

Overall findings and implications and opportunities for action



In this section...

Overall findings:

- Summary of key findings from the 10 high-level indicators
- How London is different from the rest of England
- Inequalities within London – geographical and by population groups

Implications and opportunities for action:

- Implications for strategic and partnership work
- Additional opportunities for change within different types of service/interventions

Introduction

As London boroughs prepare for the changes envisaged in *Every Child Matters* and develop greater integration through *Children's Trust* arrangements, it is imperative that we focus on planning and investing in actions which will help reduce the health inequalities experienced by London's children. New national policies present an important opportunity for organisations to work together in more co-ordinated ways to improve health outcomes. This requires investment in action to improve the determinants of health and not taking too narrow a 'lifestyle' approach.

A basis for both this report and for *Every Child Matters* is the need for good evidence to underpin policy and practice. It is worth remembering that children are experts in their own lives, and that the ECM documentation views the genuine participation of children, young people, parents, carers and families as crucially important.

Inequalities in health expose unacceptable levels of difference in life chances for children and young people living in the UK, and differences even for those living within the same city. However, the very existence of differences between boroughs and groups is evidence that things do not have to remain the way they are. We need to investigate further the key success factors in areas where good progress is being made relative to other areas so that we can implement 'what works' more widely. Sharing information on effective or promising practice is important. We also need to maximise the opportunity to use Health Impact Assessment of wider policies at local levels to include a focus on young people's health and health inequalities.

Inequalities in health develop insidiously, and need time to be put right. Not all of the indicators in this report are susceptible to fast change. However, there is some cause for optimism. Naming and identifying problems is the first step to solving them. We need to tackle the causes of avoidable ill health at root. That entails a focus on poverty, deprivation and action to improve the wider determinants of health for children.

Intervening in childhood and adolescence can save lives and close the health gap. Moreover, so long as interventions to reduce inequalities are well designed and well delivered, they can provide benefits in the here and now for children and parents, as well as promoting change later.

Key findings

Key findings from the 10 high-level indicators

Unemployment – indicator 1

Over 40% of all children in London and over half of children in inner London are living in poverty. Child poverty is strongly associated with being in a household without an adult in employment.

Unemployment and ethnicity – indicator 2

Overall in London, a third of Black and Minority Ethnic children live in households without an adult in employment. However, there are significant differences within London. For example, only 11% of Indian children live in 'workless' households, compared with 20% of white children.

Educational attainment – indicator 3

Generally, children are not performing as well in London at GCSE level as they are nationally, although this masks variations across London. In terms of the Key Stages, while Key Stage 1 results are less

good overall than national rates, performance at Key Stages 2 and 3 are improving. Even so, the results for inner London are 10% below the nationally expected levels.

Housing – indicator 4

England's ten worst local authority areas for overcrowding are all in London, and some minority ethnic groups are at particular risk for overcrowding. Children and families living in temporary accommodation are at risk of a whole range of health problems, including unintentional injury.

Crime – indicator 5

Southwark, Westminster, and Hammersmith and Fulham have the highest rates of youth victims of crime. In 2004-5, young people accounted for 21% of the accused in London – the same as the previous year. The boroughs with the greatest numbers of youth accused are Westminster, Bromley, Haringey, Croydon and Lewisham.

Air Quality – indicator 6

Indications for 2004 are that the daily mean PM₁₀ limit was exceeded at a number of sites throughout London. The NO₂ annual mean objective continues to be breached, but at fewer sites than in 2003. The ozone objective was also exceeded, but mainly at sites in outer London.

Road Traffic Accidents – indicator 7

In 2004, there were 4,200 child casualties on London's roads, although there have been decreases since the early 1990s.

Life expectancy at birth – indicator 8

Life expectancy in London in 2001-3 was 76 years for men and 81 for women, which is similar to England as a whole. Life expectancy is closely related to deprivation and there are

differences between London boroughs; more deprived boroughs had a shorter life expectancy than less deprived boroughs.

Infant mortality – indicator 9

The infant mortality rate for London was 5.7 per 1,000 births in 2001-3. The rate was higher in Southwark, Hackney, Brent, Haringey and Newham and lower in Kingston, Wandsworth, Barnet and Bromley. A major cause of infant mortality is being born too small or too early.

Self assessed good health – indicator 10

The percentage of those aged 10-14 reporting good health was similar in London (90%) to England as a whole (91%). The percentage of those reporting good health drops as young people get older, in both London and in England as a whole. There are differences between inner and outer London, with young people in inner London less positive about their health.

Overall findings

How London is different

When taken as a whole, London's performance is **similar to or better than** the rest of England on the following indicators:

- in London the proportion of people aged 15-19 who reported their health as good was similar to but slightly higher than the proportion in England (83.6% compared to 82.3%)
- for the younger age group (10-14 years), the proportion reporting good health in London was similar to but slightly lower than the proportion nationally (89.8% compared to 90.7%)

- life expectancy in London is similar to life expectancy for England as a whole
- the infant mortality rate in London (5.7 deaths per 1,000 live births) is similar to the UK rate of 5.5 per 1,000; but this is higher than most other European countries
- GCSE performance is similar to the national average, with 53% of children achieving five or more GCSEs with A* to C grades compared to 54% nationally
- around 84% of people aged 18-24 are in employment or full-time education in London, which is just above the national average (although London has the lowest proportion of people in employment compared to those in education)
- in 2004, child casualty rates on London's roads were lower than the rate for Britain as a whole – 2.6 casualties per 1,000 people under 17 years, compared with the national rate of 3.6 per 1,000
- children and young people in London had the highest fruit and vegetable consumption of any English region in 2002
- children aged 5-10 years have similar levels of mental health problems to children elsewhere in the country
- young Londoners report lower levels of alcohol consumption than young people in other regions and are considerably more likely to report that they never drink.
- London's workless households with dependent children accounted for one in five of all such households in England, with inner London having higher rates than any English region
- about 24% of dependent children in London live in households where no adults are in employment, compared with 18% nationally
- educational attainment in London at Key Stage 1 is lower than elsewhere in England with performance below the national average on reading, writing and mathematics
- 28.5% of all dependent children in London were living in overcrowded conditions in 2001 compared with the England and Wales average of 12.3% – all ten of England's worst local authority areas for overcrowding are in London
- teenage pregnancy rates are higher in London and, unlike elsewhere in England and Wales, do not show a reducing trend
- in 2003, conception rates for girls under 18 years were 21% higher in London than England, and London had the highest conception rate for girls under 16 years
- diagnoses of sexually transmitted infections continue to rise, and gonorrhoea rates in London were approximately double the England rate in 2003
- overall rates of mental disorder among children aged 5-15 years are higher in inner London than elsewhere in the UK, and were particularly high for boys aged 11-15 years

When taken as a whole, London's performance is **worse than the rest of England** on the following indicators:

- rates of illicit drug use in London remain consistently higher than in other regions in England and Wales.

London boroughs (from 7.4% to 32.7%), with outer London boroughs tending to have better performance in this area

Inequalities within London

Geographical variations

Looking at London's overall performance on health helps with identifying some issues, but masks the considerable variation that occurs within the capital in terms of both health determinants and health outcomes. Borough-level data and, where available, ward-level data, are presented in Sections 3 and 4 of this report and some of the differences between areas are summarised below. In particular, this highlights an ongoing divide between inner London and outer London on many issues.

- The proportion of young people in London reporting that their health is good varies between boroughs. For 10 to 14 year olds, the proportion ranged from 83% to 93%, and for 15-19 year olds the proportion ranged more widely from 71% to 89%.
- There are wide inequalities in life expectancy within London. At borough level, average life expectancy is closely related to levels of deprivation, which is a feature of many areas in inner London. However, previous reports have shown that there are also pockets in more prosperous outer London with low life expectancy.
- Infant mortality rates continue to vary between London boroughs and low birthweight (a major cause of infant mortality) is more than twice as high in some London boroughs than others.
- The proportion of young people who are not in full time education or employment varies widely across

- There are large differences in children's risks of being in a workless household, with inner London children at far greater risk in most cases than those in outer London
- The proportions of 15 year old children achieving five or more GCSEs at grades A* to C range from 40% to 68% across London boroughs. Key Stage 3 performance was close to the national averages for English, mathematics and science in outer London, but inner London results are around 10 percentage points below national levels
- The proportions of children living in overcrowded housing are significantly higher in inner London than in outer London
- Emergency hospital admissions for children under one year old are highest in Hackney and lowest in Havering. For those aged between one and nineteen years, emergency admission rates are highest in Hackney, as before, and lowest in Kensington and Chelsea
- Teenage conception rates in London boroughs range from the lowest in England – found in the boroughs of Richmond and Harrow – to the highest which is found in Lambeth. Teenage conception rates vary both between and within boroughs, and are clearly related to deprivation
- There is currently a lack of borough-level data on several health issues, including childhood obesity, which is linked to both short- and long-term health problems.

London's BME communities

The 2004 *Health in London* report had a specific focus on the health of London's Black and Minority Ethnic communities. Much of the information in last year's report is still current and many of its conclusions remain relevant. The full report can be found at <http://www.londonhealth.gov.uk/hinl2004.htm>

The findings below are summarised from elsewhere in this report and supplemented by a few from last year's report. They highlight the ongoing existence of inequalities between communities' access to health determinants and continued differences in communities' experience of health issues.

- In London in 2001, Black African young people were the most positive about their health, followed by Indian young people. Those reporting less positively on their health were young people who identified as Black Caribbean or Black Other.
- Maternal and neonatal outcomes are worse for women from disadvantaged, vulnerable or excluded groups. Country of birth data shows that the babies of mothers born in Pakistan had an infant mortality rate double the overall rate. Stillbirths and perinatal death rates were also significantly higher (*Health in London*, 2004).
- There are striking disparities between ethnic groups in terms of the numbers of workless households with dependent children, with one third of all of London's BME children living in a workless household compared to 19% of White children.
- There are significant differences in children's risk of being in a workless household between BME communities, with 11% of children of Indian ethnicity living in a workless household compared with 49% of children of mixed White and Black backgrounds.
- Among those aged under-25, unemployment was highest for the three Black groups (as recorded in the 2001 Census), with nearly one third of under 25s within each group being unemployed (*Health in London*, 2004).
- There are major differences in the educational attainment of different ethnic groups. In addition, native English speakers have higher attainment at each stage of school than those pupils registered as EAL (English as an additional language) which includes the majority of Indian, Pakistani, Bangladeshi and Chinese pupils in England (*Health in London*, 2004).
- Some ethnic groups are more likely to experience overcrowding in housing than others with, for example, Bangladeshi households more than five times more likely than White British households to be living in overcrowded conditions. Over half of Black African households, two fifths of Other Black households, and 38% of Pakistani households live in overcrowded conditions.
- In London, two thirds of Bangladeshi children and two thirds of Black African children were living in overcrowded housing, and rates for Mixed White and Black African, Pakistani, Other Asian and Other Black children were all over 40%.
- Ethnic minorities in Britain are at substantially increased risks of

burglary, vehicle crime and street crime (*Health in London*, 2004).

- There is currently a lack of data on the prevalence of some health issues within certain BME communities in London.
- Cigarette smoking in London is highest amongst Turkish, Bangladeshi and Irish men. Smoking rates are often, but not always, low among women in BME groups – for example only 1% of Bangladeshi women smoke (although one fifth use chewing tobacco) compared to up to 59% of Turkish women and 39% of Irish women.

Disabled children and young people

The 2003 *Health in London* report had a specific focus on the health of disabled people. As with the 2004 report, and much of the information in this the 2003 report is still current and many of its conclusions remain relevant. The full report can be found at <http://www.londonshealth.gov.uk/hinl2003.htm>

This year's *Health in London* report has not identified significant new information on disabled Londoners in relation to the indicators considered, which partly reflects the ongoing lack of reliable data on disability issues, particularly among children and young people.

However, the 2003 report highlighted that disabled Londoners fared worse on all the indicators for which relevant information was available, and a trawl of a wider range of information sources indicated that they fared worse in other dimensions too. In relation to children and young people, the 2003 report noted that there was a lack of data on the educational achievements of disabled children and limited information about disabled people's experience of

education, although one survey showed that 40 per cent of disabled people felt that teachers underestimated their ability.

Gender issues

There are differences in health-related behaviours and in health outcomes for boys and girls, although data are not available on some measures. However, some of the differences we are aware of include those summarised below:

- Life expectancy is higher in females than males
- Between the ages of 5-15 years, 19% of boys and 17% of girls eat five or more daily portions of fruit and vegetables, but in older young people (aged 16-24), more females (22%) eat the recommended five portions than males (19%)
- Rates of mental health disorders are higher among boys than girls in London, with rates among 11-15 year olds more than twice as high
- Rates of Chlamydia diagnoses have risen significantly over the last decade, with rates for girls aged 16-19 showing the steepest rate of increase
- In London there is a marked gender difference in smoking rates, with more secondary school girls aged 11-15 smoking than boys (11% and 7% respectively).

Implications for action

Planning children's services within the new structures and partnerships being developed under the ECM agenda should be better for children's well-being in the long term, with an increased focus on meeting needs and reducing inequalities right across the spectrum of services. However, in the shorter term, this makes for complex planning and relationship building, and the need to achieve multiple targets within and across organisations adds to the complexity of the situation.

In this section, we start by identifying overall recommendations for these strategic and partnership approaches to children and young people's health, before going on to identify additional opportunities for achieving change within specific types of service or intervention.

The London Health Commission and Mayor of London remain committed to influencing and co-ordinating partnership action on health at the regional level, and to supporting action at a local level. Local partnerships and leaders are also encouraged to consider ways in which they can take action to improve the health of London's children and young people and to reduce inequalities. In doing so, it is worth referring to the recommendations in previous *Health in London* reports as well as those described below; and in particular taking note of those related to ethnicity and disability highlighted in the reports which gave more detailed consideration to these areas.

Cross-cutting implications for action

Local councils, health and social care services, community and voluntary organisations and LSPs all have an important part to play in improving the well-being of children and young people

in London and in improving public health. A key challenge is to identify and make best use of the expertise, experience and opportunities each sector brings and to clearly demonstrate the relevance of the health agenda to their core business and responsibilities.

The cross-cutting implications for partnership action described below relate both to making best use of *structures and processes* for the planning and delivery of interventions, and ensuring the *content of programmes and interventions* is more appropriate and effective.

1. Listening effectively to children, young people and their parents.

What children and young people say about their health, their health services and their lives is evidence which is often undervalued and under-used. More consultations are taking place, but without use being made of the information and ideas generated, they risk provoking scepticism or cynicism in young citizens.

There have been a large number of consultations in London, some of which are referenced in this report, and **good use should be made of information and opinions already provided by children and young people.** In addition, there is likely to be benefit in a further study to synthesise some of the data from these, **and identify ways of tracking changes arising from consulting children.**

From April 2004, NHS Trusts have administered a parent survey and this will be followed by efforts to seek children's views directly. There is an opportunity to **refine performance management mechanisms to assess the whole loop – from seeking views, planning changes involving children, to making changes, monitoring them and**

seeking views on them from those affected. Incentives to act on what we learn from patients and users may be the most effective way to make sure that they are seen, heard, and responded to.

2. Tackling health inequalities

In planning, commissioning and delivering programmes for children and young people, there is a need to **focus on actions which will help reduce health inequalities in London** including:

- Investing in action to improve the determinants of health and not taking too narrow a 'lifestyle' approach
- Maximising opportunities to use Health Impact Assessment of wider policies and plans at local and regional levels to include a focus on the impact on children and young people; including, for example, planning for the Olympics
- Investigating further the key success factors in areas where good progress is being made relative to other areas
- monitoring and evaluating the effectiveness of both new and more established interventions, with a clear focus on routine collection of data on equalities dimensions, and ongoing involvement of children and young people.

3. Joint work between local authorities and primary care

Children and Young People's Plans (CYPPs) are being developed by local authorities with partners in *Children's Trusts*. Where the local authority is not responsible for a service whose work is included in the plan, the governance arrangements will need to be robust enough to ensure that the plan paints the full picture of how services are

working together to address outcomes for children and young people. The ability to **secure agreement to the widest possible scope for the CYPP and the necessary alignment with other plans** will be a key test of the effectiveness of *Children's Trusts*. Most authorities are expected to be working with partners through Children's Trusts by 2006, and all by 2008.

Joint planning with the Primary Care Trusts (PCTs) is crucial and PCTs' *Local Development Plans* should be consistent with the CYPP. The Public Health White Paper *Choosing health: making healthy choices easier* makes clear that the Government expects PCTs to be fully involved in the CYPP planning process.

One of the principles for local target setting in the *Health and Social Care Standards* and in *National Standards, Local Action* which sets out a planning framework for health and social care, is that **local primary care targets are developed in partnership with other NHS bodies and local authorities**. *National Standards, Local Action* also strongly endorses taking account of the needs of children and young people in local planning, and emphasises the **importance of considering National Service Frameworks (NSF), including the NSF for Children, Young People and Maternity Services, in local planning**. The NSF for children and young people is fully embedded in the outcomes framework developed for *Every Child Matters: Change for Children*, and the standards cannot be achieved without working with the local authority.

4. Supporting community involvement

The voluntary and community sectors (VCS) have a critical role in promoting child health and reducing health inequalities. Not only do many voluntary

Local planning for children and young people's services – some key features and opportunities for change

1. The NSF and the *Every Child Matters: Change for Children Programme* will provide opportunities for innovation and for the delivery of health care and health promotion in different settings. PCTs may wish to think in terms of what health input they can make to different settings, for example children's centres, extended schools, colleges or residential children's homes. The Strategic Health Authority (SHA) also has a role in shaping the CYPP. The *Teenage Pregnancy Strategy* is a good example of joint planning with the health service.
2. Arrangements will also need to be made to capture in CYPPs the key elements of the following plans, to ensure consistency with the strategies of other statutory partners:
 - a. The local police authority's *Three Year Strategy Plan* and local policing plan.
 - b. The statutory annual *Youth Justice Plan* prepared by the local multi-agency Youth Offending Team
 - c. The *Probation Area Annual Plan*, based on the *Business Plan of the National Probation Service for England and Wales*.
 - d. Crime and Disorder and Misuse of Drugs and Alcohol Strategies
3. *School Development Plans* will show how schools contribute to positive outcomes for children and young people. Schools are the only universal service all children have contact with most days of the week. Schools will play a key part in delivering services for children and young people, with their role in the prevention and protection agenda crucial to its success. They will need to work closely with *Children's Trusts* preparing and delivering the CYPP.
4. Other plans which need to be consistent with the CYPP are LSC local strategic plans for 14-19 education, the *Child and Adolescent Mental Health Strategies*, the *National Healthy Schools Programme* and play strategies. In addition, any planning documents on community safety, traffic, transport, culture, leisure, sports, open spaces, fire and rescue services and the wider public realm need to be taken into account insofar as they affect children and young people.

organisations have the specialist knowledge, skills and networks to reach communities and groups which find statutory bodies inaccessible, but services provided by the VCS are frequently perceived to be more inclusive and less stigmatising. Community-led responses to health issues can be very effective in meeting the health-related needs of different groups, as highlighted in the recent report on the VCS contribution to promoting mental health in BME communities (Mayor of London / African and Caribbean Mental Health Commission, April 2005).

In addition, previous *Health in London* reports highlighted the importance of **working with individuals and communities to understand different perspectives on health and illness**, and the recommendations in these reports remain relevant. The 2004 report identified the need for further work with London's BME communities to identify their own experience and expertise in dealing with health issues, increase our understanding of community-led responses to health issues, and to learn about culturally-determined approaches to improving health and responding to illness. The 2003 report pointed out the importance of working with disabled people, within the context of the social model of disability, to better understand and respond to their experience of health-related issues. Joint work with community-based organisations can increase the opportunities for this type of community engagement in health issues.

Despite the value offered by the community and voluntary sectors, however, VCS organisations frequently struggle for an equal status in planning and commissioning processes. Furthermore, many VCS organisations, especially the smaller ones, do not have the capacity to sustain their services in a

climate of short term funding and competitive tendering where price is the primary consideration. **London boroughs and NHS organisations need to individually and collectively review their working relationships with the VCS to ensure that the long term value they can offer is fully realised.**

5. Evidence-based policy and practice

The evidence base for effective public health policy and practice is growing and **all partners involved in developing and delivering children and young people's services should be encouraged and supported to make effective use of existing evidence.**

The incorporation of a Centre for Public Health Excellence into NICE in April 2004, and the work of the former Health Development Agency [http://www. publichealth.nice.org.uk/page.aspx?o=home](http://www.publichealth.nice.org.uk/page.aspx?o=home) are supporting ongoing work to provide evidence based (or evidence informed) guidance. NICE is currently developing guidance on obesity, for instance, and the new guidance on depression in children will be helpful to those trying to improve mental health and emotional well-being (NICE, 2005). Recent LHO reports on smoking, sexual behaviour and nutrition, physical activity and obesity provide some suggestion of what may work, although we need more well-tested interventions to ensure that we are doing more good than harm.

The EPPI Centre at the University of London Institute of Education provides evidence-based reports in health promotion and education (see <http://epi.ioe.ac.uk/EPPIWeb/home.aspx>) and the Child Health Research and Policy Unit at City University has a range of tools for practitioners wanting to use evidence, to access evidence summaries,

to assess how ready their organisation is to use research evidence, or to use a project planning tool to assist in planning which draws on research evidence. All of these can be found at www.whatworks-forchildren.org.uk

The data in this report provide ways in which local areas can have access to figures to enable them to benchmark progress. They add to the evidence base, and by demonstrating where things are going well, can help us to build on it. Differences across different parts of London and between diverse ethnic groups suggests that, as well as addressing problems, **we need to focus on what appears to be working well and identify approaches and interventions likely to support change in other settings.** To give an example from this report, Black African young people were the most positive of all groups about their health, followed by Indian young people.

6. Improving data and information on diverse communities

Routine NHS and local authority information systems do not enable us to look in sufficient detail at the differing prevalence of health and related needs in different communities across London. In addition, many data sets in public services use continue to be deficient in their attention to routinely collecting accurate information on equalities domains, including ethnicity and disability. And in spite of the mainstreaming of ethnicity monitoring in some settings, there are still few or no data on children's health from primary care sources, and ethnicity is still not recorded at birth and death registration.

Although there are some local analyses of health-related need (eg. based on health surveys or around individual general practices or hospitals), our

main sources of detailed information across London often have to be based on the most severe manifestation of illness or need, for example when people are admitted to hospital, or die, or when child protection procedures are initiated.

It is anticipated that the *Health in London* report series will, over time, produce important trend data for looking at changes that are happening in London. In addition, it is hoped that the planned London boost to the *Health Survey for England* will enable more data on lifestyle factors to be collected at borough level and below, and will enable trends to be monitored closely. Longitudinal studies such as *RELACHS* in East London provide an opportunity of understanding the health and health needs of minority ethnic populations living in disadvantage, and their value increases over time as they start to demonstrate where we are improving, and where we are doing less well.

However, **more attention needs to be given to building routine collection of equalities data into systems intended to monitor and evaluate services and other health interventions.** Previous *Health in London* reports considered the data needs in relation to race and disability in more detail and highlighted the importance of improving the evidence base in these areas. For example, the 2004 report on Race and Health recommended that:

- the statutory requirements associated with the *Race Relations (Amendment) Act 2000* should be used to provide a framework for and focus on increased monitoring and use of information about ethnicity

- ethnic categories should be defined as clearly and accurately as possible by those collecting information for research and service planning, enabling more focused approaches to establishing health needs and challenging health inequalities
- better links need to be established between qualitative and statistical information, at London-wide and local level.

The 2003 report on disability and health demonstrated the lack of even the most basic data in many areas related to impairment and disability. It highlighted the need for further data on the experience of disabled people in relation to the determinants of health and access to services.

In addition, this year's report demonstrates that we need to know more about the number and circumstances of vulnerable children and young people in relation to health, including those who are 'looked after', in prison or secure accommodation, and those with mental health issues. Looking on a case-by-case basis to learn what might be done differently in working with children at risk, much as currently happens in the Confidential Enquiries, may provide scope for learning and change.

We also need to know more about why some housing types, and some roads, some communities and some schools are apparently more accident prone than others. This may involve collecting data on near-accidents and averted accidents as well as the accidents which actually happen; and should include using what is already known more effectively.

Additional opportunities for action in specific service areas

Strategic change as outlined above should, in time, help partnerships to

achieve real improvement in front-line services and in the experience of children and young people living in different communities. Better collection, analysis and use of information can, and should, be used to influence decisions about resource allocations and service delivery, resulting in more effective targeting to improve the health of London's diverse communities, including those experiencing multiple deprivation.

In the remainder of this section, we highlight some additional opportunities to improve the health and well-being of London's children and young people through specific types of service and intervention. It is not intended that this be seen as an exhaustive list of areas or opportunities, rather as illustrative of the wide range of opportunities that exist for action at local levels.

7. Early years services/interventions

Reducing children's health inequalities starts with supporting parents. Parents who are healthy at the start of pregnancy generally have healthier babies. **Promoting better health for all, including those who may become parents**, is an effective way of reducing infant mortality in the long run. We need to focus on reducing smoking during pregnancy (and reducing children's exposure to second-hand smoke), improving the nutrition of women of child bearing age, providing high quality NHS services before, during and after birth and increasing breastfeeding initiation.

Infant mortality is influenced by a wide range of factors including ethnicity, socio-economic circumstances and access to appropriate health care. Higher than average mortality rates have been found in babies whose mothers were born outside England or Wales, young mothers, babies whose fathers were in

the routine and manual social class, sole-registered babies, and babies born in deprived areas. This illustrates the importance of not only focusing on health behaviours, but also **supporting interventions aimed at reducing poverty and increasing access to employment and opportunities for parents.**

8. Youth services

Both *Every Child Matters* and the recent *Youth Matters* green paper acknowledge the importance of play, recreation and leisure. **Being able to play freely and safely and having 'places to go and things to do'** consistently come up as top priorities for children and young people themselves. Adult policy makers and planners have not generally reflected these priorities and we have created an unsafe, unfriendly public space environment in too many settings for far too long.

Play and leisure not only promote physical health (more opportunities for activity being linked to obesity reduction) but are critical for promoting emotional health and well-being. Children in more deprived areas are particularly limited in their access to safe spaces and more attention needs to be given to **ensuring that provision is inclusive so that disabled children have equal access to independent play and leisure.** Work is already being developed through GLA guidance on developing local play strategies and the London Parks and Green Spaces Forum agenda, but this needs to be much higher up our agenda if we're genuine in our commitment to reflect the concerns of children and young people.

Much greater consideration must be given to the health of 14-19 year olds / teenagers who may have specific issues related to sexual health, teenage

pregnancy, crime and the fear of crime, mental health, nutrition, smoking, alcohol and drug use. In addition, evidence suggests that health behaviours that are laid down in adolescence are maintained into adulthood and influence lifelong health (Viner and Barker, 2005). Building an efficient health service for the future should include greater attention to securing adolescents' active engagement with their own health, but there is much to be done to achieve this goal.

The same age group is sometimes failed in the transition between children's and adult services and the most vulnerable of all, who may be leaving care, begin to feel the impact of yet more health damaging experiences such as unemployment or homelessness. More work is needed to **ensure that the "Growing up into adulthood" standard of the NSF is delivered** and that this group's specific needs are given more attention by all agencies not directly discussed in this report.

There are continuing concerns about the health and well-being of young people in the youth justice system with mental health and substance misuse problems being a particular concern. Work is already being undertaken under the auspices of the Youth Justice Board and there are links with the LHC development of an emotional well-being framework for children and young people in London. It will be important to **ensure that young offenders' needs are specifically addressed in these initiatives and that Youth Offending Teams are an integral part of the planning process.**

9. Education

Existing frameworks, such as *'Stand Up for Us'*, published by DfES can help to **improve the experience of young people in schools.** It covers

homophobic bullying, sex and relationships education and various measures to improve social inclusion. There is a need to continue to seek to better understand, build on and make use of information about why some children and young people are better able to benefit from education opportunities than others. For example, one factor which could be further explored is the experience of those who have succeeded in moving out of low attaining groups in education.

We know that one factor associated with doing well at school after a disadvantaged start in life is having a parent who takes an interest in a child's schooling. Current initiatives are already working to further promote this in London, and there is a need for **ongoing work to learn from and improve initiatives to support parents' engagement in their children's education**. The concept of lifelong learning clearly has implications for having an impact on employment, and given the importance of parental interest in a child's education in improving educational outcomes for children, may have an impact there too.

Attaining the National Healthy Schools Standard is an important goal for all schools by 2009. Understanding the mutual benefits of improving a child's health and education is an important aspect of the programme, and could lead to whole school and whole community approaches to child and family health. An important implication for action is for local stakeholders to get together to take action on promoting healthy eating in schools. The LHC *Healthy Young London* campaign has taken the lead on this by facilitating 'round table' events in four boroughs to identify opportunities and barriers to such joint initiatives.

10. Health and social care services

Access to interpreting and translation support is regularly highlighted as a major issue impacting on BME communities' access to services and information. Ongoing work to secure appropriate access to these services for BME communities is essential, and the LHC's Language Support Services Project is aiming to improve provision of services across public sector organisations, as well as increasing the employment opportunities these services offer within communities.

There is great scope to **reduce inequalities in the availability and experience of health services for children when they are ill**. Hospital admission rates have been falling in London and elsewhere. Hospitals are not the best places for ill children unless they need very specialist support. Given that going into hospital is disruptive for children, young people and families, opportunities are already being explored across London for different ways of looking after children when they are ill, and preventing the disruption to child and family life that happens when they are admitted. Further work is needed to explore the potential to further reduce hospital admissions.

For those children who do need to spend time in hospital, there are a number of issues which they have identified as needing attention to improve the hospital environment and the experience of children and families during hospital stays. There is some evidence that more progress has been made in listening to children than in responding to what they tell us (Curtis et al, 2004). Priorities for change among children and young people consulted in London in 2001-2 (Liabo et al, 2002) included:

- increasing the provision of age-appropriate facilities and resources
- providing continuity of care in both primary and secondary settings
- minimising problems and disruption associated with moving from child to adult services
- improving waiting facilities in Accident and Emergency departments to reduce exposure to others' illness or injury as well as violence, drunkenness and anti-social behaviour
- ensuring hospitals are accessible to disabled children
- increasing cleanliness in those hospitals where this continues to be a cause for concern.

In addition, **measures to safeguard children from abuse and exploitation** are integral to promoting current and longer-term health outcomes. Health organisations have a critical role in this and should be working alongside social services in both prevention and intervention. Services designed to support families not only have a role in preventing family difficulties but can also be part of overall strategies to promote health and well-being. Supporting parents is a crucial element of promoting the health of children. Ensuring that children and young people who are at risk of abuse or exploitation are identified and provided with appropriate support is a collective responsibility of all agencies. An example of the differential response between organisations and between boroughs was highlighted by a recent Barnardo's report on the needs of young people at risk of sexual exploitation across London (Harper & Scott, 2005).

It is essential that the health needs of children and young people requiring short- or longer-term care by local authorities are identified and met, with a focus on promoting continuity of health-related provision wherever possible. We know, for example, that children in care were five times more likely to have a mental disorder than other children and that many 'looked after' children have needs related to mental health (see Section 2 of this report for more detail). Work at both local and regional levels to plan and provide health service for London's children needs to take account of the specific needs of this group of Londoners.

11. Housing

Poor quality or temporary housing has implications for children's health in relation to accidents and infectious diseases and also for their emotional, behavioural and educational development. Temporary accommodation disrupts continuity of access to a wide variety of services, including primary health care. The number of families with dependent children and pregnant women in bed and breakfast accommodation in London has been falling, and this needs to be maintained.

There is much that still needs to be done to **maximise the health benefits known to be associated with good quality housing provision**. The London Health Commission has produced a briefing about opportunities to improve health through housing policy and practice (LHC, October 2005), supported by a web-based summary of evidence about health and housing conditions. A report from Health Bulletins Wales on Housing in 1998 lists (with evidence) a whole range of ways in which safety could be promoted through housing interventions <http://hebw.uwcm.ac.uk/healthyenvironments/Chapter11.html>

12. Planning and regeneration

Transport, environmental and play policies in London are likely to make at least as great a contribution to reducing deaths in London as the NHS. Urban planners are increasingly concerned with the safety of the built environment, green spaces and designing out crime. The Mayor's *London Plan* sets out a wide range of policies and proposals intended to improve the physical environment and quality of life in London. The Plan is supported by guidance intended to **support and influence planning-related activity in a wide range of key areas related to health** and more information on planning issues can be found at on the GLA website at <http://www.london.gov.uk/mayor/planning/key-documents.jsp>

One of the greatest opportunities for reducing deaths amongst less well off children is likely to lie with deaths from injury. Whilst motorists sometimes complain about being criminalised through speed cameras and speed limits, these are effective ways of preventing deaths. It is likely that the **20 mph zones** would be suitable for implementation over the majority of the borough road network and, if installed, would have the potential to make large casualty savings.

Moving to **air quality** and its effects on child health, there is work underway at regional level, including the Mayor's work to progress implementation of a Low Emission Zone which will limit the access of the most polluting lorries, buses and coaches to London's streets, and work to progress the Taxi Emissions Strategy, which will make all 20,000 London cabs meet the most stringent emission standard currently available. In addition, the Mayor continues to support and appraise the London boroughs' Local Air Quality Management work,

which identifies and addresses local pollution hotspots. (For a summary of this LAQM work see http://www.london.gov.uk/mayor/environment/air_quality/boros.jsp). For those wishing to monitor their local data, information can also be found at www.londonair.org.uk.

It is also **essential that planning and regeneration initiatives actively support ongoing work to improve access to employment for all**, including parents and carers. Good quality affordable childcare for those who want it, flexible working arrangements, wider access to educational opportunities for those parents who missed out on their education the first time round, and ensuring that young people can take employment and educational opportunities will provide a sound basis for eliminating child poverty by 2020. Initiatives such as the LDA's '*Diversity Works*' programme and the LHC's '*London Works for Better Health*' are seeking to address inequalities in access to employment and related opportunities.

