

The future of children and young people's services

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About us

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. For more information, visit us at www.nhsconfed.org

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Key points

- Children and young people's (CYP) services are struggling to meet increased demand and a backlog of unmet need, with waiting lists higher than those for equivalent adult services.
- Adult models of care cannot always be effectively applied to children and young people, due to the additional developmental impacts which can arise from long waits for treatment.
- Such delays can have greater longitudinal effects on a young patient's future wellbeing, with the care they receive potentially determining the course of the next seven or eight decades of their lives.
- Parents and families also need to be included and empowered through effective children and young people's services, allowing them to understand their child's condition and help manage their needs in partnership with the NHS.
- New technologies have the potential to enhance health education, allow more young patients to receive care at home rather than in hospital, and streamline some of the most overwhelmed care pathways.
- Amid a very challenging national picture, a number of pioneering NHS leaders and their partners are innovating to address the challenges their services face and improve the wellbeing of their young patients.
- Following five broad themes, this report sets out the scale of the challenges facing CYP services in England, provides examples of good practice and innovative working in the NHS today, and makes some key recommendations for the future.

Introduction

Children and young people's (CYP) services encompass every aspect of care that the NHS provides for those aged 25 and under, including physical, neurodevelopmental and mental health. While specialist paediatric trusts do provide some services, most are provided by the same acute, community, mental health and primary care bodies that provide adult services. Equally, given the age of the patients in question, educational settings and local authorities (responsible for public health and child protection) play an important role in CYP service provision.

The NHS Long Term Plan established a vision for CYP services in 2019. However, the COVID-19 pandemic disrupted those ambitions, resulting in considerable waiting lists which currently see over 400,000 children and young people nationwide waiting for care. Subsequently, recovery in CYP services has lagged behind equivalent measures for adult services. The pandemic also revealed a large degree of unmet need and has contributed to an upsurge in mental health conditions among children and young people.

Underlying this backdrop is a widening gap between the health of children from the most deprived and most well-off families. The number of children at the sharp end of these inequalities has risen and child poverty in the UK is at a record high, with 30 per cent of children (4.3 million children) living in poverty in 2022/23, in part due to the impacts of lower welfare spending.

In this context, and following on from the Darzi review, the Department of Health and Social Care (DHSC) is developing a ten-year plan for the NHS. With the government committing 'to raise the healthiest generation of children in our history', revitalising and revolutionising CYP services will need to form an integral part of this vision.

What does good look like and how do we achieve it?

The future of CYP services must focus on empowering children, young people and their families. Services must be integrated and easily accessible, providing holistic and wraparound care tailored to the child's specific needs and provided by multi-disciplinary teams (MDTs).

Focus must also be placed on accelerating a shift towards early intervention and prevention with increased community-based provision. To achieve this vision, agencies and departments will need to work across system, place and neighbourhood spatial levels.

Place is often described as the 'engine room' for integration. It is the geographic, spatial level which services are most often organised around, and the level at which local authority, the NHS and other services can work together to have the biggest impact for the local population. It also includes active engagement of patients, carers, children and young people and communities in helping to shape what happens in the place they live to improve their health outcomes.

At a system level, integrated care systems (ICSs) are the right structure to improve health outcomes for local populations, and the evolution of place and neighbourhood is a crucial element of this. Integrated care boards (ICBs) will be noteworthy contributors to any local progress on children and young people's health and care, as commissioners for most NHS services, while local authorities oversee education and other relevant areas that determine children and young people's health. Integrated care partnerships (ICPs) play a crucial role in setting the whole system strategy and exploring system-level integration between all the services that play a role.

Following five broad themes, this document sets out the scale of the challenges facing CYP services in England, provides examples of good practice and innovative working in the NHS today, and makes some key recommendations for the future.

Leaders' views

The NHS Confederation, which represents leaders from every part of the healthcare system, delivered a series of webinars in which the issues facing children and young people's services were explored by over 100 leaders from across health, education, local government and the voluntary sector. The webinars were centred around the need for recovery within children and young people's services; enhancing the role of prevention; and improving paediatric advice and care in the community. Chaired by Louise Shepherd, the chair of NHS England's Children and Young People Transformation Programme Board and chief executive of Alder Hey Children's NHS Foundation Trust, the discussions shaped a number of recommendations.

Each of the recommendations offer both challenges and opportunities to CYP services. Shifting the emphasis away from diagnosis and towards support, while not eliminating the need for medical treatment, can allow for care to be provided faster and with a reduced focus on medicalising an individual's needs. Likewise, both the management of waiting lists and lifelong patient outcomes can be improved by altering pathways where clinically advisable, especially in the long term.

To enable these changes, CYP services require support. The success of multidisciplinary teams should be emulated with systems assisted as required to adopt new methods of working and minimise workforce issues. Equally, investment in both the physical and the digital estate is essential if productivity is to be increased, with new technologies offering the potential for better care to be provided earlier if implemented in a consistent, coherent manner.

Lastly, transforming CYP services relies upon better joint working, including within the NHS; with other public bodies at a place, neighbourhood and system level (for example, education); and in government itself.

Recommendations

For recovery of children and young people's services

- New diagnostic tools with the potential to both reduce the burden of long waits on children and young people and simultaneously use NHS resources more efficiently should be promptly assessed and NICE guidance updated accordingly to encourage uptake where clinically appropriate.
- Prioritisation models which are designed specifically to consider potential developmental impacts alongside standard considerations of morbidity and mortality should be made available for clinicians adopt where appropriate.

For improving access to paediatric advice and care in the community

Support through access to digital and online resources should be expanded to reduce the impacts of long waits on patients and their families alike; empowering parents to support their child at or closer to home

Information about how symptoms present in children and young people should be made more easily accessible to parents and carers in order to support and empower them, as well as reducing pressure on services, allowing NHS resources to be used more efficiently.

For enhancing the role of prevention

- Public bodies with responsibility for the health and development of under-18s should examine the benefits of working within MDTs at place and neighbourhood levels to support children and young people.

Other recommendations

- NHS numbers and pupil identifiers should be consolidated in order to trace children and young people's needs between NHS services, education, and other bodies such as local government.
- The five 'mission boards' established by the new government and chaired by the Prime Minister should include a dedicated voice for children and young people within each.

From diagnosis to support: shifting perspectives

Increasing importance is being placed on moving away from a purely diagnosis-led model towards addressing a child's holistic needs. This includes building strong relationships with both the patient and their parents or guardian to ensure that they too receive the support and education necessary to understand their child's needs.

For example, Portsmouth has developed a model for supporting the needs of children and young people from 0-15 who are awaiting a neurodevelopmental assessment. This partnership between Portsmouth Children's Trust and Hampshire and Isle of Wight ICS identified several challenges facing children and young people in the region, including long waits for neurodivergent diagnosis, investment targeted to diagnosis rather than support and intervention, parental dissatisfaction and prioritisation of assessment over meeting needs.

Through a true system-wide response of NHS, local authority, care providers and education settings, they focused on four paradigm shifts: moving from disability to diversity; from diagnosis-led to needs-led; from clinical pathway to identifying need in partnership; and from mental health agenda to a SEND (special educational needs and disabilities) agenda. This led to the development of 'profiles', which outline a pupil's strengths and challenges according to nine neurodiverse sub-profiles.

Schools were then able to adapt to the identified characteristics of their pupils, while parents were provided with resources to allow them to better navigate their child's needs. Consequently, over two-thirds of children awaiting a neurodevelopmental assessment were able to have their needs identified and subsequently met, with a similar reduction in demand for diagnosis.

Although formal diagnosis remains essential for many (for example, to receive medication and treatment and access educational support), cutting waiting lists can be combined with addressing a young person's needs at the same time. Further longitudinal studies to quantify the long-term benefits of managing neurodevelopmental conditions in this way, including at key milestones such as the transition from primary to secondary education, could add to the model's evidence base.

Portsmouth's approach to enabling inclusion has now been referenced in the Local Government Association's (LGA) proposals to [reform SEND](#). The LGA has proposed the development of a 'core offer' of targeted multi-disciplinary support that all education settings can access without children and young people requiring a statutory plan.

Co-location of NHS and local authority staff is another example of partnership working, with speech and language waits identified as an area where waiting times have been significantly reduced. Pooled training sessions, drawing in frontline staff from across the public sector, have also been effective in spreading awareness of conditions such as sepsis in children and young people.

Similarly, new models of public education can both reduce demand for the most hard-pressed services and build confidence for parents and professionals alike. Despite requiring a relatively small share of overall NHS activity, children and young people are over-represented in terms of GP visits and A&E attendances. [Parental anxiety](#) has been suggested as a key factor explaining this disparity.

[Healthier Together](#) is a platform co-produced between parents and healthcare professionals from across Dorset, Hampshire and the Isle of Wight and provides prompt, easily understood advice and reassurance to concerned parents while simultaneously allowing for key public health messages concerning children and young people to be disseminated and updated rapidly.

By allowing parents to assess their child's condition and only escalate their concerns when clinically necessary, education can allow adults to support young people's ill-health without immediately seeking a diagnosis or treatment.

In the platform's area of operation, paediatric GP presentation rates saw a 10 per cent decrease between 2016/17 and 2019/20, while emergency admission rates decreased by 8 per cent during the same period. The resource also aims at reducing unnecessary variation between healthcare professionals and improves the overall quality of care and reduces the anxiety that inconsistent advice can generate.

Building an integrated workforce through multidisciplinary teams

MDTs are key to improving care. Drawing together existing staff currently divided between different areas of the NHS, as well as local government, education and voluntary organisations, this model of working is vital to meet children and young people's holistic needs.

The reorientation of existing workforce to support those most vulnerable in their own communities will also contribute to reducing growth in demand for acute services and shift away from a hospital-centric model of care, aligning closely with the vision set out in the [Fuller Stocktake](#). Partnerships both within and without the NHS are central to this vision, such as primary care working with nurseries to tackle dental care in the under-fives and improve MMR vaccine delivery.

Similarly, embedding dedicated paediatric social prescribers, mental health staff and occupational therapists within primary care can ensure that young patients receive the support they need sooner. This prevents further deterioration in their condition, improving young patients' outcomes while simultaneously reducing the level of resource required for treatment.

Successful working through MDTs within CYP services requires buy-in from all public bodies with which young patients interact. For example, the unique ability of schools to contribute to addressing their pupils' health needs offers their staff additional importance within an inclusive MDT.

Yet some members have reported difficulties when encouraging educational institutions to engage fully with MDTs, despite the far higher rate of permanent exclusion among [pupils with special educational needs \(SEN\)](#). With school

nursing capacity stretched far beyond acceptable limits (including an approximately 4000:1 ratio of children to nurses in England, compared to Finland's mandated maximum of 600:1), mutual workforce shortages challenge many MDTs' ability to fully encompass all the necessary skills within their tutelage.

The role of digital and online tools

Digital technology has the potential to meet demands of long waits, manage NHS resources, reach more people outside of the physical NHS estate and empower co-operation between different bodies through rapid data sharing and collaborative platforms. Consequently, online and digital tools alike have a significant role to play in transforming CYP services.

The online resource pack for parents and guardians included within the Portsmouth model of managing neurodevelopmental waiting times has been positively received. Both the resources themselves and the ease of access to them have been praised by parents, who felt they could consequently better understand the needs of their child. Similarly, the combination of standardised, national guidance with localised, targeted health messaging included within Healthier Together has empowered parents to respond appropriately to their child's ill-health, reducing both their anxieties and demand upon the NHS.

Digital innovation also has the potential to radically alter care pathways by reducing waiting times. For example, recent moves to [approve Qb testing](#) (a diagnostic screening tool for learning disabilities) as a standard part of ADD/ADHD assessments may allow for more diagnoses to be made or ruled out within six months than is currently possible. [Evidence suggests](#) that the adoption of Qb testing in the ADD/ADHD assessment pathway could cut assessment time by 20–30 per cent, creating a more efficient pathway for patients and clinicians alike.

Lastly, digital technology also has the potential to reshape treatment for children and young people. With the uptake of virtual wards already expanding across adult services, CYP services are also increasing their use across a growing number of specialisms thanks to pioneers such as Nottingham University Hospitals NHS Trust.

As well as providing treatment to the patient, paediatric virtual wards improve family wellbeing, with parents relieved of the burden of balancing visits to their child in hospital with the need to care for other children at home. Even where testing and diagnosis remains within a hospital setting, virtual wards can enable children and young people to return home far faster into a familiar, comforting environment while still being monitored and cared for by their clinical team from afar. This requires a strong framework of digital infrastructure so that accurate and timely data can be shared safely between acute, community and primary care staff.

Tailoring support to children and young people: moving away from adult models of care, treatment, and commissioning

Health leaders have also stressed the need to treat children and young people differently from adults. The potential for patient needs to evolve as a child or young person develops adds to the importance of creating bespoke models of treatment within CYP services, as has recently been highlighted by the [Children's Commissioner](#).

For example, CYP waiting lists need to be managed differently to those of adults. At present there are five priority categories for surgical validation, four of which relate to the [clinical prioritisation of elective care patients](#) (while P1 relates to emergency patients). This P-system focuses largely on measures of mortality and morbidity and as such does not take into account those areas that are of greater risk to children, including developmental delay, engagement with education and mental health impacts.

Novel approaches to patient prioritisation such as the Children's Hospital Alliance Risk Tool (CHART) can improve waiting list management by taking these developmental impacts into account, while adding no more complexity to the assessment process. It includes five simple yes/no questions related to children's risk to health and development outcomes, while aligning with the P-system to allow trusts to operate both in parallel where necessary.

The pilot of CHART has shown that investing in children's elective recovery services has the potential for wider benefits not currently captured by the P-system. NHS England has recently included CHART as an example of good

practice in an [elective toolkit](#). However, many trusts are awaiting a national direction and further support before incorporating CHART into their own services.

One specific area of treatment for children and young people that requires particularly careful design is the reformulated gender identity services being put in place following the [Cass Review](#). The number of children and young people being referred for NHS support has increased beyond the sector's capacity to meet demand, leading to [waiting lists of several years](#) in some cases. Since the initial interim Cass Review, NHS England has outlined that up to eight specialist centres would provide Gender Identity Development Services (GIDS).

With two of these hubs opened so far, at Great Ormond Street Hospital (GOSH) and Alder Hey Children's Hospital, the latest figures show that the [waiting list has risen to 5,769](#) by May 2024. The length of the waiting list to access gender services has 'significant implications' for children and their families, and young trans, non-binary and gender-diverse experience [disproportionally high levels](#) of mental ill health. To meet demand and provide a holistic, localised and timely approach, services should be delivered over multiple clinical sites, ensuring partnership working, supporting integration with children's services and facilitating early access along flexible pathways that better respond to individual needs.

Another important aspect of care, where children and young people require a different approach to that adopted for adults, concerns the monitoring of conditions and the escalation of concerns when an unwell child deteriorates. Investigations into these rare events have highlighted common themes of missed early signs of deterioration, paediatric warning systems (PEWS) have been implemented to aid clinical practice. The programme has now been renamed System-wide Paediatric Observations Tracking (SPOT) to recognise that the deterioration may occur from primary and community care, through ambulance services, emergency departments and into hospitals.

Following the introduction of Martha's Rule in April 2024, patients, families, carers and staff will have access to a rapid review from a separate care team if they are worried about a person's condition. Martha's Rule now requires an independent means by which parental concerns can be escalated, with PEWS currently requiring parents' input to be mediated through clinicians.

Responding to the establishment of Martha's Rule, SPOT aims to standardise observation metrics across the NHS and embed these methods of working. To ensure that Martha's Rule is effective it should be implemented across a standardised PEWS such as SPOT, improving how deterioration is managed and encouraging greater involvement from patients, families and carers.

Working across places, agencies, and departments

With integration essential across health and care provision, achieving this within CYP services offers both unique challenges and distinct opportunities. This includes relationships with partners outside of the NHS, as well as with other systems and trusts.

For example, some dental services are provided by community trusts yet rely upon renting surgical space from acute trusts that are seeking to reduce their own waiting lists. ICBs are wrestling with these competing pressures, especially with acute electives often used as the predominant metric for their overall performance.

New models for co-operation within CYP services such as NHS North West London ICB's [child health hubs](#) are being developed to revolutionise how the system can respond to paediatric demand. In this model, GPs are connected to consultants based in hospitals, mental health staff and other key stakeholders including the voluntary, community and social enterprise and sector (VCSE) and social workers.

Initial analysis of child health hubs (CHH) has led to a drop in hospital attendances, releasing 7 per cent of paediatric outpatient capacity and a 36 per cent drop in child GP appointments, allowing for resources to be reinvested within systems. GPs have also responded positively to CHHs, with added support from consultants allowing family doctors to address children and young people's concerns closer to home and away from more costly acute settings.

Similarly, [family hubs](#) provide integrated support for families at the place level from a variety of services. For example, joint home visits with housing association staff can address the poor housing conditions that lead to repeated

admissions by children and young people suffering from acute asthma. Preventative work, such as improving vaccination rates in the most deprived areas, has also been most effective when services are tailored to the local population, ensuring that traditional clinical settings are not the only place where vaccinations are available.

However, a lack of capital investment is holding back the implementation of new models of care within CYP services, despite the proven efficiencies and improvements in outcomes they can deliver for systems. The condition of existing estates, as well as the rise in construction costs and the flawed model for funding such improvements are all hindering transformation. As well as needing the right mix of clinical spaces, investment in up-to-date and interoperable digital systems is essential to connect and share data across settings and services providing care to children and young people.

In addition, the VCSE sector has a role to play in CYP services. For example, Eastern Local Care Partnership has established a steering group around children and young people's mental health, co-chaired by VCSE and statutory partners, to oversee a range of initiatives delivered across the partnership. These steering groups have several functions, including the creation of a knowledge bank of services for young people and their families, making it easier for them to access help for mental health and emotional wellbeing.

The deployment of trained youth mental health workers from the VCSE sector in A&E departments, such as the pilot scheme operated by Redthread in two of Nottingham's hospitals, has also been highlighted as a good example of joint working. The addition of specialist staff from outside the NHS allows for children and young people presenting in acute mental distress to be triaged quickly and provided with the services they require, instead of waiting in emergency departments for treatment and potentially needing a crisis intervention from hard-pressed, non-specialist staff.

Co-operation between health services and schools is also essential to address children's holistic needs. With schools obliged to take into account the impact of physical or mental health on a pupil's attendance, educational settings play a prominent role in both managing and determining health outcomes for children and young people. Where effective co-operation between education

and health has been established, both NHS and school leaders have reported positive outcomes.

Notably, Tendring District Council has introduced wellbeing hubs in 33 primary schools. A partnership project to help remove barriers to learning, collaborative and integrated working was paramount in the project's success and occurred at all stages. The hubs operate as an after school club where children are provided with additional structured support, and also engage and offer support to parents to help contribute to improved attainment levels at key stages 1 and 2.

Yet effective co-operation between schools and CYP services remains inconsistent, especially when including education staff within MDTs. The increasing number of state schools becoming academy trusts means an increasing number of schools are independent from local authorities and their public health functions. Likewise, workforce issues impacting schools – which are also struggling to recruit and retain staff in the face of severe budgetary pressures – can also obstruct co-operation between education and health.

Within central government as well, joint working between education and health is also essential. Yet, with NHS numbers and pupil identifiers different and unlinked from one another, connecting CYP health services with local authority and school staff is rendered more complicated than necessary.

With the Department of Health and Social Care, Department for Education and Ministry of Housing Communities and local government all holding overlapping responsibilities within children and young people's lives, inter-departmental co-operation is essential. The government's decision to establish mission boards, holding cross-cutting briefs to achieve the goals set on in its manifesto, provides an ideal platform to unite disparate thinking across Whitehall. A dedicated voice for children within these teams could further enhance their potential to change children and young people's services for the better.

Conclusion

The challenges facing children and young people's services are great, with high demand across mental, neurodevelopmental and physical health. At the same time, a range of factors including rising obesity, poor oral health and the impacts of online harms continue to undermine the health of children and young people. Against this backdrop, health, education and local government leaders, specialists and staff are responding with both determination and innovation.

NHS leaders are already offering many of the means by which CYP services can be improved. Although additional investment in CYP services would be welcomed (above all to cover the capital costs of new facilities and digital infrastructure), much of what is already being trialled requires little additional funding – with the added reminder that intervening early in a person's life has the potential to save the NHS significant sums for decades to come.

Scaling up success is dependent upon a willingness to reward and spread innovation where it already exists; improving links between services; and addressing the holistic needs of children and young people. With the impending development of the NHS ten-year plan, now is the ideal time to set out how children and young people's services can be transformed.

Appendix: Case studies

Children's Hospital Alliance Risk Tool (CHART)

This bespoke measurement scale uses five simple yes/no question to quantify the potential developmental risks that a long wait for treatment might cause a child or young person. Answering yes to three or more of the questions classifies a child as high risk, allowing for decisions to be made when managing waiting lists.

By offering a limited number of questions that do not require repeated references back to definitions, CHART can be administered by clinicians or non-clinicians and requires no greater resources to administer or analyse than the P system. Moreover, by capturing potential developmental impacts as well as the risks of mortality and morbidity to young patients, CHART can be used to differentiate between those with the same P-scores.

Clinicians have responded positively to CHART, with both the Royal College of Paediatrics and Child Health and Royal College of Ophthalmologists having endorsed the scale. Although some trusts have already expressed interest in adopting CHART, more are seeking implementation support and a strategic direction from central government before making the change themselves.

The Portsmouth Children's Neurodiversity Model

With long waiting times for neurodevelopmental assessments negatively impacting children and young people as well as their families, Portsmouth's local authority and the Hampshire and Isle of Wight (HIOW) ICB have worked together to pilot a new model for treating neurodiversity in the city.

Portsmouth Children's Trust has redesigned how it both manages waiting lists and provides support with CYP neurodiversity services. Seeking four paradigm shifts: from concepts of 'disability' to 'diversity'; moving to a needs-led rather than diagnosis-led approach to support; incorporating family and friends' observations of need alongside clinical measurements; and leading from a SEND standpoint rather than that of mental health.

An MDT has been established that can work with schools and families to co-create patient profiles using nine neurodiversity metrics to identify a child's strengths and challenges. Mainstream schools have then been able to use this information, alongside new training for staff, to adapt their facilities and ways of working to address many of the needs identified by the profiling process without requiring a formal diagnosis.

Additionally, a suite of resources has been provided for parents to better understand their child's unique needs, allowing them to help manage their conditions better both before and after diagnosis. This has been warmly received and, while not replacing the formal diagnostic process, has allowed for waiting lists to be dramatically reduced as more children's needs are being met sooner through early but less intensive intervention.

Child health hubs (Connecting Care for Children)

NHS North West London ICS, as part of their broader Connecting Care for Children programme, have developed a model of child health hubs (CHHs) within primary care. These allow GPs to communicate directly and share information with paediatricians in acute settings, as well as bringing in other specialists such as youth mental health teams alongside community services, school staff and the local VCSE.

As a result, GPs have been empowered to give stronger advice to parents and treat more young patients within primary care, reducing the need for referrals and strengthening the role of the family doctor. Continuity of care has also been reinforced, with access to specialist support giving GPs the

confidence and the ability to intervene earlier and keep a child or young person's care within their own hands.

This has delivered significant financial benefits through improved allocative efficiencies, including a 36 per cent drop in GP appointments dedicated to children and young people as well as the release of 7 per cent of paediatric outpatient capacity. Moreover, patient care has improved, above all for children coming from the most deprived families. In this way, CHHs are enabling GPs to provide higher quality, more timely and more efficient care. Meanwhile, family hubs are able to integrate well with CHHs and thereby fulfil their remit of tackling the social determinants of health more effectively.

Paediatric virtual wards (Nottingham University Hospitals)

Since the pandemic, virtual wards have been increasingly adopted as a means of allowing patients to return home quicker following hospital treatment, allowing them to recover faster while remaining under remote monitoring. Although adult patients were the first to benefit from the introduction of virtual wards, pioneering trusts are now rolling them out across a range of paediatric specialities as well.

Nottingham University Hospitals NHS Trust has achieved a sustained growth in the scope of virtual wards for children and young people. From 74 patients in September 2022 to 1,287 during May 2024, paediatric virtual wards have expanded to cover an increasing number of specialities and are forecast to continue to grow, enabled by the Nerve Centre at Home digital package which has allowed electronic patient records to be shared between primary and secondary care.

In adult services, virtual wards have been established as effective in improving patient recovery (through greater mobilisation and improved nutrition) and as efficient in terms of NHS resources, by allowing for improved clinical outcomes to be achieved in less intensive settings. However, within CYP services these benefits are joined by an added

improvement to family wellbeing, as parents are not forced to juggle visiting an ill child in hospital with caring for their siblings at home among the other pressures upon them.

Systemwide Paediatric Observation Tracking (SPOT) and Martha's Rule

With the introduction of Martha's Rule, models of assessing and escalating deterioration among children and young people are now required to change. This includes the means for parents to escalate their concerns independently from clinicians: a key principle of Martha's Rule.

Systemwide Paediatric Observation Tracking (SPOT) is designed to combine the best features of clinical judgement and patient observations with channels for independent parental escalation. Additionally, contextualising any deterioration in a child or young person's condition is necessary in order to differentiate between settings and types of care (for example, a discharge from primary care compared to an ICU).

Although almost all hospitals already have a paediatric early warning system (PEWS) in place, SPOT offers a unified approach that, while not currently mandated, will eventually become the standard of care across the NHS and the sole system on which new staff will be trained. Ultimately, SPOT forms part of the wider drive to reduce childhood mortality in England, which remains higher than in many comparable countries.

Healthier Together

Now active across 19 ICSs, [Healthier Together](#) is an online platform that provides parents with advice and information about children and young people's health. The service aims to empower parents, signposting them appropriately through consistent and clear guidance along standardised

referral pathways, while ensuring good communication between clinicians within each individual role.

Each ICS is able to offer its own version of the national site, combining local updates with whole-NHS messaging. In doing so, Healthier Together breaks down silos between settings, scales and professionals by providing a common platform to share unified health messaging. Other partners, such as VCSE, can also integrate easily and thereby enhance the local offer the website provides.

Initial data suggests a reduction in GP visits and A&E attendances where the programme is now in place, with parents better able to assess their child's needs according to a straightforward traffic light scale of concern. With children and young people over-represented in terms of presentations at GP surgeries and A&E, compared with the actual levels of pathology experienced by younger people, calming parental anxieties both allows for NHS resources to be deployed more efficiently and for children to be treated sooner in the most appropriate setting.

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