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ADCS Position Paper

A HEALTH CARE SYSTEM THAT WORKS FOR ALL CHILDREN

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The Association of Directors of Children's Services Ltd



A health care system that works for all children

Executive Summary

Every child has a right to the best possible health and wellbeing. But not all children have the same life chances to achieve good health and wellbeing. Health is shaped by social, cultural, political, economic, commercial and environmental factors.

Social inequality in the UK has become a definitive barrier to achieving improved health; the widening gap between rich and poor in the UK is damaging the health of the nation's children and young people. Children have been amongst the hardest hit by the government's programme of austerity. Today, more than four million children (one in three) are living in poverty and this is set to increase to 5.2 million by 2022, the highest level since records began. It is those from the poorest communities who experience much worse health compared with those living in the most affluent. It cannot be right that a child's health and wellbeing is in part determined by poverty.

Poverty and inequality are intrinsically linked to poor health outcomes and must be understood and addressed as public health issues. Prevention is key to lifelong health and wellbeing and should be a priority from pre-conception and through the life course. If we can get this right at the earliest point, the benefits will be lifelong and extend beyond the individual, to society as a whole.

Children are struggling with the pressures of modern life; they report being at their least happiest in a decade. A&E presentations due to self-harm and suicide rates amongst those aged 10-24 are increasing. The risks young people are exposed to have also changed over time, with many concerned about crime, particularly knife crime, digital dangers, sexual exploitation and criminal gangs. A 2017 survey of the mental health of children and young people showed that one in eight, 5-19 year olds had an identified mental health condition, yet estimates suggest a staggering 75% of young people experiencing mental health problems are not receiving the support or treatment they need.

While the recently published NHS England Long Term Plan is welcomed, more must be done to ensure that children are front and centre of the transformation of our health services and that such services work in an integrated way with education and social care services to meet the holistic needs of children. The entitlement of children to have their health needs met cannot be overshadowed by those of a growing and aging population. The children of today are tomorrow's adults - it is vital that we support them in their journey to become healthy, happy, independent and productive adults. Not only because this is the right thing to do but also because investing in childhood health and wellbeing will ultimately reduce demand on the health service and adult social care later on.

Our ability to act to improve the health and wellbeing of children at the earliest stage is becoming increasingly difficult due to growing levels of need in our communities, diminishing resources, and insufficient access to timely, high quality diagnostic pathways within the health service for children and young people. Collectively, children's services face a £3 billion funding gap by 2025. The lack of a long-term sustainable funding strategy for children's services does nothing to support our endeavour to intervene early to avoid more costly interventions further down the line.

ADCS members believe that now, more than ever, there is a real need for a national commitment to ensure that the NHS of the future has children at it's heart and children's health and wellbeing services are given parity with those of older people.

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Introduction

1. Children's health covers myriad issues. This paper focuses on those aspects of children's health where ADCS members feel there is greatest need. Given the volume of children with mental ill health and emotional distress, and the deficiency in the provision of mental health services, the main focus of the paper is the mental health and wellbeing of children. The paper takes a life course view of child health and it brings into scope specific cohorts, such as children in care and children with special educational needs and disabilities (SEND), as local authorities (LAs) have clear duties and responsibilities for these vulnerable youngsters. Principles of early intervention and integrated working are underpinning themes throughout the paper. The paper also seeks to maintain visibility on the impact of poverty and inequality on children's health and their wider outcomes, see *A Country That Works For All Children (2017)*.

2. Every child has a right to the best possible health and wellbeing. Enjoying good physical and mental health, with opportunities to live a healthy lifestyle, should be the ambition we have for all children. But not all children have the same life chances to achieve good health and wellbeing, and the health system does not always provide timely access to the right diagnostic pathways and level of care in child-centred settings that are tailored towards their needs and timescales.

3. Social inequality in the UK has become a definitive barrier to achieving improved health for all children. Since 2010, children, particularly those from large or in single parent families, have been amongst the hardest hit by the government's programme of austerity, bringing with it cuts to social security and public services. More than four million children (one in three) are now living in poverty, projected to rise to 5.2 million by 2022. Despite this, national targets to reduce child poverty have been abolished and yet child poverty rates are on course to reach the highest level since records began 60 years ago. A 2017 report by the Royal College of Paediatrics and Child Health (RCPCH) found that the widening gap between rich and poor in the UK is damaging the health of the nation's children and young people, with those from the most deprived backgrounds experiencing much worse health compared with the most affluent. Paediatricians report a growth in health problems such as severe tooth decay, obesity and respiratory illness among children living in the most deprived areas. Most startlingly, in the same communities, life expectancy overall has gone down on average by six months, and infant mortality is rising sharply. This sustained increase in infant mortality in the poorest areas, unseen in nearly 40 years, represents the starkest evidence of the impact of growing social inequalities on health.

4. With so many families (both those in and out of work) now reliant on foodbanks, how can children achieve good health, let alone develop to their full potential, when they are hungry or malnourished? In the past year alone, a third of the 1.6 million food parcels handed out by the Trussell Trust went to families with children: foodbank use spikes over the summer months, to fill the gap for children who would normally receive free school meals. The stresses and strains that material hardship places on families can lead to increased exposure to risk factors such as poor-quality parenting, parental mental ill-health and emotional distress. The cumulative impact of these factors affects children's wellbeing and thus their outcomes and future life chances.

5. ADCS members believe that poverty and inequality should be understood and tackled as public health issues. Yet LAs' ability to act to improve the lives of our most

vulnerable children at the earliest stages is becoming increasingly difficult due to growing levels of need in our communities coupled with diminishing resources. Support designed to prevent families reaching a point of crisis are under severe strain as the system becomes more and more weighted towards statutory interventions, by necessity rather than by design.

6. Prevention is the foundation for better health and wellbeing, the benefits of which extend beyond the individual to society as a whole. The recent green paper, *Prevention is better than cure (2019),* appeared to acknowledge this, yet offered little on the detail as to how that might translate to an offer for local areas, and in so doing missed the opportunity to demonstrate that the health of children is a priority.

7. Government has not put in place the necessary funding to enable LAs, nor the health service, to invest in early intervention and preventative services. We know that investing in prevention works, without this we are only storing up huge human and fiscal costs for the future. Since 2010, LA funding has been halved whilst the level and complexity of need in our communities are increasing. While the government recently confirmed that the responsibility for commissioning public health services will rightly remain with LAs, the latest spending plans sees public health receive the least generous allocation of the health and care settlement. This does nothing to allow LAs to deliver on their public health responsibilities, or to help us address health inequalities. The sector's financial position is unsustainable. By contrast, there has been significant and welcome investment in the NHS.

The NHS Long Term Plan

8. The NHS Long Term Plan was published to much fanfare. An extra £4.5 billion investment for primary and community services has been made available to support implementation of the Plan. It remains unclear if the failure to date to focus on the health needs of children will be reversed as the ambitions of the Plan are implemented.

9. The Plan outlines key proposals to improve the delivery of services to the whole population. However, while the Plan is based on common principles of prevention, early identification and treatment to support improved health, its focus on children is inadequate, limited only to specific cohorts, and those with specific conditions. This is disappointing and a missed opportunity to have taken a broader view of children's general health needs across the whole of childhood. **Long term proposals around children's health should not be limited to specific condition-based needs but must incorporate the range of health needs of children and young people, including recognition of requirements of specific vulnerable groups, for example, children in care, many of whom will have experienced adverse childhood experiences (ACEs) which impact on mental health and wellbeing.**

10. The Plan's focus on quality of care, performance and in particular waiting times, mainly apply to the assessment, diagnosis and treatment of adults, making little in the way of commitments to children. The emphasis on adult care and the different approach the Plan takes towards children and young people is discriminatory and NHS England must do better than this for children.

11. The NHS Long Term Plan sets out a vision for health services for the next decade and beyond, the shape of services in the future and spending priorities. Children should be central to that and yet they are not. Furthermore, the Plan does not attempt to address

wider children's health policy and does not seek to overcome well publicised challenges around equality of access. Nor does it seek to foster genuine co-production with other public services including LAs and schools – this feels like a missed opportunity.

12. The proposals set out for children and young people with learning disabilities and autism are welcomed, but it is disappointing that the Plan has not brought into scope the needs of children with lower level SEND. The Plan's proposal to move selectively towards a 0-25 years service offer by 2028 is too slow and simply not responsive to the needs of children and young people today. The *Children and Families Act (2014)* extended the age range of many children's services to 25 years. By the time the NHS shifts its service model, a child entering school when the legislation was enacted will have graduated.

13. It is welcomed that the NHS Long Term plan recognises the importance of speech and language therapists as a workforce in short supply but more needs to be done to ensure these services are available to all children who need them. Other professionals in health services are also in short supply including school nurses and health visitors, this must be recognised and addressed.

14. The Long Term Plan makes no reference to safeguarding the welfare of children as part of promoting good health and development. The revised *Working Together to Safeguard Children* (2018) emphasises the statutory role of health partners in this respect. The recent introduction of multi-agency safeguarding arrangements, to replace local safeguarding children's boards, offers the opportunity to reset the role of health, particularly in relation to vulnerable children. The Plan also misses an opportunity to draw systematic learning from the recently reformed child death review process.

Resetting the role of health

15. It remains unclear where children fit into the longer-term view for the nation's health service. **Directors of children's services are systems leaders and as such are ideally placed to bring coherence in this space**, particularly with the opportunities for improved integrated working that Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) promise. However, this would need to be supported by strengthened leverage to hold health services to account for the fulfilment of their statutory responsibilities. **The Department of Health and Social Care (DHSC) must strengthen the powers of the Care Quality Commission (CQC) to inspect and judge the effectiveness of the way in which health partners fulfil their statutory responsibilities to all children and young people. Where health partners are judged to be non-compliant, DHSC should take affirmative action to ensure compliance.**

16. The introduction of STPs and ICSs, as new models for collaboration between the NHS and LAs, must offer the opportunity to speed up the progress towards better integrated working and to ensure that children and young people's voices and wishes are central to this work.

17. The health system in England is beset with complex organisational structures, including a commissioning and provider split, a multitude of strategic and operational footprints that do not mirror any other local arrangements, all of which have resulted in a disparate offer for local children and their families. This does little to support the goal of equality

of access for all based on need. The NHS Long Term Plan offers little in the way of solutions to these structural problems.

18. Health and wellbeing boards are a key component of health and social care systems, bringing together commissioners across the NHS, public health, adult social care and children's services, in addition to other key partners, to ensure joint working at the local level. The requirement to work jointly to improve the health and wellbeing of local populations must also be replicated at the national level; **we need a national health and wellbeing board approach, supporting joint working across government departments and sector representative bodies, to ensure the holistic needs of children and young people are considered**.

19. The NHS operates on the principle of prioritisation on the basis of clinical need while children's services prioritise on the basis of assessed risks and/ or vulnerabilities. While it is helpful that the statutory guidance on joint strategic needs assessments suggests that health and wellbeing boards specifically consider the needs of vulnerable groups, such as children in care, it is essential that we collectively deliver on an effective and wider prevention agenda given that this has been a national ambition for so long.

20. It is vital that improvements in integrated working between health and social care take place with the move towards ICSs. There are examples of good practice across the country, including shared and fully integrated services, and this learning needs to be captured and shared so others can benefit. While the Plan speaks of the collaborative responsibility of the ICS as a structure, more detail is needed on how it will specifically address the co-funding issues and join up of support for children with SEND and those with a need but without diagnosis.

A healthy start to the early years

21. The importance of a healthy start at the very earliest stages of life cannot be overstated. We know that the impact of good health and care *in utero* can have lasting effects into adulthood and that the first 1,000 days of life, from conception to age two, is a critical phase of a child's development. We need responsive, needs-led antenatal and post-natal care, and holistic early years provision which meets the needs of the whole child in terms of their social, emotional health, and educational development. This is of even greater significance for those children most at risk of poor outcomes, including children born into poverty and social disadvantage. The stark inequalities in child health, which have widened over the last decade, have had some part to play in nearly all the leading causes of infant mortality, a strong correlation with causes of childhood mortality more generally, and an association with nearly all the leading causes of deaths of 15-19 year olds (RCPCH, 2017).

22. Over the last 20 years, children's centres have offered support to both parents and children. A six-year study on the impact of children's centres demonstrated improvements in maternal mental health and family functioning. A more recent report found a reduced use of acute hospital care for children in deprived areas who had received Sure Start services. The biggest benefits were evident in the poorest areas and were also greater over time. Although we are alert to the benefits of children's centres, a growing number are being lost from our communities due to funding pressures. LAs are working creatively in an attempt to ensure continued support is available, however, parents are not as easily able to access expert advice and are

increasingly turning to other routes, such as the internet and social media, for information.

23. Health practitioners have an important role to play in early identification of need. Community midwives and health visitors in particular have a significant advantage in understanding the needs and circumstances of families with very young children. The uptake in childhood vaccinations for every major illness is falling, leaving thousands of children under-protected. It is concerning that the apparent lack of parental confidence in vaccinations is happening at the same time as access to professional advice and ongoing support via health visitors is declining.

24. Ofsted's 2018 joint targeted area inspection (JTAI) report on neglect highlighted the difference that health agencies can have, with school nurses and dental practitioners playing key roles in identifying potential early indicators of neglect. However, as a direct result of the 23% reduction to the public health grant since 2015/16, there is now a shortage of school nurses and health visitors. **The importance of the Healthy Child Programme cannot be underestimated and our ability to deliver on this must be strengthened via adequate resourcing for delivery of the full Programme.**

25. The early identification of children with speech, language and communication needs (SLCN) is key to supporting children to thrive. Nearly one in five children starts school with some delay in their speech and language development, placing them at greater risk of falling behind in their education, and of developing emotional and behavioural problems later. Yet not all children are able to access the therapy they need to develop basic language and communication skills due to a reduction in services, long waiting times for assessments, and shortages in the workforce. There must be recognition for, as well as a strengthening of, the work LAs do to support the wider health system to help families develop their child's speech, language and communication skills, alongside the work that schools do to support pupils with SLCN to access education.

School age

26. School years are the time for developing cognitive learning, social skills, a sense of belonging, agency and personal wellbeing that will hopefully be sustained for life. While the school years should mark some of a child's happiest times, a recently published report from the Children's Society found that school age children in the UK are at their least happy in a decade. Furthermore, current statistics on suicide show an increase in the rates of young people aged from 10 to 24 years taking their own lives, with the overall rate for that age group reaching a 19-year high and the rate for young females reaching an all-time high. Children describe struggling with modern life, facing multiple pressures, both online and in the classroom, and worrying about having enough money in the future as well as finding a job. It is not surprising that crime, in particular knife crime, is also something that concerns children.

27. Poor mental health and wellbeing can have a lasting impact on a child's life chances. A 2017 survey of the mental health of children and young people showed that one in eight 5-19 year olds had an identified mental health condition, yet estimates suggest around 75% of young people experiencing mental health problems are not receiving the support or treatment they need. Teachers, pastoral staff and school nurses are in a unique position as they see children every day and can potentially spot the signs of distress quickly. However, we have a school accountability system that values attainment above all else. This combined with ongoing curriculum reforms exacerbated by a lack of SLCN

services means that growing numbers of learners are disengaged and disenfranchised by a narrowing academic curriculum which they see as having little relevance to them and their lives. Exclusions are rising and the prevalence of 'off-rolling' in some schools means that we are at risk of losing sight of a cohort of often quite vulnerable children. We need a far more inclusive education system that foregrounds the mental health and wellbeing of children equally with their educational outcomes. *The Children and Social Work Act (2017)* rightly made age-appropriate teaching of relationships and sex education compulsory in schools. From 2020, this will include a valuable focus on good mental health and the importance of healthy relationships, but without additional training and resource for teachers, the impact of this move may be limited.

28. ADCS members welcomed the priorities set out for children and young people's mental health in the NHS Long Term Plan, which rightly acknowledges the vital role of schools and colleges in the early identification and support of pupils with mental health problems. It is positive to see that clinical commissioning groups (CCGs), in collaboration with LAs and others, are taking part in the implementation of the first wave of 'trailblazer' areas to establish mental health support teams for clusters of schools and colleges. However, the scale and pace of this work is not sufficiently ambitious and millions of learners will not benefit from this policy initiative. **ADCS members support the LGA's call for mandatory on-site school counselling services for every pupil in secondary and alternative education provision. Such a service would allow many more young people to access early help and support before their needs escalate.** Furthermore, the decision to exclude schools that have had an 'inadequate' Ofsted rating from the early waves of the trailblazers is of deep concern. These schools and colleges may have learners with some of the highest levels of need, and it is wrong to assume that because a setting has had an inadequate judgement that they are not able to engage with and benefit from the support that would be offered through these teams. Only recently, a survey of 10,000 teachers conducted by the National Education Union found that 80% believed mental health support had deteriorated over the past two years with some respondents warning that it has reached "crisis point". The government must be more ambitious on the social, emotional and mental health of our children.

29. The difficulties in accessing support for children with mental health needs is a core concern for children and young people themselves, as voiced by the Youth Parliament, which has identified this as a priority issue in recent years. The systemic challenges in child and adolescent mental health services (CAMHS) are well known - growing waiting times for assessment, diagnosis and treatment; variability in the quality of care and treatment across the country; and a lack of in-patient provision. Given these challenges, many LAs are attempting to step into this space to provide for some of the needs that are unmet by the health service. Blackpool's Headstart programme, Stockport Primary Jigsaw, and Salford Emotionally Friendly Schools are just some examples of integrated approaches being taken to early resilience building and therapeutic support work in schools.

30. The principles set out in the NHS Long Term plan are silent on the challenges of accessing specialist in-patient beds (known as Tier 4 placements) for those with the highest level of need. ADCS members report growing concerns about the difficulties in accessing mental health services for those children with severe and/or complex needs who require in-patient services. The lack of Tier 4 beds is having a knock-on effect in the care system, particularly the capacity in secure children's homes, as this very specialist form of provision is being used as a proxy for secure mental health services.

As a result, frequently there are no welfare beds available in secure children's homes anywhere in the country for those young people who require them, regardless of the severity of the situation.

31. Seeking a secure welfare order for a child in crisis due to their mental health needs is far from ideal, however, there are often few, if any, alternatives. The growing delays in accessing early mental health support is resulting in issues escalating to the point of crisis necessitating a secure placement (whether Tier 4, or when this cannot be accessed, a secure children's home). Where children have accessed a secure or Tier 4 placement, there is a desperate need for more bespoke step-down provision that will support their reintegration into the community. ADCS members across the country report that health partners are drawing distinctions between children and young people's emotional and behavioural needs and their diagnosable mental health condition in order to gatekeep access to rationed CAMHS services. **There is a clear link between trauma, emotional distress and behavioural presentation, which this distinction overlooks. Health partners must take more responsibility for co-commissioning appropriate services (both secure and non-secure) for children who have emotional and behavioural needs which affect their mental health.**

32. Health partners and children's social care need to work together to meet the needs of children and young people requiring specialist residential provision. Currently there is no working definition of specialist provision that is shared between LAs, providers, Ofsted and CQC. ADCS members are concerned that some providers claiming to offer specialist therapeutic provision for children with complex mental health needs do not deliver on this promise and are therefore leaving children without the support they need. **A review is needed of specialist residential provision for children with complex mental health needs. Clear criteria should be developed which providers of specialist therapeutic services must meet to evidence the therapeutic nature of their offer.**

33. *Future in Mind (2015)* put forward a transformational vision for children and young people's mental health services, bringing together commissioners and providers of CAMHS, working with children and their parents and carers, to co-design a system that works for children and is responsive to need. The sector as a whole rallied behind the report and there was widespread commitment to implementing the proposals. **As we approach 2020, now is an appropriate time to bring the Children and Young People's Mental Health Taskforce together again to take stock of progress to date and identify what still needs to be done to make the mental health and wellbeing system work for children.** A commitment to commission research into effective interventions in tackling social, emotional and mental health problems is an important part of this.

34. While it is right to take stock, lessons must also be learned from the implementation of *Future in Mind* and the funding arrangements for local transformation plans; government must ensure that funding for children's mental health and wellbeing is used appropriately, has the desired impact, and that spend on such services is evidenced by outcomes. Much greater transparency and accountability in terms of how resources are being used to improve the health and wellbeing outcomes for children and young people is required. **We need a sustainable long-term funding strategy for children and young people's mental health that leaves no child at the mercy of a postcode lottery.**

Transitions to adulthood

35. For adolescents, approaching adulthood can often mean facing a cliff-edge in terms of the support services available to them. While the *Children Act 1989* provides for a spectrum of services to be made available to children, it is too often the case that reaching age 18 years means the application of different and higher thresholds in order to receive support from adult services. This serves to prevent young adults from continuing to benefit from support they may have come to rely on from school or children's services and continue to need in the short and/or longer term, as they transition to adulthood and greater independence.

36. 16-18 year olds who may require mental health support are particularly disadvantaged. At 16, many young people are deemed too old for support as a child from CAMHS, but before their 18th birthday they are considered still too young for support as an adult from adult mental health services (AMHS). In addition to this, there is also a discrepancy in the support available for certain conditions. For example, a child who has been receiving support for autism or ADHD may find they are unable to receive support from AMHS, because adult services commonly do not support people with these conditions due to funding pressures in adult social care and a higher threshold for accessing services. Care leavers frequently struggle to access support from AMHS despite many having a history of trauma and ACEs. Children who are not care experienced but who may be impacted by ACEs, also find that CAMHS support stops at age 16 even though they may have been supported by children's services as a Child in Need (CiN).

37. The range of risks that adolescents face are distinct from those of younger children, mainly due to contextual safeguarding risks outside the family home, including digital dangers, sexual and criminal exploitation. Over time we have got better at recognising the vulnerability of young people who display risky, harmful or criminal and/or abusive behaviours due to grooming or exploitation; our responses are evolving. Health partners involved in multiagency panels to look at the vulnerabilities of adolescents in the round e.g. exploitation, going missing, radicalisation or offending behaviours, have a key role to play in identifying and supporting young people involved in risky and harmful behaviour, and can help to bridge the cliff edge in support between children's and adult services. Continuing to work with young adults following their 18th birthday can help to ameliorate the cycle of adult disadvantage. But more is needed. There are very few services for 18-25 year olds and ADCS members are particularly concerned about the paucity of drug and alcohol services which does nothing to help young people break the cycle of addiction.

38. As noted earlier, the early identification of children with SLCN is key and missing a diagnosis of SLCN in early childhood can have a hugely detrimental impact on all areas of a child's health and development. SLCN is linked to low educational attainment, literacy and numeracy, and a higher likelihood of not being in education, employment or training. There is also a relationship between SLCN and a history of difficulties in developing and maintaining relationships with family and peers, leading to a higher risk of social isolation and loneliness and co-related issues around depression and anxiety. 65% of young people involved in the criminal justice system (CJS) have a SLCN requiring intervention, the majority of which has been previously undetected. A study carried out by the Royal College of Speech and Language Therapists found that young people with SLCN also often have a history of emotional and behavioural needs which

were identified as the primary condition requiring interventions in early childhood, but the likely underlying communication issues at the root of behaviours were missed.

39. The role that undiagnosed and unsupported SLCN plays in our understanding of these vulnerabilities and risks related to social exclusion, that can potentially push young people towards gangs and criminal exploitation, is significant and needs to be brought into sharper focus. Whilst it is welcomed that the NHS Long Term Plan acknowledges the importance of early identification of SLCN, more needs to be done to bridge the gap in services with this older cohort who have experienced poor outcomes as a result of earlier failures and missed opportunities.

Children in care

40. As a result of earlier trauma and loss, a significant proportion of children in care and those who have left care suffer from mental distress, and all too often their needs are not met, yet despite this, only a very small proportion have a clinical diagnosis. ADCS members report that engagement from mental health services is increasingly difficult to secure for children in care, and that CAMHS services expect a child to be 'stable' before accessing services. Many children who have experienced trauma and neglect will not be 'stable' until they have received support. Achieving stability must be seen as an outcome rather than an eligibility criterion for accessing services going forward.

41. Securing mental health services is even more challenging when a child or young person in care is placed away from their home authority. Support to meet physical health needs is routinely available but difficulties in securing services to meet mental health needs for 'non-resident' children and young people persist when they are placed out of their local area.

42. A trauma informed multi-agency response to supporting children in care is needed from day one of their care experience, with suitable responses put in place both in the short and longer term. Services need to be tailored to the needs, wishes and preferences of children and young people, and children must be involved in the design of the services they use.

43. Unaccompanied asylum seeking children (UASC) and young people may have distinct health needs for a variety of reasons, including previous abuse or as a result of poor conditions and trauma whilst travelling. Sirriyeh (2011) reported that several studies have found that unaccompanied minors have high levels of post-traumatic stress symptoms (around 50%). Lack of comprehensive health history of UASC on arrival into the country adds a further layer of complexity. We know from Kent County Council's review of 154 initial health assessments that 41% of unaccompanied children and young people had a mental health need, 69% had a physical health need and all had an unknown vaccination history (ADCS, 2016).

44. The trauma experienced by some UASC increases the likelihood of the need for mental health support, and places additional pressure on local CAMHS services, particularly given the lack of availability of specialist mental health support for this cohort of young people. Urgent health assessments are critical but this process is likely to be more time consuming given the lack of health history available and the need to ensure health needs are fully identified, and appropriate health plans put in place. There is a lack of additional resource for undertaking these detailed health assessments, placing additional demand on local services. The complication here is the inability to plan due

to the nature of arrivals in a local area, both spontaneous and via the National Transfer Scheme.

45. **New and bespoke pathways must be developed for UASC and their unique and complex health needs. This should incorporate fast track health assessments that are informed by existing knowledge on countries of origin and journeys, awareness of blood borne viruses, immunisation issues and similar factors; and designated nurses for children in care holding surgeries in residential units. The government should provide a national resource which local areas can draw down from.**

46. ADCS members welcome the support available to families via the Adoption Support Fund (ASF) for children who are adopted and those who have left care via special guardianship orders. However, the very existence of the ASF would not be necessary if the health service adequately funded therapeutic services for children.

Children with SEND

47. This paper does not look in any detail at the services and support available to children with SEND and their families. The provision of and demand for those services and the outcomes achieved are subject to national review.

48. *The Children and Families Act (2014)* ushered in a series of rightly ambitious reforms to reshape support for children with SEND, including extending education entitlement from birth to 25 years. Children's services now retain responsibility for children and young people with SEND up to age 25, however those services were not adequately funded to meet these expanded duties, particularly for the new responsibilities in relation to young people aged 18-25. One of the unintended consequences of the legislation is the number of learners with Education, Health and Care (EHC) plans has increased significantly, with notable growth in the age 16 years plus cohort.

49. The 2014 Act places a duty on local partners to develop joint funding arrangements to meet the needs of children and young people with SEND. However, it remains a challenge for many LAs to engage health partners in making a meaningful and consistent contribution to EHC plans and services. SEND inspection outcomes demonstrate inconsistencies in health contributions to EHC plans and varied attitudes from health partners as to their perceived responsibility (including the co-funding of specialist placements). Inspectors have noted that health outcomes are often based on service deliverables rather than a provision of child-centred support, and that the commissioning of CAMHS services has not yet caught up with the 0–25 years agenda.

50. ADCS members report difficulties in accessing continuing care funding, even for children with the most complex needs, and the inconsistency in application of the Continuing Care Framework by individual CCGs is unhelpful. This inconsistency is a particular problem for children who require additional support from health services to access education, as CCGs often cite that they are not responsible for funding this area; this is clearly unacceptable. Improved consistency in application of continuing care funding by CCGs would support the ongoing effort to develop better joint commissioning across health and social care partners. As it stands the provision of continuing care for children is not a statutory requirement, as it is in adult services. **Commissioning guidance to CCGs should be strengthened in relation to children with complex**

and continuing health care needs. DHSC should make the National Framework for Children and Young People's Continuing Care statutory.

51. ADCS welcomed the Secretary of State's response to Dame Christine Lenehan's report, *Good intentions, good enough (2017)*, exploring the experiences and outcomes of children and young people in residential schools and colleges, particularly his commitment to work with the DHSC and NHS England, to support LAs and CCGs to develop improved joint planning and commissioning of SEND provision. These are our Children (2017), explored the care and treatment of children and young people with complex needs (and behaviour that challenges) involving mental health problems and learning disabilities and/ or autism. The need for an effective Transforming Care programme for this cohort is essential, with partners working together to avoid admission but where admission is necessary, supporting successful discharge, avoiding inappropriate delay. More recent research conducted by the Children's Commissioner (2019) suggests not enough progress has been made for these children and young people.

52. The recent government announcement of a national review of SEND and the creation of a SEND Leadership Board are welcome. The review offers the opportunity to take stock of progress since the introduction of the reforms and identify future priorities in order to deliver a SEND system that truly works for children and families. It will be crucial that the workforce is considered as part of this review. As highlighted by the ADCS wider workforce position paper, *Building a Workforce that Works for All Children*, the SEND reforms were not accompanied by a national drive to recruit and train the required numbers of specialist roles to support children and young people with SEND, eg. occupational therapists, speech and language therapists, and educational psychologists. Similarly, health partners have been slow to adapt to the 0–25 years agenda, particularly in mental health services where there are particular workforce challenges, this is leading to widening inequalities in access across the country. The government must take a stronger lead in addressing workforce issues by appointing a workforce lead to oversee a coherent workforce strategy to address capacity issues and ensure that adequate and up to date training is readily available. This role should sit in the DfE, however, a working group of representatives from other relevant government departments and sector representatives, including ADCS, should be established to oversee such a strategy.

Recommendations

ADCS members are committed to achieving a country that works for all children, this includes supporting and working with a health system that has the needs of children and young people at it's heart. ADCS members urge the government and NHS England to implement the following recommendations:

1. A sustainable long-term funding strategy for children and young people's mental health that leaves no child at the mercy of a postcode lottery.

2. NHS England's long term proposals around children's health should not be limited to specific condition-based needs but must incorporate the range of health needs of children and young people, including recognition of requirements of specific vulnerable groups, for example, children in care, many of whom will have experienced adverse childhood experiences (ACEs) which impact on mental health and wellbeing.

3. DHSC and NHS England must draw on the valuable role of directors of children's services as systems leaders to help ensure the needs of children and young people are central to the future of the health service and that their health and wellbeing needs can be holistically met.

4. The DHSC must strengthen the powers of the CQC to inspect and judge the effectiveness of the way in which health partners fulfil their statutory responsibilities to all children and young people. Where health partners are judged to be non-compliant, DHSC should take affirmative action to ensure compliance.

5. Government departments should adopt a national health and wellbeing board approach, supporting joint working across government departments and sector representative bodies, to ensure the holistic needs of children and young people are considered.

6. DHSC to resource adequately the delivery of the full Healthy Child Programme.

7. Government should fund mandatory on-site school counselling services for every pupil in secondary and alternative education provision. Such a service would allow many more young people to access early help and support before their needs escalate.

8. NHS England should instruct health partners to cease using the distinction between children with emotional and behavioural needs and those with a mental health condition as a means to gatekeep access to CAMHS services. Health partners must take more responsibility for co-commissioning appropriate services for children who have emotional and behavioural needs which affect their mental health.

9. DfE and DHSC must jointly review specialist residential provision for children with complex mental health needs. Clear criteria should be developed which providers of specialist therapeutic services must meet to evidence the therapeutic nature of their offer.

10. DHSC and NHS England should bring together the Children and Young People's Mental Health and Wellbeing Taskforce to take stock of *Future in Mind* progress and identify what still needs to be done to make the mental health and wellbeing system work for children.

11. NHS England should develop new and bespoke pathways to meet the unique and complex healthcare needs of unaccompanied asylum seeking children. This should incorporate fast track health assessments that are informed by existing knowledge on countries of origin, awareness of blood borne viruses, immunisation issues and similar factors. This should be a national resource which local areas can draw down from.

12. DHSC must strengthen commissioning guidance to CCGs in relation to children with complex and continuing care needs. DHSC should make the National Framework for Children and Young People's Continuing Care statutory and fully fund it.

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ADCS
Leading Children's Services

The Association of Directors of Children's Services Ltd (ADCS)

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