Early Years (0-4 years) Needs Assessment

Westminster City Partnership

This document contributes to
Westminster's Joint Strategic Needs Assessment

Contents

Westminster JSNA Rolling Programme

Early Years (0-4 age group) Needs Assessment

This needs assessment is part of a wider rolling programme of the Joint Strategic Needs Assessment (JSNA), undertaken between Westminster City Council and NHS Westminster. The JSNA process seeks to paint a picture of unmet needs within the population and as such forms a vital part of the commissioning cycle.

This needs assessment focuses on children up to their fifth birthday. The bodies that provide, commission or monitor children's services (i.e. NHS, local authority or government) record this age group differently. Local, regional and national data use the terms *up to 5 years, under 5 years, 0-4 years and 0-5 years* for this population. This document therefore uses these terms interchangeably for this population.

Key Messages and Findings

Demography and deprivation

- Patterns of deprivation and income deprivation in Westminster map closely to areas with the highest proportion of children aged up to 5 years. Nearly one in three children lives in one of the four most deprived wards in the Borough.

- The number of births per year in Westminster is not predicted to increase significantly (2%/year) in the next decade.

- Just over a half of the under 5's are from BME groups. As a result, the ethnic profile of children aged 0-4 in the Borough is currently more diverse than in the population as a whole. It is likely that the biggest increase in terms of births will happen among the BME groups.

- Currently some 34.6% children live in households dependent on workless benefits in Westminster, compared with 19.7% in England (DWP, April 2007). The lowest proportion of lone parent households was found in the Bayswater ward (41%), whilst the highest was in the Harrow Road ward (64%). (ONS, 2001 Census)

- 35% of children and young people attending primary and secondary schools in Westminster are eligible for free school meals. This proportion is much higher than that of London, or England, as a whole.

- 45% of houses occupied with dependent children are overcrowded in Westminster. The lowest quality housing as measured by the Child wellbeing index is in Marylebone High Street Ward.

- As at 31 March 2009 there were 34 children aged below 5 years temporarily placed in Bed and Breakfast accommodation in Westminster, while waiting for allocation of a suitable self-contained property.

Maternal health

- 72% of live births in Westminster in 2007 were to mothers born outside the UK. This is much higher than in London (54%) and England (24%). Child's ethnic status is currently not recorded at birth registration.

- The wards with the lowest birth weights are characterised by ethnic groups whose babies may be smaller naturally but adverse factors associated with lower socioeconomic status characteristic for these wards, play a significant role in further lowering birth weight.

- In 2008/9 only 77% of the women who had a health and social care assessment in Westminster had it by 12 weeks and six days of pregnancy.

- Between April 2008 and March 2009, of all pregnant women booked at St Mary's with Body Mass Index (BMI) recorded, 30.4% were overweight and 13.5% were obese.[1]

- Although the numbers of actual teenage pregnancies is not very high the proportion of Westminster's teenage conceptions resulting in a termination is high and increasing (60% in 2006 and 74% in 2007).

- The gap in teenage pregnancy rates between the most and least deprived areas of Westminster is of a particular concern. A new target introduced in the recent Westminster's inequality strategy reflects this issue.

- On the whole the age of mothers giving birth in Westminster is higher than the age of mothers in London and England.

- Local audit of postnatal depression carried out in Church Street in 2004 found that 33% of first time mothers assessed were found to have postnatal depression. This is more than double of the highest national estimate.

- The prevalence of breastfeeding at 6-8 weeks was 79% in the first quarter of 2009/10. This exceeds the nationally set local target for Westminster.

[1] Overweight includes women with BMI greater or equal to 25kg/m^3 and less than 30kg/m^3; obese patients classed as those with BMI of greater or equal to 30 kg/m^3.

Children's health

- 99% of children aged less than 5 years in Westminster appear to be registered with a GP

- The percentage of NHS hearing screens complete by both 4 weeks and 3 months after birth was lower in Westminster than London and England in 2008/9. However a higher than average proportion of babies (15%) in Westminster are born in private hospitals and are tested privately.

- Where immunisation uptake is still low, this is due in part to access; problems with data recording, staffing and ensuring parents are appropriately reminded.

- There is little data locally and nationally to show the burden of illness when it comes to mental health in the 0-5 year old population.

- In 2007/08 a greater proportion of children in reception were obese compared to both London and England. Westminster school children have a significantly higher rate of dental decay than the average for London and England. The majority does not access treatment. This is mainly due to cultural tradition and service access difficulty.

- All children aged under 16 are entitled to free eye checks on the NHS. In the LA maintained schools in Westminster, all children in Reception classes undergoing the health check, have their vision screened by a trained school nurse.

- Respiratory disease was the most common reason for emergency admission (26%) in 0-5 year olds in 2005-07 in Westminster. Proportionately more children from BME groups are attending hospital for elective admissions.

- E-Start data from 2008/9 shows that across the 12 Children's Centres 6,777 children and 6929 parents/carers accessed the different activities/ services offered, calculated by activity (most individuals who attend will attend more than one activity).

Childcare and education

- Locally, there are currently childcare places for around 39% (full-time) or 60% (part time) of the population. (calculation based on ONS mid-year estimates 2007)

- Of the 113 childcare providers within Westminster for whom there is relevant data only 70 (62%) provide for children aged 0-3 as well as 3-4 years.

- All childcare settings have a statutory requirement to encourage and promote healthy lifestyles and diet. This is assessed alongside other requirements included in the EYFS guidance using a structured questionnaire at an annual visit by the LA of all childcare settings for 0-5 year olds. These visits may result in a plan of improvement being drawn up in partnership with the settings. At present, dietetic and public health advice is not sought on the healthy lifestyle element of any plan of improvement. It is also not currently possible to do detailed analysis of the data obtained from the questionnaire.

- Results of the Westminster 2007-8 Childcare Sufficiency Assessment shows that more than half of the childcare settings are unable to meet demand for children aged 0-2 years and over 1/3 were not able to meet the demand for 2-3 year olds. The ratio of Ofsted Registered 0-4 childcare places to population aged 0-4 varies from 1:1.3 in Tachbrook to 1:8.8 in Marylebone High Street. There is possible under-representation of Asian children using registered group settings.

- In 2009, 65.7% of children at the end of Reception year at Westminster's state primary schools had achieved the expected minimum level of the EYFSP (a score of 78 points or more across all areas of learning); an increase of eight percentage points from the previous year. A noticeable pattern exists reflecting that of deprivation. Children in more deprived areas achieve lower scores in particular in relation to reading, writing and calculation.

- Childcare in Westminster can be prohibitively expensive for parents in low to intermediate paid jobs. More affordable voluntary sector childcare is available in Westminster but these settings often do not provide care for the full working day. This lack of suitable and affordable childcare can represent a barrier to employment and successful outcomes for children.

Significant gaps in information/services provision

- Information and services for women during pre-conception and in the early stages in pregnancy are underutilised. This is partly due to lack of signposting and access delays but culture, population diversity and other factors are also likely to play a significant role.

- More deprived wards have a greater proportion of children growing up in families dependent on workless benefits, children in need and children on the child protection register. Deprivation is also linked to higher levels of tooth decay, lower birth weight, higher levels of maternal smoking, greater levels of post-natal depression and obesity, although this had not been investigated in detail locally as yet.

- The size of the gap between the most deprived and the least deprived wards in the Borough in terms of e.g. life expectancy at birth and

conception rates is large. Not all the gaps are known and knowledge of gaps does not always mean services are targeted to these areas.

- Current data collection by e.g. Children Centres does not show if the population targeted is the one which actually utilises the service/s. Children's Centre's have identified this problem and are currently developing systems which when rolled out will fill this gap.

- There is a lack of knowledge and data on the private schools population. The health and well being status of children attending private schools and their need for health and/or social services interventions is unknown.

- Information on the quality of nutrition and physical activity in early childcare settings is lacking as is the information on service provision in these areas. This does not allow for identification of the unmet nutritional and physical activity needs of this population.

- Information on accidents and harm to children is not easily available due mainly to lack of systematic monitoring caused by lack of targeted outcomes.

Suggestions and Recommendations

This section identifies gaps in information particularly in areas where there may be outcome deficiencies.

1. It is necessary to ensure that current local preconception and antenatal service provision is adequately signposted by all health and social care professionals working with mothers and young children. Also, that parents/carers are aware of the important stages and aspects of antenatal, postnatal and early years care, such as:
    - Antenatal screening
    - Smoking during pregnancy and after
    - Breastfeeding and weaning
    - Postnatal depression service
    - Oral hygiene of both mother and child
    - Vision checks
    - Hearing checks
    - Speech and language development
    - Diet and nutrition
    - Immunisations
    - Safety in the home

2. Some of this provision might need to be revised, tailored to different age or cultural groups, offered in different languages, to mothers having first/subsequent child, different stages of gestation and different geographical areas etc.

3. It is also important that workers in childcare settings are aware of possible signs of neglect, trauma, abuse and mental health problems among the children they see and that they know where to report, sign-post or refer such children as per documented pathways.

4. It is important to further explore how the barriers preventing parents getting back to work can be reduced e.g. around childcare provision; and how working parents can be supported to access services for their children e.g. immunisation clinics at GP practices outside working hours.

5. More detailed data and analysis is needed to support effective service provision. Data collection and measurements fulfilling the target monitoring requirements do not always provide the detail needed to target services. For instance it is not known how many mothers continue smoking or start smoking again after birth. It is known what percentage of mothers start breastfeeding and are still breastfeeding at 6-8 weeks but it is not known what socioeconomic background these mothers come from.

6. Monitoring uptake in terms of detailed population profiling is paramount to understanding how services work and if targeting was effective. For example free school meal eligibility and uptake numbers exist but not detailed information on who is actually utilising the service. A similar

situation applies to physical activity uptake and provision where little information exists on profiling the population of attendees and non attendees.

7. Gaining more detailed insight into the quality of food provided in early years care settings and/or what food is eaten at home is necessary prior to developing an educational programme promoting healthy eating and physical activity in early years childcare settings.

8. Local stakeholders should discuss, consider and agree how to address the inequality of provision for health and social care between the state and privately run early educational settings in the Borough.

9. Further consideration should be given to the issue and importance of harm in children and mothers in terms of both accidental and deliberate harm. Targeted work is currently taking place within the Borough around Hidden Harm. This includes improving data recording around parental status of individuals in treatment for drug and alcohol misuse, monitoring local services and the work they are doing with parents and referrals made to Children's Services. The outcomes of this work should be reviewed and any recommendations considered.

10. Follow up and utilise the results of initiated projects and programmes and their evaluation e.g.
    - A pilot project on oral health in Lisson Grove,
    - Monitoring of access, uptake and awareness raising of childhood immunisations, and joined-up working in this area
    - Ensuring a robust referral process is in place for following up babies whose hearing is not screened before they leave the maternity ward to eliminate future disadvantage in learning
    - Revision of screening provision for ocular anomalies in 4-5 year olds
    - The family recovery project
    - The Child Poverty programme projects
    - Healthy schools/Extended schools programme

1. Background and Introduction

1.1 The concept of need

Need as defined here implies "capacity to benefit" from an intervention. Such interventions might include the provision of information, education, assistance and protection, symptom control, treatment or cure, resulting in empowerment, independence, self management of conditions and improved health and wellbeing. Complex needs require complex solutions which are best identified and remedied through constructive multiagency working.

1.2 Which population is this needs assessment about?

This particular needs assessment relates to children aged 0-4 years (up to the child's fifth birthday). Birth to five are considered key developmental years during which family and early childcare settings determine many of a child's health and wellbeing habits and foundations. Parental and in particular maternal characteristics and behaviour during preconception, the antenatal period and post birth play key roles in the child's development alongside the general wider determinants of health such as family income (or the lack of it), access to health care interventions such as immunisations and access to early education.

This needs assessment aims to bring together the following information to paint a picture of Westminster's children in their early years with a focus on those who live in the most deprived areas and impoverished households.

This includes:

- Demographic profile of the children and their mothers;
- Socioeconomic profile of the families;
- The health and social services to which they have access;
- Who accesses the services and to what effect

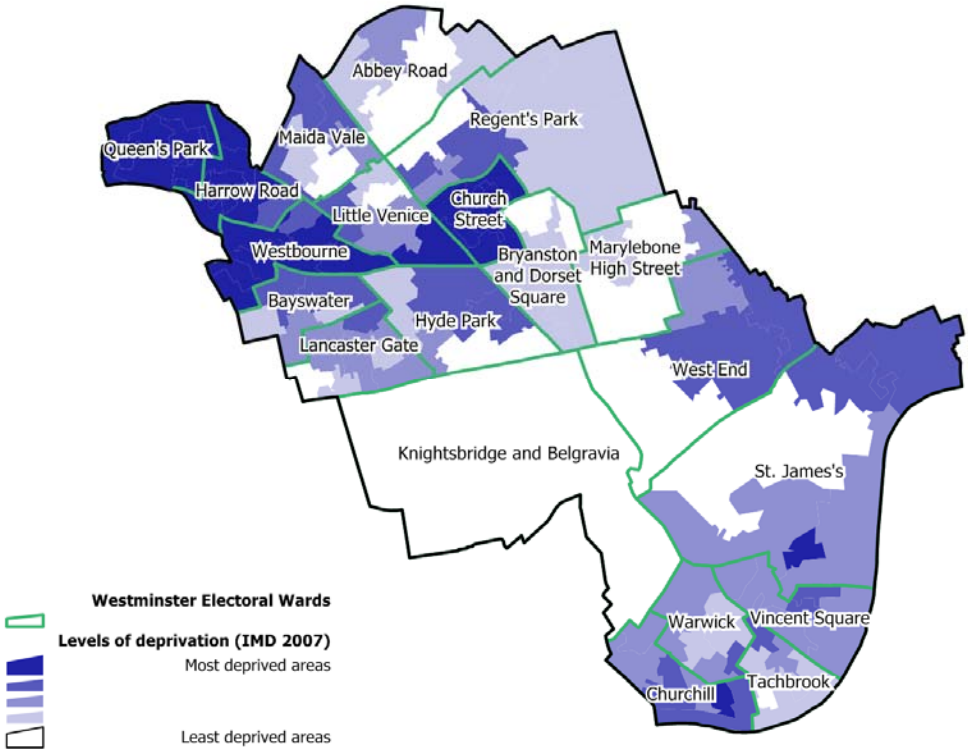
1.3 What is the issue and why is it important for Westminster?

Exposure to certain factors such as poverty, unbalanced diet, illness and un-stimulating or threatening home environments are all likely to have a detrimental effect on children's cognitive, motor and socio-emotional development as well as on their health. These can prevent children from reaching their full developmental potential. In particular, children growing up under these circumstances are likely to have poorer health, lower school achievement and lower earning potential. As adults, they are less likely to provide adequate stimulation and resources for their own children, thus contributing to the intergenerational transmission of poverty and economic inequality.

Westminster has some of the most deprived as well as the least deprived wards in the country. *Patterns of deprivation and income deprivation in Westminster map closely to areas with the highest proportion of children aged up to 5 years. Nearly one in three children lives in one of the four most*

deprived wards in the Borough (Church Street, Westbourne, Harrow Road and Queen's Park). Anecdotal evidence suggests that obesity and overweight follows the same pattern, although this has not been investigated locally yet.

Figure 1: Patterns of deprivation across Westminster Wards – Index of Multiple Deprivation, 2007



Local Area Renewal Partnerships (LARPs) have been set up in five of the most deprived parts of Westminster.

- Church Street ward
- Queen's Park ward
- Harrow Road ward
- Westbourne ward
- South Westminster (serving Churchill, Tachbrook, Warwick, Vincent Square and St James wards).

The LARPs bring together partner agencies such as NHS Westminster, the Council, the Police and the community and voluntary sector, as well as local businesses, in order to form regeneration partnerships in areas with a high concentration of social housing, higher rates of crime and a greater number of vulnerable people. Some of their key objectives are to tackle deprivation and inequalities in these areas, for example through improving housing, reducing crime and providing targeted support to children and families.

The Westminster City Plan includes a number of Local Area Agreements (LAA) for Westminster (2008-11) to help improve some of the issues which in particular impact on the health status of those living in the more deprived communities in the Borough. These include LAA 4 to tackle anti-social behaviour, LAA 8 to meet the housing need and LAA 9 to encourage children and families to have a healthy lifestyle.

2. Demographic profile of children aged 0-4 years and their mothers

2.1 Numbers of children aged 0-4 in Westminster

Estimates based on the 2001 Census data suggest that in 2007 there were some 11,800 children aged 0-4 years in Westminster. This represents a relatively small proportion of Westminster's population as a whole (5%) (similar to London (7%) and England (6%)).

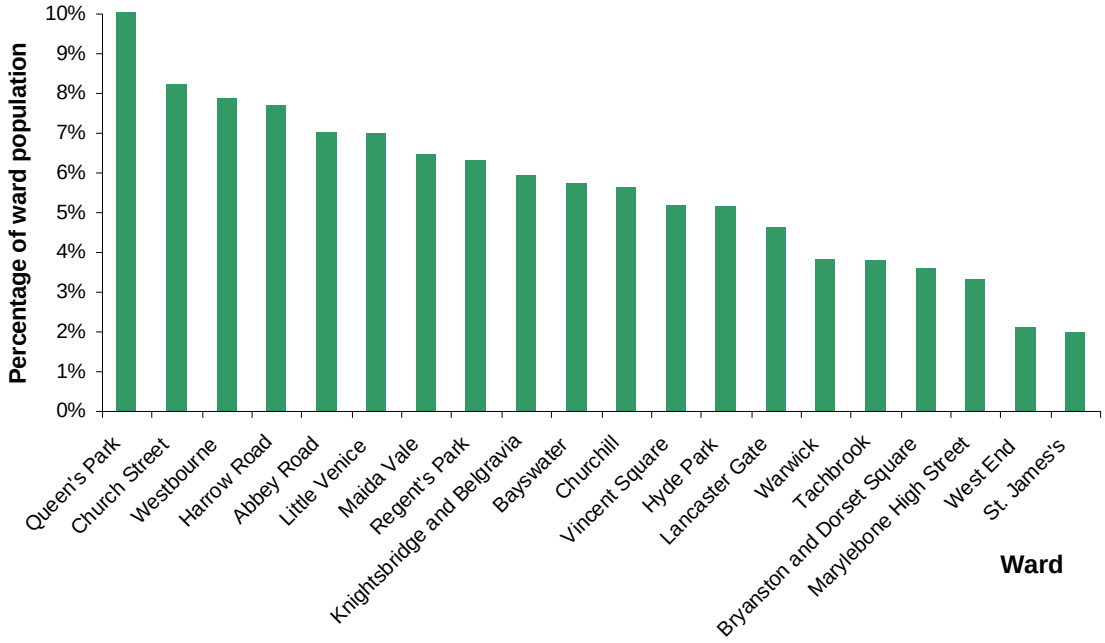
Figure 2: Westminster population aged 0-4 years (2007)

	Age 0-1	Age 1-4	Age 0-4 total	% Westminster population age 0-4
Males	1,400	4,500	5,900	5.0%
Females	1,400	4,500	5,900	5.0%
Persons	2,800	9,000	11,800	5.0%

Source – Mid-year population estimate for 2007 – Office for National Statistics

Children aged under 5 years make up different proportions of the overall population in different parts of Westminster with a larger proportion of children concentrated in the North of the Borough and in areas of highest deprivation such as Queen's Park (10%), Church Street (8%), Westbourne (8%) and Harrow Road (8%).

Figure 3: The percentage of total ward populations aged under 5 years (2009)



Source: Greater London Authority RND 2008 Ward Population Projections PLP Low[2] - for 2009

The Greater London Authority (GLA) projects that the population of under 5 year olds in Westminster will stabilise over the next twenty years (at around 12,200). The GLA 0-4 2008 projections for 2010 and 2011 are 12,096 and 12,192 respectively. By contrast the Office for National Statistics (ONS) predicts that the 0-4 population will increase to around 17,200 by 2030. Although both data sets take into account births, deaths and migration, the GLA predictions also take into account available housing stock and are generally thought to be more realistic in terms of predictions. Westminster's under five population is not projected to increase at the rate of most other inner London Boroughs.

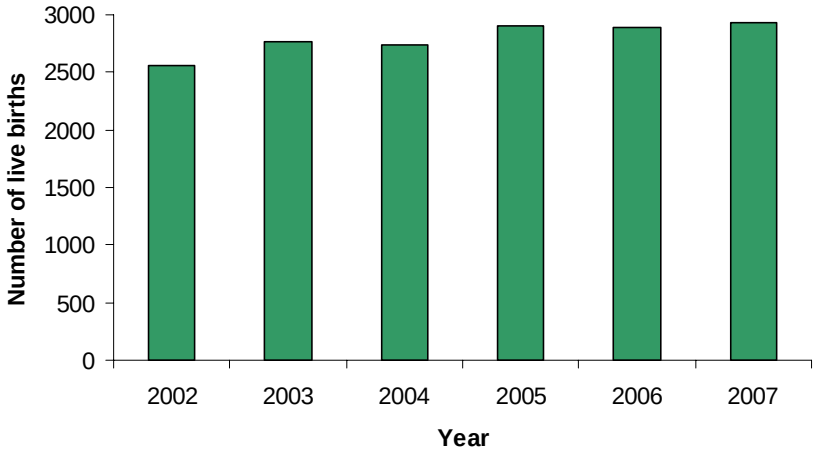
2.2 Westminster births

In 2007 there were 2929 **live births** to women living in Westminster. The numbers of children born each year have increased over the last five years (from 2554 live births in 2002). There are significantly fewer births per resident as well as per woman of childbearing age (15-44 years) in Westminster compared with London and England. The number of births per year in Westminster is not predicted to increase significantly, and the rate of increase is predicted to be lower than that for Inner London as a whole (2%

[2] GLA population predictions are generally believed to be more accurate since as well as taking into account births, deaths, international and internal migration they taken into account the available housing stock. The Post London Plan (PLP) Low is driven by the increase in homes as seen annually since mid-2001 from data collected at Borough level up to 2007 and the 2004 London Housing Capacity Study.

increase compared to 4% for Inner London between 2008/9 to 2020/1) (GLA predictions of births by age and ethnicity of mother, London Health Observatory).

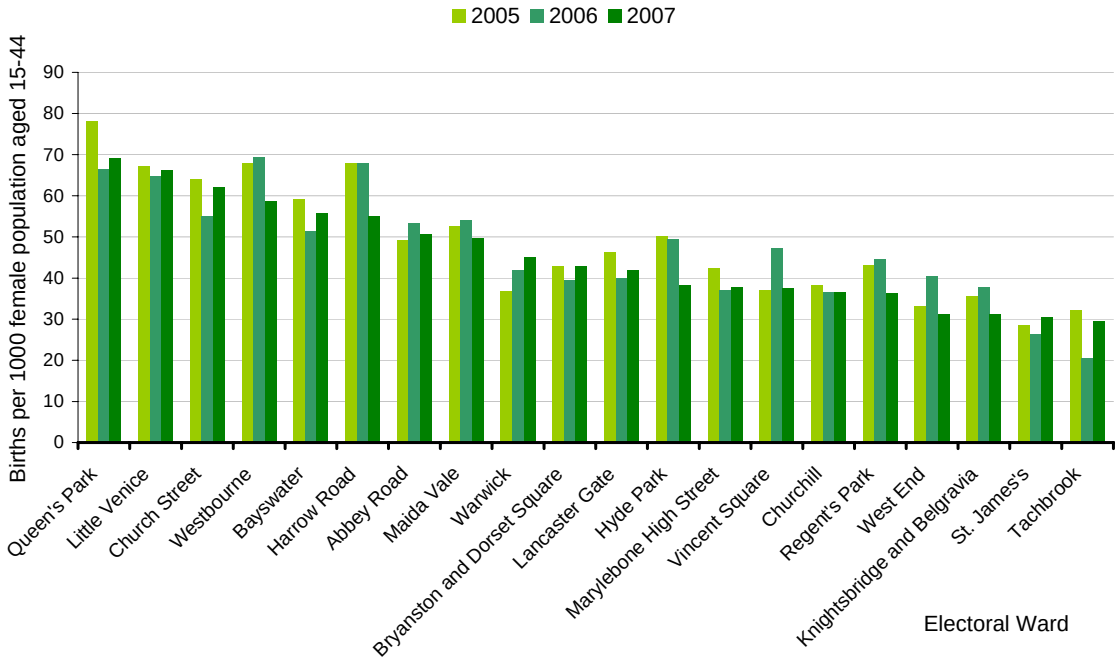
Figure 4: Number of live births to women living in Westminster by year



Source: Annual Birth Data Extracts, Office for National Statistics (ONS) Vital Statistics

General Fertility Rates[3] vary across Westminster and over time. In recent years, Queen's Park ward has had the highest general fertility rates; whereas the lowest rates have been in Tachbrook ward.

Figure 5: Birth rates by ward in Westminster, 2005-2007

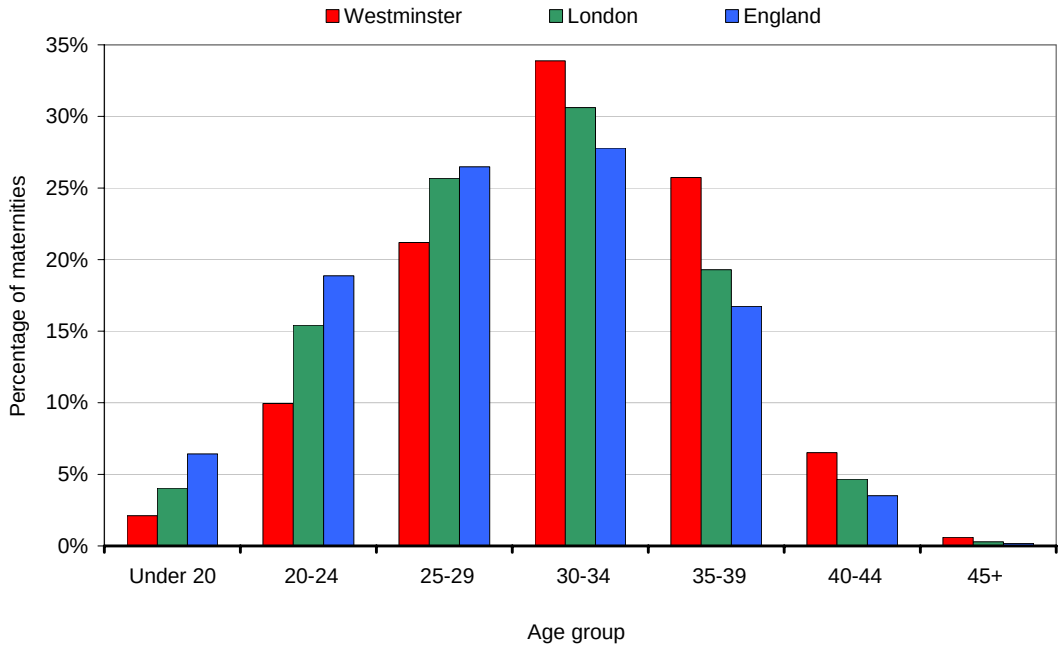


Source: ONS, Public Health Birth Files

[3] General Fertility Rate = the number of live births per 1,000 women of childbearing age (15-44 years old).

*The **age profile of mothers** giving birth in Westminster in 2007 was older than the age profile of mothers in London and England.* In 2007 only 2% (61 births) of mothers giving birth were less than 20 years of age compared to 4% in London and 6% in England as a whole. 33% of mothers were aged 35 or over, compared to 24% in London and 20% in England (ONS, Vital Statistics, 2007).

Figure 6: Ages of mothers in Westminster giving birth in 2007



Source: ONS Vital Statistics 2007

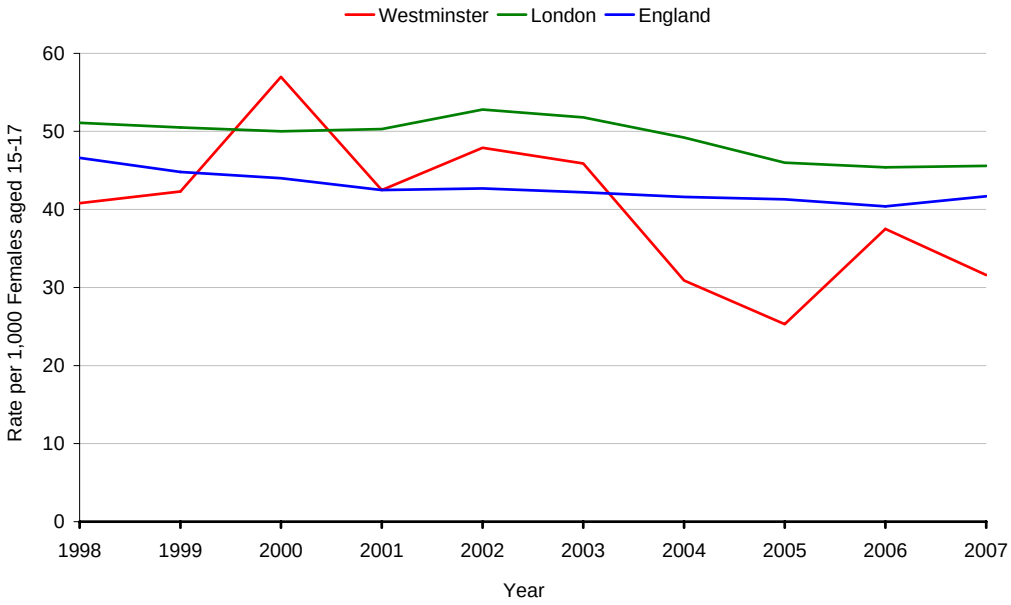
Socio-economic status, job opportunities, access to further education and training in employment all have an influence on the age at which women have children. Westminster has the third highest proportion of people with a degree or higher level of education of all local authorities in England and Wales (ONS, 2001 Census). These figures illustrate Westminster as an area of extremes of wealth and poverty.

Teenage motherhood is associated with worse social and health outcomes for both mother and child. Children born to teenage mothers (measured in girls aged 15-17) have 60% higher rates of infant mortality and are at increased risk of having babies with low birth weight. Teenage motherhood impacts on maternal prospects of continuing education, which in turn reduces the social and economic opportunities for both the mother and her child. Children of teenage parents are more likely to become teenage parents themselves perpetuating the cycle of social, material and health disadvantage in the family.

Reducing the rate of teenage conceptions in England remains a high government priority. Locally, the conception rates in girls aged 15-17 have shown a decline since 2000. However the 2006 data indicated a reverse trend, although Westminster still had lower rates than in London and England as a whole. The proportion of Westminster's teenage conceptions resulting in

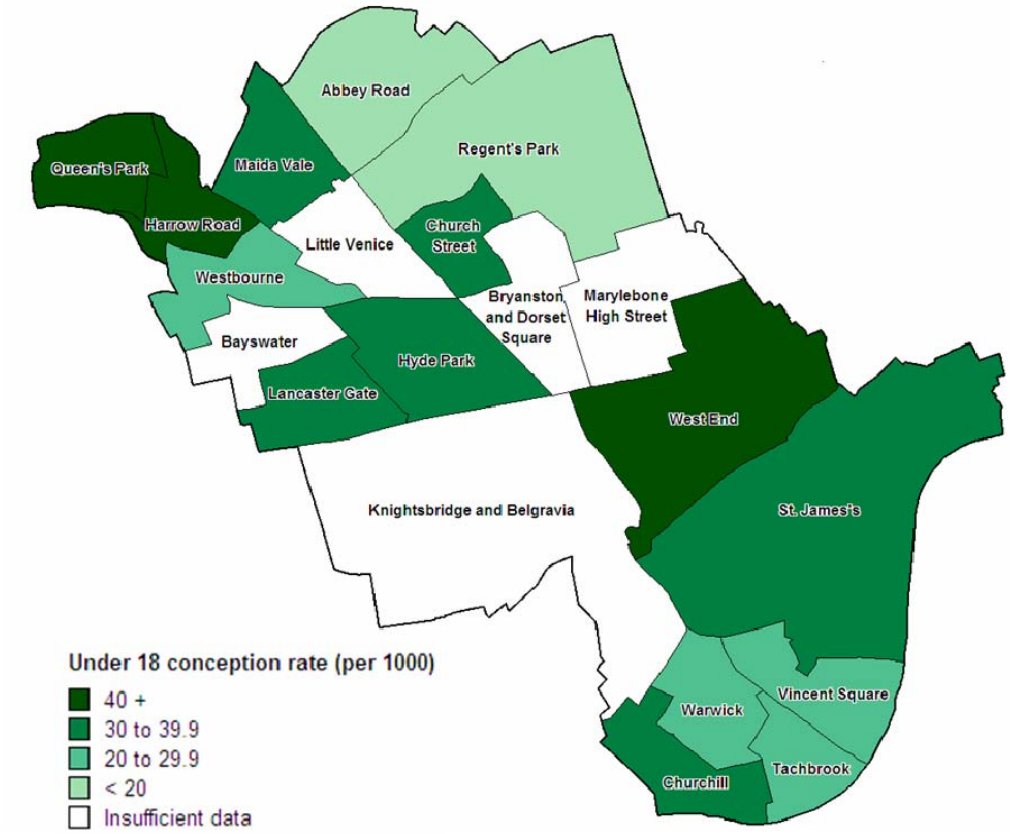
a termination is persistently high and increasing (74% in 2007 compared with 63% in London and 51% in England and 60% in 2006 locally).

Figure 7: Trends in teenage conception rates (15-17 year olds) 1998 – 2007



Source: Teenage Pregnancy Unit

Figure 8: Teenage conception rates per 1,000 by ward, Westminster – 2004-06[4]



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Source: Teenage Pregnancy Unit, Office for National Statistics

The most recent data on conceptions in girls aged 15-17 has shown that there were 70 conceptions in 2007. These are relatively small numbers subject to considerable fluctuation between years as is apparent from the sudden surge in 2006 followed by a fall in 2007.

Although overall the conception rate in Westminster is lower than the national average, some wards have higher than national rates. The three wards with the highest rates of teenage pregnancy over the years 2004-6 were Queen's Park (57.3), Harrow Road (53.3) and West End (45.5), which all had higher rates that the national figure of 41.2 per 1000 15-17 year old girls. Queen's Park and Harrow Road are two of the most deprived wards in Westminster.

The gap in teenage pregnancy rates between the most and least deprived areas of Westminster is of a particular concern. The current gap (2004/06) is 39.86 per 1000 between the most deprived and the least deprived quintiles. A new target to reduce the gap in the teenage conception rate between the most deprived and the least deprived quintiles by 30% was introduced in the

[4] Due to small numbers the ward level data has been aggregated over a three year period. To prevent disclosure and protect confidentiality ONS suppresses data for wards with fewer than five conceptions. These are the wards coded on the map in figure 8 as having 'insufficient data.'

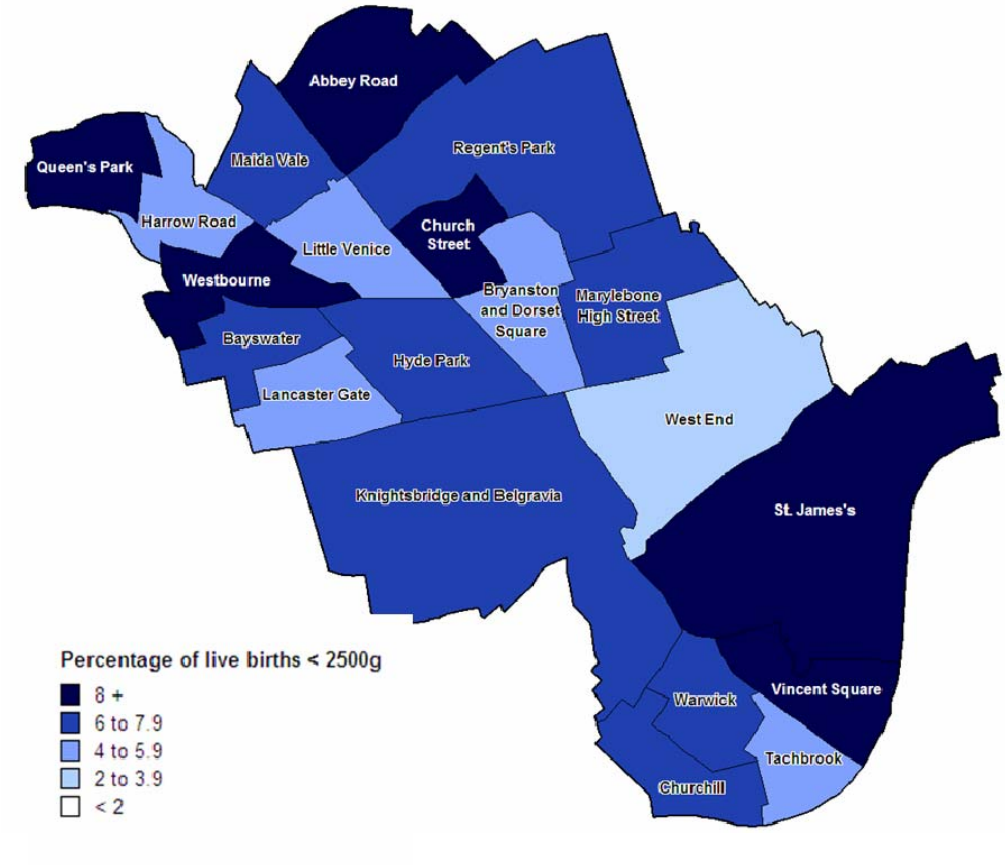
Westminster Inequalities Strategy (2009). If the target is achieved, by 2013-15, the teenage conception rate in the least deprived quintile would be 6 per 1000 and the most deprived quintile would be 33.9 per 1000.

Birth weight is an important indicator of foetal age and normal growth. Low birth weight (<2500g) is associated with premature delivery and/or lower socio-economic groups, where maternal smoking and nutrition intake during pregnancy can play a determining role. Multiple births and certain ethnic origins are also associated with lower birth weight.

Overall only 5.9% of live births in Westminster in 2007 weighed less than 2,500g and 0.7% weighed less than 1,500g compared to 7.5% and 1.3% in London and 7.2% and 1.2% in England respectively. Nearly 70% of births in Westminster weighed between 3000g and 3999g, an expected weight for a term born healthy baby. 7.8% weighed over 4,000g (Vital Statistics, ONS, 2007).

Very low birth weight and very high birth weight present a challenge – babies with very low birth weight need intensive care and very heavy babies may be difficult to deliver and may require more care at and after birth.

Figure 9: Percentage of live births weighing less than 2500g, 2004-06



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Source: London Health Observatory (LHO)

Over the time period 2004-2006, a significantly higher percentage of babies born to mothers living in the Church Street ward (9.6%) had a low birth weight. Other wards with high percentages include Westbourne (8.9%) Abbey Road (8.7%), Vincent Square (8.6%), St James's (8.5%) and Queen's Park (8.4%).

The wards with the lowest birth weights are characterised by higher proportions of Asian residents whose babies may be smaller naturally. However, it is the addition of adverse factors associated with lower socioeconomic status characteristic for these wards, such as maternal nutrition and smoking, which play a role in further lowering birth weight in these babies putting them more at risk of adverse outcomes.

In 2007 84% of Westminster babies were **born in NHS hospitals** and 15% in non-NHS hospitals. The remaining 1% of mothers gave birth at home. The percentage of mothers giving birth in NHS hospitals is lower than in London (96%) and England (97%) mainly due to the proportion of mothers giving birth in non-NHS hospitals. This reflects the pockets of affluence in the Borough. Only 1% of mothers gave birth at home compared to London (2.2%) and England (2.8%) in 2007.

Utilisation of private hospitals for birth increases with age and affluence, rising from 8% in Westminster in the under 30 year olds to 18% in the 30-39 year olds and 19% in the over 40 year olds. NHS Westminster has less control over the delivery of health promotion interventions and monitoring of early years screening coverage in private hospitals.

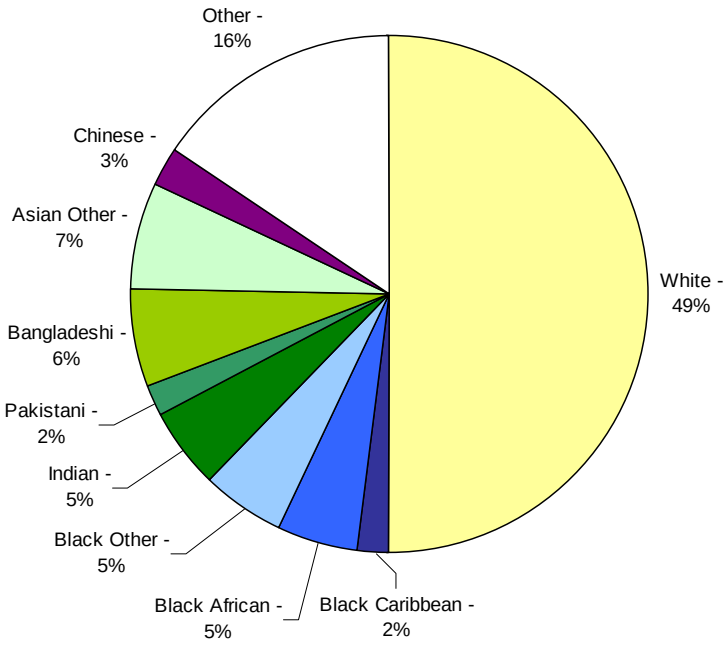
2.3 Diversity of children aged less than 5 years in Westminster

Child's ethnic status is currently not recorded at birth registration. *According to the Greater London Authority (GLA) estimates just over a half of the under 5's are from BME groups. This suggests more diversity within this population subgroup than within Westminster as a whole, where 71% are estimated to be White and 29% from BME groups.* The high percentage of children of an 'Other' ethnic group indicates children whose ethnicity is unknown and is likely to encompass individuals with a range of spoken languages and cultures that need to be considered in service provision.

The 2001 Census returns for Westminster showed that within the broad category of 'Other ethnic group', over half (54%) of individuals of all ages were self-reported to be of a North African or Middle Eastern ethnicity (also including categories of Arab, Israeli, Iranian, Kurdish and Moroccan) (Ethnic write-in (80 categories) by religion (9 categories), 2001 Census). This level of breakdown has not been provided to this level for more recent population estimates.

Enhanced recording of individual's ethnicity remains one of the priorities for the NHS, education and social services.

Figure 10: The ethnic profile of the population aged under 5 years in Westminster



Source - GLA 2007 Round Ethnic Group Projections - PLP Low – for 2008

According to the GLA predictions, the greatest increase in numbers of children aged under 5 years over the next 10 years among BME groups is expected to come in the 'Other' ethnic group. Based on the 2001 Census data it indicates that over half of this group may consist of individuals who self-reported to be of a North African or Middle Eastern ethnicity.

Services must take into account not only the number of children born but also the make up of the ethnic groups to reflect the need for services now and in the future. This is not only relevant for Children's Services but also services which provide parental education and care.

Maternal country of birth is collected at birth registration and, although not a measure of ethnicity, provides an indication of a child's ethnicity. *According to the Office for National Statistics 72% of live births in Westminster in 2007 were to mothers born outside the UK. This is much higher than in London (54%) and England (24%). This proportion has been increasing since 2001. Of those mothers born outside the UK 34 % were born in Asia, 18 % in Africa and 3% in the new European Union Countries (joining the EU since 2004) (ONS, 2007).*

Information on maternal country of birth is important for commissioning and the provision of maternal and child services, given the cultural, language and service provision differences between countries worldwide.

In 2007 69% of Westminster primary school children spoke **English as a second language**. Unsurprisingly this is a similar proportion to the percentage of live births to mothers born outside the UK in 2007. *It is*

plausible that most mothers whose children will go on to attend state primary schools remain in Westminster after giving birth.

English as a second language can present additional barriers in a child's education and their family's access to, and acceptance of, services. Apart from English, Arabic, Bengali/Sylheti, Albanian and Portuguese are the most frequent first languages spoken in Westminster schools. (WCC, 2007 School Census)

3. Socioeconomic profile of the families

3.1 Income deprived families

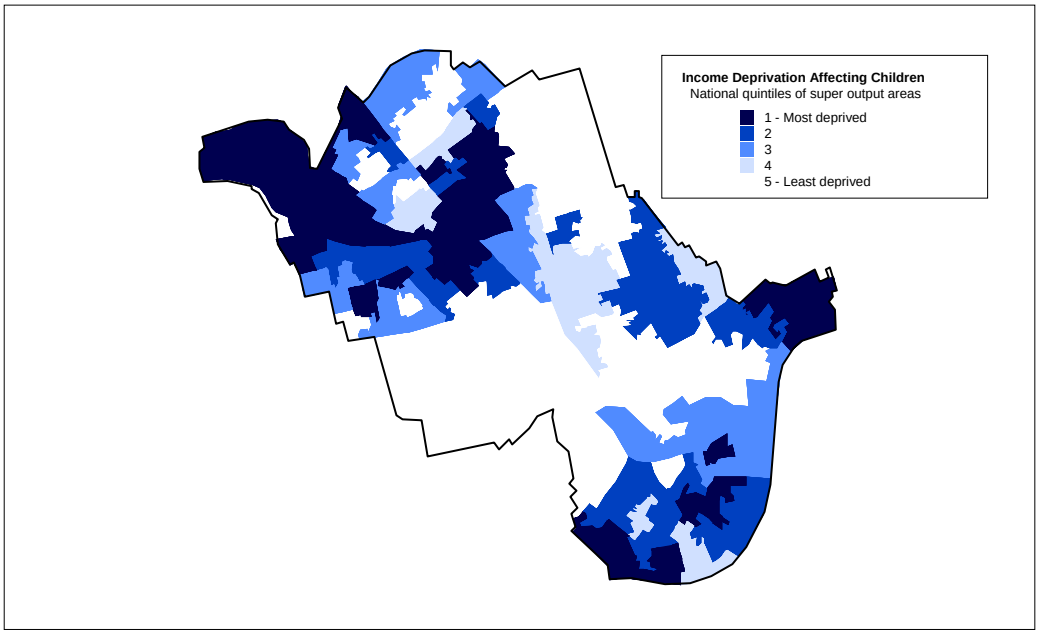
Living in an income deprived family as a child is associated with worse health outcomes, both during childhood and in future life. Deprivation is linked to other wider determinants of health such as educational attainment. It can also influence behavioural choices known to impact on the health of adults and their children such as breastfeeding, eating habits and participation in sports and exercise.

Westminster has some of the poorest children in the country. As part of the Indices of Deprivation (IMD) 2007, a sub-indicator was specifically designed to capture income deprivation affecting children. This is defined as the proportion of children under 16 living in families that are income deprived (in receipt of Income Support, Income based Job Seeker's Allowance, Working Families' Tax Credit or Disabled Person's Tax Credit below a given threshold).

Westminster is divided into Super Output Areas (SOA)[5] which enable a closer inspection of amongst other things the socioeconomic profile of specific parts of the Borough. Westminster is made up of 120 SOAs. 42 (35%) of Westminster SOAs are in the 20% most deprived SOAs in the country. This includes all of the SOAs in the electoral wards of Church Street, Harrow Road, Queens Park and Westbourne. *In 29 (24%) of the Westminster SOAs more than 50% of children live in income deprived families. In 4 of Westminster's SOAs 90% of children live in income deprived families while one SOA in the Queens Park ward has the highest proportion of children living in income-deprived families in the country at 100% (out of 32,482 SOAs) and in one SOA in Church Street, 99% of children live in income deprived families.*

[5] Super Output Areas (SOAs) are units designed for the collection and publication of small area statistics. SOAs are the building blocks for large groups of SOAs called Lower SOA, Middle SOA and Upper SOA. The SOAs are based on even population numbers (mean total population of an MSOA being 7,200) rather than geographic area.

Figure 11: Income Deprivation Affecting Children, Indices of Deprivation 2007 – national quintiles of Super Output Areas



Source: Department of Communities and Local Government (CLG)

The adverse impact of **unemployment** on physical and mental health and wellbeing of the family and its individual members in terms of, for example, higher risk of depression and increased morbidity is well documented. Such impact on parental health combined with financial hardship impacts inevitably on the wellbeing of children.

Her Majesty's Revenue and Customs (HMRC) data from 2006 indicates that the proportion of children in low income families in receipt of workless benefits in Westminster (38%) is higher than the average for central London (30%) and nationally (20%). Workless Benefits include Income Support, Job Seekers Allowance, Incapacity Benefit, Severe Disability Allowance and Pension Credit. A further 14% of children in Westminster live in families where a parent works, but they are also in receipt of working tax credit and child tax credit.

The Department for Work and Pensions (DWP) figures for April 2007, suggest that around 9940 (34.6%) children live in households dependent on workless benefits in Westminster, compared with 19.7% in England. Westminster City Council estimates from 2007 suggest that there are just under 10,000 individual parents out of work resident in the Borough.

DWP data suggests that the numbers of children living in workless families fell in Westminster between 2003 and 2007; the fall was smaller than that seen across central London and nationally. Due to the current economic climate, however, it is likely that these figures will increase again over the next few years.

To help counteract this trend, Westminster City Council is piloting two projects aimed at unemployed parents under the *Westminster Works Programme.* The Child Poverty Innovation project as a part of a neighbourhood based employment support service works in partnership with the Voluntary and Community Sector, local schools and Children Centres, Job Plus services including the Paddington Development Trust and Vital Regeneration innitiatives. It aims to target long term unemployed and economically inactive residents who are parents focussing on areas with the highest concentration of unemployment including Queen's Park, Harrow Road, Westbourne and Church Street.

The aims of the pilot are threefold:

- To increase parental employment.
- To raise family income, including through the improved take up of tax credits and benefit, including local authority administered benefits.
- To promote economic regeneration focused on families and tackling deprivation at a community wide level.

Through addressing the employment of parents, it is envisaged that the number of children living in poverty will be reduced in Westminster.

Figure 12: Indications of child poverty in Westminster LARPs

LARP area	Proportion of LSOAs within top 5% most deprived nationally (2007)[a]	Estimated no. of parents out of work (Nov 2008)[b]	No. of housing benefit claimants with children (Nov 2008)[c]	% children aged 0-4 living in households dependent on workless benefits (2006) [d]
Queen's Park	5 out of 6	1465	862	47.3%
Harrow Road	4 out of 6	1012	611	45.6%
Westbourne	6 out of 7	1461	899	49.7%
Church Street	3 out of 4	1326	857	48.8%
South Area*	none	2217	1124	23.0%

(These indicators apply to 0-15 year olds, except those dependent on workless benefits, which relate to children aged 0-4)

[a]– Index of Multiple Deprivation affecting children, 2007 – children all ages

[b] – Strategy, Planning and Performance, Westminster City Council, November 2008 – parents of children of all ages

[c] – Westminster Housing Benefits Database, November 2008 – children of all ages

[d] – Department for Work and Pensions, April 2006 – children aged 0-4

* - The South Area covers Churchill, Tachbrook, Warwick, Vincent Square and St James's Wards – the data for these wards varies, for instance the proportion of children aged 0-4 dependent on workless benefits in Churchill ward was 49.3%, much higher than the other wards in this LARP.

Source: Children Poverty Local Authority Innovation Pilot Bid, November 2008; data from the Early Years Census 2009, Westminster City Council.

The wards with a higher proportion of children who live in families dependent on workless benefits correspond to the areas of highest deprivation. As figure 12 above shows, nearly half of the population aged under 5 years in the four Local Area Renewal Partnership (LARP) areas in the north of the Borough are dependent on workless benefits. This is also the case for Churchill Ward within the South LARP area.

At a local level **eligibility for free school meals**, especially in primary schools, where the majority of the school roll live in Westminster, can be used as an indicator of poverty.

Parents do not have to pay for school lunches if they receive any of the following:

- Income support
- Income-based jobseeker's allowance
- Support under Part VI of the Immigration and Asylum Act 1999
- Child Tax Credit, provided they are not entitled to Working Tax Credit and have an annual income (as assessed by HM Revenue & Customs) that does not exceed £14,495
- The guaranteed element of State Pension Credit

35% of children and young people attending primary and secondary schools in Westminster are eligible for free school meals. This proportion is much higher than that of London, or England, as a whole.

Figure 13: Eligibility for free school meals, 2007/8

	% Children eligible for free school meals in 2007/8 Maintained Nurseries and Primary Schools
Westminster	35%
London	24%
England	16%

Source: Westminster City Council 2007; Department for Children Schools and Families (DCSF): Pupil characteristics and class sizes in maintained schools in England: January 2008 Provisional data (for London and England)

Data collected as part of the School Census shows that in January 2009 17% of pupils at maintained nurseries and 37% of primary school pupils were eligible for free school meals in Westminster. In primary schools this ranged from 2% to 56% of pupils being eligible. In 10 primary schools more than 50% of children were eligible for free school meals. A higher percentage of pupils overall were eligible in the north compared to the south of the Borough.

At June 2009 86.3% of eligible pupils in primary schools in Westminster took up the offer of free school meals. In addition 46.8% of pupils had paid school meals. In Local Authority maintained nurseries the uptake of free meals by eligible children was 75.3%. An additional 28.5% had paid meals (Westminster City Council).

Free school meals are used as an indication of child poverty, although their intention is to provide children with one nutritionally balanced meal a day during the school week. Food standards introduced in September 2008 aim to ensure that all school meals and other school food sources are healthy.

Healthy Start is a national scheme which promotes healthy eating in mothers and young children from deprived backgrounds. It is open to pregnant women and families with children under the age of four who are on:

- Income Support
- Income-based Jobseeker's Allowance or
- Child Tax Credit (but not Working Tax Credit unless their family is receiving Working Tax Credit run-on only[6]) with an income of £16,040 a year or less (2008/9)

All pregnant women under the age of 18 also qualify, whether or not they are on benefits.

Once accepted on the scheme, pregnant women and families will receive a set of vouchers through the post every four weeks. Each voucher is worth £3.10 and can be exchanged for any combination of milk, fresh fruit, fresh vegetables and infant formula milk in registered shops. Women who are eligible receive these vouchers for each child they have under the age of four.

Healthy Start also provides free vitamin supplements to qualifying pregnant women, mothers and children. Women are entitled to free vitamins during pregnancy and until their baby is one year old. Children are entitled to free vitamin supplements from 6 months of age until their fourth birthday. Letters offering entitlement to vitamin supplements can be exchanged for vitamins from the relevant distribution points such as children's clinics or GP surgeries.

As well as their vouchers, beneficiaries also get health advice about healthy eating, breastfeeding, infant feeding and using the vouchers.

Figure 14: Individuals qualifying for Healthy Start food vouchers in Westminster. 2009

4 Week Cycle - 2009		Snapshot figures (taken on one particular day, at one particular time during the 4 week cycle)		
		Numbers eligible[7]	Numbers of beneficiaries	Percentage of those eligible using the scheme
75	19 Jan – 15 Feb	2363	2013	85.2%

[6] Working Tax Credit run-on is the Working Tax Credit received in the 4 weeks immediately after stopping working for 16 hours or more per week.

[7] The eligibility data is new and should be interpreted with caution. Eligibility could never be 100% because someone would not have their application processed the same day they became eligible.

76	16 Feb – 13 Mar	2386	2021	84.7%

Source: Department of Health, 2009

Local data-collecting around individuals eligible for Healthy Start is relatively new and the figures reported above are a snapshot view and should be interpreted with caution. There are indications, however, that within Westminster around 85% of individuals qualifying for Healthy Start take up the scheme, which is higher than the national average (of around 80%).

Although we have indicative data for eligibility and uptake of the Health Start Scheme in Westminster, we do not currently have any data on how many vouchers were actually used and where (type and locality of shops) and whether the individuals in receipt of the vouchers were provided with ANY advice/suggestions for preparing and cooking the fresh fruit and vegetables provided.

Local and national intelligence also suggest that the vitamin supplement part of the scheme is under-utilised mainly due to lack of publicity and difficulty in accessing the product which has suffered periods of product discontinuation and withdrawal from pharmacies in lieu of children's clinics and GP surgeries. Early indications are that such changes have further reduced the uptake of vitamins by the eligible mothers and children and that an alternative local solution and re-launch of the campaign will be necessary to increase the uptake of this scheme aimed at reducing inequalities in health among the most disadvantaged and at risk groups of the population.

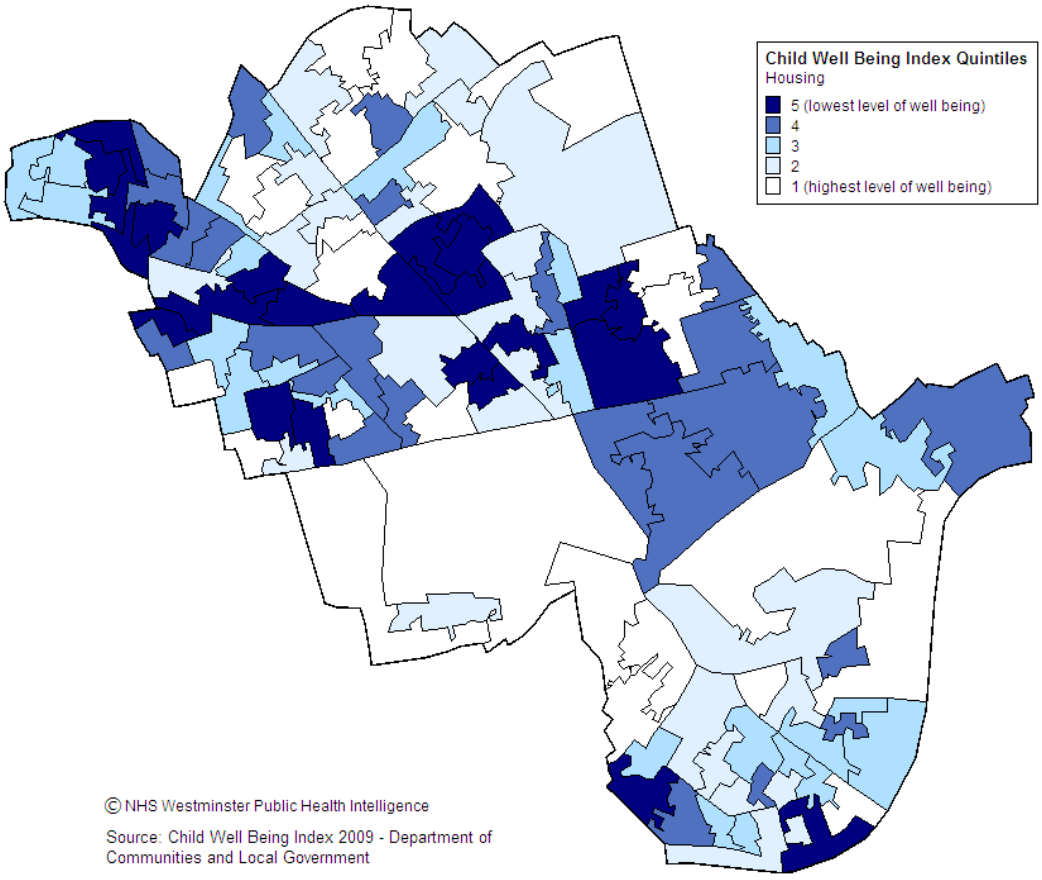
3.2 Housing

The **Index of Child Wellbeing** (CWI) 2009 represents the first attempt to create a small area index exclusively for children in England. The index is one of wellbeing rather than deprivation. The CWI is made up of seven domains, one of which is on housing.[8] Data for the housing domain was built up from various indicators from the 2001 Census around access to housing and quality of housing.[9] The Lower Super Output Area (LSOA) with the lowest wellbeing was in Marylebone High Street Ward (Department for Communities and Local Government: Local Index of Child Well-Being 2009). http://www.communities.gov.uk/publications/communities/childwellbeing2009

[8] The others 6 domains are material wellbeing, health, education, crime, environment and Children in Need.

[9] The indicators included overcrowding, 0-15 year olds living in shared dwellings, homelessness and lack of central heating.

Figure 15: Child Wellbeing Index quintiles for Housing by Westminster Lower Super Output Area



Overcrowded living conditions have traditionally been associated with an increased prevalence of mental health problems and infectious diseases. 30% of housing in Westminster is classified as overcrowded. This places Westminster as the third highest in the country in terms of overcrowded housing conditions; significantly higher than London (17%) and England (7%). *For houses that are occupied with dependent children, the overcrowding figure is 45%.*

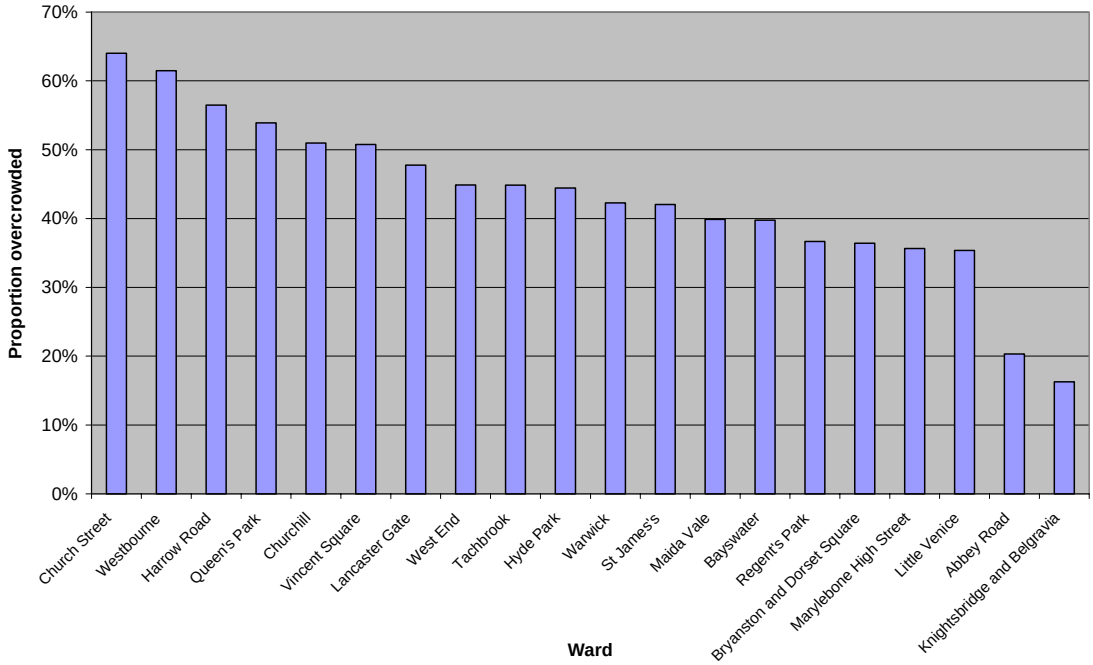
Figure 16: Proportion of housing occupied by dependent children classified as overcrowded by housing tenure, 2001 Census

Owned	Rented from Council	Other Social Rented	Privately Rented
29%	67%	51%	35%

Source: National Census 2001, Office for National Statistics, 2003.

The proportion of properties that are overcrowded varies between wards, from 16% in Knightsbridge and Belgravia to 64% in Church Street. Those areas with the highest proportions of overcrowded housing are those that are the most deprived in Westminster.

Figure 17: Proportion of housing occupied by dependent children (all ages) classified as overcrowded by ward, 2001



Source: National Census 2001, ONS 2003

Living in **temporary accommodation** is linked to worse mental and physical health outcomes. This is thought to relate to the quality of the housing and the level of access to social and health services and support networks by those who may have only recently arrived to the UK often following traumatic events in heir homeland. Alongside poor living conditions, uncertain living conditions affect educational development and attainment which is of vital importance during these formative years.

A snapshot figure taken on 31 March 2009 showed there were 34 children aged below 5 years temporarily placed in emergency Bed and Breakfast accommodation by Westminster, while waiting for allocation of a suitable self-contained temporary accommodation property (6 week target). (Data provided by Westminster City Council Housing Department)

Westminster makes every effort to move families out of emergency Bed & Breakfast accommodation within the 6 week target and this is monitored by Housing Options on a weekly basis. There are seldom more than 2-3 families per month having to wait a few days beyond this target. Most often the delays to being placed into a suitable self contained temporary accommodation property are due to either the involvement of social services which can restrict the location in which the family can be placed, or the medical conditions affecting the family limiting the types of properties which would be suitable.

As at April 2008 Westminster City Council reported a total of 1,080 primary school age children in self-contained temporary accommodation situated in Westminster and other Boroughs (APHR, 2006/7, NHS Westminster).

3.3 Lone parents

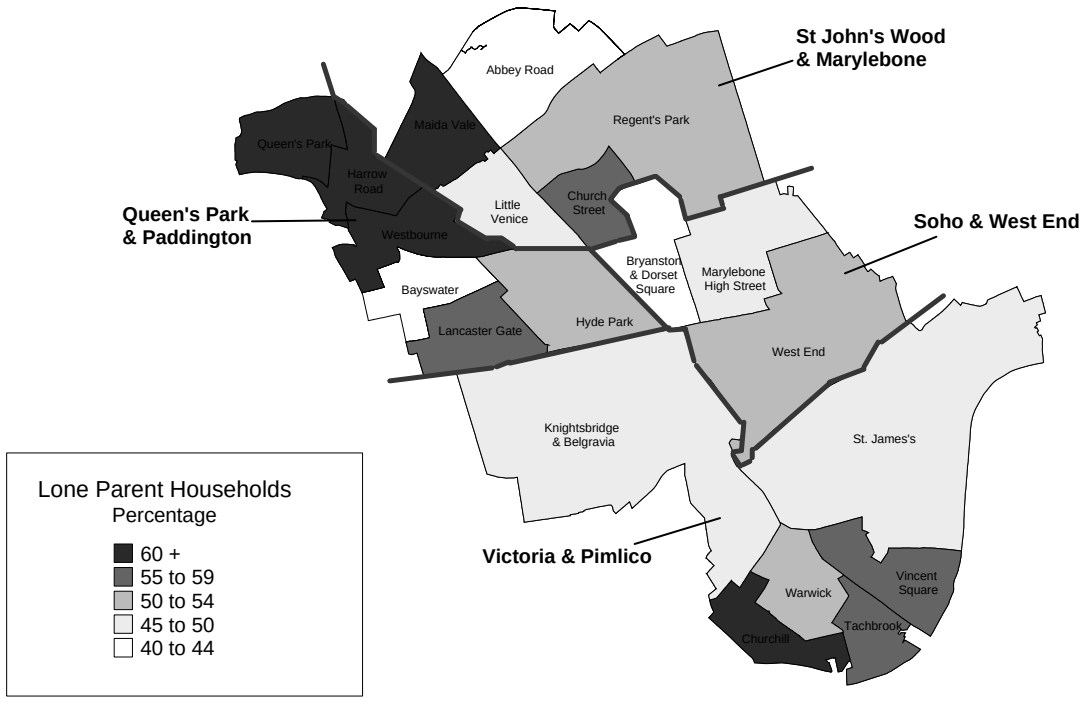
Single parent households have become increasingly common in recent years. Many children in such households maintain a good relationship with the absent parent. However, where children have a poor relationship or no relationship with one parent, or where there is family conflict, children are at increased risk of social exclusion.

In 2007 25% of babies in Westminster were **born outside of marriage** and 5% were born outside of marriage and only one parent signed the birth register. According to national statistics, infant mortality rates are higher for infants born outside marriage, although this could be a reflection of differences in social class distribution. (ONS Vital Statistics, 2007)

The diagram below presents the number of **lone parent households** with dependent children (aged 0-15 years) as a percentage of all households with dependent children. The lowest proportion of lone parent households was found in the Bayswater ward (41%), whilst the highest was in the Harrow Road ward (64%). (ONS, 2001 Census)

Lone parents may also face increased barriers to working resulting in them becoming dependent on the benefit system. Such barriers include a lack of affordable child care, limited flexibility in parental leave and leave to care for sick children, and excessive and unsociable working hours.

Figure 18: Lone Parent Households by Electoral Ward, 2001, as a percentage of all households with dependent children



Source: National Census 2001, Office for National Statistics, 2003

In May 2008, 16% of the total claimants for benefits in Westminster were lone parents (3,100 lone parents). Some wards, however had a higher proportion of lone parents claiming benefits: the figure was 21% in both Queen's Park and Westbourne Wards, 20% in Harrow Road and 19% in Church Street (Department for Works and Pensions).

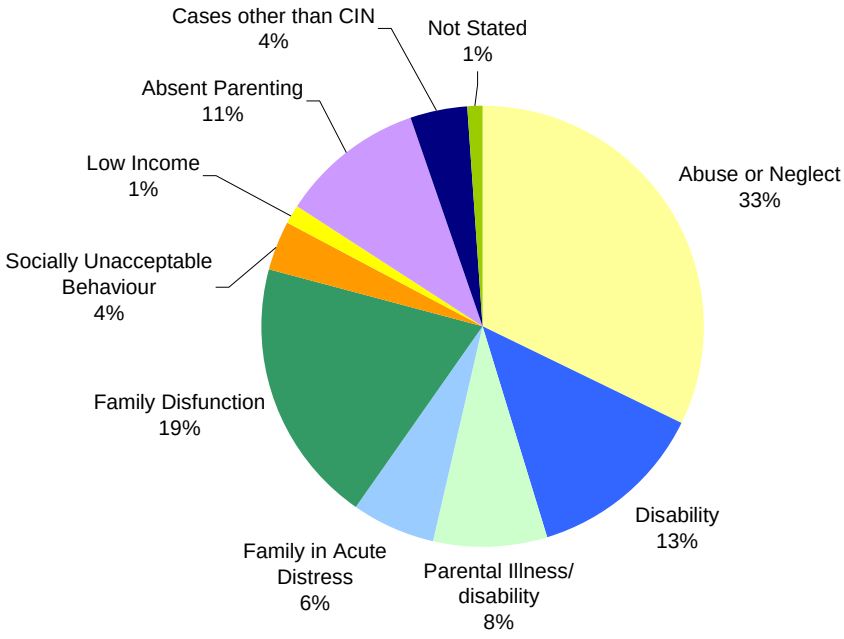
The 2001 Census found that in Westminster 68% of lone parents were employed. The figure was 50% employment in England and 43% in London. The proportions of lone parents who are employed, however, are significantly lower than the percentage of cohabiting or married mothers who are employed.

3.4 Children in need

The term "children in need" encompasses all children receiving support from social care services. 648 children aged below 5 years in Westminster currently have 'children in need status': 94 aged under 1 and 554 aged over 1 but below 5 years old. (Westminster City Council, 29 April 2009)

The most common reasons for children being classified as in need in January 2008 were abuse and neglect (33%), followed by family dysfunction (19%).

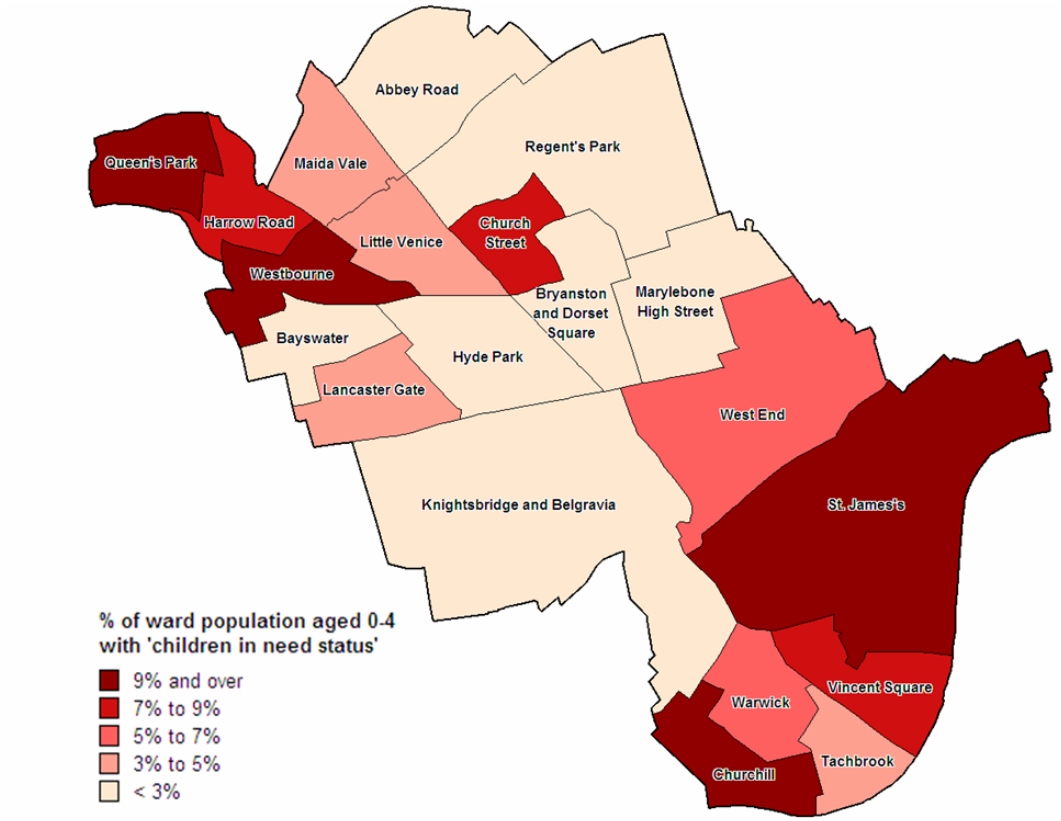
Figure 19: Reasons for children in need status, all ages, January 2008



Source – Westminster City Council

The more deprived wards in Westminster have a greater proportion of children in need. The wards with the greatest proportion of children in need are Queen's Park and Westbourne, with high rates also found in Churchill, Church Street and Harrow Road wards. These are all wards located in LARP areas.

Figure 20: Children in need aged under 5 by ward as a percentage of ward population aged under 5 (as at 29 April 2009)



© NHS Westminster Public Health Intelligence

Note - the ward of residence was unknown for 53 individuals.

Source: Westminster City Council figures applied to Greater London Authority RND 2008 Ward Population Projections PLP Low - for 2009

On 29 April 2009, there were 57 children aged below 5 on the Westminster **Child Protection Register**[10]. The numbers are too small to break down by age but of all the children on the Child Protection Register in Westminster (aged 0-17 years old) where ward of residence is known 26.4% lived in Queen's Park, 14% in Westbourne and 11.6% in Church Street, three of the most deprived wards in the Borough.

On 29 April 2009 there were 40 **looked after children** aged below 5 in Westminster. Looked after children are those children who are in the care of the Local Authority. Such children often have complex health needs compared to their peers. Many of these children are likely to be living outside the Borough. Of all the looked after children in Westminster (aged 0-17 years old), where their original home address is known, 28.8% were from Queen's Park, 11.5% from Church Street, 8.6% from Churchill, 7.9% from Westbourne and 7.2% from Harrow Road.

[10] The child protection register is a confidential list of all children in the area who have been identified at a child protection conference as being at significant risk of harm.

Parental **drug and alcohol misuse** can have serious effects on the mental and physical wellbeing of their children. As at January 2008 there were 139 clients on the Drug and Alcohol Action Team (DAAT) treatment caseload with children (8% of the total adult treatment population). 20% (n=around 40) of the children of these clients were aged under 5. Over a third of these children were living at home.

Targeted work is currently taking place within the Borough around Hidden Harm. This includes improving data recording around parental status of individuals in treatment, and monitoring local services and the work they are doing with parents, and referrals made to Children's Services. Plans are in place to carry out a needs analysis of child protection and adult substance misuse cases. This will identify gaps in service provision and recommend possible solutions to bridge any gaps between children and families, and adult substance misuse services.

There is significant evidence that children and young people are deeply affected by living in a household where **domestic violence** takes place. In 90% of incidences of domestic violence children are in the same or an adjoining room. Infants exposed to violence may not develop attachments to their caretakers which are critical to their development; in extreme cases they may 'fail to thrive'. Preschool children in violent homes may regress developmentally and suffer sleep disturbances, including nightmares. School age children who witness violence may exhibit a range of problems and behaviours including difficulties at school, depression, anxiety, anti-social behaviour, psychosomatic illness and violence towards peers.

In Westminster the 'Westminster Domestic Violence Schools Project' aims to assist schools in responding to the needs of children affected by domestic violence and to teach children and young people how to form their own healthy and safe relationships.

Large numbers of **refugees and asylum seekers** are believed to live in Westminster, although precise numbers are difficult to determine. Snapshot counts in 2006/7 suggested that Westminster City Council was responsible for providing subsistence to 145 asylum seekers. (NHS Westminster, Public Health Annual Report, 2006/07) The number of accompanied and unaccompanied asylum seeking children aged below 5 in Westminster is currently unknown. These are children with potentially high support needs.

4. Health and wellbeing of under 5 years olds

A comparison between registration data for children aged below 5 and current population estimates for the same group indicates that as many as 99% of children aged less than 5 years in Westminster may be registered with a GP (GLA RND 2008 Ward Population Projections Low). However the true number may be smaller as registered populations tend to be inflated with patients who moved out of the area and have not been removed from the register and a proportion of the registered population may reside outside Westminster. Equally some of Westminster's residents may be registered in

other neighbouring Boroughs. Health Visitors support and encourage families to register with GPs.

Figure 21: Children and Young People registered with Westminster General Practices, 2008

Age	Male	Female	Total
0	1201	1155	2356
1 - 4	4590	4634	9224
0 - 4			11580

Source: Patient Registration Database, NHS Westminster, March 25 2008

4.1 Preconception and Antenatal care

To maximise the chance of a healthy baby, potential parents are advised to lead healthy lifestyles. They should also consider any particular personal or family hereditary health conditions for which they may seek advice prior to conception.

Recently published NICE guidance for maternal and child nutrition states that advice should be given to women who may become pregnant regarding a healthy diet and taking folic acid and vitamin D supplements (2008). A set of general recommendations for preconception care advice which can be undertaken opportunistically with women of child bearing age comprises the following key areas:

- Healthy Diet and Weight
- Alcohol
- Smoking
- Chronic Diseases
- Folic Acid
- Immunity to Rubella

An organised programme for pre-conception care is currently not a feature in Westminster and any preconception advice is likely to occur in an ad hoc manner. It has been repeatedly identified that a large proportion of women of child-bearing age who are planning a pregnancy or may become pregnant do not regularly take folic acid supplements. *Evidence has identified that low pre-conception folic acid use is more likely where there is a low level of formal education, young maternal age, lack of a partner, immigrant status and unplanned pregnancy. The impact of this is seen in a lack of decline of neural tube defects in North West London.*[11]

The North West Thames Congenital Malformation Register of which Westminster is a part has recorded that there is an adjusted rate of 1.6% of

[11] North West Thames Perinatal Public Health, (2007) *Annual Report North West Thames Congenital Malformation Register*. North West Thames Perinatal Public Health, London.

births (crude rate 2.1%) that had congenital anomalies in 2006 (this includes terminations for fetal abnormality).

Early access to maternity services is a national priority reflected in the Vital Signs target which requires the local hospitals to report to NHS Westminster the number of women seen by a midwife or maternity healthcare professional for a **health and social care assessment of needs, risks and choices by 12 weeks 6 days of pregnancy**. *In quarter 4 of 2008/9 77% of the women who had a health and social care assessment in Westminster had it by 12 weeks and six days of pregnancy (n=567).*

This assessment supports women to make well-informed decisions about their care throughout pregnancy, birth and afterwards. It aims to improve outcomes and maternity experiences for mother and child. Women who start their antenatal care late are often more likely to experience serious health problems (The NHS Information Centre).

Antenatal classes are set up to prepare mothers-to-be on what to expect during pregnancy, labour and early parenthood. Many of these classes are free to access. Between August 2008 and July 2009 1026 women due to give birth at St Mary's attended antenatal classes at St Mary's Hospital. Data is not collected from clients on their age, place of residence or ethnicity. Most of these women attend a 4 week course of 2 hour sessions. Once a month St Mary's run an antenatal breastfeeding class and in addition the Physiotherapy Department runs a 'well-being in pregnancy class'. A further 44 women attended antenatal classes at Church Street Children's Centre during 2008/9. Antenatal sessions co-ordinated by Health Visitors are also available at Queen's Park and Hallfield clinics. In addition to that The National Childbirth Trust also runs antenatal classes across Westminster, for which the participants pay a fee. The numbers attending these sessions and classes are currently unknown.

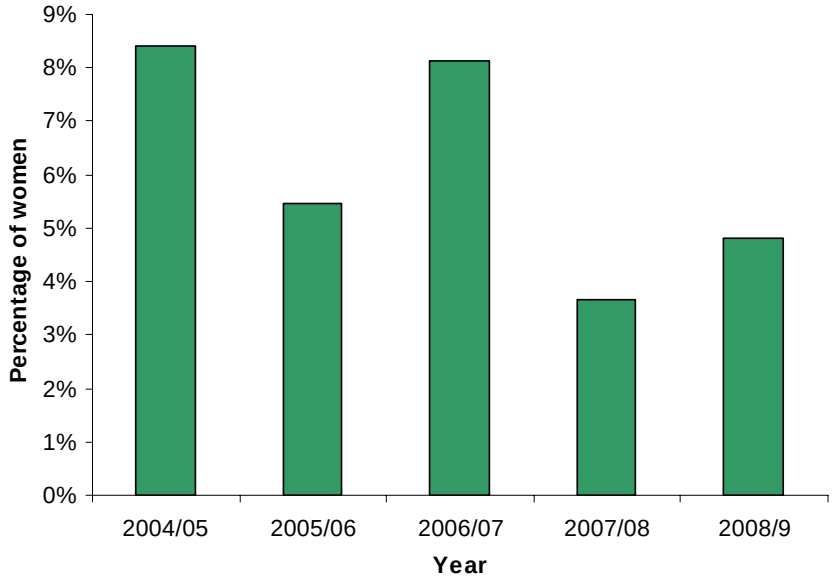
Smoking during pregnancy can have a detrimental effect upon the health of a baby in terms of low birth weight, slower growth, cot death and respiratory problems in childhood. In 2005, a national survey found that 17% of women in England and Wales smoked through pregnancy to birth. This had fallen from 23% in 2000. (Infant Feeding Survey 2005)

As with smoking habits in the general population, smoking during pregnancy and at birth is adversely associated with socio-economic class. *Women from routine or manual occupations were found to be more than four times as likely as those in managerial and professional occupations to have smoked throughout pregnancy (29% and 7% respectively).* (Infant Feeding Survey 2005)

The percentage of Westminster's women who were reported to have been smokers at the time of the delivery varies over time. Although not high quality data, the information on maternal smoking at the time of delivery as collected

by midwives shows a downward trend.[12] Overall Westminster figures are significantly lower than national figures at 4.8 % in 2008/09.

Figure 22: Percentage of women known to have been smokers at time of delivery by year



Source: NHS Westminster

Being **overweight or obese** during pregnancy can increase complications at birth. Furthermore, if the pregnant woman is obese then her unborn child is also more likely to become obese. In later life the unborn child is also more likely to develop long term illness such as diabetes, heart disease and asthma.

Between April 2008 and March 2009, of all patients booked at St Mary's (of any gestation age) with Body Mass Index (BMI) recorded, 30.4% were overweight and 13.5% were obese.[13] This proportion was slightly lower in those mothers who booked at St Mary's with a gestation of less than or equal to 12 weeks (26.2% overweight and 11.2% obese.) (CMIS, data extracted 24/06/2009). It is likely that those who booked late will be from less affluent backgrounds and or BME communities where population rates of obesity and overweight are higher.

If current trends continue, it is predicted that by 2050 as many as 9 in 10 adults and two thirds of children will be overweight in England. This is likely to impact on maternity service provision and the number of birth complications in Westminster (Foresight, 2007).

[12] This information is collected by midwives at the time of delivery and as such may not necessarily reflect the true smoking status of the mothers who may feel uncomfortable disclosing their smoking habits when asked directly by a midwife.
[13] Overweight includes women with BMI greater or equal to 25kg/m^3 and less than 30kg/m^3; obese patients classed as those with BMI of greater or equal to 30 kg/m^3.

4.2 Postnatal care

Breast milk provides complete nutrition for the healthy development of infants. **Breastfed babies** are less likely to have respiratory infections, ear problems or gastroenteritis. There are also indications that breastfeeding contributes to the prevention of obesity in later life. There are also significant benefits associated with breastfeeding for the mother – reduction of body weight being one. The World Health Organisation recommends that wherever possible infants should be breastfed exclusively from birth to six months.

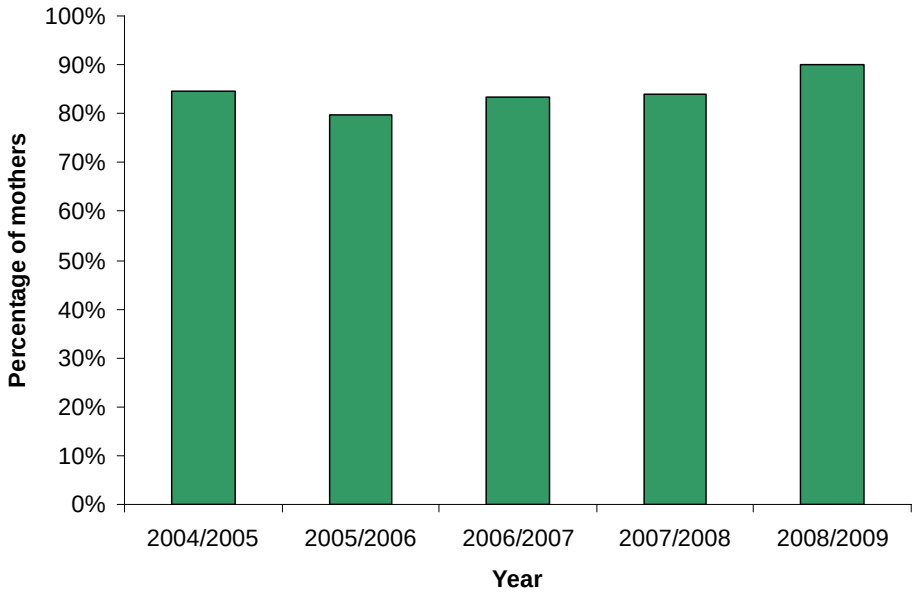
The most recent National Infant Feeding Survey was conducted by the Department of Health in 2005. This found a breastfeeding prevalence of 77% in England and Wales – a 6% rise since the previous survey in 2000. The highest prevalence of breastfeeding was found in mothers from managerial and professional backgrounds and in those with the highest educational levels, those aged over 30 and first time mothers.

The proportion of Westminster's women giving birth in NHS hospitals who have initiated breastfeeding at birth has been relatively constant and high (between 80% and 90%) during the past five years compared to England. (78% of mothers in England initiated breastfeeding in 2005).[14] However, nationally only 50% of all mothers who initiated breastfeeding were continuing to breastfeed at 6 weeks (The NHS Information Centre).

In NHS Westminster, data on prevalence of breastfeeding at 6-8 weeks are collected as part of the Vital Signs target monitoring. According to this data the prevalence of breastfeeding at 6-8 weeks was 79% in the first quarter of 2009/10. This exceeds the nationally set local target for Westminster and suggests higher continuation rate at 6-8 weeks locally than predicted nationally.

[14] Data from all the acute trusts where women residing in Westminster give birth are not available and therefore not included. For example 13.6% of all births in Westminster in 2006 took place in private hospitals.

Figure 23: Percentage of new mothers known to have initiated breast feeding in Westminster during 2004-2009



Source: NHS Westminster

Postnatal depression (PND) is a common complication of childbirth affecting between 8-15% of new mothers (BMJ, 2005). Postnatal depression can have significant adverse consequences for the mother, her family and the new baby.

In 2008/9 15% (n=216) of the mothers receiving a health visitor PND assessment by 6-8 weeks received a diagnosis of Postnatal depression. Westminster figures are therefore at the high end of national prevalence estimates. However, *a local audit of postnatal depression carried out in Church Street in 2004 found that 27% of mothers assessed were found to have postnatal depression. This number rose to 33% when only first time mothers were considered* (Leverton, 2004).

Although differences in the above reported numbers may be due to an actual reduction in the prevalence of PND in Westminster since 2004 or different diagnostics/data capture methods, given the links between deprivation and poor mental health it is most likely that the Church Street area has a higher prevalence of PND than Westminster as a whole.

The presence of PND has been linked to the occurrence of stressful life events, in particular unemployment, absence of support from spouse, family, and friends. *Other areas in Westminster where there is greater deprivation, higher unemployment and a higher proportion of lone parents, are likely to experience prevalence of PND similar to that of Church Street.*

Perinatal mental health services in South Westminster are currently provided by the Chelsea and Westminster NHS Trust. A new service is being set up at St Mary's Hospital to address the issues in the North of the Borough.

Westminster, as part of Central London Community Healthcare (CLCH), has a Health Visitor establishment of 56, based in teams currently situated in Community Health Centres or GP surgeries. These include those who provide specialist Health Visiting Services to families and children and work closely with Children's Centres in the Borough.

As part of the Healthy Child Programme all Westminster resident children aged 0-5 years and their families are offered a standardised programme of care. This includes a minimum of 4 contacts, a new birth visit, postnatal depression assessment for mother, and child health reviews at 8 months and 2 years. Integral to this core service is support and guidance for families on a range of health issues relating to child health and well being, including growth and development, parenting, infant nutrition including breast feeding, infant sleeping and behavioural management. Families access this support at home and /or at clinic sessions.

In addition to the universal programme, and often in conjunction with multi agency colleagues, health visitors also provide targeted support for children and families who need extra support, families identified as vulnerable and at risk of poor health outcomes and those children with a safeguarding plan.

Westminster is currently reviewing its Health Visiting Services and is looking at opportunities for co-locating staff in a variety of settings including Children's Centres and increasing integrated working with multi disciplinary/agency teams to focus on identifying those in most need and ensuring an early preventative intervention wherever possible.

The NHS **Newborn Hearing Screening** Program (NHSP) ensures all parents are offered hearing screening for their new child within the first few weeks of life. It is a core service within the NHS in England and part of the family of Antenatal & Newborn Screening Programs (http://hearing.screening.nhs.uk/). Screening should be offered to all babies and is usually done before mothers and babies leave the maternity unit. If this does not happen they are referred for screening in the community. The test should be completed by 4 weeks of age for well babies within hospital-based programmes and by 5 weeks in community-based programmes.

One to two babies in every 1,000 are born with a hearing loss in one or both ears. This hearing screening test will identify those early. Early identification and intervention is crucial for the development of the child and the management of his/her condition within the family and society.

Figure 24: Comparison between NHS hearing screens completed in Westminster, London and England, 2008/9

	Hearing screen complete by 4 weeks after birth	Hearing screen complete by 3 months after birth
NHS Westminster	54.40%	83.99%
NHS Westminster figures adjusted for private births[15]	*64.00%*	*98.84%*
NHS London	78.47%	92.64%
England	88.40%	96.44%

Source NHSP Trends – downloaded 30 July 2009

Locally, screening is carried out at the two local maternity units at Chelsea & Westminster Hospital and St Mary's Hospital with mop-up community clinics for missed babies. Referrals are then made to two audiology centres at St Mary's and Charing Cross Hospitals.

The percentage of NHS hearing screens complete by both 4 weeks and 3 months after birth was lower in Westminster than London and England in 2008/9. This is partly due to the fact that a higher than average proportion of babies (15%) are born in private hospitals and are tested privately. However even when adjusted for the private births, the percentage of screens completed by 4 weeks remains lower than London and England averages.

This indicates that locally the hospital-based screening programme is failing to screen all babies within the recommended timescale. The adjusted figure for hearing screens completed by 3 months (98.84%) however indicates that although they may be missed at the hospital, almost all babies have been screened by 3 months in the community.

Regular external Quality Assessments take place within the local services to review performance, service provision and referral processes.

There were positive reviews of early intervention in education and social care for Westminster, regarding support for children with hearing loss. Social care provision was said to be well above average, with appropriate services provided for all families referred. Education was found to be satisfactory, with improvements being seen in this area: since the last visit Westminster had 1.5 teachers of the deaf in post, with temporary funding for a further 0.6 teacher of the deaf, to help provide home based support.

[15] The denominator for births in 2008/9 given by NHSP Trends was 3,031. 15% of these births were removed (private births) to provide an adjusted denominator of 2576. This was then compared to the number hearing screens completed by 4 weeks given as 1,649, and the number of hearing screens completed by 3 months, given as 2,546.

The visit highlighted many areas for improvement and it was recommended that the sites be revisited in 6 months. It was also recommended that there should be an external independent review of the whole paediatric Audiology service, from screen referral for audiological assessment to ongoing medical and audiological management.

4.3 Early years

Immunisation protects children from a number of infectious and potentially fatal diseases. The nationally recommended immunisation schedule is set out in figure 25 below.

Figure 25: Schedule of childhood Immunisations

Age	Diseases protected against
Two months old	Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib); Pneumococcal infection
Three months old	Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib); Meningitis C
Four months old	Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib); Meningitis C; Pneumococcal infection
Around 12 months	*Haemophilus influenza* type b (Hib); Meningitis C
Around 13 months old	Measles, mumps and rubella; Pneumococcal infection
Three years and four months or soon after	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella

Throughout 2008-9 there has been an overall increase in the uptake of childhood immunisations in Westminster. Some of the increases have been quite modest but others have been large. Uptake in Westminster has improved to bring NHS Westminster into the top 10 London PCTs for all immunisations except the pneumococcal vaccine.

Figure 26: Childhood immunisation uptake, Westminster, 2008-9

Vaccination	Age at which data recorded	Target 08-09	Quarter 1 2008-09 Uptake Rate	Quarter 4 2008-09 Uptake Rate	Increase in uptake
DTaP/IPV/Hib	1 year	80%	88.5%	91.0%	2.5%
PCV	2 years	80%	43.7%	68.7%	25%
Hib/MenC	2 years	80%	63.8%	83.7%	19.9%

MMR1	2 years	80%	83.5%	85.4%	1.9%
DTaP/IPV	5 years	85%	68.9%	71.0%	2.1%
MMR2	5 years	78%	77.1%	79.8%	2.7%

Source: GP data, NHS Westminster

Similarly to all the other London PCTs NHS Westminster is not reaching the national targets or the ideal (95% vaccination uptake) to achieve "herd immunity" which is needed to protect those children who cannot receive vaccinations due to medical complications. Clearly improvements are needed against the latest national rates (published for quarter 2 2008-09) despite the fact that the local uptake for DTaP/IPV/Hib, MMR1 and MMR 2 were all close to the national average.

Where immunisation uptake is still low, this is due in part to access, problems with data recording and ensuring parents are appropriately reminded. As uptake is increasing, the concern that parents did not trust vaccinations has reduced.

The majority of childhood immunisations are given at GP practices by the practice nurse. Some practices run baby/child clinics where these vaccinations are provided. Such clinics are generally held during the day which can limit access for working parents. The provision of appointments for childhood vaccinations in extended hours is important in order for working parents to get their children vaccinated at the appropriate times as defined in the national schedule.

Information provided by 33 of the GP practices in Westminster shows that 24 have baby clinics at which immunisations are given. All of these clinics are held between 9am-5pm (exact times and the number of days on which these are held vary by GP practice). (Private communication with GP practices, September 2009)

Currently 36 out of the 48 GPs in Westminster provide services outside core working hours (8am-6.30pm on weekdays). In addition to baby clinics, 13 GP practices also have nursing provision for children outside of normal weekday working hours (8.30am-6pm). Only two of these practices do not offer these times to parents for vaccinations. One practice does not have a baby clinic but offers vaccinations in all sessions, including one evening during the week. (Private communication with GP practices, September 2009)

In addition to the vaccines included in the national schedule, NHS Westminster has also provided a universal neonatal **BCG** (Bacillus Calmette Guérin) vaccination programme, to protect children against Tuberculosis (TB). given the prevalence of TB in North West London is above the threshold (40/100,000) over which universal vaccination is recommended.

The neonatal BCG is given by the midwifery teams at St Mary's and Queen Charlotte's Hospitals directly after birth. Uptake for this vaccination has been

low especially at St Mary's due to ongoing staffing, management and training issues. Children who are not vaccinated in the maternity unit can receive the vaccination at a community clinic. Due to the large number of children not being vaccinated directly after birth, the waiting time in the community has increased to almost 3 months. This situation had been investigated and is currently being addressed by NHS Westminster.

Figure 27 - BCG (Tuberculosis) vaccinations in children aged less than 1 years. Data for Lisson Grove, Hallfield, Queen's Park, BessBorough, Health at the Stowe and St John and Elizabeth clinics, 2008 and 2009

	Number identified as requiring vaccination	Number vaccinated	% Vaccinated
Jan-Dec 2008	1765	1197	68%
Jan-Mar 2009	606	366	60%

Source: NHS Westminster

As of January 31 2009 there were 720 children on the *Way Ahead Register* for **Children with Disabilities and Special Needs** in Westminster. Of these, 56 were aged less than 5 years. This register aims to capture information about 0-18 year olds in the Borough whose disability means they cannot do the everyday things that their peers do. This includes physical disabilities, sensory impairments, learning disabilities and mental health issues. The register is unlikely to capture all children and young people with a disability in the Borough, due to the voluntary nature of the register.

Persistent and long term **speech, language and communication needs** (SLCN) are thought to affect up to 10% of children. Around 6% have speech and/or language problems in absence of other difficulties, such as a disability (Law et al, 2000, Law, Garrett and Nye, 2003). These 6% are thought to require targeted and/or specialist support. These children have difficulties in communicating with others, this includes not being able to express themselves effectively or having difficulty in understanding what is being said to them. *SLCN are important needs to meet, they not only impact on communication and language but have much wider effects, including abilities to regulate emotions and behaviours, being able to make friends and solve problems. Academic achievement is also at risk if children and young people are not able to communicate effectively* (Hartshome, Bush, Daly, 2008). *This can therefore impact significantly on their opportunities and wider wellbeing as an adult.*

Deprivation has been identified as increasing the risk of having worse communication skills. It has been estimated that approximately 50% of children in some deprived populations have speech and language skills that are significantly lower than those of other children of the same age (Lindsay et

al, 2008). Another group who may have SLCN are those children who have English as an additional language.

A number of studies have looked at the prevalence of mental health issues in children and young people. Prevalence estimates have ranged from 10-20%. (Bright Futures, 1999; Meltzer et al. 2005; NSF for Children 2004)

The Office for National Statistics carried out a large sample survey[16] of 5-16 year olds in Great Britain in 2004, which looked at the prevalence of mental health issues for 5-16 year olds for different population groups and different categories of mental health disorders. Overall 10% of children aged 5-16 years had some type of mental health problem or disorder. The survey found that boys were more likely than girls to have a mental disorder. Prevalence of mental health disorders in this age group was found to be higher in certain socio-demographic groups: lone parent and reconstituted families, in families where neither parent worked, in families with a gross weekly household income of less than £100, in families where someone received disability benefit, and children living in the social or privately rented sector. (Meltzer H, Ford T, Goodman R (2005) Mental health of children and young people in Great Britain, 2004. Her Majesty's Stationery Office (HMSO): London.)

Mental health problems in children are associated with educational difficulties, family disruption, disability, offending and antisocial behaviour. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, continuing into adult life and affecting the next generation. (National Service Framework for Children, Young People and Maternity Services: Key Issues for Primary Care, 2004)

It is important that those working with children and primary care providers are aware of the early signs of mental health problems, including emotional problems and take appropriate action. Effective prevention and early intervention can help improve the outcomes for children and families. (National Service Framework for Children, Young People and Maternity Services: Key Issues for Primary Care, 2004)

[16] 7,977 5-16 year olds living in private households in Great Britain were interviewed.

Figure 28: Proportions of Westminster children aged 0-5 who had a face-to-face contact with the Child and Adolescent Mental Health Service (at Central North West London NHS Foundation trust) in 2007-8 and 2008-9, by condition of primary presentation

Year	Number children aged 0-5	Proportion of known diagnoses*		
		Behavioural problems	Emotional problems	Social/ relational problems
2007/8	146	48%	29%	11%
2008/9	149	41%	34%	12%

*note that in the 2007/8 the CAMHS report had a diagnosis missing in 71 (49%) cases and in 2008/9 there were 90 (60%) cases missing.

Source: CAMHS activity data (CNWL)

The numbers of children seen at CAMHS as a proportion of the total number of children in Westminster each year are quite small. These children are those whose mental health presentation is considered serious enough to require the involvement of the CAMHS team. The numbers therefore do not show all children in Westminster who may have a mental health problem.

Of the children in this age group presenting to CAMHS, around three-quarters are aged 2 and over.[17] The ethnic breakdown of the children varied between years, with 36% being recorded as White in 2007/8 and 30% in 2008/9. Unfortunately the conditions that the children presented with are currently not recorded in all cases. To-date presenting problems has not been a mandatory piece of data to be collected electronically but this is being made an internal CNWL target, something which will aid future understanding of the service needs of this group.

Childhood obesity is a major public health challenge now and in the future. If current trends continue, it is predicted that by 2050 as many as 9 in 10 adults and two thirds of children in England will be overweight (Foresight, 2007).

Obesity in childhood is associated with the childhood onset of type II diabetes and psychological issues such as low self-esteem. There is also evidence to suggest that obese children are more likely to become obese adults, which results in an increased risk of cardiovascular disease (CVD), diabetes and some cancers.

It is important to note that parental behaviour regarding eating and physical activity habits serves as an important role model for children. It has been

[17] 32% were aged 0-1 and 68% were aged 2-4 in 2007/8; 24% were aged 0-1 and 76% 2-4 in 2008/9

found that only 3% of obese children did not have either overweight or obese parents (Healthy Weight, Healthy Lives).

Research shows that in overweight or obese households 24% of boys and 21% of girls are classified as obese compared to 11% of boys and 10% of girls in households where parents are underweight or have a normal Body Mass Index. In households where only the mother is overweight, the obesity prevalence is 15% for boys and 11% for girls. When only the father is overweight, the prevalence falls to 8% with boys and 6% with girls (APHR 2007/8, NHS Westminster).

Tackling obesity requires a whole family approach with all members of the family becoming more active and eating healthily (obesity toolkit).

As part of the National Childhood Measurement Programme (NCMP) NHS Westminster is required to weigh and measure all children in reception (age 4-5) and Year 6 (age 10-11). In the academic year 2007/08, 82% of reception children were measured, compared to 94% in 2006/7. Aggregated measurement results are communicated to individual schools and parents of individual pupils in reception classes are posted with child's measurement results. Information on where and how to seek assistance, information and specific services is a part of such communication.

Figure 29: National Childhood Measurement Programme – Reception year

	Underweight			Overweight			Obese		
	2005 /06	2006 /07	2007 /08	2005 /06	2006 /07	2007 /08	2005 /06	2006 /07	2007 /08
Westminster	Not Available	2.4%	2.1%	13.0%	11.4%	12.4%	13.4%	10.4%	11.8%
London		1.7%	1.8%	11.4%	12.0%	12.0%	10.7%	11.3%	10.9%
England		1.3%	1.3%	12.9%	13.0%	13.0%	10.0%	9.9%	9.6%

Source: National Childhood Measurement Programme, the Health and Social Care Information Centre

In 2007/08 the proportion of children measured in reception who were classified as being overweight and obese had increased since 2006/07, but it was not as high as the 2005/06 levels (13.4%). This might, however, reflect the different percentage of children measured each year rather than a real change in obesity levels. In 2007/08 a greater proportion of children in reception were obese compared to both London and England. (For further information on obesity see the NHS Westminster Annual Public Health Report on obesity, 2007/8).

The Health Survey for England 2006 found that children in semi-routine and routine households were nearly twice as likely to be obese when compared

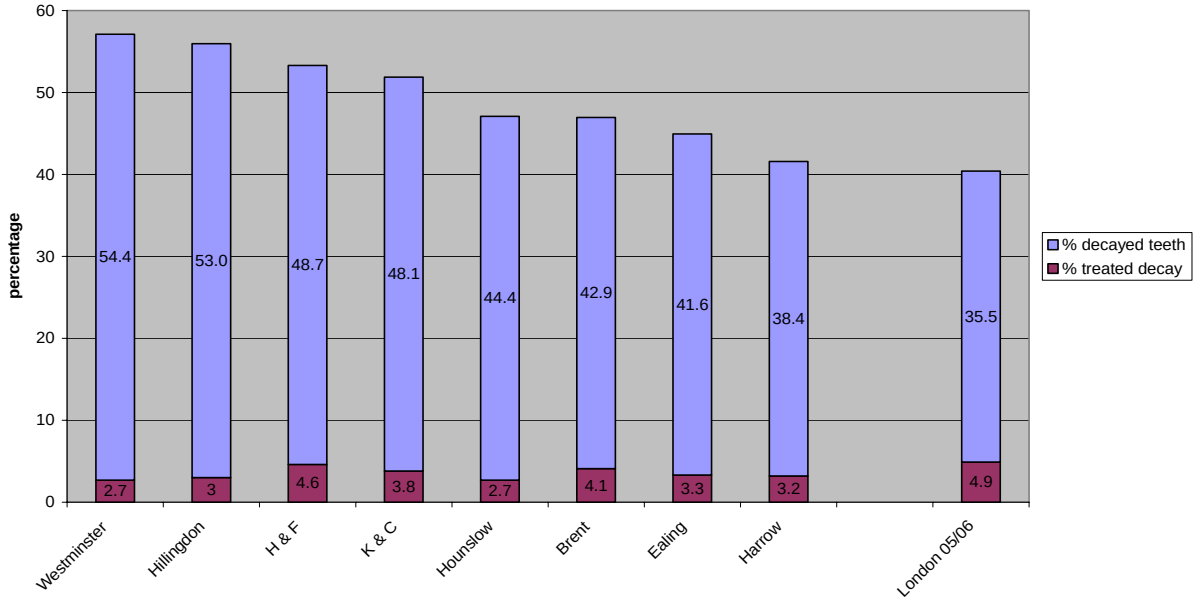
with those in managerial and professional households. (HSE 2006, Information Centre 2008)

Obesity and being overweight is also associated with certain ethnic groups. The Health Survey for England 1999 supplement on Ethnic Minority health showed that Black Caribbean, Indian, and Pakistani boys had higher rates of obesity or overweight than the general population. For girls higher rates were experienced by the Afro-Caribbean and Pakistani groups. Children of both sexes from Chinese backgrounds experienced lower levels of obesity or overweight; as did Bangladeshi boys. Differential rates of obesity and overweight amongst different ethnic groups have also been found by the national childhood measuring programme (HSE 1999, DoH 2001).

Frequent and high consumption of foods containing sugars is the main cause of **dental decay**. Children and young people may also experience erosion of their teeth mainly due to the consumption of excessive amounts of acidic fruit juices or fizzy drinks, including diet and sugar free varieties.

Westminster school children have a significantly higher rate of dental decay than the average for London and England; Westminster is amongst the 20% of Boroughs in the country with the highest rates of dental caries (tooth decay). The British Association for the Study of Community Dentistry (BASCD) survey of 5 year olds in 2005/6 found that more than half of the children in Westminster (57%) had experience of caries, compared to 40% in London and 38% in England. Only 2.7% of Westminster children were found to have dental caries that had been treated.

Figure 30: Decay experience in 5 year olds in PCTs in North West London (2005/6)



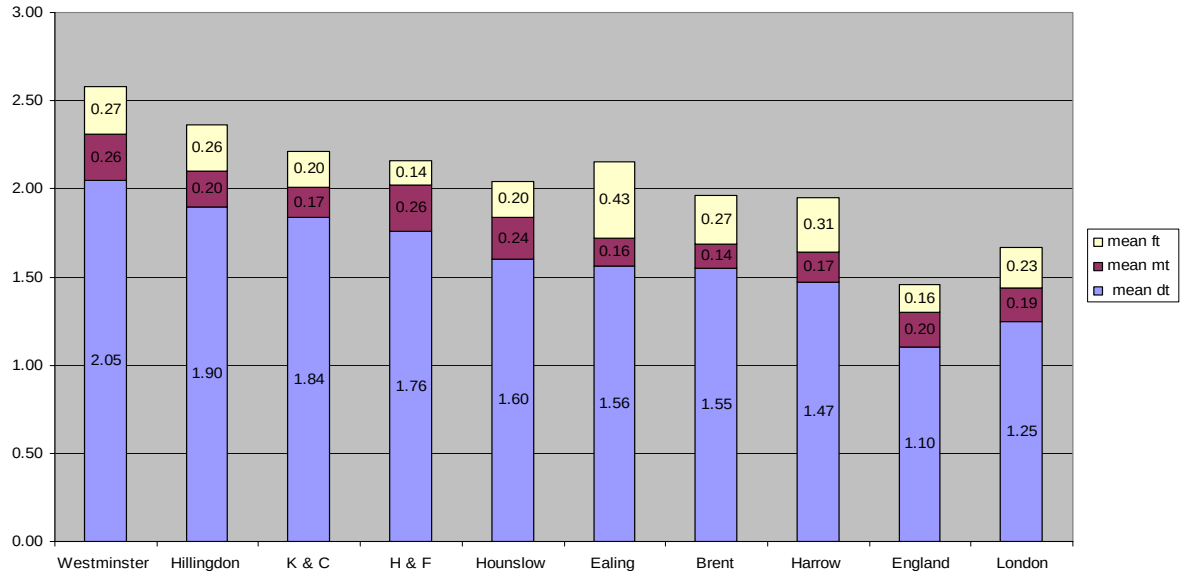
Source: British Association for the Study of Community Dentistry (BASCD) 2007

The average number of decayed, missing or filled teeth (dmft) across all children surveyed in Westminster was 2.58. In those children with decay experience, however, the average number of dmft was 4.51. This represents the highest number of mean decayed, missing and filled teeth in the North West London Sector.

The high level of tooth decay and untreated decay in Westminster may reflect the fact that certain communities do not place high importance on prevention, and only attend the dentist when they have an oral health problem which needs treating. It may also be that some dentists within the Borough are selecting adults in preference to children to deliver their activity.

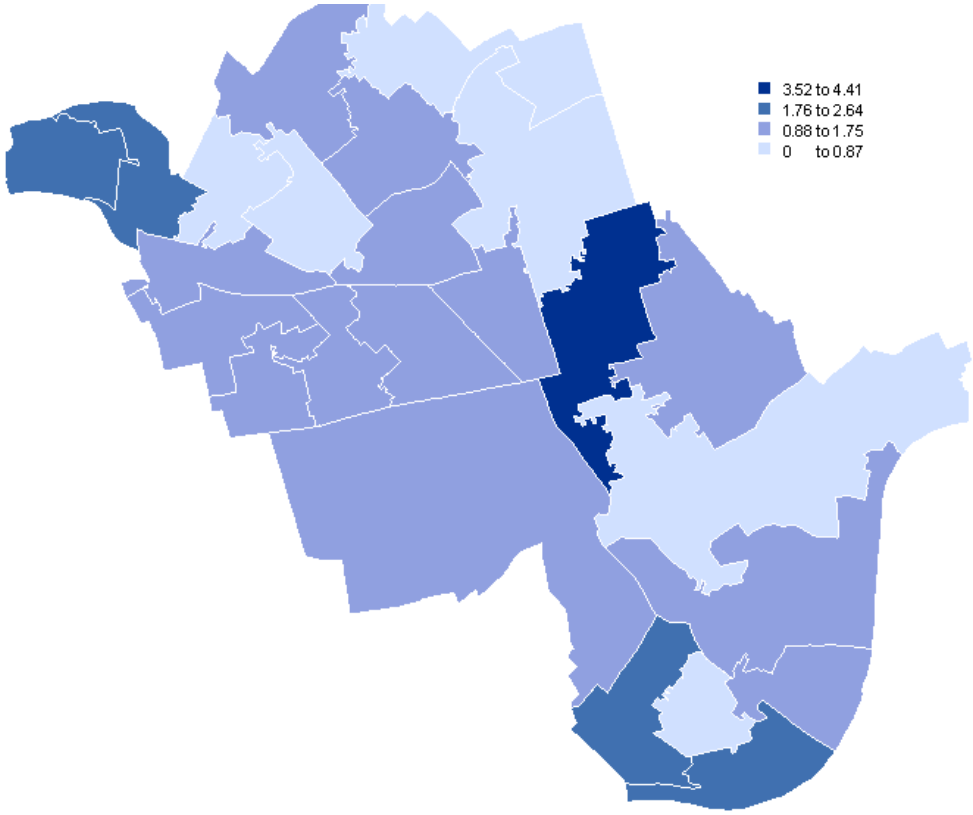
The levels of dental disease experienced by Westminster's children is very high in times when dental decay is almost entirely preventable.

Figure 31: Mean number of decayed (dt), missing (mt) and filled teeth (ft) of 5 year old children across PCTs in North West London 2005/6



Source: BASCD 2007

Figure 32: Mean numbers of decayed, missing and filled teeth in 5 year old children in Westminster wards (2003-05)



Source: British Association for the Study of Community Dentistry

Oral health inequalities persist across Westminster primary schools – the mean number of decayed, missing or filled teeth ranged from 1.6 to 5.4. The

map above shows the pattern of untreated decay in 5 year old children across Westminster wards.[18]

The map indicates a relationship between deprivation and tooth decay, with high levels of tooth decay being found in some of the more deprived wards including Tachbrook and Churchill wards in the south and Queen's Park and Harrow Road wards in the north of the Borough. The highest rates, however, were found in parts of Marylebone High Street and West End wards, which are less deprived.

The aggregate ward data reflects maintained primary school provision and depends on the catchment areas for those schools. In more affluent wards a higher proportion of children may be privately educated, and not therefore included in these figures. Furthermore, the small numbers of pupils mean that untreated decay in a few pupils in one school may strongly affect a whole ward's data.

Caries experience in primary dentition is higher among BME than in White groups, with numbers of decayed, missing or filled teeth (dmft) among Asian children being 1.5-2 times higher than in White groups (Bedi, 1989; Watt and Sheiham, 1999).

In 2008/09 2,575 children aged 0-4 years old accessed an NHS dentist in Westminster. This excludes children in Westminster who may access a private dentist or an NHS dentist in another area. Of those children, 65% (1,667) were Westminster residents. The age breakdown of Westminster children at date of acceptance on to the dentists' lists is shown in the table below.

Figure 33: Age breakdown of children accepted on Westminster NHS dentists' lists in 2008/9

Age at date of acceptance	Westminster children accessing	Westminster population	% 0-4 population accessing a Westminster dentist
0-1	56	2707	2%
1-2	205	2542	8%
2-3	351	2366	15%
3-4	484	2104	23%
4-5	571	1995	29%

Source: NHS Westminster; Greater London Authority RND 2008 Ward Population Projections PLD Low – for 2008

The proportion of Westminster children accessing a dentist in the Borough are low, particularly in the younger age groups. Some of Westminster children, however, may access a dentist in a different Borough or private dental care. It is recommended that children see the dentist as a minimum once a year. The

[18] This data is collected in Westminster primary schools where not all children will live in that ward, or even in the Borough necessarily.

recommended recall interval for children is between 4 and 12 months, compared to adults where it is 6-24 months. (NICE Dental Recall Clinical Guideline 2004)

There are differences in uptake of dental services among different ethnic groups in England. The Health Survey for England (2001) found that children in all minority ethnic groups, but especially Pakistani and Bangladeshi children, are less likely to have visited a dentist. Among those who had visited a dentist across all minority ethnic groups, the reason for the last visit was less likely to be for a routine check up, and more likely to be due to problems with their teeth, compared to the general population. Barriers to dental care include lack of information on availability of services, low priority given to oral health, language barriers, fear, and cost.

Dental caries can be entirely prevented through regular exposure to fluoride (such as fluoride toothpaste, fluoride varnish, mouthwash etc.) and the dietary restriction of foods and drinks containing non-milk extrinsic sugars. Marinho et al (2009) evidenced the effectiveness of fluoride varnish in reducing caries in primary dentition. In studies of 1,107 children there was a 33% reduction in decayed, missing or filled surfaces.

Caries are often linked to unhealthy lifestyle choices. Any oral health intervention should therefore aim to cure both the oral disease and promote healthier lifestyle choices. Oral health improvement should be integrated with other public health improvement programmes, for example, healthy schools, childhood obesity and early years nutrition.

NHS Westminster has developed a pilot pathway for children under the age of 5 which aims to:

- Improve the oral health of children through providing oral health advice and the application of fluoride varnish as a preventative measure
- Facilitate access to NHS dentistry in the area.

Delivery of the pathway is under pinned by:

- Creation of capacity to provide advice on healthy choices: this includes the dentist, dental nurses, utilising a local Children's Centre
- Creation of additional dental capacity tailored to children and their families: this includes contractual levers to ensure child friendly service
- Trageting children in an area with a large BME population

In anticipation that this pilot will be rolled out further across Westminster and in supporting efficiency gains in dental practices through a greater skill mix, NHS Westminster is also training a number of dental nurses in oral health promotion and the application of fluoride varnish.

A communications strategy has been agreed which will target mothers of children under the age of 5 years.

Vision screening *for all children at a young age is important, since the chance of some ocular anomalies being corrected increases the earlier they are detected before the age of 8.*

Conditions affecting vision and coordinated vision by both eyes occur in approximately 10% of children below 5 years of age. Early detection before the age of 5 followed by treatment (prescription glasses or an eye patch) can correct these. If these conditions are not corrected during the years of visual development (0-7 years) there can be permanent visual damage.[19]

The National Screening Committee recommends the following vision screening for all children:[20]

- By 72 hours after birth**-** as part of the routine newborn and infant physical examination (NIPE).

- At 6-8 weeks old **-** A repeat physical examination of that in the first few days. Additionally the ability to fix and follow should be ascertained.

- At 4-5 years old **-** All children should be screened for visual impairment between four and five years of age.

As part of the NHS Newborn and Infant Physical Examination (NIPE) at birth (before 72 hours) and at 6-8 weeks, newborn babies in Westminster have their eyes checked for congenital cataracts and eye abnormalities. Systems to pull together results and outcomes from these examinations are not currently in place but are being developed nationally.
http://newbornphysical.screening.nhs.uk

For children at local authority maintained primary schools whose parents consent to the entry health check, the child's vision will be screened by a trained school nurse. It is currently unknown what screening takes place in private schools. Locally data has been manually recorded for each child. From 2009-10 data will be entered on RiO making the assessment of the uptake of vision screening and the number of children with vision problems more accessible.

Parents may also choose to take their child independently to an optician at any stage in the child's development.

[19] Information from paper presented by Rowena McNamara, Consultant Orthoptist, Western Eye Hospital in January 2009, on 'Providing an Equitable Vision Screening Service for Children in North West London.'

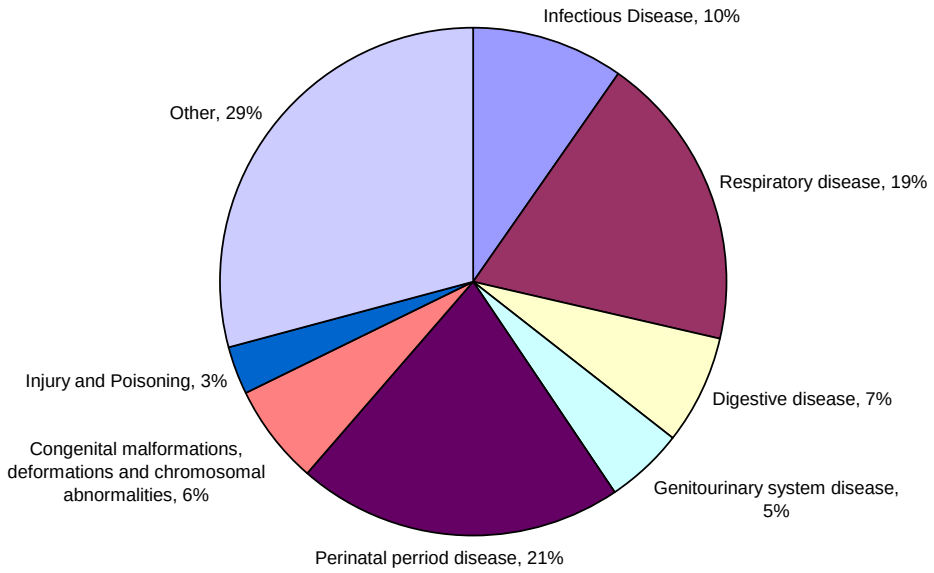
[20] Children at high risk of ocular conditions, e.g. those born prematurely, those with Downs syndrome and those with a relevant family history, will need more intensive monitoring.

All children aged under 16 are entitled to free eye checks on the NHS.

Between April 2007 and March 2008 6,678 children aged 0-15 years were examined in NHS opticians in Westminster. Of eye exams taking place in NHS opticians in Westminster, only 18% were for individuals aged 0-15, compared to 22% in London and 21% in England as a whole.

During 2005-2007, there were 1722 **emergency admissions** for babies under 1 year of age. Conditions occurring during the perinatal period (period just before to just after birth), such as birth trauma, birth asphyxia, congenital pneumonia) were the most common reason for admission, followed by respiratory disease.

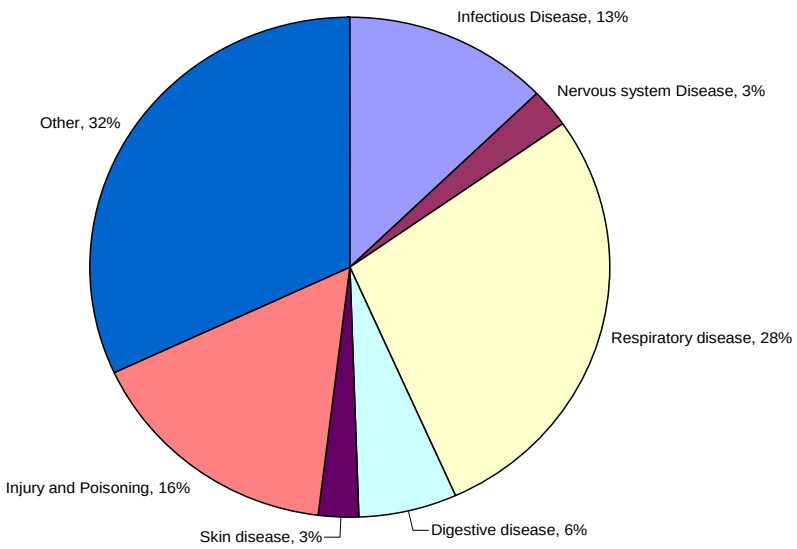
Figure 34: Emergency admissions to hospital, children aged under 1 year, Westminster 2005-2007



Source: Hospital Admissions Data, SUS (Secondary Use Service)

During 2005-2007, there were 2117 emergency admissions in children aged between 1 and 5 years of age. Respiratory disease was the most common reason for admission (26%) followed by injury and poisoning (16%).

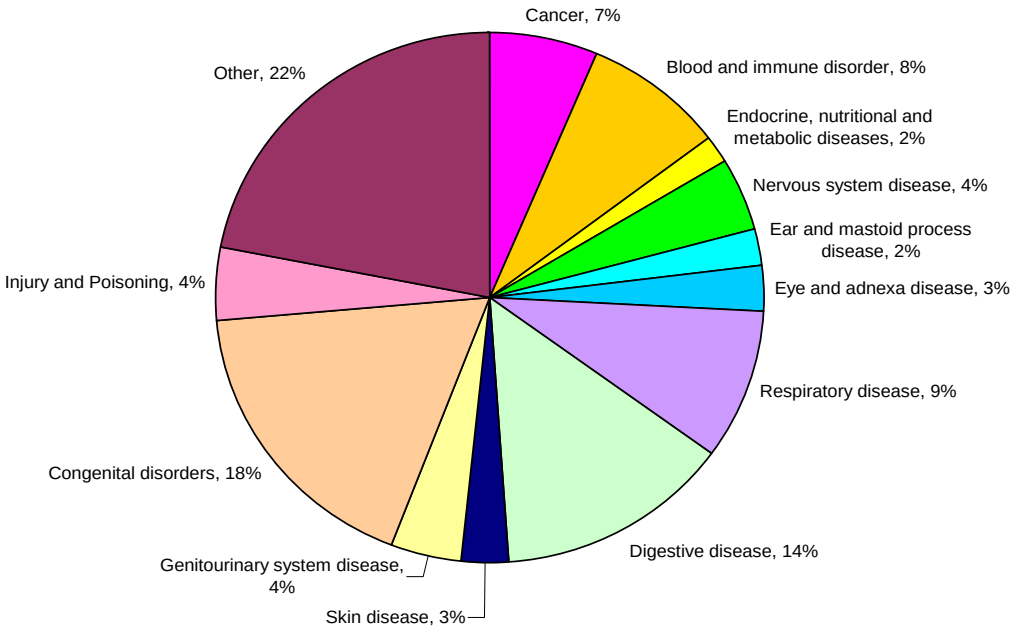
Figure 35: Emergency admissions to hospital, children between 1-5 years of age, Westminster 2005-2007



Source: Hospital Admissions Data, SUS (Secondary Use Service)

During 2005-2007 there were a total of 2501 **elective admissions to hospital** for 0-4 year olds in Westminster. Congenital malformations, deformations and chromosomal abnormalities were the most common reasons for admission followed by digestive disease.

Figure 36: Elective admissions to hospital for under 5 year olds, Westminster 2005-2007



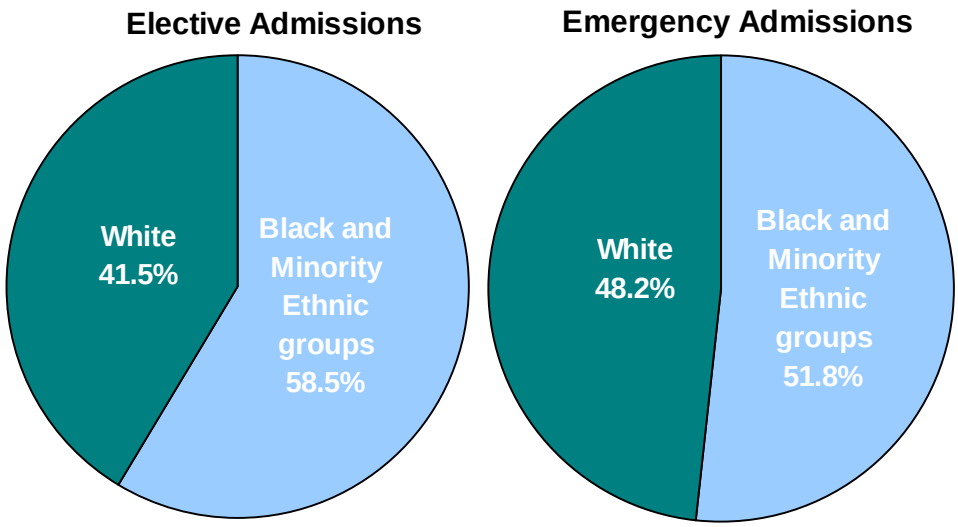
Source: Hospital Admissions Data, SUS (Secondary Use Service)

The high level of respiratory disease in children reflected here may relate to poor living conditions, such as overcrowding and dampness, which can

exacerbate and/or facilitate the spread and likelihood of a respiratory condition especially in childhood. Indoor and outdoor air pollution resulting mainly from smoking and car usage also has an adverse impact on respiratory disease. Inner city areas, such as Westminster suffer a high volume of traffic and a high density of population around busy roads.

Accidents are a leading cause of injury in children. Research has indicated that they disproportionately affect children from lower socio-economic groups. The physical environment in which a child lives can increase the risk of accidents. High-rise flats with communal stairs where stair-gates are not allowed, insecure windows, balconies, lack of public playgrounds, busy roads etc. (Child Accident Protection Trust). In Westminster in 2005-7, 3% and 16% of emergency admissions in under 1 year olds and in children aged between 1-5 years of age respectively, were for injury and poisoning. Although not all, some of these admissions will have been preventable.

Figure 37: Elective and Emergency hospital admissions for all diagnoses for 0-4 year olds in Westminster by ethnicity, 2008/9



Source: Dr Foster, output generated October 2009, Westminster registered population

Note – These pie charts contain data on known ethnicities. For elective admissions n=750, not including a further 135 unknown ethnicities (15% of total); for emergency admissions n=3997, with a further 225 unknown ethnicities (5% of total). BME groups here include the categories Bangladeshi, Indian, Pakistani, Other Asian, Black African, Black Caribbean, Other Black, Chinese, Other, Mixed White and Asian, Mixed White and Black African, Mixed White and Black Caribbean, and Other Mixed.

The GLA population projections estimate that around 50% of Westminster's population aged 0-4 is White, and the remaining 50% are from BME groups. Whereas the ethnic breakdown of emergency admissions in the 0-4 population is close to the overall population breakdown, proportionately more children from BME groups are attending hospital for elective admissions. (GLA 2007 Round Ethnic Group Projections - PLP Low - for 2008)

5. Childcare Settings and Educational Provision for 0-4 year olds in Westminster

5.1 Children's Centres

Children's Centres are service hubs that provide a range of services for children under five and their families. The Children's Centre programme is based on the idea that providing integrated education, care, family support, family learning and health services is crucial to increasing the well-being of children and their parents. Each Children's Centre has one or more outreach to provide a link between families and local services.

In Westminster there are 12 Children's Centres. Services available in Children's Centres can and do vary but all Children's Centres in Westminster deliver a 'core offer' to children and their families, including:

- Child and family health services
- Family support, including help with parenting skills
- Early learning and childcare
- Help for parents to get back to employment.[21]

Examples of services provided at Children's Centres include health visiting, speech and language therapy, housing advice, breast feeding support, dietetics, dental services and play sessions. The Children's Centres through the Early Access and Support Team (EAST) also work to identify as early as possible parents who have begun to disengage with services and consequently reduce their child's pre-school experiences.

E-Start data from 2008/9 shows that across the 12 Children's Centres 6,777 children and 6929 parents/carers accessed the different activities/ services offered, calculated by activity. It is likely, however, that some of these individuals/families accessed more than one activity during the course of the year therefore this number cannot be used to calculate the number of children and carers who accessed any activity across the Borough.

In terms of volume (defined as the number of contacts with families/children/carers counted as often as seen) the recorded activity is broadly evenly spread across the three Westminster localities (North West, North East and South) (Children's Centres Performance Report, 2008-9, Westminster City Council). That being so, in terms of reach (defined as the number of individuals seen counted only once) it would be useful to have further information around what proportion of families in the more deprived parts of the Borough are accessing Children's Centre services. It is also not

[21] Overview taken from *Children's Centres North Westminster: Handbook of activities and services for families with children under five years old, 2009* (Westminster City Council) and *Westminster Children's Centres: South Cluster Information Handbook 2009* (Westminster City Council)

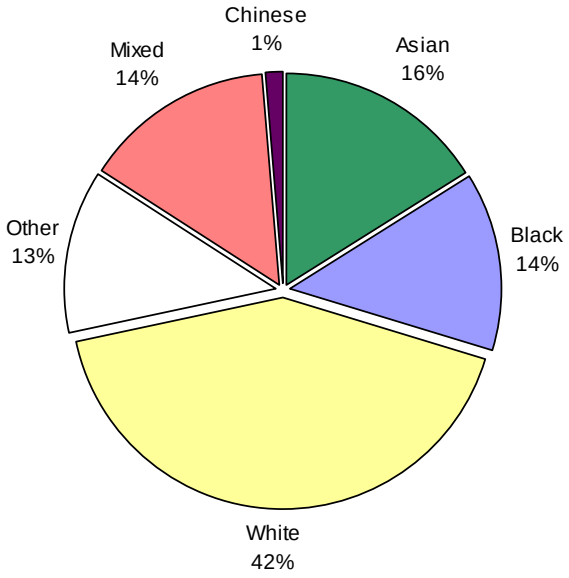
possible to draw any conclusions on issues relating to equity due to lack of suitable data.

Figure 38: Examples of activity and reach of Westminster Children's Centres in 2008/9

	Number of Children	Number of Carers
Baby-centred activities	173	206
Creches	91	26
Drop-ins	853	731
Stay and Play	100	103
Funtots	43	41
Creative play/ Music & me	31	24
Toy Library	165	167
Active Kids	89	88
Health visitor	90	90
Housing and benefits	11	66
Dietitian one to one	16	20
Antenatal Classes	-	44
Breastfeeding Support	-	9
Outreach 1st contact/1st visit/ home visits	949	1003
Outreach other	2975	3228
Other	1191	1083
TOTAL	**6777**	**6929**

Source: eStart database, Westminster City Council, report run 23 October 2009

Figure 39: Ethnicity of children aged 0-4 attending activities at Westminster Children's Centres in 2008/9



Source: eStart database, Westminster City Council, report run 23 October 2009

Of the 0-4 year olds attending activities at the Children's Centres in 2008/9, whose ethnicity is known (n=3,534), 42% were of a White ethnicity. Proportions of different ethnicities were broadly similar to the overall population breakdown. It is difficult, however, to provide direct comparisons as there was no category of 'Mixed' given in the GLA breakdown for 0-4 year olds (refer to figure 10). The majority of the Mixed ethnicities attending the Children's Centres were either White/Asian or White/Black. Ethnicity was unknown in 1,213 cases.

Nationally a Change4Life early years toolkit has recently been launched. The toolkit covers healthy eating and physical activity messages for toddlers and pre-school children and should be mailed to 3000+ Sure Start Children Centres and made available online for other providers.

The programme called Cook4Life that will focus on giving parents and families the confidence and skills to cook nutritious and tasty meals for under 5s will be delivered into Sure Start Children's Centres in early 2010.

5.2 Childcare settings

In April 2008 a new duty came into effect for Local Authorities to secure sufficient childcare to enable parents to work, or to undertake training leading to employment, under the Childcare Act 2006.

Childcare will only be deemed sufficient if it meets the needs of the community in general and in particular those families on lower incomes and those with disabled children.

The Childcare Act 2006 also re-enacts the duty for local authorities to secure a free minimum amount of early learning and care for all 3 and 4 year olds whose parents want it. Funded early education is delivered for 12.5 hours per week up to 38 weeks per year, moving to 15 hours per week across all early years settings in 2010.

Introduced in 2008, the Early Years Foundation Stage (EYFS) brought together: *Curriculum Guidance for the Foundation Stage* (2000), the *Birth to Three Matters* (2002) framework and the *National Standards for Under 8s Daycare and Childminding* (2003), building a coherent and flexible approach to care and learning. All providers are required to use the EYFS to ensure that whatever setting parents choose, they can be confident that their child will receive a quality experience that supports their development and learning. http://www.dcsf.gov.uk/everychildmatters/earlyyears/surestart/whatsurestartdoes/

Childcare Supply

Westminster City Council conducted an analysis of childcare provision across Westminster wards in 2009.[22] Although the findings are not yet finalised they give an idea of the number of places available and the types of provision within the Borough.

Figure 40: Providers and Ofsted Registered Places broken down by type and hours of provision, 2009

Type and hours of provision		No. of providers	No. of Ofsted registered places
Maintained	Maintained nursery schools/ nursery classes in schools	31 Nursery Classes in Schools / 4 Maintained nursery schools	948
Voluntary/ Private/ Independent	Full day care*	36	1686
	Sessional (mornings/ afternoons)	8	255
	Full school hours/ school hour mornings or afternoons	37	1249
Other childcare	Childminders	146 (this is now old data)	441

*This figure includes workplace nurseries
Source: Westminster City Council, 2009

[22] Data collection among the Private Voluntary and Independent (PVI) sector was done via a mixture of telephone survey (around 85-90% data collection) and websites in 2009. Not all providers supplied information for all questions so findings have to be considered as approximations.

Figure 41: Category and number of providers of early years places across the Borough, 2009

Type of provision	Number of providers
Maintained	35
Private/ Independent	44
Voluntary	26
Unrecorded	11
Childminders	146

Source: Westminster City Council, 2009

The total number of Ofsted registered childcare places (including childminders) available across Westminster is approximately 4500[23]. For each full-time place a childcare provider can offer 2 or more part-time places, increasing the potential number of children who can access childcare. Based on one child accessing 5 morning sessions, and another child accessing 5 afternoon sessions, there is 7300 available part time places across Westminster settings. Where providers are more flexible the number of these part time places can be increased further.

Of the 113 childcare settings[24] operating in Westminster across the Private, Voluntary, Independent and Maintained sector only 32 providers offer places to under 2s and a total of 71 settings cater for the 0-3 age range.

In Westminster there are currently childcare places for around 39% (full-time) or 60% (part time) of the population. (calculation based on ONS mid-year estimates 2007)

Childcare sufficiency requires there to be enough childcare provision to meet parental demand. A number of factors can impact on demand for childcare including; parental choice, faith, cost, location, Worklessness, attitudes towards childcare and the recession. Pre-school is not statutory education and in this way early education for 3 and 4 year olds, although part-funded by central government, is delivered as part of the childcare market and is supplied by childcare providers from the Private, Voluntary, Independent and Maintained sector. In this context demand and supply is very important in creating sustainable services for parents.

The 2009 GLA population predictions estimate that 4321 3-4 year olds reside in Westminster. This suggests that there are more than sufficient part time places for all children in this age group (GLA 2008 Ward Population Projections for 2009). However, this would be an unrealistic view of Westminster childcare and how it is delivered. Not all provision available would be used for the 3 and 4 year old group. Based on the premises and type of childcare being registered, Ofsted register an allocation of places for

[23] This was based on information available via a provider survey and on the Ofsted website. This does not include all of the information on the Independent sector.
[24] The number of providers varies as childcare settings close, open or vary their registration with Ofsted

different age groups. Many providers have vacancies for 3 and 4 year old as parents will often take a place in a maintained nursery class in the hope it will secure their child a place in the school. Many providers are therefore likely to be flexible with their delivery and change the number of 3 and 4 year olds or 0-3 year olds they can cater for dependent on demand. Many parents choose not to use any childcare which means that there does not need to be childcare places for 100% of the population. This would only lead to unsustainable services for parents. Not all the childcare places available to 3 and 4 year olds are offered as a free entitlement place and providers will not always facilitate parents coming only for a stand alone free early education place. Particular areas in Westminster have more sufficient childcare services to meet community need than others.

Across Westminster wards the number of children versus the number of childcare places varies between 1.4 children per place (Knightsbridge) and 5.6 children per place (Harrow Road)[25]. These estimates of coverage are based on the idea that all places in Westminster will be taken by Westminster children. Data from the most recent Early Years Census, however, showed that 36% (n=454) of children attending Westminster funded Private, Voluntary or Independent childcare settings across Westminster in January 2009 lived out of Borough (Westminster City Council). There will always be a cross borough flow of children accessing provision in neighbouring boroughs. Currently, City Council does not have enough information on the numbers of Westminster children that access provision in other boroughs, although it is expected that this will change in preparation for the Childcare Sufficiency Assessment 2011 which expects Boroughs to work together to share this information in order to understand sufficiency better.

In 2007-8 there were 1,310 full-time equivalent funded early education (free entitlement) places offered by providers in Westminster, filled by a total of 1,338 children. Knightsbridge and Belgravia, Abbey Road and Westbourne wards had the highest number of full-time equivalent places and take-up in Westminster. Of those 1,338 children taking up a place, 58% (775) were known to be from Westminster. The percentage of Westminster-resident children taking up an NEF place varied within Westminster. The wards with the highest number of non-Westminster resident children taking up a free entitlement place were Knightsbridge and Belgravia and Abbey Road, partly due to the higher levels of independent provision in those wards. A survey of 236 parents/carers as part of this assessment found that families with a parent/carer in work were more likely to access their free entitlement place. Free entitlement provision was less likely to be taken up by BME groups (Westminster 2007-8 Childcare Sufficiency Assessment, Westminster City Council).

In the survey[26] conducted as part of the Council's analysis of early year childcare in 2007/8 it was reported that 44.7% of parents used family and friends as childcare, and 43.2% used childcare that was paid for. (It was not,

[25] Population of Under 5s is based on the highest representation of under 5s between two data sources- child benefit data 2007 or mid 2009 population estimates (ONS 2007 data).
[26] There were 236 respondents to the survey.

however, reported how many children had free childcare and what proportion of children were cared for by a mixture of family and childcare settings). This was echoed in a recent parental survey of just over 100 parents where 42% did not use formal childcare, reasons for which included; not working / stay at home parent, use family and friends, cost of childcare is too expensive and children are still too young for childcare.

Sufficiency Action Plan: Redressing childcare availability gaps

- Early Years funding formula will increase the free entitlement offer for under 5s more and support a more flexible offer through a variety of childcare providers
- Start up and delivery of additional holiday childcare schemes for the 3-11 age group linked to Children's Centre and Extended Services delivery in 2010.
- Pilot 2 year old free entitlement to the 25% most disadvantaged groups.
- Develop an approved childminding network to increase childcare linked to Children's Centres and child poverty pilot activity.
- Commission childcare to support Child Poverty Pilots. Provider side supply subsidies to reduce childcare as a barrier to employment.

Childcare Affordability

Childcare in Westminster has evolved into a polarised market with provision being available to specific groups in the City.

Childcare in Westminster is typically expensive and private provision is mostly unaffordable to parents in low to intermediate paid jobs, and therefore serves the more affluent families in the City. There are a range of longstanding Private and Independent providers that have built their reputation and relationships with Westminster residents and have large waiting lists. In many cases these providers are term time only, charge on a termly basis even if a child leaves mid term, and usually have an associated deposit. Opening hours tend to reflect school opening hours, although there are Private, Independent and Montessori providers that will offer an extended day.

If roughly calculated as a weekly amount, costs in Westminster for this type of provision will range from £200 to £365 a week. These providers meet the demands of a specific cohort of parents and provide valued services in Westminster. They do not however provide childcare for intermediate or lower income families.

The more affordable and largely subsidised Voluntary providers are often located in areas which feature higher on income deprivation indices and support free access to childcare for children on a part time basis.

There is a large Voluntary sector in Westminster that deliver services on a not for profit basis. Nearly half of all the Voluntary providers in Westminster run on a sessional basis and during term time only. This means that they offer a morning session often between 9.30am and 12pm, and if they run an

afternoon session it will usually end at 3.30pm. Apart from the Maintained sector, these are the main deliverers of the free entitlement and will deliver this early education free to 3 and 4 year olds for 15 hours a week. Any additional hours taken is at a cost of approximately £40 a week. These are the most affordable providers in Westminster. They meet the needs of parents most at need (who are willing to take up formal childcare), but their delivery model does not reflect typical working hours and therefore does not support the needs of families where both parents are working.

Some providers in Westminster support the interim group, offering assisted places for parents who require financial assistance, and attempting to keep their costs more affordable for in-work parents. It remains difficult for these providers to deliver childcare affordably. In a central London environment where high staff and rental rates make the cost of delivery higher, a full day care full time childcare place for an under 2 year old costs an average of £260 per week. This can still be too expensive for parents on low and intermediate wages where Working Tax Credits are not being claimed.

There is significant maintained provision in Westminster for 3 and 4 year olds, which support the delivery of early years education (free entitlement). In turn this competition can affect the sustainability of the Private and Voluntary sector because a parent is more likely to take an early years place in maintained provision as soon as it becomes available.

The supply of affordable childcare is not enough to support parents in their back to work journey and in Westminster can represent a barrier to employment and successful outcomes for children.

Additional work is needed to:

- Engage with BME families to encourage the uptake of services available for under 5s.
- Explore ways of understanding latent demand and how additional services would encourage the take-up of formal childcare.
- Promote/ support back to work activity via family friendly initiatives which remove childcare as a barrier to employment. Westminster is piloting provider supply side subsidies linked to child poverty work to test how reducing the cost of childcare supports the back to work journey for low income and workless households.

Early Years Census

The Early Years Census is an annual statutory return made to the Department for Children, Schools and Families (DCSF) in January of each year. The Census covers any Private, Voluntary or Independent (PVI) setting where one or more children are in receipt of DCSF-funded early years education (Nursery Education Funding). Local Authority maintained nursery schools are not included. The maintained sector is included in the School Census. PVI settings where there are no funded children are not required to submit a return. Data is recorded on the number of children, their age and their ethnicity.

Figure 42: Westminster funded settings in the PVI sector and number of funded children attending, as at January 2009

PVI setting	Number of Settings	Number of Children
Private	26	491
Voluntary	27	315
Independent	12	442
Total	67	1248

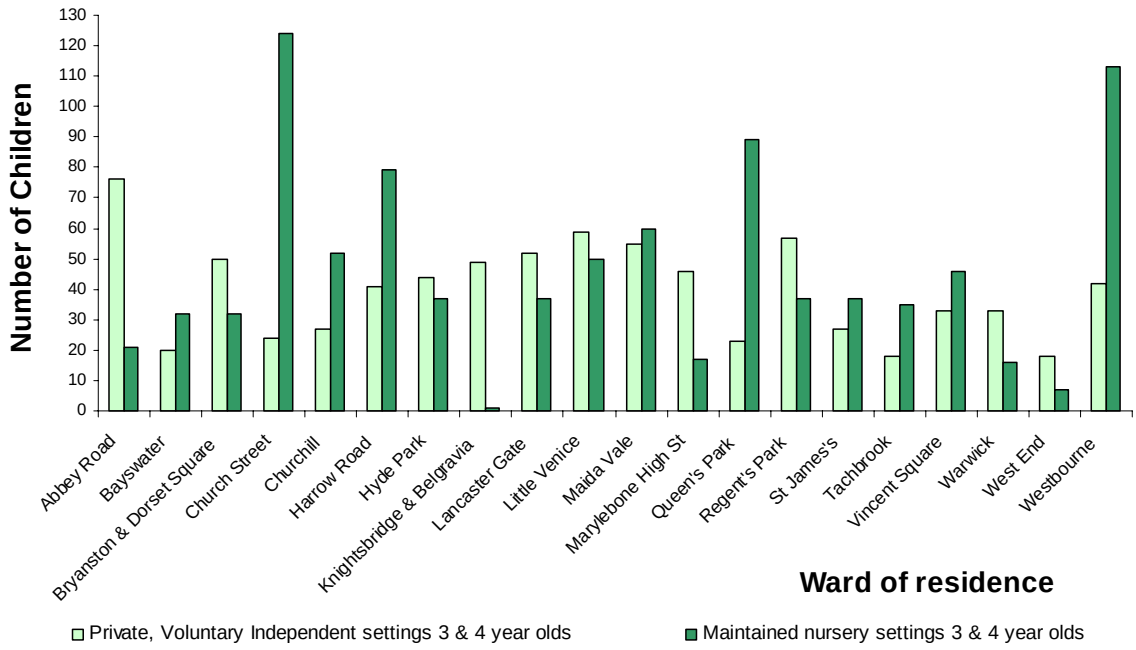
Source: Westminster City Council, Early Years Census Returns, January 2009

877 (70%) of the funded children covered in the Census were aged 3, and 371 (30%) aged 4. Of the 3-4 year olds attending the various PVI settings included in the Census, 794 (64%) lived in Westminster and 454 (34%) were from out of Borough.

The numbers of funded 3 and 4 year olds living in Westminster and attending PVI settings in Westminster varies by ward. Variation by ward is also shown by the School Census data, which includes 3 and 4 year olds attending Maintained settings. In Church Street, Harrow Road, Queen's Park, Westbourne, and to a lesser extent Churchill, wards it is noticeable that a much larger number of funded children were attending Maintained settings in comparison to PVI settings.

It should be noted that this data does not capture all 3 and 4 year olds attending early years childcare settings within Westminster; for example, the Early Years Census only captures children attending PVI settings where there are funded children. Some children attending other settings in Westminster, or out of Borough, may be missed in these two censuses. Therefore, from the available data it is not possible to know how many children are not included in the two census and why.

Figure 43: Numbers of 3 & 4 year olds attending PVI or Maintained nursery settings captured by the Early Years Census and School Census 2009 by Westminster ward of residence

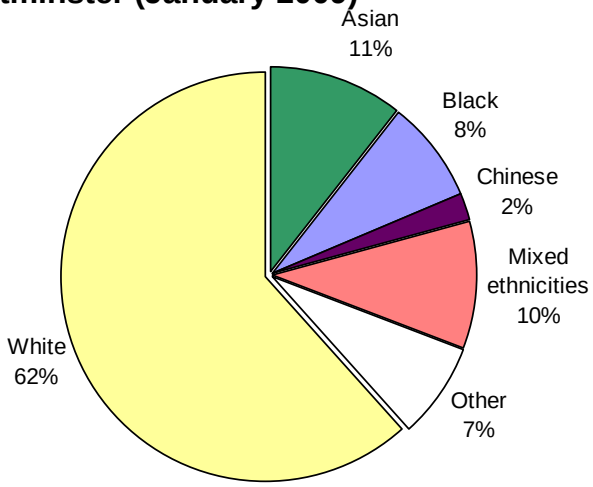


Source: Early Years Census and School Census Returns, January 2009, Westminster City Council

Note: n=922 for the Maintained sector and n= 794 for PVI sector. An additional 454 children from out of borough attended the PVI sector and 114 children attended the Maintained sector.

The ethnic breakdown of funded 3-4 year olds attending a PVI setting in Westminster indicates a potential under-representation of children from BME groups compared to the figures given in the GLA population estimates by ethnicity for 0-4 year olds. This may reflect a difference in uptake of funded childcare places in these groups compared to the White population in Westminster. This was something noted in the 2007-8 Westminster Childcare Sufficiency Assessment (see above). It may however merely relate to the fact that the two data sets cover different age groups, and that the GLA population estimates do not accurately reflect our current population profile.

Figure 44: Ethnic breakdown of funded children attending PVI sector providers in Westminster (January 2009)



N=1048 (does not include the 220 pupils whose ethnicity was unknown)

Source: Early Years Census Return, January 2009, Westminster City Council

5.3 Educational attainment

The Early Years Foundation Stage (EYFS) became statutory in September 2008. It is the new regulatory and quality framework for the provision of learning, development and care for children between birth and the academic year in which they turn five (0-5). Since September 2008 all registered early years providers have been required to complete an EYFS profile for each child at the end of the academic year in which they reach the age of five.

The primary purpose of the Early Years Foundation Stage Profile (EYFSP) is to provide year 1 teachers and parents with reliable and accurate information about each child's level of development as they reach the end of the EYFS. This is to enable the year 1 teacher to plan an effective, responsive and appropriate curriculum that will meet all children's needs, to support their continued achievement more fully.

Each child's development should be recorded against 13 assessment scales, based on the early learning goals and divided between the six areas of learning and development. Judgements against these scales should be made from observation of consistent and independent behaviour, predominantly from children's self-initiated activities. Observations should come from a variety of practitioners, with parental and child contributions equally valued. The judgements should be accurate and consistent for all settings. The Local Authority has a process of external moderation and training which supports more robust and accurate judgements and data collection.

There are six areas covered by the early learning goals and educational programmes:

- Personal, Social and Emotional Development;

- Communication, Language and Literacy;
- Problem Solving, Reasoning and Numeracy;
- Knowledge and Understanding of the World;
- Physical Development;
- Creative Development.

In 2009, 65.7% of children at the end of Reception year at Westminster's state primary schools had achieved the expected minimum level of the EYFSP (a score of 78+ across the 13 early learning goals). This was an increase of eight percentage points from the previous year. These average scores for Westminster, however, mask the large variations by school in the number of children entering year 1 who had achieved these minimum levels (Westminster City Council).

Whilst the majority of schools which had higher percentages of children meeting the minimum level of the EYFS were in more affluent wards, this was not exclusively so. Children who do not achieve the minimum level of the EYFS may be starting primary school at a disadvantage compared to their peers. This difference may also increase the work schools with lower numbers of children achieving the minimum EYFS level must do to enable all children to achieve key stages 1 and 2. However, there is no statistical correlation between EYFSP scores and achievement at KS1.

Average performance improved across all early learning goals between 2008 and 2009. Performance, however, varies across the different goals, with lower scores reported particularly around reading, writing and calculating. This is also true nationally.

Figure 45: Percentage of pupils achieving 6+ at each assessment scale

Key areas	Goals	2008	2009
Personal, Social and Emotional Development	Dispositions and Attitudes	79.5	83.3
	Social Development	72.1	74.9
	Emotional Development	64.5	68.9
Communication, Language and Literacy	Language for Communication and Thinking	64.4	74.2
	Linking Sounds and Letters	63.8	71.3
	Reading	57.9	64.3
	Writing	52.4	59.2
Problem Solving, Reasoning & Numeracy	Numbers as Labels and for Counting	86.1	88.4
	Calculating	55.3	63.8
	Shape, Space and Measures	67.7	73.4
Knowledge and Understanding of the World	Knowledge and Understanding of the World	63.8	71.7

Physical Development	Physical Development	74.1	80.6
Creative Development	Creative Development	72.6	76.9

Source: Westminster City Council, EYFSP data, 2009

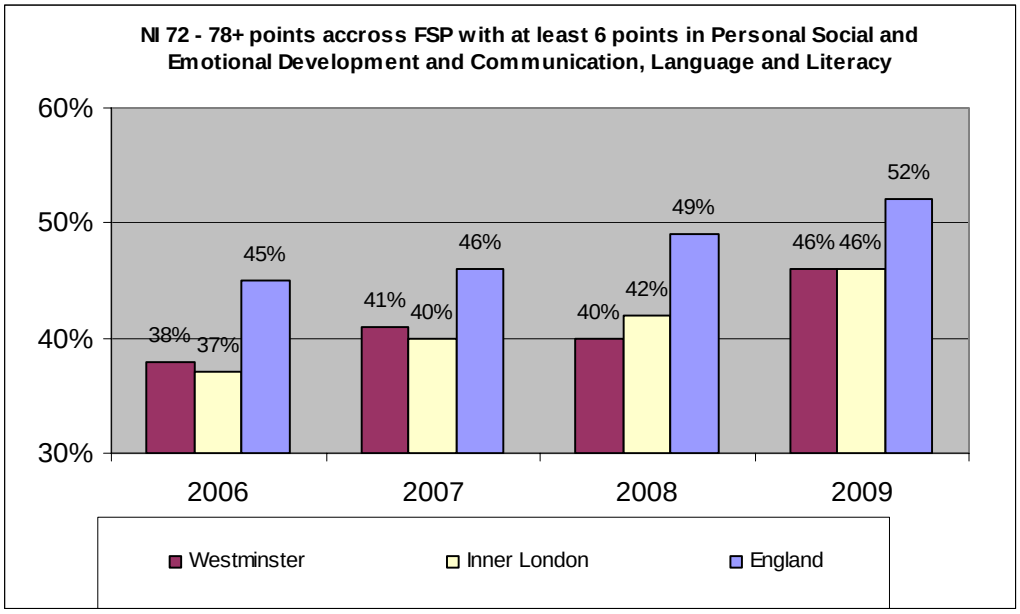
There are two national indicators and DCSF targets around the EYFS:

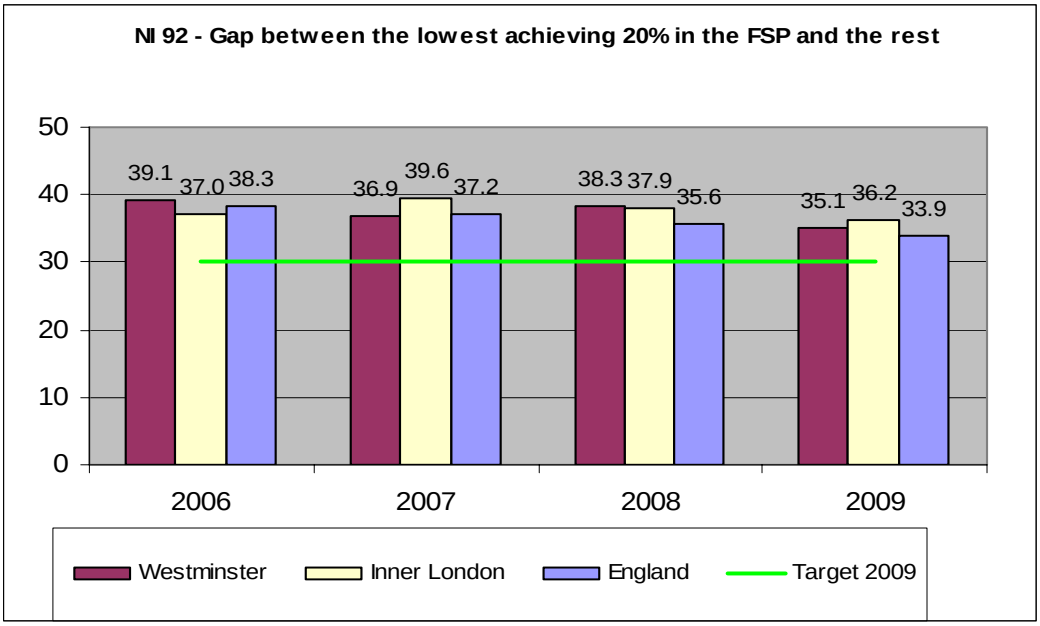
- National Indicator 72: Achievement of at least 78 points across the Early Years Foundation Stage Profile with at least 6 points in each of the scales for Personal Social and Emotional Development and Communication, Language and Literacy.

- National Indicator 92: Narrowing the gap between the lowest achieving 20% in the Foundation Stage Profile and the rest of the cohort.

As the graphs below show performance on both indicators has improved over the last few years. Fewer pupils are achieving 78+ points across EYFSP than England, but performance in this area is similar to that across Inner London. Westminster has not reached its target for 2009 in national indicator 92. Although performing marginally better than Inner London, the gap between the lowest achieving 20% and the rest of the cohort in 2009 is greater than England.

Figure 46: Reported performance for Early Years Foundation Stage Profile national indicators, compared to Inner London and England, 2006-2009





Source: Westminster City Council, EYFSP data, 2009

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