A Health Needs Assessment for 0-5 Year Old Residents of the London Borough of Hackney and the City of London

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Hackney

CONTENTS

1 ACKNOWLEDGMENTS

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2 EXECUTIVE SUMMARY

"One chance for a generation"

(All Babies Count)

"Give every child the best start in life"

(Fair Society, Healthy Lives)

All children should have the opportunity to reach their full potential, and facilitating their development during the early years is vital in supporting them to realise this aim. In order to give each child the 'Best Start In life', all those involved in working with and caring for our youngest children must take responsibility for making every contact count. They must work to tackle the health and other inequalities across broader society and ensure that, wherever a child is born and raised, they are encouraged to foster the highest aspirations. Now is the "one chance for a generation"[1]; it is imperative the very best start in life is the ultimate goal of our health and wellbeing delivery strategies for Early Years.

We know that the first five years of a child's life are some of the most crucial. 'The Foundation Years' report (2010) states that there is "overwhelming evidence that children's life chances are most heavily predicated on their development in the first five years of life". 'The Science of Early Childhood Development' (2007) declares that "creating the right conditions for early childhood development is likely to be more effective and less costly than addressing problems at a later age" and "child development is a foundation for community and economic development, as children become the foundation of a prosperous and sustainable society".

This report presents the findings of a health needs assessment – it identifies need in the 0-5 age group across the Borough of Hackney and the City of London, and delivers recommendations to guide future areas of work and inform commissioning of services for these children and their families.

Many of the findings in this report refer to the two year period of 2013-2015, in which there were 6,991 births at Homerton University Hospital (HUH), accounting for three-quarters of births to Hackney mothers. Where available, data have been included from nearby hospitals where the majority of the remainder of our residents are born.

[1] All babies count, Prevention and protection for vulnerable babies, C. Cuthbert et al, NSPCC http://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-prevention-protection-vulnerable-babies-report.pdf

2.1 The Population

2.1.1 Hackney

Hackney is the third most densely populated London borough with the Office for National Statistics (ONS) estimating 263,000 people, including 20,400 children under five years of age (mid-2014). Greater London Authority (GLA) Population Projections forecast this to rise to 282,000 people, with 20,900 children under five by 2020. It is an ethnically diverse population with only 55% identifying as White (of which over one-third are not White British). Almost 40% of the population were born outside of the UK and Hackney has the fifth highest proportion of residents who cannot speak English at all (although this stands at only 1% of the population).

Fertility rates in the north east of the borough are amongst the highest in London and are likely due to the high birth rate found in the Charedi (Orthodox Jewish) community, where more than half of the population are under 16 years of age.

The male life expectancy at birth is significantly lower than London or national averages, and the female life expectancy at birth is significantly lower than the London average (but not the national average).

For the purposes of identifying geographical areas of need in this report, Hackney has been divided according to the six Children's Centres areas A-F as shown in Figure 1 with the locations of the 23 Children's Centres highlighted.

Figure 1. Map of Hackney's and the City of London's Children's Centre areas

Source: London Borough Hackney

2.1.2 City of London

The City of London has a relatively small resident population of 8,100 found in densely populated pockets, with only 370 children under five years of age (mid-2014 ONS estimate). GLA Population Projections forecast this to rise to 9,300 people with 600 children under five by 2020. As a result of these small numbers data presented for the City of London must be viewed with some caution. The City of London is less ethnically diverse than Hackney or the London average, with 79% identifying as White. The City of London fertility rate is the lowest in London. The life expectancy at birth is significantly higher for each gender than across London or England averages.

2.2 Wider Determinants

2.2.1 Hackney

Hackney is the 10th most deprived local authority[2] in England (of 326 local authorities) in the 2015 Index of Multiple Deprivation (IMD). However, this is an improvement on the 2010 IMD where Hackney was ranked as the most deprived local authority. Hackney has seen the largest percentage point decrease in the proportion of neighbourhoods classified as highly deprived of any local authority in England, from 42% (2010) to 17% (2015).

While the proportion of children living in poverty has fallen from 49% to 30% from 2007 to 2012, this is still above the London average of 24% and almost two-thirds greater than the national rate of 19%. This places Hackney 10th in the ranking of local authorities with the highest proportion of children living in income deprivation. One quarter of all people live in houses classified as overcrowded, which is greater than the London average. Over half of households containing dependent children are socially rented, which is higher than London and national averages. However, despite this deprivation Hackney outperforms 197 local authorities when ranked according to education, skills and training in the IMD placing it in the top half of local authorities.

RECOMMENDATION
• ***Aim to see a continuation of the reduction of the proportion of children living in poverty and aspire to surpass the London average.***

2.2.2 City of London

Overall the City of London is ranked jointly with 24 other local authorities as the least deprived in the 2015 IMD rankings. The proportion of children living in poverty is only 12% (2012) which places it 277th when ranking local authorities by the proportion of children living in income deprivation (i.e. only 49 local authorities have a lower proportion of children living in poverty). However, significant pockets of deprivation persist, with 2009 data revealing that 41% of children live in poverty in Portsoken ward but only 8% in Farringdon Within. Although the total proportion of households being overcrowded is lower

[2] Using the rank of the extent summary measure of deprivation

than the London average, some ethnic groups are heavily overrepresented, with over two-thirds of Bangladeshi people living in overcrowded housing in the City of London. The total proportion of housing being socially rented in the City of London is relatively low, but over a third of households that contain dependent children are socially rented which is higher than London and national averages. The City of London outperforms 323 local authorities when ranked according to education, skills and training in the IMD, with only two local authorities performing better[3].

RECOMMENDATIONS

- ***Explore why the proportion of children living in poverty varies in the City of London;***
- ***Draw up a more comprehensive profile for Bangladeshi children living in overcrowded accommodation in the City of London.***

2.3 Antenatal Period

Unless otherwise stated, all data relating to the antenatal period are provided by Homerton University Hospital (HUH) and therefore relate primarily to women resident in Hackney.

2.3.1 Antenatal Specialist Referrals

- Midwives based at HUH made 712 referrals for specialist services in addition to universal provision for a total of 448 women over two years (2013-2015). 78 referrals were to health visitors, which were predominantly for women who had been referred to three or more services and therefore represent the most complex cases;
- Age: women aged less than 20 were more likely to be referred;
- Ethnicity: women of Black or Mixed ethnicity were more likely be referred;
- Location: fewer referrals were made within Children's Centre area B. Only 11 referrals for Orthodox Jewish women were made (of 1,248 births). 74% of the Orthodox Jewish cohort lives in area B (based around the Stamford Hill area).

RECOMMENDATIONS

- ***Improve partnership working and data sharing between midwifery, health visiting and GP services;***
- ***Work closely with the Charedi population to understand why fewer Charedi women are referred to health visitors antenatally, and work to address these problems.***

[3] However, given the very few schools in the City of London and that most children will attend some of their schooling outside of the borough, these data must be viewed with caution

2.3.2 Teenage Conceptions and Births

- The number of conceptions in women aged under 18 in Hackney has been steadily reducing over the last 15 years and the rate now equals the England average;
- During this time the total number of births to women aged 19 and under fell by 25%;
- Ethnicity: Asian women are less likely to give birth aged 19 or under;
- Location: as a proportion of all births, there are no statistical differences in births being to women aged 19 or under by Children's Centre area. However, as a proportion of all 15-19 year olds, there are significantly more births in areas B and D;
- There have been no births to women aged 19 or under in the City of London in the last five years.

RECOMMENDATIONS

- ***Continue to deliver an enhanced support service for this age group of mothers, throughout pregnancy and postnatally for two years;***
- ***Provide targeted work for vulnerable young pregnant women who fall outside of the Family Nurse Partnership referral criteria;***
- ***Focus on areas B and D to further reduce the rate of teenage pregnancies.***

2.3.3 Maternal Mental Health

- 99.9% of mothers had their mental health status recorded at delivery – 5% were 'poor' and two thirds of these were perinatal mental health service clients;
- Age: those aged 25-29 were less likely, while those aged 40-44 were more likely, to be recorded as having poor mental health;
- Ethnicity: Mixed race women were more likely to have poor mental health recorded;
- Location: those in area B were less likely to have poor mental health recorded. In only 1.5% of births to Orthodox Jewish women was poor mental health recorded (74% of the Orthodox Jewish cohort live in area B);
- Dual diagnoses: of those with poor mental health recorded, 6.2% also had substance misuse recorded (versus 0.5% of those without poor mental health). Similarly, of those with substance misuse recorded, 42% also had poor mental health (versus 5% of those without substance misuse recorded);
- Postnatal depression screening: 38% of women were recorded as having been screened, with 3% of these requiring referral. Older women were more likely to be screened, but there was no ethnicity bias in screening.

RECOMMENDATIONS

- ***Increase the rate of screening for postnatal depression by midwives, with an aim to screen all pregnant women;***
- ***Provide a named health visitor for each family to build a relationship with mothers – facilitating the screening for and discussion of mental health issues;***
- ***Encourage the integration of families into local support groups and networks to increase mental resilience and help to protect against poor mental wellbeing.***

2.3.4 Maternal Weight and Obesity

- Half of mothers giving birth at HUH were of a healthy weight at their booking visit – one quarter were overweight, and one fifth were obese or very obese;
- Age: the proportion of pregnant women being obese increases with age. Mothers over 40 years old were almost twice as likely to be obese as mothers aged under 25;
- Ethnicity: Black women were twice as likely to be obese as other ethnicities;
- Location: areas D and E had the highest proportion of obese pregnant women and areas A and F had the lowest;
- Women from the City of London had a higher proportion of healthy weight mothers and lower proportion of overweight and obese mothers than Hackney.

RECOMMENDATIONS

- ***Provide a pathway of support including midwifery, health visiting and primary care from preconception advice to returning to a healthy weight post pregnancy;***
- ***Focus support towards older mothers and mothers of Black ethnicity.***

2.3.5 Maternal Smoking

- Over 10 months at HUH, 254 pregnant women (6%) identified as smokers at their booking visit. While 39 of these stopped smoking by delivery, 18 previous ex-smokers and 16 never smokers started smoking and therefore only five fewer women were smoking at delivery than at booking;
- Current smokers were twice as likely to have a low birth weight baby compared to never or ex-smokers in Hackney and the City of London. In total, 34 babies were born of low birth weight over two years (2013-15) that could be attributable to smoking;
- Age: the rate of smoking declined with maternal age;
- Ethnicity: White mothers were most likely to smoke and, within this group, Turkish women had the highest proportion of smokers (15.4%);
- Location: lower rates of smoking were in Children's Centre areas A and B;
- Overall the proportion of low birth weight babies is fluctuating but appears to be falling in Hackney, although it remains just above the national average;
- No City of London women who delivered at UCLH were smokers on delivery.

RECOMMENDATIONS

- ***As per national guidance, implement use of carbon monoxide (CO) monitors during pregnancy and at birth to improve identification and the accuracy of prevalence;***
- ***Ensure advice and support is available for all women, not just current smokers, to reduce the risk of women starting or restarting smoking during pregnancy;***
- ***Continue to work with young mothers to ensure that they and their family members are supported to go – or remain – smoke-free;***
- ***Develop culturally appropriate interventions in the Turkish and Eastern European communities to reduce smoking amongst mothers and their family members.***

2.4 Postnatal Period / Young Children

2.4.1 Health Visiting

- To prepare for the transition of the responsibility for commissioning early years public health services to the local authority, stakeholder consultation was conducted through a workshop, interviews with key partners, and focus groups to gain a better understanding of what barriers exist in the current service and source ideas for improvements that could be implemented in the new service;
- The main concerns raised by health visitors were that there is a lack of retention of health visitor students, that staff vacancies need to be filled more promptly, and that health visitors need more opportunities to build relationships with clients;
- The mains issues raised by the stakeholder workshop (including Children's Centres, Children's Social Care and the Clinical Commissioning Group) were the need for more integrated care between different health professionals, a current lack of continuity of care, a need to make services more easily accessible to local families and a need for more safeguarding referrals to the multi-agency team by primary care;
- Focus groups with local parents revealed that their most common concerns were around consistency of care (through seeing different health visitors, each with a different focus and some providing conflicting advice), a lack of understanding of what the service involves and the service not engaging with fathers enough.

RECOMMENDATIONS

- ***Implementation of the new Health Visiting contract will provide clarification of what health visitors are to provide in order to reduce variability between visitors in the face of competing demands from different organisations;***
- ***Where appropriate, the new health visitor contract should allow for streamlining of pathways and paperwork to increase the time available to support families;***
- ***The new Health Visiting contract could consider increasing service accessibility through the provision of a range of access points that cover a variety of locations, settings and timings and through the use of telephone advice, where appropriate;***
- ***A new preceptorship programme could be developed to provide enhanced support to newly qualified staff to increase student retention, reduce staff vacancies and decrease variation in advice;***
- ***All health professionals should look to better include fathers;***
- ***The role of health visitors should be clearly explained to new parents;***
- ***The creation of a central hub for data sharing and training about when and how to share data could increase the integration between health professionals.***

2.4.2 Infant and Child Mortality Rates

- The child mortality rate is 12.8 per 100,000 (2011-13) which is above the national average of 11.9 per 100,000 but a fall from 27 per 100,000 three years previously;
- Approximately half (47%) of all child deaths reviewed by the Child Death Overview Panel (CDOP) were in neonates and over two-thirds (68%) were in infants;
- Almost half of child deaths were due to morbid conditions, a third were due to external causes and a quarter were unexpected;
- The infant mortality rate in Hackney (2011-2013) was higher than the national rate and the highest of Hackney's statistical neighbours (defined in Section 5);
- Over half (61%) of infant deaths were in boys;
- There have been no deaths of children or young people resident in the City of London during 2014/15.

RECOMMENDATIONS

- ***Enable health visitors to offer the option of a follow up home visit after the new birth visit for mothers who would like and need more support;***
- ***Encourage the development of community peer support, where champions provide home visits, to increase the availability of culturally appropriate advice;***
- ***Engage fathers and grandparents to ensure that all care providers feel confident in supporting the child.***

2.4.3 Breastfeeding

- The incidence of breastfeeding at birth is 92% in Hackney and the City of London – higher than the London average of 88% or the national average of 76% (2013/14);
- At 6-8 weeks, 84% of Hackney and City of London mothers are breastfeeding to some extent (two-thirds of these exclusively) which is higher than the London (73%) and national (51%) averages;
- 1.4% of babies were seen in HUH (2013-15) for feeding problems;
- Age: women aged under 20 were less likely to breastfeed at birth. Half as many 20-30 year olds as 30-40 year olds attended breastfeeding support groups;
- Ethnicity: mothers of Asian and Mixed ethnicities were least likely to be breastfeeding at all, and mothers of Asian and Black ethnicities were least likely to be exclusively breastfeeding at 6-8 weeks. This contradicts national findings with regards to Asian mothers. White mothers are overrepresented at support groups;
- Location: areas A and B (the latter containing the Charedi community) had higher rates of breastfeeding at birth than areas C to F, and by 6-8 weeks areas A and B had lower rates of feeding problems than area F.

RECOMMENDATIONS

- ***All major partners should work towards baby friendly accreditation;***
- ***Encourage more young mothers to attend breastfeeding support groups, in particular those from BME communities;***
- ***Provide culturally appropriate support for Asian women to continue to breastfeed at all, and to encourage more Black women to continue to breastfeed exclusively.***

2.4.4 Immunisation

- Coverage of children receiving two doses of the Measles, Mumps and Rubella (MMR) vaccine has more than doubled from below 40% in 2008 to above 80% in 2013, but it remains below the 95% coverage required to achieve herd immunity for measles;
- In area B only 65% of children receive all three doses of DTaP/IPV/Hib by their first birthday making it the only area not to reach 90% coverage in line with the schedule. This is attributed to 74% of Orthodox Jewish children being located in area B.

RECOMMENDATIONS

- ***All health professionals to highlight and discuss the importance of immunisation and to signpost to local providers;***
- ***Further explore the barriers to timely vaccination in the Charedi community and work to overcome these barriers to increase the proportion of children who are up-to-date with the schedule.***

2.4.5 Healthy Start

- 4,674 packs of Healthy Start vitamins were dispensed to 3,182 individual pregnant or postnatal women (36% of those eligible in Hackney) in 2015;
- 5,539 packs of Healthy Start vitamins for children were dispensed to 3,398 individual children (20% of those eligible in Hackney) in 2015 – uptake decreases with age;
- 76% of eligible families use the targeted Healthy Start food voucher scheme.

RECOMMENDATIONS

- ***Investigate which women are not choosing to start using vitamins and engage stakeholders to understand the barriers to their use;***
- ***Encourage mothers to continue to receive vitamins for their children throughout the four year period once they have started the scheme;***
- ***Discuss with local stakeholders whether a more targeted vitamin scheme, like that in use across much of the country, would better serve our most in need families.***

2.4.6 School Readiness

- 5,852 27-month reviews were conducted over two years (2013-15) – areas B, D and F had the lowest rates of completion and ethnicity was not recorded in 30%;
- 65% of pupils in Hackney obtained a Good Level of Development (GLD) in July 2014 – higher than London (62%), England (60%) and Hackney's 2013 result (57%);
- 67.3% of children reached a GLD in the City of London in July 2014;
- Outcomes in Hackney are as good as, or better than, London and national averages in each of the seven main areas;
- The achievement gap between the lowest attaining 20% of children and the median level of achievement is smaller in Hackney than in London or England;
- Gender: girls are more likely than boys to obtain a GLD (70% versus 60%) and achieve a higher average point score (35 compared to 33);
- Origin: children of British origin are most likely to achieve a GLD (80%) and achieve higher average total point scores (37), whereas children of a Turkish/Cypriot/Kurdish origin are least likely to obtain a GLD (50%) and have a lower point score (31);
- Location: area B has the lowest number of children achieving a GLD (54%) and a slightly lower average point score (33); area D has the highest GLD achievement rate (70%) and area A has a slightly higher average point score (35);
- 90% aged three and 97-98% aged four take up the 15 hours of free childcare funding.

RECOMMENDATIONS

- ***Increase ethnicity recording at the 27 month review;***
- ***Work with community groups and education providers to develop new culturally-appropriate ways to support children of Turkish/Cypriot/Kurdish origin;***
- ***Develop our strategy to work with the Borough's independent schools to support them, to ensure that they are giving children the same opportunity to reach a GLD as state schools, particularly with regards to the lower rate in area B.***

2.4.7 Children with Disabilities / Special Educational Needs

- There has been a 44% increase in the number of children accessing Disability / Special Needs services between 2011/12 and 2013/14;
- Gender: there are more boys with longstanding illness or disability than girls;
- Location: area C has seen a four-fold increase in service access over two years;
- Fewer than ten children had a known disability in the City of London in 2013.

RECOMMENDATIONS

- ***Explore why more children are accessing services in area C and investigate whether there are barriers to accessing services in the rest of the borough;***
- ***Ensure all health and education professionals understand how to signpost families to local disability / special educational needs services;***
- ***Link services effectively so that families receive all of the support they need regardless of where they present.***

2.4.8 Accident and Emergency Attendances and Emergency Hospital Admissions

- There were 22,465 attendances over two years (2013-15) at HUH Accident and Emergency (A&E) Department in children aged 0-4. This equates to 1.2 visits per head of the 0-4 population over this period;
- There were 3560 emergency admissions to HUH for 0-4 year olds. This is approximately 184 admissions per 1,000 of the 0-4 population;
- Attendances peak in November/December and fall to a trough in August;
- Age: the number of attendances and admissions decreases with age;
- Gender: at all ages attendances and admissions are higher for males than females;
- Ethnicity: White British children have the lowest rate of attendance and children who are White Other have the highest rate of attendance (over 4.5 times greater);
- Location: areas A, B and E have similar lower rates of admission; whereas C, D and F have similar higher rates of admission;
- Common conditions:
    - Respiratory conditions – 24.5 admissions per 1000 population. White Irish and White Other children had higher rates of admission; this was in line with their overall higher rates of admission;
    - Accidents and injuries – 11.3 admissions per 1000 population. 59% were head injuries. Boys and girls were affected similarly. Black and Asian children had lower rates of admission; this was in line with overall admission variation;
    - Gastroenteritis – 8.0 admissions per 1,000 population. Admissions peak at one year then decrease with age. Area D had the highest rate of admission;
    - Feeding problems – all admissions were for children under one year at a rate of 13.3 per 1,000 infant population.

RECOMMENDATIONS

- ***Look to understand the perceived barriers to using primary care and pilot strategies to reduce these barriers;***
- ***Engage with stakeholders to understand why children from White Other communities have higher attendance rates and provide culturally-relevant campaigns to reduce attendance;***
- ***Provide information through professionals working with young children (such as health visitors and Children's Centres) about common respiratory conditions that can be managed in the community and promote the use of primary care;***
- ***Create a targeted service for families who are repeat attenders to A&E.***

2.4.9 Childhood Weight and Obesity

- The prevalence of being overweight or obese across Hackney and the City of London at Reception and Year 6 in state schools[4] is significantly higher than London and national averages, and this is largely unchanged since measurement began in 2007;
- 73% of reception children across Hackney and the City are at a healthy weight, but 13% are overweight, 13% are obese and 1% are underweight;
- Gender: there is no statistically significant difference in obesity rates between girls and boys in Hackney and the City, while nationally boys have higher rates than girls;
- Ethnicity: obesity is more common in children of Black than White or Asian ethnicity;
- Location: Woodberry Down has the highest obesity prevalence in Hackney. Obesity prevalence is lowest in the least deprived Lower layer Super Output Areas (LSOAs).

RECOMMENDATIONS

- ***Work with all partners involved with children in the early years to develop pathways to increase efforts to prevent obesity prior to children starting school;***
- ***Provide campaigns through Children's Centres, such as advertising sports resources, to reach families with children in the early years;***
- ***Investigate the extent of obesity in local independent schools, as this accounts for 20% of children not being included in the calculation of local obesity rates;***
- ***Provide whole family, holistic support to promote weight loss, particularly in families of Black ethnicity, to prevent the generational cycle of obesity.***

[4] Of note these figures do not include the Charedi children educated in independent schools who constitute approximately 20% of children in Hackney.

2.4.10 Dental Health

- Attendance at a dentist by children in Hackney and the City of London has improved over the last six years, but in 2012 remained at only 47% over the preceding two years, below the average for London (67%) and neighbouring boroughs (56% in Tower Hamlets and 66% in Newham);
- Tooth decay is more prevalent in Hackney (31.4% aged five) than England (27.9%);
- There has been a significant rise in the rate of tooth decay in three year olds, and a small but non-significant rise in five year olds, in Hackney and the City of London;
- Location: Brownswood has the highest proportion of children with tooth decay.

RECOMMENDATIONS

- ***Provide joined-up campaigns to highlight the importance of dental health alongside diet and lifestyle advice in the effort to combat obesity, to ensure that advice is holistic and complementary;***
- ***Encourage all health professionals, in particular health visitors, to educate, promote and signpost to dental services;***
- ***Provide education and promotion around the fluoride varnish programme.***

2.5 Family Circumstances

2.5.1 Parental Substance and Alcohol Abuse

- In 2011/12 the rate of children aged 0-15 in Hackney who had parents in drug treatment was 111.3 per 100,000, similar to the England average of 110.4;
- In 2011/12 the rate of children aged 0-15 in Hackney who had parents in alcohol treatment was 105.5 per 100,000, lower than the England average of 147.2;
- In 2013-2015 no City of London mothers delivering at UCLH were recorded to have a current substance misuse or alcohol problem.

RECOMMENDATIONS

- ***Ensure all practitioners who work with families are well trained to identify substance misuse problems early, know how to refer to and actively promote the wide range of treatment services within the borough (particularly those specifically for parents), and understand that support can lead to successful recovery;***
- ***Capitalise on the inclusion of substance misuse as a criterion within the Troubled Families programme through using the expanded funding to co-ordinate additional professional support surrounding substance misuse;***
- ***Expand the number of drug and alcohol treatment services that have child care or crèche facilities available to facilitate mothers' attendance;***
- ***Increase partnership working for women with dual diagnoses of mental health and substance misuse disorders to provide a holistic package of care.***

2.5.2 Domestic Violence

- In Hackney it has been estimated that, of all women and girls aged 15-69 in 2010, 5245 were the victim of domestic violence, 5687 were the victim of sexual abuse and 9,281 were the victim of stalking. However, in 2009/10 there were only 4,665 reports of domestic violence to the Police in Hackney;
- Domestic violence status was recorded in 65% of births by City and Hackney residents at HUH and 2.3% of these had experienced domestic violence;
- Ethnicity: White women are less likely than BME women and Turkish women are the least likely to have their domestic violence status recorded during pregnancy;
- 0.7% of women were recorded as having had Female Genital Mutilation (FGM) during their maternity booking visit at HUH (2008-2014);
- 60 referrals were made to Children's Social Care 2014/15 for potential risk of FGM – in no cases the girl had FGM performed.

RECOMMENDATIONS

- ***Increase the coverage of domestic violence screening and documentation in pregnant women, with a particular focus on White women;***
- ***Routinely enquire about and record the FGM status of pregnant women at their booking visit and ensure that all women who have undergone FGM are given a full assessment and made aware of the full range of available support;***
- ***Provide a named health visitor per family to provide continuity of care which may facilitate the disclosure of women's concerns and detection of domestic violence;***
- ***Ensure all health professionals working with pregnant women and young children know how to and feel confident in reporting concerns about domestic violence (including FGM) to the Multi-Agency Risk Assessment Conference (MARAC);***
- ***Through the IRIS project help GPs to feel more able to support women who have been highlighted as at risk of domestic violence through the MARAC.***

2.5.3 Safeguarding

- 216 children were subject to a child protection plan in Hackney as of 31st March 2015, not dissimilar from 221 in 2014. The number of looked after children had shown a small rise from 330 to 343 over the same period;
- Ethnicity: 45% of looked after children in Hackney are of Black ethnicity, whereas children of White ethnicity accounted for 28%;
- The City of London had only five looked after children in both 2012 and 2013.

RECOMMENDATIONS

- ***Provide training to encourage earlier completion of the Common Assessment Framework (CAF) by health visitors for vulnerable families;***
- ***Provide training for GPs so they can better understand their role in the CAF and to encourage a greater number of referrals via primary care;***
- ***Provide more joined up working between services for complex families.***

3 INTRODUCTION

There has been a wealth of research in the past ten years demonstrating the importance of the early years of life in forming the foundation on which all future learning and development builds. Several government reviews, documented in the next section of this report, highlight concerns regarding health inequalities and the detrimental affect they have on this process. Based on these reviews the government has made the early years a key priority and a raft of new policies have been written that aim to improve outcomes for children. As part of the regeneration of the Early Years services, the responsibility for commissioning public health services for under-fives moved from NHS England to local authorities on October 1st 2015. The main programmes being transferred were the Healthy Child Programme ('Pregnancy and the First Five Years of Life') and the Family Nurse Partnership. This transition aims to allow joined up commissioning of services for children and young people from 0 to 19 years of age, and to enable the provision of local services to be guided by local needs. This health needs assessment aims to review the needs of the local population, specifically 0-5 year olds in Hackney and the City of London and their families, and highlight areas of greatest need to enable the commissioning of a service that will best address them.

3.1 AIMS

The aims of this health needs assessment are to:

- Review recent evidence, policies and guidance that inform the provision of services for the 0-5 age group in Hackney and the City of London;
- Review the demographics of Hackney and the City of London and discuss how these impact the needs of the 0-5s in these areas;
- Review the current provision of services to identify any gaps in the service and key areas for development;
- Discuss stakeholders' views of the current services on offer;
- Provide recommendations for service improvement based on the latest evidence and knowledge of the population.

3.2 METHODOLOGY

The literature review undertaken as a component of this needs assessment was conducted by identifying key policies, government documents and research papers relevant to the 0-5 population. Initial identification of documents was through a keyword search using the term '0-5s' on the gov.uk website to identify policy documents. Further searches for relevant grey literature were performed using Google, using the terms '0-5s', 'Health Visiting' and 'Healthy Child Programme'. Further relevant research papers, government documents and reviews were identified through reviewing cited papers in the relevant literature identified through the above processes.

Relevant National Institute for Health and Care Excellence (NICE) guidance was identified through searching the NICE published guidance database and through the rapid review performed by Public Health England (PHE) to update the evidence behind the Healthy Child Programme for 0-5s and is included in Chapter 7.

To accurately map ongoing areas of need, the most up to date data on priority areas have been sought and analysed and have also been used to inform recommendations.

In order to obtain information on current services and identify areas of unmet need a wide stakeholder consultation was performed and qualitative analysis of this engagement has been performed and used to inform recommendations.

Further information on the local population and specific areas of need have been obtained from locally and nationally produced documents such as the JSNA/census/local area profiles and other needs assessments.

City of London caveat

Throughout this needs assessment there are gaps in the data for the City of London. Firstly, due to the small size of the City of London many figures must be supressed, to ensure they are not personally identifiable. Where there are small numbers which are expressed as a percentage it is important to treat figures with caution because a small change in number can produce a large change in percentage and be misleading. Secondly, City of London births take place in a number of hospitals. Not every hospital has been able to provide us with the requested data, which has meant it is not possible to provide a full picture of the City of London birth and Accident and Emergency data.

4 Literature Review

4.1 National Context

The Science of Early Childhood Development[5]

The National Scientific Council, based at the Centre on the Developing Child at Harvard University, brought together neuroscientists, developmental psychologists, paediatricians and economists to critically review existing literature, to form a consensus of what is known about development in the early years. The document 'The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do' presents their review. They divided their findings into core concepts and implications for policy and practice.

[5] The Science of Early Childhood Development: Closing The Gap Between What We Know and What We Do, National Scientific Council on The Developing Child, 2007 http://developingchild.harvard.edu/resources/reports_and_working_papers/science_of_early_childhood_development/

Core concepts:

- Child development is a foundation for community and economic development, as children become the foundation of a prosperous and sustainable society
- Brains are built over time
- The interactive influence of genes and experience literally shape the architecture of the developing brain, and the active ingredient is the 'serve and return' nature of children's engagement in relationships with their parents and other caregivers in their family or community
- Both brain architecture and developing abilities are built 'from the bottom up', with simple circuits and skills providing the scaffolding for more advanced circuits and skills over time
- Stress in early childhood is associated with persistent effects on the nervous system and stress hormone systems that can damage developing brain architecture and lead to lifelong problems in learning, behaviour and both physical and mental health
- Creating the right conditions for early childhood development is likely to be more effective and less costly than addressing problems at a later age

Implications for policy and practice:

- Policies that promote supportive relationships and rich learning opportunities for young children create a strong foundation for higher school achievement followed by greater productivity in the workplace and solid citizenship in the community
- Substantial progress toward this goal can be achieved by assuring growth-promoting experiences both at home and in community-based settings, through a range of parent education, family support, early care, pre-school and education services
- When parents, informal community programmes, and professionally staffed early childhood services pay attention to young children's emotional and social needs, as well as to their mastery of literacy and cognitive skills, they have maximum impact on the development of sturdy brain architecture and preparation for school success
- When basic health and early childhood programmes monitor the development of all children, problems that require attention can be identified in a timely fashion and intervention can be provided
- The basic principles of neuroscience and the technology of human skill formation indicate that later remediation for highly vulnerable children will produce less favourable outcomes, and cost more than appropriate intervention at a younger age
- The essence of quality in early childhood services is embodied in the expertise and skills of the staff and in their capacity to build positive relationships with young children. The striking shortage of well-trained personnel in the field today indicates that substantial investments in training, recruiting, compensating and retaining a high quality workforce must be a top priority
- Responsible investments in services for young children and their families focus on benefits relative to cost. Inexpensive services that do not meet quality standards are a waste of money. Stated simply, sound policies seek maximum value rather than minimal cost

The findings of this systematic scientific inquiry are applicable to all children, and provide an evidence base for informing the design of an Early Years service which should aspire to address all of the core concepts and incorporate the policy recommendations.

Fair Society, Healthy Lives: the Marmot Review[6]

> "Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course"
>
> (Fair Society, Healthy Lives)[6]

The Marmot report was commissioned by the Secretary of State in 2008 to document the findings of their independent review – held to identify the most effective, evidence-based strategies for reducing health inequalities in England. Whilst they acknowledged that the government had already made a commitment to the early years by way of the Healthy Child Programme and Sure Start, the review concluded that reducing health inequalities required further action to 'give every child the best start in life', as "a child's physical, social and cognitive development during the early years strongly influences their school-readiness and educational attainment, economic participation and health". They further identified maternal health as an area for improvement as "maternal health, including stress, diet, drug, alcohol and tobacco use during pregnancy, has significant influence on foetal and early brain development". Furthermore, deprivation, births outside marriage, non-white ethnicity of the infant and maternal age under 20 were all independently associated with increased risk of infant mortality. It was suggested that local authorities should be involved in order to give every child the best start in life, as national policies require local delivery systems, and it would put "empowerment of individuals and communities at the centre of action to reduce health inequalities." It also concluded that a programme utilising proportionate universalism was necessary, as focusing only on the most disadvantaged would not reduce health inequalities sufficiently.

[6] Fair Society, Healthy Lives: the Marmot Review (2010)
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

The key messages of the review include:

1. Reducing health inequalities is a matter of fairness and social justice.

2. There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient.

3. Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

5. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

6. Reducing health inequalities will require action on 6 key policy objectives:

- **a. Give every child the best start in life**
- **b. Enable all children young people and adults to maximise their capabilities and have control over their lives**
- **c. Create fair employment and good work for all**
- **d. Ensure a heathy standard of living for all**
- **e. Create and develop healthy and sustainable places and communities**
- **f. Strengthen the role and impact of ill health prevention**

7. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.

8. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

Fair Society, Healthy Lives[6]

The Foundation Years: Preventing poor children becoming poor adults[7]

> There is "overwhelming evidence that children's life chances are most heavily predicated on their development in the first five years of life"
>
> (The Foundation Years)[7]

This report was commissioned by the Prime Minister in June 2010 to gain insight into poverty and life chances in the UK. The review specifically aimed to: generate debate, look at reforming poverty measures, investigate the link between a child's home environment and school readiness, and provide recommendations to the government and other institutions to reduce poverty and improve life chances for the least advantaged in society. One of the main conclusions was that the UK needed to address child poverty in a completely different way in order to achieve lasting effect on children's life chances. The review reports "overwhelming evidence that children's life chances are most heavily predicated on their development in the first five years of life" and cite crucial factors as: family background, parental education, good parenting and the opportunities available for learning and development. These factors were found to affect children's chances of achieving their full potential more than money. They further found that what mattered most in these early years included:

- A healthy pregnancy
- Good maternal mental health
- Secure bonding with the child
- Love and responsiveness of parents along with clear boundaries
- Opportunities for a child's cognitive, language, social and emotional development

Furthermore, good services were found to have a role to play including: health services, children's centres and child care, as by school age there are already very wide variations in children's ability levels. The pattern is clear – those from poorer backgrounds do worse both behaviourally and cognitively than those from more affluent backgrounds. Unfortunately, attending school does not narrow this divide, as those who perform poorly initially tend to continue to do so. The report also concluded that while assistance exists in the early years, in the form of GPs, health visitors and children's centres (to name a few), together the service is fragmented and poorly accessible to those who require it the most. At the time the report was produced it concluded that Early Years services were variable and operating with a lack of evidence underpinning their interventions. The authors recommended directing more government policy and spending towards developing children's capabilities in the early years, to help children from poorer backgrounds move up the income hierarchy based on merit. They proposed the establishment of Life Chance Indicators to measure success in improving life outcome equality, framing all recommendations by the aspirations

[7] The Foundation Years: Preventing poor children becoming poor adults, The report of the Independent Review of Poverty and Life chances, Frank Field, Dec 2010
http://dera.ioe.ac.uk/11472/1/ffreport.pdf

parents have for their children and establishing the 'Foundation Years' as the first in a trio of educational opportunities for children, the subsequent two being school and higher education. Further recommendations included directing increased funding towards factors known to improve children's life chances, such as support for parents during pregnancy and the early years, a government led strategy that aspires to narrow the gaps in outcome between poorer and richer children in the foundation years, and ensuring all disadvantaged children have access to affordable, full time, graduate-led childcare from age two. Recommendations were also made to re-establish the identification and out-reach aspect of children's centres and to use Children's Centres as community hubs which work in conjunction with third sector services rather than duplicating delivery.

Early Intervention: The Next Steps[8]

This review, requested by the government and undertaken by MP Graham Allen, reviewed early intervention for 0-3 year olds. During this time neglect, the wrong type of parenting and other adverse experiences can all have a profound effect on children's emotional development which will in turn influence their responses to events in the future and their abilities to empathise with others. The core message of the report is that early intervention is an opportunity to make lasting change to the lives of children, which in turn benefits wider society, by forestalling social problems that can continuously pass from one generation to the next. It reviews a large number of policies and programmes which highlight the benefit of early intervention programmes and recommends that the imbalance in spending between late and early interventions be redressed in light of this evidence. The primary recommendation was to develop the independent Early Intervention Foundation. The report also recommended that GP consortia and local authorities work together to commission evidence-based preventive early interventions, especially in pregnancy around antenatal education/preparation for parenthood and the first years of life. They also recommended that the success of the Family Nurse Partnership (FNP) be taken further with greater access for vulnerable first time young mothers, and that future expansion of early intervention programmes favour those which combine strong evidence bases with impact on crucial stages of development. It further recommended that all children have regular assessment from birth up to and including five years of age, focusing on social and emotional development, to promote 'school-readiness'. Finally, the report identified a need to improve workforce capability of those working with under-fives.

[8] Early Intervention: The Next Steps, An Independent Report to Her Majesty's Government, Graham Allen MP, Jan 2011
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284086/early-intervention-next-steps2.pdf

1001 Critical Days: The Importance of the Conception to Age Two Period[9]

"Pregnancy and the birth of a baby is a critical window of opportunity when parents are especially receptive to offers of advice and support"

(1001 critical days)[9]

This cross-party manifesto highlights the importance of early intervention to avoid the life-long ramifications of adverse childhood events: the best time to act being during the 1001 critical days. The manifesto reiterates evidence that has shown the importance of the quality of parent-infant attachment and the earliest experiences in a child's life, including the negative consequences of exposure to toxic stress, for brain development. It states that babies are disproportionately vulnerable to abuse and neglect, with 36% of serious case reviews involving babies under one year of age and 26% of UK babies living in complex family situations that put them at a higher risk of harm. Complex family situations include substance misuse, mental illness or domestic violence. The authors' goal is for every baby to receive sensitive and responsive care in their first years of life and for parents to feel confident in their abilities to raise their children. Parents should be assisted through seamless services in the antenatal, perinatal and postnatal periods with evidence-based services available for at risk families and those experiencing difficulties. Local services should prioritise actively identifying and reaching out to those families in need of extra services, utilising innovative commissioning and a culture of joined-up working, and ensure high quality training for the health and Early Years workforce alongside an increased evaluation of services.

Conception to age 2 – the age of opportunity[10]

"Evidence-based and well implemented preventive services and early intervention in the foundation years are more likely to do more to reduce abuse and neglect than reactive services and (in the long run) deliver economic and social benefits."

(Conception to age 2 – the age of opportunity)[10]

[9] 1001 Critical Days: The Importance of the Conception to Age Two Period, A Cross Party Manifesto, Andrea Leadsom MP et al
http://www.andrealeadsom.com/downloads/1001cdmanifesto.pdf

[10] Conception to age 2 – the age of opportunity, Addendum to the Government's vision for the Foundation Years: 'Supporting Families in the Foundation Years', wave trust in collaboration with the Department for Education
http://www.wavetrust.org/sites/default/files/reports/conception-to-age-2-full-report_0.pdf

The focus of this report is the period from conception until a child's second birthday. During this period of a child's life the environment in which they are raised, including the quality of the relationship with their caregiver, has implications for the rest of their lives.

A loving and secure relationship with parents and a quality home learning environment allow for healthy development of a child's:

- emotional wellbeing (infant mental health)
- capacity to build and maintain positive relationships
- brain function (80% of brain cell development has already occurred by age three)
- language ability
- ability to learn

"The 'soft' skills that equip a child to relate to others, thrive and then go on to learn the 'hard' cognitive skills needed to succeed academically are embedded in the earliest months of life. Poor support, particularly a failure to prevent abuse or neglect, at this stage can have a lifelong adverse impact on outcomes."

(Conception to age 2 – the age of opportunity)[10]

The report recommended that, in order to allow the child to achieve their full potential, policy should reflect the importance of:

- The relationship between the child and their primary care-giver
- The role that parental mental health, both in the antenatal and postnatal period, plays in determining the quality of that relationship, and the crucial part it plays in safeguarding children from abuse and neglect
- The increased risk that children who have multiple risk factors have of poor outcomes, and the negative impact this can have on practical parenting and secure attachment
- Evidence-based programmes which have been shown to support improved early relationships and perinatal mental health

"Nine Social Return on Investment studies showed returns of between £1.37 and £9.20 for every £1 invested"

(Conception to age 2 – the age of opportunity)[10]

The report further identified points during this period at which intervention to improve outcomes could occur:

- Pregnancy – during this time poor physical and mental wellbeing of the mother can negatively affect a child's development
- The first few months after birth – adequate nutrition is crucially important to a child's development, and breastfeeding in particular can achieve positive outcomes; other important factors include immunisation, home safety and hygiene

The report recommends that these goals can be approached through prioritising early identification of need and providing children and their families with appropriate support by:

- Ensuring midwifery and health visiting training is structured with consideration to the role and methods of social and emotional assessment
- Providing practical guidance for Early Years' practitioners
- Commissioners using best practice approaches
- Ensuring professional reflective supervision takes place, including practice to ensure self-awareness and to ensure the supervisee has emotional intelligence
- Ensuring high quality assessment, early years intervention and support
- Using preventive instead of reactive interventions that address risk factors likely to result in problems, before those problems emerge
- Fully delivering the Healthy Child Programme
- Targeted work through Children's Centres
- Ensuring midwives and health visitors are resourced and trained appropriately to enable delivery of support that can promote responsive, loving and nurturing parenting and good communication between parents and children

Factors that encourage positive development during pregnancy[10]

- Enjoying a well-balanced diet
- Not experiencing stress or anxiety
- Being in a supportive relationship and not experiencing domestic violence
- Not smoking, consuming alcohol or misusing illegal substances
- Not having poor physical, mental or emotional health
- Not being socio-economically disadvantaged
- Being at least 20 years old
- Having a supportive birth assistant at the birth itself

Measures of the quality of the home learning environment[10]

The extent to which parents take part in learning activities with their children, including:

- Reading to them
- Playing with letters and numbers
- Taking them to the library
- Painting and drawing
- Teaching them nursery rhymes and songs
- Taking them on visits
- Arranging for children to play with their friends at home

Some of the risk factors known to adversely affect the parent-baby relationship[10]

- Baby intrinsic problems: low birth weight or disabilities
- A parent lacking the ability to attune sensitively to the baby's needs
- A parent who does not interact with or who maltreats the infant
- One or both parents struggling with a mental health or substance misuse problem
- One or both parents with a background of abuse, neglect or loss in their own childhood
- Parents with inadequate income
- Parents with sub-standard housing
- Family dysfunction or experiencing domestic violence
- Being a single teenage mother without support

The millennium cohort study demonstrates correlations with income group and parenting with the likelihood of achieving good development by five years of age. Figure 2 below demonstrates that, on average, poor parenting has a greater negative impact on the chance of a child achieving good development than poverty.

Figure 2. Poverty, type of parenting and achieving good development

	Group of 5 year olds	% achieving good development
1.	No poverty and positive parenting	73
2.	No poverty and poor parenting	42
3.	Persistent poverty and positive parenting	58
4.	Persistent poverty and poor parenting	19

Source: Conception to age 2 – the age of opportunity[10]

The Early Years Foundation Stage (EYFS) Review[11]

This review examines the evidence behind children's development, learning and how best to support them in that learning. The report then looks at Early Years settings, regulation and assessment of these settings and the seven areas of learning set out in the EYFS.

Key points of relevance to this needs assessment include:

- Investments and interventions in the early years are generally more effective than those made later in a child's life
- High quality early years interventions give long tern improvements to development
- A quality home learning environment is more important for a child's intellectual and social development than a parent's career, education level or financial circumstances. Where children are not being raised in a home environment which provides this, a good quality early years setting can compensate
- Children make better all-round progress when care and education are provided jointly and educational and social education are given equal weight
- The EYFS sets standards for children's learning from birth to five and is broken down into seven categories:
    - Communication and language
    - Physical development
    - Personal, social and emotional development
    - Literacy
    - Mathematics
    - Understanding the world
    - Expressive arts and design
- Young children learn best through interaction and play

[11] The Early Years Foundation Stage (EYFS) Review, Report on the evidence , March 2011 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184839/DFE-00178-2011.pdf

The Munro Review of Child Protection: the final report[12]

This review, commissioned by the Secretary of State for Education in June 2010, set out to find an answer to the question 'what helps professionals make the best judgments they can to protect a vulnerable child?' The first recommendation is to move from a system that is over-bureaucratised and focused on compliance, to a system that values professional expertise and seeks to develop it, and concentrates on the safety and welfare of children. It also identifies a need to co-ordinate the many professionals who support children and their families both to reduce inefficiencies and omissions. The recommendations include a call for the government to place a duty on local authorities and their statutory partners to secure sufficient provision of local early help services for children and their families, to better identify when early help is needed, and provide help even if the help required does not reach the threshold for children's social care services. The report further documents the importance of having mechanisms in place to help identify children who are suffering, or may be at risk of suffering, harm from abuse or neglect and who do meet the threshold for referral to children's social care services. There is a well-established link between child abuse and neglect and parental problems, such as poor mental health, domestic violence and substance misuse. The report acknowledges the difficulties around identifying abuse and neglect as signs and symptoms may be subtle, and therefore suggests that it is extremely important that those working with children, young people and adults have easy access to social work expertise in order to discuss concerns.

Rapid Review to Update Evidence for the Healthy Child Programme 0-5[13]

The purpose of this review, undertaken by PHE, was to update the evidence underpinning the Healthy Child Programme (HCP) prior to local authorities taking over the commissioning of the under-fives public health HCP service. The review synthesises 160 relevant systematic reviews with a further 50 randomised controlled trials published from 2008-2014 about 'what works' in key areas. The key areas included: parental mental health, smoking, alcohol/drug misuse, intimate partner violence, preparation and support for childbirth and the transition to parenthood, attachment, parenting support, unintentional injury in the home, safety from abuse and neglect, nutrition and obesity prevention, and speech, language and communication. The authors also sought to draw out key messages in relation to: identifying families in need of additional support, the delivery/effective implementation of interventions at the programme/service level and individual practitioner level, workforce skills and training and the economic value/cost benefits of the HCP, including both health and wider societal costs. The key recommendations are shown in tabulated form in Chapter 7 along with relevant NICE guidance.

[12] The Munro Review of Child Protection, A child centred system, Professor Eileen Munro, Department for Education, May 2011
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

[13] Public Health England, Rapid Review to Update Evidence for the Healthy Child Programme 0-5, N Axford et al, March 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/429740/150520RapidReviewHealthyChildProg_UPDATE_poisons_final.pdf

Healthy Lives, Healthy People: Our strategy for public health in England[14]

This paper set out the coalition government's intentions for the future of public health in response to the Marmot report *Fair Society, Healthy Lives*[6]. It set out a commitment to improve the health of the poorest fastest, responding to the evidence that people living in the most deprived areas will, on average, die seven years earlier than those who live in affluent areas and those in deprived areas spend up to 17 more years of their life living with poor health. People living in poorer areas also have higher rates of mental illness, harm from alcohol, drugs and smoking and of childhood behavioural and emotional problems.

Recommendations relevant to the under-fives include:

- Improving maternal health to give children a better start in life, reduce infant mortality and the number of low birthweight babies
- Take better care of children's health and development to improve educational attainment and reduce the risks of mental illness, unhealthy lifestyles, road deaths and hospital admissions due to tooth decay

The vision for this new approach included four principles of how the service should be:

1. Responsive – owned by communities and shaped by their needs
2. Resources – with ring-fenced funding and incentives to improve
3. Rigorous – professionally-led, focused on evidence, efficient and effective
4. Resilient – strengthening protection against current and future threats to health

Through local innovation and with the assistance of the cross-government framework, the white paper proposes local communities can address inequalities and improve health at key stages of life. The aim for the key stage of 0-5 is 'giving every child the best start in life', through a commitment to reduce child poverty, investing in health visitor numbers and doubling the number of children reached by the Family Nurse Partnership programme.

The Early Years[15]

The All Party Group on a Fit and Healthy Childhood aimed to provide recommendations for a credible, feasible and evidence based early years' strategy. The group considered the antenatal period and childhood between 0-8 years of age and reviewed all areas that impact on a child's health and wellbeing, the role of the relationship between families and professionals and the importance of training and continuous professional development for the early years' workforce. The recommendations are documented below.

[14] Policy Paper, Healthy Lives, Healthy People: our strategy for public health in England, Department of Health, Nov 2010
https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england

[15] The Early Years, a report of The All-Party Parliamentary Group on a Fit and Healthy Childhood, Feb 2015
https://gallery.mailchimp.com/b6ac32ebdf72e70921b025526/files/APPG_Report_Early_YearsFINAL.pdf

Antenatal Care, Maternal Nutrition and Mental Health:

- Children's Centres to be used as antenatal care hubs with a holistic, multi-professional approach
- Mental health support to be embedded through every aspect of pregnancy and childbirth
- Extension of multi-faceted, evidence-based programmes such as the Family Nurse Partnership, prioritising access of 'at risk' groups
- A national Government communication strategy to inform women and their families about how to access antenatal care, working with Local Authorities and the voluntary sector on the best ways of reaching vulnerable groups

Infant Nutrition:

- Establishment of early parenting programmes for parents (to include fathers) at Children's Centres
- Parents/main carers with attachment difficulties to receive a programme of services designed to improve parenting skills and promote secure attachment

Early Years' Nutrition following Weaning:

- All staff working in the early years to receive appropriate training in oral health
- Revision of the HCP to include strategies to ensure that health visitors are equipped with the knowledge and skill to advise parents on early life nutrition; identifying this as a key competency for continuing professional development (CPD)

The Educational and Training Needs of Health and Education Professionals:

- Standardised healthcare professional training (annually reviewed) to enable the uniform delivery of nutritional, play and activity advice for the families and carers of pre-school children, combined with a co-ordinated early intervention strategy
- Commission the HCP in full
- Recruitment processes for early years' practitioners to assess emotional intelligence as well as knowledge base
- Develop clear, consistent and regular models of effective supervision for all professionals working within early years' settings – with CPD that is accredited, ongoing and easily accessible
- Embed instruction in play, exercise and sport into professional training courses for all those who work within the Early Years sector

Socioeconomic Inequalities:

- Increase investment in health visitor training so that it is possible to visit all mothers antenatally and keep contact with the families

Access to Advice and Assistance:

- All who have professional responsibility for pregnant women and new parents to be trained in how to offer advice in a respectful and non-judgemental manner
- Midwife/health visitors to make all interventions 'family centred' whether at hospital or in the home
- All health visitors to provide advice to families on nutrition and play at regular intervals during the pre-school period

Cultural Imperatives and Diversity:

- Promotion of community peer programmes, bringing together parents from different cultures to support new families with early feeding practices
- Better communication of guidelines and promotion of the benefits of being active from an early age across all cultural groups
- Dissemination of basic principles of a good and varied diet for toddlers aged 1-3 across all cultures, via multi-lingual literature including recipe examples and practical instruction
- Health visitor training to include cultural diversity aspects in advice on nutritionally-balanced diets for young children
- Initiatives to improve the gender make-up of the early year's workforce, including nationally-driven recruitment campaign and increasing professional pay-scales

The Role of Sleep:

- Child sleep patterns to form part of professional concern and help from health visitors/Early Years Teachers

Health Visitor Implementation Plan 2011-2015: A Call to Action[16]

In this plan the Coalition Government made the commitment to provide an extra 4,200 health visitors by 2015. It outlined the vision for a new health visiting service including the universal and targeted approaches:

Your community –a range of services available for all to access

Universal services – those services provided by health visitors, including delivery of the healthy child programme, delivered to all families

Universal plus – services available from health visiting teams if expert help is needed by families, for example around weaning or sleep

Universal partnership plus – ongoing support and other services over a period of time to deal with more complex issues

[16] Health Visitor Implementation Plan 2011-2015: A Call to Action, Feb 2011, Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213110/Health-visitor-implementation-plan.pdf

The plan called for the health visiting programme to fit with wider local services for children and families in the early years including Sure Start Children's Centres, primary care and maternity services with strong partnership working at all levels between stakeholders.

Strong partnership working at all levels[16]

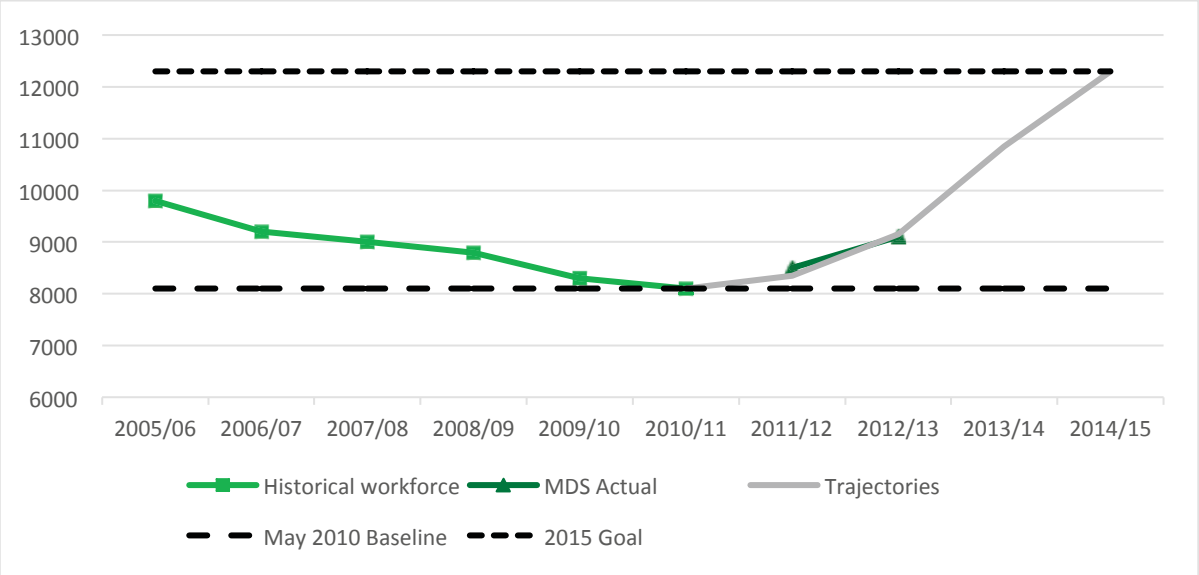
- Health visitors working across health and Early Years services and at a community level will build and strengthen partnerships, including with general practice and Sure Start Children's Centres.
- Locally, the new Health and Wellbeing Boards will bring together local authority, health, early years and other partners and will have an important potential role in ensuring the best fit between health visiting and other local services, in ways that best meet the local needs identified in the Joint Strategic Needs Assessment
- Nationally, the professions' regulating bodies, higher education institutions and many others will lead and shape action

The National Health Visitor Plan: Progress to date and implementation 2013 onwards[17]

The purpose of the Health Visitor Programme, which started in 2011, was to secure 4200 extra health visitors in an effort to improve the health visiting service throughout England by April 2015 (Figure 3). This decision was made in response to the mounting evidence regarding the significance of the early years of a child's life. The first phase of this programme reversed the decline in health visitor numbers and training places for health visitors. In 2012/13 four times as many students began health visiting training compared with 2010/11 and the workforce increased just below trajectory. This was due to a marketing campaign and strong partnership working with other relevant bodies. Early implementer sites spearheaded development of aspects of the new service model locally. There was also strengthening of skills, leadership abilities and confidence within the health visiting profession.

[17] The National Health Visitor Plan: Progress to date and implementation 2013 onwards, Department of Health, NHS England, PHE, Health Education England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/208960/Implementing_the_Health_Visitor_Vision.pdf

Figure 3. National Health Visitor Workforce (Full Time Equivalent): progress and projections



Source: The National Health Visitor Plan: progress to date and implementation 2013 onwards[17]

The purpose of the national health visitor plan is ultimately to contribute to reductions in health inequalities, improvements in health and wellbeing and a more positive experience for families and their children. The projected impact of the programme has been set out in the Public Health Outcomes Framework and the NHS Outcomes Framework. Those which have a specific focus for the programme are shown in Figure 4.

Figure 4. Indicators expected to be influenced by health visiting

Indicator	Health Visitor Impact
Under 18 conception	Can be reduced by, for example, health visitors supporting teenage mothers to take up contraception and avoid future pregnancy
Infant mortality	Can be improved through antenatal work with mothers to support quitting smoking and healthy weight
Low birth weight of term babies	
Smoking status at time of delivery	Can be improved through antenatal work with mothers to support quitting smoking
Breastfeeding (initiation and at 6-8 weeks)	Can be improved by antenatal support and by early identification and responsiveness to mothers' concerns
Vaccination coverage	Can be improved by outreach to parents who do not take up vaccination to support uptake
Child development at 2-2½ years	Can be improved through delivery of evidence-based parenting programmes and through close working with Sure Start and local authority early years teams
School readiness	
Healthy weight 4-5 years	Can be improved through encouraging breast-feeding and healthy weaning in line with the guidelines as well as healthy family nutrition
Tooth decay in children age 5	

Source: Source: The National Health Visitor Plan: progress to date and implementation 2013 onwards[17]

NHS England has also set out the outcomes expected to be positively influenced by health visiting and these are shown in Figure 5.

Figure 5. Outcomes expected to be influenced by health visiting

Domain	Areas where health visiting can impact
1: Preventing people from dying prematurely	Reducing deaths in babies and young children: • Infant mortality • Neonatal mortality & stillbirths
2: Enhancing quality of life for people with long-term conditions	Children's long term conditions: • Reducing emergency admissions for children with asthma, epilepsy and diabetes
3: Helping people to recover from episodes of ill-health or following injury	Preventing lower respiratory tract infections (LRTI) in children becoming serious: • Reducing emergency admissions for children with LRTI
4: Ensuring people have a positive experience of care	Improving women's and their families' experience of maternity services: • Women's experience of maternity care • Improving children's and young people's experience of healthcare
5: Treating and caring for people in safe environment and protecting them from avoidable harm	Improving the safety of maternity services: • Admission of full term babies to neonatal care • Delivering safe care to children in acute settings • Incidence of harm to children due to a failure to monitor

Source: The National Health Visitor Plan: progress to date and implementation 2013 onwards[17]

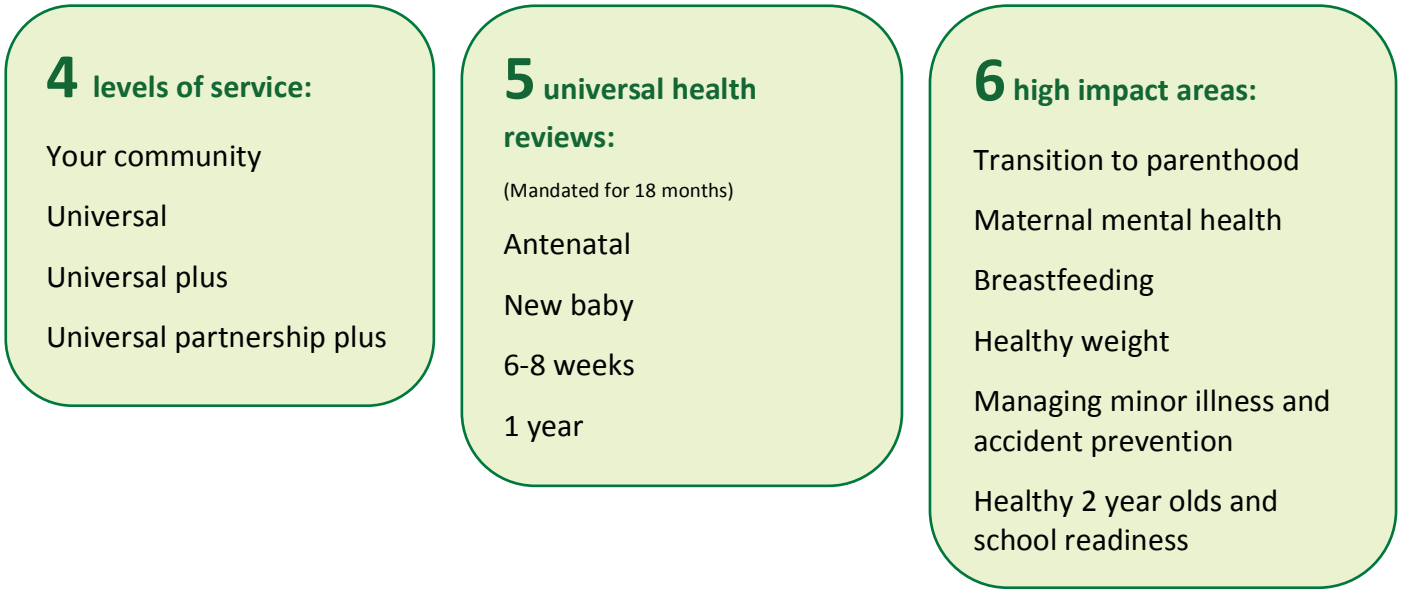
4.2 National Programmes

4.2.1 The Healthy Child Programme (HCP)[18]

4.2.1.1 Background

In 2011 the Health Visitor Programme underwent reform to improve access to services, improve families' experience, improve health outcomes and contribute to reducing inequalities. This transformed service is described as the 4-5-6 model (Figure 6).[19]

Figure 6. The 4-5-6 model



Source: The transformed health visiting service – the story so far[19]

The HCP is a public health programme whose foundations are early intervention and prevention; it begins in early pregnancy and ends in adulthood. It is a universal service for all children and their families, underpinned by a model of progressive universalism. It is also adaptable to the needs of a local population, allowing tailored delivery to, for example, homeless or travelling families. Delivery of the HCP is led by health visitors, in conjunction with an integrated service that joins together Sure Start Children's Centre staff, GPs, midwives and community nurses. The HCP includes a wide reaching and ambitious set of goals for ensuring healthy children and families including: screening tests, immunisations, developmental reviews, information and guidance on healthy choices for children and access to specialist services and wider support. The purpose of these interventions is to strengthen early years development through: fostering a strong attachment between parents and their child, encouraging positive parenting to enable promotion of the child's

[18] Healthy Child Programme, Pregnancy and the first five years of life , department for children, schools and families 2009 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

[19] The transformed health visiting service-the story so far, Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417455/4_5_6_LA_leaflet_ppt.pdf

social and emotional wellbeing, keeping children safe and healthy, initiatives to limit rates of obesity, prevention of serious communicable diseases, promotion of breast feeding and support for continuation of breast feeding, increasing school-readiness, identifying growth disorders, risk factors for obesity and developmental delay, timely recognition of safety concerns, identification of factors that could adversely affect the health of a family, and better outcomes for children at risk of social exclusion.

On 1st October 2015 the commissioning for health visiting services and the Family Nurse Partnership transferred from NHS England to local authorities. The aim of this transfer is to enable local authorities to tailor services to the needs of local children and families, integrate services in the local area, deliver joined up services for children from 0-19 years of age and offer locally sensitive commissioning in conjunction with clinical commissioning groups (CCGs) for wider services.[20]

For the first 18 months the Department of Health plans to mandate local authorities to provide the following five universal checks: [20]

- Antenatal health promoting visits
- New baby review
- Six to eight week assessment of the baby
- One year assessment
- Two to two and a half year review

4.2.1.2 Core requirements of the Healthy Child Programme[18]

Early identification of need and risk

Health and developmental reviews aim to identify a family's strengths, needs and risks, assess growth and development, detect abnormalities and give parents an opportunity to discuss concerns and aspirations for their child. These reviews take place by the 12th week of pregnancy, at the neonatal examination, at the new baby review (around 14 days old), at the baby's six to eight week examination, by the time the child is one year old and between two and two and a half years old. The review should be undertaken in partnership with the parents and useful approaches include promotional interviewing, motivational interviewing and strength based approaches. If during the review concerns are elicited and support might be required by more than one agency the CAF should be used.

[20] Local Government Association, About the transfer
http://www.local.gov.uk/health/-/journal_content/56/10180/5886759/ARTICLE

Predictors of risk during pregnancy

- Young parenthood
- Educational problems
- Parents who are not in education/employment or training
- Families who are living in poverty
- Families who are living in unsatisfactory accommodation
- Parents with mental health problems
- Unstable partner relationships
- Intimate partner abuse
- Parents with a history of anti-social or offending behaviour
- Families with low social capital
- Ambivalence about becoming a parent
- Stress in pregnancy
- Low self-esteem or low self-reliance
- A history of abuse, mental illness or alcoholism in the mother's own family

Screening and Immunisation

All screening and delivery of immunisations for 0-5 year olds is, and will continue to be, commissioned by NHS England and delivered locally by GPs. However, health visitors will continue to play an important role in providing information and advice to families about screening and immunisations following the move of commissioning responsibility for 0-5 public health services (Health Visiting services and Family Nurse Partnerships) to local authorities in October 2015.

The screening schedule of the HCP begins with the antenatal assessment of the mother, the newborn examination which includes newborn hearing screening, a physical examination by 72 hours and blood spot examination at five-eight days. At six-eight weeks a further physical examination should take place and finally a pre-school hearing and visual screen should have occurred by five years.

Immunisations as per the standard schedule should be offered to all children and their parents. Local planning should aim to target excluded or at-risk families (refugees, homeless, travelling families, very young mothers, those not registered with a GP and those who are new to an area). At every contact with a member of the HCP team the immunisation status of the child should be checked and advice given.

Promotion of social and emotional development

Practitioners should listen and observe and be able to identify when there is a problem and be able to deal with it appropriately and sensitively.

Support for parenting

This should be delivered using evidence-based programmes and practitioners who are trained and supervised.

Keeping the family in mind

Family health as a whole should be reviewed with the aim of building family strengths and resources. There is a need to promote the father's role as being important to his child's outcomes. This includes at a practical level offering services at a time which would make it easier for working fathers to attend, for example in the evenings.

Effective promotion of health and behavioural change

The HCP should encompass the NICE public health guidance on behavioural change at the population, individual and community level.

Prevention of obesity

The HCP encompasses preventing obesity in pregnancy and in the first years of life through assessment and advice and identification of those children and families most at risk.

Promotion of breastfeeding

Breastfeeding is a priority for the HCP, due to research emphasising the importance of breast milk as the best nourishment for infants up to six months old. Local breastfeeding initiatives and community groups play an important role, but more can be done to increase uptake of breastfeeding, particularly among young and disadvantaged mothers. This requires training and development of the workforce and improving availability of services, providing advice targeted at fathers, using Children's Centres to ensure accessibility of services to hard-to-reach groups and continuing to promote the Healthy Start programme.

Additional preventive programmes for children and families

The HCP advises that in addition to the above core elements, there should also be access to a range of evidence based preventive interventions, programmes and services which have been selected following a systematic review by Warwick University. It is for local commissioners to determine which of these services should be provided in their area based on their population's requirement and using a commissioning toolkit.

Sure Start Children's Centre staff work with health visitors to deliver services. Children's Centres provide support to families and aid child development through, for example, parenting classes, clinics and provision of social and educational opportunities. Joined up working involves transition of care from health visitors to school nurses when a child approaches five years old, to prepare children for school entry. School nurses lead delivery of the HCP to children aged 5-19 including developmental screening and immunisation programmes.

4.2.2 Family Nurse Partnership

4.2.2.1 Background

The Family Nurse Partnership (FNP) programme was developed by the University of Colorado over 30 years ago. It was established in England in 2007 as part of the then government's 'Reaching out' plan on social exclusion. It is currently delivered in the City of London and Hackney by Whittington Health and has been running since May 2014. It is a maternal and early years' public health preventive programme, which aims to transform the life chances of the most disadvantaged children and families in society, helping to improve social mobility and break the cycle of intergenerational disadvantage and poverty. The programme provides ongoing intensive support to young first time mothers and their babies (and fathers/other family members if mothers want them to take part). It is a targeted service that has been shown to improve outcomes for mothers and children in the short, medium and long term.

4.2.2.2 Programme content

The programme starts in early pregnancy and continues until the child's second birthday. It comprises structured home visits delivered by trained nurses weekly, fortnightly or monthly, with each visit lasting between one and one and a half hours. Within a trusting and supportive relationship between the Family Nurse and the family, themes such as attachment, relationships and psychological preparation for parenthood are explored.

Behaviour change methods are used to assist families to adopt healthier lifestyles for both themselves and their babies, provide good care for their children, and plan their futures.

4.2.2.3 Eligibility

Enrolment and participation is voluntary. All first time mothers aged 19 and under at conception, and who live in the catchment area, are eligible to take part. The aim is to enrol mothers as early as possible in the pregnancy and for them to be enrolled no later than the 28th week. Once the child has reached 2 years old the family is transferred to health visiting services to complete the remainder of the Healthy Child Programme.

4.2.2.4 Evidence

The FNP programme is primarily supported by a US evidence base, developed over 30 years, and has been shown to improve pregnancy outcomes, child health and development, and parents' economic self-sufficiency. Evidence-based outcomes are shown in the table below.

Evidence based FNP outcomes[21]

- Improvements in antenatal health
- Reductions in children's injuries, neglect and abuse
- Improved parenting practices and behaviour
- Fewer subsequent pregnancies and greater intervals between births
- Improved early language development
- Improved school readiness
- Improved academic achievement
- Increased maternal employment and reduced welfare use
- Increase in fathers' involvement

[21] The Family Nurse Partnership Programme, Information Leaflet, Produced by the FNP National Unit, Department of Health, 2012
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216864/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf

4.3 Local Services

4.3.1 Health Visiting Service

Health visiting is currently provided by Homerton University Hospital (HUH) NHS Foundation Trust division for Children's Services, Diagnostics and Outpatients. There is a health visitor linked to each general practice and Early Years setting. The workforce is currently being expanded, with a target of 99.6 whole-time equivalent (WTE) posts (see Figure 7).

Figure 7. Workforce growth and targets in HUH Health Visiting service

	March 2015	June 2015
Workforce target	99.6	99.6
Staff in post (WTE)	66.7	71.7
Gap to fill (WTE)	32.9	27.9

Source: Homerton University Hospital

4.3.2 Common Assessment Framework[22]

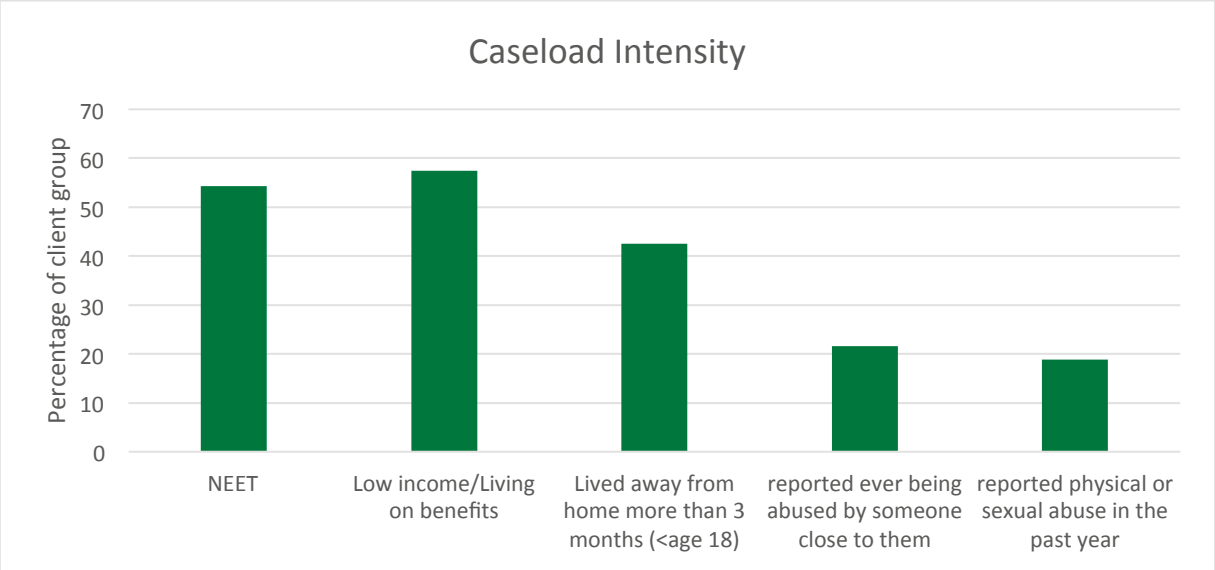
If a child needs more support than can be offered by one agency alone it is best practice for all of the involved professionals to meet with the child's carer, to create a plan of how best to support the child's needs. This is known as the Common Assessment Framework (CAF) and applies to all children and young people from before birth up to 18 years of age, or 25 for young people with learning difficulties or disabilities. Health Visitors play a key role in identifying need and referring families to the Multi-Agency team through the CAF process. The process involves establishing what extra support is required, and aims to put these services in place in a timely manner before needs escalate. When a number of professionals are involved with supporting a child, one may be appointed the 'lead professional', who will then liaise with the family and co-ordinate the services. A CAF will occur within 28 days of the need being identified, and the package of care should be in place within the following 28 days.

4.3.3 Family Nurse Partnership

In 2014/15 the Family Nurse Partnership (FNP) programme in Hackney received 75 referrals and, of these, 41 clients were enrolled (42 in total when including transfers). The characteristics of those enrolled on the programme are shown in Figure 8.

[22] http://www.hackney.gov.uk/s-common-assessment-framework.htm

Figure 8. FNP caseload intensity 2014/15



Source: FNP Annual report 2014/15

4.3.4 Children's Centres

4.3.4.1 Hackney and City of London

A key early development for young children was the introduction of Sure Start Local Programmes (SSLPs) in 1999, designed to work with parents and expecting parents to promote physical, intellectual and social development of children under four years of age, particularly in disadvantaged families. Subsequently, Sure Start Children's Centres were developed, building on SSLPs, Early Excellence Centres, the Neighbourhood Nurseries Programme and other provision. Sure Start Children's Centres provide a variety of services, including child and family health, childcare, integrated early education, parenting and wider family support including advice on employment and training for parents through links with Jobcentre Plus.[23] The grouping of local Children's Centres has been used to divide Hackney and the City of London into six areas (A-F) and these are shown in Figure 9 (the names of the corresponding 23 Children's Centres are listed in Appendix 9.1.2). These Children's Centre areas are used throughout the report to localise areas of need. The breakdown of service use by Children's Centre area and ethnicity is shown in Figures 10-12.

[23] Department for Children, Schools and Family

Figure 9. Map of Children's Centre locations in Hackney and the City of London

Source: London Borough Hackney

Figure 10. Number of children aged 0-4 attending Children's Centres by area

	A	B	C	D	E	F
2011/12	2329	3200	2173	2471	1608	2517
2012/13	2275	3590	2380	2486	1605	2460
2013/14	2434	3601	2354	2343	2043	2348

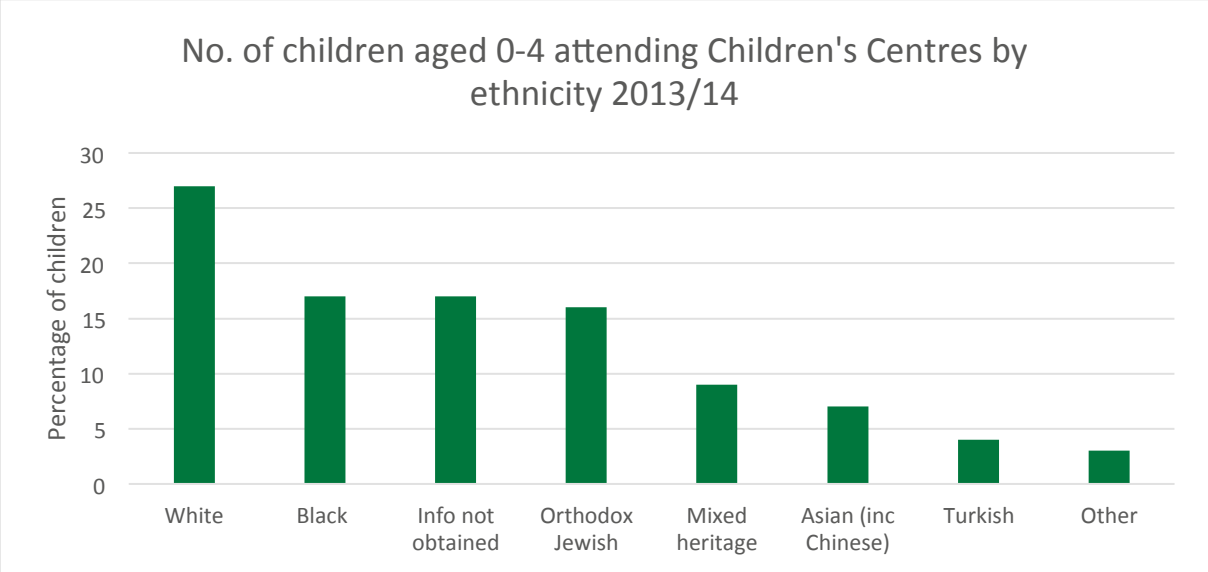
Source: Hackney Learning Trust annual report

Figure 11. Number of fathers of children aged 0-4 accessing Children's Centres by area

	A	B	C	D	E	F
2011/12	443	374	333	404	217	403
2012/13	436	426	410	427	296	415
2013/14	460	436	376	452	368	420

Source: Hackney Learning Trust annual report

Figure 12. Number of children aged 0-4 attending Children's Centres by ethnicity 2013/14



Source: Hackney Learning Trust annual report

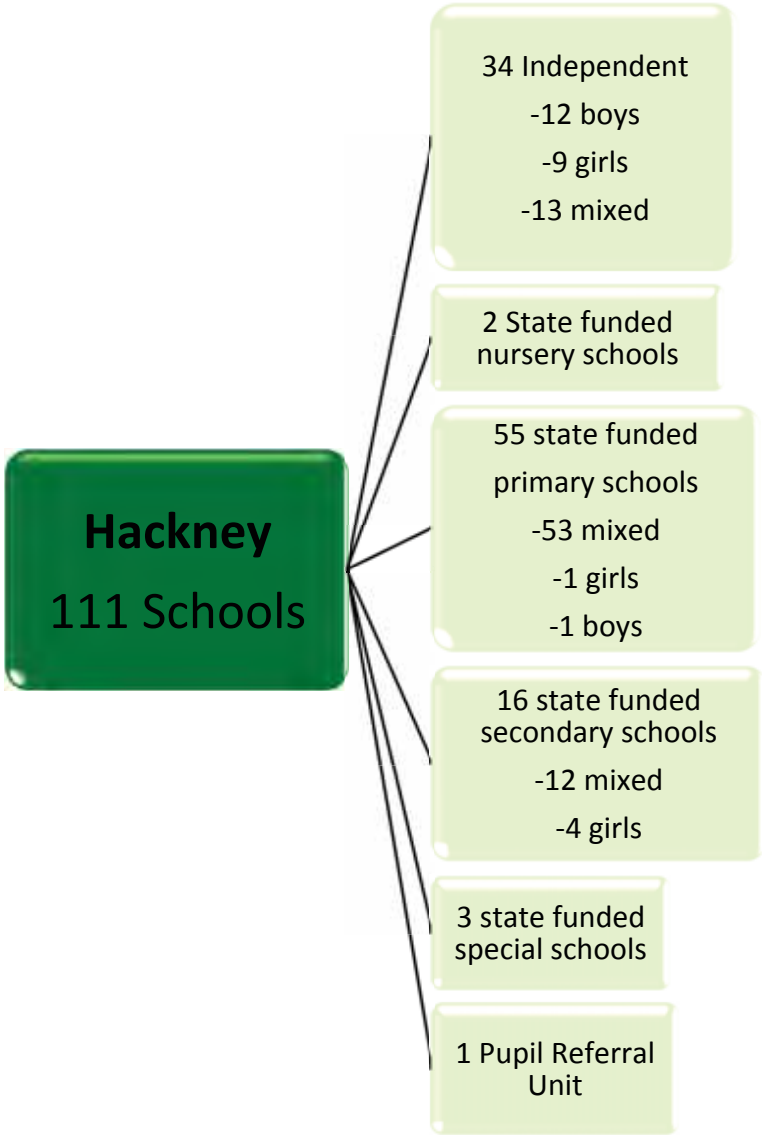
4.3.5 Education

4.3.5.1 Hackney

Within Hackney, the Hackney Learning Trust is responsible for state-provided Children's Centres, Early Years, schools, and adult education. In 2002 The Learning Trust was awarded a ten year contract to improve education services for Hackney Council. The Learning Trust was the first private, not-for-profit company in the UK to take over a council's entire education function. The Learning Trust is now embedded in the council within the Children and Young People's service and Hackney is now a borough which is demonstrating rapid improvements, innovation, sustainability and best practice in education.[24] The breakdown of school provision is shown in Figure 13.

[24] https://www.learningtrust.co.uk/Pages/About_Us.aspx accessed 30/4/15

Figure 13. Number and type of schools in Hackney

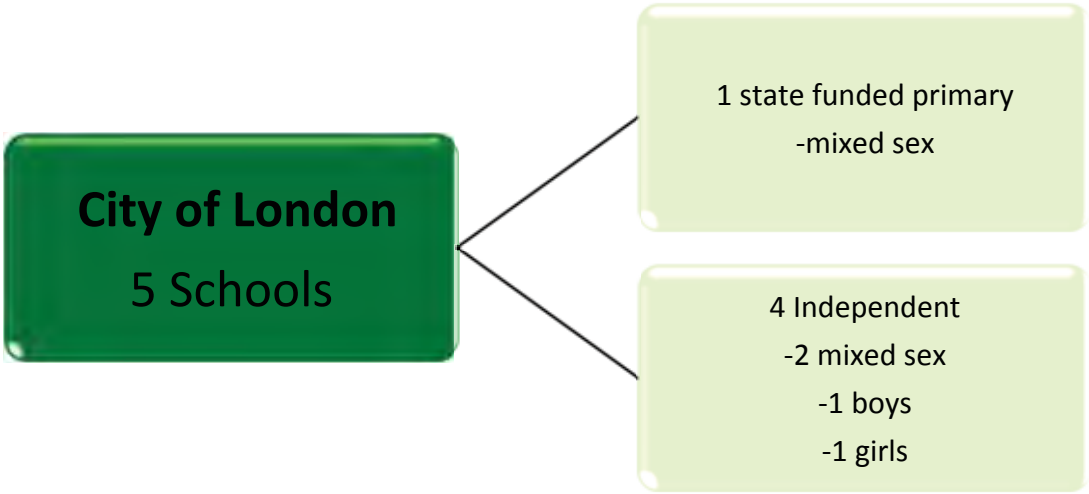


Source: 2015 school census

4.3.5.2 City of London

In the City of London the one state funded primary school is overseen by the City of London Corporation. The breakdown of schools is shown in Figure 14.

Figure 14. Number and type of schools in City of London



Source: 2015 school census

5 THE POPULATION

Where data are available, Hackney and the City of London are compared with the ONS 'London Cosmopolitan' peer group of local authorities comprising Brent, Hackney, Haringey, Lambeth, Lewisham, Newham and Southwark.

5.1 DEMOGRAPHICS - WHOLE POPULATION

Demographic information is necessary for informing both the design and delivery of local services as changes in the size and profile of the population will affect both the extent of local health need and the demand for services.

5.1.1 Population

The populations of the City of London and the Borough of Hackney are markedly different.

5.1.1.1 Hackney

Hackney is an inner London borough of 263,000 people (mid-2014 ONS estimate), who make up a remarkably diverse population. Greater London Authority (GLA) Population Projections forecast this to rise to 282,000 people by 2020. Almost 40% of the population was born outside of the UK. Hackney is a relatively young borough with a quarter of its population under 20 years of age. The proportion of residents between 20-29 years has grown in the last ten years and now stands at 21%. People aged over 55 constitute only 14% of the population. Hackney is the third most densely populated borough in London.[25] Although deprived, the borough has assets in both its physical and community resources.

[25] A profile of Hackney, its People and Place, LB Hackney Policy Team, Sep 2014

Figure 15. Hackney population estimates

	2014 mid-year (to nearest 100)	2020 projection (to nearest 100)
Male	130,700	141,200
Female	132,400	140,900
Total	263,200	282,100

Source: ONS 2014 mid-year estimates; GLA Population Projections

5.1.1.2 City of London

The City of London is one square mile in size, with its resident population of 8,100 (mid-2014 ONS estimate) found in densely populated pockets. GLA Population Projections forecast this to rise to 9,300 people by 2020. The resident population of City is dwarfed by its daytime working population, which has almost fifty times as many people.

Figure 16. City of London population estimates

	2014 mid-year (to nearest 100)	2020 projection (to nearest 100)
Male	4,500	5,200
Female	3,600	4,100
Total	8,100	9,300

Source: ONS 2014 mid-year Estimates; GLA Population Projections

5.1.2 Ethnicity and Migration

5.1.2.1 Hackney[26]

5.1.2.1.1 Ethnicity

Data from the 2011 census shows that 36.2% of Hackney's population is White British, making it the single largest ethnic group in Hackney. The second largest ethnic group is Other White at 16.1%. Hackney has a large and well established Turkish community who may fall within the 'Other White' category. The Other White ethnic category has shown a 60% increase since 2001, the highest absolute increase of all the ethnic groups. One of the most significant causes behind the increase in the Other White category is the accession of Eastern European countries in 2004 and the resultant high levels of immigration from these countries, most significantly Poland. After White British and Other White, the third largest ethnic group in Hackney is Black African, representing 11.4% of Hackney's population and a 15% increase since 2001; the largest group within this is the Nigerian community. The increase in this ethnic group can partially be attributed to natural fertility patterns, but also to new migrants. Most ethnicity populations have shown growth, mirrored by the overall 21% population growth, with the exception of Irish, Pakistani, Caribbean and White British groups. Hackney has shown increased diversity and multiculturalism since 2001, with increased ethnic integration within families and partnerships becoming increasingly ethnically mixed.

There are concerns that the ethnic categories used in national data do not adequately demonstrate the complexity of the ethnic profile in Hackney. In addition, the poor response rates to the census in the inner city call the robustness of the data into question. To address this, a study was carried out by Mayhew et al in 2011[27] which describes the ethnicity of the Hackney population in much greater detail. Here, the Turkish community appears as the third largest ethnic group. Nigerian, Ghanaian, Somali, Kurdish and Vietnamese communities are also prominent. Mayhew et al estimated the size of the Orthodox Jewish (Charedi) population as 17,587, representing 7.4% of the Hackney population. The Charedi Jewish community is concentrated in the North East of the borough and is growing, partly due to a high birth rate with an average of 5.9 children per family.

5.1.2.1.2 Country of birth

Country of birth data from the census showed that only 60.9% of Hackney residents were born in the UK, significantly lower than the national average of 86.2%, but in line with the London average of 63% and significantly lower than neighbouring borough Newham, where over half of residents were born outside the UK. 25% of those born outside the UK arrived between 10 and 20 years ago and 45% arrived between 2001 and 2011. 78% of those born outside the UK were less than 30 years old on their arrival. Within this population the largest group were those who had been born in Turkey, representing 3.6% of the total borough population. The Polish community is currently the fastest growing community in Hackney.

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[26] Census 2011, Ethnicity, Identity, Language and Religion in Hackney, May 2013, Hackney council

[27] Mayhew I, Harper G, Waples S: Counting Hackney's population using administrative data - an analysis of change between 2007 and 2011. Mayhew Harper Associates, 2011.

5.1.2.2 City of London

The largest ethnic group in the City of London is White British at 58% of the population, and in total 79% of the City of London identify as belonging to one of the White ethnic groups. While it could be argued that the City of London is less diverse than Hackney or London as a whole due to the higher proportion of White residents, it remains more diverse than the England average where 80% of residents are White British. Asian/Asian British is the next most prominent ethnic group at 13% of residents with Chinese (3.6%), Bangladeshi (3.1%) and Indian (2.9%) being the most common constituent Asian groups.

Figure 17. Census data on ethnic group

Source: 2011 census, % of resident population

5.1.3 Language

5.1.3.1 City of London and Hackney

In the 2011 census, 76% of Hackney residents and 83% of City residents cited English as their main spoken language (see Figure 18), which is significantly lower than the national average of 91%. The second most predominant language spoken in Hackney is Turkish at 4.5% and Polish is third at 1.7%. In the City of London the second most predominant language is French at 2.2% and Spanish is third at 1.8%, closely followed by Bengali which is spoken by 1.6% of residents.

Figure 18. Languages spoken by residents of Hackney and the City of London

Language	% Hackney residents	% City of London residents
English	75.9	82.9
Turkish	4.5	-
Polish	1.7	-
Spanish	1.5	1.8
French	1.4	2.2
Yiddish	1.3	-
Bengali	1.3	1.6
Portuguese	1.2	-
Gujarati	0.8	-
German	0.7	1.2
Italian	-	1.3

Source: Census 2011 % of resident population

Approximately 10% of Hackney residents who do not speak English as a main language class themselves as being able to speak English 'very well'. Despite this, Hackney has the fifth highest proportion of residents in the country who cannot speak English at all, although this represents just 1% of the population. In the City of London only 1.4% do not speak English at all or do not speak English well, which is the same as the national figure.[28]

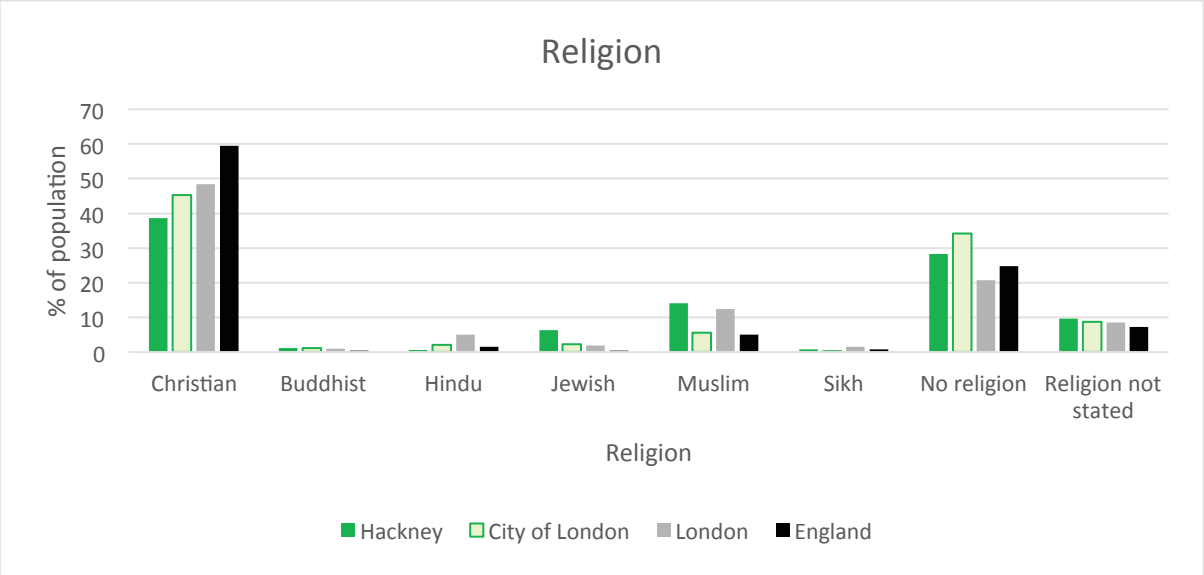
5.1.4 Religion

5.1.4.1 City of London and Hackney

The 2011 census records the most predominant religion among residents of the City of London and Hackney as Christian, reflecting the population of both London and England (see Figure 19). Hackney has a higher proportion of residents who identify themselves as either Jewish or Muslim than the populations of the City of London, London or England. The City of London has a higher proportion of residents who identify themselves as having no religion, when compared to the populations of Hackney, London and England.

[28] JSNA, City Supplement

Figure 19. Census data on religion of residents



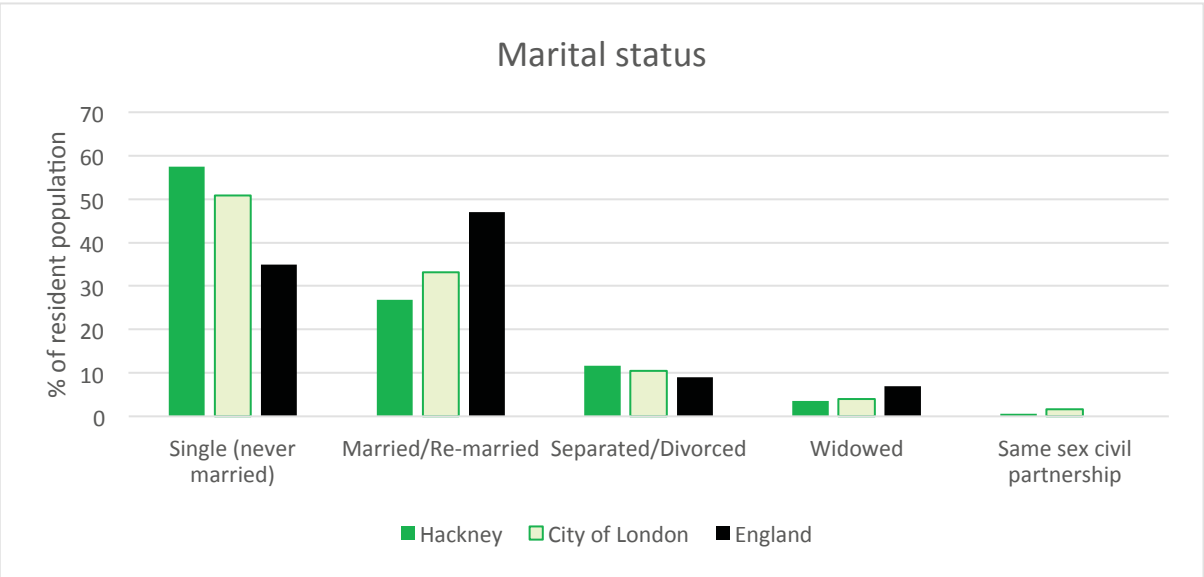
Source: Census 2011 % resident population

5.1.5 Marital status

5.1.5.1 City of London and Hackney

Hackney has a higher proportion of its residents identifying as single or separated / divorced than the City of London or England; with a lower proportion identifying as married / re-married.

Figure 20. Census data on marital status of residents



Source: Census 2011 % resident population

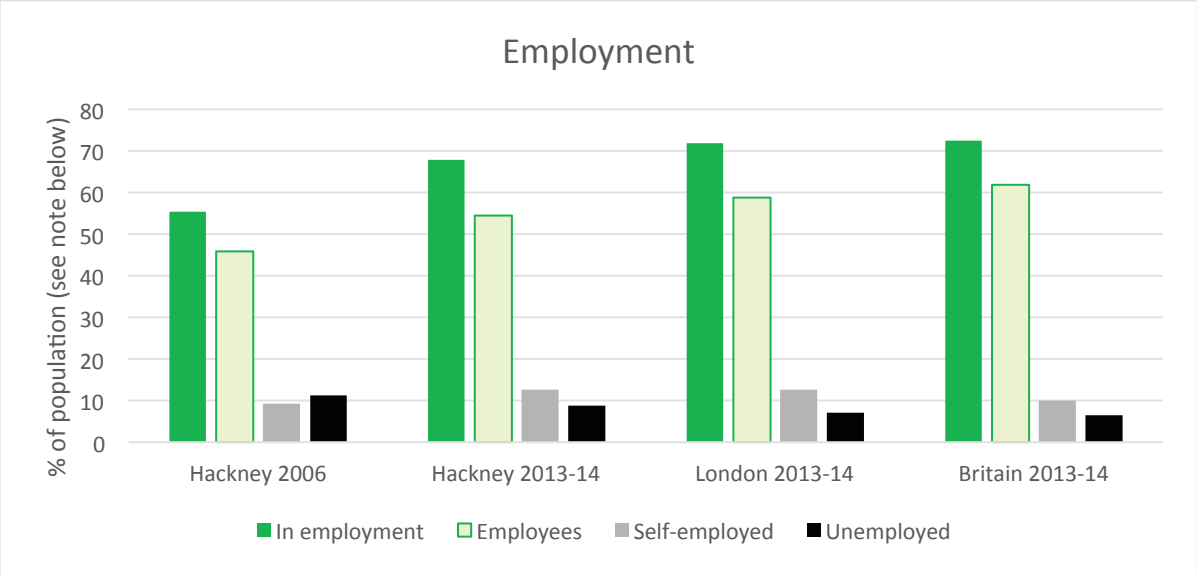
5.1.6 Employment

5.1.6.1 Hackney

Figures on employment in Hackney are taken from Nomis, a service provided by the ONS, giving up to date information on the labour market. Parental unemployment has been linked to a higher prevalence of ill health and low wellbeing in children in a number of studies[29].

The figure below demonstrates that the percentage of the population in employment in Hackney has increased since 2006 by more than 10% and that in 2013-14 employment rates in Hackney were only marginally lower than rates in London and Britain, at 68%, 71% and 72%, respectively. This reflects the slight differences in the proportion of 16-64 year olds who are unemployed – 8% in Hackney, compared with 7% in London and 6% in Britain.

Figure 21. Percentage of population in employment [30]



Source: ONS. Nomis: Oct 2005-Sep 2006, Oct 2013-Sep 2014

Short term migrants (people from outside the UK staying in the country for three to twelve months) are important because they use local services and contribute to the local economy. The 2011 census estimated there to be 2,450 short-term migrants, who are mainly people in their twenties and students, but some people were instead visiting friends and family[25].

5.1.6.2 City of London

Data on employment in the City of London are not available due to small sample sizes.

[29] For instance: Parents' labour market participation as a predictor of children's health and wellbeing: a comparative study in five Nordic countries, Pedersen & Madsen, J Epidemiol Community Health 2002

[30] Note: % for those of working age, except unemployment which is % of economically active population

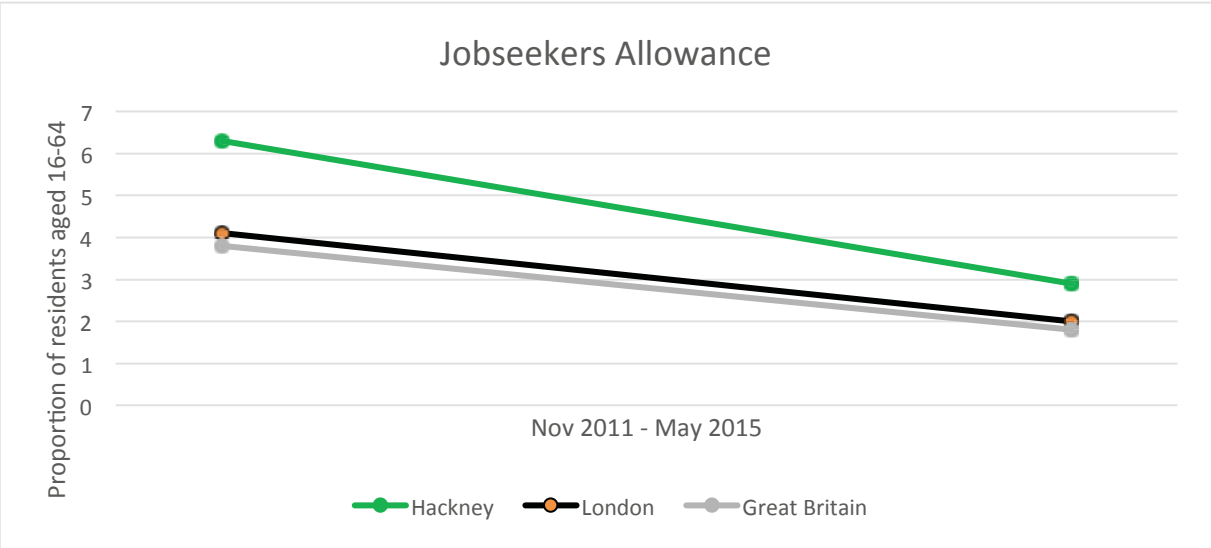
5.1.7 Jobseekers allowance

5.1.7.1 Hackney

The Jobseeker's Allowance (JSA) is payable to people under pensionable age who are available for, and actively seeking, work of at least 40 hours a week. This can therefore be used as a marker to assess those who are unemployed but looking for work, rather than unemployed due to illness, for instance. Research has shown that increased financial strain does not fully account for the rise in children's ill health associated with unemployment[31] - the strain of parents trying to find work may contribute to the negative impact on children's health.

Over the past four years Hackney has seen a sharp decline in the proportion of its 16-64 year old residents claiming JSA – from a peak of 6.3% in November 2011 down to 2.9% in May 2015 (see Figure 22). This is in line with the trend in London and Great Britain; however the rate is falling more quickly in Hackney.

Figure 22. Proportion of residents aged 16-64 claiming jobseekers allowance



Source: ONS, Nomis

5.1.7.2 City of London

Figure 23 below demonstrates that the rate and number of those claiming JSA in the City of London has been steadily declining over the past three years.

[31] Does financial strain explain the association between children's morbidity and parental non-employment? Pedersen, Madsen & Kohler, J Epidemiol Community Health 2005

Figure 23. Rate and total number of JSA claimants City of London Nov 2011-2014

	Nov 11	Nov 12	Nov 13	Nov 14
Rate of claimants	2.1	1.9	1.6	1.2
No of claimants	120	120	90	70

Source: Department of work and pensions

5.2 DEMOGRAPHICS - 0-4 YEAR OLDS

5.2.1 Population 0-4 year olds

5.2.1.1 City of London and Hackney

Figure 24 below shows the mid-2014 population estimates for the 0-4 age population of Hackney and the City of London. The total population of 0-4 year olds in Hackney is almost 20,500, whereas it is only 370 in the City of London. The projections for population growth are shown in Figure 25. The proportion of 0-4 year olds in the total population is shown in Figure 26, and the density of 0-4 year olds is shown in Figure 27.

Figure 24. Population of 0-4 year olds (2014)

	Total population	Age 0	Age 1	Age 2	Age 3	Age 4	Total 0-4
Hackney	263,150	4,300	4,374	4,150	3,892	3,733	20,449
City of London	8,072	69	75	81	83	58	366

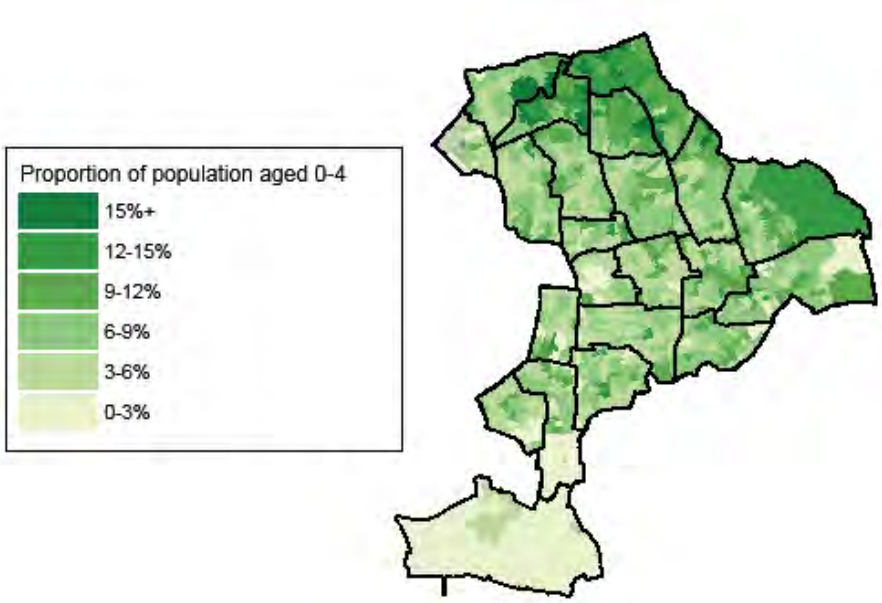
Source: ONS mid-2014 estimates

Figure 25. Population Projections 0-4 year olds

	Mid-2014 (ONS)	2014 (GLA)	2016 (GLA)	2018 (GLA)	2020 (GLA)
Hackney	20,449	20,200	20,300	20,500	20,900
City of London	366	400	500	600	600

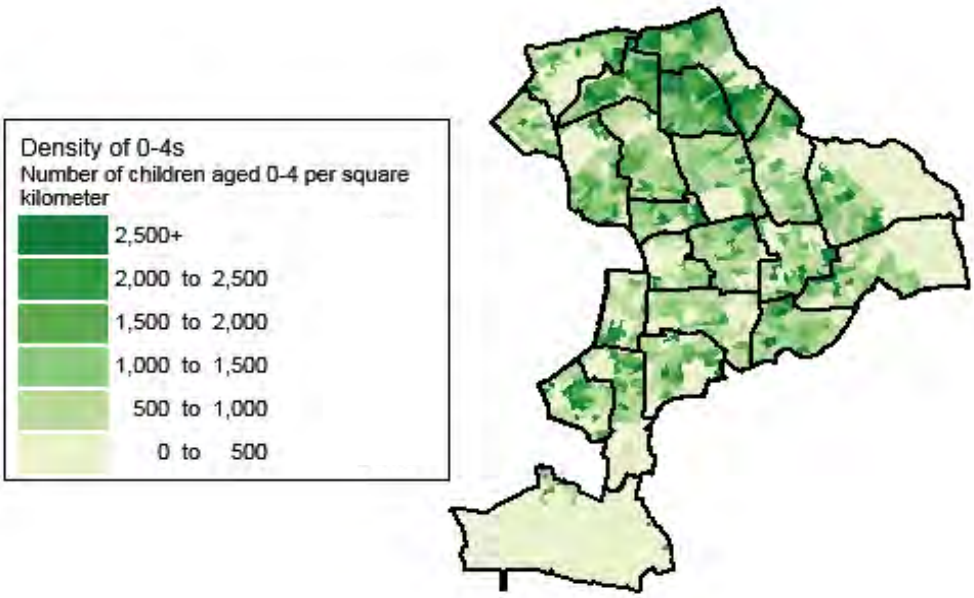
Source: ONS mid-2014 estimates, GLA Population Projections

Figure 26. Proportion of Hackney and the City's population aged 0-4



Source: ONS Census 2011

Figure 27. Number of children aged 0-4 per square kilometre in Hackney and the City



Source: ONS Census 2011

5.2.2 Fertility Rates

5.2.2.1 Hackney and the City of London[32]

The general fertility rate (total live births that occurred in the period per 1,000 females aged 15-44 (GFR)) in England and Wales using aggregated data from 2008 to 2012 is 62.2 and the London rate is 64.0. Across Hackney and the City of London the fertility rate is slightly lower at 60.1 (but stills sits between its statistical neighbours of 52.0 in Lambeth and 76.6 in Newham) following a gradual decline over the past ten years from a rate of 78 in 2004. However, this slightly lower rate is primarily due to the much lower fertility rate observed in the City of London at 38.6. In fact, some areas of Hackney have fertility rates among the highest in London, particularly in wards in the north east of the borough where the Charedi community is based[25].

The low GFR in the City of London is comprised of a wide range of rates by Ward with Cripplegate (which encompasses some of the most densely populated areas of the City of London) having the highest GFR at 48.9 and Bishopsgate (an area mostly comprising of businesses and transport hubs with very few residents) having the lowest at 13.2.

Across London, fertility varies by ethnicity with Bangladeshi, Pakistani, Other Asian, Black African and Other Black women having higher birth rates than White women.

Figure 28 shows the births to Hackney and City residents in 2012/2013 and 2013/2014.

Figure 28. Total number of Births to City and Hackney Residents, 2012/13-2013/14

	A	B	C	D	E	F	City of London	Total
2012/13	854	1,243	639	860	828	573	82	5,079
2013/14	893	1,121	640	662	818	561	61	4,756

Source: Child Health Information system

5.2.3 Hospital of birth

Figures 29 and 30 show where women from Hackney and the City of London chose to receive their maternity care (2010-2011). At this time, 77% of women in Hackney delivered at the Homerton University Hospital (HUH), and 56% of women in the City of London delivered at University College London Hospital (UCLH).

[32] Births and Fertility Rates, Borough, London datastore, Greater London Authority http://data.london.gov.uk/dataset/births-and-fertility-rates-borough/resource/1eb3c512-9abc-4392-8e87-5f7df3e24cc3

Figure 29. Hospital providing maternity services for Hackney residents, 2010/11

Hospital	Number of live births	Proportion of live births
Homerton University Hospital	3382	77%
University College London Hospital	479	11%
Whittington	202	5%
Royal London	71	2%
Other hospital	182	4%
Home	102	2%
TOTAL	4418	

Source: JSNA. Hospital data 2010-2011

Figure 30. Hospital providing maternity services for City of London residents, 2010/11

Hospital	Number of live births	Proportion of live births
University College London Hospital	46	56%
Royal London Hospital	17	21%
Homerton University Hospital	<5	--
Other hospital	13	21%
Home	<5	--
TOTAL	82	

Source: JSNA. Hospital data 2010-2011

Most of the data provided in subsequent chapters relate to that provided by HUH, as the numbers involved are larger and therefore more detailed analysis is permitted. In 2013/14 there were 3525 and in 2014/15 there were 3464 babies born to Hackney residents at HUH. Fewer than five women from the City of London delivered at HUH in 2013/14 and no women from the City of London delivered at HUH in 2014/15. As the HUH data included in this report almost exclusively relate to Hackney mothers and more than three-quarters of Hackney births occur at HUH, HUH data can be used as a marker for Hackney as a whole.

Additional data are provided for City of London mothers delivering at UCLH. There were between 41-45 births in 2013/14 and 35-39 births in 2014/15 (numbers fewer than five were reported as <5 to prevent data being identifiable). As more than half of City of London births occur at UCLH, these data will be used as a marker for all City of London births in this report.

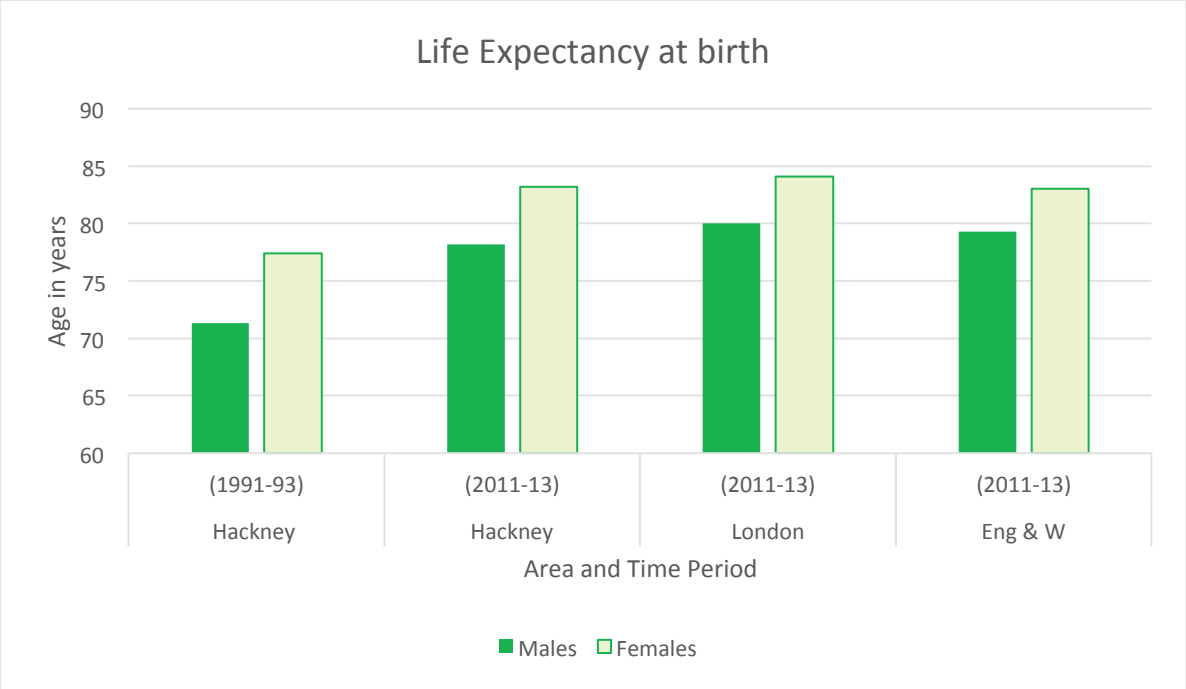
5.2.4 Life Expectancy

5.2.4.1 Hackney

Life expectancy figures are given as combined figures for three consecutive years to increase reliability at a local level. The life expectancy at birth of a male Hackney resident has increased by 6.9 years between 1991-93 and 2011-13, and the life expectancy at birth of a female Hackney resident has increased by 5.8 years over the same time period.

The life expectancy of a Hackney resident in 2011-2013 was similar to the life expectancy of residents of London and England and Wales (see Figure 31). The biggest difference in life expectancy is seen in male residents of Hackney who had a life expectancy of 78.2 years in 2011-2013 compared with a resident of London who had a life expectancy of 80 years.

Figure 31. Life expectancy of males and females at birth in years, 2011-2013

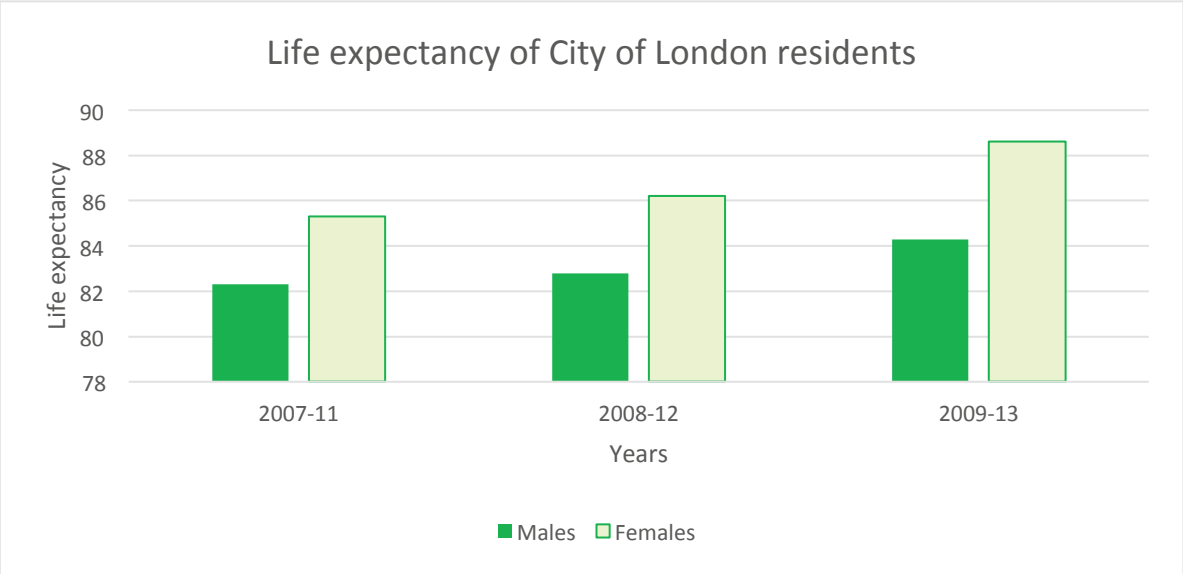


Source: ONS

5.2.4.2 City of London

The life expectancy for men and for women in the City of London has also been rising (see Figure 32). Aggregated data for 2009-13 gives a life expectancy of 84.3 years for a male resident and 88.6 years for a female resident of the City of London – both of which being higher than for Hackney, London or England and Wales

Figure 32. Life expectancy of City of London residents, 2007-2013



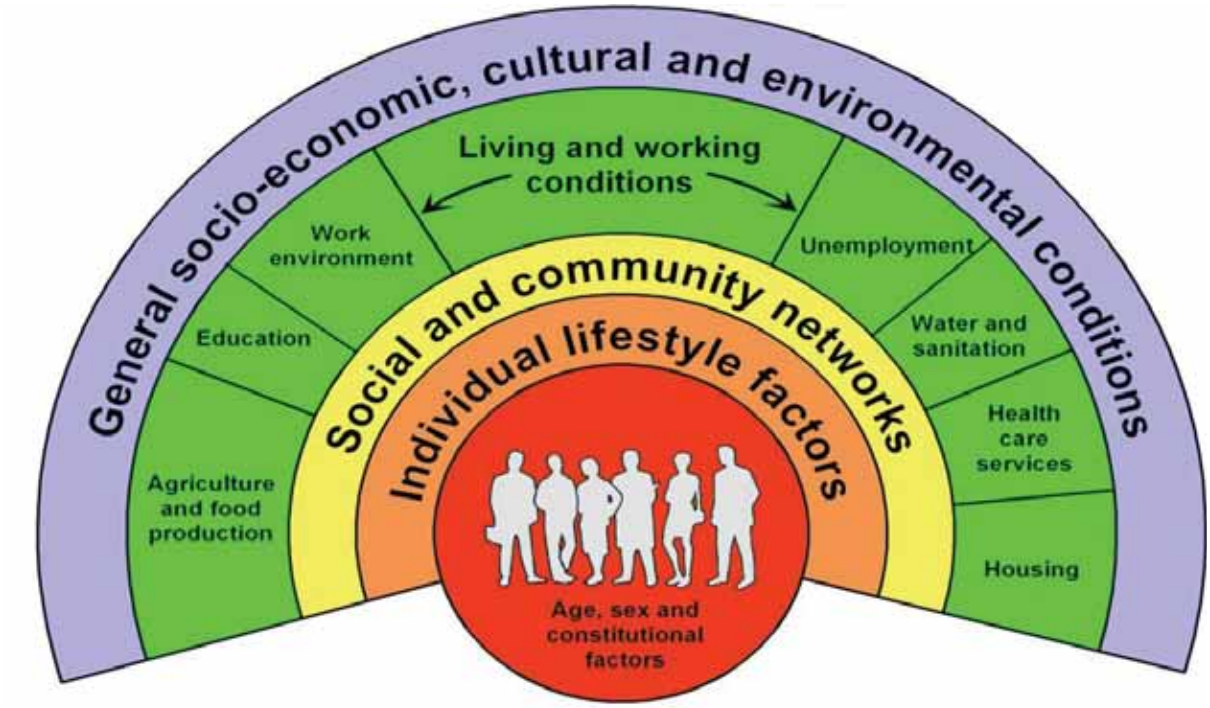
Source: Greater London Authority, 2013

5.3 WIDER DETERMINANTS OF HEALTH

"Health inequalities result from social inequalities"

Fair Society, Healthy Lives[6]

To address health inequalities, there must be action to address all the social determinants that adversely affect health. The figure below by Dahlgren and Whitehead gives a visual representation of the factors that influence the health of a population.



Source: Dahlgren and Whitehead, 1991

5.3.1 Deprivation[33]

The Index of Multiple Deprivation (IMD) is a commonly accepted measure of deprivation. The 2015 IMD was published in September 2015, however, it is largely based on data collected in 2012. It is a composite measure that combines 38 separate indicators to produce a continuous measure of relative deprivation that ranks areas from the most deprived to the least deprived. Aspects of deprivation that are included in the measure are: income, employment, health and disability, education, skills and training, housing, crime and living environment. It aims to reflect the overall experience of individuals living in a small geographical area, though not all those living in an area with a high level of deprivation will themselves be deprived, and there will be some deprived people living in the least deprived areas. Almost all (98%) of the most deprived Lower Super Output Areas (LSOAs), which are homogenous small areas of relatively even size containing approximately 1,500 people, in England are in urban areas. There are 32,482 LSOAs in England – 144 in Hackney and 6 in the City of London. The 'rank of extent' of deprivation is based on a weighted measure of the population in the most deprived 30% of all areas, whereas the 'rank of average score' includes data across the range of deprivation. Local rankings are shown in Figure 33.

[33] English indices of deprivation 2015: local authority district summaries, Department for Communities and Local Government, September 2015

Figure 33. IMD ranks for Hackney and the City of London

	Extent rank 2010 (of 294)	Rank of average score 2010 (of 326)	Extent rank 2015 (of 302)	Rank of average score 2015 (of 326)
Hackney	1	2	11	11
City of London	294	262	302	231

Source: Department for Communities and Local Government

5.3.1.1 Hackney

Hackney is ranked as the eleventh most deprived local authority in England in the rank of extent in 2015 – an improvement from being the most deprived local authority in 2010. 25 of Hackney's 144 LSOAs (17%) are in the most deprived 10% of the country. This is a fall from 42% of LSOAs being in the most deprived 10% of the country in 2010 – giving Hackney a percentage point improvement of 25%, the largest of any local authority in England. The most deprived LSOA falls within Hackney Wick ward. Only two LSOAs are not in the most deprived half of LSOAs in the country – one falls within De Beauvoir ward, and the other within Stoke Newington ward.

5.3.1.2 City of London

The City of London was ranked as the jointly least deprived local authority by rank of extent both in 2010 and 2015, as no residents live in an area classified to be within the 30% most deprived areas of the country. Using the rank of average score, the City of London has become relatively more deprived (from the 65th least deprived to the 96th least deprived). The City of London's six LSOAs vary between being in the 40% most deprived (Tower ward) to the 20% least deprived (Aldersgate and Bassishaw wards).

5.3.2 Child Poverty[34,35]

Child poverty is one of the biggest barriers in improving outcomes for children and young people. Figure 34 describes some of the reasons why.

[34] Child poverty needs assessment 2014, Hackney council http://www.hackney.gov.uk/cyps-needs-assessment.htm

[35] Reducing infant mortality in London: An evidence-based resource, Public Health England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/431516/Reducing_infant_mortality_in_London_2015.pdf

Figure 34. Consequences of poverty on mothers and babies

Mothers living in poverty are more likely to:

- Be in **poor health**
- Have more **psychological problems** in pregnancy
- **Smoke** more

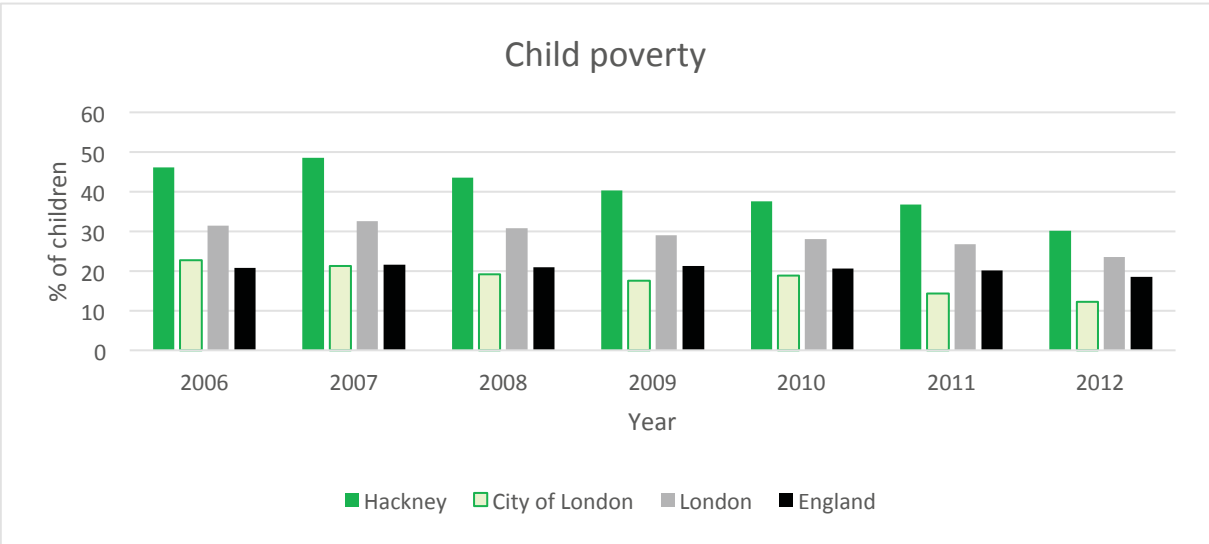
Babies born into poor families are:

- More likely to be **born prematurely** and have low birth weights
- **2 x more likely** to **die within one year** than those born to affluent families

Source: Public Health England

Child poverty is defined as children and young people living in families which are both in receipt of out of work benefits or tax credits, and have income below 60% of the national median income. Approximately 36.8% of all children in Hackney are affected by child poverty, which is almost double the proportion affected in England (20.1%) and also significantly higher than the London average of 26.7%. Hackney has the third highest rate in London, after Tower Hamlets (46.2%) and Islington (38.8%). Hackney also ranks in the top ten local authorities for 'severe' child poverty, with Save the Children estimating that approximately 22% of Hackney's children live in severe poverty – this is 4% above the London average. Despite the rate of child poverty in Hackney remaining high, it has been decreasing year on year since 2007 and has seen one of the largest reductions in the proportion of children affected by poverty when compared to its statistical neighbours (see Figure 35).

Figure 35. Child poverty 2006-2012



Source: HMRC 2006-2012

5.3.2.1 Hackney

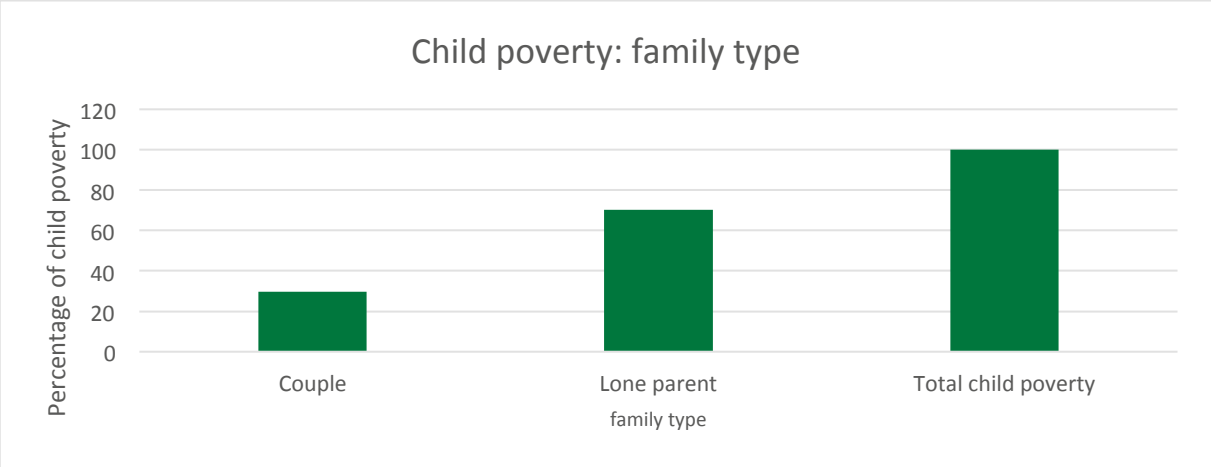
There are large differences in the rates of child poverty between wards, ranging from 44% in Wick and Haggerston to Clissold at the other end of the spectrum with only 24%.

Characteristics of child poverty in Hackney were identified in the 2013 briefing paper 'Parents and Employment'[36]:

- Family type, size and age (see Figure 36)
  - Children in lone parent families are more than twice as likely to live in poverty as those who live in two parent families
  - Lone parents make up 11% of households in Hackney. Approximately 70% of children in poverty in Hackney and 60% of children in poverty in the City of London were in lone parent families[37]
  - Children from families with two young children (aged ten and under) are more likely to live in poverty than any other family make-up
- Workless households
  - In Hackney 31% of households with children are workless, more than double the national rate of 14%
  - Approximately 60% of lone parents are in employment across England. For Hackney, however, that figure is 48%
- Benefit claimant households in the face of welfare reform
  - Income has a direct impact on children's wellbeing and development, independently of other household and parental characteristics
- Disability
  - Hackney has higher levels of disabled and long-term sick residents than its statistical neighbours, mainly in the Mixed, Asian, Black and Other ethnic groups. Rates are higher on Hackney's estates than the rest of Hackney
  - Childhood disability often leads to additional living costs and increased risk of family break-up and unemployment. Hackney has a similar proportion of disabled children to London and England for all ethnicities

[36] Families living in poverty: Parents and Employment: Scoping paper – Hackney council, December 2013 http://www.hackney.gov.uk/Assets/Documents/Parents-and-employment.pdf
[37] HMRC

Figure 36. Child poverty by family type



Source: HMRC 2011

There is national evidence that demonstrates a link between socio-economic status and attainment, with a developmental gap apparent as early as 22 months, which impacts on children's school readiness. Despite this, the gap in educational achievement between local children who live in poverty and their peers who do not live in poverty in Hackney has narrowed to 9.6% compared to 21% nationally. However, in early years, children from the most deprived 10% of areas score between four and ten points less than those in the least deprived 90% and they also perform less well at both Key Stage 2 and at GCSE.[34]

5.3.2.2 City of London

The City of London Child Poverty Needs Assessment[38] used information from key service providers and officers from the City of London Corporation to supplement data from ONS and existing reports to try and determine the extent of the problem. The needs assessment found that child poverty remains an issue in the City of London. The overall trend since 2008 shows improvement, however these numbers may be too small to accurately determine a trend. Within the City there are major differences in deprivation between geographical areas, for example Portsoken is much more deprived than Barbican. Child poverty is an issue in both workless and working households and those families who are most deprived are more likely to have been poor for generations. This has been observed to be a particular problem for the Bangladeshi community.

5.3.3 Education, employment and training

Educational achievement of parents is an important factor in the wider determinants of a child's health as "the graded relationship between socioeconomic position and educational outcome has significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health"[2]. Thus parents' level of education will affect the environment in which a child develops, as well as the health of their caregiver.

[38] Child poverty needs assessment, City of London Corporation, 2014

5.3.3.1 Available services

5.3.3.1.1 Hackney and City of London

All three and four year old children are entitled to 15 hours free Early Years Entitlement per week, across 38 weeks of the year. 20% of two year olds from some of the poorest families have been eligible for 15 hours per week of free childcare from September 2013, and 40% from September 2014. Users of childcare in Hackney do so because it enables them to train/work and because they perceive it as good for their children. For those not using childcare, preferring to stay at home (38%), currently looking for childcare (27%) and not being able to afford childcare were the main reasons (27%).

All Children's Centres across Hackney provide access to "English as a Second Language" (ESOL) classes for parents of under-fives, with the numbers of clients completing ESOL courses increasing by 42% over the past two years. Numeracy and literacy classes are widely available too, enabling parents to develop the most basic skills necessary for employment. Each Children's Centre cluster provides computing courses (from basic PC lessons to NVQ level 3) and general career development and employability sessions are widely offered to further enable parents to develop skills that may help them into work. 2,127 parents either completed a training course or found an employment placement through Children's Centres in 2012/2013, an increase of 33% over two years (see Figure 37). Children's Centre clients are largely from workless homes (60%) and so Centres are well placed to encourage unemployed or economically inactive parents to consider adult learning courses, pre-employment support and work placements. Children's Centres also reach a range of ethnic backgrounds.

Figure 37. Number of parents supported into employment, training or volunteering schemes (including ESOL) by Children's Centre area

	A	B	C	D	E	F	Total
2011/12	65	277	277	336	355	635	1852
2012/13	117	315	372	337	485	645	2127
2013/14	87	329	431	402	488	619	2162

Source: Hackney Learning Trust

5.3.4 Not in Education, Employment or Training[39]

The proportion of young people aged 16-19 who are not in education, employment or training (NEET) is an important indicator of wellbeing, as non-participation is linked to a host of poor outcomes later in life, including poor health outcomes. Approximately 11% of all

[39] Hackney state of the Borough Report 2013, Section 2 Child Poverty and Family Well-being http://www.hackney.gov.uk/Assets/Documents/Reduce-Child-Poverty-and-improve-Family-Well-being.pdf

NEETs in Hackney between 2011 and 2012 were classed as being from a vulnerable group, with mothers aged 16-19 being the largest vulnerable group at 6% of the total (Figure 38).

Figure 38. Number of NEETs by vulnerable group

NEET by Vulnerable Group 2011-2012	Teenage (16-19) mothers	19 Year Old Care Leavers	16 to 19 with LDD	Total vulnerable NEETS	TOTAL NEETS
No. per group	413	16	354	783	6983
As a proportion of total NEETS	6%	5%	0.22%	11%	100%

Source: Hackney Learning Trust

5.3.5 Housing [34]

5.3.5.1 Hackney

Poor housing, housing instability, homelessness and fuel poverty impact on many areas of a child's life and future prospects. Households with children aged under 16, lone parent households and households with four or more children are over-represented on Hackney's Housing Waiting List (HWL) and are therefore likely to be living in unsuitable or temporary accommodation. Socially rented housing is the most overcrowded tenure. Families with dependent children, lone parents and Black and Minority Ethnic (BME) residents are more likely to live in this tenure than average.

18% of households with children are on the HWL compared to only 10% of all households in Hackney. This means that households with children are almost twice as likely to be in housing need as those without children. Similarly, Figure 39 shows that, while households with children constitute 27% of Hackney's households, they occupy 49% of Hackney's HWL.

Figure 39. Family type as a proportion of Hackney's population compared with proportion on the housing waiting list (HWL)

	Number of Households	Proportion of population	Number on HWL	Proportion of HWL
Households With children <16	27,725	26.5%	5,119	49.3%
Households with 4+ children <16	2,610	2.5%	514	4.9%
Lone parent households	9,869	9.4%	1,612	15.5%
Total	104,652	100%	10,389	100%

Source: Mayhew et al, 2011[27, 40]

Hackney has relatively high levels of families with children – both lone parents and couples – who are homeless and living in temporary accommodation (698 households in 2012/13) compared to its statistical neighbours. Although this accommodation is described as 'temporary', in practice homeless households may be forced to spend a long time in such living arrangements due to the current shortage of settled housing. A Shelter survey of homeless households found that 62% of London respondents had been living in temporary accommodation for a year or more. Poor living conditions and concerns about hygiene, safety and security are often associated with temporary accommodation. Temporary accommodation can also be overcrowded and involve sharing facilities for cooking and/or bathing leading to concerns over a lack of privacy. Often temporary accommodation can only be provided at a distance from the household's local community and friends leading to feelings of isolation. Living in temporary accommodation impacts negatively on children's mental health, school attendance and future career prospects.

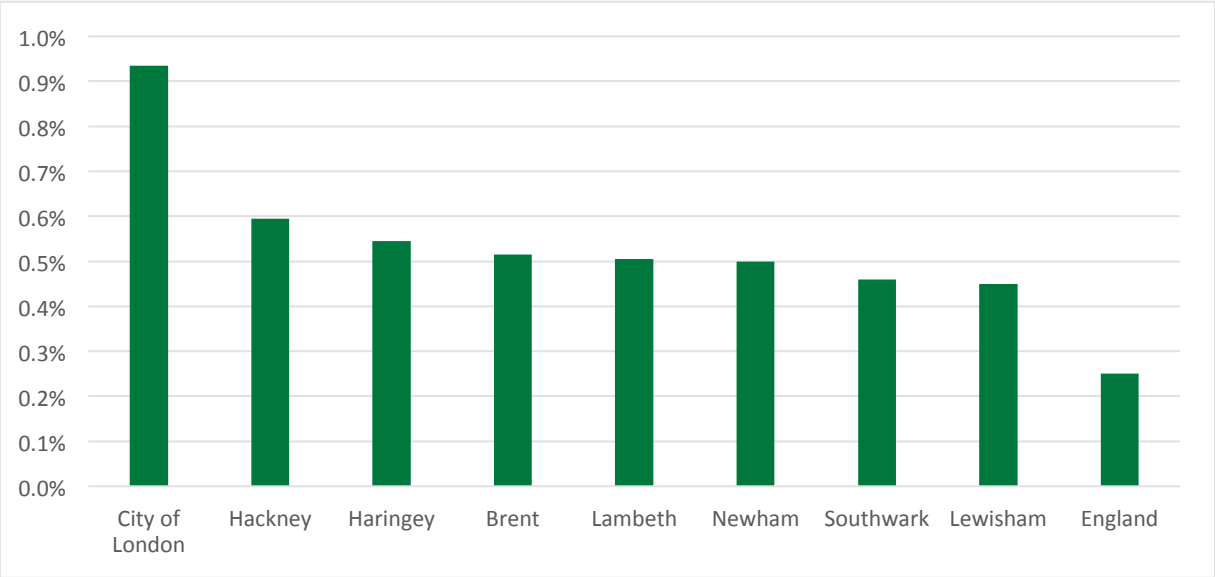
Evidence from the 2011 census found that for all family types (couple, lone parent and other), those with dependent children are more likely to live in overcrowded houses than those without dependent children. Overcrowding is mainly concentrated in the north, east and south east of the borough. The areas where overcrowding is matched by a high incidence of child poverty are in the north of Haggerston and Hoxton and south of Queensbridge, in the south of Wick and a small cluster where Hackney Central, Hackney Wick and Stoke Newington meet. In Hackney overcrowding is a particular issue for the Charedi community in the north of the borough where the average household size is estimated to be 6.3 people and approximately 33% of households are overcrowded.

[40] Note: It should be noted that in 2013 an exercise has been completed to remove around 10,000 applicants from HWL who were in the Reserve band and were no longer bidding for properties. This has reduced the numbers on the HWL meaning that recent HWL figures are likely to be lower than those of the Mayhew study

5.3.5.2 City of London

Figure 40 shows the percentage of households lacking at least one bedroom for the City of London, England and the London Cosmopolitan local authorities (2011 census). These households have been identified by comparing the number of people living in each dwelling to the number of available bedrooms. Amongst the London Cosmopolitan local authorities, the percentage of households short of at least one bedroom was highest in the City of London (more than three times the England average). Black and Asian ethnicities are most likely to be overcrowded at 35% and 27%, respectively. Within these ethnicities, the Bangladeshi community are the most likely to be overcrowded with 67% of people living in a house that lacks at least one bedroom.

Figure 40. Percentage of households lacking at least one bedroom, 2011



Source: ONS Census 2011

5.3.6 Social Capital[41,42]

Definitions of social capital vary but the main aspects include citizenship, neighbourliness, social networks and civic participation. Social networks are defined as the personal relationships which are accumulated when people interact with each other in families, workplaces, neighbourhoods, local associations and a range of informal and formal meeting places. Greater interaction between people generates a greater sense of community spirit and can increase the holding of shared values. Research has shown that higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes and lower crime rates; whereas low social capital has been identified as a predictor of risk during pregnancy.

5.3.6.1 Hackney

Surveys of Hackney residents over the last eight years have shown that Hackney residents are more likely to say that the local area is a place where people from different backgrounds tend to get on well together, than residents polled for national surveys. The percentage of residents who agreed with this statement is also rising - from 83% of residents in 2005 to 90% by 2013. However, there is some variation in the views held. Residents who moved to Hackney in the last five years are more satisfied than those who moved in over a decade ago (94% vs 86%) and people in full time work are more likely to be satisfied (91%) than those who work part time (87%) or who are unemployed (81%). While in 2005 White residents were less satisfied than BME residents, in 2013 there is no significant difference between people from different ethnic groups or from people whose first language is not English. Overall, residents' satisfaction with their local area as a place to live is now higher in Hackney than most other local authorities in England.

5.3.6.2 City of London

Results from a local survey published in May 2013 reported that satisfaction with the City as a place to live, work and run a business remains high, with over 90% of residents, workers, executives and businesses satisfied with the local area. Residents are the group most likely to be 'very satisfied'. The City scores well on all the indicators of satisfaction and participation in civil society. City residents see traffic congestion and pollution as areas needing improvement, followed by road and pavement repairs, affordable decent housing, parks and open spaces, and shopping facilities.[28]

[41] Guide to Social Capital, ONS http://www.ons.gov.uk/ons/guide-method/user-guidance/social-capital-guide/the-social-capital-project/guide-to-social-capital.html

[42] State of the Borough Report 2013, Section 3, Improve quality of life and promote safety and cohesion

5.3.7 Communities with particular needs

5.3.7.1 Hackney

5.3.7.1.1 Orthodox (Charedi) Jewish Population[43, 44]

Hackney is home to one of the largest Orthodox Jewish communities outside of New York and Israel. The Charedi community was established in Stamford Hill in the 1920s. It is a diverse community with a mix of backgrounds, countries of origin and congregations, but linked by a shared adherence to the tenets of the Torah, lifelong religious study and to marriage, family life, and supporting others.

Charedim live in concentrated communities, so that whilst they are not present in the vast majority of Britain, in Hackney they account for approximately 20% of the child population, with an even higher proportion in some wards. There is a high birth rate with annual growth of 4.2%. Over half of Charedim are under 16 and the average household size is 6.3. Families are central to Charedi culture and almost all children grow up in a nuclear family with a mother, father and siblings.

Almost all Charedi children are educated in independent Charedi settings, where Torah subjects are taught alongside secular subjects in a 'sheltered' environment. After school, young women may attend 'seminaries' and young men attend a 'yeshiva' (religious colleges).

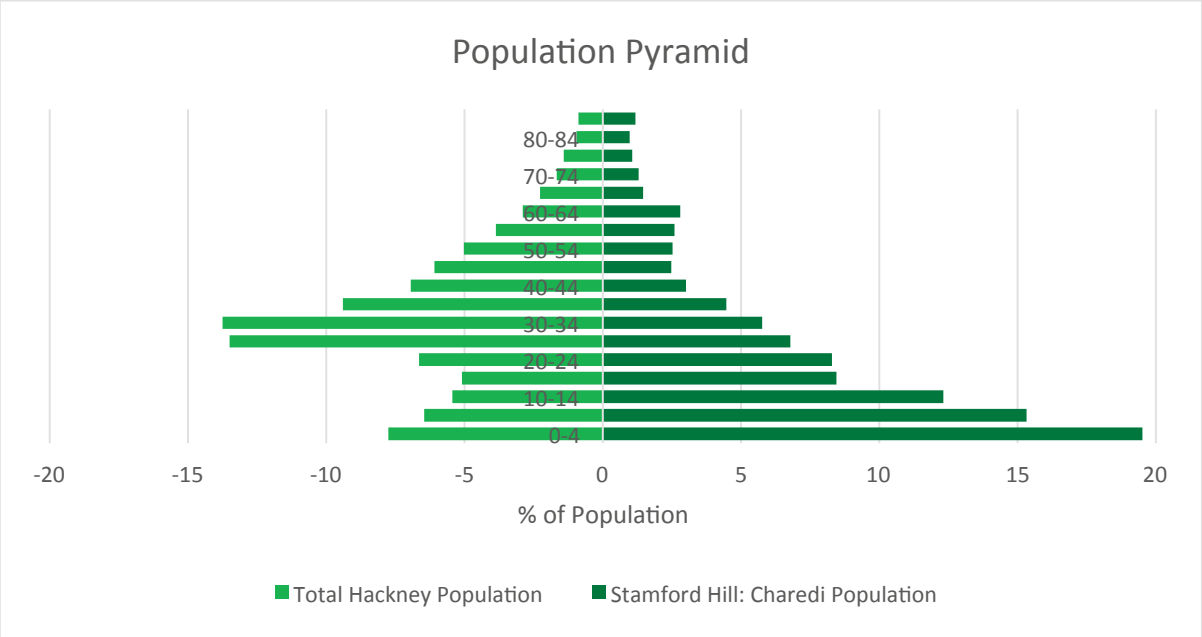
It is an economically mixed community. While very few are registered as unemployed, there are significant levels of in-work poverty and dependence on means-tested benefits. There is also a very high level of housing need because of large household sizes and the constraint of living close to community infrastructure.

Figure 41 compares the age structure of the Charedi population in Stamford Hill to that of the Hackney population as a whole and demonstrates why they are such an important cultural group when assessing the health of 0-5s.

[43] The history of Hackney's diverse communities, Hackney council http://www.hackney.gov.uk/hackney-the-place-diversity.htm#charedi

[44] Interlink, Orthodox Jewish Voluntary Action, cultural awareness presentation, July 2015

Figure 41. Age structure of Charedi population in Hackney based on 2011 Census



Source: Institute of Jewish Policy Research

5.3.7.1.2 Gypsy, Roma and Travelling communities[45]

The umbrella term Gypsies and Travellers, or Gypsy, Roma and Travellers, consists of a number of different ethnic communities. Romany Gypsies and Irish Travellers are legally recognised as ethnic groups. Although they share some cultural values such as nomadism, they remain distinct and each have their own cultures and traditions.

There are around 600-800 Gypsies and Travellers living in Hackney, and the Hackney Traveller Education Service estimates that approximately 300 of these are children. There are currently five local authority Traveller Sites in Hackney (managed by Hackney Homes) with a total of 27 pitches. Approximately 115 adults and children live on these sites; however a large number of extended families will be visitors. The national reduction in the number of traditional stopping places mean it has become increasingly difficult to maintain the travelling lifestyle and these communities often associate having to live in 'bricks and mortar' accommodation with increased isolation and a loss of cultural identity. The Gypsy, Roma and Traveller population has a long history of social exclusion, marginalisation and discrimination and despite legal protection under equality legislation they remain one of the most socially excluded groups in the country.

The life expectancy of a Gypsy or Traveller man or woman is ten years less than the national average. Gypsy and Traveller mothers are 20 times more likely than the rest of the population to have experienced the death of a child and, in 2003, less than 25% of Gypsy and Traveller children obtained 5 GCSE's at A*-C grades, compared to a national average of over 50%.

[45] Gypsy, Roma and Traveller Communities, Hackney council
http://www.hackney.gov.uk/eqal-traveller-communities.htm

5.3.7.1.3 Services available[46]

There has been an outreach nurse working within both of these communities since September 2014 with the aim of:

- Promoting access to the full range of primary and secondary health services for both communities;
- Delivering clinical health services, information and advice;
- Supporting and contributing to the delivery of commissioned children's public health programmes, for example, HCP, Healthy Start uptake, timely antenatal booking and breast feeding initiation and continuation;
- Improving immunisation rates and number of development reviews and responding to targeted campaigns as directed by PHE and NHS England;
- Promoting use of Children's Centres, assisted by an outreach worker from Daubeney Children's Centre.

Areas identified for future work include improving dental health and tackling obesity.

5.3.7.2 City of London

5.3.7.2.1 Bangladeshi community

Portsoken Ward has a high percentage of Bangladeshi families. These families typically have more children than average, often between two and five, and are living in overcrowded conditions.

Children living in households headed by someone from an ethnic minority are more likely to be living in a poor household. This is particularly the case for households headed by someone of Pakistani or Bangladeshi origin, where well over half of the children are living in poverty. In Mansell Street estate, 43% of residents are Bangladeshi. However, the tenancy profile provided by Guinness Trust showed that only 11% of tenancy holders were Bangladeshi. This confirms that the Bangladeshi community consists of larger families in this estate. Around 40% of employees of Pakistani and Bangladeshi origin in London were low paid, more than twice the rate for White British employees.[38]

[46] A report on the progress of the Outreach Nurse role within the Travelling communities, Shelley Eugene, Dec 2014

6 THE NEEDS OF THE LOCAL POPULATION

6.1 ANTENATAL

6.1.1 Antenatal Specialist Referrals

6.1.1.1 Introduction

During a woman's booking visit, midwives assess how much support a woman may need taking into account her social circumstances, health and age. Women who are identified as having a greater need than can be met by universal antenatal care alone will be referred on to those specialist services that can best support them.

6.1.1.2 Hackney and City of London

Between 2013 and 2015, 448 women (of 6,991 births) received specialist antenatal referrals. In total 712 referrals were made as 40% of women required referrals to more than one service. The greatest number of referrals was to the Public Health Midwife (363), followed by social workers (193) and health visitors (78) (see Figure 42).

Public health midwives have a role addressing factors that are likely to affect health and wellbeing both for the individual and communities. They act as an interface between groups and individuals in the population and work to develop the capacity and confidence of groups and individuals to improve their own health and wellbeing.[47]

Approximately 60% of women required referral to one service, 24% required referral to two services, and 17% to three or four services. A referral to three or four services represents the most complex cases covering a variety of needs. Those who only received one referral were more likely to be referred to the Public Health Midwife than any other service (73%); while those who received three or more services were the most likely to be referred to a health visitor (approximately 81%).

[47] Nursing and Midwifery council, Standards of proficiency for specialist community public health nurseshttp://www.nmc.org.uk/globalassets/sitedocuments/standards/1/nmcstandardsofproficiencyforspecialistcommunitypublichealthnurses.pdf

Figure 42. Number of women referred and services referred to (2013/14-2014/15)

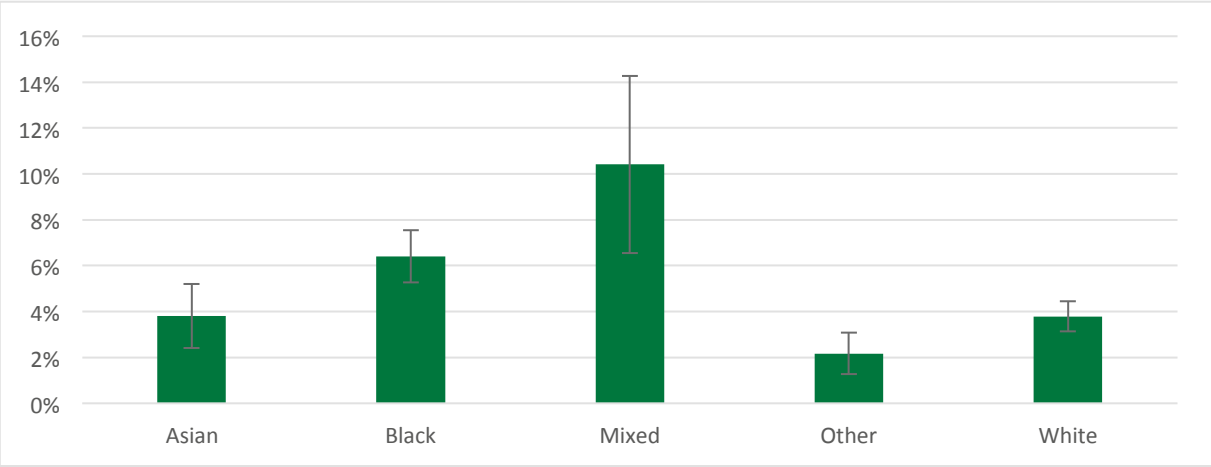
Referral to…	Number of referrals
Public Health Midwife	363
Social Worker	193
Health Visitor	78
Teenage Pregnancy	22
Domestic Violence and Hate Crime Team	13
Family Nurse Partnership	10
Sure Start	9
Substance and Alcohol Misuse Midwife	7
Women's Aid/NIA Project	7
Women's Refuge	7

Source: Homerton University Hospital

With the exception of under 20s, who are much more likely to have a referral, the number of referrals in all the other age groups as a proportion of all births is broadly similar.

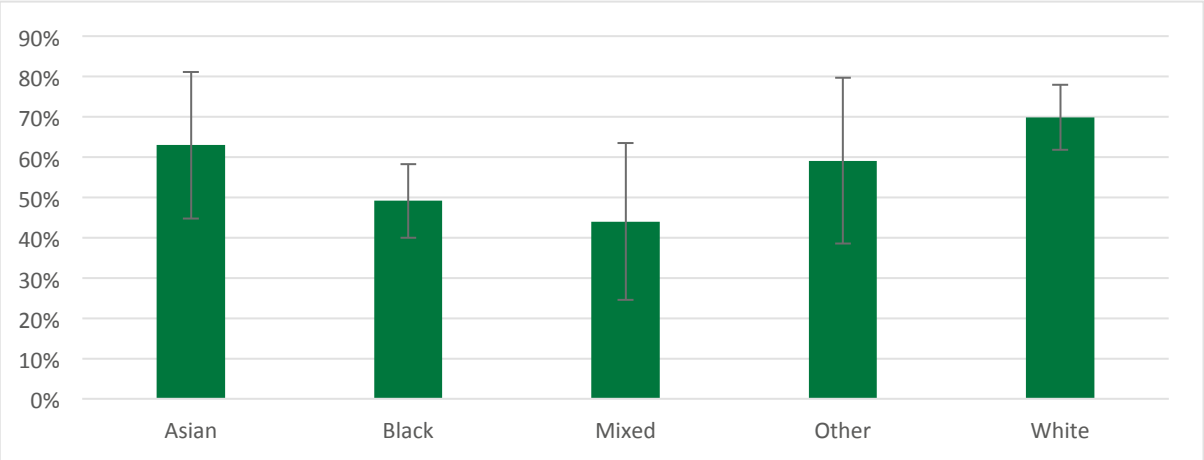
Those who are of Black or mixed ethnicity are more likely to have a referral; those who are White or fall in the 'Other' ethnicity category are less likely to have a referral. Similarly, those who are White and have a referral are more likely to have only one referral than those who are Black or of mixed race and have a referral (see Figures 43 and 44).

Figure 43. Those who have one or more referral(s) as a proportion of all births by ethnicity



Source: Homerton University Hospital Foundation Trust

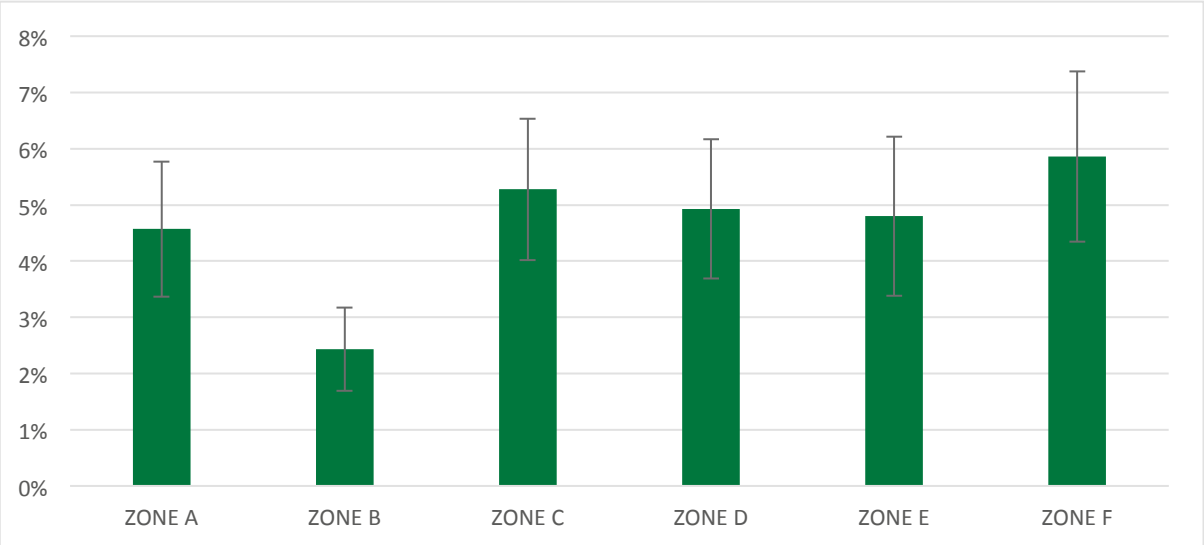
Figure 44. Those who have one referral as a proportion of those who have one or more referrals by ethnicity



Source: Homerton University Hospital Foundation Trust

Children's Centre area B has the lowest rate of women referred to services (see Figure 45). This could point to lower needs, lower detection of needs, or needs being met by other services. In particular, of the 1,237 people with their ethnicity recorded as Jewish or Orthodox Jewish, only 11 received a referral.

Figure 45. Those who have one or more referrals as a proportion of total births by Children's Centre area, 2013-15



Source: Homerton University Hospital

[For full breakdown see Appendix 9.2.1.1]

6.1.1.3 Key findings

- Midwives based at HUH made 712 referrals for specialist services in addition to universal provision for a total of 448 women over two years (2013-2015). 78 referrals were to health visitors, which were predominantly for women who had been referred to three or more services and therefore represent the most complex cases;
- Age: women aged less than 20 were more likely to be referred;
- Ethnicity: women of Black or Mixed ethnicity were more likely be referred;
- Location: fewer referrals were made within Children's Centre area B. Only 11 referrals for Orthodox Jewish women were made (of 1,248 births). 74% of the Orthodox Jewish cohort lives in area B (based around the Stamford Hill area).

6.1.2 Teenage Conceptions and Births

6.1.2.1 Introduction

Teenage mothers represent a vulnerable group who require intensive intervention. Without assistance during pregnancy and the early years there is a risk of perpetuating the cycle of disadvantage that can occur in such circumstances. Many teenage pregnancies are unplanned and approximately half end in an abortion. For the young women who choose to continue with the pregnancy they risk poor outcomes both for their own emotional health and well-being and their child's. Poverty is also a very real risk, as teenage mothers are less likely to be able to finish their education and are more likely to be a lone parent.

Teenage pregnancies have a 44% higher risk of infant mortality, a 25% higher risk of low birth weight babies at term, a 63% higher risk of child poverty, a six-fold higher rate of maternal smoking and a one third lower rate of breastfeeding initiation. Teenage mothers are three times more likely than older mothers to suffer postnatal depression and have mental health problems in the first three years of their baby's life.[48] The children of teenage mothers are also at increased risk of experiencing low educational attainment and having poor housing, poor health and lower rates of economic activity in adult life.

It is therefore vital that both early intervention and prevention strategies are adopted to address this problem. In Hackney and the City of London early intervention, and an element of prevention, is provided by the FNP (discussed in section 4.3.3). Prevention is provided through services for adolescents by the Children's and Young People's Service Plus (CYPS+) and via education in schools through Personal, Social, Health and Economic (PSHE) education.

[48] Teenage pregnancy strategy: beyond 2010

Public Health England

10 factors that play a role in producing an effective local strategy

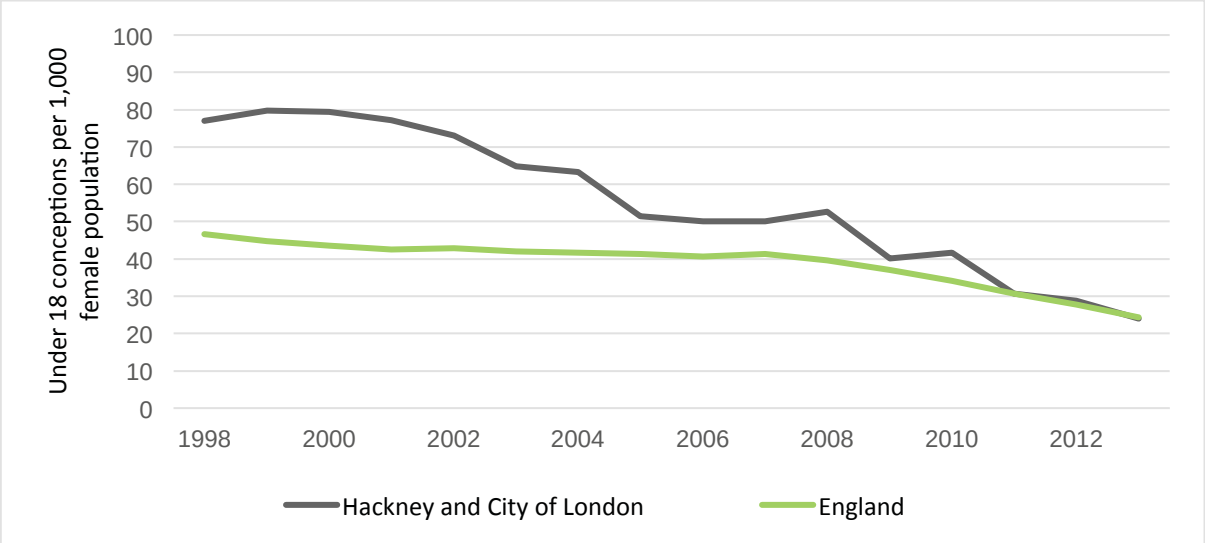
- Sex and Relationships Education (SRE) in schools and colleges
- Youth friendly sexual health services and condom schemes
- Targeted prevention for young people at risk
- Support for parents to discuss relationships and sexual health
- Training on relationships and sexual health for health and non-health professionals
- Advice and access to contraception in non-health youth settings
- Consistent messages to young people, parents and practitioners
- Dedicated support for teenage parents-including SRE and contraception
- Strong use of data for commissioning and progress monitoring

6.1.2.2 Hackney

The rate of teenage conceptions is monitored as the number of conceptions to women less than 18 years old. The number of births, however, is measured for women less than 19 years old and it is this figure that is relevant to the caseload of the FNP programme.

Figure 46 shows that the number of conceptions in women less than 18 years old in Hackney and the City of London has been falling steadily over the past 15 years: in 2013 there were 97 teenage conceptions, compared with 170 in 2010 and 273 in 1998. The rate of conceptions per 1,000 females aged 15–17 was 24.0 in 2013 – similar to the national rate of 24.3. This rate has fallen from a high of 79.8 conceptions per 1,000 females aged 15–17 in 1999.

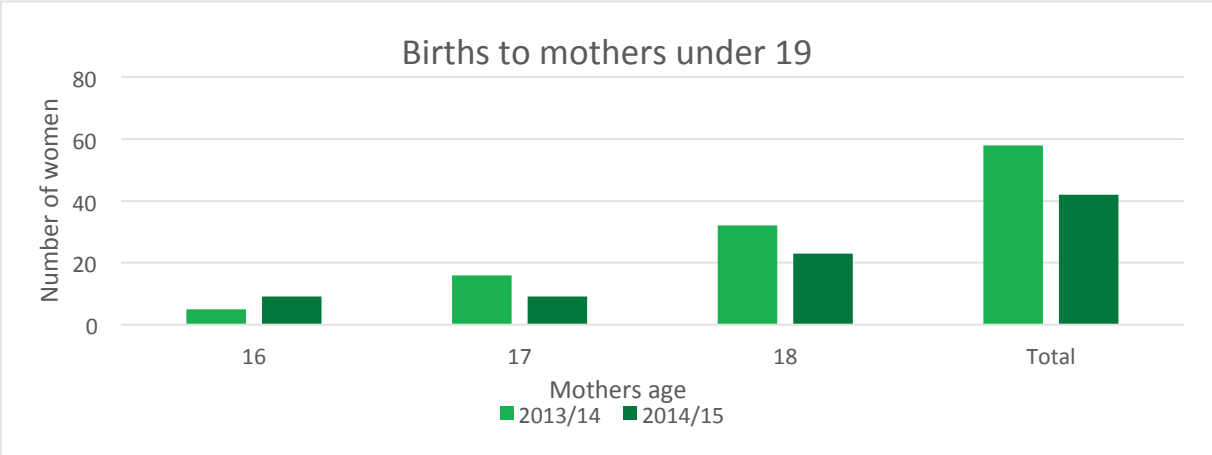
Figure 46. Rate of conceptions per 1000 females aged under 18



Source: ONS

The most recent local data from 2014/15 from HUH shows an ongoing improvement in the number of births to mothers less than 19 years old (see Figure 47). Total numbers fell by greater than 25% between 2013/14 and 2014/15.[49]

Figure 47. Number of births to mothers under 19 in HUH in 2013/14 and 2014/15

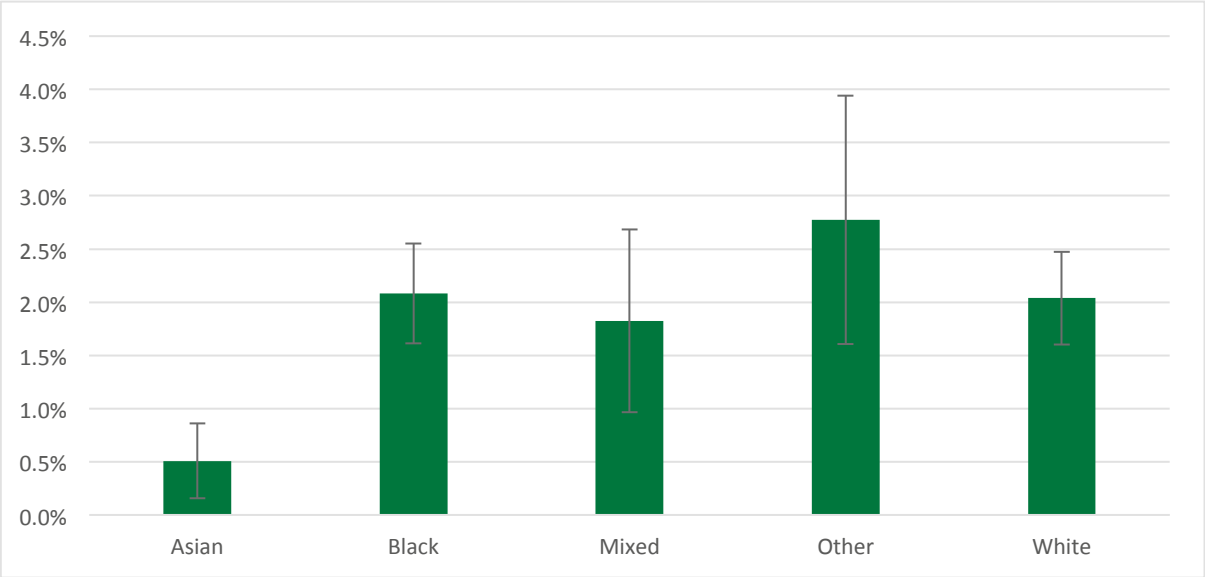


Source: Homerton University Hospital

Those who are Asian are less likely to have births at age 19 and under, whether considered as a proportion of the number of births or the total population. When considered as a proportion of the total 16-19 population, there are no statistical differences between the other ethnic groups (see Figure 48); however, when considered as a proportion of the number of births, those who are Black or Mixed race are more likely to have births at age 19 and under (see Figure 49).

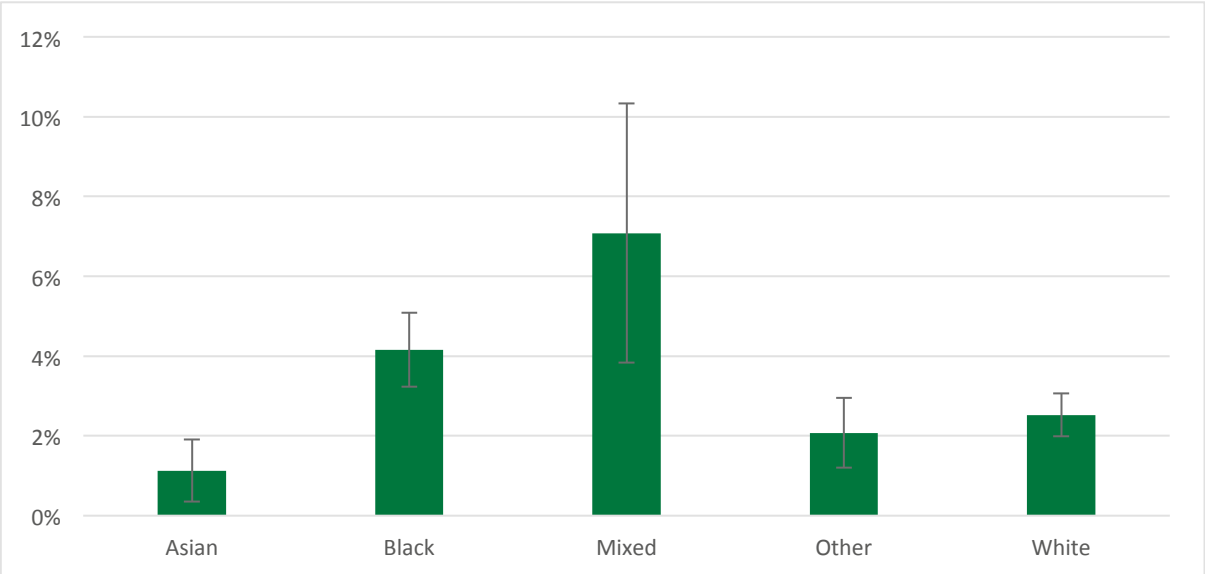
[49] Note: Due to the small numbers involved births from mothers aged 14 and 15 are suppressed to prevent identification. None of the women are residents of the City of London.

Figure 48. Births to women aged 14-19 as a proportion of 14-19 population by ethnicity, 2013-15



Source: Homerton University Hospital

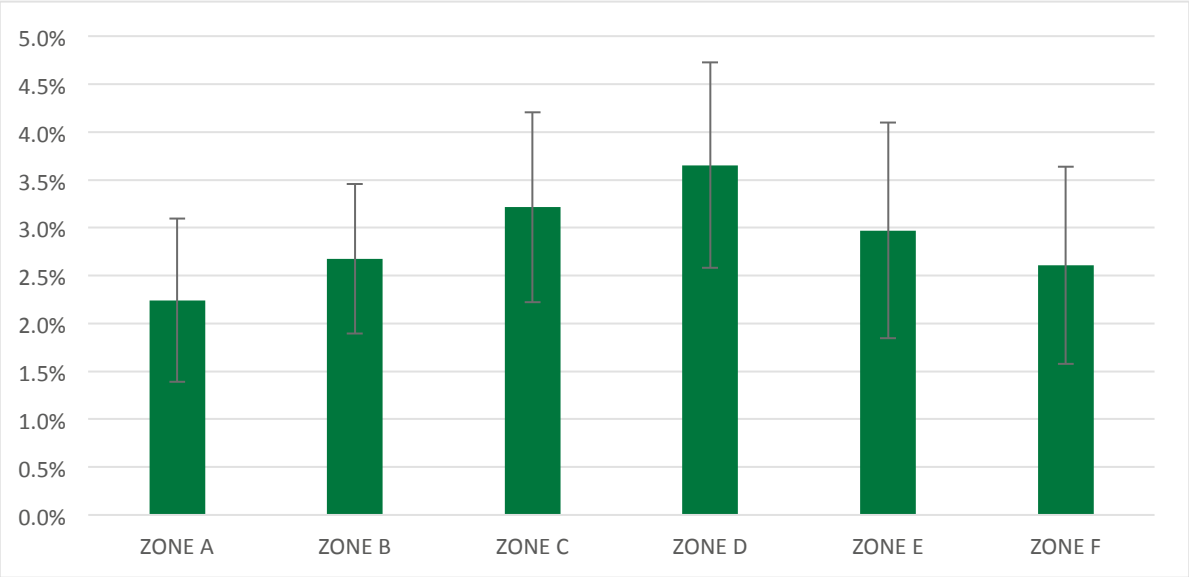
Figure 49. Births to women aged 14-19 as a proportion of total births by ethnicity, 2013-15



Source: Homerton University Hospital

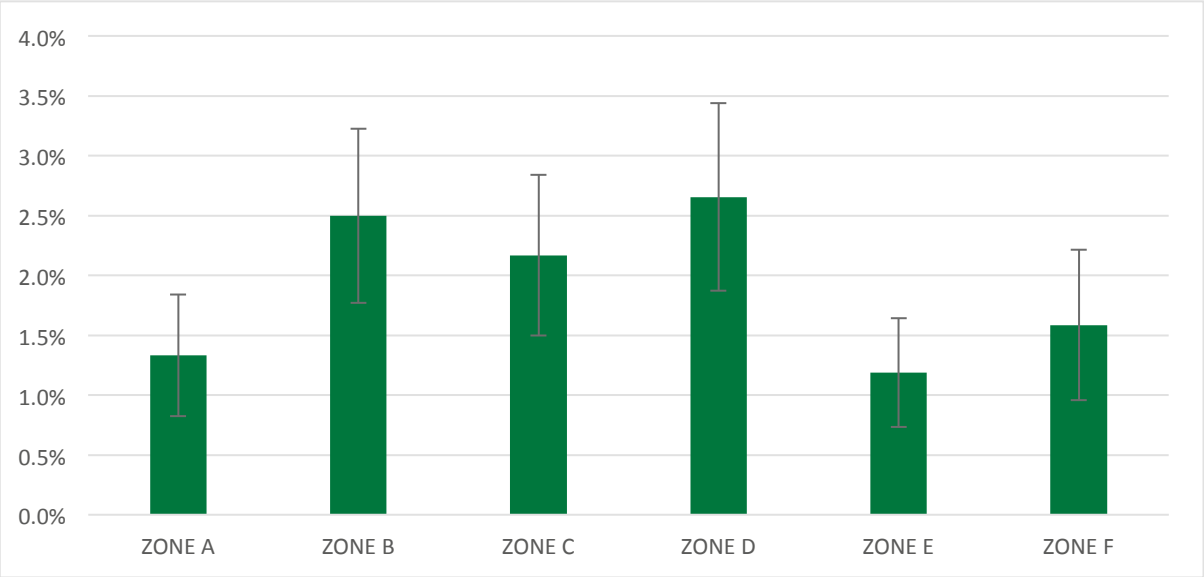
Per birth, there are no statistical differences between the rates of births in women aged 19 and under by Children's Centre area (Figure 50). However, per head of population, those aged 16-19 in areas A and E are less likely to have a child aged 19 and under while those in areas B and D are more likely (Figure 51).

Figure 50. Births to women aged 14-19 as a proportion of all births by Children's Centre area, 2013-15



Source: Homerton University Hospital

Figure 51. Births to women aged 14-19 as a proportion of estimated 14-19 population by Children's Centre area, 2013-15



Source: Homerton University Hospital

6.1.2.3 City of London

There have been no births to women aged 19 and under in the City of London in the past five years.[50]

[For full breakdown see Appendix 9.2.1.2]

[50] City of London Children's Social Care

6.1.2.4 Key findings

- The number of conceptions in women aged under 18 in Hackney has been steadily reducing over the last 15 years and the rate now equals the England average;
- During this time the total number of births to women aged 19 and under fell by 25%;
- Ethnicity: Asian women are less likely to give birth aged 19 or under;
- Location: as a proportion of all births, there are no statistical differences in births being to women aged 19 or under by Children's Centre area. However, as a proportion of all 15-19 year olds, there are significantly more births in areas B and D;
- There have been no births to women aged 19 or under in the City of London in the last five years.

6.1.3 Maternal Mental Health

6.1.3.1 Introduction

Perinatal mental health problems affect 20% of women at some point during pregnancy or in the first year after birth, with around 15% of women experiencing common mental health problems such as perinatal depression and anxiety. It has been estimated that only half of mothers with perinatal depression and anxiety are identified, despite frequent routine contact with a range of primary care services during this time period, and fewer receive sufficient treatment. A need to 'be strong and get on with it' was a significant barrier to disclosure among women in general, but is known to be a particular barrier to disclosure among African Caribbean women experiencing perinatal mental health difficulties.[51]

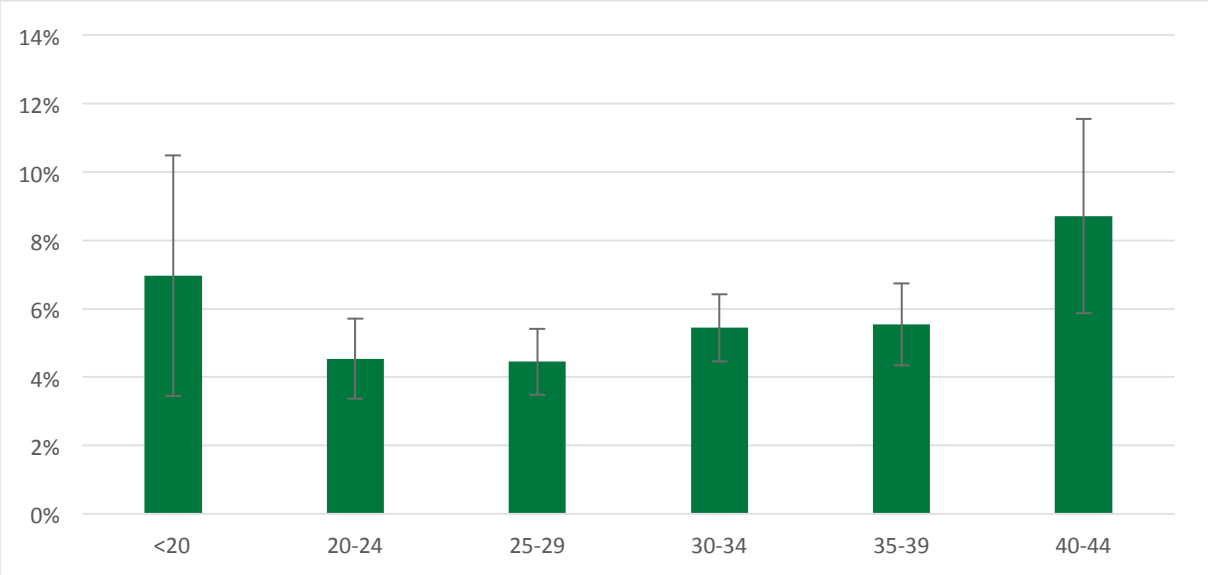
6.1.3.2 Hackney and City of London

99.9% of mothers had their mental health status recorded at birth and poor mental health was recorded in 5.3%.

Figure 52 shows that women in the 25-29 age range were slightly less likely to be recorded as having poor mental health, while those in the 40-44 age range were more likely. Other differences are not statistically significant.

[51] Falling through the gaps: perinatal mental health and general practice, Lorraine Khan, centre for maternal mental health, 2015

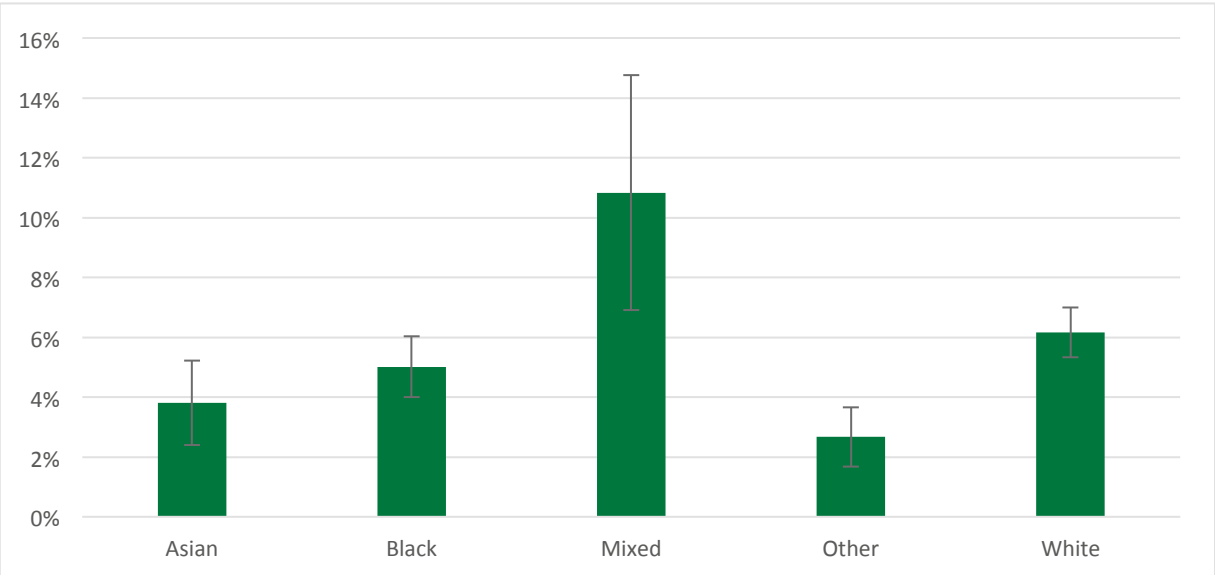
Figure 52. Maternal mental health by age, 2013-15



Source: Homerton University Hospital Foundation Trust

Those who are of mixed race were more likely to have poor mental health recorded than those of any other ethnicity. Those who are White were more likely to have poor mental health recorded than those who are Asian or in the 'Other' ethnic group.

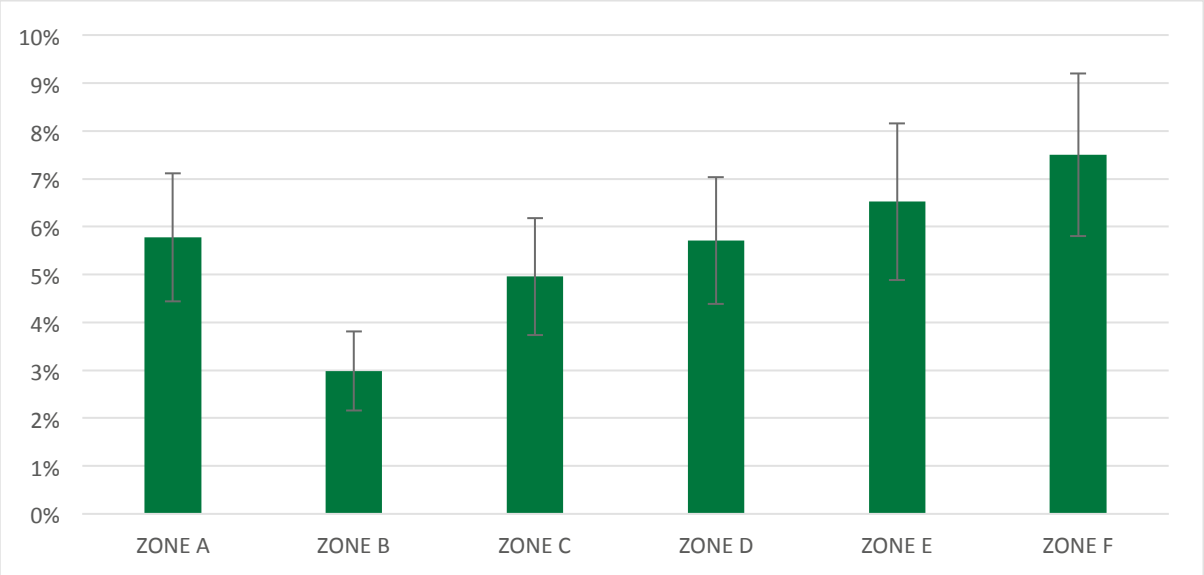
Figure 53. Maternal mental health by ethnicity, 2013-15



Source: Homerton University Hospital Foundation Trust

Those in Children's Centre area B are less likely to have poor mental health recorded. This may point to generally better mental health or lower detection of poor mental health. In particular, of the 1,248 births with ethnicity recorded as Jewish or Orthodox Jewish, while all but one have their mental health status recorded, only 19 (1.5%) are recorded as having poor mental health. 74.0% of those with ethnicity recorded as Jewish or Orthodox Jewish live in area B.

Figure 54. Maternal mental health by Children's Centre area, 2013-15



Source: Homerton University Hospital Foundation Trust

Of those with poor mental health recorded, 6.2% also had substance misuse recorded. Only 0.5% of those without poor mental health recorded had substance misuse recorded. This demonstrates that while people with poor mental health are not very likely to have comorbid substance misuse they are much more likely to have problems with substance misuse than those without poor mental health recorded.

Of those with substance misuse recorded, approximately 42% also had poor mental health recorded, compared to only 5% of those with no substance misuse recorded.

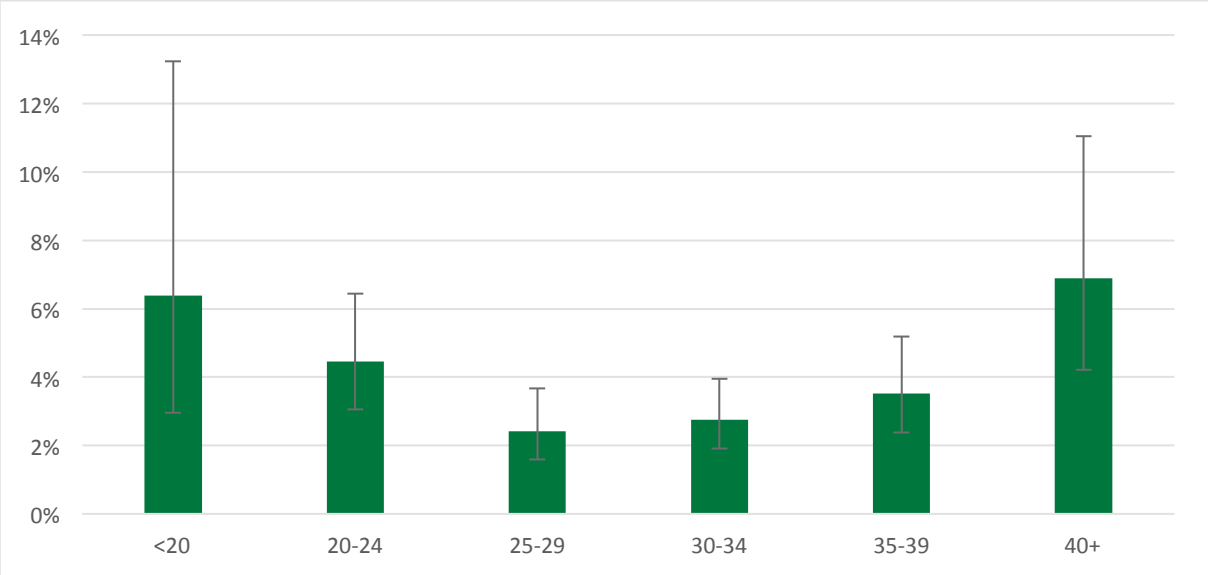
6.1.3.2.1 Services

Services in Hackney and the City of London are provided by the perinatal mental health team. The team provide care to women who have moderate to severe mental health difficulties in pregnancy or within one year of delivery. These problems can be pre-existing or arise during the perinatal period. Inpatient treatment is provided in the Margaret Oates Mother and Baby Unit, located in HUH, which has ten beds. The data below is from the perinatal mental health team and therefore excludes women with mild mental health difficulties who are managed by primary care services. No data was available from primary care.

There were 120 perinatal mental health clients resident in Hackney and the City in 2014/15. There were 3,464 births to Hackney and the City residents in the same time period, suggesting around 3.5% of residents were perinatal mental health clients.

Those in the 25-29 age group were less likely to be perinatal mental health clients than those aged over 40 (see Figure 55). No other statistically significantly different results were found by age, but this may be due in part to the small numbers involved.

Figure 55. Women requiring perinatal mental health services by age, 2014/15



Source: Homerton University Hospital Foundation Trust

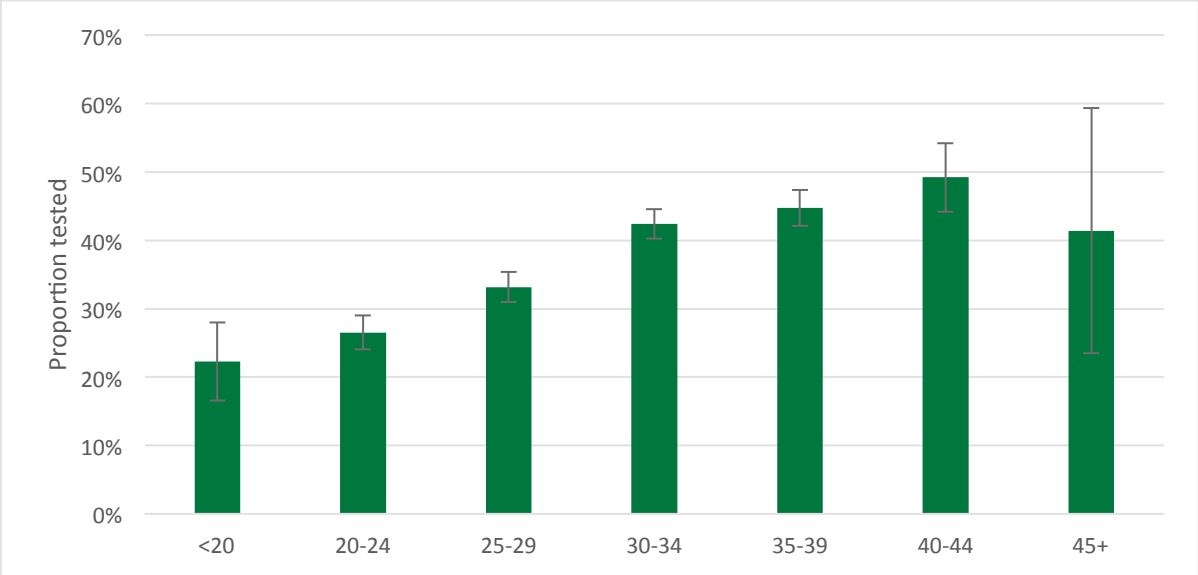
There were no statistically significant differences found in subgroup analysis by ethnicity or Children's Centre area, although this may also be due in part to the small numbers involved.

6.1.3.2.2 Screening

Of 6,991 births by City and Hackney residents at HUH in 2013/14-2014/15, in 38% post-natal depression screening was recorded. Older mothers were more likely to be screened than younger mothers. There did not appear to be a bias in screening by ethnicity. Children's Centre area information was not available. Referral rates are reported here for completeness: there were 78 instances of a referral being required, 3% of recorded assessments. However, the low screening rate means very little can be concluded about the prevalence of post-natal depression (PND) from the numbers who have a referral recorded.

The proportion of mothers screened for mood steadily increases with age (see Figure 56). At the extremes, younger mothers (under 25) are only half as likely to have a mood assessment as older mothers (over 40).

Figure 56. Ratio of mood assessments to births per age group of mother, 2013-15



Source: Homerton University Hospital Foundation Trust

There are no statistically significant differences in screening rates by ethnicity. However, 441 (17%) of tests did not have ethnicity recorded, so this missing data may mask differences.

[For full breakdown see Appendix 9.2.1.3]

6.1.3.3 Key findings

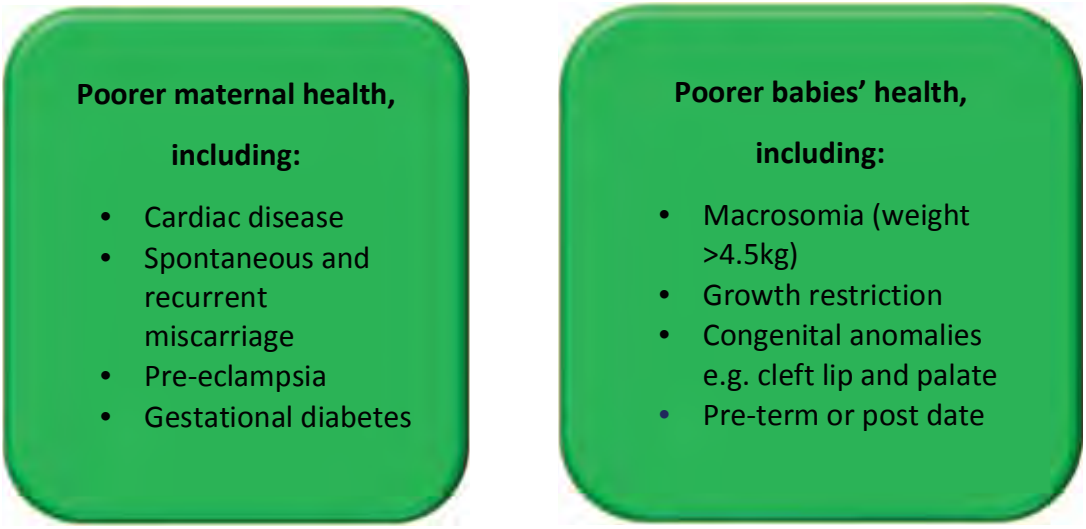
- 99.9% of mothers had their mental health status recorded at delivery – 5% were 'poor' and two thirds of these were perinatal mental health service clients;
- Age: those aged 25-29 were less likely, while those aged 40-44 were more likely, to be recorded as having poor mental health;
- Ethnicity: Mixed race women were more likely to have poor mental health recorded;
- Location: those in area B were less likely to have poor mental health recorded. In only 1.5% of births to Orthodox Jewish women was poor mental health recorded (74% of the Orthodox Jewish cohort live in area B);
- Dual diagnoses: of those with poor mental health recorded, 6.2% also had substance misuse recorded (versus 0.5% of those without poor mental health). Similarly, of those with substance misuse recorded, 42% also had poor mental health (versus 5% of those without substance misuse recorded);
- Postnatal depression screening: 38% of women were recorded as having been screened, with 3% of these requiring referral. Older women were more likely to be screened, but there was no ethnicity bias in screening.

6.1.4 Maternal Weight and Obesity

6.1.4.1 Introduction

In London, 1 in 5 women aged over 16 are obese. London has the lowest prevalence of maternal obesity with 1 in 30 pregnant women categorised as obese. In England, being over 35 years of age is a predictive factor for maternal obesity, 84.6% are White and 1 in 3 live in the most deprived quintile. The health impacts of maternal obesity include poorer health of both the mother and child.

Figure 79. Health impacts of maternal obesity[35]



Maternal obesity also impacts on mortality, both maternal and infant. Maternal obesity was responsible for 20% of maternal deaths from 2003-2005 and 50% of maternal deaths due to thromboembolism or heart disease. Maternal obesity was responsible for one in three stillbirths, one in four late foetal deaths and one in three neonatal deaths. Women who are obese are grouped as high risk during pregnancy and require additional antenatal screening, intervention and monitoring and therefore additional healthcare resources are essential due to pregnancy complications and increased use of neonatal intensive care units.[35]

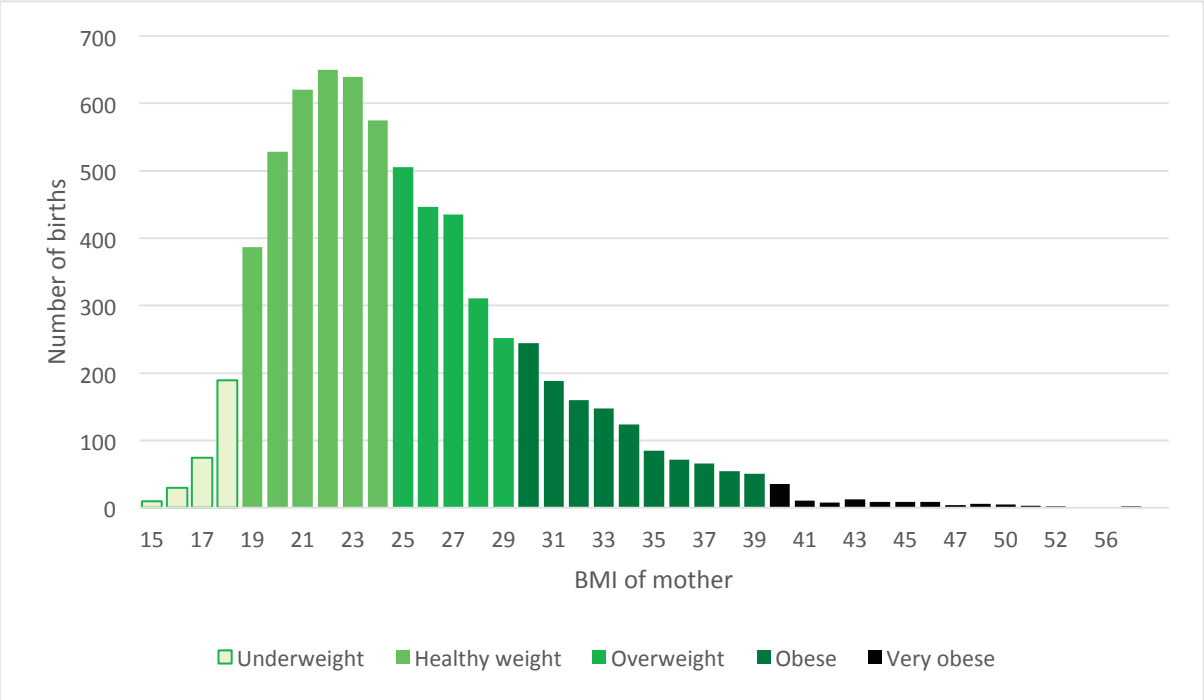
Public Health England has identified several interventions for tackling maternal obesity:

- Collaboration between professionals, incorporating community-based public health services starting from preconception
- Provision of health education on weight management, healthy eating, physical activity and ongoing support before, during and after pregnancy
- Modifying lifestyle and environmental factors through behaviour change techniques

6.1.4.2 Hackney and City of London

For residents of Hackney and the City of London who gave birth at HUH between 2013/14-2014/15, half of births were to mothers of a healthy weight at their booking appointment, just over one quarter to overweight mothers, and just under one fifth to obese or very obese mothers (see Figure 57).

Figure 57. Maternal BMI by proportion of births, 2013-15

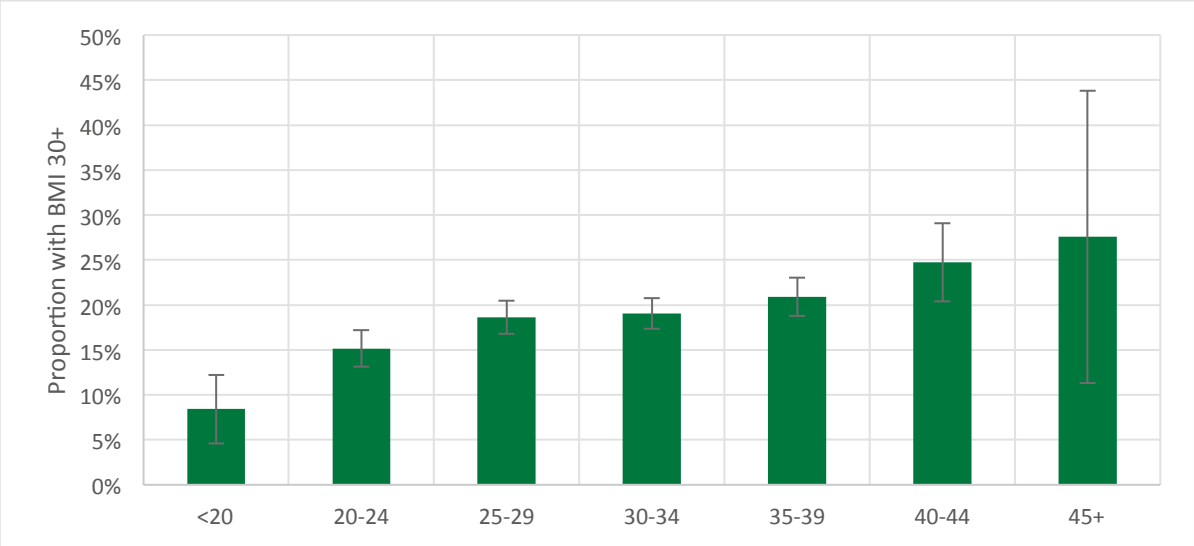


Source: Homerton University Hospital Foundation Trust

For UCLH deliveries to women of the City of London the proportion of births to healthy weight mothers is higher at approximately 75%, the proportion of overweight mothers is lower at approximately 16% and fewer than five women across the two years were recorded as obese. However, further breakdown (by age and ethnicity) has been calculated for HUH deliveries only as the numbers at UCLH are too small.

The proportion with a BMI over 30 increases with age (Figure 58). Mothers aged over 40 are almost twice as likely to be obese (25%) than mothers under 25 years of age (14%).

Figure 58. Maternal BMI greater than 30, by age, 2013-15



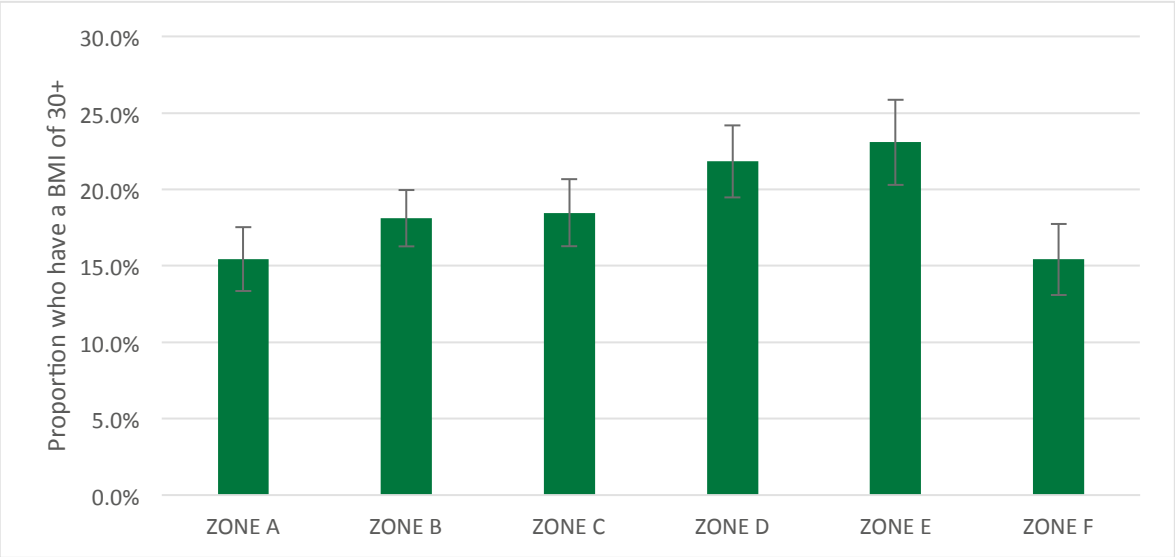
Source: Homerton University Hospital Foundation Trust

There is no statistical difference seen in the proportion of those with a BMI of greater than 40 by age, although this is likely due to the small numbers involved.

People who are of Black ethnicity are twice as likely to have a BMI of greater than 30 at their booking appointment as people of other ethnicities. Those who are Black Caribbean or Black African are most likely to have a BMI above 30 at booking. There is no statistical difference between the Other Black and Somali groups and the 'Other' groups, possibly because of the small numbers involved.

Areas A and F have the lowest proportion of those with a BMI of greater than 30, while areas D and E have the highest (see Figure 59).

Figure 59. Maternal BMI greater than 30 by Children's Centre area, 2013-15



Source: Homerton University Hospital Foundation Trust

[For full breakdown see Appendix 9.2.1.4]

6.1.4.3 Key findings

- Half of mothers giving birth at HUH were of a healthy weight at their booking visit – one quarter were overweight, and one fifth were obese or very obese;
- Age: the proportion of pregnant women being obese increases with age. Mothers over 40 years old were almost twice as likely to be obese as mothers aged under 25;
- Ethnicity: Black women were twice as likely to be obese as other ethnicities;
- Location: areas D and E had the highest proportion of obese pregnant women and areas A and F had the lowest;
- Women from the City of London had a higher proportion of healthy weight mothers and lower proportion of overweight and obese mothers than Hackney.

6.1.5 Maternal Smoking

6.1.5.1 Introduction

"Smoking is the single most important modifiable risk factor in pregnancy"

(Reducing infant mortality in London: An evidence based resource, PHE)[35]

Smoking during pregnancy can cause serious pregnancy-related health problems including an increased risk of prematurity, miscarriage, still birth, and low birth-weight. Smoking during pregnancy also increases the risk of infant mortality by an estimated 40%, with one in three sudden unexpected deaths in infancy (SUDI) being attributable to smoking. Children exposed to tobacco smoke in the womb are more likely to experience wheezy illnesses in childhood and it can be associated with childhood psychological problems such as attention and hyperactivity problems which may have a detrimental effect on the child's educational performance. In addition, infants of parents who smoke are more likely to suffer from serious respiratory infections (such as bronchitis and pneumonia), symptoms of asthma and problems of the ear, nose and throat (including glue ear).[52]

[52] NICE PH 26 Quitting smoking in pregnancy and following childbirth

"Every year in the UK over 20,000 cases of lower respiratory tract infection, at least 22,000 new cases of wheeze and asthma and 120,000 cases of middle ear disease are caused by passive smoking in children… [And] around 23,000 young people per year take up smoking before the age of 16 as a result of exposure to smoking by others in the household"

(Conception to age 2 – the age of opportunity)[10]

With regards to low birth weight (defined as weighing less than 2,500g at birth), smoking is a major contributor alongside alcohol use, substance misuse, maternal infections (such as HIV, malaria and syphilis) and maternal hypertension[53]. It is a major determinant of morbidity and mortality in its own right, alongside the detrimental effects of smoking listed above.

Smoking during pregnancy is strongly associated with a number of factors including age and social economic position. Mothers aged 20 or under are five times more likely than those aged 35 and over to have smoked throughout pregnancy. Mothers in routine and manual occupations are more than four times more likely than those in managerial and professional occupations to smoke. Pregnant women are also more likely to smoke if they are less educated, live in rented accommodation, are single or have a partner who smokes. Although many women quit smoking during their pregnancy, relapse rates are high and most start smoking again within six months of giving birth.[52]

Furthermore, parental (particularly maternal) and sibling smoking is a strong and significant determinant of the risk of smoking uptake by children and young people.[54]

[53] NHSE/PHE Guide to the early years profiles http://www.england.nhs.uk/wp-content/uploads/2014/03/hv-ey-hlth-prof.pdf

[54] Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis, Leonardi-Bee, J. et al, Feb 2011, http://thorax.bmj.com/content/66/10/847.full.pdf

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6 areas that can help reduce smoking in pregnancy:

- Identification and referral of pregnant women who smoke
- Sufficient expertise in local stop smoking services to meet the needs of pregnant women
- Smoking cessation training for all health professionals working with pregnant women
- Effective communication with women and their families
- Effective communication between health professionals
- Implementation of NICE guidelines

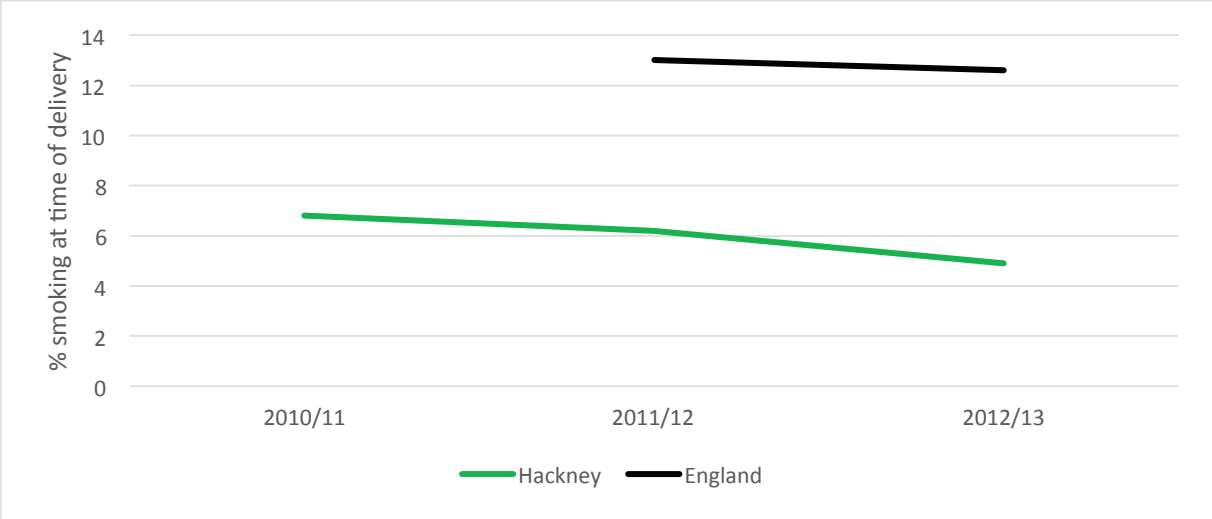
With regards to the implementation of NICE guidance, this focuses on Public Health guidance 26 which involves education, referrals to stop smoking services and the use of carbon monoxide (CO) breath tests to monitor progress.

6.1.5.2 Hackney

In Hackney, a Smoking in Pregnancy Task and Finish Group has been established to co-ordinate the efforts of the Homerton Maternity Service, the CCG Programme Board on Maternity, Health Visiting, the FNP and Hackney Council Public Health to implement NICE guidance 26 with a focus on establishing CO testing for all pregnant women. The first meeting of this Group will take place on 19th October 2015. To help achieve this aim of increased CO testing, the provision of CO monitors to the FNP has been budgeted for so they can test pregnant teenagers.

The new health visiting specification will include the requirement that all health visitors are trained up to Level 1 in smoking cessation education (also known as Very Brief Advice), and allow training up to Level 2 for those health visitors who are interested.

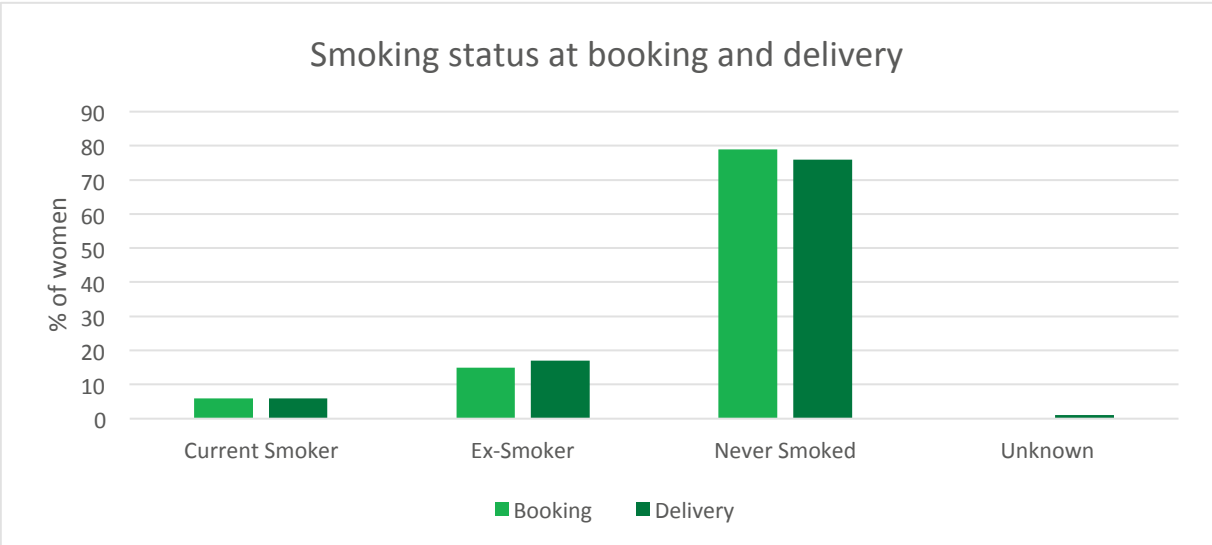
Figure 60. Smoking status at time of delivery, Hackney compared to England 2010-13



Source: Health & Social Care Information Centre

Data regarding maternal smoking was collected by HUH between 1/4/14 and 28/2/15 and is shown in Figure 61. During this time 4324 women gave birth. Information on smoking status was collected at the booking visit with the midwife and then again at delivery. At booking 79% of women identified themselves as never having smoked, 6% (264 women) as current smokers and 15% as ex-smokers; for less than 1% of women this information was not obtained. Of the 264 women who identified as smokers at booking, by delivery 225 still identified themselves as current smokers, representing smoking cessation in 15% of smokers. However, there were 18 women who identified themselves as ex-smokers at booking who by delivery identified themselves as current smokers and there were 16 women who identified themselves as never having smoked at booking who also identified themselves as current smokers at delivery. As a result, overall there were only five fewer women (0.1%) who identified as smokers at delivery than at booking.

Figure 61. Smoking status of pregnant women at booking and delivery, 2014-15

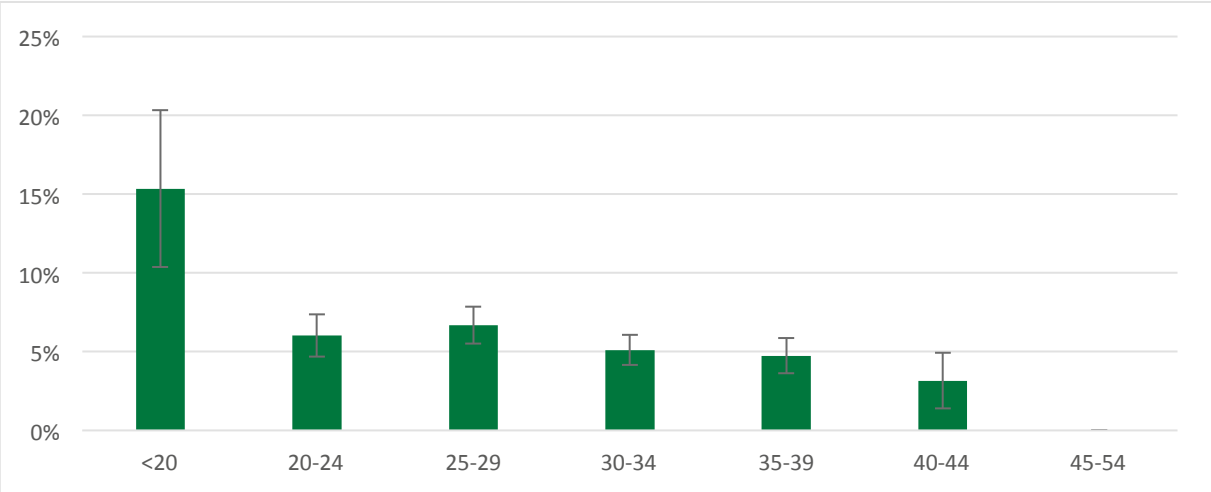


Source: Homerton University Hospital Foundation Trust

Those aged under 20 were significantly more likely to be smokers at the time of booking than any other age group, with 15.3% smokers compared to less than 7% in all other age groups. The number of smokers is small but the high proportion suggests that this group may benefit from a targeted service.

Those aged 25-29 were slightly more likely to smoke than older groups, with those over 40 years of age being least likely to smoke (see Figure 62). As would be expected from this, the proportion of ex-smokers increases with age, with the exception of the under 20s group.

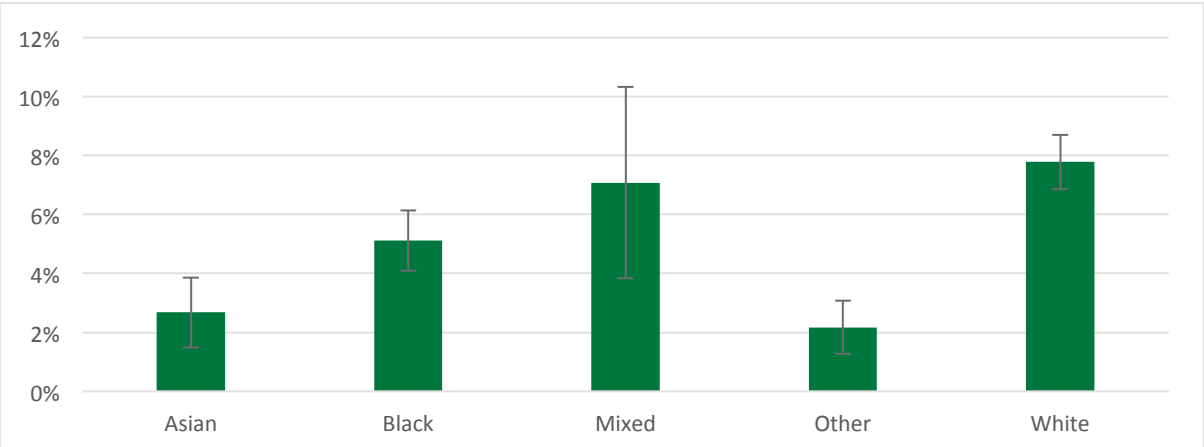
Figure 62. Smoking at birth by age, 2014-15



Source: Homerton University Hospital Foundation Trust

Those who are White were most likely to be smokers, while those who are Asian or fall into the 'Other' ethnic group were least likely to be smokers (see Figure 63). The small numbers involved in the subgroups of the White ethnic category mean that most groups are statistically similar – however, the Turkish smoking rate of 15.4% (59 of 382 women) is statistically significantly higher.

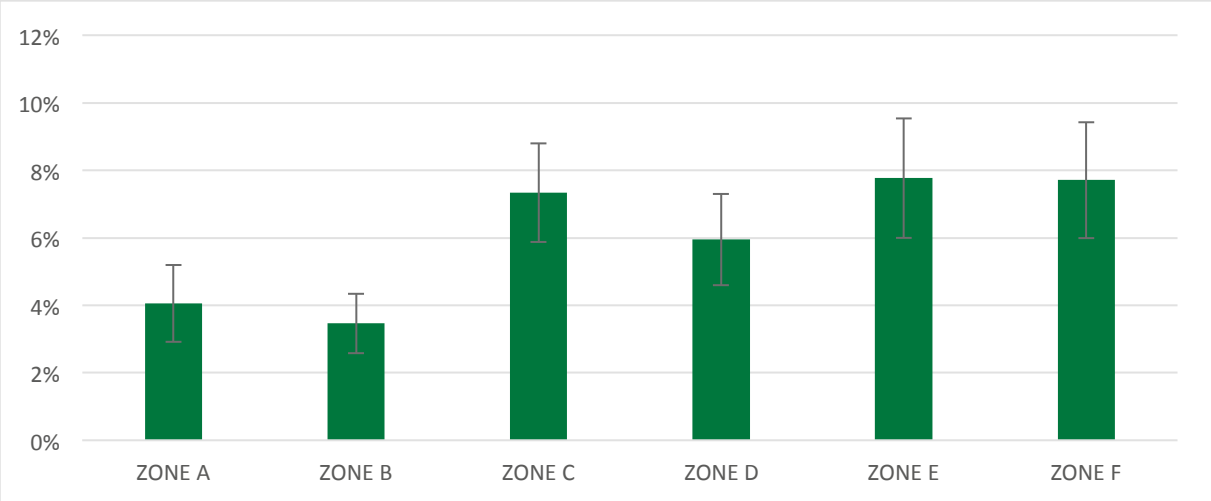
Figure 63. Smoking at birth by ethnicity, 2014-15



Source: Homerton University Hospital Foundation Trust

Lower smoking rates are found in Children's Centre areas A and B; the other four areas have statistically similar rates (Figure 64).

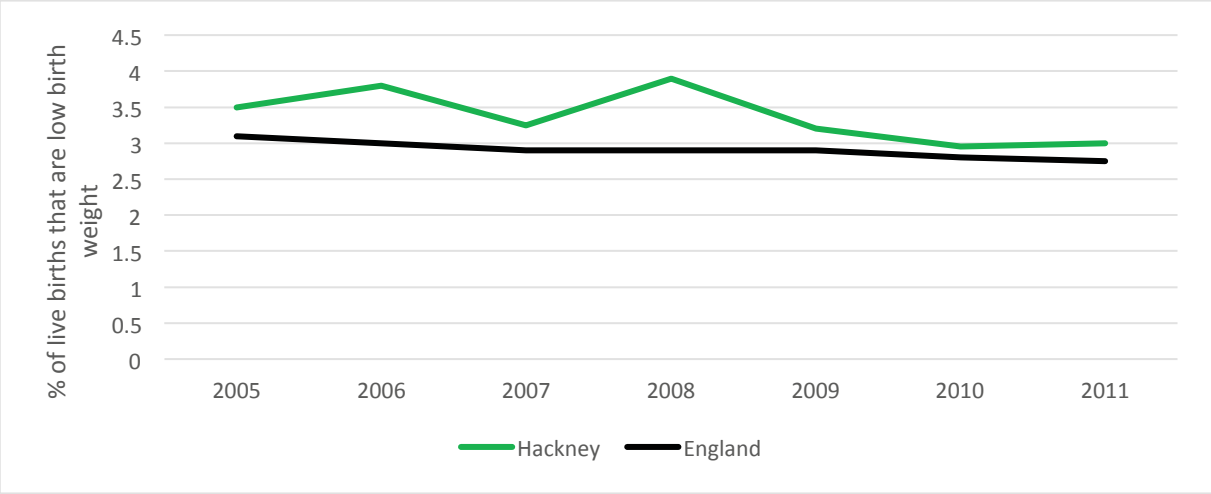
Figure 64. Smoking at birth by Children's Centre area, 2014-15



Source: Homerton University Hospital Foundation Trust

The proportion of babies being of low weight has fluctuated in Hackney, but appears to show a decrease over the most recent data sets in 2009-2011. However, the rate remains slightly higher than the England average (see Figure 65).

Figure 65. Low birth weight of term babies 2005-2011, Hackney and England



Source: ONS

Residents of both Hackney and the City of London who gave birth at HUH in 2013/14-2014/15 showed a statistically higher rate of low birth weights in babies born to mothers who are current smokers or who have substance misuse problems. Current smokers are about twice as likely to have a low birth weight baby as never or ex-smokers, and therefore the low birth weight of 34 babies in that year may be attributable to maternal smoking. However, there was not much difference (either looking at proportion of low birth weights or the distribution of all birth weights) between ex-smokers and never smokers.

6.1.5.3 City of London

For women from the City of London who delivered at UCLH, fewer than five women across both years were recorded as smokers on booking and four women were identified as ex-smokers at booking. No women were recorded as smoking at delivery across either year.

The birth weight of 79 of the 82 births to City residents in 2013 is known. Of these, approximately 9% were low birth weight. This is slightly higher than the national (England and Wales) proportion of 7% in 2013. However, when looking at low birth weight data aggregated from 2008 to 2012 inclusive, only 4% of births over the four year period were of babies with low birth weight. Due to the small numbers of births each year in the City of London this aggregate figure is more likely to be an accurate representation of the scale of the problem.

[For full breakdown, see Appendix 9.2.1.5]

6.1.5.4 Key findings

- Over 10 months at HUH, 254 pregnant women (6%) identified as smokers at their booking visit. While 39 of these stopped smoking by delivery, 18 previous ex-smokers and 16 never smokers started smoking and therefore only five fewer women were smoking at delivery than at booking;
- Current smokers were twice as likely to have a low birth weight baby compared to never or ex-smokers in Hackney and the City of London. In total, 34 babies were born of low birth weight over two years (2013-15) that could be attributable to smoking;
- Age: the rate of smoking declined with maternal age;
- Ethnicity: White mothers were most likely to smoke and, within this group, Turkish women had the highest proportion of smokers (15.4%);
- Location: lower rates of smoking were in Children's Centre areas A and B;
- Overall the proportion of low birth weight babies is fluctuating but appears to be falling in Hackney, although it remains just above the national average;
- No City of London women who delivered at UCLH were smokers on delivery.

6.2 POSTNATAL / CHILD

6.2.1 Health Visiting

To prepare for the transition of the responsibility for commissioning early years public health services to the local authority from NHS England, stakeholder consultation was conducted through a workshop, interviews with key partners and focus groups to gain a better understanding of what barriers exist in the current service and source ideas for improvements that could be implemented in the new service.

6.2.1.1 Stakeholder consultation workshop

The workshop included partners from Children's Centres, Children's Social Care and the CCG and exercises were completed on the following topics:

- Are we leaving too many parents to go it alone in the crucial time around the birth and first five years of a child's life? What should our priorities be? What support do families need more of? What needs are not being addressed?
- What might the service look like on the ground in an ideal world if you were to design the new service from scratch?
- What are the things that are currently holding you back, elements you don't like, or issues that you face? What are the things that you do like, and the reasons you use that particular solution, or service?

These activities highlighted eight key themes which are listed below. Ideas are aspirational and were not framed in the context of funding priorities.

1. Antenatal care
    a. Strengthen the antenatal period using partnership delivery with midwives and health visitors to provide more focus on the transition to parenthood, emotional attachment, bonding and child development
    b. Extend GP, midwife and health visitor link meetings to integrate antenatal care
2. New birth visit and follow up home visits
    a. Spacing the timing of the visit to reduce the overlap with midwives
    b. Focus on the emotional wellbeing of the mother and child by increasing the level of support in the first year of a child's life
    c. Provide community peer support through parenting champions home visits
    d. Offer the option of a follow up home visit after the new birth visit
3. Relationships with parents / carers
    a. Provide a named health visitor for each family to provide continuity of care
    b. Allow health visitors the time to develop a relationship, build trust and have meaningful conversations
    c. Services should also engage fathers, grandparents and carers

4. Postnatal support
    a. Provide a named health visitor for each Children's Centre and GP surgery to strengthen partnership working
    b. Provide postnatal education early to include mental health, normal development (including emotional development) and allocation of all new parents to a weaning group session as standard
    c. More contact from Children's Centre and Early Years services
    d. Building resilience in families through integrating families into local social groups/networks
    e. Provide better support for mild-moderate maternal mental health issues
5. Service delivery
    a. Empower parents to use services and seek support
    b. Make services more accessible through earlier starts, later finishes, weekend availability, different settings/access points and provide a telephone helpline
    c. Avoid a 'one size fits all approach' and be responsive to local need with services targeted to outcomes rather than outputs
    d. Provide a health assessment as part of the entry to nursery school
6. Safeguarding
    a. Complex families with safeguarding concerns at tier 2 would benefit from joint case management by health visitors and Early Years services
    b. Perform CAFs earlier to reduce the late escalation of vulnerable families
    c. Increase GPs' understanding of their roles within the Multi-Agency Team to increase referrals and provide more feedback to GPs
7. Sharing information / partnership working
    a. Improve IT links between agencies to facilitate information sharing
    b. Create a central hub for professionals to share information, stay up to date with services and provide knowledge of pathways for signposting
    c. Clarify when and how data sharing is appropriate
    d. Provide seamless care to support the journey of the child and family
8. Workforce
    a. Provide clarity of health visitors leading the delivery of the HCP in the face of competing demands from commissioners
    b. Reduce the time spent performing administration/paperwork where appropriate to allow greater time with families
    c. Provide more education to all healthcare professionals to maximise the opportunity to provide public health messages at every contact

6.2.1.2 Parent focus groups

Focus groups were conducted with local parents from both Hackney and the City of London to understand how health visiting can improve the service it provides to local families. Targeted groups were also arranged with teenage parents, Orthodox Jewish parents and fathers to identify specific needs. The eleven key themes that were raised by these groups are listed below, with illustrative quotes provided in appendix 9.2.2.1.

Consistency of care	Parents reported a lack of continuity of care with inconsistent, and sometimes contradictory, advice being provided by different health visitors
Understanding the health visiting service	Mothers lacked knowledge of what the health visiting service is able to offer them and their family and what to expect from the service
Communication style	Mothers described health visiting staff as communicating with them in a way that was not always sensitive to the needs of parents particularly at the new birth visit
Involvement of fathers	Mothers were surprised that when their partners were present the health visiting staff did not offer an inclusive approach. Mothers felt more effort could be placed on involving fathers and tailoring information to suit fathers
Respect and compassion	The need to respect the knowledge of parents was recognised as very important to the mother's exchanges with health visitors. Mothers wanted to feel they were being listened to and treated as individuals with unique experiences and knowledge
A good attitude	The attitude of health visiting staff was described as dependent on the staff member. Mothers wanted health visitors to show an interest in them and not to feel like they are just another duty for the health visitor to complete
Support offered in the home at the right time	Mothers described many benefits of health visitors coming into their home and offering support and reassurance especially for first time mothers. Some felt a home visit would be more beneficial at a later time after birth (e.g. at 15-21 days rather than 10-14 days). Some also wanted the option of more home visits during the first few months when travelling to the child health clinic was most challenging for them
The waiting room experience	At the child health clinics in GP practices the waiting room was often not a positive experience for parents. This was due to the long waiting times, lack of seating, a conveyor belt approach to services provided by staff and frustration at not being able to plan GP and Health visitor appointments together
Opportunity for privacy	Mothers wanted the opportunity to speak with a professional in an environment that offered privacy. They felt that there was no appropriate place at child health clinics to disclose personal or sensitive information
Children's Centre environment	The delivery of services within children's centres was described as appealing due to the informal nature of the environment, the comfortable seating, availability of other relevant services and opportunity to avoid being in a GP waiting room
Maternal weight management support	Young mothers raised weight management as a particular issue for them. They felt health visitors were well placed to offer weight measurement, management advice and support

6.2.1.3 Health Visiting Practitioner focus groups

Two focus groups were facilitated by Public Health and in each group there was one representative from each of the six teams.

Questions were asked around the following topics:

- How can we build capacity in the workforce?
- What would help to improve job satisfaction?
- What will support health visitors to become leaders of the HCP?
- What might the ideal child health clinic look like?

Eleven key themes were identified (listed below) and illustrative quotes are included in appendix 9.2.2.1.

Understanding why staff leave and why students do not stay	Staff were concerned about the lack of retention of students and felt frustrated at the loss of time and effort put in to training them. Staff want to know why students and experienced staff leave to try to prevent it from continuing
Adding structure to the preceptorship programme	Staff felt ensuring students and newly qualified staff are well supported by a structured training programme and high quality supervision was important for staff to gain confidence and to improve the retention of students
Clearer career pathways	A comprehensive offer of training along with clear opportunities for progression was viewed as important for attracting students
Vacancies filled more promptly	When vacancies are not filled in a timely manner the lack of staff and right skill mix can have a dramatic effect on the team's ability to deliver a good service for families. Staff felt that ensuring staff are recruited in a timely manner along with use of agency staff as backfill would help to relieve this pressure
Better or more administrative support	
Stronger leadership and support	While good supervision was described for safeguarding, some health visitors felt other areas were not as well supported
The right skill mix	
More opportunities to build relationships with clients	
Reducing the high caseload	While health visitors felt they managed to deliver the mandated components of the HCP to families, they recognised that the high caseload meant it was difficult to deliver the wider components of the HCP. Health visitors felt that there should be two health visitors allocated to GP practices with a large patient load
Making use of child health clinics	
Building better partnerships	

6.2.1.4 Comparative Consultation

Four key points from the consultation with health visiting service providers in London:

HUH have introduced the integrated two year review across the whole service with very positive results and improved uptake with positive feedback from parents and professionals. They also designate a link professional for every GP practice and early years setting. They work closely with UCL Partners to deliver various service improvement projects including 'Start at the Beginning' which aims to improve nutrition during pregnancy.

The Whittington have provided all health visitors with an iPad for mobile working which has positively impacted on service efficiency. They have also been able to support a number of nursery nurses within their service to go on to health visitor training. The Whittington are in the process of setting up a simulation room where staff can be observed with actors role-playing as clients via two way mirrors.

Lewisham and Greenwich Trust have worked with an academic from Australia to train staff in the Maternal Early Sustained Childhood Home (MESCH) visiting programme which is an intensive home visiting intervention for vulnerable families. They also offer a 3.5 year review for children who are currently receiving targeted support. All practitioners within the service are observed once or twice per year by an experienced practitioner and provided with constructive feedback.

NELFT (North East London Foundation Trust) have set up a training hub where they train and update health visiting staff (including students) for neighbouring boroughs. They work with other services to provide a variety of career pathways and professional development including allowing practitioners to complete placements with the local mental health and midwifery services.

6.2.1.5 Key findings

- The main concerns raised by health visitors were that there is a lack of retention of health visitor students, that staff vacancies need to be filled more promptly, and that health visitors need more opportunities to build relationships with clients;
- The mains issues raised by the stakeholder workshop (including Children's Centres, Children's Social Care and the Clinical Commissioning Group) were the need for more integrated care between different health professionals, a current lack of continuity of care, a need to make services more easily accessible to local families and a need for more safeguarding referrals to the multi-agency team by primary care;
- Focus groups with local parents revealed that their most common concerns were around consistency of care (through seeing different health visitors, each with a different focus and some providing conflicting advice), a lack of understanding of what the service involves and the service not engaging with fathers enough.

6.2.2 Infant and Child Mortality Rates

6.2.2.1 Introduction [35, 55]

> "One quarter of all deaths under the age of one would potentially be avoided if all births had the same level of risk as those to women with the lowest level of deprivation"
>
> (Fair Society, Healthy Lives)[2]

The infant mortality rate (IMR) is defined as the number of deaths under the age of one year per 1,000 live births. Within this measure lie two sub categories: the neonatal mortality rate (within the first 28 days of life) and the post-neonatal mortality rate (from 28 days to one year of life). To reduce the high degree of year on year variability due to small numbers, the IMR is measured using data aggregated over three years. The IMR provides an indication of the wellbeing of both pregnant women and infants.[35]

Infant mortality is a significant factor in overall life expectancy, with one in 250 infants dying in their first year. 61% of all child deaths (0-17 years) are in infancy. Many of these deaths are preventable and despite infant mortality reducing considerably in the past 30 years, the UK's perinatal and infant mortality rates remain high compared to other European states.[55]

Infant mortality shows a socioeconomic gradient and the IMR can be used as a marker of progress towards addressing inequalities. Risk factors for infant mortality include maternal factors such as age, ethnicity, and occupation (routine and manual labour categories) as well as infant factors such as low birth weight. The IMR for babies born to teenage mothers is 44% higher than mothers aged 20-39. The IMR for babies of mothers born in the Caribbean is almost twice as high as for mothers born in the UK. Babies born to mothers in routine and manual occupations have a four-fold higher IMR than those born to mothers in managerial and professional groups.[35] Low birth weight babies are 27 times more likely to die before the age of one year than babies of normal birth weight.

Most (71%) infant deaths occur in the neonatal period. Neonatal mortality rates are strongly influenced by whether delivery is at term or pre-term, with low birth weight babies accounting for two thirds of neonatal deaths. In comparison, post-neonatal mortality is thought to be influenced to a greater extent by parental circumstances, including their socioeconomic position and the care they provide for their infant and congenital abnormalities (which explain almost two fifths of post-neonatal infant deaths).[55]

The child mortality rate (CMR) includes all children aged 1-17 and is also measured using data aggregated over three years to reduce year on year variability.

[55] Facts and figures on infant mortality and stillbirths, National Child and Maternal Health Intelligence Network, 2014, PHE

6.2.2.2 Hackney and City of London

Local infant mortality rates vary nationally from 1.7 (Bromley) to 7.5 (Birmingham) per 1,000 (three-year average, 2011 to 2013), with an England average of 4.1 per 1,000. The rate in Hackney stands at 5.7 per 1,000 which is higher than the national average, and higher than Hackney's statistical neighbours (from 3.4 (Haringey) to 4.9 (Lewisham) per 1,000). In the past five years there have been no infant deaths in the City of London.

The child mortality rate in Hackney has fallen from 27 per 100,000 in 2008-2010 to 12.8 per 100,000 in 2011-13 (three year averages). It lies within the range of its statistical neighbours (from 10.0 (Lewisham) to 17.3 (Brent) per 100,000). However, it remains above the England average of 11.9 per 100,000.

Child Death Overview Panel[56]

The Child Death Overview Panel (CDOP) is an independent multidisciplinary panel that provides a review of all deaths of children who are under 18 and resident in the London Borough of Hackney or the City of London[57]. There were 35 deaths in Hackney from 1st April 2014 to 31st March 2015. Just over a third (38%) of the 34 cases reviewed by the CDOP in 2014/15 were defined as unexpected deaths – this is a decrease from 50% in the previous year, but caution must be exercised in interpreting this data as the numbers involved are small. Of these, 46% were due to morbid conditions, 31% were due to external causes and 23% were unexpected infant deaths.

Approximately half (47%) of the cases reviewed by the CDOP were neonatal deaths (an increase from 27% in the previous year) and over two-thirds (68%) were infant deaths. Over half (61%) of the infant deaths were male. Of the infant deaths reviewed by the CDOP, almost half (48%) were classified as a 'perinatal/neonatal' event, irrespective of whether the death occurred in the neonatal period. These deaths were directly related to sequelae of prematurity, antepartum or intrapartum anoxia, bilirubin encephalopathy, bronchopulmonary dysplasia and post-haemorrhagic hydrocephalus. The CDOP found that nearly a third (30%) of infant deaths were due to congenital abnormalities (be that chromosomal, epigenetic or intra-uterine environmental). 13% were due to acute medical conditions (including infections) or surgical disorders.

Sudden Unexpected Death in Infancy (SUDI)

SUDI describes the death of an infant which was unexpected and initially unexplained. Unexpected deaths are defined as those not anticipated as a significant possibility 24 hours beforehand; or where there was a similarly unexpected collapse or incident precipitating the events which led to the death.

[56] Child Death Overview Panel Annual Report, 2014/15, London Borough of Hackney, City of London Corporation

[57] City and Hackney Safeguarding Children Board website http://www.chscb.org.uk/content/72/

Risk factors for SUDI include maternal factors, social factors and infant factors. Maternal factors include age – babies born to mothers less than 20 years old have a 2.5 times higher risk of SUDI. Social factors include deprivation (3.5 times higher risk), bed sharing (a 2.7 times increased risk) and smoking (a five-fold increased risk). Infant factors are predominantly being of low birth weight, which confers a five-fold increased risk.[35]

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interventions for reducing SUDI:

- Ensuring that infants sleep in the supine position - 'back to sleep'
- Keeping the baby's head uncovered by placing the baby in the 'feet to foot' position
- Ensuring that infants sleep in a separate cot
- Ensuring that infants sleep in the same room as their parents
- Reducing parental smoking
- Encouraging and supporting mothers to breastfeed their babies

6.2.2.3 Key findings

- The child mortality rate is 12.8 per 100,000 (2011-13) which is above the national average of 11.9 per 100,000 but a fall from 27 per 100,000 three years previously;
- Approximately half (47%) of all child deaths reviewed by the Child Death Overview Panel (CDOP) were in neonates and over two-thirds (68%) were in infants;
- Almost half of child deaths were due to morbid conditions, a third were due to external causes and a quarter were unexpected;
- The infant mortality rate in Hackney (2011-2013) was higher than the national rate and the highest of Hackney's statistical neighbours (defined in Section 5);
- Over half (61%) of infant deaths were in boys;
- There have been no deaths of children or young people resident in the City of London during 2014/15.

6.2.3 Breastfeeding

6.2.3.1 Introduction

Current UK policy is to promote exclusive breastfeeding (feeding only breast milk) for the first six months. Thereafter, UK policy recommends continuing breastfeeding for as long as the mother and baby wish, while gradually introducing a more varied diet.

Breastfeeding is the optimal nutrition for young infants and also provides benefits in both the short and long term. Breastfeeding for three months in the first year of a baby's life reduces the risk of childhood asthma by 27%, type 1 diabetes by 23% and childhood obesity by 7%. Breastfeeding for six months reduces the risk of lower respiratory tract infections by 72% and gastroenteritis by 64%. With four-six months of exclusive breastfeeding, the risk of SUDI is reduced by 36%. There are also health benefits for the mother, with a faster return to pre-pregnancy weight and a possible reduction in the risk of breast and ovarian cancer.

The UNICEF Baby Friendly Initiative (BFI) was launched in the UK in 1994 in a national attempt to encourage and support women to breastfeed. This initiative provides support for health-care facilities that are seeking to implement best practice and assesses and accredits those that have achieved the required standard.[58] In order to monitor the rate of breastfeeding in the UK an infant feeding survey is carried out every five years. The last survey, in 2010, showed an increase in the prevalence of exclusive breastfeeding at birth (from 65% in 2005 to 69% in 2010), but little change after in the six week period. However, for those women who did continue to breastfeed, there was some improvement in the duration with 17% of women continuing to exclusively breastfeed for three months (up from 13%) and 12% of women exclusively breastfeeding for four months (up from 7%).

The Infant Feeding Survey shows that, nationally, mothers who are over 30 years of age, those who remained in education until at least 18 years of age, those in managerial and professional occupations and those living in the least deprived areas were more likely to breastfeed. Therefore, breastfeeding can be used as a measure of social inequality, as women who are most disadvantaged are least likely to breastfeed.[59]

The Infant Feeding Survey also showed that mothers from Asian, Black and Chinese or Other ethnic groups were the most likely to breastfeed initially, and also that the drop-out rates were relatively low among Black and Chinese or Other ethnic groups.

[58] Infant feeding survey 2010
[59] NICE PH11 Maternal and child nutrition

Public Health England

Barriers to breast feeding:

Barriers to breastfeeding:

- Mother's ill-health
- Influence of sociocultural factors
- Inadequate information and support
- Lack of conducive surroundings outside the home

Actions to increase breastfeeding:

- Expanding the baby friendly hospital initiative in health systems
- Provision of education and support antenatally and postnatally
- Limiting the marketing of breast milk substitutes

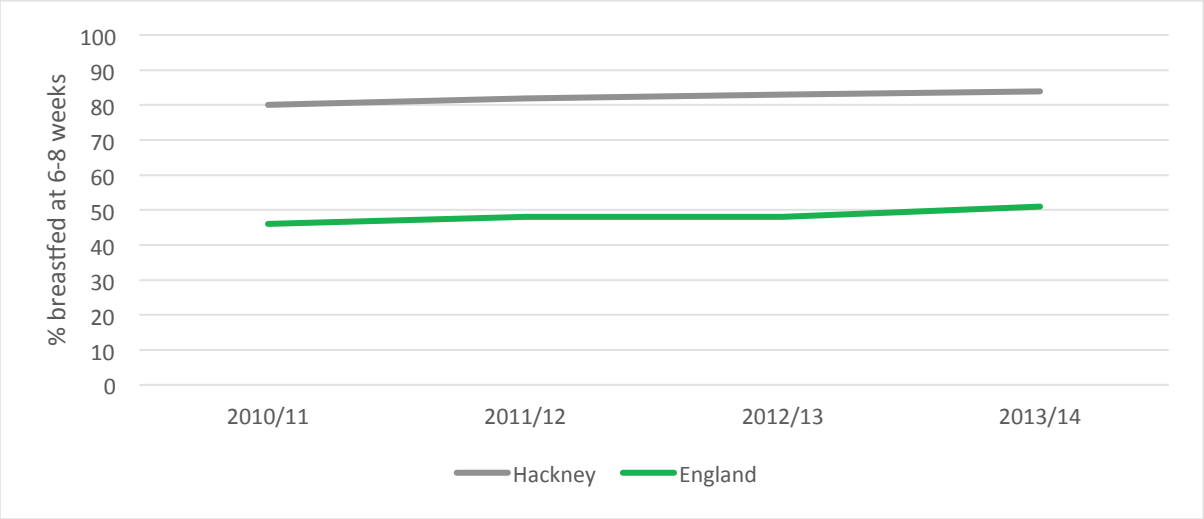
6.2.3.2 Hackney and City of London

The "Breastfeeding Welcome" scheme launched in Hackney earlier this year and aims to encourage and support the welcoming of breastfeeding mothers in the borough's public, private and voluntary sectors. The scheme aims to raise awareness of the benefits of long term breastfeeding and support women to feel able to breastfeed outside of the home.

In 2013/14, 99.3% of births to Hackney and City of London mothers had feeding status recorded at birth (higher than the 97% achieved across London and 98% nationally) and 92% of these Hackney and City babies were breastfed at birth (higher than the 88% achieved across London and the 76% nationally). At 6-8 weeks, 98% of breastfeeding statuses were recorded. 52% were breastfeeding exclusively, 32% partially and 16% were not breastfeeding at all. Therefore, in total 84% of women were breastfeeding to some extent in Hackney and the City of London at 6-8 weeks – higher than the London (73%) and national (51%) averages (see Figure 66). [60]

[60] NHS England Maternity and Breastfeeding Statistical Release, 2013/14 https://www.england.nhs.uk/statistics/statistical-work-areas/maternity-and-breastfeeding/

Figure 66. Breastfeeding prevalence at 6-8 weeks after birth

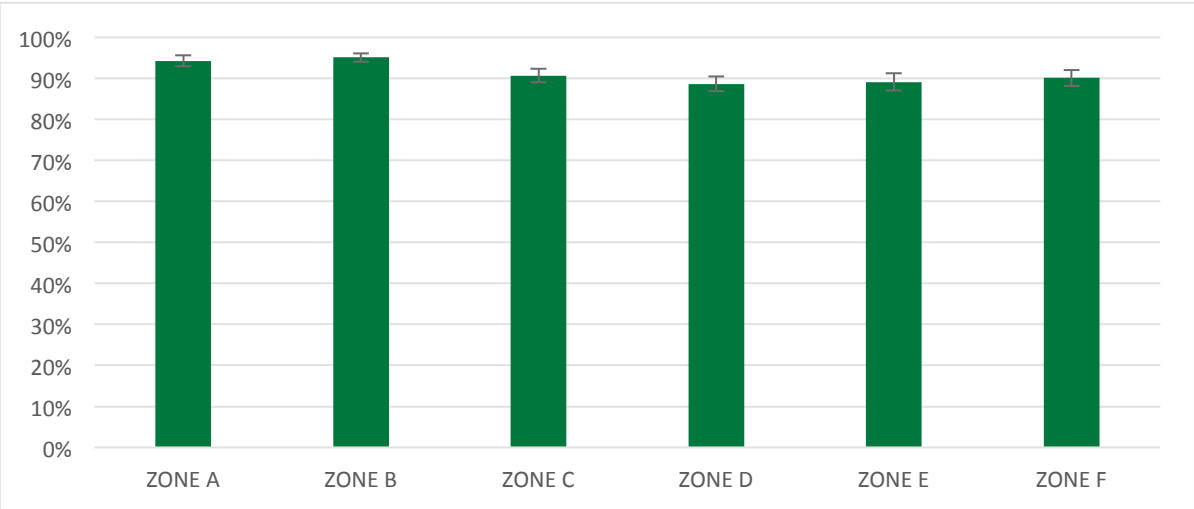


Source: NHS England Maternity and Breastfeeding Statistical Release

Women under 20 years of age were less likely to breastfeed at birth than other age groups, but there were no other statistically significant differences.

Those in Children's Centre areas A and B were more likely to breastfeed at birth than those in Children's Centre areas C-F (Figure 67).

Figure 67. Breastfeeding status at birth by Children's Centre area, 2013-15



Source: Homerton University Hospital Foundation Trust

Data from HUH for 2013-15 reveals that, at 6-8 weeks, the proportion of women who are breastfeeding at all (either partially or exclusively) is highest in those of 'Other' ethnicity at 90%, followed by those of Black ethnicity at 84%. Breastfeeding at all is lowest in women of Asian (79%) and Mixed (73%) ethnicities. However, the majority of Black women who breastfeed do so partially – giving them the highest rates of partial breastfeeding but the lowest rate of exclusive breastfeeding (37%). Conversely, while fewer women of Mixed ethnicity breastfeed at all, the majority of them do so exclusively. Not only is the proportion of Asian women who breastfeed at all relatively low, but the majority of those who

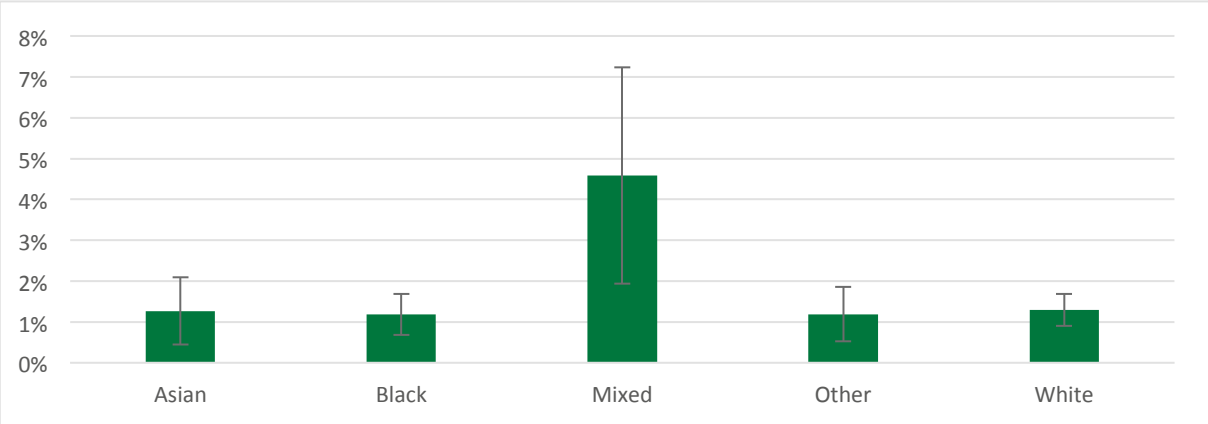
breastfeed do so partially, so that (like women of Black ethnicity) only 37% are breastfeeding exclusively at 6-8 weeks. Therefore, these results partially contradict the national results of the Infant Feeding Survey (the results of local Asian women). However, it must be noted that ethnicity was not stated for 20% of women.

Feeding problems after birth

97 people in Hackney and the City of London are recorded as having presented to HUH with feeding problems in 2013/14-2014/15. This is equivalent to 1.4% of Hackney and City of London births at HUH in that time period (although not all of those presentations had been born at HUH in that time period).

A higher proportion of those who are recorded as being of mixed ethnicity presented with feeding problems than those of any other ethnicity; this is the only ethnicity to be statistically different from the others (see Figure 68). This may point to higher need in this group, or it may point to poor recording of mixed ethnicity in the birth data.

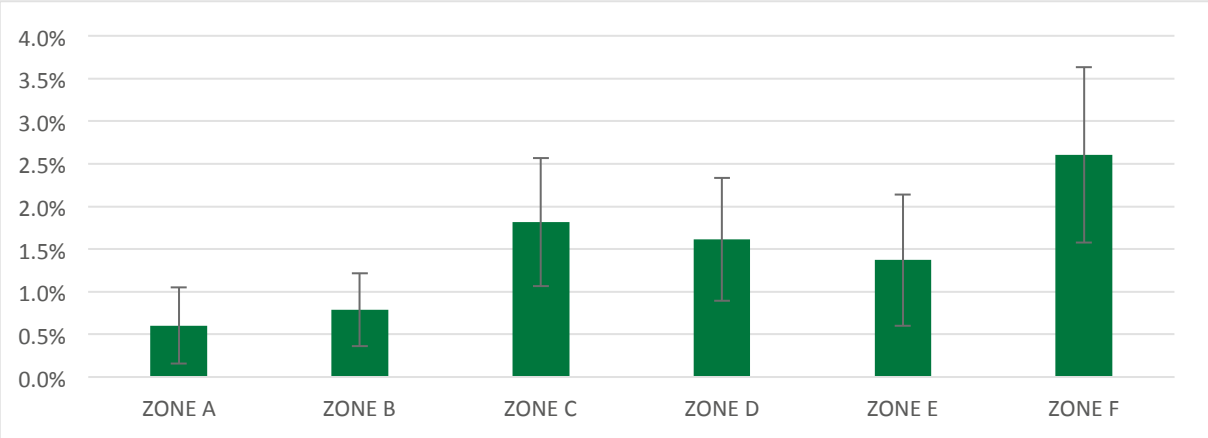
Figure 68. Feeding problems by ethnicity, 2013-15



Source: Homerton University Hospital Foundation Trust

Children's Centre areas A and B had lower rates of feeding problems than Children's Centre area F (Figure 69).

Figure 69. Feeding problems by Children's Centre area, 2013-15



Source: Homerton University Hospital Foundation Trust

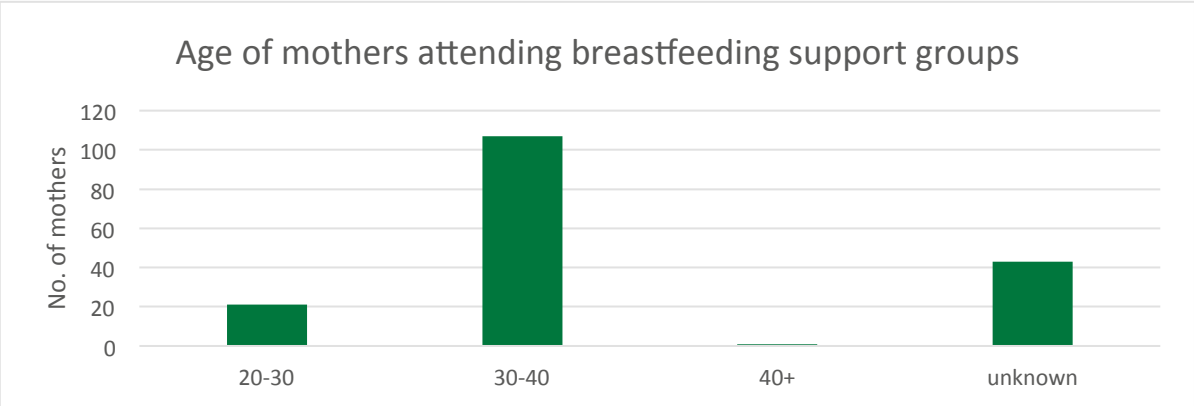
One potential cause of feeding problems is tongue tie, where the frenulum extends along the underside of the tongue. Tongue tie may cause difficulties in breastfeeding and occasionally may cause difficulties in bottle feeding. A tongue tie service is available in City and Hackney in which babies can be referred to the infant feeding specialist midwife at HUH who can confirm whether tongue tie is present, and identify whether to perform a simple outpatient procedure to divide the tongue tie.

Breastfeeding support

There are nine breastfeeding groups in Hackney providing specialist advice and support on breastfeeding. These groups are run by the Public Health Midwives and Breastfeeding Network Supports, and most are in Children's Centres. Parents are provided with information on these services by midwives and health visitors visiting families soon after discharge.

Figure 70 shows the age of mothers attending breast feeding support groups in Q2 2014/15. There were more than five times as many 30-40 year olds attending as 20-30 year olds, although it is worth noting that for 43 of the women we do not know their age.

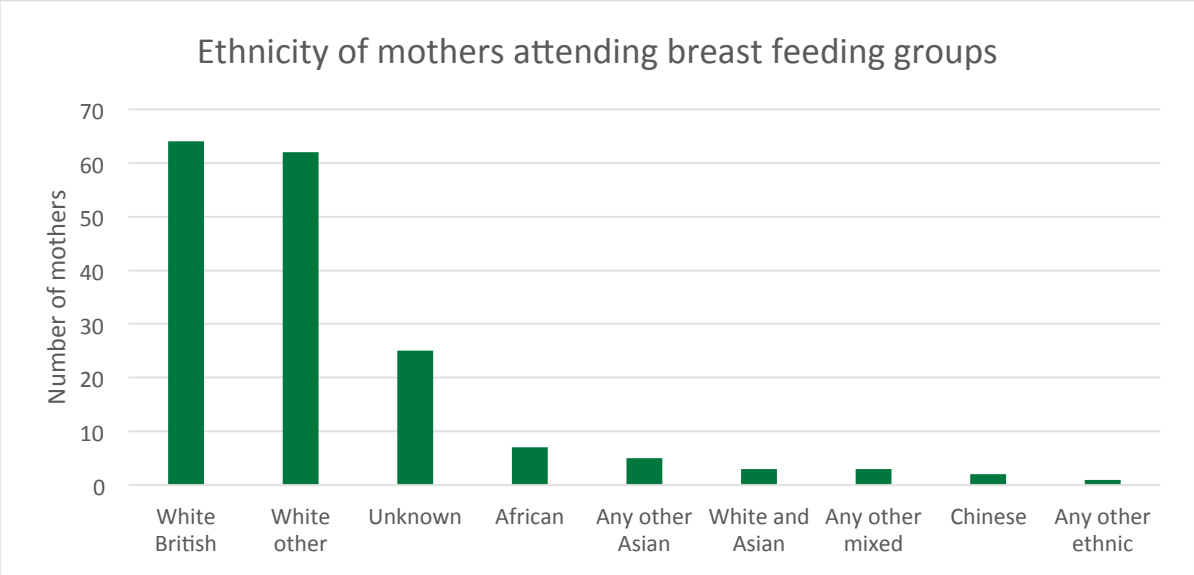
Figure 70. Age of mothers attending breast feeding groups, Q2 2014/15



Source: Homerton University Hospital, evaluation of breastfeeding services report

Figure 71 shows the number of women accessing breast feeding support groups by ethnicity (Q2 2014/15) – with the predominant ethnic group being White/White Other. White/White Other women are overrepresented in these groups as they constitute 73% of attendees (who completed the questionnaire), but only 52% of Hackney's population. This could represent poor uptake of services by other ethnic groups, other ethnic groups finding sources of breastfeeding support elsewhere or a lower response rate to the questionnaire.

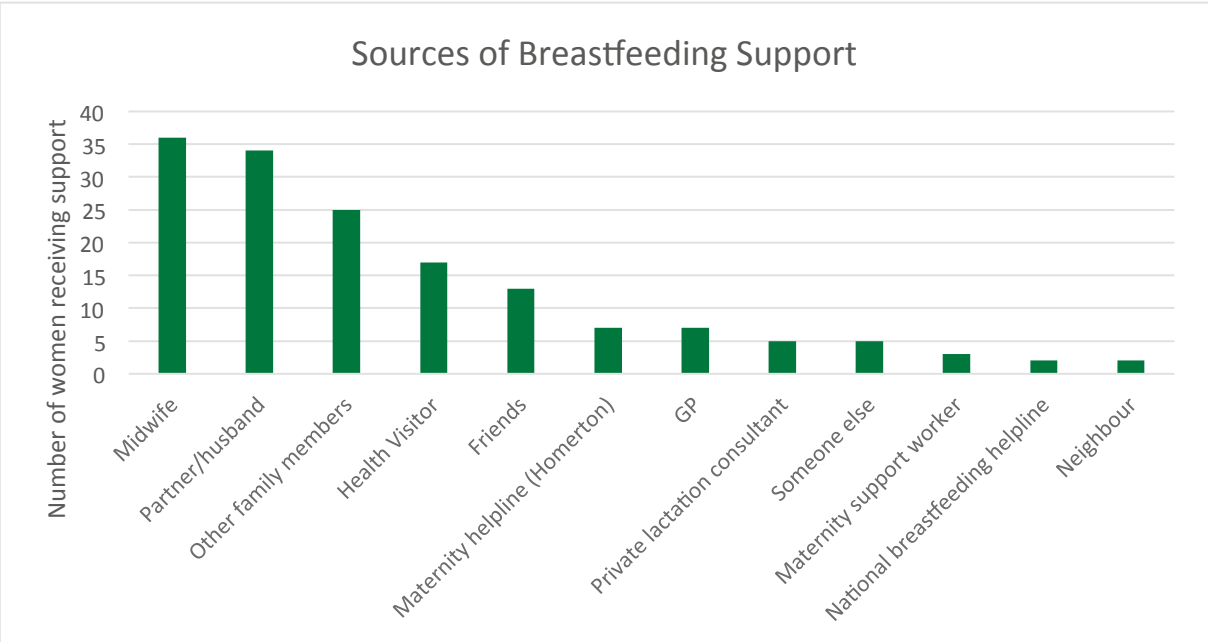
Figure 71. Ethnicity of mothers attending breast feeding groups, Q2 2014/15



Source: Homerton University Hospital, evaluation of breastfeeding services report

Figure 72 illustrates the sources of breastfeeding support. Midwives were the most common source of support (for 23% of women). Only 11% of women reported receiving assistance with breastfeeding from their health visitor.

Figure 72. Sources of breast feeding support received by mothers attending breast feeding groups, Q2 2014/15



Source: Homerton University Hospital, evaluation of breastfeeding services report

[For full breakdown see Appendix 9.2.2.2]

6.2.3.3 Key findings

- The incidence of breastfeeding at birth is 92% in Hackney and the City of London – higher than the London average of 88% or the national average of 76% (2013/14);
- At 6-8 weeks, 84% of Hackney and City of London mothers are breastfeeding to some extent (two-thirds of these exclusively) which is higher than the London (73%) and national (51%) averages;
- 1.4% of babies were seen in HUH (2013-15) for feeding problems;
- Age: women aged under 20 were less likely to breastfeed at birth. Half as many 20-30 year olds as 30-40 year olds attended breastfeeding support groups;
- Ethnicity: mothers of Asian and Mixed ethnicities were least likely to be breastfeeding at all, and mothers of Asian and Black ethnicities were least likely to be exclusively breastfeeding at 6-8 weeks. This contradicts national findings with regards to Asian mothers. White mothers are overrepresented at support groups;
- Location: areas A and B (the latter containing the Charedi community) had higher rates of breastfeeding at birth than areas C to F, and by 6-8 weeks areas A and B had lower rates of feeding problems than area F.

6.2.4 Immunisation

6.2.4.1 Introduction

The primary aim of vaccination is to protect the individual who receives the vaccine. However, vaccinated individuals are less likely to be a source of infection to others, and therefore they also reduce the risk of infection in the unvaccinated population. People who have not been immunised (by choice or for medical reasons) and those in whom immunisation did not produce a protective immune response benefit from this reduced transmission. Once the extent of effective vaccination coverage is great enough to prevent an epidemic of the disease, 'herd immunity' is said to have been reached.[61] The extent of effective coverage required to achieve herd immunity varies by disease – it is quoted as over 95% for measles, for example. With global movement, it is often important to maintain vaccine coverage even once herd immunity has been obtained, due to the risk of infected individuals entering the population and re-introducing the infection. [62] The full immunisation schedule is included in Appendix 9.2.2.3.

Children who have missed vaccinations are not only at risk of those particular infections, but are at greater risk of having other health and social wellbeing needs and may be behind on other Healthy Child Programme activities. Efforts should be made to ensure all children are immunised, even if they are older than the recommended age range, where medically appropriate. The parents of these children may need additional support, information and explanation to ensure that their children complete the vaccination programme.

[61] The green book-immunisation against infectious disease, PHE and DoH 2013
[62] NICE guidance PH21 Reducing differences in the uptake of immunisations

Groups of children at risk of not being fully immunised:

- Those who have missed previous vaccinations
- Looked after children
- Those with physical or learning disabilities
- Children of teenage or lone parents
- Those not yet registered with a GP
- Younger children from large families
- Children who are hospitalised or who have a chronic illness
- Those from some minority ethnic groups
- Those from non-English speaking families
- Vulnerable children, such as those whose families are travellers, asylum seekers or homeless

6.2.4.2 Hackney and the City of London

Under current commissioning arrangements, local GPs are commissioned by NHS England to deliver all immunisations. On transfer of commissioning responsibility for 0-5 Public Health services to the local authority, this will not include responsibility for, nor funding of, immunisations which will remain the responsibility of NHS England. Responsibility for delivery of immunisations will remain with local GPs. Hackney local authority will work with partners to ensure there is no adverse impact on families and children during and after the transition.

Measles, Mumps and Rubella (MMR)

Hackney and the City of London have been affected by three measles outbreaks in the past ten years. In 2006 there were 739 confirmed cases of measles in England & Wales of which 271 were in London. The outbreak at that time was prominent in the Traveller Community. Following this Hackney and the City of London introduced targeted interventions in the

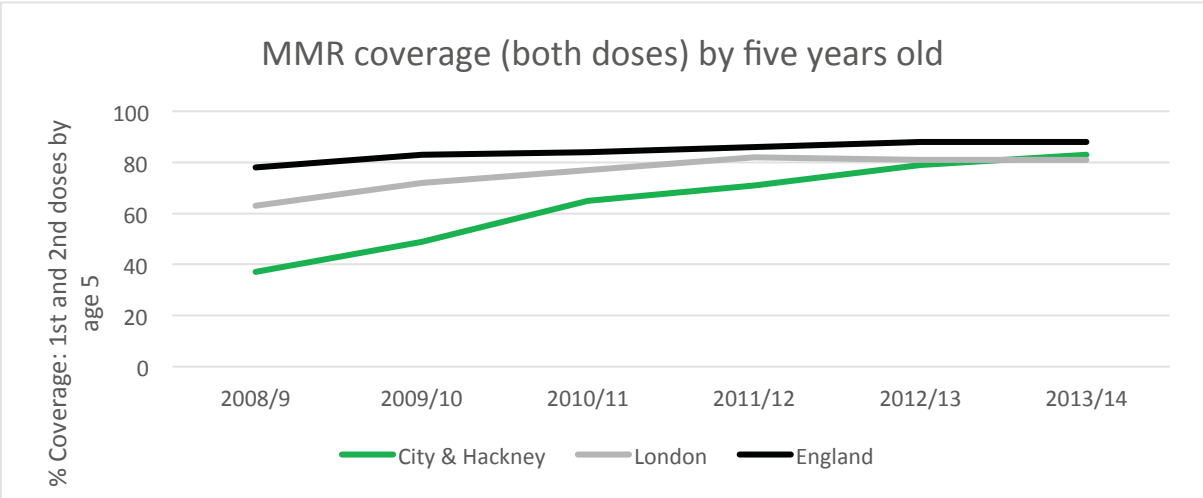
Traveller Community to try to minimise the risk of future outbreaks. In 2007 there was another serious outbreak of measles with 336 cases. That outbreak was prominent in pre-school and primary school children in Orthodox Jewish areas.

Finally, 2012 saw almost 2,000 cases of measles in England which was a record annual high. Nationally, this was attributed to the proportion of unprotected 10-16 year olds who were not vaccinated in the late 1990s and early 2000s following concern around the discredited link between the MMR vaccine and autism, allowing measles to re-establish from 2007. Of the 139 cases in London, Hackney saw the greatest number of confirmed cases at 45, equating to a local rate of 18.2 per 100,000 (the London average was 1.69 per 100,000)[63] – and of note the Orthodox Jewish community were again affected[64]. In comparison, the second most affected local authority was Barnet with 14 confirmed cases at a rate of 3.92 per 100,000.

Discussions have been held with the Orthodox Jewish community to further explore any population-specific barriers to immunisation. It was made clear that parents did not hold religious or cultural objections to the MMR vaccine, as had previously been suggested, but some parents had made a personal choice not to immunise and there were problems around access to services (for instance logistics with large families) and the provision of consistent, culturally-appropriate information. The critical importance of using all opportunities to capture the details and healthcare requirements of new arrivals to the Borough was recognised during the review of the outbreak[65].

Figure 73 demonstrates that Hackney has increased the population vaccination coverage of MMR from just below 40% in 2008 to above 80% in 2013 – surpassing the London average. However, this remains below the 95% coverage required to achieve measles herd immunity.

Figure 73. Population coverage of MMR vaccination at 5 years old

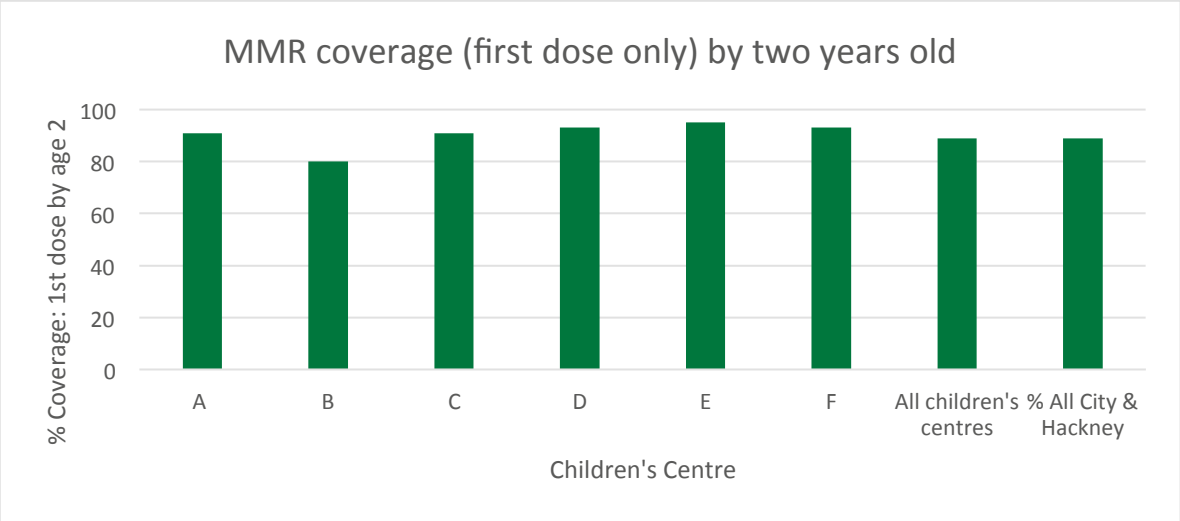


Source: Public Health England and the Health & Social Care Information Centre

[63] PHE News Release, April 2013
[64] Ongoing Measles Outbreak in Orthodox Jewish Community, London, UK http://wwwnc.cdc.gov/eid/article/19/10/13-0258_article
[65] Hackney report of health in Hackney scrutiny commission, Measles and Immunisation, Overview and Scrutiny Board 17th April 2008

When analysing the first dose of MMR alone, the average uptake across Hackney and the City of London is 89%. However, there is local variation as all Children's Centre areas achieved greater than 90% coverage except area B (which serves the Orthodox Jewish population), which achieved 80% (see Figure 74).

Figure 74. First MMR dose by two years of age by Children's Centre area, 2013/14

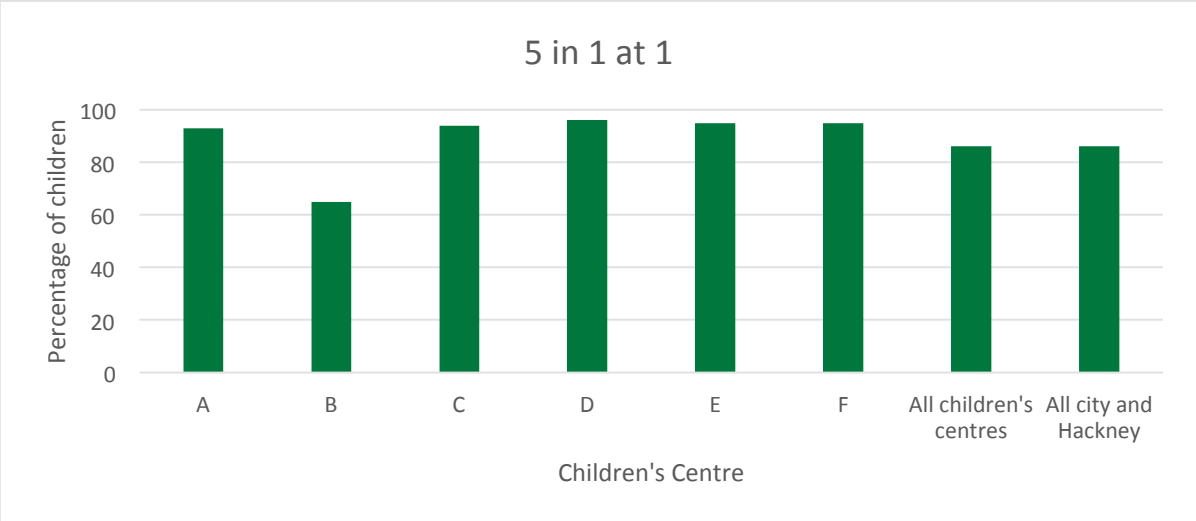


Source: Homerton University Hospital Foundation Trust

Diphtheria, tetanus, pertussis, polio and haemophilus (DTaP/IPV/Hib)

The '5 in 1' vaccination is for diphtheria, tetanus, pertussis, polio and haemophilus (DTaP/IPV/Hib) and children should have received three doses by their first birthday. This is achieved in 86% of Hackney and City of London children, but again area B is the only area not to achieve more than 90% coverage, instead achieving 65% (see Figure 75).

Figure 75. Five-in-one at one year of age by Children's Centre area, 2013/14



Source: Homerton University Hospital Foundation Trust

6.2.4.3 Key findings

- Coverage of children receiving two doses of the Measles, Mumps and Rubella (MMR) vaccine has more than doubled from below 40% in 2008 to above 80% in 2013, but it remains below the 95% coverage required to achieve herd immunity for measles;
- In area B only 65% of children receive all three doses of DTaP/IPV/Hib by their first birthday making it the only area not to reach 90% coverage in line with the schedule. This is attributed to 74% of Orthodox Jewish children being located in area B.

6.2.5 Healthy Start

6.2.5.1 Introduction

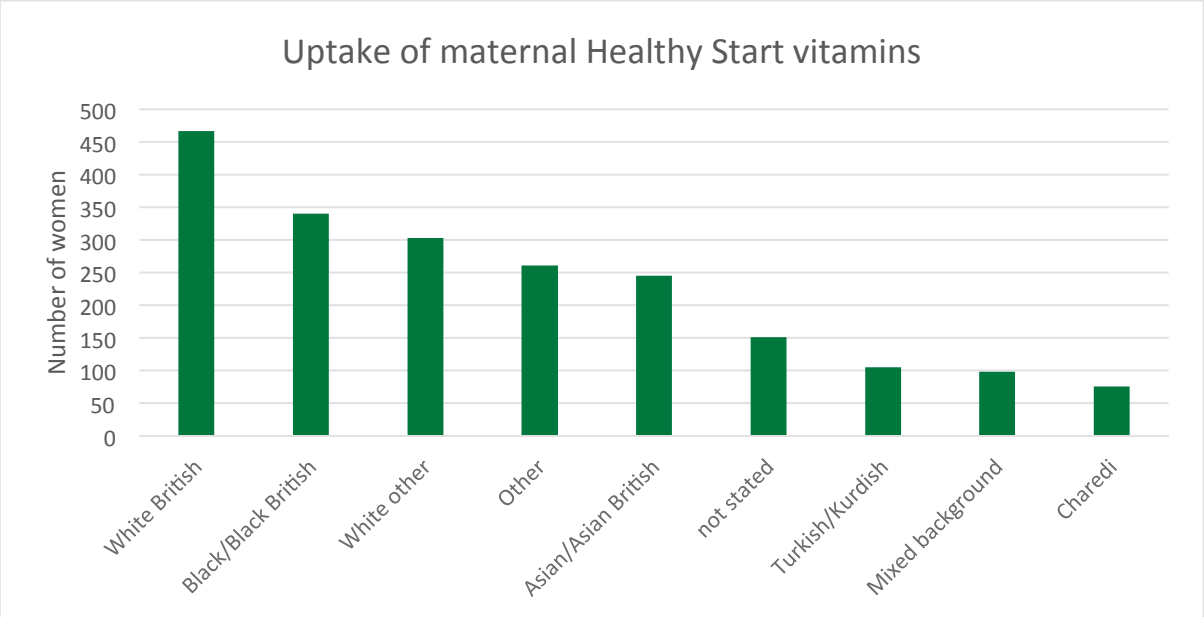
Healthy Start is a UK-wide government scheme to provide vitamins and food vouchers to pregnant women, new mothers and children until their fourth birthday. Vitamin A is too low in 8% of UK children's diets, vitamin C levels tend to be lower in children of lower-income families, and vitamin D deficiency is a risk in all pregnant and breastfeeding women (with the greatest risk being in younger mothers and those of non-White ethnicities). The food vouchers are for fruit and vegetables (fresh or frozen) and cows or formula milk.

6.2.5.2 Hackney and City of London

In many areas of the country Healthy Start vitamins are only available if someone in the family receives certain benefits or tax credits or if the pregnant woman is under 18 years old. However, in Hackney and the City of London Healthy Start vitamins are provided universally to pregnant women (from their 10th week), women who gave birth within the last year and children under four years of age. Registration for Healthy Start vitamins occurs through midwives, health visitors, Children's Centres, pharmacies or GPs and the vitamins can be collected every eight weeks from a local pharmacy.

In 2015, 4,674 adult packs of vitamins were issued to 3,182 individual pregnant or postnatal women. This equates to 36% of locally eligible women collecting one or more packs in a year. However, given that packs last for eight weeks, full uptake of the scheme would see up to six packs of vitamins being issued per eligible woman per year, but 71% of women only collected vitamins once. The breakdown by ethnicity shows that White women claimed the most vitamins, but this is not out of line with the proportion of the general population being of White ethnicity (Figure 76).

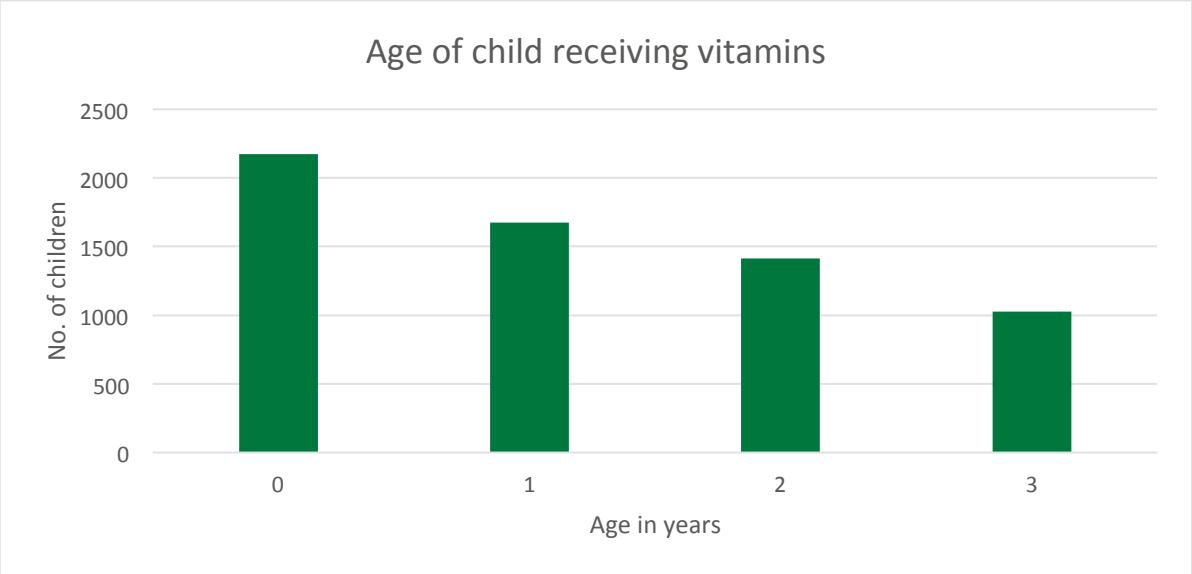
Figure 76. Uptake of Healthy Start vitamins in women by ethnicity, 2014/15



Source: London Borough Hackney

Overall, 5,539 vitamin packs were dispensed to 3,398 individual children aged under four in 2015. This is equivalent to 20% of Hackney's eligible children receiving one or more vitamin packs during 2015. However, 64% of these children only received one pack of vitamins over the year. The number of packs decreases with children's age (Figure 77).

Figure 77. Number of vitamin packs dispensed by age, 2014/15



Source: London Borough Hackney

A steering group has been convened to consult with local stakeholders and engage with local professionals to promote the uptake of the Healthy Start vitamins scheme.

Healthy Start food vouchers are not universal in Hackney and the City of London and only available locally if the family receive certain benefits, or if the pregnant women is under 18 years old (similar to Healthy Start vitamin provision in many other parts of the country). Registration involves the same health professionals as the vitamins scheme, but the vouchers must be exchanged at certain shops and supermarkets locally. A snapshot of voucher use showed that between 28th July and 24th August 2014 76.4% of 3879 eligible mothers accessed the vouchers.

6.2.5.3 Key findings

- 4,674 packs of Healthy Start vitamins were dispensed to 3,182 individual pregnant or postnatal women (36% of those eligible in Hackney) in 2015;
- 5,539 packs of Healthy Start vitamins for children were dispensed to 3,398 individual children (20% of those eligible in Hackney) in 2015 – uptake decreases with age;
- 76% of eligible families use the targeted Healthy Start food voucher scheme.

6.2.6 School Readiness

"Investing in the early years, thereby improving early cognitive and non-cognitive development and children's readiness for school, is vital for later educational outcomes"

(Fair Society, Healthy Lives)[2]

6.2.6.1 27 month review (2-2.5 year review)

At 27 months old children are developing their behaviours, speech and language, social and emotional skills and independence and the review is designed to allow identification of problems and deliver interventions to improve a child's readiness for school.

Desired outcomes include:

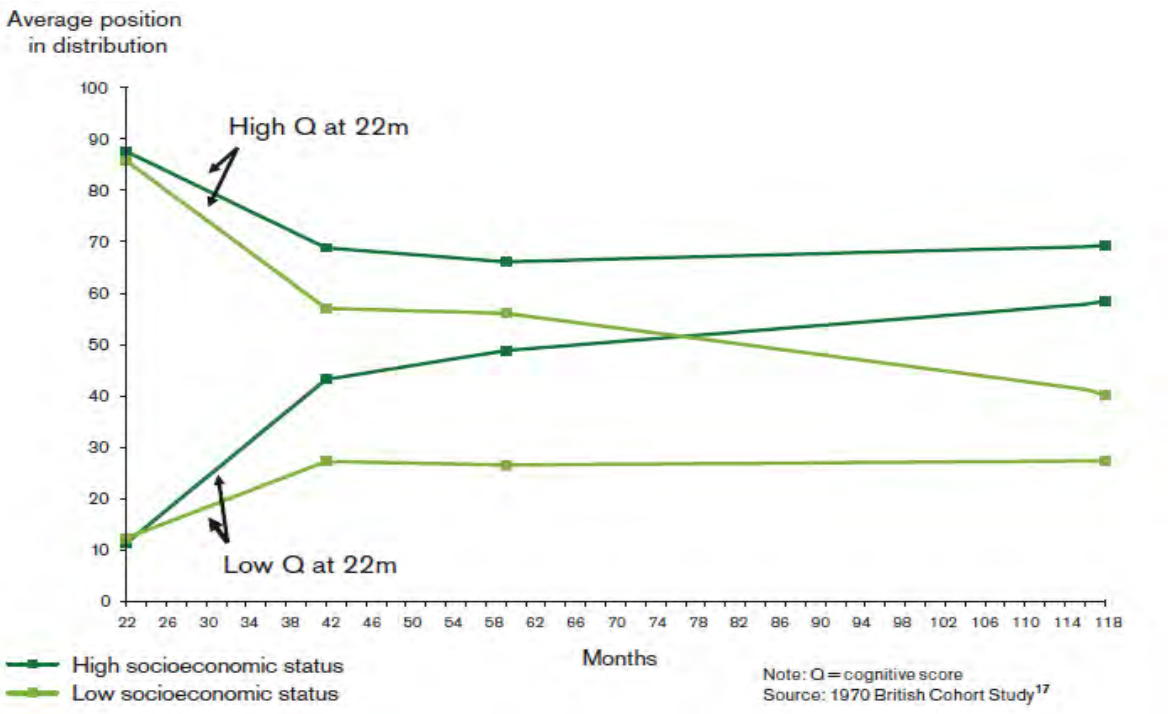
- Improved emotional and social wellbeing
- Improved learning and speech and language development both through the home learning environment and access to early years learning
- Early identification of and intervention for developmental, health or growth problems
- Improved immunisation rates
- Prevention of obesity and promotion of healthy eating behaviours
- Early detection of and intervention for psychosocial problems

Predictors of two-year-old children's vocabulary[10]

- The number of books available to the child
- Frequency of visits to the library
- Being read to by a parent
- Parents teaching a range of activities
- The number of toys available
- Attendance at pre-school

Children with low cognitive scores at 22 months but who grow up in a family with high socioeconomic status will improve their relative scores as they approach age ten. However, on average those with a high score at 22 months who live in families with low socioeconomic status will see a reduction in their scores as they approach age ten (Figure 78).[2]

Figure 78. Inequality in early cognitive development in the 1970 British Cohort Study



Source: Fair Society, Healthy Lives

6.2.6.1.1 Hackney and City of London

There were 5,852 27 month reviews conducted between 2013/14-2014/15. This is not the same cohort who gave birth during the same time period at HUH, so comparisons between the two groups are purely illustrative.

Ethnicity was not recorded in 30% of cases. The recording of mixed ethnicity data is better at the 27 month review stage than at birth. It could be argued that the data does not fully describe the population, as the options for ethnicity do not include Jewish/Orthodox Jewish. There are no statistically significant differences in the proportion of reviews that were partially completed by ethnicity.

Children's Centre areas B, D and F appear to have lower rates of 27 month reviews, while Children's Centre areas A and E appear to have higher rates. However, this comes with the caveat that the number of births at HUH may not accurately reflect the number of 27-month olds living in each zone – the rates of children born in other hospitals may vary by area, and the birth rate may have changed more in some areas in the preceding 27 months.

Children's Centre area A has a higher rate of partially completed reviews than other areas.

6.2.6.2 Early Years Foundation Stage

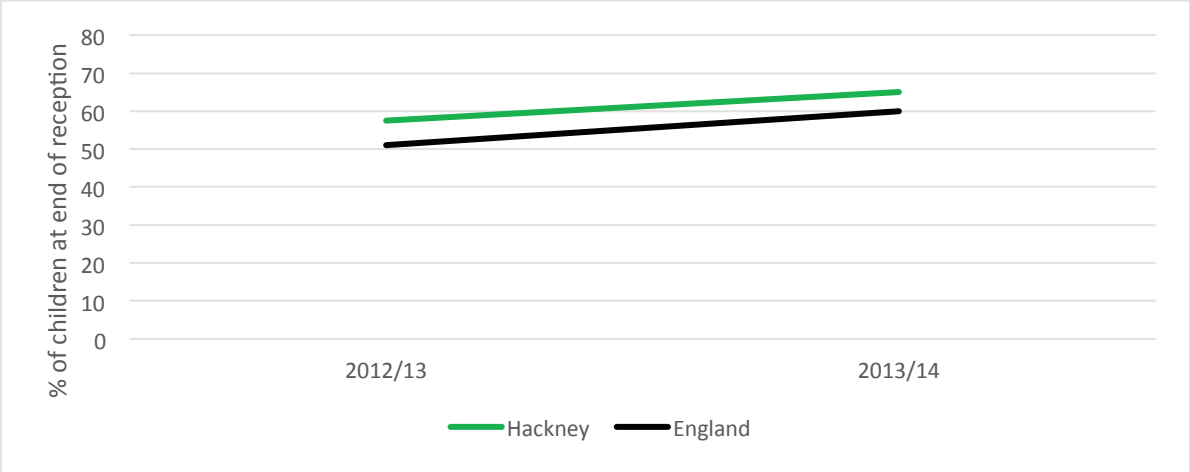
The Early Years Foundation Stage (EYFS) sets standards to which all Early Years' providers are required to meet. These standards aim to provide children with a broad range of knowledge and skills to promote school readiness. The EYFS Profile must be completed for each child in the final term of the year in which the child reaches five years of age.[66] The profile has three prime areas (Personal, Social and Emotional development; Physical Development; and Communication and Language) and four learning areas (Literacy, Mathematics, Expressive Art and Design, and Understanding the World). These seven areas are categorised into seventeen Early Learning Goals (ELGs) and teachers determine whether children are meeting expected levels (or exceeding them) for each ELG. A Good Level of Development (GLD) is reached if the child is at least at the expected level in all ELGs for prime areas, and the ELGs for literacy and mathematics learning.

6.2.6.2.1 Hackney

65% of pupils in Hackney achieved a GLD in 2013/14 (Figure 79) – higher than the previous year (57%), London (62%) and the national average (60%). This places Hackney in the top fifth nationally, despite being one of the most deprived local authorities. Hackney outcomes are as good as, or better than, London and national outcomes in each of the seven main areas. Of note, Hackney significantly outperforms national, London and inner London standards in mathematics. Hackney is only outperformed at inner London level in physical development and only by a single percentage point. This places Hackney 22nd in a national ranking of local authorities.

[66] Statutory framework for the early years foundation stage, March 2014, Department for Education

Figure 79. Percentage of children achieving a GLD at the end of reception, 2012-14



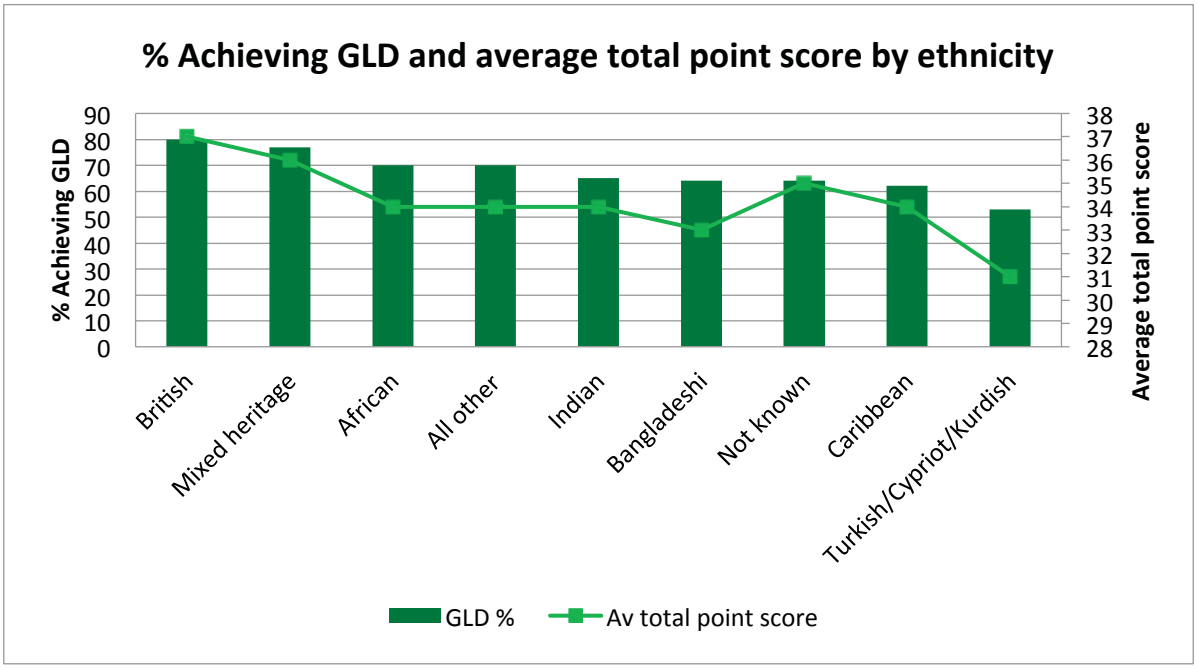
Source: Department for Education

The percentage of pupils achieving a GLD in Hackney level is 4% higher if private, voluntary and independent settings (PVIs) are not included in the figures (69% in comparison to 65%).

Within Hackney, the achievement gap between the mean score of the lowest attaining 20% of children and the median in the borough is 31.2 which is 0.7% lower than the previous year's gap, 1.6% lower than London's gap and 2.7% lower than England's average gap.

Figure 80 shows that children of British ethnicity are most likely to achieve a GLD (80%) and have the highest average total point score (37). Those of Turkish/Cypriot/Kurdish origin are least likely to achieve a GLD (50%) and have the lowest total point score (31).

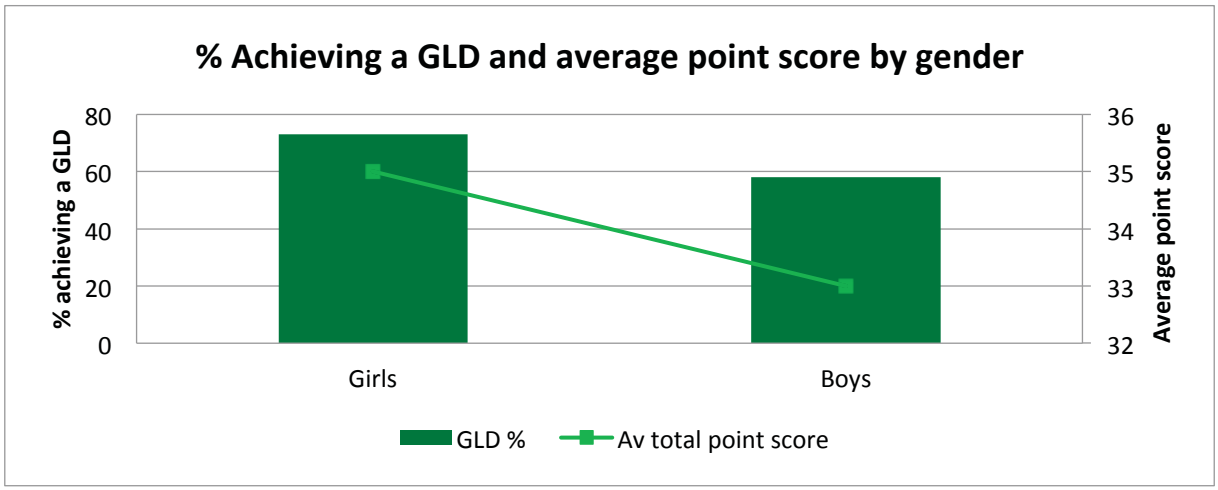
Figure 80. Percentage of children achieving a good level of development by ethnicity, 2013/14



Source: Hackney Learning Trust annual report August 2014

Figure 81 shows that not only do a higher percentage of girls achieve a GLD than boys (70% versus 60%), but they also achieve a higher average point score (35 compared to 33).

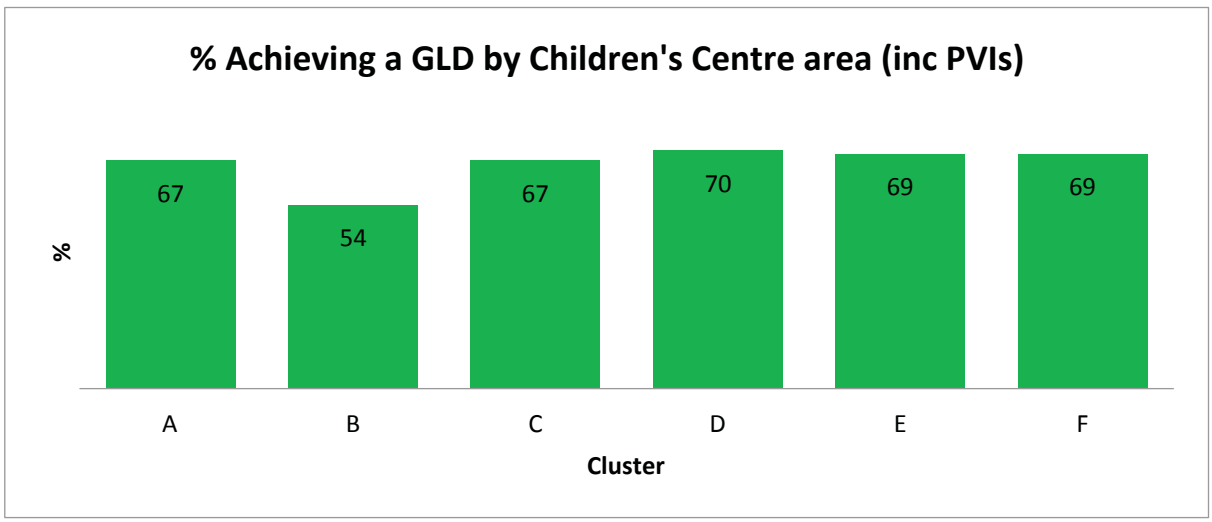
Figure 81. Percentage of children achieving a good level of development by gender, 2013/14



Source: Hackney Learning Trust annual report August 2014

Children's Centre area B has the lowest number of children achieving a GLD at 54%, compared to the highest rate of 70% in the Children's Centre area D (Figure 82).

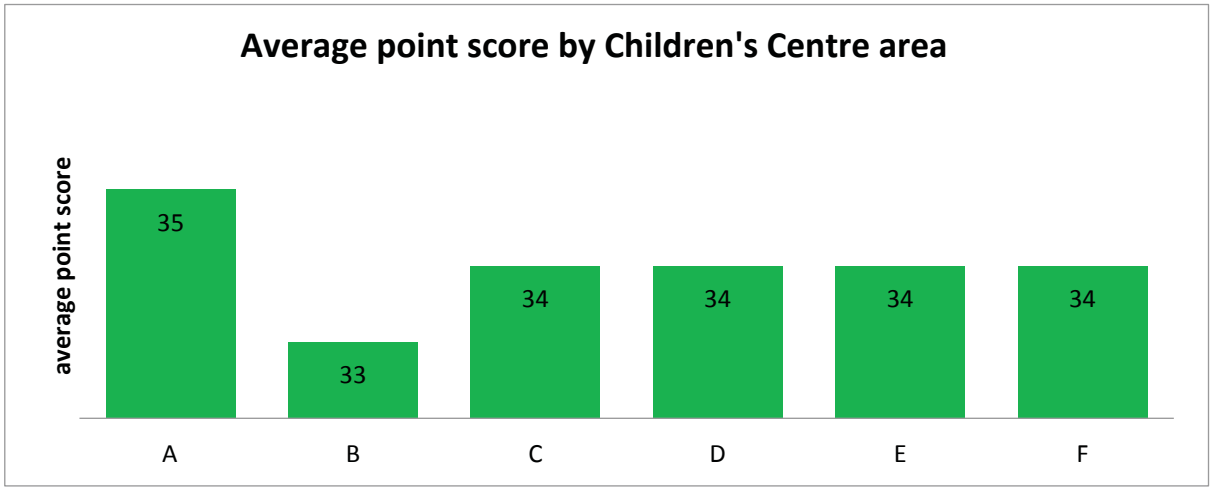
Figure 82. Percentage of children achieving a GLD by Children's Centre area, 2013/14



Source: Hackney Learning Trust annual report August 2014

In Hackney, the average point score across all ELGs is 34, in line with both London and national averages. Children's Centre area B has a lower average point score of 33 and Children's Centre area A has a higher average point score of 35 (Figure 83).

Figure 83. Average point score by Children's Centre area, 2013/14



Source: Hackney Learning Trust annual report August 2014

6.2.6.2.2 City of London

In the City of London 67.3% of children achieve a GLD.[67]

6.2.6.3 15 hours of Free Funding

Universally, three and four year olds are entitled to 15 hours of free funding for nursery education childcare per week (in term-time for 38 weeks per year). These Single Funding Formula payments can be made to all types of educational establishment – school nurseries (including private schools), Children's Centres, day nurseries, playgroups and childminders. In order to qualify for the full 15 hours, the child must attend for at least two days per week.

6.2.6.3.1 Hackney and City of London

The Learning Trust estimate that at least 90% of three year olds and 97-98% of four year olds take up their 15 hours of free childcare funding. The breakdown of these figures is shown in Figure 84.

[67] Child health profiles www.gov.uk/government/statistics/eyfsp-attainment-by-pupil-characteristics-2013-to-2014

Figure 84. Number of three and four year olds using their 15 hours of free funding, Jan 2015

	Children's Centre	Nursery	Orthodox Jewish Nursery	Playgroup	School Nursery	Total
Cluster A	41	138	303	45	375	902
Cluster B	54	86	990	27	293	1450
Cluster C	52	175	4	50	458	739
Cluster D	48	97	1	15	545	706
Cluster E	23	112	0	19	457	611
Cluster F	64	109	0	15	410	598
Total	282	717	1298	171	2652	5120

Source: Hackney Learning Trust

[For full breakdown see Appendix 9.2.2.4]

6.2.6.4 Key Findings

- 5,852 27-month reviews were conducted over two years (2013-15) – areas B, D and F had the lowest rates of completion and ethnicity was not recorded in 30%;
- 65% of pupils in Hackney obtained a Good Level of Development (GLD) in July 2014 – higher than London (62%), England (60%) and Hackney's 2013 result (57%);
- 67.3% of children reached a GLD in the City of London in July 2014;
- Outcomes in Hackney are as good as, or better than, London and national averages in each of the seven main areas;
- The achievement gap between the lowest attaining 20% of children and the median level of achievement is smaller in Hackney than in London or England;
- Gender: girls are more likely than boys to obtain a GLD (70% versus 60%) and achieve a higher average point score (35 compared to 33);
- Origin: children of British origin are most likely to achieve a GLD (80%) and achieve higher average total point scores (37), whereas children of a Turkish/Cypriot/Kurdish origin are least likely to obtain a GLD (50%) and have a lower point score (31);
- Location: area B has the lowest number of children achieving a GLD (54%) and a slightly lower average point score (33); area D has the highest GLD achievement rate (70%) and area A has a slightly higher average point score (35);
- 90% aged three and 97-98% aged four take up the 15 hours of free childcare funding.

6.2.7 Children with Disability/Special Educational Needs

6.2.7.1 Introduction

A child has Special Educational Needs (SEN) if he or she has a learning difficulty or disability which calls for them to receive special educational provision.[68] Children with long-term disabilities constitute a diverse group – some have highly complex needs requiring multi-agency support across health, social services and education; whereas others require substantially less support. Previously, children received a Statement of Special Educational Needs from their local authority if they required additional educational provision. However, under the Children and Families Act 2014, these Statements have been replaced by Educational Health and Care (EHC) plans which aim to address these broader health and social care needs. As of September 2014, only EHC plans are issued and children who already have an SEN statement will be transferred to an EHC plan within three and a half years[69].

Not only do children with SEN face barriers which make it harder for them to reach their potential due to their disability, they are also more likely to live in families that have other risk factors which are associated with poorer educational outcomes. 29% of disabled children live in poverty, rates of mild and severe disabilities are higher in families of semi-skilled and unskilled manual occupations and the lowest rate of severe disability is in families of professional or managerial backgrounds.

Nationally, only 4% of disabled children are supported by social services and families with disabled children report high levels of isolation and stress, while the prevalence of severe disability is increasing.

Services

Hackney Ark[70] is a centre for children and young people with disability and SEN. Since 2008 it has acted as a hub for services across health, education and social care from which to provide a coordinated package of care responding to the needs of the child and their family. Children referred to the Ark are assessed at a single point of entry referral meeting and their needs are then addressed by the relevant clinical teams. These teams continue to liaise with one another regarding the services being delivered to the child and their family.[71]

The Portage Service[72] provides an educational, personalised, home-visiting service for families who have a pre-school child with additional needs. They work closely with other specialties involved in the child's care. They aim to help families understand their individual child's development, offer practical ideas around optimal play for development, assist with entry to playgroup or nursery, provide support with benefits and help to promote inclusion at Children's Centres. There is also a drop-in session for children and their families weekly.

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[68] Children and Families Act 2014, Part 3, 20 (1)
[69] https://www.sense.org.uk/content/education-health-and-care-plans
[70] http://www.homerton.nhs.uk/our-services/services-a-z/c/childrens-services-in-the-community/hackney-ark.aspx accessed 30/4/2015
[71] http://www.cityandhackneycamhs.org.uk/professionals/pct-camhs/learning-difficulty/
[72] http://www.hackneylocaloffer.co.uk/kb5/hackney/fsd/service.page?id=CZk9tyF5qIQ

Further services locally include those run by Hackney Learning Trust (such as the Educational Psychologist Service, Early Support Team and the Sensory Impairment Team), Disabled Children's Social Care and local health services (for instance the Multi-Agency Referral Service and services by Speech and Language Therapy).

6.2.7.2 Hackney and City of London

In 2011 there were 1,235 girls and 1,344 boys aged 0-4 years living with longstanding illness or disability (ONS), of which 8 girls and 14 boys were severely disabled.

Fewer than 10 young people were known to have a disability in the City of London in 2013.[28]

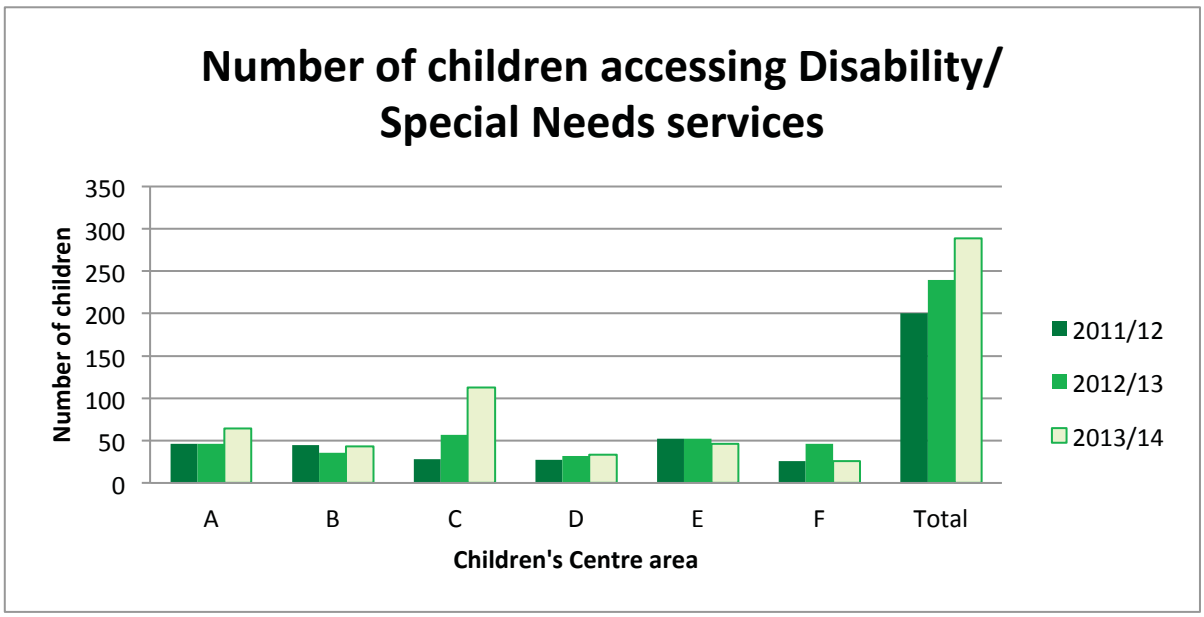
Overall there has been a 44% increase in the number of children accessing Disability/Special Needs services between 2011 and 2014 (see Figure 85). Children's Centre areas A-D have seen an increase in the number of children accessing these services, but areas E and F have seen a reduction. Area C has had the largest increase, with a four-fold increase in the number of children accessing these services over this period.

Figure 85. Number of Children accessing Disability/Special Needs Services

	A	B	C	D	E	F	Total
2011/12	46	45	28	27	52	26	200
2012/13	46	36	57	32	52	46	240
2013/14	64	43	113	33	46	26	289

Source: Hackney Learning Trust

Figure 86. Number of children accessing Disability/Special Needs Services



Source: Hackney Learning Trust

6.2.7.3 Key findings

- There has been a 44% increase in the number of children accessing Disability / Special Needs services between 2011/12 and 2013/14;
- Gender: there are more boys with longstanding illness or disability than girls;
- Location: area C has seen a four-fold increase in service access over two years;
- Fewer than ten children had known disabilities in the City of London in 2013.

6.2.8 Accident and Emergency Attendances and Emergency Hospital Admissions (0-4 years)

6.2.8.1 Introduction

On average a pre-school child will visit a GP six times per year. Once a child has reached school age this falls to between two and three GP attendances per year. Around half of children under one year of age will visit an accident and emergency (A&E) department and one third of those will be admitted.[73]

Nationally, the most common causes of attendance at A&E or emergency hospital admission in children aged four and under are illnesses such as gastroenteritis, upper respiratory tract infections and injuries.

Accidents are the principal cause of death for children and young people. In 2012, there were 464 accidental deaths nationally in those aged 0-19, and 80 of these were in children under five years of age. There are more than 450,000 A&E department attendances in under-5s each year, of which 40,000 are admitted to hospital as a result of an accident in or around the home. Common accidents include falls, burns, scalds and poisonings by medicines or cleaning products.

There is a strong association between unintentional injury and inequality, with children born into disadvantaged families being much more likely to be seriously injured and children in the poorest families being 13 times more likely to be killed. Socioeconomically disadvantaged families have been shown to have more unsafe practices than more affluent families. Fortunately there is evidence that targeted home safety education and home visiting programmes are effective in influencing the uptake of safe practices.[72]

[73] Early Years High Impact Area 5 –Managing minor illness and reducing accidents (reducing hospital attendance/admissions) DoH, LGA https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413133/2902452_Early_Years_Impact_5_V0_1W.pdf

6.2.8.2 Hackney and City of London

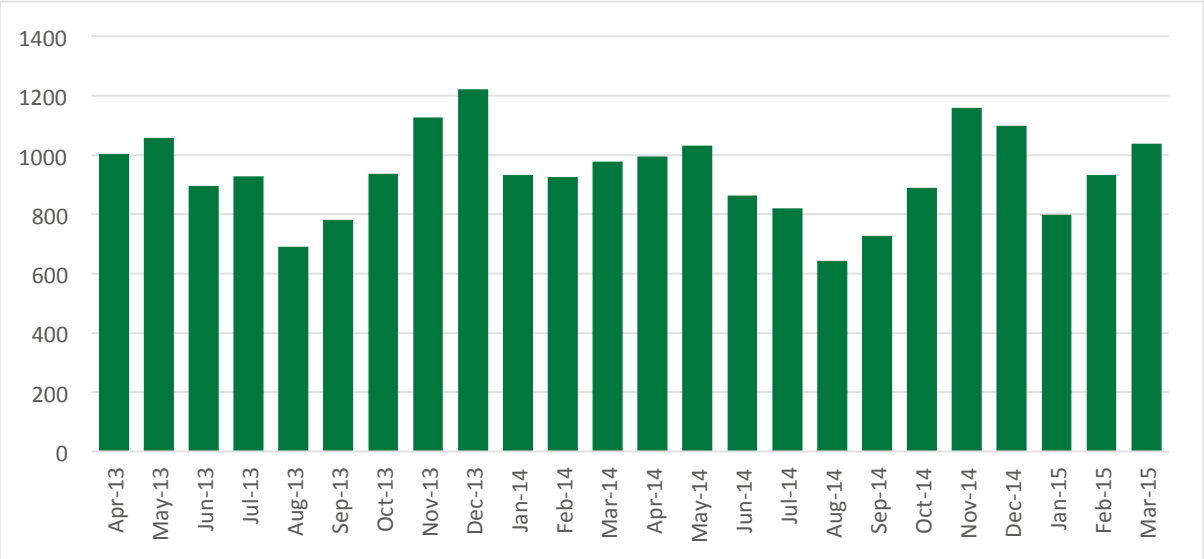
6.2.8.2.1 Accident and Emergency Attendances

There were 22,465 attendances at HUH A&E in 2013/14-2014/15 by residents of Hackney and the City of London aged 0-4 years. Using the 0-4 population given by the 2011 Census[74], there are approximately 1.2 visits per head of population per year. Children who are White British have the lowest rate of visits at 0.6 per head of population, and children who are White Other have the highest rate, at 2.8 visits per head of population.

Using data from NHS Reference Costs[75], attendances at HUH's emergency department (across all ages/conditions) cost £92 if the patient was not admitted, and £135 if the patient was admitted. HUH's emergency department costs 82% of the national average if HUH's case mix was applied to national numbers (unadjusted Reference Cost Index).

There is a clear seasonal pattern in attendances, with a peak in November/December and a trough in August (Figure 87).

Figure 87. Number of visits to A&E by 0-4 year olds each month 2013/14-2014/15



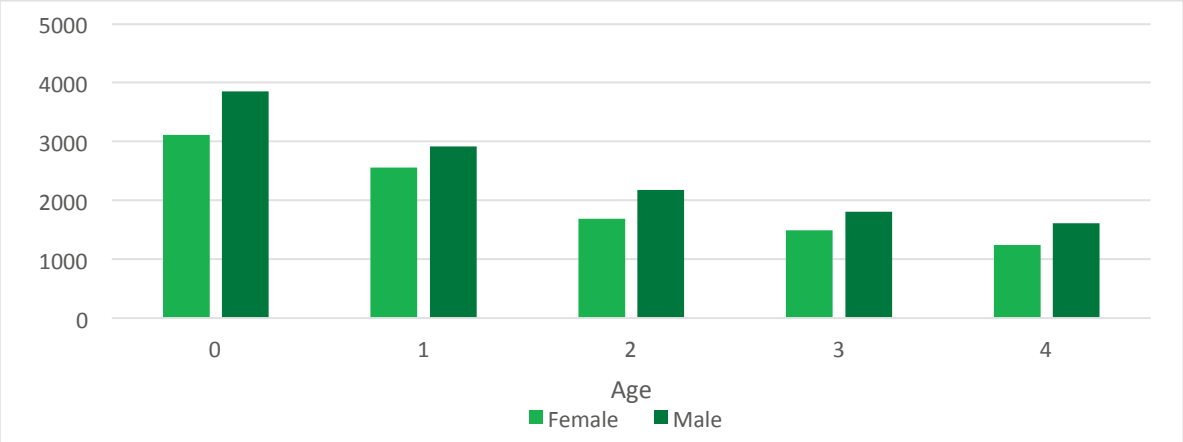
Source: Homerton University Hospital

Attendance rates decrease with age, and male children have more attendances than female children at all ages (see Figure 88).

[74] Note: ethnicity coding for the census and hospital records are slightly different, with census categories including *White: Gypsy or Irish Traveller*, placing Chinese as *Asian: Chinese* rather than *Other: Chinese*, and including *Other: Arab*.

[75] NHS Reference Costs 2013/14, Department of Health. https://www.gov.uk/government/publications/nhs-reference-costs-2013-to-2014

Figure 88. Number of A&E attendances for 0-4 year olds by age and gender, 2013-15



Source: Homerton University Hospital Foundation Trust

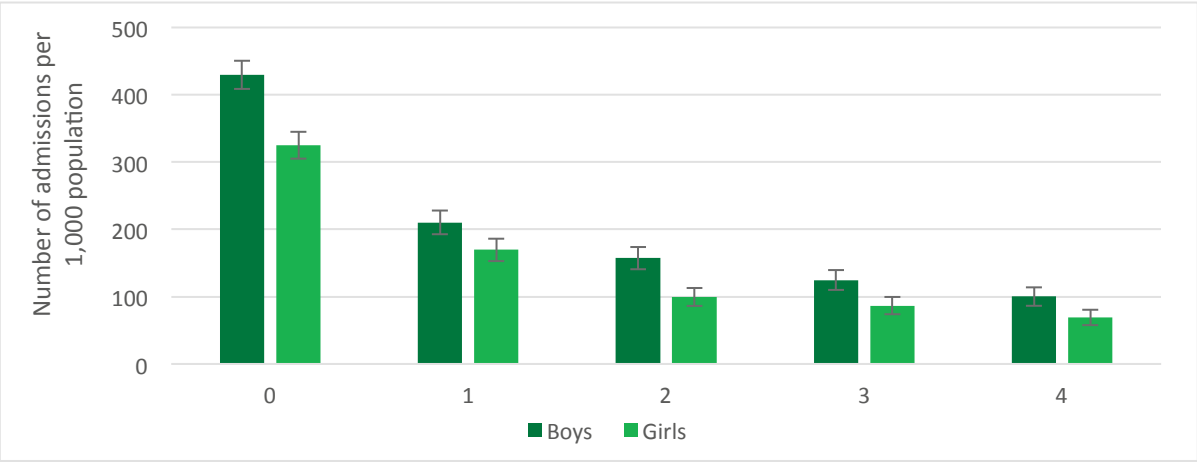
6.2.8.2.2 Emergency Admissions

General Admissions

There were 3,560 admissions of Hackney and City residents aged 0-4 at HUH over the two year period 2013-15. Using 2011 census figures[76], this is 183.6 admissions per 1,000 children. NHS Reference costs list short non-elective stays in paediatrics at HUH as £557 and long stays as £2,308. The unadjusted Relative Cost Index for paediatrics at HUH is 100% - i.e. the cost is the same as the national average if HUH's case mix were applied.

Just under half (45%) of all admissions for 0-4s are for those under one year of age, and boys account for more than half of admissions (58%) at all ages (Figure 89).

Figure 89. Admissions rate by age and gender, 2013-15

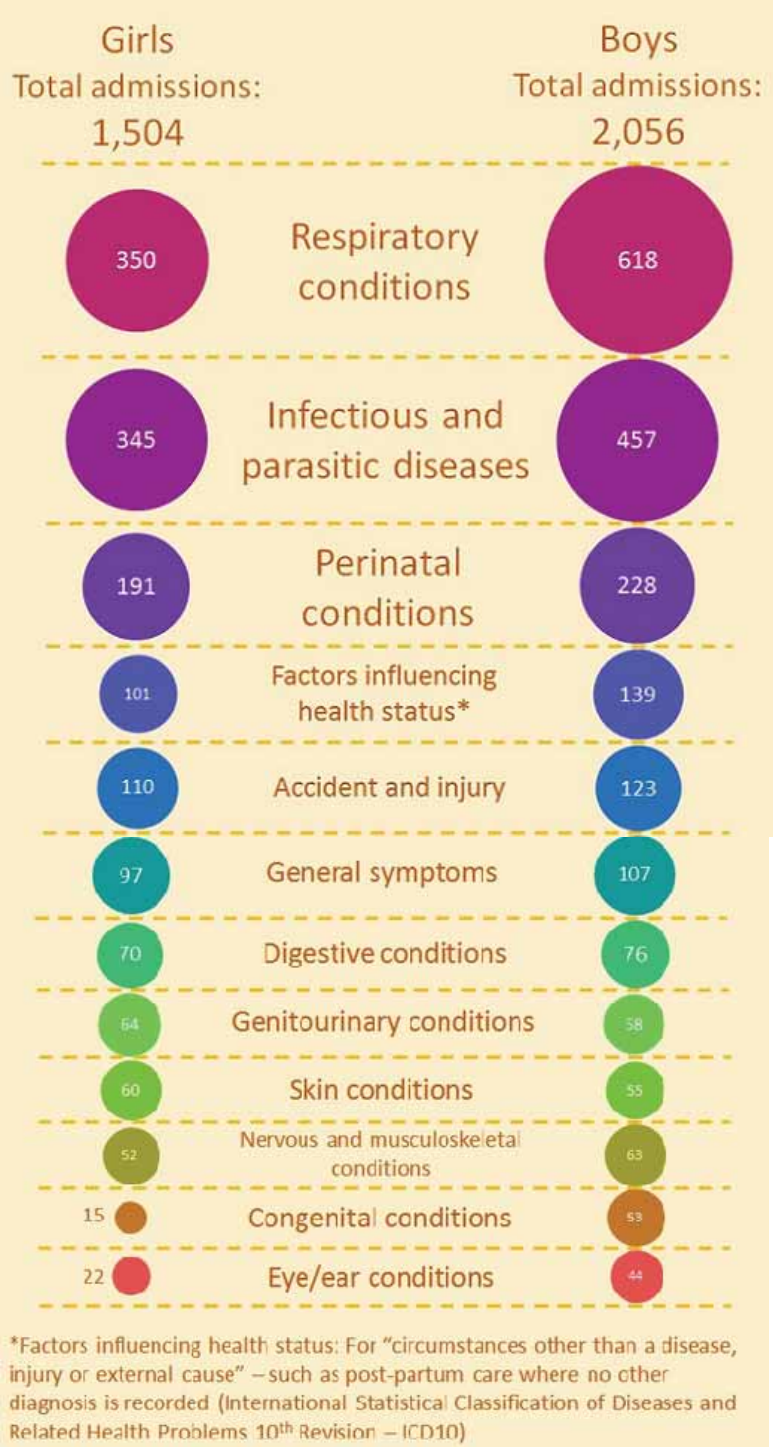


Source: Homerton University Hospital Foundation Trust

[76] Note: the 2011 Census gives a 0-4 population for City and Hackney combined of 19,385, compared to 20,500 from the GLA SHLAA 2014 estimates for 2014. The GLA estimate is likely to be more accurate at borough level, but Census figures are used because they are available in more geographic and demographic detail, allowing better comparisons between different subgroups.

There is also a gender gap in infant mortality, with boys being more likely to die than girls. This has been observed across high-income countries since the 1800s and the gap has persisted despite infant mortality falling, narrowing only in the last thirty years. Boys are more likely to be born prematurely and be vulnerable to infections in infancy, but these are just two of multiple biological and social factors likely to be at play. Locally, the increased admission rates for boys appears to be spread across a range of conditions as shown in Figure 90.

Figure 90. Reasons for admission to hospital, aged 0-4, City of London and Hackney, 2013-15



Source: London Borough of Hackney

Those who are of White, Black or Asian ethnicity have statistically similar rates of admission. However, those who are of a Mixed or 'Other' ethnicity have lower rates, but this may be an artefact of poor data recording in these categories.

Looking within each broad ethnic group, those who are White Irish or in the 'Other White' ethnic category have higher admission rates than those who are White British. Those in the 'Other Mixed' group have higher admission rates than those in specific mixed groups, although this may again point to issues with the data. Differences are not large between Asian ethnicity subgroups. Those who are Black African have higher admission rates than those in other Black groups.

The Children's Centre areas fall into two groups – areas A, B and E have similar lower rates of admission, while areas C, D and F have similar higher rates of admission.

Specific Conditions

There were 156 admissions for gastroenteritis, or 8.0 per 1,000 population. Admissions decreased with age, with similar rates per 1,000 population for 0-year-olds and 1-year-olds, and similar but much lower rates for those aged between 2-4 years. There were more admissions for boys than girls, but this effect was in keeping with the overall higher rate for boys. There were no differences by ethnicity. Children's Centre area D has a higher rate of admissions than any of the other areas for gastroenteritis (whether considered by admissions or per head of population) and there was no single large incident that may account for this difference as admissions were spread fairly evenly throughout the two year period.

There were 475 admissions for respiratory conditions, or 24.5 per 1,000 population. Admission rates decreased with age approximately in line with the rate of general admissions, with the exception of five years of age, where the rate is higher than other age groups. There are significantly more admissions for boys than girls – even once the generally higher admission rate for boys has been accounted for. There are no differences in admission rates by ethnicity for those who are Asian, Black or White. Those who are recorded to be of Mixed or 'Other' ethnicity have fewer admissions per head of population, with this persisting in the Mixed group even when general admission rates have been taken into account. This may point to genuine differences in prevalence or to issues with data recording. Those who are White Irish or White 'Other' have higher rates of admission for respiratory conditions, but these differences can be accounted for by their generally higher rates of admission. There were no other differences within the categories. The Children's Centre areas are statistically similar, both by admissions and per head of population.

There were 57 admissions for feeding problems, or 2.9 per 1,000 population. All of these admissions were for children under one year of age – this is a rate of 13.3 per 1,000 population for this group specifically. Due to the small numbers involved, further subgroup analysis by gender, ethnicity or Children's Centre area is not statistically appropriate.

There were 219 admissions for accidents and injuries, or 11.3 per 1,000 population. Over half (59%) were injuries to the head. Admissions for accidents and injuries per 1,000 population decreased with age roughly in proportion to the rate of general admissions. There is no significant difference in admission rates between boys and girls regardless of whether general admission rates have been accounted for. Admission rates are similar

across broad ethnic categories. Once general admission rates have been adjusted for, those who are Black or Asian have lower admission rates than those who are White. The Children's Centre areas are statistically similar, both by admissions and per head of population.

[For full breakdown see Appendix 9.2.2.5]

6.2.8.3 Key Findings

- There were 22,465 attendances over two years (2013-15) at HUH Accident and Emergency (A&E) Department in children aged 0-4. This equates to 1.2 visits per head of the 0-4 population over this period;
- There were 3560 emergency admissions to HUH for 0-4 year olds. This is approximately 1834 admissions per 1,000 of the 0-4 population;
- Attendances peak in November/December and fall to a trough in August;
- Age: the number of attendances and admissions decreases with age;
- Gender: at all ages attendances and admissions were higher for males than females;
- Ethnicity: White British children have the lowest rate of attendance and children who are White Other have the highest rate of attendance (over 4.5 times greater);
- Location: areas A, B and E have similar lower rates of admission; whereas C, D and F have similar higher rates of admission;
- Common conditions:
    - Respiratory conditions – 24.5 admissions per 1000 population. White Irish and White Other children had higher rates of admission; this was in line with their overall higher rates of admission;
    - Accidents and injuries – 11.3 admissions per 1000 population. 59% were head injuries. Boys and girls were affected similarly. Black and Asian children had lower rates of admission; this was in line with overall admission variation;
    - Gastroenteritis – 8.0 admissions per 1,000 population. Admissions peak at one year then decrease with age. Area D had the highest rate of admission;
    - Feeding problems – all admissions were for children under one year at a rate of 13.3 per 1,000 infant population.

6.2.9 Childhood Weight and Obesity

6.2.9.1 Introduction

The past three decades have seen a substantial rise in the prevalence of childhood obesity levels. Childhood obesity is a significant risk factor for adult obesity and obesity-related morbidities such as cardiovascular disease, type 2 diabetes, obesity-attributable cancers and osteoarthritis. A combination of genetic, metabolic, behavioural, environmental, cultural and socioeconomic factors all have a role to play in childhood obesity. Deprivation has a strong association with being overweight or obese and socioeconomic inequalities in relation to obesity and its risk factors are widening. There is also strong evidence to suggest substantial disparities in childhood obesity between ethnic groups, even after adjusting for socioeconomic status.[77]

[77] NCMP, 2013/14

The National Child Measurement Programme (NCMP) is an annual programme that monitors trends in child growth patterns and obesity in England. Data is collected from state-maintained schools only – for Hackney and the City of London this means that approximately a quarter of the population (in particular the Charedi population) are not represented due to the high prevalence of independent schools. Measurements are taken from four to five year old children in Year Reception (YR) and ten to eleven year old children in Year 6 (Y6). Participation is voluntary and parents or children are able to opt out.

The Body Mass Index (BMI) is a measure of healthy weight based on weight and height. BMI thresholds for children are not fixed as they are for adults as the relationship between BMI and body fat changes as children grow.

Lifestyle, Exercise, Activity, Positivity (LEAP)

LEAP is a multidisciplinary team (MDT) service that provides training and consultation to other professionals and offers two main services:

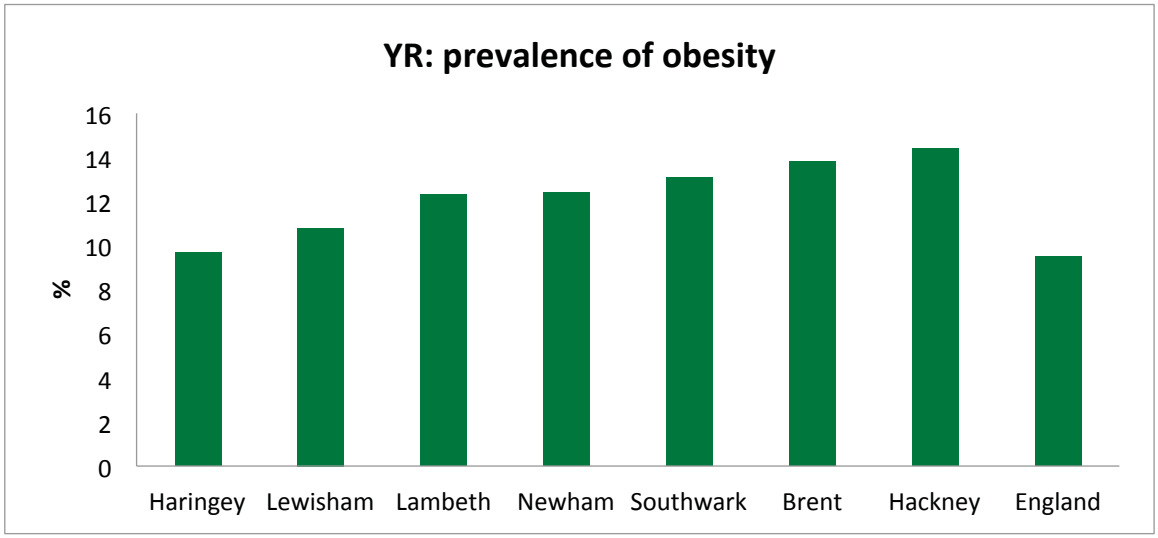
- HENRY (Health, Exercise, Nutrition for the Really Young) is an eight week group programme for parents of young children in Children's Centres across Hackney. It accepts referrals from parents or carers with children under five years of age who are keen to develop their skills to provide a healthy lifestyle for their family;

- An MDT specialist clinic at Hackney Community College offering individual and group interventions for obese children and their families. It accepts referrals from healthcare professionals for obese children, aged 0-18 years, who have a BMI between the 98th centile and +3.5 standard deviations, where universal services are inappropriate or have been unsuccessful or there are specific behavioural, dietary or medical concerns in relation to the child's excess weight. Referrals are also accepted for children where the BMI is between the 91st and 98th centile if they have known medical comorbidities, psychosocial dysfunction or complex needs/learning difficulty.

6.2.9.2 Hackney and City of London

The most recent figures (2013/14) show that the prevalence of being overweight or obese in YR in Hackney and the City of London is significantly higher than the London and national averages. When considering Hackney alone, at 14.4% the borough has the highest rates of obesity in reception children nationally. However, the differences between the local authorities with the highest levels of obesity are not statistically significant (Figure 91).

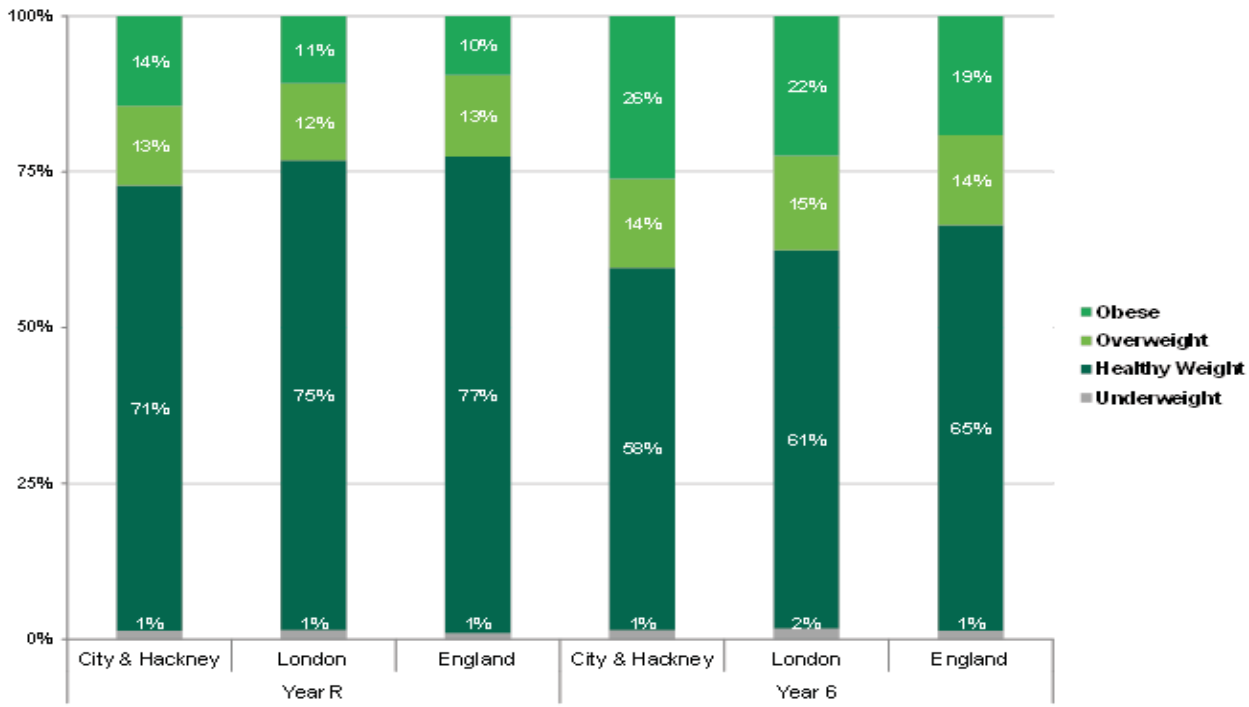
Figure 91. YR prevalence of obesity, Hackney and statistical neighbours, 2013/14



Source: NCMP 2013/14

The prevalence of healthy weight across Hackney and the City of London is 72% in YR children, with 13% being overweight, 14% obese and 1% being underweight. 4% of YR children are classed as 'Very Obese'. Between YR and Y6, the prevalence of obesity nearly doubles to 25%, with only 57% being of a healthy weight.

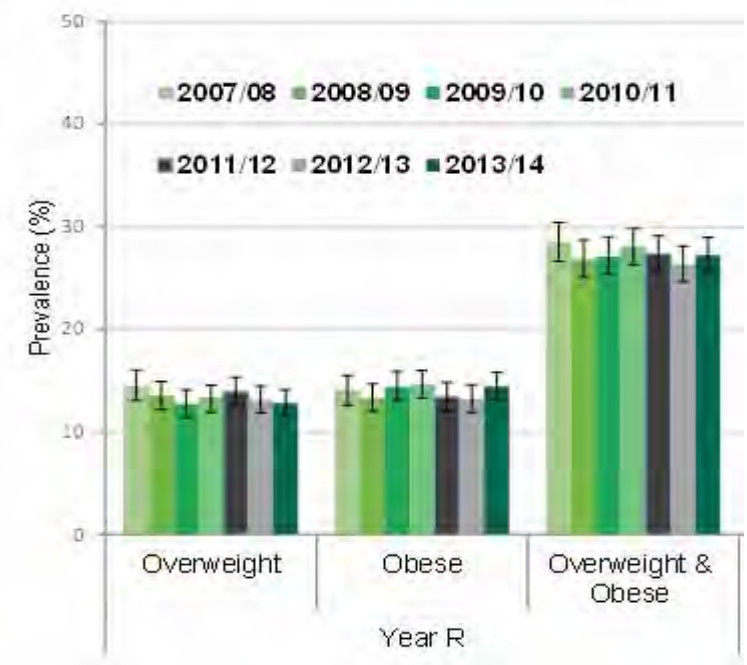
Figure 92. Distribution across weight categories (YR and Y6), City and Hackney, London and England, 2013/14



Source: NCMP 2013/14

Figure 93 shows that the scale of this problem has remained largely unchanged since routine measurement began in 2007/08.

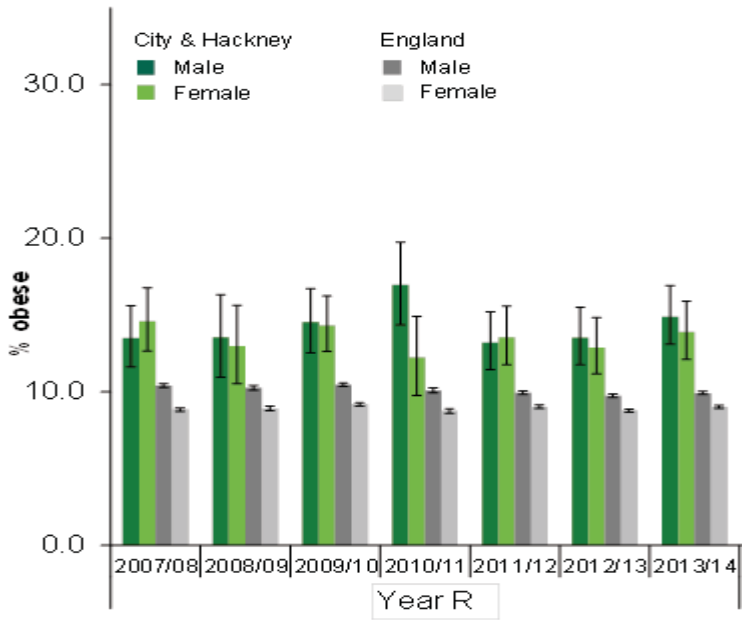
Figure 93. Prevalence of being overweight or obese in Hackney and City of London by year



Source: NCMP 2013/14

Nationally, there is a trend for YR boys to have higher rates of obesity than YR girls, but there is no significant difference in Hackney and the City of London (Figure 94).

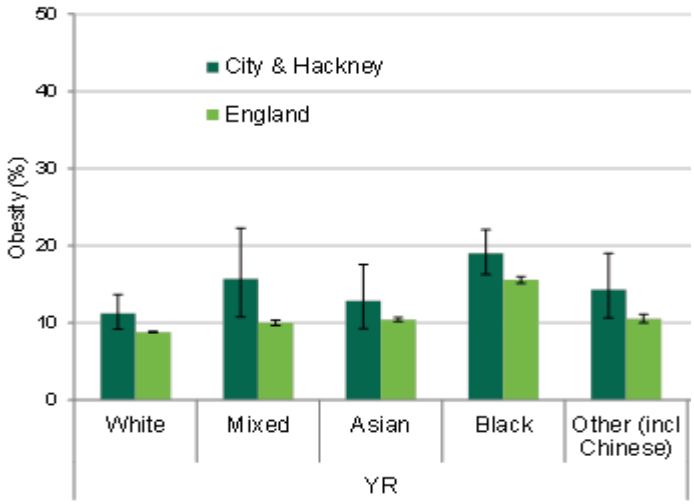
Figure 94. Obesity prevalence 2007-20014, YR and Y6, by gender



Source: NCMP 2013/14

At a national level, obesity is more prevalent in Black children than all other ethnic categories. Within Hackney and the City of London, statistically significantly more Black children are obese compared to White or Asian children (see Figure 95).

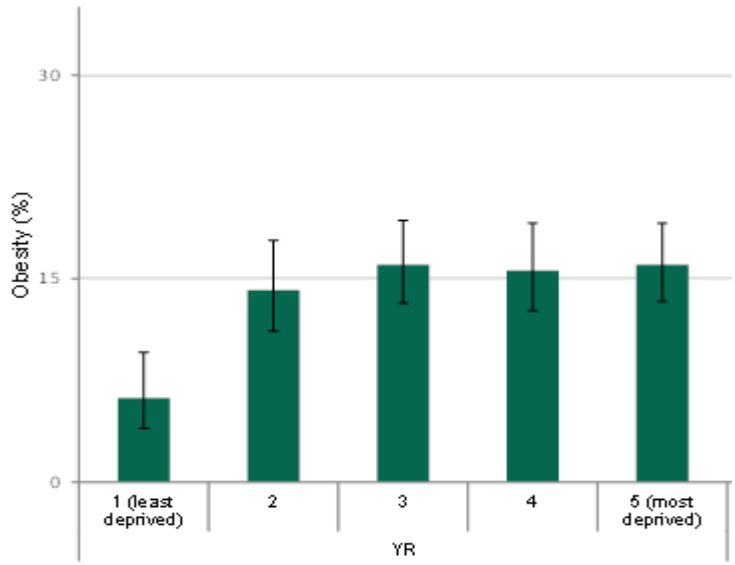
Figure 95. Obesity rates by ethnicity, 2013/14



Source: NCMP 2013/14

Figure 96 shows that obesity is significantly less common in the LSOAs deemed the least deprived, with the prevalence of obesity being similar across the other four deprivation quintiles.

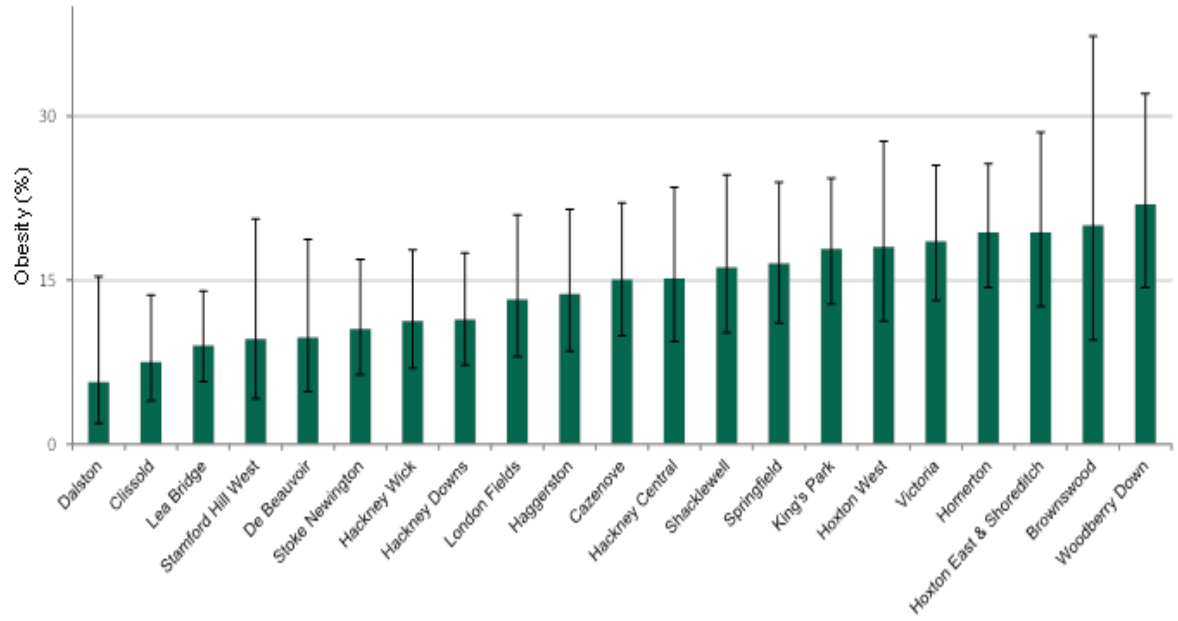
Figure 96. Prevalence of obesity by local deprivation quintiles, 2013/14



Source: NCMP 2013/14

In YR, the wards with the highest obesity prevalence are Woodberry Down, Brownswood, and Hoxton East & Shoreditch (Figure 97).

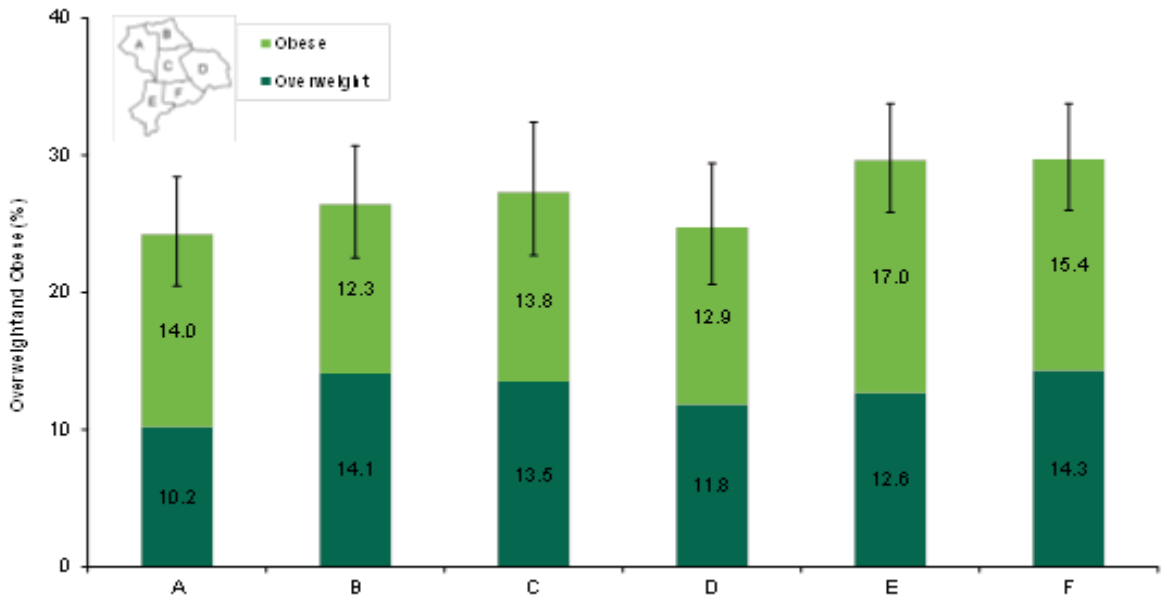
Figure 97. Prevalence of obesity in YR by ward of residence in 2013/14



Source: NCMP 2013/14

There is no statistically significant difference between Children's Centre areas (when calculated via school location) in YR (Figure 98).

Figure 98. Prevalence of being overweight or obese in YR by Children's Centre area 2013/14



Source: NCMP 2013/14

[For full breakdown see Appendix 9.2.2.6]

6.2.9.3 Key findings

- The prevalence of being overweight or obese across Hackney and the City of London at Reception and Year 6 in state schools[78] is significantly higher than London and national averages, and this is largely unchanged since measurement began in 2007;
- 73% of reception children across Hackney and the City are at a healthy weight, but 13% are overweight, 13% are obese and 1% are underweight;
- Gender: there is no statistically significant difference in obesity rates between girls and boys in Hackney and the City, while nationally boys have higher rates than girls;
- Ethnicity: obesity is more common in children of Black than White or Asian ethnicity;
- Location: Woodberry Down has the highest obesity prevalence in Hackney. Obesity prevalence is lowest in the least deprived Lower layer Super Output Areas (LSOAs).

6.2.10 Dental Health

6.2.10.1 Introduction

Poor oral health can have a significant impact on quality of life by causing pain, affecting the ability to eat a healthy diet, affecting appearance, and occasionally resulting in sepsis. These factors may also cause sickness absence from school.

Tooth decay (dental caries) is the major oral disease of childhood. Despite an overall improvement in oral health over the past 30 years, 27% of five year olds have tooth decay nationally. Tooth decay is the decalcification of the tooth surface due to frequent sugar consumption from foods or drinks. Risk factors for tooth decay include an unhealthy diet and poor oral hygiene. Tooth decay is avoided by reducing the frequency of sugar consumption and by strengthening the tooth surface with fluoride (most commonly achieved by brushing with fluoride toothpaste). Tooth decay may result in the need for tooth extraction – indeed this is the most common reason for children aged under five to require a general anaesthetic.

6.2.10.2 Hackney and City of London

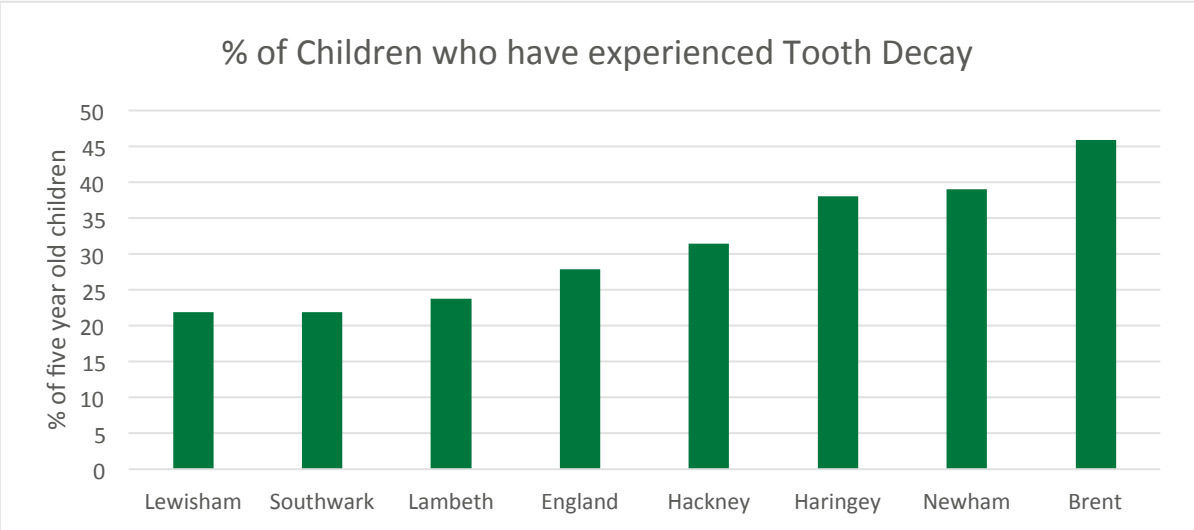
In Hackney and the City of London dental health is generally poor. In March 2012, only 47% of children and young people had seen a dentist in the previous two years, which is lower than neighbouring boroughs (56% in Tower Hamlets and 66% in Newham) and the London average (67%).[79] However, attendance has improved over the last six years.[80]

In 2012, Public Health England (PHE) conducted an Oral Health Survey of five year old children. In Hackney, 31.4% of five year old children had experienced tooth decay, with one or more teeth decayed to dentinal level, extracted or filled because of caries. This was slightly worse than the England prevalence of 27.9% and the 4th highest prevalence when compared to Hackney's statistical neighbours (Figure 99). Across Hackney and the City of

[78] Of note these figures do not include the Charedi children educated in independent schools who constitute approximately 20% of children in Hackney.
[79] A handy guide to the City and Hackney Health and Wellbeing Profile 2011/12, Hackney council, City of London corporation
[80] City and hackney health and wellbeing profile https://www.cityoflondon.gov.uk/services/health-and-wellbeing/Documents/city-and-hackney-wellbeing-profile.pdf

London these levels have shown a significant rise in three year olds, and a small but not significant rise in five year olds.[79]

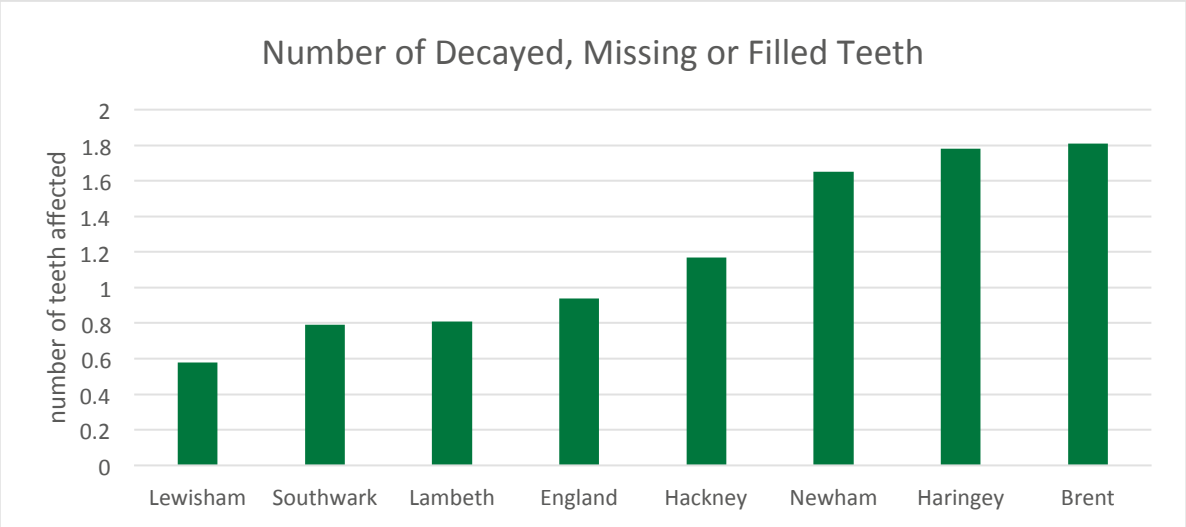
Figure 99. Percentage of 5 year old children with experience of dental decay, Hackney, England and statistical neighbours



Source: National dental epidemiology programme 2012

Nationally, of children who experience tooth decay, 3.38 teeth are affected by age five (out of 20 primary teeth). The average number of affected teeth when including those who were decay free was 0.94. In Hackney, however, the average number of affected teeth was higher at 1.17 (see Figure 100). The prevalence of decay that is related to long term bottle use is higher than the national level.

Figure 100. Average number of teeth affected by decay, Hackney, England and statistical neighbours



Source: National dental epidemiology programme 2012

The ward with the highest proportion of children affected by tooth decay is Brownswood (which is also the ward with the second highest obesity prevalence locally).[81]

There are four key programmes trying to improve dental health locally in 0-5s. Families of the youngest children are supported through the 'Smiling Start' programme which provides training for parents of children under two years of age (delivered through midwives, childminders, community nutritionists, community paediatricians and GPs) and the 'Brushing for Life' programme which promotes oral health during routine health checks by health visitors and community nurses and distributes packs of toothbrushes and toothpastes through participating Children's Centres.

As children become slightly older, they receive help to improve their own oral health through the 'Happy Smiles' programme that promotes a healthy lifestyle (mainly based in primary and secondary school-aged children, but also present in some Children's Centres) and the 'Healthy Teeth' fluoride varnish programme (which is increasingly being delivered at nurseries and primary schools to children aged between three and six years).

[For full breakdown see Appendix 9.2.2.7]

6.2.10.3 Key Findings

- Attendance at a dentist by children in Hackney and the City of London has improved over the last six years, but in 2012 remained at only 47% over the preceding two years, below the average for London (67%) and neighbouring boroughs (56% in Tower Hamlets and 66% in Newham);
- Tooth decay is more prevalent in Hackney (31.4% aged five) than England (27.9%);
- There has been a significant rise in the rate of tooth decay in three year olds, and a small but non-significant rise in five year olds, in Hackney and the City of London;
- Location: Brownswood has the highest proportion of children with tooth decay.

[81] Hackney dental health profile, dental health of five year old children, Oct 2014, PHE

6.3 FAMILY

6.3.1 Parental Substance and Alcohol Abuse

6.3.1.1 Introduction

Potential impact on children of parental alcohol misuse[10]

- Insecure attachment
- Accidental injury
- Parents may not notice when the child is unwell
- Parents may not respond to child's need for food
- Parents may be unable to respond to child's emotional and cognitive needs
- Insufficient income and poor physical standards in the home

Impact on children of parental drug dependence[10]

- Associated with difficulty meeting children's needs for safety and basic care with some degree of child neglect and emotional abuse
- Parents having difficulty in organising their own or their children's lives
- Parents being emotionally unavailable
- Parents having difficulty controlling and disciplining their children

6.3.1.2 Hackney and City of London

Hackney has a higher estimated prevalence of opiate and/or crack cocaine use across the adult population (not specifically parents) at 14.4 per 1,000 compared to 8.4 nationally. The rate of higher risk drinking in Hackney adults (19.4%) is slightly below the national average (22.3%). When considering treatment rates in parents specifically, Hackney has a similar rate of parents in drug treatment compared to national levels, and has significantly fewer parents in alcohol treatment (see Figure 101). As the prevalence of substance misuse within parents is unknown, it is unclear whether these treatment rates are a marker for prevalence (in which case Hackney is performing well), or instead represent under-treatment.

Figure 101. Rate per 100,000 children aged 0-15 with parents in drug or alcohol treatment, Hackney and England 2011/12

	Parents in drug treatment (2011/12)	Parents in alcohol treatment (2011/12)
Hackney	111.3	105.5
England	110.4	147.2

Source: Health & Wellbeing – Alcohol & Drugs, Public Health England. Figures shown indicate rates per 100,000 children aged 0 to 15 years.

In births to City of London mothers at UCLH across two years (2013-2015) fewer than ten (of approximately 80) women were recorded as having a previous substance misuse problem and no women were recorded as currently having a substance misuse or alcohol problem.

In 2014/15, 115 people who began treatment with substance misuse services in Hackney were living with children, accounting for 11% of all new service users. There are three main services that are relevant to parental substance misusers locally.

The Hackney Recovery Service was launched on 1st October 2015 and provides integrated drug and alcohol treatment for adults, alongside support for their families and carers. There is a specific family and carers' pathway and a parenting programme which includes Family Focused Outreach and Family and Couples Counselling interventions.

The Young Hackney Substance Misuse Service includes experienced treatment workers who can work with the children of parents who misuse substances to tackle this 'Hidden Harm'. In September 2015, the second Hackney Real Time Family programme was also delivered which provided a ten week group counselling programme for the most complex families.

Two Substance Misuse Liaison Midwives at HUH provide specialist support for pregnant women who have, or are at risk of, substance misuse problems. They are trained to deal with complex needs such as Foetal Alcohol Spectrum Disorders and Neonatal Abstinence Syndrome. Alongside treatment services and Children's Centres, these midwives run Orbit – a multi-agency programme supporting new parents with a history of substance misuse across the community.

6.3.1.3 Key findings

- In 2011/12 the rate of children aged 0-15 in Hackney who had parents in drug treatment was 111.3 per 100,000, similar to the England average of 110.4;
- In 2011/12 the rate of children aged 0-15 in Hackney who had parents in alcohol treatment was 105.5 per 100,000, lower than the England average of 147.2;
- In 2013-2015 no City of London mothers delivering at UCLH were recorded to have a current substance misuse or alcohol problem.

6.3.2 Domestic Violence

6.3.2.1 Introduction

Domestic violence is defined as "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality" (Home Office). This can encompass, but is not limited to, psychological, physical, sexual, financial or emotional abuse. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

One quarter of women experience domestic violence in their lifetime and over half of all violent crime experienced by women is domestic violence. Approximately 250,000 children in Britain witness domestic violence every year, and in over half of cases children are also directly abused[82]. 25% of children who witness domestic violence will go on to develop serious social and behavioural problems.[7]

Impact of domestic violence on children[10]

- Risk of physical injury during an incident
- Anxiety and distress which can express itself in anti-social or criminal behaviour
- Impact on parenting capacity and attachment
- Children exposed to domestic violence are more likely to be abused themselves than those from non-violent households

[82] Nia website: http://www.niaendingviolence.org.uk/

Many victims present with multiple needs, for example women who experience domestic violence are up to 15 times more likely to misuse alcohol and up to nine times more likely to misuse substances. It is therefore recognised that an integrated partnership response is the most effective way to tackle domestic violence. The Multi Agency Risk Assessment Conference (MARAC) is a local, multi-agency, victim-focussed meeting where information is shared between different statutory and voluntary sector agencies on the highest risk cases of domestic violence to try and address complex needs.

In Hackney, services are provided by the Nia project for women, children and young people who have experienced male violence. Services provided by Nia include:

- An Independent Domestic Violence Advocacy Service supporting women who have been identified as at "high risk" of domestic violence through referral from the Police or any agency referring into the MARAC.
- The national IRIS Project which improves the quality of care given by GP surgeries to women experiencing domestic violence which is delivered locally in Hackney.
- Play Therapy – a service for children and young people affected by domestic violence to help them understand and deal with their feelings and painful events.

A UK study has estimated that 60,000 girls under 15 years old in England and Wales in 2011 had been born to mothers who had undergone FGM[83]. Furthermore, approximately 10,000 girls under 15 who have migrated to England and Wales are likely to have undergone FGM[84]. London has the highest prevalence of FGM of any UK city with an estimated 2.1% of women affected[85]. Since April 2014 it is mandatory for NHS healthcare professionals to record FGM in a patient's healthcare record if identified through the delivery of healthcare services[86] and from October 2015 it will be a mandatory requirement for healthcare professionals, teachers and social care workers to notify the police if they discover that an act of FGM appears to have been performed on a girl under 18 years old.

6.3.2.2 Hackney and City of London

In Hackney it can be expected that, of all women and girls aged 15-69 in 2010, 5245 were the victim of domestic violence, 5687 were the victim of sexual abuse and 9,281 were the victim of stalking. However, in 2009/10 there were only 4,665 reports of domestic violence to the police in Hackney.[87] A study involving 1207 women attending Hackney GP surgeries found that women who had been pregnant in the past year had an increased risk of current violence.[10]

In 2013/14 the total number of domestic abuse incidents reported by the City's Domestic Abuse Forum (DAF) was 145 (crime and non-crime incidents). Of these, 110 were female victims and 34 were male victims (1 not stated). From January to October 2014 80% of child

[83] http://www.trustforlondon.org.uk/wp-content/uploads/2014/01/FGM-statistics-report-July-14.pdf
[84] Macfarlance & Dorkenoo 2014
[85] Prevalence of FGM in England and Wales: National and Local Estimates available at http://www.trustforlondon.org.uk/wp-content/uploads/2015/07/FGM-statistics-final-report-21-07-15-released-text.pdf
[86] FGM Prevention Programme: Requirements for NHS staff - Statement by the Department of Health and NHS England
[87] Hackney Domestic and Gender Violence Strategy 2011-2013

protection investigations with City families had domestic abuse as a risk factor. This is above the national average.[88]

One method of establishing whether a woman is experiencing domestic violence is for midwives to ask during the booking visit. Of 6,991 births by residents of Hackney and the City of London at HUH in 2013/14-2014/15 65% of records included information on domestic violence screening. Of those with a status recorded, 2.3% had experienced domestic violence (however, this figure is not robust given the low screening rate). There were no statistically significant patterns in screening rates by age. White women were less likely to have their domestic violence status recorded than women of a BME. Within White populations, people who are Turkish are least likely to have their status recorded (55.8%). There are no statistical differences between screening rates across Children's Centre areas.

HUH has been recording data about FGM in antenatal services prior to it becoming a mandatory requirement. Over a six year period (2008-2014) and approximately 36,000 births women disclosed a history of FGM on 245 occasions – equating to a prevalence of 0.7%. Data from the annual school census has revealed that approximately 3,000 girls each year are recorded as being from an ethnic group associated with a country that practices FGM. 60 referrals were made to Children's Social Care with concerns about a risk of FGM over a 10 month period in 2014/15, but in no cases did the girl have FGM performed. Conversely, there are no girls aged 0-15 living in the City of London who were born in countries where FGM is prevalent[89] and a study performed between 2005 and 2013 found that ten women with FGM had given birth in the City of London (so it is likely that only five births may have been to girls).[90]

[For full breakdown see Appendix 9.2.3.1]

6.3.2.3 Key findings

- In Hackney it has been estimated that, of all women and girls aged 15-69 in 2010, 5245 were the victim of domestic violence, 5687 were the victim of sexual abuse and 9,281 were the victim of stalking. However, in 2009/10 there were only 4,665 reports of domestic violence to the Police in Hackney;
- Domestic violence status was recorded in 65% of births by City and Hackney residents at HUH and 2.3% of these had experienced domestic violence;
- Ethnicity: White women are less likely than BME women and Turkish women are the least likely to have their domestic violence status recorded during pregnancy;
- 0.7% of women were recorded as having had Female Genital Mutilation (FGM) during their maternity booking visit at HUH (2008-2014);
- 60 referrals were made to Children's Social Care 2014/15 for potential risk of FGM – in no cases the girl had FGM performed.

[88] Strategic review of domestic abuse, City of London Corporation, February 2015

[89] Tackling & Preventing Female Genital Mutilation (FGM) - City and Hackney Strategy 2015 -2018

[90] Forward, ONS 2015

6.3.3 Safeguarding

6.3.3.1 Introduction

A report by the NSPCC, All Babies Count[1], found that 45% of serious case reviews in England relate to babies under the age of one year, and in England and Wales babies are eight times more likely to be killed than older children. They highlight the antenatal risk assessment as an area which could be strengthened. The report's principles are outlined below.

Every baby needs love, care and nurture

- The quality of parent-infant interaction is paramount
- Interventions that foster secure attachment can prevent abuse and poor parenting
- Parents' capacity for reflective functioning (or 'keeping the baby in mind') is likely to be instrumental to their ability to provide effective care
- Physical punishment of babies is ineffective and unacceptable

Services need to 'think family'

- Both adults' and children's services need to take the family context into account
- Adults' services need to consider their clients as parents
- Father figures have a profound impact on families and should share centre stage in strategies for intervention

It's never too early

- Promoting informed choices and resilience pre-conception creates the conditions for families to thrive
- The antenatal period is vital for child development and parenthood preparation

Prevention: we must do all we can to stop abuse before it starts

- Primary: Universal service providers, such as midwives, health visitors, children's centre workers and GPs play a crucial role in health promotion, identification of risk and delivery of support that can prevent maltreatment in the first place
- Secondary: Targeted services supporting specific vulnerable groups or risk factors can help to prevent abuse and neglect

It's never too late: we must stop abuse happening again

- Children's services have a crucial role in helping to avoid the recurrence of abuse and to minimise the short and long term harms to children
- Therapeutic support for children who are abused may also act as a means of prevention for the next generation

The Ofsted report 'Learning lessons from serious case reviews 2009-2010[91] examined the reviews of 194 children. Some of their key findings included:

- 36% were less than one year of age and 60% of the children were under five
- 46% of the children had died – of these, 40% were less than one year of age and 57% of the children who died were under five
- The most common features of involved families were domestic violence, mental ill health, and drug and alcohol misuse – often multiple issues were present
- Some parents were receiving their own support from agencies including adult social care, adult mental health, substance misuse, housing and probation. Often these services held important information but too often this was not shared early enough

The follow up Ofsted report in 2011 'Ages of concern: Learning lessons from serious case reviews'[92] covered 482 serious case reviews from April 2007 to March 2011. The report identified recurring messages concerning infants less than one year old:

- There were shortcomings in the timeliness and quality of pre-birth assessments
- The risks resulting from the parents' own needs were underestimated
- There had been insufficient support for young parents
- The role of fathers had been marginalised
- There was a need for improved assessment of, and support for, parenting capacity
- Practitioners underestimated the fragility of the baby
- There was a need for better coordination between the different bodies involved with safeguarding babies, particularly between midwives, health visitors and GPs
- Health professionals with significant opportunities for direct contact with families too often did not detect potential risks to vulnerable babies

There is evidence to suggest that early intervention by midwives or other health engagement at Children's Centres can directly reduce young children's risk of poor outcomes. These include a reduced incidence of low birth weight and foetal or postnatal injury, reduced risk of poor bonding, reduced child neglect and abuse, and an increased uptake of preventative health care.[10]

[91] Learning lessons from serious case reviews 2009-2010, Ofsted
[92] Ages of concern: Learning lessons from serious case reviews, Ofsted, 2011

Child Protection

Child protection involves taking steps to safeguard vulnerable children at risk of suffering from abuse – be it physical, emotional or sexual.

If there are concerns that a child may be at risk the first step is for the concerned person to speak with a social worker in the First Access and Screening Team (FAST) who use the information to consider what advice or action needs to happen next. FAST social workers are co-located with health visitors who can help to provide further information and assess risk. If they believe that a child may be in need of a statutory social work assessment they will allocate the matter to one of the social work units in Children's Social Care.

The City and Hackney Children's Safeguarding Board (CHSB)[93] is a multi-agency statutory body whose responsibility is to safeguard and promote the welfare of children through sharing information and practice across agencies. The board develops and sets policies, monitors and audits their implementation, provides training, and promotes community awareness.

Protecting children is everyone's responsibility. As such, and due to the nature of their role, health visitors have an important part to play in child protection and safeguarding children is an essential component of the service and a public health priority.[94]

6.3.3.2 Hackney

As at 31st March 2015 there were 216 children subject to a Child Protection Plan in Hackney. This was a decrease from 221 in 2014. The initial categories of abuse for children subject to a Child Protection Plan as at 31st March 2015 were:

- Neglect (36%)
- Physical abuse (10%)
- Sexual abuse (4%)
- Emotional abuse (47%)
- Multiple reasons (3%)

On 31 March 2015 there were 343 Hackney children who were looked after by the local authority. This number had increased from 330 in 2014 and from 320 in 2013.

Figure 102. Number of Hackney looked after children at 31st March, 2011-2015

	2011	2012	2013	2014	2015
Hackney	270	315	320	330	343

Source: Children's Social Care Bi-Annual Report to Members, July 2015

[93] http://www.chscb.org.uk/content/1/about-the-city-and-hackney-safeguarding-children-board
[94] 2015 – 16 National Health Visiting Core Service, NHS England Specification http://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf

Children of Black ethnicity account for nearly half of the looked after children in Hackney, whereas children of White ethnicity account for less than a third (Figure 103).

Figure 103. Ethnicity breakdown of Hackney looked after children (March 2015)

Ethnicity	%
Black or Black British	45
White	28
Mixed	19
Asian or Asian British	6
Other ethnic origin	2

Source: Children's Social Care Bi-Annual Report to Members, July 2015

6.3.3.3 City of London

The number of City of London children and families requiring statutory social care interventions is low compared with other local authorities. Very few children (six) were subject to a child protection plan in the City of London in 2012/13.

The City of London had five children who were looked after by the local authority as of March 2013. This was the same as the previous year, and half as many as in 2011 (Figure 104). The majority of these children are unaccompanied asylum-seeking children.

Figure 104. Number of looked after children in the City of London 2009-2013

	2009	2010	2011	2012	2013
City of London	15	15	10	5	5

Source: Health and wellbeing profile

6.3.3.4 Hackney and City of London

The Common Assessment Framework (CAF) is used to identify the additional needs that a child and family may have, and how best to provide services to meet those needs.

In 2013/14 there were 373 new CAFs, down from 452 in the previous year (Figure 105) due to cessation of CAFs being used alongside two year old child care applications.

Figure 105. Number of new CAFs by Children's Centre area [95]

	A	B	C	D	E	F	Total
2011/12	92	123	109	72	94	60	550
2012/13	98	82	78	68	72	54	452
2013/14	61	61	52	85	53	61	373

Source: Hackney Learning Trust

23% of CAFs were initiated by health visitors in 2013/2014, similar to 22% in the previous year (Figure 106).

Figure 106. Number of CAFs initiated by health visitors by Children's Centre area

	A	*B*	*C*	*D*	*E*	*F*	*Total*	*% of all CAFs*
2012/2013	21	16	16	13	21	12	99	22%
2013/2014	9	10	17	16	15	20	87	23%

Source: Hackney Learning Trust

6.3.3.5 Key Findings

- 216 children were subject to a child protection plan in Hackney as of 31st March 2015, not dissimilar from 221 in 2014. The number of looked after children had shown a small rise from 330 to 343 over the same period;
- Ethnicity: 45% of looked after children in Hackney are of Black ethnicity, whereas children of White ethnicity accounted for 28%;
- The City of London had only five looked after children in both 2012 and 2013.

[95] Note: Reduction in new CAFs due to cessation of CAFs alongside 2 year child care applications

7 RAPID REVIEW RECOMMENDATIONS AND NICE GUIDANCE

This rapid review was undertaken by Public Health England[13] to update the evidence underpinning the Healthy Child Programme prior to the transfer of commissioning responsibilities to local authorities. The aim of the review was to synthesise relevant systematic review level evidence about 'what works' in key areas and draw out themes around identifying and helping families in need of additional support, workforce skills and the economic value/cost benefits of the HCP.

The review includes systematic review level evidence published from 2008-2014, and focuses on universal, selective, and indicated interventions. The reviewers also performed searches for primary evidence, notably randomised controlled trials (RCTs), where they considered that significant new data had been published since the most recent systematic review. It did not include evidence related to aspects of the HCP that will continue to be commissioned by NHS England (i.e. immunisation/vaccination programmes), targeted programmes that are delivered with health visitors but not necessarily led by them, or the Family Nurse Partnership programme.

Maternal mental health	Rapid review recommendations	Relevant NICE guidance: ➢ Antenatal and postnatal mental health CG192 (Dec 2014) ➢ Postnatal care CG37 (Dec 2014) ➢ Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence CG 115 (Feb 2011)
Identification of ante-/postnatal anxiety and depression		• CG 192 - At a woman's first contact in pregnancy until one year after birth healthcare professionals should consider asking the following two Whooley depression identification questions, as part of a general discussion about a woman's mental health and wellbeing: 1. During the past month, have you often been bothered by feeling down, depressed or hopeless? 2. During the past month, have you often been bothered by having little interest or pleasure in doing things? Also consider asking about anxiety using the 2-item Generalised Anxiety Disorder scale (GAD-2) 1. During the past month, have you been feeling nervous, anxious or on edge? 2. During the past month have you not been able to stop or control worrying? • CG 192 – If a woman responds positively to any of the above questions or is at risk of developing a mental health problem or there is a clinical concern, consider using the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9) or GAD-7 scale for further assessment. Alternatively they could refer the patient to their GP or a mental health professional if a severe mental health problem is suspected • CG 37 - At each postnatal contact women should be asked about their emotional wellbeing, what family and social support they have and their

		usual coping strategies for dealing with day-to-day matters • CG 37 - Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern • CG 37 - All healthcare professionals should be aware of signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after the birth • CG 37 - At 10–14 days after birth, women should be asked about resolution of symptoms of baby blues (for example, tearfulness, feelings of anxiety and low mood). If symptoms have not resolved, the woman should be assessed for postnatal depression, and if symptoms persist, evaluated further (urgent action) • CG 192 – If a woman has sudden onset of symptoms suggesting postpartum psychosis she should be referred to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within 4 hours of referral)
Identification of severe mental illness and alcohol/ substance dependency		• CG 192 - Women should be asked about any past or present severe mental illness or specialist mental health service treatment and if either question are responded to positively, be referred to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment. Women should also be asked about any severe perinatal mental health illness in a first degree relative. If any of the above questions were responded to positively, all healthcare professionals should be alert for symptoms of postpartum psychosis in the first 2 weeks after childbirth • CG 192/CG 115 - If alcohol misuse is suspected, the alcohol use disorders identification test (AUDIT) should be used and appropriate referral made if indicated • CG 51 – If drug misuse is suspected, women should be asked if they have used drugs and if so: of what type and method of administration, in what quantity and how frequently and appropriate referral made if drug use identified
Prevention of antenatal/	• There is insufficient evidence of the benefits of feedback during ultrasound and a variety of alternative therapies in preventing	• CG 37 - Women should be encouraged to help look after their mental health by looking after themselves. This includes taking gentle exercise, taking time to rest, getting help with caring for the baby, talking to

postnatal depression	maternal anxiety or stress during pregnancy • Women who receive a targeted intervention for prevention of postnatal depression are significantly less likely to develop it than those who receive standard care • Promising interventions include: interpersonal psychotherapy, intensive home visiting by professionals, peer-led telephone support (evidence inconsistent on the latter) • Interventions currently not supported by evidence include ante natal classes that address postnatal depression, lay-based home visiting and in-hospital psychological debriefing • Group-based parenting programmes can improve a number of aspects of maternal mental health, including depression and anxiety, although they are not recommended as primary treatments	someone about their feelings and ensuring they can access social support networks
Treatment of antenatal/ postnatal depression		• CG 192 – All interventions for mental health problems should be delivered by competent practitioners, based on relevant treatment manuals, with practitioners receiving regular high-quality supervision, using routine outcome measures and with monitoring and evaluation of treatment adherence and practitioner competence • CG 192 – When a woman with a known or suspected mental health problem is referred in pregnancy or the postnatal period, assessment for treatment should take place within 2 weeks and psychological interventions provided within 1 month of initial assessment • CG 192 – Interventions should be provided within a stepped-care model of service delivery • CG 192 – Women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit
Treatment of antenatal/ postnatal anxiety		• Women with persistent sub-threshold symptoms should be offered facilitated self-help, using CBT over 2-3 months for a total of 2-3 hours over 6 sessions • Women with anxiety disorders should be offered low intensity psychological intervention e.g. facilitated self-help or high intensity psychological intervention e.g. cognitive behavioural therapy (CBT) as initial treatment

Treatment of other mental health problems		• Makes a range of recommendations specific to each mental health problem
The mother-baby relationship		• CG 192 - The nature of the relationship, including verbal interaction, emotional sensitivity and physical care should be assessed at all postnatal contacts and any concerns the mother may have regarding the relationship discussed. If problems do not resolve further intervention to improve the relationship should be considered
Implementation issues		• CG 192 - Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, service users and carers. Aim to provide a specialist multidisciplinary perinatal service which is able to provide direct services, consultation and advice to maternity services, other mental health services and community services • CG 192 - clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental health problems, to ensure effective transfer of information and continuity of care • CG 192 - pathways of care for service users, with defined roles and competencies for all professional groups involved
Workforce skills and training		• CG 192 - All healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should understand the variations in their presentation and course at these times, how these variations affect treatment, and the context in which they are assessed and treated

Smoking	Rapid review recommendation	NICE guidance: ➢ Quitting smoking in pregnancy and following childbirth PH26 (June 2010) ➢ Smoking cessation in secondary care: acute, maternity and mental health services PH 48 (Nov 2013)
Antenatal	• Psychosocial interventions during pregnancy can increase the proportion of women who stop smoking in late pregnancy, incentive based interventions show the largest effect, although caution is needed as they were only effective with intensive delivery and studies were in the US • Financial incentives show promise, and may meet the treatment needs of socio-economically disadvantaged women and heavy smokers • There is insufficient evidence to assess the efficacy, safety, or impact on birth outcomes of nicotine replacement therapy when used to promote smoking cessation during pregnancy • The provision to pregnant women of feedback on its own (i.e. not in conjunction with other strategies, such as counselling) about the effects of smoking on the unborn child and on their own health is not effective in smoking cessation • Proactive telephone counselling is effective in helping to reduce smoking in smokers who seek help from quit-lines • Self-help smoking cessation interventions appear to be effective but it is unclear whether more sophisticated , intensive approaches increase effectiveness • A review of smoking cessation relapse prevention interventions found no effect overall or by type or timing for behavioural relapse prevention interventions for pregnant or postpartum women • The evidence for the efficacy of interventions to establish smoke free homes in pregnancy and in the neonatal period is inconclusive • Specific behaviour change components within effective behavioural smoking cessation interventions include: rewards based on smoking cessation, utilising carbon monoxide measures, facilitating relapse prevention, information on consequences of smoking and cessation, facilitating problem-	• PH26 - Provide all women with information about the risks of smoking to her and the unborn baby • PH 26 - Tell partners and family members about NHS stop smoking services • PH 26 – Use carbon monoxide (CO) breath test at booking and record smoking status and CO level • PH 26 - Refer to stop smoking services: those women who say they smoke, women with a CO reading around 7ppm, women who say they have quit in the last 2 weeks and give NHS pregnancy Smoking helpline number and record in the notes. • PH 26 - Check if referral was taken up at next appointment, offer repeat referral, continue to review at subsequent appointments • PH 26 - All healthcare professionals should use any appointment or meeting as an opportunity to ask women if they smoke and if they do explain how NHS services can help people to quit and offer referral and give smoking helpline number and if trained, information on the risks of smoking to the unborn child • PH 26 - Studies have shown that cognitive behaviour therapy, motivational interviewing and structured self-help and support from NHS stop smoking services are all effective in helping women who are pregnant stop smoking • PH 26 - In other countries the provision of incentives to quit has been shown to be effective with this group • PH 26 - Interventions using a stages of change approach have had mixed success and giving feedback to pregnant women on the effects of smoking on the unborn child and on their own health (such as reports of urinary cotinine levels) is not effective

	solving, identifying relapse triggers, goal setting, assessing current and past smoking behaviour, assessing readiness to quit, appropriate written materials and facilitating social support	
Postnatal	• There is insufficient evidence to recommend one strategy over another to reduce the prevalence of children's environmental tobacco smoke exposure • Effective relapse prevention included: office based advice, education and discussion from a doctor postpartum and home and telephone counselling interventions based on motivational interviewing techniques	• PH 26 – No specific recommendations have been made for postnatal smoking cessation due to lack of evidence available for smoking intervention in this group
Identifying families with additional needs	• Women who quit smoking during pregnancy may demonstrate higher rates of relapse after pregnancy so may need additional support	
Implementation issues	• Barriers include healthcare professionals having different perceptions of their role in smoking cessation and negative perceptions about the efficacy of interventions	• PH 26 - Training should address barriers any barriers healthcare professionals may feel towards broaching smoking cessation, such as concerns about damage to their relationship with the pregnant woman • PH 48 – Ideally, pregnant or breastfeeding women should stop smoking without using licensed nicotine containing products, but if this is not possible, these products may be used
Workforce and training	• An assessment of the presence of effective behavioural change techniques within English stop smoking services concluded that only a limited number were used in practice	• PH 26 – health visitors (HVs) and other healthcare professionals should be trained to the standard of midwives who are not specialist smoking cessation advisors. They should understand the risks of smoking to women and children/unborn babies, the significant role of partners, and what NHS stop smoking services provide and how to make a referral to them (for both the woman and any 'significant others' who smoke) • PH 48 – Ensure online training can be completed and updated annually as part of NHS mandatory training

Drugs and alcohol	Rapid review recommendations	NICE guidance: ➢ Drug misuse – psychosocial interventions CG 51 (2007) ➢ Alcohol-use disorders: preventing harmful drinking PH 24 (June 2010) ➢ Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence CG 115 (Feb 2011) ➢ Antenatal and postnatal mental health: clinical management and service guidance CG 192 (Dec 2014) ➢ Pregnancy and complex social factors CG 110 (Sep 2010)
Antenatal	• Integrated and non-integrated interventions: There is some evidence that both integrated (e.g. comprehensive services that address substance misuse as well as maternal and child wellbeing through prenatal services, parenting programmes, child care and/or other child centred services in a centralised setting) and non-integrated (e.g. standalone substance misuse treatment) programmes can improve some birth outcomes for infants of women who have substance misuse problems during pregnancy. Integrated programmes showed a small improvement in parenting, but not on child protection outcomes • There is some evidence that substance abuse programmes integrated with onsite pregnancy, child or parenting services are effective in reducing maternal substance use, but no evidence that they are more effective at reducing substance use than standalone interventions	• CG 51/PH 24/CG 192 - If hazardous drug or alcohol misuse is identified during pregnancy or postpartum the woman should be referred or offered brief interventions, these typically provide information and advice and seek to motivate participants to change their behaviour • CG 192 – If harmful or dependant drug or alcohol misuse is identified in pregnancy or the postnatal period, refer the woman to a specialist substance misuse service for advice and treatment • CG 192 – Offer assisted alcohol withdrawal in collaboration with specialist mental health and alcohol services (preferably in an inpatient setting) to pregnant women who are dependent on alcohol. Work with a woman who does not want assisted alcohol withdrawal to help her reduce her alcohol intake • CG 192 – Offer detoxification in collaboration with specialist mental health and substance misuse services to pregnant women who are dependent on opioids. Monitor closely after completion of detoxification. Work with a woman who does not want detoxification to help her reduce opioid intake. Recognise the risk of accidental overdose

		in women who stop or reduce drug misuse I pregnancy but start misusing again after childbirth • CG 51 - A range of psychosocial interventions are effective in treating drug misuse, including contingency management, behavioural couples therapy for drug specific problems, various evidence based psychological interventions such as CBT • CG 192 - If harmful or dependent drug or alcohol misuse is identified the woman should be referred to a specialist substance misuse service for advice and treatment, this may entail psychosocial or psychological interventions • CG 115 - For Harmful levels of drinking and mild alcohol dependence offer psychological interventions (CBT, behavioural therapies or social network and environment based therapies), focused specifically on alcohol related cognitions, behaviour, problems and social networks. Offer behavioural couples therapy if regular partner is willing to participate. • CG 110 – Address women's fears about the involvement of children's services and potential removal of their child by providing information tailored to their needs
Postnatal	• There is little evidence for the effectiveness of home visiting interventions that address substance misuse during the postnatal period	• CG 192 – If there has been alcohol or drug misuse during pregnancy, offer treatment and support after childbirth including continuing psychological treatment and support for the woman and monitoring of the baby. A full neonatal assessment for any congenital abnormalities or neonatal adaptation syndrome should be carried out
Implementation		• CG 51 - staff should discuss with people whether to involve their families and carers in assessment and treatment plans, and to support families as appropriate

Workforce skills and training		• CG 115/CG 51 - all interventions for people who misuse alcohol/drugs should be delivered by staff who are competent in delivering the intervention and receive appropriate supervision • CG 110 – healthcare professionals should be given training on the social and psychological needs of women who misuse substances, and training on how to communicate sensitively with them

Intimate partner violence (IPV)	**Rapid review recommendations**	**NICE guidance:** ➢ **Postnatal care CG 37 (Dec 2014)** ➢ **Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively PH 50 (Feb 2014)** ➢ **Pregnancy and complex social factors CG 110 (Sep 2010)**
Prevention and identification of IPV	• There is insufficient evidence on the benefit of interventions to justify universal screening for IPV in healthcare settings • There is insufficient evidence for the efficacy of primary prevention programmes relating to IPV • While screening programmes increased screening, disclosure and identification rates, referrals to specialist agencies and services did not increase. There is no evidence that screening impacts on levels of violence or positive health outcomes • Self-administered screening instruments were more likely to encourage disclosure than face to face screening interviews, no screening tool could be identified as more effective than any other • Prevention and screening efforts for FGM are best framed in relation to benefits for women's health rather than opposing	• PH 50 – While insufficient evidence was found to recommend screening/routine enquiry, it is viewed as best practice by some professionals. Therefore it is recommended that trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services should ask service users whether they have experienced domestic violence and abuse, as routine practice even if there are no indicators. They should also be aware of local services and their referral pathways • PH 50 - Ensure people who may be experiencing domestic violence can be seen on their own • PH 50 – Ensure interpreting services are confidential and professional interpreters used • PH 50 – Practitioners should prioritise people's safety

	traditional practices or beliefs about women's rights. Training local healthcare staff may be beneficial if developed and sustained	• PH 50 – People should be referred from general services to domestic violence and abuse services if they need additional support, or immediate support. This includes advocacy, floating support, outreach support and refuges. This also includes housing workers, independent IPV advisers or a multi-agency risk assessment conference for high risk clients • PH 50 – People who have experienced IPV and have a mental health condition should receive evidence based treatment for that condition
Interventions to support pregnant women at high risk of IPV	• The evidence supports the use of multi-session psychological therapy, based on CBT, during pregnancy for women who are at risk of or who have experienced IPV. Women who receive such support are less likely to have recurrent episodes of abuse compared to those receiving standard care • Perinatal HV programmes that screen for IPV can identify significant numbers of cases, but are unlikely to reduce IPV and improve maternal and infant health unless effective interventions are implemented • Intensive advocacy may be effective in reducing physical violence for women leaving shelters two years later but not within the first year. There is insufficient evidence to support less intensive advocacy programmes • There is no evidence to support interventions to respond to pregnant women who have experienced FGM. Alternative evaluation designs should be considered	
Preventing further IPV and the adverse consequences of IPV	• There is evidence for the effectiveness of a range of different types of intervention concerned with preventing IPV, or re-abuse, and the adverse consequences of IPV (e.g. for parental mental health). These include advocacy services, skill building, counselling therapy, and multi-component interventions	• PH 50 – Specialist domestic violence and abuse services should be provided for children and young people that address the emotional, psychological and physical harms of IPV that matches the child's developmental stage (e.g. infant), interventions should be timely and continue over a long enough period to achieve lasting effects

	• There is evidence for the effectiveness of single component therapeutic interventions aimed at the mother and child (including young children) in improving child behaviour, mother-child attachment and stress and trauma related symptoms in mothers	• PH 50 – Interventions that aim to strengthen the relationship between the child and the non-abusive parent should be provided, including individual or group sessions or both and sessions should include advocacy, therapy and support that addresses the impact of IPV on parenting
Group based interventions for perpetrators of IPV	• There is insufficient evidence to draw clear conclusions about the effectiveness of CBT with men who had physically abused their female partner • A review of a broader range of interventions including CBT, psychoeducational and pro-feminist (Duluth) models found a number of positive outcomes but was unable to attribute these results to particular intervention programmes • The effectiveness of perpetrator programmes is largely limited to an assessment of their impact on criminal justice outcomes, such as arrest, assault and aggression. There is scope to extend evaluation work to include other measures of behaviour change	• PH 50 - commission and evaluate tailored interventions in accordance with national standards, ensure interventions primarily aim to increase the safety of the perpetrator's partner and children and link perpetrator services with services providing specialist support for those experiencing IPV
Identifying families in need of extra support		• CG 37 - Relevant healthcare professionals should have demonstrated competency and sufficient ongoing clinical experience in recognising the risks, signs and symptoms of domestic abuse and whom to contact for advice and management • CG 110 – Ensure a local protocol is written that is developed jointly with social care providers, the police and third sector agencies and includes referral pathways, sources of support and safety information for women
Implementation issues		• PH 50 – Provide those currently or recently affected by domestic violence and abuse with advocacy and advice services tailored to their level of risk and specific needs. The support should be offered (although not necessarily delivered) in settings where people may be identified or disclose that domestic violence and abuse is occurring

Workforce skills and training		• PH 50 - Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences • PH 50 – Provide ongoing training and regular supervision for staff who may be asking people about domestic violence and abuse • PH 50 – Level 2 staff (including HVs) should be trained to ask about IPV in a way that makes it easier for people to disclose it. Level 3 staff (including HV with additional IPV training) should be trained to provide an initial response that includes risk identification and assessment , safety planning and continued liaison with specialist support services • PH 50 – Ensure staff know how to refer children and young people to child protection services if they are affected by IPV, and also how to contact safeguarding leads, senior clinicians or managers for advice on whether referral would be appropriate. Ensure staff know about the services, policies and procedures for relevant local agencies
Preparation and support with childbirth and the transition to parenthood	**Rapid review recommendations**	**NICE guidance:** ➢ **Pregnancy and complex social factors CG 110 (Sep 2010)**
Antenatal education	• There is insufficient evidence that techniques taught in traditional childbirth classes can reduce pain in labour, there is evidence that participation in such classes can increase satisfaction with birth experience • For antenatal education there is: no evidence of impact on low birthweight; limited evidence of impact on parental health behaviours, including personal responsibility for healthcare,	• CG 110 – For young pregnant women aged under 20 a specialist antenatal service should be considered and may include: antenatal care and education in peer groups in a variety of settings and antenatal education in peer groups offered at the same time as antenatal appointments in a ‘one-stop shop’

	exercise and nutrition; and no evidence of impact on the onset of depression, but some evidence to show that group-based social support, including antenatal preparation for parenthood classes can be effective in supporting women with sub-threshold symptoms of depression and anxiety. Antenatal group work which has an interactive component and involves local experienced breastfeeders as volunteers is among a range of effective interventions to support the initiation and continuation of breastfeeding • No studies were found for the effectiveness of group-based antenatal education involving drug dependant pregnant women • There is limited evidence of the effectiveness of multimodal programmes for adolescent parents that included a combination of nurse home visiting and/or enhanced Doula programmes with group based social support • BME parents value information about potential conflicts that may arise between cultural mores and messages communicated in antenatal classes. Limited evidence has found that parents from some minority ethnic groups also value the opportunity to attend classes in community-based settings rather than city centre hospitals	
Antenatal preparation for parenthood programmes	• Antenatal programmes that focus on the transition to parenthood in high-risk couples and aim to alleviate pressures on the couple's relationship are effective in reducing relationship deterioration and strengthening parenting roles after the birth of a first child. The strongest effect is for home-based interventions for couples with multiple difficulties, so since they are expensive they are recommended as part of a stepped care approach	
Antenatal education for fathers	• Review-level evidence of the impact of antenatal classes on men's preparations for their partner's labour, birth and early fatherhood shows that fathers-to-be benefit from participation in adjunctive,	

	men-only sessions within standard antenatal classes, and that adolescent fathers benefit from participation in men-only preparation for fatherhood groups	
Identifying families with additional needs	• Psychoeducation for the transition to parenthood might only be necessary for couples assessed as being high-risk for future adjustment problems, suggesting that a stepped care approach is warranted	
Implementation issues	• Care needs to be taken to provide support that is accessible and attractive to expectant parents in higher-risk groups (e.g. teenage mothers) and in minority groups. Men value preparation for parenthood that includes a focus on fatherhood, which may involve men only sessions or sessions led by experienced fathers • Prenatal education designed to enhance couple relationship functioning or parenting, or to prevent relationship deterioration after the birth of a first child, found that best outcomes are achieved with programmes that are: designed for couples with high level of needs due to a combination of social, personal and relational difficulties, involve skills training; and are delivered in the couples own home	
Workforce skills and training	• The delivery of home visiting programmes by professional staff produces more positive effects on parent and child outcomes than delivery by para-professionals or volunteers	
Attachment	**Rapid review recommendations**	**NICE guidance:** ➢ **CG37 Postnatal care (Dec 2014)** ➢ **Antenatal and postnatal mental health: clinical**

		management and service guidance CG 192 (Dec 2014)
Identification of problems with attachment		• CG 37 - Assessment for emotional attachment should be carried out at each postnatal contact • CG 37 - Home visits should be used as an opportunity to promote parent- or mother-to-baby emotional attachment • CG 37 - Women should be encouraged to develop social networks as this promotes positive mother-baby interaction • CG 37 - Healthcare providers should offer fathers information and support in adjusting to their new role and responsibilities within the family unit • CG 192 – Recognise that some women with a mental health problem may experience difficulties with the mother-baby relationship, assess the nature of the relationship and discuss concerns, consider further intervention to improve the relationship if problems do not resolve
Kangaroo Mother Care (KMC)	• KMC in low birthweight infants an increase some measures of infant growth, breastfeeding and mother-infant attachment • Early skin-to-skin care appears to benefit breastfeeding outcomes and cardio-respiratory stability and decrease infant crying, with no apparent short-or long-term negative effects	
Infant massage	• There is no evidence to support the use of infant massage on a population basis but some evidence to support its use with disadvantaged and depressed mothers of babies	
Mentalisation-based programmes	• There is some evidence to suggest that mentalisation-based programmes are effective in reducing rapid subsequent childbearing, reducing the risk of child abuse, improving mental health and improving maternal reflective functioning	

Video-feedback	• There is good evidence to suggest that video-feedback and Video-feedback Intervention to promote Positive Parenting (VIPP) can improve parental sensitivity and improve secure attachment. There is also evidence of improvement in both internalising and externalising problems, in older children, VIPP can also improve emotional availability, child behaviour and family environment. There is also evidence of improved attachment security in highly (but not moderately) irritable infants	
Home visiting programmes	• There is evidence from one review supporting the use of home visiting to improve maternal behaviours, including sensitivity and limited evidence to support its use with preterm infants	
Sensitivity focused interventions for preterm infants	• Some brief sensitivity-focused interventions (e.g. Mother-infant Transaction Programme; Nursing Systems Towards Effective Parenting-Preterm; Guided interaction) may be effective in improving maternal sensitivity in mother of preterm infants	
Parent-infant/toddler psychotherapy	• There is evidence that this can improve infant attachment security, and limited evidence to show improvements in a range of aspects of child functioning in traumatised children (e.g. child depression, co-occurring diagnoses, child behaviour, maternal post-traumatic stress disorder and maternal depression)	
Attachment and Biobehavioural Catch up (ABC)	• Limited evidence to show reduced negative affect expression and higher levels of secure attachment and reduced disorganised attachment, although the findings for attachment were not sustained over time	
Group-based programmes	• There is limited evidence to show that a group based programme with adjunctive components can improve maternal depression and some aspects of parent-infant interaction	
Implementation	• One robust review concludes that the most effective programmes for promoting attachment are shorter in duration, provide direct	

issues	services to the parent-child dyad, use interveners with professional qualifications and assess parent-child interactions with free-play tasks • Recent reviews on the promotion of attachment security in preterm infants recommend routine inclusion of psychosocial support for the infant's mother. One study found different effects among families of higher and lower educational groups, and recommends additional reinforcement sessions for mothers in lower educational groups • Infant massage programmes are most effective with parents in the middle tier of need, and should not be used on their own for parents who are high risk. A total of 14 mechanisms need to be present to promote the likelihood of massage programmes being effective, including consistency of facilitator, small groups that are provided in appropriate settings, the teaching of infant cues, and opportunities for parental socialisation	
Workforce skills and training	• International Association of Infant Massage training provides practitioners with better preparation to deliver infant massage training compared with other programmes	
Parenting support	**Rapid review recommendations**	**NICE guidance:** ➢ **Postnatal care CG 37 (Dec 2014)**
Parenting programmes	• A review of targeted self-administered programmes for parents of children aged 2-9 years found that self-administered programmes led to outcomes similar to those achieved with more intensive therapist input • The evidence supports the use of targeted group-based parenting programmes to improve the emotional and behavioural adjustment of children aged 0-3 years and reduce conduct problems in that age-group	• CG 37 - Group based parent-training programmes designed to promote emotional attachment and improve parenting skills should be available to parents who wish to access them • CG 37 - Parents, family members and carers should be offered information and reassurance on the availability, access and aims of all postnatal peer, statutory and voluntary groups and organisations in their local community (within 2-8 weeks) • CG 37 - Both parents should be encouraged to be present during any physical examination of their baby to promote participation of both

	• There is also strong evidence to support the use of group-based parenting programmes, such as Incredible Years, to treat early signs of behavioural problems • For children with or at high risk of developing attention deficit hyperactivity disorder (ADHD) there is strong evidence for the effectiveness of behavioural interventions in reducing child behaviour problems • There is evidence for the effectiveness of Stepping Stones Triple P as an intervention for improving child and parent outcomes in families of children with disabilities • There is some evidence that group-based parenting programmes targeting adolescent parents are effective in improving a number of aspects of parent-child interaction both in the short and long term • There is evidence that parent training interventions (including one-to-one, home based and small group) can improve the parenting knowledge and targeted skills of parents with intellectual disabilities/learning difficulties, and also improve child behaviour and health • Recent RCTs – not included in the systematic reviews-provide further evidence for the impact of parenting programmes in terms of reducing behaviour problems. They also provide evidence for the effectiveness of individual or group-based parent training on reducing child maltreatment in families at risk, and for the positive impact on behaviour of parenting programmes that address specific challenges (e.g. 'fussy eating'/mealtime difficulties, and divorce)	parents in the care of their baby and enable them to learn more about their baby's needs
Postnatal education programmes	• Behavioural interventions for infant sleep in the first six months have not been shown to decrease infant crying, prevent sleep and behavioural problems in later childhood, or protect against	

	postnatal depression. In addition behavioural interventions for infant sleep that are used during the first weeks and months are associated with unintended outcomes, including increased amounts of problem crying, premature cessation of breastfeeding, increased maternal anxiety, and, if the infant is required to sleep either day or night in a room separate from the caregiver, an increased risk of sudden infant death syndrome. For older children, both family-based and pharmacological interventions that target sleep and eating problems are effective in the short term, but only systemic interventions have positive long-term effects on young children's sleep problems	
Identifying families in need of additional support	• One review of self -help parenting programmes found evidence to support the application of the Eyberg Child Behaviour Inventory in order to identify children with conduct disorders exceeding the clinical range	
Implementation issues	• The implementation of programmes with fidelity is an important component of clinical effectiveness in relation to the use of behavioural and cognitive-behavioural group based parenting programmes. Authorised workshops, a group leader certification/accreditation process, a detailed treatment manual and checklists can all help achieve a high level of treatment fidelity • Key barriers to engaging fathers in parenting programmes are: cultural (e.g. relevance to co-parents); institutional (e.g. how father-friendly the organisation is); professional (e.g. staff capabilities, attitudes); operational (e.g. disaggregation of data by sex); content (e.g. relevance to fathers) ; resource (e.g. sufficiency for implementing changes needed); and policy (e.g. clear recognition of co-parents in strategies, action plans)	
Workforce skills and training	• Several included studies draw attention to the need to train practitioners in the delivery of manualised programmes	

Keeping safe	Rapid review recommendations	NICE guidance: ➢ Postnatal care CG 37 (Dec 2014) ➢ Preventing unintentional injuries among the under-15s in the home PH 30 (Nov 2010) ➢ Strategies to prevent unintentional injuries among the under-15s PH 29 (Nov 2010) ➢ When to suspect child maltreatment CG 89 (July 2009)
Sudden infant death syndrome (SIDS)	• Evidence for the impact of home monitoring systems on preventing SIDS is inconclusive owing to the dearth of studies with a comparison group and the difficulty of drawing conclusions from the cohort studies that have been conducted (e.g. owing to different inclusion criteria, and different types of device). However, observational studies of interventions show that advice on avoiding prone sleeping position and tobacco exposure markedly reduces the incidence of SIDS. • NICE guidance on postnatal care recommends informing parents and carers that: there is an association with co-sleeping and SIDS; the association between co-sleeping and SIDS is likely to be greater when they, or their partner smoke; and the association may be greater with a) parental or carer recent alcohol consumption, or b) parental or carer drug use, or c) low birth weight or premature infants	• CG 37 - Inform parents and carers that there is an association between co-sleeping and SIDS • CG 37 - Inform parents and carers that the association above is likely to greater when they, or their partner smoke • CG 37 - Inform parents and carers that the association between co-sleeping and SIDS may be greater with: parental or carer recent alcohol consumption, or parental or carer drug use, or low birth weight or premature infants
Unintentional injury	• Parenting interventions, most commonly provided in the home are effective in reducing child injury and improving home safety • Home safety education increases the use of home safety practices and there is some evidence that it can reduce overall injury rates. There is conflicting evidence regarding provision of home safety equipment in terms of its impact on safety practices and injury rates • There is a general lack of evidence about the impact of education to prevent dog bites in children	• PH 29 – Ensure there is a child and young person injury prevention coordinator • CG 37 - All home visits should be used as an opportunity to assess relevant safety issues for all family members in the home and environment and promote safety education • PH 30 – healthcare professionals should recognise the importance of measures to prevent unintentional injuries, particularly in those living in disadvantaged circumstances • PH 30 - Parents/carers should be encouraged to undertake their own

	• There is evidence that interventions to promote the prevalence of smoke alarms or the use/maintenance of fire alarms in households with children that include education, the provision of equipment, and home inspection are effective in increasing the household possession of a functioning smoke alarm. More intensive interventions that include the fitting of equipment in addition to education, the provision of equipment, and home inspection are most effective • Home safety interventions improve poison-prevention practices such as the safe storage of medicines and cleaning products, possession of syrup of ipecac and having poison control centre numbers accessible, but the impact on poisoning rates is unclear • Home-safety interventions are effective in increasing stair-gate use and reducing baby-walker use. There is limited evidence that the provision of home safety information by health professionals and relatives can also reduce falls and fall-related injuries • There is limited evidence of the effectiveness of interventions that modify the home environment in terms of injury reduction (e.g. the provision of free/low-cost home safety equipment, advice/information, and home-based hazard-assessment)	home safety assessment using an appropriate tool • CG 37 - The healthcare professional should promote the correct use of basic safety equipment, including, for example, infant seats and smoke alarms and facilitate access to local schemes for provision of safety equipment • PH 30 – Local partnerships should help determine and address barriers to creating a safe environment such as the cost of equipment or cultural norms • CG 37 - At each postnatal contact, parents should be offered information and advice to enable them to: assess their baby's general condition, identify signs and symptoms of common health problems seen in babies, contact a healthcare professional or emergency service if required
Abuse and neglect	• There is insufficient evidence to support the use of one to one and group based parenting programmes to prevent the reoccurrence of physical abuse or neglect in families where there is a history of this, although there is some, albeit limited, evidence that some parenting programmes improve outcomes associated with physically abusive parenting • There is evidence that home visiting interventions in early childhood for at-risk families lead to reduction in Child Protection Services reports, A&E visits, hospitalisations and self-reports of abuse, as well as improved adherence to immunisations, although	• CG 37 – healthcare professionals should be alert to risk factors and signs and symptoms of child abuse • CG 37 - If there is raised concern, the HCP should follow local child protection policies

	there is some inconsistency in results across programmes identified. Home visiting by para professionals holds promise for socially high-risk families with young children, including in the area of reducing harsh parenting	
Identification of families with additional needs	• Objective risk assessments are the best way to identify families at risk of child abuse and neglect, and clinicians in contact with families during early child years are well positioned to conduct these. Risk factors include: young age; single/first time mother; history of child maltreatment; substance misuse; unemployment; and low socioeconomic status. Attention needs also to be paid to specific features of the family's physical environment. • High risk families regarding child safety include, among others, those in rented or overcrowded accommodation with high levels of turnover	• PH 29 – HVs should be alerted, using local protocols, to repeated attendances at A+E departments (or a single attendance that raises concerns) so they are aware of which families may benefit from injury prevention advice and a home safety assessment • PH 30 – Practitioners who visit children at home should be provided with mechanisms for sharing information about households that may need a home safety assessment (if family/carers agree) and priority households (such as those with children under 5 or overcrowded households) should be prioritised for assessment and installation of home safety equipment
Implementation Issues	• There are numerous facilitators (e.g. home visits, requiring families to make minimal changes) and barriers (e.g. socio-economic constraints, parental habits, cultural norms, issues of trust or a lack of control over the home environment) regarding the implementation of injury prevention interventions for children aged under	• PH 30 - recommends that education, advice and information about safety are provided during both a home safety assessment and the supply and installation of homes safety equipment. Home safety assessments and interventions should be followed up to see if there are any new requirements and to assess whether equipment installed is still functional and appropriate
Workforce skills and training	• The most effective home visiting interventions to reduce unintentional injury for children in the home are delivered by trained healthcare professionals (e.g. social workers, child health nurses, qualified family support workers, family nurses) • Where home safety equipment requires skilled fitting, it is essential in socioeconomically deprived communities that it is installed by technicians in order for it to remain installed in the long term	• CG 37 - Relevant healthcare professionals should have demonstrated competency and sufficient ongoing clinical experience in recognising the risks, signs and symptoms of child abuse and whom to contact for advice and management, as recommended by Department of Health guidance

Nutrition and obesity prevention	**Rapid review recommendations**	**NICE guidance:** ➢ **CG37 Postnatal care (Dec 2014)** ➢ **Antenatal and postnatal mental health: clinical management and service guidance CG 192 (Dec 2014)** ➢ **Maternal and child nutrition PH 11 (March 2008)** ➢ **Managing overweight and obesity among children and young people: lifestyle weight management services PH 47 (Oct 2013)** ➢ **Weight management before, during and after pregnancy PH 27 (July 2010)** ➢ **Obesity: identification, assessment and management of overweight and obesity in children, young people and adults CG 189 (Nov 2014)** ➢ **Promoting physical activity for children and young people PH 17 (Jan 2009)**
Promotion of breastfeeding	• Effective strategies to promote breastfeeding include peer support, either one-to-one or as part of a group, and structured support from professionals. Strategies that rely mainly on face-to-face support are significantly more likely to begin and sustain breastfeeding than advice offered from a distance (e.g. by telephone) • There is some new evidence that online interventions may also contribute to breastfeeding initiation and duration. The duration of effective online support is unclear • No form of antenatal breastfeeding education has been found to be significantly more effective than another in increasing breastfeeding initiation or duration	• CG 37 - All healthcare providers should implement an externally evaluated structured programme that encourages breastfeeding, using the baby friendly initiative (BFI) as a minimum standard • CG 37 - A woman's experience with breastfeeding should be discussed at each contact to assess if she is on course to breastfeed effectively and identify any need for additional support • CG 37 - Women should be given information about local breastfeeding support groups • PH 11 – Women should have access to local, easily accessible breastfeeding peer support programmes and peer supporters should be part of a multi-disciplinary team and have had appropriate training and ongoing support

		• CG 192 – Women with a mental health problem should be encouraged to breastfeed, unless they are taking carbamazepine, clozapine or lithium (valproate not recommended for treatment in women of childbearing potential), however each woman should be supported in the choice of feeding method that best suits her
Prevention and treatment of child overweight and obesity	• The most effective interventions for the prevention and treatment of overweight and obesity in children have a multi component and holistic approach that aims simultaneously to improve diet and physical activity in the multiple domains of children's lives. Specifically, they involve parents/the whole family, physical activity, nutritional education, and-for children in school/pre-school-support from teachers. Attention to social and environmental factors is important and often given insufficient attention. Narrow interventions focusing on single aspects of behaviour are unlikely to achieve long term change in efforts to tackle obesity • The following have been identified as effective components of interventions : decreasing pre-schoolers' screen time; decreasing consumption of high fat/calorie drinks/foods; increasing physical exercise; increasing sleep; modifying parental attitudes to feeding; and promoting authoritative parenting • Interventions to reduce children's sedentary behaviour have a small but significant effect on reducing time spent in these behaviours and/or improvements in anthropometric measurements. Parent training can have a significant effect on reducing children's screen time. There is evidence to recommend the use of electronic TV monitoring devices in order to achieve this • While there is evidence to support a positive relationship between increased or higher physical activity and favourable measures of adiposity in pre-schoolers, there is a need for more rigorous research designs in this age group	• PH 47 – Ensure family-based, multi-component lifestyle weight management services for children and young people are available as part of a community-wide, multi-agency approach to promoting a healthy weight • PH 47 – healthcare professionals should tell the parents/carers of children who are overweight or obese about local lifestyle weight management programmes • CG 189 – Coordinate the care of children and young people around their individual and family needs and preferences and aim to create a supportive environment that helps a child who is overweight or who has obesity, and their family, make lifestyle changes • CG 189 – Ensure that interventions for children who are overweight or have obesity address lifestyle within the family and in social settings and encourage parents to take responsibility for lifestyle changes • CG 189 – Offer regular, non-discriminatory long term follow up by a trained professional • CG 189 – Assess eating patterns and physical activity, environmental, social and family factors and be aware that people from certain ethnic and socioeconomic backgrounds may be at greater risk of obesity, different beliefs about what constitutes a healthy weight and different attitudes towards weight management • CG 189 – Consider referral to an appropriate specialist for children who are overweight or obese and have significant co morbidities or complex needs, deliver any behavioural intervention with the support of an appropriately trained professional

	• In terms of the promotion of healthy eating, the most effective strategies to increase children's acceptance of unfamiliar (and healthy) foods are: intensive; incorporate behavioural strategies; give a clear message,; and are tailored to the educational level and material resources of families • There is strong evidence that the involvement of whole families (parents and children) in interventions that promote both healthier diet and more exercise can have an impact on reduction of BMI • Interventions to increase fruit and vegetable consumption in children aged under 6 years show no, or at best, mixed effects • There is evidence that general parenting programmes that include lifestyle components such as physical activity and nutrition have small to moderate effects on weight related measures • There is a relative lack of evidence about what is effective with children under the age six years in terms of lifestyle weight management for overweight and obese children • Findings from recent RCTs not included in the systematic reviews, but including children in the 0-3 years age range, and addressing effective methods of preventing obesity in young children indicate that some home visiting programmes delivered during the postnatal period have positive effects on family/parental nutrition practices (e.g. increased duration of breastfeeding, later introduction of solid foods, less use of food as a reward or to make children feel better), and –in one study-on children's intake of water, vegetables and healthy snacks. These programmes focus on diet and/or exercise • There is also emerging evidence –again from recent RCTs that include some children in the 0-3 years age range – to support the use of group-based interventions with mother-infant dyads in	• CG 189 – Multicomponent interventions are the treatment of choice, weight management programmes need to include behaviour change strategies to increase physical activity, decrease inactivity, improve eating behaviour and the quality of diet and reduce energy intake • CG 189 – Give information on being overweight and obesity, including related health risks, realistic targets, healthy eating and voluntary organisations • CG 189 – Encourage parents of children who are overweight or obese to lose weight if they are also overweight or obese • PH 17 – Early years providers and those working in children's centres should ensure opportunities, facilities and equipment are available to encourage children to develop movement skills and provide daily opportunities for participation in physically active play

	altering maternal feeding practices (e.g. reduced sweet snack intake, increased consumption of water and fruit/vegetables) and reducing the time that children spend watching the television • Findings from recent RCTs of multi component and anticipatory guidance interventions are also promising, with evidence of impact on, for example, television viewing and family nutritional practices	
Maternal overweight and obesity	• Not addressed in Rapid Review	• PH 27 – Use the 6-8 week check as an opportunity to discuss women's weight. Offer those who are overweight/obese advice and support about how to lose weight safely after childbirth. Discuss diet and physical activity, and give details of community based services. Encourage women to breast feed • PH 27 – Explain the increased risks that being obese poses to them and if they become pregnant again, their unborn child. Encourage weight loss, offer a structured weight loss programme, referral to a dietician or appropriately trained health professional. Evidence-based behaviour changed techniques should be used • PH 27 – Local authority leisure and community services should offer women with babies and children the opportunity to take part in a range of physical or recreational activities that are affordable, and where possible offering affordable childcare • PH 27 – Women who wish to lose weight after childbirth should have the opportunity to join a weight management group or slimming club
Infant feeding problems	• There is evidence that family-based behavioural programmes are effective in ameliorating severe feeding problems in children under the age of 5	
Identifying families with additional needs	• Universal healthcare checks in the early years provide an opportunity for health professionals to identify families who may need additional support	• PH 47 - recommends that if health professionals (including health visitors) have concerns about a child's weight they should measure their BMI and use UK-WHO growth charts to determine if children are overweight or obese. They should tell parents or carers of children who have been identified as being overweight or obese about local lifestyle

	• Several socio-demographic factors are associated with a lack of physical activity, indicating groups of children and families to be given special attention	weight management programmes and make a referral if it is clinically appropriate and the family are ready (programmes aimed at children under 6 are excluded due to lack of evidence)
Implementation issues	• Greater efforts should be made to deliver parent interventions to address obesity in an accessible format (e.g. online), since for young children parents are the primary agent of change and parents can find it hard to attend face-to-face sessions owing to time commitments	• PH 11 - recommends a coordinated programme of interventions across different settings to increase breastfeeding rates: raising awareness of the benefits; giving information about the barriers and how to overcome them; providing training for professionals; offering peer support programmes, providing education and information for pregnant women on how to breastfeed; offering proactive support during the postnatal period; and implementing structured programmes that encourage breastfeeding-with the UNICEF baby friendly initiative as a minimum standard
Workforce skills and training	• Interventions that involve physical activity should be delivered by trained staff in order to ensure intervention efficacy	• CG 37 - All relevant healthcare professionals should have demonstrated competency and sufficient ongoing clinical experience supporting breastfeeding women including a sound understanding of the physiology of lactation and neonatal metabolic adaptation and the ability to communicate this to parents • PH 27 – Ensure healthcare professionals: are able to advise on the health benefits of weight management and risks of being overweight or obese before, during and after pregnancy, or after successive pregnancies, advise women on their nutritional needs at these times, have behaviour change knowledge, skills and competencies, learn communication techniques needed to broach the subject of weight management in a sensitive manner, have the knowledge, skills and competencies in group facilitation, are aware of the needs of minority ethnic groups and have knowledge of local services. Training should be regularly monitored and updated

Oral health	Rapid review recommendations	NICE guidance: ➢ Oral health: approaches for local authorities and their partners to improve the oral health of their communities PH 55 (Oct 2014)
Evidence based guidance	• There is strong evidence for interventions that contribute to the oral health of children aged 0-5 years, for example in relation to feeding practices, diet and tooth-brushing with fluoride toothpaste	
Access to fluoride	• The targeted and timely provision of toothbrushes and fluoride toothpaste reduces tooth decay • There is high quality evidence from a number of systematic reviews that fluoride varnish is effective in preventing caries	• PH 55 - recommends that local authorities and health and wellbeing commissioning partners should consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health
Oral health education/promotion	• There is inconclusive evidence for the impact on child oral health outcomes of person centred counselling based on motivational interviewing , for example with new mothers • One-off education by dental staff in the general population (e.g. dental staff providing education to new mothers or visiting schools annually) has limited effects on clinical outcomes • There is a lack of RCT evaluations of providing training to health, education and social care professionals to help them deliver oral health interventions as part of their daily professional role. However, there is some evidence of effectiveness (e.g. on maternal tooth brushing behaviour, child tooth decay). The success of such interventions will depend largely on the extent to which the education provided by practitioners is evidence based • There is evidence from comparison group studies that integrating oral health advice into home visits by health/social care workers, targeted at families at higher risk of oral disease can reduce tooth decay. This requires building the capacity of	• PH 55 – Ensure all early years services provide oral health information and advice • PH 55 – Consider giving HVs free tooth brushing packs to offer to families in groups at high risk of poor oral health, with information on when and how to brush teeth, a practical demonstration and information about local dental services

	health and social care workers to provide such support and providing regular update training	
Supervised tooth brushing	• Supervised tooth brushing (with fluoride toothpaste) in targeted childhood settings is effective in reducing tooth decay. Targeting is important: programmes are more effective in areas with high rates of tooth decay and less effective when children are already brushing their teeth twice a day with fluoride toothpaste.	• PH 55 - recommends that local authorities and health and wellbeing commissioning partners should consider commissioning a supervised tooth-brushing scheme for early years settings in areas where children are at high risk of poor oral health
Healthy food and drink policies in childcare settings	• Reviews did not identify any comparison group studies of healthy food and drink policies in childcare settings but it is argued that this intervention has value for other reasons (e.g. reducing inequalities by creating a health-promoting atmosphere, low cost/resource implications, potential for sustainability)	
Multi-component strategies	• There is evidence from one interrupted time series evaluation that oral health promotion campaigns delivered through multiple venues and targeting several aspects of oral health may be associated with a reduced risk of dental decay in children under the age of five living in deprived communities	
Identifying families with additional needs	• The main risk factors for poor oral health in children are well established. Tools that help health visitors and other professionals to assess risk are available, although as yet there is no consensus on which one is best	• PH 55 – Information from the oral health needs assessment should identify areas and groups where children are at high risk of poor oral health and provide tailored services to meet the oral health needs of these groups
Implementation issues	• Where possible, high quality oral health advice should be integrated into health programmes • Targeting high risk families is important to achieve the best effects, as is good engagement with parents, schools and dental practices • Public health approaches need to provide education that is in line with evidence based guidelines	• PH 55 - recommends that frontline health and social care staff are able to give parents, carers and other family members advice on the importance of oral health and how to promote it (e.g. promoting breastfeeding, healthy food/drink, the use of fluoride toothpaste)

Workforce skills and training	• All frontline staff in early years services, including education and health, should receive training at their induction and at regular intervals, so they can understand and apply the principles and practises that promote oral health	• PH 55 – Ensure early years services train staff in oral health promotion at their induction and regular intervals • PH 55 - recommends that health and social care staff working with children at high risk of poor oral health should receive training on a range of issues, including how good oral health contributes to people's overall health and well-being, the consequences of poor oral health, how to prevent tooth decay, techniques for maintaining good oral hygiene (e.g. the use of fluoride toothpaste), and what advice to give carers
Promotion of child development	**Rapid Review Recommendations**	**NICE Guidance:** ➢ **Social and emotional wellbeing: early years PH 40 (Oct 2012)**
Speech, language and communication	• Speech and language interventions that take place in preschool settings have a significant effect on mainly cognitive outcomes, but also social skills and progress within school • Interventions aimed at improving vocabulary through instruction, such as dialogical reading and storybook reading, have a large effect on vocabulary measures, especially when delivered by trained professionals. However middle-and upper-income at-risk children are significantly more likely to benefit from vocabulary interventions than those children also at risk and poor • Early childhood education and care programmes aimed at young children from socially disadvantaged backgrounds have considerable positive short-term effects and somewhat smaller long-term effects on cognitive development. However they cannot compensate completely for developmental deficits that are due to children's socioeconomic backgrounds	

	• Parent implemented language interventions are effective for young children with language impairments, showing a positive impact on children's receptive and expressive language skills, receptive and expressive vocabulary, expressive morphosyntax, and rate of communication • Speech and language therapy interventions for children with primary speech or language delay or disorder have mixes effects, which include a positive effect for children with expressive phonological and expressive vocabulary difficulties • There is limited evidence of the effectiveness of home based interventions (such as home visiting programmes) that are specifically targeted at improving developmental outcomes, such as cognition and intrapersonal development, for preschool children from socially disadvantaged families. The Nurse Family Partnership seems to be an exception to this statement • Recent RCTs (not included in the systematic reviews) that evaluated the effectiveness of interventions aimed at improving young children's speech, language and communication show evidence of a positive impact for some (though not all) interventions aimed at helping parents to read to and use enriched language with their children. They also show a generally positive effect for interventions aimed at supporting teachers to work more effectively (through training and/or new curricula). The interventions are mostly targeted, either at socio-economically disadvantaged children or at children with signs of difficulties in the areas of speech, language or literacy	
Social, emotional and cognitive development	• There is evidence that programmes that aim to improve young children's self-control are effective for improving self-control and reducing problem behaviours	• PH 40 – Aim to ensure universal as well as more targeted services, provide the additional support all vulnerable children need to ensure their mental and physical health and wellbeing, in conjunction with child safeguarding policies

	• Home visiting interventions for at risk families show positive benefits, including for parent-child interaction, parenting behaviour and children's cognitive and socio-emotional development • There is moderate evidence that programmes in educational and day care settings for young children can have a positive impact on various outcomes, including cognitive development, school readiness, behaviour and attainment	• PH 40 – Health and wellbeing boards should ensure the social and emotional wellbeing of vulnerable children including healthy child development and 'readiness for school' and prevent mental health and behavioural problems • PH 40 – Ensure targeted, evidence-based and structured interventions are available and that children and families with multiple needs have access to specialist services • PH 40 – Ensure procedures are in place to make referrals to specialist services, record and share information as part of the common assessment framework, integrated team working, continuity of care and avoidance of multiple assessments • PH 40 – HVs should consider evidence based interventions such as baby massage and video interaction guidance to improve maternal sensitivity and mother-infant attachment • PH 40 – HVs should work in partnership with other Early Years practitioners to ensure families receive coordinated support. HVs should offer a series of intensive home visits to parents assessed to be in need of additional support, based on a set curriculum aiming to achieve specified goals in relation to maternal sensitivity, mother-child relationship, home learning, parenting skills and practice. There should also be a focus on developing the father-child relationship, and ensure both parents can take part in home visits • PH 40 - Children's services (including health visitors) should ensure that all vulnerable children can benefit from high-quality childcare outside the home on a part or full time basis and can take up their entitlement to early childhood education where appropriate. Services should aim to enhance children's social and emotional wellbeing and build their capacity to learn

Identifying families with additional needs	• A range of factors indicate that children may need additional support with language and communication in the early years, including low income, low level of maternal education, low birthweight and parental substance misuse • A range of factors indicate that children may need additional support with socio---emotional development in the early years, including speech and communication difficulties, parental substance misuse, and intimate partner violence. Relevant professionals (including health visitors) should engage in outreach activities to reach vulnerable families	• PH 40 – Ensure vulnerable children at risk of developing social and emotional and behavioural problems are identified as early as possible by universal children and family services, health professionals in antenatal and postnatal services should identify factors that may pose a risk to a child's social and emotional wellbeing (including factors that could affect the parents' capacity to provide a loving and nurturing environment). They should discuss with the parents any problems they may have in relation to the father or mother's mental health, substance or alcohol misuse, family relationships or circumstances and networks of support, and use the early years foundation stage assessment process
Implementation Issues	• There needs to be a closer relationship between speech and language therapists, teachers and parents to increase the chances of speech and language interventions being successful • Barriers to involving parents in interventions to improve young children's social, emotional and cognitive development include a lack of parental knowledge about the content and potential benefits of services and a lack of programme flexibility • A range of approaches can enhance parents' ongoing commitment to home visiting interventions, including home visitors being flexible to parental needs in terms of delivery, and tailoring programme content based on parental needs	• PH 40 – Advises health and Early Years practitioners to be systematic and persistent in their efforts to encourage vulnerable parents to use Early Years services. Examples of recommended activities are targeted publicity campaigns, sending out repeat invitations and home visits by family support workers

Workforce skills and training	• Speech, language and communication interventions need to be implemented by individuals who have received appropriate training • For home visiting programmes, the more structured and intensive interventions (with a focus on mother---child interaction) delivered by specially trained nurses during the first 18 months appear to be more effective in terms of impact on vulnerable children's social and emotional wellbeing than lower intensity and less structured interventions involving lay providers	

8 RECOMMENDATIONS

8.1 WIDER DETERMINANTS

- ***Aim to see a continuation of the reduction of the proportion of children living in poverty and aspire to surpass the London average;***
- ***Explore why the proportion of children living in poverty varies in the City of London;***
- ***Draw up a more comprehensive profile for Bangladeshi children living in overcrowded accommodation in the City of London.***

8.2 ANTENATAL PERIOD

8.2.1 Antenatal Specialist Referrals

- ***Improve partnership working and data sharing between midwifery, health visiting and GP services;***
- ***Work closely with the Charedi population to understand why fewer Charedi women are referred to health visitors antenatally, and work to address these problems.***

8.2.2 Teenage Conceptions and Births

- ***Continue to deliver an enhanced support service for this age group of mothers, throughout pregnancy and postnatally for two years;***
- ***Provide targeted work for vulnerable young pregnant women who fall outside of the Family Nurse Partnership referral criteria;***
- ***Focus on areas B and D to further reduce the rate of teenage pregnancies.***

8.2.3 Maternal Mental Health

- ***Increase the rate of screening for postnatal depression by midwives, with an aim to screen all pregnant women;***
- ***Provide a named health visitor for each family to build a relationship with mothers – facilitating the screening for and discussion of mental health issues;***
- ***Encourage the integration of families into local support groups and networks to increase mental resilience and help to protect against poor mental wellbeing.***

8.2.4 Maternal Weight and Obesity

- ***Provide a pathway of support including midwifery, health visiting and primary care from preconception advice to returning to a healthy weight post pregnancy;***
- ***Focus support towards older mothers and mothers of Black ethnicity.***

8.2.5 Maternal Smoking

- ***As per national guidance, implement use of carbon monoxide (CO) monitors during pregnancy and at birth to improve identification and the accuracy of prevalence;***
- ***Ensure advice and support is available for all women, not just current smokers, to reduce the risk of women starting or restarting smoking during pregnancy;***
- ***Continue to work with young mothers to ensure that they and their family members are supported to go – or remain – smoke-free;***
- ***Develop culturally appropriate interventions in the Turkish and Eastern European communities to reduce smoking amongst mothers and their family members.***

8.3 Postnatal Period / Young Children

8.3.1 Health Visiting

- ***Implementation of the new Health Visiting contract will provide clarification of what health visitors are to provide in order to reduce variability between visitors in the face of competing demands from different organisations;***
- ***Where appropriate, the new health visitor contract should allow for streamlining of pathways and paperwork to increase the time available to support families;***
- ***The new Health Visiting contract could consider increasing service accessibility through the provision of a range of access points that cover a variety of locations, settings and timings and through the use of telephone advice, where appropriate;***
- ***A new preceptorship programme could be developed to provide enhanced support to newly qualified staff to increase retention, reduce vacancies and decrease variation;***
- ***All health professionals should look to better include fathers;***
- ***The role of health visitors should be clearly explained to new parents;***
- ***The creation of a central hub for data sharing and training about when and how to share data could increase the integration between health professionals.***

8.3.2 Infant and Child Mortality Rates

- ***Enable health visitors to offer the option of a follow up home visit after the new birth visit for mothers who would like and need more support;***
- ***Encourage the development of community peer support, where champions provide home visits, to increase the availability of culturally appropriate advice;***
- ***Engage fathers and grandparents to ensure that all care providers feel confident in supporting the child.***

8.3.3 Breastfeeding

- ***All major partners should work towards baby friendly accreditation;***
- ***Encourage more young mothers to attend breastfeeding support groups, in particular those from BME communities;***
- ***Provide culturally appropriate support for Asian women to continue to breastfeed at all, and to encourage more Black women to continue to breastfeed exclusively.***

8.3.4 Immunisation

- ***All health professionals to highlight and discuss the importance of immunisation and to signpost to local providers;***
- ***Further explore the barriers to timely vaccination in the Charedi community and work to overcome these barriers to increase the proportion of children who are up-to-date with the schedule.***

8.3.5 Healthy Start

- ***Investigate which women are not choosing to start using vitamins and engage stakeholders to understand the barriers to their use;***
- ***Encourage mothers to continue to receive vitamins for their children throughout the four year period once they have started the scheme;***
- ***Discuss with local stakeholders whether a more targeted vitamin scheme, like that in use across much of the country, would better serve our most in need families.***

8.3.6 School Readiness

- ***Increase ethnicity recording at the 27 month review;***
- ***Work with community groups and education providers to develop new culturally-appropriate ways to support children of Turkish/Cypriot/Kurdish origin;***
- ***Develop our strategy to work with the Borough's independent schools to support them, to ensure that they are giving children the same opportunity to reach a GLD as state schools, particularly with regards to the lower rate in area B.***

8.3.7 Children with Disabilities / Special Educational Needs

- ***Explore why more children are accessing services in area C and investigate whether there are barriers to accessing services in the rest of the borough;***
- ***Ensure all health and education professionals understand how to signpost families to local disability / special educational needs services;***
- ***Link services effectively so that families receive all of the support they need regardless of where they present.***

8.3.8 Accident and Emergency Attendances and Emergency Hospital Admissions

- ***Look to understand the perceived barriers to using primary care and pilot strategies to reduce these barriers;***
- ***Engage with stakeholders to understand why children of White Other ethnicities have higher attendance and provide culturally-relevant campaigns to reduce attendance;***
- ***Provide information through professionals working with young children (such as health visitors and Children's Centres) about common respiratory conditions that can be managed in the community and promote the use of primary care;***
- ***Create a targeted service for families who are repeat attenders to A&E.***

8.3.9 Childhood Weight and Obesity

- ***Work with all partners involved with children in the early years to develop pathways to increase efforts to prevent obesity prior to children starting school;***
- ***Provide campaigns through Children's Centres, such as advertising sports resources, to reach families with children in the early years;***
- ***Investigate the extent of obesity in local independent schools, as this accounts for 20% of children not being included in the calculation of local obesity rates;***
- ***Provide whole family, holistic support to promote weight loss, particularly in families of Black ethnicity, to prevent the generational cycle of obesity.***

8.3.10 Dental Health

- ***Provide joined-up campaigns to highlight the importance of dental health alongside diet and lifestyle advice in the effort to combat obesity, to ensure that advice is holistic and complementary;***
- ***Encourage all health professionals, in particular health visitors, to educate, promote and signpost to dental services;***
- ***Provide education and promotion around the fluoride varnish programme.***

8.4 Family Circumstances

8.4.1 Parental Substance and Alcohol Abuse

- ***Ensure all practitioners who work with families are well trained to identify substance misuse problems early, know how to refer to and actively promote the wide range of treatment services within the borough (particularly those specifically for parents), and understand that support can lead to successful recovery;***
- ***Capitalise on the inclusion of substance misuse as a criterion within the Troubled Families programme through using the expanded funding to co-ordinate additional professional support surrounding substance misuse;***
- ***Expand the number of drug and alcohol treatment services that have child care or crèche facilities available to facilitate mothers' attendance;***
- ***Increase partnership working for women with dual diagnoses of mental health and substance misuse disorders to provide a holistic package of care.***

8.4.2 Domestic Violence

- ***Increase the coverage of domestic violence screening and documentation in pregnant women, with a particular focus on White women;***
- ***Routinely enquire about and record the FGM status of pregnant women at their booking visit and ensure that all women who have undergone FGM are given a full assessment and made aware of the full range of available support;***
- ***Provide a named health visitor per family to provide continuity of care which may facilitate the disclosure of women's concerns and detection of domestic violence;***
- ***Ensure all health professionals working with pregnant women and young children know how to, and feel confident in, reporting concerns about domestic violence (including FGM) to the Multi-Agency Risk Assessment Conference (MARAC);***
- ***Through the IRIS project help GPs to feel more able to support women who have been highlighted as at risk of domestic violence through the MARAC.***

8.4.3 Safeguarding

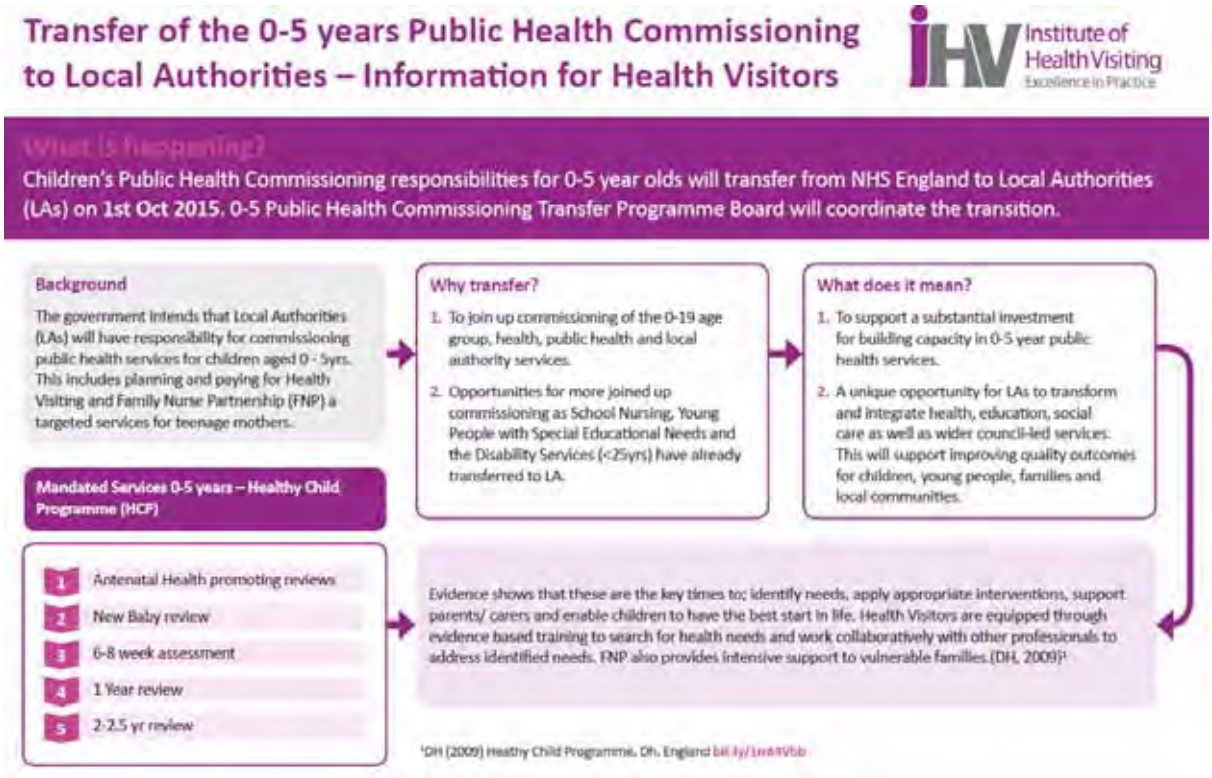
- ***Provide training to encourage earlier completion of the Common Assessment Framework (CAF) by health visitors for vulnerable families;***
- ***Provide training for GPs so they can better understand their role in the CAF and to encourage a greater number of referrals via primary care;***
- ***Provide more joined up working between services for complex families.***

9 APPENDIX

9.1 INTRODUCTION

9.1.1 Local services

Figure 107. Transfer of the 0-5 years Public Health Commissioning to Local Authorities



Source: Institute of Health Visiting

9.1.2 Children's Centres and schools

Figure 108. Key to map of Children's Centres and Children's Centre areas in Hackney and the City of London

Hackney

Area A

10. Hillside Children's Centre

21. Woodberry Down Children's Centre

Area B

3. Children's Centre at Tyssen

8. Fernbank Children's Centre

11. Ihsan Children's Centre

13. Lubavitch Children's Centre

Area C

2. Brook Community children's centre

5. Comberton Children's Centre

12. Linden Children's Centre

Area D

4. Clapton Park Children's Centre

7. Daubeney Children's Centre

9. Children's Centre at Gainsborough

15. Millfields Children's Centre

20. Wentworth Nursery School & Children's Centre

Area E

6. Comet Nursery School and Children's Centre

16. Minik Kardes Community Nursery & Children's Centre

18. Sebright Children's Centre in Haggerston Park

19. Thomas Fairchild Children's Centre

Area F

1. Ann Tayler Children's Centre

14. Mapledene and Queensbridge Children's Centre

17. Morningside Children's Centre

City of London

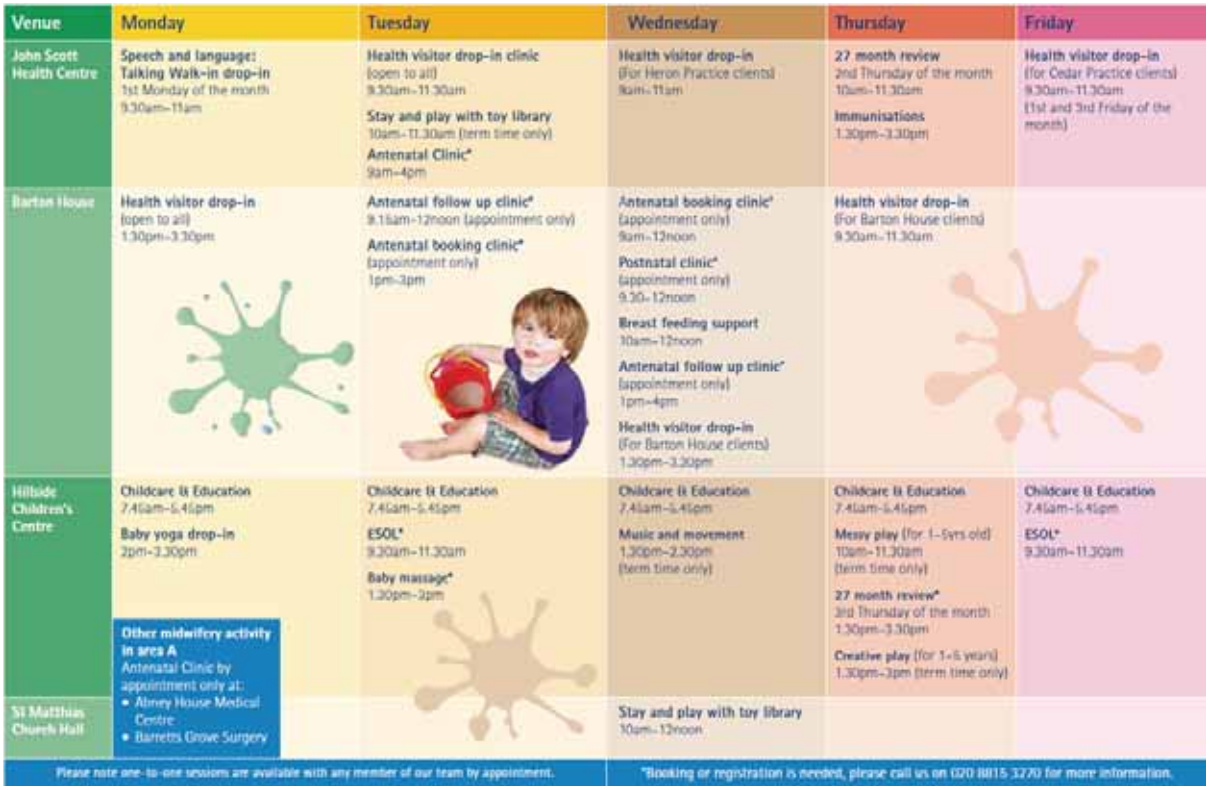
Area E

22.Cass Child and Family Centre

23. Golden Lane Children's Centre (managed by Islington Council)

Source: London Borough Hackney

Figure 109. Example of Children's Centre timetable of activities



Venue	Monday	Tuesday	Wednesday	Thursday	Friday
John Scott Health Centre	Speech and language: Talking Walk-in drop-in 1st Monday of the month 9.30am–11am	Health visitor drop-in clinic (open to all) 9.30am–11.30am Stay and play with toy library 10am–11.30am (term time only) Antenatal Clinic* 9am–4pm	Health visitor drop-in (For Heron Practice clients) 9am–11am	27 month review 2nd Thursday of the month 10am–11.30am Immunisations 1.30pm–3.30pm	Health visitor drop-in (for Cedar Practice clients) 9.30am–11.30am (1st and 3rd Friday of the month)
Barton House	Health visitor drop-in (open to all) 1.30pm–3.30pm	Antenatal follow up clinic* 9.15am–12noon (appointment only) Antenatal booking clinic* (appointment only) 1pm–3pm	Antenatal booking clinic* (appointment only) 9am–12noon Postnatal clinic* (appointment only) 9.30–12noon Breast feeding support 10am–12noon Antenatal follow up clinic* (appointment only) 1pm–4pm Health visitor drop-in (For Barton House clients) 1.30pm–3.30pm	Health visitor drop-in (For Barton House clients) 9.30am–11.30am	
Hillside Children's Centre	Childcare & Education 7.45am–5.45pm Baby yoga drop-in 2pm–3.30pm	Childcare & Education 7.45am–5.45pm ESOL* 9.30am–11.30am Baby massage* 1.30pm–3pm	Childcare & Education 7.45am–5.45pm Music and movement 1.30pm–2.30pm (term time only)	Childcare & Education 7.45am–5.45pm Messy play (for 1–5yrs old) 10am–11.30am (term time only) 27 month review* 3rd Thursday of the month 1.30pm–3.30pm Creative play (for 1–5 years) 1.30pm–3pm (term time only)	Childcare & Education 7.45am–5.45pm ESOL* 9.30am–11.30am
St Matthias Church Hall	Other midwifery activity in area A Antenatal Clinic by appointment only at: • Abney House Medical Centre • Barretts Grove Surgery		Stay and play with toy library 10am–12noon		

Please note one-to-one sessions are available with any member of our team by appointment. *Booking or registration is needed, please call us on 020 8815 3270 for more information.

Source: Children's Centre leaflet

Figure 110. Number and type of schools in Hackney and City of London

Hackney – 111 schools

- 34 are Independent. 12 boys, 9 girls, 13 mixed. 3 are "Independent Special Schools". 16 are Jewish, 5 Muslim, 4 Christian and 9 have no religious character
- 1 Pupil Referral Unit: mixed, no religious character
- 2 are state funded nursery schools: both mixed, no religious character.
- 55 state funded primary schools: 53 are mixed, 1 boys, 1 girls. 40 have no religious character, 7 are Church of England, 4 are Roman Catholic, 3 are Jewish and 1 is Muslim.
- 16 state funded secondary schools: 12 mixed, 4 girls. 11 no religious character, 2 Jewish, 2 Roman Catholic, 1 Church of England.
- 3 state funded Special Schools: all mixed, no religious character.

City of London – 5 schools

- 1 state funded primary school: mixed, Church of England
- 4 Independent schools: 2 are mixed, 1 boys, 1 girls. 2 have no religious character, 1 Church of England, 1 other Christian.

Source: 2015 schools census

9.1.3 Ethnicity

Figure 111. Census data on ethnic group

Ethnic group	Hackney	City of London	London	England
White: English/Welsh/Scottish/Northern Irish/British	36.2	57.5	44.9	79.8
White: Irish	2.1	2.4	2.2	1
White: Gypsy or Irish Traveller	0.2	0.0	0.1	0.1
White: Other White	16.2	18.6	12.6	4.6
Mixed/multiple ethnic group: White and Black Caribbean	2	0.5	1.5	0.8
Mixed/multiple ethnic group: White and Black African	1.2	0.5	0.8	0.3
Mixed/multiple ethnic group: White and Asian	1.2	1.5	1.3	0.6
Mixed/multiple ethnic group: Other mixed	2	1.4	1.5	0.5
Asian/Asian British: Indian	3.1	2.9	6.6	2.6
Asian/Asian British: Pakistani	0.8	0.2	2.7	2.1
Asian/Asian British: Bangladeshi	2.5	3.1	2.7	0.8
Asian/Asian British: Chinese	1.4	3.6	1.5	0.7
Asian/Asian British: Other Asian	2.7	2.9	4.9	1.5
Black/African/Caribbean/Black British: African	11.4	1.3	7	1.8
Black/African/Caribbean/Black British:	7.8	0.6	4.2	1.1

Caribbean				
Black/African/Caribbean/Black British: Other Black	3.9	0.7	2.1	0.5
Other ethnic group: Arab	0.7	0.9	1.3	0.4
Other ethnic group: Any other ethnic group	4.6	1.2	2.1	0.6

Source: 2011 Census, % of resident population

9.1.4 Life Expectancy

Figure 112. Life expectancy at birth in years, 2011-2013

	Hackney (1991-93)	Hackney (2011-13)	London (2011-13)	Eng & W (2011-13)
Males	71.3	78.2	80.0	79.3
Females	77.4	83.2	84.1	83.04

Source: ONS

9.1.5 Child poverty

Figure 113. Child poverty 2006-2012

	2006	2007	2008	2009	2010	2011	2012
Hackney	46.2	48.6	43.5	40.3	37.5	36.8	30.1
City of London	22.7	21.3	19.1	17.5	18.9	14.3	12.2
London	31.5	32.5	30.8	29	28	26.7	23.5
England	20.8	21.6	20.9	21.3	20.6	20.1	18.6

Source: HMRC 2006-2012

Figure 114. Proportion of households with dependent children eligible for assistance, unintentionally homeless and in priority need

	Couple with dependent children	Lone parent household with dependent children
Hackney	**0.19%**	**1.28%**
Haringey	0.07%	1.27%
Lambeth	0.18%	1.14%
Southwark	0.13%	1.22%
Islington	0.16%	0.93%
Brent	0.18%	0.75%

Source: DCLG data 2012/13 and census 2011

9.2 The Needs of the Local Population

9.2.1 Antenatal

9.2.1.1 Antenatal Specialist Referrals

Figure 115. Number of referrals required and services referred to, by midwife at booking visit

Number of referrals	People	Referrals	To Public Health Midwife		To Social Worker		To Health Visitor	
			Number	Proportion of people	Number	Proportion of people	Number	Proportion of people
1	267	267	195	73.0%	33	12.4%	2	0.7%
2	106	212	96	90.6%	87	82.1%	15	14.2%
3 or 4	75	233	72	96.0%	73	97.3%	61	81.3%

Source: Homerton University Hospital

Figure 116. Number of referrals to other services by age

	Number of births	People with one or more referrals		Exactly one referral	
		Number	As proportion of births	Number	As proportion of those with referral
<20	202	55	27.2%	30	54.5%
20-24	1,214	60	4.9%	33	55.0%
25-29	1,734	75	4.3%	46	61.3%
30-34	2,041	60	2.9%	40	66.7%
35-39	1,391	47	3.4%	29	61.7%
40+	409	14	3.4%	5	35.7%

Source: Homerton University Hospital

Figure 117. Number of referrals to other services by ethnicity

	Number of births	People with one or more referrals		Exactly one referral	
		Number	As proportion of births	Number	As proportion of those with referral
Asian	709	27	3.8%	17	63.0%
Black	1,778	114	6.4%	56	49.1%
Mixed	240	25	10.4%	11	44.0%
Other	1,012	22	2.2%	13	59.1%
White	3,251	123	3.8%	86	69.9%

Source: Homerton University Hospital

Figure 118. Number of referrals to other services by Children's Centre area

	Number of births	People with one or more referrals		Exactly one referral	
		Number	As proportion of births	Number	As proportion of those with referral
ZONE A	1160	53	4.6%	31	58.5%
ZONE B	1645	40	2.4%	29	72.5%
ZONE C	1213	64	5.3%	37	57.8%
ZONE D	1177	58	4.9%	32	55.2%
ZONE E	875	42	4.8%	25	59.5%
ZONE F	921	54	5.9%	29	53.7%

Source: Homerton University Hospital

9.2.1.2 Teenage Conceptions and Births

Figure 119. Births to women aged 19 and under by ethnicity

	Total births	19 and under births		Total 16-19 population	19 and under births	
		Number	Proportion		Number	Proportion
Asian	709	8	1.1%	1,573	8	0.5%
Black	1,778	74	4.2%	3,553	74	2.1%
Mixed	240	17	7.1%	931	17	1.8%
Other	1,012	21	2.1%	757	21	2.8%
White	3,251	82	2.5%	4,022	82	2.0%

Source: Homerton University Hospital

Figure 120. Births to women aged 19 and under by Children's Centre area

	Total births	19 and under births		Approximate 16-19 population	19 and under births	
		Number	Proportion		Number	Proportion
ZONE A	1,160	26	2.2%	1,951	26	1.3%
ZONE B	1,645	44	2.7%	1,763	44	2.5%
ZONE C	1,213	39	3.2%	1,799	39	2.2%
ZONE D	1,177	43	3.7%	1,619	43	2.7%
ZONE E	875	26	3.0%	2,190	26	1.2%
ZONE F	921	24	2.6%	1,515	24	1.6%

Source: Homerton University Hospital

9.2.1.3 Maternal Mental Health

Figure 121. Number of women recorded as having poor mental health by age

	Total with mental health recorded	Poor mental health	
		Number	Proportion
<20	201	14	7.0%
20-24	1,213	55	4.5%
25-29	1,731	77	4.4%
30-34	2,039	111	5.4%
35-39	1,389	77	5.5%
40-44	379	33	8.7%
45+	29	<5	-

Source: Homerton University Hospital

Figure 122. Number of women recorded as having poor mental health by ethnicity

	Total with mental health recorded	Poor mental health	
		Number	Proportion
Asian	709	27	3.8%
Black	1,778	89	5.0%
Mixed	240	26	10.8%
Other	1,012	27	2.7%
White	3,251	200	6.2%

Source: Homerton University Hospital

Figure 123. Number of women recorded as having poor mental health by Children's Centre area

	Total with mental health recorded	Poor mental health	
		Number	Proportion
ZONE A	1,160	67	5.8%
ZONE B	1,643	49	3.0%
ZONE C	1,210	60	5.0%
ZONE D	1,174	67	5.7%
ZONE E	874	57	6.5%
ZONE F	920	69	7.5%

Source: Homerton University Hospital

Figure 124. Relationship between poor mental health and substance misuse

		No substance misuse recorded	Substance misuse recorded
Poor mental health recorded	No	6,580 (94.3%)	32 (0.5%)
	Yes	346 (5.0%)	23 (0.3%)

Source: Homerton University Hospital

Figure 125. Women requiring perinatal mental health services by age

Age band	Births at HUH 2014/15	Perinatal mental health clients	
		Number	Proportion
<20	94	6	6.4%
20-24	584	26	4.5%
25-29	870	21	2.4%
30-34	1,017	28	2.8%
35-39	681	24	3.5%
40-44	218	15	6.9%

Source: Perinatal mental health data 2014/15

Figure 125. Women requiring perinatal mental health services by ethnicity

Ethnicity	Births at HUH 2014/15	Perinatal mental health clients	
		Number	Proportion
Asian	431	9	2.1%
Black	876	28	3.2%
Mixed	122	5	4.1%
Other	439	6	1.4%
White	1,593	53	3.3%

Source: Perinatal mental health data 2014/15

Figure 126. Women requiring perinatal mental health services by Children's Centre Area

Children's Centre area	Births at HUH 2014/15	Perinatal mental health clients	
		Number	Proportion
A	560	24	4.3%
B	821	17	2.1%
C	611	20	3.3%
D	564	29	5.1%
E	424	15	3.5%
F	484	15	3.1%

Source: Perinatal mental health data 2014/15

Figure 127. Number of women in each age bracket receiving postnatal depression screening and number requiring referral

	Births	Tests		Referral required	
		Number	Proportion of all births	Number	Proportion of all tests
<20	202	45	22.3%	<5	-
20-24	1,214	322	26.5%	13	4.0%
25-29	1,734	575	33.2%	11	1.9%
30-34	2,041	865	42.4%	27	3.1%
35-39	1,391	622	44.7%	18	2.9%
40-44	380	187	49.2%	<5	-
45+	29	12	41.4%	<5	-
Not recorded	0	6	-	<5	-

Source: Homerton University Hospital Foundation Trust

Figure 128. Number of women receiving postnatal depression screening and number requiring referral by ethnicity

	Births	Tests		Referral required	
		Number	Proportion of all births	Number	Proportion of all tests
Asian	709	208	29.3%	7	3.4%
Black	1,778	548	30.8%	16	2.9%
Mixed	240	92	38.3%	7	7.6%
Other	1,012	282	27.9%	6	2.1%
White	3,251	1,063	32.7%	24	2.3%
Ethnicity not recorded	1	441	-	11	2.5%

Source: Homerton University Hospital Foundation Trust

9.2.1.4 Maternal Weight and Obesity

Figure 129. Breakdown of births by maternal BMI

	Number	Proportion of those with BMI recorded
Underweight (BMI < 18.5)	186	2.7%
Health weight (18.5<BMI<25)	3,517	50.5%
Overweight (25<BMI<30)	1,950	28.0%
Obese (30<BMI<40)	1,189	17.1%
Very obese (BMI>40)	117	1.7%
Not recorded	32	-

Source: Homerton University Hospital Foundation Trust

Note: BMI is recorded for 99.5% of all births to City & Hackney residents

Figure 130. Maternal BMI by age

	Total	BMI>30		BMI>40	
		Number	Proportion within age group	Number	Proportion within age group
<20	202	17	8.4%	<5	-
20-24	1,214	184	15.2%	15	1.2%
25-29	1,734	323	18.6%	28	1.6%
30-34	2,041	389	19.1%	41	2.0%
35-39	1,391	291	20.9%	25	1.8%
40-44	380	94	24.7%	6	1.6%
45+	29	8	27.6%	<5	-

Source: Homerton University Hospital Foundation Trust

Figure 131. Maternal BMI by ethnicity

	Total	BMI>30		BMI>40	
		Number	Proportion within ethnic group	Number	Proportion within ethnic group
Asian	709	113	15.9%	6	0.8%
Black	1778	584	32.8%	55	3.1%
Mixed	240	35	14.6%	6	2.5%
Other	1012	143	14.1%	13	1.3%
White	3251	431	13.3%	37	1.1%

Source: Homerton University Hospital Foundation Trust

Figure 132. Number of women from each sub-group of black ethnicity with a BMI >30

	Total	BMI>30	
		Number	Proportion within ethnic group
Black: Total	*1,778*	*584*	*32.8%*
Caribbean	246	91	37.0%
African (except Somali)	913	324	35.5%
Other Black	80	23	28.8%
Black British	423	116	27.4%
Somali	116	30	25.9%

Source: Homerton University Hospital Foundation Trust

Figure 133. BMI > 30 and >40 by Children's Centre area

	Total	BMI > 30		BMI > 40	
		Number	Proportion within child centre area	Number	Proportion within child centre area
ZONE A	1,160	179	15.4%	18	1.6%
ZONE B	1,645	298	18.1%	23	1.4%
ZONE C	1,213	224	18.5%	23	1.9%
ZONE D	1,177	257	21.8%	26	2.2%
ZONE E	875	202	23.1%	13	1.5%
ZONE F	921	142	15.4%	14	1.5%

Source: Homerton University Hospital Foundation Trust

9.2.1.5 Maternal Smoking

Figure 134. Smoking and smoking history by age

	Current smokers		Ex-smokers		Never smoked	
	Number	Proportion	Number	Proportion	Number	Proportion
<20	31	15.3%	43	21.3%	128	63.4%
20-24	73	6.0%	137	11.3%	1,004	82.7%
25-29	116	6.7%	220	12.7%	1,398	80.6%
30-34	104	5.1%	389	19.1%	1,548	75.8%
35-39	66	4.7%	285	20.5%	1,040	74.8%
40-44	12	3.2%	65	17.1%	303	79.7%
45+	0	0.0%	7	24.1%	22	75.9%

Source: Homerton University Hospital Foundation Trust

Figure 135. Smoking and smoking history by ethnicity

	Current smokers		Ex-smokers		Never smoked	
	Number	Proportion	Number	Proportion	Number	Proportion
Asian	19	2.7%	58	8.2%	632	89.1%
Black	91	5.1%	221	12.4%	1,466	82.5%
Mixed	17	7.1%	75	31.3%	148	61.7%
Other	22	2.2%	65	6.4%	925	91.4%
White	253	7.8%	726	22.3%	2,272	69.9%

Source: Homerton University Hospital Foundation Trust

Figure 136. Smoking and smoking history by Children's Centre area

	Current smokers		Ex-smokers		Never smoked	
	Number	Proportion	Number	Proportion	Number	Proportion
ZONE A	47	4.1%	188	16.2%	925	79.7%
ZONE B	57	3.5%	115	7.0%	1,473	89.5%
ZONE C	89	7.3%	219	18.1%	905	74.6%
ZONE D	70	5.9%	256	21.8%	851	72.3%
ZONE E	68	7.8%	162	18.5%	645	73.7%
ZONE F	71	7.7%	206	22.4%	644	69.9%

Source: Homerton University Hospital Foundation Trust

Figure 137. Relationship between smoking, BMI, substance misuse and low birth weight

		Total births	Low birth weight		
			Number	Proportion	Statistical difference from "all" rate?
	All	6,991	538	7.7%	-
Smoking	Current Smoker	402	64	15.9%	**Y**
	Ex-Smoker	1,146	74	6.5%	*N*
	Never Smoked	5,443	400	7.3%	*N*
	Substance misuse	55	17	30.9%	**Y**
BMI	BMI>30	1,302	105	8.1%	*N*
	BMI>40	117	14	12.0%	*N*

Source: Homerton University Hospital

Figure 138. Relationship between smoking and smoking history and low birth weight

	All births	Low birth weight	
		Number	Proportion
Current Smoker	402	64	15.9%
Ex-Smoker	1,146	74	6.5%
Never Smoked	5,443	400	7.3%

Source: Homerton University Hospital

9.2.2 Postnatal / Child

9.2.2.1 Health Visiting

9.2.2.1.1 Parent focus groups

1. Consistency of care

"One week you have the loveliest person ever and the next week someone grumpy who doesn't want to be sitting there." (Young mother)

"I think they should just be consistent with what they would tell you. I know there's no right way to bring up your child and everyone will do it differently but it is confusing when you ask someone one thing and they tell you something and then someone else tells you something else." (Mother)

"I think if we had a problem I think it would be nice to see the same person, but in terms of normal development of your child, I think it doesn't really matter, you can see anyone." (Mother)

"The health visitors are very nice, they let me take my time, they ask questions, they talk to her and look at her, but I've just never seen the same person." (Jewish mother)

2. Understanding the Health Visiting service

"Letting mothers know what the health visitors role is, what they come around for. A lot of mothers don't know who to approach in certain circumstances." (Young mother)

"They have to be nurses don't they? And then they become health visitors. And I was very surprised because I think nurses know more than them." (Jewish Mother)

"It wasn't really explained to me why, the midwife says "You're discharged from our care, the health visitor will come and see you" but no one really explained why the health visitor comes or why it has to be at home. I offered to come to a clinic and they said no she'll come to us." (Mother)

"So you know what a GP does because you've been to a GP before, but when you have a baby, you don't know what a health visitor does. It's a whole new world to every new mum." (Mother)

"It wasn't made clear that I could ask for advice" (City of London parent)

3. Communication style

"They should actually know about it rather than just giving you a leaflet. If they give leaflets, they should just post them out. They don't need to come around for that." (Jewish Mother)

"It's how you feed information, they tell you your baby has to sleep on its back, but why don't they discuss it, like "how do you feel about your baby sleeping on its back? Are you OK with that?" It's not approached like that it's a barrel of information." (Jewish Mother)

"They should ask about parents' concerns and based on what the parents say, they should offer information, so like "my child is not eating well" they could give me information on feeding. Or they could ask "do you have stairs?" and then give information on safety." (Jewish Mother)

"You kind of feel like you're being told off, if you want to push immunisations off a month because of a cold or something. They tell you you can't do it, it should be more of a dialogue, we're both working together for the health of this child" (Jewish Mother)

"I did feel like we were under inspection again that was probably me rather than them" (Father)

"At the time I was thinking, hold on…are these social services?" (Father)

4. Involvement of fathers

"The second visit was a bit awkward because it was just "me, me, me" and my partner got a bit left out because she just did not look at him, she didn't even speak to him…" (Young mother)

"I was bombarded with loads of leaflets and classes and slid over a domestic violence leaflet in front of my partner." (Young mother)

"Fathers are excluded, maybe not on purpose, but the focus is on your partner or wife, and the child, and…that's it" (Father)

"It felt like I was the third on the rung of importance" (Father)

"It is endemic within all health professionals that it's always the mother who is the focus which sends messages to your children too" (Father)

"There needs to be an outward message to father's that you are responsible and you need to be involved, and this needs to go to mothers too" (Father)

5. Respect and compassion

"They need to understand that parents do know something if they do, they are qualified, but mothers know their children" (Young mother)

"My health visitors understands me and I understand them, I mean she taught me slowly how to do stuff." (Mother)

"We need reassuring as a first time mum that you're not going to come in and judge, you're just there to help." (Young mother)

"A bit more compassionate to young parents, because a lot of them I feel are a bit stuck up and look down on us as being young parents which doesn't help at all. For me it makes me think I don't want to talk to you. I'm not going to tell you my problems." (Young mother)

"They should ask more questions about us, see if we're all right not just the baby, it's just about the baby." (Young mother)

"They should look presentable, it's not just for the Jewish community, but for everyone, if you go into a hospital you wouldn't find a nurse dressed like that" (Jewish Mother)

6. A good attitude

"They should like their job, I don't like it when people do a job just for money, you can feel it, and it's like you're bothering them or disturbing them, they are like, I don't want to be here I don't care I just want to do the papers and get out, it's not nice. You can feel it obviously." (Young mother)

"Good English. They should try to understand how we feel. When I gave birth everything was a bit funny, and I got…..lady who came with attitude, I didn't like that" (Young mother)

"My first one was really nice, she was really helpful she checked [daughter] she was alright. The second one wasn't that nice." (Jewish Mother)

7. Support offered in the home at the right time

"I would [recommend the Health Visiting service to a friend], if I didn't have that, I wouldn't know all of the stuff I know, and all the stuff I needed to have, plus it's important because you want to know that your baby's okay, the first 6 weeks you're at home and you don't have time to go to the doctors, and you're learning to be a mother." (Young mother)

"I find that they come very close to the baby, sometimes you want to get adjusted with the baby, it's a bit early on, they disturb you, and you're too tired, you're not ready for it. A home visit at a later stage should be optional." (Jewish Mother)

"It's nice but it's too short, just two visits and then you have to take him to the centre or the clinic – they should stay longer with you, you are tired and funny in first few months, they should stay until four months before you get ready to go anywhere." (Young mother)

"I was meant to get a referral from the Homerton, and the health visitor really helped with advising me on the next stages, it was very beneficial as she came to my house, otherwise I wouldn't have known what to do" (Jewish Mother)

"It's also reassuring to know that you have someone coming to you, right after the birth, in case you have any concerns, they're right there on your doorstep to check up and make sure everything is OK." (Jewish Mother)

"I think it's important that they come into your house to make sure it's safe" (Jewish Mother)

"Mine asked me if I wanted her to come and visit in the home again, so she gave me that option and she came back another time to see me, she came back three times in total rather than two." (Young mother)

"They just turned up, which was a bit frustrating, so they said they would come on Friday, so you tidy up, and you don't really know which time they're coming, or they'll say they're coming at 11 and they'll turn up at 2, but I understand as they have like 10 people to see." (Mother)

8. The waiting room experience

"More chairs when you have to wait in there (the clinic) there's like ten chairs and twenty mothers and their children and their husbands and they don't bother to get up for you and you are standing there for three hours with a baby, it's ridiculous" (Young Parent)

"The waiting is horrific, they should do appointments, it's 2/3 hours waiting" (Young mother)

"It was like a cattle yard where you get 10 minutes then you have to leave." (Jewish Mother)

"The GP and health visitor didn't co-ordinate with me, my 6 week check-up and his 6 week check-up was 2 days apart. It's annoying when you're tied down to a new baby." (Jewish Mother)

9. Opportunity for privacy

"Just before the check they asked do you have your partner for support, it felt like I needed to tell everyone yeah I've got my partner with me." (Young mother)

"I went to the health clinic …. then there was a woman in the corner listening to the advice I was given, she was tapping her clock because it had reached the time limit and I had a few more concerns I would want to discuss." (Jewish Mother)

"I always feel more trusting of the nurse at the GP clinic than the health visitor, whenever I go there she always makes me feel at ease and she's very calm and knows what she's talking about. The nurses are a bit more personal." (Young mother)

10. Children's Centre environment

"Yeah, it was good it was in the centre (children's centre) not in the doctors so you could just sit there on the sofa" (Young mother)

"I prefer going to a children's centre, it's all under one roof, you don't have to search for information." (Jewish Mother)

"It's good because you're not sitting with ill people. Unless my children are super ill I wouldn't go to the doctors because they'll just tell you to take paracetamol. It's a horrible process, going to the doctors and you have to go through it because the health visitors are there." (Jewish Mother)

"I've done all of mine here at the centre [Children's Centre], and they also do the checks on a Sunday which was brilliant for me, it was convenient, at a place that I know, excellent service. It was nearby and I didn't have to wait that long, at a maximum maybe 5 minutes.

It's also good because you're not waiting with all of the sick people. They don't have a separate waiting room in the baby clinic." (Jewish Mother)

11. Maternal weight management support

"I put on a lot of weight after I gave birth and I had a problem with my thyroid and nobody asked me about my weight even the doctor, I had to ask myself the doctor that I knew from my friend about getting the three month pass free for the gym – they are not supporting you in this." (Young mother)

"I think they should check your weight after you've given birth because loads of woman put on weight – you are busy you don't even look in the mirror, and one day you find out you don't fit in your clothes anymore." (Young mother)

9.2.2.1.2 Health Visitor focus groups

1. Understanding why staff leave and why students do not stay

"We are not completely retaining our students and it would be interesting to know why not and why they are leaving?"

"The balance between those who are leaving and retiring and are we attracting them enough to stay if we don't do it now when will we do it. How many students can we keep and it takes a lot of time training students and then they leave the staff put in the time what is it so maybe some detailed breaking down of why staff leave."

"When people leave they don't do these exit interviews because I found it really useful and you get an opportunity to offload and they can improve things and take points on board you know find out what is going on and what we can change."

"Sometimes people are not very honest, (they say) 'I live very far and I want to be closer to home' but then I hear other stuff so if they are not telling why they are leaving it is going to be very difficult because a lot of us people are leaving 4 or 5 within one month and you say what is happening what is going on."

2. Adding structure to the preceptorship programme

"Newly qualified you are looking at the support because it's how you start if you that affects whether you are going to be a good health visitor if you start off stress and not supported by managers you really feel like you don't want to be here anymore so if the preceptorship is good especially for the newly qualified then a lot of people train and goes elsewhere because other places offer a good preceptorship programme because if they off that support no matter how stressful or how small the workforce is they have had that support so later on the workforce may improve but if you start off really bad…."

"Other areas have a very structured preceptorship programme so you have a long arming mentor, preceptor and a buddy so someone in your room who has qualified last year and you buddy up…. a structured procedure is needed so making it very structured so not just having a preceptor but reviewing maybe every 6 weeks with your buddy preceptor and making it very structured."

"Another thing is about communication you come in [as a newly qualified health visitor] and no one is telling you what is going on and you are the one chasing people up and it should be on your first day you come in and this is your preceptor and this is what is going to happen and this and I came in and I don't know whether it is because I was trained here because if I had gone to another trust I would have been treated differently instead of me saying do I have a preceptor and is there a preceptor pack etc."

"The students want to know what support they are going to get and they ask other staff and depending on the feedback it might change their mind as to whether they stay or not."

"It is also about the experience the students receive when they are training you have to be very positive when they are training you have to be very positive, that has an impact on whether they stay I think."

"Is very important (preceptorship/supervision) that part if it is not done well... if you are new you are holding a lot of things and if you don't have anyone to go and talk to easily you might just want to leave."

3. Clearer career pathways

"The Homerton train a lot of students and they end up going away one year down the line they need to think what is available for them think ahead what is the career pathway one year down the line you are going to make progress."

4. Vacancies filled more promptly

"Sometimes the skill mix is very short if you don't have enough we end up doing the bulk of administration."

"When people move change jobs that affects how we work and when three of those things happen at once until things go back to normal it happens again it is a constant pressure I wish something could be done."

"Any shortage of the skill mix affects the whole team I have been in four teams already and there is never enough spare capacity."

"There was the right skill mix when there was the capacity but when people leave and are not replaced you find these little gaps so you need the support and people get tired and leave but if you have the support and if it is structured."

"It can work if we have got that support which is capacity it can work because I have been here quite a long time and it can work we provide a fantastic service when we see the end product it is really nice and in my team we have quite a lot of HVs and the pressure wasn't as much you had the assessment things were put in place and everyone was working together the Children's social care, GP and especially the children's centre we can work closely but when there is that depletion of not having enough support morale just goes down but you know it can work but I am not sure when it is going to happen if they can sort out recruitment and retention."

5. Better or more administrative support

"In our team we only have one HCSW [Healthcare Support Worker] for each base and as HVs [health visitors] we end up transferring and filing records and printing new birth records and preparing new birth packs and the invites."

"Sometimes we have up to 17 clinics in a week which requires a lot of preparation and support."

"RiO2 seems much slower we take a lot of time getting things in and out of our diaries."

6. Stronger leadership and support

"Some areas have high levels of DV [domestic violence] and parenting issues, obesity and orthodox Jewish might have less CP [Child Protection] at the moment I can see a bit things are moving up as there are new recruits but with everything going on with the transition and leadership and the changes going on and I am very worried we need strong leadership, clear guidance and leadership."

"Health Visiting is very different from acute service and how we will be managed by someone across both….it should be recognised the stress of Health Visiting and more awareness amongst commissioners we are happy to talk to them and have those discussions."

"Apart from safeguarding supervision there doesn't appear to be any other type of supervision for health visitors and lot are going through stress because of that and they don't have the opportunity to offload so that should be encouraged because it makes you a better practitioner sharing and thinking about how to deal with that situation."

"It was nice to hear I didn't know what was happening in the south because I am up north I should probable come round and share."

"The forum is good but HVs [health visitors] need to be getting together on their own without senior management."

7. The right skill mix

"In Redbridge where I used to work CNNs had their roles expanded and that has led to more trouble because they miss safeguarding issues etc. and more complaints when no health visitors there and far too many phone calls to the health visitors whilst clinic running."

"I think offering the 5 elements of the HCP is very good and sometimes parents say you offer so much we are here for all the families I think having a consistent good skill mix team really supports it to work well and being very structured about having only the CHCs you really need."

"More staff, more HVs and we can deliver what we need."

8. More opportunities to build relationships with clients

"The volume and capacity means we can't build relationships."

"Now that we are trying to do it antenatally we hopefully will have more continuity and they don't need to keep telling their story."

"You yourself are representing and if you are not there it is someone else. It is a team approach as with such high numbers it can't be anything else."

9. Reducing the high caseload

"We have very big caseloads and depending on the areas we work there is very vulnerable families and we cover the whole HCP but personally when you have a caseload of 800-1000 children it is very difficult to give your best."

"We have only one health visitor per GP my practice has around 800 children but if we had two then it would be 400. It can amount to a lot with the child protection."

I think where there is good integrated team working it does work with family support CSC [Children's Social Care], GPs. We don't work alone and that's the only way we can manage this."

10. Making use of child health clinics

"Someone from the cc comes to the clinic often and she talks to them and sometimes the dietician and they have a quick chat with them and we have had a few mums go to the children centre because they have talked to them."

"Maybe we should invite other services to attend."

"The waiting times I don't think there is much we can do like I said you have one mum you spend 15 minutes who wants to offload you can't tell them to go."

11. Building better partnerships

"My practice (GP practice) it is a smaller practice and there is capacity issues so I try my best to engage him but he is very busy and after clinic I pop my head in but he cannot give himself to the joint working because he is very busy but what I get back from him is not all that I need."

"You just go and speak to the GP if you have a concern and they appreciate that and actually they often have concerns as well but as a new member of staff it is about having that confidence and building that rapport so that you can just go in and that is why I think the preceptorship is so important building that confidence from the start."

"You need that relationship so that they will call you and likewise you call them and my experience some are like that."

"CSC [Children's Social Care] sometimes don't have a clue what we offer and our remit and what we bring to the table."

9.2.2.2 Breastfeeding

Figure 139. Breastfeeding status at birth by age

	Total	Breastfeeding at birth	
		Number	Proportion
<20	202	171	84.7%
20-24	1,214	1,096	90.3%
25-29	1,734	1,587	91.5%
30-34	2,041	1,892	92.7%
35-39	1,391	1,294	93.0%
40-44	380	346	91.1%
45+	29	27	93.1%

Source: Homerton University Hospital Foundation Trust

Figure 140. Breastfeeding status at birth by Children's Centre area

	Total	Breastfeeding at birth	
		Number	Proportion
ZONE A	1,160	1,094	94.3%
ZONE B	1,645	1,565	95.1%
ZONE C	1,213	1,100	90.7%
ZONE D	1,177	1,044	88.7%
ZONE E	875	780	89.1%
ZONE F	921	830	90.1%

Source: Homerton University Hospital Foundation Trust

Figure 141. Breastfeeding at 6-8 weeks by ethnicity

	Number assessed	No breastfeeding		Partial breastfeeding		Total breastfeeding	
		Number	Proportion	Number	Proportion	Number	Proportion
Asian	360	76	21.1%	152	42.2%	132	36.7%
Black	742	116	15.6%	352	47.4%	274	36.9%
Mixed	131	35	26.7%	29	22.1%	67	51.1%
Not stated	851	154	18.1%	272	32.0%	425	49.9%
Other	658	64	9.7%	190	28.9%	404	61.4%
White	1,446	272	18.8%	346	23.9%	828	57.3%

Source: Homerton University Hospital Foundation Trust

Figure 142. Feeding problems by ethnicity

	Total number of births	Presenting with feeding problems	
		Number	Proportion
Asian	709	9	1.3%
Black	1,778	21	1.2%
Mixed	240	11	4.6%
Other	1,012	12	1.2%
White	3,251	42	1.3%

Source: Homerton University Hospital Foundation Trust

Figure 143. Feeding problems by Children's Centre area

	Total number of births	Presenting with feeding problems	
		Number	Proportion
ZONE A	1,160	7	0.6%
ZONE B	1,645	13	0.8%
ZONE C	1,213	22	1.8%
ZONE D	1,177	19	1.6%
ZONE E	875	12	1.4%
ZONE F	921	24	2.6%

Source: Homerton University Hospital Foundation Trust

9.2.2.3 Immunisation

Figure 144. Complete immunisation schedule from summer 2014

Age	Diseases protected against	Vaccine given	Site
2 months	Diphtheria, tetanus, pertussis, polio, *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib (pediacel / Infanrix IPV Hib)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
3 months	Diphtheria, tetanus, pertussis, polio, Hib	DTaP/IPV/Hib (pediacel / Infanrix IPV Hib)	Thigh
	Meningococcal C (MenC)	Men C (NeisVac-C / Menjugate)	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
4 months	Diphtheria, tetanus, pertussis, polio, Hib	DTaP/IPV/Hib (Pediacel / Infanrix IPV Hib)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
Between 12 and 13 months	Hib/MenC	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps, rubella	MMR (Priorix / MMR VaxPRO)	Upper arm/thigh
2, 3 and 4 years	Influenza (from September)	Flu nasal spray (Fluenz Tetra)	Nostrils
3 years 4 months	Diphtheria, tetanus, pertussis, polio	DTaP/IPV (Infanrix IPV / Repevax)	Upper arm
	Measles, mumps, rubella	MMR (Priorix / MMR VaxPRO)	Upper arm

Source: Public Health England

9.2.2.4 School Readiness

Figure 145. Number of 27 month reviews by ethnicity

	Births at HUH to H&C residents (2013/14-14/15)	27 month reviews (2013/14-14/15)		Partially completed	
		Number	As proportion of births at HUH	Number	As proportion of reviews
Asian	709	432	60.9%	<5	-
Black	1,778	1,172	65.9%	14	1.2%
Mixed	240	254	105.8%	<5	-
Other	1,012	531	52.5%	7	1.3%
White	3,251	1,736	53.4%	14	0.8%
Not recorded	1	1,779		11	0.6%

Source: Homerton University Hospital Foundation Trust

Figure 146. Number of 27 month reviews completed or partially completed by Children's Centre area

	Births at Homerton to C&H residents (2013/14-14/15)	27 month reviews (2013/14-14/15)		Partially completed	
		Number	As a proportion of births at Homerton	Number	As a proportion of reviews
ZONE A	1,160	1,157	99.7%	<5	-
ZONE B	1,645	1,221	74.2%	<5	-
ZONE C	1,213	1,024	84.4%	<5	-
ZONE D	1,177	913	77.6%	6	0.7%
ZONE E	875	878	100.3%	29	3.3%
ZONE F	921	711	77.2%	9	1.3%

Source: Homerton University Hospital Foundation Trust

Figure 147. Percentage of pupils achieving a GLD in City & Hackney compared to London and England

	2013 (%)	2014 (%)
Hackney	57	65
City of London		67
London	53	62
England	52	60

Source: Learning trust annual report

Figure 148. Achievement gap between the lowest attaining 20% of children and the mean

	2013	2014
Hackney	32.6	31.2
London	35.9	32.8
England	36.6	33.9

Source: Learning trust annual report

Figure 149. Average total point score

	2013	2014
Hackney	33.3	34.0
London	32.8	33.9
England	32.8	33.8

Source: Learning trust annual report

9.2.2.5 Accident and Emergency Attendances and Emergency Admissions

Figure 150. Number of visits to A&E by 0-4 year olds per head of population by ethnicity

	Hackney 0-4 population	A&E visits (2013/14-2014/15)	Visits / person
White: Total	*8,811*	*10,506*	*1.2*
English/Welsh/Scottish/N. Irish/British	6,267	3,531	0.6
Irish	89	286	3.2
Gypsy or Irish Traveller	54	-	-
Other White	2,401	6,689	2.8
Mixed/multiple ethnic group: Total	*2,189*	*1,609*	*0.7*
White and Black Caribbean	710	206	0.3
White and Black African	381	101	0.3
White and Asian	429	38	0.1
Other Mixed	669	1,264	1.9
Asian/Asian British: Total	*2,049*	*2,289*	*1.1*
Indian	566	799	1.4
Pakistani	174	220	1.3
Bangladeshi	717	715	1.0
Chinese	170	263	1.5
Other Asian	422	292	0.7
Black/African/Caribbean/Black British: Total	*4,740*	*6,380*	*1.3*
African	2,564	3,783	1.5
Caribbean	1,075	1,334	1.2
Other Black	1,101	1,263	1.1
Other ethnic group: Total	*1,360*	*1,280*	*0.9*
Arab	163	-	-
Any other	1,197	1,280	1.1

Source: Census 2011; Homerton University Hospital

Figure 151. Admissions rate by age

Age	Estimated 0-4 population	All admissions	
		Number	Per 1,000 population
0	4,292	1,619	377.2
1	4,000	761	190.3
2	3,810	488	128.1
3	3,607	382	105.9
4	3,676	310	84.3

Source: Homerton University Hospital Foundation Trust

Figure 152. Admissions rates by gender

Age	Boys			Girls		
	Population estimate	Admissions		Population estimate	Admissions	
		Number	Per 1,000		Number	Per 1,000
0	2,141	920	429.7	2,151	699	325.0
1	2,042	429	210.1	1,958	332	169.6
2	1,896	298	157.2	1,914	190	99.3
3	1,827	228	124.8	1,780	154	86.5
4	1,804	181	100.3	1,872	129	68.9

Source: Homerton University Hospital Foundation Trust

Figure 153. Admissions by ethnicity

Ethnicity		Number	Per 1,000
White: Total	*8,811*	*1,756*	*199.3*
English/Welsh/Scottish/Northern Irish/British	6,267	629	100.4
Irish	89	36	404.5
Gypsy or Irish Traveller	54	-	
Other White	2,401	1,091	454.4
Mixed/multiple ethnic group: Total	*2,189*	*260*	*118.8*
White and Black Caribbean	710	29	40.8
White and Black African	381	19	49.9
White and Asian	429	6	14.0
Other Mixed	669	206	307.9
Asian/Asian British: Total	*2,049*	*404*	*197.2*
Indian	566	145	256.2
Pakistani	174	44	252.9
Bangladeshi	717	126	175.7
Chinese	170	36	211.8
Other Asian	422	53	125.6
Black/African/Caribbean/Black British: Total	*4,740*	*929*	*196.0*
African	2,564	578	225.4

Caribbean	1,075	172	160.0
Other Black	1,101	179	162.6
Other ethnic group: Total	*1,360*	*149*	*109.6*
Arab	163	-	
Any other	1,197	149	124.5

Source: Homerton University Hospital Foundation Trust

Figure 154. Admissions by Children's Centre area

Child Centre Area	Estimated 0-4 population	All admissions	
		Number	Per 1,000 population
A	3,750	586	156.3
B	4,289	728	169.7
C	3,090	618	200.0
D	2,853	633	221.9
E	3,036	482	158.8
F	2,366	513	216.8

Source: Homerton University Hospital Foundation Trust

Figure 155. Search terms for gastroenteritis

Diagnosis	City & Hackney admissions
A099 - Gastroenteritis and colitis of unspecified origin	93
R11X - Nausea and vomiting	28
A090 - Other and unspecified gastroenteritis and colitis of infectious origin	24
P920 - Vomiting in newborn	<20
P783 – Non-infective neonatal diarrhoea	<5

Source: Homerton University Hospital Foundation Trust

Figure 156. Gastroenteritis admissions by age

Age	Estimated 0-4 population	All admissions	Gastroenteritis admissions		
			Number	Per 1,000 population	Per 1,000 admissions
0	4,292	1,619	68	15.8	42.0
1	4,000	761	50	12.5	65.7
2	3,810	488	18	4.7	36.9
3	3,607	382	10	2.8	26.2
4	3,676	310	10	2.7	32.3

Source: Homerton University Hospital Foundation Trust

Figure 157. Gastroenteritis admissions by ethnicity

Ethnicity	Estimated 0-4 population	All admissions	Gastroenteritis admissions		
			Number	Per 1,000 population	Per 1,000 admissions
Asian	2,049	404	24	11.7	59.4
Black	4,740	929	44	9.3	47.4
Mixed	2,189	260	14	6.4	53.8
Other	1,360	149	5	3.7	33.6
White	8,811	1,756	66	7.5	37.6

Source: Homerton University Hospital Foundation Trust

Figure 158. Gastroenteritis admissions by Children's Centre area

Children's Centre area	Estimated 0-4 population	All admissions	Gastroenteritis admissions		
			Number	Per 1,000 population	Per 1,000 admissions
A	3,750	586	28	7.5	47.8
B	4,289	728	25	5.8	34.3
C	3,090	618	24	7.8	38.8
D	2,853	633	45	15.8	71.1
E	3,036	482	20	6.6	41.5
F	2,366	513	14	5.9	27.3

Source: Homerton University Hospital Foundation Trust

Figure 159. Respiratory search terms

Term	Diagnosis	City & Hackney admissions
Bronchiolitis		*229*
	J219 - Acute bronchiolitis, unspecified	178
	J210 - Acute bronchiolitis due to respiratory syncytial virus	46
	J218 - Acute bronchiolitis due to other specified organisms	3
	J211 - Acute bronchiolitis due to human metapneumovirus	2
Lower respiratory		*116*
	J22X - Unspecified acute lower respiratory infection	116
Pneumonia		*88*
	J181 - Lobar pneumonia, unspecified	71
	J189 - Pneumonia, unspecified	5
	J129 - Viral pneumonia, unspecified	4
	J123 - Human metapneumovirus pneumonia	2
	J157 - Pneumonia due to Mycoplasma pneumoniae	1
	J180 - Bronchopneumonia, unspecified	1
	P239 - Congenital pneumonia, unspecified	1
	J100 - Influenza with pneumonia, other influenza virus identified	1

	J110 - Influenza with pneumonia, virus not identified	1
	J121 - Respiratory syncytial virus pneumonia	1
Asthma		*42*
	J459 - Asthma, unspecified	40
	J46X - Status asthmaticus	2

Source: Homerton University Hospital Foundation Trust

Figure 160. Respiratory admissions by age / gender

Age	Estimated 0-4 population	All admissions	Respiratory admissions		
			Number	Per 1,000 population	Per 1,000 admissions
0	4,292	1,619	214	49.9	132.2
1	4,000	761	95	23.8	124.8
2	3,810	488	67	17.6	137.3
3	3,607	382	43	11.9	112.6
4	3,676	310	56	15.2	180.6
Female 0-4	9,675	1,504	170	17.6	113.0
Male 0-4	9,710	2,056	305	31.4	148.3

Source: Homerton University Hospital Foundation Trust

Figure 161. Respiratory admissions by ethnicity

Ethnicity	Estimated 0-4 population	All admissions	Respiratory admissions		
			Number	Per 1,000 population	Per 1,000 admissions
Asian	2,049	404	54	26.4	133.7
Black	4,740	929	117	24.7	125.9
Mixed	2,189	260	24	11.0	92.3
Other	1,360	149	21	15.4	140.9
White	8,811	1,756	251	28.5	142.9

Source: Homerton University Hospital Foundation Trust

Figure 162. Respiratory admissions by Children's Centre area

Children's Centre area	Estimated 0-4 population	All admissions	Respiratory admissions		
			Number	Per 1,000 population	Per 1,000 admissions
A	3,750	586	89	23.7	151.9
B	4,289	728	116	27.0	159.3
C	3,090	618	85	27.5	137.5
D	2,853	633	66	23.1	104.3
E	3,036	482	57	18.8	118.3
F	2,366	513	62	26.2	120.9

Source: Homerton University Hospital Foundation Trust

Figure 163. Feeding problems search terms

Diagnosis	City & Hackney admissions
P928 - Other feeding problems of newborn	19
P929 - Feeding problem of newborn, unspecified	16
R633 - Feeding difficulties and mismanagement	10
P925 - Neonatal difficulty in feeding at breast	7
P923 - Underfeeding of newborn	<5
P922 - Slow feeding of newborn	<5
P924 - Overfeeding of newborn	<5

Source: Homerton University Hospital Foundation Trust

Figure 164. Accidents and injuries admissions by age

Age	Estimated 0-4 population	All admissions	Accidents and injuries admissions		
			Number	Per 1,000 population	Per 1,000 admissions
0	4,292	1,619	83	19.3	51.3
1	4,000	761	53	13.3	69.6
2	3,810	488	31	8.1	63.5
3	3,607	382	33	9.1	86.4
4	3,676	310	19	5.2	61.3

Source: Homerton University Hospital Foundation Trust

Figure 165. Accidents and injuries admissions by gender

Gender	Estimated 0-4 population	All admissions	Accidents and injuries admissions		
			Number	Per 1,000 population	Per 1,000 admissions
F	9,675	1,504	105	10.9	69.8
M	9,710	2,056	114	11.7	55.4

Source: Homerton University Hospital Foundation Trust

Figure 166. Accidents and injuries admissions by ethnicity

Ethnicity	Estimated 0-4 population	All admissions	Accident and injury admissions		
			Number	Per 1,000 population	Per 1,000 admissions
Asian	2,049	404	19	9.3	47.0
Black	4,740	929	44	9.3	47.4
Mixed	2,189	260	25	11.4	96.2
Other	1,360	149	9	6.6	60.4
White	8,811	1,756	116	13.2	66.1

Source: Homerton University Hospital Foundation Trust

Figure 167. Accidents and injuries admissions by Children's Centre area

Children's Centre area	Estimated 0-4 population	All admissions	Accident and injury admissions		
			Number	Per 1,000 population	Per 1,000 admissions
A	3,750	586	31	8.3	52.9
B	4,289	728	48	11.2	65.9
C	3,090	618	36	11.7	58.3
D	2,853	633	38	13.3	60.0
E	3,036	482	27	8.9	56.0
F	2,366	513	39	16.5	76.0

Source: Homerton University Hospital Foundation Trust

Figure 168. Search terms for accidents and injuries

ICD-10 codes	ICD-10 category	City & Hackney admissions
S00-S09	Injuries to the head	129
S10-T14	Injuries to other parts of the body	19
T36-T65	Poisoning (medical and non-medical)	44
T20-T23	Burns and corrosions	6
T66-T78	Other and unspecified effects of external causes	24

Source: Homerton University Hospital Foundation Trust

9.2.2.6 Childhood Weight and Obesity

Figure 169. Prevalence of underweight, healthy weight, overweight and obesity in YR and Y6 in Hackney, and compared to region and England

	Hackney		London	England		
	Count	Value	Value	Average	Worst	Best
YR: Prevalence Of underweight	35	1.34	1.47%	0.95		
YR: prevalence of healthy weight	1864	71.5	75.4%	76.5		
YR: Prevalence of overweight (including obesity)	709	27.2	23.1%	22.5	30.6%	12.1%
YR: prevalence of obesity	375	14.4	10.8%	9.5	14.4%	4.0%

Source: NCMP 2013/2014

Figure 170. Prevalence of underweight, healthy weight, overweight and obesity in YR and Y6 in Hackney, and compared to statistical neighbours

	Brent	Haringey	Lambeth	Lewisham	Newham	Southwark	Hackney	England
YR: Prevalence of underweight	2.16	0.89	0.97	1.12	2.95	1.09	1.34	0.95
YR: prevalence of healthy weight	71.0	78.9	74.3	74.2	74.0	70.9	71.5	76.5
YR: Prevalence of overweight (including	26.8	20.2	24.8	24.6	23.1	28.0	27.2	22.5

obesity)								
YR: prevalence of obesity	13.8	9.7	12.3	10.8	12.4	13.1	14.4	9.5

Source: NCMP 2013/2014

9.2.2.7 Dental Health

Figure 171. Prevalence and severity of dental decay at age five

Area	% children who have experienced tooth decay	Number of decayed, missing or filled teeth
Brent	45.9%	1.81
Hackney	31.4%	1.17
Haringey	38.0%	1.78
Lambeth	23.8%	0.81
Lewisham	21.9%	0.58
Newham	39.0%	1.65
Southwark	21.9%	0.79
England	27.9%	0.94

Source: National dental epidemiology programme 2012

9.2.3 Family

9.2.3.1 Domestic Violence

Figure 172. Domestic violence screening by age

	Total births	Status recorded		Yes	
		Number	Proportion	Number	Proportion of all status recorded
<20	202	122	60.4%	7	5.7%
20-24	1,214	795	65.5%	23	2.9%
25-29	1,734	1,122	64.7%	30	2.7%
30-34	2,041	1,303	63.8%	25	1.9%
35-39	1,391	911	65.5%	15	1.6%
40-44	380	261	68.7%	<5	-
45+	29	15	51.7%	<5	-

Source: Homerton University Hospital Foundation Trust

Figure 173. Domestic violence screening by ethnicity

	Total births	Status recorded		Yes	
		Number	Proportion	Number	Proportion of all status recorded
Asian	709	477	67.3%	18	3.8%
Black	1,778	1,179	66.3%	43	3.6%
Mixed	240	159	66.3%	9	5.7%
Other	1,012	674	66.6%	6	0.9%
White	3,251	2,039	62.7%	28	1.4%

Source: Homerton University Hospital Foundation Trust

Figure 174. Domestic violence screening by Children's Centre area

	Total	Status recorded		Yes	
		Number	Proportion	Number	Proportion of all status recorded
ZONE A	1,160	722	62.2%	15	2.1%
ZONE B	1,645	1,074	65.3%	9	0.8%
ZONE C	1,213	786	64.8%	28	3.6%
ZONE D	1,177	795	67.5%	14	1.8%
ZONE E	875	573	65.5%	15	2.6%
ZONE F	921	579	62.9%	23	4.0%

Source: Homerton University Hospital Foundation Trust

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DOMINE DIRIGE NOS

CITY OF LONDON

Hackney