Agenda Item No: 6

VULNERABLE CHILDREN AND FAMILIES JOINT STRATEGIC NEEDS ASSESSMENT

To: Health and Wellbeing Board

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1.0 PURPOSE

This report is to summarise the findings of the Vulnerable Children and Families Joint Strategic Needs Assessment (JSNA) and ask the Board to approve the JSNA. The full JSNA is provided at Annex 1.

2.0 BACKGROUND

It is widely accepted that adverse factors relating to a young child's family and environment cause poorer outcomes for the child, both to their safety, and to their development and behaviour[1] (National Institute for Health and Clinical Excellence (NICE), 2012). Parental mental health issues, substance misuse, domestic violence, financial stress and teenage motherhood are themes which are frequently identified as indicating poorer outcomes for children. Factors rarely occur in isolation, with certain combinations being more common than others. The children within these households are at a higher risk of poorer development and physical harm. However, it should be noted that many parents facing challenging circumstances successfully raise healthy and happy children.

Longitudinal studies, such as the Millennium Cohort Study (MCS) and the Avon Longitudinal Survey of Parents and Children (ALSPAC)[2] found a strong correlation between educational progress and many of these factors, particularly deprivation. The recently published initial findings of the age 11 survey of the MCS[3]found that, 'At age 11, parent's education and family income were the most powerful predictors of cognitive test performance across the board'.

3.0 AIM OF THE JSNA

A number of stakeholders requested a JSNA focusing on vulnerable children and families in Cambridgeshire. Children can experience many adverse 'risk factors' relating to health, family or environment. These risk factors rarely occur in isolation and can combine to lead to relatively poor outcomes later in life.

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[1]Social and Emotional Wellbeing: Early Years. NICE PH40 (2012).

[2] Preview literature review – published findings from longitudinal datasets. Sue Hennessy, Josephine Green, Helen Spilby. Mother and infant research unit, University of York. June 2008. www.chimat.org.uk.

[3] MCS Initial findings from the age 11 survey. November 2014.p51. Institute of Education, University of London. Editor Lucinda Platt.

Establishing which children face different combinations of these risk factors would allow for a whole range of services to be better targeted and coordinated to improve positive outcomes later in life.

As described in the 'Vulnerable Children and Families JSNA Update' paper to the January Health and Wellbeing Board meeting, it has not been possible to carry out the JSNA as planned, due to challenges in sharing data between organisations. This included much discussion to investigate possible routes to access the data, including with the Department of Health and the Department of Work and Pensions. The end result has been to limit the JSNA analysis to use of County Council data, and data which is publically available at small area level. Specifically:

- The outcome assessed has been limited to educational attainment at age 5-15, which is known to be a significant issue in Cambridgeshire as the gap in educational attainment for children receiving free school meals is known to be worse than the national average. Wider health outcomes could not be included in the analysis.

- The risk factors for which data could be linked for this analysis were limited to the 'deprivation quintile' of the area in which a child lived, whether a child received free school meals, and whether the child had special educational needs. Other wider risk factors including those related to health, use of health services, and parental issues such as drug and alcohol misuse, and mental health could not be included in the linked analysis.

- The JSNA aim to assess whether the most vulnerable children were in touch with services, was limited to County Council services such as family support, social care, and special education needs amongst others. It was not possible to share data to assess whether vulnerable children were receiving effective input from health services.

- Finally, because it was only possible to access data on the full population of children of school age, and not for those under 5 years, it was not possible to explore access to County Council or other services for vulnerable children before they started school.

The end result is a JSNA which although intended to be 'joint' needs assessment for vulnerable children of all ages across both local authority and health services and outcomes, is in practice focussed on educational attainment and related issues. It will therefore provide additional information to support the work underway in the strategy 'Accelerating the achievement of vulnerable groups for children and young people within Cambridgeshire 2014/-16' and this strategy is attached for information at Annex2. However, the strong correlation between educational attainment and future health, means that in the longer term this strategy is likely to have an important impact on the health and wellbeing of more vulnerable local residents.

The JSNA has a number of findings about how to ensure that the analysis initially envisaged could be undertaken in the future.

4.0 METHODOLOGY

As described above this study focused on answering the following questions:

a) *Using the data we have access to, can we identify children and young people in Cambridgeshire who have risk factors which make them potentially vulnerable to poor educational outcomes and understand what services they are in contact with?*

b) *How are vulnerability factors spread across Cambridgeshire geographically and what do the key findings from this work mean for commissioners?*

In attempting to answer question a) the JSNA combines data on attainment, County Council service use, free school meals and deprivation to build a partial picture of factors associated with poor educational attainment.

The analysis we have done takes data on children from the 2012/13 academic year (approximately 59,000 children) and identifies those children not achieving expected levels of attainment at the three stages measured, Early Years Foundation Stage (EYFS), Key Stage 1 (KS1) and Key Stage 2 (KS2). These children have then been matched against information about other relevant and available risk factors such as deprivation, access to free school meals, and special educational needs. We have then identified which of these groups of children have been in touch with county council services.

We also combine this with information about other factors, where we don't have individual level data, which influence outcomes for children and young people and draw conclusions and recommendations for commissioners.

It is important to remember that some of the children identified using the few datasets we have had access to may not require any service, as they are healthy and developing well in secure families. Equally these children will not be the only vulnerable children in the county.

Children who have poor levels of attainment are those not reaching nationally agreed levels of educational attainment. The Good levels of attainment are those children who achieve these levels of attainment.Assessments at KS2 are externally marked assessments, and are used for national reporting purposes. The other stage assessments are based on un-moderated teacher assessments. Appendix A of the JSNA provides full details of the definitions used in this analysis.

5.0 KEY FINDINGS

School Attainment, free school meals and deprivation 2012/13

- At January 2014, 14% of children aged 5-15 years (excluding those aged 6) in Cambridgeshire had **poor** attainment levels from their latest assessment results up to 2012/13. Assessments of attainment include the Early Years Foundation Stage (end of reception year, age 4-5), Key Stage 2 (age 7-10 years) and Key Stage 3/4 (age 11-15 years).Conversely, 86% of children in

Cambridgeshire had **good** attainment levels at these stages. *(Note: The proportions with poor attainment vary at each stage[4]).*

- Approximately one in three (29%) children with poor attainment levels live in the 20% most deprived parts of the county (and approximately two in three(71%) outside these areas).
- The rate of children not reaching attainment levels increases as deprivation increases.
- 20% of children with poor levels of attainment are claiming free school meals. compared to approximately 11% of children overall with an attainment record.
- 9% of those children with poor levels of attainment live in the most deprived areas **and** access free school meals.
- Of all children accessing FSMs 26% have poor levels of attainment, and 56% of those live outside the most deprived parts of the county.

Finding: Poor attainment is more concentrated is the most deprived parts of the county. However, focusing efforts on those with poor attainment at EYFS, KS2 and KS3/4, living in the most deprived parts of the county will only address 29% of poor attainment.

Use of County Council Services

- Overall, 69% of children with poor attainment and accessing free school meals are in touch with County council services. The highest concentration of these children is in Fenland but the numbers are small and may fluctuate over time. *(Note: It shouldn't be assumed that all children with low attainment/living in deprivation need to be in direct touch with services; this analysis may also underestimate the number of EYFS children in touch with services).*
- The highest proportion of children with poor attainment and accessing free school meals in touch with Council services is at KS2 with 83% of this group in touch with services. This reflects current service provision at primary school age.

Key Stage specific findings

- Children with SEN and poor levels of attainment account for 55% of all children with poor levels of attainment at KS2. Compared to all children with poor levels of attainment those with SEN are more likely to live in the most deprived areas of the county or be accessing free school meals.
- The vast majority of pupils with poor attainment levels are white British,in line with the ethnic profile of the population.
- Those of other backgrounds, 'Any other white', 'mixed white Caribbean' and 'gypsy Roma' groups are over represented within those with poor attainment levels at EYFS and KS2 but the numbers are small. At KS3/4 White British children account for 85% of all pupils and 89% of those pupils with poor attainment.
- The rate of children not achieving expected levels increases as deprivation increases. However, the pattern at KS2 is slightly different as the rate of poor

[4] The numbers used for EYFS are smaller than other Key Stages as there was only one year of data available. This was due to the fact that the assessment at EYFS changed and therefore data for children age 6 is not comparable.

attainment is statistically significantly higher in the top two quintiles for deprivation. Therefore, those who do not meet expected levels are more likely to live in the **top 40%** most deprived areas of the county.

- The proportion of pupils on free school meals and achieving **good levels** of attainmentatall three stages combined is fairly similar in the top three quintiles for deprivation and increases slightly in the 4th and 5th quintiles (least deprived).
- The proportion of pupils on free school meals and achieving **good levels of attainment** at all three stagescombinedis spread fairly evenly across the county, with a concentration of lower levels of attainment to the north of Fenland and South Cambridgeshire and to the west of Huntingdonshire.

Findings: A large proportion of children with poor levels of attainment accessing free school meals are in touch with council services, particularly at KS2.

Children with special educational needs account for a large proportion of children with poor attainment who access free school meals. This is particularly the case at KS2 when the Council is also in contact with a high percentage of these children.

The ethnic profile of children with poor attainment and accessing FSM in 2012/13 was different at KS3/4 compared to the other stages.

There are parts of the county where there lower levels of good attainment, and these are not necessarily in the most deprived parts of the county.

Other vulnerability factors

- It is estimated that 5,400 children and young people are living with a problem drinker with concurrent mental health problems, and 3,300 living with a drug user with concurrent mental health problems. A further 1,300 live with a parent with all three conditions.
- The Cambridgeshire Domestic Violence/Abuse Needs Assessment[5](May 2014) outlines the increased vulnerability that children face in households where domestic violence occurs, including pre-birth. During 2012/13, the Cambridgeshire Police received 11,286 reports of domestic violence across their area, which includes Peterborough. *(Note: Not all of these will relate to households with children).*
- Smoking in pregnancy has been shown to be linked to poorer developmental outcomes for children at the age of five years. The percentage of women who smoke at the time of delivery is 10.6% in Cambridgeshire which compares to 10.8% in East Anglia and 12% in England. The percentages are likely to be much higher in the more deprived parts of the county.
- Longitudinal studies have found maternal qualifications, language spoken at home, mother's self-rated health, depression and socio-economic situation to be common factors across educational, behavioural and health outcomes for children. The home learning environment, where mothers provide more

[5]www.cambridgeshire.gov.uk/download/downloads/id/2881/domestic_abuse_needs_assessment_2013

stimulation and teaching was found to be a protective factor. Proxy data, such as the female population aged over sixteen with no qualifications or level 1 qualifications along with information about mothers under the age of 22, provided here shows again some geographical areas outside of those most deprived for additional prevention work. Information about the home learning environment is likely to be to being gathered informally byhealth visitors who see the vast majority of mothers during pregnancy and first few years of a child's life.

The table below presents a summary of the key indicators available at district level and shows the areas that were statistically significantly high or low compared to Cambridgeshire. As can be seen Fenland appears to be high (relatively worse) for all of the indicators reported.

Table 1: Summary of indicators by district

Indicator		Cambridge City	East Cambridge shire	Fenland	Huntingdon shire	South Cambridge shire
Poor attainment (all pupils)	EYFS	High	Low	High	Low	Low
	KS2	High		High	Low	Low
	KS4	High		High		Low
Breastfeeding 6-8 weeks		High	Unknown	Low	Low	Unknown
Teenage conceptions			Low	High		
Mothers aged under 22 years		Low		High		
Hospital admissions due to unintentional and deliberate injuries	0-4 years			High		Low
	0-14 years					Low
A&E attendances (0-14 years)		High (under 5's only)	High	High	Low	Low
Female population with low qualifications		Low	High	High	High	Low
Household overcrowding		High	Low	High	Low	Low

Statistically significantly higher/worse than Cambridgeshire
Statistically significantly lower/better than Cambridgeshire

Findings:

It is difficult, to draw conclusions about detailed local geographical patterns from the data available on domestic violence, drug and alcohol treatment, smoking at time of delivery and parental mental health.

Geographical patterns, which reflect research findings on family vulnerability factors, identified in data on female qualifications and births under the age of 22 should be considered for focusing prevention work, particularly as this data is available from the census by small geographical areas(Lower super output area).

Fenland remains the district area with the highest concentration of risk factors.

Data sharing and consent

This type of analysis is limited by the availability of individual level data. For much of the sensitive data needed for this kind of work individual consent needs to be sought for its use. However, we do not routinely seek consent to use data

such as this for strategic planning purposes where the output of work is anonymised. National guidance on this issue would be helpful, and this currently severely limits the amount of cross-agency analysis that is possible.

Findings:
Consideration should be given to seeking consent to share information for strategic planning purposes where the output is anonymised, when an individual accesses services.

Recording of the characteristics of those children and families which the County council and other services are working with should be reviewed to so that key vulnerability factors the research suggests influence childhood development are recorded, such as the learning environment at home and mothers qualifications.

6.0 NEXT STEPS

This JSNA confirms many of the patterns reflected in the Accelerating Achievement Strategy, and the considerable research in this area. It also provides additional analysis which links poor attainment to county council service provision, and identifies wider determinants, which can further inform the implementation of that strategy.

We are already working closely with colleagues in CFA to disseminate the findings of the JSNA, and to ensure that relevant and highly detailed service data, on which the majority of this analysis is based, is used where possible to focus prevention work.

The recommendations here also potentially have implications for the commissioning of health visiting and other early intervention services across health and social care.

7.0 RECOMMENDATION/DECISION REQUIRED

The Health and Wellbeing Board is asked to approve the JSNA on vulnerable children and families.

Source Documents	Location
Sources are referenced throughout the report and the JSNA	