Lambeth

The health of children and young people in Lambeth

Annual Report of the Director of Public Health 2016/17

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Foreword

The health and wellbeing of children and young people is a top priority in Lambeth. The future of Lambeth, the nation, and the planet depends on children growing up healthy, resilient and happy, but our focus on children is more than self-interest. It is an absolute responsibility of adults to protect and care for people who are not able to do so on their own account. Children are the largest group on the planet in this category, and we adults are the reason they are here at all.

Most children in the UK and Lambeth are growing up well. They have opportunities that would have been unthinkable in a former age: an adequate diet, clean water to drink, opportunities to play and learn with the prospect of rewarding employment, warm safe homes, enough finances for the necessities and a little more besides, and a high probability of surviving into old age and seeing their own grandchildren do well.

Unfortunately, the benefits of the 20th and 21st centuries are not evenly spread and some of the progress experienced up to the early 2000s may be slowing down or reversing. The average Lambeth child may be doing better and experiencing better health according to some measures but inequalities in Lambeth are marked. 14,735 of our children under 16 years old (27.3 per cent of Lambeth children) live in poverty and are excluded from many of these advantages. The impact of this disadvantage is well known and includes high levels of children in care, teenage pregnancy, obesity, violence, mental ill health, substance and alcohol misuse, and homelessness.

The impact of austerity, pursued as the prevailing fiscal policy since 2010, appears to be reducing public service resources and support for the poorest, leading to a widening of the gap, especially when the impact of the property market and housing policy is factored in.

The biggest and most influential factors on child wellbeing and prospects are money, stable and loving parenting particularly in the early years of life, and education. The latter two are very much related to the first and the negative effects of poverty on health and wellbeing of children last into adulthood and are not confined to the poorest. Disadvantage works as a gradient.

Lambeth people and organisations have not sat back. There is a longstanding commitment in the borough to improve opportunities for the most disadvantaged recognising that there are no quick fixes for some of the most complex issues that face communities. Lambeth has successfully reduced some inequalities and continues to build on what has been learnt.

There continue to be immediate and future threats to the health and wellbeing of Lambeth children and young people. For instance, there will be further cuts to local government, and to social welfare and other benefits, a number of which will directly affect young people. The impact of the UK leaving the European Union on the economy of London and Lambeth is a critical uncertainty. The social and cultural setting in which we live, for instance the visibility of substance and alcohol misuse to young people, the impact of advertising, the heterogeneity of the area, and technology, especially social media and how it is used by children and adults, are other examples of the forces and societal transitions that are changing so much and so rapidly that their impact on health and wellbeing is more difficult to understand or to use to positive benefit.

If the public health achievements discussed in this report are not to be reversed, the Borough has to harness all its considerable assets and resources to the task. Now, more than ever, the strong partnerships built over the last ten years in Lambeth will be vital to ensuring Lambeth is a place where children and young people thrive ten years hence. We must face up to the complexity of the

tasks and become more adept at analysing and understanding the impact of the political, economic, environmental, social and other forces that are at work on the children and young people we are responsible for. Without so doing our policies and programmes may be inefficient, ineffective and have unintended harmful consequences.

This report is part of a deeper exploration of the wider and more complex forces affecting the health and wellbeing of children and young people and how we might work differently to plan and prepare over a longer time frame. The next few years will be extremely difficult. Usual methods, even the more collaborative approaches of more recent years, will not be adequate. Courage and commitment is needed but the alternatives do not bear thinking about.

Dr Sarah Corlett

Interim Director of Public Health 2016-17

Acknowledgments

This is my first and last Annual Report as Director of Public Health in Lambeth and I particularly wish to thank Dr Abdu Mohiddin who, as Public Health lead for Children and Young People in Lambeth, has expertly led and coordinated the process along with major contributions from every member of the Lambeth Public Health team; Hiten Dodhia, Bimpe Oki, Marie-Noelle Vieu, Veronika Thiel, James Crompton, Vida Cunningham, Judith Eling, and our National Management Trainee Robert Dunne. I also thank the members of Public Service Works; Maria Duggan, Sheila Marsh and Roma Iskander for their tireless work and expertise in engaging stakeholders and in the scenario development process which has given us great food for thought and I hope much action.

Executive Summary

This year's APHR focuses on Children and Young People (CYP), what influences their health, and how to ensure they have the best start to life, and go on to lead full and thriving lives. It is in two parts. This first part identifies the current main health issues CYP, and makes recommendations on how to improve their health. The second part (*After Tomorrow*) looks ten years ahead and is the subject of a separate report.

Influences on CYP health

The health of children is influenced by many factors and these are traditionally described as those circumstances in which they are born, live, play and work. Of these, deprivation has a substantial and lifelong negative impact on health. Whilst the proportion of children in poverty may be reducing in the borough, inequalities within the borough are rising. There are now more households in both deprived and more well off circumstances compared to a few years ago. In addition, national public spending policies have a disproportionate impact on children and young people. This is one example of the many changes, or 'forces', affecting health like technological and cultural shifts. This report considers them in more detail.

Some important health issues in Lambeth by life-course

In the early years (conception to five years old):

- Infant deaths have reduced significantly
- average school readiness has improved, but there remains substantial inequality, as children in deprived circumstances and from some ethnic groups do less well

In children of school age:

- In primary school children, emotional health may be improving, but the opposite is likely in secondary school and it is worse for girls
- Obesity may be reducing or at least stabilising

In adolescents:

- Admissions for self-harm have increased
- Sexual health remains a substantial issue, although there is some improvement
- Alcohol misuse is reducing

For all children:

- Safeguarding is a mixed picture: there are fewer children in care but there are important issues like child sexual exploitation; there is also an increase in children in temporary accommodation
- Large numbers of children have a long term condition.

The benefits of a life course approach

Public Health advocates the use of a life course approach to analyse and identify key areas of need, and to then develop mitigating actions to maximise positive developments and mitigate negative effects. This means in essence to analyse a child's life from conception onwards. The benefits of this approach are many:

- Acting in the early years is sound science and sound finance: good child health improves the health of everyone and investing in child wellbeing is effective, reduces inequalities, and leads to big social and economic returns for all
- A good start in life builds resilience and a healthy foundation for adulthood, and there is good evidence for promoting health and wellbeing in early life: improving school readiness and using a whole school approach to health and wellbeing and integrated action across services to promote good health and healthy relationships in young adults is key to success
- Safeguarding children from harm is one of the most effective ways to prevent long-term damage to a child's mental and physical health. Therefore, it must be at the heart of all initiatives across the system for all population groups.

Public health recommends adopting a Health and Wellbeing in All Polices approach, as it is a practical framework for maximising the health benefits of all local plans and investment.

Child health programmes in Lambeth

The Public Health department has been integral to some successful programmes in Lambeth that have improved the population's health and wellbeing, and reduced inequalities. Examples include reducing teenage pregnancy and childhood obesity. The factors that contributed to the success of these programmes should be used to inform future ones:

- Analysing the health and wellbeing of the whole population (not just groups who are known to be particularly vulnerable, already ill, or receiving services) to be able to identify opportunities for health improvement, and groups who also have poor health outcomes, but whose needs were currently unknown. This population segmentation will then allow for more precise use of resources
- Focusing on the wider societal, economic, environmental, policy and political influences and forces that determine health, not just on the individual risk factors or behaviours
- Being rigorous about how local services compare with best practice and identifying any gaps in services, and providing additional evidence on what works to support providers in achieving their goals
- Ensuring objective monitoring, evaluation and learning by collecting good and timely information from different sources
- Promoting, building and working with extensive partnerships between the people who need to benefit (CYP, their parents and carers) and statutory and voluntary organisations that allow beneficiaries equal voice and leadership (Co-design and co-production)
- Creating a collective understanding and agreement of the common goals and how to achieve them among all partners, and securing sustained investment over many years
- An explicit commitment to fairness and reducing inequalities.

Conclusion: dealing with complexity and the future

In many respects, health and wellbeing in children and young people in Lambeth is improving; children are more ready for school, and infant deaths, childhood obesity at reception, and teenage conceptions are reducing. However, average health measures mask important differences between population subgroups. There are substantial inequalities in all the measures reviewed in this report which means that many Lambeth children are missing out.

Austerity measures are disproportionately affecting children who are already vulnerable, especially the large number of children living in poverty in the borough. For a healthy, fair, and economically productive society, the health and wellbeing of children needs to be at the heart of policy making and investment plans.

Successful initiatives that benefit the whole population in Lambeth are based on partnership, addressing complexity, sustained commitment and long-term resourcing.

To make further progress and to reduce inequalities, Lambeth needs to focus more strongly on:

- Bringing together all relevant services into an **integrated early years programme**
- Ensuring the **London Healthy Schools programme** covers all schools
- Developing holistic and effective **integrated Young People's services** with a 'no wrong door' approach that place the relationship with young people at their heart
- A **whole population approach to safeguarding,** where safeguarding happens at every stage and in all settings for all children, thus reducing risk across all groups, leading to less harm and reduced need for support
- **Knowing the CYP population better** through improving data sharing between services to identify those at higher risk of poorer outcomes, inform priorities, and enable prompt action
- **Engaging, informing and empowering communities** to take action on their own account in line with their priorities
- A strong emphasis on health and wellbeing of children and young people within the council's commitment to **Health and Wellbeing in All Policies.**

***After Tomorrow*:** towards a better future with the second part of this report

Decisions tend to be made over a one to four year time frame in line with financial and electoral cycles. Using such short time frames risks overlooking the potential impact of slower-acting forces that impact on health – be they positive or negative. This is especially concerning for child health. Taking a much longer view of CYP health over a ten year horizon will allow partners greater ability to respond effectively to today's and tomorrow's complex environment to the benefit of the population. The next part of the Annual Public Health Report uses the data and information from this report alongside extensive interviews, focus groups and workshops to develop scenarios to inform how partners might plan more effectively to promote and protect the health and wellbeing of children and young people over the next ten years.

1. Introduction

Children have no choice who their parents are, nor can they understand that parents may be simply too depressed, enraged or spaced out to be there for them or that their parent's behaviour has little to do with them. Children have no choice but to organize themselves to survive within the families they have. Unlike adults, they have no other authorities to turn to for help - their parents are the authorities. They cannot rent an apartment or move in with someone else: their very survival hinges on their caregivers.

Van der Kolk, 2015

This report provides a high level summary of the health and wellbeing of children and young people (CYP) in Lambeth. In recognition of the nature of human growth and development the World Health Organisation definition of childhood and adolescence as being from birth to 25 years of age is used.

The main influences and wider forces that affect the health and well-being of CYP now and in the future are summarised. What works to improve the health of CYP and the potential for positive social returns on investment is considered. Some examples of where Lambeth partners have improved health and reduced inequality in CYP are reported along with a discussion of the success factors. Recommendations are made based on the need to develop, sustain and invest in a collective approach to making the whole of Lambeth a child friendly borough where the health and wellbeing of all children and young people is at the heart of local policy and action.

This report is part of a wider piece of work with local people, services, commissioners and decision makers in Lambeth who are committed to and/or responsible for the health and wellbeing of CYP. It forms the background to a participative process to improve understanding of the complex and dynamic forces that are affecting the health and wellbeing of Lambeth CYP and how effectively local strategies and actions are accounting for and responding to these influences over the longer term. It assumes that to protect and enhance life chances for all Lambeth CYP, and to counter the negative effects of some of these forces and contexts prevalent in the borough, the system and the partners that make up that system will have to be more adept and more forward thinking than to date.

2. The forces affecting the health and wellbeing of children

A complex array of social and economic factors at personal, family, community and national levels influence the health and wellbeing of children and adolescents (Kuo, Coller, Stewart-Brown, & Blair, 2016). These go beyond the biological physiological and genetic characteristics of an individual and the immediate social, cultural and economic environment of family and community to the multiple external factors which have a lifelong impact on individual and population health and wellbeing (Figure 1).

UK 21st century society is undergoing substantial and rapid transition giving rise to new and changing influences which are dynamic and interrelate within and between each other differently, changing over time in interconnected and non-linear ways that may give rise to unexpected and sometimes untoward consequences. Some societal and other transitions going on are rapid and major and act more like 'forces' than the more traditional understanding of influences or determinants (Box 1) (Lang & Rayner, 2012).

Examples of forces and transitions that are occurring include: demographic trends, widening economic disparities and poverty, new technologies including social media, local, national and

international politics, environmental degradation, conflict, human migration, biodiversity and the ecology, global warming and climate change (Rockefeller-Lancet Commission on planetary health, 2015). Almost all such forces are influenced by government policies and spending on for instance, public services, infrastructure, air, water and environmental quality, and democratic and justice systems, although other influences such as commercial interests, fashion and, technological advances are highly relevant.

These forces are affecting human health and wellbeing locally and on a large scale including at planetary level. They are profoundly affecting the daily contexts and experiences of CYP at home, school, in training, at work and in the community.

Health and health behaviours in childhood and adulthood are strongly related. The better the health and wellbeing of children and adolescents and the more opportunities societies provide for children to be healthy, the better the health and wellbeing and economic productivity of the nation overall (Dorling, Mitchell, & Pearce, 2007).

It is therefore vital for partners, local leaders and policy makers to understand how factors and forces interact with one another and their overall impact on health and wellbeing of children especially over the longer term so as to develop policy and plan investment in the light of this complex environment. Otherwise today's cultural and policy (including health policy) responses risk being out of date and inadequate. Also in times of extreme financial constraint it is essential to be confident that the impact of remaining resources is maximised.

Viewing 'planetary health' as a complex dynamic system where humanity and the planet are interdependent can inform understanding as to how these material, biological, cultural and social conditions shape how children and young people grow up (Middleton, 2017) and may enable governments and organisations to effectively address the challenges that will affect the adults and children of tomorrow.

Figure 1: The Health Map (Barton & Grant, 2006) based on Dahlgren-Whitehead concept

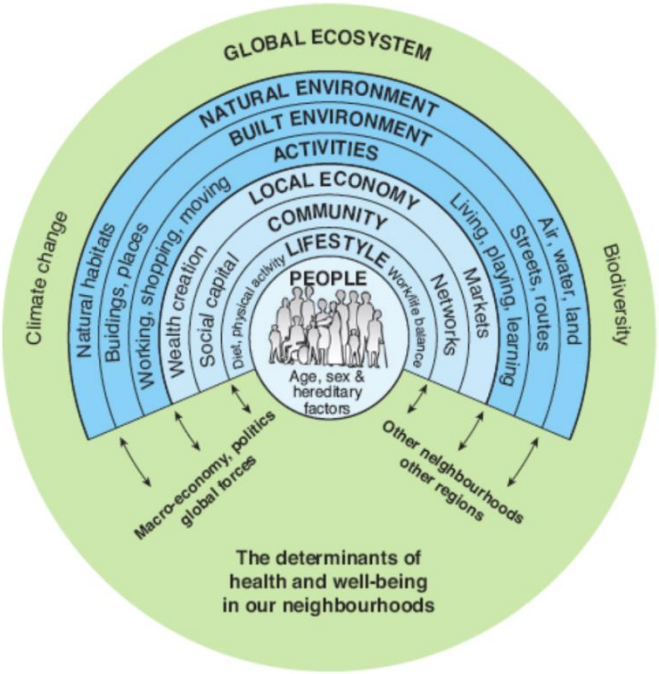


Table 1 Examples of shaping transitions or forces affecting population health

Transition (or force)	**Potential impact on CYP health & potential for intervention**
Demographic Change in birth/death rates and life expectancy	**Smaller families and greater spend per child** **Increased pressures on resources (housing, education)** Lambeth's increased population (including a large young demographic) has increased pressures on affordable housing; vastly increasing house prices. In addition, pressures on education, the National Funding Formula and increased demand on the health services will likely place additional strain on the ability of these public services to meet the needs of increasing population numbers. **Need to provide care for ageing parents** Lambeth's older populations are also increasing in number. These demographic changes in interaction, with a population that is both younger and older at the same time, present significant challenges for Borough policy, investment, and service provision.
Epidemiological Patterns of disease change with emerging and re-emerging diseases	**Increased demand for health services** **Increased long term conditions** The high comparative incidence of long term conditions, such as asthma, diabetes, and epilepsy are exacerbated by poor air quality, poor housing conditions, lack of healthy diets and little physical activity. There are also high rates of disabilities among families within Lambeth, which can have negative effects on the health and wellbeing of CYP, impacting on their parenting. Children and young people with disabilities are less likely to be in education, training, or employment. **Alcohol, Tobacco and Drug Induced Conditions** The prevalence of hospital admissions from alcohol related conditions is increasing and has become a significant challenge for Lambeth. The prevalence of smoking is also considerable, representing a major cause to ill health with statistically higher lung and oral cancer registrations than within the rest of the country. [1]

[1] Lambeth CCG, 2015, Annual Equalities Report, Lambeth, 2015

	Sexually Transmitted Infections (STIs) Lambeth has one of the highest rates of sexually transmitted infections, HIV prevalence and teenage conception rates in the UK.[2] There are significant variations between different Lambeth areas possibly pointing to high deprivation (inequality) levels throughout the Borough. **Need for early prevention of degenerative disease** The most common preventable diseases in Lambeth are cancer, HIV, cardiovascular disease, diabetes and mental illness.[3] Death rates from preventable diseases have been recorded comparatively higher than in the rest of London.
Urban Changes in urban existence alters living conditions and modes of life	**Reduced opportunities for outdoors physical activity** Lambeth is richly endowed with public open-space, despite being close to the city centre, with 64 parks and open space areas.[4] Despite increases in vital community facilities, particularly in the north of the borough (highlighting a growing inequality), recent cuts to government spending, have also reduced the number and quality of children's services, decreasing opportunities for physical wellbeing among those with the lowest income. **Health and safety concerns linked to being outdoors in city (pollution, traffic)** Air pollution is the second most significant factor impacting on public health in London, causing high numbers of premature deaths second only to smoking. All inner London boroughs, including Lambeth, are highly polluted, and this appears to affect members of deprived communities as they are more likely to live or go to school near major roads and are therefore more affected. Children are particularly susceptible; particularly when they attend schools close to roads where legal levels are exceeded daily. Also, crowding of public housing has been seen to negatively influence on the health of children and young people in urban areas. **Increased/ Decreased opportunities (diversity, educational and work experiences)**

[2] Lambeth CCG, 2015, Annual Equalities Report, Lambeth, 2015
[3] Lambeth CCG, 2015, Annual Equalities Report, Lambeth, 2015
http://www.lambethccg.nhs.uk/news-and-publications/publications/Documents/Current%20plans%20and%20strategies/Equality%20in%20NHS%20Lambeth%202015%20Annual%20Report.pdf
[4] Lambeth Community Fund, 2016, Lambeth Profile: To accompany the 2013-15 evaluation; LCF, 2016

	Despite significant benefits that economic changes and gentrification have brought to the borough (increased job opportunities, transport links and community facilities), not all residents have benefited to the same extent. Some groupings, particularly BAME groupings and people with disabilities have not felt the benefits as much as others. Lambeth is still a destination for young people from the Eurozone looking for work. The onset and roll out of Brexit may further negatively affect children and young people and the opportunities available to them.
Energy Cheaper and higher-output energy sources underpin societal and economic development	**Finite nature of non-renewable energy sources means alternatives need to be found and/or future lifestyles need to be modified** **Environmental and health impacts of non-renewable sources, particularly long term impacts of climate change on children and young people** **At present households on limited income may have to choose between heating and eating in the winter months and energy costs continue to increase.**
Economic and technological There is a shift in modes of production, with higher inputs and outputs, and technological change	**Economic productivity and prosperity affects many of the layers of influence on children and young people's health. Economic recession associated with income and spending cuts has been shown to have significant negative impacts on children's health.** Lambeth is one of the most deprived local authorities in England and recent public sector cuts are contributing to increased economic inequality/ deprivation of aspiration, resources, and life circumstances among vulnerable groups. High proportions of children and young people live in low income households, with unemployment and low pay extremely common. Children and young people growing up in these low socio- economic conditions are less likely to achieve their educational and employment aspirations as well as being more likely to develop chronic health conditions in childhood compared to more affluent children.[5] These can be exacerbated by high stress levels, violence and crime, mental health and poor social justice. **Technological changes will continue to affect many aspects of life of children and young people including how they relate to others, how they learn, how they access health care.**
Nutrition	**Need to address mismatch between food intake and needs of body in order to avoid overweight and obesity**

[5] Wickham, S., et al., Poverty and child health in the UK: using evidence for action. Archives of Disease in Childhood, 2016.

Characterised by changes in diet and physical activity	Childhood obesity, particularly among 10-11-year-old children in Lambeth has been identified as a critical factor affecting children and young people's health and wellbeing, exacerbated by Lambeth's high density of fast food takeaways, as well as a lack of physical activity. **Increasingly higher levels of obesity among poorer families.** The prevalence of children at risk of obesity is highest in the most deprived areas of London. Children from ethnic minority groups, such as Bangladesh, Black Caribbean and Black African were found to be at a higher risk of obesity.[6] **Interventions exist that increase knowledge and availability of appropriate foods and to facilitate physical activity.** • **Active Lambeth 2015-2020** • **Lambeth Early Action Partnership (LEAP) 2014** • **Lambeth Food Flagship.**
Biological and Ecological Microbiological and ecological life are both being altered by human activity	**Increasing threat from microbial disease due to increased microbial resistance and loss of biodiversity** *See Urban – Air Pollution* This includes the risk of antimicrobial resistance; the increasing resistance of some bacteria to antibiotics. This is a global threat and as London is a global city it is a substantial risk in London. Children could be at high risk if they acquire infections where there is no longer an effective antibiotic. This could include situations where a family has (in another country) purchased antibiotics over the counter or been treated by a doctor not subject to the strict regulations of the UK and EU. The local and national health system needs to be alert to the issue and restrict antibiotic use to when it is essential.
Cultural Modern life offers widened and displaced cultural	**Nature of family and access to wider support networks continues to change & affect how children are cared for & who by** **Health education needs to take account of shifting values, norms and shared meanings.**

[6] https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/glae-childhood-obesity.pdf

possibilities for how to live	Children, young people and families from BAME backgrounds may experience difficulties integrating into society due to language barriers and lack of English fluency (for instance in the Portuguese community), as well being unfairly disadvantaged in the job market (for instance amongst the black African and black Caribbean communities). Boys, particularly from BAME backgrounds, consistently perform less well than girls throughout education and are also more likely to be involved (as perpetrators and victims) in criminal activities. Domestic violence, particularly relating to African and Caribbean women as victims of abuse is a serious concern. Also, there is a suggestion that disability related hate crimes maybe increasing. Lambeth has the 7th highest crime rate in London; whilst young adults of African, Caribbean, Black and Mixed Race descent disproportionately account for higher levels of all violence perpetrated (including high incidences of knife and gang related crime).
Democratic Changes in governance in the commercial and public spheres including in accountability/transparency and democratic participation	**The Public Health role in strengthening democratic functioning implies advocating for the needs of children and young people and for reducing health inequalities** Changes in international migration and pressures on housing will probably continue to change Lambeth's ethnic and cultural profile. London's change to a much more multicultural city in the mid-20th century was based on Britain's imperial past, and most migrants came from the new Commonwealth. Since the 1980s, however, the drivers of international migration have been EU expansion and integration, people displaced by conflict and perceived economic opportunities available in UK. Most recent international migration is from EU, especially countries severely affected by the Euro zone crisis, especially Spain, Italy, and Portugal. As a result, Lambeth has significant Portuguese, Polish and Somali populations. There is a relatively small south Asian population, and the Black Caribbean community is reducing as a proportion of the population. The borough has been seen in recent decades as a place where poorer people can get established before moving on; in this way Lambeth is often referred to as an escalator borough. Brexit may significantly alter these patterns of movement in coming years.

Adapted from (Rayner & Lang, 2012)

3. The Lambeth context for children and young people

Some of the forces and transitions that maybe influencing health and wellbeing in Lambeth CYP are summarised in this section especially; population increases, ethnic diversity, inequality and poverty, UK government austerity policies, and air pollution. The table includes a broader range of factors and initial thoughts on how they might be affecting Lambeth children.

Demography

Lambeth is one of the most densely populated boroughs in England (12,016 people per square kilometre, compared to 5,518 in London and 363 in England). About 324,000 people live in in the borough (2015 estimates), almost evenly split between males and females. A much higher proportion of the Lambeth population are aged 25 – 34 years compared with than London and England (Figure 2).

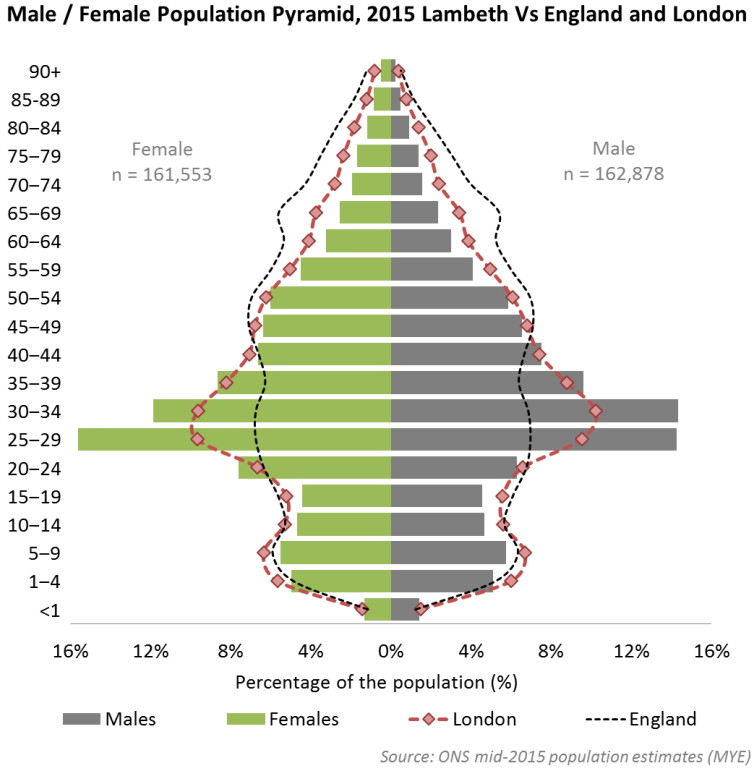
Similar to London as a whole the Lambeth population is expected to increase by 4 per cent to 339,000 by 2020, and to 355,200 2025 (a 9 per cent increase). In 2025, 20 per cent of the population is expected to be under 20, and 49 per cent will be aged 20-44 years. The proportion of the population aged 20-29 years is expected to reduce by 4 per cent.

The number of young people under the age of 25 in Lambeth has increased by 3,800 in the ten years to 2015, but the rest of the population has increased faster so this age group has decreased from 31.1 per cent to 28.1 per cent of the population.

Compared with both London and England, Lambeth's population distribution by age (Figure 2) shows a slightly smaller proportion of those aged under 20 years and a bulge in those aged 25-39.

In 2015, 201 out of every 1,000 residents moved in or out of the borough giving rise to significant population 'churn'. This is higher than in Southwark where in 2015 population turnover was 181 per 1,000. The rate has roughly stayed the same in the past ten years.

Figure 2 Lambeth's Population pyramid



Ethnicity and country of origin

The Lambeth population is extremely diverse. For instance, about 322 in every 1000 (about 104,000 people) Lambeth residents were born outside the UK. These proportions are expected to stay about the same over the next few years.

Forty four per cent of Lambeth residents are of a Black, Asian or Minority Ethnic group (BAME) including Black African (12 per cent), Black Caribbean (9 per cent) and other black background (10 per cent). Lambeth school children (not all of whom live in Lambeth) are even more diverse; in 2016 the largest groups were black African (23.1 per cent), black Caribbean (15.4 per cent) and white British (14.4 per cent), and the next group, 'white other', was the fastest growing population group (from 5.8 to 9.4 per cent in 9 years). Nearly 50 per cent of Lambeth pupils have English as an additional language to their mother tongue. Polish is the fastest growing non English mother tongue spoken in Lambeth (followed by Spanish) even though many of these children are born in the UK.

Deprivation and poverty

There are several ways to measure deprivation and poverty. Deprivation is a composite measure used for whole populations. Child poverty and children eligible for free school meals are useful direct measures in children.

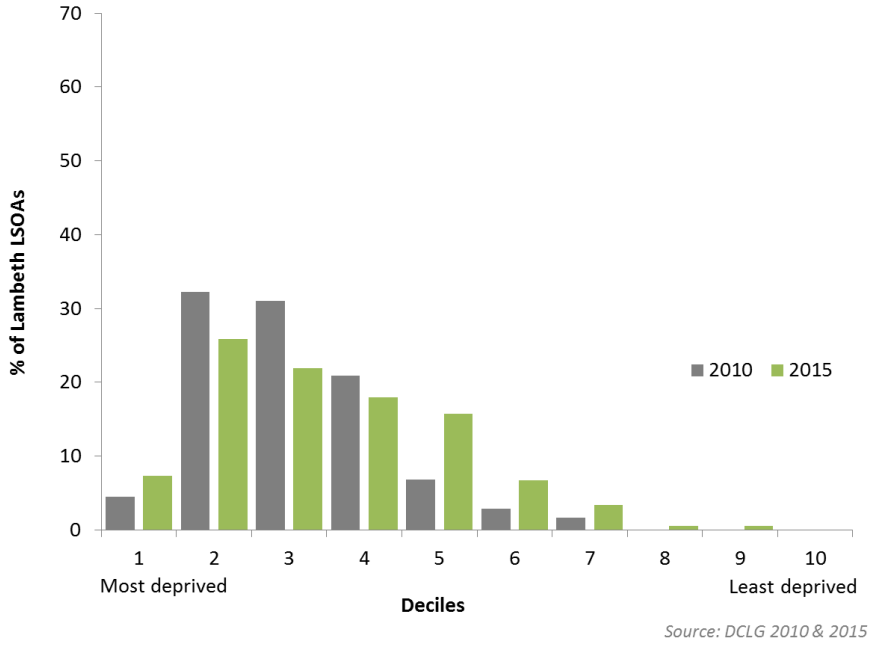
The most deprived wards in Lambeth are Coldharbour, Vassall, Thornton, Tulse Hill and Streatham Hill and the least deprived are Herne Hill, Thurlow Park and Streatham South. In 2015, Lambeth was the 44th most deprived borough in the country. This sounds like an improvement on 2010, when it was 29th, but the scale is relative, so whilst there are now a few more boroughs that are more deprived than Lambeth, it cannot be said that the absolute level of deprivation has reduced.

In Figure 3 Lambeth Lower Super Output Areas (LSOAs; postcode related groups of about 1500 people) are ranked nationally by their level of deprivation. Decile 1 contains the percentage of

Lambeth LSOAs that are in the most deprived 10 per cent of all LSOAs; decile 2 contains the next 10 per cent most deprived and so on. Nearly three quarters of the borough; 73 per cent of Lambeth LSOAS and 73 per cent of the population (that is 237,000 of Lambeth's 324,000 residents), live in the 40 per cent most deprived deciles in England. Although in 2015 a lower percentage of Lambeth LSOAs were in deciles 2, 3 and 4 than in 2010, in 2015 there was an increase in the proportion of LSOAs in the poorest category (decile 1). The proportion of LSOAs in decile 5, 6 and 7 increased suggesting they are relatively less deprived. For the first time, there are a few LSOAs in the borough in the least deprived 30 and 20 per cent of LSOAs (the 8th and 9th deciles).

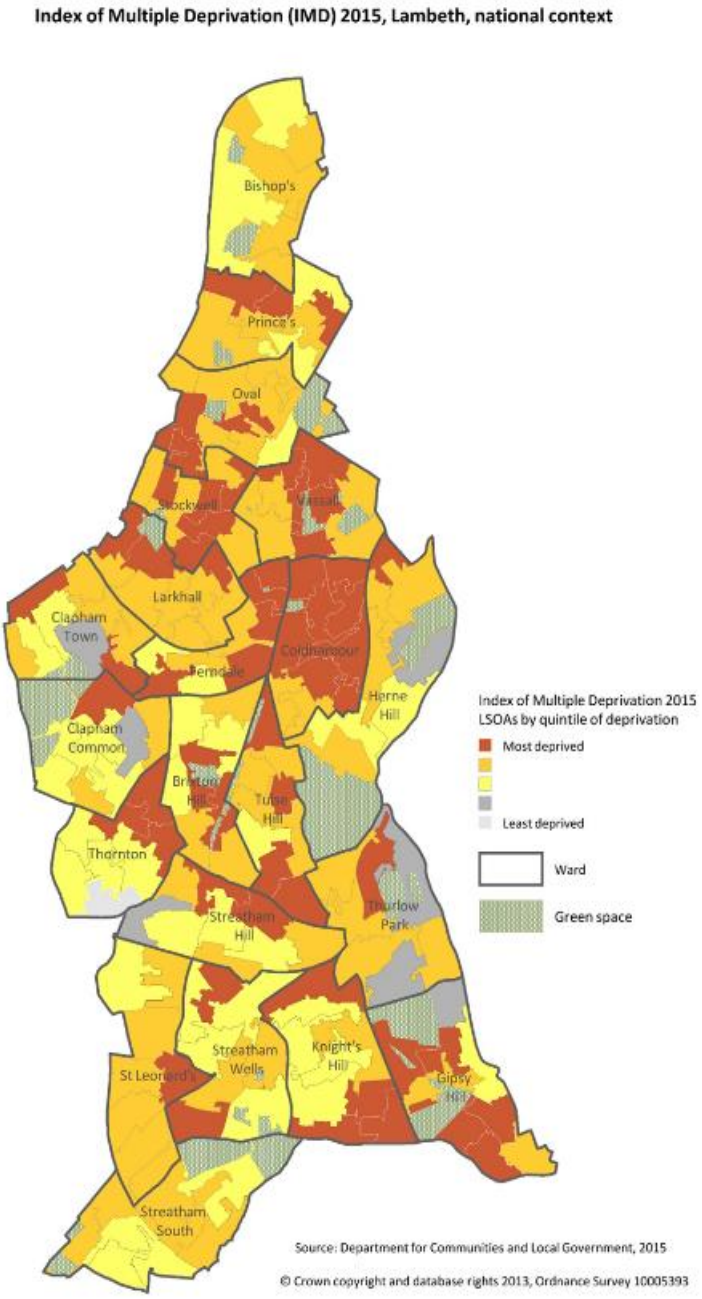
This strongly suggests there has been an increase in inequality in the borough over the five years 2010-2015. Figure 4 shows the geographical distribution of deprivation in Lambeth by LSOA.

Figure 3 Percentage of Lambeth lower super output areas in each decile of deprivation 2010 and 2015



Source: DCLG 2010 & 2015

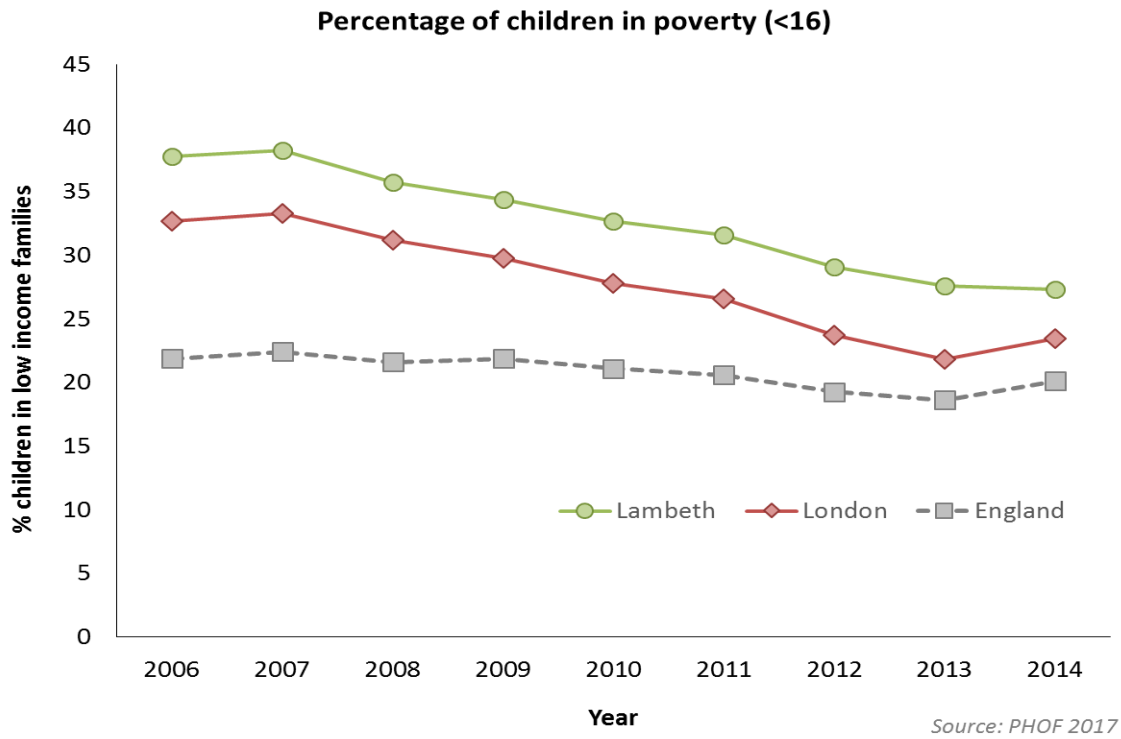
Figure 4 Geographical Distribution of deprivation in Lambeth by LSOA



Children in poverty in Lambeth

Child poverty in Lambeth, defined nationally as family income less than 60 per cent of what half of households earn, (less than 60 per cent of the median household income), is high at 27.3 per cent, or 14,700 children. This is a decline from 37.8 per cent in 2006 (Figure 5) but the way the figure is calculated changed in 2014 so it is only valid to compare the 2006-13 figures.

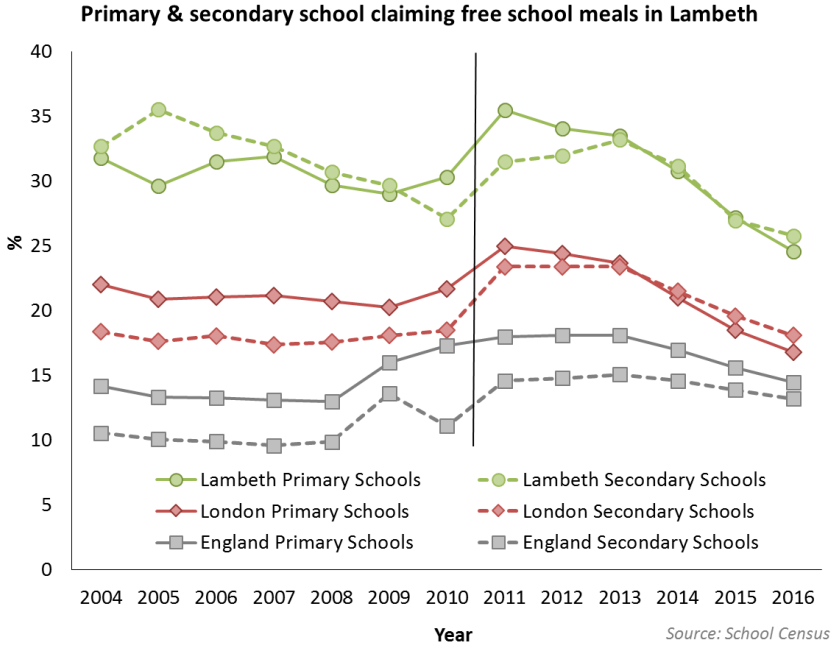
Figure 5 Percentage of Children in Poverty



Free school meals

Children are eligible for free school meals (FSM) at state schools if they or their parents are in receipt of certain benefits. In 2014 FSM eligibility was extended to all children in reception and years one and two, making the measure less useful in infant school children however the percentage of children taking FSM in Lambeth has been much higher than the London and the England averages for many years, and after a dip in the years 2007 to 2010 (2009 for primary schools) reached a peak in 2011. Since then, for reasons that are not clear, figures have been in steady decline in Lambeth, London and England, although the decline is steeper in Lambeth and London.

Figure 6 Free school meals



Austerity

Austerity (the policy of managing public debt by reducing public spending) is an example of a force which is of growing concern as the impacts of reduced household income on the health and wellbeing of CYP are well recognised. This is especially the case where families are already in poverty. Cuts to services and benefits including Disability Living Allowance/ Personal Independence Payments, Job Seekers Allowance, and housing and child benefits that will continue until at least 2019-2020, are having a cumulative and adverse effect on children, young people and families. Vulnerable groups of children including children with disabilities, refugee and asylum seeker children, and children and young people experiencing mental distress, continue to be amongst the worst affected by cuts to services. A 2016 review (British Medical Association, 2016) finds that the impact of austerity in the UK has been more detrimental to children than many other population groups. There is also a strong relationship between the impact of the recession on national economies and a decline in children's wellbeing since 2008. The combined impact of austerity and the recession have contributed to national increases in the number of children living in poverty.

Air Quality/Pollution

Air pollution has emerged as a major concern in London, especially as it affects health across the life course including in pregnancy (increasing risk of low birth weight) and childhood (for instance increasing risk of asthma). As an inner city borough with many busy thoroughfares, Lambeth is one of the top five boroughs with the highest number of people living in London's worst air quality areas, 2013 data, (GLA, 2017). In 2010 about 10,000 pupils were affected by excessive air pollution near their schools, of which 6,300 (63 per cent) were on free school meals, suggesting that schools in deprived areas are disproportionately exposed. The most recent data show that in 2013, 28 primary schools in Lambeth were affected by excessive nitrous oxide (NO_2) emissions (the sixth highest number in London), two of which were in the top 100 affected schools. Nine Lambeth secondary schools were affected by NO_2 emissions above the legal limit, joint third highest with Southwark and after Westminster and Tower Hamlets. The Mayor's Office is leading further work on air pollution in

London, and Lambeth has developed an air quality action plan (Lambeth Council,2016) that links to the Mayor's office's plans.

The impact of the forces on health and wellbeing of children and young people

We have greater understanding of some of the forces and influences in CYP than of others. Poverty, deprivation and inequality have a substantial and lifelong negative impact as children from the most deprived backgrounds experience much worse health compared with the most affluent and a substantial proportion of children in Lambeth still live in poverty. Although this proportion may be reducing in the borough, national policies related to public spending are having a disproportionate impact on children and young people and this is worse for children in low income households. There has been a polarisation of inequality in Lambeth with more households in both deprived and more well off circumstances.

Air pollution, likewise, has a recognised negative impact; children are particularly vulnerable to poor air quality and poor children are much more likely to be exposed. However the effects of high population density, the increase in the child population expected over the coming ten years, huge diversity and other features of inner city life are more difficult to assess apart from the implied additional pressure on services and infrastructure. The potential effects of technological and cultural shifts and wider national and international forces may be equally important to health and wellbeing, but are under-researched and historically have not been factored into assumptions and planning for the future. To harness the potential and mitigate the risks of the influences and forces, a different more future oriented way of thinking about them is needed.

4. Health and wellbeing of children & young people in UK and Lambeth

Understanding the impact of the forces and influences on children is limited but the combined effect is reflected in their health and wellbeing today.

A small selection of the available indicators are reviewed across the life-course, to provide insight into the health and wellbeing of children and young people in Lambeth. Where possible, data are compared with London and England.

In the UK, compared with many European children, a substantial proportion of children do not get the best start in life. Despite some improvements in the health of UK children over the last decades, there is clear disparity with the rest of Europe, and major cause for concern. According to UNICEF, compared with 29 other rich countries in 2009-10, the UK was sixteenth in terms of child health and wellbeing and only managed middle ranking in terms of material wellbeing, health and safety of children and behaviours and risks. Although just in the top third (10^{th}) for housing and environment, the UK is nearly bottom (24^{th}) for education (and is bottom for the proportion of 15-19 year olds in education; the only country in the group where participation is less than 75 per cent). In terms of behaviours and risks, UK children still do comparatively poorly in terms of teenage births and use of alcohol and cannabis (UNICEF, 2013). There has been some improvement as UK was bottom out of 21 countries in 2000-2001 but given the nation's overall infrastructure, political stability and assets, it still delivers relatively poor health and wellbeing for children.

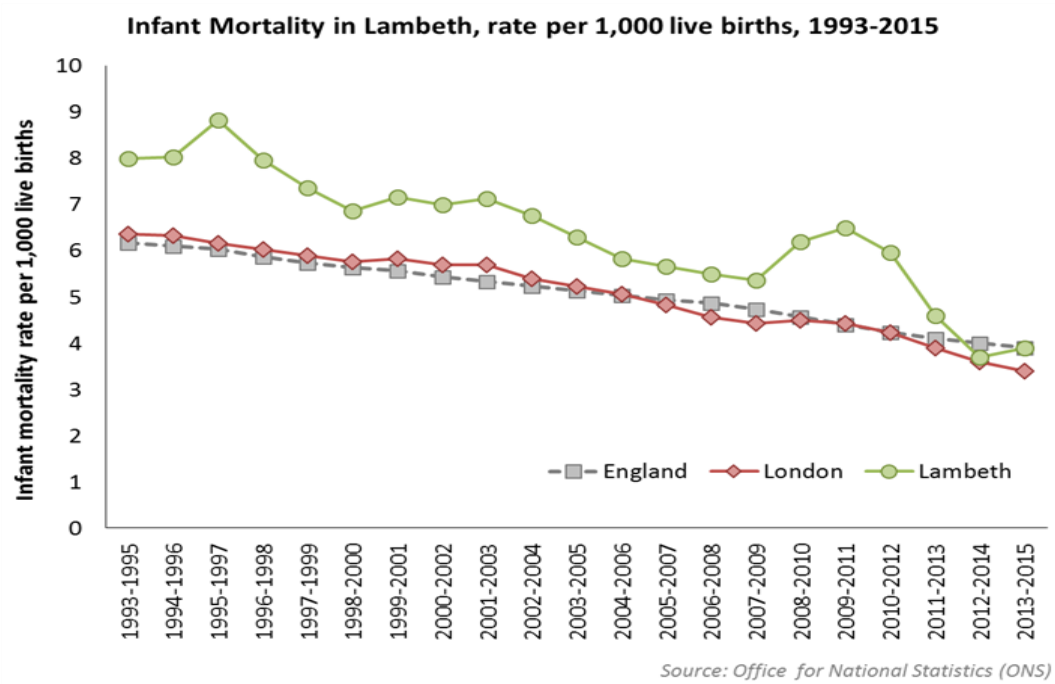
Early years (conception to school reception year)

Infant deaths

Deaths in live born children under the age of one year have declined since 1993-1995 (Figure 7). Despite some year to year variation, overall the gap between Lambeth, London and England nearly closed. This downward trend reversed in 2009-11, but the most recent Lambeth figures are once again very near to the London rates. However the UK is only 15th out of 19 western European countries on infant deaths.

Most infant deaths are due to prematurity and there is a strong association between deprivation and both prematurity and infant deaths, the latter which are more than twice as high in the lowest compared with the highest socio-economic group. Smoking in pregnancy also increases the risk of death, disability, and disease (for example stillbirth, cot death and the risk of respiratory disease across the life-course) and this is also related to socio-economic group (for instance in Scotland, 25.9 per cent of women in the most deprived areas acknowledged smoking following the birth of their baby, compared with 3.3 per cent in the least deprived areas). The overall prevalence of smoking during pregnancy in the UK is higher than in many European countries (for example 5 per cent in Lithuania and Sweden, compared with 11.4 percent in England (Royal College of Paediatrics and Child Health, 2017) but Lambeth does well as in 2014-15 only 3.4 per cent of mothers acknowledged they were smokers at delivery.

Figure 7 Infant mortality

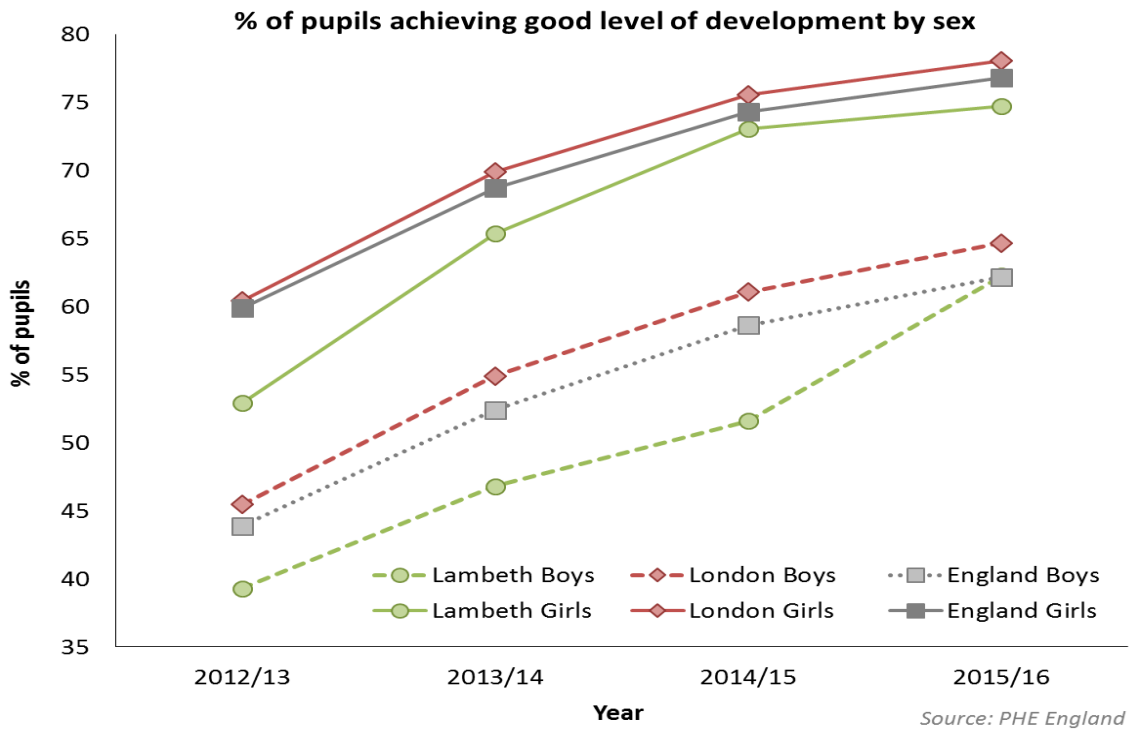


School readiness

School readiness is a helpful composite measure of both the present health and wellbeing of young children and their future potential, thus equal opportunity to be school ready is important for individuals and the population. School readiness is defined as the percentage of children reaching a Good Level of Development (GLD) at the end of reception (aged 5) and includes their achievements in communication and language, physical development, personal, social and emotional development, literacy and mathematics. Pupils have to achieve or exceed all of these goals to be included.

School readiness in Lambeth, London and England improved for boys and girls between 2012-13 and 2015-15 (Figure 8). Lambeth boys and girls are now very close to their London and England counterparts but there is considerable inequality between boys and girls. In 2016 overall, 68 per cent of Lambeth pupils reached the GLD goals, compared to 69 per cent nationally and 71 per cent in London but the difference between boys and girls is about 12 per cent.

Figure 8 Percentage of pupils achieving good levels of development



There is also considerable inequality in school readiness by socio economic status as measured by deprivation and free school meals eligibility, and by ethnic background.

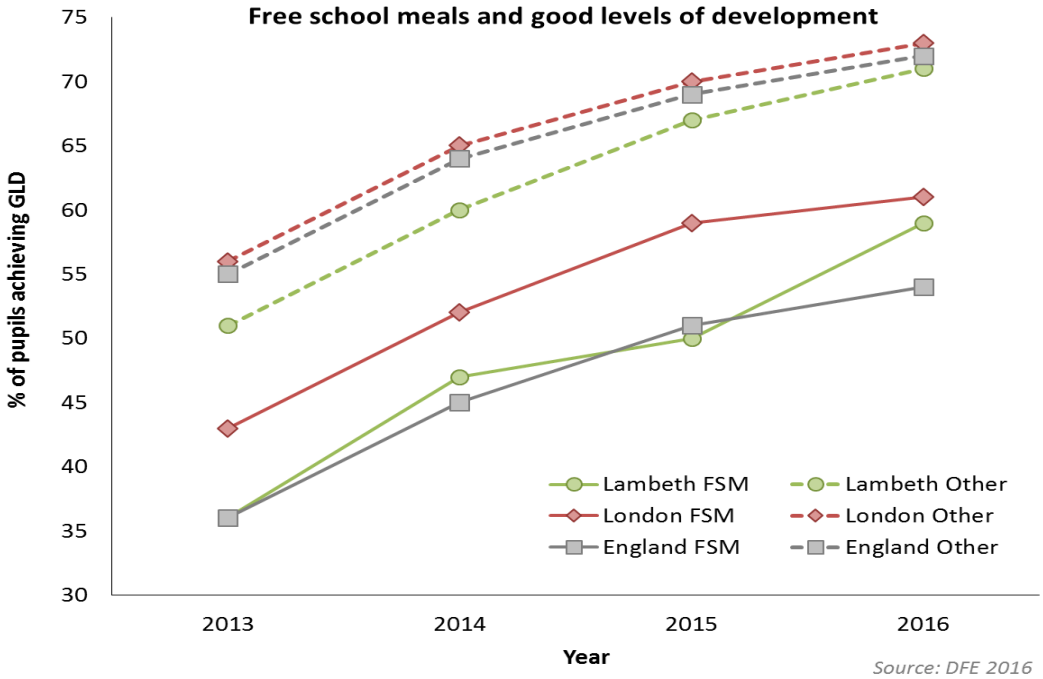
School readiness and deprivation

In Lambeth in 2016 there was a nine per cent gap in GLD achievement between children living in the most deprived areas and those living in the least deprived areas. This is an increase in the gap compared with 2010, when the gap was seven per cent and is mainly due to the drop in GLD from 65.3 to 63.8 per cent in areas in the most deprived decile.

School readiness and Free School Meal (FSM) status

Children eligible for free school meals are less school ready than their less deprived counterparts in Lambeth, London and England (Figure 9). In 2016, 59 per cent of Lambeth pupils eligible for FSM reached all GLD goals compared to 71 per cent of non-FSM pupils. Although compared with London in 2016, Lambeth pupils eligible for FSM nearly caught up with their London peers, and outperform English pupils, they remain below the levels of achievement of pupils who do not receive free school meals.

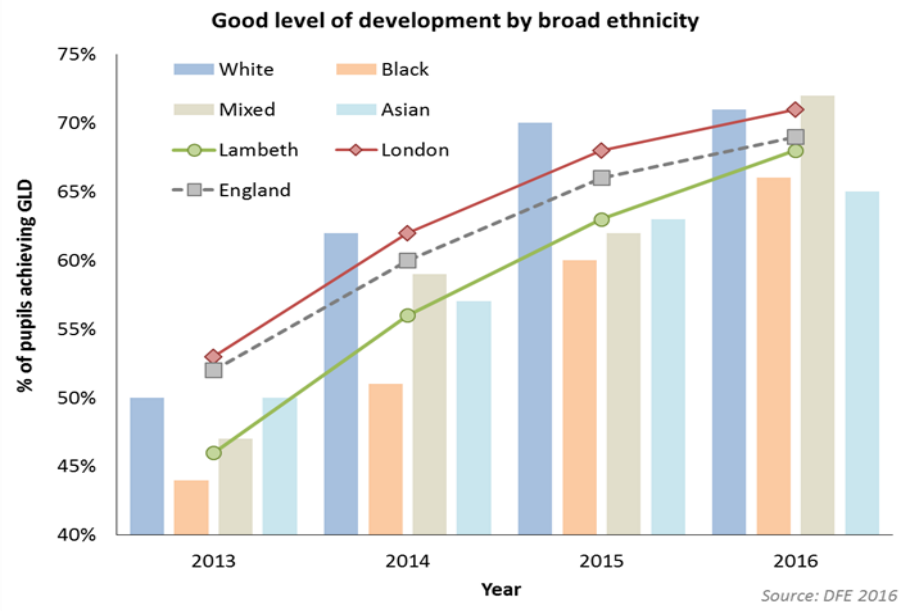
Figure 9 Free school meals and good level of development



School readiness and ethnic background

Although GLD achievement is improving in all ethnic groups and most gaps between broad ethnic groups are closing, there is still inequality (Figure 10). Pupils from white (British and non-British) or mixed ethnic background have the highest proportion reaching a Good Level of Development and achievement in the latter group markedly improved between 2015 and 2016. Black pupils have just overtaken Asian pupils, although achievement levels in Black and Asian groups are still below average. Data are not available for more detailed analysis by ethnic group. However, data held by Lambeth Council shows that Portuguese children and boys of black Caribbean descent achieve the lowest GLD rates and have done so for the past four years. It is not clear what, apart from known socio-economic factors, may be influencing this trend.

Figure 10 Good level of development by broad ethnicity

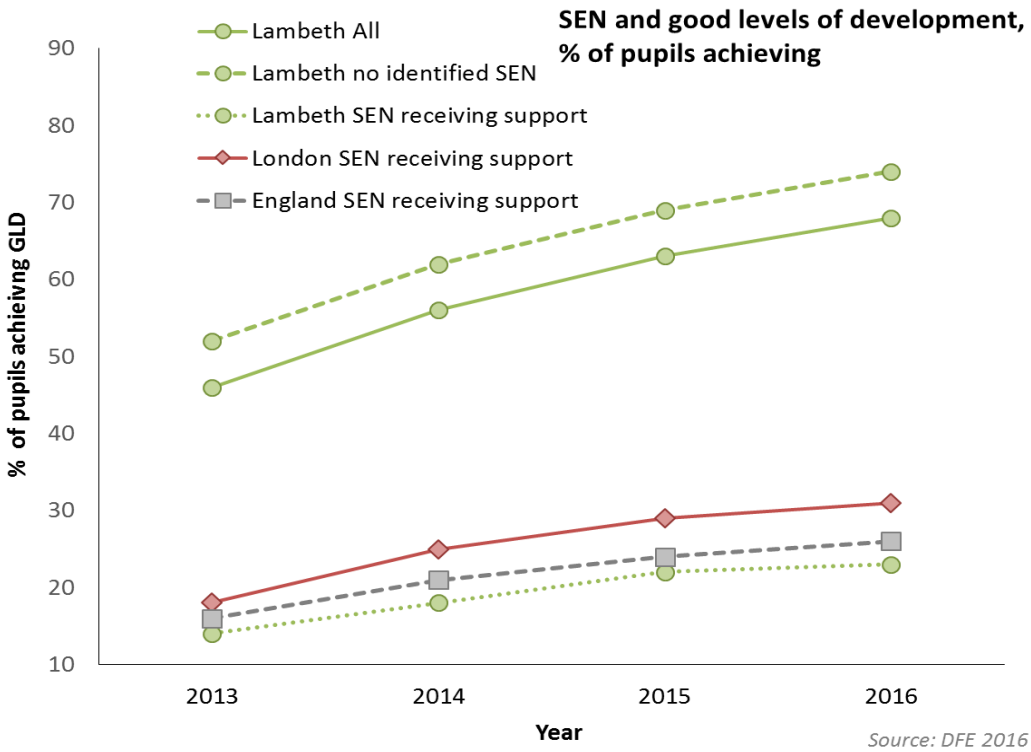


School readiness and children with special educational needs

Figure 11 compares the GLD scores between all pupils; those who have no identified special educational needs, and pupils who have special educational needs (SEN) and receive support but who do not have a statement. A statement indicates that the child's needs cannot be covered by standard school provision and requires additional support. GLD achievement is only available for SEN pupils without a statement as numbers for SEN pupils with statements are too small to be disclosed.

Whilst some difference in school readiness might be expected between pupils with and without SEN, achievement in Lambeth pupils with SEN is lower compared with London and England and the gap is also widening. There has been a change in methods of identification and categorisation of SEN, but even so the graph suggests the percentage of Lambeth pupils achieving GLD with no special educational needs has increased faster than children with SEN.

Figure 11 SEN and good level of development



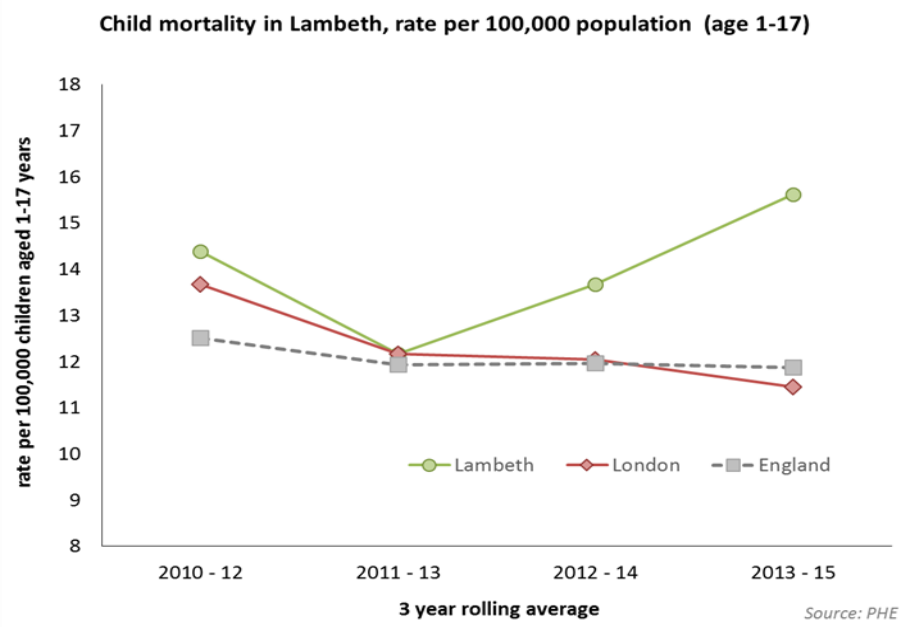
Source: DFE 2016

School-aged children & young people

Child deaths

Death in childhood is increasingly rare (although the UK still has one of the highest death rates for children and young people in Western Europe), thus Public Health England publishes death rates in children between one and seventeen years as a three-year rolling average. Separate rates for school aged children and young people are not available. Figure 12 shows a recent increase in the death rate in Lambeth children (26 deaths in the three years 2013-15). The rate is not statistically significantly different from England but is important to monitor.

Figure 12 Child mortality in Lambeth



Mental and emotional wellbeing

Good mental and emotional health in childhood are essential to development and being prepared for adulthood. More than half of all adults with mental health problems were diagnosed in childhood but research suggests that less than half were treated appropriately at the time.

There is little regularly collected, comparable local or national data on mental and emotional distress or ill health in children and young people. To gain insight into what is happening in Lambeth a number of measures are reviewed with a focus on measures where comparisons can be made between London and/or England.

A School and Health Education Survey (SHEU) of primary and secondary schools, done every two years in Lambeth since 2006, looks at many health issues and shows changes in children's self-esteem, fear of bullying, and general worries.

To estimate levels of diagnosable mental, emotional or conduct disorder in children and young people in Lambeth the following are used:

- findings from a national survey (last done in 2004) are applied to the 2014 Lambeth population, taking into account differences in age, sex and socio-economic classification (Table 2)
- the proportion of Special Educational Needs Statements that are due to emotional or mental health needs.

As a proxy for estimating the severity of mental or emotional distress, admissions for self-harm and mental ill health are presented.

The School and Health Education Survey

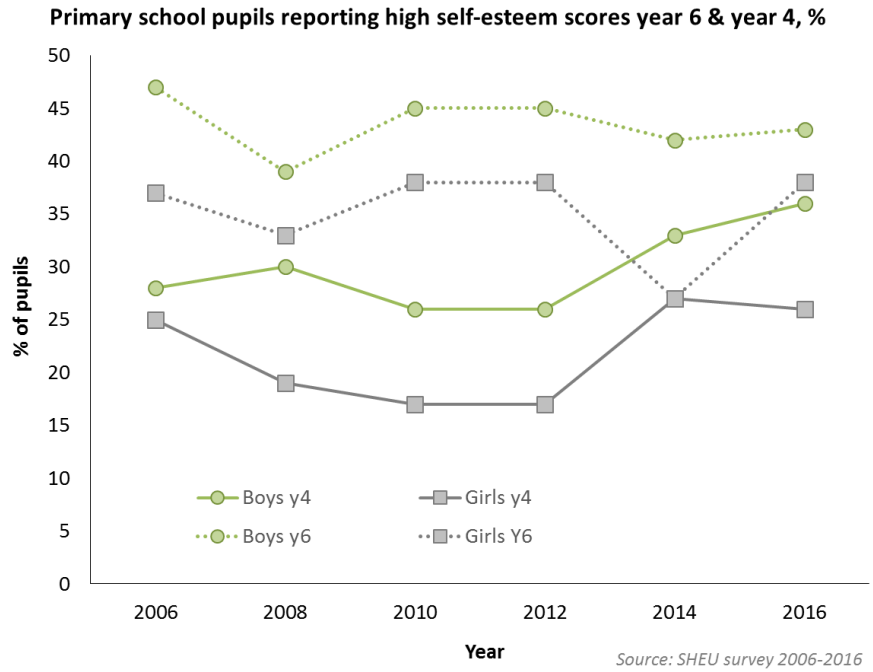
Some important findings of the SHEU Survey in Lambeth children are:

Primary Schools (years 4 and 6)

- Low self-esteem is declining in all primary school pupils from about 8 per cent of children in 2008 to only 5 per cent in 2016
- Over the same period, there has been an increase in high self-esteem in year 4 pupils, with boys consistently reporting higher levels than girls (36 per cent v 26 per cent in 2016)

- Self-esteem in year 6 tends to be higher than for year 4, with a similar gap for boys and girls although 2016 data show an upturn in girls (38 per cent) after a drop in 2014
- In 2016, 36 per cent of primary school students in Lambeth had high self-esteem
- About 33 per cent of pupils reported a fear of bullying, and 4 per cent said they were very often afraid to go to school due to fears of being bullied.

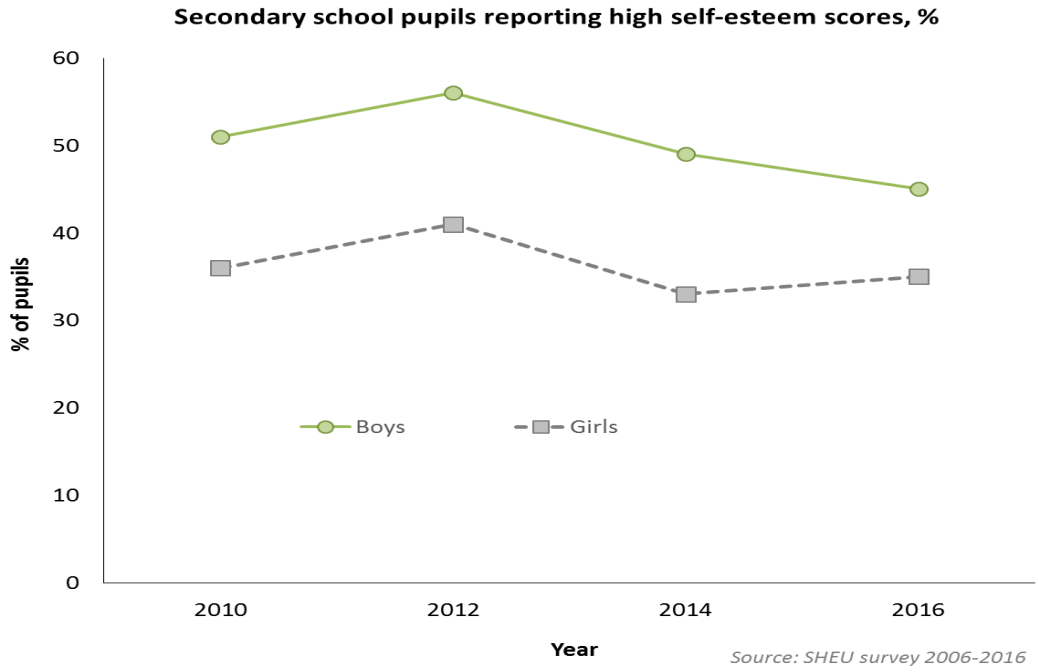
Figure 13 Primary School pupils' self-esteem scores



Secondary Schools (years 8 and 10)

- In secondary schools levels of high self-esteem were consistently higher in boys than in girls. In 2016, the gap was 10 per cent; 45 per cent of boys reported high self-esteem, compared with only 35 per cent of girls
- High self-esteem levels rose between 2010 and 2012 but were lower than 2010 in both 2014 and 2016 for boys and girls (scores for 2008 are not comparable)
- The proportion of pupils reporting medium to low self-esteem increased from 12 per cent in 2008 to 15 per cent in 2016 (no gender breakdown is available for all years, but in 2016, 19 per cent reporting medium to low self-esteem were girls and 12 per cent were boys)
- The main worries reported in secondary schools were exams and tests, as well as family and the future (changing schools, moving house, getting a job etc)
- 15 per cent reported a fear of going to school due to being bullied.

Figure 14 Secondary school pupils' self-esteem scores



Mental, emotional and conduct disorders

Applying the 2004 national survey to Lambeth shows that the estimated rates of mental ill health in Lambeth children and young people are higher than in London and England.

Table 2 Estimated prevalence of mental health disorders

Indicator	Lambeth (%)	Lambeth (number)	London	England
Estimated prevalence of any mental health disorder, 5-16, per cent (2014)	9.9	3799	9.3	9.3
Estimated prevalence of emotional disorders, 5-16, per cent (2014)	3.8	1479	3.6	3.6
Estimated prevalence of conduct disorders, 5-16, per cent (2014)	6.1	2334	5.7	5.6

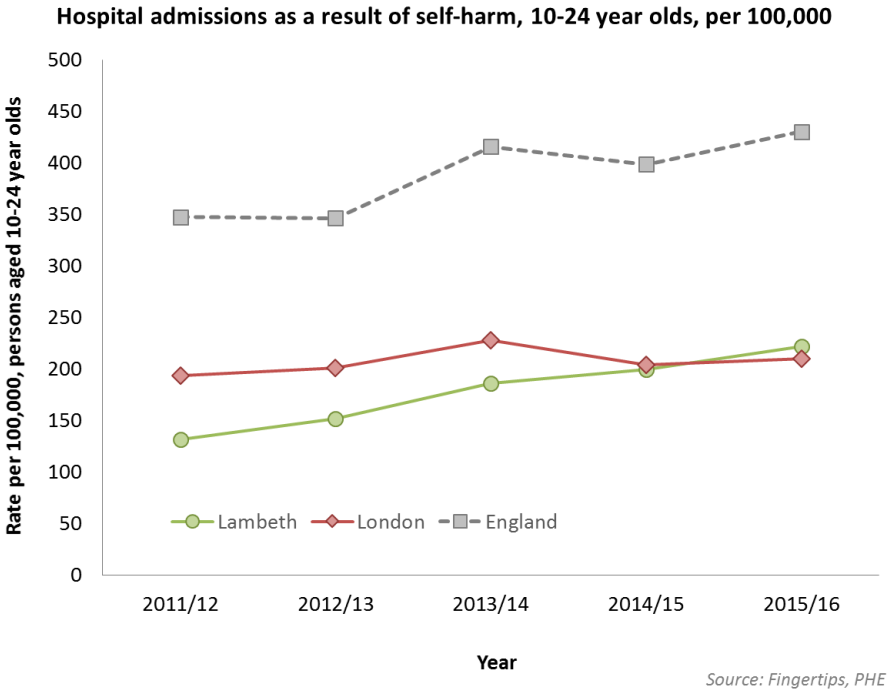
Source: PHE England, Children and Young People Mental Health Profile (2014)

In 2015, the Department of Education identified that 2.6 per cent of Lambeth school pupils (about 1000 pupils) had social, emotional or mental health needs as the main reason for their Special Educational Needs statement. This is also higher than the London and England level of 2.1 per cent and 2 per cent respectively.

Admissions to hospital

Self-harm is an indicator of mental distress but is difficult to measure unless it leads to hospital admission. Figure 15 shows that, whilst Lambeth has low admission rates for self-harm compared with England, the rate has increased over the last five years to match and slightly exceed that in London. In 2015-16, there were 113 hospital admissions for self-harm in Lambeth 10 to 24 year olds.

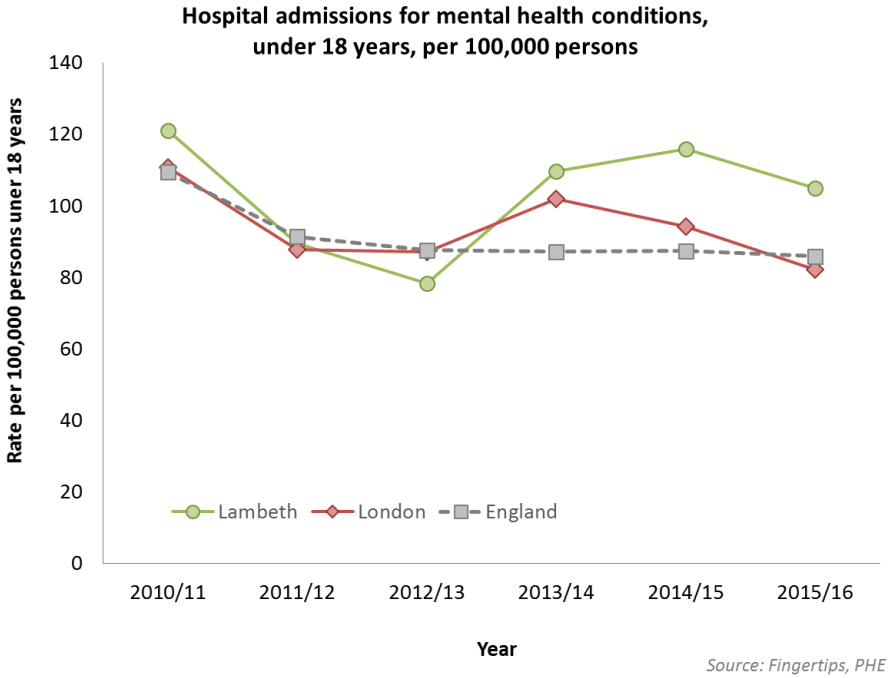
Figure 15 Hospital admissions for self-harm



Source: Fingertips, PHE

Hospital admission for mental health conditions in young people aged 0-17 years are higher in Lambeth than London and England and have increased since 2012-13, although 2015-16 does show a reduction (Figure 16).

Figure 16 Hospital admissions for mental health conditions



Source: Fingertips, PHE

Childhood Obesity

The risk of being obese is thought to be equivalent to that of smoking. Obesity substantially increases the risk of serious life-long health problems, including Type 2 diabetes, heart disease, and cancer. Being overweight or obese in childhood substantially increases the risk of being overweight

or obese as an adult and obese children experience stigma and bullying. Across England, Scotland and Wales more than one in five children in the first year of primary school are overweight or obese, and there has been minimal improvement over the past decade. In 2015-2016, 40 per cent of children in England's most deprived areas were overweight or obese, compared with 27 per cent in the most affluent areas (Royal College of Paediatrics and Child Health, 2017).

The National Child Measurement Programme (NCMP) is an annual measurement of the height and weight of reception class (4-5 year olds) and year 6 (10-11 year olds) children in England. The purpose of the NCMP is:

- To inform local planning and delivery of services for children
- To gather population level surveillance data to allow analysis of trends in growth patterns and obesity, showing underweight, healthy weight, overweight and obesity
- To increase public and professional understanding of weight issues in children
- To act as a useful vehicle for engaging with children and families about healthy lifestyles and weight issues.

The programme has been implemented in Lambeth since 2006 and is the main source of local childhood obesity data.

Although there are grounds for cautious optimism, overweight and obesity is also major problem in Lambeth children, especially in deprived groups. About 23 per cent of Lambeth children in their reception year and 39.4 per cent of children in Year 6 were overweight or obese in 2015-16. About 11 per cent in Reception and 23.2 percent in Year 6 were obese (Figure 17and Figure 18). The percentage fluctuates, but there has been a downward trend over the past 10 years. The data also suggest the gap between Lambeth and London and England may be closing.

Figure 17 Percentage of pupils who are obese at Reception in Lambeth, London and England

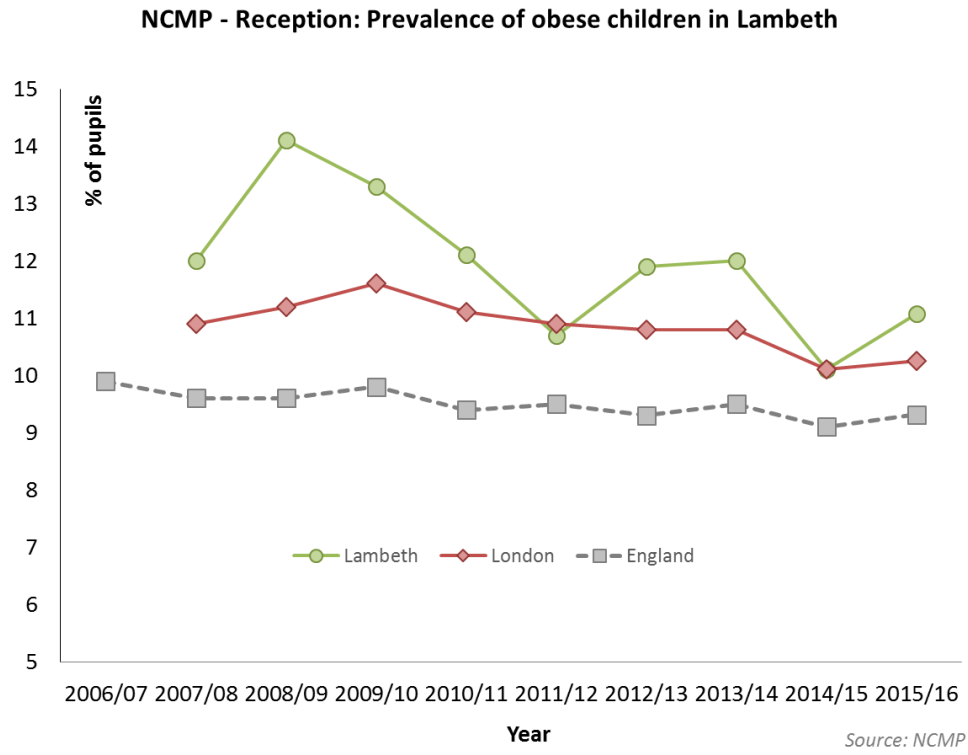
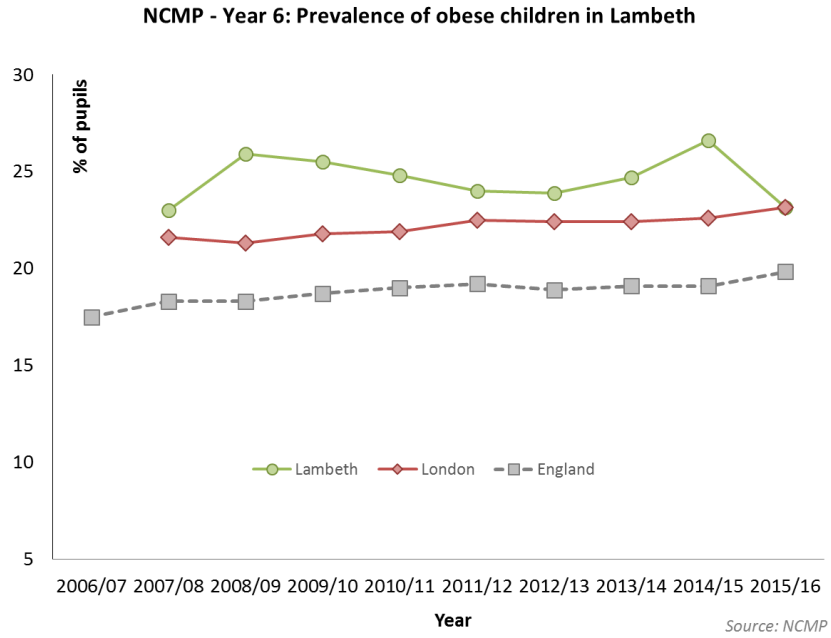


Figure 18 Prevalence of obesity in children in year 6 in Lambeth, London and England



In 2016, Public Health reviewed the Lambeth data on obesity in detail looking at gender, ethnicity and deprivation for year 6 students:

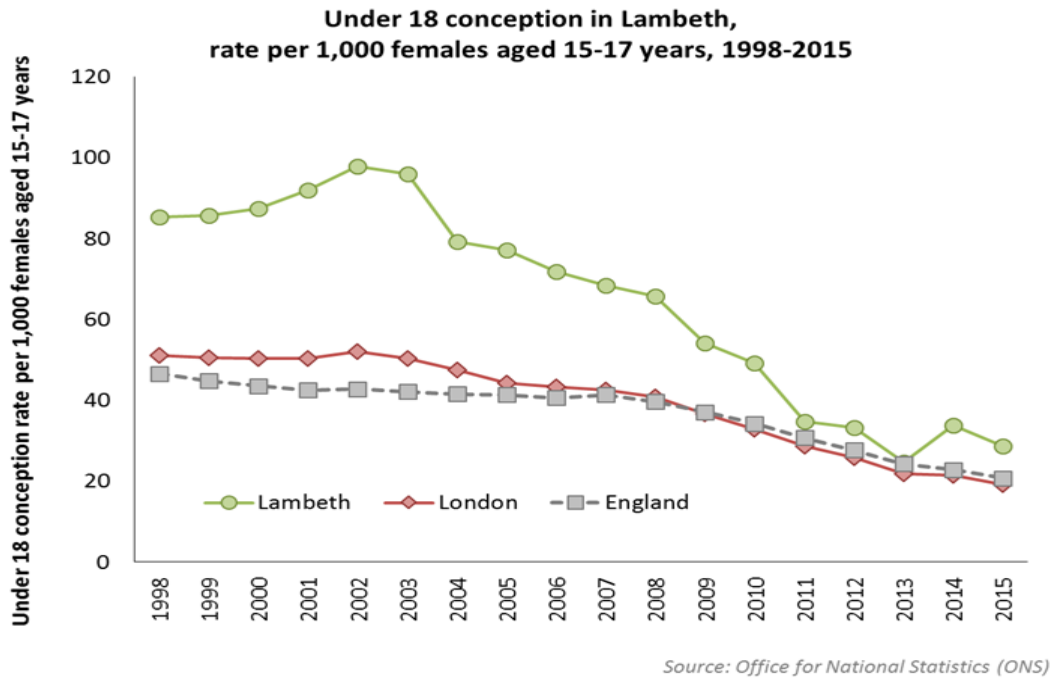
- boys are significantly more likely than girls to be obese
- all ethnic groups are more likely to be obese than white British pupils, and black Caribbean and Asian pupils are nearly twice as likely to be obese
- Children living in poverty are significantly more likely to be obese: children in the most deprived deciles (7th to 10th) are 1.5 to 2 times more likely to be obese than children in less deprived deciles

The full report is: https://www.lambeth.gov.uk/sites/default/files/ssh-lambeth-deep-dive_4.pdf

Teenage Conceptions

There has been a steady reduction in teenage conception rates (conceptions per 1,000 females aged 15-17 years) since the peak in 2002 (Figure 19). The rate in Lambeth has decreased more rapidly than in London and England, with a 70 per cent decrease since 2002 (from 406 to 123 conceptions in 2015) compared to a 61 per cent decrease in London and a 53 per cent decrease in England. There was a small increase in 2014 followed by a reduction in 2015. In spite of this good progress Lambeth still has the 3rd highest teenage conception rate in London.

Figure 19 Under 18 conceptions in Lambeth

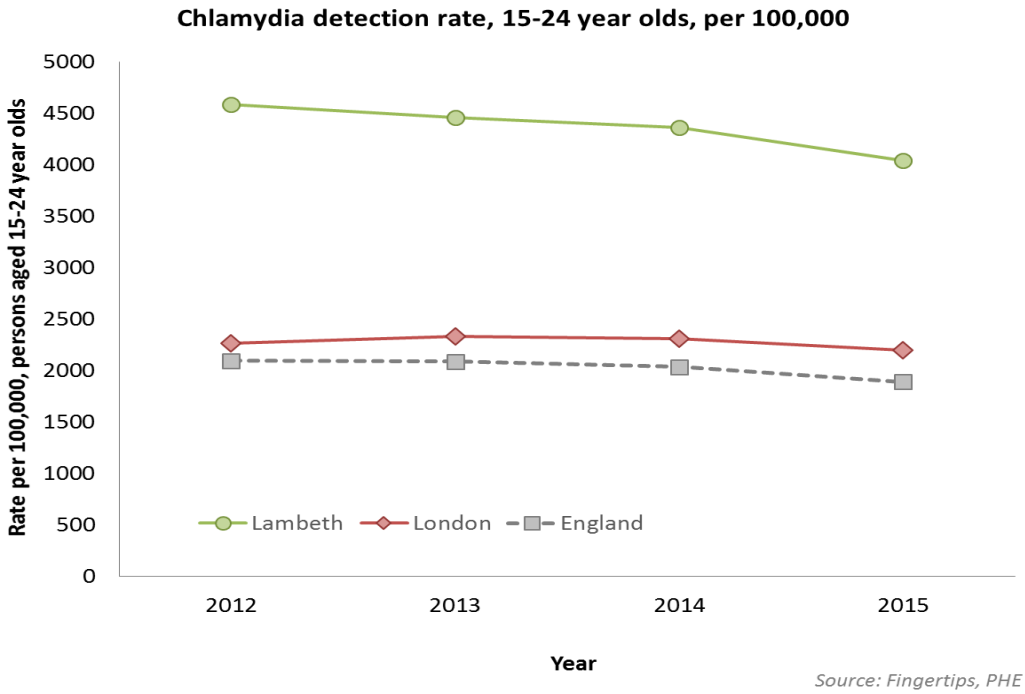


Note: Teenage conceptions data are released annually in late February / early March, 14 months after the end of the year in which the conceptions occurred.

Sexual health

Sexually transmitted infections (STIs) are a huge issue in Lambeth and this is also the case for young people in the borough. Chlamydia is the most common bacterial STI, and sexually active young people are at highest risk. Chlamydia often has no symptoms but has serious long term consequences if not treated especially for women. This means it is worthwhile screening for the infection, and there is a national Chlamydia screening programme for young people under 25 years. In Lambeth, young people are strongly encouraged to be screened and Chlamydia detections per 100,000 young people aged 15 to 24 are much higher than in London or England (Figure 20). This may be due to better screening practices or higher prevalence, but it is probably a combination of both. Detection has decreased over the last four years, in line with a smaller decline in England and London. Again, it is unclear whether this is due to lower screening numbers or a decline in prevalence.

Figure 20 Chlamydia detection rate



Source: Fingertips, PHE

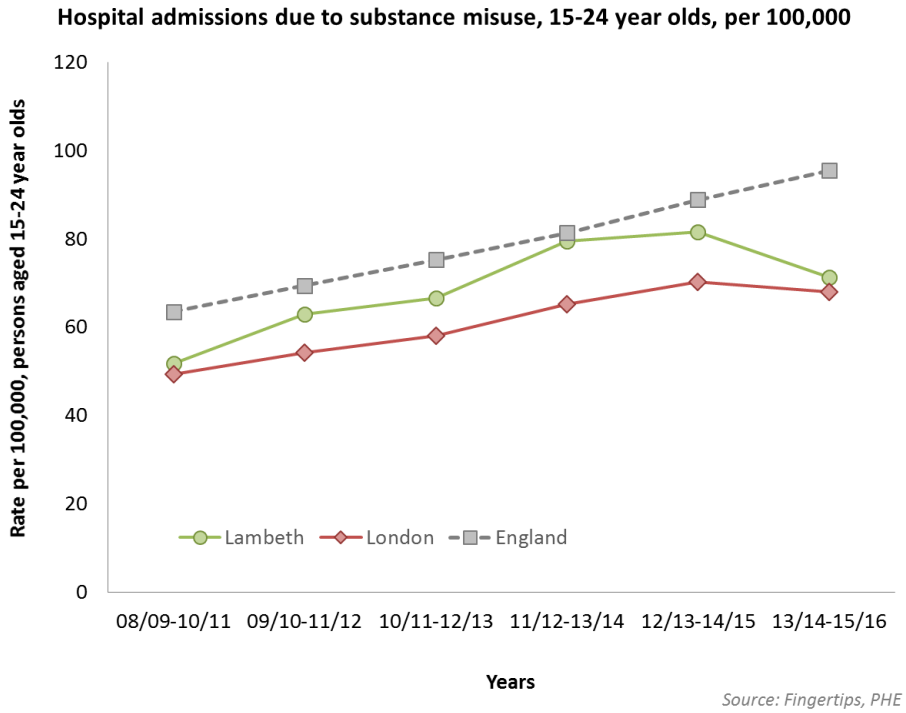
Substance misuse (drugs and alcohol)

Drug misuse

Drug misuse refers to the use of any recreational drugs with the exception of alcohol (e.g. sedatives, opioids, cocaine, tobacco etc.) that leads to harm. There are limited data available to understand the extent of misuse in Lambeth. The "What About Youth London" survey of 15 year olds showed that in 2014, 7.1 per cent of Lambeth respondents had taken cannabis in the last month which is higher than in London (5 per cent) and England (4.6 per cent).

Hospital admissions due to substance misuse in young people aged 15-24 years have risen in Lambeth in line with similar increases in London and England, although the Lambeth rate appears to have risen faster than the London rate up to the period 2012-13 to 2014-15 and then declined such that the three year rolling average for Lambeth in 2013-14 to 2015-16 is now significantly less than England, and similar to London. However, the absolute number of admissions has risen from 57 in the three years 2008-09 to 2010-11 to 80 in 2013/14-2015/16,

Figure 21 Hospital admissions due to substance misuse



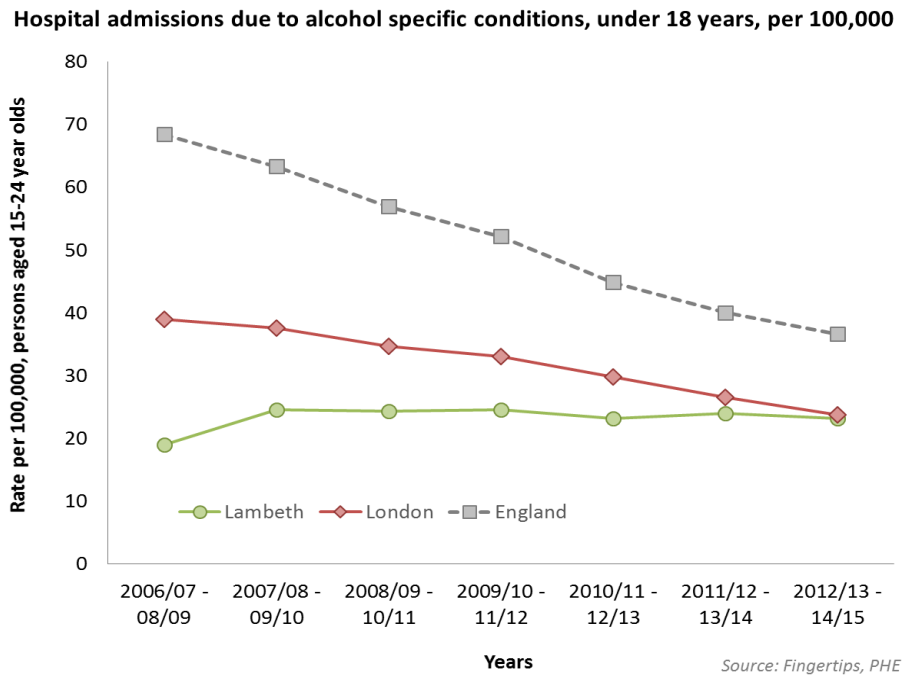
Source: Fingertips, PHE

Alcohol misuse

In 2013-2014, 13 per cent of 15-year-olds surveyed in Wales, 11 per cent in England and 13.5 per cent in Scotland reported drinking alcohol at least once a week (Royal College of Paediatrics and Child Health, 2017). The figures for Lambeth are not known but Public Health England collects numbers and rates of admission to under 18s due to alcohol-specific conditions (conditions directly caused by alcohol, e.g. alcoholic gastritis or ethanol poisoning).

The admission rate in Lambeth per 100,000 young people under 18 years increased between the three year periods of 2006-09 and 2007-10, but has since remained steady. The London rate fell over the same period and both values are now similar. The England rate has fallen more rapidly than the decline in London but in 2012-15 the Lambeth and London rates were still much lower than the England rate. This is positive but it is not known whether this is related to adolescents moderating their excessive drinking or to overall reductions in intake.

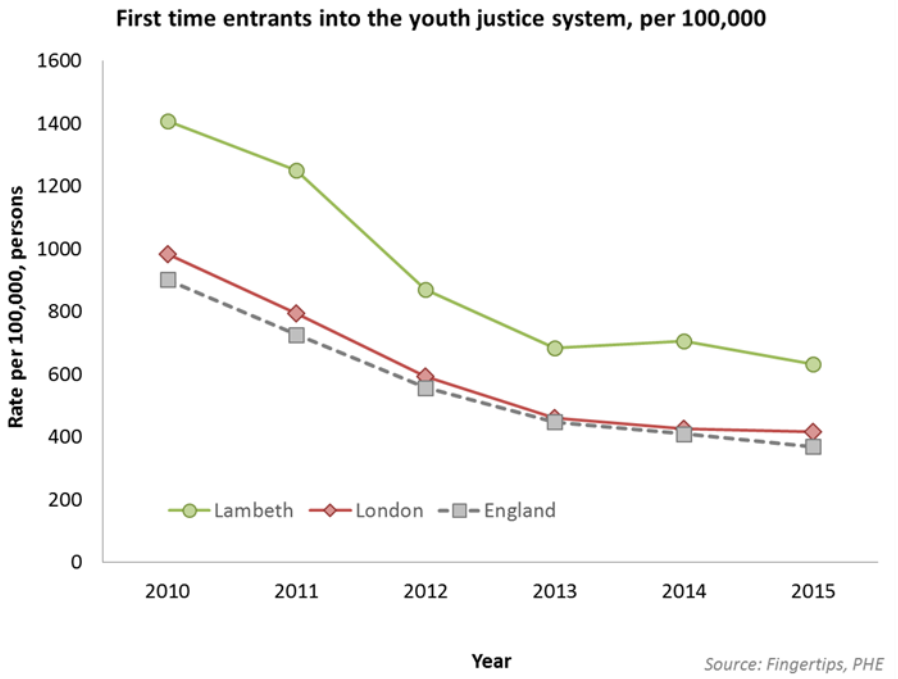
Figure 22 Hospital admissions for alcohol specific conditions in under 18s



Youth offending

The rate of first time entrants (FTEs) into the youth justice system has fallen nationally between 2010 and 2015 including in Lambeth. The rate in Lambeth has fallen more steeply than in London and England. However Lambeth started at a much higher rate, so although the gap has narrowed, Lambeth rates remain higher than London and England. The number of first time entrants into the youth justice system in Lambeth also fell substantially from 319 in 2010 to 148 in 2015. Youth violence is an element of youth offending, but data availability are limited. Lambeth Public Health is planning an in-depth piece of work on this issue.

Figure 23 First time entrants into the youth system



Long term conditions and complex needs

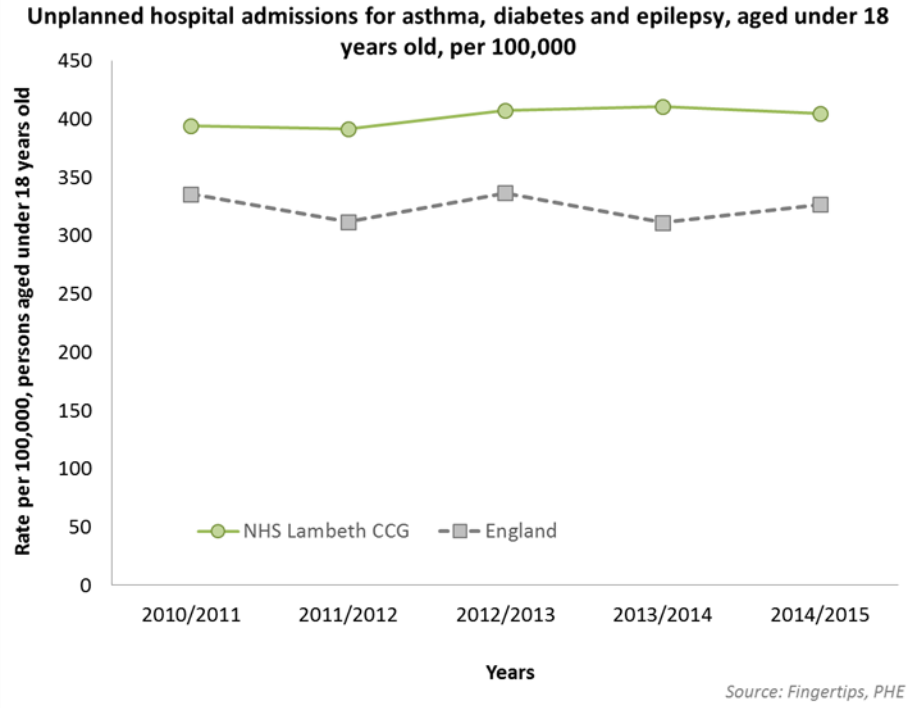
Long-term conditions such as asthma, diabetes and epilepsy are common in children and young people. About 14.2 per cent of Lambeth 15 year olds report a long term illness (defined as 'like diabetes, arthritis, allergy or cerebral palsy'). How diseases are managed and treated has a substantial impact on young people's ability to live a full life for instance playing with friends, completing their education, getting a job and having their own families.

Unplanned hospital admissions in under 19s for asthma, diabetes and epilepsy

Asthma, diabetes and epilepsy account for over 90 per cent of emergency admissions for children with long-term conditions so it is a useful measure of how well controlled these conditions are in this age-group.

There has been no significant change in the rate of unplanned hospital admissions for these three conditions in Lambeth between 2010-11 and 2014-15, but the Lambeth rate exceeds the England rate by about a fifth, which suggests scope for improvement and needs further investigation.

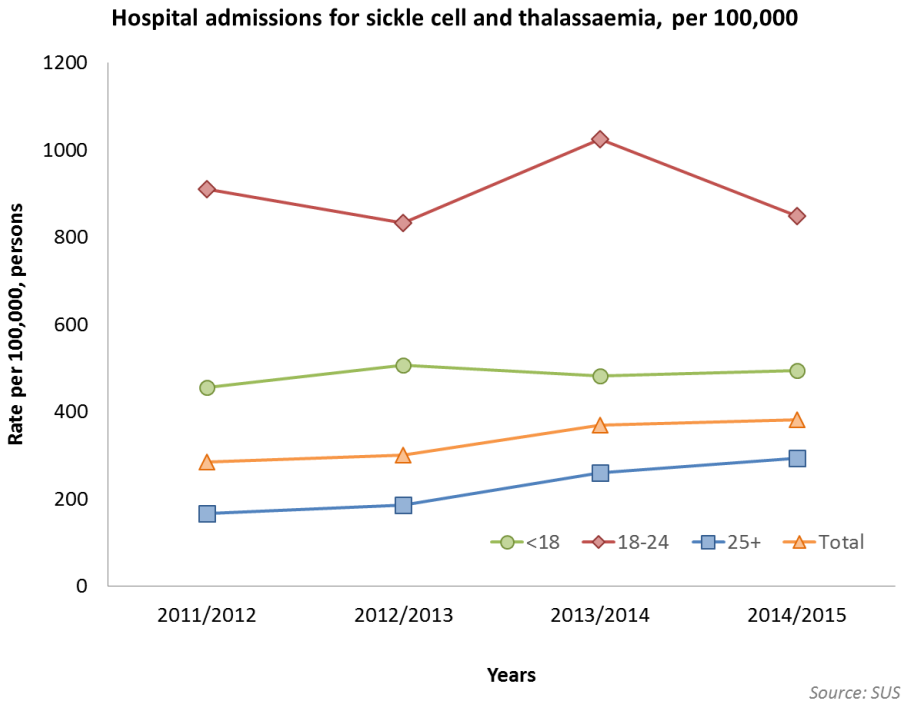
Figure 24 Unplanned hospital admissions for selected long-term conditions



Sickle cell anaemia and thalassaemia in Lambeth

Sickle cell disease and thalassaemia are inherited haemoglobin disorders (haemoglobin is a protein in red blood cells) which can lead to various and sometimes serious long term health problems in children and adults. Both disorders are more common in some groups resident in Lambeth, for instance people of African, Caribbean, Mediterranean, south Asian, southeast Asian and Middle Eastern origin. Both conditions can be mainly managed in the community or through outpatients but hospital admission rates increased slightly for the whole population between 2011-12 and 2014-15. This was partially driven by an increase in the admission rate for people over 25 years but admission rates are highest in 18 to 24 year olds, followed by admission rates in young people aged under 18 years, suggesting more can be done to manage these conditions effectively in young people.

Figure 25 Hospital admissions for sickle cell and thalassaemia



Source: SUS

Children with disabilities

There are no nationally collected data on the number of children with disabilities, and local authorities only know about children who receive social services. The best source of information comes from the school census which collects information on pupils with special educational needs and disabilities (SEND).

Children with disabilities, whether physical (e.g. visual impairments, cerebral palsy), or specific (e.g. dyslexia, dyspraxia) or moderate, and severe or multiple and profound learning disabilities, may be assessed as having special educational needs. In 2016 in Lambeth, 3,025 primary school children and 2,588 secondary school children were assessed as having special educational needs. A further 434 children with SEN attended special schools. Overall about 18 per cent of Lambeth pupils in all types of educational establishments (from nursery to secondary schools to pupil referral units (PRUs) were assessed as having SEN in 2016.

The apparent reduction in the proportion of pupils with special educational needs shown in Figure 26 is difficult to interpret and a larger piece of work on SEN is planned for 2017 to understand this better.

Figure 26 percentage of pupils with special educational needs in Lambeth

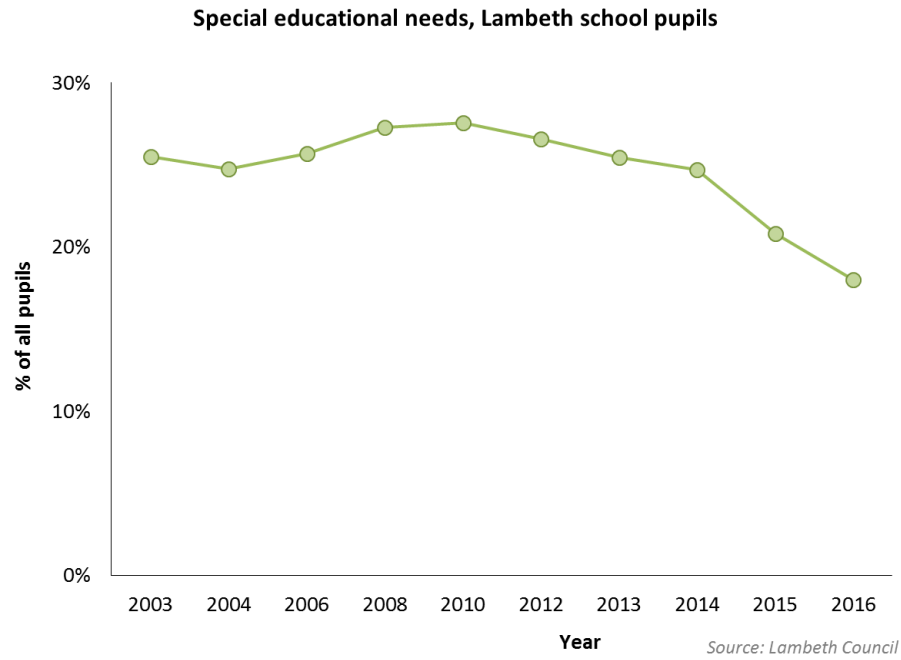


Figure 27and Figure 28 show the distribution of different reasons for SEN in primary and secondary school children in Lambeth. Only the primary disability or need is recorded. Of the total with SEN, 29.5 per cent in primary schools (speech, language and communication needs were higher at 32 per cent), 30.7 per cent in secondary schools and 84 per cent in special schools had a learning disability (LD) or were on the autistic spectrum (ASD).

Figure 27 Special Educational Needs by primary need, Lambeth primary schools

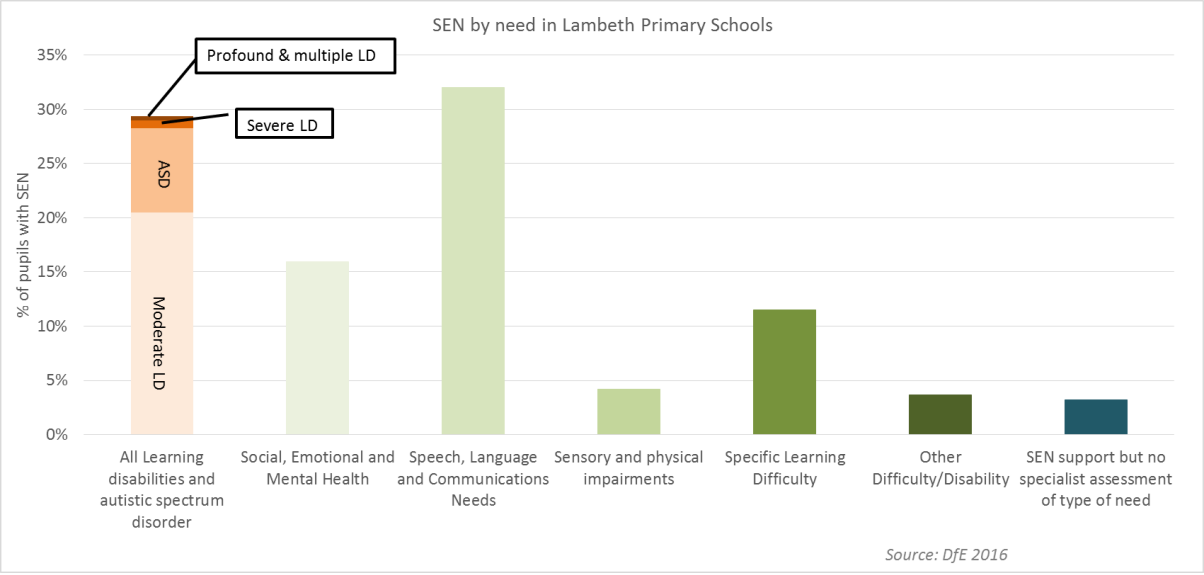
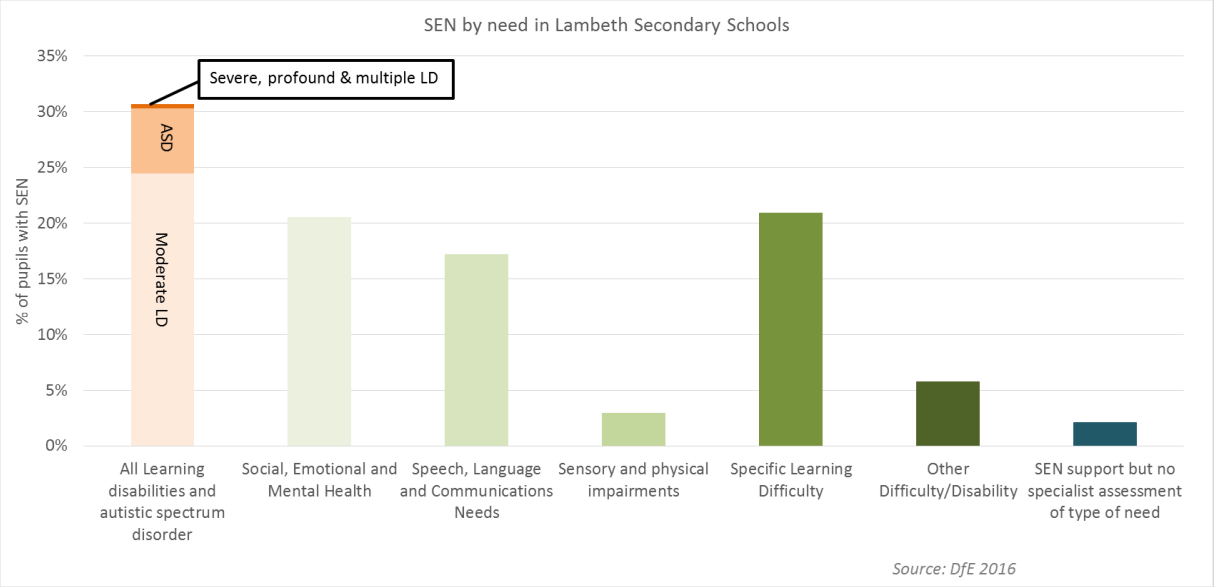


Figure 28 Special educational needs by primary need in Lambeth secondary schools



As might be expected pupils in special schools mostly have severe, profound and multiple learning disabilities or are on the autistic spectrum.

Vulnerable children

Some groups of children are at much higher risk not only of poor health and wellbeing but of actual harm. Children are at increased risk of neglect and harm where one or more of mental ill-health, substance misuse, domestic violence and learning disabilities are present (De Bell, 2015). This applies to many groups of children including:

- Children in care - Looked After Children
- Children with disabilities and special educational needs
- Children with poor school attendance or excluded from education
- Homeless young people
- Children with mental health conditions and/or substance misusers
- Refugee/asylum seeking children
- Children with signs of anti-social or criminal behaviour
- Young offenders and CYP in the justice system
- Children at risk of or victims of sexual abuse including sexual exploitation

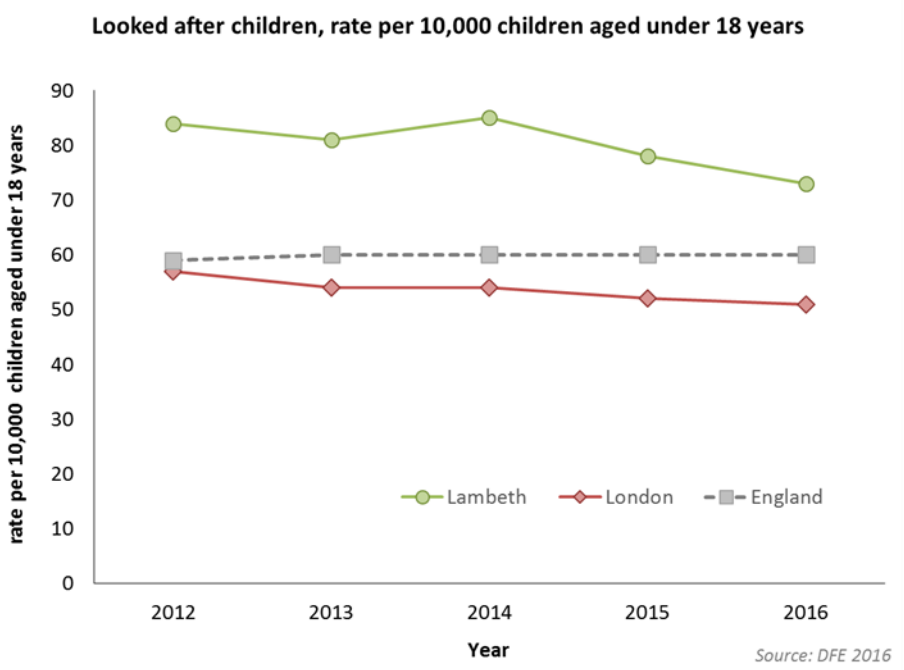
How well a local 'system' protects from and prevents harm in children is an indicator of the effectiveness and equity of the system as a whole. However, data are often difficult to compile. We therefore present information on three groups of children of particular concern in Lambeth, where some data are available: an important and known group, children in care (looked-after children); a newer less well known group, children at risk of sexual exploitation; and a group where there is increased focus, children in temporary accommodation.

Looked after children

Children can become looked after by local authorities for a range of reasons, but primarily because their safety and wellbeing is at significant risk. Children can be looked after for short or longer periods of time; most but not all children live with foster carers (though around 10 per cent of children will live in residential homes and schools). They can be looked after on either a voluntary

basis (known as section 20) or following court and care proceedings. Removing a child from his or her family carries its own risks to development and wellbeing, so this is only done when the risks of leaving the child at home are substantial.

Figure 29 Looked after children in Lambeth



The rate of looked after children in Lambeth has declined steadily over the past few years but remains significantly higher than the rest of London and England.

Rates and overall numbers have reduced for a range of reasons. Firstly there has been a stronger emphasis nationally and locally on using adoption earlier and for more children to secure permanency where there is no prospect of them returning safely to their family. Secondly, there is now better and more robust 'gatekeeping' to correctly identify those children where there is no other choice for them but to be looked after. Finally, Lambeth has privileged social work practice approaches that supports proactive work with families to reduce and manage risk more effectively.

In 2016, most looked after children were aged 10 to 15 (42 per cent), 29 per cent were aged 16 and over, with the remainder aged between under 1 to 9 years old. 58 per cent were boys and 42 were girls. 11 per cent of children who ceased to be looked after in 2016 were adopted. This is an increase compared with previous years, when the figure was 9 per cent in 2012 and 7 per cent throughout 2013 to 2015. This may in part explain the declining overall rate as national policy is now to promote early adoption of children where there is no prospect of them returning to their family.

Child Sexual Exploitation (CSE)

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/ or (b) for the financial advantage or increased status of the perpetrator or facilitator. A child or young person may have been sexually exploited even if the sexual activity appears consensual (for instance they do not recognise they are being exploited). Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology (Department for Education, 2017).

There are no estimates for the prevalence of CSE in the UK, only for child sexual abuse (CSA). The latest available study uses a survey from 2011 to estimate CSA at 0.6 per cent in under 11 year olds and 9.4 per cent in 11-17 year olds in the year preceding the study (Allnock, 2015). This would translate to a rough estimate of 1900 cases a year of child sexual abuse in Lambeth.

For CSE in Lambeth the number of referrals made to children's social care of children thought to be at risk of CSE and police reports on crimes associated with CSE are the only sources of data. In a 46 month-period between 2013 and 2016 there were 272 individual referrals for CSE to children's social care, of which 30 per cent were considered to be of sufficiently high risk to be referred to a multi-agency referral panel (MARP). 89 per cent of referrals were female aged between 8 to 19 years, most of whom were 15 years old. In 2016, there were 82 police reports of crime linked to CSE, in 17 per cent of which there was evidence that a child was being targeted for abuse. This was a drop from 2014-2015 when 100 CSE flagged cases were reported by the police in Lambeth, the third highest of London boroughs.

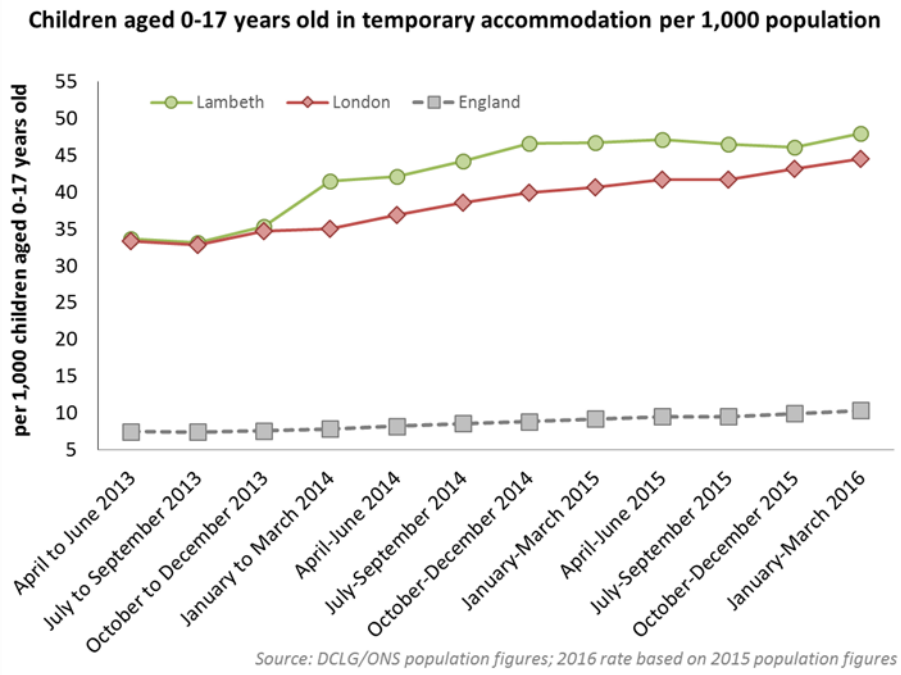
CSE that comes to the attention of services is likely to be a substantial underestimate of what is actually happening, as most victims do not disclose their abuse, or are not aware that they are being exploited until they are older.

Children in temporary accommodation

Temporary accommodation (TA) is provided by the council for residents eligible for housing support who are at risk of becoming or who are already homeless. It is included as a measure in this section (rather than in the section on influences on health) because children in temporary accommodation are at specific risk of harm for instance, due to neglect.

The rate of children in TA includes expected children, i.e. pregnant women. Figure 30 shows the rate of children per 1000 population in TA between 2013 and 2016. In 2016, 47 children per 1000 aged 0-17 in Lambeth were in temporary accommodation. The London and England values for 2016 were 44 and 10 respectively. Although Lambeth has more children in TA than London, the Lambeth rates have been relatively steady recently, whereas the London rate is increasing. Both are four times the England rate.

Figure 30 Children in temporary accommodation in Lambeth



Summary

In Lambeth

- In the early years:
    - Infant deaths have reduced significantly
    - average school readiness has improved, but there remains substantial inequality as children in deprived circumstances and from some ethnic groups do less well
- In children of school age:
    - In primary school children emotional health may be improving, but the opposite is likely in secondary school and it is worse for girls
    - Obesity may be reducing or at least stabilising
- In adolescents:
    - Admissions for self-harm have increased
    - Sexual health remains a substantial issue although there is some improvement
    - Alcohol misuse is reducing
    - Youth offending is reducing
- For all children:
    - Safeguarding is a mixed picture: there are fewer children in care but there are unmet needs where children are being sexually exploited and there is an increase in children in temporary accommodation
    - Large numbers of children have a long term condition and quality of care may not be optimal.

Although there is much greater detail in the Joint Strategic Needs Assessment on children and young people's health, it is clear from this summary that there are many gaps in the information and unanswered questions. To be more effective in the future all services need to work more closely together to improve the information available and how it is shared, analysed and used.

5. The benefits of a life course approach to child development

Given the state of health of Lambeth children and the diverse and complex forces impacting on their health and wellbeing, Lambeth partners need to adopt approaches that maximise the opportunities for all children to do well. This section is an overview of what can be done to achieve this.

Childhood and adolescence are critical developmental periods with long-term implications for the health and well-being of individuals and society. The foundations of good health and wellbeing start before birth and continue over a person's lifetime, with the potential to accumulate good health or disadvantage (Marmot, 2010; Halfon, Larson, Lu, Tullis, & Russ, 2014), see Figure 31. This means there is scope for influencing health throughout life. A life course approach to health is one where opportunities to promote and protect health and wellbeing are maximised at each life stage according to what works best at each point.

There are specific times in life when exposure to positive influences is very beneficial, as the effects are enduring. The foundations for virtually every aspect of human development (physical, intellectual and emotional) are laid in early childhood (Marmot, 2010). A child's biology and the development of body and brain means that interventions during pre-birth, infancy, and the pre-school years ('the early years') are critical to reducing health inequalities and promoting lifelong good health and resilience (National Scientific Council on the Developing Child, 2010).

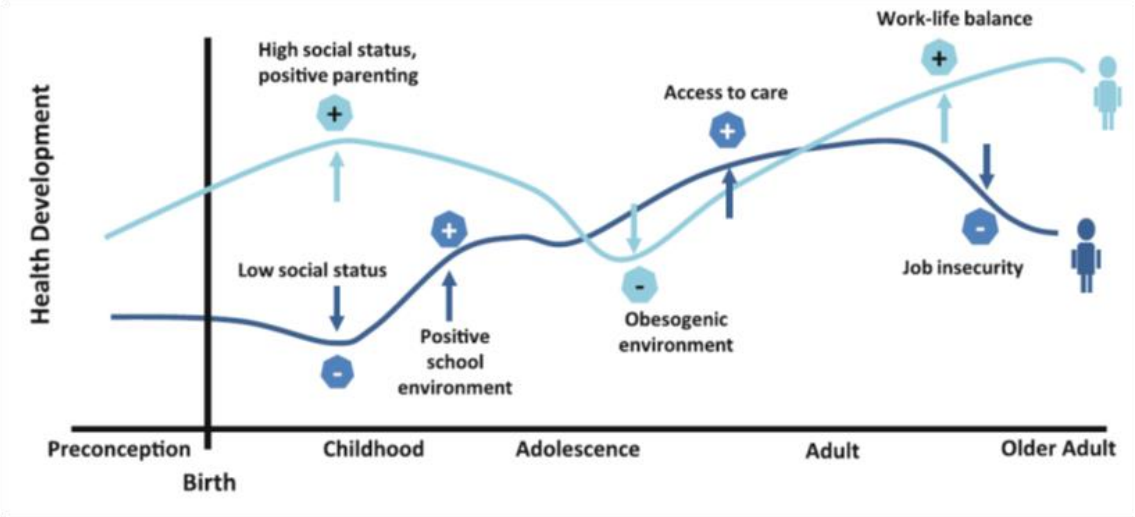
Sufficient focus and resource during the early years will also help to break the link between disadvantage and life-long poor outcomes and the benefits are likely to be widely felt in the short and longer term. Population levels of resilience and autonomy, readiness to learn, social behaviour, educational and overall attainment in life, and physical and mental health are enhanced. This benefits society and the economy as a whole.

The adolescent years from 10-19 are second only to the early years (Viner, et al., 2015) because this is a time not only of physical and mental growth and development but also of significant change in attitudes and behaviours. This means that where investment in early years is complemented by appropriate support in adolescence there is added value including where there had been earlier disadvantage such as through being in care, living in poverty and or with special educational needs.

The social and health benefits of investing in the early years are also reflected in the economic benefits and costs avoided (Wave Trust, 2013). Studies (mostly from the US) show that benefits range from 75 per cent to over 1,000 per cent higher than costs, with rates of return on investment significantly higher than those obtained from most public and private investments. UK studies confirm the significant economic benefits from early years' interventions. For example an early years preventive strategy in Croydon with a focus on preparation for parenthood (NHS Croydon and Croydon Council, 2010), showed a probable return on investment of more than £10 per £1 invested.

Conversely where poor early life experiences are combined with the multiple impacts of deprivation the impacts on a child's life may be also be life-long. This can give rise to problems in social and community cohesion, risk taking behaviour, substance misuse, youth offending, unhealthy eating, moving on to higher education, and employment as well as ill health (Marmot et al, 2010).

Figure 31 Trajectories of health across the life course with examples



Source: (Halfon, Larson, Lu, Tullis, & Russ, 2014)

This is costly to individuals, to society and to the exchequer. The Chief Medical officer (CMO) for England Annual Report 2012 (CMO, 2012) identified that for instance:

- The annual cost to the public sector in England associated with children born preterm (largely associated with poverty and smoking) until age 18 is about £1.24 billion. Total societal costs (including parental costs and lost productivity) are estimated to be about £2.48 billion
- The long-term costs of obesity in England (also related to poverty and inequality) are between £588 and £686 million a year
- The annual cost of emotional, conduct and hyperkinetic disorders in children aged 5–15 years in the UK is estimated to be £1.58 billion short term and £2.35 billion over the long term (Davis, 2012).

What works in infancy and the early years (children under the age of 5 years)

The goal in the early years is that every baby receives sensitive, appropriate and responsive care from their main caregivers in the first year of life and caregivers are confident about raising their children in a loving and supportive environment (Wave Trust, 2013).

This is achieved by taking a holistic approach to all antenatal, perinatal (around 20th week of pregnancy to around the 28th day of life) and postnatal services that enables seamless non stigmatising access to support for all families and the earliest possible engagement of Midwives, Health Visitors, GPs, Children's Centres, and other related services. Children and care givers who are more vulnerable, at risk or more marginalised, should be offered more intensive or different types of support in line with their needs. Fair Society, Health Lives (Marmot, 2010) recommends:

- Increasing the proportion of overall expenditure allocated to the early years and ensuring expenditure on early years development is focused progressively across the social gradient
- Supporting families to achieve progressive improvements in early child development, for example parenting programmes and support for transition to school
- Providing good quality early years education and childcare proportionately across the social gradient including outreach to disadvantaged families.

School readiness is a useful composite measure of the effectiveness of early years support and a strong predictor of success in later life (PHE, 2015(2)). The most effective interventions to improve school readiness are:

- reducing maternal mental ill-health
- an enriched communication environment (such as reading and speaking to children)
- enhanced physical activity
- parenting support programmes
- high-quality early education.

The Lambeth Early Action Partnership is a local example of what is being done to implement this approach (see Section 6, and http://www.leaplambeth.org.uk/ for further information)

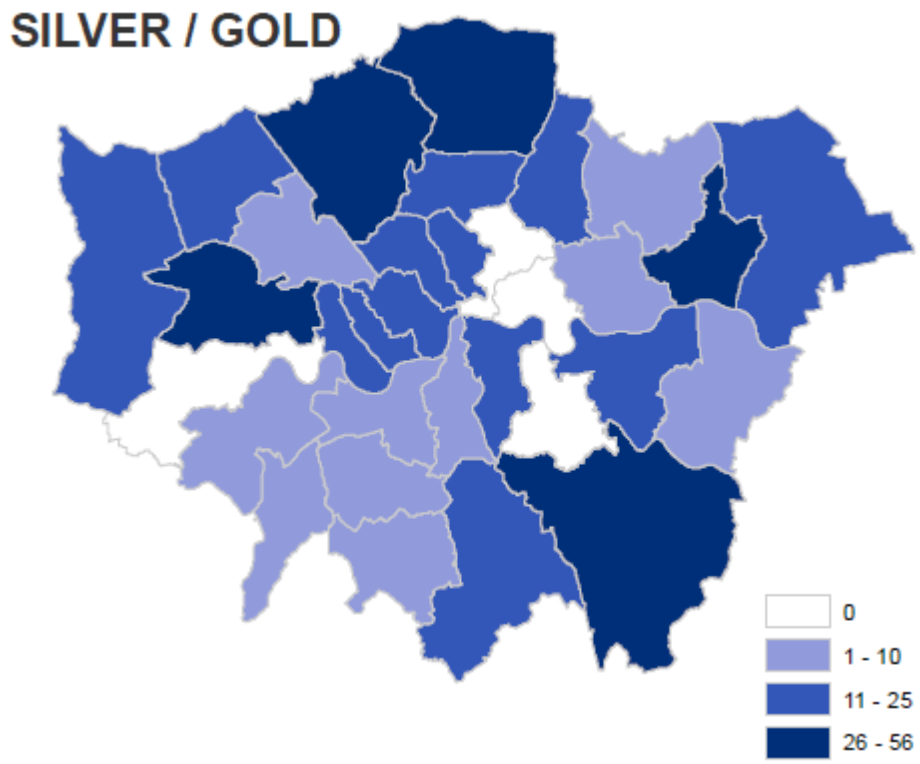
What works in school aged children (5-16 years)

As for children up to age five years, action to promote the health and wellbeing of young people in school has the potential to improve their educational outcomes (PHE, 2014). Taking a 'whole school approach' (PHE, 2015) can lead to improved body mass index, physical activity, fitness, fruit and vegetable intake, and reductions in tobacco use, and being bullied (Langford, et al., 2014). A whole school approach goes beyond the learning and teaching in the classroom to pervade all aspects of the life of a school. This includes the school policies, culture, ethos and environment (social and physical), learning and teaching (using the curriculum to develop knowledge and skills around health and wellbeing), and the partnerships with families and the community (to promote support for children's wellbeing).

A whole school approach is the philosophy of the Healthy Schools London Programme and provides a valued way for schools to review their provision and address health and wellbeing (NIHR CLAHRC North Thames&LSHTM, 2016). The programme builds on the success of the National Healthy Schools Programme, and has been adopted by most London schools. It is a voluntary awards programme that recognises school achievements in improving pupil health and wellbeing across four areas (healthy eating, physical activity, Personal Social and Health Economic (PSHE), and emotional health and wellbeing). Schools can work up from bronze, to gold standard (http://www.healthyschools.london.gov.uk/about/school-awards).

Lambeth schools participate in the London Healthy Schools programme and lots of schools register, but achievement across the borough is modest. In May 2017, 71 Lambeth schools (85 per cent) were registered (ranking 9th out of 32 London boroughs). However, only 29 of the 71 schools (41 per cent) completed the requirements for a bronze award (25th out of 32 boroughs), only five schools achieved a silver, and none a gold award. In contrast, in Tower Hamlets 97 per cent of schools register (93 schools) of which 85 have achieved bronze, 53 silver and 14 gold awards. The best performing London borough has 100 per cent registration rate (57 schools), with 32 per cent achieving bronze. It should be noted that the council has the final say in awarding the status, and Lambeth is very strict in its sign-off procedure.

Figure 32 Distribution of silver and gold Healthy Schools Programme awards by London borough, and number of schools, May 2017



Source: GLA/Healthy Schools Programme

What works for young people (early teens to 25 years)

Changes in adolescence are not only biological but also social, psychological and behavioural. There is great scope to avoid ill health and promote good health and wellbeing.

During the teenage years services that take an integrated approach to mental and physical health are essential and health, education, social care, housing, employment support and youth justice services need to work together to ensure there is 'no wrong door' so young people get the help they need without having to negotiate complicated systems. Alongside this, services need to recognise that a young person's relationships with others lie at the heart of their wellbeing (PHE, 2015(3)). This is promoted by giving young people opportunities to build confidence and skills in forming such relationships for example through; a whole school or college approach to health and wellbeing, the Personal Social and Health Education curriculum, anti-bullying interventions, supporting young people affected by violence and exploitation, and by enabling peer and staff groups to promote emotional wellbeing.

Six principles are recommended on which to base these approaches to meet young people's needs (Figure 33.)

Figure 33 Six principles for addressing young people's health needs

Source: (PHE, 2015(3))

What works for vulnerable children and safeguarding

Safeguarding is everybody's responsibility (Munro, 2015). Children have rights and all adults, communities and governments are responsible for safeguarding these rights and for ensuring that all children develop and grow up safely and well. Specific action is needed to remove vulnerable children from the harm to which they are exposed. However, it is not enough to target particular groups. A whole population approach, where safeguarding happens at every stage and in all settings for all children, reduces risk across all groups leading to less harm and reduced need for support. The aims of a whole population approach that complement a focus on vulnerable children (British Medical Association, 2013) are to:

- prevent or reduce risk of maltreatment, not just intervene once maltreatment has occurred
- reduce risk at all levels; parental, family, community and wider society
- use both universal (e.g. population awareness campaigns) and targeted (e.g. parent training) methods depending on the risk factors.

A population approach is successful when:

- Everyone is aware and knows what to do if they are concerned
- There is support available for all parents and carers to improve their parenting skills
- All professionals who come into contact with children, especially health, education and social care services are alert to potential need in a child and, or family
- Data and information on CYP is effectively shared and used across services and organisations.

Promoting a child friendly borough

As health and wellbeing is affected by the whole environment in which people are born, grow, live, learn and work there is potential to promote health and wellbeing and reduce the risk of harm to health in how all public policy is developed. For example: the design of the built environment and surrounding green space will affect how much and in what way people walk, play and come together outside their homes, which in turn will affect their physical and mental health. A road with heavy traffic will be too dangerous for children to play outside, reducing opportunities to be active and maintain healthy weight. Poor sound proofing between flats may lead to poor sleep and anxiety in neighbours of noisy households. Employment policies are also relevant, for instance adults on very low wages will have to have more than one job to make ends meet, reducing the time they can spend with their children including encouraging their development (for instance reading with them), thus risking their readiness for school.

A 'healthy public policies' (or Health in All Policies) approach is recommended by the World Health Organisation. The aim is to move beyond existing methods of 'silo-driven' policy, commissioning, and service delivery towards addressing the interconnected and complex influences on health and wellbeing more systematically. The approach is a practical opportunity for local partners and national governments to maximise the health and wellbeing benefits of any and all public policy and mitigate or avoid potential negative consequences. Lambeth has committed to taking a Health and Wellbeing in All Policies approach in its Health and Wellbeing Strategy.

Summary

Protecting, promoting and improving the health and wellbeing of children and young people are rightly top priorities in Lambeth:

- Acting early is sound science and sound finance: good child health improves the health of everyone and investing in child wellbeing is effective, reduces inequalities, and leads to big social and economic returns to all
- A good start in life builds resilience and a healthy foundation for adulthood and there is great scope and good evidence for promoting health and wellbeing in early life; improving school readiness, a whole school approach to health and wellbeing and integrated action across services to promote good health and healthy relationships in young adults is key to success
- Safeguarding must be at the heart of all initiatives across the system for all population groups
- Not acting will be costly for everyone especially in the context of the public policy and funding changes since 2009-10 in the UK and in other developed countries which pose a high risk to the health and wellbeing of CYP
- A Health and Wellbeing in All Polices approach is a practical framework for maximising the health benefits of all local plans and investment.

6. Improving health and wellbeing in Lambeth children: examples

This chapter reviews examples of where Lambeth has succeeded in improving children's health over the ten years up to 2017-2017, discusses some of the success factors and learning they may offer for the future.

The Lambeth and Southwark Children and Young People's Health Partnership (CYPHP)

This partnership aims to improve everyday healthcare for children and young people in Lambeth and Southwark. The partnership is between local children, young people, families, Lambeth and Southwark CCGs and councils, and King's Health Partners (Guy's and St Thomas' Hospital, King's College Hospital and South London and Maudsley Hospital).

The need

There are relatively high rates of long-term conditions in children and young people in Lambeth such as asthma, epilepsy and diabetes. Vulnerable young people frequently also have high needs, such as in mental health. According to some health measures, Lambeth children do not do as well as the country as a whole (and the UK compares less well than other developed countries). Lambeth has high levels of emergency department attendances, especially in children under four years, suggesting scope for improvement and the need for a more up to date model of health care developed in collaboration with children and young people and their families.

To promote good health, intervene earlier and focus on reducing inequities in access and outcomes, children's health and care services, families, communities and schools need to work better together. One method to achieve this is improving the knowledge and ability of the whole health and care workforce to support children and young people to get the right help and to communicate well with teenagers, especially on sensitive topics such as mental and sexual health.

The role of Public Health Lambeth

The public health team

- reviewed the health and wellbeing of children and young people focusing on Looked-After Children as they are particularly vulnerable and at higher risk of poor mental and physical ill health. Many local people including children and young people and services were involved and recommendations informed the CYPHP programme.
- reviewed evidence and good practice in school nurse training on long-term conditions management and mental health [and made recommendations to the] Lambeth Healthy Schools programme.
- carried out an equality impact assessment of the CYPHP programme, to ensure potential negative impacts could be prevented or mitigated especially in groups with protected characteristics under the Equality Act (2010).

What happened next

The CYPHP was granted £6m from the Guy's and St Thomas' Charity to deliver the programme over 2016-2020. This is in progress and Public Health are focusing on identifying further opportunities to prevent ill health, including for instance work with the council's Housing Department to improve indoor air quality and housing conditions to prevent asthma.

Lambeth Early Action Partnership (LEAP)

The need

Children in deprived circumstances are less likely to have a good start in life. A lot of Lambeth children are not getting the opportunities they need during their early years. In 2014 Lambeth was one of five successful areas in the country to be awarded £36m over 10 years by the Big Lottery and charged with the responsibility to improve the life chances of babies and young children in the most deprived wards of England. The competition focused on three outcome areas: diet and nutrition,

social and emotional development, and communication and language, and, required 'systems change' as an overarching goal.

Lambeth Council, Lambeth CCG and partners including King's Health Partners, the National Children's Bureau, as well as parents, local voluntary organisations and community groups, the Young Lambeth Co-operative, schools, nurseries, other statutory bodies and Lambeth police entered the competition with a bid to work in Lambeth's four most deprived wards (Vassall, Coldharbour, Stockwell and Tulse Hill).

The role of Public Health Lambeth

The Public Health team

- collaborated in developing the bid and the programme: to help identify the wards, review best practice and local health needs, and work with partners to select interventions for the bid. Interventions focused on the whole population, a life course approach and prevention.
- participates actively in LEAP including leading on insight work on the impact of population change and regeneration in the four wards.

What happened next

The programme is underway with several projects in progress for instance; parent champions and an obesity in pregnancy initiative. A review and strategy day in early summer 2017 will inform the next phase.

Vitamin D supplementation scheme for maternity and early years

The need

Vitamin D deficiency and insufficiency cause serious health problems such as rickets. Children in deprived circumstances and/or with darker skin are at higher risk of Vitamin D deficiency. The Chief Medical Officer (2012) estimated that the national prevalence of Vitamin D deficiency varied from 12-40 per cent of under-5 year olds and recommended that all pregnant women, infants and children under 5 take a daily supplement of Vitamin D to protect their health.

The role of Public Health Lambeth

Research by the Lambeth Public Health team found that Vitamin D deficiency was significant in Lambeth, and that supplementation would improve health and save money by reducing use of health services. The Public Health team worked with health services commissioners to set up a scheme to ensure all children less than four years of age and expectant mothers receive Vitamin D. The team continues to work with the community team to improve data analysis and reporting.

What happened next

The scheme started in autumn 2014. A Vitamin D card is issued by Pharmacists who report back on uptake. Staff from many children's services are being trained on the importance of Vitamin D and the Lambeth scheme so that as many children as possible are able to benefit. There was a good response from the beginning with hundreds of registrations every month. The scheme now (2016) covers about 26 per cent of eligible children and pregnant women. Uptake is particularly high in new born babies. The next stage of the programme is to promote greater awareness of the benefits for older children and pregnant women.

Childhood Obesity

The need

Lambeth has made progress in containing childhood obesity especially in the Reception year but overweight and obesity in Lambeth in children is still a serious problem, putting them at high risk of ill health, disability and premature death as adults. Obesity carries a stigma at all ages and obese children are also more likely to be bullied.

Obesity is the result of complex interacting forces at individual, community and population level so reducing obesity in the population requires sustained multi-component action. Understanding of what works continues to develop; Lambeth is contributing to the knowledge base and is applying best practice.

The role of Public Health Lambeth

At the request of PHE Lambeth Public Health Team studied why obesity appeared to have reduced in children in their Reception year. The team looked at which population groups had experienced reduced obesity, the potential role of population turnover (people moving in and out of the borough) and the contribution of local action and services to promote healthy weight.

What happened next

The study found that the significant childhood obesity reduction seen in Lambeth could not be explained by any one measure or by population turnover. Strong leadership, using best evidence, sustained action along the whole obesity pathway (not just one project), and effective partnerships accompanied by evaluation, are all likely to have played role. Highlights of the study results included:

- Obesity reduced in some children in the higher risk groups suggesting an effective approach to inequality
- Local services seem to be supporting families in greatest need; children in the higher risk groups use local interventions
- Supporting schools to make their full contribution to address childhood obesity is very important
- Children's excess weight is closely associated with family psychosocial issues; knowing this will help to improve and refine interventions and improve outcomes.

Findings are informing the next stage of the Lambeth children's healthy weight work including re-commissioning services and the Lambeth Early Action Partnership programmes to improve nutrition and diet in very young children.

The Department of Health, PHE and the Local Government Association are also using the study nationally, for instance the Department of Health has published two Lambeth case studies as part of a resource to support the Government's national childhood obesity plan.

Food, childhood obesity and health and wellbeing

The need

Access to healthy and nutritious food is essential for the population's health and wellbeing. In common with many inner London boroughs the Lambeth food system, which includes food production, processing, procurement, distribution, marketing and consumption, is not always conducive to good health. For example, people living in deprivation may find healthy food expensive to buy, may lack adequate cooking facilities or may lack confidence in how to cook healthy meals. Lambeth has high levels of food related conditions, such as childhood obesity, diabetes and

cardiovascular disease, as well as malnutrition (for instance Vitamin D deficiency). These conditions are some of the consequences of problems with the food system.

The role of Public Health Lambeth

The Lambeth Public Health team has worked with local partners and the community to:

- Carry out an extensive evidence review of the local food system
- Support the development of a food partnership
- Raise awareness of food issues
- Develop evidence based programmes to promote and improve the local food system
- Engage and work with the community to develop solutions that will improve the local food system
- Co-produce healthy eating messages with young people.

What happened next

In 2014, Lambeth was awarded Food Flagship status. Two of the projects were the Gipsy Hill 'Village Food Hub' and a healthy eating social marking campaign for young people.

Example 1: The Gipsy Hill 'Village Food Hub' Project

. The Public Health team worked with local residents and stakeholders to address local concerns about food in this deprived ward. The issues identified included:

- a lack of local markets selling affordable and healthy produce
- a need for practical knowledge and cooking skills, especially how to prepare healthy, affordable meals on a tight budget
- a lack of opportunities to use available space to grow food
- concern to support vulnerable residents such as those in need of food banks
- concern how to mitigate the impact of large numbers of fast food outlets selling the 'wrong food' especially to young people.

As a result Gypsy Hill residents organised a number of projects including: a fortnightly local fresh produce market selling affordable fresh fruit and vegetables, training workshops on healthy eating and general wellbeing, community gardening and planting, distribution of surplus fruits to residents using a team of volunteers, mapping of local fruit trees, harvesting and learning how to preserve surplus fruit and vegetables, and supporting food bank users with advice and practical skills such as preparing and cooking healthy meals on a budget.

The Lambeth Young People Social Marketing Programme- Lambeth 'Feel 100%' Campaign

This programme worked with young people from Lambeth to develop a social marketing campaign on healthy eating and nutrition for young people aged 11-18 years old including:

- working with young people to identify relevant and appropriate healthy nutrition messages
- working with and drawing on young people's expertise to identify how best to communicate these messages to other local young people
- production of messages and running a campaign to deliver the messages.

The Lambeth *Feel 100%* campaign effectively engaged young people who were both interested in healthy eating and changing their eating habits. The campaign made sense to young people; 46,343 young people and parents visited the website in the first round of advertisements, and 37,000 young people and parents during the second burst. Facebook advertisements directed audiences to

download specific recipe cards from the website. These were downloaded 2,087 times by young people and 2,236 times by parents in a space of 20 days. Learning from this programme continues to inform work with Lambeth's young people and the Lambeth Healthy Weight programme.

All the Food Flagships projects had sustainability plans included as part of the legacy and the Public Health Team is taking this forward with the council and partners.

Financial Resilience

The need

The Welfare Reform Act 2012 introduced reforms of the benefits system. Most of the changes are aimed at the working age population and their dependants (mainly children and young people). Austerity measures (wider policies to reduce public spending) also affect public services and society as a whole. The result has been reduced income in many vulnerable households, especially for families with children, increasing the risk of children living in poverty. A cap that limits the amount of benefits a family can receive was set at £23,000 in London (2016) following the lowering of an earlier cap. This has increased the number of households affected by the cap, as well as affecting those whose benefits were already capped. People on low incomes whose income is reduced still further may resort to unhealthy coping mechanisms, such as moving to overcrowded accommodation, being forced to move out of the area, spending less on food and/or heating, and getting into debt and rent arrears which may lead to eviction. Under stress, people can also resort to alcohol or substance misuse to manage stress and anxiety. All of these factors, either individually or combined, can lead to poor mental health, poor nutrition and other adverse impacts on health and wellbeing, including relationship breakdown or domestic violence with further negative impacts on the family, including children.

The council developed a programme to mitigate the negative effects of the reforms.

The role of Public Health Lambeth

Public health helped the council to develop a Financial Resilience Strategy to maximise people's income by for instance, helping them find work, supporting people to reduce their debt and use of financial products, and lobbying local employers for higher pay.

What happened next

As a result, more people are earning the London Living Wage and have access to appropriate financial products. Other outcomes include:

- Reduced problematic debt
- More people getting the benefits and credits they are entitled to
- More people able to manage their finances and cope with unexpected financial outlays
- Reduced fuel and food poverty.

The Lambeth Advice Network was set up; this includes outreach to vulnerable groups and Children's Centres, and a specialist benefit advice service. The council also supported provision of:

- The Step Up programme which offers support to residents on low wages
- The Lambeth Working and Workwise project which supports residents to find a job
- Council Tax debt support
- Voluntary 'Money Champions' who are trained to offer support and to people in their communities who need help with money worries
- Digi-buddies who support residents on benefits to become computer literate.

The Public Health team also worked with Lambeth CCG to promote benefits advice in health premises so patients likely to be affected by the changes to the benefits system get easier access to advice. The team reviewed a pilot in some GP surgeries which showed that the intervention was cost effective and readily accepted by patients and GPs.

Continuing austerity, including cuts to local authority budgets, poses a continuing risk to people's health. Public Health will continue to raise awareness of, and contribute to, action to promote financial resilience amongst the poorest in the population.

Summary

The Public Health team makes an important contribution to the success of programmes that aim to improve health and wellbeing and reduce health and other inequalities. A particular contribution is the role of the team in identifying the common success factors and learning that will inform future local programmes. The success factors in the programmes characterise a public health approach to working, for instance:

- Focusing on the health and wellbeing of the whole population (not just the groups who are particularly vulnerable, already ill or receiving services) to gain a thorough understanding of health and wellbeing needs of different population segments
- Focusing on the wider societal, economic, environmental, policy and political influences and forces that determine health not just on proximal risk factors or individual behaviours
- Being rigorous about how local services compare with evidence and best practice and identifying any gaps in services
- Ensuring good information is collected from different sources so objective monitoring, evaluation and learning is possible
- Promoting, building and working with extensive partnerships between the people who need to benefit (children and young people and their parents and carers) and statutory and voluntary organisations that allow beneficiaries equal voice and leadership
- Sustained investment by all partners over many years, with collective agreement as to the goals and how to achieve them
- An explicit commitment to fairness and reducing inequalities.

7. Conclusion and next steps: dealing with complexity and the future

In many respects health and wellbeing in children and young people in Lambeth is improving; children are more ready for school and infant deaths, childhood obesity at reception, and teenage conceptions are reducing. These are real and positive changes that will benefit thousands of Lambeth children now and in their adult lives. However, average health measures mask important differences between population subgroups. There are substantial inequalities in all the measures reviewed in this report and in the more detailed Joint Strategic Needs Assessment. This means that many Lambeth children are still missing out.

Austerity measures are disproportionately affecting children who are already vulnerable, especially the large number of children already living in poverty in the borough. This is a false economy at local and national level. For a healthy and economically productive society, the health and wellbeing of children needs to be at the heart of policy making and investment plans.

Successful initiatives that benefit the whole population in Lambeth are based on partnership, addressing complexity, sustained commitment and long-term resourcing.

To make further progress and to reduce inequalities, Lambeth needs to focus more strongly on:

- Bringing together all relevant services into an **integrated early years programme**
- Ensuring the **London Healthy Schools programme** covers all schools
- Developing holistic and effective **integrated Young People's services** with 'no wrong door' that place the relationship with young people at their heart
- A **whole population approach to safeguarding** where safeguarding happens at every stage and in all settings for all children, thus reducing risk across all groups leading to less harm and reduced need for support
- **Knowing the CYP population better** through sharing and use of services' administration data to identify those at higher risk of poorer outcomes, to inform priorities and enable prompt action
- **Engaging, informing and empowering communities** to take action on their own account in line with their priorities
- A strong emphasis on health and wellbeing of children and young people within the council's commitment to **Health and Wellbeing in All Policies**.

After Tomorrow: towards a better future with the second part of this Report

If Lambeth's partners were to take action on everything in line with the evidence, children and young people's health and wellbeing would improve quickly and substantially and save money over time. However where resources are severely constrained partners have to make extremely difficult choices. Decisions tend to be made over a one to four year time frame in line with financial and electoral cycles. The risk of using such short time frames is that the potential impact of the forces and transitions discussed, whether positive or negative, are not given adequate consideration, especially with respect to their effect on children and young people over the longer term.

Lambeth needs to develop ways to gain deeper insight into what the forces are and how they may be shaping the future, so partners can work together to achieve the conditions that promote and protect health and wellbeing for all CYP in Lambeth.

Developing scenarios is a creative and participative process that helps people to identify uncertainties, themes and risks, and how they might influence how the longer term future may evolve. Insights are gained from interviewing individuals, from focus groups, and from quantitative data to inform strategic decision making:

a scenario is a story with plausible cause and effect links that connects a future condition with the present, while illustrating key decisions, events, and consequences throughout the narrative

(Vollmar, Osterman, & Redaelli, 2015).

This report is part of a larger initiative to support Lambeth partners to respond in a more dynamic, timely, forward thinking and effective way to rapid societal change using scenario based methods. Taking a much longer view of CYP health over a ten year horizon will allow partners greater ability to respond effectively to today's and tomorrow's complex environment to the benefit of the population. The next part of the Annual Public Health Report uses the data and information from this report alongside extensive interviews, focus groups and workshops to develop scenarios to inform how partners might plan more effectively to promote and protect the health and wellbeing of children and young people over the next ten years.

Appendix 1. Progress from last APHR's recommendations

1	Prevent widening economic inequalities and work to sustain the financial resilience of residents through structural interventions, with the most critical being the promotion of the London Living Wage across our local employers.	Lambeth Council is a Living Wage accredited employer. As well as paying all our employees at least the London Living Wage, we also ask our contractors to do the same. For Lambeth residents who are in low paid jobs (around 1 in 5 Lambeth residents) there is support available. Step Up is a two year initiative, jointly funded by the Walcott Foundation and Trust for London, which helps low-paid workers in Lambeth and neighbouring boroughs progress into employment paying the London Living Wage. The programme is available to any Lambeth resident who has been earning less than the London Living Wage for the past year or more.
2	All employers in the borough should be encouraged and supported to adopt good practice in relation to health and safety compliance and evidence-based workplace health programmes.	As an exemplar, Lambeth Council has committed to working towards the London Healthy Workplace accreditation. The council will continue to seek to work with partners as part of local implementation of Health and Wellbeing in All Policies to encourage them to adopt evidence based workplace health programmes.
3	Public sector employers engaged in workplace health initiatives should be encouraged to share their knowledge and expertise with other employers as well as using their commissioning and procurement processes to encourage compliance with legislation and good employment practice	Lambeth is the first London council to sign up to the Local Authority Declaration on Sugar Reduction and Healthier Food. This is also being supported by Lambeth CCG. The Declaration consists of a series of actions relating to commissioning and procurement, employee wellbeing, raising public awareness around healthy eating and good practice policies. Further work is also being taken forward through the Health and Wellbeing Strategy commitment of implementing Health and Wellbeing in All Policies locally.
4	Homeless prevention services need to reach not only those seeking statutory assistance, but also others in critical housing situations, living in unstable or unsuitable accommodation and facing substantial housing need.	This remains an important recommendation in the context of continuing austerity
5	Work towards a co-ordinated and strategic system to identify those most likely to be at risk of food poverty and ensure that individuals and families at risk are signposted to the appropriate support services.	Lambeth was reported as being the London borough doing the most to tackle food poverty. An approach is in place to co-ordinate local action to address food poverty.
6	The universal care pathway from conception to early years in Lambeth should be strengthened using the London Maternity Standards and the enhanced Healthy Child Pathway to ensure we provide services which are fair for all and appropriate for everyone's needs.	An early years integrated pathway is being developed with partner agencies as part of the Early Years work of the Children and Families Strategic Partnership
7	The Children and Young People's Partnership extends its engagement with head teachers and governors to develop a sustainable strategy which improves young people's health and wellbeing and enables them to make healthy lifestyle choices.	CYPHP is working with Schools including on emotional health and wellbeing, and long-term condition management

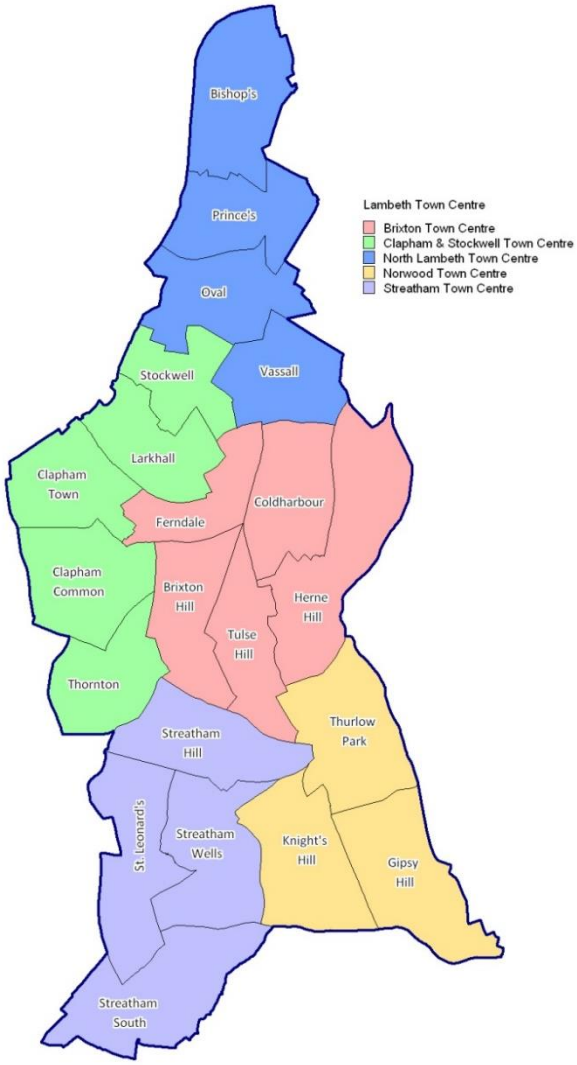
8	Social relationships and community development should be made policy priorities and should be part of future Health and Wellbeing strategies to improve worsening social isolation for some communities and vulnerable population groups	The Health and Wellbeing Strategy has promotion of community action as an action/for own and others' health; Community plan; Project Smith.
9	Referral pathways for smoking cessation need to be developed for priority groups, such as those with long-term conditions and mental health issues. These should be implemented along with measures to increase quit rate, prevent relapse and promote targeted community action against illegal sales, to particularly benefit those from disadvantaged groups	A series of consultations have been held with stakeholders. Service redesign work is underway to support the development of a commissioned local evidence based service.
10	Investigate whether existing interventions and services designed to prevent and reduce harm and treat substance misuse are actually reaching those most likely to be affected. Ensure that the services meet National Institute for Health and Care Excellence (NICE) guidelines for effectiveness and value for money.	Substance misuse services are subject to regular monitoring to ensure effective reach. Young People's services are being integrated with sexual health as per best practice. A rapid needs assessment for alcohol is underway.
11	Given the multi-factorial and complex causes of unhealthy weight, addressing obesity will require sustained and long-term investment and support from all partners.	Lambeth has continued to implement its Healthy Weight programme that has been highlighted as good practice by Public Health England, the Local Government Association and Department of Health. Progress has been made through the Lambeth Food Flagship programme and learning from the work is being taken forward by Public Health.
12	The promotion of physical activity should routinely be incorporated into building, planning, social, transport, school and workplace strategies and policies. Policies should support people to be more physically active in their everyday lives. Some population groups are less likely to be active and targeted programmes should be considered.	Taking a systematic approach to Health and Wellbeing in All Policies, Public Health has contributed to the Lambeth's housing strategy and is contributing to the following: Lambeth Your New Town Hall Wellbeing Strategy Development of Lambeth Transport Strategy Lambeth Local Plan review.
13	Comprehensive sex and relationship education should be implemented in all schools in Lambeth as part of an integrated Health and Wellbeing Programme.	There is variable provision in schools, however all schools are supported and encouraged to achieve the London Healthy Schools Award (includes SRE).
14	Improve coverage in the cancer screening programmes in Lambeth, particularly in the bowel screening programme.	The CCG has been working on improving coverage.

Appendix 2 Lambeth Annual Public Health Report – Statistical Bulletin

1. Geography

Lambeth is an inner London borough with its northern boundary on the river Thames. It is situated with Wandsworth to the west, Southwark to the east and Croydon to the south. The density of population in Lambeth is increasing and it is expected to grow steadily in the next ten years. Lambeth has 21 wards with six town centre areas, namely, North Lambeth, Stockwell, Clapham, Brixton, Streatham and Norwood, with a breadth of ethnic and cultural traditions that have established their presence in particular town centre areas and quarters. Approximately 150 different languages are spoken by families within the borough. The Chartered Institute of Public Finance and Accountancy (CIPFA) classifies Lambeth as a London cosmopolitan area similar to Southwark, Lewisham, Islington, Hackney, Tower Hamlets, Greenwich and Haringey.

Figure 1. Map of Lambeth

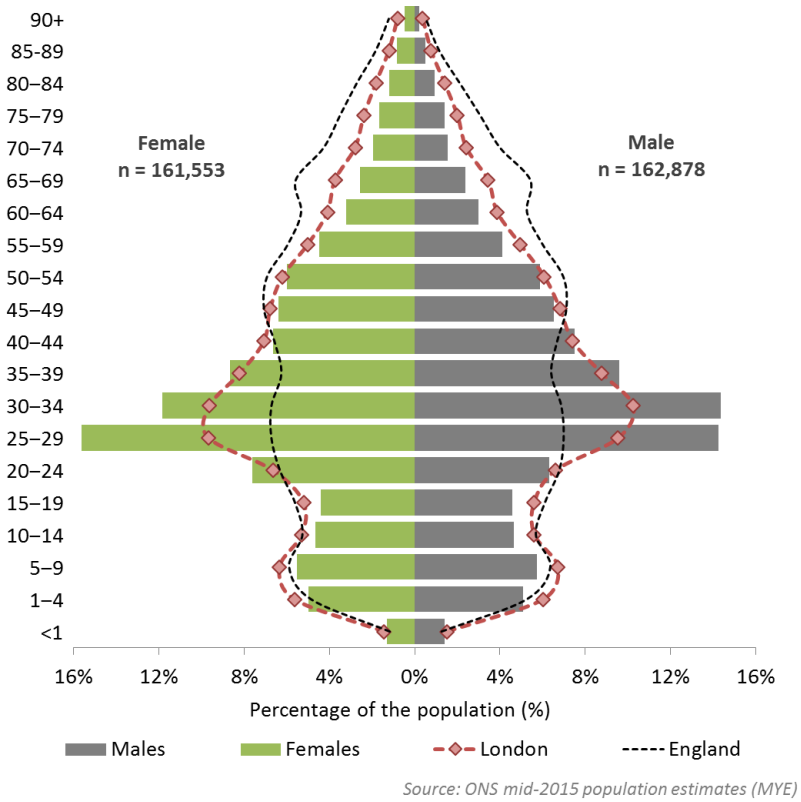


2. Population

2.1. Age Structure

The Office for National Statistics (ONS) 2015 mid-year-estimate (MYE) gives the population of Lambeth at 324,431. The number of Lambeth residents, registered with a GP practice, August 2015, was at 357,715. The General Practice registered population in Lambeth recorded for the Quality Outcomes Framework (QOF) for Lambeth CCG in 2015/16 was at 389,875.

Figure 2. Population pyramid, Lambeth Vs London and England



Source: ONS mid-2015 population estimates (MYE)

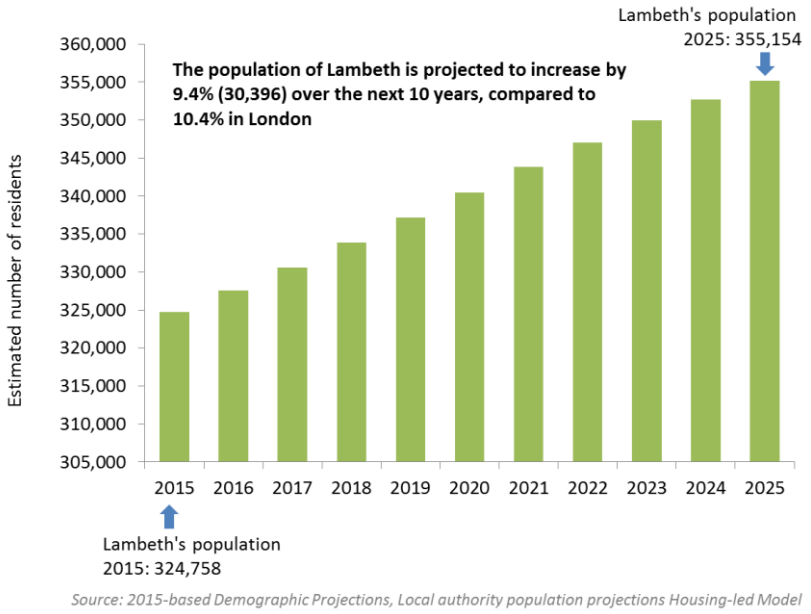
Lambeth has a relatively young age profile compared to the whole country with around 51 per cent of the population in the age group 20-44 years, compared with 34 per cent in that same age group in England. Consequently, Lambeth has a smaller proportion of older people when compared to England.

There are a similar proportion of males and females overall, however there is variation across age groups with higher proportions of males (52 per cent) in the age groups 20-44 and females (54 per cent) in the age group 60+.

2.2. Population projections

The GLA demographic projections estimate Lambeth's population to grow from 324,800 to 355,200 (increase of 30,400) over the next ten years, representing a nine per cent increase between 2015-2025.

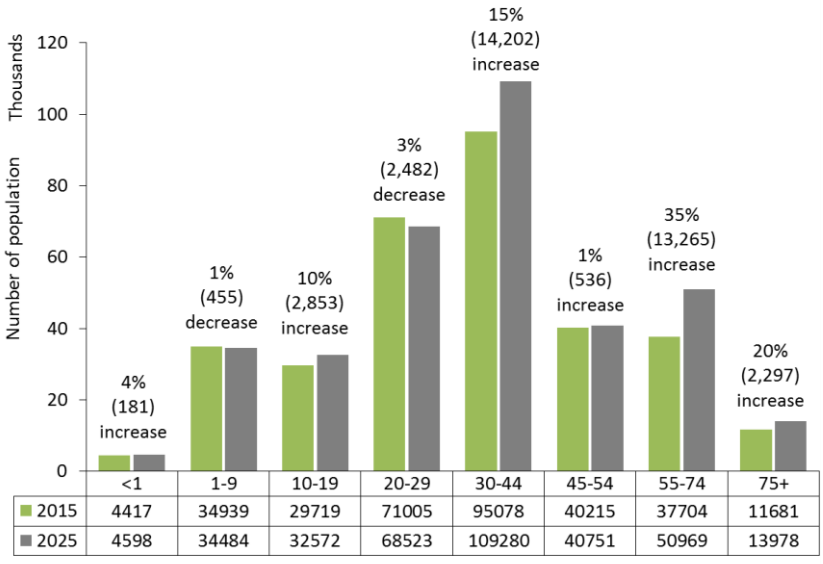
Figure 3. Change in Lambeth's population over the next 10 years



Source: 2015-based Demographic Projections, Local authority population projections Housing-led Model

These projections predict Lambeth will remain a young borough in 2025, with 20 per cent of the population aged under 20 and 50 per cent of the population aged 20-44. The projections indicate Lambeth's population aged 55+ will increase in numbers and as a proportion of the population across all age groups.

Figure 4. Change in Lambeth's population by age group



	<1	1-9	10-19	20-29	30-44	45-54	55-74	75+
2015	4417	34939	29719	71005	95078	40215	37704	11681
2025	4598	34484	32572	68523	109280	40751	50969	13978

Source: 2015-based Demographic Projections, Local authority population projections Housing-led Model

The projections suggest that the age structure of the 20-44 year old population is changing, with a reduction in the 20-29 age groups and an increase in the 30-44 year olds.

2.3. Ethnicity

Lambeth is an ethnically diverse population with the Black, Asian and Minority Ethnic (BAME) community accounting for around 42 per cent (60 per cent including white other) of the total population. Compared to England, where over 80 per cent of the population is classified as White British, Lambeth has a varied population who identify with different cultures and backgrounds.

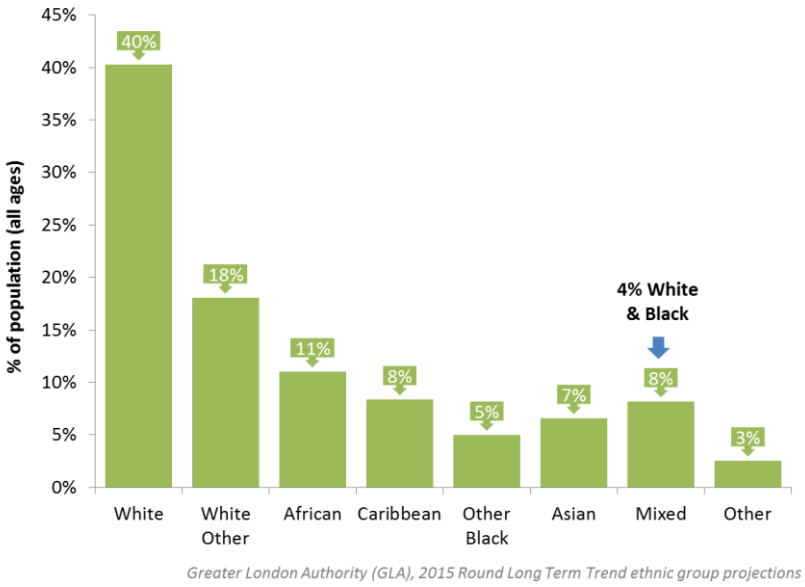
Figure 5. Lambeth's ethnicity Vs England

Percentage of the population (%)

Ethnicity	Lambeth	England
White	40%	81%
White Other	18%	5%
African	11%	2%
Caribbean	8%	1%
Other Black	5%	1%
Asian	7%	8%
Mixed	8%	2%
Other	3%	1%

Nearly 80,000 (24 per cent) of Lambeth's population are classified as Black, with higher proportions of Black African (11 per cent) than Black Caribbean (8 per cent). Nearly 60,000 (18 per cent) people are classified as white other (European) (Source: GLA 2015 Round Long Term Trend ethnic group projections).

Figure 6. Percentage of Lambeth's population by ethnic group

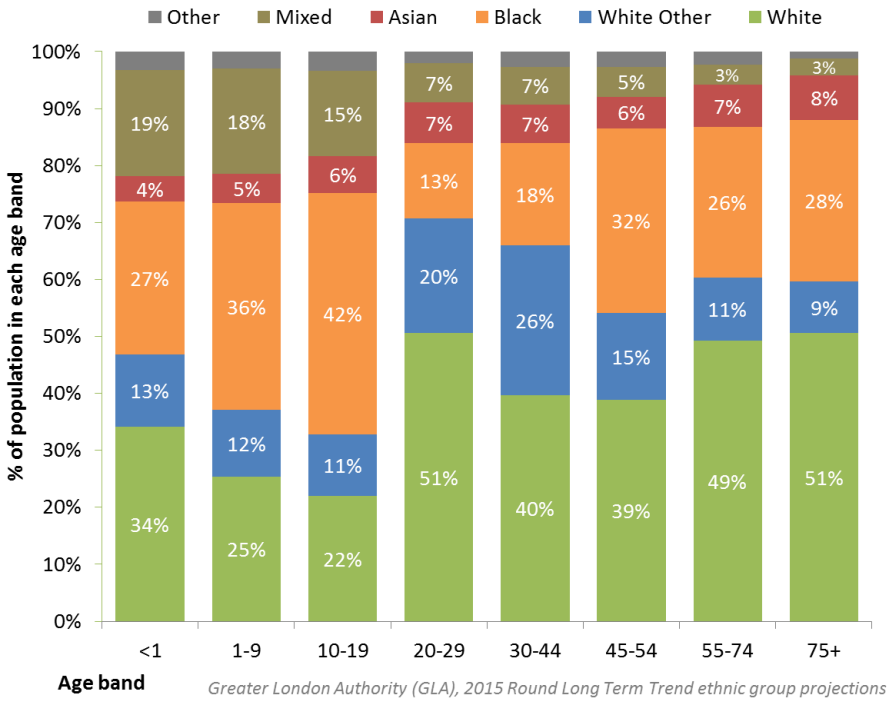


The younger aged population (under 20) is even more diverse with the Black, Asian and Minority Ethnic (BAME) community accounting for around 64 per cent (76 per cent including white other) of the under 20 population.

The graph below describes the distribution of ethnicity within age bands.

- For under 1 years, White is the main ethnicity
- For 1-9 years, Black becomes the main ethnicity with a reduction in the White group, coupled with a reduction in the White population aged 30-54. This could indicate families from White backgrounds moving from the borough (similar to the pattern in the Mixed ethnic group).
- For age group 20-29, proportionally, the White and White Other groups are increasing, suggesting there is economic migration into the borough.

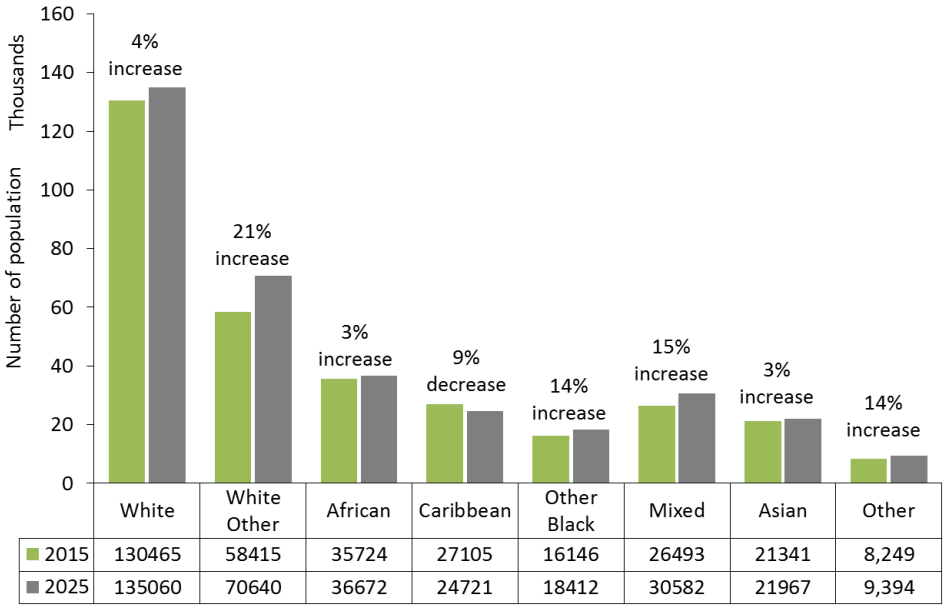
Figure 7. Percentage of Lambeth's population by ethnic group and age band



Greater London Authority (GLA), 2015 Round Long Term Trend ethnic group projections

The projections predict Lambeth will remain an ethnically diverse borough in 2025 with the Black, Asian and Minority Ethnic (BAME) community accounting for around 41 per cent (61 per cent, including white other) of the total population. The data suggests the composition is changing with increasing Black African (and other Black, Mixed) and White Other ethnic groups.

Figure 8. Population change by ethnic group in Lambeth, 2016 - 2026



	White	White Other	African	Caribbean	Other Black	Mixed	Asian	Other
2015	130465	58415	35724	27105	16146	26493	21341	8,249
2025	135060	70640	36672	24721	18412	30582	21967	9,394

Source: Greater London Authority (GLA), 2015 Round Long Term Trend ethnic group projections

2.4. Population change

The main components of population change are births, deaths, and migration. 'Natural increase' is defined as the difference between live births and deaths. 'Net migration' is defined as the difference between the number of people moving into an area and the number of people moving out.

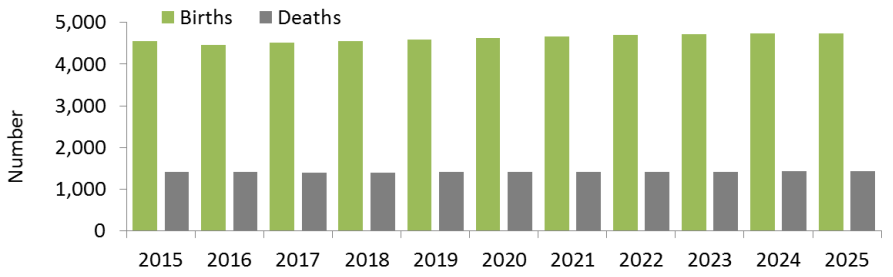
The Census 2011 estimates that 1 in 5 (59,318) residents changed address in the preceding year, either moving within Lambeth, into the area from within the UK or moved into the area from outside the UK.

It is estimated that seven per cent (19,889) of usual residents moved within Lambeth, ten per cent (31,711) of the population moved into the area from within the UK and three per cent (7,718) moved into the area from outside the UK.

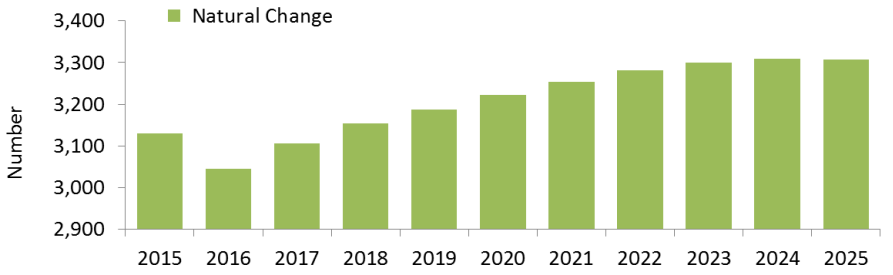
2.4.1. Natural change

Natural change is the difference between live births and deaths, with the positive natural change indicating that the number of births exceeds the number of deaths in an area. In the next ten years the increase in the Lambeth population will be partly driven by the positive natural change, with the number of births exceeding the number of deaths in all Lambeth.

Figure 9. Natural population change in Lambeth



Source: 2015-based Demographic Projections, Local authority population projections Housing-led Model

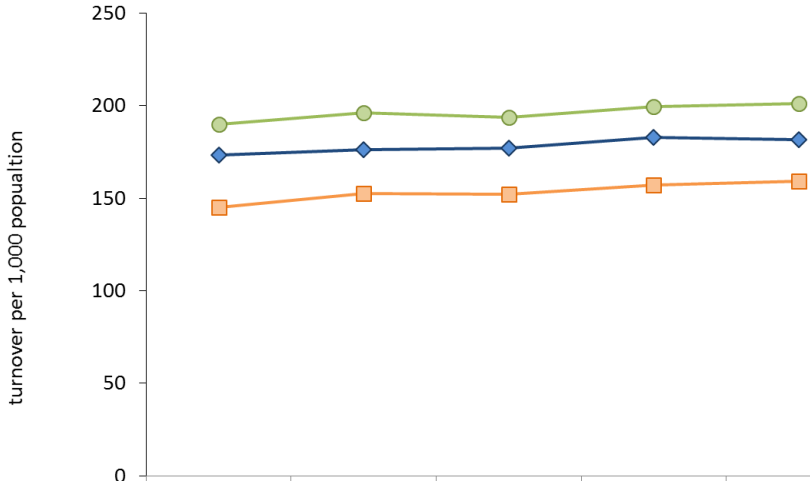


Source: 2015-based Demographic Projections, Local authority population projections Housing-led Model

2.4.2. Internal migration

Internal migration is the movement of people in (inflow) and out (outflow) of the borough. The ONS internal migration statistics estimate that in 2015 Lambeth was the fifth highest local authority in England for internal migration, 201 per 1,000 resident population.

Figure 10. Internal migration, turnover per 1,000 resident population

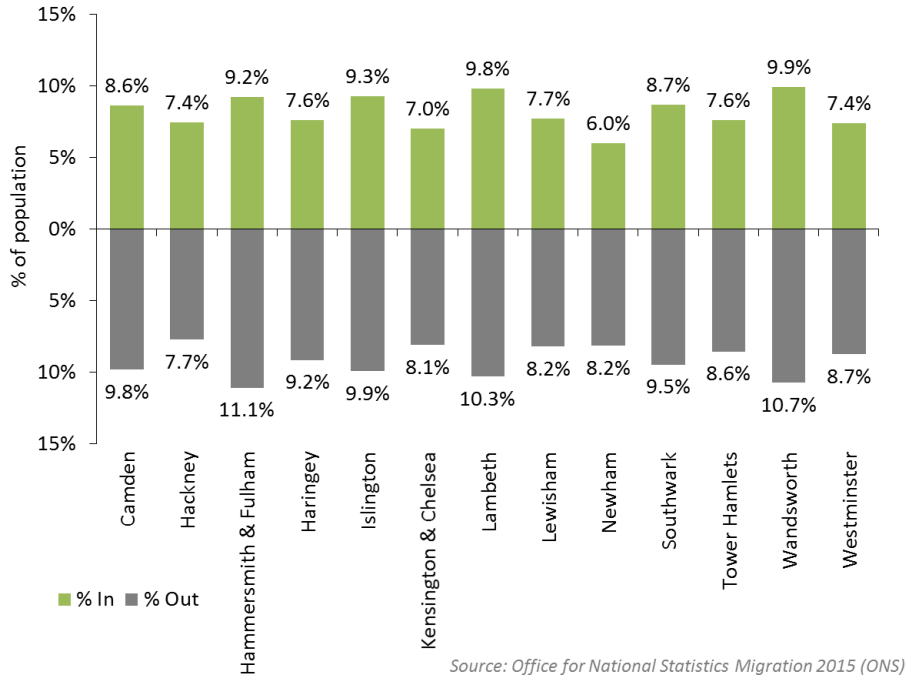


	2011	2012	2013	2014	2015
Lambeth	189.9	196.2	193.6	199.5	201.1
Southwark	173.1	176	176.9	182.7	181.4
Lewisham	145	152.6	152.2	157.1	159.1

Source: Office for National Statistics Migration 2016 (ONS)

This equates to an inflow of 31,800 persons (9.8 per cent of the population) and an outflow 33,400 (10.3 per cent of the population) persons who moved into and out of the borough within the UK. This accounts for a net difference of minus 1,570 persons.

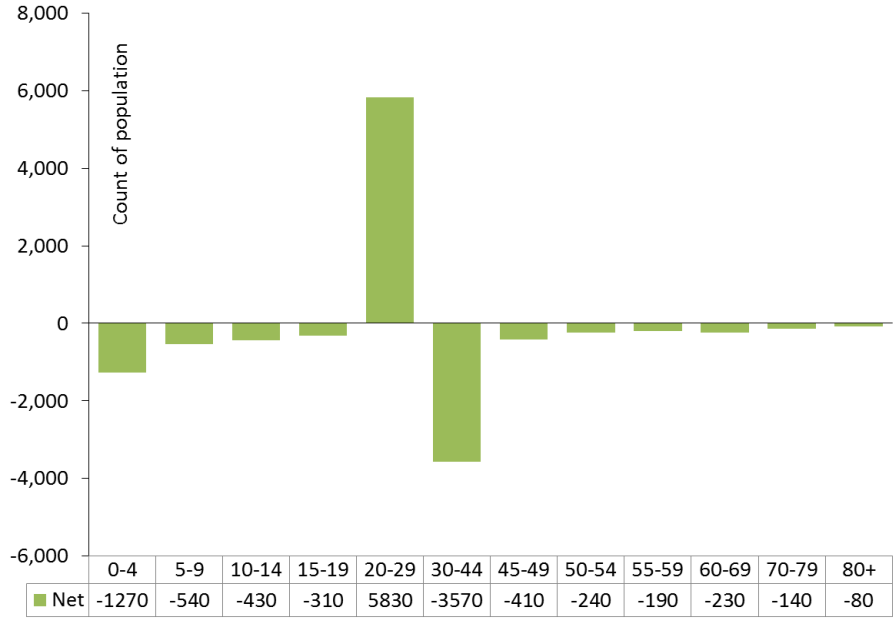
Figure 11. Internal migration, London local authorities, inflow / outflow, 2015



Source: Office for National Statistics Migration 2015 (ONS)

Variation in the net difference can be seen across age bands. The age group 20-29 years is the only age band to register a positive net increase, with large decreases recorded in the 30-44 year olds and under-5s.

Figure 12. Internal migration, by age group, Lambeth net change, 2015



	0-4	5-9	10-14	15-19	20-29	30-44	45-49	50-54	55-59	60-69	70-79	80+
Net	-1270	-540	-430	-310	5830	-3570	-410	-240	-190	-230	-140	-80

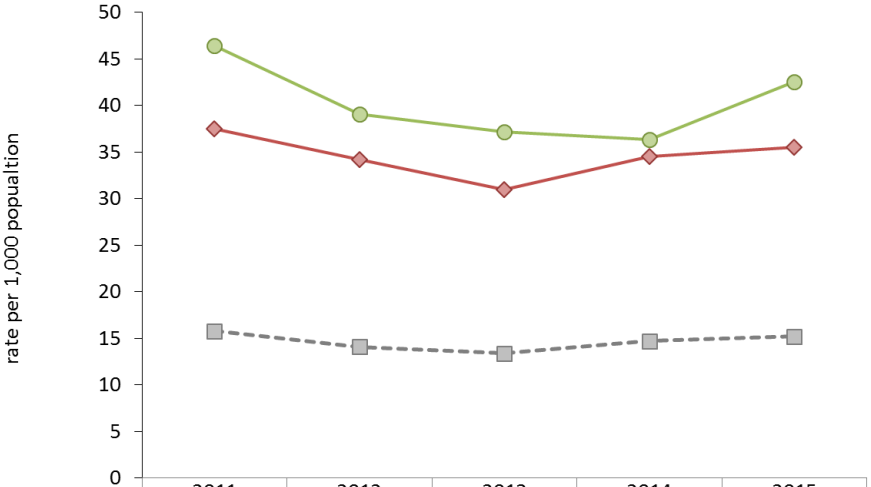
Source: Office for National Statistics Migration 2015 (ONS)

2.4.3. Long term international migration

Long-term international migration (LTIM) statistics estimate the flow and characteristics of migrants to and from the UK. A long-term international migrant is defined as someone who changes his or her country of usual residence for a period of at least a year.

The ONS estimates that in 2015, international migration accounted for 9,200 people moving into the borough from abroad and 4,602 persons moving out of the borough to reside abroad, accounting for a net migration of 4,600 persons. Compared to London and England, Lambeth experiences a higher turnover in international migration.

Figure 13. Long-term international migration, Lambeth



	2011	2012	2013	2014	2015
Lambeth	46.4	39.1	37.2	36.3	42.5
London	37.5	34.2	31	34.5	35.5
England	15.8	14.1	13.4	14.7	15.2

Source: Office for National Statistics Migration 2016 (ONS)

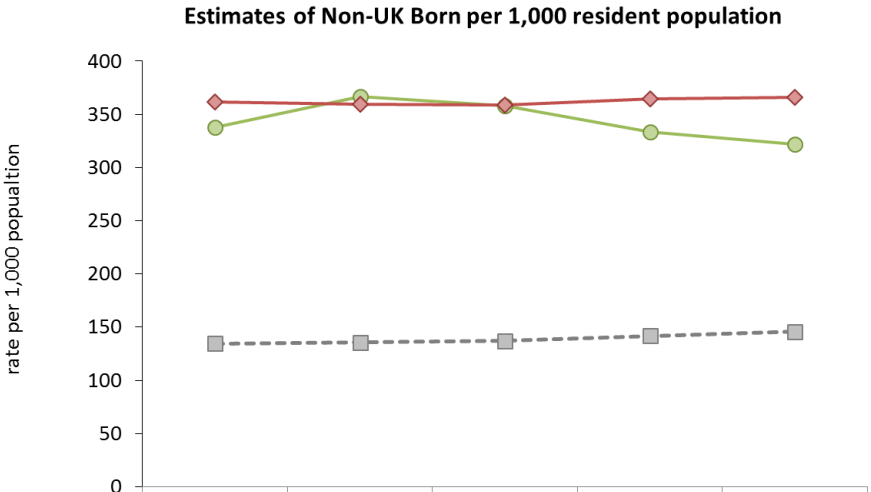
2.4.4. Non-UK born

The 2011 Census estimates that 40 per cent of Lambeth's population (120,000 persons) are non-UK born, slightly higher than in the previous Census (35 per cent).

12 per cent are from Europe, including: Portugal and Poland (2 per cent respectively), France, Germany, Italy, Spain, and Lithuania (1 per cent respectively). 10 per cent are from Africa, including: Nigeria (2 per cent), Ghana, Somalia, Kenya and South Africa (1 per cent respectively). 5 per cent are from the Middle East and Asia and 8 per cent the Americas and Caribbean, including: 3 per cent South America and 4 per cent the Caribbean.

The non-UK born rate per 1,000 Lambeth residents is less than for London as a whole, and has reduced slightly over the last few years. The rate is still twice that seen nationally.

Figure 14. Estimates of non-UK born per 1,000 resident population



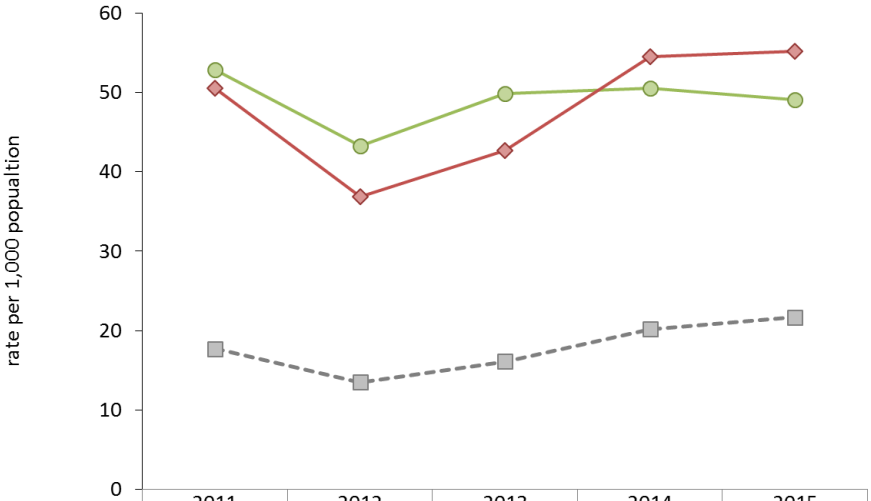
	2011	2012	2013	2014	2015
Lambeth	337.7	366.9	357.8	333.3	321.9
London	361.7	359.4	358.6	364.5	365.8
England	134.6	135.7	137	141.8	145.6

Source: Office for National Statistics Migration 2016 (ONS)

2.4.5. Migrant national insurance number (NINo) registrations

The number of NINo allocations to adult overseas nationals (aged 16-64 years) has increased from 9,893 in 2005 to 11,884 in 2015. The NINo registrations rate per 1,000 Lambeth residents is less than you would see in London, and has reduced slightly over the last few years. The rate is twice that seen nationally.

Figure 15. Migrant NINo registrations per 1,000 resident population aged 16-64 years



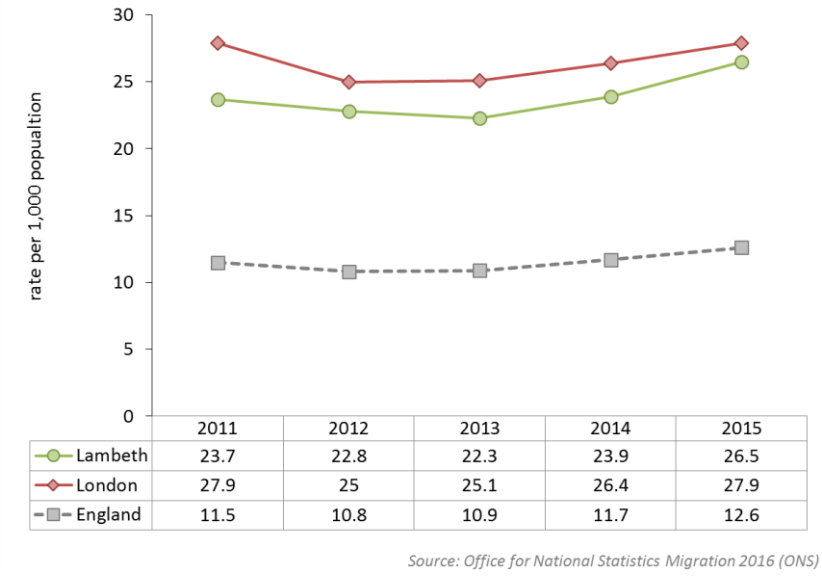
	2011	2012	2013	2014	2015
Lambeth	52.9	43.3	49.9	50.6	49.1
London	50.6	36.9	42.7	54.5	55.2
England	17.7	13.5	16.1	20.2	21.7

Source: Office for National Statistics Migration 2016 (ONS)

2.4.6. Migrant GP registrations

Over the last ten years the number and rate of migrant GP registrations has decreased in Lambeth from 9,227 (33.2 / 1,000) in 2005 to 8,586 (26.5 / 1,000) in 2015. The last three years has seen a reversal of this trends with the rate increasing, a trend seen in London, and a narrowing of the gap between Lambeth and London. The rate is twice that seen nationally.

Figure 16. Migrant GP registrations per 1,000 resident population



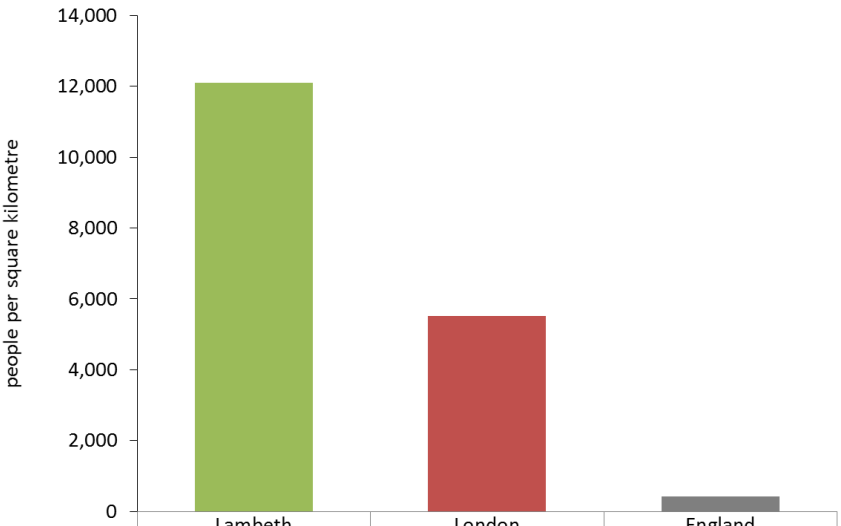
	2011	2012	2013	2014	2015
Lambeth	23.7	22.8	22.3	23.9	26.5
London	27.9	25	25.1	26.4	27.9
England	11.5	10.8	10.9	11.7	12.6

Source: Office for National Statistics Migration 2016 (ONS)

2.5. Density

Lambeth is the fifth most densely populated borough in the country with a rapidly growing population projected to grow by 9 per cent over the next ten years.

Figure 17. Population density, persons per km²

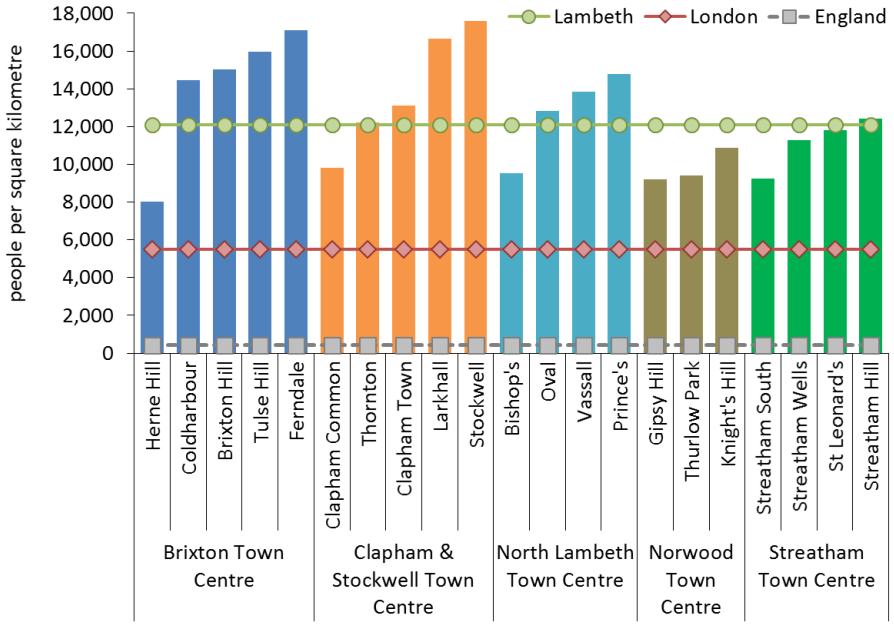


	Lambeth	London	England
Persons per km2	12101	5517	421

Source: Office for National Statitsics (ONS), Mid Yearly Estimates (MYE) 2015, Census 2011 area Km2

The population density in Lambeth is twice that experienced in London and nearly 29 times higher than in England. There is variation across Lambeth wards, with the lowest density in Norwood and Streatham town centre (south of the borough), and the highest density in North Lambeth and Brixton Town Centre (north of the borough).

Figure 18. Population density, persons per km^2, ward and town centre



Source: Office for National Statitsics (ONS), Mid Yearly Estimates (MYE) 2015, Census 2011 area Km2

2.6. Deprivation

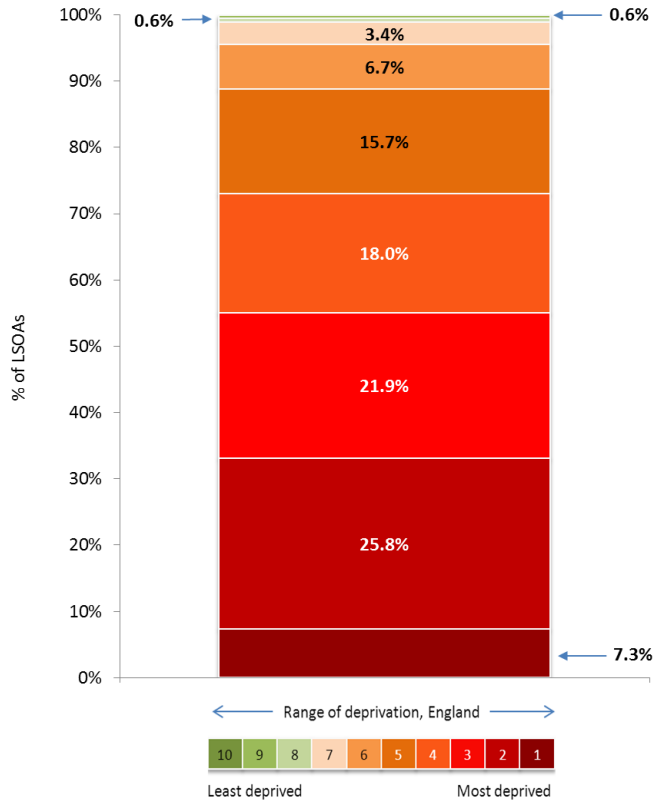
The 2015 Index of Multiple Deprivation (IMD) places Lambeth as the eighth most deprived borough in London and 44th most deprived in England. This suggests an improved relative position since 2010, when Lambeth was ranked the 29th most deprived authority in England.

IMD measures relative levels of deprivation in 32,844 small areas or neighbourhoods, called Lower-layer Super Output Areas (LSOAs), in England. Lambeth is made up of 178 LSOAs, each containing around 500 households and approximately 1,500 residents in each LSOA.

The figure below describes the proportion of LSOA for IMD in each banding of deprivation, where 1 represents the most deprived and 10 the least deprived areas in England.

Variation of deprivation can be seen across the borough, however, 13 of Lambeth's LSOAs (7.3 per cent) are in the ten per cent most deprived LSOAs in England. 33.1 per cent of LSOAs in Lambeth are in the 20 per cent most deprived areas in England and 73 per cent of LSOAs in Lambeth are in the 40 per cent most deprived areas in England.

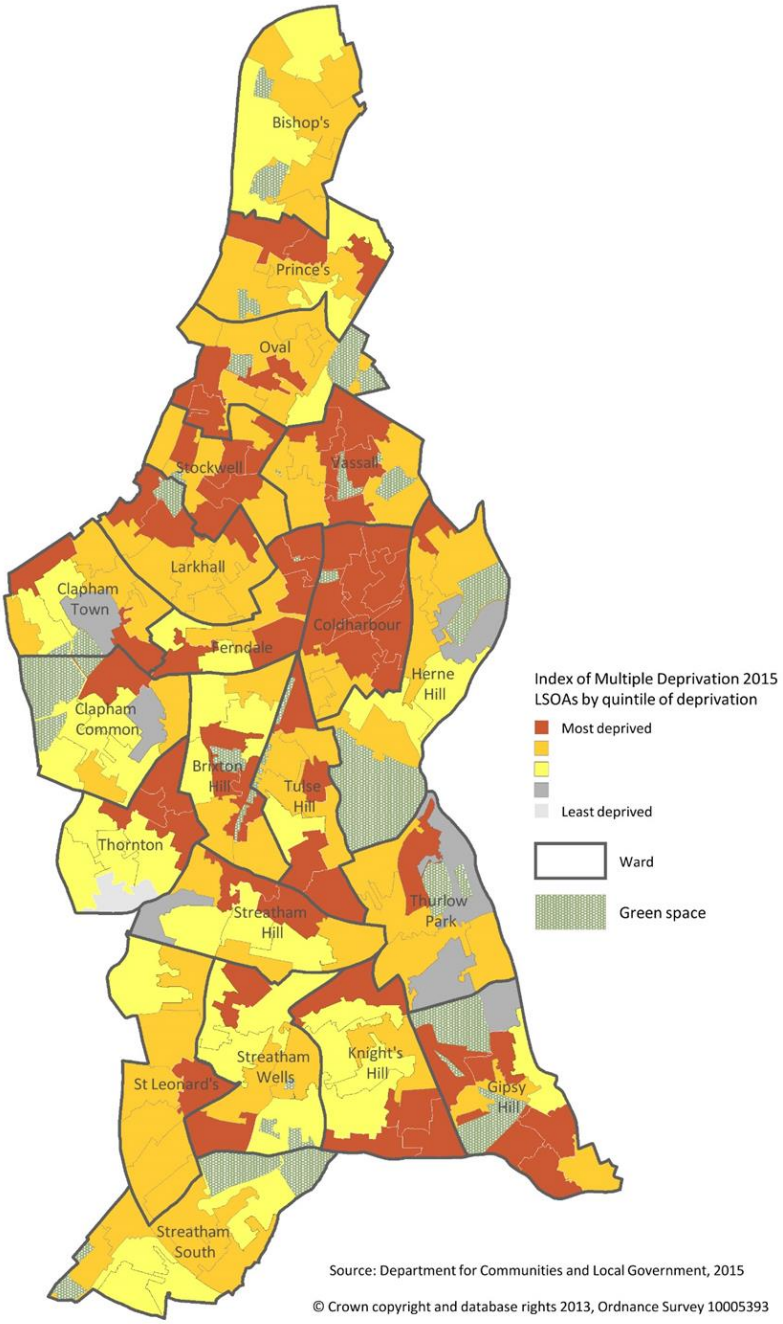
Figure 19. Lambeth Index of Multiple Deprivation 2015, national context



Source: Index of Multiple Deprivation 2015 (IMD)

The map below shows the geographic distribution of deprivation in Lambeth, according to their rank in all areas in England. The 13 LSOAs which are in the ten per cent most deprived LSOAs in England are mainly in the Centre and South West of the borough (they are located in the wards Gipsy Hill, Vassall, Coldharbour, Ferndale, Oval, Herne Hill, Knight's Hill). Coldharbour is the most deprived ward by some way, with half of its LSOAs in the ten per cent most deprived.

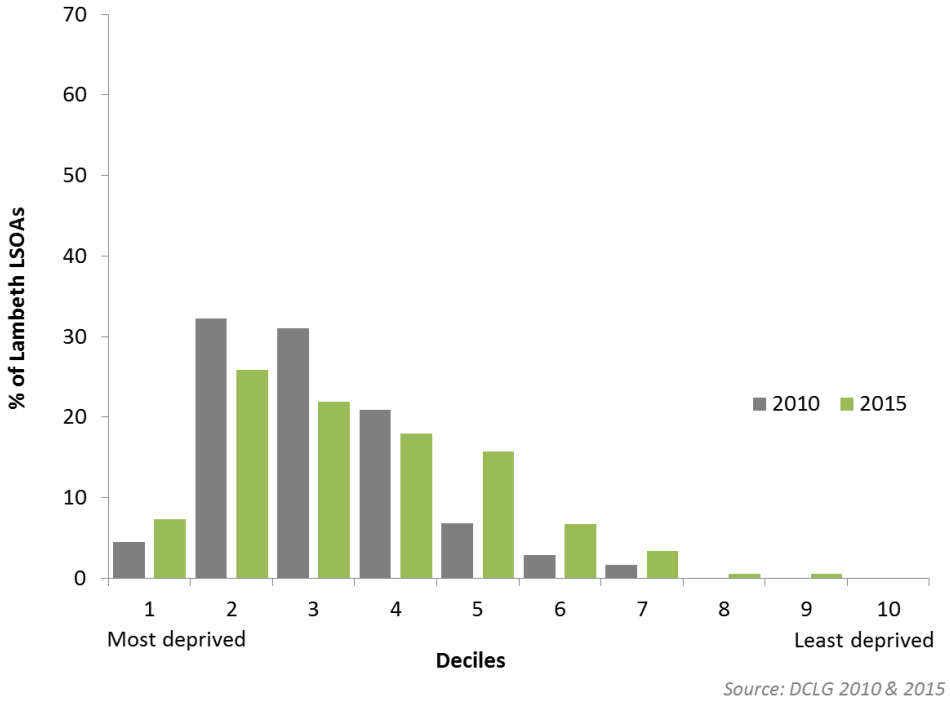
Figure 20. Map of Lambeth Index of Multiple Deprivation 2015, national context



Relative deprivation has changed in Lambeth. Compared to 2010, Lambeth has fewer LSOAs in the 40 per cent most deprived areas in England, 73 per cent in 2015 compared to 89 per cent in 2010.

The data suggest, relatively, a shift of LSOAs to the extremes of deprivation suggesting a rising gap in inequalities. This can be seen in the proportion of LSOAs in Lambeth in the ten per cent most deprived areas in England, 4.5 per cent in 2010 compared with 7.3 per cent in 2015.

Figure 21. Percentage of Lambeth's LSOAs in each decile of deprivation, 2010 vs 2015



Source: DCLG 2010 & 2015

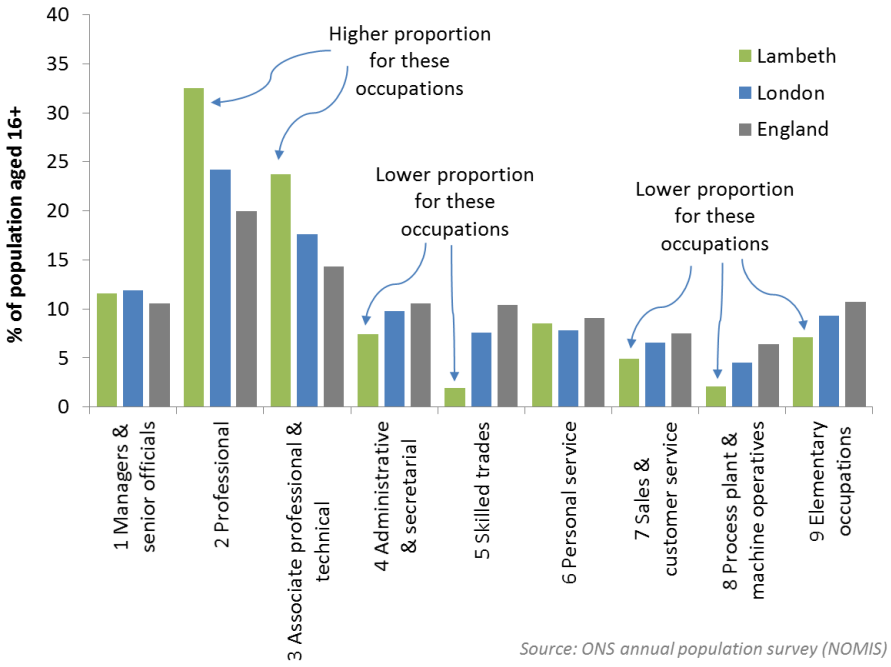
2.7. Occupational profile

Data on distribution of the adult population who are in employment is provided by NOMIS (National Online Manpower Information System) as part of the official labour market survey. The following data are segmented by the standard occupational classification (SOC) 2000.

Compared with England and London, Lambeth has a higher proportion of the adult population employed in professional and associated professional and technical occupations. Most occupations in this major group require a significant amount of knowledge and experience, education to degree or equivalent qualification, and some occupations requiring postgraduate qualifications and/or a formal period of experience-related training.

It follows that, compared with England and London, Lambeth has a lower proportion of the adult population employed in administrative and secretarial, skilled trades, sales and customer service, process plant and machine operatives and elementary occupations.

Figure 22. Employment by occupation 2016



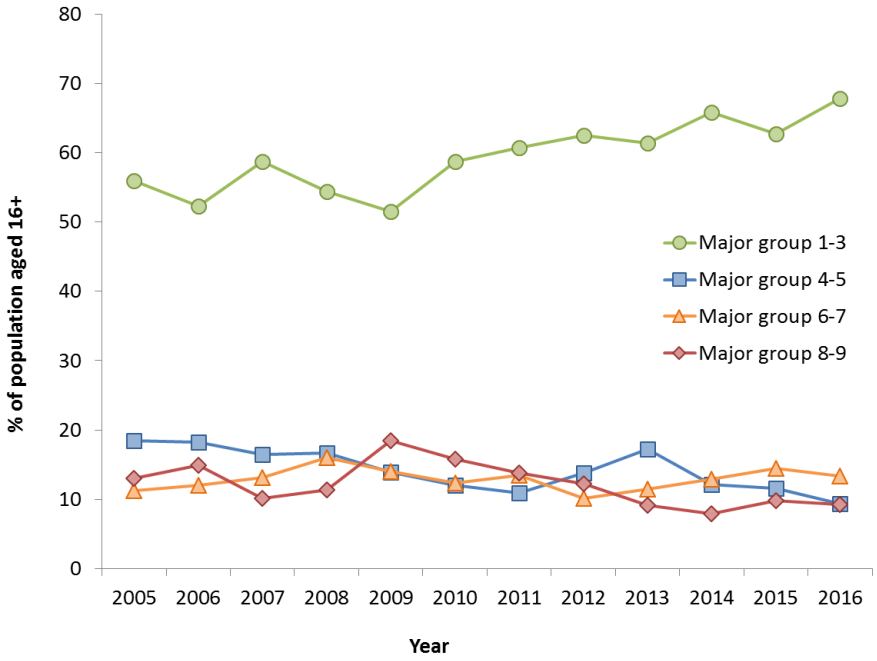
Compared with England and London, a higher percentage of the Lambeth adult population are employed in major groups 1-3, with lower proportions in all other groups.

Employment in Lambeth over time is changing, with increasing proportions of employed adults in working the three groups with the highest qualifications, and a decreasing proportion working in less and lower skilled professions.

Table 1. Employment by occupation in Lambeth, April 2015-March 2016

Occupation	Lambeth	London	England
Major group 1-3	67.8	53.7	44.9
1 Managers and senior officials	11.6	11.9	10.6
2 Professional	32.5	24.2	20
3 Associate professional and technical	23.7	17.6	14.3
Major group 4-5	9.3	17.4	21
4 Administrative and secretarial	7.4	9.8	10.6
5 Skilled trades	1.9	7.6	10.4
Major group 6-7	13.4	14.4	16.6
6 Personal service	8.5	7.8	9.1
7 Sales and customer service	4.9	6.6	7.5
Major group 8-9	9.2	13.8	17.1
8 Process plant and machine operatives	2.1	4.5	6.4
9 Elementary occupations	7.1	9.3	10.7

Figure 23. Employment by occupation 2005-2016



Source: ONS annual population survey (NOMIS)

3. Life expectancy

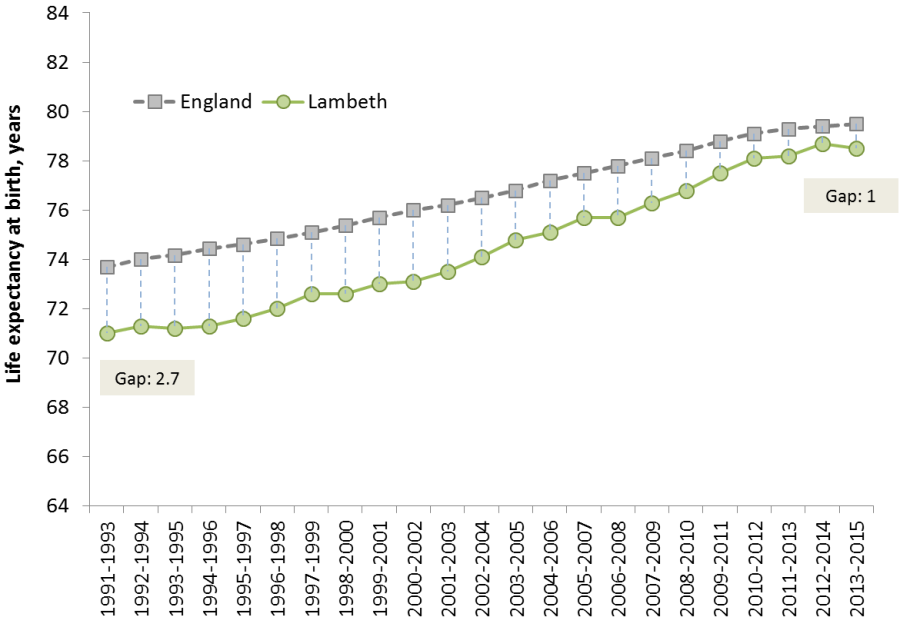
Life expectancy at birth for Lambeth men born in 2013-15 is 78.5 years, lower than London (80.2) and England (79.5). Healthy life expectancy is 59.4 years, lower than London (64.1) and England (63.4). Life expectancy at 65 years is 18.2 years, lower than London (19.1) and England (18.7). The difference in life expectancy between the least and most deprived areas is 6.1 (2012-14).

Life expectancy at birth for women in Lambeth born in 2013-15 is 83.0 years, lower than London (84.1) and similar to England (83.1). Healthy life expectancy is 63.0 years, similar to London (64.1) and England (64.1). Life expectancy at 65 years is 21.3 years, similar to London (21.7) and England (21.1). The difference in life expectancy between the least and most deprived areas is 3.0 (2012-14).

3.1. Life expectancy at birth

Male life expectancy has steadily increased over the last 20 years from 71 years 1991-93 to 78.5 years in 2013-15, and the underlying trend suggests this will continue to improve. The gap between Lambeth and England has improved from a gap of 2.7 to 1. Recent data indicates a slight reduction in life expectancy compared to previous pooled data, however this change is not significant.

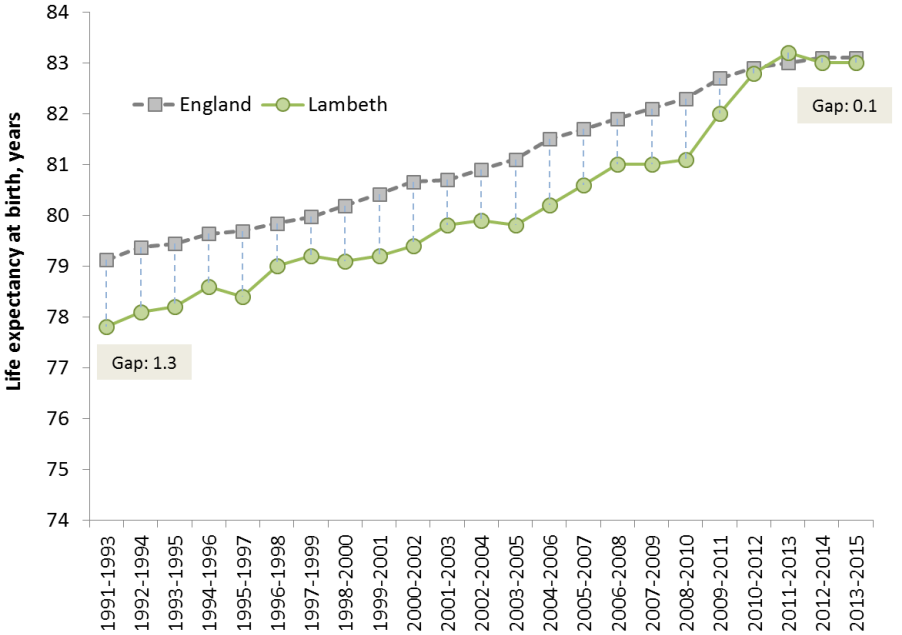
Figure 24. Life expectancy at birth in Lambeth and England, males



Source: Office for National Statistics (ONS) (PHOF 2000 onwards)

Female life expectancy has steadily increased over the last 20 years from 77.8 years 1991-93 to 83 years in 2013-15, and the underlying trend suggests this will continue to improve. The gap between Lambeth and England has improved from a gap of 1.3 to 0.1. Recent data indicates a plateauing in life expectancy compared to previous pooled data.

Figure 25. Life expectancy at birth in Lambeth and England, females



Source: Office for National Statistics (ONS) (PHOF 2000 onwards)

3.2. Life expectancy gap

The following charts show, for each broad cause of death, the percentage contribution that it makes to the overall life expectancy gap for males and females between Lambeth and England, and between the most deprived quintile of the local authority and the least deprived quintile of the local authority.

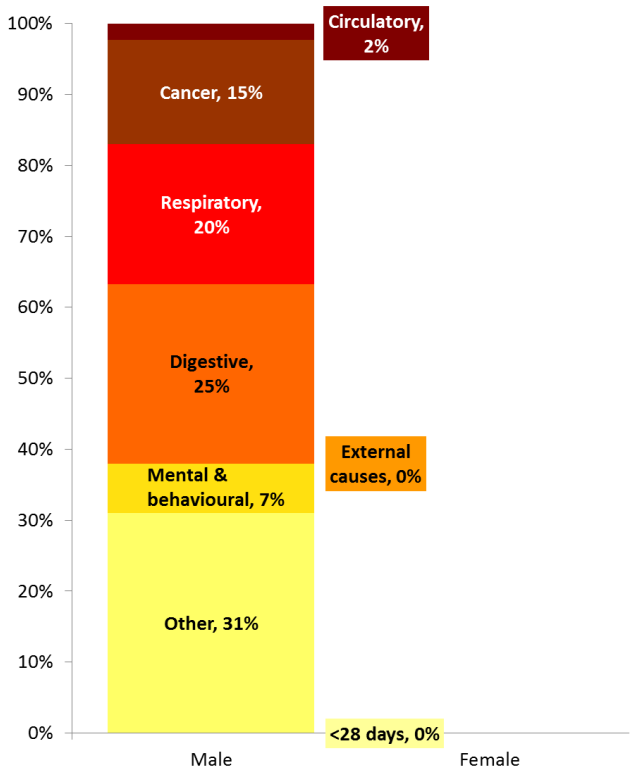
The tables show the percentage contributions for a more detailed breakdown of causes of death. The number of deaths occurring in the area in 2012-2014 are shown, and alongside, the number of excess deaths. Excess deaths are the number of 'extra' deaths that occur in the selected area because it has a higher mortality rate for that cause of death than the comparator area. If these deaths were prevented, then the contribution of that cause of death to the overall life expectancy gap would be eliminated. For some causes of death, there are no excess deaths in the selected area, and therefore no impact is made to the life expectancy gap. If this is the case the table shows a value of "..". The table records a".." for all causes of death for females, as there are no excess deaths in females in Lambeth as a result of any of the broad causes of death, i.e. life expectancy is higher or similar to England.

3.2.1. Life expectancy gap – England

The following data shows the life expectancy gap between Lambeth and England.

For males, digestive and respiratory conditions are key contributors to the life expectancy gap. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis. For males, cancer related deaths are also key, the majority of which were due to lung cancer. Chronic obstructive pulmonary disease explained the entirety of the male respiratory disease gap.

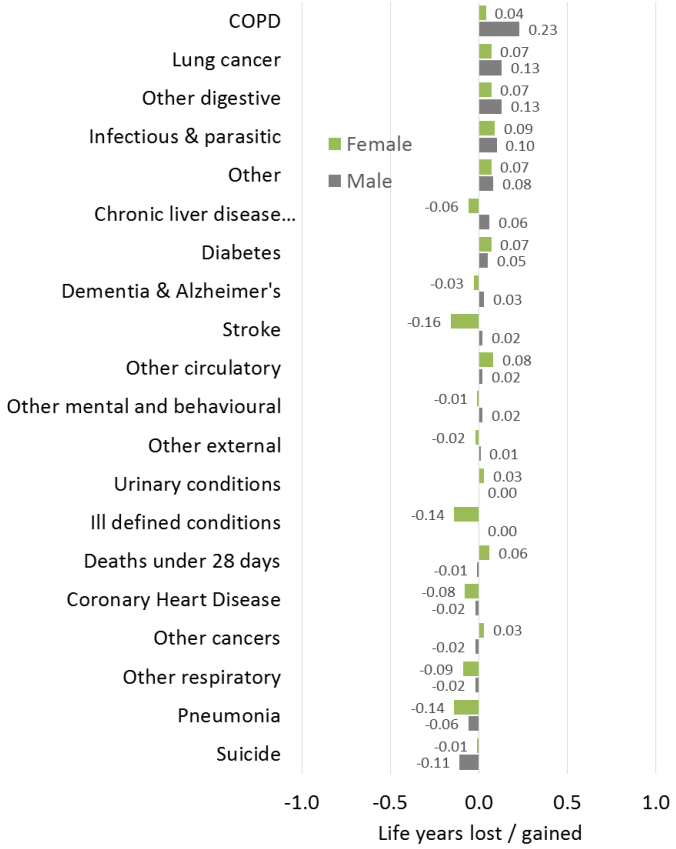
Figure 26. Life expectancy gap between Lambeth as a whole and England as a whole, by broad cause of death, 2012-2014



Source: Public Health England, Segment Tool, Life Expectancy Gap

The bar chart shows a detailed breakdown of causes of death, the years of life expectancy that would be lost or gained in Lambeth as a whole if it had the same mortality rates as England as a whole, by detailed cause of death and by gender.

Figure 27. Life expectancy years gained or lost in Lambeth as a whole if it had the same mortality rates as England as a whole, by detailed cause of death, 2012-2014



Source: Public Health England, Segment Tool, Life Expectancy Gap

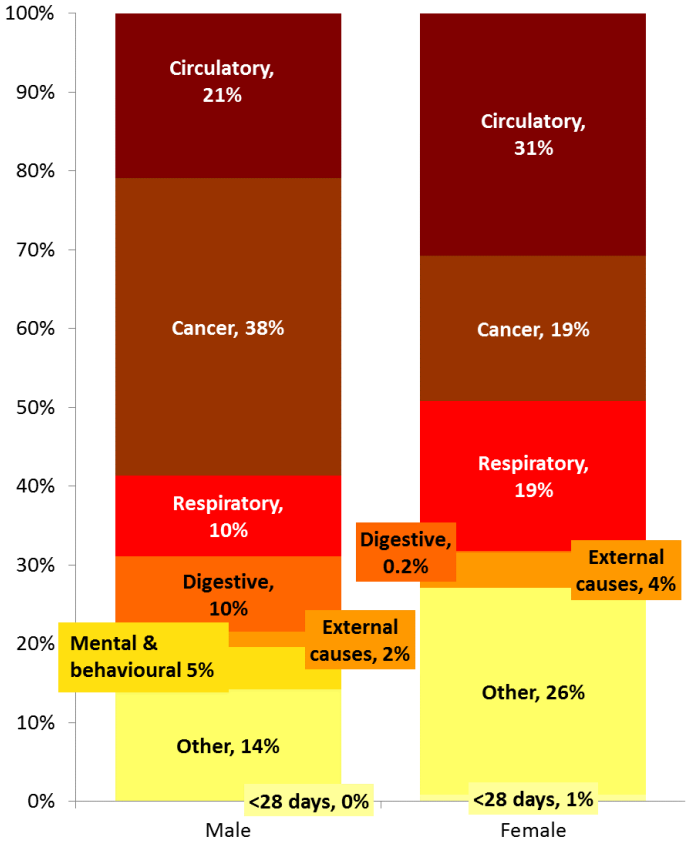
3.2.2. Life expectancy gap – Deprivation

At local level, the following data shows life expectancy gap between Lambeth's least and most deprived areas.

For males, cancer is a key contributor to the life expectancy gap, accounting for 40 per cent of the difference. Lung cancer accounts for half of that difference. Circulatory diseases account for 20 per cent of the gap, with coronary heart disease the major contributor. Both respiratory and digestive diseases account for ten per cent each, with the major contributors of COPD and chronic liver disease including cirrhosis respectively. Remaining conditions including external causes, mental and behavioural diseases, and 'other' account for 22 per cent of the gap with suicide, dementia and Alzheimer's, infectious disease and diabetes as major contributors.

For females, circulatory diseases are a key contributor, accounting for 31 per cent of the gap with coronary heart disease and stroke the major contributor. Other illnesses accounts for 26 per cent of the gap; major contributors are urinary conditions, infectious and parasitic diseases, and diabetes. Both respiratory diseases and cancer account for 19 per cent of the gap, with major contributors being COPD and lung cancer respectively.

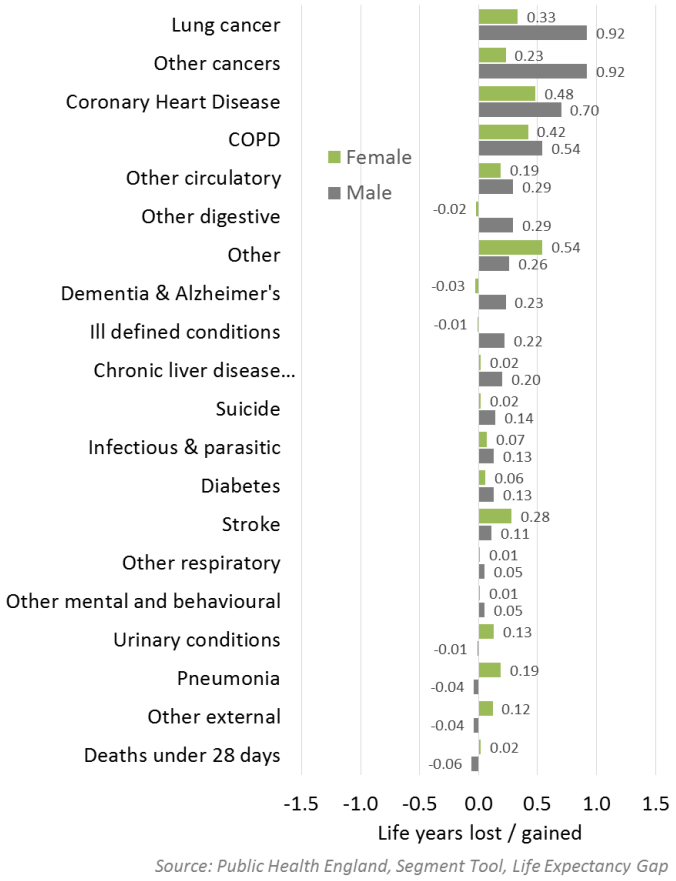
Figure 28. Life expectancy gap between Lambeth's most deprived quintile and Lambeth's least deprived quintile, by broad cause of death, 2012-2014



Source: Public Health England, Segment Tool, Life Expectancy Gap

The bar chart shows a detailed breakdown of causes of death, and the years of life expectancy that would be lost or gained in Lambeth's most deprived quintile if it had the same mortality rates as Lambeth's least deprived quintile, by gender.

Figure 29. Life expectancy years gained or lost in Lambeth's most deprived quintile if it had the same mortality rates as Lambeth's least deprived quintile, by detailed cause of death, 2012-2014

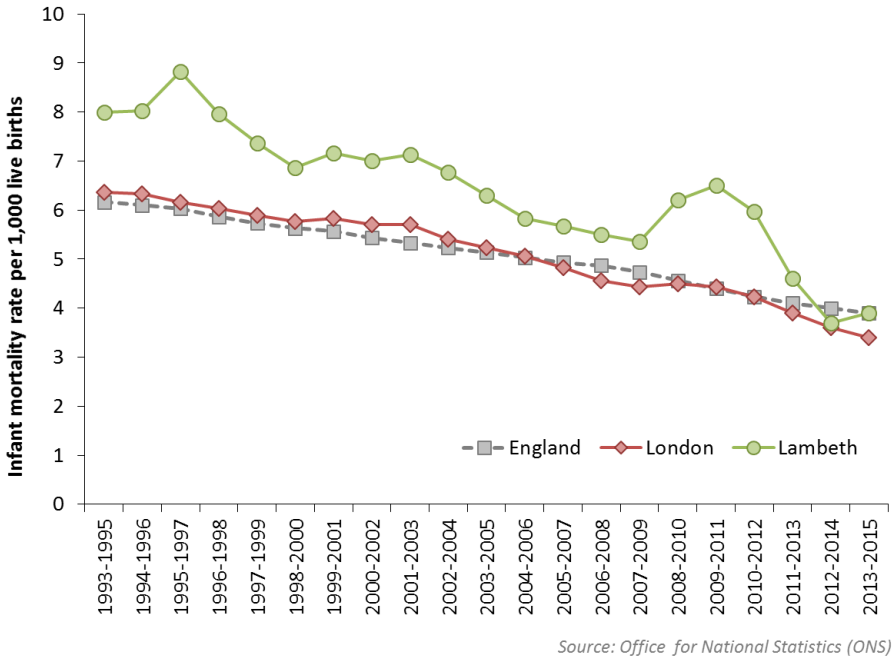


Source: Public Health England, Segment Tool, Life Expectancy Gap

4. Infant mortality

Infant mortality has decreased over the last 15 years from 8.8 deaths per 1,000 live births in 1995-97 to 3.9 deaths per 1,000 live births in 2013-15, a reduction of 56 per cent. The underlying trend suggests this will continue to improve. The gap between Lambeth and England has improved from a gap of 1.8 to 0, and compared with London the gap has improved from 1.6 to 0.5. Recent data indicates a slight increase in infant mortality compared with previous pooled data, however, this change is not statistically significant.

Figure 30. Infant mortality in Lambeth, rate per 1,000 live births, 1993-2015



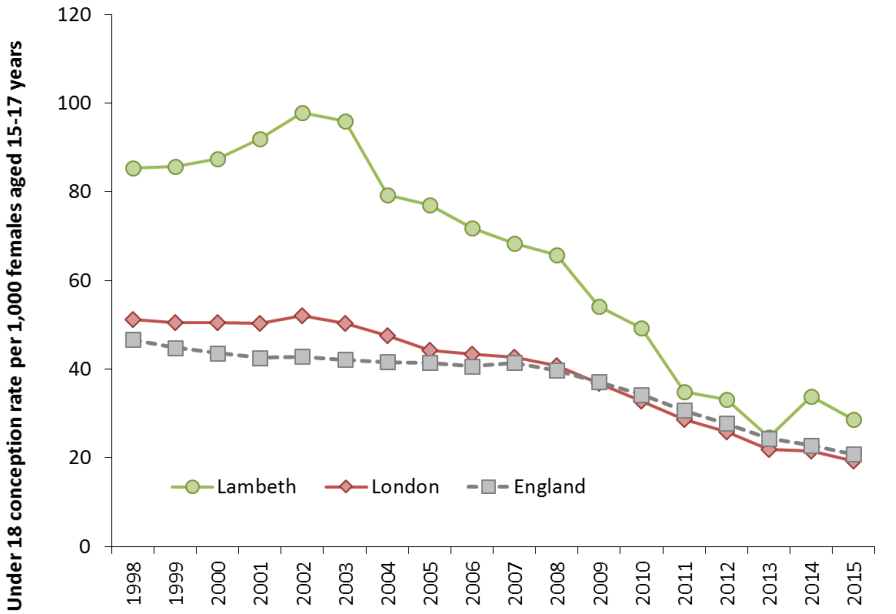
Source: Office for National Statistics (ONS)

5. Teenage conceptions

The rate of under 18 teenage conceptions has steadily decreased over the last 15 years from, 85.3 per 1,000 girls aged 15-17 in 1998, to 28.7 per 1,000 girls aged 15-17 in 2015, a reduction of 66 per cent. The underlying trend suggests this will continue to improve. The gap between Lambeth and England has improved from a gap of 39 to 8, and compared with London, the gap has improved from 34 to 10.

The rate in Lambeth has decreased more rapidly than in London and England, with a 70 per cent decrease since 2002 (from 406 to 123 conceptions in 2015) compared with a 61 per cent decrease in London and a 53 per cent decrease in England. Lambeth has the third highest teenage conception rate in London.

Figure 31. Under 18 conception in Lambeth, rate per 1,000 females aged 15-17 years, 1998-2015



Source: Office for National Statistics (ONS)

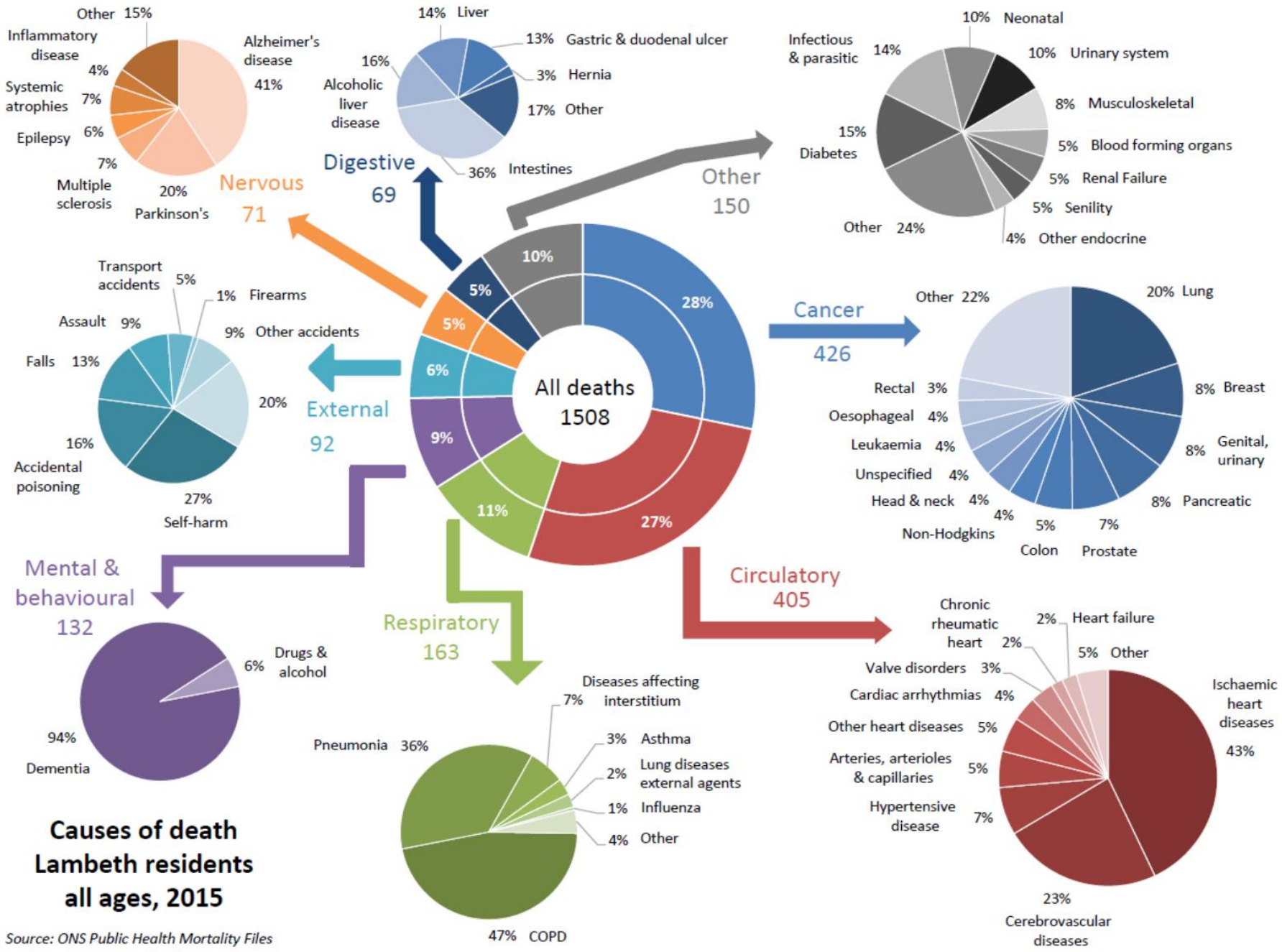
6. Mortality

The data on cause of death is derived from the Primary Care Mortality Files. The pie charts show the proportion each cause of death contributes to total deaths. In 2015, there were 1,508 deaths of Lambeth residents. Overall cancer is the largest main cause of death (28 per cent), followed by circulatory disease (27 per cent).

The main specific causes of death are ischaemic heart disease (174), dementia (124), cerebrovascular disease (95), lung cancer (85), COPD (76) and pneumonia (59).

There were 659 premature deaths (deaths in those aged 75 years or under) of Lambeth residents. Overall, cancer is the largest main cause of death (36 per cent) followed by circulatory diseases (23 per cent).

The main specific causes of premature deaths are ischaemic heart disease (72), lung cancer (45), cerebrovascular disease (35), COPD (28) and intentional self-harm (24).



Causes of death
Lambeth residents
all ages, 2015

Source: ONS Public Health Mortality Files

7. Detected prevalence of long term conditions, Quality Outcomes Framework (QOF)

Data was obtained from Health and Social Care Information Centre to understand list size and disease register size for all Lambeth CCG general practices.

Detected prevalence is a measure of the known frequency of a disease or health condition in a population at a particular point in time (and is different to incidence, which is a measure of the number of newly diagnosed cases within a particular time period).

Prevalence data within the QOF are collected in the form of practice "disease registers".

Please note that these are not age or sex standardised, and represents detected rather than true prevalence so caution is advised in interpreting results.

Figure 33. Detected prevalence of long term conditions over time

Condition	2012-13	2013-14	2014-15	2015-16
Atrial fibrillation	0.59%	0.62%	0.65%	0.66%
Coronary Heart Disease Prevalence	1.34%	1.36%	1.33%	1.28%
Cardiovascular Disease Primary Prevention Prevalence	2.07%	2.75%	1.27%	1.20%
Heart failure prevalence	0.43%	0.43%	0.44%	0.41%
Hypertension prevalence	9.19%	9.47%	9.59%	9.39%
Peripheral Arterial Disease	N/A	0.34%	0.34%	0.33%
Stroke and Transient Ischaemic Attacks (TIA) prevalence	0.89%	0.92%	0.93%	0.93%
Asthma prevalence	4.69%	4.77%	4.86%	4.67%
Chronic obstructive pulmonary disease prevalence	0.93%	0.95%	0.96%	0.93%
Obesity prevalence	8.05%	6.65%	6.35%	6.97%
Cancer prevalence	1.22%	1.35%	1.43%	1.44%
Chronic kidney disease prevalence	1.90%	1.91%	1.84%	1.78%
Diabetes mellitus prevalence	4.71%	5.01%	5.19%	5.33%
Hypothyroidism prevalence	1.70%	1.76%	N/A	N/A
Palliative care prevalence	0.16%	0.17%	0.16%	0.15%
Dementia prevalence	0.25%	0.28%	0.37%	0.35%
Depression prevalence	4.90%	5.60%	6.33%	6.77%
Epilepsy prevalence	0.52%	0.52%	0.53%	0.51%
Learning disabilities prevalence	0.33%	0.35%	0.36%	0.35%
Mental health prevalence	1.22%	1.26%	1.29%	1.27%
Osteoporosis (50+)	0.14%	0.21%	0.14%	0.19%
Rheumatoid arthritis (16+)	N/A	0.44%	0.44%	0.43%

The following spine chart shows the relative position of Lambeth CCG compared to the spread of data in England. The light grey bar shows the range of values found in England. The dark grey

sections mark out the range within which the middle half of the observed values lie (25th to 75th percentile). The black dotted line shows where the England average is. The position of the circle shows Lambeth CCG value, a diamond the London value.

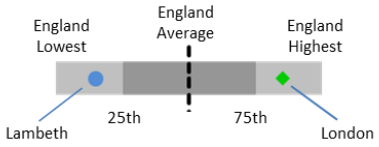


Figure 34. Spine chart detected prevalence of long term conditions 2015-16

	Indicator	No. Lambeth	Prevalence Lambeth	Eng Avg	Eng Lowest	England Range	Eng Highest
1	AF	2,568	0.66%	1.71%	0.42%		3.01%
2	CHD	4,981	1.28%	3.19%	1.28%		5.13%
3	CVD-PP	2,637	1.20%	1.06%	0.48%		1.91%
4	HF	1,610	0.41%	0.75%	0.32%		1.49%
5	Hypertension	36,613	9.39%	13.80%	7.66%		18.40%
6	PAD	1,287	0.33%	0.61%	0.23%		1.21%
7	Stroke	3,640	0.93%	1.73%	0.72%		2.67%
8	Asthma	18,194	4.67%	5.90%	3.55%		7.81%
9	COPD	3,633	0.93%	1.85%	0.76%		3.72%
10	Obesity	22,324	6.97%	9.44%	3.93%		14.84%
11	Cancer	5,614	1.44%	2.42%	0.82%		3.74%
12	CKD	5,719	1.78%	4.09%	1.50%		8.20%
13	Diabetes	17,259	5.33%	6.54%	3.62%		10.26%
14	Palliative	581	0.15%	0.34%	0.10%		0.93%
15	Dementia	1,362	0.35%	0.76%	0.29%		1.35%
16	Depression	21,685	6.77%	8.26%	4.52%		14.10%
17	Epilepsy	1,645	0.51%	0.80%	0.44%		1.94%
18	LD	1,367	0.35%	0.46%	0.19%		0.81%
19	MH	4,942	1.27%	0.90%	0.52%		1.51%
20	Osteoporosis	166	0.19%	0.31%	0.10%		0.83%
21	Rheumatoid Arthritis	1,399	0.43%	0.73%	0.40%		1.22%

8. Vital statistics

Vital statistics are provided by Office for National Statistics. The following data are key indicators for Lambeth residents compared to England.

The light grey bar shows the range of values found in England. The dark grey sections mark out the range within which the middle half of the observed values lie (25th to 75th percentile). The black dotted line shows where the England average is. The position of the circle shows Lambeth CCG value, a diamond the London value.

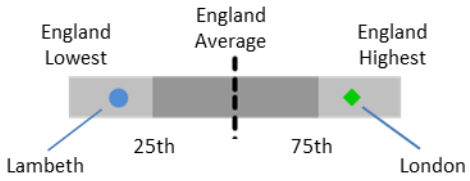


Figure 35. Spine chart vital statistics 2014

	Indicator	No. Lambeth	Value Lambeth	Eng Avg	Eng Lowest	England Range	Eng Highest
1	Total Births	4,542					
2	In marriage births	2,441	53.7%	53.1%	27.7%		81.4%
3	Live Births	4,528					
4	In marriage live births	2,435	53.6%	52.8%	27.4%		81.2%
5	Live crude rate	4,528	14.2	12.2	7.4		18.6
6	General fertility rate	4,528	52.0	62.2	37.3		82.7
7	Still birth rate	14	3.1	4.6	0.0		10.8
8	Birthweight over 4000gms	442	10.1%	11.0%	6.0%		16.6%
9	Birthweight under 2500gms	287	6.5%	7.1%	1.7%		12.1%
10	Count of deaths	1,378					
11	Crude death rate	1,378	4.3	8.6	3.5		14.4
12	infant death under 1 year	17	3.8	3.9	0.0		8.8
13	infant death under 4 weeks	15	3.3	2.7	0.0		7.2
14	infant death under 1 week	12	2.7	2.1	0.0		7.2

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