



England

Children and Young People's Programme

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What I will say
The NHSE view • Modern Service Framework • Neighbourhood MDTs for CYP • The rest of the CYP Neighbourhood
The real-world view • Clinical cases • Data from existing models • Hospital activity • GP activity • Patient experience • Spread
Discussion and next steps

What is a Modern Service Framework?

Ambition

To create a Modern Service Framework (MSF) to support consistent, high quality, and high value care across the children and young people's care pathway.

MSFs will define long term outcome goals for specific conditions, identify evidence-based interventions, and support uptake through clear standards and implementation plans. They will also highlight areas where new medicines or technologies exist or are needed, helping to accelerate innovation and improvement. They are meant to be live document and will be updated as new evidence is generated.

Objectives

An ambitious goal

All MSFs will have a mission-oriented outcome goal – a stretching 'moonshot' that describes the **10-year outcome** we wish to achieve.

This must be bold, measurable, time-bound and galvanise cross sector partners.

Delivering in partnership

The BCYP MSF will be co-produced with partners across the system, supported through leadership representation on the MSF board and wider engagement across workstreams.

Identifying interventions

The MSF will identify the interventions best placed to deliver step-change improvements to achieve the moonshot. This will include a deep analysis of the case for change, to diagnose the issues and overcome barriers systematically.

Interventions will be translated into quality standards and milestones, supported by appropriate delivery models and robust process measures to track progress.

Digital-by-default care and catalysing innovation

The MSF will outline opportunities for digital transformation across the pathway to enable digital-by-default care.

Achieving our ambition will require more than current interventions alone – we will stimulate innovation and support the development of new solutions from within and beyond the NHS including industry, third-sector and academia.

What this is

A core offer that is **part of a wider neighbourhood health system** – brings together secondary and primary care as the foundations of wider integration.

The foundations of building a neighbourhood health system **with a number of components** where the benefits increase as the model expands and the MDT membership grows.

An **evidence-based model that has proven outcomes** – reduces outpatient referrals and ED attendance and improves health equity, and patient and staff experience.

Common cases discussed by MDTs include **respiratory issues, allergies and digestive issues**. It can also offer benefits for wider groups of children, including those with more specialist healthcare needs.



What this is not

The totality of services that should exist within a neighbourhood. **Not ‘the’ model** for neighbourhood health for children and young people

A stationary or fixed model of care. It’s **not just a one-hour case discussion meeting** – the benefits are achieved across the 5 core components being in place.

The **only neighbourhood health model** that will reduce waits within a system. ICBs may need to look for wider models to improve community waiting lists.

A **specific pathway** for children and young people with complex care needs or specialist conditions however these children will also benefit. It is not a universal / prevention model – but it will enable join up with Best Start Family Hubs and other government initiative.

Context: The national Neighbourhood Health Framework was published in March 2026

The framework confirms that CYP are a priority cohort for neighbourhood health plans.



The NHS is asked to improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care.

By March 2029, the aim is to:



Reduce acute outpatient appointments for children under the age of 16 by 10%*



Make substantial progress towards **reduction of community waits for children**, as part of delivering Medium Term Planning Framework success measures.

*** Reduction in outpatient appointments can be achieved through the implementation of neighbourhood MDTs for CYP**

The published guidance sets out 5 core components of neighbourhood MDTs for CYP.

1. Case identification / referral

- Population health management and risk stratification.
- CYP who may have otherwise been referred to secondary care and/ or who would benefit from additional MDT input into their care.

2. MDT Case discussions/ triage meetings

- Virtual MDT discussion bringing together GPs, paediatricians, mental health practitioners and other MDT professionals.

3. Direct care

- In-person MDT clinics held in primary care setting.
- Replace the need for the patient and family to travel to their local hospital for an outpatient appointment.

4. Professional knowledge sharing

- 'Open access' to the designated paediatrician for GPs outside of the MDTs and clinics.
- Delivery of dedicated learning sessions.

5. CYP/family/carer engagement and health promotion

- Provide focussed support alongside the clinical discussions e.g. health promotion, training tailored for different health needs and signposting to local support services/ networks.

The exact model and workforce will be locally determined.

The core Neighbourhood MDT for CYP brings together primary and secondary care general paediatricians to support children and young people through MDT case discussions.

Integrating paediatric expertise with primary care **builds the foundations** of the model to achieve the expected benefits.



The 'Core' Neighbourhood MDT for CYP

Secondary Care
General Paediatrics and
Mental Health



Primary Care
GP

Vertical integration across health
– bringing colleagues together to
hold MDT case discussions

Once the foundations are in place, MDT membership can be expanded.



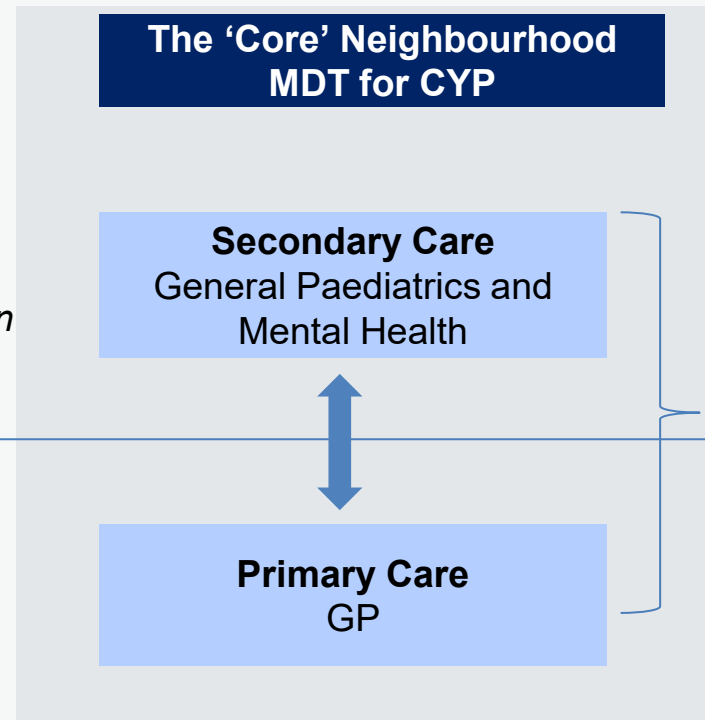
Neighbourhood
MDTs for CYP

Integrating paediatric expertise with primary care **builds the foundations** of the model. This can then be expanded to achieve greater benefits.

Horizontal integration
Widening the workforce across care, education and other key partners

Vertical integration across health
– bringing colleagues together to hold MDT case discussions

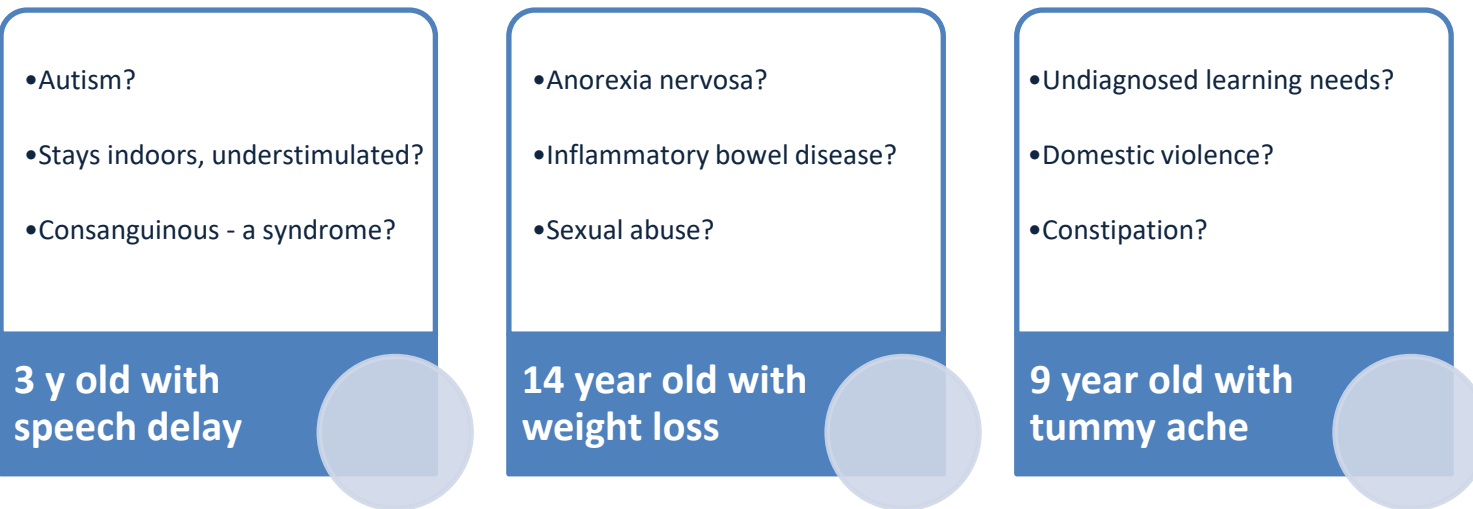
Key partners*:
Voluntary sector
Schools
Social Care
Family Hubs
Youth Centres



Extended MDT workforce*:
Health Visitors
School Nurses
Dieticians
Community Nurses
Therapists (e.g. SaLT, OT)
Social workers
Youth workers
Nurse specialist
SEND/ ND specialist support

* **Example list only.** This will be determined locally based on population needs and workforce and can be flexible rather than fixed

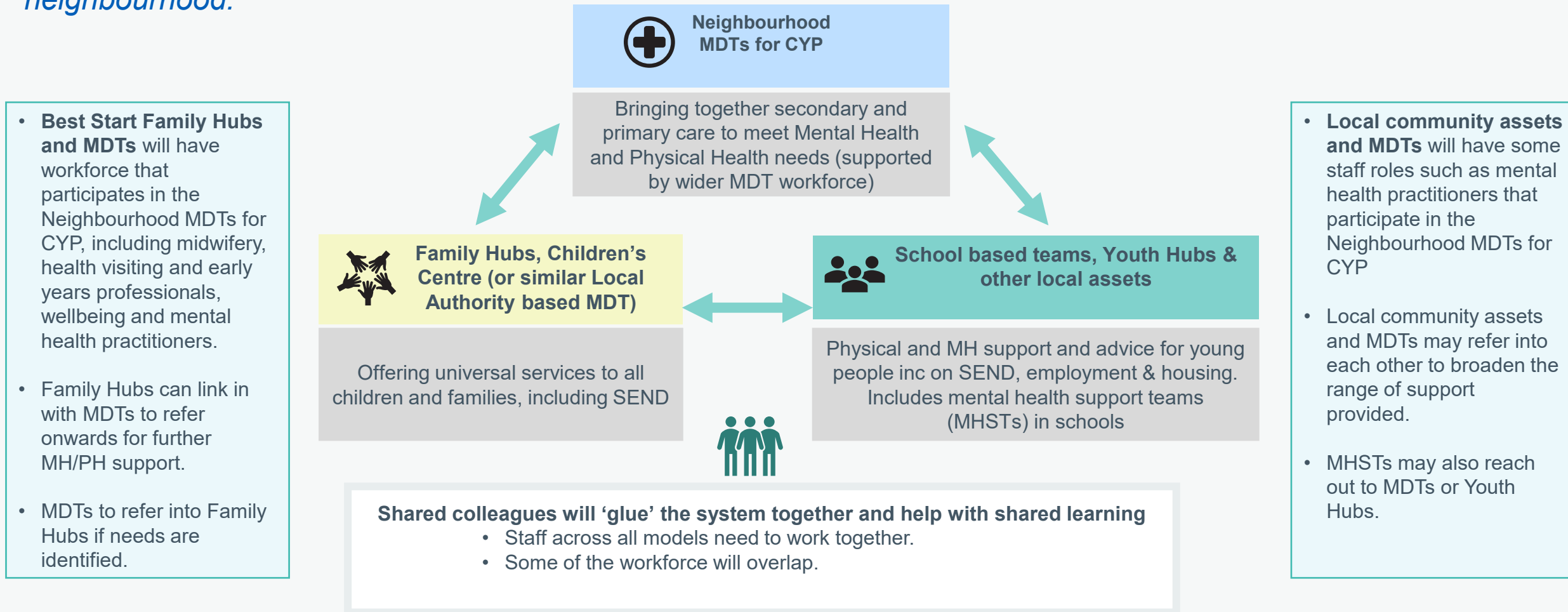
Children present with symptoms that arise from a multitude of different issues



Different professionals in the neighbourhood may have something important to offer

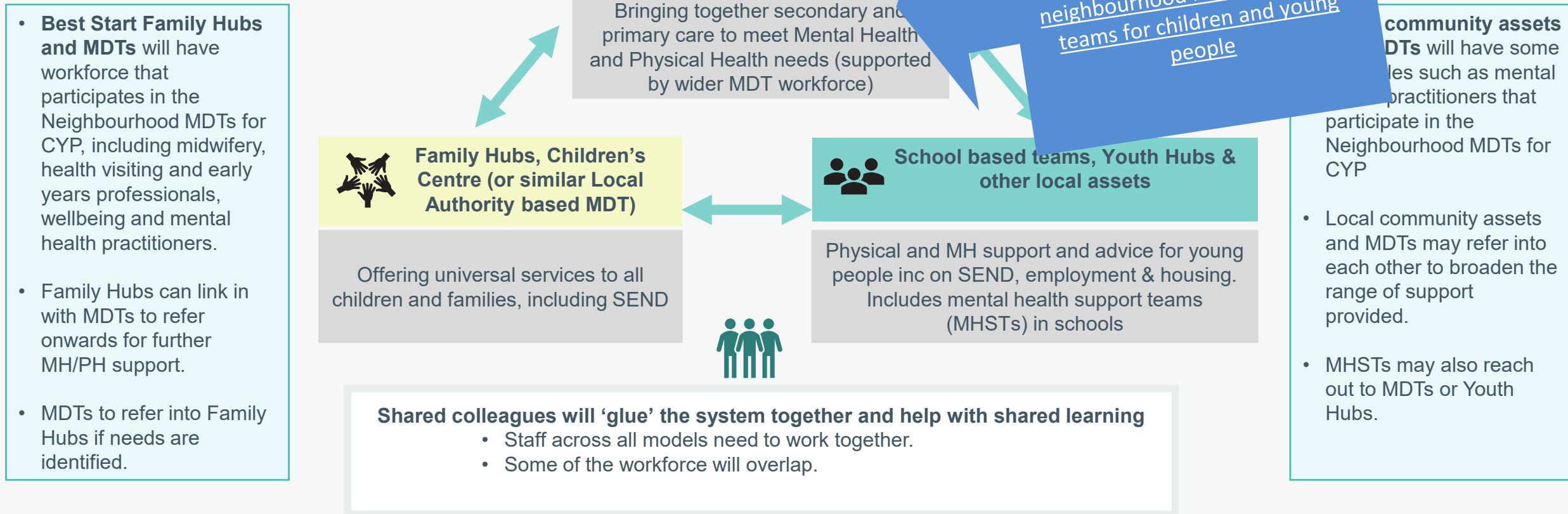
Greater benefits are realised when neighbourhood MDTs are also integrated with wider local services.

*MDTs for CYP, Family Hubs, School-based teams and Youth Hubs have fundamental differences in their function and purpose. Collectively they create a **'Team of Teams'** for children and families to flourish in their neighbourhood.*



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Patient Case Studies

Bringing the policy to life: an example of the benefits of this model

11-year-old child with autism and asthma

Transition to new school challenging - increasing emotional and behavioural difficulties

Deterioration of asthma due to worse treatment adherence

Traditional model

- The GP refers to CAMHS for behavioural support - long wait to receive outcome then referral declined.
- The GP steps up asthma treatment over several weeks but symptoms remain uncontrolled. Eventually, referred to a secondary care waiting list.

Neighbourhood MDT for CYP model

- Individualised plan made in case discussion and triage meeting attended by multiple professionals.
- The mental health professional links in with the family, school nurse and MHST to support managing the emotional and behavioural difficulties at school.
- The GP and paediatrician work together closely to support appropriate management of asthma control in primary care.
- The GP and asthma nurse specialist link in closely with the new school enabling changes in the asthma action plan to be communicated quickly.

Benefits

- Earlier access to appropriate paediatric and mental health intervention, with long waiting lists avoided.
- Support offered closer to home.
- More efficient system navigation.
- Professionals have greater understanding of local referral pathways and thresholds.
- Increased professional coordination to appropriately manage needs in primary care and education settings.

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Care to meets needs - abnormal movements 3y

GP emails Paediatrician:

child with abnormal movements – next steps?

Paediatrician advises:

Parents to video
Check BP
Appointment in 2 weeks at hub clinic

Child deteriorates and is seen in A&E:

Diagnosis made
Anti-epileptic drugs are started

Mother (who has mental health problems and lives in B&B) is supported by GP

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

A flexible pathway – headache 5y

MRI and hospital appointments triggered
by visit to A&E....

But before they happen....

...ongoing care is returned to the GP via
Child Health GP Hub and relationships

Child improves. Hospital appointments are
all cancelled

“Saved the NHS a load of appointments
and the parents a heap of worry. Nice to
see the whole point of this in action!” –
local GP

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

A flexible pathway- infant with eczema

GP asks paediatrician:

2 week baby has extremely dry skin

Strong family history of food allergy
(peanut anaphylaxis)

Should the breast-feeding mother restrict
her diet?

Paediatrician advises:

- Share photos
- Try emollients
- Speak again in a few days

GP replies:

Symptoms settle
Anxiety much reduced

How Child Health Hubs reduce waits

A standard pathway: abnormal blood tests 10y/o F

GP requests an out patient paediatric appointment:

Child with abnormal blood results— is it a sign of more serious disorder?

2 months later child seen in hospital clinic:

- Young Person has repeat blood test at the appointment
- Follow up booked
- Result comes back normal

4 months later child reviewed in hospital clinic:

- No new symptoms
- Another repeat of blood test normal
- Discharged from paediatric follow up

A flexible pathway – using the Hub relationship:

GP contacts Hub Paediatrician:

Young person with abnormal blood results— is it a sign of more serious blood disorder?

Paediatrician reviews in (Hub) clinic:

Paediatrician assesses child and reviews results: reassures likely normal for age & ethnicity

Review with GP recommended for 3 months time

3 months later:

No new symptoms, GP arranges blood tests and discusses results with paediatrician at MDT : all reassured

Parents concerns addressed more quickly, reduced anxiety, management in familiar environment, follow up by GP who knows patient and family well.

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Right person, first time
13 m boy walking on tiptoe on the right

Mother sent **photo and questions on email system** to the GP

2 days later, GP **reviewed child f2f; child was very uncooperative** but GP noted unequal leg length & unequal skin creases

Differential included hip dysplasia, injury, reactive arthritis, septic arthritis, leukaemia, dysmorphic conditions + more

GP emailed (her trusted, neighbourhood) paediatrician for guidance

Clinical discussion led to an agreed plan – **child had hip x ray**

The report confirmed hip dysplasia

GP made a targeted urgent referral to the paediatric orthopaedic clinic. **Definitive orthopaedic plan made at 1st appointment**

“ The most helpful part was being able to contact the paediatrician and relay to the parents that I was in touch with the paediatrician directly to help allay their fears . The child was upset at being brought to the doctor and I did not think waiting in A &E was going to change the management even if hip dysplasia was confirmed” - GP

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Complexity 'held' in General Practice

12 year old girl, background of anxiety, was now refusing to attend school. Known to CAMHS but had not been seen for some time. GP had assessed her and could not find a clear explanation for dramatic escalation in symptoms of lack of energy and fleeting joint pains

At the Child Health Hub, the GP and Paediatrician discussed the case and then organized a consultation with the GP, Paediatrician and the patient with her mother.

A rash was noted that had been present for 5 days.

The Paediatric consultant co-ordinated with A&E, given her extreme anxiety and unusual presentation. The child was admitted. The same consultant was a constant support to the patient and her mother as a diagnosis of Leukaemia was made.

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Social anxiety – school nurse help

“It was good to be able to get perspective from the school” - GP

Mother seeking **psychiatrist / psychologist** input for child's **social anxiety**

Child has also witnessed the death of her grandma but mother noted social anxiety predates the event

Long GP consult; behaviour appeared normal for age

Discussed in MDT

School nurse would follow up

Mental health practitioner advised bereavement support for the family

School nurse rand GP after school parents evening

School noted shy child, doing well, participating fully

School not concerned about anxiety and were supporting for bereavement

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Physical health concern – mental health help

8-year-old boy

“**screaming** all the time” concerned child is in pain

?neurological cause

MH practitioner at MDT asked what **life is like at home**, any big changes?

Child has big transitions in family life at home

School reported being upset and by himself

Child said he hated “life”

Discussed with & **referred to Early Help** to support the family with transitions & understanding children’s reactions to change.

Referral & assessment by **CAMHS Early Intervention Service**

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Physical conditions – also trigger mental health needs

12 year old child, recently diagnosed with serious physical illness, brought to MDT with **low mood** and refusing school

Through discussion, safeguarding issues revealed, **CAMHS** and school nurse led discussion around support

School nurse agreed **to support in school**, therapy team were able to support the child with **therapy**

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

A physical health issue – with mental health antecedents

14-year-old boy, morbidly **obese** brought to MDT for discussion around weight management

Child already under community dietitians. Also **struggling with other factors**, was discussed with MH practitioner and Early Help

Referral made to **CAMHS** with further information discussed in MDT. Family sadly **disengaged** from services but GP can access help with supporting family via CAMHS and Early Help in the MDT

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Supporting social determinant, earlier

Mother with 5 week twins, seeking help from the GP

Poor housing

Concern about mother's mental health and coping strategies

MDT:

Perinatal mental health professional, HV, midwife, early support & GPs attended

CAMHS under 5 and social worker were missing

At the MDT it was revealed that ...

The family had been stepped up to child protection plan from child in need plan

Mental health had discharged, so social prescriber agreed to take over

Housing was stuck. HV offered to visit and get some more data

Care for the 3 other children? Team will look at this and bring back to next MDT

"I am always so surprised, I learn so much from my MDT colleagues, even if they are not directly involved in the case" - GP

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Transition - complex neuro-disability 15y

Child has:

Recurrent pneumonia
Upper airway obstruction
Global delay
Seizures
eczema
Gastrostomy
Multiple drugs

Paediatrician sees with GP : from age 12,
seen 1 x year
in GP Hub clinic

Parent feels confident that GP
understands the case well

GP confident to take role of generalist, into
adulthood

GP says “now I understand how to help
your child

I am your **family doctor**, also here to look
after you and now know what you are
going through”

Benefits

Evidence shows that these models of care reduce outpatient appointments and ED attendance, supporting the government's priorities of reducing the waiting lists and improving waits at A&E. Qualitative feedback also shows benefits and service improvement.

Connecting Care for Children – North West London ICB

The 2015 'Child Health General Practice Hubs: a service evaluation' showed the following results for multi-practice hubs in NW London:

- 39% avoided outpatient appointments
- 22% reduction in A&E attendances
- 17% reduction in paediatric admissions

Child Health Integrated Learning and Delivery System (CHILDS) - Lambeth and Southwark

Comparing health service use for the six months before and after children are discussed in triage, for the individual child there is a:

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

Qualitative feedback from Child Health Integrated Learning and Delivery System (CHILDS) - Lambeth and Southwark

- 70% of GPs feel that the model has improved care for their CYP patients
- 60% of GPs feel that the model has improved their knowledge about child health
- 70% of GPs feel the model has improved access to advice
- 94% of parents would recommend the service to others
- 95% of parents felt the care their child received was good
- 85% of parents felt the time and date of their appointment was convenient

Evidence from more recently established models are also seeing similar reductions in outpatient referrals and a better use of consultant time:



St Austell PCN and Royal Cornwall Hospital Trust

Over the six-month pilot period, 6 MDT clinics were held and 101 patients discussed (mean of 16.8 patients per MDT)

- **57% of referrals** to secondary care were avoided.
- **42% reduction in consultant clinic time/** demand for those discussed in the MDT.
- 80% of those patients who did continue to outpatient referral had either investigations or advancing advice given to be initiated prior to their first appointment that they otherwise would not have.

University Hospitals Bristol and Weston

Over the first 9-month period, 124 patients were seen in a paediatric hub.

- **47% of patients were managed within primary care or required no further input,** avoiding unnecessary outpatient referral.
- **19% were referred to a different specialty,** speeding up the process.
- **Only 6%** of patients needed further general paediatric follow-up.
- Referral rates into general paediatrics from primary care have **started to reduce** since the hub model launched.
- **93% of parents/ carers and patients felt it was helpful** to see the GP and hospital doctor together and were satisfied with the appointment.

Royal Berkshire NHS Foundation Trust

Four GP surgeries working with paediatrics through monthly 1-hour MDTs, 10-15 patients discussed plus monthly face to face teaching sessions. In the year to Dec 2024, 129 cases were discussed.

- **69% (89 cases) of cases were managed within primary care,** avoiding unnecessary outpatient referral.
- **16% were referred to a different specialty,** speeding up the process.
- **35% reduction in average monthly referrals** from GP practices when compared to before commencement of the pilot.
- **39% reduction in formal advice and guidance** requests.

Enablers for success



Passionate first follower and early adopters

Data to support local impact

Building relationships and individuals seeing the benefits first hand

System leadership support, including funding of GPs and administrator

**THINK
BIG**

start small

Discussion

Extras

INTEGRATED CARE DESIGN PRINCIPLES

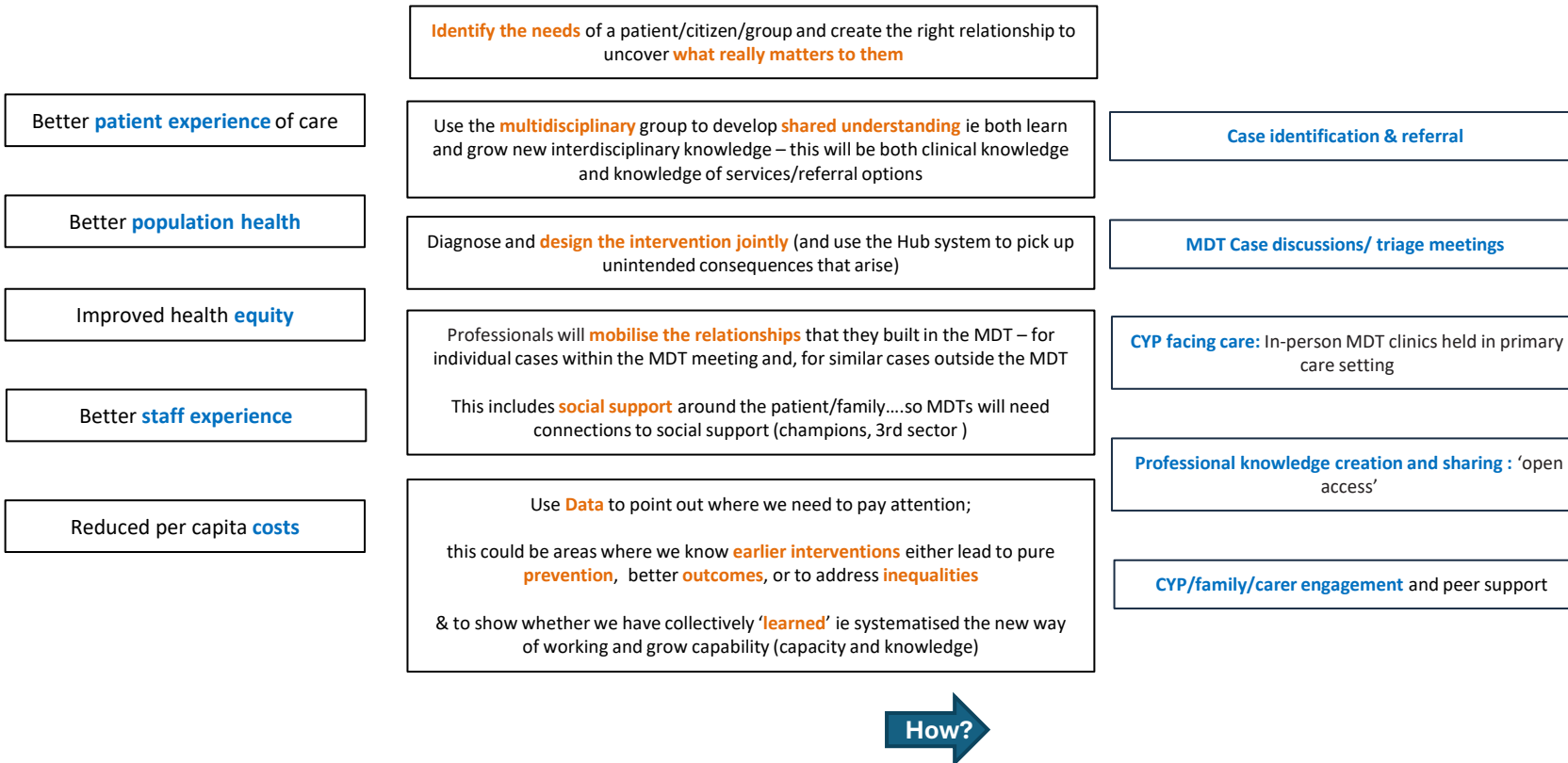
We can't do anything on our own

AIMS, INDICATORS & METRICS

PRINCIPLES IN ACTION

Why?

COMPONENTS OF THE MODEL:



Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Using trusted relationships- 15y with machete

Mother calls GP :

“My son has me in his grip and has a machete in his other hand”

Mother does not want to involve the police

GP calls SW:

Social worker can only intervene if the parent has a health issue

GP informs SW of parental health needs

Social services rapidly respond to meet needs of child and family

Bringing the policy to life: Examples from Connecting Care for Children (NW London ICB)

Health anxiety in the mother

A mum presented with a **2yo child with cold symptoms who was really well**

(the GP sees all children under 5, F2F)

Child safety netted, no signs of serious illness

Presented 3 times to GP in a week, examined, safety netted, reassured +++ each time

then went to **A&E twice** - initially was reassured by them

at next visit **had bloods & cxr (which were normal)**

Mother made a verbal complaint that GP had not managed her child's health correctly and that bloods & cxr were needed to confirm her health.

Next steps

Next steps and support



The national CYP team hosts a quarterly network meeting

And is running a series of '**Lunch and Learns**' to look at specific topic/focus areas in more depth. Sessions are running weekly until Christmas



Email england.cyptransformation@nhs.net to receive diary invites

Please keep in touch!