

Giving children a healthy start

Health report, February 2010



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Summary

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.

Children under five years living in deprived areas have a significantly higher risk of poor health

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. 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.

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. Some health indicators have indeed worsened – for example, obesity and dental health – and the health inequalities gap between rich and poor has barely changed.

Our research found that local authorities (LAs) 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 (LAAs).

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. Local bodies need to tailor and target their service provision appropriately, for these groups. But few LAs 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 this 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.

ⁱ Oneplace is an independent overview of local public services www.direct.gov.uk/oneplace



Cultural preferences can adversely affect the health of children from minority groups

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 is 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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This report assesses the local implementation of national policy from 1999 to 2009 on the health of children from birth to five years of age in England. It examines local service planning and delivery, including priority setting, and how local bodies can improve service delivery and access for vulnerable groups such as black and minority ethnic (BME) communities, lone and teenage parents. The report discusses the impact of government funding on health outcomes for the under-fives; how effectively local bodies manage their resources; and the extent to which they are providing good value for money. It provides recommendations for national and local bodies, as well as examples of notable practice.

Healthy children are more likely to become healthy adults



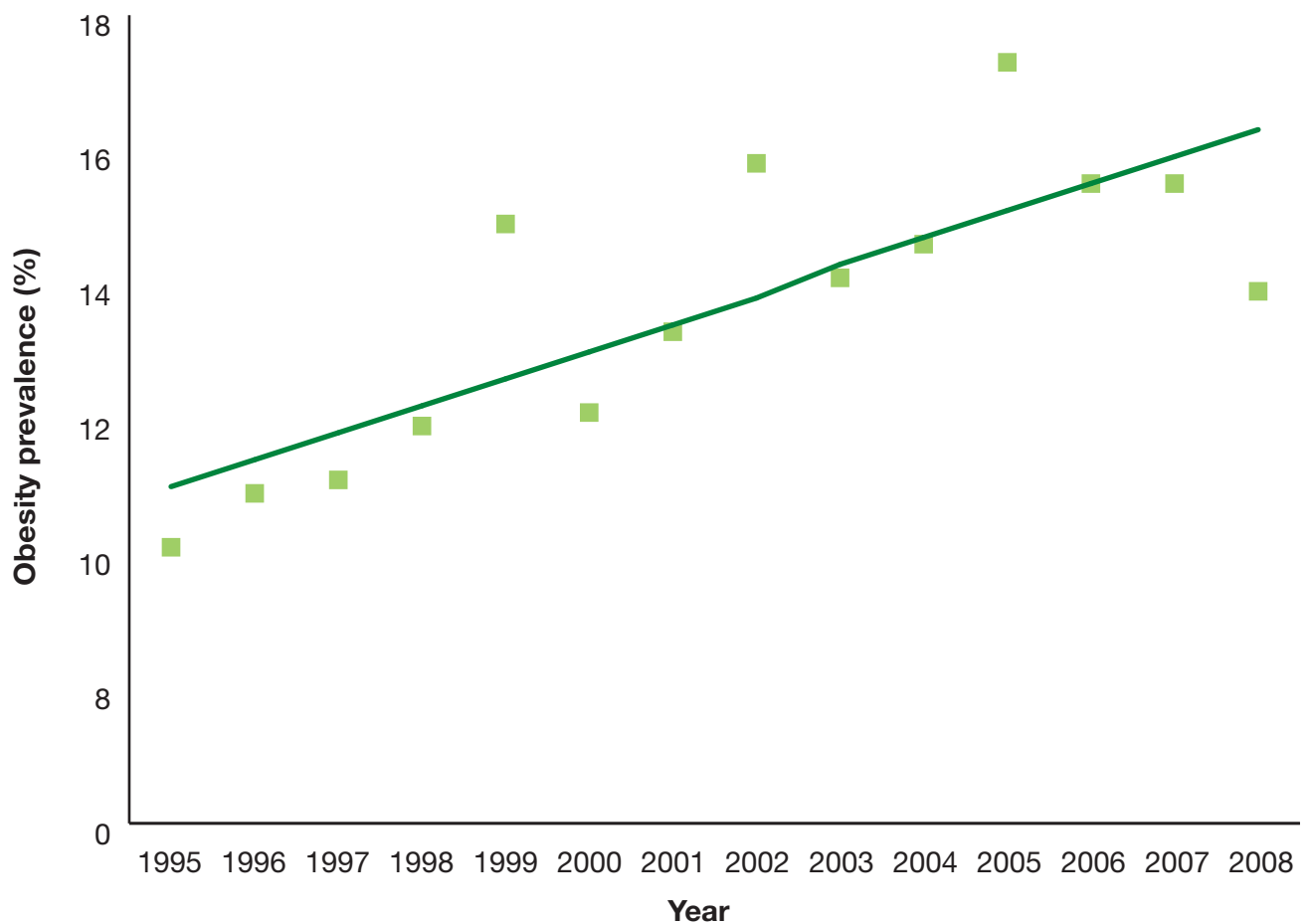
Background

Addressing health issues early in childhood has been shown to improve health outcomes in later life and can reduce demand and cost pressures on the NHS

1 The health of children under five years of age needs to be a priority area for government, LAs and PCTs. Addressing health issues early in childhood has been shown to improve health outcomes in later life. It also reduces potential additional demand and cost pressures on the NHS due to poor health. Obesity, which is a causal factor in coronary heart disease, hypertension and diabetes, currently costs the NHS £4.2 billion and wider society £15.8 billion per year – without action, the cost will more than double by 2050 (Ref. 1). Childhood obesity has risen from 10.1 to 13.9 per cent between 1995 and 2008 (Ref. 2) (Figure 1), although the rate of growth may now be slowing. In addition, children who are overweight or obese are more likely to become obese adults (Ref. 3).

2 Many factors affect an individual's health, including lifestyle and socio-economic, cultural and environmental conditions. Children living in deprived areas are 54 per cent more likely to live in workless households (Ref. 4) (including those with lone parents) and experience worse health inequalities than under-fives living in less deprived areas (Ref. 5). For example, children in this group are 19 per cent more likely to have poor dental health. Tackling such health inequalities presents challenges in service planning, delivery, and resource management to local bodies.

Figure 1: **Obesity prevalence among children aged two to ten years, 1995 to 2008**



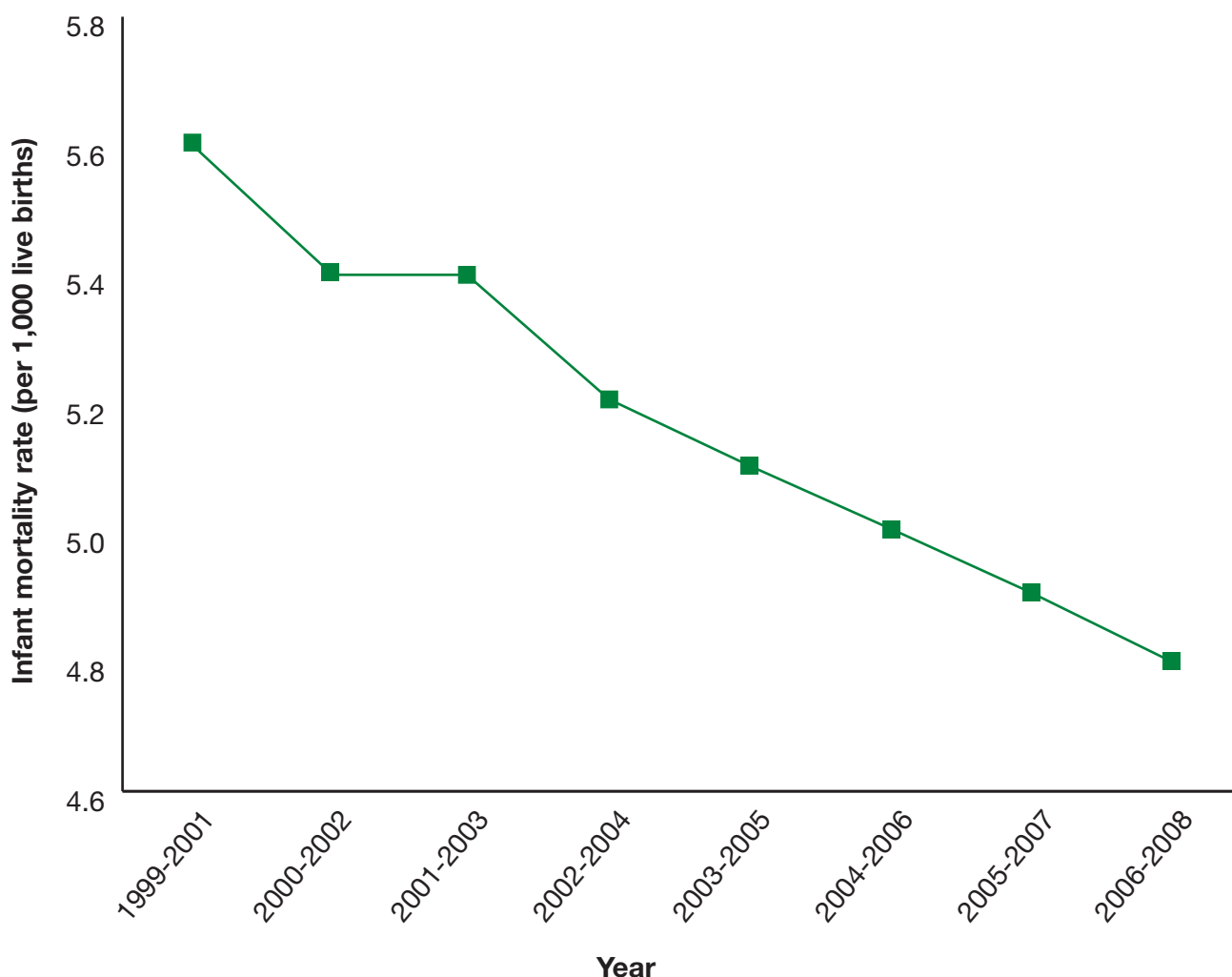
Source: *Audit Commission (Information Centre for Health and Social Care, 2009)*

3 Since 2004, the government has increasingly emphasised the importance of early intervention to ensure better health outcomes for children, prioritising maternal and early childhood health as one of several key services provided through the early Sure Start programmes and now Sure Start children's centres for the under-fives (Ref. 6). Nevertheless, this integrated approach has not yet resulted in significant improvement in health outcomes for the under-fives.

The rate of dental decay for spearhead areas is still poor compared with the national average, and getting worse

4 Some health outcomes have shown small improvements in the last ten years, such as infant mortality, which has decreased from 5.6 to 4.8 deaths per 1,000 live births (Ref. 7) (Figure 2), although this is still relatively high in comparison with other European countries (Figure 3). However, other health indicators have deteriorated – mumps, measles and rubella (MMR) immunisation rates for five-year-olds have decreased from 93 per cent to 89 per cent from 1999 to 2009 (Ref. 8) and the average five-year-old in 2005/06 had 1.47 decayed missing and filled teeth (DMFT), compared with 1.43 in 1999/00 (Ref. 9). The rate of dental decay for spearhead areas is still poor compared with the national average, and getting worse (Figure 4).ⁱ

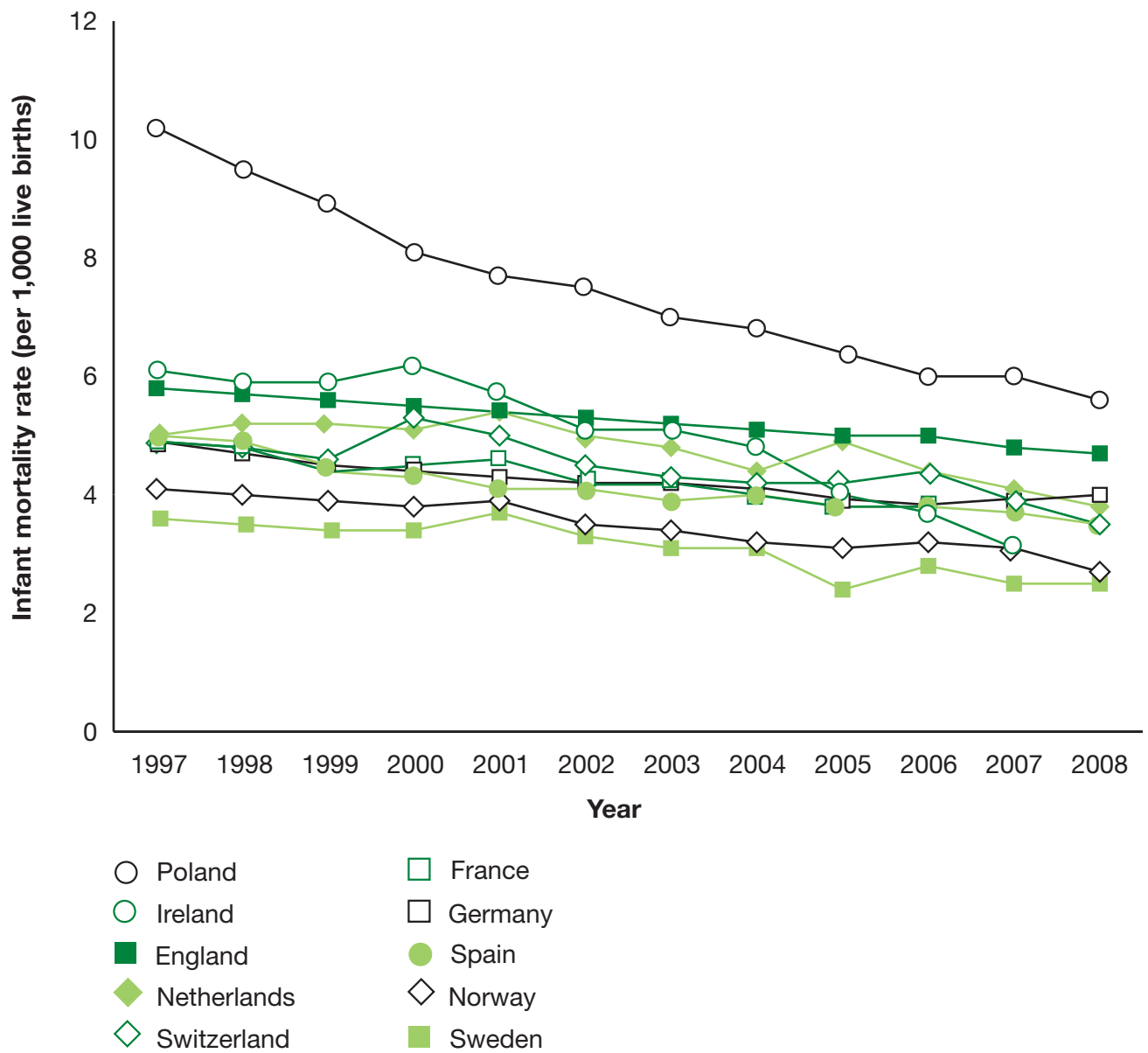
Figure 2: Infant mortality rate for England, 1999 to 2008



Source: Audit Commission (data from Office for National Statistics)

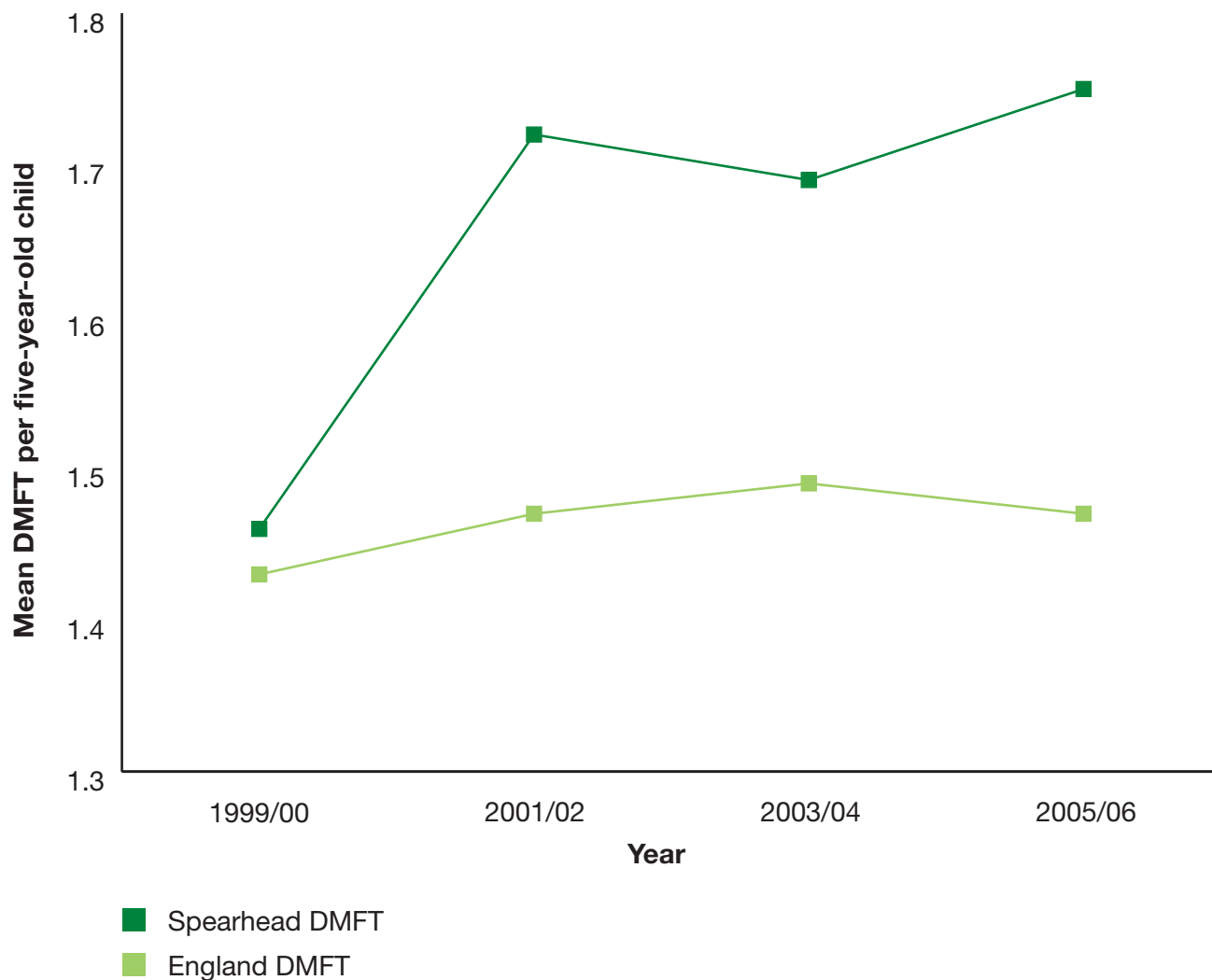
ⁱ The spearhead group is made up of 70 LA and 62 PCT areas that are in the bottom fifth nationally for three or more of the following indicators: life expectancy at birth; cancer mortality rate in under 75s; cardiovascular disease mortality rate in under 75s; and average score on the Index of Multiple Deprivation.

Figure 3: International comparisons of infant mortality rates in Europe, 1997 to 2008



Source: Audit Commission (data from Eurostat)

Figure 4: **Decayed missing and filled teeth per child in England and spearhead areas, 1999/00 to 2005/06**



Source: Audit Commission (data from British Association for the Study of Community Dentistry 1999/00 to 2005/2006)

Scope and methodology

5 This report focuses on the health of children from birth (not including pregnancy) to five years old and assesses how local bodies are addressing their health needs. While acknowledging the role of the wider determinants of children's health such as parental alcohol and substance abuse, workless households, children's emotional and mental health needs, and the needs of disabled children, these have been excluded from the scope of this report. Our methodology involved literature reviews, national and local data analysis, a survey of all top-tier LAs and PCTs (response rate 28 per cent), site visits to 12 LAs and corresponding PCTs and 16 focus groups. We also tested our findings with representative expert groups. Fuller details of the methodology are in Appendix 1.

Report structure

6 Chapter 2 examines national policy for under-fives' health between 1999 and 2009. Chapter 3 looks at local service delivery and planning, including priority setting in LAAs, and service provision by children's centres and health visitors. Chapter 4 assesses how local bodies have addressed gaps in service provision. It examines the health needs of vulnerable groups, and identifies barriers to access and service provision. It also identifies notable practice to enable local bodies to improve their engagement with these groups. Chapter 5 considers the impact of funding and resources on health outcomes for under-fives, and examines the value for money of programmes and services at local level.

National health policy for under-fives

Since 1999, there have been 27 national policies (approximately one every six months) aimed at improving the health of under-fives as a way to reduce health inequalities (Figure 5). However, much of the policy has concentrated on the 0 to 19 years age group or been encompassed within a wider population-based approach rather than specifically address the under-fives, although, more recently, there has been a greater focus on this group. Appendix 2 sets out the evolution of children’s health policy.

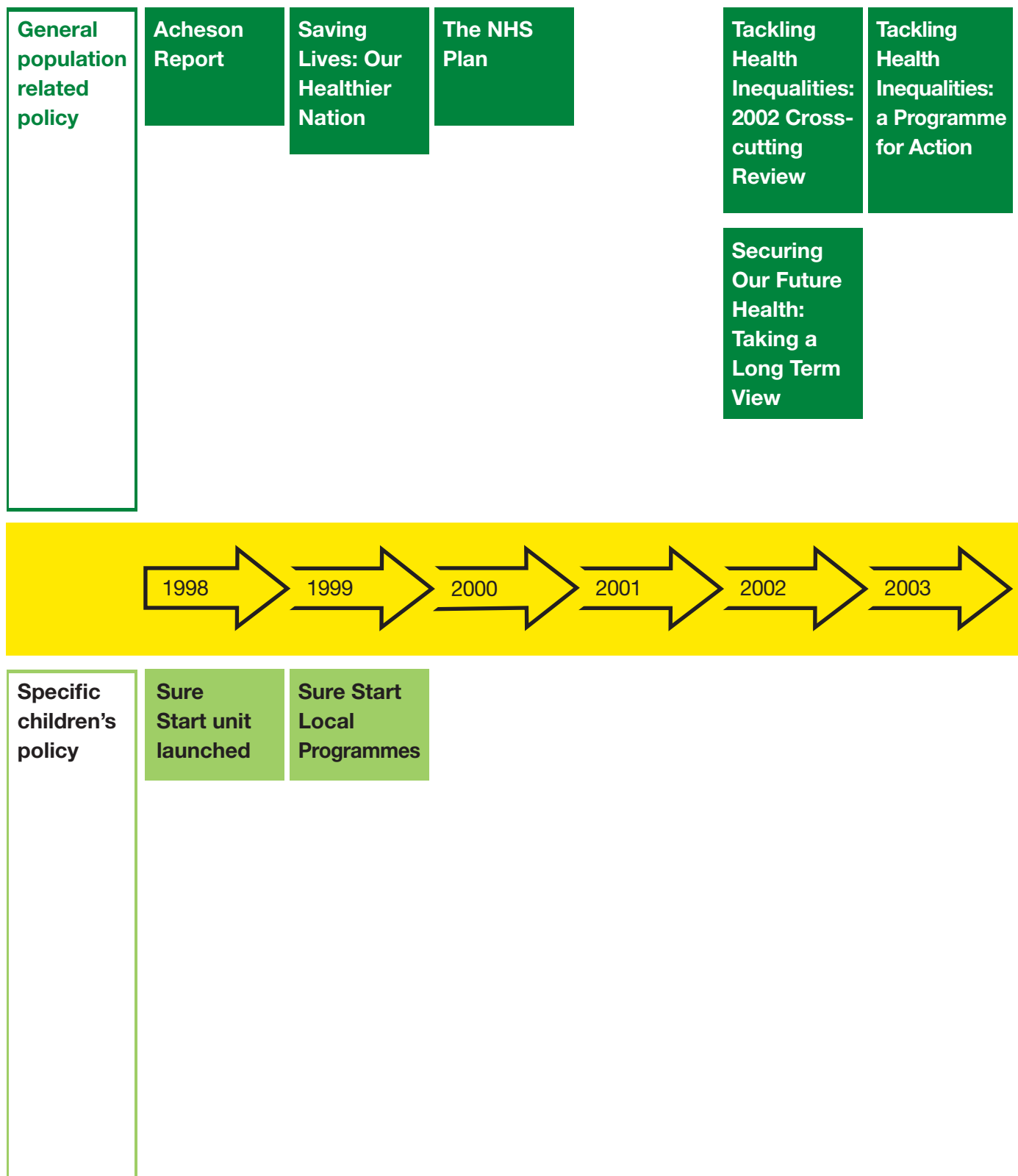
7 A key early development for under-fives was the introduction of Sure Start Local Programmes (SSLPs) in 1999 to work with parents and parents-to-be to promote the physical, intellectual and social development of children under four years old (this has now been extended to under-fives with the move to the Sure Start children’s centres programme) particularly those who were disadvantaged. SSLPs provided services including good quality play and learning experiences, primary and community healthcare, support for children and parents with special needs and parenting and family support, through a series of area-based local programmes run by local partnerships in the 20 per cent most deprived wards. The government originally aimed to have 250 operational SSLPs by 2002 but this target was later expanded and by 2003 there were 524. All SSLPs have now become children’s centres. LAs have been allocated £275 million ring-fenced funding for children’s centres based on former SSLPs as part of their Sure Start, Early Years and Childcare Grant for 2009/10.

£275m
is currently
provided
centrally to
support Sure
Start Local
Programmes

8 In 2003, there was a step-change in children’s policy with the publication of *Every Child Matters* (Ref. 10) in response to the Victoria Climbié Inquiry (Ref. 11). It set out five outcomes (be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic wellbeing) by which all services for children, young people and their families should be assessed. Its approach is now fully integrated into local planning and underpins all children’s services through measures such as Children’s Services Directors and Children and Young People plans, and delivery structures such as children’s trusts and Sure Start children’s centres.ⁱ

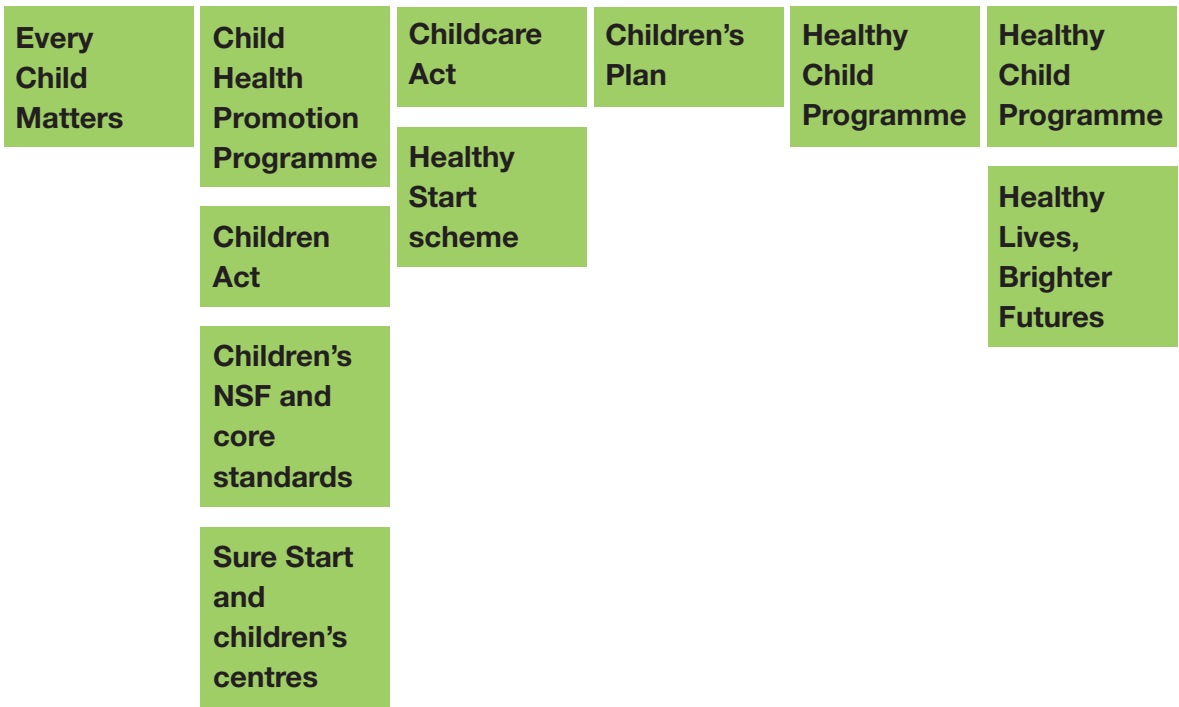
i Children’s trusts were introduced into law by the Children Act 2004. They are unincorporated associations of the key agencies involved in delivering public services to children and young people in their area.

Figure 5: Key policy affecting the health of under-fives



Note: NSF – National Service Framework

Source: Audit Commission



Sure Start children's centres

Sure Start children's centres have been developed from SSLPs, Early Excellence Centres and Neighbourhood Nurseries Programme and other provision. They provide a variety of services including integrated early education and childcare, child and family health, parenting and wider family support and advice on employment and training for parents through links with Jobcentre Plus. The centres have been rolled out in three phases with the aim to have 3,500 children's centres in place by March 2010 – one for every community. As of December 2009, there were just over 3,000. The first children's centres were originally established to serve the most deprived areas but the last phase will complete delivery of a centre for every community and cover for all under-fives in England. This represents a significant investment in early childhood services totalling £1 billion a year.

Source: Department for Children, Schools and Families

9 *Every Child Matters* was followed in 2004 by the *National Service Framework for Children, Young People and Maternity Services* (Ref. 12), which aimed to help PCTs develop health services around children and families. The Framework gave a central role to health visitors in delivering and integrating care. In addition, it introduced the Child Health Promotion Programme, now the Healthy Child Programme, updated in 2008 and 2009 (Ref. 13, Ref. 14), which intended to provide preventative services tailored to the individual needs of children and families.

10 More recently, targeted policies such as the Healthy Child Programme (Ref. 14) have concentrated on pregnancy and the first five years of life. While these policies contain measures to improve the health of under-fives, such as improving breastfeeding and developing the health visitor workforce, it is too early to assess their impact.

11 There has been variable success in implementing children's policy locally, as is evident in the progress made in achieving the Public Service Agreement (PSA) targets (Table 1).ⁱ For example, 2008 infant mortality data has shown that while the gap between the whole population and routine and manual groups has narrowed since 2002-04, it is unchanged since 2005-07. The PSA target remains challenging and further efforts will be needed to ensure that it is met. The PSA target on obesity has also been altered since its introduction, and its deadline lengthened.

i PSAs set out the key priority outcomes the government wants to achieve over a specific spending period, the latest being 2008 to 2011. Each PSA has a delivery agreement shared across contributing government departments and contains performance indicators which detail how the overall target will be measured.

Table 1: **Key Public Service Agreement targets (Comprehensive Spending Review, 2007)**

PSA target	Associated performance indicators ⁱ
PSA 12: Improve the health and wellbeing of children and young people	Prevalence of breastfeeding at 6 to 8 weeks Levels of childhood obesity ⁱⁱ
PSA 13: Improve child safety	Emergency hospital admissions caused by unintentional and deliberate injuries to children and young people
PSA 18: Promote better health and wellbeing for all	Reduce health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth

Source: Audit Commission

12 The increasing volume of national children’s policy has resulted in duplication and inconsistencies across government departments, leading to confusion locally about planning and delivering health services for the under-fives. For example, participants in our research felt that policies on World Class Commissioning and children’s trusts appeared to conflict.ⁱⁱⁱ Some children’s trusts were unsure who, between their commissioning boards and the PCT, had specific children’s health commissioning responsibilities, thus perpetuating the lack of clear senior responsibility for children’s services that was heavily criticised in Sir Ian Kennedy’s inquiry (Ref. 15) and in Lord Laming’s inquiry into the death of Victoria Climbié (Ref 11). Given this tension, the Department of Health (DH) and the Department for Children, Schools and Families (DCSF) published joint commissioning guidance in 2009 in an attempt to address this (Ref. 16).

13 The government could provide greater clarity for local bodies by reducing policy duplication and giving a sharper, more consistent focus by issuing lasting cross-departmental, age-specific policy for the under-fives. This may be partially addressed by the joint Prime Minister’s Strategy Unit/DH/DCSF review into maternity and early years, which is examining services and provision from pregnancy to two years (Ref. 17).

The government should reduce policy duplication by issuing cross-departmental, age-specific policy for the under-fives

- i** Some performance indicators attached to PSAs are also included in the National Indicator Set (NIS). Local bodies choose priorities for their LAAs from this list. Priority outcomes for government are delivered and measured in this way.
- ii** There are two indicators in the NIS for childhood obesity: NI 55 (obesity among primary school age children in reception year) and NI 56 (obesity among primary school age children in year six).
- iii** World Class Commissioning is a DH programme set up in 2007 to help transform the commissioning of health and care services by improving PCT commissioner capability focusing on 11 competency areas.

Planning and delivering local services to improve health

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LAs and PCTs are responsible for the planning and delivery of children’s health services at a local level, which are increasingly expected to be determined and commissioned by children’s trusts as they mature further (Ref. 18). This chapter examines how local bodies plan and manage service delivery to improve the health of under-fives.

LAAs and under-fives’ health

14 While we found that local bodies are aware of the health issues facing their under-fives population, they have largely focused on children aged 0 to 19 years or population-wide public health, rather than the under-fives as a targeted group. All LAs have statutory targets as part of the early years foundation stage, which measures a child’s educational attainment at age five and does not include a child’s physical health. However, when setting priorities for their LAAs, they have largely focused on children over five years who are in schools, which provide single settings in which to target and reach large numbers of children.



There has been a lack of focus by local bodies on the health issues facing under fives

15 Of the 188 indicators in the National Indicator Set (NIS) (Ref. 19), only six relate to under-fives’ health – none of which featured in the top 20 indicators chosen by local bodies in their LAAs.ⁱ Table 2 shows the relatively low take-up of these indicators by spearhead and non-spearhead LAs.

i The NIS is part of the new performance framework for local government and includes 188 indicators which represent a list of national priorities. Each Local Strategic Partnership (LSP) chooses up to 35 indicators for its LAAs which best reflect local priorities for improvement. These indicators are negotiated between LSPs and government offices. The NIS is being reviewed as part of the Comprehensive Spending Review expected in 2010/11.

Table 2: NIS indicators affecting the under-fives chosen by LAAs, 2009/10ⁱ

NI No.	Indicator title	Non-spearhead (base = 99)		Spearhead (base = 51)		Total	
		No.	%	No.	%	No.	%
116	Proportion of children in poverty	18	18	27	53	45	30
53	Prevalence of breastfeeding at 6 to 8 weeks from birth	19	19	13	25	32	21
55	Obesity among primary school age children in reception year	17	17	9	18	26	17
118	Take-up of formal childcare by low-income working families	9	9	3	6	12	8
70	Reduce emergency hospital admissions caused by unintentional and deliberate injuries to children and young people	4	4	1	2	5	3
48	Children killed or seriously injured in road traffic accidents	0	0	3	6	3	2

Source: Audit Commission (using data from the Improvement and Development Agency)

Breastfeeding has been shown to lead to improved nutrition and improved outcomes for premature babies, as well as a reduction in childhood obesity

16 Research evidence clearly demonstrates the importance of addressing health needs early in childhood. Breastfeeding, for example, has been shown to lead to improved nutrition and improved outcomes for premature babies, and a reduction in childhood obesity, regardless of social class (Ref. 20). However, despite the evidence base, National Indicator (NI) 53 (Prevalence of breastfeeding at six to eight weeks from birth) has a low take-up, particularly in spearhead areas, which have higher rates of infant mortality, low birth weights and obesity.

Priorities for under-fives and strategic plans

17 Examination of key strategic documents from LAs and PCTs in our fieldwork found inconsistencies between the partners' priorities for under-fives. LAs largely address targets in their Children and Young People's Plan, while PCTs focus on those in Vital Signsⁱⁱ and operational plans (Ref. 21).

- ⁱ Our data analysis for these six indicators showed little difference in take-up between 2008/09 and 2009/10.
- ⁱⁱ Vital Signs is a set of health outcome and quality indicators used by PCTs to develop their local operational plans for delivery of national priorities, and to help inform decision making on local targets. PCTs must include the key national priorities from Vital Signs in their operational plans but have a degree of flexibility in terms of deciding local targets. DH monitors progress against all indicators but performance manages only national priority areas, as well as those weaker-performing PCTs.

Being subject to different performance frameworks can also lead to local bodies setting different priorities or targets, resulting in a less coherent approach to improving under-fives' health. It can also adversely affect funding decisions. This is discussed in Chapter 5.

18 Such differences can be addressed through cross-referencing priorities during the development of Joint Strategic Needs Assessments and joint strategic plans.¹ In addition, children's trusts should be used to ensure consistency in service delivery across local partners (Ref. 18). Coventry Children's Trust has created a 'be healthy' subgroup containing representation from a range of provider partners in the area, to consult on strategic children's health priorities including those for under-fives. It is a useful forum in which to test and measure consistency of service outcomes and to minimise duplication of provision.

Different roles and responsibilities of children's health services

19 Services to improve the health of under-fives are delivered by several different providers including GPs and hospitals, and community services including health visitors, children's centres and the voluntary sector. These need to be integrated to be efficient and effective. *Facilitating Integrated Practice Between Children's Services and Health* (Ref. 22) provides 23 case studies demonstrating how local partners are working together to deliver integrated services.

Local services need to work together to improve the health of under-fives

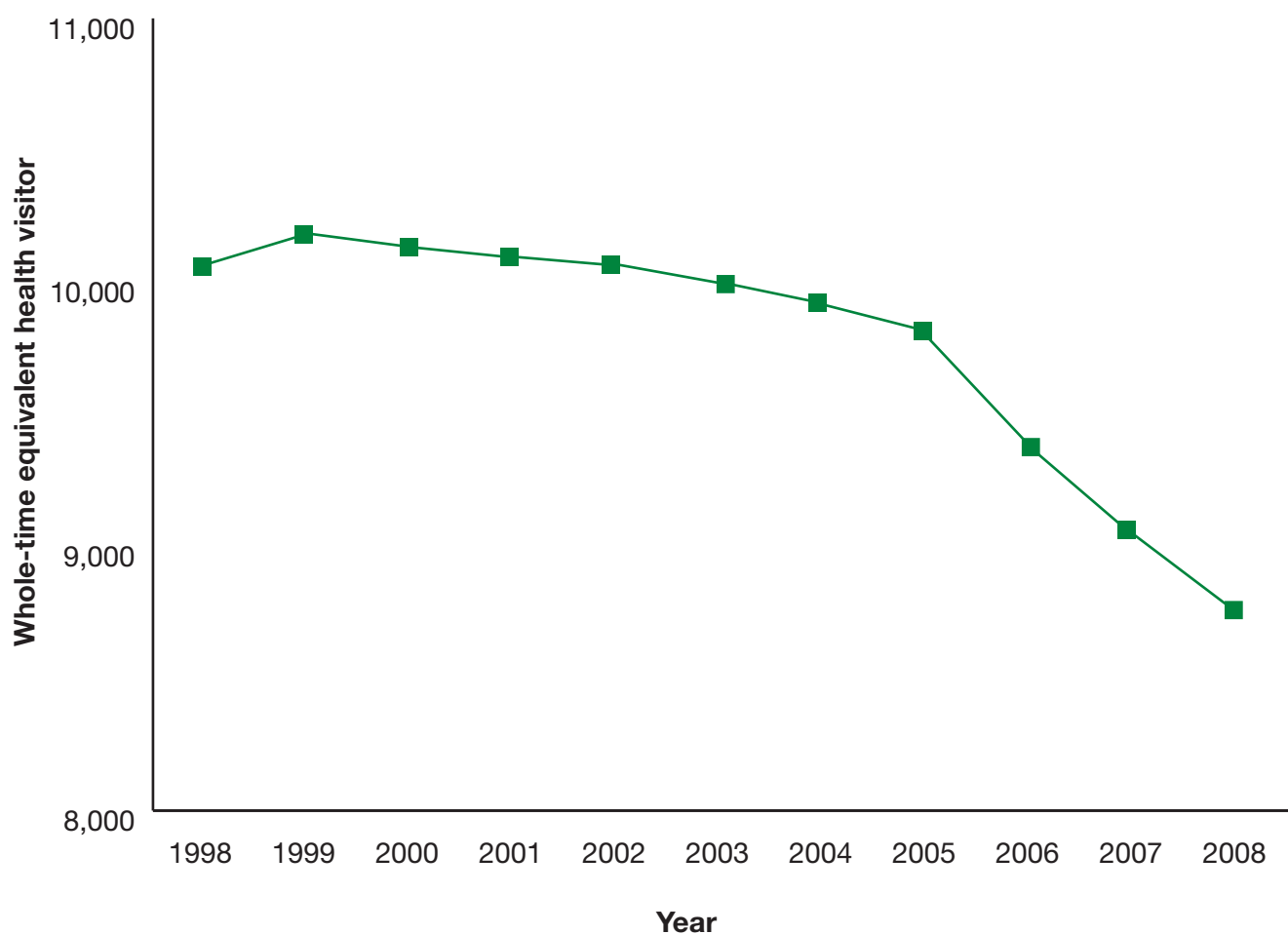
20 Many providers have multiple responsibilities in delivering children's services.

Health visitors

21 Our fieldwork identified that safeguarding is a high priority for health visitors and that, in some cases, it was considered that limited capacity made it difficult for them to discharge their wider health responsibilities. All participants in our fieldwork reported problems with the recruitment and retention of health visitors. One PCT, for example, had 14 out of 75 positions vacant.

- i** Each PCT and LA is required to produce a Joint Strategic Needs Assessment to describe the future health, care and wellbeing needs of their local community, and the strategic direction of service delivery to meet those needs.

Figure 6: Health visitor workforce, 1998 to 2008



Source: Audit Commission (data from *The Information Centre for Health and Social Care*, 2009)

22 The number of health visitors in England has declined steadily since 2004 (Figure 6) (Ref. 23). It is perceived as an unattractive career option with little chance of progression and a top band NHS salary of Grade 7 – low compared with nursing roles in the acute sector. The ageing nature of the workforce has also led to high levels of retirement among staff, who have not been replaced. Some health visitors have also been used to staff the Family Nurse Partnership (FNP) programme (discussed in Chapter 5) which has required intensive targeting of resources.

23 Several PCTs in our fieldwork were undertaking or had recently carried out reviews of their health visitor programme with the objective of more effectively utilising resources. However, few had been able to demonstrate adequate solutions.

24 The government has been working with the Community Practitioners and Health Visitors Association, on the Action on Health Visiting Programme (Ref. 24), which aims to define the key roles for health visitors, as well as addressing the recruitment and retention issues. The *Operating Framework for the NHS in England 2010/11* (Ref. 25) also highlights the need for PCTs to monitor workforce and caseloads of health visitors.



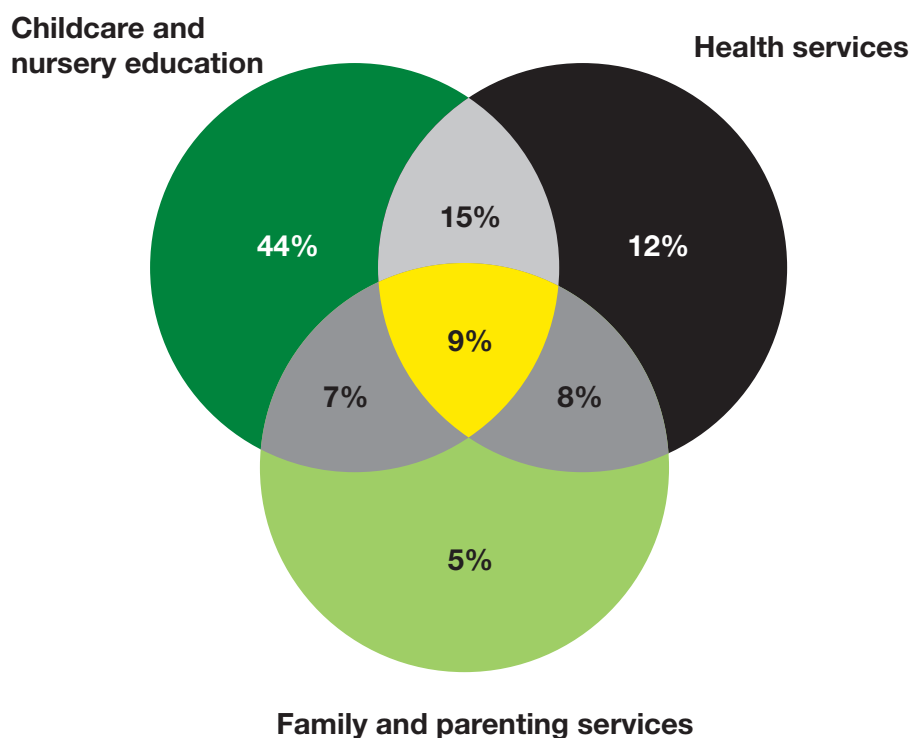
Health visitors have declined by 13% since 2004

Sure Start children's centres

25 Sure Start children's centres deliver childcare, early education, child and family health and wider family services. A recent DCSF survey of parents using children's centres identified that childcare services had a higher take-up than other services. (Ref. 26). However, the survey identified a low take-up of health services (Figure 7) and suggested that this could be due to a lack of awareness, which is consistent with our findings. DCSF has recently launched the national awareness campaign, You'll Discover More Than You Think at a Sure Start Children's Centre, in an attempt to address this. Our focus group participants used children's centres largely for childcare services and for involvement in social groups but did not associate them with health services. Nevertheless, local bodies acknowledged that there was scope to provide additional health services at children's centres.

Our focus group showed that children's centres are associated with involvement in social groups rather than children's health services

Figure 7: Take-up rates of children's centre services



Source: Audit Commission (data from DCSF, 2009)

Vulnerable parents need to be targeted to ensure a greater take-up of health and family and parenting services

26 The DCSF survey demonstrated that children's centre health services are often used to complement community health services such as those delivered by GPs (Ref. 26). Given the high take-up of childcare in children's centres, local bodies should consider targeting parents to improve the take-up of health and family and parenting services. This is discussed in greater detail in the following chapter.

Challenges to service delivery and accessibility

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Local bodies need to provide services that address the diverse needs of their residents. Mainstream services are not necessarily appropriate for children from BME, lone or young parents who have specific needs or cultural preferences. Those living in deprived areas are also least likely to be aware of local services, so take-up can be low. This chapter focuses on the challenges to providing effective services to these groups.

Identifying gaps in service coverage

IT systems can help analyse gaps in service access and provide public feedback and perception, so service strategies can be reviewed and updated

27 Few sites involved in our research had a systematic and rigorous approach to identifying the extent to which their services were reaching the intended people and what could be done to target those where take-up was low. One children's centre in our fieldwork for example had only achieved 38 per cent of its reach target. Many children's centres have only recently begun to use IT systems to analyse registration and activity data from health services. Blackpool Council uses the Softsmart systemⁱ to produce registration and take-up data for all of its children's centres and compare this with its reach targets.ⁱⁱ This enables the progress of individual centres to be monitored and where necessary additional support can be provided to help a centre reach its target. In January 2010, 66 per cent of children aged under five had been reached by Blackpool children's centres. The Softsmart system is also used to identify children and parents who are not accessing services so that they can be targeted, encouraged and supported to access services. In addition, reports are produced on the take-up across different services such as health, childcare and family support, to ensure that these services are targeted effectively.ⁱⁱⁱ

28 Non-quantitative methods of identifying gaps in service access, such as staff views and public feedback, have also been used. For example, Sandwell Primary Care Trust's Children's Commissioning Team holds staff workshops to understand areas of low service take-up when developing service strategies. In parallel with the workshops, Sandwell Primary Care Trust reviews current provision using performance and outcomes data, and also collects public feedback and perceptions of services to inform its commissioning process.

- i** Softsmart is software which provides data gathering, analysis, reporting and evaluation tools for children's centres.
- ii** Blackpool is currently using 2006 child benefit take-up data from the Department of Work and Pensions as a proxy for the total under-five population until Office for National Statistics census data is updated.
- iii** The Children's Services Mapping project may prove to be a useful tool to collect and consolidate data from local bodies in the future. The project is an online data collection and reporting system which provides information from LAs and PCTs on all children's services (not just health) in England. However, it is a recent programme and it is too early to evaluate its impact.

Service access issues for vulnerable groups

29 Vulnerable groups often do not take up health services. Our focus groups targeted BME groups; young parents (under 21 who had used teenage services); and lone parents. We found that many of the barriers to service access were similar across all these groups (Table 3).

Table 3: **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

BME groups

30 BME groups are not always confident in accessing mainstream health services because of language and cultural differences.ⁱ Those for whom English is a second language can find it difficult to understand the purpose of some services and to communicate effectively with health staff. Some BME service users believe children's centres are not hospitable to their ethnic group if none of their family or friends use the services. The provision of translators at children's centres, while encouraging take-up among some BME service users, was not favoured by others in these groups, who stated that they felt uncomfortable requesting this additional support.

'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

ⁱ There is wide diversity within BME groups. For example, in the context of our study we had parents from Black, Asian, Eastern European and Middle Eastern backgrounds who participated in our focus group research.

31 The DCSF survey of children’s centres (Ref. 26) found that no single population group was disproportionately accessing or not accessing children’s centres, and that there was a very positive response from parents who attended them – 92 per cent of parents liked children’s centres; 68 per cent were very satisfied. However, the survey showed that only 45 per cent of those eligible attended a centre, although awareness was much higher at over 70 per cent.

32 Our focus groups identified barriers to take-up of health services amongst vulnerable groups. This is particularly important given that many of these groups may have disproportionate health problems. Our research found that BME mothers were more likely to rely on family members for health advice and support in caring for their children, using their own traditional cultural health practices rather than mainstream health services, as they lacked trust in health staff. Many participants felt that health staff were inflexible with their advice, had little sympathy or understanding of their traditional cultural health practices and instead made false assumptions based on culture and ethnicity. Consequently, this deterred many BME parents in our focus groups from using mainstream health services.

Many BME mothers feel that health staff make assumptions based on culture and ethnicity



New BME migrants are unlikely to be aware of health services for under-fives

33 New BME migrants who had given birth abroad experienced particular difficulties in accessing health services for under-fives. New migrants were unlikely to be aware of community health services (other than GPs) unless referred to them or unless they knew others accessing the service. PCTs and LAs need to ensure that new migrants have access to, and awareness of, information on health services for their children. An example of a children’s centre that has successfully engaged with its BME community is the Chai Centre in Burnley, East Lancashire.

Case study 1

The Chai Centre, Burnley

The Chai Centre, led by NHS East Lancashire was established in 2004. It covers a predominantly BME community – 55 per cent Pakistani, 17 per cent Bangladeshi and 28 per cent white, with 1,173 children aged eight to five years.

The Chai Centre is a combined children's centre and healthy living centre, which facilitates links with other health promotion services for families such as healthy eating, physical activity and sexual health. The centre has a strong focus on the implementation of the Healthy Child Programme. The Children and Families Integrated Team, which includes health visitors and school nurses, delivers the core components of the Programme and the children's centre team provide additional visits to local families at two months, six months, 12 months, 18 months and two years. These visits are designed to reinforce particular health messages. For example, the six month visit focuses on weaning, reinforcing information given by the Children and Families Integrated Team at four months. This model of working with support from a PCT health coordinator is now being rolled out across Burnley for all the Children and Families Integrated Teams and children's centres. This innovative approach has seen an increase in children under four (from 457 in 2006/07 to 888 in 2008/09) and parents (633 in 2006/07 to 925 in 2008/09) registered and accessing core services (not including midwifery and health visitors) at the centre.

Source: Audit Commission

Young parents (under 21 years old)

34 Young parents have specific needs that are not always met by mainstream service provision. They experience many of the same barriers to access as BME groups, but for different reasons. Young parents suffered from a lack of confidence, often feeling isolated from friends who did not understand their circumstances, and from social networks as they were no longer in school. Consequently, young parents felt more secure when attending health groups where they could actively participate and when socialising with their peers.

Many young parents prefer to access services specifically developed for them

35 Many young parents preferred to access services specifically developed for them, as opposed to mainstream health services. Surprisingly, some young parents perceived that they were not allowed to access mainstream services such as Sure Start, believing that these were for older parents. This perception was, in part, because they had previously experienced separate tailored treatment, such as being removed from school and attending separate classes. While they had been encouraged to use youth pregnancy services, this made them feel isolated from mainstream services of which they had no experience.

36 Young parents in our focus groups were less likely to access services at children's centres, particularly if they had had a negative experience for example, older parents judging them, where they or their children were ignored, or where their children were not allowed to play with other children.

'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

Young parents can feel isolated by health staff



37 Some young parents also perceived that health staff looked down on them and told them what to do, as opposed to offering advice and information or consulting them on the health of their children. Consequently, young parents distrusted health staff and were less likely to attend group classes where they felt they had little chance to contribute. This added to feelings of being unfit mothers and reinforced their desire to remain in their teenage pregnancy groups. Some older teenage parents, however, were no longer attending a teenage pregnancy group and felt like outsiders at children's centres, with no dedicated support available to them.

38 Furthermore, many young parents had difficult home lives and family relationships, which may have developed since their pregnancy. They therefore felt apprehensive about group situations at a children's centre where, for example, they might be judged negatively. Some young parents admitted that without support from health visitors they would have remained either unaware of, or wary of, using health services.

39 Services such as teenage pregnancy and breastfeeding support not only need to be available to young parents, but also need to be delivered in appropriate settings, such as Walsall's Children's Trust Young Parent's Teenage Pregnancy Initiative.

Case study 2

Young Parents' Teenage Pregnancy Initiative, Walsall Children's Trust

Walsall's Teenage Pregnancy Initiative is a collective of key workers who facilitate teenage parent groups for parents (including fathers) under the age of 18. They provide advice and support to young parents on issues such as benefits and child and maternal health during and after pregnancy. The group advises on child health and also offers support to parents on other issues which might indirectly affect child health. The initiative is a ten-year strategy (2001 to 2011) funded through allocations from pooled resources (£314,000 in 2009).

Referrals for the initiative fluctuate annually but on average the initiative engages with 200 parents per year, although there are approximately 400 parents eligible for the service each year.

Teenage parents felt that the groups were valuable as they provided peer support, and they developed a rapport with key workers. Friendships that they made in the groups also helped them to overcome feelings of isolation. Teenage parents stated that they remained engaged with the initiative as they were made to feel welcome and part of a group, and because key workers designed activities that related to their identity as young people, as well as parents.

The Teenage Pregnancy Initiative has seen gradual but steady outcome improvements, with more teenage mothers now in education, employment and training (5 per cent increase over 2008/09), and a higher take-up of the Care to Learn free childcare programme (8 per cent to 15 per cent between 2006/07 and 2008/09).

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A recent customer satisfaction audit was positive about the programme, with 75 per cent of respondents happy with their first visit by key workers. Nearly all respondents were confident that they had received information relevant to their situation and that they understood it.

Source: Audit Commission

Lone parents

40 Lone parents often suffer from a lack of confidence resulting from fear, anxiety or depression related to past incidents – for example, an illness or a violent ex-partner. These groups often isolate themselves from the community and feel more secure in their home environments. Our focus group research found that these parents often do not access non-essential health services for their children unless encouraged to do so by a trusted health professional. Some lone parents felt uncomfortable with health visitors asking personal questions about their private lives or lifestyle choices, which they deemed to be intrusive and irrelevant to the welfare of their children. These parents felt ostracised by health staff and believed that they were judging them as unfit mothers and fathers just because they were a lone parent. This affected their take-up of services at children's centres for fear of being treated in a similar manner.

41 Encouragement from family support workers, who are more likely than frontline health services such as GPs to provide informal support, is crucial in helping lone parents to overcome these issues. Local service providers should ensure that outreach and family support workers are aware of lone parents and that they have appropriate access to health information and service provision for their children.

Improving access to services

42 Increasing service quality for, and take-up by, vulnerable groups may help to improve their health outcomes over time. In order to achieve this, local bodies should consider:

- connecting with parents' wider personal needs;
- building trust with parents;
- tailoring services;
- offering additional support for fathers; and
- improving information channels.

Connecting with parents' wider personal needs

43 Parents in our focus groups wanted support for their wider personal needs, including practical and emotional problems. Many felt that they were less likely to be able to care effectively for their children while experiencing personal problems. Parents who felt isolated expressed a wish for friendly,

The role of family support workers is crucial in ensuring lone parents have access to health information and service provision for their children

informal support, as they found some mainstream health providers intimidating. Where services catered for the personal needs of parents, they were more confident and likely to engage with other children's health services, as demonstrated in the Goodwin Volunteer Doula project in Hull.

Case study 3

The Goodwin Volunteer Doula Project, Hull

This project recruits and trains volunteer birth partners, or doulas, to support women through pregnancy, childbirth and early family life. Launched in 2005, the project currently has over 40 trained doulas who provide informal emotional support, health advice, companionship and information on local children's services to over 100 pregnant mothers from vulnerable groups in the area each year.

The project is jointly funded by NHS Hull and Hull City Council at a cost of £150,000 per year for the next five years. The project has also been awarded £270,000 from the DH over three years to support service roll-out across eight other cities in England.

Doulas are extremely valued by participants from some BME communities, who feel socially isolated because their friends and family are abroad. The volunteer doulas offer an alternative perspective on child health, providing one-to-one coaching to overcome parents' personal barriers in improving the health of children. An example is breastfeeding, where mothers can feel isolated in their difficulties – 84 per cent of the mothers in the project initiated breastfeeding in 2009 compared with a local rate of 52 per cent. There have also been increasing numbers of mothers referred to a separate Smoking Cessation in Pregnancy programme (71 per cent of smoking mothers participating in the project from April to July 2009). The women supported through the project have also experienced lower intervention rates in labour than the local rates, with a caesarian section rate in 2009 of 18 per cent compared with a local rate of 23 per cent.

In 2008, a Hull University study concluded that the doula project was perceived as beneficial by parents and doulas, reaffirmed that one-to-one care enhances the birth experience, and noted it had great potential to assist mainstream maternity provision.

Source: Audit Commission

Trust and confidence in health service staff is vital to the take-up of services by vulnerable groups

Building trust with parents

44 Trust and confidence in health service staff, such as health visitors and staff at children's centres, is vital to the take-up of services by vulnerable groups. Participants in our focus groups placed considerable emphasis on trust, particularly on the informal and friendly manner of health staff that was considered crucial among mothers who had few other social networks.

'You can't trust anyone to be with your child. As a parent you need to know that they are safe and they are well looked after, that's the main thing.'

British-Pakistani mother, Luton

45 Local bodies can build trust with parents by improving family support services. In Sandwell, maternity support workers work alongside children's centre staff including health visitors, to provide a universal service visiting mothers during and after their pregnancy, and offering advice on breastfeeding, bathing, sleeping routines, and later with weaning and nutrition. Mothers found this advice helpful and felt that the support workers had a non-judgemental and flexible stance on child health. Parents also appreciated the continuity of staff, which provided the opportunity to build a relationship and trust over time.

Tailoring services – culturally sensitive information

46 Information provided by local bodies on children's health also needs to be culturally sensitive. BME groups in particular may have specific problems in communicating and require interpreters, as demonstrated in the Roma Families' Initiative in Redbridge.

Case study 4

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 to 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.

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‘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.

‘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.

‘In health centres staff are sometimes racist, we get treated differently. So it’s easier to come here, and we wish it was open every day.’

Roma father

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

Additional support for fathers

‘At my course it’s only the mothers that are allowed to go. But the way I see it, looking after a child, it takes two people. Because at the end of the day it took two people to put them there.’

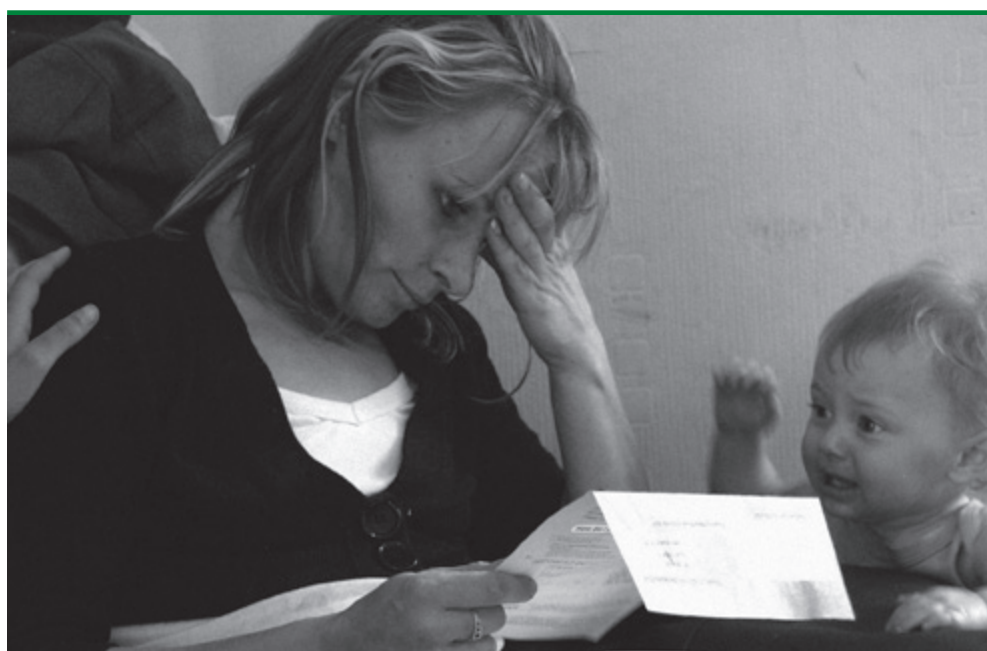
Young mother, Coventry



It’s only the mothers that are allowed to go

47 Our focus groups showed that fathers felt excluded from classes that would improve their parenting skills, and therefore from socialising with other parents. For example, in Bexley Children’s Centre, where 67.5 per cent of fathers are registered at the centre, only 17.4 per cent attend (Ref. 22). Where father/child classes had low take-up, this was in part due to the session times and a lack of awareness. While some children’s centres cater for the needs of fathers, this is not a universal service provision. Fathers in our research preferred to attend classes based around work commitments, largely weekday evenings or at the weekend, and favoured groups centred on a class or activity rather than a play session. Therefore, local service providers should consider how services could be made more accessible and tailored to the needs of fathers, not just mothers, as well as providing the wider support for fathers’ involvement with their children.

New parents can become overwhelmed by the extent of information they are expected to absorb



Local bodies need to ensure that health visitors and midwives are registering parents and children with the relevant services shortly after childbirth

Improving information channels

48 Our focus group participants felt overwhelmed by the volume of information that they received upon the birth of a new child. Given the demands of looking after a new baby, many felt that it was difficult to absorb information on their child’s health at this time. Consequently, health professionals should ensure that new parents are given timely, relevant and accessible information relating to their child’s health, delivered in a phased manner. Promotional materials publicising the benefits of child health services should also be clear, simple and culturally sensitive where appropriate.

49 Some parents were unaware of services offered at children’s centres, as their midwife or health visitor had not informed them of the available services or ensured that they were registered with the service. Many parents had only become aware of services via word of mouth and recommendations from friends. To improve engagement with children’s centre health services, local bodies need to ensure that health visitors and midwives are registering parents and children with the relevant services shortly after childbirth.

Financing and value for money in services for under-fives

Government funding for under-fives and its effect on health outcomes	40
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Since 1998/99, government funding for under-fives services has increased, although it is difficult to identify age-specific health-related funding as there are few programmes other than Sure Start that directly target this age group. Sure Start and direct funding from PCTs have led to modest health improvements despite significant investment in revenue and capital over the last decade. This chapter considers the effect of funding on health outcomes for the under-fives. It shows how local bodies could assess their expenditure on the under-fives and deliver better value for money.

The past decade has seen only modest improvements in the health of the under-fives



Government funding for under-fives and its effect on health outcomes

£10.9bn
has been
invested in
improving
children's health
for the under-
fives

50 Significant funding has been invested in improving children's health. Table 4 shows the funding for improving the general health of under-fives between 1998/99 and 2010/2011 which we estimate to be £10.9 billion (of which £7.2 billion is Sure Start funding).ⁱ

ⁱ As noted in Chapter 2, Sure Start funding provided to SSLPs previously covered health as well as childcare and wider parenting support, and has been funded differently across the different phases of the programme.

Table 4: 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

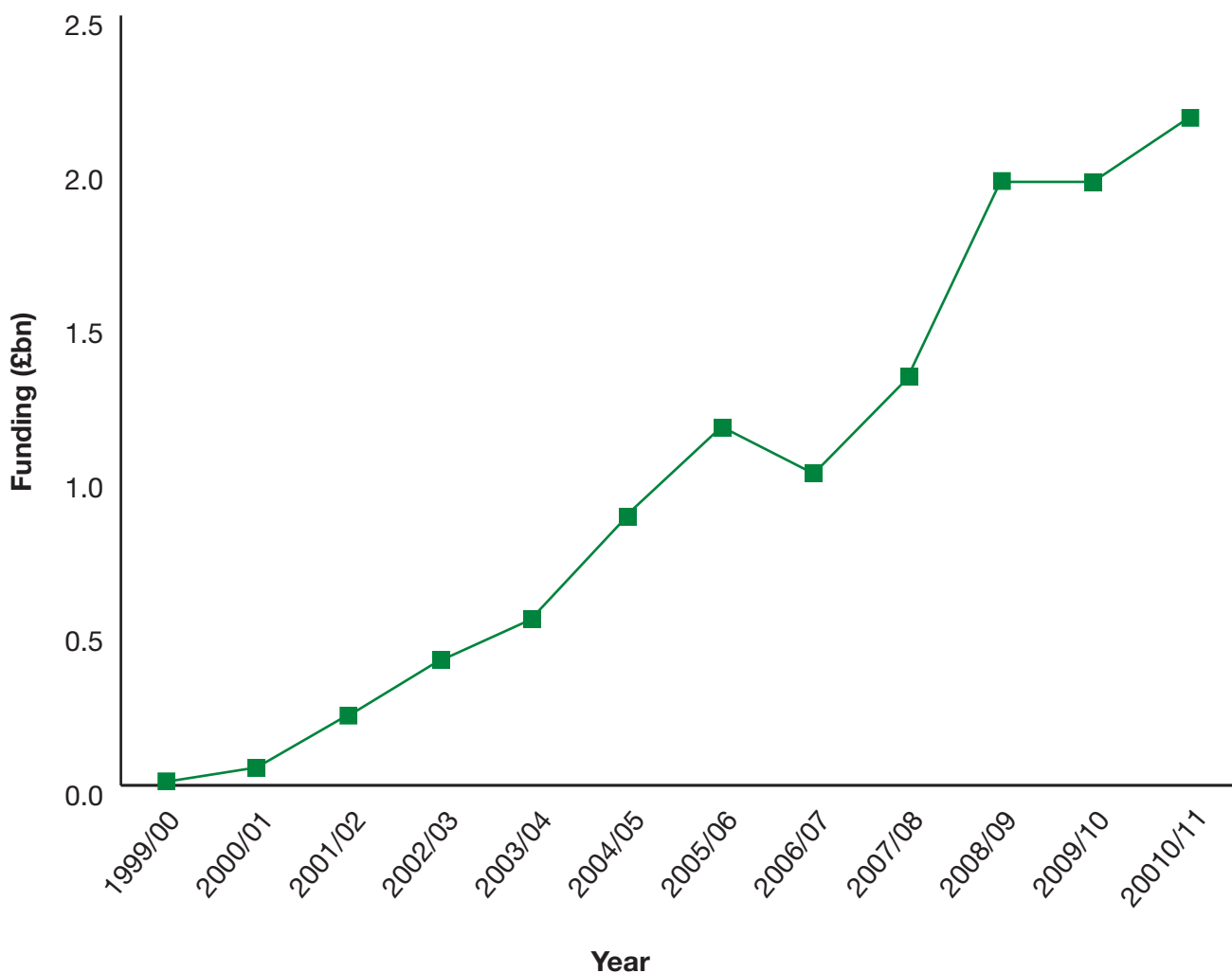
Source: Audit Commission (data from DCSF)

ⁱ Table 4 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.

51 Sure Start funding initially concentrated on the most deprived localities, although it has now been extended to provide universal access to children’s centres. £350 million of capital funding has been allocated over 2008/09-2010/11 (Figure 8).ⁱ Since 2003/04, central revenue funding for Sure Start has covered family support services, integrated early learning and administration of the centres. It has not included specific funds for health services which, subject to some tapering of the early funding stream, have been provided by PCTs from their mainstream allocations. Nevertheless, the overall aims of the programme – to promote the physical, intellectual and social development of children – have not changed.

52 An estimated further £19.1 billion will have been spent on initiatives that may have an impact on the health of the under-fives.

Figure 8: **Sure Start funding, 1998/99 to 2010/11**



Source: Audit Commission (data from DCSF)

ⁱ Funding data provided by DCSF.

53 Government funding for under-fives is delivered to LAs through annual area-based grants, which includes age-specific grants for the under-fives such as Sure Start Early Years and the Childcare Grant, which is ringfenced for early years provision. PCTs, however, receive generic funding for their populations through annual revenue allocations. Additional funding is also attached to specific health initiatives for under-fives – such as the FNP, an intensive nurse-led home visiting service focused on first-time parents under 20 years of age who are potentially vulnerable to poor health outcomes – and is targeted at PCTs with poor health outcomes.

54 Other national policies have funding attached to them that may impact on the health of under-fives. For example, *Healthy Weight, Healthy Lives: One Year On* (Ref. 27) stated that the government would provide £69 million to help PCTs combat obesity and overweight in their local areas. However, this money is delivered through general allocations and it is, therefore, unclear how much will be spent on the under-fives.

Outcomes

55 Table 5 demonstrates that, between 1999 and 2008, health outcomes for the under-fives, on the whole, have only marginally changed. While investment is arguably having a positive effect – for example, on infant mortality – it has not resulted in significant improvement in other key indicators.

56 There is still significant progress to be made in many health outcomes if spearhead areas are to close the gap with the rest of England. For example, while the gap in infant mortality between the population as a whole and routine and manual groups is closing slowly, from a 19 per cent gap in 2002-04 to 16 per cent in 2006-08 (Ref. 28), the target of 10 per cent remains challenging. Although the gap has narrowed since 2002-04, it remains unchanged since 2005-07 and further efforts will be needed to ensure that the target is met by 2010.

57 The two indicators in Table 5 relating to breastfeeding and obesity are new. The former replaced one relating to initiation and is considered more robust as it measures the total number of infants continuing to breastfeed after six to eight weeks – a point at which those who initiated breastfeeding may have already stopped. Breastfeeding initiation rates between 2006/07 and 2008/09 increased from 68.1 per cent to 71.9 per cent in England and from 62 per cent to 66.1 per cent in spearhead areas.

58 The second, relating to obesity, has only been collected for two years, making trend analysis impossible. Research by the National Heart Forum shows obesity rates using body mass index measurements are improving (1993 to 2000 compared with 2000 to 2007) (Ref. 29). However, Health Survey for England data still shows that overall, obesity rates for children increased by 29 per cent in England for children aged two to ten years between 2000 and 2007 (Ref. 30).

Table 5: **Key health outcomes for under-fivesⁱ**

Indicator	Year	England %	Spearhead areas %
Infant mortality (per 1,000 live births)	1999-2001 to 2006-2008	5.6 to 4.8	6.9 to 5.7
Low birth weights (percentage of babies born under 2,500g)	2001-2008	7.6 to 7.5	8.4 to 8.2
Breastfeeding prevalence rates (percentage of infants totally and partially breastfed after two to ten weeks)	2008-2009	28.2 to 46.4	25.5 to 41.7
Obesity in reception year children (percentage of children who are obese at four and five years old)	2006/07-2008/09	9.9 to 9.6	10.5 to 10.4
MMR immunisations two years (percentage of children immunised before second birthday)	2004-2009	81 to 85	81 to 85
MMR immunisations five years (percentage of children immunised before fifth birthday)	2004-2009	Remained at 89	89 to 90
Dental – DMFT (average teeth per five year old)	1999-2006	1.43 to 1.47	1.46 to 1.75

Source: Audit Commission (data from Office for National Statistics, NHS Information Centre, DH, National Child Measurement Programme and British Association for the Study of Community Dentistry)

59 Children’s centres are still being rolled out nationally. Sure Start has so far demonstrated limited improvements in health outcomes for the under-fives, despite a significant level of investment. The impact of Sure Start on other outcomes was outside the scope of this study.

60 The 2008 Sure Start evaluation (Ref. 31) measured 14 outcomes including language development, social and emotional development and physical health and found more consistent benefits for those living in SSLP areas compared with the 2005 evaluation (Ref. 32). The evaluation measured two health outcomes – accidental injury and immunisation take-up. While accidental injury rates declined and immunisation take-up increased, improvements were slight and were qualified by the evaluation’s authors.ⁱⁱ National evaluations of Sure Start are continuing, including a comprehensive evaluation of children’s centres, by the National Centre for Social Research and University of Oxford. This is due to be completed in 2014 and will report on a range of outcomes including child health.

i Health outcome data collected for this table is not over the same time period due to new data sets being introduced (for example, for obesity and breastfeeding data sets) or lack of available data broken down to PCT level (for example, MMR immunisations pre-2004).

ii Birkbeck noted that improvements could be a result of timing, related to when measurements were taken of children living in SSLP areas and those living elsewhere, or to differences in research design with the 2005 evaluation.

Family Nurse Partnership programme

61 The FNP programme was established in England in 2007. It provides longer-term support (up to the age of two years old) compared with that provided by health visitors (normally six months to a year). The FNP received initial investment of £7 million with an additional £30 million in 2007 to fund the roll-out and maintenance of the programme to 2011.



63 per cent of mothers participating in the FNP programme initiated breastfeeding

62 The second year evaluation of the first wave of the programme (containing ten pilot PCTs and corresponding LAs) has recently been completed (Ref. 33). It demonstrates that the FNP is continuing to have a positive impact, with improvements in smoking cessation, and breastfeeding prevalence. For example, in 2009, 63 per cent of mothers participating in the FNP initiated breastfeeding and, of this group, 32 per cent continued to breastfeed at six weeks. In addition, the evaluation also demonstrated continuing improvements in smoking cessation – a 20 per cent relative reduction in clients smoking between programme intake and near the end of pregnancy, highlighting FNP as a good example of targeted service provision for vulnerable groups which has the potential to reduce health inequalities.

63 However, the 2009 FNP evaluation showed that some issues remained, including:

- the sustainability of the pilots following the end of the prescribed period of funding (two years) including the costs involved with implementing an ongoing FNP service;
- ensuring that parents remain engaged with the programme – 14 per cent of parents dropped out in pregnancy (the government's stretch objective aimed at the more experienced sites is 10 per cent attrition for pregnancy);
- the development of nursing staff to prevent high staff turnover in some areas, due to a lack of career opportunities;

- improving engagement between FNP and local children's services commissioners and managers to assist understanding of how FNP fits into the range of services that they provide;
- improving workload – some nurses feel too much time is spent on non-FNP activities such as administration and meetings with other providers, limiting their capability to deliver services;
- providing more guidance for nurses in terms of scrutiny and data collection; and
- securing better integration of the FNP into children's centres including allocated space for nurses and ensuring that there is a policy and system for sharing information between services (Ref. 33).

64 The third wave of FNP (a total of 50 pilot sites) is currently underway with the aim of having 70 pilot sites by 2011. A further evaluation involving a randomised control trial of FNP is due to report in 2012/13. Subject to positive future evaluations, the government is planning to roll out FNP across England over the next decade (Ref. 30).

65 Roll-out will raise both funding and workforce issues. We estimate that roll-out of the FNP to the remaining 82 PCTs would cost approximately £24.6 million annually (£300,000 per site) plus set-up costs based on the costs of the first wave pilots (Ref. 34). The programme itself is also targeted at a very specific population group – first time parents under 20 – and therefore reaches only a small percentage of the potentially vulnerable groups. The FNP workforce contains high numbers of health visitors, and further roll-out would impact significantly on an already declining health visitor workforce, which may have implications for mainstream service delivery.

Achieving better value for money locally

It is increasingly important that local bodies ensure that the services they provide achieve value for money, by being effectively targeted to achieve better outcomes proportionate with the investment

66 Public services will face considerable funding pressures over the next few years. Children's services risk being given low priority at times of financial stringency and pressure. As a result, it is increasingly important that local bodies ensure that the services they provide achieve value for money by being effectively targeted and that outcomes are proportionate to the investment. Three steps need to be taken in order to achieve better value for money locally. First, as funding for under-fives' health mainly comes from general funds it is hard to identify how much is being spent. As part of our research we have developed a financial model which can be used by local bodies to address this. We are now looking to extend this model to ward level and to align it with health data at that level, following the successful application of such an approach in Vancouver (Ref. 34).

67 We tested the model in two local authorities. The results in Table 6 show the annual spend on under-fives' health services in the two LAs between 2006/07 and 2008/09. LA 2 has approximately twice as many under-fives as LA 1, and has higher levels of deprivation. Additionally, LA 2 had poorer health outcomes for under-fives during the period 2006/07 to 2008/09.

Table 6: **Spending on under-fives' health services in two LAs, 2006/07 to 2008/09**

	2006/07	2007/08	2008/09
LA 1	£	£	£
Public health strategies	0.410m	0.460m	0.575m
GP services	1.712m	1.794m	1.812m
Home services, eg health visitors	1.994m	2.090m	2.488m
Children's centres	0.912m	0.955m	1.890m
Fire, police and VCFS	0.02m	0.037m	0.115m
Hospital spend	7.645m	8.284m	7.445m
Total spend on under-fives' services	12,693m	13,620m	14,325m
Cost per head	£925	£995	£1,045
LA 2	£	£	£
Public health strategies	0.500m	0.550m	0.591m
GP services	3.774m	3.765m	3.803m
Home services, eg health visitors	5.328m	5.443m	5.568m
Children's centres	0.280m	0.420m	0.521m
Fire, police and VCFS	0.551m	0.858m	0.929m
Hospital spend	19.174m	20.205m	20.823m
Total spend on under-fives' services	29,607m	31,241m	32,235m
Cost per head	£1,029	£1,085	£1,120

Note: VCFS – Voluntary, community and faith sector.

Source: Audit Commission

68 Table 6 demonstrates a steady increase in funding per head for under-fives' health in both LAs. In particular, there have been funding increases in community services, possibly reflecting a shift towards more targeted service delivery in recent years. The analysis also shows considerable differences in the input for different services and also the take-up of hospital services by under-fives. Consequently, broad assessments can be made about the impact of the spending and any increase. In these cases, the increased investment has not led to significant improvement in health outcomes. While rates of infant mortality and obesity (in the last two years) have improved for LA 1, other outcomes remained static or deteriorated. For LA 2 overall, health outcomes have also demonstrated little improvement and obesity in children seems to be increasing.

69 The second step is to ensure that targeted provision uses evidence-based interventions and that the impact of spend is evaluated. For example, LA 2 tackled its increasing childhood obesity rates by investing £100,000 in the Baby Friendly Initiative, which is an evidence-based breastfeeding support programme.ⁱ

UNICEF Baby Friendly Initiative

The Baby Friendly Initiative established in the UK in 1994, is a global programme run by the World Health Organisation and UNICEF. The Initiative works with the healthcare sector to ensure parents are supported and informed when deciding how they feed and care for their babies. The Initiative provides support for healthcare organisations and has a staged assessment and accreditation process which recognises organisations that have implemented best practice for breastfeeding and have passed an external assessment.

Source: The Audit Commission (Information from www.babyfriendly.org.uk)

70 The third step is rigorous evaluation of impact. Our research revealed mixed results in terms of service evaluations. We found some positive ones showing, for example, improved access to services and take-up rates such as The Springboard Project evaluation.

Case study 5

Springboard Project evaluation, Blackpool

The Springboard Project was launched in 2006 as a multi-agency initiative to provide integrated support to 60 vulnerable families in Blackpool. A two-year evaluation funded by Blackpool City Council (£14,000) was undertaken by the University of Salford which aimed to:

- establish baseline targets to measure and monitor families, and to implement the recording and analysis of this monitoring; and
- measure changes in health outcomes and identify the benefits of this approach for practitioners.

>>>

i Breastfeeding has shown to improve infant nutrition, and reduce obesity rates.

Health target measurements included sexual, physical and mental health, and data on these targets was collected from practitioners involved in the project.

Four families were used as cases studies for the project, which included a cost-effectiveness exercise, using a model developed by the Office of Public Management. This identified that while there were inevitable costs involved with setting up targeted services for the families, they were outweighed by the potential benefits of joining the programme.

The evaluation found:

- improved sexual health, with only one in 21 girls aged 15 to 17 years in the programme becoming pregnant, and reduced risk factors for future pregnancies;
- three individuals stopped smoking and 35 were referred to smoking cessation programmes;
- six families newly registered with GPs; and
- twenty-two new cases of substance misuse identified – one stopped, five were in abstinence and seven were engaging in treatment.

Source: Audit Commission

71 However, where evaluations showed negative results, service alterations rarely occurred. We also found much less emphasis on value-for-money assessment for services already in operation. Local bodies will need to adopt a fundamentally more rigorous approach to analysing spending and its impact, and acting on the consequences, if the best use is to be made of the funds likely to be available in the future. For example, *Commissioning Local Breastfeeding Support Services* (Ref. 35) encourages PCTs to evaluate and decommission services that are not targeted to support local need.

72 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 is 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;

Public services will be under significant financial pressure over the coming decade

- 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.

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Appendix 1: Research methodology

To inform our report, a research programme was undertaken between December 2008 and May 2009. This included:

- desk-based research including literature reviews, review and analysis of existing legislation, policy, LAA data and good practice examples relating to under-fives' health;
- a survey to 150 top-tier LAs and 152 PCTs to gather information on service provision for under-fives, spending decisions, areas for improvement and good practice. The survey had a response rate of 28 per cent with two-thirds of responses coming from PCTs;
- twelve site visits to LAs and corresponding PCTs to carry out interviews to identify local bodies' experience of setting priorities for under-fives' health, service planning and delivery, funding and financial management, and areas of good practice. We interviewed public health directors, directors of children's services, children's service commissioners, and public health consultants;
- sixteen focus groups with representatives from BME groups, young parents and lone parents, to determine whether current services are targeted correctly and what could be improved. The focus groups took place in the same areas as the fieldwork sites;
- a funding analysis to determine spend on, and value for money of, under-fives' health services. This involved the development of a funding analysis model which was then piloted in two LAs;
- a child health indicator tool which had 25 health indicators relating to under-fives such as average DMFT, obesity rates for children in reception year, and infant mortality. This tool was used to provide baseline data to aid the selection of fieldwork sites; and
- the findings and conclusions from our research were tested with representative expert groups.

Appendix 2: The evolution of children's health policy

In addition to those policies discussed in Chapter 2, there are a number of policies detailed in Figure 5. These are briefly summarised below.

In 1980, *Inequalities in Health* advocated taking a wider socio-economic approach to addressing the health inequalities of the most deprived people in society by recommending that children be given a better start in life. It highlighted the need for early intervention to improve children's health outcomes. However, it was not until 1998 that public health policy specifically included a focus on children.

In 1998, the *Independent Inquiry into Inequalities in Health* (the Acheson Report) recommended focusing on the wider socio-economic circumstances of mothers and their children through increased benefit payments to help reduce health inequalities. Furthermore, it suggested that the government developed policies to improve nutrition and increase breastfeeding – this was one of the catalysts for the introduction of Sure Start and the child poverty PSA.

Support for children's policy continued and in 2001 *Shifting the Balance of Power* gave local bodies greater power to decide their priorities for health spending, arguably affecting the priority given to children's services and the money spent on them.

In 2004, *Choosing Health*, while still largely concentrated on population public health measures, allocated funding to PCTs through their main revenue allocations to address the public health needs of their local populations. However, this funding was not ringfenced, and it is unclear how much was spent on public health initiatives or, more specifically, on children.

In 2006, *Strong and Prosperous Communities* focused on improving the delivery of public services by PCTs and LAs and encouraged service users to have a greater say in their

provision. This policy introduced the NIS and LAAs which are key mechanisms for local service planning and delivery.ⁱ Our Health, Our Care, Our Say also required that directors of Public Health and Children's Services undertake regular strategic needs assessments of the health and wellbeing status of their populations, enabling local services to plan priorities through the new LAAs.

The Children's Plan aimed to unite and drive forward children's services policy that had been developed since *Every Child Matters*. However, despite this, and *Healthy Weight, Healthy Lives* and *Healthy Lives, Brighter Futures*, national policy is perceived locally to be firmly focused on the 0 to 19 years age group.

The early findings and recommendations from the Education and Early Years Task Group in the Marmot Review highlighted the need for a more coherent policy approach in children's services, and indicated that government should work with local areas to improve health outcomes by developing evidence-based solutions, a view consistent with our findings.

Children's health is also a priority in the *Operating Framework for the NHS 2010/11*, which identifies the importance of tackling health inequalities and highlights that spearhead areas should focus on commissioning and delivering a programme of the known evidence-based and cost-effective interventions to decrease the all-age all-cause mortality of their populations. It also focuses on the child health strategy *Healthy Lives, Brighter Futures* and suggests that PCTs review their service offer in line with this, including in their role as statutory partners in the local children's trust board, and the national rollout of Sure Start children's centres. From April 2010, children's trust boards will be responsible for developing, monitoring and reviewing the local children and young people plan.

Appendix 3: Key conclusions from *Are We There Yet? Improving Governance and Resource Management in Children's Trusts* (Audit Commission, 2008)

- Local public services need to work well together to integrate services for children.
- Five years after the Laming Inquiry, there is little evidence that children's trusts have improved outcomes for children.
- *Every Child Matters* has provided a clear focus for local agencies.
- Children's trusts need to develop substantially if they are to bring the intended benefits.
- Areas prefer to align resources than to pool budgets.
- Governing partnerships is complex, but further mandated change could cause further confusion.

ⁱ The NIS is part of the new performance framework for local government and includes 188 indicators which represent a list of national priorities. Each local strategic partnership chooses up to 35 indicators for their LAAs which best reflect local priorities for improvement. These indicators are negotiated between local strategic partnerships and government offices.

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Printed in England by AccessPlus with ISO 14001 environmental accreditation on Revive FSC and ECF 100% recycled paper

Design and production by the Audit Commission Publishing Team

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Stock code: HNR3592

Price £15

ISBN 1-86240-584-0



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