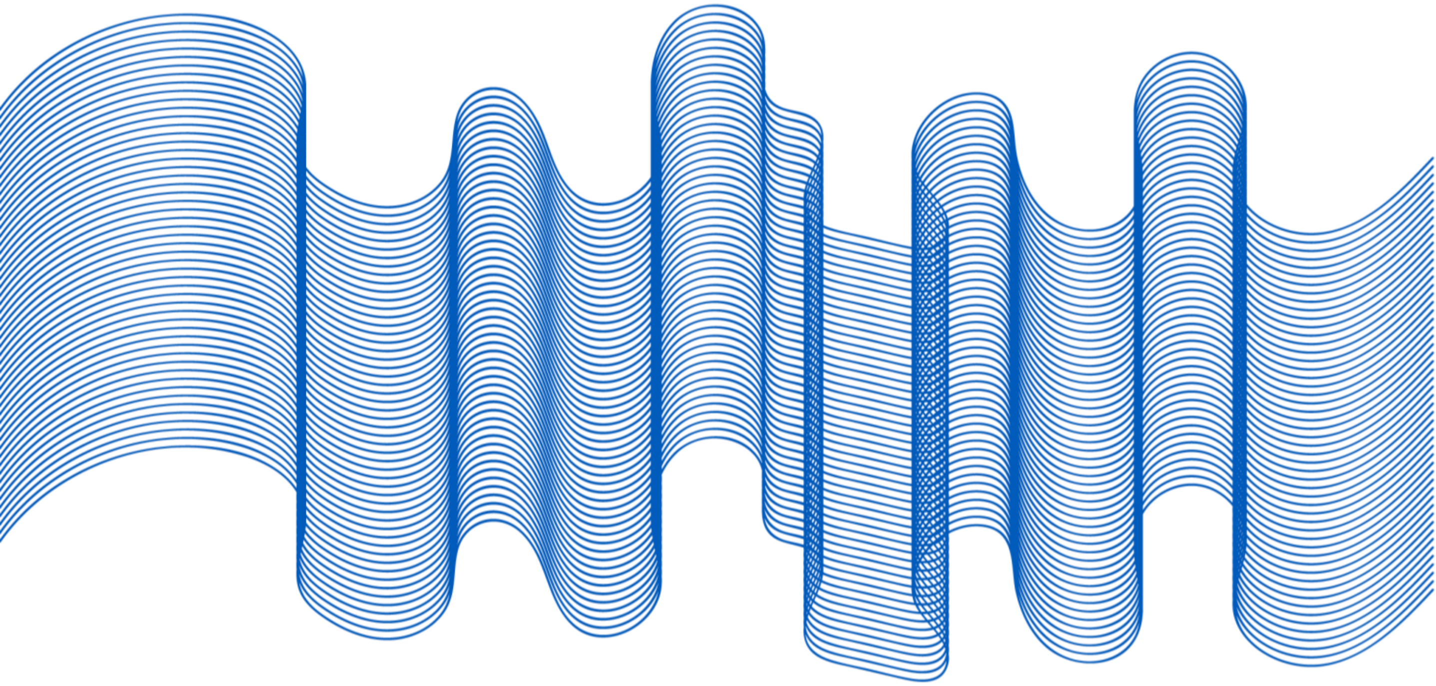
NHS
Benchmarking Network

Transforming Children and Young People's Community Services

A review of community paediatric services in England



Executive Summary

This report summarises key insights into the provision of community paediatrics services across England. The report represents aggregate data for 45 services from 38 organisations for the time period 1st April 2023 to 1st March 2024. This is a service level comparison and compares service totals and averages for a range of metrics.

How long are children waiting?

- The median of average waiting times from referral to first clinical intervention for the paediatrics services was 205 days. This is an increase of 53% compared to the last NHSBN community paediatrics data collection in 2022. 15% of services reported average wait times from referral to first clinical intervention of over a year.
- While follow-up wait times were marginally shorter, the median interval between first and second clinical intervention remains high at 181 days, with some services reporting waits exceeding 300 days.
- In areas with high levels of deprivation, children seemingly progress through triage faster (7 days); however, they appear to experience longer delays in accessing clinical care (270 days) compared to services with middle and low levels of deprivation. The comparison between IDACI scores represents small samples, so would need to be explored further to draw definitive conclusions.
- The longest waits were associated with clinical interventions for ‘Predominantly speech, language and or cognitive delay/disorder’ (384 days), Autism Spectrum Disorder (ASD) (350 days), and Attention Deficit Hyperactivity Disorder (ADHD) (341 days).
    - NB. The waiting times by service conditions had relatively low response counts due to services reporting it not possible to proportion wait times and number of children on wait lists, by the provided categories.

What are the factors impacting wait times for community paediatric services?

Variation in service models & limited extended hours provision:

- The scope of support delivered by the community paediatric service is broad, with 78.4% of respondents selecting they provided "other“ support beyond the 11 provided categories.
- Extended weekday hours are not currently offered by any of the responding services, and only 13.9% provide support during weekends. This highlights limited out-of-hours provision across the services, which may restrict service availability, contributing to longer wait times.
- Some services reported difficulty with the lack of a standard definition for a community paediatric service and the scope of services it includes.

Increase in referrals & a decrease in referral acceptance rate:

- In 2024, on average, for community paediatric services the median of referrals received per 100,000 population served was 65% higher (3,458) than the next highest children's community service benchmarked by NHSBN, speech and language therapy (2,093 referrals). Noting the composition and size of the sample for the two services differed.
- The median referral acceptance rate has decreased by 10 percentage points (pp), since the last NHSBN community paediatrics data collection in 2022, from 92% to 82% in 2024. Noting the sample varies between 2022 and 2024.
- A large referral volume alongside lower acceptance rates could suggest rising demand or possible increase in inappropriate referrals, which places additional strain on services.

Executive Summary

What are the factors impacting waiting times for community paediatric services? (cont.)

Complex, high volume caseloads:

- The median of the proportion of referrals for Education, Health and Care Plan (EHCP) advice was 17.8%. This proportion varied considerably across services, with some reporting that up to 48% of referrals were related to EHCP advice, indicating that certain services are experiencing a disproportionate demand for EHCP assessment support.
- Only 31.3% of responding services reported meeting the target of conducting the initial health assessment (IHA) within 20 days after a child is taken into care. The most commonly citied reason for delays was late notification from the local authority. The median of the average time to complete the IHA was 30 days, with 30% of services reporting average completion times exceeding 40 days.
- Caseloads remained high, the median caseload in 2022 was 296 users per clinical WTE in establishment and 233 in 2024. Noting sample composition and size varied between years.
- The median of the average time on the service's caseload was nearly 18 months, with the median ratio of service users added to service users discharged at 1.26, showing that on average caseloads have grown across the year.
- High caseloads and extended lengths of service intervention together indicates a limited capacity to accommodate new referrals, which may lead to longer wait times.

Workforce skill mix and availability:

- Non-clinical staff accounted for the highest average proportion of the workforce (28.4%), followed by medical staff (24.9%), AHPs (21.3%), and registered nurses (16.1%). Among medical staff, on average, 66.1% were consultants and 24.9% were career grade clinicians. As of 31st March 2024, there were no F1 or F2 doctors reported in the medical workforce of the project sample.
- The median of clinical staff vacancy was 7.5%, with 25 services reporting vacancy, five no vacancy and four over-establishment.
- Workforce composition and vacancy may impact the capacity required to meet demand.

Socioeconomic deprivation levels:

- Within this report, services have been peer grouped by those that have low, middle or high Index of Deprivation Affecting Children (IDACI) scores. Consequently, the sample sizes for each IDACI score is low, so any trends may reflect this small sample and must be considered when interpreting the report. It is of interest to note:
    - Compared to areas of middle or low deprivation, high IDACI areas averaged the highest number of referrals (5,202 per 100,000 population served) and the lowest referral acceptance rate (79.8%). They also had the largest number of children on waiting lists (1,773), the lowest clinical WTE per 1,000 on the caseload (2.4), and the highest WNB rate (9.4%), which may indicate barriers for more deprived communities.

Waiting times in community paediatrics appear to be influenced by factors such as high referral volumes and limited clinical staffing.

Contents

Introduction

This report contains key findings for the community paediatric service from the NHS Benchmarking Network's (NHSBN) Transforming Children and Young People's Community Services: Community Paediatrics data collection.

The community paediatrics data collection received data from 38 organisations representing 45 services across England. The data within this report represents the period of 1st April 2023 to 31st March 2024. The full selection of metrics can be found in the online toolkit on the NHSBN website.

Throughout the report, bar charts have been colour-coded into three categories relating to the Income Deprivation Affecting Children Index (IDACI). IDACI score measures the proportion of all children aged 0 to 15 living in income deprived families and can be used as a relative measure of socioeconomic deprivation for children aged 0-15 in a local area. The sample sizes for each IDACI score is low, so any trends may reflect this small sample and must be considered when interpreting the report. The IDACI score was categorised according to the following criteria:

IDACI score	IDACI category		Indication
Between 0-0.15	Low	🟦	Indicates lower levels of socioeconomic deprivation affecting children aged 0 to 15
Between 0.16-0.21	Middle	🟦	Indicates medium levels of socioeconomic deprivation affecting children aged 0 to 15
0.22 and above	High	🟦	Indicates higher levels of socioeconomic deprivation affecting children aged 0 to 15

The map below illustrates the geographical spread of submitting organisations:

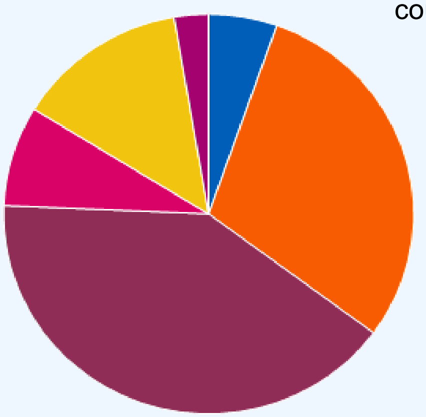
What is the scope of the community paediatric service?

Responses on the community paediatric service model displayed high levels of variation in commissioning arrangements, integration with other services, and the types of support provided by community paediatric teams.
Participants reported some confusion regarding a standard definition of a children's community paediatric service. Considerable variation in service models and levels of support highlights the complexity and diverse nature of service delivery in England.

- The majority of community paediatric services reported serving the 0-19 age group (40.5%), while an additional 13.5% extended this, from 19, to include young people aged 0-25 who have an Education, Health and Care Plan (EHCP).
- None of the responding services reported offering extended service hours between Monday and Friday, and only 13.9% reported services were available on weekends. Limited out-of-hours provision may restrict access for some families such as working families, potentially leading to missed appointments and delayed care.
- According to 2024 NHSBN data, community paediatrics had the highest reported weekend service provision compared to the following children's community services; physiotherapy (0%), occupational therapy (3.4%), dietetics (4.8%), and speech and language therapy (8.8%). Noting sample composition and size varied between the service types.

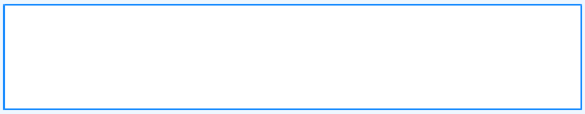
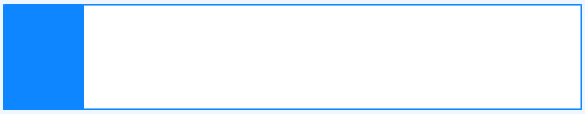
Age group served (%)

Response count = 37



		Mean (%)
0-16	🟦	5.4%
0-18	🟧	29.7%
0-19	🟫	40.5%
0-18 or 0-25 with EHCP	🟥	8.1%
0-19 or 0-25 with EHCP	🟨	13.5%
Other	🟪	2.7%

Access to 7-day services

	0% 100%	Yes (%)	Response Count
Are services available for extended hours during the week?		0%	36
Are services available for additional weekend hours?		13.9%	36

What is the scope of the community paediatric service?

Who is the service commissioned by?

	0% 100%	Yes (%)	Response Count
ICB		97.4%	38
Local Authority		18.9%	37
NHS		32.4%	37
School(s)		2.7%	37
Other		0.0%	34

Community paediatric services were primarily commissioned by Integrated Care Boards (ICBs), though some services also reported being commissioned by Local Authorities (LAs), NHS and schools. Showing multiple or joint commissioning arrangements.

Narrative responses for “Describe how your community paediatric service is commissioned” have been summarised below*:

Who are the main commissioners?	• Predominantly ICBs.
What is the predominant commissioning type?	• Mostly via block contracts. • Some service specifications are jointly written with ICBs.
What is within the scope?	• Covers children and young people (CYP), typically aged 0–19. • Some services specific to children under 5 or transitioning to adult services.
Are there examples of joint commissioning?	• LA’s involved in commissioning services for: - Children Looked After (CLA) - Special schools and SEND pathways
Additional notes	• Some services receive HEE (Health Education England) funding for training.

* A full list of narrative responses can be found in the Appendix.

What is the scope of the community paediatric service?

Support for ‘Development Delay, unspecified’ had highest number of services reporting they provided it at 100%, while the lowest number responding ‘yes’ was for ‘Palliative & End-of-Life care’ (37.1%), as well as ‘Continence’ services (38.9%). Notably, 79.4% of respondents said their service included ‘Other’ types of support, indicating that the listed service conditions may not be fully representative.

Is support provided?	0% 100%	Yes (%)	Response count
Developmental Delay, unspecified		100%	37
Predominantly motor delay/disorder		97.3%	37
Complex health needs		97.3%	37
Complex Neuro-disability		97.3%	37
ASD assessment		94.4%	36
Neurodiversity; unspecified		91.9%	37
Other		79.4%	34
Predominantly speech, language and or cognitive delay/disorder		77.8%	36
Non-neurological health conditions		70.3%	37
ADHD assessment		60.5%	38
Continence		38.9%	36
Palliative & End of Life care		37.1%	35

What is the scope of the community paediatric service?

When asked what types of support were included within the ‘Other’ category, the most frequently cited topic was support for Looked After Children (LAC), through Initial Health Assessments (IHAs) and services related to supporting fostering and adoption, often involving fostering or medical advisor roles.

Other types of support included:

- Safeguarding and child protection
- EHCP, SEND and special needs assessments
- Epilepsy

Below is a summary of narrative responses outlining how community paediatric services interact with other healthcare providers*

How do you work with acute paediatric specialists, general practioners (GPs) and other providers?

- Acute paediatric specialists
  - **Trust integration:** Some community paediatric services report being under the same Trust as acute paediatric services, allowing for easier referrals, shared electronic records and multidisciplinary teams (MDTs).
  - **Joint clinics:** For complex care pathways (e.g. epilepsy, neuro disability, neurology).
- General practitioners (GPs)
  - **Shared care agreements**: In particular for ADHD medications and melatonin prescribing.
  - **‘Advice & Guidance’ support:** Consultation with GPs to support case relevance in primary care.
  - **Training**: Communications post-appointment, training GPs or inviting them to joint clinics.
- Other providers
  - **Education providers:** Schools and SENCO were often mentioned as part of the referral and assessment processes.
  - **Local authorities**: Particular mention for services involving SEND, adoption, fostering and home adaptations.
  - **Mental Health services (CAMHS)**: Mixed responses surrounding collaboration, some reported successful joint working whilst others commented on poor communication.
  - **Voluntary and community services**: Families are often signposted to support services during wait times.

Do you have a service level agreement (SLA)?

- Most responses do not mention having a formal SLA with acute services, GPs or other providers unless it’s for specifically funded roles or shared clinics.

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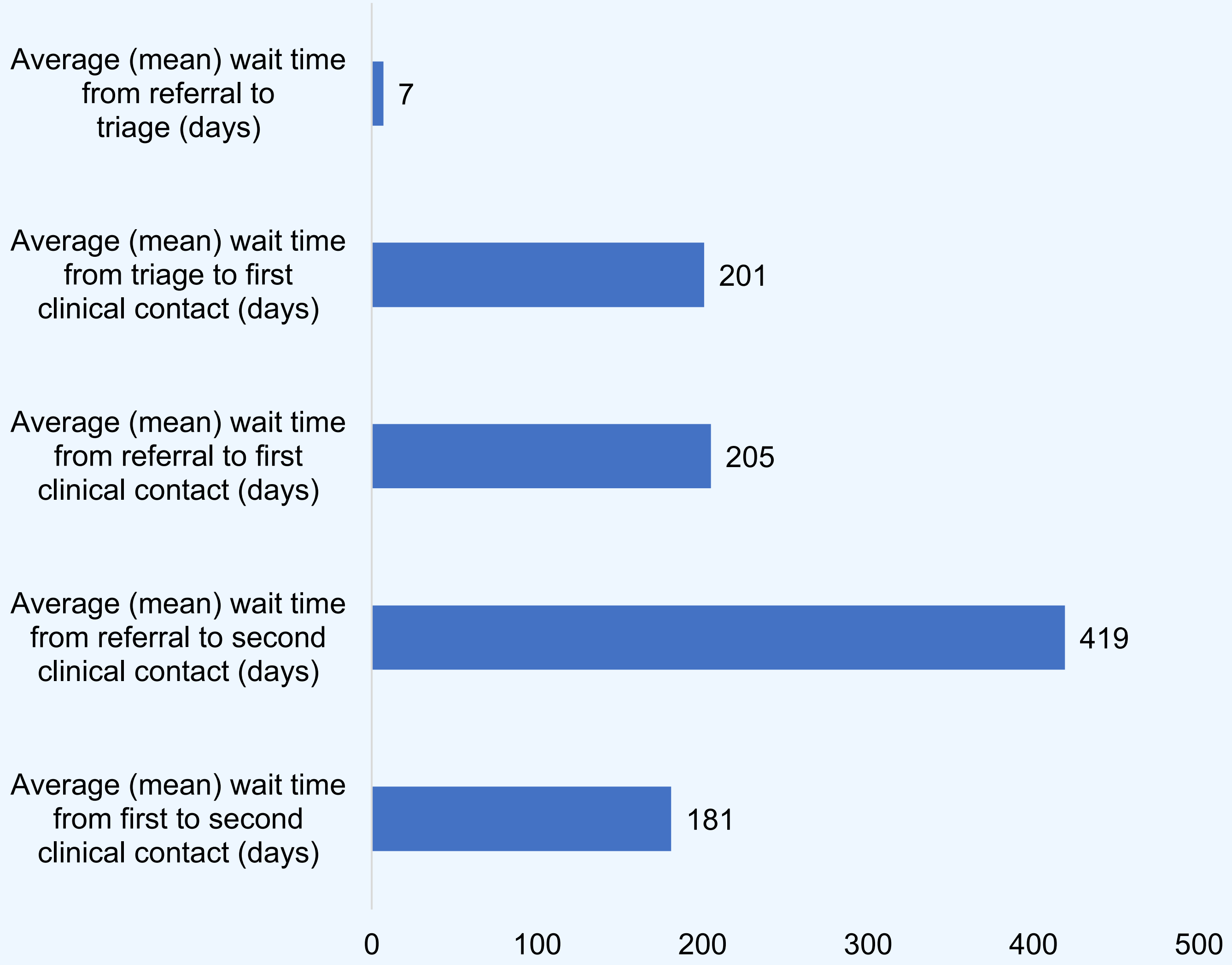
* A full list of narrative responses can be found in the Appendix.

How long are children waiting for access to community paediatric services?

Summary of median waiting times for community paediatric services (days):**



All responding services (100%) confirmed their community paediatric service routinely triages new referrals before clinician contact. When asked about the method of triage, 47.1% reported using the Electronic Referral System (ERS), 11.8% indicated reliance on a paper-based system, and 41.2% selected “Other”.

The median of the services mean waiting times was 205 days from referral to initial clinical contact. This is followed by a further median wait of 181 days for a follow-up or second clinical intervention. Long waits for community paediatric services could delay diagnosis and reduce the effectiveness of early intervention strategies. The median waiting time from referral to first clinical intervention has increased by 53% compared to when data was last collected in 2022, from 118 days to 181 days*. The spread of the data for each of the bars can be found in the subsequent pages.

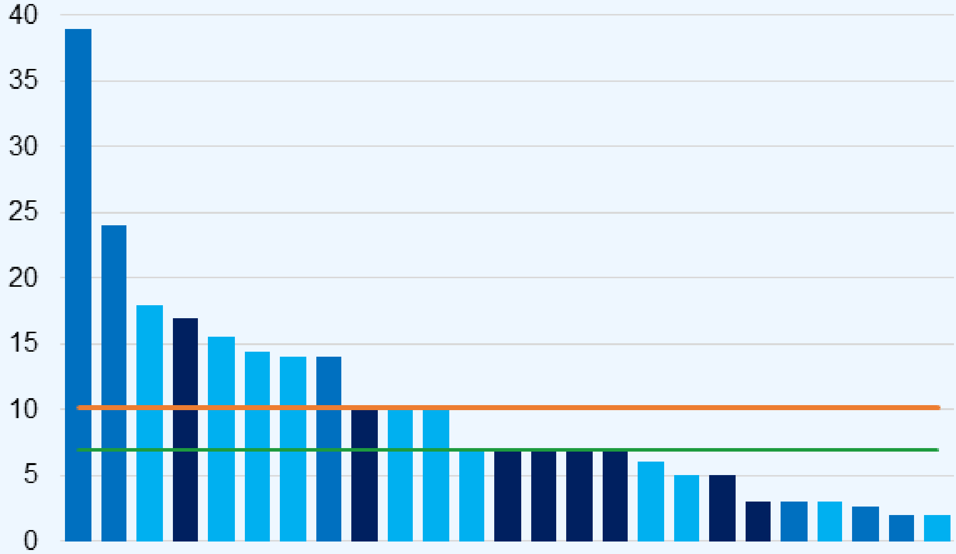
*It is important to note that the sample sizes between collections vary making the data more sensitive to variability.

**For this metric the median value of a mean is being displayed.

How long are children waiting for access to community paediatric services?

Mean waiting time for referral to triage (days)

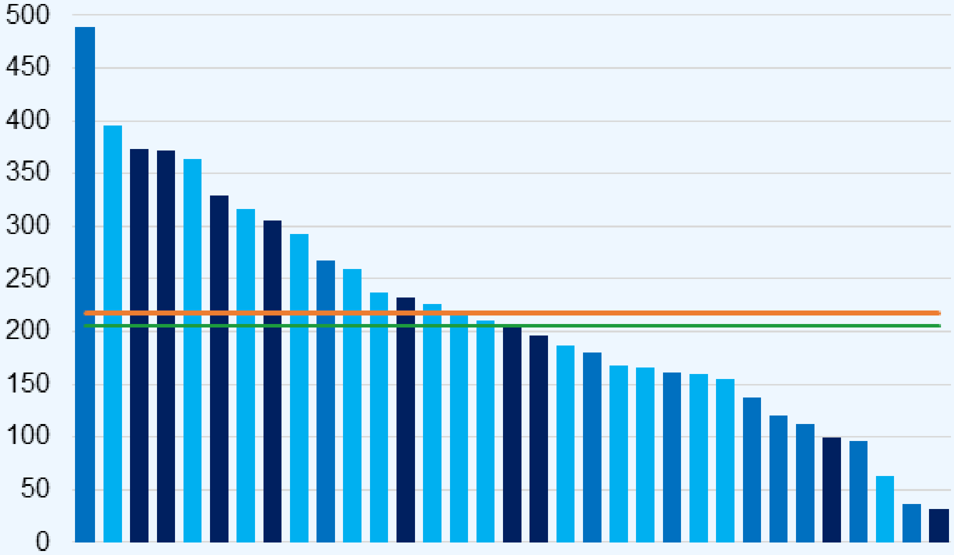
Response count = 25



Mean	10.1
Median	7.0
Low IDACI Median	10.0
Middle IDACI Median	8.5
High IDACI Median	7.0

Mean waiting time for referral to first clinical contact (days)

Response count = 33



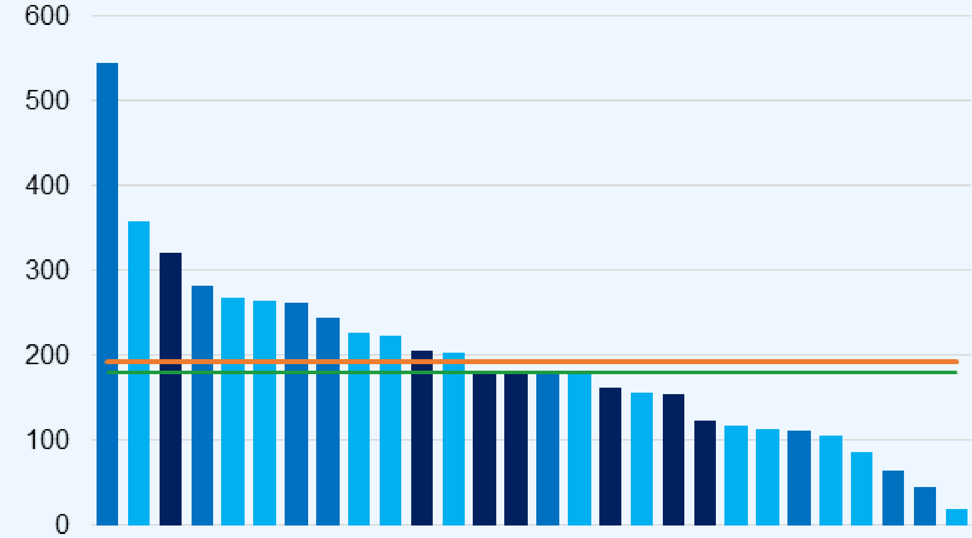
Mean	217
Median	205
Low IDACI Median	222
Middle IDACI Median	150
High IDACI Median	270

The reported average waiting times varied between 2 and 39 days from referral to triage and between 31 and 489 days from referral to first contact with a clinician. In over a third of responding services, the average wait time is 250 days or more for initial clinical intervention. Though small samples, it is interesting to see that services with higher income deprivation levels (high IDACI scores) had a median shorter wait from referral to triage (7 days) but longer median wait from referral to first clinical contact (270 days), than those with low or middle IDACI scores. As the charts show, the data for IDACI scores is quite variable and the sample too small to draw conclusions, so exploring the links between deprivation and waiting times might prove insightful as a further piece of work.

How long are children waiting for access to community paediatric services?

Mean waiting time from first clinical contact to second clinical contact (days)

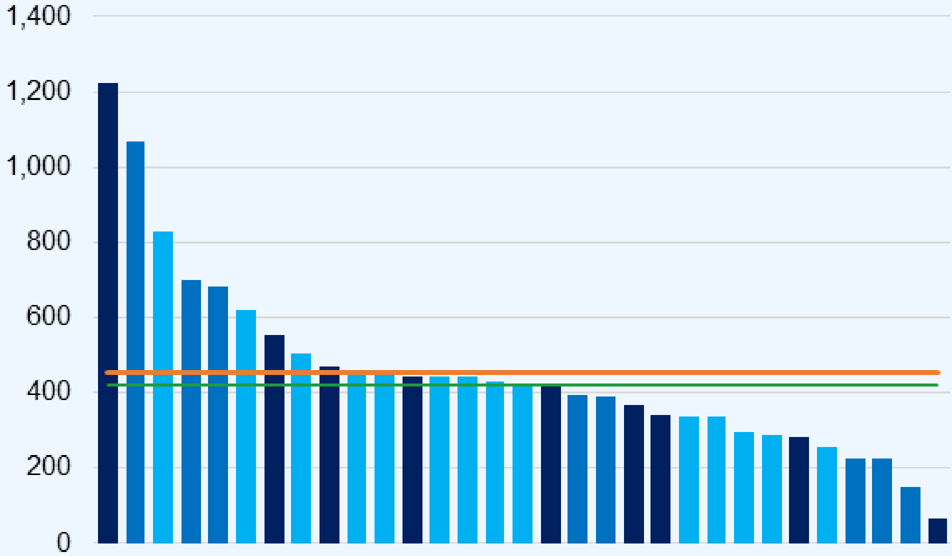
Response count = 28



Mean	193
Median	181
Low IDACI Median	192
Middle IDACI Median	245
High IDACI Median	182

Mean waiting time from referral to second clinical contact (days)

Response count = 31



Mean	455
Median	419
Low IDACI Median	441
Middle IDACI Median	394
High IDACI Median	430

Overall, services are reporting shorter mean waits for follow-up appointments (median wait time 24 days less) than for their first clinical intervention. However, there is variation in follow-up wait times, ranging from 19 days up to almost 1.5 years (544 days), highlighting potential inconsistencies in access to care.

The median for average service wait time from referral to the start of ongoing clinical support for community paediatric services was 419 days, with reported values varying from 64 days to over three years. Such prolonged waiting periods risk may negatively impact timely access to support.

How long are children waiting for access to community paediatric services?

When asked if services were able to report average waiting time in days from referral to first clinical contact for the service conditions listed, 18 of 36 respondents said “No” (50%).

Reported challenges in separating this data are listed below:

- “Inability to disaggregate patients beyond ASD and ADHD”
- “Historically, it has been challenging to collect consistent data across community services due to the absence of standardised guidelines and established reporting procedures”
- “Transition issues in the electronic patient record system”

Of those who were able to separate waiting time data, ‘Predominantly speech, language and cognitive delay’ had the highest median wait time at 384 days however, response count should be considered here. This was followed by ASD and ADHD assessments at 350 days and 341 days, respectively.

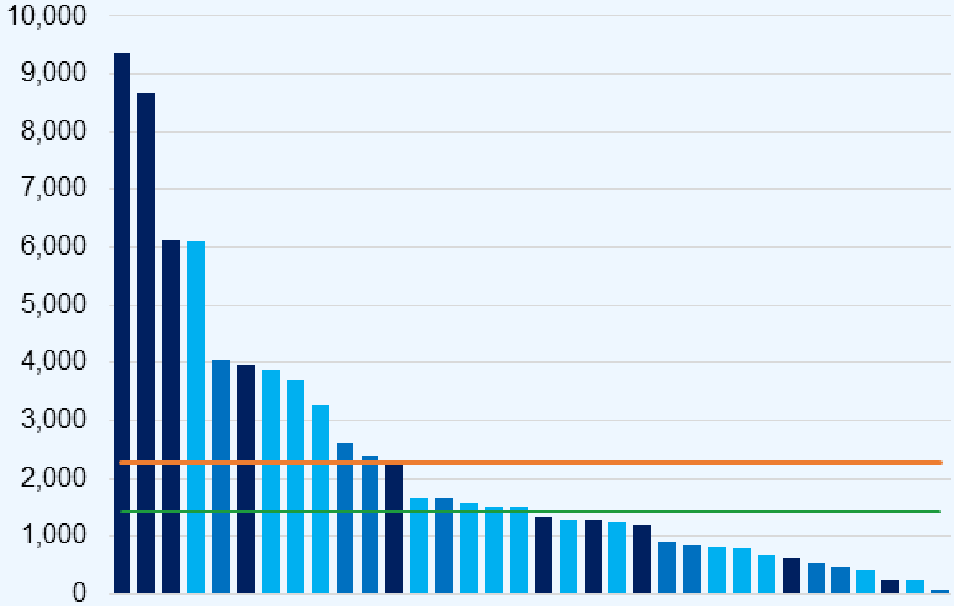
Mean referral to first clinical contact waiting time (days) by service condition

Service condition	Median	Mean	LQ	UQ	Response count
Predominantly speech, language and or cognitive delay/disorder	384	336	194	430	4
ASD assessment	350	398	248	471	17
ADHD assessment	341	401	294	395	11
Developmental Delay, unspecified	293	291	150	395	11
Neurodiversity; unspecified	249	255	152	371	7
Non-neurological health conditions	217	220	95.3	349	4
Predominantly motor delay/disorder	214	201	12	383	5
Complex Neuro-disability	158	206	84	371	7
Continence	112	133	94	193	9
Complex health needs	105	145	25.8	305	4

* Palliative & End of Life Care: response count = 1, too low to report data.

How long are children waiting for access to community paediatric services?

Total number of service users on the waiting list at the end of the year (31/03/2024)



Response count = 34

Mean	2,271
Median	1,423
Low IDACI Median	1,520
Middle IDACI Median	912
High IDACI Median	1,773

The median number of children on the service waiting list was 1,423, 157% higher than when the data was previously collected in 2022, for 31/03/2022 (552). Noting the sample composition and size varies between these two years. Looking at the spread of IDACI scores for the services shows a cluster of high IDACI score services with the largest waiting lists. Again, the sample is too small to draw definitive conclusions, but exploring in more detail the link between deprivation and access could prove a very informative next step.

A narrative question was asked to explore initiatives services are employing to reduce service waiting lists. The key themes identified are outlined below**.

Service transformation and pathway re-design

- Streamlining referrals, triage and assessment processes.
- Introducing single entry points and integrated care pathways.
- Shifting appropriate work from consultants to nurses, pharmacists and other professionals.

Capacity and workforce innovation

- Weekend and Saturday clinics.
- Skill mix models using non-medical professionals (nurse specialists and peer workers).
- Using community pharmacists and GPs to manage stable cases.

Active waiting list management

- Regular validation of waiting lists.
- Use of patient tracking lists and opt-in appointment systems.
- Patient-initiated follow-up to reduce unnecessary appointments.

*It is important to note the small sample sizes in IDACI groupings, so care must be taking when comparing these services.

** A full list of narrative responses can be found in the Appendix.

How long are children waiting for access to community paediatric services?

When asked if services could proportion the number of service users on the waiting list by the provided service conditions, 20 of 38 respondents said “No” (52.6%).

The highest median number of service users on the waiting list was observed for ASD and ADHD assessments, at 489 and 414, respectively. There was notable variation in the submitted data with the waiting list entries for ASD assessments ranging from 55 to 3,259 service users, and for ADHD assessments from 67 to 3,209 service users. There were also different response counts for each service condition, which should be considered when evaluating the data.

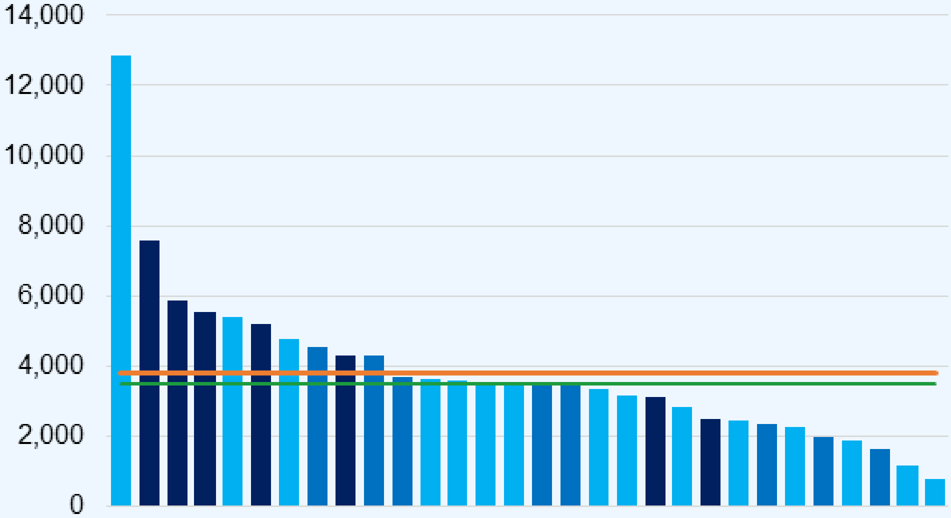
Number of service users on the waiting list for support by service condition

Service condition	Median	Mean	LQ	UQ	Proportion of waiting list by service condition (%)	Response count
ASD assessment	489	873	307	1,008	36.1%	15
ADHD assessment	414	952	119	2,559	33.1%	11
Predominantly speech, language and or cognitive delay/disorder	120	456	3.75	1,243	10.6%	4
Developmental Delay, unspecified	98	509	71.5	273	18.9%	9
Neurodiversity; unspecified	82	124	72	257	10.7%	7
Continence	79	75.9	14	123	2.9%	10
Non-neurological health conditions	37	153	7	415	3.1%	4
Predominantly motor delay/disorder	21	100	0	280	2.7%	4
Palliative & End of Life care	17	39	0	100	1.1%	4
Complex health needs	9	347	2.25	1,031	6.4%	4
Complex Neuro-disability	6	11.3	2	6	0.5%	7

What is impacting waits for community paediatric services?

Total referrals received per 100,000 population served

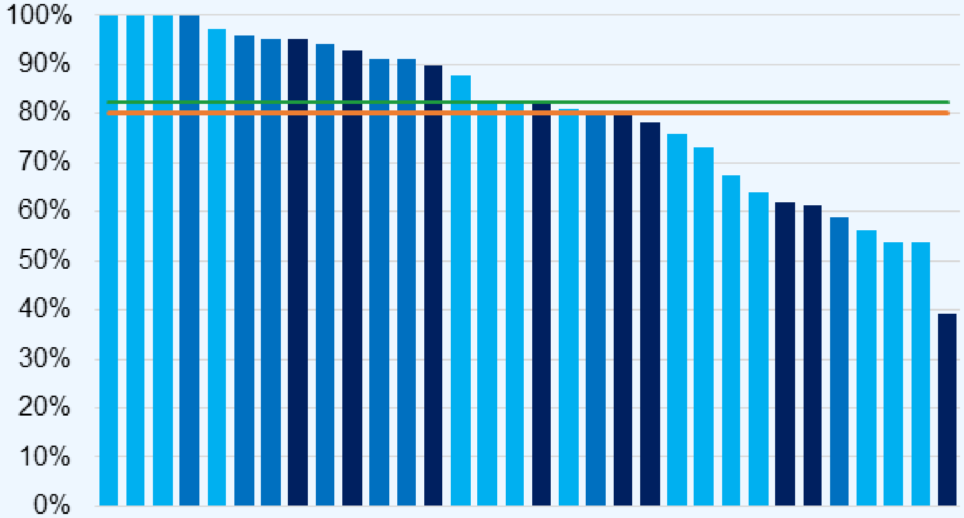
Response count = 30



Mean	3,807
Median	3,458
Low IDACI Median	3,256
Middle IDACI Median	3,434
High IDACI Median	5,202

Referral acceptance rate (%)

Response count = 32



Mean	80.1%
Median	82.2%
Low IDACI Median	81.7%
Middle IDACI Median	92.8%
High IDACI Median	79.8%

In 2024, the median referrals of received by participating community paediatric services was 65% more referrals per 100,000 population than the next highest children's community service, speech and language therapy (2,093 referrals)*, according to NHSBN data. High referral numbers can increase waiting times by creating demand that exceeds service capacity.

Services with higher IDACI scores appeared to have a higher number of referrals per 100,000 population served but a lower referral acceptance rate (79.8%), compared to areas with middle or low scores**. Since the last NHSBN community paediatrics data collection in 2022 (representing 01/04/21-31/03/22), the average referral acceptance rate has decreased from 92% to 82% in 2024*. Low referral acceptance rates may indicate service capacity limitations, where demand exceeds available resources, or reflect issues with referral quality.

*It is important to note the sample size and services in the sample varies, so much be considered when interpreting these findings.

**It is important to note the small sample sizes in IDACI groupings, so care must be taking when comparing IDACI scores.

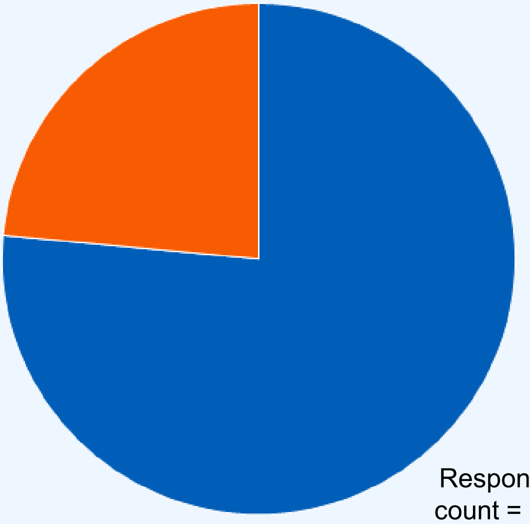
What is impacting waits for community paediatric services?

NHS England lists the following key benefits of the implementation of shared care records:

- Improved access to complete and up-to-date patient information.
- Enhanced visibility of safeguarding alerts and patient wishes.
- Streamlined processes to reduce repetitive information sharing.

It is encouraging to see that over three-quarters of responding community paediatric services (76.5%) reported having access. Access to shared care records can reduce waiting times by improving efficiency around information gathering, enabling quicker and more accurate assessments.

Do you have access to a shared care record (%)

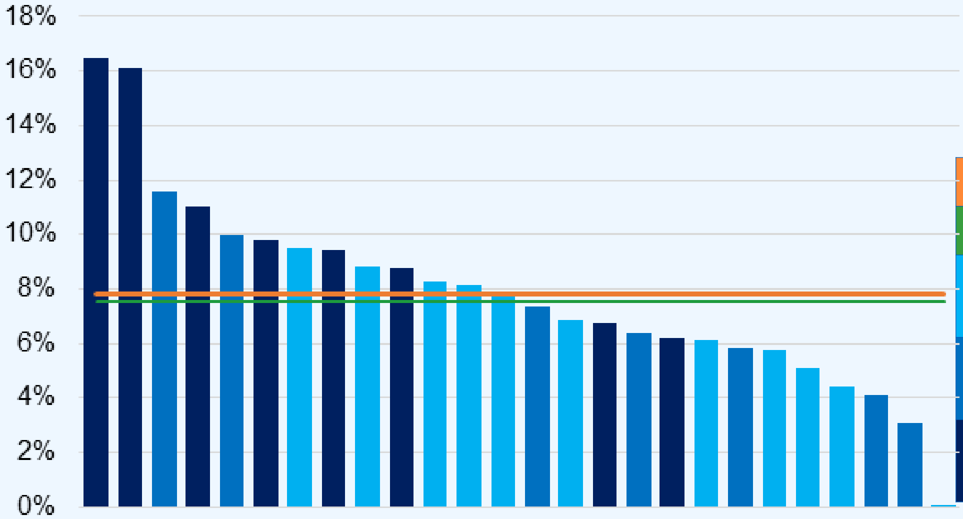


Response count = 34

Yes (%)	🟦	76.5%
No (%)	🟧	23.5%

Did not attend/was not brought rate (DNA/WNB) (%)

Response count = 26



Mean	7.8%
Median	7.6%
Low IDACI Median	6.5%
Middle IDACI Median	6.4%
High IDACI Median	9.4%

High WNB (DNA) rates reduce service efficiency by disrupting clinic flow and limiting the number of children assessed within a given timeframe. Services with higher IDACI scores are clustered towards the top of the chart for higher WNB (DNA) rates than those with low and middle scores, suggesting that families in more disadvantaged communities may face greater barriers to accessing community paediatric services*.

Notably, NHSBN data from 2022 shows that the average WNB rate for community paediatrics increased by 0.7 percentage points (pp), rising from 6.8% to 7.6% in 2024*.

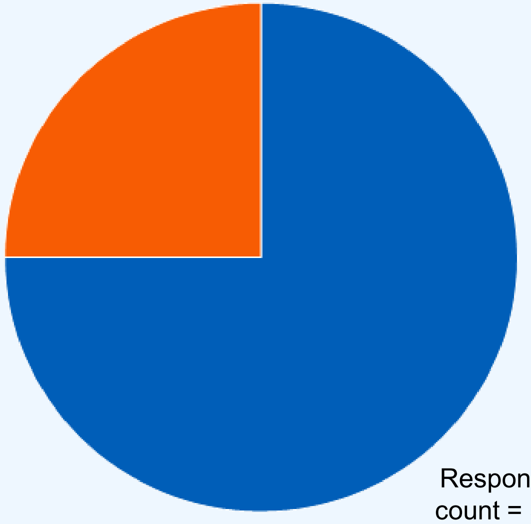
*It is important to note the small sample sizes in IDACI groupings, so care must be taking when comparing IDACI scores

What is impacting waits for community paediatric services?

The NHS Standard Contract 2024/25 states that, where local authorities request a provider's cooperation in securing an EHC assessment, the provider must use all reasonable endeavours to comply within six weeks of the request. Encouragingly, 75% of respondents reported achieving this six-week target. However, while 32 services responded to the binary question confirming compliance, only 22 were able to provide the average response time in weeks, suggesting potential inconsistencies in how this data is recorded or stored across systems.

Services with ‘middle’ level IDACI scores has a seemingly shorter average response time for EHCP advice, despite also receiving the highest number of EHCP referrals per 100,000 population served*. Further exploration into deprivation, and comparison of a larger sample is required to fully understand the pattern being shown.

Are you able to respond to EHCP advice requests within the recommended 6-week timeframe?

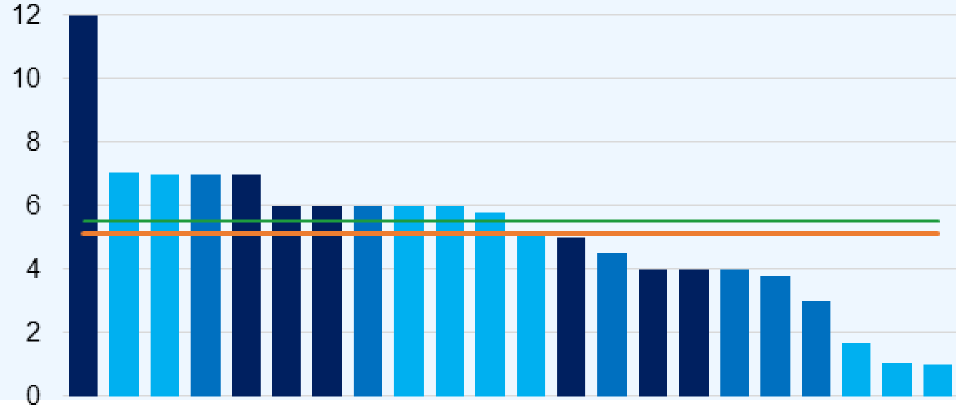


Response count = 32

Yes (%)	🟦	75%
No (%)	🟧	25%

Mean response time for EHCP advice (weeks)

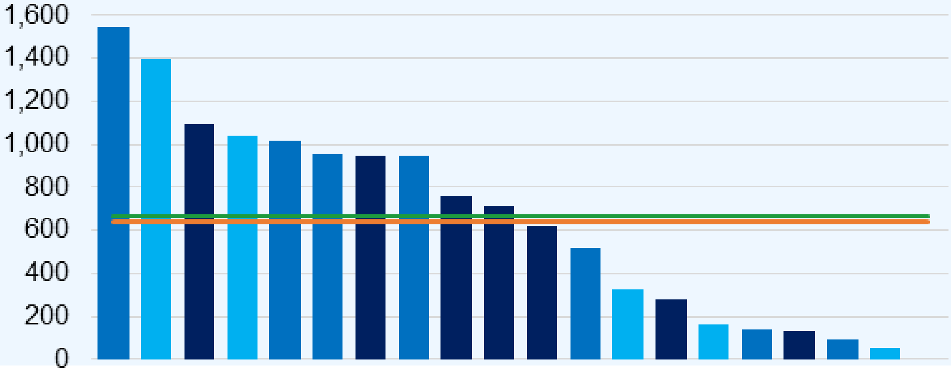
Response count = 22



Mean	5.1
Median	5.5
Low IDACI Median	5.9
Middle IDACI Median	4.3
High IDACI Median	6

Total EHCP advice referrals received per 100,000 population served

Response count = 20



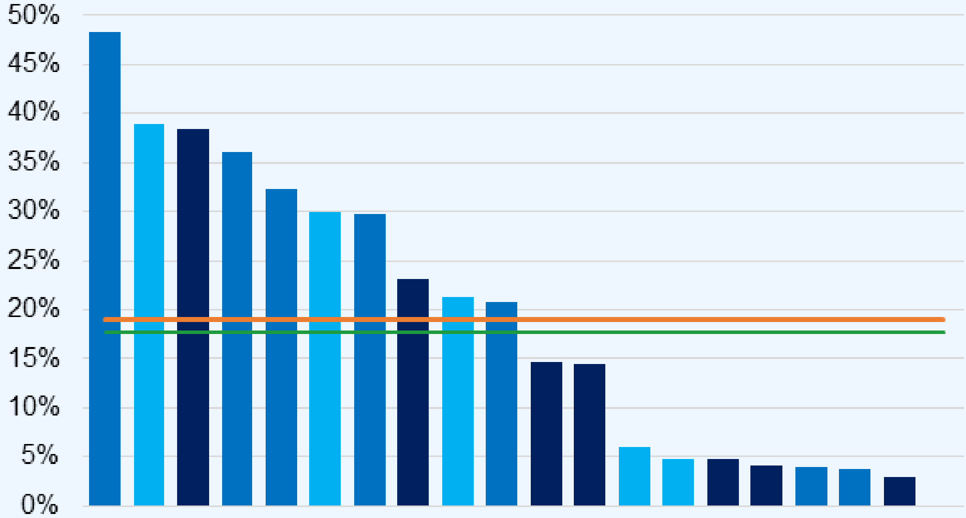
Mean	637
Median	668
Low IDACI Median	164
Middle IDACI Median	943
High IDACI Median	717

It is important to note the small sample sizes in IDACI groupings, so care must be taking when comparing IDACI scores.

What is impacting waits for community paediatric services?

Percentage of referrals received that were for EHCP advice (%)

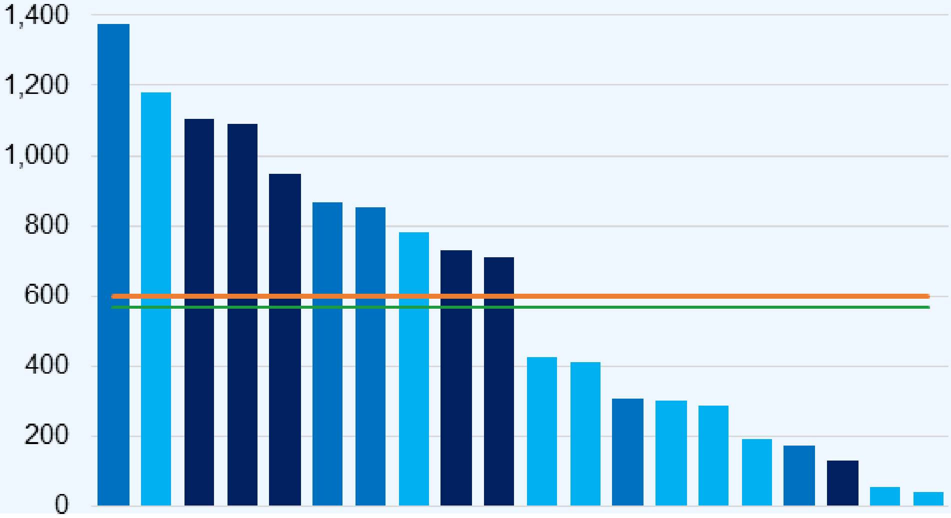
Response count = 20



Mean	18.9%
Median	17.8%
Low IDACI Median	6.0%
Middle IDACI Median	29.8%
High IDACI Median	14.6%

Number of assessments performed in support of an EHCP application per 100,000 population served

Response count = 20



Mean	598
Median	567
Low IDACI Median	357
Middle IDACI Median	851
High IDACI Median	839

There is variation in the proportion of all referrals related to EHCP advice, ranging from 0% to 48%. Similarly, the number of assessments conducted in support of an EHCP application per 100,000 population served varies considerably (from 40.1 to 1,376) suggesting that some services are being disproportionately affected by the demand for EHCP assessment support.

A higher volume of children requiring EHCP support places can increase clinical demands on services, as these assessments are resource-intensive and often require a coordinated, multi-disciplinary approach. This additional demand can divert capacity from other assessments, which may contribute to longer service wait times.

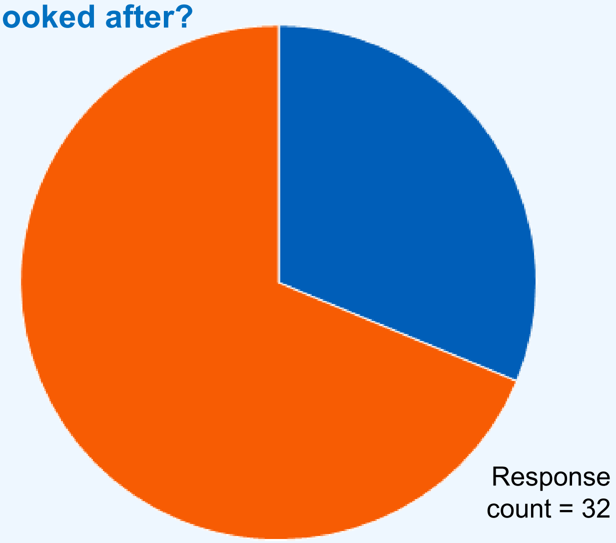
What is impacting waits for community paediatric services?

Procedures and guidance outlined by LAs and NHS trusts state that Initial Health Assessments (IHAs) should be performed within 20 days of that child being taken into care. Only 31.3% of responding services confirmed that this target was being met.

Narrative responses explaining instances of non-compliance were collected and are summarised below ranked in descending order of frequency:

- Late notification from the LA.
- Lack of doctor time and time allocated in job plans.
- Vacancy within the service.
- An increased number of Unaccompanied Asylum-Seeking Children (UASC) seeking care.

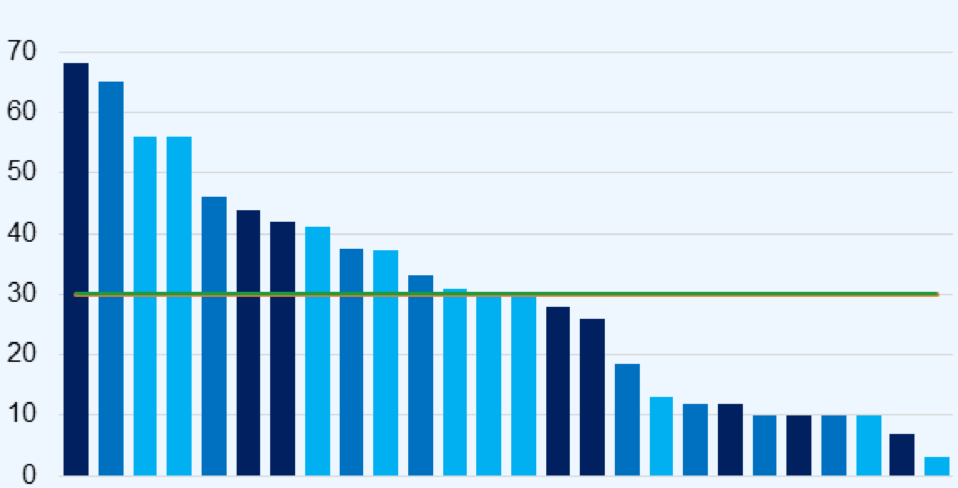
Was the service compliant with conducting initial health assessments within 20 days of a child becoming looked after?



Yes (%)	🟦	31.3%
No (%)	🟧	68.8%

Mean time for conducting an initial health assessment following a child becoming looked after (days)

Response count = 26



Mean	29.9
Median	30.0
Low IDACI Median	31.0
Middle IDACI Median	33.0
High IDACI Median	27.0

The median of the services average time taken to conduct an IHA exceeded the target by 10 days, with 16 out of 26 responding services reporting times beyond the 20-day target. There was large variation in response times, with over 30% of services reporting delays exceeding 40 days, and the longest reported time reaching 68 days.

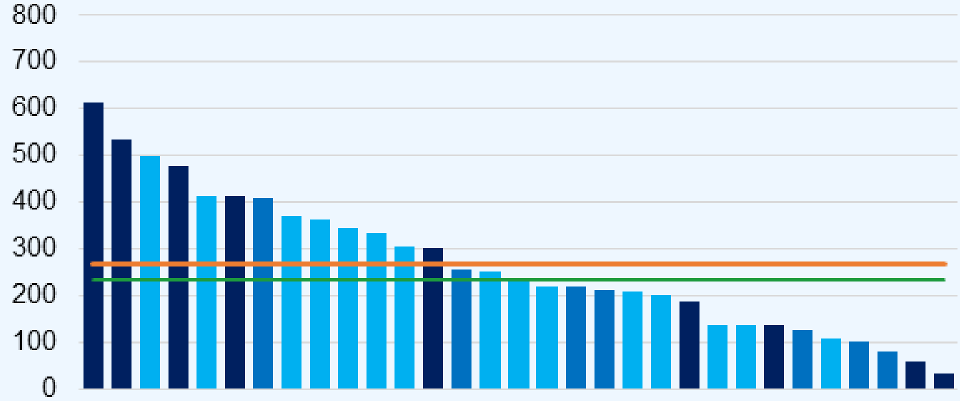
Timely IHAs are considered essential for safeguarding children in care and ensuring appropriate support however they can increase demand for community paediatric services.

What is impacting waits for community paediatric services?

Service caseload levels have remained relatively high, with a median of 296 service users per clinical WTE in 2022 (as at 31/03/22) and 233 in 2024 (as at 31/03/24)*. According to 2024 NHSBN data, community paediatric services had the highest median caseload per clinical WTE when compared to other children's community services: physiotherapy (66.3), occupational therapy (68.2), speech and language therapy (96.3), and dietetics (223)*. The median of the average times children spent on the service's caseload was nearly 18 months, with some services reporting average durations exceeding three years. A median caseload turnover of 0.5 (page 22) indicates that more children are being added than discharged within a year. Managing a high caseload with slow progression through the service limits the capacity for new referrals, thereby contributing to longer wait times.

Total number of service users on the caseload at the end of the year per clinical WTE in establishment

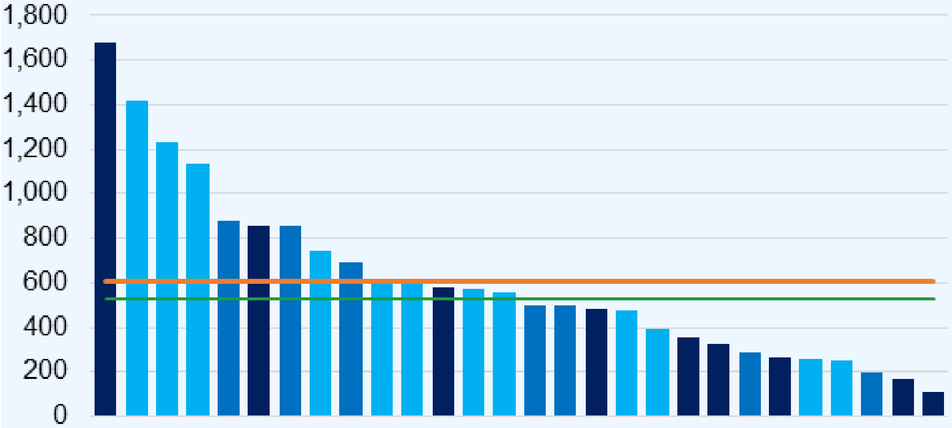
Response count = 31



Mean	267
Median	233
Low IDACI Median	277
Middle IDACI Median	212
High IDACI Median	412

Mean time on caseload (days)

Response count = 28



Mean	606
Median	526
Low IDACI Median	611
Middle IDACI Median	499
High IDACI Median	406

The age of children accessing community paediatric services varies, with some services reporting up to 70% of their caseload aged 0-5, whilst others have less than 10% (page 22). The majority of the caseload is male (64%), with the largest proportion of the caseload comprised of children from white/white British ethnicity. This is below the national average for England of white/white British by 11.5% pp (81%) (page 23).

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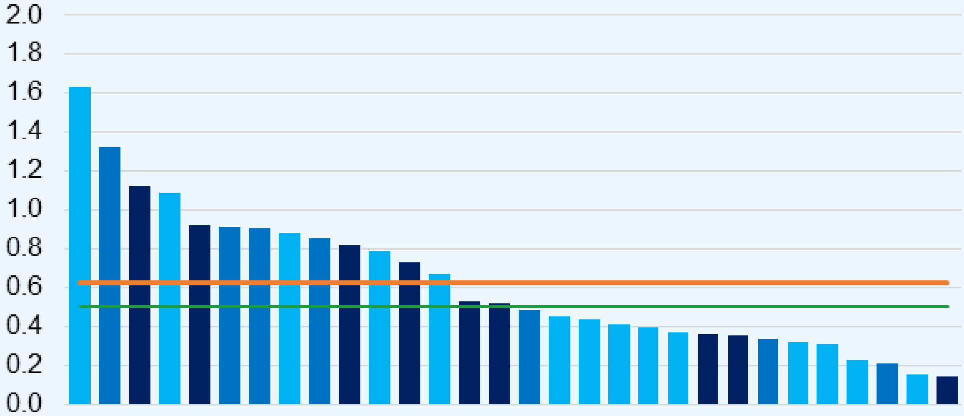
*It is important to note that the sample sizes and participants vary between years and between service types so must be considered when reviewing these comparisons.

What is impacting waits for community paediatric services?

Caseload turnover (service users discharged in year/service users on caseload at beginning of year)

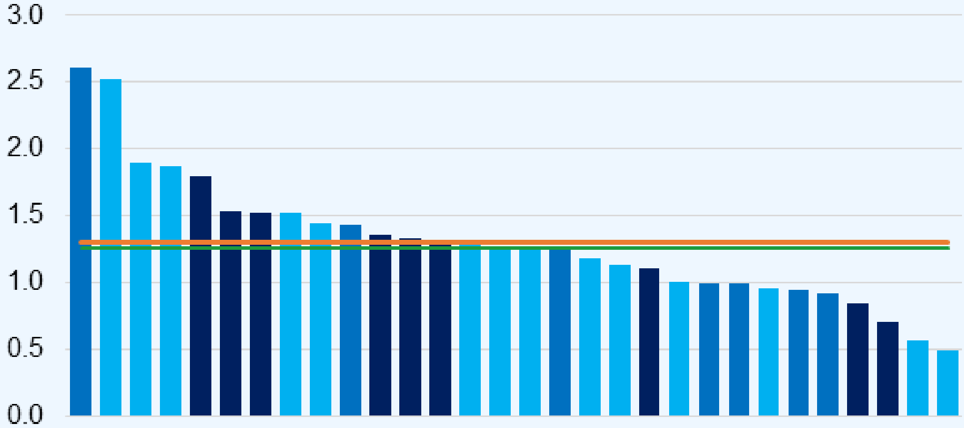
Response count = 30



Mean	0.62
Median	0.50
Low IDACI Median	0.41
Middle IDACI Median	0.86
High IDACI Median	0.52

Ratio of additions to the caseload (X) to service users discharged (1) (X:1)

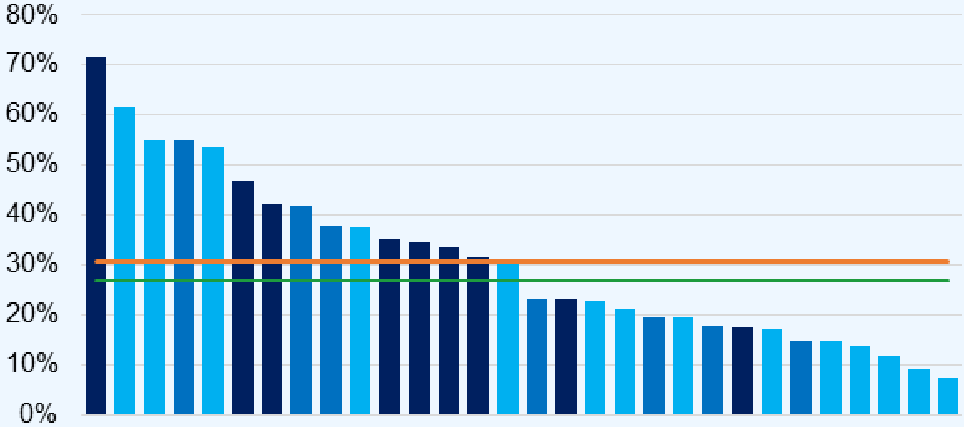
Response count = 30



Mean	1.30
Median	1.26
Low IDACI Median	1.26
Middle IDACI Median	0.99
High IDACI Median	1.34

Proportion of children aged 0-5 on the caseload at the end of the year (%)

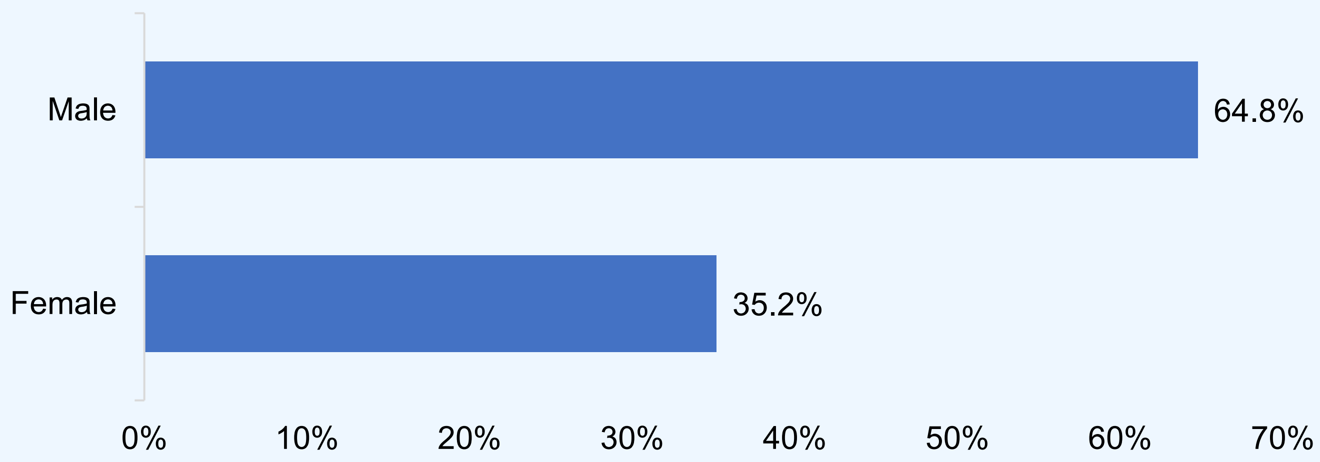
Response count = 30



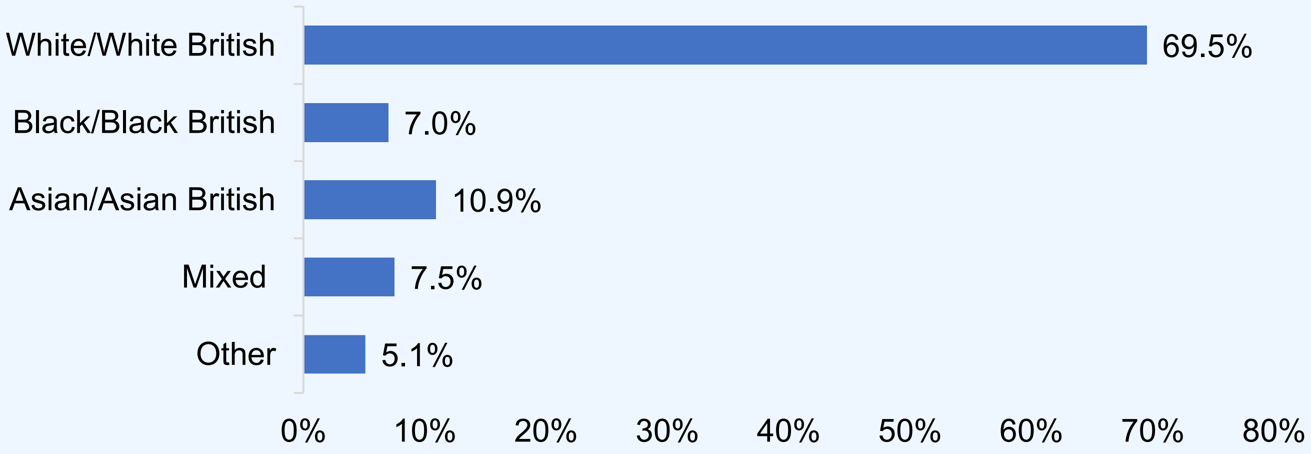
Mean	30.7%
Median	27.0%
Low IDACI Median	21.2%
Middle IDACI Median	23.2%
High IDACI Median	34.0%

What is impacting waits for community paediatric services?

Caseload by sex (M/F)(%)

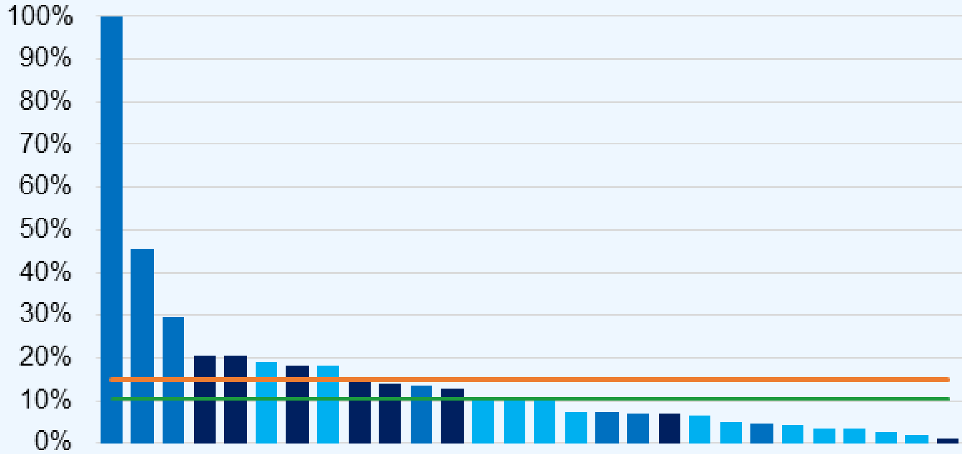


Caseload ethnicity breakdown (%)



Percentage of caseload ethnicity reported as “not stated/not known” (%)

Response count = 28



Mean	15.0%
Median	10.4%
Low IDACI Median	6.9%
Middle IDACI Median	13.6%
High IDACI Median	13.9%

What is impacting waits for community paediatric services?

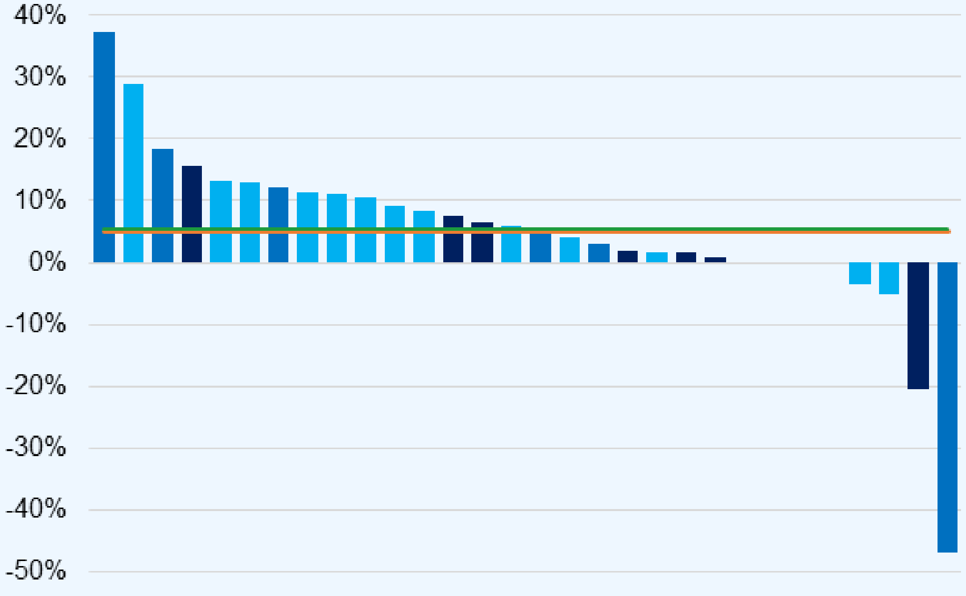
For the vacancy rate charts below, a positive value indicates vacancy whereas a negative value indicates that the service is over-established.

The median clinical staff vacancy rate for a paediatrics service was 7.5% however there is a notable range in the responses, from 66.7% over-establishment to 40.5% vacancy*. Services reporting over-establishment do not always reflect surplus capacity, as this can contain an imbalanced skill mix, which can limit the workforce’s ability to meet service demand. Higher vacancy rates can reduce available staff capacity, leading to longer waiting times.

Medical staff had the highest median for vacancy rates compared to Allied Health Professionals (AHPs), 0%, and registered nurses, 0% (page 25).

Total staff vacancy rate (%)

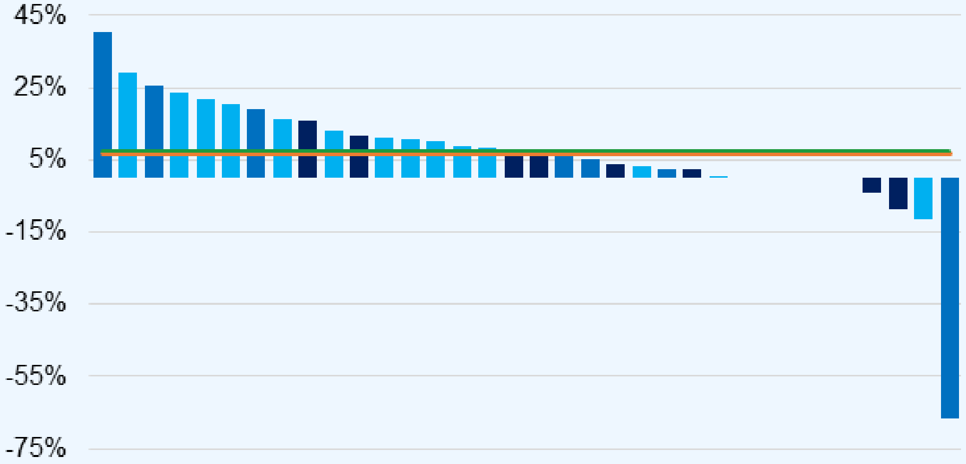
Response count = 31



Mean	5.0%
Median	5.4%
Low IDACI Median	8.7%
Middle IDACI Median	3.9%
High IDACI Median	1.8%

Clinical staff vacancy rate (%)

Response count = 34



Mean	6.9%
Median	7.5%
Low IDACI Median	10.5%
Middle IDACI Median	5.8%
High IDACI Median	7.0%

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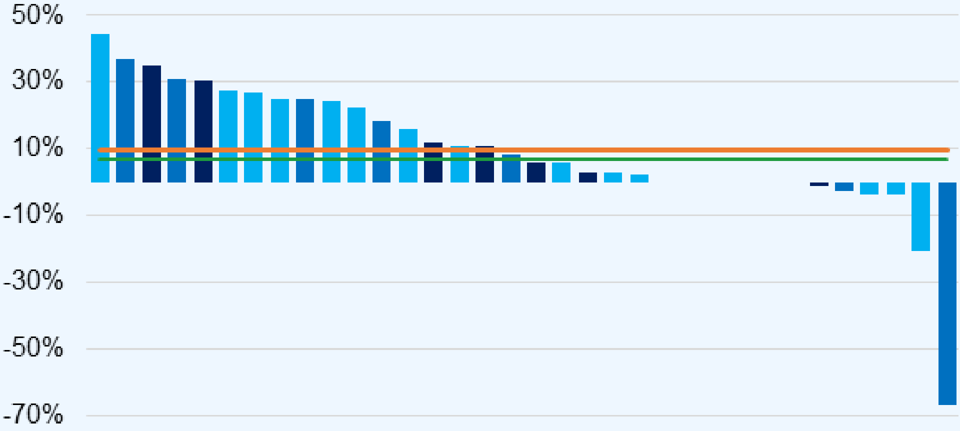
*It is important to consider that percentages can appear large when calculating vacancy/over-establishment where WTE values are small.

What is impacting waits for community paediatric services?

Medical staff vacancy rate (%)

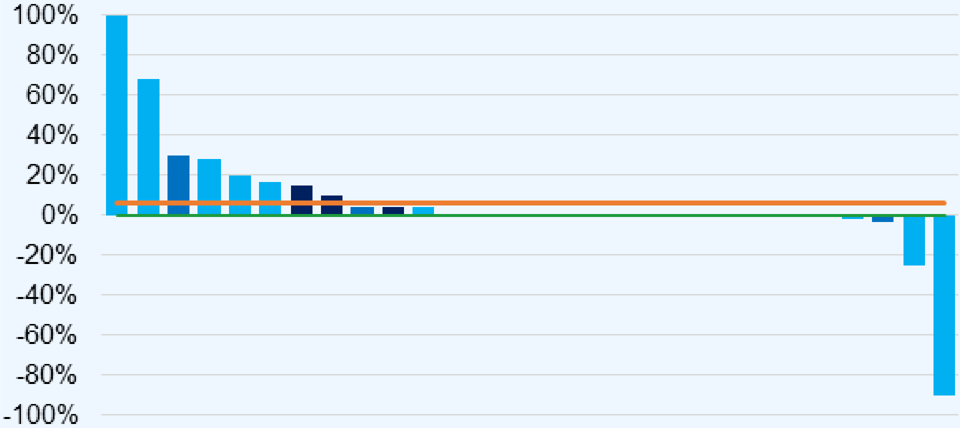
Response count = 34



Mean	9.6%
Median	7.1%
Low IDACI Median	11.0%
Middle IDACI Median	13.5%
High IDACI Median	1.5%

Registered nursing vacancy rate (%)

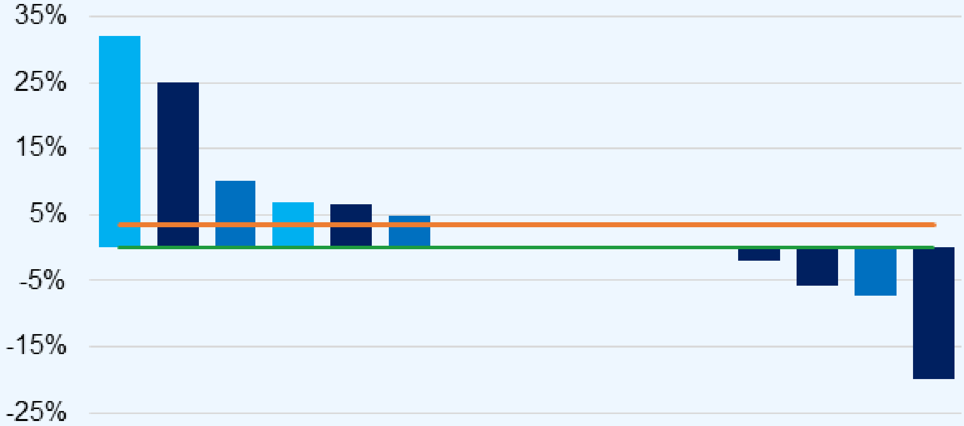
Response count = 28



Mean	6.5%
Median	0.0%
Low IDACI Median	1.9%
Middle IDACI Median	0.0%
High IDACI Median	1.0%

AHP vacancy rate (%)

Response count = 16



Mean	3.4%
Median	0.0%
Low IDACI Median	0.0%
Middle IDACI Median	7.5%
High IDACI Median	2.3%

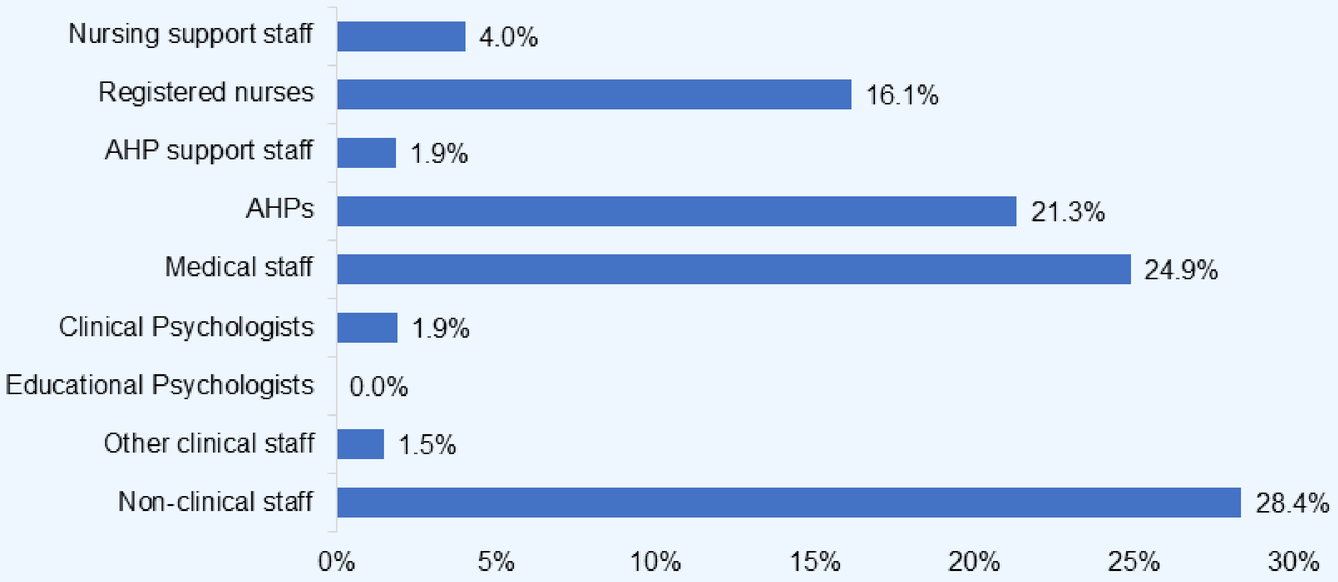
What workforce are delivering community paediatric services?

The average proportion of the workforce that was non-clinical staff ranged between a median of 7.3% and 12.4% across children's community therapy services (2024 NHSBN data). It is interesting to note that, on average, non-clinical staff accounts for the largest proportion of staff within the community paediatrics service (28.4%). This is consistent with NHSBN data collected in 2022 which also identified non-clinical staff as the largest group*. A more detailed exploration of non-clinical roles and their remit within paediatric services may provide valuable insights.

A large amount of variation was seen in the number of clinical workforce WTE per 1,000 patients on the caseload, ranging between 1.6 and 30.1. This could be reflective of the differences in service model, local population needs and workforce planning approaches.

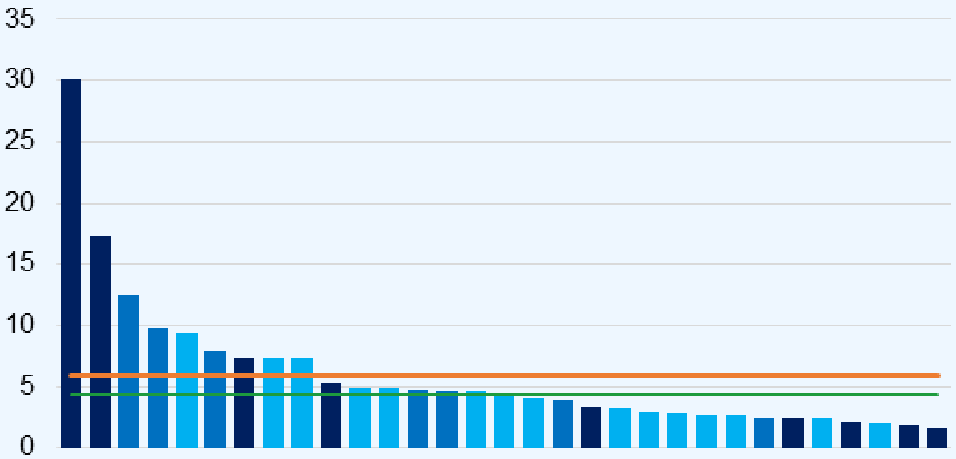
Staff discipline mix (%)

Response count = 34



Total clinical WTE in establishment per 1,000 patients on the caseload

Response count = 31



Mean	5.9
Median	4.3
Low IDACI Median	3.6
Middle IDACI Median	4.7
High IDACI Median	2.4

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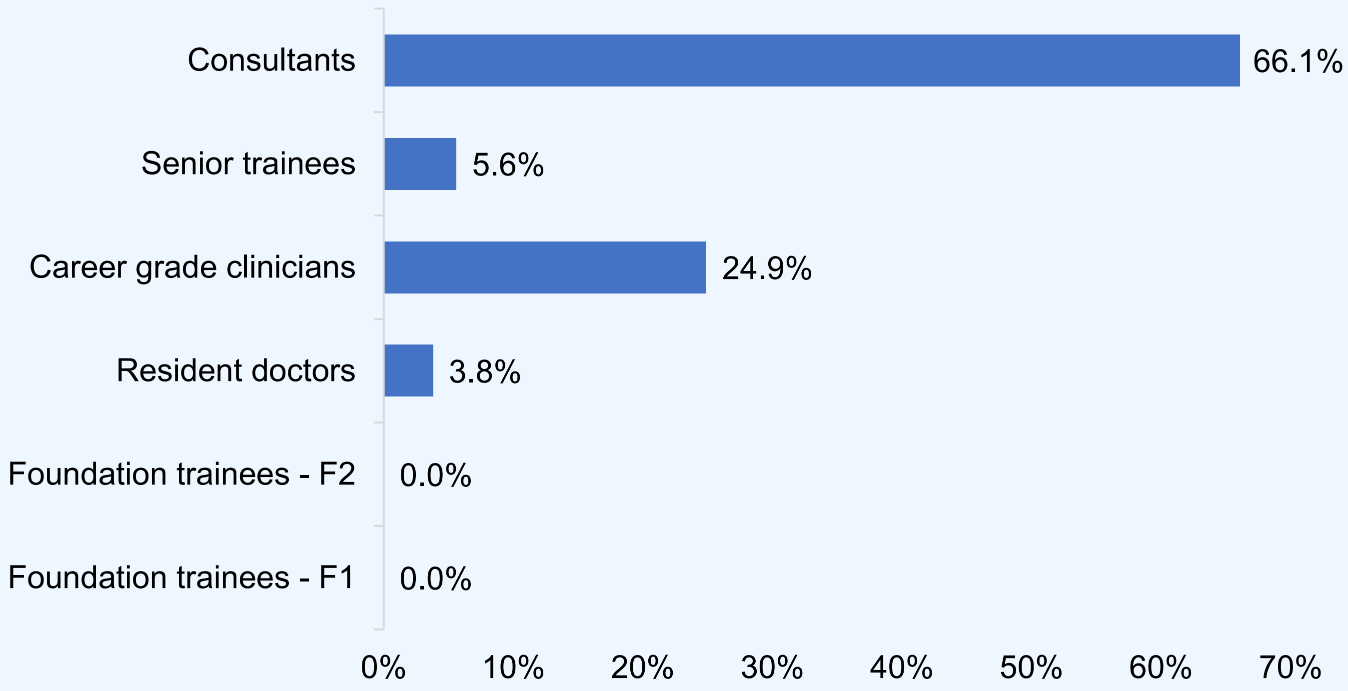
*It is important to note that the sample sizes vary making the data more sensitive to variability.

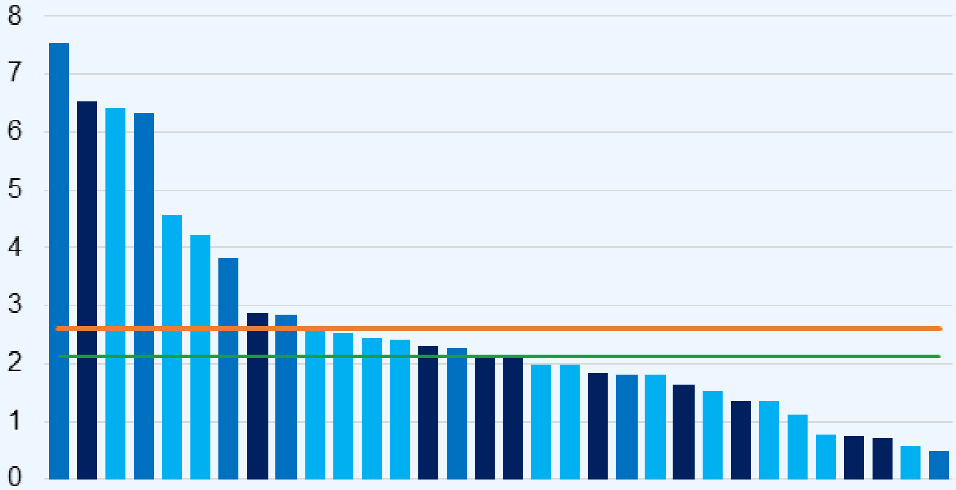
What workforce are delivering community SaLT services?

Medical staff role as a proportion of total medical staff in establishment (%)



Total medical staff WTE in establishment per 1,000 patients on the caseload

Response count = 32



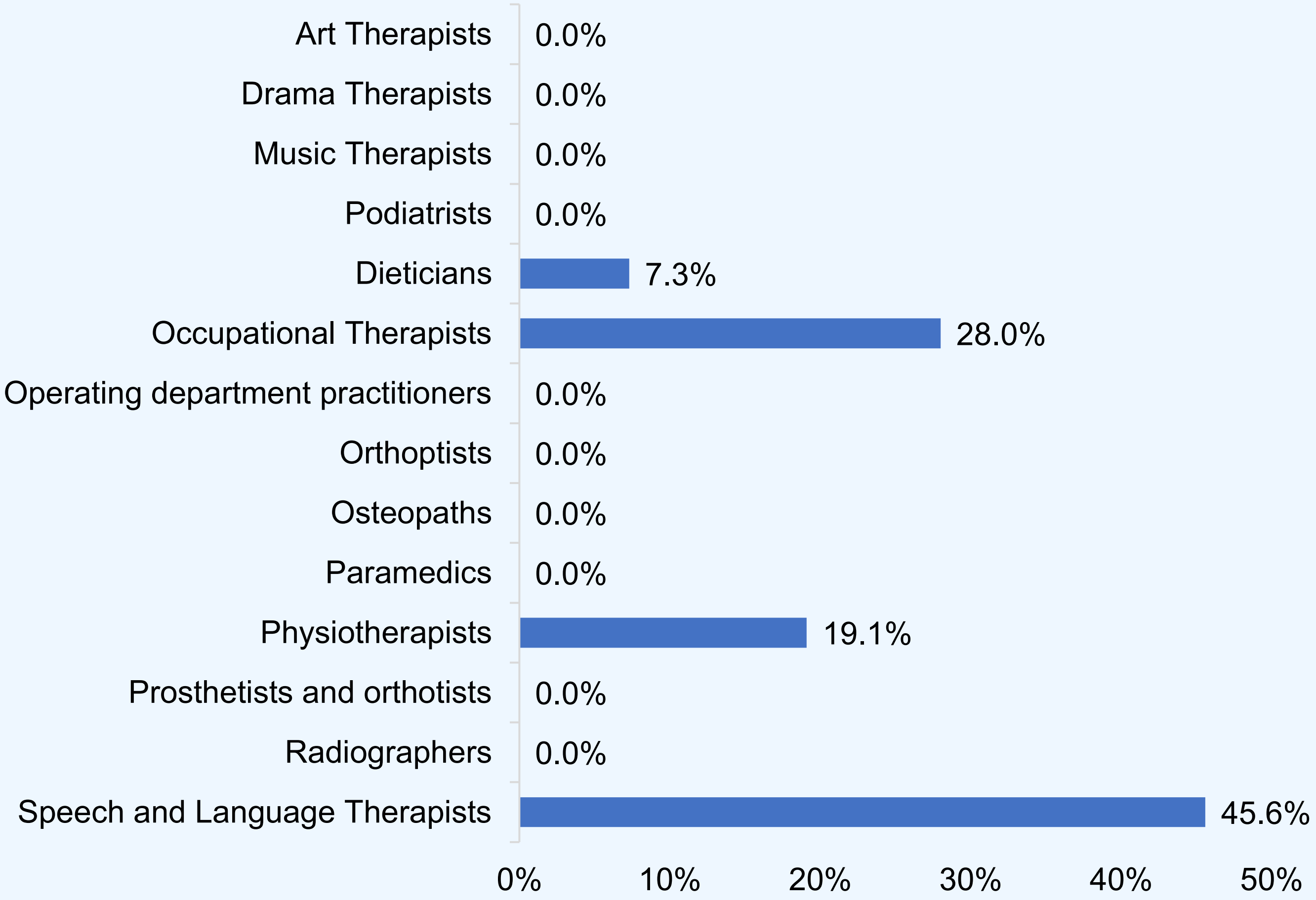
Mean	2.6
Median	2.1
Low IDACI Median	2.0
Middle IDACI Median	2.8
High IDACI Median	1.9

Consultants comprised the largest average proportion of medical staff (66.1%), with no F1 or F2 doctors recorded as of 31st March 2024. A consultant-led service model may enhance the management of complex cases; however, it may be support of other more junior medical roles may additionally help flow through the service.

What workforce are delivering community paediatric services?

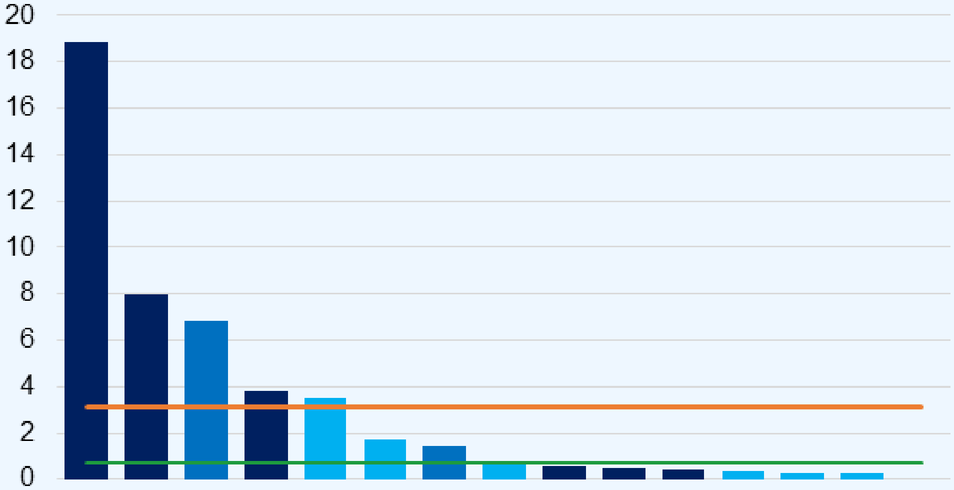
AHP role as a proportion of total AHP staff in establishment (%)

Response count = 16



AHP staff WTE in establishment per 1,000 patients on the caseload

Response count = 15

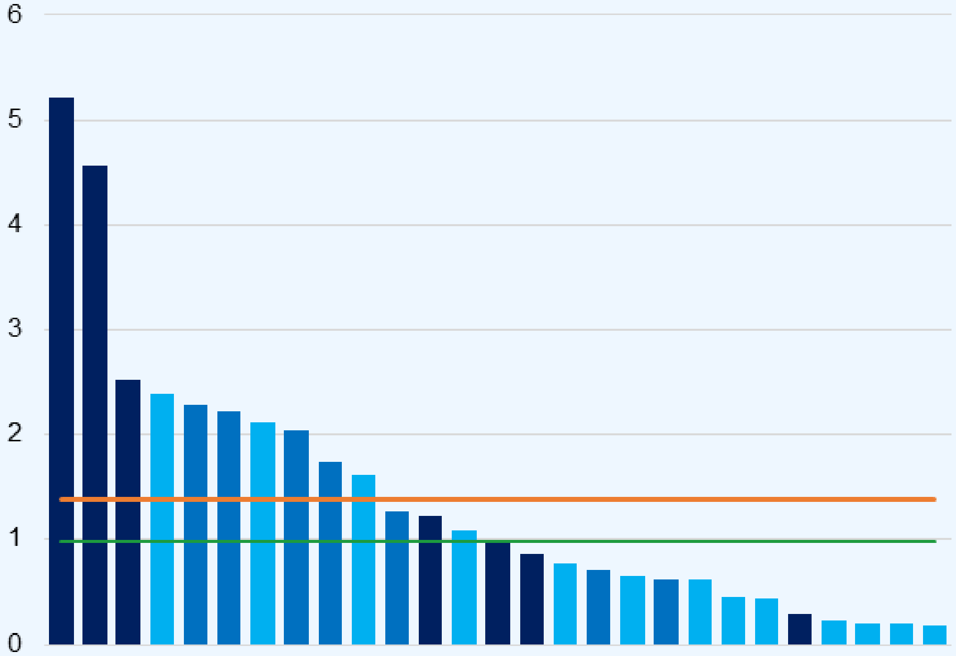


Mean	3.2
Median	0.7
Low IDACI Median	0.7
Middle IDACI Median	4.1
High IDACI Median	0.5

What workforce are delivering community paediatric services?

Registered nursing staff WTE in establishment per 1,000 patients on the caseload

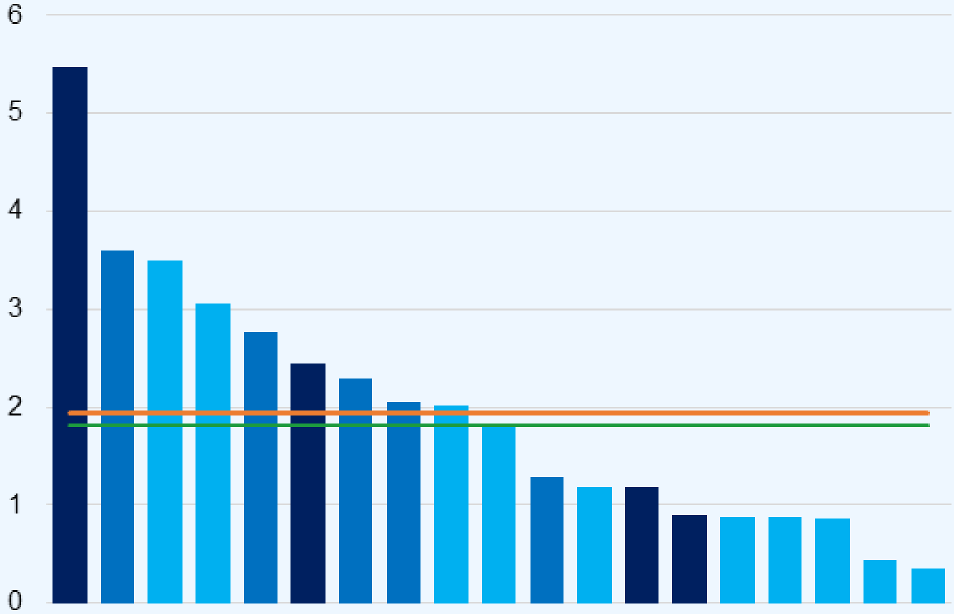
Response count = 27



Mean	1.4
Median	1.0
Low IDACI Median	0.6
Middle IDACI Median	1.7
High IDACI Median	1.0

Total nursing staff WTE in establishment per 1,000 patients on the caseload

Response count = 19



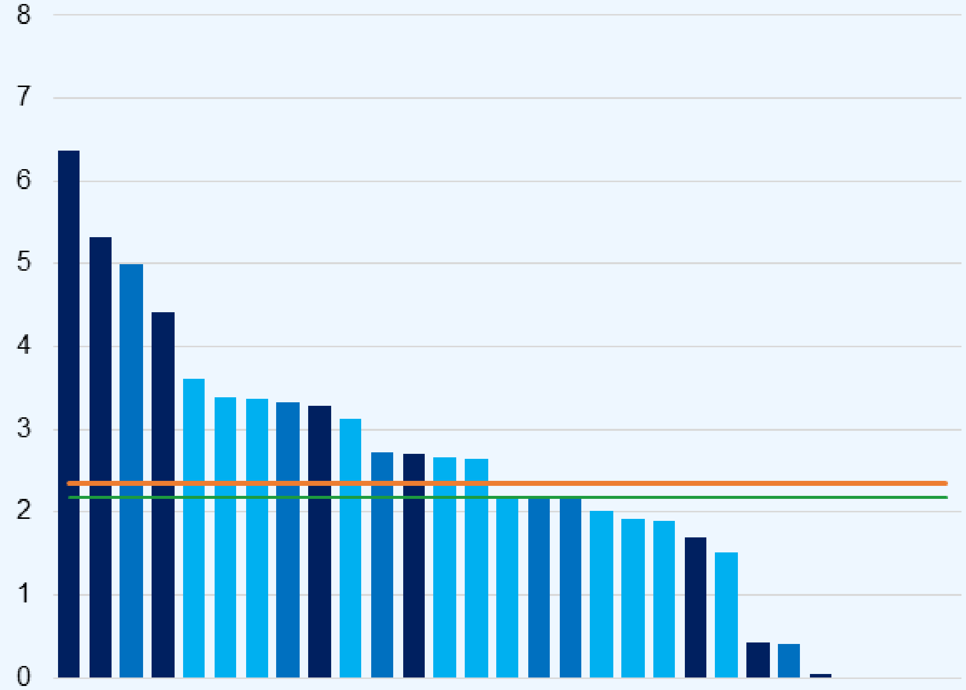
Mean	2.0
Median	1.8
Low IDACI Median	1.2
Middle IDACI Median	2.3
High IDACI Median	1.0

For services that employed AHPs, (physiotherapists, occupational therapists, dietitians, and speech and language therapists), speech and language therapists were the most common AHP; 45.6% of AHPs, on average, were speech and language therapists (page 28).
The median number of AHPs (0.7) and registered nurses (1.0) in establishment per 1,000 patients was lower than that of medical staff (2.1). Notably, the use of non-medical roles is highlighted in best practice narratives as a strategy to reduce waiting lists; therefore, this staffing mix may warrant further examination.

What workforce are delivering community paediatric services?

Non-clinical staff WTE in establishment per 1,000 on the caseload

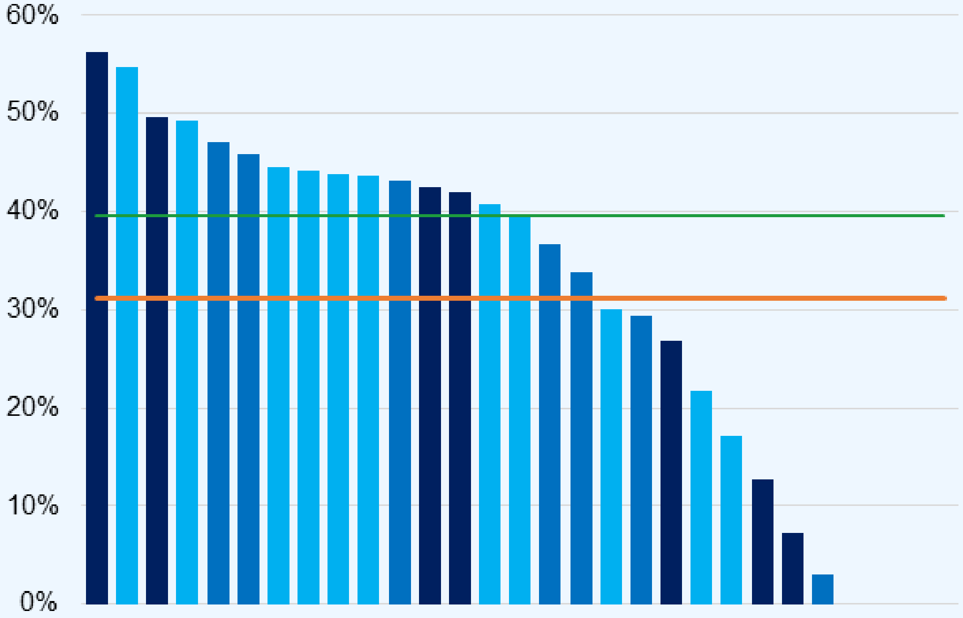
Response count = 29



Mean	2.4
Median	2.2
Low IDACI Median	2.0
Middle IDACI Median	2.2
High IDACI Median	2.2

Non-clinical staff as a percentage of total workforce (%)

Response count = 29



Mean	31.2%
Median	39.6%
Low IDACI Median	40.7%
Middle IDACI Median	35.2%
High IDACI Median	42.5%

The high level of variation in responses, with four services reporting no non-clinical staff and two reporting a majority non-clinical workforces, suggests differing delivery models across services. High levels of non-clinical staff may reduce waiting times by supporting the clinical workforce to improve service efficiency. A comparison of these varying service models may prove insightful.

How are quality and outcomes being measured in community paediatric services?

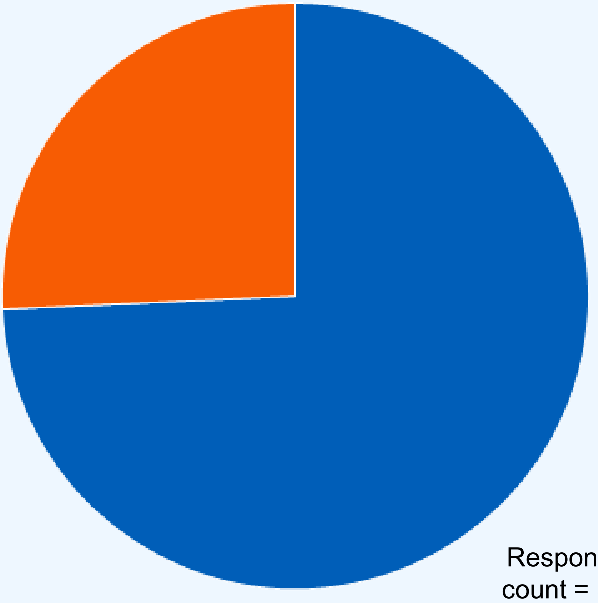
As part of measuring care quality and patient outcomes, most responding services reported using a Patient Reported Experience Measure (PREM) (74.3%). The utilisation of Patient Centred Outcome Measures (PCOMs) is less common, with only 21.9% of services reporting their use.

62.9% of responding services said they contribute to the Community Services Data Set (CSDS). Narrative responses for not completing are summarised below*:

- Being part of an acute trust with no dedicated funding to complete.
- Lack of data infrastructure.
- Some community activities are submitted via acute data sets.

Completing data returns and maintaining robust, high-quality data are essential for gaining a clear understanding of service delivery and ensuring informed strategic planning.

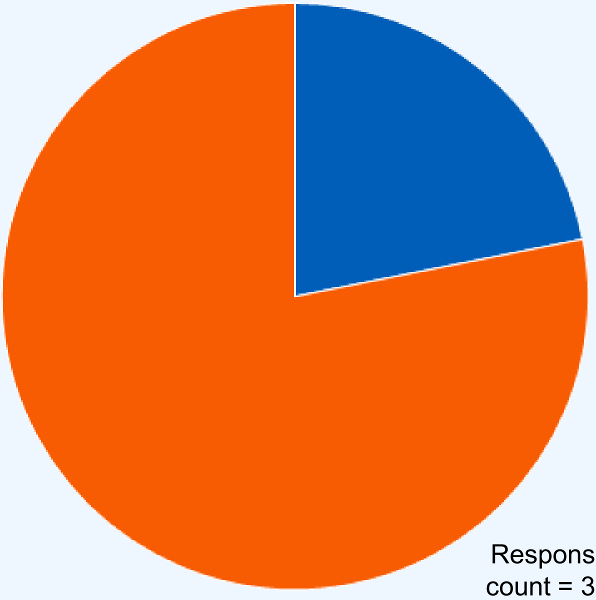
Is the service using a Patient Reported Experience Measure (PREM)?



Response count = 35

Yes (%)	🟦	74.3%
No (%)	🟧	25.7%

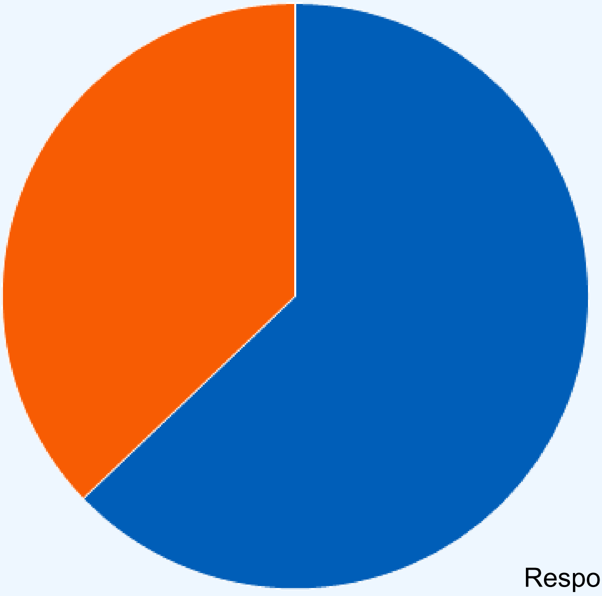
Is the service using a Patient Centred Outcome Measure (PCOM)?



Response count = 32

Yes (%)	🟦	21.9%
No (%)	🟧	78.1%

Are you completing the CSDS data set?



Response count = 35

Yes (%)	🟦	62.9%
No (%)	🟧	37.1%

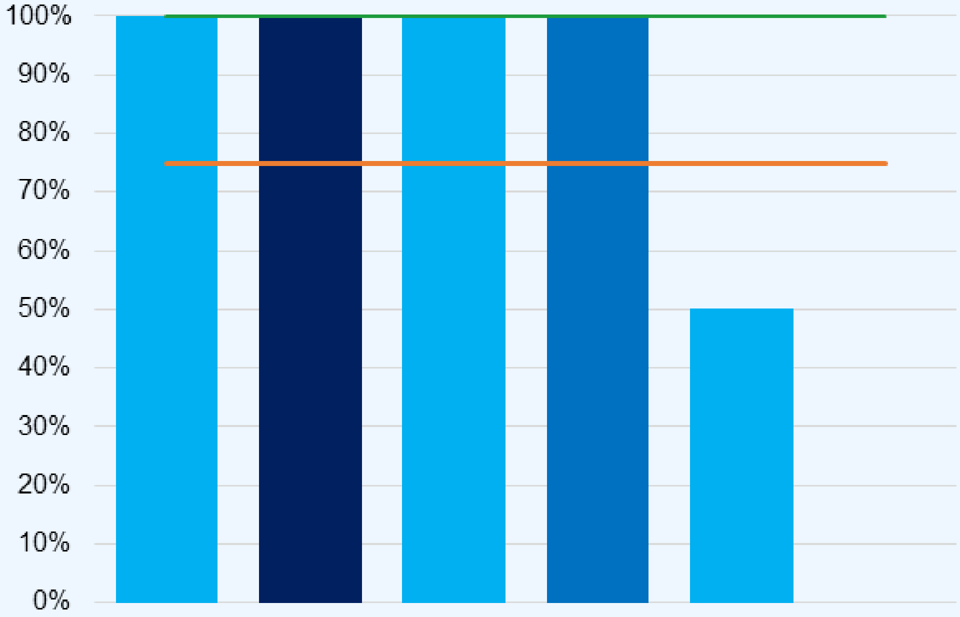
* A full list of narrative responses can be found in the Appendix.

How are quality and outcomes being measured in community paediatric services?

A documented care plan can support patients in the continuity of care among healthcare providers and can help to manage complex needs more efficiently. This question received a relatively low response count which could indicate a lack of available data for the community paediatric service. Where six services were able to answer this question, four reported 100% having it in place, one reported 50% and one reported none.

What percentage of patients on the caseload had a care plan documented and agreed with the service user/carer (%)

Response count = 6



Mean	75%
Median	100%
Low IDACI Median	100%
Middle IDACI Median	100%
High IDACI Median	50%

Methodology

Approach

Benchmarking aims to highlight how practices and standards within organisations and services compare to peers.

Using key metrics to identify variation, members of the network can use this to provoke a deeper understanding of their services, create insight, and hopefully lead to positive action.

We recognise that variation is often warranted and that it can be misleading to see a data point in isolation; with this in mind, we caveat that any narrative accompanying this report may not capture all the nuances of the provision. However, we hope it can still act as a catalyst to direct further investigation, and we wish to enable these discussions as much as possible.

Participation

This year 45 submissions were received from 38 community paediatric providers based in England.

Timeframe

The majority of the data presented in this report reflects the annual position for 1st April 2023 to 31st March 2024. Selected metrics are collected at a census point of 31st March 2024.

Where comparisons are made to 2022 data, this represents the annual position for 1st April 2021 to 31st March 2022. The impact of the COVID pandemic should be considered when making comparisons.

Data Accuracy

All project data has been submitted by providers and undergone validity testing on collection and prior to dissemination. We understand that this can still sometimes fail to capture all errors within the data, and we appreciate any feedback.

Definitions and terminology

Within the data specification, we try to provide as much guidance and definitions as possible to ensure that variation in the interpretation of the metrics is kept to a minimum.

Where service definitions are provided these align with national definitions and the data dictionaries where possible and as appropriate.

Methodology

The terms organisation, provider, services, and participant are used interchangeably to refer to submissions from Trusts (England). The use of the term ‘sample average’ throughout the report refers to the average of the responses received for the specific metric. This may vary by year and by metric as the project and data points are not mandatory. Any changes between years seen in the data may be a result of this sample variation.

Use of summary statistics

Within this report, we have used the median as the default summary statistic unless otherwise specified. However, all charts will show the sample mean (orange line) and sample median (green line) alongside each other.

When presenting data on a participant level the median represents a more accurate representation of the spread of the participants as it isn’t skewed by any outliers in the data. We encourage readers to look at the variation in responses to each question to enable a more complete picture of the values. Seeing the distribution of the relative performances should give a clear view and help select possible goals to target and identify organisations to reach out to.

It is important to note that the sample sizes/ response counts often vary between collections and metrics, so caution needs to be taking when drawing conclusions from these comparisons.

Acknowledgements

The NHS Benchmarking Network team would like to thank Gareth Jones and Rachel Porter, the Transforming CYP Community Services Clinical Advisory Group, and all the trusts that participated in the project for their support and engagement.

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(www.nhsbenchmarking.nhs.uk)

Appendix

If you provide “Other” support than the options listed, please provide examples

Organisation	Response
PD003	Assess and signpost with treatments recommended for GPs/appropriate services. Annual reviews on complex children. Non-urinary caseload for continence.
PD005	Looked After Children IHAs, Safeguarding, Adoption Medicals, Audiology.
PD007	SEN and EHCP health assessments and advice.
PD008	Looked After Children clinics; Adoption, Fostering, and Safeguarding medical assessments; school clinics; CDOP services; Health Input for EHCPs.
PD009	Sickle cell and Thalassaemia.
PD010	Presentations with epilepsy, genetic conditions, audiology, and syndromes.
PD016	Autism (0-7) and some epilepsy.
PD017	Epilepsy with neurodisability, hearing loss clinics, and autism (0-18).
PD019	Genetic conditions and continuing healthcare.
PD022	Child protection.
PD023	LAC, CP, Adoption, EHCP when known to the service.
PD025	Child protection.
PD026	Epilepsy.
PD028	Children in Care, Safeguarding.
PD030	Children and Young People with physical disabilities.

If you provide “Other” support than the options listed, please provide examples

Organisation	Response
PD031	Adoption and Looked After Children.
PD032	Looked After Children services (Initial Health Assessment and Adoption medical with adoption panel). SEND support pathways including EHCP, FASD and ARFID pathways are evolving. Neurogenetic clinics.
PD033	Investigation for sensorineural hearing loss, welfare assessments (some done by acute paediatrics).
PD041	Continence and end of life care. ASD (0-5). Medical support for safeguarding cases. Children in Care services.
PD044	Aetiology. It will also include cognitive delay/disorder.
PD045	Epilepsy, Child Protection, Adoption, Children in Care.
PD046	Statutory services, CIOC, Adoption and fostering, safeguarding, genetics, hearing loss.
PD048	Multidisciplinary feeding clinic, multidisciplinary sleeping clinic, multidisciplinary coordination assessment clinic, assessment for children for EHCP, initial and review health assessments for children looked after, adoption support, joint genetics clinics, child protection medicals, multi professions safeguarding strategy meetings, and outreach clinical to special needs school. We also do botulinum toxin injections.
PD052	Pharmacy provision for ADHD medication and related monitoring.
PD053	EHCP assessments, safeguarding work including child protection, advise on health conditions for adoptions, children in care medicals, coordination of special needs services through the role of DMO SEND.
PD056	Down Syndrome Service, Hearing Impairment Service, Visual Impairment Service, Neuromuscular conditions service, Botulinum toxin injection service.
PD057	Safeguarding medicals, LAC medicals, medical advisor.

Please provide examples of how you work with acute paediatric specialists, GPs and other providers. Do you have a service level agreement?

Organisation	Response
PD002	We work with our local partners as part of the overall CYP pathway, e.g. FTB (ongoing care of YP >16 years). We have income SLA's in place for pathways that we provide support for and expenditure SLA's where we use services from other providers, e.g. Biochemistry.
PD003	Shared care agreement with GPs with regards to medication.
PD004	The service has clear links with primary care, acute paediatrics and education. The service works with primary care practices around shared clinical care and prescribing responsibilities for children; with shared care agreements in place for children on ADHD medication. When requested, the service provides advice and training for primary care staff to enable them to monitor and manage conditions through primary care as appropriate.
PD005	Pilot with GPs to provide IHAs was unsuccessful so it is being discontinued.
PD007	Acute paediatric services are managed under the same organisation and electronic referral processes are in place via the electronic patient record system. GPs and other providers, including schools, early years settings, universal targeted health services are able to make direct referrals to the service. Shared care arrangements in place with GPs for ADHD medication.
PD008	Referral process. Comms following each appointment to GP/specialist services (with consent). MDTs when required for complex cases.
PD009	We collaborate closely with acute paediatric specialists, GPs, and other healthcare providers primarily through a structured referral process. We regularly receive referrals from them for children requiring specialist assessments, interventions, or ongoing care. Additionally, our specialist nurses may visit children in hospital or at home upon receiving these external referrals, ensuring continuity of care and appropriate follow-up support. At the present we do not have a Service Level Agreement (SLA) in place for this collaboration, but we maintain strong working relationships with these providers to facilitate seamless patient care.

Please provide examples of how you work with acute paediatric specialists, GPs and other providers. Do you have a service level agreement?

Organisation	Response
PD010	We do not have service level agreements; working with other providers is specified where possible in community services contract.
PD014	Joint working with acute paediatrics, local relationships with GPs and local authorities but no SLAs in place.
PD016	SLA for any funding related posts or arrangements (e.g. trainees, clinics with RNOH). Otherwise, no SLA for working with GPs/acute paediatrics/other providers/agencies.
PD017	No SLA for working with GPs/acute paediatrics/other providers/agencies.
PD018	Team have good working relationship with local acute trust and tertiary centres.
PD019	Paediatric continence team: we receive direct referrals from acute paediatric specialists, GPs and other healthcare professionals. Summary letters/correspondence, requests to support treatment plans with medication requests (non-prescribing nurse-led team). CYPTS: liaison via email and phone contact and MDT meetings. OT and SLT specialists in reach to neonate and SCBU in MPH. CCH: neurodisability admissions to ward, work closely with acute paediatrics teams. GP providers shared care agreement to prescribe medications. Work closely with SLT. CCN: working closely linked with acute teams and work alongside them and the ward. We only take referrals via consultants so this also enhances the links with acute services.
PD021	Referrals are sent by school SENCO to 0-19 team who collate all relevant information and send them to us. We don't usually accept direct referral from GPs. GPs are involved in shared care agreements with ADHD medication and melatonin prescriptions.

Please provide examples of how you work with acute paediatric specialists, GPs and other providers. Do you have a service level agreement?

Organisation	Response
PD022	We work as part of a system wide collaborative in relation to neurodevelopmental services; the community paediatricians are involved in this in relation to the assessment of autism for children under the age of 5 years. We have shared care agreements with GPs for the prescribing of ADHD medication. Our continence team is nurse led level 2 and we work collaboratively with universal services who deliver level 1 and acute trusts who deliver level 3. The community paediatric service delivers an MDT clinic at local acute hospital as part of a reciprocal arrangement.
PD023	There is no SLA in place across the system. We liaise by email with acute paediatricians about mutual patients. We might occasionally refer to each other but mostly if we are referring to the hospital it would be to tertiary specialities e.g. neurology, orthopaedics, gastro, etc. We write to GPs after each appointment and they occasionally contact us with queries.
PD025	SLA with ICB. GPs largest referrer group, using DXS with pre-populated forms for accuracy. We support GPs with an advice and guidance service. We have shared care agreements in place for GPs that prescribe melatonin and ADHD medication. We work alongside acute paediatricians in areas of eating disorders, child protection and with complex children. We refer to various providers for imaging and pathology.
PD026	No SLA between acute and community paediatricians.
PD028	We work closely with acute paediatrics and are working with the ICB and CFT on more integrated system wide ways of working.
PD029	Share care agreement with local GPs, cross referrals with acute paediatrics specialists within the same organisation.
PD030	No SLA in place. CYP are referred into secondary care as needed or via their GP. Service currently working on piloting e-RS for direct referrals into secondary care.

Please provide examples of how you work with acute paediatric specialists, GPs and other providers. Do you have a service level agreement?

Organisation	Response
PD031	We do not currently have a service level agreement. The community service is co-located with acute paediatrics and community paediatric consultants regularly attend GP hub clinics. GP referrals are considered using a PATCH referral form requesting Child Health Assessment. This PATCH referral form can also be submitted by a range of other providers including health visitors and education providers.
PD032	The community paediatric medical services are commissioned to support care delivery. There are a number of designated/lead roles within the community paediatric services provided. An electronic referral triage system has been established for the community paediatric service. The referrals for the neurology/neurodevelopmental/community paediatric medical service are collated and referrals are regularly triaged by a consultant to the most appropriate clinic. Referrals for statutory assessments (SEND/CLA) have separate dedicated referral pathways and administrative team. The neurology/neurodevelopmental/community paediatric service offers access to a range of clinics which are organised at a frequency which meets the current demand. The service also supports adoption panels. Autism and ADHD assessment services are provided by neurodiversity service, which is hosted by a separate provider. The service is also able to internally link with general paediatrics, all relevant paediatric sub-specialities. There is also access to the paediatric epilepsy service which has its triage pathway and epilepsy specialist clinics. The service has access to some MDTs.
PD034	Clinics/MDT with Community Physio/Dietetics/CAMHS. Child protection services work alongside acute providers.

Please provide examples of how you work with acute paediatric specialists, GPs and other providers. Do you have a service level agreement?

Organisation	Response
PD041	Our referrals are from GPs and other providers in the region including acute services. We have shared clinics such as neurology orthopaedic for children with complex disability. Complex cases can be either discussed with or referred to acute specialist colleagues in both the acute and the mental health settings. Safeguarding work is done between the community service, the acute setting, and the sexual assault referral centre. Allocation of these cases is based on a set of agreed criteria.
PD044	Community paediatric service and acute paediatric service and within the same group. The only SLA is to support skeletal surveys. Work with tertiary specialties (neurology, palliative care). Open discussion with GP regarding transition and shared care agreements..
PD045	SLA in place with acute and other providers.
PD048	We provide acute, secondary, tertiary and community children's services as well as women's and maternity services. Community paediatrics works closely with a range of specialist and acute children's services. We do not have a service level agreement.
PD049	Close working with acute wards and community services. Reactive team work closely with acute wards for review and readmission if needed. Reactive team focus on admission avoidance and therefore review following DC from hospital. Continuing care team work with children with long term health conditions. They will link with acute team for admission or support if needed. AHP have acute provision including an on-call rota. ICPS provide blood clinics ran in the community services.
PD052	Community and acute paediatrics work in alignment to deliver holistic care, there is provision to have joint clinics where needs require such as complex epilepsy.

Please provide examples of how you work with acute paediatric specialists, GPs and other providers. Do you have a service level agreement?

Organisation	Response
PD053	Community paediatrics are part of the paediatric care group which includes acute and neonates. Referrals accepted from acute paediatrics, CDC team, therapists, school nurses, health visitors, GPs and CAMHS. Following assessment and management plan, GPs are requested to continue with prescriptions required via shared care agreements and clinic letters based on the nature of the medication. Some patients are referred to acute paediatrics and other specialist services including CAMHS where required.
PD054	We provide continuity of care through shared care agreements with GP colleagues for those with long term chronic conditions. We work with acute specialists in providing ongoing community care and assessments. We work with the local authority for e.g when adaptations are required within the home or for the child, e.g wheelchair services etc.
PD055	We work closely with our acute paediatric colleagues - although have separate service line management. We also work in liaison with colleagues in CAMHS and public health nursing, which are provided by a local CIC. We receive referrals from GPs for most parts of our service..
PD056	We work with acute services for acute hospitals to provide respiratory, gastroenterology, end of life care and neurology services.
PD057	External contracts for service provision with acute providers/residential settings/education settings/Hospice providers

Please describe how the service is commissioned

Organisation	Response
PD002	We are commissioned by ICB for the services we deliver based on the needs of the children within the ICB and what other providers are commissioned to deliver.
PD003	LA for CLA and Specialist Schools. ICB for the rest of the service.
PD004	We are commissioned by the ICB.
PD005	Recurrent commissioning arrangement.
PD007	Block contract through ICB.
PD008	Service specification jointly written with ICB and continuous close collaborative working.
PD009	Service Level Agreements (SLAs) and specifications define what services providers must deliver, expected standards, and performance metrics.
PD010	Commissioned by ICB via community services contract.
PD014	Service contract.
PD016	ICB/NHS, HEE funding for postgraduate training.
PD017	ICB/NHS
PD018	ICB-funded service
PD022	ICB block contract.
PD025	ICB block budget allocation.
PD026	Commissioned on a block contract.
PD030	Health funded.

Please describe how the service is commissioned

Organisation	Response
PD031	Community paediatrics nursing is block funded within the fixed allocation agreed with the ICB. Community paediatrics medical is recorded within outpatients and is aligned to follow-ups being within the fixed element of funding and first appointments linked to ERF as per national guidance.
PD032	The service is commissioned by ICB. We link with Local authority for statutory pathways related to SEND and CLA.
PD033	Block contract. Service specification currently in discussion.
PD034	The service is commissioned by the ICB.
PD040	Commissioned by ICB. Joint assessment pathways.
PD041	Paediatrics is funded via the ICB. Other services such as public health nursing are contracted in part by local authorities but are a separate service to community paediatrics.
PD045	ICB/block contract.
PD046	ICB funded for pathways to be delivered to meet the needs of the CYP population.
PD048	The Community Paediatrics service is commissioned by the ICB.
PD049	ICB
PD055	We receive commissioning solely from our local ICB. We do not provide any services commissioned by local authorities or other services.
PD056	Block contract

Please provide any additional information regarding your service and the pathways listed

Organisation	Response
PD007	We are only able to disaggregate patients on ASD and ADHD pathways and not those on the wider community paediatrics pathways, we have therefore recorded all of these under developmental delay unspecified.
PD010	Specific data capture for questions such as this is traditionally challenging for community services. It requires guidelines and established reporting procedures that are not really in place.
PD016	We are unable to quantify metrics based on pathways into the above-mentioned categories, although some of the above-mentioned pathways are present.
PD019	CCN: We do not have waiting times, this is not how we work. Any referrals usually will need immediate medical input due to underlaying medical needs. Allocation of new referrals received via email and referral form are very quickly triaged (within the day) and allocated a CCN who will then contact the family and arrange a first visit. Therefore, the waiting time between referral and first visit is dependent on the parental wishes. For certain conditions we do have a target first visit times such as all chronic lung discharges from SNU must be visited within 2 working days. We achieve this for over 90% of such patients. We only receive between 1 and 4 referrals a month, so it is easy to achieve this.
PD033	We also undertake Initial Health Assessments for Children in Care, provide advice for children undergoing an Education Health and Care Needs Assessment and undertake some welfare medical assessments.
PD041	All of our services clinically validate clients - wait times are dependent on priority. Pathway does not impact wait - clinical need does.
PD044	Community Paediatric Service commissioned to provide ASD pathway for under 5s only. Over 5s seen for paediatric assessment, ASD pathway managed by CAMHS. Those children referred and accepted for developmental delay will include those with query motor delay/disorder as well as speech and language and/or cognitive delay/disorder. We also have a general waiting list which includes all neurodiversity unspecified as well as complex neuro-disability and complex health needs.

If compliance has not been achieved for an IHA being conducted within 20 days of the child entering care, please provide reasons for this

Organisation	Response
PD002	Delays in receiving BAAF forms from BCT and OOA services. High numbers of DNA and cancellations delaying IHA. Inadequate IHA capacity to manage referrals and peaks in referral trends.
PD003	Late notification from the Local Authority has impacted our ability to meet the 20 day target.
PD004	Mostly attributable to late requests from local authority, sustained numbers of UASC have also affected capacity due to larger numbers entering care on the same day.
PD007	Late notification from social care requesting initial health care assessment reducing the timescale for the assessment to take place before 20 day target is breached. We reached 100% compliance within 20 days of referral being received.
PD008	Impact of DNA/WNB and cancellations. Late notification by local authority. Backlog in reports being written and sent out after the IHA appointment.
PD009	The primary reasons for delays in seeing all CYPs on time include paperwork being received after the breach date by the social worker, failure to bring the child by the carer, refusal to attend, the child going missing, and conflicting priorities.
PD010	Staff shortages. High demand for services. Delays in being notified of case. We are not set up with data to answer all questions presented.
PD014	Increased demand in both IHA at a time when prioritising new patient wait times to recover performance for new patients.
PD016	Child placed out of borough; Child is missing; Refusal; DNA; Other authority child; Cancelled appointment; Late request; Child moved placements
PD018	Service has experienced delays in LA giving information and correct consent.
PD022	Capacity or peek in demand due to UASC.

If compliance has not been achieved for an IHA being conducted within 20 days of the child entering care, please provide reasons for this

Organisation	Response
PD023	There are 4 main reasons for not achieving this: 1. Delays in notification to us from the local authority - so a large proportion of the time is wasted as we are unaware that the child is in care [Avg delay where not notified on same day is 7.82 days] 2. Delays for unaccompanied asylum seekers in getting the necessary permissions and NHS number in order to proceed. [Avg time to IHA 70.25 days for 18 in area placements and 182.43 days for 12 out of area placements during that period] 3. Delays in responses from remote providers where children are placed outside our area. 4.Issues with capacity due to staff shortages and absence.
PD026	The capacity of clinic due to the number of referrals received can impact compliance. This is reviewed by the named doctor and extra clinics are added. The number of was not brought in the older age range can impact on clinic capacity. There are measures in place to encourage attendance. If a child requires an interpreter this can impact the timeliness, and whilst face to face is preferred for the child, a video interpreter will be considered to prevent delay. During the period of time, we had a number of appointments which required changing due to court directed family time. It is dependent on a referral from the local authority being received in a timely manner. Out of the 240 IHA completed 58 children's referrals were sent 20 days after the child had come into care, therefore we could not achieve compliance on any of these. We are dependent on quality assuring the IHA, they are currently quality assuring 100% of IHA's and returning the quality assured paperwork to the local authority.
PD028	Historic backlog of children in care; Lack of investment in service; Lack of doctor capacity and time allocated in job plans; Vacancies within the team.
PD030	87% conducted within 20 days. 1. CYP placed Out of borough and local team not commissioned to see - waiting for OOB team to see. 2. Late receipt of BAAFs from social care team to instigate assessment

If compliance has not been achieved for an IHA being conducted within 20 days of the child entering care, please provide reasons for this

Organisation	Response
PD031	Impossible target as child is often in care for over 20 days before a referral is made.
PD032	We breach primarily because of late notifications from social care. We are able to offer an appointment for IHA within 5-10 working days of receiving the referral and the report is shared within 15 working days of receiving the referral
PD033	Social worker not able to attend, carers cancelling appointments.
PD041	Information is reported monthly to the ICB. Case-by-case exceptions are provided. The highest percentage of breaches of the 20-working-day local authority target occur due to delays in receiving supporting information from local authorities, which should be provided within 5 working days. We aim to meet a 15-working-day completion target upon receiving the required information. The main reason for breaching the 15-working-day target is carers declining appointments within the timeframe. All refusals are reported to the local authority via the social worker.
PD044	Compliance was not achieved and service performance in attaining this was impacted by late notifications from the local authority of children and young people coming into care. The expected timeframe for the CYPiC Team to be notified and the request received is within a 5 working day period and compliance for this was low during this reporting period with 36% of requests being received within the 5 working day timescale.
PD048	Late notification from Local Authority, Young people refusing health assessments.
PD049	Paperwork from local authority, if notification was received on time. Consent not available, part A not complete, cancelled by carer, DNA, Cancelled by young person. Unable to engage with young person, staffing, admin error.
PD053	The Cohort year for 2023/24 demonstrated an unprecedented increase in children entering care.
PD055	Delay in receiving requests from the local authority and high level of appointments to which a young person is not brought.

If you are not completing the Community Services Data Set (CSDS), please provide reasons for this

Organisation	Response
PD002	Work is ongoing to develop more community services data sets, but there was no Community Paediatrics CSDS reporting in 2023-24.
PD007	All data flows directly to the ICB and to the Community Services Monthly sit-rep. We are planning to commence submission to CSDS during 25/26.
PD026	We do not receive funding to complete the CSDS. Further to this, there are potential further development costs. We submit activity through the acute dataset. There is no separate contract for Community Services. We are submitting certain activities (e.g. physio) through acute datasets
PD032	Data set is provided for looked after children's services.
PD044	To effectively manage caseload and book appointments/activity, service needs to use acute PAS system available.
PD046	Reviewing SPEC.
PD048	Our previous Electronic Health Record did not generate the required data set. We are in the process of a first submission for a limited set of data to begin with, while we build the functionality with our current EHR.
PD055	We are part of an acute hospital trust.

Please describe any initiatives being implemented to reduce waiting lists

Organisation	Response
PD002	Waiting lists/waiting times have considerably reduced and service has been meeting 0 52 week RTT breaches. Waiting lists are regularly validated to ensure CYP still require appointments with additional capacity created where required to continue reducing waits.
PD003	Service received non recurrent funding for Saturday clinics and clearing CCDS backlog.
PD004	We developed a new Community Neurodiversity Support service that provide needs led, practical and effective support and interventions to children where needs have not been met at place. Support includes complimenting and coordinating key existing resources/offers in the system arounds the identified needs of the child/family. This model is based on the Portsmouth model that has reduced the number of children being referred for specialist diagnosis and support.
PD005	Introduction of International Medical Graduate (IMG) which has been successful, Mixed results with Locums, Additional Capacity via outside provider, Introduced skill-mix - Specialist Nurses, Introduced 'Safer Waiting' initiatives including Link Nurses and Carer Peer Support Workers (CPSW)
PD007	Referral process transformation - standardisation of triage criteria and nurse link worker to pick up on gaps in referral information. ASD/ADHD transformation work to streamline pathway - single entry for ASD/ADHD to ensure triage to appropriate pathway, including joint assessment pathway (new). Sleep pilot in delivery for early support before trial of medication. School based ADHD review clinics to maximise attendance and minimise impact on school attendance. Reduction in overdue follow-ups through focused clinical validation and additional clinic capacity including weekend WLI clinics

Please describe any initiatives being implemented to reduce waiting lists

Organisation	Response
PD008	NMP - DX project for ADHD: This project is near completion and hopes to demonstrate the benefits of NMP/nurse specialists leading on the Dx pathway. This would free up consultant time, as once physical health has been assessed and differential diagnosis considered - the nurse would continue and conclude assessment. Evaluation of this project is imminent. ADHD pharmacy pilot: This involves a cohort of community pharmacists supporting ADHD medication reviews for children who are stable on their medication. The pharmacists are able to complete an interim review in the community between appointments with specialist services. This reduces the number of appointments required by our service to review the children. This pilot is currently focused on secondary school aged children. So, if stable we would see once a year, rather than twice, as the 6 month review is completed by pharmacist. Route for escalation is clear if needed. Digital contacts: We are working closely with our digital team to create digital contacts for children on the routine waiting list and also our internal waiting lists for ASD/ assessment - giving them sign posting advise. We are also developing an ADHD digital review tool - which we would be initiating with our stable children (as a QI project), to review medication. With carefully selected questions, we can assess digitally if a child is doing well on their medication, if any of the questions answered, indicate that a face to face is required, this will be facilitated. If the responses indicated that all remains well, this will be documented, and next review will be planned in line with NICE guidance. This will be supported by attendance at physical observation clinics to ensure we have all the information needed to make safe clinical decisions. Additional: In addition, the service has robust and regular PTL (patient tracking list) meetings to monitor capacity, productivity, and waits; integrated clinical pathways are being developed for Tics, FASD, GIDS; the service has worked with the local ICB through collaborative workshops to understand pressures and reasons for waiting lists and to develop a shared understanding and co-design solutions; the service is part of a multiservice business case for investment into relevant services to manage increased ND waits (awaiting outcome in the System); the service is participating in System wide development of non-health solutions to ND referrals to attempt to stem the number of referrals is appropriate support can be found in schools
PD009	Services are undergoing significant transformation through process streamlining, clinical system reconfiguration, and Quality Improvement (QI) initiatives. These changes are enabling teams to adopt new models of care, enhancing efficiency, improving patient outcomes, and ensuring services are better aligned with evolving healthcare demands.

Please describe any initiatives being implemented to reduce waiting lists

Organisation	Response
PD010	Maximise recruitment of paediatricians; Skill mix of existing workforce; Communications with SENDCOs to understand and ensure referral appropriateness; ICB has used service as conduit to commission private ASD assessment capacity. This has been successful, but has not been used for our own service waiting lists
PD014	Quality improvement on nurse led clinics to support wait times. Waiting list recovery plan included change of process to manage waste - eg. DNAs and cancellations - reduced DNAs from 12% to between 5-6%.
PD016	Filling workforce vacancies, outsourcing, pathway reviews.
PD017	Clinic bookings are adapted to waiting list; Pathway review; outsourcing.
PD018	Initiatives with ICB via local autism charity / Duty clinician of the day - Medic and Nurse / Saturday clinics and evening appointments / online support groups for sleep.
PD019	Paediatric Continence - High rates of missed appointments were impacting wait times, as often people had forgotten and would request another appointment. We have changed to an 'opt-in' service to reduce our wait times as we were experiencing high 'Child Not Brought' rates. We now send text reminders for appointments 72 and 24 hours before appointment. CCH: Recently recruited new consultant who will reduce epilepsy waiting list. Sd trainees to carry out clinics. Triage patients appropriately CYPNP: Front loading the support to all CYP on the waiting list means the risk of waiting list is significantly less and is well received by all wider stakeholders (PCF, Education etc). We can complete between 70 and 80 good quality compliant assessments on the staffing levels we have. The clinical model has been streamlined to which has double the number of assessments with the same numbers of staff over the year-18 months. The cost of each assessment is more effective than alternative private providers. Although some joint working has proved positive. Using private provider still requires time and work force from our team to ensure the correct CYP are identified and triaged for complexity.

Please describe any initiatives being implemented to reduce waiting lists

Organisation	Response
PD022	Implementation of new discharge criteria to reduce caseload and a 20% reduction in unnecessary follow up appointments; Trial (start 7/4/25) For a new one day assessment clinic for children under five for the diagnosis of autism; Increased clinics in specific geographical areas where waits were longer.
PD023	Additional capacity being added to clinics to increase number of patients seen. Reduce contact duration from 60 to 45 minutes to increase capacity. Improved data analysis on waiting lists to ensure waits minimised and all children seen as efficiently as possible.
PD025	Service has agreed extra budget for WLI (initials) and Extra hours for reviews for 2024-25. This includes some ANAs and Job Planning reviews. We check that very long waiters still need care, and have a weekly cleanse for those moved away, died or found care elsewhere.
PD026	1. Qb testing at the point of referral 2. Sharing patients between 2 sites 3. Exploring different workforce models i.e ADHD Nurses led pathway 4. Reviewed and updated referral criteria within service spec 5. Streamlined job plans 6. Converted fups to news for a period of time 7. Reduced age for ASD assessments and redirected older patients to CAMHS who are more appropriate 8. Introduced new referral forms which screen for mental health conditions-If MH conditions are present referrer will be signposted to CAMHS as we are not currently commissioned to access mental health 9. PIFU Implementation
PD028	Waiting List Initiative commenced Mid 2023.
PD030	Skill mix - created Specialty Dr post from Nov 2024 - fixed term until Nov 25 Using year end underspend (non recurrent) to support waiting times for initial paediatrician assessments via an external provider Using ICB and year end underspend (non recurrent) to support ASD waiting times via an external provider
PD031	The Neuro-disability service is currently under review by the Operational and Clinical team to formally identify current demand and capacity.

Please describe any initiatives being implemented to reduce waiting lists

Organisation	Response
PD032	Electronic referral triage with dedicated time by two clinicians Condition specific pathways Telephone clinics Specialist nurse led reviews Using GP to support with initial health assessment Senior admin support to monitor referrals and processes Virtual MDT to support complex patient care Using PIFU, monitoring DNA rates
PD033	Outsourcing, upskilling non-medical health professionals to contribute to neurodevelopmental assessments.
PD034	ADHD waiting list initiatives have included outsourcing/additional clinically resourced to reduce wait times/Triage screening process for referrals MDT triage.
PD041	Autism Hub Waiting List Initiative Neurodiversity Transformation Neurodiversity Support Service Single point of access safeguarding service
PD044	WLI's for new patients were in place during this time period to reduce waiting times and manage waiting lists, however these have since been removed.
PD046	PIFU and waiting list validation.
PD048	A range of initiatives such as including neurodevelopmental CNS to see under 5 for developmental assessment, supervised by consultants; expand the multidisciplinary team with speech and language therapists and psychologists to increase capacity for ASD assessments; try and schedule clinicians to be available to do an autism assessment at the first visit if appropriate to do so; skill up all clinicians in the team to do autism assessments
PD049	Review of Autism Diagnostic pathway and piloting new process. Reviewing original service specification in relation to Phlebotomy waiting times and reviewing process following implementation of simply book.

Please describe any initiatives being implemented to reduce waiting lists

Organisation	Response
PD052	A complete overhaul of the service and processes has been performed to streamline models of care and deliver a robust 'while you wait' offer to support families experiencing longer waits. Delivery model of care has reduced long waits by 50% in the last 12 months.
PD053	Business case submitted for additional medical staffing for the service.
PD055	County wide work to address long waiting times for autism assessment.
PD056	Service transformation project is being implemented to review service specifications, care pathways and integrate several different units of TPP SystmOne Electronic Health Record.
PD057	System wide work is ongoing reviewing NDD wait times and assessment.