

PSA Delivery Agreement 12: Improve the health and wellbeing of children and young people

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VISION

1.1 The Government is committed to improving the physical, mental and emotional health and wellbeing of children and young people from conception to adulthood – for children who are in relatively good health, those particularly vulnerable to poor health outcomes, and those who are disabled, as well as those who are ill.

1.2 Children and young people are healthier now than ever but inequalities persist. There has been a sharp increase in child obesity and rates of mental health disorders remain worryingly high. Tackling this means helping children, young people and families to make healthy choices. There must be a focus on prevention and early intervention, based on evidence of effective practice and support designed around the needs of children and young people.

1.3 A healthy pregnancy, a normal, healthy birth and a strong bond between a baby and its parents are a vital start in life. Once a baby is born, breastfeeding offers long term emotional, physical and mental benefits to mother and child. The Government wants to see the level of breastfeeding at six weeks as high as possible with parents getting help with breastfeeding and other aspects of parenting and health from health visiting and midwifery teams and General Practices.

1.4 Children's Centres have a key role in delivering good health outcomes. This includes health services provided by health visitors and their teams who provide guidance, support, health protection, promotion and surveillance to all children and families as well as the more general role of Children's Centre staff in promoting healthier lifestyles for children, particularly those at significant risk of becoming obese. This will support the Government's aim to make a significant impact on obesity among children under 11 over the CSR period. Children's Centres will also have a role in providing early identification and support, particularly important for disabled children.

1.5 As children go through school, they take more responsibility for their own health. All schools should work to meet high standards for accreditation as Healthy Schools over the CSR period, providing healthy food, encouraging physical activity,¹ and providing learning about health² as part of a healthy school environment.

1.6 Schools will also promote emotional health and resilience and by 2011 all schools will offer access to extended services which may include health or therapy services on site. Local authorities and the NHS will work together to ensure specialist services, such as child and adolescent mental health services (CAMHS), respond to the needs of children with a disability or mental health problem and enable them and their families to participate in an inclusive society and achieve their full potential.

1.7 Adolescence brings new challenges with increased exposure to risky health behaviour. The PSA to *Increase the number of children and young people on the path to success* (PSA 14), aims to help young people make healthy choices as they grow up to become adults and, potentially, parents themselves.³ It is important that they continue to lead a healthy lifestyle into adulthood. Parents who have healthy lifestyles help

¹ See also PSA 22.

² Information on Healthy Schools is at <http://www.healthyschools.gov.uk>.

³ PSA 14 includes indicators on teenage pregnancy and substance misuse.

ensure their children avoid health problems and stay physically, mentally and emotionally healthy.

1.8 The Secretary of State for Children, Schools and Families is leading a national consultation to develop a Children's Plan. This Delivery Agreement will be reviewed and updated following publication of the plan.

2

MEASUREMENT

2.1 This PSA provides a focus on five key areas, whilst highlighting the need to support the health and well-being for all children and young people. The Government will use five mutually-reinforcing indicators to monitor developments that impact on all children's health and the quality of support for disabled children and children with mental health needs. Fuller descriptions are at Annex A.

Indicator 1: Prevalence of breastfeeding at 6 – 8 weeks

- In 2005, 78 per cent of mothers began breastfeeding but only 64 per cent were still breastfeeding six weeks later. Given the significant long-term health benefits, the Government would like to see levels of breastfeeding prevalence at six to eight weeks as high as possible.¹

Indicator 2: Percentage of pupils who have school lunches

- For many children, especially those entitled to free school meals (FSM), the school lunch may be their only nutritious, cooked meal. National take up of school lunches in April 2006 was just over 42 per cent. The Government has asked the School Food Trust to work with schools, local authorities and others to increase take up.

Indicator 3: Levels of childhood obesity

- Obesity is the most serious, and growing, health challenge for children. Between 1995 and 2005, obesity among boys aged 2-10 rose from 10.9 per cent to 16.8 per cent, and for girls aged 2-10 from 12 per cent to 16.9 per cent. The Government wants to make a significant impact on this problem over the CSR period, reducing the rate of increase in obesity among children under 11 as a first step towards a long-term national ambition by 2020 to reduce the proportion of overweight and obese children to 2000 levels in the context of tackling obesity across the population.

Indicator 4: Emotional health and wellbeing, and child and adolescent mental health services (CAHMS)

- Nationally 10 per cent of children aged five to fifteen have a diagnosable mental health disorder.² The Government wants to change this situation by improving the emotional health and well-being of children. For 2008/09, the Government will secure and maintain improvements in CAMHS by measuring the percentage of Primary Care Trusts (PCTs) and local authorities who together provide a comprehensive service for their area. Four proxy measures will be used: the development and delivery of CAMHS for children and young people with learning disabilities; appropriate accommodation and support for 16/17 year olds; availability of 24 hour cover to meet urgent mental health needs; and joint commissioning of early intervention support. From 2009 the intention is to replace these measures with an outcomes measure, currently being piloted, to enable CAMHS to measure the success of their work. In addition, throughout the CSR period, a

¹ For the medium term the Government will seek to develop a broader measure of health and well-being in the very early years.

² ONS, 2004.

broader measure of children's emotional well-being, gained through an analysis of a number of questions within the Tell Us 2 survey data will also be used.

Indicator 5: Parents' experience of services for disabled children and the 'core offer'

- A new indicator will be based on parents' experience of services and the 'core offer' made in *Aiming High for Disabled Children*:³ clear information; transparent eligibility criteria and process for accessing services; multi-agency assessment; participation in shaping local services; and accessible feedback/complaint mechanism. The measure will cover the families of all children with disabilities and ask about all services provided by their local authority and Primary Care Trust (PCT). By 2011, disabled young people and their parents should be able to report a more favourable experience of these services: baseline and comparison data will drive best practice and improvements.

³ *Aiming High for Disabled Children: better support for families*, HMT/DfES, May 2007. The AHDC report makes a commitment that every local area will make a "core offer" policy statement to its customers. This form of parents charter will provide a simple, clear explanation of what parents can expect to receive in their local area in terms of information, transparency, participation, assessment and feedback, to make it clear what entitlements and services disabled children, young people and their families can expect.

3

DELIVERY STRATEGY

3.1 The delivery strategy for this PSA focuses on:

- prevention – helping children and families lead healthy lifestyles;
- early intervention – identifying risks and difficulties early and offering help promptly; and
- effective support from practitioners.

Priorities 3.2 This puts a premium on partners working together at all levels to recognise the importance of children and young people’s health; to engage children, young people and families in making healthy choices and the planning of services; to assess need; to plan and design safe, innovative, high quality, evidence-based and sustainable services; and to incentivise the use of proven good practice in improving outcomes. Specific priorities are:

- empowering children and families to meet their own health goals;
- ensuring all services that work with children, young people and families promote and support good health outcomes for them; and
- delivery priorities:
 - increasing breastfeeding at six to eight weeks;
 - increasing uptake of school lunches;
 - reducing childhood obesity;
 - improving emotional health and well-being, and child and adolescent mental health services (CAMHS); and
 - improving services for disabled children.

Delivery 3.3 The Secretary of State for Children, Schools and Families is responsible for coordinating delivery of this PSA, with the Secretary of State for Health the key partner. The Department for Children, Schools and Families (DCSF) and the Department of Health (DH) will jointly lead action across Government and liaise with other Government departments as appropriate. DCSF and DH will each take action to prioritise child health and wellbeing, to reflect the contents of this and other relevant PSAs¹ in their Departmental planning and in the Operating Framework for the NHS, and to carry through these priorities into their discussions with local delivery partners. They will act jointly to:

- set out priorities and accountabilities through this and related Delivery Agreements for other PSAs;
- set the performance system and accountability framework and report on national progress against outcomes;

¹ Especially PSAs 10, 11, 13, 14, 18 and 22.

- review the levers of health and children's services reform to ensure they support an increased focus on the health and wellbeing of children and young people;
- develop a national coalition of interests with statutory and Third Sector partners who need to work together to drive progress;
- agree how departmental resources should be used to support the PSA, including the funding and sponsoring of delivery bodies that deliver specific aspects of the PSA, and influencing local decisions to ensure services provide value for money and identifying the potential for productivity gains;
- develop the evidence base of effective health promotion, support and intervention to improve children's health, building the data and information base and sharing good practice to support effective needs assessment, commissioning and innovation;
- develop the communication and information strategy for all parts of the delivery chain so that all involved understand their role in, and the importance of, improving the health and wellbeing of children and young people;
- set the framework for the priorities, deployment and capacity of the children's health and wellbeing workforce; and
- develop effective communication with children, young people and parents so that they understand the importance of health and wellbeing to their lives, where to get advice and support, and how they can influence the design and delivery of services.

3.4 The two departments will work with other partners across Government to ensure that high quality prevention, targeted early intervention and support reduce the risk factors associated with poorer health outcomes and prompt health improvements. This will include work to eradicate child poverty, promote healthy communities and ensuring that the local government performance management system drives health improvements.

EMPOWERING CHILDREN AND FAMILIES TO MEET THEIR OWN HEALTH GOALS

3.5 Ultimately, improving health for individuals involves changing their behaviour in some way, which in turn means understanding what a healthy choice is and being motivated to make that choice when there are less healthy options. Using the knowledge gained from past, successful experience and an understanding of how individuals can be motivated to make personal change, services, working together in each specific delivery strand, will support children, young people and their parents or carers to:

- make informed healthy choices about eating well, keeping fit and avoiding risky behaviour such as smoking, unprotected sex, and substance misuse; and
- have real influence on the services they want to support them, for instance in how they want to access health advice and information, help transform school food, or shape local services for disabled children and young people.

3.6 Much of the support that families need will be drawn from the wider family, friends, parents' groups and other third sector organisations, the media and new technologies and public services such as the Child Health Promotion Programme (CHPP). This support is crucial during pregnancy and the very early years, where the impact on the development of the child is greatest and can be particularly valued by mothers and fathers. It must be evidence-based, delivered with the right training, skills and clinical governance, and accessible and targeted on need.

Information 3.7 Information should be available through the widest range of channels that can deliver sound and consistent advice. Key national sources will include NHS Direct;² NHS Choices³ and Parents Know-How⁴ (which is designed to make information more accessible to parents through channels including websites,⁵ email and SMS, with better signposting and targeting). Improved national services will be supplemented by local authority Children's Information Services. From April 2008, local authorities will be required to provide comprehensive information to help parents in their parenting role. The Government has made a commitment to have parents' forums for families with disabled children and young people in each local authority.

ENSURING ALL SERVICES THAT WORK WITH CHILDREN, YOUNG PEOPLE AND FAMILIES PROMOTE AND SUPPORT GOOD HEALTH OUTCOMES FOR THEM

3.8 All services that work with children, young people and families need to be alert to the importance of good health. Effective health promotion and support needs to go much wider than the NHS.

3.9 At regional level, Government Offices (GOs), Strategic Health Authorities (SHAs) and Regional Directors of Public Health (RDPHs) will work together with regional sports and physical activity partnerships and other regional organisations to challenge and support progress through:

- winning support for Government priorities from local authorities, Primary Care Trusts and local delivery partners;
- optimising use of public health and wider data, for example through a children's health information unit to be based in Yorkshire and Humber Public Health Observatory from April 2008;
- leading the process of developing local priorities for children's and young people's health within the national framework set by Government;
- performance management of local delivery partners through Local Area Agreements (LAA), Children and Young People Plans (CYPP), and Local Delivery Plans (LDP);
- regional liaison on regeneration and environmental issues; and

² www.nhsdirect.nhs.uk.

³ www.nhs.uk.

⁴ If delivered Parent Know How (name may change) will fulfil the manifesto commitment to deliver a parent helpline by bringing together existing helplines, improved links with Children's Information Service and, possibly, a magazine for the hard-to-reach.

⁵ <http://www.direct.gov.uk/en/Parents/index.htm>, <http://kids.direct.gov.uk/> and <http://www.direct.gov.uk/en/YoungPeople/index.htm>.

- management and direction of regional-level support and advice services such as School Sport Partnerships and CAMHS Regional Development Workers.

LAs and PCTs 3.10 Local Authorities and Primary Care Trusts will work together through children's trust arrangements to understand the full spectrum of health needs of local children and agree how they can be met. This involves:

- identifying local priorities through:
 - views of local children, young people and families, drawing on LA participation networks, the creation of Local Involvement Networks (LINKs) and Community and Local Government's Young Advisers initiative;
 - joint strategic needs assessments to be introduced in April 2008; and
 - performance against child health indicators in the Local Government National Indicator Set and the NHS data-set.
- using their Children and Young People's Plan (CYPP) and PCT Prospectus where appropriate to set out specific priorities and actions to improve health outcomes for children and young people;
- specifying how a universal child health promotion programme will be provided;
- commissioning targeted and specialist services and care pathways within allocated resource – which should be aligned between partners or may be pooled – ensuring best value and monitoring the impact on improving outcomes;
- clarifying with local partners such as schools, children's centres, third sector and local business what role each will play in supporting children's health;
- championing the interests of children, young people and families; involving them in deciding how and where services are made available and ensuring they know what help is available and how it can be accessed; and
- influencing local planning so that local communities become healthy and sustainable environments for children and families to live in.

3.11 Primary and community health services will work with partners within the strategic framework of the CYPP, Local Area Agreements and PCT local plans to plan, commission and deliver community health services across the age range, integrated as appropriate with other services such as children's centres and schools. This will include:

- securing appropriate access to first contact care and working as an appropriate conduit to acute care;
- public health, to include delivery of the universal CHPP with a focus on prevention and early intervention; and
- disease and care management of long term conditions, including disability.

3.12 Support during pregnancy and the very early years is particularly important – this is a significant window of opportunity where parents and carers are receptive and

where the neurological development of children is most vulnerable. To ensure it is underpinned by the right skills and expertise, training and clinical governance, DH will review its standard for the CHPP and publish commissioning guidance that updates the programme in the light of new knowledge, integrates parenting support and offers support for all and more help for those that need it most.

3.13 Services should work towards the full range of 2014 development standards in the National Services Framework for Children, Young People and Maternity Services. Quality and safety will be secured through system management arrangements which will include appropriate regulation, training, licensing and contracting.

Children's Centres 3.14 Children's Centres and other early years settings should give young children a healthy start in life and offer support and advice to parents. This means:

- providing a range of integrated services which maximise children's development and outcomes and reduce health inequalities e.g. parenting and family support; promoting breastfeeding; improving opportunities for play; reducing obesity; reducing smoking in pregnancy; and reducing accidents. Particular focus will be given to the most disadvantaged families;
- when providing childcare and early education, meeting the standards of the Early Years Foundation Stage (statutory from September 2007), helping babies and young children with physical development and parents' understanding of physical activity, play and healthy food;
- early identification of developmental problems that will benefit from early help, for example speech and language therapy and weight management; and
- rolling out the Early Support Programme for disabled children and improving access to childcare for parents with disabled children.

Schools 3.15 Schools have a duty to promote the well-being of pupils, formalised in the Education and Inspections Act 2006. Well-being is defined by the Children Act 2004 and includes "physical and mental health and emotional well-being" alongside the other Every Child Matters outcomes. The Extended Schools and Healthy Schools programmes encapsulate the role schools will play. All schools will be providing access to extended services by 2010. By 2009 all schools should be working towards Healthy School status with 75 per cent having achieved accreditation. By the end of the 2007 CSR period, therefore, almost all schools will be Healthy Schools offering access to extended services and will work to promote prevention through:

- promoting healthy eating, including new statutory requirements on nutritional standards for school food;
- ensuring that all 5-16 year olds participate in two hours per week of PE sport in school;⁶
- teaching children about healthy eating and lifestyle, and other skills that promote good health through Personal, Social and Health Education (PSHE);

⁶ In addition PSA 22 will ensure that by 2012 all 5-19 year olds will have opportunities to participate in an additional three hours per week of sporting activities, through a mix of school, community and voluntary providers.

- promoting the social and emotional skills of children and young people to improve their personal resilience;
- promoting healthy and sustainable transport through initiatives such as Bikeability and walking bus;
- working with children and parents to “take health home”;
- using school nursing services for front-line advice on a range of health outcomes, from the importance of healthy eating and keeping fit to emotional problems;
- offering a varied menu of activities and childcare between 8:00 a.m. and 6:00 p.m., including sports activities, play and other recreational activities;
- offering parenting support including structured parenting programmes, information sessions e.g. encouraging healthy lifestyles; and
- providing community access including for health services.

3.16 Additionally, schools will be able to support early intervention for children who are experiencing additional challenges, through:

- identifying and assessing children who may need additional support; and
- providing swift and easy access (referral) to targeted and specialist services, including to support children with behavioural, emotional and health needs.

3.17 All schools, alongside other public sector organisations, also have a duty to promote equality for disabled children, young people and adults.

3.18 Services for vulnerable children and young people have a particular role to play in supporting good health outcomes for children in care, and those in residential special schools or in the youth justice system. A measure in the National Indicator Set will enable Local Authorities and PCTs to monitor and improve the mental, behavioural and emotional well-being of children in care in accordance with the new local government performance framework. PCTs' contribution to delivering this will be reflected in the overall CAMHS indicator in the health and social care outcomes and accountability framework being developed by the Department of Health. The children in care indicator would reflect the impact of a wide range of factors ranging from CAMHS performance, placement stability, maintaining friendships, engagement in positive activities, and avoiding substance misuse.

3.19 In 2009, the Government will publish statutory guidance for health services and local authorities on improving the health of children and young people in care, including guidance on the provision of dedicated CAMH services. The Government will also support their wider health needs through improved access to positive activities.

3.20 Third sector and community organisations play a vital and distinctive role in promoting good health for children and young people, in activities ranging from health promotion to meeting the needs of particular groups. Local communities will be engaged in promoting better health and creating a healthy environment for children and families for example through DH’s “small change, big difference” social marketing initiatives.

DELIVERY PRIORITY 1: INCREASING BREASTFEEDING AT SIX TO EIGHT WEEKS

3.21 The Department of Health will support the NHS to lead activity to promote breastfeeding, working through Children's Centres and other settings; building and sharing the evidence base to inform commissioning decisions; setting the framework which ensures services are delivered by appropriately-trained practitioners; and monitoring and reporting against national progress. Other partners will take action as follows:

- **Primary Care Trusts (PCTs):**
 - ensure action via the Child Health Promotion Programme;
 - provide adequate training to the primary care workforce to give consistent advice and support to mothers; and
 - ensure that data for the PSA indicator on breastfeeding status is collected at six-eight weeks for all mothers and reported to SHAs ensuring maximum coverage.
- **Primary and community health services - GPs, health visitors, midwives, Children's Centres:**
 - actively promote breastfeeding to mothers particularly in the antenatal period and influence decision making;
 - support mothers to continue and sustain breastfeeding by identifying problems early and offering help; and
 - listen to parents' views on whether additional networks of support are needed.
- **Third Sector (e.g. National Childbirth Trust):**
 - work in partnership with PCTs, particularly with regard to training and support to mothers through advice and helplines.

DELIVERY PRIORITY 2: PROMOTE THE TAKE UP OF FREE SCHOOL LUNCHES

3.22 The DCSF will lead action to promote the take-up of school lunches, including take up by pupils eligible for Free School Meals (FSM).

3.23 The department will continue to pursue its long-standing approach to improving take up by:

- improving the quality of school food. The School Food Trust (SFT) will provide guidance and support to local authorities, caterers and schools on how to meet the nutritional standards for food in schools which – through regulations – are being introduced in stages between 2006 and 2009;
- stimulating demand for healthier food through:
 - campaigns (with the SFT) to persuade parents and children of the merits of healthy school lunches; and to persuade local authorities, caterers and schools to play a full part in driving up demand,

including addressing non-food factors (e.g. lunchtime management, queues, dining environment etc);

- a £240m subsidy of the direct costs of providing a healthy school lunch; and
- an electronic eligibility checking system for FSM to ease the application process and increase uptake by eligible families.
- Increasing capacity to deliver transformation, with a capital investment in kitchens (including – alongside regular capital funding streams – £150m targeted capital fund in 2008-11); and development and promotion of further training and qualifications for school caterers.

3.24 Other delivery partners will:

- **School Food Trust (SFT):**
 - provide support and guidance to local authorities, caterers and schools on putting the nutritional standards into practice;
 - drive up take-up of school lunches, through targeted communications and campaigns (aimed at all stakeholders, including children and families); and guidance to schools, local authorities and caterers on what works, including engaging parents and children in the change process;
 - establish regional training centres for school caterers; and
 - monitor progress on take-up through an annual survey of local authorities and tailor support accordingly.
- **Local authorities and schools (including Healthy Schools):**
 - commission and provide school lunches; and
 - encourage take-up of school lunches, for example reviewing their school food provision and lunchtime arrangements, and schools adopting a whole school approach, including teaching children through the curriculum about healthy eating, and involving children and parents in the change process.

DELIVERY PRIORITY 3: REDUCING CHILDHOOD OBESITY

3.25 Tackling child obesity requires a major campaign across Government to change public perceptions and behaviours relating to physical activity and diet. New scientific research by the Government's Foresight project shows how action is required by a wide range of partners to counteract the effects of an 'obesogenic' environment.

3.26 DH and DCSF have dual responsibility for child obesity, liaising with other Government departments such as DCMS, CLG, Defra and DfT. In autumn 2007 they will publish a national delivery plan informed by the latest research aiming to:

- change attitudes in the population through clear food labelling, review restrictions on advertising of unhealthy foods to children and pilot community-wide approaches;

- ensure that early years and school settings create a healthy environment, helping children and families establish and maintain healthy food and activity choices;
- support treatment programmes to assist changes in child and family behaviours towards maintaining a healthy weight;
- use social marketing techniques to communicate simple and positive messages about healthy lifestyles and motivate changes in behaviour;
- incentivise delivery, supported by workforce training, guidance on what works and local obesity strategies; and
- improve the evidence base through high-quality research, local data collections and an action-learning approach to treatment interventions.

3.27 Regional Public Health Groups, SHAs, and GOs will promote effective practice and facilitate cross-sector work to tackle obesity, increase physical activity, improve diet and change attitudes, support areas with the biggest challenge/highest risk; and link up with environmental and regeneration strategies issues so as to tackle the wider factors in child obesity. **Sport England and Youth Sport Trust** will develop opportunities to increase the participation of children in physical education and school sport.

3.28 Local Authorities and PCTs, working through primary care services, schools, Children's Centres, and secondary care (for complex cases) will:

- be jointly accountable for reducing child obesity in local areas;
- change behaviour in planning of local services and the built environment, and providing workforce training;
- coordinate actions to tackle childhood obesity, increase physical activity, improve diet and change attitudes in PCT local plans, the Children and Young People's Plan, and, as appropriate, the Local Area Agreement;
- commission treatment interventions aimed at overweight or obese children and their families;
- work in partnership with schools to ensure the success of the National Child Measurement Programme; and
- monitor local performance and target resources.

3.29 GPs, health visitors, midwives, school nurses, and practice nurses. Health professionals will be trained to identify overweight, at risk and obese children; raise the issue with confidence, offer advice and know where to refer children and their families; and help non-health professionals.

3.30 Schools, and other frontline services working with children. Teachers, school staff, and others working with children should understand the risks of obesity and be able to: include, in general advice to parents, advice on physical activity and healthy eating; provide specific advice to those parents who request it; and signpost children and parents to targeted interventions or more specialist services.

DELIVERY PRIORITY 4: IMPROVING EMOTIONAL HEALTH AND WELLBEING, AND CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

3.31 Children and young people can experience emotional and psychological difficulties at any age, for a wide variety of reasons and across a wide spectrum of symptoms and behaviours. DCSF and DH will be jointly responsible for ensuring an effective mix of early intervention and targeted support. They will:

- communicate the vision for supporting children’s emotional well-being and mental health, in particular the needs of vulnerable groups such as children in care, to the NHS, Local Authorities and all those working with children, young people and families in universal, targeted and specialist services;
- monitor provision of a comprehensive CAMHS and oversee progress on Standard 9 of the National Service Framework and the Mental Health Bill;
- work with partners, such as the National CAMHS Support Service to support and challenge PCTs and local authorities failing to deliver core CAMH services;
- review emerging data and evidence on implementation and outcome issues; and
- provide additional £60m funding for targeted mental health work in schools.

3.32 Other delivery partners will take action as follows:

- **SHAs/Government Offices:**
 - promote effective practice, facilitate cross-sector working and provide intensive support for areas.
- **PCTs and Local Authorities:**
 - identify coordinated actions to promote mental health and early intervention in universal and mainstream services and develop more targeted support services, and CAMH services, in PCTs’ local plans, the Children and Young People’s Plan, and, as appropriate, the Local Area Agreement;
 - commission comprehensive CAMHS through robust joint strategic needs analysis as part of their remit within the CAMHS Partnership Board;
 - identify and address the needs of vulnerable groups such as children in care; and
 - performance manage delivery of community based and specialist CAMHS.
- **Children’s Centres:**
 - recruit and retain vulnerable parents and support their emotional well-being; and

- identify and offer additional support for children displaying early signs of mental health problems, including early intervention group work and referral to more specialist services.
- **Schools (including Healthy Schools):**
 - All primary schools and 50 per cent of secondary schools implementing the Social and Emotional Aspects of Learning programme by 2012;
 - promote children’s emotional well-being and early intervention work for those children and young people at risk of experiencing mental health problems; and
 - increasing numbers of schools delivering school based mental health support.

DELIVERY PRIORITY 5: IMPROVING SERVICES FOR DISABLED CHILDREN

3.33 The DCSF/HMT Disabled Children and Young People’s Review *Aiming high for disabled children: better support for families*⁷ has made recommendations which form the core of this delivery strategy to be led by DCSF. Key actions include additional provision for short breaks and the development of a ‘core offer’ to improve the responsiveness of local services to the needs of disabled children and young people and their families. This would address the frustration felt by families in accessing services locally which have not met their needs, providing for:

- clear information;
- multi-agency assessment;
- transparent eligibility criteria and/or processes for accessing services;
- accessible feedback and complaints procedures; and
- participation in shaping local policies and services.

3.34 This needs to be taken forward in the context of implementing standard 8 of the *National Service Framework for Children, Young People and Maternity Services*⁸ that “children and young people who are disabled or who have complex health needs, receive co-ordinated, high quality child and family-centred services which are based on assessed needs, which promote social inclusion and, where possible, enable them and their families to live ordinary lives”.⁹

3.35 DCSF and DH will act jointly to communicate the vision for supporting disabled children and issue guidance on making the ‘core offer’ a reality locally. This will include:

- transforming short-breaks provision for disabled children and their parents and expanding accessible childcare;

⁷ *Aiming high for disabled children: better support for families*, HM Treasury/DfES, 2007

⁸ *National Service Framework for Children, Young People and Maternity Services*, Department of Health, 2004.

⁹ Additionally, PSA 11 covers expectations for the educational outcomes for vulnerable children.

- supporting development of a parents forum in each local authority;
- establishing a Transition Support Programme to ease the transition from childhood to adulthood;
- developing a national strategy on children's palliative care;
- piloting a National Framework for Children and Young People's Continuing Care;
- developing a tool for transition planning for young people with neuro-disabilities; and
- scoping and delivering reform of community equipment and wheelchair provision.

3.36 Other delivery partners will take action as follows:

- **PCTs and Local Authorities, primary healthcare services, and the third sector:**
 - enhance or develop parents' forums, and engage disabled children and young people, to help shape local policies and services for disabled children;
 - embed the "core offer" as an integral part of service provision to disabled children and their families;
 - jointly plan and commission enhanced and responsive short breaks and other services for disabled children and their families;
 - ensure that service provision is holistic and seamless so that disabled children are supported in all aspects of their lives and in all settings – their homes, through early years, schools (including special schools), colleges, youth and leisure services, hospitals; and
 - improve LA and PCT data on disabled children and young people to enable better planning and delivery of local services and monitor outcomes.
- **Service Providers (including schools, childcare centres, primary and secondary healthcare, third sector and private providers):**
 - meet the needs of disabled children through good information, early identification, shared assessment and coordinated provision; and
 - jointly make effective transition plans for young people's transition to adulthood.

ACCOUNTABILITY AND GOVERNANCE

3.37 The Secretary of State for Children, Schools and Families will be the lead minister for this PSA. The Senior Responsible Officer will be the Director-General for Children and Families Directorate in DCSF. He and the Chief Nursing Officer for England will co-chair a Child Health and Wellbeing Board which will:

- oversee delivery against the two cross-cutting themes and the five delivery priorities and indicators;

- provide a focus for work to implement the Children's NSF;
- identify and monitor cross-cutting activity to improve broader outcomes of health and wellbeing for children, young people and families; and
- ensure that action relating to children and young people's health and wellbeing are communicated coherently to the NHS and other delivery partners.

3.38 The Child Health and Wellbeing Board will feed into the relevant Cabinet Committee/s, which will drive performance by regularly monitoring progress, holding Departments and programmes to account and resolving inter-departmental disputes where they arise. There are also likely to be groups at Ministerial level to support the work.

Indicators and LAAs **3.39** Indicators underpinning this PSA form part of the local government National Indicator Set (NIS). Performance against these indicators will form part of each local area's discussions about Local Area Agreement (LAA) priorities with Government Offices who will co-ordinate action to respond to underperformance. Where local performance against one of the indicators is poor and improvement is considered a local priority, the local authority and its partners will agree a specific local improvement target with Government as part of the LAA process.

3.40 The LAA arrangements are consistent with the unified performance framework which DH is developing for health and social care. The framework makes the shift from centrally driven targets to be part of a "self-improving system" where patients/users and local commissioners act as the key determinant of how services are deployed. It is supported by NHS metrics which cover the full range of health and adult social care services and which map across to the NIS. The children and young people's health indicators identified to deliver this PSA are included in DH's metric set on Better Health for All and included in the NHS data-set.

CONSULTATION

3.41 The Government recognises the importance of ensuring that plans for delivering PSAs over the CSR07 period are informed by robust evidence and collaboration with stakeholders. Outcomes are more likely to be effectively delivered if all partners in the delivery chain are brought in and clear about what each needs to do to contribute to the outcome. The Secretary of State for Children, Schools and Families is leading a national consultation to develop a Children's Plan. The Prime Minister has also commissioned the NHS Next Stage Review - *Our NHS, our future*¹⁰ which is engaging the public, patients, professionals and stakeholders to identify the way forward for the NHS over the next decade and beyond. This delivery agreement will be reviewed and updated following publication of the Children's Plan and the final report of *the Our NHS, our future* review. During the development of this PSA Delivery Agreement, the following stakeholders were engaged:

- the cross-sectoral Inter-Agency Group on Every Child Matters and a group of representatives convened by the Inter-Agency Group;
- the Every Child Matters Board of Stakeholders and DCSF Third Sector Forum;

¹⁰ *Our NHS: Our future. NHS Next Stage Review Interim Report*, DH, October 2007

- consultation on specific indicators: through the disability strand of the joint HMT/DCSF Thematic Review of Children and Young People, for example at the Implementation Advisory Group for the Children's NSF;
- other Government departments, including: Health; Culture, Media and Sport; Transport; Communities and Local Government; and Environment, Food and Rural Affairs; and
- delivery Stakeholders at an event convened by the Prime Minister's Delivery Unit.

3.42 DCSF will also consult its Children and Youth Board when it reconvenes.

A

MEASUREMENT

Indicator I	Prevalence of breastfeeding at 6 – 8 weeks
Data provider	Department of Health.
Data set used	Primary Care Trust (PCT) Child Health Information records, which are reported to the Department of Health at quarterly intervals.
Baseline	Percentage of infants breastfed at 6-8 weeks in 2006-07. Baseline figures for 2007-08 will be available in September 2008.
Frequency of reporting	Quarterly - June, September, December and March,
95 per cent confidence interval at last outturn	Not applicable – data covers all children who are assessed and is not a sample. ¹
Data Quality Officer	DH, Analytical Team, Room 316, Wellington House, 133-155 Waterloo Road, London SE1 8UG.
Minimum movement required for performance assessment	To be determined. As this will be based on new data collection, the minimum movement can only be specified when a full year of data can be assessed (2008).

DEFINITION OF KEY TERMS

- *Breastfeeding:*
this is defined as an infant receiving any breastmilk at 6-8 weeks. It confers significant short and long term health benefits for both mother and infant beyond the period of breastfeeding itself.
- *Prevalence:*
this is defined as the percentage of infants being breastfed at 6-8 weeks, and is calculated using the following data lines:
 1. The number of infants due for a 6–8 week check in each quarter, at which feeding status is recorded.
 2. The number of children recorded as being breastfed at 6-8 weeks.
 3. The number of children recorded as not being breastfed at 6–8 weeks.
 4. The number of children recorded as receiving both breast milk and infant formula

A.1 Prevalence = Numerator/Denominator x 100

¹ The indicator will be based on a new requirement on PCTs to collate data on breastfeeding at 6-8 weeks. Some PCTs already collate this information but for some this will be a new process which may effect the accuracy of the returns.

A.2 Numerator is Line 2 + Line 4 = Number of children recorded as being breastfed at 6-8 weeks + Number of children recorded as receiving both breast milk and infant formula

A.3 Denominator is Line 1 = Total number of infants due for 6-8 weeks check Information is collected by Strategic Health Authorities (StHAs) from Primary Care Trusts (PCTs) and then submitted to the Department of Health at quarterly intervals.

A.4 Proxy baseline data from the National Infant Feeding Survey 2005, showed 50 per cent prevalence of any breastfeeding in England..

Indicator 2	Percentage of pupils who have school lunches
Data provider	Department for Children, Schools and Families, from the School Food Trust.
Data set used	School Food Trust Annual Survey of Local Authorities.
Baseline	42 per cent of pupils had a school lunch in 2005-06. Baseline figures for 2007-08 will be available in August 2008
Frequency of reporting	Annual.
95 per cent confidence interval at last outturn	Not applicable – data covers all children who are assessed and is not a sample.
Data Quality Officer	School Food Trust, Caxton House, Tothill Street.
Minimum movement required for performance assessment	A 0.1 percentage point movement is sufficient to make a performance assessment.

DEFINITION OF KEY TERMS

- Take-up of school lunches:*
this is defined as the percentage of pupils attending maintained primary, secondary or special schools who have a lunch at school that is provided either by the school or the local authority. This includes Free School Meals (FSM) – see below. All school lunches are now required to meet tough nutritional standards that ensure that all the food provided in a lunch is healthy and of good quality.
- Free School Meals (FSM):*
these are available to all children in non-working families, that is, those where the adults do not work, or work for less than 16 hours per week. These families are reliant on ‘welfare support payments’ and are not able to claim the additional ‘Working Tax Credit’ that is available to low income working families (adults working 16+ hours per week).

Indicator 3	Levels of childhood obesity
National target	Reduce the proportion of overweight and obese children to 2000 levels by 2020 in the context of tackling obesity across the population. Over the 2007 CSR period the Government aims to reduce the rate of increase in obesity in children under 11 years old and will monitor progress in the context of the long term target.
Data provider	Department of Health.
Data set used	Health Survey for England (HSE).
Baseline	To be confirmed by April 2008. ²
Frequency of reporting	Annual. Data available in December. ³
95 per cent confidence interval at last outturn	Last outturn (2002/03/04) was +/- one percentage point.
Data Quality Officer	Health Improvement Directorate Analysis Team, Department of Health, Quarry House, Quarry Hill, Leeds, West Yorkshire, LS2 7UE.
Minimum movement required for performance assessment	To be confirmed by April 2008.

DEFINITION OF KEY TERMS

- *Obesity:*
Obesity is defined as those above the 95th centile of BMI for age and sex based on nationally representative survey data (UK90).
- *Childhood:*
for the purposes of this PSA indicator, childhood is defined as children age 2-10 years old.

National target

A.5 The national target will be assessed when obesity data becomes available in December each year.

² The HSE data cannot be broken down into data for local areas. Progress at a local level therefore will be measured through the National Child Measurement Programme (NCMP), where PCTs are expected to weigh and measure all children in Reception Year and Year 6 and report this to the Information Centre.

³ There is a lag between the end of the collection period and data being published, of around 12-15 months.

Indicator 4	Emotional health and well being and child and adolescent health services (CAMHS)
Data provider	Department of Health.
Data set used	<ul style="list-style-type: none"> • How effectively mental health services meet children’s mental health needs. The ‘value added’ measure of the Strengths and Difficulties Questionnaire will be used to assess the impact of CAMHS.⁴ • A broader measure of children’s emotional well-being gained through an analysis of questions within the TellUs2 survey.
Baseline	The CAMHS ‘value added’ measures is currently being tested in Kent, and is subject to a full evaluation of its implementation and impact. Early testing and evaluation work in Kent in 2008 will enable a baseline to be set for 2009. Baseline data from the Tell Us 2 survey should also be available for 2009/10 following analysis of the utility of the data collected through Tell Us in 2007/08.
Frequency of reporting	Annual. Actual date still to be specified.
95 per cent confidence interval at last outturn	Not applicable – this measure is still at early stages of implementation and evaluation.
Data Quality Officer	Head, Children’s Mental Health Team DCSF and Deputy Programme Director, Children Families and Maternity, DH.
Minimum movement required for performance assessment	<p>The ‘value added’ measure is currently being piloted in Kent with a proposed effect size of 0.1.</p> <p>This will be set for the Tell Us 2 data set in 2009-10 following analysis of the utility of the data collected through Tell Us in 2007-08.</p>

A.6 The ‘added value’ measure of the Strengths and Difficulties Questionnaire (SDQ) will be used. The Strengths and Difficulties questionnaire is the agreed key measure to capture child and parent views of change in difficulties. The SDQ is a 25 item questionnaire completed by referred children aged 11-18 years and parents of children aged 3-16 years before first meeting and at six months after first appointment.

A.7 Until 2009 the indicator will be four proxy measures for the development of comprehensive CAMHS: the development and delivery of CAMHS for children and young people with learning disabilities; appropriate accommodation and support for 16/17 year olds; availability of 24 hour cover to meet urgent mental health needs; and joint commissioning of early intervention

A.8 The definition of comprehensive CAMHS is based on Appendix 2 of the Mental Health and Psychological Well being of Children and Young People Standard, which is part of the National Service Framework for Children Young People and Maternity Services. This can be found at www.dh.gov.uk.

⁴ The ‘value added’ SDQ is particularly relevant for children with significant mental health problems who are utilising mental health services. It is less appropriate for measuring the impact of preventative and early intervention supports.

Indicator 5	Parents' experience of services for disabled children and the 'core offer'
Data provider	Department for Children, Schools and Families.
Data set used	Survey of parents of children with disabilities at local authority level. Arrangements and survey methodology will be confirmed by April 2008 following a feasibility study being conducted by the Thomas Coram Research Unit (TCRU) and a pilot study from late 2007 to early 2008.
Baseline	This is a new survey that will be run for the first time in 2008-09 with a plan to provide a baseline by Autumn 2009.
Frequency of reporting	Annual. Exact dates and survey methodology will be confirmed alongside final survey arrangements.
95 per cent confidence interval at last outturn	Those surveyed will be a sample of parents or guardians of children (aged 0 to 19) who have a disability. This will be confirmed in mid-September following a feasibility study being conducted by the Thomas Coram Research Unit (TCRU).
Data Quality Officer	This will be confirmed by April 2008 following a pilot study from late 2007 to early 2008.
Minimum movement required for performance assessment	This will be confirmed in mid-September following a feasibility study being conducted by the Thomas Coram Research Unit (TCRU).

DEFINITION OF KEY TERMS

- *Service provision:*
the survey will focus on delivery of the five aspects of the core offer proposed by *Aiming High for Disabled Children: better support for families* (that is the extent to which services for disabled children are delivered with:
 - good provision of information;
 - transparency in how the available levels of support are determined;
 - participation of disabled children and their families in service planning, commissioning and delivery;
 - integrated assessment provided by different services in a coherent, coordinated way;
 - and a clear and published complaints procedure allowing feedback on services).
- *Disabled children:*
these are defined by the Disability Discrimination Act, 1995.

A.9 This is a proxy measure. The survey will cover a sample of parents of disabled children and cover their experience of services and the extent to which they experience the 'Core Offer'.

