Healthy London Partnership

Children and young people's health services in London: a case for change

April 2019

About Healthy London Partnership

Healthy London Partnership formed in 2015. Our aim is to make London the healthiest global city by working with partners to improve Londoners' health and wellbeing so everyone can live healthier lives.

Our partners are many and include London's NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, Public Health England and London Councils.

All our work is founded on common goals set out in Better Health for London, NHS Five Year Forward View and the Devolution Agreement.

About this document

This document is aimed at planners, commissioners and providers of healthcare services for children and young people. It is written to help commissioners and providers prepare and develop their local plans, to implement the children and young people's element of the NHS Long Term Plan.

Foreword

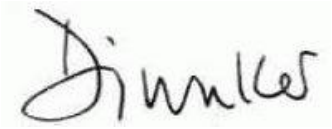
Children and young people are our future and justifiably should be enabled to achieve the best health and wellbeing possible. They should receive high quality care at the right time, in the right place, by skilled practitioners and supported to live healthy lives. We have many examples of excellence within London but this is not always consistently true for all children and young people and their families. Evidence suggests that on a range of health indices we are falling short of our aspirations in London.

Building on the work since the first case for change, and with a focus on children and young people in the NHS Long Term Plan and in the Mayor of London's Health Inequalities Strategy, the time has come to focus our regional work on improving life outcomes for all of London's children and young people. The work now required is to enhance our endeavours to reduce health inequalities and variation, as well as taking a 0-25 years approach for physical and mental health, where this makes sense. In order for us to meet our goal of London becoming the world's healthiest global city, we must ensure seamless care across organisational and professional boundaries.

The strategic partnership of the NHS, the Mayor, London Councils and Public Health England is refreshing the key elements of their combined vision for coordinated action to enable Londoners to start their lives well, live well and age well. Our vision is for children and young people to lead a fulfilling life with an emphasis on care in their communities, greater personalisation and consistent high quality health and care services. It will be our privilege to work with all our partners across health and care, to help develop localised integrated and placed based care to ensure that children and young people get the care they rightly deserve and need.

We hope that you find this a useful tool for your future planning of the best services for children and young people that are fit for the future. Together we can make a real difference.

Yours,



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Executive Summary

Children and young people (CYP) are London's future and make up a third of our population. The population of London is growing and the NHS needs to respond to this increased demand and to improve our services and outcomes for CYP. The evidence suggests that on a range of health indices we are falling short of our aspirations in London.

This document is a refresh of the 2014 *Case for Change for Child Health* in light of the recent NHS Long Term Plan and the London health and care vision to start well, live well and age well. It describes some of the achievements since its publication, the continuing issues facing young Londoners, and sets out the aspirations for London to become a truly 'baby, child and young person friendly city'. This will involve working in integrated teams to enable:

- Implementation of *NHS England Long Term Plan*
- Systematised integrated care and access to primary, maternity, acute and specialist services
- Primary care networks to build capacity and deliver a significantly increased range of support and services in primary care
- Continued raising of standards of care within acute, mental health and community services for children, young people and their families
- Integration of mental and physical wellbeing to be core to all healthcare delivery
- Transformation of services for adolescents, including expansion of mental health services to cover up to age 25

Across the system we need to support CYP and their families to live healthier lives, and promote and improve physical and mental well-being through a greater focus on:

- Increasing our prevention and disease management approaches
- Improving pathways that will benefit patients, families and staff
- Transforming, supporting and educating our workforce
- Ensuring high quality financially sustainable services

This document places children and young people at the centre of these changes. It advocates working with them as partners, utilising their energy, passion and enthusiasm. This will lead to a healthy future with the NHS, local authorities, other public bodies and the third sector, working together to deliver a healthier generation of children and young people.

1. Case for change for children's health in London

Children and young people are our future and justifiably should be helped to achieve the best health and well-being possible. They should receive high quality care at the right, time in the right place by skilled practitioners. Evidence suggests that on a range of health indices we are falling short of our aspirations in London.

This document forms a refresh of the *Case for Change for Child Health* [1] published in 2014 which set out areas for change required in children and young people's (CYP) services. It describes the current issues facing us in London, demographics, variation and outlines some best practice implemented since the original case for change. It also will assist organisations in their response to implementing the proposed London vision, *Start Well, Live Well, Age Well* and the NHS Long Term Plan[2].

1.1 Making the case for change – our aspirations

Almost a third of the population (2.8 million) of London are children, or young people aged up to 25 years. A fifth of these are adolescents (those aged 10-24)[3]. Children and young people have rights highlighted by the *United Nations Convention on the Rights of the Child (UNCRC)*, which include, "the right to be healthy, the right to be educated, the right to be treated fairly, the right to be heard and the right not to be hurt"[4]. Unfortunately, CYP are not always at the heart of health service planning with the World Health Organisation stating the UK lacks a clear policy[5]. Children and young people deserve a strong voice in the design of services for them.

London has some of the world's best health services for children and young people, but services are of variable quality, not equitably accessible and have poor outcomes. [6] The London infant mortality rate is lower than the average for England, but there are **marked inequalities and variation** between boroughs. This variation shows that we are not meeting the health needs of children and young people in London, as well as we could and should be. The Royal College of Paediatrics and Child Health's (RCPCH) 2018 report on the state of child health forecasts that: if we compare the UK to a group of wealthy EU countries, as well as Australia, Norway and Canada, even if infant mortality in the UK starts to decline at its usual rate, we will still have **an infant mortality rate in 2030 which is 80% higher** than the EU15+.[7]

There have been a number of high profile national reports into children's services, including the *National Service Framework for Children (2004)*[8], *Marmot Review (2010)*[9], *Kennedy report (2010)* [10] and more recently the *Nuffield Trust and Association of Young Peoples Health (AYPH) report (2019)*[3], all noting that in order for children's services to meet the interests of children and young people, **integrated services are imperative.** A 2016 report from the Nuffield Trust outlined the 'need for a child health system that understands CYP and their families' specific needs including the broader determinants of health and is designed to address them.[11]

This is even more crucial given the transfer of commissioning responsibilities for health visiting, family nurse partnerships and school nursing from the NHS to local authorities in 2013, under the Health and Social Care Act 2012.[12]

One of our partner organisations, Partnership for Young London, has published a Vision for Young Londoners. They state that children and young people represent 25% of our population and 100% of the future. In London, as a leading global city, we aspire to provide the best childhood services and care possible to enable our young people to thrive on their journey to adulthood. In reality, the evidence suggests that on a range of health indices we are falling short of our aspirations.

The *NHS Long Term Plan* offers opportunities for London to move towards a 0-25 years service initially for mental health, offering a more person centred approach. [2] There is the potential for London to become a truly 'baby, child and young person friendly city'. This would ensure provision of systematised care in the critical first thousand days of life, along with integrated access to primary, maternity, acute and specialist services. Adolescent services need transforming to ensure effective health support during this important transition period. Mental wellbeing could be core to delivery, with integration across health, education and adolescent services, with supported self-care easily available and easily accessed. Working alongside primary care to build capacity and deliver a significantly increased range of support and services through integration using primary care networks, with a wider range of physical and virtual services in partnership with the community and third sector.

CYP and their families need support to live healthier lives, make good decisions and promote and improve physical and mental well-being and access to services as needed, with provision to:

- Increase our prevention and disease management approaches.
- Improve pathways that will benefit patients, families and staff.
- Transform, support and educate our workforce.
- Ensure high quality financially sustainable services.

This will be beneficial for population health improvement. However, any change needs to consider the needs and views of children and young people and their families.

2. Engagement: Parent and children's views

The NHS aspires to put patients at the heart of all it does. Children, young people and their parents or carers can provide great insight into what works well and where improvements can be made. Meaningful engagement is important and our engagement strategy is to utilise existing links nationally, through organisations such as The Association for Young People's Health (AYPH) and Children England, and in London through Partnership for Young London, STPs, CCGs, providers and Healthwatch, as well as undertaking bespoke engagement work through surveys and focus groups. For example, similar to Bromley CCG's co-production with CYP around mental health and safeguarding services[13] [14] working with the Newham diabetes young commissioners[15],. More recently we have utilised the work undertaken by AYPH for the NHS Long Term Plan in which they engaged around 200 young people through a survey, webinars and working with the **NHS Youth Forum**. The British Youth Council has also ran an engagement event for 80 seldom heard young people. A summary of what young people are saying is provided below.

2.1 What do young people think?

Young people have said they want **services designed around their needs and not the services**. The most urgent thing the NHS needs to improve for CYP is **increasing mental health services (41%)** and **improving the ease of seeing a doctor when you need to (21%)**. The NHS Youth Forum highlighted the need for **improved mental health training for staff** and improved **flexibility** for young people to **access services.**

Young people felt the NHS could help more with promoting the development of good health in the first place by **linking up more with schools (30%)** and **encouraging regular checks even if nothing is wrong (30%).** The NHS Youth Forum backed this up, identifying the top prevention activity as regular health check-ins for young people.

Apart from the NHS, young people use **online resources, websites and apps, people in the family and peers as sources of information**. Young people also identified charities as important sources of support, highlighting the need for better links between the NHS and the **third sector.**

Young people stressed their need to be treated as an individual, be believed, be treated equally and understood. They want to be treated as if their opinion matters, not as if they are incapable because they are children. The NHS Youth Forum stressed the need for dedicated trained staff to meet young people's health needs and the roll out of the *You're Welcome Youth Friendly* [16] health services recommendations.

When asked how they hoped the NHS would change in the next 10 years, young people wanted more **open-minded doctors**, more **understanding and welcoming**

services, **better mental health services, well trained staff** and **adequate funding for young people**. The NHS Youth Forum agreed, stressing the need for **personalisation** of services.

The need for a **focus on particular groups of young people** including young adults and young people with protected characteristics was highlighted**. Cultural competency_training** and **embedded mechanisms for engagement and volunteering** would support this.

Finally, young people said **that services should not be separated** – they wanted clinicians to **talk to them about their health holistically,** covering both **mental and physical health.** [17] [18]

3. London's children – demographics

London has a population of over 8.8 million [19], of whom almost a third (2.81m) are aged 0 to 25. It is a young city, with over 128,000 live births to women living in London in 2016 [20], although its population is no longer the fastest growing in England (now the East Midlands) [21].

3.1 Age and sex

Figure 1 shows the age distribution of children, young people and young adults in London, in five year age groups up to 25 years. Greater London Authority (GLA) population figures show the majority of children are aged 0-4 years (June 2016 data)[22], with more males than females.

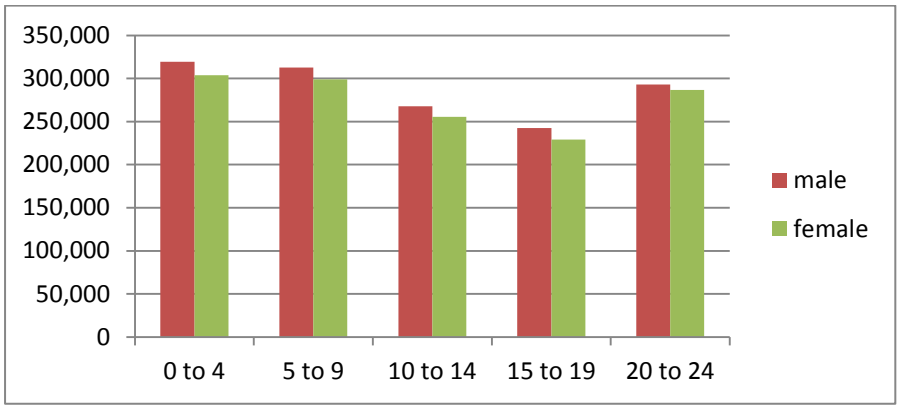


Figure 1: Age distribution of CYP in London Source: ONS Crown Copyright Reserved [Nomis 11 September 2018]

3.2 Ethnicity

In terms of ethnicity, London's schools have a proportion of children from black and minority ethnic backgrounds **double** that of schools in the rest of England. However, across London's local authorities this varies greatly, for example with 94 per cent of Newham pupils coming from a minority ethnic background, in contrast with only 33 per cent of pupils in Havering[23].

Children in London's schools speak more than 300 languages[24]. The Greater London Authority notes that 'three-quarters of primary pupils in Tower Hamlets have a first language that is other than English, compared to one in seven primary pupils in Bromley'[23].

3.3 Deprivation

Poverty is defined as children living in households with an income of 60 per cent of median income [25]. In London, in 2016 18.8% of families with children under 16 lived in low income families[26]. This ranged from 8.5% in Richmond upon Thames to 30.6% in Islington. However, the London Poverty Trust claims this is closer to 37% as 82% of London's homeless households are in **temporary accommodation** with children, **equating to around 45,000 children.** [27]

Child poverty is an important factor, and London has lower levels of maternal employment and higher levels of childhood poverty comparably to the rest of England. Mothers living in poverty are more likely to be in poor health, have psychological problems in pregnancy, and smoke more than those not living in poverty.[28] Deprivation and poverty can affect nutrition which affects long term outcomes, along with higher demands for services.

Population increases need to be considered together with London's unique demographics in order to ensure that services reflect population changes, needs and characteristics. As the children's population grows, there will be increasing demand on services, and a need for better integration and streamlining of services.

4. Why do we need to change?

4.1 Variation in healthcare

The NHS has a duty to promote equality in the services it provides. Whilst these are delivered locally they must meet national priorities. The population expects to receive the same high standards of care from all providers. The information presented here suggests there is still some variation across the capital.

What have we done?

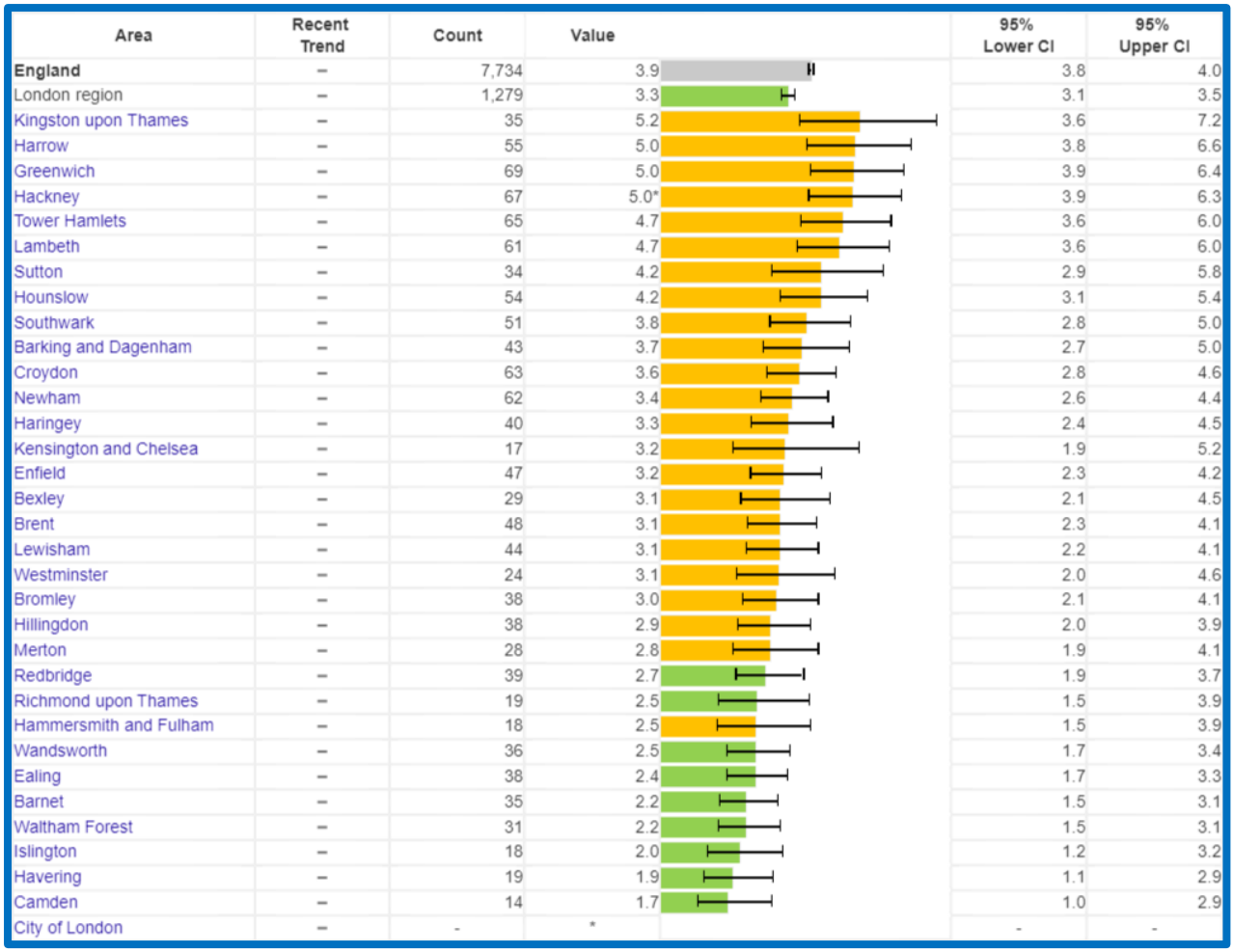
The **London Acute Care Standards for Children and Young People** have been implemented since the previous case for change.**.** These brought together a number of children's standards. Between July 2016 and the end of March 2017, 26 sites in London, with an in-patient facility for children and young people were peer reviewed against the standards. This identified the variation across the capital and where the gaps were (see page 26 for further information)

4.2 Infant and child mortality

Although there have been significant reductions in child deaths in the past three decades in England, too many children are still dying unnecessarily. [29] **675** CYP aged 0-19 years died in London in 2014. Of those 675 deaths, over half (393 babies, 58%) were in children under one year [30]. In 2016, over a third (34%) of all deaths in the UK were considered **avoidable**[31] with maternal and infant causes being the highest [32].

The infant mortality (under one year of age) rate in London between 2015 and 2017 was 3.3 per 1,000 live births, which is lower than that for England as a whole (3.9 per 1,000 live births)[33]. Risk factors for infant mortality include low birth weight, teenage pregnancy, ethnicity and deprivation.[29]

Figure 2 shows the infant mortality in all London boroughs from 2015-2017, compared to England. [32] Infant mortality rates vary between boroughs with eight London boroughs having higher infant mortality than the average for England. The lowest rates are in Camden and the highest in Kingston upon Thames.



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	7,734	3.9	3.8	4.0
London region	–	1,279	3.3	3.1	3.5
Kingston upon Thames	–	35	5.2	3.6	7.2
Harrow	–	55	5.0	3.8	6.6
Greenwich	–	69	5.0	3.9	6.4
Hackney	–	67	5.0*	3.9	6.3
Tower Hamlets	–	65	4.7	3.6	6.0
Lambeth	–	61	4.7	3.6	6.0
Sutton	–	34	4.2	2.9	5.8
Hounslow	–	54	4.2	3.1	5.4
Southwark	–	51	3.8	2.8	5.0
Barking and Dagenham	–	43	3.7	2.7	5.0
Croydon	–	63	3.6	2.8	4.6
Newham	–	62	3.4	2.6	4.4
Haringey	–	40	3.3	2.4	4.5
Kensington and Chelsea	–	17	3.2	1.9	5.2
Enfield	–	47	3.2	2.3	4.2
Bexley	–	29	3.1	2.1	4.5
Brent	–	48	3.1	2.3	4.1
Lewisham	–	44	3.1	2.2	4.1
Westminster	–	24	3.1	2.0	4.6
Bromley	–	38	3.0	2.1	4.1
Hillingdon	–	38	2.9	2.0	3.9
Merton	–	28	2.8	1.9	4.1
Redbridge	–	39	2.7	1.9	3.7
Richmond upon Thames	–	19	2.5	1.5	3.9
Hammersmith and Fulham	–	18	2.5	1.5	3.9
Wandsworth	–	36	2.5	1.7	3.4
Ealing	–	38	2.4	1.7	3.3
Barnet	–	35	2.2	1.5	3.1
Waltham Forest	–	31	2.2	1.5	3.1
Islington	–	18	2.0	1.2	3.2
Havering	–	19	1.9	1.1	2.9
Camden	–	14	1.7	1.0	2.9
City of London	–	-	*	-	-

Figure 2 Infant Mortality Source Fingertip's [34].

The child mortality rate in London in 2015-17 was 11.0 per 100,000 children aged 1-17 years. The child mortality rate ranged from 7.5 per 100,000 children in Wandsworth to 24.3 per 100,000 children in Kensington and Chelsea.

It is important to note that the child mortality figures for Kensington and Chelsea are higher than we would expect for the borough because sadly a number of children tragically lost their lives in the Grenfell Tower fire (14 June 2017).

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI Lower CI	95% Upper CI Upper CI
England	–	-	3,752	11.2	10.9	11.6
London region	–	-	616	11.0	10.1	11.9
Kensington and Chelsea	–	-	20	24.3	14.7	37.6
Redbridge	–	-	35	16.2	11.3	22.6
Greenwich	–	-	29	15.6	10.3	22.5
Sutton	–	-	18	13.9	8.2	21.9
Barking and Dagenham	–	-	24	13.7	8.7	20.5
Islington	–	-	15	13.6	7.5	22.6
Hillingdon	–	-	27	13.4	8.8	19.6
Westminster	–	-	16	13.2	7.4	21.5
Newham	–	-	30	12.0	8.0	17.2
Hackney	–	-	20	11.7*	7.1	18.2
Harrow	–	-	19	11.5	6.9	18.0
Enfield	–	-	27	11.3	7.4	16.5
Tower Hamlets	–	-	22	11.3	7.0	17.2
Haringey	–	-	18	10.6	6.3	16.9
Merton	–	-	15	10.6	5.9	17.7
Barnet	–	-	27	10.3	6.7	15.0
Hounslow	–	-	18	10.3	6.0	16.4
Brent	–	-	23	10.2	6.4	15.4
Lambeth	–	-	18	10.1	5.9	16.1
Waltham Forest	–	-	18	10.0	5.9	16.0
Bromley	–	-	20	9.8	5.9	15.1
Lewisham	–	-	17	9.7	5.6	15.6
Croydon	–	-	25	9.5	6.1	14.1
Havering	–	-	15	9.3	5.2	15.3
Bexley	–	-	15	9.1	5.1	15.0
Richmond upon Thames	–	-	11	8.6	4.2	15.5
Camden	–	-	11	8.1	4.0	14.6
Ealing	–	-	19	8.1	4.8	12.7
Southwark	–	-	14	7.7	4.1	13.0
Wandsworth	–	-	14	7.5	4.0	12.7
City of London	–	-	-	*	-	-
Hammersmith and Fulham	–	-	8	*	-	-
Kingston upon Thames	–	-	8	*	-	-

Figure 3 Child Mortality Source Fingertips

Risk factors for child deaths include:

- Factors intrinsic to the child (e.g. prematurity, chronic illness);
- Factors around parental care (e.g. basic care of the child, parental smoking);
- Environmental factors (e.g. parental age, social class); and
- Unmet service need and provision (e.g. inadequate health care, lack of support services)[29]

The RCPCH recently published its report on 'Child Health in 2030', comparing England's children with those in 15 European Union (EU) countries, as well as Australia, Canada and Norway (called the EU 15+ group)[7]. Worryingly, the report notes the decline in the UK's infant mortality has stalled and mortality has begun to rise'. UK mortality is noted to be 30% higher than the median mortality in the EU 15+ countries. Key facts are that:

- Risk factors for infant mortality are higher in the UK than the EU15+, such as higher numbers of young mothers and maternal smoking, mid-range pre-term delivery and low breast feeding rates.
- For older children, there are higher levels of deaths from medical causes, and high mortality rates from preventable causes such as infection and chronic respiratory conditions such as asthma.[3] [7]

If the UK had the same childhood mortality for children aged 0-14 years as **Sweden**, there would be **five fewer child deaths** every day, and about 1,951 fewer child deaths every year.[35].

4.3 Child death overview panel (CDOP) data

In England in 2016/17, 27% of child death reviews by CDOPs showed that the deaths had a modifiable factor. This has increased from 24% in 2015/16 [36].

Reducing child deaths in London will be achieved through a **combination of NHS interventions and actions on the wider social determinants of health.** This will require effective partnership working at a local level. Public Health England (PHE) has made a number of evidence-based suggestions [37] to achieve this including:

Infant mortality	**Child mortality**
Reduce child poverty	Reduce health inequalities
Reduce teenage pregnancy	Provide safe environments for children
Improve access to antenatal care	Optimise maternal physical and mental health
Reduce smoking in pregnancy	Increase immunisation uptake
Optimise maternal and infant nutrition	Better training of healthcare staff to improve the recognition of serious illness
Reduce sudden unexpected deaths in infancy	Communication with families to spot the signs of illness or failing health
Increase immunisation uptake	

Table 1 Adapted from Korkodilos, M (2016) Reducing child mortality in England[37]

5. Health inequalities

In terms of the wider determinants of health, key issues for children include factors like poor housing, which can lead to increased risk of respiratory admissions. The charity Shelter notes that 'poor housing conditions increase the risk of severe ill-health or disability by up to 25 per cent during childhood and early adulthood'.[38].

In terms of medical care and health services usage, a report by the Nuffield Trust[39] noted that:

- The most deprived 0-24 year olds were **58% more likely to go to A&E** than the least deprived groups, with the most deprived teenagers experiencing A&E attendance rates that were almost 70% higher than the least deprived.
- The most deprived groups were **55% more likely to experience an unplanned hospital admission** than the least deprived, despite the gap between the two groups having narrowed.
- These inequalities have a significant financial cost: if unplanned admissions for all groups were brought down to the level of the least deprived, this would lead to a decrease of around 244,690 paediatric hospital emergency admissions (based on 2015/16 figure). This would represent **a potential saving of £245 million per year** to the NHS in London.
- Unplanned hospital admissions for the ten most common conditions were consistently highest amongst CYP from the most deprived areas [39]

5.1 Social factors affecting health

Adverse childhood experiences (ACE) are defined as stressful events in childhood, and can include:

- Domestic violence
- Parental abandonment through separation or divorce
- A parent with a mental health condition
- Being the victim of abuse (physical, sexual and/or emotional)
- Being the victim of neglect (physical and emotional)
- A member of the household being in prison
- Growing up in a household in which there are adults experiencing alcohol and drug use problems[40].

Experiences in early life are increasingly recognised as having a lasting effect on adult health, both directly and through influencing adult health behaviours. An American study in 2014 made the **link between adverse childhood experiences and health and social problems in later life,** such as addiction, contact with the criminal justice system and mental health issues.[41] If estimates suggesting up to two thirds of children have experienced an ACE[42], this means that of the 2.8 million CYP in London, **approximately 1.8 million** will experience an ACE.

Adverse experiences in the early years, such as neglect and excess exposure to alcohol and cocaine use pre-birth lead to poor development, which affects later life chances. For example, a single reported adverse experience increases the risk of attempted suicide between two and five times and the poorer experiences during development the higher the risk of lifetime depressive disorders [(43)].

Looked after children have much higher levels of mental illness than their counterparts – while one in ten children nationally has a diagnosable mental health condition[(44)], 45 per cent of looked after children are estimated to have a diagnosable disorder[(45).].

The RCPCH (2013) notes that for **children in contact with the criminal justice system**, 'over a quarter of young men and a third of young women in secure settings have long standing physical complaints' [(46)]. The mental health needs of young offenders are also significant, as two thirds of young offenders are thought to have mental health problems – with 'mood disorders, anxiety and post-traumatic stress disorder being the most common' [(47)].

5.2 Prevention

5.2.1 Giving every child the best start in life

It is well known how influential the antenatal period and the first two years of life can be for a child. The two key aims are to ensure children are ready to learn at age two years, and ready for school at age five years. [(48)] Early years services are key in shaping early development, with good collaboration needed between council commissioned services such as health visiting, children's social care, and NHS commissioned services such as maternity, midwifery and perinatal mental health services.

5.2.2 The best start in life

Investing in early years services can help address health inequalities and health outcomes including: early cognitive and non-cognitive development; social development; school readiness and educational outcomes. Investment makes sense from an economic perspective as social return on investment studies show returns of between £1.37 and £9.20 for every £1 invested in the early years. [(48)]

The Healthy Child Programme sits at the heart of services commissioned by Local Authorities[(49)] for children and families. This is delivered as a universal service with additional services for those with specific needs and risks.

5.2.3 The case for strong commissioning

Local authorities have an important role in commissioning and delivering well targeted and evidence-based early year's services. National initiatives, such as the Early Intervention Grant and the expansion of the troubled families programme from 120,000 to 400,000 families[(50)], should help local authorities better tailor their early

years support to the needs of the most disadvantaged children and their families. Other initiatives include:

- The provision of 10–15 hours a week of free early education, the provision of free early education places for 2 year olds who live in households that meet the eligibility criteria for free school meals, along with children who are looked after by the local authority (Department for Education 2013) [51]

- The Family Nurse Partnership – a voluntary home visiting programme for vulnerable mothers from early in pregnancy until their child is 2.This has generated savings of more than five times the programme costs and other studies of targeted pre-school interventions have shown a wide range of positive returns on investment [52].

Finally, there is strong evidence that early intervention to support people experiencing mental health problems can produce significant cost savings and productivity improvements in the longer term for the NHS, local authorities and others [53]. For example, health visitors identifying and treating post-natal depression improves productivity and leads to cost savings in the medium to short term. Targeted parenting programmes to prevent conduct disorder pay back £8 over six years for every £1 invested with savings to the NHS, education and criminal justice systems. [54]

5.2.4 Immunisations

London is below target for immunisation. London coverage for 2017/18 for the primary immunisations (six in one vaccine: diphtheria, hepatitis B, Hib (Haemophilus influenzae type b), polio, tetanus and whooping cough (pertussis)- DTaP/IPV/Hib) was 89% in London compared to an England average of 93%. In relation to 2 year old Londoners, 85% of 2 year olds had their first dose of measles mumps and rubella vaccine (MMR) and their boosters (England's coverage was 91%). At least 76% of Londoners had completed their routine 0-5s immunisation programme compared to 86% for England. New NHS England (London) initiatives include embedding better call/recall processes and ensuring the interoperability of digital child health systems. [55]

5.2.5 Breastfeeding

In 2016/17 breastfeeding initiation data for London was available for 24 out of 33 London boroughs and no overall figure was available. The proportion of women who initiated breastfeeding in England was 74.5%. [56] Only three London boroughs had validated breastfeeding data at six to eight weeks. The proportion of women who breastfed at six to eight weeks in England was 42.7%[57].

5.2.6 Obesity

Children's obesity is a growing problem with nearly 40 per cent of London children aged 10-11 years noted to be overweight or obese. A clear deprivation gradient

exists, with obesity rates highest in the most deprived 10 per cent of the population. [58] One in four children is overweight or obese when they start school[59] (Rudolf et al 2011), which puts them at greater risk of cardiovascular disease and diabetes in later life. A whole systems approach is exemplified by Amsterdam's Healthy Weight Programme, and its three clear elements: *healthy food and drink, exercise, and sleep.* [60]

5.2.7 Smoking

Teenagers starting to smoke is an important health issue, as damage to arteries can begin at an early age. It is estimated from a recent British study that one in five teenagers started smoking by the age of 17 years. Teens were also more likely to smoke if their parents smoked [61].

5.2.8 Alcohol and substance misuse

Children and young people can be affected by substance misuse in two ways, either through their own use and/or impeded by their parents or caregivers. Both aspects need tackling. They are advised not to drink before the age of 18 years. Drinking at an early age is associated with both health and social problems and other risky behaviours (smoking and sexual activity). The two most common substances misused by young people are cannabis and then alcohol [62]. It is estimated that 18% of secondary school children had at least one drug in the previous year, and 10% of 11-15 year olds are estimated to have had an alcoholic drink in the last week, in England [63].

London's rate of alcohol specific hospital admissions for under 18 year olds is 19.4 per 100,000 children, lower than the England rate of 34.2 per 100,000[64]. We know that parental alcohol misuse is strongly implicated in domestic violence and abuse. A study of four London boroughs found that 'almost two-thirds of all children subject to care proceedings had parents who misused substances including alcohol'. [65]

5.2.9 Sexual health

Over one third (36%) of all new sexually transmitted infections in London occur in young people aged 15-24 years. Young people are an important group as they tend to have more partners and are less likely to use protection such as condoms [66]. Child sexual exploitation is also an issue which increases the risk of sexually transmitted infections.

5.2.10 Oral health

Poor oral health poses a socioeconomic burden and is the greatest cause of surgical admission for children and young people. NHS England (London) spends around £73 million per year on dental services in **primary care** for children in London [67]. In 2016-17, there were 11,632 finished consultant episodes for children with a primary diagnosis of dental decay London, at a **cost of almost £10m per year**[68].

Since the 2012 Health and Social Care Act, the system for dental commissioning has become fragmented and complex. NHS England is responsible for commissioning all NHS dental services: primary care, community and acute secondary care. NHS England is not, however, responsible for population prevention programmes and there is no separate prevention component in the primary care dental contract as this is provided as part of a patient's check-up (together with assessment, diagnosis and treatment planning). Local authority public health has the responsibility to commission or provide oral health promotion services, although this is not a mandated requirement and Public Heath England (PHE) provides dental public health professional advice and support.

What have we done?

HLP undertook work in conjunction with Queen Mary's University London on parents seeking analgesia for their child's pain published in BMJ Open [(69)].

5.3 Violence reduction and vulnerable groups of children

Violence across the capital has been increasing in recent years and admissions have risen by 60%. [(70) (71)] There were 142 homicides in London up to July 2018. [(72)] Apart from the number of fatal stabbings, there are a vastly higher number of non-fatal stabbings. A paper by Vuillamy et al (2018) from Kings College Major Trauma Centre studied 1,824 knife stabbings in young adults or people under 25 years. The findings showed a higher incidence in young boys aged 14 to 18 years, with the majority from more deprived communities.[(73)]

The new approach by the Mayor's Office for Policing and Crime (MOPAC) to violence reduction is to focus on public health, including early intervention, education and youth activities to reduce knife crime [(74)].

Certain links have also been found between school exclusion and children being vulnerable to being drawn into crime [(75)]. This is also relevant for the issue of grooming children to work in 'county lines' where young people are coerced into carrying and selling drugs to provincial towns outside London.

5.4 Long term conditions management

The UK has the highest rates of young people living with long term conditions and they are more likely to die from asthma than anywhere else in the UK.[(3)]

5.4.1 Asthma

It is estimated that 240,000 children in London have asthma, equating to three children in every classroom. Between 2012 and 2016 there were 17 deaths due to asthma in London, [(76)] the majority of which are thought to be preventable. There are over 4,000 emergency hospital admissions for asthma in children each year, **75% of which are thought to be avoidable**[(77)] with improved preventative care incorporating asthma action plans, education and risk management.

In 2018, Levy et al demonstrated through an audit in Harrow that asthma admissions could be reduced by 16% through use of a local improvement scheme to improve care and follow up.[78] If 60% of child emergency admissions for asthma were prevented, this would save £2.8 million across London. If there was a 75% reduction the savings would be even greater, at £3.5m, and if adults were included this figure would rise further again.[79]

What have we done?

The Healthy London Partnership London asthma programme's describes a set of ambitions, standards and a toolkit to help organisations implement the asthma standards and to work in a more integrated way to improve care across the capital. Parents want educated school staff and consistent policies, effective integration, improved communication, less stressful transition, easier access to emergency care and access to better consistent information, especially at diagnosis.

5.4.2 Epilepsy

Epilepsy is one of the common major long-term conditions affecting CYP. According to the best current estimates, 2,000 children and young people are thought to have epilepsy in London. The average London primary school will have approximately 1-2 pupils and the average secondary school 4-5 pupils with epilepsy (special needs schools are likely to have higher numbers). There is increasing evidence that outcomes for epilepsy are sub-optimal:

- Inadequate management has been demonstrated in almost 50% of investigated cases
- 24-59% of studied deaths in young people with epilepsy were thought to be potentially avoidable
- The proportion of UK paediatric services with access to an epilepsy specialist nurse is only 59%[80]
- Mental health co-morbidities are five times more common in CYP with epilepsy than in the general population

It is important to note that children with epilepsy do not just have medical needs, they may also have educational and social care support needs. These are estimated to be, on average, four times higher than their healthcare needs[81].

What have we done?

The are two paediatric epilepsy networks in London, North Thames and South Thames, Healthy London Partnership has worked with them and the charity Young Epilepsy to develop the London epilepsy standards to improve integrated care along with epilepsy guidance to support schools.

5.4.3 Diabetes

Of children and young people in the UK with diabetes, 95% have Type 1 diabetes whereas the remainder are largely Type 2. In London there are approximately 6,280

children and young people with Type 1 diabetes and the highest levels of children with Type 2 diabetes in the country (234 CYP). Children with Type 1 diabetes need daily insulin injections, to monitor their blood glucose levels and eat regularly. Managing the demands of diabetes in daily life can be challenging: currently only 28% of children in the London are achieving the recommended level of blood sugar control.[82]

What have we done?

A key tenet in managing these long term conditions of childhood are good acute and community care, in particular from robust school nursing provision [83]. Healthy London Partnership has produced schools guidance to assist. Integrated commissioning, utilising the existing paediatric networks in South East Coast and London, and increasing use of new technologies is key to reducing variation across the capital [2].

6. Children and young people's mental health

6.1 Levels of need

Nationally, one in nine children and young people aged between 5 and 19 years have a mental health disorder. Girls in London aged between 5 -19 years have been identified as a high risk group where emotional disorders are found to be much more common. 9.6% of girls show signs of an emotional disorder compared to 3.5% of boys. London also has the second highest rate of 5 -19 year olds with three or more mental disorders (14.9% compared to national average of 12.4%) [84]

The NHS Benchmarking Network (2018) published a comparison of 13 countries [85], in terms of children's mental health provision and use.

Some key findings for **inpatient services** were that England has:

- Slightly more inpatient mental health beds (11 per 100,000 0-18 year-olds England versus 8 per 100,000 children in other countries).
- Fewer inpatient admissions (33 per 100,000 in England versus 116 per 100,000 children in other countries).
- Longer average lengths of stay, excluding leave (72 days on average in England, the second longest).

In terms of **community children's mental health services**:

- England is above average for number of children and young people seen per 100,000 children per year: 3,837 per 100,000 (compared with 3,221 per 100,000 children internationally).
- There is **wide variation** in the number of contacts for children per year, with the UK being lowest at 4 to 5 contacts per child in services (mean average is 9 contacts per child per year).

Half of all mental health problems are established by the age of 14 years, which rises to 75% by the age of 24 years. People with **severe mental health illnesses tend to die 15-20 years earlier than those without**.[86]

6.2 CAMHS transformation

Future in Mind [87], NHS Five Year Forward View for Mental Health [86] and the NHS Long Term Plan [2] have provided the strategic vision and additional funding for improving and transforming mental health services for children and young people. A number of national transformation priorities have been identified. [88]

- Expanding access to community-based mental health services **-** by 2023/24, an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams [2].
- 95% of CYP with an eating disorder should start a NICE recommended intervention within one week if urgent, and four weeks if routine.

- Inpatient stays for CYP will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible.
- 1,700 new staff in England will be trained in CYP mental health evidence-based interventions.
- 3,400 existing CYP mental health therapists will be trained in evidence based treatments.
- All acute hospitals will have all-age mental health liaison teams in place, and at least 50% of these meet the 'Core 24' service standard as a minimum;
- There will be a 10% reduction in suicide and all areas will have multi-agency suicide prevention plans in place.
- At least 60% of people (14-65 years old) experiencing a first episode in psychosis will start treatment with a NICE recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral.

Although there has been some progress in meeting these priorities in London, there is still some way to go and concerted action across the mental health system is needed to deliver them.

6.3 Mental health in schools

NHS England Transformation of CYP mental health provision, included three core proposals: [89] [2]

- Designated and trained senior leads for mental health in schools and colleges.
- Mental health support teams of trained staff linked to groups of schools and colleges.
- 4-week waiting time to treatment for CYP mental health services.

London has been successful in receiving additional funding to pilot these three elements in the following trailblazer areas:

- Camden
- Tower Hamlets
- Haringey
- Bromley*
- Hounslow
- South West London
- West London

**- denotes the areas where the 4 week waiting time will be piloted*

6.4 Waiting times for specialist services

Access to child and adolescent mental health services (CAMHS) has been highlighted as a national problem by the Children's Commissioner for England [90],

whose 2017 report noted that 60% of areas are failing NHS England benchmarking standards.
Current access targets for CAMHS are 30% nationally for 2017/18. In London, a rapid audit of factors distinguishing clinical commissioning groups (CCGs) meeting/not meeting the access targets included having a voluntary and community sector (VCS) providing Tier 2 services for children's mental health, and having a local directory of services and support. (91)

New services will be developed for children who have complex needs, including a number of children who have been subject to sexual assault but who are not reaching the attention of Sexual Assault Referral Services. For 6,000 highly vulnerable children with complex trauma, this will provide consultation, advice, assessment, treatment and transition into integrated service. (2)

6.5 Supporting the transition to adulthood 0-25

New care models should deliver an integrated approach across health, social care, education and the voluntary sector, such as the evidenced-based 'iThrive' operating model which currently covers around 47% of the 0-18 population and can be expanded to 25 year olds. In addition, NHS England is working closely with Universities UK via the Mental Health in Higher Education programme to build the capability and capacity of universities to improve student welfare services and improve access to mental health services for the student population, including focusing on suicide reduction, improving access to psychological therapies and groups of students with particular vulnerabilities. London has a number of universities that may require support. **(2)**

6.6 Crisis care for children

Evaluations of urgent and emergency care services for children and young people in Vanguard sites found that, on average, 83% of children and young people referred to crisis and liaison services were seen within four hours (2)

What have we done?

HLP recently undertook peer reviews of mental health crisis pathways against the HLP crisis care guidance for CYP (92). A number of key themes were identified across the system including but not limited to:

- Generally engagement across the whole pathway and across pathway partners requires improvement.
- Unusual that all pathway partners had a good grasp or knowledge of the whole pathway.
- Lack of a standardised approach and service cohesiveness of each trust serving a number of boroughs.
- Variability of out of hours and extended hours arrangements.

- Variable crisis line provision, particularly out of hours, and generally CYP is an add-on to adult crisis lines with limited CYP training.
- Variability of use of safety and coping plans (who had one, structure and how to access).
- Variability of provision of health based place of safety for CYP.
- Variation in mental health liaison offering across all acute hospitals.

The 2017 HLP peer review of Paediatric Acute Care also found that:

- **CAMHS provision for CYP in crisis presenting to local trusts was inadequate** representing a system failure**.** A mental health emergency can be as devastating and as life-threatening as a physical health emergency, and the long-term effects of failing to provide effective mental health care in childhood are well recognised.
- Unfortunately the care provided to CYP in London presenting in mental health crisis is often fragmented and delayed**.** It does not address their needs and adds to their feeling of stigma; which can lead to a worse outcome. Their care can also be challenging for staff, many of whom have little training in how to deal with such young people. It is imperative that collaborative commissioning and local transformation planning should look at how the additional funding for delivering *Future in Mind* can be directed to these frontline services.

6.7 Eating disorders

Access and waiting time standards for CYP Community Eating Disorder Services (CEDS) [93] were published in 2015, and although some progress has been made by the seven CEDS already established in London, more progress is required to meet the standards, as evidenced by the self-assessment process undertaken by HLP during 2017 and 2018. Common findings included:

- Need for developing and strengthening care pathways and protocols;
- Noting that demand is exceeding commissioned capacity;
- Self-referral was not universally supported; and
- Transition and partnership working required strengthening.

What have we done?

HLP has produced guidelines for referring CYP with eating disorders for primary care clinicians

What needs to change?

We could learn from areas such as Durham and Tees in relation to crisis care, [94] in order to reduce variation between boroughs, and to provide care that is safe, immediate and available 24/7. This requires mature partnerships between the NHS and councils, with pooling of budgets with planning and provision for crisis care on a London-wide sustainability and transformation partnership (STP) / integrated care system (ICS) footprint, rather than a provider one.

Given the funding cuts to councils, and the fact that the NHS relies on good Tier 2 services to reduce demand for Tier 3, pragmatic conversations need to take place so that all commissioning is joined up, with a collective ownership of need.

Transforming access to child and adolescent mental health services (CAMHS) will require more than simply scaling up existing services. It will require a radical re-think of interventions and services, a more integrated and responsive model and an acknowledgment that infinite acute services will not be able to service the levels of rising demand in the population.

6.8 Autistic spectrum disorder and learning disability

Children and young people with a learning disability, autism or both, with the most complex needs, have the same rights to live fulfilling lives.

Diagnoses of autistic spectrum disorder (ASD) are rising and it is estimated to affect one in every 100 children. That equates to 22,000 children in London. [95] Children and their families told HLP that they were struggling to access diagnostic and support services. In addition, 'diagnostic overshadowing' occurs where other physical health concerns are attributed to a diagnosis of autism. [96]

In England, although 15% of pupils may have special educational needs, only 3% are estimated to have a formal statement of special educational need. In 2014, the process for local authorities providing statements of educational need changed, with a statutory duty for local authorities and clinical commissioning groups to jointly produce **education health and care plans** (EHCPs) to cover children and young adults up to the age of 25 years. [97] The aim is for each local authority to produce a local offer for parents of children with such needs.

The NHS Long Term Plan sets out a commitment that at least 75% of those eligible undergo a health check each year to tackle causes of comorbidity (the presence of one or more additional conditions co-occurring) and preventable deaths.

7. What are the issues for primary and community care - how should we support improvements?

7.1. What are the problems?

- 'Children are estimated to account for around a quarter of a typical GP's workload' [98]
- Not all GPs or practice nurses have the skills and confidence in their paediatric knowledge as they may not have received specific formal training in child health [11] [99]
- Young people report the lowest levels of satisfaction with GP services and have the shortest consultation times [100]
- Children and young people are twice as likely as other groups to attend emergency departments or walk-in centres rather than see their GP or practice nurse [101]
- Linkages between individual primary care organisations and services and public health services and schools vary across London and within boroughs.
- Transitory nature of London's population makes consistency and continuity of care more difficult
- Shortage of GP and nurses nationally and across London

7.2. What is the current situation?

There are around 1,600 general practices in London. There is a national focus on GP practices working at scale through **GP Federations, Alliances** or **primary care networks,** and numbers of single-handed GP practices are falling. The Next Steps To The Strategic Commissioning Framework sets out the vision and collaborative support available to strengthen primary care in London.

7.3. Successful models

The Primary Care Home (PCH) model, developed by the National Association of Primary Care, is an innovative approach to redesigning primary care. It brings together a range of health and social care professionals to provide care for their local community. Staff are drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector to focus on local population needs and provide enhanced care closer to patients' homes.

PCH shares some of the features of the proposed **primary care networks** that focus on a relatively small population (30,000-50,000), enabling primary care transformation to happen at a faster pace. Population segmentation is used to target interventions to groups and individuals. The needs of the population as a whole are used as the basis for service organisation.

Such models aim to enable better and more sustainable services for local populations to improve health and wellbeing, transform quality of care delivery,

ensure sustainable finances and improve staff satisfaction/reduce burnout. Some are trying to think about how children and young people fit into this direction of travel. **Examples in London** include:

- Hillingdon Hospitals NHS Foundation Trust (Paediatric Integrated Community Clinics)
- Imperial College Healthcare NHS Trust (Connecting Care for Children, CC4C)
- The Well Centre (Streatham)
- Children and Young People's Health Partnership in Lambeth and Southwark

Evaluation of these models and others has shown that outreach clinics or hubs prevent acute admissions to hospital, saving costs while providing appropriate care.

Modelling of the *Connecting Care for Children* programme determined a break-even point with a reduction in outpatient appointments by 20%, emergency department (ED) presentation by 10% and admissions by 2%. Evaluation of the piloted model showed reductions in these measures by 39%, 22% and 17%, respectively. [102] Up skilling of local staff working in these environments is a positive by-product.

However, truly networked care for children and young people – incorporating primary, secondary, tertiary, mental health, local authorities, schools, pharmacy and the voluntary sector – does not yet exist in London.

Primary care at scale through networks is the emerging direction with community teams wrapping around groups of GP practices, in order to respond to patients' holistic needs and leading to more tailored interventions, efficient service delivery and improved health outcomes. [2] Development also needs to include all levels of care and other organisations as part of a networked care model (see Figure 4). The NHS Long Term Plan provides the levers for change and examples of developments for adults is provided but there is no mention of the model for children and young people [2]

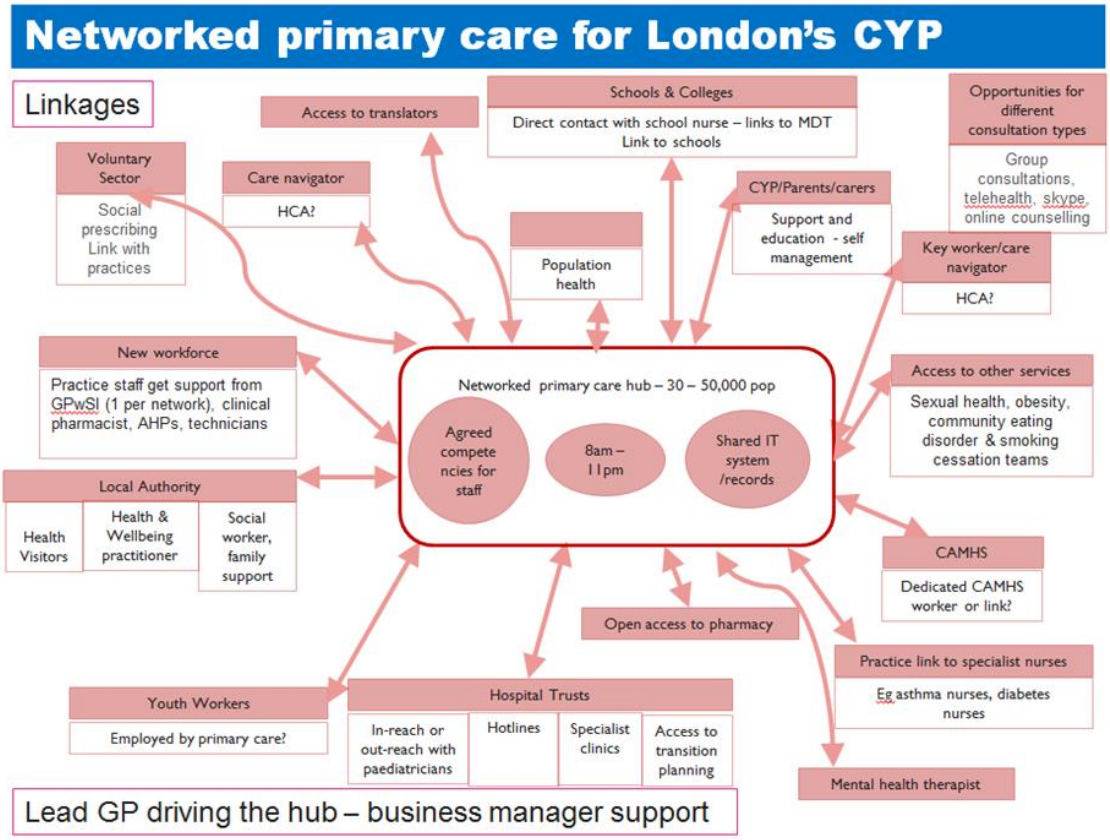


Figure 4 Proposed model of Networked care for children and young people

Network development principles include:

- A population of 30-50,000
- Determining the components of the network from the start (for example, youth worker, CAMHS, GP, local paediatrician, pharmacy, mental health support teams in schools and schools more widely, specialist community services such as Asthma (Figure 5) and epilepsy nurses, social worker, psychologist, voluntary sector organisations
- Effective communication, including development of a shared records system
- Opening hours that allow access outside school/college commitments with walk-in options
- Same day access to GP and community and acute paediatricians when necessary with rapid escalation systems in place
- Continuity of care from a multi-disciplinary team across the lifespan for children with chronic diseases including planned care to avoid unnecessary emergency department admissions
- Joint clinics between specialists and general practitioners

What will it mean for children?:

- CYP can be seen at a time that suits them and their families
- No wrong door – a service that is responsive

- CYP and parents have the tools for self-care
- Less chance of children “slipping through the net”
- More skilled staff working together
- More opportunities for social prescribing

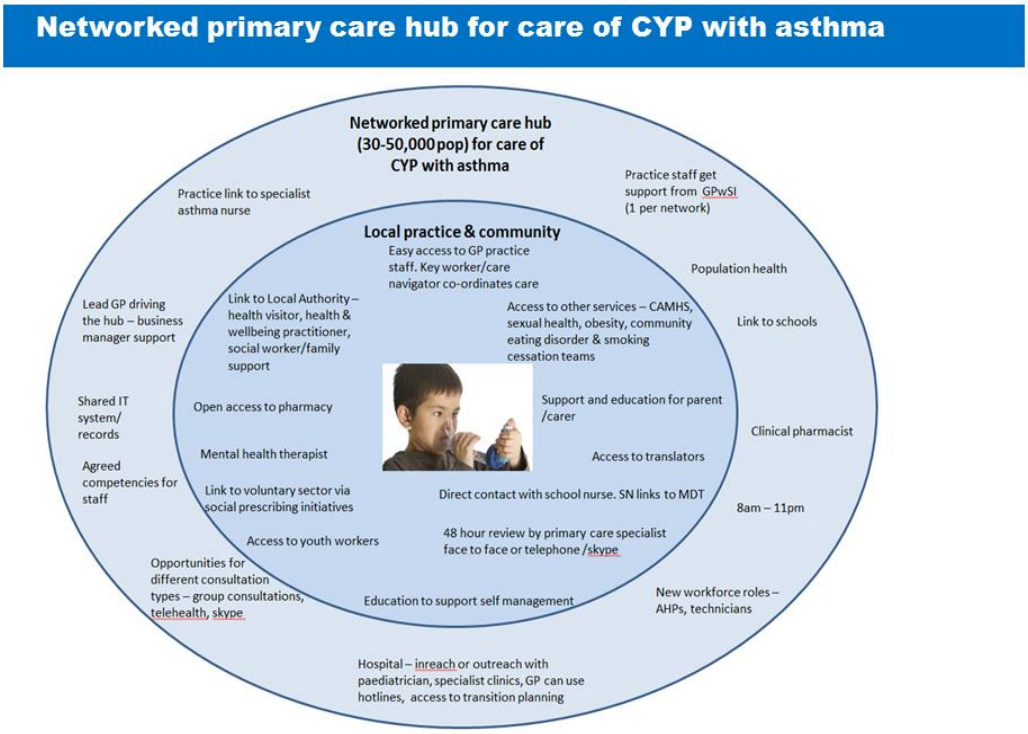


Figure 5 Example of networked care for children and young people with asthma

7.4. Transition from paediatric to adult services

Transition is broad in its definition: from paediatric to adult services (including mental health), from tertiary to secondary or primary care, from secondary care to tertiary or primary care or from primary to secondary education. In all cases, transition should be a smooth process, but it is recognised that this is not always the case.

Here, we refer to **transition from paediatric to adult health services**. It is recognised that the process is often fragmented, confusing, sometimes frightening and desperately difficult to navigate [(103)]. Effective transition from paediatric to adult services for young people improves outcomes and quality of life and NHS England have provided service specifications for diabetes and mental health. [(104)] [(105)] Whereas inadequate transition has been associated with poorer long-term outcomes.

Such transition should be viewed as a process and not a one-off event. There should be no predetermined age of transfer. The process should be unique to the individual young person and their stage of development. The findings of the London Acute Care Standards for Children and Young People demonstrated that there is **wide variation in the quality of provision for transition**, from some exemplar services (often with specific well-recognised single long-term conditions, such as diabetes) to those with long-term complex problems where adult care cannot be mapped to a single specialty. It was recognised that **effective transition requires integration across primary, secondary and community care as well as social care**.

Transition to adult services should be as **seamless and flexible** as possible for the young person. For groups not covered by health, social care and education legislation, planning for adulthood should start from age 13 or 14 (Year 9). The process of transition is expected to take longer where a child has complex needs and may last until 25. For young people entering the service close to the point of transfer, planning should start immediately. A number of resources to help can be found on the Healthy London Partnership website.

8. What will help us improve integration of services across London?

The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. Our vision is to provide the right high quality evidenced based care for CYP at the right time and in the right place. We wish to reduce inequalities and support people to manage their own health and use services appropriately. These services need to be high quality and responsive and available in the most appropriate setting identified through consistent pathways. This includes primary, secondary, tertiary and community care and encompasses schools, pharmacy and the voluntary sector. Good transitions between and within organisations with clear responsibilities for handover of care need to be outlined. This chapter outlines some of the issues within the current system and some suggestions to help improve outcomes

8.1. Baby, children and young people friendly city

Child Friendly Cities and Communities is a worldwide programme from the United Nations Children's Fund[106], which supports cities and communities to use a child rights-based approach. The framework can be used by planners, decision-makers and frontline professionals in both statutory and voluntary agencies. It helps to provide a common framework on which to describe initiatives in different parts of the system. London plans to utilise this framework with its partners to help transform services for CYP.

The seven main themes are:

- Child friendly urban design
- Natural environment
- Independent mobility
- Health and well-being
- Open spaces and recreation
- Children's participation
- Educational outcomes

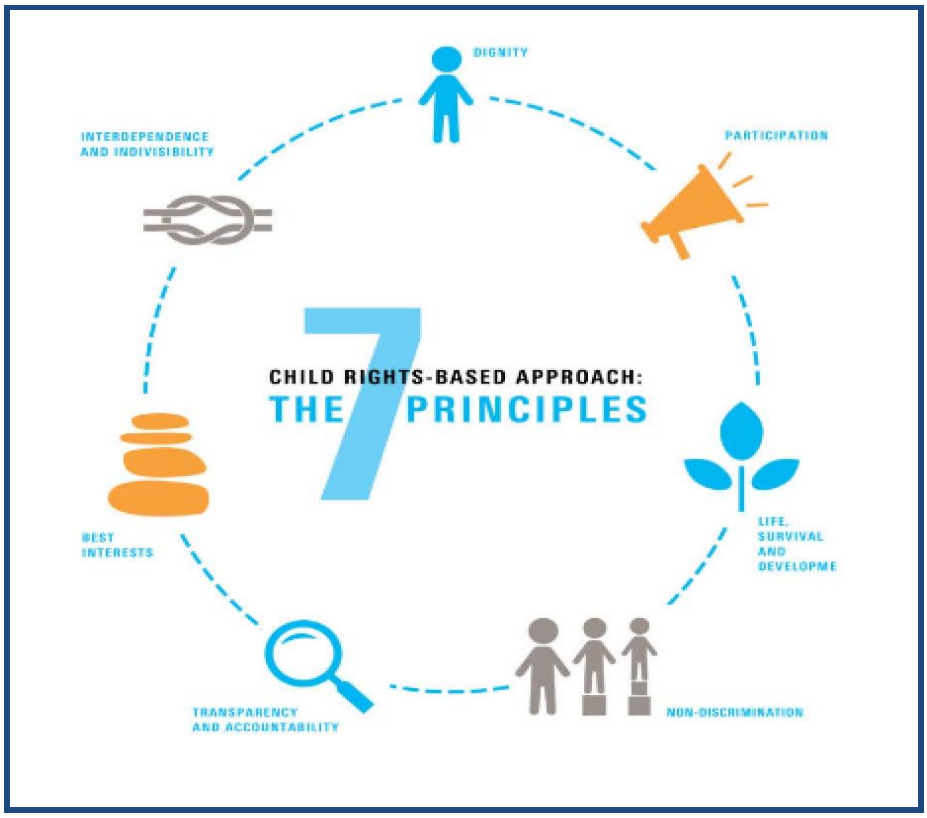


Figure 5 UNICEF 7 principles of child's rights based approach

8.2. Paediatric provider sector changes

Demand for acute paediatric services in London continues to rise: our hospitals are often the first port of call with emergency department (ED) presentations by children increasing by 20% in the last decade [107]. Presentations to the urgent and emergency care setting for problems that can be treated in the community or attendance at outpatients when care closer to home could be utilised including greater use of technological advances.

What have we done?

Healthy London Partnership undertook a study of attendances in the acute care setting and published a report reviewing the potential new models of care to reduce emergency attendance [108]. A supportive peer-led review in 2016 -17 of the 26 sites in London that deliver acute medical care to CYP was also undertaken. This assessed organisations against the London acute care standards for children and young people [109]

The **key findings** concluded that there was much to celebrate. Reviewers were of the opinion that CYP, and their families, were largely well served by the 26 hospital sites visited: their voices were heard and appropriate and often highly innovative care was provided. Paediatric staff were clearly passionate about the services they provided. On numerous occasions, reviewers commented that staff were often

working under a great deal of pressure, whether due to demand or lack of resource, but were seen to be highly committed to their work - and to the children and young people for whom they care. However, the relationships between commissioners and providers varied hugely across London.

Achievement of the London acute care standards for children and young people **was variable, in every category**, although trusts saw them as being important and were striving to meet them. Reviewers felt that full achievement of the standards may be a significant challenge on some sites.

In addition:

- Much good practice was seen in the district general hospitals (DGHs); **innovation and excellence was not limited to the specialist and academic centres.**
- Many trusts work with a number of CCGs, constantly juggling different local priorities. At times, it was observed that this resulted in **inequity of care being delivered by trusts** to CYP **depending on their CCG of origin**. Reviewers saw this as being hard for staff and unfair to the CYP the trusts looked after.
- **Resources for children's services are spread thinly** across London; at times in ways that appear unequal. The development of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICS) should help to deliver a more joined up population based approach.

Models of good practice

Reviewers made particular note of **Kingston Hospital's** Paediatric Outreach Nursing Team (PONT) which provides nursing care and advice for children at home, school and nursery who are under the care of a Kingston GP. Hours of operation were noted as being 8.00 am to 6.00 pm Monday to Friday, and 8.00 am to 4.00 pm on weekends.
Another service highlighted was the **Connecting Care for Children** (CC4C) programme run by paediatricians at Imperial College Healthcare NHS Trust. Working with local GPs, commissioning leads and social care partners, the Trust is developing pathways of integrated care with primary care services to address the high rates of paediatric emergency department and paediatric outpatient attendance across the region.

8.3. Digital transformation

Maximising the use of new technologies and effective IT strategies and systems that communicate across organisational boundaries is the strategic direction outlined in the NHS Long Term Plan. [(2)] Key enablers of child health improvement and more integrated services are improved data sharing across organisations, and better use of technology such as greater use of emails or online consultations. For example, Skype consultations have been used effectively in Newham within their diabetes team, resulting in increased attendance rates, improved outcomes and provision of more patient centred care [(110)]

8.3.1 Health information for children on their phones/devices

NHSGo is London's award winning [111] app to help CYP find advice using NHS Digital content on conditions, with rolling content on topical matters, a service finder and information about rights for CYP. NHSGo is free to download on iTunes and Google play, or via its dedicated website: www.nhsgo.uk.
The **Digital Red Book** (eRedbook, ePCHR) supports personalised care and seeks to work towards knowing where every child is and how healthy they are. Linking interoperable data within the child health information system and the proposed HLP digital health passport has the potential to provide families, healthcare and education professionals with immunisation data and development reviews. Access to this information is intended to promote strong parent-child attachment and positive parenting, resulting in better social and emotional wellbeing among children, readiness for school and improved learning.

CYP with a personalised asthma action plan are four times less likely to present to hospital. The HLP programme is testing a **digital health passport for children and young people** that is a personal health record and digitises the Asthma UK action plan. It has the potential to make long-term conditions easier and more fun to manage and connect young people, school nurses and carers. The app encourages a young person to record symptom data, such as peak flow, that can help them identify a change requiring an intervention. A key part of this project involves the **sharing of care plans** between healthcare professionals and school nurses to join up care. Results from the piloting of this app will be available before the end of this year (2019).

Working alongside One London (London Health and Care Record Exemplar) will be key to unlocking the integration of data across the capital.

8.4 Workforce

A skilled workforce is essential to the provision of safe and effective care and good experiences for children, young people and their families. The NHS workforce is under considerable strain due to a number of issues including Brexit and changes to training systems. This means that the future workforce will need to be different if services are to be sustained. It may include the introduction of care navigators, extended roles for specialist nurses, physician's assistants or other roles that work across organisational boundaries. However, we must ensure that the healthcare workforce that cares for children and young people are not viewed in isolation. Improved awareness and uptake of workforce programmes such as the Health Education England (HEE) Return to Practice programme can provide benefit to children and young people due to an increase in nursing and allied health professional staff across primary care, secondary care, mental health and public health.

The new Trainee Nursing Associate role is intended to address a skills gap between health and care assistants and registered nurses and to help meet the changing needs of patients and the public. Nursing associate is a stand-alone role and will

provide a progression route into graduate level nursing. Nursing associates are being trained to work with people of all ages and in a variety of settings in health and social care. There is an opportunity for this new role to significantly benefit children and young people who have changing, complex, and long-term care needs.

Paediatric and neonatal services have historically embraced innovative workforce solutions with the advent of advanced clinical practice, however, further progress could be made to understand how best to utilise skills of advanced clinical practitioners (ACPs) for service impact affecting children and young people. This is an exciting time because Healthy Education England (HEE) and other stakeholders are developing national consistency around role definition and competencies for ACPs across specialties. This will improve the working lives of current and future ACPs, and clearly outline a career pathway which will benefit the care of CYP.

The NHS Youth Forum has highlighted the need for improved mental health training for staff and improved flexibility for young people to access services. HLP has developed a number of resources to help educate the future workforce, such as the mental health in schools toolkit, Paediatric care in Practice e-learning portal, and the asthma and primary care toolkits

The HLP peer review of acute care (2017) mentioned previously outlined the following in relation to workforce:

- Throughout the peer review process it was noted that the effectiveness of acute care services for CYP came down to the strength of leadership, at all levels. Staff were seen to go above and beyond what was required of them because of a commitment to each other – and because of the support received from senior paediatric clinical leaders.
- A number of the London Acute Care Standards for CYP cannot be met without sufficient staff numbers being in place. For instance, not all trusts met Standard 40, which requires that a consultant paediatrician be present and readily available in the hospital to cover extended day working (up until 10pm), seven days a week. Many trusts also found it difficult to ensure that the nurse in charge overnight was supernumerary.
- Many of the trusts reviewed were doing well in terms of nurse recruitment. However, there are difficulties in recruiting to peripheral DGHs due to the differential pay for outer London hospitals. In addition, there has been a request for training funding to be available for nursing and AHPs, similar to that available to medical staff. The Capital Nurse Programme seeks to secure a sustainable nursing workforce for London. Many trusts have to **rely on 'adult' nurses** to fill paediatric rotas, it was noted that some had looked at how the paediatric skills of these nurses could be increased. For example, Barts Health NHS Trust has been running a *Managing the Sick Child* course for adult nurses since February 2017.

- Reviewers also noted that trusts have been looking at how best to deploy other professional such as **paediatric advanced nurse practitioners** (PANPs) and clinicians' assistants.* PANPs could bring a wealth of knowledge and experience to paediatric services; it was noted how effective they had been in neonatal services.

Pharmacists are a vital element of the primary and community care NHS team. Working more closely with pharmacists has significant potential to improve the care and management of children and young people with long term health needs, and reflects NICE guidelines on community pharmacies promoting health and wellbeing. Initiatives include projects aimed to improve children and young people's control and management of asthma through the use of opportunistic inhaler reviews conducted by pharmacists with patients visiting the pharmacy.

Work is being done to break down barriers between secondary and community care but the funding flows often hamper this aim. Integrated care organisations are well placed to lead the way; for instance, some staff employed by Whittington Health NHS Trust already work across secondary and community care.

Closer working relationships between and across organisations and the development of new job roles will be important to ensure better outcomes for CYP across London.

9. Future Commissioning

Cohesive commissioning of children's health and wellbeing services can be challenging due to the split nature of funding across public health, local authority, CCGs and NHS England. Improvements in services can only be made through organisations working collaboratively looking at the need of their populations. The NHS Long Term Plan may begin to unlock some of the previous issues. The future will require:

- Development of clear information and consistent standardised pathways enabling CYP to access the right care at the right time in the right place and support for the management of long term conditions.
- Greater focus on prevention to support CYP families to live healthier lives and support good decision making.
- Joint working between health and social care integrating our scarce resources wisely.
- Commissioning community and voluntary sector organisations to help provide support.
- All elements of the system working together to support good health and wellbeing.
- Maximise potential for universal services so can identify problems and take action earlier.
- Greater use of technology should be used more widely.
- Collaborating with all partners to increase efficiency and effectiveness.
- Development of more integrated person centred coordinated and proactive care.
- Provision of more joined up care closer to home through strong primary care networks.
- Provision of support to CYP as they move to adult services.

Conclusion

London has a population of over 8.8 million, of whom almost a third (2.81 million) are aged 0 to 25. The city is diverse, with over 300 languages spoken in its schools. While there are areas of excellent care for CYP in London, and things have improved since 2014, there is still great variation across the capital, both in terms of care provision and health outcomes. The evidence is clear that change needs to continue to happen both locally and pan London.

In terms of the wider determinants of health, there are still some key issues for children that we need to work through with our partners, such as the GLA and local authorities, for example around poor housing, air quality and schools. As well as improving efficiency and effectiveness as poor efficiency can lead to poor care, poor experience and poor outcomes.

Young people have said that they want services designed around their needs, an urgent improvement in increasing mental health services and an improvement in how easy it is to see a doctor when you need to. Mental health access is a challenge given increasing prevalence estimates, and access to crisis care and Tier 2 services, preventing escalation of needs, is fundamental to improving patient outcomes. Long term conditions management in children needs to change in London, and greater 'networked care' will be key.

We know how important the formative years are for children, before birth and in the first two years. Public health services, such as health visiting and children's social care, are crucial in identifying vulnerable children and ensuring families get the right support to be able to thrive. Issues for young people around adverse childhood experiences, violence reduction and risky behaviours are high on the agenda during this period.

The provider landscape is complex and fragmented, with real pressures around staffing and workforce. Innovations led by HEE for providers will be key to ensuring paediatric services are sustainable and responsive to population needs.

Harnessing the skills and leadership from across the city to improve the quality and optimise health outcomes for children and young people is crucial. The new Integrated Care Systems have the opportunity to improve health services for children and young people across the capital and for services to become the best in the world. Maximising resources may mean there needs to be greater collaboration and pooling of resources, both financial and personnel, bringing community, primary, secondary, tertiary care, public health, voluntary sector and commissioners together to reduce the variations highlighted in this document.

For up-to-date resources on the work that we are doing to support change in London please visit the CYP area of the Healthy London Partnership website: https://www.healthylondon.org/our-work/children-young-people/.

Abbreviations

ACP	Advanced clinical practitioners
ASD	Autistic spectrum disorder
AYPH	Association of Young People's Health
CAMHS	Child and adolescent mental health
CCG	Clinical commissioning group
CYP	Children and young people
ED	Emergency department
EHCP	Educational health and care plan
GP	General Practitioner
HLP	Healthy London Partnership
HEE	Health Education England
ICS	Integrated Care System
MOPAC	Mayor's Office of Policing and Crime
PANP	Paediatric acute nurse practitioners
PCH	Primary care home
PHE	Public Health England
RCPCH	Royal College of Paediatrics and Child health
SEN	Special educational need
STP	Sustainability and Transformation Partnership
UNICEF	United National Children's Fund
VCS	Voluntary and community sector

Acknowledgements

Authors: Nicola Lang with Sara Nelson, Tracy Parr, Andy Martin, Georgie Herskovits, Chris Kirkpatrick, Stephanie Simmonds.

With thanks to: Claire Robertson & Marilena Korkodilos (PHE), Emma Rigby (AYPH), Sharon Long (City of London), Lydia Lofton (HEE), Nicky Brown (PHE), Dave Finch (NWL STP).

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Further resources and case studies

- Graham Allen MP's second report to government, Early Intervention: Smart investment, massive savings (HM Government 2011a), includes an annex on the 25 best early intervention programmes in the United Kingdom.
- The Children and Young People's Health Outcomes Forum has produced two recent reports (2013a, 2013b) one on public health and prevention, the other on tackling inequalities in health outcomes.
- The Greater London Authority has set out the economic case for early years interventions to reduce health inequalities in London (GLA Economics 2011).
- The experience of the 10 pilot sites for the Family Nurse Partnership programme in England has been evaluated, detailing the health impacts and cost issues (Barnes et al 2008).
- The National Foundation for Educational Research has published a guide that develops a business case for early interventions and considers their value for money (Durbin et al 2011).
- The best start in life (The King's Fund)