Joint Strategic Needs Assessment for Children in Kent

September 2007

West Kent NHS Primary Care Trust

Eastern and Coastal Kent NHS Primary Care Trust

Kent County Council

Contents

A Joint Strategic Needs Assessment - Purpose

A Joint Strategic Needs Assessment (JSNA) is the means by which Primary Care Trusts and Local Authorities describe the future healthcare and wellbeing needs of local populations and the strategic direction of service delivery to link those needs.

The intention of this Needs Assessment is to provide an analysis of the data to show the health and wellbeing status of children in Kent, demonstrate where inequalities exist, use the views expressed by Kent children, demonstrate evidence of effectiveness of interventions, all of which are included to shape the future investment and direction of services. Accordingly the conclusions in the form of recommendations seek to define achievable improvements in health and wellbeing outcomes for Kent children, send signals to existing and potential providers of services about the scale of change, support the better delivery of health and wellbeing outcomes, inform subsequent stages of commissioning cycles, generally aid better decision making and further advise on the choice of local outcomes and targets. It is for those at county and local level using this strategic framework to detail the necessary change strategies including investments in accordance with subsequent stages in the commissioning cycle.

Strategic Needs Assessment – Its place

The place of the Strategic Needs Assessment is clear. Every Child Matters and the National Service Framework for Children are primarily concerned with standards of care in order that children's services are fit for purpose. This Strategic Needs Assessment is required in order to identify issues requiring future investment grounded upon the identification of local issues. It should also identify other change issues necessary to advance improvements in the health and welfare of children and young people. For this reason there are obvious cross links from this Needs Assessment to the Children and Young Person's Plan.

Whilst the prime audience for the Needs Assessment is the Kent Children's Trust (Commissioning), wherever possible the data is broken down to district level. Thus local Children's Consortia and emerging Local Children's Trust Arrangements can use the data in the assessment together with its policy commentary to highlight local issues reflected in the relative position of each locality to the county as a whole and to make regional and England comparisons. KCC analysts are also developing a report card for each district which will use the data stated here, summarised for focused local use.

Partnership Working

To address the range of child public health issues described requires a partnership approach – this being beyond the competency of a single agency. Every Child Matters (2003) sought to address some of the accountability gaps between agencies, between different professions and organisations and between managers and front line practitioners. Children's Trusts made up of senior officers from health, social services and education working in partnership with the voluntary and business sectors, are charged with becoming the strategic body steering reform of children's services. Children's Trusts are therefore required to conduct a systematic review of services and local needs linked to efficiency gains from reducing duplication of effort and the pooling of budgets and services becoming appropriately targeted.

The Kent agenda is significantly influenced by an impressive range of initiatives that have emerged from central government in recent times.

Some Basic Precepts

The term ‘child public health’ is used, as distinct from child health. This Needs Assessment is concerned with the populations of infants, children and young people, rather than with individuals with which the term ‘child health’ can be associated.

The term ‘health’ and specifically ‘public health’ in this context is defined as “the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society” (Acheson 1988).

Emphasis is placed on the strategic nature of the JSNA in so far as it is Kent-wide and wherever possible disaggregated to the level of district councils. However much of the data currently is not disaggregated below district council level (i.e. to ward level). The exception to this is all health data which is disaggregated to electoral wards and can be accessed via web-based tools to the Kent Public Health Observatory record.

Community views in this context have been derived from a survey of children commissioned by the County Council and undertaken by the National Foundation for Educational Research (NFER). Again the analysis to hand has only been undertaken at county level. Further analysis below county level is in hand.

Some further triangulation of analysis has been derived by reference to published literature and studies. Reference has also been made to such evidence base as exists in this area of health policy.

East Kent refers to those areas of the county covered by Eastern and Coastal Kent PCT. These comprise Ashford, Canterbury, Dover, Shepway, Swale and Thanet local authorities. West Kent accordingly refers to those areas of the county served by West Kent PCT. These comprise Dartford, Gravesham, Maidstone, Sevenoaks, Tonbridge and Malling and Tunbridge Wells local authorities. South of West Kent means Sevenoaks, Tonbridge and Malling and Tunbridge Wells.

The use of rates, is a statistical method used to adjust (control) for differences in the size of populations amongst the areas or sub-groups being compared. In calculating rates, the population provides the denominator and the number with or without a condition provides the numerator. Rates are often expressed as the number of cases per 1,000 or 100,000 population; sometimes they are expressed as a percentage.

Acknowledgement

I have sought to ground available data, the views of young people and relevant national policy into a Kent context. I should acknowledge that aspects of health policy and the approach I have used are influenced by and often attributed to Sheena Asthana and Joyce Halliday’s masterful study of health inequalities.

Thanks

I wish to express my thanks to the following people in acknowledgement of their contribution to this Needs Assessment:

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1. Key Child Public Health Issues

1.1 The key child public health problems are the dysfunctions either of poor child development opportunities or wider factors that have intervened to prevent optimal development. These include:

- Some of the highest levels of child poverty in Europe - the UK having been criticised for these levels by the World Health Organisation in 2007.
- Increasing inequalities in child health. Children from lower socio-economic families have a significantly higher chance of dying in infancy than those from higher groups;
- Emotional and behavioural problems;
- Obesity;
- Social interaction patterns;
- Teenage pregnancy – the rates of which are still the highest in Europe;
- Accidents whether at home or on the road involving children;
- Certain groups of children being placed in positions where they are unable to benefit from opportunities available to others. Specifically up to 20% of UK children are considered to be vulnerable or in need. Such children need help from public agencies if they have any chance to optimise their life chances. Such children include:

    - those in public care – this is a particular issue in Kent as authorities elsewhere in England have sent children to be cared for within the county
    - teenage parents
    - those with disabilities
    - those in need of protection
    - those in need of family support
    - young offenders
    - young drug misusers
    - children of asylum seekers

- A clustering of problems. Although each of the above challenges exerts individual effects, many of the factors that adversely affect children's health tend to cluster. Thus children with one problem are often at greater risk of experiencing others. Individual adverse factors may potentiate the effects of others. Social Scientists refer to this as 'social patterning' and some social epidemiologists view this as the pathway or cumulative model of health inequality (see 1.11 post).

Competing Policy Agendas and the Challenge of Policy Reconciliation

1.2 It is important to recognise that the children's agenda is not wholly coherent and that there are inherent tensions and contradictions in policy (Churchill 2007). The social investment approach stresses the need to address problems such as poor educational outcomes and an empowerment or ethic of care perspective that seeks to enhance children's rights, resources and wellbeing (Featherstone 2004, Williams 2004). Whilst this approach is critical in addressing disadvantage, some argue that this reformulates childhood as a public concern, reducing the view of childhood through terms of preparation for employment.

1.3 The social threat discord focuses on anti-social behaviour as a problem of behaviour of some individuals and families. This can also risk increasing parental anxiety over what constitutes good parenting (see for example Ferudi 2001). Professionals may prematurely label children as having problems.

1.4 The social justice approach focuses upon the need to redress the balance of power, resources and opportunities in society and service provision in children's favour. Not all health inequalities are unjust or inequitable. For example, in general women live longer than men – a likely consequence of biological sex differences, this is not therefore inequitable. However in cases where women have the same or lower life expectancy as men – that is where social conditions act to reduce the "natural" longevity advantage of women – this inequality is a mark of gross inequity.

1.5 Within these competing conceptualisations, Every Child Matters focuses upon an outcome-led approach. This is complicated by methodological issues and the conflicting underlying policies concerned with children's wellbeing outlined above. Such differences in approach will need to be reconciled by the Kent Children's Trust, Local Children's Trust Arrangements and through the Kent Agreement. The latter has the potential to be useful in providing a strategic framework to the planning of improvements in the wellbeing of children through the partnership approach it demands. Thus economic development, environment, community safety and the wellbeing of children need to be cohesively considered as a whole. Such an approach could promote more favourable economic and social environments for families and the wellbeing of children.

Health Inequalities in Child Public Health

1.6 There is a close affinity between child public health and health inequalities. Child health is assumed to be a period of relative equality within the totality of a life course. Key child public health issues are the dysfunctions either of poor child development opportunities or wider factors that intervene to prevent optimal development.

1.7 Some of the key health inequality approaches need to be outlined in order to understand the approach being taken within this Assessment.

1.8 The Black Report (1980) established a causal link between poor health, life expectancy and socio-economic status. Its key focus was on the causation of poverty, defined in the context of an advanced western society such as the UK as relative deprivation. The Whitehall studies (Marmot et al 1984,1991) highlighted the importance of social gradient. In other words, health inequalities is not exclusively a relationship with poverty, rather that variations in health cover the entire social structure of any society, western or otherwise. Professor Sir Michael Marmot is chairing a WHO Commission on the social determinants of health. An interim statement has been published (2007). The final report which will include major recommendations on children's health will be published in 2008. This could be a landmark in addressing the social determinants of child public health as well as the immediate causes of health inequalities.

1.9 Whilst the conclusions of the Black Report did not find favour with the Government of the time, it has nevertheless proved highly influential in launching a wide ranging enquiry amongst researchers and epidemiologists. Two of the more influential and relevant models of health inequalities research to children are the **latency** and **cumulative** models and it is important to understand each of these approaches

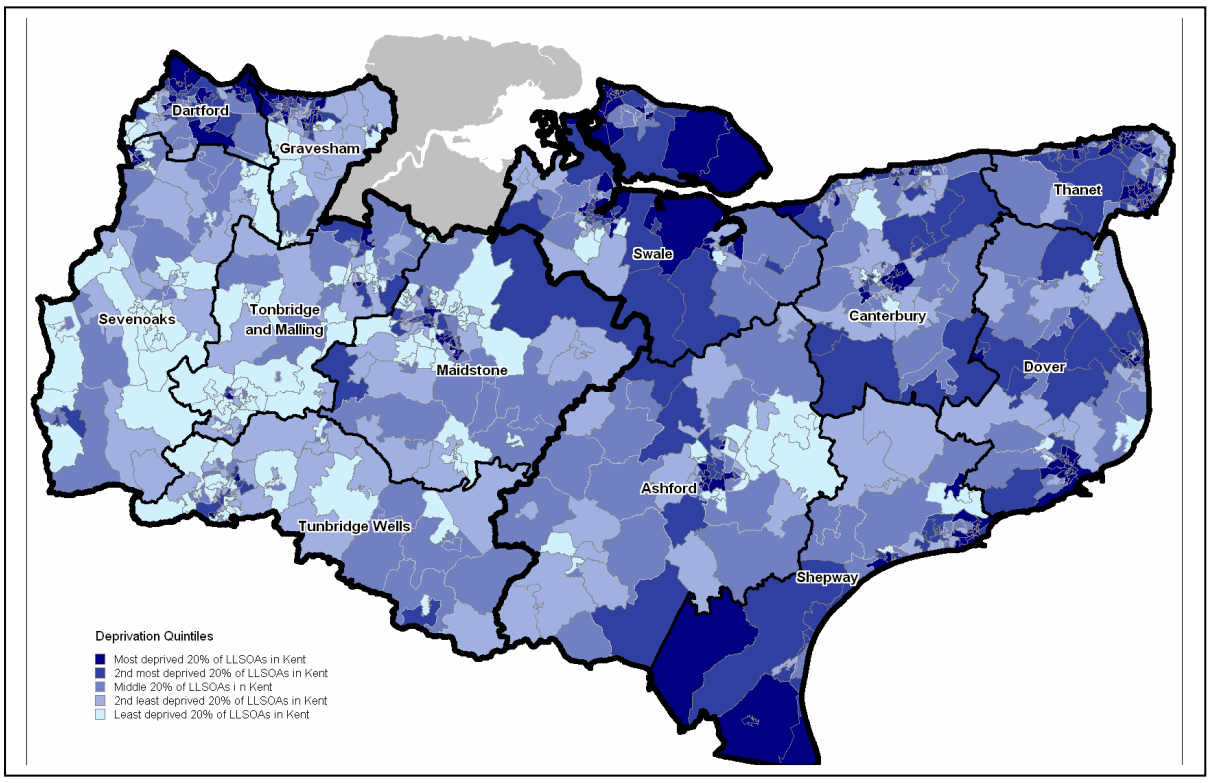
because fundamentally these approaches determine policy commentaries and the evidence base.

1.10 **Latency** effects focus on the way in which environments in early life affect adult health. Adverse biological or developmental influences at sensitive periods have lifelong impact on health and wellbeing regardless of subsequent living conditions. The latency model focuses upon clear biological and developmental pathways that can be targeted for intervention. The limitations of this approach are that it focuses upon an immediate response rather than addressing the underlying and often complex causes or influences of these adverse effects. Much epidemiological literature is focused upon the latency model because it is amenable to coherent and largely measurable study (see for example Davey-Smith et al 2003).

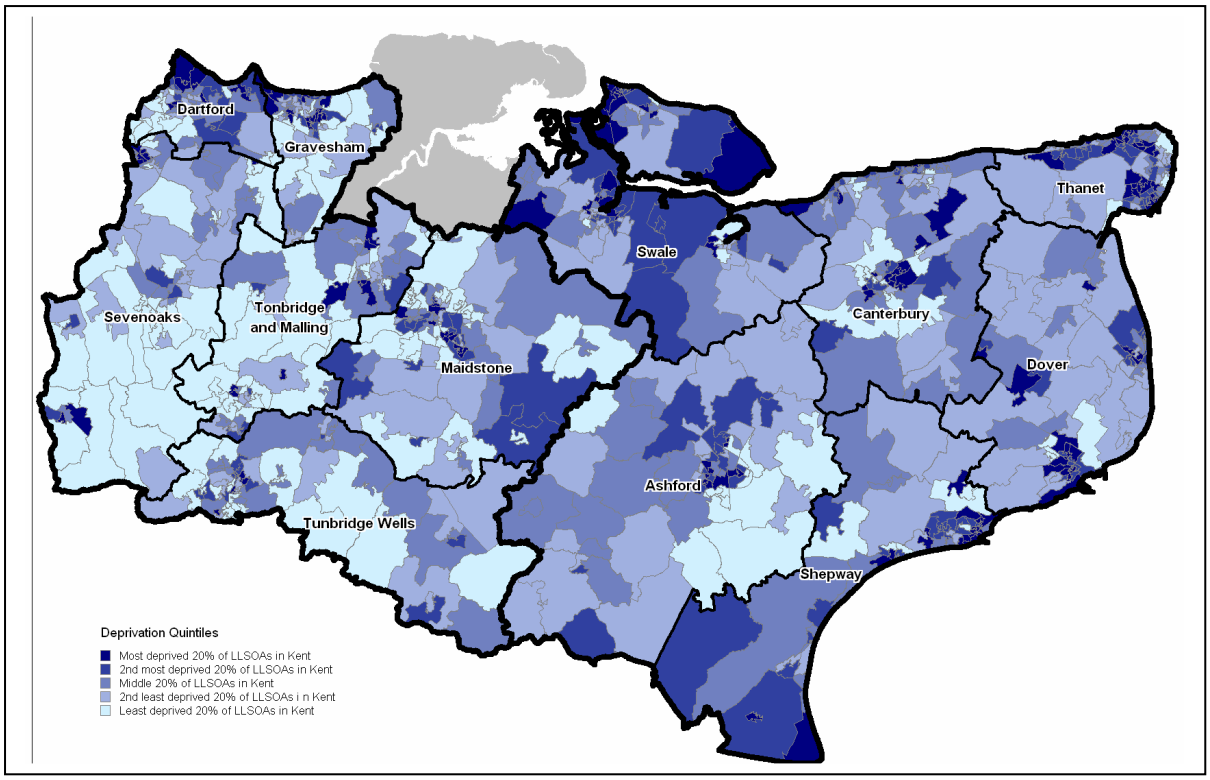
1.11 The **pathway or cumulative** model is the idea that differences in early life direct children on to different life courses. One bad experience/exposure leads to another and then another etc. Although pathway models are interested in inter-generational continuities, they should not be confused with work that attributes the transmission of poverty across generations to either genetic inheritance or the cultural attitudes of the so-called under-class. Continuities that exist in disadvantage between parent and child and between childhood and adulthood are seen as probabilistic rather than deterministic. In other words, they are amenable to positive action (Graham and Power 2004).

1.12 The maps below describe areas of the county of Kent by reference to socio-economic status, highlighting in particular those areas where there are significant concentrations of households including households with children, living in what by reference to objective measures, is described as relative deprivation.

Map 1 – Rank of Index of Multiple Deprivation Scores for LLSOAs in Kent



Map 2 – Rank of Income Deprivation Affecting Children Scores for LLSOAs in Kent



2. Early Life and Health Inequalities: Overview

Research on early life programming has been influential in highlighting the role of latent effects and in identifying a number of specific biological and development factors that can be targeted by preventative health programmes, e.g. cigarette smoking is probably the most important variable mediating socio-economic disparities in intra-uterine growth retardation. Barker (1994) emphasises the need for nutritional programmes to improve the diets of girls and young women, while others focus on the role of parenting support and pre-school provision to improve cognitive and socio-emotional function in children living in poverty or in psychologically stressful family environments. Thus there are grounds for singling out some factors as key foci for health programmes, e.g. smoking during pregnancy and specific nutritional deficiencies during pregnancy increasing the risk of brain development and during infancy and early childhood rapid weight gain indicates increased risk for obesity in childhood and later life with related diseases.

In addition to biological risk factors, a growing body of research is exploring the interplay between biological and psychological/behavioural influences. This suggests that chronic stress can have long-term consequences on physical and emotional health from the earliest stage of life. Maternal stress for instance has been implicated in risks of prematurity, adverse neuro-development and chronic degenerative disease in adulthood. During infancy and early childhood, neglect, abuse and social deprivation can produce a cascade of neuro-biological events that in turn affect emotional, behavioural, cognitive and physiological development. Thus children deprived of appropriate love and stimulation are not only at increased risk of socio-emotional and psychological problems. Key neuro-biological changes are also associated with reduced cognitive ability, impaired immune function, increased risk of cardio-vascular disease and diabetes.

Whilst care should be taken to avoid the conflation of poverty with poor parenting, there is strong evidence suggesting that parents struggling with financial problems and lack of social support are at higher risk of suffering from depression and anxiety. Poor psychological health in pregnancy is strongly associated with social disadvantage. Depression and anxiety have been associated with negative and less developmentally positive interaction with children. Parents own adult experiences together with a lack of information and education can shape attitudes to and expectations of child behaviour and development. Poverty also has a direct effect on parenting practices by undermining a family's ability to provide education resources. All these factors suggest that parents caring for children in disadvantaged circumstances are likely to need additional family support if they are to protect their children from the effects of disadvantage.

Abbreviated from Asthana and Halliday 2006

Population

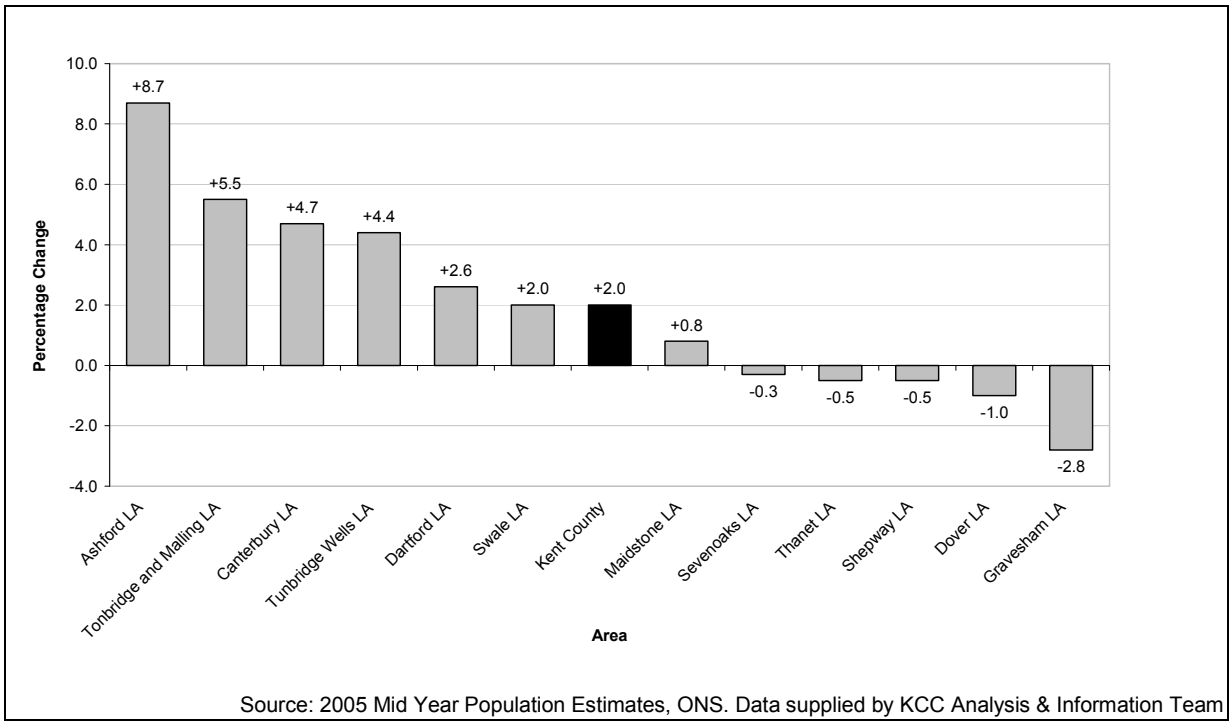
2.1 Over recent years (2000-2005) the largest growth in the 0-18 population has been in Ashford, with the major planned housing developments associated with the south east housing growth strategy. Other areas of significant growth include Tonbridge and Malling, Tunbridge Wells and Canterbury. However the same period also demonstrates the beginnings of the longer term downward trend in the numbers of children and young people relative to the population at large.

Table 1 - Change in 0-18 year old population in Kent local authority districts, 2000-2005

Local Authority	% Change
Ashford Local Authority	+8.7
Canterbury Local Authority	+4.7
Dartford Local Authority	+2.6
Dover Local Authority	-1.0
Gravesham Local Authority	-2.8
Maidstone Local Authority	+0.8
Sevenoaks Local Authority	-0.3
Shepway Local Authority	-0.5
Swale Local Authority	+2.0
Thanet Local Authority	-0.5
Tonbridge and Malling Local Authority	+5.5
Tunbridge Wells Local Authority	+4.4
Kent County	**+2.0**

Source: 2005 Mid Year Population Estimates, ONS. Data supplied by KCC Analysis & Information Team

Figure 1 - Change in 0-18 year old population in Kent local authority districts 2000-5



Source: 2005 Mid Year Population Estimates, ONS. Data supplied by KCC Analysis & Information Team

2.2 As regards future population growth, it will be noted that the population of 0-14s is forecast to decline by 5% across Kent as a whole by 2016. The decline in West Kent

is marginally less than that forecast for Eastern and Coastal Kent. Whilst this pattern of decline is broadly common to all district council areas, the notable exceptions are again Ashford and also Dartford where positive increases in numbers of children relative to the population at large are anticipated. These increases can be attributed to planned housing developments associated with the Thames Corridor developments and the Ashford Growth Area. Most parts of Kent also have planned housing developments but the anticipated outcome of these developments do not result in an overall increase in the proportion of younger people as part of local populations. The latter reflects declining fertility rates and socio-economic factors.

2.3 The decline in the number of children relative to the population at large has implications for service delivery in all agencies. Nevertheless this should not be seen as the opportunity to disinvest in services, but to enhance a service quality to meet changing and ever more complex needs.

Table 2 - 2011 and 2016 population projections by local authority of children aged 0-14, 2005

Local Authority	2005		Projected Population Aged 0 - 14		% Change	
	Population Aged 0 -14	% of Total Ward Population	2011	2016	2005 to 2011	2005 to 2016
Ashford Local Authority	21290	19.6	22290	23180	4.7	8.9
Canterbury Local Authority	22700	16.2	21560	21060	-5.0	-7.2
Dartford Local Authority	17980	19.1	19730	21180	9.7	17.8
Dover Local Authority	19150	18.1	17720	16890	-7.5	-11.8
Gravesham Local Authority	17670	18.9	16710	16640	-5.4	-5.8
Maidstone Local Authority	25970	18.3	25710	25300	-1.0	-2.6
Sevenoaks Local Authority	20000	18.5	18780	17910	-6.1	-10.5
Shepway Local Authority	17180	17.6	15890	14960	-7.5	-12.9
Swale Local Authority	23370	19.3	22490	22040	-3.8	-5.7
Thanet Local Authority	23930	18.4	23020	22610	-3.8	-5.5
Tonbridge and Malling Local Authority	21430	19.9	20790	20340	-3.0	-5.1
Tunbridge Wells Local Authority	19780	18.9	18050	15940	-8.7	-19.4
Kent County Total	**250450**	**18.5**	**242740**	**238050**	**-3.1**	**-5.0**

Source: Kent County Council Strategic Planning Analysis and Information Team

Births

2.4 Over the last ten years the number of births across Kent as a whole and indeed both PCT areas has been broadly consistent. There was a dip in the number of births in 2001 and 2002 but for the last three years the numbers appear to be approaching the established pattern of ten years previously.

2.5 The most notable trend for Kent as a whole and replicated in both PCT areas is the steady increase in the number of live births to mothers aged 35+. This is a reflection of social change with increasing numbers of planned births later in life in consequence both of the wish to establish careers and probably a product of increased housing cost.

Table 3 - Numbers of Live Births by Age of Mother, 1996-2005, Kent County

Age of Mother	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Under 20	1039	1160	1172	1370	1092	1114	1024	1022	991	1086
20-34	12782	12697	12470	11740	11253	10955	10940	11198	11328	11425
35+	1945	2130	2220	2251	2405	2575	2640	2814	2954	3102
All ages	**15766**	**15987**	**15862**	**14117**	**14750**	**14644**	**14604**	**15034**	**15273**	**15613**

General Fertility Rate

2.6 Between 1997 and 2005 there has been an overall decline in the fertility rate (live births per 1,000 women aged 15-44) in Kent. In the first three years of the new century this decline was marked, but a modest increase is indicated in more recent years notwithstanding that over the whole trend period the rate is generally downward. The fertility rate in the West Kent PCT area is consistently higher than in Eastern and Coastal Kent.

Table 4 - General fertility Rate 1997-2005 – Live births per 1,000 women aged 15-44

Local Authority	Year								
	1997	1998	1999	2000	2001	2002	2003	2004	2005
Ashford LA	61.8	61.5	61.2	58.2	61.6	62.0	63.4	61.4	61.0
Canterbury LA	54.0	49.9	50.1	46.4	45.7	47.0	47.8	44.9	46.8
Dartford LA	64.8	63.3	64.3	58.5	57.9	60.2	60.8	62.6	66.2
Dover LA	60.4	59.8	53.8	53.4	55.3	51.7	53.2	55.3	59.3
Gravesham LA	67.4	65.6	62.3	60.5	57.0	55.2	56.4	58.6	62.7
Maidstone LA	55.6	57.6	58.3	54.2	56.5	54.3	60.9	57.7	58.8
Sevenoaks LA	58.6	63.4	60.6	54.7	58.9	56.1	56.9	58.1	59.8
Shepway LA	59.9	58.0	54.1	51.1	55.9	56.2	56.1	58.3	58.8
Swale LA	67.5	63.8	62.2	59.7	59.0	59.7	57.8	60.2	60.2
Thanet LA	64.2	63.4	59.6	61.4	56.4	56.1	58.8	60.8	61.4
Tonbridge & Malling LA	65.9	64.6	61.6	60.2	59.9	59.2	57.5	61.6	57.8
Tunbridge Wells LA	63.8	67.6	61.3	59.6	55.9	57.7	59.5	58.3	54.6
Kent County	**61.6**	**61.2**	**58.8**	**56.2**	**56.4**	**56.0**	**57.2**	**57.8**	**58.5**

Ethnicity

2.7 In contrast to major conurbations and in particular inner city areas, the number of Kent children born outside the UK is small.

Table 5 - Kent 0-15 year olds born outside the UK by continent of birth, 2001

		% of all 0-15's born outside the UK							
Local Authority	**0-15's born outside the UK as a % of all 0-15's**	**Other Western Europe**	**Asia**	**Africa**	**North America**	**Oceania**	**Eastern Europe**	**South America**	**Other**
Ashford LA	2.2%	30.6%	21.8%	21.4%	8.9%	8.7%	5.6%	2.3%	0.6%
Canterbury LA	3.4%	31.7%	30.9%	12.9%	9.4%	6.2%	7.3%	1.5%	0.0%
Dartford LA	1.4%	19.6%	27.2%	24.4%	9.6%	8.0%	11.2%	0.0%	0.0%
Dover LA	3.1%	46.6%	15.7%	9.1%	16.0%	5.9%	5.5%	0.5%	0.6%
Gravesham LA	1.9%	22.2%	32.7%	12.6%	7.3%	6.3%	16.6%	1.5%	0.8%
Maidstone LA	2.2%	32.5%	27.4%	16.5%	10.1%	9.0%	2.2%	1.7%	0.5%
Sevenoaks LA	3.7%	27.1%	20.6%	16.5%	16.6%	14.3%	3.1%	1.5%	0.4%
Shepway LA	3.1%	28.1%	37.1%	11.7%	6.9%	6.3%	8.0%	1.4%	0.7%
Swale LA	1.3%	37.2%	18.6%	17.4%	11.4%	7.8%	3.9%	2.1%	1.5%
Thanet LA	2.3%	29.3%	23.3%	14.3%	6.8%	5.4%	11.2%	2.9%	6.8%
Tonbridge and Malling LA	2.3%	28.5%	19.0%	20.1%	16.6%	12.8%	1.5%	1.5%	0.0%
Tunbridge Wells LA	3.7%	27.2%	29.7%	16.0%	15.2%	7.6%	3.7%	0.6%	0.0%
Kent County	**2.5%**	**30.6%**	**25.4%**	**15.3%**	**11.8%**	**8.2%**	**6.1%**	**1.5%**	**1.1%**
England	**3.6%**	**21.4%**	**31.3%**	**21.2%**	**13.2%**	**3.9%**	**6.4%**	**1.7%**	**0.9%**

Source: 2001 Census, Standard Table 15, ONS

2.8 A dialogue of community relations is forged through practice and encounter with significant ethnic minorities who typically settle as immigrants, from which come indigenous second and third generations. The pattern of immigration in Kent has been different from much of the UK.

2.9 Notwithstanding that there are concentrations in the Thames-side area of Kent (and also the Medway Towns), there is less of a presence of communities whose descendents come from new Commonwealth countries. The marked presence of the latter groups elsewhere in the UK has justified the current categorisation for the purposes of measurement and for the assessment of need.

2.10 Overall, at nearly 96%, the population of Kent is predominantly white and is in contrast to other parts of the UK, particularly urban conurbations. The one local authority area where there is a more notable percentage of the population classified as being of ethnic minority is Gravesham, with Dartford also showing some variance from the overall Kent pattern and reflecting its geographical proximity to the edge of the London conurbation. The proportion of the population classified as being of ethnic minority is marginally higher in West Kent PCT than Eastern and Coastal Kent.

2.11 The data in tables 5 and 6 derives from the 2001 Census. This may not have captured inward migration from Eastern European states that have acceded to the EU. The extent to which inward migration involves children as opposed to adults is uncertain.

2.12 Public authorities serving the needs of children and young families need to be especially mindful of the need to assure equality and diversity policies and to ensure that staff are culturally aware in their working practices.

Table 6 - Ethnicity of resident children aged 0-15, 2001

Local Authority	All People	White		Asian		Black		Chinese/Other		Mixed Race		Total ethnic component	
		No	%	No	%	No	%	No	%	No	%	No	%
Ashford	21714	20960	96.5	157	0.7	70	0.3	65	0.3	462	2.1	754	3.5
Canterbury	24901	23917	96.0	199	0.8	75	0.3	153	0.6	557	2.2	984	4.0
Dartford	18265	17023	93.2	545	3.0	168	0.9	92	0.5	437	2.4	1242	6.8
Dover	21114	20659	97.8	107	0.5	22	0.1	70	0.3	256	1.2	455	2.2
Gravesham	20679	17938	86.7	1965	9.5	122	0.6	112	0.5	542	2.6	2741	13.3
Maidstone	27281	26265	96.3	323	1.2	61	0.2	102	0.4	530	1.9	1016	3.7
Sevenoaks	22163	21522	97.1	100	0.5	49	0.2	84	0.4	408	1.8	641	2.9
Shepway	18794	18111	96.4	228	1.2	38	0.2	60	0.3	357	1.9	683	3.6
Swale	26510	25851	97.5	150	0.6	48	0.2	61	0.2	400	1.5	659	2.5
Thanet	25518	24588	96.4	182	0.7	94	0.4	124	0.5	530	2.1	930	3.6
Tonbridge & Malling	23178	22583	97.4	105	0.5	21	0.1	74	0.3	395	1.7	595	2.6
Tunbridge Wells	21502	20693	96.2	137	0.6	47	0.2	175	0.8	450	2.1	809	3.8
Kent County	**271619**	**260110**	**95.8**	**4198**	**1.5**	**815**	**0.3**	**1172**	**0.4**	**5324**	**2.0**	**11509**	**4.2**
SE Region	**1594219**	**1481853**	**93.0**	**49096**	**3.1**	**10492**	**0.7**	**10702**	**0.7**	**42079**	**2.6**	**112366**	**7.0**
England	**9901581**	**8558564**	**86.4**	**644651**	**6.5**	**294489**	**3.0**	**81498**	**0.8**	**322379**	**3.3**	**1343017**	**13.6**

Source: ONS 2001 Census Theme Table 13

2.13 Kent County Council supports unaccompanied asylum seeking children (UASC). The next table illustrates the numbers of UASC aged 0-17 in Kent County Council's care as at 31st October 2006. These figures exclude those placed in Kent by other local authorities. The larger number of such children placed in Canterbury and also Tunbridge Wells is notable. Children in Medway are those supported by KCC but placed in that unitary authority.

2.14 The numbers reported are very small and will vary within year and between years and therefore are subject to regular monitoring and reported up-dates.

Table 7 - Unaccompanied Asylum Seeking Children (UASC) aged 0-17 in KCC care by district of residence as at 31st October 2006

Local Authority	Number of children
Ashford LA	6
Canterbury LA	59
Dartford LA	2
Dover LA	13
Gravesham LA	15
Maidstone LA	16
Sevenoaks LA	5
Shepway LA	11
Swale LA	3
Thanet LA	22
Tonbridge and Malling LA	4
Tunbridge Wells LA	37
Medway UA	1
All UASCs in KCC care	**194**

Source: Services for Unaccompanied Asylum Seeking Children (SUASC), KCC

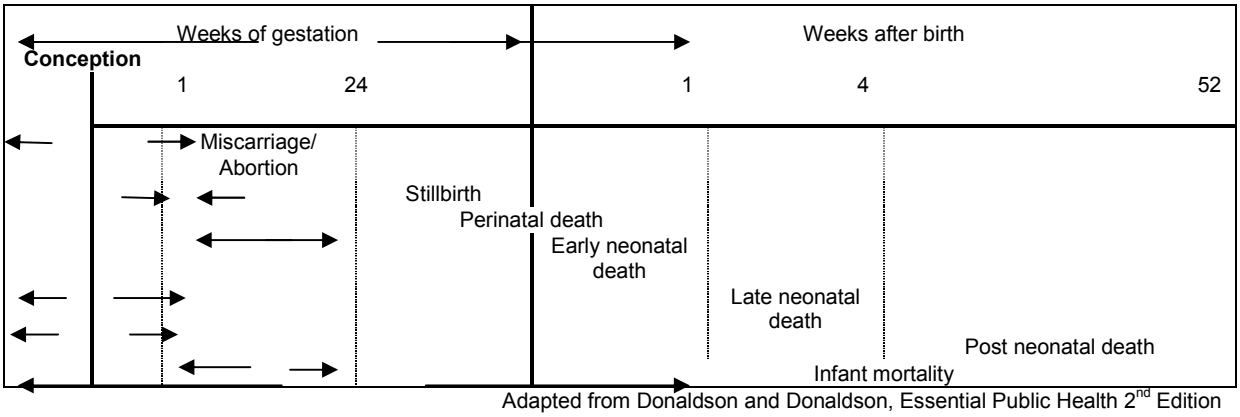
Infants

2.15 Infant mortality is a key national and international measure of infant health. One of the key national targets for improving health and reducing health inequalities relates to infant mortality. The national target is:

"To reduce the gap in infant mortality between routine/manual groups and the population as a whole by at least 10% by 2010"

2.16 Several measures of mortality are used for the period covering infancy: stillbirth rate, perinatal death rate, neonatal death rate, post neonatal and infant mortality rates.

Figure 2 - Measures of Infant Mortality



Adapted from Donaldson and Donaldson, Essential Public Health 2nd Edition

Still Births

2.17 Still birth rates (still births per 1,000 births at 24 weeks gestation or more) have been low in England and Wales for many years. Low rates therefore can be affected year on year by variations caused by single cases. In order to offer data that is statistically consistent, it is necessary to calculate rates by reference to three year rolling averages. On this basis Kent county has been consistently below the England and

Wales average for the period 1997-2005. This pattern is reflected in both Eastern and Coastal Kent PCT and West Kent PCT.

Table 8 - Still birth rates per 1,000 births, 1997-1999 to 2003-2005

Local Authority	Year						
	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005
Ashford Local Authority	4.0	4.6	3.8	5.3	4.2	5.1	4.8
Canterbury Local Authority	3.9	3.8	3.8	2.6	2.6	4.0	4.8
Dartford Local Authority	5.4	5.5	5.4	4.6	4.8	3.2	4.5
Dover Local Authority	3.0	3.4	4.8	3.7	4.1	5.1	5.5
Gravesham Local Authority	6.7	6.4	5.7	6.4	6.8	6.4	4.1
Maidstone Local Authority	4.7	4.7	3.5	3.5	3.3	4.1	4.6
Sevenoaks Local Authority	3.8	3.4	3.8	6.3	7.4	7.4	5.5
Shepway Local Authority	5.1	4.1	3.9	3.0	4.0	4.9	5.5
Swale Local Authority	6.9	5.1	4.6	4.2	6.0	5.2	4.7
Thanet Local Authority	3.9	5.4	6.4	6.2	5.1	3.9	4.0
Tonbridge & Malling Local Authority	3.5	1.8	2.6	3.9	5.5	4.9	4.4
Tunbridge Wells Local Authority	3.6	5.3	7.0	5.0	3.6	3.0	5.9
Kent County	**4.6**	**4.5**	**4.6**	**4.5**	**4.7**	**4.7**	**4.8**
England and Wales	**5.3**	**5.3**	**5.3**	**5.4**	**5.5**	**5.6**	**5.5**

Infant Mortality

2.18 Infant mortality has declined throughout England and Wales. The overall rate for Kent county has been consistently lower than the overall England and Wales rate. Because of the low incidence, it is necessary to calculate rates by reference to three year rolling averages. The infant mortality rate for West Kent has been consistently lower than the Kent county and the England and Wales rates for the entire strategic period. The rate for Eastern and Coastal Kent has been consistently above the Kent county average. In latter years it has been above the England and Wales rate but the incidence is low and the overall trend can be distorted by specific cases.

Table 9 - Infant deaths under 4 weeks per 1,000 live births, 1998-2000 to 2003-

Local Authority	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005
Ashford Local Authority	1.1	1.6	2.4	3.6	3.9	4.3
Canterbury Local Authority	3.6	3.8	4.1	3.5	4.5	3.2
Dartford Local Authority	2.0	1.2	1.5	2.1	2.4	2.3
Dover Local Authority	2.3	3.3	3.5	3.5	3.2	2.8
Gravesham Local Authority	1.8	2.4	3.4	3.7	3.4	2.1
Maidstone Local Authority	2.1	2.5	2.2	3.4	2.7	3.6
Sevenoaks Local Authority	3.4	3.8	3.1	1.7	1.1	1.4
Shepway Local Authority	4.1	3.3	4.4	4.4	5.0	5.5
Swale Local Authority	2.5	1.9	1.9	2.5	2.7	2.9
Thanet Local Authority	3.8	2.9	3.0	4.8	5.0	4.6
Tonbridge & Malling Local Authority	2.0	1.8	2.1	2.9	2.8	3.1
Tunbridge Wells Local Authority	3.2	2.5	2.3	2.0	3.1	2.5
Kent County	**2.6**	**2.6**	**2.8**	**3.2**	**3.3**	**3.2**
England and Wales	**3.8**	**3.8**	**3.7**	**3.6**	**3.5**	**3.5**

Rates of Infant Deaths Under One Year per 1,000 live Births

2.19 Throughout the strategic period the Kent county rate has been consistently below the England and Wales rate. This county position is reflected in West Kent PCT area. Overall the Eastern and Coastal Kent area is either below or consistent with the England and Wales rates. Nevertheless it should be noted that there is a steady upward rise in infant deaths in Ashford. The sharp rise over the three years 2003-05 in Shepway may need further investigation.

Table 10 - Number of Infant Deaths Under 1 Year per 1,000 Live Births, 1998-2000 to 2003

Local Authority	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005
Ashford Local Authority	3.2	3.2	3.2	4.7	4.6	5.1
Canterbury Local Authority	4.6	5.6	6.2	5.8	6.2	4.6
Dartford Local Authority	4.1	3.0	2.5	3.6	3.8	3.7
Dover Local Authority	2.9	4.5	5.3	5.5	4.5	3.4
Gravesham Local Authority	3.8	4.2	4.9	5.0	4.9	3.2
Maidstone Local Authority	3.9	4.6	4.3	4.8	3.9	4.2
Sevenoaks Local Authority	4.5	4.9	3.7	2.0	1.1	2.2
Shepway Local Authority	5.7	4.9	5.4	5.0	5.6	7.1
Swale Local Authority	4.3	3.5	3.0	3.9	4.3	5.0
Thanet Local Authority	4.7	3.7	4.0	6.4	5.9	5.5
Tonbridge & Malling Local Authority	2.8	2.3	2.6	3.7	3.9	4.6
Tunbridge Wells Local Authority	4.0	3.1	2.6	2.0	4.2	4.2
Kent County	**4.0**	**4.0**	**3.9**	**4.4**	**4.4**	**4.4**
England and Wales	**5.7**	**5.6**	**5.4**	**5.3**	**5.2**	**5.1**

Low Birthweight

2.20 The main cause of low birthweight is prematurity. Children born earlier than 28 weeks will be of very low birthweight and will require intensive or special care within the first few weeks of life. Children born earlier than 26 weeks have greatly increased chances of disability as they grow. It has been reported that one in six babies born with extremely low birthweight will have a severe disability at age 16 years and that motor, cognitive and behavioural disorders are common in very premature babies. Increased viability and survival of very pre-term infants due to advances in medical technology will account for some of the very low birth rate weights.

2.21 Although in general older mothers have larger babies than younger mothers, there are no big differences in rates between mothers of different ages. It has also been reported that teenage mothers do not have a higher rate of low birthweight than women aged 20-24 years.

2.22 The rate of very low birthweight births in Kent county is below the rate for England and Wales and this is mirrored in both Eastern and Coastal and West Kent PCTs. As regards low birthweight births, the overall position in Kent county is well below the England and Wales rate and this is replicated in both PCT areas.

See also sole registrations.

Percentage of Low Birthweight Births of all Registrations and Sole Registrations

2.23 There are no England and Wales comparisons available. It is notable that overall in Kent there are 25% more low birthweight births indicated by sole registrations relative to all such registrations.

Table 11 - Percentage low birthweight births of all registrations and sole registrations, 2001-2005, pooled

Area	All registrations: Birthweight <2500g		Sole registrations: Birthweight <2500g	
	Number	Average annual percentage	Number	Average annual percentage
Ashford Local Authority	439	6.8	24	7.0
Canterbury Local Authority	444	6.6	41	10.4
Dartford Local Authority	398	6.9	23	8.8
Dover Local Authority	379	7.1	45	11.1
Gravesham Local Authority	471	8.4	26	7.5
Maidstone Local Authority	567	7.0	49	11.4
Sevenoaks Local Authority	377	6.3	19	9.5
Shepway Local Authority	359	7.0	32	8.4
Swale Local Authority	560	7.6	52	10.0
Thanet Local Authority	587	8.7	79	11.2
Tonbridge and Malling Local Authority	452	7.0	27	11.6
Tunbridge Wells Local Authority	380	6.4	26	10.4
Kent County	**5413**	**7.2**	**443**	**9.9**

Smoking in Pregnancy

There is **conclusive** evidence that smoking in pregnancy causes:	There is **substantial** evidence that smoking in pregnancy causes:	There is **suggestive** evidence that smoking in pregnancy causes:
• Placental complications • Premature rupture of the membranes • Premature birth • Perinatal death • Reduced fetal growth (low birthweight baby) • Cot death* • Reduced lung function in infancy*	• Ectopic pregnancy • Miscarriage • Reduced rates of breastfeeding • Shorter duration of breastfeeding • Asthma* • Respiratory symptoms*	• Specific fetal malformations • Predisposition to smoke in later life • ADHD
* These are also caused by exposure to second hand smoke in childhood.		

Source: BMA 2007

2.24 Advice and support tailored for pregnant women have been shown to have only a modest effect on cessation rates and a tendency not to reach those at highest risk. A systematic review suggested that 10% of women still smoking at the time of their first ante-natal visit are likely to stop with usual care but that formal interventions can result in an additional 6-7% quitting (Lumley et al 2001). The frequency of contact with health professionals in the pre-natal period obviously offers increased opportunities for such interventions. Historically at least this potential, i.e. GP surgeries, has been under-utilised.

2.25 There is consensus that the transition from pregnancy to the post partum period is critical in preventing a relapse as is the absence of a partner who continues to smoke. It is estimated that half of all mothers who ceased smoking during pregnancy resumed within six weeks with over 70% returning within six months (Dolan–Mullen 1999). Despite this, less emphasis has been given either to the continuation of cessation or cessation by other family members.

2.26 Research also suggests that increasing support for smoking cessation during pregnancy and its subsequent maintenance could affect breastfeeding rates and suggests a legitimate component of breastfeeding support programmes. (Amir and Donath 2002).

2.27 A synthesis of published interventions designed to reduce children's exposure to passive smoking suggested that the most effective strategies concentrate on strengthening the parents' faith in their ability to create a smoke-free environment and on behavioural strategies to achieve this goal (such as smoking outside) rather than focusing merely on stopping smoking altogether (Arborelius et al 2000). This is supported by a recent meta review, which also finds evidence in favour of interventions delivered by clinicians in both the home and the clinic including information, advice and counselling.

2.28 A higher proportion of mothers smoking during pregnancy is to be found amongst residents served by Eastern and Coastal Kent PCT. Smoking patterns are increasingly socio-economically related. The pattern in Kent therefore reflects the broad socio-economic differences across the county.

Table 12 - Mothers smoking during pregnancy in Kent, 2006/07

PCT	Number of	Number	Number	Smoking	% smoking	% not	%

	Maternities	known to be smoking at time of delivery	known not to be smoking at time of delivery	status unknown	at time of delivery	smoking at time of delivery	smoking status not known
West Kent PCT	7801	1152	6632	17	14.8%	85.0%	0.2%
Eastern and Coastal Kent PCT	7590	1522	6068	0	20.1%	79.9%	0.0%
Kent County	**15391**	**2674**	**12700**	**17**	**17.4%**	**82.5%**	**0.1%**

Source: Local Delivery Plan Return 2006/07

Table 13 - Interventions during early life: summary of the evidence base - Smoking

Smoking cessation in pregnancy	Source
Advice and support tailored for pregnant women has a modest effect on cessation rates, increasing mean birth weight and reducing low birth weight. It tends not to reach those at highest risk.	Cochrane Review
Ten per cent of women still smoking at the time of their first ante-natal visit will stop with usual care. Formal interventions typically result in an additional 6% to 7% quitting.	Cochrane Review
Pre-natal counselling, combined with at least ten minutes person-to-person contact and written material tailored to pregnancy can double cessation rates.	Overview
Even reducing smoking in pregnancy can increase health outcomes	Systematic review
Exposure to passive smoking in early life	
Both home-based and clinic-based interventions by a clinician (for example information, advice and counselling) can be effective in reducing children's exposure to second-hand smoke. But studies tend to rely on self-reported health rather than biochemical measures	Review of reviews
Intensive counselling increases knowledge but few studies show a statistically significant intervention effect in terms of attitudes and behaviour (and hence exposure to environmental tobacco smoke)	Cochrane Review
Lack of review-level evidence	
Safety and efficacy of Nicotine Replacement Therapy (NRT) for smoking cessation during pregnancy	
Strategies that are effective against relapse in the postpartum period	
Interventions that include the family as a whole	
Holistic interventions that address poverty, disadvantage and increase smoking control and support in the wider community	

Breast Feeding

2.29 Breast feeding confers health advantages to the infant, the developing child and the young adult – as well as the mother (see box below).

Advantages of breast-feeding	
For the baby	**For the mother**

Lower risk of gastrointestinal infections Lower risk of respiratory infections Lower risk of atopic disorders Possibly, higher IQ in preterms Lower risk of cot death Lower risk of heart disease in later life	Cheap Convenient no sterilizing or bottle preparation No risk of error in composition Promotes postpartum weight loss Lower risk of breast cancer May promote mother-infant relationship

Source: Blair et al 2003

2.30 Breast feeding rates in England and Wales are lower than those in many other European countries. In particular, Scandinavian countries show very high rates of breast feeding initiation and women in those countries continue breast feeding for much longer than here.

2.31 The World Health Organisation recommends that babies should be exclusively breast fed for six months. This recommendation was taken up by the Department of Health in 2003.

2.32 Differences in breastfeeding behaviour may be less indicative of knowledge deficiency than of cultural attitudes. A qualitative study examining expectations and experiences across transition to motherhood found that mothers' pre-existing preferences as to infant feeding had been formed long before they became pregnant. Even women who acknowledged the health benefits of breast milk expressed firm intentions to bottle feed, in part because of cultural familiarity with infant formula, but also to a degree of embarrassment. As early as childhood girls can form opinions of breast feeding (Gregg 1989). The return to paid employment is another factor influencing breast feeding behaviour (Noble 2001; Galtry 2003). The UK's policies regarding paid maternity leave are less generous than many countries in the EU.

Table 14 - Breast feeding initiation at time of delivery – Kent county

	Eastern and Coastal Kent PCT	West Kent PCT	Kent County
Number of Births	7,590	7,801	15,391
Known to be Breastfeeding	5,225	5,443	10,668
% Breastfeeding	68.8%	69.8%	69.3%
Known not to be Breastfeeding	2,365	2,167	4,532
% Not Breastfeeding	45.3%	39.8%	29%
Breastfeeding status unknown	0	191	191
Unknown Breastfeeding %	0.0%	2.4%	1.2%

Table 15 - Interventions during early life: summary of the evidence base - Nutrition

Maternal nutritional supplements	Source
Calcium supplements reduce pre-term birth and the incidence of low birth weight, especially among women at risk of hypertensive disorders	Cochrane Review
Dietary supplementation based on balanced protein and energy content consistently improves foetal growth	Systematic review
Lack of review-level evidence	
Appropriate combinations of interventions	
Food-based as opposed to nutrient-based interventions	
Interventions relating to maternal nutrition before pregnancy and in early pregnancy	
Breastfeeding initiation and duration	

Initiation rates can be increased by: Multi-faceted interventions, including for example, health education, changes to maternity ward practice, such as unrestricted mother-baby contact and feeding and the prevention of discharge packs containing formula feeding information and samples, the use of peer facilitators and advocates	Systematic review
Education – small, informal discussion classes led by health professionals that emphasise the benefits of breastfeeding and provide practical advice. But one-to-one education sessions may be necessary to persuade women who have decided to feed infant formula to breastfeed	Other review
Training – intensive targeted lactation training for health professionals (particularly if accorded mandatory status)	Review of Reviews
A peer support component (particularly important for low-income women). But only effective as a standalone component with women intending to breastfeed	Cochrane review
Professional support increases the duration of (any) breastfeeding	Cochrane Review
Lay support is effective in promoting exclusive breastfeeding	Cochrane Review
Efficacy is increased if sessions are broad-based, span the ante and post-natal period and draw on repeated contacts with either a professional or peer educator	Systematic review
Lack of review-level evidence	
Evaluation of public policy, for example, provision of maternity leave	
Provision of supportive environment (public acceptability and social barriers to breastfeeding)	
Inclusion of issues that are important to mothers and their partners and families	

Childhood Immunisations

2.33 The immunisation programme is an essential part of protecting children's health (appendix 2). Low vaccine uptake puts children at risk, particularly in view of high rates of migration from countries that are experiencing a resurgence of certain diseases. Polio has started to re-emerge in Nigeria and diphtheria is increasing in Eastern Europe.

2.34 The percentage of children being immunised in accordance with the national vaccination and immunisation schedule by the age of one, is broadly lower than the national and indeed SHA figure.

Table 16 - Percentage of children immunised by their 1st birthday, by PCT 2005-06

PCT	No children aged 1	Diphtheria	Tetanus	Polio	Pertussis	Hib	MenC
Ashford	1300	84	84	84	84	84	84
Canterbury & Coastal	1600	89	89	89	89	89	89
Dartford Gravesham & Swanley	2700	87	87	87	87	87	86
East Kent Coastal	2300	89	89	89	89	89	89
Maidstone Weald	2800	86	86	86	86	86	86
Shepway	1000	89	89	89	89	89	89
South West Kent	2100	89	89	89	89	89	89
Swale	1000	96	96	96	96	96	96
Kent County	**14800**	**89**	**89**	**89**	**89**	**89**	**89**
South East Coast SHA	**48100**	**91**	**91**	**90**	**90**	**90**	**90**
England	**684800**	**91**	**91**	**91**	**91**	**91**	**91**

Source: NHS Immunisation Statistics, England: 2005-06, The Information Centre

2.35 By the second birthday, the overall percentage of children immunised in Kent is better than the England average and the SHA average with the exception of MenC.

Table 17 – Percentage of children immunised by their 2nd birthday, by PCT 2005-06

PCT	No children aged 2	Diphtheria	Tetanus	Polio	Pertussis	Hib	MMR	MenC
Ashford	1400	96	96	96	95	95	86	95
Canterbury & Coastal	1700	96	96	96	95	96	88	95
Dartford, Gravesham & Swanley	2700	93	93	94	93	94	80	92
East Kent Coastal	2300	96	96	96	96	96	88	95
Maidstone Weald	2900	95	95	95	95	96	84	94
Shepway	1000	95	95	95	94	95	87	95
South West Kent	2300	94	94	94	94	94	82	93
Swale	1000	98	98	98	98	98	94	98
Kent County	**15300**	**95**	**95**	**96**	**95**	**96**	**86**	**95**
South East Coast SHA	**47400**	**94**	**94**	**93**	**93**	**94**	**83**	**96**
England	**668800**	**94**	**94**	**94**	**94**	**94**	**84**	**93**

Source: NHS Immunisation Statistics, England: 2005-06, The Information Centre

2.36 By the fifth birthday, the overall Kent position is better than the England average.

Table 18 – Percentage of children immunised by their 5th birthday, by PCT 2005-06

		Diphtheria, Tetanus, Polio		Pertussis	Hib	MMR		MenC
PCT	**No children aged 5**	**Primary**	**Primary and booster**	**Primary**	**Primary**	**First dose**	**First and second dose**	
Ashford PCT	1300	95	87	95	96	87	74	95
Canterbury & Coastal	1700	95	89	94	95	88	74	93
Dartford, Gravesham & Swanley	2500	94	86	93	94	84	71	92
East Kent Coastal	2400	95	91	94	96	89	81	94
Maidstone Weald	2900	94	81	94	95	85	70	93
Shepway	1100	94	86	93	94	86	76	93
South West Kent	1900	94	87	94	94	82	72	93
Swale PCT	1000	96	87	95	96	88	77	95
Kent County	**14800**	**95**	**87**	**94**	**95**	**86**	**74**	**94**
South East Coast SHA	**48400**	**93**	**82**	**93**	**93**	**84**	**71**	**92**
England	**638200**	**94**	**80**	**93**	**93**	**87**	**74**	**92**

Source: NHS Immunisation Statistics, England: 2005-07, The Information Centre

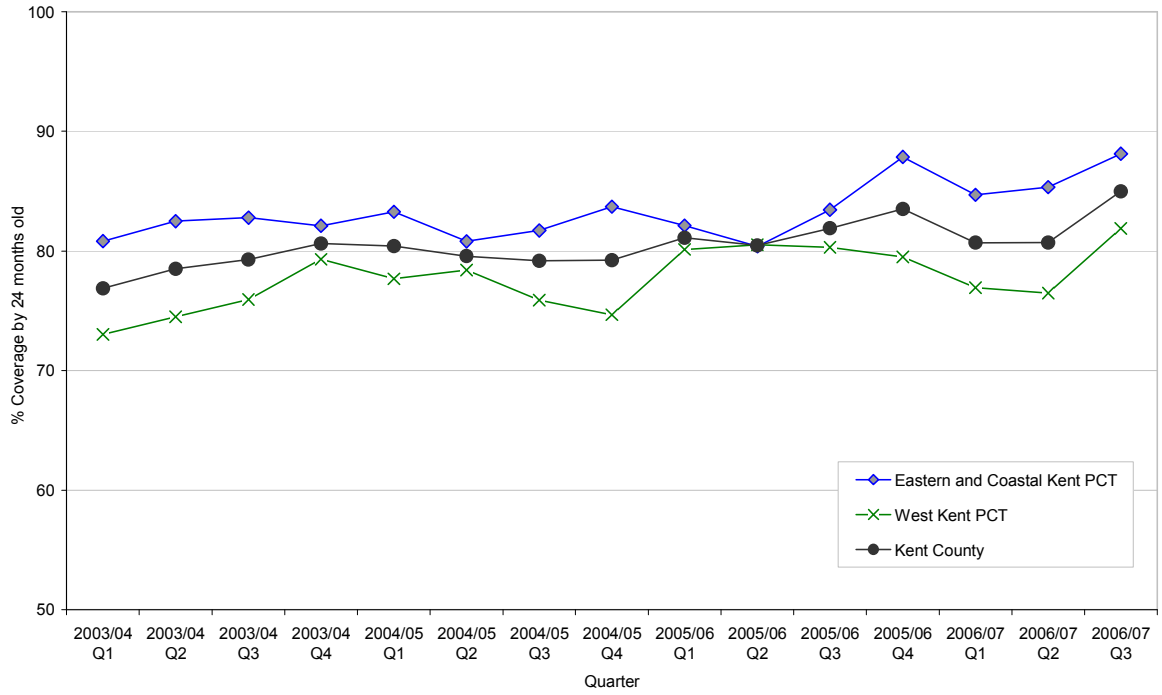
2.37 Measles has made a resurgence in the UK because take-up of the MMR vaccine dropped following a paper published in The Lancet in 1998 asserting a link between the vaccine and autism (which has been disproved by other international studies. Ten co-authors of the 1998 paper issued a retraction in 2004).

2.38 The effect of The Lancet paper has resulted in a large drop in vaccinations. The rate in Kent whilst recovering, is not at the 95% level recorded by the WHO as being necessary to prevent an outbreak. In the first six months of 2006 there were 449 cases of measles in England, the largest number of cases for 20 years. For the same period in 2007 there have been 133 cases.

Table 19 - MMR1 Vaccinations at 24 months

	2003/04 Q1	2003/04 Q2	2003/04 Q3	2003/04 Q4	2004/05 Q1	2004/05 Q2	2004/05 Q3	2004/05 Q4	2005/06 Q1	2005/06 Q2	2005/06 Q3	2005/06 Q4	2006/07 Q1	2006/07 Q2	2006/07 Q3
Eastern and Coastal Kent PCT	80.8	82.5	82.8	82.1	83.3	80.8	81.7	83.7	82.1	80.4	83.4	87.9	84.7	85.3	88.1
West Kent PCT	73.0	74.5	75.9	79.3	77.7	78.4	75.9	74.7	80.1	80.5	80.3	79.5	76.9	76.5	81.9
Kent County	**76.9**	**78.5**	**79.3**	**80.6**	**80.4**	**79.6**	**79.2**	**79.2**	**81.1**	**80.5**	**81.9**	**83.5**	**80.7**	**80.7**	**85.0**

Figure 3 - MMR1 Vaccinations at 24 months



2.39 Rates of up-take of vaccine across Kent are variable as regards measles, mumps and rubella (MMR) vaccine. The take-up in Eastern and Coastal Kent is consistently higher than West Kent.

Hospital Admissions

2.40 Over the years 2003-2006 the rate for children, as described in the age bands below, admitted to hospital is approximately ten per 100 other than for conditions originating at birth. This pattern is broadly replicated in both PCT areas though the rate of admission in West Kent PCT is marginally higher than in Eastern and Coastal Kent PCT. Admission rates are highest in the first year of life, reducing to a more constant pattern of approximately 7% by middle childhood and into adolescence. This pattern is consistent for both Kent PCTs.

Table 20 - Admissions to hospital by 0-14 year olds – Kent county by age – 2003/04 – 2005/06
(excludes admissions for conditions originating at birth)

Year	Rate of admission per 100 population				
	0	1-4	5-9	10-14	Total 0-14
2003/04	25.7	13.8	7.9	7.2	10.2
2004/05	26.8	12.9	7.7	7.0	9.9
2005/06	27.1	13.8	7.5	7.4	10.2
Year	**Number of admissions by age group**				
	0	**1-4**	**5-9**	**10-14**	**Total 0-14**
2003/04	3974	8492	6644	6668	25778
2004/05	4136	7944	6494	6421	24995
2005/06	4186	8489	6294	6778	25747

Population	15,446	61,362	84,224	92,194	253,226

Causes for Hospital Admissions

2.41 The table below sets out the causes for admission to hospital and the percentage of admissions by primary diagnosis. The highest causes of admission are for infectious diseases, respiratory conditions, gastro-intestinal conditions and signs and symptoms. The admissions tend to be highest relative to the ages of children in the first twelve months of life before settling down into a more consistent pattern by mid-childhood and into early adolescence.

Table 21 - Numbers of admissions to hospital by children aged 0 - 14 resident in Kent county by age and primary diagnosis, 2005/06 (excludes admissions for conditions originating at birth, groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality)

Primary Diagnosis	Numbers by Age Band				
	0	1-4	5-9	10-14	Total 0-14
Infectious diseases (all)	466	600	212	132	1410
- Intestinal infectious diseases (A00 - A09)	169	235	58	32	494
Malignant neoplasms (all)	20	391	352	364	1127
Neoplasms of lymphoid tissue (C81 - C96)		120	230	180	530
Benign neoplasms and neoplasms of unknown behaviour	24	59	51	99	233
Haematological conditions	26	118	96	81	321
Endocrine conditions (all)	30	93	146	223	492
Diabetes mellitus (E10 - E14)		38	47	93	179
Mental and behavioural disorders		15	19	208	243
Nervous system disorders	70	162	162	217	611
Eye conditions	24	179	171	98	472
Ear conditions	35	535	550	242	1362
Cardiovascular conditions	31	29	55	76	191
Respiratory conditions (all)	1083	1989	1058	640	4770
Acute lower respiratory tract infections (J20 - J22)	554	244	39	33	870
Acute upper respiratory tract infections (J00 - J06)	436	933	312	156	1837
Asthma (J45 - J46)	12	258	142	93	505
Influenza and pneumonia (J10 - J18)	44	180	64	42	330
Gastrointestinal conditions (all)	504	627	710	879	2720
Diseases of oral cavity (K00 - K14)	6	147	370	389	912
Diseases of appendix (K35 - K38)		6	76	191	273
Hernia (K40 - K46)	81	83	72	37	273
Non-infective enteritis and colitis (K50 - K52)	165	215	60	94	534
Skin conditions	91	156	111	167	525
Diseases of the musculoskeletal system	16	174	152	294	636
Genitourinary conditions	103	282	347	277	1009
Obstetric				5	5
Congenital abnormalities	377	485	280	230	1372
Signs and symptoms	855	1240	602	921	3618
Injury, poisoning and certain other consequences of external causes	197	987	854	1152	3190
Procedures and examinations	182	284	314	415	1195
Unknown (no primary diagnosis recorded)	51	84	52	58	245
All Admissions (non birth-related) Total	**4186**	**8489**	**6294**	**6778**	**25747**

Table 22 - Rates of admissions to hospital by children aged 0 - 14 resident in Kent county by age and primary diagnosis, 2005/06 (excludes admissions for conditions originating at birth, groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality)

Primary Diagnosis	% of Admissions by Primary Diagnosis				
	0	1-4	5-9	10-14	Total 0-14
Infectious diseases (all)	11.1	7.1	3.4	1.9	5.5
- Intestinal infectious diseases (A00 - A09)	4.0	2.8	0.9	0.5	1.9
Malignant neoplasms (all)	0.5	4.6	5.6	5.4	4.4
Neoplasms of lymphoid tissue (C81 - C96)		1.4	3.7	2.7	2.1
Benign neoplasms and neoplasms of unknown behaviour	0.6	0.7	0.8	1.5	0.9
Haematological conditions	0.6	1.4	1.5	1.2	1.2
Endocrine conditions (all)	0.7	1.1	2.3	3.3	1.9
Diabetes mellitus (E10 - E14)		0.4	0.7	1.4	0.7
Mental and behavioural disorders		0.2	0.3	3.1	0.9
Nervous system disorders	1.7	1.9	2.6	3.2	2.4
Eye conditions	0.6	2.1	2.7	1.4	1.8
Ear conditions	0.8	6.3	8.7	3.6	5.3
Cardiovascular conditions	0.7	0.3	0.9	1.1	0.7
Respiratory conditions (all)	25.9	23.4	16.8	9.4	18.5
Acute lower respiratory tract infections (J20 - J22)	13.2	2.9	0.6	0.5	3.4
Acute upper respiratory tract infections (J00 - J06)	10.4	11.0	5.0	2.3	7.1
Asthma (J45 - J46)	0.3	3.0	2.3	1.4	2.0
Influenza and pneumonia (J10 - J18)	1.1	2.1	1.0	0.6	1.3
Gastrointestinal conditions (all)	12.0	7.4	11.3	13.0	10.6
Diseases of oral cavity (K00 - K14)	0.1	1.7	5.9	5.7	3.5
Diseases of appendix (K35 - K38)		0.1	1.2	2.8	1.1
Hernia (K40 - K46)	1.9	1.0	1.1	0.5	1.1
Non-infective enteritis and colitis (K50 - K52)	3.9	2.5	1.0	1.4	2.1
Skin conditions	2.2	1.8	1.8	2.5	2.0
Diseases of the musculoskeletal system	0.4	2.0	2.4	4.3	2.5
Genitourinary conditions	2.5	3.3	5.5	4.1	3.9
Obstetric				0.1	0.0
Congenital abnormalities	9.0	5.7	4.4	3.4	5.3
Signs and symptoms	20.4	14.6	9.6	13.6	14.1
Injury, poisoning and certain other consequences of external causes	4.7	11.6	13.6	17.0	12.4
Procedures and examinations	4.3	3.3	5.0	6.1	4.6
Unknown (no primary diagnosis recorded)	1.2	1.0	0.8	0.9	1.0
All Admissions (non birth-related) Total %	**100**	**100**	**100**	**100**	**100**
Total Number of Admissions (non birth-related)	**4186**	**8489**	**6294**	**6778**	**25747**

Emergency Hospital Admissions

2.42 Over the years 2003-2006 the rate for children, as described in the age bands below, admitted to hospital is approximately six per 100. This pattern is broadly replicated in both PCT areas though the rate of admission in West Kent PCT is marginally higher than in Eastern and Coastal Kent PCT. The rate of admission in Dartford has in some years been significantly higher than across Kent as a whole. The rates in Thanet and Dover have been consistently below the average for Kent.

Table 23 - Emergency admissions to hospital by 0-14 year olds. Kent county residents by age, 2003/04 - 2005/06 (excludes admissions for conditions originating at birth)

Year	Number of emergency admissions by age					% Admissions that are emergencies				
	0	1-4	5-9	10-14	Total 0-14	0	1-4	5-9	10-14	Total 0-14
2003/04	3217	5324	3140	3592	15273	81.0	62.7	47.3	53.9	59.2
2004/05	3262	5012	3165	3546	14985	78.9	63.1	48.7	55.2	60.0
2005/06	3445	5326	2919	3788	15478	82.3	62.7	46.4	55.9	60.1

Causes for Emergency Hospital Admissions

2.43 The two tables below set out the causes of emergency admission to hospital and the percentage of admissions by primary diagnosis. The highest causes of admission tend to be for respiratory conditions, gastro-intestinal conditions and signs and symptoms. The admissions tend to be highest relative to the ages of children in the first twelve months of life before settling down into a more consistent pattern by mid-childhood and into early adolescence. In this regard a higher percentage of admissions is to be noted as regards infectious diseases for children aged 0-4 which thereafter reduces consistently through early childhood and into adolescence.

Table 24 - Numbers of emergency admissions to hospital by children aged 0 - 14 resident in Kent county by age and primary diagnosis, 2005/06 (excludes admissions for conditions originating at birth, groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality)

Primary Diagnosis	Numbers by Age Band				
	0	1-4	5-9	10-14	Total 0-14
Infectious diseases (all)	457	589	198	121	1365
- Intestinal infectious diseases (A00 - A09)	169	234	58	32	493
Malignant neoplasms (all)		65	36	59	163
Neoplasms of lymphoid tissue (C81 - C96)		20	29	38	87
Benign neoplasms and neoplasms of unknown behaviour	13	5			22
Haematological conditions	14	61	57	47	179
Endocrine conditions (all)	14	54	63	106	237
Diabetes mellitus (E10 - E14)		35	45	83	164
Mental and behavioural disorders			14	64	83
Nervous system disorders	40	77	86	118	321
Eye conditions	15	43	22	35	115
Ear conditions	30	81	42	31	184
Cardiovascular conditions	22	20	41	59	142
Respiratory conditions (all)	1028	1537	451	292	3308
Acute lower respiratory tract infections (J20 - J22)	516	238	36	30	820
Acute upper respiratory tract infections (J00 - J06)	434	850	193	98	1575
Asthma (J45 - J46)	11	250	140	91	492
Influenza and pneumonia (J10 - J18)	40	173	60	39	312
Gastrointestinal conditions (all)	403	356	220	344	1323
Diseases of oral cavity (K00 - K14)		34	16		57
Diseases of appendix (K35 - K38)		6	74	188	268
Hernia (K40 - K46)	23		5		30
Non-infective enteritis and colitis (K50 - K52)	162	206	55	63	486
Skin conditions	80	118	66	50	314

Diseases of the musculoskeletal system	12	118	109	146	385
Genitourinary conditions	82	107	112	137	438
Obstetric					0
Congenital abnormalities	132	22	21	23	198
Signs and symptoms	794	1059	487	789	3129
Injury, poisoning and certain other consequences of external causes	186	879	739	1046	2850
Procedures and examinations	74	73	132	281	560
Unknown (no primary diagnosis recorded)	45	58	21	34	158
All Emergency Admissions (non birth-related) Total	**3445**	**5326**	**2919**	**3788**	**15478**

Table 25 - Rates of admissions to hospital by children aged 0 - 14 resident in Kent county by age and primary diagnosis, 2005/06 (excludes admissions for conditions originating at birth, groups of less than 5 admissions by age and diagnosis have been omitted to protect confidentiality)

Primary Diagnosis	% of Emergency Admissions by Primary Diagnosis				
	0	1-4	5-9	10-14	Total 0-14
Infectious diseases (all)	13.3	11.1	6.8	3.2	8.8
- Intestinal infectious diseases (A00 - A09)	4.9	4.4	2.0	0.8	3.2
Malignant neoplasms (all)		1.2	1.2	1.6	1.1
Neoplasms of lymphoid tissue (C81 - C96)		0.4	1.0	1.0	0.6
Benign neoplasms and neoplasms of unknown behaviour	0.4	0.1			0
Haematological conditions	0.4	1.1	2.0	1.2	1.2
Endocrine conditions (all)	0.4	1.0	2.2	2.8	1.5
Diabetes mellitus (E10 - E14)		0.7	1.5	2.2	1.1
Mental and behavioural disorders			0.5	1.7	0.5
Nervous system disorders	1.2	1.4	2.9	3.1	2.1
Eye conditions	0.4	0.8	0.8	0.9	0.7
Ear conditions	0.9	1.5	1.4	0.8	1.2
Cardiovascular conditions	0.6	0.4	1.4	1.6	0.9
Respiratory conditions (all)	29.8	28.9	15.5	7.7	21.4
Acute lower respiratory tract infections (J20 - J22)	15.0	4.5	1.2	0.8	5.3
Acute upper respiratory tract infections (J00 - J06)	12.6	16.0	6.6	2.6	10.2
Asthma (J45 - J46)	0.3	4.7	4.8	2.4	3.2
Influenza and pneumonia (J10 - J18)	1.2	3.2	2.1	1.0	2.0
Gastrointestinal conditions (all)	11.7	6.7	7.5	9.1	8.5
Diseases of oral cavity (K00 - K14)		0.6	0.5		0.4
Diseases of appendix (K35 - K38)		0.1	2.5	5.0	1.7
Hernia (K40 - K46)	0.7		0.2		0
Non-infective enteritis and colitis (K50 - K52)	4.7	3.9	1.9	1.7	3.1
Skin conditions	2.3	2.2	2.3	1.3	2.0
Diseases of the musculoskeletal system	0.3	2.2	3.7	3.9	2.5
Genitourinary conditions	2.4	2.0	3.8	3.6	2.8
Obstetric					0
Congenital abnormalities	3.8	0.4	0.7	0.6	1.3
Signs and symptoms	23.0	19.9	16.7	20.8	20.2
Injury, poisoning and certain other consequences of external causes	5.4	16.5	25.3	27.6	18.4
Procedures and examinations	2.1	1.4	4.5	7.4	3.6
Unknown (no primary diagnosis recorded)	1.3	1.1	0.7	0.9	1.0
All Emergency Admissions (non birth-related) Total	**100**	**100**	**100**	**100**	**100**
Total Number of Emergency Admissions (non birth-related)	**3445**	**5326**	**2919**	**3788**	**15478**

Child Mortality (Non neo-natal 0-19)

2.44 Child mortality is very low in the UK these days. The table below lists the number of deaths by age group for Kent county and each district council area.

Table 26 – Deaths of children and young people aged 0-18 by age group, 2003-2005

Local Authority	0-4	5-9	10-14	15-18
Ashford Local Authority	8	4	1	4
Canterbury Local Authority	7	8	3	11
Dartford Local Authority	7		4	3
Gravesham Local Authority		2	3	6
Maidstone Local Authority	6	2	5	4
Sevenoaks Local Authority	9		2	5
Shepway Local Authority	7		3	2
Swale Local Authority	12	3	1	11
Thanet Local Authority	10	2	5	9
Tonbridge & Malling Local Authority	7	4	1	5
Tunbridge Wells Local Authority	8	1	3	5
Kent County	**88**	**27**	**34**	**76**

Source: ONS Annual District Death Extract

Child Development Programmes

2.45 Whilst the focus of public health is primarily upon populations, it is an important public health precept that every child is given the vital support to develop from birth into childhood through universal child development programmes (see appendix 1).

2.46 Early investments in the development of children can bring improvements in the life of that child, therefore bringing benefits to society. Research accumulated over a number of years indicates that most rapid mental growth occurs during infancy and early childhood and that on the whole the early years are critical in the formation and development of intelligence, personality and social behaviour (Bundy 1996). Scientific research also indicates that given the decisive influence of children's early stimulation on physical, psychological and social development, primary school and kindergarten programmes for children 4-5 years old may be too late to counteract some physical, neurological, psychological and social factors closely associated with early deprivation and lack of adequate stimulation (Bellamy 2005).

2.47 Early childhood here defined as from birth to eight years is a particularly crucial period (Bundy 1996) when physical and nutritional elements have their most profound consequences. During the later years of life, even where remediation is possible, the rate of improvement is reduced because of the relative slowing of subsequent development.

2.48 The importance of attention to the mother and to the wellbeing of the family, including measures to increase the mother's capacity to look after her children, is essential for early child survival and development. Survival, growth, and psychosocial and cognitive development are three inextricably linked developmental processes directed towards the overall wellbeing of the child (UNICEF 1998). These simultaneous processes therefore mutually affect each other. The care that is provided to the child by families, within communities and through services/institutions - affects each of the child outcomes. Survival is intimately connected with growth and development. The better the child's quality of life (good health, growth, development and active social participation), the greater the chances of his/her survival. The bigger and stronger the child, the more likely the child is to survive to enjoy good health and develop well.

2.49 Psychosocial and cognitive development is the beginning of a lifelong process of human development in which people and children learn to handle increasingly complex levels of moving, thinking, feeling and relating to others. Such development involves moving from simple to complex and from dependent to autonomous behaviour. The more advanced the development of a child, the greater the potential of that child to participate actively in life's events and to become empowered to affect others and the world around them. Good mental health is not just the absence of mental health problems. Individuals with good mental health:

- Develop emotionally, creatively, intellectually and spiritually;
- Initiate, develop and sustain mutually satisfying relationships;
- Face problems, resolve them and learn from them;
- Are confident and assertive;
- Are aware of others and empathise with them;
- Use and enjoy solitude;
- Play and have fun;
- Laugh both at themselves and at the world.

(Mental Health Foundation 2002 – as quoted in Blair et al 2003).

2.50 Attention to a child's development in all its dimensions can help increase survival and growth, even as it enhances development and the quality of life (Bellamy 2005).

Families

2.51 Broadly the constitution of families in Kent mirrors the pattern of England as a whole. A higher than average number are in families with married parents and also families where parents are co-habiting.

Table 27 - Type of families Kent children live within, 2001

	% of 0-18 year olds by family type			
Local Authority	**Lone parent family**	**Married couple family**	**Co-habiting couple family**	**Not in a family**
Ashford LA	17.7%	69.0%	12.4%	0.9%
Canterbury LA	23.4%	63.9%	11.5%	1.3%
Dartford LA	19.7%	66.0%	13.5%	0.9%
Dover LA	24.6%	62.2%	12.1%	1.1%
Gravesham LA	19.2%	66.9%	12.8%	1.1%
Maidstone LA	16.8%	72.1%	10.3%	0.8%
Sevenoaks LA	14.7%	75.2%	9.4%	0.7%
Shepway LA	24.0%	61.9%	12.9%	1.2%
Swale LA	20.5%	63.2%	14.9%	1.3%
Thanet LA	28.9%	56.3%	12.8%	2.0%
Tonbridge and Malling LA	15.5%	73.2%	10.7%	0.6%
Tunbridge Wells LA	15.5%	74.2%	9.9%	0.5%
Kent County	**20.1%**	**67.0%**	**11.9%**	**1.0%**
South East Region	**18.4%**	**70.3%**	**10.5%**	**0.8%**
England	**22.8%**	**65.2%**	**10.9%**	**1.1%**

Source: 2001 Census, Standard Theme Table 1, ONS

Lone Parent Households

2.52 According to the 2001 Census, across Kent as a whole 5.8% of households with dependent children are headed by lone parents. This percentage is low relative to some urban areas – for example 34% of households with dependent children in Lewisham were headed by a lone parent.

2.53 The percentage of lone parents who are not working (49.3%) in Kent should be noted. This represents a considerable number of children growing up in poverty for at least some periods of their lives. Poor economic circumstances and relative deprivation are associated with poorer health for children, higher demand for primary care services and social and family support as well as poor nutrition. There are a higher number of lone parent households with dependent children and in particular where the parent is not employed in Eastern and Coastal Kent PCT compared to West Kent PCT. The contrast for example between Thanet where 1 in 16 families are in relative deprivation compared to Tunbridge Wells 1 in 25 families is notable.

Table 28 - Lone Parent Households 2001

Local Authority	Number of Households	Lone Parent Households with Dependent Children		Lone Parent Households with Dependent Children, Parent not Employed	
		Number	% All Households	Number	% All Lone Parent Households
Ashford Local Authority	41449	2119	5.1	966	45.6
Canterbury Local Authority	54567	3250	6.0	1588	48.9
Dartford Local Authority	33126	1967	5.9	960	48.8
Dover Local Authority	42486	2913	6.9	1500	51.5
Gravesham Local Authority	35647	2026	5.7	1091	53.8
Maidstone Local Authority	53625	2696	5.0	1230	45.6
Sevenoaks Local Authority	44356	1952	4.4	806	41.3
Shepway Local Authority	41158	2641	6.4	1341	50.8
Swale Local Authority	49264	3036	6.2	1660	54.7
Thanet Local Authority	55234	4194	7.6	2276	54.3
Tonbridge and Malling Local Authority	42742	2120	5.0	903	42.6
Tunbridge Wells Local Authority	35941	1583	4.4	700	44.2
Kent County Total	**529595**	**30497**	**5.8**	**15021**	**49.3**
South East Region	**3287489**	**171549**	**5.2**	**76754**	**44.7**
England	**20451427**	**1311974**	**6.4**	**662905**	**50.5**

Source: ONS 2001 Census Table CS031

Sole Registered Births

2.54 Both parents are normally registered on a baby's birth certificate. Sole registration of a birth (where only the mother and not the father is registered) is usually considered to be an indication of the social exclusion status of the mother, i.e. that she is single and unsupported. Research undertaken by the London Health Observatory has shown that babies born to women who registered their baby without a partner experience higher infant mortality than those babies born to women who registered their baby with a partner.

2.55 There are no England and Wales comparisons. The registrations for Eastern and Coastal Kent PCT areas are consistently higher than those of areas within West Kent PCT.

Table 29 - Percentage of live births registered by mother only, 2001-2005

Area	2001	2002	2003	2004	2005
Ashford Local Authority	5.8	5.9	5.4	4.5	4.8
Canterbury Local Authority	6.1	6.5	5.3	5.8	5.6
Dartford Local Authority	4.4	4.1	5.8	4.2	4.3
Dover Local Authority	7.6	8.7	7.7	6.4	7.2
Gravesham Local Authority	6.7	6.6	4.6	6.6	6.3
Maidstone Local Authority	5.1	5.9	5.1	5.5	5.0
Sevenoaks Local Authority	3.7	3.4	3.2	3.3	3.2
Shepway Local Authority	8.9	6.6	7.6	8.0	6.4
Swale Local Authority	7.2	6.9	6.6	6.4	8.5
Thanet Local Authority	10.4	9.5	10.5	11.4	10.5
Tonbridge and Malling Local Authority	4.5	2.9	3.5	3.4	3.7
Tunbridge Wells Local Authority	4.3	4.9	3.2	4.2	4.7
Kent County Total	**6.2**	**6.0**	**5.7**	**5.8**	**5.9**

Unemployment and Households

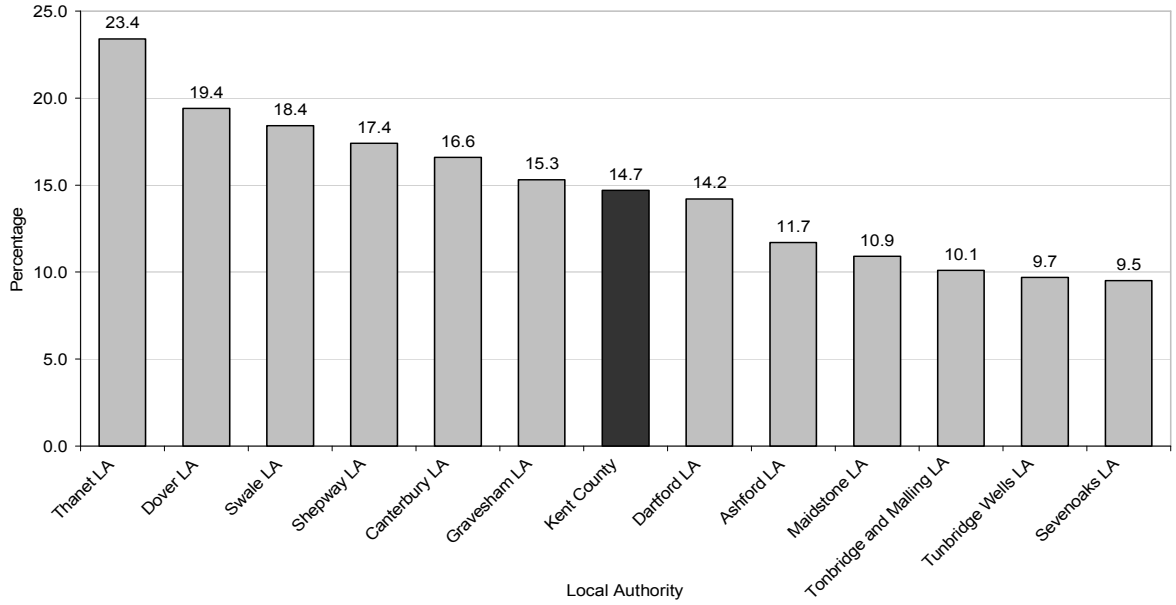
2.56 Typically households where there is no adult in employment are synonymous with the incidence of child poverty. With the exception of Gravesham, the districts with the higher incidence of such households are to be found in the east of the county and predominantly in districts with coastal towns.

Table 30 - Percentage of 0-18 year olds living in households where there is no adult in employment in Kent districts, 2001

Local Authority	% of 0-18 year olds
Ashford Local Authority	11.7
Canterbury Local Authority	16.6
Dartford Local Authority	14.2
Dover Local Authority	19.4
Gravesham Local Authority	15.3
Maidstone Local Authority	10.9
Sevenoaks Local Authority	9.5
Shepway Local Authority	17.4
Swale Local Authority	18.4
Thanet Local Authority	23.4
Tonbridge and Malling Local Authority	10.1
Tunbridge Wells Local Authority	9.7
Kent County	**14.7**
South East Region	**11.8**
England	**17.4**

Source: 2001 Census Standard Theme Table 1, ONS

Figure 4 - Percentage of 0-18 year olds living in households where there is no adult in employment in Kent districts, 2001



Source: 2001 Census Standard Theme Table 1, ONS

Health Visitors

2.57 Among all health professionals, health visitors have a particularly crucial role in delivering child development and parental education. They should have a focus on early intervention, prevention and health promotion for young children and families – in settings where their nursing and public health skills and knowledge can have great impact.

2.58 Future priorities as to practice should be on the prevention of social exclusion in children and families, the reduction of health inequalities, tackling key child public health issues, promoting infant, child and family mental health and supporting the capacity for better parenting. Specifically as regards the latter, this should include improving pregnancy outcomes, child health and development, parents' economic self-sufficiency, safeguarding children, addressing domestic violence, supporting parental relationships and fathers in their parenting role.

2.59 The core elements of health visiting practice should therefore comprise public health and nursing for the whole family, focusing on early interventions and prevention. They should have a detailed knowledge of the communities they work in and be seen to be 'local'. Accordingly they should be organised on a patch basis and not be practice attached. This requires practice to be focused upon the pro-active promotion of health and wellbeing through progressive universalism, the prevention of ill health, through home visiting where appropriate. An obligation towards the safeguarding of children requires a capacity to deliver intensive programmes for the most vulnerable children and families; managing risk/decision making in conditions of uncertainty, seeking to build therapeutic relationships to address difficult issues in families with complex needs.

2.60 It is critical that health visitor practice works across sectors, putting health into multi-agency and multi-sector working. Where necessary qualified health visitors will

supervise teams of less qualified assistants who give practical support to children and families.

Targeted Approaches to Child Development and Parental Education/All Professions, Agencies and Sectors

2.61 There is evidence that targeted approaches are increasingly recognising the importance of the social context and its influence on child development and parental support. Thus whilst in some instances the immediate beneficiaries are parents and children, the focus is on enhancing professional/support skills so that families as a whole can benefit. Many programmes include a central role for volunteers (mostly volunteer mothers) and draw on parents in various guises (from befrienders, home visitors, trained co-ordinators, project workers) to provide information, support, play and early learning and also deliver community health and social care. Throughout the reviews undertaken of such interventions, there is an emphasis on the family as a whole and parental wellbeing, rather than just a child's behaviour; the development of the role of "interested friends" rather than experts; enhanced training for practitioners in new roles; and the identification of a positive correlation between sustained involvement and functional improvement.

2.62 Home visiting has been identified as an important intervention from an inter-generational perspective, capable of producing improvements in parenting, child behavioural problems, cognitive development in high risk groups, a reduction in accidental injuries to children and improved detection and management of post-natal depression (Bull et al 2004). Its potential is further reinforced by evidence from a number of health based programmes aimed at improving ante-natal and post-natal health and child rearing strategies that have also proved capable of empowering families (Butz et al 2001: El Mohandes et al 2003).

2.63 A wide ranging evaluation of the Home Start programme extending across three years found volunteer support in the home could usefully extend and complement statutory provision, assisting with parenting difficulties, health problems, isolation and the problems of coping under stress (Frost et al 1996). However there is also a significant problem of non-use, which means that many families may fall through the statutory/voluntary gap (Oakley et al 1998). Not all evaluations are positive (see for example Goodson et al 2000: Gray et al 2001).

2.64 Post natal depression is higher in situations where mothers are subject to chronic stress factors, poverty, housing difficulties, inadequate social support.

2.65 The potential for parenting education means that it is subject to a number of policy drivers. Support for parents is recognised as a key element of public health policy. It has been recognised as one of the four key strands of government's policy to tackle child poverty (HM Treasury 2001) and is one of the four main precepts of Every Child Matters where the aim is to reform service delivery for children and protect children at risk. Other imperatives include mental health, anti-social behaviour and social exclusion, particularly in high risk areas. One of the main delivery mechanisms is Sure Start.

Table 31 - Interventions during early life: summary of the evidence base – Parenting Education and Support

Parenting Education and Support	Source
Group based behavioural interventions can improve the emotional and behavioural adjustment of children under the age of three	Cochrane Review
Parenting programmes can improve behavioural problems in children aged 3-10	Systematic review
Parenting programmes can make a significant contribution to the short-term psychosocial health of mothers	Cochrane Review
Home visiting can produce improvements in parenting, child behavioural problems, cognitive development in high-risk groups, a reduction in accidental injuries to children and improved detection and management of post-natal depression	Review of reviews
The involvement of both parents and direct work with the child increases efficacy	Overview
Lack of review-level evidence	
Role of parenting programmes in primary prevention as opposed to treatment	
Long-term effectiveness on both maternal mental health and children's adjustment	
Efficacy of relational interventions	
Ability to isolate the effective components	

Table 32 - Interventions during early life: summary of the evidence base – Early Years Education and Childcare

Early Years Education and Childcare	Source
Day care has a beneficial effect on children's development and school achievement	Cochrane Review
Limited long-term follow-up suggests increased employment, lower teenage pregnancy rates, higher socio-economic status and decreased criminal behaviour	Cochrane Review
There are positive effects on mothers' education, employment and interaction with children	Cochrane Review
Lack of review-level evidence	
Absence of UK-based studies	
Disaggregated studies allowing the effects of non-parental day care to be isolated from parental training and education	

Sure Start Programmes

2.66 Sure Start was established as an area based initiative targeting a particular sub-group of the population, children aged 0-4 and their families; it operated initially in the 500 most disadvantaged wards in England. Described as "a cornerstone of the Government's drive to tackle child poverty and social exclusion" (Tunstill et al 2002), it is significant that child health is explicitly included and the intervention is pervasive, embracing a wide spectrum of services for the early years. In addition to health, Sure

Start was aimed to influence children's ability to learn and their social and emotional development, as well as strengthening families and communities. It thus acknowledges the evidence base concerning health inequalities and specifically the life course model.

2.67 The geographical area of intervention is typically tightly defined, comprising neighbourhoods of between 400 and 800 children. By 2004 over 500 programmes were in operation across England. There is a strong emphasis on partnership working, community involvement and each local programme is managed by a partnership board drawn from the mainstream agencies providing services to children and families, voluntary and community organisations and most notably parents.

2.68 The initial rationale for Sure Start was primarily economic and the programme was led by Treasury, funds were distributed through the Department for Education and Skills (DfES) now Department for Children, Schools and Families (DCSF) and the most significant professional input at operational level was through health professionals. Based on the 'Early Head Start' programme which operated in New England in the 1990s the basic premise of the programme was that money spent on children in deprived areas in their first few years of life would lead to a significant return in later life. So the large-scale objectives of the programme related to children in Sure Start areas attaining much higher levels at Stage 1 and 2 SATS; the rationale was that Sure Start would deliver children into the educational system who were ready, able, fit and motivated to learn. They would then be much less of a drain on education, welfare and health service budgets.

2.69 The programme operates in the most deprived 20% of wards in England. Scotland, Wales and Northern Ireland have their own Sure Start programmes. The prime focus is on four core services: support for families and parents; support for good quality early learning, play and healthcare; health services and advice; outreach and home visiting; and support for children and parents with special needs including help in getting access to specialised services (Stewart 2005). The programme aimed to be non-stigmatising with all families in the selected communities eligible, notwithstanding that there is a clear focus upon deprived areas, with low incomes, child poverty and unemployment in Sure Start areas being more than double the national average (Barnes et al 2003). Additional focus commits local programmes to improving the social and emotional development of children, reducing the proportion of parents who smoke during pregnancy, increasing breast-feeding rates, improving children's language and communication skills and enhancing the employability of parents. In order to meet such a diverse set of objectives it was axiomatic that the programme would lead to significant reconfiguration of services with significant levels of joint and multi-disciplinary working.

2.70 524 local programmes in England were set up in the first phase of the programme. Up to 400,000 children were covered including a third of under fours living in poverty (Meadows and Garber 2004). Roughly £1,000 per child was committed over the programme's lifetime (Stewart 2005). This compares with some 2.9 million children below compulsory school age. For the target children an assessment by the DfES suggested considerable progress had been made in terms of parenting and family support, re-registration on the Child Protection Register and the provision of play and learning opportunities. Child health goals were however proving more elusive (DfES 2003).

2.71 The National Evaluation of Sure Start (NESS) similarly finds support for the recognition given by Sure Start to the inter-connected nature and extent of health and social problems, the provision of a long-term funding strategy, the establishment of

new relationships between professionals, parents and other members of the community, the continued focus on issues from the perspective of families and flexibility in which services are delivered (Myers et al 2004). Some tensions between nationally prescribed targets and locally identified needs have been identified.

2.72 Sure Start Centres are now Sure Start Children's Centres and are part of the network of 3,500 Children's Centres which the government has announced will provide services for every pre-school child in England by March 2010 when every community will have a Children's Centre. Commentators have suggested that the ethos that was central to the initiative is now at risk arguing that the Sure Start programme was facilitated through bottom up community development initiatives. Second and subsequent wave Children's Centres will be centrally planned by Children and Families Services (in Kent through Kent County Council and the Kent Children's Trust). Others argue that the Sure Start Programme emphasises Early Years Development and that subsequent waves of children's centres may give greater priority to early years education.

2.73 It is important to note that the capital funding available to build the second round of Children's Centres is very significantly less than was available to the original Sure Start Local programmes (some Round 2 Children's Centres in Kent will have construction budgets less than 10% of the cost of some of the earlier centres.) New Children's Centres will – in every case - be very much smaller than the first wave. However as before the targeting of such centres has been based on rational socio-economic criteria applied to electoral wards so that such centres will be targeted in areas (with one specific local exception) where on average, there are greater levels of relative deprivation.

Table 33 – Proposed Children's Centres in Kent

District	Number of Centres
Ashford	5
Canterbury	7
Dartford	7
Dover	7
Gravesham	5
Maidstone	5
Sevenoaks	2
Shepway	7
Swale	10
Thanet	9
Tonbridge and Malling	4
Tunbridge Wells	3

Impact of Sure Start programmes upon Emergency Admissions to Hospital

2.74 There is some evidence that Sure Start programmes have had a favourable impact in containing emergency admissions to hospitals when taking into account the established culture of families living in relative deprivation, traditionally having less confidence or resources when children's illnesses present. The work of health professionals working in Sure Start programmes demonstrates an impact both on prevention and also an improved confidence amongst families facing child illness incidents.

Table 34 – Emergency rates of admission of children to hospital from wards comprising Sure Start areas in Kent

	Rate of Admission per 100 population		
	2003/04	2004/05	2005/06
Northgate Ward, Canterbury	11.6	9.2	6.5
Canterbury average rate	**7.4**	**5.6**	**6.4**
Littlebrook, Dartford	15.7	19.5	7.3
Dartford average rate	**7.5**	**8.2**	**6.6**
Buckland, Dover	6.4	5.2	5.5
St Radigunds, Dover	5.3	4.2	5.7
Dover average	**4.7**	**4.3**	**4.7**
Stanhope, Ashford	8.1	8.6	8.7
Ashford average	**5.7**	**5.8**	**6.3**
Sheerness East	6.4	5.7	7.6
Sheerness West	7.9	5.2	5.8
Swale average	**6.3**	**6.1**	**6.6**
Folkestone Central	9.4	8.0	11.4
Folkestone Harbour	5.5	6.9	7.6
Folkestone Foord	4.9	4.5	7.6
Folkestone East	6.3	6.5	6.9
Shepway average	**5.5**	**5.0**	**6.1**
Northfleet North	8.8	8.8	7.0
Northfleet Riverside	6.8	7.5	7.1
Gravesham average	**6.5**	**6.7**	**5.8**

2.75 The potential range of confounders does not make it possible to completely demonstrate the causality of such programmes managing down demand.

Monitoring and Evaluation of Sure Start Children's Centres

2.76 Further to the above statement, the national Sure Start programme has now been expanded significantly, funds are no longer passed direct to the programmes but go through Local Authorities and all Children's Centres are now referred to as Sure Start Children's Centres. The funding which has been made available by government is just to deliver 'the core offer'[1] and there is effectively no provision for the direct delivery of any services. The responsibility for facilitating this has transferred from central government to local government and specifically in the local context to Kent County Council.

2.77 The National Evaluation (NESS) was based on a set of programme measures. The assumption of the policy management of local Sure Start programmes has caused some vacuum in policy, specifically what data should local Sure Start programmes be routinely collecting. For the county of Kent for 2006/07 there has been no standard set of quantifiable measures to monitor the work and thereby assess the combined effectiveness of local Sure Start programmes in the county. Each programme has extensive data on the local impact of its operations but there is little – if any – correlated data on the effectiveness across the county.

[1] * Core offer:
Early education integrated with child care
Family support and outreach to parents
Child and family health services
Links with schools and Children's Information Service (CIS)
Links with JobCentre Plus

2.78 All programmes in Kent have routinely conducted quantifiable evaluations. These range from specifically commissioned research, through local surveys to advice on forward business planning, or retrospectively as part of annual reports.

2.79 The qualitative evaluation of Sure Start Millmead by Canterbury Christ Church University (West and Carlson 2007) provides a succinct framework to summarise much of the impact of Sure Start both on children and local communities. They describe a local Sure Start programme as "claiming space". By this they include:

- Contested space – recognising many agendas at work through a Sure Start programme including the aspirations of diverse professionals, of government policy and of parental engagement in the design of delivery programmes;

- Sustaining space – the need to emphasise the importance of the relationships in which people are embedded in any change processes "people suffering depression or other forms of distress require significant others with sufficient empathy, resilience, self-understanding and knowledge to mobilise resources, including themselves, in non-threatening ways. Sure Start enabled this to happen as learning opportunities combined with counselling, sustained individual attention with collective support" (West and Carlson op cit p76);

- Transitional space: identity and risk taking - this includes supporting parents to trust more and take risks, overcoming fears of dependency with the risks of abandonment; more fundamentally it refers to a new culture amongst professionals which will encourage innovation, partnership working and engagement of parents and families in determining the nature and coverage of services;

- Transitional space of play – encouraging the capacity for play and playfulness, the letting go of conscious ego functions paralysing self-preoccupations and the development of creativity;

- Transactional space – the detailed attention necessary to facilitate and sustain parental involvement: encouraging and supporting parents in the governance and development of the programme – treating people respectfully as active citizens rather than passive consumers;

- Gendered space – the complexity and difficulty in engaging fathers in the programme notwithstanding that Sure Start can be seen as a highly gendered space in which caring in general and 'parenting' in particular, are predominantly viewed as "women's work";

- Claiming space – the struggle with the hardest to reach in the context of a programme required to expand from a focused population to a larger community and a shifting local population.

2.80 In respect of all of the above there is an underlying commitment to address long term improvement and a national imperative to deliver speedy results. Many reports from other programmes in Kent cover similar ground albeit in a less systematic (and social psychologically) based framework. Sure Start Sheerness, Sure Start Ashford and Sure Start Gravesham stress narrative to demonstrate the benefits of the programme typically through featuring case studies viewing the operations from the perspective of children and families. The Consortium of Sure Start Centres in Dover has undertaken extensive community surveys looking at the engagement of the programme with local

communities, assessing what works, what has been a success and how, grounded in user perspectives, can the programme and the overall approaches by all services be improved. A similar approach has been adopted by Sure Start Folkestone, incorporating annual programmes of evaluation into future business planning. Latterly this has been further enhanced through the Shepway Local Children's Trust Pathfinder Development plan. A similar integrated approach between evaluation and business planning is demonstrated in the Gravesham programme. Because of disruption to the management of the local programme, Sure Start Canterbury is less able to offer formalised documented evaluation reports at the present time.

2.81 A very recent national study undertaken for the government by the University of Durham, exploring the progress of almost 35,000 children has shown that there is no change in the developmental levels of pupils entering primary school, notwithstanding the introduction of several early new years initiatives over the past decade. The authors of the research, who are strongly in favour of early years initiatives, highlight the key indication – that such initiatives should be rigorously monitored "initiatives should be based on high quality evidence and be introduced in ways that allow for continuous scientific monitoring and adjustment in the light of evidence … this approach takes time ... it is not a method that offers quick fixes, but requires long term vision … [and] should play a pivotal role in making effective decisions which the government itself believes to be crucial to a child's development and their future prospects in life" (Merrell 2007).

2.82 A recent announcement from central government confirms revenue funding allocations for Sure Start local programmes and also Children's Centres until 2011. Sure Start local programmes have been identified separately from that of other children's centres and at a higher level. The effect of this is to broadly assure the continuation of local programmes over the next three years.

2.83 In the meantime, more consistent, rigorous, quantifiable evaluation measures are necessary across Kent so that the qualitative data alluded to earlier can be augmented by a framework of quantified measures. Accordingly a standard framework of such measures needs to be established under the Kent Children's Trust across the county, as a matter of some urgency.

Children's Centres and Healthy Starts

2.84 Regardless of whichever wave of Children's Centre developments, the role of Children's Centres should be to give young children a healthy start in life and offer support to parents. Specifically, building upon the experience of Sure Start programmes this means:

- Children's Centres need to be staffed on a multi-disciplinary and multi-agency basis, preferably also working with third sector organisations to provide a seamless delivery of services both in the Centres and from Centres into the community, including home visiting;
- Providing a range of integrated services to maximise children's development outcomes and reduce inequalities in health. Examples of this should include parenting and family support, the promotion of breast feeding, the identification of risk and appropriate interaction to reduce or avoid obesity, stop smoking services, the reduction of accidents. Particular focus must be given to the most disadvantaged families;

- The early identification of developmental problems that will benefit from early help, e.g. speech and language therapy, weight management;
- Rolling out Early Support Programmes for disabled children and improving access to childcare for parents with disabled children.

3. Health Inequalities during Childhood and Youth – Overview

Much less attention has been paid to the relationship between poverty and health during childhood and youth than in infancy. This is unfortunate as it is a critical period of the life course at which to target interventions. Sadly the lack of epidemiological research has been accompanied by a lack of service evaluation.

It is however possible to identify key issues and sources of vulnerability. Accidents/injuries and mental health emerge as key issues that are associated with poverty during childhood and youth. Injury is not only the most important cause of child death in the UK, it also has a steeper social class gradient than any other cause of death for this group. A relationship has also been identified between social deprivation and non-fatal injuries on the road and within the home. By contrast, risk of non-related traffic injury taking place outside the home may decrease with lower socio-economic status.

Increases in the rate of psychological disorders among young people and growing concern as to the impact of mental health problems on poor educational attainment, limited employment prospects, insecure relationships, early parenting, involvement in crime and adult psychiatric disorders has drawn the spotlight onto mental health problems in childhood and youth. However regretfully there has been a pre-occupation with symptoms rather than causes, with crime, delinquency and drug use rather than mental health per se. This is unfortunate as evidence suggests that young people suffering from mental health problems are amongst the most vulnerable in society. The prevalence of the most common disorders in childhood and adolescence are strongly associated to social disadvantage, children who have experienced significant adversity in early life being at particularly increased risk.
A range of individual family and environmental influences have been implicated in risk for mental illness, strongly demanding the need for a multi-faceted approach. Several areas of intervention are possible to address different loci of vulnerability: individually focused therapy and treatment; family therapy; parenting programmes; school based interventions and community based programmes.

Abbreviated from Asthana and Halliday 2006

Childhood Morbidity in Primary Care

3.1 Most childhood morbidity is treated by primary care including out-of-hours services, or at home. Primary care data is not readily accessible. Some data are available from national surveys. Hospital admissions and A&E attendance data can provide information about the levels of morbidity in children but they only account for a small proportion of illness that occurs in childhood and therefore should not be used as proxy measures for morbidity in general.

Limiting Long-Term Illness

3.2 Data from the 2001 Census show that within Kent County overall, 4.2% of all children have limiting long-term illness. It should be noted that limiting long-term illness is self-declared and thus not easily verifiable from other sources. The rate for Eastern and Coastal Kent at approaching 5% is significantly higher than in West Kent (3.6%).

3.3 Rates of limiting long-term illness vary by housing tenant, children living in socially rented accommodation being nearly twice as likely to have limiting long-term illnesses as those in owner-occupied housing. Children of families in private rented accommodation comprise a higher percentage than those residents in owner-

occupation. This latter pattern is consistent in both PCTs (see also page 67 Housing post).

Table 35 - Children with limiting long-term illness (LLTI), 2001. Number and percentage of all children, percentage by tenure type

Area	Number of Resident Children with LLTI	Percentage of All Resident Children with LLTI	Percentage of Children with LLTI by Housing Tenure		
			Owned	Social Rented	Private Rented
Ashford Local Authority	809	3.7	3.1	6.1	3.8
Canterbury Local Authority	1142	4.7	3.5	8.4	5.2
Dartford Local Authority	718	3.9	3.1	6.4	4.5
Dover Local Authority	1013	4.9	3.8	8.3	5.1
Gravesham Local Authority	740	3.6	3.0	5.0	4.8
Maidstone Local Authority	1054	3.9	3.2	6.9	4.1
Sevenoaks Local Authority	706	3.2	2.7	5.7	2.8
Shepway Local Authority	919	4.9	3.8	8.3	5.5
Swale Local Authority	1340	5.1	3.7	8.7	6.1
Thanet Local Authority	1360	5.4	4.4	8.0	6.0
Tonbridge and Malling Local Authority	823	3.6	2.9	6.1	3.2
Tunbridge Wells Local Authority	708	3.4	2.8	5.3	3.8
Kent County	**11332**	**4.2**	**3.3**	**7.0**	**4.9**
South East Region	**61093**	**3.9**	**3.1**	**6.6**	**4.2**
England	**418828**	**4.2**	**3.3**	**6.6**	**4.8**

Source: ONS 2001 Census Table CS017

Accidents

3.4 Injury is not only the most important cause of child death in the UK, but also has a steeper social class gradient than any other cause of death for this cohort. A child from the lowest social class is nine times more likely to die in a house fire than a child from a well off home (Roberts 2002). Safety inside the home is of paramount importance in early life with a large proportion of these injuries being potentially preventable. The wider horizons of older children however place the environment, play and being safe from traffic close to the top of their agendas (Roberts ibid). The road environment is a key locus of risk in different guises across the age spectrum, accounting for two fifths of deaths among young people aged 15-24 in the category injuries.

3.5 Much of the literature focuses upon accident prevention for the early years. Nearly half (48%) of the health promotion interventions included in Towner et al's (2001) systematic review were aimed at those aged four and under. Only under a third included interventions aimed at the 10-14 year age group and most of these were focused on the pre-teenage years.

3.6 There is evidence that single issue campaigns can be effective particularly those focusing on safety equipment such as smoke detectors. It is also notable that multi-modal interventions (i.e. legislation, education, safety equipment, environmental modification) are most likely to yield positive results. The latter approach demands a change in the culture of communities.

3.7 Road accidents involving children are more scattered than those involving adults with an obvious relationship to the roads near home. There is good evidence that area-

wide engineering schemes and traffic calming measures reduce accidents to this age group, decreasing traffic injuries on average by between 11% and 15% (Bunn et al 2003). Such schemes also have the potential to increase cycling and walking at neighbourhood level, together with the potential for children to play outdoors with concomitant benefits to both health and environment (Morrison et al 2004).

3.8 For cyclists there is some evidence that cycle training can improve safe riding behaviour and good evidence that cycle helmets offer protection from head and brain injuries, particularly at local speeds. Education campaigns may also be important (Towner and Ward 1998). The leisure environment, like roads, is similarly in the public domain and hence a legitimate target for legislation and prevention.

3.9 The home is less amenable to regulation. Fires are the second most important cause of injury to children under 15, with smokers' houses posing a particular risk. One contributory factor is likely to be the significance of deprivation.

3.10 Educational programmes alone appear to have little effect irrespective of the form they take (skills training, mass media exposure, targeted education courses).

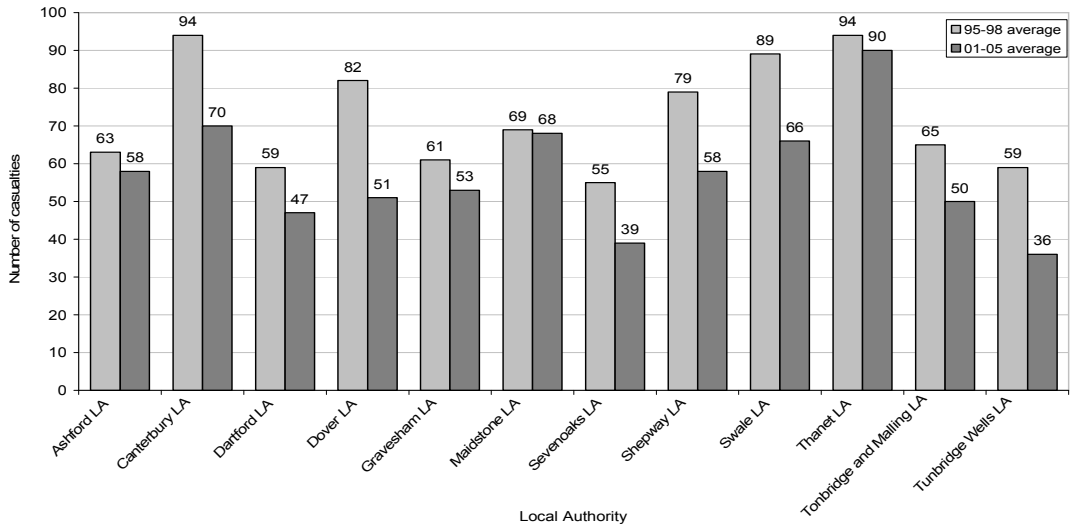
3.11 Over the ten year period described in the table below, there has been a welcome reduction in child road casualties in districts throughout the county. Thanet remains the area with the highest number and a marginal reduction only can be noted for Maidstone district.

Table 36 - Child road casualties in Kent districts, 1994-98 and 2001-05 annual averages (numbers)

Local Authority	95-98 average	01-05 average
Ashford LA	63	58
Canterbury LA	94	70
Dartford LA	59	47
Dover LA	82	51
Gravesham LA	61	53
Maidstone LA	69	68
Sevenoaks LA	55	39
Shepway LA	79	58
Swale LA	89	66
Thanet LA	94	90
Tonbridge and Malling LA	65	50
Tunbridge Wells LA	59	36
Kent County	**869**	**686**

Source: Trend Update 2005 Final Report September 2006, Road Safety Unit, KCC

Figure 5 - Child road casualties in Kent districts, 1994-98 and 2001-05 annual averages



Source: Trend Update 2005 Final Report September 2006, Road Safety Unit, KCC

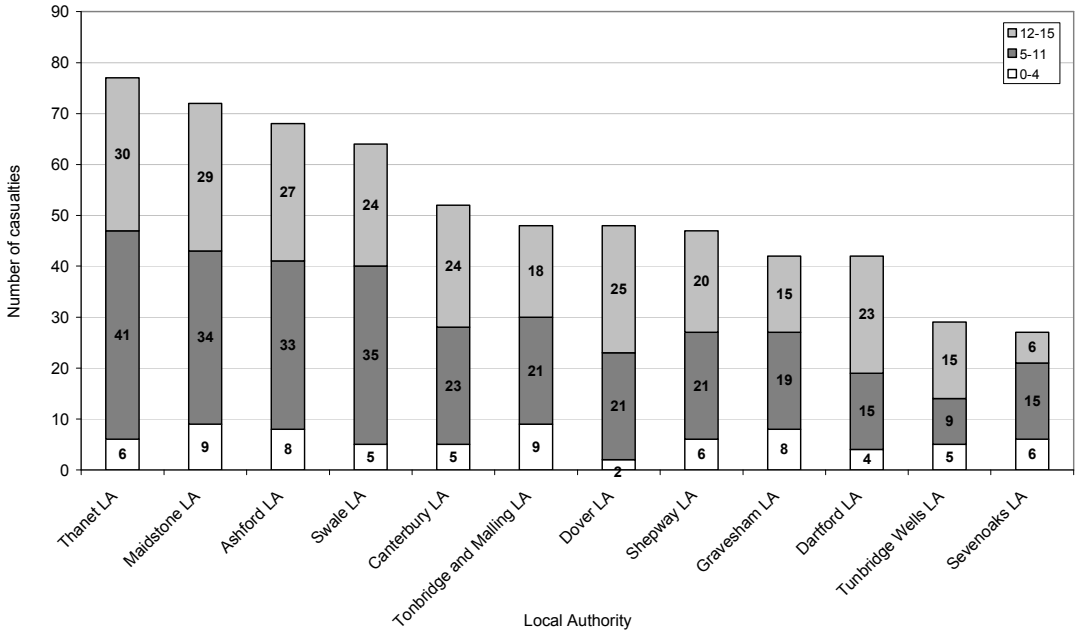
3.12 Thanet and Maidstone have higher numbers of road casualties.

Table 37 - Child road casualties by age in Kent districts, 2005 (numbers)

	Age group			
Local Authority	**0-4**	**5-11**	**12-15**	**0-15**
Ashford LA	8	33	27	68
Canterbury LA	5	23	24	52
Dartford LA	4	15	23	42
Dover LA	2	21	25	48
Gravesham LA	8	19	15	42
Maidstone LA	9	34	29	72
Sevenoaks LA	6	15	6	27
Shepway LA	6	21	20	47
Swale LA	5	35	24	64
Thanet LA	6	41	30	77
Tonbridge and Malling LA	9	21	18	48
Tunbridge Wells LA	5	9	15	29
Kent County	**73**	**287**	**256**	**616**

Source: Trend Update 2005 Final Report September 2006, Road Safety Unit, KCC

Figure 6 - Child road casualties by age in Kent districts, 2005 (numbers)



Source: Trend Update 2005 Final Report September 2006, Road Safety Unit, KCC

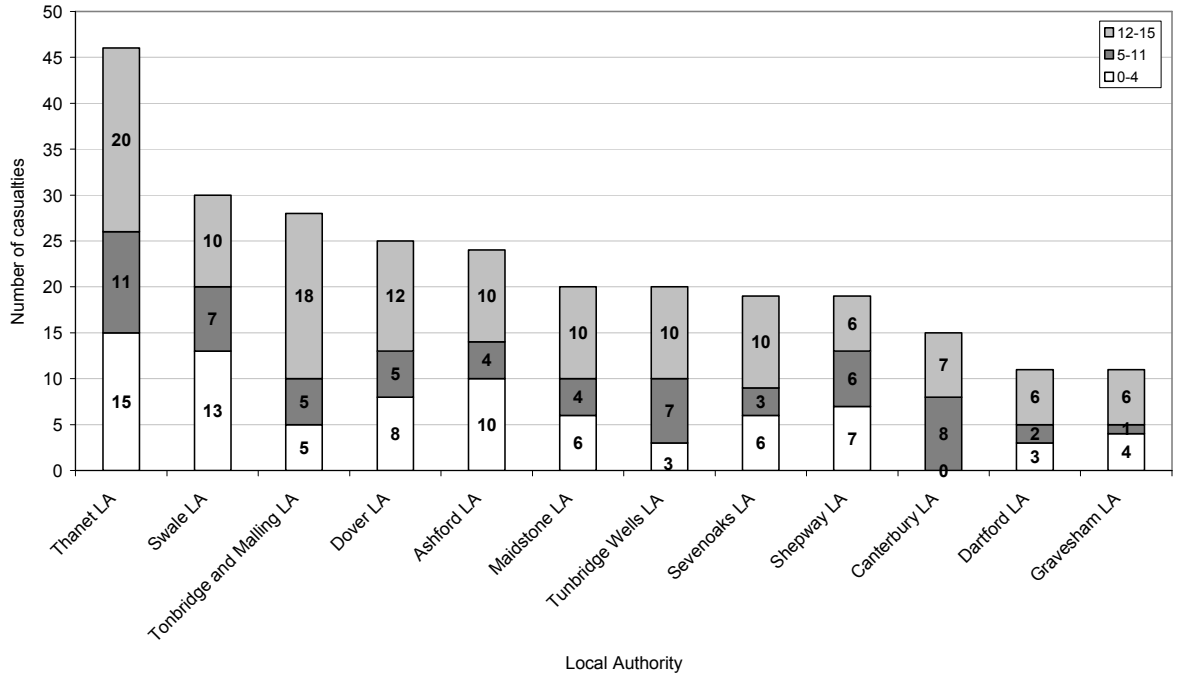
3.13 There are higher numbers of pedal cycle casualties in Thanet than the overall Kent pattern.

Table 38 - Child pedal cycle casualties by age in Kent districts, 2005 (numbers)

	Age group			
Local Authority	**0-4**	**5-11**	**12-15**	**0-15**
Ashford LA	10	4	10	24
Canterbury LA	0	8	7	15
Dartford LA	3	2	6	11
Dover LA	8	5	12	25
Gravesham LA	4	1	6	11
Maidstone LA	6	4	10	20
Sevenoaks LA	6	3	10	19
Shepway LA	7	6	6	19
Swale LA	13	7	10	30
Thanet LA	15	11	20	46
Tonbridge and Malling LA	5	5	18	28
Tunbridge Wells LA	3	7	10	20
Kent County	**80**	**63**	**125**	**268**

Source: Trend Update 2005 Final Report September 2006, Road Safety Unit, KCC

Figure 7 - Child pedal cycle casualties by age in Kent districts, 2005 (numbers)



Source: Trend Update 200 Final Report

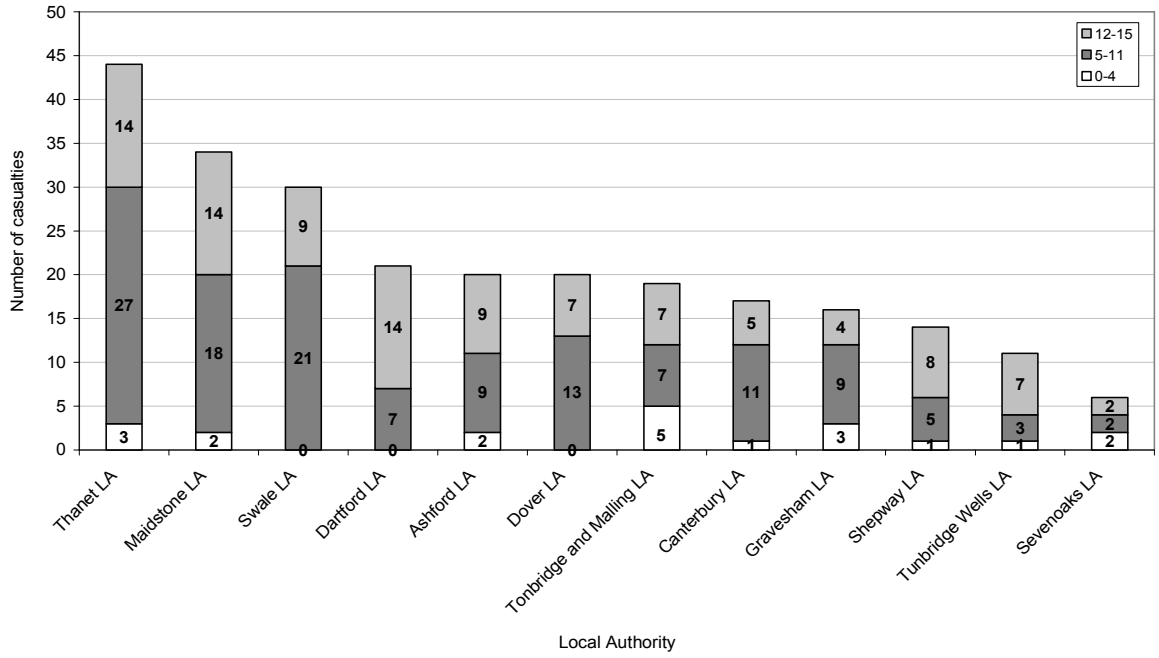
3.14 Child pedestrian casualties in Thanet, Swale and Maidstone are higher than the overall Kent pattern. Such casualties are often synonymous with deprivation factors which certainly accords with the Thanet and Swale districts.

Table 39 - Child pedestrian casualties by age in Kent districts, 2005 (numbers)

	Age group			
Local Authority	**0-4**	**5-11**	**12-15**	**0-15**
Ashford LA	2	9	9	20
Canterbury LA	1	11	5	17
Dartford LA	0	7	14	21
Dover LA	0	13	7	20
Gravesham LA	3	9	4	16
Maidstone LA	2	18	14	34
Sevenoaks LA	2	2	2	6
Shepway LA	1	5	8	14
Swale LA	0	21	9	30
Thanet LA	3	27	14	44
Tonbridge and Malling LA	5	7	7	19
Tunbridge Wells LA	1	3	7	11
Kent County	**20**	**132**	**100**	**252**

Source: Trend Update 2005 Final Report September 2006, Road Safety Unit, KCC

Figure 8 - Child pedestrian casualties by age in Kent districts, 2005 (numbers)



Source: Trend Update 2005 Final Report

Table 40 - Interventions during early life: summary of the evidence base - Accidents

Accidents	Source
Roads	
There is good evidence that:	
Area-wide engineering schemes and traffic calming measures decrease traffic injuries	Systematic review
Child restraint loan schemes and legislation produce behavioural change	Systematic review
Cycle helmets offer protection from head and brain injuries, particularly at lower speeds	Overview
Educational campaigns and legislation can increase their use	Systematic review
There is reasonable evidence that cycle training can improve safe riding behaviour	Systematic review
Leisure	
There is some evidence that:	
Improvements to playground design can reduce both the frequency and severity of injuries	Overview
Environmental engineering changes to the sports environment and prophylactic injury prevention programmes reduce injuries to adolescents	Overview
Legislation is effective for 15-24 year olds whether in sports, road or workplace settings	Overview
Home	
There is good evidence that smoke detectors and child-resistant containers reduce injury particularly if high-risk households are targeted	Systematic review/Overview
Less evidence attaches to window bars and the design of domestic	Systematic review

products	
Home visiting can substantially reduce rates of accidental injury	Overview
The role of education only reaches reasonable levels with respect to child/parent education to reduce pedestrian injuries and the use of car restraints	Overview
Multimodal interventions are the most likely to yield positive results	Systematic review
Lack of review-level evidence	
Leisure environment	
Older children	

Children and Young People Receiving Care

Looked After Children

3.15 While education plays a key role in the transmission of advantage and disadvantage across generations, one of the most powerful predictors of social exclusion in adult life is the experience of being in care. There is a well established link between deprivation and children coming into care such as unemployment, low income, inadequate accommodation and lone parent status; factors in other words that threaten the stability of family life.

3.16 The poor educational participation and performance of looked after children (LAC) has become a national concern not least because educational disadvantage leads to disadvantage in other areas. Frequent movement within the care system, school exclusion and non-attendance have been linked to educational under achievement. Some estimates suggest that children in care are ten times more likely to be excluded than those outside the care system (Brodie 2000: Goddard 2000). Only 9% of children obtained at least five GCSEs with grades A-C compared to 53% of all children (DfES 2004).

3.17 There is a high incidence of mental health problems and psychiatric disorders among looked after children. The poor mental health of children living in residential homes in part reflects selection. Children with severe behavioural difficulties are often considered unsuitable for placement in foster homes, are more likely to experience breakdowns in their placements and thus more likely to be looked after in residential homes.

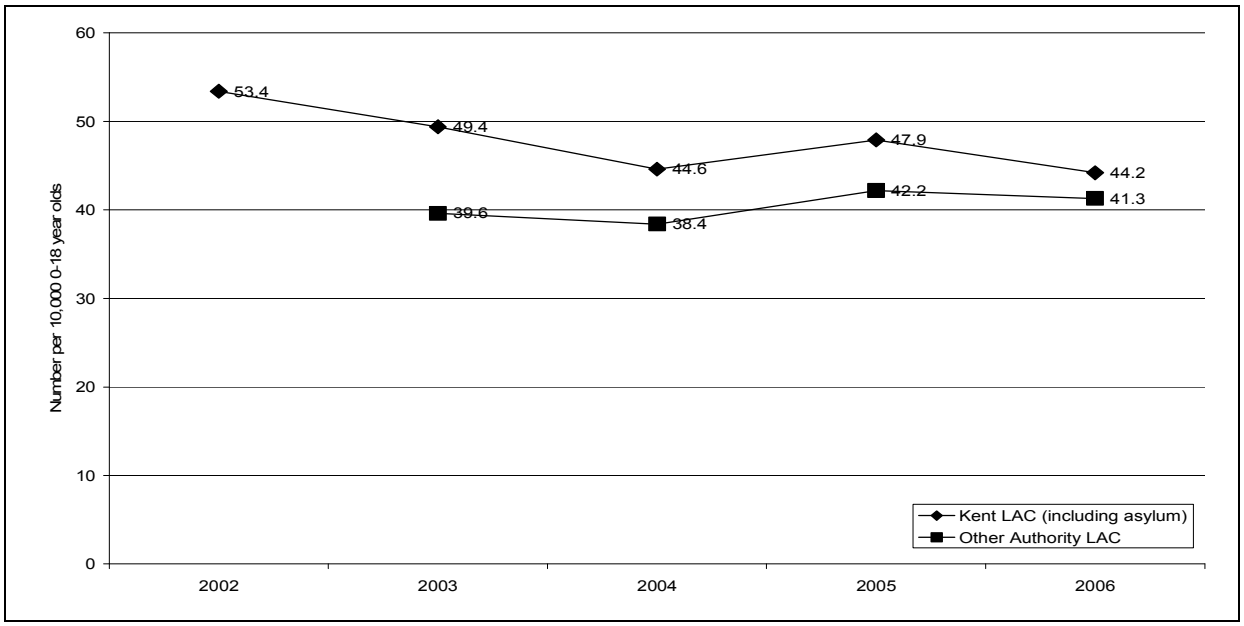
3.18 Higher than average rates of poor mental health and anti-social behaviour combined with low educational attainment significantly increase the likelihood that looked after children will experience social exclusion in later life. Nationally in 2003 22% of 16 year old looked after children were unemployed the September after leaving school, compared to 7% of all school leavers (DfES 2004). Unemployment, insufficient support from care to adult life, place care leavers at additional risk of homelessness. 20% of care leavers will experience some form of homelessness within two years of leaving care. Over a quarter of prisoners were in care as children. Young people who have been in care are two and a half times more likely to become teenage parents and the children of women who have spent time in care are themselves two and a half times more likely to go into care than their peers.

3.19 Residential care in Britain continues to be seen as a last resort. Young people living in residential homes will remain one of the most vulnerable groups in respect to both

social exclusion and health inequalities. In Kent the rate of children placed into residential care is low – an act of deliberate policy.

3.20 The number of looked after children aged 0-18 years in Kent is illustrated in the figure below. Within this it is possible to see the number of LAC who have been placed in Kent by authorities outside of Kent, in addition to those who are looked after by Kent County Council.

Figure 9 – LAC aged 0-18 years in Kent per 10,000 population aged 0-18 years (as at March each year)



Source: Policy and Performance Unit, Children, Families and Education Directorate, Kent County Council

Table 41 - Looked After Children in Kent by placement type, March 2007

Local Authority	KCC Residential Care	Independent Residential Care (P&V)	KCC Foster Care	Independent Foster Care	Placed with parents	Placed with relatives and friends	Placed for Adoption	Leaving Care	Other
Ashford LA	2	2	53	1	16	7	2	1	1
Canterbury LA	0	1	89	1	12	3	5	3	1
Dartford LA	0	0	25	0	7	0	1	0	2
Dover LA	0	1	64	0	3	8	2	1	2
Gravesham LA	0	2	50	4	4	2	6	1	3
Maidstone LA	1	1	44	6	7	3	3	3	2
Sevenoaks LA	0	1	47	2	4	7	1	0	1
Shepway LA	0	3	79	1	13	9	3	1	3
Swale LA	0	4	91	3	11	11	5	1	2
Thanet LA	1	7	156	5	27	12	18	6	6
Tonbridge and Malling LA	1	2	37	0	5	7	2	1	1
Tunbridge Wells LA	0	0	36	5	3	3	6	1	2
Disability (county wide)	3	15	28	3	0	0	2	0	1
Kent County	**8**	**39**	**799**	**31**	**112**	**72**	**56**	**19**	**27**

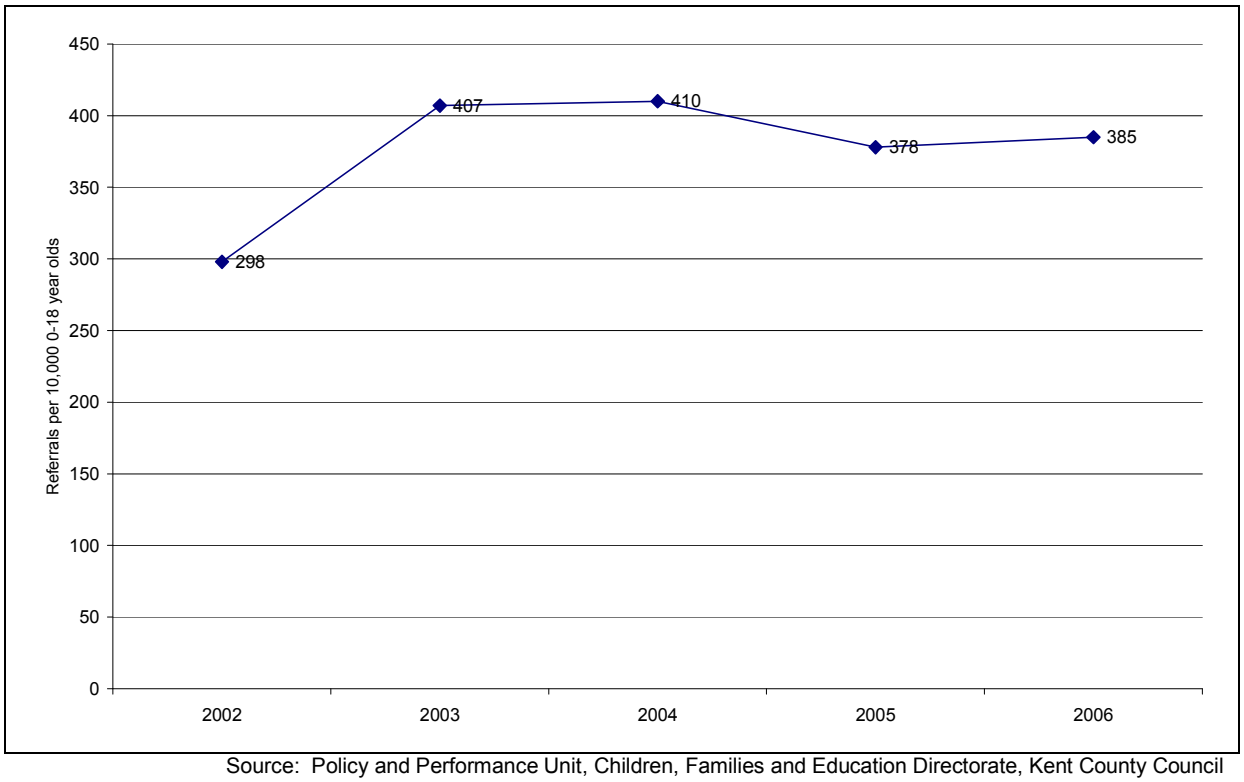
Source: Kent Children's Social Services, Monthly Performance Monitoring Report, KCC Children's Services Performance Monitoring Team

3.21 It is important to stress that the above figures relate to Kent children only and do not take account of the large number of children who are placed in the county by other authorities.

Safeguarding Kent's Children including Child Protection

3.22 The number of children and young people being supported by Kent Children's Social Services at a single point in time (between March of each year shown) is illustrated below. Between 2002 and 2003, the number supported increased by over a third, but in recent years the number has remained relatively consistent. Note that the figures are rates per 10,000 population aged 0-18 years. In 2005 the under-18 population was 327,000 so the absolute numbers would have been 32.7 times the figure shown.

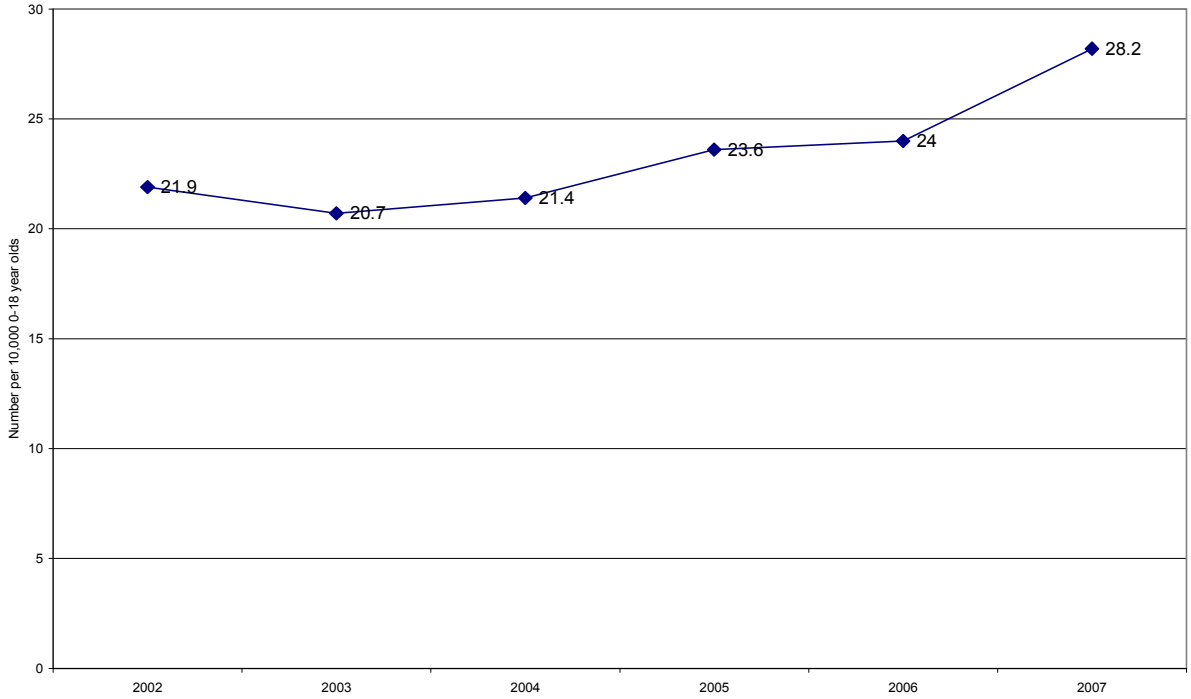
Figure 10 – Referrals to Kent Children's Social Service per 10,000 population aged 0-18 years (as at March each year)



Source: Policy and Performance Unit, Children, Families and Education Directorate, Kent County Council

3.23 The number of children in Kent who are on the Child Protection Register is shown in figure 11 below. This also shows how the number of 0-18 year olds on the Register has increased between 2003 and 2007.

Figure 11 - Number of 0-18 year olds on the Kent Child Protection Register



Source: Policy and Performance Unit, Children, Families and Education Directorate, Kent County Council

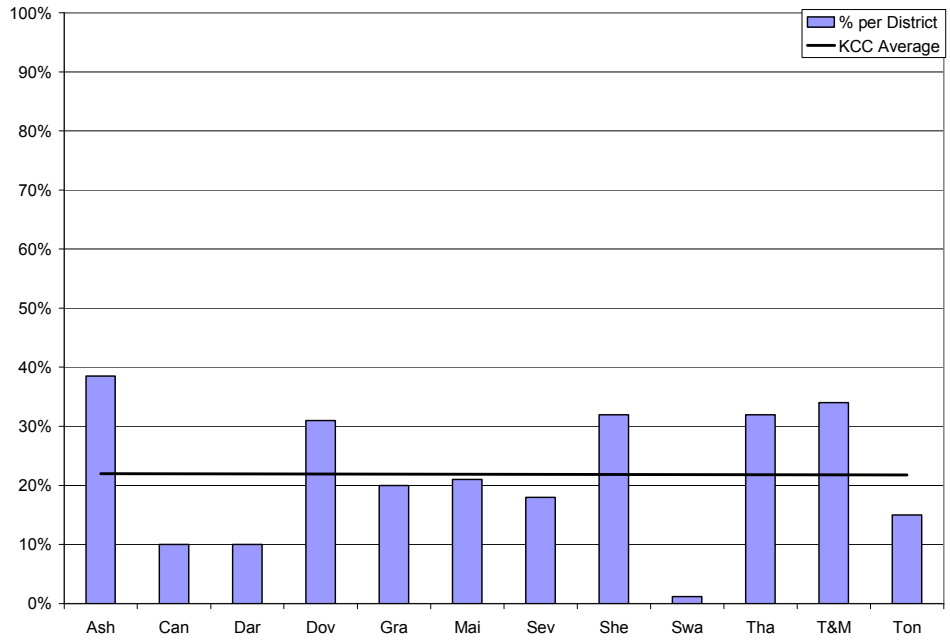
3.24 As at 31st March 2007 Kent had 864 children on the Child Protection Register, thus the rate had further risen to 28.2 per 10,000 child population. Across individual districts and given the variable impact of relative deprivation, then there is notable variation in ratios.

Table 42 – Children on the child protection register relative to the child population of Kent

			Child Protection	
	Population 0-17 years	Deprivation IMD score	Current March 07	Per 10,000 population
KCC exc asylum	306,840	16.63	864	28.16
Ashford	25,880	14.17	96	37.09
Canterbury	30,200	16.83	79	26.16
Dartford	20,360	17.80	59	28.98
Dover	23,200	19.65	58	25.00
Gravesham	22,100	18.87	65	29.41
Maidstone	30,780	12.21	96	31.19
Sevenoaks	24,580	9.78	39	15.87
Shepway	20,960	21.07	94	44.85
Swale	29,540	22.14	84	28.44
Thanet	28,160	25.30	108	38.35
Tonbridge and Malling	26.560	10.48	50	18.83
Tunbridge Wells	24,520	11.00	36	14.68

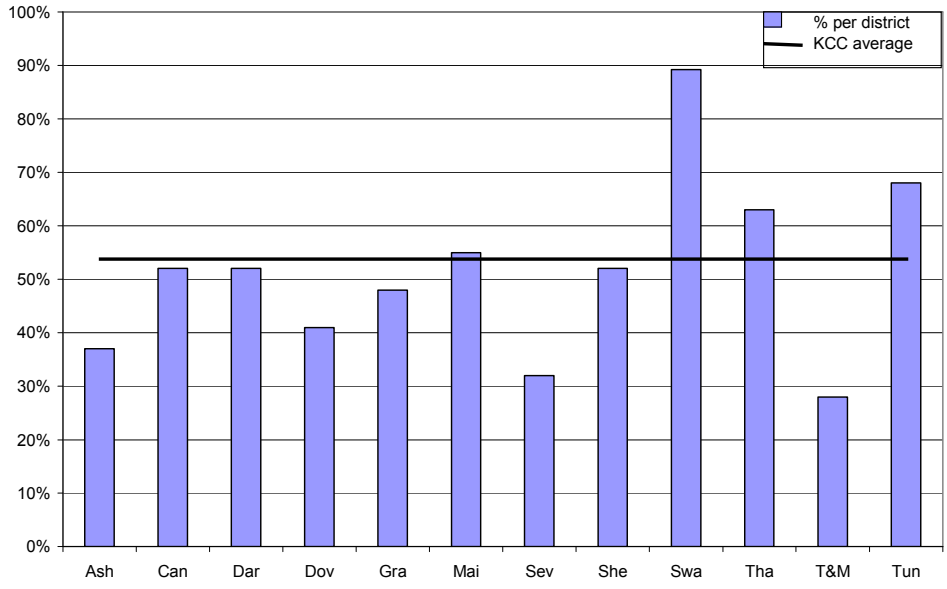
3.25 Thanet has the highest proportion of children on the Child Protection Register at 38.35 per 10,000. Sevenoaks has the lowest at 18.7 per 10,000. There is no national benchmark as to the prevalence of the child protection population. Even within the county there is variation as to the interpretation of categorised registrations.

Figure 12 – Registration by Category – Emotional abuse



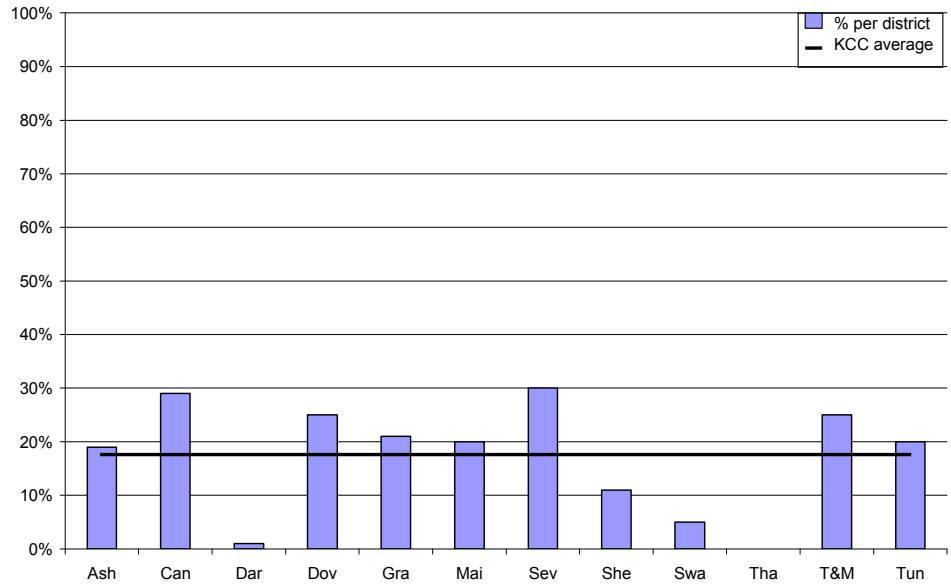
3.26 There is significant district variation with regard to children registered as being subject to emotional abuse – 1.2% in Swale to 38.5% in Ashford. Five districts have 30% or more children on the register in this category.

Figure 13 – Registration by Category - Neglect



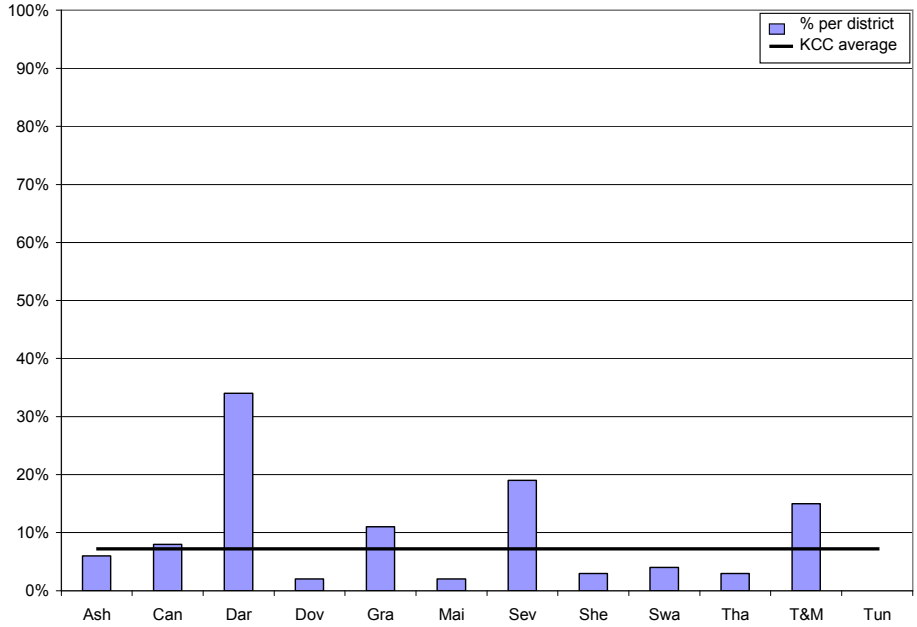
3.27 In Swale 89.2% - nearly nine out of every ten children on the register are registered as being subject to neglect. The distinction between emotional abuse and the abusive impact of neglect is blurred. Thus districts with higher averages in neglect often have lower averages in emotional abuse.

Figure 14 – Registration by Category – Physical abuse



3.28 It is most unlikely that in the course of twelve months in Thanet, no children were considered at risk from significant harm from physical abuse. However the impact of domestic abuse could be more readily accounted for in the emotionally abusive category and Thanet does record this for 32.4% of children on the register.

Figure 15 – Registration by Category – Sexual abuse



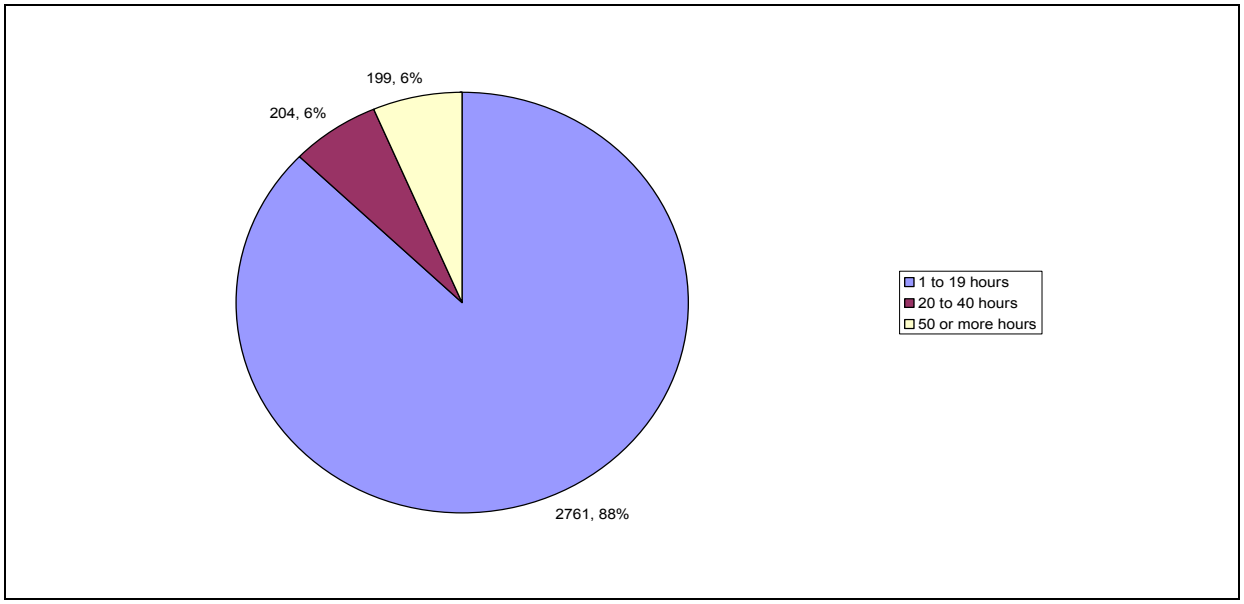
3.29 Sexual abuse constitutes relatively small numbers though a higher rate of registration can be seen in the west of Kent, specifically Dartford, Sevenoaks, Tonbridge and Malling and Gravesend.

3.30 Overall it should be noted that the higher proportion of children on the register are older children and adolescents – particularly so in Canterbury, Dover, Thanet and Sevenoaks.

Children Giving Care

3.31 The 2001 Census captured information on the number of children and young people providing unpaid care. Within Kent, 1.1% (equivalent to 3,164) of children aged 0-18 years provide some amount of unpaid care. This compared to 1.0% in the South East and 1.3% in England. The figure below illustrates the number of hours of unpaid care those children aged 0-18 years providing care provide each week.

Figure 16 – Provision of unpaid care by Kent's 0-18 year old population (as a proportion of all those who provide care)



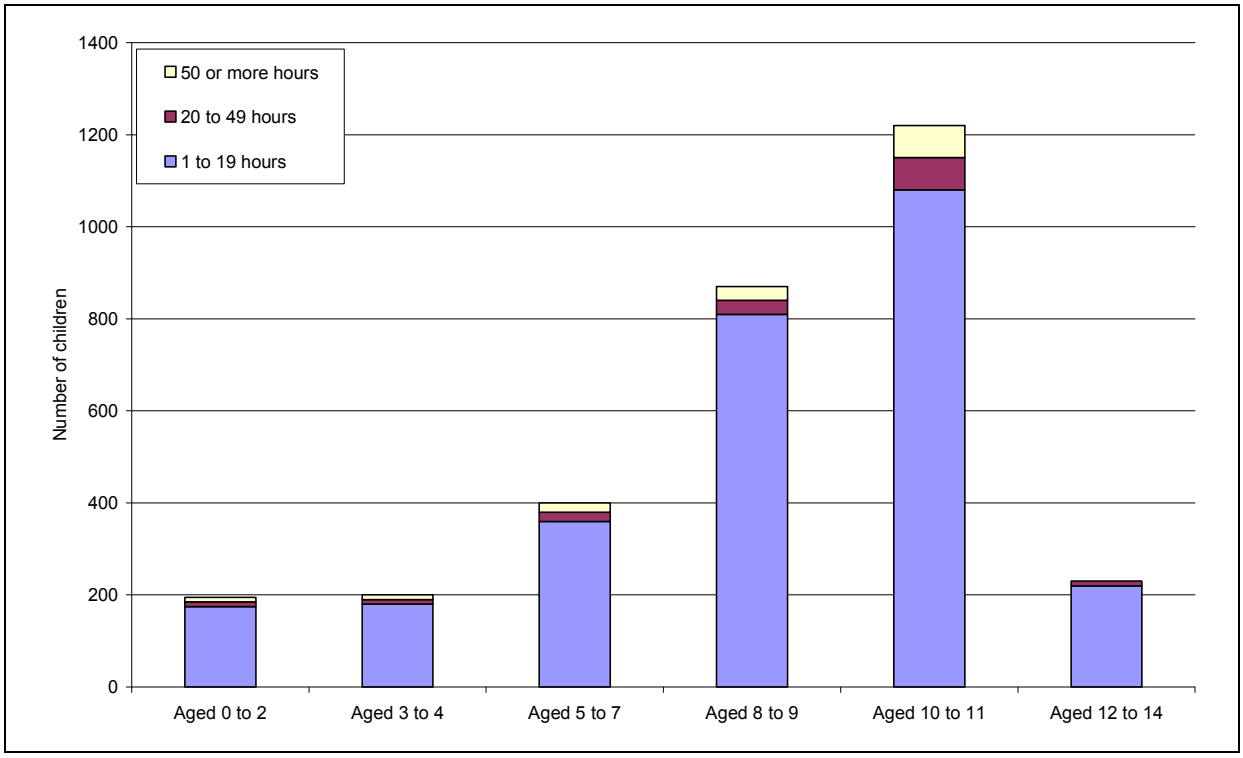
Source: 2001 Census, Standard Theme Table 1, Office for National Statistics (Crown Copyright). Data supplied by Analysis and Information Team, Kent County Council

3.32 By far the greatest proportion of children provide between 1-19 hours of care a week, but there are nearly 200 children and young people in Kent who provide over 50+ hours per week.

3.33 There is no overall geographical variation across Kent with regard to the number and proportion of 0-18 years that provide unpaid care. However the numbers in the Canterbury City Council area are high relative to the rest of Kent – a point highlighted in the 2004 Annual Report of the Director of Public Health for the then Canterbury & Coastal PCT.

3.34 The next figure illustrates the age profile of Kent children and young people who provide care. The older children and young people provide more unpaid care compared to younger children.

Figure 17 – Age profile of Kent children and young people providing care by hours of care provided



Source: 2001 Census, Standard Theme Table 1, Office for National Statistics (Crown Copyright). Data supplied by Analysis and Information Team, Kent County Council

Children of Substance Misusing Parents

3.35 Parental problems and alcohol use can frequently compromise children's health and development and children of substance misusing parents are amongst the most vulnerable children in the UK. Parental substance misuse is highly significant in child protection registration. Kent Drugs and Alcohol Action Team (KDAAT) assessing need to grade an appropriate service response has identified that:

- The co-ordination of services is complex since they require both multi-agency adults as well as children's services;
- It is necessary to map fully the services available across the county;
- There is a training issue that identifies appropriate screening tools; the identification of resilience factors and the provision of appropriate service information;
- There may be a recurrent issue of funding sustainability both as regards adult treatment services and all children's drug and alcohol services.

3.36 In view of the foregoing, the data below is at best partial. Current practice for the registration of adults undergoing treatment offers an optional field for parental status. Current practice throughout the county is variable. The high incidence of drug misusing parents in treatment in Thanet, Gravesham and Canterbury may be a partial reflection of local good practice not replicated elsewhere.

3.37 The following observations can be made on the data available. Firstly, as previously alluded to, this is a hidden problem and treatment is a declaration, whether voluntary or enforced through crime and disorder measures of assistance seeking. Behind

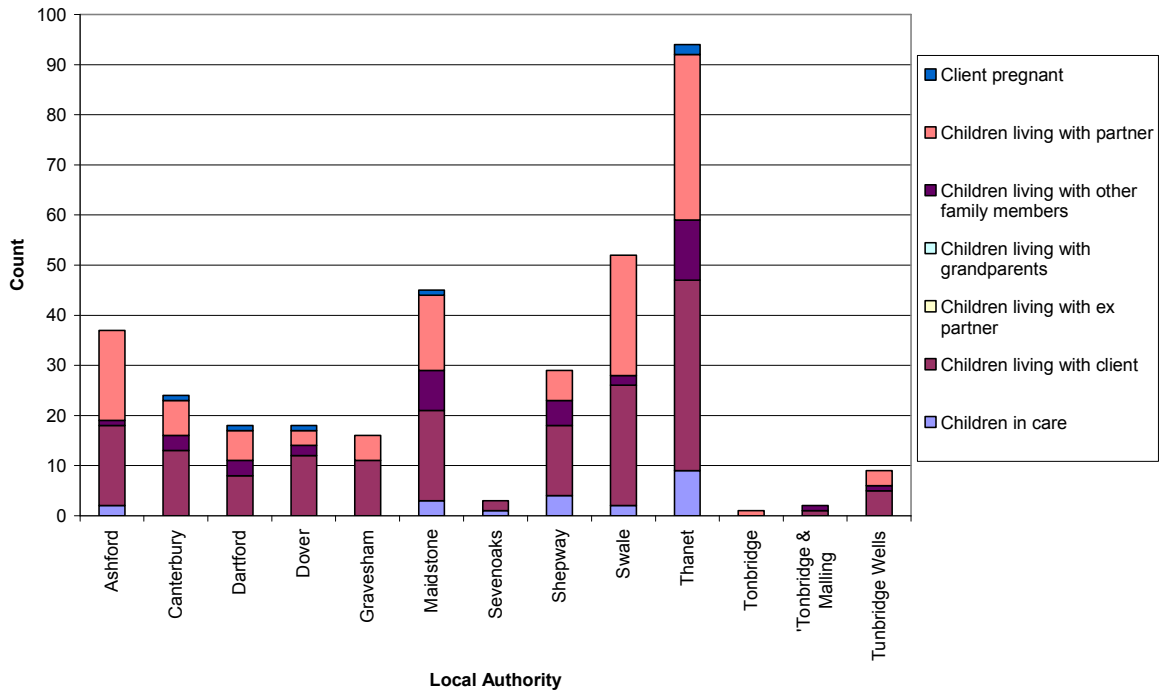
such numbers, there will be a greater number not in treatment. The data also identifies the disruption to children through the often necessary expedient of relying on the extended family.

Table 43 – Parental status by Local Authority – 2006/07

Local Authority	Children in Care	Children living with client	Children living with ex partner	Children living with grandparents	Children living with other family members	Children living with partner	Client pregnant	Grand total
Ashford	2	16			1	18		37
Canterbury		13			3	7	1	24
Dartford		8			3	6	1	18
Dover		12			2	3	1	18
Gravesham		11				5		16
Maidstone	3	18			8	15	1	45
Sevenoaks	1	2						3
Shepway	4	14			5	6		29
Swale	2	24			2	24		52
Thanet	9	38			12	33	2	94
Tonbridge						1		1
Tonbridge and Malling		1			1			2
Tunbridge Wells		5			1	3		9
Total	**21**	**162**			**38**	**121**	**6**	**348**

Source: Kent DAAT

Figure 18 – Parental status by Local Authority 2006/07



Mental Health

(see also issues of mental wellbeing 3.108)

3.38 The NHS Advisory Service review of Child and Adolescent Mental Health Services (CAMHS) 'Together we Stand' (1995) set out the currently accepted four-tier strategic framework for planning, commissioning and delivery of CAMHS. This tiered approach is intended to identify a continuum of need and ensure that a comprehensive range of services is commissioned. It also acknowledges that many different agencies contribute towards the mental health and psychological wellbeing of children and young people, including GPs, schools, social workers, youth justice workers and voluntary agencies.

3.39 Poor mental health is associated with low educational achievement, performance and absenteeism, in addition, conduct and behaviour disorders disrupt not only the learning of the individual child with the difficulty but also the learning environment of others.

3.40 There is a relationship between poor mental health, low self esteem and risk taking behaviour which impacts upon physical health, examples include smoking, bullying, substance misuse, risky sexual behaviour and teenage pregnancy, risk taking activity and injury.

3.41 Poor mental health can be an early warning of a child at risk as children and young people express internal distress in the form of mental health disorders. Abuse, neglect and sexual abuse are all associated with higher incidence of mental disorders and illness. Poor mental health, particularly conduct disorders, are associated with increased anti-social behaviour and offending.

3.42 The table below gives an indication of numbers of children and young people likely to have a mental health need which could present at or would benefit from an intervention at tiers one to four. This does not equate to the current service engagement at all tiers but there is closer correlation between the demand and prevalence at tiers three and four than tiers one and two.

Table 44 – Estimated numbers of children with a mental health need

Tier	Description	Estimated Prevalence	Estimated numbers in Kent
One	Mild emotional and behavioural difficulties	15%	51,441
Two	Moderately severe problems requiring attention from professionals training in mental health	7%	24,006
Three	Severe and complex mental health problems requiring a multi-disciplinary approach	1.85%	6,344
Four	The most severe, persistent and complex problems requiring specialist tertiary provision	0.08%	274

Table 45 – Prevalence of mental health conditions in 5-15 year olds

Disorders among all 5-15 year olds	Prevalence	Numbers in Kent
Clinically significant conduct disorder	5%	9,775
Emotional disorder	3.7%	7,223
Hyperkinetic (includes ADHD by ICD 10 definition)	1.5%	2,932
Less Common Disorders	1.3%	2,541
Overall rate	9.6%	18,767

Source: Office for National Statistics (2005) 'Mental health in children and young people in Great Britain, 2004' London: HMSO

Emotional Disorders

3.43 Emotional disorders are the most common mental health problems in children and include anxieties, phobias and depression. Anxieties and phobias are related to fear, which can be generalised, or specific to a situation or object; for example school or separation from a parent. For a problem to be classified as a disorder, behaviour needs to present as an exaggeration of normal developmental trends.

3.44 It is estimated that 1% of children and 3% of adolescents suffer from depression in any one year. Symptoms include sadness, irritability and loss of interest in activities. Associated features include changes in appetite; sleep disturbance and tiredness, difficulty concentrating, feelings of guilt, worthlessness and suicidal thoughts.

In Kent this might equate to 5,600 children and young people aged 5-19 years

Self-harm and Suicide

3.45 Self-harm and suicide can be a symptom of underlying unhappiness or emotional disorder. Self-harm can include self-cutting, burning, hair-pulling or self-poisoning. It may be linked to suicidal thoughts and is a way of coping with problems, a means of taking control, or a form of release from painful feelings.

3.46 Depression, serious mental health problems and the misuse of drugs are all factors related to suicide attempts. Young people who have already tried to kill themselves, or know someone who has tried to kill themselves are also at greater risk of attempting suicide.

3.47 Suicide rates are very low in children, but start to increase from the age of 11. Boys and young men aged 15-24 are most at risk.

In Kent this might equate to 10,000 children and young people aged 12-19 years

Eating Disorders

3.48 These are more common in young women. Up to 1% of women are affected by anorexia nervosa, where the person eats very little, effectively starving themselves and between 1-2% bulimia nervosa which involves bingeing on food followed by induced vomiting or use of laxatives. The average age of onset of anorexia is 15 and of bulimia 18. Some eating disorders are associated with other underlying mental health conditions.

In Kent this might equate to 800 children and young people aged 15-19 years

Conduct Disorders

3.49 Typical behaviour includes unusually frequent and severe temper tantrums beyond the age that this is normally seen, severe and persistent disobedience, defiant provocative behaviour, excessive levels of fighting and bullying, cruelty to others or animals, running away from home and some criminal behaviour.

3.50 These children and adolescents typically have low self-esteem, often showing marked misery and unhappiness as a result of a high incidence of depression. Some of these children lack the social skills to maintain friendships and may become isolated from peer groups.

3.51 Harsh and inconsistent parenting is the major cause of conduct disorder, but hyperactivity and a low IQ may also contribute. Family dysfunction, low income and parental mental illness are other factors which contribute to the risk of adult problems.

3.52 In children and young people with conduct disorder there is a high correlation with youth offending, anti-social personality disorder and increased risk of abusing and becoming dependent on alcohol and to a lesser extent, illicit drugs.

In Kent this might equate to 11,800 children and young people aged 5-15 years of which 8,800 would be boys

Attention Deficit Hyperactivity Disorder (ADHD)

3.53 Hyperkinetic disorder is the official term in the UK for describing children who are consistently over-active and inattentive. ADHD and Attention Deficit Disorder (ADD) are now more commonly used terms.

3.54 Signs of hyperkinetic disorder include restlessness and over-activity, inattentiveness and difficulty concentrating, acting impulsively and disruptive and destructive behaviour.

3.55 Children with hyperkinetic disorder may find it difficult to interact with other children and their inability to concentrate and restlessness at school impacts on their education and can be extremely disruptive to other pupils. Their behaviour can also put significant strains on family life. These problems can persist into adult life.

3.56 Medication such as methylphenidate can help treat hyperkinetic disorder, reducing the hyperactivity and improving concentration, although this is only a temporary effect. Evidence from randomised control trials (RCTs) (Fonagy et al 2002) suggests some areas where medication is effective. They are the first choice for ADHD, although diet may also be supportive and psycho-social treatments such as parent training or behavioural therapy can be useful adjuncts.

In Kent this could equate to 3,000 children and young people aged 5-15 years

Psychotic Disorders

3.57 Psychotic disorders cover a range of conditions where a person suffers from symptoms such as delusions and hallucinations. These include schizophrenia and bipolar affective disorder (commonly known as manic depression). The causes of psychotic illnesses are not properly understood; they can sometimes be genetic and in schizophrenia and bipolar affective disorder, abnormalities in the chemistry of the brain are thought to be involved.

Co-morbidity

3.58 Co-morbidity (co-occurrence of two disorders at the same time) is a significant issue, in addition to prevalence per se. The ONS survey found that one in five children diagnosed with a disorder had more than one disorder, the most common combinations being conduct and emotional disorder and conduct and hyperkinetic disorder.

Risk Factors

3.59 Child poverty as measured by parental income increases the risk of mental health problems in children and young people with 15% of children at the lowest income levels experiencing mental health difficulties compared to 5% of children and young people at the higher end of income levels.

3.60 Over 15% of children and young people living with a single parent have a mental health problem compared to 8% of those living with two parents.

3.61 Adverse childhood experiences are clearly associated with higher incidence of childhood mental health problems. Growing up in households where there is a parent mis-using alcohol or drugs, experiencing mental illness, domestic violence, committing sexual abuse, divorce and separation are all risk significant factors and the higher the numbers of adverse events, the stronger the risk.

3.62 Vulnerable population groups include:

- Looked After Children;
- Youth Offenders;
- Those with Learning Disabilities;
- Young Carers;
- Young Carers living with parents with mental health problems;
- Young Carers living with parents with substance misuse problems;
- Young people who are abused
- Sexually inappropriate behaviours/young abusers;

- Young people in transition to Adult Services.

3.63 In any locality there should be clarity about how the full range of users' needs are to be met, whether it be the provision of advice for minor problems or the arrangements for admitting a young person with serious mental illness to hospital.

3.64 Clear pathways should be set out to show how the range of mental health needs of children and young people will be met, whether from within services whose prime purpose is to deliver mental health care or from other services with a different primary function.

3.65 Parents whose children have mental health disorders seek help from a variety of professionals and often from more than one service.

Professionals most commonly approached are:

- Teachers (40%)
- Primary health care professionals (30%)
- Specialist educational professionals, such as educational psychologists (25%)
- Specialist CAMHS (25%) who are seeing the most impaired young people (those with more than one diagnosis)
- Paediatrics (13%)
- Social Services (13)

3.66 One in five children is estimated to suffer from mental health problems with some 10% of 5-15 year olds having a diagnosable mental disorder. The overlap between the risk factors for psychiatric disorder and youth offending is particularly pronounced with other key vulnerable groups including looked after children and the homeless.

3.67 Many young people will have multiple vulnerabilities with the widest spectrum of risk and consequent cost to society (poor educational attainment, limited employment prospects, insecure relationships, early parenting, involvement in crime and risk to health) contingent on conduct disorders and hyperactivity (Scott et al 2001).

3.68 There is thus a key role for interventions to reduce a range of negative impacts and negative chain reactions, open up new opportunities and neutralise harmful experiences (Rutter 1999). Empirical evidence suggests for example substance misuse, dropping out of education or early pregnancy, all increase the likelihood of a negative chain reaction. Positive events such as success at school (not necessarily academic) can increase self-efficiency, self-esteem and hence self-control over key life events.

3.69 The 1999 ONS survey on the mental health of children and adolescents in Britain (Meltzer et al 2000) reports high rates of service use amongst those with mental health problems including health, education, social services and the police. However only a small (unknown) proportion receive treatment from the CAMHS. In common with other countries, most children who need mental health services are not receiving specialised care.

3.70 The aetiology of emotional and behavioural disorder is poorly understood. Arguably the key focus of social concern and hence research has been in the reduction of delinquency rather than in the improvement of mental health per se. Delinquency itself is part of a larger spectrum of anti-social behaviours. Interventions in any of

these areas that address risk rather than symptoms have the potential for widespread benefits. However the nature of many of the risks militate against young people and their families either engaging with treatment programmes or remaining in treatment.

3.71 The role of poverty mediated by parenting and education has long been established as key. There has been a similar interest in the cultivation of resilience – the ability to overcome stress or adversity.

Table 46 - Interventions during childhood and adolescence: summary of the evidence base relating to health inequalities – Mental Health

Mental Health	Source
Parenting programmes with a preventative emphasis increase the social competence of children under ten years and the management skills of their parents	Overview
Family and parenting interventions can reduce the time juvenile delinquents (aged 10-17) spend in institutions	Cochrane Review
Cognitive Behavioural Therapy can be effective in the treatment of anxiety disorders, phobias and depression and (in combination with parent training) conduct disorders	Cochrane Review/Overview
Functional Family Therapy can reduce both delinquent behaviour and sibling delinquency	Overview
MST can prove effective with severe emotional and behavioural problems	Other review
Pharmacological treatments are effective for ADHD, particularly if supported by diet and psychosocial treatments (for example, parent training or behavioural therapy). Psychopharmacological treatments are also supported in the treatment of obsessive-compulsive disorder and depression and may be appropriate in the treatment of conduct problems and delinquency	Overview
Lack of review-level evidence	
A specific focus on adolescents	
Evaluation of community-based programmes for young offenders in the UK	

Environment and Housing

3.72 As part of the post-war settlement, housing was a sector in which the case for strong state involvement was generally accepted. The accumulation of public housing stock (largely local authority owned) continued to rise until 1977-78 when it accounted for 32% of the total housing stock. Between 1979 and 1997 there were radical changes. The right to buy policy together with the dearth in re-provision saw a significant decline in the local authority housing sector. As this sector has shrunk, it has come to play a residual role, primarily for the poorest of households.

3.73 From 1997 some funds were released from council house sales to address the problems of poor housing stock and further changes were facilitated through regeneration measures, particularly neighbourhood renewal.

3.74 Alongside these developments however, there has been a continued reliance upon the housing market. Such social housing that is being built is insufficient to meet demand.

3.75 Trends in housing provision have taken place within the broader context of growing inequalities in housing wealth. Between 1971 and 2002 the value of homes held by the UK population had risen fifty fold. Thomas and Dorling (2004) estimate that the wealthiest 10% of households possess over five times the housing wealth of the 10% of households with least wealth by area. However it is important to note that these figures exclude those who rent whether in the private or social sectors. Therefore they have no housing wealth and are excluded from what has become the greatest single repository for wealth held by individuals within the country.

3.76 Thus children from the poorest backgrounds will be significantly more disadvantaged with respect to their relative access to resources than those of previous generations, further widening the gap between rich and poor.

3.77 Across Kent there is considerable variation in the tenure of accommodation in which children and young people live. The largest proportion who live in owner occupied housing are in the Maidstone local authority area. Swale has the highest proportion of children living in social rented accommodation. Thanet the highest proportion living in private rented accommodation.

Table 47 - Percentage of 0-18 year olds by tenure of accommodation for Kent districts, 2001

Local Authority	Owner occupied (%)	Social rented (%)	Private rented (%)	Living rent free (%)
Ashford LA	72.6	18.8	6.9	1.7
Canterbury LA	68.9	17.8	11.3	2.0
Dartford LA	72.6	20.6	5.5	1.3
Dover LA	66.9	19.6	11.2	2.3
Gravesham LA	70.8	20.2	7.1	1.9
Maidstone LA	77.6	15.1	5.6	1.8
Sevenoaks LA	77.1	16.1	5.0	1.8
Shepway LA	66.9	17.9	13.7	1.5
Swale LA	68.4	21.1	9.1	1.3
Thanet LA	63.3	19.5	15.9	1.3
Tonbridge and Malling LA	75.2	19.1	4.4	1.3
Tunbridge Wells LA	74.1	18.4	6.0	1.6
Kent County	**71.2**	**18.6**	**8.5**	**1.6**
South East Region	**72.8**	**17.7**	**8.0**	**1.5**
England	**67.3**	**22.9**	**8.0**	**1.8**

Source: 2001 Census Standard Theme Table 1, ONS

3.78 The assumption is made that every household requires a minimum of two common rooms (excluding bathroom). If there is one room too few (a value of -1) then there is said to be overcrowding in the household. Thanet has the greatest proportion of 0-18 year olds living in overcrowded households (10.8%). This is still below the England average.

Table 48 - Percentage of 0-18 year olds living in overcrowded households by Kent districts, 2001

Local Authority	Percentage of 0-18 year olds
Ashford LA	8.0
Canterbury LA	9.9
Dartford LA	10.4
Dover LA	9.6
Gravesham LA	10.2
Maidstone LA	7.4
Sevenoaks LA	6.2
Shepway LA	10.5
Swale LA	10.4
Thanet LA	10.8
Tonbridge and Malling LA	5.8
Tunbridge Wells LA	7.4
Kent County	**8.8**
South East Region	**8.9**
England	**12.5**

Source: 2001 Census Standard Theme Table 1, ONS

3.79 Thanet and Dover have the highest proportion of 0-18 year olds living in households with no central heating (5.6%). Sevenoaks has the smallest proportion at 2%.

Table 49 - Percentage of 0-18 year olds living in accommodation with no central heating in Kent districts, 2001

Local Authority	Percentage of 0-18 year olds
Ashford LA	2.5
Canterbury LA	3.2
Dartford LA	2.8
Dover LA	5.6
Gravesham LA	2.6
Maidstone LA	2.3
Sevenoaks LA	2.0
Shepway LA	4.2
Swale LA	4.4
Thanet LA	5.6
Tonbridge and Malling LA	2.6
Tunbridge Wells LA	2.4
Kent County	**3.4**
South East Region	**3.3**
England	**5.9**

Source: 2001 Census Standard Theme Table 1, ONS

3.80 The table below is a measure of turnover. The location of hostels across Kent is noteworthy, some families being temporarily accommodated outwith their district council area.

Table 50 - Average length of stay in weeks of unintentionally homeless families and pregnant women in B&Bs and hostels, Kent 2005/06

Local Authority	B&B	Hostels
Ashford LA	4.20	0.00
Canterbury LA	3.38	0.00
Dartford LA	3.00	0.00
Dover LA	6.37	0.00
Gravesham LA	1.00	4.00
Maidstone LA	3.53	0.00
Sevenoaks LA	7.00	0.00
Shepway LA	5.53	28.92
Swale LA	4.27	35.44
Thanet LA	4.00	15.00
Tonbridge and Malling LA	5.37	0.00
Tunbridge Wells LA	0.00	15.00

Source: Audit Commission Area Profile

Youth Homelessness

3.81 Small groups of young people are specifically at risk of being homeless including:

- Care leavers;
- Teenage parents;
- Young offenders;
- Vulnerable people aged 16-17;
- Unaccompanied asylum seeking children;
- Families without recourse to public funds;
- Intentionally homeless families.

3.82 A multi-agency response is required including children's services, housing services, Connexions services, schools, specialist organisations in the third sector. Studies from housing authorities elsewhere suggest that mediation services are helpful since it is suspected that a significant driver of youth homelessness is family disagreement. It should be recognised that youth homelessness may have extensive under-recording since many in this situation unofficially live with friends on a temporary basis.

3.83 The Kent Joint Planning Board for Housing and Health will be co-ordinating a study into the extent of this issue across the county.

Education and Employment

3.84 Education plays a critical role in the link between childhood disadvantage and adult disadvantage as parental background is a significant determinant of educational performance which in turn determines access to key opportunities in adult life. The well educated are at lower risk of unemployment and more likely to obtain better paid jobs. It allows individuals to live in better conditions, consume more nutritious food and so on. By the age of 37, one third of those with very low skills do not own their own home compared to under 10% of men and women with good skills. Those with higher educational qualifications tend to enjoy more control over their working lives,

more variety and challenge with greater job satisfaction – factors that may be associated with improved psycho-social health.

3.85 Given these associations, currently levels of educational attainment suggest that many children are facing serious future disadvantage. They are also more likely to come from a background of socio-economic disadvantage. Using the indicator for low income, pupils eligible for free school meals are significantly less likely to achieve the national benchmark of five GCSE passes A-C. This social gap is reflected in access to university places – increasingly important for workplace success.

Table 51 - Percentage of pupils in Kent who are eligible for free school meals, 2005/06

Area	% of pupils
Kent	9.9

Source: Management Information Team, Children, Families and Education Directorate, KCC

3.86 Free school meals are offered to children and families who are in receipt of Income Support, income based Job Seekers Allowance, guaranteed element of State Pension Credit or receiving support under Part 6 of the Immigration and Asylum Act 1999. Such meals are also offered to children of families who are in receipt of Child Tax Credit only, but who are not entitled to Working Tax Credit and whose annually assessed income does not exceed £14,155.

3.87 The provision of free school meals has traditionally been a reliable indicator of the extent and degree of child poverty in the UK. Data to hand is disaggregated to school cluster level and therefore direct comparison is problematic. Nevertheless the following district council areas have above Kent average rates of children receiving free school meals for the academic year 2005-06: Thanet; Dover; Canterbury; Gravesham. The urban part of Swale (ie Sittingbourne and the Isle of Sheppey) together with Swanley and District, Dartford East and the urban area of Ashford also demonstrate higher than Kent averages. The district council area with the lowest percentage in Kent is Tonbridge (5.3%).

3.88 The substantive effects of social origin on educational outcomes have long been recognised. Evidence suggests that non-school factors are a more important source of variation in educational attainment than differences in the quality of education that students receive (Thomas and Mortimor 1996). This does not mean that children from socially disadvantaged backgrounds are condemned to educational failure. Schools can make a difference.

3.89 Overall there are consistently higher rates of attainment at Key Stage 2 assessment in the south of west Kent. Thanet and Swale demonstrate rates that are lower – a reflection overall of higher numbers of children who suffer disadvantage. None of the figures below relate to Kent children in private education.

Table 52 - Percentage of Kent children achieving Level 4 or above

Local Authority	English			Mathematics		
	1997	2006	% points difference	1997	2006	% points difference
Ashford LA	63	76	13	59	70	11
Canterbury LA	63	77	14	63	71	8
Dartford LA	63	79	16	62	73	11
Dover LA	64	73	9	62	70	8
Gravesham LA	59	77	18	58	73	15
Maidstone LA	68	79	11	66	72	6
Sevenoaks LA	69	81	12	70	78	8
Shepway LA	60	74	14	60	72	12
Swale LA	57	71	14	55	67	12
Thanet LA	57	71	14	55	63	8
Tonbridge and Malling LA	72	81	9	70	77	7
Tunbridge Wells LA	70	81	11	69	75	6
Kent County	**64**	**77**	**13**	**62**	**72**	**10**
South East Region	**66**	**80**	**14**	**63**	**75**	**12**
England	**63**	**79**	**16**	**62**	**76**	**14**

Source: Department for Children, Schools and Families

3.90 One academic year is not necessarily representative of a pattern which will fluctuate considerably amongst individual schools although it is possible to draw out overall patterns at local authority level. Lower rates can be shown in Dartford, Gravesham, Swale and Thanet and higher rates in Sevenoaks, Tonbridge and Malling, Tunbridge Wells and Dover. None of these figures relate to students in private education.

Table 53 - Percentage of Kent children achieving 5+ GCSEs at grades A* - C and equivalent results

Local Authority	Achieving 5+ A*-C		
	1997	2006	% points difference
Ashford LA	43.2	60.8	17.6
Canterbury LA	51.1	59.9	8.8
Dartford LA	51.8	73.2	21.4
Dover LA	47.5	64.5	17.0
Gravesham LA	38.8	55.8	17.0
Maidstone LA	53.1	65.3	12.2
Sevenoaks LA	24.4	33.6	9.2
Shepway LA	41.5	60.0	18.5
Swale LA	37.9	51.6	13.7
Thanet LA	40.4	52.8	12.4
Tonbridge and Malling LA	47.5	66.7	19.2
Tunbridge Wells LA	65.3	76.3	11.0
Kent County	**-**	**61.4**	**-**
South East Region	**47.7**	**59.7**	**12.0**
England	**45.1**	**59.2**	**14.1**

Source: Department for Children, Schools and Families

3.91 The figures below show overall a consistently high pattern across the county, reflecting the inherent selection of students who opt for higher qualifications; or more

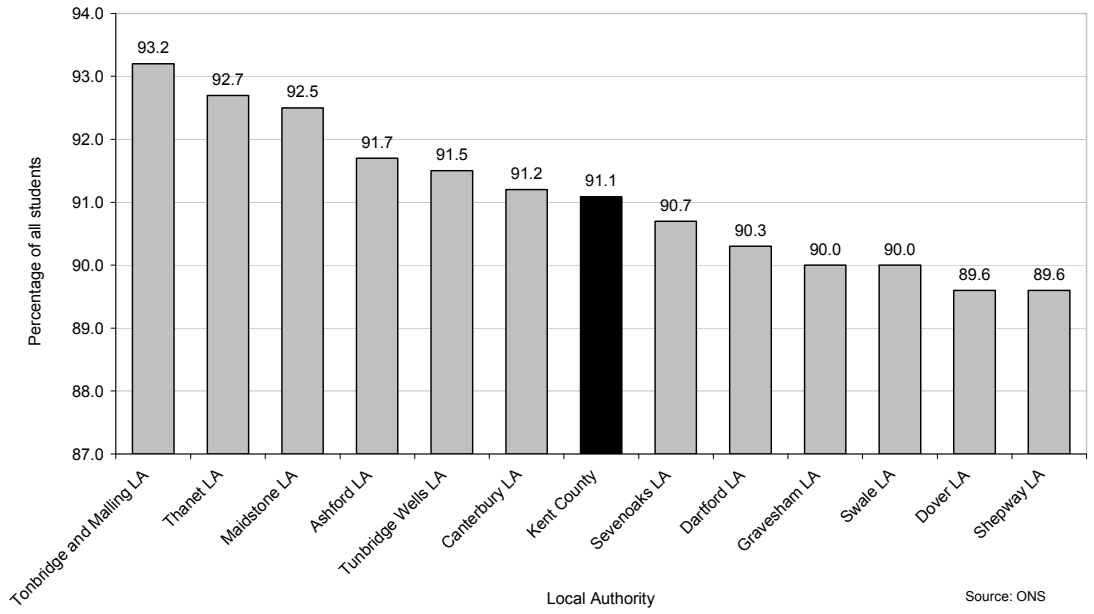
typically have the family support, cultural aspiration or social capital (Hanley 2007)[2] to do so. This is especially well illustrated by the outcome in districts in the east of the county where less optimal outcomes have been demonstrated in other educational attainment measures. None of these figures relate to students in private education.

Table 54 - Percentage of Kent students achieving 2+ GCE/VCE A Level or equivalent passes, Sept 04-Aug 05 (referenced by student residence)

Local Authority	% of all students
Ashford LA	91.7
Canterbury LA	91.2
Dartford LA	90.3
Dover LA	89.6
Gravesham LA	90.0
Maidstone LA	92.5
Sevenoaks LA	90.7
Shepway LA	89.6
Swale LA	90.0
Thanet LA	92.7
Tonbridge and Malling LA	93.2
Tunbridge Wells LA	91.5
Kent County*	**91.1**
South East Region	**93.5**
England	**92.6**
* average of constituent local authorities	

Source: ONS

Figure 19 - Percentage of Kent students achieving 2+ GCE/A Level or equivalent passes, Sept 04-Aug 05



[2] For a vivid anecdotal illustration of the importance of social capital in sustaining ambition through sixth form and into tertiary education, see Hanley (2007)

3.92 Considerable political emphasis has been placed on participation in higher education. For children aged 16+ who attend full time courses at school or college, a means tested Education Maintenance Allowance (EMA) has been introduced with the aim of encouraging children from lower income families to continue in education. It is now available nationally with approximately half of all 16 year olds in England estimated to be eligible. At the same time young people not in employment are entitled to lower rates of income support than those aged 25 or over. Entry to employment is thus being deferred.

Table 55 - Young people's views on education and their future

Whether children and young people agree with the statements	Strong agree %		Agree %		Not sure %		Disagree %		Strongly disagree %		No response %	
	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16
I think I'll be able to get the sort of job I want	24	19	43	45	24	28	1	2	<1	<1	7	5
I think my school/college is giving me useful skills and knowledge	23	16	43	54	19	18	6	5	3	1	8	5
I know what sort of job I want	40	31	26	31	22	23	4	6	2	3	7	5
I think I have a talent which will help me get the sort of job I want	28	21	34	41	26	28	3	4	1	1	7	5
I think my school/college is giving me good careers advice	15	10	28	33	30	27	13	18	6	7	8	5
I think it is OK to miss school/college if I feel like it	5	3	5	8	13	16	33	40	36	28	8	5
Qualifications are a waste of time	3	2	4	3	14	11	29	34	42	45	8	5
Survey included 10,344 11-16 year olds and 961 post 16s												

Source: Children and Young People of Kent: Survey 2006/7

3.93 Table 55 above taken from the NFER survey summarises young people's views on education and training and their confidence for the future. Two thirds of 11-16 year olds and post-16 year olds report broad optimism as to their future employment prospects, their confidence in securing their future aspirations and have confidence in the support being given to them by their school or college. Conversely a significant minority do not share this level of confidence.

3.94 The Government's Green Paper "Towards Full Employment in a Modern Society" (DWP 2001) has aimed to increase flexibility, the involvement of employers and the focus on barriers to employment.

3.95 Kent has pioneered a vocational 14-16 programme to more than 4,000 students offering choice in a diverse curriculum focused on vocational courses tailored to the needs of industry, matching skills and market requirements, supported by appropriate careers guidance. It is important that training opportunities for vocational education exist for young people who will not aspire to higher education admission.

3.96 Overall however the employment rate of 16-17 year olds who are outside of this policy envelope has not fallen. It is this younger age group (likely to include some of the most disadvantaged) who appear to be neglected by policy makers unless in education or training (Hills and Stewart 2005). The table below represents Connexions areas which are not coterminous with district councils – especially in the south west of Kent. Connexions services will be organised on the principle of targeting in areas of high need. Nevertheless high numbers of young people

classified as NEET are to be found in Thanet, Swale (both above the England average) and to a lesser extent Shepway.

Table 56 - Percentage of 16-18 year olds Not in Education, Employment or Training (NEET), November 2006

Connexions Advice Centre	% of 16-18 year olds
Ashford	5.02
Canterbury	5.75
Dartford	4.65
Dover	5.19
Gravesend	4.32
Maidstone	5.79
Shepway	6.88
Swale	8.68
Thanet	9.36
Tonbridge	2.06
Kent	**5.52**
England	**7.50**
Note: This data is based on where Connexions have their advice centres. Tonbridge advice point for example covers a massive area of west Kent including Sevenoaks, Swanley, Tunbridge Wells, Tonbridge, Cranbrook and Malling. Other advice points (centres) are more closely related to district council areas.	

Source: KCC Children, Families and Education

Schools, Health and Wellbeing

3.97 While parental circumstances and decisions influence the provision of resources that can lead to heightened risk to health or conversely to greater resilience, children's everyday lives are also highly institutionalised (Nasman 1994). Children in the UK spend much of their waking hours in formal education.

3.98 Knowledge about health behaviours remains a key weapon within the primary preventative agenda notwithstanding that it tends to be most effective as regards those at lowest risk. Schools increasingly have become a key focus for health promotion interventions such as improved nutrition and physical activity.

The National Healthy Schools Programme was established in 1999 as a joint Department of Health (DH) and Department for Education and Skills (DfES) initiative. All schools now achieving National Healthy School Status must have met national criteria using a whole school approach across the four core themes.

The National Healthy Schools Programme supports the links between health, behaviour and achievement; it is about creating healthy and happy children and young people, who do better in learning and in life. The impact of the programme is based on a whole-school approach to physical and emotional wellbeing focused on four core themes:

- Personal, Social & Health Education
- Healthy Eating
- Physical Activity
- Emotional Health & Wellbeing

The whole school approach involves working with children and young people, parents, school staff and the whole school community to provide a solid foundation from which developments and improvement are embedded in a systematic way. These processes contribute to the physical and emotional development of all members of the school community providing opportunities at school for an improvement in long-term health, reduction in health inequalities, increased social inclusion and

raised achievement for all.

Aim: To deliver real benefits for children and young people, specifically:

- To support children and young people in developing healthy behaviours
- To help raise the achievement of children and young people
- To help reduce health inequalities
- To help promote social inclusion

Targets: The Government has set a target that all schools will be participating in the National Healthy Schools Programme by 2009 and that 75% of schools will have achieved National Healthy School Status.

Outcome: Children and young people in Healthy Schools report that they feel healthier, happier and safer. Their parents say that they feel more involved in their child's health and learning and often feel better themselves. Schools state that the National Healthy Schools Programme has brought sustained improvement in behaviour, standards of work and school management.

In the academic year 2006/7 Kent Healthy Schools programme provided matched funding to all Education Clusters to enable a package of support and training to be provided to all schools. This academic year 2007/8 the programme is offering funding in the region of £5,000 to each Cluster on the condition that a number of basic criteria are met. Money has been allocted at a base level of £3,000 with the remaining funding calculated on pupil numbers.

Funding Criteria

- Cluster Plan *Achieved* Targets for December 2007, April and July 2008 to be agreed In consultation with the relevant Healthy Schools Specialist and Extended Services Development Manager and signed off by the Quality Assurance Group. Achieved targets to identify the percentage of schools it is anticipated will have achieved the Heathy School Status and the actual number. (These targets are currently under negotiation)
- Funding will be spent on acivities that directly support the achievement of the Healthy Schools Cluster targets.
- A Quality Assurance/Working Group is in place and meets on a regular basis throughout the year to oversee the ongoing delivery of the programme and support the self validation process. The respective Local Education Officer and ESDM are members of the group and play an active role.
- Funding will be transferred directly to the Cluster during the autumn term and must be spent by July 2008.

This year Clusters have not been asked to match funding but it is hoped that they will continue to work with their local Healthy Schools Practitioner/Specialist to identify priorities and provide additional support and funding as necessary.

Kent Targets

- Half of all schools will be Healthy Schools by December 2006
- All schools will be working towards being a Healthy School by December 2009
- In addition there are incremental 'achieved' targets, which all local programmes are working towards. These are:
    - December 2007 55% of schools achieving Healthy School Status
    - December 2008 65% of schools schieving Healthy School Status
    - December 2009 75% of schools achieving Healthy School Status

3.99 The role of schools in inclusion is also exemplified in the extended schools strategy. This expects all schools over time to provide a core offer of extended services including study support, parental support, family learning and improved referral to multi-agency support alongside a child care component as established by the ten year Child Care Strategy.

3.100 There is a new statutory duty on schools established by the Education Act 2000 to safeguard children and to promote their welfare.

Table 57 - Whether children (aged 7-11) have someone to talk to if they are concerned about something

Who children talk to when they need help	Yes %	No %	No response %
An adult at home	88	10	2
A friend	81	16	3
An adult at school	79	18	3
Survey included 31,517 7-11 year olds			

Source: Children and Young People of Kent: Survey 2006/7

3.101 The majority of children said that they would talk to an adult at home, a friend or an adult at school if they needed help. However between 10% and 18% of children indicated that they would not talk to these people. Overall, 2% of children (644) said they would not talk to an adult at home or at school, or even talk to a friend if they needed help. Younger children were more likely to talk to an adult at their school when they needed help compared to older children (88% of year 3 compared to 73% of year 6).

Table 58 – Whether children and young people (aged 11-19) have someone to talk to if they are concerned about something

Who children and young people talk to when they cannot deal with issues on their own:	Yes %		No %		No response %	
	11-16	Post-16	11-16	Post-16	11-16	Post-16
An adult at home	80	76	15	20	6	4
Someone else	68	79	25	17	7	4
An adult at school/college	55	58	37	37	8	5
Survey included 10,344 11-16 year olds and 961 post 16 year olds						

Source: Children and Young People of Kent: Survey 2006/7

3.102 Four fifths of 11-16 year olds and three quarters of post-16s said they would talk to an adult at home when they could not deal with issues on their own. About two thirds of 11-16 year olds and four fifths of post-16 year olds said they would talk to someone else and over half of both groups said they would talk to an adult at school or college. There was however a proportion of young people (ranging from 15% to 37%) who said they would not talk to these people when there was an issue that they could not deal with on their own. Overall, 6% of young people (565) said they would not talk to anyone if there were issues that they could not deal with on their own.

3.103 Young people aged 11-16 with special educational needs (65%) were less likely to have someone other than an adult at school/home to talk to compared to 11-16s without special educational needs (76%). Girls aged 11-16 were more likely than boys to talk to someone other than an adult at school or home when they had issues that they could not deal with alone (79% and 67% respectively). Young people in post-16 education were more likely to have someone to talk to other than someone at home or school/college than those in Key Stage 3 (71% and 82% respectively).

Table 59 - What has helped children and young people (aged 11-19) to learn as a percentage of survey* respondents, 2006/07

Very much %	Quite a lot %	A little %	Not at all %	Don't do this %	No response %

	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16
Making things/doing practical things	48	39	27	32	13	15	3	4	2	4	4	6
Trips to places	50	36	23	27	12	18	3	3	4	10	7	6
Using ICT	37	36	30	35	20	18	5	3	2	2	7	6
Using their own ideas	30	27	36	45	22	20	4	2	1	<1	7	6
Working as part of a group	30	28	35	44	21	19	5	3	2	1	7	5
Working on their own	22	27	33	44	27	20	8	3	2	1	7	6
Doing projects that cover more than one subject	25	21	25	33	26	23	9	8	6	9	8	6
Reading	16	14	21	27	31	32	14	13	10	8	9	7
* Survey included 10,344 11-16 year olds and 961 post 16s												

Source: Children and Young People of Kent: Survey 2006/7

3.104 More than half of the 11-16s and post-16s felt all of the above activities excepting for reading, helps them to learn. The proportion of young people in both groups who felt that reading helped them learn very much was similar to the proportion who felt that reading did not help at all.

3.105 Young people at Key Stage 3 (56%) are more likely to enjoy making things/doing practical things and going on trips, compared to young people in Key Stage 4 (GCSE) and post-16 education.

School Breakfast Clubs

3.106 Children who have no breakfast may be at risk from adverse effects in the long term and adverse educational and social effects in the short term as a consequence of poor concentration and behaviour at school, together with poor socialisation (Street 1998). An overview of breakfast clubs (Ani and Grantham-McGregor 1998) suggests that they may confer corresponding short term benefits on classroom behaviour, cognition, academic outcomes and school attendance. They can also provide a safe place for children to meet their friends before school.

3.107 The Department of Health established a pilot in 1999/2000 to develop school based breakfast clubs with the aim of developing preferences for healthy eating and establishing a positive start to the school day. The evaluation of the pilot suggested that the scheme was capable of reaching families most likely to be most in need of support including some families at risk of or experiencing social exclusion. A randomised control trial also found a higher proportion of breakfast club attendees had borderline or abnormal conduct and a higher total difficulties score (Shemilt et al 2004).

Issues of Mental Wellbeing

3.108 Around a quarter of young people (28% of 11-16s) and 22% of post-16s in the NFER survey reported feeling very sad or depressed at least one or two times a week. It is important to stress that depression in this context is not related to clinical diagnosis of any kind.

Table 60 - Percentage of children and young people in Kent who feel very sad or depressed most days, 2006/07

Age	% of those surveyed*

11-16	11
Post 16	17
* Survey included 10,344 11-16 year olds and 961 post 16s	

Source: Children and Young People of Kent: Survey 2006/7

3.109 Approximately half of children in Kent aged 7-11 surveyed by the NFER indicated that they have been pushed or hit by other children, called names or talked about or left out or stopped from joining in. Approximately one third of children indicate that they have been bullied at school (38%), have had their possessions broken or stolen (33%) or have been picked on in the area that they lived. 13% indicated that they had been picked on whilst on the journey to and from school. However less than half of children surveyed walked to school.

3.110 Nearly one third of 11-16 year olds (31%) and 14% of post-16 year olds said that they had been bullied at school in the last year.

Table 61 - Percentage of Kent children and young people who have been bullied, 2006/07

Age 7-11		
Whether children have been:	**% of those surveyed***	
Pushed or hit by other children	55	
Called names or talked about by other children	54	
Left out or stopped from joining in	49	
Picked on or bullied at school	38	
Had their possessions broken or stolen on purpose	33	
Picked on in the area they live	27	
Picked on going to and from school	13	
Age 11-19	**% of those surveyed***	
Whether children and young people have been:	**11-16**	**Post 16**
Bullied in the last year	31	14
*Survey included 31,527 7-11 year olds, 10,344 11-16 year olds and 961 post 16s		

Source: Children and Young People of Kent: Survey 2006/7

4 Inequalities in Health Behaviours and Life Trajectories of Children and Youth: Overview

There are strong continuities between social origin and social status of destination of children and young people. Parental socio-economic circumstances remain a major determinant of young people's life chances. Factors such as parental occupation, education and income explain a far higher proportion of the variation in school performance in the UK than in western countries on average. Rather than equalising life chances, a strong class divide persists in British education. The level of education is not only strongly influenced with income level, quality of employment, housing, food, access to leisure – all of which are factors that impinge upon adult health. It also independently shapes propensity to adopt and maintain healthy lifestyles. Those with higher qualifications are less likely to smoke, more likely to control their diet and exercise than their less educated counterparts – this even after controlling for factors such as income.

The persistence of social inequalities in terms of health risks and behaviours also suggests that social origin remains a critical determinant of health outcomes. Dietary patterns during childhood and youth vary significantly according to socio-economic status. Young people from lower socio-economic backgrounds will consume lower amounts of fruit and vegetables and higher proportions of refined and particularly starchy foods. Such children are at higher risk of being overweight and obese notwithstanding that obesity in childhood is associated with all parts of society. Problems of underweight have also been noted in national studies of boys from lower income households. This suggests that weight distribution among socially disadvantaged may be becoming increasingly U-shaped.

Problematic risk behaviours such as smoking and drug misuse during youth are more strongly associated with social deprivation. The significance of variations in health behaviours during childhood and youth to health inequalities in adulthood should not be under-estimated. Most smokers, for example, start smoking in their teenage years. Those who are in social networks where cigarette smoking is the norm are significantly more likely to take up the habit leading to both social and neighbourhood concentration in the prevalence of smoking. A strong class gradient exists between teenagers in the lowest income groups who are the heaviest smokers and those from professional backgrounds who are the lightest smokers.

Evidence of socio-economic variations in alcohol and drug misuse varies according to the definition of substance use that is adopted. Many UK surveys suggest a positive relationship between alcohol consumption and social status, young men and women from higher income groups drinking more frequently and in larger amounts. Similarly the use of cannabis and amphetamines does not appear to be strongly associated with social deprivation although young people who leave school at 16 appear more likely to have tried drugs than those who stay on to achieve higher qualifications. Against this highly problematic drug and alcohol use appear to be strongly associated with social disadvantage.

Although sexual behaviour has consequences for current morbidity as reflected by the increasing prevalence of STI in young people, early sexual activity can be perceived as part of a pathway leading to later adult circumstances. Children who start having sexual intercourse at an earlier age are significantly more likely to become pregnant as teenagers, to leave school early, to have poor employment prospects and to be lone mothers. There is some debate as to whether teenage pregnancy itself changes the life trajectories of young women whose adverse socio-economic outcomes are at least in part accounted for by individual and family background. However few disagree that teenage mothers are a vulnerable group whose economic prospects are significantly worse than those of women who defer motherhood.

Teenage Pregnancy

4.1 The national teenage pregnancy programme has been set up to reduce the rates in the UK which are amongst the highest in Europe. The UK rates were comparable with other northern European countries in the 1970s but in continental Europe, teenage pregnancy fell in the following two decades, especially in Norway, Sweden, Denmark, Germany and the Netherlands.

4.2 Evaluation of the national programme has shown overall success in managing down the rate, notwithstanding that this is substantially higher than the projected national target. Successful local programmes are characterised by:

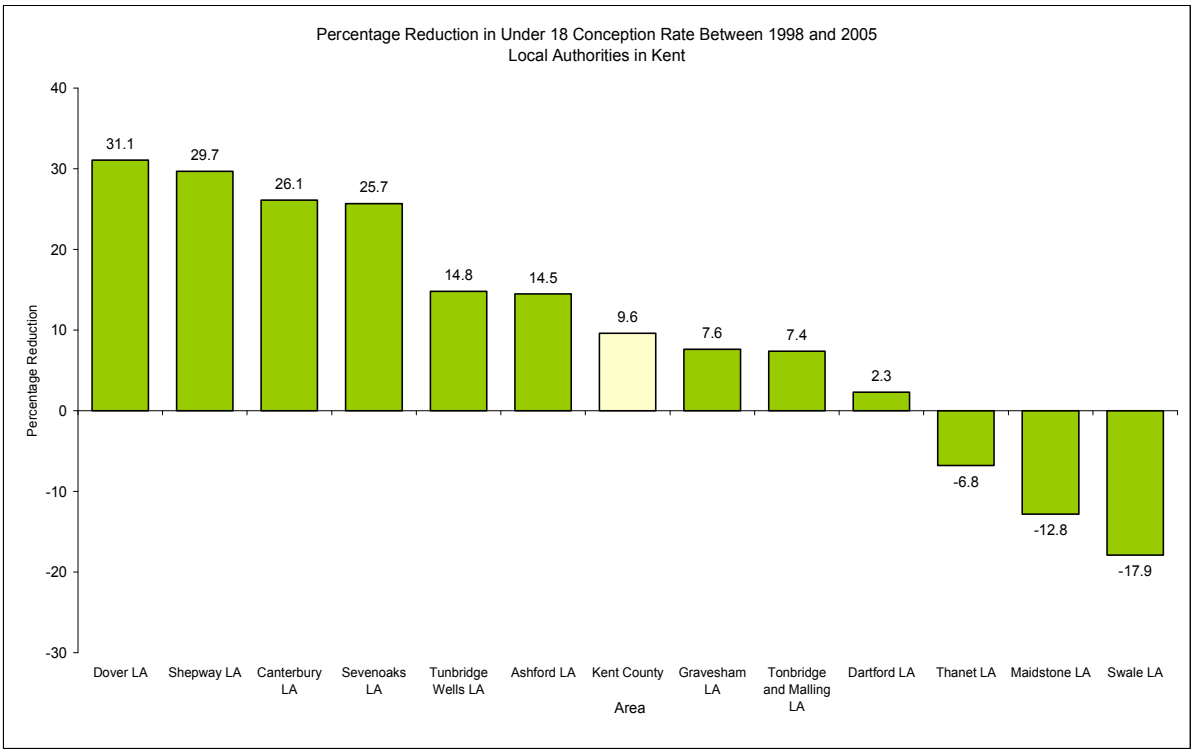
- Active engagement of the key mainstream delivery partners who have a role in reducing teenage pregnancy; health, education, children's services, youth services, voluntary sector;
- A strong local champion;
- Availability of well publicised young people centred contraceptive and sexual health advice service and strong remit to undertake health promotion work as well as delivering reactive services;
- A high priority given to Personal, Social and Health Education (PSHE) in all schools with support from the local authority to develop a comprehensive programme of Sex and Relationship Education (SRE) in all schools;
- A strong focus on targeted intervention with young people at greatest risk ot teenage pregnancy, especially looked after children;
- The availability (and consistent take-up) of SRE training for professionals in partner organisations such as Connexions Personal Advisors, youth workers and social workers working with the most vulnerable young people;
- A well resources youth service providing things to do and places to go for young people with a clear focus on addressing social issues affecting young people such as sexual health and substance misuse.

4.3 The local Kent programme has been subject to a recent KCC scrutiny committee (2007) which has made 18 specific recommendations as to how the Kent programme can be strengthened; highlighting in particular responsibility that schools have in this issue. Teenage pregnancy is not simply a public health issue. There are risk factors associated with pregnancy at an early age but these factors have more to do with socio-economic position than age.

4.4 A study commissioned by the Kent Teenage Pregnancy Partnership undertaken by the University of Kent, will shortly be published; the final outcome of an intensive survey of Kent children and of greater survey power than any nation-wide study. The survey should provide further insight into how the Kent programme can be further managed both at county and at local level.

4.5 Over the period of the teenage pregnancy programme, there has been a modest decline in the rate of teenage pregnancy in Kent. Nevertheless a significant number of children are living with a teenage mother.

Figure 20 – Percentage reduction in under 18 conception rates between 1998 and 2005



4.6 Throughout the periods monitored, the rate in Kent has been lower than the England and Wales average. Notable reductions have been achieved in Shepway, Canterbury and Dover, whilst the pattern in the west of the county has reduced at a lesser rate. Maidstone's and Swale's rates have increased. The rates are calculated on three year rolling averages.

4.7 The nature of the challenge to reduce teenage pregnancy is characterised by regular fluctuation in rates year on year.

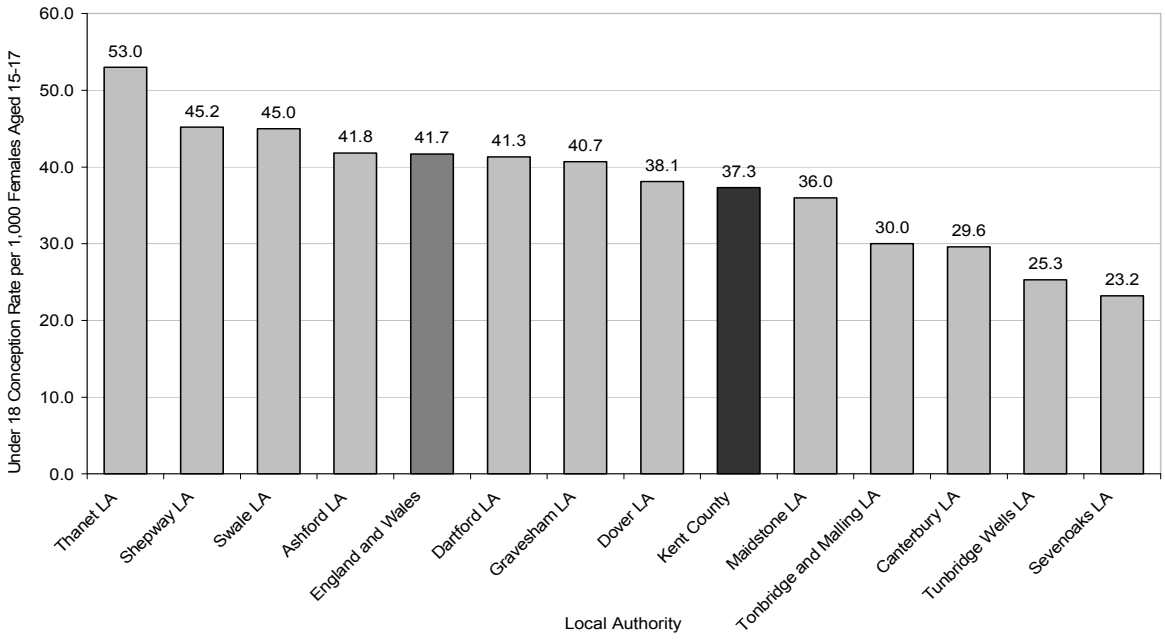
4.8 The welcome reduction is somewhat short of the national target to be achieved by 2010 and contained in the Kent LAA1 agreement.

Table 62 - Under 18 Conceptions in Kent districts, 1998-00 to 2003-05 and 2010 Target Rates

	Under 18 Conception Rate per 1,000 Females Aged 15-17						
Area	**1998-00**	**1999-01**	**2000-02**	**2001-03**	**2002-04**	**2003-05**	**2010 Target Rate**
Ashford LA	49.2	48.7	46.3	41.5	40.2	41.8	25.6
Canterbury LA	38.4	36.5	38.1	33.3	31.9	29.6	19.8
Dartford LA	43.8	46.1	48.6	47.3	45.0	41.3	19.6
Dover LA	44.8	41.4	38.9	34.6	39.1	38.1	23.6
Gravesham LA	43.0	39.8	38.4	34.9	38.4	40.7	21.6
Maidstone LA	32.2	33.8	35.9	34.9	36.2	36.0	15.6
Sevenoaks LA	27.5	23.5	22.6	22.4	23.2	23.2	15.7
Shepway LA	53.9	54.2	52.6	52.8	46.0	45.2	31.5
Swale LA	49.3	51.2	48.8	45.3	42.2	45.0	22.5
Thanet LA	61.5	59.7	57.5	50.0	48.0	53.0	29.6
Tonbridge and Malling LA	28.8	27.0	26.0	26.2	28.3	30.0	16.6
Tunbridge Wells LA	24.2	23.4	26.6	27.8	27.2	25.3	14.4
Kent County	**41.1**	**40.2**	**39.8**	**37.3**	**37.0**	**37.3**	**21.0**
South East Region	**36.6**	**35.6**	**35.1**	**34.1**	**33.6**	**33.6**	**18.9**
England and Wales	**45.4**	**43.9**	**43.1**	**42.6**	**42.3**	**41.7**	**23.3**

Source: Teenage Pregnancy Unit

Figure 21 - Under 18 conception rates in Kent districts, 2003-05



Source: Teenage Pregnancy Unit

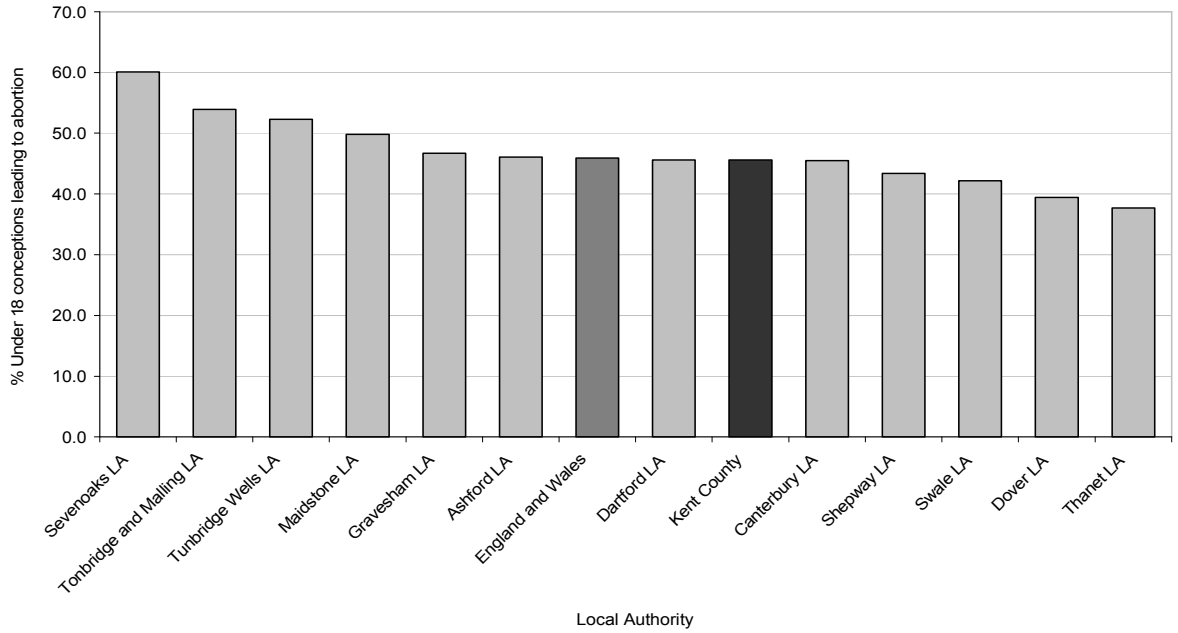
4.9 Overall there are higher rates of termination in west Kent. Easy access to termination services continues to be a challenge more particularly for some parts of east Kent. Teenage pregnancy is strongly associated with disadvantage. A significant proportion of the conceptions are less likely to be resolved in termination; in contrast to counterparts in wealthier areas. Pregnancy can be a calamity for those expected to become better educated, better skilled and to pursue a career. By contrast, motherhood can represent a rational and meaningful life option for young women with poor expectations.

Table 63 - Percentage of under 18 conceptions leading to abortion in Kent districts, 1998-00 to 2003-05

Area	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05
Ashford LA	36.0	38.6	36.1	39.8	40.3	46.1
Canterbury LA	35.2	41.6	43.8	47.0	45.1	45.5
Dartford LA	41.0	42.3	45.2	48.6	47.2	45.6
Dover LA	37.7	41.6	45.0	44.1	41.0	39.4
Gravesham LA	51.1	51.6	48.9	47.8	46.6	46.7
Maidstone LA	45.6	44.1	44.4	47.1	46.1	49.8
Sevenoaks LA	61.3	63.2	61.2	57.6	61.4	60.1
Shepway LA	35.6	38.1	40.1	40.4	41.3	43.4
Swale LA	38.0	41.2	37.8	37.0	36.1	42.2
Thanet LA	30.7	34.5	36.2	35.3	35.1	37.7
Tonbridge and Malling LA	48.4	46.8	51.9	54.1	52.8	53.9
Tunbridge Wells LA	43.9	46.7	50.3	56.2	52.0	52.3
Kent County	**40.3**	**42.6**	**43.3**	**44.6**	**43.9**	**45.6**
South East Region	**45.8**	**47.3**	**47.9**	**48.2**	**48.1**	**49.1**
England and Wales	**43.0**	**44.3**	**45.1**	**45.6**	**45.5**	**45.9**

Source: Teenage Pregnancy Unit

Figure 22 - Under 18 conceptions leading to abortion in Kent districts, 2003-05



Source: Teenage Pregnancy Unit

Conceptions in Under 16 Year Olds

4.10 Whilst the main focus of the reduction strategy is primarily upon the 15-17 year old group, it is important to highlight early conception rates since in the 13-15 year range the issue should be regarded as much as a child health issue as a matter of "teenage pregnancy". Incidence is often related to complex social circumstances.

4.11 A recent study on pregnancies amongst 16 year old young women and younger (Allen et al 2007) suggests, notwithstanding the small numbers in the study, that

relationships with parents, with the school as well as expectations for the future may have important influences on teenage pregnancies amongst this younger age group. Hosie's (2007) qualitative study further demonstrates linkages between a dislike of school, pregnancy and dis-engagement with education.

4.12 Relative to England and Wales, the Kent rate has been consistently lower and there is a welcome downward trend which is greater than the somewhat marginal decline from an England and Wales perspective. There is a marginal reduction within the area served by West Kent PCT and quite a notable reduction in Eastern and Coastal Kent. Despite this encouraging pattern, the rates are still unacceptably high, notwithstanding that the incidence is low.

Table 64 - Under 16 Conception Rates 2001-2003 and 2002-2004

Area	Under 16 Total Conception Rate per 1,000 Females Aged 13-15	
	2001-2003	2002-2004
Ashford LA	7.0	6.3
Canterbury LA	6.9	7.3
Dartford LA	8.7	7.5
Dover LA	6.2	6.6
Gravesham LA	8.0	7.9
Maidstone LA	7.4	7.5
Sevenoaks LA	4.3	3.7
Shepway LA	9.3	9.4
Swale LA	8.3	6.5
Thanet LA	11.2	9.4
Tonbridge and Malling LA	5.6	5.1
Tunbridge Wells LA	6.1	6.2
Kent County	**7.4**	**7.0**
South East Region	**6.5**	**6.2**
England and Wales	**7.9**	**7.8**

Source: Teenage Pregnancy Unit

Terminations

4.13 The table below analyses the trends relating to termination amongst conceptions in under 16 year olds. The rate within Kent County is less than the England and Wales rate. The figures as regards both PCTs appear to be consistent throughout the period 2001-2004.

4.14 Higher rates of termination are to be noted in both Ashford and Tonbridge and Malling. There is a much lower rate in Thanet which may reflect poorer geographical access to termination facilities.

Table 65 - Under 16 Conceptions leading to abortion, 2001-2003 and 2002-2004

Area	Under 16 Conceptions. % Leading to Abortion	
	2001-2003	2002-2004
Ashford LA	44.2	60.0
Canterbury LA	58.2	56.7
Dartford LA	53.5	52.6
Dover LA	47.5	43.2
Gravesham LA	46.8	48.9
Maidstone LA	60.0	58.6
Sevenoaks LA	63.0	58.3
Shepway LA	57.7	53.7
Swale LA	57.1	54.0
Thanet LA	41.7	39.4
Tonbridge and Malling LA	65.7	69.7
Tunbridge Wells LA	56.1	51.1
Kent County	**53.3**	**52.8**
South East Region	**57.6**	**58.2**
England and Wales	**56.3**	**56.7**

Source: Teenage Pregnancy Unit

Smoking

4.15 In UK surveys, the following definitions of smoking prevalence in children are used:

- Regular smokers – usually smoke at least one cigarette a week;
- Occasional smokers – usually smoke less than one cigarette a week
- Current smokers – all regular and occasional smokers.

4.16 There is some evidence that young people who smoke may under-report their usual smoking behaviour (National Statistics and NHS Information Centre 2006).

Risk factors associated with youth smoking:

- Parental smoking
- Peer influence from older siblings and friends
- Low socio-economic status
- Female
- Low parental education
- Living in a single parent household
- Poor academic performance
- Participation in risk taking activities
- Exposure to tobacco marketing activities
- Television and films
- Mental illness

Source: National Statistics and NHS Information Centre (2006)

4.17 Parental attitudes to smoking have been established as a major risk factor for smoking initiation, with permissive attitudes towards smoking increasing the risk. In England, 10% of children who smoke regularly report that they have been given

cigarettes by their parents. Children of parents who smoke are nearly three times more likely to smoke than those who come from non-smoking homes.

4.18 Smokers who begin to smoke at a young age are less likely to give up than those who start later in life. One study has shown that those who start before the age of 16 are more than twice as likely to continue smoking than those who begin later in life (Khuder et al 1999).

4.19 The majority of children surveyed in Kent understood that it was not healthy to smoke and equally, that it was not healthy to be around people who smoke. The percentage of regular smokers i.e. those smoking most days, should be noted. The formation of the smoking habit in adults is invariably taking place in late adolescence.

Table 66 – Frequency of children and young people (aged 11-19) smoking 2006/07

	Most days %		1 or 2 times a week %		1 or 2 times a month %		1 or 2 times a year %		Never %		No response %	
	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16
Whether children and young people smoke	7	15	2	3	2	4	3	5	85	73	1	1
Survey included 10,344 11-16 year olds and 961 post 16s												

Source: Children and Young People of Kent: Survey 2006/7

Table 67 - Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – Tobacco

Tobacco	Source
Smoking	
There is a lack of high-quality evidence about the effectiveness of combinations of social influences and social competence approaches in school	Cochrane Review
Enforcement of the law relating to cigarette sales to under-age youth can have an effect on retailer behaviour, but the impact on smoking behaviour is likely to be small	Cochrane Review
There is some support for the effectiveness of community-wide interventions in helping to prevent the uptake of smoking in young people based again on social learning theory/the social influences approach	Cochrane Review
There is some evidence that the mass media can be effective in preventing the uptake of smoking in young people in conjunction with other interventions	Cochrane Review
There is review-level evidence that increasing the price of cigarettes reduces tobacco use among both adolescents and young adults	Review of reviews

Alcohol

4.20 Whilst the evidence base for policy and practice in relation to substance misuse focuses on the misuse of drugs there is little in the way of an evidence base with respect to alcohol. This is as much a response to social attitudes with a general acceptance of sensible alcohol use as opposed to a concern for abstinence. The acceptance of links to social exclusion also means that alcohol misuse is increasingly seen as an integral part of the larger youth agenda and in conjunction with vulnerable groups such as the homeless, care leavers and youth offenders. There is little in the way of an evidence base in respect to alcohol misuse amongst adolescents as such.

4.21 A recent study (Viner and Taylor 2007) of 11,622 subjects from the 1970 British Birth Cohort Study, surveyed at aged 16 years (1986) and aged 30 years (2000) showed that binge drinking was reported in 17.7% of the cohort. It was associated with increased risk of drug/alcohol dependence, excessive regular consumption, illicit drug use, psychiatric morbidity, homelessness, convictions, school exclusions, lack of qualifications and lower adult social class. In short, adolescent binge drinking was a risk behaviour associated with significant later adversity and social exclusion and may contribute to the development of health and social inequalities during the transition from adolescence to adulthood.

4.22 In the 11-16 age group of the Kent Survey, 16% admitted to drinking alcohol and 9% said they got drunk at least one or two times a week. In the post-16 age group, 43% admitted to drinking alcohol and 25% said they got drunk at least one or two times a week. At the other end of the scale, 36% of 11-16s said they never drink alcohol and 61% said they never get drunk. These proportions decreased in the post-16 age group with only 11% saying they never drink alcohol and 23% saying they never get drunk.

Table 68 – Percentage of 11-19 year olds in Kent drinking alcohol and/or getting drunk

	Most days %		1 or 2 times a week %		1 or 2 times a month %		1 or 2 times a year %		Never %		No response %	
	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16
Whether children and young people drink alcohol	4	8	12	35	23	37	24	8	36	11	2	1
Whether children and young people get drunk	3	4	6	21	14	35	15	17	61	23	2	1
Survey included 10,344 11-16 year olds and 961 post 16s												

Source: Children and Young People of Kent: Survey 2006/7

Illicit Drug Use

4.23 Experimenting with unhealthy lifestyles is common among young people from all social backgrounds. Children from more deprived backgrounds are more likely to continue such behaviours into adulthood. A longitudinal study undertaken in the North of England suggests that English adolescents who try, occasionally use, or regularly use illicit drugs are not personally, educationally or socially atypical. Regular drug users are more likely, according to this study, to live in single parent families, to have poorer personal relationships with their parents and to go out in the evenings unsupervised. However in terms of their peers (age cohort) drug misusing youths could not be described as atypical (Egginton et al 2001).

4.24 The largely conventional identity of many young drug users has given rise to a normalisation thesis in respect to drug use, e.g. with regard to cannabis. It is important to stress that this does not run to heroin nor cocaine, since those drugs being more physically addictive, tend to pull people into lifestyles that centre on distancing friends to maintain a habit, i.e. it is a significant cause of crime. Moreover the normalisation thesis is not without problems. The use of heroin and cocaine is often a consequence of the normalisation of drug use and some users of recreational drugs, specifically in clubs, develop physical and psychological health problems resulting in A&E admission. Drug users with the greatest problems with regard to

health, wellbeing and economic prospects are those using heroin and crack cocaine in the poorest communities.

4.25 The Kent Drug and Alcohol Action Team Young People's Services commission interventions based on four tiers. Tier 1 is prevention work, tier 2 focuses primarily on vulnerable group interventions. Tier 3 is 1:1 care with drug workers; tier 4 involves intensive treatment sometimes in to residential settings.

4.26 For the year 2006/07 the total number of Kent young people at risk was identified and referred to KCA (the main provider of drug services in Kent) for group 2 intervention.

Table 69 – Tier 2 Outcomes

Excludees from school	Overall numbers of young people from PRUs and ACPs accessing KCA YPDAS for either 1:1 or group interventions	1097
Looked After Children	Overall number of young people from LAC and children's homes accessing KCA YPS for either support and interventions or group interventions	354
Young Offenders	Overall numbers of young offenders accessing KCA YPDAS for group interventions	519
Asylum seekers	To provide targeted drug and alcohol awareness	146
Children of substance misusing parents	To provide group intervention and 1:1 support to children of substance misusing parents	247
Total young people	Including those listed above	3285

4.27 Relative to the total number of children and young people in Kent up to 17, the numbers of young people deemed at sufficient risk for referral for specialist services is relatively small. However as referred to above, these numbers hide a far larger incidence.

4.28 A Drug Intervention Support Programme (DISP) has been commissioned to support a Kent PSA target "*to reduce the use of Class A drugs and the frequent use of any illicit drug amongst all young people under the age of 25 and especially the most vulnerable young people".* This is a level 2 programme early intervention tool for young people causing concern for their drug (or alcohol) use, to deter young people from risking drug related behaviour, to assess need and refer to other services; and specifically to provide an alternative to school exclusion and police prosecution. 384 referrals across Kent were made.

4.29 It is reported that the rate of re-offending or proceeding to committal of first offence following the completion of a DISP is currently less than 1% (2006-07). DISP provides a safety net for all young people who are at the experimental stage or vulnerable to drug use.

Table 70 - Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – Alcohol

Alcohol	Source
No firm conclusions about the effectiveness of psychosocial and educational interventions aimed at the primary prevention of alcohol misuse for those aged under 25 in the short and medium term are possible	Cochrane review
There is some evidence for effectiveness of peer-led prevention programmes and interactive programmes that foster the development of interpersonal skills. This also applies to smoking	Review of reviews

Minimum legal drinking age laws prevent alcohol-related crashes, supported by lower blood alcohol concentration laws	Review of reviews
Drugs	
Very little is known about treatment outcomes for young people	Overview
Family therapy appears to be superior to other treatment modalities in reducing substance misuse	Overview
Lack of review-level evidence	
Effectiveness of community programmes	
Interventions that focus on youth	
Initiatives to prevent progression to harder drugs and minimise harm from problematic drug use	

Obesity

4.30 Choosing Health in the South East (SEPHO 2005): Obesity stated that;

- Obesity decreases life expectancy by up to nine years and substantially increases the risk of many diseases, including heart disease, cancer and diabetes
- It has been estimated that if childhood obesity continues to rise at the current rate, children could soon expect to die younger than their parents.

4.31 In the recent Health Survey for England 2004, data showed that among boys and girls aged 2-15, the proportion who were obese increased between 1995 and 2004, from 11% in 1995 to 19% in 2004 among boys and from 12% in 1995 to 18% in 2004 among girls. In boys aged 11-15, as with younger boys, there was an increase in the proportion that were obese between 1995 and 2004 (14% to 24%). There were increases in this period among girls aged 11-15 who were overweight (14% to 19%) and obese (15% to 26%).

4.32 The alarming rate for children has led to the government setting a challenging Public Service Agreement (PSA) target, focusing on children.

'To halt the year-on-year rise on obesity among children under 11 years, by 2010, in the context of a broader strategy to tackle obesity in the population as a whole'.

4.33 Since 2006 children entering the reception year have been assessed for obesity or being overweight as part of the health checks routinely undertaken by the School Nursing Service. Year 6 children area also measured for body mass index (BMI). The latter has been problematic. Governing bodies of some schools have been reluctant to collaborate with this new programme. Moreover reflecting behaviours reported nationally, it is strongly suspected that parents with children judged to be at risk of such classification are either refusing to consent to their children's participation in such measurements or otherwise absenting their child on the day in question. There is also an anecdotal suggestion that year 6 girls are reluctant to be measured for BMI. A recent letter (spring 2007) jointly sponsored by the Department for Education and Skills and the Department of Health has been sent to every primary school in England urging greater compliance. The estimation of obesity in children and the determination of targeted response is crucially dependent upon reliable data.

Programmes Across Kent to Address Obesity

4.34 Programmes across Kent have included:

- The National Healthy Schools Programme engages everyone – staff, pupils, governors, parents and the wider community in a whole school approach that aims to improve educational achievement, health and emotional wellbeing and makes schools a safe, secure and healthy environment in which young people can learn and develop;
- Sure Start Programme – offers one stop support for childcare, early education, employment support, health advice etc with a full core offer for deprived communities. Provides advice and support to parents and parents-to-be in order to promote breastfeeding, good weaning, active play and healthy lifestyles in families with children aged 0-5;
- "Play the Big Lottery Fund" has made available £155 million to create, improve and develop children's play provision (in England) and develop innovative practice;
- School Food Agenda – to invest in improving nutrition in school meals by revising both primary and secondary school meals standards, strongly considering nutrient-based standards, reducing the consumption of fat, salt and sugar and increasing the consumption of fruit and vegetables and other essential nutrients. Subject to legislation, the new standards will be extended to cover food across the school day, including in vending machines and tuck shops. Schools will be supported with new guidance on food procurement and improved training and support for school meal providers and catering staff;
- School Fruit and Vegetable Scheme to make all 4-6 year old children in LEA-maintained infant, primary and special schools in England eligible for a free piece of fruit or vegetable every school day.

4.35 Addressing the challenge of child obesity requires:

- A change in population awareness through clear food labelling, restrictions in advertising of unhealthy foods to children and the piloting of community-wide approaches;
- A focus in early years and school settings that fosters a healthy environment, including the provision of active help for children at risk of becoming overweight;
- Support treatment programmes to assist changes in child and family behaviour towards maintaining a healthy weight;
- The appraisal of the potential of social marketing techniques to communicate simple and positive messages about healthy lifestyles;
- The provision of appropriate workforce training and the development of a targeted evidence of what works specifically as regards children and young people;
- The systematic collection of local data;
- An action-learning approach to treatment interventions.

Exercise

4.36 Boys aged 11-16 (63%) are more likely than girls (48%) to exercise for one or more hours a day. In contrast, girls (42%) are more likely to exercise one or two times a week compared to boys (25%).

Table 71 - Percentage of 11-19 year olds in Kent who exercise for 1 hour or more 1 or 2 times a week, 2006/07

	Most days %		1 or 2 times a week %		1 or 2 times a month %		1 or 2 times a year %		Never %		No response %	
	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16
Whether children and young people exercise for 1 hour or more	56	39	34	37	4	14	2	5	4	5	1	1
Survey included 10,344 11-16 year olds and 961 post 16s												

Source: Children and Young People of Kent: Survey 2006/7

Diet

4.37 It has been suggested that the Government's National Diet and Nutrition Survey (NDNS) exposes a pattern of modern malnutrition especially in low income families (Gregory et al 2000). There is a social class and income gradient, with households in the lowest income brackets consuming less fruit and vegetables, skimmed milk, fish, fruit juices and breakfast cereals than average, despite spending a greater proportion of their income on food than those in better off households.

4.38 One contributory factor is believed to be food poverty and those living in the poorest areas having reduced access (although the reasons for this are debated) to good quality affordable food. Despite suggestions that adults in poverty protect their children's diets at the expense of their own it has been suggested that 1 in 50 children do not get three meals a day (Dowler et al 2001). Social and cultural norms, knowledge and health motivation are important in this regard. Skipping breakfast for example is particularly common among adolescent girls.

4.39 The recent NFER survey of Kent children shows that 15% of primary school children do not regularly experience the occasion of a family meal most days. This rises to 32% for children 11-16 – possibly reflecting increased participation by both parents in the labour market. For over 16s, 61% of those surveyed participate in a family meal most days.

Table 72 - Percentage of children and young people in Kent sitting down to a family meal most days, 2006/07

Age band	% of those surveyed*
7-11	85
11-16	68
Post 16	61
* Survey included 31,527 7-11 year olds, 10,344 11-16 year olds and 961 post 16s	

Source: Children and Young People of Kent: Survey 2006/7

Healthy Eating Initiatives

4.40 A systematic review of interventions designed to promote healthy eating (Roe et al 1997) suggests the key is behavioural change with the intervention matched to the population characteristics. Effective interventions include a supportive family, social and structural environment, a personal approach with conduct sustained over time, multiple strategies that address barriers to change and influence the local environment and training for those involved in the delivery and support of such programmes.

4.41 The national recommendation for a healthy diet is to eat five or more portions of fruit and vegetables a day. On average in Kent, this level of consumption is only achieved by about 25% (1 in 4) of the population.

4.42 Action is needed at the levels of individuals, communities and the county as a whole, with the co-operation of a wide range of partners, seeking wholesale change in the public's perspective and behaviour and in the 'obesogenic' environment.

4.43 Following the publication of Choosing Health; making healthier choices easier (DH 2004) two documents were published to support the overall delivery plan; *Choosing Activity: a physical activity action plan* and *Choosing a better diet; a food and health action plan.* (SEPHO).

4.44 Both these documents set out a raft of national initiatives to be implemented at a local level to reduce obesity in the population.

4.45 The objectives to improve nutritional balance are:

- To increase the average consumption of a variety of fruit and vegetables to at least five portions a day;
- To increase the average intake of dietary fibre to 18gms per day;
- To reduce the average intake of saturated fat to 11% of food energy;
- To maintain the current trend in the average total intake of fat at 35% of food energy;
- To reduce the average intake of added sugar to 11% of food energy.

4.46 The data available is not disaggregated to district council areas and reflects former PCTs. Notwithstanding these limitations, it is notable that children in Swale, Dover and Thanet areas have a significantly lower consumption of fruit and vegetables compared to the England average.

Table 73 - Synthetic[3] estimate of consumption of fruit and vegetables for children, 2000-2002

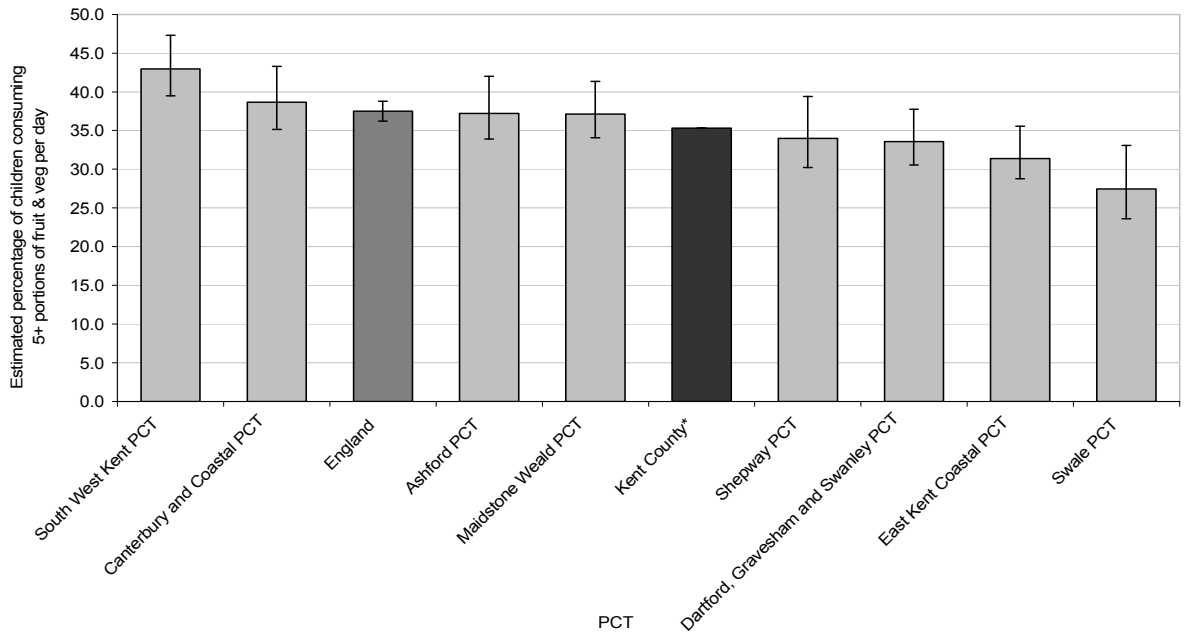
PCT	% of children aged 5-15 consuming 5+ portions of fruit and vegetables per day	95% LCL	95% UCL
Ashford PCT	37.2	33.9	42.0
Canterbury and Coastal PCT	38.7	35.1	43.3
Dartford, Gravesham and Swanley PCT	33.6	30.6	37.8
East Kent Coastal PCT	31.4	28.8	35.6
Maidstone Weald PCT	37.1	34.1	41.3
Shepway PCT	34.0	30.2	39.4
South West Kent PCT	42.9	39.5	47.3
Swale PCT	27.4	23.6	33.1
Kent County*	**35.3**	**-**	**-**
England	**37.5**	**36.2**	**38.8**

Footnote: Please note that these data were created from the ward level estimates which can also be found on the Neighbourhood Statistics website. The PCOs were built up from aggregation of "best-fit" ward data. Since PCOs and Wards are not co-terminus, this information is not exact. The national estimate is derived directly from the Health Surveys for England 2000-02 (with associated Confidence Intervals) and therefore is not a synthetic estimate.

* Kent figure is an average of constituent PCTs

Source: Synthetic Estimates of Healthy Lifestyle Behaviours, Health & Social Care Information Centre

Figure 23 - Synthetic estimate of consumption of fruit and vegetables for children, 2000



Source: Synthetic Estimates of Healthy Lifestyle Behaviours, Health & Social Care Information Centre

4.47 Around half the participants in the NFER Survey reported eating five or more portions of fruit or vegetables on most days. The proportion of post-16s who reported such consumption on most days is slightly less. 30% of 11-16 year olds and 35% of post-16 year olds reported eating take away food at least one or two times a week.

3 Synthetic estimates are estimates of incidence or prevalence that have been derived from a particular population and then applied to the demographic structure of another.

Table 74 – Percentage of children and young people (aged 11-19) eating 5 portions of fruit or vegetables a day

	Most days %		1 or 2 times a week %		1 or 2 times a month %		1 or 2 times a year %		Never %		No response %	
	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16
Whether children and young people eat 5 portions of fruit or vegetables a day	50	42	34	35	7	12	2	3	6	7	1	1

Survey included 10,344 11-16 year olds and 961 post 16s

Source: Children and Young People of Kent: Survey 2006/7

Table 75 - Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – Nutritional Status

Nutritional Status	Source
Obesity	
Two key reviews (one on treatment and one on prevention) suggest no direct conclusions can be drawn with confidence	Cochrane Review
There is some evidence that multifaceted school-based programmes that promote physical activity, modify diet and target sedentary behaviour can reduce the prevalence of obesity among school children	Review of reviews
There is less evidence that preventative efficacy attaches to any of these elements alone or to a multifaceted focus on the family	Review of reviews
Multifaceted family behaviour modification programmes can be effective in the targeted treatment of obesity	Review of reviews
Healthy eating	
Healthy eating interventions can prompt behavioural change and reduce fat intake and blood cholesterol but such reductions tend to be minimal (approximately -3% total fat intake)	Other review
Lack of review-level evidence	
Information on adolescents	
Studies from the UK	
Sustainable weight-loss treatments	
Interventions for preventing eating disorders	
Upstream interventions	

Sexual Health

4.48 Young people generally have a higher number of sexual partners, a greater number of concurrent partnerships and change partners more often than older age groups (HPA et al, 2003). As a result they are more vulnerable to acquiring a sexually transmitted infection (STI). Sexual health has deteriorated in recent years – surveillance data indicated a rise in the prevalence of acute STIs since 1999, with a particularly steep increase being noted for those aged 24 years and under. Between 1997 and 2002, diagnoses of chlamydia, gonorrhoea and new HIV infections have doubled and new diagnoses of syphilis have increased ninefold (data derived from the Health Protection Agency).

4.49 Public Service Agreement 11b requires that by March 2008, all patients attending genito-urinary medicine (GUM) clinics are offered an appointment within 48 hours of contacting the service and also that these patients are seen as soon as possible.

4.50 Comprehensive monitoring of the 'Offered' target has not been possible until very recently due to the gradual upgrading of antiquated patient administration systems. As a proxy measure, the Health Protection Agency introduced a patient survey to report the percentage of patients seen within 48 hours. Further details can be found at the following website:

http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/wtimes.htm

4.51 The survey is run for one week each quarter and completion is not compulsory, therefore the results represent a relatively small sample of the total.

Figure 24 – Percentage patients seen within 48 hours

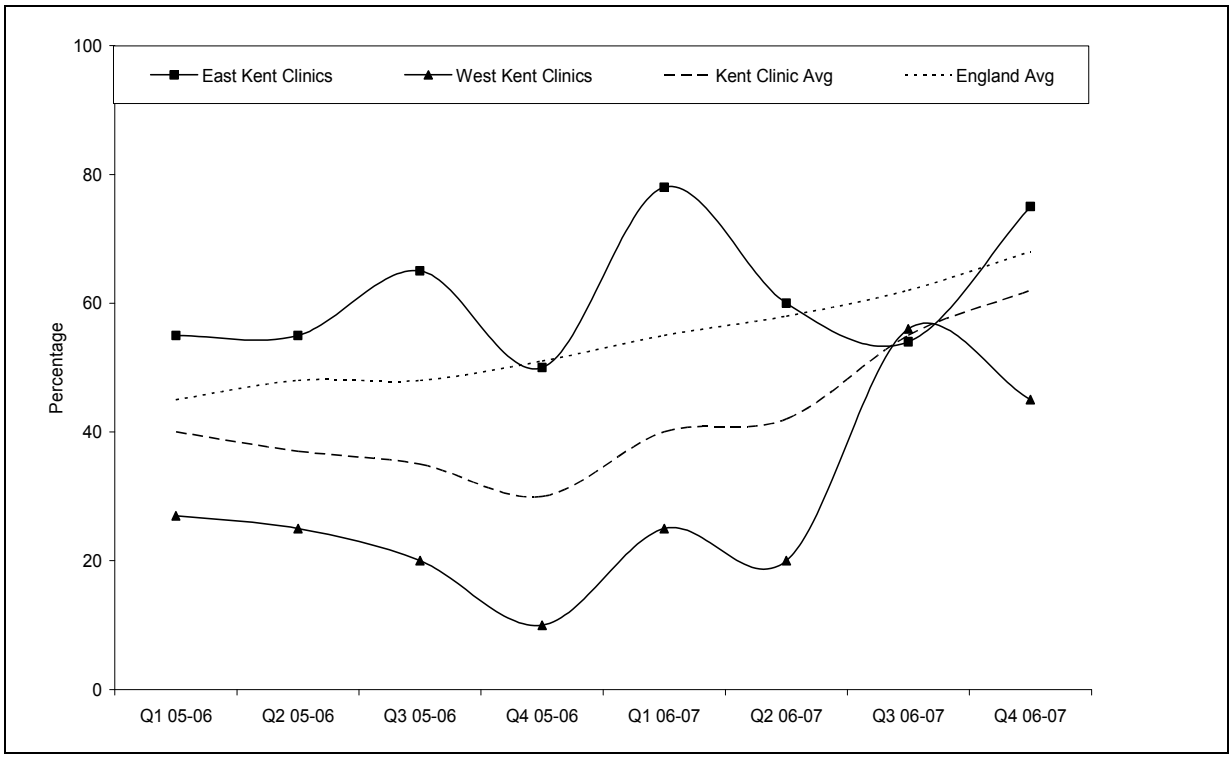


Table 76 - Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – Sexual Health

Sexual Health	Source
There is good evidence to support school-based sex education; education linked to contraceptive services alongside the community-based delivery of education, development and contraceptive services; youth development programmes; and family outreach (but this is not supported by RCTs)	Review of reviews
STI campaigns increase condom use and can delay initiation and reduce the frequency of sex, potentially reducing unintended pregnancy as well	Review of reviews
Programmes that offer educational support or improve job prospects may motivate young people to avoid pregnancy	Overview/Cochrane Review
Parenting programmes and ante-natal care programmes may be effective in	Cochrane review

improving outcomes for both teenage mothers and their infants	
Lack of review-level evidence	
Early fatherhood	
Upstream interventions versus poverty and disadvantage	
Interventions relating to the UK	

Gambling

4.52 Adolescent gambling is a cause for concern in the UK and is related to other delinquent behaviours. For instance, in one study of over 4,500 adolescents, gambling was highly correlated with other potentially addictive activities such as illicit drug taking and alcohol abuse (Griffiths and Sutherland, 1998). Another study by Yeoman and Griffiths (1996) demonstrated that around 4% of all juvenile crime in one UK city was slot machine-related, based on over 1,850 arrests in a one year period. It has also been noted that adolescents may be more susceptible to problem gambling than adults.

4.53 A typical finding of many adolescent gambling studies has been that problem gambling appears to be a primarily male phenomenon. It also appears that adults may to some extent be fostering adolescent gambling. For example, a strong correlation has been found between adolescent gambling and parent gambling (Wood and Griffiths, 1998; 2004). Other factors that have been linked with adolescent problem gambling include working class youth culture, delinquency, alcohol and substance abuse, poor school performance, theft and truancy (Griffiths 1995; Yeoman and Griffiths 1996; Griffiths and Sutherland 1998).

4.54 A MORI survey also found that:

- 17% of adolescents are regular fruit machine players (playing at least once a week);
- 3.5% of adolescents are probably pathological gamblers and/or have severe gambling related difficulties.

4.55 All studies have reported that boys play on fruit machines more than girls and that as fruit machine playing becomes more regular, it is more likely to be a predominantly male activity. Research suggests that irregular ('social') gamblers play for different reasons than the excessive ('pathological') gamblers. Social gamblers usually play for fun and entertainment (as a form of play), because their friends or parents do (i.e. it is a social activity), for the possibility of winning money, because it provides a challenge, because of ease of availability and there is little else to do and/or for excitement (the 'buzz').

4.56 Pathological gamblers appear to play for other reasons such as mood modification and as a means of escape. Like other potentially addictive behaviours, fruit machine addiction causes the individual to engage in negative behaviours. This includes truanting in order to play the machines, stealing to fund machine playing, getting into trouble with teachers and/or parents over their machine playing, borrowing or the using of lunch money to play the machines, poor schoolwork and in some cases aggressive behaviour (Griffiths 2003b). Fruit machine addicts also display bona fide signs of addiction including withdrawal effects, tolerance, mood modification, conflict and relapse.

4.57 It is clear that for some adolescents, gambling can cause many negative detrimental effects in their life. Education can be severely affected and they may acquire a criminal record as most problem gamblers have to resort to illegal behaviour to feed their addiction.

4.58 Whilst amusement arcades can be found in every town, they are a particular feature of coastal towns in Kent and it is likely that here the highest risks and incidence of adolescent gambling will be found. Further work needs to be done to analyse the local problem. Licensing authorities need to be made aware of the risks to children and young people.

Crime

4.59 Collective responsibility to prevent youth offending, shared between a range of public voluntary agencies and also the wider community, is established national policy. Youth Offending Teams (YOTs) are responsible for preventing offending and re-offending by young people. Community Safety Partnerships are responsible for cutting down overall crime levels, a significant proportion of which involve young people either as victims or offenders.

4.60 The work of YOTs tends to be dominated by courts and pre-court work, Community Safety Partnerships focus on prevention, situational measures and civil orders such as Anti Social Behaviour Orders (ASBOs). The goal of reducing young people's involvement in crime needs Community Safety Partnerships to influence work with the most prolific offenders and YOTs need to be involved in preventive measures ranging from targeted provision, such as intensive mentoring to impact on universal services – education, housing, employment and health, which make a critical difference to offending patterns in the long term.

4.61 Health and mental health services have crucial roles to play in meeting the wide needs of young offenders and a need to involve schools directly (Audit Commission 2004). Every Child Matters (DfES 2004) argues for the co-location of front line staff in Children's Centres, extended schools and health settings to increase the opportunities for the early identification of risk.

Youth Offenders

4.62 It is well established that young offenders are a vulnerable group, with complex psychosocial, physical and mental health needs. 40% of young offenders have a diagnosable mental health disorder.

4.63 Many of these young people suffer from conduct disorders, problems with social understanding and disorders on the autistic spectrum.

4.64 Generally, research suggests detection of problems in this population is imprecise and tends towards under-estimation, particularly of internalising disorders (i.e. disorders of emotion such as depression).

4.65 There are no widely used screening instruments for detecting mental health problems within the youth justice system in England, although the Youth Justice Board standard general assessment tool (ASSET) contains a brief rating of mental health status as linked to the offending behaviour. There are no statistics on reliability and validity of the ASSET.

4.66 Despite the high incidence of mental health problems in this group, only a small proportion of young offenders with mental health problems are receiving help from specialist CAMHS. The National CAMHS Mapping Exercise in 2004 showed of the total caseload of CAMHS, only 5% were young offenders.

4.67 This table represents convictions of young people and does not include those who may be cautioned. The proportion of young people entering the Youth Offending Service is small relative to the overall youth population.

Table 77 - New entrants to Youth Offending Service in Kent districts, 2005/06

Local Authority	Number of new entrants	Pop 10-17 (2005 Mid yr est)	% of 10-17 population
Ashford LA	184	11700	1.57%
Canterbury LA	161	14800	1.09%
Dartford LA	100	9400	1.06%
Dover LA	120	12000	1.00%
Gravesham LA	84	10800	0.78%
Maidstone LA	136	14500	0.94%
Sevenoaks LA	112	11900	0.94%
Shepway LA	260	10200	2.55%
Swale LA	187	14200	1.32%
Thanet LA	259	14000	1.85%
Tonbridge and Malling LA	88	12900	0.68%
Tunbridge Wells LA	83	12200	0.68%
Kent County	**1774**	**148500**	**1.19%**
England & Wales	**85467**	**5486100**	**1.56%**

Source: Data Extracted from Careworks, THEMIS return

4.68 Overall there is a downward trend in crime committed against children and young people. It is possible to hypothesise that the greater proportion of such crimes are committed by adults rather than amongst the peer group.

Table 78 - Crimes committed against 1-18 year olds in Kent, April-Oct 2003 to 2006 (Note: may be double counting if someone has been victim more than once)

	Apr-Oct			
Area	**2003**	**2004**	**2005**	**2006**
Kent	6830	7622	6696	6474

Source: Children, Families and Education Directorate, KCC

4.69 The increase in the sense of safety relative to age is a reflection of the growing confidence of young people as they mature and start to live independently.

Table 79 - Whether children and young people in Kent feel safe some/most of the time, 2006/07

	% of those surveyed*		
	7-11	11-16	Post 16
In school/college	65	91	97
In the area they live	67	90	92
Getting to and from school/college	75	91	95
* Survey included 31,527 7-11 year olds, 10,344 11-16 year olds and 961 post 16s			

Source: Children and Young People of Kent: Survey 2006/7

4.70 Table 80 demonstrates a range of issues that cause children and young people concern and potentially give rise to insecurity.

Table 80 - Things making children and young people in Kent feel unsafe where they live, 2006/07

7-11 year olds

Worry about the following:	% of those surveyed*
Broken glass on ground	69
People hanging around	68
Busy roads/speeding traffic	62
Being on a bus or train	41

11-19 year olds

	% of those surveyed*	
Feel unsafe most/some of the time due to the following:	11-16	Post 16
People carrying knives	56	44
People on drugs	49	71
Gangs	58	90
Groups of people hanging around	58	92
Dark or unlit places	56	88
People drinking/being drunk	46	73
Busy roads/speeding traffic	40	68
Broken glass or syringes lying around	32	53
Being on a bus or train	32	56

Source: Children and Young People of Kent: Survey 2006/7

Evidence of Wellbeing - Making a Positive Contribution Amongst Children and Young People

Table 81 – Whether children (aged 7-11) engage with the community

Whether children:	Yes %	Not sure %	No %	No response %
Would tell an adult if they saw someone being bullied	81	13	4	2
Help other people	80	15	3	2
Help collect money for charity	44	29	25	2
Survey included 31,527 7-11 year olds				

Source: Children and Young People of Kent: Survey 2006/7

4.71 The majority of children (about four fifths) indicated that they would tell an adult if they saw someone being bullied and a similar proportion indicated that they helped other people. A lower proportion (just over two fifths) indicated that they help collect money for charity, although a further 29% were unsure if they did.

4.72 Younger children were more likely to say that they would tell an adult if they saw someone being bullied than older children (88% of year 3 compared to 76% of year 6). Younger children were more likely to report that they help collect money for charity compared to older children (53% of year 3 compared to 39% of year 6).

Table 82 – Whether children and young people (aged 11-19) engage with the community

Do/would children and young people:	I do already %		I would like to do %		No I wouldn't do this %		No response %	
	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16
Help someone who is being bullied	27	22	55	62	9	10	9	5
Raise money for charity	26	25	51	51	18	15	6	9
Help a neighbour	30	25	45	53	16	16	9	6
Do voluntary work	14	20	41	40	35	34	10	6
Vote in a school/college election	19	17	30	31	41	47	10	5
Join in a school/college council	11	10	21	20	58	64	10	6
Survey includes 10,033 11-16 year olds and 961 post-16 year olds								

Source: Children and Young People of Kent: Survey 2006/7

4.73 About a quarter of young people in both age groups (11-16 and post-16) reported that they already helped their neighbours (30% and 25% respectively), raised money for charity (26% and 25% respectively) and helped people who were being bullied (27% and 22% respectively). Approximately half said they would like to help someone who was being bullied (55% and 62% respectively), raise money for charity (51% and 51% respectively) and help a neighbour (45% and 53% respectively).

4.74 About 40% of young people would like to do voluntary work, about 30% would like to vote in a school or college election and about 20% would like to join a school or college council. The proportions of young people already participating in these activities were between 10% and 20%.

4.75 Young people aged 11-16 who were eligible for free school meals (42%) were more likely to help their neighbour than those not eligible for free school meal (32%). However half of 11-16s (50%) who were not eligible for free school meals would like to help their neighbour compared to 40% of young people eligible for free school meals.

4.76 Young people with English as an additional language were more likely to say they would like to do voluntary work (64%), help a neighbour (59%), vote in a school election (45%) and join a school council (42%) compared to 11-16s without English as an additional language (45%, 49%, 33% and 22% respectively).

4.77 Girls aged 11-16 were more likely to say they would like to do voluntary work compared to boys (52% and 39% respectively). Girls were more likely to say they would like to help someone who was being bullied (74%), help a neighbour (65%) and do voluntary work (52%) compared to boys (59%, 47% and 32% respectively).

Table 83 – Whether children (aged 7-11) support the environment

Do children:	Yes %	Not sure %	No %	No response %
Always put litter in the bin	77	14	7	2
Recycle	67	17	14	2
Survey includes 31,527 7-11 year olds				

Source: Children and Young People of Kent: Survey 2006/7

4.78 Over three quarters of children indicated that they always put litter in the bin and over two thirds said that they recycled. 7% of children admitted to not putting litter in the bin and 14% said they did not recycle. Children eligible for free school meals were less likely to report that they recycled (59%) compared to other children (69%).

Table 84 – Whether children and young people (aged 11-19) support the environment

Whether children and young people would consider:	They do already %		They would like to do %		No %		No response %	
	11-16	Post-16	11-16	Post-16	11-16	Post-16	11-16	Post-16
Recycling	56	62	22	25	14	8	9	5
Survey includes 10,033 11-16 year olds and 961 post-16 year olds								

Source: Children and Young People of Kent: Survey 2006/7

4.79 About three fifths of young people (56% of 11-16s and 62% of post-16s) indicated that they already recycled. About a further quarter (22% of 11-16s and 25% of post-16s) reported that they would like to recycle. Young people aged 11-16 not eligible for free school meals (62%) were more likely to recycle than those young people eligible for free school meals (52%).

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Appendix 1 - Summary of recommended UK child health surveillance programme

Age	Review and screening procedures	Immunisation	Health promotion
Newborn	**Review:** Family history Pregnancy Birth **Full physical examination including:** Weight Heart and pulses Hips Birth marks Testes Head circumference plotted Eyes (exclude cataracts and squint) Guthrie test after 6 days (PKU, hypothyroidism) Sickle cell (if indicated) Cystic fibrosis **Consider** Risk factors for hearing loss – refer to *Can your baby hear you?* In PCHR. **If high risk then refer to Oto-acoustic emission, brainstem auditory evoked response**	BCK (high risk) Hep B (if mother is a carrier)	Cot death prevention Feeding technique Nutrition Baby care Crying Sleep Car safety Family planning Passive smoking Dangers of shaking baby Sibling management
10 – 14 days	Guided by results and review of neonatal check Assess and establish levels of support and assistance required Review sickle cell and thalassaemia test (if appropriate)	Review BCG and Hep B status Introduce to immunisation programme and obtain informed consent	Nutrition Breast feeding Passive smoking Accident prevention; bathing, scalding and fires Explanation of tests and results Encouraging parents to request results of all tests Significance of prolonged jaundice Depression, coping and help (parents/carers)
6-8 weeks	**Review:** Parental concerns, e.g. vision, hearing, activity Risk factors including significant family history	1st DT Pert Hib/Pol Meningococcal C	Immunisation Nutrition and dangers of early weaning Accidents; fires, falls, over-heating, scalds

	Full examination including: Weight Head circumference Centile plotting Hip check Testes Eyes – red reflex, squint, movement, tone and general development Heart and pulses Report Guthrie results back to parents		Refer parent to *Can your baby hear you?* in PCHR Recognition of illness in babies and what to do Fever management Crying Sleeping position Passive smoking Review of car safety Depression (parents/carers)
2-4 months	Parental concerns	2nd and 3rd DT Pert Hib/Pol Meningococcal C	Weighing as appropriate Maintain previous health promotion Promotion of language and social development Refer parent to *Can your baby hear you?* in PCHR Deter future use of baby walkers
6-9 months	Discussion of developmental progress, asking specifically about vision, hearing and language development Check weight and head circumference as required or if parental concern Observe behaviour and look for squints		Parental concerns Nutrition Refer parent to *Can your baby hear you?* in PCHR Accident prevention: fires, choking, scalding, burns, stair gate, fire guard, etc Review of transport in cars Dental care Play and development needs
13 months		1st MMR	
18-24 months	Parental concerns, behaviour, vision and hearing Observe gain Emphasise value of comprehension and social communication in relation to speech development (speech and language screening tests) Public health 'sign off' – check records to ensure full coverage of screening and immunisation	Review immunisation status	Safety – accident prevention, falls from heights, drowning, poisoning, road safety Development – language and play Management and behavioural issues Promote positive parenting Toilet training Diet, nutrition, prevention of iron deficiency
39-48	Enquiry and discussion of vision, squint, hearing,	Check immunisation status	Safety – accident prevention, burns, road

months	behaviour, language acquisition, development – referral as necessary Education needs and choices – notification of any special educational needs and choices Measure height and plot Check testicular descent has been recorded, if not examine Where concerns about hearing impairment, perform test (e.g. McCormick toy discrimination test) Visual acuity by orthoptist	DT/polio (pre school booster) 2nd MMR	safety, drowning, poisoning, falls from heights Development – language and play socialisation Management of behaviour issues School readiness Nutrition/diet Dental care Toilet training
5 years: school entrant	Review preschool record including a check for record of testicular and heart examination School entrant review – parent and school nurse Establish teachers'/parental concerns Height (plot and compare with previous measurements), weight and hearing sweep Visual acuity (Snellen) if not previously carried out Observation of gait and fine motor skills	Review of immunisation status	Obtain consent for planned programme and health checks Access to school health School health surveillance programme Sleep Friendships/settling at school Accident prevention, road safety, stranger danger Dentist, dietitian Management of medicines at school Care in the sun
7-8 years (Year 3)	Teacher concerns Review of records Height, weight, vision General health check Issued raised by child		Accident prevention, road safety, safety at play, stranger danger Friendships Exercise, nutrition and dental care Care in the sun
11-12 years (Year 7)	Visual acuity Colour vision General health check Issues raised by young person Support for individual programmes of care		Accident prevention Relationships Exercise/nutrition Smoking Dental care Management of medication in school Puberty/sexual health Care in the sun
12-13 years (Year 8)		Heaf test BCG	
14-15 years (Year 10)	General health check including height, weight, vision (where concerns)	TB/polio booster	Substance abuse – alcohol, smoking, drugs, solvents

	Issues raised by young person		Diet/exercise Testicular self-examination, promotion of cervical cytology Sexual health Promotion of GP well woman/man check Information about health services, e.g. teenage clinics, health shop Dental health Careers
15-16 years (Year 11)	Self-referral – issues raised by students	Information to school leavers on need for immunisations as adult catch-up immunisation	Stress management Self referral – issues raised by students

Source: Health for all children (4th edition) 2002, Oxford University Press, Oxford

Appendix 2 – Vaccination Schedule

Age	Immunisation	
1st dose at 2 months 2nd dose at 3 months 3rd dose at 4 months	Diphtheria/tetanus/pertussis/poliomyelitis/ *Haemophilus influenzae* type b, DTaP/IPV/Hib (Pediacel®)	Each dose is one injection
1st dose at 3 months 2nd dose at 4 months 3rd dose at 12 months	Meningococcal Group C At 12 months this is given combined with Hib (Hib/MenC, Menitorix®)	Three doses of vaccine are recommended for any child under 1 year of age. From 1 year to 24 years of age, a single dose is recommended
1st dose at 2 months 2nd dose at 4 months 3rd dose at 13 months	Pneumococcal Conjugate Vaccine	Each dose is one injection
1st dose at 13 months 2nd dose 3 to 5 years The aim is that the 2nd dose should be given between 3 years 4 months and 3 years 6 months	Measles, Mumps, Rubella (MMR)	Each dose is one injection
3 to 5 years The aim is that this should be given between 3 years 4 months and 3 years 6 months	Diphtheria/tetanus/pertussis/ Poliomyelitis, DTaP/IPV (Repevax®) or dTaP/IPV (Infanrix/IPV®) Between 10 September 2007 and 3 March 2009 this pre-school booster vaccine will be changed to DTaP/IPV/Hib (Infanrix-IPV+Hib®, a new combined vaccine). After this time the schedule will revert to using the previous vaccines.	One injection
Neonates at increased risk and any unimmunised children in high risk groups	Tuberculosis: Bacillus Calmette-Guérin Vaccine (BCG)	In older children, a skin test is required before immunisation
13 to 18 years	Diphtheria (low dose)/tetanus/poliomyelitis, Td/IPV (Revaxis®)	

Recommendations

General commissioning principles

1. The dataset used in the Strategic Needs Assessment should be used to guide commissioning at both county and local level.

2. The finally agreed dataset used should be standard for both county and local level.

3. As regards non-health data, further analysis of education, social care and NFER data should be undertaken to the lowest localised level of analysis. This should normally be local authority electoral ward as the common denominator to assist inter-agency partnership working and to ease re-aggregation to primary care and school cluster level.

4. Investments should be targeted in accordance with the principle of equity to areas of greatest need, as reflected in the Needs Assessment in order to maximise response and improve outcomes.

5. Further to 4 above, all funding agencies should agree differential funding targeted at those issues and also those parts of Kent identified as having greatest needs.

6. The overall decline in the number of children relative to the population at large should not be used as a savings dividend; rather as the opportunity to improve service quality and to appropriately respond to ever increasing, complex and newly emerging needs.

7. An agreed multi-agency dataset focusing towards improved outcomes for children and families needs to be agreed and populated with relevance to both Kent-wide and local levels of Kent.

8. All services should be commissioned to accord with best practice as described in the stated evidence base summarised in this Needs Assessment together with all other relevant authoritatively determined guidance. Professional practitioners should be working to stated best practice as may be determined from time to time from the evidence base.

9. All statutory agencies in Kent commissioning services with the third sector should accord fully with the terms of the Kent Compact.

Ethnicity

10. Public authorities serving the needs of children and young families need to be especially mindful of the need to assure equality and diversity policies and to ensure that staff are culturally aware in their working practices.

Smoking in Pregnancy

11. Greater efforts need to be made to strengthen the working between Stop Smoking Services and general maternity services as well as primary care services to reduce the number of women smoking in pregnancy. Specific efforts need to be focused on hard to reach groups.

12. All relevant services should be commissioned according to the stated evidence base of effective interventions to minimise smoking during pregnancy and the exposure of newly born infants and children to tobacco smoke.

Breast Feeding

13. Support to mothers breast feeding should be commissioned according to the stated evidence base and the number breast feeding needs to be substantially increased in particular localities in Kent.

Childhood Immunisations

14. A major campaign should be undertaken to maximise take-up of MMR vaccinations in order that the rates reach the 95% recommended threshold.

Health Visitors

15. Health Visitor services should be organised on a patch basis.

16. Health Visitor services should give equal commitment to their Public Health and wellbeing role as to safeguarding children. As regards their Public Health role, they should support the promotion of wellbeing to children and families, giving intensive support to the most vulnerable children and their families.

Child Development and Parental Education

17. All agencies should target their approach focusing on the family as a whole rather than children's behaviour.

18. Commissioning of services should recognise home visiting as a key intervention to addressing inter-generational improvements in parenting, child behaviour and cognitive development.

19. The use of the third sector and specifically the commissioning of Home Start programmes should be maintained throughout Kent.

20. Services for parenting education, early years and childcare should be commissioned according to the stated evidence base.

Sure Start Programme (first wave Children's Centres)

21. Notwithstanding the possibility of further central funding being available, public authorities in Kent should commit to mainstream fund established first wave Children's Centres, allowing their contribution to the support of children and local families to be continued, building on a long term programme.

22. Agencies in Kent should commit to the principle of differential funding to first wave Sure Start Children's Centres on the basis that these have been set up as targeted resources in areas of the county identified as being in greatest need.

23. Kent Children's Trust with the Kent Public Health Team should lead the rapid development of a vigorous quantifiable evaluation measure for first wave Sure Start Children's Centres – adjusting this to accord with any national evaluation tool as may be published.

Children's Centres – second and subsequent waves

24. Children's Centres in the second and subsequent waves should be commissioned on a multi-disciplinary and multi-agency basis, reflected in staffing resources, the provision of integrated services to maximise child development and outcomes and to reduce health inequalities. Services should also screen for and then support children's early development needs and provide early support services for disabled children.

Child morbidity in primary care

25. An agreed dataset of childhood conditions managed in primary care should be developed and a protocol agreed for its routine extraction and analysis for needs assessment purposes.

Limiting Long-Term Illness

26. A specific study should be undertaken into limiting long-term illness amongst children in Kent.

Accidents

27. Multi-agency initiatives led by the Children's Safeguarding Board to reduce accidents, whether on the road or at home and in leisure facilities should continue.

Looked After Children

28. That specific services supporting Looked After Children, regardless of whether these are Kent children or otherwise, should be sustained and if necessary further invested in.

29. That further studies into Looked After Children should be undertaken as this category of children is at greatest risk of low self-esteem, substance misuse, mental health problems, teenage pregnancy, criminality and poor employment patterns.

Children on the Child Protection Register

30. Led by the Kent Children's Trust Board, guidelines should be issued to ensure greater consistency in the registration of children at risk throughout Kent.

Young Carers

31. A recently published Kent strategy on children giving care should continue to be implemented throughout the county. The practice of children giving care should be minimised as a matter of principle, notwithstanding that this may have consequential commissioning implications.

Children of Substance Misusing Parents

32. A multi-agency strategy to respond to the needs of children of substance misusing parents needs to be developed involving children's services and adult drug and alcohol treatment services with commensurate investment in a response that accords with national best practice including audit surveillance and evaluation tools. Within specific agencies cross directorate working needs to be developed.

Child and Adolescent Mental Health Services

33. A recently published needs assessment of Child and Adolescent Mental Health and a related service review for Kent needs to be implemented. This requires significant financial investment and is one of the highest priorities for service commissioning.

Housing and Homelessness

34. The Kent Joint Planning Board for Housing and Health should develop a needs assessment into youth homelessness supported by a multi-agency service response, i.e. one that involves children's services, housing services, Connexions services, schools and specialist organisations from the third sector.

Education and Employment

35. The long-term health improvement benefits, life chances and positive wellbeing derived from optimising good quality educational attainment should be recognised as a key incentive in the on-going drive for improved education standards. Particular focus matched with commensurate investment needs to be made to those parts of the county where relative deprivation as defined by free school meals provision is a clear factor.

36. Considerable emphasis needs to be continued in the on-going investment of vocational training programmes for pre and post school leavers who are not aspiring to higher education.

37. A specific initiative should be set up to explore issues relating to 16-17 year olds who are not in education or employment training (NEETS) as these young people are deemed to be highly vulnerable with many at long-term risk throughout their life course.

Schools, Health and Wellbeing

38. All schools need to recognise their key role in the promotion of good health and be mindful of the statutory duty placed on schools including their governing bodies, to safeguard children and promote their welfare.

39. All schools in Kent should become Healthy Schools by 2009.

40. The provision of school breakfast clubs should be considered in every school in the county including the necessary funding to enable these to be sustained.

41. All agencies including schools, but PCTs in particular, should ensure that further investment is made in school nursing services throughout the county in order that as a minimum, the equivalent of one school nurse per school cluster should be provided.

42. All school clusters should fund and support first and second line prevention services to support children and families with emotional and behavioural issues, based upon the Canterbury Multi Agency Cascade System (MACS) exemplar.

Teenage Pregnancy

43. The recommendations of the KCC Scrutiny Committee on the Kent Teenage Pregnancy programme should be implemented.

44. Notwithstanding a commitment from central government to continue to fund the Teenage Pregnancy programme, all relevant agencies in Kent should commit to the principle of mainstreaming this programme as being necessary to focus upon and drive down the rates of teenage pregnancy in the county.

45. The Kent Children's Trust Board should issue guidance to governing bodies of schools advising of their statutory duty to safeguard children, promote their welfare and therefore co-operate positively with school nursing services and other initiatives that can contain and reduce the incidence of teenage pregnancy amongst young people of 16 and under.

46. All schools need to ensure proper Sex and Relationships Education (SRE) provision as a key part of the curriculum for young people monitored by the KCC Members Select Committee on Personal, Social and Health Education (PSHE).

47. PCTs should continue to maximise the availability of emergency hormonal contraception (EHC) through community pharmacies throughout the county.

48. PCTs should tackle the policy of large scale community pharmacy providers, typically national supermarket chains as regards their policy of non-co-operation with the provision of EHC for under 16s.

49. PCTs should seek to improve access to termination facilities, in particular for those parts of the county where travel to established centres is an issue.

Smoking

50. Kent Children's Trust in partnership with PCTs should establish specialist Stop Smoking services for children and young people. Typically this should be through increased investment in specialist school nursing services.

51. Consumer protection bodies should rigourously and steadfastly enforce the sale of tobacco materials to under 18 year olds once this change in legislation takes effect.

52. Services commissioned specifically with regard to adolescents should accord with the stated evidence base.

Alcohol

53. Further work should be undertaken in to the misuse of alcohol amongst young people particularly focusing on the relationship between alcohol misuse and social exclusion of vulnerable young people. A Select Committee of KCC Members is soon to report and its recommendations should be implemented, including those with commissioning implications.

Illicit Drug Misuse

54. The Kent Council for Addition Young Person's Service should continue to be funded.

55. The Drug Intervention and Support Programme commissioned as part of the Kent PSA programme should be mainstreamed.

Obesity

56. Substantial investment in programmes to address obesity in children and young people in Kent should be made covering:

    - A focus in early years and school settings that fosters a healthy environment, including the provision of active help for children at risk of becoming overweight;
    - Support treatment programmes to assist changes in child and family behaviour towards maintaining a healthy weight;
    - The appraisal of the potential of social marketing techniques to communicate simple and positive messages about healthy lifestyles;
    - The provision of appropriate workforce training and the development of a targeted evidence of what works specifically as regards children and young people;
    - The systematic collection of local data;
    - An action-learning approach to treatment interventions.

57. Obesity services and healthy eating interventions should be commissioned according to the stated evidence base.

Sexual Health

58. Services should be commissioned to accord with the stated evidence base.

59. PCTs should continue to increase investment in sexual health services for young people ensuring easy access to GUM services and the offering of screening for STIs – in particular chlamydia.

Gambling

60. Further assessment of the risks of gambling to young people, particularly from amusement arcades in Kent, should be undertaken.

Youth Offenders

61. Youth Offending Teams should commission preventive measures ranging from targeted provision such as intensive mentoring, to enhanced relevant interventions within universal services including education, housing, employment opportunities and health services.

62. Youth offenders should be screened for the detection of mental health problems within the Youth Justice System – requiring commensurate investment.

63. In line with the recommendations of the Kent CAMHS Strategy, youth offenders judged to have mental health problems should be referred to specialist CAMHS services as a matter of course. This will require commensurate investment and appropriate commissioning of services.

64. All agencies and practitioners should actively promote the participation of children and young people in the design and delivery of all services affecting their health and/or promoting their general wellbeing.

Kent Local Area Agreement 2

In view of the foregoing the areas of policy that could usefully be covered through the Local Area Agreement with respect to children and young people, matched by commensurate investment and supported by appropriate commissioning should include:

- A reduction on the impact of inter-generational and situational poverty on children's lives through the tackling of under-lying causes and the mitigation of the effects;
- The improvement of resilience of children and young people helping them to make informed and healthy lifestyle/safe choices including the development of coping strategies;
- A transformation in the provision of and support to children and families with mental health problems;
- Community based interventions to improve and support parenting and assuring integrated multi-agency service provision;
- The improvement of services for Looked After Children;
- The improvement of support to young carers and the minimisation of the burden carried by young carers;

- Improvements in the quality and stability of housing provision for young people and early adulthood;
- Improvements in the mental and emotional health of young people at school;
- Measures to increase the engagement and participation by young people in education and employment opportunities in order to prevent disaffection and improve long-term job security.