Bolton's HealthMatters

JSNA: STARTING WELL

POPULATION

Bolton's total population is set to increase by around 12% or around 33,000 people by 2035. Although the borough is set to gain approximately 30,000 migrants from other countries, it is projected that Bolton will lose around 14,000 residents who will move elsewhere in the UK. The borough is projected to experience a marginally higher birth rate than the national average.

The proportion of children in Bolton is slightly higher than the average for Greater Manchester or for England and Wales. In 2011, 25.8% of the population were aged 0-19, with 6.8% of these being 0-4. The population of dependent children is unevenly distributed across the borough, ranging from 26% in Rumworth to 18.6% in Little Lever & Darcy Lever. Although overall the total number of dependent children has remained relatively stable since 2001, there has been a significant increase in the number of under-fives, with 2,000 extra children in this age group now living in Bolton, reflecting a general trend across the UK. Population projections for Bolton suggest that the number of dependent children will increase by 17% between 2010 and 2035[1].

Bolton has also seen a changing ethnic composition of these births and the highest birth rates are seen in the most deprived areas of the town, where we also see the highest density of Black and Minority Ethnic (BME) residents.

LIFESTYLES

Children may have complex health and social needs and needs that are influenced by the health and life circumstances of their parents, including social exclusion, domestic abuse, poor mental health or parental substance misuse.

Smoking is one of the few modifiable risk factors in pregnancy and is the largest preventable cause of neonatal and infant ill health and death in the UK. Bolton's smoking in pregnancy rate (2011/12) is 18.3% compared to just 13.20% nationally and 17% across the North West. Children born to mothers who smoke are at increased risk of sudden infant death, complications in pregnancy, asthma, impaired lung function, and low birth weight. Almost half of women aged under 20 who have given birth at the Royal Bolton Hospital are smokers at the time of delivery, and this rate falls significantly with the age of the mother to just over one in ten mothers aged 30-34.

[1] 2011 Census.

Evidence shows that breastfeeding has a major role to play in public health, as it promotes health and prevents disease in both the short and long term for both infant and mother. As well as providing complete nutrition for the development of healthy infants, human breast milk has an important role to play in protection against gastroenteritis and respiratory infection. There are also strong indications that breastfeeding plays a role in the prevention of middle ear infection, urinary tract infection, atopic disease, juvenile onset insulin-dependent diabetes mellitus, raised blood pressure and, to a lesser degree, obesity. Bolton's breastfeeding initiation rates and prevalence of breastfeeding at 6-8 weeks rates are significantly lower than national average.

Bolton generally performs well in terms of immunisation programmes for young children and has a higher uptake than seen nationally. Over 95% of children in Bolton have received their first dose of MMR immunisation by the age of two which is significantly better than the England average. By the age of five, the percentage of children who have received their second dose is reduced to just over 90% but this is again higher than the England average.

Reception age children generally have a healthier weight than the North West and England, but are more likely to be underweight. South Asian ethnicities in Bolton are more likely to be underweight, whilst the Asian Pakistani population is more likely to be obese compared to the Asian Indian population. With some exceptions, Reception children are more likely to be obese in the more deprived South East and East of the borough.

Young parents and their children face significant challenges, as teenage parents are more likely to smoke in pregnancy, have a low birth weight baby, are less likely to breastfeed, have lower educational attainment and live in poverty. There has been an increase in teenage pregnancy emerging in areas where this has not traditionally been an issue, in less disadvantaged areas with changing community profiles.

An increase in the harmful use of alcohol has also been seen in less disadvantaged areas and the prevalence of drug misuse, domestic violence, poverty and poor parental mental health in some groups increases the vulnerability of children. Data is limited in relation to key risks, for example maternal mental health and domestic abuse, but evidence from practitioners suggests significant levels of unmet need that adversely impacts on the health and wellbeing of children.

Rising obesity levels in primary school age children is evidence that more needs to be done to establish patterns of healthy diet and physical activity in the early years, to prevent obesity developing in later life.

HEALTH

Every child's health and wellbeing is determined by a complex and wide range of influences, particularly the health and wellbeing of their adult carers. Beyond their immediate family and community, wider social and economic conditions have a powerful influence on the wellbeing and life opportunities of families.

Pregnancy and the first five years of life shape a child's life chances. Giving every child the best start in life is the foundation for their future health and wellbeing, and for the health, wellbeing and prosperity of communities.

The 'best start' means being healthy pre-conception, having a healthy pregnancy and good ante-natal preparation for becoming a parent, a positive birth and experience in the early days and weeks of life; good maternal mental health; secure attachment between parent and child; love and responsiveness of parents; promotion of physical health through good nutrition, physical activity and plan, immunisations, health screens and good dental health; opportunities for a child's physical, cognitive, language and social and emotional development.

Infant mortality is an indicator of maternal and child health and the recent reduction in infant mortality in Bolton is an encouraging sign, but the rate remains persistently high with the burden falling in the most deprived areas. Similarly stillbirth rates have also shown a recent fall from their previous high level, but these rates could be reduced further, and the incidence of low birth weight babies remains high. Breastfeeding initiation rates have improved, but increasing the health benefits to babies, by reducing drop-off rates, remains a challenge.

Low birth weight (less than 2500gm) is probably the most important factor affecting infant mortality. Bolton has a greater proportion of low birth weight births than is average for both England and the North West region and, despite the rate falling over recent years, the challenge to further reduce the rate still remains. Early access to antenatal care can reduce the chance of an individual having a low birth weight baby and can ensure factors affecting pregnancy such as diabetes, smoking, alcohol etc. can be managed effectively and ensure even weight gain is maintained.

Bolton has high rates of hospital admissions for asthma and common childhood infections, including respiratory and gastrointestinal infections. These may be related to the quality of care in community health services but are also associated with low rates of breastfeeding and environmental and economic factors, including deprivation, smoking, housing quality and affordable warmth. More than 1 in 4 households containing children and young people are in fuel poverty, and half of households headed by a lone parent are estimated to be fuel poor.

Bolton has had a relatively high rate of sudden unexpected deaths in infancy (SUDI) and has implemented an evidence-based campaign to promote safe sleeping and reduce the risk of infant deaths.

Dental health survey results show that the proportion of 5 year olds in Bolton with tooth decay is much higher than the national and regional averages[2].

The revised Early Years Foundation Stage identifies three prime areas of learning, including: Personal, Social and Emotional Development; Physical Development; and Communication and Language, which are critical to making sure children are ready to start school. It also introduces a progress check for every 2 year old in early education so parents and professionals can be confident children are developing well. Building on the local success of Every Child a Talker, an Early Language and Communication Strategy has been developed to continue to provide universal and targeted language and communication support for early education settings, particularly for those with a high proportion of English as an Additional Language children and those in the most deprived areas of Bolton.

Conduct disorder is the most common childhood mental disorder. Effective parenting interventions for parents who have children with conduct disorder can result in significant lifetime savings (14% of the savings are in the NHS, 5% in the education system and 17% in the criminal justice system).Families currently have access to a wider range of evidence-based parenting programmes to support improved outcomes.

SOCIOECONOMIC AND GEOGRAPHICAL INEQUALITIES

The health behaviours and health outcomes of distinct ethnic populations within Bolton can have a significant impact on the health indicators and the trends we see at a ward level. For example, high breastfeeding initiation and low rates of smoking in pregnancy in BME communities masks very low breastfeeding and high levels of smoking in pregnancy in deprived White British communities. Breastfeeding is highly protective of infant and child health but shows a distinct social gradient for White British mothers, with much lower rates in poorer communities. This isn't the case for BME groups, which maintain similarly high rates irrespective of deprivation.

There are wide variations across Bolton in many important health and wellbeing outcomes for children and families, including accidental injuries, healthy weight, dental health, early learning and development. These variations indicate the priority groups for early intervention to improve outcomes.

[2] National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2012

For example, over the last 3 years there has been an increase in the percentage of 5 year olds in Bolton achieving a good level of development in all aspects of personal, social and emotional development, and communication, language and literacy, as measured by the Early Years Foundation Stage Profile (EYFSP). However, whilst outcomes for most children in Bolton are improving, the overall attainment gap between the lowest 20% attaining children and the rest increased to 34.8% in 2011.

Approximately 50% of Bolton children start school age 4-5 years with speech and language difficulties. Between 2009 and 2011 Bolton was part of the government's Every Child a Talker (ECaT) programme and after the first year of the ECaT programme, data analysis for 1200 children entering reception class in September 2010 identified a 26% reduction (compared to 2009) in children starting school at risk of language delay.

Children living in the more disadvantaged areas of Bolton are more likely to be exposed to tobacco smoke, have a low birth weight, suffer accidental injuries and have poor dental health.

VULNERABLE GROUPS

Nationally there has been a significant increase in the numbers of children with complex health needs. Specialist health teams in Bolton have seen an increase in the number and complexity of referrals, particularly in the 0-5 age group. Locally Black and Minority Ethnic communities have a higher prevalence of children with severe and complex disabilities, and there are higher concentrations of children with complex health needs living in the most deprived areas. Families of disabled children in Bolton have identified five areas which have an effect on their health and wellbeing and continued capacity to care: enough sleep, short breaks, responsive/flexible support, good information and ability to work.

Bolton has a lower rate of children categorised as 'in need' than its peers, conducts a higher rate of initial assessments than the North West average. Following a significant increase in the rate of children subject to a Child Protection Plan between 2008 and 2011, reflecting national trends, the rate is now reducing. There has been an increase in the prevalence of domestic violence, substance misuse and mental health issues in relation to the families of children with Child Protection Plans.

Looked after children (LAC) are one of the most vulnerable groups in society and often do not have the benefit of strong support networks others have through family and friends. It is recognised that these children have significantly higher levels of health and emotional wellbeing needs than children and young people from comparable backgrounds who have not been subject to care orders. The number of LAC in Bolton continues to increase steadily and the proportion under 5 when entering care is higher than the national average. Young children in care often have particular health needs, including poor dental health, anxieties

and difficulties with interpersonal relationships. Disabilities and special educational need are more prevalent in children volunteered to care; a pattern reflected in Bolton. Bolton has a good record of assessing and meeting their health needs, including high uptake of childhood immunisations and dental health checks. For many of these children adoption is the agreed preferred means of achieving permanence and stability. Bolton has a good record of achieving speedy and appropriate adoption.

Further work is needed to understand the health, social and cultural needs of families in socially excluded, new and emerging communities in Bolton, particularly traveller and Eastern European communities.

The proportion of children in poverty in Bolton was 22.7% in 2011, down from a peak of 25.2% in 2003[3]. This is higher than the England average of 20.1%, but in line with similar areas. There are wide variations in levels of child poverty across the borough indicating a need for a targeted approach to tackling and mitigating child poverty in the borough, rather than a 'one-size-fits-all' response.

USE AND EFFECTIVENESS OF SERVICES

The case for a strategic focus on the early years has been powerfully made by a series of recently published national reviews including the Allen, Marmot, Field, Munro and Tickell Reviews.

Each of these reviews has a focus on prevention and early intervention. They bring together overwhelming evidence that life trajectories are set by the age of five and schools alone are not able to effectively close this gap. Early nurturing, parenting, home learning environments and quality childcare can overcome low income and deprivation and improve future life chances.

The Healthy Child Programme: pregnancy to five (2009) is the main preventative, early intervention programme for the early years. It encompasses all aspects of early child development across the three 'prime areas' of the foundation stage: physical development; personal, social and emotional development; communication and language development. Alongside Children's Centres and family support services it also delivers the model of primary and secondary prevention recommended by Munro as the key strategy to reduce the number of children at risk of suffering significant harm.

The provision of effective services and support, delivered at the right time, can build the resilience and skills of families and enhance the life chances of their children. Pregnancy and the first years of life are the time when families are likely to have the most sustained contact with universal health services in particular. This offers a unique opportunity for

[3] HMRC definition of child poverty.

preventative work and the early identification of additional needs, followed by access to pathways of appropriate support.

The promotion of positive, confident parenting should have a major emphasis in local delivery of the Healthy Child Programme, including the importance of attachment and transition to parenthood for first-time mothers and fathers.

A key role of the Healthy Child Programme is to identify children with high risk and low protective factors and to ensure that these families receive personalised, early intervention to meet their needs. Munro also recommends the creation of multi-agency community teams, including experienced social workers, to ensure early identification of children suffering or likely to suffer from significant harm. Bolton already has excellent partnership working with effective Childrens' Centre Multi-Agency Resource Panels in place. The MARP process safeguards children whilst supporting improved outcomes for children and families. The three district level MARPs facilitate collaborative working between agencies to ensure a co-ordinated step up and step down process. This supports interventions for children and families moving between levels on the Bolton Framework for Action.

The publication of the Local Government Association's Targeting Children's Centre Services on the Most Needy Families research and a recently revised inspection framework outline a clear transition to a role in co-ordinating universal provision whilst providing targeted intervention for the most vulnerable families. The majority of services will now be provided across Bolton's Children's Centres through universal health programmes and constituted parents groups and community organisations to complement the targeted services that Children's Centres provide. Identification and intervention with targeted groups within Children's Centre reach areas will be paramount, with increased expectations of evidence of impact for vulnerable families.