

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

April 2008

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VISION

1.1 The vision – as set out in the *Children's Plan* – is to make this country the best place in the world for our children and young people to grow up. Every child, whatever their background or their circumstances, should have the support they need to: be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic wellbeing.

1.2 As part of this vision, 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. This document sets out the Government's delivery strategy to improve the health and wellbeing of children and young people.

1.3 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. The Department for Children, Schools and Families, working with the Department of Health, must therefore make a reality of the principles set out in the *Children's Plan*. Recognising that it is parents rather than government who bring up children; this means ensuring that mothers and fathers, children and young people are empowered to make healthy choices. A focus on prevention, based on evidence of effective practice and designed around the needs of children and young people, is critical as is the development of care pathways for children, across clinical and other children's services. The PSA will be delivered only by looking at all aspects of the child's life in the round by making strong links to a number of the Government's other PSAs.

1.4 The first years are vital, starting with a healthy pregnancy, a healthy birth and a strong bond between a baby and its parents – with breastfeeding offering benefits to both mother and child. The Government wants to see more children thrive, with the **prevalence of breastfeeding at six weeks** as high as possible by 2011, and with mothers and fathers getting support with other aspects of parenting and healthy child development.

1.5 Getting the right help at the right time is key – from health visiting, midwifery teams, general practitioners and others. With greater co-location, Sure Start Children's Centres have a key role in delivering this support, including guidance, health protection, promotion and surveillance to all children and families, including those at risk of becoming obese. This will support the Government's aim to make a significant impact on **the level of childhood obesity** for under 11s by 2011. Also, primary and community health services working with children's centres are central to narrowing the gap in children's development to age 5 (as set out in the Government's PSA 11 to narrow the gap in educational achievement), providing early identification and support, particularly for disabled children.

1.6 As children move into school, they take more responsibility for their own health and wellbeing. All schools should work to meet high standards for accreditation as Healthy Schools by 2011, increasing the **percentage of pupils who have school lunches**, increasing physical activity¹ and providing learning about health² as part of a healthy

¹ See also PSA 22 to Deliver a successful Olympic Games and Paralympic Games with a sustainable legacy and get more children and young people taking part in high quality PE and sport.

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

school environment. Schools will **promote emotional health and wellbeing**, by 2011 all schools will offer access to extended services which includes health or therapy services on site. The Government will also provide more and better play active areas, and improved communities where children and young people are able to walk, cycle and take part in sporting opportunities.

1.7 Adolescence brings new challenges with increased exposure to risky health behaviour. The Government's PSA 14 to increase the number of children and young people on the path to success, aims to help young people make healthy choices as they grow up to become adults and, potentially, parents themselves³. It is important that they continue to lead a healthy lifestyle into adulthood. Parents who have healthy lifestyles help ensure their children avoid unnecessary health problems and stay physically, mentally and emotionally healthy.

1.8 Throughout childhood and adolescence, those with complex needs require better quality and age-appropriate services. This is why local authorities and the National Health Service (NHS) will work together to ensure improvements in specialist **child and adolescent mental health services** (CAMHS) and in **improving parents' experience of services for disabled children** and those with complex health needs. This also means ensuring more inclusive universal services, so children and young people with complex needs can achieve their full potential.

³ PSA 14 includes indicators on the under-18 conception rate and the proportion of young people frequently using illicit drugs, alcohol or volatile substances.

2

MEASUREMENT

2.1 This Public Service Agreement (PSA) provides a focus on five key areas, whilst highlighting the need to support the health and wellbeing 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 shown at Annex A.

Indicator 1: Prevalence of breastfeeding at 6 – 8 weeks

- In 2005, 78 per cent of mothers began breastfeeding but six weeks later only 64 per cent of those mothers who had started breastfeeding were still doing so. Given the significant long-term health benefits, the Government would like to see levels of breastfeeding prevalence at 6 to 8 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 2007 was just over 39 per cent. The School Food Trust is 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 2006, obesity prevalence among boys aged 2 to 10 increased overall from 10 per cent to 17 per cent and for girls aged 2 to 10 from 10 per cent to 13 per cent. The Government wants to make a significant impact on this problem over the 2007 Comprehensive Spending Review 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 5 to 15 have a diagnosable mental health disorder.² The Government wants to change this situation by improving the emotional health and wellbeing of children. Emotional health and wellbeing will be measured through the annual 'TellUs' survey of children and young people from 2008. For CAMHS, the Government will monitor improvements 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: CAMHS for those with learning disabilities; support and accommodation for 16- and 17-year-olds, appropriate to their age and maturity; 24 hour cover for urgent mental

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

health needs and specialist assessment; and joint commissioning of a full range of early intervention support services. From 2009, the intention is to introduce a new outcome based indicator on children's psychological health, to enable CAMHS to measure the success of their work.

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; transparency in how families can access services; integrated assessment; participation in shaping local services; and effective feedback. The measure will cover the families of all disabled children and ask about all services provided by their local authority and 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

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. Supporting the *Children’s Plan*, the principles underpinning this delivery agreement are:

- recognising that parents bring up children, not government, empowering children and young people to meet their own health goals;
- ensuring all those who work with children, young people and parents promote and support good health outcomes for them; and
- with a strong focus on prevention and early intervention, our specific delivery priorities will be:
 - 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 work closely 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 NHS² and to carry through these priorities into their discussions with local delivery partners. Those actions will be informed by the views of clinicians and other professionals, particularly through the work currently underway in the NHS Next Stage Review *Our NHS: Our Future*. As set out in the Children’s Plan, in 2008 a Child Health Strategy will be produced jointly between the Department for Children, Schools and Families and the Department of Health. The Strategy will be developed over the summer to take

¹ Especially PSAs 9, 10, 11, 13, 14, 18 and 22.

² *The operating framework for the NHS in England 2008/09- DH, Dec 2007.*

account of the NHS Next Stage Review, with consultation with parents, young people and stakeholders on children's health in the spring.

3.4 Building on the NHS Next Stage Review and Child Health Strategy, the two departments will act jointly to:

- set out priorities and accountabilities through this and related PSA delivery agreements;
- set the performance system and accountability framework and report on national progress against outcomes;
- 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 bodies that deliver specific aspects of the PSA, 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 delivery partners so that those 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, mothers and fathers 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.

3.5 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: improve the safety of children and young people;³ eradicate child poverty;⁴ support vulnerable groups such as children in care; promote healthy and sustainable communities; and ensure that the local performance frameworks drive health improvements.

³ As set out in the Delivery Agreement for the Government's PSA (13) to Improve children and young people's safety.

⁴ As set out in the Delivery Agreement for the Government's PSA (9) to Halve the number of children in poverty by 2010-11, on the way to eradicating child poverty by 2020.

WHAT THIS MEANS FOR CHILDREN AND FAMILIES

3.6 Ultimately, the key to success will be empowering children and families to meet their own health goals. Improving health for individuals involves changing 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 will support children, young people and their parents to:

- make informed choices about eating healthily, making breastfeeding the norm, keeping fit and avoiding risky behaviour such as smoking, unprotected sex, and substance misuse;
- influence the services they want to support them, for example, in how they want to access health advice and information, help transform school food, access and help design play facilities, or shape local services for disabled children and young people.

3.7 Much of the support that families need will be drawn from the wider family, friends, mothers' and fathers' groups and third sector organisations, the media and new technologies and public services such as the Child Health Promotion Programme (CHPP). Later in 2008, DH will publish guidance on delivery of the CHPP. This support is crucial during pregnancy and the very early years, where the impact on the health 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.

3.8 Mothers and fathers need timely and meaningful information about their child's development to help them to flourish. DCSF and DH are exploring the development of personal parent-held records that will run from birth to age 11, and potentially beyond. Additional support is also crucial for looked after children. Later in 2008, DCSF will publish revised guidance on promoting the health of looked after children, which will be statutory for both local authorities and health bodies.

3.9 Information should be available through the widest range of channels that can deliver sound and consistent advice. Key national sources will include NHS Direct⁵; NHS Choices⁶ and Parents Know-How⁷ (which is designed to make information more accessible to both mothers and fathers through channels including websites⁸, email and short message service (SMS), with better signposting and targeting). Improved national services will be supplemented by local authority Children's Information Services, and a National Breastfeeding helpline will be available for mothers and fathers to access at the time of need. From April 2008, local authorities will be required to provide comprehensive information to help mothers and fathers in their parenting role. The Government has made a commitment that parents' forums for families with disabled children and young people will be in place in each local authority.

⁵ www.nhsdirect.nhs.uk

⁶ www.nhs.uk

⁷ 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.

⁸ <http://www.direct.gov.uk/en/Parents/index.htm>, <http://kids.direct.gov.uk/> and <http://www.direct.gov.uk/en/YoungPeople/index.htm>

3.10. Across all of the PSA delivery priorities, engaging parents, children and young people in the design and delivery of services will be critical to empowering them to improving the quality of services, and making healthier choices. All delivery plans will include a range of mechanisms for engaging families – such as parents’ forums – building on best practice established at local level.

WHAT THIS MEANS FOR THOSE WORKING WITH CHILDREN AND FAMILIES

3.11 The single most important factor in delivering aspirations for children is a world class workforce able to provide highly personalised support, so Government will continue to drive up quality and capacity of those working in the children’s workforce. Currently, all services should work towards the full range development standards in the National Services Framework for Children, Young People and Maternity Services by 2014.

3.12 But to meet the vision in the *Children’s Plan* for a world class workforce, the Government will set out a long term strategy for the children’s workforce in the autumn. The strategy will be informed by a newly established Children’s Workforce Expert Group, including representatives from professional bodies responsible for standards, training and regulation. The DCSF has set out what has already been achieved and commitments over the next three years in *Building Brighter Futures: next steps for the Children’s Workforce*.⁹ It also describes the challenges that still need to be addressed.

3.13 Everyone who works with children, young people and families needs to have the right skills to make a difference – at very least, to be alert to the importance of good health, with a focus on the five specific delivery priorities. This needs to start with a better approach to working with children, young people, mothers and fathers. This change needs to happen from the start, during pregnancy and the first years, on into the school years and adolescence. For those with complex needs, especially those who require support from several services, the focus will be on delivering better quality support in a more integrated way.

In the first years

3.14 Support during pregnancy and the first years is particularly important – this is a significant window of opportunity where mothers, fathers and carers are receptive to help and where the neurological development of children is most rapid and 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 who need it most.

3.15 Moving to greater co-location of primary health care, children’s centres and other early years settings should give young children a healthy start in life and offer support and advice to mothers and fathers. This means:

- providing a range of integrated information, advice, guidance and services which maximise children’s healthy development and outcomes and reduce health inequalities, for example, parenting and family support; promoting breastfeeding and improving opportunities for play. Particular focus will be given to the most disadvantaged families.

⁹ Link can be found at <http://www.dcsf.gov.uk/publications/childrensplan/>

- 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 development and mothers' and fathers' understanding of physical activity, play and healthy food;
- expanding outreach services to enable mothers and fathers, especially those not accessing services, to benefit from the full range of support available;
- 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.

In the school years **3.16** Through the school years, children begin to take more responsibility for their health choices. Here, schools will have an important role, with a duty to promote the wellbeing of pupils, formalised in the *Education and Inspections Act 2006*. Wellbeing is defined by the *Children Act 2004* and includes 'physical and mental health and emotional wellbeing' alongside the other Every Child Matters outcomes.

3.17 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 Comprehensive Spending Review period, therefore, almost all schools will be Healthy Schools, will offer access to extended services and will work to promote healthy lifestyles and behaviours through:

- promoting healthy eating, including new statutory requirements on nutritional standards for school food;
- ensuring that all 5- to 16-year-olds participate in two hours per week of PE and sport within the school day (as set out in the Government's PSA (22) to Deliver a successful Olympic Games and Paralympic Games with a sustainable legacy and get more children and young people taking part in high quality PE and sport¹⁰);
- teaching children about healthy eating and lifestyle, and other skills that promote good health through Personal, Social and Health Education (PSHE);
- 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, mothers and fathers 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;

¹⁰ 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.

- offering a varied menu of activities and childcare between 8.00 am and 6.00 pm, including sports activities, play and other recreational activities;
- offering parenting support including structured parenting programmes, information sessions, for example, encouraging healthy lifestyles; and
- providing community access including for health services.

Children and young people with additional and complex needs

3.18 For children and young people with mental health problems, disabilities and/or complex health needs and those who are looked after, services need to be more responsive and better able to meet these needs in a more integrated way.

3.19 For universal services, this will mean ensuring services are more inclusive and respond more quickly to need. It also means those working in universal services should be able to identify children and young people with complex needs, understand the Common Assessment Framework process and undertake a common assessment when appropriate. They should understand the role of the lead professional in relation to the co-ordination of multi-agency support.

For example extended schools will be better able to support early intervention for children with complex needs, through:

- identifying and assessing children who may need additional support; including from CAMHS,
- providing swift and easy access (referral) to targeted and specialist services, including to support children with behavioural, emotional and health needs; and
- meeting their duty (alongside other public services) to promote equality for disabled children, young people and adults.

3.20 Some with complex needs will always require ongoing support – often from many services, such as specialist CAMHS and short breaks services for those with mental health problems, disabilities and complex health needs. These services will need to improve to provide a more integrated approach to meeting need, so children and young people with complex needs, and parents, experience a more positive impact.

3.21 To provide additional focus on looked after children the PSA indicators on CAMHS and services for disabled children (indicators 4 and 5) will be complemented by a indicator on the mental, behavioural and emotional wellbeing of looked after children in the Local Government National Indicator Set. In 2008, the Government will publish statutory guidance for health bodies and local authorities on improving the health of looked after children and young people, including guidance on the provision of dedicated CAMHS. The Government will also support their wider health needs through improved access to positive activities.

WHAT THIS MEANS FOR DELIVERY PARTNERS

3.22 Empowering children and families to make healthy choices, and building capacity in the workforce to provide the right kind of support, will mean empowering our partners – equipping them to use their knowledge and engage with families to identify the best ways to make things happen.

3.23 The Government is setting the direction and framework to improve child health and wellbeing, without dictating to partners how to achieve improvements. With greater autonomy to lead, our partners will work with local communities to tackle the priorities to improve children and young people's health and wellbeing. To make a sustained impact, this needs to involve all partners - in the public and third sectors, and those in the business community.

**What this means
for Strategic
Health Authorities
and Government
Offices**

3.24 At regional level, Government Offices (GOs), strategic health authorities (SHAs) and regional directors of public health (RDPHs) are expected to challenge and support progress through:

- winning support for government priorities from local authorities, primary care trusts and local delivery partners;
- engaging third sector partnerships in shared agenda, for example, regional sports and physical activity partnerships;
- leading on potential regional improvements identified through the NHS Next Stage Review;
- performance management of local delivery partners through children and young people plans (CYPP), local area agreements (LAA), and NHS PCT operational plans;
- optimising use of public health and wider data, for example, through a children's health information unit to be based in the 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;
- regional liaison on regeneration and environmental issues; and
- management and direction of regional-level support and advice services such as school sport partnerships and CAMHS regional development workers.

3.25 GOs are taking the lead role in negotiating and reviewing LAAs on behalf of government. They will be responsible for recommending that each LAA should be signed-off by Ministers, and working with GOs, SHAs take the lead role in agreeing primary care trust (PCT) operational plans, including ensuring alignment with LAAs.

3.26 SHAs are taking the lead role in negotiating and reviewing PCT operational plans. They will work closely with the GOs and the RDPHs to ensure that local areas have a joined-up approach to setting priorities on child health.

3.27 As part of their support and challenge role, GOs will agree and undertake, for each area with one or more relevant negotiated targets, a programme of engagement and support within the framework of the Joint Improvement Support Plan (JISP). All regional partners will also support regional capacity building and collaborative improvement, with Government Offices taking the lead with the Regional Improvement and Efficiency Partnership.

**What this means
for PCTs and
Local Authorities**

3.28 At local level, primary care trusts and local authorities 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:
 - joint strategic needs assessments to be made statutory from April 2008;
 - performance against child health indicators in the Local Government National Indicator Set and the NHS Operating Framework Vital Signs data-set; and
 - views of local children, young people and families, drawing on local authority participation networks, the creation of Local Involvement Networks (LINks) and the Community and Local Government's Young Advisers initiative.
- using their CYPP and PCT Prospectus to set out specific priorities and actions to improve health outcomes for children and young people;
- commissioning targeted and specialist services, ensuring best value and monitoring the impact on improving outcomes;
- working with local partners such as schools, children's centres, third sector and local business what role each will play in supporting children's health; and
- leading local planning so that local communities become healthy and sustainable environments fit for children and families to live in.

3.29 Local authorities with their partners will also need to include green space, and safe routes for children to walk or cycle to local destinations, including play sites and schools. With 3,500 new or redeveloped public play areas and 30 new adventure playgrounds by 2011 – and better qualified play workers – children will have improved access to attractive environments that promote high levels of physical activity levels and support wellbeing.

3.30 LAAs will become the key delivery contract between central and local government and its partners. Local authorities will regularly report to central government on their performance against the range of 198 cross-government outcome focussed indicators in the new National Indicator Set (NIS). The NIS includes all locally measured PSA indicators – including all five of the delivery priorities in PSA 12 on breastfeeding at 6-8 weeks, obesity among primary aged children, emotional health & CAMHS; and services for disabled children.

3.31 From the NIS, each local area will agree with government up to 35 priority indicators against which they will negotiate improvement targets. These priority indicators will be signed off by Ministers. Local areas may also agree an unlimited number of local targets, as part of their LAA, which will not be reported to central government and which need not be drawn from indicators in the national set.

3.32 PCT Operational Plans are underpinned by the NHS Vital Signs indicators, which will measure progress against national priorities, and help PCTs to make local choices and set local priorities. Nationally, information on all the indicators will be published annually for local benchmarking purposes, but - with a greater shift towards local decision making - performance management will depend on which tier a given indicator is in. The approach is described in the table below:

	Targets	Performance Management
Tier 1 National Requirements (i.e. ‘must do’)	Set nationally and cascaded to either SHA or PCT level	PCT plans agreed by SHAs and signed-off by DH Central monitoring and performance management of all PCTs via SHAs
Tier 2 National Priorities for Local Delivery	Agreed locally and signed-off by SHAs	PCT plans signed-off by SHAs Risk-based approach to performance management focussed on weak areas or organisations only
Tier 3 Local Action	Priorities and any corresponding targets agreed locally	DH would not expect to be involved in performance management

3.33 Children are identified in the 2008-09 Operating Framework as part of the national priority areas in 2008-09. Supporting this, four of the five PSA 12 priority indicators are reflected in the Vital Signs indicator set for PCTs:

- three of the five PSA 12 priorities – on breast-feeding at 6-8 weeks, obesity among primary aged children, and child & adolescent mental health (CAHMS) - are national priorities for local delivery (Tier 2). Thus, all PCTs will be required to include these in their local plans to be agreed by SHAs, and which they will be held to account for delivering. If any of these areas have been prioritised as one of the 35 designated targets in the Local Area Agreement, PCTs can - with the agreement of local partners – use this as the means to tackle the priority.
- for the PSA 12 priority on services for disabled children, an indicator on parents’ experience of services for disabled children is included in Tier 3. Thus, working in conjunction with their communities and local partners, PCTs can prioritise this area for themselves. If this area has been prioritised as one of the 35 designated targets in the Local Area Agreement, PCTs must regard to these targets as one of the LAA partners.
- although the PSA 12 priority on school lunches is not reflected in the Vital Signs indicators, PCTs are still likely to be involved as local partners, particularly in the context of delivering the PCT plan for reducing the rate of obesity among primary aged children.

What this means for the Third Sector

3.34 Third sector 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. They also have a central role in giving a voice to children and young people, and to mothers and fathers, particularly among more disadvantaged groups.

3.35 Local community groups will be engaged in promoting better health and creating a healthy environment for children and families, for example, through their involvement in the DH ‘small change, big difference’ social marketing initiatives.

What this means for inspection and assessment

3.36 Local authority, PCT and other children's services will be within the scope of the new multi-inspectorate comprehensive area assessment (CAA) led by the Audit Commission. This will report annually on performance against the national indicators, on local authorities' use of resources and direction of travel, and on risks to delivery of outcomes in the local area. The CAA will be the basis for triggering bespoke focused inspections, by the appropriate inspectorate or inspectorates, of particular services in an authority or area. There will continue to be inspection in all areas of services for children in care. The new Care Quality Commission will undertake an aligned annual health check of health bodies. This will be aligned with the CAA, for example, many performance indicators for the health check will be drawn from the local government National Indicator Set.

3.37 For services themselves, Ofsted is responsible for the inspection and regulation of day care for children, of children's social care services such as children's homes and fostering and adoption services, and for inspecting schools and colleges. Other inspectorates will also assess and inspect relevant services, including the Care Quality Commission on health services, and Her Majesty's Inspectorates of Constabulary, Prisons and Probation on police, youth offending and probation services.

3.38 The inspectorates are working closely with relevant government departments to ensure there is coherence between these different inspection and assessment systems.

3.39 Inspectorates' assessment and reports can be a trigger for following up, through the National Improvement and Efficiency Strategy, risks and under-performance.

What this means for Businesses

3.40 The main partners in business will be the food industry: manufacturers, retailers and caterers (including school caterers). As children, young people, mothers and fathers change their behaviour to improve their own health, the food industry will need to support everyone in making healthier choices. Some manufacturers, retailers and caterers have been very active in encouraging healthier eating but, given the scale of the challenge, more needs to be done.

3.41 The progress made by the Food Standards Agency and different sectors across the food industry towards reducing salt intake provides a model for successful engagement. The Government expects companies in every food sector to demonstrate their commitment by pledging action to promote healthy eating. For example, the Government will be working with industry leaders and other relevant stakeholders to finalise a Healthy Food Code of Good Practice, based on the good work that they are already undertaking. Ministers and industry leaders would then establish the Code as a challenge to the industry as a whole.

DELIVERING THE FIVE PRIORITIES

3.42 Delivering against the five priorities in this agreement will also require specific action by Government and delivery partners, ensuring at national, regional and local level that the views of children, young people, mothers and fathers shape the way support is designed and provided. This will ensure that they are empowered to make informed choices about their health, and have real influence on the services they want to support them.

Delivery Priority I: Increasing breastfeeding at six to eight weeks

3.43 The DH 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.

Specifically, the Government will:

- support a National Helpline for breastfeeding mothers at local rates, providing mothers with access to professional advice in times of need;
- create an environment in maternity units that promotes breastfeeding by encouraging them to adopt UNICEF’s Baby- Friendly Hospital Initiative;
- pilot and then roll out the new World Health Organization (WHO) growth standards – based on breastfed infants up to the age of two years;
- develop a code of best practice for employers and businesses on how to encourage, support and facilitate employees and customers who breastfeed; and
- invest in an information campaign to promote the benefits of breastfeeding as part of a wider programme of campaigns on healthy development as part of our commitment to reduce obesity, set out in *Healthy Weight, Healthy Lives*.

Other partners will take action as follows:

- **Primary Care Trusts:**
 - 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 fathers; 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 and fathers, 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 mothers and fathers’ 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 and fathers through advice and helplines.

**Delivery Priority
2: Promote the
take up of school
lunches**

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

3.45 The DCSF 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 £240 million 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 – £150 million targeted capital fund in 2008-11); and development and promotion of further training and qualifications for school caterers.

3.46 Other delivery partners will:

- **The School Food Trust:**
 - 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 tailors 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**

3.47 The Government has mapped out how it intends to deliver this priority in a new £372 million comprehensive cross-government strategy, 'Healthy Weight, Healthy Lives' launched in January 2008. It comprises five policy themes for action: children, healthier food choices, physical activity, health incentives and personalised advice and support.

3.48 The first theme of 'Healthy Weight, Healthy Lives' is critically important to the delivery of PSA 12, and includes both universal and targeted programmes across the different life stages of a child:

Pregnancy and the early years:

- identify at-risk families as early as possible, through the Child Health Promotion Programme, and promote breastfeeding as the norm for mothers; and
- ensure that early years settings create a healthy environment, helping children and families establish and maintain healthy food and activity choices.

Children and young people:

- invest to ensure all schools are healthy schools, including making cooking a compulsory part of the curriculum by 2011 for all 11–14 year-olds;
- ask all schools to develop healthy lunch box policies, so that those not yet taking up school lunches are also eating healthily develop tailored programmes in schools to increase the participation of obese and overweight pupils in PE and sporting activities;
- invest in improving cycling infrastructure and skills in areas where child weight is a particular problem, as part of the recently announced package of further funding of £140 million for Cycling England; and
- develop strong school level indicators for issues such as obesity that, when taken together, measure a school's contributions to pupil well-being.

Information to support parents:

- give better information to parents about their children's health by providing parents with their child's results from the National Child Measurement Programme (NCMP); and
- invest £75 million in an evidence-based marketing programme which will inform, support and empower parents in making changes to their children's diet and levels of physical activity.

3.49 Although the remaining four themes are not focused specifically on children, they will help to reinforce the impact of programmes that are aimed at children and families:

- *Promoting healthier food choices:* our vision for the future is one where the food that we eat is far healthier, with major reductions in the consumption and sale of unhealthy foods, such as those high in fat, salt or sugar.

- *Building physical activity into our lives* our vision for the future is one where all individuals and families are able to exercise regularly and to stay healthy and well throughout their lives.
- *Creating incentives for better health* our vision is a future where all employers value their employees' health, and where this is put at the core of their business plans.
- *Personalised feedback and support*: we would like all individuals to have easy access to highly personalised feedback and advice on their diet, their weight, their physical activity and their health, providing them with personalised information to encourage healthy behaviours.

3.50 Delivering actions within the five themes will require action from all part of society, from individuals and communities, to businesses and voluntary organisations, right up to central government. DH and DCSF have a dual lead on child obesity and will seek to support delivery across the system by providing guidance on what works, working with the relevant bodies to update curricula, and ensuring that resources are used effectively.

3.51 Driving change will involve five main areas of activity:

- **Regional Public Health Groups, SHAs, and GOs** promoting 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.
- **increase participation in sport** through the Government's PSA (22) - to Deliver a successful Olympic Games and Paralympic Games with a sustainable legacy and get more children and young people taking part in high quality PE and sport - working with Youth Sport Trust and Sport England to increase participation to at least 2 hours per week of high quality PE and sport (5- to 16-year-olds) and an additional 3 hours per week of sporting opportunities (5- to 19-year-olds).
- **Local Authorities and PCTs** will be jointly accountable for reducing child obesity in local areas, and will need to: (i) change behaviour in planning of local services and the built environment such as play facilities, and providing workforce training; (ii) commission treatment interventions aimed at overweight or obese children and their families; and (iii) monitor local performance and target resources, including working with schools to ensure the success of the National Child Measurement Programme.
- **general practitioners, health visitors, midwives, school nurses, and practice nurses.** Health professionals will be trained to measure growth; 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.
- **schools and other front-line 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 mothers and fathers, 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 & wellbeing, and child & adolescent mental health services (CAMHS)

3.52 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 wellbeing and mental health, in particular the needs of vulnerable groups such as looked after children, to the NHS, local authorities and all those working with children, young people mothers and fathers in universal, targeted and specialist services, including parenting skills;
- commission an externally-led review of CAMHS to, amongst other things, develop priority actions for national, regional and local stakeholders in delivering the proposed vision of emotional health and wellbeing. The review will report in the autumn;
- 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 CAMHS;
- set out expectations of what support should be provided to support the emotional and mental health of looked after children, including the provision of dedicated or targeted CAMHS, in revised statutory guidance;
- review emerging data and evidence on implementation and outcome issues; and
- from 2008 provide additional £60 million funding for a three year project to provide targeted mental health work in schools.

3.53 Other delivery partners will take action as follows:

- **SHAs/GOs:**
 - promote effective practice, facilitate cross-sector working and provide intensive support for areas; and
 - provide a consistent approach to performance management of PCTs and local authorities.
- **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:**
 - engage 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 and extended 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 wellbeing 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

3.54 The former DfES/HMT-led review *Aiming high for disabled children: better support for families*¹¹ 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 will 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.

3.55 This will be taken forward in the context of implementing standard 8 of the National Service Framework for Children, Young People and Maternity Services¹² 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'¹³.

¹¹ *Aiming high for disabled children: better support for families*, HM Treasury/DfES, 2007

¹² *National Service Framework for Children, Young People and Maternity Services*, Department of Health, 2004

¹³ PSA 11 covers expectations for the educational outcomes for vulnerable children.

3.56 Backed by an additional £370 million from DCSF and with additional DH funding for the NHS over the next three years, the two Departments will act jointly to communicate the vision for supporting disabled children and issue guidance on making the 'core offer' a reality locally. In addition, delivery will include:

- transforming short-breaks provision for disabled children and their parents and expanding accessible childcare;
- 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;
- improve accessibility to appropriate childcare for families with disabled children, and
- scoping and delivering reform of community equipment and wheelchair provision.

3.57 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 local authority 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

3.58 The Secretary of State for Children, Schools and Families leads this PSA. The Senior Responsible Officer is the Director-General for Children and Families in DCSF who, with the Chief Nursing Officer for England, co-chairs a Child Health and Wellbeing Board. The Board:

- oversees delivery against the two cross-cutting themes and the five delivery priorities and indicators;
- provides a focus for work to implement the National Service Framework for Children, Young People and Maternity Services;
- identifies and monitors cross-cutting activity to improve broader outcomes of health and wellbeing for children, young people and families; and
- ensures action relating to children and young people's health and wellbeing is communicated coherently to the NHS and other delivery partners.

3.59 The Child Health and Wellbeing Board escalates issues, via a Permanent Secretary chaired officials group, to the Cabinet Sub-committee for Families, Children and Young People.

3.60 At local level, the landscape for joint working between local authorities and PCTs has changed radically over the past 4 years. The *Children Act 2004* set out to local authorities, PCTs and other partners a duty to co-operate to improve children's wellbeing as defined by the 5 ECM outcomes, including being healthy. More recently, the *Local Government and Public Involvement in Health Act (2007)* includes provisions for:

- a duty on local authorities and PCTs to undertake a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing needs of the local community;
- a duty on the local authority and named statutory partners (including PCTs, NHS Trusts and NHS Foundation Trusts) to co-operate with each other in determining LAA targets, of which up to 35 will be national priority targets agreed with central government;
- a duty on those partners to have regard to those targets they have agreed; and
- the establishment of the new Local Involvement Networks (LINKs) which will help ensure local communities have a stronger voice in the process of commissioning health and social care. LINKs will also be a key mechanism for PCTs to discharge their duty to involve and consult.

3.61 The five indicators underpinning this PSA all form part of the local government National Indicator Set (NIS), while four of the five indicators (with the exception of school lunches) are part of the PCT Vital Signs indicator set within the NHS Operating Framework.

3.62 Performance against these indicators will form part of each local area's discussions about LAA priorities with GOs, who will co-ordinate action to respond to local authority underperformance. PCTs are key partners in these negotiations. 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. The negotiations for 2008-09 LAAs are due to conclude in June 2008.

3.63 PCTs are expected to take account of the ongoing LAA negotiations, in the light of the outcomes of the JSNA in agreeing their 2008-09 plans with the Strategic Health Authority. All PCT plans are signed off at the end of March 2008, and the outcome of these plans will then subsequently shape the final stages of negotiation of the LAAs in partner local authorities. See *Delivering health and well-being in partnership: the crucial role of the new local performance framework*¹⁴ for more details.

CONSULTATION

3.64 This PSA Delivery Agreement has been updated in light of the *Children's Plan*, which was published in December 2007. In developing the *Children's Plan*, the Secretary of State for Children, Schools and Families led a national consultation with parents, teachers and professionals; and established three Expert Groups across three age ranges (0-7, 8-13 and 14-19), with representation across a range of professional backgrounds and organisations. The three *Children's Plan* Expert Groups were consulted on how to update this Delivery Agreement in light of the *Children's Plan*.

3.65 The *Children's Plan* Expert Groups will continue to advise on what action should be taken and the stakeholder reference group which supports the PSA Board will ensure stakeholder feedback is fed systematically into the performance management of this PSA at national level.

3.66 A Child Health Strategy will be developed over the summer, taking account of the NHS Next Stage Review - *Our NHS, our future*¹⁵ which is engaging the public, patients, professionals and stakeholders to identify the way forward for the NHS over the next decade and beyond. As part of the Child Health Strategy, the Department will set out what this will mean for the Delivery Agreement on child health and wellbeing.

¹⁴ DH/DCLG, December 2007.

¹⁵ *Our NHS: Our future. NHS Next Stage Review Interim Report*, DH, October 2007

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MEASUREMENT ANNEX

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 April-June 2008-09 will be available in September 2008. Proxy baseline data from the National Infant Feeding Survey 2005, showed 50 per cent prevalence of breastfeeding in England.
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. The number of children recorded as being breastfed at 6-8 weeks.
 2. The number of children recorded as not being breastfed at 6–8 weeks.

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.

3. The number of children recorded as receiving both breast milk and infant formula

A.1 Prevalence = Numerator/Denominator x 100

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 (SHAs) from Primary Care Trusts (PCTs) and then submitted to the Department of Health at quarterly intervals.

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	<p>Baseline (current measure): 42 per cent of primary school pupils and 43 per cent of secondary school pupils had a school lunch in 2005-06.</p> <p>Latest (current measure): 41 per cent of primary school pupils and 38 per cent of secondary school pupils had a school lunch in 2006-07.</p> <p>Baseline figures using current measure and new measure for 2007-08 will be available in August 2008. Subsequently, school lunch take up will be reported using the new measure.</p>
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, 6-12 Tothill Street, London SW1H 9NA
Minimum movement required for performance assessment	A 0.1 percentage point movement is sufficient to make a performance assessment.

DEFINITION OF KEY TERMS

A.4 The School Food Trust has collected data annually from local authorities, with an average response rate of around 70%. To date, the survey has only covered provision contracted by the local authority – it has therefore not covered all schools. Following a recent consultation, a new measure will be introduced in April 2008, to provide a more accurate measure of school lunch take-up from 2007-08. To maintain consistency over this transition period, the current measure will also be used in 2007-08, after which it will be dropped.

A.5 The new measure will be more accurate, with improved coverage and quality, by:

- ensuring that all local authorities provide data;
- standardising the methodology used by local authorities for calculating rates of take-up;
- ensuring that all types of provision of school lunch at all schools covered by school food regulations; and all Academies and City Technology Colleges are included in calculations of take-up rates, including:
 - local authority catering services;
 - private catering contractors (either at local authority, group or individual school level); and
 - schools providing their own school lunches.

Definitions of school lunch take-up:

Current measure:

- *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).

New measure:

- **Primary schools:** The reported number of meals served as a percentage of pupils attending maintained primary schools
- **Secondary schools (index of lunch take-up):** The till receipt for a given period for all sales of food to which school lunch standards (including nutrient-based standards from 2009) have been applied, *divided by* the price of a free school meal (i.e. the monetary value in the dining room of a free school meal)

Indicator 3	Levels of childhood obesity
National target	<p>Reduce the rate of overweight and obese children to 2000 levels by 2020 in the context of promoting healthy weight across the population.</p> <p>In the context of a trajectory to reach the 2020 ambition, over the 2007 CSR period the Government aims to reduce the rate of increase in obesity in children under 11 years old.</p>
Data provider	Department of Health.
Data set used	Health Survey for England (HSE).
Baseline	<p>Using HSE data on under 11 obesity prevalence from 1995 to 2006, the linear trend over the period is a growth of 0.5% points a year.</p> <p>This trend has been used to estimate a baseline of 16.1% in 2006.</p>
Frequency of reporting	Annual. Data available in December. ²
95 per cent confidence interval at last outturn	Last outturn 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	<p>Applying the 0.5% current linear trend, the forecast trajectory over the CSR period is from 16.1% in 2006 to 18.7% in 2011.</p> <p>To demonstrate a reduction from the forecast rate of growth over the CSR period that is in line with a trajectory to reach the 2020 ambition, the prevalence of child obesity in under 11s needs to be a maximum of 18.1% by 2011.</p>

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.

² 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	<p>Emotional health data will be based on results from the annual TellUs Survey, which include measures of key risk and resilience factors for emotional well-being; friendships and relationships.</p> <p>The CAMHS data will be based on the quarterly returns on comprehensive CAHMS used for the SR 2004 target. This is currently based on three sub-measures on: emergency CAMHS; services for those with Learning Disabilities; and services for 16-17 year olds. This will be supplemented by an additional sub-measure on joint commissioning of early intervention support services from 2008-09, though this will be collected annually</p> <p>A new measure based on the impact of CAMHS is being developed, under the auspices of the independently-chaired CAMHS Review. Subject to the outcome of the review and development work, the plan is to take forward work on this measure from April 2009.</p>
Baseline	<p><i>Emotional health:</i> Baseline data from the 2008 TellUs survey (TellUs 3) will be available in November 2008.</p> <p><i>Comprehensive CAMHS:</i> baseline data on four sub-measures (see above) will be available in early 2009 from the 2008 CAMHS Mapping exercise.</p> <p><i>CAMHS outcome:</i> Subject to the outcome of development work, the plan is to implement this measure from April 2009.</p>
Frequency of reporting	<p><i>Emotional health:</i> Annual TellUs survey results in November of each year.</p> <p><i>Comprehensive CAMHS:</i> Reporting will be annual through the CAMHS Mapping exercise. The first set of data relating to the four sub-measures will be available in early 2009.</p> <p><i>CAMHS outcome:</i> Subject to outcome of development work.</p>
95 per cent confidence interval at last outturn	<p><i>Emotional health:</i> Under development, subject to analysis of the Tellus 3 data.</p> <p><i>Comprehensive CAMHS:</i> Not applicable – the existing 2007/08 Local Delivery Plan Return quarterly data covers all CAMHS services in England.</p> <p><i>CAMHS outcome:</i> Subject to outcome of development work.</p>
Data Quality Officer	<p><i>Emotional health:</i> Young People Analysis Division, DCSF, Great Smith Street, London, SW1P 3BT</p> <p><i>Comprehensive CAMHS:</i> Head of Performance Analysis, Department of Health, Quarry House, Quarry Hill, Leeds, West Yorkshire, LS2 7UE</p> <p><i>CAMHS outcome:</i> Health and Wellbeing Division, DCSF, Great Smith Street, London, SW1P 3BT.</p>
Minimum movement required for performance assessment	<p><i>Emotional health:</i> Under development, subject to analysis of TellUs 3 data.</p> <p><i>Comprehensive CAMHS:</i> No minimum movement requirement as all services report.</p> <p><i>CAMHS outcome:</i> Subject to outcome of development work.</p>

DEFINITION OF KEY TERMS

A.6 Emotional Health: The aim of this indicator is to capture one of the key elements of children's emotional health: the quality of their relationships with family and friends. The quality of relationships is a key protective factor for their emotional well-being. Four questions in the TellUs survey from 2008 have been developed and cognitively tested to capture this, and they have been included in the TellUs survey from 2008. The survey also includes questions around bullying and child safety, which will also provide useful context.

The four items are that will be used to form the indicator are:

- I have one or more good friends;
- When I'm worried about something I can talk to my mum or dad;
- When I'm worried about something I can talk to my friends; and
- When I'm worried about something I can talk to an adult other than my mum or dad.

A.7 The measure will be the percentage of children who enjoy good relationships with their family or friends. The definition of 'good' will need to be determined after an initial analysis of the TellUs³ results. This will include consideration of the distribution of responses to each item and the distribution of responses to combinations of the items.

A.8 Comprehensive CAMHS: The definition of comprehensive CAMHS is based on Appendix 2 of the Mental Health and Psychological Well being of Children and Young People Standard³, which is part of the National Service Framework for Children Young People and Maternity Services.

A.9 From 2008-09, the indicator will be based on four 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 support services.

A.10 CAMHS outcome: A CAMHS outcome measure is being evaluated in Kent in 2008, by measuring change in a child's and parent's view of difficulties prior to and six months after their first specialist CAMHS appointment. The measure used is the Strengths and Difficulties questionnaire, a 25 item questionnaire completed by referred children aged 11-18 years and parents of children aged 3-16 years. It 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.

³ This can be found at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4869049

Indicator 5	Parents' experience of services for disabled children and the 'core offer'
Data provider	Department for Children, Schools and Families (DCSF).
Data set used	<p>The DCSF will commission a new survey of parents and carers of disabled children at local authority level. The indicator will be derived from responses on the experience of local service provision (see below).</p> <p>Research is ongoing to develop an appropriate questionnaire and survey methodology. The DCSF and DH intend to finalise the survey methodology in autumn 2008.</p>
Baseline	This indicator will be based on a new survey. The survey will be conducted at national level at the end of the 2008-09 financial year to derive a national baseline. The survey will be conducted annually at local authority level from 2009-10.
Frequency of reporting	Annual. Exact dates and survey methodology will be confirmed alongside baseline survey arrangements.
95 per cent confidence interval at last outturn	Subject to the outcome of ongoing development work.
Data Quality Officer	To be confirmed with survey arrangements and methodology.
Minimum movement required for performance assessment	Subject to the outcome of ongoing development work.

DEFINITION OF KEY TERMS

- *Service provision:*
the survey will focus on the general experience of families with disabled children and how these meet the 'core offer' - national expectations for local service delivery proposed by *Aiming High for Disabled Children: better support for families*. Specifically, these expectations relate to:
 - 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
 - accessible feedback and complaints procedures.
- *Disabled children:*
these are defined by the Disability Discrimination Act, 1995.

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