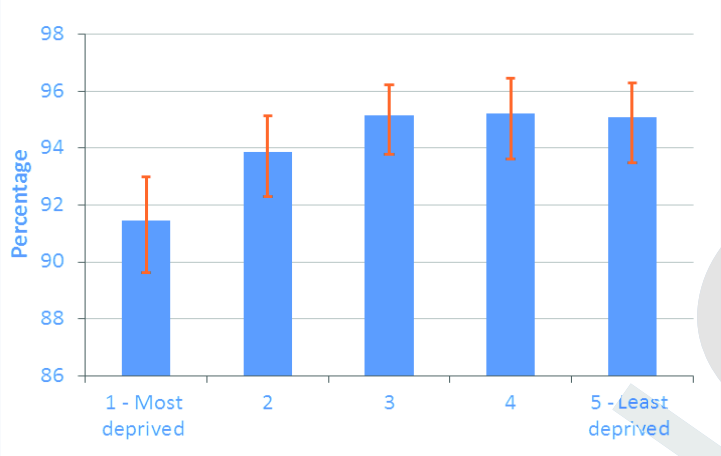


In East Sussex we are currently below the WHO recommended level of at least 95% uptake for the 5-in-1 and MMR vaccines. We should aim to increase vaccination coverage throughout the population, with a particular

focus on areas where rates are below the WHO threshold. Although there is variation between areas within East Sussex, Eastbourne, Hailsham and Seaford and High Weald Lewes Havens achieved target coverage of the 5 in 1 vaccine. No areas achieved sufficient coverage of MMR.

Spotlight on inequalities

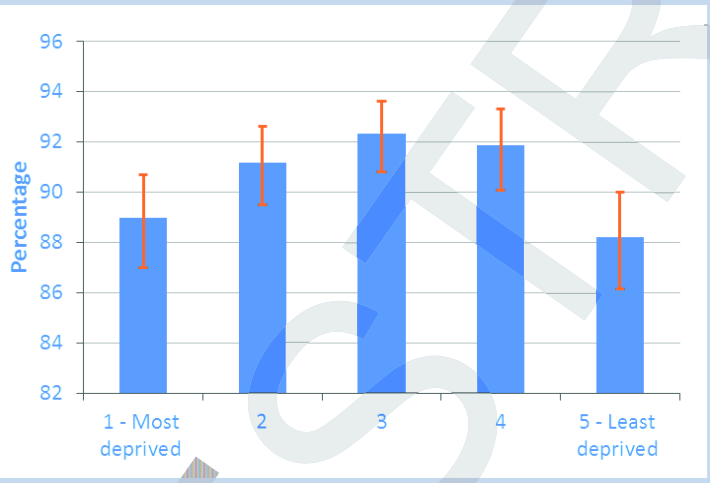
There is mixed evidence about the effect of deprivation on uptake of childhood vaccinations: Some studies have found that mothers of unimmunised infants are older and more highly qualified than those of partially immunised infants[18] . Issues linked to low uptake in more affluent areas include concerns about the safety of some vaccinations, including MMR. Other studies have shown lower uptake of vaccinations in more deprived groups and these are linked to having chaotic lifestyles, having larger families, language issues and access to vaccination clinics.



Latest data: The most deprived 20% of GP practices have a statistically significant lower coverage of the 5 in 1 vaccine compared to quintiles 3, 4 and 5, which represent the 60% of most affluent practices.

Source: NHS England, Child Immunisation Statistics

Figure 2.3.3: Percentage of children who have received the 5-in-1 vaccination by 12 months of age in East Sussex by deprivation (GP practices grouped by IDACI quintiles), 2016/17



Latest data: For coverage of two doses of MMR by 5 years of age, there is a mixed picture in East Sussex. Both the most deprived quintile and the least deprived quintile have lower rates of vaccine coverage compared to quintiles 2, 3 and 4. The data in both of these charts is supported by the evidence.

Source: NHS England, Child Immunisation Statistics

Figure 2.3.4: Percentage of children who have received two doses of MMR by 5 years of age in East Sussex by deprivation (GP practices grouped by IDACI quintiles), 2016/17

What does good look like?

For both MMR and the 5 in 1 vaccine East Sussex has very similar coverage levels to the England average at around 88% and around 94% respectively. The best in England for the 5 in 1 vaccine is a rate of 98.9% and for MMR it is 98.6%, both in North Tyneside. The top quartile is above 96.2%.

How can we improve?

An effective vaccination programme is one that achieves a high vaccination uptake in a timely way. If a sufficient proportion of the population are vaccinated against an infectious disease it will not be able to spread in the population. This will also provide protection to unimmunised infants and children as they will be very unlikely to come into contact with the disease.

We need to continue to **promote the importance of vaccination at every opportunity** including at antenatal appointments, and through primary care, midwifery, health visiting and school health services and in early years settings.

We need to **ensure that our data systems are robust and complement each other**: child health records should match GP practice data.

Children should be **invited to have their vaccine in a timely way**. GP practices should be reminded about children who appear to have missed vaccines.

School Health vaccination services could **screen children on school entry for their vaccination status** and provide advice and support to schools to encourage parents and children to be fully vaccinated.

There is currently limited evidence on ways to **successfully address vaccine refusal**[19]. We need to work with NHS England to consider strategies to increase uptake in families where a conscious decision has been made to not immunise their child in the absence of a medical indication and for those parents who are undecided about whether to have their child vaccinated or not.

What are we doing in East Sussex?

- **Maintaining high awareness of the importance of immunisation** across East Sussex
- Working across East Sussex Public Health, NHS England and the CCGs to:
  - Examine practice level rates and **recommend changes to improve uptake**.
  - **Ensure that there are no 'queues'** whereby children who are due their vaccination are not invited in a timely way.
  - **Ensure that data across GP practices** and the **Child Health Information System match** as closely as possible.
  - **Consider the use of outreach clinics in children's centre areas with low uptake** and also the **use of an expert phone line for parents** who are undecided and/ or sceptical about the safety of certain vaccines.

Key actions going forward

- **Continue to meet with NHS England and CCG Quality leads** to further review uptake data by CCG and by GP practice and identify those with the lowest rates.
- **Agree a shared plan to further improve rates**.
- **Ensure that robust processes are in place** to minimise the likelihood of 'queues' and to **ensure that data systems are as timely and accurate** as possible.
- Continue to work with NHS England to **ensure regular input to CCG Practice Nurse learning** events to ensure up-to-date information on vaccination coverage is available and disseminated to all those responsible for the immunisation of children and young people.
- **Promote the role of health visitors and school nurses in checking vaccine uptake** when they come into contact with children.

CHAPTER 3
Early Years
3.1 Healthy weight when starting school

Proportion of children at a healthy weight during their reception year of primary school

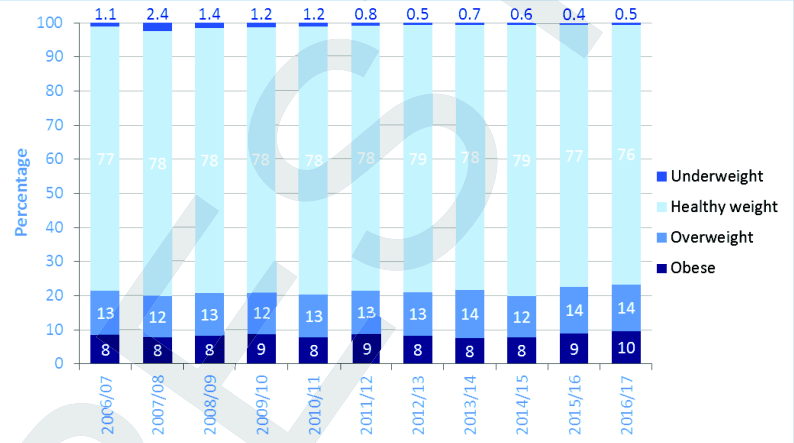
Key messages

- Weight when a child starts primary school is an important predictor of health outcomes later in life.
- Nearly one in four children in East Sussex are classified as overweight or obese during their reception year of primary school, similar to the England average.
- There has been minimal overall improvement in the proportion of East Sussex children classified as having a healthy weight during their reception year of primary school over the past decade.
- The overweight and obesity prevalence for children living in the most deprived areas in East Sussex is significantly greater than it is for those living in the least deprived areas.
- A range of interventions is required to promote healthy weight in children, including both access to healthy food and opportunities for physical activity; and to target critical periods in the life course.
- A programme to transform how nurseries and schools in East Sussex embed evidence -based health improvement activity into their work is being delivered.

What is this indicator showing us?

This indicator shows us the proportion of children who are a healthy weight (and underweight, overweight and obese) during their reception year of primary school, based upon the Body Mass Index (BMI) as a measure of weight for height relative to sex and age.

Reception Year children underweight, healthy weight, overweight or obese

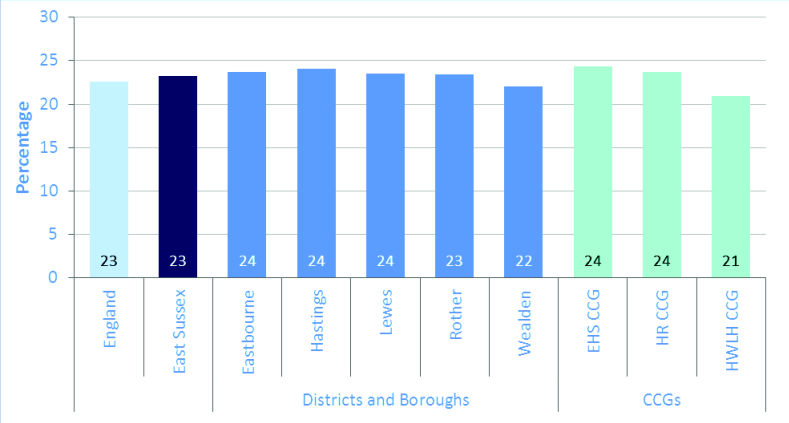


Latest data: The latest data shows that nearly one in 4 (24%) of reception year children (aged 4-5) are overweight or obese.

Trend: Over the last 11 years the rate has stayed more or less consistent with a slight increase from 21% of reception aged children classified as overweight or obese in 2006/07 to 24% in 2016/17.

Source: NHS Digital, National Child Measurement Programme Statistics

Figure 3.1.1: Percentage of reception year pupils (4-5 year olds) underweight, healthy weight, overweight or obese in East Sussex, 2006/07 to 2016/17



Latest data: Although there is variation between districts and boroughs and between Clinical Commissioning Group (CCG) areas in the proportion of reception year children overweight or obese, there are no statistically significant differences with the England average (23%).

Source: East Sussex National Child Measurement Programme data and NHS Digital statistics

Figure 3.1.2: Percentage of reception year pupils (4-5 year olds) overweight (including obese) in East Sussex by district/borough and CCG, 2016/17

Why is this indicator important?

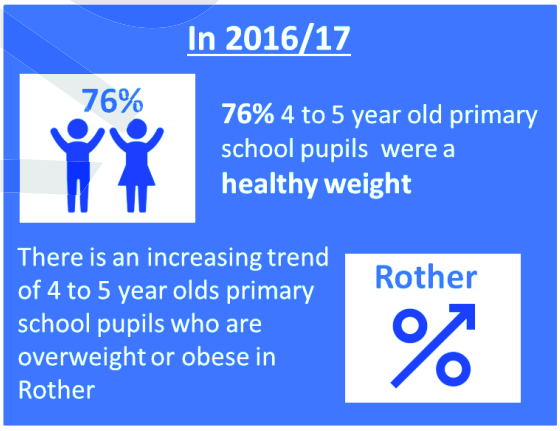
Childhood obesity is one of the greatest health threats to children and their future health as adults.

Not only does being overweight have a major impact on health and wellbeing in childhood, it is also an important predictor of being overweight and obese in later life and the associated risk to both physical and emotional health and wellbeing:

Assessing children's weight in schools is an important part of a co-ordinated approach in preventing childhood obesity. By identifying children in a systematic, timely way, we can offer guidance and support to encourage all children to maintain a healthy weight.

Where are we now in East Sussex?

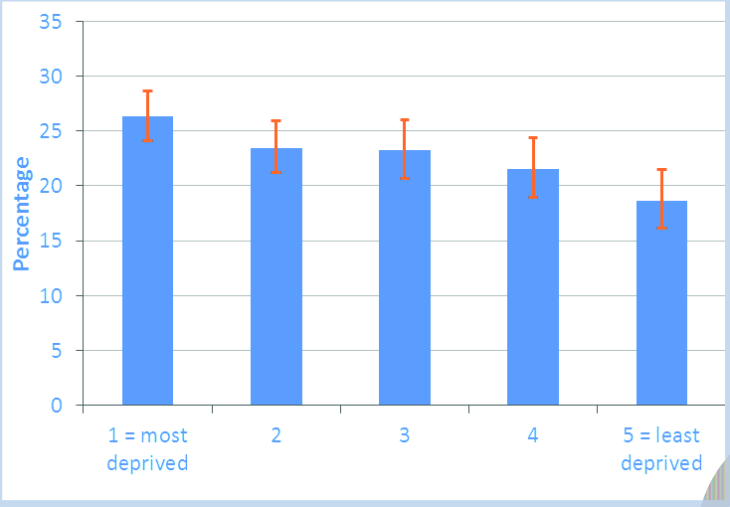
Nationally there is a target is to reduce the prevalence of obesity in reception aged children to 5%. Currently in East Sussex the prevalence of obesity in reception aged children is 10%, with 24% either overweight or obese.



There has been little change in the overall proportion of East Sussex children classified as either a healthy weight or carrying excess weight (overweight or obese) during their reception year of primary school since the National Child Measurement Programme (NCMP) was established in 2005. Since 2006/07, there has been no significant change in the proportion overweight and obese in Eastbourne and Wealden; an increasing trend in Rother and a decreasing trend in Lewes.

Spotlight on inequalities

Both national and local data show that there is a strong relationship between deprivation and overweight/obesity prevalence. Low income families may find it harder to afford a balanced diet with cheaper convenience food often being calorie dense and nutrient light. Limited time and cooking facilities are another challenge.



Latest data: Overweight and obesity prevalence for children living in the most deprived areas in East Sussex is significantly greater than it is for those living in the least deprived areas. For example, in 2016/17, 26% of Reception Year children living in the most deprived areas of East Sussex were classified as overweight or obese, compared with 19% of Reception Year children living in the least deprived areas of the county.

Source: East Sussex National Child Measurement Programme data.

Figure 3.1.3: Percentage of reception year children overweight (including obese) in East Sussex by deprivation (IDACI quintiles), 2016/17

What does good look like?

In England in 2016/17 the area with the lowest prevalence of obesity in reception aged children (4-5 years) was Kingston upon Thames with only 15% of children classified as overweight or obese. In East Sussex almost one in four children (23%) were classified as overweight or obese which is similar to the England average. The best 25% of local authorities in England had obesity rates of 8.4% or below.

Overall despite the proportion of children in East Sussex who are a healthy weight being similar to the England average, it is important to highlight that currently almost one in four children in East Sussex are carrying excess weight (overweight or obese) during their reception year of primary school, and to note that England has a comparatively high rate of obesity in reception aged children compared to our European counterparts.

How can we improve?

"Childhood obesity: a plan for action" is one of the few cross-government strategies to specifically and strategically address childhood obesity. Relevant priorities set out in the plan include:

- Helping all children to enjoy an hour of physical activity every day.
- Creating a new healthy rating scheme for primary schools.
- Making school food healthier.
- Supporting early years settings.
- Enabling health professionals to support families.

What are we doing in East Sussex?

The East Sussex Healthy Weight Partnership is a subgroup of the East Sussex Better Together (ESBT) and the Connecting 4 You (C4Y) Personal and Community Resilience steering group and brings partners from different sectors together to co-ordinate action to support healthy weight approaches across the county. The East Sussex Healthy Weight Plan 2016 – 2019 outlines an agreed vision for East Sussex, and sets out a programme of action which seeks to reduce the burden of excess weight and improve health outcomes across the county.

There are four thematic areas:

- **Environment** - creating a physical and social environment that promotes healthier lifestyle choices.
- **Workforce development** - developing the capacity and capability within the local workforce so that they are able to support others in achieving and maintaining a healthy weight.
- **Services and support** - ensuring the provision of quality services which support individuals to achieve and maintain a healthy weight and reduce their risk of developing a condition associated with excess weight.
- **Communications and engagement** - to enable people to understand the importance of a healthy weight and take action to address it.

Example activities that support achievement of healthy weight during the early years include:

- **Healthy Active Little Ones (HALO), East Sussex** – A workforce development and intervention programme to support nurseries to adopt a whole settings approach to obesity prevention and to enhance their approaches towards, and provision of, healthy food and physical activity.
- **Nursery Grants Programme** – A transformation programme building upon the approach and positive outcomes of the HALO – East Sussex programme, enabling every private and maintained nursery within eligible CCG areas to apply for a Grant of £5,000 to be used to fund evidence-based activities that seek to prevent/tackle childhood obesity.
- **Health Exercise Nutrition for the Really Young (HENRY)** -An innovative intervention to promote a healthy start in life and prevent child obesity, in which focuses on parenting, family lifestyle habits, nutrition, activity, and emotional wellbeing. The approach brings together workforce development, a preventive 8-week group parent programme, and targeted 1-to-1 support for families of children at risk of obesity or already overweight.
- **East Sussex School Health Improvement Grants** - A transformation programme enabling all state funded schools in East Sussex to access funds to develop a school health improvement plan, and using a primary prevention and whole school approach, put in place actions to address health and wellbeing priorities (including obesity) identified in the plan.
- **Beat the Street** – A community wide mass participation physical activity intervention designed to inspire communities to make small changes, such as walking or cycling to school or work every day, to improve their health, and to create lasting health benefits through creating a social norm around being active.
- **Amplification of national campaigns to promote healthy weight** (e.g. Start4Life, Change4Life, Our Healthy Year).

What are we doing in East Sussex?

- **East Sussex Health Promotion Resources Service** offers a **wide range of free resources** (leaflets, posters, teaching aids) **including those linked to tackling obesity** through heathy eating and physical activity. Resources are for use by any individuals in East Sussex who have a role in promoting health.
- **Maximising parental engagement as part of the NCMP**. The East Sussex School Health Service are currently piloting the impact of undertaking telephone calls with parents of overweight or obese children (both prior to and after receiving their child's NCMP results letter) in order to maximise behaviour change.

Key actions going forward

- **Implement the three year programme of action** from the East Sussex Healthy Weight Plan 2016-2019.
- **Ensure health visiting and school health services are maximising opportunities to support healthy weight** through diet and exercise advice to children and families.
- **Ensure that all opportunities to shape the environment to enable healthy weight are utilised** e.g. through developing healthy settings approaches in early years settings and schools and utilising planning and active travel approaches.
- **Increase availability and uptake of high quality, effective services which support increased healthy weight and reduced risk of conditions caused by excess weight:** ensuring services are targeted towards children and their families at all levels of need, especially in areas where the need is greatest.
- **Apply the Making Every Contact Count (MECC*) approach** across all organisations in East Sussex to ensure that staff and volunteers have the skills, competences and confidence to raise lifestyle issues with clients, provide brief advice and refer into services.

*MECC is

"an approach to healthcare that encourages all those who have contact with the public to talk about their health and wellbeing. It encourages health and social care staff to use the opportunities arising during their routine interactions with patients to have brief conversations on how they might make positive improvements to their health or wellbeing."

Health Education England

CHAPTER 3
Early Years
3.2 Healthy teeth and gums

Proportion of children with no obvious tooth decay at age five and average number of teeth affected by decay at age five.

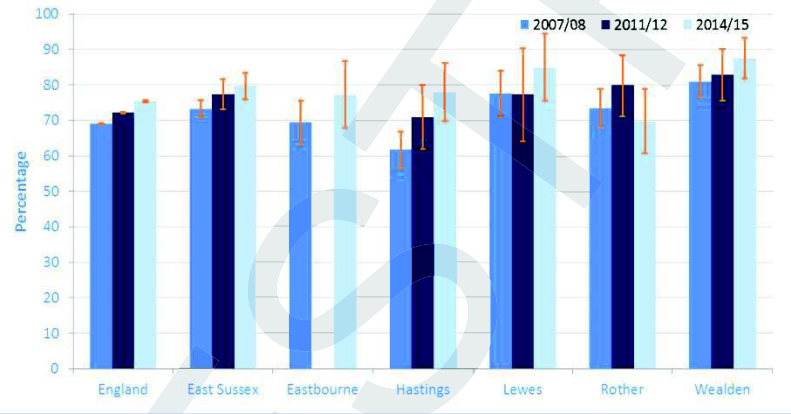
Key messages

- Good oral health is an important component of overall health and wellbeing for children. The measure can be an early indicator of the success of early years interventions e.g. weaning, diet, parenting skills.
- 80% of children in East Sussex are decay free. This is better than the England average of 75% decay free.
- Nationally, decay rates are higher for those in deprived populations; locally the differences are not statistically significant.
- For the just over 1 in 5 children in East Sussex with decay experience, on average 2.5 teeth have been affected by decay, which is fewer than the England average of 3.4 decayed teeth.
- Supervised teeth brushing at least twice a day, reduced sugar consumption and regular access to a dentist are crucial in preventing tooth decay.

What is this indicator showing us?

This indicator shows the proportion of 5-year olds with no decayed, missing or filled teeth ($d_3$mft).

5 years olds with no decayed, missing or filled teeth 2007/8, 2011/12 and 2014/15. England, East Sussex and districts and boroughs

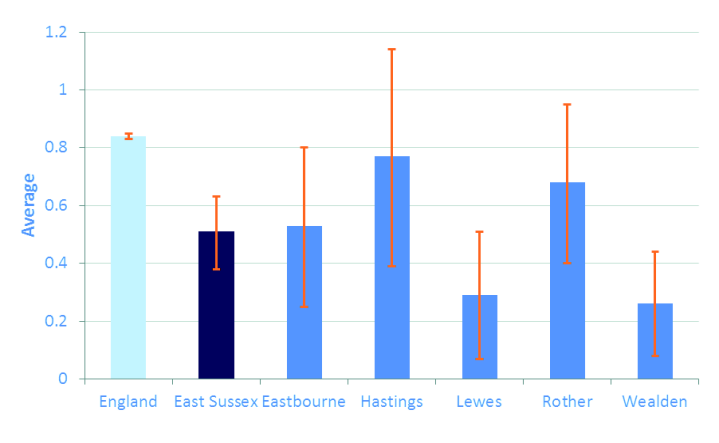


Latest data: 80% of 5 year olds in East Sussex had no decay versus 75 % in England. Rother had lowest rates of children who are decay free, significantly fewer than Wealden.

Trend: Oral health of 5 year olds has improved over the last 7 years, apart from in Rother where it has not changed significantly.

Source: PHE, Oral Health Surveys of five-year old children, 2007/08; 2011/12 and 2014/15

Figure 3.2.1: Percentage of 5 year olds with no decayed, missing or filled teeth in East Sussex by district and borough, 2007/08 to 2014/15



Latest data: The average number of $d_3$mft in East Sussex five year olds is 0.5. This is significantly lower than England average of 0.84 affected teeth. Average d3mft depends on the proportion of children affected by decay and the number of decayed teeth in those affected. Eastbourne, Wealden and Lewes have lower rates of d3mft than England.

Source: PHE, Oral Health Survey of five-year old children

Figure 3.2.2: Mean number of decayed, missing or filled teeth in five year olds in East Sussex by district and borough, 2014/15

Why is this indicator important?

Tooth decay is almost entirely preventable through good oral hygiene, fluoride toothpaste, reducing the amount and frequency of exposure to sugar and regular visits to the dentist.

Poor oral health can cause pain, infection and sepsis and may lead to problems with speech and swallowing. This can result in children missing days from school and parents losing work days. Oral health in five year olds can be considered a proxy indicator for a composite of good practice across various areas including weaning, diet and parenting skills .e.g. the ability to sustain a healthy daily routine.

Poor oral health may be an indicator of dental neglect. This is defined as 'persistent failure to meet a child's basic oral health needs, likely, to result in serious impairment of a child's oral or general health or development.' Where neglect is suspected this may raise other safeguarding concerns.

The cost of poor oral health to the National Health Service (NHS) and wider economy is significant. The NHS in England spends £3.4 billion per year on dental care.[20]

Where are we now in East Sussex?

We are aiming for a steady increase in the number of children with no tooth decay at age five across East Sussex, with an ultimate aim of eradicating tooth decay in almost all children. Early years work is important in providing the foundation for good oral health in adults.

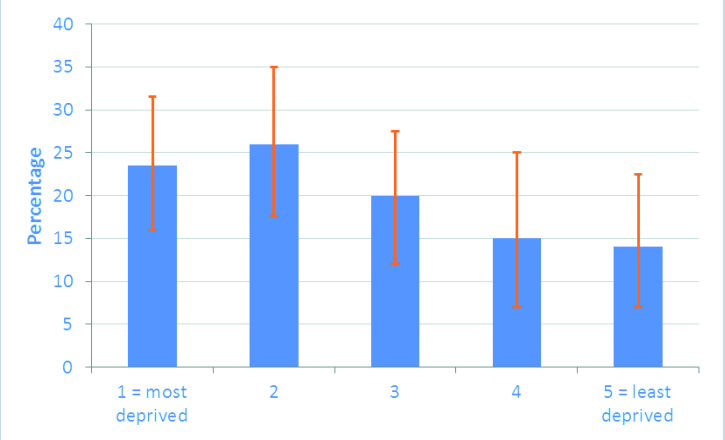
80% of children in East Sussex are decay free. Rother had the lowest proportion of decay free children in East Sussex while Lewes and Wealden had the highest proportions of decay free children.

Despite performing significantly better than the national average:

The average number of $d_3$mft in all five year olds in East Sussex is 0.5 teeth. Within East Sussex, five year olds in Eastbourne, Lewes and Wealden have the lowest mean numbers of $d_3$mft.

Spotlight on inequalities

National data shows a relationship between deprivation and decay, with children from more deprived areas having poorer oral health. Families who find it hard to manage daily routines e.g. tooth brushing and to set boundaries e.g. only consuming sugar at mealtimes are likely to have higher rates of decay. While there are not statistically significant differences, East Sussex data shows more children with decay in more deprived areas compared to less deprived areas.



Latest data: Based on PHE analysis of the 2015/16 oral health survey of 5 year olds in East Sussex, dental caries has some relationship with deprivation; however none of the differences between quintiles are statistically significant.

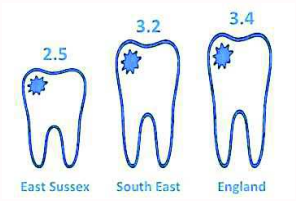
Source: PHE, Oral Health Survey of five-year old children

Figure 3.2.3: Percentage children aged 5 with decayed, missing or filled teeth in East Sussex by deprivation (Index of Multiple Deprivation (IMD) quintiles), 2015/16

What does good look like?

Across England the area with the highest proportion of five year olds with no dental decay is in South Gloucestershire (86%). East Sussex is amongst the best 25% of local authorities in the country with 80% of five year old children decay free compared to the England average of 75%.

Data from the 2015 dental epidemiology survey for five year olds shows that, similarly to survey findings in 2012, five year olds with decay experience in East Sussex have fewer affected teeth compared to England and the South East.



How can we improve?

Public Health England (PHE) guidance to local authorities for commissioning better oral health for children and young people recommends **putting children, young people and families at the heart of commissioning** and adopting a **proportionate universal approach** though **embedding oral health improvement into all children and young people's services**.

Interventions recommended include:

- Community action.
- Supporting consistent evidence informed oral health information.
- Supportive environments.
- Community based preventative services.
- Public policies e.g. sugar tax and increasing the availability of free drinking water.
- Oral health training for the wider health workforce.

What are we doing in East Sussex?

- A targeted community programme whereby **health visitors give out toothbrush packs and oral health advice** to parents at the universal 12 month and 27 month reviews.
- East Sussex Healthcare NHS Trust (ESHT) are **promoting oral health in the paediatric department** by extending coverage of the Mouth Care Matters* initiative as well as encouraging paediatricians to **include oral health as part of their overall assessment of a child**.
- The School Health Service delivers an **oral health promotion assembly in all primary schools** in East Sussex in term 4 to ensure that children are reminded how to look after their teeth.
- **The Local Safeguarding Children Board run *training on neglect* reminds professionals** of the importance of daily tooth brushing routines, a reduced sugar diet and attending dental appointments in preventing decay.
- Section 3.1 describes **interventions to improve nutrition** which **will reduce children's exposure to sugar** and improve oral health.

"Mouth Care Matters" is a Health Education England initiative across Kent, Surry and Sussex to improve the oral health of hospitalised patients by ensuring oral hygiene routines are not neglected during hospital stays, and oral health issues which are delaying recovery are treated.

Key actions going forward

- **Continue health visitor oral health programme** (handing out toothbrush packs and giving parents advice to register with a dentist at the 12 month check and 27 month).
- **Support the British Society of Paediatric Dentistry campaign** to promote dental checks by 1 year.
- **Develop oral health promotion resources for early years settings** to use alongside healthy eating activities to promote positive oral health behaviours.
- Ensure **oral health assessment** becomes **standard practice for ESHT paediatric inpatients**.
- Commission **oral health promotion training for all front-life staff working with children** in early years.

CHAPTER 3
Early Years
3.3 Hospital admissions due to accidents and injuries

Rate of emergency hospital admissions for unintentional and deliberate injuries in children under 5 years.

Key messages

- Accidents are entirely preventable, yet unintentional injuries are a major cause of ill health and disability in children in East Sussex.
- In 2015/2016 there were 419 injury-related hospital admissions across East Sussex for children under five years.
- Admission rates in East Sussex are significantly higher than England (148 versus 130 per 10,000).
- Despite recent decreases Hastings still has the highest admission rates in the county.
- 67% of non-traffic accidents in under 5s requiring hospital admission in East Sussex were recorded as happening at home.
- Injury reductions can be achieved at low cost through parent education, key staff group training and local coordination including the Home Safety Equipment Scheme.

What is this indicator showing us?

The rate of 0-4 year olds admitted to hospital due to accidents and injuries, per 10,000 population aged 0-4 years. Note this indicator is the Public Health Outcomes Framework indicator 2.07i.

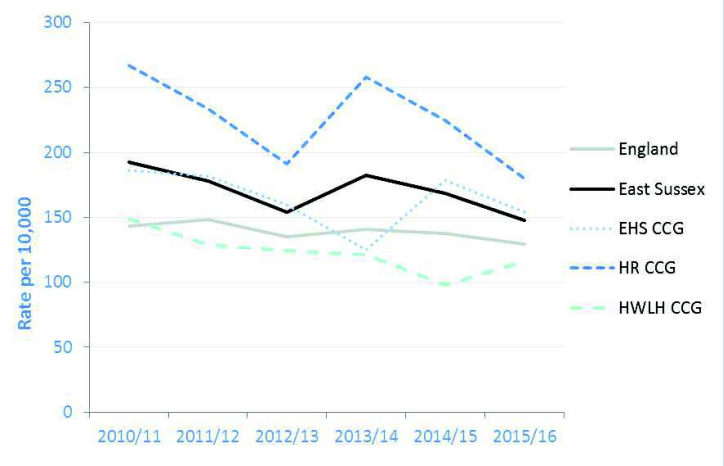
Hospital admissions caused by unintentional and deliberate injuries, 0-4 years, rate per 10,000 population.

Latest data: In 2015/16 there were 148 admissions per 10,000.population aged 0-4 in East Sussex; significantly higher than for England (130 per 10,000).

Trend: Overall for East Sussex there has been a slight decrease in hospital admissions between 2010/11 and 2015/16 albeit with higher rates in intervening years.

Source: PHE, Public Health Outcomes Framework

Figure 3.3.1: Emergency hospital admissions per 10,000 population aged 0-4 for unintentional and deliberate injury in East Sussex by district and borough, 2010/11 to 2015/16



Latest data: In 2015/16 admissions were highest in Hastings and Rother CCG area, and lowest in High Weald Lewes Havens CCG area.

Trend: Despite the overall downward trend across East Sussex over the last six years, there have been large fluctations at a CCG level. By 2015/16 the difference in accident rates between Hastings and Rother and High Weald Lewes Havens was smaller than it was in 2010/11.

Source: PHE, Public Health Outcomes Framework

Figure 3.3.2: Emergency hospital admissions per 10,000 population aged 0-4 for unintentional and deliberate injury in East Sussex by CCG, 2010/11 to 2015/16

Why is this indicator important?

Accidents are almost entirely preventable and are a major cause of ill health and disability.

Accidents and injuries are one of the main causes of ill health, disability and death in children under five years in East Sussex and England. The majority of accidents and injuries take place in and around the home in this age group; hence home safety improvement is a key preventative factor.

Accident prevention will reduce costs to the health and social care system in East Sussex.

Accidents in children aged under 5 years are strongly linked to deprivation and so efforts to reduce accidents and injuries contribute to reducing inequalities in health across the county.

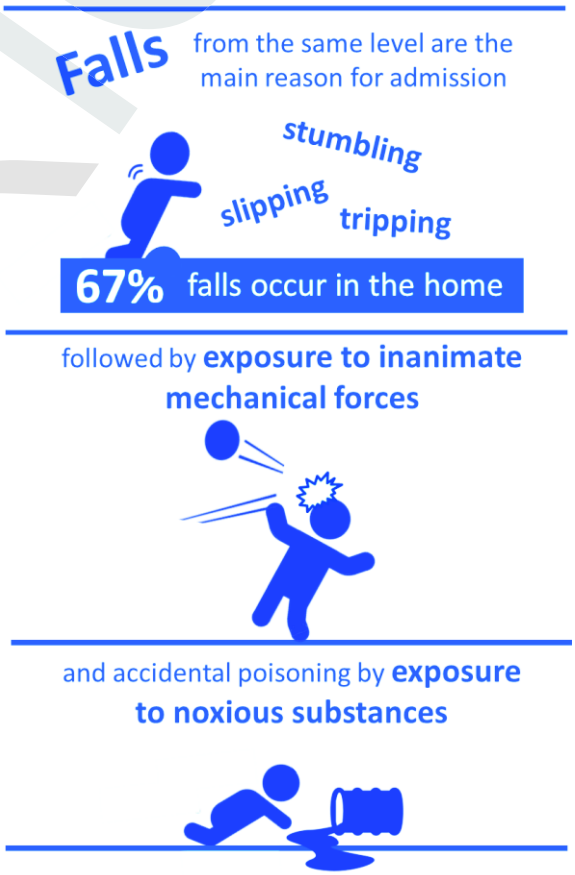
Where are we now in East Sussex?

There is no national target but an achievable target would be to reduce the rate of injuries across East Sussex to below the England rate.

Hospital admission rates are highest in Hastings and Rother CCG area and in Hastings borough and Rother district. Lewes district and High Weald Lewes Havens CCG have the lowest rates of admissions due to accidents across the county.

2015/16 data shows that the difference in accident rates between Hastings and Rother CCG and High Weald Lewes Havens CCG reduced due to a large decrease in Hastings and Rother rates and a slight increase in High Weald Lewes Havens.

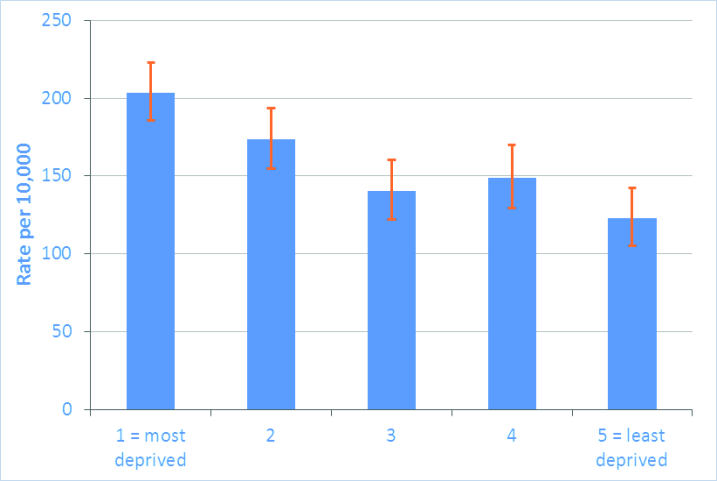
Admissions for accidents and injuries:



Source: Public Health analysis of SUS data.

Spotlight on inequalities:

Injuries are preventable and are strongly linked to levels of deprivation. There is a general increasing rate of hospital admission due to injuries with increasing levels of deprivation.



Latest: Children in the most deprived areas of East Sussex have significantly higher admission rates for accidents and injuries compared to those in the least deprived areas.

Source: East Sussex Public Health SUS extracts.

Figure 3.3.3: Emergency hospital admissions per 10,000 population aged 0-4 for unintentional and deliberate injury in East Sussex deprivation (IDACI quintiles), 2013/14 to 2015/16

What does good look like?

In England the lowest rate of admissions for unintentional and deliberate injuries in 0-4 year olds was 56 per 10,000 in Westminster, which is less than half the rate in East Sussex. The best 25% of areas in the country had admission rates below 104 per 10,000. East Sussex has significantly higher admission rates due to accidents than England with 148 versus 130 per admissions per 10,000.

How can we improve?

A **multi-sector approach** to reducing rates of accidents and injuries is required involving staff from health, education, social care, housing and emergency services. Targeted support, including equipment schemes, training and information has been shown to reduce the rates of accidents. Actions include:

- **Training key staff groups** such as health visitors, children's centre staff, early-years settings staff and early help staff to **prevent injuries** and **educate and support parents** in injury prevention and important safety practices such as safe bathing.
- Continuing to improve the promotion and distribution of a range of **home safety equipment** including safety locks for kitchen and bathroom cupboards, safety cords for blinds and curtains, stair gates, hot tap mixer valves and smoke alarms.
- **Paediatricians and hospital staff have a role to play in identifying children who may be at higher risk**, as well as **data collection on injuries**, and **supporting parents in preventing injuries**.

All of these **preventative measures are low cost and can lead to substantial cost savings** across the health and social care system.

What are we doing in East Sussex?

In addition to analysis of routine monitoring data an early alert system has been implemented at ESHT. This involves a Paediatric Liaison Nurse Service at the Trust recording data on the reasons for children (0-16 years) attending A&E in Eastbourne and Hastings. The data are sent to Public Health regularly to enable early identification of any emerging trends in accidents, allowing the relevant health and social care professionals to be alerted and additional advice to parents and preventative measures to be put in place. **Following a review of effective actions to address child accidents several activities have been commissioned** as part of a wider approach to support the reduction of hospital admissions /attendances due to injuries in children aged 0-4 years and to reducing inequalities in accidents across the county:

- **Accident prevention training** (to include Train the Trainer) for the Early Years (0-5) workforce to enhance their skills and confidence in raising the importance of measures to prevent accidents amongst families with young children. The training emphasises the importance of targeting those living in disadvantaged communities.
- Key staff groups, including health visitors, community nursery nurses, children's centre keyworkers and the Early Help Family Keyworkers carry out **home safety assessments** with families using a locally adapted Home Safety Checklist.
- **Practical support to create safer home environments** is available to targeted families with children 0-2 years. The *East Sussex Child Home Safety Advice and Equipment Service* fits home safety equipment and provides relevant evidence-based home safety education and advice at *Safe and Well* visits.

Key actions going forward

Support Health Visitors in their delivery of the Healthy Child Programme high impact area **"managing minor illness and reducing accidents".**

- **Continue to feedback A&E local data** to staff groups working with 0-5 years to **ensure accident prevention training and advice to parents is appropriate and targeted**.
- **Evaluate** the impact of **the Child Home Safety Advice and Equipment Service** and **ensure** that **interventions are reaching the families with most capacity to benefit**.
- Continue to **raise awareness of accident preventions amongst professionals** through **amplification of national safety campaigns** e.g. Child Accident Prevention Trust - Child Safety Week.

CHAPTER 3
Early Years
3.4 School readiness

Percentage of children achieving a good level of development by the end of reception (Early Years Foundation Stage).

Key messages

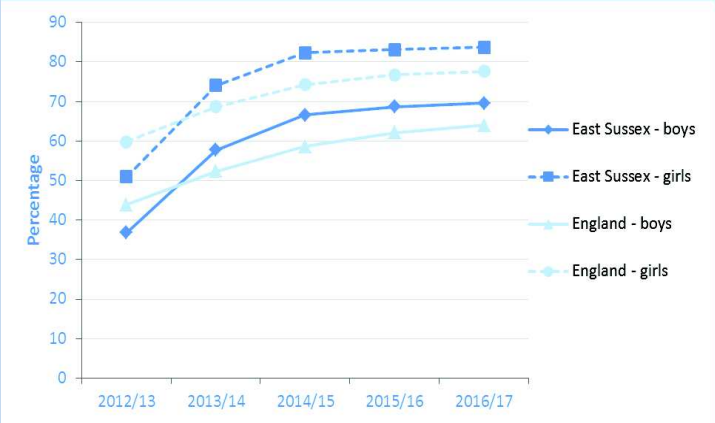
- School readiness is an important measure of early year's development across a wide range of learning areas and has been linked with better academic outcomes from primary and secondary education as well as positive behavioural and social outcomes in adulthood.
- School readiness starts at birth with the support of parents and caregivers, when young children acquire the social and emotional skills, knowledge and attitudes necessary for success in school and life.
- Pre-schools, nurseries and childminders play an important role in supporting child development and good early education experience can significantly support social mobility.
- In East Sussex 96.8% of early years providers are now rated good or outstanding by Ofsted: a 20.3% percentage point increase since 2013.This is above the national average.
- Since 2013/14 a greater proportion of children in East Sussex have achieved a good level of development compared to the England average.
- In East Sussex, fewer children eligible for free school meals (FSM) reach the expected level of achievement in phonics compared to their non-FSM peers. Boys eligible for FSM are further behind their non-FSM peers than girls eligible for FSM are.
- Every £1 spent on early years results in £13 of savings to tax payers in later years. For every £1 spent on early years education £7 has to be spent on adolescent education to get the same impact.

What is this indicator showing us?

This indicator shows the proportion of children who have reached the expected level of development (in a range of learning areas) by the end of a reception year at school and are therefore considered ready for school. School readiness is measured at the *end* of the reception year of school as this marks the end of the Early Years Foundation Stage.

The learning areas included are: personal, social and emotional development; physical development; communication and language and the early learning goals for maths and literacy.

Percentage of children achieving a good level of development at the end of reception

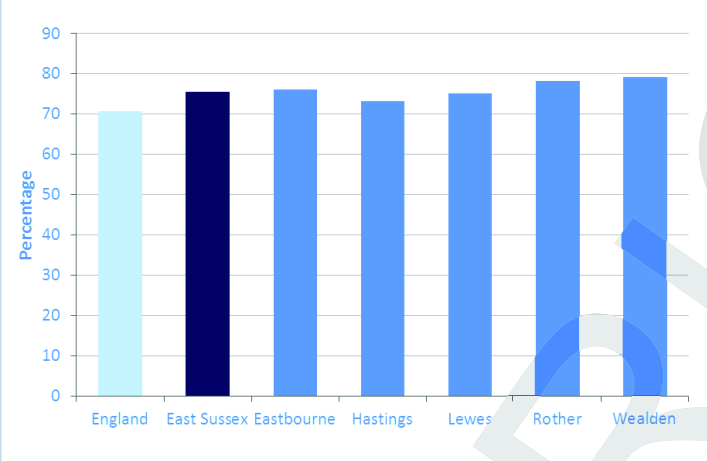


Latest: in 2016/17, 84% of girls and 70% of boys in East Sussex achieved a good level of development at the end of reception. This shows a rise for both boys and girls.

Trends: Since 2012/13 there has been an upward trend in the proportion of children achieving a good level of development at the end of reception.

Source: DfE, Early Years Foundation Stage Profile.

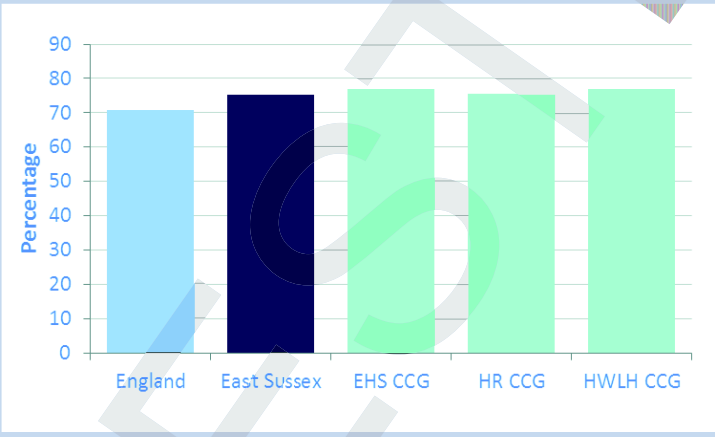
Figure 3.4.1: Percentage children achieving a good level of development by the end of reception in East Sussex by sex, 2012/13 to 2016/17



Latest: Wealden had the highest proportion of children with a good level of development (79%) and Hastings the lowest (73%). The England average was 71%.

Source: East Sussex JSNAA scorecard 2.16

Figure 3.4.2: Percentage children achieving a good level of development by the end of reception in East Sussex by district and borough, 2012/13 to 2016/17



Latest: In 2016/17 the proportion of children ready for school is very similar across all three East Sussex CCGs, ranging from 76% in Hastings and Rother CCG to 77% in High Weald Lewes Havens CCG and Eastbourne, Hailsham and Seaford CCG.

Source: East Sussex JSNAA scorecard 2.16

Figure 3.4.3: Percentage children achieving a good level of development by the end of reception in East Sussex by CCG, 2012/13 to 2016/17