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TURNING THE 10-YEAR NHS PLAN INTO A 50-YEAR LEGACY: THE CENTRALITY OF CHILDREN AND YOUNG PEOPLE

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TURNING THE 10-YEAR NHS PLAN INTO A 50-YEAR LEGACY

The NHS 10-Year Plan (NHS10YP) has ambitious aspirations to prevent illness, move healthcare to community settings, and make better use of digital technologies. These are laudable and essential objectives that now need a clear delivery plan which recognises that the foundations of lifelong health are laid in childhood.

The evidence shows that more of the same will not work (1). Childhood shapes lifelong physical and mental health through adulthood and into old age (2). We must invest upstream where these disease trajectories originate if we are serious about prevention and the NHS's future. For example, multiple long-term conditions (including cardiovascular and respiratory disease, diabetes, cancer, and mental ill-health) will only increase in prevalence if we don't address the rising obesity in primary school children.

Our health and social care systems have prioritised urgent reactive responses over earlier, proactive support. The Royal College of Paediatrics and Child Health (RCPCH) has highlighted repeatedly the problems that arise because only ~11% of health funding is spent on children and young people (CYP) - despite CYP constituting ~25% of the population and their health being the major determinant of NHS long term pressures.

Mental ill health illustrates the need for an upstream focus. One in five 8–16-year-olds has a probable mental disorder, with half of all lifetime mental health disorders developing by 14 years of age (6). If early intervention capacity is insufficient then this causes problems to escalate, crises to increase, and adult services become overwhelmed (4). This is the trajectory the NHS10YP must interrupt to reduce long-term costs and improve individual life outcomes.

To summarise: protecting the future of the NHS requires a relentless focus on CYP.

Creating the foundation for a prevention-first child focussed system

Three foundations would make the NHS10YP deliverable at scale:

1. Health and care support delivered in education settings.
2. Services integrated around families.
3. Administrative data connected across sectors.

These foundations are being laid in Bradford.

Most CYP attend nurseries and schools, which are amongst the best-placed institutions to deliver preventative approaches at scale. Schools see children daily, understand their contexts, and have trusted relationships with families. They can support children as NHS patients and help alleviate pressures elsewhere by providing space for paediatric and social care services to be delivered to communities in the places they live. Schools' positions within local systems offers the NHS a practical route for phased implementation, allowing regions to progress at different speeds by initially targeting the bottom quintile of disadvantaged wards where data from Bradford suggest that 80% of NHS pressures arise. This prioritisation of support for our most disadvantaged communities provides an effective way to operationalise proportionate universalism. Collaboration between health and education could reduce health service delivery costs, utilise school space created by falling pupil numbers, increase government's return on its educational estate investment, and avoid the capital costs associated with new buildings.

Co-locating services in educational settings helps bridge the longstanding disconnect between health and education by organising support around children and families rather than through different institutions separated for administrative convenience. In this way, help

becomes coordinated and thus more effective and cost-efficient. In Bradford (in common with other areas), we are trialling the colocation of children's paediatric and social services in schools serving disadvantaged communities ('School Health Hubs'). This begins to create integrated care delivered to families at the point when it is most effective and cost beneficial. This is how we return, in fiscally constrained times, to the successful 'Sure Start' centres approach that is now known to have supported children into healthier adulthoods (5).

However, full integration is only possible if information connects services. In Bradford, we have linked health, education, and social care data for all children across our district of 563,200 citizens. Linked administrative data enable services to see patterns that no single agency can recognise: hotspots of vulnerability, emerging risk, and the cumulative impact of disadvantage. Our approach is possible because UK citizens generally trust their data to be held locally, safely housed within the NHS, and used to improve their public services. The NHS10YP should catalyse national adoption of this regional approach, and champion adoption of the NHS number as a 'Single Unique Identifier' allowing secure, responsible sharing across health, education, and care.

These foundations would support 50 years of NHS improvement through prevention and early intervention. The task is now to implement these innovations at pace and scale.

Making earlier identification meaningful through investing in child health

Paediatric services are a unique cornerstone of prevention. Child health professionals intervene during sensitive developmental periods when timely support can alter lifetime trajectories across health, education, and wellbeing. The Schools White Paper is encouraging schools to recognise 'at risk' children earlier, which will require paediatric capacity for timely response (6). However, paediatric services currently have spiralling waiting lists, with the RCPCH estimating circa 166,740 additional patients since 2020. Earlier identification will create longer queues with the preventable burden reappearing in adult services if the NHS10YP redesign doesn't address staffing and training challenges within the paediatric and child health professions.

The same principle applies to special educational needs and disabilities. Early assessment and support for neurodevelopmental conditions, speech and language problems, and sensory difficulties reduces the risk of a child's needs escalating (1). If support is delayed (as is currently the case for too many children), then physical and mental health problems interact with poverty resulting in problems that are harder and more expensive to treat downstream (1). A failure to provide early SEND support increases the chance of adverse education and health outcomes, and subsequent involvement with the safeguarding, justice and care system that, in turn, increases the probability of poor adult health (7).

If the NHS do not start to invest upstream in childhood, then we will see an increased dependence on hospital-based care, and demand growth that repeatedly outpaces feasible workforce supply. This pressure will become structurally locked into the system for decades if the NHS10YP does not focus on CYP.

Why this matters for the NHS 10 year plan

Child-focused prevention produces benefits on different time horizons (5). In the short-term (0–3 years), stabilising children's health services reduces crisis presentations, school exclusions, and safeguarding escalations (6). In the medium term (3–7 years), demand

growth slows across CAMHS, emergency departments, and social care problems start to be managed earlier (1,6). Over longer horizons (10–20 years), healthier adolescents transition into adulthood with fewer mental-health problems, lower rates of long-term conditions, and improved participation in work and education (2,5,7).

These positive effects accrue compounded interest across a 20–50 year epoch. Lower levels of obesity, smoking, substance misuse, and untreated mental illness in adolescence will translate into less midlife multimorbidity, fewer emergency admissions, greater healthy life expectancy, and a workforce better able to sustain economic growth. The benefits also extend into the next generation, as healthier adults are more able to provide stable, nurturing environments for their own children.

We face a critical juncture. Short-term fixes and incremental patches will not sustain the NHS. The illness, disability, and lost potential that starts in childhood translates into high adult-service burden, rising long-term costs, and poorer outcomes for individuals and communities. The NHS10YP offers a route to shift the NHS from reactive treatment to earlier, more effective intervention by connecting health with education, social care, early years, and youth services, with linked data as the backbone.

Political will is required together with sustained leadership and a public committed to a country that works for all children and young people. If we put children first, the NHS10YP can deliver a legacy that lasts for the next 50 years.

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