Public Health England

Protecting and improving the nation's health

Reducing child mortality in London

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Contents

Background

- Although there have been significant reductions in child deaths in the past three decades in England, **too many children are still dying unnecessarily**

- If the UK had the same childhood mortality for children aged 0-14 years as Sweden there would be **five fewer child deaths every day** and about **1,951 fewer child deaths every year**

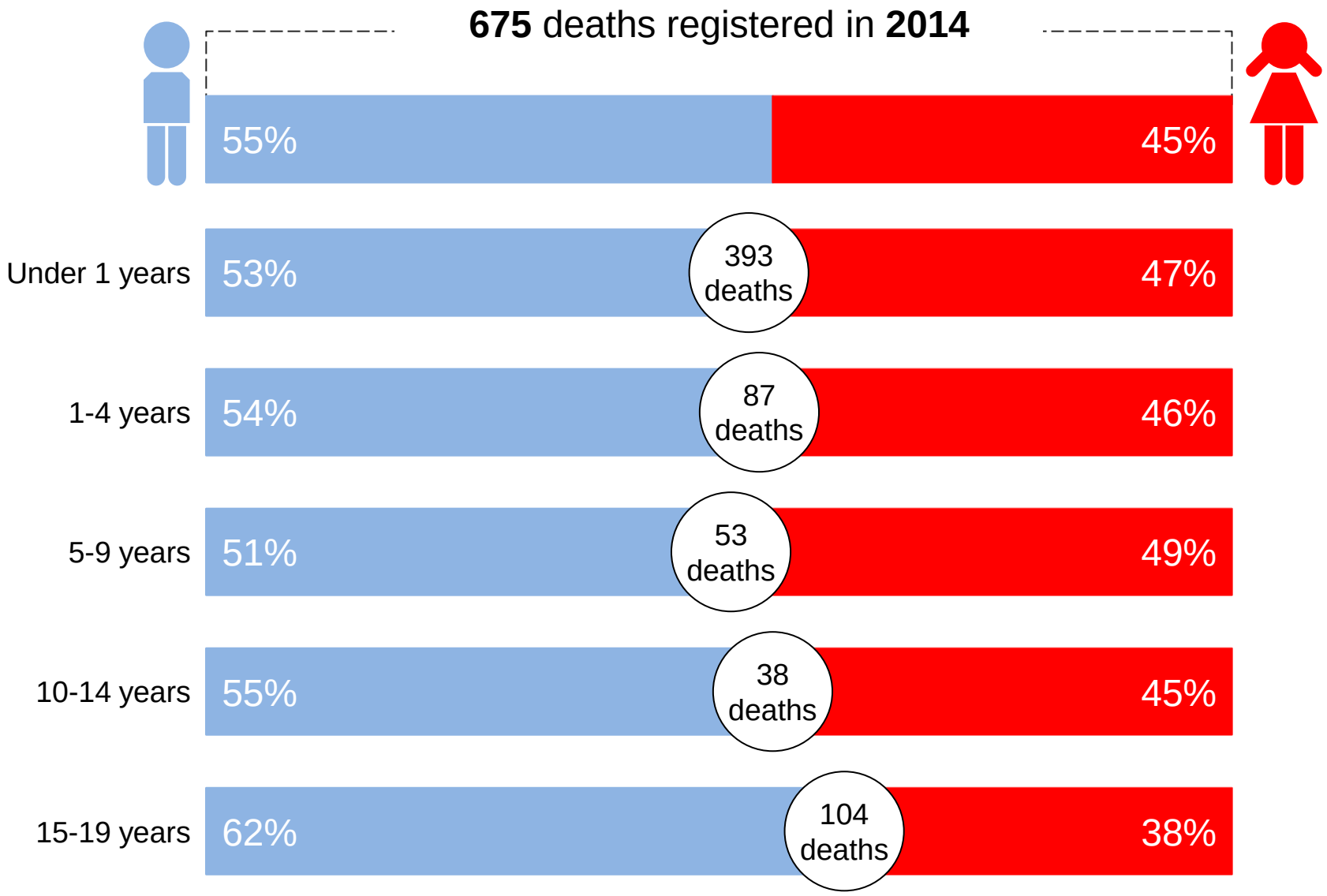
- In 2014, almost **one in three** child deaths in England and Wales was avoidable

- In 2015, about **one in four** child death reviews in England was identified by CDOPs as having a modifiable risk factor

- **675** children and young people (CYP) aged 0-19 years died in London in 2014

Wolfe I, Thompson M, Gill P et al. Health services for children in western Europe. *The Lancet* 2013; 381(9873):1224-34
Department for Education (2015) *Child Death Reviews – Year ending March 2015*

Key child mortality statistics for CYP in London



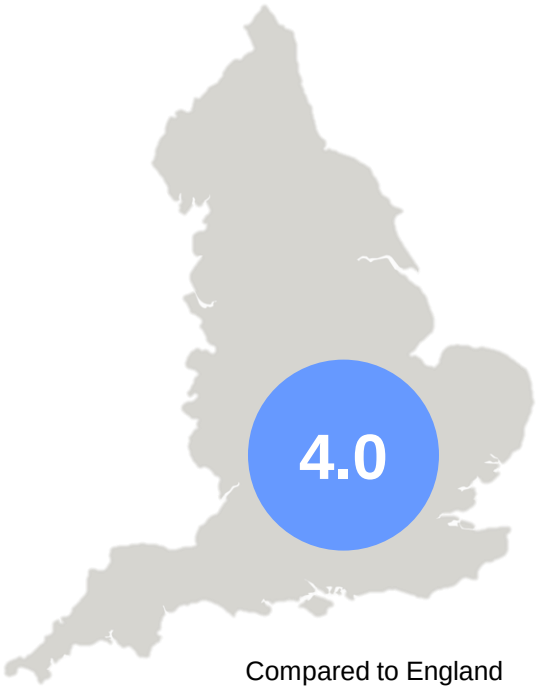
Source: ONS

Key child mortality statistics for CYP in London (2011-13)

Infant mortality

3.8

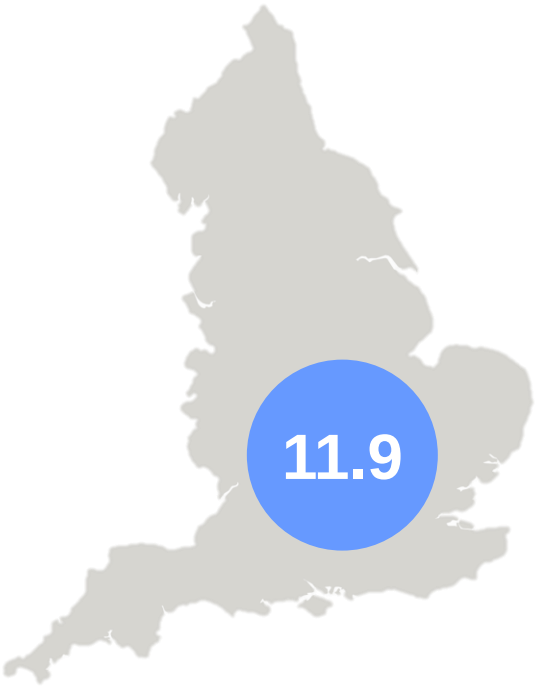
per 1,000 live births of infants under one year of age in **London** compared with the England average of



Child mortality

12.2

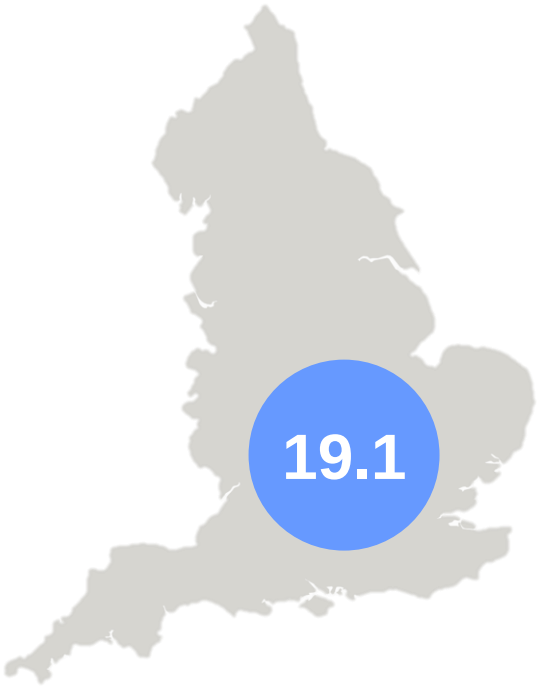
per 100,000 people aged one to 17 years in **London** compared with the England average of



Children killed or seriously injured in road traffic accidents

13.7

per 100,000 people from 0-15 years in **London** compared with the England average of

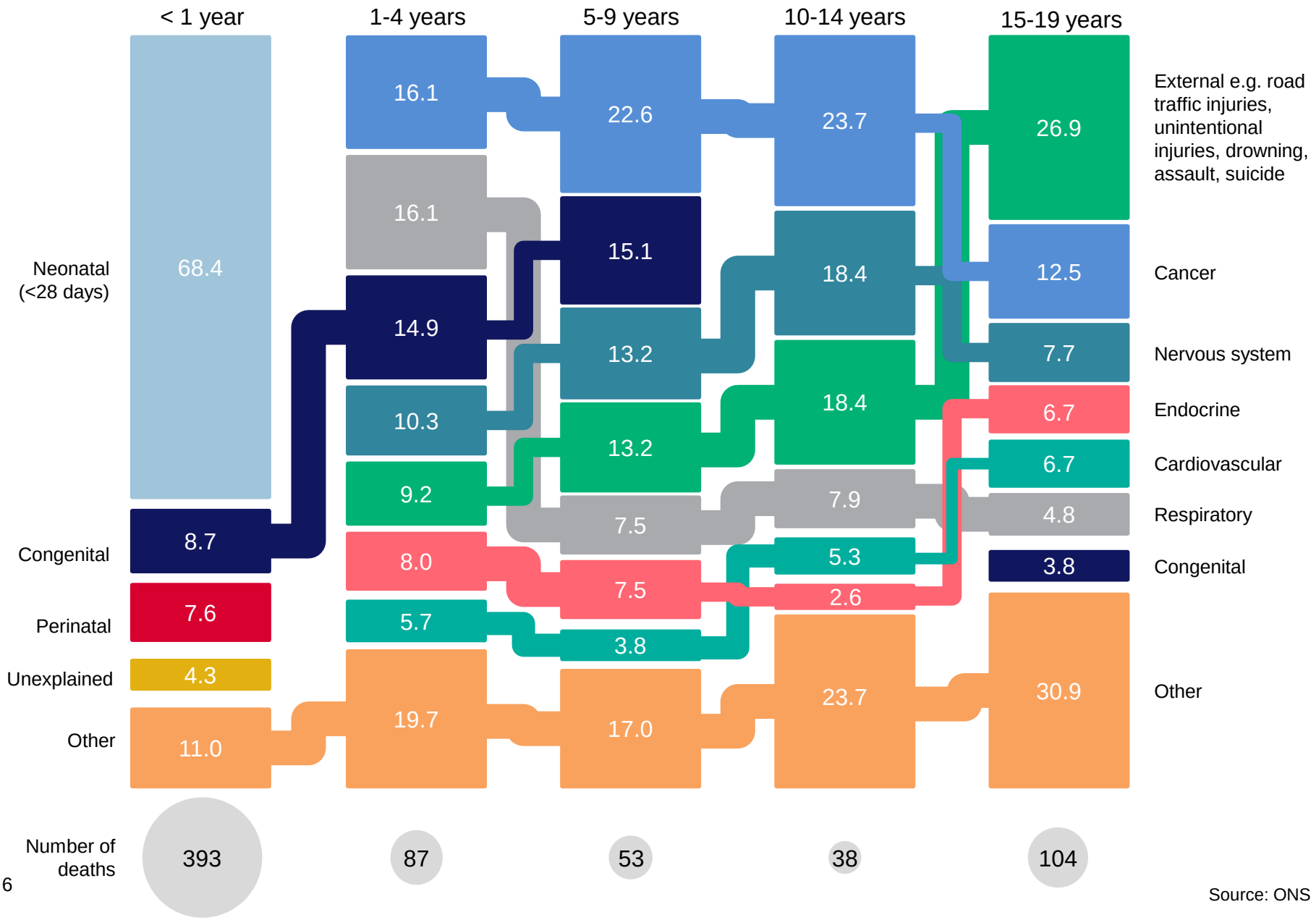


Compared to England

Better | Similar | Worse

Source: www.fingertips.phe.org.uk

Causes of deaths (%) of CYP in London (2014)

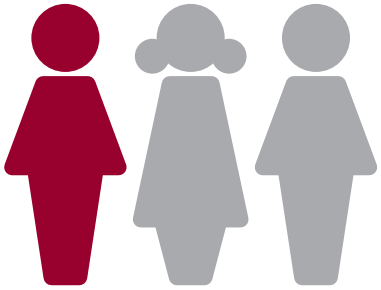


Source: ONS

Avoidable child deaths in England and Wales in 2014

In 2014 almost

1 in 3



child deaths in England and Wales was **avoidable***

72 years

of potential life is lost on average for each person aged 0 to 19 who died from avoidable* causes

Top **six** causes of **avoidable*** deaths in children and young people (aged 0 to 19 years)

Accidental injuries
13.5%

Complications of perinatal period
13.3%

Suicide and self-inflicted injuries
12.6%

Transport accidents
12.2%

Infectious diseases
11.2%

Congenital malformations of the circulatory system
9.9%

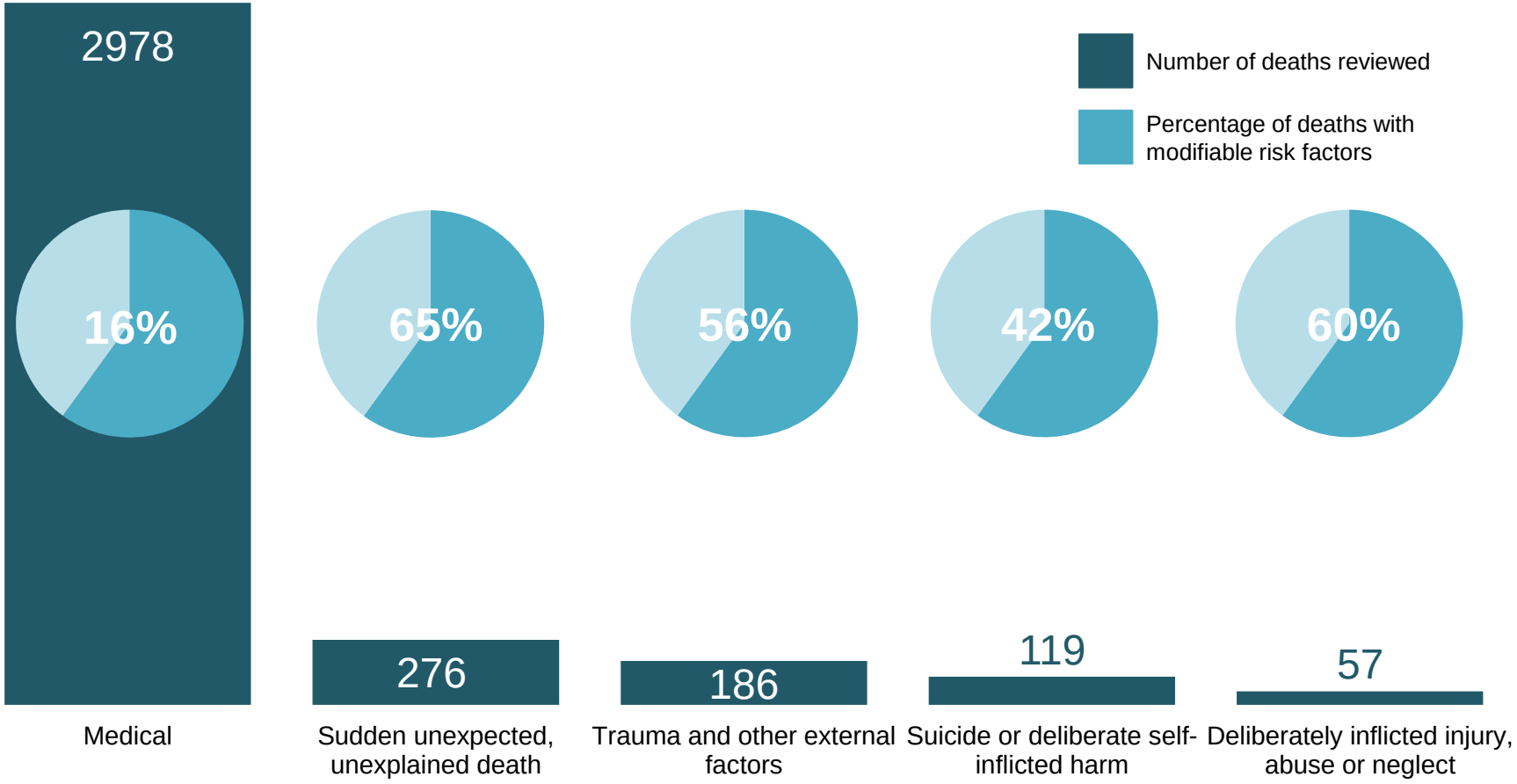
The leading causes of **avoidable** deaths in children and young people were **non-chronic conditions**

*Avoidable deaths are all those defined as preventable (could be avoided by public health interventions), amenable (could be avoided through good quality healthcare) or both, where each death is counted only once

ONS (2016) *Avoidable mortality in England and Wales 2014*

National CDOP data - year ending 31 March 2016

- The following chart shows the number of reviews for each category of death together with the proportion of these deaths with modifiable risk factors
- **Medical** causes accounted for **82%** of all deaths, **16%** of these deaths had modifiable risk factors compared to **non-medical** causes, which accounted for **18%** of all deaths but **57%** of these deaths had modifiable risk factors



Department for Education (2016) *Child Death Reviews – Year ending 31 March 2016*

Actions to reduce child death - overview

Risk factors for child deaths include:

Factors intrinsic to the child

- Prematurity
- Chronic illness

Factors around parental care

- Basic care of child
- Responding to health needs
- Parental smoking

Environmental factors

- Parental age
- Social class
- Housing

Service need and provision

- Unmet medical needs
- Inadequate health care
- Lack of support services

Actions to reduce child deaths

Reduce health inequalities

Provide **safe environments** for children and young people inside and outside their homes

Optimise maternal physical and mental health before, during and after pregnancy

Increase uptake of child immunisations

Better training of healthcare staff to improve the recognition of serious illnesses

Communication with families to spot the signs of illness or failing health

Useful resources

- ✓ Fraser J, Sidebotham P, Covington T et al The Lancet 2014:384;894-902 Learning from child death review in the USA, England, Australia and New Zealand
- ✓ Sidebotham P, Fraser J, Fleming P et al The Lancet 2014:384; 904-914 Patterns of child death in England and Wales
- ✓ Sidebotham P, Fraser J, Covington T et al The Lancet 2014: 384;915-927 Understanding why children die in high income countries
- ✓ Wolfe I, Marcfarlane A, Donkin A et al on behalf of RCPCH,NCB, BACPH (2014) Why children die: death in infants, children and young people in the UK
- ✓ Local authority child health profiles: atlas.chimat.org.uk/IAS/dataviews/childhealthprofile

References

- Department for Children, Schools and Families (2007) Patterns and causes of child deaths: Information sheet
- Department of Health (2007) Review of the Health Inequalities PSA Target
- Korkodilos M, Cole M (2016) The health and wellbeing of children and young people in Barking & Dagenham, Havering and Redbridge

Actions to reduce child death - reducing infant mortality

Risk factors for infant mortality include:

In 2014, the infant mortality rate (IMR) was **28x higher** for **low birth weight** babies than for babies of normal birth weight

The IMR for babies born to **teenage mothers** is **44% higher** than mothers aged 20-39

In 2014, the IMR was **2.5x higher** in babies in families in the **routine and manual** group compared with those in higher managerial and professional groups

In 2014, the IMR of babies of mothers born in **Pakistan** was **2.1x higher** than babies of mothers born inside the UK

Actions to reduce infant mortality

Co-ordination and leadership
Vital for an effective cross-agency approach

Commissioning
Integrated commissioning to ensure a whole systems approach

Communication
Understand the preferences and needs of the local population

Care pathway development
Vital to support sustained improvements in service delivery and quality

Useful resources

- ✓ University of Oxford, National Perinatal Epidemiology Unit (2015) Inequalities in Infant Mortality Work Programme
- ✓ Royal College of Paediatrics and Child Health and National Children's Bureau (2014) Why children die: death in infants, children and young people in the UK Part B
- ✓ National Institute for Health and Care Excellence (2014) clinical guideline 37 Postnatal care
- ✓ National Institute for Health and Care Excellence (2014) NICE guideline PH26 Quitting smoking in pregnancy and following childbirth

References

- ONS (2016) Statistical Bulletin. Childhood mortality in England and Wales: 2014
- PHE London (2015) Reducing infant mortality in London: an evidence-based resource

Actions to reduce child death - improving communication

Good communication with families and between professionals is an **essential** component of high-quality care

Factors contributing to poor communication include:

Individual ability
Human factors that influence the effectiveness of communication include skills and ability, attitude, stress, distractions

Team behaviours
Role confusion and professional conflict

Organisational
- Working arrangements creating barriers to effective communication
- A lack of staff and inadequate resources

Actions to improve communication

Families
Clear information given to families in a manner they can understand

A clearly documented information 'passport' for children with long-term conditions

Organisational
Make effective communication an organisational priority

Tools
These include:
- The 'SBAR' (Situation, Background, Assessment, Recommendation) tool
- Clinical handover routines
- Safety briefings

Useful resources

- ✓ patientsafety.health.org.uk/resources?f[0]=field_tags:58&f[1]=field_area_of_care:22
- ✓ www.institute.nhs.uk/safer_care/safer_care/Situation_Background_Assessment_Recommendation.html

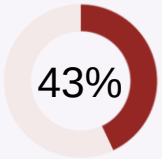
References

- Child Health Reviews UK (2013) Co-ordinating Epilepsy Care: a UK-wide review of healthcare in cases of mortality and prolonged seizures in children and young people with epilepsies
- National Children's Bureau (2008): a shared responsibility safeguarding arrangements between hospitals and children's social services
- Lim I (2014): effective communication among healthcare workers to improve patient safety and quality
- RCOG (2010): improving patient handover

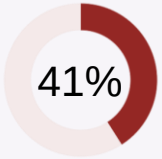
Actions to reduce child death - Improving quality

All CYP are entitled to receive **appropriate** healthcare wherever they access it. In a national survey of CYP and their families:

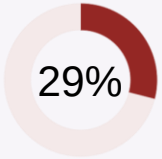
of 8-15 year olds felt that staff did everything they could to help control their pain



of 12-15 year olds were not fully involved in decisions about their care



of parents and carers felt that staff were not always aware of their child's medical history before treating them



of parents and carers did **not** feel that staff 'definitely' knew how to care for their child's individual or special needs

The six domains to improve quality

1. **Safe care** through training, continued education, strong leadership and sharing good, safe practice
2. **Effective care** through evidence-based practice
3. **Person-centred care** to ensure the person and their family are involved in decisions about their care
4. **Timely care** delivered at the right time, by the right person, with minimal delays
5. **Efficient care** to allow redistribution of resources to get greater value of the resources committed to delivering care
6. **Equitable care** to maintain the same quality of care regardless of the varying personal characteristics of patients

Useful resources

- ✓ www.improvement.nhs.uk
- ✓ www.rcpch.ac.uk/improving-child-health/quality-improvement-and-clinical-audit/quality-improvement-and-clinical-audit

References

- Care Quality Commission (2015) Children and young people's inpatient and day case survey 2014
- RCPCH (2015) Quality improvement in child health: strategic framework

Actions to reduce child death - reducing SUDI

Every **11** days in London a baby dies from SUDI* risk factors include:

Low birth weight
5x higher risk

Smoking
5x higher risk

Deprivation
3.5x higher risk

Bed sharing
2.7x higher risk

Mothers <20 years
2.5x higher risk

Actions to reduce SUDI

Ensure safer sleeping practice for babies

Reduce parental smoking

Encourage and support mothers to breastfeed

Change knowledge and behaviour through clear communication of risk factors

Useful resources

- ✓ www.bestbeginnings.org.uk/babybuddy
- ✓ www.gov.uk/government/uploads/system/uploads/attachment_data/file/431396/London_sudden_deaths_in_infancy_update_factsheet.pdf
- ✓ www.lullabytrust.org.uk
- ✓ National Institute for Health and Care Excellence (2014) NICE guideline PH26 Quitting smoking in pregnancy and following childbirth
- ✓ Public Health England London (2014) The health and wellbeing of children and young people in London: an evidence-based resource

References

- PHE London (2015) Reducing infant mortality in London: an evidence-based resource

*SUDI: Sudden Unexpected Death in Infancy

Actions to reduce child death - reducing suicides

149 children aged 10-19 years in England committed suicide in 2014, almost **three** children every week

Risk factors include:

Biological

- Family factors eg mental illness or history of suicide
- Physical illness and long-term conditions

Psychological

- Alcohol or drug abuse
- Bereavement and experience of suicide
- Mental ill health, self-harm and suicidal ideas
- Social isolation or withdrawal

Environmental

- Abuse and neglect
- Bullying
- Suicide-related internet use
- Academic pressures related to exams

Actions to reduce suicide

Tailor approaches to improvements in mental health

Reduce access to the means of suicide

Support the media in delivering sensitive approaches to suicide

Support research, data collection and monitoring

Provide better information and support to those bereaved or affected by suicide

Useful resources

- ✓ www.gov.uk/government/collections/suicide-prevention-resources-and-guidance
- ✓ www.supportaftersuicide.org.uk/
- ✓ www.samaritans.org/about-us/our-organisation/national-suicide-prevention-alliance-nspa
- ✓ www.beatbullying.org/dox/resources/resources.html
- ✓ www.stonewall.org.uk/at_school/education_for_all/default.asp

References

- Butterworth S, Suicide and self-harm in young people: risk factors and interventions
- Department of Health (2012) Preventing suicide in England: a cross-government outcomes strategy to save lives
- National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (2016) Suicide by children and young people in England

Actions to reduce child death - home safety

Unintentional injuries in and around the home are a **leading** cause of **preventable** death and a **major** cause of ill health and disability

Every year over **62** children under 14 die as a result of an accident in the home

Over **76,000** children under the age of 14 are admitted for treatment

Each year about **two million** children under the age of 15 are taken to A&E after being injured in or around the home

Risk factors for unintentional injuries include age < 5 years, boys and deprivation

£15.5-87 million
Estimated annual hospital costs of severe, unintentional injuries to children

Actions to improve home safety

Environment
Improvement in planning and design results in safer homes and leisure areas

Education
Increasing the awareness of the risk of accidents in a variety of settings and providing information on ways of minimising these risks

Empowerment
Accident prevention initiatives, which have been influenced by the community, are more likely to reflect local need and therefore encourage greater commitment

Enforcement
Child safety legislation. Local councils assess hazards to privately rented homes

Useful resources

- ✓ www.chimat.org.uk/earlyyears/injuries
- ✓ www.gov.uk/government/publications/reducing-unintentional-injuries-among-children-and-young-people
- ✓ www.capt.org.uk/
- ✓ www.rospa.com/

References

- Department of Health (2012) Our children deserve better: prevention pays
- www.rospa.com/home-safety/advice/general/facts-and-figures/
- www.rospa.com/home-safety/advice/child-safety/accidents-to-children/#who

Actions to reduce child death - reducing road traffic injuries (RTIs)

7 children are killed or seriously injured on Britain's roads every day

15 people are seriously injured for every **1** person aged < 25 years who dies in a RTI

16 **deaths or serious injuries** to children under 16 years **each week** occur between 8am to 9am and 3pm to 7pm

547 million pounds is the estimated annual cost of child road deaths and injuries

936 **fewer** serious or fatal injuries to child pedestrians and child cyclists annually would occur if all children had a risk of injury as low as children in the least deprived areas

Actions to reduce RTIs

Improve safety for children travelling to and from school
Including developing school travel plans, education and engineering measures to physically change the road environment

Introduce 20mph limits in priority areas as part of a safe system approach to road safety
Supported by providing publicity, information and community engagement

Co-ordinate action to prevent traffic injury
Within local authorities to encourage active travel and create liveable streets

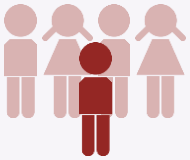
Useful resources

- ✓ www.capt.org.uk/resources/road-safety

References

- www.makingthelink.net/tools/costs-child-accidents/costs-road-accidents
- PHE (2014) Reducing unintentional injuries on the roads among children and young people under 25 years

Actions to reduce child death - reducing domestic abuse

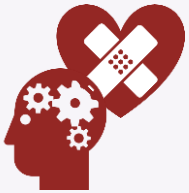


About **one in five** children aged 11-17 years has been exposed to domestic abuse

About **130,000 children** live in households with **high-risk** domestic abuse

62% of children exposed to domestic abuse are directly harmed

80% of children exposed to domestic abuse are known to at least one public agency



Children suffer multiple **physical** and **mental health** consequences because of living with domestic violence

Actions to reduce domestic abuse

- Educating and challenging young people about healthy relationships, abuse and consent
- Earlier identification and intervention to prevent abuse
- Improving access to parenting programmes which specifically address domestic abuse
- Moving to an integrated model of family support
- Strengthening the role of health services and providing effective help through specialist children's services
- Changing perpetrators' behaviours to prevent abuse and reduce offending
- Building the evidence base in what works in early intervention and tackling perpetrators

Useful resources

- ✓ www.caada.org.uk
- ✓ www.nspcc.org.uk
- ✓ www.ncdv.org.uk
- ✓ www.gov.uk/government/uploads/system/uploads/attachment_data/file/337615/evidence-review-interventions-F.pdf

References

- CAADA (2014) In plain sight: effective help for children exposed to domestic abuse
- Home Office (2016) Ending violence against women and girls Strategy 2016-2020
- Radford L et al (2011): child abuse and neglect in the UK today
- Safe Lives (2015) Getting it right the first time

Bereavement support

1 in 20 children in England has been bereaved of a parent or sibling by the time they are 16 years old. In 2015, that was about **33,210** children aged five to16 years in London

Children from disadvantaged backgrounds are **more likely** to be bereaved of a parent or sibling

Childhood bereavement may have both **short** and **long-term** impacts on children's wellbeing and educational achievement

Bereaved children are **1.5x more likely** than other children to be diagnosed with 'any' mental disorder

The death of a parent is associated with **lower** employment rates at the age 30

Actions to support bereaved children

Support for families
Providing information about how children grieve, what can help and what services there are

Support in schools
Developing a co-ordinated school approach such as staff training, school counselling services and peer support

Specialist support
Providing outreach and specialist support for those who are vulnerable or traumatised

Useful resources

- ✓ www.childhoodbereavementnetwork.org.uk
- ✓ www.cruse.org.uk
- ✓ www.griefencounter.org.uk
- ✓ www.hopeagain.org.uk
- ✓ www.www.tcf.org.uk
- ✓ www.winstonswish.org.uk
- ✓ www.nhs.uk/Livewell/bereavement/Pages/children-bereavement.aspx

References

- Aynsley-Green A, Penny A, Richardson S BMJ Supportive and Palliative Care (2011) Bereavement in childhood: risks, consequences and responses
- Parsons S (2011) Long-term impact of childhood bereavement. Preliminary analysis of the 1970 British Cohort Study (BCS70): London, Child wellbeing research centre
- Penny and Stubbs (2014) Childhood Bereavement: what do we know in 2015? London: National Children's Bureau
- www.childhoodbereavementnetwork.org.uk/research/local-statistics.aspx

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About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities.
It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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