CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM

CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM – REPORT OF THE PUBLIC HEALTH AND PREVENTION SUB-GROUP

Public Health and Prevention

The foundations of good health and well-being

Our Aim

The Public Health Group of the Children and Young People's Health Outcomes Forum focused on developing suggestions and recommendations for how the new health system could improve the life chances of children and young people by promoting good health and acting early where problems are developing. Our aspiration is that the new system supports all infants, children, and young people; helped by their families, to lead healthy lives as they grow and develop into adults.

Throughout our work, we have been guided by the Faculty of Public Health's definition of public health:

> *'The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.'*

Background

Public health for children and young people aims to promote their health, prevent disease, develop their resilience and foster equality starting before birth through childhood and the teenage years and into young adulthood. Trends for children and young people's health shows that in some areas there has been little change, in other areas there have been significant improvements, and yet there are others where things have got worse[1]. Despite some important improvements in numbers of young people smoking and a decline in teenage pregnancies, more children and young people under 19 years of age are obese, and more are dying in this country than in other countries in northern and western Europe. The data also tells us that we are worse than other countries in Europe for many outcomes that can be improved through better health promotion and preventative interventions. This alone makes a compelling case for change.

The foundations of good health and well-being are laid at the start of life in pregnancy, childhood, and in adolescence especially the teenage years.

> *'What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status.'*
>
> 'Fair Society, Healthy Lives' (The Marmot Review)[2]

Evidence demonstrating the impact of positive and negative experiences during pregnancy and the early years of life on a child's health and well-being throughout childhood and into adult life continues to mount. The work of Graham Allen and Iain Duncan Smith support the growing body of evidence about how children develop, how their brains grow and how the quality of their early life experiences can make a real difference to their life chances.[3] In his review of children's services, Professor Sir Ian Kennedy concluded:

> *"Perhaps the single most important cultural shift that is needed from the NHS is to invest in the development of children in their early years (from minus nine months to two or three years old).*

These early years are absolutely central to the developmental fate of a child, yet until recently they have received virtually no attention."

'Getting it right for children and young people –
Overcoming cultural barriers in the NHS so as to meet their needs'[4]

Emerging knowledge about adolescent brain development[5] shows an equally important challenge for adolescents who in puberty and pre-puberty face the beginning of a rapid and dramatic re-organisation of the brain. These changes affect behaviour and attitudes at a time when health and well-being choices can be challenging for them. Heightened sensitivity to reward occurs in early adolescence, whereas the development of the impulse control and strategic decision-making functions occurs more gradually over a longer period of time. Social capabilities, such as the ability to recognise emotions in others[6] and the ability to understand another person's point of view are temporarily compromised or still undergoing development into late adolescence.[7] These changes in social functioning occur at a time when peer interaction is increasing and reliance on parents and family is decreasing. The combination of these changes can lead to greater risk-taking behaviours.

The Health Behaviour of School Aged Children study, funded by the Department of Health, has shown how having a sense of belonging, autonomy, building social relationships and social support operate as protective factors for young people in relation to multiple health-risk behaviours.[8] Levels of autonomy within the family and a sense of belonging at school and feeling safe in the local community were found to be important predictors of adolescent health related behaviours and well-being.

Extensive research has shown that people who are most affected by societal inequalities due to factors such as low income, social position, ethnic origin, geography, or age are more likely to have poorer physical and mental health than the general population.[9,10] Children who are resilient have the ability to adapt despite experiences of significant risk or trauma.[11,12] Breaking the link between disadvantage and poor physical and mental health is crucial to narrowing the health gap and maximising opportunities for children and young people and the generations that follow. In recent years, successive reviews have demonstrated the economic and social value of prevention and early intervention programmes starting in pregnancy and continuing through the early years, childhood and the teenage years.[13,14,15,16]

Children and young people are rightly a target for public health services. The fact of their youth means there is time to prevent damaging behaviours and attitudes developing and time to help them establish good patterns of managing their health for the rest of their lives. Children's early intervention and prevention public health is delivered through the evidence-based Healthy Child Programme 0–19 (HCP), which provides screening, immunisation, health and development reviews including sight and hearing for children and covers the period from pregnancy to 19 years of age.

Key Facts

- **Low birth weight** is strongly associated with perinatal and infant deaths. Babies just below the low birth weight threshold (2,000 to 2,500 grams) are five times as likely to die as an infant as those of normal birth weight;[17]
- Children of mothers who have **postnatal depression** (PND) are less likely to show secure attachment at 36 months[18], are more likely to have social, emotional and cognitive problems at

age 5[19] and are more likely to experience depression by 16 years.[20] PND affects around 70,000 women per year in England and Wales;

- More than 1 in 5 children are **overweight or obese** by age 3 – around one third of young people aged 11–15 are overweight and around 1 in 5 are obese;
- Approximately 7% of five year olds entering school in England – nearly 40,000 children in 2007 – have **significant difficulties with speech and/or language**;[21]
- Only 15% of girls and under a third of boys report meeting the Chief Medical Officer's guidelines for **physical activity** of at least one hour of physical activity each day;
- The **under-18 conception** rate in 2010 fell by 24.3% to 35.5 per 1,000 girls aged 15–17, down from 47.1 in 1998, and the lowest rate since 1969, however, Britain still has one of the highest teenage pregnancy rates in the western Europe and young people carry the highest burden of sexually transmitted infections;
- Among 16–19 year olds in Britain over a 25 year period, the proportion who **smoke** has fallen from a third to a fifth;
- The proportion of young people who **drink alcohol** has reduced substantially in the last decade – from approaching 50% of 15 year olds in England in 2002 to around 30% today, however, those that do drink reported their consumption in the previous week to be an average of 12.1 units for 11–13 year olds and an average of 12.9 units for 15 year olds;
- **Suicide** rates among 15 to 24 year-old young men have fallen over the last 10 years from 16.5 per 100,000 in 2000, to 10.5 per 100,000 in the latest statistics from 2009;
- **And the costs of inaction are huge:**
  - 8 in 10 obese teenagers went on to be **obese** adults;
  - half of life time **mental illness** starts at age 14; and
  - more than 8 out of 10 adult **smokers** started before 19.

The outcomes we are seeking to achieve through the new health system are:

- babies, children and young people have positive attachment with their parents;
- babies, children and young people live healthy lifestyles and have a positive sense of well-being;
- babies, children and young people develop and achieve their potential;
- babies, children and young people are in the best possible health at birth, have good nutrition and maintain a healthy weight;
- babies, children and young people are protected from ill health, injuries, and physical and mental health problems;
- children and young people are involved in decisions about their health and well-being.

Through these outcomes, the root causes of health inequalities can be addressed and inequalities measurably reduced.

Approach taken

Engagement with children, young people, and other stakeholders

The Public Health Group comprised specialists in maternity, babies, children and young people as a public health population. A list of members is included at Annex 1. We carefully considered submissions from stakeholders responding to the open call by the Forum and met with professionals,

commissioners, academics and others with a range of expertise including pregnancy and birth, nursing and midwifery, health visiting, early years, children in public care, disability, special needs, public health, well-being and schools.

Unlike other stakeholders in public health and the NHS, children and young people do not have a voice in the democratic process that defines how the public wishes to see its health provision delivered. Unlike adults, they are not routinely present in planning, commissioning and delivery processes. For this reason, we considered it imperative to hear the views of children and young people. This included a review of what children and young people themselves have said about their health and health systems over the last five years, the results of which are in the National Children's Bureau's, 'Listening to children's views on health provision – A rapid review of the evidence'.[22] The Rapid Review told us just how important it is to children and young people that they are seen as active agents in relation not only their own health but also in relation to the health system.[23] We also benefited from direct engagement with over 350 young people about the relevance of the public health outcomes to their lives. The National Children's Bureau analysed the views for us in the 'Children and young people's views about health outcomes' report.[24]

Review of NHS and Public Health Outcomes Frameworks

We reviewed the outcomes and indicators in the **NHS Outcomes Framework 2012/13** and the **Public Health Outcomes Framework for England, 2013–2016**. We also discussed and debated a large number of potential new indicators that could be reported at national or local levels with a view to making recommendations about indicators that could fill gaps in future NHS or public health outcomes frameworks or could inform future service provision and commissioning from a public health perspective.

Development of recommendations

Our discussions both as a group and with other stakeholders considered not only what is important for children, young people and their parents, but also how the elements of the new NHS and the public health system could deliver health promotion and illness prevention and protection services and programmes such as the 'Health Visitor Implementation Plan 2011–15: A Call to Action'[25] that will make a difference to this population. This informed the development of suggestions that we believe will help those working in each part of the system to improve the life chances of all infants, children and young people.

Findings and Conclusions

The need for the health system and the culture within the system to take a positive attitude to health promotion was repeatedly reinforced in our consultation. There was a clear message that this should be through an 'assets based approach' that nurtures the strengths and resources which children, young people and their families and communities have at their disposal rather than a negative 'deficit approach'.

We heard a lot about how health promotion for children and young people has focused predominantly on reducing specific health-risk behaviours or sets of compartmentalised 'fixable faults' and this focus on separate behaviours has tended to preclude the inter-relationship between health-risk behaviours and the contextual factors. This inter-relationship may either increase risk,

for example living in a community where early sexual activity is the norm, or operate in a protective manner, for example where schools, including academies, employ school nurses and provide high quality health promotion in high risk communities.

Furthermore, we heard that insufficient consideration has been given in public health policy to building health engagement, resilience, self-esteem and self-efficacy that might promote well-being in children and young people. Some progress has been made however, and there has been valuable learning in the last decade from the 'wrap around the child' approach of Every Child Matters, the multi-agency collaboration of the Teenage Pregnancy Strategy and the Positive for Youth policy statement.

Increasingly, positive approaches to health and development, where children and young people become agents of health promotion themselves, are being seen as a way to unlock some of the existing barriers to effective action on health inequities, so far characterised more by deficit or treatment-based approaches. In his review of children's services in the NHS, Professor Sir Ian Kennedy noted that we need to do more to promote a positive view of health.[26] We welcome this thinking and it has underpinned our approach to this task.

What children and young people told us about health promotion and illness prevention

From the Rapid Review and supported by the views gathered from children and young people for the School Nursing Development Programme's consultation,[27] we found that with regard to health promotion, children and young people generally:

- understand that peer pressure and advertising can work against healthy choices;
- need better information and advice about healthy lifestyles;
- believe that too many public health campaigns are aimed at adults;
- connect being healthy with 'things to do' in their area and access to public transport and sports facilities;
- want involvement in the design, development and evaluation of child friendly campaigns and services;
- recognise and value the role of the school in encouraging healthy behaviour; and
- recognise there is a place for social media and want a trusted internet source of accurate health information.

Most young people consulted thought that the outcomes in the Public Health Outcomes Framework for England, 2013–2016 were important, to varying degrees:

- The public health outcome indicators the young people considered most important were: domestic abuse, poverty and 16–18 years olds not in education, employment or training (NEETs);
- Young people were neutral about the importance of school readiness, first time entry into the justice system and tooth decay; and
- Young people saw health problems such as tooth decay as illustrative of old age and it appears that they did not make any link between this type of condition and their own behaviours as children, young people nor as adults.

Public health outcomes indicators

The Public Health Outcomes Framework for England, 2013–2016 already includes a significant number of indicators for children and young people. Our full recommendations for indicator refinement and development are set out in Table 1 and fall into three categories:

- adjustments in data gathering and reporting for named existing indicators;
- new indicators where we know data are available at either national or local level; and
- new indicators where a new data collection at either national or local level would be required.

Adjustments in data gathering

Our approach to reviewing the public health outcomes framework (PHOF) was based on the life-course. Unless specifically pertaining to a specific age such as 'low birth weight 'or 'child development at 2–2½ years' many of the indicators applicable to children and young people are defined to include all ages from 0–19. Through our deliberations we concluded that reporting on different age groups is necessary to better understand where needs lie. Those identified needs should then be mapped to the developmental stages from conception through pregnancy and birth, the early years, mid-childhood to adolescence, the teenage years and young adulthood. If we are going to tackle health inequalities and target services to particular groups, it is important the information is also analysed by specific groups. For example, those with special needs and disabilities, particular ethnic communities, those in poverty where nutrition, poor housing, suicide, limited access to green spaces and limited access to education or skills training may be challenging and those in higher socio-economic groups where self-harming, termination rates and eating disorders are a cause of concern, as well as those living away from home and being the responsibility of the State.

We recommend that, with immediate effect, all data about children and young people are presented in 5 year age bands through childhood and the teenage years. We suggest wherever appropriate, adopting the World Health Organisation age bands of 0–4, 5–9, 10–14 and 15–19 years. This will enable commissioners, Health and Well-being Boards (HWBs) and service providers to compare their area to similar localities and to national or international performance. This approach should apply to both 'placeholder' indicators in development (e.g. 'school readiness' and 'emotional well-being of looked after children') and new indicators where it is appropriate to do so. We are aware that where the measure applies to school-aged children, the education system age bands matching education transition points may be appropriate. The data can be audited in either way. ChiMat can provide advice at www.chimat.org.uk.

New indicators

We believe there to be some gaps in the PHOF indicators applicable to children and young people. In particular, those which measure emotional health and resilience as well as those across key lifestyle areas such as physical activity and substance misuse. There is evidence of poor outcomes in these areas yet there is little or no data available to drive improvements through the locally devolved public health system.

Maternal mental health – There is good evidence about the importance of good maternal and parental health on the physical and emotional outcomes for children. Parental health lays the foundation for healthy fetal development,[28] a child's physical and emotional development and in shaping the life course from childhood to adult life.[29] Poor maternal mental health during pregnancy is

associated with low birth weight and increased rates of mental ill health in children. **We recommend that in 2013 the Department of Health explore the development of a new outcome measure on maternal mental health including postnatal depression for early implementation.**

Maternal substance misuse – Misuse of substances such as tobacco, alcohol or drugs during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy. We suggest that measures of women abusing alcohol or non-prescription drugs at the time of booking with maternity services should be included in future PHOFs. This would not only be a measure of the effectiveness of general population health promotion education and messaging, but also enable maternity professionals to develop a personalised plan of care to help the mother make healthier lifestyle choices to protect the health and development of her baby. **We also propose that the indicator on the proportion of women smoking in pregnancy is extended to look at the proportion of those who stop during pregnancy.**

Self-reported health and well-being – The Rapid Review told us that children and young people consider there to be a variety of key factors that contribute to their sense of well-being including family, friends, activities, being safe, enjoying school and being healthy including having good mental health. When asked, children and young people identified bullying, racism, self-harm, depression, stress, the home and school environments as public health issues that they considered to be as important as the more typically highlighted health issues such as obesity, smoking or substance misuse.

The Rapid Review also told us that young people want to be asked about their health and about the health issues that are important to them. They felt that there was insufficient attention paid to their health and well-being needs and they want their experiences to inform commissioning decisions and be used as evidence to highlight young people's public health needs.

We recommend that the Department of Health, with partners, develop a population-based survey of children and young people to look at trends in health and well-being.

Such a survey should provide local level information to inform the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Well-being strategy with regard to a number of the proposed indicators, including:

- self-reported well-being;
- lifestyle areas such as smoking prevalence, drink and drug use, physical activity, nutrition and diet;
- percentage of children and young people with mental health problems who experience stigma and discrimination;
- percentage of children and young people who experience bullying; and
- percentage of young people who experience gender based, homophobic and sexual violence.

This will be informed by the work of the Children's Society and Office of National Statistics following the 'Good Childhood Inquiry' on a new well-being indicator, which can inform and even guide the work to be done before a new indicator is capable of application whether nationally or locally.

It is our view that the measurement of progress towards the outcomes requires a regular gathering of the views of children and young people themselves and that this should be done in a systematic way

to ensure a reliable standard of evidence and allow local areas to benchmark their outcomes. Cost efficiency and comparability would suggest that several indicators, beyond 'well-being' can be clustered and reported on together using a survey methodology and perhaps building on an existing platform such as the Health Behaviours of School Age Children survey.

The Department for Education (DfE) and the Young Foundation have developed a Framework of Outcomes for Young People[30] which demonstrates the importance of young people's personal and social development and the critical role of the services that support it. These services which resonate with public health delivery play a vital role in developing social and emotional capabilities such as confidence, resilience and self-discipline, which evidence shows are fundamental to improving the education, employment and health outcomes for young people. The Framework will help services to prove their impact, and help commissioners and funders to feel confident in investing in approaches that build social and emotional capabilities. It identifies seven core capabilities: communication; confidence and agency; planning and problem solving; relationships and leadership; creativity; resilience and determination; and managing feelings.

Access to age-appropriate health information – Children and young people acknowledge the importance of being healthy and having a healthy lifestyle, but do not always feel they have access to the information and advice that would enable them to make healthier choices. We suggest that the population-based survey of children and young people include a measure of children and young people having access to age appropriate health information to support them to lead healthy lives.

PHOF Indicator suggestions

Our final recommended indicators are in Table 1. We have endeavoured to frame the indicators using positive language (e.g. 'prevalence of healthy weight') as opposed to negative language (e.g. 'prevalence of obesity') wherever possible.

A key to the classification of the changes is below.

1	No change to existing Outcomes Framework indicator
2	Extension of existing indicator reflect the life course
3	Adaptation of indicator to make more relevant to children
4	New indicator or area to be included in framework

Assessment of indicator readiness:

Red	New data source required (or adaptation to existing data source)
Amber	Data available, definition needs development
Green	Indicator readily available
Blue	Indicator in, or being developed for, existing outcomes framework

Table 1 – Health Promotion and Illness Prevention Outcomes for Children and Young People in the Public Health Outcomes Framework

	Indicator/Outcome	Change	Indicator Status	Proposed data source
Domain 1 – Improving the wider determinants of health	Children and young people in poverty	1	Blue	DWP
	Number of children and young people living in decent housing	4	Red	DCLG
	Statutory homelessness	2	Amber	DCLG
	School readiness	1	Blue	DfE
	Pupil absence – for all children, those with LTCs, disabilities, LAC, and mental health problems	3	Red	DfE
	Educational attainment and progress for all children, pupils on Free School Meals, children and young people with LTCs – including long term mental health problems – and disabilities, mental health issues, disaggregated by social deprivation	4	Red	DfE
	First time entrants to the youth justice system	1	Blue	MoJ
	16-18 year olds not in education, employment or training	1	Blue	CCIS
	Killed or seriously injured casualties on England's roads	1	Blue	DfT
	Domestic abuse	2	Blue	Home Office
	Violent crime and sexual violence	2	Amber	Home Office
	Utilisation of green space for exercise/health reasons	2	Blue	MENE survey
	Proportion of children who experience bullying	4	Red	*New survey of C&YP (1)*
	Proportion of children and young people with mental health problems who experience stigma and discrimination	4	Red	*New survey of C&YP (1)*
	Social connectedness	2	Blue	
Domain 2 – Health improvement	Low birth weight of term babies	1	Blue	ONS
	Breastfeeding	1	Blue	DH
	Prevalence of exclusive breastfeeding at 4 months	2	Red	*New data source*
	Smoking status at time of delivery – Percentage of women stopping smoking during pregnancy	3	Amber	Maternity dataset
	Percentage of women abusing alcohol or non-prescription drugs at the time of booking with maternity services	3	Amber	Maternity dataset
	Under 18 conceptions	1	Blue	ONS
	Number of births conceived to under 18s	3	Green	ONS
	Child development at 2–2.5 years	1	Blue	*tbc*
	Healthy weight in 4–5 and 10–11 year olds	1	Blue	NCMP
	Healthy weight in young people	2	Red	*New survey of C&YP (1)*
	Hospital admissions and A&E attendances for accidental and unintended injuries; and non-accidental injuries, neglect and maltreatment in children and young people	3	Amber	HES
	Self-reported well-being (all children and young people, LAC, and those with LTCs and disabilities)[i]	3	Red	*New survey of C&YP (1)*
	Smoking prevalence – 15 year olds	1	Blue	IC
	Hospital admissions as a result of self-harm	1	Blue	HES
	Diet – Percentage of children and young people who eat at least 5 portions of fruit and vegetables a day; mean number of portions of fruit and veg eaten per day	2	Red	*New survey of C&YP (1)*
	Physical activity – Physical activity in 5–9, 10–14 and 15–19 year olds	2	Red	*New survey of C&YP (1)*
	Alcohol related A&E attendances and hospital admissions	2	Amber	HES
	Access to non-cancer screening programmes	1	Blue	Maternity dataset
	Percentage of women presenting as a healthy weight at the time of booking with maternity services i) in their first pregnancy; ii) in their second or subsequent pregnancy	2	Amber	Maternity dataset
	Prevalence of drinking and substance misuse in children and young people	3	Amber	IC
	Proportion of children and young people who play games on a computer 2+ hours on weekdays	4	Green	HBSC
	Proportion of mothers with mental health problems, including postnatal depression	4	Red	*New data source*
	Proportion of parents where parent child interaction promotes secure attachment in children age 0–2	4	Red	*New data source*
	Proportion of parents with appropriate levels of self-efficacy	4	Red	*New data source*
	Children and young people have access to age-appropriate health information to support them to lead healthy lives	4	Red	*New survey of C&YP (1)*

i Emotional well-being of Looked After Children is currently included in the Public Health Outcomes Framework. We recommend extending this to other groups. ONS are currently developing a measure of well-being for children.

	Indicator/Outcome	Change	Indicator Status	Proposed data source
Domain 3 – Health protection	Number of young people aged 15-19 presenting with HIV at a late stage of infection	1	Blue	HPA
	Chlamydia diagnoses (15–24 year olds)	1	Blue	HPA
	Treatment completion for TB	1	Blue	HPA
	Population vaccination coverage – Vaccination coverage of preventable notifiable diseases	1	Blue	HPA
Domain 4 – Healthcare, public health and preventing premature mortality	Infant mortality	1	Blue	ONS
	Mortality in childhood and young people *(link to NHS Outcomes Framework Domain 1)*	2	Green	ONS
	Tooth decay in children and young people aged 5	1	Blue	NW PHO
	Suicide	2	Green	ONS
	Emergency admissions within 30 days of discharge from hospital *(and within 48 hours to link with NHS OF)*	3	Amber	HES

We envisage that the proposed indicators would inform or drive the planning by HWBs supported by Children's Trusts (Children's Act 2004, s12a) or their successors, Local Children's Safeguarding Boards, local authority public health and children's services and schools and in turn, the commissioning practices of Clinical Commissioning Groups (CCGs), the NHS Commissioning Board (NHS CB) and Public Health England.

The new health system

If there is a theme to our recommendations and suggestions then it is leadership – looking to ensure that there is visible and pro-active leadership for children and young people at all levels of the system, leadership in all the new organisations and leadership to ensure that children and young people do not fall down the cracks of the new system.

With the development of Public Health England (PHE) and the linking of public health, children's services and other local government responsibilities through HWBs, a locally sensitive and nationally supported public health offer is soon to be in place led by Directors of Public Health. Ensuring it addresses all life stages and all population cohorts has been an important backdrop to our work. We have made recommendations and suggestions for each part of the new system on leadership, planning and commissioning, service provision and integration and monitoring and accountability. We believe these recommendations, delivered through the new public health system, can deliver real improvement to the life chances of all infants, children and young people.

We know that information is power. An effective system is one in which the public and patients are more in control of their lives, and this requires quality information. Hence, information needs to be in forms and in places that are accessible to children, young people, their parents or carers, and by those who make provision for their health.

Public health is about populations. Some sub-populations occur in small numbers and can too easily be omitted from planning and commissioning considerations. If we are going to tackle health inequalities the emerging system needs to be designed to include all sub-populations of children and young people with health needs, with effective improved communication across all relevant partners/ professionals. We would also encourage schools, further education and youth settings to promote and protect children and young people's health and well-being through their ethos, values and curriculum supported by existing duties and regulations.

Secretary of State for Health

In discharging his duty under the Health and Social Care Act 2012 to 'take such steps as the Secretary of State considers appropriate for improving the health of the people of England' we suggest that the Secretary of State for Health:

- ensures that PHE has a clear leadership function both nationally and locally for babies, children and young people and parents and takes a life course approach across health promotion, protection and public health advice for health services;
- holds PHE to account for improving health and well-being outcomes for babies, children and young people; and
- ensures that his Mandate to the NHS CB sets out objectives that contribute specifically and explicitly to health promotion for babies, children and young people.

In his role as Chair of the Cabinet Sub-Committee on Public Health, we would encourage the Secretary of State for Health to focus the Committee's work on children's health and well-being outcomes and hold other government departments to account on health outcomes for babies, children and young people and families.

Public Health England

One of PHE's key business functions will be to provide leadership to the public health delivery system and promote transparency and accountability by publishing outcomes, building the evidence base, managing relationships with key partners, and supporting national and international policy and scientific development. We therefore suggest that PHE:

- adopts a life course approach in its own design and delivery model. PHE needs to lead and tackle the inequalities agenda in its narrative line reflecting the indicators that we propose for children and young people in the PHOF. If the language of children and young people as well as families is not included specifically and explicitly in the architecture of PHE then there is a high risk of reverting to an adult driven public health service, the natural default of a system developed and designed by adults;
- maintains and builds on the national Child and Maternal Health Observatory (ChiMat) intelligence and expertise to ensure a strong surveillance function on children and young people sits within its evidence and intelligence function;
- provides benchmarking data in a timeframe to be agreed with ChiMat and HWBs on the PHOF indicators relating to children and young people to Directors of Public Health and Directors of Children's Services in local authorities to help inform their JSNAs and health and well-being strategies;
- co-produces the means for sector-led improvement to ensure improvements in children and young people's public health outcomes with local authorities and bodies such as the Association of Directors of Children's Services (ADCS), the Local Government Association (LGA) and the Society of Local Authority Chief Executives (SOLACE);
- develops national campaigns specifically focused on children and young people by working collaboratively with them so that these campaigns contribute to improving their outcomes;
- supports the development nationally and locally of innovative ways to communicate health information to children and young people, e.g. social media; and

- **works in partnership with HEE to assess at the earliest opportunity the workforce required to support Directors of Public Health in ensuring the needs of children and young people are met locally and create a public health workforce development programme with maternity, children and young people at its heart.**

Chief Medical Officer (CMO)

As the professional head of all Directors of Public Health, the CMO is responsible for preparing policies and plans and implementing programmes to protect the health of the public, to promote and take action to improve the health of the population and reduce health inequalities. We suggest:

- **the Chief Medical Officer 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, in order to support the Forum's recommendation on a research strategy.**

Local Government Directors of Public Health (DsPH)

In their new role in local government, DsPH will be the principal adviser on health to elected members and officials. We suggest that DsPH:

- **as statutory members of HWBs, demonstrate that they have comprehensive data for all children and young people within their JSNA 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;**
- **work together with their Clinical Commissioning Groups (CCGs) and with maternity and child health services to identify and meet the needs of their local population;**
- ensure that children and young people who are vulnerable to poor outcomes such as low birth weight infants, those in care, and those with long-term conditions and disabilities are clearly represented in local priorities;
- ensure that children and young people are involved in commissioning of public health services aimed at children and young people; and
- ensure that public health services and programmes contribute to local Safeguarding Children plans and interventions.

Health and Well-being Boards

HWBs offer the opportunity for system-wide leadership to improve both health outcomes and health and care services. They have a duty to promote integrated working,[31] and their core purpose is to drive improvements in health and well-being by promoting joint commissioning and integrated delivery. The complex nature of the outcomes we are seeking to achieve through a complex provider chain and workforce, further support the importance of joined up planning and commissioning at a local level and agreement over shared outcomes across the public sector including health, education, transport, social care, schools and police.

We would encourage local commissioners to ensure the Healthy Child Programme for 0–5s and 5–19s is used as the basis for ensuring all children and young people received the care and services that they require, and that this is supported and delivered by the expanding health visiting workforce using the

transformed service model outlined in '*A Call to Action*' and school nurses using the new school nursing model described in '*Getting it right for children, young people and families – Maximising the contribution of the school nursing team: Vision and Call to Action*', which has been developed with children and young people.

The interaction of the local health system with schools will be very important. We have been heartened to hear from a variety of academies and other schools, that they recognise the link between healthy students and improved achievement, however we remain concerned that with the Ofsted framework no longer inspecting well-being and the focus on the standards agenda, schools may not give health and well-being issues the priority they deserve. It will be important that the legally underpinned link through the Duty to Cooperate, between schools and other local services is used in ways which allow schools to both contribute to and benefit from locally coherent public health strategies which should flow from the JSNAs.

We suggest that in the development of JSNAs, HWBs:

- adopt the indicators that we propose for children and young people in the PHOF; and
- use the PREview planning resources that can help target preventive resources where they are most needed (e.g. by identifying sub-populations in the community such as teenage parents, travellers, refugees/migrants, black and minority ethnic communities, looked-after children, and children with disabilities).[ii]

We would like to see all HWBs use the products and tools developed by the National Learning Network for HWB's 'Improving services through joint working (Children)' learning set. Their products include a review of key policy documents on children and young people's health and well-being, a synopsis of findings from the numerous high level reviews of the past two years, and a series of case studies on joint working to improve children's services.[iii] We would like to draw particular attention to their poster (re-produced as Annex 2) which outlines key success factors, key strategic questions and challenges for boards, the spectrum of children's health needs that HWBs will need to consider and a list of further resources.

Local Authorities, the NHS CB and CCGs as Commissioners

There is a real opportunity for improving how, where, when and by whom health and well-being services are delivered locally. We are already seeing some services including school nursing and speech and language therapy being commissioned by academies in addition to the locally available core offer. In addressing the wider determinants of health and meeting the needs of infants, children and young people 'in the round' charities, private and public sector providers need to be commissioned in a manner which ensures coherence from the perspective of the user, whether child, young person or parent. We suggest:

- commissioners ensure an approach to contracting which delivers a coherent and not a fragmented service offer for children, young people and their families. For example, health visitors and midwives have different roles but both have a major contribution to maternity and postnatal care and some aspects of the roles are determined in legislation. Local service configuration, delivery

ii http://www.chimat.org.uk/preview

iii These products are available on the LGA' Knowledge Hub, https://knowledgehub.local.gov.uk/group/nationallearningnetworkforhealthandwellbeingboards/forum/-/message_boards/message/7671646

and resourcing needs to be addressed through local partnership working between commissioners, midwifery and health visiting service leads, and health and social care practitioners to ensure the best local services for families. The 'Health visiting and midwifery partnership – pathway for pregnancy and early weeks' is a useful tool;[iv]

- the NHS CB, in collaboration with PHE, works closely with local authorities to ensure the smooth transition of commissioning public health services for children under five years from NHS CB responsibility to local authority responsibility by 2015. The two years, 2013/14 and 2014/15, provide an opportunity to develop joint commissioning of all components of the HCP; and
- commissioners think carefully and work together in how they monitor the delivery of outcomes and evaluate performance on the way. There is a risk that a small local provider could have multiple models of monitoring to manage detracting from their delivery capacity to impact positively on children and young people's health.

The importance of ensuring that services for children and young people are appropriate and welcoming are the function of the 'You're Welcome' standards, which is a cornerstone to in the School Nursing Development Programme and has been endorsed by the World Health Organization and validated by researchers at University College London.[32,33] The standards were developed with children and young people. They will add real value in the public and patient involvement agenda if they are promoted and adopted in a more systematic manner, beyond the current *ad hoc* model of adoption. This has the potential to lock in the health work more closely with DfE which developed Young Inspectors, as well as ensure we are able to drive the 'listening and informing' priorities of children and young people. We therefore suggest that:

- the 'You're Welcome' criteria are incorporated by CCGs and applied by the Directors of Public Health as part of the commissioning decision making as well as being crafted into contracts; and
- the NHS CB promote You're Welcome principles in their commissioning guidelines to be issued to CCGs. Other well-developed programmes and delivery frameworks such as the Healthy Child Programme, the Health Visitor Implementation Programme and the Healthy Schools and Further Education Programmes could act as an effective vehicle for improving outcomes.

HealthWatch

Local HealthWatch needs to focus on engaging with children and young people. Children and young people are not a special interest group like those with specific conditions or living in untypical circumstances. Children and young people want what adults and older people have already achieved within the LINks framework, which is to have their experiences and views clearly informing delivery and service improvement. We therefore recommend:

- **That HealthWatch England, as the national champion for health and social care, 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.**

The NHS

We would expect to see a specific role for the NHS in promoting heath, rather than just responding to poor health. Pre-school children typically see their GP six times a year and children represent around

iv http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133021.pdf

25% of a GP population.[34] Building on the contribution public health nurses and public health specialists are making, we need to make public health everyone's business. The recognised and positive overlap between the NHS and public health commissioning and delivery activity legitimates this expectation and it fits well with the 'make every contact count' approach. We suggest:

- NHS Compacts between NHS CB and CCGs in local areas highlight a specific role for the NHS in promoting heath for children, young people and their families.

This means we expect every contact with a healthcare professional to promote healthy behaviours, communicating in child, parent and young person friendly ways.

Monitor and CQC

Monitor and CQC are the national accountability mechanisms of the system, identifying where providers and services are not delivering what is needed. While it may not yet be clear how they will do this, we recommend:

- Monitor and CQC take due consideration of the specific interests and direct views of infants, children and young people.

NICE

Key to delivering improved health outcomes is high quality evidence, which leads to the setting of standards for treatment and services. In developing its public health guidance, on topics such as 'Maternal and child nutrition', 'Social and emotional well-being in primary education' and 'School-based interventions on alcohol', NICE has tried to involve children and young people as well as parents in its work, and we commend it for this. NICE standards will have an impact on contracts that will in turn impact on children and young people's health offer in their local areas. We would like to see children and young people's public health considerations embedded as NICE takes on more public health related themes. NICE guidelines need to stipulate appropriate age limits to avoid children and young people's needs being missed in translation as per the current patient experience guidelines.

Other issues

Workforce development

The public health workforce is diverse both in the nature of the functions it performs and in the places it works, but needs to be considered in an integrated manner. The transition of public health from the NHS to local authorities will require the public health workforce to develop new skills and new ways of working. The consultation document, '*Healthy Lives, Healthy People: Towards a workforce strategy for the public health system*'[35] set out a strategic vision for a workforce that will contribute to the future public health system. One of the document's key messages was that local health strategies should highlight innovative and evidence based developments to build capacity in children's and workplace public health through the contribution of directors of public health working across local government.

Nursing services, particularly school nursing, promote good health by supporting school age children and young people in all educational settings and help bridge any gaps between services. Early years practitioners, children's centre outreach workers, youth workers, field and residential social workers, community police officers for example, trained and supervised by health professionals, could have a

responsibility to promote and share health prevention information and could be a field-force to deliver the promotion of healthy living on an even wider front.

We welcome the expansion and transformation of Health Visiting services and the expansion of the Family Nurse Partnership Programme. These practitioners and others, including midwives in particular, early years practitioners and allied health professionals should be available to support parents in effective parenting approaches and to deliver improved health and well-being outcomes. We would like to draw attention to new pathways developed through the Health Visitor Implementation Programme that provide guidance to support midwives, health visitors and school nurses to deliver improved shared outcomes and greater integration of services.[36,37]

The role of Health Education England and its relationship to the Faculty of Public Health and other professional bodies such as the National College of Social Work, National College for School Leaders and the DfE Teaching Schools Programme will all be critical to supporting public health outcomes delivery. There is a need for integrated/coordinated training for long-term conditions, mental health and public health.

Education and Learning settings

> *'The considerable amount of time children and young people spend in school means that schools have the potential for fulfilling an important role in promoting the health and well-being of children and young people and laying the foundations for healthier outcomes in adulthood…'*
>
> 'Fair Society, Healthy Lives' (The Marmot Review)

Children's centres and other early years settings, schools and colleges are vital to effective health promotion and prevention and those developing local health and well-being strategies need to find effective and mutually beneficial ways of working with them. This can be done in a number of ways and already we have heard through the forum how local areas are developing new ways of working with schools to improve health outcomes. Locally, the Director of Children's Services has a statutory responsibility to act as the champion of children and their parents and will play a particular role in ensuring this encompasses both health, social and educational outcomes. The HWB and the local strategies they design and implement will be the key to a planned programme of engagement with local schools.

For schools themselves, opportunities to promote health exist through the curriculum, targeted interventions, onsite services, provision of physical activity and healthy eating opportunities, reinforcing positive individual and peer group behaviour, and creating a healthy ethos. We know parents demand a healthy school environment and expect schools to prioritise their children's welfare.

As well as good physical and emotional health being ends in themselves, they are also key contributors to broader outcomes such as improved learning and achievement and to the long-term prospects of young people as they move into adulthood. We know, for example, that children and young people with poor health are at greater risk of lower levels of educational attainment and of failing to achieve their full potential.

We have been heartened to hear from a variety of academies and other schools, that they recognise the link between healthy students and improved achievement. We recognise they are best able to

identify the challenges for children and young people and act upon them. They should be able to draw on health experts locally and capitalise on the expertise of school nursing service which working with other professionals, can support schools in developing health reviews at school entry and key transitions, managing pupils' well-being, medical, long-term condition needs and developing schools as health promoting environments. We have also seen how programmes such as Healthy Schools and Healthy FE are still thriving in some areas and making a significant contribution to health improvement. We were particularly glad to see that the London Mayor's Office is funding a Healthy Schools programme to respond to the childhood obesity issue in the capital. This is a welcome example of local areas taking action with health and education partners working in concert.

We recognise that schools have a duty to promote health and well-being, yet we know teachers are not public health specialists and do not receive initial training or professional development in this area. They often have to rely on external agencies for support and guidance and this support is much reduced given different public service reforms and funding reductions. However, our consultations clearly show that schools are still welcoming of support and guidance in this area and the Government needs to get a better balance between reducing bureaucracy and ensuring schools get the guidance and leadership that they need in this area. We suggest that Government works with the National College for School Leadership and the Teaching Schools Council to look at ways in which the teaching schools network can improve training and development for teachers in the area of health and well-being.

The Personal Social Health and Economic (PSHE) Education programme of study supports schools to teach and promote a healthy lifestyle. We know the Department for Education is currently reviewing this and we would strongly urge that this review reinforce the importance of well-taught PSHE and how it can contribute to better learning and health outcomes. There must be a strong and unequivocal message from Government that the subject is important and it should be planned, coordinated, assessed, monitored and evaluated in all schools. We also feel, as with one of the major themes of this report – that children and young people should be involved in this process, influencing provision from the start as well as having a say in how learning develops.

The National Curriculum Review, when it reports, should include the promotion of health and well-being. The DfE should ensure that the best examples of PHSE practice are shared with all schools and that there is a credible and visible process for ensuring that best practice and teaching materials are balanced and evidenced based. Particular attention should be paid to ensuring schools have access to good quality advice on sex and relationships and drug education, the two weakest areas of PSHE identified by Ofsted.

The delivery of personal social and health education in schools and colleges alone will not be sufficient. Addressing health inequality and building resilience in even the most challenged young people can be delivered in youth work settings when youth workers are working to support ' young people's physical and mental health and emotional well-being.[38] Schools, youth and college settings can all benefit from being supported by HWBs to deploy their curricula to improve health outcomes particularly those in the PHOF.

Legal Framework

All this needs to be delivered through the legal framework for children and young people, which includes:

- the **Duty to Cooperate to improve well-being** (CA2004 s10), which while open to broad and local interpretation provides leverage through the naming of the relevant partners, including schools, the explanation of well-being and the importance of parents and carers. This helps schools in their efforts to be part of the local public health landscape for example in the delivery of PSHE;
- the **Integration Duty,** which refers both to integration within the health services and to integration of health services with social care and health related services (HSC Act 2012, 13N);
- the **duty to secure, so far is reasonably practicable, equality of access for all young people to the positive, preventative and early help they need to improve their well-being** (E&I Act 2007 S507B) set out in its statutory guidance that the help should 'improve young people's physical and mental health and emotional well-being' among other things;
- the **Health Inequality Duty** (HSC Act 2012), which underpins the entire health and social care system; and
- the **Public Sector Equality Duty,** which applies to under 18s as well as adults (Equality Act, 2010). The responsibilities of health commissioners and providers under this duty 'to promote good relations and equality of opportunity' need to be understood in relation to children and young people specifically.

As children and young people under 18 are a 'protected characteristic' under equalities legislation, the Equality and Diversity Council should act as a champion for the integration of children and young people throughout the health system including public health.

We would like to see a system where children and young people are as well informed and engaged in their health and well-being as it is possible to be, particularly in ways consistent with the **UN Convention on the Rights of the Child particularly Article 24**.

> *'States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health.'*

States should place special emphasis on the provision of primary and preventive health care, public health education and the reduction of infant mortality. Their active engagement is an investment for life and a valuable asset to improve the delivery of public services.

Conclusion

This is a once in a lifetime chance to make a step change in the way in which public health considers, reflects and includes the voice and meets the health prevention, promotion and protection needs of its child population. It is imperative this chance is not missed. The Public Health Group has therefore drawn out the role to be played by all parts of the new system in considering children and young people as an important part of the public health population.

Our key worry is the lack of visible leadership for children and young people's issues and in some key areas the lack in data that would enable better leadership.

It is not for health services alone but for all those services, whether public, private or voluntary to play their part in helping every child and young person, regardless of their ability or vulnerability, to be as healthy as they can be during childhood and through into the rest of their lives. We believe that adoption of the proposals in our report will move us all a long way forward.

Annex 1: Public Health and Prevention Theme Group Members

Professor Debra Bick	Professor of Evidence-Based Midwifery Practice, Kings College London
Professor Mitch Blair	Consultant and Reader in Paediatrics and Child Health, Imperial College London
Simon Blake, OBE	Chief Executive, Brook
Dr Dick Churchill	Associate Clinical Professor in Primary Care, University of Nottingham Medical School
Andy Cole	Chief Executive, BLISS
Dr Helen Duncan	Programme Director, Child and Maternal Health Observatory (ChiMat)
Naomi Eisenstadt, CB	Senior Research Fellow, University of Oxford
Dame Elizabeth Fradd, DBE	Independent Health Service Advisor and Chair of the Health Visitor Taskforce
Jean Gross, CBE	Former Communication Champion for Children
Dr Dougal Hargreaves	Paediatric Registrar, UCL Institute of Child Health
Barbara Hearn, OBE Co-lead	Deputy Chief Executive, National Children's Bureau
Dr Ann Hoskins Co-lead	Interim Regional Director of Public Health/Director of Children, Young People and Maternity, NHS Northwest
Anthony May	Corporate Director for Children, Families and Cultural Services, Nottinghamshire County Council
Dr David Richmond	Vice President, Royal College of Obstetricians and Gynaecologists
Dr Sonia Sharp	Executive Director of Children, Young People and Families Portfolio, Sheffield City Council
Dr Russell Viner	Professor of Adolescent Health, UCL Institute of Child Health

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Annex 2

Health and wellbeing boards and children, young people and families

Key success factors

- A local partnership dedicated to children and young people (linked into the governance of health and wellbeing boards) is essential.
- Commissioning of NHS services for children and young people must sit alongside commissioning of all services for children (the concept of holistic commissioning).
- Health and wellbeing boards should prioritise interventions for children and young people which are proven to work.
- Commissioning of services should be informed by the views of children, young people, parents and families.
- Health and wellbeing boards should ensure a focus on early intervention, within an overall understanding of a 'lifecourse' approach to provision.

Key strategic questions and challenges for boards

- Does the health and wellbeing board link effectively with the local children's trust, safeguarding board and clinical commissioning groups (CCGs) to ensure cohesive governance and leadership across the children's agenda?
- Does the health and wellbeing board have an agreed process to ensure children's issues receive sufficient focus?
- Has the health and wellbeing board contributed to defining the early help offer, as recommended by Professor Munro?
- Is the health and wellbeing board making appropriate use of local mechanisms to listen to the views of children, young people and families?
- Does the local health and wellbeing strategy analyse and prioritise the health needs of children and describe success?
- Have the views of frontline staff and clinicians been factored into the board's planning?
- Has the health and wellbeing board got an agreed method of engaging with schools?
- Has the health and wellbeing board got a clear plan to maximise the use of public assets (children's centres, schools, youth services, health centres, etc.) to improve health outcomes for children?
- Is the health and wellbeing board satisfied that the common assessment framework is sufficiently embedded in the local partnership?

This poster was produced in June 2012 by the health and wellbeing board learning set for children and young people. It represents their key learning and does not necessarily showcase best practice but aims to provide health and wellbeing members with an accessible and helpful resource. This learning set was led by Anthony May, Corporate Director for Children and Families and Cultural Services for Nottinghamshire County Council, anthony.may@nottscc.gov.uk.

For further information, or to comment on this poster, please email hwb@nhsconfed.org.

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Vision

That health and wellbeing boards make an effective contribution to improving health and wellbeing outcomes for children and young people.

Supported by

Department of Health · Local Government Association · NHS Confederation · NHS Institute for Innovation and Improvement

Further resources

- The Department of Health Children and Young People's Health Outcomes Strategy (due to be published in July 2012)
- A plethora of Local Government Association resources, collated by the LGA: www.local.gov.uk/childrens-health
- Local authority child health profiles (published by the Child and Maternal Heath Observatory – ChiMat): www.chimat.org.uk/profiles
- The NHS Atlas of Variation in Healthcare for Children and Young People: www.chimat.org.uk/variation
- NHS Confederation review of policy documents on children and young people's health and wellbeing: www.nhsconfed.org/hwb
- Assured Safeguarding – GP and Health Leader Edition (safeguarding advice for GP and health leaders developed by the East Midlands group of Directors of Children's Services): www.jriep.com
- Commissioning Child Health and Wellbeing Services (information and guidance framework developed by the East of England Strategic Network for Child Health and Wellbeing Commissioning Champions) – EOE Info and guidance framework
- National Institute for Health Research (for health-related research materials): www.nihr.ac.uk
- A guide for commissioners of children's and young people's and maternal health and wellbeing services NHS North West: www.northwest.nhs.uk/childhealth

The spectrum of children's health needs

Taken from the project scope of the Department of Health Children and Young People's Health Outcomes Forum

- Health promotion, prevention and improvement
- Primary care
- Children with poor mental health
- Urgent care for children with acute illness
- Children with long-term conditions
- Children with complex health needs
- Children with disabilities
- Looked after children
- Palliative care
- Ensuring the use of medicines for children optimises health outcomes
- The health sector's contribution to safeguarding children
- The health sector's contribution to support for troubled families

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