Foundations

What Works Centre for Children & Families

THINKING ABOUT YOUR LOCAL POPULATION NEEDS

A guide to doing a population needs assessment for Family Hubs

Applied resource

FAMILY HUBS PLANNING FRAMEWORK

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Visit **https://foundations.org.uk/our-work/reports/family-hubs-planning-framework** to download the other Family Hubs Planning Framework resources.

About Foundations

At Foundations, the national What Works Centre for Children & Families, we believe all children should have the foundational relationships they need to thrive in life. By researching and evaluating the effectiveness of family support services and interventions, we're generating the actionable evidence needed to improve them, so more vulnerable children can live safely and happily at home and lead happier, healthier lives. Foundations was formed through the merger of What Works for Children's Social Care (WWCSC) and the Early Intervention Foundation (EIF).

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WHAT IS THIS GUIDE ABOUT?

To effectively underpin local development of the Family Hubs and Start for Life programme,[1] all local areas need to do a local population needs assessment or show that it has been done recently. When planning for your family hub model, you will need to consider services that are relevant to all children and young people from 0–19 years old, and up to age 25 for those with special educational needs and disabilities (SEND).

We have produced this guide to help you plan, transform and (ultimately) deliver these services. You can use it to assess and understand the needs of local families who are covered by your family hub model.

The guidance sets out a step-by-step approach on how to conduct a population needs assessment, which includes some of the data that can be collected to understand need(s) that fall across the full scope of local family hub offers (ages 0-19/25).

The guide also explains what should be covered in a maternity and early years needs assessment (ages 0–5). This will help you understand needs that relate to the services and activities that are part of the local family hubs offer:

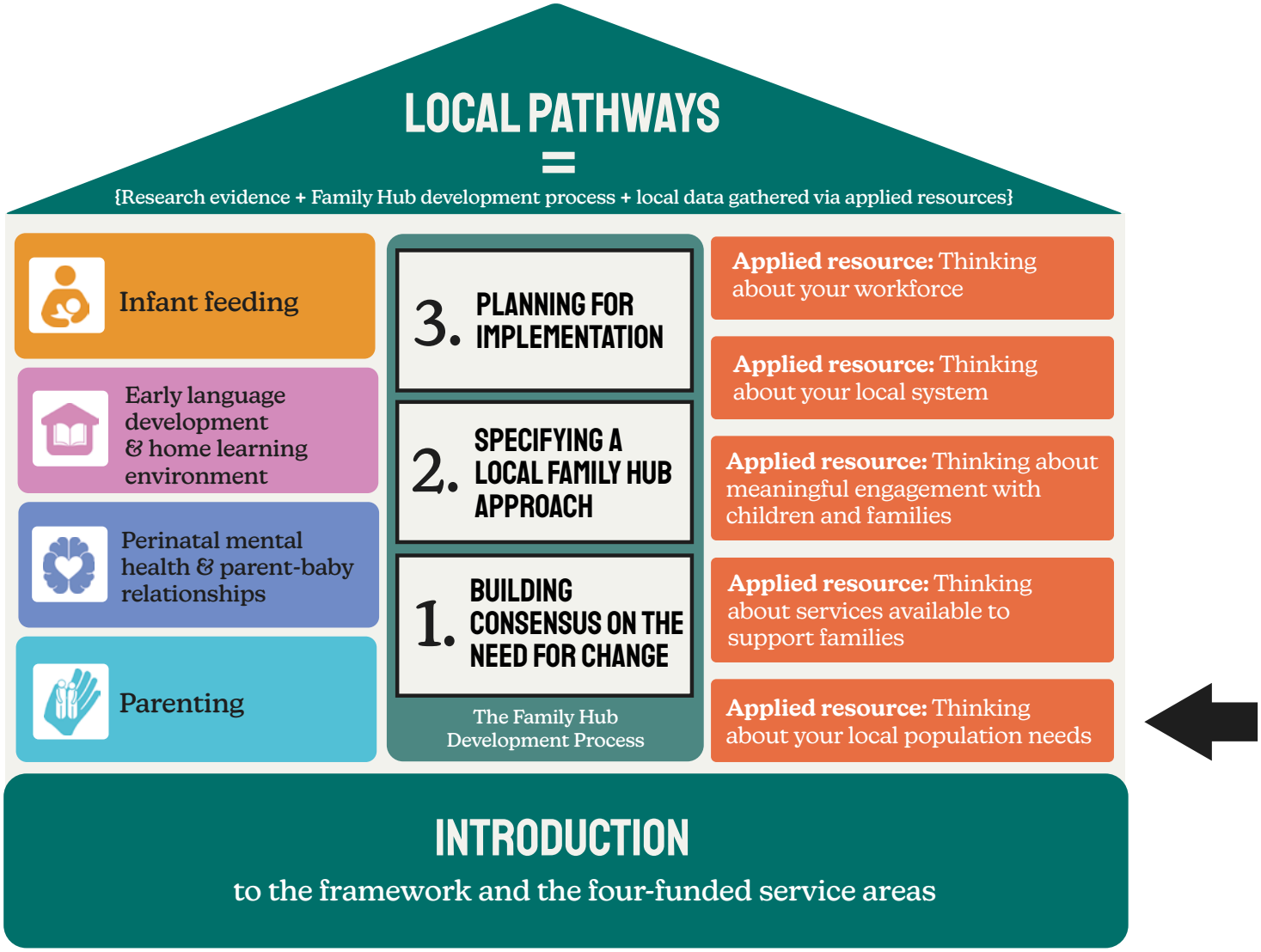
- parenting support
- perinatal mental health and parent–infant relationships
- early language and the home learning environment
- infant feeding.

The population needs assessment is one part of a contextual assessment that will help you develop your local family hub approach.

1 Department of Health and Social Care and Department for Education (2022), Family Hubs and Start for Life programme guide, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1096786/Family_Hubs_and_Start_for_Life_programme_guide.pdf

Figure 2

The overall structure of the Family Hubs Planning Framework alongside the processes necessary for planning and implementing the Family Hub model in your local area.



The arrow shows where thinking about your local population needs sits within the wider framework of resources and processes.

WHAT IS A POPULATION NEEDS ASSESSMENT AND HOW WILL IT HELP ME?

A population needs assessment is a process of finding out what needs people in your local area have, who has them now and who might have them in the future, and what services might be needed to support these needs. The needs assessment helps you understand the needs in your local area by analysing a range of information and evidence.

In the context of family hubs, a full population needs assessment will support you to:

- develop family hub services that are informed by the needs in your local area
- make sure support can be offered early to target and reduce adverse experiences and support children's development
- improve outcomes for children and families by ensuring services are closely aligned to local needs
- achieve better value for money by closely aligning services to local needs.

A population needs assessment helps you to work out demand by assuming that certain characteristics and conditions of your local population indicate current or future demand for services. You start with a broad overview, deepening the understanding of needs across your local population as you work through the process. An evidence-informed needs assessment will help you to:

- bring together evidence you can use when developing your family hub[2]
- identify health inequalities and specific at-risk groups (for example, by type of need, geographical location, or age range)

WHAT DO WE MEAN BY EARLY?

In the context of Family Hubs, 'early' means activities that support children's development at all ages, to stop problems from becoming entrenched. This includes, for instance, support that is offered:

- early in a child's life
- soon after a child shows signs of atypical development
- once a child or family have a recognised difficulty or problem.

Early intervention is vital for identifying children who may be showing atypical development and for supporting children to develop the skills and abilities that will set them up for life.

2 See: https://www.nationalcentreforfamilyhubs.org.uk/toolkit

- get agreement from local partners and key stakeholders on the need for change
- inform how services are planned and delivered at a community level (including commissioning and workforce planning)
- inform the implementation and evaluation of family hubs agendas including the outcomes that family hubs aim to achieve and baseline data to use when measuring and monitoring changes over time.

HOW DO I GET AN OVERVIEW OF MY LOCAL POPULATION NEEDS?

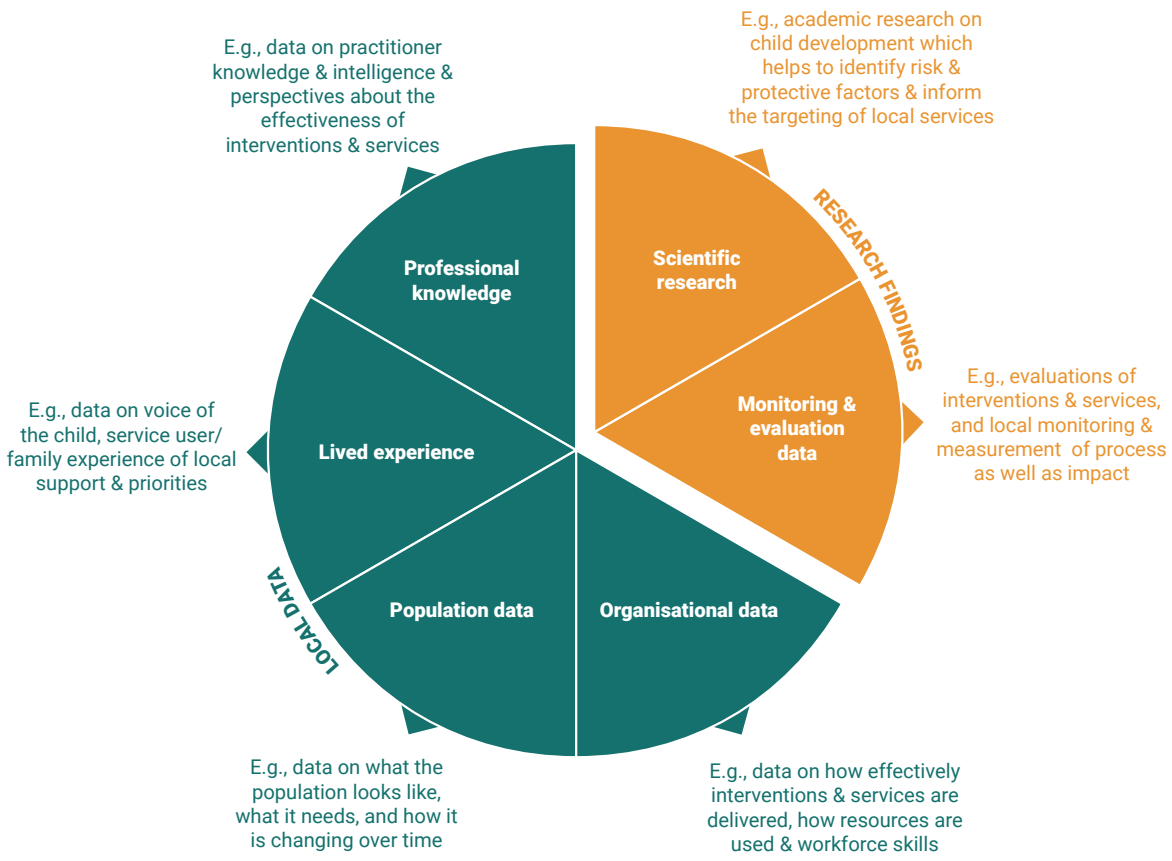
To accurately describe your population, you should look at a wide range of evidence. The scope and scale of family hubs may seem daunting. However, when you have good-quality data and information from a wide variety of sources, you will be able to see a detailed picture.

First, think about what level of needs assessment will be most helpful for different areas. At some points you may need to 'zoom out' to take a broad, high-level view of the family hubs offer in your local area for ages 0–19 (and 0–25 for children and young people with SEND). At other times you may need to 'zoom in' to specific areas, such as services and activities that are available as part of the Start for Life areas in the 0–5 age group.

Figure 2 below shows the different types of evidence that you can look at to get an accurate understanding of needs in your local area. It includes evidence from research, local data, and professional knowledge and experience.

Figure 2

Using and generating evidence: combining research findings and local data



Source: Leading and delivering early childhood services: 10 insights from 20 places across England and Wales, available at: https://www.eif.org.uk/report/leading-and-delivering-early-childhood-services-10-insights-from-20-places-across-england-and-wales

To get a rich understanding of need, you will need to triangulate the evidence you collect. Triangulation means comparing and contrasting different types of evidence to understand needs from different points of view and gain an all-round picture. You can triangulate:

- different types of evidence, as shown in shown Figure 2 above
- previous needs assessments from relevant services
- family health needs assessments
- joint strategic needs assessments (JSNAs).

Triangulation is especially helpful when some of your data is less up to date than data from other sources.

If you don't have the exact data you need, you might need to use proxy measures to fill gaps in your understanding. Proxy measures are measures that are related to the data you need. They can provide estimates in the absence of exact data. For example, sometimes data on referrals made to different services and interventions can be useful as proxy measures for understanding need.

When you are using a previous needs assessment as evidence, think about how things have changed since the assessment was done. Consider:

- recent events (such as the Covid-19 pandemic and increases in the cost of living)
- changes to the workforce or how services are delivered
- new data from children, young people, families, and professionals that may explain any changes to local services or the make-up of your local population.

The Family Hubs and Start for Life programme guide[3] sets out what you need to consider when assessing local need. You can include these approaches and activities in each step of your local needs assessment.

3 See Annex G in the Family Hubs and Start for Life programme guide: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1096786/Family_Hubs_and_Start_for_Life_programme_guide.pdf**

FAMILY HUBS AND START FOR LIFE PROGRAMME GUIDE: WHAT TO CONSIDER WHEN DOING A LOCAL NEEDS ASSESSMENT

1. Build on existing population needs assessments

Upper-tier local authorities will have a joint strategic needs assessment (JSNA), and your local area may have other, more specific needs assessments that relate to children and families. These may need refreshing, supplementing, or adapting, but they are a good place to start.

2. Use baby- and child-centred data

Population needs assessments that are aggregated from 'person-centred' data sources, which in this case will be baby- and child-centred data, can help you to understand the scale and severity of challenges, and build a picture of the needs of children and their families.

3. Consider the risk factors

Data gathered can be analysed according to risk factors that can adversely affect children's outcomes. Risk factors that affect children's development exist at the individual, family, community, and societal level.

4. Conduct deeper analysis

Cross-referencing and overlaying different sources of data can help to outline population needs with more clarity and detail. For example, you can map children's and families' needs by geographical location to explore where families with higher levels of need are more likely to live. Some questions about local needs cannot be directly answered by analysing local data. You may need to use proxy measures, national prevalence data, research evidence, and triangulate data from different sources to get a more accurate picture of the needs of local children and their families.

5. Engage stakeholders

You will need insights from families and practitioners to make sense of the story the data is telling. By engaging stakeholders, you can test emerging conclusions and sense-check priorities and any planned commissioning that follows. Consider engaging with:

- the Start for Life workforce, such as health visitors, midwives, and early years practitioners
- speech and language therapy service leads
- education settings
- early help service and Supporting Families leads
- youth workers and youth justice services
- safeguarding partners
- wider stakeholders, such as voluntary sector, community sector and faith partners.

HOW DO I PLAN MY APPROACH?

When doing your population needs assessment, you will want to engage and work with other service leads, partnership agencies, local communities, service providers and service users. When you plan how and when this will be done, you will need to make sure you allocate enough time and capacity.

A downloadable template has been created to help guide local areas through this step-by-step approach (see **Appendix B**.) It includes a visualisation of the approach with a 'checklist' and is intended as a source of inspiration as you work through completing your local population needs assessment.

Step 1: Establish the right team

It is important to think about who will be part of the core working group to complete this needs assessment. Strategic leads (or sponsors) can help you make connections with key stakeholders. The local transformation team and data analysts can help with capturing information. Many local areas appoint a coordinator to manage tasks such as arranging and running workshops, getting key stakeholders involved, and planning and delivering the project from beginning to end. The coordinator may be from a relevant sector, and they usually have the following core skills and qualities:

- strong project-management skills
- an overview of the system
- strong and persuasive communication skills, with the energy to motivate stakeholders and articulate what is needed from the project
- authority in their leadership (which steers the project), and the ability to respect and reassure colleagues so that all stakeholders feel included in a shared endeavour
- the ability to understand and develop the responsibilities of their role quickly and confidently, with clear thinking.

Step 2: Plan your approach

Allow yourself and your colleagues plenty of time to plan how you will do your needs assessment. In your plan, describe how you will keep to timescales, what needs to be delivered and, where appropriate, the budget. Together, think about who needs be involved at each stage. You may want to ask yourselves these questions:

- Where might we source evidence from to get an all-round picture? (See examples of combining different research findings and local data in **figure 2**)
- How might we collect evidence from parts of the system where there seem to be gaps?
- How are we going to bring together all the information we have collected to understand our local need? How will we make sense of what it has told us?

You may find it useful to set dates for meeting with colleagues to review your findings and adapt your plans if needed. Developing a family hubs needs assessment is an iterative and continual process, which means you will be developing and updating information as you go (rather than completing steps without revisiting them).

You may also find it useful to consider the questions that you would like to answer. At some points, you may 'zoom in' to focus in detail on one part of the system; at others, you may 'zoom out' to look back at the broader overview as the picture emerges. This is a complex and dynamic process, so developing questions you want to answer at the outset will help you keep on track. For example, you may ask 'What do we need to know or understand about our local context to ensure our family hubs offer will meet the needs of local children and their families?' or 'How do we know local support for infant feeding is reaching the families who need it the most?'

Step 3: Understand the risk factors

Having a good understanding of the risk factors that can threaten child development will guide you on where to seek information from. It can also give you clues about how to identify the children and young people who are most likely to benefit from early intervention. These risk factors exist at different levels and interact in complex ways. Some risks (such as the effects of a premature birth) are at the level of the individual child. Other risks work at the family level, while others work at the level of the local community or society as a whole.

All aspects of children's individual, family, community, and societal contexts influence their health and development in a cascading way, over time (see figure 3 below). This means that the outcomes we see later in a child's development are a culmination of the factors and interactions they have experienced earlier in life.

Some risk factors can affect a child's development in many ways over a long period. For example, poverty and economic stress can have a big impact on parents' ability to provide the calm, consistent, nurturing environment that best supports their child's development. Other factors that have a negative influence on a child's development over time include, for example, genetically determined cognitive and physical disabilities, ongoing conflict between parents, violence in the community, and limited employment opportunities.[4]

4 For more information about risk factors, see EIF (2018), Realising the potential of early intervention, available at: https://www.eif.org.uk/report/realising-the-potential-of-early-intervention

Figure 3

Risk factors occurring in a child's life

Step 4: Collect your data

To work as efficiently as possible, plan how much time you will need to collect data for your family hub needs assessment. Think about:

- What data do you already hold and understand? For example, you may have a relevant and recent joint strategic needs assessment (JSNA) and a wide range of population data. You may also be able to use relevant data from recent consultations with parents, children, and families.
- What data do you still need? In some areas, you may feel that you need to spend more time talking to communities, children, and young people to get an all-round view, collecting new data held by partner organisations, or identifying statistical neighbours.

WHAT DO WE MEAN BY POPULATION?

When doing a needs assessment, a population may be:

- the people in a geographical area
- a whole group or community with shared characteristics
- a school community
- a more specific group, such as young children, adolescents and young people, looked-after children, care leavers, or families seeking asylum.

In the case of family hubs, the population is children and parents and caregivers of children from conception up to age 19 (or up to age 25 for those with SEND).

When thinking about what data you need to collect, consider the different types and sources of information available. For example, as well as quantitative data (for example, statistics or prevalence rates) is it important to gather qualitative data from stakeholder engagement, professional knowledge, organisational information and lived experiences. Examples of qualitative data that might be useful include survey responses, interviews, focus groups, community feedback events, or information from relevant Patient and Public Involvement (PPI) groups. It is essential to get the views of local stakeholders to gain a clear understanding of user experiences. This information may draw your attention to a gap in a service or a workforce shortfall that was not obvious from desk-based research alone.

When making decisions – either about direct practice or about commissioning and designing services – it is vital to use feedback from a variety of sources alongside professional judgement. For guidance on collecting the views and experiences of children, young people, and families, see the **applied tool** in this framework on thinking about meaningful engagement with children and families.

Several demographic characteristics are important for understanding needs and describing the local population.

When you build a population profile, you might develop a profile for the whole local area or for a smaller area (such as a district, a ward, or the catchment of a family hub). The population profile should include the following information:

- current and future estimates for the usual resident population, including how many children are in the local area including their age, their gender, and where they live
- information about the composition of households in the population, including whether people in a household are married or in a civil partnership and how many children are in the household
- the prevalence of certain risk factors
- characteristics and conditions that affect how likely individuals are to have particular needs
- who in the population has particular needs and how severe they are
- the different barriers that people in the population might face when accessing relevant services

Again, you may be able to use data from previous joint strategic needs assessments (JSNAs) and other population-specific needs assessments to make this process as efficient as possible. Some population indicators, such as the Fingertips tools[5] published by the Office for Health Improvement and Disparities and the National Supporting Families Outcome Framework data[6] published by the Department for Education and the Department for Levelling Up, Housing and Communities, may also help you to understand the level of need in your local area by comparing it with other statistical or geographical areas and tracking changes over time.

To help you complete your needs assessment, Table 1 outlines some data that can be used to understand need(s) that fall across the full scope of local family hub offers (ages 0-19/25). However, these are only suggestions, and it is not a full list. As a guide, the different types of research evidence and local data outlined in **figure 2** are included throughout the potential data sources in [square brackets].

5 See: https://fingertips.phe.org.uk/profile/child-health-profiles
6 See: https://www.gov.uk/government/publications/supporting-families-programme-guidance-2022-to-2025/chapter-3-the-national-supporting-families-outcome-framework

PAUSE AND REFLECT: IDENTIFY NEED AMONG GROUPS AT RISK OF BEING EXCLUDED FROM OR UNDERREPRESENTED IN POPULATION NEEDS ASSESSMENTS

There is evidence to show that previous initiatives aimed at holistically improving children and family services have faced challenges in reaching the most vulnerable families. To ensure services in your family hubs offer are accessible to all families, consider focusing on specific populations in your local area to identify needs that may be 'hidden', underrepresented, or missing in the data available.

Being able to identify needs among different groups in your population helps to ensure that the services offered in your family hubs model are aligned with the needs identified among families, improving the likelihood of services benefitting families most in need of universal, selective, and targeted services. Families who are underrepresented across datasets or underserved by local services available are at risk of being excluded from and underrepresented in population needs assessments.

Consider focusing on identifying need among the following populations in your local area, in addition to any other groups you understand to be more vulnerable from your own local expertise and research:

- Fathers
- Minority Ethnic Families (see **Improving the way family support services work for minority ethnic families report (2022)**)
- Community movement and migration, for example Gypsy, Roma and Irish Traveller communities, and people seeking asylum and refugee status
- Families with insecure immigration status, including those with no recourse to public funds
- Families and children identified as being at risk of exploitation
- Children and young people not in education, employment, or training

To support local areas to explicitly identify needs among groups at risk of being excluded from or underrepresented in population needs assessments, a template has been developed to support with data collection and analysis (see **Appendix B**.)

When examining the data, some characteristics and conditions will be associated with all of the Start for Life services and activities. However, some will be more important to consider in relation to some activities than to others, and some may be relevant to only one funded area. In the following guidance, **we have used icons to highlight when a factor is particularly relevant** for understanding needs related to one or more of the Start for Life services and activities.

 Parenting support

 Infant feeding

 Perinatal mental health & parent-infant relationships

 Early language & home learning environment

A note on language: We have adopted language principles that enable us to consistently use respectful language that reflects society's diversity[a]. Throughout this applied tool, the descriptor 'minority ethnic' is used as an adjective, for example, 'minority ethnic family'. By placing the descriptor 'minority' before 'ethnic', and not the other way round, we acknowledge that all people have an ethnicity but not all are minoritised. Likewise, even in circumstances where minority ethnic families are more prevalent, minority ethnic families, children and young people may still experience minoritisation. See Improving the way family support services work for minority ethnic families report (2022) for more information.

a See: https://www.eif.org.uk/about/edi-at-eif/our-principlees-for-language-and-writing

Table 1. What to consider as part of a local population needs assessment for Family Hubs: ages 0–19/25)

Characteristic	Why is this important?	Guiding questions	Potential data sources
Ages of children	Information about the ages of children and young people in your local area helps you work out what proportion of the local population is in the target population for the local family hubs offer, in particular the Start for Life services and activities	• How many children are aged 0–19? And how many with SEND are aged 0–25? Can you break this down into smaller age groups? For example, 0–2, 2–3 and 3–5? **Consider:** Broad age ranges can help you identify needs at different stages in children's lives. For example, early years (0–5), primary school, secondary school, and young adults. • Has the number of children in each age group increased or decreased? Is there any reason it will change over the coming years? • What is the gender distribution of these children? • Where do these children live? **Consider:** You could use this demographic information to build 'heat maps' to show where in your local area there is likely to be most need.	• Office for National Statistics: population estimates; 2021 Census • Office for Health Improvement and Disparities: **Fingertips public health data** • Department for Education: **children in need census data** • Joint strategic needs assessment (JSNA).

Characteristic	Why is this important?	Guiding questions	Potential data sources
Number of births	The total number of births helps you work out what proportion of the local population is in the target population for the local family hubs offer, in particular the Start for Life services and activities. This helps you plan your services and workforce: how many families need to be catered for across family hubs offers?	• How many babies are born in the local area in one year? • Has this increased or decreased? Is there any reason this will change over the coming years? • Where do families with new babies live? • Are local rates of perinatal mortality (stillbirths and neonatal deaths) higher or lower than the national average? Are the national trends in perinatal mortality by ethnicity reflected in your local data? **Consider:** There may be births registered in neighbouring local areas that are not counted within your local area data. For example, is there a large or popular NHS maternity service in a neighbouring local area that local families would travel to receive care? Are there NHS maternity services within your local area that are or have become unfavourable with families? If so, local births may be registered in neighbouring local areas.	• NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** • Office for National Statistics: **births in England and Wales dataset** • Office for Health Improvement and Disparities: **Fingertips public health data** • Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) UK **Perinatal mortality surveillance report (2020)** • **MBRRACE-UK Perinatal Mortality Surveillance State of the Nation Report (2021)** • **Ockenden report (2022)**.
Parents' marital or civil partnership status	Being a single parent places increasing demands on parents. Single parents are more likely to experience poor mental health, economic hardship, and social isolation. In turn, each of these factors is associated with poor outcomes for children – for instance, behavioural difficulties, delay in readiness for school, and speech and language delays.	• How many babies are born to a single parent? • How many households with children are headed by a single parent? • What is the gender distribution of single parents?	• Office for National Statistics: **births in England and Wales dataset** • Office for National Statistics: **families and households in the UK 2021**

Characteristic	Why is this important?	Guiding questions	Potential data sources
Ages of parents	The ages of parents are consistently connected with the outcomes for their children. Younger parents are more likely to: • experience economic hardship and social isolation • have fewer educational qualifications • be in unstable employment • smoke. Younger mothers are also more likely to experience intimate partner violence and experience mental health difficulties before and after the birth. All these factors are associated with poor child outcomes, such as behavioural difficulties, delay in readiness for school, speech and language delays, sudden infant death syndrome, and longer-term difficulties in academic achievement and mental health.	What is the average age of first-time parents/ mothers? • What is the average age of all parents? • How many young mothers (under 25) are there? How many young fathers (under 25) are there? • Where do these young families live in the local area? • Are younger parents in your area more likely to be single parents? (See 'Parents' marital and civil partnership status'.) • Among young families (with parents under 25), what is the average number of children? (See 'Parents' marital and civil partnership status'.)	• NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** • Office for National Statistics: **births in England and Wales dataset**

Characteristic	Why is this important?	Guiding questions	Potential data sources
Economic deprivation 	Evidence clearly shows that children who grow up in poverty or economic disadvantage are far more likely to have poor physical, social, emotional, cognitive, and behavioural health and developmental outcomes than other children. This can happen: • in a direct way – for example, in how parents interact with their children using language and scaffolding behaviours • in an indirect way, when stress and limited financial resources limit parents' ability to give their children an enriching enough environment. Being unemployed can affect parents' mental health and wellbeing, the relationship between them, and their co-parenting ability. This can have a negative impact on children's health and development. By the time a child is 2 or 3, they may have learning gaps in their social and emotional skills. These gaps grow throughout primary and secondary school, and they can have a negative impact on the child's outcomes later in life, such as their mental health, relationships, entry into the workforce and future earnings.	• What proportion of children are experiencing economic deprivation? • What proportion of parents live in the most deprived areas within the local authority? • What proportion of children receive free school meals? • Where are the areas of deprivation within the local authority? Where do children who experience economic deprivation live? • Are children who experience economic deprivation more likely to have younger parents or single parents? (See 'Ages of parents' and 'Parents' marital and civil partnership status'.) • What proportion of families has no recourse to public funds? **Consider:** The funding family hubs receive for the early language and home-learning environment programme is targeted at disadvantaged families.[7] To make sure those who need it most can access this support, include data on how many children are experiencing economic deprivation and where they live.	• Department for Work and Pensions: national statistics on households below average income • Office for Health Improvement and Disparities: Fingertips public health data • Office for National Statistics: population by index of multiple deprivation (2001–2019) • Children's Commissioner: local and national data on childhood vulnerability • Ministry of Housing, Communities and Local Government: data on income deprivation affecting children • Department for Education: data on free school meals • Office for National Statistics: worklessness • Department for Work and Pensions: statistics on education provision for children under 5 years of age

7 See Annex J of the Family Hubs and Start for Life programme guide, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1096786/Family_Hubs_and_Start_for_Life_programme_guide.pdf

Characteristic	Why is this important?	Guiding questions	Potential data sources
Ethnicity	• UK evidence shows clear links between ethnicity and inequalities in children's health and development outcomes, and minority ethnic children are more likely to experience disadvantage. These inequalities span all aspects of children's development. Here are some examples. • By the age of 4 or 5, Gypsy/Roma and Irish Traveller children are less likely than children in all other ethnic groups to reach developmental targets for communication and language, and physical, social, and emotional development. • Pakistani, Bangladeshi, Black Caribbean, Black African, 'Other' Black, 'Other' White and Mixed White/Black Caribbean children are less likely than average to be school-ready • Asian children and Black children are more likely than White children to be born prematurely and with a low birthweight. In turn, they are more likely to have physical illness, disability, neurodevelopmental delay and disability, behavioural difficulties, and cognitive developmental delay.	• What proportion of the local population is from a minority ethnic group? Can you break this down more to understand what proportion of parents are from a minority ethnic group? • Where do minority ethnic families live in the local area? • Are minority ethnic families more likely to experience economic deprivation? (See 'Economic deprivation'.) • Are minority ethnic families more likely to have parents who are younger or single parents? (See 'Ages of parents' and 'Parents' marital and civil partnership status'.) • What proportion of families are refugees or asylum seekers? **Consider:** Follow the Race Disparity Unit's standards for ethnicity data.[8] Check that the data is meaningful and representative.[9]	• Office for National Statistics: population estimates; 2021 Census • Joint strategic needs assessment (JSNA) • NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** [ethnic category of mother].

8 See: https://www.gov.uk/government/consultations/standards-for-ethnicity-data/standards-for-ethnicity-data

9 For example, see the NHS guidance on why it is important to ask about ethnicity: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/ethnicity

Characteristic	Why is this important?	Guiding questions	Potential data sources
Housing	Housing quality and housing stability affect children's health and development. This includes experiences of homelessness, temporary accommodation, overcrowded housing, and the home learning environment i.e., the physical characteristics of the home environment such as enriching books, toys, and educational activities, as well as parent–child interactions and learning support provided in around the home. Experiencing homelessness or living in temporary accommodation affects children's behavioural, social, cognitive, psychological, and physical health and development. These negative effects can be: • direct – for instance, no safe space to play and learn, less sleep, more disruption, lost belongings, lost friendships and community, more stigma • indirect – parents are dealing with more stress, which reduces their ability to parent sensitively and responsively. A good-quality home learning environment supports children's readiness for school and can reduce many of the risks that interfere with some children's ability to learn. Unfortunately, disadvantaged children are less likely to experience a high-quality home learning environment, and this has been exacerbated during the pandemic.	• How many families (or children) are living in overcrowded housing? • How many families (or children) are living in temporary accommodation? • How many families are owed a statutory prevention or relief duty as part of statutory services? • What is the proportion of children who are experiencing economic deprivation?[10] **Consider:** The funding family hubs receive for early language and the home learning environment programme is **targeted at disadvantaged families, such as those experiencing economic disadvantage or children with SEND**.[11] To make sure people who need it most can access this support, consider data on the prevalence and location of children experiencing economic deprivation and low-quality home learning environments.	• Office for National Statistics: 2021 Census [occupancy rating (bedrooms) by household composition] • Office for Health Improvement and Disparities: **Fingertips public health data** [family homelessness] • Department for Levelling Up, Housing and Communities: **statistical dataset on live tables of homelessness** • Department for Levelling Up, Housing and Communities: **statutory homelessness in England** • Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data**

10 For more details, see 'Early language and the home learning environment' in **Appendix A**.
11 See Annex J of the Family Hubs and Start for Life programme guide, available at: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1096786/Family_Hubs_and_Start_for_Life_programme_guide.pdf**

Characteristic	Why is this important?	Guiding questions	Potential data sources
Children with SEND	The most recent official statistics (2012) show there were 0.8 million disabled children and young people aged 0–18 in the UK, which is 6% of all children. Children with neurodevelopmental disabilities (such as autism, ADHD, and Tourette's syndrome) are the largest group, making up about 3–4% of children in England. More recent research suggests that over 2% of children and young people in the UK are autistic. Children with SEND face unique challenges and more barriers in having their individual needs met, and special educational needs and disabilities become more prevalent as children grow older. Evidence shows: • children with SEND are at more risk of experiencing interparental conflict, harsh parenting, and various forms of childhood maltreatment and abuse. • parents of children with SEND are at more risk of experiencing poor mental health and interparental conflict. Child disabilities can introduce high levels of stress into the interparental relationship and a unique set of co-parenting challenges. This can include the disappointment and guilt that many parents experience when coming to terms with their child's disability, or the extra stress of navigating complex health or education systems to make sure the child's needs are met. In many instances, a child's disabilities can add to the family's financial burden, resulting in decisions to sacrifice positive activities that might have reduced the negative impact of the child's disability.	• How many children and young people have needs related to SEND? • How many of those are 0–19, and how many are 0–25? Can you break this down into smaller age groups? For example, can you break the 0–5 age group into 0–2, 2–3 and 3–5? • Where are children with SEND more likely to live? • Are there any disparities locally between the prevalence of children with SEND and the prevalence of local educational, health and care (EHC) plans in place? Disparities may indicate the level of unmet need among local families. • Are there local associations between economic deprivation and the prevalence of SEND or EHC plans? **Consider:** The funding family hubs receive for the early language and home learning environment programme is **targeted at disadvantaged families, such as those experiencing economic disadvantage or children with SEND.**[12] To make sure people who need it most can access this support, you should consider data on the prevalence and location of children experiencing economic deprivation and low-quality home learning environments.	• Office for Health Improvement and Disparities: **Fingertips public health data** • Department for Education: **special educational needs: analysis and summary of data sources** • Department for Education: **data on Special educational needs in England** • Department for Education: **data in education, health and care plans** • Department for Education and Department for Levelling Up, Housing and Communities: **data in the national supporting families outcome framework** **Tip:** Data on referrals can be a useful source of information for understanding needs related to SEND. Consider neurodevelopmental pathway referrals (for example, autism) and speech and language therapy, for example. **Consider:** Do any local voluntary and third-sector organisations have a good understanding of SEND-related needs in the local area? **[Engaging stakeholders]** Can professionals working in local health and social care systems provide insight on local SEND needs? **[Professional knowledge]** Can any local support groups provide in-depth data on experiences of children with SEND? **[lived experience]**.

12 See Annex J of the Family Hubs and Start for Life programme guide, available at: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1096786/Family_Hubs_and_Start_for_Life_programme_guide.pdf**

Characteristic	Why is this important?	Guiding questions	Potential data sources
Children in need	Children known to children's social care are arguably the most vulnerable in society. A 'child in need' (CIN) is a child: • who is disabled • is unlikely to reach or maintain a satisfactory level of health or development, or • whose health or development will be significantly impaired without the provision of children's social care services.[13] The circumstances that lead to a child becoming known to children's social care are never positive and frequently involve high levels of family dysfunction and economic deprivation. The life chances of children in need are poor. They are more likely to have delayed school readiness, special educational need(s), and experience behavioural difficulties as they enter school. Maltreated children are also 1.5 times more likely to have a physical health problem. A disproportionate number of infants are identified as children in need – probably because they are more physically vulnerable than older children. Neglect is the most common reason, followed by domestic abuse, parental substance misuse and parental mental health problems. These all put children's health and development at risk before they enter school. There is no single 'cause' of child maltreatment. Instead, it becomes more likely with a combination of risks at the level of the child, the family, the community, and society. There are several factors that can increase the risk of child maltreatment, but factors that consistently increase the risk include: • experiencing absolute poverty • economic deprivation • community violence • parental mental health • parental substance misuse As such, families already working with early help and specialist safeguarding services are more likely to experience risk factors including housing instability, financial difficulties, and poor mental health.	• How many children have been identified as 'in need' in the local area? What is the age breakdown of these children? Has this number risen or fallen recently? • How many children in need are: children on a Child in Need Plan (CINP), children on a Child Protection Plan (CPP), or Looked After Children (LAC)? • What are the characteristics of these children? Consider age, ethnicity, economic deprivation, and location. • What is the prevalence of expectant parents or parents with a baby or young child who have previously had a child removed or placed into care? • Children living in the most deprived communities are 12 times more likely to be identified as 'in need' than children living in the least deprived areas. Rates of abuse and neglect are highest in neighbourhoods marked by strong income disparities. What proportion of children are experiencing economic deprivation? Where do these families live? (See 'Economic deprivation'.) • What is the number of children who receive an Early Help Assessment (EHA)? What proportion of the total population of children is this? Are some groups of children over or under-represented in the figures? **Consider:** By mapping the key characteristics that place infants and young children at risk of entering the care system, you can target early support and early intervention at the families who need it most. This can prevent 'causal' factors from worsening and disadvantaging children's early development.	• Department for Education: **children in need census data** • **The independent review of children's social care (2022)** • Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data** **Consider** • Stratified caseload data from health visitors may provide an indication of the proportion of children on universal, universal progressive, targeted and specialist caseloads. • Can professionals working in local health and social care systems provide insight on the needs of children who are on the 'edge of care' or in the care system? **[Professional knowledge]** • To what extent are current services effectively identifying and supporting children in need? **[Organisational data]** • Can any local support groups provide in-depth data on experiences of children's social care? **[Lived experience]** • Do any local voluntary and third-sector organisations have a good understanding of children's social care needs in the local area? **[Engaging stakeholders]** **Tip:** Consider that domestic abuse, poor mental health, and substance misuse occurring at the same time may have cumulative effects. For more information, see predictions from the Children's Commissioner on estimating the prevalence of these characteristics and conditions.

13 Children Act (1989) **https://www.legislation.gov.uk/ukpga/1989/41/contents**

Characteristic	Why is this important?	Guiding questions	Potential data sources
Parental alcohol and substance misuse	During pregnancy, high levels[14] of maternal alcohol consumption and maternal substance misuse[15] are consistently associated with poor outcomes for children's health and development, and even death. There is a higher risk of: • stillbirth • neonatal death • premature birth • cognitive developmental delay • behavioural difficulties • foetal alcohol spectrum disorders • child abuse • neglect. Substance misuse is often accompanied by other risk factors, such as poor maternal mental health, economic deprivation, and complex social needs. Parental substance misuse[16] is also associated with poor outcomes for children. These include a higher risk of: • sudden infant death syndrome • child abuse and neglect • early dysfunctional parent–child relationships • behavioural difficulties • delayed school readiness • poor academic achievement. Understanding the proportion of parents who experience alcohol and substance misuse provides an indication of the proportion of children who are at risk of poor outcomes, and who would benefit from early, targeted, and intensive support to prevent problems developing or worsening as children grow.	• What proportion of expectant parents are recorded as misusing drugs, alcohol or both? • What is the estimated proportion of children who experience parental alcohol and substance misuse? • Where are children who experience parental substance misuse likely to live in the local area?	• Office for Health Improvement and Disparities: **Fingertips public health data** • NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** • Office for Health Improvement and Disparities: **national drug treatment monitoring system** • Department for Education: **children in need census data** ['primary need' data on parental disability or illness] • Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data** **Consider** • Do any local voluntary and third-sector organisations have a good understanding of needs among parents and families who experience alcohol and substance misuse? **[Engaging stakeholders]** • Can professionals working in local health and social care systems provide insight on family need? **[Professional knowledge]** • Can any local support groups provide in-depth data on experiences of parental alcohol and substance misuse? **[Lived experience]** • To what extent are current services effectively identifying and supporting these families? **[Organisational data]** **Tip:** Consider that domestic abuse, poor mental health, and substance misuse occurring at the same time may have cumulative effects. For more information, see predictions from the Children's Commissioner on estimating the prevalence of these characteristics and conditions.

14 High levels include series of acute intoxication, harmful use, or dependent us.
15 Substance misuse includes misuse of prescription drugs or using illegal drugs as part of an addiction or not.
16 Parental substance abuse includes patterns of alcohol or drug use that lead to clinically significant impairment or distress, binge-drinking, misuse of prescription drugs, or use of illegal drugs It doesn't have to be classed as an addictive disorder.

Characteristic	Why is this important?	Guiding questions	Potential data sources
Domestic abuse	Around one in five children in the UK experience domestic abuse. Children who have experienced domestic abuse are significantly more likely to: • experience abuse in their own adult relationships • misuse drugs or alcohol • have lower levels of wellbeing. In the early years, children exposed to domestic abuse are at risk of poor outcomes including: • poor mental health • behavioural difficulties • developmental delay Domestic abuse can have a profound impact on children and young people's mental health. Children who live with domestic abuse are more likely to suffer from: • post-traumatic stress disorder • depression • emotional and behavioural difficulties. Children who are exposed to domestic violence without being physically harmed themselves display similar psychological and social outcomes as children who have been abused but not exposed to violence between parents. Women who experience domestic violence during pregnancy are more likely to have mental health problems before and after the birth (the perinatal period), including depression, anxiety, and post-traumatic stress disorder. Domestic violence is also common among women with severe mental illness who are referred to specialist perinatal mental health services. Domestic violence often starts or escalates during a pregnancy. It is strongly associated with suicide and murder during the perinatal period as well as other negative obstetric and neonatal outcomes. Understanding the proportion of parents who experience domestic abuse provides an indication of the proportion of children who are at risk of poor outcomes in the early years and would therefore benefit from early and specialist support to prevent problems from developing and becoming entrenched as the children grow.	• What proportion of adults are survivors of domestic abuse in the local area? • What proportion of children are exposed to domestic abuse in the local area? • Where are children who experience domestic abuse likely to live in the local area?	• Department for Education: **children in need census data** [Primary Need data] (This data will under-represent the number of children exposed to domestic violence because it covers children in need only – children who are not identified as 'in need' or referred to social services are not included.) • Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data** **Consider** • Do any local voluntary and third-sector organisations have a good understanding of the prevalence and impact of domestic abuse in the local area? **[Engaging stakeholders]** • Can professionals working in local health and social care systems provide insight on family need? **[Professional knowledge]** • Can any local support groups provide in-depth data on experiences of domestic abuse? **[Lived experience]** • **Tip:** Consider that domestic abuse, poor mental health, and substance misuse occurring at the same time may have cumulative effects. For more information, see **predictions from the Children's Commissioner** on estimating the prevalence of these characteristics and conditions.

Characteristic	Why is this important?	Guiding questions	Potential data sources
Parental conflict 	Parental conflict is a normal part of relationships and family life. However, it exists on a spectrum of severity and it is the frequency of the conflict, its intensity, and how it is resolved that can negatively affect children. Parents or couples who engage in frequent, intense, and poorly resolved interparental conflicts put children's health, development, and long-term life chances at risk. The outcomes can include: • behavioural problems (both externalising and internalising problems) • developmental delay • poor academic performance • problems with physical and mental health • social and interpersonal problems • maltreatment and abuse in various forms These outcomes can converge and build up throughout a childhood and adolescence, which can significantly reduce a person's overall life chances. Destructive parental conflict is linked to poor child outcomes regardless of whether or not: • the parents are together or separated • the family situation is seen as 'high risk' – in other words, not just in families where parents have separated or divorced or where there is domestic violence. The factors that increase the risk of parental conflict include: • poor parental mental health • economic disadvantage • worklessness • substance and alcohol misuse Understanding the proportion of families who are experiencing interparental conflict gives you an indication of the proportion of children who are at risk of poor outcomes. You can use this data to estimate the proportion of families who would benefit from early and targeted support to prevent problems from arising and escalating over time as children develop.	• What is the estimated proportion of children experiencing parental conflict and relationship distress in the local area? • When looking at the risk factors for increasing parental conflict (for instance, poor parental mental health, economic disadvantage, worklessness, and parental substance and alcohol misuse), what is the likelihood that children are experiencing parental conflict? • Where are children who experience parental conflict likely to live in the local area?	• Department for Education: children in need census data ['primary need' data] • Department for Work and Pensions: parental conflict indicator • EIF's step-by-step guide on needs assessment for parental conflict • Department for Education and Department for Levelling Up, Housing and Communities: national supporting families outcome framework data **Consider** • Do any local voluntary and third-sector organisations have a good understanding of how common interparental conflict is in the local area and what impact it has? **[Engaging stakeholders]** • Can professionals working in local health and social care systems provide insight on family need? **[Professional knowledge]** • Can any local support groups provide in-depth data on experiences of interparental conflict? **[Lived experience]**.

Characteristic	Why is this important?	Guiding questions	Potential data sources
Parental mental health  	Evidence consistently shows that poor parental mental health and insensitive or insecure parent–infant relationships can lead to poor outcomes for children. 'Poor parental mental health' includes: • various clinical and subclinical forms of depression and anxiety • less common but more severe conditions, such as eating disorders, bipolar disorder, psychosis, obsessive compulsive disorder, post-traumatic stress disorder and personality disorders. Poor maternal mental health during pregnancy is linked to poor birth outcomes such as preterm birth and traumatic births. Severe mental health problems can reduce a parent's capacity to care for their child. It is also a leading cause of death (most often through suicide) for women during the first 12 months after giving birth. Parents with poor mental health may find it difficult to understand and respond sensitively to their children's needs. Insensitive parenting (regardless of whether a parent has poor parental mental health) is associated with social, emotional, self-regulatory, and behavioural problems as children develop including an insecure attachment, self-regulatory problems, and behavioural problems once children enter school. Importantly, experiencing more than one mental health condition is common. This can have a cumulative negative impact on children's health and development.	• What proportion of women who are pregnant or have a new baby (up to one year after the birth) experience mental health difficulties? • Are national trends in maternal mental health seen in local data? • Where are families who experience poor mental health likely to live? • When looking at the risk factors for mental health difficulties during pregnancy (for instance, single parenthood and economic deprivation), what proportion of women would be expected to experience mental health difficulties in the local area?	• Office for Health Improvement and Disparities: **Fingertips public health data** • NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** • Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data** **Consider** • Do any local voluntary and third-sector organisations have a good understanding of paternal mental health needs in the local area? There is a national shortage of data on paternal mental health. **[Engaging stakeholders]** • Can professionals working in local health and social care systems provide insight on family mental health needs? **[Professional knowledge]** • Can any local support groups provide in-depth data on experiences of perinatal mental health, particularly for marginalised and high-risk groups? **[Lived experience]** **Tip:** Consider that domestic abuse, poor mental health, and substance misuse occurring at the same time may have cumulative effects. For more information, see **predictions from the Children's Commissioner** on estimating the prevalence of these characteristics and conditions'.

Characteristic	Why is this important?	Guiding questions	Potential data sources

Youth crime and violence	In England and Wales, 49,100 offences among 10–17-year-olds resulted in a caution or sentence in 2019/20.[17] Children and young people who get involved in crime and violence are vulnerable. They have been led to a point of crisis because their needs and difficulties have not been identified or responded to appropriately by the adults and systems around them.
	
	The circumstances that lead to children and young people becoming involved in crime and violence are not positive. They often involve high levels of deprivation as well as family and social dysfunction. Not surprisingly, the life chances of children and young people who become involved in crime and violence are poor: they are at more risk of dying from any cause, especially suicide or alcohol and substance misuse.
	
	There is no single 'cause' of children and young people becoming involved in crime and violence. Instead, the likelihood increases with a combination of risks and a lack of protective factors at the level of the child, family, community, and society. The risk factors include:
	
	• experiencing dating violence
	• bullying (perpetration and victimisation)
	• being male
	• the number of siblings in the household (for example, being an only child or having more than four siblings)
	• substance misuse (at the individual or family level)
	• childhood maltreatment
	• economic disadvantage
	
	The protective factors that may be missing include:
	
	• positive and responsive family relationships
	• education and employment opportunities
	• positive relationships with peers and other social relationships.
	
	Data from the Home Office suggests that violence (self-reported) and risk of carrying weapons peaks at age 15.[18] Importantly, the Crime Survey (analysed by the Children's Commissioner in 2019) shows that a low proportion of children who are involved with crime and violence through gangs are known to the authorities.[19]
		• What is the prevalence of offences that result in a caution or sentence among children?
		• What are the demographic characteristics of these children in terms of age, ethnicity, deprivation, and location?
		• Where are the areas of deprivation in the local authority? Where do children who experience deprivation live?
		• What proportion of children are exposed to family and social dysfunction?
		• What proportion of children experience substance misuse themselves or parental substance misuse? (See 'Parental substance misuse'.)
		• Evidence shows youth crime and violence are associated with:
		  • behavioural problems (including aggression)
		  • learning and developmental disorders
		  • mental health problems (including self-harm)
		• What is the prevalence of these characteristics and conditions among children and young people?
			• Office for National Statistics: crime in England and Wales: police force on crime and serious violence
			• Department for Education: **data on permanent exclusions and suspensions**
			• Ministry of Justice: **criminal justice statistics by age**
			• Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data**
			• NHS: **data on hospital admissions for assault by sharp object** and **mental health of children and young people**
			• Office for Health Improvement and Disparities: **Fingertips public health data**
			• See the latest evidence available from the Youth Endowment Fund on **youth crime and violence** including **evidence and gap map of interventions to prevent children getting involved in violence**
			
			Consider
			
			• Do any local voluntary and third-sector organisations have a good understanding of youth crime and violence in the local area? **[Engaging stakeholders]**
			• Can professionals working in local health, policing, education and social care systems provide insight on children and young people becoming involved in crime and violence? **[Professional knowledge]**
			• Can any local support groups provide in-depth data on experiences of youth crime and violence, particularly for high-risk groups? **[Lived experience]**

17 See Ministry of Justice and Youth Justice Board (2021), Youth Justice statistics 2019/20, available at: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/956621/youth-justice-statistics-2019-2020.pdf**

18 See Home Office (2018), Serious violence strategy, available at: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf**

19 See Children's Commissioner (2019), Keeping kids safe: improving safeguarding responses to gang violence and criminal exploitation, available at: **https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/02/CCO-Gangs.pdf**

PAUSE AND REFLECT

- Is the data that you have collected complete, relevant, timely, robust, and inclusive?
- How does the information relate to the risk factors?
- How does the data you have collected relate to the four key domains of child development (physical, cognitive, social and emotional, and behavioural)? (See **Appendix A**)
- Do you have a wide cross-section of views (for instance, from fathers, mothers, grandparents, and groups with protected characteristics) across the age range?
- Have you achieved a balance between information about individual children and information about whole family needs (parents and caregivers, children with needs, siblings, and the wider family)?
- Do you feel that the views reflect all people's experiences 'on the ground'?
- Are there any big gaps in the data that could be filled?

Step 5: Analyse and understand

You should now have a rich stream of evidence based on your local research, your conversations, and your knowledge of the national evidence base. At this stage it is important to consider what story the evidence is collectively telling you about the local area and what issues family hubs can or should help to address. Work with a small group of colleagues, including your data lead, to answer the following questions:

- What does the information tell you?
- Are the themes that you identified similar to or different from the views of stakeholders?
- What is consistently similar? What is different?
- What would you like to explore in the new information that you have gained (what deeper analysis do you want to do)?
- Where are the most pressing needs in the local community, and which children and families are experiencing them?

PAUSE AND REFLECT

- Are you clearer about the key challenges in the area that need to be addressed?
- Are you clearer about which children and families to prioritise?
- Where are the needs situated in terms of place? What did your research tell you about how and where to offer support to meet the need (for instance, in a family hub building, through outreach, in an education setting, in a library or through a virtual and digital offer)?
- What key themes are emerging? Have you discussed them with governance structures to identify how you will delve deeper, and with whom? Do the themes align with current service delivery models?
- How might you find any extra information that you need?
- Have you triangulated the data to get an all-round view of needs?
- Have you identified any missing data? Is the missing data qualitative or quantitative?
- What can you learn by looking at different data sources together, for example housing and parental mental health?
- What sorts of open questions can you ask to start a conversation and find out more?
- What are the barriers and enablers to addressing these needs?
- When you consider the needs identified, do they align with current service delivery?
- Are you clear about the places where services will need to be offered to fulfil the family hub delivery principles of 'Access, Connections and Relationships'?
- If the needs do not align with current services, which ideas and impressions are you discussing that could address the need? How might this translate into your new family hub offer?

Step 6: Test and confirm your conclusions and outputs

Share and discuss the information you have collected with others. This will help you to interpret and triangulate the evidence to ensure it provides a balanced perspective. It will also help you to check that stakeholders recognise the story that the evidence tells about your local area and help with selecting priorities for action based on this story.

Using the breadth of data outlined in this applied tool will provide the evidence base that underpins decisions throughout the rest of the process. Ultimately, it will provide shared ownership of the final business case. Investing time and effort to ensure the data is relevant and well presented will pay dividends as you move through your change process.

WHAT NEXT?

As part of your local population needs assessment, you might have already considered and analysed population needs that relate to the Start for Life services and activities: parenting support; perinatal mental health and parent–infant relationships; early language and the home learning environment; and infant feeding. If you have **not** covered this, follow the guidance below on understanding your local population need for maternity and early years support.

Step 7: Formal decision making and next steps

At this point, it is important to check that stakeholders recognise the story that the evidence tells about your local area. This will help you to build consensus and prioritise what you would like your family hubs to focus on. Local leadership and partnership groups can then plan the actions and progress needed to achieve these goals.

- How will your findings be communicated to your wider stakeholders?
- Is there shared understanding of priorities amongst local leaders, including operational and strategic leaders?
- Is there a shared understanding of how the needs assessment and identified priorities underpin the delivery of family hubs goals?
- What are the steps that need to be completed to confirm actions with local leaders and partnership groups?
- Is the governance structure in place clear and in a position to deliver on agreed actions?

UNDERSTANDING YOUR LOCAL POPULATION NEED FOR MATERNITY AND EARLY YEARS SUPPORT

To understand needs that relate to the Start for Life services and activities in the local family hubs offer, you will need to look more closely at factors associated with child health and development in the early years (conception through to age 5). You can do this as part of a maternity and early years needs assessment for family hubs. The guidance in this section sets out:

- what to cover as part of a maternity and early years needs assessment for family hubs
- some of the data you can collect to understand local needs
- guiding questions to help you plan and prioritise offers included in the Start for Life services and activities.
- You should use this guidance alongside the step-by-step approach to doing a needs assessment (see **section 4**).

What do we know about child development in the early years?

The early years (conception to age 5) are a period of rapid growth and development. Life experiences during this time lay the foundations for a child's cognitive, social and emotional, physical, and behavioural health and development for the rest of their life.

Positive and nurturing care and experiences during this time will support children as they grow and develop, but negative or 'adverse' experiences can have lasting consequences for children. Adverse experiences include:

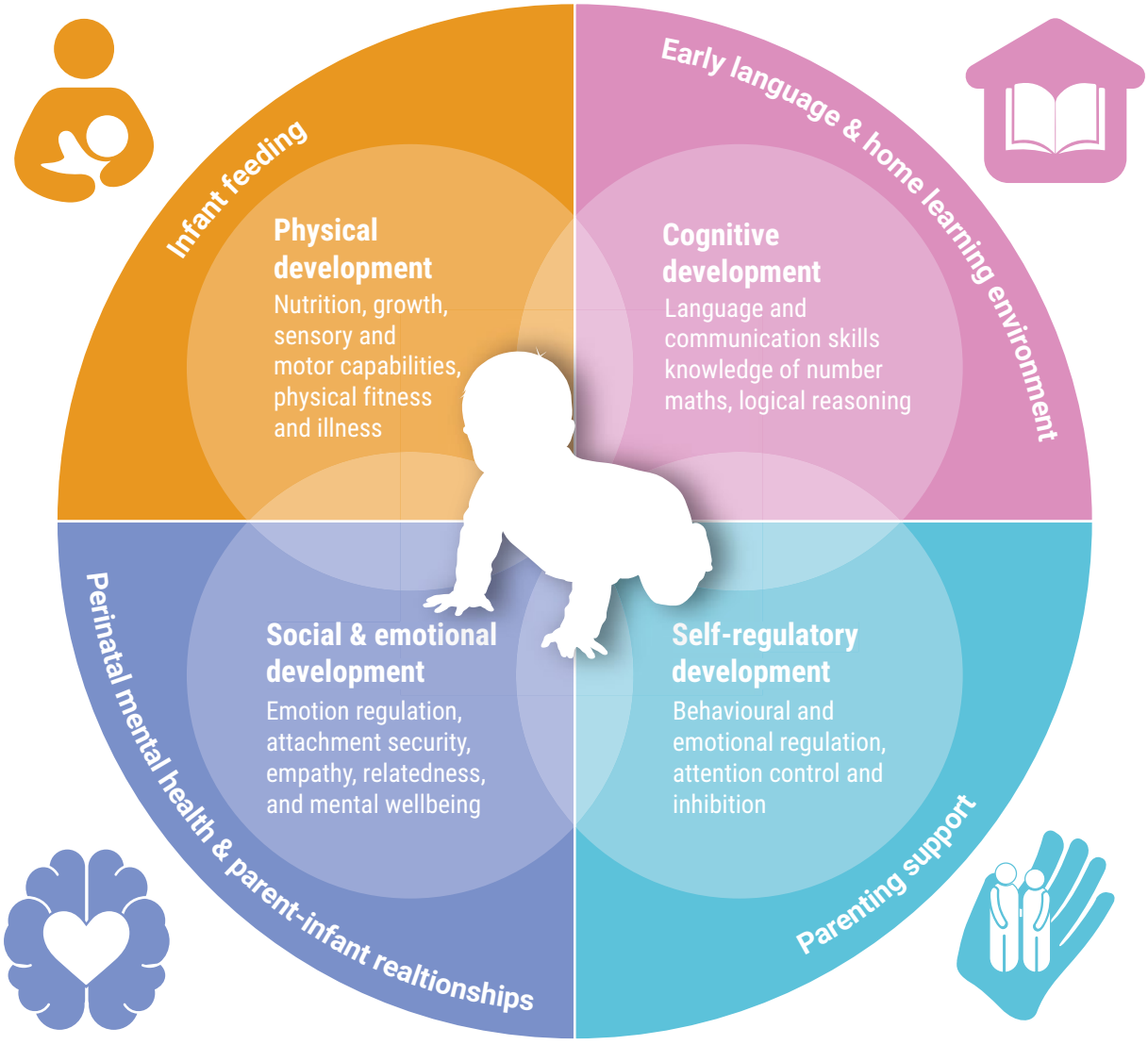
- experiencing maltreatment
- poor early relationships between parents and infants
- destructive parental conflict
- poverty
- domestic abuse
- parental substance misuse.

Adverse experiences during the early years are associated with poor outcomes for children in the short term and the long term. Early intervention is support and intervention that is offered in a timely and responsive way to prevent problems from arising, worsening, or becoming entrenched. This can reduce the risk or effects of poor child outcomes, while supporting the four key domains of children's development:

physical, cognitive, behavioural, and social and emotional. Figure 4 shows how the Start for Life services and activities support these four domains.[20]

Figure 4

How the four domains of child development are supported by the Start for Life services & activities



What should I cover in a maternity and early years needs assessment?

By providing effective, evidence-based universal and targeted services that meet the needs of families and children in the early years, we can ensure children have the best start in life and that families receive support and intervention when they need it. In turn, this can improve life outcomes for children and their families and reduce the impact of inequalities – especially for families who need support most.

20 For more details of how the Start for Life services support the four domains of children's development, see **Appendix A.**

Research evidence tells us what characteristics and conditions are important for either supporting or disadvantaging children's early development. The aim of conducting a maternity and early years needs assessment for family hubs is to map the level of need in the local population. By asking different questions about the population, and using the information and evidence we collect to answer these questions, we can map:

- how many of these characteristics and conditions are in the local population (that is, what the local level of need is)
- how many children and families experience characteristics and conditions that put their development at a disadvantage
- how severe the related needs are
- who has these needs.

In the case of family hubs, you can design the needs assessment to include data that helps you map the needs that are related to the Start for Life services and activities. For instance:

- How many children experience behavioural difficulties whose families may benefit from parenting support? **(parenting support)**
- How many new parents are there in the local area? Given that around one in 10 new fathers and one in five new mothers experience mental health problems during pregnancy and the first two years after a child is born, how many parents in this local area would benefit from mental health support? **(perinatal mental health)**
- How many parents have experienced perinatal loss (stillbirth or neonatal death) recently or after a previous pregnancy, and would benefit from mental health support, or support in pregnancy and in the perinatal period if they are fearful or worried about loving their new baby? **(parent–infant relationships)**
- How many children are living in absolute low-income households (economic deprivation), and how many have SEND, who would benefit from home learning environment support? **(home learning environment and early language)**
- How many babies are born in the local area each year? What is the breastfeeding rate at 6–8 weeks postpartum in the local area, and how many families would benefit from support with infant feeding? **(infant feeding)**

When examining the data, some characteristics and conditions will be associated with all of the Start for Life services and activities. However, some will be more important to consider in relation to some activities than to others, and some may be relevant to only one funded area. In the following guidance, we have used icons to highlight when a factor is particularly relevant for understanding needs related to one or more of the Start for Life services and activities.

Key characteristics and conditions: risk and protective factors for maternity and early years

Risk and protective factors exist at the level of the individual child, the family, the community, and society as whole, and they interact in complex ways.

You will already have considered some of the factors when looking at the demographic characteristics. When doing this maternity and early years needs assessment for family hubs, you'll need to look more closely at these factors associated with child health and development in the early years (conception through to age 5). These factors include birth outcomes, parental mental health and parental substance misuse, as shown in Figure 5 below.

Figure 5

Risk Factors Associated with Child Health and Development in the Early Years

All aspects of children's individual, family, community, and societal contexts influence child health and development in a cascading way over time. However, for the purposes of this maternity and early years needs assessment for family hubs, you will need to look more closely at the factors associated with child health and development in the early years (conception through to age 5), highlighted in white. [Source: EIF (2018), Realising the potential of early intervention, available at: https://www.eif.org.uk/report/realising-the-potential-of-early-intervention]

The tables on the following pages provide a framework for gathering data that is relevant to the early years. They outline what type of data you need and why it is important. You can use the guiding questions as a starting point for analysing the data. This will help you make sense of the data in the local context and give it meaning. Some potential data sources are provided, but this is not a full list and other data sources may be more relevant to your local area. As a guide, the different types of research evidence and local data outlined in **figure 2** are included throughout the potential data sources in [square brackets].

Table 2. What to consider as part of a local population needs assessment for Family Hubs: maternity and early years (ages 0–5)

Characteristic	Why is this important?	Guiding questions	Potential data sources
Preterm births	Women are more likely to give birth prematurely if they smoke during pregnancy, experience economic deprivation, are younger, experience alcohol or drug misuse during pregnancy, or have poor mental health. In the UK, Asian women, Black women, and minority ethnic women are also at more risk of giving birth prematurely. It is important to know what proportion of the total number of births in the local population are preterm (that is, babies born before 37 weeks). The evidence shows clearly that being born prematurely is associated with a higher risk of poor outcomes across children's development, including: • physical illness and disability • neurodevelopmental delay and disability • behavioural difficulties • cognitive developmental delay. There is also a clear association between how prematurely a baby is born how likely they are to have the associated negative outcomes. For example, 10% of all babies born premature (less than 37 weeks) will have a permanent disability (such as deafness, blindness, cerebral palsy, or lung disease), and this increases to 50% for babies born extremely premature (less than 26 weeks). Understanding the proportion of infants in the population who are born premature (and so are at risk of developmental delay and disability) can help you forecast the proportion of families who would benefit from proactive targeted support in the early years as their children develop. Offering early, targeted, and more intensive support earlier in children's development can prevent problems from developing or worsening as they grow.	What proportion of all births in the local area are preterm? • Where are parents who give birth to preterm babies likely to live? • Are national associations between preterm birth and ethnicity reflected in the local data? • Are national associations between preterm birth and economic deprivation reflected in the local data? • Has the prevalence of preterm births increased or decreased over time? Is there any reason this would rise or fall over the coming years? • Within this data, how many neonatal deaths, stillbirths or miscarriages are recorded? These parents may need additional targeted support. **Consider:** There may be births registered in neighbouring local areas that are not counted within your local area data. For example, is there a large or popular NHS maternity service in a neighbouring local area that local families would travel to receive care? Are there NHS maternity services within your local area that are or have become unfavourable with families? If so, local births may be registered in neighbouring local areas.	• NHS maternity annual statistics: maternity services data set (MSDS) and hospital episode statistics • Office for Health Improvement and Disparities: Fingertips public health data **Consider:** • Do any local voluntary and third-sector organisations have a good understanding of needs among parents of premature infants? **[Engaging stakeholders]** • Do any local parent and family support groups have in-depth data on experiences on having a premature baby? **[Lived experience]** • Can professionals working in local maternity systems provide insight on family or children's need? **[Professional knowledge]**

Characteristic	Why is this important?	Guiding questions	Potential data sources
Low-birthweight infants	Evidence shows clearly that low and very low birthweights are associated with adverse outcomes throughout children's development, including poor physical health, behavioural difficulties, and cognitive delays. Low birthweights are defined as follows: • low: less than 2,500g • very low: less than 1,500g • extremely low: less than 1,000g. Most infants whose birthweight is very low or extremely low are born premature. For low birthweight infants born at term (37 weeks or more) their birthweights will fall below the lowest centile line (<0.4th centile). The association between low birthweight and poor health and developmental outcomes is linked to mechanisms that are: • direct – for instance, intrauterine growth restrictions from placental insufficiency, brain injury as a result of prematurity or physiological immaturity • indirect – for instance, the availability and quality of neonatal care, neurodevelopmental therapy. Understanding the proportion of infants in the population who are born with low birthweights (all categories) and so are at risk of developmental delay and poor health outcomes can help to forecast the proportion of families who would benefit from proactive and targeted support in the early years as their children develop. Offering early, targeted and more intensive support can prevent problems from developing or worsening as children grow. Women are more likely to give birth prematurely if they smoke during pregnancy, experience economic deprivation, are younger, experience alcohol or drug misuse during pregnancy, or have poor mental health. In the UK, Asian women, Black women, and minority ethnic women are also at more risk of giving birth to low-birthweight infants.	What proportion of all babies in the local area are born with low, very low, or extremely low birthweights? • Where are parents who give birth to low-birthweight infants likely to live? • Are the national associations between low birthweight and ethnicity reflected in the local data? • Are the national associations between low birthweight and economic deprivation reflected in the local data? **Consider:** There may be births registered in neighbouring local areas that are not counted within your local area data. For example, is there a large or popular NHS maternity service in a neighbouring local area that local families would travel to receive care? Are there NHS maternity services within your local area that are or have become unfavourable with families? If so, local births may be registered in neighbouring local areas.	• NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** • Office for Health Improvement and Disparities: **Fingertips public health data** **Consider:** Do any local voluntary and third-sector organisations have a good understanding of needs among parents of low-birthweight infants? **[Engaging stakeholders]** Can professionals working in local maternity systems, health visiting services, GP services or speech and language services provide insight on family need? **[Professional knowledge]** How effectively are current services identifying and supporting these families? **[Organisational data]**.

Characteristic	Why is this important?	Guiding questions	Potential data sources
Infant feeding 	Breastfeeding for longer and with greater exclusivity is associated with lower risks of gastrointestinal, respiratory and ear infections, and less risk of infants being admitted to hospital for these conditions. Breastfeeding also protects infants against necrotising enterocolitis (NEC) and is linked to reductions in sudden infant death syndrome. Continuing with breastfeeding over time is linked to protecting children against: • allergic diseases (that is, asthma, eczema, allergic rhinitis) • cardiovascular disease (for example, being overweight or obese, and type-II diabetes). In the UK, nine out of 10 mothers who stopped breastfeeding before six months said they would have preferred to breastfeed for longer. Understanding the proportion of infants who are not breastfed at birth and in the early postnatal period (up to eight weeks after the birth) can indicate the proportion of children who are at risk of poor health outcomes before they enter school. Statistics on the proportion of women who breastfeed allow you to work out the proportion of women who don't. In turn, that indicates the proportion of families who would benefit from early, proactive, and targeted postnatal care and support to: • prevent breastfeeding problems from arising or worsening • ensure more families are able to breastfeed their infants for longer. Breastfeeding rates are lowest among mothers aged under 25, White parents, women who smoke, and parents who experience economic deprivation. Women who have poor mental health during and pregnancy and after the birth (postpartum) are also less likely to breastfeed than women without clinical or subclinical mental health conditions.	• What proportion of the population are young parents? Women who are younger are less likely to breastfeed (see 'Ages of parents'). • What proportion of the local population is White? White parents are least likely to breastfeed (see 'Ethnicity'). • What proportion of parents live in the most deprived areas in the local authority? Families who experience economic deprivation are least likely to breastfeed (see 'Economic deprivation'). • What proportion of pregnant women smoke during their pregnancy? Women who smoke are significantly less likely to begin breastfeeding or to breastfeed for as long as women who do not smoke (see 'Parental smoking status'). • What proportion of women who give birth in local maternity services are identified as having mental health needs? Poor maternal mental health is negatively associated with breastfeeding rates over time (see 'Perinatal mental health').	• Office for Health Improvement and Disparities: **Fingertips public health data** • NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** **Consider** • Do any local voluntary and third-sector organisations have a good understanding of infant feeding support needs in the local area? **[Engaging stakeholders]** • Do any local parent and family support groups have in-depth data on experiences of infant feeding? **[Lived experience]** • Can professionals working in local maternity systems, health visiting services or GP services provide insight on families' or children's need? **[Professional knowledge]** **Tip:** The gap between breastfeeding initiation rates (the number of families who start breastfeeding) and breastfeeding rates at 6–8 weeks postpartum (the number of families who continue breastfeeding) can indicate how much need there is for support.

Characteristic	Why is this important?	Guiding questions	Potential data sources
Complex social factors	In the context of pregnant women, the National Institute for Health and Care Excellence (NICE) defines 'complex social factors' as: • experiencing substance misuse (drugs or alcohol) • being a recent migrant, asylum seeker or refugee, or having difficulty reading or speaking English • being young (under 20) • experiencing domestic abuse.[21] When women experience these complex social factors during their pregnancy, there is a higher risk of: • miscarriage • premature birth • low infant birthweight • stillbirth • neonatal death • maternal death. If a baby is born premature or with a low birthweight, or if their mother dies, these poor outcomes can have cascading negative impacts on developmental outcomes as the child grows. Although the absolute number of poor outcomes associated with complex social factors is relatively low, the negative impact on children's health and development can be long-lasting. Understanding the number of infants born to women who experience these complex social factors can help to forecast the number of families who would benefit from intensive and targeted support during pregnancy and in the early years as their children develop, to stop problems from emerging or becoming entrenched.	• What proportion of women in the local area who give birth experience complex social factors? • Where are women who experience complex social factors likely to live? • Are children born to women who experience complex social factors more likely to have younger parents or experience economic deprivation? (See 'Ages of parents' and 'Economic deprivation'.) **Consider:** There may be births registered in neighbouring local areas that are not counted within your local area data. For example, is there a large or popular NHS maternity service in a neighbouring local area that local families would travel to receive care? Are there NHS maternity services within your local area that are or have become unfavourable with families? If so, local births may be registered in neighbouring local areas.	• NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** • Office for Health Improvement and Disparities: **Fingertips public health data** • Office for Health Improvements and Disparities: **national drug treatment monitoring system** • Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) UK: **perinatal mortality surveillance report (2020)** **Consider** • Do any local voluntary and third-sector organisations have a good understanding of need among the target population? **[Engaging stakeholders]** • Can any local support groups provide in-depth data on experiences of complex social factors? **[Lived Experience]** • Can relevant health and social care professionals provide insight on families' or children's need? **[Professional Knowledge]** **Tip:** Consider the data for each factor in the definition of 'complex social factors' individually if the data for 'complex social factors' measure is not available.

Characteristic	Why is this important?	Guiding questions	Potential data sources
Parental smoking	Parental smoking is consistently associated with poor outcomes for children's health and development and worsens existing health inequalities. Poor outcomes associated with smoking are observed in instances where women smoke during their pregnancy and when children and pregnant women are exposed to second-hand smoke in the home. Smoking during pregnancy is associated with a wide variety of adverse outcomes for infants including low birthweight, heart defects, diabetes, and asthma. Among women who smoke during pregnancy, the more cigarettes they smoke a day, the higher the risk of poor outcomes. However, negative birth outcomes are still seen among mothers who smoke less than one cigarette a day. Exposing infants to second-hand smoke is associated with a variety of poor outcomes for children's health, including: • sudden infant death syndrome • lower respiratory tract infections (such as pneumonia and bronchiolitis) • middle ear infections • asthma. Children born to women who smoke during pregnancy are also more likely to experience developmental delays (including speech and language delays) and behavioural difficulties as they enter school. Understanding the proportion of women who smoke during pregnancy and the proportion of parents who smoke can help to: • identify need for support to stop smoking (smoking cessation) • forecast the proportion of children at risk of poor health and development outcomes before they enter school, reflected in data on healthcare and early years education needs. Effective interventions that increase smoking cessation among this targeted group can prevent these poor outcomes from occurring.	• What proportion of pregnant women smoke during their pregnancy? • Where are women who smoke during pregnancy likely to live? • Are the national associations between smoking status during pregnancy and premature birth or low birthweight reflected in your local data? • Are the national associations between economic deprivation and smoking status during pregnancy reflected in your local data? • Smoking during pregnancy is most common among women under 20. Are younger parents (mothers and fathers) more likely to smoke during a pregnancy? (See 'Ages of parents'.)	• Office for Health Improvement and Disparities: **Fingertips public health data** • NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** **Consider** • Can professionals working in local health systems (for instance, local maternity systems, health visiting services or GP services) provide insight on family need? **[Professional knowledge]** • How effectively are current services identifying and supporting pregnant women and parents who smoke? What is the uptake and success of current smoking cessation programmes? **[Organisational data]**.

For a full description of the following characteristics and conditions, see Table 1 What to consider as part of a local population needs assessment for Family Hubs (ages 0–19/25).

Table 2.2. What to consider as part of a local population needs assessment for Family Hubs: maternity and early years (ages 0–5)

Characteristic	Guiding questions for the use of this data in a maternity and early years needs assessment	Potential data sources
Parental alcohol and substance misuse	• What proportion of pregnant women drink alcohol during pregnancy? • What proportion of pregnant women are recorded as misusing substances during pregnancy? • What is the estimated proportion of children who experience parental alcohol and substance misuse? • Where are children who experience parental substance misuse likely to live in the local area?	• Office for Health Improvement and Disparities: **Fingertips public health data** • NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** • Office for Health Improvement and Disparities: **national drug treatment monitoring system** • Department for Education: **children in need census data** [primary need data on parental disability or illness] **Consider** • Do any local voluntary and third-sector organisations have a good understanding of needs among parents and families who experience alcohol and substance misuse? **[Engaging stakeholders]** • Can professionals working in local health and social care systems provide insight on family need? **[Professional knowledge]** • Can any local support groups provide in-depth data on experiences of parental alcohol and substance misuse? **[Lived experience]** • How effectively are current services identifying and supporting these families? **[Organisational data]** **Tip:** Consider that domestic abuse, poor mental health, and substance misuse occurring at the same time may have cumulative effects. For more information, see **predictions from the Children's Commissioner** on estimating the prevalence of these characteristics and conditions.

Characteristic	Guiding questions for the use of this data in a maternity and early years needs assessment	Potential data sources
Children in need	How many children under 5 were identified as 'in need' in the local area? Has this increased or decreased recently? • How many children aged under 5 years are classified as children in need i.e., children on a Child in Need Plan (CINP), children on a Child Protection Plan (CPP), Looked After Children (LAC)? What are the characteristics of these children in terms of age, ethnicity, deprivation, and location? • What proportion of children are removed from families at birth? • What proportion of expectant parents or parents with a baby or young child have previously had a child removed or placed into care? • Children living in the most deprived communities are 12 times more likely to be identified as 'in need' as children living in the least deprived areas, with studies showing that rates of abuse and neglect are highest in neighbourhoods marked by strong income disparities. What proportion of children are experiencing economic deprivation? Where do these families live? (See 'Economic deprivation'.) • How many children are classed as in need of an Early Help Assessment (EHA)? **Consider:** Mapping and understand key characteristics that place infants and young children (aged under 5) at risk of entering the care system will enable local areas to target early support and intervention that can prevent 'causal' factors from worsening and negatively impacting children's early development.	• Department for Education: **children in need census data** • **The independent review of children's social care (2022)** • Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data** **Consider** • Stratified caseload data from Health Visitors may be able to provide an indication of the proportion of children on universal, universal progressive, targeted and specialist caseloads. • Can professionals working in local health and social care systems provide insight on the needs of children on the 'edge of care' or who are in the care system? **[Professional knowledge]** • How effectively are current services identifying and supporting children in need? **[Organisational data]** • Can any local support groups provide in-depth data on experience of children's social care? **[Lived experience]** • Do any local voluntary and third-sector organisations have a good understanding of children's social care needs in the local area? **[Engaging stakeholders].** **Tip:** Consider that domestic abuse, poor mental health, and substance misuse occurring at the same time may have cumulative effects. For more information, see **predictions from the Children's Commissioner** on estimating the prevalence of these characteristics and conditions.

Characteristic	Guiding questions for the use of this data in a maternity and early years needs assessment	Potential data sources
Domestic abuse	• What proportion of adults are survivors of domestic abuse in the local area? • What proportion of children are exposed to domestic abuse in the local area? • Where are children who experience domestic abuse likely to live in the local area?	• Department for Education: **children in need census data** [primary need data] (This data will under-represent the number of children exposed to domestic violence because the statistic is among children in need only – children who are not identified as 'in need' or referred to social services will not be included.) • Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data** **Consider** • Do any local voluntary and third-sector organisations have a good understanding of how common domestic abuse is in the local area and what its impact is? **[Engaging stakeholders]** • Can professionals working in local health and social care systems provide insight on family need? **[Professional knowledge]** • Can any local support groups provide in-depth data on experiences of domestic abuse? **[Lived experience]** **Tip:** Consider that domestic abuse, poor mental health, and substance misuse occurring at the same time may have cumulative effects. For more information, see **predictions from the Children's Commissioner** on estimating the prevalence of these characteristics and conditions.

Characteristic	Guiding questions for the use of this data in a maternity and early years needs assessment	Potential data sources
Parental conflict 	• What is the estimated proportion of children experiencing parental conflict and relationship distress in the local area? • When looking at the risk factors for increasing parental conflict (for instance, poor parental mental health, economic disadvantage, worklessness, parental substance and alcohol misuse) what is the likelihood that children are experiencing parental conflict? • Where are children who experience parental conflict likely to live in the local area?	• Department for Education: **children in need census data** [Primary Need data] • Department for Work and Pensions: **parental conflict indicator** • For more information, see EIF's **step-by-step guide on needs assessment for parental conflict** • Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data** **Consider** • Do any local voluntary and third-sector organisations have a good understanding of how common interparental conflict is in the local area, and what impact it has? **[Engaging stakeholders]** • Can professionals working in local health and social care systems provide insight on family need? **[Professional knowledge]** • Can any local support groups provide in-depth data on experiences of interparental conflict? **[Lived experience].**

Characteristic	Guiding questions for the use of this data in a maternity and early years needs assessment	Potential data sources
Parental mental health  	• What proportion of pregnant and postnatal (up to one-year) women experience mental health difficulties? • Are national trends in maternal and paternal mental health seen in local data? • Where are families who experience poor mental health likely to live? • When looking at the risk factors antenatal mental health difficulties (for instance, single parenthood and economic deprivation) what proportion of pregnant women would be expected to experience mental health difficulties in the local area?	• Office for Health Improvement and Disparities: **Fingertips public health data** • NHS maternity annual statistics: **maternity services data set (MSDS) and hospital episode statistics** • Department for Education and Department for Levelling Up, Housing and Communities: **national supporting families outcome framework data** **Consider** • Do any local voluntary and third-sector organisations have a good understanding of paternal mental health needs in the local area? There is a national shortage of data on fathers' mental health. **[Engaging stakeholders]** • Can professionals working in local health and social care provide insight on family mental health needs? **[Professional knowledge]** • Can any local support groups provide in-depth data on experiences of perinatal mental health, particularly for marginalised and high-risk groups? **[Lived experience]** **Tip:** Consider that domestic abuse, poor mental health, and substance misuse occurring at the same time may have cumulative effects. For more information, see **predictions from the Children's Commissioner** on estimating the prevalence of these characteristics and conditions

Data on contact points and referrals can be useful for understanding needs across different services and developmental domains.

You can use data on key characteristics and conditions associated with early health and development (that is, risk factors and protective factors) to project or estimate the level of need, who has the needs, and how severe they are. Cross-referencing this with the level of referrals and contact points can tell you whether the needs are being met or not. Examples of relevant data include:

- What is the prevalence of new birth visits completed within 14 days? How does the prevalence of births compare with the prevalence of completed new birth visits? What are the demographic characteristics of families who receive a new birth visit compared to those who do not receive a visit?
- What is the prevalence of completed health visitor reviews at 1, 2 and 2.5 years old? What are the demographic characteristics of children who receive reviews compared to those who do not receive reviews?
- What is the uptake of 15-hour and 30-hour entitlement for early education and childcare (early years provision) for eligible disadvantaged 2-, 3- and 4-year-olds? What are the demographic characteristics of children who receive the entitlements compared to those who do not?
- What is the prevalence of referrals made to specific services (such as neurodevelopmental pathway referrals, speech and language therapy and occupational therapy)? What are the demographic characteristics of children and families who are referred, and how does this compare with the demographic profile of the local population?

Outcomes measures can be used as one way of combining research evidence and local data (figure X.1) when gathering and triangulating different sources of data on needs in maternity and early childhood services. For example: Using and generating evidence – combining research evidence and local data

- What is the prevalence of children achieving a good level of development across the five developmental domains assessed at the 2- to 2.5-year-old review? What are the demographic characteristics of children who achieve a good level of development, and how does this compare with the demographic profile of the local population? Are there children who are disproportionately over- or under-represented?
- What is the prevalence of children achieving a good level of development at the end of reception according to the early years foundation stage profile? What are the demographic characteristics of children who achieve a good level of development, and how does this compare with the demographic profile of the local population? Are there children who are disproportionately over- or under-represented?

WHAT NEXT?

Once you have worked through the processes and guidance set out in this section of the applied tool, you will need to bring together what you have found into a coherent narrative. This should be developed into an appropriate output that outlines the needs and challenges that are relevant to your local area, including pressures faced by more vulnerable subgroups. To help you do this, see **Step 5** Analyse and understand and **Step 6** Test and confirm your conclusions and outputs.

The following guiding questions may help you to plan and prioritise offers that will be made as part of the Start for Life services and activities.

Understanding need in parenting support

- Describe the current context of parenting support in your local area.
  Consider: who is the target population? Where do they live (geographically)? Are there any subgroups of families who are more vulnerable and may have extra (or different) needs?
- What challenges and pressures are local families facing with parenting?
- What proportion of families is likely to need support with parenting, and how do you know this?
- Which families are most (or more) likely to need support? How do you know this?

Tip: Look at key data points and compare them with national averages or statistical neighbours to understand whether the local population (or vulnerable subgroups) have relatively high or low needs across different areas. Areas that rank lower than the national average may indicate greater need. Areas that rank higher than the national average may indicate that needs are being met and services focus on sustaining good practice.

Consider: Does the data indicate where (geographically) support will be needed most (or more)? Are there 'hot spots' where need has increased? Has the data uncovered any unmet needs?

Understanding need in perinatal mental health and parent–infant relationships

- Describe the current context of perinatal mental health and parent–infant relationships in your local area.
  Consider: who is the target population? Where do they live (geographically)? Are there any subgroups of families who are more vulnerable and may have extra (or different) needs?
- What challenges and pressures are local families facing with perinatal mental health and parent–infant relationships?
- What proportion of families is likely to require need with perinatal mental health and parent–infant relationships, and how do you know this?

- Which families are most (or more) likely to need support? How do you know this?

Understanding need in early language and the home learning environment

- Describe the current context of children's early language and the home learning environment in your local area.
  Consider: who is the target population? Where do they live (geographically)? Are there any subgroups of families who are more vulnerable and may have extra (or different) needs?
- What challenges and pressures are local families facing with early language and the home learning environment?
- What proportion of families is likely to require support with early language and the home learning environment, and how do you know this?
- Which families are most (or more) likely to need support? How do you know this?

Understanding need in infant feeding

- Describe the current context of infant feeding in your local area.
  Consider: who is the target population? (In this case, it will be expectant parents and families with infants up to 2 years old.) Where do they live (geographically)? Are there any subgroups of families who are more vulnerable and may have extra (or different) needs?
- What challenges and pressures are local families facing with feeding their infants?
- What proportion of families are likely to need support with infant feeding, and how do you know this?

- Which families are most (or more) likely to need support? How do you know this?

REFLECTIONS

Once you have worked through the processes and guidance in this applied tool, you will have developed a coherent narrative that:

- describes your local context
- provides a clear understanding of the level of risk factors in your local population
- provides an understanding of the challenges and barriers experienced by local families
- tells a comprehensive story of the needs of families.

REFLECTIONS (CONT.)

You can then take stock of what you have learned and identify any areas where more work needs to be done. This will help you build on your population needs assessment as you develop your family hub approach. To take stock, ask yourself these questions:

- What have you and the team learned from this process?
- Where are the gaps in evidence and understanding of local population needs?
- What are the next steps for completing or updating the population needs assessment for family hubs?

APPENDIX A: HOW THE START FOR LIFE SERVICES & ACTIVITIES SUPPORT THE FOUR DOMAINS OF CHILD DEVELOPMENT

Funded service and activity	What do the services and activities aim to do?	How do the services and activities relate to the four domains of children's development?
Parenting support Family Hubs and Start for Life programme guide (August 2022), pages 35–38 Family Hubs and Start for Life programme guide (August 2022) Annex A and Annex H	Early help services for parents and carers that aim to make the transition to parenthood as smooth as possible for parents and emphasise the importance of responsive and sensitive caregiving. Parenting support services aim to prevent problems from occurring and stop them from becoming worse when they arise. All parents and carers can benefit from light touch help and support such as advice and signposting, and therefore a universal offer should be made available for all parents. However, some parents face other challenges and circumstances where they will need more intensive support. Therefore, targeted offer(s) should be made available for parents and carers with greater need.	Evidence shows parental sensitivity and responsiveness, together with appropriate boundary setting and predictability are all associated with improved and more positive outcomes for children in the short- and long-term. For example, parental sensitivity and responsiveness is associated with children's social and emotional development: Parents and carers foster attachment security through parenting behaviours that are predictable, sensitive and responsive to the child's needs. These feelings of attachment security allow children to develop positive expectations of themselves and others. This in turn, improves their ability to form positive relationships with others and reduces risks of depression and other poor mental health outcome. Parental responsiveness and sensitivity are also associated with positive and improved cognitive development (such as speech and language development, success in school), behavioural development (for instance, conduct disorders, antisocial behaviour, and bullying), physical development, and almost all outcomes on the early years foundation stage measures.

Funded service and activity	What do the services and activities aim to do?	How do the services and activities relate to the four domains of children's development?
Perinatal mental health and parent–infant relationships Family Hubs and Start for Life programme guide (August 2022) Pages 38–42 Family Hubs and Start for Life programme guide (August 2022) Annex A and Annex I	Funding has been dedicated for moderate-to-severe perinatal mental health support as part the NHS Long Term Plan and Maternity Transformation Programme. It is therefore expected that perinatal mental health support offered as part of family hubs should complement the existing offer and be dedicated towards universal support for parent–infant relationships and mild-to-moderate perinatal mental health problems that emerge during pregnancy or within the first two years postpartum. Services and activities offered as part of this programme should raise awareness and increase understanding of common mental health problems experienced by parents antenatally and postnatally (up to two years), prevent difficulties from emerging, identify problems when they do emerge, and support families to understand and build early healthy relationships with their infants. In practice, it is likely there will be overlap in services and activities designed to support perinatal mental health, parenting, and parent-infant relationships.	Evidence consistently shows that poor parental mental health and insensitive or insecure parent–infant relationships are associated with poor outcomes for children's health and development across the lifespan. Poor parental mental health includes maternal mental health during pregnancy and postpartum as well as having a family member (parent or other primary caregiver) with poor mental health in the household. Parents with poor mental health may find it difficult to understand and respond sensitively to their children's needs. Insensitive parenting (in the presence or absence of poor parental mental health) is associated with a variety of social, emotional, self-regulatory, and behavioural problems as children develop, including an insecure attachment, self-regulatory problems, and behavioural problems once children enter school. For example, parental depressive and anxiety symptomology and parental stress are associated with internalising problems (for instance, anxiety, emotional reactivity, depression, and withdrawal) and externalising problems (for instance, hostility, aggression, conduct disorders, and attention) in children. Importantly, mental health conditions and symptomology are highly comorbid, and increasing comorbidity can have a cumulative negative impact on children's health and development outcomes. Conversely, good parental mental health and sensitive, responsive, and secure parent–infant relationships support children's physical development (for example, healthy eating habits), cognitive development (for example, language skills), social and emotional development (for instance, emotional regulation, establishing and maintaining positive relationships) and behavioural development (such as self-regulation or impulse control).

Funded service and activity	What do the services and activities aim to do?	How do the services and activities relate to the four domains of children's development?
Early language and the home learning environment Family Hubs and Start for Life programme guide (August 2022) Pages 42–44 Family Hubs and Start for Life programme guide (August 2022) Annex A and Annex J	The implementation of targeted, evidence-based interventions that train practitioners to support parents with their home learning environment. By definition, the home learning environment encompasses both the physical characteristics of the home environment such as enriching books, toys and educational activities, as well as positive and sensitive parent–child interactions and learning support provided in around the home. Services and activities delivered as part of this offer aim to support educational and school readiness of children who were babies during the pandemic and will soon be entering school. Some of the offers included as a minimum expectation include parental access to information on the home learning environment and how parents can support children's' speech and language development; staff training to deliver targeted, evidence-based interventions to parents of 3–4-year-olds who would benefit most (for example, children from disadvantaged backgrounds or with additional needs); and that parents of pre-schoolers can access home learning environment programmes through a variety of practitioners and pathways, including speech and language therapists, health visitors, midwives, early years practitioners, and voluntary and community sector organisations.	In the first five years of life, the environment plays an increasingly important role in shaping children's cognitive development. In the early years, parents primarily determine what their children learn and how they learn it through the quality of learning materials they provide and their ability to respond to their child's unique learning needs. Having a stimulating home learning environment that is responsive to children's learning needs can support children's cognitive development, including speech and language development. Early cognitive competencies are predictive of later school achievement. In particular, cognitive capabilities at age four are reliable predictors of children's academic success from reception onwards. In addition, early language acquisition and cognitive development impacts on all aspects of children's non-physical development. For example, it supports children's social and emotional development such as the ability to manage emotions and communicate feelings, which in turn supports children's behavioural development such as the ability to establish and maintain positive relationships. Frequent, high-quality infant-directed speech and behaviours that are responsive to children's developmental needs are found to make the greatest impact in supporting early cognitive and language outcomes. The quality of the home learning environment plays significant role in supporting children's school readiness and can reduce many of the risks that interfere with some children's ability to learn. Unfortunately, studies consistently show that disadvantaged children are less likely to experience a high-quality home learning environment, a factor exacerbated during the pandemic. For example, having limited access to resources can limit parents' ability to provide an enriching home learning environment, higher levels of family stress can substantially reduce parents' ability to sensitively respond to a child's needs, and limited quality time together engaging in meaningful activities can reduce the quality and variety of vocabulary children are exposed to in interactions. These early experiences of disadvantage may place children at risk of developmental delay. Regular home visits that help disadvantaged parents provide an enriching home learning environment have the strongest potential for closing the income-related learning gaps that are already present by the age of three.

Funded service and activity	What do the services and activities aim to do?	How do the services and activities relate to the four domains of children's development?
Infant feeding Family Hubs and Start for Life programme guide (August 2022) Pages 44–49 Family Hubs and Start for Life programme guide (August 2022) Annex A and Annex K	Multicomponent infant feeding support is the most effective way of supporting parents to feed their babies as they want to, increasing breastfeeding rates, and ensuring parents can meet their infant feeding goals. The minimum expectations and 'go further' options provided assume local areas will have the flexibility to tailor services to meet varying local need(s). Key aspects of support offered should include: information and education antenatally for parents to make informed decisions about how to feed their infants; one-to-one practical help and support on hospital wards and family hubs to initiate breastfeeding, safe bottle feeding, responsive feeding and relationship-building; access to drop-in infant feeding support sessions/groups; access to virtual support; and coherent and joined-up system-level initiatives that ensure families can access support and information across services. The NHS Long Term Plan (LTP) set out an ambition for all maternity services to deliver an accredited, evidence-based infant feeding programme, such as UNICEF Baby Friendly Initiative. All new initiatives funded by the family hubs and Start for Life programme should complement this ambition and should ensure that families experience a seamless transfer of care from maternity to community.	Breastmilk is the most nutritious source of food for infants and has numerous health benefits for both mother and baby. Breastfeeding for longer and with greater exclusivity is associated with reduced risks of gastrointestinal, respiratory and ear infections and reduces the risk of infants being admitted to hospital for these conditions. Breastfeeding also protects infants against necrotising enterocolitis (NEC) and has been linked reductions in the incidence of sudden infant death syndrome. When considering the health benefits of breastfeeding over time, breastfeeding is linked to protection against allergic diseases (that is, asthma, eczema, allergic rhinitis) and cardiovascular disease (that is, overweight and obesity, and type-II diabetes) in childhood, and reduced incidence of dental disease. Importantly, breastfeeding also reduces poor maternal health outcomes and is associated with reduced likelihood of gestational and type-II diabetes mellitus, and significantly reduced risks of breast and ovarian cancer. Despite the recognised benefits of breastfeeding and that eight out of 10 mothers in the UK report wanting to breastfeed their infants, the UK has one of the lowest rates of breastfeeding in the world where early discontinuation of breastfeeding remains a problem for families. Only 34% of babies in the UK are receiving any breastmilk at six-months, less than 1% of babies are exclusively breastfed at six-months, and nine out of 10 mothers who stopped breastfeeding before six months said they would have preferred to breastfeed for longer.

APPENDIX B: TEMPLATES

1. Population needs assessment: Collecting and analysing data **[Download]**
2. Population needs assessment: Identifying need by collecting and analysing data for groups at risk of being excluded from or underrepresented in population needs assessments **[Download]**
3. Population needs assessment: Step-by-Step guide to completing a population needs assessment checklist and flowchart **[Download]**