

Royal College of Psychiatrists' briefing

Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: A Green Paper | July 2018



This briefing sets out the key recommendations included in our own response to the Green Paper, and the corresponding information included in the Government's response to the consultation published on 25th July 2018.

Many of our recommendations are reflected in the document, which is positive. It is particularly good to see that:

- ✓ Funding will be allocated to provide supervision to the newly formed Mental Health Support Teams (MHSTs) from qualified staff in NHS children's mental health services.
- ✓ Additional resources are being made available to enhance the workforce and recruit around 200 additional therapists for the four-week waiting time pilot sites (on top of the 1,700 additional therapists as per the Five Year Forward View for Mental Health).
- ✓ The Government wants the new capacity provided by MHSTs to be the focus for collaboration not just across health and education but also other services, the majority of which we mentioned in our response.
- ✓ The Green Paper proposals will be included in the new ten-year ambitions on mental health, which should be at the heart of the NHS plan published in November 2018.
- ✓ The Government confirmed its commitment to ensure that the MHSTs reach those most in need of the support and are accessible to all, including the majority of groups that we mentioned in our response.
- ✓ The Department for Education (DfE) is setting up a team with representatives from across the sector to review the support needed for students in the transition into university, particularly those with or at risk of mental health issues.
- ✓ To be part of the 'waiting time standards' pilot, areas will need to demonstrate robust data collection and flow of information to the Mental Health Services Dataset.
- ✓ The Government has recently announced its intention to make health education a compulsory part of the curriculum for the first time and has launched a consultation on the draft regulations and guidance.

However, some of our questions remain unanswered. We will continue to work with NHS England (NHSE) on the implementation of the proposals and the development of the long-term plan for the NHS.

The core proposals

1. Be more ambitious in the roll-out of the proposals, following evaluation of the pilots.

Current plans aim for full roll-out by 2028, leaving a generation of children without support. We called on the Government to be more ambitious in the roll-out of the proposals, following evaluation of the pilots.

Other respondents, including some young people, thought the roll-out plans should be implemented more quickly and cover more of the country. On the other hand, others expressed concerns about the capacity of the NHS to respond to the proposals and felt a more cautious, stepped approach would be better, welcoming the plan to test the Green Paper's announcements in a trailblazer programme.

The overall ambition will not change. The Government wants to use the first trailblazer areas to demonstrate that this approach can be a success and, building on the experience and evidence from the trailblazers, roll-out the approach across the country.

In 2016, the Government set out plans to implement the national waiting time standards for children and young people with an eating disorder. Two years in, there have already been remarkable improvements to the availability and quality of eating disorder services provided to children and young people.

The building blocks that underpin these policy changes (workforce, funding, data, etc.) have been set up very quickly and effectively. We therefore believe the building blocks to implement waiting time standards for CAMHS should take less than 10 years to be set up.

2. Put in place a range of measures to improve recruitment and retention of multi-professional teams, including child and adolescent psychiatrists, nurses, psychologists, allied health professionals and social workers.

The response does not specifically refer to child and adolescent psychiatrists, or initiatives to improve recruitment and retention of multi-professional teams.

However, the Government states that additional resources are being made available to enhance the workforce: *'The proposals represent a transformational new way of working, and the creation of a brand new workforce. The new MHSTs will also be considered when developing the health and care workforce strategy, and in the context of the NHS long-term plan. Our estimates suggest that at full roll-out, the new MHSTs could comprise up to 8,000 new staff. This is comparable in size to the entire current children and young people's mental health services workforce in the NHS, which is around 7,000 full time equivalent staff.'*

In year one, resources should be sufficient to provide more than 300 new staff. This will be in addition to the therapists required for the four week waiting time pilot sites and will be on top of the current workforce and existing commitments made in the 'Five Year Forward View for Mental Health.'

The Government will expect local areas to determine what their workforce needs might be, and the trailblazers will test the right number and mix of staff in the MHSTs. However, we would like the Government to clarify where the new workforce will come from.

3. Include child and adolescent psychiatrists, higher trainees and speciality doctors in CAMHS on the national shortage occupation list.

This is not mentioned in the response; however, we know that the Migration Advisory Committee is currently reviewing the national shortage occupation list (NSOL). We will continue to campaign for child and adolescent psychiatrists, higher trainees and speciality doctors in CAMHS to be included on to the list.

4. Strengthen proposals to address issues in relation to:

Early years

The Government states that: *'On the importance of children's early years in securing good mental health, as stated in the Green Paper, we know that early years' brain development is a key factor for a child's future, with evidence suggesting links between brain development and a range of outcomes, including mental and physical health. We commit to considering further analysis in areas which may include:*

- supporting healthcare professionals to understand the importance of healthy, low stress pregnancies and healthy childhoods; and*
- increasing the capability of midwives to support women with perinatal mental health issues.'*

Although we welcome the additional resources to be allocated to perinatal mental health services, we are disappointed that the Government has not made any commitment to invest in mental health services for preschool children. This is particularly important given the cuts to council budgets that have resulted in the funding for Sure Start being halved over eight years.

We call on the Department of Health and Social Care (DHSC) to develop a national Perinatal, Parental Mental Health and Early Years Mental Health Strategy, working with the Ministry of Housing, Communities and Local Government (MHCLG), NHSE, Public Health England and Health Education England.

In addition, we call on the Government to ensure local areas commission evidence-based parenting programmes. Information about parenting should also be universally included in antenatal classes.

18-25-year-old young people

The Green Paper set out the Government's intention to create a new partnership focused on the mental health of 16-25 year olds. Following an initial meeting with a cross section of stakeholders in May, the For further information, please contact Zoé Mulliez, Policy and Campaigns Officer | zoe.mulliez@rcpsych.ac.uk

Cabinet Office has been working with the DHSC, the DfE and a range of other organisations to consider next steps in this area.

It is not clear what those next steps are and we will seek clarification from the DHSC and the DfE.

Children with special educational needs and difficulties, children with behavioural problems and their families

The Government states that: *'Schools already have a clear duty to take action to safeguard pupils where they have concerns that a mental health issue might lead to harm. They also have a responsibility under the Special Educational Needs and Disability Code of Practice to identify and provide support for pupils who have special educational needs, including needs resulting from social, emotional and mental health needs. These requirements are covered by the mandatory roles of the safeguarding lead and the special educational needs co-ordinator (SENCO) respectively.*

The role of the Designated Senior Lead will be to establish a whole school approach to mental health to ensure that those responsibilities are carried out in the context of a wider approach that also incorporates preventative activity and promotion of good mental wellbeing and resilience amongst students and staff.'

The response also refers to the "Transforming Care" programme, which includes *'a significant focus on children and young people with a learning disability and/or autism, and behaviours which challenge, and / or with a mental health condition, as part of the overall approach to ensuring that people with learning disability of all ages are able to live in the community and get the right support to avoid crisis'*.

The response does not give due consideration to children and young people with intellectual disabilities and other learning needs and/or neurodevelopmental problems. This is very disappointing considering that those children and young people with intellectual disabilities have higher rates of mental health and behavioural problems: 30% have mental health or behavioural problems, and though only making up 2% of the population they make up 15% of children and young people with mental health and/or behavioural problems.

Those children and young people may be in different places such as specialist schools, residential schools (including publicly funded private placements), BESD/PRUs, support units within mainstream settings... Any assessment and treatment to support them requires specialist knowledge, experience and a modification of approach.

Therefore, additional expertise, experience, training and specialist supervision will be required for these groups, as recommended in the NHS England's CYP IAPT LD/ASD curriculum and NICE guidance. Providing MHSTs with specialist knowledge and support from intellectual disability psychiatrists, psychologists and learning disability nurses will be essential to ensure this vulnerable group of children can receive the support they need.

Children who are not in education

We and other respondents expressed concerns about access to the MHSTs for home-educated children and those not attending state or mainstream education.

The Government will *'seek to use the trailblazer programme as the opportunity to test many of the issues raised in the consultation, such as how the teams can best work with vulnerable children and young people, work with those not in state maintained or mainstream education, and link with the range of professionals already working with young people (including educational psychologists, staff in primary care, General Practitioners, youth workers, social workers, staff in children's services, early help teams, school nurses, health visitors, school counsellors, youth offending teams, and voluntary and community sector organisations).'*

Young people with substance misuse problems

Issues in relation to young people with substance misuse problems have not been specifically addressed in this response.

Health inequalities

On disadvantage and inequalities more widely, the Government says it is committed to taking action. Examples of activities include:

- Investment of £365 million (over 2015/16 to 2020/21) to support perinatal mental health.

For further information, please contact Zoé Mulliez, Policy and Campaigns Officer | zoe.mulliez@rcpsych.ac.uk

- A new programme to invest up to £39 million to reduce parental conflict through evidence-based intervention.
- Investment in the Troubled Families Programme. Backed by £920 million from 2015 to 2020, the programme's keyworkers will work intensively with up to 400,000 disadvantaged families, working with the whole family to overcome their multiple and complex problems – such as family conflict, truancy and worklessness, rather than focusing on a single family member or problem.
- The “Healthy Child” programme is implementing a wide range of policies to improve child health including the transformation of children’s mental health and maternity services. As local authorities are best placed to target children’s services to meet the needs of their local population, they will receive over £16 billion between 2015/16 and 2020/21 to spend on public health. This is in addition to NHS spend.
- Spending on mental health is planned to increase to a record £11.86 billion in 2017/18 and will include improving access to liaison psychiatry in every A&E department and putting crisis resolution and home treatment teams on a 24/7 footing.

Connections with other parts of the system

The Government wants the new capacity provided by MHSTs to be the focus for collaboration not just across health and education but also other services – a multiagency approach focused on collectively understanding and meeting the needs of children and young people in an area.

The Government expects the new teams to work across organisational boundaries and closely with colleagues in other services: *‘The CQC identified the need for a “shared understanding” between different services; the design of the teams should in particular enable better joint working between health and education services, as well as working with other services as described.’*

In addition, the Government wants to test how the Green Paper proposals link to other initiatives, such as the DfE’s social mobility-focused “opportunity areas”.

However, it is unclear how this multiagency approach will work in practice. There have already been many initiatives to improve system working, but the same barriers to achieve the best possible outcomes remain, including poor sharing of information between the different services involved in children and young people’s mental health which may lead to safeguarding concerns.

Although we welcome the Government’s plan to improve timely access to inpatient beds, we also urge the Government to invest in areas such as social care, primary care and paediatric services. Such additional support is essential to prevent crises and medicalisation of social difficulties, and to ensure that specialist CAMHS are used appropriately.

Data and research

The response does not mention the prevalence survey, but the Government’s response to the Health and Education Select Committees’ inquiry does.

It states that the prevalence survey is expected to be published in autumn 2018. It also states that the Government is *‘considering a ‘keep-in-touch’ exercise and subsequent follow-up survey at three or five years after the original data were collected’*.

This will be the first prevalence survey of children and young people to focus on their mental health since 2004, and this had implications on service planning and workforce projections. We would like the Government not just to consider, but to commit to:

1. Undertake the keep-in-touch exercise. It will enable them to maintain contact with the children and young people who participated to the prevalence survey, particularly the most vulnerable young people.
2. Undertake a follow-up survey to explore the outcomes of the care children receive from this survey. Longitudinal data offers the opportunity to track change over time, while repeated surveys only offer a snap shot
3. Undertake regular repeat prevalence surveys.

5. Ensure that the changes that take place are properly evaluated to ensure that we learn from the data generated on how best to support school-age children in the community.

Many respondents said it was essential for the trailblazer programme to be robustly evaluated and that practice and interim lessons learnt should be shared with others.

The Government states that: *'In the first wave of trailblazers, we are expecting to recruit between ten and 20 areas to be fully operational by the end of 2019. We want to ensure that the first wave of trailblazers cover as wide a range of local characteristics as possible to ensure that we can thoroughly test the delivery model and learn lessons to inform future roll-out.'*

The first trailblazer areas are expected to cover a mixture of rural and urban areas, different types of school and college provision, and areas with social deprivation, inequalities, or other local needs. To ensure coverage of trailblazers across the country, trailblazers will be selected on a regional basis. (...)'

Those areas will have to meet expected levels of investment in mental health and demonstrate progress in increasing access to mental health services for children and young people in line with national and local targets: *'The rationale for this approach is to ensure that areas are able to take on the challenges of this programme quickly, with the capability to test different models; build effective relationships with schools, colleges and NHS providers; and demonstrate that the additional support helps children and young people'*

We believe that areas that face challenges should also be incentivized to be part of the trailblazer approach and should receive extra support. This will be crucial to test whether the Green Paper proposals can be implemented universally across all areas.

The Mental Health Services and School Links pilots programme underlined the lack of available resources to deliver the offer universally across all schools within many areas, and we need to learn from this conclusion.

In addition, we understand that an Expert Group has been established to discuss how best schools and colleges can measure the impact of what they do. We believe this should include:

- Monitoring referrals to the new school-based teams and CAMHS (as well as between them)
- Monitoring waiting times for both
- Monitoring clinical outcomes and the types of problems referred to both
- Gathering qualitative data on how the Designated School Leads, MHSTs and CAMHS work together

6. Increase and ring-fence national funding for CAMHS.

The Government said that the commitment to make available £300 million of funding to implement the Green Paper proposals still stand.

7. Hold every CCG to account in achieving the Mental Health Investment Standard (both including and excluding dementia and learning disability spend), and impose regulatory sanctions on CCGs who have not met the MHIS.

There is no mention of the MHIS in the response. However, we know that the MHIS has been successful in driving growth in mental health spending overall and this needs to continue to be assessed and assured at a CCG level.

The new MHIS includes a requirement for CCGs to increase their spending on mental health by a greater proportion than their overall rise in allocation from 2018/19.

8. Ensure Mental Health Trusts' income continues to grow to reflect additional monies made available to CCGs, the forecast rise in demand on secondary mental health services, and the additional mental health workforce posts required to be in place before 2021.

There is no mention of this in the response. The RCPsych Policy and Campaigns team will continue to support the College in its campaign to ensure mental health services receive more funding.

9. Improve the accuracy of mental health data, and in particular the financial data reported by CCGs, address non-compliance in CCG data returns and take regulatory action where appropriate.

For further information, please contact Zoé Mulliez, Policy and Campaigns Officer | zoe.mulliez@rcpsych.ac.uk

Data quality generally remains a concern. As a result, several indicators and future placeholders have been removed from the last Dashboard. The RCPsych Policy and Campaigns team will continue to support the College in campaigning for improving the quality and flow of data, particularly for children and young people's services.

10. Publish the delayed Mental Health Dashboard and commit to a quarterly publication timetable for the duration of the Five Year for Mental Health.

The latest Dashboard data available (published at the end of March 2018) covers up to Q2 of 2017/18. We expect the new dashboard data to be published imminently.

11. Incorporate the Green Paper's proposals post 2021 in the next mental health strategy.

The Government has recently announced a historic funding settlement for the NHS, and have asked the NHS to produce a major new long-term plan in return. The new ten-year ambitions on mental health should be at the NHS plan's heart; and the initiatives set out in the Green Paper support this plan and are important first steps towards the Government's longer term ambitions on mental health.

Mental Health Support Teams

12. Clearly set out which professionals will comprise MHSTs, what their professional standards will be, who will train and supervise them, and where the funding will come from.

Many respondents – including us – were keen that the contribution of existing professionals was maximised and that the proposed teams collaborated with the broad range of organisations and services that work with children and young people. It was also noted that the proposed teams should not divert resources away from existing efforts to improve access to therapeutic support for children and young people.

The Government responded that there are *'no ready-made answers about the overall make-up of teams and how they should operate, and we are clear that we do not want to impose a model that doesn't take account of the existing local context'*. National roll-out will be designed on the basis of the experience from the trailblazer programme.

Professional standards and training

The Government agrees that the teams should only provide evidence-based interventions, the impact of which can be measured and evaluated:

'We are working with Health Education England and NHS England, together with leading clinical experts, to develop an evidence-based curriculum for training the new teams' staff. This will include building on the existing Children's Wellbeing Practitioner programme which is already being provided. The teams will need to work effectively within the school and college environment, and to understand issues impacting children and young people's mental health within this context. Their training will recognise the need to help parents to support children and young people's mental health, as well as the value of peer-based activities.'

Funding

The Government has chosen to fund MHSTs via CCGs. It states that: *'there are a number of advantages to this approach, including the ability to use established NHS regional and local assurance processes during implementation. MHSTs will provide a 'core offer' of evidence based mental health support, but CCGs will have flexibility to design teams according to local need and existing provision. Whilst CCGs will be the funding route for the first set of trailblazers, we expect schools and colleges, along with Local Authorities and other local bodies to work in partnership with CCGs in the application process and in designing and leading delivery. These partnerships will have the flexibility to design the teams according to local need and existing provision.'*

Supervision

Supervision should be provided by qualified staff in NHS children's mental health services. We will ask the DHSC who these professionals will be, how they will be selected and how they will be trained to provide appropriate supervision.

As MHSTs are likely to enrol in a 6-month training programme (details about this programme are currently unknown), there will need to be very robust supervision mechanisms in place to ensure high-quality support can be provided.

13. Ensure MHSTs are integrated both within CAMHS and educational institutions, and test a model by which CAMHS would manage them.

The Government is open to a range of delivery models for the teams. For example, some teams could be led by groups of schools, others by voluntary and community sector organisations or further education colleges.

It also explains: *'Our proposals also have multiple complexities including joining together different sectors, and the need to carefully integrate the existing structures of support for children and young people in local areas. It is essential that the new MHSTs, and the funding that goes with them, are developed carefully so as to work alongside existing good practice and services, rather than disrupting or replacing them. This will take time to do properly and we want to use the first trailblazers to demonstrate that this approach can be a success, and to build on the experience and evidence to roll-out the approach across the country.'*

14. Provide more funded staff to CAMHS so that they can offer the necessary oversight and support to the newly formed teams.

The funding available to support the teams will also support the cost of supervision from qualified staff in NHS children's mental health services. However, details about how this will work in practice have not been provided.

15. Ensure training will equip teams with the ability to identify the mental health needs of vulnerable groups of children and young people, and to refer them appropriately.

The Government states its commitment to ensure that the MHSTs reach those most in need of the support, and are accessible to all: *'We especially want the teams to be able to work with children in need and vulnerable children who might have more limited contact with mainstream schools and colleges and will encourage trailblazers to test this.'*

This might include alternative provision or special school pupils in contact with the criminal justice system and some children and young people who have experienced the care system. Children and young people from the Armed Forces community can also face challenges to their mental health due to issues such as frequent mobility both within the UK and overseas, operational deployment and family separation. Those who might be affected include children of military personnel and young people dependent on military personnel. The new support teams will be well-placed to identify mental health needs of these children and young people and provide support.

We will also be using the teams to test recommendations made around improving mental health support for looked after and previously looked after children. These recommendations were made by an expert working group we commissioned, and were set out in a report. To test these recommendations, we will link up Green Paper trailblazer programme areas with pilot areas that will be testing improved mental health assessment approaches for looked after children later in 2018. We will also look to test how teams can act as a focus for joint working and links to specialist mental health support for looked after children, to address some of the issues highlighted by the report.

Examples of good practice highlighted by the consultation suggest that settings which provide education and support to children with more complex needs, such as Pupil Referral Units, often have more experience of making links to mental health services. They can help co-ordinate support for mainstream education settings. We would therefore expect them to play a key role in a number of trailblazers.

Not all pupils out of mainstream settings are vulnerable, but they might still need access to support. For instance, apprentices and other 16-18 year olds in work-based educational training may only have limited contact with colleges. We will also look to explore whether some areas in the trailblazer programme can test how these young people can best take advantage of MHSTs when needed.'

16. Provide clear guidance to ensure that, when disorders start to move from mild to moderate, MHSTs understand when specialist support is needed and can refer appropriately.

This is not specified in the response. We will ask the DHSC how we can ensure this will be covered in the training provided to MHSTs (which will start in January 2019).

17. Ensure MHSTs help prepare young people for university life and provide appropriate support to vulnerable groups of young people before they go to university (for instance, by helping them identify and write their needs on their university application forms, and facilitate links with the relevant university support services).

The Government supported the launch of a new University Mental Health Charter in June 2018, aiming to drive up standards in promoting student and staff mental health and wellbeing. Universities will be awarded a new recognition for meeting improved standards.

The DfE is now setting up a team with representatives from across the sector to review the support needed for students in the transition into university, particularly those with or at risk of mental health issues. The Department has also committed to consider development of a workable disclosure agreement for universities that would give them permission to share information on student mental health with parents or a trusted person.

Piloting a waiting time standard

18. Ensure that any evaluation of the pilot looks at: the waiting time between first assessment and starting treatment, which professional does the first assessment, the access criteria to CAMHS, the number and types of referrals declined and why, the ratio of staff in each CAMHS team delivering assessment and treatment, and the ratio of referrals to discharges from each CAMHS team.

The 'waiting time standard' pilots will take place in a number of CCGs that are hosting trailblazers, but are likely to cover a greater area and population than that covered by the MHSTs, given the large range of numbers of schools in different sized CCGs. Pilots will be expected to achieve the four week waiting time ambition for as many children and young people who need treatment as possible.

The Government confirms that it will record data on:

- how quickly children and young people access services
- how quickly they start treatment
- what outcomes are achieved.

It will monitor:

- the impact of the new MHSTs on referrals into NHS services
- activity to ensure the pilot areas do not raise thresholds or reduce access in order to meet the target
- activity to ensure that nearby areas do not suffer adverse effects as a result of the pilot.

It will encourage pilots to develop and test innovative approaches to ensuring fast access to quality care. It will also be required to demonstrate a sustainable approach, which can be continued beyond the period of the pilots.

We believe the Government should also look at:

- Which professional does the first assessment
- The access criteria to CAMHS
- The number and types of referrals declined and why
- The ratio of staff in each CAMHS team delivering assessment and treatment
- The ratio of referrals to discharges from each CAMHS team.

19. Ensure that local sites bring a whole-system approach to testing the standard, including a system to ensure data can flow easily and safely between different systems and providers.

As part of the selection process for pilot areas, the Government will agree with local areas the proportion of children who will be seen within four weeks and their trajectory for achieving this, based on their current performance. The waiting time ambition will apply across all referral routes available in the pilot area, including self-referral, or referrals through GPs.

For further information, please contact Zoé Mulliez, Policy and Campaigns Officer | zoe.mulliez@rcpsych.ac.uk

To be part of the pilot, areas will therefore need to demonstrate robust data collection and flow of information to the Mental Health Services Dataset. The Government will also consider areas' current access and waiting time performance to ensure an appropriate level of ambition and to provide meaningful findings to determine future roll-out.

Areas will also have to demonstrate progress in increasing access to mental health services for children and young people in line with national and local targets, however it is unclear what those targets are. We will ask the DHSC to provide further information.

20. Routinely publish information on waiting time figures in all areas, not just the piloted areas, alongside needed and actual workforce numbers and number of referrals declined.

The response does not mention a requirement for all areas to publish information on waiting time figures, alongside workforce numbers and number of referrals declined.

Through the pilots, and through monitoring the impact of MHSTs on referrals and specialist NHS children's mental health services, the Government aims to understand the costs, benefits, challenges and indicators of success of introducing a four week wait. This will inform future roll-out, and the approach to moving from pilots to implementation across 20-25% of the country by the end of 2022/23, as stated in the Green Paper.

21. Publish the delayed mental health care pathways for children and young people's mental health services, including the recommended waiting times (developed by the National Collaborating Centre for Mental Health and commissioned by NHSE).

There is no mention of the mental health care pathways for children and young people's mental health services in the response to the Green Paper. The College will continue to campaign for the publication of such pathways.

Schools and colleges

22. Make the Designated Lead for Mental Health role mandatory for schools and colleges to give the Green Paper proposals the best chance of success.

Some respondents – including us - suggested that the lead role be made mandatory. Children and young people also felt that since it was not suggested that the lead should be a mandatory role, many of their peers could lose out if their school or college chose not to appoint a lead.

The Government remains of the view that a Designated Senior Lead role should not be mandatory: *'As we have heard in the consultation, it is essential that schools and colleges are able to have the flexibility to deliver the role so that it fits with their existing staffing responsibilities and approach to supporting mental health and wellbeing.'*

(...) The provision of free training, as well as the provision of MHSTs and improved access to specialist services through the four week waiting time pilot, provides an incentive for schools to identify a lead to help them to benefit fully from the additional support.'

23. Ensure training is high-quality, regularly updated and consistent across the country.

The Government agrees with respondents who suggested that, in order to support leads, training for the role should be substantial and appropriately long-term. It should provide both knowledge and a basis for reflective practice.

'We will ensure that training for leads is based on evidence and good practice. The training will make clear how the role can be beneficial to the school, and how responsibilities can be delivered in effective and manageable ways that are adaptable to different types and sizes of schools and colleges. The aim is to support a lead in every school and college so we want to ensure that the training is available to each institution, rather than funding in proportion to the number of pupils.'

24. Make a) the whole of Personal, Social, Health and Economic mandatory from 2019 for all pupils, in all schools, and b) mental health and emotional wellbeing required components of the PSHE curriculum for every age group.

The Government has recently announced its intention to make health education a compulsory part of the curriculum for the first time and has launched a consultation on the draft regulations and guidance.

This follows on from the call for evidence (separate to the Green Paper consultation) on the scope and content of Relationships Education in primary schools and Relationships and Sex Education (RSE) in secondary schools, and on the status of Personal, Social, Health and Economic Education (PSHE), which received around 23,000 responses (including 2,400 from young people).

The Government states that: *'This is a significant step designed to ensure young people are taught core content on physical health and mental wellbeing. It will provide them with the information they need to make good decisions about their own health and wellbeing, recognise issues in themselves and others and, when issues arise, seek support as early as possible from appropriate sources.'*

Mental resilience and wellbeing will form a key element of this new subject, as well as ensuring that pupils understand that good physical health contributes to good mental wellbeing, and vice versa. The consultation closes in November 2018, after which we will lay regulations in Parliament and publish guidance, allowing schools to begin teaching the new subjects from September 2019. They will be required to do so from September 2020.

To support this, we are looking at how we can best support schools to have access to the best, most innovative teaching materials developed by experts.'

END.