Education Select Committee Inquiry: Child Well-being in England

Written evidence submitted by the Royal College of Paediatrics and Child Health

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EXECUTIVE SUMMARY

1. The Royal College of Paediatrics and Child Health (RCPCH) welcomes the improvement in the UK's overall ranking of child wellbeing in the UNICEF Innocenti Report Card 11 (the Report Card); however the RCPCH also notes that this improvement must be taken with caution, acknowledging that the data only captures the start of the economic downturn, and therefore may not be a true representation of the health wellbeing of children in England today.

2. Despite apparent improvements, the UK falls behind several European neighbours on various indicators of wellbeing, stressing a need for greater investment in the health and wellbeing of children and young people from conception, through infancy to young adulthood. Conversely, these findings highlight the potentially devastating impact of recent austerity measures and fiscal policies which have significantly reduced the health and social support provided to vulnerable children and families in England.

3. Members of the Inquiry Panel is asked to acknowledge and respond to the following:
   - Recognition of the persisting effect of maternal age as a risk factor for premature death and reduced wellbeing throughout childhood and adolescence.
   - Provision of high quality school-based sexual and reproductive health education as well as universal access to affordable and appropriate reproductive health services across all communities.
   - Sustained investment in and expansion of universal and targeted support services for parents during pregnancy and the first weeks and months of life.
   - Further investment in population-level and targeted initiatives to reduce smoking rates during pregnancy.
   - Introduction of evidenced-based policy and legislation to reduce incidence of road accidents involving children and young people.
   - Investment in programmes and support for harm minimisation in the home and community.
   - Priority be given to ensuring sustained investment in the prevention, early intervention and appropriate timely treatment for mental health issues during childhood and adolescence.
   - Continued recognition of the importance of reducing childhood obesity though implementation of policy recommendations outlined in *Measuring Up: a 2013 report from the Academy of Royal Colleges.*
   - Introduction of comprehensive health promotion programmes in schools and communities which aim to drive healthier behaviours and which collectively tackle mental health and wellbeing, social and emotional health, and drug and alcohol use.

PART ONE: LEAGUE TABLE OF CHILD WELL-BEING

Dimension 2: Health and safety

Health at birth (infant mortality and low birth weight)

4. The UNICEF report card recognises health at birth as an important measure of child wellbeing. Although more research is needed to better understand the differences in infant mortality between the UK and

better performing countries, the authors acknowledge that these differences are likely to be due to variations in the commitment by each country to protect every mother and child in the earliest days and weeks of life rather than a lack of fundamental public health provisions. The 2013 Child Health Reviews - UK (CHR-UK) report *Overview of child deaths in the four UK countries* prevents a similar hypothesis, suggesting that some child deaths could be prevented, assuming there are modifiable factors related to children's environment or in the way their family or health services care for them.

5. The CHR-UK report found a persisting effect of young maternal age as a risk factor for death throughout childhood. Results showed that children born to mothers less than 30 years of age were an increased risk of death compared to mothers aged 30-34 years; this association was independent of birth weight but closely linked to social disadvantage. The data also showed that although children born to mothers aged under 20 years had the highest risk of death, there were many more deaths in children with mothers aged between 20-25 years and 25-29 years, highlighting the importance of interventions not only targeted at those at the highest risk, i.e. very young mothers, but to all mothers under 30 years, particularly those most disadvantaged in our society[1].

6. The UK has a significantly higher teenage pregnancy rate compared with other European nations; a statistic also noted in the Report Card. Compared with a European average of 2.7 per cent, the UK is reported to have a teenage pregnancy rate of over five per cent[2]. Additionally, teenage fertility is one of the few indicators in the Report Card where the UK has not shown an improvement in the past ten years. This should send a clear message to policy makers regarding the importance increasing the knowledge, skill and capacity for young people in the UK to make informed decisions in relation to their reproductive health. This will only be achieved through a commitment to the provision of high quality school-based sexual and reproductive health education as well as universal access to affordable and appropriate reproductive health services across all communities; particularly those with high rates of teenage pregnancy.

7. Given the high proportion of young mothers in the UK, investment in targeted early intervention programmes, such as the Family Nurse Partnership (FNP), which aims to improve the knowledge, skills and capacity for healthy pregnancies and positive early parenting must continue. The programme is currently offered to women under 20 years of age, however given that women up until 30 years appear to also carry an increased risk of infant mortality, consideration should to be given to how this programme could be expanded to meet the needs of all young women deemed to be at an increased risk of poor child health outcomes.

8. The universal Health Visitor Programme (HVP) is also an important resource for families, providing parents and children with structured health assessments and interventions during the first 2.5 years of life. This universal offering, however, must also have capacity to act as a platform for comprehensive assessment and referral of a child and family where a need for additional support is identified. While current expansions to both of the FNP and the HVP are welcomed, governments and local authorities must also ensure that these programmes receive sustained investment and that the universal offering of the HVP is not comprised as a result of reduced local budgets.

9. Smoking during pregnancy is recognised as one of the most important preventable factors associated with adverse pregnancy outcomes[2], including low birth weight, a measure which the Report Card indicates could be significantly improved in the UK. Data shows that whilst smoking rates in the UK are declining, infants from deprived backgrounds more likely to be born to mothers who smoke, and to have much greater exposure to second-hand smoke in childhood[3]. Prevalence of smoking during pregnancy in the

[1] RCPCH & UCL. *Overview of child deaths in the four UK countries: report September 2013.* Child Health Reviews-UK, London: RCPCH; 2013.

[2] Euro-Peristat Project with SCPE and EUROCAT. European periantal health report. The health and care of pregnant women and babies in Europe 2010. May 2013. Available at http://www.europeristat.com

[3] *Statistics on Women's Smoking Status at Time of Delivery - England, Quarter 3, 2011-12.* 16 February 2012. Retrieved 24 February 2014 from http://www.hscic.gov.uk/catalogue/PUB05158

UK is significantly higher than Sweden, a country that is coincidently one the strongest performers on the low birth weight indicator. In the UK around twelve per cent of women smoke during pregnancy, compared to Sweden where 6.5 per cent of women smoke at the beginning of pregnancy and 4.9 per cent by the time the baby is due[2]. A reduction in smoking rates during pregnancy will only be achieved through appropriative policy and initiatives which are aimed at both population and individual levels, including the introduction of plain packaging legislation, to reduce the number of young people taking up smoking, in addition to high quality, evidenced-based, antenatal smoking cessation services which are tailored to meet the needs of disadvantaged women as recommended in NICE Guidance 26[4].

Child health (the 0-19 death rate)

10. The Report Card illustrates the importance of keeping children and young people socially, emotionally and physically safe; with a large proportion of the mortality burden during childhood and adolescence attributable to preventable causes such accidents, injuries and self-harm. The CHR-UK report found that boys aged 10 to 18 years stand to gain the most from preventative policies to reduce injury-related deaths across childhood, however it is also worth noting that England was found to have the lowest mortality due to injury of all four UK countries for each age and sex group and in the majority of time periods between 1980 and 2010[1].

11. A significant proportion of deaths during childhood and adolescence occur as a result of road traffic accidents, with transport accidents accounting for a large proportion of unintentional injury deaths in one to nine year olds and 10 to 18 years olds[1]. There are a number of policy levers which could be implemented to improve the safety of young drivers and passengers, which would align UK policy and legislation with international best practice. A recent evidence review commissioned by the Department of Transport recommended the introduction of a Graduated Licensing Scheme. Graduated Licensing Schemes have a long history in many countries including the US, Australia and New Zealand, where there is substantial evidence of their success in reducing road related injury and mortality in young people[5,6,7,8,9]. Roll out of 20 mile per hour speed restrictions in all towns and cities across England should also be considered as a further mechanism for making England's roads safer for children and young people.

12. In addition to road accident prevention, it is paramount that children, young people and their families have adequate knowledge and skills to minimise hazards at home and in the community. Public awareness campaigns and the provision of developmentally appropriate safety equipment should remain a priority, and all local authorities should consider re-introducing child health safety schemes which target families most in need. The Chief Medical Officer for England in her annual report also recognised a need for more to be done to understand and prevent strangulation as a result of blind cords[10].

13. The importance of social and emotional safety must also be acknowledged in the context of child and youth mortality, despite an absence of internationally comparable data on mental health, child abuse and neglect, as acknowledged by authors of the Report Card. Mental health must be recognised as a priority area for improving the wellbeing of England's children and young people, particularly given that there has

[4] NICE. Public health guidance 26guidance Quitting smoking in pregnancy and following childbirth. NICE; 2010. Retrieved 24 February 2014 from http://www.guidance.nice.org.uk/ph26

[5] Curry AE, Mirman JH, Kallan MJ, Winston FK, Durbin DR. Peer passengers: how do they affect teen crashes? *J Adolesc Health*. 2012 Jun;50(6):588-94. doi: 10.1016/j.jadohealth.2011.10.016. Epub 2012 Jan 23.

[6] Williams, AF. 2007. Contribution of the components of graduated licensing to crash reductions. *Journal of Safety Research,* 38(2):177-84. Epub 2007 Mar 26.

[7] Cooper D, Atkins F, Gillen D. Measuring the impact of passenger restrictions on new teenage drivers. *Accid Anal Prev.* 2005 Jan;37(1):19-23.

[8] Begg D, Stephenson S. Graduated driver licensing: the New Zealand experience. *J Safety Res*. 2003 Jan; 34(1):99-105.

[9] Department of Transport. Novice drivers: Evidence review and Evaluation Pre-driver training, Graduated Driver Licensing. 2013 retrieved 29 Jan 2014 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249282/novice-driver-research-findings.pdf

[10] Department of Health. 2013. Annual Report of the Chief Medical Officer Our Children Deserve Better: Prevention Pays, 2013. Retrieved 21 February 2014 from https://www.gov.uk/government/organisations/department-of-health

been no decline in deaths due to intentional injuries (i.e. self-harm, assault or undetermined intent) in 10 to 18 year olds in any UK country since 1980[1].

14. Approximately 75 per cent of lifetime mental health disorders (excluding dementia) have their onset before 24 years of age, with the peak onset of most conditions from 8 to 15 years[11]. Social disadvantage and adversity is strongly linked to increased risk for mental health difficulties in childhood and adolescence[10], with children and young people in the poorest households three times more likely to have a mental health problem than their wealthier counterparts[12]. Sustained investment in prevention, early intervention and timely treatment for mental health issues during childhood and adolescence must be a priority across all levels of government, with targeted supports available for vulnerable children most at risk, specifically looked after children, children involved in the youth justice system and children from families with a history of mental ill health.

Dimension 4: Behaviours and risks

Eating and exercise

15. The Report Card demonstrates there are opportunities to improve eating and exercise habits of children and young people that would help align child wellbeing in the UK with better performing countries. *Measuring Up: a 2013 report from the Academy of Royal Colleges* sets out clear recommendations in relation to tackling the obesity crisis; recommendations which are relevant to the indicators on eating and exercise outlined in the Report Card. There is still a lot of progress to be made on many of the recommendations from *Measuring Up* including the piloting of a high sugar beverage tax, ensuring healthy food standards are rolled out in academy and free schools, and a ban on advertising foods high in saturated fats, sugar and salt before 9pm and on 'on demand' services.

Risk behaviours

16. The Report Card shows the UK having some of the poorest indicators in relation to alcohol and cannabis use, suggesting that more must be done to tackle risk taking behaviours in children and young people. Deprivation, poor parental connection, low self-esteem and poor mental health are often responsible for a these behaviours[13], therefore drug and alcohol education must form part of comprehensive health promotion programmes in schools and communities to drive healthier behaviours in children and young people, with underlying mental and social health challenges addressed alongside this issue and not in isolation[10].

Exposure to violence

17. The Report Card also shows the UK performing poorly on indicators of bullying and fighting. More must be done to improve the social and emotional health and wellbeing of children and young people, particularly those in disadvantaged communities, through comprehensive health promotion approaches aimed at promoting respect and inclusion, tackling bullying and building resilience in children and young people, which once again should be addressed alongside other social, health and wellbeing needs.

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[11] Suhrcke M, Puillas D, Selai C: Economic aspects of mental health in children and adolescents. In Social cohesion for mental wellbeing among adolescents. Copenhagen: WHO Regional Office for Europe, 2008:43-64.

[12] Green H, McGinnity A, Meltzer H, Ford T, Goodman R: Mental health of children and young people in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave, Macmillan, 2005.

[13] Institute of Medicine and National Research Council. *The Science of Adolescent Risk Taking.* 2011., as cited in Department of Health. 2013. Annual Report of the Chief Medical Officer Our Children Deserve Better: Prevention Pays, 2013. Retrieved 21 February 2014 from https://www.gov.uk/government/organisations/department-of-health

Measuring the early years

18. The Report Card discusses in detail the absence of internationally comparable data sets to monitor the developmental progress of young children. The authors give the Early Development Index (EDI) as an example of a population tool shown to be successful for monitoring early years investments in health, education and social care in Canada and Australia. The Department of Education should consider the feasibility of introducing such a data collection system in England, but also recognise that the introduction of such as system would not remove the need for better monitoring and reporting of broader health and wellbeing outcomes in children and young people. The Department of Health and Department of Education should develop a systematic approach for monitoring health and wellbeing by bringing together existing data sets and identifying gaps in current data collection in England; imperative to this would be routine collection and dissemination of mental health data.

PART THREE: CHILD WELL-BEING – THE TEN YEAR RECORD

19. While an improvement in the UK's overall ranking on the UNICEF league table for child well-being is welcomed, this improvement should be taken with caution, as even the authors acknowledge, this data only reflects the start of the economic downturn and therefore may not be a true representation of the wellbeing of England's children today. There is a significant risk that many of the gains which are articulated in the report will be reversed as a result of the economic crisis, falling incomes, and austerity policies which have seen significant cuts to the support services available for vulnerable families[14].

20. Even with apparent improvements, the UK consistently lags behind many of its European counterparts on a number of wellbeing indicators, in particular those related to the health and safety of children and young people. Perhaps the strongest example of the UK's poor performance is captured in a recent analysis of child and adolescent mortality data which concluded that if the UK were to have the same childhood mortality rate as Sweden, Europe's best performing country in relation to child mortality, 1951 deaths could be avoided every year[15].

[14] Wolfe, I. Disproportionate disadvantage of the young: Britain, the Unicef report on child well-being, and political choices. *Arch Dis Child, 2013, 99*(1):6-9

[15] Wolfe, I. et al. Health services for children in western Europe. The Lancet, 2013 , 381(9873): pp. 1224-1234