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Please read this chapter in conjunction with -

**JSNA Chapters:**

[Warrington JSNA Children and Young People - Healthy Weight Chapter](#)

[Warrington Joint Strategic Needs Assessment Index](#)

[Warrington JSNA Wider Environmental Context and Transport Chapter](#)

[Warrington JSNA Healthy Weight Chapter](#)

[Warrington JSNA Housing Chapter](#)

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[Warrington JSNA Teenage Conceptions Chapter](#)

[Warrington JSNA Children and Young People - Immunisations Chapter](#)

[Warrington JSNA Children and Young People - Emotional Health and Wellbeing Chapter](#)

[Warrington JSNA Early Help and Targeted Services for Children and Families Chapter](#)

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## Warrington Joint Strategic Needs Assessment (JSNA) 2011 - Children and Young People - 0-5 Years Chapter



The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities.

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# Executive Summary

## Scope of the Chapter

The information contained in this chapter is based on the structure contained in the *Healthy Child Programme - Pregnancy and the First Five Years* (Department of Health, 2009a) which looks at pregnancy, the child, parenting and family. The information contained in this chapter compares Warrington to regional and national data. The data for Warrington has also been analysed at geographical and GP level.

It is acknowledged that this chapter may not include all the information available about children aged 0 to 5 years. However, it does contain all information that is held by Public Health and Information that is available to the public from the internet.

## Introduction

Applying a life course approach to the health and wellbeing of children and young people takes into account the impact of disadvantage, which starts before birth and accumulates throughout life. Research has shown that the formative years can influence health in later life. Giving every child the best start in life lays the foundation for better health outcomes. This requires multi-agency/partnership working.

There is a complex interaction between biological, genetic, social and behavioural factors across the life course. There is evidence to support a health promoting environment as early as pre-conception (early support for a healthy pregnancy). Families at higher risk and with lower protective factors need to be identified to improve health outcomes.

The Healthy Child Programme (0-5 years) provides a vital, evidence-based, good practice framework to work collaboratively across the early years settings to provide universal and targeted support for families most in need. The Healthy Child Programme (HCP) recommends that a multidisciplinary team delivers the HCP across localities – in primary care, in schools, in the community etc. It could include health visiting, community paediatricians, sexual health services, primary mental health workers, immunisation teams, safeguarding professionals, and a range of public health and health promotion specialists. The HCP team can also facilitate access to a wider range of specialist support, including: Child and Adolescent Mental Health Services (CAMHS), specialist children's and families' social care, speech and language therapy (SALT), and specialist support for children and young people.

Warrington's Child Poverty Strategy and the Children and Young People's Plan recognise the need to provide early intervention with families according to need. Increasing the protective factors will break down the cycle of generational disadvantage and ultimately improve health and wellbeing outcomes.

## Key Issues and Gaps

Infant mortality rates are very low in Warrington.

Warrington has a lower level of low birth weight births than England and the North West. Within Warrington, the more deprived wards tend to have a higher percentage of low birth weight births. However, some of the more affluent wards also have a higher percentage than the Warrington average.

Warrington has lower initiation and continuation rates for breast feeding when compared to national figures. Initiation rates were very low in the more deprived wards of Warrington.

Emergency admission rates for children aged under 5 years are significantly higher in Warrington than the average for England, with the more deprived wards experiencing the highest rates. Respiratory disease is amongst the most common causes of admission, along with injuries and poisonings, and infectious illnesses.

Warrington has a lower level of children under 4 years at risk of child abuse and neglect than England and the North West.

There is no agreed, co-ordinated, universal and targeted prevention and early intervention approach to children and young people's health and wellbeing. There needs to be a clear focus on reducing health inequalities for those health indicators that show a variation within Warrington's more affluent and deprived areas, in order to achieve health improvements/outcomes and health behaviour changes.

## Recommendations for Commissioning

- Reduce the health inequalities and achieve health outcomes using an agreed, co-ordinated, universal and targeted prevention, as well as early intervention, approach.
- Ensure that maternity services are integrated with the health visiting services and other community children's health services, as well as with children's centres and other local authority commissioned or provided services for 0-5 year olds.
- Reduce infant mortality through the implementation of initiatives aimed at improving maternal and infant health. For example, reducing pregnancy in under-18s, preventing sudden unexpected death in infancy and implementing the child poverty strategy.
- In collaboration with the local Hospital Trust and key partners, further investigate the high rates of emergency admissions amongst young children in Warrington, to better understand the reasons, and to ensure that appropriate action is taken to reduce avoidable admissions and ensure the right care pathways are in place and followed.
- Investigate the resource and capacity implications of delivering the Family Nurse Partnership Programme.
- Implement the Healthy Child Programme (DH, 2009a) relevant to maternal and newborn health.

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## 1) Who's At Risk and Why

In 2008/09 there were just over 90,000 babies born in the North West. The North West has the same proportion of babies born with low birth weight as the England average (7.4% of live and still births). However, there is variation across the North West and across localities/ wards. The North West experiences relatively few maternal deaths.

**Infant mortality** (the death rate amongst babies less than one year old) is used as an indicator of population health, in that it reflects socio-economic factors and maternal health. Infant mortality formed part of the previous government's plan to tackle health inequalities, with a 10% reduction in the gap between rates in 'routine and manual' (R&M) socio-economic groups and England as a whole required by 2010. Infant mortality was the second aspect of the health inequalities Public Service Agreement (PSA) target that was a mandatory indicator for both PCT and local government. Of the infant deaths that occurred in the North West, more than half occurred in children who lived in the most deprived areas.

There are a number of factors associated with an increased risk of infant mortality. The National Support Team for Infant Mortality (IMNST) brought together information on the range of factors that are known to impact on infant mortality and modelled the potential contribution of each to a reduction in infant mortality (DH, 2007c).

The Department of Health (DH, 2007c) suggest that meeting the child poverty strategy, by helping lone parents into work and ensuring that parents stay and progress in their jobs, will decrease the 2002-04 gap in infant mortality by 3 percentage points.

Lowering the prevalence of parental obesity in the R&M group and reducing smoking in pregnancy could further decrease the 2002-04 gap by almost 5 percentage points. These topics are discussed in more detail in the Pregnancy Chapter of the JSNA.

Children exposed to tobacco smoke are at much greater risk of sudden unexpected death in infancy (SUDI), meningitis, lung infections and ear disease (NICE, 2012).

Preventing 10% of SUDI in the R&M group could reduce the 2002-04 infant mortality gap by 1.4 percentage points. The current information provided to mothers needs to be maintained to achieve this reduction and it is recommended that the Back to Sleep campaign is targeted at the 'routine and manual' population. SUDI can also be reduced by tackling overcrowding in this group, and it is estimated that this could reduce the gap by a further 1.4 percentage points. There is more information on overcrowding in the JSNA Chapter on Housing.

An important aspect of reducing infant mortality is teenage pregnancy. To reduce the 2002-04 gap by 1 percentage point, a reduction of 44% is needed in under-18 conceptions in the R&M group. The Department of Health recommends prevention and support for 'at risk' teenagers as an appropriate intervention. There is more information on this topic in the Teenage Conceptions Chapter ([teenage conceptions data, charts and maps available here](#)).

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## 2) The Level of Need in the Population

### 2.1) The Child

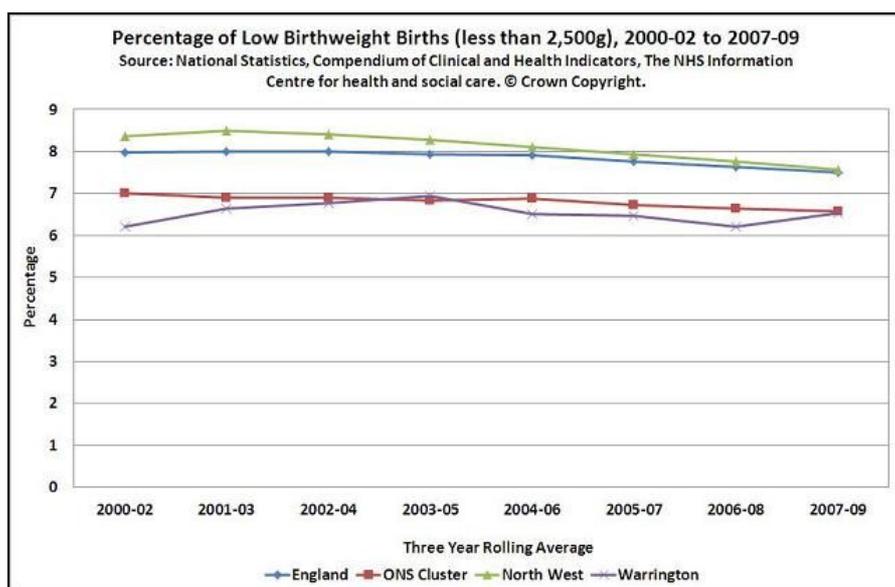
**2.1.1) Infant Mortality:** The number of infant deaths in Warrington per year is very small. Using 3-year pooled data for 2008-10, there were 34 deaths amongst babies aged under one year, giving a rate of 4.6 per 1,000 live births. This rate is the same as the rate for England.

In England, infant mortality rates remain higher than average for babies with fathers in routine and manual occupations (4.7 deaths per 1,000 live births) and for births registered by the mother alone (5.9 deaths per 1,000 live births). In contrast, infant mortality rates remained lowest for babies whose fathers were in managerial and professional occupations, at 3.1 deaths per 1,000 live births (DH, 2011a).

As with other health indicators, there is variation within Warrington. However, the very small number of deaths means it is not feasible to calculate robust LSOA or ward level rates, as even aggregating a number of years will still result in very small numbers at this level. In view of these issues, in order to monitor the health inequalities target at a local level, it is necessary to look at other indicators of infant health. Low birth weight is a useful indicator and the Government has proposed two further indicators which can be used as interim measures for the infant mortality indicator; breastfeeding initiation (discussed in this Chapter) and smoking in pregnancy (discussed in the Pregnancy Chapter).

**2.1.2) Low Birth Weight Births:** The birth weight of a baby is considered to be low when the weight is below 2500 grams. Low birth weight is predictive of increased risk of ill health and the incidence is linked to socio-economic and lifestyle (e.g. smoking) factors. In Warrington, the percentage of births under 2,500 grams has fluctuated over recent years. However, the overall trend has shown that it is keeping relatively stable. The trend for England, the ONS Cluster, and the North West is showing a slight reduction in the percentage of low birth weight births, as shown in Chart 1.

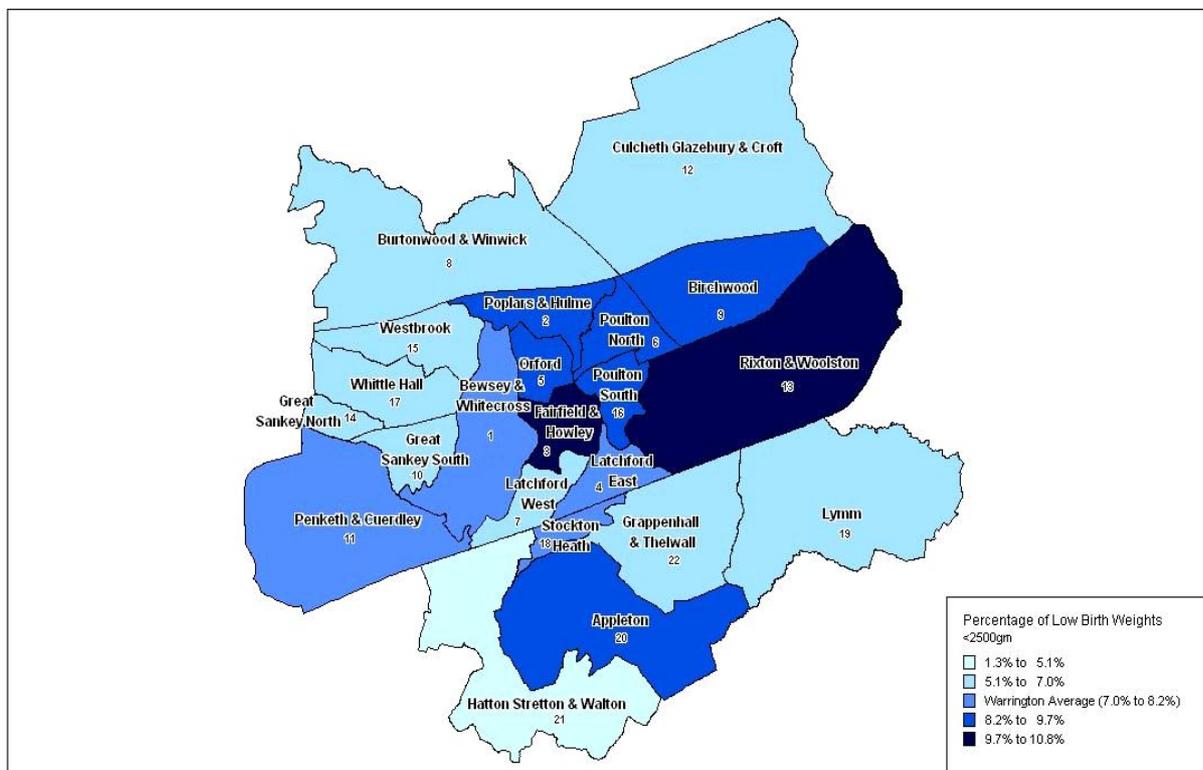
**Chart 1: Percentage of Low Birth Weight Births (less than 2,500g), 2000-02 to 2007-09**



(Source: National Statistics, Compendium of Clinical and Health Indicators, The NHS Information Centre for Health and Social Care. © Crown Copyright.)

With the exception of Latchford West, the inner, most deprived, Warrington wards tend to have a higher percentage of low birth weight babies than the Warrington average (7.4%). Rixton and Woolston, which is one of the most affluent wards in Warrington (19th most deprived ward), had the highest percentage of low birth weights (10.7%) as shown in Map 1. However, it should be noted that there were no significant differences in the percentage of low birth weight birth between the wards in Warrington.

**Map 1: Percentage of Low Birth Weights (Under 2500gs)**



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Licence number 100019918  
August 2011  
G:\HP\GIS\DATA\WORKSPAC\...  
C&YP Updated Maps

Percentage of births with a low birth weight (<2,500gms)  
by electoral ward  
1st January 2008 to 31st December 2009

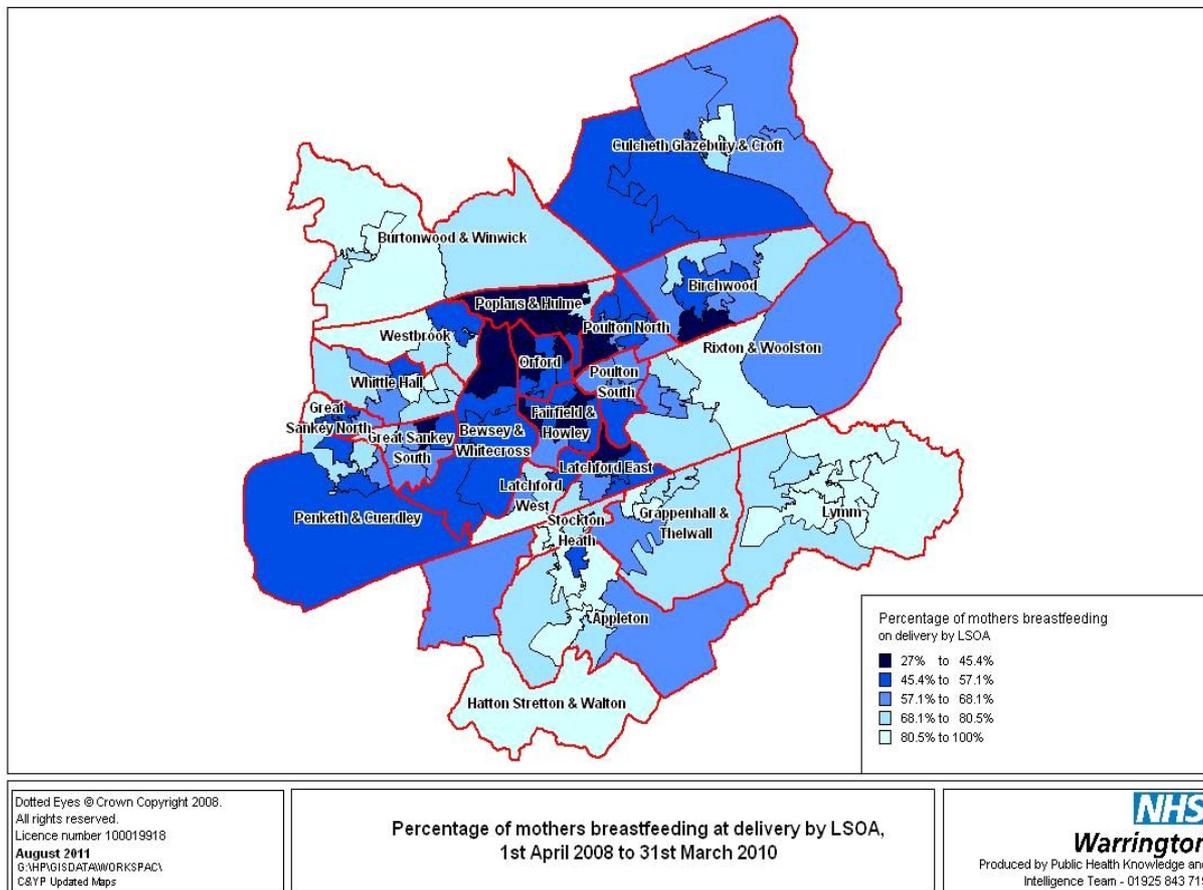
**NHS**  
**Warrington**  
Produced by Public Health Knowledge and  
Intelligence Team - 01925 843 719

**2.1.3) Breastfeeding:** There are three Department of Health (DH) vital signs for breastfeeding: *initiation of breastfeeding (VS 7102b)*, *prevalence of breastfeeding (at 6-8 weeks) (VSB11\_05)* and *breastfeeding coverage (VSB11\_06)*.

Warrington continue to fail their vital signs for initiation of breastfeeding. The 2010/11 breastfeeding initiation rate in Warrington was 61.4% (England 73.5%) and the target set by the DH was 64%, with this target increasing by 5% in 2011/12 and 2012/13. The prevalence of breastfeeding at 6-8 weeks (where babies are breastfed partially or totally) was 34% in Warrington, compared to the national average of 45.2% for the same time period, meaning that Warrington failed the DH target of 48.7%. Warrington now consistently pass their coverage target (and have done for the last two years), after failing this in all previous years, even with the target increasing by 5% in 2010-11. Data (Q4 2010/11) sourced from ChiMat breastfeeding profiles (ChiMat, 2011) has shown that Warrington had significantly worse breastfeeding initiation rates than England (Warrington – 61.98%; England – 73.43%), significantly worse prevalence of breastfeeding at 6-8 weeks than England (Warrington – 33.39%; England – 45.22%) and significantly worse percentage of babies ever put to the breast than England (Warrington – 64.80%; England – 79.10%) (ChiMat, 2011).

Breastfeeding within Warrington is much less prevalent in the more deprived areas of the borough, as illustrated in Map 2. Breastfeeding initiation was very low in the wards of Poplars and Hulme, Bewsey and Whitecross, Orford, Poulton North, Fairfield and Howley, and parts of Latchford East.

**Map 2: Percentage of Mothers Breastfeeding on Delivery, 2008 to 2010**



Small amounts of alcohol pass into breast milk if a woman chooses to drink whilst breastfeeding. This can make the milk smell different, which may affect the baby's feeding, sleeping or digestion. Research shows that occasional drinking whilst breastfeeding, such as one or two units, once or twice a week, is not harmful to the baby. However, it is recommended to wait for a couple of hours after a drink before breastfeeding (NHS Choices, 2011).

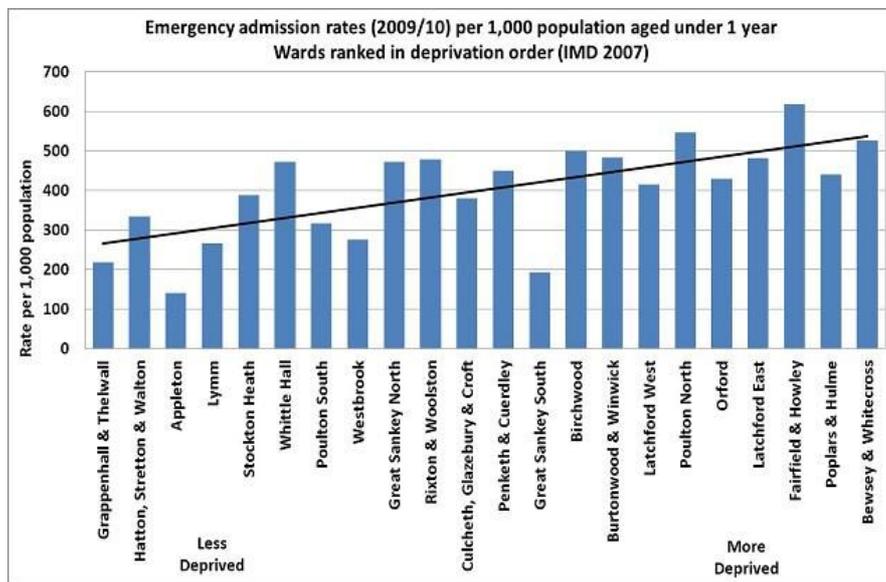
**2.1.4) Immunisations** are most effective if the majority of the population is immunised. This creates 'herd immunity' and protects against epidemics. To achieve herd immunity, 95% of the population need to be immunised and this is the national target uptake for childhood immunisations. Generally, with the exception of MMR, uptake of all childhood immunisations is high, but does not achieve the 95% target. MMR uptake is generally lower and rates have fluctuated over recent years, mainly as a result of media scares. For more information, please refer to the Childhood Vaccination and Immunisations Chapter.

## 2.2) Parenting and the Family

**2.2.1) Emergency admission** rates for children under 5 years are significantly higher in Warrington than the national average. There are around 2,500 emergency admissions per year of Warrington children aged 0 to 4 years, and the admission rate in 2011/12 was approximately 24% higher than the average for England. Trend analysis suggests that rates are decreasing over time, but they remain significantly higher than the England average.

Rates are highest in the more deprived areas. Some of the high rates in the most deprived wards might be explained by proximity to the hospital. Warrington Hospital is located in the Bewsey and Whitecross ward in Central Warrington, which has an emergency admission rate for children under 1 year of 526.3 per 1,000 population, but it has been evidenced that deprivation is a major factor in the rate of emergency hospital admissions.

**Chart 2: Infant Emergency Admission Rates, 2009/2010**



(Source: NHS Warrington, Oracle Data Warehouse, 2011)

It is possible to identify the main reasons for admission using the primary diagnosis codes as recorded on the hospital record. For emergency admissions in 2009/10 amongst infants aged under one-year, the main reasons for admissions were: *diseases of the respiratory system*, which accounted for approximately 25.3% of all emergency admissions in the age group and *conditions originating in the perinatal period* (period just after childbirth), which accounted for 18.5%. Approximately 15.2% of emergency admissions in infants were for ill-defined symptoms, including coughs, fever, breathing difficulties, skin conditions and pain. *Infectious and parasitic diseases* accounted for 14.8% of admissions in the year.

**2.2.2) Gastrointestinal Infections and Respiratory Tract Infections:** The purpose of monitoring emergency hospital admissions for gastrointestinal infections and respiratory tract infections is to help monitor the success of the NHS in treating, outside hospitals, types of childhood gastroenteritis and respiratory tract infections that have a limited need for hospital-based care and low mortality. This includes:

- Encouraging breastfeeding, smoking reduction, better diet, hygiene, and management of infections.
- Better support for young parents in the care of their children and in the management of illnesses in the home.
- Providing support, as well as facilitating access to health advice and therapy, through NHS Direct.
- Enhanced primary care (ChiMat, 2011).

During 2009/10, the rate of emergency hospital admissions due to gastroenteritis in children aged less than one year was significantly higher in Warrington (391.67 per 10,000 population) when compared to England (254.18 per 10,000). This was also true for ages 0 to 4 years (Warrington – 152.99 per 10,000; England – 130.15 per 10,000) (ChiMat, 2011).

The rate of emergency admissions due to respiratory tract infections was significantly higher in Warrington for ages 2 to 4 years (Warrington – 45.88 per 10,000; England – 25.18) and ages 0 to 4 years (Warrington – 135.9 per 10,000; England – 115.26 per 10,000) during 2009/10 (ChiMat, 2011).

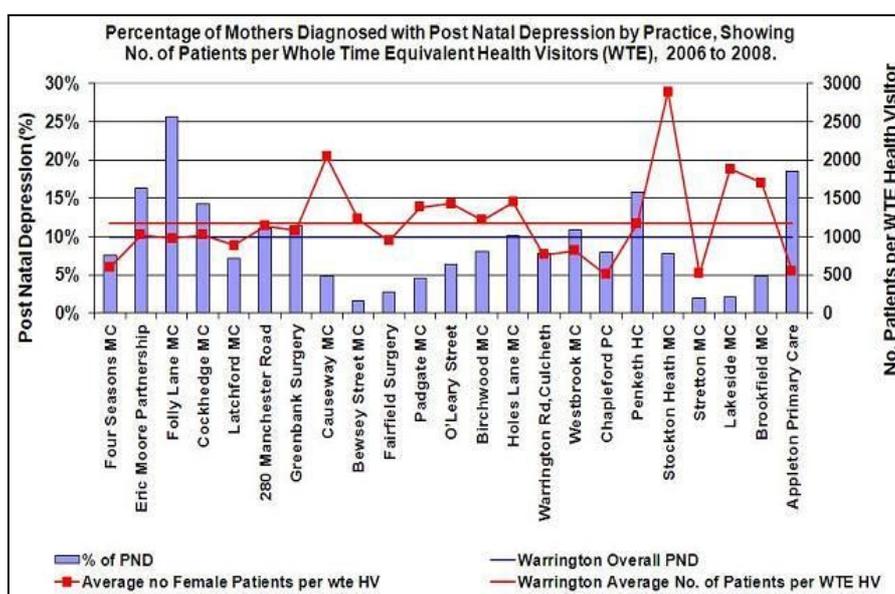
**2.2.3) Post Natal Depression (PND)** is a form of clinical depression and can occur up to six months after giving birth. The Edinburgh Postnatal Depression Scale is used by health visitors to detect PND. If a new mother scores 13 or more they are likely to develop PND. Nationally, it is estimated that for every 1,000 live births, 100-150 women will suffer a depressive illness and one or two women will develop a puerperal psychosis (a severe mental disorder that occurs after giving birth) (Scottish Intercollegiate Guidelines Network, 2002). There are approximately 2,000 births every year in Warrington and application of national PND prevalence suggests that 200-300 mothers a year may develop PND in Warrington.

If left undiagnosed, PND can last for months and, in very rare occasions, years (Royal College of Psychiatrists, 2009). Untreated postnatal depression can be detrimental to an infant's development. Failure to treat the disorder may result in a prolonged, detrimental effect on the relationship between the mother and baby and on the child's psychological, social and educational development (Murray and Cooper, 1997).

In 2004, a Practice Staff Equity Audit was undertaken. Information relating to health visitors was obtained in this year from health visitor teams. It has not been possible to obtain an up-to-date dataset and therefore this data was used. As health visitors work in teams that cover more than one practice, the total number of hours worked by each particular team was totalled, along with the total female 15 to 44 year population of all practices managed by the team. The provision of health visitors has been expressed as a rate per 1,000 population.

Chart 3 presents PND data for 23 Warrington practices, with the number of female patients per whole time equivalent (WTE<sup>1</sup>) health visitor (HV).

**Chart 3: Post Natal Depression, by Practice, 2006 to 2008 aggregated data, with the Number of WTE Health Visitors**



(Source: NHS Warrington Mental Health Needs Assessment of the Adult Population)

The chart suggests there is not an association with the number of health visitors and the number of patients diagnosed with PND over the three years. Appleton Primary Care and Folly Lane appear to have a higher percentage of patients with PND and health visitors at both practices have lower caseloads than the Warrington overall average. Reasons for the higher PND prevalence would need to be investigated further to see if some practices are more effective at diagnosing PND, as opposed to the area actually having a higher number of PND patients.

Data suggests that PND prevalence in Warrington is decreasing from 14% of mothers diagnosed with PND in 2006 to 10% in 2008. However, a complete set of data and on-going monitoring are required to robustly assess whether this trend continues and truly reflects PND prevalence (NHS Warrington, 2009).

**2.2.4) Child Abuse and Neglect:** Warrington has a lower level of children under 4 years at risk of child abuse and neglect than England and the North West. A child protection plan is formulated to protect a child if they are deemed to be at continuing risk of significant harm. Significant harm includes any physical, sexual, or emotional abuse, neglect, accident or injury that can adversely affect the progress and enjoyment of life. This can also include seeing or hearing the ill treatment of another person. Using data from 2011, it is estimated that 2.4% of children under the age of 4 in Warrington have a child protection plan, compared to 3.0% in England and 3.1% in the North West.

As of 31st December 2011, there were 195 children overall with a current child protection plan in Warrington (Warrington Borough Council, 2012). More than 50% of children with a child protection plan are within the 0 to 5 age group (see Table 1).

**Table 1: Age Breakdown of Warrington Children with a Child Protection Plan, 31st December 2011**

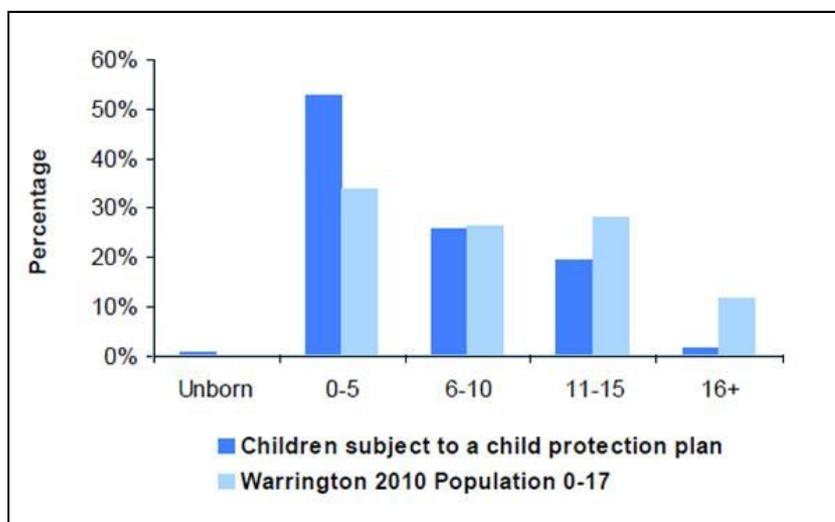
Age	Total
Unborn	-
0-5	103
6-10	50
11-15	38
16+	-

(Source: Warrington Borough Council, 2012)

Numbers less than five, but not zero, are represented by '-'

Chart 4 indicates that over half the child protection plans in Warrington are for children aged 0 to 5. The chart also shows that, although the largest proportion of all Warrington children fall into this age group, it does not wholly account for the increased number of child protection plans in this group.

**Chart 4: Age Distribution of Warrington Children with a Child Protection Plan and All Warrington Children**



(Source: Warrington Borough Council, 2012)

There is more information on child abuse and neglect in the Early Help and Targeted Services Chapter of the JSNA.

### Footnotes

<sup>1</sup> 1 WTE is one full time post, but could be, for example, two part time posts of 0.5 WTE.

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## 3) Current Services in Relation to Need

**3.1) Breastfeeding:** Due to the poor performance regarding breastfeeding initiation and prevalence, Warrington Health Consortium lead a Strategy Group to drive breastfeeding developments across the hospital, community services, local authority and the voluntary sector. In 2009, a bid was won to secure funding from the Department of Health, NHS Warrington and Warrington Borough Council to create three new posts to support breastfeeding (0.5 WTE Infant Feeding Coordinator, 1 WTE Peer Support Coordinator for 18 months and 0.75 WTE Breastfeeding Project Officer).

This group has been overseeing the following:

- The improvements in breastfeeding data collection.
- The accreditation of the Hospital and Community Services to Unicef's Baby Friendly Initiative, which includes a robust workforce development programme.
- The development of Warrington's peer mentoring programme, Bosom Buddies.
- Support for breastfeeding through groups and clinics in the community.
- Communications, promotion of breastfeeding and social marketing campaigns.
- Pathway developments, including complex medical problems and breastfeeding support pathways.
- Work with GPs to improve the quality of support offered through general practice.

Some strands of this programme are medium-term initiatives designed to transform the breastfeeding workforce, raise standards within healthcare providers and to change the culture in the parts of Warrington where breastfeeding is not the norm. We are therefore yet to see the impact of some of these initiatives on breastfeeding rates. This programme is coordinated by the Commissioning Development Manager (Children's Services).

**3.2) Screening - Newborn and Infant:** There is a national screening programme that is delivered for newborn babies and young children by a number of health professionals, including midwives, GPs, health visitors, and school health advisers, to carry out checks for health conditions. Screening is delivered as part of universal services and funded mostly within block contracts. This means that, currently, there are no robust commissioning arrangements in place to ensure the quality and high performance of these screening programmes. Specifications and monitoring datasets need to be developed for the services to ensure that performance issues are monitored and addressed.

There have been national and regional programmes (e.g. for Newborn and Infant Physical Examination - NIPE) to improve the standards of some screening programmes in recognition that they are not as robust as required in all areas.

The Hall guidelines (Hall and Elliman, 2002) suggest that vision screening should be delivered through an orthoptic-led service, as well as gaining records from GPs about the delivery of the 6-8 week check. The Commissioning Development Manager has led the work on these issues and there is currently no activity taking place to develop localised specifications for screening programmes. The Assistant Director of Public Health offers clinical expertise on screening and retains an overview of the programmes.

### 3.3) Early Years Support:

- Parenting – This is provided by a multitude of health, voluntary sector and local authority services and is led by the local authority. Strategic work has not been part of a work programme for Public Health or commissioning.
- Emotional Health and Wellbeing – Promotion and support for families and young children is provided as part of the Healthy Child Programme. However, funding has been withdrawn from health and the local authority over the last 5 years for targeted provision for emotional health and wellbeing. There have been no health promotional campaigns run by NHS Warrington on this topic for children and young people.
- Healthy Child Programme – The Public Health Nursing Team (health visiting and school health) are delivering elements of the Healthy Child Programme. However, robust arrangements are not currently in place across agencies to ensure that this programme is delivered according to the guidelines. Elements of this will be picked up in the Health Visiting and School Health Review in 2011 (as part of CQC recommendations in 2009 and 2011) that is led by the Commissioning Development Manager and supported by Public Health.

**3.4) Family Nurse Partnership:** This evidence-based programme is not commissioned in Warrington and, although it is a national government and Department of Health commitment for 2011-12, there are no current plans to roll out this programme. The Community Services Unit are delivering a more intensive model of health visiting for a small number of vulnerable families.

**3.5) Immunisation and Vaccination Programmes:** The childhood vaccination schedule (Department of Health, 2011b) aims to deliver protection against the following preventable childhood infections, which are provided between the ages of two months and eighteen years:

- Diphtheria
- Tetanus
- Pertussis (whooping cough)
- Haemophilus influenzae type b (Hib)
- Polio
- Meningococcal serogroup C (MenC)
- Measles
- Mumps
- Rubella
- Human Papillomavirus

For more information about vaccination services, please see the JSNA chapter on Childhood Immunisations.

**3.6) Health Visitors** offer a universal service to all families with young children to support them in keeping their child safe, healthy and happy. The Warrington team has a variety of staff to ensure that the individual needs of each family are met. Health visitors arrange to visit new parents at home within 2 weeks of the birth of their baby and every family with a child under 5 has an allocated health visitor. Parents can call their health visitor, arrange further home visits, or visit the Health Advice session.

For families with particular needs, specialist support is available. For example, the specialist nursery nurse offers help with sleeping patterns, eating, and potty training. The health visitors work with other agencies to offer support with issues, such as relationships, lifestyle or behaviour, which could affect a child's health and wellbeing (Warrington Information Service, 2011a).

During 2011 there were 61 Health Visitors in Warrington, which equated to 51.24 WTE staff.

**3.7) Children's Centres:** Warrington has 12 Sure Start children's centres across the borough. Sure Start children's centres support families with young children from pregnancy to age five and are on the same site as schools, nurseries, and leisure centres. They work closely with other organisations, such as Job Centre Plus, Citizens Advice Bureau and Life Long Learning, so that families can access all the support they need in one place. The Department of Health (2009a) describes children's centres as a way of delivering community-based services that are visible and accessible to families who might be less inclined to access traditional services.

Children's centres are subject to Ofsted Inspections to ensure that performance is measured and accountable to the government. Some centres benefit from the input of a qualified teacher, whereas others offer signposting to **0-5's day care, crèche facilities for those attending courses** at the children's centre, details of childcare and local schools, and breakfast and after school groups. There is further information about childcare provision in Warrington in the JSNA Chapter on Early Help and Targeted Services for Children and Families.

**3.8) Vulnerable Families:** Family Pathfinders is a new programme that combines adult and children's services to create a 'team around the family' that provides intensive supports to families with multiple and complex problems. Families included in this programme are usually known to a number of agencies and have received multiple interventions that have not been successful. A small team of family support workers co-ordinate an intensive multi-agency package of support to meet the individual needs of each family. Using solution focused interventions, the programme works to enhance the existing strengths of the family and encourages them to find their own solutions to their difficulties (Warrington Information Service, 2011b).

NSPCC, Warrington Children's Society and St. Joseph's Family Centre all provide a wide range of services related to the needs of adults and children who are coping with family breakdown, domestic abuse and other complex pressures within their family.

**3.9) WBC Children and Young People's Services:** The Common Assessment Framework (CAF) team leads on the integrated working agenda across Warrington and has responsibility for the implementation and operation of Warrington's Family Support Model. The CAF team plays a key role in supporting the domestic abuse agenda in Warrington with a focus on the early identification of children and young people with additional support needs and provide appropriate, timely and co-ordinated interventions.

Warrington is involved in the planning stage of a Department for Education Safeguarding Pilot exploring early intervention through a community-based, family approach to improve approaches to frontline practice in child protection and safeguarding where families are experiencing domestic violence and the additional risk factors of mental illness and substance misuse. In 2012, the pilot will commence multi-agency training for managers in supporting frontline practitioners to develop their skills and confidence in responding to domestic abuse.

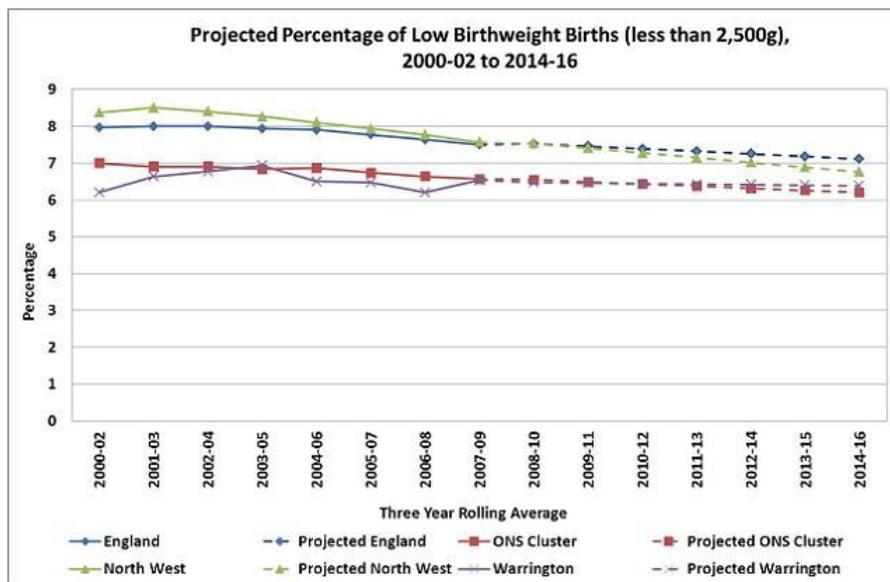
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## 4) Projected Service Use and Outcomes in 3-5 Years and 5-10 Years

It has been projected that the percentage of low birth weight births will remain at the current percentage if historic trends were to continue in Warrington (see Chart 5). The projection does not take into account any future initiatives aimed at improving the health of the mother during pregnancy and, as a result, the health of the baby, such as smoking cessation services and healthy weight projects.

**Chart 5: Projected Percentage of Low Birth Weight Births (less than 2,500g), 2000-02 to 2014-16**



(Source: Data relating to 2000-02 to 2007-09 from NCHOD, 2011)

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## 5) Evidence of What Works

Lifestyles and habits established during childhood influence a person's health throughout their life. Failure to meet the health needs of children and young people accumulates problems for later life (please see the Children's Emotional Health and Wellbeing Chapter). Research has shown that children's health and wellbeing directly impacts on their attainment and attendance. Healthier, happier pupils perform and behave better in school. An evidenced-based approach to child health and wellbeing, using prevention and early intervention, should reduce costs to Warrington in the short and longer term.

Within the Public Health Strategy (Department of Health, 2010a) there is key support for health and wellbeing throughout life. The Government recognises the importance of 'Developing Well' (encouraging healthy habits and avoiding harmful behaviours) and 'Growing Well' (identifying, treating and preventing mental health problems and creating resilience and self-esteem). Local Authorities will receive a 'health premium' based on the progress they make in improving the health of the local population and reducing health inequalities (Department of Health, 2010b).

There is also emerging evidence to suggest that early intervention from midwives or health engagement at children's centres leads to a direct reduction of young children's risk of poor outcomes, including:

- Reduced incidence of low birth weight and of foetal and postnatal injury
- Improved uptake of preventative health care
- A lower risk of poor bonding and attachment
- Reduced child neglect and abuse

**5.1) Breastfeeding:** The positive health benefits for breastfed children are well documented. Evidence shows that breast milk has antibodies which protect against infections such as gastroenteritis, respiratory illness, urinary infections, and ear infections. In addition, it reduces the risk of childhood diabetes and leukaemia, and of allergic conditions, such as asthma and eczema. Research also suggests that infants who are not breastfed are much more likely to be admitted to hospital in their first year of life.

NICE (2008) recommends that peer-support programme for women who breastfeed are commissioned. In addition, there is the following NICE guidance:

- Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households (NICE, 2008)
- Postnatal care (NICE, 2006)

**5.2) Immunisations:** School based vaccination can be very effective, if it is supported by the schools, as it allows for increased access for the recipients. The Human Papillomavirus programme has shown how effective a school vaccination delivery model can be if the resources are available for increased provision and access for children.

A Cochrane systematic review (Glenton et al., 2010) looked at the effects of interventions by Lay Health Workers<sup>1</sup> (LHWs) in primary and community health care on maternal and child health and the management of infectious diseases. The review found that the quality of the effectiveness of LHWs in promoting childhood immunisation uptake was moderate.

**5.3) Obesity:** There is documented research to show that children who are obese are likely to have obese parents and that adult health and inequalities can be influenced by the intrauterine environment (whilst the baby is still in the womb). There is a significant relationship between maternal obesity, macrosomia (a baby weighing more than 4500 g (9lb 15oz) at birth), and the subsequent development of childhood and adult obesity ([child obesity data, charts and maps available here](#)). Maternal obesity and weight gain during pregnancy are related to higher BMI in childhood and subsequent obesity in adulthood (National Obesity Observatory, 2010).

**5.4) Post Natal Depression:** NICE (2007) guidance regarding antenatal and postnatal mental health suggests that, for mild or moderate depression, therapies such as self-help strategies, home listening visits and brief CBT interventions are recommended. The guidance also warns that the risks involved when prescribing antidepressants to women who are pregnant or breastfeeding are not well known.

NICE (2007) state that clinical networks, managed by a coordinating board of healthcare professionals, commissioners, managers, service users and carers, should be established for perinatal mental health services. These networks should provide a clear referral system, a pathway of care for service users, specialist advice regarding the use of antidepressants during maternity, and effective transfer of information and continuity of mental health care,

In addition, there are also the following publications:

- *PH11 Maternal and child nutrition* (NICE, 2008)
- *Making it better: For mother and baby* (Department of Health, 2007b)
- *Delivering health services through Sure Start Children's Centres* (Department of Health, 2007a)
- *Family Nurse Partnership programme* (Department of Health, 2008)

#### Footnotes

<sup>1</sup> *Members of the community who have received some training to promote health or to carry out some healthcare services, but are not healthcare professionals.*

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## 6) (Target) Population/Service User Views

There are no user views at the time of publication.

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## 7) Unmet Needs and Service Gaps

The data has shown that breastfeeding uptake is low in the more deprived areas and it is recommended that initiatives to promote breastfeeding are targeted in these areas.

There is no agreed, co-ordinated, universal and targeted prevention and early intervention approach to children and young people's health and wellbeing. There needs to be a clear focus on reducing health inequalities for those health indicators that show a variation within Warrington's more affluent and deprived areas, in order to achieve health improvements/outcomes and health behaviour changes.

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## 8) Recommendations for Commissioning

- Reduce the health inequalities and achieve health outcomes using an agreed, co-ordinated, universal and targeted prevention, as well as early intervention, approach.
- Ensure that maternity services are integrated with the health visiting services and other community children's health services, as well as with children's centres and other local authority commissioned or provided services for 0-5 year olds.
- Reduce infant mortality through the implementation of initiatives aimed at improving maternal and infant health. For example, reducing pregnancy in under-18s, preventing sudden unexpected death in infancy and implementing the child poverty strategy.
- In collaboration with the local Hospital Trust and key partners, further investigate the high rates of emergency admissions amongst young children in Warrington, to better understand the reasons, and to ensure that appropriate action is taken to reduce avoidable admissions and ensure the right care pathways are in place and followed.
- Investigate the resource and capacity implications of delivering the Family Nurse Partnership Programme.
- Implement the Healthy Child Programme (DH, 2009a) relevant to maternal and newborn health.

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## 9) Recommendations for Needs Assessment Work

- Understand why breastfeeding uptake and initiation rates remain stubbornly low in Warrington.
- A complete set of data and on-going monitoring are required to robustly assess whether the apparent reduction in post natal depression continues and truly reflects PND prevalence.
- Specifications and monitoring datasets need to be developed for newborn and infant health screening services to ensure that performance issues are monitored and addressed.

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