## Summary: Intervention & Options

<table>
<thead>
<tr>
<th>Department /Agency: Dept. of Health, Depart. for Children, Schools and Families</th>
<th>Title: Impact Assessment on Healthy Lives, brighter futures: The strategy for children and young people's health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage: Final Proposal</td>
<td>Version: 0.2</td>
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**Available to view or download at:**

**Contact for enquiries:** Abigail Merrett  
Telephone: 0207 972 4478

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**What is the problem under consideration? Why is government intervention necessary?**
The past decade has seen the development of a significant body of evidence-based policy on child health and continued improvements in children, young people and families' health and health care. But there remain significant challenges which need to be addressed so that:
- health outcomes are world class;
- services are of the highest quality;
- children and young people's experience of services is excellent;
- health inequalities between different groups are minimised.

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**What are the policy objectives and the intended effects?**
The Strategy is intended for both commissioners and the public and sets out why child health matters; what good child health outcomes look like; and how Government will enable and promote joint delivery across the NHS and local government children's services. It builds on the existing frameworks of Every Child Matters and the National Service Framework for Children, Young People and Maternity Services. Four over-arching ambitions are identified: achieving world class health and wellbeing outcomes; achieving services of the highest quality; achieving excellent experiences of services; and minimising health inequalities.

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**What policy options have been considered? Please justify any preferred option.**
1. Do nothing.
2. Develop a vision and strategy for improving outcomes for child's health and wellbeing.

**The preferred option is 2.**
The strategy brings together a range of existing policies (and proposals for piloting new policies) which provides a comprehensive picture for families, commissioners and providers of services of what more needs to be done to improve child health outcomes and support local delivery.

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**When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?**
Implementation reviews will be completed for policy proposals outlined in the strategy, where these are implemented at a national level. The Departments will review overall progress in 3 years time.
Ministerial Sign-off

For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:

Hon. Ann Keen - Parliamentary Under-Secretary of State for Health  Date: 11 February 2009
### Summary: Analysis & Evidence

<table>
<thead>
<tr>
<th>Policy Option:</th>
<th>Description:</th>
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<tbody>
<tr>
<td></td>
<td>Description and scale of <strong>key monetised costs</strong> by 'main affected groups' The strategy sets out the framework within which PCTs, local authorities and partners will develop plans for improving services for children and make local decisions. IAs for individual policies will include estimates of overall cost impacts.</td>
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#### ANNUAL COSTS

<table>
<thead>
<tr>
<th>One-off (Transition) Yrs</th>
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<tbody>
<tr>
<td><strong>Average Annual Cost (excluding one-off)</strong></td>
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<tr>
<td><strong>Total Cost (PV)</strong></td>
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Other **key non-monetised costs** by 'main affected groups' -

#### ANNUAL BENEFITS

<table>
<thead>
<tr>
<th>One-off Yrs</th>
<th>£</th>
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<tr>
<td><strong>Average Annual Benefit (excluding one-off)</strong></td>
<td>£</td>
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<tr>
<td><strong>Total Benefit (PV)</strong></td>
<td>£</td>
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Other **key non-monetised benefits** by 'main affected groups' -

### Key Assumptions/Sensitivities/Risks

- **Price Base Year**
- **Time Period Years**
- **Net Benefit Range (NPV)** £
- **NET BENEFIT (NPV Best estimate)** £

| What is the geographic coverage of the policy/option? | England |
| On what date will the policy be implemented? | current |
| Which organisation(s) will enforce the policy? | PCTs LAs SHAs |
| What is the total annual cost of enforcement for these organisations? | £ N/A |
| Does enforcement comply with Hampton principles? | Yes |
| Will implementation go beyond minimum EU requirements? | No |
| What is the value of the proposed offsetting measure per year? | £ N/A |
| What is the value of changes in greenhouse gas emissions? | £ N/K |
| Will the proposal have a significant impact on competition? | No |
| Annual cost (£-£) per organisation (excluding one-off) | Micro | Small | Medium | Large |
| Are any of these organisations exempt? | No | No | N/A | N/A |

### Impact on Admin Burdens Baseline (2005 Prices)

<table>
<thead>
<tr>
<th>Increase of £</th>
<th>Decrease of £</th>
<th>Net Impact £</th>
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<tbody>
<tr>
<td><strong>Key:</strong> Annual costs and benefits: Constant Prices</td>
<td>(Net) Present Value</td>
<td></td>
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</table>
[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]
Health lives, brighter futures: The strategy for children and young people’s health – Impact Statement

Introduction

1. Healthy Lives, Brighter Futures: The strategy for children and young people’s health sets out the Government’s vision for an integrated approach to improving children’s health and wellbeing, building on the National Service Framework for Children, Young People and Maternity Services\(^1\), Every Child Matters\(^2\), the Children’s Plan\(^3\) and High Quality Care for All: NHS Next Stage Review Final Report\(^4\).

2. This is a joint strategy between the Department of Health and the Department for Children, Schools and Families, (who have the cross-government lead for children and young people). Many of the policies and programmes relating to children’s health and wellbeing are joint programmes between the two Departments. This is an overarching impact statement encompassing a number of existing strategies and programmes which are already in place and new pieces of work in the early stage of policy development, signposting where specific Impact Assessments (IA) are planned. The overall cost impact is difficult to quantify, since specific changes will be made locally. Separate IAs will cover national programmes and these will include estimates of overall cost impacts.

Why a Child Health Strategy

3. Being in good health (physical, emotional and mental) enables children and young people to make the most of their opportunities in life. Poor health is a barrier to learning, achieving, employment, taking part in social activity, the community and enjoying life. Children and young people deserve to enjoy the best possible health so that they can make the most of their childhood. And, crucially, having and maintaining good health in childhood and acquiring the habits of healthy living reduces the risks of chronic and acute ill health in adult life.

4. The strategy sets out:

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\(^2\) Every Child Matters. 2003 Department for Education and Skills.
\(^3\) The Children’s Plan, Building Brighter Futures. Department for Children, Schools and Families – December 2007
• **why** child health matters – investing in health benefits families, society, and the NHS;
• **what** good child health and wellbeing services and outcomes look like (building on the existing policy base of the National Service Framework and Every Child Matters programme); and
• **how** the child health system will deliver that vision, with an emphasis on joint delivery with wider children’s services and seamless services built around children and families.

5. The strategy draws together a wealth of existing material to bring together for families and children, and for those who commission and provide services for them, what existing policies mean for different age groups and for children and young people with differing needs. It also sets out next steps for development, including proposals for new initiatives and pilots to help strengthen local delivery of these policies and widen their impact. It also sets out how developments in delivery systems in the NHS and in local government children’s services can together enable joint local delivery of improved outcomes for children. As such, the strategy brings together a range of existing and new policies and proposals.

6. This document does not attempt to assess the impact of the strategy overall. Where specific proposals for national change are referenced, these will be subject to partial and full Impact Assessments over the coming months for the specific policies and programmes concerned.

7. Since much of the strategy is concerned with improving the reach of existing programmes, an overarching Equality Impact Assessment (EQIA) has been prepared. Again, specific EQIAs will also be prepared for individual policies and programmes over the coming months, as appropriate.

8. The proposals, and the impact statement and EQIA, will apply to England only.

**Background - analysis of problem**

9. There are approximately 12 million children and young people in England, making up 25 per cent of the population, for whom good health and wellbeing is an essential part of the quality of their life.
10. Progress has been made in securing better health and wellbeing outcomes for children and young people, underpinned by significant additional investment in health and wider children’s services. But there remain challenges, set out below, in ensuring high quality outcomes, services, and experiences for all children, young people and families.

11. First, particular health outcomes show cause for concern. These are highlighted by international comparisons and where there are potentially challenging trends. For example, though our infant mortality rates are at historically low levels, they are still around twice as high as Sweden, which has some of the lowest rates in the world. Areas in which trends show cause for concern include childhood obesity, the prevalence of certain sexually transmitted diseases, and the volume of alcohol consumed by young people who drink. For instance, obesity rates for 2-10 year olds have risen by more than 50% from 1995 to 2006 (from 10% to around 15% for girls and from 10% to 17% for boys).

12. Second, we know that there is often considerable variation in the quality of health services. Recent evidence from the Healthcare Commission highlighted that, while around a quarter of hospital services for children were good or excellent, too many were considered to be in need of improvement. Similarly, another recent study found a worryingly high number of factors in child deaths were avoidable, or potentially avoidable.

13. Third, the experiences of parents and their children in using health and related services can be further improved. Against a background of rising expectations of public services, a series of reviews on disabled children, mental health services and speech and language needs report confusion among parents and children about the support they can expect to get, and significant disparities in the ease and quality of support. And there is more to do to improve the experiences and

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6 As opposed to the proportion of children who have ever had a drink, which continues to decline.
7 Evidence to support the Children’s Plan. DCSF 2007.
12 A Review of Services for Children and Young People with Speech, Language and Communication Needs.
engagement of fathers. Ensuring the engagement of service users is especially important for the most disadvantaged mothers and fathers, for whom service providers may need to offer support tailored to their specific needs.

14. And fourth, while the health of most families and children has improved, health inequalities persist. In England today, social status and place of birth continue to be strongly associated with health outcomes for children and young people. For example, children in low-income households, living in single parent families, families where parents have low educational attainment, or families where parents are unemployed, are more likely than their peers to suffer from emotional health and wellbeing problems. This remains the case even where there has been significant improvement in some outcomes. For example, although the rate of child deaths from accidents halved from 1981 to 2001 – children of parents who have never worked or who are long-term unemployed are 37 times more likely to die as a result of exposure to smoke, fire or flames than children of parents in higher managerial and professional occupations.

15. Consultation has also highlighted the complexity and challenge of joining up across health, education and social care services to deliver better outcomes for children and young people. It has shown that more can and should be done to enable effective local leadership and partnerships to flourish. In particular, consultation revealed the need to do more to align systems supporting frontline local delivery, across governance arrangements, commissioning, access to information, workforce development, and action to drive improvements in quality and outcomes.

Proposals for Action identified in the Child Health Strategy

16. Paragraphs 9-15 above set out the rationale for improving the health and wellbeing of children and young people. The strategy sets out the services that are in place or planned for each age group, and proposals (which will be subject to separate IA, as appropriate) for improvement, as follows:

Early Years

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14 Staying Safe: A consultation document. HMG 2007
17. The core programme that oversees the health and development of children and supports parents from pregnancy through to age 5 is the Healthy Child Programme (formerly the Child Health Promotion Programme – CHPP). The strategy includes proposals and actions to strengthen support for local delivery of this programme through:

- further development of the health visitor workforce;
- developing and testing a new programme for antenatal education and preparation for parenthood;
- developing e-learning for frontline practitioners;
- including the Healthy Child Programme within the national community services contract for the NHS;
- ensuring that every children’s centre has access to a named health visitor;
- updating the Personal Child Health Register (Red Book) to reflect the Healthy Child Programme, along with additional information.

18. These next steps build on the CHPP which has already been the subject of an IA\textsuperscript{15}.

19. To ensure the benefits of the Healthy Child Programme extend to the most vulnerable, the Government will expand its pilot programme for the Family Nurse Partnership, which provides a structured and evidence based home visiting programme for vulnerable first time young mothers and their families\textsuperscript{16}. The programme has been proven to have lasting long-term impacts, such as reductions in children’s injuries and in adolescent anti-social behaviour, and improvements in prenatal health. Though too early to demonstrate the longer term impact in this country, the first year evaluation of the programme looks promising.\textsuperscript{17} Development of further evidence on effectiveness and costs is planned as the programme is developed. A Year 2 formative evaluation report by Birkbeck is due in 2009 and a randomised controlled trial is due to complete early in 2013.

20. The government has been trialling ways of embracing new technologies to support parents in bringing up their children. In particular, we have successfully trialled and are now rolling out the NHS Early Years Lifecheck to provide an online tool that

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\textsuperscript{15} Child Health Promotion Programme Impact Assessment - [http://www.ialibrary.berr.gov.uk/ImpactAssessment/?IAID=4736ec8a2aab4aab8a644b0abc1ca6aa](http://www.ialibrary.berr.gov.uk/ImpactAssessment/?IAID=4736ec8a2aab4aab8a644b0abc1ca6aa)


promotes parental engagement and support of positive behaviour and health promotion for parents and carers of babies aged 5-8 months old. The Early Years Lifecheck (ELC) is a tool, which supports families to identify the help and support that they need to ensure that their child achieves the healthiest outcome possible. It builds upon the emphasis in Choosing Health\textsuperscript{18} and Our Health, Our Care, Our Say\textsuperscript{19} on enabling people to take responsibility for their own health.

21. Evidence\textsuperscript{20} shows that the proportion of babies that are breastfed at birth rises significantly in settings that have adopted the principles of the UNICEF Baby Friendly Initiative (BFI). The BFI provides support for healthcare facilities that are seeking to implement best practice, and offers an assessment and accreditation process that recognises those that have achieved the required standard. The Government is investing £4 million in 2008/09 to promote the BFI in areas with the lowest rates of breastfeeding. There will also be a strengthened focus on breastfeeding through Sure Start Children’s Centres and primary care.

22. The strategy highlights the importance of Sure Start Children’s Centres as a new universal service offering opportunities for the delivery of integrated support including high quality child health services. DCSF having consulted on proposals to ensure that Sure Start Children’s Centres are placed on a statutory legal basis, and this is included in the Apprenticeships, Children, Skills and Learning Bill\textsuperscript{21}.

23. The Government will be publishing a National Tobacco Control Strategy and will be setting out actions for protecting children from smoking. This will include supporting Sure Start Children’s Centres to host NHS Stop Smoking Services for mothers and fathers.

School Age Children

24. The strategy sets out existing provision to support the health of school age children through the school curriculum, extended schools and the healthy schools

\textsuperscript{18} Choosing Health: Making Healthier Choices Easier: \url{www.dh.gov.uk/en/Publichealth/Choosinghealth/index.htm}
\textsuperscript{19} \url{http://www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/index.htm}
\textsuperscript{21} \url{http://www.everychildmatters.gov.uk/aims/childrenstrusts/}
programmes, through the school health service and primary care. It sets out proposals to:

- develop the school age elements of the Healthy Child Programme,
- consulting (led by DCSF) on school-level wellbeing indicators, to be reflected in future OFSTED inspections;
- enhance the Healthy Schools Programme;
- increase physical activity
- roll out the NHS Teen LifeCheck\(^\text{22}\) in the most deprived areas from January 2009 and nationally from Spring 2009 (NHS LifeCheck is subject to a separate impact assessment);
- improve the quality and consistency of Personal, Social, Health and Economic (PSHE) alongside the intention to make it statutory within the curriculum;
- introduce pilots for free school meals;
- put the guidance for the NHS on children in care on a statutory footing – a gap analysis on current provision is being undertaken, which will inform any future IA.

**Young People**

25. The strategy sets out existing policies on the provision of age appropriate advice and services to adolescents. New proposals are:

- action to implement the PE and Sport Strategy for Young People
- supporting local adoption of the “You’re Welcome” standards for accessible adolescent health services;
- developing a Healthy Further Education (FE) Programme (an IA will be undertaken as part of this work)
- to launch a new information campaign for young people on contraceptive methods;
- to promote involvement of young people and their parents in service development.

\(^{22}\) NHS Teen LifeCheck Evaluation Report
26. The strategy also cross references plans to enhance support to vulnerable young people through:

- increasing the reach of Family Intervention Projects (FIPs);\(^{23}\)
- development of a wider health and social care strategy for children and young people in contact with the Criminal Justice System (work is underway on an IA).

Children & Young People with acute or additional health needs

27. The strategy sets out services available for children and their families in the event of sudden acute illness or ongoing additional health need such as a long-term or chronic physical or psychological condition. It draws on existing work including Aiming High for Disabled Children, the children’s palliative care strategy\(^{24}\), and confirms that £340m is available in PCT allocations over the 3 years 2008/09 to 2010/11, including £30m for palliative care, to support improvements in services for disabled children and in palliative care. It builds on the work of Strategic Health Authorities on care pathways for children as part of the NHS Next Stage Review\(^{25}\). It also confirms the Government response to the Bercow Review\(^{26}\) of services for children with speech, language and communication needs, and draws on the findings and recommendations of the review of child and adolescent mental health services (CAMHS).

28. Proposals for development are:

- encouraging better local information for parents and children;
- developing models of good practice on urgent and emergency care services for children;
- updating guidance on Managing Medicines in Schools;
- developing models of best practice to improve children’s community nursing provision;
- individual care plans for all disabled children, in line with commitments in High Quality Care for All, the report on the NHS Next Stage Review
- supporting the delivery of self management programmes for children and young people through the voluntary sector and social enterprise;

\(^{23}\) http://www.homeoffice.gov.uk/documents/youth-crime-action-plan/
\(^{25}\) http://www.ialibrary.berr.gov.uk/ImpactAssessment/?IAID=2f778d9d3ed044c2baefe51f5e1d6d53
\(^{26}\) http://www.dcsf.gov.uk/bercowreview
• funding a series of pathfinders to explore best practice in commissioning services for children with speech, language and communication needs, to begin work in 2009.
• putting in place new projects on the commissioning and provision of equipment for children with disabilities. The conclusions will be published in due course;
• launching a national framework for assessing children’s continuing care needs, following consultation (to be subject of a separate (partial) IA as part of the consultation);
• inviting LAs and PCTs to pilot individual budgets for disabled children;
• learning from SHA pathfinder projects on improving access to allied health professional services for children and young people.

System Level Transformation

29. Building on wider work by DCSF and DH, including the NHS Next Stage Review, the strategy sets out proposals to support local leadership and partnership working for improved child health, through better aligned delivery systems in respect of:

• effective local leadership, joint working and planning;
• stronger joint commissioning;
• effective use of information;
• workforce skills and capacity;
• drivers for improved quality.

30. On local leadership, consultation in 2008 on Children’s Trusts has supported proposals for a stronger statutory framework, to strengthen Children’s Trusts to enable them to secure measurable improvements in the health and wellbeing for children, young people and their families. As a result the Government has brought forward legislation to put Children’s Trust Boards on a statutory footing and to place a duty on those Boards to develop, publish and monitor the Children and Young People’s Plan. The strategy also references support to the Royal College of Paediatricians plans to develop an accreditation scheme for GP practices, which will be the subject of an independent report in 2009, and other action to strengthen the engagement of GPs.

27 Children’s Trusts: Statutory guidance on inter-agency cooperation to improve wellbeing of children, young people and their families. DCSF. 2008
31. **Joint commissioning** involves working across organisational boundaries, aligning systems and processes and where appropriate aligning or pooling budgets. Different systems and different approaches mean this can be complex. In parallel with the Child Health Strategy, the government is publishing *Securing better health outcomes for children, young people and families through world class commissioning* to provide clarity, making it easier for each commissioning organisation to understand its partners’ organisational language and pressures. This is not a new requirement or burden, but an explanation and translation of existing guidance with the intention of supporting people to do what they are charged with doing in a way that is easier and more efficient. A Commissioning Support Programme has been procured to assist development of world class commissioning competency across all the Children’s Trust partners.

32. **On effective use of information** the strategy sets out a number of steps to support commissioners and providers in making better use locally of data on child health.

33. **On workforce**, the strategy builds on 2020 Children and Young People’s Workforce Strategy. The DH is developing modelling tools to help SHAs consider any additional local workforce needs and build them into their future plans. The NHS Operating Framework for 2009/10 asks SHAs to develop strategic workforce plans which deliver improved health outcomes in maternity, neonatal and children’s services and help tackle inequalities. The plans should support the delivery of high quality services as close to home as possible and in a range of settings, for example children’s centres. PCTs will want to consider how their local workforce plans support the local services offer.

34. **On improving quality**, the strategy sets out proposals for ensuring child health is addressed within wider plans to strengthen voice and choice, to drive quality systems, and for the assurance system.

**Costs and benefits**

35. The overall cost impact is difficult to quantify, since specific changes will be made locally. Separate IAs will cover national programmes and these will include estimates of overall cost impacts, where appropriate.
36. The evidence base behind the National Service Framework for Children, the Children’s Plan and a range of other evidence on specific policies and strategies on aspects of child health includes compelling evidence\textsuperscript{28, 29} and makes the case that the policy framework set out in the strategy will:

- Deliver evidence based interventions to improve health outcomes for children and young people, promoting health, preventing ill health and responding effectively to acute illness and long-term conditions;
- Support children’s and young people’s wider wellbeing, building mental and emotional resilience, supporting fullest participation in education and wider development;
- Have long-term benefits in terms of children’s attainment and future life chances;
- Deliver consequential benefits in terms of costs to the NHS and wider economic benefits including improved participation in employment and wider society.

\textsuperscript{28} Evidence to inform the National Service Framework for Children, Young People and Maternity Services
Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

<table>
<thead>
<tr>
<th>Type of testing undertaken</th>
<th>Results in Evidence Base?</th>
<th>Results annexed?</th>
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<tbody>
<tr>
<td>Competition Assessment</td>
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<td>No</td>
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<tr>
<td>Small Firms Impact Test</td>
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<td>No</td>
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<tr>
<td>Legal Aid</td>
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<td>Sustainable Development</td>
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<td>Rural Proofing</td>
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Annexes
Healthy lives, brighter futures: Equality Impact Assessment

INTRODUCTION

1. There are approximately 12 million children and young people in England, making up 25 per cent of the population for whom good health and wellbeing is an essential part of the quality of their life.

2. This equality impact assessment (EQIA) considers the possible impact of Healthy lives, better futures, The strategy for children and young people’s health on children, young people and their parents and carers according to age, disability, race, religion and beliefs, gender and sexual orientation. The assessment aims to identify any potential issues contained in the strategy relating to these groups and ensure development of the strategy has taken account of the potential issues and that they inform continuing developments to reduce inequality.

3. The strategy draws together a wealth of existing material to bring together for families and children, and those who commission and provide services for them, what existing policies mean for different age groups and for children and young people with differing needs. It also sets out next steps for development, including proposals for new initiatives and pilots to help strengthen local delivery of these policies and widen their impact. The strategy includes a number of policy proposals which will be developed separately, with their own EQIA, as appropriate.

CHALLENGES AND PRIORITIES

4. Children and young people are healthier than ever before and are benefiting from the wider improvements in the NHS, but there is still more to be done if we truly want to be world class. Our analysis of the available evidence (some of which is detailed below according to the equality dimension) identifies challenges that the child health strategy aims to address:
• Particular health outcomes show cause for concern;
• There is often considerable variation in the quality of some health services;
• The experience of parents and their children in using health and related services can be further improved; and
• While the health of most families and children has improved, health inequalities remain.

EVIDENCE BASE

Age

• Obesity has risen by almost 50% in England since 1979, and the country has the third highest proportion of 13 year olds who are obese, out of 35 developed countries. Children from lower soci-economic groups are more likely to be obese. Obesity increases the risk of developing type II diabetes, cardiovascular disease, respiratory disease, liver disease and some cancers. Up to 79% of obese adolescents remain obese into adulthood.

• Only 54% of PCTs have management guidelines for children and young people with diabetes.

• Sexual behaviour is often unsafe in adolescence; teenagers have more sexual partners than other age groups. Recent trends in common sexually transmitted infections (excluding HIV) in the United Kingdom show an increase in the number of diagnosed cases of 16-19 year olds of over 100% between 1997 and 2006 (26,700 in 1997 to around 53,000 in 2006), a far higher increase than for other age groups.

• In 2006 nationally 40% of young people aged between 11 and 18 thought

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30 Children’s Plan, Building Brighter Futures. DCSF 2007
31 CMO Annual Report 2007
32 Making Every Young Person with Diabetes Matter. Department of Health 2007
33 CMO Annual Report 2007
that their Personal Social and Health Education was either poor or very poor, whilst 33% thought it was average. Only 55% of all 12-15 year olds, and 57% of girls aged between 16-17 years of age had been taught how to use a condom. Women from poorer backgrounds or areas with higher unemployment are more likely to become teenage mothers.

- There are increasing numbers of survivors of congenital and childhood illness and these young people have particular needs which need to be addressed.

- Despite the health issues young people have, they are less likely than any other group to visit their general practitioner, although many say they have concerns they would like to discuss. New approaches are needed to make health programmes and health services more teen centred.

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34 Are you thinking about it? Campaign
35 UK Youth Parliament
36 CMO Annual Report 2007
37 Improving services for children in hospital, Healthcare commission, 2007
38 Young Patients Survey, Healthcare Commission, 2004
39 Equality Impact Assessment for the ongoing programme of updates to the manual of cancer services and supporting guidance
40 Sickle Cell Disease in Childhood – Standards and guidelines for Clinical Care. NHS Antenatal and Newborn Screening Programmes
42 Health of Ethnic Minorities - New survey highlights health differences of ethnic groups. The Information Centre
43 Equality Impact Assessment – Health Inequalities: Progress and Next Steps
44 Impact Assessment of NHS Next Stage Review of proposals for primary and community care 2008
45 Self selected from the 2001 Census Categories
47 Care Matters, Transforming the Lives of Children and Young People in Care. DCSF 2007)
48 CMO Annual Report 2007
49 Equality Impact Assessment – Health Inequalities: Progress and Next Steps
50 Office of National Statistics survey
52 Becoming A Father by Debbie Singh and Mary Newburn. 2007
53 The Children's Plan for Parents and Families. DCSF 2007
55 Aiming High for Disabled Children: better support for families. HMT. 2007
56 Care Matters: Time for Change Department for Education and Schools. 2007
• The Healthcare Commission report in 2007 highlighted that the majority of hospital services for children were in need of improvement.\textsuperscript{37}

• During admission to hospital, 85\% of young patients stayed on a children’s ward, 5\% on an adult ward and 4\% on an adolescent or teenage ward. Of those young patients who would have preferred to be on an adolescent ward, 58\% were actually on a children’s ward and 16\% on an adult ward\textsuperscript{38}.

• For teenagers and young adults with cancer, it is estimated that 70\% are not treated in a setting appropriate to their age.\textsuperscript{39}

**Ethnicity**

There are just under 9 million 5-18 year olds living in England. The table below provides a breakdown by age group and ethnic category: 51\% of the 0-18 population are male.

<table>
<thead>
<tr>
<th>Population by ethnic category and age group, England 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>White</strong></td>
</tr>
<tr>
<td>0-4</td>
</tr>
<tr>
<td>5-11</td>
</tr>
<tr>
<td>12-15</td>
</tr>
<tr>
<td>16-18</td>
</tr>
<tr>
<td>0-18</td>
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</tbody>
</table>

• Some diseases are more prevalent in some groups, for example, sickle cell disease mainly affects people of African and Caribbean origin. In Jamaica the median survival of sickle cell anaemia is 53 years for men and 58.5 for women, rates for the UK are likely to be similar.\textsuperscript{40} We know for sickle-cell
disorders the emergency admission rate for children is over 9 times higher in the 20% most deprived regions than in the 20% least deprived regions.

- Autism, psychosis and conduct disorders are more common in second generation African Caribbean children, whereas emotional disorders were more common in indigenous children.  

- Among children, where obesity is a predictor of future health problems among the general population, obesity was relatively high among Black African, Caribbean and Pakistani boys (42%, 39% and 39%) and Black African and Caribbean girls (42% and 40%). Within the general population, 30% or boys and 31% of girls are classed as overweight or obese.

While we have limited quantified data on the specific experiences of services of children and young people of BME origin, there is sufficient evidence of concern among BME people of all age groups to suggest the need for further attention to the specific experience of children and young people. For example:

- There are marked differences in satisfaction with primary care services, people from BME groups report significantly worse access than white British people. Performance on access is worse for people from Pakistani and Bangladeshi backgrounds: there satisfaction with their level of access is 10-20 percentage points below that reported by people from white British backgrounds.

- Patient satisfaction survey showed that members of some BME groups, along with commuters and people living in more deprived areas are more likely to be dissatisfied with services – they want greater control over how and when they access primary care.

- People from most BME groups are less likely than white British people to use hospital services. For example, compared to 26% of white British people using hospital services in the previous year, 18% of those from an Indian
background did so. However, as a higher proportion (31%) of people from a black Caribbean background used hospital services in the last year. These statistics partly reflect the age profile of these different groups, but also the cultural attitudes to using hospital services.\textsuperscript{45}

- Higher proportion of people from BME groups experience deprivation in terms of socio-economic status, and poverty as indicated by eligibility to free school meals. The highest proportions of children eligible for free school meals are among Travellers of Irish Heritage, Gypsy / Roma, Bangladeshi and Black African.\textsuperscript{46}

- 26% of Looked After Children are from a BME group\textsuperscript{47}, and we know the Looked After Children tend to have a broader range and higher level of need than their peers, yet 1 in 5 do not receive annual healthchecks.\textsuperscript{48}

**Gender**

- The percentage of 11 to 15 years olds smoking has not fallen since 2004, and girls are more likely to smoke than boys. Someone who smokes at 15 years of age is three times more likely to die of smoking related cancer than someone who has smoked from their mid-20.\textsuperscript{49}

- There is evidence of gender differences in health risk factors such as obesity, linked with the generally higher prevalence of obesity in less advantage social groups. A girl with an overweight or obese mother or with both parents overweight or obese is more likely to be obese. Boys are more likely to be obese in households where the mother is overweight or obese.\textsuperscript{50}

- One in ten children and young people aged 5-16 have a clinically recognisable mental disorder. Among 5-10 year olds, 10% of boys and 5% of girls had a mental disorder. Among 11-16 year olds, the proportions were 13% for boys and 10% for girls\textsuperscript{51}. A 2005 survey found that as many as 1:5 girls between the ages of 15 and 17 had self-harmed and just under 1:5
adolescents (both boys and girls) had considered self-harm.  

- New fathers often feel ill-informed and unsupported by health professionals, despite wanting to be involved. In a large scale survey a third of new fathers felt inadequately informed on vital issues, notably about mood swings in pregnancy, what to expect in labour, post-natal depression, coping with the baby’s crying, bathing the baby, the impact on the couple’s relationship, breast-feeding and bottle-feeding.

- Public services often do not reach out to fathers, particularly when the partner does not live with the child.

Disability

- It is estimated there are 770,000 disabled children under age 18.

- A series of reviews on disabled children, mental health services and speech and language communication needs continue to report confusion among parents and children about the support they can expect to get and significant disparities in the ease and quality of support.

- There are increasing numbers of survivors of congenital and childhood illness and these young people have particular needs that are not currently being addressed adequately.

- Disabled children are less likely to achieve as much in a range of areas as their non-disabled peers.

- Children and young people in care, including disabled children and young people, suffer significantly poorer outcomes than the rest of the general population, for example, 45% of children in care are assessed as having a mental health disorder compared with around 10% of the general population.
CONSULTATION AND EVIDENCE GATHERING

5. In developing the strategy, we engaged with parents, young people, children, stakeholders and practitioners about how to address the health challenges and issues of providing accessible health care of consistently high quality to those who need it. Annex A includes further details of consultations. The engagement included:

- a national deliberative event for 60 parents and 28 young people aged 16-19; with balanced representation from parents of children aged 0-7, 8-13, and 14-19, and 18 professions, 23% of parents and 29% of the young people were BME;
- deliberative workshop with parents of disabled children and those with complex health conditions, 19% of participants were BME;
- Focus groups with young children aged between 7 and 15 years; and an on-line survey for young people.\(^{58}\)

6. Discussions focused on addressing:

- What they think of the health and social care services they currently receive;
- What they view as important qualities in such services; and
- What improvements they would like to see made to services.

7. The national events were designed around an agenda that allowed the debate to be led by the participants’ ideas and priorities. Participants from these events were invited to submit additional comments to the Child Health Strategy team via a Department of Health email address.

\(^{58}\) NCB Survey – Have your say on the Child Health Strategy
8. The outputs from these discussions build on consultations undertaken on the existing frameworks such as the National Framework for Children, Young People and Maternity Services and the Children’s Plan. These were subject to extensive consultation and engagement during their development. The strategy also draws on NHS Next Stage Review which included specific activity on children.

**POTENTIAL FOR EQUALITY OF OPPORTUNITY: SUMMARY OF ASSESSMENT**

9. The analysis of the evidence provides important detail about the differences in views, experiences and outcomes between children and young people of different ages, gender, and ethnicity and for children and young people with acute or ongoing additional health needs. As an overarching strategy, the Child Health Strategy seeks to address the areas of concern through broad measures to improve accessibility and personalisation of services, taking account of the need within these to promote equality. Inevitably, much of the strategy is concerned with the further development of age-appropriate services, from early years through to arrival at adulthood. There is also a specific focus on the additional needs of disabled children and young people, building on Aiming High for Disabled Children. Ethnicity and gender issues are being addressed within individual workstreams where there is evidence of differential need. Work is also proposed to strengthen the future information and evidence-base, to support future equality monitoring.

10. The strategy also builds on wider Government action to tackle health inequalities. Earlier this year *Health Inequalities: Progress and Next Steps* was published, including measures that will have a direct and indirect impact on the health and wellbeing of children and young people and support the proposals in *Healthy lives, brighter futures*.

11. The next section addresses some specific equality themes:

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59 Health Inequalities: Progress and Next Steps. DH 2008
Age

12. The strategy recognises that the health and wellbeing needs of children and young people are different from those of adults, and require a different, discreet response. Additionally, the needs will vary significantly between young children and teenagers. Access to universal services is provided through a variety of professions and settings, such as GPs, Health Visitors, schools and Children's Centres, based on the principle of providing support for all; with more support for those who need it most and access to specialist services for those who need them.

13. The strategy takes a life stage approach when considering a range of universal, targeted and specialist services in supporting improved health and wellbeing; during pregnancy and the first years of life; for school age children; and for young people. It considers separately the response to securing the best outcomes for children and young people with acute or ongoing additional health needs. Further details of the proposals for each of these groups is contained in the main Impact statement.

Pregnancy and the early years

14. The strategy pays particular attention to this age group, as pregnancy and the early years are one of the most important stages in the life cycle for health. This is when the foundations of future health and wellbeing are laid down, and when parents are most receptive to information and make changes in their lifestyle if necessary to give their child a good start in life.

15. The strategy sets out actions to improve the health and wellbeing in pregnancy in the first years of life through improving the reach and delivery of the Healthy Child Programme and highlights the importance of Sure Start Children’s

60 The ‘Healthy Child Programme’ formally known as the Child Health Promotion Programme is a universal early intervention and prevention programme for children and families.
Centres as a new universal service offering new opportunities of integrated support.

School age children and young people

16. As children grow up they become increasingly aware of health-related matters and can be expected to take on additional responsibility for their own health and wellbeing. They also need opportunities to access information and support on health as part of their daily lives. So the strategy places a particular emphasis on the role of schools. This includes the vital role schools can play in helping to link services – for example in allowing pupils easy access to specialist health support often on school sites.

17. Age specific proposals include developing the school age elements of the Healthy Child Programme to set out a school age health offer in the way that has been done for 0-5 years. This will reinforce the importance of prevention, early intervention and health education, focusing on the needs of all young people, especially the most vulnerable.

18. The strategy highlights the Government’s vision for the 21st Century School, which recognises the role played by schools in supporting the range of children’s outcomes, supported by the duty that schools now have to promote pupils’ wellbeing. Schools have a lot of information on which to self-evaluate their performance on attainment but there is less information available on which they are able to assess their contribution on other outcomes. For these reasons, the Department for Children, Schools and Families (DCSF) is currently consulting on guidance illustrating how schools can best promote well-being and on the support they can expect from their local authority and Children’s Trust. In addition to this guidance, DCSF and Ofsted have consulted on a package of school-level wellbeing indicators, to be reflected in future Ofsted inspections 2009. These well-being indicators will provide

61 Schools’ Role in Promoting Wellbeing: Draft Guidance for Consultation, DCSF, 2008
additional, benchmarked data to inform schools’ evaluation of their contribution to well-being.

19. The strategy also proposes an enhanced Healthy Schools Programme to help schools to become centres of excellence for promoting both universal health improvement for all pupils and additional support targeted on those identified as most at risk.

20. To improve provision for adolescents, the principles of the National Healthy Schools Programme will be extended into the Further Education sector to create a whole college framework which will help improve access for students and staff to health related advice, information and guidance and promote positive health and healthy activities.

21. Though significant progress has been made in improving support for all young people in making healthy choices, the recent report by England’s Chief Medical Officer 62 makes clear that there is more to do. A step change is needed in the effectiveness of services for young people. Key to ensuring that young people can access the support that meets their discreet needs is ensuring that the settings for such support is age-appropriate and fits around their lifestyles. We know from the deliberative events that many young people express reservations about accessing services – particularly when they want sensitive or confidential advice.

22. To support young people an NHS Teen Life Check has been developed: an independent on-line tool which allows young people age 12-15 to assess their current health and wellbeing, plan improvements and changes to life style as well as signposting them to further resources of advice and support. The NHS Teen LifeCheck will be rolled out to 83 of the most deprived Local Authority areas in England from January 2009.

23. The strategy sets the aim of building holistic services that provide the full range of advice, support and care that young people need, helps them make health choices and gives them access to healthy opportunities. The Teenage Health Demonstration Sites are exploring the essential elements for successful adolescent health services. Further roll-out of the “You’re Welcome” standards across England will promote the delivery of health services in settings that are age-appropriate and fit around young people’s lifestyles.

24. The strategy recognises that importance of supporting young people through the transition to adulthood, especially in the case of disabled young people and those with complex health needs. It references the £19m Transition Support Programme that was launched in December 2008 to improve support to disabled young people and highlights existing guidance on good practice.

Each of these proposals is targeted toward securing the most appropriate support at a particular life stage or age, and therefore envisaged to have a positive effect on age-inequality.

Disability

25. For children and young people with mental health problems, disabilities and/or complex health needs services need to be more responsive and better able to meet these needs in a more integrated way. For universal services this will mean ensuring services are more inclusive and respond more quickly to need and identify promptly those children and young people with complex health needs. Some with complex health needs will also require more specialist and/or Child Adolescent Mental Health Services (CAMHS) and short breaks services for those with mental health problems, disabilities or complex health needs.

26. The strategy sets out services available for children and their families with long-term or complex health needs. It draws on and reinforces the existing policy frameworks set out in Aiming High for Disabled Children (AHDC) - which sets out a range of measures designed to improve the lives of disabled
children and their families through measures to support: access and empowerment for disabled children and families; services that respond to need and timely support and improve service quality and capacity. The Strategy confirms the funding available in PCT allocations to support such improvements in services for disabled children and in palliative care.

27. It also takes account of

- the Bercow Review\textsuperscript{63} which was established to specifically address the needs of children and young people with speech, language and communication needs; and
- the review of CAMHS\textsuperscript{64} on action needed to improve outcomes for the mental health and psychological well-being of children and young people.

28. Many of the issues and challenges identified through our discussions with parents are consistent across a range of different needs, whilst others are very specific to a particular condition. The strategy identifies both regional and national steps to tackle both some of the cross-cutting challenges for services for children with acute or additional health needs.

29. Our consultation highlighted the variability across local areas in how well children with long-term conditions are supported in school. Some parents report satisfaction, others report a failure of health and education service to work together effectively to support the needs of individual children. Diabetes UK, is leading a project to better understand the extent of good and bad practice. DCSF will update and reissue guidance on Managing Medicines in Schools, which will include clear statements of expectations of different partners, including schools and PCTs. It is particularly important that children and young people have the right support in managing additional health needs in school settings so they have every opportunity to thrive.

\textsuperscript{63} The Bercow Report. A Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs. DCSF 2008

\textsuperscript{64} Children and young people in mind: the final report of the National CAMHS Review. 2008
30. To improve the evidence base a new national disabled children’s indicator will be developed based on parents experience of services and of the “core offer” made in Aiming High for Disabled Children (Core offer covers - clear information; transparent eligibility criteria and process for accessing services; multi-agency assessment; participation in shaping local services; and accessible feedback/complaint mechanisms). The measure will cover the parents of children with disabilities and ask about all services provided because of their disability by their local authority and PCT. By 2011 disabled young people and their parents should be able to report a more favourable experience of these services: baseline and comparison data will drive best practice and improvements.

31. For CAMHS a new outcomes based indicator on children’s psychological health is being developed.

**Ethnicity**

32. While information is available on need, and will inform the planning and commissioning of services, evidence on the experiences and outcomes for BME children and young people is not as robust as we would wish. Given this, particular care was taken to ensure that BME parents and young people were well represented in our strategy consultations and deliberations. Despite this the deliberations did not elicit any specific issues relating to ethnicity.

33. Existing policies and strategies aim to reduce specific conditions that may affect some BME groups disproportionately. These are addressed through other strategies and initiatives for example, screening programmes and the obesity strategy.

34. We also expect the strategy to have wider benefits for the most disadvantaged BME children and young people. We know that some BME groups are disproportionally represented in socially disadvantaged groups and will experience the impact of broader health inequalities discussed in the strategy.
For example, 26% of Looked After Children are from a BME group\textsuperscript{65}, and we know the Looked After Children tend to have a broader range and higher level of need than their peers, yet 1 in 5 do not receive annual health checks.\textsuperscript{66} Accordingly measures aimed at tackling inequalities and improved access to both universal services for vulnerable young people should be of benefit.

35. As any new policies announced in the strategy are further developed or piloted, consideration will be given to whether ethnicity issues require a specific policy response.

36. To improve our information base, in developing the new indicator on experience around services for disabled children we will include identification of ethnic origin. This information will help to improve our understanding of the impact of policies. Work planned on minimum datasets for child health, maternity and CAMHS will include testing of demographic data including ethnicity and religion or faith. This will be used to compare outcomes for different groups and also identify factors influencing care. We will also commission the Child and Maternal Health Intelligence Unit (ChiMat) to undertake work on identifying and drawing together all health and wellbeing data sources on ethnicity of children and young people. These measures will help to inform those planning or commissioning services locally to focus on local priorities and needs as well as informing future policy development.

\section*{Religion or belief}

There is insufficient data to quantify the likely impact of the strategy on people of different religions or beliefs.

\section*{Gender}

37. The key issues to emerge on gender were:

\textsuperscript{65} National Statistics. Children looked after in England 31 March 2007. DCSF
\textsuperscript{66} Care Matters, Transforming the Lives of Children and Young People in Care. DCSF 2007)
- differing patterns between boys and girls on lifestyle issues such as smoking and obesity
- differing prevalence of certain conditions such as problems with mental health and psychological well-being
- opportunities for better engagement with fathers on their children’s health and well-being.

38. Social marketing and other work designed to tailor engagement with young people and support them in making healthy choices will take account of a range of behavioural and social determinants, including gender issues. Similarly, existing strategies for services such as CAMHS recognise the differing levels of risk for girls and boys.

39. The strategy recognises that more can be done to engage fathers in their children’s health and wellbeing in the early years. It promises:

- practical support for Sure Start Children’s Centres in supporting fathers;
- identification of best practice in providing overnight facilities near maternity units for fathers, work to ensure families are aware of arrangements for fathers to stay with partners when they are in labour, and engagement of fathers and mothers in the planning of new maternity facilities;
- development of a new Antenatal Education and Preparation for Parenthood Programme, to be tested in a variety of settings where parents access health services;
- pilots of new methods of engaging mothers and fathers in the delivery of the Healthy Child Programme, in particular to ensure that fathers are involved in the scheduled reviews which are at the heart of the programme, drawing on the principles of the Family Nurse Partnership programme, which have been proven to be particularly successful at improving engagement of relatively disadvantaged parents;
- promoting action by providers of child health services to engage fathers so that they are encouraged and able to play a full and active part in their child’s health and well-being;
• piloting a fathers’ Early Years Lifecheck, which will provide fathers with tailored information on their baby’s health and development.

These proposals are intended to have a positive impact and this is very likely

**Sexual orientation**

40. There is insufficient data to quantify the likely impact on people of different sexual orientations.

**Transgender**

41. There is insufficient data to quantify the likely impact on transgender people.

**Improving service delivery**

42. The strategy also sets out proposals to strengthen local delivery systems. Of particular relevance are proposals on:

- commissioning – to strengthen the systematic planning and commissioning of services in response to local need;
- information – improving the use of data to support development and benchmarking of children’s services, including a specific commitment to strengthen the future information base of equality monitoring; and
- workforce planning and development, including development of the health visiting workforce, which has a particular role in reaching out to and working with vulnerable groups.

43. Both DCSF and DH have put in place major programmes to support the development of commissioning in the education and care sectors and in the NHS, respectively. But there has not yet been work to bring these support
programmes together and to address the particular challenges of commissioning for children’s health.

44. A unified framework for Children and Young People’s Health, *Securing better health for children and young people through worldclass commissioning* will be supported by a joint commissioning support programme to promote stronger commissioning of services for children’s and young people’s health at a local level. These tools will highlight the importance of listening to the views of children, young people and their families as part of the commissioning process is key. Taken together these developments should improve the sensitivity of commissioning to the full range of children and young people’s needs.

45. The strategy sets out a number of measures to improve the **quality and use of data** relating to children and young people’s health. These include:

- establishing a long-term role for the Child Health and Maternity Intelligence Unit (ChiMat);
- testing, with a view to begin to roll-out minimum NHS datasets;
- developing a model to build commissioners’ understanding of the relationship between healthcare spend on children and outcomes; and
- providing better data on experience and outcomes; and publishing best practice on data collection.

46. A number of these are referenced earlier in this EQIA. Across all of these strands, we shall look to develop a stronger information based for monitoring the equality impact of future developments.

47. The right **workforce**, with the right skills, competencies and experience, is critical to improving outcomes and experience for all children and families. A wide range of staff in different services and with different professional and other backgrounds contribute to children’s health and wellbeing. In December 2008, the DCSF published *2020 Children and Young People’s Workforce Strategy*, that spans the children’s workforce. It sets the context for work to
ensure a common foundation understanding of children’s health and wellbeing, across all those who work with children. Similarly, the NHS Next Stage Review and its plans for “a High Quality Workforce” set the framework for further development of the NHS workforce. Strategic Health Authorities’ work on the child health pathway has already begun to prioritise the workforce needs in delivering high quality and personalised care for all children. Modelling of the Children’s Community Workforce is also underway and will include workforce development in specific areas such as CAMHS and speech, language and communication needs.

NEXT STEPS

48. The strategy identifies a number of areas for further development to provide a stronger information base for monitoring equality impact of future developments. This further work is set out in the table below:

<table>
<thead>
<tr>
<th>Issue identified</th>
<th>Action</th>
<th>Timeframe</th>
<th>Lead Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability – lack of information on experience of services</td>
<td>Develop national disabled children’s indicator based on parents’ experience of services (this will capture the child’s ethnicity)</td>
<td>2009</td>
<td>DH/DCSF</td>
</tr>
<tr>
<td>Child adolescent mental health services</td>
<td>Develop indicator to measure success of CAMHS, (including exploring capturing information on the child’s ethnicity)</td>
<td>2009</td>
<td>DH/DCSF</td>
</tr>
<tr>
<td>School wellbeing indicators</td>
<td>Follow up consultation on school-level wellbeing indicators</td>
<td>2009</td>
<td>DCSF/OFSTED</td>
</tr>
<tr>
<td>Engagement and</td>
<td>Department of Health and</td>
<td>Ongoing</td>
<td>DH/DCSF</td>
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</table>
ongoing consultation on child health and wellbeing

Department for Children, Schools and Families have a broad range of stakeholders forums at both official and ministerial level who will be engaged in the ongoing monitoring and development of the impact of the strategy

Need to build evidence base on Data and information

ChiMat to map current availability of ethnic group information available from child and maternal health data sources 2009 DH

Develop a model to build commissioners’ understanding of the relationship between healthcare spend on children and outcomes. 2009 -2010 DH

Work on providing better data on experience and outcomes 2009 -2010 DH/DCSF

Publish best practice on data collection – as part of the Aiming High for Disabled Children programme June 2009 DH/DCSF

CONCLUSION

49. The strategy sets out an extensive cross-government framework for addressing the identified challenges through both existing policy commitments and additional measures as they relate to children and young people’s health and wellbeing. As the specific policies are developed and piloted equality
issues will be further considered as the individual strands of work are taken forward.

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For the record
Prepared by
Name and Date
Abigail Merrett DH - Feb 2009

Endorsed by
Heather Gwynn DH Director
Anne Jackson   DCSF – Director
### 2008

**CHILD HEALTH STRATEGY STAKEHOLDER ENGAGEMENT DURING DEVELOPMENT**

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
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<tbody>
<tr>
<td>Jan</td>
<td>Child Health Strategy workshop, hosted by Department of Health, attendees included officials from across Department of Health and Department for Children, Schools and Families and key national stakeholder groups</td>
</tr>
<tr>
<td>March</td>
<td>Children’s Plan: Time two Talk deliberative events – 2 workshops on health</td>
</tr>
<tr>
<td>March – April</td>
<td>Child Health Strategy workshop – hosted by National Children’s Bureau (attendees included senior practitioners and policy makers from across disciplines and sectors)</td>
</tr>
<tr>
<td>March – April</td>
<td>On-line survey for children and young people, undertaken by National Children's Bureau. Have you say about the Government's proposed new Child Health Strategy</td>
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<tr>
<td>June</td>
<td>Primary Care Trust Chief Executive and LA Director of Children’s Services Sounding Board Group</td>
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<td></td>
<td>Health Lives, brighter futures – national deliberative event with parents and young people (aged 16-19)*</td>
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<tr>
<td></td>
<td>Health Lives, brighter futures – eight focus group discussions with children and young people (aged 7 – 15)</td>
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<tr>
<td></td>
<td>Healthy Lives: brighter futures – a workshop event with parents of people with long-term conditions*</td>
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<td></td>
<td>Workshop with Together for Children, Local Authority and Primary Care Trust officials to discuss links between child health and children’s centres</td>
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<tr>
<td></td>
<td>Workshop with the Training and Development Agency and front-line practitioners to discuss links between child health and the extended schools programme</td>
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<tr>
<td>July</td>
<td>Child Health Inter-Agency Group (whose membership includes: ACEO, ADSS, Barnardo’s, CS, ConfEd, TCG, LGA, Metro Police, NCB, NCH, NCVCCO, NHS Confed, NSPCC, SOLACE)</td>
</tr>
</tbody>
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**Strategic Health Authority Workforce Leads**

Board of Stakeholders: cross-Gov Ministers, CO, HMT, HC, LGA, UCPHVA, DCDC, 11 Million, ACPO, RCPCH, FPI, NYA, NSPCC, UNISON, PLP, Essex Police, ECIOCBI, EHRC, NCVYS, ADSS, CS, OFSTED, FRCYP, ASCL, DH, NCB, CSCI, TPSIAG, WHS&SPC, WCC, NCH, CF, UNICEFUK, NCVCCO, NHSConfED,
Health impact test

The whole focus of the Child Health Strategy is to promote a positive impact on health. This is reflected throughout the main body of the Impact Statement. The strategy is designed to help reduce health inequalities. The evidence base behind the National Service Framework for Children, the Children’s Plan and a range of other evidence on specific policies and strategies on aspects of child health, such as the Healthy Child Programme and the Family Nurse Partnership make the case for the Strategy, which sets out the framework with which PCTs, local authorities and partners develop plans for improving services for children and make local decisions.
Sustainable Development Impact Assessment: Child Health Strategy

Brief description of the policy objective:

1. The CHS is intended for both commissioners and the public and sets out why child health matters; what good child health outcomes look like; and how Government will enable and promote joint delivery. It builds on the existing frameworks of Every Child Matters and the National Service Framework for Children, Young People and Maternity Services. Four over-arching ambitions are identified through the strategy: achieving world class health and wellbeing outcomes; achieving services of the highest quality; achieving excellent experiences of services; and minimising health inequalities.

2. The vision and strategy for child health and wellbeing brings together a range of existing policies to put together a comprehensive picture for families and for commissioners and providers of commissioners, and sets out proposals for next steps, including initiatives to support improved local delivery.

Summary of issues highlighted by completing Stretching the Web

Environmental:

3. There is a clear statement encouraging environmentally friendly lifestyles:

‘Wider environmental factors also have a huge impact upon children’s and young people’s ability to stay healthy. For example, walking or cycling to school or play areas is a key way to improve children’s health and reduce obesity. At the same time reducing pollution, and increasing road safety and community cohesion; and outdoor play in green spaces benefits children psychologically and physically. Even small amounts of green space are shown to have qualities that facilitate relaxation and recovery from mental fatigue and stress, particularly for those with symptoms of Attention Deficit Hyperactivity Disorder (ADHD).

‘There is compelling evidence on the benefits of play to children, both for enjoyment and developing the skills needed to prosper in childhood, and as preparation for later life. This includes the development of social skills, risk management skills and brain development associated with the ability to learn. This compelling evidence has led the
Government to commit record new investment in healthy neighbourhoods and communities. Between 2008 and 2011, £235m is being invested to support every local authority to provide a variety of designated public play areas, free of charge, that are both safe and accessible. This investment in innovative and stimulating local play areas will have an emphasis on the needs of 8-13 year olds and increase their opportunities to be active. Further support has also been provided to planners to help them consider the impact of planning on play and broader physical activity patterns. And in recognition of the importance of a clean and healthy environment, a Children’s Environment and Healthy Strategy has been consulted upon and will be published later this year.\(^67\)

4. The physical make up of the places where children live has a major impact on their health. The Strategy could have addressed areas such as: walking and cycling routes for the journeys made by children; their proximity and accessibility to green spaces for play, recovery and mental health; curbing their intake of air pollution and noise; and details of joint working with DfT and CLG, in particular on making this happen at local level.

**Potential impact of the predicted effects of climate change**

5. The impact on climate change is likely to be minimal. However, if an increasing number of parents made lifestyle changes as set out above, over time this would lead to a reduction in carbon usage through (1) reduction of cars on the road; and (2) reduction in amount of electricity used for leisure purposes (watching TV / playing on the computer).

6. There are also indirect but potentially powerful consequences resulting from reducing pollution, as children and families replace car journeys with more sustainable forms of transport and use less electricity. For example, asthma is a (for the most part low level) chronic illness that requires NHS medication and support, and the physical impacts of obesity (e.g. Type 2 diabetes) can also require treatment. There is a significant carbon cost to sourcing and transporting medication, and taking children for appointments to doctors and hospitals.

7. If conditions resulting from environmental factors such as asthma, eczema, obesity and arguably emotional wellbeing are on the increase, there are significant financial

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and environmental costs arising from treatment as GP surgeries, hospitals and a range of care options and staff are needed to operate to support them.

8. Recent research by the SDC suggests that pharmaceutical industry carbon emissions are also significant. (See further NHS England Carbon Footprinting Report, Sustainable Development Commission (2008) http://www.sd-commission.org.uk/publications.php?id=733)


- Children living within 500 metres of a major road for a sustained period of time (eight years), were found to have substantial deficits in lung function compared with children living at least 1,500 metres away.13
- UK traffic levels increased by 10 per cent between 1994 and 2004 and the trend is set to continue.14 Poor air quality is more likely to have its worst effects on people who are already susceptible to respiratory problems or cardiovascular disease and on those whose age makes them vulnerable.15
- An international study has shown that the UK has the highest asthma rates in the world, with 21 per cent and 25 per cent of 6-7 and 13-14 year-olds respectively reporting asthma symptoms within the last year.18
- Several studies have shown that occupants of vehicles can be exposed to internal air that is more polluted than that outside. In an Amsterdam study, the exposure of cyclists travelling the same routes was always lower than vehicle occupants.19
- Childhood (ages 2 to 15) obesity in England rose from 11 per cent to 18 per cent in boys and from 12 per cent to 18 per cent among girls between 1995 and 2005. Evidence for adults shows that using cycling to increase activity contributes to protecting against obesity – 0.5-1kg can be lost each month through regular cycling.20

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13 Gauderman, WJ et al., Effect of exposure to traffic on lung development from 10 to 18 years of age: a cohort study. The Lancet (early online publication) 26th January 2007.
14 The Urban Environment produced by the Committee on the medical effects of air pollutants. Royal Commission on Environmental Pollution, TSO (2007).
16 Brunton G, Oliver S, Oliver K and Lorenc T, A synthesis of research addressing children’s, young people’s and parents views of walking and cycling for transport. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London (2006).


Sustainable Development Unit’s Sign Off:
Louise Jordan, DCSF. 11 September 2008