

# Improving Children and Young People's Health Outcomes: a system wide response

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# Ministerial Foreword

The Children and Young People's Health Outcomes Forum Report – informed by engagement with some two thousand people – children and young people and their families and those working in the wider health and social care system – set out a compelling case for change. The challenge for us all is to ensure that, together, we secure the improvements.

There is clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant shorter and longer term positive impacts. Smoking, alcohol, poor nutrition, and stress or the absence of a warm loving relationship can have significant shorter and longer term negative impacts.

Early intervention can prevent ill health and reduce mortality and morbidity for children and young people. Healthy behaviours in childhood and the teenage years set patterns for later life. Continued support for children and young people can mean that society as a whole can reap all the benefits of a resilient next generation, which is healthier and happier.

The causes of avoidable childhood deaths are complex and differ at each stage of childhood. Securing a reduction in mortality and morbidity, requires a multifaceted approach, encompassing effective public health interventions in pregnancy, the early, school and teenage years, alongside improvements in health care from conception to adulthood. It also requires a focus on the groups of children who experience the worst outcomes.

High quality, evidence based and safe care are what should define health services for children and young people. We know how important it is to children, young people and their families that they are able to access the care and treatment that is right for them, as close to home as possible.

The need for integrated care coordinated around and tailored to the needs of the child or young person and their family is clear and fundamental to improving their health outcomes. Integration means the joins between services and commissioning responsibilities are invisible because organisations are working in partnership to deliver the best care across whole pathways and life stages. It means children, young people and parents don't have to keep repeating their information, that records are not lost or duplicated, that individuals and their needs do not fall between gaps and that resources are focused on the same goals.

The Government's modernisation of the health and care systems will improve the quality and efficiency of the services children, young people, and their families receive through the creation of a more autonomous system, with decision-making devolved, where possible, to local organisations and professionals with children young people and their families involved in decisions about their care and the design of services.

Quality, timely data is critical for us to be able to assess the effectiveness of the services we provide for children, young people and their families. Many of the systems and data currently in use require significant development to meet future needs and to support the development of the outcome measures the Children and Young People's Health Outcomes Forum recommended.

In the new health and care system, every organisation needs to demonstrate how it can best contribute to people's health and wellbeing at every stage of life. Leadership and accountability for improving health outcomes across the whole life course must be embedded and demonstrated throughout the system at every organisational level – national, regional and local.

In this document we set out the first stage of our collaborative work to improve health outcomes for children and young people, informed by the Forum's comprehensive recommendations. To measure up to the best, we need a long-term focus on getting things right for children and young people and we all have a part to play. Some changes will be made quickly. Others require long-term development work, demanding unprecedented, systematic collaboration across primary, secondary and tertiary care, public health and wider children's services.

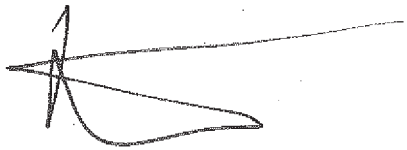
At national level a new Children and Young People's Health Outcomes Board, led by the Chief Medical Officer will bring together key system leaders in child health to provide a sustained focus on improving outcomes across the whole child health system.

A new Children and Young People's Health Outcomes Forum will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

It is imperative that the health and care system works well for children, young people and their families. Too many children are not getting the care and support they need. Not enough focus has been put on this issue for too long.

I am determined to play my part in securing the changes children and young people need. Alongside this document, we are publishing a pledge to improve health outcomes for children and young people. This pledge brings together our shared ambitions for children and young people's health.

I am calling on all those who have a contribution to make to join me in signing up to this pledge and working together to improve health outcomes for children and young people.

A handwritten signature in black ink, appearing to read 'Dan Poulter', with a long horizontal stroke extending to the right.

DR DAN POULTER  
Parliamentary Under Secretary of State – Health  
February 2013

# Improving Children and Young People's Health Outcomes: a system wide response to the report of the Children and Young People's Health Outcomes Forum

Our ambition is to improve health outcomes for our children and young people, making them comparable to the best in the world.

The Children and Young People's Health Outcomes Forum played a leading role in setting this ambition. This document sets out the system's response to the Forum's recommendations published in July 2012. It outlines the concrete actions already in train and the longer term development work that will deliver real and measurable change in children's health and wellbeing over time.

This response to the Forum's recommendations is set out under the following headings:

1. Introduction
2. Putting children, young people and their families at the heart of what happens
3. Health outcomes that matter most for children, young people and their families
4. Acting early and intervening at the right time
5. Integration and partnership
6. Safe and sustainable services
7. Workforce, education and training
8. Knowledge and evidence
9. Leadership, accountability and assurance
10. Incentives for driving service improvement

# 1: Introduction

- 1.1 In January 2012, the then Secretary of State for Health established the Children and Young People's Health Outcomes Forum composed of individuals with a wide range of expertise and a shared commitment to improving the health of children and young people. The Forum was asked to:
- identify the health outcomes that matter most for children and young people;
  - consider how well these are supported by the NHS and Public Health Outcomes Frameworks, and make recommendations; and
  - set out the contribution that each part of the new health system needs to make in order that these health outcomes are achieved.
- 1.2 The Forum's work – which took into account the views of some 2,000: children, young people and their families and those working in the health and care system – highlighted two key messages:
- too many health outcomes for children and young people are poor and for many this is related to failures of care;<sup>1</sup> and
  - there is substantial and unexplained variation in many aspects of children's healthcare.<sup>2</sup> The UK is worse than many other countries in Europe for many outcomes that could be improved through better healthcare and preventative interventions.<sup>3</sup> There are also wide differences in health outcomes between groups and families with a social gradient, resulting in avoidable health inequalities.
- 1.3 The Forum's Report set out a compelling case for change. It described:
- the need for comprehensive system wide change;
  - the scale of the challenge to deliver the step change required to improve outcomes; and
  - opportunities to influence the new health and care system.
- 1.4 Since the Forum's Report was published in July 2012, the Department of Health (DH) has continued to lead the transition to the new health and care system. The NHS Commissioning Board (NHS CB) was established as an executive Non Departmental Public Body (NDPB) in October 2012. Across the country clinical commissioning

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1 CEMACH report 2008

2 NHS Atlas of Variation in healthcare for Children and Young People 2012

3 Improving child health services in the UK: insights from Europe and their implications for NHS reform BMJ 2011 Wolfe I, Cass H et al



groups (CCGs) are preparing to take on responsibility for commissioning services for their local communities from April.

- 1.5 From April 2013, the health system will be better placed to address the scale of this challenge. A new clinically led NHS will focus on outcomes, not process targets. There will be an enhanced role for local authorities in health improvement and shared leadership of the system through health and wellbeing boards, with a strong consumer voice through local Healthwatch.
- 1.6 Since 2010, the DH has published three outcomes frameworks, one for each part of the health and care system. The outcomes frameworks for Public Health, Adult Social Care and the NHS are intended to provide a focus for action and improvement across the system. Each of the outcomes frameworks include the main outcomes for health and care that matter most to all of us. The three outcomes frameworks provide assurance and accountability and provide a focus for quality improvement.
- 1.7 The first Mandate from the Government to the NHS CB, published in November 2012, sets the ambition to give children the best start in life. It asks the NHS CB to pursue the following as part of its objectives:
- *to improve the standards of care and experience for women and families during pregnancy and the early years of their children's life;*
  - *working with the Department of Health and Healthwatch England, to consider how best to ensure that the views of children, especially those with specific healthcare needs, are listened to;*
  - *working together with schools and children's social services, to support and safeguard vulnerable, looked-after and adopted children, through a more joined-up approach to tackling their needs;*
  - *to demonstrate progress in continuing to improve safeguarding practice in the NHS;*
  - *to extend and ensure more open access to the Improving Access to Psychological Therapies (IAPT) programme, in particular for children and young people;*
  - *to ensure smooth transitions between children's and adult services; and*
  - *to support children and young people with special educational needs or disabilities, to ensure that these children and young people have access to the services identified in their agreed care plan and that, from April 2014, their parents are able to ask for a personal budget based on a single assessment across health, social care and education.*
- 1.8 The Mandate covers the period from April 2013 to the end of March 2015.

- 1.9 Public Health England (PHE) comes into being in April 2013 and local authorities are establishing health and wellbeing boards as the forum where key leaders from across the local health and care system work together to improve the health and well-being of their communities population and reduce health inequalities. PHE will have a life stage focus, firmly committed and designed to improve health outcomes for all ages, including children and young people.
- 1.10 The NHS Trust Development Authority (NHS TDA) and Health Education England (HEE) are also being established. Healthwatch England has been formally established and is now helping to support local authorities to set up local Healthwatch organisations across the country.
- 1.11 All of these bodies are bound together by a shared ambition to improve health and care outcomes for the people of this country and to help narrow the gap between vulnerable and disadvantaged groups and the rest of the population. Along with the DH and other organisations in the health and care system, they have welcomed the important messages that the Forum has given. They have embraced the opportunity to ensure that the needs of children and young people are designed into the way they will work from the outset, in line with the UN Convention on the Rights of the Child.
- 1.12 In addition, organisations in other sectors have programmes of action that are complementary to and interdependent with the emerging plans in the new organisations. They make an essential contribution in responding effectively to the Forum's recommendations and have worked in partnership with the DH since the Forum's report was published to develop this first wave of action.
- 1.13 The full system wide response to the Forum's recommendations is set out in detail in the following sections.

## 2: Putting children, young people and their families at the heart of what happens

### The Forum recommended:

- all health organisations must demonstrate how they have listened to the voice of children and young people, and how this will improve their health outcomes;
- the revised NHS Constitution is drafted in such a way as to be applicable to all children, young people and their families; and
- Healthwatch England gives appropriate consideration to the importance of all children and young people's voices to inform its work programme, and is able to demonstrate this through its annual report. Local Healthwatch include children and young people's voices as core to their work and demonstrate this through their reporting mechanisms.

### The System's Response

- 2.1 DH strongly supports the *You're Welcome* quality framework for making health services young people friendly and will continue to promote the approach with all our partners as they develop their commissioning and delivery plans.
- 2.2 The NHS CB has committed in *Securing Equity and Excellence in Commissioning Specialised Services* that patients should also be able to express their views on the services they have received and their experiences, and to do so using their chosen technology (phones, web, email, social media etc).
- 2.3 Clinical Reference Groups have produced a set of common standards for all specialist services where children or young people are in hospital, including mental health services. Service specifications were consulted on till the end of January 2013.
- 2.4 The Care Quality Commission's (CQC) purpose is to drive improvements in the quality of health and adult social care through regulating and monitoring services; through putting people's views and experiences at the centre of its work; through drawing on its intelligence and unique insight to provide an authoritative voice on the state of care; and through working with strategic partners across the system. This includes the regulation of health services received by children and young people. CQC is currently consulting on its strategic direction for the next three years. As part

of this consultation it ran focus groups with children and young people to discuss its future strategy.

- 2.5 CQC is developing an approach to involving children and young people in its inspection activity. This includes using children and young people as 'experts by experience' to support its inspectors when they inspect registered providers. It is also developing information about CQC in a child and young person friendly format to help them understand more about CQC and what to expect in providers that are registered with CQC. CQC is running a number of workshops with children and young people to progress this work.
- 2.6 CQC is also developing a joint approach with Ofsted which is covered in Section 4. The NHS TDA will be including in its planning guidance that trusts are expected to:
- Demonstrate that they have listened to the voice of patients including children and young people; and
  - Set out how they will fulfil their responsibilities for children and young people and how accountability will be exercised at every level.
- 2.7 Following advice from the Future Forum on strengthening the NHS Constitution, DH is working on developing alternative versions, for example a one side summary and an improved easy read version to make the Constitution more accessible and relevant for different groups and communities.
- 2.8 Healthwatch England, the new consumer champion in the health and care system, launched in October 2012, will have a key role to play in enabling the collective views of all those who use health and social care services to influence national policy, advice and guidance. It will be particularly important that the voices of people from all parts of society are able to be heard, including vulnerable and marginalised groups, recognising the diversity of the population.
- 2.9 Healthwatch England has appointed a leading advocate for children, Christine Lenehan (one of the Forum co-chairs), as one of its members. This demonstrates a clear commitment to ensuring a strong voice for children and young people and their families informs early strategic priorities for the new organisation. Healthwatch England's stakeholder engagement plan has targeted key organisations representing children and young people.
- 2.10 DH, the LGA, Healthwatch England and other key stakeholders, such as the National Children's Bureau, the National Youth Council and the Children's Rights Commissioner, are working in partnership to support local authorities and local Healthwatch organisations in understanding the issues that are important to children

and young people's issues and becoming equipped to engage and involve children and young people in their work.

- 2.11 From April 2013 local Healthwatch organisations will be set up and will ensure the views and experiences of all local people, including children and young people, have influence both through involving them in monitoring services, making reports and recommendations based on what they say is important, and through their statutory seat on health and wellbeing boards.
- 2.12 The active and systematic involvement and participation of children, young people and their families is built into this work **and** the mechanisms being put in place to build momentum, in line with the observations of the UN Committee on the Rights of the Child on compliance of UK healthcare with the UN Convention on the Rights of the Child.<sup>4</sup>

## Listening to the Voice of Children and Young People in the East of England

The East of England Children's Team are assisting their emerging local Healthwatch in executing their statutory function to include the whole local population through the creation of a Healthwatch Ambassador for Children and Young People. They are recruiting from a pool of experienced and trained young people who have completed the Prince's Trust employment based Health and Wellbeing programme, which incorporates the Royal Society for Public Health Level 1 and 2 Award in Understanding Health Improvement.

Key tasks of the role include:

- The development of a local Children and Young People's Organisation Directory to promote inclusion of all groups, provide local signposting and promote sustainability.
- Meeting with existing local groups of children and young people to hear their views on local priorities and development of themes for reporting back to local Healthwatch and therefore health and wellbeing boards.
- Developing a relationship with local support systems to signpost to those who may be of potential assistance.
- Collating views from local Healthwatch to feed into the East of England Strategic Network for Child Health and Wellbeing.

The benefits include the effective involvement of children and young people in decisions about the health and social care system, giving young people a development opportunity and well informed decision making.

<sup>4</sup> CRC/GBR/CO/4 20 October 2008. Committee on the Rights of the Child Forty-ninth session, Consideration of Reports Submitted By States Parties under Article 44 of the Convention Concluding Observations.

# 3: Health outcomes that matter most for children, young people and their families

## The Forum recommended:

- with immediate effect, all data about children and young people should be presented in 5 year age bands through childhood and the teenage years;
- four new outcome indicators for inclusion within the NHS Outcomes Framework:
  - time from first NHS presentation to diagnosis or start of treatment;
  - integrated care – developing a new composite measure;
  - effective transition from services for children and young people to those for adults; and
  - age-appropriate services – with particular reference to teenagers.
- strengthening patient experience measures. By 2013–14, DH and the NHS CB should incorporate the views of children and young people into existing national patient surveys in all care settings;
- specific outcome measures and indicators for the very wide variety of illnesses and conditions of children and young people including where appropriate patient rated outcomes;
- an indicator in the Public Health Outcomes Framework measuring the proportion of mothers with mental health problems, including postnatal depression and the proportion who are offered appropriate, evidence based intervention and support;
- the indicator in the Public Health Outcomes Framework on the proportion of women smoking in pregnancy is extended to look at the proportion of those who *stop* smoking during pregnancy;
- the development of two new surveys:
  - a population-based survey of children and young people to look at trends in health and wellbeing; and
  - a survey to support measurement of outcomes for children with mental health problems.

## The System's Response

- 3.1 The NHS Outcomes Framework 2013–14 includes measurable outcomes to demonstrate improvement in critical areas: for example in infant and perinatal mortality, and through better support to children and young people with asthma, diabetes and epilepsy.
- 3.2 A number of improvements recommended by the Forum have now been included in the NHS Outcomes Framework 2013–14:
- a new indicator to measure potential years of life lost for children and young people;
  - a new indicator to measure cancer survival for children; and
  - all data will be presented<sup>5</sup> in 5 year age bands up to 25 to enable effective transition to be monitored.
- 3.3 The NHS Outcomes Framework 2013–14 has placeholders for developing an indicator for measuring improvements in children and young people's experience of care. The DH is leading work to identify the best ways to capture the patient experience of integrated care across all ages and patient groups, recognising that there will be different patterns of use and behaviour amongst specific groups of young people. The findings will inform the development of outcome measures.
- 3.4 Nineteen of the 66 indicators in the Public Health Outcomes Framework 2013 – 2016 have a primary focus on maternity, children and young people. A further 21 include younger age groups alongside adults. The Public Health Outcomes Framework domain on the social determinants of health highlights the links between wider social factors and health outcomes.
- 3.5 Significant development work is underway on measures of women's experience of maternity services (NHS Outcomes Framework), children and young people's experience of healthcare (NHS Outcomes Framework), child development at 2–2½ years (Public Health Outcomes Framework) and school readiness (Public Health Outcomes Framework).
- 3.6 The DH is investigating the feasibility and appropriateness (according to agreed criteria) of implementing *all* of the Forum's wide-ranging recommendations on the development or extension of measures for the NHS, Public Health, Adult Social Care and Commissioning Outcomes Frameworks.<sup>6</sup> The Department will not be able to add

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<sup>5</sup> Where technically feasible and statistically robust

<sup>6</sup> Changes to the PHOF will need to be considered as part of a wider exercise considering the content of this framework post 2016.

new indicators to the current Public Health Outcomes Framework which has been set for 3 years. The Forum's recommendations of additional indicators will be considered in the selection process for new indicators. Working with partners, including other Government Departments, the DH will take forward a programme of work to explore detailed options and development costs to implement new or extend existing, data sources and measures in the following priority areas:

- NHS Outcomes Framework
  - strengthening work on measurement of children and young people's experience of care, exploring extension of existing national surveys (such as GP Patient Survey), and Friends and Family Test;
  - integrated care;
  - time to diagnosis/start of treatment;
  - transition from services for children/young people to those for adults; and
  - impact of poor physical and mental health or disability on education.
- Public Health Outcomes Framework
  - maternal mental health; and
  - the prevalence of mental health problems in children and young people.

3.7 We know that there are gaps in the Public Health Outcomes Framework for young people, particularly indicators around physical activity, alcohol, drug use, and wellbeing. This is not because they are not important issues which local areas should focus on improving but because we do not have the means to collect this data. We welcome the recommendation to implement a health and wellbeing survey for young people to address this and we begin by trialling a local-level health and wellbeing survey to test out the best way of collecting the data and how we might ensure a robust response rate.<sup>7</sup>

3.8 As well as local level data for improving health outcomes for young people it is important we measure ourselves nationally and internationally to ensure we are working towards outcomes for children and young people that are up there with the best in the world. We will therefore continue to fund the WHO Health Behaviour of School Aged Children Study which will give us unique and valuable data to be compared internationally.

3.9 We will also extend the 2013 England-only questions in the survey to look more at the issue of resilience and bullying and add further questions to understand health

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<sup>7</sup> If this trial is successful and a full survey is developed the areas will be considered for inclusion in the Public Health Outcomes Frameworks as part of the post 2016 exercise



education in schools. We will introduce new questions to understand young people's views on the use and experience of health services and their access to age appropriate information on health. Furthermore, we will introduce questions on self-harm and mode of travel to school.

- 3.10 The DH will work with partners to explore the potential to present existing data to highlight the outcomes of vulnerable groups (for example those who are looked after, recently adopted, with long-term conditions, disabilities and those living in poverty). Data could support the development of the child poverty needs assessment which local authorities with their statutory partners are required to publish under Part 2 of the Child Poverty Act 2010.
- 3.11 DH has also given a commitment to disaggregate data for indicators in the NHS and Public Health Outcomes Frameworks by inequalities and equalities characteristics where possible, to support local priority setting and to enable a sharper focus on inequalities in outcomes.
- 3.12 The NHS Atlas of Variation in Healthcare for Children and Young People 2012 supports local areas in understanding their performance against others in England. PHE has committed to continuing to produce the Atlas of Variation in Healthcare for Children and Young People, and in conjunction with the Health Intelligence Network will update this annually, to support commissioners in identifying where their outcomes can be improved in line with the best areas in the country.

## Improving Access to Psychological Therapies (IAPT) for Children and Young People: strengthening the focus on outcomes

The Children and Young People's IAPT programme focuses on building collaborative relationships with children, young people and parents and encourages clients to identify and achieve their own goals as well as seeking improvements in symptoms or day to day functioning. Current evidence suggests that where services use such monitoring appropriately and fully in therapeutic contact and in clinical supervision and service development, clients achieve better outcomes.

The project has mandated the collection of measures at assessment, review and discharge, and in addition, frequent (and where possible) session by session measures. The sessional measures include symptom measures, the identifications of goals and feedback on how the session went from the client's point of view – did they feel listened to, did they feel they had a plan of action. The goals and symptoms measures are chosen with the client. The outcome measures are used in sessions to help support discussion with young clients and their families, and help therapists and supervisors to ensure that the therapy offered is helping the child or young person achieve their goals. Therapists have observed that for some children and young people, using the measures and feedback has enabled the child or young person to 'find their voice' in a way they couldn't before. The following case studies demonstrate the use of outcome monitoring to improve clinical practice. In the longer term the intention is to include CYP IAPT data in the CAMHS Minimum Dataset to drive wider service developments.

### Case One

An 8 year old boy referred with severe anxiety who got very upset about talking about his problems was able to write down on the feedback forms about the things that frightened him. This provided the therapist with the key information to begin treatment rather than spending more time trying to draw the child out verbally.

### Case Two

*"Using an anxiety symptom measure (RCADS) with a 17 years old young woman who had not attended for a couple of months as a means of a review – it really helped to have a different conversation and also to have more of a focus for the work. The goals measures were very helpful for monitoring progress by both the child and clinician".*

### Case Three

*"I (the therapist) have obtained feedback that surprised me, given my subjective experience of a session. The anxiety symptom measure has been an excellent tool in refocusing work, for ongoing cases. It has been exciting to explore the data in supervision, and it has contributed helpfully to clinical discussion. These discussions are more transparent to children and young people using the service than before...."*

# 4: Acting early and intervening at the right time

## The Forum recommended:

- all organisations in the new health system should take a life-course approach, coherently addressing the different stages in life and the key transitions instead of tackling individual risk factors in isolation;
- Directors of Public Health, through their health and wellbeing board, should ensure that they include comprehensive data for all children and young people within their Joint Strategic Needs Assessment – including those requiring tailored provision, such as those who are looked after, those with disabilities and long term conditions and those in contact with the criminal justice system; and
- a series of recommendations for CCGs, Local Authorities and Directors of Children's Services in relation to improving outcomes for looked after children and care leavers.

## The System's Response

- 4.1 The Public Health White Paper highlighted the importance of early interventions to improve health and reduce health inequalities across the life course. In addition to steps already in train to improve maternity services and associated outcomes, including reducing stillbirth, DH is committed both to improving the delivery of the Healthy Child Programme 0 – 5 through expanding the health visitor workforce by 50% to 4,200 by 2015 and also to doubling the number of places on the Family Nurse Partnership programme for teenage mothers to 13,000.
- 4.2 DH will continue to focus on younger children to ensure they and their parents get good advice about healthy living. Start4Life is being redeveloped to provide material in relation to key behaviours in pregnancy and starting well to age 5. For 5 to 11 year olds, Change4Life continues to be the sole centrally-funded social marketing programme for health-related behaviours for both families and adults, encouraging people to 'eat well, move more and live longer'. Since its launch, over 500,000 families have joined Change4Life and more than a million mums say their families have changed their behaviour as a result of the campaign.
- 4.3 We recognise that too often approaches to public health and health improvement have focused on individual lifestyle issues and not enough on the individual and the wider determinates of health. We welcome the focus on an 'assets based' approach

to improving health outcomes which sits a person's 'wellbeing' at the centre of holistic positive approaches to health. Children and young people's resilience, self-esteem and confidence lie at the heart of improving their ability to manage risk and we will continue to engage with the new system in spreading this emerging evidence and the approaches it suggests. The enhanced role for local authorities in health improvement and shared leadership of the system at local level through health and wellbeing boards provides the opportunity for improving health outcomes throughout the life course.

- 4.4 Being physically active is important for children and young people. The health benefits include promotion of healthy weight, enhanced cardio-metabolic and bone health and improved psychological wellbeing. But we know that levels of physical activity are lower in many children than recommended. The Health Survey for England (2008) reported that only 32% of boys and 24% of girls aged 2–15 years were achieving 60 minutes of at least moderate activity each day.
- 4.5 We are beginning to appreciate the wider role that physical activity can play as a key protective asset for young people's health and wellbeing. Findings from the WHO Health Behaviour of School aged Children Survey (2011) report that young people who reported low life satisfaction also reported the lowest levels of participation in physical activity. Among young people from low socio-economic backgrounds the highest levels of life satisfaction were reported by those young people who undertook physical activity every day.
- 4.6 In 2011 the Chief Medical Officers of the four home countries launched new UK-wide guidelines for physical activity. The guidelines recommend that all children over five should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day, with vigorous intensity exercise being incorporated at least three days a week. For the first time, recommendations have also been made to reduce the amount of time spent being sedentary.
- 4.7 There of course has never been a better opportunity in which to use the power of sport to engage children and young people to lead healthier lives. We need to capitalise on the great opportunity to developing a lasting Olympic legacy that "inspires a generation". Sport can bring people together, bond communities, raise aspirations and speak to people like very few things can.
- 4.8 The School Games is the Government's framework for competitive school sport, which is designed to get everyone involved and getting active. Already over 16,000 schools have signed up to be part and a network of 450 School Games organisers are actively working across the country to make it happen. What's more, over 12,000 young volunteers are accessing training as young officials, coaches, team managers,

journalists and event organisers – demonstrating the wider catalyst and potential school sport has.

- 4.9 DH is also supporting children and young people to take the first steps into sport and physical activity by investing in Change4Life Sports clubs. These clubs are an innovative model of school sports delivery that aim to engage the least active children in sport. To date, 3,000 clubs in secondary schools have been established giving young people the opportunity to take part in handball, fencing, boccia, volleyball, table tennis, badminton or even wheelchair basketball. There are over 4,500 primary school clubs with children having fun whilst gaining fundamental physical literacy skills in an “adventure”, “target” or “creative” club. An independent evaluation reports an impressive 166% increase in the number of “non-sporty” children saying they choose to play sport every week and an 89% increase in those who now enjoy playing sport.

### **Case Study: Harrow School Improvement Partnership Engaging the least active children through Change4Life Sports Clubs**

Alexandra School is an ethnically diverse primary school in Harrow for children with special educational needs. It includes an Autistic Specific Environment and provides a friendly and caring environment in which children feel valued and secure.

The Change4Life Sports Club consists of targeted children, who are overweight, are not physically active, or lack social skills and several other non-targeted peers to ensure that the clubs are inclusive and the target children do not feel ostracised. We set up several activities within the PE hall and the children can choose and rotate throughout the session, giving them freedom to make their own choices and fully engage with and enjoy the club. After the active part of the session we have 5 minutes to discuss how our bodies feel, what good is being done and various other subjects including healthy eating. We recently hosted a celebration event called “The Big Picnic”. All schools in the borough who have been involved in Change4Life Sports clubs were invited to bring children and parents to enjoy an afternoon of activities based on the Change4Life Sports clubs and of course, enjoy a healthy packed lunch on the school field! We worked with the Primary Care Trust (PCT) and Local Authority to organise the event and invited local sports clubs, coaches and fitness experts to run various activities. Children from our club were also given responsibility to organise and run activities throughout the day. There was an award ceremony, recognising the best clubs and children.

There have been several changes noted by children and staff since the clubs have started in the school. Children thoroughly enjoy the C4L clubs and there have been several occasions when previous 'non-doers' have asked teachers when their next session is. Every child is doing at least one extra hour of structured physical activity per week, and most importantly, enjoying doing it! Teachers and other staff have noticed an increased drive and motivation to learn both immediately after the sessions and throughout the school day from the children who are involved in C4L clubs. This has led to better learning and less instances of disruptive behaviour, which was a common occurrence previously. The Big Picnic was a great chance for the school to open its doors to other schools and invite them in to mix with Alexandra's children. This will break down barriers and hopefully dispel the misconceptions that many people have about special schools.

The news of this success has spread through the borough and now 15 schools are involved in the C4L Sports Club programme. A recent survey of Harrow's clubs revealed that 100% of schools who run the C4L sessions have seen an increase in children's motivation and self-esteem. Weight loss and an increased understanding of how to stay healthy have also been frequently reported. Recognising the impact that C4L can have, many schools are investing in equipment and resources to support the programme themselves by running fund raising events and requesting sponsorship from local organisations.

- 4.10 The use of tobacco among young people continues to remain a serious health concern. The national ambition, set out in the Tobacco Control Plan, is to reduce the number of 15 year olds smoking in England to only 12% by 2015. Recent legislation stopping sales from vending machines and phasing out the display of tobacco products in shops will help to achieve this goal. The Government has also recently consulted on standardised packaging of tobacco products. It has an open mind on this issue and any decisions to take further action will be taken only after full consideration of the responses, evidence and other relevant information.
- 4.11 Levels of overweight and obesity in children also remain high – putting them at greater risk of being overweight and obese later in life and developing serious health problems like Type 2 diabetes, some cancers, heart disease and liver disease. The Government has set out its national ambition for a sustained downward trend in excess weight in children by 2020. The Call to action on obesity (2011) sets out the approach and the role that a wide range of partners can play.
- 4.12 As well as providing robust local-level data on levels of overweight and obesity in local communities, the National Child Measurement Programme will continue to provide an opportunity for engagement with families – through the provision of result letters and follow-up advice and support to parents on maintaining a healthy

weight. The National Child Measurement Programme will be a mandated function of local authorities from April 2013. Changes to the programme will enable the data to better inform public health intelligence on how child weight status affects health through the life-course.

- 4.13 The approach to obesity through the new system will also see greater support for local areas in taking effective action to meet the needs of their local communities – for example by developing new National Institute for Health and Clinical Excellence (NICE) guidance on weight management services for children and young people. At the local level, schools are a key setting for health promotion and prevention. The Government has commissioned an independent review of what more needs to be done to ensure that all children in English schools are offered good food and given an education that cultivates in them an understanding of food and nutrition.
- 4.14 The Public Health Responsibility Deal is a key element of national work to address obesity and improve diet right across the life-course, which helps parents to make more informed and healthier choices for their families. The Responsibility Deal has already led to action to reduce calories, salt and trans fats, and to enable consumer choice by labelling calories in out of home settings. There are early industry signatories to a new pledge to increase uptake of fruit and vegetables, work towards on a new salt reduction strategy, and pledges are planned for 2013 on food promotions and reducing saturated fats. The Government has also announced a way forward on nutrition labelling on the front of food packs which will give consumers clear, consistent information to help them make healthier food choices for themselves and their families.
- 4.15 The Secretary of State for Education has appointed independent reviewers Henry Dimbleby and John Vincent to produce a practical action plan for school food in 2013. The School Food Plan (<http://www.education.gov.uk/schoolfoodplan>) aims to ensure that all children eating in English schools are offered good food and given an education that cultivates their understanding of food and nutrition.
- 4.16 Food choices made by many adolescents are poor. Since eating patterns established during adolescence may remain throughout the life cycle identifying the influences, which affect food behaviour is important to address chronic disease in later life. We will continue to look for opportunities to inform, educate and influence the environment to improve access and availability to healthier dietary choices for this population group.
- 4.17 Government is also taking forward the commitment in the 2010 drug strategy, to provide accurate information to young people, and their parents/carers, about drugs and alcohol through education and the FRANK service. We continually monitor the

advice and information that FRANK provides, ensuring that we keep up to date with emerging drug trends and data.

- 4.18 Since FRANK was launched in 2003, it has changed and developed to meet the needs and requirements of young people in the modern digital world. The service can now be accessed via the helpline, email, SMS, website and mobile site. In January 2013 Live Chat launched from the website and allows users to ask questions online.
- 4.19 We are also looking to improve the ways that FRANK presents information on the website, making content more interactive to prompt an active consideration and contemplation of the issues surrounding drugs and alcohol. We will increase the focus on developing resilience skills in young people so that they can resist pressure from peers and others to start using drugs.
- 4.20 The number of young people in England in 2011/12 who needed help for drug or alcohol use has fallen for the third year running. The number treated for Class A drugs such as heroin, cocaine or ecstasy has reduced by more than two thirds from five years ago, to 631 from a peak of 1,979 (in 2006–07). The vast majority of under-18s (92%) receive support for primary problems with cannabis or alcohol. The proportion of under-18s who left specialist services having successfully completed their programme rose to 77% in 2011–12 from 50% five years ago.
- 4.21 Those who use drugs or alcohol problematically are likely to be vulnerable and experiencing a range of problems, of which substance misuse is one. This means that the commissioning and delivery of specialist drug and alcohol interventions for young people should take place within the wider children and young people's agenda – so that all their needs are met, rather than addressing their alcohol and/or drug use in isolation. As well as addressing young people's alcohol and/or drug use, evidence suggests that substance misuse interventions contribute to improving health and wellbeing, educational attendance and achievement, and reduced risk-taking behaviour, such as offending, smoking and unprotected sex.
- 4.22 Specialist substance misuse services for young people are intervening quickly and effectively – in 2011–12 the average wait for a young person to start getting help was just two days. From April 2013 they will be supported by PHE which will be responsible for promoting evidence-based practice.
- 4.23 To support those working in schools and local authorities, the Department for Education (DfE) are setting up a new drug and alcohol information and advice service for practitioners working with young people. They are also finalising the contract for the Early Intervention Foundation, which will provide a central point to help local commissioners make decisions based on robust evidence of cost, benefits, risks and project outcomes.



- 4.24 We also recognise the strong call from children and young people themselves around making sure they have access to the right kind of information to help them live healthier lifestyles and avoid risky behaviour. To support this the DH will develop a new strategy for using marketing to improve health outcomes among young people. A new, audience-driven approach moves from multiple campaigns about single issues to an integrated approach based on a holistic view of young people. The aim of this strategy will be to better equip young people to manage risky lifestyle behaviours, supporting them to take responsibility for their health, and helping them to reach their full potential.
- 4.25 The role of schools in supporting pupils' knowledge and understanding of health issues is important and vital element of equipping young people to be able to grow up taking responsibility for their own health. The DfE is currently reviewing the national curriculum and the role Personal, Social, Health and Economic Education will play as a current non-statutory programme of study. While not dictating the content of drug education, the DfE has an interest in building the capacity of schools and others to use approaches that are evidence-based. To that end the Centre for the Analysis of Youth Transitions has developed a database of programmes and interventions that have good evidence of impact on outcomes for young people. This includes the impact of drug and alcohol education programmes. The database can be found at <http://www.ifs.org.uk/centres/caytRepPublications>.
- 4.26 A recent report by the Kings Fund<sup>8</sup> highlighted the way in which behaviours such as smoking, excessive alcohol use, poor diet and low levels of physical activity are clustered in more disadvantaged groups, and clearly this will also impact on what is seen as normal by children in families in these groups.
- 4.27 As the Forum's report noted and welcomed, the Health and Social Care Act 2012 introduces new health inequalities duties for the Secretary of State for Health, NHS CB and CCGs.
- 4.28 The Secretary of State's duty is "to have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service", covering both NHS and public health functions (including PHE) for all the people of England. NHS CB and CCGs have duties to "have regard to the need to reduce inequalities in access to, and outcomes from, health care for patients." These duties are enacted from April 2013. One of the key levers in the drive to narrow the health gap across communities and generations is evidence about these inequalities in health behaviours. This highlights the need to include comprehensive data for all children and young people within Joint Strategic Needs Assessments (JSNAs).

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8 Kings Fund *Clustering of unhealthy behaviours over time – implications for policy and practice August 2012*

- 4.29 The NHS CB wants to put an end to unjustifiable variations in services and reduce health inequalities by ensuring that access and provision are consistent and fair. The NHS CB will be held to account against its Mandate from the Government and success will be measured not only by improvements in health outcomes, but also by progress in reducing health inequalities and unjustified variation. It has appointed a Deputy Medical Director with responsibility for health inequalities, and a further appointment is planned with a specific focus on these issues in children and young people and to lead on the recommendations in the Marmot report.
- 4.30 Health and wellbeing boards, with their membership of clinical commissioning groups, Directors of Public Health (DsPH), and Directors of Children's Services, together with a representative from local Healthwatch, will all have access to quantitative and qualitative evidence relating to the needs of children and young people in the area, including those in vulnerable circumstances but also looking more widely across the social gradient of health. Commissioners should look to provision of better-integrated care where this will help improve quality or reduce health inequalities – not only across health and social care services, but with any health-related service.
- 4.31 We have put in place a work programme to improve outcomes for vulnerable children, including looked after children:
- Statutory guidance on JSNAs and Joint Health and Wellbeing Strategies (JHWSs) will emphasise that these must include the health and social care needs of all children and young people, including those in vulnerable circumstances, such as looked after children or those who have been adopted. Due to their experiences, these groups have a high incidence of multiple and complex needs.
  - The Deputy Children's Commissioner's inquiry into child sexual exploitation in gangs and groups highlighted the disproportionate risks facing looked after children living in residential care, particularly those who are placed a long way from their home. DfE with DH and others have been taking forward urgent action to reform children's residential care. This has included an expert working group looking at the quality of children's homes, and another expert group has focused specifically on the issue of 'out of area' placements. Announcements about the action planned to improve the care of this group of children and young people will be made in early 2013.
  - The CQC is currently working with Ofsted to develop a programme of joint inspections of services for looked after children, fostering and adoption services. The new inspections will look at the contribution of both health and social care to providing health services to improving the health and wellbeing of these children. This will be a four year programme of inspections of every local authority area and will begin in April 2013. The final inspection methodology will be published shortly.

- Strategic Health Authorities (SHAs) and the DH have been working with NHS CB, Monitor, Royal Colleges and other partners to develop a national currency and tariff for statutory health assessments for looked after children. Proposals to mandate the currency and provide a non-mandatory tariff from April 2013 have been road tested with a view to final publication at the end of February 2013. This should both improve the quality of health assessments undertaken out of area and decrease the disputes between commissioners and providers about the costs of such health assessments.
- In addition to the emphasis in both the Mandate and the JSNA and JHWS guidance, DH will include evidence based material relevant to adoption in both the children and young people's mental health e-portal (to be delivered by 2014) and the NHS Information Service for Parents. DfE will fund NICE to develop guidance on care and services to promote permanence for children with attachment disorder issues, including those who have been adopted, by 2014/15.
- NICE is developing a health and social care quality standard for the health and wellbeing of looked after children and young people as part of a pilot programme of work, to be published in April 2013, which will set out the priority areas for quality improvement to meet the needs of this highly vulnerable group.
- The Royal College of Nursing (RCN) in conjunction with partner organisations will update the intercollegiate frameworks in light of NHS structural changes in England to ensure roles and responsibilities of all are clearly understood:
  - *Looked after children: knowledge, skills and competence of health care staff.*
  - *Safeguarding Children and Young people: roles and competences for health care staff.* See also paras. 9.8–9.11 on safeguarding.

4.32 The Forum's report also highlighted the importance of early diagnosis and initiation of effective interventions, particularly for vulnerable children, including those with a disability or special educational needs. The joint partnership between DH and DfE to improve outcomes and the range of measures set out in the draft Children and Families Bill, will help to ensure that children's and families' needs are identified at an early stage and that they are able to get the help and support that they require.

4.33 Improving children and young people's mental health is an important ambition, by promoting emotional resilience, good mental health and providing early and effective evidence based treatment for those who need it. The Mental Health Strategy Implementation Framework sets out specific actions which local organisations can take. Schools and colleges in particular have a key role to play in promoting good mental health for all children and young people, targeted support for those at risk of poor mental health and in intervening early when problems become apparent. DfE

have commissioned a consortia of voluntary organisations to support schools in playing their part for example through strengthening their commissioning capabilities.

- 4.34 The new maternity, children and young people's health intelligence network (see chapter 8) will ensure that DsPH have access to evidence on children and young people, including a focus on those with specific needs through PHE's knowledge and intelligence service.

## Case Study

### QK – Putting health at the heart of school life

QK is a large and diverse High school, the Head teacher was keen to improve the health and wellbeing of students, whilst removing the barriers to learning. She identified the need for a full time school nurse as part of the school's early intervention team. The school's senior management and the Senior Leadership Team at CLCH NHS Trust created a new fulltime post based in the high school.

Within QK, the school nurse provides a visible, accessible and confidential service for all young people, it builds on the new DH vision for School Nursing (DH 2012), thus ensuring services are tailored to meet the needs of young people as they arise, giving more support to those who need it most and at times when they need it.

#### We set out to:

- Improve the health outcomes for young people by having a full-time School Nurse based in one secondary school.
- Provide early intervention when problems arise alongside tailored support to overcome issues that get in the way of pupils learning.
- Provide a School Nursing service which is **visible, accessible** and **confidential**, ensuring young people know who their School Nurse is and how to access the service if they have health concerns.
- Ensure school staff understand the School Nurse's contribution to a young person's health and wellbeing.
- Increase effective multi-agency working and joint approaches to safeguarding children and improve their life chances.
- Reduce the number of children who need Child Protection Plans through early involvement with pupils and their families to tackle problems as they arise.

- Support young people to take more control of their health and lifestyle.
- Contribute to the School's PSHE programme, ensuring young people have a good knowledge base of Sexual Health and Healthy Relationships.

Early review of the scheme shows the following:

- Young people reporting satisfaction with the access and service.
- By becoming involved with young people and their families earlier and providing support, we have seen a reduction in the number of children on Child Protection Plans.
- An increase in rate and uptake of Immunisations.

We are currently in the process of evaluating the pilot to look at how the approach has impacted on students, and we will be learning from 'Patient Stories' to make further improvements.

# 5: Integration and partnership

## The Forum recommended:

- the NHS Number should be used as the unique identifier to bring together health, education and social care data for all children and young people;
- the NHS CB and Monitor should prioritise and promote the issue of integrated care provision in their regulatory and performance roles within the NHS, and work with the CQC and Ofsted in developing a framework across non-health providers;
- DH should work with other government departments and partners to achieve better integration of health with education, social care and other local authority led services; and
- DH and partners should select some sentinel conditions and pathways which reflect needs along the life course in order to monitor significant risk of gaps in services, including prevention, and provide focus on improving integration of care.

## The System's Response

- 5.1 Creating a system which offers seamless, person-centred care sits at the heart of the Government's modernisation of the health and care system. The Health and Social Care Act 2012 puts CCGs and health and wellbeing boards at the forefront of planning and delivering integrated care.
- 5.2 Health and wellbeing boards will be a forum for local commissioners across the NHS, public health and social care, as well as elected representatives and representatives of Local Healthwatch, to consider how to improve the health and wellbeing of the local population, and reduce health inequalities. The key benefits of establishing these boards will be to increase the influence of local people in shaping services through democratically elected councillors and local Healthwatch, so that services can better meet local need, be more joined up for the people using them and improve integrated working.
- 5.3 Locally developed and agreed JSNAs and JHWSs will set out what local priorities local commissioners will work on together to deliver the best possible services for their communities. The Act places duties on national bodies to ensure that their work must support the integration of care.
- 5.4 In addition, the Lead Member for Children's Services (LMCS) and the Director of Children's Services (DCS) has a key leadership and statutory role to play and is responsible for the education and children's social services functions of the local

authority as well as ensuring the council is serving the most vulnerable children and young people well. They have a key responsibility for championing a shift towards prevention and early intervention and in listening and responding to the views of children and young people. They also work together with the lead member for adult services to give clear political leadership on effective transition arrangements.

- 5.5 But it is too easy to focus the discussion on integrated care around integration of structures, funding streams or processes, rather than the perspective of children and their families or carers using the services, a point emphasised by the Forum's report. This has led to excessive focus on the means to achieve integrated care rather than the ends – to improve how a service is experienced by the child or young person.
- 5.6 It is also important to recognise that integration for children is different to that of integration for adults. Integration for children includes a range of services including education, health and children's social care services. Partnership working with other services and across Government is therefore crucial to this vision of children and young person-centred services.
- 5.7 The Forum's report identifies sharing of information between services as essential to integration. Providers need the same knowledge, often at the same time, about the child or young person and their family.
- 5.8 Forum members Sir Cyril Chantler and Jean Gross, recently met senior officials from DfE and DH as part of on-going discussions to consider the potential for using the unique NHS identifier more widely. There is broad agreement for the need for services to work together and share information to support children in a range of circumstances. This is a complex area and further work is planned to develop an appropriate approach.
- 5.9 The work of the information sharing group is now complete. The focus of the work has been on information sharing between early years practitioners (for example, staff in children's centres or nurseries) and health professionals. The group's discussions and scrutiny covered the use of both information sharing of population data (such as new birth data) and individual data about a particular child or their family. We expect the final report of the Group, entitled 'Information sharing in the Foundation Years', to be published shortly.
- 5.10 The NHS Outcomes Framework 2013–14 has a placeholder for developing an indicator for measuring improvements in people's experience of integrated care.<sup>9</sup> The Department of Health is leading work to identify the best ways to capture the

<sup>9</sup> *The NHS Outcomes Framework 2013–14*, Technical Appendix (2012), p.85.  
<https://www.wp.dh.gov.uk/publications/files/2012/11/121109-Technical-Appendix.pdf>

patient experience of integrated care across all ages and patient groups. The findings will inform the development of outcome measures.

- 5.11 An Integration Board on children and young people's health has been established, bringing together NHS CB, PHE, Local Government Association (LGA), Society of Local Authority Chief Executives ((SOLACE) and Association of Directors of Children's Services (ADCS) to ensure better integration of public health and care for 0–19s.
- 5.12 The Mandate sets an objective for the NHS CB to work with others to tackle practical barriers preventing services working together.
- 5.13 NHS CB is part of a single Integrated Care (IC) Collaborative programme with key national partners (DH, LGA, Monitor). The NHS CB Chief Nursing Officer is the Senior Responsible Officer (SRO), reflecting the key focus on patient experience. The IC Collaborative's work plan is currently based on four Key Lines of Enquiry:
- How do we define integration?
  - What is the case for change for commissioners? (where does IC have the most impact and benefit for patients?)
  - What are the national enablers and barriers and how can we address them?
  - How can we support local commissioners and providers? (i.e. health and social care).
- 5.14 The first priority has been to define integrated care from the patient/user perspective, for people of all ages including children, so the NHS CB can use this as the basis for all its plans, both individually and through the Collaborative IC programme. National Voices is leading this work and is involving children and young people in the developing 'narrative' for person-centred, co-ordinated care.
- 5.15 CQC requires registered providers of health and adult social care to be compliant with the 16 outcomes in the *Essential standards of quality and safety*. Outcome 6 requires providers to cooperate with other providers. When the care and treatment of service users is shared with, or transferred to, others, the CQC expects providers to be able to demonstrate evidence of:
- appropriate care planning through cooperation of those relevant, and
  - appropriate information sharing particularly around admission, discharge and transfer, and coordination of emergency procedures supporting individuals to access the right health and social care to meet their needs.
- 5.16 The CQC's *Guidance about Compliance* for this standard describes what children who are moving to access adult services should expect and should experience.



- 5.17 Monitor's duty, as set out in the Health and Social Care Act 2012, is to enable integration relating to the provision of healthcare services with health-related services or social care services and co-operation between healthcare providers. Its duty is applicable to all user groups that receive services from providers subject to the licence and it will consider explicit reference to children and young people in the guidance that it will be developing alongside the licence condition.
- 5.18 DH is working with DfE to secure a solution to linking health and education data.
- 5.19 DH and DfE will work with the new Children and Young People's Health Outcomes Forum to consider how to:
- effectively measure the outcomes of integrated commissioning for children with special educational needs or disability who have an Education, Health and Care plan drawing on the evidence from local Pathfinders;
  - prioritise improvement outcomes for children and young people with challenging behaviour; and
  - best support young people with complex needs in making the transition to adulthood.
- 5.20 The Care and Support Bill has new provisions on transition for children to adult care and support, to ensure that the law plays a part in encouraging better practice. The provisions will remove barriers and clarify the role that adult care and support should play in planning better transition. The Bill will ensure that no child reaching the age of 18 should go without the care and support they need around the point of transition. It will require local authorities to maintain children's services until they have adult care and support in place, so there is no gap.
- 5.21 The following case study sets out how the new system will work:

### Case Study

#### Ensuring children with special educational needs get the right care

NHS Newtown CCG has responsibility for a population of approximately 500,000 people; around 10 children are born each year with cerebral palsy in its area, some of them with learning difficulties and other complex conditions.

The PCTs which had commissioning responsibility before 2013 faced criticism from parents that the full health needs of their children who have cerebral palsy were not well met, with uncoordinated services and gaps in provision.

The Government's Mandate for the NHS for April 2013 to March 2015 requires the NHS CB to continue to improve services for both disabled children and adults. It identifies a particular need for improvement in supporting children and young people with special educational needs or disabilities.

The Newtown Health and Wellbeing Board (HWB) undertakes a Joint Strategic Needs Assessment for the local area. As well as representatives of the local authority, CCG and NHS CB, the board includes the local Director of Children's Services and patient representatives through local Healthwatch, who highlight the need for better services for families with disabled children; this is identified as a strategic priority for the local NHS in the agreed Joint Health and Wellbeing Strategy.

NHS Newtown CCG involves the board in developing its commissioning plans. The HWB, in exercise of its statutory role, tells the CCG that the draft plans do not sufficiently reflect the priority of the JHWS strategy to meet the needs of disabled children; the CCG revises the plan working with local Healthwatch to reflect the views of Children and Young People.

The CCG agrees section 75 arrangements with the local authority to pool budgets for disabled children, and agrees an integrated approach to commissioning with the education sector, which draws on the work of a neighbouring SEND pathfinder. The CCG joint funding is agreed for speech and language therapy, occupational therapy and physiotherapy, to be made available to families in a variety of settings, and for community nursing support. The CCG reconfigures services to provide additional sessions of respite care at the local children's hospice, and respite at home by community nurses.

From 2014, the CCG and local authority formally integrate their commissioning for disabled children; each child is assessed quickly by appropriate professionals in a single, co-ordinated process, with the child and their family agreeing the outcomes they want. Each child has an Education, Health and Care plan, setting out the services they need to meet these outcomes, and agreeing a budget, to come from the partners, to pay for these. Some families request a personal budget and use this to choose and buy speech and language therapy, and additional respite care themselves.

- 5.22 The joint commitment by the DH and DfE to introduce an integrated health and education review for 2–2½ year olds by 2015 is a good example of the DH working with other government departments and partners to achieve better integration of services. This will bring together the Healthy Child Programme 2 year review and the Early Years Foundation Stage progress check in a coherent, integrated way, drawing on the different skills and experience of the of the health and education practitioners working with the child.

- 5.23 The Mental Health Implementation Plan has also set out some ways in which services can work in partnership to achieve better outcomes for children and young people. For example, it recognises that children's social services can work alongside CCGs, schools and wider children's services to focus on early intervention and integrated support, such as offering evidence-based parenting interventions to families with children at risk of conduct disorder and improving emotional support for children on the edge of care, as well as looked after and adopted children.
- 5.24 Ofsted will develop two new frameworks for integrated inspection: one, jointly with the CQC, for the inspection of services for looked after children, for implementation in April 2013; and one, jointly with the CQC, HMI Constabulary, HMI Probation, and HMI Prisons, for the inspection of child protection services in local areas from June 2013. In both of these major inspection programmes integration and partnership will be key.
- 5.25 The Royal College of General Practitioners (RCGP) alongside the Royal College of Paediatrics and Child Health (RCPCH), and RCN will be publishing a guide to commissioning a good child health service in 2013. This will outline the key values and principles for how best care for children can be delivered within the individual health economy of each local area.
- 5.26 The RCGP will reconvene the joint working group with RCPCH, and RCN and will also engage with the Royal College of Midwives (RCM) in 2013 to further develop guidance for General Practitioner (GP) commissioners to increase the integration of child healthcare and the provision of services for children by local authorities, health and wellbeing boards and the third sector. As part of this, the RCGP will be developing plans to improve the experience of transition from children and young people's services those for adults by 2014.
- 5.27 The Joint Commissioning Panel for Mental Health which is a collaboration across the RCGP and RCPsych and other organizations interested in commissioning for mental health and learning disabilities (including the Association of Directors of Adult Social Services (ADASS), NHS Confederation, MIND, Rethink, National Survivor User Network (NSUN), New Savoy Partnership (NSP), RCN, the British Psychological Society (BPS)) has produced guidance for commissioners of mental health services for young people making the transition from CAMHS to adult services (2012) and is about to publish guidance for commissioners of child and adolescent mental health services.

## 6: Safe and sustainable services

### The Forum recommended:

- the NHS CB must ensure there is a nationally designated, strategic managed network for children and young people. This should include maternity and neonatal care;
- CCGs need to develop local networks and partnerships with providers to address and deliver the sustainable provision of local acute, surgical, mental health and community children's services and to ensure both care closer to home and no gaps in provision;
- the NHS CB, with CCGs, should address service configuration to meet the needs of children and young people on a sustainable, safe and high quality basis;
- from April 2013, the reporting of medication errors to the National Reporting and Learning System should become mandatory as part of the reporting for the NHS Outcomes Framework, and should become part of the regulatory framework for CQC and Monitor;
- with immediate effect, the Royal Pharmaceutical Society should work with the Colleges and the NHS Institute for Innovation and Improvement to develop a bundle of interventions in order to eliminate or reduce drug errors; and
- DH should commission a study, in 2013, to quantify the harm to children and the costs that arise due to errors from unlicensed and off-label prescribing and through lack of age-appropriate formulations.

### The System's Response

- 6.1 In April 2013 the NHS CB will launch its first four Strategic Clinical Networks, which will tackle areas of major challenge where a whole system, integrated approach is necessary to achieve a change in quality and outcomes for patients. One of these is specific to children and young people: *Maternity and Children*. Its purpose is to help local commissioners of NHS care reduce unwarranted variation in services, to support change projects and to improve outcomes.
- 6.2 The Strategic Clinical Network for Maternity and Children will be organised under Domain Three of the NHS Outcomes Framework: helping people to recover from episodes of ill health or following injury. Improvements in patient experience and patient safety underpin all NHS care and will be embedded within it.
- 6.3 The NHS CB has allocated £42 million to support its strategic clinical networks and clinical senates in 2013–14. Strategic clinical networks will work on the guiding principle of engaging patients and the public in all their work.

- 6.4 Patient safety is a priority across the whole healthcare system and it is vital that the particular patient safety needs of children and young people are fully embedded in health services that this vulnerable group of patients engage with. The NHS CB, through the patient safety domain, will lead the development of a children and young people's patient safety strategy to ensure that children and young people are kept safe from avoidable harm whenever they put their trust in our healthcare system.
- 6.5 The NHS CB will prioritise service configurations that strike a balance between specialisation/centralisation of services versus care closer to home. This is particularly important for the care of children and young people, and their families. This applies to support to CCGs in their commissioning, and to directly commissioned services, including specialised children's services. (The case study from Newcastle illustrates the wide ranging benefits of this approach – see the end of the chapter).
- 6.6 Following a current review of paediatric neurosurgical services, children's neuroscience networks will be established across England. The NHS CB is developing a process for agreeing network configurations against agreed standards: key elements will be stronger co-ordination of care for patients and their families and aiming for 24/7 paediatric care.
- 6.7 Four newly designated children's epilepsy surgical services started in autumn 2012. There will also be seven new congenital heart networks across England and Wales by 2014.
- 6.8 A series of proposals has been produced in relation to children's rare and complex brain tumours. These are now being considered by professional associations and a task group will make recommendations for commissioning in 2013–14.
- 6.9 In relation to specialist cancer services, service improvement changes are being developed for teenagers and young adult cancer pathways. The NHS CB will continue to work with providers to transform care for teenagers and young adults with cancer by delivering age-appropriate care, with the aim of improving services and outcomes.
- 6.10 The Forum recommended that the reporting of medication errors to the National Reporting and Learning System (NRLS) should become mandatory as part of the reporting for the NHS Outcomes Framework, and should become part of the regulatory framework for CQC and Monitor. However, mandating the reporting of all medication errors would be very onerous to the NHS and the regulators, detracting from patient care, and of unclear benefit.

- 6.11 The number of serious medication errors reported to the NRLS already forms part of the NHS Outcomes Framework and serious medication errors have to be reported to CQC under CQC's registration requirements. In addition the NHS CB is exploring how to improve our measurement of patient safety in general through a new indicator related to in-hospital deaths involving unsafe care and specifically in relation to medicines, through the development of a specific medicines 'safety thermometer' – a point prevalence survey tool to measure of harm in care related to common medication errors.
- 6.12 To plan and oversee the system wide response in relation to children's medicines, the Chief Pharmaceutical Officer and President of the RCPCH will jointly chair a Board involving members of Royal Colleges, the NHS Institution for Innovation and Improvement and others, to identify and oversee the development of a programme to optimise the use of medicines in children. This Board will report jointly to the CMO and Chief Executive of the NHS CB, and will be a sub-committee of the CMO's Children and Young People's Health Board.
- 6.13 The Board's work will include:
- improvements to workforce capacity and capability;
  - engaging children, young people and their parents in good medicines use;
  - the industry and role of the regulator; and
  - the development of appropriate outcome indicators.
- 6.14 The Medicines and Healthcare products Regulatory Agency (MHRA) will continue to work with NHS medicines information and reporting services and the Child Health Safety Board hosted by the RCPCH so that captured events can be subjected to signal detection and evaluated for potential regulatory action.
- 6.15 The MHRA will encourage increased paediatric adverse event reporting by building on its existing Yellow Card Strategy, promoting submission of reports on medication error and off-label use. Paediatric signal detection and evaluation will be strengthened within the new European framework. Paediatric Risk Management Plans will be developed where appropriate for newly authorised medicines, supported by post-authorisation efficacy and safety studies, in particular recognising where off-label use may occur. The MHRA will work in partnership with other stakeholders such as Royal Colleges to develop active surveillance schemes.
- 6.16 The Forum recommended that DH commission a study to quantify the harm to children and the costs that arise due to errors from unlicensed and off-label prescribing and through lack of age – appropriate formulations. We will consider commissioning an audit of adverse events and serious reportable incidents to allow

identification of the most serious causes of harm, and then further, focused follow up work could be developed from this knowledge.

- 6.17 The Chief Pharmaceutical Officer is investigating potential action to address the issue that many medicines brought in to the market before 2007 (when paediatric development was obliged by legislation) are not licensed for use in children, although they form the majority of medicines used.

## Case Study

### The children's acute nursing initiative team, Newcastle

The children's acute nursing initiative (CANI) team was created to facilitate much earlier hospital discharge for children and young people living in Newcastle with acute illnesses and exacerbations of chronic conditions. The service creates a "virtual ward in the community" so that children with stable conditions can be nursed safely at home. This significantly shortens admission periods and facilitates more "timely" discharge, thus reducing family stress and disruption and the economic impact of hospitalisation.

The objectives of the service are to:

- provide a high-quality, flexible and responsive service;
- shorten admission periods, and facilitate timely discharge;
- increase patient choice and offer care closer to home; and
- improve trust, efficiency and effectiveness.

Nursing care by the CANI team includes:

- further clinical monitoring, assessment and continued treatment;
- intravenous medication for a large number of conditions, up to three times a day;
- support and advice to reduce parental anxiety; and
- further education and information to empower parents to care for their child during the period of illness and recovery.

In the first year, the service has facilitated the early discharge of 335 children and freed up 2,318 acute bed days (1,372 days in cubicles). The service won the *Health Service Journal* 2010 award for enhancing quality and efficiency in services for children and young people.

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An evaluation of the services provided by the CANI team, managed by Newcastle Hospitals NHS Foundation Trust, showed that during the fiscal year 2008–09, 274 patients were referred from the hospital to care within the home. This resulted in 1,996 potential bed/cubicle days saved, which is equivalent to £1.1 million in hospital costs. After accounting for CANI staffing and equipment costs, the potential saving to the trust amounted to £923,768.



# 7: Workforce, education and training

## The Forum recommended:

- HEE should prioritise children and young people, providing early strategic direction for workforce planning, education and training for the core and specialist children's health workforce;
- HEE should identify a lead LETB to co-ordinate education, training and workforce development to reduce variability and maintain national standards;
- as a matter of priority, the Centre for Workforce Intelligence, in conjunction with key professional bodies whose members provide services to children and young people, should undertake a scoping project to identify and address the issues of providing a safe and sustainable children and young people's healthcare workforce;
- the RCGP proposal to extend GP training to allow for adequate training in paediatrics and physical and mental child health is supported; and
- all general practices that see children and young people should have a named medical and nursing lead. All general practice staff should be adequately trained to deal with children and young people.

## The System's Response

- 7.1 HEE agrees in principle with the recommendations. The DH will work with HEE on the steps needed to provide a safe and sustainable healthcare workforce for children and young people. A lead LETB will be selected to co-ordinate education, training and workforce development to reduce variability and take forward education and training.
- 7.2 The Centre for Workforce Intelligence (CfWI) has identified the children and young people's workforce as an area where work should be undertaken in the next business year, subject to agreement of the Commissioning Group. In order to ensure that the views of the Children and Young People's Health Outcomes Forum are fully understood and feed into the business planning process, a meeting between the CfWI, HEE, DH and the Forum Co-Chairs is being organised for early in 2013.
- 7.3 The Education Outcomes Framework (EOF) is the high level strategic workforce planning, education and training framework, providing a clear line of sight to the

outcomes within the NHS and Public Health Outcomes Frameworks, to variation in standards and ensuring excellence in innovation. The EOF sets out the key domains which will be used as a basis for DH to hold HEE to account for the outcomes it secures through the LETBs and its oversight of the commissioning of education and training services

- 7.4 The RCGP has submitted a proposal for an extension to the training of GPs for a fourth year to include paediatrics, child health and mental health. DH is supportive of the proposal and will carry out work on the economic and affordability cases with a range of key organisations. The Department is also awaiting the outcome of the independent Greenaway report "The Shape of Training" expected this year.
- 7.5 The RCGP has also given careful consideration to the Forum's recommendation that 'All general practices that see children and young people should have a named medical and nursing lead'. With children and young people representing 25% of primary care patients RCGP support this aspiration – the presence of a named lead at practice level is one of the most effective means by which care can be enhanced in primary care. The practical and resource implications of establishing a lead in every practice require further exploration and RCGP is committed to working with NHS CB, DH, the General Pharmaceutical Council (GPC) and others to consider this proposal in more detail.
- 7.6 The NHS CB will either directly commission, or support CCGs to commission services for children and young people that are delivered by professionals with appropriate knowledge and skills. This is applicable to the clinical commissioning guidance developed to support CCGs and through the specialised commissioned National Programme of Care for Women and Children.
- 7.7 Providers of NHS primary medical care will be within the CQC's regulatory remit by April 2013. The standards it inspects against include a number about staffing and the skills and competences of staff.
- 7.8 The RCGP and RCPCH will continue to work together to develop opportunities for all GPs to experience acute childhood illness in a specialist setting during their GP Specialist Training Programme.
- 7.9 The Royal College of Physicians (RCP) are keen to maintain a strong focus on adolescent and young adult health. The RCP's Young Adult and Adolescent Steering Group plans to influence its members and fellows, through highlighting the issues, guidance and disseminating evidence-based practice. The Steering Group has worked (and continues to work) on:
- involving young people in its initiatives;

- contributing to publications in Clinical Medicine (the academic journal of the RCP);
- competencies on key aspects of YAA care embedded with CMT and higher training curricula;
- assessing knowledge of specific issues relating to YAA care in the MRCP exam;
- working to develop and deliver a course for established consultants, and trainees to up-skill physicians in the provision of YAA care; and
- ensuring that all specialties have a structure to include paediatric colleagues in developing transition guidelines.

7.10 The RCP intends to work with the RCPCH to produce a common competency framework with appropriate training for physicians providing adolescent and young adult care.

7.11 The RCN will revise 'Getting it right for children and young people. A self-assessment toolkit for practice nurses.', in conjunction with the RCGP, to establish a clear framework outlining the expected knowledge, skills and competence of all nursing staff in GP practices, walk-in-centres and minor injury units.

## 8: Knowledge and evidence

### The Forum recommended:

- the NHS CB, with support from Health and Social Care Information Centre (HSCIC), should establish electronic child health records, accessible for both patients and professionals;
- the NHS CB, with support from the HSCIC, should improve the quality of routinely collected data, collecting them once and using them for multiple purposes, as well as making secondary uses data readily available to and useable by clinical professionals;
- the Chief Medical Officer should consider how an intelligence network for children and young people's healthcare, which crosses all settings, can be established by 2013, to drive up standards and effective use of data, information and intelligence in decision making;
- NICE and the NHS CB work with the professional bodies to expand and prioritise the Quality Standards work programme as it applies to children and young people; and
- the Chief Medical Officer should use her role as head of research and development to stimulate the development of academic child health, both physical and mental, and the evidence base for practice and improving outcomes.

### The System's response

8.1 With the vast majority of people using the internet now, and having access to higher quality data, there is a need to move more quickly to make health information more easily available to everyone. The Government's Mandate to the NHS CB therefore sets out that:

- everyone who wishes will be able to get online access to their own health records held by their GP by March 2015;
- the NHS CB will promote the implementation of electronic records in all health and care settings;
- work will be done to develop secure linking of these electronic health and care records wherever they are held, so there is a complete a record as possible of the care someone receives;
- clear plans will be in place for those records to be able to follow individuals, with their consent, to any part of the NHS or care system;

- everyone will be able to book GP appointments and order repeat prescriptions online;
- everyone will be able to have secure electronic communication with their GP practice with the option of e-consultations becoming much more widely available; and
- significant progress will be made towards three million people with longterm conditions being able to benefit from telehealth and telecare by 2017.

- 8.2 RCGP with a number of partners and stakeholders has a project in place to establish patient online access to their own health records. The issues relating to children and young people form part of the project. On telehealth and telecare, children and young people with diabetes in the East of England are part of a project examining the use of these technologies, with very good short term outcomes to date.
- 8.3 PHE is establishing a health intelligence network for children and young people. This will be one of a number of health intelligence networks which mirror the priorities of the strategic clinical networks proposed by the NHS CB. The network will address both public health and NHS services. Through strong partnerships with the voluntary and academic sectors, NHS commissioners and providers, and, critically, children and families themselves, the network will exploit information to influence the wider determinants of health, drive up standards in healthcare and improve health and wellbeing outcomes and reduce health inequalities on an on-going basis.
- 8.4 The Chief Knowledge Officer's Directorate within PHE will produce a regularly updated report on indicators within the Public Health Outcomes Framework. This will include benchmarking information for local authorities wherever possible broken down to ward-level information.
- 8.5 The health intelligence network will support this work by reporting indicators that extend to children, young people and young adults into the age-group bandings requested by the Forum. Specific children and young people's health outcomes will be published, which pull together all relevant indicators from the various system outcome frameworks into one place, adding to these over time as the new outcome indicators proposed by the forum become available. PHE will take a lead in facilitating the development of the new indicators and interfacing with existing Outcomes Frameworks.
- 8.6 In having responsibility for both intelligence and screening PHE will have the opportunity to improve join-up across information systems to ensure that all women and their babies are offered appropriate screening and that all those who receive positive results are helped into diagnostic and treatment services.

- 8.7 PHE will deploy successful approaches taken toward surveillance of health protection issues to a range of health challenges including those facing children and young people, to better promote targeted public health action. The Chief Knowledge Officer's directorate will build on the success of disease registration for cancer to extend surveillance on congenital anomalies to 100% coverage. This will enable both early identification of threats to population health and better management of individual cases promoting better long-term outcomes. The new health intelligence network will explore how to extract and use data from Child Death Overview Panels to better understand threats to child safety and lead to improved approaches to safeguarding.
- 8.8 There is a clear ambition for the better use of information to drive up quality of care, improve outcomes, reduce health inequalities and increase both the productivity and efficiency of services. One of the ways in which this will be achieved is by ensuring anonymised information is available to improve health and care. This information flows from clinical services, where it is collected once and once only as part of the interaction between clinical professionals and their patients.
- 8.9 The HSCIC have a role to collect, de-identify, link and publish this information, in order to support decision-making and innovation. The maternity and children's dataset is the means to do this: by taking data from a mothers maternity record and from Child Health Information Systems it will provide the data source to report on how well NHS and Public Health services are improving outcomes for women and children.
- 8.10 The national Child and Maternal Health Observatory (ChiMat) was established to provide wide ranging, authoritative data; evidence and practice relating to the health of women and children. ChiMat will transform to become the children and young people's specialist intelligence function within the Chief Knowledge Officer's Directorate of PHE. This will secure and develop existing capacity and capability in health intelligence and knowledge management and enable a strong foundation for the emerging health intelligence network as well as providing some of the central support that NHS providers are likely to require for the implement the Maternity Child and CAMHS datasets.
- 8.11 The new national Maternity, Child and CAMHS dataset is currently in its implementation phase and the data has been specified for collection from all NHS organisations from April 2013.
- 8.12 Child Health Information Systems (CHIS) are patient administration systems that provide a clinical record for individual children and support a variety of child health and related activities, including universal services for population health. CHIS are

recognised as the main record of child health at a local level, including immunisation, screening, on-going development and any specific health issues.

- 8.13 Work has been on-going to improve and bring greater consistency to CHIS across England. A comprehensive national clinical specification of functionality was published in 2012<sup>10</sup> and underpins arrangements with the NHS CB, which will be responsible for ensuring the effective provision of CHIS from April 2013. The intention is to:
- improve data quality, collect once and enable sharing;
  - allow for better information exchange across other multiple agencies leading to improved outcomes for the child; and
  - help to deliver consistency in functionality and efficacy of these important information systems during transition to the future health and care systems.
- 8.14 PHE's Chief Knowledge Officer will provide a Senior Responsible Owner role for CHIS, managing agreements with the NHS Commissioning Board and ensuring continuous improvements are promoted, PHE will continue the project started during 2012 to promote better links between maternity services and CHIS.
- 8.15 The NICE quality standards programme will deliver the health related quality standards described in its work programme and prioritised in consultation with the NHS CB and the social care related topics with the DH and DfE. An antenatal quality standard has been published and the postnatal care quality standard is in development. A further ten quality standards for children are already in development and a further 32 have been referred as a library of topics to be developed in due course.
- 8.16 The NHS CB, DH and DfE will work with NICE to prioritise further Quality Standards for Children and Young People and support their uptake.
- 8.17 The NHS CB is trialling quality dashboards in 2012/13 for 20 prescribed service areas. Twenty dashboards have been developed including four that are particular to children and young people. Providers will be populating information into these in the following areas: paediatric neurosciences, paediatric intensive care, neonatal critical care and congenital heart services (paediatric cardiac services). Work will continue in 2013–4 to develop quality metrics for all other prescribed services.
- 8.18 In seeking to stimulate the development of academic child health, DH will take into account the ways in which the NIHR and the Policy Research Programme are already

<sup>10</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_133870](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133870)

delivering positive changes such as doubling the number of NIHR Academic Clinical Fellowships (ACF) and Clinical Lectureships (CL) allocated annually between 2006 and 2012. The specialty with the highest allocation of ACFs and CLs over 2008–2012 is Paediatrics. This is one of the largest specialities and also one of those with the highest proportion of academic trainees. Notwithstanding this progress, we recognise that the academic discipline of child and adolescent psychiatry is not as strong as it used to be. We will consider this alongside other areas of need in selecting priorities for future rounds of ACF and CL recruitment.



# 9: Leadership, accountability and assurance

## The Forum recommended:

- all organisations leading the new system – DH, PHE, the NHS CB, Monitor, local authorities and CCGs – should clearly set out their responsibilities for children, young people and their families and how accountability will be exercised at every level in the system, and should be transparent about the funds they spend on child health;
- DH, the NHS CB and PHE should identify national clinical leadership on children and young people, for example through a deputy reporting to the Chief Medical Officer in DH and a National Clinical Director reporting to the Medical Director within the NHS CB;
- CQC should make maximum use of thematic reviews to examine aspects of the new health system from a children and families' perspective; and
- DH and the NHS CB should publish a full accountability framework for safeguarding children in the wider health system as soon as possible. As part of the new multi-agency inspections, CQC should consider how all parts of the health system, including relevant adult services, contribute to effective local safeguarding.

## The System's Response

### Leadership

- 9.1 The DH, in its role as steward of the health system, has policy leadership across the life course starting from pregnancy. On the system's behalf, it is establishing a new Children and Young People's Health Outcomes Forum to keep up the momentum for improvement to outcomes for children and young people. The Forum will provide both expertise in child health and constructive challenge to the next phase of this work. Its first meeting will be held on 13 February 2013. The Forum will hold an annual summit involving CMO to monitor progress on child health outcomes and make recommendations for their improvement.
- 9.2 In addition, effective partnerships are developing across the health and care system between the DH, the new NDPBs and the LGA, SOLACE and ADCS. They will provide strategic leadership, bringing national and local together, to bring about improvement in outcomes for children and young people.

- 9.3 The NHS CB has appointed five National Directors, one for each domain of the NHS Outcomes Framework. In addition to these, it is appointing a number of National Clinical Directors (NCDs) including a National Clinical Director for Maternity and Women's Health and a National Clinical Director for Children and Young People, and Transition to Adulthood and a Deputy National Director with responsibility for health inequalities duties in quality and access to services.
- 9.4 The NCDs will have a responsibility for driving improvement in their area. Specifically, they will drive and enable change on key areas for action, engage with clinicians and patients, agree outcomes by which services will be judged, and support the NHS CB to construct the suite of commissioning instruments to effect that change
- 9.5 A key criticism in the Forum's report in relation to public health was the "lack of visible leadership for children and young people's issues and in some key areas the lack of data that would enable better leadership". Public Health England has appointed a Director of Child Health and Wellbeing and a Chief Knowledge Officer who will provide clear leadership for these areas.
- 9.6 The CMO has established a new Children and Young People's Health Outcomes Board, which met for the first time in October 2012. This brings together key system leaders in children's services to bring coherence and a sustained focus on improving outcomes across the whole child health system.
- 9.7 CMO's personal leadership will be manifested in 2013 when one volume of her 2012 Annual Report will focus on child health, promoting resilience and giving children the best start in life.
- 9.8 The CQC is exploring how thematic reviews or themed inspections can be used to make judgements about the quality and safety of health services from a children and families perspective. This may include work carried out by CQC alone or in collaboration with other inspectorates. It is currently working with Ofsted, HMI Prisons, HMI Probation, HMI Constabulary, and HM Crown Prosecution Service Inspectorate to develop a new programme of inspections of child protection arrangements to start in June 2013. Inspections will focus on the child's journey and experience through all of the health system.
- 9.9 In a complex, multi-agency system, it is essential to have clarity on roles, responsibilities and accountabilities. That is why, in parallel with the revision of statutory guidance led by DfE, DH has been working with the NHS CB and partners to develop an accountability and assurance framework for safeguarding in the reformed NHS.

- 9.10 We have put in place a work programme to ensure arrangements for safeguarding are robust and effective.
- In September 2012, the NHS Commissioning Board Authority issued interim advice for clinical commissioning groups on arrangements to secure safeguarding of both children and adults in the future NHS. The NHS CB will shortly publish an update to that interim advice that provides further clarity on accountabilities for safeguarding children in the NHS.
  - DH and the NHS CB have established a Safeguarding Children Transition Board, bringing together key system leaders in order to develop a shared understanding of respective responsibilities from April 2013.
  - DH has commissioned NICE to develop a health and social care quality standard for child maltreatment, with a focus on the recognition of and response to concerns about abuse and neglect and effective interventions.
  - A number of indicators in the Public Health Outcomes Framework are relevant to safeguarding, including the measurement of child development at 2–2½ years, and others such as those relating to school readiness, alcohol-related hospital admissions and domestic violence.
- 9.11 DH's child protection-information sharing project, announced in December 2012, will enhance national IT systems in emergency departments and other unscheduled care settings to include information on the child protection status of individual children. It will start to be introduced in NHS hospitals in 2015. The project has the strong support of DfE and other key partners.

# 10: Incentives for driving service improvement

## The Forum recommended:

- DH, in its system oversight role, should maintain a focus on the pattern of funding flows across the NHS, local authorities, public health and, where relevant, wider care or wellbeing, to ensure that perverse incentives are not adversely affecting patient care or service provision;
- the NHS CB and Monitor should prioritise and promote the issue of integrated care provision in their funding, regulatory and performance roles within the NHS, and DH should address this issue across government for those services that fall within the remit of local authorities, education, or other government departments; and
- Monitor and the NHS CB should ensure that they continue with the outcome-orientated development of Payment by Results currencies and tariffs for child health related areas.

## The System's Response

- 10.1 As steward of the health and care system, the Department has a responsibility to ensure that the system is fit for purpose and sustainable for the future, with a focus on continuous improvement.
- 10.2 The outcomes frameworks provide the health and care system, the public and Parliament with robust and comparable outcomes-focused information, which show how far the system is delivering better outcomes for patients and users. They allow local partners to compare their performance against others, stimulating conversation, learning and spreading best practice
- 10.3 The NHS CB and Monitor become jointly responsible for the 'National Tariff' as specified in the Health & Social Care Act 2012 from 2014/15. The DH, NHS CB and Monitor are working closely together to manage the transition from existing arrangements undertaken by DH and review the clinical priorities and approach to the first National Tariff in 2014/15.
- 10.4 The NHS CB and Monitor are also taking the opportunity to undertake some strategic work on pricing. It will draw on previous development work and international evidence, and focus on how payment mechanisms can be used as a key tool for

clinically- led commissioning to incentivise and support improved health outcomes for patients, whilst recognising that pricing may not be the only lever to achieve this.

- 10.5 Monitor's current role overseeing the governance of NHS foundation trusts will continue alongside new functions that will be set out in the new provider licence (which includes a condition relating to Monitor's duty to enable integrated care), its key tool for regulating providers of NHS services. Through the licence it will monitor the financial health of providers (social care providers will be exempt from the licence) and take appropriate action if there are warning signs of a provider getting into difficulty, with commissioners taking the main responsibility for ensuring the continuity of services in their local area.
- 10.6 Monitor is in the process of developing its strategy and proposals on pricing alongside the NHS CB, including tariffs that are independent of the provider setting.
- 10.7 CQC uses a wide range of data and intelligence to enable it to target its regulatory activity, including a Quality and Risk Profile (QRP) for each registered provider. These consider a wide range of information and risk factors including local and national data and population factors and where it is relevant will use any new data sources or information about children and young people's experiences of care.

February 2013