
Written evidence submitted by the National Network of Designated Healthcare Professionals for Children (NNDHP) (HB139)

Summary

1. Children are not seen as being of equal standing as adults and are therefore not treated fairly in the National Health Service. That is the argument of this submission, and it includes a practical account of what the Health Bill 2026 could do to begin to right that wrong.
2. The Health Bill 2026 is the most significant reorganisation of NHS commissioning since 2012. It is the government's legislative response to Lord Darzi's Independent Investigation of the NHS in England (DHSC, first published September 2024; revised edition issued 14 May 2026), which established that children represent 24% of the population but receive only 11% of NHS expenditure (September 2024 edition, p.41, paragraph 9). On 7 October 2024, the then Secretary of State told the House of Commons "I can guarantee that children and paediatric care will be front and centre of [the 10-year] plan.¹
3. The Bill as it is currently drafted falls short of honouring that commitment. In a 200-page document that creates new duties, new governance structures, and new accountability mechanisms for NHS commissioning, children do not appear as a substantive policy object. The term 'adult social care' appears fourteen times as a named commissioning category. Paediatrics, children's safeguarding, CAMHS, and designated professionals for children appear zero times.²
4. This submission is made by the National Network of Designated Healthcare Professionals for Children (NNDHP). Our members are the designated doctors and nurses for safeguarding children, looked-after children and child death review panels within Integrated Care Boards (ICBs) across England. We are an adult voice of children's experience in health policy. We identify six areas where we suggest the Bill should be strengthened. We are prepared to elaborate any of these in a supplementary submission or in oral evidence.

¹ Hansard, House of Commons, 7 October 2024, col.83, debate on NHS Performance: Darzi Investigation.

² Verified by systematic text search of the Health Bill [Bill 9, 59/2] as introduced 14 May 2026. 'Adult social care' appears fourteen times as a substantive commissioning category requiring specific structural and information architecture (clauses 5, 9, 10, 13, 14, 17, 18, 20, 21, 24, 25, and Schedules 3 and 4). The terms 'paediatrics', 'children's safeguarding', 'CAMHS', and 'designated professional' do not appear as substantive policy objects. All appearances of 'children' in the Bill are in Schedule 11 (consequential amendments), equality characteristics lists, or administrative name-substitutions.

1. About the NNDHP

5. The National Network of Designated Healthcare Professionals for Children (NNDHP) is the national body representing designated doctors and nurses for safeguarding children, looked-after children, and child death review processes in NHS Integrated Care Boards across England. The roles and responsibilities of designated professionals are defined in

statutory guidance: Working Together to Safeguard Children 2026 (Department for Education, March 2026), paragraphs 259 and 277-8. Within that framework, ‘designated’ means a dedicated professional with specific roles and responsibilities centred on the provision of clinical expertise and strategic advice.³ Working Together 2026, paragraph 278, and child death review statutory and operational guidance⁴ set out the scope of those responsibilities in detail, including the requirement for ICBs to employ or contractually secure designated professionals in numbers equating to the size and complexity of their child population.

6. We are an adult voice for children’s experience of health policy: we act as an expert and independent voice for children, and support and challenge those that are accountable for the systems that are supposed to protect them. We support NHSE, civil servants, and national policy forums. We have had discussions about the consequences of workforce reductions in the structures set out in chapter 4 of Working Together 2026, and we are confident that the Bill as it is currently drafted falls short of what its statutory framework requires.

³ HM Government (Department for Education), *Working Together to Safeguard Children 2026*, March 2026 (hereafter WT 2026), paragraph 259, p.110, paragraph 277-8, p.116, footnote 225, p.151.

⁴ Department of Health and Social Care / NHS England, *Child Death Review: Statutory and Operational Guidance (England)*, published 15 October 2018 updated 20 September 2019).

2. The Statutory Framework: What the Law Already Requires

7. We would like to be clear about the legal standard against which the Bill should be measured. We do not say that the government should create new legal obligations for children’s welfare. The obligations exist already. The Bill should be measured against the need to operationalise them.
8. The NNDHP’s standing to comment on health commissioning strategy derives directly from the statutory definition of safeguarding. Working Together to Safeguard Children 2026 defines ‘safeguarding and promoting the welfare of children’ as including: ‘preventing impairment of children’s mental and physical health or development’ and ‘ensuring that children grow up in circumstances consistent with the provision of safe and effective care.’⁵ The health commissioning decisions that this Bill lays out — how ICBs are constituted, what they are required to plan for, how inequalities are to be addressed — are therefore directly within the scope of the safeguarding framework. It is difficult to envisage what element of a child’s welfare is more important than their health. That is why we believe that designated professionals, whose roles are defined by that framework, have standing to comment on this Bill.
9. The Children Act 2004, section 11, places a statutory duty on specified organisations — including ICBs — to make arrangements to ensure their functions are discharged having regard to the need to safeguard and promote the welfare of children. This is not a discretionary duty.
10. Working Together to Safeguard Children 2026 — statutory guidance issued by the Department for Education in March 2026 under section 7 of the Local Authority Social

Services Act 1970 and section 10(8) of the Children Act 2004 — opens: ‘Nothing is more important than children’s welfare.’⁶ Paragraph 12 states: ‘A child-centred approach is fundamental to safeguarding and promoting the welfare of every child. All practitioners should follow the principles of the Children Act 1989 and 2004. These Acts make clear that the welfare of children is paramount...’⁷ The word ‘all’ in that sentence means every NHS commissioner, every ICB, and every NHS provider — not only those in direct clinical contact with children.

11. The paramountcy principle — section 1(1) of the Children Act 1989, which provides that when a court determines any question with respect to a child’s upbringing ‘the child’s welfare shall be the court’s paramount consideration’ — is not, on the authority of Working Together 2026 itself, confined to judicial proceedings. It is the animating obligation of the entire multi-agency safeguarding architecture. It is also the standard, we argue, against which every commissioning decision that might affect children should be measured, and by extension, those legislative decisions that create commissioning structures.

12. Unused

⁵ WT 2026, bullet point 3-4, p.6 This is part of the full definition of ‘safeguarding and promoting the welfare of children’ at this location.

⁶ WT 2026, Introduction, p.5.

⁷ WT 2026, paragraph 12, p.10. This formulation has been present in substance since Working Together 2013, pp. 7- 8.

⁸ Unused

3. The Legislative Context: How Health Partners Came to Share This Responsibility

13. It is also important to be clear about the legislative journey that makes this submission both appropriate and, we suggest, inevitable. The Children Act 1989 established the paramountcy principle and placed duties on local authorities to promote the welfare of children in their area. The Children Act 2004 strengthened the multi-agency framework and placed the section 11 safeguarding duty on a range of public bodies including health services.
14. The critical development for the NHS was the Children and Social Work Act 2017, which amended the Children Act 2004 to establish new local arrangements for safeguarding and promoting the welfare of children. A central feature of those arrangements is that three statutory safeguarding partners — the local authority, the police, and NHS Integrated Care Boards — are given joint and equal responsibility for determining how safeguarding arrangements should work in their area.⁹ For the first time, health partners were placed on equal footing with local authorities in the statutory safeguarding architecture, not merely as co-operating agencies but as co-equal partners with joint and equal accountability.
15. The Health Bill 2026 reorganises the NHS commissioning architecture that those ICBs operate within. It does so without any provision that recognises, protects, or

operationalises the joint and equal safeguarding responsibility that the 2017 Act established. The Bill is not merely silent on children. It is silent on the specific statutory development that made the NNDHP's challenge to this Bill both necessary and legitimate.

⁹ *Children and Social Work Act 2017, section 16, amending Part 2 of the Children Act 2004. See also: House of Commons Library, 'Child protection: an overview of child protection legislation in England', Research Briefing SNO6787, p.4.*

4. The Evidence: What Structural Neglect Produces

16. The argument that children are not seen as being of equal standing as adults and are therefore not treated fairly in the NHS is not an assertion of intent. It is a description of outcomes. The following domains of evidence establish what the structural failure to prioritise children's health in NHS commissioning has produced.

4.1 The 11/24 Disparity

17. Lord Darzi's Independent Investigation of the NHS in England (DHSC, first published September 2024; revised edition 14 May 2026) established that children represent 24% of the population but receive only 11% of NHS expenditure (September 2024 edition, p.41, paragraph 9). He found that over 100,000 children were waiting more than a year for mental health assessment (*ibid.*, p.3, paragraph 7), and that referrals to children's mental health services had increased at 11.7% per year, compared to 3.3% per year for adults (*ibid.*, p.19, paragraph 6). As of June 2024, of more than 50,000 people waiting over a year for community services, 80% were children and young people.¹⁰
18. The 11% funding figure for a population share of 24% is not a historical artefact. It is the cumulative consequence of commissioning architecture that has never been required, by any primary legislation, at least as far as we can establish, to treat children as a distinct and specifically resourced population. The Health Bill 2026 does not change that.

¹⁰ The 24%/11% figure, the 100,000-children mental-health-waiting figure, and the referral growth rates (11.7% vs 3.3%) appear in the main report; the figure that 80% of those waiting over a year for community services are children and young people appears in Lord Darzi's summary letter to the Secretary of State. Both published at gov.uk/government/publications/independent-investigation-of-the-nhs-in-england.

4.2 Infant Mortality: A Silent National Scandal

19. The United Kingdom's infant mortality rate has deteriorated significantly relative to comparable countries. Analysis by the University of York, published in August 2024, established that the UK ranked 10th in the OECD in 1960 and had fallen to 29th out of 38 OECD countries by 2021. Office for National Statistics data show that 2,240 infants died before their first birthday in England in 2022 (up from 2,209 in 2021), a rate of 3.9 infant deaths per 1,000 live births¹¹. The figures have more meaning perhaps when

compared to Finland's infant mortality rate - for many years at about half that of UK - carrying with it the implication of excess infant deaths of many hundreds each year¹².

- 20.** The United Kingdom failed to meet the United Nations Millennium Development Goal to reduce infant mortality by two-thirds between 1990 and 2015: the UK achieved a reduction of only approximately half, to 3.9 per 1,000, against a target of 2.6.¹³ Researchers have warned that further rises are possible due to recent increases in vaccine-preventable diseases, including 14,894 cases of pertussis in England and eleven infant deaths from January to December 2024 alone.¹⁴
- 21.** The UK's infant mortality rate is not a random misfortune. It is the measurable consequence of systematic under-investment in children's health services. When the Health Bill 2026 reorganises NHS commissioning without a child impact assessment and without any mechanism to address the 11/24 disparity, it creates the architecture for the next decade of this outcome. The children who will die unnecessarily in 2030 are already born.

¹¹ Akanni, Udu, Esan, Black et al. *Infant mortality in England: August 2024*. NHA (2024) www.healthequitynorth.co.uk p2

¹² Eurostat Infant Mortality Rates (updated April 2026) https://ec.europa.eu/eurostat/databrowser/view/demo_minfind/default/table?lang=en&category=chldy.th.chld.chld_hlth

¹³ The UN Millennium Development Goal target for the UK was 2.6 per 1,000 live births by 2015; the UK achieved 3.9.

¹⁴ UKHSA Confirmed cases of Pertussis in England by month 2024 <https://www.gov.uk/government/publications/pertussis-epidemiology-in-england-2024/confirmed-cases-of-pertussis-in-england-by-month#fnref:2>

4.3 Cancer: Invisible Children in a Failing System

- 22.** NHS patients, including children, have a legal right under the NHS Constitution to start non-urgent consultant-led treatment within 18 weeks of referral and to receive a cancer diagnosis or have it ruled out within 28 days of urgent referral. These rights apply to all ages. The 62-day standard requiring treatment to begin within two months of urgent referral has not been met since December 2015. In April 2026, only 70% of patients received diagnosis and first treatment within 62 days against a standard of 85%.¹⁵
- 23.** The structural failure for children is not the absence of a legal standard but two compounding gaps. First, the NHS has not historically published age-disaggregated referral-to-treatment or cancer waiting time performance data, making it impossible to know how children specifically are faring within the overall failure. The January 2025 Reforming Elective Care plan committed to 'greater transparency' with publication of adult and children's elective performance metrics — the fact that this commitment was announced in 2025 is itself evidence of what had been absent.¹⁶
- 24.** Second, and specifically for cancer, kidney and neuroblastoma tumours have been shown to be larger or more advanced at diagnosis in the United Kingdom compared to other EU countries, which experts link directly to delays in diagnosis.¹⁷ The Health Bill 2026 creates no child-specific cancer pathway accountability mechanism and no requirement to publish child-disaggregated cancer waiting time data.

¹⁵ Nuffield Trust, ‘Cancer waiting time targets’ (indicator), at nuffieldtrust.org.uk

¹⁶ Department of Health and Social Care and NHS England, *Reforming Elective Care for Patients*, published 6 January 2025 (paragraph 67). england.nhs.uk/long-read/reforming-elective-care-for-patients.

¹⁷ CCLG: The Children & Young People’s Cancer Association, ‘New guidance for UK GPs aims to cut delays in childhood cancer diagnosis’, ecancer.org, 9 April 2026

4.4 Obesity: The Slow Emergency

- 25.** Childhood obesity in England represents a slow emergency with well-documented long-term consequences. National Child Measurement Programme data for 2024/25 recorded that 10.5% of children in Reception (aged 4–5) and 22.2% of children in Year 6 (aged 10–11) were living with obesity — with Reception obesity at one of the highest levels recorded since the programme began in 2006/07.¹⁸ The deprivation gradient is stark and has widened over time: obesity prevalence in the most deprived areas is more than double that in the least deprived (14.0% against 6.9% in Reception, and 29.3% against 13.5% in Year 6), directly connecting obesity to the structural health inequality addressed in section 4.5 below.
- 26.** The Health Bill 2026 creates a ‘neighbourhood health plan’ framework under clause 24 as the replacement for joint forward planning. That framework contains no requirement to address childhood obesity as a specific commissioning priority, no child-specific public health obligation, and no accountability mechanism for the health consequences of childhood obesity that have harmed child and adult health for decades, and which will present as adult disease in the NHS for decades to come.

¹⁸ Department of Health and Social Care / Office for Health Improvement and Disparities, *National Child Measurement Programme, England, 2024/25 School Year*, published November 2025 “Patterns and trends in child obesity in England”.

4.5 Poverty and Health Inequality

- 27.** Poverty is the primary upstream driver of health inequality in children. The relationship is both direct — through food insecurity, housing instability, and cold homes — and indirect, through the neurobiological consequences of adverse childhood experiences (ACEs), which include poverty as a documented stressor. A systematic review and meta-analysis in *The Lancet Public Health* established that individuals with four or more ACEs are at substantially elevated risk of multiple long-term health conditions and that associated costs to health systems across Europe and North America run to hundreds of billions of US dollars annually, with more than 75% of those costs arising in individuals with two or more ACEs¹⁹
- 28.** The Health Bill 2026, clause 4, substitutes a new section 1C into the NHS Act 2006 requiring the Secretary of State to ‘have regard to the need to reduce inequalities’. This duty is expressed in entirely age-neutral language. The Secretary of State could satisfy it in law by focusing entirely on adult waiting lists and older-age morbidity while leaving the 11/24 disparity intact. There is no requirement to disaggregate inequality data by age

group or to assess the effect of commissioning decisions on children's health inequality specifically.

¹⁹ Bellis, M.A., Hughes, K., Ford, K., Hardcastle, K.A., Sharp, C.A., Wood, S., Homolova, L. and Davies, A., 'Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systematic review and meta-analysis', *The Lancet Public Health*, 4(10), e517–e528, October 2019. DOI: 10.1016/S2468-2667(19)30145-8

4.6 Children in Care: Falling Through the Gap

- 29.** Children in care are among the most medically complex and most vulnerable children in England, with significantly elevated rates of physical health conditions, mental health difficulties, and developmental delay. Working Together to Safeguard Children 2026, paragraphs 277–278, requires ICBs to employ or contractually secure designated professionals not only for safeguarding children but specifically for looked-after children, in numbers equating to the size and complexity of the child population in line with the Intercollegiate Document (Royal College of Nursing, 2025).²⁰
- 30.** The Children's Wellbeing and Schools Act 2026 made some progress on the health assessment framework for looked-after children, including strengthened duties on local authorities in relation to health assessments. However, the corresponding commissioning duty on ICBs to resource those health assessments adequately is absent from the Health Bill 2026. Children in care fall precisely at the boundary between local authority responsibility and NHS commissioning — and the Bill, which reorganises the NHS side of that boundary, does not attend to what happens to children at it.

²⁰ WT 2026, paragraphs 277–278, p.116, footnote 146, referencing: Intercollegiate Document (2025), *Safeguarding children and young people — roles and competencies for healthcare staff* (Royal College of Paediatrics and Child Health 2025).

4.7 Disabled Children and Those with Communication Difficulties

- 31.** Disabled children represent a population whose health needs are among the most complex and whose experiences of the NHS are among the least understood. The Health Bill 2026 creates no child-specific commissioning obligation for disabled children's health services, no requirement to assess the adequacy of provision for children with SEND in the new neighbourhood health planning framework, and no accountability mechanism for the transition between children's and adult health services — a documented point of systemic failure for disabled young people.
- 32.** A specific and acute concern is the situation of children and young people with learning disabilities, autism, or significant communication difficulties who present in crisis. Due to the absence of adequate community support, these children regularly occupy acute hospital beds not because they require acute medical care but because no suitable alternative exists. The Learning from Lives and Deaths — people with a learning disability and autistic people (LeDeR) programme, run by NHS England and King's College London, has consistently found that people with a learning disability die around 20 years earlier than the general population (a median age of death of approximately 62–

63 years), and that a substantially higher proportion of their deaths are avoidable — around 39%, compared with approximately 21% in the general population.²¹ For children specifically, the absence of adequately commissioned community provision is a direct causal factor in both acute bed use and in the elevated risks of harm that accompany inappropriate placement.

- 33.** Children and young people with communication difficulties face a further compounding risk: they are among the most vulnerable to abuse and exploitation, and among the least able to report what is happening to them through the channels the safeguarding and reporting architecture assumes. The Health Bill 2026, which reorganises the commissioning architecture for the services these children depend on, is silent on all of this.

²¹ NHS England and King's College London, *Learning from Lives and Deaths — people with a learning disability and autistic people (LeDeR): mortality data for 2024*. Median age of death approximately 62–63 years; approximately 39% of deaths avoidable, against approximately 21% in the general population; the report places particular emphasis on lower median ages of death among people from minority ethnic groups. <https://www.kcl.ac.uk/ioppn/leder/leder2024/leder-2024-report.pdf>

4.8 A Pattern Across the Parliamentary Session

- 34.** The weakness of child health issues in the Health Bill 2026 is not an isolated failure we believe. Some early analysis of legislation enacted across the 2024-26 parliamentary session, appears to show a similar structural pattern in each: provisions designed for adults extended to children without child welfare architecture, and opportunities to embed the paramountcy principle declined. When this work is completed, we will happily present an overview document as a supplementary paper.
- 35.** We believe there is a systemic institutional default — the condition in which adult needs are treated as the primary policy object across an entire legislative programme, and children's needs are rendered invisible not through malice but through the unreflective assumption that adult-designed systems will adequately serve children. The Committee has the opportunity to require the Health Bill 2026 to be an exception to that pattern.

5. A Government Measured Against Its Own Standard

- 36.** The evidence in section 4 is not evidence of incidental failure. It is evidence of structural indifference or neglect — the cumulative outcome of NHS commissioning that has never been required by primary legislation to treat children as a distinct and specifically resourced population.
- 37.** This structural anomaly is directly at odds with the government's own stated commitments. Working Together to Safeguard Children 2026 declares in its opening sentence that 'nothing is more important than children's welfare' — a declaration present in every edition since at least 2018, across three governments. Lord Darzi identified the 11/24 disparity as an urgent priority for the 10-year plan. The Secretary of State guaranteed at the despatch box that children would be 'front and centre.'

38. The Health Bill 2026 is that plan's legislative vehicle. It has been introduced without a Child Impact Assessment. It has been drafted without naming children as a substantive commissioning population. It abolishes NHS England and reorganises ICB governance without any provision to ensure the safeguarding workforce is protected. It creates new duties on the Secretary of State to reduce inequalities without naming children. It abolishes Healthwatch without creating any replacement mechanism for children's voice across the health system.
39. The NNDHP does not suggest bad faith. We suggest structural default — the unreflective institutional assumption that adult-designed systems will adequately serve children. Working Together to Safeguard Children has stated since at least 2013 that the welfare of children is paramount and that this obligation rests on all organisations, not only courts. The Health Bill 2026 should enact that standard in the commissioning architecture it creates for the next decade. It does not. The Committee, in its line-by-line scrutiny of the Bill, has the power to table and recommend amendments. That is the opportunity to change that.

6. Proposed Amendments: Strategic Advice

40. The following six amendments are the NNDHP's strategic advice to the Committee on what the Bill needs in order to honour the government's declared commitments. We present the first three in full with proposed amendment text. We flag the remaining three and are prepared to elaborate in a supplementary submission or oral evidence.

Amendment A (Primary): Child Impact Assessment Duty

41. The Bill has been introduced without a Child Impact Assessment despite being the legislative vehicle for reform responding directly to findings about children's under-funding. We propose a new clause requiring the Secretary of State to publish, within six months of Royal Assent, a Children's Health Impact Assessment assessing the effect of each substantive provision on children's health outcomes and rights. This standard is already required in Scotland under the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024, section 17, and was applied to the Children's Wellbeing and Schools Act 2026.

PROPOSED AMENDMENT: Clause [X] — Children's Health Impact Assessment

After clause 4, insert a new clause: 'Within six months of this Act receiving Royal Assent, the Secretary of State must publish a Children's Health Impact Assessment assessing the effect of each substantive provision of this Act on: (a) the health outcomes of children under 18 in England; (b) the obligations of NHS bodies under the Children Act 2004 and Working Together to Safeguard Children; and (c) the United Kingdom's obligations under the United Nations Convention on the Rights of the Child (Cm 1976). The Secretary of State must lay the Assessment before Parliament.'

Amendment B (Primary): Designated Safeguarding Professionals Workforce

42. Working Together to Safeguard Children 2026, paragraphs 259 and 277–278, requires ICBs to employ or contractually secure designated doctors and nurses for safeguarding children, looked-after children, and child death review panels, in numbers that ‘equate to the size and complexity of the child population in line with professional guidance’²² — specifically the Intercollegiate Document (RCN, 2025). This is the first edition of Working Together to make the staffing numbers obligation explicitly contingent on the Intercollegiate Document. The Health Bill 2026 creates no mechanism to enforce, protect, or resource this obligation.

PROPOSED AMENDMENT: Clause [X] — Designated Safeguarding Professionals: Workforce Duty

After clause 12, insert a new clause: ‘(1) Each Integrated Care Board must employ, or have in place a contractual agreement to secure the services of, designated doctors and nurses for the safeguarding of children, for looked-after children, and for child death review panels, in numbers that comply with the professional guidance on staffing levels issued under paragraph 278 of Working Together to Safeguard Children (as updated from time to time). (2) Each Integrated Care Board must include in its annual report a statement of its compliance with subsection (1). (3) The Secretary of State must issue statutory guidance to ICBs on the implementation of subsection (1).’

²² WT 2026, paragraph 278, p.116, footnote 146, referencing: Intercollegiate Document (2025), Safeguarding children and young people — roles and competencies for healthcare staff Royal College of Paediatrics and Child Health, 2025.

Amendment C (Primary): Children and the Reducing Inequalities Duty

43. Clause 4 creates a reducing inequalities duty in age-neutral language. It does not require disaggregation of inequality by age group, by developmental stage, or by the documented relationship between adverse childhood experiences and long-term health inequality. It does not require the Secretary of State to address, or even measure, the 11/24 disparity. We propose amendment of clause 4 to name children as a specifically identified population within the inequalities duty, and to require periodic reporting on health inequality affecting children including an assessment of NHS expenditure per capita relative to population share.

PROPOSED AMENDMENT: Clause 4 — Amendment to Reducing Inequalities Duty

In the substituted section 1C(1)(a) of the NHS Act 2006, after ‘the people of England’ insert ‘including children under the age of 18 as a distinct population whose health needs and developmental stage require specific consideration’. After section 1C(1)(b), insert new subsection (3): ‘The Secretary of State must publish, at intervals of no more than three years, an assessment of health inequalities affecting children under 18, including an assessment of NHS expenditure per capita on children relative to adults and relative to children’s share of the population.’

Amendment D (Supplementary): Patient Involvement and Children’s Voice

44. Clause 5 creates patient involvement and choice duties modelled on adult self-advocacy. It makes no reference to children’s legal capacity, Gillick competence, Fraser guidelines, or any age-appropriate mechanism for hearing children’s own voices, including children with communication difficulties. Working Together to Safeguard Children 2026,

paragraph 11, requires as a foundational principle that ‘children’s wishes and feelings are sought, heard, and responded to.’²³ We propose amendment of clause 5 to require child-specific involvement mechanisms appropriate to children’s age, maturity, and capacity. Full drafting available on request.

²³ *WT 2026*, paragraph 11, p.10.

Amendment E (Supplementary): Children’s Health Planning

- 45.** Clause 22 abolishes sections 14Z52–57 of the NHS Act 2006 — the joint forward planning duties for ICBs and their partners — which were the primary planning vehicle through which children’s services, SEND provision, and looked-after children’s health could be foregrounded in ICB planning cycles. The replacement neighbourhood health plan (clause 24) contains no equivalent child-specific requirement. We propose that ICBs be required to produce a children’s health plan as a statutory component of their neighbourhood health planning obligations, with explicit provision for disabled children’s health commissioning and the SEND health assessment framework. Full drafting available on request.

Amendment F (Supplementary): System-Wide Children’s Voice

- 46.** Sections 64–65 and Schedules 9–10 abolish Healthwatch England and Local Healthwatch arrangements without creating any replacement mechanism for aggregating and escalating children’s experiences across the health system. Children cannot self-advocate as adult patients can, and those with communication difficulties or learning disabilities are further disadvantaged. We propose a new clause requiring the Secretary of State to establish a mechanism for the systematic collection and escalation of children’s and young people’s experience of NHS services. Full drafting available on request.

7. Summary

- 47.** The NNDHP asks the Committee to act on the evidence presented in this submission. Children represent 24% of the population and receive 11% of NHS expenditure. The UK’s infant mortality rate has fallen from 10th to 29th in the OECD since 1960. Children’s cancer tumours are diagnosed at more advanced stages in the UK than in comparable countries. Over 100,000 children wait more than a year for mental health assessment. Children with learning disabilities and who grow into adults with learning disabilities die around 20 years earlier than the general population. The Bill is silent on disabled children and those with communication difficulties, who face the greatest risks of harm and the greatest barriers to being heard. The Health Bill 2026 creates no mechanism to address any of these facts.
- 48.** The government has declared, in its own statutory guidance, that nothing is more important than children’s welfare — a declaration made in every edition of Working

Together to Safeguard Children since at least 2018, across three governments and multiple Secretaries of State. The Children and Social Work Act 2017 placed health partners on equal and joint statutory footing with local authorities in the safeguarding architecture. The NNDHP's six proposed amendments are the mechanism by which the Bill can begin to reflect that commitment and that legislative progress, once the Committee exercises its power to recommend them.

A (Primary — draft text provided): Child Impact Assessment Duty — new clause after clause 4.

B (Primary — draft text provided): Designated Safeguarding Professionals Workforce Duty — new clause after clause 12.

C (Primary — draft text provided): Children and the Reducing Inequalities Duty — amendment to clause 4.

D (Supplementary): Patient Involvement and Children's Voice — amendment to clause 5.

E (Supplementary): Children's Health Planning — amendments to clauses 22 and 24.

F (Supplementary): System-Wide Children's Voice — new clause on children's experience mechanism.

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