Education Select Committee Inquiry: Child Well-being in England

Written evidence submitted by the Royal College of Paediatrics and Child Health

March, 2014

EXECUTIVE SUMMARY

1. The Royal College of Paediatrics and Child Health (RCPCH) welcomes the improvement in the UK's overall ranking of child wellbeing in the UNICEF Innocenti Report Card 11 (the Report Card); however the RCPCH also notes that this improvement must be taken with caution, acknowledging that the data only captures the start of the economic downturn, and therefore may not be a true representation of the health wellbeing of children

UK is significantly higher than Sweden, a country that is coincidently one the strongest performers on the low birth weight indicator. In the UK around twelve per cent of women smoke during pregnancy, compared to Sweden where 6.5 per cent of women smoke at the beginning of pregnancy and 4.9 per cent by the time the baby is due[2]. A reduction in smoking rates during pregnancy will only be achieved through appropriative policy and initiatives which are aimed at both population and individual levels, including the introduction of plain packaging legislation, to reduce the number of young people taking up smoking, in addition to high quality, evidenced-based, antenatal smoking cessation services which are tailored to meet the needs of disadvantaged women as recommended in NICE Guidance 26[4].

Child health (the 0-19 death rate)

10. The Report Card illustrates the importance of keeping children and young people socially, emotionally and physically safe; with a large proportion of the mortality burden during childhood and adolescence attributable to preventable causes such accidents, injuries and self-harm. The CHR-UK report found that boys aged 10 to 18 years stand to gain the most from preventative policies to reduce injury-related deaths across childhood, however it is also worth noting that England was found to have the lowest mortality due to injury of all four UK countries for each age and sex group and in the majority of time periods between 1980 and 2010[1].

11. A significant proportion of deaths during childhood and adolescence occur as a result of road traffic accidents, with transport accidents accounting for a large proportion of unintentional injury deaths in one to nine year olds and 10 to 18 years olds[1]. There are a number of policy levers which could be implemented to improve the safety of young drivers and passengers, which would align UK policy and legislation with international best practice. A recent evidence review commissioned by the Department of Transport recommended the introduction of a Graduated Licensing Scheme. Graduated Licensing Schemes have a long history in many countries including the US, Australia and New Zealand, where there is substantial evidence of their success in reducing road related injury and mortality in young people[5,6,7,8,9]. Roll out of 20 mile per hour speed restrictions in all towns and cities across England should also be considered as a further mechanism for making England's roads safer for children and young people.

12. In addition to road accident prevention, it is paramount that children, young people and their families have adequate knowledge and skills to minimise hazards at home and in the community. Public awareness campaigns and the provision of developmentally appropriate safety equipment should remain a priority, and all local authorities should consider re-introducing child health safety schemes which target families most in need. The Chief Medical Officer for England in her annual report also recognised a need for more to be done to understand and prevent strangulation as a result of blind cords[10].

13. The importance of social and emotional safety must also be acknowledged in the context of child and youth mortality, despite an absence of internationally comparable data

been no decline in deaths due to intentional injuries (i.e. self-harm, assault or undetermined intent) in 10 to 18 year olds in any UK country since 1980[1].

14. Approximately 75 per cent of lifetime mental health disorders (excluding dementia) have their onset before 24 years of age, with the peak onset of most conditions from 8 to 15 years[11]. Social disadvantage and adversity is strongly linked to increased risk for mental health difficulties in childhood and adolescence[10], with children and young people in the poorest households three times more likely to have a mental health problem than their wealthier counterparts[12]. Sustained investment in prevention, early intervention and timely treatment for mental health issues during childhood and adolescence must be a priority across all levels of government, with targeted supports available for vulnerable children most at risk, specifically looked after children, children involved in the youth justice system and children from families with a history of mental ill health.

Dimension 4: Behaviours and risks

Eating and exercise

15. The Report Card demonstrates there are opportunities to improve eating and exercise habits of children and young people that would help align child wellbeing in the UK with better performing countries. *Measuring Up: a 2013 report from the Academy of Royal Colleges* sets out clear recommendations in relation to tackling the obesity crisis; recommendations which are relevant to the indicators on eating and exercise outlined in the Report Card. There is still a lot of progress to be made on many of the recommendations from *Measuring Up* including the piloting of a high sugar beverage tax, ensuring healthy food standards are rolled out in academy and free schools, and a ban on advertising foods high in saturated fats, sugar and salt before 9pm and on ‘on demand’ serviceTf 0 Tc 0 Tw ( )Tj -c(C)-1I1. idMbD <</ Tf -0.0

Measuring the early years

18. The Report Card discusses in detail the absence of internationally comparable data sets to monitor the developmental progress of young children. The authors give the Early Development Index (EDI) as an example of a population tool shown to be successful for monitoring early years investments in health, education and social care in Canada and Australia. The Department of Education should consider the feasibility of introducing such a data collection system in England, but also recognise that the introduction of such as system would not remove the need for better monitoring and reporting of broader health and wellbeing outcomes in children and young people. The Department of Health and Department of Education should develop a systematic approach for monitoring health and wellbeing by bringing together existing data sets and identifying gaps in current data collection in England; i 8(ol)3(s)]TJ 0 Tc 0 1B