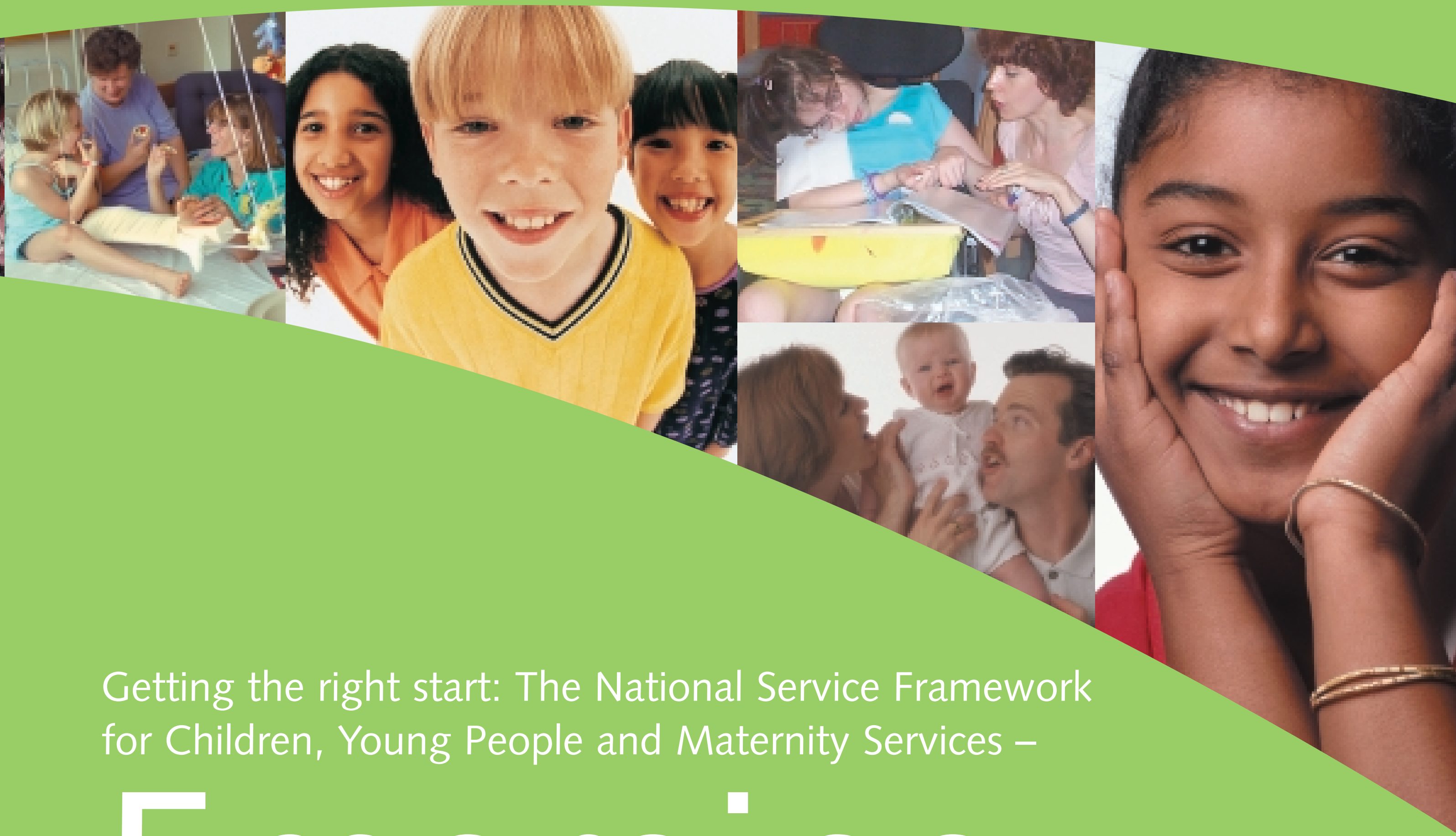
Department of Health



Getting the right start: The National Service Framework for Children, Young People and Maternity Services –

Emerging findings

Department of Health

Getting the right start: National Service Framework for Children

Emerging Findings

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Foreword

Nothing matters more to families than the health, welfare and future success of their children. Today's young people are our future teachers, our scientists and our doctors, our employers and our workforce. Our future success depends on the fulfilment of the hopes, dreams and potential of our children being realised. Children are vital for our national and personal survival – they are the life blood of the nation and they are the living message we send to a time we will not see.

Healthy children have more chance of becoming healthy adults, and much adult disease and many emotional and psychological difficulties may have their roots in childhood. For the first time, the demographic profile of England has changed, with a declining birth rate and more people living longer. Profound changes are occurring in our multicultural society with changes in the skills needed for employment and changes in family structure. Of particular concern is the effect of inequalities and poverty on the life and health of children and young people. We want to ensure that the services we provide are truly child-centred and enable children to have a fulfilling and enjoyable childhood, as well as laying the foundations for healthy adult life.

For all of these reasons, the Government is committed to improving the life and health of our children and young people. It has initiated a cross-government agenda, one component of which is the creation of the Children's Taskforce – one of ten – charged with ensuring that *The NHS Plan* is delivered for children, overseeing the *Quality Protects* programme and with specific responsibility for overseeing the development of the Children's National Service Framework (NSF). This report is intended to set out the overall direction of travel for the NSF, prior to its publication next year, to help local health communities in planning and improving services.

For many children the support offered to them and their families through social care services is crucial. This NSF includes standards covering both health and social care services, and a key theme of this Emerging Findings document is the importance of integrated working between health and social care to support children who are disabled, who have mental health problems, or who are otherwise in special circumstances. For many children this joined-up working is essential to improving the quality of their lives and future life chances.

There is much that is very good about the services provided by the NHS and Local Authorities to support parents, children, young people and families. We have a workforce dedicated to children and young people: lives are being saved; diseases previously thought to be incurable are now being treated effectively, and children are being protected.

The fact that all is not well, however, was exposed by the Inquiry led by Sir Ian Kennedy that was triggered by the tragic failures in care management for children subjected to heart surgery in Bristol. The second phase of the Inquiry was dedicated to an examination of the standing, status and delivery of children's health services nationwide. Its criticisms serve as a 'wake-up' call to all involved in the delivery of services to support children, young people and families. Further difficulties in the provision of effective health and social care for children have been shown in past reports and in the circumstances surrounding the death of Victoria Climbié, these being the subject of the recent Inquiry led by Lord Laming.

The Children's NSF offers an opportunity to improve the lives and health of children and young people through the development of effective, evidence-based and needs-led services, and to improve their experiences and satisfaction with services. It sets out a challenging agenda, with three key objectives, namely, to put children and their families at the centre of care; to develop effective partnership working so that the needs of the child are always considered, and to deliver needs-led services.

The NSF should not be seen to be the 'end' in itself – it is a means to an end. It will set out a 10-year direction of travel, and acknowledge that there are difficulties in achieving rapid change, not least because of the shortage of skilled staff in disciplines supporting children, young people, parents, families and carers. Moreover, effective change will only happen through the active engagement of all staff at the local level. Effective planning of services will be needed, linked to new ways of thinking strategically and with more effective advocacy for the needs of children and young people. We need to build leadership capacity and secure the active participation and involvement of children, young people and carers in the design and development of services to match their needs.

Developing effective services also needs strong partnership working. At a local level, health and social care are working together with a range of partners to develop co-ordinated support that makes sense to children and families. This NSF is being developed as part of a broader focus on children, which includes support to local partners to establish Children's Trusts, and the forthcoming Green Paper looking at services for children at risk. Implementation of standards over the longer term will take place in that context, and will need to take account of these developments.

Many people have been engaged in the work that is leading to the production of this NSF. It is my great privilege to chair the Children's Taskforce and to lead the development of the standards. I would like to take this opportunity to express my thanks to all concerned, but particularly to my colleagues who are participating in the External Working Groups and the underpinning activities.

The Children's NSF provides for the first time an outstanding opportunity to improve the lives and health of our most precious resource – our children and young people. I hope that these Emerging Findings will help those who are starting to think about how the NSF will improve services for children, young people and their families and pregnant women.

Professor Al Aynsley-Green
National Clinical Director for Children

1: Introduction

1.1 Children and young people make up around one quarter of the total population of England. They deserve the best care. They have legally enforceable rights as children and their families have the right to have their family life upheld and respected. Their vulnerability and often the inability when young to articulate what they are feeling poses a challenge for all those involved in delivering health and social care services to meet their individual needs as effectively as for adult services. We need services for children to act as a springboard for success, which not only take care of children, but also provide them with a real chance to succeed in life: services that focus on protection, prevention and above all on opportunity; on ending inequalities and creating chances that will be fulfilled throughout their lives.

1.2 Every parent and carer will be aware of the acute anxiety and stress caused by their child having an injury or illness, emotional problems or being born with a disability. Nothing matters more to parents than the health, wellbeing and safety of their children. The objective of this NSF is to improve the standard of services and reduce inequalities in care and support services. It provides a landmark in the development of services for children and young people and a real opportunity to give them, and pregnant women, the best start in life to prepare them for getting the most out of going to school, to deal with the problems which all children face during their childhood and, later, to take their place as active citizens in society.

1.3 Experience in early life – and before birth – has a crucial impact on the life chances of each individual and on adult life. Every child will come into contact with some health or social care services, and these early experiences will influence their future attitudes and the use they make of these services. In England, there are approximately 3 million children aged under 5 years, 6.4 million aged from 5 to 14, and 3.1 million are young people aged between 15 and 19. Children and young people from ethnic minority backgrounds make up about one fifth of the total population aged under 20. This is a much higher proportion than for older age groups, and is a crucial consideration in the design and delivery of services. In total, there are:

- 12 million children;
- 400,000 children in need;
- 59,700 Looked After Children;
- 320,000 disabled children;
- 600,000 live births a year;
- approximately 1 million with mental health disorders.

1.4 The health and wellbeing of children is determined by a wide variety of factors, some of which lie beyond the remit of this NSF. However, the NHS and local authorities have a role to play within Local Strategic Partnerships in tackling some of these factors. This NSF is not being developed in isolation from, but in the context of broader government strategies to support children and families, tackle inequalities, improve public services and end child poverty. The forthcoming Green Paper on children at risk will look at how services can effectively support children at risk of a range of poor outcomes. The NSF for children, young people and maternity services is a 10 year programme intended to stimulate long term and sustained improvement in care. It aims to ensure fair, high quality and integrated health, social care services from pregnancy, where every child's life begins, right through to the transition to adulthood.

1.5 The NSF will set out ways of supporting the child through a number of journeys – the journey of growing-up, of dealing with particular problems including injuries and illnesses, mental health problems and the journey that some families have to make in negotiating their way through a complex and bewildering web of apparently unlinked services. These Emerging Findings are derived from the work that the External Working Groups (EWGs) have done over the past year. They are being published now to inform health and social care communities of some of the main themes likely to be included in the NSF as it is developed over the next year; to inform and feed into Local Delivery Plans, and to seek views. Inevitably there will be changes made over the next year or so as the material is refined and developed to take account of further work and the views expressed as a result of this consultation. The document also includes some pointers for use by the NHS, Social Services and Councils with responsibility for starting local implementation of the full NSF.

1.6 In considering what services are needed for children and young people, the NSF will place considerable emphasis on the whole child rather than solely the individual services with which children come into contact. Parents repeatedly stress how important it is that their child is seen as an individual but within a family, school and community context, and not just as someone with a particular condition or disability. Maximising the potential of each child is of paramount importance to the family and to society as a whole. The NSF will need to consider all the stages of a child's life, the transition between each of them and the transition to adulthood as part of a journey, with different needs and challenges at each stage. Effective professional handover during the transitions is essential in ensuring that young people do not fall between different services.

1.7 This NSF is not only about services for children and young people but also covers maternity services, from pre-conception care through to the post-natal period. This is clearly of great influence on the child's life, with an emphasis on 'the best possible start'. The maternity EWG is considering services holistically, focusing on the needs of mothers-to-be and families, and acknowledging the twin aims of maternity services: to lead to a healthy baby and a healthy mother.

Developing NSFs

1.8 The NSF programme – part of an overall programme to improve quality – has been successful in terms of driving up standards of services within the framework of national standards. The Children's NSF is being developed in the context of change across the NHS and local government. We intend to modernise our key public services so that they work in a new spirit of partnership to support children and their families. In developing the NSF, we have looked at the evidence of what will help to achieve change. Public sector reform including *Shifting the Balance of Power* has altered the way that health and social care services are delivered and is moving money and responsibility out to local health communities. The establishment of Strategic Health Authorities and Primary Care Trusts (PCTs) provides an opportunity to deliver more closely integrated services. *Improvement, Expansion and Reform: the Next 3 Years, Priorities and Planning Framework 2003–2006*, has set a number of targets for the NHS and social services. Although many of these targets are applicable to children and young people, including new objectives on child and adolescent mental health services, they are not intended to cover every area in which improvement is needed. *Improvement, Expansion and Reform* recognises that there will be other developments during that time, including this NSF, which will need to be taken into account and work initiated on implementation.

1.9 This NSF recognises that there will be much greater flexibility at the local level to plan to meet local priorities and to use local innovation, within the framework of national standards. Partnership between different agencies on local service development will be key to the success of this approach. The NSF will depend on delivery by multi-disciplinary teams and interagency working with strong leadership to champion real change and genuine modernisation. We need organisations that learn from each other and engage frontline managers and staff in shaping as well as delivering policy. The biggest challenge for us all is to raise and then to sustain high standards of care.

1.10 Progress against the standards in the NSF will be implemented and monitored in various ways:

- PCTs can set local indicators and performance manage progress locally – commissioning will continue to be fundamental to driving change.
- Each PCT will already have in place a named individual with responsibility for planning and delivering services for children and young people.
- Commission for Health Improvement and Social Services Inspectorate (Commission for Healthcare Audit and Inspection and Commission for Social Care Inspection when established) will take account of NSF standards in their regular inspections of health and social care organisations and can undertake themed inspections.
- Arrangements for improving the patient experience will enable users of services to identify where services are not meeting standards locally (including Patient Advisory and Liaison Services, Patients Fora and nationally developed surveys).
- The Modernisation Agency, National Institute for Clinical Excellence and Social Care Institute for Excellence will promulgate, spread and support best practice and leadership programmes.
- Information on services will be improved in line with *Information in the 21st Century* and the NSF Information Strategy.
- Performance Indicators will be included in the Performance Assessment Frameworks that relate to the NSF standards.
- Strategic Health Authorities will monitor PCTs on delivery of the Priorities and Planning Framework targets which apply to this NSF and to identify and address risks through the performance management process.

Scope and structure

1.11 In tackling this ambitious task, the Taskforce divided the work into different areas looking at different groups of children and care settings. However, the intention has been to take a holistic view of the lives of children rather than pigeonhole them into categories. All children whatever their sex, age, race, faith, or disability should be able to receive high quality services. The individual EWGs[1] have worked hard to develop common themes to avoid setting-up any new silos which could jeopardise the integrated and co-ordinated approach to service delivery that is needed. There are inevitably numerous and complex interactions between all the modules. The themes underpin a common vision, which is described in the next section. A short section on each main work area describes the importance and relevance of the issues under discussion and suggests additional actions to facilitate local planning and discussion.

1.12 A standard for the care of children in hospital are being published first and separately from this document. This was a decision taken in the light of the concerns expressed in the Kennedy Report. Children spend the great majority of their time in the community – at home and at school – and most treatment is delivered outside the hospital setting. But hospitals are an important setting for children who are ill or injured – though publishing this standard first does not mean that hospitals make the only significant contribution to child health. A new EWG has been set up to look at the ill child in a more general context, including long term conditions, acute illness and minor illness in all settings in which children are treated (including self-management). Work on developing standards will continue in the External Working Groups with the engagement of key stakeholders. This Emerging Findings document

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[1] Health of all children, maternity services, child and adolescent mental health services, disabled children, children in special circumstances, hospital and acute services and the use of medicines in children.

is intended to make clear the direction the work is taking. We welcome comments on any aspect of it. The document is also intended to identify key points for early consideration by service providers and commissioners.

Terminology

1.13 Throughout this document, we have used the term 'parents' as shorthand to include mothers, fathers, carers and other adults with responsibility for caring for a child or young person, including, for example, those with responsibilities for looked after children and young offenders. References to 'children' include young people up to age 19 unless otherwise specified.

Consultation process

1.14 Further information about the work of the Taskforce and the NSF is included at www.doh.gov.uk/childrenstaskforce

1.15 The development of the NSF is intended to be an inclusive process in keeping with the aim of improving the engagement with patients, the public and staff. We want you to be central to the development of the NSF. We would like to involve not just senior managers and representative organisations, but frontline managers and staff who will be crucial to achieving change. A series of conferences has been held to discuss the early findings and more events will take place over the next year. Details of how to respond to this document are set out at the back.

1.16 The final NSF will take account of the findings of the recently-published Inquiry into the death of Victoria Climbié *(The Victoria Climbié Inquiry)* and the forthcoming Green Paper on children at risk. A draft standard on child protection is attached at Annex B for consultation.

Starting local implementation

1.17 *Improvement, Expansion and Reform* sets out the priorities, targets and capacity assumptions for the NHS and social services over the next three years (see 1.19 below). Paragraph 1.19 sets out those that are relevant to demonstrate how they will help to prepare for the children's NSF. *Improvement, Expansion and Reform* also acknowledges that, in addition to the existing priorities, there will be developments during the three year planning period including this NSF which the NHS and social services will need to start work on in preparation for meeting the standards over the next decade.

1.18 In addition, health communities will also wish to review all the services that local agencies, including the voluntary sector, provide for children, what resources are available including any earmarked money, and compare these to local need. Strong commissioning will be needed to implement the changes set out in the hospital standard and to prepare for the full NSF. Leadership will be crucial in building and sustaining professional ownership for the full NSF. In particular, health communities may find it helpful to:

- Depending on the level of local knowledge, review and map the needs and characteristics of the population and obtain baseline information on provision by local agencies, including the voluntary sector, and use of all local children's and maternity services. This could include the number of disabled children or those in 'special circumstances' (see paragraph 6.2). Look at data such as the local birth rate and the number of low birth weight babies.
- Consider how the principles of other service improvement and modernisation initiatives could be applied to children's services.

- Consider current analysis of service usage to identify which groups of pregnant women, children and young people have difficulty in accessing services.
- Identify and, where appropriate, formalise local and supra-local clinical and commissioning networks.

Improvement, Expansion and Reform

1.19 Health communities will wish to consider how the following priorities, targets and national capacity assumptions set out under the following headings in *Improvement, Expansion and Reform* can be applied to improve delivery for children, young people and maternity services.

Improve access for both emergency care and planned care

Objective:

To provide fast, safe and high quality emergency care and fast convenient access and patient choice for planned care.

Targets:

- Improving access to all services through better emergency care, reduced waiting, increased booking for appointments and admission, and more choice for patients.

Cancer – smoking

Targets:

Reduce the rate of smoking, contributing to the national target of: reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the 4 week stage by 2006.

Carers Grant

National capacity assumptions:

An additional 130,000 carers a year receive services in 2006, using the increased investment in the existing Carers Special Grant. [Note that 20% of the Carers Grant funding has to be spent on Children's Act services. This will be £20 million for 2003/04.]

Coronary heart disease

Objective:

All appropriate units should participate in national [CHD] comparative studies for paediatric [and adult] cardiac surgery.

Mental health

Objective:

The Mental Health NSF and Suicide Prevention Strategy set out a modernisation programme to:

- Reduce the suicide rate and deaths by undetermined causes by 20% by 2010.
- Improve access to general community Mental Health Services.

Improvement, Expansion and Reform stated that the children's NSF and its emerging findings will set out the standards and milestones for improvement in child and adolescent mental health services, including year on year improvements in access. Section 7 and Annex C (A Comprehensive CAMHS) provides the detailed guidance referred to.

Targets:

- All child and adolescent mental health services to provide a comprehensive service including mental health promotion and early intervention by 2006.
- Increase child and adolescent mental health services by at least 10 per cent each year across the service according to agreed local priorities (demonstrated by increased staffing, patient contacts and/or investment).

Life chances for children

Objectives:

Ensure the NHS and local government work together to improve life chances for children by:

- addressing issues identified in the Kennedy Report including preparation for and implementation of the first module of the Children's NSF. [Note that this includes ensuring that someone has been appointed to lead on children's issues and represent them on the Board.]
- engaging fully with the ongoing development of cross-agency preventive work to support children and families, including local prevention strategies, and the continued development of Sure Start and Children's Centres.

Targets:

- Substantially narrow the gap between the educational attainment and participation of children in care and that of their peers by 2006.
- Improve the level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75 per cent of those achieved by all young people in the same area by March 2004, and maintain this level up to 2006.
- Reduce by 2004, the proportion of children aged 10–17 and looked after continuously for at least a year who have received a final warning or conviction, by one third from September 2000 position. Maintain this reduction up to 2006.
- Maintain current levels of adoption placement stability so that quality is not compromised whilst increasing the use of adoption to the levels set out in *Improvement, Expansion and Reform.*

National capacity assumptions:

- All Local Authorities to have in place robust mechanisms for partnership working with relevant agencies to achieve targets.
- Improvement in the stability and quality of placements for looked after children including through recruitment/retention and support to foster carers over this period to support targets in line with the Choice Protects Review.

Improving the patient experience

Objective:

The NHS will be transformed through better engagement with patients, the public and staff. The 5 key dimensions for a good patient experience are:

- Improving access and waiting.
- More information, more choice.
- Building closer relationships.
- Safe, high quality, co-ordinated care.
- A clean, comfortable, friendly environment.

Targets:

- Improve the 5 key dimensions of the patient's experience as evidenced by increasingly positive local annual survey results, and other patient focused performance indicators, including those developed for the star ratings system. Agree, implement and jointly monitor local improvement plans as a result of surveys, with Patient Forums, as they come on stream during 2003.
- Strengthen accountability to local communities through improved engagement with them, as evidenced by annual Patient Forum reports to the Commission for Patient and Public Involvement in Health, and annual publication of a patient prospectus covering local health services.
- Introduce bedside TV and telephone systems in every major hospital by December 2003.

Reducing health inequalities

Objective:

To reduce inequalities in health outcomes across different groups and areas in the country. Initially the focus is on reducing the gap in infant mortality and life expectancy at birth, and on reducing teenage pregnancies.

NHS improvement, expansion and reform should narrow the health gap by:

- ensuring that the distribution of health benefit from service expansion and development consistently favours individuals and communities that have been traditionally under-served.
- ensuring that service planning is informed by an equity audit and supported by an annual public health report by the Director of Public Health.
- tackling the wider determinants of health – agreeing a single set of local priorities with local authorities and other partners, contributing to regeneration and neighbourhood renewal programmes, and ensuring the NHS makes a full contribution to support the *Sure Start* programme.
- building capacity for public health improvement and protection in PCTs.

Targets:

- Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between "routine and manual" groups and the population as a whole by 2010, starting with children under one year.
- Deliver an increase of 2 percentage points per year in breastfeeding initiation rate, focusing especially on women from disadvantaged groups.
- Achieve agreed local teenage conception reduction targets while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter in line with national targets.

National capacity assumptions:

- Improved access to services for disadvantaged groups and areas, particularly:
  - Early antenatal services booking
  - Antenatal and child health screening services
  - Sexual health services
  - Strengthened primary care services through increased numbers of health professionals and improved facilities in under-served and deprived areas.

Drug misuse

To contribute to delivery of the National Drugs Strategy by reducing the harmful effects of substance misuse.

This will be achieved through expansion and improvement of drug treatment services, and by contributing to the Strategy target to reduce the use of Class A drugs, and frequent use of any illicit drug by young people.

Physical facilities

Objective:

To create a clean, comfortable, well-maintained physical environment which is fit to deliver modern, convenient care. This includes delivering sufficient physical capacity in the right place to implement the NHS's key priorities, increasing diversity of provision through use of non-NHS providers where appropriate, and ensuring that physical facilities are modernised in line with the vision set out in the *NHS Plan*.

Workforce

Objective:

To support delivery of NHS priorities by ensuring there are sufficient numbers of appropriately trained, motivated staff working in the right locations. The HR Strategy for the NHS sets out a managed programme for a rapid expansion in the NHS workforce, introduction of more flexible ways of working and improving the working lives of staff.

National capacity requirements:

All but in particular:

- Increase the number of staff available.
- Increase workforce capacity and productivity through skill mix and continuing professional development; moving work from doctors to other healthcare professionals and from healthcare professionals to the support workforce, supported by pay modernisation, and service redesign.

IM&T

Objective:

To provide information management and technology to support delivery of fast, seamless and convenient care to patients. IM&T will facilitate greater patient choice, giving patients better information about options for their care.

Targets:

All but in particular:

- electronic records – implement key elements of electronic records by December 2005.

2: Emerging aims and vision

2.1 A vision is starting to emerge of what really good services for children and families would look like and what changes are needed to deliver them. The children's NSF will be founded on a number of fundamental values and guiding principles including those developed to underpin all government strategies on children and young people, which are set out at Annex A.

Aims

2.2 The NSF has three main aims:

• Improving services

2.2.1 Parents'/carers' expectations of services have undoubtedly risen as technological advances have provided the opportunity to improve outcomes through improved clinical interventions and better communications. Some children with complex health needs who would not have survived even ten years ago are surviving into adulthood. The public is also expecting more convenient and accessible services delivered when and where they need them in modern premises with up-to-date equipment. The NSF will help to meet those expectations but also to make clear that this is a two-way process with responsibilities on both sides: responsibility for improving services for people who need them, on the part of the NHS and local authorities, and responsibility for using services wisely on the part of the public.

2.2.2 In common with other NSFs, the intention is to ensure that services are of high quality, appropriate and accessible when they are needed in a modern environment. Some services will need to be delivered more proactively and systematically. There is evidence that investing in improving services will also help to reduce costs later on: earlier access to better child and adolescent mental health services, for example, can help to prevent the later development of more complex problems and significantly improve quality of life.

2.2.3 Improving the quality of all services for children must not be just a time-limited, knee-jerk reaction to Kennedy's and Laming's concerns but a real and sustainable drive to raise standards for children, young people and pregnant women which will require commitment from all involved. Clinical governance, listening to the views of service users and improved multi-agency partnership working and training will be key, and will include the systematic use of quality assurance systems including clinical audit and better use of information. Children's services in the future should benefit from:

- High standards of evidence-based care set by the National Institute for Clinical Excellence and the Social Care Institute for Excellence so that technical excellence is achieved.
- The new agencies such as the Commission for Healthcare Audit and Inspection, the Commission for Social Care Inspection and the National Patient Safety Agency for inspection and performance management.

- Information to support commissioners of services, whether based in Children's Trusts, local authorities or PCTs.
- Advice and tools to ensure that all staff dealing with children are appropriately trained.
- A change in the hearts and minds so that we no longer see the attitudes which parents have been upset by in the past where they are made to feel inadequate, at fault or in the way.
- An optimum configuration of services (eg through Managed Clinical Networks).
- A better quality of environment (ie: the settings where services are delivered).

2.2.4 Common across all strands of the NSF is the need to ensure that all those working with children and families have the necessary values, competencies, skills, and ongoing training to enable them to recognise and respond to the identified needs of children. The level and depth of these skills will vary depending on the role of the professional but they need to engender a genuinely child-centred approach, without prejudicial views of particular groups of children and with high expectations for all. Common training modules, delivered on a multi-agency basis, are one way of increasing inter-agency understanding and these will be considered in the development of the NSF.

2.2.5 In the same way, pregnant women and new mothers need care that is demonstrably appropriate, safe and sensitive. Those responsible for their care need to have appropriate skills and competencies and adopt a woman-centred approach without prejudicial views of particular groups of women or families.

• Tackling inequalities

2.2.6 Tackling health inequalities is a high priority for government and key to the NSF programme. Inequalities in health outcomes have persisted despite increased prosperity and reductions in mortality over the last twenty years. There is a strong correlation between health inequalities and poverty and deprivation that begins at birth and continues throughout life. For example, the infant mortality rate among children in social class V in 1999–2001 was more than double that for Social Class (SC) I, with rates rising from 3.8 deaths per thousand live births in SCI to 5.4 in SCIII (manual), 6.4 in SCIV and 8.0 in SCV. Also, children in SCV are five times as likely to suffer accidental death than their peers in SCI, five times as likely to be killed when pedestrians, and their chances of dying in a residential fire are fifteen times greater. Other dimensions of health inequalities include: ethnic group, gender, and disability. The long term strategy for addressing health inequalities across government, with key partners locally and in communities, will be set out in an All-government delivery plan to be published in early 2003. Information on health inequalities can be found on the Department's website at: www.doh.gov.uk/healthinequalities.

2.2.7 Existing socio-economic disadvantage not only impacts on the health of the current generation, but is passed on to future generations. Tackling health inequalities by addressing the health needs of children and families is key to the inter-generational cycle of health inequalities which can cause poor health outcomes from one generation to the next in some disadvantaged families and areas.

2.2.8 Following a commitment in *The NHS Plan*, national health inequalities targets have been set in the areas of infant mortality and life expectancy. The infant mortality target aims to reduce infant mortality in SCV relative to the population as a whole by at least 10% by 2010. The life expectancy target seeks to improve life expectancy in the worst areas by narrowing the gap with the rest by at least 10% by 2010. *Improvement, Expansion and Reform* includes measures that can help to tackle health inequalities – through means such as increasing breastfeeding, reducing the number of low-birth weight babies, improving the life chances of children, reducing infant mortality and improving life expectancy in the most deprived groups and areas. These are key targets underpinning this NSF. The extra funding coming into health and social services provides an opportunity to make real improvements; many of the changes set out in the priorities framework will deliver improvements for the whole population. Like the Older People's NSF, this NSF will build on those priorities and show what can be achieved if health and social care agencies work with each other effectively, and with communities, to meet the identified needs of this important part of the population. Initiatives such as integrated children's centres and Healthy Schools also underpin the Government's commitment in this area.

2.2.9 Exclusion from ordinary child and family activities and opportunities, and some mainstream and community services and facilities, is commonly experienced by disabled children and their families. Disabled children and their families should be able to participate in valued childhood experiences such as play, leisure and education, and have access to the same range of opportunities, life experiences and mainstream services as other children and families. In addition, some children may be excluded from services for other reasons such as their ethnicity, or perhaps because they live in a rural area where access to services such as leisure facilities is poor. Whatever services are available should be open and accessible to all children to maximise not only their potential in preparation for adult life, but also their experience and enjoyment of childhood and all that it should entail.

2.2.10 There is also evidence to show that children in special circumstances achieve on average poorer outcomes than children in the population as a whole. Looked after children have greater unmet health needs, poorer educational attainment and are more likely to become homeless or go to prison. There is similar evidence for other groups of children, for example:

- children in domestic violence refuges have high levels of unmet health needs especially in relation to mental health difficulties
- children of problem drinkers have higher levels of behaviour problems, school-related problems and emotional disturbance than children in other families
- young people within the criminal justice system are estimated to be three times as likely to have mental health problems as those in the general population
- teenage pregnancy is associated with increased risk of poor social, economic and health outcomes for mother and child.

2.2.11 The most recent Confidential Enquiry into Maternal Deaths (CEMD) provided an indication of the inequalities that need to be overcome in order to provide a truly equitable service to all. It is worth bearing in mind that although the CEMD only covers deaths, similar findings have also been demonstrated in studies in the many more women who suffered a "near miss", in other words who were ill with a life-threatening complication of pregnancy.

2.2.12 The CEMD found that women in the lowest social class, whose cases were almost always associated with severe social exclusion, were 24 times more likely to die than women in the top two classes. Furthermore, 30 per cent of women from vulnerable groups, including those who did not speak English, those who suffered domestic violence and very young mothers, failed to attend for antenatal care until at least 6 months of pregnancy or missed more than four antenatal visits.

- Enhance partnership

2.2.13 *The NHS Plan* seeks to promote partnership between agencies. Nowhere is this more necessary than in meeting the needs of children and families, who consistently express frustration at the poor co-ordination of services. Partnership and co-ordination are key to achieving change and this will involve better, shared use of information. Partnership with the community is also fundamental to the success of *The NHS Plan* and encourages agencies to seek the views of pregnant women, children, young people and their families not only in planning their own care, but also in designing services that meet their needs.

2.2.14 In December 2002, guidance on the production of local authority preventative strategies was published by the Children and Young People's Unit (see paragraph 2.7). Children's Trusts will explore new forms of partnership intended to bring together those responsible for commissioning and, where appropriate, delivering services for children. In all areas, not just those piloting Children's Trusts, partnerships will need to be developed at both strategic and operational levels. Systems and processes, effective communication and teamworking and the use of information in order to support a seamless experience for children will need to be developed in all localities.

Themes for the NSF

2.3 From the earliest discussions, there has been a striking similarity in the issues identified by stakeholders, including young people themselves. This section articulates some of those themes and how they relate to particular groups of children, and will help inform the next stage of development of the NSF.

Prevention and health promotion

2.4 Preventing ill health, accidents and getting into trouble is one of the most important – and sometimes one of the most challenging – roles that parents face. It is also of great significance to the whole community in which children live and is the responsibility of many different agencies. The aim should be for agencies to work together to reduce the risk and the damaging consequences of risks including substance misuse and teenage pregnancy, such as contracting preventable disease. Many public health interventions undertaken in PCTs and local authorities are intended to prevent ill health and accidents which requires a number of agencies to work together collaboratively.

2.5 If children, young people and families are to be helped to reach their full potential, they need ready access to local services which promote health and wellbeing, including emotional wellbeing. The promotion of health needs to be tackled imaginatively, using a variety of media and developing incentives which appeal to children and young people on their terms and in their language. Health promotion for women from pre-conception, throughout pregnancy and after the birth, including encouraging women to breastfeed, is important for women themselves and for giving their baby the healthiest possible start. The information produced should support children and young people in making healthy choices so they can fulfil their potential and maximise their health and wellbeing. Information should be accessible to all women, children and young people including learning disabled women and children and those with sensory impairment.

2.6 Children at risk of poor health and social outcomes can often be identified by professionals from an early age, but often the presence of multiple risk factors is not considered in an integrated way across agencies. Opportunities for early preventive interventions, which would avoid the need for later crisis interventions, are missed and effective interventions are not delivered in an efficient co-ordinated way, which can be in part due to communication and organisational barriers. Screening and surveillance programmes do not consistently reach all sections of the population – in particular, families living in poverty. Improved access to these services is therefore essential but, equally, ensuring that staff have the skills needed to identify problems early is important.

2.7 Many existing prevention strategies, designed to support other NSFs, in particular, CHD, Diabetes and the Cancer Plan, will be equally applicable to this NSF. In addition, the Government is asking all those responsible for planning, commissioning and delivering services to children and young people to agree a co-ordinated local preventative strategy; this will facilitate local discussion. Key areas that need to be tackled include:

- preventing injury
- early detection and intervention for developmental needs and preventing disability
- encouraging children to develop healthy lifestyles and be more physically active
- promoting positive mental health and emotional wellbeing, and building self-esteem
- increasing the take-up of immunisations to reduce the impact of preventable diseases
- comprehensive screening and health surveillance.

Early identification and intervention

2.8 The earlier any potential difficulties are identified, the more potential exists for overcoming those difficulties. Where a serious disease or disability is identified in a child, telling a parent of this diagnosis must be one of the hardest jobs that health care professionals have to tackle. Our vision is of a service where this is always handled with compassion and an understanding of how it feels to be on the receiving end of a serious diagnosis for one's child, including before birth. Wherever possible, additional needs, impairments or rare health conditions should be identified as soon as possible and parents and children informed of these in a sensitive manner. Intervening early requires effective and co-ordinated planning, can help to minimise the impact and can improve the outcome for the child. Early intervention can also be of benefit in terms of reducing the need for costly and unpleasant interventions later on and can substantially improve quality of life.

2.9 Children and young people who are at risk of achieving poor outcomes need to be identified at an early stage and should be provided with a range of non-stigmatising services which meet their needs if they are to fulfil their potential. Children and young people who may be suffering harm should have their needs assessed and be provided with services to protect them. High quality, holistic assessment of the developmental needs of children and their families can help to ensure timely and appropriate intervention and services. A seamless, dynamic assessment that focuses on the child's developmental needs, parenting capacity and family and environmental factors needs to be undertaken collaboratively by relevant professionals/agencies, working with the children and parents, with each contributing to the overall framework of assessment. Workers from different agencies being able to share information about children, subject to confidentiality and consent, can ensure that those at risk of achieving poorer outcomes are offered appropriate services and do not fall through the net. Better identification and follow-up can be achieved by workers having access to appropriate information from other agencies so that they can undertake assessments and intervention on information already generated rather than having to gather the same information several times. All upper tier and unitary local authorities have been asked to develop Identification, Referral and Tracking systems to identify children at risk of social exclusion, refer them to the most appropriate service and track their progress to ensure that they do not subsequently fall through the net (see also paragraph 9.16). This builds on the work of the Connexions Service, which has begun to bring such a service together for all 13–19 year olds, including the development of assessment, referral and follow-up tools.

2.10 Disabled children, including those with serious mental health problems, require a comprehensive diagnosis and assessment to identify the social and physical barriers which may inhibit their access to the best possible quality of life and to the intervention and support services agencies available to help remove some of these barriers. Many families report high levels of unmet need in areas such as information, childcare, equipment provision, therapy services and housing. Effective early intervention is necessary to optimise children's health, social, emotional and cognitive functioning and educational achievement, leading to better outcomes for the whole family. Early interventions for the families of disabled children include timely therapy services and the provision of equipment to promote the child's chances of inclusion in the local community and his or her best possible developmental progress. Using the Department of Health/Department of Education and Skills (DH/DfES) *Together from the Start* Guidance (2002) on services for disabled children aged 0–2, can help provide effective early identification and intervention. DfES/DH are currently running an Early Support Pilot Programme to develop good practice on implementation (www.espp.org.uk).

2.11 There is increasing evidence of the importance of the early identification of children with mental health problems. When such problems are well-established and persistent, the levels of impairment are greater and interventions may be more difficult to implement. All agencies have a part to play in recognising the early signs of a child in need of additional help, and should be capable of providing such help, before referral to more specialist services becomes necessary.

2.12 Prenatal and antenatal services have a role in the early identification of conditions that might put either the mother or her child at risk. Plans can then be made to manage the pregnancy and birth accordingly or to start preparing for early or ongoing treatment and support of the woman or her child.

Empowerment, self-management and family support

2.13 Any family may need support at some time during their child's journey to adulthood. Each stage of childhood, from pregnancy onwards, brings its own unique challenges, frustrations and rewards – from the crying baby to the troubled teenager. Supporting families should be the responsibility of the whole community and of many agencies in the statutory, independent and voluntary sectors whose role can include providing information and support in times of crisis, short term breaks and providing a key worker to guide the family through the system.

2.14 Knowing at what point to seek help for a child who is sick or in trouble is difficult for every parent or carer. The modern NHS and Social Services provides many alternatives to the traditional sources of medical advice, including Walk In Centres, Family Centres and NHS Direct. Systems are needed to give parents and pregnant women the confidence to deal with minor childhood or pregnancy-related problems, which do not need medical help, and to know what to look out for which might be more serious. Enabling and empowering people to take responsibility for maintaining their own and their family's health is key to driving up the standards of services for those who do need professional help.

2.15 Parenting style is known to have a pervasive influence on health and wellbeing in adult life, especially mental health. Group-based and individual parenting advice, including home visiting support, can improve a range of outcomes in varied settings, including in socio-economically deprived families and families whose children who have behavioural problems. However, the availability of such support is patchy and not sustained; take-up is often low due to restrictions on access, lack of publicity, transport and childcare problems.

2.16 It is important that children's and parents' views are sought, recorded and taken into account when assessments are undertaken and plans made to deliver services including medical treatment, in a way that is appropriate to the age and developmental stage of the child (including children with complex communication needs). Disabled children and those with long term conditions can help to plan their own treatment goals. Pregnant women, children, young people and parents also need to be involved in making decisions about the planning, development and design of services generally to ensure that services are accessible, respectful, empowering and responsive to their needs. Ensuring user participation in designing and improving the quality of services is key to *The NHS Plan*.

2.17 User involvement is also vital in planning maternity services. Women need to be empowered to participate in and own their own care plans; and women, their families and the public should have a voice in planning and evaluating local maternity services.

Child-centred care

2.18 Reports on children's services frequently call for care to be child-centred, but without being explicit about what that entails – it is easier to describe and identify where services have failed to be child-centred. The NSF will articulate what is meant by truly child-centred services. Part of this is in acknowledging that children are different from adults for several reasons:

- Children's physiology differs from that of adults and changes as they grow and develop.
- Children suffer from a different range of diseases and disorders to those commonly seen in adults. This includes a number of rare and often complex congenital and inherited disorders.
- Children's cognitive capacity, and level of understanding, for example, about their bodies, illness and death, may differ from that of most adults and changes as they develop.
- Children's legal status, for example, in respect of consent to treatment, differs from that of adults, and changes, in the eyes of the law, at certain key points in chronological age, and with development and emotional factors.
- Children are more vulnerable to abuse than most adults, and have a greater need for safeguarding.
- Children using health services are usually accompanied by a parent or other responsible adult. This person may have distinct legal rights in respect of the child, for instance, over consent to treatment. They will also have their own needs, for example, for explanation and reassurance.
- Children are strongly affected by the context in which they live. Usually their most important context is a family; followed by a school, groups of friends, neighbourhood and community.
- Children will become adults; and there is a growing understanding of the effects of childhood experiences, including illness, on their adult life.

2.19 Set against this background, much of what made Professor Kennedy so angry about what he saw of the services offered to children in hospitals falls into place. Kennedy found services that treated children as if they were simply mini-adults, 'needing smaller portions'; that made little effort to tailor explanations to the understanding of children or their carers; and that failed to note significant contextual matters that might affect the progress of disease and recovery. He found staff skilled in treating adults; but with no specific additional training in treating children; and facilities designed with little acknowledgement of the differing needs of small children, older children, adolescents, parents and carers. He found hospitals operating in self-contained worlds, as if the prior experience of the child in front of them had no bearing; and as if what happened to them afterwards, or outside the hospital, was of no concern.

2.20 Although Kennedy was describing the care of children in hospitals, these shortcomings apply in many of the services our EWGs observed. To address this, many initiatives have prescribed child-centred care as a means of looking at the 'whole child' rather than as a presenting illness or problem. Schemes such as *Sure Start* have found innovative ways of placing the child at the centre and reshaping services.

This involves listening to the views of children and their families, including their need for advocacy, recognising their emotional and psychological as well as their physical needs, and delivering services that are appropriate to their particular age and stage of development. Key to this is that agencies should work in partnership in a co-ordinated way with care delivered by multi-disciplinary teams following a coherent pathway. Use of joint finance and joint commissioning of services, particularly using Health Act flexibilities, is one way of achieving this. Children's Trusts are another.

2.21 For disabled children, including those with learning disabilities, locality based multi-agency arrangements covering education, social services and health are essential to improve planning, commissioning and monitoring of services. Effective partnership working can be enhanced by the use of locally based and nationally compatible, multi-agency databases containing core data on disabled children, including shared and agreed definitions. The role of someone to act as key worker for children and families with high levels of need is something that would help to achieve this.

2.22 Professionals working with adults with a range of problems which might impact on their parenting capacity also need to consider whether those adults have children. Many children are in special circumstances because of the needs of their parents or carers – often those special circumstances are that the child themselves acts as a carer. Many of these adults will be receiving services to help address their needs, for example, the children of parents with alcohol-related problems. It is vital, therefore, that when adults who have caring responsibility for children are receiving such services, these take account of the developmental needs of the child. Systems are needed to ensure that their parenting capacity is assessed and that the needs of children or any future children are assessed. Equally, services provided to a young carer should consider the needs of their family and parents, rather than addressing each individual in isolation from their family context.

Woman-centred care

2.23 In the maternity workstream, the priority is to ensure that maternity services are sensitive to each woman's needs. From pre-conception to post-birth it will focus on the woman's needs and expectations. It will seek to offer women greater choice over maternity services. There needs to be an emphasis on promoting normality in pregnancy and childbirth for all women when appropriate, balanced with early identification and management of relevant social, medical and psychiatric problems. Services also need to focus on how best to involve the father in the process of supporting his partner and his child.

Transition and growing-up

2.24 Watching their offspring develop from dependent and biddable children to self-centred, self-conscious teenagers with a seemingly inexplicable penchant for loud music, late nights, unhealthy food, mobile phones and their own generation's unique language and values can be extremely trying for parents, as can progression between any of the other stages of childhood. Supporting young people and encouraging them to start to make their own way in life and take responsibility for their own actions and decisions is essential if they are to grow up into independent adults. If moving to adolescence brings with it challenges for all families, those with additional and sometimes complex needs such as mental health problems or special educational needs may find it more difficult to make these transitions successfully and may require additional support. The Connexions service offers support to all young people at this crucial stage which, according to their needs, might be some simple advice and guidance on options up to intensive support from a personal adviser to help them identify aspirations and barriers and broker a holistic package of specialist support.

2.25 The different stages of a child's life will be considered throughout the NSF since different services are needed along the way which are sensitive to the young person's stage of development. There is no convenient 'one size fits all' policy for meeting the needs of young people with particular problems, and flexible services which allow some choice are needed.

2.26 Transitions between different services are also key to meeting the needs of children and young people. Young people with a long term medical condition, for example, will frequently need to move to adult services. There should always be a smooth transition from children's to adult services. Moving from, child to adult specialist cardiac or mental health services, for example, should not be a frightening experience or one that results in an apparent downgrading of care, which is how it is frequently perceived at present. It should be part of a managed and co-ordinated process with the young person and family fully involved at all stages.

2.27 There is growing evidence that childhood experiences including illnesses and treatments have repercussions in later life. These can include both physiological problems such as infertility as a result of early drug treatment for cancer, or mental illnesses such as a first episode of psychosis. The use of any interventions will, therefore, need to include an evaluation and open discussion of what is likely to be best for the child in the long term.

2.28 Disabled young people often have poor experiences of transition support. They need high quality, multi-agency support allowing them to have choice and control over life decisions and, in particular, to maximise education, training and employment and leisure opportunities with a view to living independently. High quality transition services need to be delivered in a multi-agency context. The Connexions service has a specific role in providing support to young people with statements around the transition to post-16 education, training or employment – working with them to identify their needs and broker appropriate provision and support.

2.29 The NSF for mental health recognised the importance of ensuring the smooth transition of care for young people from Child and adolescent mental health services (CAMHS) to services for adults. When the mental health care of a young person needs to transfer to services for working age adults, a joint review of the young person's needs must be undertaken to ensure that effective handover of care takes place. This should be incorporated into a care plan under the Care Programme Approach arrangements for adult services.

Safeguarding

2.30 Children, when asked what their priorities are, identify the overriding need to feel safe – safe to walk the streets or to participate in normal family or school life without risk of danger. Sadly, not all children are able to do so. The *Victoria Climbié Inquiry* will inform the development of the NSF over the next years but, inevitably, the need to protect all children from harm should be recognised in every setting of care, as well as educational settings where children spend much of their time. A first draft of the aim for safeguarding and suggested actions is at Annex B. This will be further developed as Lord Laming's report into Victoria Climbié's death is considered in more depth.

2.31 Children have a right to be protected from harm and those children who have been abused should have their needs and those of their carers assessed in order to provide appropriate support and services. All adults have a responsibility to protect children from significant harm, emotional or physical. What is needed are services which will prevent children from being subject to significant harm, safeguard children who are suffering or likely to suffer significant harm, and facilitate the full recovery of those children who have suffered harm. The needs of all children including those who are disabled, who are at higher risk of being abused, need to be addressed.

2.32 The hospital standard will define the interventions needed to deliver safe clinical practice – errors in relation to children can be catastrophic and the consequences more complex than in adults. Reducing the risk of clinical errors and learning from mistakes where they do occur is an integral part of clinical governance for children wherever they are treated.

2.33 Negligent maternity care, which results in damage to the baby, is a catastrophe for the baby and the family. Maternity services amount to less than 5 per cent of all care in the secondary sector but account for 50 per cent of all monies paid out in litigation. The government has already expressed a wish to reduce negligent harm by 25 per cent before 2005 and the standard set out for maternity services will aim to facilitate optimal care and reduce disastrous outcomes.

Access

2.34 Our vision is of an equitable access for all children and pregnant women, whatever their circumstances, to appropriate and responsive services in a variety of settings and locations when needed. Although improving access, including reducing waiting times, is one of the key targets in *The NHS Plan*, children and young people have additional needs that affect their ability to access services. A trip to the GP's surgery for a mother with a sick toddler and a baby in tow can be quite a challenge, particularly for a family in a rural area or in any area where transport is poor, and making this whole experience more convenient and less stressful is a challenge for children's services. Providing greater choice is essential so that people can choose between different settings of care (such as primary care, Walk In Centres or extended schools) or even between different service providers (ie hospitals in different locations). Electronic booking will be rolled out, improving convenience for patients. The NSF will consider how Out of Hours services can be improved to meet the needs of children and families.

2.35 Schools – working closely with other bodies such as PCTs and social services – are being encouraged to develop 'extended' services such as health and social care, and parenting support services. These might include services aimed specifically at children and young people, or could include universal services for the whole community, such as a GP's surgery. 'Full service' type extended schools will be created in the most deprived areas, offering health and social care alongside childcare, adult and family learning and other services; and support will be provided to other schools who wish to develop such services. Besides providing easy physical access to services in a less stigmatised environment, extended schools will enable a comprehensive joined up approach to service provision for pupils, families and the whole community. The provision of readily accessible and young-person friendly health and social care services clearly has the potential to improve pupil's physical and mental health and can have positive effects on motivation, attendance, behaviour and achievement. The DfES publication *Extended Schools: Providing Opportunities and Services for All*, provides guidance on developing school-based services.

2.36 Teenagers who think they may be pregnant should be able to seek help and advice in a variety of ways. Young people identify a range of barriers to accessing services, in particular concerns about confidentiality, lack of understanding about the services available, a perception that services are unwelcoming and uncertainty as to whether professionals will take them seriously. These concerns need to be addressed if we are to meet their needs effectively.

2.37 All disabled children and their families need equitable access to services (health, education, play and leisure and social services) irrespective of their impairment, ethnicity, social circumstances or geography. Care and support services promoting inclusion that are sensitive and responsive to the child's developmental needs and cultural needs, are known to be most effective in producing good outcomes.

2.38 Services need to be delivered in a way that ensures that they are accessible and appropriate for all children and young people in a range of special circumstances (see paragraph 6.2). There is evidence that children in special circumstances often have greater health needs than the general population but conversely have more difficulty accessing services. Take-up of services by different groups of children should be monitored as a way of ensuring that there really is equitable access for all.

2.39 For pregnant women, access to the right care at the right time in their pregnancy is key to ensuring a good outcome for themselves and their baby. There are marked differences across the country in the availability of different kinds of maternity care which need to be addressed. Maternity services need to be designed to encourage early access; they need to be visible and clearly geared to the needs of the local population. All women need easy access, where appropriate, to community, hospital and specialist services. All babies will need good care in the neonatal period from their mothers, supported by health care professionals.

The following sections give a very brief overview of the work of the EWGs and the issues identified and shows the relevant objectives, targets and capacity assumptions in *Improvement, Expansion and Reform.*

3: Healthy Children and Young People

Aim: To promote accessibility to, and high quality in, the universal services which every child and young person needs, from birth to age 19, to achieve optimum health and wellbeing.

3.1 All children and young people will need to access some services between birth and adulthood. It is recognised that children do not fit into neat categories and that a child can be ill one day, and healthy the next – or troublefree one day and troubled the next. The NSF will set standards to support children in their development, maximise their potential and deal with any difficulties encountered on the way – whether these are in the area of mental health or risk-taking activities. However, there are some services which every child needs – such as immunisation, primary care and dentistry. Being a child who is disabled or looked after should not prejudice the right to these universal services and the NSF will address the needs of all children.

3.2 Children and young people often do not access the services they need: this is particularly true of children and young people most at risk of poor health outcomes in whom it can be far harder to identify conditions such as mental health problems. Too often, services are designed with adults in mind. Referral mechanisms can be unco-ordinated and complex, and fail to effectively track individuals to ensure they receive the full range of care they need. Better outcomes may be achieved through more joined-up working between various partners and agencies, and new and better ways of sharing information. We need flexibility at the point of delivery to ensure those with most difficulty accessing services get something that from their point of view is worth the effort. The development of local preventative strategies, supported by systems for identification, referral and tracking of children and young people at risk of social exclusion, should facilitate this. The Connexions service is being set up with young people at the heart of its design and delivery, giving them a real voice in the way services are delivered, and in some cases providing a personal adviser who can help ensure that specialist interventions are co-ordinated.

3.3 Families living in poverty make less use of health services, especially preventive health services, and demonstrate poorer health and social outcomes. There is a marked social gradient in the prevalence of poor health and social outcomes, such as infant mortality, dental caries, poor mental health, substance misuse, smoking and teenage pregnancy. Accidental injury is amongst the most common causes of death in childhood and disproportionately affects children from poorer families, in particular deaths from house fires and road accidents. The amount of physical activity undertaken by children has decreased, both in and out of school, and levels of overweight and obesity have increased since the mid-1980s. As part of the government's overall strategy to increase physical activity DfES and DCMS are implementing the PE, School Sport and Club Links Delivery Plan. This will enhance sports opportunities for all children but in particular those who are currently marginalised within school sport. The importance of establishing healthy eating patterns early in life is widely recognised. It is also the case that England does not compare favourably with other European countries on key indicators of child health in the general population, for example, obesity. The importance of establishing healthy eating patterns and developing a healthy lifestyle early in life is widely recognised. Through the delivery of effective Personal, Social and Health Education children should learn about what makes a healthy lifestyle and how to make informed choices.

3.4 There are a limited number of common conditions, such as constipation and asthma, that account for a large proportion of contacts with the health service, but there are significant variations in how effectively these conditions are treated. Children, young people and their carers will all need access to good quality clear information at times – perhaps to help them manage a minor illness themselves, to support those in the roles of parents or carers, or to know what services are available locally and where they can get help.

Improvement, Expansion and Reform sets out the following objectives, targets and capacity assumptions:

Reducing health inequalities:

NHS improvement, expansion and reform should narrow the health gap by:

- ensuring that the distribution of health benefit from service expansion and development consistently favours individuals and communities that have been traditionally under-served;
- tackling the wider determinants of health – agreeing a single set of local priorities with local authorities and other partners, contributing to regeneration and neighbourhood renewal programmes, and ensuring the NHS makes a full contribution to support the *Sure Start* programme.

The following targets are relevant:

- Deliver an increase of 2 percentage points per year in breastfeeding initiation rate, focusing especially on women from disadvantaged groups.
- Achieve agreed local teenage conception reduction targets while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter in line with national targets.
- Improved access to services for disadvantaged groups and areas, particularly:
  - Child health screening services
  - Sexual health services.

Smoking (cancer):

- Reduce the rate of smoking, contributing to the national target of: reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the 4 week stage by 2006.

Drug misuse:

- To contribute to delivery of the National Drugs Strategy by reducing the harmful effects of substance misuse. This will be achieved through expansion and improvement of drug treatment services, and by contributing to the Strategy target to reduce the use of Class A drugs, and frequent use of any illicit drug by young people.

4: Maternity

Aim: To define the standards that will enable childbearing women and babies to achieve optimum health and wellbeing.

4.1 To promote the best outcomes for women, babies and their families, maternity services need to be woman-focused; involving service users in all aspects of care and service provision. It is important to promote normality throughout pregnancy and childbirth, while balancing this with early identification and management of relevant social, medical and psychiatric problems. A key theme of the maternity workstrand is reducing inequalities in health and in access to services. Services will need to meet agreed standards of care for all women and babies. Achieving this will involve developing the workforce's skills and competencies and enhancing communication and teamwork between health care professionals, with social care professionals and with women. Collecting high quality maternity information is necessary for effective audit and planning. Services also need to focus on how best to involve the father in the process of supporting his partner and his child.

4.2 To ensure that women and babies get the best possible care, individualised care plans based on informed choice need to be agreed by the woman and health care professionals throughout pregnancy, childbirth and into the post-birth period. Taking into account the needs and preferences of the woman and her family, a good antenatal/birth care plan offers appropriate and realistic options for place of birth, appropriate care and support in labour and is backed up by co-ordinated emergency care provision for both the woman and the baby.

4.3 In the post-birth period, the two main aims are to give the newborn baby the best possible start and help the mother recover fully from the birth both physically and mentally. Postnatal services include building on the support and information to the woman and her family already given in the antenatal period; supplemented, as necessary, by tailor-made plans to meet the individual needs of women and babies. Diagnosing and treating postnatal depression is key since this is known to have a long term impact on the child and the family. Services should include appropriate care for:

- Healthy babies;
- Babies with specific needs (for example, resulting from prematurity, or disability);
- Vulnerable women with physical and mental healthcare needs, including postnatal depression and teenage parents; and
- Families experiencing pregnancy loss or bereavement.

4.4 From pre-conception to post-birth all women need to have appropriate access to community, hospital and/or specialist services, including women with:

- Healthy and uncomplicated pregnancies;
- Complicated pregnancies due to medical, psychological or social reasons; and
- Ethnicity, poverty or social exclusions issues, – eg prisoners, women with enduring mental health problems, women with disabilities, and women from transient populations.

4.5 This can be helped by: setting standards of care to reduce health inequalities; recognising cultural diversity and providing appropriate communication and support; and by providing flexible services, for instance considering innovative approaches for women who have difficulty accessing services.

Improvement, Expansion and Reform sets out the following objectives, targets and capacity assumptions:

Reducing health inequalities:

- To reduce inequalities in health outcomes across different groups and areas in the country. Initially the focus is on reducing the gap in infant mortality and life expectancy at birth.
- Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between “routine and manual” groups and the population as a whole by 2010, starting with children under one year.
- Improved access to services for disadvantaged groups and areas, particularly antenatal services.

5: Disabled Children and Long Term Conditions

Aim: To ensure that disabled children and young people enjoy the highest quality of life possible, gain maximum benefits from educational opportunities, health care and social care, and that their needs and those of their families are promptly and sensitively addressed and their choices respected.

5.1 There are approximately 320,000 disabled children. 110,000 of these are severely disabled and 2,265 disabled children were looked after by local authorities (as at 31 March 2001).

5.2 Due to medical advances, the life expectancy of severely disabled children is improving and there are growing numbers of families now caring for severely disabled children at home. A third of parents with a severely disabled child under the age of 2 use more than three pieces of equipment daily to provide basic care. Four out of five 12 to 14 year old severely disabled children need help with self-care eg feeding, washing, dressing and toileting. There is also concern about the increase in the number of children being diagnosed with autism. Families of disabled children often require support from a wide range of agencies, including health, education and social services. Disabled children want to join in with family life, to enjoy valued childhood and teenage experiences and to develop their independence. However, many disabled children are excluded from these activities. Implementation of the Disabled Discrimination Act 1995 should help to improve the situation for these children.

5.3 There is a compelling body of evidence from research and inspection reports that disabled children and their families do not always receive the support they need and face many social and physical barriers to full participation in society, for example, unequal access to education, employment, leisure activities, housing, and health care. There are also particular concerns about services for children with life-limiting and life-threatening conditions. The government's White Paper (DH 2001), Valuing People, A New Strategy for Learning Disability for the 21st Century took a life long approach to disability from childhood to old age, recognising that disabled people have enduring needs for support and that learning disabled people moving from children's to adult services sometimes fall between the gaps in services.

5.4 Families need a seamless child and family-centred service that addresses all types of need, provides continuity across all transitions in the child's family life, and is not limited by separate agency roles and responsibilities. A diagnostic and assessment process carried out promptly and leading to an agreed multi-agency plan can best meet the family's needs. In particular, many children require the timely provision of therapy services and community equipment services to help encourage inclusion in local community and the best possible developmental progress. Many disabled children will have a special education need and require multi-agency support to enable them to attend their local mainstream school. Flexible child-care and short term breaks can reduce the need for more expensive services.

5.5 To improve co-operation between social services, health service, schools and Local Education Authorities (LEAs), some areas have multi-agency groups at a senior level to plan and commission services. Some groups also involve housing, transport and leisure services to promote inclusion in community and report to Local Strategic Partnerships. Many have included *Sure Start*, Early Years Development and Childcare Partnerships, and local Children's Funds in this group. Some have undergone reviews to consider how to improve service provision by using Health Act flexibilities and co-location of services from a multi-agency base. Some are considering how to include disabled children in local proposals for 'extended schools'. Others have set up shared databases of core data and are using agreed definitions when planning services and sharing information. Some agencies have reviewed services using DH/DfES guidance *Together from the Start*, and have protocols around joint/complementary assessments which implement fully the *Framework for the Assessment of Children in Need and their Families* and the SEN Code of Practice. When improving multi-agency working, many agencies have found using workforce training on disability equality and inclusion issues very effective. Some agencies are jointly reviewing services to meet the particular needs of the growing numbers of children with autism and those with complex and continuous health needs. The active involvement of children and parents in decisions regarding their treatment, care and service planning, is seen as key to service improvement.

5.6 Following the setting up of Learning Disability Partnership Boards and Connexions Partnerships, many agencies are reviewing their services so that disabled young people can access high quality multi-agency transition services into adulthood, which allow them to have choice and control over life decisions and, in particular, to maximise education, training and employment and leisure opportunities to live independently.

5.7 The work on disabled children will look to build on the progress made by the *Quality Protects* programme which has included specific, ring-fenced funding for improving services for disabled children and their families since 2001/02. The government set objectives for disabled children which are a social services lead priority, but requiring joint working with the NHS, education and the voluntary sector. Next year (2003/04), the ring-fenced money will double from £15m to £30m. The Carers and Disabled Children Act 2000 introduced direct payments for parents with disabled children to increase choice and flexibility for families in accessing the service of their choice. Following recent changes to the regulations governing direct payments, councils now have not just a power, but a duty, to make direct payments. Inclusion of children in the Carer's Grant is also leading to increases in the levels of provision of short term breaks for parent carers. The Carers Grant is increasing on a year by year basis and will, by 2005/06, double to more than £185 million. It is expected that 20 per cent each year will be spent on children's services.

Improvement, Expansion and Reform sets out the following objectives, targets and capacity assumptions:

Make plans to improve the provision of short term breaks for parent carers from the increased investment in the existing Carers Special Grant, 20 per cent of which has to be spent on Childrens Act services. This will be £20 million for 2003/04.

In addition, in line with the *Quality Protects* programme:

- Jointly review how the £30 million available in 2003/4 through the Quality Protects programme is being used to improve services for disabled children and their families, so that they receive appropriate, and well co-ordinated, health and social care services.

- Increase the use of Direct Payments to parents on disabled children to give maximum flexibility over how, when and where support services are arranged.

6: Children in Special Circumstances

Aim: To ensure that children and young people in special circumstances are provided the most appropriate services to help maximise their social, emotional and physical development within, where possible, stable family settings; and, by doing so, narrow the gap in outcomes between children and young people in special circumstances and their peers.

6.1 This section in particular will need to take account of the proposals to be set out in the Green Paper on Children at Risk to be developed over the next few months, and the recently published Inquiry Report on Victoria Climbié which has recommended changes in the way that services are delivered. The work of the cross-cutting Spending Review 2002 on Children at Risk has been taken into account in developing these emerging findings. In addition, the emerging findings of the Children in Special Circumstances External Working Group looks to build on the success of *Quality Protects* – a five year £885m programme to improve the lifes of children in need. *Quality Protects* has been the main driver for delivering the *Improvement, Expansion and Reform* targets to improve the lives of looked after children. A draft standard on child protection is included for consultation at Annex B. Further work will be done to refine this in the full NSF and to ensure that it is supported by clinical governance and quality assurance arrangements, in the light of the government's response to *The Victoria Climbié Inquiry*.

6.2 The term 'children in special circumstances' covers a variety of groups of children whose particular circumstances will often lead to them achieving poorer outcomes than their peers. This has been used instead of the narrower 'children in need', as defined in the Children Act 1989, to encompass a broader group of children but in any local population is likely to include:

- Children and young people living away from home; including those looked after by local authorities, those privately fostered, young people living independently and children and young people who go missing from home or from care.
- Children engaged or who have been engaged in anti-social or offending behaviour, including those in secure accommodation or Young Offenders Institutions.
- Asylum-seeking children, both with families and unaccompanied.
- Children with troubled parents, for example children of substance misusing parents, children living with domestic violence, children whose parents have mental health problems, children with parents in prison, and young carers.
- Young parents.
- Children who are abused, including children and young people abused through prostitution.

6.3 The definition of children in special circumstances should be used in an inclusive way to cover all children whose circumstances mean that they are at risk of achieving poorer outcomes. It should not be used to ration services.

6.4 Over a third of a million children in need, as defined by the Children Act, were known to social services departments in England in a typical week in 2001, including about 12,600 asylum-seeking children. It has been estimated that there are almost a million children living in a family with a problem drinking parent, around 125,000 children with a parent in prison, 100,000 children who are homeless and 50,000 or more young carers. Some 90,000 teenagers become parents in England each year and the number of young people in secure units or prison is rising.

6.5 Children in special circumstances may need help from specialist services to meet their needs. Equally, however, mainstream, universal services need to be accessible and meet the needs of children and young people in special circumstances. There is evidence that some children in special circumstances have poorer access to mainstream services. For example, children living in domestic violence refuges often find it hard to access services and a third of looked after children do not have an annual dental check.

6.6 From 2003/04 LEAs will have access to £84m of Standards Fund money through the new Vulnerable Children Grant. This new grant brings together a number of smaller grants and makes a considerable increase. Its objective is to secure improved access to education for vulnerable children. It will provide high quality education for those unable to attend school or whose circumstances make it difficult for them to do so; support attendance and reintegration into school and provide additional educational support to enable vulnerable children to achieve their full potential. Key groups are: looked after children; children who are unable to attend school because of medical needs; traveller children; asylum-seekers; young carers; school refusers; and teenage parents.

Improvement, Expansion and Reform sets out the following objectives, targets and capacity assumptions:

Ensure the NHS and local government work together to improve life chances for children by:

- promoting the secure attachment of children to carers capable of providing safe and effective care for the duration of their childhood;
- enabling looked after children to gain maximum life chance benefit from educational opportunities, health care, social care and other services;
- engaging fully with the ongoing development of cross-agency preventive work to support children and families, including local prevention strategies, and the continued development of *Sure Start* and Children's Centres.

Targets:

- Substantially narrow the gap between the educational attainment and participation of children in care and that of their peers by 2006.
- Improve the level of education, training and employment outcomes for care leavers.
- Reduce by 2004, the proportion of children aged 10–17 and looked after continuously for at least a year who have received a final warning or conviction, by one third from September 2000 position.
- Maintain current levels of adoption placement stability… whilst increasing the use of adoption.

National capacity assumptions:

- Improvement in the stability and quality of placements for looked after children including through recruitment/retention and support to foster carers over this period to support targets in line with the Choice Protects Review.

The target for reducing local conception is also relevant to improving the life chances of children in special circumstances.

7: The Mental Health and Psychological Wellbeing of Children and Young People

Aim: **To meet the needs and views of children and young people with mental health problems, together with those of their families and carers, in order to improve their life chances within family, social and educational settings. This requires access to appropriate, high quality services that respect difference and diversity, take into account the best available evidence of effectiveness, and are delivered within a reasonable time frame and in an appropriate setting by a competent, skilled and supported multi-disciplinary workforce.**

Rationale

7.1 There is clear evidence about the level of mental health needs of children and young people. Several studies suggest that up to 2 million under 16 year olds in England may require help at some time, of whom about half suffer from mental health disorders and a smaller number have severe mental illnesses. Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers continuing into adult life and affecting the next generation.

7.2 Recently there has been a concerted effort, nationally and locally, to improve service provision. Significant progress has been made through the establishment of local multi-agency Child and Adolescent Mental Health Services (CAMHS) Development Strategies. This has resulted in greater co-ordination of services in many localities and increased recognition across children's agencies of the central importance of children's mental health. The challenge now is for commissioners and providers to respond to *Improvement, Expansion and Reform*, which states that CAMHS should provide comprehensive services (including early intervention and health promotion) by 2006. This stated that the Children's NSF and its emerging findings would set out the standards and milestones for improvement in CAMHS, including year on year improvements in access. Commissioners and providers need to target the new investment wisely, to ensure that a comprehensive service is available to every child and family (Annex C sets out the elements of a comprehensive service).

7.3 Children's mental health is everyone's business – all people, agencies and services in contact with children and young people have a part to play. The ability of each to contribute effectively depends upon the level of training and support they receive, including that from specialist CAMHS. In turn, the ability of CAMH services to respond and to meet the needs of the population they serve relies on their capacity, capability and organisation.

Commissioning

7.4 High quality commissioning is vital for CAMHS. Hence commissioners need the appropriate skills, knowledge, time and authority to commission effectively. There should be full participation and ownership of the commissioning process by health, social services and education with effective links with all other key partners. Use should be made of lead or joint commissioning arrangements as required with appropriate use of pooled budgets and other Health Act flexibilities.

7.5 The planning and commissioning of a comprehensive service should be informed by a regularly updated multi-agency assessment of need, taking account of the needs of groups for whom there is currently poor or no provision. These include children with learning disability, autistic spectrum disorders, minority ethnic groups, children and young people requiring in-patient care, children and young people with behavioural problems and those in the criminal justice system. This should be incorporated into the local CAMHS Development Strategies for all four tiers and should be informed by clinicians' and users' views. Early intervention and mental health promotion should be offered in every locality. PCTs need also to clarify the arrangements for commissioning and funding the more highly specialist services (including Tier 4), taking account of the regional or supra-regional nature of the provision and the definitions for specialised services.

7.6 The current level and deficits in provision, across the tiers and over the age range 0–18 years, should be established by reference to the multi-agency mapping of services and their usage. This should include an audit of staffing of all specialist CAMHS so that developments in service provision are linked to workforce and training requirements. Each locality will need to make clear decisions about the relative priorities between the many agencies and services to which CAMHS have a contribution to make.

Partnership

7.7 Services, including for those whose needs are complex and persistent, have to be co-ordinated and integrated across health, education, social care, youth justice and voluntary sector agencies. There should be effective joint provision of services and smooth transitions between tiers and services when required. Services should be organised around the child. Specific skills are needed for the consultation/liaison involved in partnership work and joint training is needed for effective collaborative working.

7.8 Examples where multi-agency partnership within CAMHS is essential include:

- Child protection and post-protection services as set out in the recommendations of *Working Together to Safeguard Children*; contributing to the assessment of complex child abuse cases, to the assessment and provision of post-abuse therapeutic services and to services for looked after and adopted children.
- Delivery of services to children and young people with significant behavioural difficulties ('conduct disorder'), who are at risk of exclusion, and which should be based on agreed protocols.
- Agreements between health, education and social services, and youth justice, which may need to be organised across several PCTs/boroughs, for the joint funding, assessment and provision of services, including specialist residential provision when required, for children and young people with complex, severe and persistent behavioural and mental health needs. There need to be contingency arrangements for tackling unusual cases.
- The assessment and provision of the educational needs of children and young people with mental health problems, including those with special educational needs and/or learning disabilities, whether they are living in the community, in hospital or in residential settings.

This can include planning to contribute to locally agreed joint initiatives such as behaviour and educational support teams (BESTs).

- Appropriate, negotiated, resourced and integrated CAMHS contribution to youth justice services.
- Protocols between CAMHS and Adult Mental Health Services to ensure collaborative working arrangements and joint provision, where appropriate.
- Arrangements for joint training and provision for the identification, support, safeguarding and assessment, where appropriate, of children of mentally ill and drug and alcohol dependent parents and those in families subject to domestic violence.
- Development of Early Intervention teams for young people with a first-episode psychosis that effectively integrate child, adolescent and adult mental health services through joint commissioning and collaborative working arrangements.
- Collaborative arrangements with paediatric units and wards for the joint care of children, where appropriate, protocols for the management of deliberate self-harm and the availability of paediatric liaison by CAMHS professionals.

Developmentally appropriate care

7.9 There needs to be clarity about the age range for which CAMHS is the appropriate provider; and better handling of any transition to adult mental heath services. The expectation is that over the period of the implementation of the NSF, CAMHS will make the transition to covering the age range 0–18 years. This requires local agreements for handling referrals of young people between the ages of 16–18 years and for the effective, flexibly organised transition of care for young people from CAMHS to adult services. The impact of extending the age range for CAMHS at local level will need to take account of the resources required to meet the increasing incidence of severe mental illness in later adolescence. In the meantime, further attention needs to be paid to the safety of young people cared for in adult psychiatric beds until sufficient adolescent beds become available. We strongly recommend the adoption of one of the existing sets of standards for in-patient units. (Quality Network for In-patient CAMHS.)

Evidence-based practice, training and a skilled and competent workforce

7.10 Commissioners and providers should ensure that the skills and competencies of the CAMHS workforce at all levels of service provision meet the mental health needs of the population served. In addition to the generic skills that are required to work with and support children, young people and their families, this requires that the workforce should be trained, supervised and supported to be capable of delivering a full range of interventions, based upon the best available evidence. Considerable advances have been made in establishing a firm evidence base but where this is limited, creative and innovative practice should also be encouraged, taking into account the views and wishes of the users of the service and subject to the process of audit and evaluation.

7.11 There are significant and new training requirements for services if we are to provide high quality and accessible CAMHS. All local services should collaborate to provide for their CAMHS training needs. This applies to all those who have a role to play in support of children's mental health professionals across health, social care, education, youth justice and the voluntary sector (Tier 1); to the established CAMHS professions including nurses; and for the emerging workforce, whom it is hoped to recruit to newly designated roles within the child mental health services, such as child mental health workers and paediatricians with a specialist interest in child mental health.

Service composition

7.12 A critical mass of staffing is required for services to be safe, timely and effective and able to respond to the wide range of needs which include: specialist and multi-disciplinary services (Tiers 2, 3 and 4), support, consultation and face-to-face work within primary care settings (Tier 1), teaching, training, consultation and liaison, research and audit. The precise level of staffing will vary according to indices of deprivation, whether the service is in a rural or urban setting, and teaching responsibilities. As services take on the new responsibilities determined by the NSF, additional staffing may be required locally.

7.13 People with the necessary skills and competencies to deliver a comprehensive CAMHS include child psychiatrists, clinical child psychologists, CAMHS trained nurses, occupational therapists and other allied health professionals, social workers, child and adolescent mental health workers, child psychotherapists, family therapists and specialist teachers. Community paediatricians also make a significant contribution to the service. Depending on the particular service delivered, teams should be able to offer a full range of therapeutic modalities. Professional and team isolation should be avoided and CAMHS professionals should work closely together to ensure that services are well-integrated across the tiers and agency boundaries.

7.14 The infrastructure to support the delivery of high quality services includes the provision of a dedicated CAMHS manager, administrative and secretarial support, networked IT, telephones, offices, buildings which are appropriately designed and decorated to meet the needs of the users in an age appropriate way and the availability of clinical resources such as play material, video equipment and one way screens.

Access

7.15 Services need to be offered as near to home as possible and in a number of settings to take account of the different needs of infants, children, young people and their parents and carers. They should include locations such as schools, homes and family centres, which may be perceived as less stigmatising, as well as traditional clinic settings.

7.16 The care of seriously disturbed children and young people (Tier 4) should be provided by a network of services that include NHS, social care and youth justice provision, voluntary sector and the private sector, offering in-patient/residential, day-patient, in- and out-reach and therapeutic foster care. These services should be closely linked to the local community CAMHS. In many parts of the country and for some groups of children, for example those who are learning disabled, this will require a significant investment in, and development of, new staffing, additional buildings and refurbishment of current facilities.

Users' views

7.17 Consultation with users has highlighted the need to develop users' fora. However, a variety of creative approaches are needed to enable both adult and child services users to be consulted on their views and involved in the development of services. Young people and adults wish for as much transparency as possible in all the processes of assessment and treatment and a desire to be seen as partners in the process. The issue of stigma is particularly important and means that for many users, the location of services in local community settings is preferred, although confidentiality is also of concern. However, timeliness and effectiveness of the interventions offered is crucial, irrespective of where they are seen.

Audit and outcomes

7.18 All services should routinely audit and evaluate their work. The information can be used to enhance work with individual children and their families, to inform clinicians, users and commissioners and to further service development.

Improvement, Expansion and Reform sets out the following objectives, targets and capacity assumptions:

- All child and adolescent mental health services to provide comprehensive service including mental health promotion and early intervention by 2006.
- Increase child and adolescent mental health services by at least 10 per cent each year across the service according to agreed local priorities (demonstrated by increased staffing, patient contacts and/or investment).

8: The Use of Medicines in Children

Aim: **To ensure that children and young people are provided with the most effective medicines as part of a comprehensive management pathway developed between the healthcare professional, the child or young person and their parent or carer.**

8.1 The use of medicines is the most common therapeutic intervention carried out in the NHS. At least 20 per cent of PCTs' funds are spent on medicines. The NSF will include advice on managing medicines effectively for children as this is an essential part of their overall care, particularly for those with long term or acute medical conditions.

8.2 Most parents and carers are familiar with the child who does not want to take his or her medicine and it is important that medicines are available in the most suitable, and palatable, formulation. The use of medicines in children is complicated by the fact that medicines are handled differently by the child's body as they grow from neonates to infants through to adulthood. The intention is to provide children with access to medicines underpinned by the best possible evidence for their use, produced by national bodies such as National Institute for Clinical Excellence (NICE).

8.3 A major issue is the use of medications prescribed for children which are 'off label' or which may not be licensed. This is necessary because pharmaceutical companies either have not applied for a licence, or to extend a licence for use with children, or because they have applied but have provided insufficient data to give reassurance on the safe and effective use in children. This is recognised as being an unsatisfactory state of affairs and steps are being taken to increase the range of products and formulations which carry a licence for use in children across the age ranges

8.4 Medication reviews can help to ensure that medicines are used to their best effect. It is known that almost 50 per cent of medicines are not taken as prescribed; indeed, adverse reactions to medicines are implicated in 5–17 per cent of hospital admissions. Targeting children in greatest need of medication reviews could result in improved health outcomes and wellbeing. The introduction of supplementary prescribing by pharmacists and nurses will provide greater flexibility, improved access, and overcome some of the barriers that currently exist in the provision of holistic care to children. Appropriate use of Patient Group Directions can also be helpful.

8.5 The administration of medicines in different settings raises several issues, for example, in schools or in pre-school care. Issues include the accountability of those involved, the need for training, especially for people in schools and nurseries, effective team working and communication. The use of medicines in the home also raises specific challenges particularly for those requiring sophisticated treatments such as Total Parenteral Nutrition and growth hormone.

8.6 Children may sometimes find it difficult to take their medicines as prescribed. The principles of concordance are extremely important. Involving parents, carers and children in decisions about their medicines and supporting them to take their medicines effectively could have considerable benefits for improving their health. The NSF will also consider when it is appropriate to transfer responsibility for taking medicine from parents to children, and how to enable children and, in particular, adolescents to manage their conditions more effectively.

8.7 The provision of accessible and understandable information, both electronically and in written form, will be covered in the NSF including ways of promoting self-care and encouraging people to manage minor or self-limiting illness in their children. The community pharmacist who sees well and unwell children and provides easy access to advice on self-care, minor ailments, Over-the-Counter and prescription medicines has a valuable role to play in empowering parents of chronically ill children to help them administer their medicines effectively. Their role in providing advice on healthy lifestyles, responding to symptoms, differentiating major disease versus minor illness and when to refer to a GP, is important as they are often the first point of contact for ill children; the NSF will evaluate how this role can be enhanced.

8.8 Providing information electronically about medicines for health care workers can be useful in supporting prescribing and ensuring that children get the medicines that are appropriate for their age, development and size. Patient-held records provide an opportunity to empower families and carers to look after children with chronic medical conditions and these are strongly supported by parents.

9: Underpinning Work

A wide range of work is in progress to support the development of the NSF:

Research and development

9.1 Work is in hand to support the development of the NSF and, in particular, to assess the strength of evidence for the interventions set out for each standard. The EWGs have also been asked to consider the longer term strategy for research in the children's field and set some priorities to improve the evidence base to find out what really works. The evidence base underpinning the standards will be published.

Clinical governance

9.2 Optimising clinical outcomes for children, young people and expectant mothers is one of the most important aspects of this NSF which seeks to address the concerns highlighted by the Kennedy Report on the Bristol Royal Infirmary. The NSF will highlight opportunities for promoting and implementing all aspects of clinical governance in these areas.

9.3 This includes promoting clinical effectiveness. The aim of the NSF is not to develop or promulgate clinical guidelines or appraisals itself – these will be commissioned from NICE to complement the NSF. Some of the appraisals already produced by NICE are relevant (eg the management of ADHD, juvenile arthritis, the use of Methylphenidate for ADHD, and the use of inhalers in children with asthma). Further relevant guidelines and appraisals are under development (eg an appraisal of drug treatments for epilepsy in children, guidelines for the management of depression in children and for the diagnosis and management of epilepsy) or under consideration for referral to NICE (eg appraisals on parent training programmes for behavioural disorders in children, appraisals of drug treatments for asthma and for eczema).

9.4 The soon to be established Office for Health Care Information within the Commission for Health Improvement has a remit to develop a programme of national clinical audits. Initially the programme will be based on the inherited National Clinical Audit Programmes (NCASP) previously managed by NICE and the Department of Health. Included in these programmes are national clinical audits in paediatric cardiac care, diabetes in children and parenteral nutrition of infants admitted to neonatal units. The Department will set clinical priorities for the Office's future national clinical audit work programme which will reflect the national clinical priorities including the Children's NSF.

Workforce: more staff working differently

9.5 An adequate and competent workforce is fundamental to the successful delivery of *The NHS Plan* and the NSF. New national workforce planning and development structures have been set up to meet the challenge of delivering a multi-professional and integrated health and social care workforce to support service improvement. In particular, the Children Care Group Workforce Team (CGWT) was established to take a national view on the health and social care workforce pressures and priorities for children's and maternity services and to support the development and implementation of the NSF. The Green Paper on children at risk is also likely to recommend changes to the workforce.

9.6 For certain staff groups, the predicted demand will outstrip the projected supply. If local funding and training capacity is available, increasing training places for these groups will go some way towards bridging the gap, but in itself is unlikely to be sufficient to meet demand. The Children CGWT has therefore recognised the urgent need to support innovative solutions to develop more staff working in new ways across health, social care and education agencies. These include freeing up the training system, improving recruitment, retention and return of staff, exploring new ways of working and mixing different skills together maximising opportunities from innovative service configuration and increasing productivity.

9.7 The Children CGWT's approach is to consider the skills and competencies needed in the workforce to deliver quality person-centred care for children and expectant mothers. Some good practice has been collected and disseminated via the CGWT website (www.doh.gov.uk/cgwt) and the South East London Workforce Development Confederation (WDC).

9.8 The Children CGWT has also been working closely with the Changing Workforce Programme (part of the NHS Modernisation Agency) to look at new ways of working with children and expectant mothers. It has commissioned a scoping exercise to identify new ways of working in caring for new-born babies and their families, and subsequently set up a pilot site to look at the implementation of selected new or amended roles in the immediate post-birth care of new-borns. The pilot will consider work within a neonatal care network including retrieval/transfer, acknowledging the different levels of cover necessary to meet the European Working Time Directive. The pilot will consider new or revised job roles, which more clearly meet the needs of the individuals and use the skills of staff more effectively, resulting in improved access and quality of care for patients and improved staff recruitment and retention. These will subsequently be spread across other pilot sites and networks wishing to implement the model.

9.9 *Skills for Health* have been commissioned to develop a skills and competencies framework for children's services. This framework will identify what people need to know and be able to do to deliver high quality, child-centred care to the standards defined in the NSF. It will be supported by practical implementation tools for local service and workforce planners, including WDCs, and will have a variety of uses, including assisting with developing job descriptions, appraisal and personal development planning and training needs analysis, team and organisation development, education commissioning and qualifications development.

9.10 The NHS Leadership Centre are developing a Leadership Programme for both individuals and teams working with children and expectant mothers. The priorities of this programme are currently being discussed but are likely to include the development of a Children's Champions Network across education, health and social care.

Improvement, Expansion and Reform sets out the following targets, priorities and capacity assumptions:

- To support delivery of NHS priorities by ensuring there are sufficient numbers of appropriately trained, motivated staff working in the right locations.

National capacity requirements:

- Increase the number of staff available.

- Increase workforce capacity and productivity through skill mix and continuing professional development; moving work from doctors to other healthcare professionals and from healthcare professionals to the support workforce, supported by pay modernisation, and service redesign.

Information management and technology

9.11 The NSF will only achieve its goals if high quality information is available to support services, professionals, carers and, most of all children, young people and expectant mothers. The development of a supporting information strategy for the NSF is, therefore, key to its successful delivery. The strategy will cover information:

- for children, parents and expectant mothers on how to keep healthy;
- about services and access to services;
- about individuals' care and to support the 'care pathway';
- to support practice; and
- for monitoring and continual improvement of services.

Information in the 21st Century is the most recent policy statement from the Department of Health, identifying the priorities for developing the NHS and social care. The NSF information strategy has to clearly identify which information requirements will be dealt with through the generic development of the Integrated Care Record Service and which are specific requirements, unique to the needs of children and children's services.

9.12 The following principles will be applied in developing the information strategy:

- All information collected is valid, relevant, accurate, up to date, easily accessible and well-presented.
- The language and definitions used to describe and define conditions and problems is agreed and used in all agencies that support children and families.
- Professionals and families should be helped in rapid and accurate decision-making through the availability of high quality evidence and knowledge.
- The quality of care received relies on the availability, use and quality of information.
- The development of a common data set for all children from birth that meets the needs of all those who come into contact with, or provide services to children, young people and their families. This would avoid the need for duplication in information collection as well as ensuring that there are no gaps or discrepancies.
- The individual care record should be developed as an integral part of the developing Integrated Care Records Service currently under development.

Improvement, Expansion and Reform sets out the following objectives, targets and capacity assumptions:

- To provide information management and technology to support delivery of fast, seamless and convenient care to patients.

Targets include:

- Electronic records – implement key elements of electronic records by December 2005.

Confidentiality

9.13 Confidentiality is a particular issue in relation to services for children and young people. This has been identified by all the EWGs as something that needs further thought. The Department of Health is currently consulting on proposals on confidentiality which are set out at www.nhsia.nhs.uk.confidentiality/pages/consultation. Young people aged 16 or 17 are regarded as adults for the purposes of consent to treatment and are entitled to the same duty of confidentiality as adults. Similarly, the duty of confidentiality owed to a person under 16 in any setting is the same as that to any other person – this is enshrined in professional codes. Under 16s can consent to their own medical treatment, without parental involvement, provided that the health professional considers them competent to fully understand the implications of any treatment and to make a choice of the treatment proposed.

9.14 The health professional must ensure that the criteria known as the 'Fraser guidelines' are met. Where the young person is not judged competent to consent to his or her own treatment, the consultation should still remain confidential, in line with professional codes.

Information sharing

9.15 Whilst giving priority to respecting confidentiality, it is clear that more effective information sharing is essential to enhance the quality of children's services. This is dependent on individuals and agencies working more effectively together, sharing common interests, including information, and reducing the duplication which causes so much frustration to families. Effecting change in this area is not just about having the technology in place but ensuring that people work together in the best interests of children. Research on the piloting of a multi-agency approach to using the Integrated Children's System will provide important information on the issues which arise in multi-agency and inter-agency working, such as aligning assessment processes where appropriate, recording and exchange of information on a local level. The increased ability to link the records of mothers and children will help to ensure the best interests of the child are served. Several pilots are in place to evaluate how best to approach this and the results together with those from the Integrated Children's System multi-agency study will inform the information strategy being developed for the NSF.

9.16 All those responsible for planning, commissioning and delivering services to children and young people have been asked to come together to agree local preventative strategies, including systems for identification, referral and tracking (IRT) of children and young people at risk of social exclusion. Such IRT systems, working across the local authority, health bodies and other agencies that provide services to children and young people, will be a key mechanism to help deliver the local preventative strategy. The Children and Young People's Unit (CYPU) is working with 10 Trailblazer areas across England on a project to identify, develop and disseminate approaches to IRT systems.

Physical facilities

9.17 Talking to children who use health and social care facilities, including hospitals, shows how important the environment is to them – the facilities, the food and the décor, which can make a difference to how they feel about their whole experience of health and social care. NHS Estates has, therefore, put together an overarching strategy to accompany this NSF which looks at what is important for children about the hospital environment, whether they are there as patients or visitors. More detailed documents which map to the main areas of the NSF, including a separate document for maternity services, will follow. Similarly, food is of considerable importance to children staying in hospital – NHS Estates has produced a document on improving food for children which is also intended to support this NSF. Those responsible for implementation will wish to look at both of those supporting documents which can be obtained from www.betterhospitalfood.com and www.nhsestates.gov.uk.

Improvement, Expansion and Reform sets out the following objectives, targets and capacity assumptions:

- [Make progress towards the overall objective] to create a clean, comfortable, well-maintained physical environment which is fit to deliver modern, convenient care. This includes delivering sufficient physical capacity in the right place to implement the NHS's key priorities.

Implementing the NSF – planning and commissioning

9.18 Commissioning will be one of the most significant tools in the successful delivery of the NSF standards. Most areas already have in place a Children and Young People's Strategic Partnership or an equivalent body. Local health communities will be considering how to develop their planning systems, and are likely to build on partnerships already in operation. Children and Young People's Strategic Partnerships will be organised around natural child populations, which will vary – for many, this is likely to follow local authority boundaries although larger county councils may have two or more partnerships.

9.19 Many health bodies will already have identified posts with responsibility for planning and delivering children's services in line with the response to the Kennedy Report. In particular, all trusts which provide services for children including PCTs, and the Strategic Health Authority should have a nominated lead for children. These posts will make a significant contribution to the baseline assessment process.

9.20 The initial assessment of services which will be needed in preparing for the NSF is a complex task. For it to succeed, time will need to be spent developing partnerships between different stakeholders in addition to establishing a common language and a sound information base. The methodology devised to map CAMHS may be useful in developing an analytical tool to establish and baseline services in other areas.

Improving the patient experience

9.21 Many of the issues considered in this document are aimed at improving the patient experience which is a key element in *Improvement, Expansion and Reform*. The hospital standard will show what this will mean for children and young people in the hospital environment where the provision of a bedside TV and telephone and a friendly environment can make an important contribution to the delivery of a child-centred service. Having an active Patient Advisory and Liaison Service which looks explicitly at the needs of children and young people is also key.

9.22 Obtaining feedback from patients and taking account of their views and priorities is vital for bringing about improvements in the quality of care, and for placing the patient at the centre of services. The National Patient Survey Programme, now led by the Commission for Health Improvement, aims to provide high quality information on the patient experience, for use by trusts and for national monitoring and performance assessment. The programme includes trust-based surveys, which will allow trusts to benchmark patient experience against other trusts, and NSF-based surveys, to give a national picture of the implementation of NSF standards. The programme of NSF surveys will address different aspects of children's services, as the different parts of the NSF are rolled out. The trust-based programme will also be developed to address services for children.

Improvement, Expansion and Reform sets out the following objectives, targets and capacity assumptions:

- Improve the 5 key dimensions of the patient's experience as evidenced by increasingly positive local annual survey results, and other patients focused performance indicators, including those developed for the star ratings system. Agree, implement and jointly monitor local improvement plans as a result of surveys, with patient Forums, as they come on stream during 2003.
- Strengthen accountability to local communities through improved engagement with them, as evidenced by annual Patient Forum reports to the Commission for Patient and Public Involvement in Health, and annual publication of a patient prospectus covering local health services.

10: Responding to this document

A range of practical guidance will be developed to support local implementation of this NSF.

Details of work in hand and related initiatives will be given on the website.

The website address is www.doh.gov.uk/nsf/children.htm

If you have comments on this document you can write to:

Claire Phillips
Project Manager
Children's National Service Framework
Room 526
Wellington House
133–155 Waterloo Road
London
SE1 8UG

or email at MB-Childrens-NSF@doh.gsi.gov.uk

Please send your comments within 3 months of the publication date by 10 July 2003.

Annex A: Principles for Children and Young People's Policies and Services

In *Building a Strategy for Children and Young People* – the government's proposals for an overarching strategy – a set of principles were put forward. These principles have been kept in the forefront of the development of this NSF.

We believe that all policies and services for children and young people should be:

1) **Centred on the needs of the young person**
The best interests of the child or young person should be paramount, taking into account their wishes and feelings.

2) **High quality**
Policies and services should aspire to and reach high standards of quality for the benefit of their customers – the children and young people should gain from them.

3) **Family orientated**
Full recognition must be given to family members – including extended and close family – who contribute significantly to the wellbeing of children and young people.

4) **Equitable and non-discriminatory**
All children and young people should have access to, and be enabled to participate in, services that they need, when they need them, in a way which respects diversity and their individual needs.

5) **Inclusive**
Policies and services should be sensitive to the individual needs and aspirations of every child and young person taking full account of their race, ethnicity, gender, sexual orientation, and ability or disability.

6) **Empowering**
Children and young people should have opportunities to play an effective role in the design and delivery of policies and services.

7) **Results orientated and evidence-based**
High quality research, evaluation, monitoring and review should ensure that decisions that affect children and young people are well informed.

8) **Coherent in design and delivery**
Services should be woven together in a coherent, integrated and cross-sector form where it is evident how progress and change expected for children and young people will be achieved.

9) **Supportive and respectful**
Policies and services should be delivered in a manner that is respectful and supportive of children and young people and ambitious for their futures.

10) **Community enhancing**
Communities should be empowered to make positive changes for their children and young people, so that improvements can be owned and sustained locally.

Annex B: Draft Standard on Child Protection

Aim/area to be covered by standard

Children have a right to be protected, and adults a responsibility to protect them, from harm. Children who have been neglected or abused, other children in the household and their carers should be assessed and services and support provided to meet identified needs.

In every area there will be systems and services in place which will aim to promote children's wellbeing and prevent them from suffering harm, safeguard children who are being harmed, and facilitate their full recovery.

Action

- Over half of the recommendations in Lord Laming's report relate to improving basic good professional practice in police, health and local government services. A checklist of these recommendations has been issued and chief executives asked to ensure that this basic good practice is in place.

Other suggested actions

- In every area there is a preventative strategy, with the aim of raising awareness of how to safeguard children among agencies, staff and the wider community and ensure they know what to do if they have concerns about a child's welfare.
- In each area, agencies work collaboratively to develop and implement relevant child protection policies, procedures and protocols.
- Staff having contact or working with children are recruited and managed in a manner that safeguards children (including police checks and whistle blowing).
- All staff (including managers and support staff) working with children, or their parents and carers, receive adequate training on child protection issues in order to safeguard children.
- Children who may be or are suffering significant harm are assessed in terms of their developmental needs, their parents' capacity to respond to those needs appropriately and wider family and environmental factors. Such assessments incorporate the wishes and feelings of the children.
- Based on this assessment, relevant services are provided to address the child's identified needs, including ensuring that they are safeguarded from further harm, and provided with services that promote their development and enable them to recover from abuse or neglect and promote their developmental progress.
- Based on the above assessment, services are provided to other children of the household, parents, carers and wider family members, including those with responsibility for the abuse or neglect, in order to help them ensure that the vulnerable children are safe and their developmental progress is being maximised.
- All agencies contribute to Serious Case Reviews and ensure that action plans are drawn up and implemented.

Annex C: A Comprehensive CAMHS

1. *Improvement, Expansion and Reform* has set the expectation that a comprehensive child and adolescent mental health service (CAMHS) will be available in all areas by 2006. This means that in any locality there is clarity about how the full range of user's needs are to be met, whether it be the provision of advice for minor problems or the arrangements for admitting to hospital a young person with serious mental illness.

2. Clear pathways should be set out to show how the range of mental health needs of children and young people will be met, whether from within services whose prime purpose is to deliver mental health care or from other services with a different primary function. This will not necessarily mean that all services will be in their final configuration or available in every locality by 2006. Where local provision is not appropriate or possible, commissioners will need to set out the collaborative arrangements that will ensure that there is an agreed care pathway to meet the specific needs from an alternative service. Further improvements and developments will be required throughout the lifetime of the NSF implementation to extend the range of services provided and ensure the highest standards of care. The aspiration should be to continually improve and develop the services in the context of multi-agency partnerships across the spectrum of need, and informed by the best available evidence.

A comprehensive service in practice

3. Commissioners will require a clear definition and description of a comprehensive CAMHS. This can be set out under a number of separate headings:

Underpinning principles:

- Access to CAMHS should be available to all children and young people regardless of their age, gender, race, religion, ability, class, culture, ethnicity or sexuality.
- Effective CAMHS commissioning is a multi-agency activity and requires that the commissioners have the requisite skills, knowledge, time and executive authority to undertake the task.
- Both the commissioning and delivery of services should be informed by a multi-agency assessment of need that is updated regularly. This needs to incorporate:
  - Locally adjusted epidemiological information on the prevalence of children's mental health problems to reflect the diversity of the population and other local demographic circumstances.
  - An assessment of the needs of particular groups of children and young people in the locality who are vulnerable or at risk.
  - An audit of services currently provided by all agencies that address both directly and indirectly the mental health needs of children and young people.
  - An analysis of current service usage.
  - The views of all stakeholders including those of the children, young people and families.

  - The available evidence of the efficacy and effectiveness of interventions and service models.
  - Current national and local policy priorities.
- Services should be commissioned to ensure that the workforce is of sufficient critical mass to have the capability to meet the range of defined needs safely, effectively and efficiently.

Range of services:

- The range of services and their settings should reflect the specific needs:
  - related to the age of children and young people using the service.
  - related to the circumstances of the child particularly if they may affect their access to services.
  - associated with the presence of a learning disability.
- Arrangements should be in place to ensure that 24 hour cover is provided to meet urgent needs and a specialist mental health assessment should be undertaken within 24 hours or during the next working day.
- There needs to be a balance of service provision in order that all levels of need can be met as required:
  - Within primary level services (tier 1), those in contact with children need to be able to have sufficient knowledge of children's mental health to be able to: identify those who need help; offer advice and support to those with mild or minor problems; and have sufficient knowledge of specialist services to be able to refer on appropriately when necessary.
  - Child mental health workers (tier 2) need to be available to support, train, liaise with, consult to and provide direct work with other agencies providing services for children.
  - Specialist multi-disciplinary teams in all localities should be able to provide:
    - specialist assessment and treatment services.
    - services for the full range of mental disorders in conjunction with other agencies as appropriate.
    - a mix of short term and long term interventions and care according to levels of complexity, co-morbidity and chronicity.
    - a full range of evidence-based treatments.
    - specialist services that are commissioned on a regional or multi-district basis, including in-patient care.

Workforce and skills:

- The professional mix within specialist services and teams should be balanced to ensure availability of an appropriate representation of skills, in particular professional and team isolation should be avoided in all services.
- The skills, competencies and capabilities that are necessary, all services should ensure they can:
  - work across agency boundaries and within a variety of settings.
  - engage children, young people and their families who have difficulty accessing services.
  - deliver interventions based on the best available evidence.

- Services require management expertise with sufficient knowledge, understanding and executive authority to be able to support the effective and efficient multi-agency delivery of CAMHS.
- The administrative workforce should be sufficient to ensure that all necessary administrative functions, including data collection, can be fulfilled.
- Commissioners in conjunction with specialist providers should support the development of CAMH expertise within all children's agencies.

Training and development:

- Clear supervisory arrangements and structures should be in place to ensure accountable and safe service delivery.
- Multi-professional training and consultative work, undertaken both within and across agencies, is essential.
- The necessary resources to support the training and development requirements of the CAMHS workforce should be available.

Organisational arrangements:

- Agreed protocols should be in place to manage waiting lists and times according to need.
- Services should be accommodated in buildings fit for supporting all the expected functions.
- Where services are located in non-CAMHS dedicated community settings (e.g. schools) arrangements should be made to provide suitable accommodation for supporting service delivery.
- The equipment and accommodation used for direct work with children should ensure that children's safety is of paramount concern.
- IT resources and equipment to support high quality care and the monitoring and evaluation of services should be available in all appropriate settings.
- Where interfaces exist between services, as between adult and children's mental health services, arrangements should be negotiated to ensure clarity and effectiveness of separate and joint service responsibilities and smooth transitions of care.
- Where service delivery demands effective partnerships between agencies (e.g. children and young people with complex, persistent and severe behavioural disorders) joint protocols should be agreed at senior officer level between the NHS, social services and education.
- Clinical governance arrangements should ensure that all staff are trained, supported and able to deliver sound, ethical and safe services.

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London SE1 6XH

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