2002

Walsall Health Authority

GROWING UP IN WALSALL

The 2002 Annual Report
of the Director of Public Health Medicine

Walsall NHS
Health Authority

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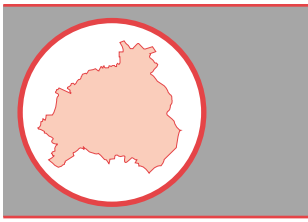

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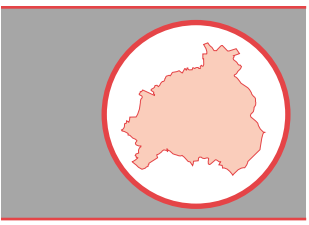

FOREWORD

Ensuring the health and welfare of children and young people is of key importance in improving the nation's health in the 21st century. In anticipation of the National Service Framework for Children this report focuses on children and young people in Walsall. The significance of child health is recognised in the new Walsall Health Improvement and Modernisation Plan, which sets a key action to develop a comprehensive strategy and action plan for children's services, and identifies specific targets, for example, around teenage pregnancy and healthy schools. Achieving these targets presents challenges for Walsall. This report is the continuation of a long tradition of theme-based annual reports in Walsall, a format which has been successful in providing a fulcrum for much of the strategic work in the Borough.

This report is published at a time of unprecedented organisational change in Walsall. The Health Authority will be disestablished from April 2002 when a new Walsall Primary Care Trust (PCT) will be formed and take over the Health Authority's responsibilities. It has been a privilege to be part of the team at Walsall Health Authority, committed to tackling inequalities and improving health in Walsall. My annual reports have made significant contributions to these achievements.

The new PCT will face challenges and opportunities – challenges in consolidating existing work towards improving health, and opportunities for re-engineering services to meet the needs of Walsall people. The Public Health Team in the new PCT will be ready to respond enthusiastically to these challenges and opportunities.

Dr Sam Ramaiah
Director of Public Health Medicine
March 2002

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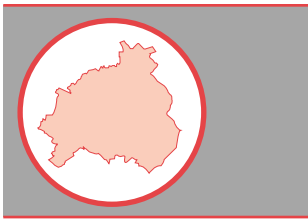
INTRODUCTION



The broad definition of children and young people used in the report is all those aged 19 and under. Population estimates for the year 2000 showed that approximately one quarter of Walsall's population was aged 19 and under, accounting for nearly 69,000 individuals. The issues affecting children and young people are many, and differ as children grow older. In this report we focus separately on different age groups to allow specific issues to be addressed. The report provides an overview of the issues involved, although a brief report of this nature cannot claim to be comprehensive.

Small area analysis presented in this report goes down to electoral ward level wherever possible. Information for Primary Care Groups is provided on the basis of the 2 PCGs extant at 31st March 2001. However, it should be noted that the organisation and structure of health services in Walsall are in a period of transition with the establishment of one Primary Care Trust in April 2002.

The remainder of this report is divided into seven Chapters:

Chapter 2 sets the scene in terms of the number of children and young people in Walsall now and predicted trends into the future. Population characteristics including ethnicity and children born into one-parent families are also described.

Chapter 3 focuses on income, and examines the socio-economic conditions in which children and young people live in Walsall. This chapter provides specific indicators of child poverty including data from the Department of Transport, Local Government and the Regions (DTLR).

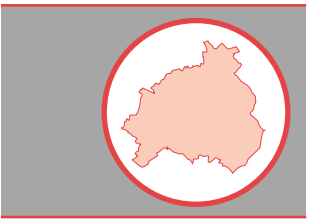
Chapter 4 looks at the youngest children, infants from birth to one year. Key issues include the trends in, and causes of infant mortality and stillbirths. Prematurity, low birthweight and congenital abnormality are important issues for this age group and information for Walsall is provided. One way of improving the health of babies is to increase rates of breastfeeding, and this chapter also provides information on breastfeeding rates for Walsall and advice on how rates might be improved.

Chapter 5 concentrates on the early years – children aged from 1 to 4 years. The need for child care and nursery education is highlighted, and the Surestart initiative is described. A key health issue in this age group is immunisation. The chapter describes trends in immunisation rates in Walsall, including the current downward trend in uptake of the Measles, Mumps and Rubella combined vaccine (MMR). Advice on the safety and importance of the MMR vaccine is provided.

Chapter 6 moves on to look at children and young people of school age. Education is a vital factor in child welfare, and much of the chapter provides detailed information on a range of aspects of education in Walsall. The lifestyles of children and young people holds the key to many aspects of future health, and information from a major survey of school children in Walsall is provided, highlighting a number of areas of concern. In the second part of the chapter we look at teenage pregnancy as an issue. Finally we focus on some of the key aspects of youth justice, and report on the causes of child mortality in Walsall.

Chapter 7 covers a number of issues that can affect children of all ages both before school age and during their school careers. These issues may generate particular health needs including disability, the need to protect children from abuse or neglect, children looked after by the local authority, and domestic violence.

Chapter 8 ends the report with a review of healthcare for children in Walsall. Admissions to the Accident and Emergency Department and the Paediatric Assessment Unit at Walsall Manor Hospital are described, with particular focus on the reasons for admission according to age group. The final section looks at issues around child health screening, including tests for Down's Syndrome, haemoglobinopathies, HIV, Cystic Fibrosis, metabolic diseases, and information about hearing screening.



DEMOGRAPHY

This chapter sets the scene for Walsall, outlining how many children there are now and will be in the future, what ethnic group they belong to and a little about how they and their families live.

Population: numbers and projections

The resident population estimates for mid-2000 in Table 2.1 show that approximately 26% of the population of Walsall are aged 19 and under. That is an estimated 68,723 people.

There are approximately 95 females to every 100 males.

Table 2.2 shows population figures from a different source: the registers of GP practices in Walsall. The totals here differ from Table 2.1, which shows the resident population estimates. It should be noted that the tables relate to different years, and therefore comparisons should be made cautiously. The Practice List total for 'registered and resident' population is 4,833 lower than the ONS estimate. This is important: the reasons for the difference may be significant. However, they are not well understood. Possible reasons include the following:

- Parents not registering their children with a GP
- The population estimates being inaccurate
- Residents registering with GPs outside Walsall

It is also possible that the real discrepancy is even greater, due to names not being removed from Practice Lists when families move out of the area. Interestingly, the discrepancy between the two tables generally decreases with age.

This highlights a difficulty in developing public health information for PCTs. Should we use a GP list-based view of the PCG/PCT or a resident-based one? For questions on the management of primary care resources a list-based view is most appropriate. For issues of public health, where a defined population is needed, the resident-based view is preferred.

The only ward-based population estimate gives the number of children under 16 years by ward (Table 2.3). These estimates, by Oxford University, show that the population of children under 16 as a proportion of the total population in each ward ranges from a low of 17% in Paddock and Pheasey, to over a quarter in Blakenall, Palfrey, Birchills Leamore and St. Matthews. The difference in age bands used means that this table is not comparable to the others used in this section.

Table 2.1 Walsall resident population estimates mid-2000, by age group

	Persons	males	females
All ages	260900	129554	131346
Under 1	3262	1664	1598
1-4	13560	7020	6540
5-9	17674	9037	8637
10-14	17558	8936	8622
15-19	16669	8634	8035
0-19 years	68723	35291	33432
% 0-19 years	26.3	27.2	25.5

Source: Office for National Statistics

Table 2.2 Walsall child population from GP practice lists, Oct 2001, by age group and sex

Age	Sex	Resident and registered	Non-resident and registered	Total
Under 1	Male	1317	92	1409
	Female	1357	89	1446
1 to 4	Male	6463	437	6900
	Female	6147	433	6580
5 to 9	Male	8247	592	8839
	Female	7925	593	8518
10-14	Male	8548	616	9164
	Female	8080	603	8683
15-19	Male	8066	547	8613
	Female	7740	544	8288
Total Sum of Male		32,641	2,284	34,925
Total Sum of Female		31,249	2,262	33,511
Total Sum		63,890	4,546	68,436

Source: Walsall Health Authority

Figure 2.1 (overleaf) show that the population under 19 years is expected to decline steadily over the next 20 years, following the trend of the population as a whole from 258,000 in 2001 to 241,000 in 2021.

Table 2.3

Walsall ward population estimates children under 16, 1998

WARD	TOTAL POPULATION	CHILDREN UNDER 16	% OF CHILDREN UNDER 16
ALDRIDGE CENTRAL AND SOUTH	12,700	2,200	17.3
ALDRIDGE NORTH AND WALSALL WOOD	13,100	2,500	19.1
BENTLEY AND DARLASTON NORTH	14,500	3,500	24.1
BIRCHILLS LEAMORE	13,800	3,600	26.1
BLAKENALL	12,200	3,500	28.7
BLOXWICH EAST	11,700	2,400	20.5
BLOXWICH WEST	15,500	3,300	21.3
BROWNHILLS	12,500	2,700	21.6
DARLASTON SOUTH	12,900	3,000	23.3
HATHERTON RUSHALL	13,800	2,700	19.6
PADDOCK	13,500	2,300	17.0
PALFREY	15,000	4,000	26.7
PELSALL	14,100	2,600	18.4
PHEASEY	9,400	1,600	17.0
PLECK	10,900	2,400	22.0
ST. MATTHEW'S	12,800	3,300	25.8
SHORT HEATH	12,000	2,100	17.5
STREETLY	13,600	2,300	16.9
WILLENHALL NORTH	13,100	2,800	21.4
WILLENHALL SOUTH	14,100	3,300	23.4

Source: Social Disadvantage Research Group, Oxford University

Ethnicity

There has been a substantial growth in the ethnic minority population in Walsall since the 1991 Census, although this might be exaggerated by under-recording of the black and ethnic minority community in the 1991 census. A key source of data prior to the results of the 2001 Census being available is the school rolls for Walsall. Primary school populations are more closely representative of their surrounding neighbourhoods than secondary schools, since secondary pupils travel to a wider catchment area. In January 2001 18.8% of primary school children in Walsall were from ethnic minorities (Table 2.4). This has not changed much since 1998.[1]

For this report, the primary school data were broken down geographically into the areas covered by the two primary care groups. This shows a significant difference between the two populations. This will have important implications for the health strategies of the two localities, given the differing natures of health risks and lifestyles in different ethnic communities.

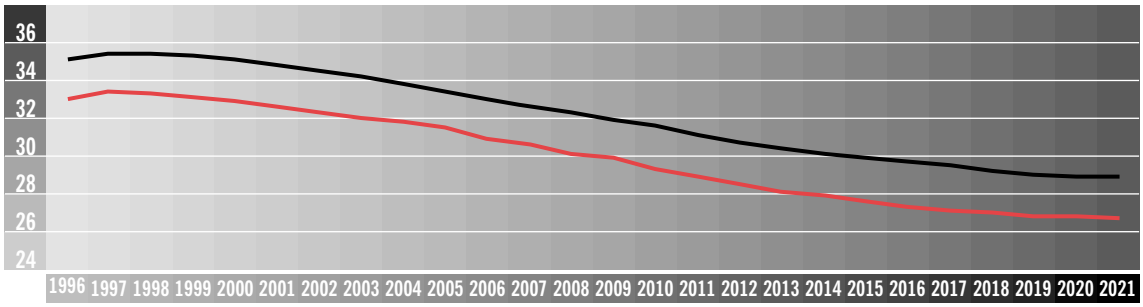
Table 2.4

Ethnicity of Walsall primary school children, January 2001, by locality and compared to all-age population for Walsall from the 1991 census

ETHNIC GROUP (%)	PRIMARY SCHOOL POPULATION			1991 population all ages
	Walsall	North West PCG	South East PCG	
White	81.2	88.4	75.1	90.4
Black Caribbean	1.4	1.0	1.8	0.9
Indian	6.4	5.1	7.5	4.7
Bangladeshi	1.8	0.8	2.6	0.6
Pakistani	6.4	2.3	9.9	2.4
Other	2.8	2.4	3.1	1.0
Total	21,220	9,742	11,478	100.0

Source: 1991 Census: Walsall MBC, Annual Schools' Census (Form 7) January 2001; PMA calculations

Figure 2.1 Walsall's population projections in thousands, ages 19 and under, 1996-2021



Source: Office for National Statistics

Table 2.5

Births to one-parent families, Walsall wards, 2000

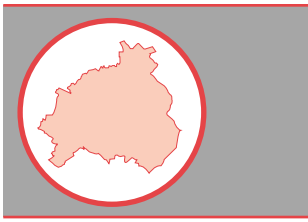
RESIDENTIAL AREA	TOTAL BIRTHS	PERCENTAGE OF BIRTHS TO ONE-PARENT FAMILIES
ALDRIDGE CENTRAL AND SOUTH	123	8%
ALDRIDGE NORTH AND WALSALL WOOD	124	10%
BENTLEY AND DARLASTON NORTH	208	14%
BIRCHILLS LEAMORE	239	12%
BLAKENALL	209	29%
BLOXWICH EAST	147	18%
BLOXWICH WEST	178	18%
BROWNHILLS	157	10%
DARLASTON SOUTH	161	17%
HATHERTON RUSHALL	161	12%
PADDOCK	110	3%
PALFREY	313	7%
PELSALL	142	6%
PHEASEY	89	2%
PLECK	171	11%
ST. MATTHEW'S	243	12%
SHORT HEATH	104	13%
STREETLY	80	0%
WILLENHALL NORTH	135	16%
WILLENHALL SOUTH	209	20%
WALSALL	3303	12.7%

Source: Walsall Community Health Trust

One-Parent Families

Table 2.5 shows that in 2000 12.7% of births in Walsall were in families where only one parent was in the household. This compares to a proportion of total births in 2000 occurring outside marriage of 44.5% in Walsall, 39.8% in the West Midlands and 39% in England and Wales.[2] This indicates how many births must be occurring in families where although the parents are not married, they bring up the children together. However the data may contain inaccuracies due to the way it is recorded. This is by observation and by what the parent states about their living arrangements to the midwife or health visitor. Nevertheless it still provides a useful overview of what is happening across the borough. In 2000 the highest proportion of births recorded to one-parent households, 29%, is in Blakenall ward. Overall, wards in the North and West of the borough have the highest proportion of births to one-parent households.

INCOME



The evidence that low income, and income inequality, are associated with poor health has been mounting steeply in the last quarter century. Many of the risks described later in this report are greater for those with low incomes, a case established by national research, but repeatedly illustrated in the distribution of local health data.[3][4] As a recent study of health inequality puts it:

'It is clear that from the time they are born, young children have a very different experience of factors hazardous to their health. An individual's chance of experiencing multiple health risks throughout life is influenced powerfully by social position'.[5]

It has been found that as well as an association between poverty and poor health, the degree of inequality in a society, that is, the width of the gap between better and worse off, affects health significantly. For example, a study of the income distribution within 13 of the main industrialised nations found that a more egalitarian distribution of income was related to lower all-cause mortality in both sexes in most age groups.[6]

The Government has recognised the importance of this in many areas of policy, perhaps most significantly in its target to reduce the number of children in households receiving an income below half the average. The relationship between income and health inequality is built into the Department of Health's strategy 'Tackling Health Inequalities', for example in its aim to reduce the gap in infant mortality between manual groups and the population as a whole by at least 10% by 2010, reversing a trend.[7]

The maps that follow in this chapter are therefore central to the purpose of this publication. Maps showing variation in health, for example on low birthweight, should be compared with the distribution of families receiving low incomes. The point should be made that receipt of benefits is not a direct measure of income, particularly since take-up of means-tested benefits is not universal. However, families with children are the most likely of all groups to claim the benefits used in this chapter, with take-up in excess of 90% for all benefits except Council Tax Benefit. The measures used here are therefore widely employed to assess the distribution of low income at regional and local levels.

The 'Indices of Deprivation 2000' and the Child Poverty Ward Level Index.

The Government has produced new 'Indices of Deprivation 2000' which rank local authorities' estimated levels of deprivation, using a number of perspectives. The approach has been developed by the Social Disadvantage Research Group at the University of Oxford, and uses improved access to data sources to construct a much more sophisticated index at ward level than previously.

The Department for Local Government and the Regions (DTLR) Indices ('ID 2000') are made up of six separate Domain Indices at ward level (Income, Employment, Health Deprivation and Disability, Education Skills and Training, Housing and Geographical Access to Services). There is also a supplementary Child Poverty Ward Level Index.[8]

Table 3.1 provides Walsall's ward rankings for the Child Poverty Ward Level Index. The Index Score is based on the percentage of children in each ward living in families that claim the following means tested benefits: Income Support, Job Seekers Allowance (Income Based), Family Credit and Disability Working Allowance. A Child Poverty Index score of, for example, 71.05, as in Blakenall, means that 71.05% of 0-16 year olds in that ward are living in families claiming means tested benefits. These levels do not take account of households entitled to such benefits but not claiming to them. This was a problem particularly with Family Credit; but this was replaced in October 1999 by the more generous Working Families Tax Credit. This means that future Indices will not be comparable with this one, since the threshold of child poverty will have been raised.

The rank is the ward's position out of 8414 wards in England. The rank of the most deprived ward is 1.

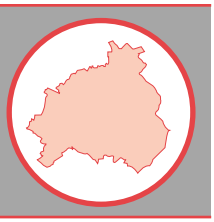


Table 3.1

Child poverty in Walsall wards: Ward Level Index and national rankings, 2000

WARD	CHILD POVERTY INDEX SCORE	RANK OF CHILD POVERTY INDEX SCORE
BLAKENALL	71.05	124
ST. MATTHEW'S	66.12	221
DARLASTON SOUTH	59.23	467
PALFREY	58.87	490
PLECK	58.32	508
BIRCHILLS LEAMORE	58.11	520
BLOXWICH EAST	52.85	786
BENTLEY AND DARLASTON NORTH	51.14	900
BLOXWICH WEST	47.74	1151
WILLENHALL SOUTH	46.71	1236
BROWNHILLS	42.74	1590
HATHERTON RUSHALL	34.75	2410
WILLENHALL NORTH	29.04	3136
SHORT HEATH	28.02	3279
PELSALL	25.92	3621
ALDRIDGE NORTH AND WALSALL WOOD	25.51	3675
ALDRIDGE CENTRAL AND SOUTH	22.40	4218
PADDOCK	20.72	4525
PHEASEY	17.69	5192
STREETLY	5.38	8152

Source: DTLR

The colour-coding shows that Blakenall and St. Matthew's are in the poorest 5% of wards nationally for the Child Poverty Index; and that seven Walsall wards are in the poorest 10%. Four of these are in North West PCG, and three in South East.

Table 3.2

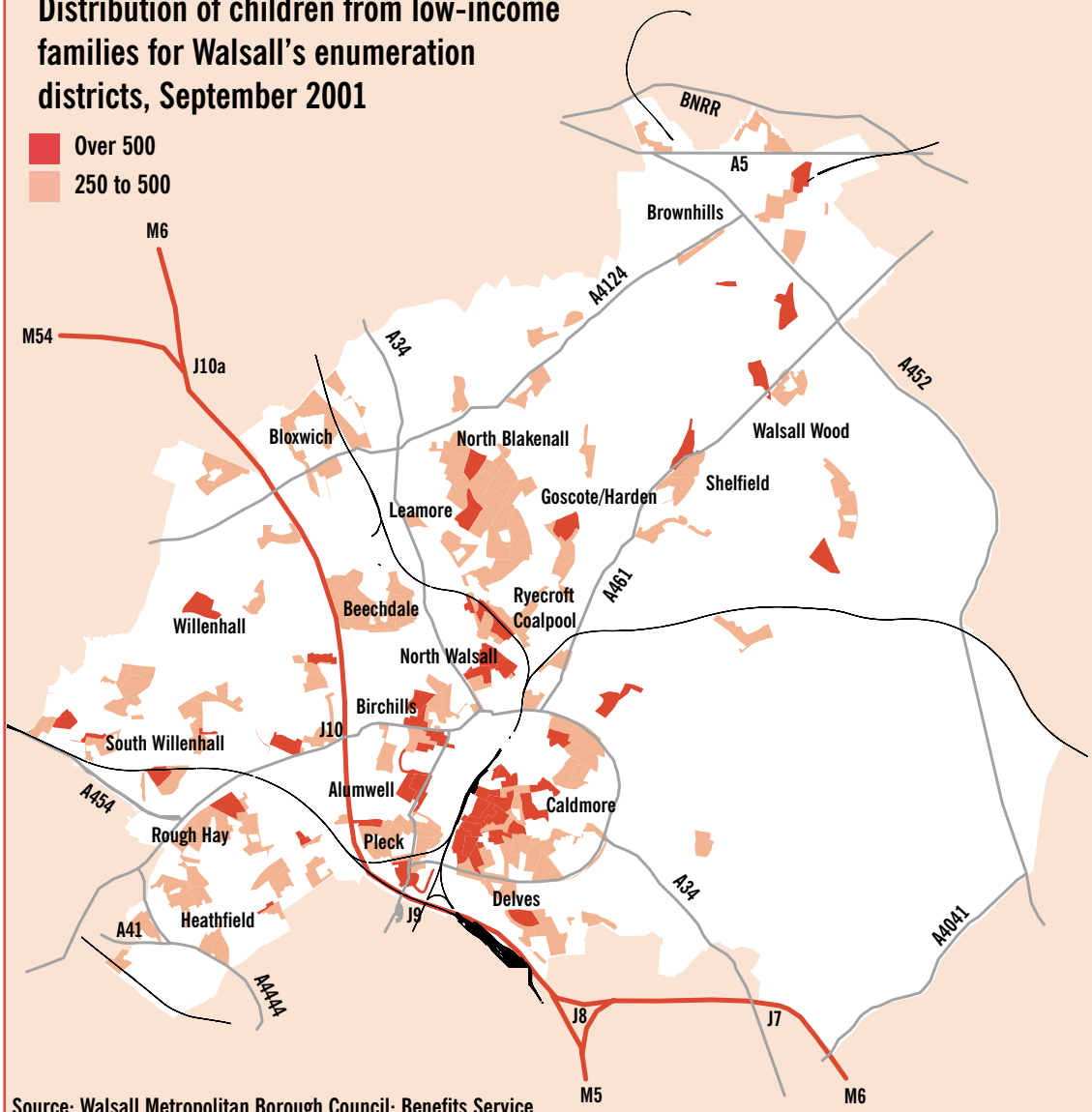
Children in households receiving Housing and/or Council Tax Benefit in Walsall per thousand occupied households, September 2001

WARD	NO. CHILDREN IN FAMILIES RECEIVING BENEFITS	RATE/1000 OCCUPIED HOUSEHOLDS
PALFREY	1425	293
BLAKENALL	1166	257
PLECK	997	247
ST MATTHEWS	1238	229
BIRCHILLS LEAMORE	1174	222
DARLASTON SOUTH	1002	220
BENTLEY AND DARLASTON NORTH	1083	203
WILLENHALL SOUTH	962	170
BLOXWICH EAST	785	167
BLOXWICH WEST	830	135
BROWNHILLS	632	128
HATHERTON RUSHALL	574	103
WILLENHALL NORTH	455	93
SHORT HEATH	375	81
PELSALL	400	68
ALDRIDGE NORTH AND WALSALL WOOD	354	68
ALDRIDGE CENTRAL AND SOUTH	276	53
PADDOCK	211	40
PHEASEY	121	34
STREETLY	37	7

Source: Walsall Metropolitan Borough Council: Benefits Service, Local Taxation, and Strategic and Environmental Planning Services

Map 3.1

Distribution of children from low-income families for Walsall's enumeration districts, September 2001



Source: Walsall Metropolitan Borough Council: Benefits Service, Local Taxation, and Strategic and Environmental Planning Services

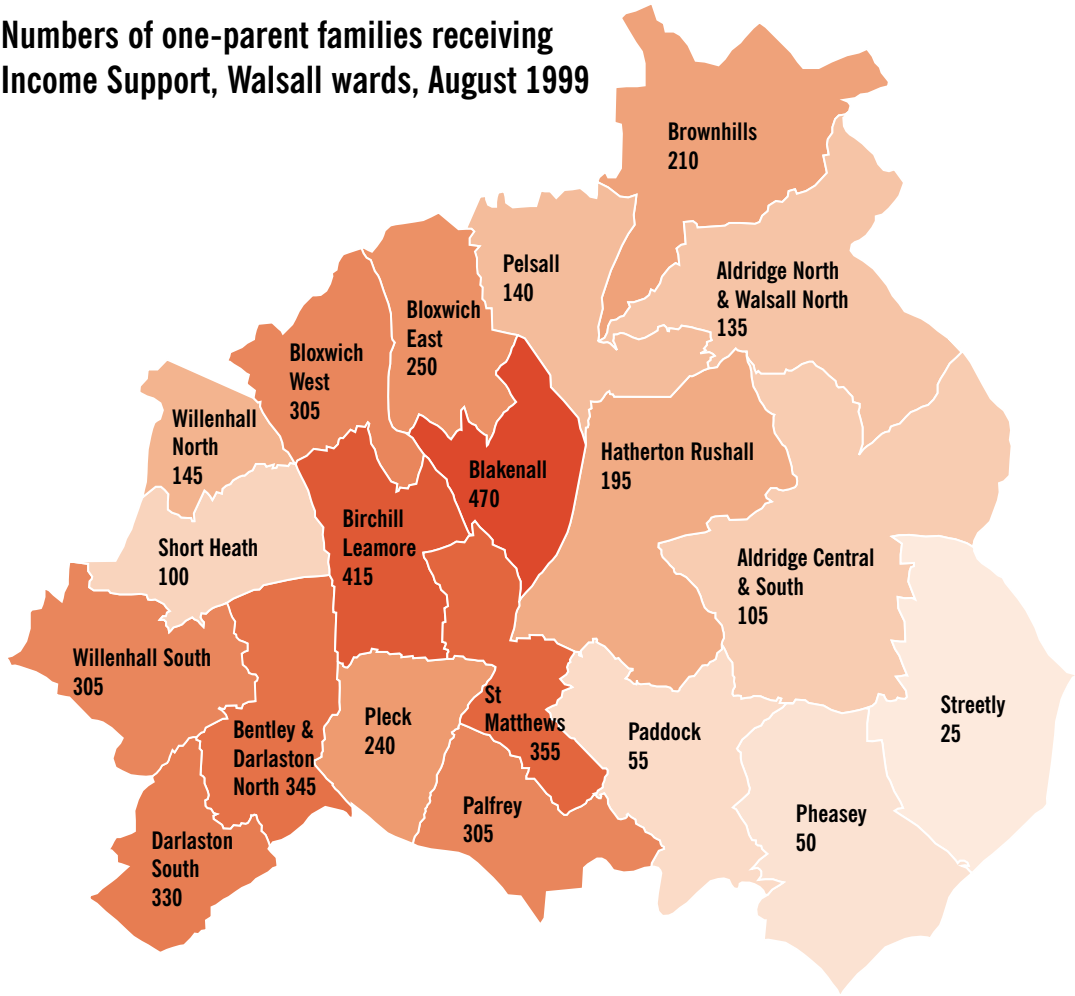
Children in families receiving Housing and /or Council Tax Benefit

Another way of measuring child poverty in Walsall is created from local sources, produced by the Council's Benefits Service, and translated into geographical terms by the Council's Strategic and Environmental Planning Services with the help of the Local Taxation Unit (Table 3.2). It identifies all the children in families receiving Housing and/or Council Tax Benefit in September 2001. This will include households receiving Income Support and Income-related Jobseeker's Allowance, but also those with other kinds of low income, including low wages and Incapacity Benefit.

The way it is presented is not just about the number of children in such families. Because it is presented as the rate of such children per 1000 occupied households, it also conveys the density of the population of such children in an area. This will help us to understand to what degree the numbers of children from families on low incomes influence the nature, and the needs, of a community. For example, it tells us that the density of children from families on low incomes is 42 times greater in Palfrey than it is in Streetly. It reflects both child poverty and the level of the child population in each ward. Map 3.1 uses the same data to show the distribution of children from low income families on a small area basis in Walsall.

Map 3.2

Numbers of one-parent families receiving Income Support, Walsall wards, August 1999



Source: ONS, Neighbourhood Statistics

Children in one-parent families in receipt of Income Support

Map 3.2 shows the numbers of one-parent families receiving Income Support in each ward in Walsall in August 1999. The higher numbers are shown in a darker shade. The totals by primary care group are shown in Table 3.3.

In 1995/96, an estimated 63% of one-parent families were living at a level of income below half the average, compared to an estimated 23% of two parent families.[9] Research in the mid-Nineties looked at the sacrifices made by parents on low incomes to meet the needs of their children. It found that 'parental poverty, as with childhood poverty, was concentrated among the majority of lone parents who did not work'. Three-quarters of lone mothers 'often' went without new clothes, more than half went without new shoes, and one in eight often went without food. These mothers were 14 times more likely to go without food than mothers in two-parent families not on Income Support. Among single mothers not on Income Support, the proportions of deprivation were also disturbing. It shows that working for poor wages does not take many one-parent families very far. More than half of lone mothers who were not on Income Support 'often' went without new clothes, more than 40% went without new shoes, and one in 14 often went without food.[10]

Table 3.3

One-parent families in Walsall receiving Income Support by locality, August 1999

PCG	NO. OF ONE PARENT FAMILIES
SOUTH EAST PCG	1815
NORTH WEST PCG	2665
WALSALL	4480

Source: ONS Neighbourhood Statistics

INFANTS

This chapter covers the period from birth to the age of one year. It deals with some key issues concerning the healthy survival of babies, and with mortality.

Infant mortality has been chosen as a key indicator in the National Health Inequalities Targets[7]. A new report underlines how appropriate this is. Analysis of stillbirths and infant deaths in 2000 found that of births jointly registered by both parents, the babies of fathers in social class V (unskilled manual occupations) had infant mortality rates more than double those for babies of fathers in Social Class I (professional occupations): 7.9 per 1,000 live and stillbirths compared to 3.6 respectively.[11]

In 2000 98.8% of babies in Walsall were born in NHS hospitals[2] (94% in Walsall Manor Hospital).[12] 39 babies (1.2% of total births) were born at home. In 1998 this peaked at 1.6%. This compares to 2.1% nationally being home births in 2000.[2]

Stillbirths

Figures 4.1 shows stillbirth rates. The increase in 1993 reflects a change to the definition of stillbirths from deaths from 28 weeks gestation to deaths from 24 weeks gestation.

The stillbirth rate for Walsall fluctuates between years because the numbers are very small. The West Midlands rate is higher than the rate in England and Wales. Changes are less marked than in the late 1970's and 1980's. In the last two years it appears the rate of still births per 1,000 births has fallen in Walsall, although it must be remembered that these figures are small and therefore wide fluctuations between years can be observed.

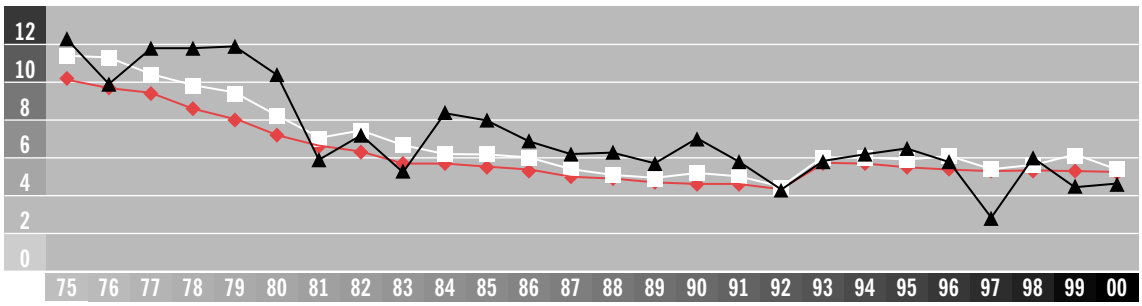
The causes of still births in the West Midlands in 2000 were as follows:[13]

- Unexplained death before labour (69%)
- Congenital anomaly (13%)
- Events during labour (12%)
- Other specific causes such as circulation problems, tumours (6%)

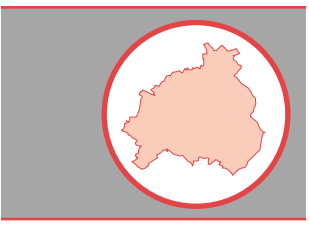
The West Midlands Perinatal Institute has developed a new classification system which identifies the relevant condition at death (ReCoDe). This has identified that 63% of the 'unexplained' stillbirths had intrauterine growth failure (poor growth during pregnancy leading to low birth weight) before their demise. The 8th Annual Report of the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) report found that many of these deaths are potentially avoidable.[14]

Figure 4.1 **Stillbirths rates per 1,000 total births, Walsall, West Midlands and England and Wales, 1975-2000**

	1994		1995		1996		1997		1998		1999		2000	
	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate
England & Wales	3813	5.7	3600	5.5	3539	5.4	3439	5.3	3417	5.3	3305	5.3	3203	5.2
West Midlands	418	6	400	5.9	412	6.1	361	5.4	365	5.6	391	6.1	348	5.6
Walsall	22	6.2	13	6.5	20	5.8	10	2.8	21	6.0	15	4.5	15	4.6



Source: West Midlands Perinatal Institute ◆ England and Wales □ West Midlands ▲ Walsall



In 2000, 7 out of the 15 stillbirths in Walsall occurred at 32 weeks gestation or greater, a point at which the foetus would be mature enough to do well after induced delivery.[2]

Stillbirth rates are higher in teenage and older mothers. Between 1994-1999 the highest mean stillbirth rates were in 11-15 year olds (10.4 per 1,000 total births) and 35-39 year olds (8.7 per 1,000 total births) compared to all ages (5.3 per 1,000 total births).[2]

Perinatal mortality (stillbirths and deaths occurring under seven days of life)

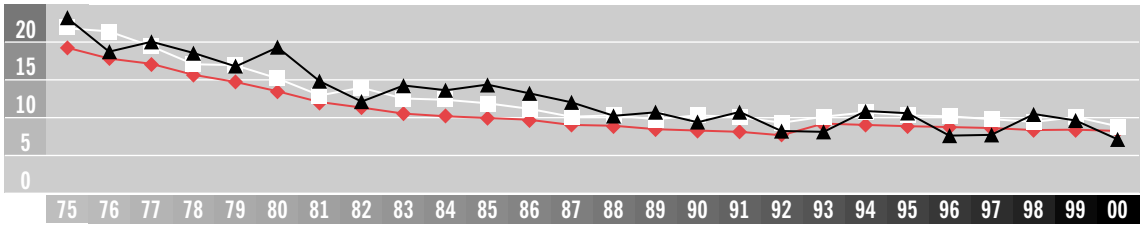
Rates of perinatal mortality are shown in Figure 4.2. Perinatal mortality reflects child and maternal health as well as the quality of health services. Just 50 years ago in Britain 1 in every 20 babies was either born dead or died within a week of birth.[15] Whilst the perinatal mortality rate has fallen steadily there is still considerable regional variation. The rate in the West Midlands is higher than that for England and Wales. The rate in Walsall fluctuates from year to year because the numbers are small.

Neonatal mortality (deaths occurring under 28 days of life)

Figure 4.3 shows neonatal mortality rates. Again the numbers for this indicator are low, so that it is difficult to identify clear local trends. The Walsall rate increased over the four years 1996-1999, but fell in 2000. It was above the national level for all but two years since 1994. Most neonatal

Figure 4.2 Perinatal mortality rates per 1,000 total births, Walsall, West Midlands and England and Wales, 1975-2000

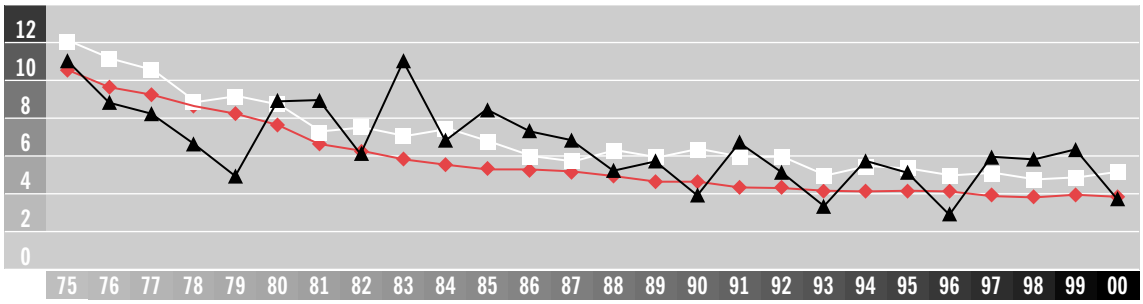
	1994		1995		1996		1997		1998		1999		2000	
	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate
England & Wales	5955	8.9	5694	8.7	5622	8.6	5398	8.4	5252	8.2	5113	8.2	4963	8.1
West Midlands	733	10.6	684	10.2	694	10.2	646	9.7	606	9.3	634	9.9	597	9.7
Walsall	38	10.7	37	10.5	26	7.5	27	7.6	36	10.3	32	9.5	23	7.0



Source: West Midlands Perinatal Institute ◆ England and Wales □ West Midlands ▲ Walsall

Figure 4.3 Neonatal mortality rates per 1,000 total births, Walsall, West Midlands and England and Wales, 1975-2000

	1994		1995		1996		1997		1998		1999		2000	
	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate
England & Wales	2749	4.1	2678	4.1	2675	4.1	2523	3.9	2399	3.8	2419	3.9	2335	3.8
West Midlands	371	5.4	350	5.3	339	4.9	333	5	305	4.7	304	4.8	312	5.1
Walsall	20	5.7	18	5.1	12	2.9	21	5.9	20	5.8	21	6.3	12	3.7



Source: West Midlands Perinatal Institute ◆ England and Wales □ West Midlands ▲ Walsall

deaths occur under 7 days: 8 out of the 12 deaths in Walsall in 2000 fell into that category.

The main cause of neonatal mortality nationwide is prematurity, accounting for 47.2% of all deaths under the age of 28 days. The next most common cause is congenital malformation, accounting for 24.4% of all deaths under the age of 28 days.[14] In Walsall between 1996 and 2000 prematurity accounted for 61% of deaths under seven days after birth and congenital anomaly for 28%.[13]

Premature births

Table 4.1 looks at the number of babies who were born prematurely i.e. before 37 weeks of pregnancy at Walsall Manor Hospital in 2000. This includes spontaneous deliveries and deliveries which have been brought on because of complications in the pregnancy. Very premature babies (born before 27 weeks of pregnancy) have the worst outcome. The number of babies delivered at this stage of pregnancy is reported to have declined in 2000. [12]

Figure 4.4 indicates that, overall, the proportion of low birthweight babies in Walsall is higher than the national average, and appears to have risen over the decade.

Low birth weight arises either because the baby is small for the stage of pregnancy (s/he did not grow well) or premature or both.

The ranking of low birthweight in Walsall in Map 4.1 corresponds to the rankings of deprivation presented in Table 3.2 on the proportions of children in households receiving Housing or Council Tax Benefit by ward. The wards with the highest incidence of low birthweight are Palfrey, St. Matthews, Birchills Leamore, Bentley and Darlaston, Pleck, Willenhall South and Blakenall. A study by the Office for National Statistics has found that babies with fathers in social classes IV and V (unskilled and unemployed) have an average birthweight 130 grams lower than those with fathers in classes I and II (professional and managerial).[16]

However, it should also be pointed out that small babies born to Asian women of smaller stature than women of European origin are not necessarily a problem. This is likely to be a factor in Palfrey, St. Matthews and Pleck, and to a lesser extent in Willenhall South, Bentley and Darlaston North, and Birchills Leamore.

Low birth weight due to prematurity is a factor in perinatal mortality in Walsall. At Walsall Manor Hospital there were 24 perinatal deaths in 2000. 62.5% (15) of these had birthweights less than 2500g. 73% (11) of the babies with low birth weight were also reported as premature. 20% (3) were reported as having intrauterine growth retardation. 8% did not have weights recorded in the report.[12]

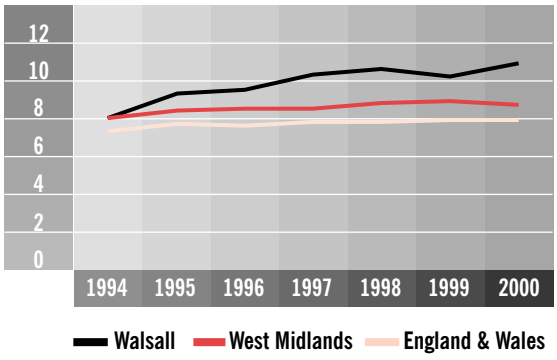
Table 4.1 Prematurity rates and mortality at Walsall Manor Hospital, 2000

GESTATION	NUMBER (% OF BIRTHS AT WALSALL MANOR)	NUMBER WHO DIED (% OF BABIES BORN AT THIS GESTATION)
Under 27 weeks	13 (0.3)	5 (38)
28-31 weeks	33 (0.9)	7 (21)
32-36 weeks	297 (8)	7 (2)
Total	343 (9.2)	19 (5.5)

Source: Walsall Manor Hospital
Note: This may include some non-Walsall residents and will exclude the 5% of women who deliver at other hospitals

Figure 4.4

Low birth weight babies (live and stillborn <2500g) as a proportion of total births, Walsall 1994 - 2000.



Source: Office for National Statistics: Vital Statistics
Note: Birth weight less than 2500gms. Live and stillbirths

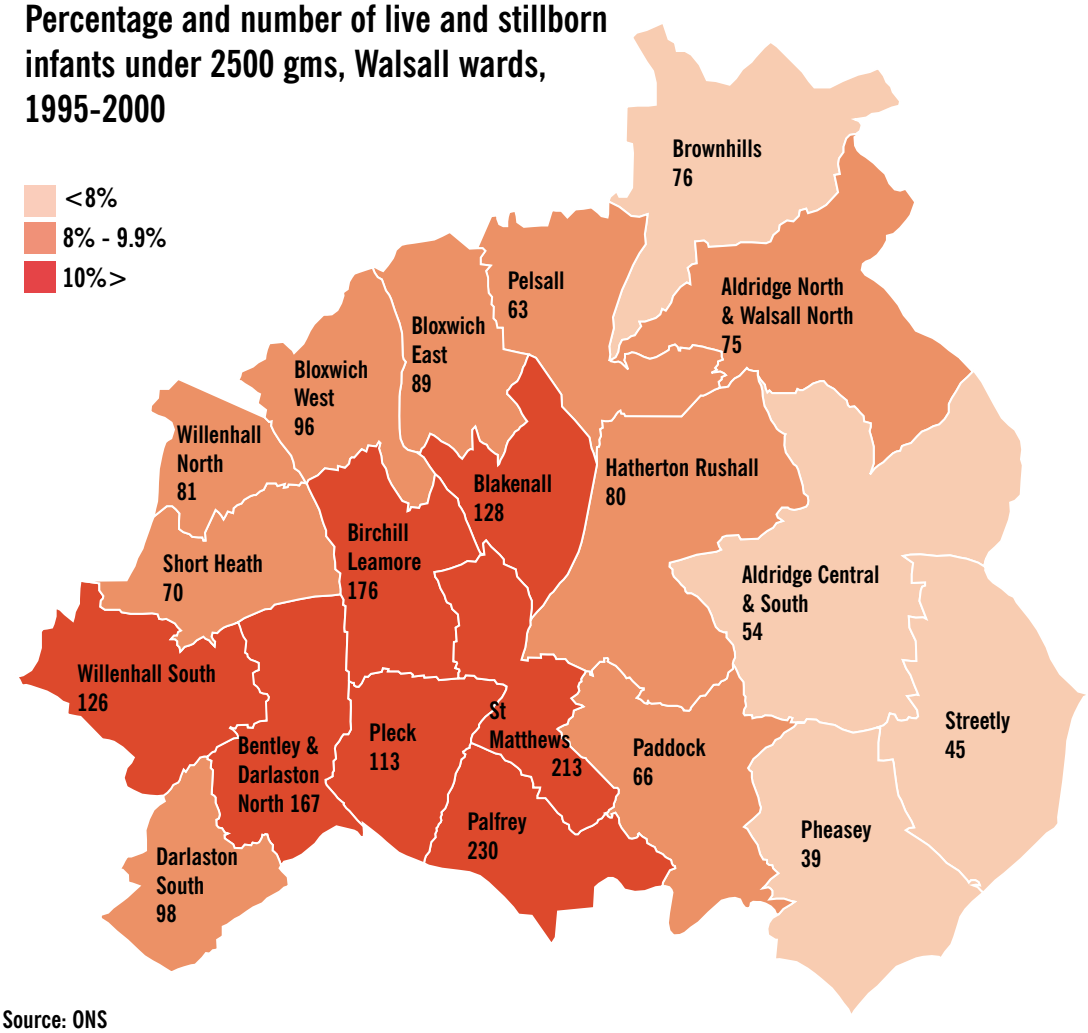
Table 4.2 Main causes of low birthweight

IN THE MOTHER	IN THE BABY
■ Multiple pregnancy e.g. twins, triplets ■ Smoking (reduces birthweight by 150-250g) ■ Low socio-economic class ■ Drinking alcohol ■ Hypertension ■ Poor nutrition ■ Youngest and oldest mothers	■ Congenital abnormality ■ Infection ■ Fetal toxins ■ Prematurity

Source: Donaldson and Donaldson, 2000

Map 4.1

Percentage and number of live and stillborn infants under 2500 gms, Walsall wards, 1995-2000



Source: ONS

Notification data for congenital malformations are maintained by the West Midlands perinatal institute on the West Midlands Congenital Anomaly Register CAR.

Table 4.3 shows that the rate per 10,000 total births with Down's Syndrome for Walsall (1.9/10,000) is significantly lower (at 95% level of confidence) compared to both the West Midlands (4.5/10,000) and England and Wales (4.9/10,000). Down's Syndrome is related to increased maternal age and this may be a confounding factor here.

Differences in the rates of all other categories between Walsall, West Midlands and England and Wales do not reach statistical significance. This is important to note because it indicates that these congenital abnormalities are not contributing to mortality to a greater extent in Walsall than elsewhere.

Preventing neural tube defects such as spina bifida

- Improving folic acid status in early pregnancy reduces the incidence of neural tube defects[17] [18] [19]
- Women who could become pregnant and women who are less than 12 weeks pregnant should take 400 micrograms of folic acid as a supplement
- To reach almost all women in the very early stages of pregnancy, when few are sure if they are pregnant, universal fortification of flour has been recommended by the Committee on Medical Aspects of Food and Nutrition Policy (COMA).[20]
- A public consultation to take into account additional factors was launched by the Department of Health and the Food Standards Agency in 2000.

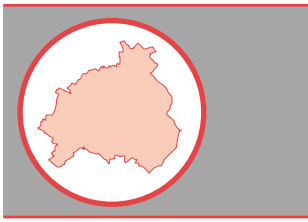


Table 4.3 **Congenital Malformation rates for Walsall, West Midlands and England and Wales, 1994-1999**

	ALL CENTRAL NERVOUS SYSTEM ANOMALIES		ANENCEPHALUS		SPINA BIFIDA		DOWN SYNDROME		CLEFT PALATE / LIP	
NUMBER AND RATE PER 10,000 TOTAL BIRTHS (95% CONFIDENCE INTERVAL)	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
ENGLAND AND WALES	1497	3.9 (3.7 – 4.1)	162	0.4 (0.35 – 0.48)	352	0.9 (0.8 – 1.0)	1916	4.9 (4.7 – 5.2)	3484	9.0 (8.7 – 9.3)
WEST MIDLANDS	219	5.5 (4.7 – 6.2)	30	0.7 (0.5 – 1.0)	65	1.6 (1.2 – 2.0)	179	4.5 (3.81– 5.12)	409	10.2 (9.2 – 11.2)
WALSALL	10	4.8 (1.8 – 7.8)	2	1.0 (0 – 2.3)	5	2.4 (0.3 – 4.5)	4	1.9 (0.04 – 3.80)	23	11.0 (6.5 – 15.5)

Source: Public Health Common Data Set

Breastfeeding

Breastfeeding is known to be associated with healthier babies. Good evidence of this has arisen from studies of the effect of giving premature babies breast milk rather than standard formula. Babies given human milk for just one month showed major advantages in neurodevelopment at 18 months and in verbal IQ, pattern of allergic reactions and atopy, waist-hip ratio, linear growth, and bone mineralisation at 7.5-8 years.[21]

Map 4.2 shows the percentage of mothers recorded as breastfeeding on transfer from the midwife to the health visitor about ten days after birth. It conveys a very clear message, that there are low levels of breastfeeding in the north and west of Walsall. The distribution corresponds with that of deprivation, though not in the south of the borough, where it may be that high levels of breastfeeding in the large ethnic minority communities raise the percentage. This reflects national findings.[22] Those shown here are being used to target wards with a mother-to-mother support programme funded through the Neighbourhood Renewal Fund.

The importance of nutrition in the early months also extends to the foods introduced to babies at the start of weaning with the introduction of semi-solid foods from four months. It is an ideal time to introduce vital foods such as fruit and vegetables, since there is evidence that this period has an impact on food preferences throughout life. The BMJ publication 'Growing up in Britain' contains summaries of recent findings that nutrition in early life has a big impact not only on future general health, but on the development of the brain.[22]

Promoting Breastfeeding

- Breast feeding is a key public health measure which offers benefits to both mother and baby
- Cultural factors such as media representation of bottle feeding as 'normal' and facilities to breast feed babies in public places are likely to influence mothers' choice and ability to breast feed
- Some evidence that small, informal discussion classes led by health professionals with practical advice can increase initiation rates
- Use of leaflets alone is not recommended
- Peer support programmes may increase the numbers of women breastfeeding.

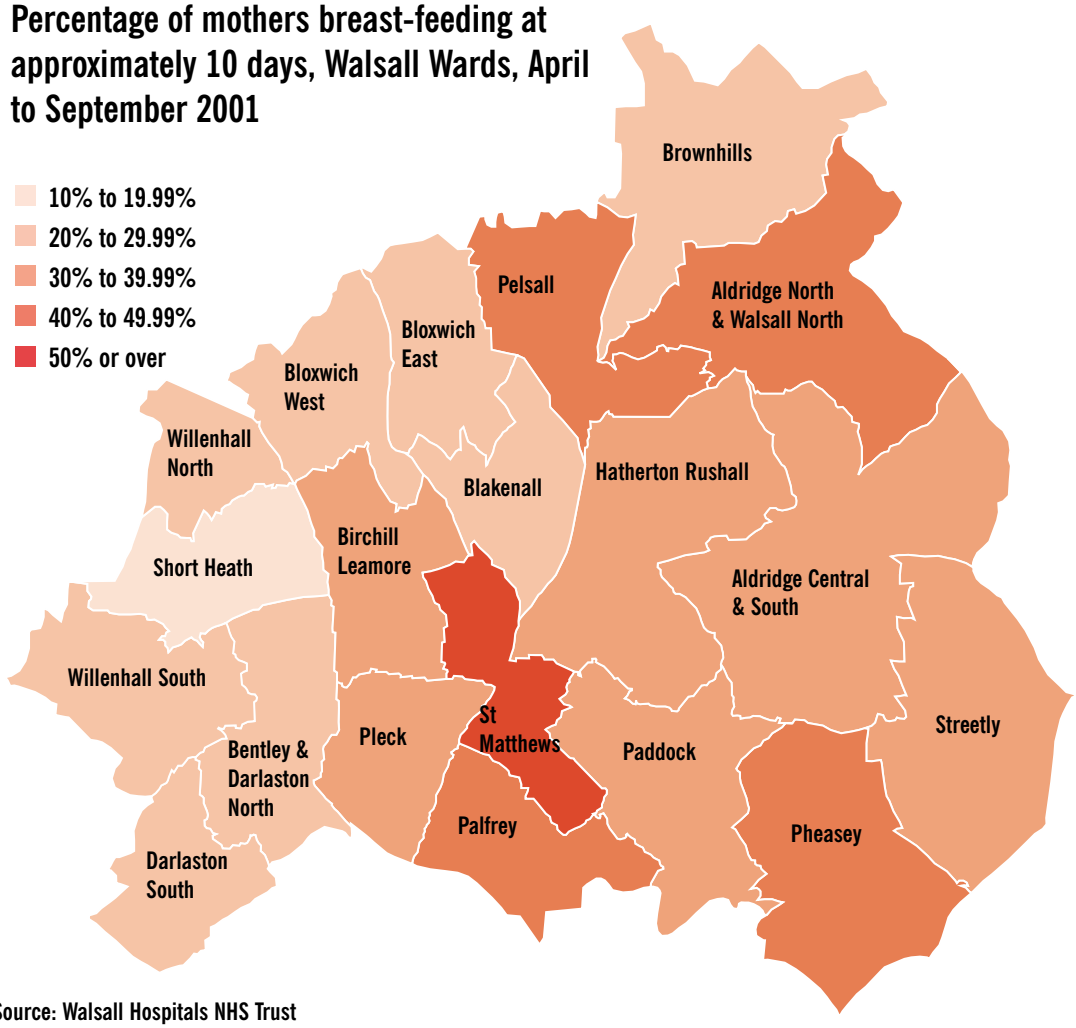
Source: Effective Health Care Bulletin July 2000[23]

Infants: aged under one year

Infant mortality (meaning deaths in those aged less than a year) was chosen by the Government as a major target for reducing health inequality in February 2001.[7] This complements other targets with an inequality focus such as in the areas of smoking and teenage pregnancy. Taken together these targets reflect efforts to reduce the broad spectrum of inequalities. Progress will be assessed by a basket of indicators which are being developed. These will reflect a broad range of activities and will be taken forward locally by Health Improvement and Modernisation Programmes (HiMPs) and Local Strategic Partnerships.

Map 4.2

Percentage of mothers breast-feeding at approximately 10 days, Walsall Wards, April to September 2001



Source: Walsall Hospitals NHS Trust

Starting with children under 1 year the target is, by 2010, to reduce by at least 10% the gap in mortality between manual groups and the population as a whole.

This is a national target, and the data do not exist locally to be able to set a Walsall target in the same precise terms. This would not necessarily be desirable in any case, since the national target is based on the father's occupational social class recorded at registration of the birth, and excludes births outside marriage registered by the mother only. Another problem is that the numbers are very low in Walsall, and to divide them further according to measures of social class would make the data even less reliable than they are: there are considerable year-on-year fluctuations. Overall infant mortality rates
are falling. However the projected trends suggest the gap is widening between manual groups and the population as a whole. The social gradient of social class 5 is about 1.7 times that in social class 1.[7]

Figure 4.5 shows that the infant mortality rate in Walsall has generally been falling since 1982 although there are considerable year on year fluctuations because of the small numbers involved.

Between 1993 and 2000 there were 188 deaths in children under 1 year in Walsall. 52 deaths were between 28 days and one year and 136 deaths were under 28 days.[2]

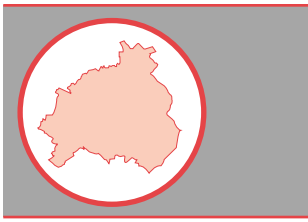
Overall the main cause of death for children aged 28 days to 1 year is from 'signs, symptoms and ill-defined symptoms'. This includes sudden infant death syndrome (SIDS), from which 10 children died in the period. Infectious and parasitic diseases such as meningococcal infection and intestinal infectious diseases were the second most common cause of death amongst children between 28 days and 1 year in Walsall.

Infant mortality and stillbirths in Walsall in 2000

In Walsall in 2000 71% of infant deaths occurred neonatally and 47% occurred under seven days, where the causes are inter-linked to causes of stillbirth. Table 4.4 summarises the rates and main causes of infant mortality and stillbirths in Walsall.

Reducing sudden infant death syndrome (SIDS) and infectious disease, although important, is unlikely to make a large impact on infant mortality. The results will be gained from tackling the causes of neonatal mortality and stillbirths.

As prematurity is a major cause of neonatal mortality we need to investigate further the causes of prematurity in Walsall in order to predict and prevent it; and to address the factors associated with low birthweight, by addressing the socio-economic factors that underpin health inequality. At a local level, it is vital to address the health behaviours, also associated with deprivation, that are associated with low birthweight, such as the quality of maternal diet from the time of conception through pregnancy, and smoking in pregnancy.[22]



Preventing sudden infant death syndrome (SIDS)

- Put baby to sleep on his/her back
- Don't dress baby too warmly or overheat room
- Don't smoke near baby

Preventing serious infections

- Meningitis due to Haemophilus influenzae type B (Hib) and meningococcal group C has significantly reduced since the introduction of routine immunisation for these diseases.[24] [25]
- But vaccines are not available for all types of meningitis
- So parents and professionals must remain alert for the signs and symptoms of meningitis

Data on Accident and Emergency attendances and on referrals to the Paediatric Assessment Unit for this age group can be found in the healthcare section in Chapter Eight.

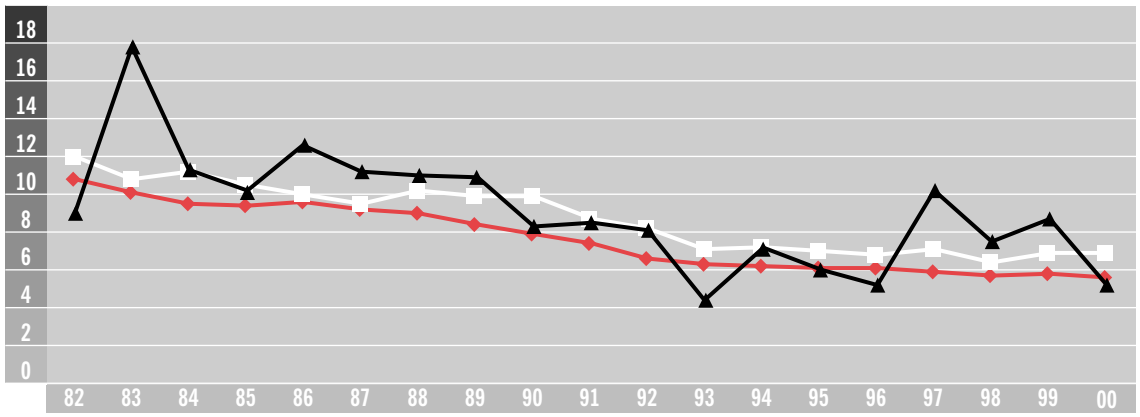
Table 4.4 Infant mortality and still births in Walsall 2000

	RATE	NUMBERS	PATTERN OF MAIN CAUSES
STILLBIRTHS	4.6 PER 1,000 TOTAL BIRTHS	15	'UNEXPLAINED'(63% OF THESE IN WEST MIDLANDS RELATED TO POOR GROWTH), CONGENITAL ANOMALY, EVENTS DURING LABOUR
DEATHS UNDER 7 DAYS OLD	2.4 PER 1,000 LIVE BIRTHS	8	PREMATURITY, CONGENITAL ANOMALIES
DEATHS UNDER 28 DAYS (NEONATAL MORTALITY)	3.7 PER 1,000 LIVE BIRTHS	12	PREMATURITY, CONGENITAL ANOMALIES
DEATHS UNDER 1 YEAR (INFANT MORTALITY)	5.2 PER LIVE BIRTH	17	UNDER 28 DAYS – PREMATURITY, CONGENITAL ANOMALIES. 28DAYS – 1 YEAR -ILL DEFINED CONDITIONS INCLUDING SIDS, INFECTIONS

Source: Walsall Health Authority

Figure 4.5 Infant mortality rates per 1,000 live births, Walsall, West Midlands and England and Wales, 1982 - 2000

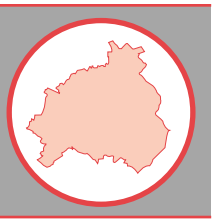
	1994		1995		1996		1997		1998		1999		2000	
	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate	No.	rate
England & Wales	4120	6.2	3968	6.1	3989	6.1	3825	5.9	3605	5.7	3635	5.8	3399	5.6
West Midlands	498	7.2	469	7	462	6.8	472	7.1	418	6.4	440	6.9	427	6.9
Walsall	25	7.1	21	6	18	5.2	36	10.2	26	7.5	29	8.7	17	5.2



Source: West Midlands Perinatal Institute

◆ England and Wales □ West Midlands ▲ Walsall

Chapter Five



EARLY YEARS: CHILDREN AGED 1-4

Walsall is working hard to tackle inequalities in the early years of childhood. This section looks at some of the activities and highlights areas for further work.

Child care and nursery education

In response to the Government's National Childcare Strategy, Walsall Early Years Development and Childcare Partnership is working to develop a wide range of childcare provision in order to give parents choice over the childcare they wish to access. Various funding regimes will support these developments including the Neighbourhood Nurseries Initiative, which concentrates on developing childcare in areas of deprivation (see Chapter Three for detail of these). Walsall has high nursery education provision, but the location of provision is currently under examination to ensure that nursery places are located in the areas where they are most needed and surplus provision is reduced. A new unpublished Audit of Childcare by Walsall Early Years provides a basis for planning both the development of childcare and nursery education provision.

Sure Start in Walsall

Sure Start is a government programme for very young children living in poverty. Its aim is to close the gap in outcomes between children growing up in poverty and the wider child population. It is a joined-up approach to ensure that children most at risk of poor health outcomes are not further disadvantaged by poor services that do not meet their needs. Sure Start works by establishing partnerships across agencies, community groups and local parents at local level in areas of deprivation. The programmes work to nationally determined objectives and targets. Targets for reduced smoking in pregnancy, decreased need for speech therapy, reduced child protection registrations, teenage pregnancy and youth offending have been set. Each programme covers an area of about 750 children under 4 years. Within each area the programme is available to all local families. Key services include home visiting to all new parents, quality play and child care and enhanced health advice.

There are two Sure Start projects in Walsall: one in Palfrey and one in Blakenall. In line with the NHS Plan, there are plans to increase this to four, to include Birchills and Alumwell / Pleck as well. The projects cover only parts of these wards.

Some of the activities in Walsall include work with mothers with post-natal depression, support groups for young fathers, smoking cessation sessions for parents, play and learning opportunities and childcare services.

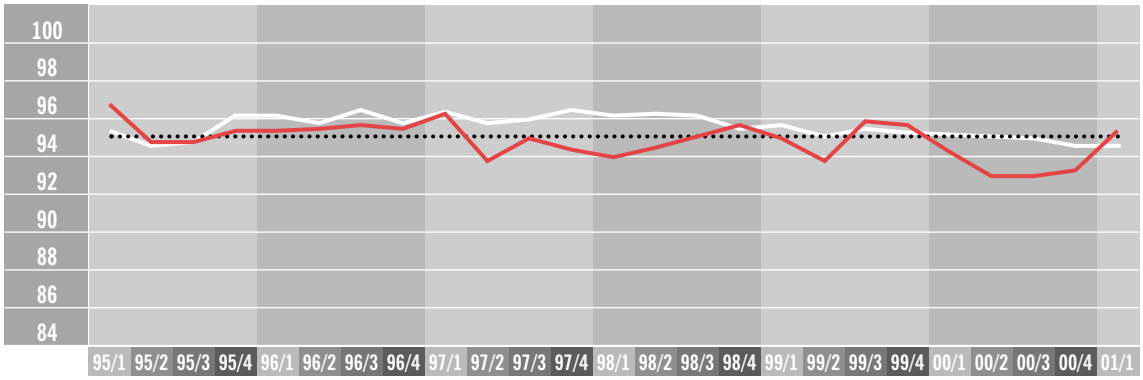
There is work going on to collate relevant health service data for these project areas on a regular and routine basis, so that it is readily available to those who need it. This will help to evaluate these projects. If they are successful, thought will be given to making them more widely available.

Other projects which are tackling inequalities in early years include Home Start, parent education programmes and the Parenting Arts Project. A series of forums is being developed, known as Children and Family Partnerships, in order to bring together professionals and local communities to influence the planning and delivery of local services which impact on children and families.[26]

Immunisation

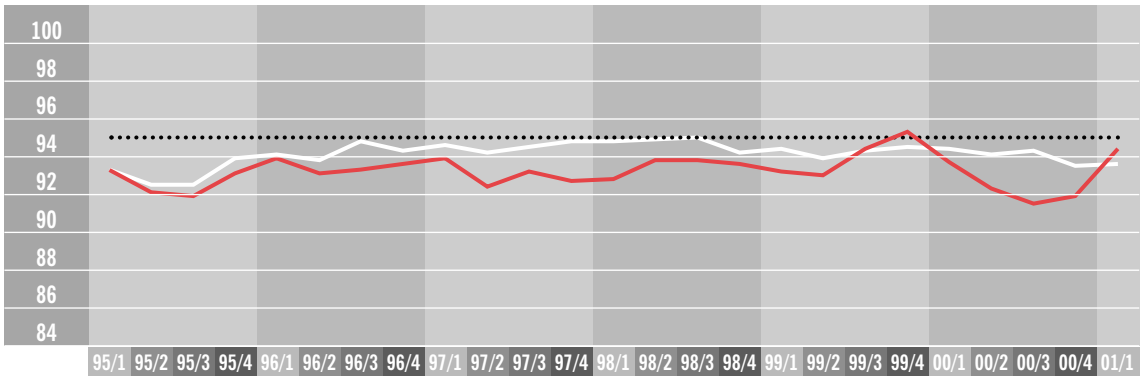
Figures 5.1 to 5.4 show immunisation coverage rates for children in Walsall. Tetanus and oral polio vaccines are given at the same time as diphtheria vaccine during infancy and the coverage rates are very similar. They are therefore not shown separately. Pertussis (whooping cough) vaccine is also given at the same time but is subject to more parental refusal and is therefore shown. Between 1995 and 2000 coverage rates at 24 months for diphtheria, pertussis and haemophilus influenza type B (Hib) have tended to be below the coverage rate in the West

Figure 5.1 Diphtheria immunisation coverage (%) at 24 months, Walsall and West Midlands Conurbation, April 1995 - June 2001



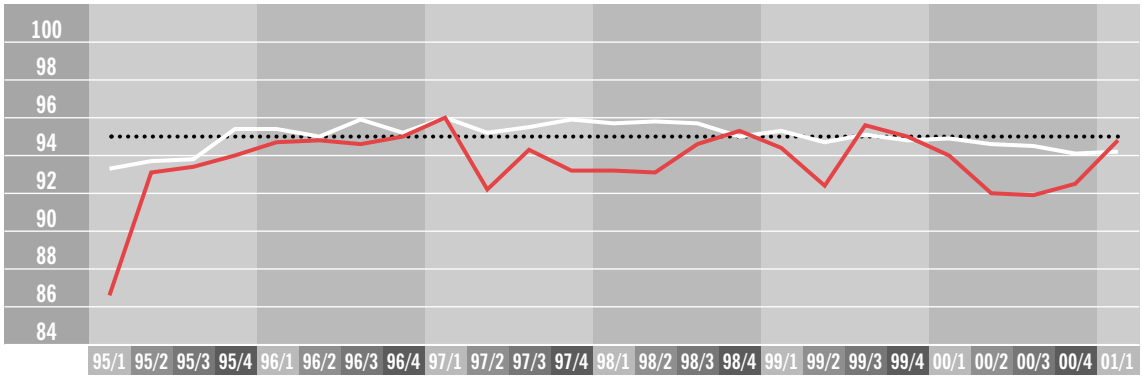
Source: CDSC West Midlands

Figure 5.2 Pertussis immunisation coverage (%) at 24 months, Walsall and West Midlands Conurbation, April 1995 - June 2001



Source: CDSC West Midlands

Figure 5.3 Hib immunisation coverage (%) at 24 months, Walsall and West Midlands Conurbation, April 1995 - June 2001



Source: CDSC West Midlands

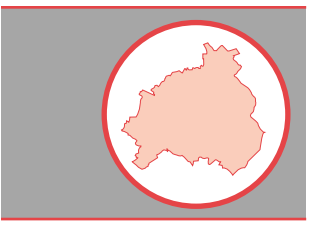
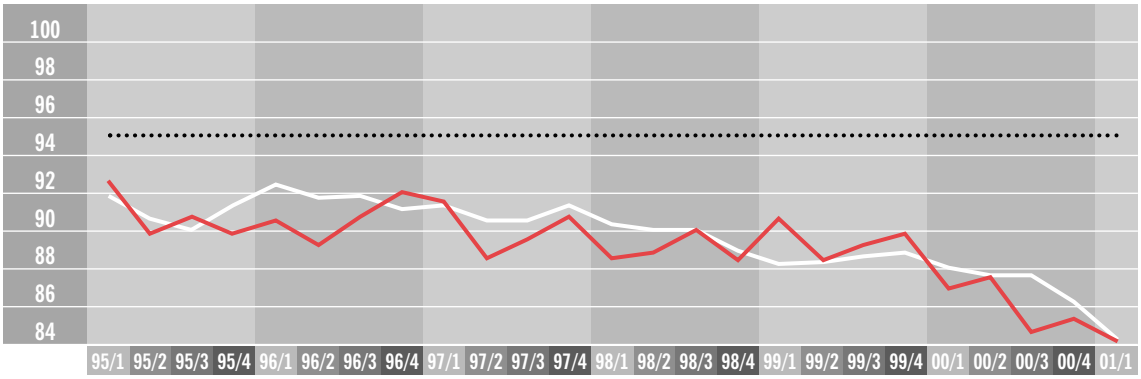


Figure 5.4 MMR immunisation coverage (%) at 24 months, Walsall and West Midlands Conurbation, April 1995-June 2001



Source: CDSC West Midlands

Midlands conurbation and often were below the national targets. This has in part been due to poor data collection. This has recently been rectified with the appointment of two dedicated information officers. Reporting is now complete and timely. There has been a marked improvement in rates in the first quarter of 2001 (April – June 2001). This is because the data reflects more accurately the uptake. The coverage rate for mumps, measles and rubella (MMR) vaccine is below the national target and falling, resembling the trend in the West Midlands conurbation and elsewhere. This is because of continuing parental concerns about the safety of the vaccine. There has been renewed media interest and publicity following an article[27] which suggested a link between MMR vaccine and inflammatory bowel disease and autism. Media interest has also focussed on the use of single vaccines instead of the recommended combined one. Though parental concern is understandable, the available evidence does not support these concerns and MMR is recommended as a safe vaccine.

The case for MMR

- MMR vaccine protects children against mumps, measles and rubella
- Measles is a very infectious disease which can have serious complications and can kill
- Mumps was the main cause of viral meningitis before MMR was introduced. Now it is infrequent. School outbreaks still occur, especially involving young people who have either received one vaccine dose or none at all. In Walsall there were 200 cases of mumps in the year 2000. (6 hospitalised cases)
- Rubella can cause great damage to unborn babies
- Measles is rare in the UK now because of high immunisation rates, but 95% of people need to be immunised to prevent outbreaks
- Recent outbreaks of measles in Dublin and Holland left some children dead
- In nearly 30 years over 500 million doses of MMR have been given worldwide. It has an excellent safety record
- Multiple studies and reviews show no link between MMR and autism or bowel disease[28] [29] [30] [31] [32] [33] [34]
- The practice of giving the vaccines separately leaves children exposed to mumps, measles and rubella for longer and means more injections

Looking at immunisation uptake by residence area can help in planning campaigns to boost immunisations. Information is also available by GP practice but is not shown here. The wards that have persistent problems in reaching 90% uptake, or worrying persistent downward trends, are shown in Table 5.1. Efforts to increase immunisation should be particularly targeted in these areas. Meningitis C vaccine (Men C) was introduced in 1999 and is given at the same time as diphtheria and the other infant vaccinations. Some wards are persistently below 90% for meningitis C uptake and the reasons for this need to be investigated.

Mortality age 1-4

There were 31 deaths in this age group between 1993 and 2000. Infectious and parasitic diseases were the most common cause of death (7 instances). There were also several deaths as the result of accident (5) and diseases of the nervous system and sense organs.(5)[2] Numbers are very small but each death is a tragedy for a family, some are potentially avoidable and not insignificant in terms of years of life lost.

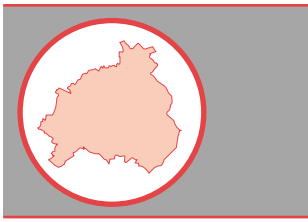


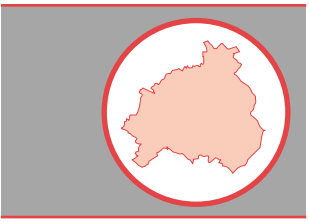
Table 5.1 Walsall wards where immunisation uptake at the 2nd birthday was below 90% or persistently falling in each quarter since April 2000

LOCALITY	WARD	VACCINE AFFECTED	PERSISTENT/DOWNWARD TREND
NORTH	BLAKENALL	DIPHTHERIA,	DOWNWARD TREND
		MEN C	PERSISTENT <90%
	BLOXWICH WEST	MEN C	PERSISTENT <90%
WEST	WILLENHALL NORTH	MEN C	PERSISTENT <90%
	BENTLEY, & DARLASTON NORTH	MEN C	PERSISTENT <90%
	DARLASTON SOUTH	MEN C	PERSISTENT <90%
SOUTH	ST MATTHEWS	MEN C	PERSISTENT <90%
	PLECK	MMR	DOWNWARD TREND
	PALFREY	MMR	DOWNWARD TREND
		MEN C	PERSISTENT <90%
EAST	ALDRIDGE CENTRAL & SOUTH	MMR	DOWNWARD TREND
	PELSALL	MMR	DOWNWARD TREND
	STREETLY	MMR	PERSISTENT <90%
		MEN C	PERSISTENT <90%

Source: Walsall Community Health Trust

Data on Accident and Emergency attendances and on referrals to the Paediatric Assessment Unit for this age group can be found in the Healthcare section on page 37.

Chapter Six



EDUCATION

This chapter covers children and young people of school age. The first part is centred on some of the key education data that create a picture of likely future health needs, since low levels of educational achievement are associated with poor adult health.[3] The second deals with the lifestyles of Walsall's young people and how these influence their health for good or ill. The third part looks at two particular issues with an important health dimension for the age group: teenage pregnancy and young offenders. The chapter ends with a brief summary on mortality among school-age children and young people. Issues concerning attendance at hospital in Walsall are dealt with in Chapter Eight on healthcare.

The role of schools in influencing the health of children and young people is increasingly recognised. The Walsall Healthy Schools programme has almost fifty schools involved in various stages of development. The national objective is that all 137 schools in the borough should be involved in the Healthy Schools Programme by 2002, and the Health Action Zone objective is that all schools should be accredited by 2005. The launch of the National Healthy School Standard in October 1999 gave new guidance on the framework of the programme.

Education

Much of the data below is taken from the Walsall Metropolitan Borough Council Annual Schools' Census (Form 7) Return to the Department for Education and Skills, January 2001[35]

Free School Meals

Pupils whose parents receive Income Support or Income-related Jobseeker's Allowance are eligible for free school meals.

21% of Walsall's primary school children were eligible for free school meals in January 2001.

Since low income is associated with lower educational attainment as well as poor health, areas where high proportions of pupils receive free school meals are likely to need more educational, social, health and economic resources, in order to reduce inequality.[3]

The totals of primary school pupils eligible for free school meals in schools in each primary care group are shown in Table 6.1. About 16% of those eligible for free school meals in primary schools did not take them up on the day selected for a count, according to Walsall's Annual Schools Census. This will include those who were absent on that day. Others may not take them up because of stigma.

The proportions of those in secondary schools are not a reliable indicator of need within wards, since older children and young people are more likely to travel outside their immediate neighbourhood to school.

Secondary schools

Secondary school pupils are divided into two age groups in the data given to the Government: those of compulsory school age, and those above compulsory school age.

Looking at those of compulsory school age, a total of 3,323 pupils in Walsall's public sector secondary schools were eligible for free school meals – 18% of the total. Of these, 30% (996) had not taken them up.

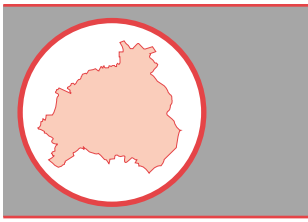
Of those above compulsory school age, only 13% were eligible for free school meals. This is perhaps an indication of pupils from better-off families being more likely to continue their education.

Table 6.1

Total primary school pupils eligible for free school meals, by locality, January 2001

PCG	TOTAL PRIMARY SCHOOL PUPILS
SOUTH EAST PCG	2,286
NORTH WEST PCG	2,808
WALSALL	5,094

Source: Walsall Metropolitan Borough Council Annual Schools Census



Pupils with English as a second language

This is another important indicator of educational need. In Walsall's primary schools, there was a big difference between the two Primary Care Group areas.

In South East PCG area, almost a fifth of primary school pupils had English as their second language.

In North West, the percentage was 8% - less than one in 12.

A geographical breakdown of pupils with English as a second language makes less sense at secondary school level, since pupils travel more to their schools. In the borough as a whole, 13% of secondary school pupils had English as a second language.

Ethnic breakdown

The ethnic breakdown of primary school pupils is given in Chapter Two. The breakdown of secondary school pupils is almost identical to that in primary schools: there are slightly more Indian, and slightly fewer Pakistani pupils.

Special schools

508 pupils attended Walsall's seven special schools in January 2001. 46% of these pupils were eligible for free school meals, suggesting a far higher level of deprivation among parents of pupils in special schools. Most pupils in special schools have mild learning difficulties or emotional and behavioural difficulties, both closely associated with poverty.

The ethnic breakdown of pupils in the borough's special schools was almost identical to that of other schools, though there were fewer pupils of Indian origin than would be expected, and more of Pakistani origin. 15% had English as a second language.

Statement of special educational needs

This issue is covered in Chapter Seven in the section on disability.

Exclusions from school

Only six children were excluded from primary school in January 2001. They were aged between 8 and 11.

48 pupils were excluded from secondary school in January 2001. 35 were male and 13 female.

Only one special school pupil was excluded.

During the year 2000/2001, from all schools, a total of 56 pupils were permanently excluded. All but 10 were of secondary school age. Walsall's rate of permanent exclusions is very close to the average for England. It improved each year from 1997/98 to 1999/2000, but fell back in 2000/2001, particularly in the primary sector. There were no permanent exclusions in special Schools in 2000/2001.[36]

Absences from school

Unauthorised absences in Walsall's secondary schools totalled 0.74% of all classes, well below the national level of 1.1%. The equivalent figure for primary school classes was 0.5%, the same as the national rate.[36] The rate in primary schools in 1997/98 was approaching double the national average, but has fallen substantially in the past three years.

Authorised absences in Walsall's secondary schools totalled 9% of all classes, compared to 8% in England. The equivalent figure for primary school classes was 6.6%, compared to 5.6% for England.

Educational attainment

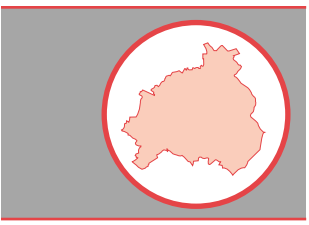
The Government's new 'Indices of Deprivation 2000', which rank estimated levels of deprivation in local authorities and their electoral wards, summarise educational attainment in an Education, Skills and Training Domain (see more about the 'Indices of Deprivation 2000' in Chapter Three).

Five of the six indicators used relate to attainment at school, or whether young people stay on at school. The sixth, 'working age adults with no qualifications', takes a longer view of the impact of under-attainment at school. The indicators are as follows:

- Working age adults with no qualifications (3 years aggregated Labour Force Survey data at district level, modelled to ward level) for 1995-1998
- Children aged 16 and over who are not in full-time education (Child Benefit data – DSS) for 1999
- Proportions of 17-19 year old population who have not successfully applied for higher education (UCAS data) for 1997 and 1998
- Key Stage 2 primary school performance data (Department for Education and Employment (DfEE), converted to ward level estimates) for 1998
- Primary school children with English as an additional language (DfEE) for 1998
- Absenteeism at primary level (all absences, not just unauthorised) (DfEE) for 1998

In the Education Domain score, 0 represents the mean, and a positive value indicates relative deprivation.

The rank shown in Table 6.2 is the ward's position out of 8414 wards in England. The rank of



the most deprived ward is 1.

The national rankings of Walsall's wards are remarkable. Only four wards are outside the poorest 20% of wards in England. Four, Blakenall, Birchills Leamore, Brownhills and Willenhall South, are in the poorest 1%. Another seven are in the poorest 10%.

In the West Midlands, only Sandwell had comparable rankings, with two-thirds of its wards in the poorest 10%. In Wolverhampton eight out of twenty were in this position, but in the rest of the urban authorities in the West Midlands the proportion was around a quarter.

Lifestyles in Walsall: storing up a future

This section summarises the results of a major survey of health-related behaviour in Walsall schools, both primary and secondary, in 2001.[37] The survey covered 2,485 primary school pupils, most of them aged 9 or 10 (Years 5 and 6), representing a third of the borough's school roll for those years, and 1,136 students in secondary schools, mostly aged 12 or 14 (Years 8 and 10), representing 16% of the borough's school roll for those ages. It is an authoritative statement of the way young people in the borough live, and should inform preventative health strategies for some years to come. The survey was also carried out in 12 other areas outside Walsall, and comparisons have been made with data from this larger reference population. Future analysis of survey data is being undertaken which will allow analysis according to population characteristics, for example by ethnic group.

Diet

Some of the most striking findings are those that identify strong indications of inadequate diets in parts of the school population. For example:

- 13% of those who took part in the survey did not have any lunch at all on the day before the survey. 36% had no more than a drink for breakfast on the day of the survey. This rose to 46% among girls aged about 14.

- Significantly more secondary pupils in Walsall reported having nothing to eat for breakfast compared to other survey findings: this was particularly so among girls around 12 years old, and to a lesser extent among girls around 10 years old in primary schools, of whom 10% had no more than a drink for breakfast.
- The results from girls aged around 14 gave cause for concern: 18% said they had not had lunch the previous day; and of the 46% who said they had had no more than a drink for breakfast on the day of the survey, nearly half had had nothing at all. 61% said they would like to lose weight.

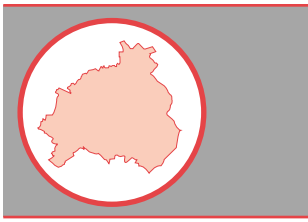
Table 6.2

Education domain scores and ranking for Walsall wards, 2000

WARD	EDUCATION DOMAIN SCORE	RANK OF EDUCATION DOMAIN
ALDRIDGE CENTRAL AND SOUTH	-1.06	7461
ALDRIDGE NORTH AND WALSALL WOOD	.63	2008
BENTLEY AND DARLASTON NORTH	2.01	91
BIRCHILLS LEAMORE	2.49	19
BLAKENALL	2.63	11
BLOXWICH EAST	1.18	807
BLOXWICH WEST	1.59	289
BROWNHILLS	2.30	37
DARLASTON SOUTH	2.01	94
HATHERTON RUSHALL	1.10	950
PADDOCK	-.16	4705
PALFREY	1.01	1113
PELSALL	.92	1289
PHEASEY	.93	1270
PLECK	1.83	157
ST. MATTHEW'S	1.40	469
SHORT HEATH	1.53	326
STREETLY	-1.17	7662
WILLENHALL NORTH	1.10	949
WILLENHALL SOUTH	2.22	48

Source: DTLR

- 1% Poorest
- 10% Poorest
- 20% Poorest



- Compared with pupils in other surveys, significantly more secondary pupils in Walsall (aged around 12 and 14) said that they had fizzy drinks on most days. Lower proportions of Walsall pupils reported consuming dairy products on most days. The boys were less likely to eat wholemeal bread or vegetables compared to those in other areas, and the girls were less likely to eat fresh fruit.

- Significantly more pupils in Walsall's primary schools (aged around 9 or 10) drank fizzy drinks, and ate sweets frequently, compared to those in other areas. Over a half drank fizzy drinks, and over a half ate sweets or chocolates, on most days. More than a third of boys rarely or never ate salads. In the primary school sample, under a third of pupils said that they ate vegetables on most days.

- More girls in the Walsall survey reported that they would like to lose weight compared to those in other areas.

Table 6.3 is reproduced from the Survey report which compares foods frequently eaten in Walsall with equivalent figures from other survey areas.

In the UK a fifth of all children eat no fruit in a week.[38]

Increasing fruit and vegetable consumption is considered the second most effective strategy to reduce the risk of cancer, after reducing smoking, and it has major preventive benefits for heart disease too. Eating at least five portions of fruit and vegetables a day could lead to estimated reductions of up to 20% in overall deaths from chronic diseases.[38]

Information is important but the choices people can make are shaped by the availability and affordability of food locally. Both national Government and Walsall's Health Action Zone have recognised that improving pupils' diet is a major objective for the Healthy Schools Programme. Resources have been put into a 'Good Grub for Kids' project, into the introduction of Breakfast Clubs, and work to improve the quality of school meals.

Walsall is a pilot for the National School Fruit Scheme. 12 schools have undertaken the pilot. The scheme has been extended to all Walsall primary schools with Key Stage 1 classes from April 2002. Every child aged four to six will be entitled to a free piece of fruit each school day.

Table 6.3 **Walsall secondary school pupils responding that they ate specific foods 'on most days', 2001**

YEAR 8 BOYS (AGED AROUND 12)	WALSALL 2001(%)	WIDER AREA (%)	YEAR 8 GIRLS (AGED AROUND 12)	WALSALL 2001(%)	WIDER AREA (%)
1 DAIRY PRODUCE	57	64	1 DAIRY PRODUCE	58	64
2 SWEETS ETC.	54	47	2 SWEETS ETC.	48	46
3 FIZZY DRINKS	51	42	3 FRESH FRUIT	44	50
4 CRISPS	46	47	4 CRISPS	44	49
5 FRESH FRUIT	39	42	5 FIZZY DRINKS	40	31
6 CHIPS OR ROAST POTATOES	34	31	6 VEGETABLES	38	46
7 MEAT	30	37	7 SALADS	30	27
8 VEGETABLES	27	29	8 WHOLEMEAL BREAD	29	31
9 SUGAR COATED CEREALS	27	27	9 CHIPS OR ROAST POTATOES	25	27
10 WHOLEMEAL BREAD	25	32	10 LOW CALORIE DRINKS	24	28

Source: Walsall Health Authority with Schools Health Education Unit, Exeter, 2001

Physical activity

Physical activity in childhood and adolescence is important both in maintaining physical and psychological health, and in preventing chronic disease in later life. It also contributes to the maintenance of a healthy body weight. This is important when considering that girls wish to lose weight, and the tendency of a significant minority to go short of food.

Pupils were asked on how many occasions they had exercised enough to breathe harder in the last week. 57% of primary pupils and 63% of secondary pupils said they had done so at least twice. It is recommended that young people should take part in what adds up to at least half an hour of at least 'moderate intensity' activity per day. Figure 6.1 represents a lower level than this. Boys generally exercise more than girls; and generally Walsall pupils were exercising less than their counterparts elsewhere. The percentage taking this level of exercise appears to increase up to Year 8 (around age 12), and then fall back, particularly among girls.

A significantly lower proportion of Year 10 boys in Walsall (aged around 14) undertook physical activity three times or more in the past week, which is a measure of a higher level of exercise, compared to elsewhere (39% compared to 47%).

Interestingly, enthusiasm for physical activity was not reflected in participation: 84% of primary pupils and 79% of secondary pupils said that they enjoyed physical activity 'quite a lot' or 'a lot'. This suggests that there is potential for promoting more physical activity.

Alcohol

38% of secondary school and 21% of primary school pupils had had at least one alcoholic drink in the past week. Levels of drinking among primary school children were not higher in Walsall than elsewhere, but levels in secondary school were.

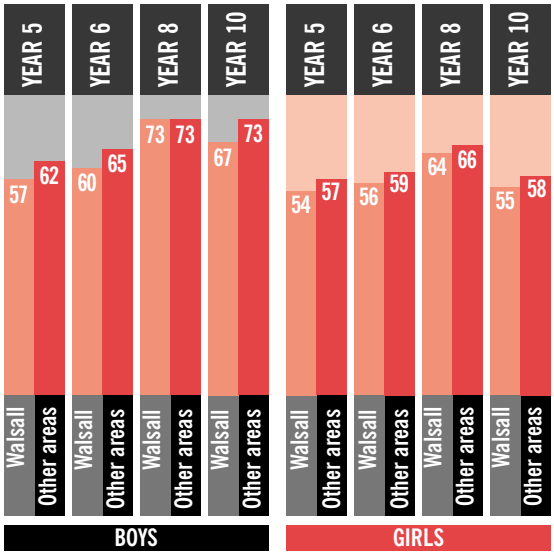
The advised weekly limit for adult men is 21-28 units, and that for adult women 14-21 units. This level is believed to be inappropriate for children and young people although there is a lack of guidance on what constitutes sensible drinking for young people. Among boys around the age of 14, 4% were drinking over 21 units a week. Among girls aged around 12, 10% were drinking over 14 units, well over the percentage in other areas. The proportion of this group who had had an alcoholic drink in the past week was also well above the proportion elsewhere, at 27% compared to 22%.

Pupils aged around 14 in Walsall were significantly more likely to have bought alcohol from an off-license than their equivalents in other parts of the country: one in five had done so in Walsall.

This may be an area that would show significantly different results if the findings were broken down by ethnic group, since some cultures are far less likely to drink alcohol. Excessive consumption of alcohol is an important risk factor in stroke and coronary heart disease, as well as being a major factor in crime, violence, accidents, damaged relationships, unwanted pregnancies and time lost from work.

Figure 6.1

Percentage of pupils responding that they had exercised enough to breathe harder twice or more in the last week, Walsall and other areas.



Source: Schools Health Education

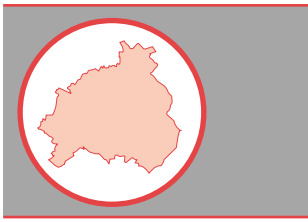
Smoking

16% of the secondary school pupils and 2% of the primary school pupils in the survey reported smoking during the past 7 days.

Significantly more girls about the age of 12 in Walsall had smoked than in other areas: 14% compared to 9%. Girls in secondary schools were markedly more likely to smoke than boys:

- at around 12 years old, 6% of boys had smoked in the last 7 days, compared with 14% of girls;
- at around 14, 19% of boys had smoked compared to 27% of girls.

Generally, 17% of secondary pupils said they



smoked 'regularly' or 'occasionally'.

Pupils aged around 14 were far more likely to have smoked more than 10 cigarettes in the last week than those aged around 12. 19% of girls aged around 14 had smoked more than 10 cigarettes, and 15% of boys. However, 29% of girls in that age group said they smoked regularly or occasionally, compared to 20% of boys.

This finding is alarming given that lung cancer death rates in women have increased since 1970, and are expected to increase further.[39] Also, smoking in mothers is linked to babies with low birthweight.[40]

76% of regular smokers wished to give up smoking.

Of those with a parent who smoked, 23% of secondary school pupils smoked. The proportion rose to 35% among girls aged around 14. Where no parent smoked, only 10% of those pupils smoked.

Of those who had a close friend who smoked, 33% smoked. The proportion rose to 45% among girls aged around 14. Where secondary pupils did not have a close friend who smoked, only 2% smoked.

A fifth of primary school children thought that in the future they might smoke, or would smoke.

An international study of smoking in young people concluded that a combined approach was needed to reduce levels, including a complete ban on tobacco advertising, increasing prices, restricting tobacco product sales to tobacconists (rather than, for example, supermarkets), mass media education, and intensifying school education.[41] As the White Paper, 'Our Healthier Nation', put it in 1999:

'Smoking is the most important modifiable risk factor for coronary heart disease in young and old… A lifetime non-smoker is 60 per cent less likely than a current smoker to have a coronary heart disease and 30 per cent less likely to suffer a stroke… While the proportion of young people starting to smoke is similar across social classes, by their 30s half of the better-off young people have stopped smoking while three quarters of those in the lowest income group carry on'.[39]

Although there is a little evidence yet as to the effectiveness of strategies to prevent the uptake of smoking among children, it is recommended that a comprehensive, community-wide approach is likely to have the greatest long-term population impact. In Walsall, children as young as 3 years old are exposed to smoking education and prevention measures designed to reduce the uptake of smoking as part of the Healthy Schools Programme and PSHE curriculum. In terms of community-led approaches, Walsall's HAZ Steering Groups have commissioned a number of arts-based pilot projects that aim to address smoking/ tobacco issues with young people in an engaging and innovative way. The Smoking Reduction Project Officer based at Walsall Council (funded through the HIMP Performance Scheme) launched the 'Validate' Proof of Age Card Scheme for 16-18 year olds in 2001 in order to reduce underage sales of cigarettes. In addition, the Officer is planning to pilot smoking cessation support groups with pupils from two secondary schools in 2002/03.

Drug use and awareness

38% of secondary school pupils and 18% of primary school pupils were fairly sure or certain that they know someone who takes drugs. This does not reflect the numbers who actually take drugs, but may indicate how close pupils are to a possible source of supply.

The Walsall figures for 'knowledge of a drug user' were slightly lower than elsewhere, with the exception of girls about 12 in Walsall, who were significantly more likely to know a drug user than their contemporaries elsewhere.

Significantly fewer pupils aged around 14 had been offered cannabis than those elsewhere.

28% of pupils aged around 14 had been offered drugs other than cannabis, compared to about 12% of those aged around 12.

15% said they had taken some form of illegal drug; 10% said they had taken an illegal drug in the last month. This is similar to other areas.

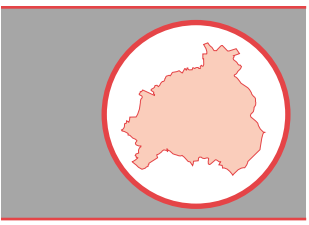
There is a sharp increase in experience of drugs between the ages of 12 and 14.

Fewer pupils in Walsall 'knew nothing' about listed illegal drugs than in other areas; and fewer in Walsall thought that these drugs were 'always unsafe'. For a number of drugs, there was a marked increase in the proportion of pupils believing they were 'always unsafe' between the ages of 12 and 14. This was the case with barbiturates, ecstasy, hallucinogens, and solvents; among girls only, amphetamines, opiates and poppers; and among boys only, heroin and tranquillisers.

15% of pupils around the age of 14 had taken an illegal drug and alcohol on the same occasion.

47% of pupils said they had found school lessons about illegal drugs 'quite useful' or 'very useful'. This was particularly marked among pupils aged around 14 in Walsall, whose approval, at 60%, was significantly higher than in other areas.

A European Drugs Initiative Project, which aims to develop a system aimed at preventing and decreasing drug use among 10-13-year-olds, has carried out a detailed survey of drug use in Walsall, together with samples in Sandwell and



Israel, as part of its development process. The findings supplement those of the Schools Health Education Unit used in this section.[42]

Bullying and safety in the streets

Bullying is widespread in Walsall as elsewhere, according to the Schools Health Education Unit research, though its incidence falls with age. Pupils were asked whether they felt afraid to go to school because of bullying 'sometimes', 'often', or 'very often'. Girls appear to be much more vulnerable to bullying than boys. The difference between the sexes appears to diminish with age: the level of bullying experienced by girls starts very high, at 52% in Year 5 (around age 9), and then falls more steeply than the level among boys to 24% at age 14. The level among boys falls from 34% at year 5 to 18% at Year 10.

Analysis focused on cases where bullying was persistent and may have severe consequences for the child or young person: that is, where pupils said they felt afraid to go to school because of bullying 'often', or 'very often'. Here, there is a different pattern between the sexes. Serious bullying experienced by boys seems to diminish with age, from 9% at the age of 9 (Year 5) to 4% among secondary school pupils. However, with girls, there is a peak at Year 8 (aged around 12), with a high level of persistent experience of bullying of 10% of girls.

Pupils were asked whether others may fear going to school because of them. Far fewer responded positively to this question. In the case of boys, 10% in Year 5 admitted that they might be involved in bullying, falling to 4% in Year 10. The proportions were much lower among girls, varying between 2% (Year 6) and 5% (Year 10). This may mean either that few bullies are responsible for the experience described in the figures above; or that respondents were simply less candid.

Primary school pupils were asked where the bullying occurred. The most common places were at school at breaktime, both inside and outside. There was lower incidence of bullying at or near home in Walsall than in other areas.

The picture on the streets was different for secondary school pupils. A third of them rated the safety of their area when going out after dark as poor or very poor, significantly higher in Walsall than in other areas. Girls felt more vulnerable than boys: 40% of girls aged around 12 felt unsafe in these circumstances.

Boys were more likely to feel unsafe during the day in Walsall than those living in other areas. Boys in Walsall were also more likely to feel unsafe going out in the day than girls.

Self-esteem and well-being

Results of previous Health Behaviour of School-Aged Children studies have provided evidence that young people who are socially well-integrated and are able to interact effectively with other people report significantly better health than young people who are isolated.[43]

In terms of this report, this means a virtuous circle: such young people will be, for example, more likely to take up exercise, and therefore more likely to be healthier and to relate well to other people; and those with higher self-esteem will be less likely to be bullied, or to bully.

The Schools Health Education Unit study created a self-esteem 'score' based on responses to ten statements about social confidence and relationships with friends.

Among primary school pupils, in Walsall and elsewhere, boys generally score higher than girls. The proportion of pupils ranked as having 'high self-esteem' was generally lower in Walsall than in other areas, though not significantly so, except in the case of Year 5 boys (aged around 9).

The proportion of primary school pupils ranked as having 'low self-esteem' was generally higher in Walsall than in other areas.

Among secondary school pupils, again the scores for boys were generally higher than those for girls. While the proportions of boys with high self-esteem were similar in Walsall to other areas, the proportion of girls with higher self-esteem were significantly higher than in other areas among girls in Year 8 (aged around 12), and significantly lower in girls aged around 14.

Interestingly, there were significantly fewer pupils around the age of 12 in the low self-esteem category in Walsall than elsewhere, while there was little difference at the age of 14.

Relationships, sex, and sexually transmitted disease

The survey has detailed findings on these issues. Here, we confine ourselves to just two matters.

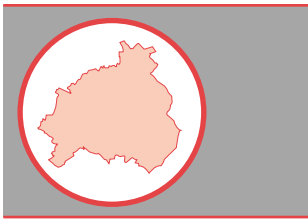
First, sources of information about sex. For boys both aged around 12 and around 14, school was the main source of information. For girls, friends and parents were the main sources, followed by school.

Questions put to pupils aged around 14 on the means of transmission of HIV infection showed lower awareness in Walsall than elsewhere. Awareness of HIV / AIDS was also lower in Walsall's primary schools than elsewhere.

The Children's Fund

The Children's Fund is a government initiative to

tackle child poverty which includes preventative services for children aged 5-13 years old. Walsall has already identified key areas of work. These will include activities to ensure that all children have the opportunity to live healthily and it will tackle some of the issues raised in this section of the report.



Teenage Conceptions

Conception rates

Tables 6.4 and 6.5 show that from 1996 to 1998, Walsall had a rate of conceptions per 1000 women aged under 16 and under 18 which was significantly higher than both the regional and national average.[44] Overall 223 conceptions were recorded in under 16's in Walsall in 1996-1998, and 976 conceptions in under-18's. Table 6.6 puts the under-18 conception rates in a geographical setting within Walsall. The higher teenage conception rates are highlighted in red , and the lower in pink. The pattern of distribution corresponds to that of deprivation, with higher levels in the deprived wards of Blakenall, Bloxwich East and Darlaston South.

Conceptions for ages 15-17 in Walsall in the years 1995-97 were compared with the figures for other health authorities in the West Midlands, making a distinction between those leading to maternities and those leading to terminations. Walsall had a conception rate of 62.2 per 1000 women aged 15-17, with only Sandwell having a higher rate (67.8 per 1000). Of the 912 conceptions recorded for Walsall, 646 led to maternities (71%) compared to 266 terminations (29%)[2]

Termination of pregnancy

Recorded rates of termination in women aged 11-15 and 16-19 in Walsall were similar to those seen at regional and national level between 1997 and 1999.[44] There has been no significant change in rates over the 3 years.

However, if we take numbers of terminations as a percentage of conceptions in the age group 15-17 (figure 6.2), a very different picture emerges, for that age group at least. This shows Walsall to have a percentage of conceptions leading to terminations markedly lower than other health authority areas in the West Midlands. This may reflect medical beliefs or policies, or cultural beliefs in Walsall's population.

Table 6.4 Conceptions for Walsall, West Midlands and England and Wales, aged under 16 years, 1996 - 1998

	NUMBER OF CONCEPTIONS	RATE PER 1000 WOMEN AGED 13-15	95% CONFIDENCE INTERVAL	
			LOWER CONFIDENCE LIMIT	UPPER CONFIDENCE LIMIT
ENGLAND AND WALES	25,566	9.1	9.0	9.2
WEST MIDLANDS	3,143	10.6	10.2	11.0
WALSALL	223	14.9	13.1	17.0

Source: Office for National Statistics

Table 6.5 Conceptions for Walsall, West Midlands and England and Wales, aged under 18 years, 1996 - 1998

	NUMBER OF CONCEPTIONS	RATE PER 1000 WOMEN AGED 15-17	95% CONFIDENCE INTERVAL	
			LOWER CONFIDENCE LIMIT	UPPER CONFIDENCE LIMIT
ENGLAND AND WALES	130,909	46.4	46.2	46.7
WEST MIDLANDS	15,418	52.0	51.2	52.8
WALSALL	976	66.1	62.2	70.2

Source: Office for National Statistics

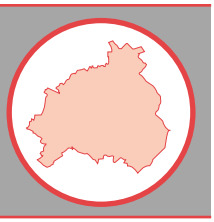


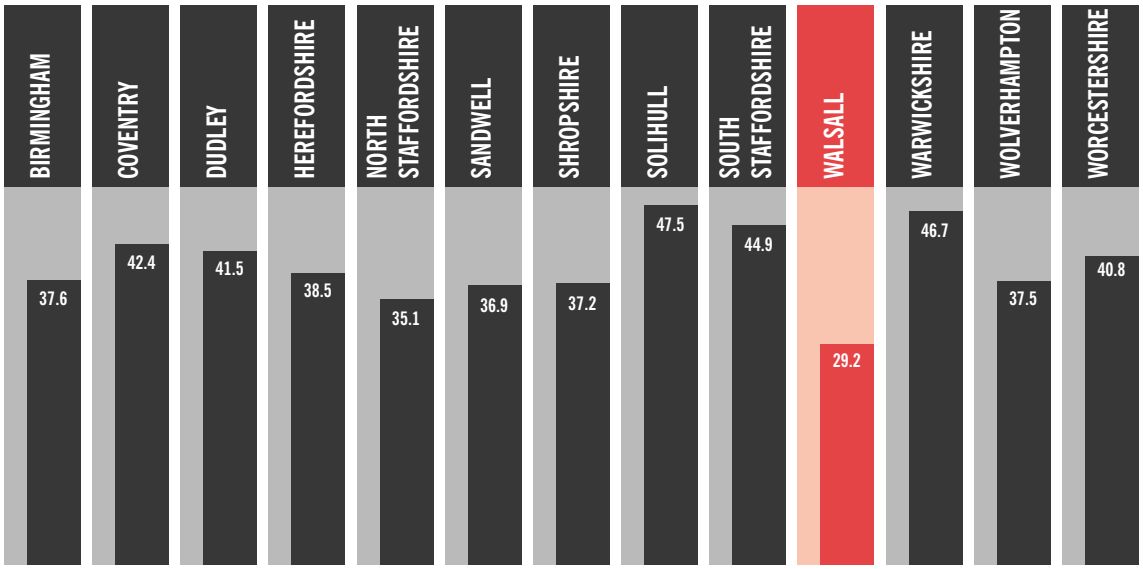
Table 6.6 Conceptions in under 18's, Walsall wards, 1995 - 1997

WARD	POPULATION	No.	RATE/1000	LOWER 95% CONFIDENCE LIMIT	UPPER 95% CONFIDENCE LIMIT
WALSALL MD	29942	912	30.5	28.5	32.4
ALDRIDGE CENTRAL AND SOUTH	1107	22	19.9	18.3	21.4
ALDRIDGE NORTH AND WALSALL WOOD	1269	37	29.2	19.3	39.1
BENTLEY AND DARLASTON NORTH	1853	68	36.7	26.4	47.0
BIRCHILLS LEAMORE	1839	50	27.2	19.8	34.6
BLAKENALL	1829	89	48.7	38.8	58.5
BLOXWICH EAST	1349	65	48.2	38.4	58.0
BLOXWICH WEST	1627	61	37.5	27.4	47.6
BROWNHILLS	1331	41	30.8	22.4	39.2
DARLASTON SOUTH	1562	73	46.7	35.4	58.1
HATHERTON RUSHALL	1455	40	27.5	19.4	35.6
PADDOCK	1261	15	11.9	6.3	17.5
PALFREY	2435	53	21.8	13.7	29.8
PELSALL	1328	25	18.8	13.4	24.2
PHEASEY	864	12	13.9	7.6	20.2
PLECK	1432	49	34.2	22.1	46.3
ST.MATTHEW'S	1742	62	35.6	26.0	45.2
SHORT HEATH	1157	33	28.5	20.7	36.3
STREETLY	1224	13	10.6	4.7	16.5
WILLENHALL NORTH	1487	54	36.3	25.8	46.8
WILLENHALL SOUTH	1792	50	27.9	19.5	36.3

Source: Walsall Health Authority. 1999 ADS adjusted to ONS (1996 based) projections for 2000
1999 ADS adjusted to ONS (1996 based) projections for 2000

- Conception rate significantly higher than the rate for Walsall
- Conception rate significantly lower than the rate for Walsall

Figure 6.2 Percentage of conceptions leading to termination, West Midlands Health Authorities, women aged 15- 17, 1995 - 97



Source: ONS

Table 6.7 Birth registrations in Walsall by maternal age, 1994 - 1999

AGE OF MOTHER	1994	1995	1996	1997	1998	1999
ALL AGES	3538	3502	3434	3543	3476	3342
11-15.	15	15	12	19	18	19
16	37	43	36	34	49	55
17-19	317	283	307	361	394	342

Source: ONS Vital Statistics Note: Live births, births by maternal age

Table 6.7 reports birth registration statistics by maternal age for Walsall from 1994 to 1999. This shows a rise in numbers in the 16 and under age group, from 52 in 1994 to 74 in 1999.

A multi-agency partnership oversees the implementation of the teenage pregnancy strategy which includes support for young mothers as well as preventative work.

Youth Justice

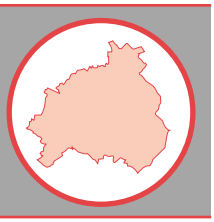
Figures from the Walsall Youth Offending Team's Youth Justice Plan (2001/2002) give some sense of the profile of children and young people who commit offences, and what those offences are. They show that:

- Violence against persons by males peaks between 14 and 16
- Death or injury by reckless driving by males peaks from 15 to 17
- Burglary by males peaks at 16
- Theft and handling by males peaks between 14 and 17, and is the only category committed by significant numbers of girls, peaking at 16
- Arson and criminal damage by males peaks between 13 and 16[45]

These categories of offence account for nearly two-thirds of all offences.

The career pattern of offenders taken to court in the period April 2000 - March 2001 was also examined. Nearly half were first offenders, and just over one in ten were 'persistent offenders'. Other figures in the Youth Justice Plan show that each 'persistent offender' in the calendar year 2000 was responsible for 71 offences.[45]

Youth Offending Teams are now using, as from 1st April 2000, a standard risk and needs assessment profile for use with young offenders aged 10-17, called ASSET. One of the key objectives of the profile, which was developed by the Probation Studies Unit at Oxford University, is "to identify the primary risk factors linked to offending by young people."[46] The information is



still being collated electronically in Walsall, with the aim of using the information they provide to highlight factors that may discourage offending and inform decisions for intervention.

Mortality

Schoolchildren aged 5-14

The number of deaths among children and young people is very low, so that it is difficult to identify significant trends. In the past eight years (1993-2000) there have been 55 deaths in the age group 5 to 14, 34 female, and 21 male. Causes of death show a different pattern from those of younger children. Accidents were the main cause (16 deaths of which 9 involved motor vehicles). The second most common cause of death in this age group was from malignant neoplasms (cancers) which caused 15 deaths in the period. The third most common cause of death was diseases of the nervous system and sense organs (6 deaths)[2]

Adolescents, aged 15-19

Among the 15-19 year old age group there were 57 deaths in the period 1993-2000, 39 of them male and 18 female. Of the total, 23 were accidents, of which 18 involved motor vehicles. Of these 3 were drivers, 13 were passengers, and 2 pedestrians. The second major cause of death in this age group was external causes of injury and poisoning (12 deaths). This included deaths from suicide and undetermined injury.[2]

Our Healthier Nation has a target to reduce the death rate from accidents by one fifth.[39] This is not age specific, but accidents in children make a contribution to the total.

Accidents in childhood remain a priority for Walsall Health Improvement and Modernisation Programme (HIMP).

KEY ISSUES AFFECTING CHILDREN OF ALL AGES

This chapter covers some key issues that can affect children both before school age and during their school careers. They are about experiences that may generate particular health needs: disability, the need to protect children from abuse or neglect, children looked after by the local authority, and finally, associated with the latter two but meriting its own section, domestic violence.

All of these areas are priorities for the Children's Taskforce, one of ten Taskforces established in 2000 to implement the Government's NHS Plan. One of its projects is Quality Protects, a major programme aimed at reforming the management and delivery of children's social services. It focuses on children looked after by local authorities, children in the child protection system, and disabled children. The project Safeguarding Children aims to ensure that children, particularly those in care, are properly looked after and protected from abuse. This includes developing new standards for residential and fostering services for children. The Disabled Children project brings together all services for disabled children across both health and social services, applying the standards of Quality Protects and overseeing the implementation for children of the new strategy for Learning Disability, 'Valuing People'. The impact of domestic violence on children is overseen with other initiatives affecting children by a co-ordinating programme, 'Cross Government Support for Families and Young People at Risk'.

Some of the responses to these initiatives in Walsall are summarised in the rest of this chapter.

Child protection

Children who are referred to Walsall Social Services as needing protection have their details recorded in a Child Protection Register.

The national rate of child protection registration was 28 per 10,000 in 1999[48]. Table 7.1 shows that the registration rate in Walsall was higher than nationally in 1999, but has reduced in each of the subsequent two years.

The commonest category of registrations throughout from April 2000 – March 2001 was for neglect. This has been an on-going trend and there is variation between the wards[49] which the Area Child Protection Committee (ACPC) is actively investigating.

Between April 2000 and March 2001 8.9% of registrations were re-registrations and 4% remained on the register in excess of two years.[49]

Walsall Social Services Department now keep a database which records associated issues e.g. domestic violence, parental substance misuse and when this is fully functional it will provide some very useful information on some of the underlying causes and consequences of child protection in Walsall.

The agencies involved in child protection are working together to develop an information sharing protocol for both operational and strategic data related to child protection which will in due course be supported by more integrated electronic systems.

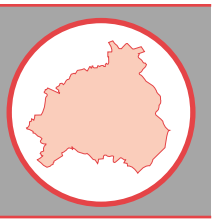
Childhood sexual and other abuse is known to be more frequent in the histories of individuals with both mental illness and personality disorder.[50] There is an association between the identification of abuse through placement on Child Protection Registers, and low social and economic status.[51]

Table 7.1

Children registered on the Walsall Child Protection Register, April 1999 - March 2001

YEAR	NUMBER	RATE PER 10,000 CHILDREN UNDER 18 YEARS
1999	202	30.8
2000	192	29.2
2001	189	29

Source: ACPC Business Plan April 2001-March 2002



Children who are looked after by the local authority

The number of children looked after by the local authority increased by a fifth between March 1999 and September 2001, from 339 to 410. A key indicator of the quality of local authority care is the percentage of looked after children who have moved home three or more times within a year. This has improved over the same period, from 21% in 1999 to an expected proportion of 15% in March 2002.[52]

"Although it costs more to keep a child in residential care than it does to send a child to Eton, young people continue to leave care disadvantaged in terms of their physical and mental health, education, employment prospects, housing and social status. All have profound effects for their adult health."[53]

The health of looked after children is often poor in comparison to that of their peers with higher levels of substance misuse,[51] higher rates of teenage pregnancy[54] and a greater prevalence of mental health problems.[55]

Because a child being looked after by the local authority may not have a single person familiar with their medical history, symptoms which normal parents would notice may go unremarked.

Walsall now has a co-ordinator in post funded through the Health Action Zone and Quality Protects to promote the health of looked after children. The main activities are:

- To establish a detailed health register of all looked after children within the child health system
- To ensure that all looked after children are offered regular and appropriate health needs assessments
- To ensure access to services required so identified needs are met
- To develop record keeping and information systems and to avoid duplication of effort

Of 290 children who had been in the looked after system for at least 12 months on 30 September 2001, 266 were up to date with their immunisations, 264 had had a dental check, 227 had had a health assessment. The aggregate figure used as an indicator for Quality Protects is 87% (personal communication).

This work is being developed through mainstream services without extra funding. We are working towards the awaited national guidelines from the Department of Health on promoting health in looked after children.

Children with disabilities

Walsall Community Health Trust maintain what is known as a transitional database. It consists of children who have statements of special education need and therefore only includes school age children. A statement of special educational need is not a diagnosis of disability but it is indicative.

Table 7.2

Children with disabilities in Walsall, by sex and category, December 2001

DISABILITY CATEGORY	MALE (No.)	FEMALE (No.)	TOTAL (No.)
PHYSICAL	168	74	242
HEARING	34	10	44
VISION	49	16	65
COMMUNICATION	21	11	32
LANGUAGE	149	86	235
BEHAVIOUR	145	64	209
LEARNING DISABILITIES	411	183	594
TOTAL	977	444	1,421

Source: Walsall Community Health Trust

Note: Transitional database of children with special educational needs

Table 7.3

Children with disabilities in Walsall, by disability category and severity, September 2001

DISABILITY CATEGORY	MILD	MODERATE	SEVERE	LEVEL UNKNOWN	TOTAL
PHYSICAL	23	88	95	5	211
HEARING	6	9	11	15	41
VISION	12	19	14	17	62
COMMUNICATION AND LANGUAGE	45	52	113	29	239
EMOTIONAL AND BEHAVIOURAL	19	12	50	123	204
LEARNING DISABILITIES	24	387	91		502
TOTAL	129	567	374	189	1259

Source: Walsall Community Health Trust Note: Transitional database of children with special educational needs

The information is shared between agencies as a basis for improving services with parental consent.

Table 7.2 summarises the available figures. The total number on the database is 1,421. This is regarded as an underestimate, since there are likely to be far more children with behavioural difficulties than are included here, due to a reluctance to label children. It is a question of where we draw the line with 'disability'.

It is striking that more than two-thirds of those with statements are boys.

A picture of the extent of moderate and severe disability in each category can be gained from Table 7.3. The overall figures in Table 7.2 are slightly higher than those in Table 7.3, reflecting the continuous work on the database which improved in quality and completeness between September and December 2001.

Children seen at Walsall Child Development Centre (CDC)

The CDC is located in Shelfield. It provides multi-disciplinary assessments and intervention for children with potential developmental or handicapping problems and special educational needs up to the age of 5 years. Children in special schools are followed up in school. Occasionally children in mainstream school are followed up too. The clinics held at the CDC are separate to the assessments.Like the data given above, these figures do not give us the total picture of childhood disability in Walsall as some children may not attend the CDC. They may be treated in other settings or may be undiagnosed and not receiving a service. However these figures are likely to include the most severely affected children being cared for in Walsall, and they do show the demand currently being placed on the CDC.

The numbers of children seen at paediatric clinics at Walsall Child Development Centre shown in Figure 7.1 increased from 1996/97 to a peak in 1999/2000. There has been a decrease in 2000/01 but the numbers remain greater than in 1996/97. These figures include medical examinations following a statement of special educational need, home visits, and developmental, hearing, neurology and general paediatric clinics.

The number of children attending for assessment at the Child Development Centre increased in 2000/01. This is because a new system of a brief initial assessment was introduced which allowed certain children to be fast-tracked to follow-up services, bypassing the usual two week block assessment.

For all years, reflecting the figures given earlier, approximately twice as many boys as girls were seen.

The CDC knows of 135 children (112 boys, 23 girls) in Walsall diagnosed as having significant communication disorders including autistic spectrum disorder.

The CDC knows of 72 children (38 boys, 34 girls) with Down's Syndrome in Walsall. Although the numbers are small they appear to have reduced, possibly because of improved pre-natal diagnosis leading to termination of pregnancy.

There are 141 children (83 boys, 58 girls) with cerebral palsy known to CDC. The CDC now sees very few children with spina bifida and/or hydrocephalus.

Figure 7.1

Children seen in paediatric clinics at Walsall Child Development Centre, April 1996 - March 2001

Source: Walsall Child Development Centre

Receipt of Disability Living Allowance

The other indicator of severe disability is receipt of Disability Living Allowance, which is awarded where a person requires frequent attention concerning bodily functions throughout the day or night, or continual supervision in order to avoid danger to him/herself or others. As the numbers in Table 7.4 are for receipt, they will be an underestimate, excluding those whose families have not claimed for them. At 31st May 2001, this shows there were 1315 people under 19 years of age in Walsall in receipt of Disability Living Allowance.

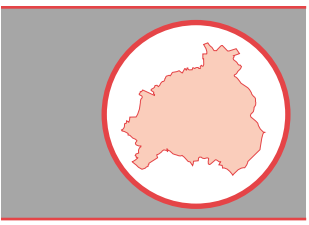


Table 7.4

Disability living allowance in payment to children and young people in Walsall, May 2001

AGE	No. OF AWARDS
0 - 4 YEARS	200
5 - 9 YEARS	420
10 - 15 YEARS	465
16 - 19 YEARS	230
ALL AWARDS	1315

Figures are rounded to the nearest 5

Source: Department for Work and Pensions Information Centre.

Domestic violence

Domestic violence is widespread, though it is significantly under-reported. Research has suggested that a victim of domestic violence will on average be assaulted 35 times before seeking help. Women in all social positions experience it, and children are profoundly affected by it. The 2000 Walsall Public Health Report describes some of the severe health and social consequences for children of violence, abuse and separation involving family conflict.[56]

In assessing the scale of domestic violence in Walsall, we can only deal with reported incidents of different kinds. The total number of incidents reported to the Police in Walsall in the year to March 2000 was 3,738 (Walsall's Responsible Authorities Group, 2000).

Homelessness and the Women's Refuge

Large numbers of children suffer the extreme consequences of homelessness as a result of their mothers fleeing the home for safety. As many as 40% of all Walsall's families accepted as unintentionally homeless in the year ending in March 2001 were fleeing domestic violence: 578 families giving the reason for their homelessness as 'violent breakup of a relationship'. It is estimated from returns provided by the Council's Housing Services that the total number of children involved was nearly a thousand.[57]

The Women's Refuge in Walsall report similar figures, shown in Table 7.5. In the year to September 2001 they gave shelter to 619 women and 833 children. These are not necessarily the same families as those recorded by Housing Services.

The Refuge report that they are not able to meet current demand from women and their children. However, new investment means that their capacity is to be doubled by 2003. While they welcome that, they are concerned about a lack of resources to deal with the needs of children who have lost their homes due to domestic violence.

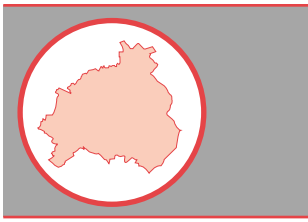
Table 7.5

Children given shelter by Walsall Women's Refuge, by age, year ending September 2001

AGE	No. OF CHILDREN
0 - 3 YEARS	317
4 - 7 YEARS	259
8 - 11 YEARS	185
12 - 16 YEARS	72
TOTAL	833

Source: Women's Refuge, c/o Caldmore Area Housing Association Ltd.

HEALTHCARE



Children needing health care are seen in a variety of settings:

- the primary health care service which includes GPs, midwives, health visitors, practice nurses, school nurses, pharmacists, dentists, opticians;
- the community paediatric service which provides largely secondary specialist paediatric care in a community setting and provides the main health services for children with developmental problems, disabilities; educational problems, children in need of protection or care and immunisation advice.
- the acute hospital which includes out-patients, accident and emergency, the assessment unit and in-patient wards

In this chapter we focus on three areas only: accident and emergency attendances, admissions to the paediatric assessment unit at Walsall Manor Hospital (to develop a picture of the problems presenting to the acute hospital), and screening which is an important part of the NHS Plan.

Accidents and Emergencies

This section looks at the numbers of Walsall residents aged under-16 attending Walsall Manor Hospital Accident and Emergency Department (A&E) from 1st April 1999 to 31st March 2000, and some of the causes for their attendance.

Attendances at A&E

Overall 13,712 children aged under 16 attended the A&E department at the Walsall Manor Hospital between 1 April 1999 and 31 March 2000 (Table 8.1). Overall 7,891 males attended A&E compared to 5,821 females. This does not represent all A&E attendance by Walsall residents: significant numbers go to New Cross, Wolverhampton, and Good Hope, Sutton Coldfield.

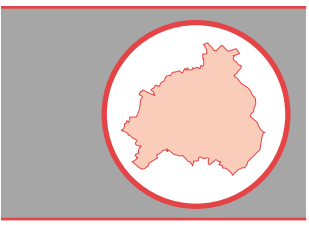
Completeness of reporting

There was some incompleteness in A&E records of diagnosis. Overall 21% of those attending Accident and Emergency had no diagnostic information recorded. Recording was lowest for the under-1s with nearly 40% of cases having no diagnostic information recorded. Although this may mean that nothing abnormal was detected, there is a category for "Nothing Abnormal Detected", and it cannot be assumed that absence of diagnostic information indicates that nothing was found. In the analysis below, only those cases with data have been considered, and readers should note this.

Table 8.1 **Attendances at Walsall Manor Hospital Accident and Emergency Department, by age group and sex, April 1999 - March 2000**

AGE GROUP	MALE		FEMALE		TOTAL	
	NO	%	NO	%	NO	%
< 1 YEARS	299	3.8	219	3.8	518	3.8
1- 4 YEARS	2378	30.1	1995	34.3	4373	31.9
5 -9 YEARS	2053	26.0	1411	24.2	3464	25.3
10 - 15 YEARS	3161	40.1	2196	37.7	5357	39.1
TOTAL	7891	100	5821	100	13712	100

Source: West Midlands Accident and Emergency Surveillance Unit



Diagnostic categories – common diagnoses

Table 8.2 shows the top 10 diagnostic categories for all age groups. Classification "diagnosis not classifiable" is reported but is not included in the ranking. These 10 categories plus "diagnosis not classifiable" accounted for 84% of males and 82% of females. A total of 20 other diagnostic categories made up the remainder. Overall the commonest diagnosis was laceration, with approximately twice as many boys as girls being diagnosed (1199 vs. 578). Soft tissue inflammation accounted for 13.9% overall, being slightly more common in the girls. Head injury was diagnosed in twice as many boys compared to girls (655 vs 361). Five of these diagnostic categories relate to injury.

Among under-ones, overall respiratory conditions were the commonest diagnosis at 23%. 14% of cases were discharged with "nothing abnormal detected" – the highest proportion of all the age groups. This indicates the role that the accident and emergency department plays in reassuring worried parents.

Among the age group 1 – 4, lacerations were the commonest problem (17.3%), followed by head injury (13.5%). Both diagnoses accounted for more boys than girls.

Among 5 to 9 years olds, again lacerations were the commonest problem (21.8%), with over twice as many boys than girls affected (407 vs 186). The second most common was soft tissue inflammation. Head injury, the third most common diagnosis, was also more likely to seen in boys than girls (169 vs 90).

Among 10 to 15 years olds, soft tissue inflammation was the commonest recorded diagnosis (22%). Lacerations were the second most common diagnosis, with well over twice as many boys than girls affected (405 vs. 155). Dislocations and fractures accounted for 11% of attendances, with nearly twice as many boys than girls affected (310 vs 159).

Table 8.2 **Attendances at Walsall Manor Hospital Accident and Emergency Department, ages 0-15, by top ten diagnoses, April 1999 - March 2000**

RANK	CONDITION	MALES		FEMALES		TOTAL	
		NO	%	NO	%	NO.	%
1	LACERATION	1199	19.1	578	12.7	1777	16.4
2	SOFT TISSUE INFLAMMATION	811	12.9	697	15.3	1508	13.9
3	HEAD INJURY	655	10.4	361	7.9	1016	9.4
4	DISLOCATION/FRACTURE /JOINT INJURY/AMPUTATION	541	8.6	355	7.8	896	8.3
-	DIAGNOSIS NOT CLASSIFIABLE	466	7.4	422	9.3	888	8.2
5	CONTUSION/ABRASION	472	7.5	330	7.3	802	7.4
6	SPRAIN/LIGAMENT INJURY	318	5.1	291	6.4	609	5.6
7	RESPIRATORY CONDITIONS	314	5.0	197	4.3	511	4.7
8	FOREIGN BODY	190	3.0	200	4.4	390	3.6
9	ENT CONDITIONS	178	2.8	133	2.9	311	2.9
10	GASTROINTESTINAL CONDITIONS	136	2.2	147	3.2	283	2.6

Source: West Midlands Accident and Emergency Surveillance Unit

Our Healthier Nation has a target to reduce the rate of serious injury from accidents in all ages by at least one tenth by 2010.

Road traffic accidents

Figure 8.1 shows that, of the 227 under 16s recorded as attending A&E due to road traffic accidences (RTAs), 52% were 10-15 year olds, and of these there were more boys than girls (72 vs 46). Males of all ages were more likely than girls to have an RTA recorded.

Complementary to Our Healthier Nation targets, the Government has set a target of a 50% reduction by 2010 of the number of children killed or seriously injured on the road compared to 1994-1998.[58] In Walsall in 1994-1998 the average number of children killed or seriously injured was 42, so a 50% reduction would be 21 by 2010.[59] The Road Safety Unit and others are working to achieve this with education, training, publicity and safer routes to school and the current trend is on target.

A useful summary of effective interventions to prevent childhood accidents. is contained in a Health Evidence Bulletin.[60]

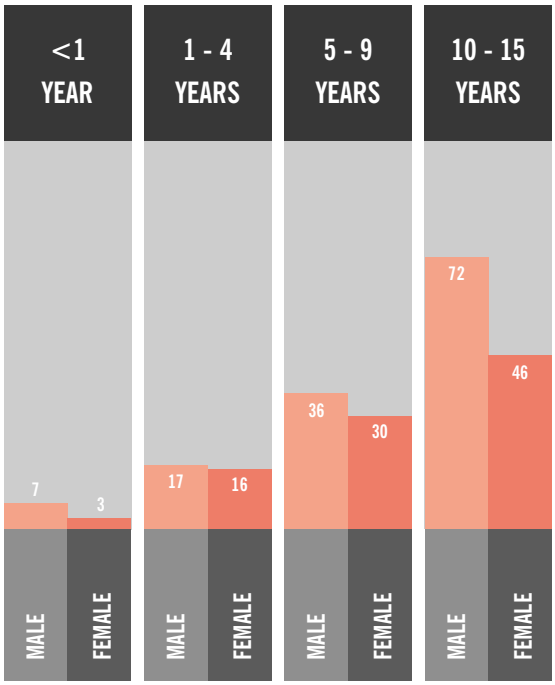
Time of arrival at A&E

The time of arrival data were only available for all patients seen at the Manor Hospital rather than Walsall residents only (Figure 8.2). However, the majority of cases were Walsall residents, and the proportions in each time band are unlikely to be significantly affected by inclusion of non-Walsall residents. Overall 76% of arrivals were between 8am and 8pm. Only 5% occurred between midnight and 8 am. Figure 8.2 shows that the main variation is that a higher proportion of those attending from midnight to 8am are aged under 5 years – although these are smaller numbers; while those aged 10-15, and to a lesser extent those aged 1-4, predominate during the day. Night attendance may reflect the incidence of respiratory problems at those hours. Higher daytime attendance by older groups reflects the high incidence of accidents in those age bands.

Planning for Minor Injuries Units should take account of this.

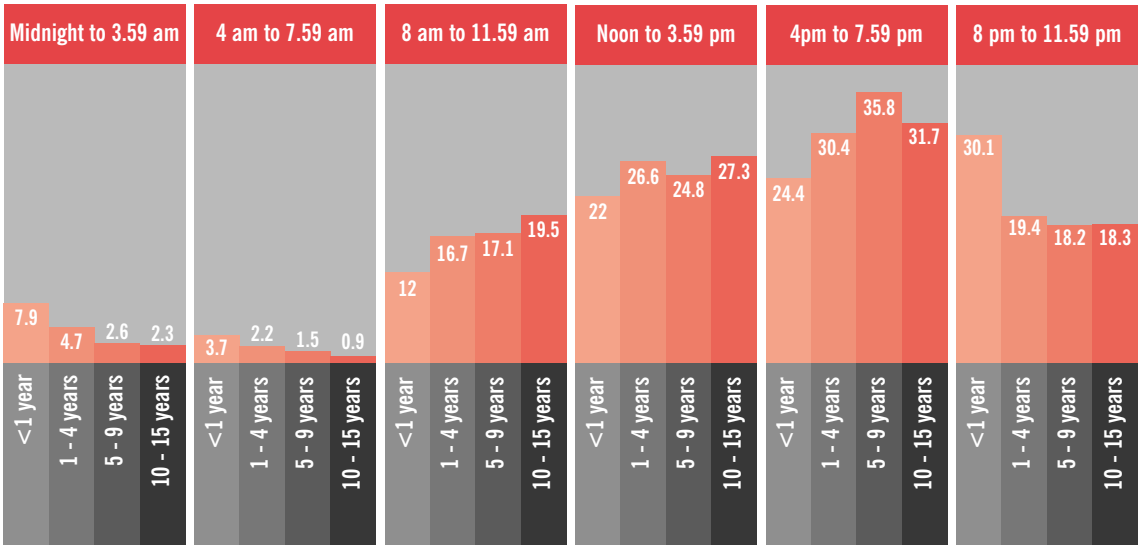
Figure 8.1

Attendances at Walsall Manor Hospital Accident and Emergency Department with Road Traffic Accidents, aged under 16 years, 1999 - 2000



Source: West Midlands Accident and Emergency Surveillance Unit

Figure 8.2 Percentage attendances at Walsall Manor Hospital Accident and Emergency Department, aged under 16 years, by time of arrival and age group, 1999-2000



Source: West Midlands Accident and Emergency Surveillance Unit

Outcomes from A&E attendance

Once again the data for outcomes from A&E attendance include a small proportion of non-Walsall residents. Overall 70% of attendances resulted in a discharge from A&E. 13% of attendance required admission to a ward, this being commonest in the under-1's, of whom 42% were admitted. 10% of cases were referred to other services. 5% of cases left A&E before treatment.

Admissions to Paediatric Assessment Unit (PAU), Walsall Manor Hospital

Children are usually referred to this specialised children's medical assessment and observation unit by their family doctor.

Age and sex

Children aged less than 1 year made up 38% of the admissions, and those less than 5 made up 83%. There were no significant differences in the age distributions for males and females. Overall slightly more males than females were admitted (52% vs. 48%).

Neonates (aged under 28 days)

The commonest reasons for admission in neonates were feeding problems (11 cases), problems specific to neonates including neonatal jaundice (6 cases), and respiratory problems (6 cases), and gastro-intestinal problems (5 admissions).

Children aged 28 days - 1 year

The commonest reasons for admission amongst the under-1s was respiratory complaints (95 cases, 33%) followed by gastro-intestinal problems (77 cases, 27%). Acute infections including tonsillitis made up 17% of admission to PAU (48 cases).

Pre-school (age 1 - 4)

Similar to the under-1s, the commonest reason for admission in pre-school age children was respiratory conditions (104 cases, 28%), followed by gastro-intestinal problems (99 cases, 26%) and acute infections (74 cases, 20%). 28 children (7%) were admitted with nervous problems including epilepsy and migraine, with smaller numbers admitted as a result of skin problems (17) and poisoning (15).

Age 5 - 9

In the 5 to 9 age group, acute infections including tonsillitis made up 28% of admissions (27 cases), followed by gastro-intestinal problems (24 cases, 25%) and respiratory conditions (22 cases, 23%).

Age 10 - 14

Of the 40 admissions in this age group 10 (25%) were related to nervous system problems including epilepsy and migraine. 6 admissions (15%) related

Table 8.3 Paediatric Assessment Unit admissions by age group and sex, September 2000 – August 2001

AGE GROUP	MALE		FEMALE		TOTAL	
	NO	%	NO	%	NO	%
(LESS THAN 1 MONTH)	18	4.1	19	4.7	37	4.4
<1 YEAR	158	35.7	131	32.2	289	34.0
1 - 4 YEARS	191	43.2	188	46.2	379	44.6
5 - 9 YEARS	49	11.1	48	11.8	97	11.4
10 - 14 YEARS	22	5.0	18	4.4	40	4.7
15 YEARS ONLY	4	0.9	3	0.7	7	0.8
TOTAL	442	100.0	407	100.0	849	100.0

Source: Audit department, Walsall Manor Hospital

to gastro-intestinal problems, and 5 (12%) to respiratory conditions.

15 year olds

Only 7 15 year olds were admitted to the PAU during the period investigated. Of these, 5 were admitted due to poisoning or toxic effects. The PAU does not admit persons aged 16 or over.

Acute Health Services for Children

The Kennedy Report[61] looked at children's heart surgery at the Bristol Royal Infirmary and drew wider lessons for the health services as a whole.

In relation to the care of children it recommended:

1. That children and their health care needs must be given higher priority in the NHS
2. Services should be child centred and well-led
3. Children in hospital must be cared for in a child centred environment, by staff trained in caring for children and in facilities appropriate to their needs
4. There should be greater integration of primary, community, acute and specialist health care for children
5. Children and their families should be fully included and involved in their care

In response to the inquiry the National Service Framework will adopt a modular approach and will start with acute services. These first standards are expected in 2002.

The West Midlands region is also developing standards for the care of critically ill children.

Child health screening

Screening for disease in childhood is interwoven with general maternal care, health promotion and child development services. The main aim is to prevent conditions that impair child development and accentuate inequalities.

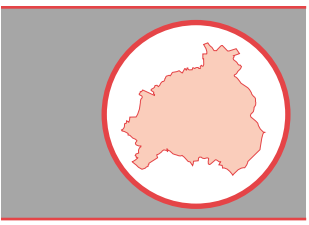
Antenatal and neonatal screening

The NHS Plan[38] says that by 2004 there will be effective and appropriate screening programmes for women and children including a new national linked antenatal and neonatal screening programme for haemoglobinopathy and sickle cell disease.

Down's Syndrome screening

A blood test that assesses the level of 2 substances (AFP and HCG) is offered to all pregnant women in Walsall at around 16 week's gestation. If this test indicates an increased risk of a baby with Down's Syndrome, then amniocentesis is offered. Termination of pregnancy is one option should the amniocentesis confirm Down's Syndrome. Counselling is provided throughout the process using leaflets and link workers so women and their families can make informed choices.

The uptake of the initial blood test at Walsall Manor Hospital is 58.4% (April 2000-March 2001). This excludes some tests sent directly by GPs.



In the year 2000 150 women had an amniocentesis at Walsall Manor Hospital (4% of maternities). 24% of these were due to maternal age, 73% due to a raised AFP/HCG result, and the others were for a previous abnormality or family history. 3 were confirmed positive for Down's Syndrome and the pregnancies were terminated. One miscarriage occurred after amniocentesis.[12]

There are varying screening and diagnostic tests for Down's Syndrome. The results of a large research project assessing which are the most useful are expected soon.[62] Walsall has recently appointed a specialist midwife who will lead the development of the Down's Syndrome screening programme in line with any national recommendations.

Meanwhile there is a growing private sector for screening for Down's Syndrome, which creates an inequity of service.

Haemoglobinopathy (thalassaemia and sickle cell disease)

In Walsall screening, in the form of a blood test, is selective and offered to ethnic minority women 10-16 weeks into pregnancy. If the mother is identified as a carrier, testing is offered to her partner with a view to offering pre-natal diagnosis. Although there is no formal neonatal screening programme for haemoglobinopathy in Walsall at the moment any at risk pregnancies not identified antenatally are followed up neonatally. The programme is overseen by the laboratory at Walsall Manor Hospital.

However the determination of ethnic origin is likely to be inconsistent and inadequate, leading to low coverage. Information on carrier status is neither well documented nor adequately shared with the services involved.

A national policy is expected in autumn 2002 which will set out how the programme should develop.

HIV

Confidential, voluntary HIV testing is offered to all pregnant women. Information and support are offered. Link workers are available as required. The programme has been running for about 1 year. The current uptake of the test is 65.7%, which means that there is some way to go to meet the national target of 90% by December 2002.[63]

Cystic Fibrosis

If there is a family history of cystic fibrosis, blood is taken from the baby's umbilical cord at birth.

Subject to the National Screening Committee's advice, the Government is preparing to develop a universal newborn screening programme for cystic fibrosis. 20% of Health Authorities are already offering this service. Walsall is waiting for detailed guidance before making changes to local services.

Metabolic diseases - e.g. phenylketonuria and hypothyroidism

These are screened for universally, using the heel prick blood test taken about 7 days after birth. Regular update sessions are held to ensure that all staff are competent in the policies and procedures.

Hearing screening

Walsall currently offers a targeted neonatal hearing screening programme to babies who are considered at high risk of developing hearing problems, i.e. babies admitted to neonatal units, babies with a family history of deafness, babies with particular illnesses.

In 2000/2001, 284 referrals were made to the targeted screening programme. (8% of births in Walsall Manor Hospital). 13% of these babies were not tested prior to discharge/transfer mostly because of lack of out of hours cover and late referral. 7% of babies referred failed the initial test, 3% went on to have further tests. No severe hearing losses were identified.[64]

All babies currently have a health visitor distraction test at about 8 months.

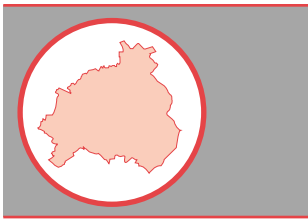
The National Screening Committee has recommended that the distraction test should be replaced by a universal neonatal hearing screening programme. The Department of Health expects that all PCT's will offer this by 2004/2005, and Walsall District Audiology group is working hard to develop its policies and procedures. Walsall plans to offer an integrated service with initial screening being performed in hospital before the baby leaves for home, with community screening available for those who for one reason or another got missed in hospital, and a centrally based follow up for babies who fail the test.

Young children

In the last decade the whole programme of screening in early childhood has been reviewed, and a comprehensive set of recommendations has been produced, which is known as 'Health for all Children 4'.[47]

The aim is to achieve a programme available to all, plus additional services targeted to those who need them. The community paediatric services and primary care teams in Walsall are working together to take this forward.

Glossary



Abortion
The expulsion or removal of an embryo or foetus from the uterus at a stage of pregnancy when it is incapable of independent survival (i.e. at any time between conception and the 24th week of pregnancy).

Acute infection
A rapid, sometimes severe, invasion of the body by harmful organisms

AFP
Alpha Foetal Protein

All central nervous system anomalies
All abnormalities of the brain and spinal cord

Anencephalus
Failure of development of the forebrain, its coverings and the skull. Most affected infants are stillborn, whilst the remainder usually die within hours of birth.

Antepartum fetal death
Death of a baby before the onset of labour

Atopy
An hereditary predisposition toward developing certain hypersensitivity reactions, such as hay fever or asthma, upon exposure to specific substances

Autism/autistic spectrum disorders
A disorder of childhood characterised by marked deficits in communication and social interaction

CESDI
The Confidential Enquiry into Stillbirths and Deaths in Infancy

Cleft palate / lip
A congenital fissure in the lip or roof of the mouth resulting from incomplete fusion of the palate during embryonic development

Conception
The entity formed by the union of the male sperm and female ovum

Confidence intervals
A statistical measure which gives a range of values within which we expect the true variable in question to lie with a given level of certainty, e.g. 95%

Congenital anomaly
A physical malformation, chromosomal disorder or metabolic abnormality which is present at birth

Cystic fibrosis
An hereditary disease that usually develops in early childhood. It is characterised by production of abnormally viscous mucus usually resulting in chronic respiratory infections and impaired pancreatic function

Diptheria
An infection of the upper respiratory tract, and sometimes the skin. Potentially fatal if untreated

Down Syndrome
A chromosome abnormality. Characteristics of these children include learning disability, narrow slanting eyes and short stature.

ENT conditions
Diseases of the ear, nose and throat.

Foetal toxins
Substances which have a harmful effect on the foetus

Gestation
The period of development in the uterus from conception until birth; pregnancy

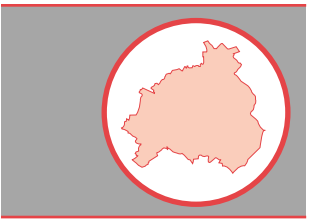
Haemoglobinopathy
A disorder caused by the presence of abnormal haemoglobins in the blood, e.g. sickle cell disease

HCG
Human chorionic gonadotrophin

Hib
A bacterial infection of young children which causes meningitis and respiratory infections

HiMP
The Health Improvement Plan is a local plan of action to improve health and modernise services. From 2002 they will be known as Health Improvement and Modernisation Plans

Hypertension High blood pressure
It is a major cause of heart attacks and strokes.



Hypothyroidism
Diminished production of thyroid hormone which can lead to low metabolic rate, tendency to weight gain and learning disability

Infant Mortality
Death in the first year following live birth; on or before the 365th day of life (366th in a leap year)

Infant mortality rate
The number of deaths under the age of 1 year following live birth, per 1000 live births per year

Inflammatory bowel disease
A chronic disorder of the gastrointestinal tract characterised by inflammation of the intestine and resulting in abdominal cramping and persistent diarrhoea

Intestinal infectious disease
Illness, often food-borne but sometimes passed from person-to-person, with vomiting and diarrhoea as the predominant symptoms

Intrapartum event
Event occurring during labour

Intrauterine growth failure
Babies that have failed to reach their growth potential during pregnancy.

Local Strategic Partnership
A non-statutory single body that operates at a level which enables strategic decisions to be taken. Includes health and local authorities but also the business, community and voluntary sectors.

Low birthweight
A child born weighing less than 2.5 kg

Measles
A viral infection whose main features are fever, rash and respiratory disease.

Meningococcal infection
An infection that may present as meningitis, septicaemia or both. Symptoms include fever, headache, neck stiffness and photophobia. There is a vaccine for meningitis C but, as yet, not for group B.

Mumps
An acute infectious disease characterised by fever and inflammation of the parotid gland.

Neonatal
Period of infancy between birth and 27 completed days of life.

Neonatal mortality rate
The number of deaths in the first 27 completed days of life per1000 live births per year.

Neural Tube Defect (NTD)
A group of conditions, including spina bifida and anencephaly, that arise from a failure of normal development of the central nervous system during the first few weeks of embryonic life.

Otitis media
Inflammation of the middle ear

Paediatric
The medical specialty concerned with the study and treatment of children in health and disease during development from birth through adolescence

Perinatal
Period of infancy between 24 weeks of gestation and six completed days of life

Perinatal mortality rate
Number of stillbirths together with deaths up to six completed days of life per1000 total births per year

Persistent offender
Denotes those who offend repeatedly. A small number of persistent offenders commit most of the crime; e.g. the Home Office estimates that five percent of young men are responsible for at least two-thirds of the offences committed by their age group

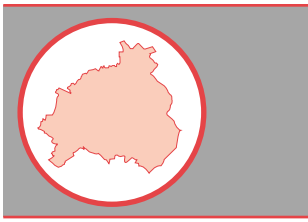
Pertussis (whooping cough)
An acute bacterial respiratory infection that can be severe in young infants

Phenylketonuria (PKU)
A genetic disorder in which the body lacks the enzyme necessary to metabolize phenylalanine to tyrosine. Left untreated, the disorder can cause brain damage and progressive learning disability as a result of the accumulation of phenylalanine and its breakdown products.

Polio
An acute viral infection of the nervous system which can cause paralysis and sometimes death

Prematurity
An infant born at a gestational age of less than 37 weeks

Renal Disease
Diseases relating to the kidney



Resident populations
Population residing in a defined geographical area

Rubella
A viral infection characterised by a rash and fever. Can cause birth defects if contracted by the mother in the first trimester

Screening
Screening aims to reduce the risk of disease, premature death or disability. Members of a defined group are asked a question or offered a test in order to identify those at risk of disease so further definitive tests can be offered. Prior to screening, people may be unaware that they have, or are at risk of, disease.

Sickle cell disease
A group of inherited disorders of abnormal haemoglobin which is more common in certain ethnic groups. It is characterised by anaemia and acute exacerbations called 'crises'

Small for stage of pregnancy (small for gestational age)
Babies are described as small for stage of pregnancy if their weight is less than the 10th centile on a growth chart

Soft tissue inflammation
Heat, redness and swelling of skin and muscle

Special educational needs (SEN)
A pupil is defined as having special educational needs (SEN) if he or she has a learning difficulty which requires special educational provision to be made. In most cases, it is the pupil's mainstream school that will make this provision

Spina bifida
An abnormality in the fetus which leads to the spinal column being imperfectly closed and results in the protrusion of the spinal cord. This can cause physical and learning disability

Statement of SEN
A statement specifies the special educational provision needed and the type of school the child should attend when the pupil's needs cannot reasonably be met by the school the child currently attends.

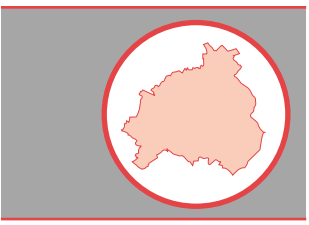
Stillbirth rate
Number of stillbirths per 1000 total births per year

Stillbirths
The legal definition in England and Wales is 'a child which has issued forth from its mother after the 24th week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life'.

Sudden Infant Death Syndrome (SIDS)
Sudden death of an infant or young child, which is unexpected by history, and in which a thorough post-mortem examination fails to demonstrate an adequate cause of death

Termination of pregnancy (TOP)
An abortion (see definition above) which is induced for medical or social reasons

Thalassaemia
A group of inherited disorders of haemoglobin metabolism. In its severe form regular blood transfusions are needed



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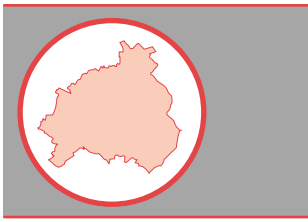

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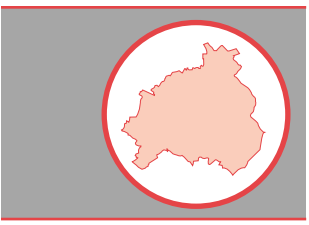

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