

## Chapter 1

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# Chief Medical Officer's summary

### Chapter author

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## Introduction

My annual report must fulfil two functions: to provide **an assessment of the state of the public's health and to advise government on where action is required. To achieve this, as with my 2011 report, I am continuing with two volumes.** The first volume is a compendium of the data and information used to describe the health of the population. The narrative of this second volume (hereafter called 'this report') fulfills the independent advocacy role of the Chief Medical Officer.

Volume one of the 2012 report will be available shortly and contains data and trend analyses of many of the health issues mentioned in this report. The 2011 annual report (volumes one and two) is available at [www.gov.uk](http://www.gov.uk).

### The purpose of this report

This report sets out my response as Chief Medical Officer to **the challenges to the health and wellbeing of our children and young people.** To produce this report **I have drawn on the expertise of a broad range of experts, academics, clinicians and service providers who have set out the evidence about the challenges faced** by policy makers, researchers and front-line professionals such as teachers and clinicians. Crucially, though, **I have also listened to and drawn on evidence from children and young people themselves as well as those who care for them.**

### The choice of focusing on the health and wellbeing of children and young people

I have chosen to focus on children and young people, and in particular on whether we are giving them a good start and building their resilience, for a number of reasons:

- **The evidence base for the life course approach is strong.** What happens early in life affects health and wellbeing in later life. There is increasing evidence that, in England, we are not doing as well as we should to achieve good health and wellbeing outcomes for our children and young people – when we compare both historically and within and between countries for mortality, morbidity, wellbeing, social determinants and key indicators of health service provision.
- **The variation we see within our country shows us what 'good' looks like** and what is possible: we know we can do better.
- While our economic future may be challenging, there is a growing business case for improving the lives of children and young people. Improving health has the potential to **benefit our nation economically.**

Throughout this report I refer to children and young people using the United Nations definition of young people,<sup>1</sup> which includes all those under the age of 25. I have chosen to extend the age cut-off for this report to under 25 (rather than

stopping at adolescents at age 16–18) because I have listened to the evidence of experts who make two clear arguments for the extended definition. First, that **key elements of development, particularly emotional development, continue until the early 20s.** Second, many services end for young people at 16 or 18, yet adult services may not always start at this point. It is thus important to ensure that service provision fits with the evolving scientific evidence base.

### The intended audience for this report

This first chapter is my response to the evidence base underpinning **the challenges facing children and young people today, and is therefore aimed at policy makers and politicians.** This report shines a light on those issues that require specific focus by politicians and makes recommendations aimed at policy makers, health and social care commissioners, police and crime commissioners, and providers of health, social care, education, housing and beyond.

In addition to making recommendations for action by specific bodies, I am also publishing, for the first time, **short summaries for key organisations and individuals to enable them to quickly identify what they can do to improve the health and wellbeing of the children and young people they support, educate and care for.**

The remainder of this report consists of chapters written by internationally recognised experts who were asked to provide an assessment of the key issues facing the health and wellbeing of children and young people in England today. These chapters were written to inform me, as Chief Medical Officer, of the areas I need to champion for action. The chapters were written by the authors and represent their views rather than mine, but they provide the evidence base on which my calls for action are made. Accompanying this report is the Atlas of Variation in Healthcare for Children and Young People 2013, published as an annex to this report, which has been updated and expanded and provides data that have helped shape my thinking.

I have chosen to look at the evidence using a life course approach. Additionally, I have examined four other groups of children and young people, the business case for investing in the health of children and young people, and the views of young people and their families. I have chosen these four groups because they exemplify the challenges that we face. By looking at two disease areas, mental health and neurodevelopmental disabilities, key themes emerge around **the importance of data, service provision and prevention.** Focusing on looked-after children and youth justice reveals themes around **the importance of early life determinants such as parenting and the inequalities that exist in child health.**

This report is not aimed at the general public but, as it addresses issues that affect all of us, it will be useful to those with an interest in this area.

# Recommendations

## Introduction

In the next section I lay out my recommendations. I have grouped these recommendations under themes; ensuring that early action happens, proportionate universalism, engaging with children and young people and building resilience. In the Annex, I have tabulated the recommendations for easy reference. **These recommendations broadly fall into three types; the voice of children and young people, building services and joining services, the economic case for a shift to prevention.** The recommendations I have developed are grounded in the data. While developing this report I have sieved and cogitated on the evidence, and this has led me to believe that we, as a nation, need to strengthen our efforts and develop more co-ordinated approaches to child health and wellbeing if we are to improve outcomes.

The review of the evidence by experts clearly identifies that children and young people in England are not doing as well as they could; with high mortality, morbidity and inequality. In the UK the equivalent of 132,874 excess person years of life are lost per year in the UK, when our mortality is compared to the best performer – Sweden.<sup>2</sup> As an example of morbidity: fewer of those under 25 years old with Type 1 diabetes in England and Wales have good diabetes control compared to their peers in other countries; only 16% achieve HbA1C's under 7.5%. In the equivalent audit in Germany and Austria, 34% of young people achieved this standard.<sup>3</sup> One example of inequality in health is that there would be a 59% potential reduction in psychological and behavioural problems, in children and young people with conduct disorders if all children had the same risk as the most socially advantaged.<sup>4</sup>

Perhaps the most challenging question is why we fare worse than other similar countries. The causes are complex and multifactorial. From listening to many passionate advocates and experts during the course of developing this report it is clear that there is great depth and breadth of enthusiasm, but this does not come together in a fully co-ordinated manner. I welcome the attention that this topic generates, but I believe that the messages need to be clearer and more co-ordinated to allow strong policy responses. I understand that some believe that the best way to achieve this is through altering government structures or processes; others look to the creation of umbrella groupings. **I hope that my report will provide a unifying call around the need, the evidence and achievable actions.**

I am therefore proposing as my first recommendation that England should consider adopting a National Children's Week. While there are international precedents for such events in countries with better health outcomes, to date there is no evidence of correlation. I believe, though, that it is appropriate to undertake this approach in England and evaluate the impact.

A National Children's Week, supported by the Cabinet Office, Public Health England (PHE) and the Children's Commissioner could provide a focal point for all those who are committed to working for improved outcomes for children and young people. Such a week would be the annual opportunity to identify where we stand with respect to children's health and wellbeing outcomes and the wider determinants of health. This week would also build on PHE's and the Department of Health's development work on Start4Life and the Information Service for Parents.

The week could also be an opportunity to highlight how to improve wellbeing. This builds upon evidence that a mechanism to ensure wellbeing amongst young people is to allow them the opportunity to give back to society.<sup>5,6</sup> I welcome recent efforts to encourage community engagement, social cohesion and the transition to adulthood through programmes such as National Citizen Service.<sup>7</sup> Thus this week would showcase young people's achievements, the benefits of youth volunteering and opportunities such as National Citizen Service and the Campaign for Youth Social Action. By focusing attention on young people, this week would also be a lightning rod for the public to better understand the complexity of issues and proposals for improvements.

This would provide an opportunity for synergy between third sector organisations, private institutions and public institutions involved with children and young people. It would showcase to the wider public the efforts of young people, so that we could become a nation that celebrates children and young people more and recognises the positive contributions they make.

**Recommendation 1:**  
**Cabinet Office supported by Public Health England, and the Children's Commissioner, should consider initiating an annual National Children's Week.**

## Ensuring that early action happens

The evidence base clearly identifies that **events that occur in early life (indeed in fetal life) affect health and wellbeing in later life.** Whether this is through changes in genetic expression, how the brain is formed or emotional development, we increasingly understand that what happens in these years lays down the building blocks for the future.

**This is particularly the case at times of rapid brain growth in the early years (i.e. from birth to 2 years) and adolescence. Increasing investment in research in recent years is helping to explain the complicated links between psychology, sociology and biology.** This understanding underpins the concept of the life course, that each stage of life affects the next. Therefore, to try to impact on the diseases of adult life that make up the greatest burden of disease, **it makes sense to intervene early.**

This report draws together both the evidence for early action and, supports this with the economic argument for why this is important. **We know that in straitened financial times it is challenging to identify resources to allocate**

**upstream**, that is before problems have developed. It is hard to balance the need to respond to the pressures of the here and now with the evidence that we should be investing in the future: children and young people. **The evidence base increasingly suggests that failure to invest does not make economic sense.** Our analysis for this report identifies that:

- **the annual cost to the public sector in England associated with children born preterm until age 18 is around £1.24 billion** – total societal costs (including parental costs and lost productivity) are around £2.48 billion in total
- the potential annual long-term cost to UK society of one major kind of injury, severe traumatic brain injuries, is estimated at between £640 million and £2.24 billion in healthcare, social care and social security costs and productivity losses
- **the long-term costs of obesity in England are £588–686 million per annum**
- for mental health disorders the annual short-term costs of **emotional, conduct and hyperkinetic disorders among children aged 5–15 in the UK are estimated to be £1.58 billion and the long-term costs £2.35 billion.**

**Acting early is underpinned by sound science and sound finance.** There are increasingly good data on the return on investment and future cost savings from prevention and early intervention, **for example a 6–10% annual rate of return on investment for spend on intervention in the early years.**<sup>8</sup>

This report also identifies that young people are disproportionately disadvantaged: **26.9% of children and young people (age 0–19) are in or at risk of poverty or social exclusion, compared with the overall population rate of 22.6%.** These figures compare poorly with the best performing country – the Netherlands, with 15.7% in or at risk of poverty.<sup>9</sup> Therefore, **the very group in our population on which science suggests we should be focusing investment is the group that we disadvantage the most.**

I believe that acting early matters. I am therefore recommending that PHE in collaboration with the Early Intervention Foundation examine the extent of early action in health spending, alongside that of other government departments and continue to monitor this over time, building on the work of the National Audit Office. It is also why I strongly support the work of the Big Lottery Fund's A Better Start programme, which aims to improve the life chances of children in their first years by investing £165 million for up to 10 years.<sup>10</sup> Acting early does not mean just acting in early life therefore I am further encouraged that the Big Lottery Fund will shortly announce a new investment to increase the resilience of young adolescents and prevent the onset of mental disorders. Both of these long-term schemes will be evaluated in a robust and timely manner.

### Recommendation 2:

**Public Health England in collaboration with the Early Intervention Foundation should assess the progress on early intervention and prevention, continue to develop and disseminate the evidence base for why this matters and build advice on how health agencies can be part of local efforts to move from a reactive to a proactive approach.**

### Recommendation 3:

**Public Health England, working with Directors of Public Health and Health and Wellbeing Boards, should support the work of the Big Lottery Fund programmes and ensure that the lessons learnt are disseminated.**

### Proportionate universalism

If the argument that early action is important is accepted, as it should be, the question then becomes – how to act? **Proportionate universalism – improving the lives of all, with proportionately greater resources targeted at the more disadvantaged** identifies that a combination of approaches are needed; those that target and those that are more universal. Universal approaches tend to be the most upstream i.e. those based around primary prevention through encouraging the adoption of healthy lifestyles and reducing risks e.g. vaccination programmes. Targeted approaches can be both preventative e.g. seeking to reduce risk, for example current Vitamin D supplementation to specific high risk groups, or secondary prevention, also known as early intervention – seeking to act once early signs are seen, e.g. speech and language interventions.

**I strongly support programmes such as the Healthy Child Programme**, which underpin the public health efforts directed towards children and young people, and seek to include both universal and targeted approaches. The Healthy Child Programme is an evidence-based approach to ensure that children have the best start in life, underpinned by key health professionals, particularly health visitors. **I welcome the current drive to increase health visitor numbers** and the approach taken to transform their profession which clearly articulates the proportionate universalism approach, with a range of services from universal to universal plus and beyond.<sup>11</sup> This work, alongside similar work by school nurses, is critical, as are the commendable efforts of the Department of Health and the Department for Education to meld programmes of school readiness assessment with developmental health checks, culminating in a combined assessment at 2–2½ years. It is, however, fundamental, as changes in health, public health and social care commissioning responsibilities roll out, to ensure that the progress made to date is maintained and built on.

Straitened times potentially force those delivering the Healthy Child Programme to make difficult choices, to cherry pick parts of the programme and only focus on statutory elements or to limit investment just to the most needy. **I am therefore pleased to see the linkage of public health efforts, including the Healthy Child Programme, to public**



## health outcomes indicators<sup>12</sup> by PHE and the Child and Maternal Health Intelligence Network.<sup>13</sup>

To ensure that the Healthy Child Programme continues to be up to date I am asking PHE in association with the National Institute for Health and Care Excellence (NICE) to update the evidence base for the Healthy Child Programme, beginning with pregnancy and the first five years. This work will support the transition of commissioning responsibilities from NHS England to local authorities, overseen by PHE on behalf of the Department of Health.

### A further universal approach is to encourage exercise.

I welcome efforts to encourage more people into physical exercise – a key preventative approach, for example Join In.<sup>14</sup> The recent report by the four UK Chief Medical Officers identifying how much physical exercise should be taken clearly set out the evidence base.<sup>15,16</sup> This report shows that **children and young people are failing to meet this guidance**. I note the efforts by the Welsh Government with respect to improving access to swimming for children; I know too that many attempts have been made to open access further within England.<sup>17</sup> Some local authorities have developed innovative partnerships to utilise facilities out of regular hours. With this in mind, I am recommending that local authorities and schools **develop innovative approaches to widening access to their sports facilities in order to allow children and young people to exercise more easily**.

The area of nutrition exemplifies the challenge for identifying how to promote good health. The growing concern over the prevalence of disease related to Vitamin D deficiency suggests to me that we should re-examine whether the Healthy Start vitamin programme should become a universal offering. There is a growing body of evidence to suggest that providing free vitamins to targeted groups has not led to high enough levels of uptake. This in turn has therefore not impacted on reducing the morbidity associated with vitamin deficiency.<sup>18</sup> I am therefore recommending that NICE examines the cost-effectiveness of the Healthy Start vitamin programme becoming universal.

The Scientific Advisory Committee on Nutrition (SACN) has already recommended mandatory fortification of flour with folic acid to reduce the risk of pregnancies affected by neural tube defects such as spina bifida.<sup>19</sup> SACN subsequently reviewed the potential relationship between high folate status and bowel cancer, concluding that there was no substantial basis for changing their recommendation on folic acid fortification.<sup>20</sup>

I commend the ongoing work of SACN on the impact of current access to iodine intake and health,<sup>21</sup> and look forward to their findings.

**I welcome too the expansion of successful targeted programmes such as the Family Nurse Partnership, and the hugely important work of the Social Mobility and Child Poverty Commission** and their decision to explore the inter-relationships with health for those most in need.<sup>22</sup>

I recognise the important role that programmes such as the Troubled Families Programme can have in turning the lives of families around, helping adults into work, and supporting children to do well at school and build opportunities for their future. The health of carers and children is a crucial foundation upon which to base an effective programme and I know that health organisations play a central role. I am therefore recommending that PHE should work with key health organisations as the Troubled Families Programme grows to ensure this.

### Recommendation 4:

**Public Health England should undertake a Healthy Child Programme evidence refresh, starting with the early years.**

### Recommendation 5:

**Public Health England should work with local authorities, schools and relevant agencies to build on current efforts to increase participation in physical activity and promote evidence based innovative solutions that lead to improved access to existing sports facilities.**

### Recommendation 6: Nutrition

- **CMO recommends that NICE examines the cost-effectiveness of moving the Healthy Start vitamin programme from a targeted to a universal offering**
- **Department of Health to set out next steps in the light of evidence from the Scientific Advisory Committee on Nutrition (SACN) about folic acid**
- **Action is taken if required on iodine following recommendations by SACN**

### Recommendation 7:

**The Social Mobility and Child Poverty Commission and Public Health England should work together to ensure that efforts to narrow attainment gaps in education complement efforts being made to narrow health inequalities.**

### Recommendation 8:

**Public Health England should work with NHS England, the Department for Communities and Local Government and the Department of Health to identify how the health needs of families are met through the Troubled Families Programme.**

## Engaging with children and young people

This report clearly identifies the **all-too-common mismatch between the expectations of children and young people and their families and the reality of healthcare delivery**. I am pleased to see:

- the work of NHS England to develop a Friends and Family Test for children and young people
- the ongoing work on the trial health and wellbeing local level survey for children and young people

- the recent development of a forum of young people which will work with, and guide the work of, NHS England around children and young people.

To me it is clear, through the voices of the children and young people who contributed to this report, that they want us to go further. The Government's pledge to improve children and young people's health outcomes identifies the importance of responding to their needs; the first priority: 'Children, young people and their families will be at the heart of decision-making.'<sup>23</sup> The Department of Health has previously focused on this through the You're Welcome initiative.<sup>24</sup> This allows organisations to self-identify how young person centric they are.

I am therefore recommending that the Department of Health, NHS England and PHE build on the work of You're Welcome and the suggestions in the Children and Young People's Manifesto for Health and Wellbeing in Chapter 4 and **develop a 'health deal' for children and young people**. This would clearly identify what is expected of health organisations that serve them and how they can best engage with healthcare. Central to the development of this work is the engagement of children and young people in the process at national and local levels, as well as leading children and young people's organisations such as the National Children's Bureau and the Association for Young People's Health. I would expect this to also fully consider the needs and views of those groups of children and young people who experience additional disadvantage, including looked-after children, young people in the justice system, disabled young people, black and ethnic minorities and those who are victims of neglect and abuse. Developing a compact between young people and health providers which stresses responsibility on the part of young people with promises of more young people friendly care is crucial to re-engineering professional relationships that can address the challenge of the current burden of disease such as long-term conditions.

**A fundamental principle is that the workforce that cares for children and young people must be properly trained to deliver age-appropriate care.** This is why I am recommending that Health Education England (HEE) ensure that such training is commissioned. Part of the challenge for children and young people identified in this report is navigating our complex health and care system. I warmly welcome the earlier work by the NHS Institute for Innovation and Improvement, to develop lesson plans which teach all children and young people, in an age-appropriate manner, how and where to find necessary support and care in the NHS.<sup>25</sup> I also therefore recommend that HEE ensures that training develops a workforce that is able to assist children and young people in identifying where to go for care and when.

Furthermore **I am keen to see that the extension of GP training includes as part of the core component training on paediatrics and child health.** Following the Secretary of State for Health's announcement that older people would benefit from a named GP to provide continuity of care, I believe that **there are certain groups of children**

**who would benefit similarly, in particular those with long-term conditions such as diabetes and mental health disorders.**

### Recommendation 9:

**The Department of Health, NHS England and Public Health England, alongside representatives of children and young people, should build on the You're Welcome programme and the vision outlined in the recent pledge for better health outcomes for children and young people to create a 'health deal' which outlines the compact between children and young people and health providers, and creates a mechanism for assessing the implementation of this.**

### Recommendation 10:

**Children with long-term conditions, as vulnerable people, should have a named GP who co-ordinates their disease management.**

### Recommendation 11:

**As plans are made to extend GP training, paediatrics and child health should be part of the core component of extended training.**

### Recommendation 12:

**Health Education England should commission education to ensure that the workforce is trained to deliver care that is appropriate for children and young people, in the same manner as is being currently carried out for age-appropriate care for older people.**

### Recommendation 13:

**Health Education England, the Department of Health and Public Health England should work to ensure that commissioned education of health professionals stresses the important role of school nurses.**

## Building resilience

The seminal work of researchers such as Sir Michael Rutter clearly identifies the importance of ensuring that young people are equipped with the skills and knowledge to navigate the complexities of life. **Rutter uses a powerful metaphor to explain the importance of this approach.**

**We vaccinate our children against infection** by using modified strains or parts of the infective organism that we are aiming to protect against (e.g. measles). This means that, while we cannot fully eliminate the risk to young people of exposure to the pathogen, they are equipped later when challenged to mount a successful immune response. **Similarly, we need to develop strategies to enable young people to be able to mount successful responses against life's challenges, and to do this we need to inoculate them and thus develop resilience.** By exposing young people to low doses of challenges, in safe and supported environments, we strengthen their ability to act effectively later in life. This report identifies many of the key factors that are needed to ensure that such exposure is safe. In particular there is **increasing evidence that schools and local authorities can successfully step in.** I am

therefore very pleased to see the recent publication by NICE of a local government public health briefing entitled *Social and emotional wellbeing for children and young people*,<sup>26</sup> which should provide those involved in commissioning and delivering services for children and young people with the information to adopt an approach that increases resilience and wellbeing.

I am recommending that PHE works with leading organisations in school health improvement, such as the Education Endowment Foundation, to develop and disseminate the evidence base, attempt to identify a marker of resilience and nurture implementation strategies to support organisations such as schools and colleges that wish to use this approach.

Just as schools and other organisations can play an important role in resilience, so too can they play an important role in wellbeing. **There is a strong association between school connectedness or sense of belonging and wellbeing.**

To date, there has been considerable success in addressing behaviours that can increase harm to health, for example smoking. **These behaviours are often called 'risky behaviours'; however, in this report they will be grouped as 'exploratory behaviours' in order to be fair and destigmatised. Evidence suggests that resilience and feeling connected have a positive effect in reducing participation in exploratory behaviours. So too does having strong communication between parents and young people.** My report identifies that there is increasing evidence of the interactions between different exploratory behaviours. I therefore support the work of PHE to develop an adolescent health framework and recommend that the framework addresses exploratory behaviours as a group rather than as individual topics, and pays special heed to how families and organisations can facilitate this. Furthermore, **I support PHE's planned youth social marketing programme Rise Above, which will engage young people on issues around exploratory behaviours through multiple platforms.**

Just as important as addressing exploratory behaviours is improving healthy behaviours. I acknowledge the efforts of school nurses in health promotion and coordinating health and wellbeing services in school. I support and welcome the agenda developed in the School Food Plan<sup>27</sup> to improve the eating habits of young people and the quality of food provided. There is a similar need to encourage increased exercise, with recent evidence showing that only half of children and barely a third of girls meet the recommended standard. I am very pleased to see the effect of the London 2012 Olympics legacy supporting efforts by the Department for Education, the Department for Culture, Media and Sport, schools and the voluntary sector to encourage school exercise programmes, for example Change4Life Sports Clubs and the £300 million investment in primary school sport.<sup>28</sup> These both engender better health and create the sense of connectedness that is so important to wellbeing.

Listening to the voices of children and young people it is clear that they value education and knowledge about health. Evidence also identifies the benefit that good education about health can have on health behaviours. I believe that **successful schools are increasingly showing how improved educational results are achieved by looking holistically at children and young people. The recent School Food Plan and the offer of extended free school meals are examples of how practice has been changed because of the potential benefits to educational attainment and wellbeing.** I therefore recommend that PHE and the PSHE Association work to develop models of good practice to show how these schools have demonstrated success in educational attainment, in part through activities beyond didactic education, thereby allowing others to embrace such steps. Areas that could be explored would be personal, social, health and economic (PSHE) education, a subject that forms a bridge between health and education by building resilience and wellbeing.

## Recommendation 14:

**PHE should develop and enact a youth social marketing programme, "Rise Above" to engage young people around exploratory behaviours through multiple platforms.**

## Recommendation 15:

**Public Health England and other leading organisations working in the field should work together to strengthen the evidence base for programmes that develop resilience in young people.**

## Recommendation 16:

**Public Health England should develop an adolescent health and wellbeing framework which includes the inter-relationships of exploratory behaviours. As part of their public-facing work, Public Health England should model engagement with young people on multiple health and wellbeing issues through a variety of platforms.**

## Recommendation 17:

**Public Health England, the PSHE Association and other leading organisations in the field should review the evidence linking health and wellbeing with educational attainment, and from that promote models of good practice for educational establishments to use.**

## Oversight

The new landscape of the NHS and the focus on integration (vertical and horizontal) are of fundamental importance to children and young people. However, current health and social care utilisation by children and young people is different from adults. Thus it is fundamental that children and young people's needs are fully addressed and not lost in the bigger picture of health and social care reform.

**I welcome the enthusiasm and energy of the Maternity and Children's Services Strategic Clinical Networks** and the efforts that they are making, led by NHS England,



to deliver change and improvement in local systems. I am also very **pleased to see the evolution of the Child and Maternal Health Intelligence Network** which will provide strong data support for changes in healthcare for children and young people at a national and local level. One example of the important data now becoming available is that of the Child and Maternity Dataset – allowing us for the first time to map influences in pregnancy and their effects at scale. **I also welcome the new NHS England Maternity and Perinatal National Clinical Audit, supported by the Healthcare Quality Improvement Partnership**, which will provide invaluable information with evidence-based questions and outcomes-focused data to describe trends in outcomes, morbidity and mortality.<sup>29</sup> It will be complementary to Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBRRACE-UK).<sup>30</sup> I believe that the collection of such data is fundamental: locally this allows the provision of key evidence to underpin health and wellbeing boards' joint strategic needs assessments, and nationally it permits transparent sharing and examination of the data, looking at variation and questioning causation.

**I believe that the work of the Children and Young People's Health Outcomes Forum has been invaluable in identifying the key indicators for child health and wellbeing.** I therefore suggest that the Children and Young People's Health Outcomes Forum highlights the progress towards this and other key health indicators at their annual summit, thereby shedding light on this fundamental information. Having an annual opportunity to examine how well we are doing, led by experts, is an important mechanism to ensure progress.

As strong regulatory frameworks develop, it is fundamental that they oversee the relevant interactions to ensure that children and young people, particularly those with additional needs whether due to disability, safeguarding or other issues, do not fall between the gaps. **I therefore welcome the reviews by the Care Quality Commission (CQC) to enhance healthcare services for children and young people in care and recent care leavers and those in need of safeguarding**<sup>31</sup> as well as the review looking into children and young people with complex health needs transitioning to adult services.<sup>32</sup> I believe that the development of case-tracking methodology will help to highlight the issues faced by families, in particular as the pathways of care cross regulatory boundaries. I am therefore recommending that Ofsted and the CQC work together to develop inspection methods and regulatory questions that probe the interconnectedness of health and other services.

**I also welcome the creation of Healthwatch**<sup>33</sup> and the involvement in this of organisations and individuals who are focused on the needs of children and young people, which will enable users of services to maintain a voice in the improvements to the services that they receive.

**Recommendation 18:**  
**The Children and Young People's Health Outcomes Forum annual summit should provide an opportunity**

**for the review of health outcomes that are relevant to children, and to examine regional variation.**

**Recommendation 19:**  
**Regulators, including the Care Quality Commission and Ofsted, should annually review the effectiveness of inspection frameworks and the extent to which they evaluate the contribution of all partners to services for children and young people. This includes the contribution of statutory partners, local safeguarding boards and health and wellbeing boards to the health and protection needs of children and young people.**

### Professional responsibility

**All health care professionals have a responsibility to safeguard children and young people in their care.** Health care regulators such as the General Medical Council and Nursing and Midwifery Council have guidance in place in respect of the responsibilities of their professional members. Indeed recent General Medical Council guidance particularly stresses that safeguarding is part of the role of all doctors and thereby marks an important evolution in our attempts to protect the most vulnerable in society.<sup>34</sup> I believe that one of the key strengths of the UK health system is our family-orientated approach to care. The role of GPs is fundamental in providing holistic care which joins up the needs of the whole family. However, **just as safeguarding is everyone's business, so too should be thinking about the whole family.** I therefore recommend that the Royal Colleges use the opportunity of the review of the *Safeguarding Children and Young people: roles and competences for health care staff – intercollegiate document* to embed the whole family as integral to the professional responsibility of all healthcare professionals. I would additionally **urge the professional colleges/bodies of other health care professions, including for nursing and allied health professionals (AHPs), to review their guidance and documentation to ensure that family health is central to multi-professional practice.** I know that this work seeks to embed learning at all stages of career development. I am especially keen that this should be built into continuing professional development via a variety of means, including e-learning and further emphasis within the RCGP safeguarding toolkit.

**Recommendation 20:**  
**The review of 'Safeguarding Children and Young people: roles and competences for health care staff – intercollegiate document' should embed the professional responsibility to the whole family, and professional bodies should develop the necessary innovative tools to support this.**

### Mental health

The recent extension of Improving Access to Psychological Therapies (IAPT) to children and young people and the soon-to-be-reached figure of 60% geographical coverage are to be applauded, as is the focus on this area by the National Clinical Director for Children, Young People and Transition to Adulthood. I also **welcome the creation of the national**



**Child and Adolescent Mental Health Services (CAMHS) data set** which will allow valuable insight into care provision to be addressed. However, **CAMHS services face pressure and cuts** as the part of their budget that is supported by local authorities comes under budgetary constraints. To ensure that provision meets demand it is therefore imperative that data are collected on the prevalence and incidence of mental health conditions and an annual audit of services and expenditure in the area undertaken.

**I welcome the development of the trial health and wellbeing local level survey for children and young people.**<sup>35</sup> This builds on the national work of Office for National Statistics (ONS) in this area, supplementing local data and widening the ages included. This will provide key information to underpin the work of cross government and beyond working. **As 75% of adult mental health problems begin before age 18 it is imperative that the burden of disease is monitored regularly.**<sup>36</sup> I therefore recommend that the Mental Health of Children and Young People in Great Britain, 2004 survey is repeated, and is extended to include those with underlying neurodevelopmental issues, those aged under 5, ethnic minorities and those in the youth justice system. These data will therefore form a core part of local authority joint strategic needs assessments, commissioning and balancing finite resources.

## Recommendation 21:

- **The Department of Health should work with Office for National Statistics, Public Health England and relevant third sector organisations to investigate opportunities to commission a regular survey to identify the current prevalence of mental health problems among children and young people, with particular reference to those with underlying neurodevelopmental issues, those aged under 5, ethnic minorities and those in the youth justice system.**
- **This data collection should include international comparisons and be linked to the Child and Adolescent Mental Health Services data set, providing key data for developing local services to meet clinical need.**
- **An annual audit of services and expenditure in the area should be undertaken.**

## Research call

As the burden of disease continues to shift towards long-term conditions, there has been considerable focus on how to meet this challenge in adults. **The data on mortality for children and young people dying from non-communicable disease in the UK, and the variation shown in long-term condition management by the Atlas of Variation in the Health of Children and Young People 2013, attest to how much further effort is required for children and young people.** The National Institute for Health Research will support a programme of evaluative research that increases the knowledge base. This will also help to build research capacity in the area.

I am absolutely committed to supporting the work of the Royal College of Paediatrics and Child Health Child Mortality Taskforce. I commend the recent work of the Clinical Outcome Review Programme: Child Health Reviews to better understand the causes of death in young people. I fully support the collaborative efforts of the Department for Education and the Department of Health to reposition the Child Death Overview Panels within the remit of the Department of Health in order to facilitate improved insight from these deaths for healthcare. Furthermore, I am keen to build on the work carried out in Northern Ireland by the Chief Medical Officer, Dr Michael McBride, and others such as the Child Accident Prevention Trust (CAPT) to better understand and reduce deaths from blind cords. **Pooling data on patterns of child deaths allows key trends such as these to be identified.**

## Recommendation 22:

**The National Institute for Health Research should develop a research call to provide the evidence base to improve health outcomes for long-term conditions in childhood, to match the best worldwide.**

## Recommendation 23:

**The National Institute for Health Research (NIHR) Clinical Research Network, including the NIHR Medicines for Children Network, should work with children and young people to input to the design of clinical studies in order to facilitate increased participation of children and young people in drug and other trials.**

## Recommendation 24:

**The four UK Chief Medical Officers have agreed that the Chief Medical Officer in Northern Ireland, Dr Michael McBride, will lead a group with the four public health agencies and The Royal Society for the Prevention of Accidents (RoSPA) to develop strategies to combat blind cord deaths.**

## Conclusion

As Chief Medical Officer, my role is to collate, evaluate and articulate the evidence on key topics such as child health and wellbeing. My recommendations seek to catalyse change based on the evidence provided in this report. However, as I said in the Foreword, I do not underestimate the enormity of effort required to bring about real change in this area, for the **health and wellbeing of children and young people is a complicated mixture of genetics, sociology and psychology. Committed collaborative efforts are required.** Perhaps more than the effect of any one single recommendation, I believe that the benefit of this report will be to remind us all of how much the health and wellbeing of children matters to us all. Despite the continued efforts of many across many fields, **the evidence still points to room for improvement. We need everyone in the public services to 'think family and children and young people' at every interaction.** Increasingly, the wider benefits of such action are being honed into clear numerical

statements. We cannot waste the lives of children, we need to ensure we have a healthy population able to ensure our continued economic viability; we need to make sure our children start school ready and able to learn, and leave school fit for work. Such strong evidence should never be ignored: **rarely in health are there such opportunities to improve lives as well as show economic benefit** – surely addressing this means acting not just because our hearts tell us to do so, but because, with increasingly clear evidence, our heads should also encourage us.

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