Health Profile for Lambeth 2022

Section 3 - Healthy Start in Life

Contents

Findings

3.6% of live births are low weight

3.6% of live births weighing less than 2500g

4.3% infants deaths aged less than 1 years old

Infant mortality rate was 4.3% per 1,000 (of all live births)

1 in 5 children with dental decay

19.4% of children under 5 have experience of dental decay.

1 in 5 children not school ready by age 5

610 children didn't achieve at least the expected level of development in communication and language skills, by aged 5

1 in 4 children obese

23% of children aged 10 to 11 years (Year 6) were obese, significantly worse than England

Less than 90% target coverage for most vaccinations

2% increase in the population over the next 10 years

3.1 Low birthweight

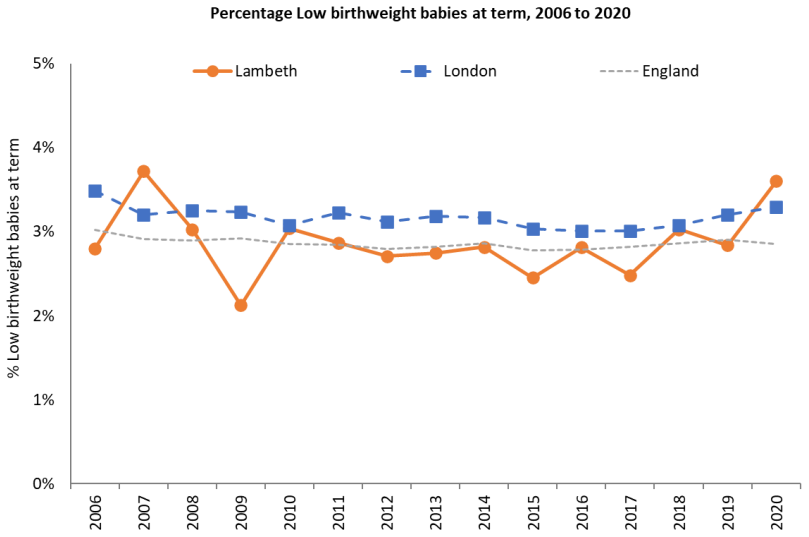
Low birth weight is defined by the World Health Organisation as a birth weight less than 2500 grams. Low birth weight infants account for 2.9% of all live births in England. In the UK and other developed countries, it is a major cause of infant mortality.

Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birthweight births could indicate lifestyle issues of the mothers and/or issues with the maternity services.

In Lambeth, there was little change in the proportion of babies born at full term with a low birthweight between 2010 and 2019, remaining at just under 3%. For the time period between 2010 and 2019, the percentage of low weight term babies in Lambeth was not significantly different to the England average. In 2020, there was a slight increase to 3.6%, significantly worse than the England average. **Figure 3.1**

As reported by the Office for Health Improvement & Disparities (OHID), there has been no significant change in the trend based on the 5 most recent points (2016 to 2020).

Figure 3.1 Percentage of Low birthweight



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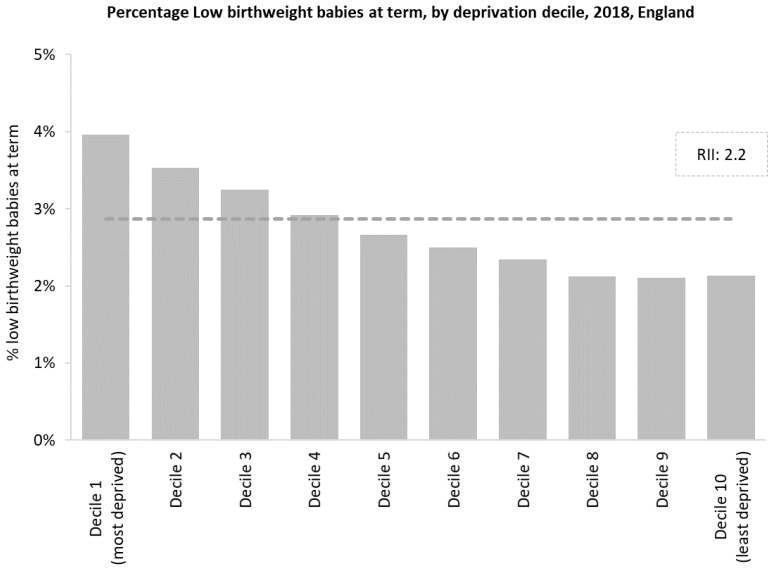
3.1.1 Inequalities for England

Deprivation (IMD 2019)

In 2018 the proportion of babies born at full term with a low birthweight in the most deprived areas was more than double the proportion in the least deprived areas, as measured by the Relative Index of Inequality (RII) figure 3.2**.** The relative index of inequality is a summary measure of inequality. It measures the relative difference between the most and least deprived areas and is presented as a ratio. For low birthweight the RII is 2.2, meaning that the level in the most deprived areas is 2.2 times higher than the least deprived.

Analysis by deprivation back to 2010 shows that this inequality remained broadly similar. [1] The analysis for April 2020 to March 2021 suggests that these inequalities have remained throughout the pandemic. [2]

Figure 3.2 Low birthweight babies at term by deprivation decile



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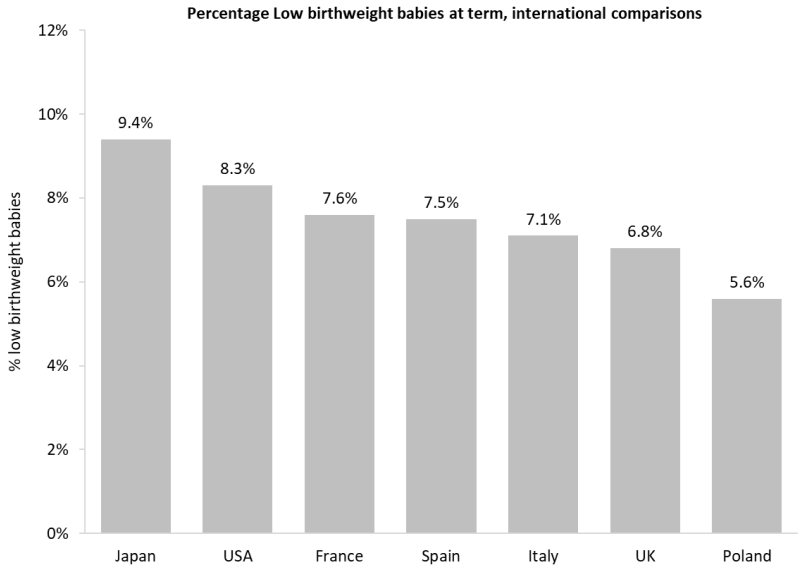
Ethnicity

There are well-established inequalities by ethnic group in low birthweight [3]. During April 2016 to March 2020 and the pandemic period from April 2020 to March 2021, low birthweight was highest among Asian and Black groups and lowest in the White group. [2]

International comparison

International comparisons of low birthweight in **figure 3.3**, presented for the latest year available, are measured as a proportion of all live births only (excludes still births). Of the eight countries with recent data, Japan has the highest proportion (over 9% in 2019), while the UK rate is just under 7%.

Figure 3.3 Percentage of Low birthweight babies (live births), international comparisons, 2019



Source: Organisation for Economic Co-operation and Development

3.2 Infant mortality

Infant mortality covers all deaths within the first year of life. The majority of these are neonatal deaths which occur during the first month and the main cause is related to prematurity and preterm birth, followed closely by congenital anomalies. [4]

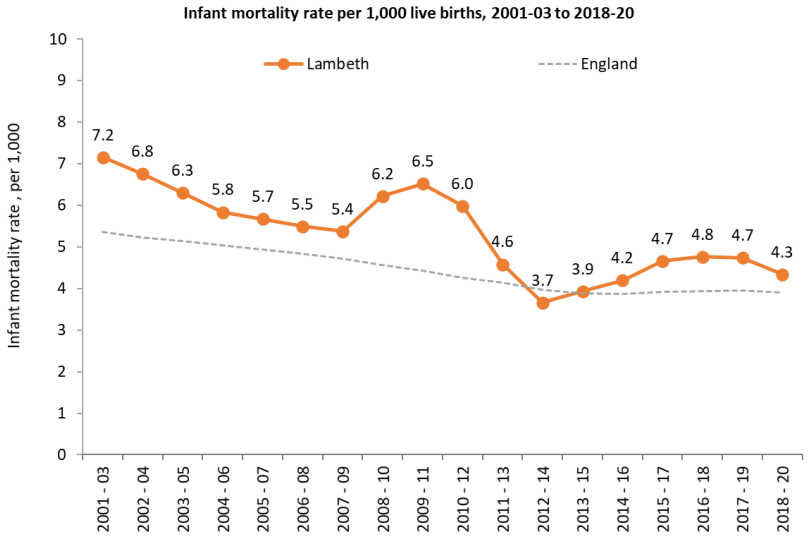
Figure 3.4 presents trends in infant mortality rates from 2001- 2003 until 2018-2020. They are presented on a three-year rolling average basis to smooth out variation.

Overall, the Lambeth rate fell from 7.2 per 1,000 live births in 2001-2003 to 4.3 in 2018-2020. Over this period, the rate has fluctuated, with an increase seen in 2008-10 to 2009-11 (6.2 to 6.5 respectively) which was significantly worse than the England average.

There have been no significant improvements in recent years, but rates remain significantly higher than the England average (3.9 per 1,000).

The impact of the pandemic on the infant mortality rate is not yet known, however provisional data suggest that there has been little change [5].

Figure 3.4 Infant mortality rate per 1,000 live births, 2001-03 to 2018-20



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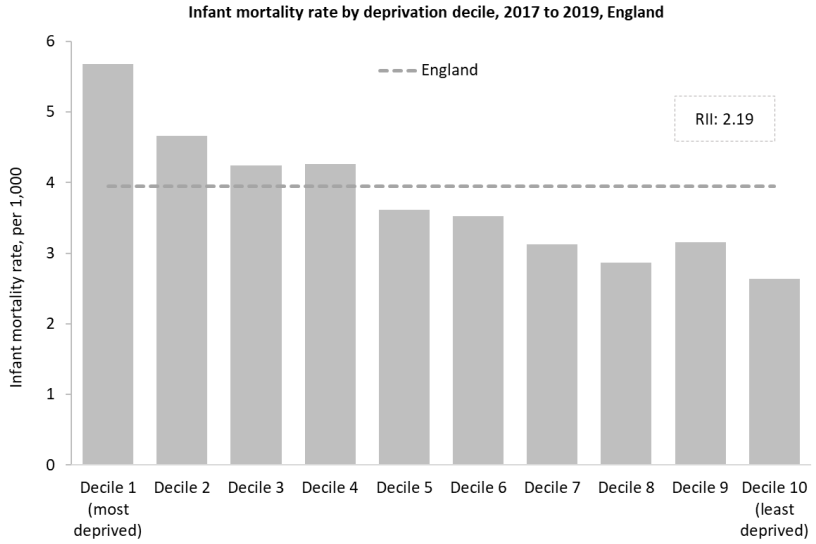
3.2.1 Inequalities for England

Deprivation (IMD 2019)

There are substantial inequalities in infant mortality rates figure 3.5 In 2017 to 2019, the rate in the most deprived areas was more than double that in the least deprived areas, as measured by the RII. Longer-term analysis shows that the inequality in infant mortality rates has remained broadly similar in the past decade. [1]

Figure 3.5 Infant mortality rate by deprivation decile, 2017 to 2019, England



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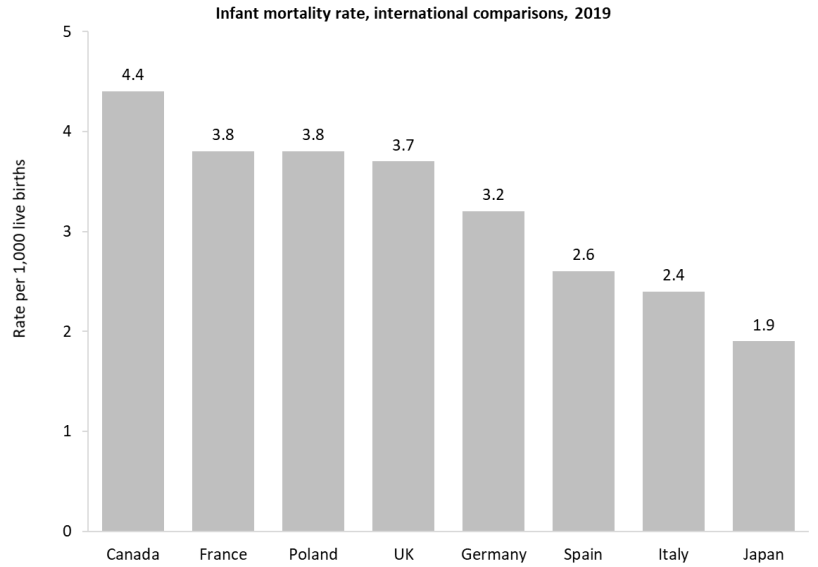
Ethnicity

In 2018, infant mortality rates were highest in the Black Caribbean (6.5 per 1,000 live births) Black African (6.4) and Pakistani (6.3) groups and lowest in the White British (3.2) and White Other (2.7) groups. [4]

International comparison

Among the 9 countries examined in figure 3.6 Canada had the highest infant mortality rate in 2019, and Japan had the lowest rate. The UK had a relatively high rate among the European countries presented, although rates were similar to France and Poland, and the UK's position relative to other European countries has worsened over the last 3 decades. [6]

Figure 3.6 Infant mortality rate, international comparisons, 2019



Source: Organisation for Economic Co-operation and Development

3.3 Dental Health

Dental decay remains a serious child health issue and is a major cause of hospital admission in children in England, but it is largely preventable. [7] If left untreated tooth decay can cause pain, infection, lack of sleep and time off school which in turn affects their ability to learn, thrive and develop.

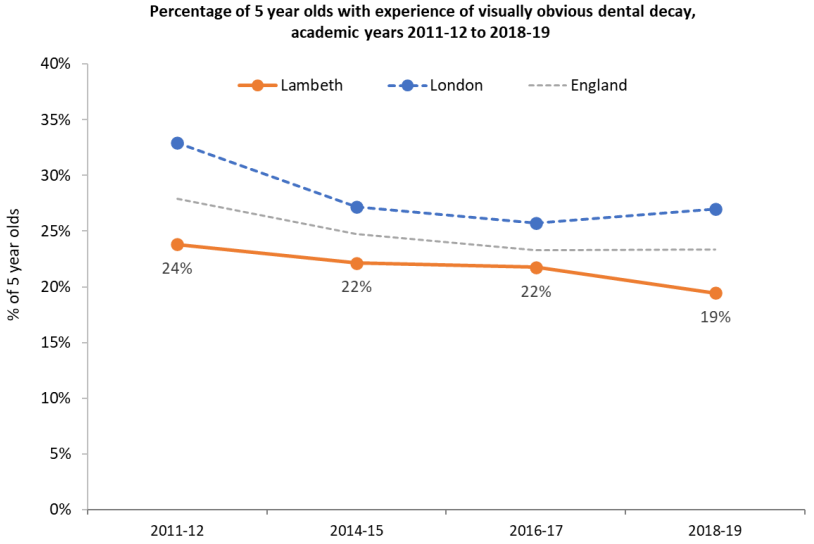
Figure 3.7 shows trends in the percentage of children aged 5 years with experience of obvious dental decay.

In Lambeth, the percentage of children aged 5 years with experience of obvious dental decay has consistently decreased each academic year since 2011-12 where the rate was 23.8%.

The most recent data for the year 2018-19 shows 19.4% of children under 5 have experience of dental decay.

For the time period between 2011-12 to 2018-19, the % of children aged 5 years with experience of obvious dental decay in Lambeth was not significantly different to the England average.

Figure 3.7 Percentage of 5 year olds with experience of visually obvious dental decay, academic years 2011-12 to 2018-19



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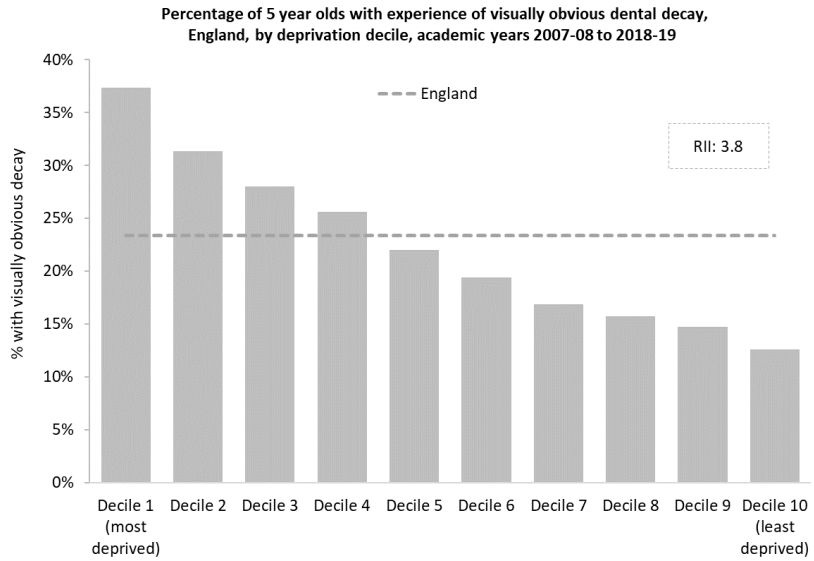
3.3.1 Inequalities for England

Deprivation (IMD 2019)

Figure 3.8 shows that, in the academic period 2018 to 2019, children from the most deprived areas were 3.8 times more likely to have experienced dental decay than those from the least deprived areas (as measured by the RII).

This inequality is wider than in 2011 to 2012 when the RII was 3.2. [1]

Figure 3.8 Percentage of 5 year olds with experience of visually obvious dental decay, by deprivation decile



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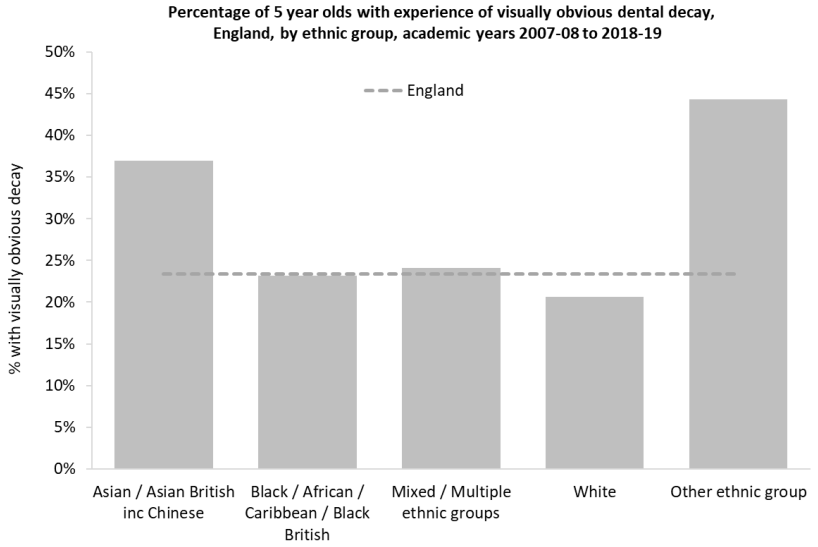
Ethnicity

Figure 3.9 shows that prevalence was highest in the Other ethnic group (44.3%) and the Asian ethnic group (36.9%) and lowest in the White ethnic group (20.6%).

Figure 3.9 Percentage of 5 year olds with experience of visually obvious dental decay, by ethnic group



Source: Office for Health Improvement & Disparities. Health Inequalities Dashboard. https://analytics.phe.gov.uk/apps/health-inequalities-dashboard/© Crown copyright 2022

3.4 Child development

Starting primary school is a significant milestone in a child's educational journey. Language and communication skills are fundamental to young people's potential development and achievements later in life. [8]

Disparities in child language capabilities are recognisable in the second year of life and are clearly having an impact by the time children enter school. If left unsupported, these children are more likely to fail to achieve their full potential.

Inadequate communication skills can lead to poorer adult outcomes in literacy, mental health, and employment. [9]

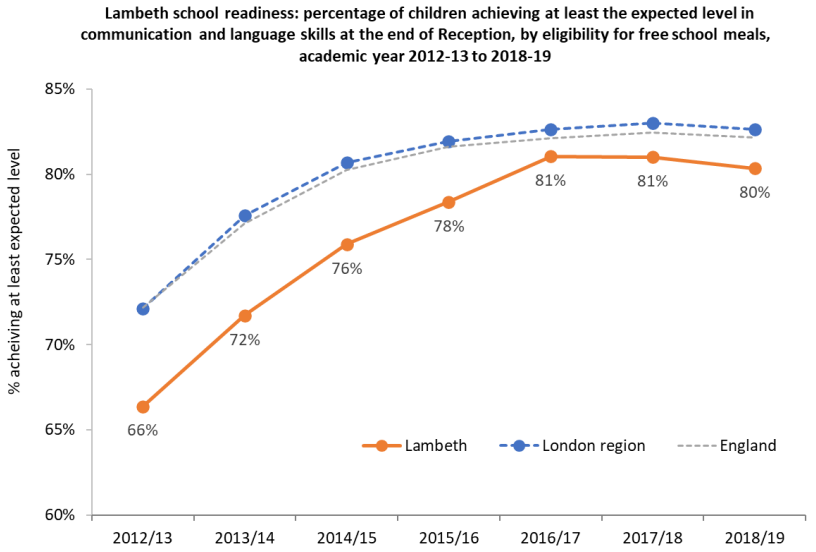
Being able to express themselves, interact with peers and make themselves understood helps to build a child's confidence and boost their self-esteem. [10]

In the academic year 2018 to 2019, 80.4% of Lambeth children achieved at least the expected level of development in communication and language skills at the end of Reception year. This is an improvement since 2012 where the proportion was 66.4%, an increase of 21%, **figure 3.10**.

For each academic year since 2012-13, the percentage of Lambeth children achieving at least the expected level of development in communication and language skills at the end of Reception year has been significantly lower compared to London and England.

As reported by the Office for Health Improvement & Disparities (OHID), based on the 5 most recent points (2014-15 to 2018-19) indicates the trend is increasing and getting better.

Figure 3.10 Lambeth school readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception, by eligibility for free school meals



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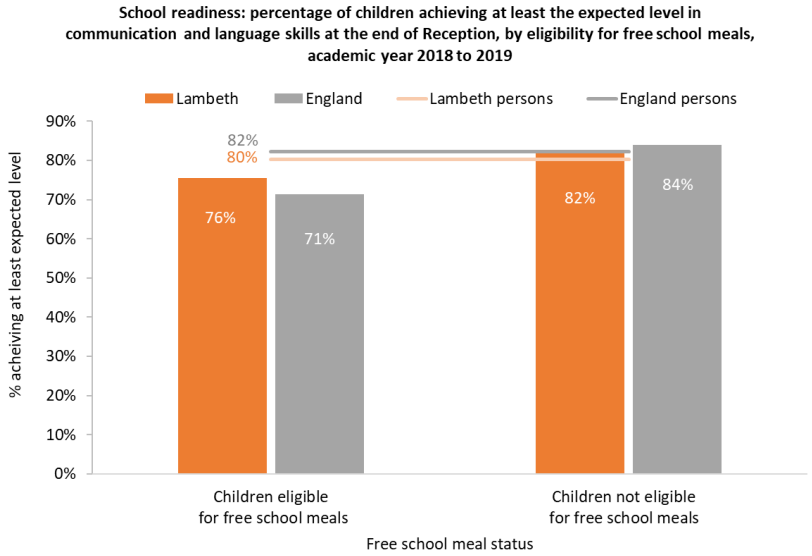
Lambeth Early Action Partnership (LEAP) have produced more detailed work comparing developmental milestones in LEAP areas versus the rest of Lambeth and is available in the poster "Is communication and language development an inequalities issue for children in Lambeth? Comparing developmental milestones of 5-year-olds in the LEAP area with the rest of Lambeth"

3.4.1 Inequalities for Lambeth and England

Free school meal status

Inequalities in child development are evident for children who are receiving free school meals in England where the proportion of children achieving at least the expected level in communication and language skills at the end of Reception is lower than the proportion for all children, figure 3.11.

Figure 3.11 Lambeth school readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception, by eligibility for free school meals



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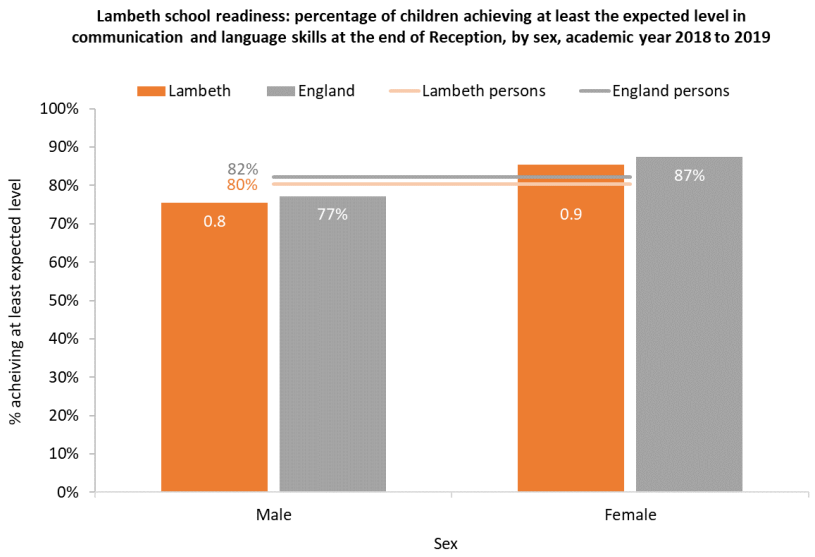
Sex

Fewer males (75.4%) than females (85.4%) achieved a good level of development in Lambeth. This is also the case in England where 77.2% of males compared to 87.4% of females achieved a good level of development, figure 3.12.

Figure 3.12 Lambeth school readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception, by sex, academic year 2018 to 2019



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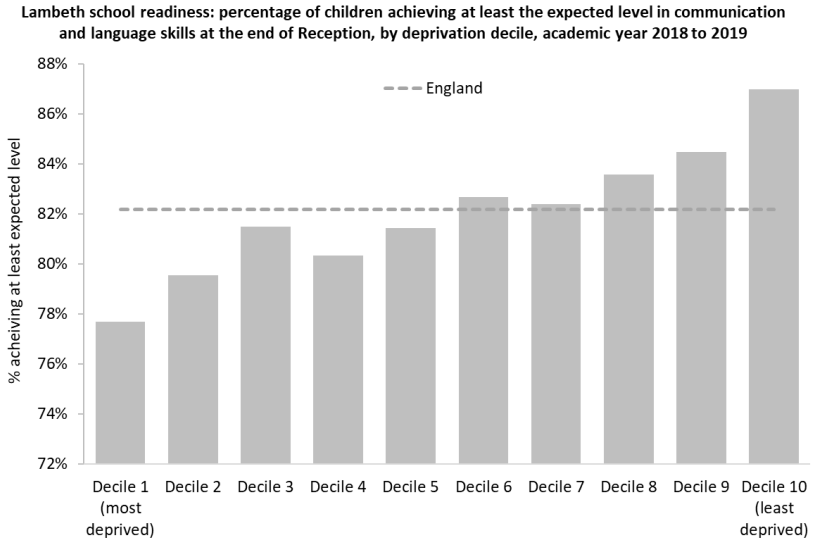
English deprivation (IMD 2019)

Figure 3.13 shows that a clear gradient can be seen between child development and deprivation with 77.7% children living in the most deprived areas achieving the expected level compared with 87.0% of those living in the least deprived areas. Comparable data for other countries are not available for this indicator.

Figure 3.13 School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception, England, by deprivation decile, academic year 2018 to 2019



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3.4.2 Covid and child development

Due to the pandemic, data on child development at the end of the Reception year was not reported for the academic year of September 2019 to July 2020. In March 2020 early years settings were closed to most children, with only children from key workers and vulnerable families continuing to attend (around 7% of children aged two to four years). [11] Outside formal settings, young children may have experienced a lack of social activities and interactions that would normally have helped to prepare them to start school, for example spending time with grandparents and play sessions with other children.

Although the full impact of the pandemic on early years development will not be known for some time, a study carried out by the Education Endowment Foundation (EEF) found that of schools surveyed in England, 76% reported that children who started school in the autumn 2020 term needed more support than previous cohorts. Almost all surveyed schools indicated concerns about pupils' communication and language development (96%), personal, social, and emotional development (91%) and levels of literacy (89%). [12]

3.5 Childhood obesity

There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age. [13] [14], [15]. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

Prevention and treatment of childhood obesity presents a significant public health challenge. Obesity in childhood can result in the early onset of cardio-metabolic, respiratory, and musculoskeletal conditions, as well as adverse psycho-social outcomes and an increased risk of living with obesity and associated mortality and morbidity later in life. [16]

In Lambeth, in the academic year 2019 to 2020, data from the National Child Measurement Programme (NCMP) showed that, 10.4% of children aged 4 to 5 (Reception year) were obese, **figure 3.14**. This is not significantly different to the England average and is a decrease since 2009 to 2010 where 12.1% of reception children were obese. Based on 5 years of data from 2015-16 to 2019-20, there has been no significant change in the percentage of obese children in Reception year.

Twenty-three percent of children aged 10 to 11 years (Year 6) were obese, a decrease from 25.5% in 2009 to 2010 **figure 3.15**. Since 2009-10, the percentage of obese year 6 children has been significantly worse than England overall. Based on 5 years of data from 2015-16 to 2019-20, there has been no significant change in the percentage of obese children in year 6.

Figure 3.14 Reception: Prevalence of obesity (including severe obesity), 2009-10 to 2019-20

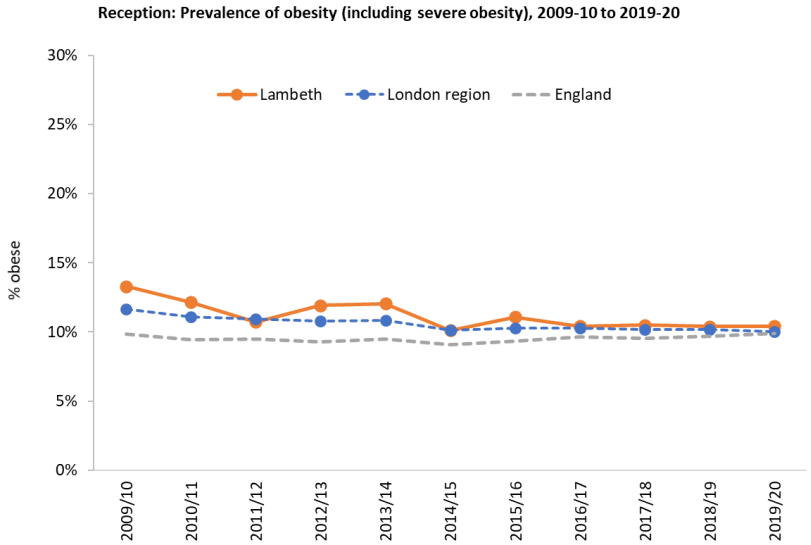

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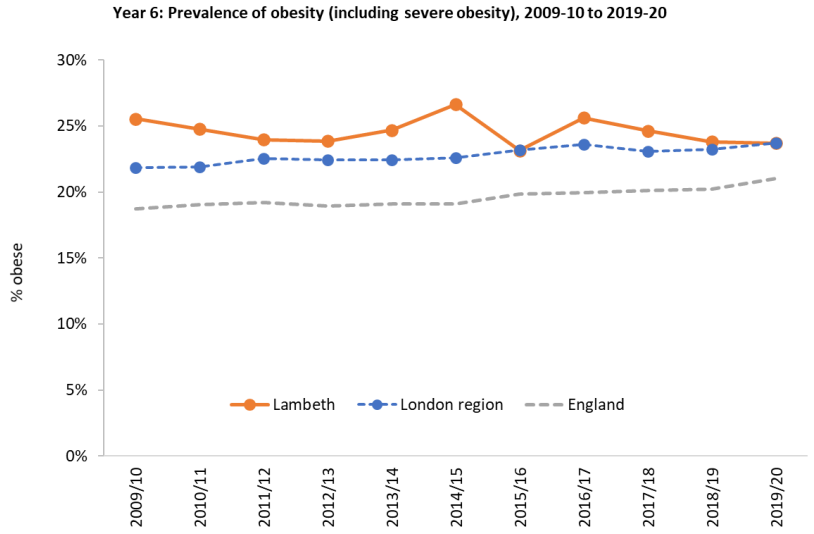
Figure 3.15 Year 6: Prevalence of obesity (including severe obesity), 2009-10 to 2019-20



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3.5.1 Inequalities for England

Deprivation

Figures 3.16 and 3.17 show wide inequalities in childhood obesity. In both age categories, children in the most deprived areas were more than twice as likely as children in the least deprived to be obese, as measured by the RII.

Figure 3.16 Prevalence of obesity in children aged 4 to 5 (reception), by deprivation decile, England, academic year 2019 to 2020

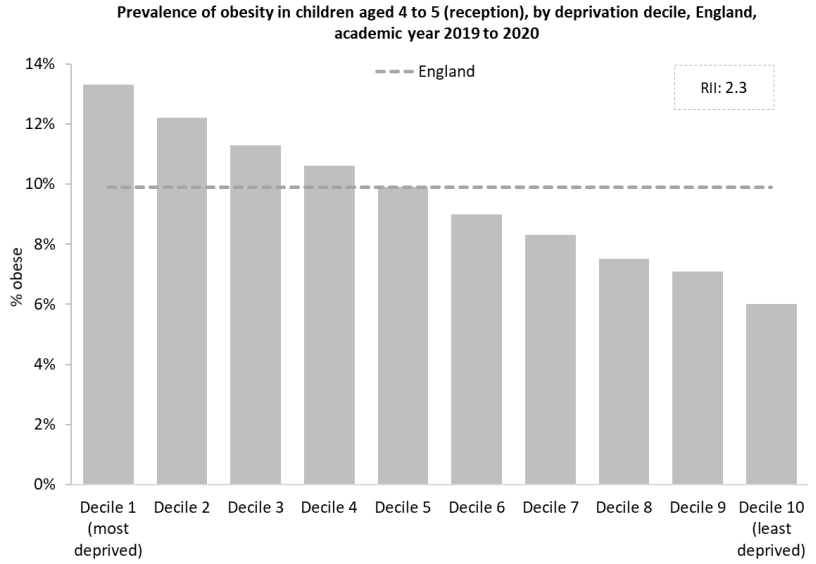

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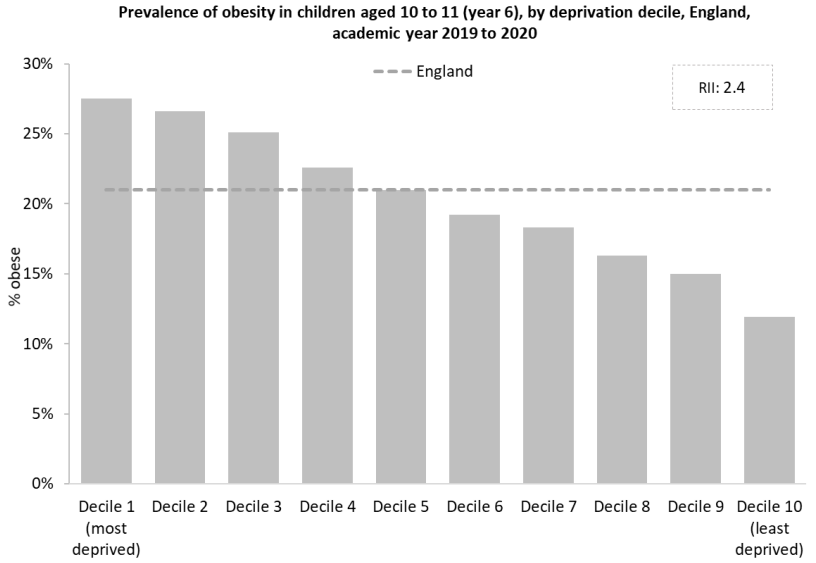
Figure 3.17 Prevalence of obesity in children aged 10 to 11 (year 6), by deprivation decile, England, academic year 2019 to 2020



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Ethnicity

As can be seen in figures 3.18 and 3.19, there are also inequalities by ethnic group. The Black African ethnic group had the highest prevalence in children aged 4 to 5 years (15.9%) and the Black African, Black Caribbean and Bangladeshi ethnic groups had the highest prevalence in children aged 10 to 11 years (around 30%).

Figure 3.18 Prevalence of obesity in children aged 4 to 5 (reception), by ethnic group, England, academic year 2019 to 2020

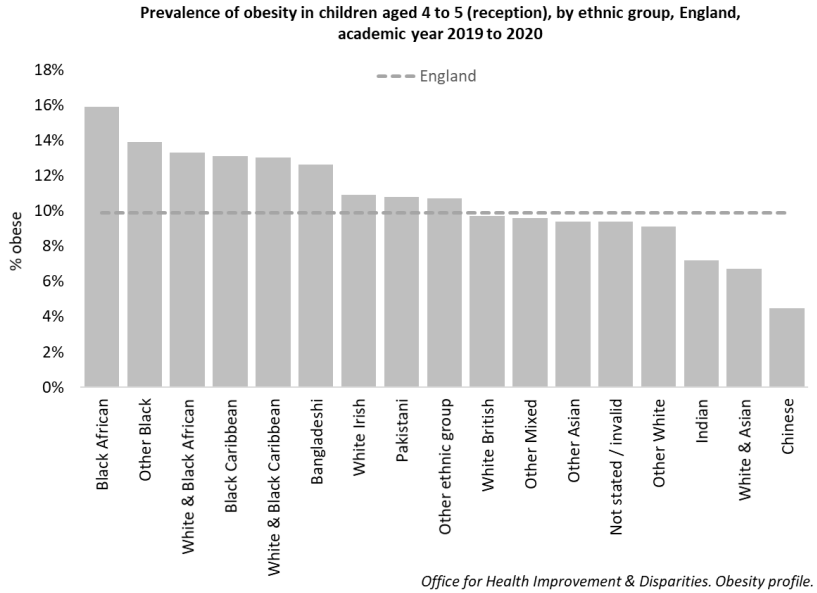

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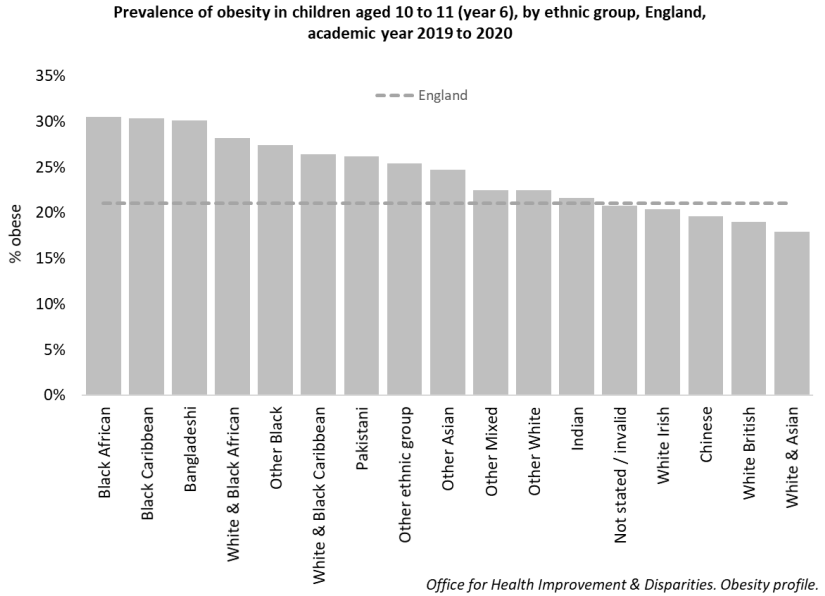
Figure 3.19 Prevalence of obesity in children aged 10 to 11 (year 6), by ethnic group, England, academic year 2019 to 2020



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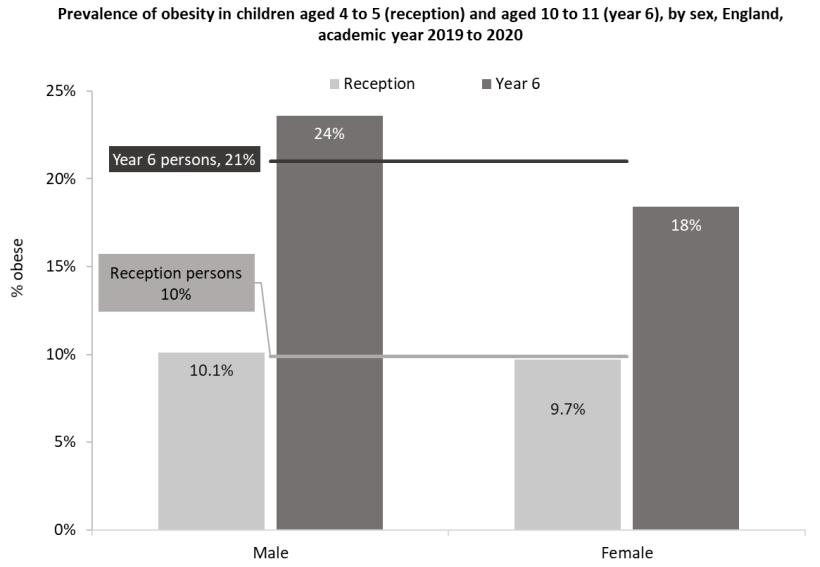
Sex

There is an inequality between males and females; In England, (in the academic year 2019 to 2020), in Reception and Year 6, there was a higher prevalence of obesity for males (10.1%, 23.6% respectively) than females (9.7%, 18.4% respectively) (**Figure 3.20**).

Figure 3.20 Prevalence of obesity in children aged 4 to 5 (reception) and aged 10 to 11 (year 6), by sex, England, academic year 2019 to 2020



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3.5.2 The impact of COVID-19 on child obesity and physical activity

The latest findings from the National Child Measurement Programme (NCMP) suggest that obesity has increased across all regions in both reception-age children and children in Year 6. A link between weight gain and time spent out of school in the holidays has previously been demonstrated. [17] Closure of schools, sporting and leisure facilities, park facilities and recreational areas, together with an increase in screen time (television, phones, computers etc.) over the pandemic period have led to a reduction in physical activity in children and young people. [18] Sport England survey estimates for London suggest activity decreased during 2019/20 to 41.9% down from 46.1% in 2018/19. However, there was some improvement in 2020/21 when physical activity increased to 44.4%

A link between weight gain and out of school time in the school holidays has previously been demonstrated. [19] Closure of schools, sporting and leisure facilities, park facilities and recreational areas, together with an increase in screen time over the pandemic period have led to a reduction in physical activity in children and young people. [17]

Recent evidence from Sport England suggests that in England, there has been a reduction in physical activity in boys, and an increase in physical activity for girls during the pandemic. It also suggests that differences by deprivation have widened.

3.6 Childhood vaccinations

Immunisation is a safe and highly effective way to protect children and young people against serious and potentially fatal diseases.1The UK national childhood immunisation schedule includes several different vaccinations.

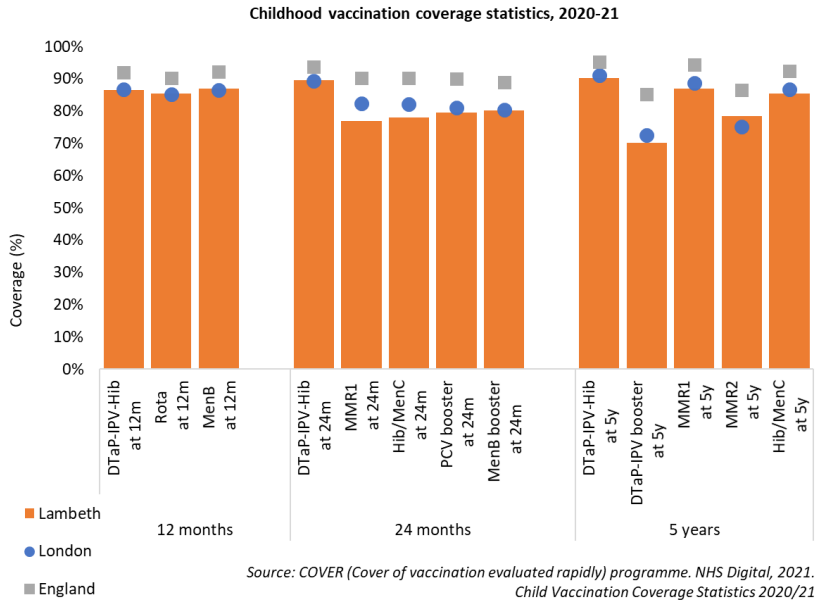
Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

The World Health Organisation (WHO) has set vaccination coverage targets at global and WHO regional levels, which have been adopted by the Department of Health at national and local levels. The 95% target for vaccination coverage is required nationally to ensure control of vaccine preventable diseases within the UK routine childhood vaccination programmes, with at least 90% coverage in each geo-political unit.

Previous evidence shows that highlighting vaccination programmes encourages improvements in uptake levels. NICE guideline, NG218, aims to increase the uptake of all vaccines provided on the NHS routine UK immunisation schedule by those eligible. It supports the aims of the NHS Long Term Plan, which includes actions to improve immunisation coverage and support a narrowing of health inequalities.

High vaccination rates provide increased probability of immunity throughout the population (herd immunity), which is particularly important for protecting individuals who cannot be vaccinated and can also lead to the elimination of some diseases. Even when a disease is no longer common in the UK, without sustained high rates of vaccination it is possible for these diseases to return [20] as demonstrated by recent measles outbreaks. [21], [22]

Figure 3.21 Childhood vaccination coverage statistics, 2020-21



Source: COVER (Cover of vaccination evaluated rapidly) programme. NHS Digital, 2021. Child Vaccination Coverage Statistics 2020/21

Figure 3.21 shows that in 2020/21, Lambeth achieved lower coverage for most childhood vaccinations compared to London and England. (For vaccinations in the main age categories in the NHS vaccination schedule).

3.6.1 5-in-1 /6-in-1 (DTaP/IPV/Hib) – 1 year old

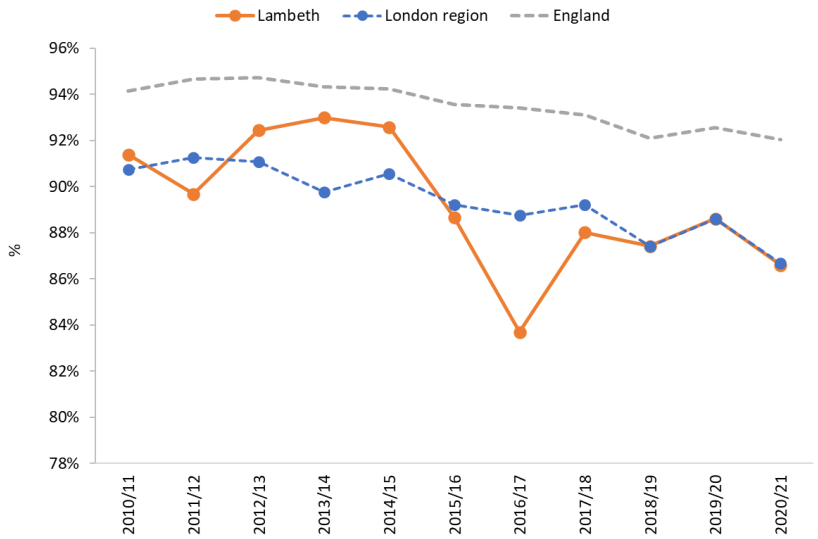
The 5-in-1 vaccination protects against five diseases: diphtheria, tetanus, whooping cough (pertussis), polio and Haemophilus influenzae type b (Hib); a single injection administered on three separate occasions at 8, 12 and 16 weeks of age. In Autumn 2017, this was replaced with a 6-in-1 vaccination which additionally includes a vaccine that protects against hepatitis B (HepB).2

The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against diphtheria, pertussis (whooping cough), tetanus, Haemophilus influenzae type b (an important cause of childhood meningitis and pneumonia) and polio (IPV is inactivated polio vaccine).

As seen in **figure 3.22,** Lambeth has continually achieved below 90% coverage since 2015/16. Coverage has fallen by 5% (91.4% in 2010/11 falling to 86.6% in 2020/21). Year on year, since 2010/11, Lambeth has consistently achieved lower coverage than London.

There has been no significant change in coverage between the 5 most recent points (2016/17 to 2020/21) as reported by the Office for Health Improvement & Disparities (OHID).

Figure 3.22 Population vaccination coverage - Dtap / IPV / Hib (1 year old), 2011/12 – 2020/21



Source: COVER (Cover of vaccination evaluated rapidly) programme. NHS Digital, 2021. Child Vaccination Coverage Statistics 2020/21

3.6.2 Pneumococcal (PCV) vaccine – 1 year old

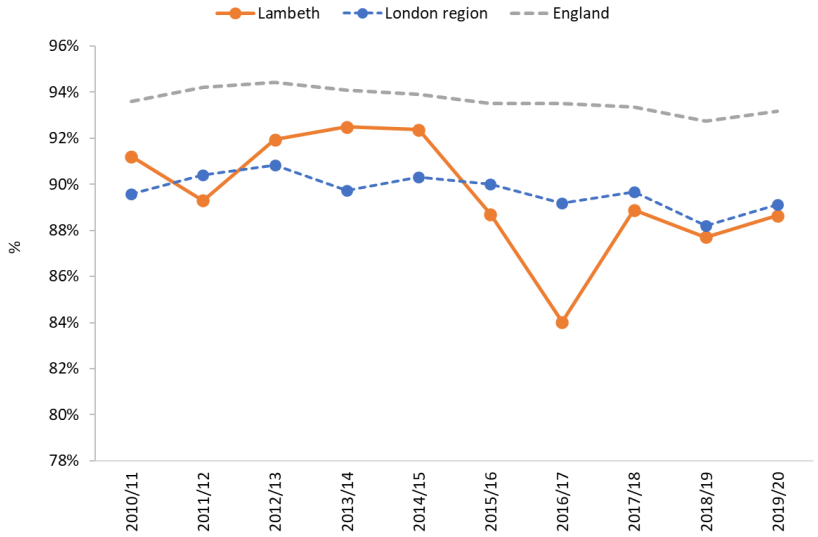
The pneumococcal vaccine protects against serious and potentially fatal pneumococcal infections. It's also known as the pneumonia vaccine. The PCV vaccine protects against pneumococcal infections that can cause pneumonia, septicaemia, or meningitis.

The PCV vaccine is given to all children under two years old as part of the childhood vaccination programme. Previous evidence shows that highlighting vaccination programmes encourages improvements in uptake levels.

Since 2015/16, Lambeth has continually achieved below 90% coverage. Coverage has fallen by 3% (91.2% in 2010/11 falling to 88.6% in 2019/20) Year on year, since 2015/16, Lambeth has consistently achieved lower coverage than London. (Figure 3.23)

There has been no significant change in coverage between the 5 most recent points (2016/17 to 2020/21) as reported by the Office for Health Improvement & Disparities (OHID).

Figure 3.23 Population vaccination coverage – PCV, 2011/12 – 2019/20



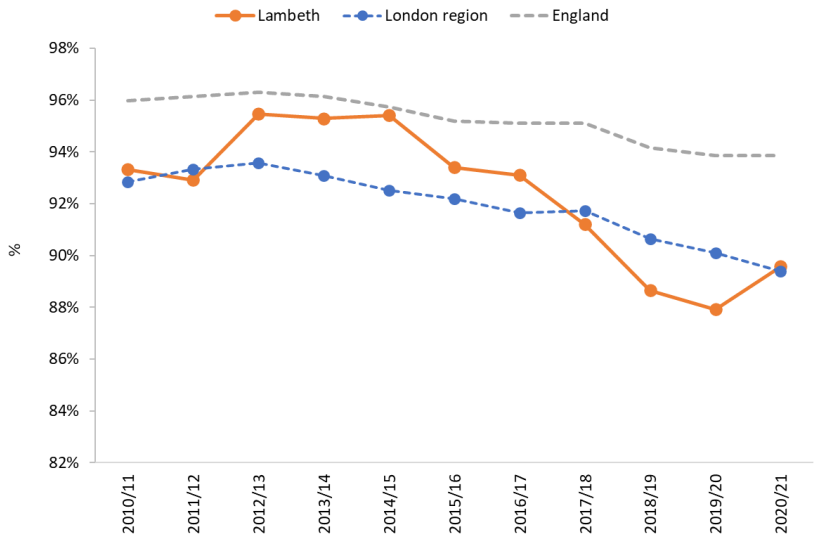
Source: COVER (Cover of vaccination evaluated rapidly) programme. NHS Digital, 2021. Child Vaccination Coverage Statistics 2020/21

3.6.3 5-in-1 /6-in-1 (DTaP/IPV/Hib) – 2 years old

Since 2018/19, Lambeth has continually achieved below 90% coverage. (Figure 3.24).

As reported by the Office for Health Improvement & Disparities (OHID), based on the 5 most recent points (2016-17 to 2020-21) indicates the trend is decreasing and getting worse.

Figure 3.24 Population vaccination coverage - Dtap / IPV / Hib (2 years old), 2011/12 – 2020/21



Source: COVER (Cover of vaccination evaluated rapidly) programme. NHS Digital, 2021. Child Vaccination Coverage Statistics 2020/21

3.6.4 Hib / MenC booster - 2 years old

The Hib/MenC vaccine is a single injection given to boost protection against Haemophilus influenzae type b (Hib) and meningitis C.

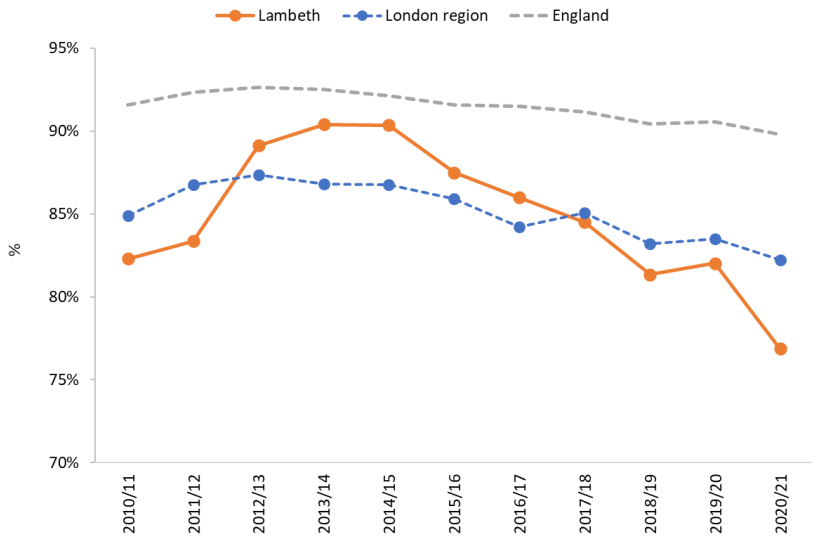
Hib and meningitis C infections are serious and potentially fatal. They can both cause meningitis and blood poisoning (sepsis).

The Hib / MenC booster increases the protection a child gets from the first course of Hib vaccine when they are 8, 12 and 16 weeks old, and the MenC vaccine when they are 12 and 16 weeks. This boosted immunity lasts into adulthood.

Since 2010/11, Lambeth has continually achieved below 90% coverage. figure 3.25.

As reported by the Office for Health Improvement & Disparities (OHID), based on the 5 most recent points (2016-17 to 2020-21) indicates the trend is decreasing and getting worse.

Figure 3.25 Population vaccination coverage - Hib / MenC booster (2 years old), 2011/12 – 2020/21



Source: COVER (Cover of vaccination evaluated rapidly) programme. NHS Digital, 2021. Child Vaccination Coverage Statistics 2020/21

3.6.5 MMR for one dose - 2 years old

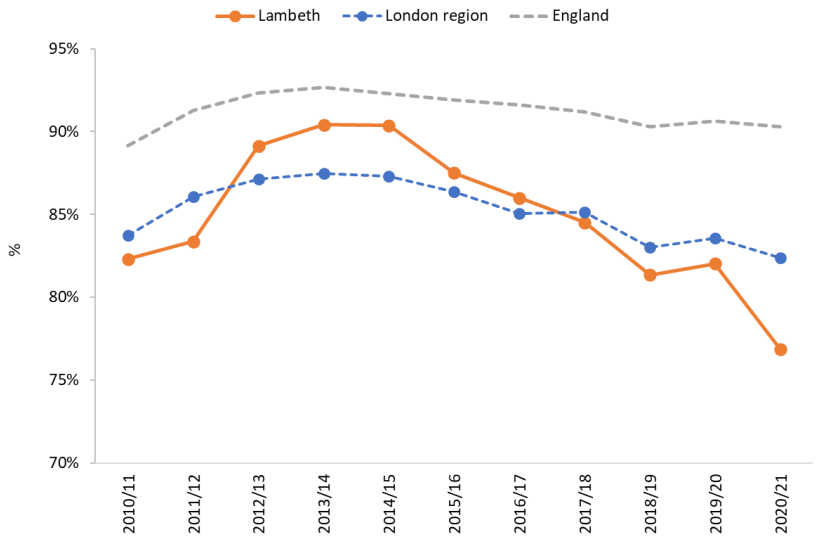
MMR is the combined vaccine that protects against measles, mumps, and rubella. Measles, mumps, and rubella are highly infectious, common conditions that can have serious complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.

The first MMR vaccine is given to children as part of the routine vaccination schedule, usually within a month of their first birthday. They'll then have a booster dose before starting school, which is usually between three and five years of age.

Since 2015/16, Lambeth has continually achieved below 90% coverage. (Figure 3.26).

As reported by the Office for Health Improvement & Disparities (OHID), based on the 5 most recent points (2016-17 to 2020-21) indicates the trend is decreasing and getting worse.

Figure 3.26 Population vaccination coverage - MMR for one dose (2 years old), 2011/12 – 2020/21



Source: COVER (Cover of vaccination evaluated rapidly) programme. NHS Digital, 2021. Child Vaccination Coverage Statistics 2020/21

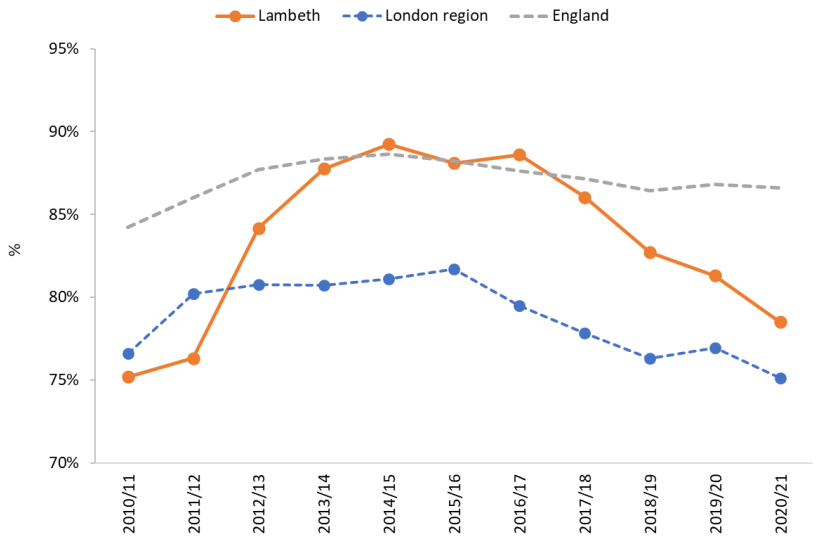
3.6.6 MMR for two doses (5 years old)

Since 2012/13, although Lambeth has had higher coverage for MMR (for 2 doses, aged 5) vaccination coverage than London, this has consistently been lower than the 90% target coverage, figure 3.27.

As reported by the Office for Health Improvement & Disparities (OHID), based on the 5 most recent points (2016-17 to 2020-21) indicates the trend is decreasing and getting worse.

Since 2017/18, the Lambeth coverage dropped below that of England and the gap each year has been widening.

Figure 3.27 Population vaccination coverage - MMR for two doses (5 years old), 2011/12 – 2020/21



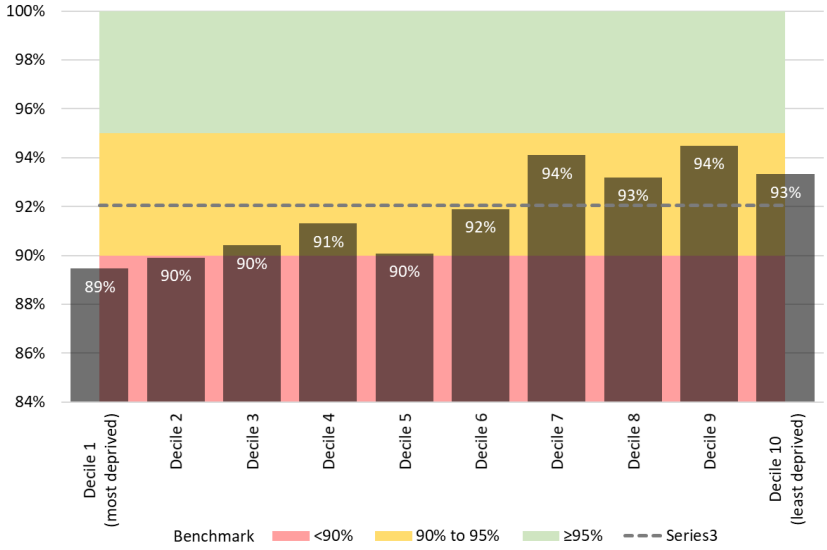
Source: COVER (Cover of vaccination evaluated rapidly) programme. NHS Digital, 2021. Child Vaccination Coverage Statistics 2020/21

3.6.7 Inequalities for England

Inequalities exist for childhood vaccination coverage rates. Vaccine coverage should be increased from early childhood to adolescence, with a particular focus on groups where uptake rates are known to be lower. Targeted public health messaging should take causes of inequalities in vaccine uptake into account, for example, ethnicity, deprivation, geography, and religious belief. [23], [24], [25]

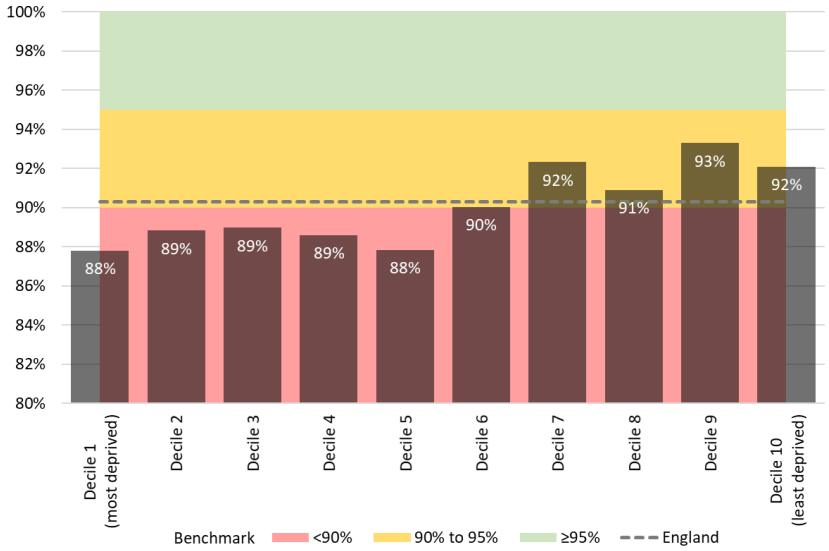
Looking at deprivation and vaccination coverage in England, a clear gradient can be seen in **figures 3.28, 3.29 and 3.30** where there is lower coverage of vaccinations in the more deprived deciles compared to coverage in the less deprived deciles.

Figure 3.28 Inequalities - coverage of Dtap / IPV / Hib (1 year old), 2020/21, by IMD 2019 decile



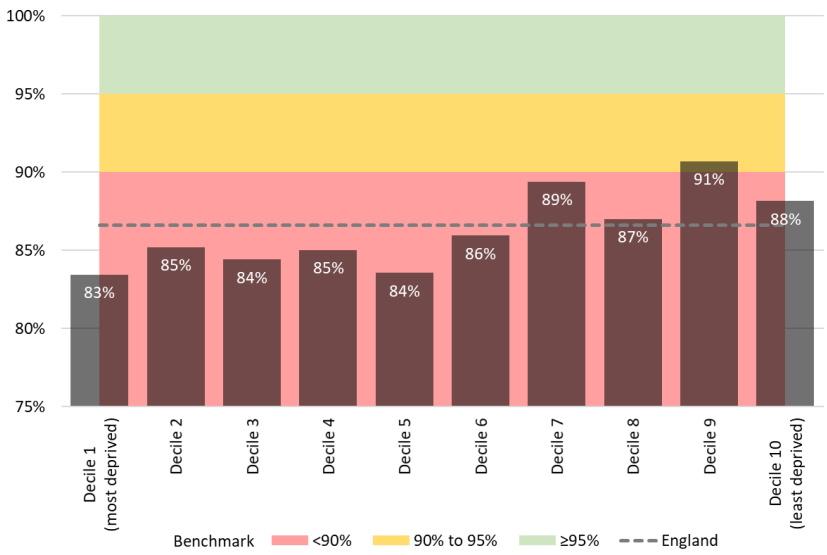
Source of graphs: Office for Health Improvement & Disparities. Child and Maternal Health Dashboard. https://fingertips.phe.org.uk/profile/child-health-profiles/© Crown copyright 2022

Figure 3.29 Inequalities - coverage of MMR for one dose (2 years old), 2020/21, by IMD 2019 decile



Source of graphs: Office for Health Improvement & Disparities. Child and Maternal Health Dashboard. https://fingertips.phe.org.uk/profile/child-health-profiles/© Crown copyright 2022

Figure 3.30 Inequalities - coverage of MMR for two doses (5 years old), 2020/21, by IMD 2019 decile



Source of graphs: Office for Health Improvement & Disparities. Child and Maternal Health Dashboard. https://fingertips.phe.org.uk/profile/child-health-profiles/© Crown copyright 2022

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