Primary Care Services for Children and Young People: A Review of the Key Literature

October 2007

NHS Primary Care Contracting & Primary Care Unlimited
Primary Care Services for Children and Young People: A Review of the Key Literature

1. Introduction

This literature review has summarised the key documents which both recognise primary care’s valuable contribution to the health and well-being of all children and young people and outline the impact upon future primary care services. The document is divided into a number of sections:

- Section 1 – Policy and guidance for children’s services
- Section 2 – The NSF and primary care
- Section 3 – Children with more complex needs
- Section 4 – Children’s services and commissioning reform
- Section 5 – Additional evidence
- Section 6 – Key messages from this Literature Search
- Section 7 – References.

Section 1 – Policy and Guidance for children’s services

1.1 Every Child Matters and the National Service Framework

The Green Paper *Every Child Matters (2003)* and the Change for Children programme, set out five outcomes to ensure that every child and young person has the opportunity to fulfil their potential. The five outcomes stipulated are:

- Being healthy
- Staying safe
- Enjoying and achieving
- Making a positive contribution
- Economic well being

To achieve these outcomes, valuable contributions from children and young people, parents and carers, public organisations, voluntary, community and private sectors will be necessary. This document was followed by the publication of *Every Child Matters: next steps (2004)*, which set out the future direction for the delivery of children’s services to achieve the five outcomes.

Chapter 3 (p26) looked at the two aims of maximizing opportunities and minimizing risk to children and young people with exemplars given which provided better access to universal services through the primary health care route. *Every Child Matters* also set the framework for supporting children, young people and families in need of more specialist support.

Subsequently, the *National Service Framework for Children, Young People and Maternity Services - Core Standards (2004)*, advocated a shift towards services being designed and
delivered around the needs of the child. Furthermore, early intervention to prevent illness or to minimise the affect of illness was seen as key to ensuring that all children and young people realised their full potential. The NSF was published as a ten year plan. By 2014, the expectation being that health, social and education services would work together to provide better, fairer access to services and meet the evidence-based standards set out, ensuring cross-sector working and smooth transitions in partnership with children, young people and families.

In all, 11 Standards were set out in the NSF. Part 1 consists of the first five Core standards, these being applicable to all children and covering:

- Promoting Health and Well being, Identifying Needs and Intervening Early
- Supporting Parenting
- Child, Young Person and Family Centred Services
- Growing Up into Adulthood
- Safeguarding and Promoting the Welfare of Children and Young People

Part 2 (Standards 6-10) relates to specific groups of children and covers:

- Children and Young People who are ill
- Children and Young People in Hospital
- Disabled Children, Young People and those with Complex Health Needs
- The Mental Health and Psychological Well-being of Children and Young People
- Medicines for Children and Young People

Part 3 (Standard 11) covers maternity services.

**1.2 Children’s Trusts**

Children’s Trusts, or equivalent arrangements, are intended to bring together education, health, social services and other partners, to promote cooperation with the aim of improving children’s well-being. The Children Act 2004 required local authorities in England to develop Children’s Trust-type arrangements and altered the statutory frameworks within which local authorities operate. The National Evaluation of Children’s Trust Pathfinder Final Report (2007) provided some headline messages from these early arrangements.

Children’s Trusts have acted as catalysts for more integrated approaches to diagnosis and provision of services for children. Joint commissioning arrangements have begun to develop as well as joint workforce development, training and new, more flexible types of professional roles. There are early signs that these arrangements can have positive health and well being outcomes for children and young people, despite the complexity of the local change process.

Lessons learned from these pathfinders have significant implications for primary care, not least its role in the collaborative development and implementation of the Children and Young People’s Plan (CYPP). Commissioning budgets can be pooled or aligned for health with protective mechanisms to ensure these funds are not used to recover financial deficits. Joint commissioning arrangements require collaborative working, including primary care input into service re-design, with a greater understanding and engagement of GPs in this process. There is also a need for better integration of IT systems and information sharing arrangements, including understanding the different language used in different provider sectors.
The most significant outcome has been the benefit of working in co-located, multi-disciplinary teams with the workforce developing generic skills and with lead professionals emerging. These lead roles could be filled by local GPSI’s. Further professional development and training is necessary in communication, intervention, listening and disability awareness. In terms of outcomes so far, Children’s Trust arrangements have had a positive effect on efficiency, integration and freeing up of resources to re-invest into preventative work. More detailed development of local outcome indicators around the five priorities of Every Child Matters is now needed.

1.3 Sure Start Children’s Centres

There is a duty on local authorities under Section 4 of the Childcare Act (2006) to work with partners such as the NHS to improve outcomes for all children and reduce health inequalities by providing integrated early years services. Delivering health services through Sure Start Children’s Centres (2007) describes how Centres have developed from the original Sure Start local programmes and by 2010 there will be 3,500 Children’s Centres with one in every community.

Children’s Centres will provide better access to health for those excluded from mainstream services. The Centres help to deliver the Child Health Promotion Programme as set out in the NSF core standards and enable better integration with other agencies. Children’s Centres gain the skills and expertise of health professionals, through co-location, to provide:

- early years provision;
- a childminders’ network;
- parenting education and family support services;
- education, training and employment services;
- health services; and
- access to wider services.

The Child Health Promotion Programme, maternity, health visiting and other parenting support services are expected to be delivered from Children’s Centres, especially in more deprived areas. Health services provided in a Children’s Centre could also include well baby clinics/cafes, parent craft classes, immunisation sessions or even specialist sessions such as asthma, dermatology or paediatric out-patients.

For PCTs, Children’s Centres will help to deliver key Public Health priorities as laid out in the NHS Operating Framework 2007-08 including reducing health inequalities, adult smoking rates, the rise in childhood obesity and under 18 conception rates. It will do this by making services more visible and accessible as well as having a strong focus on assertive outreach into the community. Furthermore, primary care professionals should have a wide-ranging role in the design and development of the Centres including service re-design, delivery of new services at all levels and by a wide variety of practitioners, signposting, and information sharing into and out of the Centres. There are significant opportunities for PCTs and Practice Based Commissioners (PBC’s) for improving children’s health, providing new and innovative primary care services and as a means of targeting resources more effectively for vulnerable children and families and those with complex needs.
1.4 Safeguarding Children

*Working Together to Safeguard Children (2006)* sets out statutory guidance on how organisations and individuals work together to safeguard and promote the welfare of children, and the shared responsibilities of these organisations and individuals. The Local Authority has a duty to safeguard and promote the welfare of children and young people. The document reflects Standard 5 of the NSF.

Primary care has a responsibility to work as an active partner in this relationship. In particular, services and practitioners should ensure appropriate and timely prevention, identification, and intervention with an all-pervading approach to safeguarding. Primary care will need to respond to concerns about the welfare of the child, provide initial health assessment, act urgently where needed, and help implement any action. Primary care professionals should be aware of these responsibilities, cooperating fully with all necessary agencies under the Local Safeguarding Children Board and be able to recognise risk factors, contribute to reviews and child protection conferences and follow up plans. Furthermore, it is primary care’s responsibility to ensure good access to services and to offer families reliable advice, information and signposting to other services available. Primary care professionals may also be invited to the Child Death Overview Panel or be part of serious case reviews.

Training issues are important in primary care and support should be offered from other agencies once training needs have been identified, with targeted training to primary care professional groups where appropriate.

**Section 2 – The NSF and primary care**

The *National Service Framework for Children, Young People and Maternity Services – Key Issues for Primary Care (2004)* was aimed specifically at primary care organisations, providers and health professionals. It focused on the requirements for GPs and all members of the primary healthcare team to help implement and achieve the standards of the NSF.

Clearly, GP practices and other primary care professionals such as attached Health Visitors have a number of responsibilities in delivering the core Child Health Promotion Programme, deliver the GMS Additional Service, and links with local Children’s Centres. These include preventing infectious disease by checking and providing immunisations, comprehensively assessing child health and intervening early if appropriate, following up non-attendance, promoting positive mental health with effective prevention and early intervention to help reduce the burden on Child & Adult Mental Health Services (CAMHS).

With many contacts per year (6 pre-school and 2-3 at school age), primary care professionals also play a key role in helping to promote better teenage health - reducing teenage pregnancy, smoking, substance misuse, STIs and suicide. There is also a responsibility to support parents, including those who have special needs or who have children with special needs, and support adults who may be caring for Looked After Children by providing good advice, information and signposting to other more specialist services. There is a requirement on all healthcare professionals to keep good records and share information across services, respecting rights, confidentiality and consent issues. Primary care professionals should be aware of increased
vulnerability of some children and respond to concerns about safety and welfare, protecting children from harm.

Professional training and development issues relating to children with specific conditions, disabilities or more complex needs are essential to support the delivery of the NSF Standards 6-10. There is a need for alternatives to hospital services as well as good discharge planning in primary and social care for children in hospital, enhanced self-care, and information around managing minor illnesses and injuries. Developing robust appointment booking systems and drop-in sessions will improve access outside school hours and offer wider choices for children and families. Assessing ill children should be done by competent, trained staff using recognised guidelines with re-assessment in primary care where appropriate.

Health Visitors and GPs have a key role in early identification of mental health concerns with appropriate referral to more specialist services, such as CAMHS and Community Mental Health Practitioners using agreed protocols. A professional Children’s Clinical Network can operate with contribution from all primary care professionals, keeping them in touch with lead paediatricians or key workers.

Finally, medicines management issues in primary care are numerous and complex and are made more sensitive when applied to children. For example, prescribing dosages, shared decision-making and concordance with medicines, information to patients on medicines, medication reviews, and supporting parents or carers in the administration of medicines to children. As with adult medication, clinical governance procedures need to be robust, including the training and competency development that may be necessary for those primary care professionals who ensure the safe and effective use of medicines for children.

Section 3 – Children with more complex needs

3.1 Children’s Palliative Care

Recent data from *Palliative Care Statistics for Children and Young People (2007)*, published by Health and Care Partnerships Analysis, suggests there is an increasing prevalence of children with conditions requiring palliative care with 20,000 between the ages of 0-19 years likely to require palliative care (16/1000 population). Even though number of neonatal deaths has fallen in the last few years, three quarters of deaths occurred in hospital and within 40 minutes of a hospice and 30 minutes of a specialist palliative care service. Most parents would have preferred their child to die at home.

The burden on hospital usage is significant. There has been an increase in demand for palliative care services over the last nine years. In 2005-06, a third of bed days for all patients aged 0-19 years had conditions that may lead to an eventual need for palliative care. Even though there were no differences in quality of access to palliative care across sampled regions, those children who died in hospital needing palliative care also had on average 2.4 admissions to hospital in the 12 months prior to their death. About a third of NHS expenditure and bed occupancy are attributable to those who need palliative care in this age group, costing £536 million each year.
The independent review, *Palliative Care Services for Children and Young People in England (2007)*, provides further evidence of service need and service change. It found that there were strong overlaps between children with palliative care needs and those with disabilities, resulting in the need for these services to be planned and commissioned together. There was a lack of understanding of the issues and little evidence of health, social care and education working together with responsible, accountable leaders. However, there was evidence of tired and committed parents needing support and a committed workforce battling against the system.

The review found huge variability in availability of services, with multiple agency assessments and patients experiencing gaps between health and social care. The review also found that there was strong support for implementing the full range of services developed by the Association for Children’s Palliative Care (ACT), particularly 24/7 community-based advice services for parents/carers. Without these services there has been a high use of expensive A&E and inpatient hospital care. Furthermore, the review reported significant voluntary sector support for children’s palliative care but problems involving this sector in service planning and commissioning. Supporting children in the community is far more cost-effective than waiting until the child reaches crisis.

In the main, the review found children’s palliative care services and funding to be varied, unplanned and short term. Too many key services are reliant on short-term grants or voluntary provision. The recent national announcement of £27million targeted at children’s hospices will help but sustainable solutions to increase availability and access need to be found. Further, it is recommended that palliative care services for children should be planned and commissioned with a population no fewer than 1 million to maximise cost-effectiveness, the best clinical networks, and more integrated services. Paediatric Palliative Care Networks have excellent potential but development has been patchy and they require further support to gain momentum and effective working. That said, individual key workers remain essential to maintain strong, personal contact with children and families in need of palliative care services.

As well as specialist paediatric care, the types of core palliative care services likely to be accessed include community nursing teams, hospices, specialist respite care as well as more mainstream children’s services. This would mean planning and commissioning changes at every level.

For primary care, improved data collection, needs assessment and information transfer is required with development of a consistent, ‘single assessment’ process for children with palliative care needs. Access to the full range of services is necessary with a greater focus on community-based services to promote independent living. Use of the ACT Transition Pathway will provide a greater focus on improving the poor state of transition services into adulthood. More training and development of basic competencies is required, with career pathways for nurses made clear, and best practice information sharing is necessary for primary care professionals. Improved audit, regulation and benchmarking processes need to be developed to ensure standards are raised. PCTs should ensure a reasonable level of spend on children’s palliative care with new money targeted appropriately.
3.2 Children’s Mental Health

Children and Adolescent Mental Health Services (CAMHS) vary considerably with differing baseline starting points and priorities. *Promoting the mental health and psychological well-being of children and young people: report on the implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services (2006)* highlights medium term priorities for CAMHS as well as models of good practice for primary care and emphasises the need for local, sustainable services.

Increased staffing levels, skills and competencies are needed across the primary care and CAMHS workforce with core training in mental health promotion highlighted as a key development area, particularly for nurses. This will help promote psychological well being to mothers, with supported parenting, and be spread across more vulnerable groups. Training will help improve the recognition of mental health problems in children and encourage more appropriate onward referral to specialist services.

The report recommends that more community-based teams to ensure improved equality of access to services and to address those with more complex needs. This would be supported by intensive multi-agency outreach services and Paediatric Liaison services. Outcome monitoring in primary care needs to be further developed as well as ensuring buildings are fit-for-purpose and levels of user involvement improved and sustained.

The implementation of NICE guidance covers all services provided in primary care as part of Standards for Better Health and good clinical governance. NICE guidance specific to this area includes *Antenatal and postnatal mental health: clinical management and service guidance (2007)* which recommends the support and treatment of women following birth which ensures the child is being cared for appropriately, including if the mother is suffering from depression. To ensure safeguarding, guidance encourages community nursing staff and GPs to recognise symptoms and ask specific questions about the mothers mental well-being.

The NICE guidance for *Depression in children and young people: identification and management in primary, community and secondary care (2005)* covered detailed information on routine assessment by health professionals including identifying risk of childhood depression and evaluating all psychosocial risk factors. It emphasised when and where psychological therapies could and should be provided with training being provided by trained CAMHS professionals. It recommended that anti-depressants should not be used for mild depression. Psychological therapy should be used as first line treatment for moderate to severe depression with anti-depressents only used in combination with concurrent psychological therapy. The guidance also stressed the need for good communication between health professionals and children, parents or carers by providing supportive information such as self-help guides or local self-help groups as well as treating each child, and the decision-making process in their care according to their individual needs and wishes.

Primary care will be involved in many areas of guidance implementation. It will be useful to have representation on in any guideline implementation group, carry out baseline assessments such as GP clinical information systems or evaluating the range, quality and compliance of mental health services in primary care. For PBC’s, the guidance has implications for use of commissioning resource, action planning and review and monitoring of implementation arrangements as well as service improvements as a result of the guidance. Considering all this,
guideline implementation is therefore likely to benefit from more joint commissioning arrangements in primary care.

3.3 Children in Care

Children who are in the care of local authorities are described as 'looked-after children'. They are one of the most vulnerable groups in society. The majority of children who remain in care are there because they have suffered abuse or neglect. Recent statistics show that 60,000 children were looked after in 2005-06 (although 90,000 passed through care in the year). 70% were in foster care and 3700 children were adopted in this year. The majority of these children have been living in care for over 2.5 years. More children are tending to stay in care until their 18th birthday and there were 320 mothers aged 12 and over who were looked after at 31 March 2006. There are now several national targets to reduce the numbers of looked after children, to decrease the time spent in care and to increase the number of those adopted.

Promoting the Health of Looked After Children (2002) guidance sets out the revised legislative framework for safeguarding and promoting the health of looked after children and young people. It describes the levels of unmet health need and the rationale for the service delivery model as well as setting out the role and responsibilities of different agencies and the principles of good health care. This is set within a framework for assessment, planning, intervention and review of the health needs of looked after children. It also provides guidance on the health needs of children and young people in specific circumstances.

The primary care team has an important role to play, particularly in many instances in providing continuity before, during and after the child is looked after. They can act as advocates for the health of each looked after child/young person and ensure timely, sensitive access to core services or referrals to specialist services. Community-based teams or practices should provide timely summaries of health information and maintain records of health assessment and contribute to any action plan. They must ensure clinical records identify the “looked after” status of the child/young person, so that their particular needs can be acknowledged, and undertake regular clinical record review. GPs and nurses working in primary care or as PBC’s can assist PCTs in fulfilling their responsibilities as commissioners of services to improve the health of looked after children. They can provide expert advice and contribute to, planning, strategy and audit of quality standards for health services for looked after children.

Healthy Care (2005) is a national programme developed by the National Children's Bureau (NCB) and funded by the Department for Children, Schools and Families, which aims to promote a healthy care environment where looked-after children and young people experience a genuinely caring, supportive, stable and secure relationship with at least one committed, trained, experienced and supported carer and live in an environment that promotes health and wellbeing within the wider community. Children and young people will have opportunities to develop personal and social skills to care for their health and wellbeing and receive effective healthcare, assessment, treatment and support. The programme provides a multi-agency framework for local partnerships to achieve the five outcomes for children set out in Every Child Matters. It provides a national standard that reflects best operational practice and offers a set of tools and resources for local organisations.

The Green Paper Care Matters: Transforming the Lives of Children and Young People in Care (2006) set out a radical package of proposals for addressing the widening gap of outcomes for children in care compared with others, such as poorer educational achievement (despite
recent improvements) and greater vulnerability. The proposals cover children moving in and out of care, the role of the corporate parent, better placements with more support for foster carers, improved educational support, and strengthening the support provided for children in care through transition into adult life.

Primary care’s contribution towards these changes will revolve around more strategic commissioning as well as professional support for core primary care services, integrated working and early identification and intervention. This will mean improvements in the links between adults’ and children’s services, a more preventive approach where health problems are identified earlier with earlier intervention together with sustained, multi-disciplinary support for children in care. In addition, better integration of health and social care will help in piloting new ‘social care practices’, there will need to be improved support offered by school nurses within the setting, better training for primary care professionals and improved access to Children’s Centre services. In terms of commissioning, PCTs and PBC’s will need to link into the proposed regional commissioning units to secure better value for money for placements.

3.4 Children with Learning Disabilities

The *Valuing People* (2001) report described evidence that people with learning disabilities do not access routine primary care services as much as the general population although they often have greater health needs than other children. It is suggested that these inequalities are a result of a failure to be pro-active in providing accessible, high quality health services. This was reinforced by *Equal Treatment – Closing the Gap* (2007) published by the Disability Rights Commission. National targets have been set for statutory organisations to improve the outcomes for people with long term conditions by offering personalised care plans for vulnerable people most at risk.

In relation to primary care services, the single biggest difference that can be made to improve outcomes is for general practices to provide systematic annual health checks and development of Health Action Plans for people with learning disabilities (now described in detail in the *Primary Care Service Framework: The management of health for people with learning disabilities* (2007)). Furthermore, the Mencap report *Death by Indifference* (2007) showed that information transfer and communication between GP practices and other services was a key requirement for improved services for people with learning disabilities.

3.5 Children in Transition

Many children and young people will now survive into adulthood with complex conditions. *Transition: getting it right for young people. Improving the transition of young people with long term conditions from children’s to adult health services* (2006) makes clear suggestions for improving transitional services. These include recognition of the importance of the process, adequate consultation with professionals and users, flexibility in the timing of transition, a period of preparation for children and families, better information transfer and better monitoring until the young person is established into adult services. The report provides a number of models for transition including dedicated follow-up and co-ordinating services or joint approaches to provide seamless clinics for both children’s and adult services. These models can be led from paediatric, hospital or community settings.
Along with these useful models, the report suggested a number of actions which may impact on primary care commissioners and providers. These include having a dedicated senior lead clinician to drive the overall strategic planning of transitional services, agreed ways to measure effectiveness such as DNA rates on 2\textsuperscript{nd} appointment at the adult service, specific research and clinical audit, training and workforce development around transition issues, and developing better partnership working using Youth Services or Connexions as examples.

In specific clinical areas, transition services are poor for children with palliative care needs. The recent review suggests the use of the ACT Transition Pathway. NICE guidance for depression in children recommends that CAMHS should improve collaboration with adult services which should be informed by the Care Programme Approach. CAMHS should also improve the sharing of information to other services and consider continuing the care of those with recurrent depression rather than discharge, or those still recovering from a first episode of depression.

Section 4 – Children’s services and commissioning reform

Recent aspects of NHS reform have had a significant impact on the way health services are planned and commissioned including the contractual and operating relationships between commissioners, their strategic partners, and provider organisations. The key national policies include:

- The \textit{Choosing Health} (2004) White Paper emphasised the need to support people and families in making healthy lifestyle choices. It recognised that patterns of behaviour are often set early on and that support in children’s early years can prevent negative effects later in life. Sure Start local programmes and children’s centres have a good track record of providing programmes that support families in developing healthy lifestyles.
- \textit{Commissioning a Patient-Led NHS} (2005) stated that the NHS should be moving from a provider driven service to a commissioning driven one. The document set out the importance of expert and imaginative commissioning in order to achieve the aim of a patient-led NHS.
- \textit{Health Reform in England} (2005) described the different reforms that are being made to the healthcare system and explained how they are expected to interact. The document reinforced the importance of good commissioning in achieving services that meet the needs of the local population whilst also obtaining good value for money.
- The White Paper on community services, \textit{Our health, Our care, Our say} (2006), emphasised the importance of good commissioning in providing integrated services, building on good local partnerships, and providing more care within the community. The White Paper stated that commissioners should commission for ‘health and well-being’ to ensure that health improvement is at the heart of the commissioning process.
- \textit{Health reform in England: update & commissioning framework} (2006) provided a detailed framework for commissioning. The framework included policy and implementation guidance on commissioning and PBC and expectations of how PCTs, GPs and health and social care commissioners will work together.
- The \textit{Commissioning Framework for Health and Well-being} (2007) re-emphasised the priorities from the Our health, Our care, Our say White Paper and provided further guidance on joint commissioning between PCTs and Local Authorities with a focus on
more individualised healthcare, more integrated services and commissioning for improved health and well-being outcomes. This approach has now laid the foundations for all future commissioning processes with a shift towards more preventative healthcare. The Children's Centres approach fits well within this framework. Its focus is on improving outcomes, including the promotion of health and well-being, for children and families. Multi-agency teams in Children's Centres have been able to offer new and innovative services that are designed around the needs of the child and family. They also have a track record of community engagement and user participation. PCTs can strengthen their patient involvement and choice agenda by drawing upon the learning from Children’s Centres’ experience of engaging with communities. The Joint Planning and Commissioning Framework for Children, Young People and Maternity Services (2006) set out the principles for developing comprehensive, integrated services for children and families including Joint Strategic Needs Assessments. PCTs, PBC’s and health professionals are then able to influence the design and provision of services to address these needs.

- **Improving the quality and outcomes for services to children and young people through effective commissioning (2007)** provides a self-assessment tool for commissioners, highlighting best practice to ensure children and young people’s services meet the needs of the population and reduce health inequalities. Commissioners therefore need to understand the complexities of care pathways for children and young people and to work closely with partner organisations in assessing local needs, designing and planning the required services, and exploring joint financial arrangements. The development of Children’s Trust arrangements and duties set out in the Children’s Act (2004) underpins this.

- **Aiming High for Children: supporting families (2007)** provides further cross-government support for the children’s agenda through sustained investment in the Comprehensive Spending Review (period 2008-9 to 2010-11). This investment will focus on early year’s services, childcare support and Sure Start Children’s Centres, more personalised and responsive packages of support for families, more outreach services, and support for families to break the cycle between poor child outcomes and complex need.

- Under the Comprehensive Spending Review (2008-9 to 2010-11) specific national investment for disabled children has also been announced. **Aiming High for Disabled Children: better support for families (2007)** has three priority areas to improve outcomes for disabled children. These are:
  - access and empowerment – engaging disabled children and their families to ensure they have a say in provision of more appropriate services allowing for more flexible and tailored provision. This will include a standard offer encompassing information, transparency, participation, assessment, and feedback. Individual Budgets will be piloted as well as the further spread of good practice on engagement.
  - responsive services and timely support – a national disabled children indicator will be part of the new set of priority Public Service Agreements, evaluation and benchmarking good practice on early interventions, improvements in data collection and data coordination, continued roll out of the Early Support Programme, and a Transition Support Programme for the critical transition to adulthood.
improving quality and capacity – further provision of short breaks for disabled children, more accessible childcare, reform of community equipment and wheelchair provision, and research into the skills and behaviours required by the workforce.

- ‘Shaping health care for the next decade’ is the NHS next stage review was announced in July 2007. This review will examine how the NHS can provide better access to safer, high quality care for all, whilst delivering value for money for taxpayers. An interim report is due in Autumn 2007 with the final report available in July 2008.

Section 5 – Additional evidence

The BMJ article Young people’s health: the need for action (2005) calls for a much keener focus on the health of young people, particularly as three quarters of young people attend their GP practice each year. This is critical as, during adolescence, young people begin to explore ‘adult’ behaviours including smoking, drinking, drug use, violence, and sexual intimacy. However, there is evidence that services, and where they are delivered from, are not designed around the needs of young people (reinforced by the You’re Welcome quality criteria for young people’s services, 2005) and address only single issue approaches and not more holistic, integrated and preventive health care.

The article makes a number of suggestions to improve primary care services, particularly in GP settings. These include developing ‘Expert Patient’ initiatives specifically for young people, using IT to engage more young people, getting teenagers to re-register (14-15 years) with practices so as to develop a relationship with practitioners. It also suggests extending provision in primary care to include co-located services such as sexual health, drug, alcohol, counselling and youth psychiatric services as ‘one-stop-shops’ for young people.

The British Journal of General Practice article Honey, I shrank the kid’s health service (2007) questioned family practitioner support for children and young people’s healthcare because so few 11-14 year olds were recorded as having contact with general practice. However, it did praise the excellent work done by Sure Start Children’s Centres. It suggests that children may increasingly and appropriately be seen by nurses rather than GPs and that the focus should move away from that of what the profession wants to more of what patients want the profession to create for them in the community.

In Facing the Future: a review of the role of the health visitor (2007) it has been proposed to reform the existing health visiting service into a fully integrated preventive service for children and families acknowledging the public health context. The core elements of health visiting should be in public health and nursing, working with the whole family and providing early intervention and prevention. The focus of health visitors should be early intervention, prevention and health promotion for young children and families as this is where their nursing and public health skills and knowledge can have the greatest impact.

This review set out a number of priorities for health visitors in their day-to-day work. As highly trained professionals, health visitors should be responsible for the ‘difficult things’ such as managing risk and safeguarding children, addressing children with complex needs, leading multi-skilled teams and delivering population level outcomes. The primary role of the health visitor should be either leading and delivering the Child Health Promotion Programme or delivering intensive programmes for the most vulnerable children and families. Health visiting
services should be located in either Children’s Centres or as part of the primary health care team.

The revised *Quality and Outcomes Framework (2006-07)* mentions children specifically in a number of indicators including:

- Patient Experience 6 – convening focus groups for particular service needs eg mother and young children
- Asthma 1 – register of all patients with asthma (detailing how to obtain a definitive diagnosis in children)
- Diabetes 19 – register of all patients aged 17 years or over (but excluding those aged 16 and under as care is usually under the control of specialists)
- Management 1 – access to information on local child protection procedures.

*Department of Health and RCGP seminar (20th July 2007)* discussed how primary care could best meet the needs of all children and young people, identifying services that were well provided for and where there were significant gaps in services. The seminar identified the need to ensure that all practitioners working with children and young people needed to have appropriate *skills, competencies and education* to improve outcomes. This would mean further support for generalists, training for all primary care practitioners with safeguarding and child protection, developing competency measures, and encouraging peer networks and PwSI to support the primary to secondary care interface. For *commissioning*, opportunities for PBC to develop joint commissioning through children’s trust arrangements, shifting unnecessary referrals to primary care, developing the public health and prevention role and recognizing the existence of differing local populations were important. In terms of *data and information*, more meaningful population data needs to be available and used with updated directories of local services. Confidentiality issues between agencies don’t have to be a barrier with opportunities for improved pathways through multi-agency working and effective use of the Common Assessment Framework. Services need to be provided in the *location* that best meet the needs of the users, be it general practice, schools or other community facility as one-stop-shop approach or drop-in service.

In conclusion, the context of multi-agency commissioning, service delivery, access and treatment pathways shows that primary care is critical to successful children and young people’s services.

**Section 6 – Key messages from this Literature Search**

**6.1 What should good primary care look like?**

Building on the discussion outcomes of the recent DH and RCGP seminar and based on the literature search evidence, the following lists some focal points for future primary care.

1. Move away from single issue services to more holistic, universal primary care services for all children, ensuring equal access for hard-to-reach groups, using progressive universal approach.
3. Increased use of skill mix and the full range of primary care providers to achieve the objectives of Every Child Matters, CYPP, and improved population health.
4. More services that are focused on prevention and early intervention, provided by primary care professionals scaling up and referring to the next level as appropriate.
5. Recognising the need to use Sure Start Children's Centres as a community focal point (hub) for integrated services (potentially including core medical services).
6. Use of integrated IT, data and information across key stakeholder agencies.
7. Core competency framework, based around Child Health Promotion Programme, public health, and understanding of complex needs of children should be implemented for all primary and social care practitioners.
6.2 Theoretical primary care model for children’s services

- Hub provides integrated primary care services; could also be virtual
- Children’s primary care hub
  - Children’s Centre (with schools)
  - GP
  - Home

PCT/LA/Children’s Trust strategic ‘umbrella’ agreeing Children and Young Person’s Plan following Joint Strategic Needs Assessment

Commissioning and Performance Man’gt Framework for the hub

- Other partner agencies
- Other potential primary care providers
- Assertive outreach services
- 24/7 advice services
  - CHPP
  - Palliative care
  - CAMHS
  - ‘Risky’ behaviour services
  - Interactive IT health
  - Minor ailments/injuries
  - Medicines Management
  - Parenting support
  - Transition coordination
- Specialist services
- Other independent contractors

6.3 Selection of key deliverables for commissioners, providers and practitioners

<table>
<thead>
<tr>
<th>Commissioners</th>
<th>Providers/Practitioners</th>
</tr>
</thead>
</table>
| **PCTs**  
1. Protection of commissioning resource for children’s services  
2. Joint commissioning opportunities with LA/Children’s Trust, particularly for children with more complex needs  
3. Ensure optimal contract value via leverage of existing mechanisms (ie GMS, PMS, QOF) including contractual penalties/rewards around core and additional services | **GP Practices and GPs**  
1. Maximise CHPP in core and Additional GMS, linking with Health Visitors and Children’s Centres  
2. Develop GPSI practitioner competencies to support Children’s Centre services  
3. Extend range of children and Young People preventive and health promotion services outside school hours, in child friendly environments using progressive universal approach |
4. Co-locate services in Sure Start Children’s Centres
5. Review Community Nursing roles and links with GP
6. Ensure commissioning across whole children’s pathway using PBC
7. Improve use of joint strategic needs assessment to provide services which reduce health inequalities
8. Commission alternative providers to improve choice, access, quality and value for money such as voluntary/third/independent sector
9. Support and develop local Children’s Clinical Network

**PBC’s**
10. Explore opportunities for joint commissioning under Health Act flexibilities
11. Early win focus on urgent care demand management, particularly children’s minor ailment/injury services
12. Business plan for service provision across whole children’s pathway, particularly preventive services and health and well-being initiatives, to deliver Every Child Matters objectives
13. Greater involvement in CYPP delivery
14. Collective commissioning plans with other PBC groups/localities to ensure economies of scale

**Local Authorities**
15. Joint commissioning opportunities with PCT/Children’s Trust, particularly for children with more complex needs
16. Further explore use of Individual Budgets for children’s services
17. Commission alternative providers to improve choice, access, quality and value for money such as voluntary/third/independent sector

**Community Pharmacists/Dentist/Optometrists**
9. Greater involvement in children’s medicines management, potentially through Children’s Centres
10. Improved range of integrated provision of preventive child health and well-being services either through core contracts or enhanced services
11. Deliver performance against CYPP objectives (Balanced Scorecard)

**Community Nursing teams**
12. Review health visiting role and further integration with PBC groups, GP practices and Children’s Centres to deliver CHPP
13. Extend role of Community Matrons to address children ‘at risk’ of hospital admission
14. Development of integrated team working with more flexible use of skill mix and generic working
15. Deliver performance against CYPP objectives (Balanced Scorecard)

**CAMHS**
16. Closer integration with other primary care services, possibly through Children’s Centres
17. Provide training for other generalist primary care practitioners
<table>
<thead>
<tr>
<th></th>
<th>Community Paediatricians</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.</td>
<td>Deliver performance against CYPP objectives (Balanced Scorecard)</td>
</tr>
<tr>
<td>19.</td>
<td>Role clarification in relation to position and function of community paediatrics encouraging local flexibility.</td>
</tr>
<tr>
<td>20.</td>
<td>Deliver performance against CYPP objectives (Balanced Scorecard)</td>
</tr>
</tbody>
</table>
Section 7 - References

5. Department of Health (2007). *Delivering health services through Sure Start Children’s Centres*
8. Department of Health (2007). *Palliative Care Statistics for Children and Young People*
13. Department of Health (2002). *Promoting the Health of Looked After Children*
18. NHS Primary Care Contracting (2007). *Primary Care Service Framework: The management of health for people with learning disabilities*
19. Mencap (2007). *Death by Indifference – Following up the Treat me right! report*

20. Department for Education and Skills and the Department of Health (2006). *Transition: getting it right for young people. Improving the transition of young people with long term conditions from children’s to adult health services*


30. HM Treasury and Department for Education and Skills (2007). *Aiming High for Disabled Children: better support for families*


36. *Quality and Outcomes Framework (2006-07)*

37. Department of Health and RCGP seminar (20th July 2007)