Halton Joint Strategic Needs Assessment 2014

Background, Methodology and Key Findings

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Halton Safeguarding Children Board

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Number of pages	28
Date release	April 2014
Description	This document constitutes chapter 1 of the 2014 Children's Joint Strategic Needs Assessment (JSNA) for Halton. The document describes the JSNA policy context, methodology and framework for developing the JSNA as well as data limitations. It also details the main findings and priorities to emerge from each chapter.
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Related documents	none

Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.

Abbreviations

A&E	Accident and Emergency (also called 'Casualty' – hospital facility)
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CICOLAs	Children In Care Outside Local Authority
CMO	Chief Medical Officer
CYPP	Children and Young People's Plan
DCSF	Department for Children, Schools and Families
DfE	Deaprtment for Education
FSM	Free school meals
HSCB	Halton Safeguarding Children Board
HNA	Health Needs Assessment
HSE	Health Survey for England
JSNA	Joint Strategic Needs Assessment
LAIT	Local Authority Interactive Tool (DfE indicator tool)
LSCB	Local Safeguarding Children Board
NEET	Not in education, employment or training
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
MMR	Measles, Mumps and Rubella (usually used to refer to the triple vaccine)
SEN	Special Educational Needs

Contents

1. Introduction

The Joint Strategic Needs Assessment (JSNA) is a systematic way of assessing the health and social needs of the local population. The JSNA should enable strategic partnerships and commissioning leads to make informed decisions about local action and services across a wide range of needs. It not only looks at the overall health and social needs of children & young people, but considers inequalities in outcomes and experience for specific groups. This relates to children living in areas of deprivation, to age and gender, to disability, and to vulnerable groups.

Increasingly JSNAs are being seen as a process of continuous development and improvement, rather than single documents produced once every few years.

Whilst there are no direct policy implications in revising the JSNA in itself, the findings should inform commissioning decisions, including the Children & Young People's Plan. As such the findings may impact on policy and commissioning decisions. The value of the JSNA lies in the degree to which it is understood and valued by strategic partnerships and commissioning leads - the extent to which it is a useful tool to inform their decision making. To fulfil this, it needs their active engagement to ensure it is 'fit for purpose'.

Responsibility for developing the JSNA

The Health & Wellbeing Board has overall responsibility for the JSNA and its development is led by the public health team.

Although the JSNA has been in existence since 2008 and has been used by commissioners to inform decision making, the Children's Trust Executive Board wanted a fresh approach to the next iteration of the children's JSNA. In particular the impact of the Marmot review on health inequalities, has laid the foundations for local areas to relook at their approaches. The life course approach advocated by Marmot has been used in the development of the Health & Wellbeing Strategy and its action plans and is now used to summarise the JSNA on an annual basis.

A working group, made up of members from the Children's Trust Executive Board and Commissioning Partnership, developed a framework for the refresh of the children's JSNA. This follows the life course but allows for the needs of vulnerable groups to be considered in detail as well.

In addition there is a local protocol between the Health & Wellbeing Board and the Halton Safeguarding Children Board (HCSB) which includes recognition for the need for joint ownership for the JSNA between these two boards. A paper was taken to the October 2013 HSCB Executive Board to agree the scope of this element of the JSNA. It was agreed it

needed a more in depth approach than the current chapter, titled 'vulnerable children'. Authors were identified from the HCSB and the scope agreed. A paper was also presented to the December 2013 HSCB on the framework for the Safeguarding chapter. This is detailed in the methodology section alongside the overall JSNA framework.

Regular progress reports were provided to the Children's Trust Executive Group, the Children's Trust Commissioning Partnership and the HCSB Executive Board at key stages of development.

2. National Policy Context for JSNA

2.1. What is JSNA?

The definition from the Department of Health's JSNA Guidance[1] is:

> *"Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services and informs future service planning taking into account evidence of effectiveness".*

JSNA identifies 'the big picture', in terms of the health and wellbeing needs and inequalities of a local population. The basis of a high quality and robust JSNA is the analysis of current and predicted health and well-being outcomes. The JSNA process should be underpinned by partnership working, community engagement and evidence of effective interventions to address the issues identified.

Breaking the phrase down into its constituent parts is useful in defining what it means in practice:

Joint -The duty to undertake JSNA was introduced in 2007 in recognition that strategic planning for health and wellbeing was best done in partnership, and based on evidence. It is intended to provide a powerful model for joint working in every locality. The Health & Social Care Act sets out the role that JSNA, and its local evidence of need, should play in the work of the Health & Wellbeing Board and the Joint Health & Wellbeing Strategy.

Thus, a key element of the JSNA is that it should involve all the important stakeholders in identifying needs and acting upon them. Crucially the JSNA provides a new framework for health and social care to collectively work in partnership to identify the needs of the population they serve and to work together in commissioning services to meet those needs.

Strategic - the JSNA should identify those needs and service requirements that are most relevant and important to its population. The needs assessment process should provide health and social care organisations with evidence based identification of the key needs of its population and should therefore define the strategic direction in commissioning of

1.Department of Health (2013) Statutory guidance published on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategieshttp://webarchive.nationalarchives.gov.uk/20130805112926/https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/18/files/2013/03/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

services. This strategic direction should consider both todays and future health and social care needs.

Needs assessment - there are many definitions of needs assessment. In order to identify health and wellbeing needs the assessment process should make use of existing information, identify information gaps and should include the views of service users, patients and the population. Importantly the needs assessment must include outputs that can be translated into actions for the commissioning and delivery of health and social care services, health improvement and wellbeing programmes and other interventions. The process should consider social inclusion and should identify inequities and inequalities in health and well-being and in current service delivery.

2.2. How should a JSNA be done?

Whilst producing a JSNA is a mandatory requirement, keeping with the 'light touch' approach from national government, Department of Health guidance on the preparation of the JSNA allows for local initiative and discretion. The guidance does however make it clear that the JSNA should be seen as an evolving process of understanding local needs and establishing agreed priorities, rather than as a traditional planning document to be produced at a single point in time.

3. National and Local Policy Context for Child Health & Wellbeing

Since the publication of the National Service Framework for Children in 2004 there have been a wide range of national policy directives concerned with improving the health and wellbeing of children and young people and ensuring the most vulnerable in society are protected from harm and helped to achieve their full potential. One of the most recent reports is the 2012 annual report of the Chief Medical Officer.

3.1. Chief Medical Officer's annual report 2012: Our children deserve better: prevention pays[2]

The Chief Medical Officer (CMO) for England chose to focus the 2012 annual report on the health and wellbeing needs of children and young people. This was done for a number of reasons:

- The evidence base for the life course approach is strong. What happens early in life affects health and wellbeing in later life. There is increasing evidence that, in England, we are not doing as well as we should to achieve good health and wellbeing outcomes for our children and young people – when we compare both historically and within and between countries for mortality, morbidity, wellbeing, social determinants and key indicators of health service provision.
- The variation we see within our country shows us what 'good' looks like and what is possible: we know we can do better.
- While our economic future may be challenging, there is a growing business case for improving the lives of children and young people. Improving health has the potential to benefit our nation economically.

This report is published in two volumes.

The first chapter is the CMO response to the evidence base underpinning the challenges facing children and young people today. The report highlights issues that require specific focus by policy makers, health and social care commissioners, police and crime commissioners, and providers of health, social care, education, housing and beyond.

Volume two focuses on an examination of the life course stages experienced by those up to the age of 25 years. In addition, four other groups of children and young people were focused on: those with neurodevelopmental disabilities, those with mental health problems, looked after children, and those in the youth justice system. The report also looks at the economic argument for early intervention. The report contains a sizeable annex, the *Atlas of*

2.https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

variation in healthcare for children and young people, which describes some of the variation in health and healthcare across England.

3.2. Children and Families Bill[3]

The Children and Families Bill takes forward the Coalition Government's commitments to improve services for vulnerable children and support strong families. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background. The Bill will reform the systems for adoption, looked after children, family justice and special educational needs. It will encourage growth in the childcare sector, introduce a new system of shared parental leave and ensure children in England have a strong advocate for their rights.

This is a joint Bill, presented by the Secretary of State for Education and on behalf of the Departments for Business, Innovation and Skills, Work and Pensions and the Ministry of Justice. The Bill's provisions have been developed following several independent reviews and extensive consultation. Key reforms within the Bill are commitments to:

- Have more children being adopted by loving families with less delay.
- Improving life chances for all looked after children by improving educational attainment levels. The Bill requires every local authority to have a 'virtual school head' to champion the education of children in the authority's care, as if they all attended the same school.
- Reforming the family justice system to help deliver better outcomes for children and families who go to court after family separation or where children may be taken into care.
- Transforming the system for children and young people with special educational needs (SEN), including those who are disabled, so that services consistently support the best outcomes for them. The SEN system will be expanded from birth to 25, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met.
- Reforming childcare to ensure the whole system focuses on providing safe, high-quality care and early education for children.
- Make sure that the Children's Commissioner can act as a strong advocate for children, helping to embed a culture where children's rights and interests are duly recognised. The Bill will help improve the Children's Commissioner's effectiveness, taking forward recommendations in John Dunford's Review of the Office of the Children's Commissioner.
- Encouraging the full involvement of both parents from the earliest stages of pregnancy, including by promoting a system of shared parental leave, and to extending the right to request flexible working to all employees.

3.www.education.gov.uk/childrenandfamiliesbill

3.3. Fair Society Healthy Lives[4]

This report, published in February 2010, often referred to as the 'Marmot Review' was an update on previous reports on health inequalities. Lead by Professor Sir Michael Marmot, this independent review drew on national and international research, which showed that the elements contributing to excellent opportunities and outcomes for children and young people are wide ranging. However, in countries where children and young people have the best outcomes, four common features were identified that have the most significant impact:

Family and parenting – This involves good relationships between parents and their children; a warm, firm and positive parenting style; a stable family unit; good relationships between children and extended family members and between siblings.

Pregnancy and early years support – This includes support throughout pregnancy to age five through childcare, pre-school education, physical and emotional health.

Education – Where children have a solid foundation that promotes lifelong learning, those aged five to 18 achieve good learning outcomes within formal education or training. This is enhanced by access to and achievement within higher education.

Material wellbeing –The quality of environment and the personal and public resources available to a child or young person as they grow up impacts on their outcomes. Children's personal resources are often determined by their parents' prosperity.

The review concluded that reducing health inequalities would require action on six policy objectives which were split across the life course:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

An outcomes approach using this life course would need to include measures to ensure all children and young people can:

- be happy and enjoy their childhood
- have access to sufficient material resources
- build and maintain positive relationships and good social skills
- develop respect and responsibility for themselves, for others and their community
- have good emotional health and wellbeing

4.http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

- have good physical health
- enjoy good educational achievement
- develop realistic, but challenging aspirations
- be safe and learn to make good decisions regarding safety
- have access to the appropriate information and services
- be able to access stimulating and enjoyable leisure and cultural opportunities.

3.4. Early Intervention is essential

A range of reviews conducted by:

- Professor Sir Michael Marmot: Fair Society, Healthy Lives
- The Rt Hon Frank Field MP: The Foundation Years: Preventing Poor Children Becoming Poor Adults
- Graham Allen, MP: Early Intervention, the next steps
- Dame Clare Tickell: Review of the Early Years Foundation Stage
- Professor Eileen Munro: Review of Child Protection

Have all made it clear that early intervention and support is vital to enable all children to maximise their potential. **The *Allen Report*[5]** sets out the working definition for "Early Intervention" in that it should be used to describe the "general approaches, and the specific policies and programmes, which help to give children aged 0-3 the social and emotional bedrock they need to reach their full potential, and to those which help older children become the good parents of tomorrow" (0-18 years old). The report also sets out the "core message on early Intervention" which defines it as an approach "which offers our country a real opportunity to make lasting improvements in the lives of our children and forestall any persistent social problems and end their transmissions from one generation to the next and to make long term savings in public spending". It notes the current context that" many programmes and policies across the world have been given the title and kudos of 'Early Intervention'. Not all of them deserve this status".

It sets out the rationale for and Early Intervention approach namely that:

> *"Many of the costly and damaging social problems in society are created because we are not giving children the right type of support in their earliest years, when they should achieve their most rapid development".*

3.5. Making Sure the NHS meets the needs of children and young people

Sir David Nicholson asked Professor Sir Ian Kennedy to undertake this independent review amid widespread concern about the services provided by the NHS to children and young people. The resulting report ***Getting it right for children and young people***[6] concentrates on

5. http://www.dwp.gov.uk/docs/early-intervention-next-steps.pdf
6. Download full review (PDF, 5195K)

understanding the role of culture in the NHS. It focuses on those areas where there are cultural barriers to change and improvement. It examines the NHS's position in a wider system of care and support, so as to understand and improve the NHS's provision of services to children and young people.

The review uncovered many cultural barriers standing in the way of improving services for children and young people. These were created, and operate, at a number of levels, from Whitehall, through regional and local organisations, to contacts between individual professionals, and with children, young people and those looking after them. The report makes several recommendations for improvement.

The review was published at the same time as an engagement document, ***Achieving Equity and Excellence for Children***[7] in which the Government sets out a new vision for the health of children and young people. It is the beginning of an ongoing dialogue on how to ensure high-quality services for children and young people.

In the past, the NHS was not always set up to put the needs of patients and the public first. Too often patients were expected to fit around services rather than services around patients. Nowhere has this been more evident than for children, young people and their families, as Sir Ian Kennedy has shown in his report.

Children and young people are mostly healthy and therefore, thankfully, will never feature highly where decisions are taken based on the burden of disease or on cases of premature death. But illness and injury can have a long-lasting impact on a young person's life and ultimately on their life chances and therefore on our economy and society. In turn this can impact significantly on their family's life.

3.6. Continuing to Improve Outcomes

3.6.1. National Outcomes Frameworks

In recognition of the changes to the health and social care system, as a result of the Health & Social Care Act, three new outcomes frameworks have been developed:

- Public Health Outcomes framework
- NHS Outcomes Framework
- Social Care Outcomes Framework

7.Achieving Equity and Excellence for Children

Many of the old national indicators for children and young people were incorporated into these, especially the public health outcomes framework, which includes indicators for child poverty, school readiness, immunisations, obesity and many others. Using the latest year for which comparable data is available, Halton's outcomes against each national outcome framework indicator is detailed in Table 1 (note not all data is currently available at local authority level or for NHS outcomes framework at CCG level).

Table 1: Halton outcomes against national outcomes framework indicators

Public Health Outcomes Framework indicators	How well is Halton doing against this indicator? (using latest comparable data available)
1.01i - Percentage of all dependent children under 20 in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)	Significantly worse England average
1.01ii - % of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is < 60% median income) for u-16s only	Significantly worse England average
1.02i-ii - School Readiness: All children achieving a good level of development at the end of reception as a percentage of all eligible children.	Worse England average across all school readiness indicators (significantly worse for most of the indicators)
1.03 - % of half days missed by pupils due to overall absence (incl. authorised and unauthorised absence)	Better England rate
1.04 - Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population	Rate similar to England
1.05 - % of 16-18 year olds not in education, employment or training (NEET)	Rate worse England but has been improving
2.01 - % of all live births at term with low birth weight	Rate higher than England but not statistically worse
2.02i - % of all mothers who breastfeed their babies in the first 48hrs after delivery (initiation)	Rates worse than England average but signs that they are beginning to improve.
2.02ii - % of all infants due a 6-8 week check that are totally or partially breastfed	
2.03 - % of women who smoke at time of delivery	Rates above England average
2.04 - Rate of conceptions per 1,000 females aged 15-17 (<18s)	Rate has reduced substantially but remains about North West and statistically worse than national average
2.04 - Rate of conceptions per 1,000 females aged 13-15 (<16s)	Rate higher than England but not statistically worse
2.06i-ii - % of children aged 4-5 (Reception) and aged 10-11 (Year 6) classified as overweight or obese	Rates have fallen but remain above the North West and worse than England averages
2.07i-ii - Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years per 10,000 resident population and in young people aged 15-24 per 10,000 resident population	Rates for both age groups statistically worse than England averages
2.08 - Average difficulties score for all looked after children aged 4-16 who have been in care for at least 12 months on 31st March (emotional wellbeing of looked after children)	Score similar to North West and England ones. Not statistically comparable.
3.02i-iii - Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24 using CTAD data	Rates are higher than England
3.03i-xii Population vaccine coverage	Coverage above England rates for most vaccinations.
4.01 - Rate of deaths in infants aged under 1 year per 1,000 live	After years of being above the England

births (Infant mortality)	average, local reductions mean Halton now has similar rates to England.
4.02 - Tooth decay in children aged five years	After years of being above the England average, local reductions mean Halton now has similar rates to England.
NHS Outcomes Framework indicators	**How well is Halton doing against this indicator? (using latest comparable data available)**
Potential years of life lost from causes considered amenable to healthcare: adults, children and young people	Only available at England level
Reducing deaths in babies and young children	Neonatal and still births rate higher than England but local numbers low.
Unplanned hospitalisations for asthma, diabetes and epilepsy in under 19s	Higher than England but rate not statistically significantly higher.
Emergency admissions for children with lower respiratory tract infections	Statistically significantly higher than England. Higher rate than Merseyside but not statistically significant difference.
Women's experience of maternity services	Indicator at CCG level not yet available
Improving children and young people's experience of healthcare :	Indicator under development

3.6.2. The Children and Young People's Health Outcomes Forum Report[8]

Informed by engagement with some two thousand people – children and young people and their families and those working in the wider health and social care system – this sets out a case for change.

There is clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence based early intervention can have significant shorter and longer term positive impacts. Smoking, alcohol, poor nutrition, and stress or the absence of a warm loving relationship can have significant shorter and longer term negative impacts.

Early intervention can prevent ill health and reduce mortality and morbidity for children and young people. Healthy behaviours in childhood and the teenage years set patterns for later life. Continued support for children and young people can mean that society as a whole can reap all the benefits of a resilient next generation, which is healthier and happier.

The causes of avoidable childhood deaths are complex and differ at each stage of childhood. Securing a reduction in mortality and morbidity, requires a multifaceted approach, encompassing effective public health interventions in pregnancy, the early, school and teenage years, alongside improvements in health care from conception to adulthood. It also requires a focus on the groups of children who experience the worst outcomes.

8. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216854/CYP-Public-Health.pdf

High quality, evidence based and safe care are what should define health services for children and young people. We know how important it is to children, young people and their families that they are able to access the care and treatment that is right for them, as close to home as possible.

The need for integrated care coordinated around and tailored to the needs of the child or young person and their family is clear and fundamental to improving their health outcomes. Integration means the joins between services and commissioning responsibilities are invisible because organisations are working in partnership to deliver the best care across whole pathways and life stages. It means children, young people and parents don't have to keep repeating their information, that records are not lost or duplicated, that individuals and their needs do not fall between gaps and that resources are focused on the same goals.

In January 2014 the Child and Maternal Health Intelligence Network, CHIMAT (now part of Public Health England), published a first version of the Children and Young People's Health Outcomes Framework[9].

This new resource brings together and builds on health outcomes data from the Public Health Outcomes Framework and the NHS Outcomes Framework. It responds to the Children and Young People's Health Outcomes Forum's recommendation that a version of these frameworks be created which highlights areas of particular relevance to improving the health outcomes of children and young people.

A number of important additional indicators were also recommended by the Children and Young People's Health Outcomes Forum. These will be added to the Framework over the next year, as the data becomes available, together with increased detail for existing indicators. These indicators, when viewed together, will inform discussions and encourage improvements in services and health outcomes for children and young people.

This section details the main national policies which affect the health and wellbeing of children and young people. There are many more, including many that relate to particular groups or young people or conditions. Many are detailed in specific chapters of the JSNA. The most up-to-date and comprehensive list of these can be found on the CHIMAT website at http://www.chimat.org.uk/youngpeople/govpol

A useful source of national guidance to improve outcomes for children and young people can be found at the Centre for Excellence and Outcomes in Children and Young People's Services via their website http://www.c4eo.org.uk/

9. http://fingertips.phe.org.uk/profile/cyphof

4. Methodology

4.1. Local approach

As detailed in section 2 there is no set way of developing the JSNA. Locally, it was agreed that a standard approach to developing the individual elements of the JSNA may not be the most appropriate. Some issues may be best dealt with by short 'profiles' e.g. the section on detailing the population breakdown and socio-economic circumstances of children & young people in the borough. For other issues in-depth needs assessments would be more appropriate.

A number of strategies were written during the latter half of 2013 with others planned for 2014. These include those written to support health & wellbeing strategy priorities as well as other public health priority issues. Rapid needs analyses have been/will be conducted for these and this information will support the JSNA. These cover:

- Cancers (completed)
- Mental health strategy (completed)
- Drugs strategy (completed)
- Alcohol Strategy (January-June 2014)
- Sexual health (2014: dates TBC)

A separate piece of intelligence work has been carried out to support the Child & Family Poverty Strategy and action plan. This is summarised in the demographics profile section of the JSNA. Two rapid health needs assessments were conducted during 2013 to support reviews of joint Halton Borough Council and Halton Clinical Commissioning Group services. These covered Child & Adolescent Mental Health and Speech, Language and Communication Needs. Halton Public Health also commissioned an in-depth needs assessment of learning disabilities and autism covering children and adults on a Liverpool City Region footprint (data reported at local authority level) which was published October 2013. All of these form part of the JSNA. Summary information has been taken from other needs assessments with links to full documents.

4.2. Overseeing development of the JSNA

4.2.1. The working group

Once it was agreed to review and revise the children's JSNA a small working group was established to take this forward. The group began by looking at existing needs assessments that should feed in to the JSNA, mapped the 'what', 'who', 'when' and 'review schedule' of these. The working group split into a number of smaller 'author groups' for each chapter,

supported by information leads from Public Health, Customer Intelligence Unit and Performance.

A template, slightly revised from the 2011 JSNA, was used to guide construction of each chapter. However, it was more important to cover each issue as information emerged rather than follow a template strictly. Therefore the breadth and depth of each chapter was dictated by the issues it covered rather than being restricted to page limits. Some of the chapters had not featured to any great extent in previous JSNAs, others had been covered within topic-based chapters and a few subject to in-depth needs assessments over the last year or two. The working group continued to meet at regular stages of JSNA development to ensure momentum was maintained as well as dealing with consistency and duplication issues.

The JSNA schedule was developed to ensure key findings were available in time to support the development of the 2014 Children & Young People's Plan (CYPP). The JSNA lead is a member of the CYPP working group.

4.2.2. Frameworks for the JSNA

A framework for the development of the new JSNA has been agreed with authors identified for each section. This was presented to the Children's Trust Executive Group October 2013 and refined to combine elements on physical and learning disability and complex needs in to one section. The framework is across the life course, in line with the Marmot review of health inequalities, with additional sections to reflect vulnerable groups.

The framework for the 2014 children's JSNA is:

1. Background, methods and key findings
2. Population and socio-economic profile
3. Maternal health
4. Early years: 0-4 years
5. School age children 5-18 years
6. Educational attainment and employment
7. Safeguarding
8. Children with disabilities & complex needs, including learning disabilities and autism
9. Children in Care
10. Engagement and user views

There is a chapter in the 2011/12 JSNA on vulnerable children which needed updating for the 2014 JSNA. However, many issues relating to safeguarding are not covered in it. A number of external JSNAs were examined to see how other areas had looked at this issue. Most were brief documents and sections, primarily limited to descriptions of the number

and rate of children in need, children subject to Child Protection Plans with some including reasons for this. Some looked at child and adult safeguarding together. The HSCB Executive Board examined these and decided to adapt one to cover:

- *Protection from maltreatment e.g.* Child sexual exploitation, bullying, domestic violence and abuse, neglect, parental substance misuse, parental mental health, parental learning disability
- *Protection from impairment to health or development e.g.* teenage pregnancy, sexual health, self-harm, young carers, substance misuse in young people, children with mental health problems, young offenders
- *Ensuring Safe and effective care e.g.* Children referred to social services, children in care, children subject to a Child Protection Plan
- *Ensuring a Safe Environment e.g.* Child deaths, unintentional injuries, Accident and Emergency attendances, Road Traffic Accidents, Young people as victims of crime
- Complex and Multiple Needs
- Safeguarding Processes and Targeted Provision

Duplication with other chapters was discussed throughout the development of the chapter and the detail included in one chapter with summary information and a web link in the other. The Safeguarding chapter is constructed in line with the Levels of Need framework.

4.3. Data analysis, including access to data and information

The JSNA uses a wide variety of data from both national and local sources, including:

- Office of National Statistics (census population data)
- Index of Multiple Deprivation
- Health & Social Care Information Centre
- Department for Education (including Local Authority Interactive Tool: LAIT, February 2014)
- Local Performance systems
- Local providers
- CHIMAT
- Research papers
- National policy

The JSNA uses routinely collected data to profile the local population in terms of numbers who may potentially be at risk of a range of developing a range of conditions and problems. Where appropriate, it uses research to stratify the overall population, according to different levels of severity and types of condition.

The JSNA uses estimated data as well as numbers known to services. In this way, it attempts to describe any gaps between the total population who may have a need/condition and those known to services.

In this way the JSNA uses the same methodology as in-depth health needs assessments (HNAs). HNAs are a way of estimating the extent and nature of a population so that appropriate support is planned accordingly. The needs assessment can help:

- Estimate the current and future needs of a population
- Indicate the distribution of need: geographically and/or by sub-groups within the population of interest
- Identify the gap between met and unmet need.

HNA is a systematic method for reviewing the health needs and issues facing a given population, leading to agreed needs (priorities) for that population. The starting point in HNA is a defined population. This population can be defined in a number of ways. By:

- Geographic location – e.g. people living in a neighbourhood or catchment area
- Setting – e.g. school, workplace, prison or hospital
- Social experience – e.g. age, ethnicity, homelessness
- Experience of a health condition – e.g. disease, mental illness or physical disability.

Various models have been developed but the main components of the model used by public health are:

- *An epidemiological approach* – an examination of available information on incidence and prevalence, including hospital and primary care contacts, local audits, and estimates from local and national surveys
- *A comparative approach* – comparing local estimates of disease and/or activity with other similar areas or national data to assess if need is greater or lesser than expected
- *A corporate approach* – this approach gathers information on perceived needs from a wide range of health professionals, other sectors, patients and the community.The benefit of this approach is that it can be responsive to local concerns and encourages ownership of the issues that need to be addressed. The disadvantage is that if it is carried out in isolation it can focus on the stakeholders concerns, which may be influenced by political agendas, and can identify demands rather than need.

Thus, evidence of population need is collected in a systematic way from multiple sources from which the most important needs will emerge from more than one source.

Being able to describe the needs, using normative, comparative and expressed data is only part of the process of conducting a health needs assessment. It is also important to know which interventions are best suited to addressing which needs. Each chapter includes a list of national best practice from sources such as NICE (National Institute of Health & Clinical Excellence), Department of Health, and Department for Education as well the Marmot Review Team and others.

The breadth and depth of the JSNA is only as good as the information we have access to. There were delays in accessing some of the previously routinely collected data. This has been managed by the Public Health Intelligence Manager, supported by both Customer Intelligence Unit, Children & Enterprise Directorate performance and data quality staff and CCG colleagues, to ensure as much data as possible was available to authors. Access to outcomes data from services has been patchy with changes in both commissioning and provider organisations as well as IT changes having contributed to this, with some new systems still not operational. This meant authors had to, at times, take a pragmatic approach on data/information availability. Any core data not available at time of writing or that could not be accessed has been reported on in the specific chapter section it relates to.

Data was collated by the Public Health Team and provided to each chapter group.

4.4. Benchmarking borough outcomes: use of national, regional and statistical neighbours

Is important to be able to contextualise local data to determine whether outcomes seen locally are as expected, better or worse than other areas. Traditionally, North West and England averages are used to compare local data and this is replicated in the JSNA. However, a more robust approach which enables comparison with boroughs that are statistically similar is also presented where the data is available. Thus outcomes can be compared to a broadly similar population.

The Department for Children, Schools and Families (now Department for Education) commissioned a Children's Services Statistical Neighbour Benchmarking model in February 2007. The model defined for each local authority a robust set of statistical neighbours for all Local Authorities. This statistical neighbour grouping continues to be used e.g. by the Department for Education Local Authority Interactive Tool (LAIT), the latest version of which was published December 2013. Halton forms part of a statistical neighbours grouping with 10 other local authorities. The statistical neighbour comparison data shown throughout the JSNA uses an average derived from all 11 boroughs in the group. There may be some under calculation where 1-2 boroughs' data is not represented in national datasets due to small numbers. Statistical neighbour averages are not calculated where 3 or more borough's data is not available for a particular indicator. The group is made up of the following local authorities:

- Halton
- Darlington
- Hartlepool
- North East Lincolnshire
- Redcar & Cleveland
- Salford
- South Tyneside
- St. Helens
- Stockton on Tees
- Sunderland
- Tameside

Statistically neighbours analysis is not available for all indicators presented in the JSNA. Whilst individual areas data may be available, it is often only presented as crude or directly age standardised rate. It has not been possible to calculate statistical neighbour group averages when data has only been available as a rate. In this case only North West and England comparisons have been made.

5. Key Findings and Priorities

Most children lead happy, healthy lives with good relationships with family and friends. However, some do experience ill health or exhibit behaviours which put them at risk of harm or development of ill health. The findings and priorities emerging from the JSNA highlight the main areas of ill health, low levels of achievement and risk taking behaviours that contribute to these. Whilst many findings and priorities are specific to a particular life course stage or group, several themes did emerge across the JSNA.

Key themes:

- Emotional health & wellbeing and mental ill health
- Accidents
- Maintaining good results for many indictors and continuing to drive them in the right direction
- Some issues remain significant and resistant to change. Even for issues that have improved e.g. education attainment for children in care compared to general population, there remain inequalities across the borough that need to be addressed.
- Significant time of change: new services and payment tariffs, organisational change and financial pressures against a back-drop of welfare reforms and continuing economic hardship.

Maternity

1. Monitoring the impact of the introduction of a maternity Payment by Results tariff on local services, and mitigating any unforeseen consequences
2. Family Nurse Partnership - commission of the service and project implementation, including streamlining with existing services
3. Comprehensive universal service to all women and families, including the additional antenatal visits made by health visitors
4. Early access to antenatal services for all women, targeting vulnerable groups
5. Concentrated work on early recognition, treatment and support for maternal emotional health
6. Breastfeeding initiation – monitor initiation rates by borough when available, focused work to improve rates.
7. Improving women's awareness of the harm caused by alcohol and smoking during pregnancy. Monitor Smoking at the time of delivery by borough when available and commission accordingly.
8. Sudden infant death syndrome awareness raising, information to women
9. Method of delivery, including, Caesarean section rates

Early Years

1. Maintain and improve the delivery of a comprehensive universal offer to all young families
2. Focusing efforts to improve child development through:

    a. Physical health
    b. Communication and language skills
    c. Personal, social and emotional development
    d. Maximising the mother and child bond, and parenting skills
    e. Improved breastfeeding rates, particularly initiation rates

Delivery of high quality early years provision

3. Immunisations:

    a. Maintain increases in rates for children under 24 months,
    b. Capture children under 5 who missed their primary immunisations
    c. Catch up campaigns for older children, such as MMR[10] (in response to outbreaks)

5. Hospital admissions: Rates of emergency hospital admission in Halton are high compared to England. Admissions for gastroenteritis are statistically higher than the England average, in order to improve this priorities include breastfeeding and weaning practices, in respect to healthy eating.
6. Accidents: The rate of hospital admissions and accidents is higher in Halton than the England average. Commissioners should endeavour to ensure all services working with young families promote accident prevention to their clients and signpost as appropriate. Ensure providers are meeting NICE[11] guidelines in respect to accidents and road traffic accidents.
7. Obesity: continue work in the early years on breastfeeding, weaning, healthy eating and exercise which all contribute to reduce obesity in reception aged children.
8. Improvements in dental health of 5 year olds needs to be maintained and further improvements made, through evidence based oral health programmes.

10. MMR = triple vaccination for Measles, Mumps and Rubella
11. NICE – National Institute for Health & Clinical Excellence

School Age children

1. Maintain and improve reductions in teenage pregnancy, substance use (tobacco, alcohol and drugs), hospital admissions due to alcohol.
2. Maintain current reduction and continue to reduce the proportion of children who are overweight and obese. Do this through whole systems plans to tackle the 'obesenogenic' environment, as well as programmes to help children and their families who are already overweight to achieve and maintain a healthy weight.
3. Develop whole system, co-ordinated approaches to tackle high Accident & Emergency attendances and hospital admissions due to accidental injuries. Use NICE guidance to ensure a systematic, strategic approach to accident prevention is required with action aimed at the home (where most younger children have their accidents) and the wider built environment including the roads.
4. Look at ways to gather local intelligence on levels of mental wellbeing as well as mental ill health and factors that contribute to both.
5. Ensure integrated preventative and support services are in place that are family-focused to help both parents and children cope with parental mental health, alcohol and substance misuse problems.
6. The prevention, diagnosis, and early access to treatment for individuals with mental health problems should be a priority, including a clear pathway and adequate provision of CAMHS. This work is underway.
7. Hospital admissions due to self-harm although reducing are high in Halton. Commissioners should strive to improve the emotional resilience, peer support and access to appropriate service for children and young people who regularly self-harm.
8. There are high rates of immunisation against cervical cancer. The uptake rates for HPV in Halton are the highest in the North West. These should be maintained.

Education and Employment

1. Attainment in the Early Years Foundation Stage: Focusing upon the prime areas of learning and development as identified in the Framework for the Early Years Foundation Stage:

    a communication and language
    b physical development
    c personal, social and emotional development

There are four specific areas through which the prime areas are strengthened and applied:

    d literacy
    e mathematics
    f understanding the world

g expressive arts and design

Closing the gap in educational attainment for vulnerable groups including:

a Children and young people with Special Educational Needs (SEN)
b Children in Care
c Children and young people in receipt of Free School Meals (FSM)
d Young people with an academic age of 16-18 years who are not in education, employment or training (NEET)
e Children and young people in any other identified vulnerable groups including gender gaps

3. Children and young people with English as an Additional language (EAL) has been identified as an emerging rising need

Safeguarding

Based on the Halton Safeguarding Children Board Annual Report 2012/13 and supported by JSNA analysis the following priorities are outlined in the Local Safeguarding Children Board (LSCB) Business Plan 2013/15:

1. Identify and prevent children suffering harm – The rationale being that the LSCB identified that Halton had a low Child in Need population compared with statistical neighbours. Children were coming into care who were not known previously to Children's Social Care. Address the low number of CAF (Common Assessment Framework).
2. Protect children who are suffering or at risk of suffering harm – The rationale being the low Child in Need population, low number of children subject to Child Protection Plan, and the low number of children subject to Child Protection Plan for a second or subsequent time compared with statistical neighbours. The LSCB also identified that the Escalation Policy was not being used, with a lack of apparent challenge by partners.
3. Ensure that children are receiving effective early help and support – The rationale being the number of children coming into care previously not known to Children's Social Care. Also the low number of CAFs and high percentage of Lead Professionals from Children's Services and primary schools, indicating a lack of engagement in early help and support by other partners.
4. Support the development of a safe and informed workforce, including volunteers – The rationale being that all LSCBs have functions relating to learning and improvement, training and safer workforce.
5. Engage with Children and Young People, their Families and Communities in developing and raising awareness of Safeguarding – The rationale being that

awareness raising is a function of all LSCBs, and that the LSCB sees safeguarding children as everyone's business.

Embedded across all of these priorities is a focus by the LSCB on particularly vulnerable groups of children and young people. This includes: children at risk of sexual exploitation; Missing children; children with disabilities; Young Carers; Children in Care and Care Leavers.

Disabilities

1. Research undertaken into the pattern of child disability suggests that there has been an increase in the number of disabled children. This is especially so for those with complex needs and this increase is projected to continue, with improvements in medical technology as well as population changes being the drivers.
2. The rate of children with life limiting conditions is higher in Halton than for the North West and England. This appears to be due to improved medical technologies rather than an increase in incidence. Such children are more likely to need complex care packages and palliative care.
3. The percentage of Halton school children with a Special Educational Need is higher than the North West, statistical neighbours and England averages. These figures should be read in context; Halton schools and settings, in conjunction with Local Authority officers services and health, work proactively to develop innovative ways of supporting all school children & young people, without the need to place them into a set category within the graduated approach. Our Early Help policies and interventions will continue to become embedded within all areas of practice in the next few years and this, along with the new approach enshrined within the draft Code of Practice 2013, should ensure that there is a continuing reduction in the identification of SEN within existing classifications.
4. The percentage of Children in Need assessed as having a disability is lower in Halton than for its comparators. However, this is likely to be due to the borough's approach to early help and support and the range of services such as short breaks.
5. Three conditions account for over 90% of emergency admissions for children under 19s with long-term conditions. These are asthma, diabetes and epilepsy. For all three of these conditions the borough has higher rates of emergency hospital admissions than England. Work is needed to address these.
6. National research indicates that obesity levels are significantly higher for children who have disabilities, especially where this includes a learning disability. Local action needs to consider ways of supporting children who may find it difficult to participate in current service options.
7. Mental health and emotional support needs of children with disabilities need to be tailored to meet their specific needs

Children in Care

1. The borough has a lower rate of children in care than comparators. However, numbers have risen. This rise may put pressure on placement stability and impact on outcomes for children in care.
2. The borough is a net importer of children in care from other local authorities (CICOLAs). This put considerable additional capacity issues into local service provision.
3. Compared to statistical neighbours, NW and England, the Children in Care in Halton:
    - See a higher proportion having placement stability
    - Are more likely to be placed in the borough (70%, 86% within 20 miles of home)
    - Are more likely to be up-to-date with their immunisation schedule, have had their annual health check, to have had their annual dental check
    - Have slightly lower mental wellbeing scores
    - Have higher proportions reaching their expected level of educational achievement.
4. There remains a gap in educational achievement between children in care and non-Children In Care in the borough although the gap is narrowed. In particular there are gaps in English and Maths at all key stages for Children in Care compared to Halton overall and England overall achievement. This is consistent with regional and national experience. Positive discrimination to provide additional educational support to children in care should be considered.
5. Due to the way that the Pupil Premium funding is calculated the rising numbers of children in care are placing financial pressure on being able to meet the funding allocations for children and schools. This has occurred this year and with the changes in the eligibility criteria from April 2014 this is likely to continue. This will inevitably have an impact on schools' ability to provide additional support for Children in care and therefore may have a detrimental impact on their educational outcomes.
6. National research suggests Children in Care are more likely to suffer mental health and emotional wellbeing problems. Although there is no data at a local level to determine this, the annual health assessments undertaken for Children in Care for 12 months or more does show emotional and behaviour difficulties to be the most prevalent issues identified. Commissioners should ensure opportunities to improve the health and wellbeing for Children in Care are maximised, and that the health of Children in Care is a priority.