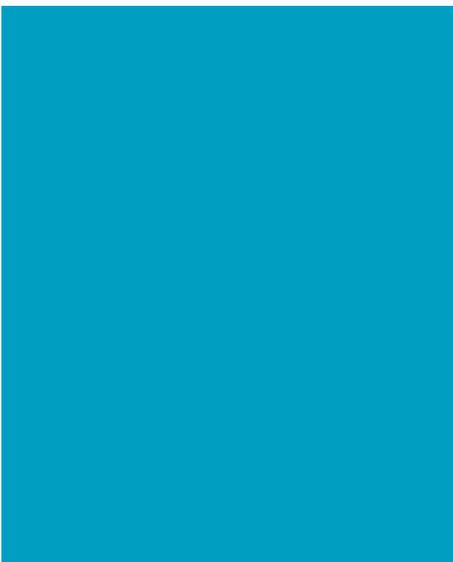




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Guide to the Early Years Profiles



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Guide to the Early Years Profiles

Supporting interpretation and use of early years profiles data

First published: March 2014

Table of Contents

Executive Summary	5
Section 2: Introduction	6
Section 3: Health outcome indicators	8
Section 4: Under 18 conceptions	10
Section 5: Infant mortality	14
Section 6: Low birth weight of term babies	21
Section 7: Smoking status at time of delivery	26
Section 8: Breastfeeding (prevalence at 6-8 weeks)	30
Section 9: Vaccination coverage	34
Section 10: Child development at 2-2¹/₂ years (placeholder)	38
Section 11: School readiness	43
Section 12: Healthy weight (excess weight at 4-5 years)	48
Section 13: Tooth decay in children age 5	52
Section 14: Acknowledgements	56
Appendix 1: Summary of technical information	57

1 Executive summary

NHS England and Public Health England's (PHE) Child and Maternal Health Intelligence Network have developed profiles of public health outcomes relating to the early years.

This is the Early Years Profiles and can be downloaded at:

<http://atlas.chimat.org.uk/lAS/dataviews/earlyyearsprofile>

This guide has been developed in partnership between NHS England and PHE to support interpretation of the data produced by the early years profiles; guide effective evidence-based actions to improve outcomes; and help commissioners and providers to use the data to inform wider strategies on the health and wellbeing of children in early years and their families.

The original motive for development of this guide was to support health visitors in their child and family oriented outcome focus, and their leadership role in improving the health and wellbeing. However the guide has a much wider purpose: that of supporting the development of effective partnership health and wellbeing strategies for young children and their families.

This first version of the guide covers the following indicators: under 18 conceptions, infant mortality, low birth weight in term babies, smoking at time of delivery, breast feeding, vaccination and immunisation, child development, school readiness, excess weight and tooth decay. It also addresses the key issues of maternal mental health, transition to parenthood and early attachment. Future versions will cover non-elective hospital admissions as an indicator of managing minor illness and for accident prevention, and maternal mental health.

For each indicator the guide sets out its importance and relevance, the strengths and weaknesses of the indicator, effective interventions to improve outcomes and the resources available. It is not intended to be exhaustive and is fully referenced to more detailed and authoritative sources of information.

This guide should be read alongside:

- Healthy Child Programme DH, (2009)
- Children and Young People's Health Benchmarking Tool - www.phoutcomes.info/profile/cyphof
- Resources for health visitors on the Child and Maternal Health Intelligence Network website – www.chimat.org.uk

2 Introduction

- 2.1 The early years (from 0 – 5) are critical in shaping health and wellbeing throughout life. Improving outcomes for children, families and communities, as well as creating services that provide better access and experience are essential. Giving every child the best start in life is crucial to reducing health inequalities across the life course¹.
- 2.2 During pregnancy and in the first two years of the child's life the baby's brain and neurological pathways are set for life. It is the most important period for brain development, and is a key determinant of intellectual, social and emotional health and wellbeing²³⁴⁵.
- 2.3 NHS England and PHE's Child and Maternal Health Intelligence Network have developed profiles⁶ of public health outcomes relating to the early years as a subset of indicators from the Children and young people's health benchmarking tool⁷.
- 2.4 The profiles have been produced in the first instance to support commissioners and providers of health visiting services in assessing the priorities for, and outcomes of, the transformation of health visiting services in line with the Government's commitment set out in the Health Visitor Implementation Plan⁸. However, more importantly, it supports setting local partnership priorities for action and measurement of impact of partnership interventions.
- 2.5 The profiles will support commissioners and providers in understanding the timescales from effective intervention to improved outcomes. It will also inform discussion around the development of intermediate indicators of success for outcomes which can only be influenced in the longer term.
- 2.6 This guide therefore, has been designed to support interpretation of the data produced by the profiles, guide effective evidence-based action to improve outcomes and help commissioners and providers to use the data to inform wider strategies on the health and wellbeing of children in early years and their families.
- 2.7 The data will support the updating of local Health and Wellbeing Boards' early years section of Joint Strategic Needs Assessments and can be used in conjunction with the Children and young people's health benchmarking tool⁹.

¹ <http://www.england.nhs.uk/wp-content/uploads/2013/06/nati-hlth-vis-pln.pdf>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

³ <https://www.gov.uk/government/policies/giving-all-children-a-healthy-start-in-life>

⁴ http://www.wavetrust.org/sites/default/files/reports/conception_to_age_2_-_the_age_of_opportunity_-_web_optimised.pdf

⁵ http://www.c4eo.org.uk/news/files/New_opportunities.pdf?dm_i=7SL,13JJK,3Z030W,3F1HP,1

⁶ The Early Years Profiles: <http://atlas.chimat.org.uk/IAS/dataviews/earlyyearsprofile>

⁸ <http://www.england.nhs.uk/wp-content/uploads/2013/06/nati-hlth-vis-pln.pdf>

⁸ <http://www.england.nhs.uk/wp-content/uploads/2013/06/nati-hlth-vis-pln.pdf>

⁹ <http://fingertips.phe.org.uk/profile/cyphof>

2.8 The guide supports effective intervention on the ‘6 high impact priority areas’ for health visiting:

- i. Transition to parenthood and the early weeks including early attachment (see section on child development)
- ii. Maternal mental health (PND) (see section on child development).
- iii. Breastfeeding (initiation and duration)
- iv. Healthy weight (to include nutrition and physical activity)
- v. Health and wellbeing at 2 (development of the child two year old review (integrated review) and support to be ‘ready for school’)
- vi. Managing minor illness and reducing accidents (reducing hospital attendance and admissions)

2.9 Breast feeding, excess weight at 4-5 years and child development at 2-2 ½ years are included in this guide as specific outcomes from the Public Health Outcomes Framework (PHOF). In this edition, maternal mental health, transition to parenthood and early attachment are dealt with in the section on child development. Information on effective interventions to support managing minor illness and reducing accidents, as well as further information on early intervention and transition to parenthood and maternal mental health will be in the next edition, albeit with placeholders for the outcomes for the last two.

2.10 Local pathways will be guided by local needs and local resources and should be developed in line with evidenced-based guidance by local commissioners and providers working together. This guide has been designed to support this work.

2.11 Consultation responses suggested that this guide should address the issues of cost-effectiveness of early years interventions. While we recognise that this a central issue for commissioners of early years services, particularly local authorities, this was judged to be beyond the scope of this guide. The case for early intervention is well researched and cost effective. Further information on this can be found in reports such as the Allen report¹⁰¹¹.

10

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61012/earlyintervention-smartinvestment.pdf

¹¹ http://www.london.gov.uk/sites/default/files/early_years_report_opt.pdf

3 Health outcome indicators

3.1 The Public Health Outcomes Framework¹² (PHOF) and the NHS Outcomes Framework¹³ include a range of outcome indicators which are amenable to effective interventions by integrated early years services.

3.2 Those indicators of specific focus for the early years programme are:

Table 1: Health Indicators and potential impact of effective early years services¹⁴

Indicator	Impact of effective early years services
Under 18 conceptions*	Can be reduced by, for example, health visitors supporting teenage mothers to take up contraception and avoid future pregnancies.
Infant mortality#	Can be improved through antenatal work with mothers to support quitting smoking and substance misuse and maintaining a healthy weight.
Low birth weight of term babies*	
Smoking status at time of delivery*	Can be improved through antenatal work with mothers to support quitting smoking.
Breastfeeding (prevalence at 6-8 weeks)*	Can be improved by antenatal support and by early identification and responsiveness to a mother's concerns.
Vaccination coverage*	Can be improved by outreach to parents who do not take up vaccination.
Child development at 2-2 ½ years* (placeholder)	Can be improved through delivery of evidence-based parenting programmes and through close working with children centres and local authority early years teams.
School readiness*	
Excess weight at 4-5 years*	Can be improved through encouraging breastfeeding and healthy weaning in line with the guidelines, as well as healthy family nutrition.
Tooth decay in children age 5*	

Note: * Public Health Outcomes Framework
 # NHS Outcomes Frame work
 Placeholder status indicates under development
 Source: *HV Implementation Plan (DH, June 2013)*

¹²

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf

¹³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf

¹⁴ <http://www.england.nhs.uk/wp-content/uploads/2013/06/nati-hlth-vis-pln.pdf>

- 3.3** The profiles are reported at local authority level and is available from the PHE's Child and Maternal Health Intelligence Network website¹⁵. Some Clinical Commissioning Groups (CCG) and local authorities are not coterminous therefore, for indicators that are originally produced at CCG level, PHE uses a proxy measure to display the data at local authority level.
- 3.4** For commissioners or children's services leads, this guide supports decisions about where best to invest preventive resources in order to most effectively improve outcomes for young children and their families.
- 3.5** For health visitors, midwives, primary care, early years and other professionals working in prevention and early intervention, these profiles clarifies the evidence base on effective interventions to improve outcomes for the children and families they work with.
- 3.6** A summary of the technical information associated with the early years guide can be seen in [Appendix 1](#).

¹⁵ <http://www.chimat.org.uk/>

4 Under 18 conceptions

4.1 Importance and relevance of this indicator

Most teenage pregnancies are unplanned. In England around 26,000 young women aged under 18 became pregnant in 2012 and just under half (49%) of these pregnancies ended in an abortion¹⁶.

While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is difficult. Teenage pregnancy often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and wellbeing and the likelihood of both the parent and child living in long-term poverty¹⁷. As an alternative, abortions represent an emotional cost to the parent and an avoidable cost to the NHS.

Continuing to reduce under-18 pregnancies is a high priority for both health and local authority children and young people's services. This indicator signals the continuing importance of teenage pregnancy as a key measure of health inequalities and child poverty¹⁸ evidenced by:¹⁹

- 15% of all young people not in education, training or employment are teenage mothers or pregnant teenagers;
- Teenage parents are 20% more likely to have no qualifications at age 30;
- Teenage mothers are 22% more likely to be living in poverty at 30, and much less likely to be employed or living with a partner; and
- Teenage mothers have three times the rate of postnatal depression and a higher risk of poor mental health for three years after the birth.

Outcomes are also worse for children²⁰:

- Teenage mothers are three times more likely to smoke throughout their pregnancy;
- Babies born to teenage mothers are at an increased risk of prematurity, congenital abnormality and low birth weight;
- Teenage mothers are 50% less likely to breastfeed, with negative health consequences for the child; and
- Children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems.

¹⁶ Office for National Statistics 2013

¹⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216162/Improving-outcomes-and-supporting-transparency-part-21.pdf

¹⁸ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216162/Improving-outcomes-and-supporting-transparency-part-21.pdf

¹⁹ Teenage Pregnancy Strategy: Beyond 2010, Department for Children, Schools and Families and the Department of Health, 2010

²⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

Data definition

Rate of conceptions per 1,000 females aged 15-17

Numerator: Total conceptions to all women aged under 18

Denominator: Total female population aged 15-17

A three year age group (15–17) is used as the denominator population for each year rate because the vast majority of conceptions to under-18 year olds occur in this age group (95%). The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived.

4.2 Strengths and weakness of the indicator

Conception statistics are estimates derived from: maternities (the number of pregnant women who have one or more live or stillbirths) plus legal abortions. This information is obtained from administrative sources (abortion notifications and birth registrations²¹).

The abortion notifications and birth registrations go through an agreed series of checks before being supplied to the Office of National Statistics (ONS) to ensure that they are of sufficient quality.

Conception statistics do not include miscarriages or illegal abortions. It is estimated that one in five confirmed pregnancies will end in miscarriage²². It is impossible to determine the extent of illegal abortions, for example, by women using drugs bought from the Internet. The only statistics available are where complications arise from illegal abortions resulting in the use of NHS services or death. Given the steady rise in numbers of legal abortions since 1968, and the improvements in access to abortion it can be assumed that the vast majority of abortions carried out in England and Wales today are legal (Abortion Review, 2012)²³.

Annual conception statistics are released around February, fourteen months after the end of the data year. The release of each conceptions publication is announced on the UK National Statistics Publication Hub²⁴ at least four weeks before publication.

²¹ <http://www.ons.gov.uk/ons/guide-method/method-quality/quality/quality-information/population/quality-and-methodology-information-for-conception-statistics.pdf>

²² <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/miscarriage.aspx>

²³ www.abortionreview.org/index.php/site/article/962/

²⁴ www.statistics.gov.uk/hub/release-calendar/index.html

4.3 Options for action

4.3.1 Commissioning and coordinating sexual health services²⁵

The Local Regulations 2013²⁶ require local authorities to arrange for the provision of certain mandated public health services. These include:

- Local open access sexual health services
- Free sexually transmitted infections (STI) testing and treatment, and notification of sexual partners of infected persons; and
- Free contraception and reasonable access to all methods of contraception.

The 2007, NICE guidance *Prevention of sexually transmitted infections and under 18 conceptions*²⁷ gives clear guidance on the role of early years staff in ensuring sexual health services, including contraceptive and abortion services, are in place to meet local needs.

4.3.2 The role of early years staff, primary care and health visitors in reducing teenage conceptions

All services should include:

- Arrangements for the notification, testing, treatment and follow-up of partners;
- Ensure staff are trained;
- Ensure there is an audit and monitoring framework in place; and
- Focus on vulnerable young people aged under 18. Teenage mothers should have access to contraception immediately after birth to reduce repeat abortions. This may include young people from disadvantaged backgrounds, who are in, or leaving, care or who have low educational attainment.

Where appropriate, provide one-to-one sexual health advice on:

- How to prevent and get tested for STIs and how to prevent unwanted pregnancies;
- All methods of reversible contraception, including Long Acting Reversible Contraception (LARC) in line with NICE clinical guideline 30²⁸;
- How to get and use emergency contraception; and other reproductive issues and concerns;
- Provide supporting information on the above in an appropriate format;
- Regularly visit (for example health visitors or FNP) vulnerable women aged under 18 who are pregnant or who are already mothers as these mothers are at high risk of repeat conceptions²⁹

²⁵ <http://pathways.nice.org.uk/pathways/preventing-sexually-transmitted-infections-and-under-18-conceptions/preventing-sexually-transmitted-infections-and-under-18-conceptions-overview#content=view-node%3Anodes-commissioning-and-coordinating-sexual-health-services>

²⁶ <http://www.legislation.gov.uk/ukxi/2013/351/regulation/6/made>

²⁷ <http://publications.nice.org.uk/prevention-of-sexually-transmitted-infections-and-under-18-conceptions-ph3>

²⁸ <http://guidance.nice.org.uk/CG30>

²⁹ <http://www.nice.org.uk/nicemedia/pdf/PHI003guidance.pdf>

- Discuss with them and their partner (where appropriate) how to prevent or get tested for STIs and how to prevent unwanted pregnancies. The discussion should cover the above outlined areas and include the provision of supporting information in an appropriate format;
- Where appropriate, refer the young woman to the relevant agencies, including services concerned with reintegration into education and work.

4.4 Resources

Department for Children, Schools and Families (2008) *Getting maternity services right for pregnant teenagers and young fathers*

<http://www.swpho.nhs.uk/resource/item.aspx?RID=41060>

Department of Health (2010) *Teenage Pregnancy Independent Advisory Group Final Report. Teenage pregnancy: Past successes - future challenges*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181078/TPIAG-FINAL-REPORT.pdf

NICE (2005) *Long Acting Reversible Contraception*, CG30, London.

<http://guidance.nice.org.uk/CG30>

NICE (2007) *One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups*. London

[.http://www.nice.org.uk/nicemedia/pdf/PHI003guidance.pdf](http://www.nice.org.uk/nicemedia/pdf/PHI003guidance.pdf)

NICE (2007) *Prevention of sexually transmitted infections and under 18 conceptions*, PH3 London.

<http://www.nice.org.uk/PH3>

NICE, (2007) *Interventions to reduce substance misuse among vulnerable young people*, PH4, London.

<http://publications.nice.org.uk/interventions-to-reduce-substance-misuse-among-vulnerable-young-people-ph4>

NICE Pathways (2011) *Prevention of sexually transmitted infections and under 18 conceptions* London.

<http://pathways.nice.org.uk/pathways/preventing-sexually-transmitted-infections-and-under-18-conceptions>

Public Health England *Teenage conception knowledge hub - Child and Maternal Health Intelligence Network*

<http://www.chimat.org.uk/teenconceptions>

5 Infant mortality

5.1 Importance and relevance of this indicator

The infant mortality rate (IMR) is the number of children who die aged less than 1 year old per 1,000 live births.³⁰ The IMR is widely regarded as one of the best single indicators of population health, as well as providing an indication of the wellbeing of infants, children and pregnant women. It is also considered an indicator of progress towards addressing inequalities.

Most causes of infant deaths show a socio-economic gradient. Deprivation, births outside marriage, non-white ethnicity of the infant, maternal age under the age of 20 are independently associated with an increased risk of infant mortality.

In April 2012³¹, ONS reported that:

- In 2010, the infant mortality rate was four deaths per 1,000 live births, the lowest ever recorded in England and Wales, and compares with an infant mortality rate of 12 deaths per 1,000 live births in 1980 and five deaths per 1,000 live births in 2009;
- Infant mortality rates in 2010 were lowest among babies of mothers aged 30 to 34 years (four deaths per 1,000 live births) and highest among babies of mothers aged 40 years and over (six deaths per 1,000 live births); and
- In 2010, the infant mortality rates for very low birth weight babies (under 1,500 grams) and low birth weight babies (under 2,500 grams) were 165 and 37 deaths per 1,000 live births respectively.

The 2011 Mortality Monitoring Bulletin³² using the National Statistics socio-economic classification³³ shows infant mortality rates are highest for babies whose fathers have never worked, are long-term unemployed or students, or whose occupational details could not be classified (5.4 deaths per 1,000 live births in 2008-10). The ONS describes this group as 'other' in its reporting. Rates may vary between these different sub-groups, so figures for the 'Other' group should be interpreted with caution.

Data definition

Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births.

Rates are based on pooled data for three year periods.

Numerator: The number of infant deaths (aged under 1 year) in the respective calendar years

³⁰ http://www.ons.gov.uk/ons/dcp171766_283988.pdf

³¹ http://www.ons.gov.uk/ons/dcp171766_283988.pdf

³²

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216659/dh_131738.pdf

³³ <http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html>

Denominator: The number of live births in the respective calendar years

This indicator supports the Government's direction for public health on starting well through early intervention and prevention. Reducing the risk of infant mortality will improve the life chances, health and wellbeing of both the mother and the baby³⁴.

5.2 Strengths and weakness of the indicator

This indicator is produced annually by the ONS (giving it a high level of validity) at national level it includes ethnicity, socio-economic classification and mother's country of birth. This indicator is produced at national, regional, local authority and PCT level.

The annual publication Child Mortality Statistics³⁵ (formerly DH3) contains data on stillbirths, infant deaths and childhood deaths. It includes figures on infant deaths linked to their corresponding birth records and is based on childhood deaths that occurred in England and Wales³⁶.

The number of infant deaths per year is low. Fluctuation in the data is reduced by using three year rolling averages. This results in a time lag before any improvement can be measured locally.

This indicator includes births of babies that are born with only fleeting signs of life and die shortly after birth such as extreme prematurity and congenital abnormalities. Some families choose not to have a medical termination for personal reasons. This may skew the data depending on the local demographic profile.

5.3 Options for action

5.3.1 Commissioning and coordinating maternal and child health services

The Department of Health published the Infant Mortality Taskforce Report *Tackling health inequalities in infant and maternal health outcomes (2010)*³⁷ which highlighted interventions that will have a demonstrable impact on the gap and are likely to reduce infant mortality overall.

The health of a baby is affected by the health of the mother. What a child experiences during the early years lays down a foundation for the whole of his or her

³⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216162/Improving-outcomes-and-supporting-transparency-part-21.pdf

³⁵ <http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/index.html>

³⁶ <http://www.ons.gov.uk/ons/guide-method/user-guidance/health-and-life-events/mortality-metadata.pdf>

³⁷

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215869/dh_122844.pdf

life. Giving every child the best start in life is essential to reducing health inequalities across the life course³⁸.

5.3.2 The role of early years staff, primary care and health visitors in reducing infant mortality

Interventions to reduce infant mortality have been identified by the Department of Health³⁹ and these are categorised into three groups:

- Interventions that have a demonstrable impact on reducing health inequalities;
- Interventions that are likely to impact on the infant mortality gap; and
- Interventions that will reduce infant mortality overall.

5.3.2.1 Interventions that have a demonstrable impact on reducing health inequalities

5.3.2.1.1 Reducing maternal obesity

NICE guidance on the management of obesity⁴⁰ and behaviour change⁴¹, and the Foresight report⁴², identify pregnancy as a critical period to address obesity in a woman's life course and to initiate behaviour change. However, caution is required to avoid compromising fetal growth.

NICE also refers to the management of obesity during pregnancy in its guidance on maternal and child nutrition⁴³ and in its clinical guidelines for antenatal care⁴⁴, diabetes in pregnancy⁴⁵, and intrapartum care⁴⁶. Overall, these guidelines consider obese women to be among the high risk groups that require additional screening, intervention and monitoring.

³⁸ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

³⁹ http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081336.pdf

⁴⁰ NICE. Obesity: The Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children. London: NICE; 2006.

⁴¹ NICE. Behaviour Change at Population, Community and Individual Levels. London: NICE; 2007

⁴² <http://www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesities/reports-and-publications>

⁴³ NICE. Maternal and child nutrition: guidance. London: NICE; 2008.

⁴⁴ NICE. Antenatal care: routine care for the healthy pregnant woman. London: NICE; 2008

⁴⁵ NICE. Diabetes in pregnancy: management of diabetes and its complications from pre-conception to the postnatal period. London: NICE; 2008

⁴⁶ NICE. Intrapartum care: Care of healthy women and their babies during childbirth. London: NICE; 200

In July 2010 NICE published guidance on weight management before, during and after pregnancy⁴⁷ with the following recommendations:

- Professionals should use any opportunity, as appropriate, to provide women with a BMI of 30 or more with information about the health benefits of losing weight before becoming pregnant (for themselves and the baby they may conceive). This should include information on the increased health risks their weight poses to themselves and would pose to their unborn child;
- Professionals should offer a weight-loss support programme involving diet and physical activity;
- Professionals should use the 6–8 week postnatal check as an opportunity to discuss the woman's weight and ask those who are overweight, obese or who have concerns about their weight if they would like any further advice and support now, or later;
- During the 6–8 week postnatal check, or during the follow-up appointment within the next 6 months, professionals should provide clear, tailored, consistent, up-to-date and timely advice about how to lose weight safely after childbirth; and
- Professionals should be aware of the issues that can affect nutrition including fussy eating and psychological impact on behaviour and parental body image and the impact on infant and children feeding.

5.3.2.1.2 Reducing maternal smoking (see page 21 – Section 6)

5.3.2.1.3 Reducing teenage pregnancies (see page 8 - Section 3)

5.3.2.1.4 Reducing sudden unexpected death (SIDs) in infancy in the routine and manual (R&M) labour groups

- Ensure all staff who have contact with families are aware of SIDs prevention advice and share this in the antenatal and newborn period⁴⁸. This includes: always placing a baby on its back to sleep; keeping a baby smoke free during pregnancy and after birth; placing a baby to sleep in a separate cot or Moses basket in the same room as the parents for the first 6 months; breastfeeding the baby; and always having a new mattress for each new baby.⁴⁹
- Parents who have suffered a sudden and unexpected death of a baby often feel anxious when they have another baby. The Care of Next Infant (CONI) programme supports families before and after the birth of their new baby. CONI is run in hospitals and community health centres and involves health visitors, midwives, paediatricians and GPs⁵⁰;
- Recommendations should include: never sleep on a sofa or in an armchair with a baby; don't sleep in the same bed as a baby if you smoke, drink or take

⁴⁷ <http://publications.nice.org.uk/weight-management-before-during-and-after-pregnancy-ph27/recommendations>

⁴⁸ <http://www.nhs.uk/Conditions/Sudden-infant-death-syndrome/Pages/Introduction.aspx>

⁴⁹ <http://www.lullabytrust.org.uk/safer-sleep>

⁵⁰ <http://www.lullabytrust.org.uk/coni>

drugs or are extremely tired, if your baby was born prematurely or was of low birth weight; avoid letting a baby get too hot and don't cover a baby's face or head while sleeping; and don't use loose bedding⁵¹;

- Parents to be given advice regarding safe use of blinds to reduce the risk of harm from blind cords;
- Monitor all child deaths through the Child Death Overview Panel⁵², sharing lessons learnt with all relevant stakeholders.

5.3.2.1.5 Meeting the child poverty target

- Professionals should ensure greater focus on the early years or Foundation Years (pregnancy to age 5) in their efforts to improve the life chances of disadvantaged children;
- Professionals should ensure improved delivery of Foundation Years services by opening up commissioning to different types of providers, encouraging co-location of services, better sharing of data on disadvantaged children, and better use and collection of evidence about what works.

5.3.2.1.6 Reducing household overcrowding in the routine and manual group

- Local authorities have a statutory responsibility for tackling overcrowding⁵³. A coordinated approach between local authorities, housing associations and others will improve housing for disadvantaged families.

5.3.2.2 Interventions that are likely to impact on the infant mortality gap

5.3.2.2.1 Ensuring that all pregnant women have a health and social care needs assessment by the twelfth completed week of pregnancy

- Professionals should ensure pregnant women are offered information based on the current available evidence together with support to enable them to make informed decisions about their care. This information should include where they will be seen and who will undertake their care⁵⁴.

5.3.2.3 Interventions that will reduce infant mortality overall

5.3.2.3.1 Effective implementation and monitoring of the antenatal and newborn screening (National screening programme)

- Ensure members of staff are able to discuss antenatal and newborn screening⁵⁵ and refer when appropriate.

⁵¹ <http://www.lullabytrust.org.uk/safer-sleep>

⁵² <https://www.gov.uk/government/publications/child-death-overview-panels-contacts>

⁵³

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081336.pdf

⁵⁴ <http://publications.nice.org.uk/antenatal-care-cg62/key-priorities-for-implementation>

⁵⁵

5.3.2.3.2 Prevention of maternal and infant infections (National screening programme)

- Ensure members of staff are able to discuss maternal and infant infections and refer when appropriate; and
- Ensure members of staff are able to discuss the benefits of adult and child vaccination programme.

5.4 Resources

DH (2007) *Implementation plan for reducing health inequalities in infant mortality: a good practice guide*, London.

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081336.pdf

Marmot, Michael Author (2010) *Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010*. London: Marmot Review.

<http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

NICE (2004) *Caesarean section*, CG13 [replaced by NICE clinical guideline 132] London.

<http://www.nice.org.uk/nicemedia/pdf/cg013niceguideline.pdf>

NICE (2006) *Brief interventions and referral for smoking cessation in primary care and other settings*, PH1, London.

<http://publications.nice.org.uk/brief-interventions-and-referral-for-smoking-cessation-ph1>

NICE (2006) *Obesity: The Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children*, CG43, London.

<http://publications.nice.org.uk/obesity-cg43>

NICE (2006) *Postnatal care: Routine postnatal care of women and their babies. Clinical guidelines*, CG37, London

<http://www.nice.org.uk/nicemedia/pdf/CG37NICEguideline.pdf>

NICE (2007) *Antenatal and postnatal mental health: clinical management and service guidance*, CG45, London.

<http://www.nice.org.uk/gs/searchtracker/GUIDANCE/11004>

NICE (2007) *Behaviour Change at Population, Community and Individual Levels*, PH6, London

<http://www.ncsct.co.uk/usr/pub/guidance-on-behaviour-change-at-population.pdf>

NICE (2007) *Intrapartum care: care of healthy women and their babies during childbirth*, CG55, London
<http://publications.nice.org.uk/intrapartum-care-cg55/guidance>

NICE (2008) *Diabetes in pregnancy: management of diabetes and its complications from pre-conception to the postnatal period*, CG63, London.
<http://www.nice.org.uk/nicemedia/pdf/cg063guidance.pdf>

NICE (2008) *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households*, PH11, London
<http://publications.nice.org.uk/maternal-and-child-nutrition-ph11>

NICE (2011) *Caesarean section*, CG132 [replaced NICE clinical guideline 13] London
<http://www.nice.org.uk/nicemedia/live/13620/57163/57163.pdf>

Public Health England *Infant mortality profiles - Child and Maternal Health Intelligence Network*:
<http://atlas.chimat.org.uk/IAS/dataviews/infantmortalityprofile>

Public Health England *Maternity knowledge hub - Child and Maternal Health Intelligence Network*:
<http://www.chimat.org.uk/maternity>

Public Health England *Obesity knowledge hub - Child and Maternal Health Intelligence Network*:
<http://www.chimat.org.uk/obesity>

6 Low birth weight of term babies

6.1 Importance and relevance of this indicator

Low birth weight is a major determinant of mortality, morbidity and disability in infancy and childhood and also has a long-term impact on health outcomes in childhood and adult life^{56 57}. 64% per cent of infant deaths in England and Wales in 2003 were of babies weighing less than 2,500g (low birth weight)⁵⁸.

There has been a continuing rise in the proportion of low birth weight babies in the late 1980s and 1990s from 6.7% in 1989 to 7.6% in 1999⁵⁹. Most of this increase is explained by the increased number of multiple births (it is now recommended that a maximum of two embryos are implanted during IVF) and the increased survival rates of lighter babies due to technical advances⁶⁰.

Low birth weight in particular is associated with poorer long-term health outcomes and evidence also suggests that maternal health is related to socio-economic status⁶¹. Mothers living in the most deprived areas had an increased risk of having a low birth weight baby compared with mothers living in the least deprived area (39% in the 1980s and 29% in the 1990s), after taking account of their age at the time of the birth, ethnicity and limiting long-term illness⁶².

Development begins before birth when the health of a baby is crucially affected by the health and wellbeing of their mother. Low birth weight in particular is associated with poorer long-term health and educational outcomes⁶³.

Mothers from non-white ethnic groups had a 62% increased risk of having a low birth weight baby when compared with white mothers, after taking account of their age at the time of the birth, household and area characteristics⁶⁴.

⁵⁶ http://www.who.int/nutrition/topics/feto_maternal/en/

⁵⁷ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report>

⁵⁸ Office for National Statistics (1988–2003) *Mortality Statistics: childhood, infant and perinatal, England and Wales*, Series DH3. HMSO/TSO: London.

⁵⁹ Office for National Statistics (1988–2003) *Mortality Statistics: childhood, infant and perinatal, England and Wales*, Series DH3. HMSO/TSO: London.

⁶⁰ Macfarlane A and Mugford M (2000) *Birth Counts: Statistics of Pregnancy and Childbirth*. Volume 1, TSO: London.

⁶¹ Jenkins H, Meltzer P B, Jones T, Brugha P, Bebbington M, Farrell D, Crepaz-Keay and Knapp M (2008) Foresight Mental Capital and Wellbeing Project. *Mental health: Future challenges*. London: The Government Office for Science.

⁶² <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report>

⁶³ Jefferis B J M H, Power C and Hertzman C (2002) Birth weight, childhood socioeconomic environment, and cognitive development in the 1958 British birth cohort study. *BMJ* 325:305.

⁶⁴ Bakeo A and Clarke L (2006) Risk factors for low birthweight based on birth registration and census information, England and Wales, 1981–2000, *Health Statistics Quarterly* 30. Summer 2006. National Statistics

Data definition

Percentage of all live births at term with low birth weight

Numerator: Number of live births at term (≥ 37 gestation weeks) with low birth weight ($<2500\text{g}$)

Denominator: Number of live births at term (≥ 37 gestation weeks)

This indicator supports the Government's strategy for improving public health on starting well through early intervention and prevention⁶⁵. It has also been included in the Department of Health Business Plan⁶⁶ within the context of addressing issues of premature mortality, avoidable ill health, and inequalities in health, particularly in relation to child poverty.

6.2 Strengths and weakness of the indicator

This indicator is produced annually by the ONS (giving it a high level of validity) but there is a reporting time lag of 21 months.

Low birth weight has long been important as a public health indicator. Low birth weight and socio-economic status at a population level is associated with lifestyle factors and access to maternity services⁶⁷.

Recent research about the impact of pregnancy and early-life events on infant development, cognitive development and lifelong illness, indicates that a broader definition of the outcome of pregnancy is needed than birth weight alone⁶⁸.

While low birth weight continues to be useful in focusing attention on a healthy start to independent life, it has also become increasingly evident that the cut-off value of 2,500g may not be appropriate for all settings. Some countries with high incidence of low birth weight do not necessarily have high mortality rates, as for example in Sri Lanka⁶⁹. Therefore the demographic profile of the local population needs to be taken into consideration.

⁶⁵

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

⁶⁶ <https://www.gov.uk/government/publications/department-of-health-corporate-plan-2013-14/department-of-health-2013-14-corporate-plan>

⁶⁷ <http://www.nice.org.uk/nicemedia/live/13167/50822/50822.pdf>

⁶⁸ http://www.childinfo.org/files/low_birthweight_from_EY.pdf

⁶⁹ Pathmanathan, I., et al., *Investing in Maternal Health: Learning from Malaysia and Sri Lanka*, Health, Nutrition, and Population Series, World Bank, Washington, D.C., 2003. IN UNICEF (2004) Low Birth Weight.

6.3 Options for action

Birth weight is affected to a great extent by the mother's own fetal growth and her diet from birth to pregnancy, and thus, her body composition at conception; women of short stature, women living at high altitudes, and young women have smaller babies.

Once pregnant, the mother's nutrition and diet, lifestyle (e.g., alcohol, tobacco or drug misuse) and other exposures (e.g., malaria, HIV or syphilis), or complications such as hypertension can affect fetal growth and development, as well as the duration of pregnancy.

6.3.1 The role of early years staff, primary care and health visitors in infant mortality prevent low birth weight include:

6.3.1.1 Optimising maternal health

- Health professionals should assess women at any opportunity during the preconception period and during pregnancy regarding fitness and lifestyle and offer advice and refer to specialists as appropriate⁷⁰⁷¹.

6.3.1.2 Micronutrient supplementation

- Health professionals should take particular care to check women are following advice to take a vitamin D supplement during pregnancy and while breastfeeding. Women at greatest risk of deficiency include women who are obese, have limited skin exposure to sunlight or who are of South Asian, African, Caribbean or Middle Eastern descent⁷².
- Pregnant women (and those intending to become pregnant) should be informed that dietary supplementation with folic acid, before conception and throughout the first 12 weeks, reduces the risk of having a baby with a neural tube defect (for example, anencephaly or spina bifida). The recommended dose is 400 micrograms per day⁷³.

6.3.1.3 Preventing and treating infectious diseases

- Pregnant women should be offered routine screening for infections as per the antenatal screening programme, these include hepatitis B, Human Immunodeficiency Virus (HIV), rubella and syphilis⁷⁴⁷⁵ because there is strong evidence to support its clinical and cost effectiveness⁷⁶.

⁷⁰ <http://www.nice.org.uk/nicemedia/pdf/cg062niceguideline.pdf>

⁷¹

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

⁷² <http://publications.nice.org.uk/maternal-and-child-nutrition-ph11>

⁷³ <http://www.nice.org.uk/nicemedia/pdf/cg062niceguideline.pdf>

⁷⁴ <http://infectiousdiseases.screening.nhs.uk/>

⁷⁵ <http://infectiousdiseases.screening.nhs.uk/cms.php?folder=2386>

⁷⁶ <http://www.nice.org.uk/nicemedia/pdf/cg062niceguideline.pdf>

6.3.1.4 Educating girls and expectant mothers

- Professionals should ensure women are aware of the benefits of all antenatal screening and early access to health care during pregnancy.

6.3.1.5 Preventing teenage pregnancies (see page 21- Section 3)

6.3.1.6 Reduce poverty

- Professionals should give young people the information and support they need to make the right decisions to help reduce teenage pregnancy rates, risky behaviours such as substance misuse, toxic relationships and prevent involvement in crime and anti-social behaviour;
- Professionals should help young people at risk of not achieving their full educational potential to engage and achieve in education or training;
- Professionals should help young people develop the personal and social skills they need for learning and the transition to the world of work, for example referring to self-discipline, relationship-building and decision-making;
- Commissioners should work to improve delivery of Foundation Years services by opening up services to different types of providers, encouraging co-location of services and enabling better sharing of data on disadvantaged children⁷⁷.

6.4 Resources

Department of Health (2009) *Healthy Child Programme*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

National Screening Committee (2013) *Infectious Disease Screening, National Screening Programme*

<http://infectiousdiseases.screening.nhs.uk/>

NICE (2006) *Obesity: The Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children*. (CG 43) London.

<http://publications.nice.org.uk/obesity-cg43>

NICE (2007) *Antenatal and postnatal mental health: clinical management and service guidance*, CG45, London.

http://www.nice.org.uk/_gs/searchtracker/GUIDANCE/11004

NICE (2007) *Interventions to reduce substance misuse among vulnerable young people*, PH4, London

<http://publications.nice.org.uk/interventions-to-reduce-substance-misuse-among-vulnerable-young-people-ph4>

⁷⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49515/social-justice-transforming-lives.pdf

NICE (2008) *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households*, PH11, London
<http://publications.nice.org.uk/maternal-and-child-nutrition-ph11>

NICE (2010) *Pregnancy and complex social factors*, PG110, London
<http://www.nice.org.uk/nicemedia/live/13167/50822/50822.pdf>

NICE (2010) *Antenatal care*, CG62, London
<http://www.nice.org.uk/nicemedia/live/11947/40115/40115.pdf>

NICE Pathways (2011) *Prevention of sexually transmitted infections and under 18 conceptions*
<http://pathways.nice.org.uk/pathways/preventing-sexually-transmitted-infections-and-under-18-conceptions>

Public Health England *Maternity knowledge hub - Child and Maternal Health Intelligence Network*:
<http://www.chimat.org.uk/maternity>

7 Smoking status at time of delivery

7.1 Importance and relevance of this indicator

Tobacco use remains one of England's most significant public health challenges. While rates of smoking have continued to decline over the past decades, around 21% of adults in England still smoke. The Department of Health (2011) *Healthy Lives, Healthy People: A Tobacco Control Plan for England* sets out the nation's priorities⁷⁸. Prioritisation of this indicator locally will support local tobacco control strategies.

Smoking is the primary cause of preventable morbidity and premature death, accounting for nearly 80,000 deaths in England in 2011.

Smoking rates are much higher in some social groups, including those with the lowest incomes. These groups suffer the highest burden of smoking-related illness and death. Smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. Consequently, tackling tobacco use is central to realising the Government's commitment to improve the health of the poorest, fastest⁷⁹.

Smoking in pregnancy has detrimental effects for the growth and development of the baby and health of the mother. Smoking in pregnancy leads to: a 60% increase in the risk of infertility compared with non-smokers; 3,000–5,000 miscarriages in the UK each year; 14,000–19,000 babies in the UK born with low birth weight; and 2,200 premature births per year in the UK.⁸⁰ On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes⁸¹.

Encouraging pregnant women to stop smoking during pregnancy may also help them stop smoking for good, and thus provide health benefits for the mother and reduce exposure to second hand smoke for the infant.

The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth). The inclusion of this indicator will ensure that the local tobacco control activity is appropriately focused on pregnant women to support the attainment of this national ambition.

Data definition

⁷⁸

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf

⁷⁹

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf

⁸⁰ Royal College of Physicians, 2010. *Passive Smoking and Children*, London: RCP.

⁸¹

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf

Proportion of women smoking at time of delivery

Numerator: Number of women who smoke at time of delivery

Denominator: Number of maternities

7.2 Strengths and weakness of the indicator

The data from CCGs is subject to quality checks; the number of mothers smoking plus those not smoking must be less than or equal to the number of maternities and the number of maternities is checked to see if it is consistent with previous trends. It is recommended that there be less than 5% of records with an unknown smoking status.

The Health and Social Care Information Centre (HSCIC) publish all the submitted data and in order to assist users in the interpretation of the data they also publish a data quality report with the publication. This is a colour coded chart by CCG that in addition to providing the information for users to interpret the data also serves as a driver to improve data quality. The confidence limits around the data also represent where an area had a high number of unknowns.

This data is currently published by the HSCIC at national (and CCG) level on a quarterly basis. The annual data collected at quarter 4 is used to assess year on year performance. While this quarterly data are published by the HSCIC, individual quarters should not be added together to form the annual figures for this indicator⁸².

A more detailed breakdown of geographical and socio-economic indicators of smoking at time of delivery is available in the Infant Feeding Survey⁸³ which is collected every five years.

The nationally mandated maternity and children's dataset will start collecting patient level data later in 2013/14. Once the coverage and quality of this dataset is sufficient it will take over the monitoring of smoking at time of delivery and the quarterly return will cease.

7.3 Options for action

7.3.1 The role of early years staff, primary care and health visitors to reduce smoking during pregnancy

NICE describes interventions to support quitting smoking in pregnancy and following childbirth⁸⁴ which are summarised below:

- Recognise that because the health gains are so large, even small successes with pregnant smokers are worth higher levels of investment; and

⁸³ <http://www.hscic.gov.uk/catalogue/PUB08694>

⁸⁴ <http://guidance.nice.org.uk/PH26/Guidance/pdf/English>

- Professionals and commissioners should ensure the smoking status of pregnant women is recorded to ensure accuracy of this indicator.

7.3.2 Provide cessation services

- Train all those who work with pregnant women in brief intervention skills;
- Offer interventions throughout pregnancy;
- Focus on key stages, pre-pregnancy and from birth to 5 years for cessation and support to prevent relapse following the birth;
- Be aware that possible intervention points include initial GP or midwife consultation, booking visit, at home, hospital or community antenatal clinic, antenatal care visits and postnatal home visits; and
- Build cessation programmes around the context of pregnant women's lives.

7.3.3 Connect existing services with cessation services

- Establish links within the local community including children centres, contraceptive services, fertility services, antenatal and postnatal services to ensure that women who are ready to quit are signposted to appropriate services;
- Target cessation programmes at both pregnant women and their partners or family members;
- Offer intensive interventions from a trained cessation specialist to all smokers early in their pregnancy; and
- Promote the use of Nicotine Replacement Therapy (NRT) for pregnant women who smoke heavily and have been unable to stop using behavioural methods only.

7.3.4 Use available information

- Improve the data quality from providers then use this data for the local area to focus and plan cessation services for pregnant women. For example, of the number of women who are pregnant at any one time, how many of them smoke? Which areas have the highest rates of smoking, low birth weight and infant mortality?
- Ensure that all members of staff are aware of the location of local services in GP practices, pharmacies and in community settings such as healthy living centres and the type of support they offer.

7.4 Resources

Department of Health (2009) *Healthy Child Programme*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Department of Health (2013) *Reducing Smoking- Policy*
<https://www.gov.uk/government/policies/reducing-smoking>

Health and Social Care Information Centre (2010) *Infant feeding survey*
<http://www.hscic.gov.uk/catalogue/PUB08694>

Health and Social Care Information Centre (2014) *Maternity and Children's Data Set*
<http://www.hscic.gov.uk/maternityandchildren>

NICE (2006) *Brief interventions and referral for smoking cessation in primary care and other settings*, PH1, London.
<http://publications.nice.org.uk/brief-interventions-and-referral-for-smoking-cessation-ph1>

NICE (2008) *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities*, PH10, London
<http://guidance.nice.org.uk/PH10>

NICE (2010) *Quitting smoking in pregnancy and following childbirth*, PH26,
<http://www.nice.org.uk/nicemedia/live/13023/49345/49345.pdf>

NICE (2013) *Smoking cessation in secondary care: acute, maternity and mental health services*, PH48
<http://www.nice.org.uk/nicemedia/live/14306/65863/65863.pdf>

Public Health England *Maternity knowledge hub - Child and Maternal Health Intelligence Network*:
<http://www.chimat.org.uk/maternity>

8 Breastfeeding (prevalence at 6-8 weeks)

8.1 Importance and relevance of this indicator

The World Health Organisation⁸⁵ (WHO) and the DH⁸⁶ recommend exclusive breastfeeding of infants up to the age of six months. In fact a third of women stop breastfeeding soon after birth⁸⁷.

Although a minority of infants cannot be breastfed due to maternal health or other reasons, the benefits of breastfeeding are well established:

- Reduced hospital admissions of infants for diarrhoea and vomiting and respiratory infections;
- Reduced middle ear infections, enterocolitis and marginal improvement in cognitive outcomes⁸⁸;
- Reduced risk of sudden infant death;
- Improved attachment and bonding between mother and baby; and
- Reduced lifetime risk of obesity and diabetes⁸⁹.

In addition, women who breastfeed have a reduced risk of ovarian and breast cancer throughout their lifetime.

In economic studies, increasing rates of breastfeeding in infants have been found to have an overall cost benefit for families, health services and the wider society.

Inclusion of this indicator will encourage the continued prioritisation of breastfeeding support locally.

Increases in breastfeeding prevalence are expected to reduce illness in young children. This will in turn reduce hospital admissions of children aged under 12 months and the associated avoidable costs to commissioners.

Data definition

Breastfeeding prevalence at 6-8 weeks after birth

Numerator: Number of infants who are totally or partially breastfed at 6-8 week check

Denominator: Total number of infants due a 6-8 week check

⁸⁵ <http://www.who.int/features/factfiles/breastfeeding/en/index.html>

⁸⁶ <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/why-breastfeed.aspx>

⁸⁷ http://www.unicef.org/nutrition/index_24824.html

⁸⁸ <http://www.nhs.uk/news/2011/03March/Pages/breastfeeding-linked-to-school-grades.aspx>

⁸⁹

http://www.unicef.org.uk/Documents/Baby_Friendly/Research/Preventing_disease_saving_resources.pdf

8.2 Strengths and weakness of the indicators

From April 2013, NHS England took over responsibility for the collection of breastfeeding initiation and breastfeeding at 6-8 weeks. NHS England is replacing the Primary Care Trust (PCT) level reporting with GP practice level collections because it better enables reports to be produced by CCG and local authority. This approach has been ratified by the child nutrition leads within NHS England, DH and PHE. Under these data collection changes, practice level data will be submitted to the Unify2 data collection system directly by providers in two separate collections: one from maternity providers for breastfeeding initiation and another by Child Health Information System (CHIS) providers for breastfeeding at 6-8 weeks.

All the submitted data is published in the final reports, but data that does not pass the validation does not have published rates. Data validation criteria for breastfeeding initiation data state that the number of mothers breastfeeding plus those not breastfeeding must be less than or equal to the number of maternities, and the number with known breastfeeding status known must be above 95% of all maternities. The number of maternities is also checked to ensure it is consistent with ONS maternity trends.

The data is published with confidence intervals and conditional formatting is used to demonstrate where the submitted data has failed the validation criteria. The data will be published by NHS England at national (Trust and CCG) level on a quarterly basis. The annual data collected at quarter 4 is used to assess year-on-year performance. While quarterly data are published, individual quarters should not be added together to form the annual figures for this indicator⁹⁰.

A more detailed breakdown of geographical and socio-economic indicators of breastfeeding is available in the Infant Feeding Survey⁹¹ which is collected every five years. This includes a details breakdown of drop off rates.

The HSCIC will start collecting patient level data directly from Trusts and child health systems later in 2013/14. Once the coverage and quality of this dataset is sufficient it will take over the monitoring of breastfeeding and the quarterly return will cease.

Another challenge is determining the timing of breastfeeding cessation. Since data collection is only required at birth and at 6-8 weeks, it is difficult to determine at which point mothers tend to stop breastfeeding and therefore difficult to identify the optimal time for appropriate intervention⁹².

8.3 Options for action

Commissioners and clinicians need to review the proportion of infants being breastfed in the local population, and share good practice particularly among localities that have a similar socio-economic and ethnic profile.

⁹¹ <http://www.hscic.gov.uk/catalogue/PUB08694>

⁹³ <http://guidance.nice.org.uk/PH11>

Commissioners and managers are advised to implement a structured programme to encourage breastfeeding within their organisations.

8.3.1 The role of early years staff, primary care and health visitors to increase breastfeeding⁹³

- Encourage breastfeeding by providing information, practical advice and ongoing support and advice on how to store expressed breast milk safely;
- Share breastfeeding information, including technique and good management practices that would help a woman succeed, such as detailed in the UNICEF 'Baby Friendly Initiative'^{94,95};
- Routinely inform fathers about the health benefits of breastfeeding, giving them advice and encouraging them to be supportive about breastfeeding – the father's involvement is a key predictor of breastfeeding initiation and maintenance;
- Use children's centres to make antenatal and postnatal services more accessible to hard-to-reach groups;
- Raise the profile of baby cafes in the community and breastfeeding peer support;
- Promote access to online support e.g. the information service for parents⁹⁶ and UNICEF guidelines to promote and sustain breastfeeding⁹⁷;
- Identify why mothers do not initiate or continue breastfeeding, then identify if there are any unwarranted variations among social, ethnic or other groups in the local population, to understand the reasons for low rates and to target any relevant interventions;
- Raise the profile of the Healthy Start initiative, whereby mothers receive advice on healthy eating and breastfeeding⁹⁸;
- Provide women with information and advice on the benefits of taking a vitamin D supplement (10 micrograms [μg] per day) during pregnancy and while breastfeeding; and
- Once infants are aged 6 months, encourage and help parents and carers to progressively introduce them to a variety of nutritious foods, in addition to breast milk.

8.4 Resources

CMO's annual report 2012: *Our Children Deserve Better*

<https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays>

⁹³ <http://guidance.nice.org.uk/PH11>

⁹⁴ <http://www.nice.org.uk/nicemedia/live/11947/40115/40115.pdf>

⁹⁵ <http://www.unicef.org.uk/babyfriendly/>

⁹⁶ <http://www.nhs.uk/start4life/Pages/healthy-pregnancy-baby-advice.aspx>

⁹⁷ <http://www.unicef.org.uk/babyfriendly/>

⁹⁸

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Department of Health (2013) *Diet and Nutrition Survey of Infants and Young Children, 2011 Executive Summary*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/139571/DNSIYC_Executive_Summary_UK_updated.pdf

Department of Health (2014) *Breastfeeding statistics*
<https://www.gov.uk/government/organisations/department-of-health/series/breastfeeding-quarterly-statistics-england>

Dyson L, Renfrew M, McFadden A et al. (2006) *Promotion of breastfeeding initiation and duration. Evidence into practice briefing.*
http://www.nice.org.uk/niceMedia/pdf/EAB_Breastfeeding_final_version.pdf

Health and Social Care Information Centre (2010) *Infant feeding survey*
<http://www.hscic.gov.uk/catalogue/PUB08694>

Health and Social Care Information Centre (2014) *Maternity and Children's Data Set*
<http://www.hscic.gov.uk/maternityandchildren>

NICE (2008) *Guidance for midwives, health visitors, pharmacists and other primary care services to improve the nutrition of pregnant and breastfeeding mothers and children in low income households*, PH11, London.
<http://guidance.nice.org.uk/PH11>

NICE (2006) *Postnatal care: Routine postnatal care of women and their babies. Clinical guidelines*, CG37, London
<http://www.nice.org.uk/nicemedia/pdf/CG37NICEguideline.pdf>

NICE (2006) *Postnatal care: Routine postnatal care of women and their babies. Costing report. Implementing NICE guidance in England*, CG37, London
<http://guidance.nice.org.uk/CG37/CostingReport/doc/English>

NICE (2008) *A peer-support programme for women who breastfeed. Commissioning guide. Implementing NICE guidance.* London
<http://www.nice.org.uk/media/63D/7B/BreastfeedingCommissioningGuide.pdf>

Public Health England *Breastfeeding profiles - Child and Maternal Health Intelligence Network:*
<http://atlas.chimat.org.uk/IAS/dataviews/breastfeedingprofile>

Public Health England *Maternity knowledge hub - Child and Maternal Health Intelligence Network:*
<http://www.chimat.org.uk/maternity>

UNICEF(2012) *The evidence and rationale for the UNICEF UK Baby Friendly Initiative Standards and Preventing disease and saving resources.*
<http://www.unicef.org.uk/BabyFriendly/Resources/General-resources/Preventing-disease-and-saving-resources/>

9 Vaccination coverage

9.1 Importance and relevance of this indicator

After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health.⁹⁹

In 1911, 130 out of every 1,000 children born in England and Wales died before their first birthday; in 2011 this had decreased to 4.3 per 1,000. The decrease in infant deaths between 1911 and 2011 is because of considerable improvements in health care, including the control of infectious diseases and public health infrastructure over this time period.¹⁰⁰

Many vaccine preventable childhood diseases are now so rare that it is easy to underestimate the importance of children's vaccinations. However, whooping cough and diphtheria are still a threat. The diseases are rare now, but if children are not vaccinated, they can return with a vengeance. After ill-founded concerns about the safety of the whooping cough vaccine in the 1970s and 80s, parents stopped vaccinating their children against the disease. This led to three epidemics, and at least 100 children died after catching the disease. When Russia's childhood vaccination programme collapsed during the break-up of the Soviet Union, it triggered a mass epidemic of diphtheria¹⁰¹.

Measles, mumps and rubella used to be common childhood diseases. MMR coverage is a good indicator for the whole vaccination programme. Following the introduction of the MMR numbers of cases were low. However in recent years coverage of the MMR reduced, again because of ill-unfounded concerns about safety, and there continues to be outbreaks of measles across the country.

Data definition

MMR vaccination coverage for two doses (5 year olds)

Numerator: Number of children at age 5 years who have received two doses of MMR vaccine within each reporting area [at present CCG responsible population]

Denominator: Number of children at age 5 years resident within each reporting area [at present CCG responsible population]

If enough people in a community are vaccinated, it is harder for a disease to pass between people who have not been vaccinated. This is called 'herd immunity'. Herd immunity is particularly important in protecting people who cannot get vaccinated

⁹⁹ <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/VaccinationImmunisation/>

¹⁰⁰ http://www.ons.gov.uk/ons/dcp171766_283988.pdf

¹⁰¹ <http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-saves-lives.aspx>

because they are too ill, or they are having treatment that damages their immune system¹⁰².

Vaccination coverage of MMR is the good indicator of the level of protection a population will have against vaccine preventable communicable diseases. MMR rates function well as an indicator of other immunisation rates because it is the vaccine whose coverage levels have been most affected by public concerns. If MMR levels are high, then it is usually found that other immunisation rates are high. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

9.2 Strengths and weakness of the indicator

Information on childhood immunisation coverage is collected through the Cover of Vaccination Evaluated Rapidly¹⁰³ (COVER) data collection from Child Health Information Systems (CHISs) for most CCGs, or from GP systems for a small number of CCGs.

The COVER programme monitors immunisation coverage data for children in the United Kingdom who reach their first, second or fifth birthday during each evaluation quarter. This information is promptly fed back to local level, creating the opportunity to improve coverage and to detect changes in vaccine coverage quickly¹⁰⁴.

Data collections are quality assured at the time of collection by PHE and further data validation and quality assurance is carried out by HSCIC prior to publication¹⁰⁵.

There have been data quality issues reporting locally due to the CHIS system. For the last four years work has been done to improve the accuracy of the data, for example, removing children who are no longer registered with a GP and identifying the true number of registered children with a GP.

It is still up to the guardian of the child to consent to vaccination. Due to personal reasons such as religious belief, perceived harm from the vaccine or a lack of understanding of the importance of immunisation, some people choose not to vaccinate their child.

9.3 Options for action

There should be a multifaceted, coordinated programme across different settings to increase timely immunisation among groups with low or partial uptake. The programme should form part of the local child health strategy and should include the following actions¹⁰⁶:

¹⁰² <http://www.nhs.uk/Conditions/vaccinations/Pages/How-vaccines-work.aspx>

¹⁰³ <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/VaccineCoverageAndCOVER/>

¹⁰⁴ <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/VaccineCoverageAndCOVER/>

¹⁰⁵ <https://catalogue.ic.nhs.uk/publications/public-health/immunisation/nhs-immu-stat-eng-2011-2012/nhs-immu-stat-eng-2011-12-rep.pdf>

¹⁰⁶ <http://guidance.nice.org.uk/PH21>

- Monitor vaccination status as part of a wider assessment of children and young people's health;
- Ensure there is a coordinated immunisation programme to ensure population coverage;
- Ensure there are robust information systems in place to collate vaccination coverage in a timely fashion and identify areas of low coverage;
- Ensure all staff involved in immunisation services are adequately trained and have access to up-to-date evidence-based information e.g. PHE resources;
- Ensure updates to the childhood immunisation programme and schedule are monitored and services adapted appropriately;
- Consider using pharmacies, retail outlets, libraries and local community venues to promote and disseminate accurate, up-to-date information on childhood immunisation;
- Ensure there is an identified professional in every health and social setting where children and families attend who is responsible and provides leadership for the local childhood immunisation programme e.g. GP surgeries, nurseries, schools, colleges of further education and children centers;
- Commissioners of children's services in primary care, children's centres and immigration services should improve access to immunisation services for those with transport, language or communication difficulties, and those with physical or learning disabilities. For example, provide longer appointment times, walk-in vaccination clinics, services offering extended hours and mobile or outreach services. The latter might include home visits or vaccinations at children's centres;
- Ensure there is a mechanism to assess the risks of children and families for targeted vaccinations e.g. BCG and Hepatitis B.

9.4 Resources

Department of Health (2009) *Healthy Child Programme*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Department of Health (2013) *Immunisation*

<https://www.gov.uk/government/organisations/public-health-england/series/immunisation>

NICE (2009) *Reducing differences in the uptake of immunisations*, PH21.

<http://guidance.nice.org.uk/PH21>

NICE (2013) *Immunisation for children and young people overview*.

<http://pathways.nice.org.uk/pathways/immunisation-for-children-and-young-people>

NICE (2009) *Reducing the difference in immunisations: costing templates*

[Reducing the differences in the uptake of immunisations: costing template](#)

Public Health England *Vaccinations & immunisation snapshot - Child and Maternal Health Intelligence Network*
<http://atlas.chimat.org.uk/IAS/profiles/servicereports>

10 Child development at 2-2 ½ years (placeholder)

10.1 Importance and relevance of this indicator

The Government's Early Years Policy Statement 'Supporting Families in the Foundation Years' (2011)¹⁰⁷ sets out the Government's recognition of the importance of pregnancy and the first years of life. This is a strong commitment to ensuring all children get the best possible start in life. It also included a commitment to developing an outcome measure of child development at 2-2½ years¹⁰⁸.

Child development in the earliest years of life is crucial and fundamental to later outcomes and life chances. In particular, evidence^{109 110 111 112 113} suggests that the promotion of very young children's emotional wellbeing (sometimes referred to as promoting infant mental health) can be an important foundation for their wider and longer term development.

Early child development can be fundamentally affected by the relationship between each child and his or her primary caregiver. In turn, that relationship is likely to be affected by factors in the caregiver's wider environment.

It is vital that agencies work together as set out in the revised Working Together to Safeguard Children¹¹⁴ in all circumstances where a child is considered to be at risk of abuse or neglect, including if there are concerns that a child's health or development might be at risk of being significantly impaired without the provision of additional services¹¹⁵.

The indicator definition requires further development

2.5i Proportion of children aged 2-2½ years who received an assessment as part of the Healthy Child Programme or an integrated review (using any tool)

The number of children aged 2-2½ years that complete any Healthy Child Programme or integrated review as a proportion of total number of children within this age group.

2.5ii Proportion of children aged 2-2½ years offered ASQ-3 as part of the

¹⁰⁷ <https://www.gov.uk/government/publications/supporting-families-in-the-foundation-years>

¹⁰⁸ <http://www.education.gov.uk/childrenandyoungpeople/earlylearningandchildcare/developing/a0074569/developing-a-new-vision-for-the-early-years>

¹⁰⁹ http://www.wavetrust.org/sites/default/files/reports/conception_to_age_2_-_the_age_of_opportunity_-_web_optimised.pdf

¹¹⁰ <http://grahamallenmp.co.uk/static/pdf/early-intervention-7th.pdf>

¹¹¹

<http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk>

¹¹² <https://www.gov.uk/government/collections/tickell-review-reports>

¹¹³ <https://www.gov.uk/government/collections/munro-review>

¹¹⁴ <http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children>

¹¹⁵ http://www.wavetrust.org/sites/default/files/reports/conception_to_age_2_-_the_age_of_opportunity_-_web_optimised.pdf

Healthy Child Programme or integrated review

The number of children aged 2-2½yrs for whom ASQ-3 is completed as part of the HCP or integrated review as a proportion of total number of children within this age group.

10.2 Strengths and weakness of the indicator

Data from either the Healthy Child Programme review or the integrated review at 2-2½ years will be collated from local child health information systems via the HSCIC¹¹⁶.

Work is on-going to explore the feasibility of this data collection route. Once established, the Maternity and Children's dataset will be modified in order to provide the mainstream vehicle for data collection. The data collection will comply with the governance arrangements for similar data collections managed by HSCIC¹¹⁷.

Full data for this indicator is not likely to be available before 2016 based on 2015/16 data.

Interim data collection will report the proportion of children aged 2-2½ years who receive an assessment as part of the Healthy Child Programme review or an integrated review and the proportion of children aged 2-2½ years offered ASQ-3 as part of the Healthy Child Programme review or an integrated review.

10.3 Options for action

10.3.1 The role of early years staff, primary care and health visitors to improve child development at 2-2½ year development

10.3.1.1 Early child development promotion in pregnancy¹¹⁸

- Ensure health professionals are well equipped to detect stress, anxiety and depression during pregnancy;
- Provide referral to appropriate psychological or other interventions for antenatal anxiety and depression. Ensure there are enough trained professionals to provide this help;
- Target maternal stress during pregnancy, for instance by focusing on reducing domestic violence and supporting the quality of relationships during this stressful time. These measures could reduce the risk of children having symptoms of ADHD or conduct disorder and showing later criminal behaviour; and

¹¹⁶

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263662/2901502_PHO_F_Improving_Outcomes_PT2_v1_1.pdf

¹¹⁷

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263662/2901502_PHO_F_Improving_Outcomes_PT2_v1_1.pdf

¹¹⁸ http://www.wavetrust.org/sites/default/files/reports/conception_to_age_2_-_the_age_of_opportunity_-_web_optimised.pdf

- Consider whether antenatal parent preparation classes could include a discussion on the emotional impact of becoming a parent and not just focus on the more practical elements of birth options and bathing a baby.

10.3.1.2 Secure attachment

- Practitioners should have a good understanding of attachment as it relates to the child's key relationships and their own relationship with the child;
- Review health visitor training to include a session on evaluation of the interaction between the mother and baby. Ideally, this should be carried out throughout the Healthy Child Programme¹¹⁹ at a universal level and used as a determinant for the need for additional services such as Universal Plus¹²⁰.

10.3.1.3 Specialist parent-infant psychotherapy support

- At the universal level, promote at every opportunity, in multiple settings, and in particular through children's centres, how families can support the development of emotional health in their babies and toddlers; and
- When significant risk is identified, implement targeted preventive interventions, through the provision of well-resourced specialist NHS (or high quality alternative) Perinatal Parent Infant Mental Health Service support as well as access to regular and skilled supervision.

10.3.1.4 Specific options for health visitors in relation to social/emotional development

- Health visitors should be trained in the use of motivational interviewing for use from first contact onwards. This would help them to re-visit areas of risk outlined during the early pregnancy and discuss these areas of vulnerability with the mother and (if appropriate) her partner; and
- Professionals such as health visitors should be trained to evaluate the interaction between the mother and baby.

10.3.1.5 Improve parenting capability

- Invest in proven, effective (and cost-effective) programmes appropriate to the local demographic profile and needs.

10.3.1.6 Improve quality of early years services

- Developing effective multi-agency working and delivery through identifying and following the principles of such highly successful multi-agency practices such as the Highland Region Streamlined Rapid Reaction system¹²¹, and case studies from the Local Government Association knowledge hub and DH early implementer sites;

119

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

¹²⁰ http://www.wavetrust.org/sites/default/files/key_publications/conception_to_age_2_-_the_age_of_opportunity_framework_for_local_area_service_commissioners_.pdf

¹²¹

http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/20110707_early_years_report_web_v3.pdf

- Explore the potential of linking in with local interventions around the Troubled Families initiative, especially where the focus is on working through a single key worker and dealing with problems in a more holistic way;
- Ensure effective action is taken to identify and address the needs of expectant parents and those very young children most at risk of poor outcomes through full delivery of the Healthy Child Programme and targeted work through children's centres, and by ensuring that midwives and health visitors are resourced and trained to provide a level of support that promotes sensitively responsive, loving, nurturing parenting and a good two-way relationship and communication between parents and children to promote sound social and emotional development¹²²; and
- The Healthy Child Programme needs further development of detailed clinical guidance (as for the Two Year Review) for earlier ages (e.g. first year of life) so that it can be commissioned and disseminated in a similar way. This development would include expanding assessment of attachment and specialist pathways, parental and infant mental health, drug and alcohol, domestic abuse, relationships, and links to 'Pregnancy, Birth and Beyond'. PHE are to have commissioned such a review which is due to report in June 2014.

10.3.1.7 Children's centres

- Prioritise high quality outreach and family support to work with the most vulnerable families suffering multiple risk factors, who may need long-term support to help them benefit from other services;
- Develop a defined role for health visitors in leading services and/or teams within children's centres;
- Develop the role of children centres in identification of high risk families and referral to mental health, substance misuse, domestic violence services¹²³;
- Explore the potential for health visitors to act as team leaders, supervisors, and/or mentors, building capacity and skills within the children's centre team and contributing to better integrated delivery and improved information sharing;
- Explore the potential for shared local targets to help drive and incentivise integrated delivery. Develop local measures of success for children's centres (not necessarily for payment by results) which link to those in the Children and young people's health benchmarking tool and the Healthy Child Programme; and
- Develop integrated assessments and reviews (2 to 2 ½ years integrated review).

10.4 Resources

CMO Annual Report (2013) *Chapter 6 Life Stage: Early Years*

<https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays>

¹²² http://www.wavetrust.org/sites/default/files/key_publications/conception_to_age_2_-_the_age_of_opportunity_framework_for_local_area_service_commissioners_.pdf

¹²³ <http://www.4children.org.uk/Files/d7b88a0a-d86c-4eeb-a359-a18700e5572b/APPG-report-January-2013.pdf>

Department of Education (2011) *Evidence pack for Supporting Families in the Foundation Years*:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262397/DFE-00214-2011.pdf

Department of Health (2009) *Healthy Child Programme*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Health and Social Care Information Centre (2014) *Maternity and Children's Data Set*

<http://www.hscic.gov.uk/maternityandchildren>

Public Health England *Perinatal and infant mental health knowledge hub - Child and Maternal Health Intelligence Network*

<http://www.chimat.org.uk/pimh>

WAVE Trust (2013) *Conception to age 2- the age of opportunity. Framework for local area service commissioners.*

http://www.wavetrust.org/sites/default/files/key_publications/conception_to_age_2_-_the_age_of_opportunity_framework_for_local_area_service_commissioners_.pdf

WAVE Trust (2013) *Conception to age 2- the age of opportunity. Full report*

http://www.wavetrust.org/sites/default/files/reports/conception_to_age_2_-_the_age_of_opportunity_-_web_optimised.pdf

UCL Institute of Health Equality (2012) *An Equal Start improving outcomes in children centres*

<http://www.instituteofhealthequity.org/projects/an-equal-start-improving-outcomes-in-childrens-centres>

11 School readiness

11.1 Importance and relevance of this indicator

Globally, school readiness is gaining currency as an indicator to close the learning gap and improve equity in achieving lifelong learning and full developmental potential among young children. It does so by considering all children, especially the vulnerable and disadvantaged, including children with disabilities, ethnic minorities and those living in rural areas¹²⁴.

The ability of young children to manage their emotions and behaviours is an important prerequisite for social adjustment and school readiness. With an increase in early-onset behavioural difficulties in children, understanding changes in child behaviour during the preschool years and the factors that influence it is a priority for policy and practice¹²⁵.

There can be many reasons why a child fails to attain competence in literacy and grapho-motor skills, some of which are already addressed by services within the education system and initiatives to support development in the early years. Nevertheless, there remains a significant percentage of children whose mastery of basic skills continues to fall below expected levels at the end of primary education¹²⁶. Children from poorer backgrounds are more likely to lack basic skills.¹²⁷ This is an important contributor to inequality. One area that has not received sufficient attention in recent years is developmental and physical 'readiness' for formal education.¹²⁸

The Early Years Foundation Stage (EYFS) in 2013 shows¹²⁹:

- At a national level, the achievement gap between the lowest attaining 20% of children and the mean is 36.6%. 91 local authorities have an achievement gap which is less than the national figure; the remaining 61 are above; and
- Of those children in the 30% most deprived super output areas in England, 44% achieved a good level of development. This compares with 56% of children resident in other areas and shows a gap of 12%.

Readiness for school requires much more than a child simply reaching the chronological age required for school entry. Growth and physical development are as important to education as they are to the field of developmental medicine but have been largely overlooked by the educational system since the phasing out of routine developmental tests for all children¹³⁰.

¹²⁴ http://www.unicef.org/education/files/Chil2Child_ConceptualFramework_FINAL%281%29.pdf

¹²⁵ <http://www.teamaroundthechild.com/images/stories/journal-pdfs/Reflexes.pdf>

¹²⁶ Ofsted(2010). Reading by six: how the best schools do it. www.ofsted.gov.uk/publications/100197

¹²⁷ Goodman, A. and Gregg, P.(2010). Poorer children's educational attainment: how important are attitudes and behaviour? Joseph Rowntree Foundation. www.jrf.org.uk/publications/educational-attainment-poor-children

¹²⁸ <http://www.teamaroundthechild.com/images/stories/journal-pdfs/Reflexes.pdf>

¹²⁹

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252223/SFR43_2013_Text.pdf

¹³⁰ <http://www.teamaroundthechild.com/images/stories/journal-pdfs/Reflexes.pdf>

Data definition

1.2i The percentage of children achieving a good level of development at the end of reception

This rating is drawn from the Early Years Foundation Stage Profile (EYFSP). The EYFSP is the assessment carried out by teachers at the end of Reception and is used to inform plans for child development, informing Key Stage 1 teachers and parents about each child's development and needs. It can thus be seen as a measure of 'school readiness'. The EYFSP requires teachers to assess whether children are 'emerging, expected or exceeding' against 17 early learning goals in the EYFS.

Children are defined as having reached a good level of development at the end of the EYFS if they achieve at least the expected level in:

- The early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and;
- The early learning goals in the specific areas of mathematics and literacy.

The EYFSP¹³¹ is a teacher assessment of children's development against the 17 early learning goals at the end of the EYFS (the end of the academic year in which the child turns 5). It supports a smooth transition to Key Stage 1 (KS1) by informing the professional dialogue between EYFS and KS1 teachers. This information should help Year 1 teachers plan an effective, responsive and appropriate curriculum that will meet the needs of all children. It is also used to inform parents or carers about their child's development.

11.2 Strengths and weakness of the indicator

The pilot of this profile involved a sample of approximately 500 schools across 19 local authorities¹³². Assessment data from the pilot was used to develop a new Good Level of Development (GLD) indicator. In the new EYFSP, children will be defined as having reached a GLD at the end of the EYFS if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and in the specific areas of mathematics and literacy.

¹³¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190639/DFE-RR291.pdf

¹³² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190639/DFE-RR291.pdf

11.3 The role of early years staff, primary care and health visitors to enable school readiness¹³³

11.3.1 Understand attachment

It is generally accepted that infants can and do form secure attachments with a small number of key caregivers, including early years practitioners. Attachment is an important feature of good early years practice in a number of respects:

- Practitioners should have a good understanding of attachment as it relates to the child's key relationships and their own relationship with the child; and
- Practitioners should be able to build warm, responsive and sustained relationships with young children confirmed by visual, auditory and physical contact. Continuity and consistency of primary care is important e.g. key person systems.

11.3.2 Support effective parenting

- Professionals working with children and families should have skills to offer evidence-based interventions, including parenting programmes, where appropriate.

11.3.3 Understand the importance of speech and language development

- Ensure children and families have access to timely high quality support for speech, language and communication skills which is essential for both effective parenting and good early years' provision.

11.3.4 Develop practitioners and managers who are emotionally competent

- Ensure professionals working with children and young people particularly health visitors, are recruited on personal as well as professional attributes. It might be possible to select early years staff for their emotional resilience and emotional intelligence.

11.3.5 Coordinated early years programme

- Develop local pathways to ensure timely referrals between professionals and early recognition and access to services for families at risk;
- Develop the role of children's centres to improving school readiness and in the early identification and intervention of additional needs including behavioural problems. To achieve this, the services provided need to address the determinants of the link between children living in less advantaged circumstances, their subsequent low achievement at school and poorer outcomes in adult life; and
- Ensure good quality childcare for pre-school children promoting social, emotional and mental development as well as providing support for working

¹³³ http://www.wavetrust.org/sites/default/files/reports/conception_to_age_2_-_the_age_of_opportunity_-_web_optimised.pdf

parents. All 3 and 4 year olds are entitled to 15 hours childcare paid for by the government¹³⁴.

11.4 Resources

Department for Education (2012) *Early Years Foundation Stage Profile Results in England*

<http://www.education.gov.uk/rsgateway/DB/SFR/s000961/index.shtml>

Department of Education (2012) *Statutory Framework for the Early Years Foundation Stage: Setting the standards for learning, development and care for children from birth to five*

<http://www.education.gov.uk/aboutdfe/statutory/g00213120/eyfs-statutory-framework>

Early Education (2012) *Development Matters in the Early Years Foundation Stage*

<http://www.foundationyears.org.uk/wp-content/uploads/2012/07/Development-Matters-in-the-Early-Years-Foundation-Stage.pdf>

Early Education (2012). *Understanding the revised Early Years Foundation Stage*. Helen Moylett and Nancy Stewart

<http://www.early-education.org.uk/publications-and-resources>

Department of Education (2012) *Statistics - national statistics Early Years Foundation stage profile results: 2012 to 2013*

<https://www.gov.uk/government/publications/early-years-foundation-stage-profile-results-2012-to-2013>

Eleanor Cotzias, Tara Whitehorn, STA Teacher Assessment & Moderation team (2013) *Topic Note: Results of the Early Years Foundation Stage Profile (EYFSP) Pilot Research report*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190639/DFE-RR291.pdf

Office for National Statistics Neighbourhood Statistics (NeSS). 2012. *Early Years Foundation Stage Profile by gender in England (referenced by location of pupil residence) 2010*

http://www.neighbourhood.statistics.gov.uk/dissemination/instanceSelection.do?JSAllowed=true&Function=&%24ph=60_61&CurrentPageId=61&step=2&datasetFamilyId=2264&instanceSelection=128009&Next.x=13&Next.y=9

The Wave Trust (2013) *Conception to age 2- the age of opportunity. Framework for local area service commissioners*.

http://www.wavetrust.org/sites/default/files/key_publications/conception_to_age_2_-_the_age_of_opportunity_framework_for_local_area_service_commissioners.pdf

UNICEF (2012) *School Readiness: a conceptual framework*

http://www.unicef.org/education/files/Chil2Child_ConceptualFramework_FINAL%281%29.pdf

¹³⁴ <https://www.gov.uk/free-early-education>

UCL Institute of Health Equality (2012) *An Equal Start improving outcomes in children centres*

<http://www.instituteofhealthequity.org/projects/an-equal-start-improving-outcomes-in-childrens-centres>

12 Healthy weight (excess weight at 4-5 years)

12.1 Importance and relevance of this indicator

The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the twenty-first century¹³⁵. Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity – for example, raised blood pressure, fatty changes to the arterial linings and hormonal and chemical changes such as raised cholesterol and metabolic syndrome – can be identified in obese children and adolescents¹³⁶.

Obesity is a priority area for Government. The Government's "Call to Action" (2011) on obesity included national ambitions relating to excess weight in children¹³⁷.

The National Child Measurement Programme (NCMP) (now collected via local authorities) measures the height and weight of around one million school children in England every year, providing a detailed picture of the prevalence of childhood obesity. The latest figures, for 2012/13, show that 18.9% of children in Year 6 (aged 10-11) are obese and a further 14.4% overweight. Of children in Reception (aged 4-5), 9.3% are obese and another 13.0% overweight. This means one third of 10-11 year olds and over a fifth of 4-5 year olds are overweight or obese¹³⁸.

Childhood obesity is an outcome of a myriad of risk factors, including biological and lifestyle factors, environment, culture and social structures. It is well recognised that children who are obese are likely to have obese parents¹³⁹¹⁴⁰. Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the accumulation of excess body fat.

The Foresight report (2007)¹⁴¹ referred to a "complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain". The Foresight map was divided into seven cross-cutting predominant themes:

¹³⁵ <http://www.who.int/dietphysicalactivity/childhood/en/>

¹³⁶ http://www.noo.org.uk/NOO_about_obesity/child_obesity

¹³⁷ <https://www.gov.uk/government/news/department-calls-for-action-on-obesity>

¹³⁸ <http://www.noo.org.uk/NCMP>

¹³⁹ Parsons, T.J. et al. Childhood predictors of adult obesity: a systematic review. [Review] [283 refs]. International Journal of Obesity & Related Metabolic Disorders: Journal of the International Association for the Study of Obesity 1999; 23 Suppl 12: pp.S1-S107.

¹⁴⁰ Patrick, H. and Nicklas, T.A. A review of family and social determinants of children's eating patterns and diet quality. Journal of the American College of Nutrition 2005; 24(2): pp.83-92.

¹⁴¹ <http://www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesities/reports-and-publications>

- **Biology:** an individual's starting point - the influence of genetics and ill health;
- **Activity environment:** the influence of the environment on an individual's activity behaviour, for example a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and showers;
- **Physical Activity:** the type, frequency and intensity of activities an individual carries out, such as cycling vigorously to work every day;
- **Societal influences:** the impact of society, for example the influence of the media, education, peer pressure or culture;
- **Individual psychology:** for example a person's individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences;
- **Food environment:** the influence of the food environment on an individual's food choices, for example a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables near home; and
- **Food consumption:** the quality, quantity (portion sizes) and frequency (snacking patterns) of an individual's diet.

Childhood obesity links closely with the Infant Feeding Strategies¹⁴² and Adult Obesity Strategies¹⁴³. The preschool years (ages 2–5) are a key time for shaping lifelong attitudes and behaviours, and childcare providers can create opportunities for children to be active and develop healthy eating habits and act as positive role models¹⁴⁴.

Data definition

2.6i Percentage of children aged 4-5 classified as overweight or obese

Numerator: The number of primary school age children in Reception (aged 4-5 years) with valid height and weight recorded (in a particular school year) who are classified as overweight or obese

Denominator: The total number of primary school age children in Reception (aged 4-5 years) with valid height and weight recorded in a particular school year

The published figures define a child as overweight (including obese) if their BMI is greater than or equal to the 85th centile of the British 1990 (UK90) growth reference.

¹⁴² <http://www.unicef.org.uk/BabyFriendly/Resources/General-resources/Global-Strategy-for-Infant-and-Young-Child-Feeding/>

¹⁴³ <https://www.gov.uk/government/news/department-calls-for-action-on-obesity>

¹⁴⁴ <http://publications.nice.org.uk/obesity-cg43>

12.2 Strengths and weakness of the indicator

Data on the National Child Measurement Programme (NCMP) are published annually by HSCIC: <http://www.ic.nhs.uk/ncmp>.

NCMP measures sex and ethnic group at an individual level. However data on health-related behaviour is not collected. The presence of the lower super output area of residence (LSOA), derived from home postcode of the child, allows for some consideration of the effect of demographic determinants.

Data quality issues which affect NCMP data include variation between local authorities. Previous NCMP analysis has shown an association between low rates of participation and a lower reported prevalence of obesity for that area. This is likely to occur because those children who do not take part are more likely to be obese and overweight than children who do participate. The closer the participation rate is to 100% the greater the chance that the children measured by the NCMP are representative of the underlying population¹⁴⁵. Accuracy of measurements and the use of different measurement tools, as well as when in the school year the measurements are taken affected data quality.

Improvements to NCMP data quality and participation may influence the outcomes of analysis. Therefore, the observed changes in children's BMI may not necessarily all reflect real changes in the population. Some may reflect changes in data quality or participation that have changed between areas or population groups over time affecting the different cohorts of children.

12.3 Options for action

12.3.1 The role of early years staff, primary care and health visitors to reduce childhood obesity¹⁴⁶

- All actions aimed at preventing excess weight gain and improving diet (including reducing energy intake) and activity levels in children and young people should actively involve parents and carers;
- Professionals working with children and families should be trained in evidence-based intervention to reduce obesity for example through culture and behaviour change and improved nutrition and promotion of physical activity¹⁴⁷;
- Local pathways and referral criteria should be available for staff;
- Professional working with children and families should be trained in evidence based interventions promoting the benefits of breastfeeding (see section 7);
- Families of children and young people identified as being at high risk of obesity, such as children with at least one obese parent, should be offered on-going support from an appropriately trained health professional. Individual as well as family-based interventions should be considered, depending on the age and maturity of the child;

¹⁴⁵ http://www.noo.org.uk/uploads/doc/vid_8969_NCMP_DataQuality_Participation.pdf

¹⁴⁶ <http://publications.nice.org.uk/obesity-cg43>

¹⁴⁷ <http://www.noo.org.uk/LA/tackling>

- All schools, nurseries and childcare facilities should ensure that preventing excess weight gain and improving children’s diet and activity levels are priorities by:
 - Minimising sedentary activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions;
 - Implementing Children School Trust, School Food Standards¹⁴⁸, Eat Better Start Better Programme¹⁴⁹ and Caroline Walker Trust¹⁵⁰ guidance on food procurement and healthy catering.
- Staff should ensure that children eat regular, healthy meals in a pleasant, sociable environment free from other distractions (such as television). Children should be supervised at mealtimes and, if possible, staff should eat with children; and
- Midwives, GPs, health visitors and their teams should be encouraged to provide age appropriate information and advice to pregnant women and parents of young children about nutrition and physical activity for the whole family as set out in *Healthy Child Programme: Pregnancy and the first five years of life*¹⁵¹.

12.4 Resources

Department of Health (2009) *Healthy Child Programme*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Department of Health (2011) *Call to Action on Obesity*

<https://www.gov.uk/government/news/department-calls-for-action-on-obesity>

Food Standards Agency (2013) *Guidance for Caterers*

<http://www.food.gov.uk/scotland/scotnut/healthycatering/pubinstguide>

NICE (2006) *Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children*, CG 43.

<http://publications.nice.org.uk/obesity-cg43>

NICE (2010) *Weight management before during and after pregnancy*, PH27.

<http://guidance.nice.org.uk/PH27>

Public Health England *Obesity knowledge hub - Child and Maternal Health Intelligence Network*:

<http://www.chimat.org.uk/obesity>

¹⁴⁸ <http://www.childrensfoodtrust.org.uk/schools/the-standards>

¹⁴⁹ <http://www.childrensfoodtrust.org.uk/pre-school/eat-better-start-better>

¹⁵⁰ <http://www.food.gov.uk/multimedia/pdfs/walkertrustreport.pdf>

¹⁵¹

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

13 Tooth decay in children age 5

13.1 Importance and relevance of this indicator

Good oral health is an integral part of overall health. Poor oral health has a significant impact on quality of life causing pain and sepsis; affecting appearance and leading to a lack of confidence; loss of nights' sleep; missed school and affecting the ability to eat a healthy diet.

Avoidable and unpleasant dental treatment including extractions under general anaesthetic which represent an avoidable risk to life can be avoided through maintaining good oral health.

Despite an overall improvement in oral health over the past 30 years, over 27% of 5 year olds have tooth decay¹⁵². Tooth decay (dental caries) is the decalcification of the tooth surface, which can lead to tooth decay. The cause of tooth decay is frequent sugar consumption in foods or drinks. It can be prevented by reducing the frequency of sugar consumption and by strengthening the tooth surface with fluoride, most commonly through brushing with fluoride toothpaste.

The 2012 National Dental Epidemiology Programme for England, oral health survey of 5 year old children¹⁵³, showed overall improvements in the prevalence and severity of tooth decay in young children:

- The prevalence nationally of overall tooth decay in 5 year olds has reduced from 30.9% to 27.9%;
- The proportion of children with untreated decay has reduced from 27.5% to 24.5%;
- Children with sepsis in their mouths has reduced from 2.3% to 1.7% since 2008; and
- 72.1% of 5 year olds are free from tooth decay, up from 69.1% in 2008.

Oral health inequalities can be observed in age, gender, socio-economic and education level within England. Tooth decay still remains a major health problem for many groups of people in the England, particularly for those from socio-economically deprived or vulnerable groups. The incidences of oral cancer (with tobacco consumption and alcohol misuse as risk factors) and periodontal (gum) disease (risk factors include poor oral hygiene and smoking) are also strongly related to social and economic deprivation¹⁵⁴.

¹⁵²

<http://www.nwph.net/dentalhealth/Oral%20Health%205yr%20old%20children%202012%20final%20report%20gateway%20approved.pdf>

¹⁵³

<http://www.nwph.net/dentalhealth/Oral%20Health%205yr%20old%20children%202012%20final%20report%20gateway%20approved.pdf>

¹⁵⁴ <http://www.nice.org.uk/nicemedia/live/13664/63821/63821.pdf>

Data definition

Rate of tooth decay in children aged 5 years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted – decayed/missing/filled teeth (dmft)

Numerator: Total number of decayed, missing or filled teeth in the survey sample of 5-year-old children

Denominator: Number of 5-year-old children in the survey sample.

13.2 Strengths and weakness of the indicator

The oral health of 5 year olds has been measured by regular surveys. The sample is children attending mainstream schools who are 5 years old at the time of the survey. Calibrated examiners examine children and record the number of decayed (d), missing (m) and filled (f) primary teeth making up the dmft index of decay in primary teeth. Tooth decay in the primary teeth is a good predictor of decay levels in the adult teeth. Results are presented in two ways – the severity of tooth decay - average numbers of decayed, missing or filled teeth (dmft) – and the prevalence, or percentage of children with at least one tooth decayed missing or filled (dmft>0).

Especially following the introduction of a requirement for positive consent, participation levels have caused issues with the data. Non- responders to the survey tend to be from the more deprived areas. There is an established relationship between deprivation and tooth decay whereby children from more deprived areas tend to have higher levels of tooth decay. In some areas due to low participation rates it is possible that the figures may underestimate the true level of disease.

Average borough-level figures also mask inequalities which exist within local areas. Small sample sizes or small numbers of children result in wide confidence intervals on the data when analysed by locality or ethnic group.

Apparent trends may be misleading as each survey covers a distinct cohort of children.

13.3 Options for action

Interventions to improve oral health should not be carried out in isolation but in conjunction with interventions on healthy weight, in the context of healthy lifestyles, following a common risk factor approach.

13.3.1 Individual advice

Health visitors and those working with young children and their families should:

- Support mothers to breastfeed, with weaning delayed until six months;
- Support weaning on to a healthy diet of sugar-free snacks and drinks;

- Encourage keeping sugary snacks and drinks to mealtimes only with healthier snacks such as fresh fruit, bread, milk or water between meals;
- Support parents to begin to brush children's teeth twice daily with a smear of full strength fluoride toothpaste as soon as teeth come through at around 6-8 months and provide advice on pre-teeth care;
- Distribute oral health promotion packs (where available);
- Encourage parents and child to visit dentist regularly for preventive check-ups.

13.3.2 Community level programmes

- Support all settings used by young children and their families to improve choices available such as sugar-free snacks and drinks;
- Ensure affordable toothbrushes and toothpaste are available to parents living in areas of socio-economic deprivation, e.g. through children's centres or distributing toothpaste and brush via health visitors or by post; and
- Consider the use of targeted programmes to increase fluoride on children's teeth where they are particularly at risk from decay (for example brushing in nurseries, fluoride varnish).

13.3.3 Visiting the dentist regularly for preventive advice and fluoride application¹⁵⁵

- Maximise the potential of the dental team (dentists, hygienists, nurses, technicians, oral health promoters and educators) to adopt and deliver proactive preventive approaches; and
- Develop targeted approaches for the more vulnerable and harder to reach children and their parents.

13.4 Resources

Department of Health (2007) *Dental Screening (Inspection) in Schools and Consent for Undertaking Screening and Epidemiological Surveys Gateway Approval*
Reference Number: 7698

<http://217.35.77.12/archive/england/papers/health/pdfs/04142282.pdf>

Department of Health (2007) *Guidance: Valuing People's Oral Health: A good practice guide for improving the oral health of disabled children and adults*

http://www.sepho.org.uk/Download/Public/12757/1/valuing_peoples_oral_health%5B1%5D.pdf

Department of Health (2009) *Delivering Better Oral Health – a toolkit for prevention provides an evidence base of interventions for prevention of dental diseases in children*

http://www.oralhealthplatform.eu/sites/default/files/field/document/NHS_Delivering%20Better%20Oral%20health.pdf

¹⁵⁵ <http://www.nice.org.uk/nicemedia/live/13664/63821/63821.pdf>

Department of Health (2009) *Healthy Child Programme*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

NHS England (2013) *Securing excellence in commissioning NHS dental services*
<http://www.england.nhs.uk/wp-content/uploads/2013/02/commissioning-dental.pdf>

NICE (2013) *Oral health - local authority commissioned dental health programmes: draft scope consultation comments table*
<http://www.nice.org.uk/nicemedialive/13664/63821/63821.pdf>

NICE guidance: Local authority oral health improvement strategies. Due for issue October 2014. www.nice.org.uk

North West Public Health Observatory (2013) *National Dental Epidemiology Programme for England, oral health survey of 5 year old children 2012*
<http://www.nwph.net/dentalhealth/survey-results5.aspx?id=1>

Scottish Intercollegiate Guidelines Network (2005) *Prevention and management of dental decay in the pre-school child*
<http://www.sign.ac.uk/pdf/sign83.pdf>

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Appendix 1 Summary of the technical information

PH OF Indicator Number ¹⁵⁶	NHS OF Indicator Number ¹⁵⁷	Indicator Name	Data Source	Level of collection	Frequency of Publication	Lag Time in months	Publication Source	Expected publication date(s) of 2013/14 data (subject to change due to data availability) ¹⁵⁸
1.2	No	School Readiness	Early Years Foundation Stage Profile	LA	Annual	<i>TBC</i>	<i>TBC</i>	<i>TBC</i>
2.1	No	Low birth weight of term babies	ONS	LA/CCG	Annual	21	ONS	<i>TBC</i>
2.2	Linked 2.3ii	Breastfeeding prevalence at 6-8 weeks	UNIFY	CCG	Quarterly	6 week after quarter end	NHS England	March 2014
2.3	No	Smoking status at time of delivery	Omnibus	CCG	Quarterly	6 week after quarter end	HSCIC	March 2014
2.4	No	Under 18 Conceptions	ONS	LA	Annual	About 14 months	ONS	February 2014
2.5	No	Child development at 2-2 ½ years #	<i>TBC</i>	LA	<i>TBC</i>	<i>TBC</i>	<i>TBC</i>	<i>TBC</i>
2.6	No	Excess weight at 4-5 years	NCMP IT system (from Sept 2013)	LA	Annual	~6 months	HSCIC	December 2014
3.3	Linked 1ai and 1aii	Vaccination coverage - MMR at 2 years	COVER	PCT/CCG	Quarterly or annual	~6 months	HSCIC	End of September 2014
4.1	1.6i	Infant Mortality	ONS	LA/CCG	Annual	~12 months	ONS	
4.2	No	Tooth decay in children age 5	Dental Epidemiological Programme	LA	One off publication	<i>TBC</i>	Dental Epidemiological Programme	2011/12 available now.

Note: # Placeholder status indicates- under development

¹⁵⁶ DH (2012) Improving Outcomes and supporting transparency. Part 2: Summary technical specifications of public health indicators
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216162/Improving-outcomes-and-supporting-transparency-part-21.pdf

¹⁵⁷ DH (2012) The NHS Outcome Framework 2013/14 Technical Appendix
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213057/121109-Technical-Appendix.pdf

¹⁵⁸ http://www.hscic.gov.uk/media/11813/Clinical-Commissioning-Groups-OIS-Publication-Schedule/pdf/CCG_OIS_publication_schedule_02_Sept.pdf