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Healthy Child Programme

From 5–19 years old

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Healthy Child Programme

From 5–19 years old

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Foreword by Dr Sheila Shribman

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There has never been a stronger focus on the health and wellbeing of children and young people than there is today. The foundations of a healthy and fulfilled adult life are laid in childhood and adolescence. Health is key to our ambition for this to be the best country for children and young people to grow up in, as *Healthy lives, brighter futures* (DH/DCSF, 2009a) made clear. It set out how we will achieve world-class health outcomes and minimise health inequalities by delivering services of the highest quality, while providing an excellent experience for children, young people and their families who use them and are involved in their development. A key ambition of the Healthy Child Programme (HCP) is to make 'everywhere as good as the best', developing real improvements in outcomes and a focus on quality, innovation, productivity and prevention.

In 2008, we published the updated Child Health Promotion Programme (CHPP, now the HCP for pregnancy to five years of age). This document now continues that early intervention and prevention programme on through the school years to the age of 19, consolidating the good practice programmes, clinical and other interventions for this age range in one document. Commissioners and providers will want to consider the implications for delivery of the HCP as a whole. As the *operating framework for the NHS in England 2009/10* sets out, primary care trusts (PCTs) will want to review the transparency of their service offer in line with *Healthy lives, brighter futures* and local priorities, and this may include delivering a high-quality HCP.

This evidence-based programme is a good practice programme outlining recommendations for a universal service to promote optimal health and wellbeing, appropriate for all children and young people – wherever they are – and additional services for those with specific needs and risk factors. It recommends the different roles and responsibilities of health practitioners, children's services practitioners, education providers and others working with children, young people and their families. It also covers the role of health and children's services commissioners. Services may be delivered and staff deployed in different ways according to local circumstances and needs assessment, but if health inequalities are to be reduced and in time eliminated, the same high-quality services should be in place across the country.

In the current economic climate, there is pressure on resources and, rightly, a focus on what is proven to work. Reviewing existing working practices against the good practice

framework set out in the HCP may, in some instances, lead to change, as we move towards one 'Team Around the Child'. Similarly, 'doing what we ought to do', underpinned with good evidence and ongoing evaluation rather than 'what we have always done', is likely to change working practices. The HCP emphasises that robust needs analysis is a pre-requisite to effective and efficient resource allocation.

This is an incremental early intervention programme which will build on existing good practice: everything that is described in the HCP in terms of service provision, workforce development and delivery is already in operation or under development somewhere. New ways of working – HCP Teams across a locality and School Health Teams, for example – offer exciting opportunities to capitalise on the skills and commitment of all who contribute to children's and young people's health and wellbeing. Our ambition is that areas will start to use this schedule of good practice to evaluate and develop their local services, and will continue to develop their programmes in the coming years.

This evidence-based good practice programme is not set in stone. We expect it to develop and adapt over time as new evidence and research emerge and as lifestyles and technologies evolve. We recognise that parents and carers have the primary responsibility to ensure that children and young people lead safe, healthy lives and grow to healthy adulthood, and we seek to strengthen the support available to help them fulfil that role. We believe that partnership working – particularly through the joint development and ownership of the Children and Young People's Plans (CYPPs) by local authorities (LAs), PCTs, Children's Trusts and their partners – will help local areas to focus

better on the health and wellbeing of their children and young people.

We know that there are certain aspects of the programme – data capture and analysis and information-sharing systems, for example – which will be crucial to its success. We know too that we need a skilled and flexible workforce, strong local leadership and an infrastructure that is capable of innovating, adapting and responding to the changing needs of children, young people and their families. Strategic monitoring, evaluation and quality improvement by commissioners and service providers – and importantly, scrutiny by and involvement of children and young people and their families themselves – will be important factors in the HCP's impact, effectiveness and success.

I would like to thank the many people who have contributed to this publication, in particular the members of the HCP 5–19 Expert Group and especially Professors David and Sue Hall who reviewed the evidence so thoroughly.



Dr Sheila Shribman

National Clinical Director for Children,
Young People and Maternity
Department of Health

Executive summary

This good practice guidance sets out the recommended framework of universal and progressive¹ services for children and young people to promote optimal health and wellbeing.

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It brings together the wide range of recommended programmes and interventions for local areas to consider. It outlines suggested roles and responsibilities to enable the progression of evidence-based service innovation and improvement. Its implementation is designed to encourage the development of high-quality services that make a measurable contribution to the prevention of ill health and to the reduction of health inequalities. Quality is fundamentally linked to efficiency – doing things right the first time, so that they don't have to be done again, and only doing those things that are underpinned by robust evidence. This programme therefore draws on expert professional opinion and service user experience to provide robustness to these **recommended actions** that commissioners and practitioners should consider.

The 5–19 Healthy Child Programme (HCP) also examines systems and tools that will facilitate the development of the programme over the coming years, the impact of policy and organisational changes on local delivery

and the workforce implications of a coherent, holistic approach to children's and young people's health and wellbeing. It recognises the contributions of a range of skilled professionals in helping to make England the best place in the world in which to grow up.

This HCP extends the universal progressive model of child development which starts with the 0–5 HCP (*Healthy Child Programme: Pregnancy and the first five years of life* (DH/DCSF, 2009c – formerly the CHPP)) into later childhood and adolescence. Since the publication of the 0–5 HCP, commissioners and providers have been anticipating this development.

Chapter 1 describes the importance of the HCP to healthy childhood and adolescence; who may deliver and support delivery; where and how it might be delivered; and the measurable gains in the quality of services and potential outcomes.

Chapter 2 describes the context for the programme: the changing policy context; emerging research on neurological development in childhood and adolescence;

¹ See Abbreviations and definitions.

new technologies; and new approaches to data collection and information sharing.

Chapter 3 outlines the recommended components for the successful delivery of the 5–19 HCP. It covers prevention and early intervention; key health issues; safeguarding; health development reviews; screening and immunisation programmes; creating the right environment to deliver the HCP; and support for parents.

Chapter 4 contains the HCP schedule, which sets out both the core recommended universal programme for all children and young people, and additional preventive elements that the evidence suggests may improve outcomes for children and young people with medium- and high-risk factors.

Chapter 5 sets out the good practice infrastructure for delivery of the 5–19 HCP.

The **Annexes** in this document provide greater detail on certain aspects of the HCP such as commissioning, safeguarding and the skills and competencies of those delivering the programme.

Chapter 1

Introduction

This chapter outlines:

- what the HCP is;
- the importance of prevention and early intervention;
- who the HCP is for;
- how to use the guidance;
- who will deliver the HCP; and
- the outcomes the HCP will contribute to.

The best possible health underpins a child's or young person's ability to flourish, stay safe and achieve as they grow up. Health is crucially linked with education – for example, a child who does not master the basics of reading and numeracy may experience not only education but health problems in the future. On the other hand, good health and emotional wellbeing are associated with improved attendance and attainment at school, which in turn lead to improved employment opportunities. In addition, children who thrive at school are better placed to act on information about good health.

What is the 5–19 Healthy Child Programme (HCP)?

The HCP sets out the good practice framework for prevention and early intervention services for children and young people aged 5–19² and recommends how health, education and other partners working together across a range of settings can significantly enhance a child's or young person's life chances.

² Up to the 20th birthday.

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The foundations of the HCP lie in the five *Every Child Matters* (HM Government, 2004) outcomes that children and young people identified as fundamental to their lives:

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution; and
- achieve economic wellbeing.

It also takes forward the *National Service Framework for Children, Young People and Maternity Services* (DH/DfES, 2004) and the child health strategy, *Healthy lives, brighter futures* (DH/DCSF, 2009a).

The HCP is designed to help local children's services planners use their resources as effectively as possible, informed by the best available evidence. In particular, it aims to help them:

- base their children's and young people's services on robust needs assessment;
- prioritise programmes which are evidence supported;

- stop using interventions that are shown to be ineffective; and
- make best use of their workforce.

The HCP is a progressive universal programme – i.e. it outlines the recommended good practice framework of a universal service appropriate for all children and young people and additional services for those with specific needs and risk factors. **The HCP contains no new statutory requirements** and any existing statutory requirements are highlighted in Chapter 4. Although it mainly focuses on 5–19-year-olds, the schedule in Chapter 4 also addresses the key transition into primary school.

In particular, this guidance outlines the **recommended**:

- full range of interventions that commissioners and the local 5–19 HCP workforce may wish to consider to support 5–19-year-olds and their families;
- schedule of interventions (see Chapter 4) divided into age bandings – 5–11 years old, 11–16 years old and 16–19 years old – with an emphasis on transitions between stages;
- HCP components and infrastructure (see Chapter 3, Chapter 5 and referenced annexes); and
- skills and competencies of the HCP workforce (see Annex C).

It also sets out how the HCP can support the commissioning process (see Annex D).

The importance of prevention and early intervention

Lifestyles and habits established during childhood, adolescence and young adulthood influence a person's health throughout their life. For example, up to 79 per cent of obese

adolescents remain obese in adulthood, and adolescents who binge drink are 50 per cent more likely to be dependent on alcohol or misusing other substances when they reach the age of 30 (CMO, 2007).

Failure to meet the health needs of children and young people stores up problems for the future. For example, 84 per cent of young people with diabetes are poorly controlled and at risk of early complications,³ and sexually transmitted infections (STIs) in young people uncertain or fearful of accessing sexual health services can have a major impact on their adult health.

³ Based on the percentage of children and young people under 16 within National Institute for Health and Clinical Excellence (NICE) HbA1c target bands, National Diabetes Audit, England and Wales 2005/6.

Costs

The case for prevention and early intervention is reinforced by the long-term costs of inaction or delay. For example, weight-related problems are forecast to cost £50 billion to the wider economy by 2050 (Foresight, 2007). *Securing Our Future Health* (Wanless, 2002) demonstrated the importance of public engagement with health, a process which is only likely to be successful if it starts early in life.

An evidence-based approach using prevention and early intervention should reduce costs to society and to health, education and wider children's services in the long term.

Firstly, by withdrawing or avoiding investment in activities which are not supported by the evidence (e.g. testing colour vision, routine physical examination at school entry).

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Secondly, by investing money now to save greater costs to society in the long term. For example, one American study found that family therapy for young offenders costs an average of \$2,380 per participant but saved taxpayers and victims of crime an estimated \$52,156 per participant in the longer term (Drake et al., 2009).

Thirdly, by improving service quality. For example, a sexual health service offering the full range of modern contraception to all young people could save at least £500 million over 15 years, as well as improve the quality of services offered to each young person (Armstrong et al., 2005). This is largely due to a move from combined oral hormonal contraception to longer-acting methods.

The National Institute for Health and Clinical Excellence (NICE, 2005) estimated that if 7 per cent of women switched from the pill to long-acting reversible contraception (LARC) methods (doubling current usage to 15 per cent), the NHS could save around £100 million each year through reducing unplanned pregnancies by 73,000.

Lastly, it may be more cost-effective to prevent ill health than to treat established disease. For example, school-based interventions to reduce obesity have been shown to be effective in reducing obesity prevalence in girls, in turn reducing their likelihood of developing stroke, angina, heart attacks, hypertension and type 2 diabetes. Wang et al. (2003) calculated that over a period of 25 years, the cost per quality-adjusted life year (QALY)⁴ gained was \$4,305 in their study.

⁴ A year of life adjusted for its quality or its value. A year in perfect health is considered equal to 1.0 quality-adjusted life year.

A focus on prevention and early intervention also has a vital role to play in breaking the cycle of health inequalities within families (see Marmot, 2009). Many problems present in early childhood and adolescence, making these crucial stages for interventions.

Who is the 5–19 HCP guidance for?

This HCP good practice guidance is for all organisations responsible for commissioning services for 5–19-year-olds' health and wellbeing as well as frontline professionals delivering those services.

The 5–19 HCP recognises the key role of both health and non-health professionals in promoting children's and young people's wellbeing and is therefore aimed at the full range of practitioners in children's services. These include:

- **health service providers** (e.g. school nurses,⁵ general practitioners (GPs), paediatricians, sexual health professionals and specialist child and adolescent mental health service (CAMHS) providers);
- **education providers** (e.g. staff within schools such as Healthy Schools co-ordinators and physical education (PE) teachers, Further Education (FE)⁶ institutions and short stay schools (formerly Pupil Referral Units)); and
- **wider services for children and young people** (e.g. youth workers, local youth justice services and the voluntary sector⁷).

⁵ Nurses working in schools are often called 'school health advisers' or 'health advisers'.

⁶ FE refers to all 16+ education (except sixth form schools) including FE colleges and institutions, work-based learning or alternative training providers.

⁷ See diagram 1 on page 17 outlining who delivers the HCP.

How to use the 5–19 HCP guidance document

This document is not intended to be read from start to finish. Different stakeholders will want to use it in different ways. For example:

- Those delivering the HCP should read Chapter 4, which lists the schedule of recommended interventions to be delivered at various ages. They should also read Chapters 3 and 5, which contain useful background on how to deliver the schedule, together with Annex C.
- The leader of the local 5–19 HCP Team will want to read Chapters 3, 4 and 5, and should also read Annex C, which describes the recommended core competencies of the workforce and the leadership role.
- Planners and commissioners of services for 5–19-year-olds and their families should note the schedule in Chapter 4. They will also find Annex C useful. In addition, Annex D outlines how the HCP can support commissioners.

Who will deliver the HCP?

Strategic level

The Children's Trust is the local partnership which brings together LAs, PCTs and others who have responsibility for services for children, young people and their families⁸ and whose shared purpose is to improve

⁸ The 'relevant partners' of the Children's Trust have a duty to co-operate to improve all outcomes for children (including the physical and mental health and emotional wellbeing of children and young people), set out in Section 10 of the Children Act 2004. What the duty to co-operate means is explained in *Children's Trusts: Statutory guidance on inter-agency co-operation to improve wellbeing of children, young people and their families* (2008), but this will shortly be replaced by new statutory guidance on Children's Trusts which will be issued for consultation in November 2009. The new guidance takes account of new provisions to strengthen Children's Trusts in the Apprenticeships, Skills, Children and Learning Bill, expected to become law in November 2009.

children's and young people's lives. Local areas will want to consider how their Children's Trust Board (CTB)⁹ will agree in the Children and Young People's Plan (CYPP) the local strategy for co-operating to deliver the HCP, including the key contributions from the Children's Trust partners towards its implementation.

The jointly owned CYPP¹⁰ will provide the framework within which individual organisations and institutions should agree local needs and priorities, resource their services and monitor progress. Operational planning, investment and delivery of services will rest with the Children's Trust partners, but the exact configuration of commissioning and service provision will depend on local arrangements and partnerships. A range of organisations and institutions may be responsible for investing in services to ensure delivery of the 5–19 HCP across a variety of settings. These organisations include PCTs, strategic health authorities (SHAs), LAs, GPs and schools themselves.

The CTB should be clear who is responsible for strategic leadership of the HCP programme (see Chapter 5).

Operational level

At an operational level, the HCP is delivered primarily by the **HCP Team**. The HCP may be commissioned from one provider or from more than one. The team may be single provider, multiple provider through single-line management or through a partnership

arrangement. The team will be supported by a range of partners (see diagram 1).

The HCP Team is a multidisciplinary team delivering the HCP across localities – in primary care, in schools, in the community, in the youth justice system etc. It could include primary care, the School Health Team (with the school nursing service at its core), community paediatricians, sexual health services, primary mental health workers, immunisation teams, safeguarding professionals, youth workers, counsellors and a range of public health and health promotion specialists (e.g. tobacco, drugs, dietetics). The HCP Team can also facilitate access to a wider range of specialist support, including: CAMHS, specialist children's and families' social care, speech and language therapy (SALT) and specialist support for children and young people with acute or additional health needs.

It is recommended that the leader of the local 5–19 HCP Team has a core set of competencies to lead this team (e.g. this could be a PCT locality lead for children's and young people's health and wellbeing with appropriate public health, management and leadership skills). See Annex C for more information.

Who else contributes to delivery of the HCP?

Delivering the HCP in schools

Schools have an important role to play in promoting healthy lifestyles and, as appropriate, providing extra support to at-risk children. This is underpinned by schools' statutory duty to promote the wellbeing of their pupils, to provide healthy school food and their statutory provision of PE and – subject to consultation – Personal, Social, Health and Economic (PSHE) education.

⁹ Subject to the passage of the Apprenticeships, Skills, Children and Learning Bill, the CTB will become a statutory body from April 2010 and will take on statutory responsibility for preparing, publishing, revising and monitoring the delivery of the Children and Young People's Plan (CYPP), with the first jointly owned CYPP in place by April 2011.

¹⁰ The CYPP will set out the joint local strategy for how the partners in Children's Trusts will co-operate to improve children's lives.

The enhanced Healthy Schools Programme, extended services, the National Curriculum (e.g. for Sex and Relationship Education (SRE) and PE) and the Pupil Guarantee provide the context within which the HCP is delivered in schools.

It is recommended that the HCP is delivered in schools by **School Health Teams**, who provide a key link between health, education and wider children's and young people's services, providing guidance and support on a range of health-related issues. The School Health Team will comprise appropriate members of the HCP Team (as determined by needs assessment) working with and supporting educational colleagues, in individual schools, in clusters of schools and across localities. The composition of School Health Teams will vary from locality to locality according to local needs and service configurations, but in most cases they will have school nurses at their

core, working with a range of other professionals and support staff (*Healthy lives, brighter futures*, DH/DCSF, 2009a). The size of individual School Health Teams will depend on the size of the population they are serving and on the range of issues they are expected to address. In a small community, the 'team' might be one or two professionals, able to call for additional support from the wider HCP Team and other specialists. In other contexts, there might be a number of professionals from different disciplines (e.g. school nursing, youth work, sexual health services, dietetics) working together to deliver services and interventions to many children and young people in a large school or across a number of education settings.

The contribution of the school nursing service

The school nursing service lies at the heart of the School Health Team and forms part of the wider HCP Team. *Aiming high for young people* (HM Treasury/DCSF, 2007) proposed reshaping the existing school nursing service to enable it to be at the centre of emerging or newly developed multidisciplinary teams being established as part of the *Every Child Matters* reforms.

The 5–19 HCP offers the opportunity to ensure, in line with the *Choosing Health* (DH, 2004) commitment on access to school nursing, that schools will have access to the expertise of school nurses and their colleagues. The range of services and breadth of provision will be determined by local needs assessment. There are good examples across the country of services being reconfigured in these ways, so making better use of existing skills sets. Good practice examples will be showcased on the supporting HCP online resource which will be available in 2010/11.

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The HCP will offer a number of opportunities to enrich the workforce, in terms of both skills and competencies and leadership. There is likely to be a significant leadership role for school nurses, as core members of the School Health Team. School nurses will, over time, be increasingly leading and influencing, ensuring strong links and partnerships with other professionals and providers, according to local and school community needs assessment. This is likely to involve co-ordinating the delivery of the HCP in schools/group of schools, ensuring that health elements of the programme are delivered and quality and outcomes monitored, and providing services directly, especially where these require nursing skills and expertise.

Delivering the HCP in Further Education

Supported by the Healthy FE Programme, FE institutions will determine local need and their staff (student support, counsellors and nurses) will wish to consider working with members of the HCP Team to create a learning environment where positive wellbeing is the expectation for both learners and staff.

Families

Children, young people and their parents and carers are key to the HCP's success. They should be engaged early in local planning and have access to comprehensive and accessible information about what local services and support are available at different life stages.

Children's and young people's health and wellbeing are influenced by their parents and carers, their family, friends, community and the wider environment in which they live. All these factors should be considered in delivering the HCP locally, making partnership working a fundamental part of the infrastructure.

Delivering the HCP to 'hard-to-reach' children and young people

A considerable number of young people (such as many of those highlighted in Annex E) remain a challenge for mainstream services to reach. These include homeless young people, runaways, truants and other transient groups who may be particularly hard to reach and who may find it difficult or frightening to access traditional services.

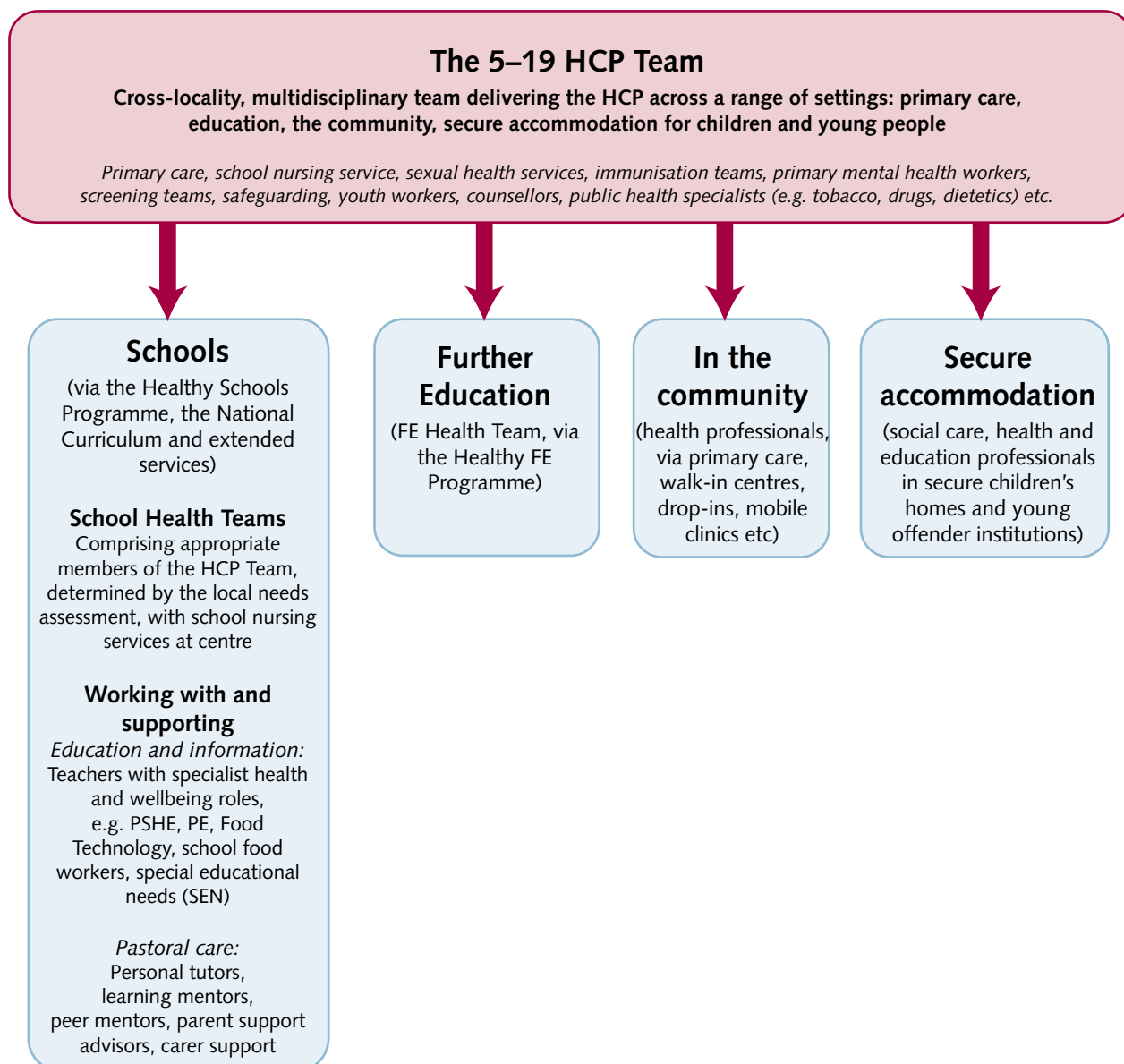
Youth workers, charities and other voluntary sector organisations, often working in outreach or non-traditional settings, can make significant contributions to the health and wellbeing of such young people. Commissioners should be mindful of the potential and expertise of voluntary sector partners, as well as the different professionals within the HCP Team itself.

HCP settings

The range of services and settings is best determined by assessed need, offering children, young people and their families choice in how, where and when they access the support and care they need, regardless of where they are:

- in the family home or other care settings;
- in schools, in the context of the duty on schools to promote pupil wellbeing, the National Curriculum and Healthy Schools, with healthy school lunches and access to extended services;
- in FE, through the Healthy FE Programme;
- in the community (through primary and community healthcare, walk-in centres, drop-ins, mobile clinics, childcare settings and youth clubs etc);
- in hospitals; and
- in the youth justice system, including ensuring continuity of care for children

Diagram 1: Who will deliver the HCP?



and young people placed away from their home or community or moving between establishments in the secure estate.

What outcomes might the 5–19 HCP contribute to?

The core ambition of the HCP is that it results in healthier, happier children and young people who are ready to take advantage of positive opportunities and able to reach their full potential. This should be made possible for *all* children and young people, regardless of health status or home background.

Effective delivery of this good practice programme, over time, may contribute to improvements in:

- the quality and experience of health services;
- health and wellbeing outcomes (such as increased immunisation uptake, improved management of chronic conditions and reduced bullying);
- broader health and wellbeing outcomes (such as higher life satisfaction, participation in positive activities);
- educational outcomes;

- targeting of and support for particularly at-risk children and young people; and
- data capture and analysis.

See Annex H for detailed information on desired outcomes.

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Chapter 2

The context

This chapter provides information on:

- the policy landscape;
- new information on neurological development;
- the development of new technologies; and
- new approaches to data collection and information sharing.

The policy landscape

Since publication of the *National Service Framework for Children, Young People and Maternity Services* (DH/DfES, 2004) there have been significant policy developments which have been built into this 5–19 HCP.¹¹ In particular:

- Promoting health and wellbeing is increasingly central to the role of schools (and is formalised within schools' statutory duty to promote children's wellbeing and the increased prominence of health in the National Curriculum). *Your child, your schools, our future* – the Department for Children, Schools and Families (DCSF) White Paper (DCSF, 2009a) – gives a commitment that every pupil will go to a school that promotes their health and wider wellbeing.
- Since September 2009, all schools have been encouraged to raise their status in the enhanced Healthy Schools Programme by developing an outcomes-based model that is universal and targeted on those children and young people who are most at risk. They will be encouraged to choose two

priorities – one reflecting a Children's Trust priority (informed by local area agreement (LAA) priorities) and one reflecting a priority of the individual school.

- Children's Trusts and their partners, including schools, are being encouraged to set out a clear framework for early intervention, identifying and taking action to support at-risk children.¹²
- In recognition of the crucial importance of ongoing support throughout adolescence, a Healthy FE Programme has been set up and the role of colleges in promoting the wellbeing of its locality strengthened.
- Services are being encouraged to become more young people friendly through the roll-out of the *You're Welcome* quality criteria (DH, 2007). In addition, an adolescent health e-learning programme provides doctors, nurses and allied health professionals with the skills to respond to children's and young people's needs.¹³

¹² A consultation document on how to improve the quality of early intervention practice will be published in late 2009.

¹³ Details about the adolescent health e-learning programme for 11–19-year-olds are available at: www.rcpch.ac.uk/Education/Adolescent-Health-Project. The 0–5 strand of this programme is currently being developed and will be available in 2010. It is also planned to develop a 5–11 strand.

¹¹ See Annex A.

(this material is being used to improve training for youth workers,¹⁴ and extension to teachers is also being explored).

- Increased integrated service delivery through Sure Start children's centres and providing access to a core offer of extended services through schools is being encouraged.

The HCP supports the NHS in driving forward a focus on quality, innovation, productivity and prevention. It takes account of the *NHS Next Stage Review Final Report* produced by Lord Darzi (Darzi, 2008) which sets out a vision of high-quality care for all. It also recognises the impact of LAAs and the NHS operating framework on service developments.

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New information on neurological development

Adolescence is a time of rapid cognitive change (e.g. from concrete to more abstract thinking) and social/behavioural development. Using modern imaging and functional techniques, research is starting to demonstrate how changes in neurological structure and function relate to developmental changes,¹⁵ and how areas of the brain responsible for executive control and decision-making continue to mature until the mid-20s.

Although behaviour and choices should be understood within their social context, greater understanding of neurological development may improve our ability to understand young people's perspectives and better engage with them about the health choices they make.

Understanding these changes and their impact on behaviour and cognition is important not only for the HCP workforce, but also for parents and carers and young people themselves.

Development of new technologies

Advances in technology are also likely to impact on the development of the 5–19 HCP. For example, new channels to deliver information, advice and guidance (IAG) such as through the internet (e.g. Teenage Health Freak,¹⁶ Talk to Frank,¹⁷ R U Thinking,¹⁸ the NHS Teen LifeCheck,¹⁹ youthhealthtalk²⁰), digital TV, helplines and text messaging services will affect the way information is

15 Campbell I and Feinberg I (2009) Longitudinal trajectories of non-rapid eye movement delta and theta EEG as indicators of adolescent brain maturation, *PNAS* 106(13): 5177–80.

16 www.teenagehealthfreak.org (holistic health advice for young people)

17 www.talktofrank.com

18 www.ruthinking.co.uk

19 www.teenlifecheck.co.uk

20 www.youthhealthtalk.org

14 www.nya.org.uk/target-youth-services/health-youth/health-resources#Good%20Practice%20Guidelines%20For%20Healthy%20Youth%20Work

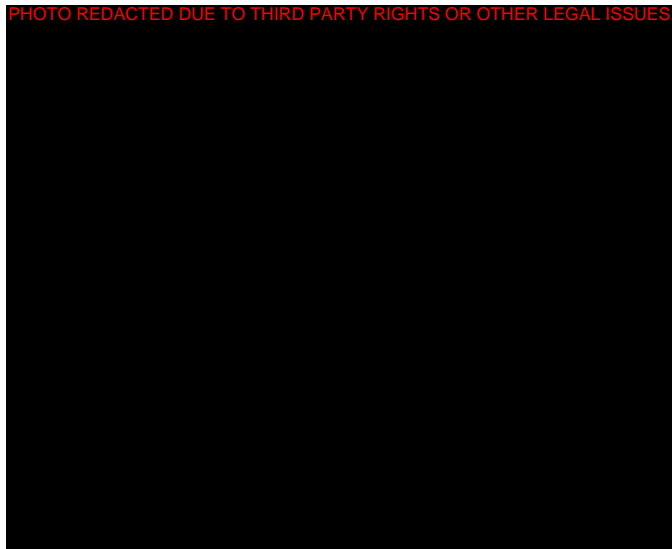
presented. Sophisticated games consoles offer potential, for example, to promote individual programmes of physical activity.

New approaches to data collection and information sharing

The 5–19 HCP reflects existing and potential developments in methods of data capture and application and information sharing. Many of these developments are already under way, while others are at an early stage of thinking and planning. They include the following:

- The recognition that, within the next five to ten years, all NHS practitioners will be using **electronic records**, easing the transfer of information between, for example, the HCP Team or School Health Team and general practice.
- The expansion of the **Summary Care Record**, controlled by the patient, with details of – for example – medicines and allergies, which will provide those working with children and young people with important information to keep them safe and well. In time, this might contain information about immunisations and vaccinations etc, and this could become an especially valuable resource for children and young people with chronic conditions in the management of their care.
- The potential offered by **HealthSpace** – an online personal health and care record owned by the patient. Not only could this begin to encourage young people on the path to personal responsibility for their own health, but it might in time become the delivery system for the proposed questionnaire completed at the primary–secondary transition.
- As described in *Healthy lives, brighter futures* (DH/DCSF, 2009a), the Department of Health (DH) is testing, with a view to rolling out, **minimum NHS datasets for child health, maternity and CAMHS**. This development will support improvements in clinical practice and also help those commissioning services locally to focus on local priority and need. The first phase of the roll-out of the Child Health Dataset will focus on monitoring and implementation of the HCP. This will help to improve LAs' and PCTs' understanding of the complex relationship between child health spend and children's health outcomes.
- **ContactPoint** will give professionals such as doctors and nurses, the police, teachers and the voluntary sector, who have received the appropriate training and authorisation, a quick way to find out who else is working with the same child or young person. The use of this directory should help to address current communication issues between professionals by clarifying the appropriate person to contact with regard to an individual child or young person.

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The HCP and those delivering it will require flexibility to adapt their processes and systems as new technologies and communication channels come on stream. Children and young people are generally far more advanced than adults in their use of technology, so their involvement and input will prove crucial in making best use of these exciting possibilities.

Information sharing

It is important that professionals have clarity on when and how information can be shared legally and professionally to achieve the right balance between protecting sensitive data and ensuring that information is shared appropriately. Local protocols and procedures should be in place to support this.

The cross-government *Information Sharing Guidance* (HM Government, 2008d), aimed at those who work with children and adults, has been well received and widely endorsed by a number of health bodies, including many of the Royal Colleges. To support the guidance, DCSF has produced a number of products including a pocket guide, a quick reference guide and an introductory training course on CD-ROM.²¹

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²¹ These are all available to order, free of charge, via the DCSF website: www.dcsf.gov.uk/ecm/informationsharing

Chapter 3

Recommended components

This chapter describes the recommended components that local commissioners and practitioners will wish to consider for the successful delivery of the HCP. In particular, it describes the HCP's focus on:

- prevention and early intervention;
- key health priorities;
- safeguarding;
- health development reviews;
- screening;
- immunisation programmes;
- signposting of services;
- environments that promote health; and
- support for parents and carers.

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The HCP will be most successful if:

- all staff delivering the HCP are appropriately trained and skilled;
- all services are delivered in the appropriate 'environment': e.g. all health services for children are child friendly and those for young people conform to the *You're Welcome* quality criteria (DH, 2007);
- service providers view young people holistically and not simply in terms of the presenting problem. This means they are alert to the interplay between multi-factorial risks: for example, young people abusing drugs and alcohol will often have higher rates of sexual health and mental health problems;
- all schools are Healthy Schools and are working towards health and wellbeing outcomes through the enhancement model;
- all schools are working towards providing access to the full range of extended services;
- schools understand their responsibilities for intervening early to support at-risk children and young people;
- all FE colleges and organisations are making full use of the Healthy FE Framework;
- the curricula for PE and PSHE are delivered effectively;
- the core skills and competencies required by the 5–19 HCP Team are met (see Annex C);
- the configuration of services and allocation of staffing and resources are underpinned by a systematic assessment of population needs; and
- children, young people and their families/carers are consulted and engaged in service design and delivery.

Variability in **how** services are provided is acceptable and indeed desirable, but not variability in **content or quality** – which increases inequalities in health. This programme is designed to support local areas in minimising such inequalities.

Prevention and early intervention

Focusing on early intervention and prevention, rather than on treating a problem after it has developed, is both socially and economically more effective in the long term. Supporting children and young people through childhood and adolescence into adulthood lays the foundations for a healthy, fulfilled life (see Chapter 1 for further details).

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Key health priorities

It is recommended that local priorities are determined by local needs assessments (see Chapter 5). However, there are a number of key national health areas which have a particular strong focus in this 5–19 HCP. These are outlined below.

Health inequalities

Certain groups of children and young people have particular vulnerabilities and susceptibility to poor health outcomes (see Annex E).

The HCP seeks to reduce health inequalities and meet the needs of the most at-risk children, young people and families through a progressive universal model.

Emotional health, psychological wellbeing and mental health

Improving emotional health and wellbeing and delivering a comprehensive range of CAMHS is central to the HCP. Early intervention is crucial when young people first experience mental distress, by building their resilience and providing them and their families with appropriate support.

Those working with children and young people need to listen well, observe carefully, understand when things are going wrong and be able to deal with this sensitively, drawing on expert support when they reach the limit of their personal competence. Health professionals who deal with children should be familiar with the ways in which distress in or about school can present as physical illness. Equally, those working in school settings should consider the underlying causes of a child's distress and whether additional support is needed.

Following the CAMHS Review's final report (National CAMHS Review, 2008), the Government has agreed to take forward some of its key recommendations, including:

- improving access for children, young people and their families to mental health support through universal services;
- improving mental health services for at-risk children and young people (such as children in care, those with disabilities and those with behavioural, emotional and social difficulties); and
- ensuring that parents and carers can access advice and support when they are concerned about their children's mental health.

Promoting healthy weight

Promoting healthy weight and preventing and managing obesity have become pressing public health priorities. Many practitioners have a role to play in encouraging children and their families to eat well and be more physically active. Positive approaches to achieving and maintaining a healthy weight are particularly important for young people with disabilities, who are often less active than their peers.

Physical activity is a key approach to tackling obesity and excess weight, as well as contributing to wider wellbeing. Play, particularly unstructured play, is one of the best ways for children to expend calories. Increasing the amount of time children spend playing could contribute to reducing obesity. The London 2012 Olympic Games offer a national focus for promoting physical activity. The schedule in Chapter 4 sets out the range of recommended physical activities that should be available to all children and young people.

In 2008 the Government launched the PE and Sport Strategy for Young People which states that by 2011 the ambition is **to offer all children at least five hours of PE and sport every week**. This is often referred to as the '5 hour offer'. Schools have a key role to play as the strategy describes that:

- all 5–16-year-olds will be given the opportunity to take part in two hours of curriculum PE each week, plus up to three hours of school and community sport; and
- 16–19-year-olds will be given the opportunity to take part in up to three hours of school/college and community sport.

Schools should also consider how they can provide supervised play opportunities as a possible means of engaging children and young people in more physical activity.

Good food habits at home and school are essential to support healthy weight and attitudes to nutrition. Schools are required to ensure that all food provided in schools complies with standards that support a balanced nutritional intake.

Schools are also encouraged to increase the number of children eating a midday school meal, to maximise the numbers benefiting from a balanced meal, which reinforces sensible eating patterns and improves behaviour and readiness to learn. Access to a healthy school lunch is particularly important for children from poorer families, and schools should seek to ensure that all children eligible for a free school meal take up their entitlement.²²

²² Further advice on nutritional standards and what works for schools in increasing take-up of school lunch is at: www.schoolfoodtrust.org.uk

Clear guidance for commissioners and a framework of training providers has been developed to help local areas develop weight management services to respond to families and children who seek help after taking part in the National Child Measurement Programme (NCMP) (Cross-Government Obesity Unit, 2008 and 2009).

Note that consent is not required for the NCMP, although parents and carers have the right to withdraw their child from the programme, and so PCTs have a duty to ensure that all parents and carers receive a letter of explanation.

Long-standing illness or disability

Many children and young people live with a long-term condition such as asthma, epilepsy or diabetes, or a disability. The HCP describes some of the support services that can help children and young people manage the physical and emotional effects of these conditions and achieve their full potential, enjoying the same opportunities as their peers both in and outside school.

Teenage pregnancy and sexual health

Over the last decade considerable policy attention has been given to a reduction in teenage pregnancy rates through the Teenage Pregnancy Strategy. Since 1998, there has been a steady downward trend in the under-18 conception rate and a significant reduction of 24 per cent in births.²³ Some areas where LAs working with PCTs have fully implemented the strategy have seen conception rate reductions of over 30 per cent. This joint working has included targeted support for young people most at risk of early sex and teenage pregnancy – such as young people in or leaving care and those with poor educational

attainment – and made links to other risky behaviour such as substance use, most notably alcohol consumption.

The HCP, through its articulation of the recommended universal and progressive services, is central to helping local areas accelerate and sustain reductions in the under-18 conception rate and the incidence of STIs beyond 2010. The provision of high-quality, accessible contraception and sexual health services, with sufficient capacity to meet the needs of the local population, is an essential part of joint commissioning for the CYPP (DCSF/DH, 2009).²⁴

Forthcoming DH guidance on commissioning contraception and abortion services will help PCTs to commission high-quality services for young people.

Prevention services for STIs should also include appropriate information and advice about preventing human immunodeficiency virus (HIV). HIV remains a serious health issue for which there is no cure.

A new sexual health media campaign will be launched by DH/DCSF in late 2009. The campaign will have a strong early focus on helping people, particularly young people, to make effective contraceptive choices.

Drugs, alcohol and tobacco

Levels of substance misuse and smoking among children and young people appear to be in a downward trend. However, while the number of young people regularly consuming alcohol is falling, those who do drink are drinking more with more serious consequences for their health and wellbeing.

²³ www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/statistics/statistics

²⁴ See also the Sex Education Forum website http://partner.ncb.org.uk/Page.asp?originx_784wa_21042403840053g59p_200610203221g

Children's Trusts should be involved in treatment planning, working with the PCT. Services for young people should be able to identify and meet substance misuse needs and provide a route to specialist services.

Safeguarding

Safeguarding children and young people is everybody's business. All professionals should possess the knowledge and skills to safeguard and promote the welfare of children and young people. They need to be able to identify and respond appropriately to early signs that children, young people and their families need additional support as well as when children and young people are in need of safeguarding. An understanding of information sharing in relation to early intervention and to safeguarding is essential. (See Annex I for more details.)

Health and development reviews

The evidence suggests that there are key transition points that provide logical opportunities to review children's and young people's health.

A number of reviews are recommended through the 5–19 HCP schedule in Chapter 4. The core purpose of health and development reviews is to:

- assess the child's, young person's and family's strengths, needs and risks;
- give children, young people and parents/carers the opportunity to discuss their concerns and aspirations;
- assess physical health, growth and development and immunisation status;
- assess any mental or emotional health issues; and

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- ensure that appropriate support is available to meet educational and health needs such as language and communication.

It is recommended that these reviews occur at the following transition points:

- reception/Year 1 (age 4–5) – school entry assessment (transition from 0–5 HCP (*Healthy Child Programme: Pregnancy and the first five years of life* – DH/DCSF, 2009c))/school entry questionnaire;
- Year 6/7 (age 10–12) – assessment at transition from primary to secondary school; and
- mid-teens, when young people are embarking on the next transition stage.

In addition, reviews are described for:

- looked after children; and
- children and young people with disabilities or special educational needs (SEN) at transition.

Screening programmes

Screening is an integral part of the universal HCP. Screening programmes require local implementation of an agreed pathway, including clear guidelines on referral for assessment, diagnosis and treatment where necessary. Data and information systems should be capable of identifying those children who should be offered screening, managing them through the pathway, and ensuring that the best outcomes are reached for the child and family. The information and IT systems should also enable adequate fail-safe systems and support performance management of the screening programme.

Screening programmes are under continual review. Further information on screening is provided on the UK National Screening Committee (NSC) website.²⁵

Protocols about consent and parental permissions should be followed. The recommendation of the UK NSC is that the explicit informed consent of parents should be obtained before any screening test is carried out. 'Informed consent' means a parent is given information and then voluntarily agrees to continue. Informed consent is very important in the context of screening because screening is not just a test – it is one step in a whole programme of events necessary to achieve risk reduction.

See Annex F for full details.

Immunisation programmes

Immunisations should be offered to all children, young people and their parents or carers according to the routine immunisation schedule. It is recommended that, at every contact, members of the HCP Team should

identify the immunisation status of the child or young person.

It is also recommended that children, young people and their parents or carers are provided with good-quality, evidence-based information and advice on immunisations, including benefits and possible adverse reactions. Children and young people who have missed immunisations should be referred to their GP practice or other provider to receive outstanding vaccines. In addition, it is good practice for those immunising children and young people to use the opportunity to promote health and raise wider health issues with them and their parents or carers. The preparations for such interventions provide ideal opportunities to reinforce key health messages and signpost on to additional information and sources of help.

See Annex G for full details.

Signposting services

If children, young people and families have easy access to convenient health support and advice that is tailored to their needs and expectations across the key life stages, their needs are more likely to be met. However, it is a frequent complaint of children, young people and parents/carers that information on services and how to access them is hard to find.

While younger children may access health advice and support with their parents' help, as they mature and develop greater independence they should have independent access to information about the health and support services available, offered in the range of locations that young people use. It is good practice for services to be well publicised in appropriate formats and media. Online

²⁵ www.screening.nhs.uk

information sources for young people should also be widely advertised.

Some GP practices contact young people registered with them by way of a 'birthday card'/letter on their 16th birthday – or earlier in their mid-teens. This contact can provide the opportunity to increase young people's awareness of their right to choose their GP; offer young people the opportunity to make an appointment to discuss their health and wellbeing; and notify them of the range of health services available in different settings in their local area. DH will explore the efficacy and impact of such interventions further with a view to establishing whether this is an intervention that local areas may wish to consider implementing more widely.

Environments that promote health

The following actions are recommended:

- **All schools** are working towards Healthy School status and the new enhanced programme and, through access to extended services, offering swift and easy access to other services including health;
- **All FE colleges and institutions** use the Healthy FE Framework and success measures,²⁶ with input from the HCP Team as required, determined by local needs assessment. The additional needs of more at-risk students should be a particular priority.

Around three-quarters of FE colleges have now developed on-site health advice services, providing their students with quick and easy access to advice and support on contraception and sexual health. FE colleges and PCTs have been provided with guidance to support the broadening of on-site advice (DfES/DH, 2007).

- **All pupils receive a comprehensive age-appropriate programme of PSHE**, to which the HCP Team contribute as appropriate. This should include appropriate drugs and alcohol education²⁷ and SRE²⁸ and other inter-related areas, such as accident and injury prevention (including road accidents). PSHE contributes to staying safe and the **statutory** safeguarding duty on schools.

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27 The drugs guidance provides guidance on all matters relating to drug education, the management of drugs within the school community, supporting the needs of pupils with regard to drugs and drug policy development. The guidance is based on principles that underpin good practice in drugs education and managing drugs incidents. It is intended to help schools formulate a planned, co-ordinated and considered response to drugs.

28 The SRE guidance aims to clarify what schools are required to do by law and give guidance on some of the issues involved in developing a policy on SRE. It also shows how SRE should be taught within the PSHE framework.

These publications are available from <http://publications.teachernet.gov.uk/>

26 www.excellencegateway.org.uk/hfep

The Government has announced its intention to make PSHE (including SRE) statutory. Depending on the legislative process, this will be statutory in September 2011. In the meantime, all schools should be delivering PSHE in line with the key stages 3 and 4 personal wellbeing programme of study, and the Qualifications and Curriculum Development Agency's end of key stage statements for key stages 1 and 2. Revised SRE guidance (for all key stages) is expected to be published in 2010.

While primary responsibility for delivery of the PSHE curriculum rests with schools, the School Health Team may be able to provide valuable input.

- **Services for young people conform to *You're Welcome* quality criteria (DH, 2007) and are delivered by appropriately trained staff.**

Evidence shows that access to healthcare advice and services (including high-quality contraceptive and reproductive services) when young people need them is highly valued by them. They should be delivered in a variety of ways including nurse drop-in clinics in schools and FE, GP practices, youth centres, pharmacies etc. The exact configuration of services will depend on assessed local need.

Privacy, confidentiality, warmth and friendliness, competence and accessibility are all important components of such services. (In this context 'privacy' refers to whether the young person can access the service without peers or other people knowing why they are there; and 'confidentiality' refers to the duty on healthcare staff not to pass on information without the consent of the young person or child/family except in

specified circumstances.) Full guidance on these exceptions is available from HM Government's *Information Sharing Guidance* (HM Government, 2008d). The *You're Welcome* quality criteria have been successful in focusing attention on achieving these goals.

Support for parents and carers

The parent-child relationship is vital to children's development, learning, achievement and wider wellbeing. Poor parenting is a risk factor for mental health problems while good parent-child relationships reduce the risk of children adopting unhealthy lifestyles, such as smoking.

A strong parent-child relationship (including children's relationships with fathers) is important as children develop from dependent children to adults. Parenting teenagers can bring anxiety and frustration and present very different issues compared with the challenges faced by parents and carers of younger children. High-quality support can help to give parents confidence to talk openly with their children, to identify any problems (e.g. eating disorders) and can support parents and carers in setting boundaries.

Healthy lives, brighter futures (DH/DCSF, 2009a) set an expectation on Children's Trust partners to set out a clear local offer to parents.

LAs are under a legal duty to provide a range of information that parents may need to support their children through to age 19 (HM Government, 2006b, at section 12). Families Information Services (FISs) provide information about childcare and other services and facilities, including those for physical and

mental health. Further information can be found in **statutory** guidance.²⁹

PCTs are expected to set out what children and families can count on from their health services locally – through local service directories and PCT prospectuses.

The HCP Team should be able to signpost parents and carers to the local FIS. It should also ensure that information on the 5–19 HCP and local services is available in health, education and community settings, and promote national support such as helplines and internet sites (including the DCSF Parent Know How Programme and NHS Choices).

Increasingly the information will become available via other channels for those who do not use the internet. These include telephone helplines, print media, GP practices, schools etc.

Parents/carers of children with additional health needs

Parents and carers of children with additional health needs (e.g. disabled children or those with long-term conditions) need clear local information on sources of urgent help and out-of-hours support. Local approaches to tackle this may include creating public information campaigns to improve understanding of children's care pathways and simplifying points of access for out-of-hospital services.

Nationally, additional information will be made available through NHS Direct and NHS Choices, and a national core offer will set out non-statutory standards that disabled children, young people and their families can expect in

terms of accessing information on universal and specialist services.

Additional support for parents and carers

The 5–19 HCP also includes:

- a range of evidence-based parenting support programmes (see Chapter 4 and Annex B);
- a comprehensive resource for parents and carers which will be developed in 2010/11. It will give developmental milestones for children's and young people's health at each key stage and outline how parents and carers can support their children's wellbeing at each stage; and
- online resources and tools for practitioners, including examples of good practice.

Interventions and support services recommended for parents who themselves have health or other problems are listed in the schedule in Chapter 4.

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²⁹ <http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00943-2007&>

Chapter 4

The 5–19 Healthy Child Programme schedule

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The following schedule contains a set of recommended actions for local areas to consider. This good practice framework is informed by the best current evidence for a universal service appropriate for all children and young people and additional services for those with specific needs and risk factors. As outlined in Chapter 1, **the schedule contains no new statutory requirements and any existing statutory requirements are highlighted.** The detailed content of

the programme will always be ‘work in progress’, as research³⁰ and social changes continue to suggest new priorities for the HCP. In addition, local circumstances and local needs assessment will have an impact on the way in which the HCP is delivered in different parts of the country.

³⁰ For example, NICE will continue to be a key source of information on effective interventions.

(a) Sharing information about pre-school background

At school entry it is recommended that pre-school information collected about health (via the health visiting team as per the 0–5 HCP) and learning and development (via Sure Start children's centres and Early Years teams) should be available and passed on to inform the background data supporting the school entry assessment.

Responsibility: The primary responsibility for ensuring that health information is passed on to the school should lie with the health visiting team (as per the 0–5 HCP) and the school nurse or other School Health Team member. Responsibility for ensuring that information about learning and development is passed on to the school, in accordance with statutory data protection requirements, should lie with the Early Years team, Sure Start children's centres and reception class staff. Appropriate information should be shared to ensure a holistic view of the child (HM Government, 2008d).

(b) Health assessment at school entry in reception/Year 1 (4/5 years)

At school entry, it is recommended that the school nurse or other School Health Team member:

- takes over responsibility for a child from a health visitor;
- reviews immunisation status, identifies any outstanding immunisation/s and refers to GP practice or other provider for vaccination as required;

- reviews access to primary care;³¹
- reviews access to dental care (DH/BASCD, 2007);
- reviews appropriate interventions for any physical, emotional or developmental problems that may have been missed or not addressed;
- provides children, parents and school staff with information on specific health issues;
- measures height and weight for the NCMP and feeds back the results to parents/carers;
- ensures that hearing screening is carried out in line with NSC guidelines;³²
- screens all children between 4 and 5 years of age for visual impairment in line with NSC guidelines;³³ and
- is alert to risk factors and signs and symptoms of child abuse, and follows local safeguarding procedures where there is cause for concern.

Systems should allow appropriate information about the child's health needs to be shared between the school and the primary healthcare team/GP. Systems should also ensure that any child subsequently joining the school is incorporated into the system and has the necessary review.

Responsibility: PCTs via the School Health Team and/or wider HCP Team.

³¹ Children not registered with a GP are a special case and may be at increased risk of health problems, particularly if they have recently arrived in the UK from overseas. Every effort should be made to ensure that they register. When parents repeatedly fail to respond to requests regarding the child's health or to take up advice for referrals, without good cause, it may be necessary to consider whether this is a safeguarding issue.

³² Parental concern about hearing should always be noted and acted on.

³³ This should be conducted either by orthoptists or by professionals trained and supported by orthoptists.

Universal

Responsibility for vision and hearing

screening: The PCT lead of the local screening programme should be responsible for ensuring access to screening, diagnosis and appropriate management of cases. The lead should also facilitate arrangements for quality assurance and improvement of these services, which is key to delivering improvements in outcomes through an equitable and universal service.

Many areas administer a questionnaire to parents at school entry. There is currently no standard model for this questionnaire. Therefore, **subject to successful piloting of a standardised approach**, we are likely to recommend that **this model questionnaire for parents** explores their child's health and wellbeing and underpins a health review at school entry, managed by the School Health Team. The evidence suggests that its purpose would be to identify:

- children who have missed out on primary care in the pre-school years;³⁴
- health problems that are of relevance to school (including immunisation status and any chronic health needs); and
- any problems that are worrying the parents.³⁵

DH and DCSF, working with the Child and Maternal Health Observatory (ChiMat), will be developing a rigorously tested online prototype in 2010/11.

Those interpreting the questionnaire (the School Health Team or wider HCP Team)

should take into account that parents assess their child's progress by comparison with other children in their area and thus may underestimate, for example, the extent of language delay.

It is recommended that local areas aim for 100 per cent coverage of the children in the locality, using whatever information systems are available, and the information gathered should be shared between health and education. The administrative aspects of the questionnaire do not require a professional qualification, and could be carried out by someone trained in data collection and entry, including issues of privacy, confidentiality and accountability.

This is also an opportunity to cross-validate information with general practice and ensure that there is good communication between general practice and School Health Teams.

It is good practice to have in place follow-up procedures by a member of the HCP Team or onward referral on an individual basis where any concerns are highlighted or identified, or where parents fail to return questionnaires.

Responsibility: PCTs via the School Health Team and/or wider HCP Team.

There is **no evidence** to support the re-introduction of a routine (universal) school entrant physical examination at the start of primary education.

³⁴ These children should be referred to their GP for any health assessments and care that may be needed.

³⁵ The school should make it clear that every parent is expected to complete and return the questionnaire and non-responders should be followed up. Some schools already make the return of the questionnaire a prerequisite for school entry.

(c) Emotional health, psychological wellbeing and mental health

Emotional health and psychological wellbeing support

It is recommended that children and their families should have access to emotional health and psychological wellbeing support through the full range of universal services. HCP Teams should contribute, as appropriate.

Healthy Schools have a strong whole-school focus on the promotion of positive emotional health and wellbeing by working through national criteria. Enhanced Healthy Schools may also wish to develop targeted mental health outcomes as part of their health and wellbeing priorities. Examples of other interventions supporting mental health promotion in schools are listed below.

Social and emotional aspects of learning (SEAL):

It is recommended that all pupils have appropriate support for their social and emotional development, such as can be provided through the primary SEAL programme.

Targeted Mental Health in Schools (TaMHS):

Where local areas are implementing this programme, participating schools will provide access to a range of support models. Interventions could include: supportive and inclusive school culture and environment; training for teachers in mental health/emotional wellbeing issues; and social and emotional learning programmes such as problem solving, social awareness and access to other support, including counselling, primary mental health workers, group-based support and links to specialist CAMHS support (DCSF, 2008a).

Bullying

Schools have a legal duty to have measures in place to prevent and tackle bullying. Providing a safe and happy learning environment is integral to achieving the wider objectives of school improvement: raising attainment; improving school attendance; promoting equality and diversity; and ensuring the welfare of all members of the school community.

Responsibility: Primary responsibility sits with schools, supported by the School Health Team, as appropriate.

(d) Promoting healthy weight

National Child Measurement Programme

Measurement of children's height and weight in reception year and Year 6, and provision of feedback of results and general advice/information to parents if requested.

The NCMP operates under regulations under the NHS Act 2006, and is supported with non-statutory guidance.

Responsibility: PCTs working with partners.

Physical activity

The Chief Medical Officer recommends that all children and young people aged 5 and over should have a total of at least 60 minutes of at least moderate intensity physical activity each day, and at least twice a week this should include activities to improve bone health (activities that produce high physical stresses on the bones), muscle strength and flexibility (CMO, 2004).

- Every school is required to deliver the National Curriculum on PE. While there is no statutory minimum PE lesson time per

Universal

week, there is an aspiration for all 5–16-year-olds to access two hours of PE in the curriculum plus an additional three hours of sport per week within and beyond the school. This was set out in the PE and Sport Strategy for Young People in 2008.

Status: Statutory requirement to provide National Curriculum on PE.

- All schools should by 2010 have in place a **school travel plan** that, among other things, encourages pupils to walk or cycle as the first-choice mode of travel.³⁶
- Schools should also consider how they can provide opportunities for children to partake in unstructured play opportunities during the school day.

Nutrition

Most of the food and drink that children consume is provided by their family whether at home or not. All children need a balance of the right nutrients in the right amounts and to avoid excessive intake of foods high in fat, salt or sugar. The Change4Life³⁷ campaign promotes an easily accessible set of behaviours on nutrition and physical activity in everyday life.

- All schools should follow **statutory nutritional standards** and schools should be providing good-quality, healthy food that children want to eat, in pleasant dining areas.

Status: statutory in all schools from 2009.

- **Breakfast clubs** can play a major role in helping to improve attendance and

motivation, and in increasing social inclusion. They also provide an important opportunity to promote healthy eating among children, young people and their families.

Responsibility: Primary responsibility for physical activity, travel and school food sits with schools, supported by the School Health Team, as appropriate.

(e) Ongoing support throughout primary school

Safeguarding

All those working with children should be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern. Schools have a duty to safeguard and promote the welfare of their pupils. *Working Together to Safeguard Children* (HM Government, 2006a) sets out how organisations should work together and the actions to be taken when abuse or neglect is known or suspected.

Responsibility: All.

Status: Statutory.

Identification of additional needs

As part of their role in early intervention, teachers and colleagues should use the Common Assessment Framework (CAF) to raise concerns in an accessible and speedy way and to alert and access support from the School Health Team or HCP Team special educational needs co-ordinator (SENCO) as appropriate. There should be agreed access for professionals to specialist CAMHS. This could include issues of overweight and obesity and draw on ongoing observational data about emerging developmental, emotional adjustment, educational or behavioural

³⁶ www.teachernet.gov.uk/wholeschool/sd/managers/travel/STAToolkit

³⁷ www.nhs.uk/Change4Life/Pages/default.aspx?gclid=CKvpgMvllJOCFYNu4wodNWOA3g. See especially the 'Partners & supporters' area.

difficulties or risk factors that might affect educational progress; provide an opportunity for parents and carers to discuss family concerns and receive advice on matters relating to school progress; and provide an opportunity for the healthcare team to review any conditions or health problems that have developed since school entry and update any routine healthcare procedures such as immunisations.

Good practice examples of existing referral mechanisms and protocols will be available on the HCP web resource in due course.

Responsibility: Primary responsibility sits with schools, supported by the School Health Team, as appropriate.

(f) Support for parents and carers

It is recommended that information, advice and support are available to all parents and carers (e.g. through FISs, NHS Choices and forthcoming HCP online resources).

Responsibility: LAs and PCTs, with the HCP Team and School Health Team having a role in signposting.

Progressive

(a) Immunisations for at-risk children

Check status (see Annex G) and refer to GP practice or other provider as required.

Responsibility: PCTs via School Health Team and/or primary care.

Status: Statutory (see footnote for further detail).³⁸

(b) Emotional health, psychological wellbeing and mental health

The following services should be available and easily accessible:

- Professional consultation from referral to primary, targeted and specialist CAMHS support (across tiers 2, 3 and 4) for young people at risk of and/or experiencing poor mental health³⁹ where there is an identified need.
- Schools taking part in the TaMHS model provide access to additional support for those children who need it most and their families (DCSF, 2008a). Interventions can include parent training/education programmes, therapeutic support for depression – cognitive behavioural therapy

(CBT), psychoanalytic child psychotherapy or family therapy depending on symptoms and associated problems. They will also link with specialist CAMHS support.

Responsibility: PCTs via School Health Team, working with education colleagues; in other settings (e.g. the community), appropriate members of the HCP Team with CAMHS and other specialist colleagues.

(c) Overweight and obese children

Parents of overweight and obese children should receive:

- appropriate information and signposting to further sources of advice/support; and
- referral to appropriate weight management services to enable the child to move towards and maintain a healthier weight, and an assessment of underlying health issues/co-morbidities as appropriate.

Responsibility: Depending on setting, School Health Team or appropriate members of the HCP Team with specialist colleagues.

(d) Specific groups of at-risk children and families

It is recommended that schools and the HCP Team identify children and families with particular vulnerabilities. Many will be identified through the individual health assessment at school entry, but also through ongoing observations throughout the early years and during the primary school years. Appropriate additional support/referral should take place where necessary. The HCP health visitor will have a key role in ensuring that there are robust arrangements for identifying where families need extra support, assessing

³⁸ PCTs have a **statutory duty** to make sure that arrangements are in place for the following immunisations to be delivered: all routine childhood immunisations, influenza and adult pneumococcal vaccination and the routine HPV vaccination. PCTs also have a responsibility to provide primary medical services which could include targeted vaccines such as hepatitis B and BCG.

³⁹ Targeted support and interventions – key focus on building resilience and preventing the development of significant problems for individuals and families exposed to significant risk. Specialist services – key focus on interventions to address significant, complex and persistent difficulties which may take place on an intensive or long-term basis.

needs and co-ordinating multi-agency activity. This may be in place already; however, a CAF may be needed to assess individual children's needs and establish a 'Team Around the Child'. It will then fall to the primary healthcare team for continuity (for the 5–19 age group).

Responsibility: School Health Team, working with education colleagues; in other settings (e.g. the community), appropriate members of the HCP Team with specialist colleagues.

Looked after children

- Each child who becomes looked after should have a holistic **health assessment on entering care**. The responsibility for health assessment is shared between the LA and the PCT. The social worker needs to ensure it is initiated and carried out, and the NHS is responsible for actually undertaking the assessment and developing the healthcare plan according to local arrangements. The assessment covers physical health, mental and emotional wellbeing, and health promotion.
- Arrangements must allow for the review of the health assessments and the plan which is described below (for children over 5, at least once a year).
- Every looked after child should also have a health plan which forms part of their care plan and sets out the objectives, actions, time-scales and responsibilities arising from the health assessment. Arrangements must also be in place for the annual health assessment reviews to be undertaken.

Status: Statutory.⁴⁰

- It is recommended that the HCP Team is notified of all looked after children in their area via a locally agreed process, and contributes to their care and support.
- LAs are required to make sure that a strengths and difficulties questionnaire (SDQ) is completed for each of their looked after children aged between 4 and 16 inclusive. The questionnaire should be completed by the main carer, preferably at the time of the children's statutory annual health assessment. The LA will need to distribute and explain how to use the questionnaires to each carer.
- It is recommended that all looked after children have access to assessment, treatment and support through specialist CAMHS.

It should also be recognised that some looked after children may have even greater needs or face additional access barriers (e.g. those with a disability and/or special education needs; children from black and minority ethnic (BME) groups; children in custody including the secure estate; refugee/unaccompanied asylum-seeking children; lesbian, gay, bisexual and transgender (LGBT) children and young people).

Responsibility: The looked after children lead in the Children's Trust has the responsibility to ensure that these interventions are being delivered according to local protocols and practice.

⁴⁰ See *Promoting the Health of Looked After Children* (DH, 2002) available on www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005321 for an outline of both the statutory requirements and practice guidance for looked after children (updated guidance will be published in November 2009).

Progressive

Children with complex welfare needs

Children and young people with complex welfare needs who are looked after by the LA should have access to multidimensional treatment foster care⁴¹ where this is in operation and where individual assessment of clinical need indicates that the evidence would support this approach.

Responsibility: LAs.

Targeted approaches for children with special educational needs

Children may fail to make progress at school because of an underlying SEN. Children's learning difficulties should be identified early, assessed, and appropriate intervention made.

When a child is not making sufficient progress at school, whether or not they have been identified as having SEN, the school should, in the first instance, be using educational interventions to accelerate their progress. If progress is not made – despite such interventions and advice from experts external to the school – schools and/or parents/carers should be asking their LA to arrange a statutory assessment of SEN (DCSF, 2008b). When making an assessment the LA must ask for health advice (DfES, 2001, paragraph 7.82⁴²). The School Health Team should liaise with the wider HCP Team and the designated medical officer (paragraphs 10.23 and 10.24 of the SEN Code of Practice) to facilitate this.

Dyslexia and literacy difficulties should be detected early and addressed, in line with the graduated approach proposed by Sir Jim Rose

as part of his review of the primary curriculum (Rose, 2009). Lack of response to initial intervention should lead to a comprehensive assessment, including consultation with appropriate health professionals. Where there is significant concern regarding mental or physical health, social interaction or family circumstances, early involvement of health professionals may be advisable.

Protocols should allow the School Health Team to alert and access early support from the HCP Team (or as appropriate, the SENCO or CAMHS) about emerging developmental, educational or behavioural difficulties or risk factors that might affect educational progress; and to provide an opportunity for parents to discuss family concerns and receive advice on matters relating to school progress.

Where there is concern about a child, the CAF process should be instigated to gain a holistic view of all the child's needs.

Further guidance is provided by the **statutory SEN Code of Practice**.

Status: See the **SEN Code of Practice which sets out schools', LAs' and others' SEN statutory duties**.

Responsibility: Primary responsibility sits with schools, supported by the School Health Team, as appropriate.

Children with complex health needs

- By 2010, all children with long-term medical conditions and/or significant disabilities should have an individual care plan (DH/DCSF, 2009a).
- Guided by this plan, health professionals and teaching staff to anticipate, avoid and respond appropriately to events such as

⁴¹ www.mtfce.org.uk

⁴² The SEN Code of Practice sets out schools', LAs' and others' SEN statutory duties, including schools' and LAs' duties to identify, assess and make provision for children with SEN.

seizures or asthma exacerbations – thus contributing to a reduction in the number of emergency admissions to hospital.

- Key workers of those with an individual care plan should liaise with the HCP Team to ensure that their care is co-ordinated where possible with universal services.
- Co-ordinated palliative and end-of-life services should be available for all those in need of them.
- Children with long-term medical conditions should, as far as possible, be managed with a medication regimen that does not require them to receive medicines during school hours (school nurses may be involved in such cases where this is not possible) and should initially be identified by the school entry questionnaire.

Responsibility: PCTs.

- Schools should have policies on managing pupils' medicines and on supporting pupils with medical needs (DfES/DH, 2005⁴³). Updated DH/DCSF guidance is to be published in 2010.
- Schools should have in place anti-bullying policies for all children, including those with disabilities and those who are overweight or obese, who are at increased risk of bullying.

Responsibility: Schools.

Young carers

- The Children's Trust should have systems in place to ensure that the needs of young carers and the person being cared for are assessed and that co-ordinated support

offered to the family to ensure that the child is protected from having to take on inappropriate or harmful caring roles.

- The HCP Team to contribute to care package agreed through local multi-agency arrangements.

Responsibility: As described.

(e) Support for parents and carers

Family Pathfinders

In areas delivering this service,⁴⁴ disadvantaged families should be offered intensive help and support. HCP Teams should be aware of the participating families and offer support as necessary.

Family Intervention Projects

In areas operating these projects, families with multiple problems should have access to Family Intervention Projects (FIPs)⁴⁵ to provide targeted whole-family support, including health services. HCP Teams should refer and support as required.

Parenting Early Intervention Programme

In areas operating this programme, HCP Teams should be aware of it, and refer and support parents, as appropriate.

Parents with alcohol or drug misuse problems

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.

⁴³ *Managing Medicines in Schools and Early Years Settings* provides advice for schools and their employers to help in the development of such policies.

⁴⁴ www.everychildmatters.gov.uk/parents/pathfinders

⁴⁵ The primary objective of FIPs is to support and challenge vulnerable families in chaotic households to tackle issues such as poor parenting, poor mental health, drug and alcohol addiction, anti-social behaviour and debt issues: www.dcsf.gov.uk/ecm/thinkfamily

Progressive

- It is recommended that the HCP Team is aware of, and contributes as appropriate to, the care package led by the specialist service, including identification of any safeguarding concerns and links to appropriate children's services (HM Government, 2006a).
- The Local Safeguarding Children Board must ensure that clear protocols are in place between adult treatment services and children's services.

Responsibility: As described.

Parents with mental health problems⁴⁶

- Referral of one or both parents to specialist adult mental health (AMH) service.
- The HCP Team to contribute to care package led by specialist service.
- The HCP Team to ensure that any safeguarding concerns are identified and that links are in place to appropriate children's services.

Responsibility: Specialist AMH services, with input from the HCP Team as appropriate.

Parents who smoke

It is recommended that all healthcare professionals use the 3A approach to supporting people who smoke to quit – **Ask** if they smoke, **Advise** them about stopping and the efficacy of local NHS Stop Smoking Services, and **Act** by offering a referral to the local service. The local NHS Stop Smoking

Services offer the most effective evidence-based opportunity to stop smoking.⁴⁷

Responsibility: PCTs via specialist NHS Stop Smoking Services.

Families or environment where there is domestic violence

- Follow local guidelines.
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- The HCP Team to contribute to care package led by specialist service.
- The HCP Team to ensure that any safeguarding concerns are identified and that links are in place to appropriate children's services.

Responsibility: Specialist services, with input from the HCP Team, as appropriate.

Parents with learning difficulties

- Provision of information about the support available to parents with learning disabilities, and assistance given in interpreting information and accessing other sources of support.
- Further support designed to address the parent's individual needs might include speech, language and occupational therapy.

Responsibility: Specialist adult services, with input from the HCP Team, as appropriate.

⁴⁶ The Parental Mental Health and Child Welfare Network is a development network set up to promote joint working between social care and health staff working with parents with mental health problems and/or their children. It can be found at: www.pmhcwn.org.uk

⁴⁷ Local NHS Stop Smoking Services can be found at <http://smokefree.nhs.uk>

(a) A health review at school transition in Year 6/7 (10–12 years)

Some areas have developed a review process at transition to secondary school which involves administering and reviewing questionnaires.

Subject to successful piloting,⁴⁸ we may recommend that two questionnaires – one for young people and one for parents – are administered to review young people's health and wellbeing. Information from the questionnaires (and subsequent follow-up) will make a valuable contribution to the school self-evaluation form (SEF). The evidence suggests that the aims and objectives of this approach could include:

- introducing the School Health Team and school nurse, and explaining how to access health advice and information (including services in primary care, pharmacies and the community) at a time when many pupils feel anxious and stressed;⁴⁹
- allowing parents to raise any concerns and offering them advice to support their child through the transition;
- checking immunisation status and providing information about vaccines that will be offered in the future (i.e. Td/IPV and human papillomavirus (HPV) vaccinations);
- checking that any important information about past or current health problems has been transferred from the previous school;

- responding to health and wellbeing concerns raised by the young person or their parents;
- identifying incipient mental health problems, eating disorders etc;
- interpreting the body mass index score as part of the NCMP and explaining the implications for diet and lifestyle; and
- offering an open invitation to request a face-to-face consultation with a member of the School Health Team, such as the school nurse.⁵⁰

The School Health Team should consult with education colleagues about the best way to administer the questionnaires. The data analysis would be the responsibility of the HCP Team.

This is also an opportunity to cross-validate information with general practice and ensure that there is good communication between general practice and School Health Teams.

Responsibility: School Health Team and the wider HCP Team, working with education colleagues.

(b) Engaging with primary care in mid-teens

A further contact point is recommended in mid-teens as young people assume greater independence over their own health. **Subject to successful piloting,** we may recommend that primary care services learn from existing good practice and communicate directly with young people in their mid-teens and by their 16th birthday (for example, one approach

⁴⁸ DH will set up a pilot in 2010/11 to test this approach. The findings will be shared on the HCP web resource.

⁴⁹ This is perhaps best done by a combination of written information, a website and a meeting with the whole class or school year intake.

⁵⁰ Pupils with complex needs or problems, along with their parents, should be offered an interview with the appropriate member of the School Health Team, such as the school nurse.

Universal

many GP practices use is to send a 'birthday card' or letter). This communication is intended to: inform young people of their right at 16 to choose their GP; offer them the opportunity to make an appointment to discuss their health and wellbeing; and notify them of the range of health services available in different settings in their local area.

(c) Immunisations⁵¹

Review immunisation status and include arrangements to ensure Bacille Calmette-Guérin (BCG) (against tuberculosis), hepatitis B and seasonal influenza vaccinations are offered to those young people who are at clinical risk (see Chapter 3 and Annex G).

Responsibility: PCTs via the HCP Team.

HPV vaccination

Girls aged 12–13 and those in the catch-up programme to be offered the HPV vaccine which protects against cervical cancer.

Responsibility: PCTs via the HCP Team.

Td/IPV vaccination

Young people between the ages of 13 and 18 should be offered the 'school leavers' booster' which provides protection against tetanus, diphtheria and polio.

In addition, those immunising young people can also use the opportunity to promote health and raise wider health issues with them and their parents or carers.

Status: Statutory (see footnote for further detail).⁵²

Responsibility: PCTs via the HCP Team.

(d) Emotional health, psychological wellbeing and mental health

It is recommended that young people and their families have access to emotional health and psychological wellbeing and mental health support (including early identification of eating disorders) through universal services (NICE, 2009). HCP Teams should contribute, as appropriate.

Healthy Schools have a strong whole-school focus on the promotion of positive emotional health and wellbeing by working through national criteria. Enhanced Healthy Schools may also wish to develop targeted mental health outcomes as part of their health and wellbeing priorities.

Examples of other interventions supporting mental health promotion in schools are listed below.

Social and emotional aspects of learning

As for children 5–11 (see page 35).

Targeted Mental Health in Schools

As for children 5–11 (see page 35).

⁵¹ Further information is available in *Immunisation against Infectious Disease* (DH, 2006) at: www.dh.gov.uk/greenbook and www.immunisation.nhs.uk

⁵² PCTs have a **statutory duty** to make sure that arrangements are in place for the following immunisations to be delivered: all routine childhood immunisations, influenza and adult pneumococcal vaccination and the routine HPV vaccination. PCTs also have a responsibility to provide primary medical services which could include targeted vaccines such as hepatitis B and BCG.

Bullying

As for children 5–11 (see page 35).

(e) Promoting healthy weight

Physical activity

As for children 5–11 (see pages 35–36).

Nutrition

As for children 5–11 (see page 36).

It is recommended that pupils attending secondary school and special schools are offered a curriculum that includes the importance of a healthy, balanced diet, and the necessary skills for food preparation and making healthy food choices.

(f) Sexual health

Contraceptive and sexual health services

PCTs and LAs should work together to ensure that all young people have easy access to confidential contraceptive and sexual health services, commissioned to meet the *You're Welcome* quality criteria (DH, 2007). Services should be delivered by well-trained staff, offering advice, guidance and the full range of services, including prompt access to emergency hormonal contraception, choice of effective contraception, including LARC, unbiased support and advice for unintended pregnancy with swift referral to antenatal care or NHS-funded abortion services and treatment for all STIs (DH/MedFASH, 2005). Information about local services should be routinely provided to all young people within PSHE and well publicised in the local area. Service information should be provided to all relevant professionals to encourage swift referrals for young people who need specialist advice. Young people should also be reminded

about the continuing risk of a range of STIs, including HIV. In addition to providing young people with effective contraception, local areas should continue to promote and increase access to condoms to prevent STIs.

Chlamydia screening

All sexually active young people under the age of 25 should be encouraged to be screened for chlamydia annually or whenever there is a change of sexual partner. On-site services providing the full range of contraception and chlamydia screening (alongside other health advice) are strongly recommended.

All contraception, sexual health and chlamydia services should be integrated and meet the *You're Welcome* quality criteria (DH, 2007).

In addition, all professionals should seek opportunities for health promotion about sexual health and contraception, and substance misuse (including alcohol, drugs and smoking).

Responsibility: School Health Team with support from specialist providers, as appropriate.

(g) Ongoing support 11–16

Safeguarding

As for children 5–11 (see page 36).

Identification of additional needs

As for children 5–11 (see pages 36–37).

(h) Support for parents and carers

As for children 5–11 (see page 37).

Progressive

(a) Immunisations for at-risk children and young people

Check status (see Annex G) and refer to GP practice or other provider as required.

Status: Statutory (see footnote for further detail).⁵³

Responsibility: PCTs via School Health Team and/or primary care.

(b) Emotional health, psychological wellbeing and mental health

It is recommended that the following services are available and easily accessible:

- Emotional health and psychological wellbeing services in universal and mainstream settings, dealing with the early manifestations of problems without the need for onward referral. This will require a workforce that is trained to promote emotional health and psychological wellbeing and to respond appropriately.
- Access to professional consultation and referral to targeted and specialist CAMHS support (across tiers 2, 3 and 4) for young people at risk of and/or experiencing poor mental health⁵⁴ should be swift. Members of the HCP Team should be fully conversant with the role they can play in

managing early symptoms in universal settings without the need for onward referral, but should also be conversant with referral protocols when these become necessary.

- Delivery of the TaMHS initiative (DCSF, 2008a) where this programme is in local operation. Interventions could include family-based approaches addressing the full range of a family's needs; individual support taking a CBT approach; and therapeutic support for depression – CBT, psychoanalytical child psychotherapy or family therapy depending on symptoms and associated problems. Also, referrals to specialist CAMHS support.

Responsibility: School Health Team, working with education colleagues; in other settings (e.g. the community), appropriate members of the HCP Team with specialist colleagues.

(c) Overweight and obese young people

As for children 5–11 (see page 38).

(d) Drug and alcohol misuse

Referral of young person to local specialist services as part of a multi-agency strategy.

Responsibility: Depending on setting, School Health Team or appropriate members of the HCP Team with specialist colleagues.

(e) Smoking cessation

It is recommended that all healthcare professionals should use the 3A approach to supporting young people who smoke to quit – **A**sk if they smoke, **A**dvice them about stopping and the efficacy of local NHS Stop Smoking Services, and **A**ct by offering a

⁵³ PCTs have a **statutory duty** to make sure that arrangements are in place for the following immunisations to be delivered: all routine childhood immunisations, influenza and adult pneumococcal vaccination and the routine HPV vaccination. PCTs also have a responsibility to provide primary medical services which could include targeted vaccines such as hepatitis B and BCG.

⁵⁴ Targeted support and interventions – key focus on building resilience and preventing the development of significant problems for individuals and families exposed to significant risk. Specialist services – key focus on interventions to address significant, complex and persistent difficulties which may take place on an intensive or long-term basis.

referral to the local service. The local NHS Stop Smoking Services offer the most effective evidence-based opportunity to stop smoking.

Responsibility: NHS Stop Smoking Services.

(f) Specific groups of at-risk young people

Looked after young people

As for looked after children 5–11 (see page 39). In addition, as children develop through adolescence a range of key health areas such as emotional health, risky sexual health behaviours and substance misuse problems tend to be over-represented among looked after children or care leavers. It is essential that health reviews and subsequent services meet these needs effectively.

Young people with complex welfare needs

As for children 5–11 (see page 40).

Targeted approaches for young people with special educational needs

As for children 5–11 (see page 40). In addition, as part of the transition care plan (see section below), consideration should be given to appropriate future education, training and employment planning.

Young people with complex health needs

As for children 5–11 (see pages 40–41).

In addition, as young people with disabilities move towards adulthood, national guidance on transition should be followed (DH/DfES, 2006; DCSF/DH, 2007; DH, 2008b). In particular, the health transition plan needs to be developed by the young person, supported

by the most relevant health professional/ transition key worker or other relevant multidisciplinary team member who can review it regularly with them.⁵⁵

Responsibility: According to local protocols.

Young carers

As for children 5–11 (see page 41).

Young people in contact with the youth justice system⁵⁶

The HCP Team will have a role in:

- supporting young people and their families to use mainstream services, including registration with a GP and re-entry into school, and reducing difficulties when young people leaving custody have been removed from their home GP's list;
- assessing their needs and developing a health delivery plan to compensate for missed preventive support (including missed or due immunisations), and offering early intervention and treatment as necessary;
- tailoring co-ordinated, multi-faceted care to individual needs, including communication and language needs, learning difficulties and disability, and mental health problems;
- ensuring continuity of healthcare for young people sentenced to custody and placed in an establishment out of their home area or moved between establishments during their sentence. Close links with on-site health staff will be needed, to ensure that information about young people's health and mental health is made available to

⁵⁵ Transition planning templates are available at www.transitionpathway.co.uk

⁵⁶ Young offender institutions which are part of HM Prison Service, secure training centres run by private operators, and secure children's homes.

Progressive

those dealing with their education and behaviour needs (DH, 2008a);

- ensuring that local substance misuse services are meeting this group's needs via input into the young people's substance misuse treatment plan;
- ensuring that advice and support are provided on relationships and sexual health, and that young people who are already parents are identified and provided with co-ordinated care; and
- the negotiation of a safe and effective transition to appropriate adult provision.

Responsibility: PCTs, working with the local youth justice service.

Substance misuse interventions for young people in the secure estate

- The health assessment should consider whether there are any substance misuse needs of looked after children. Local substance misuse services should pay particular attention to the needs of looked after children in their treatment planning, and ensure that services are accessible to this group with clear, effective referral routes in place.
- Healthcare screening should be undertaken as soon as possible after a young person's arrival, in line with the recommendations contained in the clinical guidance.⁵⁷
- Young people should receive a substance misuse assessment to identify:
 - those who have not used substances or who have only used on an occasional basis;

- those who use substances and have no immediate or significant problems but could benefit from targeted interventions; and
- those who use substances and are experiencing current harm, and who would benefit from specialist treatment.

- Every young person who is assessed as needing targeted services or specialist treatment should have a substance misuse plan developed by their substance misuse worker (YJB, 2009).

Responsibility: The Young People's Substance Misuse Service provider, commissioned via the Youth Justice Board (YJB), with the National Treatment Agency (NTA) responsible for clinical guidance etc.

(g) Support for parents and carers

Family Pathfinders

As for children 5–11 (see page 41).

Family Intervention Projects

As for children 5–11 (see page 41).

Parenting Early Intervention Programme

As for children 5–11 (see page 41).

Multisystemic therapy⁵⁸

In areas operating these projects, it is good practice for HCP Teams should be aware of, refer and support families in the project as required.

⁵⁷ *Guidance for the Pharmacological Management of Substance Misuse among Young People in Secure Settings* (YJB/DH/NTA) (forthcoming).

⁵⁸ Multisystemic therapy (MST) is a family- and community-based treatment programme for young people with complex clinical, social and educational problems such as violent behaviour, drug abuse and school expulsion.

Parents with alcohol or drug misuse problems

As for children 5–11 (see pages 41–42).

Parents with mental health problems

As for children 5–11 (see page 42).

Parents who smoke

As for children 5–11 (see page 42).

Families or environment where there is domestic violence

As for children 5–11 (see page 42).

Parents with learning difficulties

As for children 5–11 (see page 42).

Universal

Young people over the age of 16 may be in a wide range of settings: in FE, in sixth form schools, in work or training, or none of these (not in education, employment or training – NEET). For maximum impact, services should take account of the differing needs of this highly diverse group of young people.

(a) Immunisations

As for young people 11–16 (see page 44).

Status: Statutory (see footnote for further detail).⁵⁹

(b) Young people entering Further Education⁶⁰

It is recommended that information about a young person's support needs in respect of personal, social and health issues should be shared with the FE institution they are entering. This information should be transmitted to colleges by all relevant agencies working with a young person through a single information process. Some young people entering FE can be especially at risk, so there are issues about continuity of care and the appropriate exchange of information about pre-existing conditions or problems, as well as ensuring the provision of ongoing support and services.

Students enrolling in FE institutions generally complete an enrolment form that includes health-related questions, but may be anxious

about disclosing personal information which they (erroneously) believe will affect their chances of acceptance. FE institutions should therefore ensure that such concerns are reduced by good information and publicity materials.

As the HCP develops, the following factors will help to support FE learners (and their families/carers) better and encourage better exchange of information between schools and FE and health services:⁶¹

- the engagement with the Healthy FE Programme;
- the forging of strong links between local HCP Teams and their FE colleagues, particularly personal tutors;
- FE institutions becoming 'relevant partners' in the Children's Trust; and
- the responsibilities of FE organisations in supporting the economic and social wellbeing of their communities.

(c) Emotional health, psychological wellbeing and mental health

It is recommended that young people and their families have access to emotional health, psychological wellbeing and mental health support through universal services. HCP Teams should contribute, as appropriate, paying particular attention to young people's needs at the transition between CAMHS and AMH services.

Responsibility: CAMHS, primary care and HCP Team as appropriate.

⁵⁹ PCTs have a **statutory duty** to make sure that arrangements are in place for the following immunisations to be delivered: all routine childhood immunisations, influenza and adult pneumococcal vaccination and the routine HPV vaccination. PCTs also have a responsibility to provide primary medical services which could include targeted vaccines such as hepatitis B and BCG.

⁶⁰ FE refers to all 16+ education (except sixth form schools) including FE colleges and institutions, work-based learning or alternative training providers.

⁶¹ Particularly information about mental health and mental illness from GPs and mental health professionals to health staff working with FE students.

(d) Sexual health

Eighty per cent of under-18 conceptions are to 16- and 17-year-olds, many of whom will be in the FE sector. Students should be provided with advice and support on relationships and sexual health, with information about local services. To help increase early uptake of contraception and use of condoms, PCTs and LAs should consider with FE colleges the benefits of establishing on-site services (DfES/DH, 2007). Currently around 80 per cent of FE colleges in England have some on-site sexual health service and funding has been made available through SHAs to improve provision.

Contraceptive and sexual health services

As for young people 11–16 (see page 45).

Chlamydia screening

As for young people 11–16 (see page 45).

Responsibility: HCP Team, with input from specialist providers.

(e) Physical activity

As part of the PE and Sport Strategy set out in 2008, the aspiration is for all 16–19-year-olds to have access to three hours per week of college and community sport.

Note: The transition from secondary education at 16 coincides with the most significant drop-out of young people from physical activity and organised sport; it also marks the end of curriculum PE for most. Organisations and institutions should therefore endeavour to encourage and facilitate physical activity. The FE Sports Co-ordinator programme will increase opportunities for young people, aged between 16 and 19 and in education,

to participate, perform, lead and volunteer in sport.

(f) Ongoing support

It is recommended that those working with young people aged 16–19 (such as youth workers and trainers) should exploit opportunities to offer health information, advice and support as appropriate.

Safeguarding

All those working with young people should be alert to risk factors and signs and symptoms of child abuse and follow local safeguarding procedures where there is cause for concern. *Working Together to Safeguard Children* (HM Government, 2006a) sets out how organisations should work together and the actions to be taken when abuse or neglect is known or suspected.

Responsibility: All.

(g) Support for parents and carers

As for children 5–11 (see page 37).

Progressive

(a) Immunisations for at-risk young people

Young people who are at increased risk of contracting hepatitis B and those who are more likely to develop complications from influenza should be immunised (see Annex G).

(b) Emotional health, psychological wellbeing and mental health

Access to professional consultation and referral to targeted and specialist CAMHS support (across tiers 2, 3 and 4) for young people at risk of and/or experiencing poor mental health⁶² should be swift. Members of the HCP Team should be fully conversant with the role they can play in managing early symptoms in universal settings without the need for onward referral, but should also be conversant with referral protocols when these become necessary. CAMHS is available for young people aged up to 18.

(c) Drug and alcohol misuse

Referral of young person to local specialist services as part of a multi-agency strategy.

Responsibility: Specialist services.

(d) Smoking cessation

As for young people 11–16 (see pages 46–47).

(e) Specific groups of at-risk young people

Looked after young people

As for young people 11–16 (see page 47).

Young people with complex welfare needs

As for children 5–11 (see page 40⁶³).

Targeted approaches for young people with special educational needs

As for young people 11–16 (see page 47).

Refer also to the audit of policy and procedures for the transition of young people from children's to adult health services in *Transition: Moving on Well* (DH, 2008b).

Responsibility: PCTs.

Young people with complex health needs

As for young people 11–16 (see page 47) but with particular attention at the transition at 16 when school and social care may change. Complex care planning should include accommodation and housing.

Responsibility: PCTs/LAs.

Young people leaving care

Care Orders automatically end when the young person reaches 18. Care leavers should have a full copy of all social care health records (including genetic background and details of illness and treatments) and be equipped to manage their own health needs. HCP Teams should provide support as required, including in the transition from children's to adult health services, and

⁶² Targeted support and interventions – key focus on building resilience and preventing the development of significant problems for individuals and families exposed to significant risk. Specialist services – key focus on interventions to address significant, complex and persistent difficulties which may take place on an intensive or long-term basis.

⁶³ Multidimensional treatment foster care is suitable for young people up to the age of 18.

contribute to the young person's Pathway Plan in line with national guidance.⁶⁴

Responsibility: LAs.

One-to-one sexual health interventions for highly at-risk young people

In line with NICE guidelines (NICE, 2007), it is recommended that at-risk young people under the age of 18 (e.g. from disadvantaged backgrounds, who are in – or leaving – care and/or who have low educational attainment), are offered one-to-one sexual health advice, if appropriate. The advice should cover: how to prevent and/or get tested for STIs and how to prevent unwanted pregnancies; all methods of reversible contraception, including LARC (in line with NICE clinical guideline 30); how to get and use emergency contraception; and other reproductive issues and concerns.

Responsibility: PCTs, via a range of health professionals.

Young people in contact with the youth justice system

As for young people 11–16 (see pages 47–48), plus the negotiation of a safe and effective transition to appropriate adult provision.

Substance misuse interventions for young people in the secure estate

As for young people 11–16 (see page 48).

(f) Support for parents and carers

Young parents

In areas where the Family Nurse Partnership is available, ensure that young parents (mothers and fathers) have access to the programme from early pregnancy (see Annex B).

Responsibility: PCTs.

Family Pathfinders

As for children 5–11 (see page 41).

Family Intervention Projects

As for children 5–11 (see page 41).

Multisystemic therapy

As for young people 11–16 (see page 48).

⁶⁴ The Children (Leaving Care) Act 2000 requires all eligible, relevant and former relevant children to have a Pathway Plan which will focus on arrangements for the young person's successful transition to independence. The Pathway Plan will take account of the assessed health needs of the young person and set out clearly how these are to be met.

Chapter 5

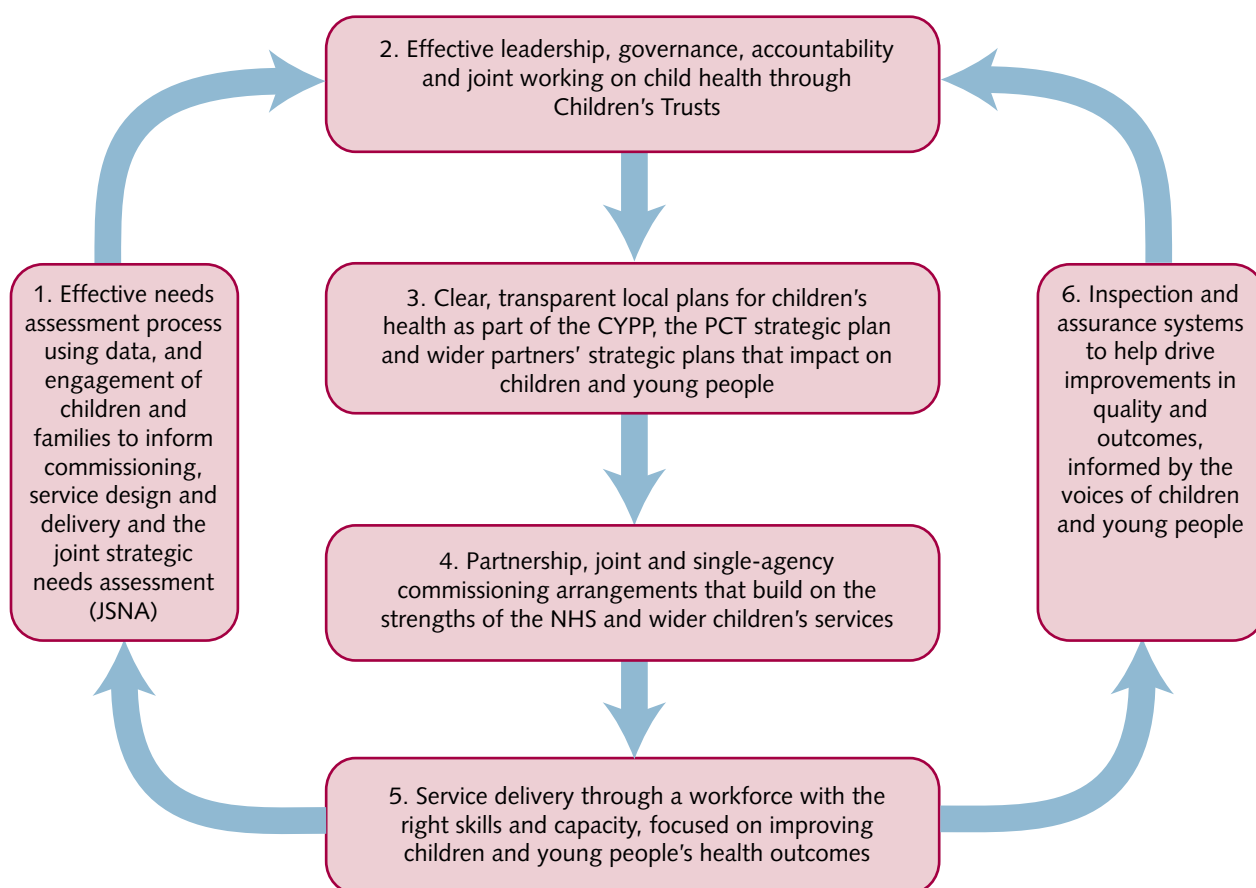
Infrastructure

The systems, process and tools outlined in this chapter will help to support the successful delivery of the 5–19 HCP. What follows are **recommended actions** for local organisations to consider.

The diagram below shows the delivery components of the HCP. This chapter addresses each of these areas in turn.

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Diagram 2: HCP delivery components



Needs assessment

At population level (i.e. the population covered by a PCT or Children's Trust), commissioners need a reliable, consistent, systematic, IT-based process for jointly assessing needs.

A needs assessment for a school or group of schools will provide a clear picture of the school community, to enable identified needs to be met. As part of the enhanced Healthy Schools Programme model, schools can be supported to develop a health needs analysis, which may provide a useful model for systematic data collection. This needs assessment will combine a range of school and local health and wellbeing information to inform the priorities and outcomes that schools will work towards. The Healthy FE Framework will assist colleges to profile their students' needs.

At an individual level, children, young people and families need a skilled assessment so that the programme is personalised to their needs and choices.

Determinants of health

Many of the wider social determinants of children's health and wellbeing such as housing, transport and leisure facilities are the prime responsibility of other partners. These services need to 'Think Children and Young People'. It is recommended that commissioners ensure that wider partners are aware of the needs of children and young people through the JSNA process owned by the Local Strategic Partnership, as well as through the CYPP.

Data should be collated to provide the epidemiological basis for health needs assessment and the determination of risk and predictive factors.

Information on uptake rates, weight and height measurements, immunisation coverage, access to dental care, screening and other measures (such as access to sexual health and reproductive services) should be used for the strategic planning, monitoring, evaluation and quality improvement of the HCP.

For maximum impact, it is good practice for needs assessments to identify any specific issues for local communities within the overall population, and take account of their needs (see Annex E.) Monitoring outcomes for sub-populations will help to ensure that the HCP is making a full contribution towards addressing health inequalities.

In assessing local needs and planning provision, it is recommended that commissioners pay particular attention to at-risk children and families who may or may not be accessing services and who historically have poorer health outcomes. They will want to encourage children's services and adult services to work together to ensure that the whole family is supported and that services 'Think Family'.

Workforce needs assessments

Needs assessments and planning should also consider the workforce implications of service development. For NHS services, commissioners will want to consider the services to be delivered and have a strategic overview of the local workforce. Providers will want to consider the capacity and skills of the current and future workforce to determine whether any investment is needed in training or continuing professional development. These considerations will then feed into the SHAs' education commissioning plans. Teacher workforce development is the responsibility of the Training and Development Agency for Schools, whose involvement will be crucial to the development of the HCP.

Leadership and governance

Local commissioners and providers need to be confident that robust clinical governance arrangements as well as professional leadership and support are in place for all health services, to ensure protection of the public and safe practice.

The Children Act 2004 introduced a duty of co-operation between LAs and their strategic partners (including SHAs and PCTs), a duty for LAs to put in place co-operation arrangements to facilitate integrated working (known as Children's Trusts), and a duty on LAs (through Directors of Children's Services) to co-ordinate the production of the CYPP (the overarching vision of all services for children and young people in a given area). In addition, there is a duty on schools to promote the wellbeing of their pupils (in the Education and Inspections Act 2006).

Healthy lives, brighter futures (DH/DCSF, 2009a) commits the Government to:

- strengthening Children's Trusts by placing their boards on a statutory footing;
- transforming the CYPP from a plan owned by the LA to one owned in partnership by the CTB and implemented by its members; and
- including frontline providers of education (e.g. maintained schools, academies, non-maintained special schools, FE colleges and Jobcentre Plus) as statutory 'relevant partners' covered by the duty to co-operate with the LA. The management committees of short stay schools will also become 'relevant partners' in the Children's Trust.

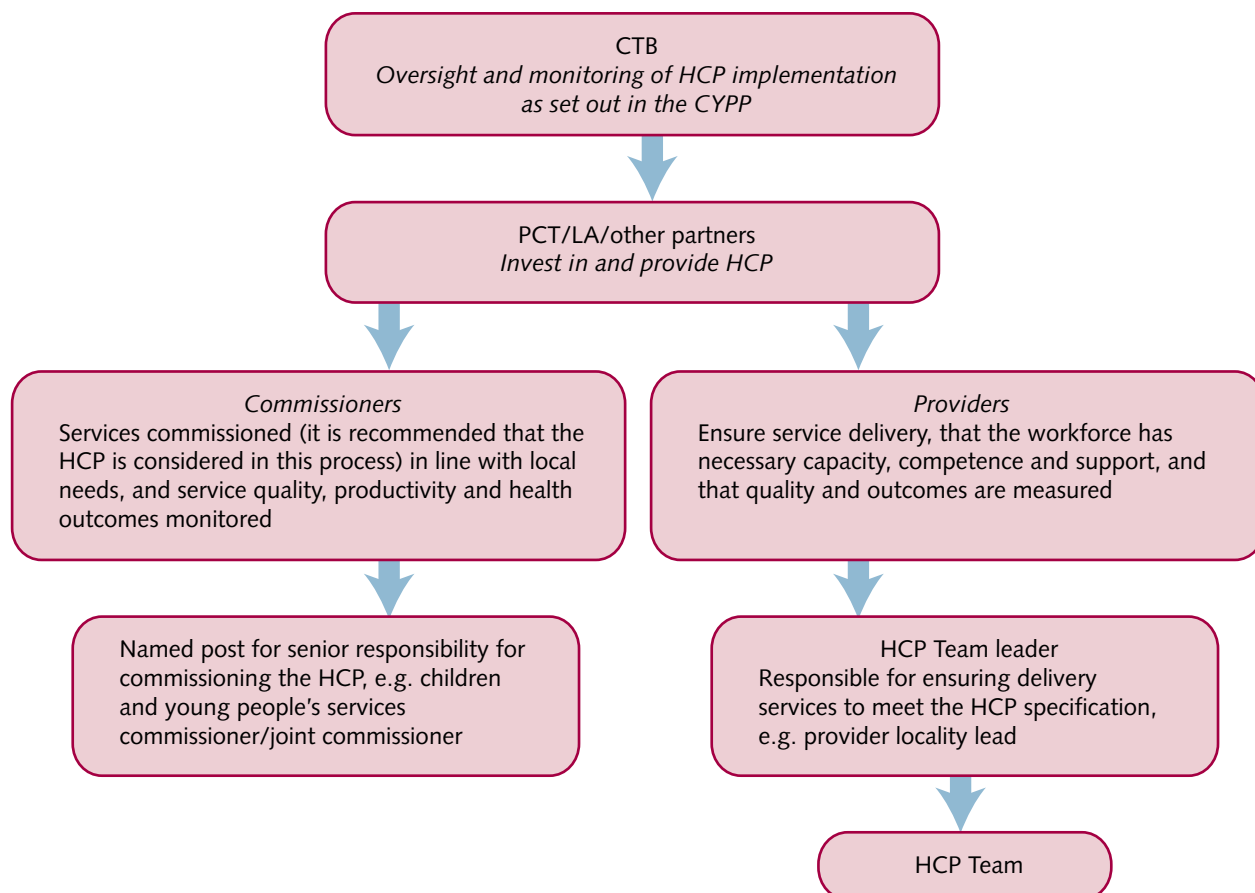
These strengthened arrangements are reflected in the HCP and are being introduced by the Apprenticeships, Skills, Children and Learning Bill which is currently before Parliament.

There will be an expectation of senior-level representation from the PCT on the CTB, with expertise and accountability for children's health. The jointly-owned CYPP will set out the CTB's members' strategy for co-operation in order to improve the wellbeing of local children and young people. It will contain jointly agreed plans, reflecting shared priorities in PCT plans and LAAs, to address the health needs of children and young people, including the most at risk and those with additional health needs.

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Diagram 3: Local governance



Local governance model for the HCP

The CTB is responsible for setting the strategic framework within which the CTB partners improve children's and young people's wellbeing. This framework is set out in the CTB's CYPP. The CYPP sets out the joint strategies of partners on how they will co-operate to improve children's and young people's wellbeing, including the HCP. Local arrangements will determine the precise structures, but a possible model is demonstrated above.

PCTs, together with practice-based commissioners and other partners, will be likely to lead the health elements of HCP commissioning. Delivery of the HCP currently sits mostly with PCT community provider organisations. They would be expected to lead on and co-ordinate delivery of the HCP, given that they are likely to have the strongest skill

sets. Other CTB partners will have a role in contributing to both the commissioning and the delivery of the programme. Executive leadership of the HCP is likely to sit with a senior health professional (although this is for local determination). For, example, this could be a Director of Public Health or the PCT executive lead for children and young people.

Local structures and circumstances will determine the exact configuration of the team delivering the HCP: in some areas it might be exclusively delivered by one provider organisation, in others the team might be a partnership between a number of different service providers, drawn from a range of organisations such as education providers, the LA and the voluntary sector, with different bodies leading on individual elements of the HCP schedule.

Local plans

Subject to the passage through Parliament of the Apprenticeships, Skills, Children and Learning Bill, the CTB will take on responsibility from the LA for preparing, publishing, reviewing, revising and monitoring the delivery of the CYPP, with the first jointly owned CYPP in place by April 2011. The CYPP will be implemented by individual partners.

The JSNA informs – and is in turn informed by – the CYPP. The JSNA – a shared statutory duty between the Directors of Children's Services, Adult Social Services and Public Health – describes the health and wellbeing of the local population, models future needs and identifies health inequalities. All of these will inform the CYPP. The priorities coming from the CYPP will then inform the JSNA as it is updated. The priorities set out in the NHS operating framework for PCTs will also inform the development of the CYPP.

The CYPP covers the full range of services for children and young people (DCSF, 2009b). CTBs will be expected to set out the arrangements they have made locally to ensure effective early intervention to meet the needs of at-risk children. The CYPP should also consider the needs of parents and carers – which are crucial to improving outcomes for children.

The JSNA and CYPP should both inform broader strategic planning by the PCT, the LA and wider partners whose remit will cover some of the social and environmental determinants of children's and families' health and wellbeing. A key element of the CYPP is the requirement to carry out a comprehensive needs assessment to identify gaps in service provision and inform strategic commissioning priorities over the period of the plan.

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The JSNA and CYPP should address both the healthcare and the health promotion needs of the local population, and should pay particular attention to those small groups of children who have significant needs.

Additional support for vulnerable families

The CAF should be used where there are issues that may require support from more than one agency. All practitioners working with children and young people should be aware of the CAF and know how to either complete a common assessment themselves or arrange to have one carried out. Everyone working with children should be aware of the sorts of situations that indicate the need for a common assessment. For more details on the CAF see Annex B.

The HCP Team should also be prepared to engage in the 'Team Around the Child' to support at-risk children and young people (Children's Workforce Development Council, 2009a and 2009b).

In some areas, pilot projects are testing new approaches to supporting highly at-risk young people and their families (see Annex B). In areas where such projects are in operation, the HCP Team should be aware of their aims and referral protocols.

Commissioning arrangements

Stronger joint commissioning

Commissioning for children and young people needs to:

- look across all local services, including health, care and education services;
- consider the child in his or her family setting;
- consider the needs of potentially small numbers of children with complex needs as well as the needs of larger population groups; and
- bring together different perspectives across the CTB.

See Annex D for more information on commissioning.

Effective use of data as part of commissioning and delivery

Local delivery partners need access to and the capability to share (as appropriate) the right information. This will require the right IT systems being in place.⁶⁵

Information sharing between education settings and primary care needs to improve, so confidentiality procedures should be in place and understood by all. Existing documentation could be used to double-check that, for example, school entry questionnaires have been returned and acted on. For the commissioning cycle, this means information to support needs assessments including JSNAs and CYPPs, service planning and

specifications, contracting and monitoring. All of these are dependent on good-quality, timely information on population needs, resources, activity, outcomes and the user experience.

The HCP workforce should have access to tools such as ContactPoint and National eCAF to support effective information sharing. ContactPoint is currently being rolled out: it is a quick way to find out who else is working with the same child or young person, making it easier to deliver more co-ordinated support. National eCAF will be the secure online system for electronically creating, storing and accessing information captured through the CAF, bringing the additional benefit of e-enablement⁶⁶ to those already using CAF by increasing standardisation and reducing duplication of work. It will allow practitioners to work together more effectively across geographic and organisational borders when helping a child or young person. Health professionals would require similar access to the SCR with the permission of the carer or competent child, if emergency health problems arose or to assist in the management of a chronic disease.

Indicator sets that underpin the measurement of national priorities have been developed to provide those involved in all aspects of health services for young people with access to information:

- The national indicator set of 188 indicators measures the performance of LAs (working alone or in partnerships) against national priorities.
- NHS Vital Signs measures PCTs' performance against national priorities in the NHS. Relevant indicators include under-18 conception rates, obesity,

⁶⁵ It is acknowledged that the ambitions set out in this guidance will be challenging to achieve systematically until the appropriate IT and data systems currently under development are in place. The Community Information Project within the Transforming Community Services programme is supporting developments to the scope, accuracy and reporting of community information through the development of a community dataset. A minimum mandatory dataset (with the necessary IT to support collection) is planned for implementation in April 2011. Integral to this development is the adoption of mobile technology to improve access to information at the point of care.

⁶⁶ www.pasa.nhs.uk/pasaweb/nhsprocurement/npep

immunisation, smoking among over-16s, chlamydia prevalence and hospital admissions by unintended and deliberate injuries. Thirty-one of the NHS Vital Signs form part of the national indicator set, to allow for the alignment of priorities.

- JSNAs allow PCTs and LAs to identify shared priorities.

More targeted information, better-quality data and better use of data are still needed to support local commissioners and deliverers of services.

The national ChiMat⁶⁷ is responsible for the provision of data, information and intelligence to support the planning and delivery of services in a way which improves health and wellbeing. This includes the development of approaches to maximise decision making capability and the utility of information arising as a result of the child health and maternity core minimum datasets. ChiMat will also:

- provide products to reduce duplication of effort and support the local workforce in using knowledge, information and tools to improve commissioning;
- develop predictive tools and new approaches to identify both populations and individuals at risk of poor outcomes;
- provide information on children with long-term conditions and develop analytical tools to help local organisations to identify the condition management interventions, which reduce emergency hospital admissions and improve both outcomes and system productivity;
- collaborate with leading academics to provide evidence to inform policy development and evaluation;

- publish best practice on prevalence and needs assessments as part of the Aiming High for Disabled Children programme to help areas improve their knowledge of local populations and put the appropriate services in place; and
- support regional organisations with the development of metrics and dashboards to track the implementation of the NHS Next Stage Review.

A skilled workforce

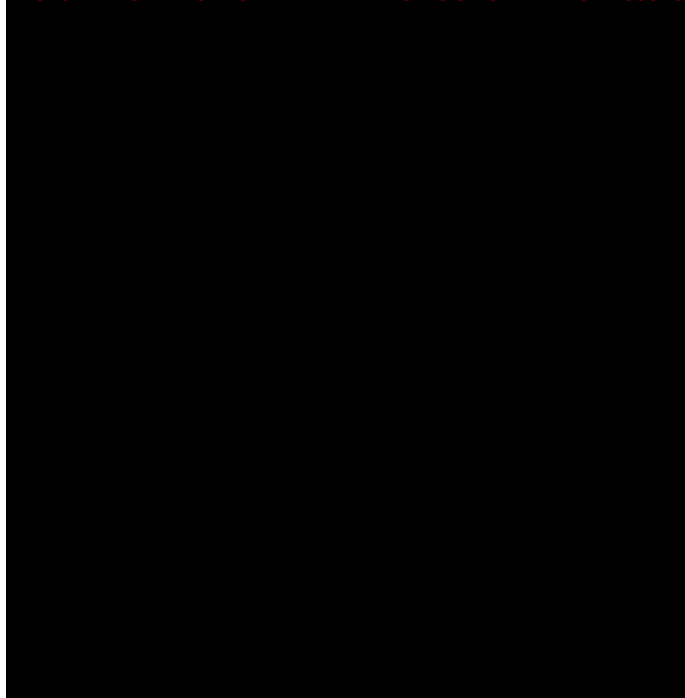
The right workforce with the right skills is critical to ensure effective delivery of the HCP.

The *Common Core of Skills and Knowledge for the Children's Workforce* – often referred to as the Common Core (HM Government, 2005a) – sets out the basic skills and knowledge needed by people whose work (paid or voluntary) brings them into regular contact with children, young people and families. It supports integrated working by contributing to the use of a common language.

The Common Core provides a strong foundation for the development of a skilled workforce but in some areas, notably emotional distress and incipient mental health problems, further training and development may be required. All those working with children and young people should have a basic understanding of mental health and know how to support children and young people experiencing problems or how to help them access appropriate support from other professionals.

In addition, all professionals need the knowledge and skills to safeguard and promote the welfare of children and young people. They need to be able to identify and respond appropriately to early signs that

⁶⁷ www.apho.org.uk/default.aspx?QN=CHIMAT_HOME



children, young people and their families need additional support, as well as responding when children and young people are in need of safeguarding. An understanding of information sharing in relation to early intervention and to safeguarding is essential.

Quality and outcomes

Supporting improvements in quality and outcomes is a key aim of the 5–19 HCP. For example, the HCP:

- emphasises that robust **needs analysis** is a pre-requisite to effective resource allocation;
- provides clarity on the components of a **high-quality programme of services** to promote children's and young people's health and wellbeing;
- provides **clarity on the skills and competencies of the workforce** and the ways in which professionals across a range of sectors should work together;
- gives **clear outcomes** and brings together a range of local and national indicators which may be used to measure progress;

- **supports public recognition of success** – whether on routine indicators (through ChiMat) or on specific initiatives such as gaining *You're Welcome* accreditation and Healthy School status;
- provides an emphasis on **high-quality leadership**. The National Leadership Council, for example, is a sub-committee of the NHS Management Board and will champion the transformation of leadership across the NHS;
- **recognises the need for robust assessment and inspection systems** to safeguard and drive forward improvements in the quality of care. The Care Quality Commission (CQC)⁶⁸ is the independent regulator of health and social care in England and has a key role in supporting this. This role is complemented by the Office for Standards in Education, Children's Services and Skills,⁶⁹ which inspects and regulates wider care for children and young people; and
- **promotes innovation in services and dissemination of good practice** through case studies and signposting to relevant information, which will be held on HCP webpages on the DH website. Search online at www.dh.gov.uk. The HCP also recognises that the 5–19 HCP will develop and adapt over time as new evidence and research emerges and as lifestyles and technologies evolve.

See also the Transforming Community Services (TCS) guides and *High Quality Care for All: NHS Next Stage Review Final Report* (Darzi, 2008) for further information and support (see Annex A).

⁶⁸ www.cqc.org.uk

⁶⁹ www.ofsted.gov.uk

Annex A

Strategic policy context

Healthy lives, brighter futures – The strategy for children's and young people's health was published in February 2009 (DH/DCSF, 2009a). This strategy outlines the Government's vision for improving health and wellbeing outcomes for all children and young people, for supporting a reduction in health inequalities and for building on and providing a seamless link with the 0–5 HCP. The 5–19 HCP will make a crucial contribution to achieving these goals. The HCP was first introduced in the *National Service Framework for Children, Young People and Maternity Services* (DH/DfES, 2004). Building on this, the 0–5 HCP was published in 2008. The 5–19 HCP extends this updated programme to cover the full age range outlined in the National Service Framework (NSF).

The NSF has been a crucial part of the Every Child Matters programme (established in 2004), which set out the Government's aims for every child, whatever their background or circumstances, to have the support they need to:

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution; and
- achieve economic wellbeing.

The above is also complemented by a range of public service agreement targets that the Government has set itself for improving children's and young people's health.

A range of additional strategies has also been developed to support delivery of this agenda. These include:

- *Youth Matters* (HM Government, 2005b);
- *Teenage Pregnancy Next Steps* (DfES, 2006);
- *The Children's Plan* (DCSF, 2007);
- *Healthy Weight, Healthy Lives* (Cross-Government Obesity Unit/DH/DCSF, 2008)
- *Youth Alcohol Action Plan* (HM Government, 2008a);
- *Youth Crime Action Plan* (HM Government, 2008b);
- *The Children's Plan One Year On* (DCSF, 2008c);
- *Staying Safe Action Plan* (DCSF, 2008d);
- *Your child, your schools, our future: building a 21st century schools system* (DCSF, 2009a)
- *The protection of children in England: action plan* (HM Government, 2009a);
- *Healthy Weight, Healthy Lives: One Year On* (Cross-Government Obesity Unit, 2009b);

- *Be Active, Be Healthy: A plan for getting the nation moving* (HM Government, 2009b); and
- *Healthy Children, Safer Communities*.⁷⁰

The 5–19 HCP provides a key framework that supports delivery of the NHS Next Stage Review at national and local level.

The NHS has recently developed its vision for the next ten years through *High Quality Care for All: NHS Next Stage Review Final Report* (Darzi, 2008). The final report sets out wide-ranging proposals that place quality of care at the heart of everything the NHS does. Its ambitions are for an NHS that:

- helps people to stay healthy;
- gives people more rights and control over their own health and care;
- gives patients even greater influence over the services they use;
- is pioneering, embracing the best new ideas and treatments; and
- values its staff and empowers them to lead local change.

The *NHS Next Stage Review: Our vision for primary and community care* (DH, 2008c) sets out how community health services for all ages (including children and young people) will be transformed in the coming years. This programme has implications for ensuring the commissioning and delivery of community health services for children and young people is of the highest quality, and is underpinned by world class commissioning (see Annex D). The Transforming Community Services (TCS) guide for children, young people and families, and the TCS guide for health, wellbeing and reducing inequalities that are part of *Transforming Community Services: Ambition Action, Achievement* (DH, 2009a) provide evidence on best practice for improving services and developing the workforce.

⁷⁰ Strategy and action plan to promote the health and wellbeing of children and young people in contact with the youth justice system (forthcoming).

Annex B

Programmes and interventions that can contribute to delivery of the 5–19 Healthy Child Programme

Universal support for children and young people

Health reviews

See Chapters 3 and 4.

Sure Start children's centres

Sure Start children's centres support young children under 5 and their families by providing easy access to services such as: integrated early education and care; health, parenting and family support; links to training and employment opportunities; and information and help from multidisciplinary teams of professionals. By 2010 there will be 3,500 children's centres – one for every community.

Healthy Schools Programme

The Healthy Schools Programme requires a whole-school approach to health promotion across four core themes: PSHE; healthy eating; PE and physical activity; and mental health and psychological wellbeing. The enhanced programme in place from September 2009 builds on the wellbeing element of the 21st-century school.⁷¹

Extended services

By 2010 all schools will be providing access to a core offer of extended services. Those services include: swift and easy access to specialist health and social care services; parenting support; childcare in primary schools; a varied range of activities, including study support in a safe place for primary and secondary schools; and community use of facilities including adult and family learning and information and communication technology.

Healthy FE Programme (including sports co-ordinators)

A whole-college framework is being developed to help improve access for students and staff to health-related advice, information and guidance, and to promote positive health and healthy activities. This will provide the underpinning, positive environment for more specific initiatives, including providing more healthcare facilities on-site. Education sport co-ordinators are being introduced into every FE college in order to expand the sporting opportunities offered to young people.

School Health Teams

See Chapter 2.

⁷¹ www.healthyschools.gov.uk

Healthy opportunities

School meals: Schools are now required to ensure that all food they provide complies with standards that support a balanced nutritional intake. Schools are encouraged to increase the number of children eating a school lunch. This is particularly important for children from poorer families, and schools should seek to ensure that all children eligible for free school meals take up their entitlement.

Sitting down with friends at lunch can help children to learn social skills. Recent research by the School Food Trust also suggests that improving the food provided and the dining environments at lunchtime can have a beneficial impact on learning-related behaviours in the classroom after lunch in both primary and secondary settings.⁷²

Cooking: By 2011, learning to cook a range of simple, nutritious meals will be a compulsory curriculum entitlement for every 11- to 14-year-old.

Recreation: LAs are under a statutory duty under the Children Act 2004 to provide recreation for children and young people.

PE: At least two hours of high-quality PE per week within the school day for all 5–16-year-olds, and a further three hours per week of additional sporting opportunities beyond the school day for all 5–19-year-olds. The Youth Sport Trust and Sport England are working closely with School Sports Partnerships and County Sports Partnerships to ensure that high-quality sporting opportunities are available for young people beyond the school day, whether on school sites or elsewhere. The Association for Physical Education (afPE)

recommends, for all children and young people 5–18, participation in a minimum of one hour of at least moderate intensity physical activity every day.

Swimming: Free swimming as part of the Free Swimming Programme is available for under-16s in participating LAs.

Additional healthy opportunities: Access to additional healthy opportunities in the community such as team sports, dance, volunteering, drama and music.

The Travelling to School Initiative: This sets out a series of measures to support LAs and schools to encourage more children to walk or cycle to school. By 2010 all primary and secondary schools in England are expected to have a school travel plan in place.

Change4Life

Change4Life is a social marketing campaign that helps families to eat well, move more and live longer. It provides resources, ideas and events that focus on eight key messages. Schools and other organisations can access branding and toolkits to help promote these messages to pupils and parents.⁷³

Immunisation programmes

See Annex G.

Social and emotional aspects of learning

SEAL provides teachers with a way of teaching social and emotional skills to pupils through a whole-school approach and across the curriculum. As of July 2009, 89.5 per cent of all primary schools and 64 per cent of secondary schools are using SEAL.⁷⁴ It is an aspiration that all schools are using SEAL.

⁷² www.schoolfoodtrust.org.uk/doc_item.asp?DocCatId=1&DocId=106;
www.schoolfoodtrust.org.uk/doc_item.asp?DocCatId=1&DocId=107

⁷³ www.nhs.uk/change4life

⁷⁴ <http://nationalstrategies.standards.dcsf.gov.uk/node/87009>

PSHE and SRE

PSHE and SRE contribute to staying safe and the statutory safeguarding duty on schools. See Chapter 3.

The new primary curriculum, with integrated work in PE, health and wellbeing, supports this agenda.

Universal information, advice and guidance (IAG)

The Government is reforming IAG for young people to ensure that it supports the Raising the Participation Age to 18 agenda and encourages higher aspirations and achievement in learning. A guarantee of IAG lies at the heart of the reforms. LAs will be expected to offer stronger strategic leadership of IAG and to commission high-quality services from Connexions, voluntary and community service organisations and private sector organisations.

Positive activities

Provided through a wide range of statutory and voluntary sector youth work providers, offering 'places to go, things to do and people to talk to' in communities and on residential activities, encompassing the uniformed groups (Scouts and Guides etc.) and opportunities for young people to have a 'voice and influence' on local services and their provision, and accessing a range of health-promoting activity and education.

You're Welcome quality criteria

DH has developed and published the *You're Welcome quality criteria: Making health services young people friendly* (DH, 2007), which is a set of principles to support health service providers and commissioners to improve service acceptability, accessibility and quality. The criteria are designed to be applied

to all health services in the community and in hospitals, including specialist provision.

Public health media campaigns

For example: Want Respect, Use a Condom (raising awareness among sexually active teenagers of the risks of unprotected sex and on associating condom use with gaining peer respect); Know Your Limits (urges young drinkers to know their limits and stay within them, designed to get the message across that too much alcohol makes people feel invincible when they are at their most vulnerable); and the I Wanna Be Like You marketing campaign (which highlights the damaging role of adults in promoting smoking among young people).

NHS Teen LifeCheck

The NHS Teen LifeCheck is a confidential, online tool that has been designed to empower young people aged 12–15 to take greater control of their health and wellbeing.⁷⁵

Websites/helplines

For example, FRANK (online and over-the-phone information and support for young people about the risks and dangers of drugs and their use) and Sexwise (provides similar support and advice on sexual health issues). Teenage Health Freak is another well-regarded and well-used site developed by two GPs using young-person-friendly language.

HealthSpace

Anyone with an email address who is 16 years old or above and living in England can open a basic HealthSpace account, which allows people to store and keep track of their health information, such as blood pressure, blood sugar levels, height and weight, and 'peak

⁷⁵ www.teenlifecheck.co.uk

flow'. In time, it will allow people to access their own health record.

Online parental and carer support

For example, the DCSF Parent Know How programme.⁷⁶ This programme has been designed to transform the provision of support and information to all parents. It has a particular focus on meeting the needs for parents who are not as well served by current services as they could be. This includes parents of disabled children, fathers from all backgrounds and parents of teenage children.

Working with key third and private sector organisations to deliver services, Parent Know How enables support through telephone helplines, digital services and syndicated print, video and audio content.

The Parent Know How directory

An online signposting system on Directgov for services which may be of benefit to parents. It offers parents and those working with them the ability to search for information about childcare and family services in their local community and nationally. The directory will increasingly be available on LA, voluntary and private sector websites.

Early intervention for at-risk children and young people

Targeted youth support

Targeted Youth Support (TYS) brings together schools, health services, the voluntary sector, police, youth service providers, Connexions and other partners in order to improve the way that at-risk young people are supported. YYS focuses on the early identification of at-risk young people, prevention of problems before they escalate, and multi-agency

support co-ordinated by a lead professional when problems do emerge.

Positive Activities for Young People

Positive Activities for Young People (PAYP) was launched in July 2003 and provides a broad range of constructive activities for 8–19-year-olds at risk of social exclusion. PAYP is targeted specifically at young people not fully engaged in education, those with a low level of school achievement, and those at risk of becoming involved in crime and anti-social behaviour. Referral agencies include youth offending teams, Connexions and Behaviour Improvement Programmes in schools.

Common Assessment Framework⁷⁷

The CAF is a key part of delivering frontline services that are integrated and focused around the needs of children and young people. It is a standardised approach to conducting a holistic assessment of a child's or young person's 'additional needs' and deciding how those needs should be met in a co-ordinated way. It has been developed for use by **all** professionals – including health – across children's services in England so that they can communicate and work more effectively together. This also reduces the need for children and families to re-tell their stories to different practitioners.

'Additional needs' are defined as those which need targeted support within universal settings.

⁷⁶ www.dcsf.gov.uk/parentknowhow

⁷⁷ www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/caf/cafframework

Targeted Mental Health in Schools programme

This aims to support the development of innovative models of emotional and mental health support in participating schools for children and young people aged 5–13 at risk of, and/or experiencing, mental health problems, and their families. The Government announced the roll-out of TaMHS in November 2008, with a further 55 LAs joining the project in April 2009 and a further 72 scheduled to join in 2010.

National support programme for mental health

In November 2008, *Children and young people in mind: the final report of the National CAMHS Review* was published. One of the key recommendations was to set up a national support programme to help local areas to deliver on this challenging agenda. The Government has also agreed in principle to take forward other key recommendations within the report on: improving access for children, young people and their families to mental health support through universal services; improving the access to, quality and impact of mental health services for at-risk children and young people; and ensuring that parents and carers have access to high-quality advice and support when they are concerned about their children's mental health.

MST/MST-CAN projects

MST is an evidence-based community programme now being piloted to support young people and their families where those young people are at risk of out-of-home placement in either care or custody. MST teams work with young people and their families to: increase parenting capacity; increase young people's engagement with education and training; promote pro-social activities for parent and child; reduce young

people's offending behaviour; increase family cohesion; and tackle underlying health or mental health problems in the young person or parent, including substance misuse.

Looked after children: Mental health strengths and difficulties questionnaire, multidimensional treatment foster care

All LAs are now assessing the mental health and emotional wellbeing of children in care through SDQs. LAs, as corporate parents, will be expected to use the data to inform priorities and their arrangements for commissioning services for children in care, and to work with carers to ensure that effective intervention is always taken when an SDQ suggests that a child or young person has a significant mental health problem.

The pilot programme of multidimensional treatment foster care for adolescents with complex needs and challenging behaviour includes teams providing intensive support to foster carers, children and birth families. The programme has achieved a substantial improvement in future placement stability.

Early Support Programme (ESP) for disabled children

The ESP provides young disabled children and their families with joined-up, co-ordinated services and better, more accessible information. The ESP promotes the 'Team Around the Child' approach, providing a structured framework for lead professionals who are taking on a key worker role with families. The ESP approach has now been introduced to nearly 90 per cent of LAs across the country – providing them with training, materials and the culture change required to make a real difference to families on the ground.

Staying Positive – The Young People's Expert Patient Programme (YPEPP)

Young people coping with disability, a long-term condition or other complex healthcare needs, and their families, will often become experts in their own care. The YPEPP has been developed to ensure that young people have the same access to self-care support as adults. The children's self-management programme shows improvements by participants in areas such as medication adherence, communication with healthcare professionals, self-confidence, peer issues and school attainment. It has particular value in supporting young people as they make the transition to adult services.

Transition Audit Framework/Transition Support Programme

The Transition Support Programme will tackle the barriers that prevent LAs and PCTs from meeting their duties towards disabled young people to ensure that they experience a smooth transition to adult life, with the right support to make choices that other young people take for granted. The audit framework supports commissioners and providers in designing services. The transition between young people's and adult services is particularly important in mental health, where services for 16–24-year-olds continue to develop.

Aiming High for Disabled Children (AHDC) programme

AHDC aims to transform the experience of services for disabled children and their families. This comprehensive programme includes a range of measures to support access and empowerment for disabled children and families, responsive services and timely support, and improved service quality and capacity. Recent additional funding will support the NHS in delivering commitments made around palliative care, short breaks, community equipment and wheelchair

services. This will enable health, social care education commissioners and providers to work together locally to build more responsive services.

Special educational needs provision

Better Communication (DH/DCSF, 2008b) – the Government's response to the Bercow Review of services for children with speech, language and communication needs (SLCN) – sets out a series of initiatives to improve services for children with SLCN.

Commissioners in LAs and PCTs are being encouraged to improve joint commissioning of effective services for children with SLCN, which are often variable and inequitable. Initiatives to support improved commissioning include local commissioning pathfinders, which are helping to develop a joint commissioning framework, appropriate tools and guidance, and a research programme to produce evidence on the cost-effectiveness of interventions to support the progress of children with SLCN.⁷⁸

Managing Medicines in Schools guidance

To support children with long-term conditions in schools, *Managing Medicines in Schools* will include guidance relating to children with complex health needs as well as clear recommendations for different partners, including schools and PCTs.

Family Intervention Projects

FIPs provide targeted whole-family support, including health services for some of the most at-risk children and families in the country. All LAs are receiving funding to provide support and challenge to families with multiple problems.⁷⁹ These projects deliver a multi-agency support package that addresses

⁷⁸ www.dcsf.gov.uk/slcnaaction

⁷⁹ www.dcsf.gov.uk/ecm/thinkfamilygrant

the needs of the whole family. A key worker works closely with the families co-ordinating services, such as CAMHS, adult mental health services and young people and adult substance misuse services. They provide practical support such as parenting and life skills, using a combination of support and sanctions. An independent evaluation report (White et al./NCSR, 2008) is now available.

Family Pathfinders

Family Pathfinders will introduce an integrated approach to supporting families with complex needs, including better integrated services and multi-agency teams. They will test the 'Think Family' approach, which will consider the needs of the entire family rather than just the individual members within them, in 15 LA areas. These areas will disseminate the findings across all LAs aiming to help to tackle intergenerational inequalities and exclusion, and help to enable local families to help themselves.

The approach follows four principles:

- No wrong door – contact with any service offers an open door into a system of joined-up support.
- Look at the whole family – services working with both adults and children take into account family circumstances and responsibilities.
- Provide tailored support to need – tailored and family-centred packages of support are offered to all families at risk.
- Build on family strengths – practitioners work in partnerships with families, recognising and promoting resilience and helping them to build their capabilities.

Parenting Early Intervention Programme (PEIP)

The PEIP targets parents of children aged 8–13 at risk of negative outcomes and will roll out evidence-based parenting programmes across the majority of LAs between 2008/09 and 2010/11. An evaluation of the original pilot found that the PEIP almost halved the number of parents who classified their children as having significant behavioural difficulties (Lindsay et al., 2008).

Family Nurse Partnership (FNP)

FNP is an evidence-based, intensive and preventive programme for vulnerable, first-time young parents. Specially trained family nurses visit parents from early pregnancy until the child is two years old. The goal of the FNP is to improve antenatal health, child health and development and parents' economic self-sufficiency. Building on the relationship, the programme guidelines, methods and materials guide mothers, and fathers if present, to care well for their child physically and emotionally as well as pursuing their own life course.⁸⁰

Parent support advisors

Parent support advisors give one-to-one support to parents needing extra help with certain issues – such as school behaviour, school attendance and engaging with schools – in order to encourage effective dialogue between parents and teachers about their child's progress, learning and development.

⁸⁰ www.dcsf.gov.uk/everychildmatters/strategy/parents/healthledsupport/healthledsupport

Annex C

Recommended core competencies of the 5–19 Healthy Child Programme Team

The right workforce, with the right competencies, is critical to successful delivery of the 5–19 HCP and improving outcomes and experiences for children and young people and their families.

Children and young people have said that they want to receive services and care from a workforce:

- which is positive, has a young outlook, is relaxed in dealings with them, is open-minded and unprejudiced, and is trustworthy;
- whose behaviour is characterised by fairness, willingness to trust and believe in the child or young person, asking and listening, helpfulness in creating understanding among their peers, not prejudging their needs or characteristics, keeping promises and ease of contact; and
- whose processes are transparent, honest, inspected and explained – with visible actions as a result, channels to voice opinion, providing real options, supported by enough resources/staffing, realistic, and without undue pressure or cause of unnecessary worries.

The *2020 Children and Young People's Workforce Strategy* (DCSF, 2008e) sets out the Government's vision that everyone who

works with children and young people should be:

- **ambitious** for every child and young person – helping those they work with to succeed and committed to helping every child to meet their full potential as healthy and safe, independent learners, thinkers and members of society;
- **excellent** in their practice – driven by evidence, reflective in their practice, committed to continued development and improvement, confident in their specialist skills and knowledge, and respectful of the skills and knowledge of colleagues;
- **committed** to partnership (with children, young people and their families) and integrated working (learning from and respecting each other's contribution, and working together across all sectors and agencies); and
- **respected** and valued as professionals – people who work with children and young people, including the volunteer workforce, will have the skills, knowledge and professional empowerment to make a difference and will be recognised and rewarded for what they do. They will have access to good-quality and relevant training and have strong, professional leadership, committed to excellence.

The 5–19 HCP Team

It will be for local areas to define and then build their 5–19 HCP Team as determined by local need – i.e. decisions about the sort of practitioners needed should be based on the competencies required to deliver desired outcomes. However, the recommended core competencies of the 5–19 HCP Team are outlined below:

Leadership

- A team led by a professional with the appropriate competencies to oversee delivery of the HCP to a defined population (ideally, although not necessarily, a health professional).

Identifying needs

- A team that understands the implications of the health needs assessment which underpins the configuration of services.
- A team with the necessary skills to identify particularly at-risk children and young people, assess and respond effectively to their needs early and demonstrate a commitment to reducing health inequalities.

Skills and knowledge

- A team where all practitioners are able to demonstrate a basic level of competence in the six areas of *The Common Core of Skills and Knowledge for the Children's Workforce* (HM Government, 2005a).

These are:

- effective communication and engagement with children, young people, their families and carers;⁸¹
- child and young person development;

- safeguarding and promoting the welfare of the child (every adult who works with a child or young person has a duty to safeguard and promote their welfare and should follow local safeguarding procedures where there is cause for concern (CQC, 2009));
- supporting transitions;
- multi-agency working; and
- sharing information (HM Government, 2008d).

- A team with appropriate qualifications and training – allowing progression, continuing professional development and mobility across the children's and young people's workforce. Examples include all doctors, nurses, allied health professionals, youth workers and teachers receiving appropriate training (including the adolescent e-learning programme,⁸² the forthcoming strand focusing on 5–11-year-olds and the CAMHS module on the school-age child⁸³).
- A team with up-to-date knowledge and skills across key areas. This 5–19 HCP identifies key health areas and advances in our understanding of child development and effective interventions. The knowledge and skills of the team delivering the HCP will need to reflect these changes and be flexible and receptive to future developments. In addition to existing public health and child development knowledge and skills, topics identified in this guidance for greater focus are:
 - the promotion of emotional health and wellbeing;
 - the early identification and prevention of obesity;

⁸¹ <http://hbr.nya.org.uk>
(Hear by Right is a tried and tested standards framework for organisations across the statutory and voluntary sectors to assess and improve practice and policy on the active involvement of children and young people.)

⁸² www.rcpch.ac.uk/Education/Adolescent-Health-Project
⁸³ <http://learning.camhs.org.uk>

- knowledge about vaccine preventable diseases and the universal and targeted immunisation programmes;
 - reducing alcohol misuse;
 - reducing teenage pregnancy and STI rates (including knowledge and skills to effectively deliver PSHE and SRE);
 - factors influencing health choices and behaviour change;
 - parenting support, using strength-based and promotional intervening skills and tools (including a focus on supporting fathers);
 - high-level skills to deliver an intensive programme to at-risk children, young people and their families; and
 - an understanding of national screening programmes.
- School and children's centre leaders will need to have an understanding of how to promote health and wellbeing. The National College for Leadership of Schools and Children's Services has been supporting school and children's centre leaders with this important new agenda since the inception of the Every Child Matters Change for Children Agenda and associated Children's Act 2004 and Education and Inspections Act 2006 with the statutory duty on schools to promote the wellbeing of their pupils.

Guidelines

- A team that applies good practice guidelines, where available, to ensure robust and consistent delivery of services. For example:
 - *You're Welcome quality criteria: Making health services young people friendly* (DH, 2007);
 - *The Good Practice Guidelines for Healthy Youth Work*;⁸⁴ and
 - DH revised guidance for healthcare professionals on the provision of contraceptive services for under-16s.⁸⁵

Teamworking

- A multiskilled team working in partnership with the full range of practitioners and settings required in order to meet the health and wellbeing needs of children and young people in the locality. Teamworking can greatly benefit from, but does not depend on, co-location. What matters is that people meet regularly to review the programme and discuss individual children and young people. Teamworking across service boundaries requires practitioners to:
 - develop trusting relationships, based on a shared purpose, values and language;
 - understand confidentiality and consent and know when and how to share information appropriately;
 - make use of common processes, such as the CAF; and
 - nominate a lead professional to co-ordinate activity.
- A team that, while recognising the school as a key setting, is able to work flexibly across a range of settings to ensure that children and young people have access to the appropriate services and support.
- A team where everyone is aware of their own areas of responsibility and those of others, how they interact and overlap with other roles, the skills and knowledge they require to do the job and the limits to their competence.

⁸⁴ www.nya.org.uk/information/122161/goodpracticeguidelines

⁸⁵ www.dh.gov.uk/en/Publicationsandstatistics/Publications/publicationspolicyandguidance/DH_4086960

- A core team with clear arrangements for engaging and drawing in support from services outside the core team (while also recognising where issues can be dealt with in-house and avoiding unnecessary referrals).

Accountability

- Clear lines of accountability and responsibility are in place, especially when these transcend traditional organisational boundaries.

Parents and carers

- A team with the competencies and capacity to build effective relationships with parents and carers and support them in promoting healthy lifestyles. All practitioners working with this client group are expected to demonstrate compliance with the National Occupational Standards for Work with Parents.⁸⁶

Administrative support

- A team that has appropriate administrative arrangements in place so that practitioners can use their time most effectively.

The HCP Team leader

It is recommended that the leader of a locality-wide HCP Team has a core set of competencies to lead this team effectively across the whole population of school-aged children:

- Leadership skills to oversee the delivery of the HCP to a defined population.
- A good level of understanding of local population needs.

- A strong holistic public health focus (prevention, early detection and management of poor health, as well as the development of child wellbeing).
- Leadership skills to plan and deliver effective immunisation programmes **or** to ensure that these services are being provided locally to meet the needs of children and young people.
- Is aware of, and ensures that the team follows, local safeguarding procedures.
- Facilitation – ensures that the various team members contributing to the HCP communicate with each other and provide an holistic, co-ordinated service tailored to local needs.
- The skills to ensure that the universal needs of families are met and that robust arrangements are in place for identifying children, young people and families who need extra support, assessing their needs and co-ordinating multi-agency activity.
- The ability to quality-assure the services delivered (e.g. a service merely handing out condoms is not a gold standard sexual health service) and monitor outcomes and delivery of the programme.

⁸⁶ Nationally agreed statements of competence which describe what an effective and competent worker does and needs to know in order to deliver quality in their job, as well as describing how they should promote and support effective information sharing (see www.parentinguk.org/2/standards).

Annex D

Notes for commissioners

Commissioning for the 5–19 HCP is a robust process underpinned by WCC competencies. *Securing better health for children and young people through world class commissioning: A guide to support delivery of Healthy lives, brighter futures: The strategy for children's and young people's health* (DH/DCSF, 2009b), published alongside the child health strategy, sets out the vision for commissioning for all health services for children and young people, including the 5–19 HCP.⁸⁷ It outlines the three phases of commissioning for children's health outcomes and how the WCC competencies apply across these stages.

This annex outlines how the HCP can support commissioners through these phases. It applies across all services including the PCT, LA and more widely. This includes joint commissioners working on behalf of more than one partner.

Phase 1: Needs assessment and strategic planning

- Framework for assessing current outcomes (see Annex H) and for early identification of population needs (see Chapter 5). These will guide the JSNA and development of CYPP.
- Schedule of evidence-based universal and targeted services (see Chapter 4). This includes statutory obligations

(e.g. arrangements for looked after children), national recommendations and guidelines (e.g. immunisation schedule, NSC recommendations) and evidence-based recommendations from the literature review and expert review process. This schedule encourages commissioners to:

- identify evidence-based interventions to address local needs (bearing in mind that implementing a programme well may be as important as choosing the right intervention); and
 - identify currently provided services that are not supported by evidence and decide whether continued investment in these services is justified.
- Guidance on identifying important groups of at-risk children and families and the infrastructure required to meet their needs (Annex E).
 - Summary of strategic policy context, important recent initiatives and new research relevant to children's and young people's health (Annex A and Chapter 2).
 - Evidence base to support the principle of investing in preventive services for children and young people (Chapter 1).
 - Summary of new tools to support information sharing and needs assessment (Chapter 2).

⁸⁷ See also Department of Health (2007) *Promoting mental health for children held in secure settings: A framework for commissioning services*. London: DH (available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073414).

Phase 2: Shaping and managing the market

- Guidance on organisational and governance arrangements for HCP Teams (Chapters 1 and 5).
- Guidance on workforce aspects of service delivery (Annex C).
- Case studies and examples of good practice (see the forthcoming HCP webpages on www.dh.gov.uk).
- Summary of new tools to support information sharing and needs assessment (Chapter 2).

to deliver positive outcomes for children and young people.

A commissioning community of practice, including an online presence developed with commissioners, facilitates networking and resource exchange.

The local Children's Trust will have a commissioning champion acting as the key link for the programme. In addition, the SHA should be linked into the programme's regional structure.

Phase 3: Improving performance, monitoring and evaluating

- Summary of expected HCP outcomes (Annex H).
- Metrics for use in contracts and for monitoring performance against those contracts. These include indicators:
 - drawn from PSA targets;
 - drawn from the 198 LAAs (performance framework);
 - the NHS operating framework Vital Signs; and
 - indicators reflecting best practice.

Further support

DCSF, in partnership with DH, has made significant support available through the Commissioning Support Programme for CTBs.⁸⁸

The programme provides access to examples of good practice and expertise that already exist, and provides structured support to all partners in Children's Trusts to enable them to identify the opportunities and challenges around the strategic commissioning of services

⁸⁸ www.commissioningsupport.org.uk.

Annex E

Identification of children and young people with particular vulnerabilities

It is recommended that systems are in place for identifying particularly at-risk children and young people, so that appropriate support can be given. Practitioners and commissioners need to be aware of additional risk factors associated with the following groups and ensure additional targeted/specialist support is available.

Children and young people with complex or enhanced needs

These include children and young people who:

- are ill;
- are disabled;
- have complex or long-term health needs;
- have SEN; and
- have mental health problems which require a multidisciplinary approach.

Children and young people whose family background puts them at higher risk

These include:

- families where one or both parents grew up in care;
- parents with serious mental health, drug or alcohol problems;

- parents who have learning difficulties;
- children and young people who have experienced neglect;
- families living in poor/deprived housing;
- families with a young mother or young father;
- families where a close family member is in custody;
- families where the mother's main language is not English;
- families where the parents are not co-resident; and
- families where overweight and obesity are prevalent.

Children and young people not accessing or poorly served by existing services

These include:

- looked after children whose health outcomes are often poor, especially as regards mental health;
- young carers;
- those children and young people who had little or no health surveillance or screening in the early years;
- homeless children and young people or those living in temporary accommodation;

- refugee children and young people and asylum seekers;
- travellers;
- children and young people in custody including the secure estate;
- BME children and young people; and
- LGBT children and young people.

Children and young people with particular behaviour/lifestyle risks

These include children and young people who:

- are not in education, employment or training; and/or
- are engaging in or at increased risk of engaging in risk-taking behaviour (e.g. drugs, alcohol, unsafe sex).

Service providers have a responsibility to all children and young people, regardless of setting, so the HCP should apply, for example, to those educated at home, those attending short stay schools and those in contact with the youth justice system (in the community or the secure estate).

There is also a responsibility to help manage the transition of young people vulnerable to poor outcomes and those with long-term conditions to adult services. This includes young people suffering from mental disorder and the management of their transition into AMH services.

Any system of early identification has to be able to:

- identify the risk factors that make some children and young people more likely to experience poorer outcomes in later childhood, adolescence and adulthood, including family and environmental factors;
- include protective factors as well as risks;
- be acceptable to parents, children and young people;
- promote engagement in services and be non-stigmatising;
- be linked to effective interventions;
- capture the changes that take place in the lives of children, young people and their families;
- include parental, child and adolescent risks and protective factors; and
- identify safeguarding risks for the child and young person.

Annex F

Screening programmes

For primary school aged children

At or around the time of school entry every child should have a vision and hearing test performed to prescribed guidelines. Parents should be told that they are welcome to attend the screening tests but that if they are unable they should give permission for them to be done in their absence. **Colour vision screening should not be done.**

Height and weight should be measured and plotted on a chart to identify children with growth disorders which can also be used as part of the NCMP.

For secondary school aged young people

Vision screening

There is no evidence for or against a further universal vision test when starting secondary school but opinion suggests that this should be undertaken in schools with very high levels of deprivation; in the remainder, any child with concerns about vision, or learning or physical co-ordination problems, should be advised to attend an optometrist.

Chlamydia screening

Genital *Chlamydia trachomatis* infection is the most commonly diagnosed bacterial STI in genitourinary medicine clinics in the UK. The infection can cause pelvic inflammatory disease (PID) in women and reduce fertility in men, possibly by damaging sperm. The goal of the National Chlamydia Screening

Programme (NCSP) in England is to control chlamydia through the early detection and treatment of asymptomatic infection; to prevent adverse outcomes such as reduced fertility; and to reduce onward disease transmission. The NCSP has taken innovative approaches using a wide variety of patient recruitment methods, premises and personnel to ensure wide coverage.

Men and women aged under 25 years who have ever been sexually active are offered, or may request, a chlamydia screen. Those aged under 16 may be included if deemed Fraser competent to consent.⁸⁹ Contacts of screened positives are included, regardless of age. Sexually active men and women under the age of 25 should be encouraged to get screened annually or whenever there is a change in sexual partner. The NCSP is a complicated and demanding programme to provide on a national scale. Coverage of the most at-risk groups and the need for repeated testing are likely to remain challenging; ensuring easy access to tests and treatment is therefore essential.

⁸⁹ www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086914.pdf

Annex G

Immunisation programmes

Immunisations should be offered to all children and young people in accordance with the routine immunisation schedule.⁹⁰

GP practices and child health information systems/child health record departments maintain a register of children and young people, issue immunisation invitations, record details of immunisations given and maintain a record of any adverse reactions on the GP record.

Local planning should aim to target excluded or vulnerable families.

PCTs are responsible for making contractual arrangements with the NHS (or other providers) for delivery of immunisation programmes as outlined in the routine immunisation schedule. Some PCTs have dedicated vaccination teams to administer vaccines to school age children; in other areas the task falls largely to the school nursing team, some of whom will use the contacts to deliver health promotion. A few PCTs currently commission GP practices to offer immunisation to school age children. Current evidence suggests that the routine immunisation of school age children is most efficiently delivered through schools. This approach is likely to provide higher vaccine

coverage and be more acceptable to parents and pupils.⁹¹

Local needs assessment and skills mix should determine the most effective use of staff to deliver against local and national priorities. Arrangements should be in place to ensure the human papillomavirus (HPV) vaccination for 12–13-year-old girls, as well as tetanus, diphtheria and polio vaccine (td/IPV) for teenagers, are provided.

At both primary and secondary school entry and on other opportunistic contacts, completion of the pre-school programme should be checked by health professionals delivering the HCP. Particular attention should be taken to ensure children and young people have received two doses of the measles, mumps and rubella vaccine (MMR)⁹² and are thereby protected against measles, mumps and rubella.

If outstanding immunisations are identified, children and young people should be referred to their GP practice or another provider to receive the necessary vaccines.

Bacille Calmette-Guérin (BCG)

The universal BCG vaccination programme delivered through schools was replaced in 2005 with an improved programme of targeted vaccination for those individuals who are at greatest risk.

⁹⁰ The current routine immunisation schedule, together with additional vaccines recommended for some groups, can be found at www.immunisation.nhs.uk. Further information is available at www.dh.gov.uk/greenbook.

⁹¹ Also see further guidance from NICE on increasing immunisation uptake among those aged under 19 years where uptake is low (<http://guidance.nice.org.uk/PH21>).

⁹² It is never too late to have the two doses of MMR.

The programme identifies and vaccinates babies, children and young people who are most likely to catch the disease, especially those living in areas with a high rate of tuberculosis (TB) or who were born, or whose parents or grandparents were born, in a country where the prevalence of TB is high.

Hepatitis B

Children and young people at increased risk of contracting hepatitis B should be immunised. These will include those who live in close contact with someone infected with hepatitis B, those who regularly receive blood transfusions (for example, haemophiliacs) and those who travel to countries where hepatitis B is common. In the UK, hepatitis B infection is most common among people born in countries where its prevalence is high. Acquisition of hepatitis B infection in adulthood is more likely through sexual transmission or the sharing of blood-contaminated needles by injecting drug users.

Seasonal influenza

Children and young people who are more likely to develop complications from influenza should be immunised with the seasonal influenza vaccine. These include those:

- with chronic (ongoing) lung diseases such as cystic fibrosis and severe asthma;
- with diabetes;
- with a suppressed immune system; and
- with serious liver, heart or kidney disease.

Human papillomavirus vaccine

In September 2008, an HPV vaccination programme was introduced. The HPV vaccine protects against cervical cancer caused by HPV types 16 and 18 (which account for over 70 per cent of cervical cancer cases). Three doses of the vaccine are needed over about a six-month period. The HPV vaccine is routinely offered to girls aged between 12 and 13 years (school year 8). A catch-up programme running between 2008 and 2011 is also offering the vaccine to girls up to the age of 18.

Tetanus, diphtheria and polio booster

Td/IPV is a booster vaccine given to young people between the ages of 13 and 18, boosting protection against tetanus, diphtheria and polio (IPV inactivated polio vaccine).

Annex H

Outcomes expected from implementation of the 5–19 Healthy Child Programme

Effective delivery of this good practice programme, over time, may contribute to improvements in a number of areas. These are outlined below.

Improved quality of services

Improving the quality and reach of existing services and health promoting settings are necessary precursors to improving the health and wellbeing of children and young people. The following are examples of key markers on the journey to health and wellbeing improvement:

- proportion of children who receive vision and hearing screening tests at or around school entry;
- proportion of children who complete immunisation by recommended ages e.g. girls in secondary school completing their three-dose course of the HPV vaccine and teenagers receiving the Td/IPV vaccine;
- proportion of initial assessments for children's social care carried out within seven working days of referral;
- proportion of children with long-term medical conditions and/or significant disabilities who have an individual care pathway in place;
- proportion of PCTs and LAs that are providing a comprehensive CAMHS; and

- proportion of looked after children who receive a specialist CAMHS.

Progress may also be reflected in uptake of quality-assured national schemes, including:

- proportion of PCTs implementing *You're Welcome* quality criteria;
- proportion of schools with National Healthy School Status and participation in the Healthy School enhanced model;
- proportion of FE institutions using the Healthy FE Framework; and
- numbers of doctors, nurses and allied health professionals trained in adolescent health through the Adolescent Health Project e-learning programme.⁹³

Improved experience of services

In turn, implementation of the 5–19 HCP should result in greater satisfaction of children, young people and their families' experiences with health services and wider health promoting settings. Examples of key measures are:

- children's, young people's and parents' perceptions of the extent to which schools promote healthy lifestyles;

⁹³ www.rcpch.ac.uk/Education/Adolescent-Health-Project

- proportion of young people who feel they have easy access to appropriate health services;
- proportion of young people who know where and how to access contraceptive and sexual health services;
- proportion of young people who feel their health practitioner keeps things confidential;
- proportion of parents who know where and how to access parenting advice; and
- parents', children's and young people's experience of services for disabled children.
- rates of hospital admissions for alcohol-related harm; and
- numbers of children and young people with good control and management of chronic illness or disability.

Contribution to improved broader health and wellbeing outcomes

While recognising that most areas of children's and young people's lives are determined by a wide range of individual, family, community and societal factors, effective implementation of the 5–19 HCP should over the longer term make a significant **contribution** to a number of broader wellbeing outcomes for children and young people. Once again, many of these are measured as part of national indicator sets and form a key part of local delivery plans for children and young people. As far as possible, there should be a balance between indicators of positive contributions as well as those that are more prevention focused.

Examples include:

- participation in positive activities;
- school attendance rates;
- permanent school exclusions;
- achievement at key stage 1, 2, 3 assessments and GCSE;
- achievement of a level 2 qualification by the age of 19;
- proportion of 16–18-year-olds who are not in education, employment or training; and
- number of first-time entrants to the youth justice system aged between 10 and 17 years.
- rates of obesity;
- under-18 conception rates;
- proportion of young people who frequently use illicit drugs, alcohol or volatile substances;
- proportion of young people smoking;
- rates of chlamydia diagnoses;
- rates of hospital admissions caused by unintentional and deliberate injuries to children and young people;

Improved health and wellbeing outcomes

Implementation of the 5–19 HCP should contribute to a number of improved public health outcomes for children and young people over the longer term. Many of these outcomes are already being monitored as key indicators within national strategies and local plans. Examples include:

Improved data collection and analysis for needs-led commissioning and service provision

Regular review of all these indicators should take place at local, regional and national levels. In addition to looking 'population wide', the position of specific sub-groups with particular vulnerabilities (see Annex E) should be monitored. There is also a need to focus on age and gender differences, recognising that children and young people are not a single homogeneous group. At local, regional and national level, commissioners and providers need to be clear as to how they will act on what the data tells them.

Drawing together all this information can also provide a useful starting point for a needs analysis of where activity is most needed. As most of these indicators are already national and local commitments, data are readily available e.g. through local JSNAs and annual reporting for comprehensive area assessments, as well as the National ChiMat⁹⁴ and other public health observatories.⁹⁵

⁹⁴ www.apho.org.uk/default.aspx?QN=CHIMAT_HOME

⁹⁵ www.apho.org.uk

Annex I

Safeguarding

Transforming services designed to protect and safeguard children and young people will require strong and effective leadership, robust staff training, support and clinical supervision, early intervention, adequate resources, excellent performance management, inspection and support.

In addition to the statutory named nurse in the safeguarding children role for each provider organisation, HCP Teams might find it helpful to have an individual (in NHS terms, at least a Band 6) to take the lead on complex child protection and safeguarding cases, alongside the lead (of similar seniority) on public health.

All those working with children and young people (including staff in accident and emergency departments, ambulatory care units, walk-in centres, schools and colleges, and minor injury units) should fully understand local referral arrangements. If safeguarding children is everybody's responsibility, then everybody should know how, and who, to contact if they are concerned about a child or young person. As Lord Laming's report (Laming, 2009) has made clear, the safety of a child ultimately depends on staff having the time, knowledge and skill to understand the child or young person and their family circumstances, and this responsibility lies with the whole team. Safeguarding issues are just as important for older children and young people as they are for younger children and babies.

In addition, staff should be aware of the impact of parental health problems – particularly drug or alcohol misuse or mental health – on children. Staff should consider what extra support children may need and be clear about referral routes where safeguarding issues are identified.

The operating framework for the NHS in England 2009/10 (DH, 2008d) sets out the expectations of the NHS for safeguarding children at paragraphs 48 and 49. Following reports by the CQC into the care of Baby Peter, and the CQC national safeguarding review (CQC, 2009), the NHS Chief Executive wrote to the NHS to outline the action required (DH, 2009b).

The role of schools

Schools and early years settings play a key role in early identification, intervention and support for children at risk of significant harm or who have additional needs. Schools and early years settings should prioritise safeguarding children within their school improvement plans.

Schools should also ensure they work closely with adult services to identify children who have parents with complex needs that could be putting the child at risk, such as chronic substance misuse, poor mental health and domestic violence in the household.

All staff in schools should be sensitive to warning signs of possible abuse or neglect,

for example: poor physical care, smelly and/or dirty clothes, poor dental care and untreated caries, stealing food, foraging in bins, late collection by a parent/carer, a reluctance to go home, etc.

Children absent from school

Poor attendance or significant and unexplained absences, while primarily an education service concern, often have health implications, particularly if poor health is, or is being used as, the reason for non-attendance. Such behaviour can easily become entrenched, and in the long term dropping out of education can have serious adverse health implications including a high risk of teenage pregnancy or offending behaviour.

A recent review of Serious Case Reviews found that 13 of the 19 children aged 4 and over who died or experienced significant harm had been showing signs of poor school attendance (Brandon et al., 2008). While these cases are exceptional, poor or erratic attendance not uncommonly has safeguarding implications and in every case, staff should think about where early intervention support may be needed.

The role of Further Education

FE institutions should also follow good practice on safeguarding young people, and guidance via the Healthy FE Programme, will be provided in Spring 2010 to enable them to do so.

Information sharing

Local organisations should work towards a system of information sharing across health services where children, young people and families are aware of what information is collected and who has access. It should be made clear that while health records are held

in confidence, information will be shared where professionals involved in a child's care believe that the child is at risk of significant harm. Where the risks to children are clearly understood (e.g. when children are in custodial settings), it is essential that information is shared so that their needs can be met. In these circumstances information sharing should be the norm, not the exception. For details see *Information sharing: Guidance for practitioners and managers* (HM Government, 2008d – paras 3.11 and 3.36) and *When to share information: Best practice guidance for everyone working in the youth justice system* (DH, 2008a).

Parents or carers should be aware that the safety and wellbeing of the child or young person is paramount, and that information may need to be shared to protect them where there are concerns in respect of safeguarding. The same protocols should be followed, and the same information exchanged, with a young person who is regarded as in need of safeguarding, except in certain circumstances (as outlined in the previous paragraph).

Frontline staff and their managers should be trained to understand the laws governing data protection and privacy, ensuring that an appropriate balance is struck between protecting the privacy and confidentiality of individuals and allowing appropriate information sharing between professionals.

Further information

Additional advice and guidance is available from NICE and e-Learning for Healthcare.⁹⁶

⁹⁶ NICE (www.nice.org.uk/CG89); and safeguarding e-learning packages for health and social care professionals (www.e-lfh.org.uk/projects/safeguarding/index.html)

Developing the Healthy Child Programme

The 5–19 HCP has been developed in consultation with a wide range of stakeholders. Professors David and Sue Hall (leading child health academics) were commissioned to carry out an extensive review of the evidence. This has been key to informing the 5–19 HCP. A series of consultation events were held with children, young people and parents to inform this work. In addition, a 5–19 HCP Expert Advisory Group provided significant input throughout the development of the programme. This group consisted of a range of stakeholders from different disciplines such as education, school nurses, commissioners, GPs, hospital and community paediatric services, CAMHS and the youth sector. Two national consultation events were also held with around 60 experts to explore the key issues to include in the 5–19 HCP and reach consensus on the main research findings. There was also significant engagement and consultation with all relevant government departments, particularly DH, DCSF and Department for Communities and Local Government.

DH and DCSF will continue to work with key partners to develop a robust evaluation of the 5–19 HCP. Further details to follow on the forthcoming HCP web resource.

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Abbreviations and definitions

AHDC – Aiming High for Disabled Children programme

AMH – adult mental health

BCG – Bacille Calmette-Guérin

BME – black and minority ethnic

CAF – Common Assessment Framework

CAMHS – child and adolescent mental health services

CBT – cognitive behavioural therapy

ChiMat – Child and Maternal Health Observatory

CHPP – Child Health Promotion Programme

CTB – Children's Trust Board

CYPP – Children and Young People's Plan

DCSF – Department for Children, Schools and Families

DH – Department of Health

ESP – Early Support Programme

FE – Further Education

FIP – Family Intervention Project

FISs – Families Information Services

HCP – Healthy Child Programme

HIV – human immunodeficiency virus

HPV – human papillomavirus

IAG – information, advice and guidance

JSNA – joint strategic needs assessment

LA – local authority

LAA – local area agreement

LARC – long-acting reversible contraception

MMR – measles, mumps and rubella

MST – multisystemic therapy

MST-CAN – multisystemic therapy for child abuse and neglect

NCMP – National Child Measurement Programme

NCSP – National Chlamydia Screening Programme

NICE – National Institute for Health and Clinical Excellence

NSC – National Screening Committee

NSF – National Service Framework

NTA – National Treatment Agency

PAYP – Positive Activities for Young People

PCT – primary care trust

PE – physical education

PEIP – Parenting Early Intervention Programme

Progressive – the term 'progressive' in relation to children's and young people's services means services that are provided for children and young people with additional needs and risk factors

PSHE – Personal, Social, Health and Economic education

SDQ – strengths and difficulties questionnaire

SEAL – social and emotional aspects of learning

SEN – special educational needs

SENCO – special educational needs co-ordinator

SHA – strategic health authority

SLCN – speech, language and communication needs

SRE – Sex and Relationship Education

STI – sexually transmitted infection

TaMHS – Targeted Mental Health in Schools

TCS – Transforming Community Services

Td/IPV – tetanus, diphtheria and polio (with inactivated polio vaccine)

TYS – targeted youth support

Universal – the term 'universal' in relation to children's and young people's services means services that are relevant to all children and young people

WCC – world class commissioning

YJB – Youth Justice Board

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