



Giving children a healthy start

This summary is an overview of our full health report published on 3 February 2010

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Our work across local government, health, housing, community safety and fire and rescue services means that we have a unique perspective. We promote value for money for taxpayers, auditing the £200 billion spent by 11,000 local public bodies.

As a force for improvement, we work in partnership to assess local public services and make practical recommendations for promoting a better quality of life for local people.

Children have a right to enjoy the best possible health, but there are significant differences in their experiences. Children under five years living in deprived areas are 8 per cent more likely to be obese; 9 per cent more likely to be of a low birth weight; and 12 per cent more likely to have an accident than those living in the rest of England. Evidence clearly demonstrates that improving early years' health contributes considerably to better health outcomes in later life, with reduced levels of diabetes, coronary heart disease and hypertension, all of which have a significant impact on the NHS as well as wider society, children and their families.

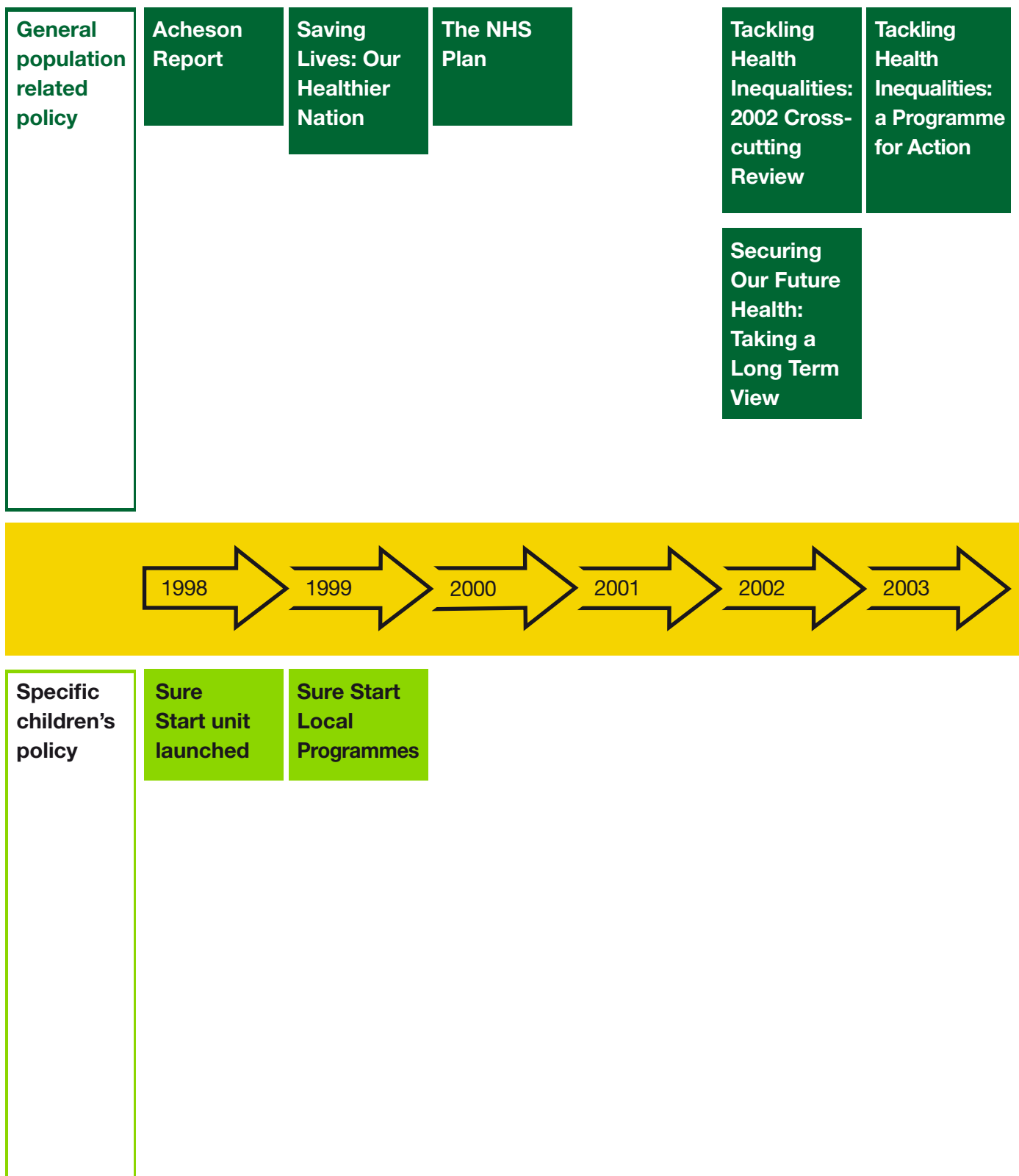
What has been the scope of government policy?

Children's health has been an increasing priority for the government over the last ten years. Between 1999 and 2009 the government published over 20 policies relating to the health of under-fives (Figure 1). However, except for Sure Start and more recent policies such as the Healthy Child Programme, policy statements have largely focused on the 0 to 19 years age group or wider population public health, rather than on the under-fives.

How has money been invested?

Between 1998/99 and 2010/11 we estimate that £10.9 billion (including £7.2 billion for Sure Start, which had dedicated funding for health improvements in the early phase of roll-out) will have been invested in programmes aimed in whole, or in part, at improving the health of the under-fives, but this has not produced widespread improvements in health outcomes (Table 1). Some health indicators have indeed worsened – for example, obesity and dental health – and the health inequalities gap between rich and poor has barely changed.

Figure 1: Key policy affecting the health of under-fives



Note: NSF – National Service Framework

Source: Audit Commission



Table 1: **Funding for under-fives, 1998/99 to 2010/11ⁱ**

Funding	1999/2000 – 2001/02 £millions (actual)	2002/03 – 2004/05 £millions (actual)	2005/06 – 2007/08 £millions (actual)	2008/09 – 2010/11 £millions (estimated)
For under-fives (capital)				
Sure Start Local Programmes		430		0
Children’s centres	0	13	675	351
Subtotal		1,118		351
For under-fives (revenue)				
Sure Start Local Programmes	141	840	1,074	838
Children’s centres	0	13	656	2,205
Health visitors	965	965	900	840
Subtotal	1,106	1,818	2,630	3,883
Other funding with impact on under-fives’ health				
PCT public health spend and LA children’s service grants	599	3,251	3,010	6,440
Children’s policy (with health impact) and Health policy (with impact on children)	915	0	1,515	1,721
Other general funding	242	279	306	773
Subtotal	1,756	3,530	4,831	8,934

Source: Audit Commission (data from DCSF)

ⁱ Table 1 includes only general health funding and not hospital spend, which is outside the scope of the study. The table does not include payments to GPs, including under the Quality Outcomes Framework, that relate to services for under-fives as this is not collected nationally for specific age groups.

How have local bodies responded?

Our research found that local authorities and primary care trusts (PCTs) were aware of the key health issues affecting the under-fives in their areas, but this was not always reflected in strategic plans, and was rarely given priority in local area agreements.

Children from minority groups have poorer health outcomes and their parents are less likely to access mainstream health services due to lack of awareness or cultural preferences. Our focus groups targeted black and minority ethnic (BME) groups, young parents (under 21 who had used teenage services) and lone parents. Many of the barriers to service access were similar across all these groups (Table 2).

Table 2: **Focus group findings: Barriers to service access and common themes for vulnerable groups**

Group	Barriers and common themes			
BME	Language barriers	Preference for traditional cultural health practices	Dislike judgmental nature of health professionals	New migrants unaware of services
Young parents	Isolation from friends and family	Preference for attending health services targeted at teenagers	Dislike judgmental nature of health professionals (and other parents)	Enjoy the social nature of services
Lone parents	Lack of confidence brought on by depression or anxiety	Need for informal support	Dislike judgmental nature of health professionals	

Source: Audit Commission

‘Parents in the Portuguese community don’t speak English; they don’t know how to communicate with people so they just don’t use children’s centres.’

Portuguese mother, Luton

‘Yeah, I went to a Sure Start. I felt uncomfortable as soon as I walked in and as soon as one of the older parents’ kids went near mine they pulled them away.’

Young mother, Coventry

Local bodies need to tailor and target their service provision appropriately for these groups. But few local authorities and PCTs in our research had a rigorous approach to identifying the take-up of existing services and addressing any gaps.

We found notable practice. The case studies in the report and Oneplace show local bodies that are successfully addressing the challenges presented in engaging their vulnerable groups and providing tailored services to help improve the health of the under-fives.ⁱ There are also other examples on which to build. Additionally, some services, such as children's centres, are still developing.

Case study 1

Roma Families' Initiative, Redbridge

One local children's centre in Redbridge runs a group three times a week for Roma children and parents or carers, the majority of whom do not speak English. The group was set up to assist children with their health needs and to prepare them for early education. The centre organises Romanian-speaking frontline workers to attend the group to translate and support parents. In addition, a health visitor also runs a clinic once a week to carry out services such as post-natal screening and to help parents register with GPs.

The programme has been running for nearly two years and has expanded from an initial group of 25 children to 475 children, largely through word of mouth.

'I didn't know about the group when I was pregnant, but another [Roma] mother told me about it. Before this I had only seen the health visitor once.'

Roma mother

The group was also promoted with a leaflet in Romanian that was circulated in the community. The initiative receives £65,000 Sure Start funding through Redbridge Council.

Local parents who use the groups found them to be helpful for their children's mental and physical health, and an important forum for their community to discuss issues relating to their children.

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‘I come here because it is sociable. The children can play together, but we can also talk together to solve problems about the children’s health. And we are happy to see the children improving.’

Roma mother

Parents in the group reported that they used very few formal health services for their young children due to language issues. Many also felt that health practitioners were prejudiced against them.

Consequently, the group provides a comfortable forum where parents can consult health professionals with other members of their community present, and with a translator at hand. On average, ten mothers receive health advice and support from a dedicated health visitor each week.

Source: Audit Commission

What needs to happen now?

Public services will be under significant financial pressure over the coming decade and the investment in early years’ health has not so far resulted in notably improved outcomes. We consider that better value for money could be obtained for the amount already being invested if, in future:

- local services work under a single joint set of priorities and targets, supported by a clear statement of government policy that is not subject to frequent revision and addition;
- responsibility (and therefore accountability) for commissioning and delivering services are clear locally;
- the amount spent on under-fives’ health within an area is identified and its targeting reviewed, so as to have most impact on the most vulnerable groups;
- data on the extent to which intended users are actually accessing services is routinely examined and action taken accordingly to identify and attract those that are not;
- the targeting and impact of individual interventions and services are rigorously reviewed, and investment and disinvestment decisions made accordingly;
- local statutory bodies monitor the quality and impact of services for the under-fives in the light of financial pressures to ensure that they are maintained; and
- the good practice that is evident in some localities is celebrated and information about it widely shared.

Recommendations

Government should:

- continue to develop and actively promote age-specific cross-departmental children's health policy for the under-fives, thereby reducing inconsistency, and duplication between departments, and better informing local service planning and delivery;
- undertake a review of the funding and workforce implications before continuing to roll out the Family Nurse Partnership programme; and
- monitor and review the impact of the current economic downturn and potential financial impact on the provision of children's services.

Local authorities and primary care trusts should:

- ensure that their Children and Young People's and Operational plans contain appropriate and challenging targets for improving the health of the under-fives that are jointly set and consistent with each other;
- be clear about where accountability for commissioning and delivering services lies;
- continually assess the quality of services and progress on health outcomes being achieved in the light of financial pressures to ensure that they are maintained;
- have a clear understanding of the resources being allocated to under-fives and the impact on health outcomes;
- use targeted evidence-based interventions to improve the health of the under-fives, particularly those in vulnerable groups, evaluating their impact and ceasing to invest in those that show a poor return;
- rigorously assess the take-up of services and improve engagement with parents and service users to raise awareness of, and increase access to them;
- ensure that professionals deliver information for new parents about their child's health so it is phased to help understanding. It should be timely, relevant, accessible and culturally sensitive where appropriate; and
- use the good practice available in this report and elsewhere such as Oneplace and *Facilitating Integrated Practice Between Children's Services and Health*.

Children's health services should be reviewed to include groups not accessing current services, with a particular focus on vulnerable children

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We welcome your feedback. If you have any comments on this report, are intending to implement any of the recommendations, or are planning to follow up any of the case studies, please email:

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