Office for Health
Improvement
& Disparities

Child health profiles and indicators

Summary of feedback exercise and response

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Introduction

Child health profiles have been published nationally since 2011 for each upper tier local authority in England. A 4-page summary gives a snapshot report of child health. Alongside the publication, an interactive version of the profiles is updated with new data throughout the year and includes a more extensive range of indicators for child and maternal health. Public Health England (PHE) produced these statistics until 2020 and carried out the 2021 survey. PHE was dissolved in September 2021 and responsibility for these statistics passed to the Office of Health Improvement and Disparities (OHID).

Thank you to all of those who took the time to respond to the survey about the content and format for future child health profiles and indicators. The exercise takes place at regular intervals to make sure that these outputs continue to meet the needs of users.

We have now reviewed the comments we received and will be using this information to shape the profiles in coming years. This report summarises the feedback we have received and the way that we intend to respond to the points raised in developing future child health profiles and indicators.

Methodology

The Child Health Profile User Survey took place between 3 August and 24 September 2021. A link was given on the home page for child and maternal health profiles on the Fingertips tool. An invitation to complete the survey was also included in the PHE Gateway Cascade and PHE Statistics bulletin. The survey had multiple choice and free text questions. There were 63 valid responses to the survey in 2021, with 25 of these respondents also completing the more detailed questions (38 opted to complete only the final questions and some respondents did not answer all of the questions). The responses are summarised below. All percentages are given as a percentage of all respondents irrespective of whether responders answered the question unless otherwise stated.

A summary of the questions asked in the survey is given at appendix 1.

General comments

The following section gives background to the profiles and our response to some of the more general points raised by users in their feedback.

Suggestions for additional indicators

While issues may be important in some local areas, the generalised nature of the child health profiles means that we cannot include information about all issues while maintaining a concise report. Additional indicators on a range of themes are available on the Fingertips tool. The interactive version of the child and maternal health profiles has been on Fingertips since 2016 and offers access to a wider range of indicators than those contained in the snapshot reports.

Timeliness of data

We always aim to use the most recently published data available at a national level. There is often a time lag between the data's collection and publication which can mean that data relates to events which occurred more than a year ago. On occasions, we use older datasets to ensure important health issues are not omitted because they are the best and most recent available for national reporting.

Geographical areas covered by the profiles

A small number of users have said that they would find it useful to have child health profile data broken down by smaller geographical levels such as wards. The snapshot reports have been specifically developed to meet the needs of those working at upper tier local authority level. This reflects the public health responsibilities which sit with these organisations and the way in which wider services which affect child wellbeing, such as education and social services, are often based on these boundaries.

A wider range of indicators by life course stage and in themed views, including clinical commissioning group (CCG) level data, are available in the Fingertips Child and Maternal Health section.

Some lower geographical level indicators are available through Local Health and National general practice profiles which now includes a domain for maternal and child health.

Disparities

Many suggestions asked for additional information to allow a better assessment of disparities for children who are looked after, entitled to free school meals or classed as

having known special educational needs and disabilities (SEND). In addition, some users asked for more segmentation of existing indicators, for example by ethnicity and language, particularly for Early Years Foundation Stage (age 5) and for speech, language and communication skills. Where data is available, information about disparities is already included in the inequalities data view for school readiness indicators in the Early years profiles in Fingertips. Which data is available varies depending on the indicator but does include data at an England level for deprivation, ethnicity, first language status, special educational needs status (SEN) and month born. All school readiness indicators include data about sex for England and upper tier local authorities.

Work is underway to identify where it may be possible to include further information about inequalities based on the current source data for indicators. Not all characteristics are available in all the relevant data sources for national reporting. Sometimes it is not possible to segment data further where information governance would require the data for many areas being suppressed to avoid disclosure of information about individuals. In addition, there is a risk of releasing small numbers in cross sections of data that might lead to personal identification. For these reasons, it is not always possible to provide more detailed breakdowns of data.

Providing the most relevant indicators

Respondents were asked to offer feedback on their main priorities for child health and also how useful they find individual indicators. This information is being considered, as well as overall feedback from the survey, alongside other sources of priorities such as OHID priorities and the NHS Long Term Plan. The profiles and indicators are modified over time to respond to changes in priorities, while continuing to represent the breadth of issues which are relevant to child and maternal health. Local Knowledge and Intelligence Services can also offer advice including how to access detailed data where local areas wish to consider issues in depth.

The Local Knowledge and Intelligence Service can be contacted using the emails below:

North East	LKISNorthEast@phe.gov.uk
North West	LKISNorthWest@phe.gov.uk
Yorkshire and the Humber	LKISYorkshireandHumber@phe.gov.uk
East Midlands	LKISEastMidlands@phe.gov.uk
East of England	LKISEast@phe.gov.uk
West Midlands	LKISWestMidlands@phe.gov.uk
London	LKISLondon@phe.gov.uk
South East	LKISSouthEast@phe.gov.uk
South West	LKISSouthWest@phe.gov.uk

Feedback on specific topics

As part of this year's exercise, we sought feedback on how users access and make use of the profiles, we proposed changes to the timing and frequency of updates and the methods used for the smoking at the time of delivery indicator. The questions covered specific indicators both in the interactive version and the snapshot reports. The following section summarises the questions asked in the survey, the feedback received from users and our response.

Ways to look at the data

Respondents were asked how they would prefer to view information about child health in their area (see appendix 1 question 15). They could choose as many responses as they agreed with from a list of six. Most respondents (90.5%, 57 respondents) chose 3 or more and (39.7%, 25 respondents) chose all 6 ways to look at the data (294 responses from 63 respondents).

The ability to look at trends over time was the most popular option (85.7%, 54 respondents), closely followed by the ability to compare and benchmark data across areas (84.1%, 53 respondents), look at visualisations of the data, such as graphs, maps and charts (84.1%, 53 respondents) and look at inequalities between population groups (81.0%, 51 respondents). Both remaining options were also popular (compare multiple indicators (68.3%, 43 respondents); and read a text summary and interpretation of the data for my area (63.5%, 40 respondents).

This indicates that all of the options currently available are valued. On this basis we will maintain a broad range of options, including the option to read a text summary and interpretation of data for each area (the snapshot report).

Activities

We asked respondents what they want to be able to do with the information from child profiles (6 options for activities as well as the option to add further suggestions in a free text box: 203 responses from 63 respondents). Answers to this questions will help inform decisions about the design of technology and formats for sharing data used in the future.

Most (74.6%, 47 respondents) wanted to browse data online. More than half wanted to download and save datasets (63.5%, 40 respondents), read a professionally formatted report on screen (54.0%, 34 respondents) or send a professionally formatted report to others (50.8%, 32 respondents). More than two out of five (42.9%, 27 respondents) wanted to print a professionally formatted report.

All respondents chose at least 1 of the 6 options. Almost two thirds of respondents (65.1%, 41 respondents) selected between 3 and 6 options. The results also suggest opportunities to build user awareness, confidence and skills, particularly around interoperable features to analyse data (33.3%, 21 respondents). The OHID local knowledge and intelligence teams who work to support the understanding and application of data and intelligence at a local level will consider this finding in developing the programme of support they offer.

Devices

Respondents were asked what devices they used to access the child health profile PDF reports (see appendix 1 question 17). They were given a choice of 4 devices and could choose as many as applied. The option to describe other devices was also given. Answers to this question will help inform decisions about the design of technology and formats for sharing data used in the future. Most respondents (98.4%, 62 respondents) used a desktop or laptop computer. A fifth (20.6%, 13 respondents) used either a mobile phone (12.7%, 8 respondents) or tablet (7.9%, 5 respondents), and just over 1 in 10 respondents (11.1%, 7 respondents) used a printed copy.

Most respondents (73.0%, 46 respondents) used just 1 device and a fifth (20.6%, 13 respondents) used two, with other respondents using 3 or more device types.

Uses

We asked respondents what uses they made of the Child Health Profile PDF reports. Five options were given, from which respondents could choose as many as applied. Respondents were also able to tell us about other uses in a free text box. The most popular uses for the Child Health Profile were to inform health and wellbeing reports (68.3%, 43 respondents), make presentations to stakeholders (66.7%, 42 respondents), inform business cases (58.7%, 37 respondents), prepare board reports (55.6%, 35 respondents) or to inform joint strategic needs assessments (JSNA) (49.2%, 31 respondents).

(11%, 7 of 63 survey respondents did not provide a reply to this question.) Respondents also told us they use the reports in various other ways to:

- benchmark local performance against other areas, view trends over time as a tool for service development and to provide other monitoring
- prepare for and support whole-system approaches such as for childhood obesity interventions
- shape health services in response to findings and inform integrated care system (ICS) and CCG priorities and planning

- commission and create service specifications
- inform safeguarding partnerships
- support schools to plan curriculum provision

Most (65.1%, 41 respondents) use them in 3 or more ways. More than a third (34.9%, 22 respondents) described 5 or 6 uses. The profiles are intended for use by local government and health service professionals to understand the needs of local communities, improve the health and wellbeing of children and young people and reduce health inequalities. The responses indicate that the profiles are used to understand these needs and inform local planning.

Overall usefulness of child health profiles

Users were asked to rate the overall usefulness of the snapshot reports. Levels of satisfaction in the profiles are high (table 1). Around 9 in 10 respondents (88.8%, 56 of 63 survey respondents) rated the overall usefulness of the child health profiles 2021 as "very useful", "useful" or "quite useful" and more than half of respondents described them as “very useful” (52.4%, 33 of 63 responses). More than half of respondents provided comments which noted the usefulness of the profiles and described how they informed local planning and service improvement.

Table 1: overall usefulness of the snapshot reports (comparison of 2019 and 2021 feedback exercises)

Percentages in this table only are percentages of those who answered the question rather than of those who completed the survey. They are rounded to the nearest whole number. This is for consistency with the method used in reporting findings from 2019.

Response	2021	2019
Very useful	54% (33 responses)	52% (43 responses)
Useful	28% (17 responses)	37% (30 responses)
Quite useful	10% (6 responses)	10% (8 responses)
Not very useful	Fewer than 3 responses	Fewer than 3 responses

(Fewer than 5 of 63 survey respondents did not provide a reply to this question or answered 'don't know'.)

Frequency and timing of future updates to the child health profile snapshot reports

In the optional detailed section of the survey we asked "Do you object to the decision to update Child Health Profiles PDF reports every other year?" Three fifths who provided a response for this question (60.0%, 15 of 25 respondents) told us that they would not object to the decision to update the snapshots every other year, while 28.0% (7 of 25 respondents) would object. This represents a shift from the last survey when most users (59 out of 82 responses) thought that the annual update should continue.

(12.0%, 3 of 25 survey respondents who opted to complete the detailed survey did not provide a reply to this question.)

In addition to the votes (Yes/No), we received 14 comments on the decision to delay the next update of the reports to March 2023. Many of the comments received were nuanced and complex to analyse:

Of those respondents who said they would not object, 10 out of 15 provided comments. Of these comments, 4 were unconditionally positive and 6 were positive but with conditions or reservations (usually that access to timely underlying data updates continued).

Of those respondents who said they would object, 4 out of 7 provided comments. Of these 3 were unconditionally negative. Possible mitigation was suggested such as a shortened, simplified data summary.

The nature of all 14 comments can be divided into three broad categories:

Most comments (10 of 14) featured the importance to users of ongoing, accessible, timely annual data updates for example to inform planning, commissioning and evaluation for the short and longer term

Some comments (4 of 14) mentioned COVID -19 and 2 of these specified the need for considered analysis of the impacts of on children and families while others focussed on the urgency with which this information is required

A few responses pointed out that some people who normally rely on the snapshot profile format may require additional support or help to gain new skill sets to access the same data from the alternative sources

Concerns were mostly around timeliness of data and access to relevant information to inform recovery from COVID-19. As noted in the feedback survey, the pandemic is likely to make it difficult to make meaningful statements about trends for many indicators which are

due to be updated in 2022 (data for 2020 to 2021), especially for those indicators based on hospital admissions. Some updates to source data such as for school readiness and conceptions have also been delayed by the pandemic, meaning that it will not be possible to update them in early 2022. The commentary and interpretation included in the snapshot reports is the main difference between these and data which will continue to be available and updated in the interactive Fingertips version. The delay should also increase our capacity to carry out detailed and more targeted analysis of the potential impact of the pandemic on the health and wellbeing of children, young people and families.

Proposals about a new source and method for the existing smoking in pregnancy indicator

Respondents were given an opportunity to read a brief proposal to move away from the Smoking at time of Delivery (SATOD) dataset to a new Maternity Services Dataset (MSDS) source and method for the existing national and local smoking in pregnancy indicator. The published indicators based on this would be quarterly indicative statistics at CCG level and annual indicator production at CCG, local authority and other geographies, potentially to include primary care networks and integrated care systems.

The majority (76.0%, 19 of 25 detailed respondents (5 did not respond to this question)) agreed with the proposal. Positive comments mentioned a preference for the richness of the MSDS as the new data source for the indicator, using the opportunity to streamline data collections, and confidence that any issues identified to begin with will be addressed.

Most respondents who commented raised concerns about short term data quality in MSDS, but half of those who did this also welcomed the change as an opportunity to stimulate improvement in the longer term.

Respondents also requested early sight of any differences between indicators as this would be useful to communicate early to stakeholders and elected members. It was pointed out that areas may have set local key performance indicators (KPIs) using CCG data from the current data source and will need to adjust them accordingly. A concern was expressed about the impact of out of area bookings and the possible impact on indicators, depending on whether data is based on patient registration or residence and whether the data is aggregated for CCG or local authority. Such issues as well as a potential shift in SATOD values for many areas, with values unable to be published for a small number of areas, have been anticipated. For this reason, we plan to run both methods alongside each other for a year to allow local areas to explore the reasons for the difference before the requirement to submit aggregate figures is removed.

Summary of detailed feedback

About two fifths (39.7%) of respondents completed the optional detailed section of the survey (25 of 63 respondents).

Usefulness of specific indicators

We currently provide child health indicators across a broad range of topic areas in the child and maternal health profiles in the Fingertips tool. Child health profiles distil information from across a wide range of subjects that are relevant to sustaining and improving child health and wellbeing. The range of specialists who refer to Child health profiles is also broad. Respondents (24 out of 25 respondents who completed the detailed section of the survey) told us whether each of 31 indicators listed in the survey (Appendix 2: indicators in the 2021 survey) was "Very useful", "Useful", "Quite useful", "Not very useful", or "Not useful at all".

Satisfaction levels with indicators in the 2021 survey was high, the majority of detailed respondents telling us that indicators are either very useful or quite useful (range 80.0 % to 96.0%, across all 31 indicators in the survey) and only 9 indicators being judged "Not useful at all" by a small proportion (usually less than 5%) of respondents. For this reason, we will be retaining the current complement of existing child health profile indicators in the snapshot reports.

Suggestions for improvement and requests for additional information

At the end of the survey, users were given the opportunity to offer more general suggestions for improvement or request additional information. These suggestions are noted below together with our response to the points made (table 2).

Table 2: Detailed suggestions received and our response

	Feedback	Response
1	Add indicators about COVID-19 such as the number of hospitalisations including for systemic inflammatory response syndrome (SIRS) and indicators for long COVID.	Specialist tools have been set up to help monitor COVID-19 elsewhere such as: UK Summary coronavirus (COVID-19) in the UK COVID-19 Health Inequalities Monitoring for England (CHIME) tool Wider Impacts of COVID-19 on Health (WICH) monitoring tool To avoid duplication, we will seek to signpost these resources where appropriate.
2	Provide more information about variation in child demographics (across different local authority areas)	Where it is appropriate to make comparisons between areas, such as around life expectancy, demographic information is included in the Fingertips tool, including in the Child and maternal health profiles. The inequalities tab within the tool breaks indicators down into different demographic groups such as age, sex, ethnicity and deprivation where data is available to do so. There is guidance available for users about how to use Fingertips. Further detailed demographic

	Feedback	Response
		data is available from the Office for National Statistics.
3	Add more data about vulnerable children and safeguarding issues which may increase during COVID-19 recovery. A measure of levels of adverse childhood experience may be difficult to produce but would be very welcome.	To maintain a concise report, we are unable to include such detailed information about this important issue in the snapshot reports. There is, however, detailed data in the Children and young people's mental health and wellbeing profile, with various indicators about children known to be experiencing abuse or neglect in its Primary prevention: Adversity section. In 2020, work on a public health-informed approach to vulnerability in childhood considered adverse childhood experiences and the data available around childhood vulnerability more generally. As part of this, a narrative report about improving health outcomes for vulnerable children and young people has been developed for each upper-tier local authority. The reports summarise data and evidence at local authority level to support decision-making and prioritisation.
4	Provide indicators on speech, language and communication (formally assessed capability levels) across a wider range of ages, including early years and foundation stages	We currently provide indicators about speech, language and communication or related topics for children age 2 to 2 1/2 years and at the end of reception in the Early years profile. Where data is available, information about disparities is already included in the inequalities data view for school readiness indicators in the Early years profiles in Fingertips. Which data is available varies depending on the indicator but does include data at an England level for deprivation, ethnicity,

	Feedback	Response
		first language status, special educational needs status (SEN) and month born. All school readiness indicators include data about sex for England and upper tier local authorities. The equivalent data to create specific speaking, listening and communication skills indicators is not published for Key Stage 1 and Key Stage 2. Speech, language and communication needs assessment reports have been developed on the Fingertips platform. They give an indication of the needs of children in the area, by bringing together a range of relevant data and evidence on demographics, prevalence and some of the risk factors for each upper tier local authority.
5	Use data from ASQ assessments carried out by health visitors to measure child development milestones at two to two and a half years. We would like to be better at tracking speech and language development, particularly because of the impact of COVID-19 and the ASQ data could help with this.	ASQ data underlies the aggregate data used to create 6 existing developmental indicators at local and national level including Child development: percentage of children achieving the expected level in communication skills at 2-2½ years. These indicators are based on data collected from local authorities on a voluntary basis through an interim national reporting process for universal health visiting services and in the Early years profiles. In the future data for statistics will be drawn from ASQ data submitted to NHS Digital's Community Services Dataset (CSDS). A 2021 report illustrated some potential advantages of the more detailed CSDS data

	Feedback	Response
		source: Experimental statistics investigating disparities in early child development.
6	Include information about physical activity.	Since the content of the snapshot reports was last reviewed, an indicator of the 'Percentage of physically active children and young people' has been added to the Public Health Outcomes Framework (PHOF). Three years of annual data up to 2019 to 2020 is now available through Fingertips. This is next due to be updated in March 2022. We will consider how this can best be incorporated into the interactive version of the profiles, as well as future snapshot reports.
7	Provide information about the degree to which local children and young people have access to greenspace or outdoor space	Potential data sources have been considered to produce a suitable indicator about child wellbeing and access to outdoor space (see Technical Appendix: Measuring mental wellbeing in children and young people - an indicator guide) but no suitable dataset has been identified as the basis for routine, timely indicators at a local authority level on this topic. Data is currently only available to publish information at a national level. Should such data become available in the future for local authorities, we will investigate the creation of indicators for inclusion in the child and maternal health profiles.
8	Provide information for children who are obese between the ages of 11 and 18 and for early years (such as body mass index (BMI) at two and a half years).	We recognise the importance of healthy weight in childhood, but we are unaware of a current nationally available dataset which we could use as the basis

	Feedback	Response
		of indicators for all local authorities other than those already published based on data from the National Child Measurement Programme for reception and Year 6. While there is information in the Health Survey for England at a national level, the sample sizes do not allow the publication of data for smaller geographical areas. Should such data become available in the future, we will investigate the creation of indicators for inclusion in the child and maternal health profiles.
9	Include information about feeding status on discharge from midwife or on day 5 as this would show those who have actively started breastfeeding as opposed to babies put to the breast after delivery which is not the same as breastfeeding initiated. Midwives collect this data.	We currently publish information on babies who receive breastmilk for their first feed. While midwives may collect and record data at other points locally, this is not routinely available at day 5 from a national data collection such as the MSDS. This may become available in the future.
10	Provide longer-term breastfeeding rates as we know there is a big drop off at 6 to 8 weeks.	Data is published on a quarterly and annual basis for breastfeeding at 6 to 8 weeks for local authorities and England. We are unaware of a current nationally available dataset which we could use as the basis of indicators for all local authorities which cover breastfeeding rates at older ages but this may become possible in time as more data is collected routinely through the digital child health record. Should such data become available in the future, we will investigate the creation of indicators for inclusion in the child and maternal health

	Feedback	Response
		profiles in the Fingertips tool. Work is also underway to conduct an Infant Feeding Survey following the commitment made by government in Advancing our health: prevention in the 2020s. The survey will provide valuable information on infant feeding behaviours including breastfeeding, the use of foods and drinks other than breastmilk in infancy and other related matters for England. The intention is for data collection to begin in 2022. A final report on the findings is anticipated in 2024.
11	Include more information about referrals to children's and adolescents' mental health services (CAMHS), such as those offered by local trusts and CAMHS services	We recognise the importance of mental health and especially promoting good mental health and mental wellbeing as children and young people are developing. For more specific information about this, please refer to the children and young people's mental health and well-being profile which includes three indicators in the Services section. One of these is New referrals to secondary mental health services, per 100,000 children under 18 years (<18 yrs). Caveats in the definition explain some of the difficulties in providing more exact data such as that requested nationally.
12	Include information about prevalence of maternal mental health difficulties	OHID is working to develop prevalence estimates of perinatal mental health problems. This is looking at prevalence of existing (that is with onset before pregnancy) and new mental health problems (common mental disorders (CMD), post-traumatic stress disorder (PTSD), serious mental

	Feedback	Response
		illness (SMI), eating disorders and personality disorders) for mothers from pre-conception until 2 years post birth to align with the NHS long term plan. It is hoped the work will be completed in 2022.
13	Include some more crime data for children and young people under 18 or between 18 and 24.	While data is available for England, we are unaware of a current nationally available dataset which we could use as the basis for indicators on such topics for all local authorities.
14	Include information about smoking status at time of 'booking' or in early pregnancy (up to 12 weeks), in addition to smoking status at time of delivery.	For reasons of space it is not always possible to include all the indicators that are relevant to each subject area specifically in the summary child health profile snapshot. We will, however, continue to include data for at least one indicator about smoking in pregnancy. An additional indicator for smoking in early pregnancy is already included in the pregnancy and birth indicators in the interactive profiles.
15	Include information about dental registrations.	We are unaware of a current nationally available dataset which we could use as the basis of such indicators for all local authorities. Should such data become available in the future, we will investigate the creation of indicators for inclusion in the child and maternal health profiles in the Fingertips tool.
16	It would be useful to include the statistical neighbours' average value or range	By using the interactive profiles, users can select "compare areas" from the data view and choose the "Area", "Area type" and "Area Type to group by" through the recently updated geographies menu on the top ribbon to compare local authority results to their

	Feedback	Response
		CSSNBT nearest neighbours and compare CCG results to the 10 most similar CCGs. (Remember to tick the box on the right above the display table for the cross-area view to activate the selection.) More detail of options are available in the Fingertips Introduction (user guide) and as new developments are announced on the Fingertips home page, which also provides a simple jump off point to other profiles.
17	Include more intelligence on health-related behaviours of school-age children such as drinking, smoking and drug taking. Encourage the development of robust surveys on children's health behaviours similar to the Health Survey for England or Annual Population Survey to cover under 16s or under 18s too. Consider how consistent questions in school health-related behaviour questionnaires might help create comparable data for local areas.	Local authority level data on self-reported alcohol use from the What About YOUth? survey is available on the Fingertips Health behaviours in young people profile. We are unaware of a more recent nationally available dataset which we could use as the basis for indicators on such topics for all local authorities but recognise the value of comparable data around young people's health behaviours. We understand the importance of collecting data efficiently which can inform local benchmarking and seek to encourage the establishment of common standards, definitions and the addition of specific questions about children and young people's health when opportunities arise. Data is published at a national level for smoking, drinking and drug use by NHS Digital in the Smoking, drinking and drug use among young people in England survey.
18	Make a spreadsheet of all the data by local authority easy to access	A range of download options are available. More details are available in the Fingertips

	Feedback	Response
		Introduction (user guide) and as new developments are announced on the Fingertips home page.
19	Offer more supporting materials such as an online tutorial on how to select and compare specific areas.	More details about using Fingertips are available in the Introduction (user guide). A beginner's guide to using Fingertips API is available.
20	When selecting a new indicator, the area defaults to the North East region. It would be good if the area filter could be fixed to save having to reselect it.	Thank you for this feedback which we will consider as part of ongoing improvements to the Fingertips tool.

Conclusions

The findings from this survey will be used to inform the development of child health profile snapshot reports in the future as well as the interactive child and maternal health profiles on the Fingertips tool. Dates for future releases are given on the statistics release calendar.

Appendix 1: summary of survey questions

Introductory questions

All respondents were asked the introductory questions (grouped questions 1 to 4):

Which area of England do you work in?

Respondents were given the following answers to choose from:

East Midlands

East of England

London

North East

North West

South East

South West

West Midlands

Yorkshire and the Humber

National

Which of the following best describes your work?

Respondents were given the following answers to choose from:

Public Health England (national)

Public Health England (centre)

local authority

central government

NHS provider

NHS commissioner

NHS England

professional body or regulator

charity or voluntary sector

academic or research institution

other, please specify

Which are your top 3 priorities for child health?

Respondents were given the following answers to choose from, with the option to select no more than 3:

accidents and injuries

alcohol use

breastfeeding

child development

childhood obesity

child poverty

drug use

immunisations

long-term conditions

mental health

oral health

sexually-transmitted infections

smoking

teenage pregnancy

other, please specify

Respondents were then given the choice to:

- tell us in a little more detail what you think of the indicators in the profile and how we calculate them, or
- jump to the final questions in this survey

Questions about indicator usefulness

Respondents who contributed a detailed response (grouped questions 5 to 11), were asked to describe each indicator as either very useful, useful, quite useful, not very useful, or not at all useful. A full list of the indicator titles for which responses were sought is provided in Appendix 2.

In addition, detailed respondents were asked:

> Is there any additional information we should include in the profiles?
>
> Do you have any other suggestions about how the profiles could be improved?

Questions about the decision to delay the next snapshot report

Only detailed respondents were asked:

> Do you have any comments on the decision to delay the next update of the reports to March 2023?
>
> Do you object to the decision to update Child Health Profiles PDF reports every other year?
>
> Please give reasons for your answer.

Questions about proposals for a new source and method for the existing smoking in pregnancy indicator

Only detailed respondents were asked (grouped questions 12 to 14):

> Would you like to read a brief proposal about a new source and method for the existing smoking in pregnancy indicator and answer some questions about this proposal?
>
> Do you agree or disagree with the proposed change in source and method for the national and local SATOD indicator?

Do you anticipate any specific concerns with the proposed changes?

Any other comments about the proposed changes?

Final questions

All respondents were asked (grouped questions 15 to 20):

Thinking about the Child Health Profile PDF reports and the interactive version of the profiles, how do you prefer to view information about child health in your area?

What do you want to be able to do with the information?

What device(s) do you use to access the Child Health Profile PDF reports?

What do you use the Child Health Profile PDF reports for?

How useful have you found the Child Health Profiles 2021?

What benefits do you think the Child Health Profiles bring to your work?

Appendix 2: indicators in the 2021 survey

List of indicators for which responses were sought in the detailed section of the survey:

1. Infant mortality rate
2. Child mortality rate (age 1-17 years)
3. MMR vaccination for one dose (2 years) DTap / IPV / Hib vaccination (2 years)
4. Children in care immunisations
5. Children achieving a good level of development at the end of reception
6. GCSE attainment: average Attainment 8 score
7. GCSE attainment: average Attainment 8 score for children in care
8. 16 to 18 year olds not in education, employment or training
9. First time entrants to the youth justice system
10. Children in relative low income families (under 16 years)
11. Households with children homeless or at risk of homelessness
12. Children in care
13. Children killed or seriously injured (KSI) on England's roads
14. Low birth weight of term babies
15. Obese children (4-5 years)
16. Obese children (10-11 years)
17. Children with experience of visually obvious dental decay (5 years)
18. Hospital admissions for dental caries (0-5 years)
19. Under 18 conceptions
20. Teenage mothers

21. Admission episodes for alcohol-specific conditions - under 18s
22. Hospital admissions due to substance misuse (15-24 years)
23. Smoking status at time of delivery
24. Baby's first feed breastmilk
25. Breastfeeding prevalence at 6-8 weeks after birth
26. A&E attendances (0-4 years)
27. Hospital admissions caused by injuries in children (0-14 years)
28. Hospital admissions caused by injuries in young people (15-24 years)
29. Hospital admissions for asthma (under 19 years)
30. Hospital admissions for mental health conditions
31. Hospital admissions as a result of self-harm (10-24 years)

The online profiles have 33 indicators, but the list above is shorter (31) because:

- responses for 2 immunisations indicators (MMR vaccination for one dose (2 years) and DTap / IPV / Hib vaccination (2 years)) were combined and
- one indicator (Children in absolute low income families (under 16s)) is available online but not in the snapshot reports. The companion indicator, Children in relative low income families (under 16 years), was included

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