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Guidance on neighbourhood multidisciplinary teams for children and young people

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Purpose

This guidance outlines the principles and core components that underpin all neighbourhood multidisciplinary teams for children and young people.

It should be read alongside the 2025/26 priorities and operational planning guidance (https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/) and the Neighbourhood health guidelines 2025/26 (https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/), which sets out the six core components of neighbourhood health models. One of these components is the neighbourhood multidisciplinary team (MDT). This guidance provides further details for this core component, specifically for children and young people.

In 2025/26, integrated care boards (ICBs) have been asked to initially prioritise adults, children and young people with complex health and social care needs who require support from multiple services and organisations. This guidance supports ICBs focusing on children and young people in 2025/26, as well as when scaling and expanding the neighbourhood approach over the coming years.

The specific design of each neighbourhood multidisciplinary team for children and young people will need to be locally determined to reflect the local population and their needs.

The case studies in appendix 1 (https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/#appendix-1-case-studies) provide examples of how these principles and core components have been implemented across different localities.

Background

Children and young people represent a third of England's population. Identifying and meeting their needs at the earliest opportunity is vital to giving them the best possible start in life.

Lord Darzi's investigation of the NHS in England (https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england) highlighted concerns about the growing gap between demand and capacity of services for children and young people. An unprecedented increase in the demand for services coincides with increasing complexity in the health and care needs of children and young people (https://www.rcpch.ac.uk/resources/transforming-child-health-services-england-blueprint).

The government has committed to moving to a neighbourhood health service with more care delivered in local communities. Neighbourhoods (https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf) (populations circa 30,000 to 50,000 people) are served by groups of GP practices working with NHS community services, social care and other providers to deliver more co-ordinated and proactive services, including through primary care networks. The NHS 10 Year Health Plan will seek to set out how the NHS can deliver change to achieve these ambitions.

Improving outcomes and experience for children and young people through neighbourhood MDTs

Neighbourhood MDTs for children and young people will provide integrated care that provides timely access to specialist advice, including paediatric and mental health expertise, through primary care-led team working. This will deliver care closer to home and improve the outcomes and experience for children and young people, as well as their families and carers.

Greater benefits are realised when neighbourhood MDTs are integrated with wider local services, especially education, social care, voluntary sector, and community and social enterprise (VCSE) partners to provide holistic, targeted needs-led planning and support.

This approach will enhance the current primary care offer for children and young people who might otherwise require referrals to secondary care, community services or other health and social care support. It also increases the opportunities for early intervention and prevention support, especially for children in their early years.

Implementing these models of care will reduce pressures on secondary care services by reducing both outpatient referrals and A&E attendances (https://adc.bmj.com/content/101/4/333). These models also contribute to improved quality of care alongside improving clinical knowledge among professionals.

Neighbourhood MDTs for children and young people aim to achieve parity of esteem between mental and physical health by embedding mental health expertise within MDTs, bridging the gap between primary care and children and young people mental health services (CYPMHS).

The neighbourhood MDTs alone will not overcome the sustained pressures on health services, particularly those where current demand far exceeds capacity. However, the MDTs can help streamline appropriate referrals and access and provide support to children and young people, as well as their families and carers, while waiting for diagnostic assessments and treatment.

Service details

This guidance is not a service specification. Service design and implementation will depend on local factors including demographics, population needs, the local healthcare infrastructure, the resources available, geography and capital considerations.

Special consideration should be given to ensuring reasonable adjustments are made for children and young people with a physical disability, a learning disability, special educational needs, sensory impairment or neurodivergent condition.

Core components

- case identification
- MDT case discussion and triage
- direct care
- professional knowledge sharing
- CYP/family/carer engagement and health promotion

1. **Case identification**

GPs and other health and care professionals proactively identify children and young people who would benefit from additional support and refer them on to the MDT case discussion.

A population health management approach should be used for case identification. As detailed in the Neighbourhood health guidelines 2025/26 (https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/), ICBs have been asked to apply a consistent system-wide population health management method to their analytics platforms to segment and risk stratify populations, based on complexity and forecasted resource use.

Risk stratification allows targeted intervention and can reduce disparities in access, experience and outcomes, supporting the reduction in health inequalities.

Referral routes should be determined locally with consideration given to who can refer into the service, for example, GP or other health and MDT members, education settings, families and carers or self-referral.

2. **MDT case discussion and triage**

The MDT case discussion and triage meeting brings together GPs, the designated paediatrician, the mental health professional(s) and other MDT members.

The referred cases are discussed and the most appropriate next steps for the child or young person and their family or carer are agreed. This may include onward referrals to the neighbourhood MDT clinic, secondary care, community services such as CYPMHS, school nursing services, follow-up by the GP or other appropriate pathways. Feedback from the discussion is provided to the child or young person and their family or carer, as well as to the referrer.

The neighbourhood MDT may also help directly facilitate referrals into secondary or community services, with evaluation suggesting this improves acceptance rates.

The expectations for MDT case discussion and triage meetings are:

- at least 1 meeting will take place every month
- they will usually be virtual and last 1 hour

- they will consistently involve the same designated paediatrician and mental health professional(s) to ensure continuity, strengthen relationships and enhance the sharing of professional expertise within the neighbourhood MDT

The composition of the MDT will be determined locally and depend on workforce and patient need. Membership of the MDT can be fixed (with the same members joining every meeting) or flexible (with relevant members joining based on the referred cases).

It is essential that the MDT maintains links with wider hubs such as family hubs and youth hubs. Consideration should also be given to maintaining links with VCSE organisations for wider support.

3. **Direct care**

Neighbourhood MDT clinics, located in the GP practice or other community settings, allow direct care to be delivered to children and young people who need it.

For those who require specialist input from a general paediatrician, MDT clinics may replace the need to travel to the local hospital for a paediatric outpatient appointment.

The expectation is that MDT clinics will:

- take place at least once a month
- ideally be delivered jointly by the designated paediatrician and the GP

For those requiring support with mental health needs, direct care enables earlier access to support. The specific mental health offer of each neighbourhood MDT for children and young people should be determined locally but could include:

- assessment
- case formulation to support care planning
- treatment (psychological and pharmacological)
- provision of self-help resources, social prescribing and signposting
- support for system navigation
- support during waiting periods for specialist assessments or treatments

MDT clinics can also be used to integrate wider health and social support services, such as early years support or asthma specialists.

4. **Professional knowledge sharing**

GPs are provided with increased access to the designated paediatrician and mental health professional(s) outside of the scheduled triage and case discussion meetings and clinics, for example, by email or phone.

Bringing together MDT professionals facilitates a shared understanding of different specialties. For example, partnership working across professions and sectors enables development and streamlining of care pathways.

MDT members support integration by offering knowledge on service navigation, including referral pathways, eligibility criteria and processes for accessing specialised services. This co-ordinated approach minimises duplication, reduces delays and ensures timely access to the most appropriate support.

Neighbourhood MDTs also provide the opportunity for dedicated learning sessions. For example, interdisciplinary learning could be delivered at the MDT case discussion meeting about a specific area of children and young people's healthcare. MDT members should also share their learning with colleagues outside the team, encouraging wider dissemination.

5. **Children and young people, family and carer engagement and health promotion**

Neighbourhood MDTs should provide focused support for local needs. Examples include health promotion, training tailored for different health needs, supported self-management for families and carers and signposting to local support services and networks.

Co-development of neighbourhood MDTs for children and young people is vital to their success. Building meaningful and ongoing engagement with children and young people from the start, as well as with family and carer champions, will help to deliver a patient-centred service.

Footprint and service delivery location

Neighbourhood MDTs for children and young people will be delivered at a neighbourhood and primary care network level.

Direct care will be delivered in primary care or community settings. MDTs will need to consider the available estates for delivering direct care and ensure they are fully accessible with reasonable adjustments in place. Virtual working is recommended for the MDT case discussion and triage meetings.

Target population

Neighbourhood MDTs for children and young people will provide a universal service available to all babies, children and young people.

It is recommended that the service is available up to the age of 18 with consideration for extending the provision through to 25 years old to support better transition into adult services.

Consideration should be given to a more flexible age limit for children and young people with special educational needs and disabilities, as well as those in complex situations with multiple needs.

Workforce requirements

Each neighbourhood MDT for children and young people will be made up of a core workforce with links to an extended team that enables access to additional specialist resource as needed. The extended MDT members will be locally determined and will be dependent on the workforce resources available and the needs of the local population.

Membership of the MDT can be fixed (with the same members joining every meeting) or flexible (with relevant members joining based on the referred cases).

Core clinical workforce for every neighbourhood MDT for children and young people includes:

- GP
- paediatrician
- mental health professional(s) (with specialist clinical supervision and consultation)

The extended MDT includes a wider workforce. Greater benefits are realised when neighbourhood MDTs are also integrated with wider local services, especially with education, social care and VCSE partners, to provide holistic, targeted support.

The membership of the extended MDT will be locally determined and may include:

- allied health professionals, for example, dietitian, occupational therapist, physiotherapist, speech and language therapist
- autism and learning disability keyworkers
- children's community nurse
- Early Help keyworker
- family hub keyworker
- health visitor
- health and justice link worker
- mental health support teams in schools
- nurse specialist, for example, asthma, learning disability
- practice nurse
- pharmacist
- public health, prevention and support
- school nurse
- social prescribing link worker
- social worker
- specialist professionals providing support for needs related to special education needs, neurodevelopmental conditions, including autism and ADHD, and learning disabilities and physical disabilities
- voluntary, community and social enterprise partners
- wellbeing practitioner
- youth worker

The MDTs will require project management. Dedicated resources to undertake this role are recommended to support mobilisation, data sharing, data collection, reporting and administration.

It is best practice to assign a care co-ordinator to act as the point of contact between the MDT and the patients, family and carers, to improve both their experience and continuity of care. The role could be undertaken by any member of the MDT team and will support referrals into the MDT triage and any onward referrals required.

All health and social care providers registered with CQC must ensure their staff receive training on learning disability and autism appropriate to their role. This legal requirement was introduced by the Health and Care Act 2022.

Integrated care board and system level support

Integrated care boards (ICBs) as commissioners should ensure system-level support is available for the MDTs in their area. This support will include:

- strategic planning, building on understanding of the children's education, health and care system
- development of the case for change and public engagement needed to support this
- strategic and clinical oversight and governance
- management of any contractual variations required because of the new model
- co-ordination function for delivery and monitoring of the transformation and change
- analysis and evaluation of systems benefits and improved outcomes

Intended outcomes of neighbourhood MDTs for children and young people

We would expect to see:

- increased patient satisfaction (via Friends and Family test or other qualitative measures)
- reduction in outpatient referrals for certain specialties, such as general paediatrics
- reduction in waiting time for certain outpatient appointments, such as general paediatrics
- reduction in number of A&E attendances and re-attendances
- reduction in number of acute mental health presentations in crisis
- reduction in non-elective admissions
- reduction in subsequent GP appointments for children and young people who have been discussed in the MDT
- increased rates of school readiness
- increased rates of school attendance

There may also be condition-specific outcomes that can be improved, for example, reduction in the number of asthma exacerbations.

NHS England will work with regional children and young people's leads and ICBs to support implementation and the sharing of learning.

Data and information sharing and governance

Legal framework

The law allows personal data to be shared between those offering care directly to patients.

It also protects children's confidentiality when data about them is used for other purposes. In these cases, data cannot identify individual patients unless they have the consent of the patient themselves. These secondary uses of data are essential to run a safe, efficient and equitable health service.

It is not necessary to seek consent to share information for the purposes of safeguarding and promoting the welfare of a child (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2) provided there is a lawful basis to process any personal information required.

Data and clinical record sharing should adhere to national guidance (https://www.england.nhs.uk/long-read/data-and-clinical-record-sharing/).

Specific considerations about data sharing and collection

Neighbourhood MDTs for CYP will need to consider the different purposes they wish to collect and share data for and how data can be used to achieve the aims of the MDT and monitor outcomes/ measure impact.

MDTs will need to ensure the correct data sharing agreements and data protection impact assessments are completed for sharing data. Support and information can be accessed via their ICB.

See appendix 1 (https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/#appendix-1-case-studies) for a case study about how the Child Health Integrated Learning and Delivery System (CHILDS) team has established data sharing and collection.

Contracting considerations

A lead organisation typically needs to be assigned as part of the ICB's provider selection process. They will be the contractual lead for the neighbourhood MDTs for children and young people and will negotiate the services of other MDT members.

Options for this could include:

- the participating acute trust or other NHS trust acts as the contract lead and negotiates the time of the GP and other MDT members
- a lead general practice in the primary care network acts as the contract lead and negotiates the time of the acute trust paediatrician and other MDT members
- another local provider organisation is nominated as contract lead and negotiates the time of the GP and MDT members

Both the ICB and lead contract organisation should be involved in discussions as any agreed arrangements for providing new or different services need to be referenced in the NHS Standard Contracts between them. It is recommended that desired outcomes are also written into the contract with the selected provider, probably as part of the service specification.

A short-term basic risk share agreement may be beneficial between the commissioner and different providers to ensure any adverse financial consequences are managed fairly across participating organisations.

See appendix 1 (https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/#appendix-1-case-studies) for a case study about how Connecting Care for Children has done this in practice in North West London ICB.

Co-development and working in partnership

Co-development through partnership working with children, young people, families, carers and the wider community helps ensure services meet people's needs, improving their experience and outcomes.

ICBs and trusts have a legal duty (https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/#annex-b-legal-duties-and-responsibilities) to make arrangements to involve the public in their decision-making about NHS services. NHS England has published statutory guidance (https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/) for commissioners and providers for working in partnership with people and communities.

See appendix 1 (https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/#appendix-1-case-studies) for a case study about how this worked in practice at The Well Centre in London.

Appendix 1 – Case studies

- Connecting Care for Children, London – a mature model
- The Well Centre, London – an open access model
- Sparkbrook Children's Zone, Birmingham – an integrated Early Help model
- East Lancashire Child and Adolescent Services Primary Care Team, Lancashire – an integrated mental health model
- Connected Care Network, Birmingham – a digitally enabled and VCSE integrated model
- Child Health Integrated Learning and Delivery System, London – a population health management focused model
- Bromley Child Health Integrated Partnership, London – a rapidly adopted model

Connecting Care for Children, London – a mature model

Connecting Care for Children (CC4C) is an established model in North West London ICB that places general practice at its heart and reinforces the GP's role in delivering high-quality care for children and young people and their families. CC4C has served as a pioneering model that has been replicated across the country.

The model aims for integration between GP practices and paediatric services, as well as integration across various child and family agencies and organisations. The model has 3 central components: public and patient engagement, specialist outreach and open access to specialist expertise.

A whole population approach aims to drive prevention and improve equity. It divides the childhood population into 6 segments:

- healthy child
- vulnerable child with social needs
- child with single long-term condition
- child with complex health needs
- acutely mild-to-moderately unwell child
- acutely severely unwell child

For each of these segments, CC4C envisages a team around the child, delivering the right care, at the right place, first time.

Service evolution

The CC4C model was driven by paediatricians at Imperial College Healthcare NHS Trust, with local GPs and commissioning leads. Developed through extensive stakeholder consultation and co-design, the CC4C model launched in 2014 with 3 child health hubs with paediatricians from St Mary's Hospital. Over time, it expanded to 8 hubs across 4 London boroughs, each located in local GP surgeries and serving around 50,000 residents. Inspired by its success, 15 additional hubs were established in North West London, supported by paediatricians from other local hospitals. This created a network of 23 hubs across 6 boroughs.

The funding arrangements for the current model uses repurposed consultant time to reduce the number of hospital outpatient slots and instead support general practice. Seed funding was from a mix of sources, including charity, innovation funding and the former Health Education England.

North West London ICB has a partnership working agreement between each primary care network and the ICB. For the primary care network, this outlines:

- the data reporting requirements
- the funding and support they will receive
- the support from the ICB

Participating acute trusts are advised that all face-to-face joint clinics are coded and counted as first outpatient appointments. Currently, virtual MDTs are counted and coded as Advice and Guidance and payment flows under the elective recovery fund arrangements.

The Whole Systems Integrated Care (WSIC) data-sharing system has been a key enabler. The system enables professionals to see selected information about the person they are caring for. This is done via an integrated care record created using information from the range of care providers involved in a person's treatment. It is stored in a data warehouse, and its use is governed by a legal document, the Whole Systems Integrated Care NWL Digital Information Agreement.

Additionally, the WSIC dashboards provide clinicians and care professionals providing direct care to patients with a suite of tools. Alongside cases identified by members of the MDT, dashboards can be used to find and manage patients who require more targeted and proactive care.

The core clinical workforce for each hub consists of:

- 1 paediatrician
- 1 lead GP

Service delivery

1. **Case identification**

- Proactive case identification is established by encouraging all partners connected to the child health hub to identify those that may benefit from a co-ordinated management plan. Locally determined criteria for case identification can include re-admissions data, frequency of attendance at A&E or children and young people with long-term conditions.
- Referrals are made via EMIS or SystmOne (primary care computer systems) or email, and the referring GP is encouraged to attend the allocated MDT for their case. For clinic referrals, the referring GP is asked to clearly articulate the clinical question they would like to be addressed.

2. **MDT case discussion and triage**

- Monthly 1-hour meetings discuss approximately 10 cases.
- All MDT case discussion meetings involve the lead GP and general paediatrician, but all community professionals involved in any aspect of the healthcare provision for children and young people are invited to attend. The exact professionals contributing to each MDT therefore varies in each hub depending on local need. On average, there are 15 to 25 participants from approximately 7 different professional backgrounds at each meeting. A hub co-ordinator maintains an active list of MDT participants.
- Outcomes of 154 referrals to MDT case discussion over 1 year:
    - 59% given advice to enable management in primary care
    - 20% given advice to refer to specific named health professionals, such as dietitian, physiotherapist or specialist mental health services
    - 21% booked into the joint clinic in the child health hub

3. **Direct care**

- A joint monthly clinic is held by the general paediatrician in the primary care setting. A hub co-ordinator sends appointment details and reminders. A different GP is in attendance each month which enables GPs from all associated practices to experience joint working. Approximately 6 to 7 children and young people are seen in each clinic.
- Specialist clinics are held as needed, for example, joint transition clinics or clinics for patients with long term conditions.
- Outcomes of 126 patients seen in the joint clinic over 1 year:
    - 75% assessed and discharged
    - 17% referred to tertiary paediatrics or specialist community services
    - 6% referred for specialist investigation
    - 2% booked for further follow up in child health hub

4. **Professional knowledge sharing**

- GPs have open access to their “neighbourhood” paediatrician from the local hospital with a phone and email contact available for advice.

- GP trainees attend the clinic on a rotational basis. Learning points from each MDT case discussion meeting are distributed to all health professionals associated with the hub by the paediatrician.

5. **Children, young people, family and carer engagement and health promotion**

- "Practice champions" are volunteers from the GP practice population who provide peer support, encourage self-management and support the co-design of child health hub services. Champions provide insights into the priorities that matter to families and the lived experience of services they use. CC4C has worked with local champions to address these priorities. For example, to increase knowledge of childhood vaccination; to support young people who are moving into adult services; to encourage healthy eating and exercise; and to help refugee families understand how to navigate health services.
- CC4C has worked alongside families of the 8 North West London boroughs and the local ICS to help set the ICS objectives for children and young people. 6 priority themes emerged: access to mental health support, mental health support in schools, navigating the system, young people's ownership of their healthcare, pressures on families and maintaining a healthy weight. This has informed ongoing co-production work within CC4C.

Impact

Children, young people, family and carer experience

- 100% of families (60 responses) would recommend the service to friends and family.
- 99% felt confident in the care they were receiving in the child health hub
- 88% reported that, as a result of the child health hub appointment, they felt more comfortable about taking their child to see their GP in the future.

System efficiency

The CC4C model releases net additional 7% capacity from general paediatric outpatients. Evaluation showed:

- 81% reduction in outpatient appointments (42% shifted to out of hospital, 39% avoided)
- 22% reduction in A&E attendances
- 17% reduction in paediatric admissions

Professional experience

- 100% of professionals (50 responses) "agreed" or "strongly agreed" the hubs helped them to gain knowledge of local services, improved collaboration and professional relationships.
- 89% "agreed" or "strongly agreed" the hubs increased professional capability. The development of social capital, which was defined as "trust, reciprocity and collaboration", was the benefit most strongly identified (82% strongly agreed).

The Well Centre, London – an open access model

The Well Centre is an open-access hub for young people aged 11 to 20 who live or have a registered GP in the Lambeth or Wandsworth London boroughs. Approximately 1,000 young people access the service annually.

The core elements of the Well Centre are that it is GP-led, youth-friendly and responsive to young people's needs. More recently, the service has shifted its focus to addressing mental health concerns, adapting to the needs of the young people it supports.

Local context

Both London boroughs have high rates of deprivation and considerable income inequality. In Lambeth, over 60% of young people accessing the Well Centre are from the 2 most deprived quintiles.

In addition, a considerable number of young people accessing the Well Centre fall into the categories of interest for the Violence Reduction Unit – a disproportionate number in comparison to the incidence of these issues in the general population. Staff at the centre report the general incidence of trauma is high, including a high proportion of young people who had suffered from domestic violence or lived in an environment where others were victims. There is high demand for mental health and wellbeing support. In 2022/23, the main presenting concerns to the Wandsworth part of the service related to anxiety and panic (31%) or depression/low mood (28%). The remainder included anxiety and depression (15%), behaviour issues (anger and aggression, 11%), issues relating to autism spectrum disorder or ADHD (12%) or issues relating to gender identity (2%).

Service evolution

The service was launched in Lambeth in 2011, jointly designed and developed by general practitioners and a youth work charity. In 2019, a new part of the service for Wandsworth was commissioned through a model of GPs in the Wandsworth borough working in their own practices.

The core clinical workforce across both boroughs consists of:

- 5 GPs (including the clinical lead and founding GP)
- 2 CYPMH practitioners
- 11 health and wellbeing practitioners

Service delivery

1. **Case identification**

- Open access referrals come from other health services, social services, voluntary sector organisations or through self-referral or family contact.

2. **MDT case discussion and triage**

- All patients have a 40-minute initial assessment by a GP. This holistic "health check" is specifically tailored for young person-centred biopsychosocial interviewing in primary care settings.
- All new referrals and the most appropriate allocation of care are discussed in weekly MDT triage meetings.
- Case reviews take place during monthly MDTs with a CYPMH consultant.

3. **Direct care**

- Flexible service delivery provides young people with the most appropriate service depending on their concerns.
- Services include health education, intervention or social prescribing for needs around substance misuse, diet, mental or sexual health, or they may be referred on to other services in the community or secondary care.
- Most care can be delivered in-house by either a GP or other practitioners, such as youth workers or health and wellbeing practitioners. There is close liaison with other services.
- In 2022/23, the Lambeth team provided 5,083 appointments, with 36% delivered by a GP, 57% by a health and wellbeing practitioner and 7% by a counsellor. The Wandsworth team provided 1922 appointments, with 42% delivered by a GP, 34% by a health and wellbeing practitioner, and 24% by a counsellor.
- Follow-up sessions are usually 20 minutes face-to-face or 10 minutes by telephone.

- The Wandsworth contract specifies that up to 8 contacts are included as part of the service. Delivery in Lambeth is more flexible, and young people remain registered with their "home" GP during their contact with the Well Centre.

4. **Professional knowledge sharing**

- Education on young people's health is offered to local GPs and allied health professionals. It has also offered a range of additional activities, including specialist workshops, school visits, youth centre outreach work. The team also deliver primary care support to youth offending teams or other organisations working with this age group.
- The Well Centre also works with secondary care in 2 large local hospital trusts, providing 4 health and wellbeing practitioners who support young people with diabetes to actively manage their own care.

5. **Children, young people, family and carer engagement and health promotion**

- The Well Centre was founded with a strong commitment to youth engagement in the planning and delivery of the service. In the beginning, young people participated in:
  - service design
  - decoration
  - use of space
  - registration design
  - prototyping of journey through the service
- A quarterly youth participation group consisting of current and previous service users ensures continued engagement. The group discusses themes such as what young people might want to change about the Well Centre. It also considers session numbers, session content and communications.
- There is also good engagement with young commissioners from the local boroughs, and the service is inspected by young people from the local HealthWatch.
- Groups for young people on specific health promotion and wellbeing topics are run by 2 health and wellbeing practitioners and are always well attended.

Impact

Clinical outcomes

- Quantitative data indicates that 82% of young people attending the Well Centre have shown improvement in their WHO-5 Wellbeing Index scores (a validated wellbeing questionnaire). On average, scores increased by 62%, with a 10% change representing a significant improvement.

Experience of young people

- 94% (77 responses) of young people would recommend the service.
- A large proportion of positive feedback related to the friendliness of staff, which created trust and space to confide.

Experience of professionals

- Professionals report improved knowledge and confidence alongside being able to deliver improved access to services, especially for those who live in more deprived neighbourhoods.
- Professionals have also observed improvements in onward referrals for interventions and support from other services. This focus on early intervention helps to redirect cases from emergency care and CAMHS and provides the most appropriate timely support for children and young people.

Sparkbrook Children’s Zone, Birmingham – an integrated Early Help model

Sparkbrook Children’s Zone (SCZ) is a partnership project between Birmingham Children’s Hospital, a local Early Help team and a single primary care network.

A key component of the SCZ offer is the co-located Early Help support service, aimed at addressing the social determinants of health. This approach plays a pivotal role in signposting and referring families to local support services to prevent costly late interventions.

Local context

The Sparkbrook ward has a large population from minority ethnic backgrounds (85%) and a high population density (the second highest in Birmingham) with a high proportion of young people (about one-third are aged 0 to 15).

Sparkbrook is Birmingham’s most deprived ward, with almost half of children in the area defined as living in poverty. 93% of residents live within the nation’s most deprived 10% of areas, compared to 40% citywide. 89% of families accessing SCZ are from the most deprived quintile.

The pilot site was selected due to the area’s high levels of diversity and deprivation, infant mortality, childhood obesity, special educational needs and disabilities, poor oral health, and low immunisation uptake. High levels of unnecessary A&E attendances were also recognised before the pilot.

Service evolution

SCZ was established in March 2022 as a pilot integrated health and social care clinic through a single primary care network of 8 GP surgeries, with a list of 14,000 children and young people.

The initial pilot relied on 2 funding streams, including local authority and Early Help support. Partnership development facilitated the co-location of an existing mental health service with SCZ, strengthening the available mental health offer. The local authority initially funded a healthy weight programme, but this funding has since ended, prompting SCZ to deliver a service to address the resulting gap in provision. There are ongoing challenges around data sharing and consistency of funding for SCZ.

The initial pilot ran in a single community venue, co-located with other community services and family support. A second clinic was developed to improve accessibility to reduce a high proportion of missed appointments. Further expansion has led to an out of hours clinic from 5pm to 8pm in a nearby GP surgery which has effectively addressed high numbers of missed appointments.

The key workforce covering a single primary care network of 8 GP surgeries includes:

- a GP lead
- a paediatric consultant lead
- a paediatric nurse (band 6)
- an Early Help lead alongside 4 other professionals from Early Help (programme manager, communication and development office and family support advisors)

Service delivery

1. **Case identification**

- Referrals are identified by GPs and made via EMIS. Children, young people, family and carers can also self-refer through their GP.
- The SCZ model does not have any triage or case discussion, and all cases referred are offered direct facing care.

2. **Direct care**

- A 4-hour clinic is delivered 2 to 3 times per week by a GP, paediatrician and paediatric nurse.
- The paediatric nurse completes a well child check, including oral health screening, immunisation check and feeding and toileting concerns. The GP or paediatrician completes an extended clinical assessment.
- During these initial assessments, a third of children, young people, family and carers are identified to have needs that could benefit from support from the Early Help service:
    - the main themes of needs relate to those with neurodiversity and behaviour or sleep issues, mental health and housing
    - 39% of these cases benefit from co-ordinated support via the Family Connect Form – a comprehensive tool for capturing detailed information on a family's circumstances and needs. This enables professionals from various disciplines to collaborate more effectively, allowing for the early identification of potential risks and the organisation of MDT support around the family to meet needs before they escalate
- A mental health service is also co-located on the clinic day allowing direct access as soon as needs are identified.
- Outcomes of 2072 attendances at the SCZ clinics over 2.5 years:
    - 70% are discharged
    - 6% follow up with SCZ
    - 5% follow up with GP
    - 4% referred to secondary care
    - 0.9% emergency admission to hospital
    - 27% referred for Early Help support
- Outcomes from Early Help support:
- 94% of cases supported by Early Help do not require escalation to social services support.

3. **Professional knowledge sharing**

- The key workforce delivers a quarterly virtual 1-hour learning session open to all partners connected to the SCZ model.
- The co-location of multiple services within SCZ encourages informal interdisciplinary knowledge sharing and streamlines referral pathways.

4. **Children, young people, family and carer engagement and health promotion**

- Within the clinics and community outreach, SCZ focuses on key priorities around immunisations, oral health, diet, nutrition and home safety.
- Summer holiday sessions with the paediatric nurse have allowed 264 families to access support using the Healthier Together NHS app, vaccines, preparing Year 6 children for secondary school, feeding issues and oral hygiene.
- A 5-month project with the local youth centre empowered a group of young people to become "Youth Health Champions" to impact local positive behavioural change relating to childhood obesity and oral extraction and decay.
- A school programme delivers "Healthy Habits" workshops to families with the support of 26 primary schools.
- Responsive outreach to 65 schools and in-person sessions for families led to an increased vaccination uptake during a measles outbreak.

Impact

Project monitoring data and evaluation reporting by Birmingham Health Partners have shown impact in several areas:

Parent and carer experience

- Survey feedback indicates overall satisfaction rating as 4.2/5 (42 responses).

- Positive feedback has been linked to a more geographically accessible service and easier pathways between services.

Specialist input

- 94% of cases supported by Early Help within SCZ do not require onward escalation to social services support, highlighting the effectiveness and timeliness of intervention.
- The SCZ model provides access to a clinic with paediatrician input in 1 week, a significantly reduced wait compared to a wait of 7 months in Birmingham Children's Hospital.

Health outcomes

- Co-ordinated response to a measles outbreak was possible through shared decision-making among professionals and SCZ being trusted as a community-focused service.

MDT experience

- Professionals report improved collaboration between health and Early Help service has improved communication and interprofessional learning.
- Increased job satisfaction has also been reported due to being able to spend more quality time with children, young people and families and address their holistic needs.

Cost effectiveness:

- Most children and young people are discharged as their needs can be met within the service. Fewer secondary care referrals and emergency department attendances have led to savings of £44.08 per patient compared to standard primary care.
- There are additional system savings from intervening early, effectively mitigating the escalation of problems, thereby reducing the demand for more resource-intensive and costly interventions.

East Lancashire Child and Adolescent Services Primary Care Team, Lancashire – an integrated mental health model

The East Lancashire Child and Adolescent Services (ELCAS) Primary Care Team was set up to increase primary care capacity for managing mental health needs and improve access to secondary care when required.

The team is an example of a sustainable and complementary service development within a specialist children and young people's mental health service.

Local context

The team covers East Lancashire and Blackburn with Darwen, an area of 13 primary care networks with a resident population of 556,000.

It is a diverse socioeconomic area but includes 4 of the 10 boroughs in England with the highest child poverty levels. One of the boroughs has the highest proportion of children in relative low-income families in the UK (https://www.gov.uk/government/statistics/children-in-low-income-families-local-area-statistics-2014-to-2023/children-in-low-income-families-local-area-statistics-financial-year-ending-2023#proportion) at 43%.

Service evolution

The design of the ELCAS Primary Care Team model was informed by the THRIVE framework (https://implementingthrive.org/about-us/the-thrive-framework/#:~:text=The%20THRIVE%20Framework%20for%20system%20change%20%28Wolpert%20et,from%20the%20Anna%20Freud%20National%20Centre%20for%20Childre) for system change. This is a person-centred and needs-led approach to delivering mental health services for children, young people and their families. It conceptualises need in 5 categories: thriving, getting advice, getting help, getting more help and risk support.

In 2016, ELCAS primarily comprised of a child and adolescent psychiatry-led specialist CAMHS team, focused on the “getting more help” aspect of the THRIVE framework. In 2016, in response to GP feedback, ELCAS developed an approach to embed the “getting advice” aspect of the THRIVE framework into primary care.

Primary mental health workers (PMHWs) were employed by ELCAS but based in GP practices across Pennine Lancashire. Initially 3 PMHWs were appointed with non-recurrent funding for a 1-year pilot. Their roles were evenly split, with 50% of their time dedicated to consultation and training for professionals and the remaining 50% focused on direct clinical care. This has evolved to a permanently funded team, with design influenced by GP and primary care network leads, commissioners, service users, and ELCAS service and team leads.

Successful recruitment and retention have led to an experienced team with a broad range of expertise, with PMHWs appointed from diverse professional backgrounds including psychology, nursing and social work. Band 6 and band 7 PMHWs are co-located in adjacent primary care networks to create a supervisory structure. This supports integration with mental health services providing “getting help” or “getting more help”, as well as providing consultation and training to other local agencies. Parenting practitioners deliver parent training groups, now in conjunction with Mental Health Support Teams in schools.

More recently, ELCAS has worked with local primary care networks to establish a new role, child and young person’s wellbeing practitioner (CYWP), created through the Additional Roles Reimbursement Scheme (https://www.england.nhs.uk/gp/expanding-our-workforce/) and NHS England pilot funding. This band 5 practitioner delivers longer-term psychological intervention within these primary care networks for children identified as requiring help by PMHWs based in the team.

The team across 13 primary care networks currently consists of:

- 1 consultant child and adolescent psychiatrist (1.25 programmed activities per week)
- 1 team lead (Band 8a)
- 8 primary mental health workers (including Band 6 PMHWs and Band 7 senior PMHWs)
- 1 children and young people’s wellbeing practitioner (Band 5)
- 2 parenting practitioners (Band 4)
- 1 GP specialty trainee
- 1 administrator

Service delivery

1. **Case identification**

- PMHWs provide a “single point of consultation” for professionals in the primary care networks, advising on how best to support children and young people’s mental health needs. Requests for non-urgent advice and consultation are accepted flexibly (in person, by telephone or email), with a response within 7 days.
- If the PMHW feels direct care following consultation is appropriate (or is unsure what is required), they will arrange assessment without the need for a written referral.
- The team also accepts written referrals from professionals and online self-referrals. There are 3 referral meetings each week, where written referrals are triaged.
- Acceptance criteria are broad and map onto NHS England model specifications for Tier 2/3 CAMHS, with routine assessment of neurodevelopmental disorder a notable exclusion.

2. **Multidisciplinary case discussion**

- The team holds a weekly MDT meeting to discuss all cases initially assessed by PMHWs and any complex cases that require additional input. The team can bring any case for MDT discussion at any time. Approximately 15 cases are discussed each week.
- All team members attend the MDT meeting, and external visitors (including GPs and VCSE partners) can be invited to gain familiarity with the model and share learning.

- Each meeting lasts 2.5 hours and is usually virtual, with 1 face-to-face meeting monthly at the ELCAS hub.

3. **Direct care**

- PMHWs deliver brief case management using the assessment, consultation and brief intervention (ACBI) approach (https://acbi.me.uk/). This is a person-centred model of consultation allowing clinical care to be typically delivered in up to 3 sessions by experienced practitioners.
- The CYWP delivers evidence-based low-intensity psychological interventions for anxiety, depression and conduct difficulties, including guided self-help.
- Care is delivered flexibly, including in primary care settings or remotely, using the Attend Anywhere platform.
- If a child or young person require further interventions from specialist CAMHS teams, the ELCAS MDT can facilitate this seamlessly without the need for further referral.

4. **Professional knowledge sharing**

- PMHWs join various child health and multi-agency support hubs operating across the different primary care networks.
- PMHWs offer training flexibly within their primary care networks and organise bespoke sessions for GP practices and other community services. The team also delivers Youth Mental Health First Aid training to professionals in the region.
- The weekly MDT meeting often includes continuing professional development activity.
- A GP specialty training post was developed in the team in 2018 and has proved popular, leading to an additional post being created. Regular teaching is delivered for all local GP specialty training posts in their academic programme.

5. **Children, young people, family and carer engagement and health promotion**

- 2 parenting practitioners facilitate the “incredible years parenting programme”. This offer rotates across all primary care networks. This is now in conjunction with Mental Health Support Teams based in primary schools. Groups have previously been delivered multilingually in English and Urdu.
- The team offers a weekly virtual drop-in session to support access for children, parent and professionals to “get advice”, including on an unnamed basis.
- The team has trialled use of personal health budgets (https://www.england.nhs.uk/personalisedcare/personal-health-budgets/), as an NHS England exemplar site, to complement the personalised care delivered by the ACBI model (https://www.acbi.me.uk/?Introduction). This involves identifying goals with children, young people, and their family and carers, and using small grants to help them achieve these where appropriate.

Impact

Children, young people, family and carer outcomes

- 79% of children and young people receiving direct care from the team in the ACBI model did not require onward referral to specialist CAMHS teams. This indicates the potential scope for managing needs in primary care settings or on digital platforms.
- Child Outcomes Research Consortium analysis shows statistically significant mean improvements in patient and clinician-reported outcome measures.

Identifying need and improving pathways to care

- Service evaluation has shown a statistically significant increase in referral and acceptance rates from a host GP practice since the deployment of a PMHW there. The practice sustained this referral rate during the COVID-19 pandemic.

Workforce experience

- GPs were able to have informal discussions with PMHWs and seek advice about children and young people. GPs felt they could recognise problems earlier and were able to access help more quickly (https://bjgpopen.org/content/4/4/bjgpopen20X101075).

Connected Care Network, Birmingham – a digitally enabled and VCSE integrated model

Inspired by the Connecting Care for Children model in London, Connected Care Network (CCN) was established in North Solihull, Birmingham. It operates across health, education, social and voluntary and community sectors, shifting away from standardised solutions in favour of an approach that considers local relationships, demographics and need. The CCN aims to provide a digitally enabled, integrated model of care that ensures the right care at the right time in the right place.

The commissioning of 2 local VCSE organisations as lead delivery partners demonstrates how bringing together the health and VCSE sectors can deliver holistic, integrated care in a community.

The model also focuses on enabling children and young people and their family and carers to “tell the story once”, reducing the frustrating burden on families to repeat their needs.

Local context

The North Solihull primary care network is the largest in the Birmingham and Solihull ICB, with approximately 20,000 registered children and young people. 100% of the population lives in neighbourhoods classed as the most deprived 20% in the country, with more than 50% living in the most deprived 10%. 30% of under-5 years are defined as living in poverty. 21% of children and young people living in North Solihull have special educational needs, compared to the borough average of 15%.

The Joy App has been pivotal in providing an ICB-approved software solution for integration. This platform connects with primary care clinical systems and is flexible enough to be suitable across organisations. Alongside an intuitive client management system, the ability to track referrals and record outcome measures has made it core to the CCN’s integration success.

Service evolution

Extensive stakeholder engagement was carried out with children, young people, family, carers and key stakeholders at “place” and commissioning level to determine local priorities. This led to joint planning and pooling of resources from various agencies.

2 of the lead delivery partners are part of a well-established and connected network of VCSE organisations focused on children and young people. This was made possible by providing contracting and funding through the ICB, with the full-scale model operating from August 2023.

Local partners from across the system continue to join, enabling the CCN to expand its breadth and reach. The CCN prioritises identifying and using existing processes, teams, professionals and organisations. Where gaps are identified, the CCN takes the lead in creating new pathways to address these. This has often meant needing to find new funding and grants.

The key workforce across the primary care network is:

- GP clinical lead
- health and wellbeing coordinators (band 4)
- operational lead (band 5)

Service delivery

1. **Case identification**

- Referrals are received from local professionals through an online referral form, co-ordinated by the Joy App. There are no referral criteria other than a professional requiring support to address a need they have identified for a child, young people, family or carer.
- The top 5 referring agencies to the CCN are primary care, schools, Solihull Youth Justice Service, the local authority inclusion service and VCSEs.

2. **MDT case discussion and triage**

- Triaging of needs is facilitated by completing a holistic "tell the story once" form with the child or young person and their family or carer. While this is usually completed by the care co-ordinator following referral, a deliberately flexible approach allows other professionals, including psychologists, teachers, family support workers or GP to complete the form if more appropriate.
- All referrals are discussed at a weekly MDT to identify the most appropriate support and create a plan of action.
- The core attendees at each MDT include the GP clinical lead, the health and wellbeing co-ordinators, the operational lead and VCSE organisations representatives. Any professional is welcome to join, with the core group maintaining links to wider professionals for specific guidance as required.
- The outcome of the MDT discussion and plans for follow up are communicated to the child or young person, family, carer and referrer via the Joy App.
- The CCN MDT completes all recommended referrals to local services, agencies and organisations including forwarding the completed "tell the story once" form to reduce the burden on children, young people, families or carers of having to repeat their story.

3. **Direct care**

- The GP clinical lead provides 2 telephone clinics per week, primarily for children and young people with long-term health conditions or challenges navigating the health system.

4. **Professional knowledge sharing**

- The evolution and success of the CCN has been based on professional relationship building, trust and delivering positive outcomes across the board and across the system
- Partnership working has facilitated improved local care pathways, including a new dental pathway with direct referral established through the CCN.

5. **Children, young people, family and carer engagement and health promotion**

- Stakeholder engagement and co-design have been prioritised from the outset to identify local needs and tailor the CCN model to these.
- Early recognition and intervention to meet low-level needs is provided through family support home visits, workshops, parent meet-ups and signposting.
- The CCN works with social prescribing teams, community development teams, VCSE organisations and schools, leveraging local resources and knowledge to find tailored support for local communities.
- The CCN supports children and young people while on waiting lists for specialist services. Additionally, the service has evolved to address unmet needs that were identified through local evaluation – specifically for help with sleep and diet. Early-stage development of a pathway for care-experienced children and young people is also underway through partnership working with specialist nurses.

Impact

Children, young people, family and carer experience

- The "tell the story once" approach has received positive feedback from families. It addresses a priority identified in stakeholder engagement by reducing the need for families to repeatedly share their stories to multiple professionals and services.

Clinical outcomes

In the first 6 months of the pilot, the CCN found:

- an average 56% reduction in all self-reported issues
- 90% of children and young people reported an increase in being able to better manage their long-term health condition
- 63% reported improvement in managing day-to-day mental health needs
- 44% reported a reduction in feeling socially isolated
- 75% felt more supported in their education

System efficiency

Data comparing practices have shown CCN leads to:

- 25% fewer referrals into community CYPMHS
- 40% fewer referrals to autism assessment services
- 27% fewer referral to community paediatrics

Estimated cost savings (in April 2024, based on 427 cases referred) include:

- 569 GP appointments saved (saving approximately £17,000)
- reduction in outpatient appointments for 12% of children and young people (saving an estimated £10,400)
- 5,124 hours of support provided outside clinical and therapeutic support (saving over £400,000)

These estimated savings relate to health services; the CCN also anticipates savings across the broader system (for example, education) and the child or young person's life course.

System co-ordination

- The Joy App enables streamlined referrals and flow of information between professionals and services that support child and young people, thereby building capacity.
- It also enables data collection and outcomes measurement across the system partners. Stakeholders have provided positive feedback on the system's user friendliness and capabilities.

Child Health Integrated Learning and Delivery System, London – a population health management focused model

The Child Health Integrated Learning and Delivery System (CHILDS) framework is established across the 2 boroughs of Lambeth and Southwark, arising from the Children and Young People's Health Partnership.

The framework helps deliver holistic, personalised biopsychosocial care. It uses health data science and population health management tools for higher-quality care and continuous learning. Through using data, the frameworks help to proactively identify children or young people who need early intervention, prevention and care. This helps reduce health inequalities, ensuring care for children and young people with the highest needs.

Local context

Lambeth and Southwark are 2 of London's most densely populated boroughs with a combined population of 650,000 of which 110,000 are children and young people. Both boroughs rank within England's 5% most deprived local authority areas.

The CHILDS model supports a proportionately higher number of children and young people living within the most deprived areas. 61% of children and young people discussed in triage and 50% of those seen by the nursing service live in the most deprived quintile, compared to 42% of all children and young people in the local population who live in the most deprived quintile.

Service evolution

The Children and Young People's Health Partnership (CYPHP) was established in 2012. After piloting child health teams in 2014 and conducting a randomised control trial (https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(23)00216-X/fulltext) comparing intervention and control practices from 2016 to 2021, integrated child health teams now work across all GP practices in both boroughs. The proactive nursing service is also now "business as usual" and offered to all children in the boroughs.

In 2022, a clinical audit found that 18 to 20% of children and young people discussed by the child health teams had mental health needs. In response, a pilot has been launched to integrate mental health support directly into the child health teams.

The CHILDS model currently has 15 child health teams covering 100% of children and young people in both boroughs with approximately 400 to 500 cases discussed per month.

Each child health team includes:

- 1 GP lead
- 1 designated paediatrician
- 1 designated children's community nurse

Service delivery

1. **Case identification**

- GPs can make referrals to the child health teams via email or EMIS (the primary care patient record system). This pathway is open for non-urgent needs that do not require specialist surgical, ENT, mental health or neuro-developmental input.
- Children can also be referred following emergency care attendances, through child health team discussion or via hospital discharge plans. Families can self-refer to the specialist nursing service.
- Proactive case identification through primary care records identifies those with long-term conditions and risk factors, who may benefit from early intervention and personalised care. Children and young people, and their families or carers are then asked to complete an online biopsychosocial health check, which is triaged by the nursing team.

2. **MDT case discussion and triage**

- Each child health team holds a weekly meeting to review all referrals. All resulting plans are documented in EMIS. The outcome is sent to the GP and admin support via a "task" in EMIS.
- Possible outcomes of the triage meetings:
  - Advice and Guidance to GPs (approximately 65%)
  - booked into the child health clinic, held in primary care (approximately 15%)
  - referral to a specialist team (approximately 12%)
  - referral to the specialist children's community nursing service (approximately 8%)

3. **Direct care**

- A clinic is held every 4 to 6 weeks for children and young people the child health team have triaged. Appointments are directly booked using EMIS.
- The paediatrician sees the child or young person in a primary care setting, documents the consultation on EMIS and generates a letter to the referring GP. Any actions or outcomes relevant to the referring GP will be allocated as “tasks” via EMIS for both the GP and administration team. If the child needs to be referred to a specialist clinic, the paediatrician will aim to do this during the clinic.
- Comparing health service use for the 6 months before and after children and young people are seen in a clinic, there is a 40% reduction in primary care appointments with a GP or practice nurse.
- Within the Children’s Community Nursing Service:
    - specialist children’s nurses provide support with medicine management and treat diagnosed conditions (asthma, eczema and constipation)
    - referrals to the nursing service are through active case identification through EMIS, referrals from the child health hub team or self-referral

4. **Professional knowledge sharing**

- A monthly 1-hour session is available for all partners who care for children and young people in the primary care network, for example, any interested GP or nurse in primary care, health visitors, school nurses or mental health practitioners. The sessions aim to develop relationships between the designated paediatricians, local GPs and wider partners.
- Sessions involve case reviews of complex cases and clinical queries, as well as shared education to support professionals to manage children and young people’s health needs in primary and community care.
- There are also monthly child health webinars for GPs and other professionals on a range of topics requested by GPs.

5. **Children, young people, family and carer engagement and health promotion**

- The service provides health packs tailored for different health conditions for families to support health promotion and supported self-management.

Impact

Family experience

- 94% of families would recommend the service to others, 95% felt the care their child received was good, and 85% felt the time and date of their appointment was convenient.

Specialist input

- The average waiting time to access a clinic with paediatrician input in the CHILDS model is 3 weeks. This compares to the 7-week average wait for an outpatient clinic for general paediatrics.

Health outcomes

- The service has facilitated clinically significant improvements in eczema symptom control (96% of discharged patients had improved scores in validated symptom measures) and uncontrolled asthma (90% of those with uncontrolled asthma at initial assessment were discharged with reasonably or well controlled asthma).

System efficiency

- Comparing health service use for the 6 months before and after children and young people are discussed in triage, there is a:

- 36% reduction in primary care appointments with a GP or practice nurse
- 27% reduction in A&E attendances
- 62% reduction in non-elective admissions to hospital
- 29% reduction in all paediatric outpatient appointments

GP experience

- 70% of GPs felt the child health teams had improved care for their patients, 70% felt it had improved access to advice and 60% felt it had improved their knowledge about child health.

Data sharing and collection arrangements from Child Health Integrated Learning and Delivery System – London

The CHILDs team has established data sharing and collection processes for the following purposes:

Data for service delivery and monitoring

- Access to primary care records for secondary care clinicians (this requires a data sharing agreement and data protection impact assessment)
- Recording outcomes (including consistent documentation of MDT discussions and clinics by using standardised templates)
- Monthly reporting on activity and outcomes (this requires a data sharing agreement and data protection impact assessment and includes GP Federations running searches of activity captured using the templates and sending to the CHILDS team)
- Patient and GP feedback on the service through surveys
- Identifying those who may have an unmet need (this includes a search of diagnosis codes and medications in primary care records to find those with certain conditions)
- Identifying unmet needs (this requires a data sharing agreement and data protection impact assessment and includes families filling in an online biopsychosocial “health check” to understand their level of need)
- Monitoring symptom control (this is assessed at every appointment with the nurse)

Data for population health management

- Data extracts from primary care (this requires a data sharing agreement and data protection impact assessment and includes GP Federations extracting primary care data on behalf of the GP practices)
- Data extracts from community and secondary care data extract (this requires a data sharing agreement and data protection impact assessment and includes data extract from each hospital)
- Pre-assessment health check data (this requires a data sharing agreement and data protection impact assessment and includes pseudonymised biopsychosocial information to understand wider population health needs*)*
- Public health information (for example, deprivation indices and air quality)

Child health services research

- Data extracts from primary care, secondary care and health information (these are the same extracts as for population health management).
- Ethical approval and consent are also required to undertake health services research.

Bromley Child Health Integrated Partnership, London – a rapidly adopted model

Bromley Children's Health Integrated Partnership (BCHIP) is a new pathway for referring children to general paediatrics. The model was based on the CHILDS model developed in Lambeth and Southwark and rapidly scaled up in the first year.

Local context

Bromley is the largest borough of London by area. Its population is over 350,000, of which approximately 22% are children and young people. The communities within Bromley differ considerably: the densely populated areas bordering inner London boroughs have higher levels of deprivation and illness prevalence. There is a large part of the borough with lower levels of deprivation and some small communities are spread over a large rural area.

The proportion of residents from minority ethnic backgrounds in Bromley is higher than the average for England but lower than the London average.

Before the pathway's introduction, paediatric secondary care services in Bromley were under significant pressure. At the end of 2022, there was a 39-week wait for outpatient general paediatric appointments despite an increase in the number of new patient appointments being offered.

Service evolution

The core PCN team consists of:

- 1 consultant paediatrician
- 1 community paediatric nurse
- 1 lead GP

Service delivery

1. Case identification

- GPs and allied primary care healthcare professionals can refer into BCHIP.
- No referral letter is required as EMIS clinic notes can be used to inform triage discussions.

2. **MDT case discussion and triage**

- A weekly virtual MDT discussion includes the core team, which includes the lead GP, consultant paediatrician and community paediatric nurse. Up to 10 new referrals are discussed each week.
- Typical outcomes are:
  - discharge with Advice and Guidance following triage discussion
  - GP to request further investigations and re-refer for review
  - recommendation of trial of treatment and then review with advice to re-refer if unsuccessful or if there are ongoing issues
  - recommendation of referral to a community service or specialist service – referral is done directly by the BCHIP team where possible
  - booked into a face-to-face BCHIP appointment
- Outcomes of the triage meetings are immediately shared with the referrer via EMIS. An MDT summary note is also transcribed directly to the EMIS patient record, and the referring professional is notified of this new entry.
- Outcomes of 1,219 cases discussed in triage:

    - 54% discharged from service
    - 25% referred into the BCHIP face-to-face clinic
    - 7% referred to specialist secondary care
    - 5% inappropriate referral
    - 3% referred into community services
    - 6% further review in triage required or no outcome recorded

3. **Direct care**

- Children and young people needing face-to-face assessment are asked to attend the monthly joint clinic with the GP and consultant paediatrician at a GP surgery within one of the primary care networks.
- A maximum of 12 patients are seen in each 4-hour clinic.
- Outcomes of approximately 300 children seen in the B-CHIP clinic:
    - 76% discharged from service
    - 10% further review in primary care
    - 11% referred to specialist secondary care
    - 3% referred into community services

4. **Professional knowledge sharing and communication**

- The GP for the joint clinic rotates monthly, ensuring that GPs from all practices can attend the joint clinics.
- A WhatsApp group for each primary care network core group has been established, enabling smooth communication of non-clinical information within the delivery groups
- “Lunch and learn” webinar sessions are available to all GPs across the borough. These provide greater partnership work, collaboration and education. These are recorded and available offline for any member of the Bromley primary healthcare team.

5. **Children, young people, family and carer engagement and health promotion**

- Children and young people were given a say from the beginning by involving them in the decision of the service name.
- Informal feedback and patient engagement continue through the face-to-face clinic, with a patient survey content informing ongoing refinement and evolution of the final model.

Impact

Children, young people, family and carer experience

- Of approximately 100 anonymous responses, 99% reported the overall care received was “very good” or “good”, and 100% reported the date and time of the appointment were convenient.
- 88% preferred being seen in a local clinic over an outpatient hospital department. 11% reported no preference.
- Parents frequently reported that the compressed timeframes and the proximity of the clinic supported a reduction in time taken out of school and work, which for many families has a significant socio-economic impact. The model has indirectly supported the reduction of health inequalities, notably within Bromley’s Core20 population.

Specialist input

- BCHIP clinic has a 4 to 6 week wait time between referral into the service and access to a clinic with a paediatrician if this is required. This represents a 33-week reduction, compared to the 39-week wait in the pathway before BCHIP implementation.

- Twice as many children referred are receiving prompt advice or remote management than previously, when they had to wait to be seen in a hospital clinic before any specialist advice was available.

System efficiency

- Following the implementation of BCHIP in June 2023, the local general paediatric service received a significant reduction in referrals, from 421 referrals per month (April to July 2023) to an average of 40 referrals per month (October 2023 to January 2024).

Primary care clinician experience

- 100% reported BCHIP had improved access to advice, 64% felt it had improved their knowledge about child health, and 93% felt it had improved care for children and young people.

Appendix 2 – Opportunities for increasing support for specific needs

Neighbourhood MDTs for children and young people will provide a universal integrated care offer, including mental health support, with additional opportunities to deliver targeted support for those with needs that demand greater coordination and continuity of care.

The specific approach for each MDT will be shaped by the local context, considering the strengths of existing services and established service partnerships in each area.

Examples of targeted support from existing services

- **Asthma:** Connecting Care for Children (CC4C) in North West London has enhanced its core offer by delivering asthma-focussed MDT meetings and asthma-focused clinic days. Risk stratification using primary care records allows identification of children and young people with the greatest needs based on number of A&E attendances, exacerbations, risk factors and salbutamol prescriptions received. This targeted offer allows the team to optimise care by providing inhaler technique reviews, ensuring up-to-date asthma management plan and facilitating annual reviews.
- **Autism and ADHD:** Health and wellbeing navigators within the neighbourhood MDT in East Kent and Medway and Swale work alongside the family and school to facilitate the completion of referrals for autism and ADHD. This co-ordination streamlines the referral process, reducing pressures on the GP. The navigators also provide emotional and wellbeing support to children and young people and their families and carers while waiting for diagnostic assessments.
- **Complex situations with multiple needs:** Nurse specialists allocated to children with multiple needs are invited to join MDT meetings at Connecting Care for Children (CC4C) to provide specific guidance to primary care clinicians and paediatricians. This has enabled better co-ordination between specialist health services and between health and education teams, leading to a smoother transition to adult care for patients with neurodisabilities.
- **Mental health needs:** The East Lancashire Child and Adolescent Services Primary Care Team delivers evidence-based, low-intensity psychological interventions for anxiety, depression and conduct difficulties, including guided self-help. Brief case management allows clinical care to be typically delivered in up to 3 sessions. If someone requires further support from specialist mental health services, this can be facilitated seamlessly without the need for further referral.
- **Wider educational support:** The Connected Care Network (CCN) in Birmingham works closely with local partners to support children and young people and families and carers to improve school attendance, enhance educational attainment, particularly those who are at risk of being “not in employment, education or training”. Partnership working includes agencies providing mental health and wellbeing support, as well as employment and skills support. It also includes Solihull Council’s Inclusion service and the education, health and care plan service. The CCN input into professionals’ meetings, providing direct support and help develop integrative community and school support plans.
- **Wider social support:** “Early Help” support is a key component of the Sparkbrook Children’s Zone offer. 30% of children and young people, family and carers referred for clinic assessment have wider social concerns such as domestic violence, housing, parenting support and financial difficulties. This integration and co-location of Early Help ensures support from family support advisors can be accessed as soon as the need is identified.

Examples from Connecting Care for Children

Example 1: Child with complex health needs (for example, neurodisability, Down's syndrome, multiple food allergies)

Situation: Marie has Down's syndrome. She has a paediatrician and assigned nurse specialist who she sees regularly. She presents to A&E with difficulty in breathing.

Action: Discussion at MDT after A&E presentation enables Marie's care co-ordination to be planned and managed between the family, primary care and secondary and community care.

Marie's assigned nurse specialist connects with the local team by joining the MDT case discussion meeting to provide specific advice and support. The nurse specialist also liaises with the school nursing team to ensure Marie's mainstream school are aware of any changes in her health needs or support plans.

Result: The MDT professionals and family have increased confidence to manage minor inter-current illnesses despite the complex health background. Benefits also include fewer A&E attendances and smoother transition to adult care.

Example 2: Child with social needs (for example, safeguarding issue or teenage self-harm)

Situation: Carlo has poor speech and language skills. He sees the GP with his mother who explains they have poor housing, significant financial difficulties and Carlo doesn't sleep.

Action: At the MDT case discussion meeting, the GP and health visitor discuss how to support the family to access resources at the local early years centre, as well as providing speech and language support.

Result: There is an increase in the MDT confidence and skills to identify and support the family with social needs and refer to local resources appropriately. MDT discussions can also highlight safeguarding concerns for children and young people that may not have otherwise been on the radar.

Example 3: Acutely severely unwell child (for example, sepsis, trauma, meningitis, surgical emergency)

Situation: Ahmed is brought to his GP with a temperature of 39 and vomiting. He is unwell and the GP calls 999.

Action: All paediatric admissions for this pathway are retrospectively discussed at MDTs, enabling the team to understand early warning signs and gain skills in identifying potential early interventions to prevent deterioration – such as, risk identification and appropriate, rapid referral.

Result: The MDT professionals strengthen their skills in identifying and accurately diagnosing acutely severely unwell children requiring hospital admission, reducing the number of cases where care may be delayed due to warning signs being missed or misdiagnosed.

Example 4: Supporting a young person with complex neuro-disability

Situation: Noah has multiple and complex health conditions, including recurrent pneumonia, upper airway obstruction, global delay and seizures.

Action: From the age of 14, Noah accesses his annual health check through the MDT clinic with GP and paediatrician input.

Result: The family feels confident that they know the GP team closely and the GP is confident to take the role of generalist into adulthood.

Appendix 3 – The evidence base

The Darzi investigation emphasised known sustained pressures on access to health services for children and young people.

- Children and young people are the most likely age group to attend A&E with concerns that could be managed effectively in primary care or community settings. A&E attendance for children and young people is predicted to increase by 50% by 2030.
- Children and young people are disproportionately represented in the demand for mental health services, with referrals increasing at more than 3 times the rates of adult referrals. During 2022/23, 949,200 children and young people had active referrals to mental health services. This is 8% of England's total population of people under 18 years (https://www.childrenscommissioner.gov.uk/resource/childrens-mental-health-services-2022-23/).
- Across community health services, children and young people face significant waits for diagnostic assessments and access to the subsequent support they need. In community paediatrics, the average wait time from referral to diagnosis exceeds 2 years for autism and ADHD, and over 3 years for cerebral palsy (https://www.childrenscommissioner.gov.uk/resource/waiting-times-for-assessment-and-support-for-autism-adhd-and-other-neurodevelopmental-conditions/). Between 2022 and 2024, 17% of children waited over 4 years for their diagnosis in community paediatrics. Significant waits are also seen for access to vital therapies, with wait times of 11 months for physiotherapy, 9 months for speech and language therapy and 6 months for hearing services.

These systemic issues are contributing to poorer outcomes for children and young people, including:

- high prevalence of emergency admission and death rates for childhood asthma (https://stateofchildhealth.rcpch.ac.uk/evidence/long-term-conditions/asthma/) places the UK among the highest in Europe.
- prevalence of mental health conditions among children and young people has increased (https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up) from 1 in 9 in 2017 to 1 in 5 in 2023. Nearly three-quarters of children and young people with a mental health condition also have a physical health or developmental condition
- 2.5 million children and young people in England are affected by excess weight, with 1 in 5 children leaving primary school living with obesity (https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2023-24-school-year)
- children with a learning disability are more likely to die in childhood than their non-disabled peers. Children with a learning disability accounted for 31% of all deaths among children and young people (https://www.ncmd.info/publications/child-death-learning-disability-autism/), yet the prevalence of learning disabilities among this age group is 2.5%
- a third of children start school without the range of skills needed to succeed (https://www.n8research.org.uk/media/CotN_Preschool_Report_9.pdf), with associated impact on educational attainment and later health
- the number of 18 to 24-year-olds economically inactive due to mental or physical ill-health almost doubled (https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/) between 2012 and 2022

Publications

- Academy of Medical Royal Colleges. (2023). ‘Securing our healthy future: Prevention is better than cure’ Available from: https://www.aomrc.org.uk/wp-content/uploads/2023/09/Securing_our_healthy_future_0923.pdf (https://www.aomrc.org.uk/wp-content/uploads/2023/09/Securing_our_healthy_future_0923.pdf)
- Economics by Design (2023). ‘North West London Integrated Care System Child Health Hub ICS Value Analysis Final’. Available from: nwlicbchhebdvalue-analysis–final-website-jacx-mallender.pdf (imperial.nhs.uk) (https://www.cc4c.imperial.nhs.uk/-/media/cc4c/documents/nwlicbchhebdvalue-analysis--final-website-jacx-mallender.pdf?rev=2dbe8dc1081e4bfc8d1008871d061c48&hash=33E0DD48CEDDB9FF1C5EC8D9D150E5BE)
- Hassanzadeh et al. (2021). ‘Data-driven, integrated primary and secondary care for children: moving from policy to practice’. Journal of the Royal Society of Medicine. 2021, 114(2) 63–68. Available from: https://doi.org/10.1177/0141076820968781 (https://doi.org/10.1177/0141076820968781)
- Royal College of Paediatrics and Child Health. (2018). ‘The case for investing in integrated child health services for the acutely unwell child and long term conditions’. Available from: https://www.rcpch.ac.uk/sites/default/files/generated-pdf/document/The-case-for-investing-in-integrated-child-health-services-for-the-acutely-unwell-child-and-long-term-conditions.pdf (https://www.rcpch.ac.uk/sites/default/files/generated-pdf/document/The-case-for-investing-in-integrated-child-health-services-for-the-acutely-unwell-child-and-long-term-conditions.pdf)
- Ipsos Mori (2024). ‘Children and young people integration pilots: national programme evaluation’. Evaluation report for NHS England.
- Montgomery-Taylor et al. (2015). ‘Child Health General Practice Hubs: a service evaluation’. Archives of Disease in Childhood. Available from: https://doi.org/10.1136/archdischild-2015-308910 (https://doi.org/10.1136/archdischild-2015-308910)
- The King’s Fund (2014). ‘Imperial child health general practice hubs’. Available from: https://archive.kingsfund.org.uk/downloads/5712m6524?locale=en (https://archive.kingsfund.org.uk/downloads/5712m6524?locale=en)
- The Association for Young People’s Health (2024). ‘Delivering an innovative model of holistic primary care to young people through the Well Centre: Current successes and challenges’. Evaluation report. Available from: https://ayph.org.uk/wp-content/uploads/2024/09/The-Well-Centre-AYPH-Evaluation-Report-FINAL.pdf (https://ayph.org.uk/wp-content/uploads/2024/09/The-Well-Centre-AYPH-Evaluation-Report-FINAL.pdf)
- Hagell A and Lamb S (2016). ‘Developing an integrated primary health care and youth work service for young people in Lambeth: learning from the Well Centre’. Journal of Children’s Services. Available from: https://doi.org/10.1108/JCS-10-2015-0029 (https://doi.org/10.1108/JCS-10-2015-0029)
- Melyda et al (2024). ‘Integrating health care and early years support for children and young people living in deprivation: A cost effectiveness analysis of a novel integrated clinic in Birmingham, UK’. Available from: https://doi.org/10.1101/2024.09.26.24314416 (https://doi.org/10.1101/2024.09.26.24314416)
- Litchfield et al. (2024). ‘Staff experiences and perspectives of delivering an integrated child health and social care service in community settings: A qualitative exploration using the SELFIE framework’. Available from: https://doi.org/10.1101/2024.10.03.24314613 (https://doi.org/10.1101/2024.10.03.24314613)

- Litchfield et al (2024). 'Understanding the influence of leadership, organisation, and policy on delivering an integrated child health and social care service in community settings: A qualitative exploration using the SELFIE framework'. Available from: https://doi.org/10.1101/2024.11.20.24317624 (https://doi.org/10.1101/2024.11.20.24317624)
- Bird et al (2024). 'Exploring the impact of integrated health and social care services on child health and wellbeing in underserved populations: a systematic review'. Available from: https://doi.org/10.1101/2024.01.05.24300706 (https://doi.org/10.1101/2024.01.05.24300706)
- Lambert et al. (2020). 'GP perceptions of community-based children's mental health services in Pennine Lancashire: a qualitative study'. BJGP Open. Available from: https://doi.org/10.3399/bjgpopen20X101075 (https://doi.org/10.3399/bjgpopen20X101075)
- Rafi R and Washbourne K (2024). Connected Care Network Pilot Update. Report.
- Macaulay C et al. (2024). 'Impact of poverty and ethnicity on asthma symptoms and outcomes in children'. Archives of Disease in Childhood. Available from: https://doi.org/10.1136/archdischild-2024-rcpch.166 (https://doi.org/10.1136/archdischild-2024-rcpch.166)
- Macaulay C et al. (2023). 'The impact of local child health team triage on health service use: the CHILDS model of care'. Archives of Disease in Childhood. Available from: https://doi.org/10.1136/archdischild-2023-rcpch.201 (https://doi.org/10.1136/archdischild-2023-rcpch.201)
- Wolfe at al. (2023). 'Effect of the Children and Young People's Health Partnership model of paediatric integrated care on health service use and child health outcomes: a pragmatic two-arm cluster randomised controlled trial.' The Lancet Child & Adolescent Health. Available from: https://doi.org/10.1016/S2352-4642(23)00216-X (https://doi.org/10.1016/S2352-4642(23)00216-X)

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