



department for
children, schools and families



*Department
of Health*

Healthy lives, brighter futures

The strategy for children and young people's health



A commitment from
The Children's Plan



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Joint Ministerial Foreword	2
Executive summary	4
1. Introduction	10
2. Building on progress: the framework for child health	18
3. Pregnancy and the early years of life (up to 5 years)	22
4. School-age children	36
5. Young people	50
6. Services for children with acute or additional health needs	64
7. Making it happen: system-level transformation	80
8. Next steps: supporting local delivery	98
Annex A: National Service Framework for Children, Young People and Maternity Services – Standards	101
Annex B: Public Service Agreements, NHS Vital Signs and Local Area Agreements	103
Annex C: Consultations with children, young people, parents and stakeholders	107
Annex D: The Healthy Child Programme – recommended schedule from pregnancy to 5 years	108

CONTENTS

JOINT MINISTERIAL FOREWORD



By the Secretary of State for Children, Schools and Families and the Secretary of State for Health

We cannot overstate the importance of children and young people's health. A healthy start in life is at the heart of a happy childhood and the ability of every young person to achieve their potential and grow up well prepared for the challenges of adolescence and adulthood.

Children and young people are healthier than ever before, but we now have the opportunity to go further. We know that we must do more to provide mothers and fathers with the support they need to give their children the best start and to help young people to make healthy choices as they grow up and take more responsibility for themselves.

Our two departments have come together to produce this long-term strategy to improve health outcomes for all children and young people. It is a direct response to the views and concerns of young

people, parents and professionals working with children and families.

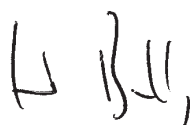
We have met many children and young people in the process of putting this strategy together. They have told us that they want easier access to health services to support their psychological as well as physical health. Parents and carers have told us that they want better information about what services are available locally. Many parents have said that there need to be better links between health and children's services. Frontline staff want help to overcome the barriers to providing excellent, integrated health services that they know children and families need.

Healthy lives, brighter futures sets out how we will work in partnership with local authorities and primary care trusts and those working across children's health services to build the quality of support for families at key stages in their children's lives.

Every family will have easy access to support from pregnancy and early years of children's life, with more health visitors, and a strengthened role for Sure Start Children's Centres, with each centre having access to a named health visitor. There will be further expansion of the successful Family Nurse Partnership programme for vulnerable first-time mothers and the development and testing of a new Antenatal and Preparation for Parenthood Programme for mothers and fathers.

For school-age children and their families, there will be a core health programme, the 'Healthy Child Programme', to set out clearly what services should be available to parents, children and young people from 5 to 19, supported by 21st Century Schools with a focus on pupils' health and wellbeing, and pilots to test the impact of extending free school meals to a greater number of pupils. Young people will be given more opportunities for sport and better access to health services that are tailored to helping them deal with the health challenges of adolescence.

For families who rely on health services for urgent, short-term care as well as those who need ongoing support for children with complex and long-term conditions, we know that timely access to high quality support is crucial. We are making new commitments to strengthen urgent care and specialist support, so that every child can reach their full potential. We will test innovative approaches to the provision of community equipment and make sure that by 2010 all children with complex health needs have individual care plans to support co-ordinated care.

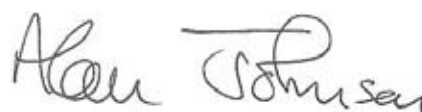


Ed Balls
**Secretary of State for Children, Schools
and Families**

This will be backed by £340 million from each of our departments to improve the experience of disabled children and their families through better access to short breaks, community equipment and wheelchair services, as well as palliative care and end-of-life care.

Improving children's health from birth to 19 is an ambitious agenda. In order to drive change in every area, we know that we need stronger joint leadership to plan, commission and monitor the delivery of excellent services. The strategy sets out how we will help those on the frontline make a reality of this vision.

With schools, GP practices, hospitals, Sure Start Children's Centres, the voluntary sector and government all playing their part in support of families, we can ensure that every child has a healthy start in life and a brighter future. Working together, we can continue to work towards our goal to make this the best place in the world to grow up.



Alan Johnson
Secretary of State for Health



EXECUTIVE SUMMARY

- 1 Children and young people are healthier today than they have ever been. Medical, technological, social and economic advances have radically cut infant mortality rates and given many children and young people a healthier start to life than they could ever have enjoyed before. There is more support for parents, children and young people in promoting health and wellbeing and in meeting additional health needs. There are: thousands more professionals with specialist skills working with children; new Sure Start Children's Centres providing integrated services; reduced waiting times for access to healthcare; and new sources of information and advice. There is also a greater focus on health and wellbeing in our schools and colleges, and more choice over how to access healthcare.
- 2 To deliver our 2020 ambition of making England the best place for children to grow up, we need to support families in securing world-class health and wellbeing outcomes for their children. This means continuously driving up the quality of our services for all parents and children, and ensuring that those improvements are reflected in the experience of services for children, young people and their families. At the same time it means doing more for the most vulnerable, to reduce the persisting inequalities in health and wellbeing outcomes for different groups. Better support in the early years and through childhood and adolescence will lay the foundation for better health and life chances into adulthood, so this strategy sets out how we will build on progress through the achievement of:
 - world-class health outcomes
 - services of the highest quality
 - excellent experiences in using services
 - minimising health inequalities.
- 3 Parents are the key to achieving the best physical and mental health and wellbeing outcomes for their children. This strategy sets out the principles of the relationship between parents and services, and will establish what parents and their children can expect from their services. These principles are that:
 - Mothers and fathers are provided with the information they need to help their children lead healthy lives, with local areas setting out what parents will be able to receive in their communities.
 - Public sector settings provide healthy environments and encourage children and young people to make healthy choices.
 - The right services are in place to meet the specific health needs and expectations of children and their families.
 - Extra support is provided for those from the most disadvantaged backgrounds.
- 4 These ambitions underpin the policy recommendations that follow – recommendations that seek to cement, not replace, the standards and ambitions set through the *National Service Framework for Children, Young People and Maternity Services* (see Annex A) and the *Every Child Matters* programme for improving outcomes for children. And they build on the consistent approaches of the *NHS Next Stage Review* and *The Children's Plan*, details of which are set out in Chapter 2. The policies that follow will help to ensure that our existing ambitions for children, young people and families are realised and that improvement continues.

5 This strategy sets out the plans for universal, targeted and specialist support across three life stages – early years and pregnancy; school-age children; and young people – as well as the additional support for children and young people in need of acute or ongoing healthcare. It also sets out how the delivery system can be supported in taking forward the recommendations – in particular, how the range of services in contact with children and young people can work better together, and with families, to achieve common aims. In accordance with our commitment to implementing the United Nations Convention on the Rights of the Child, this strategy is underpinned by the general principles and basic health and welfare articles of the convention.¹

Pregnancy and the early years

6 During pregnancy and the early years of their children's lives, parents have access to a wide range of services in support of their children's health, from midwives to childcare practitioners. But the extensive consultation with parents, children and young people undertaken to develop this strategy has demonstrated that we can do more to provide further support for parents and their children at this time.

7 One of the key principles underpinning this strategy is to ensure that parents get the information they need to support their children's health. **Local areas will be expected to set out what children and families can expect from their health services locally** – to help them to access the support they need, when they need it, from pregnancy through to services aimed at young people up to the age of 19.

8 To ensure that the right services are in place to meet the needs and expectations of children and their families, additional improvements will be made to antenatal and early years services. In doing so, the focus will be on ensuring that the right services, support and advice are available for all parents, and that more intensive support is given to the most vulnerable. The improvements include:

- **Further development of the health visitor workforce** to deliver the Healthy Child Programme.
- **The development of a new Antenatal and Preparation for Parenthood programme** that, following successful testing, will help engage parents, including those from more disadvantaged backgrounds.
- **The expansion of the successful Family Nurse Partnership Programme**, which provides intensive support from highly trained nurses for the most vulnerable first-time mothers. It will be expanded from 30 to 70 sites by 2011, with a view to rolling out this support for the most vulnerable first-time young mothers across England over the next decade.
- **A strengthened role for Sure Start Children's Centres** – both through additional health-based programmes, focusing on reducing obesity and smoking, and by ensuring that each centre has access to a named health visitor.

¹ www.unicef.org/crc/

School-age children

- 9 As children grow up they become increasingly aware of health-related matters and can be expected to take on additional responsibility for their own health and wellbeing. Schools and school health services, GP practices, paediatricians, children's services (including behaviour support and social care services), child and adolescent mental health services and others play a hugely important role in supporting children and families to lead healthy lives. Health and wellbeing is central to the concept of the 21st Century School.
- 10 To support local areas:
- **An improved Healthy Child Programme for school-age children will be developed**, which will set out what services should be available to all parents in all areas.
 - The role of schools in promoting pupils' health will also be supported through **strengthening the National Healthy Schools Programme**.
 - **The creation of a world-class system of PE and sport, offering 5- to 16-year-olds 5 hours a week** – a significant contribution to the exercise they should undertake – and giving them high quality sports in the run-up to, and after, the London 2012 Olympics.
 - **Pilots will be established to build the evidence base on the impact of extending free school meal criteria to a greater number of pupils** (including, in some areas, by putting in place free school meals for all primary pupils).
 - We will **improve the quality and consistency of Personal, Social, Health and Economic (PSHE) education and intend to make it statutory within the curriculum**.

Young people

- 11 Adolescence is not only a key transition point between childhood and adulthood, it is a distinct developmental stage in its own right, characterised by dramatic physical and neurological changes, and emotional development.
- 12 This strategy sets out a number of proposals to help ensure that young people are given access to healthier opportunities:
- The PE and Sport Strategy for Young People includes a **commitment to offer 16- to 19-year-olds three hours high quality sports a week**.
 - **The 'You're Welcome' standards will be rolled out across England**, so that all young people, wherever they live, will be able to access young people-friendly health services.
 - **A new campaign to increase young people's knowledge of effective contraceptive methods** will be launched, backed by increased investment of around £27 million a year from 2008-09² in contraceptive services in a range of settings.

² Throughout this document the use of a hyphen (-) denotes reference to a financial year, e.g. 2008-09. The use of a slash (/) denotes reference to an academic year, e.g. 2008/09.

Services for children with acute or additional health needs

- 13** Ensuring that services are of high quality and are responsive to the needs and expectations of those who use them is especially important when children and young people have acute or additional health needs, including disabled children and children with complex health needs.
- 14** To support children and families with acute or additional health needs, the strategy highlights features of safe and sustainable services including managed clinical networks and sets out steps to improve information; secure the right skills and roles; personalise care; and redesign services. The strategy:
- **Establishes the funding available in the NHS over three years for palliative care and end-of-life services, short breaks, community equipment and wheelchair services for disabled children and young people – this funding will total £340 million in NHS allocations over the three years 2008-09 to 2010-11, including £30 million to meet commitments made on palliative care and end-of-life care, in addition to the £340 million revenue funding already announced by DCSF for the Aiming High for Disabled Children programme for children's services.**
 - **Sets out plans to test and expand new approaches to the provision of services –** for example by extending the learning from innovative work on wheelchair services by Whizz-Kidz and Tower Hamlets PCT to other parts of London.
 - **Promises that all children with complex health needs have an individual care plan by 2010,** to support co-ordinated care for children with complex health needs when navigating between numerous different services.

Making it happen: system-level transformation

- 15** The individuals and organisations that lead, plan, commission and ultimately deliver child health services are crucial to the success of this strategy. They are the commissioners of health promotion services and services for children who are sick or who have ongoing, additional health needs. And they are the frontline staff working with children and families.
- 16** In order to support these individuals and organisations in working together to deliver improvements for children and their families, the Government will:
- **Promote joint leadership and strengthen local accountability arrangements for children's health,** including putting Children's Trust Boards on a statutory footing, and transforming the Children and Young People's Plan from a local authority plan into one owned by the Children's Trust Board.
 - **Promote action to ensure that all organisations with responsibility for child health and wellbeing are fulfilling their statutory responsibilities for safeguarding children.**
 - **Improve the engagement of GPs with Children's Trusts,** by setting an expectation that directors of children's services will consult with primary care trusts (PCTs) to secure GP membership on Children's Trust Boards.
 - **Introduce a high-level joint commissioning guide** to support local authorities and health bodies (in particular PCTs) to commission child health services – the guide is being published alongside this strategy.

- **Promote better use of data, including development of minimum child health datasets and models for the planners and commissioners of services**, for example to improve local authorities' and PCTs' understanding of the complex relationship between child health spend and children's health outcomes.
- **Strengthen the child health workforce** – through work that will help SHAs assess the roles, skills and capacity they need in their local children's workforce, for example whether there are sufficient health visitors; to help expand their trained paediatric workforce, including community children's nurses and paediatricians; and through work on extending GP training being led by the Royal College of General Practitioners.
- **Further promote the voice of children and young people**, through commitments to ensure that children and young people's views are given prominence in future assessments of healthcare organisations.
- **Ensure that robust arrangements are in place to promote and ensure the quality of health services.**



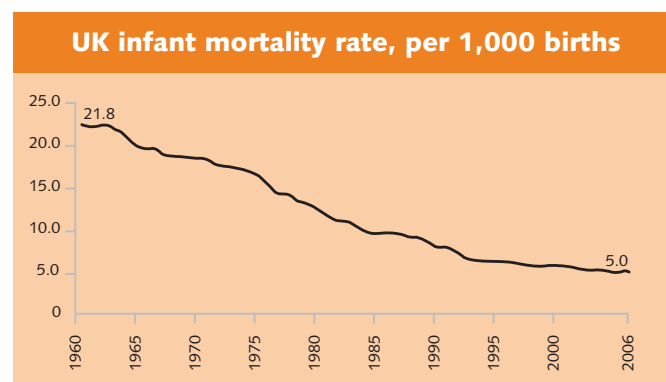


INTRODUCTION

Children and young people are healthier than ever before

- 1.1** Children and young people growing up in England today are healthier than they have ever been before. In the immediate post-Second World War period, the four traditional killer diseases of children (scarlet fever, diphtheria, measles and whooping cough) were common, and cancer was usually incurable. Most dramatically, as many as 1 in 20 children would die in infancy.³
- 1.2** Before 1948, there was little or no free healthcare for children. The National Insurance Act 1911 was revolutionary for its time, because it provided health and unemployment insurance for most of the working population, but it still left dependents without free access to even the most basic medical care.
- 1.3** In the period since the end of the Second World War, the adoption of well-structured public health and immunisation programmes, antibiotic treatment for bacterial infections, alongside other advances in medical knowledge, care and treatment, have transformed our ability to prevent and treat childhood illnesses. Our understanding of how babies' brains develop, of how early attachment between baby and mother influences a child's long-term development, and of the importance of mental as well as physical health, has also improved considerably.
- 1.4** The broader factors that influence children's health and wellbeing have also improved markedly over the past half-century: there is better sanitation, a safer water supply and better air quality, as well as improvements to the built environment through higher-quality housing and safer transport. Most families are significantly better off and parents have higher expectations and aspirations for their children's health – mostly as a result of these broader changes – than they did before.

- 1.5** These medical and social changes have had dramatic impacts. In England today, the previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving, and the UK infant mortality rate has fallen to 5 per 1,000 live births – less than a quarter of what it was at the beginning of the 1960s (see chart below).⁴



The past decade has seen continued improvements

- 1.6** The past decade has seen continued improvements in children, young people and families' health services. These advances have been made possible through significant increases in health and education expenditure, and a renewed focus on services that respond quickly and effectively to children and families' needs and expectations.
- 1.7** There has been significant investment in the children's workforce over the past decade. Sure Start Children's Centres – an entirely new universal service for 0- to 5-year-olds – have been established to help provide health and education services in the early years of a child's life alongside schools, community health services and GP practices. There are almost 3,000 Sure Start Children's Centres in place today, and by 2010 there will be 3,500 – one in every community.

³ *The Welfare State in Britain since 1945* (3rd Edition), Lowe, R., 2005; *Child Health: 1948-2008*, Jamieson M., 2008.

⁴ *Infant Mortality Rates*, Office for National Statistics, 1960 to 2006.

1.8 Schools increasingly see securing children's wellbeing as central to their role. The majority of schools have now achieved Healthy Schools and Extended School status (with over 60% of schools in both programmes). This translates to around 3.7 million children and young people currently enjoying the benefits of attending a Healthy School. Children and young people in those schools say they feel healthier, happier and safer, while parents say they feel more involved in the children's health and learning.⁵

1.9 Children and young people have also benefited from the wider improvements in the NHS. In 2007-08, 97.9% of people attending an emergency department were seen within four hours, with children often being given priority through the system. Similarly, there were 24,000 attendances by under-17-year-olds at NHS walk-in centres in 2005 (the first full year after the centres were piloted). And last year there were 1.4 million calls by or on behalf of children to NHS Direct (introduced in 1998).

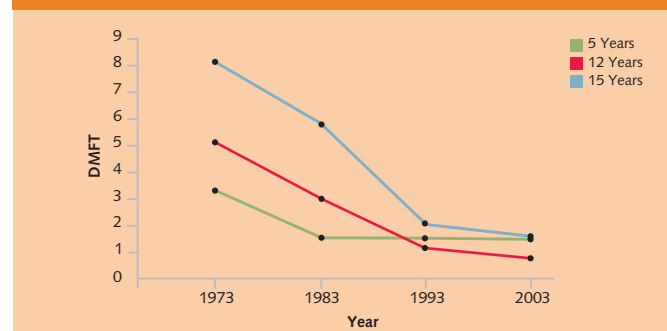
1.10 The expansion of vaccination programmes has been one of the most significant public health successes of the past 50 years, and has continued over the last decade. For instance, the introduction of the pneumococcal vaccination as part of the childhood immunisation scheme in September 2006 has helped to avert an estimated 470 cases of serious illness, and up to 28 deaths, in the first 18 months of the programme. A new vaccination programme was launched in 2008 offering 300,000 girls per year a chance to be protected against cervical cancer, saving up to an estimated 400 lives per year.

1.11 Progress has been made on improving access to child and adolescent mental health services (CAMHS) – there has been a considerable increase in expenditure on CAMHS and an increase in staffing. The number of children, young people and their families being seen by services has increased, and the numbers waiting

have reduced significantly. There has also been progress in the provision of age-appropriate care for 16- and 17-year-olds, and in the provision of services for children and young people with a learning disability who also have mental health problems.

1.12 National surveys undertaken every 10 years, together with more frequent local NHS surveys, show that the oral health of children in England is the best since records began. In the early 1970s, around 30% of children started school with no experience of tooth decay; by 2003 this figure had risen to 59%. The proportion of older children with decayed, missing or filled permanent teeth (DMFT) has also dropped. In 1973, 93% of 12-year-old children had tooth decay in England; by 2003, this had fallen to a historic low of 38%.⁶

Average number of decayed, missing or filled permanent teeth (DMFT) per child in England, 1973–2003



1.13 New services and information campaigns have been put in place to support families in tackling some of the current and future health threats facing the modern world: pandemics, obesity, smoking, mental health, drugs and alcohol. New technologies and innovations have led to improvements to treatments, as well as to new ways of providing information and advice. For example, the *Parent Know How*⁷ portfolio of services includes a free 24-hour telephone helpline and an online service for the parents of

⁵ *Children's Health, Our Future: A review of progress against the National Service Framework for Children, Young People and Maternity Services*, Department of Health, 2007.

⁶ *2003 Children's Dental Health Survey*, Office for National Statistics, www.statistics.gov.uk/children/dentalhealth/

⁷ *Parent Know How: Working together, supporting families*, www.dcsf.gov.uk/parentknowhow

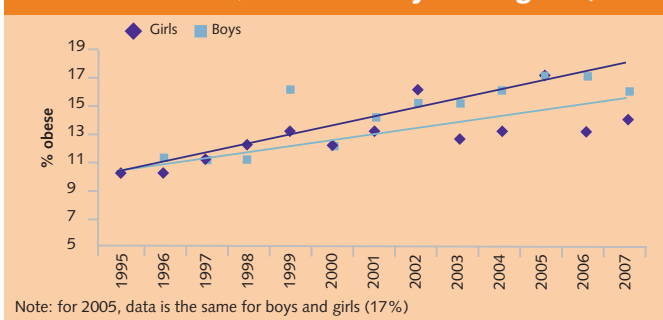
disabled children. For young people, the FRANK campaign, launched in 2003, provides online and over-the-phone information and support about the risks and dangers of drugs and their use.⁸ *RUthinking*⁹ provides similar support and advice on sexual health issues.

But we need to do more to become world-class

1.14 The Government has demonstrated the priority it attaches to children and young people's physical and mental health through the investment it has made in children's services. Improvements have been seen. But more needs to be done.

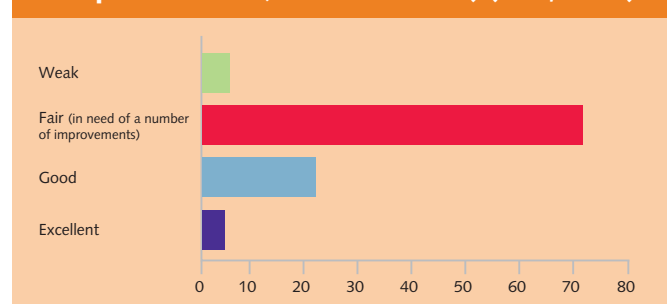
1.15 First, particular health outcomes give cause for concern. International comparisons and worrying long-term trends demonstrate where there is room for improvement. For example, though infant mortality rates in England are at historically low levels, they are almost twice as high as in Sweden, which has one of the lowest rates in the world. Trends that give cause for concern include childhood obesity, the prevalence of certain sexually transmitted infections, and the volume of alcohol consumed by young people who drink.¹⁰ For instance, the trend of obesity rates for 2 to 10-year-olds has risen by around 50% from 1995 to 2007 (from 10% to around 14% for girls and from 10% to 16% for boys).

Obesity prevalence among 2- to 10-year-olds, 1995–2007 (Health Survey for England)



1.16 Second, there is often considerable variation in the quality of our health services. Recent evidence from the Healthcare Commission highlighted that, while around a quarter of hospital services for children were good or excellent, too many were considered to be in need of a number of improvements (see chart below). Another recent study found that a worryingly high number of factors in child deaths were avoidable, or potentially avoidable.¹¹ And finally, our extensive consultation with parents and young people demonstrated that there are still some health and health-related services that need to be improved.

Overall Healthcare Commission scores for children's hospital services (across 6 services) (HCC, 2007)



1.17 Third, the experiences of parents and their children in using health and related services can be further improved. Against a background of rising expectations of public services, experience remains variable, especially for some of those in greatest need. A series of reviews on disabled children, mental health services and speech and language needs, reported confusion among parents and children about the support they can expect to get. There is more to do to improve the experiences and engagement of fathers in particular, as well as parents and children from more disadvantaged backgrounds. And across the board, parents will generally expect more of the services they use as a result of the increased standards of living they now enjoy and the increased ability to tackle previously common diseases.

⁸ www.talktofrank.com/home_html.aspx.

⁹ www.ruthinking.co.uk

¹⁰ As opposed to the proportion of children who have ever had a drink, which continues to decline.

¹¹ *Why Children Die*, CEMACH, 2008.

1.18 And fourth, while the health of most families and children has improved, health inequalities persist. In England today, social status and place of birth continue to be strongly associated with the health outcomes for children and young people – in terms of life expectancy, a boy born in Manchester is likely to live 10 years less than a boy born in the London areas of Kensington, Chelsea and Westminster.¹² Children in low-income households, those living in single-parent families, children in care, teenage mothers, families where parents have low educational attainment, or families where parents are unemployed, are all more likely than their peers to suffer from emotional health and wellbeing problems.¹³ This remains the case even where there have been significant improvements in some outcomes. For example, although the rate of child deaths from accidents halved from 1981 to 2001, children of parents who have never worked or who are long-term unemployed are 37 times more likely to die as a result of exposure to smoke, fire or flames, than children of parents in higher managerial and professional occupations. There also remains a strong association between dental disease and material and social deprivation.

1.19 Evidence of the effects of multiple disadvantages experienced by young people in contact with the criminal justice system illustrate the need for a co-ordinated response:

- Around half have problems with peer and family relationships.
- Two-thirds come from backgrounds where family structure has broken down.
- One-third have been looked after by the local authority.
- Three-quarters have a history of temporary or permanent school exclusion.
- A third have severe and complex mental health problems.
- A quarter have learning disabilities and 30% have a physical disability.
- Over half have communication, speech, language and literacy problems.

- A high proportion have histories of high levels of smoking and illegal drug misuse, with misuse of alcohol as one of the biggest problems.
- And among these young people, there are high levels of dental health problems, sexually transmitted infections, asthma and blood-borne virus infections such as hepatitis B and C.

Why it is important to focus on children and young people's health

1.20 Good health for children and young people is crucial, because it enables them to make the best of their opportunities in education and in developing healthy lifestyles. It promotes better health and wellbeing in adulthood and an ability to contribute fully to wider society. It will also help to break down the inter-generational cycle of poverty, deprivation and joblessness that affects many in disadvantaged groups and areas.

1.21 There is an ever-increasing evidence base on the factors that influence child development, in particular how the child's early experiences can have life-long consequences. Parents are children's first carers and promoters of their health – the home environment, including parents' own physical and mental health needs and behaviours, has a crucial impact on a child's outcomes. Evidence illustrates the 'conveyor-belt' effect, in which carrying excess weight in childhood can continue through to adulthood and impact upon a wide range of outcomes, including increased risks of coronary heart disease and cancer.

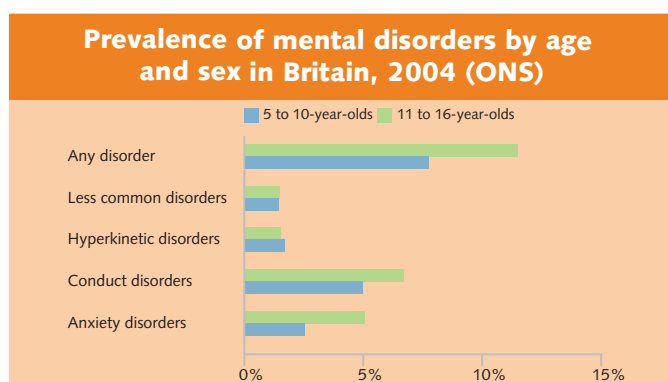
1.22 Mental health and psychological wellbeing are fundamental to broader health and wellbeing. Studies have shown that of those with mental health problems at age 26, half had first met criteria that identifies a psychiatric disorder by 15, and nearly 75% had done so by their late teens. In 2004, around 10% of 10 to 16-year-olds had a diagnosable mental health disorder (see chart opposite) and some have argued that the wider costs of mental health problems in the UK might be as high as £77 billion.¹⁴ Much more is

¹² *2007 Status Report on the Programme for Action*, Department of Health, 2008.

¹³ *Maintaining the momentum: towards excellent services for children and young people's mental health*, NHS Confederation, 2007.

¹⁴ *The Depression Report: A New Deal for Depression and Anxiety Disorders*, The Centre for Economic Performance's Mental Health Policy Group, June 2006.

now known about the factors that can positively impact upon psychological health and wellbeing, and what can be done to help children and young people. Mental health and psychological wellbeing is affected positively and negatively by a child's own make-up; the influence of their parents, carers, families and wider communities; and by their everyday experiences in places such as children's centres, schools and youth services. Unless a person is feeling mentally healthy, it is difficult for them to have optimum physical health and wellbeing.¹⁵



1.23 For children in need of specialist healthcare, getting it right in the early years is especially important. Disabled children, for instance, may require specialist assessment for support services and equipment, which will not only radically improve the quality of their lives but may prevent the onset of wider developmental problems.

1.24 Good health in childhood is also to be valued because of the effects it can have upon other important child and lifetime outcomes. There is a strong relationship between good health in childhood and school attendance and attainment, and these in turn are associated with improved life chances such as employment opportunities and the chance to make a positive contribution to society. Early intervention and preventative services focused on the young have key roles in breaking the inter-generational cycle of health

inequalities. Childhood and adolescent problems can be strong predictors of poor outcomes later in life, and problems left too long without intervention may never be tackled effectively.

1.25 In other words, improving health outcomes in the short-term can have significant short- and long-term benefits for children and young people, for the National Health Service and its partners, and for society more generally.

Improving children and families' health and wellbeing

1.26 Addressing these challenges will help us achieve our objective of making England the best place in the world in which to grow up.¹⁶ Good physical and mental health is a crucial part of that objective, and closely linked to general wellbeing. Broader factors influence children and young people's wellbeing – the five Every Child Matters outcomes (be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic wellbeing) reflect that, and have provided a framework for the Government's far-ranging programme that includes action on child poverty, positive activity and play, educational attainment and staying safe.

1.27 This strategy is specifically concerned with action to promote health – providing opportunities for improved physical and mental health and providing high quality services when needed. Recognising the interdependence of outcomes, such as between health and wellbeing and the ability to learn and achieve, it will draw on some of the wider actions and recognise some of the wider determinants of good physical and mental health, including the impact of the environment – the home, the local neighbourhood, the schools and other community settings.¹⁷

1.28 The risk factors associated with different vulnerable groups – such as children in care, those at risk of abuse, asylum-seeking children,

¹⁵ *Children and young people in mind: the final report of the National CAMHS Review*, 2008.

¹⁶ *The Children's Plan*, Department for Children, Schools and Families, 2007.

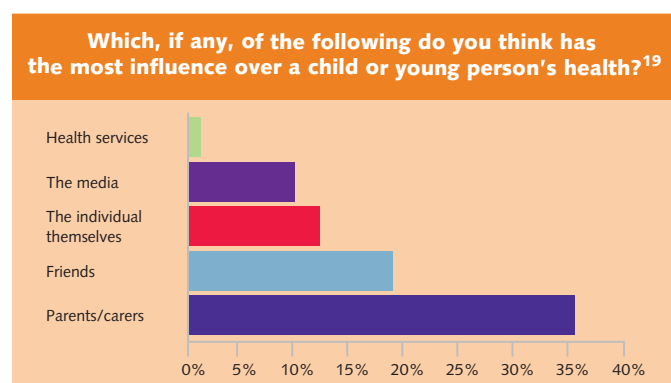
¹⁷ *Children and young people's views on health and health services*, National Children's Bureau, 2005.

or young carers – will vary, but the imperative to provide the right targeted support to secure their health and wellbeing will not.

A partnership between services, children and parents

1.29 These improvements need to be achieved through an agreement between health practitioners and services and parents, children and young people. The principles that underlie this agreement flow through the policy recommendations that are set out in subsequent chapters.

1.30 The family's side of this agreement relates to the primary responsibility that mothers and fathers have in promoting their children's health. It is parents that bring up children, not governments, nor indeed health services.¹⁸ And as young people grow up, they will take on increasing responsibility for their own health and wellbeing. This reflects the views of children and their parents about their relative influences upon children and young people's health (see chart below).



1.31 For its part, the Government will create the right framework to enable those delivering services locally to work together in support of children and families, so that:

- Mothers and fathers are provided with the information they need to help their children live healthy lives, including through local areas setting out what parents will be able to receive in their areas.
- Public sector settings provide healthy environments and encourage children and young people to make healthy choices.
- The right services are in place to meet the specific health needs and expectations of children and their families.
- Extra support is provided for those from the most disadvantaged backgrounds.

What success will look like

1.32 Children and young people will see improvements against each of the above challenges through:

- **World-class health outcomes** – including significant reductions in the rates of childhood obesity,²⁰ improvements in childhood mental health and wellbeing, and progress in those services where international comparisons and domestic trends show room for improvement. These outcomes will bring the health and wellbeing of children and young people up to the standards experienced by those in the highest-performing countries in the world.
- **Services of the highest quality** – through better and more integrated commissioning and planning of health and related services, delivered by well-trained professionals. This will lead to higher-quality care for parents and their children through universal services like schools, GP practices and Sure Start Children's Centres, as well as high quality care for children and young people who are ill, or who need ongoing specialist healthcare and support.

¹⁸ *The Children's Plan*, Department for Children, Schools and Families, 2007.

¹⁹ Joint Department of Health and Department for Children, Schools and Families deliberative event, Leeds, June 2008.

²⁰ In particular through implementation of *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England*, HM Government, 2008. The initial focus of this strategy has been on children: by 2020, we aim to reduce the proportion of overweight and obese children to 2000 levels.

- **Excellent experiences of services for children, mothers and fathers** – through more convenient health support and advice tailored to the needs and expectations of children, young people and parents, rather than those of service providers. This will help meet the increasing expectations of parents and children.
- **Reducing health inequalities** – through identifying and expanding services to those children, young people and families who are in need and from disadvantaged groups and areas. This will help improve health outcomes for these groups through better access to services and more effective outreach. The Government will monitor health inequalities and service use through a range of measures, including infant mortality rates.

Healthy lives, brighter futures: how this document is structured

1.33 The next chapter sets out the cross-government framework for taking forward these improvements. Chapters 3 to 5 set out the existing commitments and proposed improvements for children and young people's health and wellbeing at particular life stages: during pregnancy and the first years of life; for school-age children; and for young people. Chapter 6 looks at support for children and young people in the event of acute illness and support for those with additional health needs.

1.34 Together, Chapters 3 to 6 set out the vision for improved services and support for children and parents. Chapter 7 sets out plans to support local action through improvements to governance, planning, commissioning, workforce and use of information. Chapter 8 discusses next steps following the publication of this strategy.





BUILDING ON PROGRESS: THE FRAMEWORK FOR CHILD HEALTH



- 2.1** Improving children and young people's outcomes, health services and experiences in using services and, in addition, reducing inequalities will be challenging. However, there is a strong policy framework on which to build, developed with input from parents, children and young people and stakeholders, and many examples of good local practice.
- 2.2** *The National Service Framework for Children, Young People and Maternity Services*, published in 2004, is a 10-year programme that was developed with extensive engagement from healthcare practitioners, parents, children and young people. It put in place national standards for the first time for children's health and social care and remains the most comprehensive policy guidance that underpins focused improvements in children and young people's health and wellbeing. A full list of the National Service Framework (NSF) standards is set out in Annex A.
- 2.3** The standards relate to the quality of universal services; to children and young people with particular health needs; and to the needs of parents and babies from pregnancy through to the first three months of parenthood. Alongside the NSF, the Child Health Promotion Programme was introduced, designed to promote health and wellbeing from pre-conception to adulthood, integrating pre-school and school-age health promotion and assessment, including screening and immunisation.
- 2.4** The NSF has been a crucial part of the Every Child Matters programme, which set the Government's aims for every child, whatever their background or their circumstances, to have the support they need to:
- be healthy
 - stay safe
 - enjoy and achieve
 - make a positive contribution
 - achieve economic wellbeing.
- A particular focus of the Every Child Matters programme has been to encourage integrated design and delivery of services around the needs of children, young people and families (see Chapter 7), in order to help organisations to work together to deliver improved outcomes for children. This strategy takes the Every Child Matters aims and objectives as its starting point, in particular by encouraging more integrated support for children to be healthy.
- 2.5** The NSF and Every Child Matters are complemented by the objectives and targets that the Government has set itself for improving children and young people's health nationally and locally (see Annex B for full details). The Government's overarching, three-year Public Service Agreements (PSAs) include targets to reduce child poverty (PSA 9), improve the health and wellbeing of children and young people (PSA 12), improve child safety (PSA 13), increase the number of children and young people on the path to success (PSA 14), provide better health and better care for all, including tackling health inequalities (PSAs 18 and 19), and deliver a sustainable Olympic legacy with more children and young people participating in physical education and sport (PSA 22).
- 2.6** Several of these ambitions are being addressed through other strategies, such as the *Staying Safe Action Plan*, the *Youth Alcohol Action Plan*, the *Teenage Pregnancy Strategy* and the *Youth Crime Action Plan*. Towards the end of 2008, the Government also published the *2020 Children and Young People's Workforce Strategy*, a review of the delivery of sex and relationship education in schools and its responses to the independent reviews of CAMHS (Child and Adolescent Mental Health Services) and SLCN (Speech, Language and Communication Needs).²¹ Existing strategies include action on childhood obesity and excess weight and action on health inequalities.

²¹ *Staying Safe Action Plan*, DCSF, February 2008; *Youth Alcohol Action Plan*, DCSF, June 2008; *Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies*, Department for Education and Skills, 2006 and *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts*, DCSF, July 2007; *Youth Crime Action Plan*, Home Office, July 2008; *2020 Children and Young People's Workforce Strategy*, DCSF, December 2008; *Review of Sex and Relationship Education (SRE) in Schools: A Report by the External Steering Group*, DCSF, October 2008; *Children and young people in mind: the final report of the National CAMHS Review*, 2008; *Better Communication: An Action Plan to Improve Services for Children and Young People with Speech, Language and Communication Needs*, DCSF, December 2008, www.dcsf.gov.uk/slcnaaction/

- 2.7** Childhood obesity is particularly harmful because of the number of children concerned, and the fact that it not only limits a child's ability to enjoy a full and active life, but also increases the risks of diabetes, cancer, and heart and liver disease in later life. The *Healthy Weight, Healthy Lives* strategy builds on other initiatives such as the government-led 5 A DAY fruit and vegetable campaign, and sets out the ambition for the UK to be the first major nation to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight.²²
- 2.8** While these strategies and reviews relate to specific policy areas, both the Department of Health and the Department for Children, Schools and Families have also recently established ambitious, long-term plans for health and for children, young people and their families. These were set out through the *NHS Next Stage Review*,²³ *The Children's Plan* and *The Children's Plan One Year On*²⁴ and reflect the Government's overarching ambition for world-class public services – empowered citizens fostering professionalism in the workforce and strategic leadership by government.²⁵
- 2.9** The final report of the *NHS Next Stage Review*, published in July 2008, set out a vision for a 21st-century NHS with wide-ranging proposals that place quality of care at the heart of everything the NHS does, empowering the public and staff to secure the effective, personalised care that we all expect. Its ambitions are for an NHS that:
- helps people to stay healthy
 - gives patients more rights and control over their own health and care
 - gives patients even greater influence over the services they use
 - is pioneering, embracing the best new ideas and treatments
 - values its staff and empowers them to lead local change.
- 2.10** As part of the Review, the 10 NHS strategic health authorities (SHAs) were asked to develop their own regional visions for the NHS, engaging with thousands of staff and stakeholders to do so. In each region, clinical working groups looked at how best to provide services for their local populations. This included groups looking at maternity and services for the newborn, and at the needs of children. The SHAs published their regional visions in early summer 2008. The final report of the Review and supporting strategies set out the Government's response in the form of a document that is designed to support local action to make these ambitions a reality.²⁶ This strategy shows what impact the *NHS Next Stage Review* vision will have for children, young people and their families and reflects the four key principles for the NHS through which the Review is being taken forward: subsidiarity, local leadership/devolution, clinical leadership and systems alignment.
- 2.11** *The Children's Plan* aims to make England the best place in the world for children and young people to grow up. It provides five guiding principles which underpin the chapters that follow:
- Government does not bring up children, parents do – so government needs to do more to back parents and families.
 - All children have the potential to succeed and should go as far as their talents can take them.
 - Children and young people should enjoy their childhood as well as growing up prepared for adult life.
 - Services should be shaped by and responsive to children, young people and families, not designed around professional boundaries.
 - It is always better to prevent failure than tackle a crisis later.

²²*Healthy Weight, Healthy Lives: A Cross-Government Strategy for England*, HM Government, 2008.

²³*High Quality Care for All: NHS Next Stage Review*, NHS/Department of Health, 2008.

²⁴*The Children's Plan*, Department for Children Schools and Families, 2007 and *The Children's Plan One Year On*, Department for Children, Schools and Families, 2008.

²⁵*Excellence and Fairness: Achieving world class public services*, Cabinet Office, 2008.

²⁶www.ournhs.nhs.uk

- 2.12** Through, in particular, its proposals on how to better support mothers and fathers in fulfilling their responsibilities, and through its support for even greater integration of health and children's services, this strategy supports the vision and principles of *The Children's Plan*.
- 2.13** This strategy builds on *The Children's Plan* and the *NHS Next Stage Review*, in particular in setting out how we will improve health and health services for children, young people and their parents up to 2020. This will help us to achieve our four overarching objectives, namely to achieve world-class health outcomes, services of the highest quality and excellent experiences when using services, and to minimise health inequalities.



**PREGNANCY AND THE
EARLY YEARS OF LIFE
(UP TO 5 YEARS)**

3.1 During pregnancy and the early years of their children's lives, parents have access to a wide range of services in support of their children's health, from midwives to childcare practitioners. But the extensive consultations with parents, children and young people undertaken to develop this strategy have demonstrated that we can do more to provide further support for parents and their children at this time.

3.2 One of the key principles underpinning this strategy is to ensure that parents get the information they need to support their children's health (see Chapter 7). Local areas will be expected to set out what children and families can expect from their health services locally – to help them to access the support they need, when they need it in pregnancy and the early years.

3.3 This chapter sets out what services have been put in place to support mothers, fathers and their young children. It also sets out the additional improvements that will be made to antenatal and early years services. In doing so, the focus will be upon ensuring that the right services, support and advice are available for all parents, and that more intensive support is given to the most vulnerable. These policies include:

- Further development of the health visitor workforce to deliver the Healthy Child Programme.
- The development of a new Antenatal and Preparation for Parenthood Programme which, following successful testing, will help engage all parents, including those from more disadvantaged backgrounds.
- The expansion of the highly successful Family Nurse Partnership, which provides intensive support from highly trained nurses for the most vulnerable young first-time mothers. It will be expanded from 30 to 70 sites by 2011, with a view to rolling out this support across England over the next decade.
- A strengthened role for Sure Start Children's Centres – both through additional health-based

programmes, focusing on reducing obesity and smoking, and by ensuring that each centre has access to a named health visitor.

Services for parents, babies and young children up to 5 years old

3.4 A wide range of guidance and care is available for parents, babies and young children from before pregnancy through to the age of 5, provided by a number of different professionals. A summary of this support is set out in the table overleaf.

3.5 The Government has published separately a framework for maternity services. The framework document, *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service*, published in April 2007, set out the delivery framework for providing safe, high quality maternity care for all women. England is one of the safest countries in which to give birth, but women's views of the quality of services and their experiences is variable.

3.6 *Maternity Matters* introduces a new national choice guarantee for women, making it easier for them to access maternity services. This means that by the end of 2009 all women will have choice over the type of antenatal care they receive, where and how they have their baby and where they access postnatal care.

3.7 We are working closely with PCTs to ensure that additional staff are in place to meet local needs. In February 2008, we announced measures to recruit an additional 1,000 midwives by 2009, rising to around 4,000 by 2012, which is contingent on rising births. Additional measures and improvements are set out in regional visions for maternity and newborn services developed in each strategic health authority area as part of the *NHS Next Stage Review*, and will be supported by further national work, including that of the National Neonatal Taskforce (formed in February 2008). This strategy complements, but does not seek to replace, *Maternity Matters*.

Proactive support	Full assessment of needs and risks by 12 weeks of pregnancy. Advice during pregnancy on, for example, nutrition, smoking, alcohol and breastfeeding	Mothers and fathers have the chance to discuss becoming a parent, and to discuss what they can expect from local services	Face-to-face support with caring for a new baby and adjusting to life as a new parent
Protection	Support with breastfeeding. A series of five immunisation appointments between 2 months and 13 months of age to protect against infectious diseases, and screening		
Reviews	A child health record (the 'Red Book') setting out the local services available and to record a child's health and development	A series of scheduled health and developmental reviews to check that babies/children are healthy and parents are being supported	
Access to additional support	Access to support through websites and phone lines (for example, NHS Direct, NHS Choices – including a new Pregnancy Care Planner)	Access to additional elements of the Healthy Child Programme through Children's Centres, health clinics and GP practices	Access to 12½ hours for free early learning education for 3- to 4-year-olds, 38 weeks a year

3.8 The core programme that oversees the health and development of children and supports parents to protect and promote their child's health is the Healthy Child Programme.²⁷ The programme has been built on evidence gathered by experts over many years, and includes screening, health and development reviews, immunisations, health promotion and parenting support which every family is entitled to. This programme is offered in local GP surgeries, clinics or Sure Start Children's Centres, or – where appropriate – at home, and should engage both mothers and fathers. The Healthy Child Programme will help parents understand the full range of services provided through the programme as set out in Annex D.

3.9 During pregnancy, for example, the Healthy Child Programme gives mothers and fathers the opportunity to prepare for becoming a parent, and discuss what services they can call on if required. Parents also receive a personal child health record (the 'Red Book'), which provides a record of child development, growth, immunisations and the results of screening tests. And at around 12 weeks of pregnancy, as part of the maternity assessment, all mothers-to-be are offered a review

of their health and social needs by a maternity health professional. Following the birth of their child, mothers and fathers can expect to receive a schedule of reviews, screening tests, physical examinations, developmental checks and immunisations for their child, as well as information and guidance, and support with breastfeeding. Key stages are the new baby review, the 6-8-week review, immunisation contacts, a review by one year and the 2- to 2½-year-old reviews. All of these provide valuable opportunities to engage with parents' concerns and aspirations for their child.

3.10 Contact between services and families through the Healthy Child Programme also offers opportunities to distribute additional information which signposts other sources of advice, such as the *Parent's Guide to Money*, a resource guide designed to help expectant parents plan their family finances.²⁸

3.11 For parents of disabled children who may need much more frequent contact with a range of health services and professionals, the Early Support Programme is leading to improvements in the information provided and better co-ordination and sharing of information between services.

²⁷ Following the publication of this strategy, the Child Health Promotion Programme will be renamed the Healthy Child Programme. Our discussions with parents highlighted the need to use language that is more meaningful to them. While the Child Health Promotion Programme is widely used by professionals, the Healthy Child Programme will help parents understand the content of the programme, and will make it easier for local areas to communicate. The aim is to encourage parents to ask for and use those services that will promote their children's health and wellbeing in the early years.

²⁸ Information on the *Parent's Guide to Money* is available at www.fsa.gov.uk

3.12 Underpinning the Healthy Child Programme are those services provided through GP practices and acute settings, particularly if a child becomes ill. The GP or paediatrician will more often than not be the first port of call when a parent has a health concern about their child, and other healthcare practitioners will refer children on to GPs or paediatricians should a health problem arise.

3.13 Over the past decade, there has been a great expansion in access to childcare and early education. Every 3- to 4-year-old is now entitled to 12½ hours of free early years education each week for 38 weeks a year, and the Government has committed to extending this entitlement to 15 hours per week by 2010. The *New Opportunities White Paper* announced the extension of that entitlement to disadvantaged 2-year-olds in all local authorities as a first step in creating an entitlement for all 2-year-olds. The Government set out its future plans for improving the sufficiency, quality, accessibility and affordability of childcare in its January 2009 document *Next Steps for Early Learning and Childcare*.

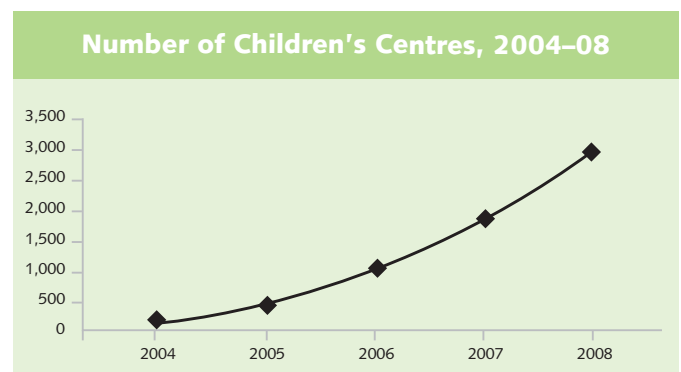
3.14 Evidence shows that high quality pre-school experience can have positive effects on children's social, emotional and cognitive development, so the Government has combined the expansion of early learning and childcare with a focus on improving the quality of provision. In order to ensure that early years provision is of consistently high quality, an Early Years Foundation Stage has been introduced, providing a single framework for early learning and childcare. It reflects what good parents and carers do with their children – and is based firmly around a philosophy of play-based learning which supports all aspects of children's development. It sets out the level of cognitive, social, physical and personal development that most children reach by the age of 5.

3.15 The focus on quality and expansion of services through the Healthy Child Programme and early

learning opportunities has been supported by the provision of increasingly integrated services. Of particular importance has been the development of a new universal service in the form of Sure Start Children's Centres, which help to link services provided for mothers, fathers and their children from the antenatal period through to when a child starts primary school (see case study overleaf).

3.16 Sure Start Children's Centres help to deliver the Healthy Child Programme, but they will also help parents to access high quality early years learning and childcare services. For example, they may offer parent and toddler groups which allow mothers and fathers to learn from each other as well as from professionals. Sure Start Children's Centres thereby help to provide all parents with a source of easily accessible advice about how they can effectively support their child's early learning, development and mental health. In doing so, they can help with the early identification of children with specific developmental difficulties, so that they can receive extra support as soon as possible.

3.17 Each centre will tailor the services it provides to the needs of the communities it serves as well as individual parents. By 2010, the Government has pledged to have in place a Sure Start Children's Centre for every community – at least 3,500 – and is already well on the way to achieving that target with almost 3,000 already in place (see chart below).



CASE STUDY: Everton Early Childhood Centre

The Everton Early Childhood Centre incorporates a maintained nursery school and a range of social services day nurseries. The centre is part of a network of 19 local schools, which includes 13 primary schools and offers provision for up to 188 children aged 0 to 5 and their families, from 8am to 6pm, five days a week, 50 weeks a year. The centre's site hosts teams from the Alder Hey Children's Hospital, local child and adolescent mental health services (CAMHS) and the local primary care trust (PCT). For centre users, easy access to an ophthalmologist, paediatrician and clinical psychologist is a major benefit. The centre also operates a community parents programme, where local parents volunteer to give their peers information and support in areas such as postnatal depression, healthy eating and behavioural problems.

- 3.18** Sure Start Children's Centres have a particular focus on improving support to families who have been less inclined to access traditional services which may not have met their individual needs. This is part of a broader approach to engaging children and parents from more disadvantaged backgrounds, including through health visitors, outreach workers and policy which focuses on the needs of the whole family, rather than individuals in isolation.²⁹ *The Children's Plan*, for example, set out a commitment to provide for an additional two outreach posts for Sure Start Children's Centres serving the most disadvantaged communities.
- 3.19** The Government has also addressed more specific concerns relating to inequalities between different groups in terms of infant mortality and the first years of life. The *Implementation Plan for Reducing Health Inequalities in Infant Mortality* identified a range of measures to reduce the differences between groups with regard to infant mortality rates, with a particular focus on those local authorities facing the biggest challenges.³⁰ These included a focus on reducing teenage conceptions (including repeat conceptions), housing overcrowding, smoking in pregnancy particularly among pregnant teenagers, and child poverty. The *Implementation Plan* also addresses issues relating to black and minority ethnic groups living in areas of disadvantage, some of whom suffer infant mortality rates that are almost twice as high as the national average. In November 2008 the Department of Health asked Professor Sir Michael Marmot to lead a review, drawing on the excellent evidence of the WHO's social determinants of health commission, based on the best global evidence on how we can do more to tackle health inequality in this country.
- 3.20** Road accidents are a leading cause of death and a significant cause of hospital admissions in the 0 to 17 age group. Casualties are disproportionately drawn from children and young people from disadvantaged backgrounds – a child in the lowest socio-economic group is five times more likely to die in a pedestrian accident than a child in the highest socio-economic group. In 2000, the Government put in place a new road safety strategy, setting a target of a 50% reduction in the number of children and young people killed or seriously injured by 2010. This target was met well ahead of time.
- 3.21** Unintentional injuries remain a major safety risk for children in the UK, particularly for children under 5. To reduce accidents in the home, *The Children's Plan* announced £18 million over the three years 2008-11 to fund home safety equipment such as stair gates for disadvantaged families. The *Staying Safe Action Plan* also committed to issuing guidance for frontline practitioners on common risks in the home

²⁹ *Reaching Out: Think Families*, Cabinet Office (Social Exclusion Task Force), 2007.

³⁰ *Implementation Plan for Reducing Health Inequalities in Infant Mortality*, Department of Health, 2007.

and the most effective forms of intervention to prevent accidents and injuries, and to the launch of a major new communications campaign on children's safety. It also outlined the key commitments the Government will be taking forward over the three years 2008-09 to 2010-11 to improve young people's safety.³¹ The *Staying Safe Action Plan* also committed the Government to carry out a Priority Review of local area accident prevention and to make recommendations. The report of the Priority Review has just been published.³²

3.22 Inequalities remain in relation to children's oral health.³³ Sure Start Children's Centres, along with wider health services' contact with parents, provide opportunities for oral health promotion, and the Brushing for Life scheme provides free packs with toothbrushes, toothpaste and advice on brushing. Parents have the primary role in helping their children observe good oral hygiene but evidence also suggests that fluoridating water is an effective step to take in reducing inequalities in oral health,³⁴ increasing the number of children without tooth decay in a given area by 15%. The Government has therefore changed the law to enable the implementation of water fluoridation schemes in high-need areas if local communities agree.

3.23 One of the most important developments for vulnerable families has been the piloting of the Family Nurse Partnership programme. This is an evidence-based home-visiting programme conducted by specially trained nurses and targeted at some of the most vulnerable teenage mothers and their families. The nurses build close, supportive relationships with families and guide young first-time parents so that they adopt healthier lifestyles for themselves and their babies, provide good care for their babies and plan their future life goals. The Family Nurse Partnership has been tested in 10 sites across England since 2007 with an extra 20 sites starting in 2008-09.

3.24 The programme's goals are to improve antenatal health, child health and development, and

CASE STUDY: Family Nurse Partnership

In County Durham and Darlington, those testing the Family Nurse Partnership programme are already seeing the positive effects locally, finding that there was an 'increase in confidence of young parents on the programme from dads and partners participating, and a willingness from young parents to learn about the development of their child and health-related issues'. The programme manager, Jan Finn, believes that the work taking place is crucial to preventing social exclusion: "These are the vital first years and we have to help these young people get it right."

economic self-sufficiency. In the USA, where the programme was developed, it has been proven to have lasting health and wider impacts, such as reductions in children's injuries and in adolescent anti-social behaviour, fewer subsequent pregnancies and improvements in prenatal health. Though too early to demonstrate the longer-term impact in this country, the first-year evaluation of the programme looks promising.³⁵ Because it is targeted at the most vulnerable families, the Family Nurse Partnership model is helping to achieve the goal of reducing inequalities between groups.

3.25 As well as the testing of the Family Nurse Partnership, there are a range of existing measures in place to support improved outcomes for teenage parents. These should reduce the chances that their own children will in turn become teenage parents, as their children will be less likely to experience some of the factors that are known to be associated with teenage pregnancy.³⁶ The measures are crucial in supporting the wider efforts to narrow inequalities and tackle child poverty.

³¹ *Staying Safe Action Plan*, Department for Children, Schools and Families, February 2008.

³² *The Priority Review of Accident Prevention Amongst Children and Young People*, Department for Children, Schools and Families, Department of Health, and Department for Transport, 2008. www.everychildmatters.gov.uk/socialcare/safeguarding/stayingsafe/accidents/

³³ *Choosing Better Oral Health: An Oral Health Plan for England*, Department of Health, 2005.

³⁴ *A Systematic Review of Public Health Water Fluoridation*, NHS Centre for Review and Dissemination, 2000.

³⁵ *Family Nurse Partnership: First Year Pilot Sites Implementation in England*, Department for Children, Schools and Families Research Report, 2008.

³⁶ *Teenage Parents Next Steps*, Department of Health/Department for Children, Schools and Families, 2007.

Further improvements for mothers, fathers, babies and young children

3.26 Though significant progress has been made in improving services for babies, young children and their parents, more can be done to achieve the aims of world-class health outcomes, excellent experiences for children and their parents, services of the highest quality, and a reduction in health inequalities:

- (i) Enhancing the visibility, impact and workforce support for the Healthy Child Programme
- (ii) Further improving antenatal and postnatal support, including for fathers
- (iii) Strengthening the role of Sure Start Children's Centres in promoting child health
- (iv) Expanding the Family Nurse Partnership model and extending early intervention for vulnerable parents

(i) Enhancing the visibility, impact and workforce support for the Healthy Child Programme

3.27 We know that parents have a good level of knowledge about specific parts of the Healthy Child Programme – such as the personal child health record (Red Book) and the role played by midwives and health visitors – but do not have the same level of awareness about all the support on offer or how to access it locally. Chapter 7 therefore sets out a pledge to ensure that organisations providing services that promote children and young people's health provide accessible, comprehensive information about these services to children and families in all local areas. In the early years this will cover the information currently provided through NHS Choices and the Pregnancy Care Planner.

3.28 To further support consistency and quality, guidance on the national standard contract for community services includes a service specification for the Healthy Child Programme.³⁷ National

standard contracts provide the key accountability mechanisms between commissioners and providers of NHS services by defining expectations, quality measures where available, responsibilities and local freedoms in improving the quality of care and access to care. The national Transforming Services Programme is co-producing transformational guides and a quality framework for community services. Services for children, young people and families are a priority group in this work. This will ensure ongoing monitoring of the quality of the Healthy Child Programme.

3.29 To complement this work, **we will commission with local areas a review to assess the commissioning and delivery of the Healthy Child Programme.**

3.30 The Healthy Child Programme is led by health visitors and delivered by health visitors and other frontline practitioners, working with parents and their children. We expect to see a growing number of health visitors taking this forward, and will work with the profession to promote recruitment and ensure strong professional support for this important role.

3.31 Health visitors and all involved in delivering the Healthy Child Programme will benefit from more targeted training. **An e-learning programme will be developed for frontline health professionals to ensure they have the skills and knowledge they need to deliver the Healthy Child Programme.** This programme will include modules on attachment and neurological development, speech and language development, the promotion of healthy weight, and relationship support, recognising that the birth of a child is a period during which relationships are at greatest risk. This will help practitioners increase their knowledge and skills with respect to the psychological wellbeing of families.

³⁷ *Community NHS Contract Integrated Guidance*, Department of Health, December 2008.

CASE STUDY: Integrated health services – Rochdale Children's Centres

Since the beginning of Sure Start local programmes, Rochdale Children's Centres have benefited from strong working partnerships with both the PCT and the acute trust. This has led to reshaping of mainstream services making them more accessible and responsive to community need. One example is that, out of 11 antenatal clinics in the borough, nine are based within Children's Centres. Midwives have reported a positive impact on their workload as there are so many other professionals and services available on site that are supporting families. The number of fathers attending antenatal and parent craft sessions has increased dramatically, helped by the parent empowerment worker who attends and encourages dads to be involved. A GP works once a week from one of the centres which complements the baby clinic that takes place on this site. More recently, childhood immunisation for all infants has taken place in the centre as well as check-ups for 2-year-olds, alongside the antenatal clinic, baby massage and weaning sessions. So families don't have to go far to find all they need under one roof.

(ii) Further improving antenatal and postnatal support, including for fathers

3.32 One of the most important ways of improving young children's outcomes and users' experiences is through the better engagement of fathers. There is strong evidence that early involvement of fathers has significant benefits for children's social, emotional and intellectual development and wellbeing.³⁸ But despite the immensely important role that fathers play, it is too often overlooked, particularly during pregnancy and the early years. Our ambition is to ensure that fathers, as well as mothers, are fully engaged in the range of services supporting healthy child development. This is particularly important in the early years, and we will focus on improvement in fathers' involvement in maternity services, antenatal support, parenting groups and the scheduled reviews of the Healthy Child Programme. In November 2008 we published research on fathers' engagement with a range of public services, including those relating to children and young people's health. This showed that fathers were often the invisible parent, not actively contacted or engaged by services.³⁹ In addition we will consider the specific needs of fathers as

we develop the range of proposals set out in this strategy, working closely with stakeholders over the coming months.

3.33 One area in which services have proved to be successful in engaging fathers has been in Sure Start Children's Centres. Independent evaluations show that fathers believe that Sure Start Children's Centres are an important source of support in raising their children, particularly in the case of lone parents.⁴⁰ But they also suggest that there are fewer opportunities for fathers to engage than mothers. The Department for Children, Schools and Families will therefore work with Together for Children – which supports the Department on the delivery of Sure Start Children's Centres – to **provide practical support that will further help Sure Start Children's Centres to support fathers**. We will also **use the current review of outreach workers in Sure Start Children's Centres to consider what further support can be given to fathers, particularly those from the most vulnerable groups**.

3.34 The research undertaken to inform this strategy has demonstrated the importance of engaging fathers in other areas too. For example, in many parts of England, maternity services are

³⁸ *Fathering and Child Outcomes*, Flouri, E., 2005; The development of father-infant relationships, Parke et al., in *The Role of the Father in Child Development* (4th edition), Lamb, M.E. (ed.), 2004.

³⁹ *A review of How Fathers can be better recognised and supported through DCSF policy*, DCSF Nov 2008 (DCSF reference DCSF-RR040 (full report), and DCSF-RB040 (research summary)).

⁴⁰ *How well are they doing? The impact of children's centres and extended schools*, Ofsted, 2008.

implementing new ways of engaging fathers and providing training for midwives to help support this. Others are finding ways to allow fathers to stay in hospitals when their partners are in labour wards. The Government has recently updated best practice guidance to state that maternity units should have overnight facilities for partners of women in labour provided within or near the unit, and that mothers and fathers should expect to be involved in the planning process for any new maternity facilities.⁴¹ **Further work will be undertaken with SHAs to identify best practice in this area. In addition, we will work to ensure that families are aware of the arrangements for fathers staying with their partners when they are in labour, to help inform the choices they make over their maternity care.**

3.35 Following the birth of a child, all parents need source of easily accessible advice about how they can effectively support their child's early learning and development. Sure Start Children's Centres can provide this support, tailored to parents' and communities' needs. Before a child is born, education and support can be just as important in helping to engage parents at a time when mothers and fathers are especially keen to learn and make changes to their lifestyles. The consultations with parents and practitioners have, however, demonstrated that more can be done to improve the quality and consistency of these services. This is particularly true for the most vulnerable parents, such as teenage mothers and young fathers, who often feel excluded from antenatal education.⁴²

3.36 **The Government will therefore work with practitioners and service users and will draw on the latest evidence to develop a new Antenatal Education and Preparation for Parenthood Programme. This will be tested in a variety of settings where parents access health services, such as GP practices and Sure Start Children's Centres, to determine its suitability to become**

more widely available. It will seek to improve access to high quality antenatal education and support to help prepare parents for parenthood from early pregnancy onwards using a model of progressive universalism. In addition, we have produced a new booklet called *Baby's Here*, which will provide information for new fathers as well as mothers on areas such as what to expect when a baby is born, and where to go for further information and advice. A copy is being provided to all new parents through Bounty Packs between October 2008 and March 2009.

3.37 **To improve postnatal support, we will work with identified PCTs to pilot new methods of engaging mothers and fathers in the delivery of the Healthy Child Programme, in particular to ensure that fathers are involved in the reviews which are at the heart of the programme.** The pilots will be informed by the highly personalised principles upon which the Family Nurse Partnership programme is based. These have proved particularly successful at improving engagement of relatively disadvantaged parents. **We will also further develop and produce guidance on children's 2- to 2½-year review within the Healthy Child Programme.**

3.38 These new services will help to provide greater engagement of parents, building on what we know works in related fields. At the same time, the Government has been trialling ways of embracing new technologies to support parents in bringing up their children. In particular, we have tested the NHS Early Years LifeCheck⁴³ as a web-based tool to support parents and carers with babies who are 5 to 8 months old by giving them easy-to-understand information and advice in areas such as playing and learning, protection against disease, sleeping and feeding. It works by asking parents and carers a number of questions, and enabling them to choose which areas they would like to know more about, and where to go for additional help or advice.

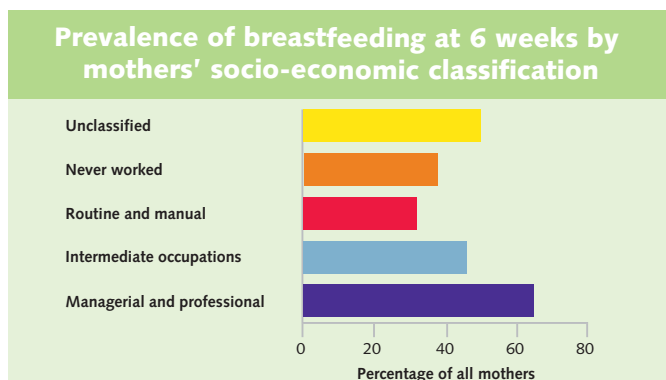
⁴¹ *Children, Young People and Maternity Services: Health Building Note 09-02: Maternity Care Facilities*, Department of Health, 2008.

⁴² Research conducted by Birkbeck College; consultations carried out with parents to inform the development of this strategy.

⁴³ www.nhs.uk/lifecheck

3.39 Following these successful trials, we have started to roll out the NHS Early Years LifeCheck in the Spearhead and Communities for Health areas.⁴⁴ National roll-out will commence in 2009. In addition we will develop a Fathers' Early Years LifeCheck, which will provide fathers with tailored information on their baby's health and development.

3.40 We also need to do more to improve outcomes and experiences in some specific areas such as breastfeeding. The reasons for focusing on breastfeeding are clear: babies who are not breastfed are five times more likely to be admitted to hospital with gastroenteritis and they are more at risk of becoming overweight or obese in later childhood.⁴⁵ Increasing breastfeeding can help to reduce inequalities in health outcomes, as relatively disadvantaged groups tend to breastfeed less. Teenage mothers, mothers from lower socio-economic groups and mothers with lower educational levels are least likely to initiate, and find it harder to sustain, breastfeeding (see chart below on prevalence of breastfeeding at 6 weeks by socio-economic group).



3.41 In 2005, 78% of mothers began breastfeeding but six weeks later only 64% of those mothers who had started breastfeeding were still doing so. Given the significant long-term health benefits, including reduced rates of obesity in later life, we would like to see levels of breastfeeding prevalence at 6 to 8 weeks as high as possible by 2011 (see Annex B for full list of Public Service

Agreement indicators).⁴⁶ The new Antenatal Education and Preparation of Parenthood programme will support this ambition, but we also need to do more to have a more immediate impact across all child health settings.

3.42 Evidence shows that the proportion of babies that are breastfed at birth rise significantly in settings that have adopted the principles of the UNICEF Baby Friendly Initiative. The Baby Friendly Initiative provides support for healthcare facilities that are seeking to implement best practice, and offers an assessment and accreditation process that recognises those that have achieved the required standard.

3.43 We would like to see all relevant hospitals and community settings adopt the principles of the UNICEF Baby Friendly Initiative. We are therefore investing £4 million during the year 2008-09 to promote the Baby Friendly Initiative in areas with the lowest numbers and rates of breastfeeding and to encourage breastfeeding more generally. We will also provide a strengthened focus on breastfeeding through Sure Start Children's Centres and primary care. This will include training for frontline staff to promote and support breastfeeding; the establishment of peer support groups; and the provision of easily accessible and timely advice to mothers, both through the National Breastfeeding Helpline and the breastfeeding DVD *From bump to breastfeeding*. By summer 2009, we also aim to provide Commissioning Guidance to assist PCTs in providing coherent services that will promote breastfeeding and reduce health inequalities.

3.44 Parents need the right information at the right time to promote the healthy development of their children. One of the ways in which parents are able to find out more and record their child's early development is through the personal child health record (PCHR) or 'Red Book'. This provides a record of child development, growth, immunisations and the results of screening tests. In the deliberative events held to inform

⁴⁴ The Communities for Health programme was announced in the *Choosing Health* White Paper and consists of 83 of the most deprived local authority areas in England.

⁴⁵ *Infant Feeding Survey*, Scientific Advisory Committee on Nutrition, 2005.

⁴⁶ *PSA Delivery Agreement 12: Improve the health and wellbeing of children and young people*, HM Treasury, 2007.

the development of this strategy, parents told us that they really valued the 'Red Book'. They also said that they would like easier access to information that would support them in the healthy development of their children. These findings support earlier work conducted as part of *The Children's Plan*, including a proposal by one of *The Children's Plan* expert groups to build on the success of the PCHR by making sure it gives parents more of the information they want.⁴⁷

3.45 We will work with the Personal Child Health Record (PCHR) National Working Group to develop the 'Red Book' so that it reflects the Healthy Child Programme and the Early Years Foundation Stage as well as signposting parents to information sources such as Birth to Five⁴⁸ and children's services, to support parents as the child moves into early years services.

(iii) Strengthening the role of Sure Start Children's Centres in promoting child health

3.46 The development of a new universal service in the form of Sure Start Children's Centres offers new opportunities for integrating services around the needs of parents and children up to the age of 5. In addition to providing advice and support for all parents, Sure Start Children's Centres play a crucial role in reaching out to the most vulnerable parents in the delivery of the Healthy Child Programme, early learning and childcare. As we near 2010, when every community in England will be served by a Sure Start Children's Centre, we will continue to strengthen the role that they play in integrating early childhood services including health, education and other services for parents by ensuring they have the right legal base in place, building on the duty on local authorities in the Childcare Act 2006 to make arrangements to provide integrated early childhood services, and the duty on PCTs and others to work together with the local authority in carrying out that duty.

3.47 Between September and November 2008 we consulted on proposals to ensure that Sure Start Children's Centres become an established part of the universal services available for young children and their families, and that local authorities and their partners have clear duties to establish and maintain sufficient Sure Start Children's Centres to meet local needs. The consultation closed on 6 November and the responses have been strongly supportive of our proposals.

3.48 We therefore plan to establish Sure Start Children's Centres on a statutory legal basis as part of the Apprenticeships, Skills, Children and Learning Bill.⁴⁹ This will help ensure that all partners have greater clarity and certainty about the role the centres play in every community and, in turn, that families are able to access high quality services through Sure Start Children's Centres in every area.

3.49 A statutory footing would provide Sure Start Children's Centres with a strong legislative platform, and we can also do more to help provide stronger links between healthcare practitioners in different settings. For example, health visitors who lead the Healthy Child Programme need to work across GP practices and Sure Start Children's Centres. Through the development of this strategy, parents and healthcare practitioners highlight some excellent examples of joint working across the Healthy Child Programme, including through Sure Start Children's Centres. Practitioners also highlighted that more could be done to provide a link between all Sure Start Children's Centres and health visitors. For example, parents have sometimes received visits from both Sure Start Children's Centre outreach workers and health visitors after the birth of a child without being clear what the purpose of each visit is.

3.50 We need to enable effective integration and co-ordination of services to provide a joined-up approach for families and to establish clear

⁴⁷ *The Children's Plan*, Department for Children, Schools and Families, 2007.

⁴⁸ *Birth to Five: Your complete guide to parenthood and the first five years of your child's life*, Department of Health, May 2007.

⁴⁹ www.dcsf.gov.uk/childrenskillsandlearningbill/

accountabilities for outreach work and home visiting of families to ensure effective safe services. To do this we will ensure that there is **joint working between health visitors (who are key to the delivery of the Healthy Child Programme) and Sure Start Children's Centres. We will ensure that every Sure Start Children's Centre will have access to a named health visitor to work as part of the team and oversee the health work of the Centre. We will ensure that, within local services, health visitors have clear responsibilities and support to lead the Healthy Child Programme.**

3.51 We will work with the profession during 2009, to publish further information on the scope and nature of both the **Sure Start Children's Centres named health visitor's role and health visitor's responsibilities and the support they require to lead the Healthy Child Programme.** This will include information on how health visitors can best provide support and supervision for outreach work and home visiting with families in pregnancy, with a new baby or young child, to secure safe and high quality care and practice and clarify accountabilities in local settings.

3.52 Health and other services for children – such as childcare and advice on parenting and nutrition – all share the aim of ensuring that young children develop as well as possible up to the age of 5. We want parents to receive a high quality advice and support service during the early years and expect local authorities and PCTs to work closely together to ensure that happens and to communicate clearly what help is available locally. These services will ideally be delivered through the Sure Start Children's Centre, which provides an easy-to-access single point of contact for families. In many areas, this already works very well thanks to the enthusiasm and commitment of all the staff and the local leaders of health and children's services.

3.53 Proposed new and stronger arrangements for Children's Trusts provide the opportunity to

ensure that there are more consistent and high quality early years services in every area. The current and developing statutory framework makes clear that partners are expected to work together to develop and provide services for families. PCTs and local authorities will want to agree how they will work together to ensure that families can access all the services they need for their young children, and a new jointly owned Children and Young People's Plan will be the appropriate place for partners to set out how this will work in practice. Children's Trust partners will want to communicate what is available in the early years to parents in their area.

3.54 We can also do more to build upon the success of existing health-based programmes delivered through Sure Start Children's Centres, so as to ensure that there is an enhanced focus on healthy development within Sure Start Children's Centres. **The Government will therefore extend successful health-based programmes delivered through Sure Start Children's Centres,** for example, evidence-based programmes which tackle childhood obesity. One such programme is HENRY,⁵⁰ which tackles early childhood obesity by training community and health practitioners to work more effectively with parents and young families.

3.55 And we can also do more in Sure Start Children's Centres to help pregnant women and mothers to give up smoking, or wider substance misuse, particularly during pregnancy. The latest figures show a slight overall decline in smoking rates during pregnancy – falling from 19% in 2000 to 17% in 2005 – but this masks a slight increase in rates of smoking in pregnancy among women from the routine and manual group, from 28% to 29%.⁵¹ The health of babies can be put at serious risk if their mother smokes during pregnancy, contributing to an estimated 40% of all infant deaths,⁵² and the risk to children continues if they are exposed to secondhand smoke, especially in enclosed places like the home or private vehicles. Growing up, children are significantly more likely to

⁵⁰ Health, Exercise and Nutrition for the Really Young, www.henry.org.uk.

⁵¹ 2007 Status Report on the Programme for Action, Department of Health, 2008.

⁵² Levels of excess infant deaths attributable to maternal smoking during pregnancy in the US. Salihu H. et al. *Journal of Maternity and Child Health*, 2003; 7: 219-227.

become smokers themselves if their parents smoke, perpetuating health inequalities caused by tobacco.

3.56 Following consultation, the Government will publish a National Tobacco Control Strategy⁵³ and will be setting out actions for protecting children from smoking. This will include supporting Sure Start Children's Centres to host NHS Stop Smoking Services for mothers and fathers. The Government is also encouraging closer working⁵⁴ between substance misuse treatment services and maternity services, to provide better support to pregnant substance misusers and reduce prenatal harm to children.

(iv) Expanding the Family Nurse Partnership model and strengthening early intervention

3.57 The measures set out in this chapter will help all parents in the support they give to their babies and young children. Many of the proposals – in particular those that will enhance the role played by Sure Start Children's Centres – are also likely to result in disadvantaged parents being given additional support. But the Government wants to build on the success of programmes that go even further to improve the outcomes for the most vulnerable children and parents. The Family Nurse Partnership model has demonstrated the benefits that evidence-based early intervention with the most vulnerable parents can bring.

3.58 We will therefore expand the Family Nurse Partnership programme by further increasing the number of PCTs and local authorities testing the programme between 2009 and 2011. If the testing continues to go well, we plan to have 70 sites in place by April 2011. We want to make sure that we learn and build solid foundations in this country so that the programme will be sustained for the long term. A randomised controlled trial is being conducted to determine the full impact that Family Nurse Partnerships are having for children and families in England.

It takes time to carry out the initial evaluations, to train nurses and to establish Family Nurse Partnerships on the ground, so if the research findings are positive we would like to see this support offered to the most vulnerable first-time young mothers across England over the next decade. The Family Nurse Partnership programme makes an important contribution to the Healthy Child Programme and we expect it to be commissioned as part of that programme.

3.59 One of the important principles underpinning the Family Nurse Partnership model is the systematic offering of the programme to those who would most benefit from it. Early identification of individuals at risk is the first step towards engaging families and offering them programmes and services that will help parents to do the best for their child and improve their child's health and wellbeing.

3.60 The Department of Health is therefore working with the Child and Maternal Health Observatory (see paragraph 7.46) to develop a predictive tool for child health and wellbeing to help services identify those families that would benefit from being offered additional support through personalised services from early pregnancy onwards. This work builds on the development of the 12-week maternity assessment of risk, needs and choices.

⁵³ *Consultation on the Future of Tobacco Control*, Department of Health, 2008.

⁵⁴ *Drugs: Protecting Families and Communities Action Plan 2008-11*, HM Government, 2008.





4

**SCHOOL-AGE
CHILDREN**

- 4.1** As children grow up they become increasingly aware of health-related matters and can be expected to take on additional responsibility for their health and wellbeing. Schools and school health services, GP practices, paediatricians, children's services including behaviour support and social care services, child and adolescent mental health services and others play a hugely important role in supporting children and families to lead healthy lives.
- 4.2** This chapter sets out the services available to support children of school age to lead healthy lives. To help fulfil local areas' new responsibilities to ensure that parents are fully aware of the local health services available for them and their children, this chapter also sets out additional policies including:
- An improved Healthy Child Programme for school-age children which will set out what services should be available to all parents in all areas.
 - Schools' role in promoting pupils' health will also be supported through strengthening the National Healthy Schools Programme.
 - The creation of a world-class system of PE and sport, offering 5- to 16-year-olds 5 hours a week – a significant contribution to the exercise they should undertake – and giving them high quality sports in the run-up to, and after, the London 2012 Olympics.
 - Pilots will be established to build the evidence base on the impact of extending free school meal criteria to a greater number of pupils (including, in some areas, by putting in place free school meals for all primary pupils).
 - We will improve the quality and consistency of Personal, Social, Health and Economic (PSHE) education and intend to make it statutory within the curriculum.

Services for school-age children

- 4.3** A wide range of support and healthy opportunities are available for children of school

Proactive Support	A curriculum that covers age-appropriate support and advice on sex and relationships, substance misuse, diet and nutrition, physical education and sport. School and community health centres		
Healthy opportunities	Access to a school lunch service that meets nutritional standards	Five hours PE and sport a week; and free local swimming for under-16s (as well as school swimming)	Access to additional healthy opportunities in the community
Reviews	Ongoing physical and developmental reviews delivered through school – including height and weight measurements, vision and hearing tests	Ongoing series of immunisations, screening and monitoring through the school health service	
Access to additional support	Access to advice and support through websites, phone lines, and Parent Support Advisors	Access to confidential pastoral support within school, and access to wider health support outside school	Swift and easy access to specialist health support

age – both in and out of school. These are summarised in the table on the previous page and discussed in more detail below.

- 4.4** When a child reaches school age, the kind of support that is provided necessarily changes, and it becomes even more important for services to be linked to places that are convenient and accessible for children, as well as their parents.
- 4.5** School Health Teams provide a key link between education and health services, providing guidance and support on a range of health-related issues. Though their composition will vary across different primary care trusts (PCTs), school health services will usually have at their core a group of school nurses working with or supported by a range of other practitioners and support staff. School nurses and school health services more generally can help to provide information on where to go for more specialist support, including child and adolescent mental health services and specialist children's and families' social care.
- 4.6** Looking forward to the London 2012 Olympics, the Government has launched an ambitious new PE and Sport Strategy for Young People. We will create a world-class system as part of the legacy of the Olympics, and as part of that we aim to offer all 5- to 16-year-olds 5 hours sporting activity a week. Schools will still play a major role in providing this, co-ordinated by our national network of 450 school sport partnerships. Community, sport and youth clubs also have a key role, co-ordinated by 49 county sport partnerships. The challenge will be not only to lay on high-quality PE during the school day, but to persuade children (and their parents) to take part in sport in their leisure time. We expect local authorities and PCTs to support, and work with, school and county sport partnerships, and to use the PE and Sport Strategy for Young People to achieve local improvements in child health (physical and mental), obesity and exercise.
- 4.7** There is also a wide range of services for school-age children that supports their broader health and wellbeing. Between 2003 and 2008, more and more children have been provided with 2 hours PE and sport a week through their schools.⁵⁵ And the Government's £140 million Free Swimming Programme has been put in place to help local authorities provide free swimming to the under-16s. In addition, by 2010 all schools will have school travel plans, encouraging pupils to walk or cycle to school.⁵⁶ Children's health is also supported through ensuring that school lunches meet nutritional standards and the increased emphasis on practical cooking and healthy eating in the new secondary curriculum. These changes will be built upon over the coming years so that, by 2011, learning to cook a range of simple, nutritious meals will be a compulsory curriculum entitlement for every 11- to 14-year-old.
- 4.8** The renewed focus on healthy eating and cooking and increasing levels of physical activity will help to support the broader efforts to tackle obesity, as set out in the cross-government *Healthy Weight, Healthy Lives* strategy. This builds upon and extends existing initiatives, such as the School Fruit and Vegetable Scheme, which is part of the 5 A DAY initiative.
- 4.9** PSHE education provides pupils with knowledge, understanding, skills and attitudes that can help them to make informed decisions about other aspects of their lives relating to their health and wellbeing. PSHE education covers a wide variety of areas, including education about drugs, alcohol and tobacco, mental health and psychological wellbeing, and sex and relationships. In addition to this content provided through the teaching of PSHE education, schools are increasingly using the Social and Emotional Aspects of Learning framework, which provides teachers with a way of teaching social and emotional skills to pupils across subjects.

⁵⁵ *School Sport Survey, 2007/08*, Department for Children, Schools and Families.

⁵⁶ *At Least Five a Week: Evidence on the Impact of Physical Activity and its Relationship to Health*, Department of Health, 2004.

- 4.10** Accidents remain a leading cause of death and injury to children and young people (although rates have been falling in recent years). Therefore, one of the commitments in the *Staying Safe Action Plan* is to set up a new Child Safety Education Coalition (CSEC) to encourage greater high quality provision and evaluate the effectiveness of practical safety education for children in England, and ensure that more children, including disabled children, have access to practical safety education activities.
- 4.11** Mental health problems are more common in older children than young children, among children who live in families with a low income, and among those who are vulnerable for other reasons, such as those in care, or those with a learning disability. The importance attached to mental wellbeing in schools has been underlined through additional investment. In particular, the Targeted Mental Health in Schools project aims to support the development of innovative models of therapeutic and holistic mental health support in schools for children and young people aged 5 to 13 at risk of, and/or experiencing, mental health problems, and their families. The project began in April 2008 when 25 local authorities and their corresponding PCTs commenced pathfinder work. In November 2008, the Government announced that a £60 million project will cover all local authority areas by 2011.
- 4.12** Providing access to parenting support is one of the core criteria of the Extended Schools programme, and among other things can help tackle early emotional and behavioural problems. The National Institute for Health and Clinical Excellence (NICE) has identified that parenting programmes with a strong evidence base can be effective in tackling conduct disorders and improving parents' ability to manage their child's behaviour. The Parenting Early Intervention Programme (PEIP), which targets parents of children aged 8 to 13 at risk of negative outcomes, will roll out evidence-based parenting programmes across all local authorities from April 2009. An evaluation of the original pilot found that the PEIP almost halved the number of parents who classified their children as having significant behavioural difficulties.
- 4.13** School health services are underpinned by a range of additional, complementary services provided by schools, local authorities and NHS trusts, often working together and with third sector providers. This range of services is particularly important to children with ongoing additional health needs. As with the early years, GP practices, primary care teams and paediatricians provide a service in the event that children of any age become ill.
- 4.14** Through the curriculum, and through the opportunities that schools and school health services provide pupils, a wide range of support, advice and health-related opportunities are available. Two national programmes bring together many of these activities – the Extended Schools and Healthy Schools programmes. The programmes are helping schools to improve the quality and consistency of services provided in or linked to schools. In order to become an Extended School, for instance, schools need to demonstrate that they provide access to a core range of activities (including childcare), parenting and family support, and swift and easy access to targeted and specialist services for children needing support or advice on emotional, behavioural, health or other difficulties.
- 4.15** In this way, Extended Schools play a key role in integrating services, including through their location on school sites. The range of activities, which may include the provision of breakfast clubs before school begins, is likely to be of particular benefit for children from more disadvantaged backgrounds, and there is already some evidence to suggest that Extended Schools may help to reduce inequalities in attainment between different groups of pupils.⁵⁷

⁵⁷ *Evaluation of the Full Service Extended Schools Initiative: Final Report*, Department for Education and Skills Research Report, 2007.

- 4.16** The National Healthy Schools Programme similarly requires a whole-school approach to health promotion across four core themes: PSHE education; healthy eating; physical activity; and mental health and psychological wellbeing.
- 4.17** These two programmes can be seen as part of a broader vision, set out in *The Children's Plan*, of the 21st Century School. *The Children's Plan* describes a model of the 21st Century School, working closely with other schools and further education colleges, parents, employers and within the Children's Trust to support children's wellbeing across all the Every Child Matters outcomes.
- 4.18** Wider environmental factors also have a huge impact upon children's and young people's ability to stay healthy. For example, walking or cycling to school or play areas is a key way to improve children's health and to reduce obesity, at the same time reducing pollution, and increasing road safety and community cohesion. And outdoor play in green spaces benefits children psychologically and physically. Even small amounts of green space are shown to have qualities that facilitate relaxation and recovery from mental fatigue and stress, particularly for those with symptoms of Attention Deficit Hyperactivity Disorder (ADHD).
- 4.19** There is compelling evidence on the benefits of play to children, both for enjoyment and developing the skills needed to prosper in childhood, and as preparation for later life. This includes the development of social skills, risk management skills and brain development associated with the ability to learn. The Government has therefore committed to record new investment in healthy neighbourhoods and communities. Between 2008 and 2011, as announced in *The Children's Plan*,⁵⁸ £235 million is being invested to support every local authority to provide a variety of designated public play areas, free of charge, that are both safe and accessible.

- 4.20** This investment in innovative and stimulating local play areas will have an emphasis on the needs of 8- to 13-year-olds and increase their opportunities to be active. In December 2008, the Government announced the acceleration of this capital investment programme, so all local authorities will be able to access play funding of at least £1m by spring 2009.
- 4.21** Further support through training and guidance will also be provided to planners to help them consider the impact of planning on play and broader physical activity patterns. And in recognition of the importance of a clean and healthy environment, a Children's Environment and Health Strategy has been consulted upon and will be published later this year.⁵⁹

Further improvements for school-age children

- 4.22** This section sets out how we will achieve our ambitions for school-age children by:
- (i) Developing the Healthy Child Programme for school-age children
 - (ii) Increasing physical activity
 - (iii) Developing School Health Teams in every local area
 - (iv) Further developing schools' roles in promoting children's health and wellbeing
 - (v) Improving teenagers' access to information and advice
 - (vi) Strengthening PSHE education
 - (vii) Increasing the uptake of healthy school meals
 - (viii) Doing more for particular groups of disadvantaged children, in particular children in care
- (i) Developing the Healthy Child Programme for school-age children**
- 4.23** The Healthy Child Programme is designed to promote health and wellbeing from pre-conception to adulthood, integrating pre-school

⁵⁸ *The Children's Plan*, Department for Children, Schools and Families, 2007.

⁵⁹ *A Children's Environment and Health Strategy for the United Kingdom: Consultation Document*, Health Protection Agency, 2008.

and school-age health promotion and assessment. A great deal of work has been done recently to ensure that a clear set of services has been outlined for pregnancy and the first five years of life.⁶⁰

4.24 We will now develop the school-age elements of the Healthy Child Programme to set out a school-age health offer in the way that we have done for 0- to 5-year-olds. This will include details of what services should be available for all children, in addition to the services that will help support children and families from more vulnerable backgrounds. We aim to publish best practice guidance in 2009. And we will support local areas to do more to ensure that the programme is highly visible to local families and communities, particularly as we know that parents are less confident and well informed about what their children can expect and where they can find services as their children get older.

4.25 Chapter 7 sets out why local areas will be expected, through the Children's Trust, to publish information on what children and families can expect from their health services locally, including with regard to school-age pupils.

4.26 The Healthy Child Programme for these older children will reinforce the importance of prevention, early intervention and health education, focusing on the needs of all young people and especially the most vulnerable, on workforce development and on how to assess health needs to ensure best use is made of skills and resources. It will also build on the proposals within this and the following chapters – in particular those relating to school health services, and the Extended and Healthy Schools programmes. Consultations with stakeholders took place throughout the autumn of 2008.

(ii) Increasing physical activity

4.27 The PE and Sport Strategy for Young People will focus between 2008 and 2011 on a number of areas, contributing to children's overall health and fitness:

- Giving children a sense of entitlement to 5 hours PE and sport a week, and so stimulating demand.
- Improving the quality of provision by training for teachers, coaches, and sports and dance clubs.
- Providing a more diverse and attractive range of sports and dance through Sport Unlimited.
- Creating a national competition framework, so that all children can enjoy competitive sport, whether team or individual, whether competing against others or against a personal best.
- Encouraging more children into leadership and volunteering in sport.
- Providing more sporting opportunities for gifted and talented pupils, and for children with disabilities.
- Ensuring 11-year-olds can swim 25 metres and understand water safety, as set out in the National Curriculum.
- Minimising the potential for sports injuries and accidents, and ensuring excellent child protection in sport.

(iii) Developing School Health Teams in every local area

4.28 At present, school health services vary widely in the services they provide and the practitioners that they are composed of across England. The future publication of the Healthy Child Programme for school-age pupils will give clarity to the health services that should be available to all children, and the school health service will play the lead role in its delivery. Exactly how this is done will depend upon how local areas arrange their individual team in response to the specific needs of their communities. It will, however,

⁶⁰ *The Child Health Promotion Programme: Pregnancy and the First Five Years*, Department for Children, Schools and Families/Department of Health, 2008.

CASE STUDY: Small steps lead to big changes – Health Challenge Programme in schools, National Children’s Bureau (NCB)

NCB has piloted and is currently evaluating an exciting ‘Health Challenge’ which aims to help children and young people, their families and schools to initiate and sustain healthy lifestyle changes. Commissioned by the Food Standards Agency, the programme has been delivered in partnership with Kent Healthy Schools Programme and Kent County Council. The programme is centred around a ‘challenge’ model where participants choose at least one challenge or goal from across three areas (physical activity, feeling good inside and healthy eating) that they aim to stick to for a four-week period. Participants were selected based on health inequalities indicators and were from some of the most deprived parts of Kent. Preliminary indications from the evaluation suggest that each of the six pilot schools has been able to adapt the programme, making it their own through a distinct mix of individual, class and whole-school activities. Over 1,000 students took part in the challenges – including both organised group exercise in the form of dance or walking a mile a day and personally chosen challenges such as trying new healthy foods or walking or cycling to school instead of using the car or bus. Encouragingly, primary schools appear to have been able to involve pupils almost without exception, with the overwhelming majority reporting successful completion of their challenge, having enjoyed the experience and aspiring to ‘keep it up’.

require all areas to develop School Health Teams with the necessary skills and capacity to provide the range of services set out in the Healthy Child Programme.

- 4.29** The Healthy Child Programme will also require the School Health Team to work alongside a broad range of local partners – including those schools that the School Health Team will be linked to, and the more specialist support provided through child and adolescent mental health services and other practitioners. In this way, the School Health Team will provide both a universal service for all pupils, as well as more targeted health advice and support for those more vulnerable children who need it most.
- 4.30** The range of services linked through school health services is demonstrated by areas like Tameside. At Tameside PCT the school health service is comprised of doctors, school nurses, physiotherapists, speech and language therapists, dentists and chiropodists.⁶¹ Together with the broader school health service team, school nurses in Tameside have a range of important responsibilities that include setting up immunisation and vaccination programmes; running drop-in clinics; and helping to smooth the transition to primary school through a health assessment soon after a child has started primary school.⁶² They also have a broader advisory role to play in helping to support pupils with health issues such as diet and nutrition, physical activity, mental health and psychological wellbeing, puberty, smoking, and sexual health.
- (iv) Further developing schools’ roles in promoting children’s health and wellbeing**

- 4.31** The Government has recently set out a vision of 21st Century Schools, which recognises the role played by schools in supporting the range of children’s outcomes, and is currently consulting on how to make a reality of this vision.⁶³ 21st Century Schools are schools which deliver

⁶¹ www.tameside.gov.uk/schools/healthservice

⁶² *The Child Health Promotion Programme: Pregnancy and the Early Years*, Department of Health/Department for Children, Schools and Families, 2008.

⁶³ *21st Century Schools: A World-Class Education for Every Child*, Department for Children, Schools and Families, December 2008.

CASE STUDY:
Bringing health services directly to young people – TeenTalk@kidbrooke, Kidbrooke Secondary School, Greenwich

The drop-in health centre is based in the school's premises and is the result of collaboration between Kidbrooke School, Greenwich Council, Greenwich Teaching primary care trust and partner agencies to bring health services directly to young people. The centre is a 'teacher free zone', led by a multi-disciplinary staff in partnership with a wide range of specialist services running regular clinics and sessions, and offering confidential counselling for students (e.g. for advice about physical, sexual and emotional health issues) who may be unlikely to seek support in more formal health settings. TeenTalk receives an estimated 900 visits per term – raising awareness of health issues among students, encouraging them to take responsibility for their own health. Due to the success of the centre, six other schools in Greenwich now have a health centre.

excellent personalised education and development; a strong focus on improving health and wellbeing for children and young people, particularly through their role in early intervention, and provide a wider community resource to support families and communities. Thus the 21st Century School builds on the foundations laid by the Healthy Schools and Extended Schools programmes.

4.32 The duty that schools now have to promote pupils' wellbeing is a central part of this vision. The Department for Children, Schools and Families

consulted in 2008 on guidance illustrating how schools can best promote wellbeing, and on the support they can expect from their local authority and Children's Trust. Schools have a lot of information on which to self-evaluate their performance on attainment, but there is less information on which to assess a school's contribution to other outcomes. For this reason, DCSF and Ofsted are jointly developing a package of school-level indicators that schools and Ofsted can use in assessing this wider role. In a joint consultation, which ended in January, DCSF and Ofsted proposed a package of indicators, including both hard indicators and parent and pupil views, to be reflected in the Ofsted cycle of inspections beginning in September 2009. The indicators will inform Ofsted judgements, though inspection judgements will not be based upon the indicators alone.

4.33 To ensure the school's contribution to all aspects of wellbeing are properly recognised, **the Department for Children, Schools and Families has announced its intention to develop a new "School Report Card"**, which will provide simple and clear information about each school's performance and achievements across the full range of its responsibilities, including the contribution it is making to its pupils' wellbeing. The School Report Card will become the underpinning assessment of every school's performance, alongside Ofsted inspection judgements. The Government is consulting on the broad design of the Report Card as part of the wider consultation on delivering 21st Century Schools.⁶⁴

4.34 To further enhance the role of schools, the Government will develop an enhanced Healthy Schools Programme to help schools to be better able to promote both universal health improvement for all pupils and provide

⁶⁴ *A School Report Card: Consultation Document*, Department for Children, Schools and Families, December 2008.

additional support targeted on those identified as most at risk. The criteria underpinning this programme will focus on improving health outcomes for children and young people and will coincide with the new Ofsted inspection framework to be introduced in September 2009, which will incorporate the new wellbeing indicators.

4.35 We will build on progress in bringing together the Healthy Schools and Extended Schools programmes and related initiatives such as the School Fruit and Vegetable scheme. The Department of Health and the Department for Children, Schools and Families will put in place a joint operations group to ensure that these programmes are aligning policy, communications, key messages, effective practice and delivery systems.

(v) Improving teenagers' access to information and advice

4.36 Supporting good health and wellbeing for children, young people and families is central to improving health outcomes. The review of the Healthy Child Programme from pregnancy to 19 will ensure that evidence-based care is delivered by skilled and competent health professionals. **In developing the Healthy Child Programme for older children, we will explore how we can deliver against an aspiration that every teenager can have access to a professional, with appropriate health skills, to talk to about their health issues.**

4.37 New technologies are also helping to provide more targeted, secure, but still accessible information. This is true for practitioners across a number of different fields. *ContactPoint*⁶⁵ for example, will enable practitioners to find out who else is working with the same child or young person, making it easier to deliver more co-ordinated support.

CASE STUDY: Joint working between a primary school, The Place2Be and Barnardo's Young Carers on emotional support for children

A Key Stage 2 pupil was referred to The Place2Be by a GP. There had been a change in the child's behaviour and the child was clearly struggling with some family issues, exhibiting signs of anxiety and panic attacks. For a number of weeks the child was withdrawn during sessions with The Place2Be counsellor and spoke very little, concentrating on paintings and drawings to explore emotions. As the relationship between The Place2Be counsellor developed, the child began to talk about a severely disabled brother and the impact that his care and his behaviour had upon the family life. The school project manager and counsellor consulted the child's mother and then referred the child to Barnardo's Young Carers. They contacted the family within a week to arrange further visits and support. The change in the child after the initial contact was immediate, the anxiety decreased and the child's mood began to lift. The Place2Be counsellor continued to provide individual emotional support while Barnardo's Young Carers offered social activities to the child outside the family home. The joint working between the school and outside agencies has had a sustained and positive effect upon the life and the mental health of this child.

⁶⁵ www.everychildmatters.gov.uk/deliveringservices/contactpoint

4.38 In order to ensure that the parents of school-age children have access to high quality information about their children's learning and development, we will pilot the concept of an online parent-held record for the parents of children over the age of 5. The pilots will ensure that the confidentiality of users is respected and that the data held is compliant with rigorous data security requirements by building on the existing technical and security architecture used by schools rolling out online systems as part of the online reporting initiative being led by British Educational Communications and Technology Agency (Becta). The pilots will launch in January 2010.

4.39 The NHS Teen LifeCheck is a confidential, online tool that has been designed to empower young people aged 12 to 15 to take greater control of their health and wellbeing by raising awareness of their risk-taking behaviour, supporting them in planning improvements to their lifestyle, and signposting further sources of support and advice. **We will roll out NHS Teen LifeCheck to 83 Spearhead and Communities for Health areas⁶⁶ in January 2009 and extend nationally during spring 2009 as part of the national NHS LifeCheck campaign.**

(vi) Strengthening Personal, Social, Health and Economic (PSHE) education

4.40 The importance of good quality Personal, Social, Health and Economic (PSHE) education has never been greater. PSHE education has a major contribution to make to young people's personal development and wellbeing – a key indicator of the success of a 21st Century school. It equips children and young people with the knowledge, understanding and practical skills to live healthy, safe, fulfilled and responsible lives. However, we know that the quality of PSHE education varies significantly across the country. The most recent Ofsted subject report on PSHE education says that while overall the quality is improving, it remains patchy and that some sensitive issues

within PSHE – including sex and relationships education – are not generally taught well.

4.41 Ofsted's findings are supported by a survey of around 20,000 young people conducted for the UK Youth Parliament. The report says that 40% of young people described the sex and relationships education they had received as either 'poor' or 'very poor', with a further 33% describing it as only 'average'.⁶⁷ And finally, 95% of those who teach PSHE education believe it is as important as other curriculum subjects, and 90% think that it should be made a statutory part of the curriculum.⁶⁸ This is compelling evidence which suggests that we need to do more to ensure that the quality and consistency of PSHE education is improved across England.

4.42 In recognition of the key role it plays in equipping children and young people with the knowledge and skills they need to lead healthy and successful lives, Ministers announced their intention to make PSHE education statutory in October 2008. This is consistent with the Children's Plan on schools' role in developing young people in the round, as well as ensuring that they receive an excellent education, and with the priority we expect schools to give to the issues it covers.

4.43 At the same time Ministers launched an independent review of how making PSHE education statutory might be achieved in the most effective and practicable way. Sir Alasdair Macdonald, the head teacher of Morpeth school in Tower Hamlets, is conducting the review and will report to Ministers in April 2009. Proposals for the statutory implementation of PSHE will be the subject of a full public consultation.

4.44 PSHE education can help children and young people to recognise and manage risks and contribute to their safety and wellbeing. To

⁶⁶The Communities for Health programme was announced in the Choosing Health White Paper and consists of 83 of the most deprived local authority areas in England and includes all of the 70 Spearhead areas.

⁶⁷Online survey conducted as part of the Sex and Relationships Education Review.

⁶⁸Ibid.

support improved teaching of risk management, the *Staying Safe Action Plan* committed the Government to explore ways in which child safety education could be reflected in the National PSHE Continuous Professional Development Programme for teachers and other professionals supporting PSHE education. **We are considering a new module on understanding and managing risk, with a view to rolling it out in autumn 2009.**

(vii) Increasing the uptake of healthy school meals

4.45 A number of important changes have been introduced recently to support schools to equip pupils with the skills that will allow them to cook simple, nutritional meals. Well-balanced school meals are one way in which schools and local authorities can address concerns over childhood obesity. For some children, the school lunch may be their only nutritious, cooked meal of the day. The Government has set itself a target of increasing the uptake of school meals⁶⁹ and has asked the School Food Trust to work with schools, local authorities and others to increase take up. This work has demonstrated the considerable scope that schools and local authorities have to increase uptake – for example through improved dining room environments, pupil consultation on menus, and by ensuring that food is well presented.

4.46 Local authorities have also been experimenting with ways of increasing school meal uptake. One such example was Kingston-upon-Hull, where the local authority experimented with the Eat Well Do Well programme, which introduced free school meals for all pupils of primary school age alongside increased curricula and parental support. An evaluation of the scheme suggested that it had not only increased the uptake of school lunches, but had improved pupils' concentration and behaviour in the classroom, as well as other outcomes.⁷⁰

4.47 The Government is keen to learn lessons from this work and would like to develop the evidence base. **The Department for Children, Schools and Families and the Department of Health will initiate pilots, testing the health and educational outcomes we could expect from introducing free school meals for all primary pupils. The pilots will also test extending free school meals eligibility to a wider group of low income families than current rules allow.**

4.48 The departments have invited local authorities and PCTs to bid jointly to run one of these pilots. The Government wants the pilots to start in the summer term, with pupils receiving their free lunches from September 2009. The summer term will be used to prepare and establish the pilots and the evaluation arrangements. **The pilots will run for two years to July 2011. The departments will set up a joint fund of £20 million to implement and evaluate the pilots, which will be matched by £20 million from local authorities and PCTs.**

4.49 Some local authorities feel that the current pricing arrangements prevent them from innovating locally, should they wish to. At present, local authorities and schools are legally required to charge the same price for the same meal for all pupils, except for those eligible for a free school meal or where an authority decides to offer free school meals to all pupils in primary or secondary schools. This prevents local authorities or schools from introducing innovative new schemes to give free school meals to particular groups of pupils or to offer subsidised meals to, for example, second or third children in a family. **The Government will therefore consult on whether to change the law to allow those local authorities and schools that wish to develop different approaches to offering subsidised meals to do so.**

⁶⁹ PSA Delivery Agreement 12: Improve the health and wellbeing of children and young people.

⁷⁰ *Evaluation of the Eat Well Do Well Programme: Kingston Upon Hull's School Meal Initiative*, University of Hull, 2008.

(viii) Doing more for particular groups of disadvantaged children, in particular children in care

4.50 One of the key principles of this strategy is the commitment to support better those from particularly disadvantaged backgrounds. Children and young people in care and leaving care are one such group. The majority of the 60,000 children who are in care at any one time are there because they have suffered abuse or neglect. Of all children in care, 45% are assessed as having a mental health disorder compared with around 10% of the general population. Children in care may well have health needs arising from:

- Living in families affected by drugs, alcohol or domestic violence.
- Additional needs or a disability.
- Coming from highly mobile families.
- A significantly higher risk of becoming a mother before the age of 18.

They may also have experienced poorer access to services including universal services such as dental services, immunisations, routine child health surveillance and health promotion because of language or cultural barriers.

4.51 A great deal has recently been done to further support children in care. In particular the *Care Matters White Paper*⁷¹ set out a radical package of proposals for transforming the lives of children in care. The Children and Young Persons Act⁷² and the Care Matters implementation plan provide a strong framework for improvement. The plan describes how we can best deliver better outcomes for children in care, and help local partners achieve the ambitious goal of ensuring every child in care grows up safe, happy, secure and loved.

4.52 One area that will be strengthened further relates to statutory guidance. Guidance is in place for the health promotion of looked after



⁷¹ *Care Matters: Time for Change*, Department for Education and Skills, 2007.

⁷² www.opsi.gov.uk/acts/acts2008/ukpga_20080023_en_1

children that holds statutory status among local authorities.⁷³ The guidance requires local authorities to put in place arrangements to ensure that every child in care has their health needs assessed on entering care and has a health plan setting out how their needs will be met and regularly reviewed. Though it holds statutory status for local authorities, it is currently non-statutory for the NHS.

4.53 The Government has therefore committed to re-issuing this guidance to place it on a statutory footing for both healthcare bodies and local authorities to help to remove any inconsistencies and promote more co-ordinated care.

4.54 Fieldwork to inform the development of the revised guidance in relation to current practice in the provision of health services is now complete and the Government expects to consult on the revised guidance shortly. This will provide important policy context for the public health guidance on the physical and emotional health and wellbeing of looked after children and young people which is being developed by NICE and the Social Care Institute for Excellence.

4.55 Children in care are between four and five times more likely to have a mental health problem than other children. The Government is committed to improving the mental health and emotional wellbeing of children in care and has introduced an indicator in the National Indicator Set to ensure identification, measurement and action. All local authorities are now assessing the mental health and emotional wellbeing of children in care through strengths and difficulties questionnaires (SDQs). **The Government will expect local authorities, as corporate parents, to use the data to inform priorities and their arrangements for commissioning services for children in care and to work with carers to ensure that effective action is always taken when an SDQ suggests that a child or young person has a significant mental health problem.**

4.56 The pilot programme of Multi-dimensional Treatment Foster Care (MTFC) for adolescents with complex needs and challenging behaviour is beginning to make a difference to outcomes for those who have been in the programme. The model, developed by the Oregon Social Learning Centre, includes teams providing intensive support to foster carers, children and birth families. The programme has achieved a substantial improvement in future placement stability. **We are developing MTFC pilots for younger children. Local authorities should consider how aspects of this specialist model could benefit wider groups of foster carers.**

⁷³ *Promoting the Health of Looked-After Children*, Department of Health, 2002.





5

YOUNG PEOPLE

The health challenges and opportunities for young people

- 5.1** Adolescence is not only a key transition point between childhood and adulthood, it is a distinct developmental stage in its own right, characterised by dramatic physical and neurological changes, and emotional development.
- 5.2** This chapter sets out the wide range of services that are currently available to support the health of young people including their psychological wellbeing as well as their physical health. In addition, this chapter sets out a number of steps to help ensure that young people are given access to healthier opportunities:
- Implementing the PE and Sport Strategy for Young People which includes a commitment to offer 16- to 19-year-olds three hours high quality sports a week.
 - The 'You're Welcome' standards will be rolled out across England, so that all young people, wherever they live, will be able to access young people-friendly health services.
 - A new campaign to increase young people's knowledge of effective contraceptive methods will be launched, backed by increased investment of around £27 million a year from 2008-09 in contraceptive services in a range of settings.

Health services for young people

- 5.3** As they begin to enjoy greater independence, teenagers want to test boundaries and experiment with new experiences. This is a normal and important part of growing up. But in contrast to many of our European neighbours, too large a group of young people in England are taking risks with their current and future health. Among economically developed countries, young people in the UK have the highest levels of risk-taking, particularly in relation to under-age drinking.⁷⁴ Given the strong link between

good physical and mental health and learning, achievement and enjoyment, it is essential, at one of the most important points in a teenager's personal, social and academic life, that we provide the very best care and information.

- 5.4** This strategy recognises the importance of young people's mental health and psychological wellbeing to their personal and social development. It is the foundation upon which so many other choices – about sex and relationships, alcohol, smoking and drugs, physical activity, eating habits etc. – depend. Early intervention when young people first experience mental distress, building young people's resilience and providing both them and their families with appropriate support, is therefore crucial.
- 5.5** Many young people are in school and can therefore expect to be able to access the services set out in the previous chapter. But as they grow older they should find that services are offered in a way and with a focus that speaks to their particular needs. This includes, for example, accessible sexual health advice, and integrated youth support services providing information, advice,



⁷⁴ *Inequalities in Young People's Health*, HBSC International Report, C. Currie, 2008.

Proactive support	Integrated youth support services providing information, advice and support		Information campaigns providing advice on public health issues
Healthy opportunities	Positive activities		Three hours of sporting opportunities per week for all 16- to 19-year-olds
Age-appropriate services	Quality standards for settings providing services to young people	Health professionals and youth workers with specialist training	Confidential health and wellbeing advice from professionals
Access to additional support	Access to advice and support through websites, phone lines, the Teen LifeCheck and local integrated youth support	Health and wellbeing services offering a range of support in community and educational settings	Access to pastoral support in further education institutions

healthy opportunities and support. They should also expect a range of positive activities such as sports, leadership and volunteering, drama and music. It is crucial that those young people who need ongoing contact with health services or support benefit from early planning for transition to adult physical or mental health services. The range of health-related services available for young people is set out in the table above.

5.6 Young people increasingly take on additional individual responsibilities for their own health and wellbeing. They will be making a broader range of lifestyle choices, and will draw on care, support and advice from a wider range of sources – whether they be at home or in school, further education, in the workplace, or in the wider community. Psychological support, through these formative years in particular, is crucial. To help young people have more control over their own health and related records. Anyone with an email address, who is 16 years old or above and living in England, can open a basic HealthSpace account, which allows people to store and keep track of their health information, such as blood

pressure, blood sugar levels, height and weight, and ‘peak flow’. In time, it will allow people to access their own health record (people living in participating regions can already access their summary care record through an advanced HealthSpace account). For those over 16 years of age, HealthSpace will provide a convenient and useful source of health information.

5.7 An effective way in which positive behaviours in young people have been encouraged in recent years has been through public health campaigns. Campaigns use a range of media, and messages are often supported by websites and online resources. A current example is the ‘Know Your Limits’ campaign that urges young adult drinkers to know their limits and to stay within them, designed to get the message across that too much alcohol makes people feel invincible when they are at their most vulnerable. The campaign uses television advertisements, posters and a website to deliver advice on sensible drinking and staying safe while enjoying a good night out. While aimed at 18- to 24-year-olds, it also reaches out to younger audiences.

- 5.8** Other examples include the 'I Wanna Be Like You' marketing campaign which highlights the damaging role of adults in promoting smoking among young people. The 'Want Respect, Use a Condom' campaign focuses on raising awareness among sexually active teenagers of the risks of unprotected sex and on associating condom use with gaining peer respect. Among the target group of 16- to 18-year-olds there has been a steady increase in the proportion who intend to use condoms and believe that condom use shows respect. Public health campaigns, alongside the support of families and targeted services, have made a significant contribution towards tackling public health challenges.
- 5.9** In January 2009 the DCSF also launched draft information and advice around alcohol for parents, carers and young people. This was based on guidance from the Chief Medical Officer and will give parents clear information about the impact of alcohol on young people's health, and guidelines to help them decide when and how their children should first drink alcohol. The advice and information will be developed into a major social marketing campaign in spring 2009.
- 5.10** Support and advice is also available online and through dedicated phone lines. Such advice can be particularly powerful in that it is accessed by young people on their own terms, and can carry guarantees of anonymity should young people want it. The FRANK campaign for instance, launched in 2003, provides online and over-the-phone information and support for young people about the risks and dangers of drugs and their use.⁷⁵ In the last year alone FRANK answered over 350,000 telephone calls and had almost 5 million visitors to its website, with 94% of 15- to 18-year-olds recognising FRANK adverts and 82% aware of the free telephone helpline. The helpline, promoted through the Teenage Pregnancy Strategy RUthinking campaign, provides similar support and advice on sexual health issues.
- 5.11** Young people need opportunities to engage in positive activities if healthy choices are to be a reality for them. The successes in the 2008 Olympic and Paralympic Games and the once-in-a-lifetime opportunity represented by the London 2012 Olympic and Paralympic Games create the platform for developing a world-class community sports system. The PE and Sport Strategy for Young People extends to 16- to 19-year-olds, and the world-class system being created will also offer them three hours sporting activities a week.
- 5.12** As set out in Chapter 4, school and county sport partnerships will work with schools, FE colleges, community, sport and youth clubs to attract young people to take part in more sport. This reflects that young people may be based in sixth-form, college or work settings. The partnerships will also consider how young people not in education, employment or training can access sport.
- 5.13** A new development is the introduction of sports co-ordinators in FE colleges in England from September 2008. Again, local authorities and PCTs should support and work with the school and county sport partnerships, and use the PE and Sport Strategy for Young People to achieve local improvements in young people's health (physical and mental), obesity and exercise. Since September 2008, 358 co-ordinators have been appointed.
- 5.14** Local authorities are already under a duty to secure young people's access to a wide range of positive leisure time activities. *Aiming High for Young People: A Ten Year Strategy for Positive Activities* set out an ambitious vision of all young people being able to participate regularly in positive activities, supported by significant investment. The investment includes £190 million in 'myplace' – the new capital investment programme that will transform the activities, services and facilities available to young people in their communities.

⁷⁵ www.talktofrank.com/home_html.aspx

CASE STUDY: Providing frontline services where they are needed most – York College

York College, supported by Connexions (York and North Yorkshire) Young People's Substance Misuse Initiative (York) and the local PCT, are providing joined-up services where they are needed most, i.e. where large numbers of young people congregate. With nearly 4,000 full-time students, the college is ideally placed to address student needs, particularly when many of these students come from rural environments where services are difficult to access.

Students are benefiting from swift and easy access to targeted and specialist services. The team of specialist practitioners includes counsellors, advisers in substance misuse, homelessness, sexual health and mental health, and a Connexions personal adviser. The team are supported by the local PCT, who provide a drop-in service twice a week using specialist nurses. They provide confidential advice on sexual health matters and operate the C-Card scheme, a free condom distribution service. It is not unusual for two practitioners to work simultaneously with the same student if they present complex issues.

- 5.15** The further education environment differs significantly from that of schools with greater freedom for students and fewer opportunities to inform and educate 'captive' audiences. The further education sector is often dealing with young people who may struggle when finding themselves in a new environment that lacks the structure and support mechanisms of formal schooling, as well as particularly disadvantaged or at-risk young people, including increasing numbers of younger students, those with learning difficulties and disabilities and those with special educational needs.
- 5.16** Around three-quarters of further education colleges have now developed on-site health advice services, providing their students with quick and easy access to advice and support on contraception and sexual health. Many young people are reluctant to access contraceptive and sexual health services through GPs and traditional, clinic-based, all-age sexual health services. They want to access services in settings that fit with their daily lives, that are confidential and young-people-centred.
- 5.17** As well as contributing to tackling key public health concerns – such as unplanned pregnancies and sexually transmitted infections – helping students access support early can improve rates of retention and achievement. Further education colleges and primary care trusts (PCTs) have been provided with guidance to support the broadening of on-site advice.⁷⁶
- 5.18** Young people will access health services outside of the school, college or work setting. They will do this more readily if the settings for such support are age-appropriate and fit around their lifestyles. The Department of Health has developed and published the *You're Welcome Quality Criteria: Making Health Services Teenage Friendly* – a set of quality principles and criteria for various health settings.
- 5.19** Health support and advice services are also increasingly integrated in non-traditional health or education settings or services, particularly for vulnerable young people. The Targeted Youth Support reforms have brought together schools, health services, the voluntary sector, police and other partners to improve the way that vulnerable young people are supported. These

⁷⁶ www.everychildmatters.gov.uk/resources-and-practice/IG00244/

CASE STUDY: 'You're Welcome' and the Parallel Young People's Health Centre

The Parallel Young People's Health Centre is a PCT-led service based in Bolton. Young people have been involved in service planning, delivery and monitoring of Parallel from the outset, and staff have welcomed the adoption of the 'You're Welcome' quality criteria. Through various consultations, young people said that they sometimes found clinic times restrictive, particularly college students, who only had free time earlier in the day. They also said that they would like to be able to speak to a nurse about various health-related issues, but had difficulty in contacting a nurse by phone.

The use of the 'You're Welcome' self-assessment process enabled Parallel to ensure that all aspects of accessibility were taken into account – such as physical access to the building, as well as improving access to services outside of clinic hours. A 'nurse on duty' system was introduced, ensuring that a nurse is now available each day to advise young people, professionals and parents via the telephone. The nurse will also see any young people who turn up outside clinic times for a face-to-face consultation. Clinic times have also been extended to start earlier one day a week to support college students. Feedback from young people indicates that these changes have been welcomed and have improved patient satisfaction and choice.

reforms focus on the early identification of vulnerable young people, prevention of problems before they escalate, and multi-agency support co-ordinated by a lead professional when problems do emerge. Crucially, the reforms place young people and their families at the centre, enabling them to take an active role in shaping the services they receive.

- (i) Making health services young people-friendly
- (ii) Increasing physical activity
- (iii) Developing a Healthy FE Programme
- (iv) Improving support in making healthy choices
- (v) Enhancing the evidence and skills to inform policy and practice for young people's health services
- (vi) Targeting support for vulnerable young people

Further improvements for young people

5.20 Though significant progress has been made in improving support for all young people in making healthy choices, the recent report by England's Chief Medical Officer made clear that there is still more to do.⁷⁷ To achieve our aims of securing world-class health and wellbeing outcomes, providing better services, improving experiences in using these services and reducing inequalities in health outcomes for young people, this section will set out steps for further improvements in the following areas:

(i) Making health services young people-friendly

5.21 As with services for younger children, parents and babies, the Government would like to see more being done to ensure that people are aware of the health services available to them locally. This is why **local areas, through the Children's Trust, will be expected to set out what children, young people and families can expect from their health services locally.** This will help make services more visible to young people in their local areas.

⁷⁷ *On the State of Public Health: Annual Report of the Chief Medical Officer 2007*, Department of Health, 2008.

5.22 We want to promote services that provide the full range of advice, support and care that young people need, services that help them make healthy choices and give them access to healthy opportunities. Exploration of different types of adolescent health provision will continue. Confidential drop-in centres, located at school, college or in the community, offering information and advice on a wide range of health and wellbeing topics, are popular with young people and increasingly being developed.

5.23 The four Teenage Health Demonstration Sites are exploring the essential elements for successful adolescent health services.⁷⁸ Key factors for consideration when planning services include the type and location of settings, the mix of drop-in and by-appointment services, and the balance of types of staff who are experienced and skilled at working with young people. **The learning from this work will be disseminated widely to help others plan their services for young people. We will also support the roll-out of the 'You're Welcome' standards across England, so that all young people, wherever they live, will be able to access young people-friendly health services.**

(ii) Increasing physical activity

5.24 The PE and Sport Strategy for Young People will focus between 2008 and 2011 on a number of areas, contributing to young people's overall health and fitness:

- Giving young people a sense of entitlement to three hours sport a week, and so stimulating demand.
- Improving the quality of provision by training for teachers, coaches, and sports and dance clubs.
- Providing a more diverse and attractive range of sports and dance through Sport Unlimited.
- Creating a national competition framework, so that young people can enjoy competitive sport, whether team or individual, whether competing against others or against a personal best.

- Encouraging more young people into leadership and volunteering in sport.
- Providing more sporting opportunities for young people with disabilities.
- Minimising the potential for sports injuries and accidents, and ensuring excellent child protection in sport.

(iii) Developing a Healthy FE Programme

5.25 Schools across England have benefited from the introduction of the National Healthy Schools Programme, which supports them in developing a healthy school environment (from education to school meals). More also needs to be done for those individuals who attend further education colleges, particularly as this group of young people are more likely to be from relatively disadvantaged backgrounds. **We will therefore extend the principles of the National Healthy Schools Programme into the further education sector to create a whole college framework to help improve access for students and staff to health-related advice, information and guidance, and will promote positive health and healthy activities.**



⁷⁸ The demonstration sites are in Bolton, Hackney (London), Northumberland and Portsmouth.

CASE STUDY: Chlamydia testing at Middlesbrough College

The Chlamydia Screening Programme for County Durham, Darlington, Tees Valley and Hambleton and Richmondshire has established working links with 20 local colleges. Screening programme staff attend freshers' fairs in September. Each college is then offered two testing events per year.

At Middlesbrough College the testing event was held in October on two of the four campuses. Information was sent out to students by the welfare officer via email. On the day, 97 tests were taken from students at the Kirby Campus and 78 at the Marton Campus. These one-day events involved three visiting staff from the screening programme. Overall, approximately half of the students who tested were young men, with 86% of tests at the Marton Campus being from males. The average rate of positivity was 8.5%. Dates were booked for two weeks later so that the screening staff could come back and provide treatment. Test results were sent out by text message, email, letter or phone depending on the preference of the young person. Postal screening kits were made available from the student welfare officer following the event, to maintain a level of service for the students. Ruth Robson, who helps run the college outreach sessions, explains: "There is no need to build barriers around chlamydia testing. Not all young people in college have had sex, but if you have, you need to have a test. Testing is so straightforward, it just involves a urine sample."

5.26 This will provide the underpinning, positive environment for more specific initiatives, including providing more healthcare facilities on-site. We are also **investing £6 million over the three years 2008-09 to 2010-11 to support PCTs and further education colleges to improve information and advice on contraception to young people in further education**. Over time, we expect these colleges to extend the range of health advice available, to support students in developing healthy lifestyles. Further education colleges and PCTs will be expected to forge strong links, together with other providers of health and wellbeing services, including the voluntary sector.

(iv) Improving support in making healthy choices

5.27 Evidence demonstrates that England compares poorly with the best-performing countries in a number of key public health areas. It is important that young people have access to consistent, evidence-based advice to support them in making healthy choices, and that society supports them in those choices.

5.28 England also compares poorly with similar countries on sexual health. Since the launch of our Teenage Pregnancy Strategy, we have reversed the previous upward trend in teenage pregnancy and brought rates down to the lowest levels in over 20 years, with some areas of the country seeing very significant reductions. But we need to make urgent progress towards our ambition of halving the under-18 conception rate by 2010, and bringing it down to levels comparable to other Western European countries. And while we have seen reductions in some sexually transmitted infections (STIs), young people aged 16 to 24 still account for nearly half of STIs diagnosed despite making up only 12% of the population.

5.29 We have set out clear guidance to local areas on what works to reduce teenage pregnancy, drawn from the international evidence base and learning from areas with declining rates. Critical to accelerating progress is improving young people's knowledge and use of effective contraception. Research in the USA found that 86% of the decline in the US teenage pregnancy

rate was due to improved contraceptive use. Yet we have evidence that young people have very limited knowledge of contraceptive methods – particularly the safe and very effective long acting reversible methods of contraception (LARC) – to prevent repeat abortions or births.

- 5.30** We are therefore looking for a step change in both awareness and provision of the full range of contraception, including LARC. **A new campaign to increase young people's knowledge of effective contraceptive methods will be launched, backed by increased investment of around £27 million a year from 2008-09 to improve access to contraception.**
- 5.31** Identified priorities for this funding include teenage pregnancy 'hotspot areas', and areas with high abortion and repeat abortion rates. We have made clear that this funding should be used to ensure that all young people have easy access to high quality contraception advice, including LARC, and to improve training of health professionals in providing contraception.
- 5.32** From 2009-10 onwards, GPs will be given greater incentives, through the Quality and Outcomes Framework, to provide advice on sexual health – specifically advice on contraception, particularly long acting methods. To strengthen provision of contraception at abortion services, the standard NHS contract for 2009-10 includes a new clause to ensure that abortion providers improve access to contraception.
- 5.33** Key to ensuring that all young people get the high quality support they need is for local authorities and PCTs to work together on joint needs assessments and to jointly commission contraception and sexual health services in the health, school/college and community youth settings that meet the needs of their teenage population. All services should meet the 'You're Welcome' quality standards,⁷⁹ with clear care pathways between services to ensure continuity
- of support. **We will shortly be publishing best practice guidance to provide specialist advice on commissioning reproductive health services.** In addition, the National Chlamydia Screening Programme has published guidance on commissioning chlamydia screening programmes.
- 5.34** As part of Extended Schools and Healthy Schools, many schools now provide access to specialist advice and support from health professionals on-site. Around 30% of secondary schools and a third of Pupil Referral Units have health drop-ins offering advice and treatment on contraception and sexual health and many include other advice on healthy eating, substance misuse and smoking cessation. **Working with the National Children's Bureau, we will be developing a resource pack for schools, providing practical advice and support on setting up on-site health advice services, which will be available in early 2009.**
- 5.35** To improve young people's awareness, the Department of Health, with the Department for Children, Schools and Families, are **developing a new information campaign aimed at increasing young people's knowledge and trust in the full range of effective contraceptive methods, to be launched later this year.**
- 5.36** Obesity rates in England continue to rise. Although England now has put in place a comprehensive strategy across the age ranges, we still do not know enough about how to influence young people with regard to encouraging them to achieve and maintain a healthy weight.⁸⁰ **We will therefore examine the available research and emerging evidence on how best to influence young people's diets and levels of physical activity, and will develop a teenage social marketing campaign as part of the Change4Life⁸¹ movement.**

⁷⁹ *You're Welcome quality criteria: Making health services young people friendly*, Department of Health, April 2007.

⁸⁰ *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England*, Department of Health, 2008.

⁸¹ Change4Life is a brand new movement with a single but crucial goal: to help every family in England eat well, move more and live longer – www.nhs.uk/change4life

CASE STUDY: Anti-smoking initiative for young people in Bristol

The local authority in Bristol is using peer influence to its advantage, by training students to discourage their classmates from taking up smoking. As part of their work with the National Healthy Schools Programme, they introduced the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) into all their secondary schools, an anti-smoking initiative that trains students to promote anti-smoking messages among their peers. What makes the ASSIST initiative unique is the fact that it's led by students, rather than being classroom-based and delivered by teachers. It enables 12- and 13-year-olds to be trained as 'peer supporters' who promote anti-smoking messages in their everyday conversations with classmates – and it's proving remarkably successful. They learn about the risks of smoking and the various benefits of stopping, as well as being equipped with negotiation, communication and group work skills. ASSIST is a well-researched programme, which has been developed by the University of Bristol and Cardiff University and funded by a grant of £1.5 million from the Medical Research Council. It is still early days, but Bristol schools are already starting to see real evidence of behavioural change on smoking.

- 5.37** Levels of alcohol use by young people fell between 2006 and 2007 but prior to that, there is no consistent pattern. Overall levels remain relatively high, particularly among the most vulnerable young people, and England again performs relatively poorly internationally. Hospital admissions related to young people's misuse of alcohol and drugs have risen.
- 5.38** The 10-year Cross-Government Drugs Strategy emphasised the importance of preventing harm to children, young people and families affected by substance misuse.⁸² The strategy promoted the joint-commissioning of specialist treatment centres, bringing together support around the needs of vulnerable young people with substance misuse problems.
- 5.39** Our recent review of drug and alcohol education has also informed Ministers' recent decision to make PSHE education statutory within the curriculum. The recent *Youth Alcohol Action Plan* set out a series of measures to reduce excessive drinking by children and young people under the age of 18, including through proposals to tackle the problems associated with young people drinking in public places, such as anti-social behaviour and crime.
- 5.40** Smoking by young people has declined over the last decade – latest figures show that 6% of 11- to 15-year-olds smoke regularly and that 20% of 16- to 19-year-olds smoke, down from 31% in 1998.⁸³ Action has already been taken to tackle tobacco use by young people such as raising the age of sale for tobacco products, strengthening sanctions against retailers for persistent sale to under-18s and the introduction of hard-hitting picture warnings on tobacco packaging. **The Government will outline further actions to tackle smoking among young people following the recent consultations on the National Tobacco Control Strategy.**⁸⁴

⁸² *Drugs: protecting families and communities*, HM Government, 2008.

⁸³ *General Household Survey 2006: Smoking and drinking among adults, 2006*, E. Goddard, Office for National Statistics, 2008.

⁸⁴ *Consultation on the future of tobacco control*, Department of Health, 2008.

CASE STUDY: Inter-agency working to raise mental health awareness in Southampton

The Child and Adolescent Mental Health Team at Southampton City PCT has devised a first-aid course, 'Emotional First Aid for Young People'. It aims to teach those who work with young people to recognise the signs of mental illness and to help them learn how to provide support, and encourage the person to seek help. Initially, around 50 professionals from education, social care, youth services and health will become emotional first-aid trainers, training others working with children and young people, and significantly increasing mental health awareness and potential for early identification and intervention. The course will bring about many benefits in the community, including better recognition of mental disorders, changes in beliefs about treatment, and decreased social distance from people with mental illnesses. It will also increase the confidence of people who work with young people in providing help. CAMHS also provides a 14-week (halfday per week) course for anybody working with children and young people in the city. It offers insight into specific disorders and aims to increase the knowledge, awareness, confidence and capability in mental health awareness of those who attend.

(v) Enhancing the evidence and skills to inform policy and practice for young people's health services

5.41 Chapter 7 explores the wider skills and capacity issues needed to support this strategy. But the distinct health needs of young people require a distinct response, and professionals need appropriate skills and training. Some issues will require a specialist health response. The Department of Health has supported the Royal Colleges' development of a competency framework for clinicians working with adolescents delivered via e-learning, and will continue to support its roll-out more widely across other professional groups.

5.42 As proposed in *Aiming high for young people: a ten-year strategy for positive activities* (2007), we are exploring the potential for a flexible, skilled specialist adolescent health and wellbeing workforce, offering a range of health and social care in a variety of settings, as determined by local needs assessment, focused on early intervention and health promotion. There will be a strong emphasis on mental health and psychological wellbeing. Non-health professionals

working with young people also need a basic understanding of healthy development, to support them in their roles. For example, the National Youth Agency has recently developed Healthy Youth Work guidelines to ensure that youth workers have the skills to support young people's health and wellbeing.

5.43 The launch of the Association for Young People's Health in February 2008 established the national body to promote and raise awareness of adolescent health and wellbeing issues, relevant training, standards and professional development. **We will expect to see the systematic involvement of young people and their parents in service development, supported by accredited frameworks for young people's involvement such as 'Hear by Right'**.⁸⁵

5.44 We want to strengthen the evidence base on young people's health and wellbeing, and in particular on interventions to support young people in adopting more healthy behaviours. Making best use of existing research evidence will be an important part of this if we are to achieve an impact in the short- to medium-term.

⁸⁵ <http://hbr.nya.org.uk>

We will also explore options for identifying and addressing significant gaps in the evidence base where new research may be needed. Allied to this, we will explore the potential for academic chairs in adolescent health to advance our understanding of adolescence and of how best to meet young people's health needs through appropriate education and service provision.

(vi) Targeting support for vulnerable young people

5.45 Some young people face multifaceted problems as a result of wider social, economic or environmental factors, making them vulnerable to poorer health and wellbeing and to negative wider outcomes and more likely to show the most worrying levels of unhealthy behaviour. For instance, children in low-income households, living in single-parent families, families where parents have low educational attainment, or families where parents are unemployed, are more likely than their peers to suffer from mental health problems.⁸⁶ An analysis of some of the characteristics of the risk factors affecting young people in contact with the criminal justice system shows that:

- Around half have problems with peer and family relationships.
- Two-thirds come from backgrounds where family structure has broken down.
- One-third have been looked after by the local authority.
- Three-quarters have a history of temporary or permanent school exclusion.
- One-third have severe and complex mental health problems.
- A quarter have learning disabilities and 30% have a physical disability.
- Over half have communication, speech, language and literacy problems.
- A high proportion have histories of high levels of smoking and illegal drug misuse, with misuse of alcohol as one of the biggest problems.
- Among these young people, there are high levels of dental health problems, sexually transmitted infections, asthma, and blood-borne virus infections such as hepatitis B and C.

CASE STUDY: Tailoring health services for vulnerable children and young people in Southampton

Access to Health (based in the 'Quay to Health' health suite located at The Quays Swimming and Diving Complex in the city) is a multi-agency project aimed at young people aged 13 to 18 who are looked after by Southampton City Council, care leavers or those who are identified as children in need who are at risk of becoming 'looked after'. It offers this client group a range of health-related services in a 'health-promoting' setting. The environment created is safe and supportive, and aims to encourage young people who may not routinely access mainstream services the opportunity to positively engage with health professionals. Young people are encouraged to undertake a programme in the gym and use the swimming facilities. Health-promoting activities such as arts and health workshops and activity weekends complement the physical benefits, and help build the young people's self esteem. The professionals involved come from a variety of background in the public and third sector. Around 300 young people accessed the service between January and July 2008.

⁸⁶ *Maintaining the momentum towards excellent services for children and young people's mental health*, NHS Confederation, 2007

- 5.46** These statistics make obvious the need for universal services to identify risks early to allow for effective intervention and support. There is also a need for further, targeted support services to meet the additional needs of vulnerable young people, and to support them in taking greater responsibility for their health and wellbeing.
- 5.47** Family Pathfinders, being funded by the Department for Children, Schools and Families, will test the 'think family' approach,⁸⁷ which will consider the needs of the entire family rather than just the individual members within them, in 15 local authority areas. These areas will disseminate the findings across all local authorities aiming to help to tackle inter-generational inequalities and exclusion, and help to enable local families to help themselves. Funding will be available for April 2009 to support all local authorities to deliver 'think family' reforms to help the most vulnerable families. The approach follows four principles:
- **No wrong door** – contact with any service offers an open door into a system of joined-up support.
 - **Look at the whole family** – services working with both adults and children take into account family circumstances and responsibilities.
 - **Provide tailored support to need** – tailored and family-centred packages of support are offered to all families at risk.
- **Build on family strengths** – practitioners work in partnerships with families, recognising and promoting resilience and helping them to build their capabilities.
- 5.48** The Family Pathfinders will introduce an integrated approach to supporting families with complex needs, including better integrated services and multi-agency teams.
- 5.49** We have also committed to increasing the reach of Family Intervention Projects (FIPs) to provide targeted whole-family support, including health services for some of the most vulnerable children and families in the country. FIPs were set up to tackle persistent anti-social behaviour, prevent cycles of homelessness and achieve the five Every Child Matters outcomes for children and young people. New projects will include a focus on preventing offending and reducing child poverty through working with families with problems known to lead to poor child outcomes such as substance misuse, domestic violence and mental health issues. The Government aims for the projects to have reached 20,000 families by 2011.
- 5.50** The expansion of FIPs will be delivered in partnership with local health services, which will help tackle issues around domestic violence, mental ill-health and substance misuse in vulnerable families. Current projects have

CASE STUDY: Family Intervention Projects

Sue, the key worker for a family involved in a Family Intervention Project, was concerned that all of the children in the family had weight problems. Sue arranged for the children to have school dinners, rather than packed lunches, to help control their lunch portions and ensure that they were getting a nutritional meal at lunch times. She discussed healthy eating with the mother and encouraged her to walk her children to school rather than take the car. She also convinced the father to take the children to the park at weekends to play football, and encouraged the children to join after-school sports clubs. This resulted in the children losing weight.

⁸⁷ www.cabinetoffice.gov.uk/social_exclusion_task_force/news/2008/080110_families.aspx

developed the role of a 'nominated health professional' to ensure that families are fast-tracked to the health services that they need. A recent evaluation of FIPs (July 2008) found a number of improvements in health and parenting. Additionally, the proportion of families to have issues with domestic violence reduced by two-thirds, and the proportion of families with child protection issues by the time they left the project was halved (21% to 10%).

5.51 Previous commitments have been made to test different interventions to tackle mental health problems in at-risk children and young people, to prevent the onset of additional problems later in life.

5.52 Multisystemic therapy (MST) is an evidence-based community programme now being piloted to support young people and their families, where those young people are at risk of out-of-home placement in either care or custody. MST teams work with young people and their families to increase parenting capacity, to increase young people's engagement with education and training, to promote pro-social activities for parent and child, to reduce young people's offending behaviour, to increase family cohesion and to tackle underlying health or mental health problems in the young person or parent, including substance misuse.

5.53 Eight pilot sites were operational at the end of 2008 with two further sites due to come on stream in early 2009. **An additional MST programme for child abuse and neglect (MST-CAN) is currently being developed and will become operational in a single site by June 2009. A national research programme, including a randomised control trial, has been commissioned to monitor outcomes for young people and families to assess the cost-effectiveness of the programme.**

5.54 **A health and social care strategy for children and young people in contact with the Criminal Justice System** is being developed to address the following objectives:

- To secure the engagement of young people and their families and support their use of the appropriate mainstream services, including registration with a GP and re-entry to school, further education or training/employment.
- To assess needs, and design a health delivery plan that will make up for missed preventive support, early intervention and treatment that will be of benefit.
- To secure co-ordinated, multifaceted care tailored to individual needs, and negotiate a safe and effective transition to appropriate adult provision.



**SERVICES FOR
CHILDREN WITH ACUTE
OR ADDITIONAL HEALTH
NEEDS**

6.1 Ensuring that services are of high quality and are responsive to the needs and expectations of those who use them is especially important when children and young people have acute or additional health needs.

6.2 This chapter explains the range of support and services for children and young people with additional, complex or acute health needs. It sets out the approach and some of the existing initiatives that apply to this group, and puts forward policies that will further support these children and their families. It also:

- Clarifies the funding available in the NHS over three years for palliative care and end-of-life services, short breaks, community equipment and wheelchair services for disabled children and young people – this funding will total £340 million in NHS allocations over three years from 2008-09, in addition to the £340 million revenue funding already announced for local authorities.
- Sets out plans to test and expand new approaches to the provision of services – for example by extending innovative work on wheelchair services in Tower Hamlets to other parts of London.
- Promises that all children with complex health needs will have an individual care plan by 2010, to address the frustrations faced by parents of children with complex health needs when navigating between numerous different services.

The spectrum of acute or additional health needs

6.3 Most children are likely to be sick at some point during their childhood. The majority of their health needs will be dealt with in the home, perhaps with some additional advice from NHS Direct, a health visitor or a GP.

6.4 More serious needs – in terms of urgency or complexity – will require more specialist support, perhaps in hospital or via specialists in other community settings. Some children will have ongoing additional health needs – they may have a disability, or a long-term or complex physical or psychological condition that needs to

be managed. Some conditions will be relatively common, while others will be very rare. A small number of children will need end-of-life care and some will have palliative care needs over years rather than months.

6.5 The following statistics give a flavour of the prevalence of these needs in a typical year in an average-sized health community with a population of around 80,000 children and young people up to the age of 18.⁸⁸

- There will be around 18,000 GP consultations with children and young people up to the age of 18.
- There will be around 19,000 emergency attendances at A&E by children and young people (0- to 16-year-olds).
- About 3,800 will be admitted to hospitals via emergency departments.
- Around 7,800 will have asthma; over 300 will have epilepsy; around 100 will have diabetes (though only one or two of those will have type 2 diabetes); around 35 will have sickle cell disease; and around 30 will have cystic fibrosis.
- Around 7,500 5- to 15-year-olds will have a recognisable mental disorder.
- Around 4,000 will have a physical disability – of whom around 130 will be referred to wheelchair services.
- Over 10 will be diagnosed with cancer.
- Around 125 will need palliative care.⁸⁹

The challenges of meeting these acute or additional health needs

6.6 Behind these figures lie a number of challenges and opportunities for health services, reflected in the work that strategic health authorities (SHAs) have begun on pathways of care for children as part of the *NHS Next Stage Review*. The high number of children and young people's attendances in primary care highlight the need for GPs and their teams to provide age-appropriate services and to have the right training, skills and competencies to recognise serious illness in children and fulfil their safeguarding obligations.

⁸⁸ Primary care trusts (PCTs), with their local partners, are responsible for commissioning health services in a local area. An average PCT has a population of around 340,000 of whom some 78,200 will be aged under 19. The figures listed are approximations based on a variety of different sources.

⁸⁹ Children's palliative care is concerned with the treatment of children with life-limiting or life-threatening conditions. It meets the need to maintain quality of life, not just in the dying stages but also in the weeks, months and years before death, and is characterised by concern for symptom relief, promotion of general wellbeing, and psychological and social comfort for the children and their families. *Palliative Care Services for Children and Young People in England. An independent review for the Secretary of State for Health*, Professor Sir Alan Craft and Sue Killen, 2007.

6.7 Acute illness or injury in children brings challenges – symptoms will often manifest themselves differently in children than in adults so specialist paediatric skills are needed. Some of the skills required are highly specialised or dependent on other specialist services.⁹⁰ These services need to be delivered through sustainable clinical networks of care, to ensure that mental and physical healthcare is of high quality, located in appropriate settings and as close to home as possible. This applies to surgical as well as to medical services.⁹¹ Establishing local networks for the provision of urgent care for children can lead to improvement in care by ensuring best use of the paediatric skills of the local workforce.⁹²

6.8 We know that many children and young people with long-term conditions have not benefited from the improved health outcomes experienced by adults with long-term conditions. For instance, a recent audit showed that 84% of children under 16 with diabetes in England and Wales had poor or very poor diabetic control.⁹³ Asthma UK estimates that 75% of hospital admissions for children with asthma are preventable. The outcomes of the many rare disorders are more difficult to compare. The need for children with long-term conditions and those with complex continuing care needs to have access to high-quality specialist services, when needed, and appropriate care – including community nursing services – close to home, requires services to be delivered through effective networks of care.

6.9 Indications are that more children than ever before with a severe disability and complex needs are living longer – in many cases into adulthood. This is due to a number of factors, including increased survival of pre-term babies, advances in technology and breakthroughs in medical science. This has significant implications for families, child and adult service providers and the broader community.

6.10 Work undertaken as part of this strategy with parents of disabled children highlighted some of the frustrations and difficulties that remain in navigating health, education and social care systems, punctuated by individual experiences of good service. Children and families can still encounter professionals with relatively poor knowledge of a child's condition; experience a fragmentation of services for children with complex health needs; or encounter variability in services available between different areas.

The current approach to providing services for children and young people with acute or additional health needs

6.11 Families, children and young people need to know how to get the right help to cope with sudden, short-term physical or mental illness, with long-term or complex medical conditions, with disabilities, and with palliative and/or end-of-life care. As summarised in the following table, they want timely, accessible, high quality support, tailored to their needs – allowing for choice over how care is provided. They also need the range of universal services described in previous chapters to be inclusive and responsive to their needs.

6.12 While some highly specialised services will need to be provided from centres of expertise, as far as possible people want help to manage health needs in ways that minimise disruption to family life, to the child's wider development, and to their participation in education and social activities. This is consistent with the service vision set out in the National Service Framework.

6.13 A number of 'exemplars' have been published, supporting services by articulating best practice in care for children with specific conditions – such as asthma, acquired brain injury, autistic spectrum disorders, continence issues, and support for children requiring long-term ventilation, in the community.

⁹⁰ *Commissioning Safe and Sustainable Paediatric Services. A Framework of Critical Inter-Dependencies*, Department of Health, 2008.

⁹¹ *Surgery for children – delivering a first class service, Report of the Children's Surgical Forum*, Royal College of Surgeons, England, 2007.

⁹² *Modelling the Future II*, Royal College of Paediatrics and Child Health, 2008; *Services for Children in Emergency Departments*, Royal College of Paediatrics and Child Health, 2007.

⁹³ Based on the percentage of children and young people under 16 within National Institute for Health and Clinical Excellence (NICE) HbA1c target bands, National Diabetes Audit, England and Wales 2005-06.

High quality	Care that is safe and effective, delivered swiftly by professionals with the right skills in an appropriate setting.
Personalised	Personalised, multi-agency co-ordinated services from the point of referral through identification and assessment to delivery. Assessments should include consideration of mainstream, inclusive options, and should set out individual support plans. Care should be as close to home as possible.
Participation and feedback	Routine involvement of children and young people in need of specialist support and their families to help them make informed decisions about their treatment, care and support, and to assist in shaping services.
Information and transparency	Information tailored to the needs of children and their parents, in a readily accessible range of formats. Transparency about resources, and how services work together and are commissioned.

6.14 The *NHS Next Stage Review's High Quality Care For All* report set a new foundation for a national health service that empowers staff and gives patients choice. It seeks to ensure that healthcare will be of high quality and personalised. Over the past few years the Government has, with the support of children and families, other independent experts, clinicians and the third sector, undertaken a number of pieces of work to identify what 'high quality and personalised services' means for groups of children with specific additional health needs. These build on the principles set out in the National Service Framework and through Every Child Matters.

6.15 An expert working group has considered issues regarding anaesthetic and other services available to children in hospitals who are critically sick or injured, resulting in a set of recommendations.⁹⁴

The recommendations stressed the need for care to be delivered through managed clinical networks⁹⁵ making the best use of specialist expertise, standardising care, and improving access. These themes are consistent throughout recent work on specialist services to support children with additional health needs. For instance, the principle of managed clinical networks is particularly important for neonatal services – services providing care for premature or sick newborn babies.

6.16 A Neonatal Taskforce was formed in February 2008, in part to take forward the recommendations of a recent report on neonatal services⁹⁶ and to consider how networks of neonatal care can be best supported.

⁹⁴ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062668

⁹⁵ Managed clinical networks are defined as 'a linked group of health professionals and organisations from primary, secondary and tertiary care and social care and other services working together in a co-ordinated manner with clear governance and accountability arrangements (Department of Health policy collaborative, 2004).

⁹⁶ *Caring for vulnerable babies: The reorganisation of neonatal services in England*, National Audit Office, 2007.

- 6.17** Similarly, the NHS standards and guidelines for clinical care of sickle cell disease in childhood make a strong case for the need for managed networks to address both the clinical and social impacts of the disorder. Sickle cell disease is now the most common genetic condition in England, affecting more than 1 in 2,000 live births, with the highest prevalence occurring in people of African and African-Caribbean origin.⁹⁷
- 6.18** In 2007 the National Clinical Director for Children, Young People and Maternity Services set out the clinical case for change in services for children and young people, in *Making It Better: For Children and Young People*.⁹⁸ The report outlined how services are being reconfigured to meet the needs of young patients and stressed the need for services to be local where possible, and specialist where necessary; and the need for children, young people and their parents to be fully engaged in making informed choices about their care and in planning of services. It highlighted that children with long-term conditions, in particular, benefit from having their hospitalisations minimised where possible, and their support in the home or community enhanced by the reorganisation of service delivery.
- 6.19** For young people with long-term conditions or ongoing mental health problems, it is important that care and support do not fall away or become fragmented as they come into contact with adult services. A guide on *Transition: getting it right for young people* has been published, setting out measures to improve the transition of young people with long-term conditions from children's to adult health services.⁹⁹ It includes an audit framework to support commissioners and providers in designing services. The transition between young people's and adult services is particularly important in mental health, where services for 16- to 24-year-olds continue to develop.
- 6.20** Independent reviews add value by providing external views of how well services are doing in meeting the needs of their users, and providing expert opinion on where improvements can be made. Through the Children and Adolescent Mental Health Services (CAMHS) Review, independent experts were asked to develop recommendations to improve the emotional wellbeing and mental health of children and young people and to improve delivery of services to meet the educational, health and social care needs of children and young people at risk of and experiencing mental health problems.
- 6.21** The CAMHS Review's final report published in November 2008¹⁰⁰ highlighted that considerable improvements have been made to the support and services delivered in this area, but that there is still a great deal of change that needs to take place at all levels of the system, to support the delivery of integrated, child and family-focused mental health and psychological wellbeing services that are organised around children and young people's needs. The review makes 20 challenging recommendations to Government across all aspects of children's mental health and psychological wellbeing services.
- 6.22** The Government has set up a National Advisory Council to act as a champion for children's mental health and psychological wellbeing issues, advise Government on implementing the recommendations that have been set out in the Review's report and hold Government to account for successful delivery. It will also set up a National Support Programme to support local areas to deliver on this challenging agenda.
- 6.23** The Government has also agreed in principle to take forward, as soon as practicable, other key recommendations within the report on improving access for children, young people and their families to mental health support through universal services; improving the access, quality and impact of mental health services

⁹⁷ *Sickle Cell Disease in Childhood: Standards and guidelines for clinical care*, NHS Antenatal and Newborn Screening Programmes, 2006.

⁹⁸ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065036

⁹⁹ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4132145

¹⁰⁰ *Children and young people in mind: the final report of the National CAMHS Review*, 2008.

CASE STUDY: Joining up support for disabled children through the Early Support Programme

The Government's Early Support Programme (ESP), hosted by the Royal National Institute for Deaf People (RNID), has made a real difference to the lives of young disabled children and their families, providing them with joined-up, co-ordinated services and better, more accessible information. ESP promotes the 'team around the child' approach, providing a structured framework for lead professionals who are taking on a key worker role with families – a role that we know makes a real difference to their lives. Having started as a small pathfinder project in 2003 to test out different approaches to support young disabled children, ESP is now a mainstream government programme. The ESP approach has now been introduced to nearly 90% of local authorities across the country – providing them with training, materials and the culture change required to make a real difference to families on the ground.

for vulnerable children and young people; and ensuring that parents and carers have access to high quality advice and support when they are concerned about their children's mental health; and improving the access, quality and impact of mental health services for vulnerable children and young people, including those with autism.

6.24 John Bercow MP's recent *Review of Services for Children and Young People with Speech, Language and Communication Needs (SLCN)*¹⁰¹ shone a spotlight on a crucial set of services, to help shape and target support at a time of record investment. The Government welcomed the report and published *Better Communication: An Action Plan to Improve Services for Children and Young People with SLCN* in December 2008.¹⁰² The Action Plan provides details of a range of initiatives to improve services for children and young people with SLCN, including those with the most severe speech and language impairments, culminating in the National Year of Speech, Language and Communication in 2011-12.

6.25 Through the wider Aiming High for Disabled Children Programme, the Government has published national expectations of how disabled children and families in every area can expect

services to be provided – the 'core offer' – and has already announced £340 million revenue funding for local authorities to deliver the programme in addition to £90 million capital funding announced in the *Children's Plan*.¹⁰³ Local services have also been provided with advice on targeting health promotion, on issues such as oral health,¹⁰⁴ for disabled children.

6.26 An independent review was also conducted on palliative care services for children and young people, informing *Better Care: Better Lives*¹⁰⁵ – the first national strategy for children's palliative care. The strategy's service development goals cover improved data; equality of access to universal services; responsible and accountable leadership; choice of preferred place of care; better end-of-life care; stronger commissioning and value for money; successful transition between children's and adult services; and planning and developing an effective and responsive workforce. Progress will be monitored through a senior stakeholder group.

Further improvements for children and young people with acute or additional health needs

6.27 All of these pieces of work have been crucial in setting out specific elements of good practice

¹⁰¹ www.dcsf.gov.uk/bercowreview

¹⁰² *Better Communication: An Action Plan to Improve Services for Children and Young People with Speech, Language and Communication Needs*, DCSF, December 2008, www.dcsf.gov.uk/slnaction/

¹⁰³ For details of the programme see: www.everychildmatters.gov.uk/ahdc

¹⁰⁴ *Valuing People's Oral Health: A good practice guide for improving the oral health of disabled children and adults*, Department of Health, 2007

¹⁰⁵ *Better Care: Better Lives. Improving outcomes and experiences for children, young people and their families living with life-limiting and life-threatening conditions*, Department of Health, 2008.

in meeting acute or additional health needs for specific groups of children. Many of the issues and challenges identified are consistent across a range of needs, while others are very specific to a particular condition. The following section identifies both regional and national steps to tackle some of the cross-cutting challenges for services for children with acute or additional health needs. The regional steps have been identified through the work of SHAs in developing future visions of care for children that are based on local needs and priorities:

- (i) Improving information
- (ii) Securing the right skills and roles
- (iii) Personalising care
- (iv) Service redesign – driving up quality

as well as some of the challenges specific to particular services:

- (v) Services for disabled children and those with complex health needs
- (vi) Access to allied health professionals and psychological therapy services

(i) Improving information

6.28 All families need to be confident that they can access experienced professional advice and support at any time of day or night in the event of illness. In their work on the children's care pathway, SHAs have highlighted the importance of clear local information on sources of urgent help and out-of-hours support. Local plans to tackle this include instituting public information campaigns to support understanding of children's care pathways;¹⁰⁶ and simplifying points of access for out-of-hospital services for children.¹⁰⁷

6.29 But the importance of information for parents and young people on the availability of local services is not limited to acute needs. It is also vital for children and young people with

ongoing additional needs, and the Government's Action Plan *Better Communication* recognised its importance for families with children with speech, language and communication needs. Work already planned to improve information includes:

- Publication by PCTs of patient prospectuses for people of all ages.
- Strengthening the information available through NHS Direct and NHS Choices.
- A national core offer, which sets out the standards that disabled children, young people and their families can expect in relation to information – this will cover access to universal as well as specialist services.¹⁰⁸

6.30 Building on this, we will expect partners in Children's Trusts to work together to ensure that they make information available on the local service offer, setting out what local support is available and how and where it can be accessed. This should include links to local support groups and third sector organisations. Chapter 7 provides further detail.

(ii) Securing the right skills and roles

6.31 SHAs also recognised the importance of key staff in frontline services having skills and experience in diagnosing and supporting the acutely ill child, and some identified the need to improve paediatric experience in primary care.

6.32 Chapter 7 sets out a package of measures around improving the skills and capacity of the workforce. We have also begun a study with a consortium of Royal Colleges, which will assess children's urgent and emergency care pathway from primary to secondary care. This will use the National Institute for Health and Clinical Excellence (NICE) guidelines *Feverish illness in children: Assessment and initial management in children younger than 5 years* as an indicator condition. We expect the study to report in June 2009.

¹⁰⁶ North East Strategic Health Authority.

¹⁰⁷ South East Coast Strategic Health Authority.

¹⁰⁸ www.everychildmatters.gov.uk/resources-and-practice/IG00320/

CASE STUDY: Integrating services in Walsall for children who have complex needs

Team Around the Child (TAC) in Walsall was established in 2002 for children aged up to 5 years who have complex needs. This has improved co-ordination of early intervention, resulting in truly integrated services which are family centred and provide support that is needs led. Initially this is achieved through a meeting between the child and their family and TAC team members, to gather the family story and then to begin to identify those support services required. Early provision aims to meet the most pressing needs while exploring longer-term concerns and hopes. This is followed by the allocation of a team tailored to meet the individual needs and introduced at a pace that suits the family. Progress, success and celebration are promoted in a model of delivery that truly focuses on the child and family rather than being a medical, educational or social model of delivery. The Family Service Plan (FSP) enables the team to monitor progress and share celebrations while setting new steps and ensuring that interventions are integrated and co-ordinated. The team is pulled together through the role of the key worker who may act in one or more of many roles, e.g. co-ordinator, befriender, information source, signposting services. As a result of establishing TAC, transition has become an integral part of the journey for the family and their team in ensuring smoother transit on into school.

- 6.33** We will then **develop models of best practice which can support commissioners and providers to improve services for children and young people who need urgent and emergency care. Within guidance on the national standard contract for community services there are four service specification examples of good practice.** The four areas covered are Urgent Care, Children and Young People with Complex Needs, the Healthy Child Programme, and Child and Adolescent Mental Health Services provided within the community.
- 6.34** Children and families also need support to manage ongoing physical and psychological conditions. It is particularly important that children and young people have the right support in managing acute or additional health needs in school settings, so that they have every opportunity to thrive. We know there is variability across local areas in how well children with long-term conditions are supported in school. While in some cases parents report total satisfaction, others report a failure of health and education services to work together effectively to support the needs of individual children.
- 6.35** To make use of their expertise to build services around the needs of children and families, we are working with the third sector. For example Diabetes UK is leading a project to better understand the extent of good and bad practice. Our work with the third sector both as part of the Government's consultation on the 21st Century School and outside it, will inform work with schools to support children with additional health needs.
- 6.36** We will also update and reissue our guidance on **Managing Medicines in Schools and support this with a new awareness-raising campaign. This will include guidance relating to children with complex health needs as well as clear statements of expectations of different partners, including schools and PCTs. We will develop this guidance in consultation with expert organisations such as Diabetes UK.**

6.37 Community children's nurses have a role in working with schools, primary care and families in supporting children with identified health needs outside hospital. They provide advice and treatment and monitor progress – and are the bedrock of local service provision for children and young people with disabilities, long-term conditions and complex health needs. They are often best placed to take on the role of a lead professional, liaising with other agencies on behalf of, or in collaboration with, the child and family to ensure that their wishes, views and choices inform their ongoing care and to explore how best to move towards a multi-disciplinary approach and a more integrated care package in the location of the child and family's choice.

6.38 Commissioners will need to consider how to support the development of community children's nursing services capable of providing an all-round care package, including end-of-life care, 24 hours a day, seven days a week in the location preferred by the child and family.

6.39 **For the health workforce, we will work in partnership with staff to develop an effective approach to supporting the health needs of vulnerable children through a multi-disciplinary community children's service, of which nursing will be a central component.** We will look at links with other professions and give clarity on the role of the community children's nurse, the services they provide and models of care delivery that will respond most effectively to care closer to home, parental choice and the needs of children with complex and/or continuing care needs.

(iii) Personalising care

6.40 Personalising care for children and families means delivering care as close to home as possible; working across service boundaries to co-ordinate care around the needs of individual children and families; and delivering age-appropriate services. Children, young people and

their parents need to be engaged effectively in the design of services, and have a meaningful voice in the assessment of services, if care is to become truly personalised.

6.41 For children and young people, the concept of care closer to home needs to include support to maximise their participation in education and other social and developmental activity. So thinking about the pathway and the multi-disciplinary team around the child needs to extend to education as well as social care. It is also important to consider the need for psychological wellbeing to be integrated with physical healthcare, recognising that children with long-term physical conditions also have increased rates of mental health problems.

6.42 Children with ongoing acute or additional health needs should experience services organised around those needs. **By 2010, all children with complex health needs will have an individual care plan.** Work will be undertaken to ensure that these build on the existing Common Assessment Framework and Care Programme Approach used in CAMHS, and the existing co-ordination roles of key workers and lead professionals in children's services. **There will be pilots to test and evaluate new and innovative ways of providing better integrated care as part of the NHS Next Stage Review and these will take account of commitments to promote better integration around primary and community services for people of all ages.** There are specific instances where plans for personalised budgets can offer parents more control over decisions on their children's care, to suit their personal circumstances and choices.

6.43 Young people coping with disability, a long-term condition or other complex healthcare needs, and their families, will often become experts in their own care. The Young People's Expert Patient Programme – Staying Positive – has been developed in response to the National Service

CASE STUDY: Providing age-appropriate treatments for teenagers

The Melanie Richardson Adolescent Unit is a 12-bedded unit within the Oxford Children's Hospital, comprising two four-bed wards and four single rooms, complete with dayroom, school room and high-tech equipment and facilities such as broadband access which helps the young people maintain links to their schools. It mainly treats 13- to 16-year-olds (excluding obstetrics and significant mental health cases) plus some older young people with long-term conditions. There is a strong focus on outpatient and daycare facilities, allowing young patients wherever possible to return home at night, as they have said they prefer. The hospital's Young People Executive (YIPPEE) – over a dozen 8- to 15-year-olds – advises on design and approach. Nurses on the unit liaise with up to 30 different consultants who provide care for the young patients.

Framework's commitment that young people should have the same access to self-care support as adults.¹⁰⁹

6.44 The children's self-management programme has been designed and piloted, with evaluation showing improvements by participants in medication adherence, communication with healthcare professionals, self-confidence, peer issues and school attainment. It has been shown to have particular value in supporting young people as they make the transition to adult services.

6.45 **The Government will promote the development of self-management programmes for children and young people being delivered through the voluntary sector and social enterprise, and will**

encourage local areas to assess how self-management programmes can be made available to their local communities.

6.46 Personalised care also means ensuring that services are provided in a way that is appropriate to the needs of particular age groups. Importantly, we know that this can improve outcomes as well as the quality of experience for children and young people. Teenagers in hospital are a case in point: when treated in dedicated adolescent facilities, they are more likely to report excellent care and to feel secure. Similarly, it is important that professionals have the right skills and experience to provide an age-appropriate service. For instance, professionals coming into contact with teenagers need to be able to recognise and identify support for young people who may have been self-harming.

6.47 There is also a need to strengthen the evidence base for many aspects of treatment of childhood conditions, to guide quality improvements that are comparable with those in adult care. For instance, a large number of medicines used for treating children are not licensed for children. In the last two years, the National Institute for Health and Clinical Excellence (NICE) has produced a number of clinical guidelines on childhood conditions, and the Medicines for Children Research Network has been established to start to address some of the gaps in evidence. In future, European Union regulations will encourage research on new medicines in children, but the need to secure a strong evidence base to underpin current treatment practices with existing medicines will remain.

(iv) Service redesign – driving up quality

6.48 Extensive consultation with stakeholders and work on the *NHS Next Stage Review* has highlighted strong commissioning as key to improving the range of services for children and young people with additional health needs.

¹⁰⁹ www.staying-positive.co.uk/

Strengthening the commissioning of appropriate acute care for children and young people is also key to ensuring safe and sustainable services. SHAs will have a role in ensuring that robust arrangements are in place, and that they draw effectively on the clinical leadership of paediatricians.

- 6.49** The redesign of services that allows care to be local where possible, and specialist where necessary, requires trusts to ensure that there is the appropriate paediatric workforce in acute settings to provide 24-hour safe and high quality services. Meeting the requirements of the European Working Time Directive brings additional challenges. Work with the Royal College of Paediatrics and Child Health to consider these challenges will be prioritised, so that local areas can be supported in the modelling of services.
- 6.50** Regional SHA visions for children's services emphasised the need for care pathways and clinical networks to drive quality and services design. We will support local clinical leadership and local plans through the national enabling strategies of the *NHS Next Stage Review*.
- 6.51** The typical population data set out in paragraph 6.3 demonstrates that different commissioning arrangements may be needed for different services. For instance, there will be some very specialist aspects of services for the smaller groups of children with complex conditions that may need to be commissioned across larger areas than the PCT, reflecting agreed care pathways and clinical networks. To support improvements across the full spectrum of need, **a joint commissioning framework for children's health services is being published alongside this strategy.**¹¹⁰ This will set a context within which specific problem areas can be tackled – whether within or alongside Children's Trust arrangements.

- 6.52** The Bercow Review¹¹¹ into services for children with speech, language and communication needs (SLCN) clearly set out the variability in speech and language therapy provision. As announced in *Better Communication: An Action Plan to Improve Services for Children and Young People with SLCN*, published in December 2008,¹¹² **the Government will help children's services and primary care trusts to jointly commission better specialist SLCN services, including communication aids, for those that need them by developing and learning from good practice through pathfinders in up to 20 areas.**

- 6.53** The Government wants lessons to be learned nationally, so the pathfinders will inform development of a supplemental joint commissioning framework on SLCN and guidance for all areas. Improved joint commissioning will help all children with SLCN whether primary, like specific language impairments or a stammer, or secondary and related to another need, like autistic spectrum disorders or physical disabilities.

- 6.54** We will also look to prioritise work to improve the commissioning and provision of equipment



¹¹⁰ *Securing better health for children and young people through world-class commissioning: A document to support delivery of Healthy lives, brighter futures*, Department for Children, Schools and Families/ Department of Health, 2008.

¹¹¹ *The Bercow Report: A Review of Services for Children and Young People with Speech, Language and Communication Needs*, Department for Children, Schools and Families, 2008.

¹¹² *Better Communication: An Action Plan to Improve Services for Children and Young People with Speech, Language and Communication Needs*, DCSEF, December 2008, www.dcsf.gov.uk/slcnaaction/

CASE STUDY: Developing targeted and specialist support with third-sector providers (Whizz-Kidz)

The partnership between Whizz-Kidz and Tower Hamlets PCT gives local disabled children and young people access, for the first time, to customised mobility equipment and wheelchair skills training that meets their complete needs in school, at home and at play. The partnership provides advice, equipment and support from a child's early years right through the transition to adulthood, enabling them to live more independently in the future. In 2007, Whizz-Kidz and Tower Hamlets Wheelchair Services worked together to quantify the local need, and collectively identified children under the age of 18 who were currently unable to access a wheelchair that met their clinical, educational and social needs. Following one year of partnership working, in April 2008 the PCT invited Whizz-Kidz to become the lead provider of the wheelchair service for children and young people in Tower Hamlets.

for disabled children more widely. We know that there are a range of barriers to effective commissioning, and new projects will look at:

- **Action to develop a more responsive market for community equipment for children.**
- **Working jointly with commissioners and providers, including the third sector, to develop commissioning models for children's equipment, including regional or sub-regional commissioning, and run a programme of regional pilots to start in 2009-10.**

6.55 To improve joint commissioning and the provision of wheelchairs for children, a partnership will be established between Whizz-Kidz and the London SHA, in conjunction with PCTs and local authorities. This will build on the already successful, innovative model being used by Whizz-Kidz in partnership with Tower Hamlets PCT (see case study opposite). It will focus on commissioning, training, support and advice to disabled children and young people across London. The partnership will ensure that a greater number of children get the wheelchairs they need, when they need them, and will help them to secure maximum independence.

6.56 The Autism Education Trust was established by the voluntary sector in November 2007, with funding from the DCSF, to improve the co-ordination and provision of services for children with autism. The Trust's review of provision for children and young people with autism found that there is significant scope for improvement in local outreach and support services and how outcomes for children are monitored.¹¹³ In conjunction with the DH and DCSF jointly sponsored support provided by the Commissioning Support Programme across all aspects of children's commissioning, **we will also fund the Autism Education Trust to make support for local authorities and PCTs to improve the commissioning of services for children with autism a priority for its work in 2009-10.**

6.57 Further work will also be put in hand to support stronger commissioning of the full pathway for CAMHS, in line with the recommendations in the final report of the independent review of CAMHS. This will be underpinned by the NHS Standard Contract for Mental Health and Learning Disability Services. The standard contract sets out a range of nationally mandated requirements, such as care planning, requirements for local determination and

¹¹³ *Educational provision for children and young people on the autism spectrum living in England: a review of current practice, issues and challenges*, Autism Centre for Education and Research, University of Birmingham, November 2008.

agreement as well as the development of detailed service specifications.

6.58 Quality standards and quality measures will also support improvements in service quality and experience, and work will be undertaken nationally to complement locally developed quality standards and measures. Work across the NHS is in hand to develop quality standards for neonatal services which will be launched in summer 2009 to provide NHS trusts and commissioners with the tools to benchmark and set indicators to drive up quality.

6.59 Performance indicators have already been developed across a range of service areas (Annex B) and further work is under way to develop indicators on emotional health and wellbeing services, and on the experience of services by parents of disabled children. Over time, information on performance of clinical networks will include information on children's outcomes, to help identify weaknesses in pathways of care and to drive up quality.

(v) Services for disabled children and those with complex health needs

6.60 In *Aiming high for disabled children (AHDC)*,¹¹⁴ the Government set out measures designed to transform the experience of services for disabled children and their families. This comprehensive programme includes a range of measures to support access and empowerment for disabled children and families, responsive services and timely support, and improved service quality and capacity.

6.61 In addition to the £340 million revenue funding already announced by the Department for Children, Schools and Families for the AHDC programme, the Government is investing a further £340 million as part of PCT allocations to cover the three-year period from 2008-09 to 2010-11, to support the NHS in delivering commitments made around palliative care,¹¹⁵ short breaks, and community equipment and wheelchair services. This will enable health, social care and education commissioners and providers to work together locally to build more responsive services.

6.62 The additional £340 million includes £30 million to meet commitments made for children and young people in need of palliative care and



¹¹⁴ *Aiming high for disabled children: better support for families*, Department for Education and Skills and HM Treasury, May 2007.

¹¹⁵ *Improving outcomes and experiences for children, young people and their families living with life-limiting and life-threatening conditions*, Department of Health, 2008.

end-of-life care – including capacity building, 24-hour crisis support and short breaks. These commitments are being taken forward locally and regionally, through networks of care. Ministers will continue to chair an oversight group to monitor progress nationally and to advise on barriers to embedding the long-term goals of the *Better Care, Better Lives*¹¹⁶ strategy.

6.63 Children's 'continuing care' is a general term that describes a package of care needed over an extended period of time for children with complex healthcare needs that arise because of disability, accident or illness. The Government has consulted on a national framework for assessing children's continuing care to support more consistent and transparent local assessment arrangements.

6.64 One of the proposals set out in *Aiming high for disabled children* was to pilot individual budgets for disabled children and young people. Following scoping work and building on existing practice in developing individual budgets for adults, **a number of local authorities – with their PCT partners – will shortly be invited to express an interest in becoming a disabled children individual budget pilot area**, to test approaches to give young people and their families more control over their care.

6.65 Offering greater choice and control to disabled young people in the transition from childhood to adulthood is a priority. In addition to individual budget pilots, the £19 million Transition Support Programme which the Government launched in December 2008 will tackle the barriers that prevent local authorities and PCTs from meeting their duties towards disabled young people to ensure that they experience a smooth transition to adult life, with the right support to make choices that other young people take for granted. The programme will focus on those with the most complex needs, including children

with autism whose needs services can struggle to meet.

6.66 The Department for Children, Schools and Families and the Department of Health have published good practice guidance for children's services, health professionals and their partners on effective transition planning for young people with complex health needs or a disability.¹¹⁷ Wider partners include housing, transport and employment services, and they need to come together to ensure that young people make the transition into adulthood with support for independence, choice and inclusion – key themes of the Valuing People programme.¹¹⁸

(vi) Access to allied health professional services and psychological therapies

6.67 Though data is not collated nationally, we know from our engagement with children, young people and stakeholders that effective access to allied health professional (AHP) services, such as physiotherapy and occupational therapy, remains variable. Many SHAs are working with their partners on delivering sustainable improvements.

6.68 The improved AHP service offer announced in October 2008, and reinforced through the NHS Operating Framework for 2009-10, is inclusive of AHP services. It has three components: collection of referral to treatment data for all AHP services backed by service improvement support; encouraging the local extension of self-referral to AHP services to improve ease of access; ensuring quality metrics developed are inclusive of the AHP contribution and empowering patients to have more control. We will ensure that this work explicitly addresses the accessibility and quality of AHP services for children.

¹¹⁶ *Better Care: Better Lives. Improving outcomes and experiences for children, young people and their families living with life-limiting and life-threatening conditions*, Department of Health, 2008.

¹¹⁷ www.everychildmatters.gov.uk/resources-and-practice/IG00322

¹¹⁸ www.valuingpeople.gov.uk/index.jsp

6.69 The Government will work with the SHAs who identified this as a priority issue through the *NHS Next Stage Review* as pathfinders in improving access to allied health professional services for children and young people, and will share the learning nationally. We know some areas have successfully included all allied health professional services within a model whereby no child or young person will have to wait longer than 18 weeks between referral and treatment. The learning from SHAs' work will inform the ongoing exploration of options to improve access to allied health professional services, in order to ensure that the quality of service children and young people receive is consistent with the broader improvements experienced in other areas of healthcare.

6.70 The Government has already announced additional funding rising to £173 million by 2010-11 for the development of increased psychological therapy services. An improving Access to Psychological Therapies programme has been established with the aim of supporting PCTs in implementing the National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from anxiety disorders. Eleven pathfinders have been established to develop defined care pathways and service specifications. The pathfinders each identified an interest in addressing the specific barriers and positive benefits for improving access to psychological therapies for particular sections of their local population. They included the following PCTs, with their associated special interests:

- Hertfordshire PCT: New Mothers and Fathers
- Salford PCT: New Mothers and Fathers
- Bury PCT: Children and Young People.





MAKING IT HAPPEN:
**SYSTEM-LEVEL
TRANSFORMATION**

7.1 The individuals and organisations that lead, plan and deliver child health services are crucial to the success of this strategy. They are the commissioners of health promotion services and services for children who are sick or who have ongoing, additional health needs. And they are the frontline staff working with children and families.

7.2 This chapter sets out a simplified model for children’s health delivery, in addition to proposals for the further support that will be given to help these individuals and organisations deliver improvements for children and their families. These include commitments to:

- Promote joint leadership and strengthen local accountability arrangements for children’s health, including putting Children’s Trust Boards on a statutory footing, and transforming the Children and Young People’s Plan from a local authority plan into one owned by the Children’s Trust Board.
- Promote action to ensure that all organisations with responsibility for child health and wellbeing are fulfilling their statutory responsibilities for safeguarding children.
- Introduce a high-level joint commissioning guide to support local authorities and health bodies (in particular PCTs) to commission child health services (the guide is published alongside this strategy).
- Promote better use of data, including development of minimum datasets for child health and models for the planners and commissioners of services, for example

to improve local authorities’ and PCTs’ understanding of the complex relationship between spending on child health and children’s health outcomes.

- Strengthen the child health workforce – through work that will help regions to assess whether there are sufficient health visitors and help to plan their paediatric workforce needs, as well as work on GP training being led by the Royal College of General Practitioners.
- Further promote the voice of children and young people through commitments to ensure that children and young people’s views are given prominence in future assessments of healthcare organisations.
- Ensure robust arrangements are in place to promote and ensure the quality of health services.

Delivering children and young people’s health services

7.3 As the following, albeit simplified, diagram sets out, delivering on our objectives to achieve world-class outcomes, the highest-quality services, excellent experiences and reduced inequalities will require system-wide transformation. It will mean joined-up local governance, planning and commissioning, feeding through to improved service delivery. It will also mean supporting the efforts of local bodies in the use of child health data, including information drawn from close engagement with children and young people (and their parents). It will mean ensuring that the right workforce, with the right skills, is in place. And it will mean recognising the

A simplified model for the delivery of child health services



vital role that our inspection and assurance systems play in helping to encourage and drive improvements in quality and outcomes.

Further improving the child health system

7.4 This chapter identifies some specific improvements needed to align the delivery system around the health and wellbeing needs of children, young people and their families, building on the boxes in the diagram on the previous page:

- (i) Effective local leadership and joint working, and clear, transparent planning
- (ii) Working together to safeguard children
- (iii) Building on the strengths and expertise of GPs
- (iv) Stronger joint commissioning for children's health
- (v) Effective use of data to support commissioning and delivery
- (vi) A workforce with the right skills and capacity to deliver for children's health outcomes
- (vii) Drivers for improved quality, including a stronger emphasis on children and young people's voices

(i) Effective local leadership and joint working, and clear, transparent planning

7.5 Many local partners need to work together to plan and deliver joined-up health services around the child, in particular local authorities and PCTs.¹¹⁹ But they need a framework that allows them to do this. Government Offices and strategic health authorities (SHAs) have a role in supporting local partners and in providing challenges to ensure that service planning and delivery are focused on local needs and priorities, including those of children. Central government has created more space for focus on locally agreed priorities (see Annex B for a list of relevant Public Service Agreements, NHS Vital Signs and Local Area Agreements).

7.6 Recognising the importance of joint working, new duties of co-operation between local authorities and their strategic partners, including SHAs and PCTs, were introduced through the Children Act 2004 to improve the focus on children's wellbeing. Guidance required all local authority areas to put in place arrangements – broadly grouped as Children's Trust arrangements – to support integrated working by April 2008. Significant flexibilities were afforded in what shape those arrangements should take. Powers to allow for the pooling of budgets and arrangements for integrated inspection were introduced to support the process. Those flexibilities have allowed local partners to adapt partnership arrangements to meet local circumstances, recognising for example the varying configurations of local authorities and PCTs within Children's Trusts.

7.7 The Children Act 2004 also introduced a duty on local authorities – through directors of children's services – to co-ordinate the production of a strategic Children and Young People's Plan (CYPP), in order to provide an overarching vision for all services for children and young people in a given area. The CYPP covers the full range of services for children and young people including health and public health services as well as child and adolescent mental health, sexual health, school health services and services for children and young people with acute or additional health needs.

7.8 Although the CYPP is owned by the local authority (until proposed legislative changes make it the responsibility of the Children's Trust Board) it is vital that all those providing services to children and young people co-operate in the development of the plan. In January 2009, the Department for Children, Schools and Families published updated guidance on the scope, content and delivery of CYPPs. That guidance also outlined legislative proposals to strengthen CYPPs.¹²⁰

¹¹⁹ *Children's Trusts: Statutory guidance on inter-agency cooperation to improve well-being of children, young people and their families*, Department for Children, Schools and Families, November 2008.

¹²⁰ *Children and Young People's Plan Guidance 2009*, Department for Children, Schools and Families, January 2009.

CASE STUDY: An innovative model of integrated health, education and social care has been established within Northumberland's Family and Children's Trust (FACT)

In 2007, the NHS reorganisation of PCTs, including clearer separation of commissioning and provider functions, presented an opportunity to formalise integrated management arrangements, working practices and processes between the NHS, local authority and other partners. NHS North of Tyne has commissioned the FACT to deliver integrated management and community child health services. Responsibility for child health has been delegated to the Executive Director of Children's Services, who is accountable for delivering commissioned health outcomes. Professional lines of accountability for nursing, allied health professionals and medicine are retained within the primary care organisation. Strategic leadership within the FACT includes NHS management and a clinician. This arrangement has ensured the effective engagement of health, and has supported transformational cultural change within a framework of joined-up thinking, planning and service delivery. A range of integrated frontline delivery has been achieved through this arrangement. One example is the creation of 15 FACT teams of health and social care professionals, to strengthen safeguarding arrangements. Another is that NHS speech and language therapy services and the education communication support service have been joined up, to deliver a single service and point-of-entry for children with communication needs.

- 7.9** The 2007 Local Government and Public Involvement in Health Act also established a duty on upper-tier local authorities and PCTs to publish a Joint Strategic Needs Assessment (JSNA) setting out the health needs of the local population. Guidance now dictates that this feeds directly into the Children and Young People's Plan as well as being taken into account by the local authority and its partners in preparing the Sustainable Community Strategy. The JSNA is a further tool for establishing a shared vision of local service needs.
- 7.10** While significant progress has been made in establishing joint working among local partners, there is also evidence that more could be done to assist local areas in their ambitions to provide more effective, integrated working. Evidence suggests that there is substantial variation in the form and effectiveness of Children's Trusts across England, and that, while some progress has been made to encourage better co-ordinated working between organisations, more needs to be done. The challenge now is to ensure that this good practice is widely implemented and deeply embedded.
- 7.11** *The Children's Plan: Building Brighter Futures* commits the Government to strengthening Children's Trusts so that they deliver real measurable improvements for all children and young people in every local area and have in place by 2010 consistent high quality arrangements to identify all children who need additional help and intervene early to support them. To deliver on this commitment – and following consultation – we have revised the statutory guidance on Children's Trusts and **have introduced legislation to:**
- **Strengthen the governance arrangements** by placing the Children's Trust Board on a statutory footing. Membership of the Board will include senior level representation from the PCT.
 - **Extend the ownership of the CYPP to include the whole partnership by placing the duty to develop, publish and monitor it on the Children's Trust Board as a whole**, including health bodies as well as the local authority.

CASE STUDY: Children's trust arrangements

Children's Trusts are at varying stages of progress and development, with some examples of excellent practice around the country. A number of patterns have been observed with regard to Children's Trust arrangements across the country.

- All areas have a children's trust strategic board established, but there remain problems engaging partners in some cases, including PCTs and GPs.
- The leadership role of the Director of Children's Services and his/her counterparts in the children's trust partner organisations is particularly crucial to ensuring more integrated services for children and young people.
- Instances of conflicting targets and priorities for Children's Trust partners can make partnership working more difficult.
- While many areas are moving towards more joint commissioning arrangements, commissioning is under-developed in many areas.

- **Include frontline providers of education, including schools and further education colleges, as statutory 'relevant partners' of the Children's Trust.** This will reflect the role of the '21st Century School' acting as a hub for a wider range of children's services within the local community (see Chapter 4).

7.12 These steps will make for greater local clarity and transparency between partners and the public, including clearer understanding of the local leadership for children's health and wellbeing. In many areas there are already highly effective relationships between Children's Trust partners that have led to better services for children and families, and any changes to Children's Trusts will not seek to interfere with these models, or to cut across local ownership. In many (if not most) cases, local partners have taken a pragmatic approach to establishing Children's Trusts and have done so highly effectively.

7.13 Changes to Children's Trusts should enable greater consistency in the level of engagement between local authorities and PCTs in every area. There will be an expectation of senior-level representation from the PCT, with expertise and

accountability for children's health. The jointly owned CYPP will contain agreed plans, reflecting shared priorities in PCT plans and Local Area Agreements, to address the health needs of children and young people, including the most vulnerable and those with additional health needs. As many local areas have already shown, this kind of strong local partnership is critical to ensuring that services are designed around need. Strong local partnerships and plans also provide the right context within which to promote integrated working, while ensuring that the legitimate concerns of many professional staff, including health professionals, about issues of standards and governance are addressed appropriately.

7.14 The recent consultations have highlighted some of the practical obstacles to developing robust joint plans, including misalignment between funding and commissioning cycles, and the need to be clear about roles and responsibilities in addressing joint objectives for areas of overlapping responsibility such as sexual health services, child and adolescent mental health services (CAMHS), services for disabled children, and services for children in care. All of these

obstacles can be exacerbated in areas where local authorities and PCTs are not co-terminous.

- 7.15** To support progress, and to promote greater transparency over the local use of resources as a foundation for better integrated planning and commissioning, the Department of Health and Department for Children, Schools and Families will work together to support local areas in identifying and sharing best practice and to encourage further innovation. **The two departments will develop guidance that will set out in more detail how the new arrangements should work, including steps to promote transparency over resources, while also supporting the ability of local areas to innovate.**
- 7.16** The Department of Health has already set out how PCTs should work together where it is necessary to resolve where lead responsibility for a patient's care lies.¹²¹ Similarly, no child should miss out on high quality care and support because partners in a local area cannot agree how to work together effectively to achieve better outcomes. We would expect Children's Trust Boards to ensure that agencies have agreed appropriate local arrangements to resolve any such difficulties. In exceptional circumstances, where the quality of care that children receive and their outcomes are at risk because of a failure of local partnership working, we would expect SHAs to broker a resolution, working with the GO where necessary.
- 7.17** In addition, we want children, young people and families to have access to information on the local health services and support at key life stages. To increase transparency over the services available across the age ranges from pregnancy and the early years through to age 19, PCTs are expected to set out what children and families can count on from their health services locally – through local service directories and PCT prospectuses. Across England, the NHS

Choices website sets out information and advice on what services are available and how they can be accessed. The website also has an A to Z directory of advice on children's health issues, with signposts to other trusted sources of advice. Increasingly the information will become available via other channels that are being developed for those who do not use the Internet.¹²²

- 7.18** Similarly, local authorities are required to provide a range of information that parents may need to support their children through to the age of 20.¹²³ It is important that children, young people and families can access transparent information on the local health services offered, regardless of which route they take to find it. The Government has published an NHS Constitution that includes a wider pledge that the NHS will commit to inform the public about the healthcare services that are available locally and nationally. This will apply to all organisations providing NHS services that promote children's and young people's health in local areas.
- 7.19** **In setting out expectations for strengthened arrangements for Children's Trusts and CYPs, we will expect Children's Trust partners to ensure that children and families are provided with accessible and comprehensive information about what child health services, advice and support are available locally. This expectation was set out in the Children's Trust guidance published in November 2008.**
- 7.20** In taking forward the recommendations of *Healthy Weight, Healthy Lives*¹²⁴ and *The Play Strategy*,¹²⁵ Children's Trust partners will work with planners, highways officers and managers of public spaces to help them shape healthy environments for children. We will encourage these officers working with Children's Trust Boards and wider local governance structures like the local strategic partnership to think about the health and play needs of children in their neighbourhoods, to consider children's health

¹²¹ *Who Pays? Establishing the Responsible Commissioner*, Department of Health, September 2007.

¹²² www.nhs.uk

¹²³ *Duty to Provide Information, Advice and Assistance: Guidance for Local Authorities, Childcare Act 2006*, Department for Children, Schools and Families, 2008.

¹²⁴ *Healthy Weight, Healthy Lives: a Cross-Government Strategy for England*, Cross-Government Obesity Unit, Department of Health and Department for Children, Schools and Families, January 2008.

¹²⁵ *The Play Strategy*, Department for Children, Schools and Families and Department for Culture, Media and Sport, December 2008.

implications when making planning decisions and to promote child-friendly environments through local spatial and transport frameworks. It will also be important for Children's Trust partners to consider the broad range of factors that impact on children's health such as housing, where evidence suggests that housing needs are sometimes considered in isolation from a child's health outcomes.¹²⁶

(ii) Working together to safeguard children

7.21 Safeguarding children is one very important area in which all the local partners need both to meet their own individual responsibilities and to work together effectively to support children at risk. All organisations that work with children have statutory responsibilities in relation to safeguarding children and promoting their welfare. Under the Children Act 2004, Local Safeguarding Children Boards (LSCBs) bring together NHS bodies – SHAs, PCTs, NHS Trusts and NHS Foundation Trusts – with local authorities and others, as statutory partners in co-ordinating the safety of children. Other health agencies can also be involved where this is deemed useful, for example dental health services, drug and alcohol misuse services, sexual health services, and pharmacists, and all should support the LSCB in its role.

7.22 Health services are also required to contribute fully in Serious Case Reviews and Child Death Reviews. As announced in the *Staying Safe Action Plan*, additional NHS monies of £10 million per annum over the period 2008-09 to 2010-11 are being provided to support health professionals in their participation in the new Child Death Review processes.

7.23 Following the tragic case of Baby P in Haringey, Lord Laming has been commissioned to carry out a swift independent review of the progress being made across England in implementing

effective arrangements for safeguarding children. A stocktake of LSCBs and a study of Serious Case Reviews have been brought within the framework of that review. In the meantime, the Chief Executive of the NHS has asked all NHS organisations to review their arrangements for child protection, and Ed Balls similarly wrote to all Lead Members and Directors of Children's Services asking them to satisfy themselves as to the effectiveness of local arrangements. The Healthcare Commission is undertaking a swift analysis of whether health organisation boards are applying national child protection standards as rigorously as they should be, and early findings will inform Lord Laming's review. Lord Laming has been asked to report, with recommendations for action, early this year.

(iii) Building on the strengths and expertise of GPs

7.24 Consultations on Children's Trusts have emphasised the important role that GPs and GP practices can play within local services for children – as individual clinicians who are often a family's first point of contact and may help point them in the direction of other services; as practices working together with other local services; and, increasingly, as practice-based commissioners. This strategy includes a number of initiatives that will help promote stronger engagement between GPs and their partners in wider children's services at all levels.

7.25 Strengthened Children's Trusts should provide an opportunity for GPs to become more involved in the planning of children's services, to which they have vital expertise to contribute. The work of Children's Trusts would be significantly improved by greater input from GPs, with their extensive experience of dealing with the health needs of children and families. It is also vital that the children's services provided in every area support the work of local GP practices.

The statutory guidance on Children's Trusts,

¹²⁶ *Joint Working Between Housing and Children's Services*, Communities and Local Government and Department for Children, Schools and Families, 2008.

published in November 2008, says that **Directors of Children's Services are expected to consult PCTs to secure a lead GP on the Children's Trust Board – to provide their professional expertise and offer advice on how to involve the wider community of GPs in developing and delivering the CYPP.** Depending on local circumstances, the Children's Trust might invite individual GPs, members of the Professional Executive Committee of the PCT, or representation from a practice-based commissioning group.

- 7.26** These new arrangements will provide an opportunity for local areas to learn from one another about how best to ensure that GPs and GP practices are involved in Children's Trust work and about the benefits that GP involvement can bring. **Once new arrangements for Children's Trusts have settled down, we intend to identify and share best practice to make sure the work of GPs is effectively embedded in the Children's Trust.**
- 7.27** Children and young people currently make up a significant proportion of the patients that GPs see on a daily basis. But at present less than 50% of GP trainees receive acute paediatric training experience. **In order to better support the professional practice of individual GPs, we are asking the Royal College of General Practitioners (RCGP), as part of its forthcoming review of the duration of GP training, to consider whether training around child health needs should be given greater prominence.** One of the recommendations the RCGP might consider is the expansion of posts to accommodate both paediatric specialty and GP training requirements, supported by the right number of paediatricians who can provide the teaching and supervision necessary.
- 7.28** The *NHS Next Stage Review* announced a new strategy for developing the Quality and Outcomes Framework (QOF) for general practice, including introducing an independent and transparent process for developing and reviewing the indicators used to assess and reward quality of care. **In order to underline the importance of children's health, the Government would support the development of better indicators for child health in the QOF through this process, based on the best available evidence of clinical effectiveness and cost effectiveness.**
- 7.29** For GP practices, the new practice accreditation scheme being developed by the RCGP will promote improvements in organisational standards as part of the wider ambition to drive continuous quality improvement in primary care. This will include looking at whether practices have the right systems in place to identify and respond to the specific needs of their patients, including children and those who are vulnerable or at risk. In parallel, the Department of Health's programme to develop wider community health services, as announced in the *NHS Next Stage Review*, will help the NHS and the healthcare professions to promote closer joint working between GP practice teams and community health teams.
- 7.30** Much of this strategy has considered how we can promote effective integrated services that meet the needs of children and their families. In primary care, new opportunities for better integrated services are opening up. For example, each PCT has been asked to develop a new GP-led health centre (bringing together new GP services and wider community-based services), and a number of PCT plans include child-related services.

7.31 The increased focus on joint needs assessment and commissioning across PCTs and local authorities, including through CYPPs, provides wider opportunities to commission more integrated services for children and young people. **The Department of Health has invited proposals for a number of integrated care pilots that test and evaluate new ways in which PCTs can commission more integrated services, promote greater clinical collaboration and innovation, and secure more personal, responsive care and better outcomes for local populations.**

7.32 It is important that practice-based commissioners understand and take account of the strategic direction set by the CYPP. There is scope for the development and roll-out of practice-based commissioning to develop incentives to promote stronger engagement with Children's Trust partners and to support the integration of services to meet need.

(iv) Stronger joint commissioning for children's health

7.33 Stronger commissioning for children's health has been a recurrent theme – in stakeholder engagement on this strategy, in work on Children's Trusts, and in the Bercow and CAMHS reviews.¹²⁷ Analysis conducted to inform the Government's work on Children's Trusts suggested that most areas are still at an early stage with respect to joint commissioning – with a large minority of local areas planning to develop strategies for joint commissioning in 2008-09.

7.34 Commissioning for children's health needs to meet a number of different challenges:

- Joint commissioning for health and wellbeing needs to look across health, care and education services, involving multiple commissioners and

providers within the framework of community plans and Local Area Agreements.

- While the Children's Trusts will bring together an overview of action to promote health and wellbeing across a local area, the PCT's perspective will also include the full-care pathway – from health promotion and prevention through to primary, secondary and tertiary care.
- Commissioning needs to consider the child in his or her family setting – for vulnerable children in particular, there may be a need to co-ordinate services for children with support for the family as a whole.¹²⁸
- Commissioners will need to balance attention to universal services with improving outcomes for potentially small numbers of children with complex needs.
- While there is relatively good information on activity and costs in hospitals and schools, information on community services, which are at the heart of support for children's health and wellbeing, has been relatively weak. Action to sharpen commissioning for community health services is opening up new opportunities.

7.35 The Department of Health has set out an ambitious aim – for all health commissioners to become world class commissioners. World class commissioning is a new approach to commissioning which focuses on delivering better health and wellbeing for all.

7.36 Commissioning for children's health is no different. World class commissioning will help the commissioners of children's health services to secure the most appropriate mix of services to meet the needs of children, young people and their families in the short and longer term. It will ensure a clear focus on delivering improved outcomes.

7.37 The Department for Children, Schools and Families has also put in place programmes to support the development of commissioning in the children's

¹²⁷ *The Bercow Report: A Review of Services for Children and Young People with Speech, Language and Communication Needs*, Department for Children, Schools and Families, 2008; *Children and young people in mind: the final report of the National CAMHS Review*, 2008.

¹²⁸ www.cabinetoffice.gov.uk/social_exclusion_task_force/news/2008/080110_families.aspx

services and care sectors. It is now essential that the two departments bring support for commissioners together in order to address the particular challenges of commissioning for children's health.

7.38 The Department for Children, Schools and Families, in partnership with the Department of Health, is making significant investment available through the joint Commissioning Support Programme for Children's Trusts. The programme aims to transform the commissioning of services for children, young people and families by Children's Trusts and their partners, and thus improve outcomes for all children and young people.

7.39 Both departments expect the programme to be the primary source of support for commissioning child health services. Designed in consultation with commissioners in PCTs and local authorities, the programme will make use of the many examples of good practice and expertise that already exist in order to support commissioners to meet their practical, local delivery challenges for children's health – as well as the whole range of positive outcomes for children and young people.

7.40 A community of practice will facilitate networking and resource exchange between commissioners, and a programme of bespoke support, including peer coaching, training and workshops for commissioners, will be available to help solve specific local commissioning challenges. The programme will work closely with regional partners – SHAs, Government Offices and Regional Improvement and Efficiency Partnerships – to ensure that the support offered can be accessed by those bodies and aligned with other support as appropriate.

7.41 **The contract for the Commissioning Support Programme was awarded in November 2008 and will begin to offer support and guidance over the coming months.**

7.42 In developing this strategy, a large number of commissioners of children's health services were consulted. They emphasised that it was important to bring together these two programmes in order to assist commissioners in understanding each other's requirements.

7.43 As a first step in developing practical guidance for commissioners of children's health, **the two departments have produced a high-level joint commissioning guide to support local authorities and health bodies (in particular PCTs) to commission child health services.**¹²⁹ **The guide is being published alongside this strategy and sets out the vision for improving health outcomes for children and young people through joint commissioning.** The document:

- Establishes who is involved in the commissioning process for children's health.
- Outlines the world class commissioning competencies in the context of improving health outcomes for children, young people and their families.
- Aligns the 2006 nine-step joint planning and commissioning cycle with the more recent health commissioning cycle for children's services.
- Describes the support available to Children's Trusts through the Commissioning Support Programme as they develop and improve their joint approaches to strategic commissioning.

(v) Effective use of data to support commissioning and delivery

7.44 PCTs and local authorities, service providers, frontline staff and families all need access to timely information on population needs, resources, services, outcomes and user experiences to support all the phases of the commissioning cycle. This includes joint strategic needs assessment, service planning and specification, contracting and monitoring information. Using this information will support improved value for money, for

¹²⁹ *Securing better health for children and young people through world-class commissioning: A document to support delivery of Healthy lives, brighter futures*, Department for Children, Schools and Families/ Department of Health, 2009.

example through the NHS national model contracts and the NHS payment-by-results tariff. Frontline staff need access to information on good practice and benchmarking data on quality and outcomes.

- 7.45** Work is in hand to strengthen these arrangements and ensure that those involved in commissioning and delivering health services for children and young people have access to high quality information. Of central importance here are the indicator sets that underpin the measurement of national priorities. Following the local government White Paper *Strong and Prosperous Communities*, a national indicator set of 198 indicators was agreed that will measure the performance of local authorities and their partnerships against national priorities.¹³⁰ Similarly, the NHS Vital Signs measure PCTs' performance against national priorities in the NHS. PCTs and local authorities will identify their shared priorities that meet the needs of local people within the national indicator set, as set out in Annex B.
- 7.46** In addition to these indicator sets, there is a need for more targeted information that can help to support local commissioners and deliverers of services. In order to improve the quality and use of data relating to children and young people's health, we will do the following:
- **Establish a long-term role for the Child and Maternal Health Observatory (ChiMat)** – which is a child and maternal health observatory that assembles and publishes information from PCTs and local authorities about spending, activity, workforce and other areas relating to child and maternal health. It will provide products to reduce duplication of effort and support the local workforce in using knowledge, information and tools to improve commissioning.¹³¹
 - **Test, with a view to beginning roll-out, of minimum NHS datasets** for child health, maternity and CAMHS. This will support improvements in clinical practice and also help to inform those planning or commissioning services locally to focus on local priorities and needs.
 - **Develop a model to build commissioners' understanding of the relationship between healthcare spend on children and the resulting outcomes.** This will include, for example, how much PCTs spend on child health, and greater information about the long-term outcomes of interventions, particularly those relating to complex health needs.
 - **Work on providing better data on experience and outcomes.** Work is under way to identify effective quality metrics, as part of wider *NHS Next Stage Review* work (see paragraph 2.9). Public Service Agreement indicators will be available to assess progress on the Healthy Child Programme outcomes in disadvantaged areas, and we are developing an indicator to measure parents' experience of services for disabled children, to benchmark progress.
 - **Publish best practice on data collection** – as part of the Aiming High for Disabled Children programme, in order to draw on what works to help local areas improve their knowledge of local populations, to put in place workable data collection frameworks and to use data and evidence more effectively.
- 7.47** Across all of this work we shall look to develop a stronger information base for monitoring the impact of future developments in terms of equalities.
- 7.48** Better information will help to create greater transparency within the system with regard to the costs and use of services. Important developments include:
- A new NHS national standard community contract, with accompanying guidance, that includes components on services for children

¹³⁰ *The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of National Indicators*, Department for Communities and Local Government/HM Government, 2007.

¹³¹ www.csip.org.uk/~chimat/

and young people, including the Healthy Child Programme, urgent care, complex needs and child and adolescent mental health services.

- The ongoing piloting of children's community tariffs, and development of metrics and measures for benchmarking services. These will help provide a mechanism for identifying the costs of out-of-hospital services, so that: those services are more transparent and commissioning of them is more robust; efficiencies can be identified; and high quality care can be properly rewarded.

7.49 These initiatives will develop improved transparency, tools and information for commissioning and delivery organisations. But very often the relevant information will be held by one local body or another, and the question will then be how to share appropriate information across sectors. The stronger role proposed for Children's Trusts and their boards will help.

7.50 But feedback from consultative events with frontline staff suggests that they sometimes feel constrained by uncertainty about when they can share information lawfully and about how requirements on confidentiality and consent apply. Information sharing is essential to enable early intervention and preventative work, for safeguarding and promoting welfare and for wider public protection. The Government has set out in broad terms the need to share information appropriately, to ensure that children and young people are kept safe and receive the support they need.¹³² There was also some concern expressed about the extent to which working practices and cultures in different health and education settings might constrain the extent to which information is shared.

7.51 Research conducted by Together for Children – which supports the Department for Children, Schools and Families on the delivery of Sure Start Children's Centres – has demonstrated the

clear benefits of putting in place effective local mechanisms for sharing information, for example in helping to develop multi-agency support networks for vulnerable parents (see also the case study on Willington Sure Start Children's Centre, over the page).¹³³

7.52 The Government would like to see information being appropriately shared across settings where it can help deliver improvements in children and young people's health.¹³⁴ Frontline practitioners have raised questions about how best to approach this as services come together in new ways in Sure Start Children's Centres. **For this reason, the Department of Health and the Department for Children, Schools and Families will work with Together for Children to develop a programme of support that will enable more appropriate and effective information sharing locally. This will be rolled out from spring 2009.** New developments such as ContactPoint, a key part of the Children's Plan to improve the health, wellbeing and safety of all children, will also help. ContactPoint will provide practitioners with a quick way to find out who else is working with the same child or young person, making it easier for them to work as a team and deliver more co-ordinated support. The first phase of delivery began in January 2009.

7.53 The programme will look at how best to promote appropriate information sharing to improve support offered by services in Sure Start Children's Centres, for example, to encourage breastfeeding, promote support and engagement with new partners, and support initiatives with families on obesity. The programme will help to target these programmes effectively and prevent duplication between services. We will also consider what lessons this work may yield for settings other than Sure Start Children's Centres and the partners they work with.

¹³² *Information Sharing: Guidance for practitioners and managers*, Department for Children, Schools and Families and Department for Communities and Local Government, 2008. This HM Government guidance covers both children's and adults' services.

¹³³ *Health Toolkit: Case Studies*, Together for Children, August 2008.

¹³⁴ For example, services sharing data should have systems in place to protect confidentiality, ensure security of records, and meet data protection and consent requirements.

CASE STUDY: Information sharing, Willington Children's Centre, County Durham

Families using the Willington Children's Centre in County Durham are benefiting from the high level of integration and information sharing between health, local authority and other partners. Appropriate consent at each stage is a vital component to maintain the trust of parents using services. Clear policies and protocols give providers reassurance about how information will be used sensitively and kept confidentially, overcoming misunderstandings about what is legal and appropriate. This means that staff working across a full range of services – from GPs, midwives, health visitors, through to children's centre staff and schools to specialists such as social care and domestic violence teams – are all confident in joining two-way exchanges of data and confidential records about individual families. This close working helps to identify families in need of services, and promotes more effective targeting of action to encourage parents to become involved and use the services that can benefit their families. It also provides a secure context that supports and promotes use of the Common Assessment Framework.

(vi) A workforce with the right skills and capacity to deliver for children's health outcomes

7.54 The right workforce, with the right skills, competencies and experience, is critical to improving outcomes and experience for children and families. A wide range of staff in different services and with different professional and other backgrounds contribute to children's health and wellbeing. For high quality services we need:

- The general health service workforce, for example GPs and staff in emergency departments or NHS walk-in centres, to be equipped to identify and respond to the health and ill health needs of children and families and to be aware of their safeguarding children responsibilities¹³⁵ when they are concerned about a child's welfare and safety.
- The dedicated children's health workforce – including paediatricians, midwives, health visitors, community children's nurses, school health services, neonatal nurses, CAMHS professionals, and allied health professionals – to have the capacity and capability to provide proactive universal services and to respond to children and young people with acute and complex needs.

- A wider children's and young people's workforce that has core competencies in supporting healthy child development and fulfilling child protection and safeguarding responsibilities.
- Other professionals working in local authorities, such as planners, highways officers and green space managers, who understand the role that they can play in supporting children's health through the design, development and management of the environments in which children live.

7.55 The Department for Children, Schools and Families published *2020 Children and Young People's Workforce Strategy* in December 2008. This sets out the way forward for the children and young people's workforce as a whole, as well as priorities for development in each part of it. The goal is to ensure that all parts of the workforce achieve the Government's vision that people who work with children and young people should be ambitious for every child and young person; excellent in their practice; committed to partnership and integrated working; and respected and valued as professionals.

¹³⁵ *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children.* HM Government 2006.

- 7.56** The Workforce Strategy strategy makes it clear that the local Children and Young People's Plan (CYPP) should include a strategy for the children and young people's workforce which, subject to legislation, would be the joint responsibility of all partners who make up the Children's Trust Board.
- 7.57** Health professionals will often need to work closely with professionals from other parts of the workforce to meet the needs of children and young people. It is critical that all parts of the workforce have the capacity, support and leadership they need to be able to contribute effectively to improving outcomes. A particular priority for the *2020 Children and Young People's Workforce Strategy* is improvement in social work. To support this, the Department of Health and Department for Children, Schools and Families have established a joint Social Work Taskforce which will conduct a review of challenges facing the profession and drive a comprehensive and long-term programme of reform.
- 7.58** As the Workforce Strategy recognises that, following the *NHS Next Stage Review*, all NHS workforce development will be guided by the following principles:
- The workforce will be developed in co-production with the NHS; the Government has a central enabling role but details of change must be determined locally – consistent with the principle of subsidiarity, by which we mean that decisions should be made at the most appropriate level with local decisions being made to fit the local situation.
 - Effective change will be delivered with clinical ownership and leadership.
 - The whole system must be in alignment with key goals, e.g. achieving complex cultural changes, such as making “quality” the organising principle, requires all the different parts of the system to pull in the same direction.
- 7.59** SHAs have already begun to prioritise their children's workforces as they respond to the NHS Operating Framework, the *NHS Next Stage Review* and its plans for “a High Quality Workforce”. In addition, the Department of Health is introducing a national and co-ordinated Modernising Careers Programme for nurses, doctors, allied health professionals and scientists. It is also exploring the opportunity and impact of moving towards a graduate registered nursing profession.
- 7.60** There has been a significant increase in the NHS workforce since 1997 and much good work is already in progress. But there are still pressure points around some services, for example paediatrics, maternity services, neonatal services, health visiting, school nursing and community children's nursing services. The Department of Health is continuing to work with commissioners, providers, SHAs and the relevant professional bodies to understand and resolve the issues, taking into account workforce planning capability, the way in which services are delivered, new ways of working, education and training, regulation, and staffing numbers. The *NHS Next Stage Review* places a new emphasis on developing commissioners as leaders and managers in the organisations in which they work. There will be investment in new programmes on clinical and board leadership, with clinicians encouraged to be practitioners, partners and leaders in the NHS.
- 7.61** **As part of the development of this strategy, the Department of Health, in partnership with SHAs, is developing workforce modelling tools that will help SHAs to consider these pressure points and any additional workforce needs in delivering high quality and personalised care for all children.** Transparency in this modelling and needs analysis process will support benchmarking. The work will have particular attention to the following areas.

- 7.62** For health visitors and other community staff, new opportunities are opening up as a result of the Healthy Child Programme, the emerging clarity on how school health services can work with schools, and the various reviews identifying best practice models for children with acute or additional health needs (see Chapter 6). Together these provide a sounder basis for identifying and planning for the community children's health workforce. In particular, we expect to see expansion in the health visitor workforce as local commissioners and service providers work in partnership and with their SHAs to plan delivery of the Healthy Child Programme. We shall work with the NHS and the professions to promote recruitment of health visitors and support their professional development.
- 7.63** Similar planning and modelling work will address school health teams, and will underpin commissioning and service plans in response to the Neonatal Taskforce, the CAMHS Review and the Bercow Review. For the Bercow Review this work will be linked to the pilots being established to support the commissioning of services for those with speech, language and communication needs.
- 7.64** In the acute sector, planning will need to take account of the additional pressures on the paediatric workforce in order to maintain and improve quality and meet the European Working Time Directive (WTD). Increasingly, acute services will be provided by fully trained staff working in multi-disciplinary teams, and the Department of Health will work closely with the Royal Colleges to better understand and address the implications of these changes. These are more challenging for paediatric and maternity services than for most specialities because of existing staffing pressures and the need to provide 24/7 on-site specialist care, with very limited opportunities for cross cover. The Royal College of Paediatrics and Child Health, the Royal College of Obstetrics and Gynaecology and the Department of Health are therefore working together to support the NHS with workforce planning and the implementation of the European WTD.
- 7.65** In summary, the workforce modelling will cover a wide range of health professionals supporting the health and development of children and young people. It is important to ensure that this takes place within the context of a broader, strategic vision for the regional workforce. For these reasons, **the NHS Operating Framework for 2009-10 requires SHAs to develop a strategic workforce plan incorporating workforce planning, education commissioning, and talent and leadership development, in order to build on this modelling work and to support implementation of the goals of this strategy and of SHAs' local visions.**
- 7.66** Wider work with professional leaders, frontline staff and others on transforming community services will also support the most effective development of professional roles and of new approaches to multi-disciplinary working, within the NHS and in wider teams. Practical support includes the new e-learning programme to equip health visitors to lead the Healthy Child Programme and support vulnerable groups, in response to requests from health visitors themselves (see Chapter 3).
- (vii) Drivers for improved quality, including a stronger emphasis on children and young people's voices**
- 7.67** Empowering citizens – through extending choice, allowing their voices to be heard, stronger local accountability, and providing greater transparency over service performance – will help deliver world-class public services. Empowering patients was set out as a pivotal theme in the *NHS Next Stage Review*. We need to ensure that all these ingredients are in place, to promote high quality health services for children and young people focusing on:

- A strong voice for children, young people and parents in the design and delivery of services, so that staff and services learn from their experience.
- Better measures of service quality.
- Spreading innovation and best practice throughout the system.
- Robust assurance systems, including performance assessment and inspection.
- An emphasis on high quality leadership.

Each of these areas is considered in turn in the following paragraphs.

7.68 Initiatives to strengthen the voice of children, young people and parents in shaping services include:

- Implementing comprehensive Area Assessments – which from April 2009 will replace the Comprehensive Performance Assessments, Annual Performance Assessments and Joint Area Reviews (all methods of assessing quality of services and provision in a given area) – which will assess the performance of areas in achieving better health outcomes for children and young people, including how the views of children and young people are taken into account in doing so.
- Ensuring that children’s voices are given prominence in the new Care Quality Commission’s assessments of healthcare organisations.
- Exploring the feasibility of developing child and parent reported outcome measures to sit alongside quality measures and accreditation schemes. This will particularly be the case for children with long-term conditions.
- Ensuring service user feedback drives more responsive services, starting with feedback on maternity services, including input to the NHS Choices pregnancy care planner. Children and young people’s participation programmes – such as that run by Young Minds – provide a valued source of engagement and advice for those designing and delivering services.¹³⁶

7.69 Government will work with clinicians in developing appropriate metrics of high quality healthcare for children and maternity services, and encourage local areas to augment any national indicators with their own measures of quality. Indicators are also being developed to measure and focus improvements in, and experiences of, services for the parents of disabled children and those using CAMHS. The Healthcare Commission has consulted on a number of potential indicators and these are likely to be included in the forthcoming “assured list” of nationally recognised quality indicators. These will help NHS organisations in picking up their performance on key metrics of child health. Further indicators of the quality of maternity and child health services will be developed in coming years.

7.70 We need to promote and spread leading-edge practice, especially in the community services that are so important to children and families. A Transforming Community Services Programme has been established, working with stakeholders to develop strategies and initiatives to improve the quality and responsiveness of community health services available to NHS patients.¹³⁷ Community-based healthcare for children, young people and families has been identified as one of the six key clinical areas that are integral to the programme, and will provide a context for much of the work identified above as well as for sharing best practice. Chapter 8 details how the programme will help take forward key elements of this strategy.

7.71 The link between good leadership and the quality of patient care is becoming more and more apparent and we need to further develop clinical and managerial leadership. The *NHS Next Stage Review* sets out comprehensive measures, starting early and continuing throughout the career path, to develop leadership and managerial skills among healthcare professionals in the NHS. A new Leadership Council, chaired by the Chief

¹³⁶ www.youngminds.org.uk/

¹³⁷ Community care broadly relates to services provided outside hospitals and in the community, which are the first point of contact for children, families and young persons, such as community nurses, school nurses, health visitors, midwifery, and allied health professionals. They are mainly provided by PCTs but can also be by social services, independent and the third sector.

Executive of the NHS, will be a system-wide body responsible for championing and overseeing all matters of leadership across healthcare. It will have particular focus on standards (including overseeing the new certification, the development of the right curricula, and assurance) and with a dedicated budget, will be able to commission development programmes.

7.72 Safety and quality is everybody's business, with a fundamental responsibility resting with professionals and the organisations they work in. Assessment and inspection have important roles in promoting and driving improvement in the quality of care. The Healthcare Commission plays that role in relation to the healthcare and public health of the population, alongside a role in equipping patients and the public with the best possible information about the provision of healthcare. It will be brought together with the Commission for Social Care Inspection and the Mental Health Act Commission in a new Care Quality Commission from April 2009, providing a more consistent approach for all types of services through a new registration regime, and carrying enhanced powers to provide greater protection for patients and services users.

7.73 Both the Healthcare Commission, and in future the Care Quality Commission, are complemented in their roles by Ofsted – the Office for Standards in Education, Children's Services and Skills – which inspects and regulates wider care for children and young people. The Government will be working with these partner organisations to promote a sharper focus on children and young people's health. **This will include supporting partnership and joint working between inspectorates on children's services.**





NEXT STEPS:
**SUPPORTING
LOCAL DELIVERY**

- 8.1** This strategy has set out ambitions for children's health and wellbeing in addition to proposals to realise them. It builds on firm foundations already put in place through Every Child Matters to support local partnership working and the robust policy framework in the *National Service Framework for Children, Young People and Maternity Services*. Achieving world-class health outcomes for children and young people will depend critically on the commitment and expertise of local leaders and practitioners in all the services that work with them. The strategy puts in place strengthened arrangements for delivery – well supported clinicians and other professionals, leadership through Children's Trusts and tools to support local planning and delivery.
- 8.2** Primary care trusts and local authorities now have a key role in making this strategy a reality. With their Children's Trust partners, they can reflect its ambitions in their local Children and Young People Plans, in engaging children, young people and families in discussing how local services can address their health needs, and in driving progress on key local priorities through Local Area Agreements.
- 8.3** Some of the proposals will be developed regionally, embedded in the delivery plans of the 10 strategic health authority (SHA) visions for children's health published as part of the *NHS Next Stage Review*. Regional delivery partners in SHAs and Government Offices – including directors of children and learners, regional directors of public health, the clinical chairs of the SHA working groups, and various children's leads – will work together in developing solutions, securing innovation and sharing best practice.
- 8.4** Centrally, we will enable local improvements in three ways.
- 8.5** First, we have ensured that the funding is in place to deliver improved outcomes. Billions of pounds are being invested over the period 2008-11 in the frontline services supporting children and families, allowing those services to tailor their support to the needs and priorities of their local populations. This includes the £340 million over 2008-09 to 2010-11 for disabled children in NHS allocations announced through this strategy. Additionally, grants of programme monies are being invested over the same period in specific services – such as the £3 billion for the Sure Start, Early Years and Childcare Grant.
- 8.6** Second, we will ensure that the policies set out within this strategy are supported through work on enabling systems and on linked programmes and reviews. In particular:
- The **NHS Operating Framework for 2009-10** confirms the priority attached to children and young people's health and wellbeing and sets out expectations that PCTs will use this strategy to inform commissioning decisions.
 - The **Transforming Community Health Services Programme** is taking forward key elements of the Government's vision for primary and community care. It will include a focus on services for children and families and will support some of the development work set out in this strategy on commissioning, the community contract, pricing of community services and quality.
 - The development of **quality metrics** for services for children and young people will sit alongside the broader work on quality announced through the *NHS Next Stage Review*.

CASE STUDY: **Joint commissioning in Plymouth**

The young person's treatment service based at the Harbour Centre in Plymouth is jointly commissioned by a range of partners, including the local authority, the PCT and the Youth Justice Board.

The service offers community detoxification, medical and comprehensive substance misuse assessments, psychosocial interventions for young people and their family members, specialist harm reduction services plus advice and information.

All young people assessed as requiring treatment intervention jointly agree a care plan with their key worker that identifies treatment outcomes and review dates. There are currently no waiting times for young people to access the specialist services, for which they can self-refer.

- The strategy's workforce proposals, including those on training, planning and education, will be aligned to the **workforce and leadership** programmes of the *NHS Next Stage Review*, and taken forward in the context of the *2020 Children and Young People's Workforce Strategy* which sets out the Government's strategic priorities for the long-term development of the children's workforce as a whole.
 - Work to take forward the recommendations of the recent reviews of **child and adolescent mental health services, speech, language and communication needs, sex and relationship education, and drugs and alcohol** will be developed in line with proposals set out within this strategy.
- 8.7** And third, we will ensure that, as both the Department of Health and the Department for Children, Schools and Families develop the proposals described in this strategy, we do so in partnership with stakeholders from across the public, private and voluntary sectors.
 - 8.8** Finally, we will go back to the children, young people, parents and practitioners who helped us develop this strategy to demonstrate how their input has been reflected.

ANNEX A: NATIONAL SERVICE FRAMEWORK FOR CHILDREN, YOUNG PEOPLE AND MATERNITY SERVICES – STANDARDS

Standard 1: Promoting Health and Wellbeing, Identifying Needs and Intervening Early

The health and wellbeing of all children and young people is promoted and delivered through a co-ordinated programme of action, including prevention and early intervention wherever possible, to ensure long-term gain, led by the NHS in partnership with local authorities.

Standard 2: Supporting Parenting

Parents or carers are enabled to receive the information, services and support which will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe.

Standard 3: Child, Young Person and Family-Centred Services

Children, young people and families receive high quality services which are co-ordinated around their individual and family needs and take account of their views.

Standard 4: Growing Up into Adulthood

All young people have access to age-appropriate services which are responsive to their specific needs as they grow into adulthood.

Standard 5: Safeguarding and Promoting the Welfare of Children and Young People

All agencies work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed.

Standard 6: Children and Young People who are ill

All children and young people who are ill, or thought to be ill, or injured will have timely access to appropriate advice and to effective services which address their health, social, educational and emotional needs throughout the period of their illness.

Standard 7: Children and Young People in Hospital

Children and young people receive high quality, evidence-based hospital care, developed through clinical governance and delivered in appropriate settings.

Standard 8: Disabled Children and Young People and Those with Complex Health Needs

Children and young people who are disabled or who have complex health needs receive co-ordinated, high quality child and family-centred services which are based on assessed needs, which promote social inclusion and, where possible, which enable them and their families to live ordinary lives.

Standard 9: The Mental Health and Psychological Wellbeing of Children and Young People

All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality multidisciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.

Standard 10: Medicines for Children and Young People

Children, young people, their parents or carers, and healthcare professionals in all settings make decisions about medicines based on sound information about risk and benefit. They have access to safe and effective medicines that are prescribed on the basis of the best available evidence.

Standard 11: Maternity Services

Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.

ANNEX B: PUBLIC SERVICE AGREEMENTS, NHS VITAL SIGNS AND LOCAL AREA AGREEMENTS

Public Service Agreements

Since their introduction in the 1998 Comprehensive Spending Review (CSR), Public Service Agreements (PSAs) have played a vital role in galvanising public service delivery and driving major improvements in outcomes. PSAs set out the key priority outcomes the Government wants to achieve in the next spending period (2008-11). The PSA indicators all feature in the national indicators set and as appropriate in the NHS Vital Signs. The Child Health Strategy will contribute to the achievement of these PSAs, but will also be underpinned by them – particularly where they relate to the broader determinants of health, such as living in poverty.

PSA 9: Halve the number of children in poverty by 2010/11, on the way to eradicating child poverty by 2020

Children who grow up in poverty are less likely to stay on at school, to attend school regularly, to get qualifications or to go on to higher education, and more likely to become young parents, locking whole families into intergenerational cycles of deprivation. Reducing the number of children who are born into poverty will increase the number of children born into opportunity, including with regard to health and broader life chances.

Indicator 1: Children in absolute low-income households.

Indicator 2: Children in relative low-income households.

Indicator 3: Children in relative low-income households and material deprivation.

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

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

Indicator 1: Prevalence of breastfeeding at 6-8 weeks.

Indicator 2: Percentage of pupils who have school lunches.

Indicator 3: Levels of childhood obesity.

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

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

PSA 13: Improving child safety

Improving children's safety means tackling a wide range of issues – abuse and neglect, accidental injury and death, bullying, crime and anti-social behaviour – as well as ensuring a safe home environment.

- Indicator 1: Percentage of children who have experienced bullying.
- Indicator 2: Percentage of children referred to children's social care who received an initial assessment within seven working days.
- Indicator 3: Emergency hospital admissions caused by unintentional and deliberate injuries to children and young people.
- Indicator 4: Preventable child deaths as recorded through child death review panel processes.

PSA 14: Increase the number of children and young people on the path to success

Most young people are already on a path to success – they do well at school, make a successful transition to adult life and go on to build successful careers and families. However, not all young people are on this path and many experience problems in their teenage years such as falling behind at school or getting involved with drugs, criminal and other unacceptable behaviour. Sometimes these problems are only temporary setbacks, which are rapidly overcome, but for some young people, problems can prove more severe and entrenched. This can have serious consequences for their health, wellbeing and development.

- Indicator 1: Reduce the proportion of 16- to 18-year-olds who are not in education, employment or training (NEET).
- Indicator 2: More participation in positive activities.
- Indicator 3: Reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances.
- Indicator 4: Reduce the under-18 conception rate.
- Indicator 5: Reduce the number of first-time entrants to the criminal justice system aged 10-17.

PSA 18: Better health for all and better care for all

Improving people's overall life expectancy and tackling the inequalities gap is key to achieving better health and wellbeing for all. A focus on ill-health prevention and promotion of good health, and tackling health inequalities will help people to live healthier lives for longer and take more control over their own health.

- Indicator 1: All age all cause mortality (AAACM) rate.
- Indicator 2: Difference in AAACM between England average and Spearhead areas.
- Indicator 3: Smoking prevalence.

Indicator 4: Proportion of people supported to live independently (all ages).

Indicator 5: Access to psychological therapies.

PSA 19: Ensure better care for all

To provide people with more convenient services, in more local settings, which help them to manage their own health and improve their experience of the whole care pathway. Meeting the challenges for this PSA is not simply about increased investment and transforming how care is delivered by individual organisations, but transforming the whole system of care delivery.

- Indicator 1: The self-reported experience of patients/users.
- Indicator 2: NHS-reported referral-to-treatment times for admitted patients.
- Indicator 3: NHS-reported referral-to-treatment times for non-admitted patients.
- Indicator 4: The percentage of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices, by 12 completed weeks of pregnancy.
- Indicator 5: Long-term conditions.
- Indicator 6: GP services.
- Indicator 7: Healthcare-associated infection rates – MRSA.
- Indicator 8: Healthcare-associated infection rates – *Clostridium difficile* (CD).

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

The UK has committed to deliver an Olympic Games and Paralympic Games in 2012 which will be a successful and inspirational world sporting event for athletes and the viewing public. The benefits arising from the Games include; the economic boost from increased investment, training and jobs; sports participation for all; the cultural opportunities brought by the Cultural Olympiad; raising national pride and the UK's international profile; and increasing community engagement. The Government is also committed to creating new opportunities for all children and young people in England to participate in high quality physical education (PE) and sport. These opportunities will contribute not only to the 2012 legacy, but also to other government policies to promote the health and well-being of children and young people.

- Indicator 5: Percentage of 5- to 16-year-olds participating in at least two hours per week of high quality PE and sport at school and the percentage of 5- to 19-year-olds participating in at least three further hours per week of sporting opportunities.

Local Area Agreements (performance framework)

Local Area Agreements (LAAs) set out the priorities for a local area agreed between central government, the local area (the local authority and local strategic partnership (LSP)) and other key partners at the local level. LAAs are at the heart of the new performance framework for local authorities and their partners. LAAs bring together national standards and priorities set by government with local priorities, informed by the vision developed by the local authority and its partners. They will deliver a better quality of life and stronger local economies for people by giving them improved public services, which are suited to the area in which they live.

The LAA is negotiated between the LSP and the regional Government Office. The LSP consists of all the key players in a local area who deliver services. The local authority has a statutory duty to prepare the LAA.

A single set of 198 national indicators was announced as part of the CSR 2007 covering the period 2008-09 to 2010-11. The national indicators:

- Will be the only measures on which central government will performance manage outcomes delivered by local government working alone or in partnership.
- Will fit into the performance frameworks for other local partners – such as the police and NHS – strengthening the focus on organisations working together to deliver joined-up and complex outcomes.
- Replace all other existing sets of indicators including Best Value Performance Indicators and Performance Assessment Framework indicators.
- Will be reported on by all areas from April 2008.

While all 198 indicators will continue to be collected and reported on by local authorities, only up to 35 of these will be chosen as designated targets for each LAA which will help them reach their agreed priorities over a three-year trajectory. LSPs can also include additional local targets. These will not be reported on to central government but as they will be of key importance locally, progress towards meeting them will be taken into account as part of the new Comprehensive Area Assessment. The indicators relating to child health include:

- emotional health of children
- effectiveness of CAMHS
- take-up of school lunches
- prevalence of breastfeeding at 6-8 weeks
- services for disabled children
- obesity among primary school-age children in Reception Year
- obesity among primary school-age children in Year 6
- children and young people's participation in high quality physical education and sport
- emotional and behavioural health of looked-after children
- under-18 conception rate
- prevalence of chlamydia in under-25s
- substance misuse by young people
- AAACM rate
- early access for women to maternity services
- children travelling to school – mode of travel usually used
- children and young people's satisfaction with parks and play areas

NHS Operating Framework and Vital Signs

The Operating Framework for 2008-09 set out the business processes required throughout the system to support delivery against the national priorities, ensure local accountability and drive transformation for the benefit of patients. As part of the NHS Operating Framework for 2008-09, a new approach was introduced to planning and managing priorities both nationally and locally. The key elements of the business process included:

- **Vital Signs:** clarification on measures of progress against the national priorities and helping primary care trusts (PCTs) to make local choices and set local priorities.
- An initial focus for 2008-09 on an annual **operational plan** for each PCT.
- **Strategic plans** for the medium term, developed by each PCT by autumn 2008 and signed off by the strategic health authority (SHA).
- **Talent plan and leadership development plan** at SHA level for 2008-09. From 2009-10 onwards, PCTs will also have these in place.

The Vital Signs form part of each PCT's operational plan, which sets out the PCT's priorities for the year. There are a number of Vital Signs which have been identified nationally and each PCT works on them each year to ensure that they deliver the best possible outcomes locally against these Vital Signs. Nationally identified Vital Signs include the child health priorities, for example: AAACM rate; obesity among primary school-age children; proportion of children immunised; percentage of infants breastfed at 6-8 weeks; chlamydia testing; and under-18 conception rate. In tandem with these national priorities, there are also a number of local Vital Signs. Examples of local priorities include the timeliness of social care packages, hospital admissions caused by unintended/deliberate admissions, and parents' experience of services for disabled children.

PCT operational plans comprise:

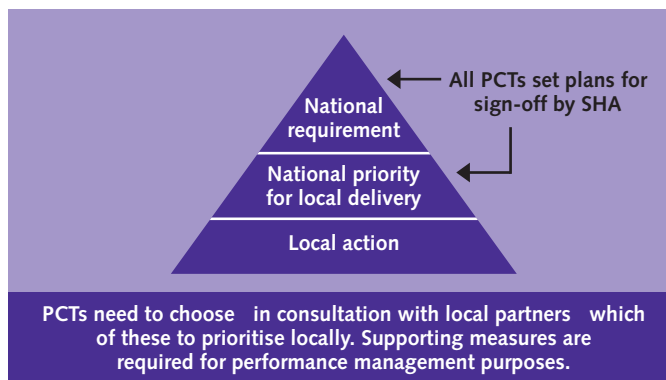
- 1) **National requirements** set by the Department of Health and cascaded to PCT level, or in the form of SHA envelopes, and subject to performance management involving a significant degree of challenge. These areas require plans submitted by PCTs or trusts, agreed by SHAs, with SHA plans signed off by DH. These plans are monitored and performance managed.
- 2) **A set of national priorities for local delivery** where nationally we know there is work to do, but where we recognise that organisations need a greater degree of flexibility about how they do it and where local targets need to reflect different starting points and the challenges of different demographics.
- 3) **A set of local priorities** which PCTs can, in conjunction with their communities, prioritise for themselves where to drive service improvement harder in the areas that will make the most difference to their population.

The NHS Vital Sign national priorities relating to children and young people's health include:

- improving access to maternity care
- conception rate in under-18s
- obesity in primary school children
- CAMHS effectiveness
- breastfeeding at 6-8 weeks
- percentage rate of complete immunisations

The NHS Vital Signs local priorities relating to children and young people's health include:

- hospital admissions from injuries
- parents' experience of services for disabled children



ANNEX C: CONSULTATIONS WITH CHILDREN, YOUNG PEOPLE, PARENTS AND STAKEHOLDERS

2008	Day	Event	Location
January	21	Child Health Strategy workshop – attendees included officials from across the Department of Health and Department for Children, Schools and Families and key national stakeholder groups	London
March	8	Children’s Plan: Time to Talk deliberative events – two workshops on health	London and Portsmouth
	18	Child Health Strategy workshop – hosted by the National Children’s Bureau. Attendees included senior practitioners and policy makers from across disciplines and sectors	London
March – April	One-month survey	Online survey of children and young people, undertaken by the National Children’s Bureau – have your say about the Government’s proposed new Child Health Strategy	Web-based
June	10	Primary Care Trust Chief Executives and Local Authority Directors of Children’s Services Sounding Board Group	London
	14	Healthy Lives, Brighter Futures national deliberative event – with parents, young people (aged 16-19), and frontline practitioners. Involved around 100 people from across England who shared their views with Ed Balls and Alan Johnson on children’s health and health services	Leeds
	16	Child Health Stakeholder Advisory Group – chaired by Sheila Shribman, National Clinical Director for Children	London
	17	Workshop with Together for Children, local authority and primary care trust officials to discuss the links between child health and Sure Start Children’s Centres	London
	20	Workshop with the Training and Development Agency and frontline practitioners to discuss links between child health and the Extended Schools programme	London
	23–25	Healthy Lives, Brighter Futures focus groups – eight focus group discussions with children and young people (aged 7-15)	London, Farnham, Birmingham, Newcastle, Leeds
	26	Healthy Lives, Brighter Futures workshop event – with parents of children and young people with long-term conditions and complex needs	London
July	4	Children’s Inter-Agency Group discussion on the Child Health Strategy – membership includes the Association of Directors of Children’s Services, NHS Confederation, Royal College of Paediatrics and Child Health, Barnardo’s, Children’s Society, Connaught Group, Local Government Association, Metropolitan Police, National Children’s Bureau, National Children’s Homes, National Council of Voluntary Child Care Organisations, National Youth Agency, National Society for the Prevention of Cruelty to Children, Society of Local Authority Chief Executives and Senior Managers	London
	15	Strategic health authority workforce leads – meeting	London
	17	Board of stakeholders – consultative event	London

ANNEX D: THE HEALTHY CHILD PROGRAMME – RECOMMENDED SCHEDULE FROM PREGNANCY TO 5 YEARS

'We have just found out that we are having a baby – what services will we be offered that will help our baby to grow up healthy and happy?'

As well as the usual maternity services, your family will be offered the following programme of health reviews which will:

- support you to provide the best care for your child
- protect your baby from serious infectious diseases
- check whether he or she is developing normally

In pregnancy:

- A full assessment of your health and wider needs will be carried out by a maternity health professional when you are around 12 weeks' pregnant.
- During pregnancy, you and your partner will be given information and offered guidance on subjects such as nutrition, smoking, alcohol and breastfeeding.
- You will both be offered the opportunity to join a local group to learn about becoming a parent and to prepare for the birth.
- You will meet someone from the Healthy Child team before you have your baby. The Healthy Child team is led by a health visitor, who works closely with your GP and local Sure Start Children's Centre. The team includes people with different skills and experience such as nursery nurses, children's nurses and early years support staff.

This will help you to get to know individuals from the team and find out what services you will be offered. You and your partner will also have the chance to discuss becoming a parent and what support is available if you need it. At this point, you will be given your child's health record (the 'Red Book') which will tell you what services you are entitled to and will record their health and development.

After birth:

- Maternity services will support you with breastfeeding, caring for your new baby and adjusting to life as a parent.
- Your baby will be examined and receive a number of tests, including a hearing test.
- Some babies will need immunisations against TB and/or Hepatitis B.

By 14 days:

- By the time your baby is 14 days old, you will see a health professional, who will usually be a health visitor, who will carry out the 'new baby review'. This will include a discussion on feeding your baby, becoming a parent and how to help with your baby's health and development.

Between 6 and 8 weeks:

- Your baby will be given a number of tests and a full physical examination by a health professional.

At 8 weeks:

- Your baby will be given the first set of immunisations and you will have the opportunity to raise any worries or ask for information.

At 3 months:

- Your baby will be given the second set of immunisations and you will have the opportunity to raise any worries or ask for information.

At 4 months:

- Your baby will be given the third set of immunisations and you will have the opportunity to raise any worries or ask for information.

If you have any worries between these times, would like to find out more about your own or your baby's health or have your baby's weight checked, you can contact the team, which includes a health visitor, or go to a local child health clinic.

By 1 year:

- Your baby will have a second full review of his or her health and development. You and your partner will have the opportunity to discuss any concerns and to prepare for toddlerhood. The topics covered at this time include language and learning, safety, diet and behaviour.

At 12 months:

- Your baby will be given another immunisation and you will have the opportunity to raise any worries or ask for information.

At 13 months:

- Your baby will be given the MMR (measles, mumps and rubella) immunisation and PCV (against pneumococcal infection) and you will have the opportunity to raise any worries or ask for information.

Between 2 and 2½ years

- Your child will have a third full health and development review and you and your partner will have the opportunity to raise any concerns, ask questions and to prepare for the next stage of your child's development and your role as parents. At this age, the review will cover topics such as speech and language, learning, diet, safety and behaviour.

By now, it is likely that your child will be benefiting from early years learning, such as that provided in your local Sure Start Children's Centre. Over the next few years his/her carers will work with you and the Healthy Child team, so that your child stays as healthy as possible and develops well emotionally and socially. Throughout this, the Healthy Child team is available for information and guidance.

At school entry (4-5 years):

- Your child's health will be reviewed; this includes sight and hearing tests and measurement of height and weight.

When your child reaches school age, the school nursing team and school staff will support you on your child's health and development. They will work with you to make sure that he/she is offered the right immunisations and health checks as well as being there for advice and support on all aspects of health and wellbeing, including emotional and social aspects.

The Healthy Child team is led by a health visitor, who works closely with your GP and local Sure Start Children's Centre. The health visitor makes sure that all children and families in the community are offered a high quality Healthy Child Programme. The Healthy Child team will include people with different skills and experience such as nursery nurses, children's nurses and early years support staff.

This programme will be offered to you in your GP's surgery, local clinic or Sure Start Children's Centre and should be timed so that both mothers and fathers can be there. Some reviews may be done at home.

'What if things don't work out as planned and I need extra help?'

The Healthy Child Programme builds on the expertise and strengths that all families have. At the same time, families are different and some children and parents need extra support at the beginning or at other times while their child is growing up. Becoming a parent can be more difficult if you are young, living on a low income, your child is ill or disabled or for a variety of other reasons. The Healthy Child Programme therefore includes other services for families needing additional guidance and support. The health visitor will make sure that your child has an individual Healthy Child plan which reflects your particular strengths, needs and choices.



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