CHILDREN AND YOUNG PEOPLE CHILDREN OVERVIEW AND SCRUTINY COMMITTEE

6 DECEMBER 2016

RE-COMMISSIONING OF MEDWAY CHILD HEALTH SERVICES

Portfolio Holder:	Cllr David Brake, Adults Services
	Cllr Andrew Mackness, Children's Services
Report from:	Dr Andrew Burnett, Director of Public Health
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Summary

This paper is intended to outline the proposed approach and direction of travel for the re-commissioning of Medway's paediatric health services, which includes the 0-19 Healthy Child Programme (HCP) and community paediatric health services.

The paper provides details of the proposed approach of integration and associated implications relating to cost, benefit and risk, and seeks support and input from Public Health and Children and Adult's Directorate Management Teams to progress commissioning based on the proposed timeline.

The paper seeks to provide a solution for how a number of services currently commissioned by Medway Council's Public Health Directorate and the Partnership Commissioning Team can be commissioned to drive efficiency and integration into the paediatric services landscape, whilst delivering service improvements. The proposal is to run a single commissioning process that is underpinned by aligned outcome frameworks and, to tender for two individual lots of services, and to develop a system for ongoing integrated contract management.
The appended commissioning timeline works towards a contract award date in October 2017 with a period of provider mobilization to follow; based on legal advice, this is the latest point in time at which a contract containing some elements of current service provision could be awarded due to some contracts not able to be extended beyond this point. As such there is a risk relating to the proposed timeline, whereby any slippage causing a delay to the contract award date would mean that elements of service may be required to be commissioned independently rather than in an integrated manner.

Annual total costs of current services considered within this paper are approximately £5.7m for public health commissioned services, and £5.8m for CCG commissioned services.

1. Budget and Policy Framework

1.1 The budget for the Universal Healthy Child programme Services has been delegated to Medway Council and is a mandatory universal function attached to the Public Health Grant. Currently in Medway we spend around £5.7 million per annum on delivering the Healthy Child Programme in Medway.

1.2 The budget for community paediatric health services is held by the CCG and is used to commission a range of mandatory and non mandatory services that support children, young people and families who are vulnerable or have specialist medical, neurodevelopmental or health needs, which may be linked to learning disability. The approximate budget for these services is currently £5.8 million per annum. The whole process is being managed by Medway Council via the Public Health and Partnership Commissioning teams.

1.3 All of the included service areas contribute to a huge range of local and national policies;

- CCG Priorities – Prevention / Early diagnosis / Better care / Better integration / Quality and safety / Value for money
- Medway Council - Supporting Medway's people to realise their potential / resilient families, all children achieving their potential in schools.
- Public Health England – Health Matters – Giving Every Child the Best Start in life /Obesity Strategy

<u>Current Budgets</u>

1.4 The current (Council) budget for the core services to be included in the Universal Healthy Child Programme which come from the Public Health Grant is approx. £5.7 million. The budget for the Community Paediatric Health Services (CCG) is approximately £5.8 million.

<u>Cost Modelling</u>

1.5 A majority of budget costs for these services relate to staffing costs. As a result of this the Public Health team were able to secure funding via Health Education England to undertake some workforce modelling (Benson Wintere) which has allowed us to understand the health visiting and school nursing workforce and the role it plays and also assess our need and staffing levels compared to nearly 30 other local authorities.

1.6 As a result of this modelling we have been able to develop a cost efficient model which still meets national requirements and factors in local need. These modelling tools were used in depth to come up with the financial modelling.

1.7 The review of community paediatric services provided by Medway NHS Foundation Trust (MFT) via the block contract in 2015 has identified likely service pressures, although these continue to be the subject of negotiation between the MFT and NHS Medway CCG. Financial modelling of current services provided by MFTt and Medway Community Healthcare (MCH) has been undertaken; as a new model of service provision is developed in the coming months, likely costs of a new service that will be funded by NHS Medway CCG will emerge. Efficiency gains are anticipated in relation to administrative support for an integrated service, reduction in service duplication, improved rates of attendance and early diagnosis.

2. Background

2.1 Paediatric Health Service provision in Medway has been fragmented in its delivery for a number of years. This is attributable to a number of different factors:

- A range of commissioners (CCG/Public Health /Medway Council/PHE)
- Organic service growth without effective commissioning control in some areas
- Different priority areas and deliverables
- Focus on outputs rather than outcomes
- IT, technology and communication barriers

2.2 The transfer of Health Visiting from NHS England (NHSE) to Medway Council in October 2015 and the partnership commissioning review of community paediatric health services in 2015 provided an opportunity to redesign community-based paediatric healthcare and deliver efficiencies into the system.

2.3 On the 22 July 2015, Medway Council's Extended Management Team met to discuss developing an integrated approach to the commissioning and delivery of health and wellbeing services for children and young people. In a paper that was jointly written by partnership commissioning and public health, a number of options were tabled and the group recommended that preferred option was an 'abridged model' of integration. This would include the integration of services, but would not extend as far as being complete integration of all service lines and would test the market for larger scale integration in the next round of commissioning. Since that point both Public Health and the Partnership Commissioning team have been reviewing their services and are now at a point where recommissioning needs to take place.

2.4 Following in depth discussions between Public Health and Partnership Commissioning a model of integration has been identified which allows for the integration of a number of services and functions, helping to build service efficiency. This model is based on a shared set of outcome frameworks, to enable practitioners from across the workforce to pull in the same direction and focus on providing services that deliver meaningful results.

2.5 This model allows for flexibility and clear financial and operational autonomy, negating risks to Medway Council and the CCG respectively, and providing an innovative and improved child health offer to our residents.

3. Proposal for Change

3.1 Options for how integration could be taken forward were discussed at Medway Council's Extended Management Team in July 2015. This paper builds on the discussions at that meeting; the proposal is to work to a single commissioning timeline with integrated consultation, market engagement and procurement processes, underpinned by a shared outcomes framework, for two lots of services. Each lot would have a separate contract, and performance management of these contracts would be aligned to ensure ongoing integration between service areas (see figure 3.6 for detail).

3.2 There would be a number of key themes to drive improvements, efficiencies and changes via the new service. These would include elements such as;

- Driving efficiency and engagement through better use of technology
- Improved data capture and reporting
- Clearer links and responsibilities around Early Help and Safeguarding
- Driving change in key areas identified in the Needs Assessment such as improving school readiness and improved diagnosis of conditions such as ADHD to bring into line with national standards.
- A seamless service from pre birth to 19
- Better assessment of individual needs and more robust referral processes
- Better integration and pathways between special needs nurseries and mainstream nurseries.

4. Healthy Child Programme - Medway Council Services (Lot 1)

4.1 <u>Background – Healthy Child Programme</u>

4.1.1 The Transfer of the 0-5 (Health Visiting and Family Nurse Partnership (FNP)) element of the Healthy Child Programme (HCP) from NHS England in October 2015 means that Medway Council (Public Health) are responsible for the core elements of the Healthy Child Programme 0-19. These services are currently delivered by MCH and this builds on the existing HCP services commissioned by Public Health;

- Healthy Visiting (delivered by MCH)
- School Nursing (delivered by MFT)
- National Child Measurement Programme (YrR delivered by MFT & Yr6 by PH)
- Oral Health Promotion (delivered by MCH/ Medway Council PH Team)

4.1.2 The Healthy Child Programme (HCP) is the prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity. It focuses on providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. Due to its universal reach, the HCP provides an invaluable opportunity to identify those families that are in need of additional support and those children who are at risk of poor outcomes.

4.1.3 Health visiting and school nursing are universal services, this means that all families in Medway are able to access and obtain the services they need regardless of circumstances that they are entitled to as part of the Healthy Child Programme. This is without suffering financial hardship by paying for them. Health visitors carry out a series of mandated checks with at least 90% of the 0-5 population (which in Medway is approx. 17,000 children) which check physical and mental development at key stages, as well as mental health assessments for mothers – this way any remediable conditions can be identified early and addressed, so reducing the burden on health and social cares services if left unchecked.

4.1.4 School nursing also conduct a series of developmental checks, health screens and are a key health lead around child protection. Reducing the universal nature of these services will mean an increase in levels of child protection, demand on social care and potentially a reduction in Key stage 1 results.

4.2 0-19 integration

4.2.1 In spring 2016 Public Health England released a 0-19 Service Specification which identified a clear national direction of travel for PH Healthy Child Programme Services to be recommissioned together for better outcomes and a more joined up service.

4.2.2 Following transition in October we have worked closely with Medway Community Healthcare as providers of the 0-5 service to better understand the service and its strengths and weaknesses and as a result a lot of work on service improvement, data capture and analysis has been undertaken. In Medway the Health Visiting Team (Alongside Children's Centre's) form the core 0-5 Early Help offer for the Council.

5. Community Paediatric Health Services – NHS Medway Clinical Commissioning Group (Lot 2)

5.1 Background – Community Paediatric Health Services

5.1.1 The review of community paediatric health services, undertaken in 2015, identified a number of areas that require significant change to improve the quality of services for children and families, and to focus on outcomes. In

addition, MFT has continued to highlight a cost pressure across all children's service lines, and Medway Community Healthcare report that there are capacity pressures in relation to paediatric therapy services. These cost and capacity pressures have arisen as a result of increasing levels of health need in Medway's child population, and from services operating without specifications and growing beyond block values to meet local demand.

5.1.2 Another factor that must be noted is that this area of provision has suffered in Medway in recent years as a result of the former Child Development Centre (CDC) being discontinued, which has exaggerated the effect of service fragmentation. After a number of years without a CDC, a new CDC facility is currently being developed and provides an opportunity to facilitate multidisciplinary working in the interests of children, young people and their families, and to help drive efficiency into service delivery.

5.2 Community Paediatric Service Integration

5.2.1 There is currently no formal integration of community paediatric services that are provided under the contracts with the two main providers in Medway. As a result, joint working between practitioners is limited. This lack of integration means that the services are fragmented and duplication of care and approach is common and therefore patients find it difficult to understand and access. This is the case despite the fact that in a large number of cases the children and families that are case loaded by each service are the same, and despite practitioners consistently reporting that multidisciplinary assessment processes would be a significant improvement in relation to the current system.

5.2.2 Using the available funding to create an integrated service that is focused on core outcomes, with strong links to the progressive universal services that are to be included in the 0-19 public health services and with a focus on family support and building resilience, will help to improve the service offer for children, young people and their families, and will help to reduce areas of duplication – for example multiple assessment and review processes.

5.2.3 These proposals have been discussed with Medway CCGs clinical lead for children and families services, who is in agreement that such integration would be in the best interests of children and families. A discussion as to how the CCG sees these outcomes being delivered alongside the Medway model of health would be sought moving forward – some services are already delivered from healthy living centres, but there is the potential for additional advice and support to be focused in community hubs to improve access and multi disciplinary working across Medway.

5.3 Proposed model of integration

5.3.1 After detailed discussion between colleagues in Medway Council's Public Health Directorate and Partnership Commissioning Team, it has been agreed that services should be commissioned on the basis of a clear hard outcomes framework and that service specifications should be based strongly around the delivery of these outcomes and not on output measures as has traditionally been the case.

5.3.2 Service provider(s) will be supported to deliver on the specified outcomes in a number of ways, including by being enabled to link into existing and emerging models of practice and allied professionals from across the children's workforce. Examples of this are that the CCG could support the service to provide interventions and advice as a part of the developing Medway model of delivering health and care, by enabling them to have a presence at the integrated service hubs that will be delivering a wider range of community-based services across Medway. Similarly, providers may be able to provide interventions in a model that is linked to the emerging system of early help and social care hubs in Medway. In addition, commissioners will ensure that services are able to work effectively alongside schools to ensure that school staff are able to effectively meet the needs of children that have medical conditions; this will help to build workforce capacity and supports inclusivity and its associated positive benefits.

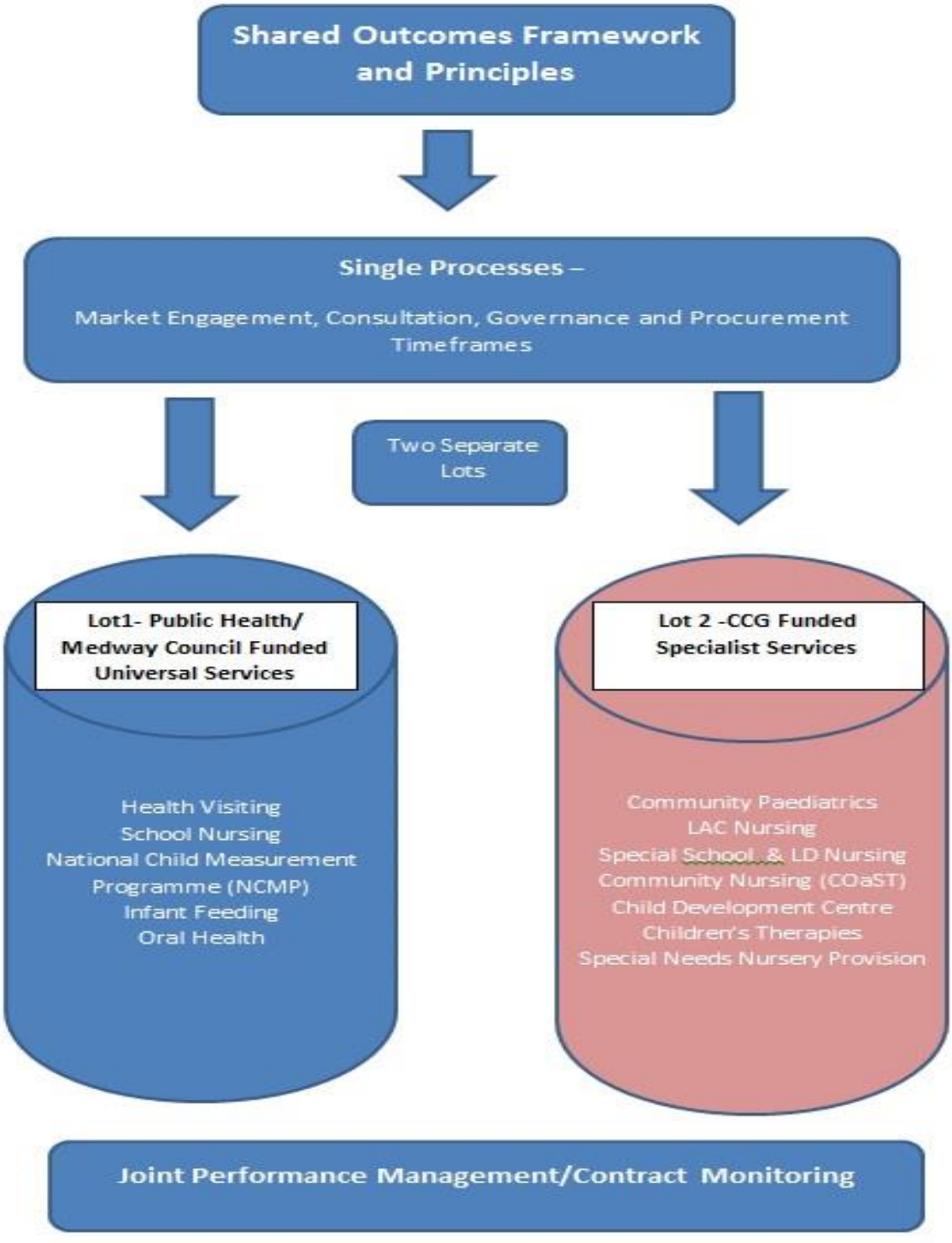
5.3.3 A comprehensive hard outcomes framework is in the process of being developed and will form a core element of the consultation and engagement work that is scheduled as a part of the commissioning timeline. In some cases, this may give rise to service elements that are similar to that which already exist in Medway, however it is anticipated that the use of a central outcomes framework and dialogue about how services can be provided will allow for significant innovation and flexibility in the way that outcomes for Medway's children and young people are delivered.

5.3.4 As such, it is proposed that there will be one commissioning and procurement exercise for this work. Bids single providers, consortiums, or from a lead provider with the opportunity to contract with allied service providers will be welcomed.

5.3.5 The commissioning timeline is attached in appendix one and the proposal for the structure of integration are outlined in the diagram below.

5.4 Model of Integration

5.4.1 The diagram below demonstrates the model of integration.



6. Advice and Analysis

6.1 It is advised a model of integration, as outlined above, is taken forward in Medway. This will allow providers the opportunity to deliver multi-disciplinary assessments and interventions, facilitate earlier intervention, enable efficiency gains to be made, and will improve communication

between service areas in the interests of children, young people and their families.

6.2 The Equality Impact Assessment is included as Appendix 5

6.3 The proposal includes the recommissioning of paediatric health services for all children in Medway, and will therefore have an impact on services that are accessed by children that are looked after by the local authority. In addition, nursing services for looked after children, such as statutory health checks, will form part of this service and may be provided differently as a result. Commissioners will ensure that the service(s) that arise as a result of this commissioning process will not have negative implications for looked after children; on the contrary, it is expected that changes will be positive insofar as that services that are specifically provided for looked after children will be more closely aligned with a range of health services to reduce multiple appointments and focus on holistic needs.

7. Risk Management

7.1 Risk is set out at Appendix 3.

8. Consultation

8.1 A six week consultation was undertaken in April/May 2016 to support the Healthy Child Programme (HCP) Needs Assessment. This work was led independently by Involve to Change and engaged professionals and parents in a range of issues relating to child health services in Medway. It involved questionnaires, focus groups and interviews and captured views of over 400 people. This information is being used to inform our approach to recommissioning and service redesign of the HCP in Medway. Public Health also consulted GPs around the Healthy Child agenda at the July PLT event and received positive feedback and a collection of views from over 25 GPs and practice nurses on their priorities for Child Health. All of this information is summarised in Appendix2. The Needs Assessment for Service in Lot2 is attached in appendix5

8.2 A period of public and staff consultation is factored into the timeline (appendix 1). The proposal is to consult on priorities and the outcomes that paediatric health services should be looking to deliver, and to take the results of this consultation forward into a process of formal dialogue with potential providers, during which time models of service delivery will be discussed and service specifications will be drawn up.

8.3 Despite the final model of service provision not being finalised at this point, commissioners consider that these proposals do constitute a substantial variation in service provision. Children and families in receipt of services from which the funding for this work is derived will continue to be in receipt of services that are delivered by health professionals with specialist skills, designed to meet presenting needs; the organisation and method of delivery is likely to change for some service users and patients. The purpose of this proposal is to generate improvements in services, including improvements to patient flow and multidisciplinary working.

8.4 Dedicated resource will be required to ensure that consultation relating to this proposal is undertaken thoroughly and effectively. It is proposed that a combination of resource from Medway CCG, partnership commissioning, and public health is used to enable effective consultation plans to be drawn up and implemented. Some additional resource may be required to undertake in-depth and skilled consultation with selected children and families, however this requires further scoping and discussion as a part of the planning process.

9. Financial and Legal Implications

9.1 Legal

9.1.1 The legal implications thus far for this recommissioning are as follows: The School Nursing contract cannot be extended beyond the end of October 2017 therefore if a contract can't be awarded within this period then there will have issues with no legal School Nursing Service and risk the ability to combine services and therefore enable efficiencies linked to integration.

9.1.2 There is a core offer and a national service specification that includes mandated elements such as the 5 mandated checks that legally the Council has to deliver as part of the Public Health Grant which is made under 31(8) of the Local Government Act 2003

9.1.3 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council has power to review and scrutinise any matter relating to the planning, provision and operation of the health service in Medway. This Committee has the remit to review and scrutinise health services for children and must invite interested parties to comment on particular matters under review or scrutiny and take into account relevant available information and in particular, relevant information provided by Healthwatch Medway. The Committee may make reports and recommendations and reports to relevant NHS bodies or health service providers.

9.1.4 These organisations are also under a statutory obligation to consult the Committee on any proposal for a substantial development or variation of children's health services in Medway. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment.

9.1.5 The terms "substantial development" and "substantial variation" are not defined in the legislation. Medway has developed an assessment questionnaire for use by responsible bodies wishing to consult Medway Council's Overview and Scrutiny Committees on proposed health service reconfigurations (as completed and attached as Appendix 1). The questionnaire asks for information relating to accessibility, impact of the proposed change, numbers of patients and service users affected and methods of service delivery. It also asks for assurance that the proposed

change meets the Government's four tests for health service reconfigurations (as introduced in the NHS Operating Framework 2010-2011). This will assist the Committee to assess whether the proposed change is substantial or not and, in either case, to provide comments to the relevant responsible body.

9.1.6 In addition, the public sector equality duties Medway in the exercise of their functions, must **have due regard for the need to**:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

9.2 Financial

9.2.1 The proposal based on the proposed timeline would see financial efficiencies made by recommissioning via a distinct universal lot and still achieving the same or improved outcomes and protecting Universal services. A zero based budgeting approach has been applied using the Benson Wintere Workforce Modelling tool and it has been identified that through integration and better use of technology Lot 1 will cost 15% less than the current services. This will be fully realized in the 18/19 year with some part year savings made in 17/18.

9.2.2 It is expected that as the processes and outcomes relating to the 0-19 public health work improves in efficiency and coverage of contacts with Medway's children and young people increases, there will be a greater identification of need and higher rates of onward referral into more acute services in the short term, thus creating a spike in demand. Demand on services would be expected to decrease over time, as the preventative elements of the work take effect and reduce escalation into secondary services.

9.2.3 The proposed model provides the opportunity for further savings to be identified by providers, either through having savings made by delivering both 'lots' of services or, indeed, for savings to be made by different lots being delivered by separate providers. It would also be unlikely that providers would come in at the maximum price of the cost envelope for contracts of this size.

9.2.4 There will be a year on year efficiency target for providers in both lots giving ongoing savings for both the Council and the CCG, and providers would be encouraged to identify further innovative ways of identifying operational and financial efficiencies as a part of the commissioning process.

10. Recommendations

10.1 The Committee are recommended to:

- comment on the proposals and forward the comments to Cabinet for consideration.
- Note that the proposals are deemed to constitute a substantial variation at this stage. Depending on the results of consultation and engagement, the level and type of services that are available to children and families may be broadly similar to the current service offer. The organisation and delivery of such services are likely to undergo change, to ensure that service improvements are realised for service users and their families.

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Appendices

Appendix 1 – Substantial Variation Questionnaire
Appendix 2 – Timeline
Appendix 3 – Risk Register
Appendix 4 – Healthy Child Programme Needs Assessment Summary
Appendix 5 – Equality Impact Assessment
Appendix 6 – Acute Child Health Services Needs Assessment

Background papers

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/492086/HCP_5_to_19.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/554499/Service_specification_0-19_commissioning_guide_1.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/518657/Service_specification_CG2_FINAL_12_Feb.pdf

Appendix 1

MEDWAY COUNCIL
Gun Wharf
Dock Road
Chatham ME4 4TR

Health Overview and Scrutiny

Assessment of whether or not a proposal for the development of the health service or a variation in the provision of the health service in Medway is substantial

A brief outline of the proposal with reasons for the change

Title - Medway 0-19 Children's Community Health Services

Commissioning Body and contact details:
Medway Council Public Health Department, Gun Wharf, Dock Road, Chatham, Kent, ME4 4TR. Officer contact: James Harman, james.harman@medway.gov.uk
NHS Medway CCG, 50 Pembroke Court, Chatham Maritime, Kent ME4 4EL. Officer contact: Michael Griffiths, michael.griffiths@medway.gov.uk

Current/prospective Provider(s):
Medway Foundation Trust
Medway Community Healthcare
Medway Council

Outline of proposal with reasons:
Public Health now has the commissioning responsibility for the main body of the workforce of the Healthy Child Programme (Health Visiting/School Nursing) following the transfer of the 0-5 services from NHS England (NHSE) in Oct 15. Contracts are currently on a rolling basis and are held with separate providers. Medway Council would like to commission a new integrated child health service for Medway; this would include core services and, additionally, other associated services which are currently commissioned by other bodies such as Oral Health (NHSE) and School Based Immunisations (NHSE).

Similarly, NHS Medway CCG currently holds contracts for children's community health services with different organisations. This has contributed to children's health services becoming fragmented in their delivery in recent years. The CCG wishes to integrate provision contained in existing contracts to improve patient experience and deliver increased efficiency.

The proposal is to undertake a single commissioning exercise, with two defined lots of services available, underpinned by shared outcomes and a process of joint contract management. One lot will be funded by Medway

Council and one will be funded by NHS Medway CCG. This will result in more integrated services with clearer pathways and more focussed use of the resources available. It will also deliver some cost savings for Medway Council as a result of the efficiencies of the different services combining.

Intended decision date and deadline for comments (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require the local authority to be notified of the date when it is intended to make a decision as to whether to proceed with any proposal for a substantial service development or variation and the deadline for Overview and Scrutiny comments to be submitted. These dates should be published.

Initial proposals on timeline and direction of travel expected to be approved via appropriate Governance routes in Autumn 2016, and by Medway Council Cabinet on 20th December 2016.

This will inform the timetable and methodology moving forward. Medway Council is required to award a new contract in October 2017, based on legal advice relating to existing contracts.

Alignment with the Medway Joint Health and Wellbeing Strategy (JHWBS).
Please explain below how the proposal will contribute to delivery of the priority themes and actions set out in Medway's JHWBS and:

- how the proposed reconfiguration will reduce health inequalities and
- promote new or enhanced integrated working between health and social care and/or other health related services

The new service will support three of the five H&WB Strategy strategic themes
• Give every child a good start
• Improve physical and mental health and wellbeing
• Reduce health inequalities

The integration of a number of services means that there will be a more joined up model for parents, children and young people, as well as professionals working with families across Medway.

Developing new pathways, shared resources and IT systems will mean the Child Health services across Medway will be far better placed to influence change and improve outcomes of the health of children, young people and their families in Medway.

Please provide evidence that the proposal meets the Government's four tests for reconfigurations (introduced in the NHS Operating Framework 2010-2011):

Test 1 - Strong public and patient engagement

(i) Have patients and the public been involved in planning and developing the proposal?
(ii) List the groups and stakeholders that have been consulted
(iii) Has there been engagement with Medway Healthwatch?
(iv) What has been the outcome of the consultation?
(v) Weight given to patient, public and stakeholder views

(i) Have patients and the public been involved in planning and developing the proposal?

8 weeks of consultation engagement has been undertaken in March and April 2016 through Primary Insight work with service users and partners. This was carried out via a variety of forms including Focus Groups, Interviews, research and a Survey which reached over 400 participants (Service Users & practitioners). This was consulting on current needs, services and priorities for the future.

It is anticipated that a further 6 week consultation will take place in early 2017

At the moment, there is no fixed view on how services will be modelled moving forwards; commissioners plan to use the time available in the commissioning timeline to identify how services would best be structured in the future. A strong consideration of how future services are shaped will be the outcomes of further public consultation, and as a result of the planned market testing and competitive dialogue with current and potential service providers.

(ii) List the groups and stakeholders that have been consulted

Focus Groups and interviews have taken place with:

- Health Visiting
- Midwifery
- School Nursing
- GPs
- Practice nurses
- Social Care
- Parents and Carers
- Children's Centres
- Nursery Nurses

Questionnaires with responses from over 60 professionals and 300 parents and carers have been completed.

(iii) Has there been engagement with Medway Healthwatch?

Not at this stage; we are awaiting formal governance sign off to proceed

(iv) What has been the outcome of the consultation?

The consultation work undertaken so far forms part of our Needs Assessment and has informed our outcomes framework. These documents will in turn influence the design and content of the service specifications.

(v) Weight given to patient, public and stakeholder views

Equal weighting to professionals and practitioner views

Test 2 - Consistency with current and prospective need for patient choice

The proposal aims to make services more community-focussed, and to increase service efficiency. This will lead to improved accessibility, which is a key driver in this commissioning work. Although subject to refinement as a result of consultation and dialogue with providers, it is envisaged that the service will continue to be delivered in accessible locations across Medway, and will include greater levels of multidisciplinary working and patient-centred planning to ensure that patients can exercise choice and control in relation to the services that they receive.

Test 3 - A clear clinical evidence base

(i) Is there evidence to show the change will deliver the same or better clinical outcomes for patients?
(ii) Will any groups be less well off?
(iii) Will the proposal contribute to achievement of national and local priorities/targets?

(i) Is there evidence to show the change will deliver the same or better clinical outcomes for patients?

A national service specification has been developed for an integrated 0-19 services and close reference to this will be made as new services are shaped throughout the commissioning process. In addition, the proposal advocate a shift away from output and process measures, to a set of services that are more focused on outcomes, which will allow greater focus on delivering clinical effectiveness.

Previous service reviews and needs assessments have informed this proposal, and have been signed off by relevant clinical leads across NHS Medway CCG and Public Health. This has helped to inform the planned outcomes framework, and will inform future outcomes priorities when considering areas that are highlighted as either weaknesses or needing further development.

Various elements of national best practice will be weaved into service expectations moving forward. For example, elements of children's continence

services will be contained within the service expectations, and will be based around national best practice documents and discussion with subject matter specialists. It is envisaged that moving towards a system of greater multi disciplinary working will enable elements of service provision, such as assessment for Autism Spectrum Disorder, to become more closely aligned with guidance produced by the National Institute of Health and Care Excellence.

(ii) Will any groups be less well off?

It is not envisaged that any groups will be less well off as a result of these proposals. It is expected that efficiency improvements will offset financial savings that Medway Council is seeking to achieve as a result of these proposals, enabling services to continue to be provided with little detriment to patients and service users. Should the highest level of financial savings be required from this work, there is a risk that service reductions would be necessary, which would potentially result in reduced services for some children and families.

A Diversity Impact Assessment has been undertaken; at this juncture, no detriment to any group with protected characteristics is foreseen. This document will be kept live throughout the commissioning process as developments relating to the proposals take shape.

(iii) Will the proposal contribute to achievement of national and local priorities/targets?

The Healthy Child Programme is a nationally mandated programme and the outcomes locally will contribute toward strategic objectives within the Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy, the Public Health Outcomes Framework, as well as impacting other local service plans across the Council and CCG.

Specifically, this proposal will contribute to the following priorities:

- CCG Priorities – Prevention / Early diagnosis / Better care / Better integration / Quality and safety / Value for money
- Medway Council - Supporting Medway's people to realise their potential / Giving every child the best start in life
- Public Health England – Health Matters – Giving Every Child the Best Start in life /Obesity Strategy

Test 4 - Evidence of support for proposals from clinical commissioners – please include commentary specifically on patient safety

This piece of work is being taken forward jointly between Medway Council and NHS Medway CCG, and therefore all proposals within the model will be jointly agreed. Mechanisms to ensure quality and safety, governance and accountability arrangements will be a key consideration at an early stage of

service model development, and will be fully articulated in the service specification.

The direction of travel in relation to this commissioning work has been signed off by NHS Medway CCG's commissioning committee, a formal subgroup of the CCG's Governing Body, and which contains clinical representation. In addition, the CCGs clinical lead for children and family services is supportive of the proposals and public health's directorate management team, which includes public health consultants, is also supportive of the proposal.

Effect on access to services

(a) The number of patients likely to be affected
(b) Will a service be withdrawn from any patients?
(c) Will new services be available to patients?
(d) Will patients and carers experience a change in the way they access services (ie changes to travel or times of the day)?

(a) The number of patients likely to be affected?

As this service is primarily a universal one it will impact approximately 70,000 children and young people. The fertility rate in Medway is higher than England and the population of children and young people is expected to reach 78,000 in the next 20 years. There is no proposal to reduce the universal element of this service and as such service users should receive a more cohesive service as a result.

For the more acute health services, exact numbers of patients that are likely to be affected is difficult to accurately quantify at this stage as the degree of crossover between service caseloads is approximate. It is expected that approximately 7,500 children will be affected across services identified in lot two.

(b) Will a service be withdrawn from any patients?

It is not envisaged that any service will be withdrawn from patients.

(c) Will new services be available to patients?

Service reviews have identified some areas of care that are currently not well catered for in Medway. It is envisaged that increased levels of joint working and improved workforce skill will enable additional services to be delivered; sleep and continence services are examples of this.

(d) Will patients and carers experience a change in the way they access services (ie changes to travel or times of the day)?

A significant proportion of services contained within this proposal are delivered in community settings or in the homes of service users, and it is envisaged that this will continue to be the case.

One of the changes that we expect from the proposal is that a greater

proportion of services will be delivered in appropriate community settings, with a subsequent reduction of services being delivered in the acute hospital setting.

Subject to the outcomes of further consultation work, it is possible that a more flexible offer for children and families will be delivered as a result of this work.

Demographic assumptions

(a) What demographic projections have been taken into account in formulating the proposals?
(b) What are the implications for future patient flows and catchment areas for the service?

(a) What demographic projections have been taken into account in formulating the proposals?

The increasing birth rate has been taken into consideration in relation to future service planning

(b) What are the implications for future patient flows and catchment areas for the service?

The integration of services should ensure more timely patient flows with better understanding by professionals of service thresholds. Focusing services around the needs of children and families and supporting these needs with tailored planning will ensure that patients are in receipt of the right services to meet their needs and that the patient journey and flow is optimised. There are no catchment area implications.

Diversity Impact

Please set out details of your diversity impact assessment for the proposal and any action proposed to mitigate negative impact on any specific groups of people in Medway?

A diversity impact assessment has been undertaken and is attached to this assessment. This contains details of risks and mitigation.

Financial Sustainability

(a) Will the change generate a significant increase or decrease in demand for a service?
(b) To what extent is this proposal driven by financial implications? (For example the need to make efficiency savings)
(c) What would be the impact of 'no change'?

(a) Will the change generate a significant increase or decrease in demand for a service?

It is envisaged that there will not be significant change in demand for services in the short term. It is expected that as the processes and outcomes relating to the 0-19 public health work improves in efficiency and coverage of contacts with Medway's children and young people increases, there will be a greater identification of need and higher rates of onward referral into more acute services in the short term, thus creating a spike in demand. Demand on services would be expected to decrease over time, as the preventative elements of the work take effect and reduce escalation into secondary services.

(b) To what extent is this proposal driven by financial implications? (For example the need to make efficiency savings)

There is the need for Medway Council to make cost efficiencies, however the driver is to have an improved and more integrated child health service which delivers improved outcomes and provides better value for money.

(c) What would be the impact of 'no change'?

The risk of not integrating paediatric health services as outlined in the proposal is that the current fragmentation of service delivery is maintained, and potential service improvements and financial efficiencies are not realized.

Gaps in services have proven to be difficult to address within current service alignment, and it is likely that this would continue.

Separate commissioning arrangements for services across lots one and two would be required. This would likely require a greater degree of resource allocation from commissioning and procurement teams.

Wider Infrastructure

(a) What infrastructure will be available to support the redesigned or reconfigured service?

(b) Please comment on transport implications in the context of sustainability and access

(a) What infrastructure will be available to support the redesigned or reconfigured service?

The redesigned service will not require any change to the existing physical infrastructure. Service design will take into account accessibility of services and it is anticipated that accessibility will improve for those people who need the services most.

The mobilisation and continued performance management and contract support will be delivered by both Partnership Commissioning and Public Health teams. A healthy child partnership board with representation from CCG, Children's Centres, Public Health, Social Care and GPs has been established to consult on the recommissioning and will remain in place to support the redesigned service post tender award.

(b) Please comment on transport implications in the context of sustainability and access

There may be an additional need for transport for children and families that will be required to access services at the forthcoming child development centre in Strood. This need will be further explored during the consultation period and options for how transport could be provided will be investigated by officers.

Is there any other information you feel the Committee should consider?

No

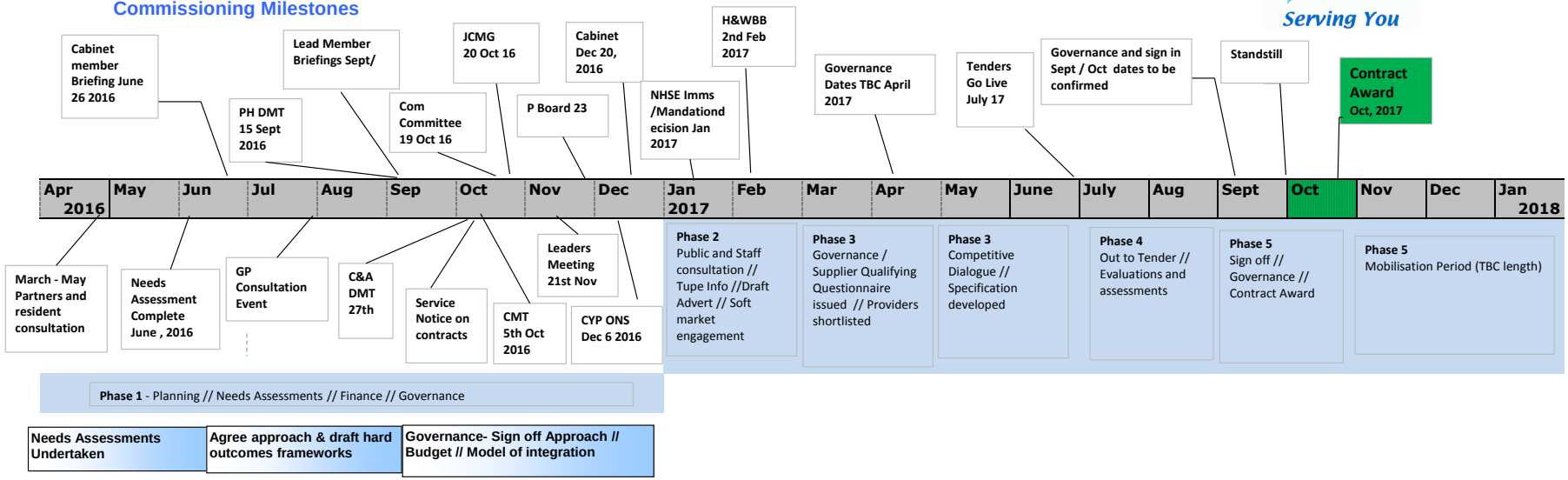
Please state whether or not you consider this proposal to be substantial, thereby generating a statutory requirement to consult with Overview and Scrutiny

At this juncture, commissioners consider this variation to be substantial. The extent to which this proposal generates significant change to the current system of service provision will depend on the outcome of further consultation and engagement work, scheduled for early in 2017. The proposal is to commission services in a more integrated manner, and is likely to mean that services will be delivered with clearer pathways and improved joint working.

APPENDIX 2

Medway Child Health Recommissioning Project

Commissioning Milestones



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APPENDIX 3

Medway Child Health Re-Commissioning Risk Register
Note: A Risk is a potential problem with enough significance to adversely impact on the success of the project

RISK NO	DESCRIPTION of RISK (There is a risk that…)	RAISER	Consequence/IMPACT (Which will cause….)	RISK OWNER	**ORIGINAL SCORE** (Consequence x Likelihood)	**CURRENT LIKELIHOOD** Rare (1) Unlikely (2) Possible (3) Likely (4) Almost Certain (5)	**CURRENT CONSEQUENCE** Negligible (1) Minor (2) Moderate (3) Major (4) Catastrophic (5)	**CURRENT SCORE** (Consequence x Likelihood)	Progress on action including date updated Action taken to reduce the impact and/or probability of becoming an issue (mitigation)	DATE CLOSED
1	Commissioning timeline	James Harman / Michael Griffiths	The commissioning timeline is not met, causing a delay in service implementation and possible service gaps as notice will have been served on current contracts. *Note: School Nursing contract ends in Autumn 2016 and can only be renewed for 1 additional year*	James Harman	12	3	4	12	Work in this area must be prioritised relative to other projects to reduce the risk in this area and ensure that the commissioning timeline is met.	
2	DoH remove/increase mandations for Health Visiting	James Harman	Outcomes and KPIs will need to be reviewed and potential impact on budget and overall service delivery	James Harman	9	3	3	9	Consultation response completed. Expected announcement November 16	
3	If CCG and Council budgets are merged there is a risk that any future savings that are made could be borne by the Council or the CCG	Aeilish Geldenhuys / Helen Jones	Targets identified by Public Health and the CCG change. Having a single budget also means that there is a threat to the universal services as more acute services can often take priority, reducing the emphasis on prevention.	Aeilish Geldenhuys / Helen Jones	9	3	3	9	To have an integrated model which is abridged (two separate budgets) would negate this risk	
4	Market capacity	James Harman / Michael Griffiths	The market does not have capacity to respond effectively to the commissioning opportunity	James Harman / Michael Griffiths	3	3	1	3	Market engagement events and a paediatric market position statement will help the market to understand and mobilise towards the presenting opportunity. The separating into two lots also reducess risk relating to market capacity	
5	Financial risk	Aeilish Geldenhuys / Helen Jones	The budget to deliver the services is not sufficient to deliver all desired outcomes	Aeilish Geldenhuys / Helen Jones	12	3	4	12	Detailed financial modelling relating to service provision will be undertaken to help identify accurate likely service costs, to be agreed by appropriate Council and CCG governance boards.	
6	Relocation of services from acute to community setting	Michael Griffiths	An element of the work will be to deliver services in the most appropriate and accessible setting possible, and will require some services that are currently provided in the acute hospital setting to be delivered in community venues. In some cases this will carry an element of risk around how the needs of patients are met, and may initiate silo working between the commissioned service and those services that remain in the acute setting.	Michael Griffiths	9	3	3	9	Through engagement and dialogue with potential providers, service pathways will be developed to ensure that strong joint working is embedded between new services and those provided in acute settings. Ensure that new models of working have appropriate clinical and quality and safety review.	

Likelihood score

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10

APPENDIX 3

1 Negligible	1	2	3	4	5

	1–3 Low risk	Can be managed by routine procedures to be implemented by team leaders, ward managers or a designated
	4–6 Moderate risk	Specific responsibility for risk assessment and action planning must be allocated by a senior manager to a
	8–12 High risk	Urgent senior management attention needed. Within one month an appropriate action point must be agreed,
	15–25 Extreme risk	Immediate action required. A Director must be informed and he/she will take responsibility for immediately

Medway Healthy Child Programme 0-19:

Needs assessment

Summary report

July 2016

Nicola Ellis

Public Health Specialty Registrar

Medway Public Health Directorate

Contents

1. Introduction

1.1 Background

The Healthy Child Programme (HCP) is the key universal public health programme for improving the health and wellbeing of children and young people. The programme is evidence based, focuses on early intervention and prevention and aims to prevent poor health outcomes in child health and development, and contribute to a reduction in health inequalities.

The HCP pathway covers the period from conception to 19 years of age, but is split into two phases – Pregnancy and the first five years of life (0-5) and Children from 5 to 19 years old (5-19). Since October 2015, local authorities have been responsible for commissioning both phases of the HCP. Commissioning responsibility for public health services for 5-19 year olds, including school nursing, transferred to local authorities in April 2013, followed by the transition of the 0-5 elements, including health visiting and Family Nurse Partnership in October 2015.

There is a national shift towards developing an integrated and seamless pathway across the Healthy Child Programme (0-19). Public Health England (PHE) recently published guidance to local authorities to support the commissioning of integrated 0-19 HCP services. Conducting a needs assessment is an important first step in the process of developing an integrated child health service specification in Medway and commissioning a new service.

1.2 Purpose

The overall aim of the needs assessment is:

To gather and analyse national and local information on the Healthy Child Programme 0-19 that can contribute to shaping and planning an integrated 0-19 public health programme to be commissioned in 2017.

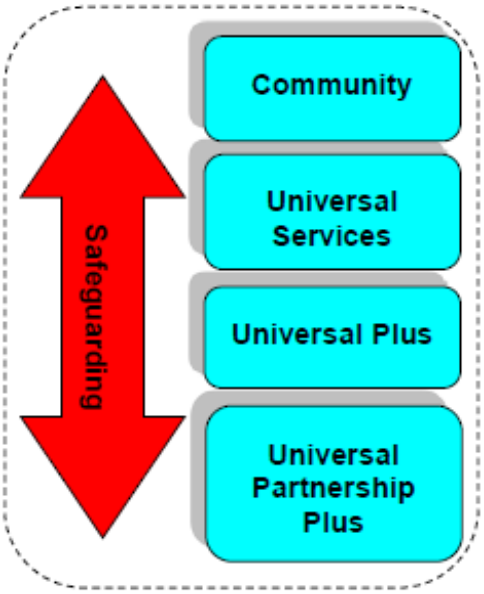
The objectives are to:

- Provide a profile of the health status and needs (met and unmet) of children and young people aged 0-19 years old in Medway according to outcomes relevant to the HCP as measured by quantitative data and local insight;
- Identify the national policy drivers, best practice and evidence for delivering the HCP in a way that improves outcomes and reduces health inequalities for children and young people;
- Deliver an assessment of the current Healthy Child Programme workforce, identifying their capacity, current areas of focus and how they compare to others area in England
- To provide evidence based recommendations for a Medway HCP model that supports the public health needs of children and young people, their families and schools and that provides value for money within the constraints of the agreed financial envelope

1.3 Scope

The scope of the 0-19 health needs assessment is defined by the requirements of the Healthy Child Programme. The HCP is a progressive universal service, which means that it includes universal services which are offered to all families, with additional services offered to those children and families with specific higher risks and needs. This is represented by the four tiers set out in the Figure 1, which describe the service model currently adopted by health visiting and school nursing:

Figure 1: Four levels of intervention in health visiting and school nursing



The full list of services which are currently within the scope of the review and therefore relevant to the needs assessment are:

- Health visiting
- Family Nurse Partnership / teenage parent pathway
- School nursing
- Infant feeding
- National Child Measurement Programme
- Oral health promotion
- School based immunisations
- Enuresis (bedwetting) service
- Looked After Children nursing
- Child Health Information Service

The recommended components of the HCP across the 0-19 pathway are as follows and all fall within the scope of the needs assessment:

- Prevention and early intervention
- Health improvement – emotional and mental health and wellbeing, healthy weight, breastfeeding, drugs, alcohol and tobacco, sexual health, long term conditions, oral health
- Safeguarding
- Health and development reviews
- Screening
- Immunisations
- Health care services
- Living environment
- Parents and carers

The needs assessment will place particular emphasis on the six high impact areas for health visiting and school nursing, which have been described by the Department of Health (Table 1). The six high impact areas are areas where health visitors and school nurses can have a significant impact on health and wellbeing and on improving outcomes for children, families and communities, including preventing safeguarding concerns. However, safeguarding

remains a crucial part of the health visiting and school nursing roles and sits within the Universal Partnership Plus element of both services.

Table 1: Six high impact areas for health visiting and school nursing

Health visiting	School nursing
Transition to parenthood and early weeks	Building resilience and supporting emotional wellbeing
Perinatal mental health	Managing risk and reducing harm
Breastfeeding	Improving lifestyles
Healthy weight	Maximising learning and achievement
Managing minor illnesses and reducing incidents	Supporting additional health and wellbeing needs
Health, wellbeing and development of child aged 2 and support to be ready for school	Seamless transition and preparing for adulthood

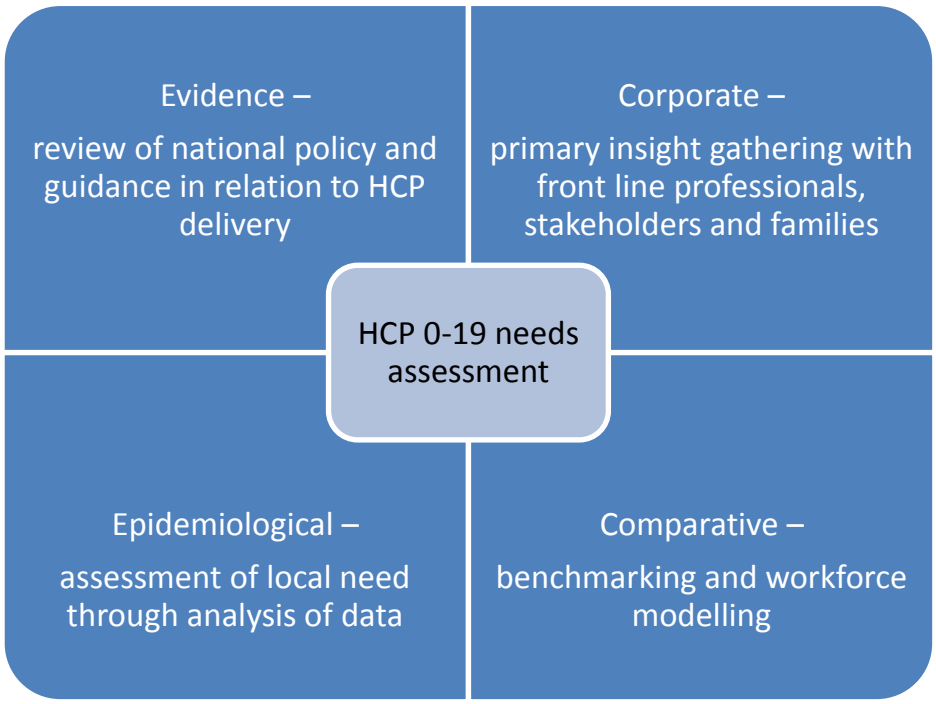
The PHE guide to commissioning the 0-19 pathway also recommends that a further two areas could be considered in the service specification for 0-19 services and are therefore also within the scope of the epidemiological needs assessment.**Error! Bookmark not defined.** A 'high level' overview will be provided for these areas:

- Support for children with additional health needs or long term conditions or disabilities
- Provision for vulnerable young people aged 19-25 transitioning to adult services

1.4 Method

The HNA is comprised of four main components (Figure 2):

Figure 2: Components of the 0-19 Health Needs Assessment



2. Results

2.1 Literature review

The research question for the literature review is as follows:

What are the most effective service structures, interventions and contact points for delivering the 0-19 Healthy Child Programme to ensure positive health and wellbeing outcomes for children, young people and families?

Specific areas of interest include:

- What are the most effective age ranges for public health nurses for children and young people to work within?
- What combinations of professionals and forms of team working are most effective and do parents find most helpful?
- What divisions of responsibilities and team structures can best ensure that transition between services is as smooth as possible?
- How can public health nursing for children and young people best fit with and integrate with early years and schools structures?

The findings from the literature review are divided into the following areas:

- National policy and guidance
  - An overview of the Healthy Child Programme and the key professional groups involved.
  - Other national policies, briefings and guidelines that inform and shape the delivery of health services for 0-19 year olds.
- High impact areas for health visiting and school nursing
  - The evidence to support best practice delivery against the six high impact areas for health visiting and school nursing.
- Schedule of contacts with children and young people in the 0-19 programme

The most important areas are described below, and the full report can be found in Appendix 4.1.

2.1.1 National policy and guidance

Delivering the Healthy Child Programme

'Nurses 4 public health'

In January 2016, the Royal College of Nursing produced the report 'Nurses 4 Public Health': The value and contribution of nursing to public health in the UK.[i] The report argues that nurses are ideally suited and uniquely placed to respond to public health challenges as they understand the particular risks of individuals, but also know the populations and communities they work in.

Traditionally public health nurses have been seen as those in specialist community roles such as health visitors, school nurses and occupational health nurses and in some cases

specialist practitioners. However, there is an increasing need now for all nurses to become agents of public health and promote health as part of their clinical practice.

The key messages and recommendations from the report are:

- Public health is everyone's responsibility and should not be seen as a niche or separate area of practice. Nurses have the skills and are best placed to provide meaningful public health interventions across all health and social care settings as part of holistic patient-centred care.
- Many aspects of what nurses do are hidden – these aspects need to be articulated by nurses and leaders to ensure those commissioning services and providers managing capacity understand the impact of changes to models of care.
- Nurses have enhanced assessment skills which are not always recognised, even by themselves. These need to be better identified and acknowledged as a key part of the unique role nurses have in wider public health work.
- Educationalists (policy makers, commissioners, lecturers and trainers) need to increase the focus on public health in all programmes. Public health across the curricula should be mapped not only where it is directly taught but also where attendant skills are developed. This is reinforced in the recommendations from the Shape of caring review (Willis, 2015) which clearly identified the need for nurses to develop public health skills and competence across in all areas of practice.
- Nursing leadership of the public health agenda needs to be scoped. So there are champions at local as well as national level to make sure nursing teams are contributing to public health at all applicable opportunities.
- Nursing staff are an integral and fundamental part of the public health workforce and this needs to be clearly reflected in policy and future commissioning.
- Nurses need to be "skilled-up" to work with commissioners so meaningful key performance indicators, service level agreements and local incentive targets (such as CQUINs (Commissioning for Quality and Innovation)) are set which reflect public health nursing.

The nursing roles with potential for a public health role within the delivery of the Healthy Child Programme are:

- Midwives
- Neonatal nursing
- Health visitors
- School nursing
- Special school nursing
- Practice nursing in primary care
- Looked After Children's nursing
- Children's community nursing
- Paediatric nursing in secondary care
- Learning disability nursing

Public health nurses

Public health nurses are the main professional group responsible for the delivery of the Healthy Child Programme. Public health nurses are registered nurses and/or midwives with

specialist additional training to develop knowledge and skills that bring together individual, family and community interventions to improve health in populations by assessing and responding to local need.

Public health nursing services provide universal support, and due to their close relationships with families and community settings, including early years and education settings, health visitors and school nurses are key in supporting the local authority area's Early Help system, which encompasses early intervention, and the Troubled Families programme.

Public health nurses use strength-based approaches, building non-dependent relationships to enable efficient working with their population (children, young people and families) to support behaviour change, promote health protection and to keep children safe. Health visiting and school nursing teams will be led by a qualified health visitor or school nurse.

In May 2016, the Chief Nursing Officer for England published a report 'Leading Change, Adding Value' which provides a framework for all nursing, midwifery and care staff.[ii] It builds upon a previous document called 'Compassion in Practice'[iii] and is directly aligned with the NHS Five Year Forward View[iv] in seeking to develop new ways of working that are person-focused and provide seamless care across health and social care. It aims to target three crucial gaps identified in the Five Year Forward View:

1. Health and wellbeing – nursing should practice in ways which prevents avoidable illness, protects health and promotes wellbeing and resilience
2. Care and quality – practising in ways which provide safe evidence- based care which maximises choice for patients.
3. Funding and efficiency - practising in ways which manage resources well including time, equipment and referrals.

Other professions / services involved in HCP delivery

In order to deliver the Healthy Child Programme, a number of other professionals and services must be involved in order to deliver joined up services and more specialist support where necessary. These include:

- Midwives

The Healthy Child Programme begins at conception, and therefore midwifery and maternity services are crucial to the delivery of the early stages of the programme. The Healthy Child Programme 0-5 sets out the contacts and services that should be delivered up to 28 weeks pregnancy, after 28 pregnancy and from birth to 1 week after delivery. Public Health England guidance states that midwives are able to use every contact with women to make assessments and discuss issues including mental health, smoking, nutrition, exercise etc. Clinical Commissioning Groups are responsible for commissioning midwifery services.

- GPs and practice nurses
- Pharmacists
- CAMHS and perinatal mental health services

- Speech and language therapy
- Early years providers
- Weight management services
- Stop smoking services
- Alcohol and substance misuse services
- Community paediatrics and secondary care
- Children's social care services including Child Protection, Children in Need, Looked After Children, Early Help and Troubled Families.

National policy relating to the Healthy Child Programme

There other several other national policy documents and guidance which shape the Healthy Child Programme delivery and agenda:

- 1001 critical days, Cross-party manifesto
    - Focuses on the period from conception to the age of two
- Giving every child the best start in life, Public Health England
    - Ready to learn at age two
    - Ready for school at age five
- Improving young people's health and wellbeing: A framework for Public Health, Public Health England
    - Putting relationships at the centre
    - Focusing on what helps young people feel well and able to cope
    - Reducing health inequalities
    - Championing integrated services
    - Understanding changing health needs as young people develop
    - Delivering accessible, youth friendly services
- Children and Young Peoples Health Outcomes Forum
- Chief Medical Officers report, 2012
- Family Friendly Framework, British Association for Community Child Health (BACCH) and British Association for Child and Adolescent Public Health (BACAPH)
    - The basics – Fundamentals to service delivery
    - Pathways – Patient journey
    - Networks – Structure for delivering the pathways
    - Whole system – brings the basics, pathways and networks together

2.1.2 High impact areas of the Healthy Child Programme

Health visiting

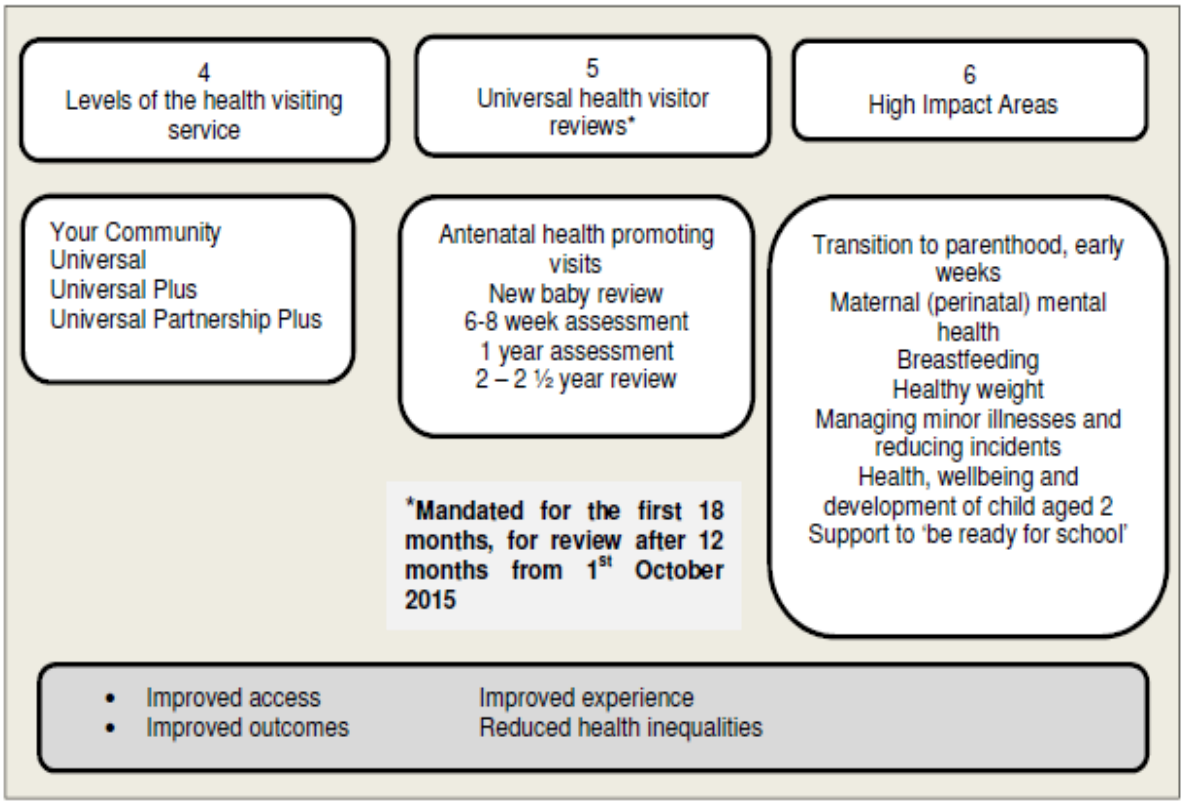
Health visitors are highly trained specialist community public health nurses. They are qualified nurses or midwives who have an additional diploma or degree in specialist community public health nursing. The wider health visiting team may also include a skill mix consisting of nursery nurses, healthcare assistants and other specialist health professionals.

In 2011, the coalition government introduced the National Health Visitor Plan. The purpose of the programme was to secure an additional 4,200 Health Visitors and transform the health visiting service across England by April 2015. The programme has resulted in an increased

number of Health Visitors across the country; by 2012/13 four times as many health visitors were in training than in 2010/11 and the total workforce had increased to 9,113 full time equivalents.[v]

The health visiting service works across a number of stakeholders to lead the delivery of the Healthy Child Programme 0-5. A national Health Visiting core service specification was produced by NHS England for 2015/16[vi] and this has been followed by a commissioning guide with model service specification for local authorities to commission across the 0-19 pathway in 2016.**Error! Bookmark not defined.** Both documents detail the core elements for the commissioning of any health visiting services which are built around the '4-5-6' delivery model, comprising of the 4 levels of the health visiting service, 5 mandated checks and 6 high impact areas (Figure 3).

Figure 3: '4-5-6' model for the health visiting service



4 levels

Health visiting services use a 4 tiered progressive model to build community capacity to support children. This involves building community capacity to support parents of young children; universal reviews to identify need for early intervention and targeted services; targeted packages of care to meet identified need for example on early attachment, maternal mental health or breastfeeding or nutrition, and contributing and/or leading packages of integrated care for those identified as having complex needs or being at risk, including troubled families and safeguarding.

5 reviews

The 5 evidence-based reviews are the mandated HCP health and development assessments and reviews forming the basis for a range of preventive and early intervention

services to meet need: 1) the antenatal health promoting visit; 2) new baby review; 3) 6 to 8 week (health visiting) assessment; 4) one year assessment; and 5) 2 to 2½ year review.

6 high impact areas

The 6 high impact outcomes of health visiting and 0 to 5 services contribute to setting the foundation for future health and wellbeing set out above. They are based on evidence of where these services can have significant impact (for all children, young people and families and especially those needing more support) and impact on health inequalities. The six high impact areas for 0-5 child health services are:

1) Transition to parenthood and supporting early attachment
2) Maternal mental health
3) Breastfeeding
4) Healthy weight
5) Preventing accidents and managing minor illness
6) Development at age two, underpinning school readiness.

School nursing

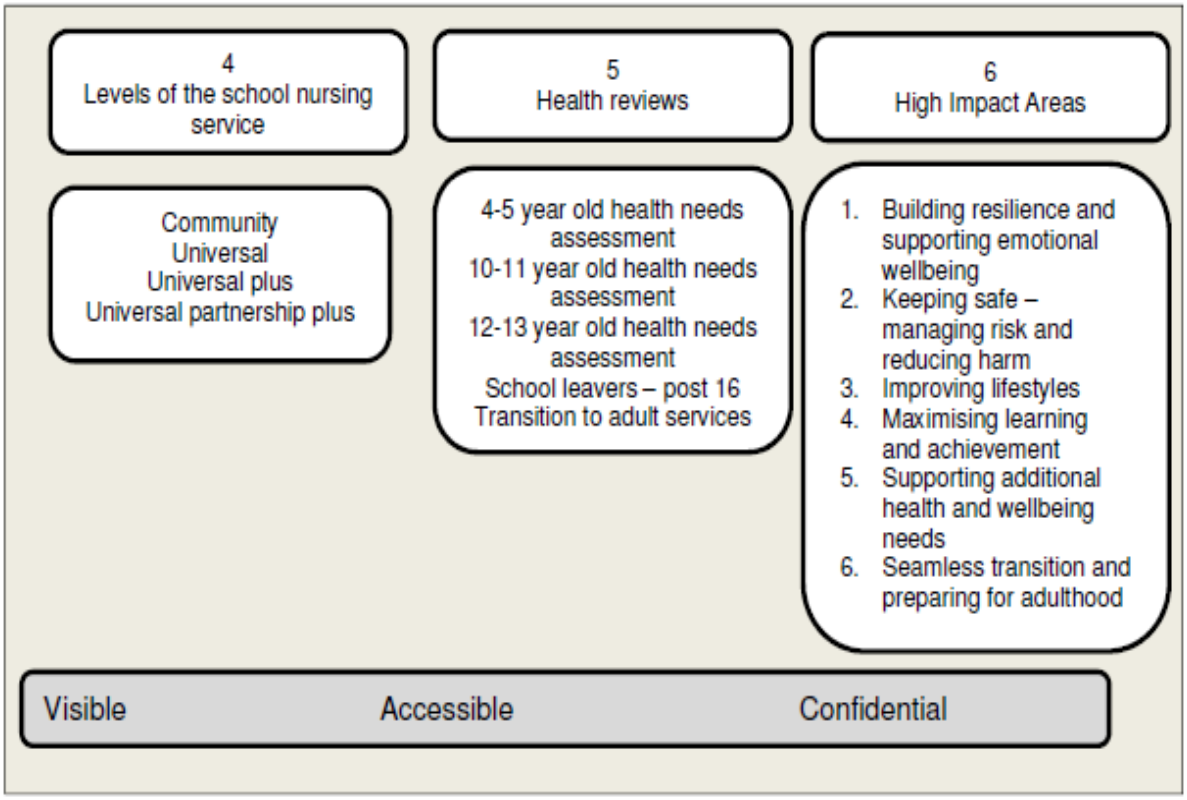
School nurses lead and deliver the Healthy Child Programme 5-19. School nurses are qualified nurses or midwives with specialist graduate level education in community health and the health needs of school age children and young people. The school nursing team can also operate with skill mix by way of support from Staff Nurses and Healthcare Assistants.

The Department of Health published 'Getting it right for children, young people and families: Maximising the contribution of the school nursing team – Vision and call to action' in 2012.[vii] This document set out a vision and model for 21st century school nursing service which covers the four levels of support described previously and is therefore closely aligned with the health visiting service model.

Following this and after responsibility for commissioning school nursing was transferred to local authorities, the Department of Health and Public Health England jointly published 'Maximising the school nursing contribution to the public health of school-aged children: Guidance to support the commissioning of public health provision for school aged children 5-19'.[viii] The document set out the core school nursing offer and recognised that, unlike in health visiting, the school nursing workforce is relatively small and therefore cannot deliver the extensive Healthy Child Programme alone and in isolation. It is therefore important that the role of school nurses is clearly defined locally and robust arrangements are in place to support multi-agency working.

The local authority guide to commissioning across the 0-19 pathway which was published in 2016 builds on the 4 levels of school nursing and proposes a '4-5'6' model for the service too (Figure 3).

Figure 4: '4-5-6 model for the school nursing service



5 reviews

The health reviews are not mandated checks (as for health visiting), but are recommended to take place at 4-5 years, 10-11 years, 12-13 years, at school leaving age (16) and at transition to adult services and adulthood.

6 high impact areas

The 6 high impact areas have been developed to help improve outcomes for children, young people and families. They are based on evidence of where these services can have significant impact and impact on health inequalities.

1) Building resilience and supporting emotional wellbeing
2) Keeping safe – managing risk and reducing harm
3) Improving lifestyles
4) Maximising learning and achievement
5) Supporting additional health and wellbeing needs
6) Seamless transition and preparing the adulthood

The responsibility for commissioning the immunisation element of the school nursing role lies with NHS England, and not with local authorities. Local clinical commissioning groups have responsibility for commissioning clinical support for children with additional health needs or long term conditions and for special school nursing for children in special schools.

2.1.3 Schedule of contacts with children and young people in the 0-19 programme

Table 2 shows all of the contacts that should take place with children and families as part of the Healthy Child Programme schedule. The health professional usually responsible for delivering these is indicated by the colour of the cell.

Table 2: Healthy Child Programme schedule

	Antenatal		Postnatal						Early years						Primary school							Secondary school					School / college / employment / other			
	0-28 weeks	28 - 40 weeks	72 hours	1 week	2 weeks	4 weeks	8 weeks	12 weeks	16 weeks	6 months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
														Year R	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11				
Visits and assessments	Booking appointment assessment	Antenatal visit	Newborn physical examination	New birth visit			6-8 week check				1 year review	Integrated 2 year review		School health entry questionnaire						Health needs assessment		Health needs assessment			School leavers	Preparation for adulthood and transition to adult services			
Screening	Foetal anomaly screening			Bloodspot screening	Newborn hearing screening		Physical examination							Hearing and vision screening															
Surveillance														NCMP						NCMP									
Immunisations							DTaP/IPV/ Hib, PCV, Men B, Rotavirus	DTaP/IPV/ Hib, Men C, Rotavirus	DTaP/IPV/ Hib, Men B, PCV		Hib/Men C, MMR, Men B	Influenza	DTaP/IPV, MMR, influenza	Influenza	Influenza	Influenza	Influenza					HPV (girls) x2	Td/IPV booster, MenACWY							
Looked after children											Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review	Annual health review

Usual lead professional
Maternity services
Health visiting
Primary care
School nursing
LAC nursing
Not currently delivered

Table 3 lists the schedule of universal contacts, screenings and reviews set out in the Healthy Child Programme that are currently offered in Medway. This list does not include the immunisations – these are covered separately in tables 4-6.

Table 3: Timetable of potential contact points with children aged 0-19 in Medway

Current responsibility	Current provider	Name	Stage
Midwifery	Medway Foundation Trust	Antenatal assessment and screening	10 weeks – 20 weeks
		Newborn physical examination	By 72 hours
		Bloodspot screening	5-8 days
		Newborn hearing screening	By 4 weeks
Health visiting	Medway Community Healthcare	Antenatal	Pregnancy from 28 weeks
		New birth visit	1 -14 days
		Health visitor check	6-8 weeks
Primary care	GP practices	Physical examination	6-8 weeks
Health visiting	Medway Community Healthcare	1 year review	9-15 months
		2 -2.5 year review	24-30 months
School nursing	Medway Foundation Trust	School health entry screen	4-5 years (Reception)
		NCMP	4-5 years (Reception)
		Hearing screening	4-5 years (Reception)
Optometrists	Maidstone and Tunbridge Wells NHS Trust	Vision screening	4-5 years (Reception)
Public health	Medway Council	NCMP	10-11 years (year 6)

Source: Medway Public Health directorate

In addition to these are the following reviews and contacts that take place across education, health and social care, but which may not be currently implemented or received by all children in Medway:

- Looked after children – annual health review
- 10-11 year old health needs assessment
- 12-13 year old health needs assessment
- School leavers – post 16
- Transition to adult services

The delivery of immunisations also provides universal contacts with children and families. The immunisations in pregnancy and 0-5 years are usually delivered in primary care by Practice Nurses.

The HCP 0-5 states that immunisations should be offered to all children and their parents. GPs and child health record departments should maintain a register of children under five years and invite families for immunisations. At every contact, members of the HCP team should identify the immunisations status of the child and use every contact to promote immunisation. In addition, those immunising children should use the opportunity to promote health and raise wider health issues with parents.

Table 4: Immunisations for pregnant women in England, 2016

Stage	Diseases protected against	Vaccine name
At any stage of pregnancy During flu season	Influenza	Inactivated flu vaccine
From 20 weeks gestation	Pertussis	dTaP/IPV

Source: Public Health England

Table 5: Immunisations schedule for 0-5 year olds in England, 2016

Child age	Diseases protected against	Vaccine name
Eight weeks	Diphtheria, tetanus, pertussis, polio and Hib – Dose 1	DTaP/IPV/Hib
	Pneumococcal – Dose 1	PCV
	Meningococcal group B – Dose 1	Men B
	Rotavirus gastroenteritis – Dose 1	Rotavirus
Twelve weeks	Diphtheria, tetanus, pertussis, polio and Hib – Dose 2	DTaP/IPV/Hib
	Meningococcal group C – Dose 1	Men C
	Rotavirus gastroenteritis – Dose 2	Rotavirus
Sixteen weeks	Diphtheria, tetanus, pertussis, polio and Hib – Dose 3	DTaP/IPV/Hib
	Meningococcal group B – Dose 2	Men B
	Pneumococcal – Dose 2	PCV
One year	Hib and meningococcal group C (booster)	Hib/Men C
	Pneumococcal – Dose 3 (booster)	PCV
	Measles, mumps, rubella – Dose 1	MMR
	Meningococcal group B – Dose 3 (booster)	Men B
Two – Four years	Influenza – Annually (1 September - 31 March)	Flu
Three years and four months	Diphtheria, tetanus, pertussis and polio	DTaP/IPV
	Measles, mumps, rubella – Dose 2 (booster)	MMR

Source: Public Health England

Immunisations for children aged five and over are usually delivered by school nurses in the school setting. Table 17 lists the immunisation schedule for school aged children in England for 2016/17. In subsequent years, children in later school years will be added to the schedule e.g. in 2017/18 children in year 4 will be included and in 2018/19 children in year 5.

Table 6: Immunisations schedule for 5-19 year olds in England, 2016

Child age	Diseases protected against	Vaccine name
Five-six years (Year 1)	Influenza (1 September – 31 March)	Live attenuated

Six-seven years (Year 2)	Influenza (1 September – 31 March)	influenza vaccine (LAIV) nasal spray
Seven-eight years (Year 3)	Influenza (1 September – 31 March)	
Twelve – thirteen years (Girls) (Year 8)	Cervical cancer caused by HPV types 16 and 18 Genital warts caused by HPV types 6 and 11 – Dose 1	HPV
Twelve – thirteen years (Girls) (Year 8)	Cervical cancer caused by HPV types 16 and 18 Genital warts caused by HPV types 6 and 11 – Dose 2 (6 months later)	
Fourteen years (School year 9)	Tetanus, diphtheria and polio	Td/IPV
	Meningococcal groups A, C, W and Y	Men ACWY

Source: Public Health England

1. Antenatal visit

The HCP 0-5 states that an antenatal review for prospective mother and father with the HCP team should take place after 28 weeks. This should cover the following:

- Emotional preparation for birth, carer-infant relationship, care of the baby, parenting and attachment
- Inform about sources of information on infant development and parenting, the HCP and Healthy Start
- Distribute newborn screening leaflet
- Provide guidance on reducing risk of SIDs
- Distribute and introduce personal child health record (red book)

2. New birth visit

The new baby review by 14 days with mother and father should be a face to face review by a health professional, to include:

- Infant feeding
- Promoting sensitive parenting
- Promoting development
- Assessing maternal mental health
- SIDs
- Keeping safe

3. Health review at 6-8 weeks

A physical examination of the baby will take place at 6-8 weeks in primary care. In addition to this, the health visitor will meet with the family to discuss breastfeeding status, maternal mental health, promote immunisations and discuss other concerns facing the parents.

4. One year review

The health review by 1 year should include:

- Assessment of the baby's physical, emotional and social needs
- An opportunity for parents to talk about any concerns they may have
- Supporting parenting
- Monitoring growth
- Health promotion
- Promote immunisations

5. Two – two and a half year review

The 2-2.5 year review is offered to all families. It is led by a health visitor and can take place at the home, local clinic or children's centre. The universal review provides an opportunity to discuss and promote a child's health and development and to identify children who are not developing as expected and who may require additional support. As part of the review, health visitors will work with parents to complete an Ages and Stages Questionnaire (ASQ) about their child's development.

The review is an opportunity to:

- Assess the health and development of the child within the context of his or her environment at home and family circumstances
- Ensure that families are linked in with the right services and support
- Identify and address issues that the parent or carer may have regarding the child's health
- The HCP 0-5 states that the review should include the following:
- Review with the parents the child's social, emotional, behavioural and language development
- Review development and respond to any concerns expressed by the parents
- Offer parents guidance on behaviour management
- Offer parents information on what to do if worried about their child
- Promote language development
- Provide encouragement and support to take up early years education
- Give health information and guidance
- Review immunisations status
- Offer advice and information on nutrition and physical activity
- Raise awareness of dental care, accident prevention, sleep management, toilet training
- Offer information on local services

The Public Health England guidance on Health Matters: Giving every child the best start in life states that where a child already attends an early years setting, the two year health review should form part of a holistic integrated review which ***includes*** the progress check undertaken at age two by early years providers (the EYFS 2 year progress check). The integrated review may be done jointly or through systematic sharing of information and should be undertaken in partnership with parents.**Error! Bookmark not defined.**

Indeed, the National Children's Bureau (NCB) states that from September 2015, local areas will be expected to integrate health and education child development reviews. The Early Years Foundation Stage (EYFS) Progress Check at age two (delivered by early years practitioners in a child's early years setting) will be brought together with the Healthy Child Programme (HCP) 2-2½ year old health and development review (delivered by health visiting teams), where possible, in an Integrated Review.[ix] The review will make use of an evidence-based tool the Ages & Stages Questionnaire (ASQ-3™), alongside a wider review of the child's health, learning and development and other contextual factors.

The integrated review should be carried out in accordance with the following key principles:

1. The Integrated Review should engage parents, particularly those who are disadvantaged

The Integrated Review values active participation from parents both intellectually and emotionally in their child's assessment and in making decisions.

2. The Integrated Review should engage the child, where they are participating:

The child should be at the centre of the review, should enjoy the experience, interact and participate, helping to show what they can do, alongside the information given by parents and the ongoing observations of their early years practitioner.

3. The Integrated Review should be a process of shared decision making:

Practitioners and parents should respect each other's perspectives and contribute together to decisions on realistic and achievable actions to support the child's wellbeing. This can include agreeing changes in how both parents and the early years setting can best support the child's health, learning and development.

The NCB identifies two possible models for delivery of the integrated review:

1. Integration through information sharing before and after separate reviews

2. Integration through joint review meetings involving health, early years and the family

6. Four –five year old health needs assessment

At school entry it is recommended that pre-school information collected about health (from health visiting) and learning and development (early years providers) should be available and passed on to inform the school entry assessment. A questionnaire is then usually administered to parents to collect further information on the child from the parents perspective. It is recommended that local areas aim for 100% coverage and the information gathered should be shared between health and education. The HCP 5-19 recommends that at school entry the school nurse or other school health team member:

Takes over responsibility for a child from a health visitor (NB – This means that school nursing assume responsibility for children at age 4, even though pathway starts at age 5)

- Reviews immunisation status
- Reviews access to primary care
- Reviews access to dental care

- Reviews appropriate interventions for any physical, emotional or developmental problems that many not have been addressed
- Measures height and weight for the NCMP
- Ensures hearing screening and vision screening is carried out according to guidelines
- Is alert to risk factors and signs and symptoms of child abuse.

The HCP 5-19 states that there is no evidence to support the re-introduction of a routine, universal school entrant physical examination at the start of primary education.

7. Ten-eleven year old health needs assessment (year 6)

The HCP 5-19 recommends a health review at school transition in year 6/7 consisting of two questionnaires – one for young people and one for parents – to review young people's health and wellbeing at transition to secondary school. The evidence suggests that the aims and objectives of this approach could be:

- Introducing the school health team and school nurse and explaining how to access health advice and information at a time when pupils feel anxious and stressed
- Allowing parents to raise any concerns and offering them advice to support their child through transition
- Checking immunisation status and providing information about vaccinations offered at secondary school
- Checking that any important information about health problems has been transferred from the previous school
- Responding to health and wellbeing concerns raised by the young person or parents
- Identifying incipient mental health issues
- Interpreting the NCMP results and explaining implications for diet and lifestyles (NB – the NCMP is also completed in year 6 of primary school – in their last year before transition to secondary school).
- Offering an invitation to request a face to face consultation with a member of the School Health / school nurse team.

8. Twelve-thirteen year old health needs assessment (year 8)

In Medway, children start secondary school in year 7 (aged 11-12 years). The Public Health England guidance for 0-19 HCP commissioning includes 12-13 years as one of the five reviews to be completed in the 5-19 programme. It recommends that a health needs assessment takes place in the second year of secondary school when children are aged 12-13 years. HPV immunisations for girls are also completed in this year.

9. School leavers - 16

The HCP continues until young people reach the age of 19. Assessment of health need and ensure adequately supported when leaving school setting.

The 5-19 HCP document from 2009 states that a further contact point is recommended in mid-teens as young people subsume greater responsibility over their own health. In 2009, they stated that subject to successful piloting, we may recommend that primary care

services communicate directly with young people in their mid teens and by their 16th birthday. The communication is intended to inform young people of their right at 16 to choose a GP, offer them the opportunity to make an appointment and notify them of other services in the area.

It is also recommended in the HCP 5-19 that information about a young person's support needs should be shared with any further education institutions that they enter post 16.

10. Transition to adult services

A targeted review is recommended for those with higher needs to ensure that the transition to adult services is seamless. Further information on the transition to adult services is provided in the previous section on the six high impact areas for school nursing.

2.1.4 Key themes

The key themes from the review of policies and guidance relating to the delivery of the Healthy Child Programme can be summarised as follows:

Delivery of the HCP

Recent guidance has highlighted the importance of nurses as public health professionals and positions them as central to the delivery of local public health programmes. This includes not just public health nurses (health visitors and school nurses) as the key deliverers of the Healthy Child Programme, but the wider nursing workforce in community and primary care. This wider body of nursing professionals have a key role in health promotion and sharing public health messages to the families that they work with, as well as meeting their more acute and complex direct health needs.

Antenatal and perinatal care

- Midwives and maternity services are crucial to the delivery of the Healthy Child Programme and their potential role in communicating health promotion messages is significant. There is a risk that they could be neglected as stakeholders as local authorities are not responsible for commissioning the service.
- Midwives could play a greater role in the promotion and delivery of immunisations, as well as healthy lifestyle messages.

Early years

- There is a large focus on investing in and strengthening the 0-2 years offer, with a lesser focus on 2-4 years and school age children.
- All local areas should be conducting an integrated 2 year review. This can be delivered as one joint review or as two separate reviews facilitated by information sharing. Children who are not in an early education setting at two years should receive a health review and be encouraged to attend an early years setting.
- There are limited opportunities for the Healthy Child Programme to engage with children from the age of 2 - 4 years. Young children will be seen in primary care by Practice Nurses for immunisations and parents will complete the school application process when children turn three.

- All children aged three and four are entitled to 15 hours a week of state-funded early education and 96% of children take up these places. There is potential for closer working between health and early education during this period.
- It is set out in the Healthy Child Programme that information about children from the health visiting service should be transferred to the school nursing team at school entry.

School age

- It is recommended that each school should have a named school nurse so that they can work in partnership to help them deliver the health and wellbeing agenda.
- The NCMP is completed in reception year and year 6, but there is a lack of continuity of support and surveillance between these years. The school nursing service could play a greater role in the surveillance and coordination of overweight and obesity in between the NCMP measurements.
- The Healthy Child Programme states that a health needs assessment should take place in year 6 to support transition into secondary school. This could be conducted as part of NCMP.
- There are limited universal contacts once children reach secondary school age, aside from the delivery of immunisations. There are no professionals to 'hold the ring' and providing health assessments to determine health needs and to refer to and liaise with services. It is recommended that another health needs assessment takes place when young people are 12/13 years old.
- Schools are being asked to take a lead on and be responsible for many areas of health and wellbeing, including emotional health and support for children with long term conditions. It is therefore essential that health professionals work in partnership with schools.
- School nurses should be visible, confidential and accessible – to schools and to young people. Young people want an integrated, youth friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope – the school nursing service is well placed to fulfil this role as they sit outside of social care, education and other health services that young people may be engaged with.

Post 16 services

- There is currently a lack of provision and a great need to provide support to young people after they reach the age of 16 to help them prepare for adulthood.
- School nursing services need to engage with further education institutions e.g. colleges and sixth forms to identify local needs and areas where they can provide support to young people.
- There is a need to support young people as they transition to adulthood and into adult health and social care services to equip them to be empowered to take responsibility for and to manage their own health and wellbeing.

2.2 Local data

The aim of the epidemiological needs assessment is to provide a profile of the health and wellbeing needs of children and young people aged 0-19 years in Medway in order to ensure that future service provision is designed to deliver the requirements of the Healthy Child Programme.

The objectives are as follows:

- To identify the priority health and wellbeing nedes of children in Medway from conception through to 19 years of age
- To build a picture of the cross cutting issues affecting children and young people which link to the wider public health agenda and departmental priorities
- To complement the other elements of the wider needs assessment
- To inform the service specification for 0-19 universal child health services in Medway and shape the commissioning process
- To provide baseline information that can be used to inform the future performance management of the service

The epidemiological needs assessment has been divided into the following areas:

- Demography
- Wider determinants of health
- Health improvement
- Health protection
- Health care
- Vulnerable children

The data has been collated from publicly available sources including Office for National Statistics (ONS), Public Health England Fingertips (PHE), Health and Social Care Information Centre (HSCIC) and the National Child and Maternal Health Intelligence Network (CHIMAT) (part of PHE) as well as from services across Medway Council. Where possible, data has been presented for the financial year 2014/15, and where this is not available the most up to date data available as of March 2016 has been used.

A summary of the findings of the epidemiological needs assessment are described below:

2.2.1 Demography

Overview

Medway has a relatively young population with approximately 70,000 children and young people under 20 years of age. The fertility rate in Medway is higher than England and the population of children and young people is expected to reach 78,000 in the next 20 years. Families in Medway also tend to be larger than average. Overall, Medway is less ethnically diverse than England as a whole, but among school pupils there are high levels of diversity and the area is becoming more diverse over time. In some areas of central Medway, over 50% of school pupils are non White British.

Key points

- Fertility in Medway is higher than in the South East and England, but has shown a downward trend since 2012, following the national picture.
- Life expectancy at birth in Medway is significantly lower than in England.
- Just under a fifth of births in Medway are to mothers born outside of the UK with Nigeria, Poland, India, Slovakia and Germany being the most common countries of origin.
- There are approximately 70,000 children and young people aged 0-19 years resident in Medway and the population is younger than England overall.
- The population of children and young people in Medway is projected to increase by 12% to approximately 78,000 over the next 20 years. The increase is expected to be greatest in 10-14 year olds.
- The wards with the greatest number of children and young people resident (Gillingham North, Chatham Central and Gillingham South) are also among the most deprived wards in Medway and account for nearly a quarter of the total number of children under five.
- There is greater ethnic diversity amongst the 0-19 population in Medway than for Medway overall, however Medway is less ethnically diverse overall than England.
- The most diverse areas are Chatham Central, River, Gillingham South, Gillingham North and Luton & Wayfield wards, with the exception of River these are also the most deprived areas in Medway.
- Medway has become more ethnically diverse between the 2001 and 2011 censuses; the proportion of the population that is White British and White Irish has decreased, whilst there have been large increases in the Black African, Mixed White and Black African, and Asian populations.
- School data indicates that Medway is more diverse than the 2011 census suggests; 23% of primary school pupils and 20% of secondary school pupils in Medway are from a minority ethnic group, and 11.4% identify a language other than English as their first language; Polish, Panjabi, Yoruba (Nigerian) and Slovak are the most common.

2.2.2 Wider determinants of health

Overview

Many children in Medway are growing up in challenging circumstances; levels of child poverty are high and a fifth of children in the area live in a low-income household. A significantly higher proportion of children and young people in Medway provide unpaid care to family members or experience family homelessness, than is seen nationally.

Overall, children in Medway perform well at school in reception year and at key stage 1, but there are inequities in attainment between boys and girls, different ethnic groups and based on Free School Meal status. However, by the time children reach key stage 2, performance tends to be worse than the England average and at GCSEs it is similar to the national average. A high proportion of pupils in schools in Medway receive support for Special Educational Needs and rates of fixed and permanent exclusions from schools are high.

Medway has one of the highest levels of young people not in education, employment or training in England and the number of young people in the youth justice system is also high.

Key points

- A fifth of children in Medway live in low income households, and since 2009, child poverty has been significantly higher than the England average.
- The most deprived wards in Medway in terms of overall deprivation and income deprivation affecting children are Luton and Wayfield, Chatham Central, Gillingham North, Gillingham South and Strood South.
- 11% and 14% of pupils in mainstream primary and secondary schools respectively are eligible for free school meals, and this increases to 31.9% for pupils at special schools and 38.3% for pupils in Pupil Referral Units (PRU).
- Families in Medway are more likely to be large (3+ children), than nationally.
- The rate of family homelessness in Medway is 3.3 per 1,000 households, which is equivalent to 361 households. This is significantly higher than the South East and England and has nearly doubled since 2012/13.
- Nearly 9,000 women in Medway experience domestic abuse per year and referrals to domestic abuse support services have increased dramatically.
- The proportion of children in Medway providing unpaid care to family members is significantly higher than the England average.
- 70.7% of children achieve a good level of development at the end of the early years foundation stage, which is significantly higher than England. However, the gap between boys and girls is larger in Medway than nationally, and attainment is poorer in White pupils, compared to Asian and Mixed children, and among pupils who are eligible for Free School Meals and children receiving SEN support, compared to all other pupils.
- Performance of pupils in the phonics screening check at key stage 1 is significantly better in Medway than England, but at key stage 2 assessments pupils in Medway perform worse than England. Attainment at key stage 4 is similar to the national average, but has declined slightly in recent years.
- The proportion of pupils given SEN support in Medway is higher than England.
- Medway has a higher proportion of its pupils receiving permanent and fixed exclusions from school, than nationally. Absence rates are similar to England.
- Medway ranks 10th worst out of local authorities in England for the proportion of 16-18 year olds who are not in education, employment or training (7.5%).
- The rate of 10-18 year olds who have entered the youth justice system is higher in Medway than the South East and England and has been increasing; though, the rate of first time entrants to the youth justice system is lower than England.

2.2.3 Health improvement

Overview

The health and wellbeing of children and young people in Medway is mixed compared with the England average; in some areas Medway performs relatively well, but in others there are high levels of need and risky behaviours which contribute to poor health outcomes.

Diet and nutrition from infancy through to adolescence could be improved in Medway. Just over two thirds of new mothers initiate breastfeeding, which is significantly lower than the national average, and the uptake of Healthy Start vitamins is low. At the age of 15, 45.2% of

young people consume five or more portions of fruit and vegetables per day, which is significantly below the national average. Data shows that the oral health of children in Medway is better than England; however, there has been a dramatic increase in the rate of hospital admissions for extractions due to tooth decay in children under 10 in the last year.

The proportion of young people in Medway undertaking regular moderate-to-vigorous physical activity is similar to other areas; however, the proportion of young people who are sedentary for many hours of the day is significantly higher. Levels of overweight and obesity in children are similar to the national average, although there is variation between different areas of Medway and different ethnic groups.

Overall, the teenage conception rate in Medway has fallen in recent years, but it has been consistently above the South East and the England average since 2010. Levels of chlamydia screening are higher than the national average and the chlamydia detection rate is similar to England, indicating good chlamydia control in Medway.

The rate of smoking in pregnancy in Medway has been consistently higher than the England average and has not followed the national rate of decline. There are also high rates of smoking among young people; one tenth of 15 year olds are reported to be current smokers. Nearly two thirds of 15 year olds in Medway report ever having drunk an alcoholic drink, which is significantly higher than England (62.4%). Although, the rate of alcohol specific hospital admission among young people is significantly lower in Medway, than nationally. Furthermore, estimates of drug taking behaviours among young people and hospital admissions for substance misuse are also below the national averages.

The emotional wellbeing and mental health of young people in Medway is worse than the England average and there are several week waiting times for CAMHS. The rate of hospital admissions for mental health among children is statistically similar to the England average. It is also estimated that at any time 439 women in Medway require support during pregnancy or the postnatal period due to maternal mental health issues.

Key points

- Just over two thirds of women initiate breastfeeding in Medway, and this is below the England average. Breastfeeding initiation is lower among younger women and those living in more deprived areas.
- Only 69% of families in Medway take up their entitlement to the Healthy Start scheme and uptake of Healthy Start vitamins is very low.
- Many young people in Medway have a poor diet as indicated by the low proportion of 15 year olds that eat five + portions of fruit and vegetables a day.
- The proportion of children in Medway undertaking regular moderate-to-vigorous physical activity is similar to other areas; however, the proportion of young people who are sedentary for many hours of the day is high.
- A fifth of children aged 4-5 and a third aged 10-11 are classified as overweight or obese in Medway, but this is not significantly different to England.
- The oral health of children in Medway is slightly better than the national average and there is good access to primary dental care reflected in lower hospital admissions for extractions.

- Overall, the teenage conception rate in Medway has fallen in recent years, but it has been consistently above the South East average and significantly above the England average since 2010. Data on abortions suggest that abortions among women under 18 and repeat abortions are an issue in Medway.
- The proportion of women smoking in pregnancy is consistently higher than the national average and there has been no sustained improvement in the proportion of women who successfully quit. Younger women and those from more deprived areas are less likely to set a quit date and successfully quit.
- A tenth of 15 year olds are current smokers and two thirds have ever had an alcoholic drink, which are both higher than average. However, alcohol specific hospital admissions among young people are lower than average and have been declining.
- Nationally, cannabis is the most commonly used drug among young people and four-fifths (86%) of young people in specialist services in England say they have a problem with this drug. A tenth of 15 year olds in Medway have ever tried cannabis, similar to the national average.
- The emotional wellbeing of young people in Medway is significantly poorer than the national average.

2.2.4 Health protection

Overview

Newborn and antenatal screening in Medway is generally delivered at or above the recommended acceptable levels. Uptake of antenatal screening is high and very small numbers of cases of HIV, hepatitis B or syphilis are identified**.**

Uptake of the prenatal influenza (44.6%) and pertussis (60.0%) vaccines are slightly higher in Medway than Kent and England (2014/15); however flu vaccination uptake is a long way below the 75% target. Uptake of childhood immunisations has historically been generally high in Medway; however, the rates have fallen since 2013, in part due to data reporting issues. Uptake of the HPV vaccination in girls is 80% in Medway which is slightly higher than Kent, and uptake of the tetanus, diphtheria and polio booster and the Men C vaccine is slightly lower in Medway than Kent.

Key points

- Screening for HIV, syphilis, hepatitis B and rubella is routinely offered to all pregnant women. Uptake of screening is high and very small numbers of cases of HIV, hepatitis B or syphilis are identified. Rubella susceptibility screening in pregnancy will end in April 2016.
- Antenatal sickle cell and thalassaemia screening and fetal anomaly screening is delivered above the acceptable level in Medway.
- In 2014/15, 95.7% of babies in Medway received the newborn bloodspot screening test, which is similar to the South East (95.2%) and England (95.8%) averages. The proportion of newborn bloodspot screening tests recorded on the Child Health Information System in the recommended timeframe is 72.1% in quarter 2 2015/16. This is well below the acceptable (95%) and achievable (99%) target.

- Four fifths (79.5%) of babies who require further investigation following newborn hearing screening receive audiological assessment within the recommended timeframe. This is far below the acceptable level (90%) and achievable level (100%) and is the second lowest of all CCGs in Kent.
- Uptake of the influenza vaccine in pregnancy and the prenatal pertussis vaccine is slightly higher in Medway than Kent and England; however flu uptake is a long way below the 75% target
- Historically, the uptake of primary immunisations in children in Medway has been generally high. A decline in the uptake of childhood vaccinations has, however, been apparent since 2013, which is most likely due to data reporting. Recorded uptake of the MMR2 vaccine by five years of age has dropped to 75.9%.
- Uptake of the HPV vaccination in girls is 80% which is slightly higher than Kent. However, uptake of the tetanus, diphtheria and polio booster and the Men C vaccine in secondary school is slightly lower in Medway than Kent. Since September 2015, the Men C vaccine has been replaced with a new Men ACWY vaccine.

2.2.5 Health care

Overview

The proportion of babies born with a low birthweight (LBW) is similar in Medway to the national average, but it is significantly higher in Chatham Central, Luton and Wayfield and Strood South wards, than less deprived areas. Infant and child mortality rates in Medway are also similar to England. The rate of hospital admissions for accidents in injuries in children aged 0-14 in Medway is significantly higher than the national average, although for young people aged 15-24 it is significantly lower.

Key points

- A tenth of women in Medway had their booking appointment after 12 weeks and 6 days in Medway in 2013. Younger women, ethnic minority groups and women living in more deprived areas are significantly more likely to access antenatal services late.
- In 2014, 2.7% of all live births beyond 37 weeks gestation in Medway weighed under 2.5kg and are classified as LBW. This is similar to the England average of 2.9%. The percentage with LBW is significantly higher in Chatham Central, Luton and Wayfield and Strood South wards compared to those born in Rochester South, Horsted and Hempstead and Wigmore wards.
- Infant mortality rates have decreased nationally and in Medway over the past decade. Infant mortality rates in Medway are now lower than in England, although not statistically significantly so. In 2013, the rate of infant deaths was 3.4 per 1,000 live births, equivalent to 12 infant deaths. The child mortality rates in Medway are similar to the national average.
- The deaths of 118 infants and children were reviewed by the Child Death Overview Panel between 2008/09 and 2014/15. Two thirds (65.3%) of deaths were classified as expected, and just over a third (34.7%) unexpected. Over half (59.3%) occurred among males and 40.7% among females, and just over a fifth (20.3%) had an ethnic background other than White British (76.3%). A perinatal / neonatal event , often

associated with premature birth, caused 42.4% of these deaths and further 18.6% due to conditions caused by chromosomal, genetic or congenital anomalies.

- The rate of hospital admissions for injuries in children aged 0-14 in Medway is significantly higher than the South East and England. The most common reason among children 0-4 is 'head injury' and in children 5-14 is 'dislocation/fracture/joint injury/amputation'.
- The rate of hospital admissions for injuries in young people aged 15-24 is significantly lower than England.
- The crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents is 12.2 per 100,000 in Medway, and this is not significantly different to the England average (17.9 per 100,000) (2012-2014).
- In 2014, 81 children in Medway were involved in road traffic accidents resulting in serious or slight injuries.

2.2.6 Vulnerable children and young people

Overview

Vulnerable children and those with additional health needs often require extra targeted health and wellbeing support and are more at risk of having poorer emotional health and wellbeing and engaging in risky health behaviours.

There are many vulnerable children in Medway; the area has high rates of Looked After Children, Children in Need and children with a Child Protection Plan. There are estimated to be 5,500 – 5,800 children and young people in Medway affected by disability. There is a high prevalence of autism and between 50 and 100 children have a severe disability in Medway.

Rates of A&E attendances among infants and children are lower than England. However, rates of hospital admissions for gastrointestinal infections in infants are very high in Medway. Unplanned hospital admissions in children and young people for asthma, diabetes and epilepsy are also significantly higher than average. Possible reasons for this might include service related issues, issues related to self management or data reporting.

Key points

- The rate of Looked After Children in Medway is higher than the England average. In September 2015, there were 444 Looked After Children in Medway. Numbers are projected to increase in 2016 and 2017.
- The proportion of Looked After Children who received an annual health assessment and are up to date with their immunisations is higher in Medway than in the South East and England. However, the proportion who have seen a dentist in the last year is significantly lower.
- Throughout 2014/15 there were 4,259 children in need in Medway. This is equivalent to a rate of 681.0 per 10,000 children, compared to 602.8 in the South East and 674.4 in England. The most common primary need at assessment was for ‘abuse and neglect’ (61.6%) and 15.8% of primary needs were recorded as family dysfunction.

- Fifteen per cent (15.4%) of children in need in 2014/15 have a recorded disability. The most common disability is Autism or Asperger Syndrome (55.7%) or another form of learning disability (41.2%).
- In 2014/15, 539 children in Medway became subject to a child protection plan, which is equivalent to a rate of 86.2 per 10,000 children. This is higher than the South East (51.5 per 10,000) and England (53.7 per 10,000) rates.
- The rate of hospital admissions for babies under 14 days and the rate of A&E attendances for children aged 0-4 is statistically lower than nationally. Rates of admissions for infants due to respiratory infections are lower than average.
- However, the rate of hospital admissions for gastroenteritis in infants is very high; it is significantly higher than the South East and England and the rates are the highest or second highest in the group of CIPFA statistical neighbours.
- There are estimated to be 3,385 children in Medway with nocturnal enuresis and 1,960 with daytime continence issues.
- Asthma, diabetes and epilepsy are among the most common long term conditions experienced by children. The directly standardised rate of unplanned hospital admissions for asthma, diabetes and epilepsy in under 19s in Medway is 508 per 100,000, which is significantly higher than England (327 per 100,000) (2014/15) and is the highest rate for all CCGs in the South East.
- There are estimated to be approximately 5,500 – 5,800 children and young people in Medway affected by disability. There is a high prevalence of autism and between 50 and 100 children have a severe disability in Medway.

2.3 Primary insight

In late February 2016 Medway Council commissioned Involve to Change to carry out a primary insight investigation into the Healthy Child Programme (HCP) in Medway. The aim of the review being to provide the qualitative element of the health needs assessment to help understand the underlying reasons, opinions and motivations of children, young people and families in Medway with regards to child health services. The primary insight work seeks to provide insights into how Healthy Child Programme services currently operate from the perspective of service users and providers in order to inform recommendations for future service models and outcomes.

The following information on the methodology is taken from the Involve to Change primary insight report (Appendix 4.3).

The target groups for inclusion in the primary insight were from 3 distinct categories;

Category A: HCP practitioners (School Nurses, Health Visitors, Nursery Nurses)
Category B: Partners (Schools, Children's Centres, Midwifes, community nursing, GP's, Social Care and other partners)
Category C: Service users to include current and previous service users, users from areas of high deprivation, first time parents, non-service users and children in primary and secondary education.

The areas we were tasked to explore primarily were as follows:

- What are the most valued elements of the service? (Categories A/B/C)
- What are the barriers to better service provision? (Categories A/B/C)
- What opportunities are there to integrate the services with other functions? (Categories A/B)
- What other Public Health Interventions could HCP practitioners deliver as part of an integrated service? (Categories A/B/C)
- Which of the mandated checks are most/least valued by service users? (Categories C)
- What the safeguarding role is or should be within the respective services? (Categories A/B)
- What are the positive impacts/outcomes that School Nursing and Health Visiting have on other public sector services? (Categories A/B)
- Is there any technology that could make the role more efficient? (Categories A)
- What are the referral pathways to secondary care services (CAMHs/SALT/Stop Smoking Services etc) like? (Categories A/B/C)
- How accessible are the services? (Category C)

2.3.1 Service user views

A total of 281 online and paper questionnaires were fully completed and in addition to focus groups which were completed with parents in children's centre venues in Medway.

Conception to five years

The most important priorities for parents and carers in the 0-5 period were identified as:

- First Aid training (73.7% very important)
- Breastfeeding (62.0%)
- Socialisation for the child (60.9%)
- Speech and language early identification and support (61.5%)
- Hearing test referrals (60.0%)
- The two areas which had the highest proportion of respondents stating there were not important were 'potty training advice' (5.2%) and school readiness (3.3%), but this may reflect fact that only parents of children aged 0-3 were invited to complete the section.

Parents provided their views and experiences of the mandated health checks from 0-5 years. The findings were:

- There is a high level of take up and satisfaction with antenatal contact and new birth visit as well as a high take up of GP 6-8 week medical check, but evidence of some dissatisfaction (16.2%) with this latter review.
- There is less awareness and take up of health visitor checks at 6-8 weeks for maternal mood and breastfeeding status – e.g. 35% state not receiving 6-8 breastfeeding and there is evidence of some confusion among parents about the 6-8 week checks i.e. who delivered them and whether they had received them
- The questionnaire demonstrated that there is good awareness of the 4 month starting solid sessions

- Excluding those who stated that the 1 year and 2-2.5 year review were not yet applicable, 1/3 of parents were not offered / did not take up these checks. Only a very small number were dissatisfied.
- However, parents ability to accurately recall these checks and relate their experiences to the correct check listed in the questionnaire might be limited. .

The most important aspects of children's health services were reported as :

- Being seen by competent professionals who can communicate well (81.2% very important)
- Having the right help provided quickly once problems are identified (80.8%)
- To be treated with dignity and respect (77.7%)
- Having health problems identified early (75.4%)
- Accessing services in the right place and at the right time (69.5%)

However, in terms of the barriers to accessing services child health services 64.8% of parents stated that there is 'not enough information / not knowing what is available'. Nearly half (47.6%) do not have 'confidence / not feeling comfortable to do so' and 47.2% stated that opening hours / appointment times are not convenient.

The preferred locations for accessing child health services were a children's centre, at home, or in an educational setting e.g. school / nursery. There was no clear view on when is the most suitable or convenient time in the day or week to engage with child health services. The preferred methods for information sharing were email, text message, and then letters.

Additional comments:

- Positive experiences and views on Medway Hospital and the care offered in pregnancy and during delivery
- Support needed in the home to address postnatal wellbeing and mental health issues in the early weeks
- Experience with second or subsequent children not as thorough as with first child and parents feel they're not offered the full range of services when could benefit from greater support due to needs of different age children.
- Children's centres very highly regarded for their role in signposting to services and in reducing isolation, anxiety and encouraging mothers to socialise. Breastfeeding peer support groups were particularly valued.
- Parents noticed a gap between the amount of support received up to 1 year until the 2-2.5 year review.

Parents of primary school age children

The most important priorities for parents / carers with children at primary school were identified as:

- Bullying (71.9% very important)
- Mental health and emotional wellbeing (62.5%)
- School readiness / transition and progress (64.1%)
- Access to First Aid (59.3%)

- Nutrition and physical activity (52.8%)
- Parents more likely to identify school readiness as a priority once children start school – possibly an indicator that parents don't consider it at an early enough stage.
- Smoking, alcohol and drugs were considered the least important issues, nevertheless around 60% of parents thought that they were very important or important issues
- 22.0% stated that sexual health is not important

Additional comments:

- Parents with school age children commented that they would have benefitted from support in preparing children for school in practical and emotional terms, but not a priority for those with under 4s currently.
- School entry checks valued - "It is nice to get the letter about height and weight – I included it in my daughter's red book which was lovely as it feels like the red book becomes redundant when they stop being babies"
- Support needed for parents home-schooling their children through school nursing

Parents of secondary school age children

The most important priorities for parents / carers of children at secondary school age were identified as:

- Mental health and emotional wellbeing (86.9% very important)
- Bullying (84.4%)
- Sexual health (82.6%)
- Puberty and development (80.8%)
- Drugs (76.9%)
- School readiness / transition and progress was rated as not important by 3% of respondents – the highest of all issues.

2.3.2 Professional and front line staff views

38 questionnaires were completed by staff in Medway. Half of the staff that completed a questionnaire were from the health visiting or children's centre teams. According to professionals, the most important elements provided under the HCP are:

- Supporting emotional wellbeing of children (Most important - 88.6%)
- Safeguarding (85.7%)
- Bonding and attachment (80.6%)
- Reducing infant mortality (80.0%)
- Improving life expectancy and healthy life expectancy; reducing hospital admissions caused by unintentional and deliberate injuries (72.2%)
- Reducing excess weight in 4-5 and 10-11 year olds was the area that the smallest proportion of respondents rated as very important (44.4%).

The key themes from the questionnaires and the focus groups and interviews that were completed are:

- Professionals feel children's centres work very well and are integrated with other teams
- However, there can be disparities in the services provided to families in different localities in Medway, difficulties reaching 'hard to reach' families, lack of staff and poor communication. Respondents also highlighted variation across in Medway in terms of quality and quantity of service offered with respect to children's centres and community midwifery
- Referral pathways to secondary care could be improved – for most services 'fairly effective' was the most common response among respondents and 18.2% of people said the CAMHS pathway was 'not at all effective'.
- Communication
    - Lack of information sharing and communication between different services resulting in 'silo' working
    - Co-location of teams was suggested as a solution
    - Children's social care and the school nursing service were highlighted by participants as challenging to work jointly and share information with
    - Communication with children's centres was viewed positively
    - Professionals have experienced difficulties referring to CAMHS
- Technology
    - Different systems are used across the 0-19 pathway by different providers and some are still paper based
- School readiness
    - Concern among professionals that families do not have much contact with the HCP following the 2-2.5 year check until they start school
    - Many children not 'school ready' when they start reception and this places pressure on teaching staff and school nursing services

Views of the following groups were not able to be collected as part of this rapid piece of insight gathering, but it is important to acknowledge that these would provide another perspective and that their views are crucial to developing the Healthy Child Programme in Medway:

- School children and young people
- Further views from parents of children attending school
- School staff e.g. headteachers, SENCos, teachers involved in PSHE delivery and any school health staff employed directly by the school
- Providers of CAMHS, speech and language, sexual health and other services for children and young people in Medway
- Fathers
- Young and vulnerable parents

Involve to Change concluded that the following areas would benefit from further investigation and consideration:

- Whether there is a way to plug the gap between 1 year check – 2 year check and 2 year check – school entry
- Emotional health and wellbeing – better support for children and young people and women suffering postnatal depression
- Referral processes for secondary services and social care

- School readiness
- Breastfeeding
- Support for teenage mothers – more support for young parents within the programme, especially for those who return to school, and outside of the programme
- Working with GPs on signposting – common theme amongst members of the public that GPs were not aware of the HCP and didn't use the resources available when dealing with patients

2.4 Benchmarking and workforce modelling

Benson Wintere conducted a benchmarking and workforce modelling exercise of the current health visiting and school nursing services in Medway. The Benson Model is a demand led approach which starts with the needs of the local population ensuring local requirements and Healthy Child Programme objectives are part of the service offer. Demand profiling demonstrates support requirements for the local child population in each team, sensitised in accordance with local complexity and geographics. This identifies a theoretical workload and facilitates development of new workforce structures and assessing effectiveness of the existing workforce.

The modelling was completed via a series of workshops which were held from March – May 2016. The main findings from the model were:

Health Visiting –

- Workforce capacity is 89% and is approaching a sufficient size to deliver the current service specification. Two of the three geographical teams show a shortfall and one team is adequately resourced.
- The workforce analysis shows a shortfall of around 4 whole time equivalents (WTE).
- The number of Health Visitors at Band 6 and 7 is correct, but a greater number of Band 5 Community Staff Nurses and fewer hours of Band 4 Community Nursery Nurses are needed to match the Benson Wintere model. This means that skill mix could be improved and efficiencies made with a greater number of Band 5 roles.
- FNP was not included within the modelling and so is effectively additional specialist support

Figure 5: Medway health visiting service workforce analyser, July 2016

Workforce Analyser	TL	PT	HV*	HV	CSN	CNN	HVA	ADM	Total WTEs
Existing staff (FTE)	3.00	3.60	4.86	47.35	8.64	5.51			72.96
(Headcount)	3	4	6	55	13	7		0	88
Funded roles (FTE)	3.00	3.60	2.86	48.34	9.31	4.58	0.000	0.000	71.69
Benson Model (FTE)	3.00	3.60	2.98	49.79	13.98	3.54	0.00	0.00	76.89
(Headcount)	3	4	5	51	15	7			85

Source: Benson Wintere

School Nursing –

- Workforce is slightly lower than the size needed to deliver services
- The workforce analysis shows that Band 6 School Nurses have not been assigned enough clinical responsibilities and there needs to be a reallocation of workload
- Safeguarding seems to be the biggest area of work followed by immunisations and NCMP. There seems to be little time spent on wider PH functions.
- The MAFF post was not included within the modelling

Figure 6: Medway school nursing service workforce analyser, July 2016

Workforce Analyser	TL	PT	SN*	SN	CSN	SHSW	HCA	ADM	Total WTEs
Existing staff (FTE)	2.32	0.40	1.58	6.26	4.25	4.17			18.98
(Headcount)	3	1	2	8	7	5		0	25
Funded roles (FTE)	2.32	0.40	1.58	6.26	4.31	4.17	0.00	0.00	19.04
Benson Model (FTE)	2.32	0.40	1.58	5.05	6.58	4.04	0.00	0.00	19.97
(Headcount)	3	1	2	6	9	6			26

Source: Benson Wintere

3. Recommendations

3.1 Key principles of an integrated Healthy Child Programme in Medway

- All staff delivering the programme are appropriately trained and skilled
- All services are delivered in the appropriate 'environment' – eg, child-friendly environments, accessible and health settings
- Effective and appropriate use of skill mix across the service
- Effective and consistent delivery of physical education and Personal, Social, Health and Economic education (PSHE) curriculum
- Clear and effective communication and referral routes with Social Care, Midwifery, Early Help and Acute Services
- Effective and innovative use of IT and Social Media
- Single points of contact one website/one helpline
- All staff should be Making Every Contact Count Ambassadors
- Services and resources are flexible and informed by population needs
- Clear and effective service offer and pathway for young and vulnerable parents
- Children and young people, families and carers are engaged in service design and delivery and are encouraged to feedback their views
- Services should take a 'whole family' approach when supporting children and young people
- All information about children and young people is shared between professionals at the key transition points within the service.
- The service supports family and education settings such as children's centres and schools to adopt and share important public health messages
- The service is visible and its role is clear to children, young people and families, as well as the services that they work with.

3.2 Priorities for the 0-19 outcomes framework

The needs assessment has highlighted the key issues affecting children, young people and their families at different stages of the 0-19 pathway. The recommendations for the needs assessment have been developed into priority outcome areas which will provide the structure for the outcomes framework for the 0-19 service. These are as follows:

Achieving a healthy pregnancy and birth (Prenatal – 8 weeks)

- Promote good early nutrition for mother and baby
    - Breastfeeding
    - Healthy Start vitamins
- Support for maternal mental health
- Reduce the harm caused to babies and children by parental smoking
- Reduce illness preventable by immunisations
- Reduce unplanned pregnancies and subsequent births in under 18s
- Support parents to manage housing, employment, debt and other issues that impact on child health and development

Healthy infancy and supporting the early years (8 weeks – 2 years)

- Reduce the harm caused to babies and children by parental smoking
- Reduce illness preventable by immunisations
- Provide parents with practical support to adopt healthy behaviours and routines
    - Introducing solid foods
    - Healthy Start
    - Physical activity
    - Sleep
- Ensure the early identification and management of issues and additional needs
- Reduce the rate of and provide appropriate support and management of minor illnesses and infections
    - Respiratory and gastrointestinal infections
- Support parents to manage housing, employment, debt and other issues that impact on child health and development

Healthy development and being ready to learn (2 years – 2.5 years)

- Children are supported to achieve their potential developmental goals
- Reduce illness preventable by immunisations
- Ensure the early identification and management of issues and additional needs
    - Vision, hearing and speech development
    - Other significant issues
- Support parents to manage housing, employment, debt and other issues that impact on child health and development
- Support and encourage the adoption of healthy behaviours in the family
    - Healthy weight
    - Oral health

School readiness (2.5 years – 5 years / reception)

- Ensure all children achieve the appropriate level of continence
  - Daytime and nocturnal dryness and soiling
- Reduce illness preventable by immunisations
- Reduce the rate of and provide appropriate support and management of minor illnesses and infections
  - Respiratory and gastrointestinal infections
  - Admissions for accidents and injuries
- Ensure all children are able to achieve their full potential from school
- Support and encourage the adoption of healthy behaviours in the family
  - Healthy weight
  - Oral health
  - Physical activity
- Families are able to manage behaviours that challenge and cause stress to the family
- Ensure the early identification and management of issues and additional needs
  - Vision and hearing
  - Other significant issues

Primary school - Key stage 1 and 2 (5 years – 11 years)

- Ensure health issues are appropriately managed in school and school attendance is maximised
- Reduce illness preventable by immunisations
- Raise awareness of and promote the adoption of healthy lifestyle choices
  - Healthy weight
  - Oral health
  - Physical activity
- Ensure the early identification and management of issues and additional needs
- Build resilience and promote positive emotional wellbeing
- Children are ready for the transition to secondary school

Secondary school – Key stage 3 and 4 (11 years – 16 years)

- Raise awareness of and promote the adoption of healthy lifestyle choices
  - Healthy weight
  - Physical activity
  - Smoking
  - Drugs and alcohol
- Reduce illness preventable by immunisations
- Build resilience and promote positive emotional wellbeing
- Young people are supported to have healthy relationships and good sexual health
  - Teenage pregnancy
  - Sexually transmitted infections
  - Contraception
  - Access to sexual health services
- Ensure the early identification and management of issues and additional needs

- Ensure health issues are appropriately managed in school and school attendance is maximised

Adolescence (16 years – 19 years)

- Ensure young people are prepared and equipped to make decisions about and manage their own health and wellbeing
- Raise awareness of and promote the adoption of healthy lifestyle choices
    - Smoking
    - Drugs and alcohol
- Young people are supported to have healthy relationships and good sexual health
    - Teenage pregnancy
    - Sexually transmitted infections
    - Contraception
    - Access to sexual health services
- Ensure young people with additional health issues and needs continue to be supported and are prepared for the transition to adult services

3.3 Cross-cutting issues

There are a number of issues identified by the needs assessment which are cross cutting – they are issues which affect children and young people across the 0-19 pathway and are key determinants of the health and wellbeing of the 0-19 population of Medway. These include:

- Domestic violence
- Child sexual exploitation
- Neglect
- Young carers
- Troubled families

These issues require an intensive and targeted response through safeguarding and looked after children services. The 0-19 outcomes framework will include hard outcome measures that address the need to 'reduce risk from harm and improve safety' in all areas of the 0-19 pathway.

4. Appendices

4.1 Literature review report

4.2 Epidemiological report

4.3 Primary insight report

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APPENDIX 5

Diversity impact assessment

Guidance on carrying out a diversity impact assessment

A diversity impact assessment (DIA) (sometimes referred to as an equality impact assessment - EIA) is a process that helps you demonstrate that you have complied with the Council's statutory obligation to put fairness and equality at the centre of any change to service provision, policy or strategy and taken into account the impact on individuals.

The DIA process helps you to assess the likely impact any such change may have on all sections of the community and/or council staff, including people with protected characteristics as defined in the Equality Act 2010 ("the Act").

By considering the likely impact **before any decisions** are made that will result in a change to service, this process helps you to find ways that can prevent, or at the very least, reduce any potential adverse impact. You cannot fulfil your duty by justifying a decision **after** it has been taken.

Protected characteristics (Equality Act 2010)

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

Why carry out a DIA?
Carrying out DIAs, and making sure decision makers take into account the findings of DIAs, is one way that the Council can demonstrate compliance with its public sector equality duty under the Act. Section 149 of the Act states that public authorities must, in the exercise of their functions, have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

Service improvement
DIAs are an effective tool to drive forward improvements to services which benefit our communities.

Medway's approach
In 2013, Medway reinforced its support to continue using DIAs as an effective way to demonstrate our focus on customers and citizens.

One of the two values of Medway Council is:

"*Putting our customers at the centre of everything we do*".

Carrying out DIAs is a vital tool for managers to ensure that they incorporate this value in the way they deliver services.

What if we don't carry out a DIA?
Done badly or not at all, it carries significant risks in terms of compliance with legal requirements and Council policy. There is no legal requirement to carry out a DIA, but without one, it's hard to show that the Council has fulfilled its legal duties to have due regard to the matters in the Act. This could result in Council decisions being challenged in the courts, in delays, legal costs and damage to the Council's reputation.

Diversity impact assessment

Failure to carry out a DIA would also be a lost opportunity to improve the quality and accessibility of services for our residents.

What support is available to help me carry out an assessment?
Contact your Performance & Intelligence hub if you require any help carrying out the DIA.

Stage 1: Getting started – Identify what you are assessing?

Why are you carrying out a DIA? Be clear about what it is you are trying to assess. Are you trying to assess the impact of a proposed new service, project, strategy or policy - or the impact of a proposed change to an existing one of the above?

When is a DIA required?
You must assess the impact on protected characteristic groups (or any other disadvantaged groups) **before any decisions** are made in relation to any of the above.

You can only assess the likely impact of any proposed change if you have sufficient evidence on which to base your judgment.

Stage 2: Gathering evidence

What evidence do I gather?

All relevant evidence which will support your judgment about the likely impact (whether this is a negative or positive impact) on the protected characteristic groups.

Keep it in proportion
The amount of evidence collected should be proportionate to the scale and impact of the issue being assessed.

You need evidence to help you answer the following questions:

Can you quantify the current service?

- Actual number of service users
- Profile of service users (age/ethnicity/disability etc)
- Potential number of service users (enclosed Medway community profile information may be useful)
- Customer satisfaction results
- Budget information
- Performance information
- Benchmarking information

Can you quantify the scale of any problem which this proposed change is attempting to resolve?

- Number of incidents
- Number of complaints
- Previous DIAs addressing this

Can you quantify what changes are being proposed?

- What new/different services will look like compared to the current service

Can you quantify who will be impacted by the change?

- Numbers of staff
- Numbers of existing customers
- Numbers of potential customers
- Contractors/other groups/all of Medway community
- What protected characteristics do any of the above have

Who have you consulted to identify what the impact on the above groups will be, or what solutions could mitigate any adverse impact?

- Existing service users and/or their families/carers
- Staff/legal dept
- Other stakeholders
- Other organisations
- Service user, or performance information
- Staff forums

Where **evidence is missing**, and where appropriate, you should consider obtaining new evidence. This can be included in your Action Plan.

Again, remember any additional work to obtain new evidence must be proportionate to the subject under assessment.

Stage 3: Assessing the impact

How do I use the information gathered?
You must make an assessment regarding the likely impact that the proposed change will have on the protected characteristic groups.

You will need to identify if the impact is positive, negative, or a mix of both.

Diversity impact assessment

'Positive impact' could include how the change may **advance equality** and/or **foster good relations between people who share a protected characteristic.**

You will need to identify how significant the impact is in terms of its nature and the number of people likely to be affected.

No adverse impact

There is likely to be no adverse impact on any of the protected characteristic groups. What happens next?

Complete the DIA and include evidence to show why you judge that there will be no adverse impact. This information will be vital should the DIA be challenged at a future date.

No further work is required on the DIA unless there is a significant change in the future which requires a new assessment.

Adverse impact

There is likely to be an adverse impact on one or more protected characteristic groups. What happens next?

You need to identify how you can avoid any adverse impact or at least mitigate the adverse impact.

You must set out in the Action Plan what mitigating measures you intend to put in place.

What if there are no options which will mitigate adverse impacts?

If you can't mitigate the adverse impact, it is important that you state that this is the case, and why, as it will act as an important early warning to managers and councillors.

What if I don't know what the impact will be?

If you don't know, you must demonstrate how you plan to get evidence of the likely impact. Include this in your Action Plan.

What should Action Plans contain?

The Action Plan is an important part of the DIA. It should include actions showing how you intend to:

- Mitigate adverse impacts
- Obtain new evidence to enable an informed judgment on the likely impact to be made

All actions should be Specific, Measurable, Achievable, Realistic and Time bound (SMART).

Stage 4: Recommendation

Based on the evidence available, the lead officer may include a recommendation for decision makers to consider.

If there is insufficient evidence to make a recommendation, say so. You may be able to make a recommendation once further evidence is obtained.

Stage 5: Authorisation

The completed DIA must be signed by your Assistant Director as confirmation that:

- The evidence included is satisfactory
- The action plan to mitigate adverse impacts and/or obtain new evidence is satisfactory
- Relevant service managers are aware of the content of the DIA
- The recommendation is satisfactory

What next?

All reports being submitted to Cabinet regarding a proposed change to a service, strategy etc must include a copy of the relevant DIA. Cabinet has to have due regard to equality matters when making decisions. It cannot do so if it does not have the relevant information in the report when it makes its decision.

All DIAs are published on the Council's internet site (including those which do not go to Cabinet). Email a copy of your completed DIA to the Corporate Performance & Intelligence hub where arrangements are made to publish on the internet.

Stage 6: Monitoring the Action Plan

The Action Plan should be incorporated into your existing service plan so that it can be monitored as part of your existing service plan monitoring process.

Diversity impact assessment

Community & Workforce Equality Data

It is vital that we have a good understanding of who our customers are so we can deliver services that are targeted to meet their needs. This section contains information about the people who make up the rich and diverse Medway communities.

We have used the Census 2001 and 2011, the Department of Communities and Local Government: Indices of Deprivation 2015 and the Office for National Statistics (ONS) mid-year population estimates for the UK 2014 to get an up to date picture of what our communities look like today, and how they have changed. The majority of this data still relates to the Census 2011, as this remains the most current dataset available for this data.

Medway Community: Key changes	
Population increased	Medway's population increased from 249,288 in 2001 to 263,925 in 2011, a 5.9% increase. The population has continued to grow since 2011 and it stood at 274,015 in 2014, an increase of 3.8% since 2011 (ONS, mid-year population estimates 2014).
Ageing population	Medway's population is progressively ageing. There has been a decrease in the proportion of people in the 0-18 age group (24.1% in 2014 compared to 26.6% in 2001). The 19-64 age group remained static, and there has been an increase in the population aged 65 and over (from 12.6% in 2001 to 15.3% in 2014). Medway's population remains younger than England and Wales, but the older population has increased at a faster rate in Medway.
More ethnically diverse	Medway has become more ethnically diverse since 2001. The Black and Minority Ethnic (BME) population increased from 5.4% in 2001 to 10.4% in 2011. The BME population is lower than England and Wales but has seen a faster increase in the past decade. White British is still the largest ethnic group, 85.5% of the population. The White Other group has seen the biggest increase of any ethnic group, increasing by 4,849, from 1.5% in 2001 to 3.2% in 2011. The increase in ethnic diversity is greater for younger age groups.

Diversity impact assessment

Limiting long term illness increase	The percentage of people with a Limiting Long Term Illness has increased from 15.6% in 2001 to 16.4% in 2011. The proportion of the population whose day-to-day activities are limited is less than England and Wales, but has increased at a faster rate between 2001 and 2011.
Unpaid carers increase	The number of unpaid carers increased from 7.7% in 2001 to 10% in 2011.
Increase of those who state no religion	In 2011, 58% of residents identified themselves as Christian, a reduction of 14 percentage points from 72% in 2001. 30% of residents stated they have no religion, an increase of 13 percentage points from 17% in 2001. Medway had a higher proportion of the population who stated they have no religion, but had fewer people who stated their religion as Christian. 2% of residents were Muslim, an increase of 1 percentage point since 2001. The rate of change was faster Medway than in England and Wales (No Religion and Muslim increasing at a faster rate, and Christianity decreasing at a faster rate).
Increase in deprivation	Medway is ranked 118th most deprived Local Authority of 326 (1st being the most deprived) in England in the 2015 Index of Multiple Deprivation. This is a relatively worse position than the index in 2010, when Medway was ranked 132nd most deprived of 326.

Medway Community: Profile	
5 urban areas	Medway is made up of five urban centres: Chatham, Gillingham, Rochester, Strood and Rainham. It also includes an extensive rural area on the Hoo Peninsula and the area of Cuxton and Halling to the west of M2.
Increasing population	Between the 2011 Census and the ONS mid-year population estimates 2014, the population has grown by 10,090 people, up to 274,015. This compares to the increase of 14,637 people between 2001 and 2011.

Diversity impact assessment

Includes areas of deprivation	Medway is ranked 118th most deprived Local Authority of 326 (1st being the most deprived) in England in the 2015 Index of Multiple Deprivation. This is a relatively worse position than the index in 2010, when Medway was ranked 136th most deprived of 325. While Medway has many areas that fair poorly on income and employment deprivation - the main domains in the multiple index - crime stands out as a particular weakness (ranking 53 out of 326 Local Authorities in England), followed by 'education, skills and training' (which ranks 86 out of 326).
More households with dependent children	The number of households with dependent children rose to over 34,300. However, there has been a greater increase in the numbers of non-dependent children (a dependent child is a person aged between 0 and 15 or a person aged 16 to 18 who is in full time education). This suggests that there are a number of new smaller families.
More unpaid carers	The number of unpaid carers has increased from 7.7% in 2001 to 10% in 2011.
Lone parents increased	As per Census 2011 data, 7.9% of all households were lone parents with dependent children. 44% (3,681) of households in this group did not have an adult in employment. This is an increase from 6.8% in 2001.
Occupied households increased	The number of 'household spaces' in Medway stands at 110,263, with 96.3% (106,209) of households occupied, both having increased from 2001.

Diversity impact assessment

Higher economic activity	The 2011 Census showed a higher economic activity rate in Medway, 71.1%. There were increases in the number of people working part-time or as self-employed, but a fall in the number of people working full-time. Also, unemployment levels increased since 2001. The latest ONS Annual Population Survey (July 2014 to June 2015) showed the economic activity rate in Medway at 77.7%. This rate was slightly above the same figure for Great Britain (77.5%) for the same period, and lower than the South East rate (80.1%). The employment rate for men aged from 16 to 64 was 83.8%, while the corresponding employment rate for women was 71.6%. Unemployment rate for July 2014 to June 2015 was 7.6%, having remained stable in the past four quarters. However, Medway levels are significantly higher than those for the South East (4.4%) and Great Britain (5.7%). Accordingly with above figures on employment by gender, the unemployment rate for men was 8.2%, lower than the female rate of unemployment, 8.7%.
More highly qualified	At December 2014, Medway residents were more highly qualified than they were in 2001. The rate of Medway residents with NVQ1 and above qualifications for calendar year 2014 was 85.6%, and has remained quite stable since the previous year. This rate compares favourably against Great Britain rate (85%), and is lower than in the South East (89.2%). There are still fewer residents with the highest level qualifications, although the rate of residents with NVQ4 and above qualifications have increased steadily from 2011, reaching circa 26% by end year 2014. However, this rate is still considerably lower than in the South East (39.1%) and Great Britain (36%).
Above average households own home	68% of households owned their own home, either with a loan, mortgage or outright. Although this is a decrease of 7% from 2001, it is still above the national average percentage of 64%. (Census 2011)

Diversity impact assessment

Increase of cars and vans available for use	The number of cars and vans available for use by households increased from just under 119,000 in 2001 to just over 133,000 in 2011, an increase of 12% .The proportion of households with access to 2 cars rose while the proportion with access to 1 or no car reduced. (Census 2011)

Medway Community: Gender and age	
Gender	The gender split in Medway has remained steady since 2011 Census. In 2014 women represented 50.4% of Medway's population with men representing 49.6%. The gender and age breakdown in Table 2 below shows that there was a greater representation of men within the population than women up to the age group of 45-49 when the positions level out and then reverses. Women are in the majority for all age groups above 45. The difference in proportion of women over men is more acute in the 75 and over age band.
Age	Medway's population is slightly younger than the South East or England. Medway's population aged 18 and under have increased from 2011 to 66,099 in 2014 (2.1%). However, this is still below the 2001 population of 66,406. The population aged 19 to 64 has continued to grow standing at 166,096 people in 2014, up 3,900 since 2011 (2.4%). Medway's population is ageing at a faster rate with 4,815 more people now aged 65 and over since 2011. This age group accounted for 41.820 people in 2014. This meant an increase of 13% between 2014 and 2011. Since 2001 Medway's population aged 65 and over has increased by 32.7%.

Table 1 shows changes as a proportion of the population in each of the three age groups. It can be seen that the proportion of 0 to 18 year olds has declined since 2001, whilst the 19 to 64 year olds has remained static and the 65 and over has increased notably.

Table 1 Population by age group in 2001, 2011 and 2014

Diversity impact assessment

Age group	Proportion population 2001	Proportion population 2011	Proportion population 2014
0-18	26.6%	24.5%	24.1%
19-64	60.7%	61.5%	60.6%
65 and over	12.6%	14.0%	15.3%

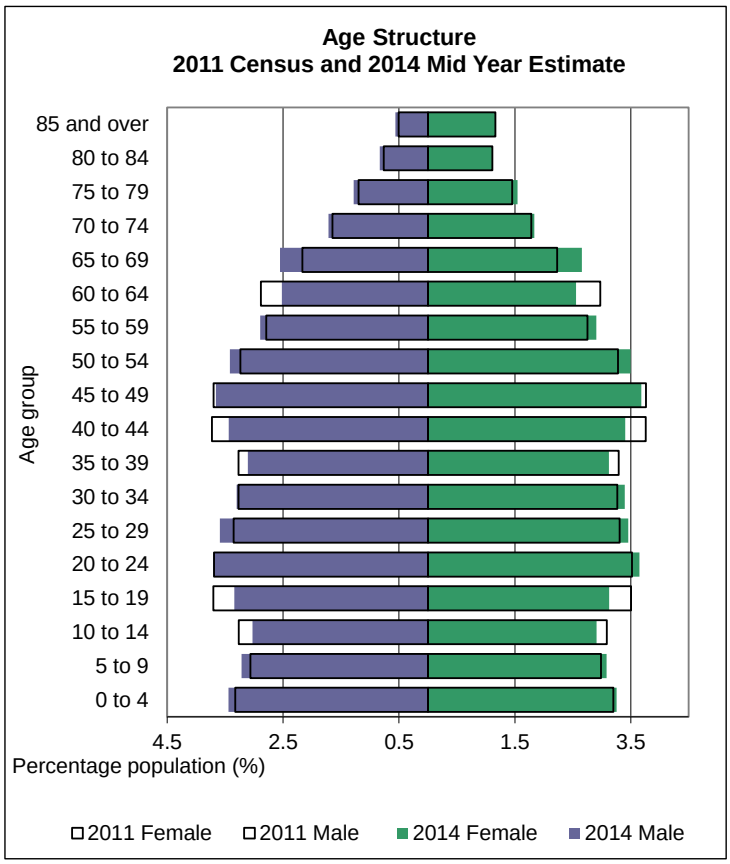
Source: Census 2001, Census 2011 and ONS mid-year population estimates 2014

Table 2 shows how Medway's population spreads over the different age groups, and the split by gender for mid-year population estimates 2014. Also, Figure 1 graph shows the age and gender profile of Medway's population in 2014 compared to 2011.

Table 2 Population – mid-year population estimates 2014

Age Group	All People %	Men %	Women %
0 to 4	6.7	3.4	3.3
5 to 9	6.3	3.2	3.1
10 to 14	5.9	3.0	2.9
15 to 19	6.5	3.3	3.1
20 to 24	7.4	3.7	3.7
25 to 29	7.0	3.6	3.5
30 to 34	6.7	3.3	3.4
35 to 39	6.2	3.1	3.1
40 to 44	6.8	3.4	3.4
45 to 49	7.3	3.7	3.7
50 to 54	6.9	3.4	3.5
55 to 59	5.8	2.9	2.9
60 to 64	5.1	2.5	2.6
65 to 69	5.2	2.6	2.7
70 to 74	3.6	1.7	1.8
75 to 79	2.8	1.3	1.5
80 to 84	1.9	0.8	1.1
85+	1.7	0.6	1.2
Total	100.0	49.6	50.4

Figure 1 Age structure



Source: Census 2011 and ONS mid-year population estimates 2014

The number of births started to increase from 2007. This can be seen in Figure 1, with increasing numbers of 0 to 9 year olds. The population aged 10 to 19 has reduced reflecting a decline in births from 1997 onwards. The

number of young adults aged 20-34 has increased. Overall, the number of adults aged over 40 has increased whilst adults in the 35-39 age range has reduced. Furthermore, the number of residents aged 60 to 64 has dipped, as the post war baby boomers move into the 65 to 69 aged group creating the notable increase in both the male and female populations. The population over 69 has increased, particularly in the range 70-79.

The median age of Medway residents is 38, lower than the national median age of 40.

Medway Community: Sexual Orientation

Information on sexual orientation is not included in the Census. The Office for National Statistic (ONS) has been testing the sexual identity question for use within surveys. Stonewall the campaigning organisation for Lesbian, Gay and Bisexual (LGB) people estimates that 5% – 7 % of the community are LGB.

However the ONS asked the sexual identity question in the Integrated Household Survey (IHS) 2009-2010, and the results showed that 1.5% of the population identify as LGB.

Table 3 below shows the estimated numbers of residents in Medway that would be expected to be LGB based on the sources described above.

Table 3 LGB residents in Medway

Estimated percentage / numbers of LGB residents in Medway (based on 274,015 population)		
ONS	**Stonewall**	
1.5%	**5%**	**7%**
4,110	13,701	19,181

Source: ONS and Stonewall.

Medway Community: Gender Reassignment

Information on the numbers of people who may have reassigned their gender is not collected to enable a profile for Medway to be included in this report. Press for Change (the UK's leading experts in transgender law) and the Gender Trust (an organisation supporting all those affected by gender identity issues) have produced statistical estimates of 25 per 100,000 population

based on research into the numbers of people who have undergone gender reassignment procedures.

Based on the above estimate, Medway would expect to have around 69 residents who would be in their reassigned gender or undergoing the process of having their gender reassigned. Although this would be a very small section of the community it is important to remember that this section of the community can face significant obstacles in being accepted.

Medway Community: Marriage and Civil Partnership

Cohabiting couples account for 13.1% of the population compared with the national level of 11.9%. (Census 2011)

There are 97,095 married people living in Medway, 46.1% of the population. Since 2001 there has been a 6.1 percentage point decrease in the population who are married.

Medway ranks quite low both nationally and regionally in terms of the proportion of people who are married. Conversely, Medway ranks quite high for people whose marital status is separated or divorced. In respect of single people who have never married, Medway's proportion is the same as that for the region.

The 2011 Census for the first time collected information on civil partnerships, reflecting the fact that the Civil Partnership Act (2004) came into effect in the UK in December 2005. There are just under 360 people living in a registered same sex civil partnership, the low numbers reflect its relatively new legal status (Census 2011).

Following implementation of the Marriage (Same Sex Couples) Act 2013, the first marriages of same sex couples took place on 29 March 2014. Civil partners have been able to convert their civil partnership into a marriage, if they so desired, from 10 December 2014.

Medway Community: Disability

82% of residents described themselves as being in good or very good health, accurately representing the national average of 81% (Census 2011).

Fewer than 10% of residents provided unpaid care for someone with an illness or disability, an increase of 2.3% from 2001.

There is no single measure of disability. The Census question in 2011 focused on asking people if they had a Limiting Long Term Illness (LLTI), the results show that 16.4% of Medway residents have a disability / LLTI.

Table 4 Disability/Limiting Long Term Illness (LLTI)

Limiting Long Term Illness (LLTI) (2011 Census)		
Medway Total	**Number**	**%**
	43,354	16.4

Source: Census 2011

Medway Community: Ethnicity and National Identity

Medway has become more ethnically diverse since 2001. The White population has remained virtually static, whilst the Black and Minority Ethnic (BME) population has doubled in the same period.

In 2011 BME communities made up 10.4% of Medway's population, up from 5.4% of the population in 2001. White communities (White British, White Irish, White Gypsy and Irish Traveller and White Other) made up 89.6% of the population in 2011, down from 94.6% in 2001. Table 5 below shows the breakdown of Medway's population by their ethnic group and how this has changed between 2001 and 2011.

Table 5 Medway's population by their ethnic group

Ethnic Group	2001 Census %	2011 Census %	2011 Census Number
White	94.6	**89.6**	236,579
Mixed	1.1	**2.0**	5,176
Asian	3.4	**5.2**	13,615
Black	0.7	**2.5**	6,663
Other	0.2	**0.7**	1,892
All Groups	100	**100**	263,925

Source: Census 2011 and 2001

When breaking down the ethnic groups further, the 2011 Census shows that White British represented the majority of the community (85.5%) with White Other* * being the second highest (3.4%), followed by Indian (2.7%)

* To compare 2011 Census with 2001, White Gypsy or Irish traveller has been combined with White Other.

Diversity impact assessment

Between 2001 and 2011 the White population has remained static, however, there have been some significant changes within the groups that make up this population; 'White British' and 'White Irish' decreased between 2001 and 2011, by 4,475 and 370 respectively. At the same time the White Other* population increased by 5,359 people. This rapid increase in the White Other population has offset the declines in the White British and Irish populations.

All other ethnic groups, except White British and White Irish, increased between 2001 and 2011. As a proportion of the total population there has been a significant increase in the representation of White Other (1.5% to 3.4%), Black African (0.3% to 1.8%), Asian Indian (2 % to 2.7%) and Asian Other group (0.2% to 1%) since the 2001 Census.

Table 6 shows that the BME population in Medway in 2001 and 2011 was greater than the average for the South East, and considerably smaller than England as a whole.

Also, the BME population varies by both age and gender. There are slightly more males than females stating they were from a BME community. Figure 2 below shows the breakdown of Medway's BME population by age. Overall Medway's BME population tends to be younger with the highest proportion amongst those aged 24 and under (14%) and lowest amongst those aged 65 and over 3.9%.

Table 6 Black and Minority Ethnic (BME) population in Medway, South East and England

BME Population	2001 Census %	2011 Census %
England	9.1	14.3
Medway	**5.3**	**10.4**
South East	4.9	9.4

Figure 2 White population versus BME population

Source: Census 2001 and Census 2011

Diversity impact assessment

Between 2001 and 2011 there was an increase in Medway's population born in the UK, however, the population born outside the UK has increased at a faster rate meaning the proportion of Medway's population born in the UK actually fell. 11% (27,300) of residents were born outside the UK with 5% (13,100) arriving here during the last 10 years. The greatest increases were from populations born in continental Europe, Africa and the Middle East. The changes in the representation of different ethnic groups are further illustrated below with the top languages, other than English, spoken in the Medway community (top ranking languages in largest font size) (Source 2011 Census).

Figure 3 Languages – other than English – mostly spoken in Medway

Source: Census 2011

Medway Community: Religion and Belief

Table 7 below shows the religions represented in Medway in 2001 (in percentage and absolute number) and 2011 (in percentage). Figure 4 shows that the majority of residents in Medway state they are part of the Christian religion (57.8 %), a fall of 14 percentage points since 2001 Census.

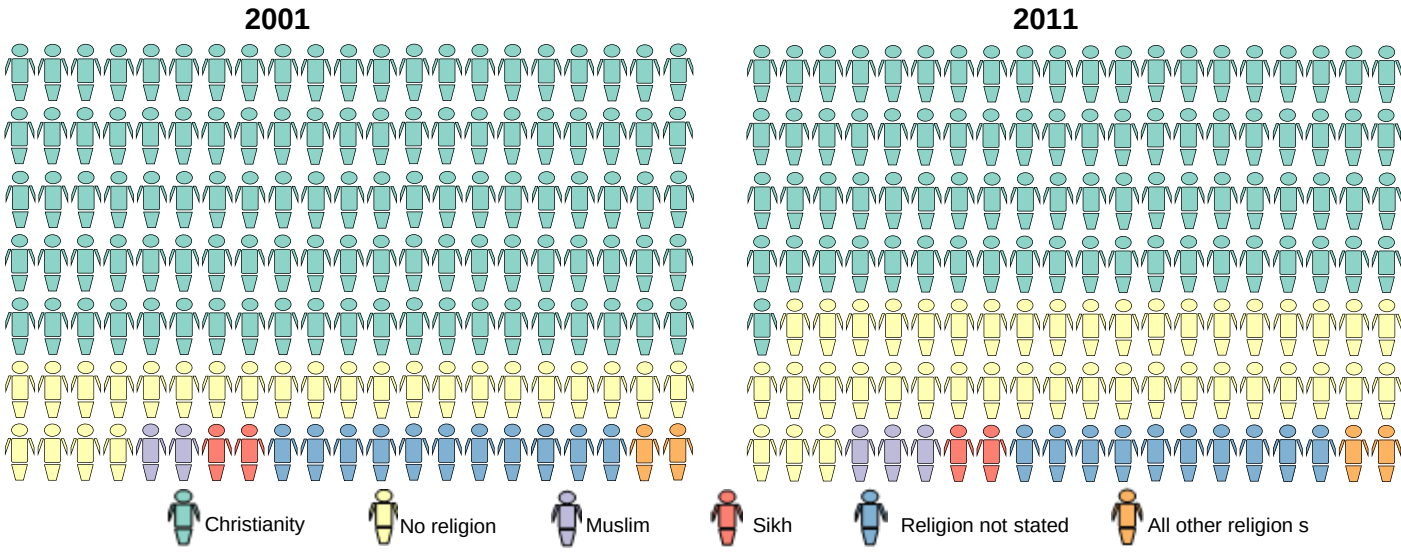
The second largest group indicate that they have no religion (29.9%) has increased by 13 percentage points since 2001. Muslims represent the next most significant religion, up by 1 percent point to 2%. Sikh, Hindu, Buddhist, Jewish and all other religions were much smaller proportions of the population.

Table 7 Religions in Medway

Religion and Belief	2001 %	2011 Number	2011 %
Christian	72.0	152,637	57.8
Buddhist	0.2	937	0.4
Hindu	0.7	2,756	1.0
Jewish	0.1	208	0.1
Muslim	1.1	5169	2.0

Sikh	1.2	3846	1.5
All Other religions	0.3	1,392	0.5
No religion	16.7	78,955	29.9
Religion not stated	7.8	17,985	6.8
Total	**100**	**263,925**	**100**

Figure 4 Religions in Medway



Source: 2001 and 2011 Census

Medway Council workforce: Profile

The council is committed to providing equal opportunities and access to all, and its employment policies aim to ensure that no employee is discriminated against, either directly or indirectly, or victimised on the grounds of their race, disability, sex, sexual orientation, religion or belief, age, marital or civil partnership status, any stage of gender reassignment or any other protected characteristic as stated under the under the Equality Act 2010.

The council's commitment to equalities and its *Be Yourself at Work* campaign strives to enable employees to feel comfortable to be themselves at work. This is not only good for the employee but it is accepted that those who can be themselves at work perform better.

The council undertook an anonymous voluntary employee engagement survey in the summer of 2014 and achieved a 38% response rate. The survey included a number of questions relating to equalities and the culture of the council.

When asked whether respondents felt comfortable to be themselves at work without fear of discrimination, a very positive 85% either agreed or strongly agreed that they could, with 76% believing that Medway Council has a strong equality culture.

Medway Council employs 2,441 people (at 30 September 2015, excluding staff based in schools). The Children and Adults Directorate is the largest directorate employing 935 staff followed by Regeneration, Community and Culture (RCC) Directorate employing 760 with Business Support Directorate (including Public Health) employing 746 staff.

Women represent 72% of the council workforce (excluding staff based in schools). In terms of ethnicity, the majority of staff classifies themselves as White (90.2%) with 8.1% Black, Asian and other Minority Ethnic, and 1.7% for whom the information is incomplete or has been refused.

In terms of ethnicity, the majority of staff classify themselves as either White British, Irish or other (90.2%) with 7.7% from Black, Asian and multi ethnic groups.

Medway Council workforce: Gender (non schools staff)

Table 8 Medway Council - gender

Gender – Sep 2015	Business Support Department	Children and Adults: Non Schools	Regeneration, Community and Culture	Public Health	Medway Council	Medway Community (Aged 16 to 64)
Women	71.3%	83.5%	56.8%	81.9%	71.9%	49.9%
Men	28.7%	16.5%	43.2%	18.1%	28.1%	50.1%
Total	100%	100%	100%	100%	**100%**	**100%**

Source: Medway Council HR Services and ONS mid-year population estimates 2014.

Males are underrepresented in the workforce with 28.1% compared with 50.1% in the community.

Medway Council workforce: Disability (non schools staff)

Table 9 Medway Council - disability

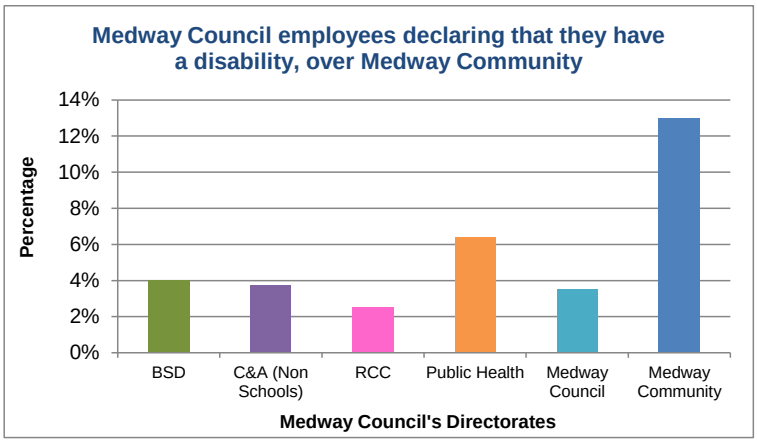
Disability - Sep 2015	Business Support Department	Children and Adults: Non Schools	Regeneration, Community and Culture	Public Health	Medway Council	Medway Community (aged 20 to 64)
Yes	4.0%	3.7%	2.5%	6.4%	**3.5%**	**13%**
No	94.8%	93.7%	95.9%	86.2%	**94.4%**	**87%**
Not Stated /Refused	1.2%	2.6%	1.6%	7.4%	**2.1%**	**0%**
Total	100%	100%	100%	100%	**100%**	**100%**

Source: Medway Council HR Services workforce monitoring Sept 2015 and Census 2011.

Figure 5 displays the percentage of non-school based employees who have declared that they have a disability. These figures would appear to show that this minority are under represented within the council's workforce when compared with the Medway community (the community figures are from age 20 as 2011 Census data about this characteristic is only available in 5 year age groups).

However, it should be noted that employees with disabilities may choose not to declare their disability to their employer for a number of reasons. This can be demonstrated within the results of the 2014 anonymous employee engagement survey. When asked to declare whether they had a disability, 9.2% of all respondents stated they had compared to 3.6% who had declared a disability on the HR system.

Figure 5 Medway Council workforce: Disability (non-schools staff)



Source: Medway Council HR Services workforce monitoring Sept 2015

Other results from the employee survey relating to disability are as follows:

- 73% of respondents with a disability have declared it to their manager
- 8% of those declaring a disability have made use of Access to Work funding

Diversity impact assessment

The council is continually striving to increase the percentage of disabled staff within the workforce and also to encourage employees to declare their disability. The '*Be yourself at work'* campaign aims to encourage employees to complete their personal details on the HR selfserve4you system. Further initiatives are being arranged to raise awareness of why the council needs equalities data and details of this can be found in the final paragraph 'Pro-active measures toward an inclusive workforce'.

Working as a *Positive About Disability* employer (in conjunction with Jobscentreplus) and displaying the two ticks symbol, reinforces the council's commitment to those with disabilities and gives the council the opportunity to regularly review, build upon and celebrate best practice in the employment arena. In doing so, the council needs to provide evidence that it meets the following commitments:

(i) To interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their abilities.

(ii) To ensure there is a mechanism in place to discuss at any time, but at least once a year, with disabled employees what can be done to make sure they can develop and use their disabilities.

(iii) To make every effort when employees become disabled to make sure they stay in employment.

(iv) To take action to ensure that all employees develop the appropriate level of disability awareness needed to make the commitments work.

(v) Each year to review the five commitments and what has been achieved, to plan ways to improve on them and to let employees and the Jobcentre know about progress and future plans.

Some of the initiatives that have been implemented to encourage the recruitment of those with disabilities and also to ensure those who become disabled can remain in employment include:

- Placing details of job advertisements within specialist magazines;
- Ensuring all managers responsible for recruitment undertake the necessary equality and diversity training;
- Ensure that all managers and job applicants are able to request details of support available such as Access to Work;
- An on-site occupational health provision to support employees who become disabled during their working life;

- A redeployment service which gives priority to those with disabilities to access vacancies and to help place those who become disabled during their working life in alternative positions to enable them to stay in employment.

Support for those with disabilities is also available through the Disabled Workers Forum.

The council has also made a commitment to be mindful, to raise awareness and to provide support to those with mental health conditions by signing up to the Mindful Employer Initiative. This is reviewed every three years. The last review took place in 2013.

Medway Council workforce: Age

The council has an ageing workforce; this is reflected in Figure 6 and Table 10, which show an increasing proportion of staff across the 30 to 59 age groups in all directorates. Only the Public Health Directorate shows a higher proportion of employees in the 25-29 age group, while has a smaller proportion of employees in the 40-44 band.

The council has regard to the age profile of its current staff and the under-representation of those within the 16-24 age range. Due to this, the council has agreed within its Age Discrimination Policy (July 2012) to reserve the right to take positive action measures to assist with its workforce planning to attract into its service younger people.

Figure 6 Age of Medway non-school based staff

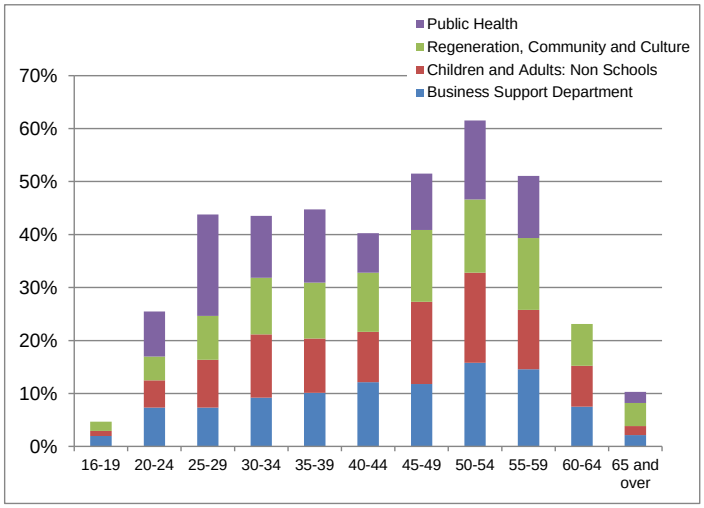


Table 10 Non-school workforce

Medway Council	
Age Group	%
16-19	1.4
20-24	5.7
25-29	8.7
30-34	10.8
35-39	10.4
40-44	10.7
45-49	13.7
50-54	15.6
55-59	12.9
60-64	7.4
65 and over	2.7

Source: Medway Council workforce monitoring Sept 2015

Some of the positive measures undertaken to increase this demographic include the introduction of a graduate scheme and apprenticeships which could lead to permanent employment, as well as an internship programme for students.

Medway Council workforce: Ethnicity

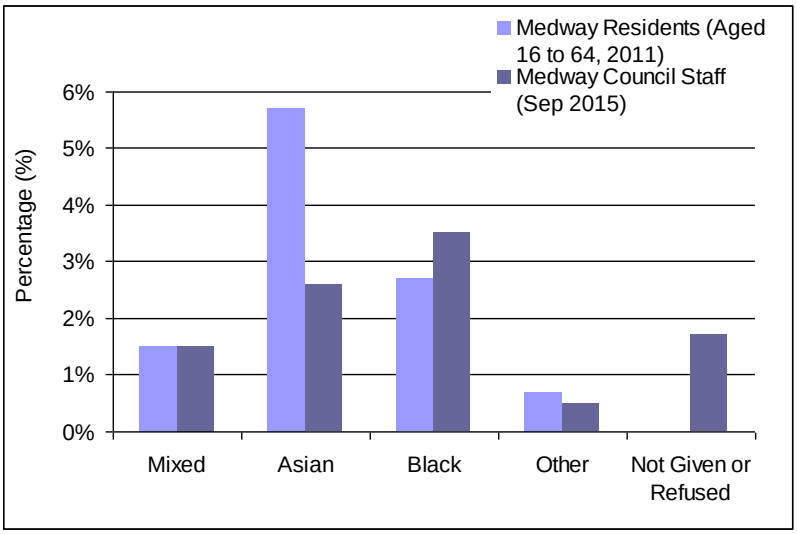
Table 11 Medway residents and Medway Council (non-school based staff) ethnicity structure

	Medway Residents (Aged 16 to 64, 2011)	Medway Council Staff (Sep 2015)
White British, Irish, other	89.3%	90.2%
Multi ethnic	1.5%	1.5%
Asian or Asian British	5.7%	2.6%
Black or Black British	2.7%	3.5%
Other	0.7%	0.5%
Not Given or Refused	N/A	1.7%

Source: Census 2011 and Medway Council workforce monitoring Sept 2015

Table 11 above shows that the White (British, Irish and other White) community is very similar in the council and in the community, and the Black ethnic group is slightly over represented among the council workforce. On the other hand, the Asian Ethnic group is under represented among the council workforce. The Multi ethnic group is balanced in the council versus Medway Community.

Figure 7 Medway residents and Medway Council (non-school based staff) ethnicity structure



Source: Census 2011 and Medway Council workforce monitoring Sept 2015

The Asian community is the least proportionally represented group, with a 3.1% difference between the Asian minority group and Council staff. On the other hand, the Black community is slightly over represented in the council in comparison to Medway Community.

Medway Council workforce: school based staff

Medway Council employees based on schools are 2,933. The figures below are related to the profile of this specific workforce.

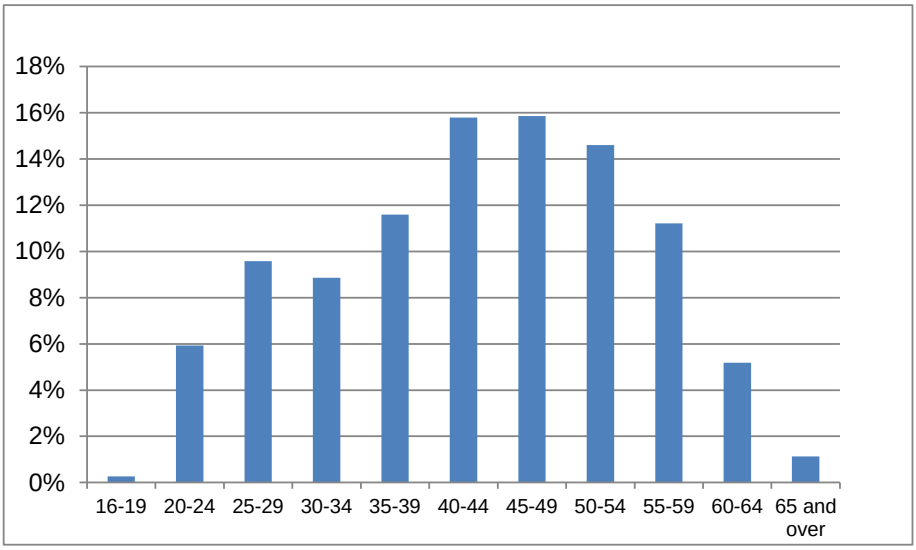
Gender	90.8% of the school based staff are females, and 9.2% are males.
Disability	1.1 % of the school workforce have declared that they have a disability, and 96.9% have declared that they do not have a disability. 2% of the school based staff have not given information about this characteristic.

Diversity impact assessment

Age

The spread of school based workforce is shown in Table 12. It shows how school staff is mainly concentrated in the age groups between 35 and 59 years. 40-44 and 15-49 age bands include the highest share of employees (almost 16%).

Table 12 Age spread of Medway Council's school based staff



Source: Workforce Profile at 30 September 2015 (Medway Council HR's Department)

Ethnicity

Table 13 Medway residents and Medway Council (school based staff) ethnicity structure

	Medway Residents (Aged 16 to 64, 2011)	Medway Council School based Staff (Sep 2015)
White British, Irish, other	89.3%	93.6%
Multi ethnic	1.5%	0.8%
Asian or Asian British	5.7%	2.6%
Black or Black British	2.7%	0.6%
Other	0.7%	0.3%
Not Given or Refused	N/A	2.0%

Source: Census 2011 and Medway Council workforce monitoring Sept 2015

Other protected characteristics

Due to low declaration levels on the HR Selfserve4you system, data relating to the other protected characteristics such as sexual orientation and religion is not sufficient to enable any meaningful analysis. However, these figures are gradually increasing as a result of proactive measures that have been undertaken during 2014/15. These are highlighted in the section below.

Diversity impact assessment

Medway Council Staff: Key differences compared with the Medway community profile	
Less male staff	28.1% of the workforce (non school) are male compared to 50.1% of the community (taking into consideration males between 16 and 64). The gap is larger when comparing figures with school based staff. Only 9.2% of the school based staff are males.
More female staff	71.9% of the workforce (non school) are female compared to 49.9% of the community (taking into consideration males between 16 and 64). As above, the gap is larger when comparing figures with school based staff, as 90.8% of the school based staff are females.
Disabilities under represented	Only 3.5% of the council's non-school staff has reported a disability, and 1.1% of the school-based staff. However, there are 13% of residents who have reported a disability.
Workforce is older	Percentages of council's staff in age brackets from 16 to 29 are lower than in the community. For example, 5.7% of the council's workforce is between 20 and 24, while in this age band, the community percentage is 11.4%. The larger difference is in the age group 16-19, which includes 8.1% of the community, compared to 1.4% of the council's non school-based staff, and 0.3% of the school-based staff. Workforce and community proportion of people aged 30 to 44 are very similar, while the above trend reverses after 44 years old. For example, 12.9% of the council's staff is in the 55-59 band, while the percentage is 9.0%. We have only compared age bands up until the age of 64, as after then, staff have a choice, and can decide to keep on working or not.
Differences in ethnic minorities being represented	While the white and multi ethnic populations are very similar in both – council and community – environments, there are some significant differences when comparing Asian and Black ethnicities. Black ethnic groups are slightly over represented among the

	council workforce, with 3.5% of Black workforce versus 2.7% of Black population in the Medway community. On the other hand, the Asian ethnic group is under represented among the council workforce, and there are 2.6% of Asian staff compared to 5.7% in the community. There are larger differences when comparing community figures against school-based staff, where the White ethnic group is over represented, and the rest of the ethnic groups are significantly under represented.

Proactive Measures toward an inclusive workforce

The council is taking pro-active measures toward building a supportive and inclusive workforce, some examples are as follows:

1.0 Declaration week - background

Historically, the data held on the HR system relating to individuals from certain minority groups is limited due to low self-declaration levels. In order to redress this issue, HR Services, together with the staff forums, the Industrial Chaplaincy, the Corporate performance and intelligence team and a representative from the Medway Maker engagement champions designated a week in July to encourage employees to update their personal details on the HR system and also to explain to staff why their details were being requested.

During the week a number of events took place including:

- lunchtime equality event led by the employee forums and the Industrial Chaplaincy to raise awareness of equality issues. This involved showing a series of short films in the Gun Wharf café area and providing information about the support available to staff from minority groups through the forums. The Medway Makers engagement champions also supported this event.

- hands-on training and assistance for staff on the Selfserv4you system at designated areas at Gun Wharf and satellite buildings

- a query ‘hot-line’ through to the hradvice line to respond to requests from staff in terms of renewing passwords and dealing with Selfserve queries

Results of Declaration Week

The results of Declaration Week showed a slight increase in declarations for the following:

- County of birth from 7.3% to 10.3%
- Religion from 33.4% to 36.9%
- Nationality/Citizenship from 15.8% to 16.5%

The largest increase was from those employees declaring their sexuality which rose from 34.8% to 38.1%. This is very positive and is likely to be the result of having an active LGBT forum and the continual work undertaken to support staff from the LGBT community through the annual Stonewall workplace Equality Index Top 100 Employers benchmarking exercise.

Results for ethnic origin and those declaring a disability showed marginal decreases. However, it was promising to see that the percentage of those refusing to answer equality questions had decreased on the majority of equality strands.

The results, whilst positive still do not provide a significant amount of data for the council to gain a confident picture of the make-up of its workforce in terms of minority groups. However, it is envisaged that further progress will be on-going with the excellent support the employee equality forums provide to staff, together with organisational policies and processes. It is envisaged that Declaration Week will be an annual event.

- Using the data from the employee survey to help inform policy and process changes and shape future equality related initiatives.
- The Medpay performance related pay scheme, seeks to reward those who are actively engaged in equality work over and above their normal duties (providing all normal targets have been met).
- The Make a Difference employee recognition awards scheme, through the Inclusion and Diversity Award recognises excellence in those who have demonstrated how they have improved the access, participation, achievements or life chances for the communities we serve and for the employees of Medway Council.
- Employees are offered a comprehensive training facility on equality and diversity via e-learning

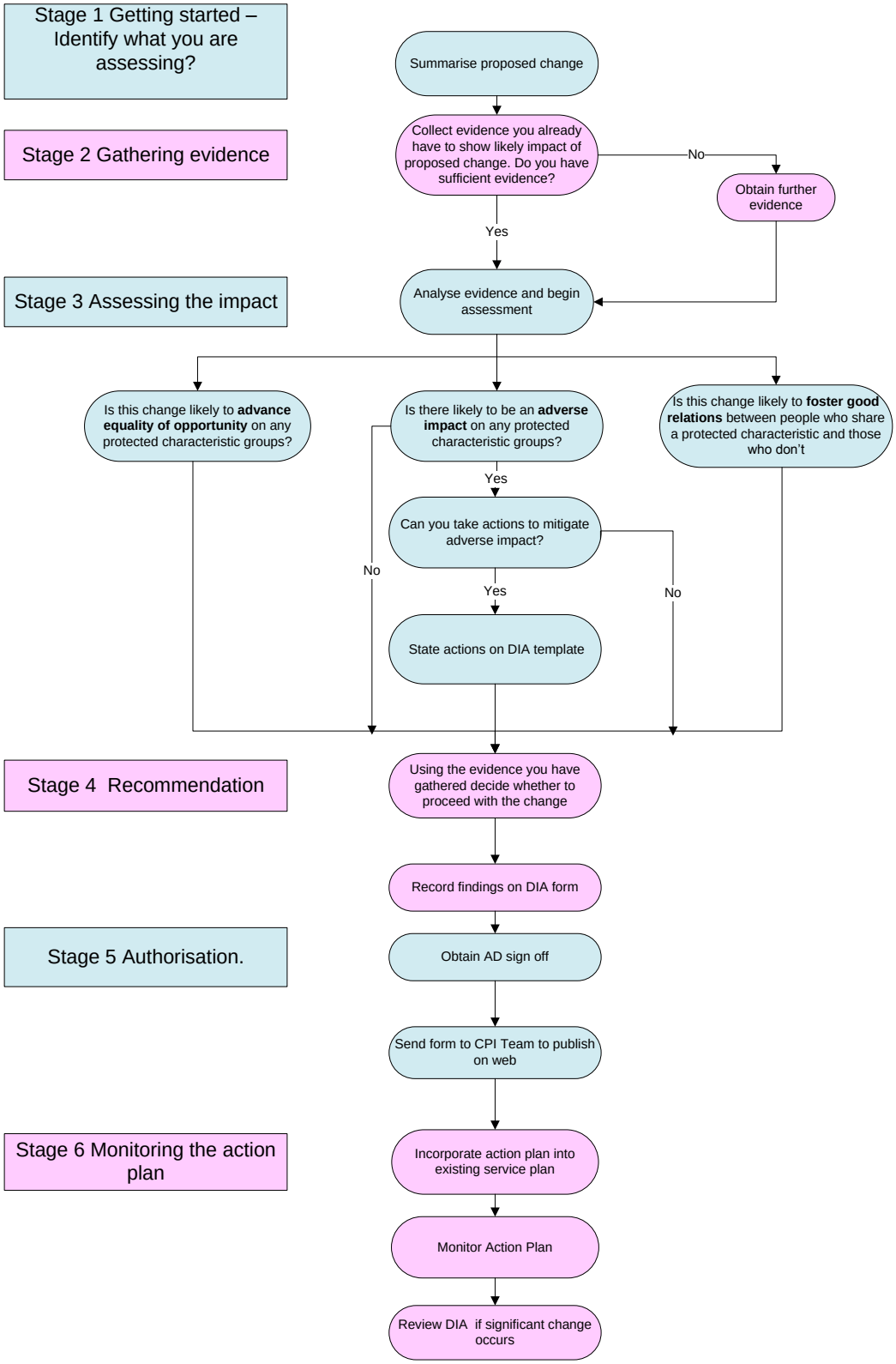
- Employees are offered support via the Disabled; Black; and Lesbian, Gay, Bisexual, Trans, and Questioning employee groups
- Committing to working toward the Positive about Disability Two Ticks accreditation every year.
- Committing to working toward the principles of the Mindful Employer Charter for employers who are positive about mental health
- Ensuring that all new and revised employment policies are assessed through the Diversity Impact Assessment process.
- Analysing the recruitment, promotion and exit data by the Protected Characteristics.

Contact: Medway Workforce: Employee Engagement Manager
sandra.steel@medway.gov.uk

Contact: Community Profile: David Holloway, Corporate Intelligence Analyst
david.holloway@medway.gov.uk

Diversity impact assessment

DIVERSITY IMPACT ASSESSMENT FLOWCHART



Diversity impact assessment

TITLE *Name / description of the issue being assessed*	Re commissioning of child health services , 19/25 services
DATE *Date the DIA is completed*	04/09/16
LEAD OFFICER *Name, title and dept of person responsible for carrying out the DIA*.	James Harman, Senior Public Health Manager, Public Health Medway Council Michael Griffiths, Partnership Commissioning Lead – Children and Families, Medway Council & Medway CCG

1 Summary description of the proposed change

- *What is the change to policy / service / new project that is being proposed?*
- *How does it compare with the current situation?*

Re commissioning of an integrated 0-19/25 service, including health visiting, school nursing, children's therapies services and community paediatrics (which includes children's community nursing, learning disability nursing, special needs nursery provision and special school nursing.

Currently the 0-19 offer is comprised of a number of separately commissioned services delivered by a number of different providers. Children's health services are part of block contracts held by the acute and community providers. Services within the block have grown to meet perceived need, sometimes in isolation from other provision, resulting in fragmentation and duplication.

The proposed recommissioning will match services more closely to need and ensure a more equitable spread of provision: as an example, the current special needs nursery sessions can only be accessed by a small number of parents who are able to travel to Rainham, and the current building is sub-optimal. Future provision will aim to be accessible to more families and operate from more suitable premises.

In line with the recommissioning process locally the Family Nurse Partnership (FNP) service has been decommissioned, however the investment remains within the provider to develop a more inclusive offer going forward. This offer aims to support more families with a more locally focussed offer.

2 Summary of evidence used to support this assessment

- *Eg: Feedback from consultation, performance information, service user records etc.*
- *Eg: Comparison of service user profile with Medway Community Profile*

An extensive needs analysis has been undertaken (see appendix 2 and 3) Benson Wintere workforce modelling for health visiting suggests that the same level of service can be provided with a slightly adjusted work force skill

mix.

3 What is the likely impact of the proposed change?

Is it likely to :

- *Adversely impact on one or more of the protected characteristic groups?*
- *Advance equality of opportunity for one or more of the protected characteristic groups?*
- *Foster good relations between people who share a protected characteristic and those who don't?*

(insert ✓in one or more boxes)

Protected characteristic groups	Adverse impact	Advance equality	Foster good relations
Age		**x**	
Disabilty		**x**	
Gender reassignment			
Marriage/civil partnership			
Pregnancy/maternity		**x**	
Race			
Religion/belief			
Sex			
Sexual orientation			
Other (eg low income groups)		**x**	

4 Summary of the likely impacts

- *Who will be affected?*
- *How will they be affected?*

Children aged 0 to 19, and up to 25 in the case of disabled children and/or those with special educational needs, will be affected alongside their parents/carers.

For disabled children, the success of service provision will be judged by the positive outcomes achieved for children and young people, rather than the historical output model (where numbers on caseload and number of contacts are monitored primarily). Services where there are currently identified gaps and inequity of provision (eg continence) will be enhanced. Provision will be designed to support inclusion and enable children to stay in their communities.

It is recognised that parents/carers of disabled children are more likely to have a lower income and less access to their own transport: more provision within the community will help to address these issues.

The decommissioning or FNP could be deemed as having a negative impact on first time mothers of the eligible age range. A large number of the families currently being supported by the service naturally graduate around the time the service comes to an end. Those families remaining will have an identified support package in place to be delivered by the replacement vulnerable parents service.

The development of a new vulnerable parent pathway is more inclusive, support will be available to a wider number of people with additional vulnerabilities identified and supported by the bespoke service.

5 What actions can be taken to mitigate likely adverse impacts, improve equality of opportunity or foster good relations?

- *Are there alternative providers?*
- *What alternative ways can the Council provide the service?*
- *Can demand for services be managed differently?*

Service specifications will meet NICE guidance and other appropriate standards and the tender(s) will be subject to a competitive process. There will be an expectation for primary care services to have a greater role in supporting disabled children than heretofore, in order to manage demand on secondary and tertiary services.

The current level of investment is remaining the same enabling the development of the replacement service. This will minimise impact on current eligible families as the new service will be in place as the old one comes to an end.

At present likely numbers for the new vulnerable parents pathway are largely unknown so we are working with local services to pull data sources together to ensure the service is fit for purpose and able to meet any likely demand. The current level of investment is remaining the same enabling the development of the replacement service. This will minimise impact on current eligible families as the new service will be in place as the old one comes to an end. Consideration is also being given as to whether this is a bespoke service for vulnerable parents of whether this is built into existing health visiting services.

6 Action plan

- *Actions to mitigate adverse impact, improve equality of opportunity or foster good relations and/or obtain new evidence*

Action	Lead	Deadline or review date

Diversity impact assessment

Consultation with children, young people and their families regarding proposed models of service, and any potential adverse impacts identified and mitigated within the service specification	MG/JH	By March 2017
Performance management requirements will include evidence of reach to vulnerable groups	MG/JH	October 2017 on
A further EIA will be undertaken as part of the first year review of the new service, in order to identify and address any unforeseen adverse impacts	MG/JH	October 2018

7 Recommendation

The recommendation by the lead officer should be stated below. This may be:

- *to proceed with the change, implementing the Action Plan if appropriate*
- *consider alternatives*
- *gather further evidence*

If the recommendation is to proceed with the change and there are no actions that can be taken to mitigate likely adverse impact, it is important to state why.

The recommendation is to proceed with the change and implement the Action Plan as detailed.

8 Authorisation

The authorising officer is consenting that:

- *the recommendation can be implemented*
- *sufficient evidence has been obtained and appropriate mitigation is planned*
- *the Action Plan will be incorporated into the relevant Service Plan and monitored*

Assistant Director	
Date	

Contact your Performance and Intelligence hub for advice on completing this assessment

RCC:	**phone 2443**	**email: annamarie.lawrence@medway.gov.uk**
C&A: (Children's Social Care)	**contact your normal P&I contact**	
C&A (all other areas):	**phone 4013**	**email: chrismckenzie@medway.gov.uk**
BSD:	**phone 2472/1490**	**email: corppi@medway.gov.uk**
PH:	**phone 2636**	**email: david.whiting@medway.gov.uk**

Send completed assessment to the Corporate Performance & Intelligence Hub (CPI) for web publication (corppi@medway.gov.uk)

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Partnership Commissioning

Needs analysis

For review of children's community health services, 2015

Contents

1. Introduction

The intention of this needs analysis is to inform the review of Medway Foundation Trust (MFT) children's services and MCH children's therapy services undertaken by Partnership Commissioning between July – November 2015.

"Health services for children and young people with SEN or disabilities provide early identification, assessment and diagnosis, intervention and review for children and young people with long-term conditions and disabilities, for example chronic fatigue syndrome, anxiety disorders or life-threatening conditions such as inoperable heart disease…
The multi-disciplinary child health team, including paediatricians, therapists, clinical psychologists, dieticians and specialist nurses .. provide intervention and review for children and young people with SEN and disabilities and should contribute to supporting key transition points, including to adulthood. They aim to provide optimum health care for the children, addressing the impact of their conditions, managing consequences for the families and preventing further complications. Health professionals advise education services on managing health conditions such as epilepsy and diabetes, and health technologies such as tube feeding, tracheostomy care and ventilation in schools. They are able to provide an ongoing overview of health and wellbeing. They seek advice from paediatric specialists when necessary and facilitate training for education staff".[1]

The analysis compares Medway statistics and projections against national, regional and statistical neighbour data in terms of general prevalence and also against the four categories of the 'NHS at Home' model[2]:

- Acute and short term conditions
- Long term conditions such as asthma and epilepsy
- Disabilities and complex health needs, including learning disability and Autism
- Life limiting and life threatening illness such as cystic fibrosis and childhood cancer

In terms of population data, many existing reports are based on the Office of National Statistics (ONS) estimate which is slightly lower than that of the GP registration data recently made available (see Fig 1). Wherever possible, GP data has been used.

Source	Medway number
Office of National Statistics 2013 mid-year estimate of 0 -19 population[3]	69,000
GP registered 0 – 19 population, July 2015[4]	73,513

Figure 1 Child population estimates

Childhood disability affects a sizeable proportion of children and disabled children are a diverse group who experience a wide range of conditions. However, because young people

[1] SEN Code of Practice 2014, Section 3
[2] NHS at Home: Community Children's Nursing Services DH March 2011 & Commissioning Comprehensive Children's Community Nursing Services, SE Coast Strategic Clinical Network April 2015
[3] ONS
[4] Numbers of Patients Registered at a GP Practice - July 2015

have lower overall morbidity than older age groups this can result in their health needs being overlooked within health design and commissioning[5].

Some children and young people will have highly complex needs requiring multi-agency support across health, social services and education – the most extreme example perhaps being those who are technology-dependent. Other children will require substantially less support, nevertheless have a long-term disability.

Children with disabilities and long term conditions are also a group with conditions that will follow varying courses including:

- Lifelong (e.g. Deafness)
- Slowly deteriorating (e.g. muscular dystrophy)
- Potentially curable (e.g. cancer)
- Variable course (e.g. cystic fibrosis)[6]

For many children with one diagnosis, multiple coexisting conditions - also referred to as comorbidities - will be the rule rather than the exception.

- A young person with cerebral palsy that affects all four limbs is likely to have speech, eating, chest and gastrointestinal problems as well as being more likely to have intellectual disability, visual impairment and require equipment support for mobility and to enable them to achieve their academic potential.[7]
- 60-70% of people who have an autistic spectrum condition will also have a learning disability
- For children and young people with learning disabilities, the prevalence rate of a diagnosable psychiatric disorder is 36% compared with 8% for those who did not have a learning disability. These young people were also 33 times more likely to be on the autistic spectrum and were much more likely than others to have emotional and conduct disorders[8]

Inferences drawn from any needs analysis of childhood disability will need to take account of the above complexities, and further work should be undertaken to look at disability and ill health relative to specific populations such as Looked After Children and Black and Minority Ethnic children.

[5] Key Data on Adolescence 2015 Hagell A, Coleman J and Brooks F (2015)
[6] Children and Young People's Health Outcomes Forum – Report of the Long Term Conditions, Disability and Palliative Care Subgroup
[7] Ibid.
[8] Foundation for People with Learning Disability

2. Headlines

- Using an estimated general disability prevalence rate of 8% means that approximately 5,500 to 5,800 children and young people in Medway may be affected by disability or illness that causes them difficulty with everyday life. This is in line with caseload information across community health services

- Medway is in line with its statistical neighbours[9] in terms of the percentage of children and young people who have a statement of Special Educational Need/ Education, Health and Care Plan (SEN/EHCP), and just over national and regional rates

- Medway has substantially more school pupils assessed as needing special educational needs support without a formal statement of SEN/ EHCP than its statistical neighbours

- Medway is an outlier in comparison to its statistical neighbours in relation to the number of children with Autism known to schools, and the data suggests that diagnosis rates are approximately double the national prevalence rate

- Autistic Spectrum Disorder is the most frequently identified need for children with a statement/EHCP Plan, followed by moderate learning difficulty, behavioural/emotional difficulty, and speech, language and communication needs

- Medway children with an existing illness or disability spend longer in hospital when admitted than comparators

- Current projections of spend on 21 packages of care for children with continuing care needs/the subject of trip-partite funding amount to over £1 million for next financial year.

- Medway is an outlier for unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. The causes of variation may include[10]

    - suboptimal symptom management and secondary prevention in the community
    - suboptimal emergency care in the accident and emergency (A&E) department
    - differences in admission criteria among paediatric clinicians

- Medway children with complex health conditions experience longer hospital stays than children from similar CCGs and regionally: Medway is rated 196th out of 221 CCGs for Length of Stay (LoS) for children with complex health conditions

- Outpatient caseloads for ADHD are in line with national prevalence estimates

- A potential indicator of capacity issues is the percentage of appointments cancelled by the hospital with between 1 and 6 week's notice. The MFT target for the percentage of appointments cancelled by the hospital with between one and six weeks notice is 10%, but the rate for the Community Paediatric department is 56.8% (8th highest out of 30 departments), and is being investigated as a part of the review work.

[9] See Appendix x
[10] NHS Atlas of Variation: Child Health

- Key local data which would tell us more about the needs of children and young people is not currently available, and limits further detailed information that would otherwise be included in this needs analysis. An agreed suite of caseload data common to all services would be beneficial, to include diagnosis, assessment, levels of activity, types of intervention and outcomes.

3. General prevalence of childhood disabilities and impairments

Assessments of the rate of UK childhood disability vary somewhat according to the source, the definition and the ages of the children considered. However, the most common definition of disability is based on the Disability Discrimination Act (DDA) and subsequently (from October 2010) the Equality Act (EA), which focuses on "*physical or mental impairments that have a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities".*

Two useful studies are helpful in assessing prevalence: the Family Resources Survey and research conducted by the Centre of Longitudinal Studies.

a. Family Resources Survey 2013/14[11]

- Extensive information on disability is collected in the Family Resources Survey (FRS); it now stands as one of the key sources of information on the populations of disabled adults and children[12]
- The measure used is a longstanding illness, disability or infirmity which causes a significant difficulty with day-to-day activities
- In 2013/14, 7% of children were considered disabled (see Fig.x)

Age	% of all individuals
0-4	4
5-9	7
10-14	9
15-19	8
Across all ages	7

Figure 2 Childhood disability estimates, FRS

b. Centre for Longitudinal Studies, University of London 2013[13]

This research examined disability in children via two cohort studies:

The Millennium Cohort Study (MCS)

- 19,000 children born in 2000-2001 and surveyed at 9 months, and at ages 3, 5 and 7 years
- 11% of the sample were considered to have a long standing illness which limited day-to-day activity e.g. Type 1 diabetes, asthma, mental health problems and physical impairments

The Longitudinal Study of Young People in England (LSYPE)

[11] Family Resources Survey, DWP
[12] Porter J, Daniels, H, Georgeson J, Hacker J, Gallop V, Feiler A, Tarleton B and Watson D (2008) Disability Data Collection for Children's Services Research Report, DCSF.
[13] Trajectories and transitions in the cognitive and educational development of disabled children and young people, CLS Institute of Education, University of London

- Large scale representative study of nearly 16,000 young people born in the early 1990s
- 7% fell into the category of long standing illness which limited day to day activity, mirroring the findings of the Family Resources Survey

4. Medway Prevalence

The CHIMAT[14] Medway Disability Needs Assessment estimates that 12,263 of Medway children and young people may be living with longstanding illness or 'mild' disability, with an additional 49 being 'severely disabled'. This equates to 18% of the ONS 0-19 population. The methodology used is a projection of the prevalence rates calculated by the Office of National Statistics (ONS) in 2004 using data from the General Household Survey and the Family Fund Trust register of applicants on to 2011 child population figures. This would seem an overestimation when compared to the studies above, and may more closely reflect the rates of Special Educational Need experienced by children at any one time (commonly assessed as 20%).

Globally, school readiness is gaining currency as an indicator of full developmental potential among young children. It does so by considering all children, especially the vulnerable and disadvantaged, including children with disabilities, ethnic minorities and those living in rural areas.

	2013	2014
Medway	33.60	34.00
South East	33.60	34.70
Statistical Neighbours	33.19	34.16
England	32.80	33.80

Figure 3 Percentage of children achieving expected developmental goals

Elements from the Early Years foundation stage profile 2014[15] show that the percentage of young children in Medway achieving their expected developmental goals is slightly better than the England average, and in line with statistical neighbours and regional figures (Figure 3)..

Young children are in general achieving or bettering the expected levels for communication and language, physical development and personal, social and emotional development compared to England, the region, and statistical neighbours, and children identified as having special educational needs (without a statement or EHC plan) are clearly being well supported (Figure 4).

Medway	2013	2014
South East	18.00	24.00
Statistical Neighbours	15.20	21.10
England	16.00	21.00

Figure 4 Percentage of non-statemented children with SEN achieving a good level of development

[14] National Child and Maternal Health Intelligence Network Disability Needs Assessment
[15] https://www.gov.uk/government/statistics/early-years-foundation-stage-profile-results-2013-to-2014

The FRS and Centre for Longitudinal Studies findings discussed above suggest a national childhood disability prevalence rate of 7% to 11%, although 7% is the generally accepted figure.

However, there is a known link between poverty and increased rates of disability[16]: the Medway rate of child poverty stood at 21.2% in 2012, considerably higher than the South East figure of 14.2%[17] . An estimated prevalence rate of 8% may be a reasonable assumption for overall prevalence of disability in Medway.

With a Medway child population (0 -19) of approximately 69,000[18], this would give a figure of 5,520 children and young people in Medway with a long standing illness or disability. Using the 2014 GP registration figure of 73,513, this would equate to 5,881 children and young people.

This analysis has not examined the number of children with additional needs who may be receiving focused support from universal services such as health visiting, or from Local Authority services such as Portage, but has concentrated on children and young people on the caseload of community health services (MFT and MCH) and children's social care (Medway Council).

Using NHS numbers to identify individual children appearing on MCH and MFT community health caseloads shows the following:

- A total of 7,480 children and young people were on the caseload of one or more of the health services. This includes children from Swale as well as Medway: the ratio of Medway activity to Swale activity is generally taken to reflect a 70-30 split, which would mean a total of 5,236 Medway children and young people on the caseloads. This is in line with the 8% prevalence estimated above

Again assuming a 70:30 ratio:

- 3,824 Medway children are only on the caseload of one service
- 1,887 Medway children are only being seen by Community Paediatrics
- 1,526 Medway children are only on the Children's Therapies caseload
- 1103 Medway children are on the caseload of 2 services
- 270 Medway children are on the caseload of 3 services
- 38 Medway children are on the caseload of 4 services

[16] "For children in low socio-economic households, the odds of being reported to have a disabling chronic condition were 70% greater than for those in better off households" Childhood Disability and Socio-Economic Disadvantage: The Evidence, Warwick Medical School 2013
[17] Medway Child Health Profile 2015, Public Health England
[18] 2013 projection from 2011 Census

A common belief is that a core group of children and young people may be receiving several services, and that the system is prone to duplication, but this does not seem to be the case. Further examination of the detail is needed to understand the story behind these headline figures; not all caseload information has been able to be matched during the course of this work (for example Medway Council's Portage service do not collect NHS numbers).

5. Special Educational Needs (SEN)

SEN is of limited use as a proxy indicator of disability as not all disabled children will have a special educational need and not all children with an educational need will have a disability or long lasting illness. There is some crossover between SEN and disability however, and many children with SEN will be users of local secondary healthcare services.

The broad areas of educational need as defined by the SEN Code of Practice are communication and interaction, cognition and learning, specific learning disabilities (encompassing a range of conditions such as dyslexia, dyscalculia and dyspraxia), and social, emotional and mental health difficulties.[19]

Medway is line with its statistical neighbours in terms of the percentage of children and young people who have a statement of educational need/EHC plan, and just over national and regional rates[20] (Figure 5).

	January 2015		
	Total pupils	Pupils with statements or EHC plans	% of total school population
England	8,438,145	236,165	2.8
South East	1,366,780	40,035	2.9
Medway	**45,510**	**1,378**	**3.0**
Dudley	47,217	1,378	2.9
Havering	38,707	920	2.4
Northamptonshire	117,153	3,368	2.9
Rotherham	44,030	1,031	2.3
Southend-on-Sea	29,653	956	3.2
Swindon	31,920	1,207	3.8
Telford and Wrekin	28,310	1,001	3.5
Thurrock	26,314	934	3.5

Figure 5 Percentage of chidlren with statement of educational need/education, care and health plan

The internal Medway Council database of pupils with statements/plans (April 2015) contains 1,555 entries broken down by primary need (Figure 6).

[19] Special Educational Needs and Disability Code of Practice 2014
[20] SFR25 Special Educational Needs in England: January 2015

Figure 6 demonstrates that Autistic Spectrum Disorder is the most frequently identified need, followed by moderate learning difficulty, behavioural/emotional difficulty, and speech, language and communication needs.

Category	Number of pupils	As a % of number of pupils with statement/EHC plan	As a % of total school population (as of January 2015)
Other	6	0.38	-
Profound and Multiple Learning Difficulties	9	0.57	0.01
Visual Impairment	19	1.22	0.04
Hearing Impairment	48	3.0	0.1
Specific Learning Difficulty	74	4.75	0.16
Physical Disability	64	4.1	0.14
Severe Learning Difficulty	161	10.3	0.35
Speech, Language and Communication Needs	176	11.3	0.38
Behavioural, Emotional and Social Difficulties	180	11.6	0.39
Moderate Learning Difficulties	386	24.8	0.8
Autistic Spectrum Disorder	432	28	0.94

Figure 6 Breakdown of statement/plan by primary need

In comparison with its statistical neighbours, Figure 7 shows that Medway is an outlier for the percentage of children who do *not* have an SEN Statement or EHC plan but *are* assessed as in need of SEN support (previously those pupils falling within the 'school action' and 'school action plus' categories[21]):

Area	% school population in need of SEN support but who do not have SEN statement or EHC Plan 2015
Havering	7.9
Southend-on-Sea	8.7
Northamptonshire	9.5
Kent	11.3
Thurrock	11.5
England	12.6
Swindon	13.1
North Lincolnshire	13.8
Dudley	14.2
Rotherham	14.2
Telford and Wrekin	15.2
Medway	17.0

Figure 7 Percentage of children without statement or plan but assessed as having SEN

[21] Ibid.

From 2015, children without a statement or plan are also having their primary need recorded (NB Social Emotional and Mental Health has replaced the category previously used i.e. Behaviour, Emotional and Social Difficulties). Figures 8 and 9 show the most common categories of need of primary and secondary school pupils in comparison to national, regional and statistical neighbour data[22].

In relation to primary school pupils, Medway primary schools have the second highest rate of children with social, emotional and mental health needs, and the third highest in terms of speech and language in comparison to statistical neighbours.

Primary school pupils (with SEN but without statement/EHC plan)								
Area	**Specific Learning Difficulty**		**Moderate Learning Difficulty**		**Social, Emotional and Mental Health**		**Speech and Language**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%***
England	56,190	10.5	131,530	24.6	83,595	15.6	148,085	27.7
South East	11,620	13.5	19,880	23.1	14,115	16.4	23,645	27.5
Medway	438	11.4	428	11.1	725	18.8	1,216	31.5
Dudley	268	6.9	1,227	31.6	561	14.4	1,273	32.8
Havering	67	3.8	437	25.0	151	8.6	665	38.1
Northamptonshire	603	10.3	1,225	20.9	1,121	19.1	1,525	26.0
Rotherham	841	29.6	456	16.1	321	11.3	537	18.9
Southend-on-Sea	151	10.0	678	44.7	225	14.8	256	16.9
Swindon	320	13.9	508	22.1	389	16.9	471	20.5
Telford and Wrekin	187	8.3	723	31.9	306	13.5	556	24.5
Thurrock	135	9.0	403	26.9	275	18.3	384	25.6
Statistical neighbour mean		10		25		14.8		25.6

Figure 8 Primary school pupils most common educational needs

*Expressed as a percentage of all pupils with a type of need

Medway is the highest scoring of its statistical neighbours for social, emotional and mental health concerns amongst secondary school pupils, joint highest (with Rotherham) for secondary school pupils on the Autistic Spectrum, and lowest scoring for moderate learning difficulties.

Secondary school pupils (with SEN but without statement/EHC plan)								
Area	**Specific Learning Difficulty**		**Moderate Learning Difficulty**		**Social, Emotional and Mental Health**		**Autistic Spectrum Disorder**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%****

[22] Ibid.

England	77,965	20.9	92,770	24.9	72,065	19.3	30,845	8.3
South East	14,770	24.9	12,730	21.5	11,820	19.9	5,545	9.4
Medway	521	19.2	422	15.5	644	23.7	422	15.5
Dudley	395	17.5	830	36.8	297	13.2	161	7.1
Havering	89	8.2	442	40.9	121	11.2	115	10.6
Northamptonshire	923	24.1	864	22.5	666	17.4	411	10.7
Rotherham	537	21.7	554	22.4	454	18.3	385	15.5
Southend-on-Sea	101	11.2	462	51.3	161	17.9	48	5.3
Swindon	318	19.3	392	23.8	314	19.1	118	7.2
Telford and Wrekin	332	21.6	461	30.1	301	19.6	119	7.8
Thurrock	308	28.1	285	26.0	245	22.3	45	4.1
Statistical neighbour mean		19.3		26		18.3		7.8

Figure 9 Secondary school pupils most common educational needs

** Expressed as a percentage of all pupils with a type of need

In terms of children with autism known to schools, 9.1% of the SEN population is the England average, compared to 18.1% in Medway.[23]

6. NHS At Home: Acute and short term conditions

Nationally, under 20s account for over 4.9 million (26.5%) Accident and Emergency department attendances each year. This compares to 3.6 million (19.4%) A&E attendances by those aged over 65[24].

In the general population, acute illness in children with breathing difficulty, fever or diarrhoea and vomiting can usually be managed with nursing observation at home when hospital admission would normally be considered necessary[25]: in 2013/14, over 40% of under-five attendances at Medway Foundation Trust Emergency Department did not result in investigation or treatment, costing an average of £50 per child, according to the South East Coast Strategic Clinical Network (SECSCN). 7,317 children aged under five attended in 2013/14; this could potentially mean nearly £150,000 spent on unnecessary attendances. An under-fives admission to hospital with zero length of stay costs an average of £1,198.49 per child.

Those children with an existing illness or disability may also of course experience an acute episode or need short term care. Figure 10 below shows the length of hospital stay following admission for Medway children with complex health conditions, compared to the four most similar CCGs (as defined by NHS RightCare Commissioning for Value) and the Southern Region[26]. Medway children spend approximately one third longer in hospital than the comparators.

[23] Public Health England Learning Disability Profiles 2013/14
[24] Hospital Episode Statistics – Accident and Emergency Attendances in England – 2012/13
[25] Sartain SA, Maxwell MJ, Todd PJ et al. (2002) Randomised controlled trial comparing an acute paediatric hospital at home scheme with conventional hospital care. Archives of Disease in Childhood 87: 371–375. Referenced in NHS at Home: Community Children's Nursing Services DH March 2011
[26] Reviewing children and young people's use of secondary care, Public Health England/CHIMAT

	Bed days
NHS Medway (number)	3,808
NHS Medway (rate per 100,000)	6,607.7
4 'most similar' CCGs	3,944.3
Southern Region	3,693.8
Significance	Worse than similar CCGs and the region
Rank (of 221 CCGs) 1 indicates 'best'	196

Figure 10 Length of Stay, children with complex needs

MFT caseload and resources

The Children's Outreach & Specialist Team (COaST) caseload holds a small number of children with acute conditions such as Henoch-Schonlein Purpura (HPS), children requiring short term heparin injections and children with special needs who (following orthopaedic surgery or road traffic accidents) need dressings changed, and cannot get to community wound clinics.

As part of the scoping for a North Kent Community Nursing Team business case[27] an audit was undertaken by COaST to understand in more detail the economic benefits that a "hospital at home" element of a community children's nursing service could bring through undertaking activity in the community that would have previously been undertaken in a hospital setting (short stay paediatric assessment unit or children's ward). The audit was then validated by Kent and Medway Commissioning Support Service. The results of the audit and its financial implications are presented in Figures 11 and 12 below.

Ward attendances						
Reason	**Jan. 2014**	**Feb. 2014**	**9 April – 7 May 2014**	**Total attendances**	**14/15 Paediatric Ward Attender Tariff £135**	**14/15 Community Attendance Tariff £101.38**
Blood Tests	30	39	37	106	£14,310	£10,746
BP & urine check	0	0	2	2	£270	£203
Central line access	8	1	2	2	£1,485	£1,115
Dressing change	6	5	7	18	£2,430	£1,825
Enema/constipation	8	5	0	13	£1,755	£1,318
Enteral feeding tube re-insertion	0	0	9	9	£1,215	£912
Head measurement	0	0	1	1	£135	£101
Intramuscular injections	1	3	0	4	£540	£408
Insulin injections	0	0	2	2	£270	£203

[27] 'New North Kent Community Child Nursing Service' Medway CCG Commissioning, Finance and Performance Committee 20.8.2014

New diabetic	1	4	0	5	£675	£507
Nasogastric tube	18	22	0	40	£5,400	£4,055
Oral medication administration	1	0	1	2	£270	£202
PEG tube	2	1	0	3	£405	£304
Removal staples/sutures	2	0	0	2	£270	£203
Stool sample	0	0	1	1	£135	£101
Urine/weight/BP/other observations	2	4	0	6	£810	£608
Total	96	116	86	298	£39,420	£29,360

Figure 11 COaST Audit, interventions

NB attendances attract two tariff payments.

In patient		
Dolphin Ward - In Patients	**No. of days (9th April to 7th May 2014)**	**2014/15 Tariff**
Non Elective	5	£1,258
Non Elective Short Stay	1	£765
Total	**6**	**£2,023**

Figure 12 COaST Audit, LoS

The consequent business case[28] states that:
"If the activity was aggregated over a 12 month period (recognising that there may well be seasonal fluctuations and children with more complex conditions e.g. a child with a bone infection that would require more frequent attendances) the approximate income stream that could be reinvested in a community children's nursing service model would be … £181,956 ..apportioned across Medway / Swale based on population split of 73% / 27%, savings (for Medway) would be £132,827.88".

Teams across the South East Coast region, with others across the UK, completed a Royal College of Paediatrics and Child Health (RCPCH) survey on Community Children's Nursing Teams during May 2014; there were 70 responses.

All respondents stated that they provide services for all categories listed; acute, long-term conditions, disabilities and complex conditions but the highest majority (87.5%) was in relation to children with life-limiting and life-threatening illness, while 46.9% of respondents said that they spent 25% of their time on care for children with acute and short-term conditions. It was the RCPCH view that CCGs need to ensure all 4 categories have equitable access.

[28] New North Kent Community Children's Nursing Service paper, Medway CCG C,F&P 20.8.2014

7. NHS At Home: Long term conditions

In 2011 it was estimated that 15% of children aged 0 to 15 had a long standing illness[29]. In Medway, using 2013 ONS population estimates, this would equate to 8,198 children and young people. Among the most common of long term conditions are asthma, epilepsy and diabetes. Medway is an outlier for unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, with a rate of 441 per 100,000 population compared to the England rate of 311 per 100,000.[30]

a. Paediatric Asthma

Asthma is a chronic inflammatory disorder of the airways affecting many children and young people. It is a complex and episodic disorder. Drawing on data from the 2010 Health Survey for England (which focused on respiratory disease), Figure 13 shows how the prevalence of lifetime asthma increases with gender and age, with four times as many young people aged 13-15 with the condition compared to those aged 0-3. This may be partly due to differences in diagnosing very young children, as asthma cannot be formally diagnosed in children under 5.

Prevalence of lifetime doctor-diagnosed asthma in England, by age and gender, 2010		
	Males	Females
	%	%
0-3	7	5
4-6	15	10
7-9	20	12
10-12	22	17
13-15	28	21
Source: HSCIC (2011) Health Survey for England 2010: Respiratory Health		

Figure 13 Asthma prevalence in children

National data	Medway
Estimates of asthma prevalence vary considerably. Asthma is the most common long-term medical condition[31]: according to the British Thoracic Society about a fifth of children (21%) have a diagnosis of asthma. In 2010/11 the all age prevalence of asthma in England, based on GP register data was 5.9%, whereas in the Health Survey for England in 2010, 9.5% of adults and children	15,437 Medway children could have a diagnosis of asthma (based on GP registrations 0-19)

[29] Health Survey for England, 2011 – Health and Social care Information Centre
[30] Children and Young People's Health Benchmarking Tool, Public Health England
[31] NICE Quality Standard for Asthma 2013

reported having asthma, using the same definition of receiving asthma treatment in the last year. (This is of importance as those not on registers are at high risk of not receiving regular reviews of their asthma management and therefore are at increased risk of A&E attendance and hospital admission).	4,337 to 6,983 Medway children could have a diagnosis of asthma (based on GP registrations 0-19)
Severe problematic asthma that is poorly responsive to the common asthma treatments has been reported in approximately 4.5% of children with current asthma[32]	195 to 694 Medway children may have severe problematic asthma

Emergency paediatric asthma admissions in Medway are significantly worse than the rates for the region and the four most similar CCGs (Fig 14):

Paediatric Asthma Emergency Admissions 2013/14 CHIMAT DMT	Admissions	Bed days
NHS Medway (number)	178	201
Rate per 100,000 population	258.4	291.7
South (rate)	156.7	185.3
Significance*	Worse	Worse
4 most similar CCGs	110.2	216.5
Significance**	Worse	Worse
Rank (of 221 CCGs) 1 indicates 'best'	169	-

Figure 14 Emergency paediatric admissions

Asthma UK estimates that 75% of hospital admissions for children with asthma are preventable: Figure 15 shows projected potential cost savings which could be achieved through reduced admissions, based on 2013/14 data and costs[33]. The cost per admission is the tariff for non-elective spells. (Cost savings should be considered an approximate guide rather than a specific amount).

	Medway	England	The best	The best

[32] European Respiratory Society, the European Lung White Book

[33] Extracted from Disease Management Information Tool, Public Health England and National Child and Maternal Health Intelligence Network.

			performing 25%	performing 5%
Asthma admissions per 100,000 population aged 0-18	258.4	197.5	108.5	75.0
Cost per admission	£661	£661	£661	£661
Total cost per 100,000 population aged 0-18	£170,779	£130,556	£71,728	£49,582
		If Medway's performance matched England	**If Medway's performance matched the best performing 25% of CCGs**	**If Medway's performance matched the best performing 5% of CCGs**
Potential cost savings per 100,000 population aged 0-18		£40,222	£99,050	£121,197
Potential total cost savings - total approximate figure		£27,700	£68,200	£83,400

Figure 15 Cost of asthma admissions

Detailed research carried out by Medway Council's Public Health Directorate[34] found rates of admission have increased in recent years; however the recorded prevalence of asthma in Medway by GP practice is below the England average of 5.9% (based on 2012/13 Quality and Outcome Framework data). In Medway, the overall prevalence[35] of diagnosed asthma was 5.6%, with considerable variation by practice, where prevalence ranged from 3.5% to 7.1%. Public Health concluded that seemed unlikely that this degree of variation reflected genuine differences in asthma prevalence between practices, and suggested that it is likely that there is a considerable level of underdetection.

It was also suggested that there was room for improvement in the management of paediatric asthma in primary care as a significant number of children in a hospital admissions audit were found to have symptoms for two or more days before admission. The latest data from CHIMAT for hospital admissions shows a downward trend, although the Medway rate is still higher than comparable CCGs (see Fig 16)

[34] Emergency admissions for asthma in children in Medway, 2014, Report by Medway Public Health
[35] All ages – not possible to obtain specifically for children

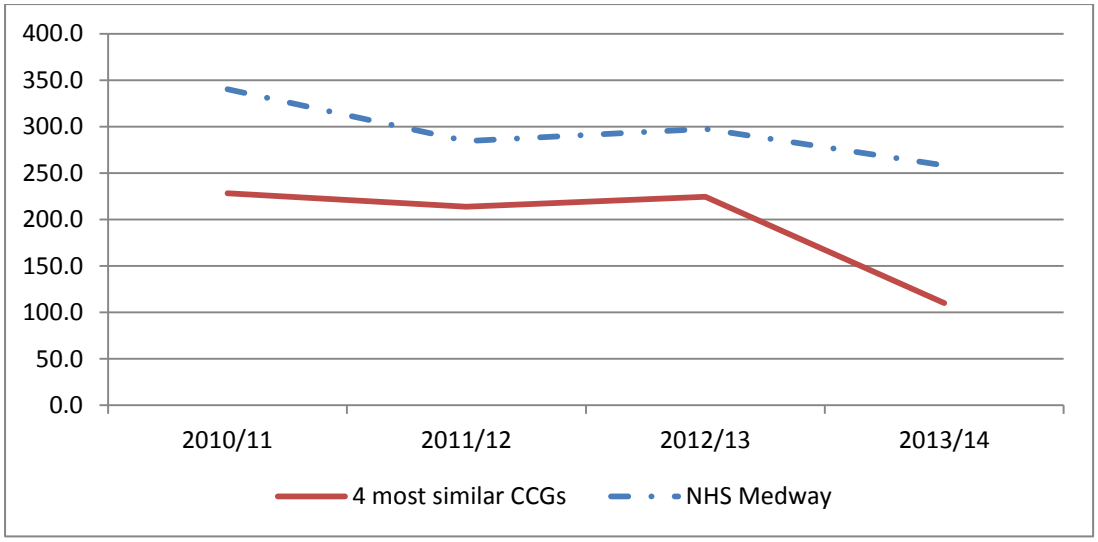

Figure 16 Asthma admissions per 100,000 population

SECSCN[36] recommendations for asthma are in the process of being produced with the East of England region which is leading the national work. Locally the work will focus on supporting the Programme to provide a proposed model of care, including

- CCN and Clinical Nurse Specialists integrated community working models linked with School Nursing
- Primary Care education for diagnosed asthma – Health Education England are producing a GP self-assessment tool for asthma
- Medicines in schools - clarifying the role of school nurse
- Reviewing the recommendations relating to children and young people within the National Review of Asthma Deaths[37]

MFT Children's Services caseload and resources

COaST has a caseload of 28 children with chronic respiratory, asthma and bronchiectasis. The staff team includes 3 whole time equivalent specialist respiratory nurses (one at Band 7, two at Band 6).

Medway Asthma Self Help

Medway Asthma Self Help (MASH) is a small voluntary organisation in Medway which offers access to a specialist asthma nurse, asthma allergy testing, lung function testing and advice. It receives £11,000 p.a. funding from Medway CCG.

In 2013-2014 MASH provided 151 clinic appointments. Of these, 59% were for children aged 0-16, and of those 43% of children were under the age of five. There were also 123 telephone consultations, of which 54% concerned a child. The following assessment was received from Dr Alaisdair Stewart, Respiratory Consultant at Medway Maritime Hospital;

MASH plays and ever increasing role in the management of asthma across the Medway Towns. It seems increasingly patients find it difficult to see their GP or asthma nurses particularly at times that suit them. Many are not getting written asthma management plans nor do the practice health care professionals have time to go over things and explain about

[36] South East Coast Strategic Clinical Network
[37] https://www.rcplondon.ac.uk/projects/national-review-asthma-deaths

the disease and its management…The service is equivalent to that provided by most average district general hospitals at a fraction of the cost.

b. Epilepsy

National data	Medway
Epilepsy is one of the most common serious neurological disorders seen in primary care. Around 600,000 people in the UK have a diagnosis of epilepsy and are prescribed anti-epileptic drugs (AEDs) – the equivalent of 10 per 1,000 people[38]	2,710 people (all ages) could have a diagnosis of epilepsy
The number of children and young people aged 18 years and under with epilepsy is near 1 in 220[39]	Approximately 330 young people could have a diagnosis of epilepsy (based on GP registrations 0 -19)
More than one in five people with epilepsy have learning or intellectual disabilities	Approximately 66 of Medway young people with epilepsy could also have learning or intellectual disabilities

2013/14 data taken from CHIMAT's Disease Management Tool shows that the Medway rate of 0 -19 admissions for Epilepsy is significantly higher the national rate and that of similar CCGs (see Figure 17)

Epilepsy 13/14 CHIMAT DMT	Admissions	Bed days
NHS Medway (number)	79	71
Rate per 100,000 population	114.7	103.1
England (rate)	77.8	153.9
Significance*	Worse	Better
4 Most similar CCGs (rate)	65.5	114.6
Significance**	Worse	Same
Rank (of 221 CCGs) 1 indicates 'best'	185	76

Figure 17 Epilepsy admissions

[38] Epilepsy Action
[39] Young Epilepsy

*When compared to England
** When compared to the average of the four most similar CCGs

Data for 2013/14 demonstrates a rising trend in admissions (see Figure 18)

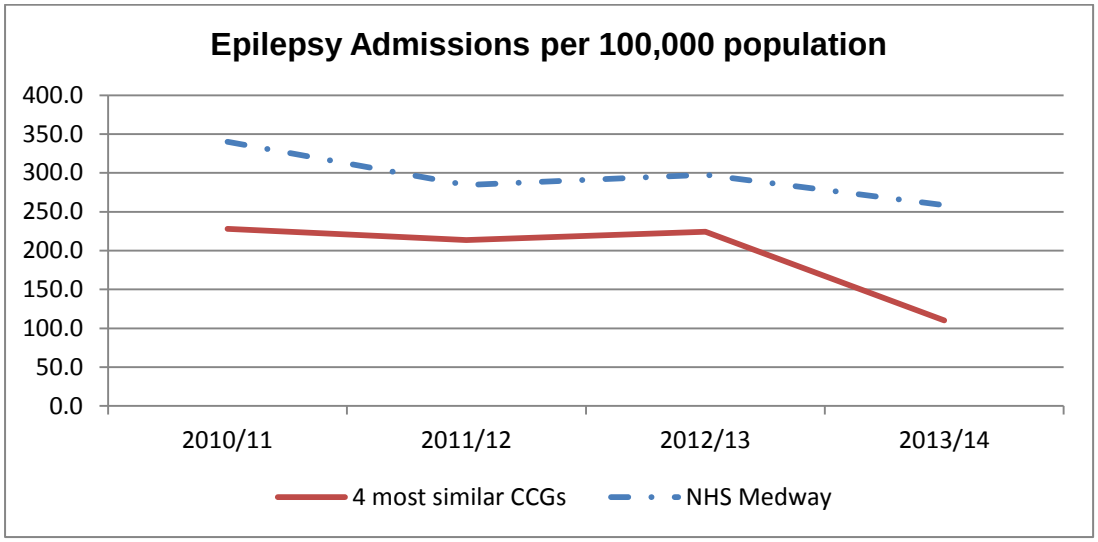

Figure 18 Epilepsy admissions per 100,000 population

CHIMAT's projected savings from improved performance are shown in Fig 19:

Epilepsy	Medway	England	The best performing 25% CCGs	The best performing 5% CCGs
Admissions per 100,000 population aged 0-18	114.7	77.8	44.4	29.3
Cost per admission	£702	£702	£702	£702
Total cost per 100,000 population aged 0-18	£80,496	£54,610	£31,195	£20,534
		If Medway's performance matched England	**If Medway's performance matched the best performing 25% CCGs**	**If Medway's performance matched the best performing 5% CCGs**
Potential cost savings per 100,000 population aged 0-18		£25,887	£49,302	£59,962
Potential total cost savings - total approximate figure		£17,800	£33,900	£41,300

Figure 19 Projected savings from improved performance

MFT Children's Services caseload and resources

Of 167 referrals to the Community Learning Disability Nursing service, 4 were identified as having epilepsy alongside other conditions, and one child out of 19 attending Woodlands Special Needs Nursery is diagnosed with epilepsy.

The figure for the number of children with epilepsy on the Community Paediatric caseload is not available; however a neurologist will also see patients who have co-morbid epilepsy and data may be obtained as part of the review.

Children's Social Care

A snapshot analysis of children and young people designated as disabled on Medway Council's social care recording system, Frameworki, found that 46 out of 580 children were recorded as having epilepsy (8%).

c. Diabetes

National data	Medway
The current estimate of prevalence of Type 1 diabetes in children and young people under the age of 15 in England and Wales is 187.7 per 100,000[40].	This is the equivalent of 109 of our 58,000[41] under 15s being diagnosed with Type 1 diabetes
The national target is an HbA1c level of less than 7.5%. The national average of patients achieving this target is 17.4%[42].	Fewer young people are at risk of diabetic complications as the Medway Diabetes team reported that 18.1% of their patients reached the national target level[43].
Diabetes emergency admissions for under 19s is 60/100,000	The emergency admission rate is 91/100,000 considerably worse than the national rate. Medway ranks as 196th out of 221 CCGs, where 1 indicates 'best'[44]. Bed days per 100,000: Medway is ranked 211 out of 221[45].

In Medway, children and young people aged 0 – 19 are admitted to hospital at the same rate as nationally and in similar CCGs, but spend more days in hospital when admitted (See Figure 20), however the most recent data shows a downward trend. (see Figure 21[46])

Diabetes admissions 2013/14 (CHIMAT DMT)	Admissions	Bed days
NHS Medway (number)	51	173
Rate per 100,000 population	74.0	251.1

[40] Diabetes UK
[41] ONS based estimate
[42] By measuring glycated haemoglobin (HbA1c), clinicians are able to get an overall picture of what the average blood sugar levels have been over a period of weeks/months. For people with diabetes this is important as the higher the HbA1c, the greater the risk of developing diabetes-related complications
[43] National Paediatric Audit (2011/12)
[44] CHIMAT Disease Management Toolkit (DMT)
[45] Ibid.
[46] Ibid.

England (rate)	57.1	129.7
Significance*	Same	Worse
4 most similar CCGs (rate)	63.1	110.2
Significance**	Same	Worse
Rank (of 221 CCGs) **1 indicates 'best'**	176	202

Figure 20 Diabetes admissions and bed days

*When compared to England
** When compared to the average of the four most similar CCGs

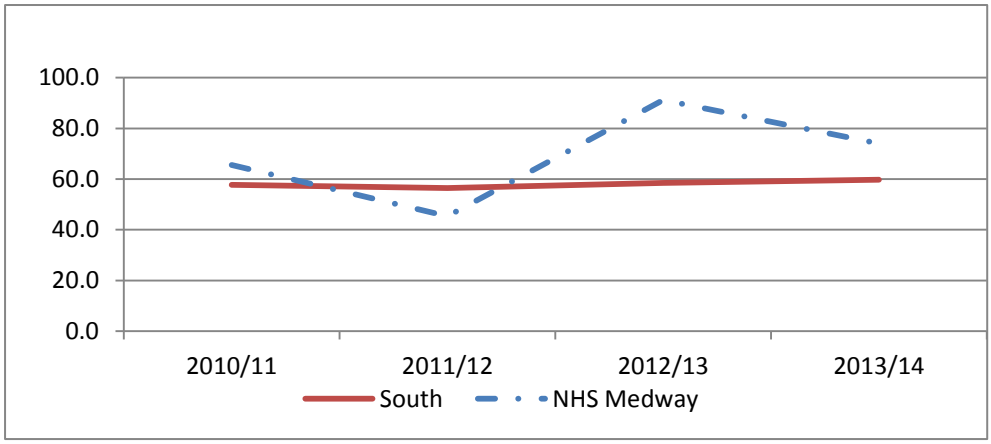

Figure 21 Diabetes admissions per 100,000 population

Figure 22 illustrates CHIMAT estimate of the savings that could be made if performance improved:

	Medway	England	The best performing 25%	The best performing 5%
Admissions per 100,000 population aged 0-18	74.0	57.1	36.2	26.1
Cost per admission	£918	£918	£918	£918
Total cost per 100,000 population aged 0-18	£67,956	£52,461	£33,197	£23,975
		If Medway's performance matched England's	If Medway's performance matched the best performing 25% of CCGs	If Medway's performance matched the best performing 5% of CCGs
Potential cost savings per 100,000 population aged 0-18		£15,495	£34,759	£43,981
Potential total cost savings - total approximate figure		£10,600	£23,900	£30,300

Figure 22 Estimated savings from improved performance

MFT Children's Services caseload and resources

COaST have a Medway caseload[47] of 191 young diabetics, 144 receiving multi dose injection and 47 on an insulin pump.

The staff team in place to meet the paediatric diabetes best practice tariff consist of a Diabetes CNS Band 7 (0.69 wte[48]), Diabetes sisters Band 6 (2.37) Diabetes dietician Band 6 (1 wte) Diabetes psychologist Band 6 (1 wte) and a Diabetes MDT co-ordinator Band 4 (0.8 wte).

NB The SECSCN Maternity, Children and Young People Plan 2015/16 includes the deliverables of agreed models of care and smooth transition pathways from childhood to adult services for children and young people with diabetes, epilepsy and asthma.

8. NHS At Home: Disabilities and complex continuing care conditions

The prevalence of severe disability is increasing[49].

The Family Resources Survey 2013/14 calculated the percentage of disabled children with specific impairments, and (assuming disability prevalence in Medway of 8% of the 0 -19 GP registered population), Fig 23 estimates the potential number of children in Medway affected:

Impairment type	% of disabled children	Medway projection (number)
Vision	10	588
Hearing	9	529
Mobility	24	1,411
Dexterity	11	647
Learning	31	1,823
Memory	13	764
Mental health	16	470
Stamina/breathing/fatigue	31	1,823
Socially/behaviourally	33	1,940
Other	24	1,411

Figure 23 Number/percentage of Medway children affected by specific impairments

Figure 24 shows the Medway spend on the most complex children, as assessed by NHS England[50]:

2% Most complex patients (16.2% of CCG Spend)				
Age	**Number of complex patients**	**Mean number of admissions**	**Mean number of different conditions**	**Total spend (£000s)**
0	25	7.8	3.76	904
1-4	15	9.5	3.53	331
5-9	15	7.4	3.20	395
10-14	16	5.6	2.38	373

[47] June 2015
[48] Whole time equivalent
[49] CHIMAT Disability Needs Analysis July 2015
[50] Commissioning for Value: Integrated care pathways Feb 2015

15-19	18	6.5	2.00	431

Figure 24 Spend on complex children

Learning disability

Every term schools report to the Department for Education about all children who have special educational needs and the type of need they have. There are four levels of learning difficulties: specific difficulties such as dyslexia (excluded from this analysis), moderate learning difficulties, severe learning difficulties and profound and multiple learning difficulties. The school census covers all pupils enrolled in state-funded primary, secondary or special schools. A formal medical diagnosis is not required; as such these numbers may not reflect those seen in data from medical sources.

- Children who have a moderate learning difficulty have difficulty in all areas of learning. They may have speech and language delay
- Children with severe learning difficulties will have serious difficulty in participating in ordinary school programmes without support. Many have limited communications and self-help skills
- Children with profound and multiple learning difficulties have very severe difficulty in learning combined with physical or sensory disabilities. They require a high level of adult support for both learning and personal care needs

Public Health England has compiled learning disability profiles from the DfE reports[51].

Figure 25 compares Medway rates with England and the South East region:

Rate per 1000 pupils			
	England	**South East region**	**Medway**
Children with moderate learning difficulties known to schools per 1000 population	15.6	13.8	14.9
Children with severe learning difficulties known to schools per 1000 population	3.73	3.34	2.8
Children with profound and multiple learning difficulties known to schools per 1000 population	1.27	1.04	Value suppressed for disclosure control due to small count
Children with autism known to schools per 1000 population	9.1	10.00	18.1

Figure 25 Children with learning disabilities known to schools

Figure 26 compares Medway with its statistical neighbours:

[51] http://fingertips.phe.org.uk/profile/learning-disabilities/data

Rate per 1000 pupils				
Statistical neighbour	Children with moderate learning difficulties known to schools per 1000 population	Children with severe learning difficulties known to schools per 1000 population	Children with profound and multiple learning difficulties known to schools per 1000 population	Children with autism known to schools per 1000 population
Dudley	31.1	Value suppressed	0.79	8.3
Havering	14.7	3.56	Value suppressed	6.3
Medway	14.9	2.80	Value suppressed	18.1
Northamptonshire	12.3	3.71	Value suppressed	9.2
Rotherham	14.7	3.07	1.37	17.8
Southend on Sea	26.2	4.92	1.46	8.00
Swindon	17.7	3.75	1.92	9.2
Telford & Wrekin	31.4	Value suppressed	3.2	6.6
Thurrock	29.0	1.72	Value suppressed	9.2

Figure 26 Children with LD known to schools - comparison with statistical neighbours

Medway is an outlier in relation to the high prevalence of children with Autism known to schools, and at the lower end of the scale for children with learning disabilities known to schools. It is likely that higher rate of children with Autism known to schools relates to the higher rate of ASD diagnosis in Medway comparative to the national prevalence estimate. The latest prevalence studies of autism indicate that at approximately 1% of the population in the UK may have autism.[52] In Medway this would amount to approximately 735 of the GP registered 0 – 19 population, however diagnoses are running at approximately twice that rate.

Global Developmental Delay

A child may be described as having global developmental delay (GDD) if they have not reached two or more milestones in all areas of development (called developmental domains). These areas are:

- Gross and fine motor skills
- Speech and language (expressive and receptive)
- Cognitive skills such as the ability to learn new things, process information, organise their thoughts and remember things
- Social and emotional skills - interacting with others and development of personal traits and feelings, as well as starting to understanding and respond to the needs and

[52] National Autistic Society/NICE

feelings of others. Children and young people with generalised developmental delay experience higher rates of emotional and behavioural difficulties than other children

A snapshot analysis of children and young people designated as disabled on Medway Council's social care recording system, Frameworki, found that 66 out of 580 children were recorded as having a specific diagnosis of GDD (11%).

The most common causes of GDD are problems with the child's genes or chromosomes, for example Down syndrome or Fragile X syndrome. Sometimes, problems with the structure or development of the brain or spinal cord may be the reason for a child having GDD. Other causes can include premature birth, childhood infection (for example meningitis) or metabolic diseases, such as having an underactive thyroid gland (hypothyroidism) or other problems affecting babies before they are born. Toxic substances such as alcohol in the case of Foetal Alcohol Syndrome can also contribute. For some children, the cause of the GDD is never identified[53]. Many of the most severe cases of childhood disability will feature GDD in addition to other complex health needs.

Complex health needs

CHIMAT estimates 12,263 of the Medway 0 – 19 population are living with longstanding illness or 'mild' disability, and an additional 49 are severely disabled[54]. However the relevant COaST caseload is approximately twice the latter estimate (Figure 27).

Specialism	Conditions	Caseload (Medway only)
Complex health needs	Cardiac	3
	Hepatic	0
	Renal	3
	Acute	15
	Metabolic	3
	Enteral	51
	Rheumatology	7
	Bladder/bowel	6
	Neurological/ degenerative	4
	Other	3
	Total	**95**
Continuing care	Long term ventilation	10
Total		**105**

Figure 27 Medway COaST caseload June 2015

Figure 28 compares the length of stay following admission in Medway children with complex conditions aged between 14 days and 15 years with England and similar CCGs. Medway children experience longer hospital stays than similar CCGs and regionally[55], and is rated 196th out of 221 CCGs.

[53] Definition from Contact a Family
[54] CHIMAT Disability Needs Assessment
[55] Reviewing use of secondary care: children and young people with any complex condition, PHE and CHIMAT 2013/14

Children and young people with any complex condition 2013/14	Bed days	Average length of stay (days)
NHS Medway (number)	3,808	4.19
NHS Medway (rate per 100,000)	6,607.7	-
England	4,530.1	3.27
Significance*	Worse	Higher**
4 'most similar' CCGs	3,994.3	2.94
Significance**	Worse	Higher***
Rank (of 221 CCGs) 1 indicates 'best'	196	180

Figure 28 Length of stay, complex conditions

*When compared to England average ** When compared to the average of the 4 'most similar' CCGs *** Not statistically tested

A review of current research on specialist home-based nursing services did not find supporting evidence for a reduction in access to hospital services or a reduction in hospital readmission rate for children with acute and chronic illnesses using specialist home-based nursing services; however, the only summary finding across a few studies was that there is a significant decrease in length of hospitalisation[56]. This appears not to hold true for Medway.

Figure 29 also shows an upwards trend for total bed days spent after admission for this group of children compared to the south east region[57]:

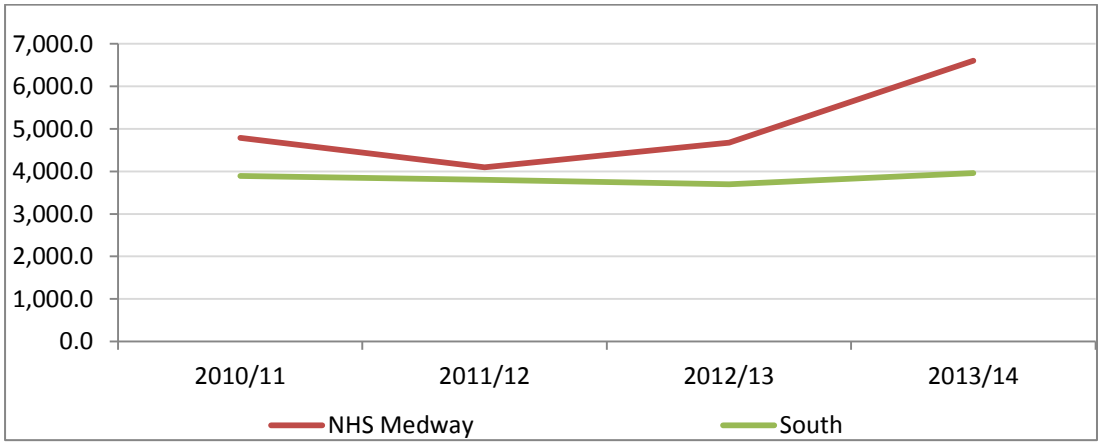

Figure 29 Paediatric complex conditions - total bed days following admission per 100,000 population

[56] Specialist home-based nursing services for children with acute and chronic illnesses Parab CS, Cooper C, Woolfenden S, Piper SM June 2013

[57] Reviewing use of secondary care: children and young people with any complex condition, PHE and CHIMAT 2013/14

Autism and ADHD

Autism

As of April 2015, 432 Medway children and young people had a statement of SEN or EHC plan with ASD as the primary need. A further 422 secondary school students were identified as having a special educational need in relation to ASD, but were not subject to a statement or plan (Figure 30).. As previously noted, Medway is an outlier in comparison to its statistical neighbours for the number of children with Autism known to schools and the data suggests that diagnosis rates are approximately double the national prevalence rate

	Number	As a % of school population (45,510 as of January 2015)
Medway pupils with statements/plans where ASD is the primary need	432	0.94
Secondary school pupils with SEN but no statement/plan where ASD is the primary need	422	0.92

Figure 30 ASD as a primary need

Around 70% of people with autism also meet diagnostic criteria for at least one other (often unrecognised) psychiatric disorder that further impairs psychosocial functioning, for example, attention deficit hyperactivity disorder (ADHD) or anxiety disorders. Intellectual disability (IQ below 70) coexists in approximately 50% of children and young people with autism.

ADHD

According to the full NICE guideline on ADHD:

"ADHD (as defined in DSM-IV-TR) is a common disorder. In the UK, a survey of 10,438 children between the ages of 5 and 15 years found that 3.62% of boys and 0.85% of girls had ADHD (Ford et al., 2003). This survey was founded on careful assessment and included impairment in the diagnosis".[58]

Taking the Ford prevalence findings above together with Medway 0 – 19 population data taken from GP registration statistics results in an estimated 1,770 children and young people diagnosed with ADHD (1,464 males and 306 females). This is in line with current actual outpatient caseloads: of 4,768 Medway outpatients, 1060 (22%) are Medway children receiving ADHD medication and reviewed on a twice yearly basis. Of these, 130 (12%) are aged 17 years 8 months and above, but currently have no adult service to transition to.

From the figures above, it would appear that the commonly held belief that Medway is an outlier in terms of ADHD diagnoses is inaccurate. The rate of diagnosis in Swale is skewing the figures: overall 2.4% of the Medway 0-19 population is diagnosed with ADHD compared to 3.5% of the Swale population. Spend on medication in Swale per capita of the 0 – 19 population is over 50% higher than spend in Medway (Fig 31).

[58] Diagnosis and management of ADHD in children, young people and adults, National Clinical Practice Guideline Number 72 National Collaborating Centre for Mental Health, commissioned by NICE

2013/14	Medway	Dartford Gravesham Swanley	Swale	W Kent	Thanet	S. Kent Coastal	Ashford
Population 0-19[59]	73,513	63,068	26,971	114,133	33,398	44,721	31,572
Total spend on ADHD medication	£722,720	£620,414	£614,345	£722,720	£128,561	£142,068	£82,804[60]
Spend per capita	£9.83	£9.83	£22.70	£6.33	£3.85	£3.17	£2.62

Figure 31 ADHD prescribing costs by CCG

Options for future commissioning in relation to neuro-developmental disorders are currently being considered.

9. MFT caseload and resources

Community Paediatricians

Referrals are accepted to the Community Paediatric Service in respect of developmental concerns (pre-school children), learning difficulties (aside from specific learning difficulties in isolation, e.g. dyslexia), behavioural difficulties and suspected ADHD (primary school age only), suspected ASD (pre school and primary age children only), movement disorders/tics, and anxiety in primary school children if there is evidence to suggest an underlying neurodevelopmental problem.

In the calendar year 2014, there were 2066 referrals. 1378 were accepted (67%) and 649 rejected (31%). 2% were on hold/awaiting further information.

Figure 32 shows the reason for referral (available for 1,302 of the accepted referrals - more than one reason may apply):

Reason for referral	Number	% of the number of accepted referrals
Behaviour	278	20%
ADHD	364	26%
Social/communication	273	20%
Developmental delay	257	19%
Dyspraxia	8	8%
Learning difficulties	34	2%
Motor disorders	26	2%
Complex neuro development	11	1%
Sleep	24	2%
Hearing	52	4%

Figure 32 Referrals to Community Paediatric Service 2014

[59] Population estimates from GP registration statistics July 2015
[60] Total spend information from South East CSU cost and activity modelling presentation to pathway steering group 17.6.15

- Referrals from Chatham are significantly lower than other areas of Medway
- The main reasons behind accepted referrals are the interlinked issues of behaviour, ADHD and social and communication difficulties, followed by developmental delay
- GPs make the most referrals, but have half their referrals rejected (other main referrers have a rejection rate of approximately 25%)
- Chatham GPs make the fewest referrals, but have the highest number of rejections.
- GP referrals related to hearing have a rejection rate of 84%
- Whereas referral activity looks similar for the financial years 13/14 and 14/15 (1837 referrals received in 13/14 and 1782 in 14/15), these overall figures mask a substantial decrease in Medway referrals in the first 3 months of 2015, and an increase in referrals from Swale
- A potential indicator of capacity issues is the percentage of appointments cancelled by the hospital with between 1 and 6 week's notice. The Trust target is 10%, but the Community Paediatric rate is 56.8% (8th highest out of 30 departments[61])

No detailed breakdown by other disability is available because of provider IT issues.

Learning Disability Nursing

The Learning Disability Nursing team comprises:

- Team Leader Band 7: 1.0 wte. This post manages the LD nursing team and special school nursing.
- Community Learning Disability Sister Band 6: 0.8 wte
- Community Learning Disability Staff Nurse Band 5: 2 wte
- Band 6: 1.0 wte –vacant post, currently out to advert.

The client group is children and young people with moderate/severe or profound and multiple learning disabilities, excluding those with a mild learning disability or ADHD without a moderate or severe learning disability.

In May 2015, the caseload was 106 children and young people aged 2 to 17, 73% male and 27% female. 41% of diagnoses featured autism and 37% global developmental delay. 23% featured severe or moderate learning disability, and included 8 children with Down Syndrome.

From April 2014 to May 2015, 150 referrals were accepted, predominantly from community paediatricians (63%). The main reasons for referral were behavioural issues (50%), sleep (38%) and toileting/continence (13%). Support was also sought after diagnosis, and around diet and personal safety/sexualised behaviour.

Special School Nursing

Special school nurses aim to facilitate regular access to school for children and young people with learning disabilities and complex health needs.

[61]MFT Integrated Quality and Performance Report July 2015

Staffing comprises a Team Leader at Band 7 (1.0 wte) who also manages the Learning Disability Nursing Team, 1 wte School Nurse Band 6, 4.5 wte Community Staff Nurses at Band 5 and one 0.6 wte School Health Support at Band 3.

Currently the team work in two Medway special schools, Abbey Court and Danecourt. Abbey Court School has 140.5 pupils with severe and profound and multiple learning disabilities, and complex health needs (the school based on two sites and includes a nursery provision). Danecourt School has 148 pupils with moderate to severe learning disabilities.

Special Needs Nursery

The client group for this service is children with learning disabilities and associated healthcare needs aged 18 months to 5 years.

From January 2015 to April 2015 one referral was accepted for the nursery, and one for assessment. Four referrals were rejected (two for the nursery and two for assessment). All referrals were regarding concerns about delayed development.

Sources of referral include the local authority led Information Sharing and Assessment Panel (ISAP), health visitors, paediatricians, children's therapists and Portage.

As of June 2015, 19 children attended nursery sessions (maximum of two 2.5 hour sessions) and 3 children attended the assessment nursery for 1.5 hours each Friday. Children attending the nursery have a range of severe/complex conditions and co-morbidities (see Figure 33 – NB total does not equate to the number of children attending as children may have more than one condition)

Condition	Number of children affected
ASD	7
Spina bifida	1
GDD	9
Cerebral Palsy	2
Genetic disorder	5
Visual impairment	5
Hydrocephalus	2
Cardiac defects	2
Epilepsy	1
Hearing impairment	2

Figure 33 Special Needs Nursery caseload

10. Medway Community Healthcare Children's Therapies Team

This service aims to meet the needs of children and young people who present with a primary health need and require assessment and intervention from one or more of the following disciplines: Physiotherapy, Occupational Therapy, Dietetics, Podiatry, Speech & Language, and Continence (Level 2).

Neurological Physiotherapy

Conditions seen by the team may include:

- neurological conditions e.g. cerebral palsy, head injury
- neuromuscular disorders e.g. muscular dystrophy
- developmental delay
- congenital disorders e.g. spina bifida, limb deficiencies
- congenital syndromes and metabolic diseases
- conditions where mobility is affected e.g. oncology

The caseload as of June 2015 included 165 children in the early years age range and 241 school age children and young people. Of these, 238 had been assessed as requiring direct support of 10 to 16 contacts per year, and 69 were assessed as requiring intensive support of between 20 and 30 contacts per year.

Musculo-skeletal Physiotherapy (MSK)

Conditions include torticollis (twisted neck), plagiocephaly (flattening of one side of the skull), talipes (club foot), rheumatological conditions, orthopaedic and post fracture. Children with short term conditions are offered a maximum of 6 treatments. Children with long term conditions are seen according to need, but for no more than 10 treatments per year. The June 2015 caseload comprised 552 children and young people.

Podiatry

Referrals are accepted for any child with a condition affecting their lower limb, including hemiplegia. Children with long term conditions are seen according to need, but for no more than 10 treatments per year. The June 2015 caseload comprised 119 children and young people.

Occupational therapy, Early Years

Referrals accepted where children have physical ***or*** sensory difficulties which are significantly impacting upon performance of functions of daily living and are out of line with the child / young person's overall level of development. The June 2015 caseload comprised 52 children, with 19 receiving direct support of up to 16 contacts per year and 26 children receiving intensive support of up to 30 contacts per year.

Occupational therapy, school age children and young people

The team see children where physical difficulties are causing functional problems which impact on daily life and are out of line with overall level of development. The June 2015 caseload comprised 160 children, with 150 receiving direct support of up to 10 contacts per year and 10 children receiving intensive support of up to 20 contacts per year.

Speech and Language Therapy, Early Years

This team supports pre-school children with swallowing difficulties as well as a variety of communication difficulties including receptive and expressive language, speech sounds, social interaction and stammering/stuttering children needing alternative methods of communication – e.g. signing or computer aided communication devices. The June 2015 caseload comprised 656 children, with 340 receiving direct support of up to 12 contacts per year and 230 children receiving intensive support of up to 30 contacts per year.

Speech and Language Therapy, school age children and young people with Education, Health and Care plans or a primary health need

As of October 2015, a total of 690 children and young people were on the caseload, with 332 receiving the direct package of up to 12 contacts a year and 75 receiving the intensive package comprising up to 30 contacts per year.

Continence Advisory Service

The role of the continence advisor is to train others (e.g. health visitors, community nurses, school nurses and GPs) to enable them to provide first level treatment for enuresis, constipation and toilet training problems. The caseload includes children with complex disabilities, children with complex bladder/bowel problems and children where level 1 input has not had any impact on the difficulties within 3 months. The June 2015 caseload comprised 116 children. Children with continence products are offered annual review. Children with other continence needs are seen for between 3 to 10 treatments a year according to need.

Dietetics

Some children seen by a dietician may have additional complex needs, and will be seen by at least one other member of the children's therapy team. These children may include those who have epilepsy, cerebral palsy, Autism, genetic conditions or syndromes and or learning difficulties in addition to a nutritional problem and/or poor growth. These children often cough, gag or choke on food or drinks, have recurrent chest infections, are extreme fussy eaters, or have poor or excessive weight gain. 187 children were on the caseload in June 2015.

11. Medway Council Services Children's Social Care, including the 0 – 25 Disability Service

The 0 to 25 team offers a range of services for disabled children and young people with severe disabilities and complex health needs to help them remain living at home or move towards independence. They can support children that have

- a severe and profound learning, physical or sensory disability
- long-term, complex medical needs
- life-limiting or threatening illnesses

They may not be able to help those that have:

- a disability that is not severe or has low impact on a family or individual
- behavioural problems due to social and environmental factors (ie. not associated to a disability)
- a diagnosis of ADD/ADHD alone
- mental health needs alone
- a diagnosis of specific learning difficulties alone (eg. dyslexia, dyspraxia)

Disabled children may also be supported by other social care teams should they be in need of safeguarding or become Looked After by the local authority.

An October 2015 analysis of children and young people designated as disabled on Medway Council's social care recording system, Frameworki, identified a group of 580 children where a disability was recorded (See Figure 34 for a breakdown by disability grouping). It should be noted that this cohort includes cases recorded as closed as well as open to the 0-25 Disability Team, Social Care Occupational Therapy, and/or other Children's Social Care teams and may not represent the totality of disabled children held on the system. There is no current way to routinely access robust electronic caseload information on numbers or needs.

Disability group	Includes:	Number	Percentage
Social and Communication	Autistic Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD)	284	49%
Neurodevelopmental	Global Developmental Delay (GDD), Learning Disability, Speech and language delay	218	38%
Mental Health	Anxiety, Depression, Obsessive Compulsive Disorder (OCD), Oppositional Defiant Disorder (ODD)	65	11%
Neuro/degenerative	Epilepsy, Cerebral Palsy, Muscular Dystrophy, Hemiplegia, Spina Bifida, Paraplegia	77	13%
Rheumatological	Disorders affecting joints, bones, muscles and soft tissues such as Perthes, juvenile arthritis, hypermobility, scoliosis	33	6%
Sensory difficulties	Sensory processing disorder/sensory integration	41	7%
Hearing impairment		28	5%
Visual impairment		39	7%
Bladder and Bowel	Hirchsprung's	14	2%
Metabolic	Batten disease, Sickle Cell, Infantile Parkinsonism	10	2%
Respiratory	Cystic Fibrosis	11	2%
Cardiac		8	1%
Cancer		7	1%
Renal		4	1%

Figure 34 Frameworki caseload

(Percentages add up to more than 100 as some children have more than one disability)

Figure 35 shows individual disorders/disabilities of note:

Disorder/disability	Number	Percentage
ASD	200	34%
Epilepsy	46	8%
Cerebral Palsy	15	3%
Down Syndrome	17	3%
Cystic Fibrosis	4	0.6%

Figure 35 Disorders and disabilities of note within the caseload

Aut Even is a specialised respite provision in Medway for children and young people with disabilities, offering overnight as well as day breaks. A recent examination of their current caseload shows that over half the children and young people requiring overnight respite have ASD, and many display extremely challenging behaviours. Around a quarter have complex physical disabilities requiring nursing care. A fifth are identified as being learning disabled, and a fifth as having Global Developmental Delay.

NHS At Home: Life limiting/life threatening illness including palliative/end of life care

There are over 300 conditions which fall into the life-limiting and life-threatening classification, and these may be considered within four categories:

- Life limiting conditions for which curative treatment may be feasible but can fail. Access to palliative care services may be necessary when treatment fails or during an acute crisis. *Examples:* Cancer, irreversible organ failures of heart, liver and kidney
- Conditions where premature death is inevitable. There may be long periods of intensive treatment aimed at prolonging life and allowing participation in normal activities. *Examples*: cystic fibrosis, Duchenne muscular dystrophy
- Progressive conditions without curative treatment options. Treatment is exclusively palliative and may commonly extend over many years. *Examples:* Batten's Disease, Mucopolysaccharide and Lysomal Storage diseases
- Irreversible but not progressive conditions causing severe disability leading to susceptibility to health complications and likelihood of premature death *Examples:* Severe cerebral palsy, multiple disabilities such as following brain or spinal cord injury, complex healthcare needs, high risk of an unpredictable life threatening event or episode[62]

In 2011, the Health and Social care Information Centre estimated that 6% of children aged 0-15 had a limiting long standing illness. In Medway, this would amount to 3,279 children and young people.

Research in 2012[63] estimated the extent of life-limiting and life threatening illness in children by local authority area. Figure 36 compares Medway with its statistical neighbours:

[62] Volume 1 Commissioning Guidance - Comprehensive Children's Community Nursing Services

Local Authority	Number of cases	Population	Prevalence per 10,000 population
Swindon	158	47010	33.6
Havering	177	50201	35.3
Thurrock	129	39978	32.3
Telford & Wrekin	112	46608	24
Dudley	211	69117	30.5
Rotherham	192	61885	31
Southend	137	41765	32.8
North Lincolnshire	99	38822	25.5
Medway	238	65,678 (ONS)	36.2

Figure 36 Estimated extent of life-limiting and life threatening illness

Cystic Fibrosis

Cystic fibrosis (CF) is the most common life-limiting disease in the UK, affecting about 7,700 people in England (1 in 2,500 live births)[64].

COaST carry a Medway caseload of 13 young people with CF, and also support some children registered in the Dartford and Gravesham NHS Trust area who would otherwise have to travel to London for care (which could result in increased exposure to infection).

Cancer

Cancer in children is rare. About one in 600 children develops a cancer by age 15 years. There are approximately 1,400 new cases of cancer among children 0-15 years in the UK each year; an annual incidence rate of approximately 1:7700.[65]

Most of the cancers affecting children differ from those affecting adults. Treatment is frequently complex and intensive but cure rates among children are much higher than for most adult cancers, and overall more than 80% of children are completely cured. A significant proportion of these will experience long-term side effects from their treatment.[66]

Across the 0-19 age range, the highest incidence of cancer is among children 0-4 years, reducing among children 5-14, and rising again among teenagers over 15 years. The incidence of childhood cancer in each region is similar to across the UK. The literature suggests a plateau had been reached in childhood cancer incidence rates from the mid-1990s onwards.[67]

COaST carries a caseload of 10 Medway children suffering from cancer & leukaemia.

[63] Fraser LK, Parslow RC, McKinney PA, Miller M, Aldridge JM, Hain R, Norman P (2012) Life-limiting and life-threatening conditions in children and young people in the United Kingdom
[64] NHS England
[65] Specialised Commissioning Team, NHS England July 2015
[66] ibid
[67] Ibid.

Continuing Care

A continuing care package will be required when a child has needs arising from a disability, accident or illness that cannot be met by existing universal or specialist services alone. A continuing care package will include a range of service commissioned by the NHS and local authorities.

Eleven children with complex medical needs are currently receiving packages of care from COaST, at a projected 2015/16 cost of £736,771. Six of the children require long term ventilation via tracheostomy (see 'Trends' below).

Children and young people who are in residential placements and in receipt of tri-partite funding

Currently ten children are in receipt of tri-partite funding from the Medway CCG Continuing Care budget, and Medway Children's Social Care and Education budgets, at a projected total annual cost of over £1.6 million. The health element amounts to £346,645, compared to £860,751 for children's social care and £557,344 for education.

Seven of the ten have a diagnosis of Autistic Spectrum Disorder, and five have mental health difficulties. The Department of Health is currently consulting on the Framework for Children and Young People's Continuing Care, which intended to provide revised guidance for CCGs and local authorities on the process for assessing, deciding and agreeing packages of continuing care for children and young people

Impact of disability and illness

The functional impacts of disability, illness and impairment on the daily life of children and young people are varied in terms of their severity and longevity. At the time of writing, Medway Council is tendering for 'short breaks' provision for disabled children. Providers have been given the following illustrative levels of need that the range of services will encompass:

Children and young people accessing *universal* services may have

- Some limitations of function or poor coordination
- A known controlled health condition which causes minor disruption to daily tasks
- Some difficulty in meeting their personal care needs
- Occasional seizures
- Behaviours that can be difficult to manage at all times

Children and young people accessing targeted services may

- Be unable to walk without aids and unable to manoeuvre and / or transfer without support
- Have health needs that have a significant impact on their development and learning
- Require assistance from others for all their personal care
- Have regular seizures that impact on their learning and development

- Have challenging behaviours that impact significantly on their life in the community and require specialist provision to enable them to function socially and / or educationally
- Require greater supervision than other children of the same age

Children and young people accessing *specialist* services may

- Be dependent on others for support with all their personal care
- Have complex health needs that prevent them from participating in social and educational activities
- Have severe challenging behaviours that impact on all aspects of their functioning or poses a significant risk to themselves or others
- Need constant supervision and doesn't perceive danger to themselves or others
- Be unable to walk and use a wheelchair or is fully dependent on others for mobility
- Have seizures in frequent succession that cannot be controlled by medication

The numbers of children and young people falling into each category are currently unknown.

Referral and caseload information can give an indication of the main support needs of disabled children and young people.

The Special Needs nursery staff provide advice, support and implement child centred programmes in relation to:

- Toileting
- Behaviour
- Cognition
- Social skills
- Communication aids
- Sensory
- Physical development
- Speech and language/communication
- Play skills
- Visual and hearing impairments

And can provide support and care in relation to:

- Gastrostomy
- Oxygen therapy
- Tracheostomy
- Epilepsy
- Asthma

The main reasons for referral to the Learning Disability Nursing Team were for support for behavioural issues (50%), sleeping problems (38%) and issues with toileting/continence (13%). Support was also sought after diagnosis, and around diet and personal safety/sexualised behaviour.

Functional difficulties can have a major negative impact on the lives of individual children, and on their families, not only in terms of physical health but in relation to emotional well being. Support from allied health, social care and education professionals post diagnosis and assessment is key to maintaining family life as well as to the overall health of the child.

12. Trends

- Recent clinical advances in Neonatal and Paediatric Intensive Care have increased the incidence of survival of children with life threatening or life limiting conditions. Over the same period technological advances have produced a range of portable, easy to maintain, reliable and efficient mechanical ventilators. As a result, children who have long-term breathing difficulties needing either temporary or permanent ventilatory assistance have an increased potential for survival and a consequent rise in demand for appropriate services

- EPICure[68] is a series of studies of survival and later health among babies and young people who were born at extremely low gestations – from 22 to 26 weeks. EPICure has found that survival for births of 24 and 25 weeks rose significantly between 1995 and 2006. Children born at extremely low gestational ages face a range of risks as they grow up (although for half of the children there are no health problems or only minor problems)

    - *Cerebral Palsy*
      Although the chances of cerebral palsy at around 20% are relatively high compared to the normal population (2-4 per 1000 births), most children with cerebral palsy have mild associated disability and attend mainstream school, with only 7% have severe associated problems
    - *Learning Difficulties*
      A large proportion of children will need some help at school – around 2 in 3 in our study, although the proportion who go to special schools is only around 1 in 8. The main problems seem to be associated with attention in the classroom (not usually hyperactivity), and problems with short-term or working memory and slow processing of information
    - *Behaviour*
      Overall behaviour problems are found in just over 1 in 4 children. Inattention remains the commonest problem for extremely preterm children, and some children get anxious and worried with this.
    - *Chest problems*
      Extremely preterm children tend to have more chestiness than their full term classmates which is related to asthma, and children take more medicines to help prevent wheeze and cough. This seems to be because the lungs have difficulty in reaching their full development after such early births. Major illness with chest problems decreases as the child grows up.

[68] http://www.epicure.ac.uk/

- Although the population of older people is rising, the percentage with a limiting illness is decreasing. Conversely, the percentage of children with disabilities/life limiting illness is increasing. Generational health improvements have mitigated the effects of population ageing, meaning that the population rate of sickness fell between 1980 and 2008. Planning based only on age leads to overestimation of the population level of health care need if successive cohorts are becoming healthier[69]

- The Children and Young People's Health Forum has conducted a recent review of children and young people's health outcomes for the Chief Medical Officer, in response to a recommendation from her, which found:
    - Improvement in child and adolescent mortality has been less in the past 40 years than in comparable developed countries which puts us towards the bottom of countries in the European Union
    - There are worrying negative trends e.g. emergency department attendances among children and young people have risen by 40% over recent years and hospital admissions for common childhood conditions such as infant feeding difficulties, for bronchiolitis and self-harm have also risen significantly; and
    - Whilst there have been some improvements in areas such as teenage pregnancy conception rates, smoking during pregnancy and deaths of young people due to road traffic accidents, the top line outcome data still masks inequalities within our country and often do not compare favourably to other nations and health systems
    - The Forum is also concerned about the rising use of urgent/emergency healthcare among all age groups, in particular those with long term conditions.

[69] Exploring the limitations of age-based models for health care planning
Thomas Mason, Matt Sutton, William Whittaker, Stephen Birch Centre for Health Economics Manchester 2015

Appendix 1: Statistical Neighbours

Statistical neighbours provide a method for benchmarking progress.

For each local authority (LA), the Department for Education designate a number of other LAs deemed to have similar characteristics. These designated LAs are known as statistical neighbours. The National Foundation for Educational Research (NFER) was commissioned in 2007 by the Department to identify and group similar LAs in terms of the socio-economic characteristics, each LA was assign 10 such neighbours.

Statistical neighbours currently identified (via the Local Authority Interactive Tool) are

- Dudley
- Swindon
- Havering
- Northamptonshire
- North Lincolnshire
- Thurrock
- Southend-on-Sea
- Rotherham
- Kent
- Telford and Wrekin

A group of 'most similar' CCGs, have been identified by NHS England, Public Health England and NHS Right Care as part of the Commissioning for Value programme. They are

- NHS Dartford, Gravesham and Swanley CCG
- NHS Basildon and Brentwood CCG
- NHS Greater Huddersfield CCG
- NHS Hartlepool and Stockton-On-Tees CCG
- NHS Telford and Wrekin CCG
- NHS Swale CCG
- NHS Swindon CCG
- NHS Redditch and Bromsgrove CCG
- NHS Warrington CCG
- NHS Bedfordshire CCG

Appendix 2: Glossary

ADHD

ADHD is a behavioural disorder which often becomes obvious in early childhood. The behaviours are due to underlying problems of poor attention, hyperactivity and impulsivity Children with ADHD can have other problems such as learning difficulties, Autism, conduct disorder, anxiety and depression. Neurological problems like tics, Tourette's, and epilepsy can also be present. Children with ADHD can have problems with coordination, social skills and seem to be disorganised (Royal College of Psychiatrists)

Autism

The term autism describes qualitative differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and rigid and repetitive behaviours, often with a lifelong impact. In addition to these features, children and young people with autism frequently experience a range of cognitive, learning, language, medical, emotional and behavioural problems, including: a need for routine; difficulty in understanding other people, including their intentions, feelings and perspectives; sleeping and eating disturbances; and mental health problems such as anxiety, depression, problems with attention, self-injurious behaviour and other challenging, sometimes aggressive behaviour. These features may substantially impact on the quality of life of the individual, and their family or carer, and lead to social vulnerability.[70]

Batten's Disease

The group of diseases known as Batten disease or the neuronal ceroid lipofuscinoses (NCLs) are rare genetic disorders of the nervous system. These are serious conditions that shorten the lifespan of those affected. Symptoms include loss of vision, epilepsy and loss of abilities, including walking, eating and talking.

Cerebral Palsy

Cerebral palsy is the general term for a number of neurological conditions that affect movement and co-ordination.

Specifically, cerebral palsy is caused by a problem in the parts of the brain responsible for controlling muscles. The condition can occur if the brain develops abnormally or is damaged before, during or shortly after birth.

The symptoms of cerebral palsy normally become apparent during the first three years of a child's life.

The main symptoms are muscle stiffness or floppiness, muscle weakness, random and uncontrolled body movements and balance and co-ordination problems. These symptoms can affect different areas of the body and vary in severity from person to person. Some people will only have minor problems, whereas others will be severely disabled.

Many people with cerebral palsy also have a number of associated problems, including repeated seizures or fits, drooling problems and swallowing difficulties. Some people with

[70] NICE/SCIE guidance 'The management and support of children and young people on the autistic spectrum'

the condition may have communication and learning difficulties, although intelligence is often unaffected.

Obsessive Compulsive Disorder (OCD)
A mental health condition where a person has obsessive thoughts and compulsive activity.

Cystic Fibrosis (CF)
Cystic fibrosis is an inherited disease caused by a faulty gene. This gene controls the movement of salt and water in and out of cells, so the lungs and digestive system become clogged with mucus, making it hard to breathe and digest food. There is currently no cure for cystic fibrosis but treatments are available to manage it, including physiotherapy, exercise, medication and nutrition.

Developmental co-ordination disorder (DCD) (also known as dyspraxia)
This is a condition affecting physical co-ordination that causes a child to perform less well than expected for his or her age in daily activities and appear to move clumsily. Early developmental milestones of crawling, walking, self-feeding and dressing may be delayed in young children with DCD, and drawing, writing and performance in sports are usually behind what is expected for their age.

The problem is not due to general delays in development or a learning disability, and is not caused by cerebral palsy or another neurological disorder (conditions affecting the nervous system).

Although signs of the condition are present from an early age, children vary widely in their rate of development and DCD is not usually definitely diagnosed until a child with the condition is around five years old or more.

Down Syndrome
Down syndrome, also known as Down's syndrome, is a genetic condition that typically causes some level of learning disability and characteristic physical features. Around 775 babies are born with the condition each year in England and Wales. All children with Down's syndrome have some degree of learning disability and delayed development, but this varies widely between individual children. Around one in every 10 children also experience additional difficulties such as autism spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD).

Dyscalculia
This is a specific learning difficulty affecting the ability to make sense of and work with numbers.

Dyslexia
Dyslexia is a common learning difficulty that mainly affects the way people read and spell words. Itis a spectrum disorder, with symptoms ranging from mild to severe and is thought to affect an estimated 1 in every 10 people in the UK to some degree (NHS England).

Endocrinology
Speciality concerned with hormone under and over production

End-of-life care
This is the care of a person during the last part of their life, from the point at which it has become clear that the person is in a progressive state of decline.

Epilepsy
Epilepsy is a common serious neurological condition where there is a tendency to have seizures that start in the brain. Epilepsy is most commonly diagnosed in children and people over 65, and there ar eover 40 different types.

Foetal Alcohol Syndrome (FAS)
Children with FAS have problems with their neurological development, abnormal growth, and have characteristic facial features which result from their foetal exposure to alcohol Neurological problems are caused by damage to the central nervous system (brain and spinal cord). The problems experienced are likely to change as an infant grows up and different problems may be seen at different stages of development, from childhood, adolescence, and into adulthood.

These may include: learning disabilities, poor academic achievement, poor organisation, lack of inhibition, difficulty writing or drawing, balance problems, attention and hyperactivity problems.

Fragile X syndrome
Fragile X syndrome is the most common identifiable cause of inherited intellectual disability. It arises from changes on the X chromosome in a specific gene that makes a protein necessary for brain development. Boys are usually more severely affected than girls as they have only one X chromosome. The main feature is intellectual disability. This can range from very minor, so that the person has a normal IQ and shows no sign of fragile X syndrome, to severe intellectual difficulty.

Other problems include delayed and distorted speech and language development. There can be difficulties with the social use of language and speech. There may also be repetitive behaviour, attention deficits and overactivity. In some individuals there may be evidence of autistic-like features, such as poor eye contact, hand flapping, social anxiety, abnormal shyness and an insistence on routine. Thirty per cent of people with fragile X syndrome develop epilepsy.

Global Developmental Delay:
A child may be described as having global developmental delay (GDD) if they have not reached two or more milestones in all areas of development (called developmental domains). These areas are:

- Motor skills - either gross motor skills like sitting up or rolling over and fine motor skills, for example picking up small objects
- Speech and language - which also includes babbling, imitating speech and identifying sounds, as well as understanding what other people are trying to communicate to them

- cognitive skills - the ability to learn new things, process information, organise their thoughts and remember things
- Social and emotional skills - interacting with others and development of personal traits and feelings, as well as starting to understanding and respond to the needs and feelings of others

Haemotology
Diagnosis and treatment of diseases of the blood

Hemiplegia
Hemiplegia (sometimes called hemiparesis) is a condition that affects one side of the body. It is caused by injury to parts of the brain that control movements of the limbs, trunk, face, etc. This may happen before, during or soon after birth (up to two years of age approximately), when it is known as congenital hemiplegia (or unilateral cerebral palsy), or later in life as a result of injury or illness, in which case it is called acquired hemiplegia.

One child in 1,000 is born with hemiplegia, making it a relatively common condition. About 80% of cases are congenital, and 20% acquired.

Henoch-Schonlein Purpura
Henoch-Schönlein purpura (HSP) is a rare condition in which blood vessels become inflamed. It typically results in a rash and joint and stomach pain.HSP can affect people of any age, but the majority of cases occur in children under 10.

Heparin
Heparin is used in the treatment and prevention of blood clots.

Hirschsprung's disease
Hirschsprung's disease (HD) is a disease of the large intestine that causes severe constipation or intestinal obstruction

Hypermobility
Hypermobility is the term used to describe the ability to move joints beyond the normal range of movement. In many people joint hypermobility is of no medical consequence and commonly does not give rise to symptoms For a small percentage of the population hypermobility may be associated with joint and ligament injuries, pain, fatigue and other symptoms.

Insulin Pumps
Insulin pumps are portable devices attached to the body that deliver constant amounts of rapid or short acting insulin via a catheter placed under the skin. They are seen as a better alternative to insulin injections as they reduce the need for multiple insulin jabs per day and give the user increased ability to control blood glucose levels. Around 1 in 1,000 people with diabetes wears an insulin pump.

Infantile parkinsonism

Infantile parkinsonism is a progressive disease causing unsteadiness and severe difficulties with movement

Juvenile arthritis
Most types of childhood arthritis are known as juvenile idiopathic arthritis (JIA). JIA causes pain and inflammation in one or more joints for at least six weeks.

Life-threatening
A life-threatening disease is a disease that is potentially fatal, likely to result in imminent death. It includes conditions caused by both natural (e.g. infective) and unnatural (e.g. trauma) factors. Children with life-limiting illnesses may also develop life-threatening complications that are mostly responsible for their death.

Life-limiting
A life-limiting illness is an illness which may not be immediately life threatening but which imposes limits on a person's quality and/or quantity of life.

LOS
Length of Stay

Long term condition
Defined by DH as "those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. The life of a person with a LTC is forever altered – there is no return to 'normal'."

Mucopolysaccharide Diseases
Mucopolysaccharide and related Lysomal Storage Diseases are individually rare; cumulatively affecting 1:25,000 live births. One baby born every eight days will be diagnosed with an MPS or related disease. These multi-organ storage diseases cause progressive physical disability and, in many cases, severe degenerative mental deterioration resulting in death in childhood.

Multiple Dose Insulin Therapy - Multiple Daily Injections
Multiple dose injection (MDI) therapy, also known as multiple daily injections, is an alternative term for the basal/bolus regime of injecting insulin. The therapy involves injecting a long acting insulin once or twice daily as a background (basal) dose and having further injections of rapid acting insulin at each meal time.

Muscular dystrophy
The muscular dystrophies (MD) are a group of inherited genetic conditions that gradually cause the muscles to weaken, leading to an increasing level of disability. MD is a progressive condition; it often begins by affecting a particular group of muscles, before affecting the muscles more widely.

Some types of MD eventually affect the heart or the muscles used for breathing, at which point the condition becomes life-threatening. There is no cure for MD, but treatment can help to manage many of the symptoms.

Oppositional Defiant Disorder (ODD)
Tantrums and some oppositional behaviour can be part of normal development for most young children and can be an expression of boundary testing when learning social rules. In roughly five per cent of children and young people this negative behaviour is severe, persistent and enormously challenging and may involve serious and repeated rule breaking and aggressive behaviour, which is often disturbing to others. Family relationships can become strained and school progress may be affected. Conduct disorder (CD) and oppositional defiant disorder (ODD) are the diagnostic terms for those types of long-lasting, aggressive and defiant behaviours that are extreme.

Paraplegia
Paralysis of the legs and lower body, typically caused by spinal injury or disease.

PEG tube
Percutaneous endoscopic gastrostomy is a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and oesophagus.

Perthes' disease
Perthes' disease is a condition where the top of the thigh bone in the hip joint (the femoral head) softens and breaks down. It occurs in some children and causes a limp, pain and stiffness. The bone gradually heals and reforms as the child grows.

Portage
Portage is a home-visiting educational service for pre-school children with additional support needs and their families.

Quality and Outcomes Framework (QOF)
A voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results.

Scoliosis
Scoliosis is the abnormal twisting and curvature of the spine.

Sensory processing difficulties
Difficulty in taking in, integrating and making use of sensory information. This can affect the ability to learn as well as the development of behaviour, social and motor skills.

SEN Support
Extra or different help is given from that provided as part of the school's usual curriculum. The class teacher and SEN Coordinator (SENCO) may receive advice or support from outside specialists. This category replaces the former 'School Action' and 'School Action Plus' categories.

Sickle cell anaemia
Sickle cell anaemia is a serious inherited blood disorder where the red blood cells, which carry oxygen around the body, develop abnormally.

South East Coast Strategic Clinical Network (SECSCN)
Strategic Clinical Networks (SCNs) work in partnership with commissioners (including local government), providing clinical advice and leadership to support their decision making & strategic planning.

Spina Bifida
A fault in the development of the spinal cord and surrounding bones (vertebrae), leaving a gap or split in the spine.

Statement/ EHC plan
A pupil has a statement of SEN or an EHC plan when a formal assessment has been made. A document is in place that sets out the child's needs and the extra help they should receive.

Tracheostomy
A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to aid breathing.

Type 1 Diabetes
Around 10% of all diabetes is type 1. In type 1 diabetes, the pancreas (a small gland behind the stomach) does not produce any insulin, the hormone that regulates blood glucose levels. Type 1 diabetes can develop at any age, but usually appears before the age of 40

Appendix 3: Data Sources

Source	Type	Link
CHIMAT	Disability Needs Assessment by LA	http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=46&geoTypeId=
CHIMAT	Improving Services Toolkit: Improving acute and community services for children and young people who are ill. The toolkit examines emergency hospital admissions for children with common childhood conditions, such as respiratory and gastric conditions. It also looks at how long children spend in hospital, and presents similar information specifically for children who have complex conditions such as congenital heart conditions, cerebral palsy or metabolic disorders. Information is presented by CCG area.	http://www.chimat.org.uk/ISTOOLKIT
Department for Education	Early Years foundation stage profile results 2013-14 at national and LA level	https://www.gov.uk/government/statistics/early-years-foundation-stage-profile-results-2013-to-2014
Department for Education	Special educational needs in England, January 2015. Information from the school census.	https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2015
Department for Work and Pensions	Family Resources Survey – an annual report that provides facts and figures about the income and living circumstances of household and families in the UK	https://www.gov.uk/government/collections/family-resources-survey--2
Health & Social Care Information Centre (HSCIC)	Number of patients registered at a GP Practice by single year of age (SYOA), gender, and in 5-year age bands	http://www.hscic.gov.uk/article/2021/Website-Search?productid=18318&q=ccg+code&sort=Relevance&size=10&page=1&area=both#top
HSCIC	Accident and Emergency Attendances	http://www.hscic.gov.uk/catalogue/PUB13464

	in England 2012-13	
HSCIC	Health Survey for England 2011, Health, social care and lifestyles	http://www.hscic.gov.uk/catalogue/PUB09300
National Child and Maternal Health Intelligence Network (CHIMAT)	Child Health Profiles by LA and CCG	http://atlas.chimat.org.uk/IAS/dataviews/childhealthprofile
NHS England	Commissioning for Value data packs and online tools for CCGs	http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/
Office of National Statistics (ONS)	Population estimates	http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/2013/sty-population-estimates.html
Public Health England	Child Health Profile by LA	http://atlas.chimat.org.uk/IAS/dataviews/report/fullpage?viewId=493&reportId=535&geoId=4&geoReportId=4618
Public Health England	Children and young people's health benchmarking tool	http://fingertips.phe.org.uk/profile/cyphof
Public Health England	Learning Disability Profiles	http://fingertips.phe.org.uk/profile/learning-disabilities/data
Public Health England/CHIMAT	Disease Management Information Toolkit: information at CCG level on emergency hospital admissions for patients aged under 19 years with a primary diagnosis of asthma, diabetes or epilepsy, including emergency admission rates, bed days and lengths of stay against a range of different comparators.	http://www.chimat.org.uk/default.aspx?QN=CHMTDMIT

Key:

MC	Medway Council
MCCG	Medway Clinical Commissioning Group
MFT	Medway Foundation Trust
MCH	Medway Community Healthcare
NHSE	National Health Service England

Appendix 4: Services in Medway for children and young people with long term conditions/complex health needs

Service	Description	Age range	Universal, Targeted, Specialist?	Provider	Commissioner
0 – 25 Disability Team	Social work team working with children and young people who have a severe and profound learning, physical or sensory disability/long-term, complex medical needs/life-limiting or threatening illnesses. Assessment and provision of social work support including non-medical care including equipment for daily living, access to respite. . Many cases held within the Disability 0 – 25 Team are provided with direct payments and/or respite services only. For these cases a decision has been made that reviews will be held on an annual basis instead of the current six monthly review. These cases will be referred to as 'Enablement' and will not have an allocated social worker or regular social worker visits.	0 - 25	S	MC	n/a
Acute specialisms	Cardiology, ear, nose & throat, endocrinology, gastroenterology, haematology, immunology, metabolic disorders, nephrology, neurology, respiratory, rheumatology, paediatric surgery, urology	0 - 16	S	MFT	MCCG
Allergy clinic	Only NHS allergy service in Kent. Weekly clinics	all	T	MFT	MCCG

Service	Description	Age range	Universal, Targeted, Specialist?	Provider	Commissioner
	for both adults and children.				
Blood tests for children	Drop in or booked appointment – latter preferred to avoid distressing child while waiting		T	MCH	MCCG
Children's Emergency Department	Dedicated waiting and treatment area for children, open from 8am until midnight daily and staffed by children's nurses with the support of A&E doctors	0 - 15			
Children's Outreach and Specialist Team (COaST)	Hospital based team of specialist nurses providing a service to children with life limiting/life threatening/complex conditions in their own homes	0-18 (over 18 in some cases)	S	MFT	MCCG
Community Nursing Team for children and young people with learning disabilities	Community nursing service for children and young people who have been diagnosed with a moderate/severe or profound and multiple learning disabilities.	0 - 18	S	MFT	MCCG
Community Paediatrics	Specialist child health assessment and diagnostic service; formulation of management plans, provision of the needs of patients with complex medical needs and multiple clinician involvement	First year of life to 18 years. Up to age 19yrs if in a special school	T,S	MFT	MCCG
Continence advisor	The continence advisor is able provide support to children over the age of four with bladder or bowel dysfunction. Promote continence and manage incontinence by providing written information, education, treatment, management and support to children, their families and to staff responsible for their care. (health visitors are able to provide advice and support for children under four)	4+	T	MCH	MCCG
Dermatology	Dermatology clinics for adults and children with eczema, psoriasis, acne, solar keratosis, long	All	T,S	MCH	MCCG

Service	Description	Age range	Universal, Targeted, Specialist?	Provider	Commissioner
	standing warts and verrucas. Diagnostic biopsies and cryo surgery are also undertaken.				
Dermatology	The dermatology department offers a full range of dermatology services in a purpose built, dedicated unit, run by a team of specialist clinicians – includes paediatric clinic	All	T,S	MFT	MCCG
Educational Child and Community Psychology Service (ECCPS)	ECCPS supports the learning, social, emotional and behavioural development (SEBD) and mental health needs of children and young people, and psychologists have specialist skills in areas such as autism, hearing and visual impairment, speech and language and behaviour. The team offers support to schools on a wide range of issues at individual, group and whole school level and also work with children, young people, schools, families and other professionals in a range of contexts within the community.	0 - 25	U,T,S	MC	N/A
Dolphin Ward	Medical, orthopaedic, surgical and ear, nose and throat (ENT) ward	0 - 16	S	MFT	MCCG
Family Nurse Partnership	Intensive, structured, home visiting programme, which is offered to first time parents under the age of 18. A specially trained family nurse visits the mother regularly from early pregnancy until the baby is 2 years old	Under 18	S	MCH	NHSE (on behalf of the Secretary of State) until October 2015 then MC Public Health Directorate
Foetal Medicine	The foetal medicine service at Medway is run in partnership with the Harris Birthright Centre (Kings) and runs a weekly consultant-led clinic for all suspected and confirmed foetal abnormalities		S	MFT	MCCG
Health Visiting	Lead the delivery of the 0-5 Healthy Child Programme: includes breast feeding,	0-5	U,T,S	MCH	Public Health Directorate, MC,

Service	Description	Age range	Universal, Targeted, Specialist?	Provider	Commissioner
	immunisations, behavioural management, mental health, healthy diet and lifestyle, child development and assessment, parenting. The Universal Partnership Plus level of the service requires health visitors to play a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.				from October 2015
Looked After Children's Health Team	Health assessments and follow ups for LAC. Includes care leaver nurse.	0 – 25	S	MFT	MC/MCCG
Midwifery	Perinatal care for mother and child	Pre birth to 6 weeks	U,T,S	MFT	MCCG
Nutrition and Dietetics	See children who have complex needs in addition to their nutritional needs and who are seen by at least one other member of the children's therapy team. includes those who have:- epilepsy, cerebral palsy, Autism, genetic conditions or syndromes and or learning difficulties in addition to a nutritional problem and/or poor growth. These children often cough, gag or choke on food or drinks, have recurrent chest infections, are extreme fussy eaters, or have poor or excessive weight gain. Do not see normally developing children who are overweight, have allergies or intolerances, children with cystic fibrosis or diabetes (community paediatric service supports these children).		T,S	MCH	MCCG
Occupational Therapy (Hospital)	Service to in patients	All	S	MFT	Medway CCG
Occupational Therapy	OT service with 2.65 WTE staff. 2 staff focus on	0 - 25	T/S	Medway	Medway Council

Service	Description	Age range	Universal, Targeted, Specialist?	Provider	Commissioner
(children's social care)	equipment/adaptations, 1 on re-ablement.			Council	
Occupational Therapy (Community)	Work with children who have difficulties with the practical and social skills necessary for their everyday life including motor co-ordination difficulties, visual motor integration difficulties (the ability to combine the understanding of what is seen with fine motor/pencil skills), visual perceptual difficulties (the ability to recognise, interpret and understand what is seen), sensory processing difficulties, autism spectrum disorders, attention deficit/hyperactivity (ADD/ADHD), complex/moderate/mild physical disabilities, developmental delay	0 – 18	T, S	MCH	MCCG Schools
Oliver Fisher Special Care Baby Unit	For babies born prematurely or who are sick and need intensive care; 26 cots including 8 intensive care cots. Babies may stay under the care of the neo-natal department for as long as 18 months.	0 – 18 months	S	MFT	MCCG
Penguin Assessment Unit	Hospital ward - medical and nursing assessment and care	0 - 16	S	MFT	MCCG
Physical and Sensory Service (PASS)	Specialist teachers aiming to provide the earliest possible intervention to inform and advise on access to learning opportunities in the home environment, early years settings and schools for children with hearing, visual and physical impairments – provision ranges from weekly home visits to annual monitoring visits in schools. The team consists of qualified education professionals including teachers holding the mandatory qualifications to work with children with hearing and visual impairments. PASS supports the transition process when pupils move from school to HE and FE colleges, the workplace and care in	0 - 25	S	MC	N/A

Service	Description	Age range	Universal, Targeted, Specialist?	Provider	Commissioner
	the community.				
Physiotherapy (community)	Conditions seen by the team may include orthopaedic and rheumatological, acute injuries e.g. fractures, sports injuries neurological conditions e.g. cerebral palsy, head injury, neuromuscular disorders e.g. muscular dystrophy, developmental delay, congenital disorders e.g. spina bifida, limb deficiencies, congenital syndromes and metabolic diseases and other conditions where mobility is affected e.g. oncology	0-19	T, S	MCH	MCCG
Physiotherapy (acute)	Service to inpatients in Medway Maritime Hospital	All ages	S	MFT	MCCG
Podiatry	The paediatric podiatry service accepts referrals for any child that has a condition affecting their lower limb. This includes children with a hemiplegia who have leg length differences.		T	MCH	MCCG
Portage	Home-visiting educational service for pre-school children with additional needs and their families	0 - school age	T	MC	n/a
Portage Sensory Service	Education sessions (massage, swimming, yoga) for pre-school children with sensory difficulties	0 to school age	T	MC	n/a
School Nursing	School nurses will support pupils with chronic health issues, for example epilepsy, asthma and severe allergy and assist school in developing individual care plans to meet the needs of the children/young people. Where additional health needs are identified, school nurses ensure they receive an early response, including appropriate referral to specialist services and signposting to other agencies as per the relevant pathway.	5-19	U, T, S	MFT	Public Health Directorate MC

Service	Description	Age range	Universal, Targeted, Specialist?	Provider	Commissioner
Special Needs Nursery	Pre-school sessions and assessment for young children with moderate/severe learning disabilities and additional healthcare needs	18m to 5 years	S	MFT	MCCG
Speech and Language Therapy, children under five	Assessment and support to children with speech, language, communication or swallowing difficulties.	0-4	T, S	MCH	MCCG
Speech and Language Therapy, school age children	Assessment and support to children with speech, language, communication or swallowing difficulties.	5-18	T, S	MCH,	MCCG and MC via pooled funding, schools