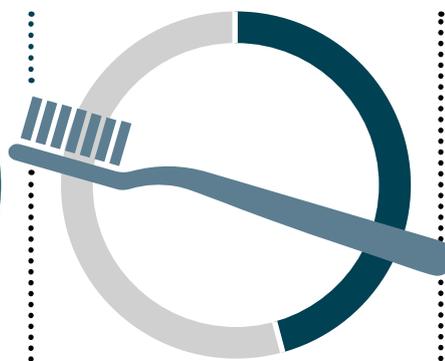


CHAPTER 8: Health promotion and use of health services



OVER 80%
of secondary school pupils
in the UK receive teenage
vaccinations including
MMR, MenACWY and HPV



46%
of 15 year olds
have decay in their
permanent teeth



The number of referrals to
specialist children's mental
health services has
increased by 26% over the
last five years.



**SCHOOLS, PARENTS, PEERS AND THE
VOLUNTARY SECTOR ALL PLAY A MAJOR
PART IN HEALTH PROMOTION FOR
YOUNG PEOPLE**

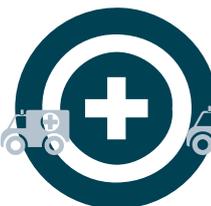
For every 1000 people under
18, although approximately
140 will have mental health
problems, only 18 will be on
the formal child and adolescent
mental health services caseload



**52% OF BOYS
AND 57% OF GIRLS**
in Year 10 (aged 14-15) have visited
their GP in the past 3 months



A third (32%) of those age 16-25
who could not get to see the GP
when they wanted then went to
Accident and Emergency



A&E attendances for
15-19 year olds have
risen by 10% since
2010/11



Health promotion and use of health services

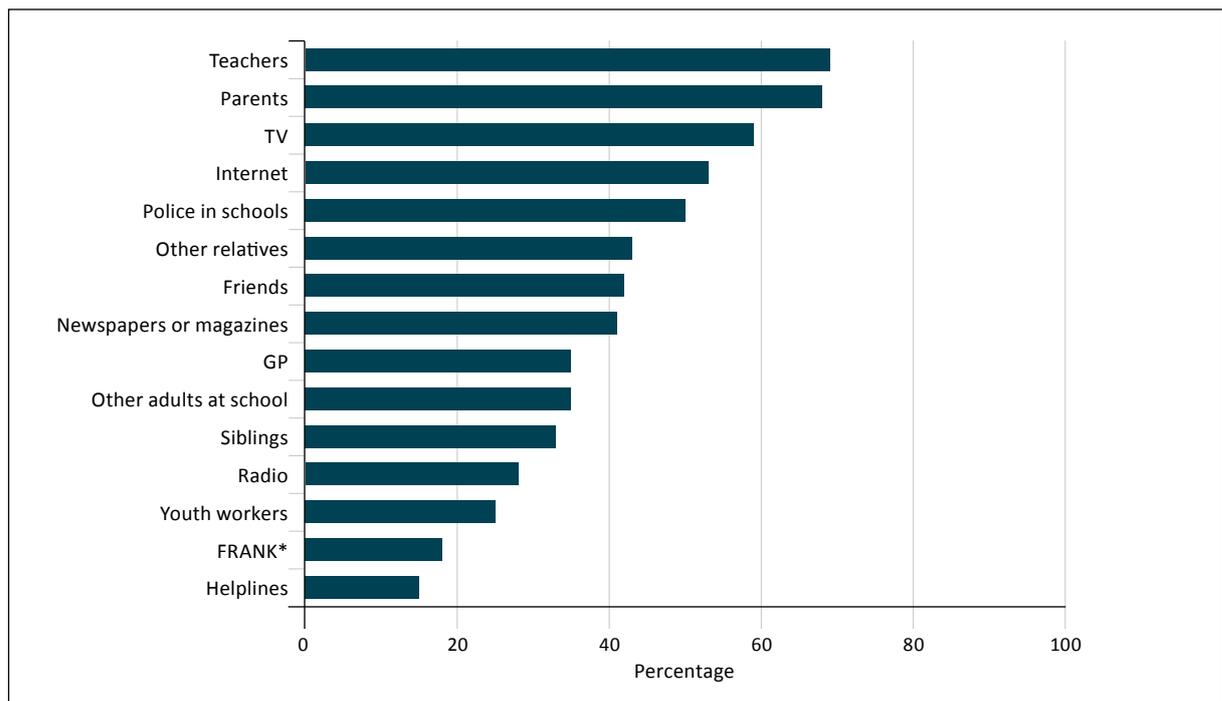
Good outcomes for young people rely on an interaction between their needs and how well services can meet them. In this chapter we look at young people's views on and use of health services, from community based health promotion through to NHS inpatient care.

Health promotion

One of the key challenges for young people is the transition to independence that takes place across the second decade of life. Learning how to recognise health issues and manage the process of getting help is very important at this time. Supporting young people through this process means empowering them to take control of their health and giving them the information they need to seek appropriate services.

Health promotion for this age group tends to focus on sexual health, physical activity, smoking, drinking and drug use, and diet and nutrition. Interventions to promote health can address individual behaviour and can also target wider social and environmental factors. Interventions aimed at changing individual behaviour include stopping smoking programmes, promotion of dental check-ups, or school based relationship and sex education. Wider population interventions might include media information campaigns or policy such as advertising bans, tax incentives and pricing structures (for example, in relation to alcohol sales) and clearer food labelling. There are very few representative data on how these wider population interventions might impact on young people, mainly because undertaking the studies that would answer the question is methodologically complex and expensive, and the effect sizes are probably small at the individual level. However, we do have more information on the effectiveness of health promotion as delivered through schools, vaccination programmes, access to helplines and individual level support and advice.

Chart 8.1: Sources of helpful information about drug use, school pupils in England, 2013



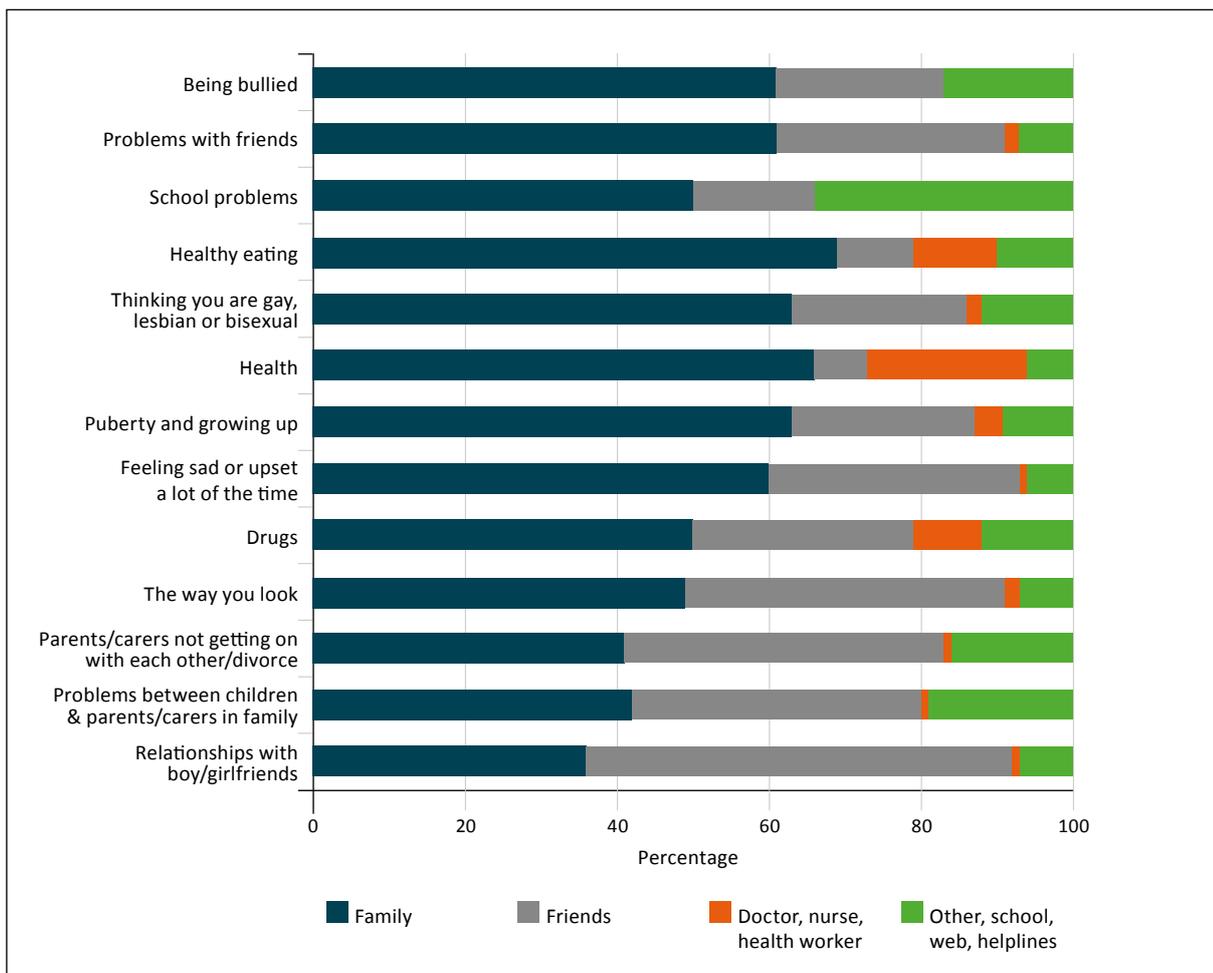
Source: HSCIC (2014), Smoking, Drinking and Drug Use Among Young People in England > [DOWNLOAD DATA](#)

* Department of Health 'Talk to FRANK service'

When asked about sources of helpful information, for example about drug use, young people report that they use a wide range of sources. Questions asked in the 2013 HSCIC Smoking, Drinking and Drug Use Survey (SDDU) showed teachers and parents came top of the list. **Chart 8.1** ranks the sources that young people mentioned in the survey. The findings were similar to those in the 2012 National Survey on Sexual Attitudes and Lifestyle (Natsal-3), showing schools, parents and health professionals were the preferred sources for information about sex and relationships for 16-24 year olds (Tanton et al, 2016).

Chart 8.2 draws on data from the Exeter Schools Health Education Unit to show peers feature strongly as sources of information and support among 12-15 year olds. However, many young people often report turning first to their family for information, help and advice, with the exception of sex and relationships and parental conflict. These findings illustrate the value of providing support to parents in communicating with their teenage children. Importantly, primary care services also feature as a source of advice and help for a wide range of issues, highlighting the value of helping GPs and others to understand and prioritise young people's health.

Chart 8.2: Where 12-15 year olds first go for help or information about emotional and physical health issues, England, 2014

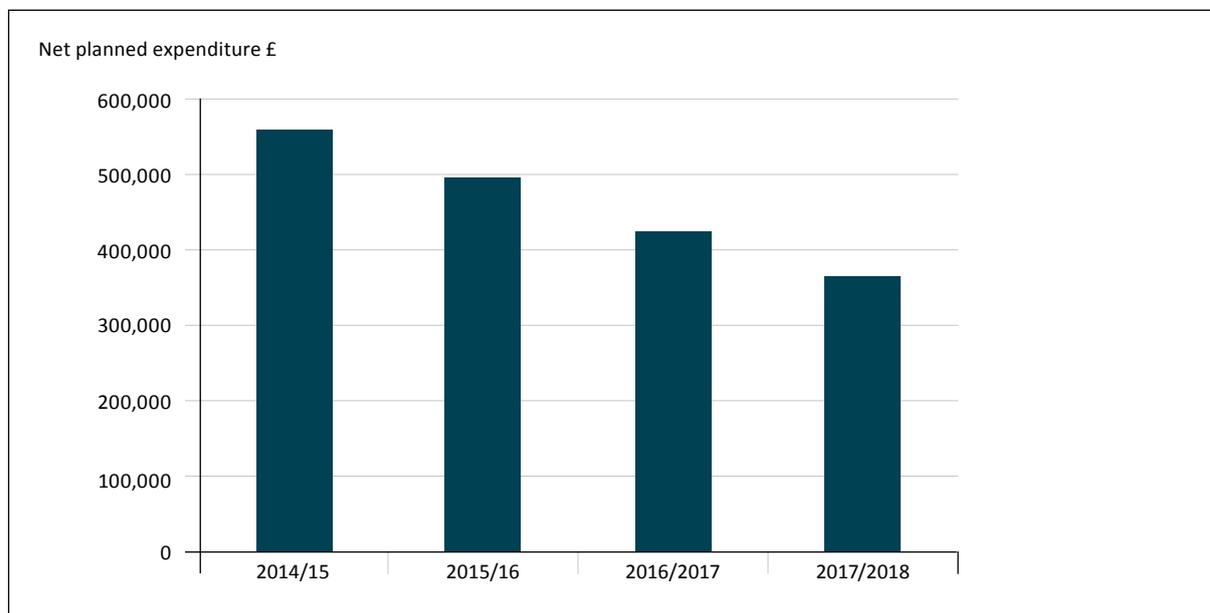


Source: Balding and Regis (2014), Young People into 2014 > [DOWNLOAD DATA](#)

As these surveys show, schools clearly play a major role in health promotion through the provision of personal, social, health and economic education (PSHE). The wider aim of PSHE is “...to equip pupils with a sound understanding of risk and with the knowledge and skills necessary to make safe and informed decisions” (Department for Education, 2013). The 2017 Child and Social Work Act made sex, relationships and health education statutory in all secondary schools in England from September 2020 (Department for Education, 2017). It will be important to watch how this is applied in practice, and to measure what young people think about the information they are given. There is also increasing evidence for modifying the whole school environment as an intervention to reduce bullying victimisation in schools, and to address closely related risk and health outcomes in young people (Bonell et al., 2017). Whole school approaches or interventions are multi-faceted and encourage the active participation of parents, students, teachers and the wider school community, to plan, implement and evaluate school policies, procedures, teaching and learning and professional development (Cross et al, 2003).

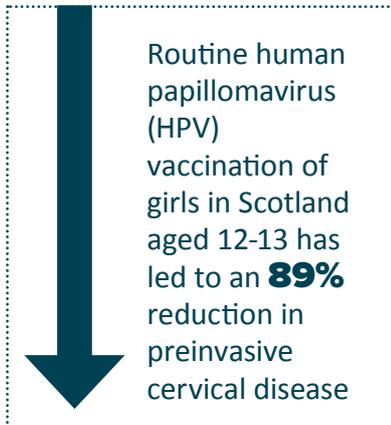
An important part of the landscape of health promotion and early intervention relates to youth service provision. This includes community based universal and early intervention, some school based early interventions, support for vulnerable young people, and other services. A number of local authorities no longer provide some or all of these services (Education Policy Institute, 2018). **Chart 8.3** presents the trends in local authority universal and targeted youth services funding in England over the last three years, clearly showing the decline.

Chart 8.3: Trends in local authority universal and targeted youth services funding, England, 2014/15-2017/18



Source: Department for Education(2017) Planned LA and school expenditure: 2017 to 2018 financial year > [DOWNLOAD DATA](#)

Immunisation



Source: Palmer et al (2019)

In the UK the human papillomavirus (HPV) vaccine has been routinely offered to girls aged 12-13 since 2008, and this is due to be extended to boys from September 2019. It helps protect against cancers caused by HPV, including cervical cancer, some mouth and throat cancers, some cancers of the anal and genital areas, and genital warts. Recent analysis from Scotland has concluded that the programme has led to an 89% reduction in preinvasive cervical disease (Palmer et al, 2019).

In 2017/18, 83.4% of Year 9 females in England completed the two-dose HPV vaccination course (Public Health England, 2019a). The uptake is similar in other UK countries, at 83% in Wales in 2018, for example (Public Health Wales, 2018). Data from England have shown that the prevalence of high-risk HPV has reduced with

the increasing number of young women who receive the vaccine (Mesher et al, 2018).

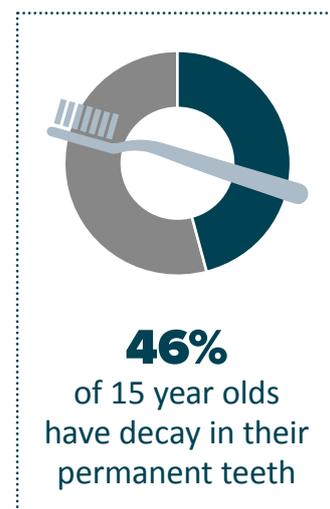
Secondary school age children are also due a teenage booster of the measles, mumps and rubella (MMR) vaccination, and a dose of the MenACWY vaccine, which protects against serious infections including meningitis and septicaemia. The MenACWY vaccine was added to the national immunisation programme in August 2015, and can be requested from the GP up until the young person's 25th birthday. It is advised that students going to university for the first time ensure that they have had their dose. The average coverage for the school based MenACWY adolescent vaccination programme in England in 2018 was 84.6% (Public Health England 2019b).

Dental health

In 2016 Public Health England launched the Children's Oral Health Improvement Programme Board, with the aim of reductions in the number of children with tooth decay and a reduction in the oral health gap for disadvantaged families (Public Health England, 2016).

However there has not been a Children's Dental Health Survey since 2013 (HSCIC, 2015). At that time a third of 12 year olds (24%) and nearly half of 15 year olds (46%) had decay in their permanent teeth. More than a quarter of 15 year olds reported being embarrassed to smile or laugh due to the condition of their teeth. Young people who were eligible for free school meals were twice as likely to have severe or extensive tooth decay.

The most recent Adult Dental Health survey was undertaken even longer ago, in 2009, covering England, Wales and Northern Ireland. At that time only 23% of 16-24 year olds achieved 'excellent oral health', which included criteria such as having 21 or more natural teeth, 18 or more sound and untreated teeth and roots and no decay detected at any site. In 1978 16 to 24 year olds had 27.4 teeth on average compared with 28.6 in 2009 (HSCIC, 2011).

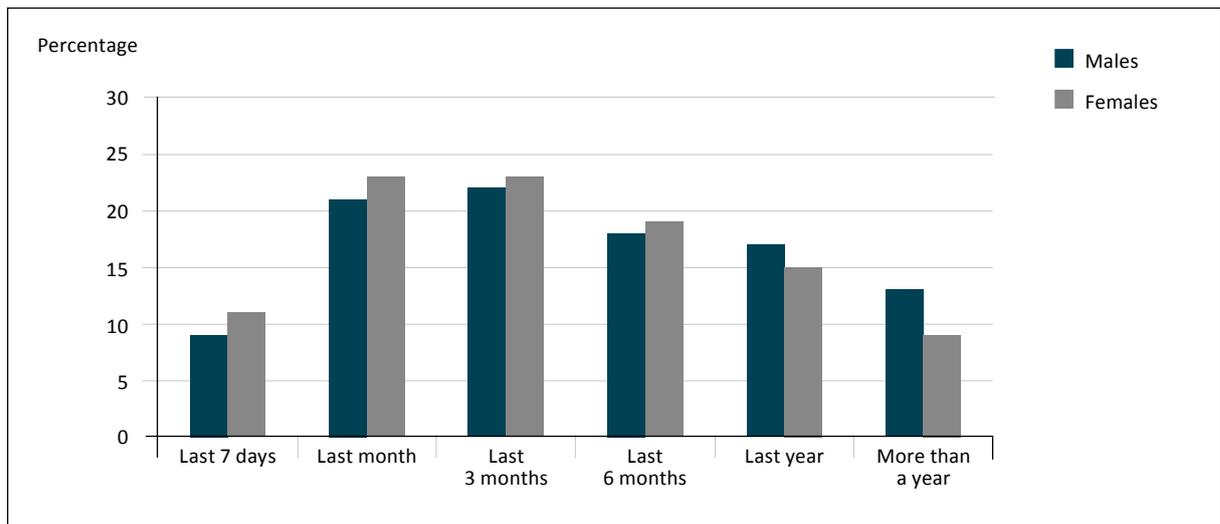


Source: HSCIC (2015) Children's Dental Health Survey 2013

Use of primary care and community clinics

Young people access their GPs regularly for a wide range of health issues. Generally it is estimated that young people visit the GP several times a year. In their teens this averages out at approximately twice a year for young men and more than four times for young women (HSCIC, 2009), although we note that these data are now 10 years old. Both the Exeter Schools Health Unit 'Young People into 2018' study and the Health Behaviour in School aged Children (HBSC) study provide more up to date estimates of the time since last visit to the doctor. **Chart 8.4** shows the data from the 'Young people into 2018' study where over half of Year 10 pupils (aged 14-15) reported that they visited within the previous three months (52% boys, 57% girls).

Chart 8.4: Last visit to the doctor by Year 10 pupils (aged 14-15), England, 2018

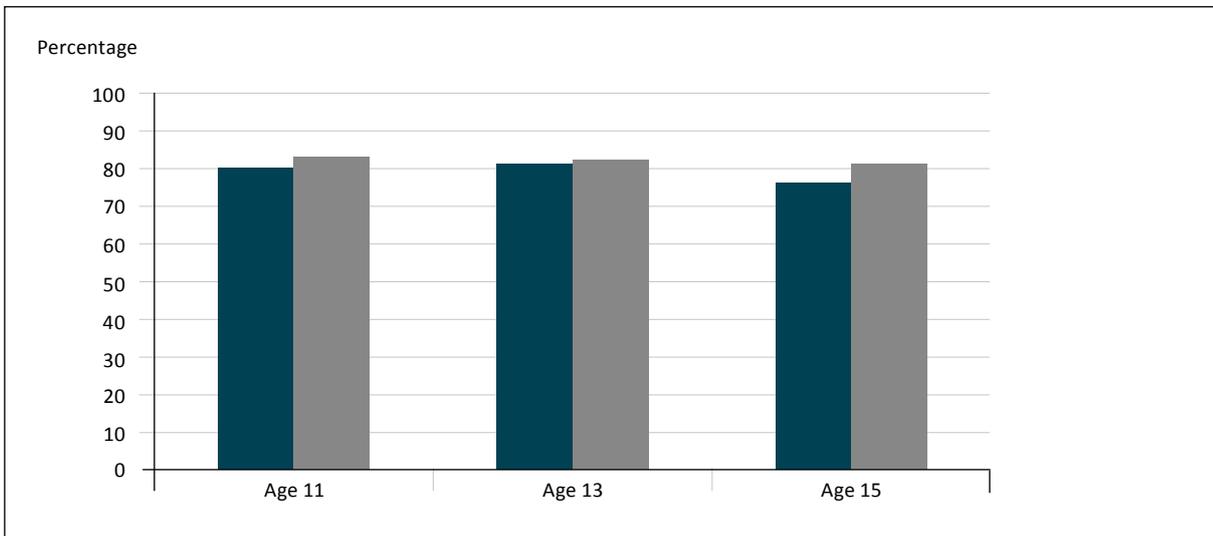


Source: Balding and Regis (2018), Young People into 2018 > [DOWNLOAD DATA](#)

Slightly different rates of consultation were reported by the 11-15 age group in the last HBSC survey in 2015, where overall 78% of boys and 82% of girls said they had visited the GP in the last year (Brooks et al, 2015). **Chart 8.5** shows that there was little variation in the rates by gender or age across the ages of 11, 13 and 15. Although estimates of attendance vary depending on age group and survey, it is evident young people are frequent users of primary health care, particularly young women.

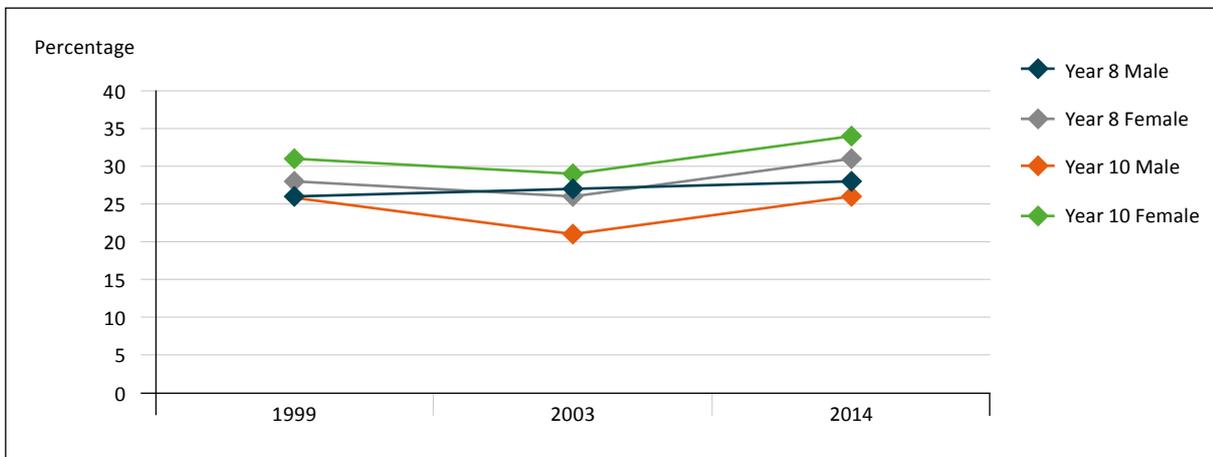
The most recent 'Young people into 2018' survey (Balding and Regis, 2018) explored time trends in attendances at GPs for secondary school age children from 1999 to 2014. As **Chart 8.6** shows, there was no clear trend. On average, across all the years, genders and ages, 28% of secondary school pupils in the survey reported visiting the GP in the last month.

Chart 8.5: Proportion of young people 11, 13 and 15 visiting the GP in the last year, England, 2014



Source: Brooks et al (2015) Health Behaviour in School-aged Children England National Report > [DOWNLOAD DATA](#)

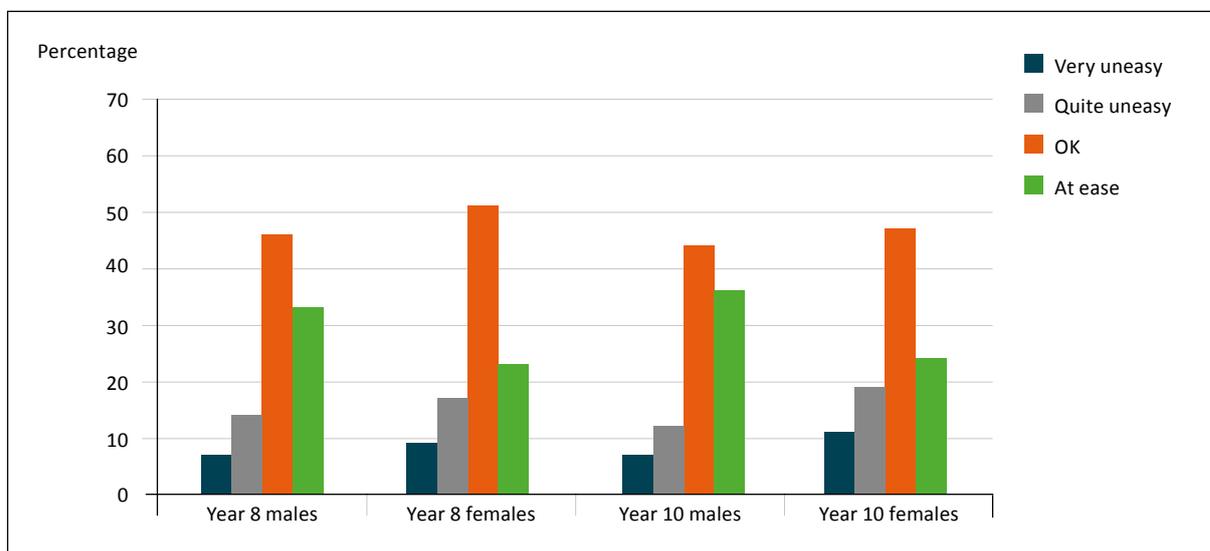
Chart 8.6: Time trend in young people's visits to the GP in the past month, England, 1999-2014



Source: Balding and Regis 2018, Young People into 2018 > [DOWNLOAD DATA](#)

The ‘Young people into 2018’ survey also regularly reports on teenagers’ experience of talking to their GP, with **Chart 8.7** showing one quarter of girls (26% of Year 8 and 30% of Year 10) reported feeling ‘quite uneasy’ or ‘very uneasy’ with their doctor on their last visit, while boys reported more ease. In comparison, in the last HBSC survey 89% of young people reported that their GP treated them with respect, and 52% reported that they were able to talk about personal things with their doctor (Brooks et al, 2015). Overall the findings highlight the importance of supporting GPs to provide youth friendly services. Secondary analysis of the HBSC data has shown that poor experience on any of the measures was associated with increased risk of self-harm and sleeping problems (Yassaee et al, 2017).

Chart 8.7: Extent to which young people at secondary school felt at ease with their GP at their last visit, by age and gender, England, 2018



Source: Balding and Regis (2018), Young People into 2018 > [DOWNLOAD DATA](#)

Experiences of young people aged 16-24 are assessed in NHS patient surveys, and **Chart 8.8** shows that ratings of confidence, trust and being listened to were generally high. However, experiences relating to practicalities and the convenience of visiting general practices were rated as lower. A third (32%) of those who could not get to see the GP at the time they wanted then went to Accident and Emergency, and nearly two thirds (60%) made use of NHS telephone services (presumably mostly by ringing 111).

We have previously noted the dearth of more up to date and detailed information about young people's usage of primary health care services and further research is still needed. Fifteen years ago, Churchill et al (2000) undertook a survey identifying the range of conditions that prompted young people to seek a primary health care consultation. The most common were respiratory, dermatological and musculoskeletal conditions and problems associated with ears, nose and throat. New data on this topic are now needed urgently. Data on young people's experiences with the wider range of professionals involved in primary health care – such as practice nurses – are also lacking.

Chart 8.8: Experiences in general practice of young people aged 16-24, England, 2018

Confidence and trust in the healthcare professional you saw	94%
Involved as much as you wanted in decisions about care & treatment	92%
Needs met at last general practice appointment	92%
Healthcare professional good at listening to you	86%
Overall, good experience of GP practice	78%
Satisfied with the type of appointments offered	72%
Easy to get through to someone at the GP practice on the phone	68%
Overall good experience of making an appointment	65%
Satisfied with general practice appointment times	60%
If you wanted to see a GP but GP was closed, which other service did you use?	
Contacted NHS service by telephone	60%
I went to A&E	32%
A healthcare professional called me back	18%
I went to another NHS service	16%
I saw a pharmacist	14%
Can't remember	11%
I went to another GP service	9%
A healthcare professional visited me at home	2%

Source: NHS England 2018 GP Patient Survey > [DOWNLOAD DATA](#)

Child and adolescent mental health services (CAMHS)

Child and adolescent mental health services (CAMHS) are delivered through a network of providers offering universal, targeted and specialist services. These are organised in four 'tiers'. Tier 1 consists of universal services provided through early year services and primary care. Tiers 2 and 3 provide targeted services through youth offending teams, school and youth counselling, and specialist community based psychiatric and psychological services. Tier 4 consists of inpatient and very specialised outpatient services.

Among every 1000 people under 18, **only 18** will be on the formal child and adolescent mental health services caseload

Source: NHS England (2018)

Useful information about the structure and provision for CAMHS in England are provided in NHS England's CAMHS benchmarking reports. The 2018 report estimated only 18 in 1000 children and young people under 18 were on the community mental health services caseload (NHS England, 2018). This figure relates to referrals to Tiers 2 and 3, not including inpatient services. In a survey of 3,750 young people aged 12-16 in UK secondary schools, only 5% of those at high risk of depression or self-harm had seen specialist CAMHS in the previous six months. Amongst those with probable depression, 79% had seen their GP (Sayal et al, 2014).

It is difficult to estimate the size of the 'treatment gap' between those who meet the threshold for intervention and those who receive treatment. As the estimate of the level of diagnosable mental health problems in young people is approximately one in 8 of the population of this age (Chapter 7), these benchmarking figures suggest that a very small proportion of those with difficulties are referred and accepted for treatment. After referral there is a further treatment gap, as some are not accepted for treatment, and others experience a long wait. The English Children's Commissioner has estimated that of those referred to CAMHS in 2017, less than a third received treatment within the year (Children's Commissioner, 2018). The average waiting time to the start of treatment is three months (NHS Benchmarking Network, 2018).

The number of referrals to specialist children's mental health services has increased by **26%** over the last five years. This is also despite a population increase of only 3%



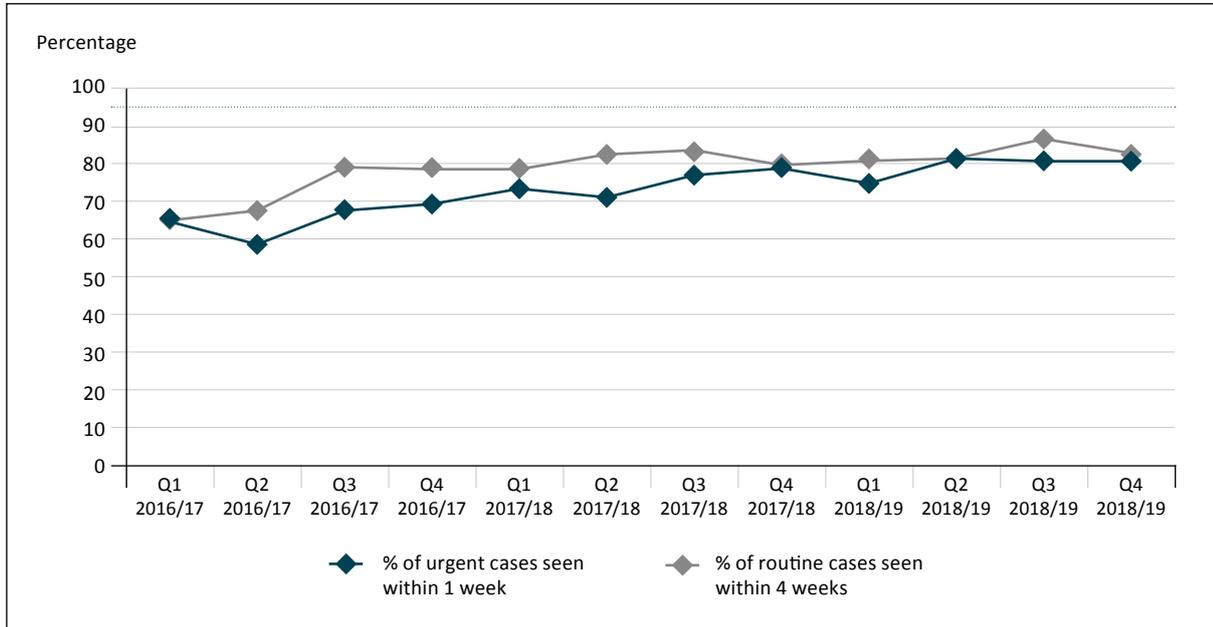
Source: Education Policy Institute (2018)

It is also worth noting that the benchmarking statistics also show there are only 75 full-time working equivalent people in the community CAMHS workforce per 100,000 population (age 0-18). Community CAMHS teams are made up of community psychiatric nurses, therapists, family support workers, specialist practitioners, peer support workers, psychologists, non-medical prescribers and psychiatrists. Despite relatively low numbers of people in the CAMHS workforce in relation to the size of the population, there is evidence of increases in CAMHS referrals over the last five years (Education Policy Institute, 2018).

In addition to limitations in capacity to respond at the community CAMHS level, specialised inpatient beds (Tier 4) are also very restricted with approximately 1,600 across the whole of England.

The average length of stay in a specialist bed is 146 days for an eating disorder and 255 days for secure CAMHS (NHS Benchmarking Network, 2018). With respect to the case of eating disorders, recent data suggest that the proportion of children and young people who are receiving timely access to treatment has gradually improved over the last two years (**Chart 8.9**).

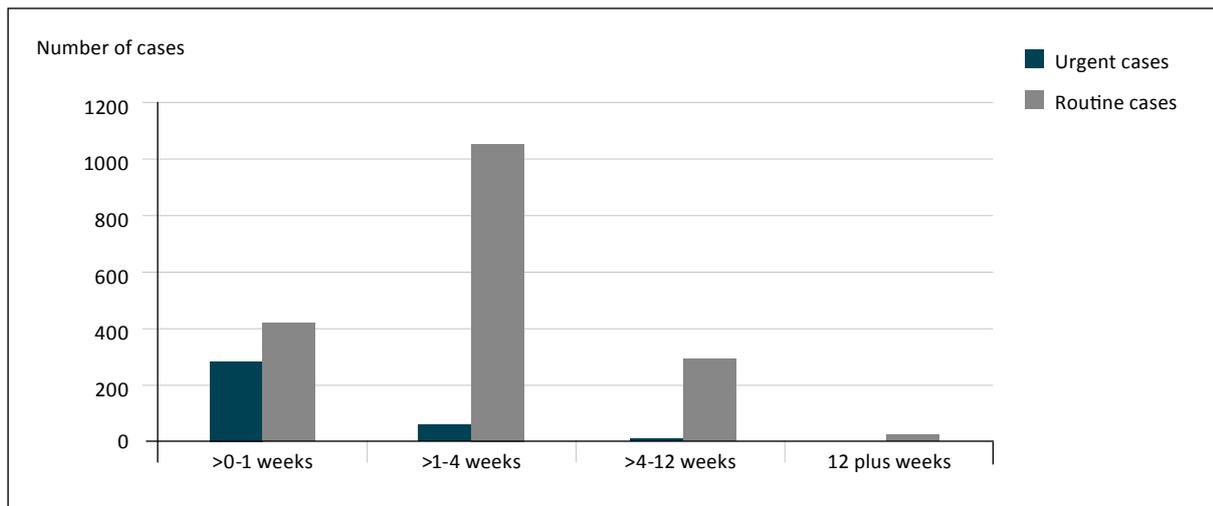
Chart 8.9: Proportion of children and young people with an eating disorder receiving timely access to treatment, England, 2016-2019



Source: NHS England, Children and Young People with an Eating Disorder Waiting Times > [DOWNLOAD DATA](#)
 Note: 95% dotted line – national standard

However it seems that the issues with access particularly relate to routine problems (perhaps in the early stages of disease), as **Chart 8.10** shows. Delays for routine appointments for eating disorders are far longer than for urgent cases.

Chart 8.10: How long do children and young people (age 19 or under) with an eating disorder wait to start treatment? England, 2018/19

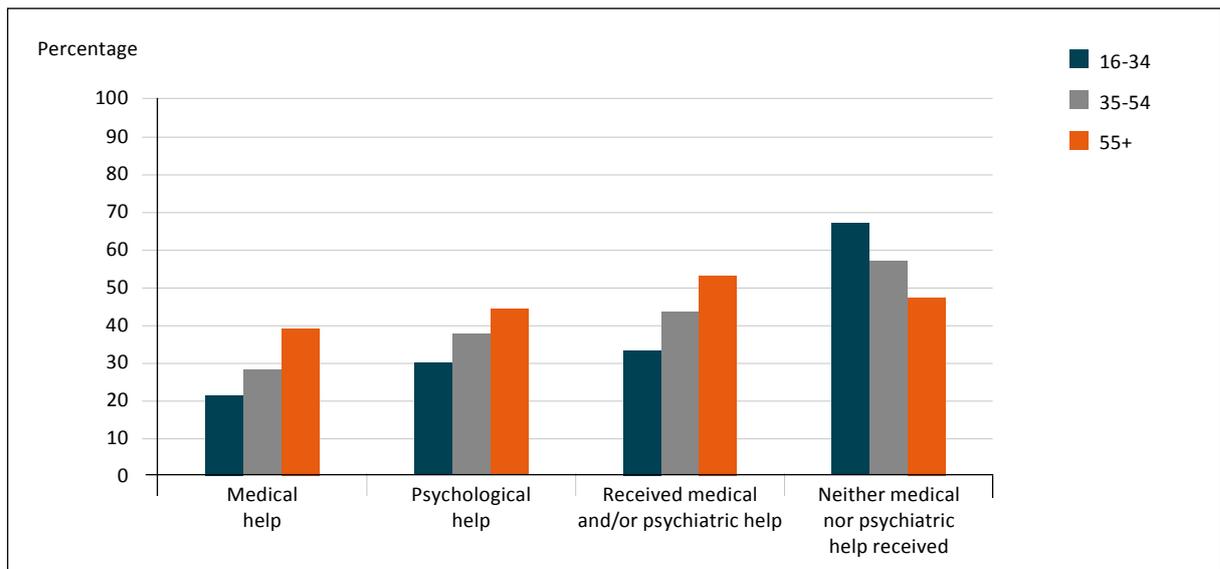


Source: NHS England, Children and Young People with an Eating Disorder Waiting Times > [DOWNLOAD DATA](#)

Information on CAMHS from these sources does not record provision from the voluntary and independent sectors, who often provide services to fill the treatment gap. Voluntary organisations in particular have a key role in providing prevention, early intervention services and support for the significant proportion of young people who do not meet the threshold for CAMHS (Care Quality Commission, 2017a). Many voluntary organisations run helplines and websites as well as face-to-face interventions, often providing services that no other agencies offer for children and young people and their families.

It is difficult to find similar data on young adults who have transitioned from CAMHS into adult services, or who are referred to services for the first time between 18 and 25 years. Analysis of the Adult Psychiatric Morbidity Survey has provided estimates of the proportions of people aged 16-34 who report receiving treatment after a suicide attempt. **Chart 8.11** shows that rates for receiving treatment are lower for this age group than for older adults, with 67% of those aged 16-34 receiving no intervention at all, compared with 47% of those over 55 years (McManus et al, 2016). This may be as much about help seeking behaviour as about availability of treatment options, but available statistics raise the possibility of a shortfall of services for young adults as well as those under 18.

Chart 8.11: Proportion of those who have attempted suicide who report receiving medical or psychological help, by age, England, 2014



Source: McManus et al (2016) Adult Psychiatric Morbidity Survey > [DOWNLOAD DATA](#)

Hospital admissions and secondary care

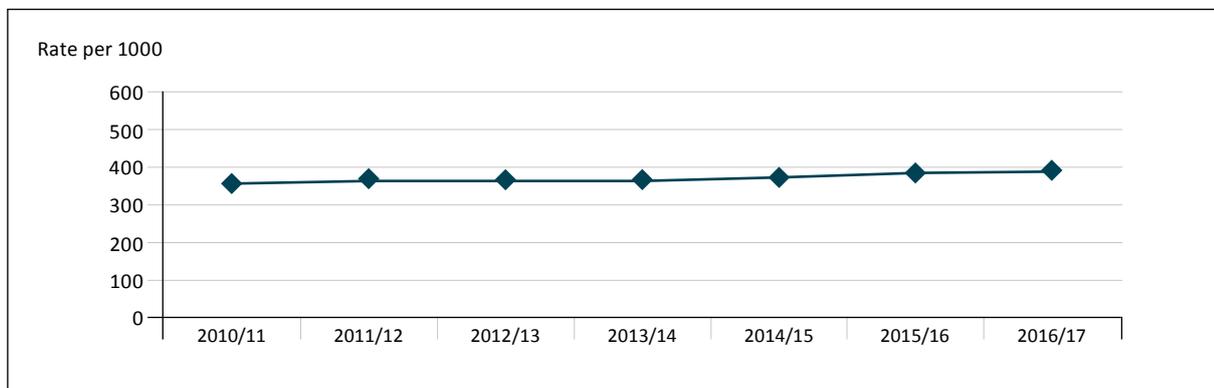
Young people have lower overall morbidity than older age groups and this fact can result in their health needs being overlooked within service design and commissioning. Nationally there are very few hospital facilities specifically for teenagers. Yet many young people have hospital admissions, particularly those with a longterm or chronic condition. Age appropriate services can make an important difference for young people.

Many hospital admissions take place through accident and emergency (A & E) departments. The Care Quality Commission (CQC) estimates place this at 47% of admissions for those aged 12-15 (CQC, 2015). A study of 10,455 attendances by 8,303 young people aged 13-17 showed that reasons for attending

A & E included injuries (72%), abdominal pain (16%), self-harm (11%), fits, faints and funny turns (10%), breathing difficulties (7%) and intoxication (6%) (Shanmugavadivel et al, 2014). It is also worth noting that around one quarter of teenagers and young adults with cancer are diagnosed at A & E, having presented as emergencies (National Cancer Intelligence Network, 2013). Children with longterm conditions such as asthma, diabetes or epilepsy have increased risk of emergency admissions, and this is reduced for children who are seen more frequently in primary care (Cecil et al, 2018).

The NHS England Hospital Episode Statistics in **Chart 8.12** show that rates of attendances at A & E departments for those aged 15-19 rose by approximately 10% between 2010/11 and 2016/17. However, larger rises have been seen in recent years for those aged under 0-4 in comparison to teenagers (Keeble and Kossarova, 2017).

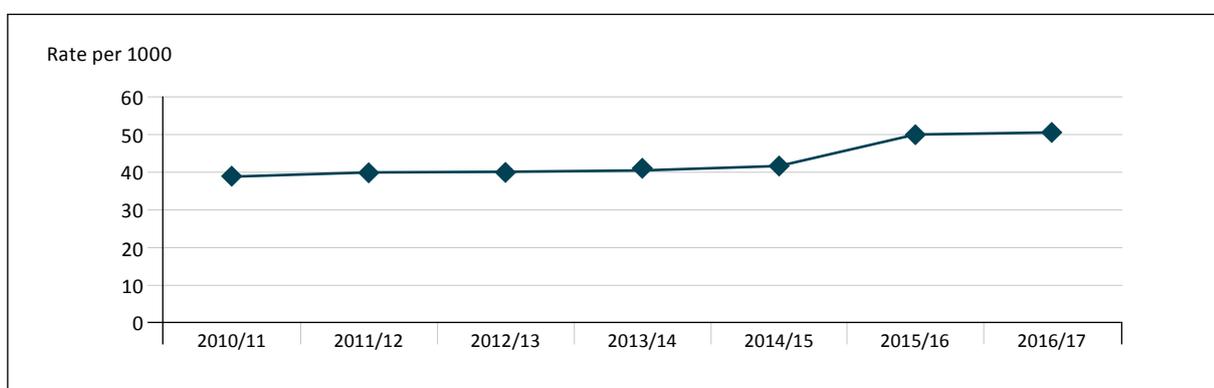
Chart 8.12: Accident and emergency hospital attendances 15-19 years, England, 2010/11 to 2016/17



Source: NHS Digital Hospital Episode Statistics (HES) 2019 > [DOWNLOAD DATA](#)

Other than A & E attendances, young people are also admitted to hospital as non-emergencies. **Chart 8.13** shows that rates of elective admission for this age group have risen by approximately 30% since 2010/11.

Chart 8.13: Elective admission to hospital for 15-19 year olds, England, 2010/11 to 2016/17



Source: NHS Digital Hospital Episode Statistics (HES) 2019 > [DOWNLOAD DATA](#)

The Care Quality Commission regularly surveys large samples of under-16s about their experience of being in hospital. **Chart 8.14** presents results from the last survey, which show that while the majority of under-16s felt things were clearly explained and that they were involved in decisions about their care and treatment, a significant minority did not. The CQC also reported that 90% of young people aged 12-15 in hospital reported that they were able to speak to a doctor or nurse without their parent of carer being there, which is an important part of youth appropriate healthcare (Care Quality Commission, 2017b).



Source: Care Quality Commission (2017b)

Chart 8.14: Young people’s views on hospital inpatient experiences, 8-15 years, England, 2016

Did the member of staff treating you give you information about your care in a way that you could understand? (12-15y)	
Yes, definitely	87%
Yes, to some extent	12%
No	1%
When the hospital staff spoke with you, did you understand what they said? (8-15yr)	
Yes	68%
Yes, sometimes	30%
No	2%
Were you involved in decisions about your care and treatment? (8-15yr)	
Yes a bit	43%
Yes a little	41%
No	16%
Before the operations or procedures, did hospital staff explain to you what would be done?	
Yes	93%
Sort of	6%
No	1%

Source: Care Quality Commission (2017) Children and young people’s inpatient and day case survey 2016 > [DOWNLOAD DATA](#)

Finally, hospital episode statistics have suggested children and young people from more deprived areas account for a greater proportion of inpatient care than those from more affluent areas (Hargreaves et al, 2012). For more on health inequalities, see Chapter 9.

Transition from children's to adult services

Increasing numbers of children with longterm conditions are surviving into adulthood because of improved healthcare, and research has demonstrated a steady increase in the number of children living with a life-limiting condition, particularly in the 16-19 age group (Fraser et al, 2012).

Adolescence is a time of moving to independent use of healthcare. Successful management of ongoing conditions can reduce the need for emergency care and improve outcomes. Young people with longterm conditions spend a lot of their lives interacting with the health service, including investigations, monitoring, treatment and rehabilitation. Continuity of care is vital in longterm conditions such as diabetes, kidney disease and epilepsy as well as mental health (Royal College of Nursing, 2004; Singh, 2009; Allen et al, 2010; Brodie et al, 2011; Joint Commissioning Panel for Mental Health, 2012; Hepburn et al, 2015). Good transition programmes have been shown to result in statistically significant improvements in young people's health outcomes (Crowley et al, 2011).

However, there are very few data on young people's journeys through the transition from child services to adult services. A CQC report on children's transition to adult health services reported that only 50% of young people and parents said they had received support from a lead professional in the process leading up to transition (Care Quality Commission, 2014). In one of the few studies to follow a systematically identified cohort of young people Singh et al (2010) reported one third were not referred on to adult services and one fifth of those referred on were never seen. Fewer than four per cent were reported to have experienced optimal transition. Guidelines from the National Institute for Health and Care Excellence (NICE, 2016) aim to improve the planning and delivery of care for this age group as they move from child to adult services.

Evidence is growing that elements of successful transition programmes are patient education and specific transition clinics (Crowley et al, 2011). Northumbria Healthcare NHS Foundation Trust and Newcastle University recently completed a five year programme of research on transition (Colver et al, 2019). The team concluded that key elements of good transition programmes included commitment from senior providers and commissioners, trust-wide approaches to transitional health care, joint work between adults' clinicians, children's clinicians and general practitioners in planning transition procedures, appropriate parental involvement, specific promotion of young people's confidence in managing their own health, and opportunities to meet the adult team before transfer.

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