Bristol Clinical Commissioning Group

AGENDA ITEM NO: 5

Bristol's rising child population - a strategic response

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Date of meeting	5 Sept 2013

1. Purpose of this Paper

Bristol's Joint Strategic Needs Assessment (JSNA) process has focussed in detail on the recent increase in the child population in Bristol, looking at the evidence and considering the impacts of this (present and future) on the whole health, care and education system in order to assist the Health and Wellbeing Board to develop a strategic response to this issue.

This draft summary report and potential actions have been further developed through input from leadership teams across Bristol City Council and NHS Clinical Commissioning Group (CCG), as well as health partners and the Children and Young People Outcomes Board. It is still intentionally work-in-progress, and no firm courses of action are suggested at this stage.

2. Context

This work has being co-chaired by Service Directors Claudia McConnell (Children and Young People Services and Bristol CCG) and Kelechi Nnoaham (Public Health).

The development of the JSNA and Health and Wellbeing Strategy highlighted that a key aspect of Bristol's population profile is a rapid and continuing growth of the child population in the city. In addition, the 2011 Census gave a different age profile for Bristol with even more children than projected, especially in the Inner City.

It also became evident that whilst different parts of the health, care and education system are working hard to try and keep on top of this increase in demand, at times this is happening in isolation and there is a need for a joined-up, strategic response.

3. A) Key points on population changes

- In the last decade Bristol's child population has been consistently rising, and is now the highest it's been since the early 1980's (see fig 1a in Appendix A).
- The change has not been equal across the city, partly linked to migration. Bristol's child population increased much more in the Central or Inner City wards

in the last decade, and in South Bristol fell slightly (although South started with a higher child population) (fig 1b, 2001-11 by CYPS Area[1]).

- Bristol's growth in child population is significantly greater than the national average. Between 2002 and 2012, the number of children under 5 in Bristol rose by 34%, almost double the 18% rise in England (15% in the South West). This was the 2nd highest of the Core Cities (Manchester 1st on 44%) – see fig 2a.

  Children and young people 0-19 in Bristol rose by 10% between 2002 and 2012, almost 3 times the 3.5% rise in England and 5 times the rate for the South West (2%). This was 3rd highest of the Core Cities (Manchester 1st on 14%) - fig 2b.

- The current rise is mainly an increase in young children under 5 years, so mainly affecting early years services (fig 3a & 3b). This rise in young child population is also higher than was predicted prior to the Census, especially in Inner City (fig 5). Child population numbers will remain high as these children grow, and increasingly affect services for school-aged children.

- Birth rates in Bristol (2012) are now 22% higher than they were in 2005. These rates have risen consistently across the city (fig 7). Recent data suggests average rates may be levelling off now. However, rates in some wards are continuing to rise, and there are variations in fertility rates across the city (fig 8).

- Other drivers behind this increase include international migration to Bristol in the last decade, including families with children and young working-age adults who have since had children here, which may explain patterns in fig 4.

  Actual child numbers across Bristol now (fig 18 is a snapshot in April 2013 using GP registration data by wards) shows half of the 6 highest wards are in the Inner City (Lawrence Hill 1st, Ashley 3rd and Easton 5th), plus Filwood (South) has the 2nd highest numbers with Hillfields (East) 4th and Southmead (North) 6th.

- Increasing levels of ethnic diversity in Bristol is even more so for the child population. For children (0-15), the Bristol average is 27.8% BME (or 31.9% BME including non-British white children), considerably higher than the overall rates in Bristol (16% BME population or 22% BME including non-British white).

  There are very large differences across the city in numbers and proportions of children (0-15 yrs) who are BME, ranging from 6% in Whitchurch Park to 83% in Lawrence Hill - fig 6b (or 7% to 86% BME including non-British white children, with the same wards lowest and highest).

[1] CYPS is Bristol City Council's Children & Young People's Service, and has 3 Areas: South, North & West, and East Central. The CCG has 3 Localities: South, North & West, and Inner City & East (similar but not identical).

- Population projections are not certain, partly linked to unknown future migration patterns, but even if the birth rates remain stable as suggested, the increase in number of young children will become sizable increases through primary and then secondary school ages, with changing impacts on service (fig 9).

3. B) Summary themes emerging for action

There are some clear initial themes emerging for further investigation and potential actions, as summarised below. As these are developed they should maintain a focus on the need to reduce health inequalities, particularly for vulnerable or disadvantaged groups within the child population, as well as quality service provision for all.

For some of the themes identified there are already specific programmes of work in progress to address the issues raised, which are highlighted in the text.

3.1 Improving integration

This has several strands. For example, at a Primary Care level services could work more like a "team" locally, with key staff such as midwives and health visitors working equally closely with GPs, community child health services and CYPS.

Within the First Response project (front door access and triaging for all children who need help or there is a concern) and Targeted & Integrated Family Support (T&IFS) project, a lot of work has been done with health colleagues to work in a multi-agency way. This work is being led from within CYPS in the Council. Further integration is the aspiration, not just across primary health care settings but within the area based targeted and integrated family support model, using the single assessment framework and existing settings such as Children's Centres.

Potential action to recommend
Develop specific health representation on the First Response team, to access health data systems (eg to check who the relevant GP is). Ideally also clinical expertise to advise re subsequent pathways (this aspect may not be an easily identifiable post).

Other examples are closer partnership working with Dentistry, to better promote oral health, and developing better links to Pharmacy facilities in the community.

A new Health Integration Team (HIT)[2] is being developed to address Paediatric Health Inequalities, which could be an appropriate forum to develop this partnership working. Children's oral health will be one of the work-streams for this HIT.

Potential action to recommend
Develop through "Bristol Inequalities in Early Years Health and Wellbeing HIT"

[2] This HIT is "Bristol Inequalities in Early Years Health and Wellbeing Health Integration Team", proposed for autumn 2013. For more info on HITs, see www.bristolhealthpartners.nhs.uk/health-integration-teams

Children's Centre links with GP practices could be developed following the model of health visitor links. School nurses and GP surgeries could work more closely together.

Links are being developed between Children's Centres and Inner City GP practices.

Also, Child development, including readiness for school, is part of the above HIT.

Potential action to recommend
Further strengthen joint working within the Targeted and Integrated Family Support, using the single assessment framework being rolled out, to include these links.

Key workers and services could join up more at the point of delivery, such as through First Response, and link up better with Housing and homelessness services.

It is planned that health will be integral to First Response (plus improve links with homelessness and housing). "Key working" is a central part of the agreed model for T&IFS Services and services for SEN and Disabled Children.

Potential action to recommend
The Health and Wellbeing Board take a leadership role to drive this forward.

Emotional health and wellbeing
Children's Centres have bid for funding to support an Infant Mental Health pilot. There is also an additional Health Integration Team (HIT) being planned on Perinatal Mental Health.

"Think Family" and safeguarding of children will be included within the core specification for the adult mental health services.

The role of Primary Mental Health Specialists (tier 2 CAMHS) within multi-agency teams is critical to supporting emotional health and wellbeing.

Potential action to recommend
Health and Wellbeing Board to promote development of "family links" to adult Mental Health, drug and alcohol services.

3.2 Improving intelligence

We need to better utilise the "voice of the community" to support quantitative data and use more "soft intelligence" to model impacts. For example, different communities may have different attitudes towards child protection.

Intelligence is a priority in the Bristol Children & Young People's Plan (2011-14): "Improve our joint understanding and forecasting of demographic changes". Developing quantitative data is also part of the Paediatric Health Inequalities HIT.

First Response will be gathering new data and intelligence, and link to the Outcomes Framework. Consider ways to collect and analyse this as standard process.

Potential action to recommend
Develop asset-based approach to highlight community input and best practice.

Improve data linkage across systems, identifying gaps and potential methods to fill them, to enable better development of services. Develop better modelling; for example try to develop joint intelligence on the potential impact of Romanian & Bulgarian migrants on the future child population, or to model the impact of welfare reform changes on child poverty (and subsequent child health impacts).

The Disability Trends Modelling Project (joint across CYPS, Public Health and Health providers, to develop a better understanding of the increasing numbers of children in Bristol with additional needs) is also developing an "in-principle" case for why this is needed, with interim recommendations re best practice in data linkage.

The Paediatric Health Inequalities HIT may develop joint work on the impacts of welfare reform changes on child health inequalities, but would require additional input from partner organisations.

Potential actions to recommend
Consider proposals from Disability Trends Modelling Project and Paediatric Health Inequalities HIT.

There needs to be better join up of information across provider and commissioner organisations to improve planning, and sometimes to clarify who is the lead.

The CYPS Joint Commissioning Team is considering the "lead commissioner" role to ensure arrangements have a consistent quality of challenge and support provided.

Potential actions to recommend
Link improvements within the Council's own data and intelligence teams (Intelligent Council programme) across the wider landscape. Strengthening of the JSNA governance and operational functions are currently underway.

3.3 Skills

There is potential for staff across all health and community settings to make better use of each other's expertise, especially with regard to specialised paediatric skills. For example, it's estimated that only 30% of GPs have paediatric training. Doctors with paediatric skills (GPs and/or secondary care Paediatricians) as well as community practitioners, could link up more to support other Doctors / services / GP practices.

Education needs of service providers may be a cross-cutting theme in the Paediatric Health Inequalities HIT.

Training needs of staff in understanding health beliefs of particular community groups, particularly around disabled children with complex needs.

As part of CYPS work to deliver a multi-agency early help offer, multi-agency training

is being rolled out, in relation to thresholds, single assessment and means of accessing advice and support. This will require clear commitment from all staff.

3.4 Access to health services

Support people, especially recent migrant families, to understand the health system, self-care and the need for immunisations. This needs to be culturally sensitive and VCS partners have expertise in this area, as do Health Link workers from Bristol Community Health (commissioned by the CCG), who have the potential to provide this support in practices. Also, simplify the branding of the NHS offer.

Potential actions to recommend
Further develop outreach services into migrant communities to ensure that communities are aware of services, and of any eligibility needs to access them.

Also, address this in the streamlining of the City Council Information, Advice and Guidance project ("Universal Front Door").

English for Speakers of Other Languages (ESOL) for Health delivered through children's centres and other settings could reduce translation costs and increase appropriate access to services. (NB Estimate 30% of Emergency Department attendance is minor illness and injury which could be better treated elsewhere).

CYPS is currently leading a major bid for community-based English Language services, including an ESOL related 'app' to be used by families to navigate local services - including health services.

CYPS School Standards work has identified issues for schools in East Central[3], partly connected to the increase in children with English as Additional Language.

3.5 Health in Schools

Establish what schools need and to try to model health support services to offer this. Schools may be willing to buy support if they can see what it is with clear benefits, and a reasonable cost. The offer may not always be clear at the moment – need to promote evidence more vigorously, re why healthy children learn better.

The Bristol School Organisation Strategy 2012-16 includes detailed city-wide information, largely using similar demographic information to the JSNA, but a different focus.

In many schools the links between children being happy and healthy and improved learning and life-chances are strongly understood, and the Healthy Schools team work hard to support this. This approach may not be uniformly implemented, given competing demands on schools that now need to commission support directly, and there may be need for more support services.

[3] "East Central" is the term used by CYPS, whereas "Inner City & East" (ICE) is used by the CCG. The only difference is Cabot ward, in ICE for CCG, but in North & West for CYPS. All other ward allocations are the same

Potential action to recommend
Develop stronger "health offer". Query whether Healthy Schools be developed along Trading with Schools lines? Needs further discussion re appropriate route.

At present not all schools or academies have school nurses, which was raised as a concern. In the absence of national direction, need to consider a local consensus.

Action in progress
The Bristol Children & Young People Outcomes Board have taken this as a specific action within their remit, and have a discussion on "school nurses" as an agenda item at the next Board meeting.

Have child emotional health and wellbeing at the heart of the health and wellbeing strategy, and demonstrate impacts on standards, attainment and life chances.

Emotional health is a priority in Bristol's Children & Young People's Plan (2011-14).

Potential action to recommend
Develop stronger "health offer" through implementation of Health and Wellbeing Strategy in this area.

3.6 Location of services

Consideration should be given to the co-location of primary and secondary care in some instances in order to focus on providing services people want rather than on the historical offer. (For example, some primary care services available at A&E?).

Bristol City Council buildings and NHS buildings should be looked at in the round to develop more flexible usage plus co-location of some services.

Within the CYPS programme areas the issue of co-location with partners is being actively considered and opportunities are being identified.

Potential action to recommend
Further discussions to take place (internally within the council and with partners) on the accommodation strategy for face-to-face engagement with service users.

Immunisation could be undertaken in different settings to increase take-up? (Note differences in take-up by Area (chart 20, appendix A): lower in Inner City & East).

Immunisation delivery is now responsibility of Public Health England (PHE).

Potential action to recommend
Develop specific recommendations for local partnership working with PHE.

3.7 Demonstrating Impact

Get better at demonstrating impact through more long-term analysis and evaluation of what is effective.

A CYPS Outcomes Framework is in development to allow systematic evaluation of the services redesigned by Children First, with appropriate indicators.

Map out where we spend money (contracts and commissioning) in different sectors and step back and look at the overlaps and impacts to get a more strategic view.

The new Commissioning Boards are using this approach. Eg SEND+ considered an early cut of the "whole" picture around SEN and Disability, which will be refined. Also the Disability Trends Modelling Project is utilising a “fuzzy logic” technique to link different data-sets within the City Council and NHS, which has potential to be more widely applied.

Potential action to recommend
A joint-sector approach to see the whole picture and highlight overlaps and cross-benefits will also support an increase in efficiency.

3.8 Service re-design and targeting

There is a need to balance the provision of universal services for all children with targeted services for those most in need. We also need to be able to respond to changes in current demand, whilst re-focussing services to reduce preventable increases in future demand where possible. Implications around efficiency and affordability may need to be addressed through the implementation of the Health and Wellbeing Strategy, and how the above balance will be maintained should there need to be a shift from universal services towards more targeted ones.

Consider re-focussing capacity of community child health services to areas of highest need.

Re-design systems to promote more early intervention to try to reduce higher need (and higher cost) demand later on.

Bristol’s Safeguarding Children Board is to publish “thresholds guidance” for all services including “early help”, in line with statutory requirements in autumn 2013. These are currently in discussion with partners and other stakeholders.

Action to note
The Children First Programme (lead by CYPS) is premised on a shift in resource allocation to target those most in need. Systems re-design towards earlier intervention is a fundamental part of the programme, in particular, Targeted & Integrated Family Support offer and First Response.

Numbers of Looked After Children in Bristol (Children in Care) have risen over the last 4 years, and we have a higher rate than statistical neighbours / national average (see chart 14 in appendix A).

Note - The proportion (rate per 10,000 of the under 18 population) has decreased slightly over the 4 years (possibly reflecting the investment and energy Bristol has focussed on early intervention to meet this challenge) but numbers have risen.

The Balance of Placements Children First project aims to deliver services to more effectively meet this challenge, to get the right placements for children in and leaving care and improve outcomes. This will be done through targeted early help, a core pathway into and through services, a focus on permanent families for children and increasing local sufficiency to reduce out of authority placements (also saves costs).

Potential action to recommend
Improving intelligence around children in care populations

4. Key risks and Opportunities

Services may need to be delivered in new ways to meet these demographic pressures, as outlined within the sections above.

5. Conclusions

Bristol's child population has increased markedly, and the make-up of this population within and across the city is substantially different to just a few years ago. This is impacting on services across Bristol, and will continue to do so over the next decade and beyond. In order to respond to changes in current demand, and prepare for future service pressures while maintaining a focus on reducing child health inequalities, we need a joint, strategic approach to developing services and a formal action plan to take this forward with all relevant partners.

6. Recommendations

For the Health and Wellbeing Board (HWB) to appoint a cross-partner working group to build on the themes in this report and develop a formal Action Plan, and report back to the HWB in Feb 2014 for consideration.

The proposal is for this next stage to be directly led by Service Director Claudia McConnell, as the joint children's commissioning lead for CYPS and the CCG, with direct support from the Public Health Child Health Consultants, and other partners to be appointed. The Terms of Reference will need to clarify the scope of this work.

7. Appendices

The Key points on population changes section highlights significant changes noted through the JSNA "Child population" process, which are further expanded in the data summary as Appendix A.

Initial stakeholder meetings were held with key partners to identify key impacts - Appendix B outlines the feedback in further detail, and Appendix C is the delegate list.

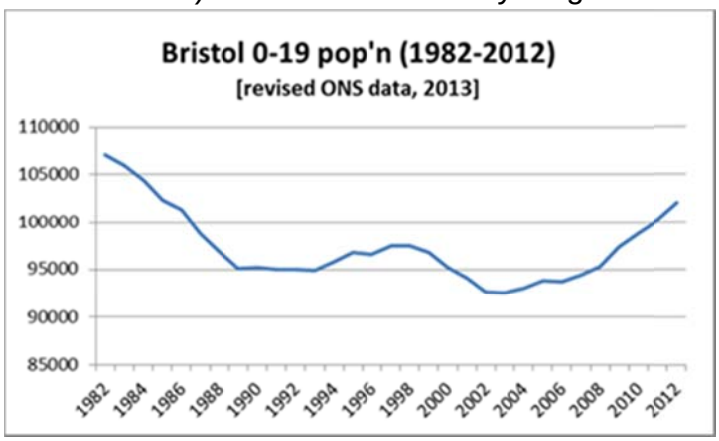
Appendix D is a list of on-going key engagement meetings.

Appendix A – JSNA Child population Summary

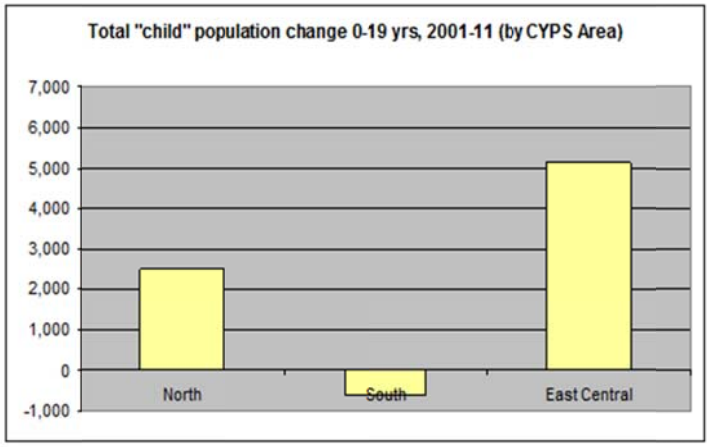
Change in Bristol child population

1. Large rise in child population

a) back to levels of 30 yrs ago

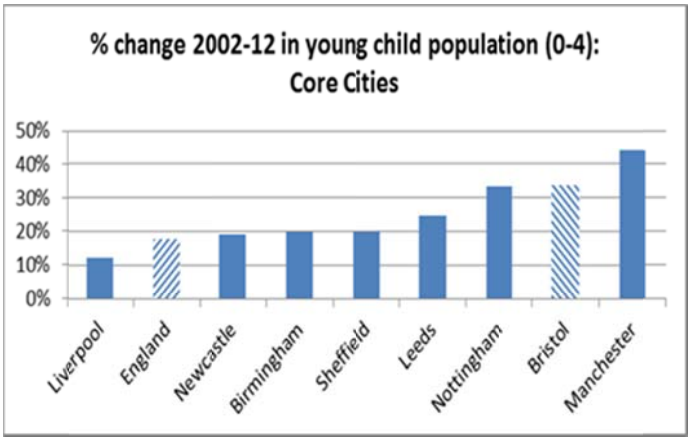


b) differences across Bristol re change in overall numbers

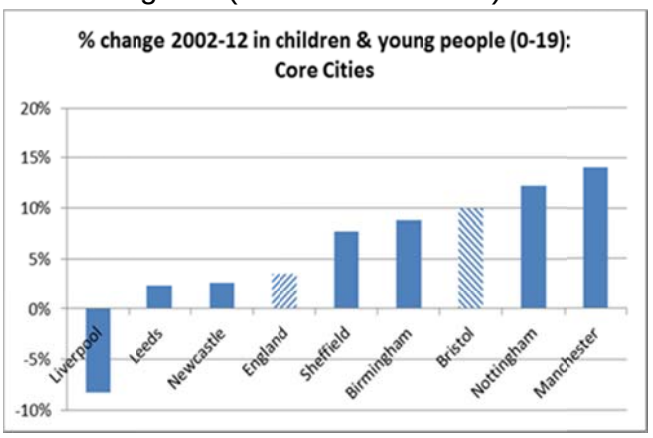


2. Benchmark increase against England & Core Cities

a) young child population: 2nd highest (2x national % rise)

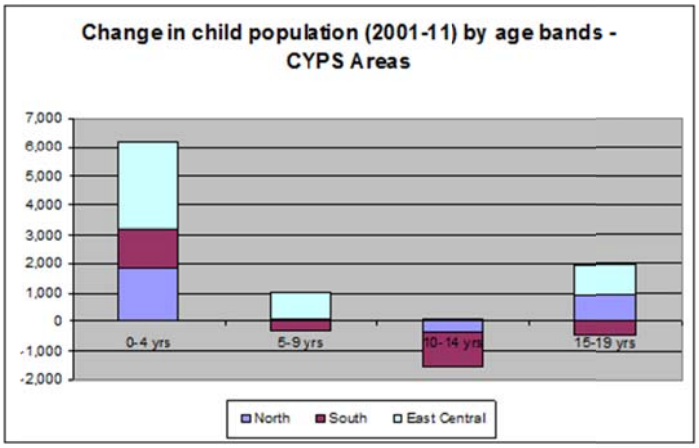


b) children & young people (0-19): 3rd highest (3x national % rise)

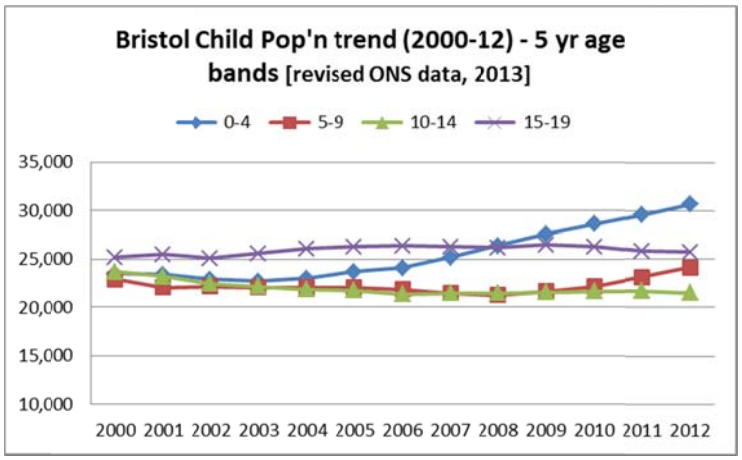


3. Increase by age band is mainly in 0–4's

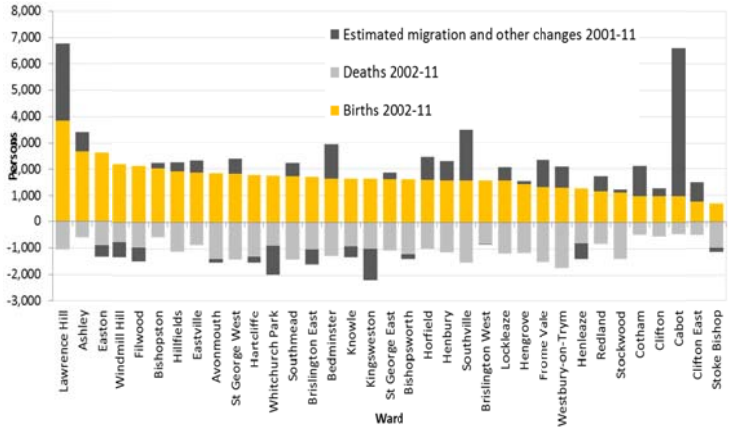
a) across all areas of Bristol (2001-11)



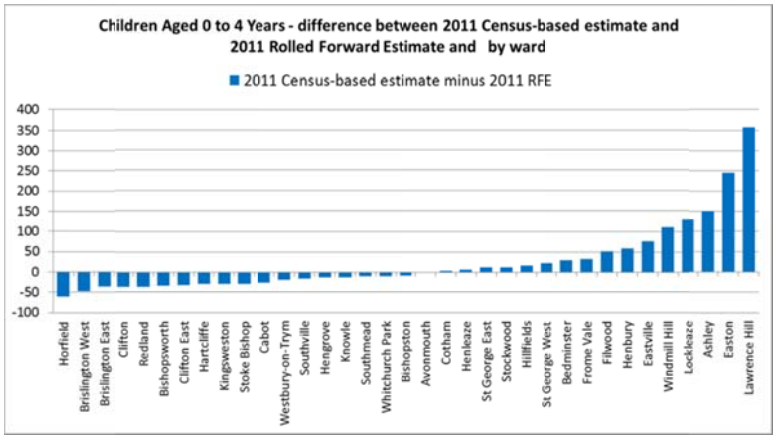
b) Trend 2000-12 shows rise in 0-4's, & now in 5-9's



4. Increase in Central wards driven largely by international migration and higher birth rates of the new communities

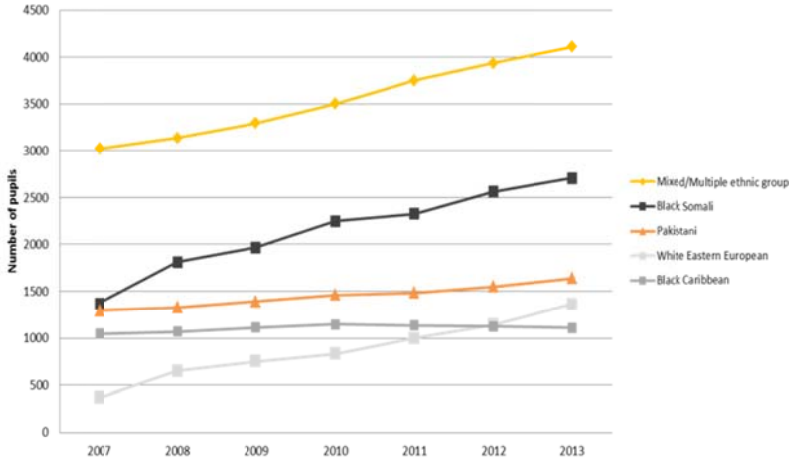


5. Census showed higher child population than previously estimated, especially under 5's in Central wards:

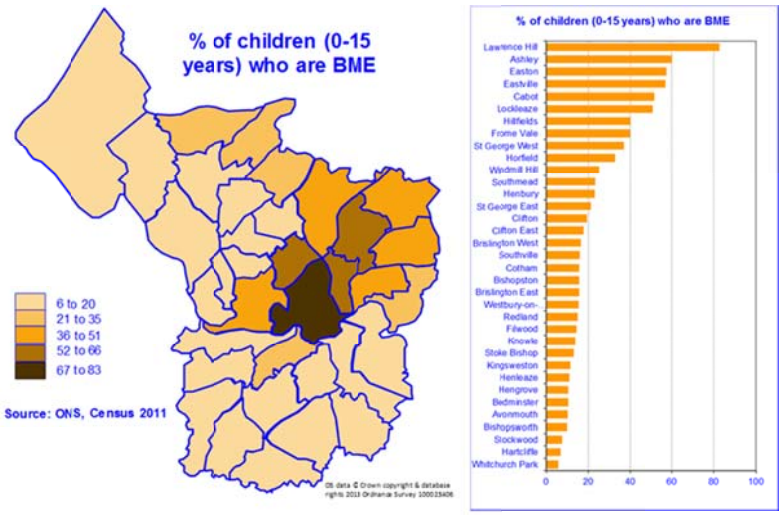


6. Increasing ethnic diversity (increasingly in Central & East)

a) School Census trend (2013):

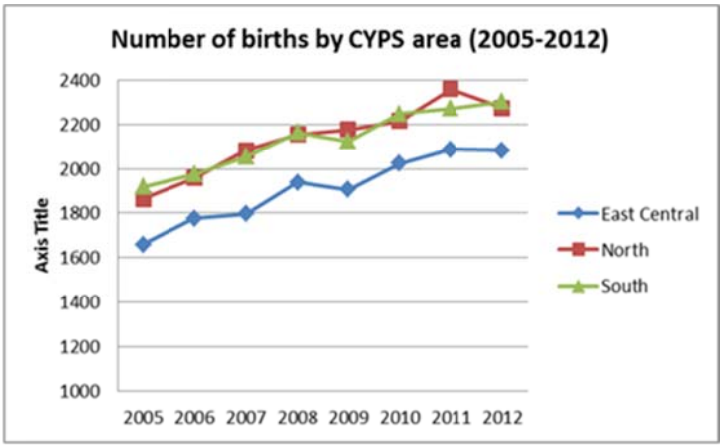


b) Child BME % (Census 2011)

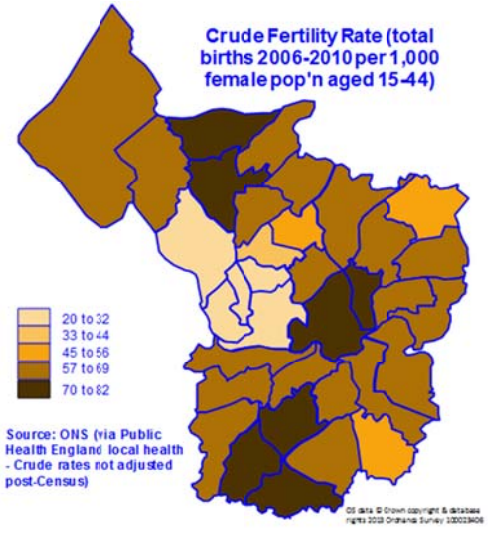


7. 22% increase in numbers of births – possible levelling off?

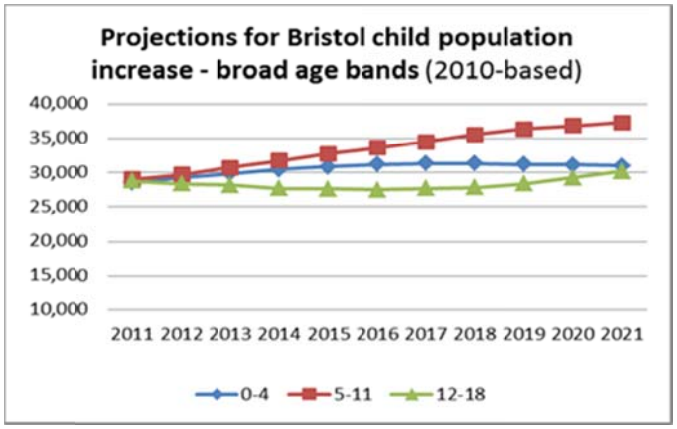
[NB 2012 is different data source]



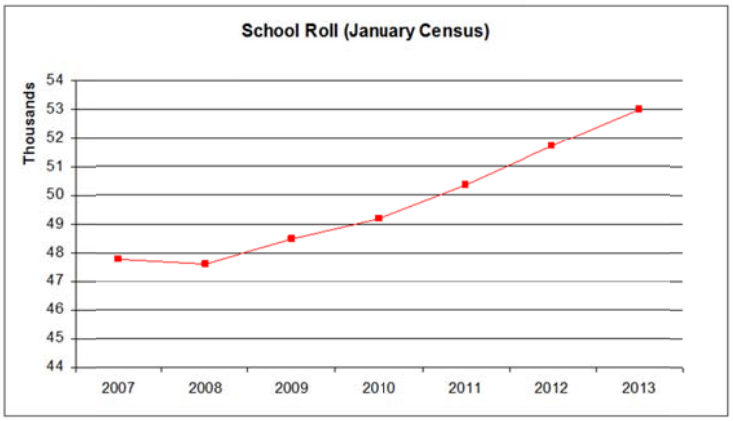
8. Fertility rates – variations across Bristol, different reasons



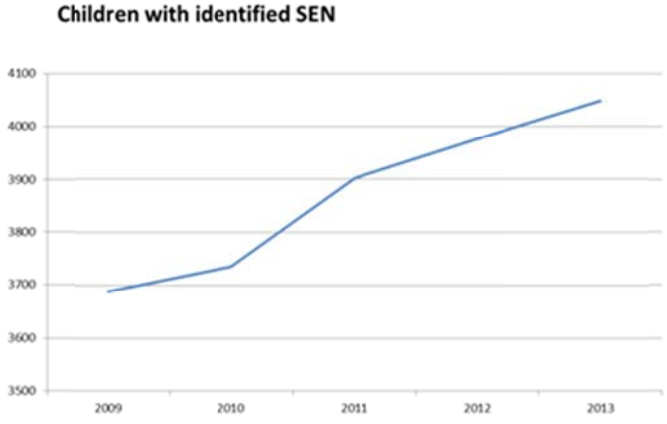
9. Predictions suggest that under 5 population will plateau in the future, but with increase in Primary school age *[NB Under 5 projection may change]*



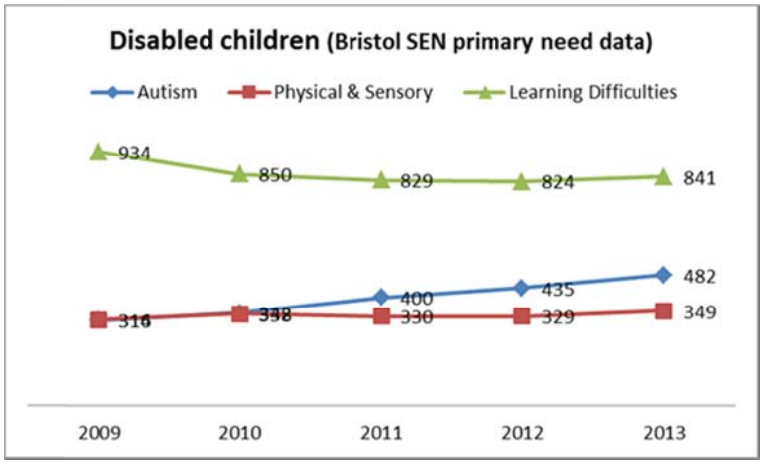
10. Pressure on School places *(Note – School Organisational Strategy addresses this in detail)*



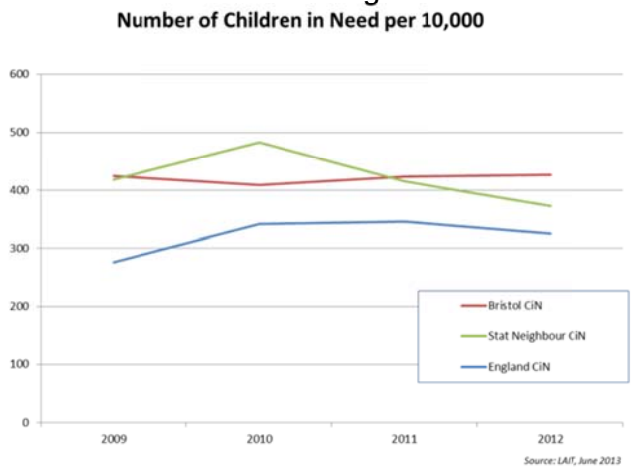
11. Rise in children with Special Educational Needs, SEN (increase of 300 over 4 years)



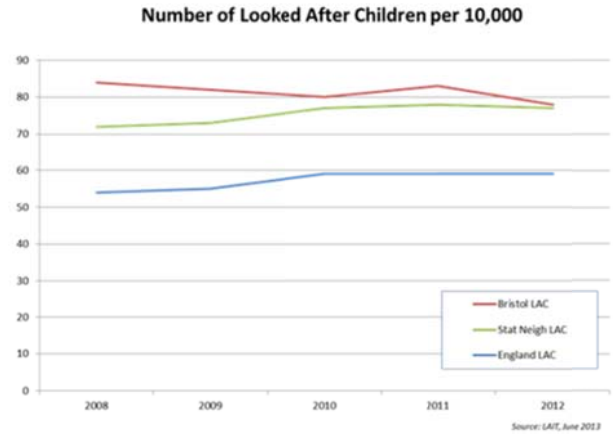
12. Disabled Children - increasing complexity of need *[Extracts from SEN data as interim proxy - shows increase in Autism - limited as is only school age]*



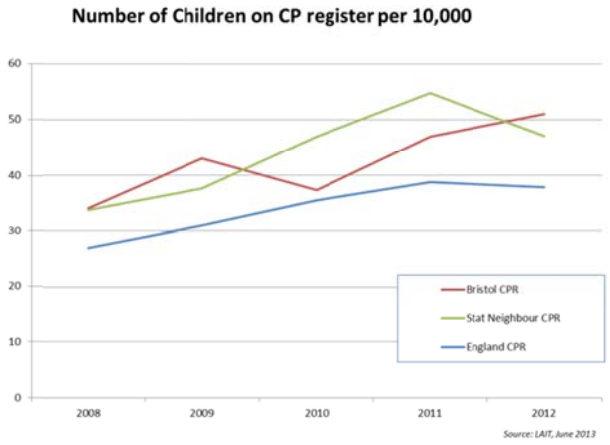
13. Children In Need rate per 10,000 appears fairly static, but actual numbers rising



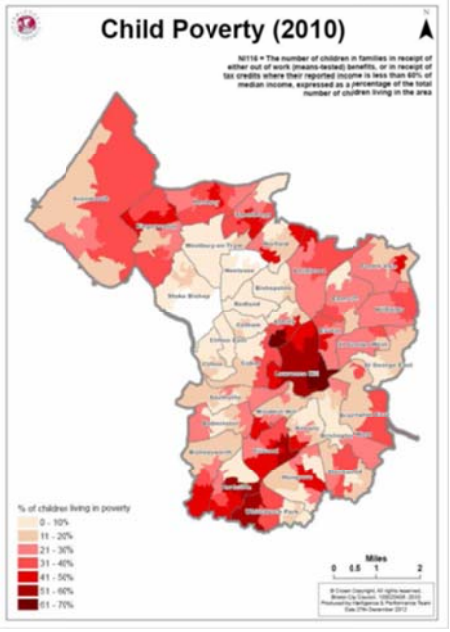
14. Looked After Children – stable rate but above average (& actual numbers rising)



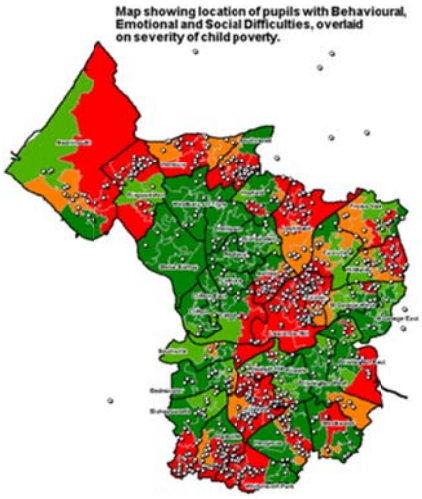
15. Numbers (and %) rising of children on Child Protection list



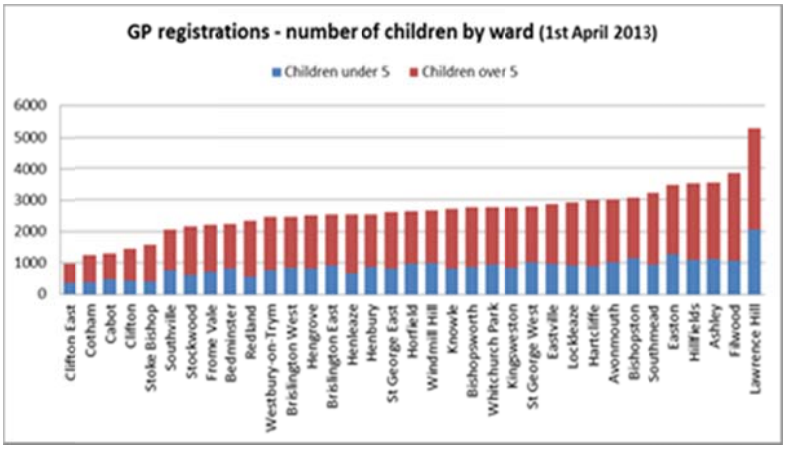
16. Child Poverty - 1 in 4 children in Bristol are living in poverty compared to 1 in 5 nationally, but big differences across the city



17. There are links between poverty and children with SEN



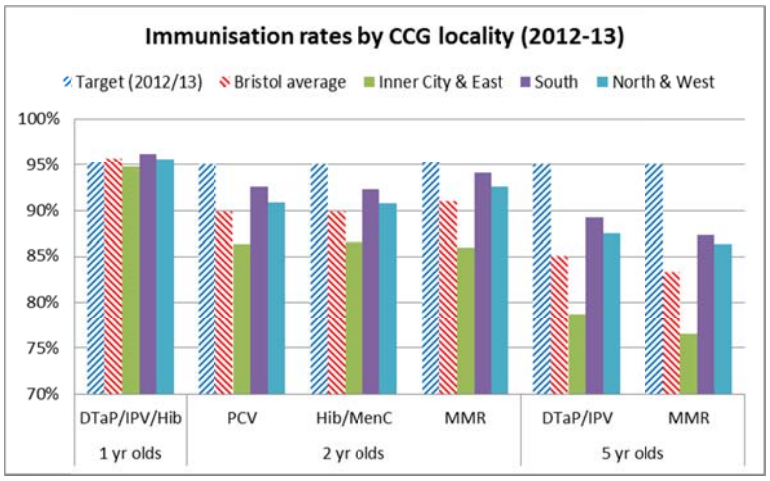
18. Increase in GP list sizes – disproportionate impact of young children on workload



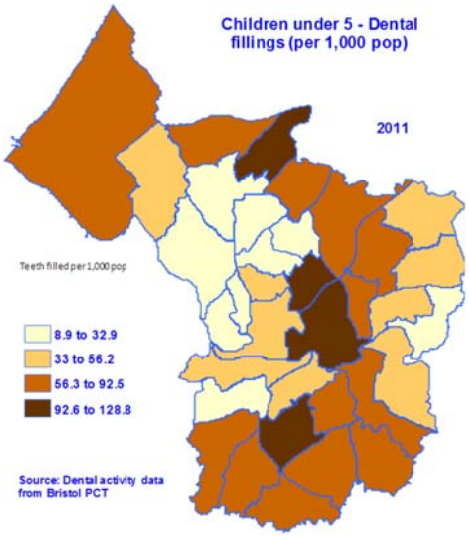
19. Increasing pressures on school nursing, out of hours services, health visitors

20. Pressure on services, such as Community paediatrics, CAMHS, maternity and perinatal care

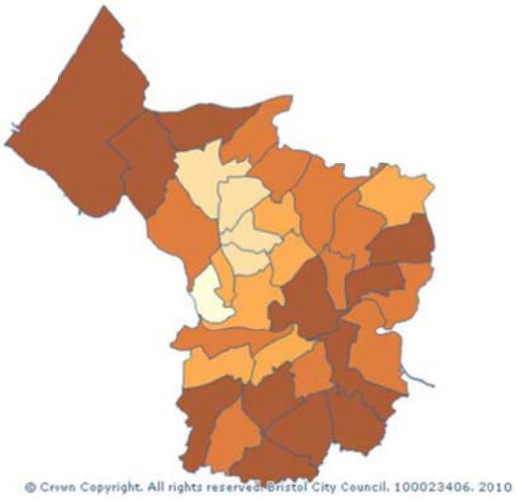
21. Immunisation coverage – differences across city, being lower in Inner City & East



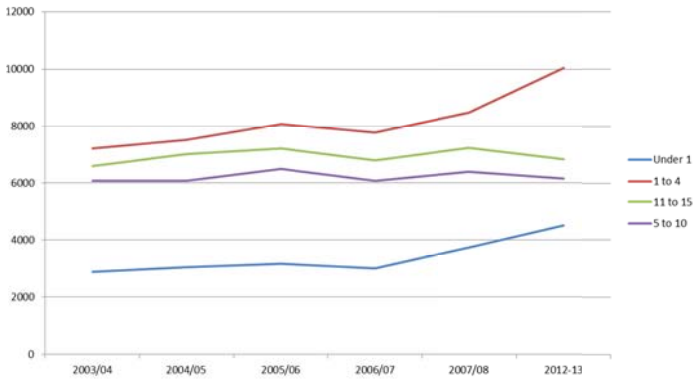
22. Poor dental health maps onto areas of deprivation:



23. Childhood obesity is still an issue, with differences over Bristol [eg 19% of Yr 6 children obese (2011/12)]



24. Growth in numbers of children presenting at Emergency Dept is due to under 5's:



Appendix B

Table discussion notes from JSNA Seminar on Bristol's Rising Child Population - A Strategic Response

Discuss the current and future potential impact of the rise in the children's population on *your topic area*. Please consider the following questions:

- What are the consequences of these impacts for the health and wellbeing of the children receiving these services?
- Where could different parts of the sector work better together on this issue?
- What actions can we recommend to the Health and Wellbeing Board? These could be longer term strategic intentions, or shorter term more tactical actions.

Table 1 – Primary health care

Consequences

- List sizes increasing and profile of lists [becoming more diverse and complex] – impacts on GP registers / workloads
- Health education needs increasing in the community [eg Health Link workers] and specialist needs - eg assistance to understand health system; self–care; need for immunisations
- Training needs for staff - eg understand health beliefs of community groups / around disabled children with complex needs
- Adapt services for community – eg Paediatrician GPs in Lawrence Hill; FGM service
- Some shifting of universal to targeted services in order to keep in budget (restrict access if lower need or charge for service?)
- Re-directing allocation of budgets – eg children centre allocation
- Impact of people moving in – increase workload for health visitors etc for new people on case load. Plus impact of deprivation, as turnover of patient lists is generally higher in more deprived areas, adding to practice workloads.

Improve linking within sector

- Practices – PH strategy locally – services could act as a "team" locally as all primary care providers (+ others in community) – eg midwives assisting with flu vaccine?
- Add [merge] extra services into primary care settings – eg health visitors, midwives
- Need true partnership – eg dentistry to promote oral health
- Children centres links with GP practices could be developed following model of health visitor links

Recommendations to HWB

- "Voice of community" needs to complement quantitative data

- Need to get ahead of the curve – eg pre-empt increase in need in Romanian community [link worker?] / Develop models to respond rapidly based on previous experience
- Reallocation of home visitor and midwifery services or capacity (and other services as appropriate) to areas of highest need
- Physical accommodation for additional services in local areas [Bristol Council facilities or buildings and NHS buildings need to be looked at together – more flexible use of buildings plus good co-location of services is key for partnership]

Table 2 – Secondary health care

Consequences

- Secondary care is affected by the rise in diverse ethnicity of Bristol child population, and the increasing complexity of child health issues.
- Increase in numbers of children living in deprivation and impacts this has on child health *[Note – link to Child Poverty figures]*
- Note that 30% of Emergency Dept attendance is estimated to be minor illness and injury, which could be seen by in a Minor Injuries Unit, or at their GP surgery or Out of Hours GP service.

Improve linking within sector

- Intelligence and information – join up across provider and commissioner organisations to improve planning – need to clarify who is the lead?
- Review “branding” of NHS offer and simplify (including review opening hours)
- ESOL [English for Speakers of Other Languages] for Health through children’s centres and other settings [NB partly this need is also a consequence of reducing adult learning] – could also reduce translation & interpretation costs
- Potential for Drs with paediatric skills (GPs and/or secondary care Paediatricians) to link up more to support other Drs / GP practices [eg estimate that only 30% of GPs have paediatric training]

Recommendations to HWB

- Consider more co-location of primary & secondary care – focus on providing what people want rather than sticking with what we offer
- Consider impacts of reducing resources more explicitly, and need to provide effective services more efficiently.

Table 3 – Schools

Consequences

- Health agenda vs School standards (attainment) agenda - School resources are spent on attainment at expense of wider issues

[Tension between what's needed to support holistic growth of the child (wellbeing) and resources being focussed on short-term exam attainment as this is what's measured]

- Physical impact of space restrictions on Emotional health & wellbeing (EHWB) & Health in general

[School facilities becoming overcrowded as add on more classes due to population growth, so proportionately less physical or outdoor space for recreation and increasing injuries & behavioural problems. Esp issue in areas where children have little play space locally]

- Greater need for partnership working due to reduced availability of early intervention or family support available

[Social workers etc used to be able to get involved when schools saw a problem was building, but now so over-stretched they only work with children or families in crisis. Linked to rise of numbers on Child Protection register]

- Widening of health inequalities due to erosion of universal or preventative services and less support from the voluntary & community sector (VCS)

[Cuts in funding for many services that used to support schools in wider agenda]

- Changing landscape of schools has created <u>many</u> challenges
- Role of school nurse – currently have very little time to support individual schools or do any of the "health promotion" type work that schools need

Improve linking within sector

- Engagement of Health agenda in schools – in all school settings 0-18
- Make links stronger between health and attainment - help schools to see if they address child health & wellbeing issues they <u>also</u> improve standards
- Closer working relationship between Health and Education at national policy levels would be helpful.
- Establish what schools need – try to model health support services to offer this and consider flexible cost options to suit. [It was also felt that these services are there, but perhaps offer is not always clear to schools]

Recommendations to HWB

- Put Child Health and Emotional Health & Wellbeing at the heart of the Health and Wellbeing Strategy – highlight impacts it has on standards, attainment & life chances
- Need to give "teeth" to the Strategy (to balance out the pressure on standards & other agendas)

[What will be measured re improving child health? What are the sanctions if schools don't comply?]

- Recommend that all schools (inc Academies) have School nurses
- Promote evidence [why healthier children learn better, etc]

Table 4 – Social care, neighbourhoods and housing

Consequences

- Housing – in Lawrence Hill & population expansion, is housing a key factor? Social housing system is led by people's preferences – is there some way we can reduce demand? Is a Programme in Council's Landlord Services to make existing properties bigger (as demand for big properties to accommodate large families is such that if waiting list closed now would still take 10 years to clear at current levels). The "total benefit cap" is a disincentive to housing associations building bigger houses.
- Still not enough school places.
- Social care element [increase in need]
- Do we include data from Voluntary & Community Sector (VCS) organisations?
- Look at impacts of Population Density.
- Increasing pressure on services can lead to higher thresholds – eg Child Protection
- Pressure on Health visitors getting out to everyone they need to
- Pressure on maternity & mid-wives – people going into labour and being told that local hospital is at capacity so have to go elsewhere
- Support for mothers with post-natal depression - VCS cannot meet the need
- Focus of Health Visitors is mainly on "vulnerable people" (no longer universal)
- Increase in school transport costs – due to increase in children with SEN

Improve linking within sector

- Key workers / services talking to each other at the point of delivery – invest in joining up more – expand the scope of work such as First Response eg link up with Housing & homelessness services
- Get better at using local "soft intelligence" to model impacts – eg different communities will have different attitudes to referring to child protection. Look at long-term trends more.
- A&E could ask if people are registered with GP and signpost them? [Noted that there is a lot of work going on about appropriate use of A&E]
- Children's Centres are constantly trying to increase their reach – about linking a lot of services together
- Do immunisations in Health Centres [Noted that the lowest Imms take-up in is Inner City]

- It is hard to see the totality of VCS services – need to join this up better and map it out [Asset approach].
- Map out where we spend money (contracts & commissioning) in different sectors – step back and look at overlaps and impacts to get more strategic view.

- Better engagement with people on the ground, linking to other services – eg school nurses & GP surgeries, breaking down barriers.

Recommendations to HWB

- Re-design systems to promote more Early Intervention to try and reduce higher need demand
- Get better at demonstrating impact through more long-term analysis and evaluation (to help us re-design services better) [Noted that CYPS is making this shift]
- Information campaign on how to use your Health systems – more culturally sensitive approach to this. Utilise wealth of expertise in VCS.

Appendix C – JSNA Seminar delegate list (5 June 2013)

JSNA Seminar re Child population rise - Attendance list				
Representation	**Name**	**Job title**	**Organisation**	**G1 (Primary care)**
Co-chair / Public Health	Kelechi Nnoaham	Service Director - Public Health	Bristol City Council - Public Health	1
Community Health	Joanna Smith	Partnership Manager (CCHP)	Community Children's Health Partnership	1
Public Health - Children	Jo Williams	Consultant in Child Public Health	Bristol City Council	1
CCG Inner City & East locality	Ewan Cameron	Chair of Inner City & East locality	Bristol CCG	1
VCS (in Inner City)	Ian Lawry	CEO, Wellspring	Wellspring Healthy Living Centre	1
Early Years	Rachel Williams	Early Years Manager, Children's Centre and Family Support	Bristol City Council	1
NHS England	Lesley Woakes	Head of Primary Care and Public Health	NHS England (Bristol, North Som, Somerset & S Glos Area Team)	1
Representation	**Name**	**Job title**	**Organisation**	**G2 (Secondary care)**
Co-chair / Children & Young People's Service	Claudia McConnell	Service Director, Commissioning for Children/Young People	Bristol City Council and Bristol CCG	2
Bristol Public Health	John Twigger	Public Health Intelligence Team Manager	Bristol City Council - Public Health	2
Bristol Children's Hospital	Giles Haythornthwaite	Consultant, Bristol Children's Hospital	Children's Hospital	2
Children & Maternity Commissioning Manager (CCG)	Inge Shepherd	Programme Manager Children and Maternity Commissioning	Bristol CCG	2
NBT [Acute Trust] Strategic Planning	Mike Coupe	Strategy and Business Planning	NBT - North Bristol Trust	2
VCS (in Inner City)	Rhian Loughlin	Head of Services	Wellspring Healthy Living Centre	2

Representation	Name	Job title	Organisation	Group 3 (Schools)
JSNA Manager	Nick Smith	JSNA Project Manager	Bristol City Council [and Bristol CCG]	3
Children & Young People Service	Scott Morris	Intelligence & Performance Team	Bristol City Council	3
Young People (Public Health)	Rachel Cooke	Young People's Public Health team	Bristol City Council	3
Young People (Public Health)	Julie Coulthard	PSHE/Drug Education Consultant.	Bristol City Council	3
Schools	Tony Phillips	Head	Chester Park Junior School, Fishponds	3
Commissioning / Emotional Health & Wellbeing	Hannah Russell	Emotional Health & Wellbeing Joint Commissioning Development Officer	Bristol City Council	3
	Joel Almeida	Health Economics and Quantitative Modelling consultant	Plateau	3
Representation	**Name**	**Job title**	**Organisation**	**G4 (Social care, housing &Neigh'hoods)**
Bristol Health Strategy	Kathy Eastwood	Health Strategy Service Manager	Bristol City Council	4
Children & Young People Service	Andrew Turvey	Manager - Intelligence and Performance Team	Bristol City Council	4
Neighbourhood & City Development	Kevin Mulvenna	Senior Policy & Projects Officer, Strategic Housing	Bristol City Council	4
HealthWatch	Claire Littlejohn		The Care Forum	4
VCS - Children	Asma Ahmad	Children and Young People's Network Coordinator	VOSCUR	4
BCC - Census & Planning	Jayne Mills	Research & Statistics manager	Bristol City Council	4
Young People (Public Health)	Anne Colquhoun	Young People's Public Health team manager	Bristol City Council	4

Appendix D – JSNA Child population rise report: Engagement list

Meeting / Seminar / Board	Date (2013)	Date to return?
JSNA Advisory Group – Themed meeting	25th April	N/A
JSNA Seminar – Extraordinary meeting *(see appendix B for key output & C for attendees)*	5th June	N/A
Children & Young People's Service (CYPS) leadership team (DLT)	19th June	
Bristol Children's Outcomes Board	26th June	
City Council Strategic Leadership Team (SLT)	9th July	Due Autumn 2013
CYPS "Conversation" (reps from all CYPS teams)	19th July	
Clinical Commissioning Group (CCG) leadership team	25th July	Due mid-Sept 2013
City Council Cabinet member briefing (Portfolio: Health & Social Care)	31st July	
Public Health leadership team (DMT)	12th Aug	
City Council Cabinet member briefing (Portfolio: Children, young people and education)	19th Aug	
Bristol Health and Wellbeing Board	Due 5th Sept	Propose 27th Feb 2014
CCG Locality GP Forums (for information): • North & West • Inner City &East • South	13th Aug Due 10th Sept Tbc	