Submitted online via the Change.NHS.uk portal

Monday 2 December 2024

1. What does your organisation want to see included in the 10 Year Health Plan and why?

Health inequalities:

The Association of Directors of Children's Services (ADCS) believes that every child has a right to the best possible health and wellbeing, but not all children have the same opportunities to achieve good health. Health is shaped by social, cultural, political, economic, commercial and environmental factors, and while some of these levers might fall beyond the remit of the NHS, they should provide the building blocks for any strategic health plan. Almost a third of children in England are living in poverty after housing costs in 2023/24, (End Child Poverty Coalition, 2024) and it is well-established that poorer communities experience much worse health outcomes. The pandemic highlighted the socio-economic inequalities that are present across the country, e.g. global majority mothers have poorer experiences and outcomes in maternity services (CQC, 2024), so understanding and addressing such health disparities must be a priority.

More widely, recent research has highlighted concerns about the physical health of children and young people in this country, from rising obesity and levels of diabetes to hospitalisations for dental concerns. The IPPR's Health and Prosperity Commission recently called for a "new beginning" for childhood health following a breakdown in the health inheritance, noting for the first time since the Poor Laws 200 years ago, this generation of children are not guaranteed to live a longer, healthier life than those who came before them (IPPR, 2024).

Prioritising children:

Since the NHS Long Term Plan was initially introduced, children's health outcomes have worsened across a variety of domains. Maternal death rate has increased, fewer children in care are up to date with immunisations, there are more Accident and Emergency attendances for children under four years old; and one in five children and young people (a record high) are now reported to have a probable mental health disorder (NHS Digital, 2023). While much attention has understandably been given to the aging population and growing financial pressures in adult social care, there seems to be public recognition that children are being failed by the health system. Lord Darzi's recent investigation highlighted that children's physical and mental health has been deteriorating in recent years and that there are real concerns about the NHS's capacity and capability to deliver high quality care for children (DHSC, 2024). The Care Quality Commission's latest annual state of the nation highlighted their concern for children and young people's mental health services, and recommended that a greater focus on children and young peoples' services is needed at a local and national level (CQC, 2024).

The previous Plan outlined key proposals to improve the delivery of services to the whole population, and was based on common principles of prevention, early identification and treatment, focusing only on specific conditions e.g. eating disorders, and cohorts e.g. babies, rather than taking a life-course view. The New 10 Year Plan must take a broader view of children's general health needs across the whole of childhood, incorporating the range of health needs of children and young people, including recognition of requirements of specific vulnerable groups. Despite making up 24% of the population, children only account for 11% of NHS expenditure. They rarely make it onto ICB agendas, in part, due to limitations of the roles of executive lead roles for children and young people and SEND. Prioritising and investing in children's physical and mental health and wellbeing now will have a positive effect on later health outcomes and subsequent spend over the life-course.

Parity of esteem for mental health:

Mental health featured prominently in the previous Plan, however, demand has risen exponentially and more children than ever are experiencing poor mental health. Children and Adolescent Mental Health Services (CAMHS) are stretched more than ever and long waiting lists for assessments and diagnosis followed by further waits for treatment are causing heightened distress for children, contributing to family breakdown and rising demands on children's services. Each CAMHS has their own eligibility criteria, offering support to specific mental health problems, at a certain threshold of severity and length of time of presentation, and exclusion criteria, e.g. the absence of other conditions like autism or ADHD. Many children are turned away and offered inadequate support, if any, leading to an escalation of their needs. Where children do meet those thresholds, they often face long waiting times, with 40,000 children waiting more than two years to access support (Children's Commissioner, 2024).

Approximately half of mental health illnesses experienced in adulthood are thought to begin in childhood. Prevention, better identification and early intervention in childhood can help avoid later crisis, improving both quality of life and demand on public services. CAMHS must be prioritised within the 10 Year Health Plan and resources must be allocated accordingly across all levels of need.

Children's mental health is at crisis point and we must be ambitious about change. All children must benefit from this renewed focus and targets must be ambitious to achieve this. We should aim to have Mental Health Support Teams (MHSTs) in 100% of schools as soon as possible to ensure that children receive access to early help and support before their needs escalate to the point of needing more intensive support from CAMHS teams, inappropriate placement on paediatric hospital wards or an urgent response from children's social care. Targets of 50% of schools by March 2025 is too little too late, considering that half of mental health conditions in adults start before the age of 14 years old (RCPCH, 2021). Increasing resources for prevention and addressing early mental health and wellbeing needs before they escalate will significantly reduce later spend.

System-wide collaboration:

The 10 Year Plan must align with other cross-governmental policy developments. For example, the previous Plan's proposal to move selectively towards a 0-25 years service offer for children with Special Educational Needs and Disabilities (SEND) by 2028 was too slow, lagging behind the rest of the system by 14 years following the introduction of the Children and Families Act 2014. The New 10 Year Plan must be mindful of, and responsive to, changes in policy direction and arising needs. The NHS must be prepared to take accountability for and make changes in line with DfE's agenda for change in relation to SEND.

There are other examples where health and social care could be better joined up. For example, a single-age point of transition between children's and adult mental health services in line with that of social care, would significantly improve the ease of transitions, particularly if thresholds for support were aligned to avoid the 'cliff edge' once a child turns 16, 17 or 18 years old depending on local access criteria.

Joint accountability:

ADCS members have become increasingly concerned with the rising number of young people with complex needs linked to trauma who are being made subject to Deprivation of Liberty (DoLs) orders and ending up in high-cost placements which do not necessarily meet their needs. The reduction of mental health bed days, without the alternative community provision being in place,

has resulted in LAs needing to find alternative placements for these children at the point of crisis, however, therapeutic, caring provision simply does not exist, and LAs are only able to "contain" these children without the right expertise, often in unregistered placements. Joint accountability and integrated services are needed to meet the needs of this vulnerable group, provide continuation of support and support step down into other types of provision or return to their families.

In the absence of a clear framework or shared guidance, children's social care and health partners are trying to negotiate commissioning arrangements at the point of crisis, resulting in delayed and poor-quality support, and leading to reduced life outcomes, at great expense to the public purse. Instead, focus should be on identifying and meeting children's needs through planned, integrated services and joint funding agreements. To do this, the Continuing Care Framework urgently needs reviewing, particularly in relation to children who require additional support from health to access education, and for children with complex needs and challenging behaviour. The provision of continuing care for children should be made statutory, as it is for adults. In the long-term, a place-based funding model similar to the Better Care Fund, would be more effective, providing more sustainable, child-centred care and better outcomes. It is not clear why children were not included in these frameworks and funds from the outset.

A children's health workforce strategy:

There are shortages across the children's health workforce which are impacting on children's outcomes. Too many children are languishing on waiting lists while their needs escalate without effective, timely treatment and support. We urgently need more qualified speech and language therapists, occupational therapists, school nurses, and health visitors, to name just a few. In line with emerging SEND policy developments, a comprehensive children's health workforce strategy is needed to ensure that children can access the assessments they need and the treatment and support they require as early as possible.

2. Shift 1: Hospital to community

There are a number of barriers which make it difficult for children to attend CAMHS appointments, including inaccessibility of services, travel costs and the lack of support to attend them. Strict policies result in children being stopped from accessing much needed services after missing appointments. For many children, they are experiencing a vicious circle where instability in their lives contributes to their mental health issues which in turn exacerbates that instability. Removing much-needed services removes the opportunity for children to regain stability. Inserting these services into the community would make it far easier for children to attend appointments, as would policies which are more flexible and adaptable to children's circumstances. This is particularly relevant for those children in care who experience multiple placement breakdowns and must start from scratch at the bottom of a new waiting list every time they move to a new area. Mental health services should be prioritised for children in care, so progress is not lost.

The aim to reduce the number of tier 4 bed days is unarguable; these placements are highly restrictive, often far from home, and the isolation from family and friends can impact on recovery, leading to increased lengths of stay. Being removed from family members, peers and everyday life removes the opportunity that children and young people have to form support networks and develop the social, cognitive and practical life skills needed to become independent adults. However, there has been too little focus and investment on building appropriate community services. Where children reach crisis, families often feel ill-equipped to keep their child safe at home due to a lack of available support, resulting in an increased reliance on children's social care to step in. It can be no coincidence that the number of tier 4 bed days effectively halved from 117,000 in 2017/18 to 64,000 in 2023/24 (RCPSYCH, 2024), which coincided with the rapid

increase in applications for deprivation of liberty orders from 102 to 1,232 over the same time period (Cafcass, 2024).

More children than ever before are entering the care system, and in the absence of tier 4 beds or sufficient secure welfare settings, LAs have been left with no choice but to apply for DoL orders in order to keep the child safe. The broken children's care placement market (CMA, 2022) is simply not set up to provide the therapeutic support these children need, due to a number of complex factors. As mentioned previously, new joint funded, integrated provision is desperately needed to meet the therapeutic and care needs of this cohort, alongside appropriate, linked step-down support.

Providing wrap-around care and therapeutic support, whether in a child's family home, foster home or a children's home, would provide their family and carers with the support and confidence needed to care for their child. Unlike in-patient settings, the child would stay close to, and connected with, their everyday lives and the people that matter most, equipping them with the independence and skills they'll need for adulthood, reducing the likelihood that they'll be dependent on mental health and care services in the future.

It is right that tier 4 bed days for autistic children and children with learning disabilities are also reduced in line with proposals in the new Mental Health Bill. However, considering that around a quarter of children subject to DoL orders have the application made due to challenging behaviour related to their disability (NFJO, 2023), appropriate high quality community services which meet the specific needs of these children, wherever their home, must be in place before such changes occur.

3. Shift 2: Analogue to Digital

4. Shift 3: Sickness to Prevention

Demand for children's mental health services far outweighs the resources currently available. Understanding of poor mental health has moved on significantly in recent years. We know more about mental health assessment, treatment, its relationship to trauma, mental health inequalities and the potential impact of poor mental health on both life outcomes and NHS spend. A reform of children's mental health services and a review of funding is urgently needed to ensure that adequate resources are being spent effectively and that children's needs are being assessed and treated as early as possible, in a way which is accessible for them. In order to avoid escalation, education, social care and health partners must adapt a trauma-informed approach to mental health prevention. Data should be used to identify which individual children, year groups, or communities are most at risk of developing poor mental health, and timely, targeted interventions should be deployed to reduce the likelihood of needs developing. While the current CAMHS system is based on a highly restrictive medical model, moving to a more flexible, needs-based model will ensure that children's presenting mental health needs can be effectively met, no matter what the cause or whether they meet the threshold for a diagnosis, meaning that no children fall between the cracks or are left without help until they reach crisis point.

5. Ideas for change

As already described, ADCS believes funding and outcomes for children should be prioritised at every level of the health system and this should be reflected in CQC inspections for NHS Trusts and Foundation trusts, and in the monitoring of ICBs. A review and subsequent reform of children's mental health services is required to ensure that the needs of children today are being met. We must move away from a medicalised model of mental health to a biopsychosocial model which also considers the psychological and social factors which impact on mental health and seeks to address

these in the round. Eligibility criteria should be replaced with assessment of presenting need and support should be provided which best meet the child's specific profile of needs, using a trauma-informed approach.

For children with more complex needs, health and social care partners should work together to provide wrap around care in the home, and local, joint-funded and integrated provision with connected step-down support for children who are unable to live at home. Ideally, there should be a place-based funding model similar to the Better Care Fund which should be extended to children, providing more sustainable, child-centred care and better outcomes. Focus must be on prevention, early assessment and support for children's needs, with a comprehensive health workforce strategy to ensure there is enough capacity within the system.

6. **Specific policy ideas for change**

Quick wins:

- Conduct a root and branch review of children's mental health services
- In some areas, CAMHS services work with young people up to age 16 and yet adult mental health services do not work with people under 18
- Where CAMHS do work with young people up to age 18, due to long waiting lists, 16- and 17-year-olds may not receive any support before being re-referred to adult services and starting the wait all over again
- All CAMHS services should work with young people up to age 18, and those who turn 18 while on the CAMHS waiting list should be prioritised by adult services so they are not disadvantaged
- Children in care, and care experienced children and young people, should be prioritised for CAMHS services in line with the new corporate parenting duties and should not have to rejoin waiting lists when they move to a new area
- MHSTs should be rolled out across all schools
- The NHS should develop a comprehensive children's health workforce strategy
- The Continuing Care framework should be reviewed and updated, particularly in relation to increased complexity of challenging behaviour and to ensure consistency between ICBs
- Children and young people should be a priority for all ICBs, executive lead roles relating to children should take the lead on this.

Mid-term aims:

- DHSC should embrace integration with children's social care by delegating the resources and responsibilities for commissioning and provision of all children's community and mental health services to place-based integrated partnerships. This could be achieved using existing legal flexibilities under Section 75 of the NHS Act 2006
- Funding and outcomes for children should be prioritised at every level of the health system and regulation and monitoring should reflect this through specific targets for ICBs and NHS Trusts and Foundation trusts
- Achieve true parity of esteem for mental health
- Develop a transitional service between children and adult's mental health services to avoid the cliff edge of support once children turn 18

- Develop provision in line with any proposals from the DfE to reform the SEND system, including better assessment services for autism and ADHD
- Use data and an enhanced understanding of health inequalities to identify those who might be more susceptible to developing poor mental health and provide timely interventions.
- Develop a place-based funding model similar to the Better Care Fund and led by the Director of Children's Services as champion for children, would be more effective, providing more sustainable, child-centred care and better outcomes.

Long-term aims:

- Follow the recommendations of the review of children's mental health to ensure that all levels of need are met at the earliest possible juncture by multidisciplinary teams working in the places and spaces that suit children's lives and preferences.
- Step down frequency of tier 4 bed use only once effective community provision is in place.