GREATER LONDON AUTHORITY

Pan-London Healthy Early Years Programme Health Impact Assessment and Health Inequalities Impact Assessment.

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Executive Summary

Health impact assessment is a systematic process by which the potential effects of a programme, such as the Pan-London Healthy Early Years (PLHEYs) Programme, on the health of the population can be assessed. A health inequalities impact assessment goes further, considering how the programme may affect groups differently. The process aims to enhance positive consequences and identify means by which any negative consequences can be avoided or minimised. This report describes the health impact and health inequalities impact assessment which was carried out for the PLHEYs Programme. The process included screening to confirm the need for a health impact assessment, analysis of data relating to health inequalities in the early years, detailed impact assessment on the proposed tool and stakeholder consultation.

In London, 90% of three and four year olds benefit from funded early years education, as well as 46% of eligible (the most deprived 40%) two year olds. There will also be a considerable number of children accessing additional early years care paid for by their parents or carers. This means that a PLHEYs Programme has the potential to benefit a considerable number of London children. However, there are differences in take up of childcare between groups, for example those in more deprived areas have lower take up. This means it is important to ensure that a PLHEYs programme has a good level of take up in more deprived areas in order to avoid worsening health inequalities. Settings in these areas may also require additional support in order to participate.

Analysis of data, on both health and outcomes at the Early Years Foundation Stage, confirms that there are certain groups that persistently have worse outcomes across a range of areas. These include boys, those from some minority ethnic groups and those from lower socio-economic backgrounds. However, in some cases, both nationally and at a local level, there may be differences from this pattern. This means it is important settings have access to information on the most important priorities within their area and the groups most affected.

Assessment of the proposed tool for the PLHEYs programme demonstrated that although likely to enhance health and reduce health inequalities, there were a number of things which need to be considered to maximise this. In particular this includes the support settings will need from both Local Authorities and the Greater London Authority (GLA) to implement a PLHEYs programme effectively. As well as access to local information this might include sample policies and easy access to up to date guidance and useful resources. It is also essential to get the right balance between ensuring that the assessment process is not overly burdensome, while making sure it is sufficiently challenging to have a meaningful impact.

The majority of stakeholders consulted thought the proposed tool would help in meeting health, wellbeing and school readiness outcomes. The proposed assessment framework, based around OFSTED areas, was very popular with some, but others felt that health outcomes needed to be much more visible and the framework should be based around health themes instead. The general consensus was that the tool needed to be simplified as it could be too labour intensive to complete, in particular for childminders and smaller settings. The majority of stakeholders did not feel any groups would be disadvantaged by the

PLHEYs programme, but raised the need for additional support for some settings in order to enable them to participate and therefore avoid worsening inequalities.

Overall the health impact and health inequalities impact assessment suggests that the PLHEYs programme should have a positive effect on both health and health inequalities. However, some changes may be required to the existing tool in order to maximise the positive effects, and careful consideration needs to be given to the support available, from both the GLA and Local Authorities, to settings and childminders who participate in the PLHEYs programme. Additional consultation is likely to be required with staff working in early years settings and childminders to ascertain their views on the PLHEYs programme. Take up of the programme will need to be monitored to ensure it is being taken up equitably across London, in particular in areas with a higher level of deprivation or where more of the population is from an ethnic minority group. After the initial pilot an evaluation should take place to assess whether the programme is having an impact and identify any changes required.

Introduction

Health impact assessment (HIA) has been defined as a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. A health impact assessment aims to assess the likely health consequences of implementing a proposal and recommends how good consequences can be enhanced and negative consequences avoided or minimised. It also aims to look at which groups will benefit the most and which will benefit less.[1]

Health inequalities are unfair differences in outcomes between groups. They arise as a result of differences in social and economic conditions which can influence lifestyle, behaviours, risk of illness and actions taken when illness occurs. Essentially they are considered unfair because they are avoidable. In general more affluent people have better health, with the worst health being found among the poorest. However, there may also be differences on other grounds, such as age, gender, ethnicity, disability and sexuality.[2] A health inequalities impact assessment (HIIA) involves a systematic approach to considering how a policy may affect groups differently. It can provide a means for considering how a policy can mitigate, prevent or undo inequalities between groups. As well as proactively trying to decrease inequalities it needs to identify unintended consequences which may increase inequalities.[3]

Screening

The first stage of a health impact assessment is the screening stage. The purpose of this stage is to identify whether a health impact assessment is required. The Department of Health has developed a toolkit to assist with health impact assessments.[4] This has been adapted for use in the HIA/HIIA for a proposed Pan-London Healthy Early Years (PLHEYs) Programme. The results of the initial screening are shown in table 1.

Table 1: HIA/HIIA-screening.

Screening question	**No** **If there will be no health impact provide a brief explanation for your response**	**Yes** **If there will be health impact(s) provide a brief explanation**
Will the proposal have a direct impact on health, mental health and wellbeing? For example would it cause ill health, affecting social inclusion, independence and participation? Will any socioeconomic or equalities groups be particularly affected?		The healthy early years programme aims to increase physical and emotional health in young children in early years settings. If implemented effectively it should also result in improved health of parents and early years workers. Groups particularly affected

		will be those who use childcare for their children or who access early years settings such as children's centres, but this is likely to be a considerable proportion of children-for example 92% of eligible 3 and 4 year olds access early years education.[5] However if there are differences between socioeconomic and other groups in terms of use of childcare and early years settings this could lead to differences in effect between groups. If implemented widely the programme has the potential to reduce health inequalities, however if there are differences in take up between areas, with lower take up in settings with more children from disadvantaged backgrounds then it could worsen them.
Will the policy have an impact on social, economic and environmental living conditions that would indirectly affect health? For example would it affect housing, transport, child development, education, good employment opportunities, green space or climate change? Will any socioeconomic or equalities groups be particularly affected.		Through improving the health of young children a healthy early years programme would also impact on future school readiness, which in turn influences educational outcomes, future life chances and health. As for question 1 for effect on particular groups-effect may vary depending on differences in parents' use of early years settings for their children and how widespread the take up of a healthy early years programme is by early years settings.
Will the proposal affect an individual's ability to improve their own health and wellbeing? For example will it affect their ability to be physically active, choose healthy food, reduce drinking and smoking?		If implemented successfully the programme should improve young children's understanding of how to live a healthy lifestyle, and increase healthy behaviours. Values and behaviours acquired in early childhood are likely to have a lasting

Will any socioeconomic or equalities groups be particularly affected?		effect. If implemented effectively it should lead to similar benefits for parents and early years workers. As for question 1 for effect on particular groups-effect may vary depending on differences in parents' use of early years settings for their children and how widespread the take up of a healthy early years programme is by early years settings.
Will there be a change in demand for or access to health and social care services? For example: Primary Care, Hospital Care, Community Services, Mental Health and Social Services? Will any socioeconomic or equalities groups be particularly affected?		Initial impact on services is likely to be minimal, but longer term there may be reduced demand through improved health and educational outcomes in those who have been part of this programme. As for question 1 for effect on particular groups-effect may vary depending on differences in parents' use of early years settings for their children and how widespread the take up of a healthy early years programme is by early years settings.

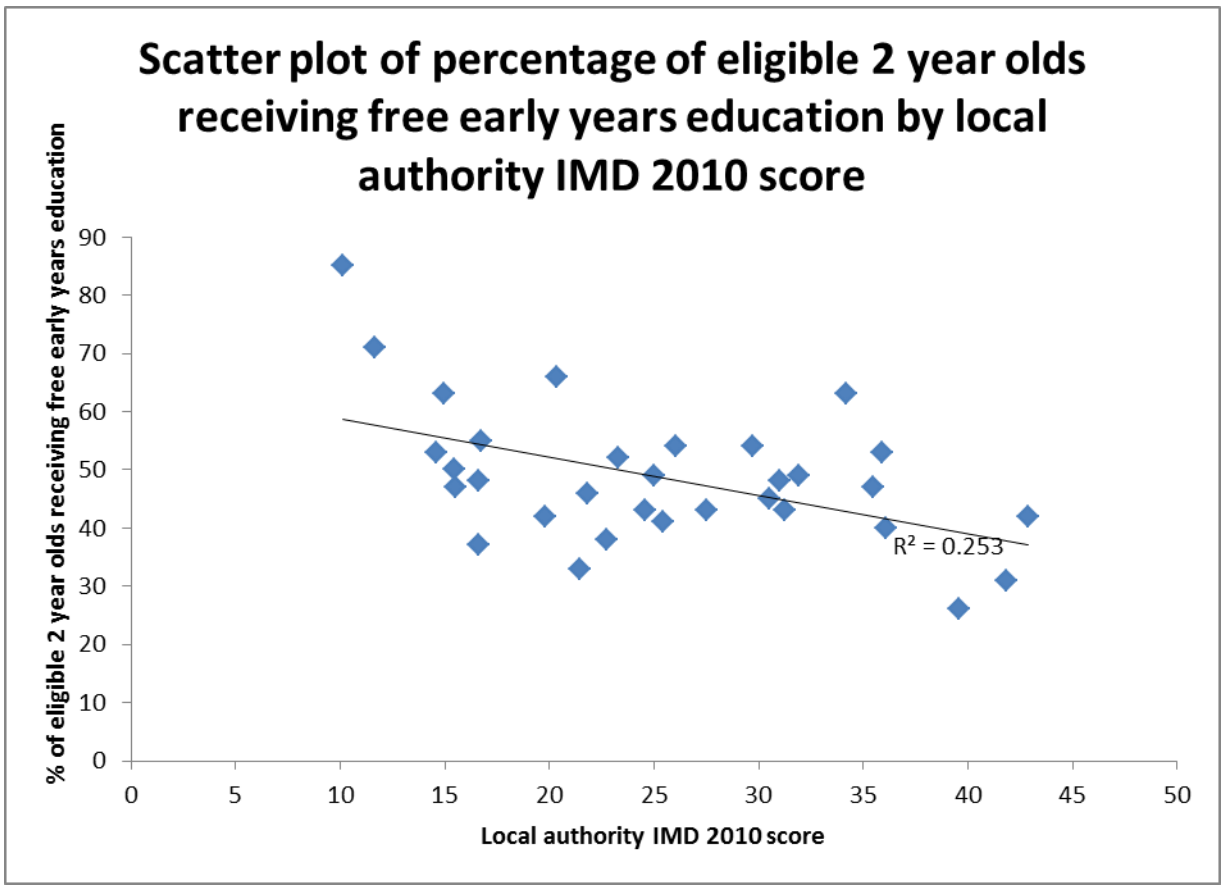
Users of early years settings

The London Childcare Report (2014)[6] contains some analysis of who is using childcare within London. Information in this section is taken from this report unless otherwise stated. In 2013 mid-year population estimates showed that there were 621,300 0-4 year olds in London Local Authorities. London has proportionally more single parent households than other regions within the UK. 36% of London's population were born overseas, and in 2012 57% of live births in London were to mothers born outside of the UK. There were a total of 32 full time childcare places per 100 children under five in London in 2014. There has been shown to be less nursery provision in deprived areas as there tends to be lower demand for it.

In January 2014, only 46% of eligible two year olds (the most deprived 20%) were placed with childcare providers for their free entitlement. The reasons for this include some parents choosing not to take up the offer of free childcare and local authorities not having sufficient provision for all eligible two year olds. Eligibility has subsequently increased to the most

deprived 40% of two year olds, but take up in January 2015 remained 46% in London. However this varied from 26% (590 children) in Tower Hamlets to 85% (330 children) in Richmond. Some of this difference may be due to differences between local authorities in terms of the number of eligible children they need to find places for, with local authorities with higher levels of deprivation having many more eligible children. [7] Figure 1 is a scatter plot showing the relationship between the local authority IMD 2010 score and the percentage of eligible two year olds receiving free early years education.

Figure 1: Scatter plot showing relationship between local authority IMD 2010 score and the percentage of eligible 2 year olds receiving free early years education.



Source: Department for Education (uptake figures). IMD 2010 scores from East Midlands Public Health Observatory.

Some local authorities also have a shortage of places for three and four year olds. In London as a whole, 90% of three and four year olds benefited from funded early education places (15 hours a week). This varied by local authority from 69% in Westminster to 102% in Havering.[8]

Some sectors of the population have been shown to be less likely to take up free early years education. These include children with special educational needs, those from families where mothers have no qualifications, children in low income families, children from large families and children from some minority ethnic groups. For example an analysis of uptake of free early years education by three and four year olds, carried out in 2008-2009, showed that compared with all three and four year olds (86% uptake) uptake was:

- Similar in children with disability (87%)
- Lower in those with special educational needs (81%)
- Lower in those with lowest household income (77%) compared with highest (92%)
- Lower where mother had no educational qualifications (76%) compared with mother with degree (93%)
- Lower in those from 20% most deprived areas (77%)
- Lower where more than five children in family (76%)
- Higher where mother was of Indian (91%) or white British (89%) ethnicity and lower in those where mother was of black Caribbean (74%), black African (71%) or Pakistani (72%) ethnicity.

However, a more recent report published by the Department for Education[9], found that among children aged 0-14, children from Black Caribbean (69%), other mixed (59%) and White British (58%) families were the most likely to receive formal childcare and children from Asian Pakistani (41%), other Asian (41%) and Bangladeshi (35%) families were least likely to. In common with the findings above was that children with special educational needs were less likely than those without to receive formal childcare (46% compared to 56%). Children with health problems or disabilities were also less likely to receive childcare than those without such problems (48% compared to 56%).

This report found that overall across England, 75% of pre-school children were using some form of childcare. This was more common in 3-4 year olds (92%) than 0-2 year olds (61%). This included informal care eg by grandparents, as well as formal care. Again 3-4 year olds were more likely to be using formal childcare (90% of 3-4 year olds compared to 40% of 0-2 year olds). Pre-school children spent an average of 6.1 hours a day in childcare, and 21 hours a week. Three to four year olds spent an average of 25 hours a week and 0-2 year olds 18 hours. Pre-school children from families with higher average incomes spent longer in childcare than those with lower incomes (29 hours a week in families earning £45,000 or more compared with 15.6 to 20 hours in families earning up to £30,000).

In 2014, 15 London Local Authorities did not have sufficient provision for disabled children and a further eight did not know if they did.

In terms of the quality of early years education received, children from disadvantaged families have been found to be more likely to receive their free early education from a setting with graduate staff, because they are more likely to receive it in schools and children's centres. However, disadvantaged children who attend childcare in voluntary and private settings are more likely to attend a setting that is not graduate led and Ofsted ratings are on average lower in disadvantaged areas.

Given that at least where three and four year olds are concerned, the majority are in an early years setting for at least their free entitlement of 15 hours a week , overall a Healthy Early Years Programme is likely to have a positive effect on health inequalities. This is likely to be increased by the fact that the offer of free early education for two year olds is only available to the most deprived 40%. Even though this is only taken up by just under half of eligible two year olds, they remain those who are most likely to benefit from a Healthy Early Years Programme.

However, the data does show that there are differences in take up of childcare between groups. As the Healthy Early Years Programme is aimed at children in early years settings, this means that there is the potential for it to worsen inequalities between groups, if those with the greatest level of need are least likely to use childcare. In addition, if a Healthy Early Years Programme is implemented in London it will be important to monitor which early years settings are taking it up, in order to ensure it is not being disproportionately taken up by settings with children with a lower level of need. If this proves to be the case early years settings in areas with high levels of deprivation or with a high proportion of the population from an ethnic minority background for example, may need additional encouragement and support to participate in this programme.

Evidence about existing inequalities in health/school readiness indicators.

Obesity

The National Child Measurement Programme (NCMP)[10] records height and weight of children in reception year (aged 4-5 years) and year 6 (aged 10-11 years) in English state-maintained schools. In 2014/15 there was a 95% participation rate in London (compared with 96% for England).[11] Data from 2014/15 has been analysed by the Health and Social Care Information Centre. Although overall prevalence of overweight and obesity is available at local authority level, analysis by factors such as sex, ethnic group and level of deprivation is only available at the level of England. In London in 2014/15, 12.0% of reception aged children were overweight (compared with 12.8% for England) and 10.1% were obese (compared with 9.1% for England).

The analysis found that prevalence of obesity and overweight was higher in boys than girls, with 9.5% of reception age boys and 8.7% of girls being classified as obese, and 13.1% of boys and 12.1% of girls being overweight. The prevalence of underweight was also higher in reception age boys than girls, with 1.2% of boys and 0.7% of girls being underweight.

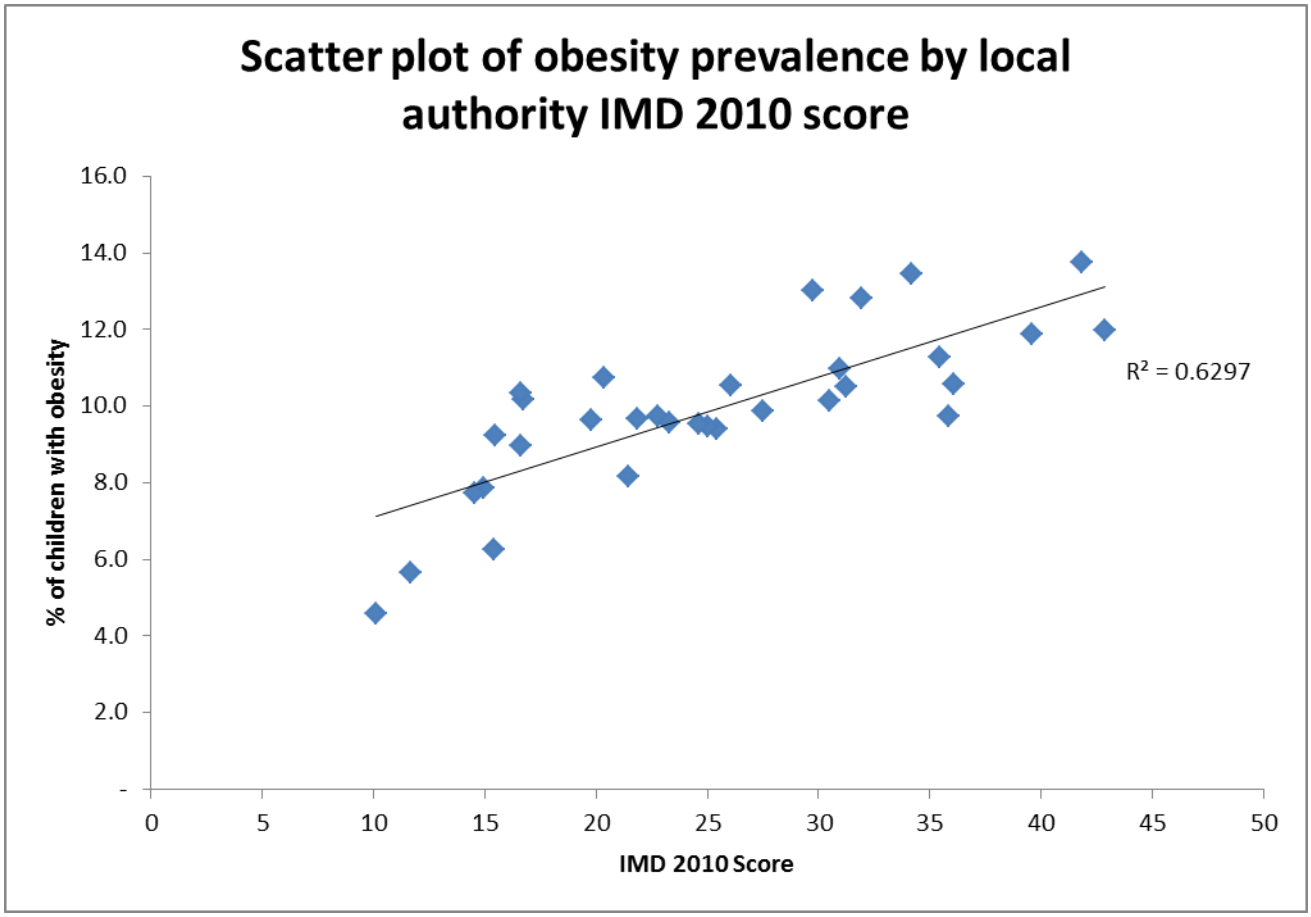
There is a strong relationship between deprivation and obesity, with the prevalence of obesity increasing with level of deprivation. In reception year the prevalence of obesity was 12.0% in children living in the most deprived area, compared with 5.7% in the least deprived areas. Of concern is the fact that this difference has increased since 2007/08. There is also a relationship between being underweight and deprivation. 1.2% of children in the most deprived areas are underweight, compared with 0.8% in the least deprived areas.

Obesity rates also vary by ethnic group. In reception year it was significantly higher than the national average for children from Black or Black British (14.7%), ‘any other ethnic group’ (11.0%), Asian or Asian British (10.0%) and ‘mixed’ (9.9%) ethnic groups. It was significantly lower than the national average in White (8.5%), ‘unknown’ (8.8%) and Chinese (7.6%) ethnic groups. Prevalence of underweight was significantly higher than the national average (1.0%) in the Asian or Asian British ethnic group (3.6%) and significantly lower in those of White ethnicity (0.6%).

There may be confounding factors taking place as urban areas of high deprivation also have a higher proportion of the population from non-white ethnic groups. This has not been adjusted for in the analysis.

Within London there is considerable variation in prevalence of obesity in reception year children. This varies from 4.6% in Richmond to 13.8% in Newham. Figure 2 is a scatter plot showing the correlation between local authority IMD 2010 score and the percentage of reception aged children who are obese, for local authorities within London. This shows there is a strong relationship between obesity and deprivation.

Figure 2: Scatter plot of obesity prevalence in reception year by local authority IMD 2010 score for local authorities within London.



Source: NCMP data from Health and Social Care Information Centre. IMD 2010 scores from East Midlands Public Health Observatory.

Breastfeeding

Data from the 2010 UK Infant Feeding Survey[12] showed that the in 2010 the initial breastfeeding rate in England was 81%. This includes all babies who were put to the breast, even if it was just on one occasion. The highest incidences of breastfeeding was found in mothers aged 30 and over (87%), those from ethnic minority groups (97% for Chinese or other ethnic group, 96% for Black and 95% for Asian ethnic group), those who left education aged over 18 (91%), those in managerial and professional occupations (90%) and those living in the least deprived areas (89%). Breastfeeding rates were lowest in those under 20

(58%), White mothers (79%), those from routine and manual occupations (74%), those who had never worked (71%), those who were 16 and under when they left full time education (63%) and those living in the most deprived areas (73%). Initiation rates for breastfeeding in London were 94%, which was higher than the rest of the country, and likely to be due to high numbers of mothers from ethnic minority backgrounds living in London.

By the time the baby was six months old. 34% of mothers were still breastfeeding. Again this was highest in mothers from managerial and professional occupations (44%), those who left education aged over 18 (46%), those aged 30 or over (45%), those living in the least deprived areas (40%) and those from ethnic minority groups (66% for Chinese or other, 61% for Black and 49% for Asian and Mixed ethnic groups). It was lowest in those who left full time education at 16 or under (17%), those living in the most deprived areas (31%) and White mothers (32%). Again breastfeeding rates at six months were higher in London (51%) than in the rest of the country.

Physical activity

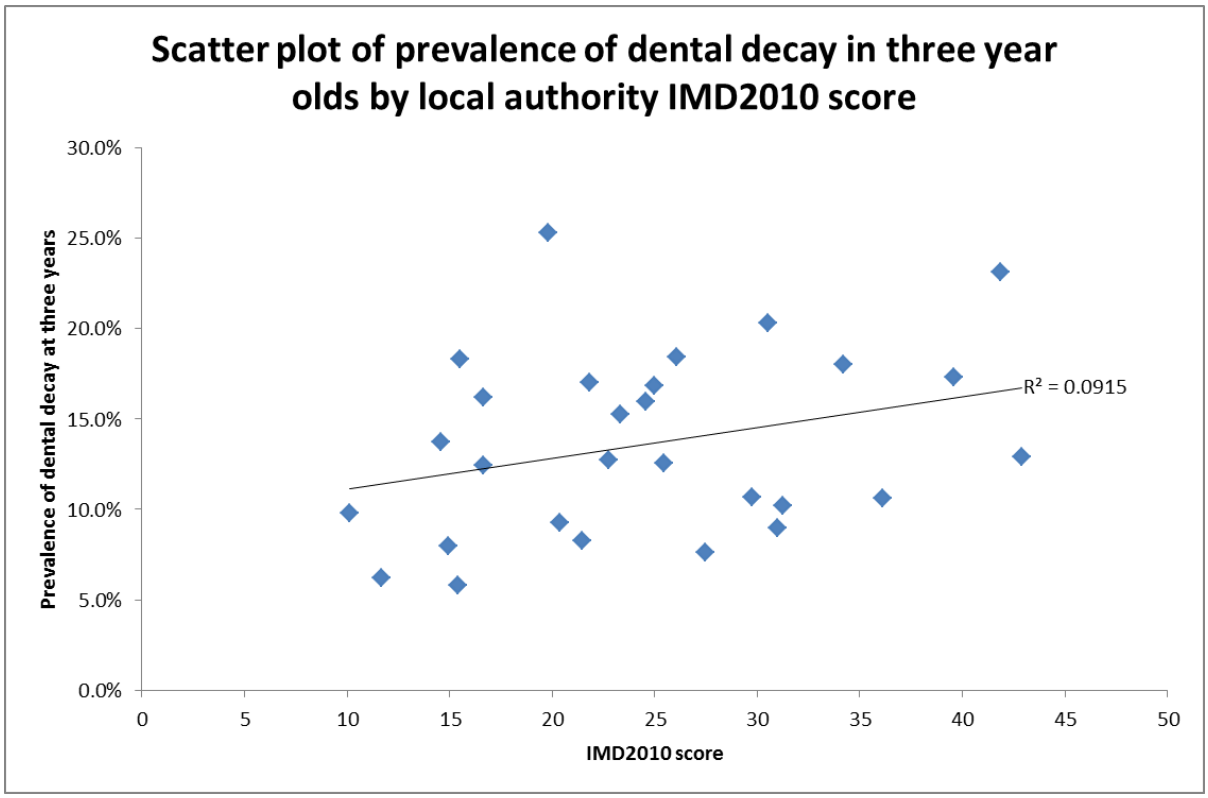
In terms of physical activity, a review by the British Heart Foundation[13] found that findings on the relationship between sex and physical activity in the early years were mixed. Although there were early suggestions that boys were more active than girls, the most recent studies showed either no effect or inconsistent findings. The results of studies looking at the effect of age on physical activity were also inconsistent. No association was found between socioeconomic status and physical activity in the early years. Data on the percentage of children achieving at least expected in the physical development goals of the Early Years Foundation Stage (EYFS) is shown under EYFS data.

Oral health

Data from the Dental Public Health Epidemiology Programme on the dental health of three year olds[14], showed a weaker association between the prevalence of dental decay and deprivation than is the case at five years old. At three years old 19% of the prevalence and 25% of the severity was shown to be explained by deprivation. At five years old 44% of the variation in prevalence of decay between local authorities was explained by deprivation.

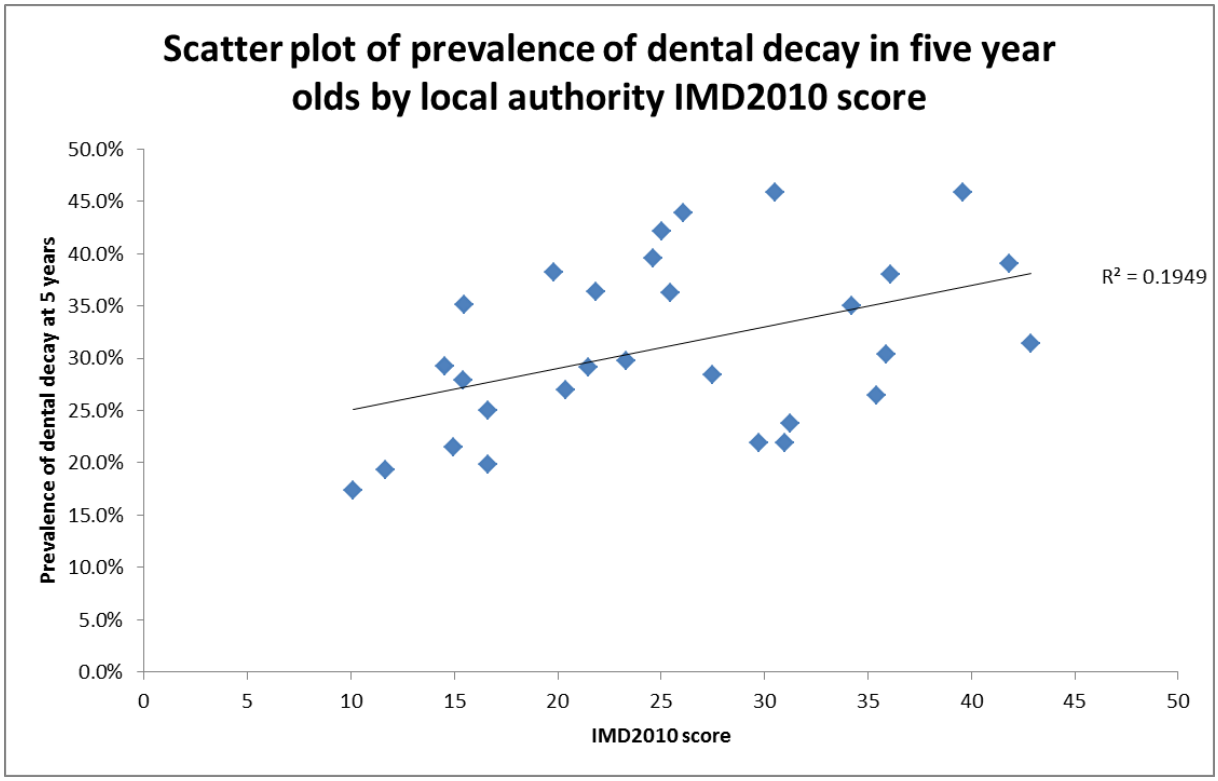
In London local authorities a similar, though less strong result is seen as shown in figures 3 and 4.

Figure 3: Scatter plot of prevalence of dental decay at three years by local authority IMD2010 score.



Source: Public Health England, Dental Public Health Epidemiology Programme.

Figure 4: Scatter plot of prevalence of dental decay at five years by local authority IMD2010 score.



Source: Public Health England, Dental Public Health Epidemiology Programme.

A study of three and four year olds carried out in East London found there were significant ethnic differences in oral health. Children from a White Eastern European background were significantly more likely than any other ethnic group to have untreated caries. Children from Bangladeshi and Pakistani backgrounds also experienced poorer oral health than White British children.[15] These findings are similar to a Danish study[16] which found that children from backgrounds other than Danish had a higher prevalence of tooth decay at age 3, and a higher mean number of teeth affected. With the exception of Pakistani children this was also true at age 5. The most significant differences were found in Albanian children. There were significant differences between Danish parents and ethnic minority parents in terms of the percentage who were employed and levels of education. They also found that parents from ethnic minority backgrounds started brushing their children's teeth later and stopped helping them to brush them at a younger age than Danish parents. Children from ethnic minority groups were found to consume sweets and sweetened foods and drinks more often than Danish children. A briefing paper for the Race Equality Foundation[17] which reviewed some of the literature on this topic, found that although the relationship between ethnicity and dental caries was complex, higher levels of caries were generally found in children of Pakistani and Bangladeshi origin, even after adjusting for socioeconomic status. Weaning habits may contribute to this as Asian mothers have been shown to be more likely to bottle feed for longer and to add sugar, rusks, baby rice or cereals to bottled drinks. There is also evidence to suggest that there are differences between ethnic groups in use of dental services. Pakistani and Bangladeshi children were less likely to visit a dentist, and those who had visited a dentist were more likely to have done so due to a dental problem rather than for a check-up.

Early Years Foundation Stage

Early Years Foundation Stage data[18] shows that girls perform better than boys on all key measures. Overall 66% of children in England achieved a good level of development in 2015; however this was achieved by 74.3% of girls compared with 58.6% of boys.

Girls were more likely than boys to achieve at least expected in all early learning goals, with 72.6% of girls and 56% of boys achieving this. The gap for the percentage achieving at least the expected level is largest in: writing (14.7%); exploring and using media and materials (11.6%); reading (11.3%); being imaginative (11.1%); and managing feelings and behaviour; (10.2%). The gap is the narrowest for technology at 2.3 percentage points.

There were also differences by ethnic group, with 67% of White pupils achieving a good level of development, compared with 64% of Asians, 65% of Blacks, 67% of Chinese and 68% of mixed ethnic group pupils.

Children receiving free school meals were less likely to achieve a good level of development, with only 51% reaching this standard in 2015, compared with 69% of those not receiving free school meals. Pupils with special educational needs (SEN) were also much less likely to achieve a good level of development, with only 21% of all SEN pupils achieving this, compared to 71% of those without a SEN.

Table 2 shows the percentage of children in each London local authority who achieved a good level of development in 2015 by gender, ethnicity and whether they have free school meals. This shows that as is the case for England, girls are consistently more likely to

achieve a good level of development than boys. In London as a whole, Black pupils were the group least likely to achieve a good level of development, however there is considerable variation in this by local authority, and in some areas it was White pupils who were the group least likely to achieve a good level of development. For London as a whole there was a gap between children eligible to receive free school meals and those not receiving free school meals in the percentage achieving a good level of development. There was considerable difference between local authorities in how wide the gap was, and in the case of Hackney there was no difference.

Table 2: Percentage of children achieving a good level of development in 2015.

	Boys	Girls	White	Mixed	Asian	Black	Chinese	FSM	No FSM	All
Barking and Dagenham	60	76	65	68	73	70	79	59	69	68
Barnet	60	76	70	72	72	63	83	57	70	68
Bexley	70	83	76	76	82	79	82	65	78	76
Brent	57	70	63	67	68	62	56	59	64	63
Bromley	67	81	74	74	76	72	82	53	76	74
Camden	56	70	65	72	55	60	73	53	66	63
City of London	64	85	x	100	56	x	x	x	77	76
Croydon	57	72	64	66	68	63	62	54	67	65
Ealing	62	78	71	77	72	66	x	61	71	70
Enfield	57	72	*	*	*	*	*	56	66	64
Greenwich	71	83	76	84	80	79	77	68	79	77
Hackney	62	74	74	77	74	72	81	68	68	68
Hammersmith and Fulham	61	77	71	70	67	66	x	68	69	69
Haringey	60	76	67	71	77	67	55	61	69	67
Harrow	64	77	66	73	77	57	85	58	71	70
Havering	61	76	69	68	70	70	81	53	71	68
Hillingdon	60	71	64	70	70	60	70	49	67	65
Hounslow	56	74	66	71	67	58	73	54	66	64
Islington	55	73	65	69	60	58	50	56	68	64
Kensington and Chelsea	60	72	71	65	74	60	100	54	68	65
Kingston upon Thames	65	80	74	68	67	68	87	54	74	72
Lambeth	52	73	70	62	63	60	70	50	67	63
Lewisham	72	83	82	82	76	75	76	71	79	77
Merton	61	75	69	66	67	64	67	55	69	68
Newham	63	75	66	75	72	70	65	68	69	69
Redbridge	60	75	68	70	72	64	71	51	69	68
Richmond upon Thames	66	78	72	70	78	63	76	45	73	71
Southwark	63	78	74	72	63	70	64	64	72	71
Sutton	56	73	65	69	60	60	70	46	66	64
Tower Hamlets	54	70	61	58	64	60	69	56	64	62

Waltham Forest	60	75	68	70	70	67	61	62	68	68
Wandsworth	63	77	75	67	67	59	68	57	72	70
Westminster	56	73	70	66	59	58	71	55	69	65
London	**61**	**76**	**70**	**71**	**70**	**67**	**73**	**59**	**70**	**68**

*Ethnicity not recorded in more than 50% of pupils.
x Figures not shown to protect confidentiality
Source: Department for Education

Table 3 shows the percentage of children in London who achieved a good level of development, based on the Income Deprivation Affecting Children Index (IDACI). This shows a 13 percentage point difference between the 10% most deprived and the 10% least deprived children.

Table 3: Percentage of London children achieving a good level of development by IDACI decile, 2015.

IDACI decile	**Percentage achieving a good level of development**
0 - 10 % most deprived	64
10 - 20 %	65
20 - 30 %	68
30 - 40 %	70
40 - 50 %	70
50 - 60 %	73
60 - 70 %	75
70 - 80 %	75
80 - 90 %	78
90 - 100 % least deprived	77

Source: Department for Education

Tables 4 to 6 show the percentage of children in England 2015 who achieved at least expected in the communication and language; physical development; and personal, social and emotional development learning goals, by gender, ethnicity, whether they received free school meals (FSM) or had special educational needs.[19]

Table 4: Percentage of pupils achieving at least expected in the communication and language learning goals in 2015.

		Listening and attention	**Understanding**	**Speaking**
	All Pupils	86	85	84
Gender				
	Boys	81	81	80
	Girls	91	90	89
Ethnicity				
	White	87	87	86
	Mixed	87	87	86
	Asian	82	80	78

	Black	83	83	81
	Chinese	83	78	73
	any other ethnic group	79	76	73
	unclassified	82	81	80
Free School Meals (FSM)				
	FSM	77	76	75
	all other Pupils	87	87	86
Special Educational Needs (SEN)				
	No identified SEN	90	90	89
	All SEN pupils	46	45	41

Source: Department for Education

Table 5: Percentage of pupils achieving at least expected in the physical development learning goals in 2015.

		Moving and handling	**Health and self-care**
	All Pupils	90	91
Gender			
	Boys	85	88
	Girls	94	94
Ethnicity			
	White	90	92
	Mixed	91	92
	Asian	88	88
	Black	89	89
	Chinese	93	89
	any other ethnic group	89	87
	unclassified	88	89
Free School Meals (FSM)			
	FSM	83	85
	all other Pupils	91	92
Special Educational Needs (SEN)			
	No identified SEN	93	95
	All SEN pupils	55	57

Source: Department for Education

Table 6: Percentage of pupils achieving at least expected in the personal, social and emotional learning goals in 2015.

		Self-confidence and self-awareness	**Managing feelings and behaviour**	**Making relationships**
	All Pupils	89	87	89
Gender				
	Boys	85	82	85

	Girls	92	93	93
Ethnicity				
	White	90	88	90
	Mixed	89	88	90
	Asian	85	86	86
	Black	86	85	86
	Chinese	84	86	86
	any other ethnic group	84	83	85
	unclassified	86	84	86
Free School Meals (FSM)				
	FSM	81	79	82
	all other Pupils	90	89	90
Special Educational Needs (SEN)				
	No identified SEN	93	92	93
	All SEN pupils	53	48	52

Source: Department for Education

Immunisations

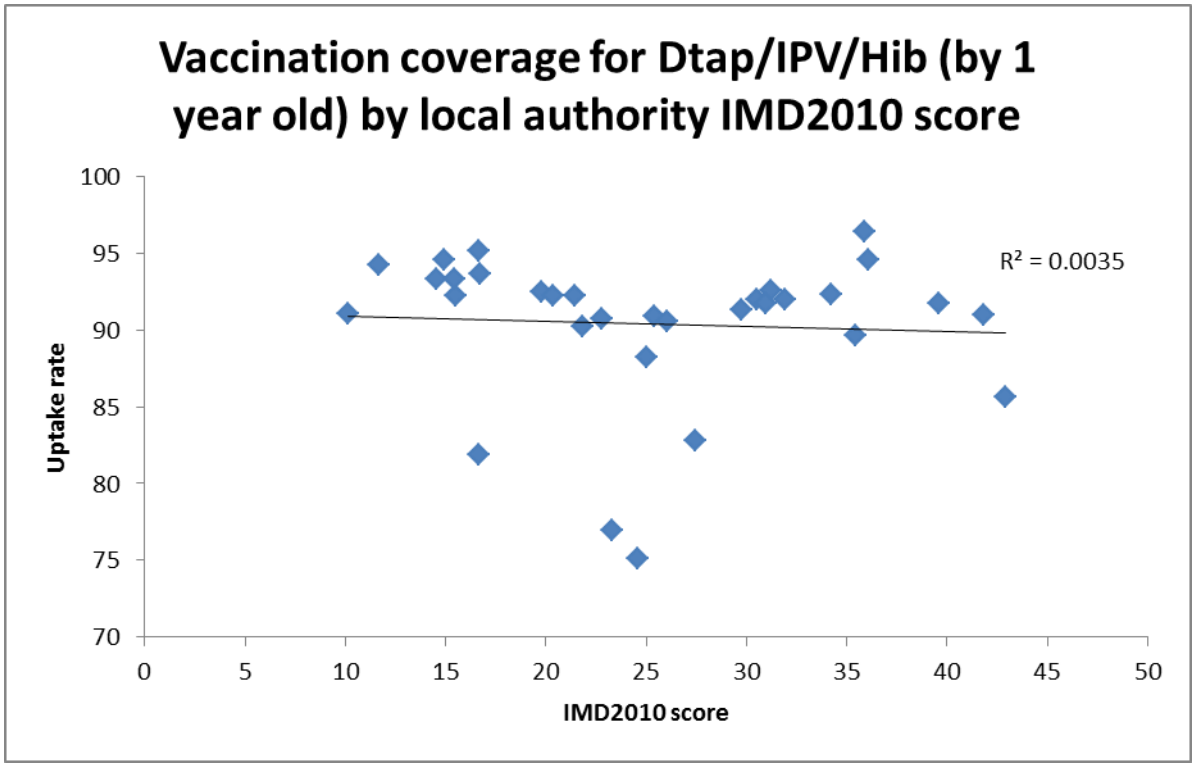
Evidence suggests that there are inequalities in uptake of immunisations, with certain groups being at increased risk of not being fully vaccinated[20]. These groups are:

- those who have missed previous vaccinations (whether as a result of parental choice or otherwise)
- looked after children
- those with physical or learning disabilities
- children of teenage or lone parents
- those not registered with a GP
- younger children from large families
- children who are hospitalised or have a chronic illness
- those from some minority ethnic groups
- those from non-English speaking families
- vulnerable children, such as those whose families are travellers, asylum seekers or are homeless.

In addition some groups are less likely to receive certain vaccines. For example MMR uptake may be lower in children of highly educated parents and those living in more affluent areas. Children with more affluent parents are more likely to be vaccinated with MMR on time or not at all, whereas late vaccination is associated with socio-economic disadvantage.

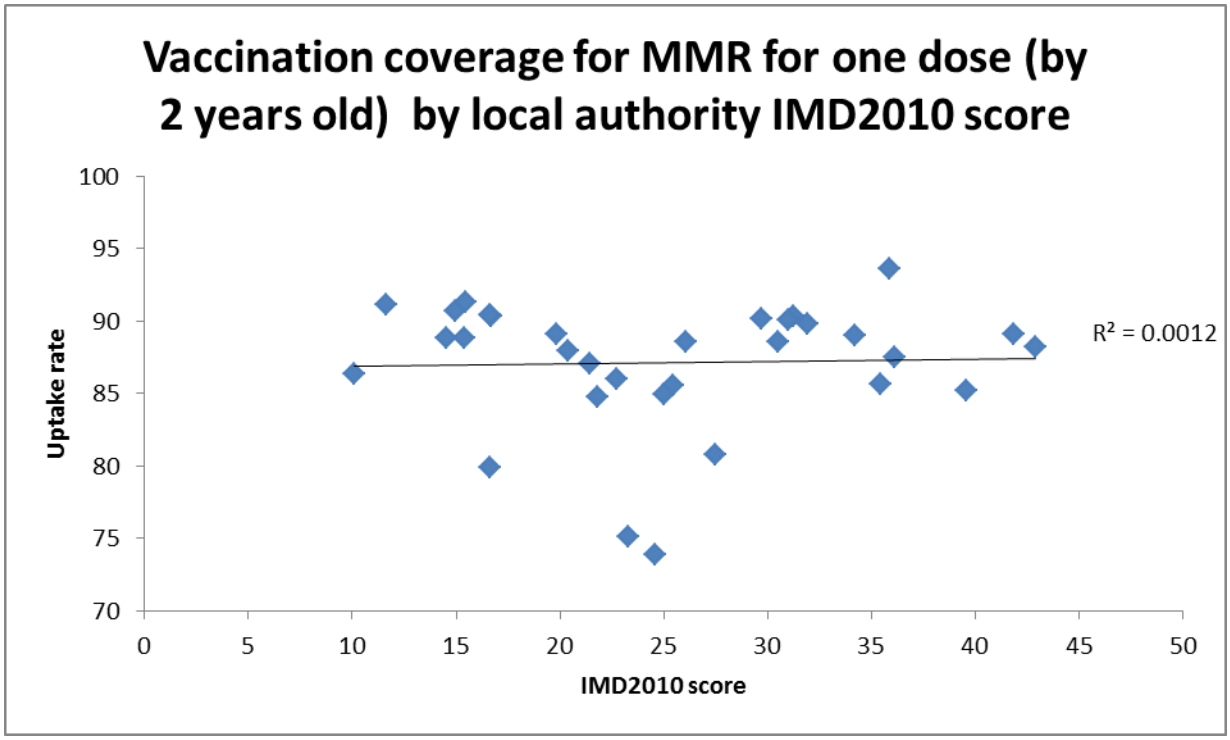
Looking at vaccine uptake data for London by local authority IMD2010 score, there was no clear relationship between level of deprivation and vaccination uptake. This is illustrated in figures 5 and 6 for vaccination coverage for Dtap/IPV/Hib (by 1 year old) and for one dose of MMR (by 2 years old), but no clear link was seen for any of the pre-school vaccines.

Figure 5: Vaccination coverage for Dtap/IPV/Hib (by 1 year old) by local authority IMD2010 score.



Source: Public Health Outcomes Framework

Figure 6: Vaccination coverage for MMR for one dose (by 2 years old) by local authority IMD2010 score.



Source: Public Health Outcomes Framework

Immunisation uptake data by ethnic group is not available. A London based study of childhood vaccination coverage by ethnic group found that consistently good coverage of the primary immunisation course was achieved across the five largest ethnic groups. Ethnic groups with the lowest coverage were generally smaller. Deprivation was not a strong indicator of coverage. However there was an interaction between ethnicity and deprivation. Reduced coverage by deprivation was seen in the White British and unknown ethnic groups and the opposite for Indian and White-Other/mixed/unspecified groups.[21]

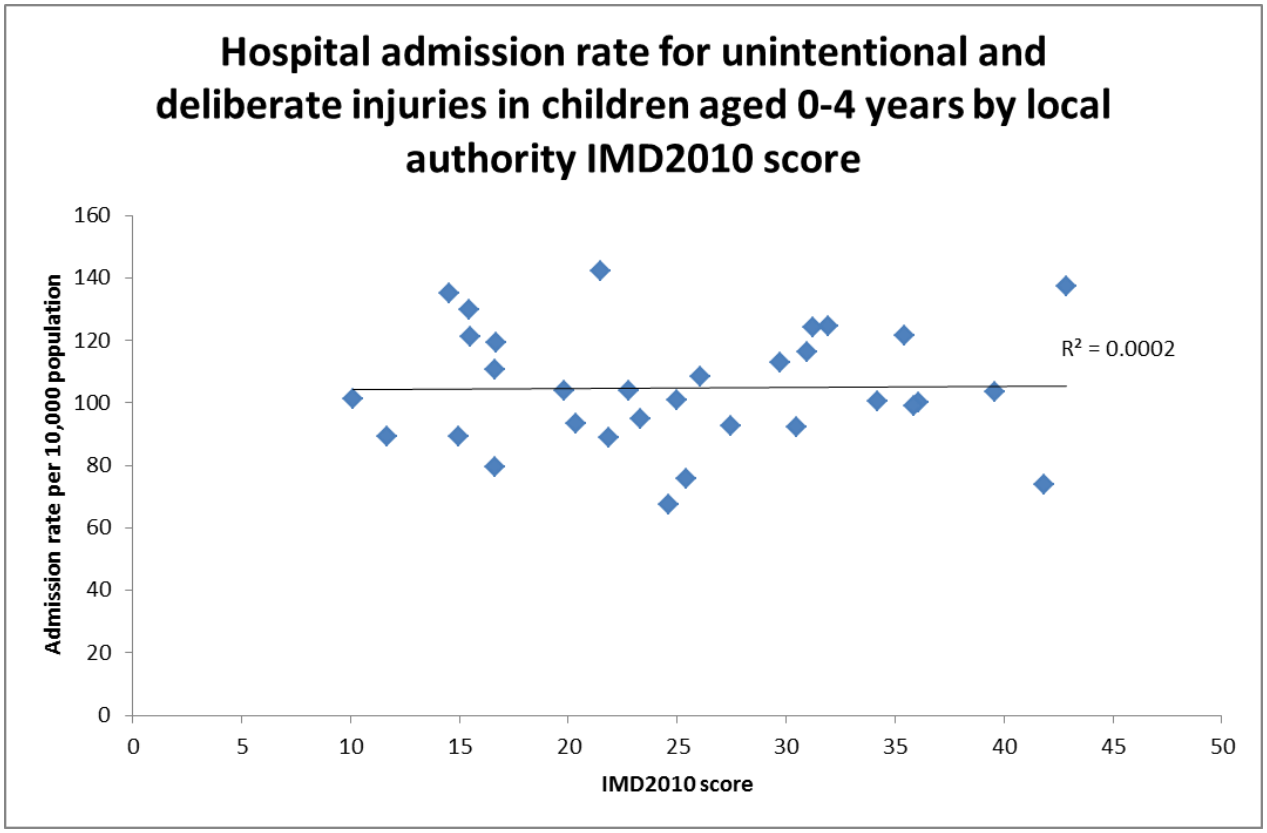
Injuries

Evidence shows there is a social gradient for injuries.[22] Children of parents who have never been employed or are long term unemployed are 13 times more likely to die from an unintentional injury than children whose parents are employed in higher managerial or professional occupations. Analysis carried out by Public Health England shows that emergency hospital admission rates for unintentional injuries in the under-fives is 45% higher in the most deprived than the least deprived areas. This inequality may be much larger for some injury types, for example children living in the most disadvantaged areas had a 50% higher risk of requiring primary or secondary care attendance as a result of being burned, scalded or poisoned than those in the most advantaged areas. There is also a gender difference with boys having higher rates of hospital admission and death than girls.

There is limited evidence on ethnic differences in injury rates in pre-school children within the UK. A study from the US of children under 5 with injuries sustained at home, found that injuries from burns were more common in Black children.[23]

Figure 7 shows the rate of hospital admissions for unintentional and deliberate injuries in children aged 0-4 years by local authority IMD2010 score. Although there is considerable variation between areas no clear relationship with deprivation is seen at local authority level.

Figure 7: Hospital admission rate for unintentional and deliberate injuries in children aged 0-4 years by local authority IMD2010 score.



Source: Public Health Outcomes Framework

Chronic conditions

Data from the general lifestyle survey[24] shows that among children aged 0-4 years, 11% of White children had a long standing illness, compared with 6% of Asian children and 2% of those from other ethnic backgrounds. A limiting illness was reported for 4% of White children, 1% of Asian children and 0% of those from other ethnic backgrounds. There is also variation by socio-economic background, but there was no clear pattern. For example a long standing illness was reported by 3% of those from large employer and higher managerial parental occupations, 8% from higher professional occupations, 10% for both lower managerial and professional occupations and routine occupations, 4% for intermediate occupations, 6% for small employers and own account workers and 12% for both lower supervisory and technical, and semi-routine occupations. More boys than girls reported both a long standing illness (11% compared with 7%) and a limiting illness (4% compared with 3%).[25]

It is not just the prevalence of long term conditions that is important, but the outcomes from these conditions. For example, in the case of Type 1 diabetes, there are differences in incidence by ethnicity and socio-economic status. Non-Hispanic White children generally

have the highest rates, and lower rates are seen in other ethnic groups. There are also thought to be higher rates in children of higher income or socio-economic status. However, ethnic minority children are less likely to receive all the recommended healthcare processes, have lower attendance in clinics and worse outcomes. Measures of control of blood sugar are also worse in children from ethnic minority groups and lower socio-economic status.[26]

Summary

Analysis of data across existing health/school readiness indicators, as it relates to inequalities, confirms that there are certain groups that persistently appear to have worse outcomes across a range of areas. These include boys, those from some minority ethnic groups and those from lower socio-economic backgrounds. However, there are some areas where there are important differences from this pattern, for example White groups have lower breastfeeding rates than many ethnic minority groups. There may also be important differences at local authority level, for example in children achieving a good level of development by ethnic group. Therefore in implementing a PLHEYs Programme, as well as ensuring there is sufficient focus on the groups which commonly have worse outcomes, settings will need to ensure they are giving sufficient attention to addressing inequalities within groups in their areas, where this may differ from the usual pattern.

Assessment of impact on health and inequalities

Table 7 shows an initial assessment of some of the potential impacts on health and health inequalities, carried out on the assessment tool developed for the PLHEYs programme.

This demonstrates there are a number of possible areas which need to be considered to enhance effects on health and reduce health inequalities. In particular it will be worth considering the support which settings will need from boroughs and from the Greater London Authority (GLA) to implement this effectively. Some settings are likely to require more support than others. Examples of support which might be needed are access to local data on health inequalities in the early years, sample policies and easy access to up to date guidance on health topics relevant to the early years. It will also be essential to get the right balance between ensuring that the assessment process is not overly burdensome to settings, while making sure it is sufficiently challenging to have a meaningful impact on health, for example ensuring that policies and procedures are not just in place, but based on the latest guidance and staff are aware of and following them. Although the tool is designed for self-assessment, it might be worth considering a quality control process, in which a random sample of settings are looked at in more depth.

Table 7: Assessment of the potential impacts on health and health inequalities of the PLHEYs programme assessment tool

Programme component	Potential health impacts	Recommendations to maximise positive impact on health	Potential impact on health inequalities	Recommendations to maximise positive effects on health inequalities
Promotion and oversight of the PLHEYs programme				
How effectively the PLHEYs programme is promoted to settings and level of take up.	Take up by settings will support health improvements in all areas covered by programme in children, families and staff.	Encourage widespread take up of the programme by settings.	If take up of the PLHEYs programme is greater in more advantaged areas/settings with more advantaged children there is potential that this programme could worsen health inequalities. However, if there is a good level of take up across all settings and particularly in settings with more disadvantaged children then it will help reduce inequalities.	Ensure settings with more disadvantaged children are supported and encouraged to take up the PLHEYs programme. These settings may require additional support to enable them to do this. Monitor the level of take up in different settings and areas to ensure it is not being disproportionately taken up in more advantaged areas.
Effectiveness of the assessment process.	A robust assessment process will support genuine health improvements in all areas covered by the programme in children, families and staff.	Settings need to demonstrate meaningful actions to support and improve health. Ensure assessment process is supportive but settings are encouraged to aim high and set sufficiently challenging improvement goals.	Will support a reduction in health inequalities, provided that the assessment process is robust and ensures that meaningful action to address local health priorities and areas of inequality are taken by the setting.	Ensure a robust assessment process is in place. Ensure settings know how to access data on health inequalities faced by children living in their area in order for them to identify appropriate actions to address these.
Effectiveness of leadership and management:				
Procedures, policies and statements.	Additional policies required for PLHEYs (over	Ensure quality control measures are in place, to	Ensuring settings participating in the	Ensure appropriate quality control measures are in

Programme component	Potential health impacts	Recommendations to maximise positive impact on health	Potential impact on health inequalities	Recommendations to maximise positive effects on health inequalities
	and above those already statutory as part of the EYFS) will increase settings' awareness of the importance of healthy food, physical activity and immunisations/infection control. This should lead to improved health in children, staff and families in those areas provided policies are followed in the setting. Policies already required for the EYFS, for example SEN policy will also help promote improvements in health. However, if settings have policies in place but these are not consistent with the latest evidence and guidance, then the impact on health will be less.	check a sample of policies in different settings. This process should confirm that policies are consistent with current guidance and there is evidence that settings are following the policies. Ensure processes are in place to keep settings up to date with important changes in national guidance, so that policies are consistent with this. This might be done through a centrally managed website for the PLHEYs programme.	PLHEYs programme have appropriate policies and procedures in place should help reduce health inequalities by ensuring settings are following the latest guidance. If settings in more disadvantaged areas have less well qualified staff and therefore less well developed policies then there is potential to worsen health inequalities.	place. Settings with less qualified staff may require additional support in developing policies and procedures. A centrally managed website could contain example policies from areas with good practice that settings could adapt for local use.
Our leadership and management ensure all staff are confident to identify, raise concerns and follow procedures relating to safeguarding within and beyond the setting. All staff	Good safeguarding training and increased awareness of staff about potential safeguarding concerns will have positive impact on children's health through early identification of any problems and	Ensure the training staff are accessing is of a sufficiently high quality. Settings to also consider the impact of bullying and harassment on staff and that staff are aware of how to tackle this if it is	Early identification of potential safeguarding concerns will help reduce health inequalities by ensuring children and parents can access appropriate support and services at an early stage	Ensure staff in all settings are aware of how to access high quality training.

Programme component	Potential health impacts	Recommendations to maximise positive impact on health	Potential impact on health inequalities	Recommendations to maximise positive effects on health inequalities
understand the impact of abuse on a child's wellbeing and learning.	appropriate referral. It may also support improvements in parental health if problems are recognised early and where appropriate parents are provided with referral to services and appropriate support. Will support emotional wellbeing if children, parents and staff feel safe and secure within the setting.	occurring.	and action is taken to protect children when they are at risk.	
We have effective communication systems and working relationships with other professionals to support our work with children and their families	Good relationships with other professionals will ensure families are given the most appropriate advice and are more likely to be accessing the services they need, which will help improve the health of children and their parents.	Having a named person eg health visitor or children's centre lead is a necessary start but setting also need to ensure effective working relationships are truly in place if impact on health is going to be realised.	This will depend on how effective the working relationships are in reality. If effective relationships are in place then this should help reduce health inequalities if settings are working with other professionals to support children and families.	Ensure relationships are as effective as possible. Consider requiring evidence of how services work effectively together, not just that there is a named person in place.
We provide initial and on-going professional development within and beyond the setting to enable all staff to develop the skills, knowledge and understanding to	Improving staff training on aspects of health and wellbeing for young children will help them to understand how the actions they take within the setting can promote	Ensure staff are receiving training on health issues most relevant to their local community.	Should have a positive effect on health inequalities through ensuring staff in all participating settings have improved knowledge about aspects of health	Ensure training is of high quality and on a varied range of health issues which are relevant to the local community.

Programme component	Potential health impacts	Recommendations to maximise positive impact on health	Potential impact on health inequalities	Recommendations to maximise positive effects on health inequalities
effectively support all aspects of health and wellbeing within their role.	this. This may also have a positive impact on staff health eg through better understanding of the importance of a healthy diet and physical activity.		and wellbeing for young children.	
We are aware of how to support staff's social, emotional and physical health and wellbeing	Staff health improved, but also means they are acting as good role models to children and families, so should indirectly have an impact on their health as well.	Settings are aware of services available locally and support staff to access them.	Should have a positive effect on health inequalities as many staff working in childcare settings are on low incomes and likely to have worse health.	Settings are aware of services available locally and support staff to access them.
Our listening culture promotes health and enables children, staff and parents and carers to influence change.	Will help empower children, parents and staff and contribute to emotional wellbeing if they feel that their opinion is valued. Issues identified will be those which are important to them and therefore there is more likely to be motivation to change and improved health behaviours if they are part of designing solutions.	Ensure any consultation is genuine and acted upon and children, parents and staff are actively involved in identifying possible actions.	Should have a positive impact as will enable children, parents and staff to identify issues that are most important to them. However this requires that efforts are made to seek the views of all as more disadvantaged groups could be less likely to contribute, for example if there is a language barrier.	As well as providing mechanisms for parents/carers/staff to give feedback, settings should actively seek the opinions of those who are less well engaged.
Quality of teaching, learning and assessment:				
We consider individual children's needs, interests and stages of	Planning and responsiveness to children's needs in the	Ensure both universal and targeted measures are in place so that the setting is	Should help reduce health inequalities as it is a needs based approach.	Make sure settings are aware of the issues within their area and groups of

Programme component	Potential health impacts	Recommendations to maximise positive impact on health	Potential impact on health inequalities	Recommendations to maximise positive effects on health inequalities
development to plan experiences that will support each child's health and wellbeing	areas of communication and language, physical development and personal, social and emotional development will help improve children's health and wellbeing in these areas.	planning experiences that will benefit a wide range of children, as well as targeting the additional needs of specific children.		children most likely to be affected, in particular for health problems that may be less immediately obvious.
All staff are confident to contribute high quality observations to assess children's health and wellbeing on a daily and weekly basis. These assessments, alongside those from parents and carers inform planning, provision and support for each child.	Should support improvements in children's health and wellbeing through identification of individual needs and provision of appropriate support.	Ensure staff receive high quality training to enable them to do this well.	Should help reduce health inequalities through addressing the needs of individual children.	Parents and carers in more disadvantaged areas may need additional support in helping their children progress.
We are able to identify early and plan, with parents and carers and partners, for children's additional physical, social, emotional and mental health needs.	Should support improvements in children's health and wellbeing through identification of individual needs and provision of appropriate support.	Ensure staff receive high quality training to enable them to do this well. This may include accessing specific training where a child has a less common problem.	Should help reduce health inequalities through addressing the needs of individual children.	Parents and carers in more disadvantaged areas may need additional support in helping their children progress.
We celebrate diversity and promote equality and inclusive practice in all aspects of work with children and families. This	Will help support emotional wellbeing of children through inclusive practice and valuing their different cultural practices.	While celebrating diversity need to also recognise where practices which are more prevalent in some cultures may have a	Inclusive practices should help reduce health inequalities by making sure all are valued.	While celebrating diversity need to also recognise where practices which are more prevalent in some cultures may have a

Programme component	Potential health impacts	Recommendations to maximise positive impact on health	Potential impact on health inequalities	Recommendations to maximise positive effects on health inequalities
reflects the 'Fundamental British Values' of democracy, rule of law, individual liberty, mutual respect and tolerance for those with different faiths and beliefs.		negative impact on health, for example high sugar content in weaning foods in some communities. While valuing cultural differences staff need to feel confident in giving advice when practices may be damaging to health.		negative impact on health, for example high sugar content in weaning foods in some communities. While valuing cultural differences staff need to feel confident in giving advice when practices may be damaging to health.
Personal development, behaviour and welfare:				
All elements of our practice promote the characteristics of learning where children's emerging interests and abilities support them to be deeply engaged, motivated and creative in their thinking, choosing and playing.	This should help support children's social and emotional wellbeing as well as physical activity and motor development.	Ensure outdoor, active play is incorporated within this.	Should help reduce health inequalities provided all children are involved and targeted additional support is given where needed.	Ensure targeted support is available based on the needs of individual children.
We meet the individual health and wellbeing needs of children through an effective key person system that supports the development of close attachment. This system is part of our holistic approach to health, care and education.	Will help in promoting social and emotional wellbeing in children.	Ensure good communication between key person and parents, who can provide advice to parents on where to access additional support for them or their child if this is required in particular in promoting good attachment between children and their parents	Should help in reducing health inequalities by ensuring those children who do not have a close attachment with their parents have an adult they are able to form a close attachment with.	Recognise that some children will need additional support and time to develop a close attachment with their key person and ensure the key person has sufficient time and attention to meet individual children's needs in this area.

Programme component	Potential health impacts	Recommendations to maximise positive impact on health	Potential impact on health inequalities	Recommendations to maximise positive effects on health inequalities
		or carers.		
We ensure that staff plan and provide opportunities that support all children's understanding of how to stay safe and healthy (physical, social and emotional health).	Will help in supporting children to have good physical, social and emotional health.	Ensure staff have appropriate training, including staying up to date, and enough time to plan appropriate opportunities for children.	Should help reduce health inequalities by meeting the needs of all children.	Ensure sufficient time and targeted support is available to meet the needs of those who may need extra support in any of these areas.
Children have daily access to the outdoors and the natural environment	Will help promote physical activity and good mental health.	Ensure children have adequate exposure to green spaces.	Should help reduce health inequalities by giving all children the opportunity for outdoor activities.	Ensure adequate exposure to outdoor activities in particular for those children who may have limited exposure to this in their home environment.
We are a health promoting environment and provide up-to-date information. Our staff are confident to support parents and carers directly and to enable them to access additional help relating to social, emotional and physical health and wellbeing.	Should help promote health across a range of areas.	Ensure staff have access to regular training on health issues and access to the most up to date guidance.	Will help reduce health inequalities if staff are able to provide additional support to those parents, carers and children who require it.	Staff need to have sufficient time to build relationships and communicate with parents, especially where they may require help with more sensitive issues.
Silver and Gold award				
Identify 3 areas of work to develop based on children, families or staff needs.	Should be based on identified needs within the setting and therefore be expected to have a	Choose areas with the greatest level of need and where there is most evidence that the chosen	Requiring at least one of the areas to be targeted to the specific needs of a child or group of children	Ensure the needs of more disadvantaged groups are recognised within the areas chosen for action.

Programme component	Potential health impacts	Recommendations to maximise positive impact on health	Potential impact on health inequalities	Recommendations to maximise positive effects on health inequalities
	positive health impact in the area chosen.	actions can have a positive impact.	should have a positive impact on health inequalities.	

Stakeholder Consultation

Consultation with stakeholders about the potential impact of the tool on health and inequalities took place in May and June 2016, through means of a survey and a round table event.

Survey findings

In total 27 people responded to the survey. The majority of these (70.4%) were from local authorities. No respondents were childminders or from private, voluntary or independent nurseries or children's centres. One respondent was from a social enterprise nursery group.

Most respondents thought that the proposed framework would help (69.2%) or partly help (26.9%) settings and childminders to meet child health outcomes. Findings were similar for child wellbeing outcomes, with 65.4% thinking the framework would help settings and childminders meet child wellbeing outcomes and a further 30.1% thinking it would partly help. In terms of school readiness outcomes, 76.0% thought it would help settings and childminders meet them, and a further 16.0% thought it would partly help.

The respondents were given the opportunity to make additional comments, which helped illustrate the reasons for their responses. Issues raised by respondents included:

- The framework will support settings and childminders in what they are already doing.
- The health outcomes and impact need to be more clearly visible.
- Greater focus is needed on certain areas eg breastfeeding, healthy start, smoke free homes, toileting independence.
- Concerns about capacity of staff to complete paperwork.
- Concerns it duplicates information settings are already statutorily required to provide.
- Settings may need support to engage eg supporting tools.
- Children's centres also need to be part of a PLHEYs programme.
- Insufficient for settings/childminders just to have information available, they also need to consider how they promote and share it.
- Organisations need to be working together.
- Defining school readiness is difficult and needs careful thought, in particular to ensure that children with disabilities or SEN are not excluded.
- There needs to be an evaluation of the impact if a programme is introduced.

Sample quotes are provided to illustrate some of these issues.

> "I think the framework will assist settings capture much of what they are likely already doing to contribute towards the health and well being of children within their care. Settings, including childminders as part of their registration process are much better at asking about the holistic health needs of the child as they are acutely aware how this can impact on the child's ability to settle, learn and enjoy their early years in education."

“Again the health outcomes and impact need to be clearly visible, as the current framework is very EYFS and Ofsted requirement led.”

“The information is clearly set out and demonstrates how health and wellbeing can be interwoven into other areas within a setting.”

“This will help raise awareness of the importance of children's well being and it's impact on health. However as in the previous answer, this will be more successful if all services work together to ensure there is a culture shift, that has this awareness at its core.”

“Yes in principle - however their workforce and financial capacity will affect the impact - how has the framework considered that? childminders will find this harder to complete.”

“I think it will guide them in collating the outcomes they need to achieve but it will not necessarily support them to achieve theses outcomes, I think they may need more supporting tools for this.”

“It will aid them if they are already of that mind set. I am a little concerned that EY settings may see this as another certificate on the wall rather than a way of being. I guess it depends on how it is contextualized and rolled out.”

“This will depend on how "school readiness" is defined and need to be aware of any inequalities that a definition could reflect and are not linked to specific skill for example writing, caring for self in toilet as these may exclude children with disabilities or SEND. It also needs to be clear that these skills/attributes would be reached at end of Foundation stage.”

“Good link to EYFS however they are already working towards this and I worry about duplication of information that they are being asked to submit.”

Most respondents (88.5%) thought that the awards pathway, outcome framework and guidance were appealing and understandable. In terms of the bronze planning tools, 46.2% thought they were user friendly and a further 50.0% thought they were partly user friendly. Some felt that the paperwork was a bit overwhelming and there was overlap with what were already statutory requirements. The need for local information and training opportunities to be included within the documentation was also highlighted, as well as making the link with local priorities for example from the local health and wellbeing board. Some liked the link to OFSTED areas, whereas others felt the headings should be more health focussed.

“The guidance notes are very clear and detailed • The pathway, audit and action plan align really closely and nicely to OFSTED areas, which I think is a good selling point for settings • A real positive that should be highlighted to Early Years Leaders is that consideration has been given to align the framework to the OFSTED inspection framework which setting leaders are very familiar with already.”

“It is overall detailed and will put settings off especially child-minders. Almost as if they are been set to fail. It will be best if the headings were Health focussed so Oral Health Physical Activity Healthy Eating Immunisations Emotional Wellbeing

Breastfeeding Smoking Cessation. A lot of the criteria in the documents are statutory and should already be done so putting the health headings and linking them with the statutory key areas makes more sense."

In terms of inequalities, 62.5% did not feel there were any groups that might be disadvantaged by the programme. There were two main groups identified as being potentially disadvantaged by the programme. The first was those who did not attend early years settings or childminders or who are being looked after by family members. The second group, was some of the settings-for example childminders with English as a second language, childminders and smaller nurseries who may have less resources and need more support to participate in the PLHEYs programme, and settings without a dedicated co-ordinator. One respondent also expressed the concern that those from low socio-economic backgrounds, with English as a second language or from a minority ethnic group could be disadvantaged because of a lack of understanding from parents about the PLHEYs programme and therefore a lack of support for childminders who want to participate.

Round table event

The round table event was attended by 41 people. The majority (22) were from local authorities; there were eight people representing the Greater London Authority, one from a clinical commissioning group and 10 from other organisations. Other organisations represented included Active Movement, Active Matters, Children's Food Trust, Public Health England, London Sport, Transport for London, Health Education Partnership, Hackney Learning Trust and The Education Network for Waltham Forest. Unfortunately there were no nursery staff or childminders at this event.

The findings from this event were very similar to those identified during the survey. Some liked the framework and its link to the OFSTED areas, feeling this would be readily understandable by settings. However, others were concerned that health areas, although there, were not visible enough within the framework as it stands. They felt that it needed to be structured by health themes, for example physical activity, healthy weight etc. This is important if the PLHEYs programme is to deliver good health outcomes for children. If health is not sufficiently visible within the framework, settings may not see the value of participating, and if they do participate may not achieve the best outcomes if they are not completely clear on what they are trying to achieve.

The framework was felt to be too long and labour intensive, which could be off-putting to smaller settings and childminders who have limited capacity and time to complete it. There is overlap with statutory requirements, which means settings will be providing this information twice. The need to demonstrate a meaningful impact and ensure it is not just a tick-box exercise for settings was also commented on. The need for support for settings participating within the programme was discussed. Examples of support they may require included central co-ordination, training, resources, networking and sharing good practice, practical ideas and concrete examples.

As well as the concerns that health themes were not sufficiently visible within the tool, there were also specific areas people felt needed a greater focus. Examples included breast feeding, food growing, promoting healthy packed lunches in settings where food not provided and oral health. As the majority of these themes were considered in developing the

tool, it is possible that the OFSTED themed, rather than health themed, framework made it even harder to see where some of these things would fit.

In terms of the impact on inequalities a range of ideas were discussed. It was felt that the tool may be useful in enabling conversations on inequalities. However, varying capacity in settings and within Local Authorities might impact on take up of the PLHEYs programme. In particular the need to consider how to engage and support settings where there was no Local Authority support available was mentioned as a particular concern. One area where settings are likely to require support from Local Authorities is in accessing data to identify the relevant inequalities locally. Local priorities were felt to be important and attendees thought these should be the areas that settings focussed on in Gold and Silver awards. Attendees also felt that children's centres should be able to participate in the PLHEYs programme even when not directly providing child care.

Although the school readiness focus was popular, the difficulties of defining this were discussed, especially in terms of ensuring a definition was also applicable to children with special needs and disabilities, who may never be able to do some things, for example walk. It was felt to be important to adapt definitions, where applicable, to ensure they focus on children achieving their potential, even if they may never meet EYFS standards.

There were also concerns about how level of take up in deprived areas could impact on health inequalities, if take up was lower in more deprived areas. The Healthy Schools London programme was discussed, where this has not proved to be an issue, however the differences between schools and early years settings, for example in terms of staff qualifications were recognised. Other issues raised in terms of health inequalities were the need to consider cultural religious factors, in particular when thinking about healthy eating and weight.

Conclusions

Analysis of data on health and school readiness indicators, confirms that there are groups of children who persistently have worse outcomes across a range of areas. These include boys, some minority ethnic groups, and those from lower socio-economic backgrounds. However, there are some exceptions to this at both national and local level, and therefore it is important that participating settings have access to information about health inequalities and health priorities locally.

Overall the health impact and health inequalities impact assessment suggests that the PLHEYs programme should have a positive effect on both health and health inequalities. However, some changes may be required to the existing tool in order to maximise the positive effects, and careful consideration needs to be given to the support available, from both the GLA and Local Authorities, to settings and childminders who participate in the PLHEYs programme. Additional consultation is likely to be required with staff working in early years settings and childminders to ascertain their views on the PLHEYs programme.

Recommendations

- Conduct additional consultation with staff working in early years settings and childminders about their views on the PLHEYs programme.
- Increase the visibility of health themes within the existing tool or change to a tool based on health themes. Consider consulting with staff working in early years settings and childminders about their preferences.
- Simplify the tool, for example consider making reference to statutory requirements and asking settings to confirm they have met them.
- Ensure sufficient provision is made in any school readiness definition and where appropriate within the tool for disabled children and those with special educational needs.
- Ensure a focus on local priorities in silver and gold awards.
- Agree and define the support which would be expected to be provided by Local Authorities, and that which the GLA will provide.
- Consider a centrally run PLHEYs programme website with information and resources.
- Ensure there is sufficient support provided to settings to enable them to participate in the PLHEYs programme, for example information on local priorities and health inequalities, sample policies, links to high quality websites and resources. In particular consider the requirements of those settings which may have a greater need for support, for example small settings, or childminders with English as an additional language.
- Ensure the assessment process is supportive but sufficiently challenging to lead to improvements in children's health and wellbeing. Ensure quality control is built into the process.
- Monitor take up of the PLHEYs programme to ensure it is being taken up equitably across London, in particular in areas with a higher level of deprivation or where more of the population is from an ethnic minority group.
- Conduct an evaluation of the PLHEYs programme after the initial pilot to assess whether the programme is having an impact.

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