Royal College of Paediatrics and Child Health
Leading the way in Children's Health

10 Year Health Plan for England
RCPCH organisational response
2 December 2024

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

Children and young people (CYP) represent the future of our society yet their physical and mental health is deteriorating, which have implications for the health and economic wellbeing of the nation. Paediatricians and the wider child health workforce are working hard to deliver safe and high-quality services for children and to implement innovative models of care. **We need a rebalancing of the health system so there is a greater focus on meeting the needs of CYP.**

This is a call for equity: it is unacceptable that children's health services have been deprioritised and underfunded compared to adult care. It is also good economic sense: investing in children's health offers high economic returns[1] and is essential if we want to have a healthy nation.

The state of child health and child health services

CYP make up around 25% of the population but just receive 11% of health funding, which means it's not equitable based on population split or demand for services. Our Blueprint for Child Health Services highlight the consequences for not prioritising CYP:

- Child health outcomes have deteriorated and demand for health services has increased over the last decade due to preventable and non-preventable causes of childhood illness. This includes increased respiratory illnesses, medical complexity, and prevalence of obesity and mental health.

- The gap between demand and service capacity has widened and our members tell us there is no longer the appropriate level of capacity to meet local demand for child health services.
- Children are now waiting longer than adults to access healthcare. The number of children waiting for over 52 weeks for an appointment increased by 60% for elective paediatric services, and 94% for community health services in just two years.
- Long waits for care are damaging for CYP as many interventions need to be given by a particular age or developmental stage, and year-long delays for surgery, speech and language therapy or paediatric input can be irreversible for children.
- Children are now too frequently bypassing primary care with families seeking hospital-based care, often for conditions that could be managed closer to home. A review in North West London found that 59% of babies who were brought to ED did not require any further investigation, treatment or admission, and were sent home after parental reassurance.[2]

Overarching recommendations

The RCPCH fully supports the proposed shifts from hospital to community, analogue to digital, and from treatment towards prevention. However there are foundational changes that need to be put in place to ensure the NHS as a whole works better for children. Without these, child health services will not meaningfully benefit from any of the proposed shifts.

Our recommendations for transforming child health services that we want to see included in the 10-Year Health Plan are:

Prioritise children's health in national plans

1. Children, young people and child health services must be specifically considered throughout the 10 Year Plan, including in proposals for each of the three shifts. The Plan must recognise that children have distinct needs, interact with the health system differently and often encounter a wider range of services than adults.

2. Rebalance away from acute metrics against which systems have historically been assessed, towards metrics which consider community provision, holistic care, and health outcomes. While we accept the need for a reduction in the overall number of targets, there should nevertheless be clear metrics which capture how services and ICBs are meeting the physical and mental health needs of CYP, including factors such as school readiness and attendance,

vaccination rates and A&E attendance rates. (NB: we would be pleased to work with government to define a full suite of metrics).

3. National prioritisation categories and risk frameworks must take into account the differential risks experienced by CYP, including the impact of long waits on children's healthy development and ability to participate in education.

Ensure fair funding for children

4. Introduce a Children's Health Investment Standard to address the investment gap between child and adult health services. Similar to the Mental Health Investment Standard, this would require ICBs to increase their spending on children's health services at a faster rate than their spending on other services, and gradually move towards more equitable service funding.

Make devolution to Integrated Care Systems work better for children

5. Establish clear national oversight of Integrated Care System performance for CYP.

6. Set clearer expectations for Integrated Care Systems through a CYP waiting times standard, and offer dedicated support and guidance to Integrated Care Boards to tackle long waits in childhood and ensure no child is left waiting for over 18 weeks for care.

Support a sustainable child health workforce

7. Review the modelling on children's health which underpins the NHSE Long Term Workforce Plan. Investment in the workforce should be evidence-based and fair, and should consider the increased demand and complexity of child health.

8. Develop a national child health workforce strategy which takes a whole system approach to recruitment and retention.

9. Commit to expanding training places for paediatricians and the wider child health workforce, with a focus on the community child health workforce.

Patient voice

CYP through RCPCH &Us are calling for **a child rights-based approach** (Unicef[3]) in how they are involved (Article 12), how they have access to the best health and healthcare services possible (Article 24) and that duty bearers, such as public sector services including the NHS and Governments, act in their best interests (Article 3) when developing the NHS 10 Year plan. Please refer to the separate submission from RCPCH &Us for more detail on how this can be adopted.

RCPCH &Us engaged with over 2000 CYP across England in November 2024. This included CYP aged 7 to 25 from different locations, socio-economic backgrounds, with those who have health and disability experiences and from a range of ethnic backgrounds. Engagement with CYP replicated the "Start Here / Your Experiences / Your Ideas" elements of the Change NHS Portal.

Through our analysis, whilst not a representative sample of children, young people and young adults, our comparison of our subgroup data (ethnicity, gender, age and disability) and the numbers involved provides us with statistical confidence in our overall findings. (Full data available on request via and_us@rcpch.ac.uk)

Sustainability

As the impacts of the climate and nature crisis deepen, so too will the burden on our health service. Children are particularly vulnerable to changing environmental risks. Alongside the UK Health Alliance on Climate Change (UKHACC), we believe that the 10-year plan should consider the increasing risks while also adapting to deliver a more environmentally sustainable service.

To meet the demand for rapid change, sustainability needs to be hardwired into broader NHS accountability mechanisms. For example, NICE should incorporate environmental costs and benefits alongside clinical effectiveness and financial costs in its judgements, and relevant metrics should be included in the oversight and assessment framework and CQC assessment processes for ICSs and Trusts, and the annual planning guidance.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

RCPCH has long called for a greater focus on and investment in children's community health services. Many children and families want to be able to access high-quality health services closer to home. However, for this shift to work well for children and be sustainable for the child health workforce, children's community health services urgently require further investment and service transformation.

The key challenges are:

- **Community child health teams are already overstretched,** with record-high waiting lists, limited resources, and longer waits than almost any other part of the health system.
- Increased medical complexity in childhood has put pressure on community services, but there has been no increased investment. **Children make up a quarter of all patients waiting for community services, but over 80% of patients waiting for over a year**[4]. The number of children waiting over a year for community paediatric care has increased by 430% in two years[5].
- **Community workforce shortages** – There are growing workforce gaps, and the College has estimated that a 50% increase in community paediatricians is needed to meet current demand. Other professions such as CYP speech and language therapists and occupational therapists also face significant recruitment and retention challenges. The ageing workforce compounds this issue, with the average community paediatrician now 52, over half working less than full time, and many signalling their intention to retire in the next few years.
- **There are also challenges in primary care, where a majority of the workforce have no postgraduate training on children's health. Less than half of GPs now receive postgraduate training or placements in children's health.** Many GPs only have a few weeks of relevant undergraduate training but are expected to be the first line of assessment and treatment for CYP. GPs are under considerable pressure. Alongside improving training on child health, the primary care workforce needs adequate investment, support and the capacity to do this well.
- **The health system has been overly focused on acute metrics, leaving children's community services largely invisible at national and ICB levels.** This is compounded by challenges with funding flows to community services to improve provision.

Enablers:

- Relevant service evaluations have shown clearly that children and families welcome this shift to the community, as it can minimise disruption and enable them to access care closer to home. When done well, community teams often lead the way in terms of the provision of high quality, holistic care, with input from mixed, multidisciplinary teams which is highly beneficial for children.
- Shifting care into the community can be highly cost effective and reduce pressures elsewhere in the system, for example reducing unnecessary Emergency Department attendance. NHS Confed have estimated that for every £1 invested in community or primary care, there is a £14 return[6]. While it is essential that, at least in the short-term, funding for paediatric community services is additional to funding for acute paediatric services, given the extent of pressures in acute paediatrics and risk to safety, developing capacity in the community is likely to save costs in the long run.
- Paediatric exemplars like 'hospital at home' initiatives and Child Health GP Hubs show that this shift can work well for children, with the right support. Many families, and indeed much of the workforce, want to return to a true 'family doctor' model in primary care.
- There are various good practice models which have developed integrated approaches between primary and paediatric care, resulting in more streamlined care pathways for children and their families. One example is Connecting Care for Children (CC4C)[7], which has established 25 'Child Health General Practice Hubs' that offer joint clinics delivered by GPs and paediatricians; access to rapid paediatric advice for primary care clinicians; and longer-term upskilling. Some approaches have established true multidisciplinary child health teams in primary care services, including the GP, a linked paediatrician, children's community nurses, social workers and members of the local voluntary sector such as children's link workers or youth workers. Analysis from CC4C demonstrates the impact of this integrated approach across their pilot sites, including an 80% reduction in outpatient referrals from GP practices part of CC4C, a 22% reduction in A&E attendance, and significant cost savings.
- Neighbourhood health teams could be a highly effective model for children however they must consider the distinct needs of CYP and ensure an appropriate workforce skill-mix.

We recommend:

- **The government should urgently address the current long waiting times in community child health services as a core part of recovery plans,** before progress can be made on a wider shift into the community. This should be central to any new efforts on elective recovery, and ICBs and Trusts should be supported to reduce their long waits, and ensure no child is left waiting for over 18 weeks for healthcare

- **Invest in the community child health workforce**. This includes addressing the growing workforce gaps for community paediatricians, speech and language therapists, occupational therapists and physiotherapists. This will involve some additional investment but also work to understand the barriers to working in the community.
- **Develop a training framework on children's health competencies for all GPs**, to ensure they have the knowledge, experienced and confidence to manage common paediatric presentations. This framework should be developed by NHSE WT&E, the Royal College of General Practitioners (RCGP) and RCPCH.
- **Embed models of joint working between primary care and paediatric teams.** Models of joint working between primary care and paediatric teams should be implemented by every Integrated Care System and Primary Care Network. The degree of joint working can flex based on local need and working arrangements, Approaches should be developed using examples of best practice, such as the Child Health GP Hub model.
- **Ensure plans for neighbourhood health teams will work for CYP** and provide safe and effective care for all ages. Child health professionals should be a core part of these neighbourhood teams, and workforce planning should consider the needs of different ages of CYP: from babies and infants, school-age children, and adolescents who are often forgotten in service design.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

RCPCH welcomes the digital shift and the potential to improve care for children and young people (CYP). However, it is essential that the shift from analogue to digital is not designed only with adults in mind but instead ensures that digital transformation of child health services happens at the same time and at the same rate.

The key challenges are:

- **The current lack of data linkage and information sharing across children's health and care services** poses a significant challenge to providing high quality care, identifying risk of harm, and making the most of digital technologies. There are significant gaps when it comes to information about children's health needs and outcomes. Only 24% of Local Authorities and 16%[8] of ICBs link health data on CYP.
- **Children are assigned different 'identifiers' by various agencies** (including by the NHS, schools, and social care) which can make it harder to identify and link data held by different settings about the same child to identify risks or improve care. There is currently little standardisation of data capture in child health services. Partial and disconnected records across services leads to uncoordinated care and the potential for health or safeguarding issues to be overlooked and leaving vulnerable children 'invisible'[9].
- **Ambiguity in primary legislation on information sharing[10]** between CYP health, care and education services reduces confidence among child health professionals about what they can, and should, legitimately share. This means children's services are often and unnecessarily left behind in technological innovation or new approaches to data sharing, leading children's services systematically disadvantaged.
- **Slow, poorly connected and difficult to use day-to-day systems** currently make clinicians' lives harder and their work less efficient. This is a challenge across the health system but is particularly common in community child health services, which are often underfunded and have poor technological infrastructure. For example, many community child health services still use paper records, and may be unable to send digital prescriptions, meaning they have to go via the GP.
- While CYP are often thought of as a 'digitally literate' group, they can face significant **barriers in using technology in health and care**. Digital, or

telephone systems may not be the preferred communication method for CYP when it comes to their health, as navigating these systems can be confusing and they may not have access to devices and the internet, or a confidential space. With 62% of 5-15-year-olds sharing devices[11], and poor internet access, particularly in less well served areas, digital healthcare consultations can enhance anxiety levels for CYP.

- There is **often unequal access to using technology in health and care**. Child poverty is at an all-time high in the UK; some young people don't have access to a stable internet connection, available data or an appropriate device. Without further consideration, the digital shift poses the risk of further isolating underserved CYP from accessing medical support.
- There are **patient safety concerns for CYP, when using Electronic Prescribing and Medicine Administration (EPMA) systems**, with significant errors found within children's inpatient settings[12]. Many systems either default to the standard adult dose, have no dose limits, or are not specific to a paediatric condition, leading to unsafe doses of medicines, causing significant harm or death if administered incorrectly.

We recommend:

To enable better use of technology in health and care and ensure new technologies in health settings are suitable, safe, and accessible for CYP, the 10-year plan should:

- **Fully consider children and child health services in national plans to develop a digital health record, a key part of which is the digitisation of the red book.** The development of a digital red book should be accelerated, and it should go beyond growth charts and vaccine records to provide a full picture of a child's health. The red book should remain accessible to parents, and should be integrated into wider plans for the digital health record that will follow a child throughout their life course.
- **Implement the NHS number as a Single Unique Identifier (SUI) for children:** Having a SUI is crucial to enable data linkage on children's health, care and safeguarding needs[13]. Implementing the NHS number as a SUI will support better identification of risks and enable more joined-up care between the NHS and health and care provision that takes place elsewhere e.g. in schools, early years settings, social care providers, local authority SEN teams, and other agencies. Benefits of a SUI have been evident in the Connected Bradford Whole System Data Linkage Accelerator project[14], leading to improved local health systems, implementation of preventive interventions, and better population health management.

- **Invest in improving the quality and accessibility of online health information and resources for families,** including Patient Focussed Medicine Information**.** This can be achieved through improvements to NHS online, with digital resources designed with children and families in mind, with paediatric input and a focus on inclusivity, accessibility and interactivity. **The CYP 'arm' of NHS online could be replaced with the successful paediatric exemplar, Healthier Together**[15]. Evidence from this programme shows that these resources can increase the likelihood of self-care, improve health literacy, and reduce unnecessary Emergency Department (ED) attendance for minor complaints, which is particularly high for children. This can lead to cost-savings, as a review of North West London ICS found that the cost of babies who were brought to ED unnecessarily was £1.8million per year [16].
- **Prioritise the inclusion of all CYP, particularly underserved populations, in the shift to digital care**. This includes ensuring CYP have suitable WiFi or funding mobile data as needed. The Children and Young People's North East and North Cumbria (NENC) Diabetes Network improved access to diabetes technology for ethnic minorities and deprived families by providing repurposed mobile devices, SIM cards, and laptops to clinic attendees[17]. CYP must also be offered a face-to-face option for medical consultations, rather than only a digital option to mitigate confidentiality or safeguarding concerns.
- **The British National Formulary for Children (BNFC) standardised dose based on age, weight, body surface area should be used for EPMA systems to calculate paediatric dosages and must be checked by an appropriate clinician**. Local guidelines should supplement the BNFC, preserving governance clarity and consistency for paediatric dosages.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

We welcome the shift to prevent illnesses before they happen and to shorten the amount of time people spend in ill health. However, to deliver on this ambition, RCPCH strongly recommends that a life course approach to prevention is taken to spot illnesses and tackle the causes of ill health.

The key challenges are:

An inadequate priority given to child health and the prevention of ill health in childhood. We are concerned that a focus on early detection of illness and enabling people to live independently for longer risks framing the NHS 10-year plan around adult's health needs.

Many lifelong health issues are established in childhood and adolescence. Evidence demonstrates that CYP in England currently experience some of the worst health outcomes with widening health inequalities compared with other similarly developed countries.[18] These health outcomes are often preventable, however if left untreated children will grow up with unaddressed ill health issues, multiple morbidities and poor health outcomes, which are harder to reverse in adulthood.

- The prevalence of obesity in Reception aged children in 2023/24 was 9.6%, and it more than doubles to 22.1% for year six children. For children living in the most deprived areas, obesity prevalence was over twice as high compared with those living in the least deprived areas.[19]
- Uptake for all routine childhood vaccinations decreased in 2023-24 and no vaccines met the 95% coverage target.[20]
- Nearly 1 in 3 (29.3%) of 5-year-old children had tooth decay in 2022. [21] Tooth decay is the leading cause of hospital admission in 5-9 year olds, however children living in the most deprived communities are over three times more likely to be admitted to hospital for tooth decay than those living in the least deprived.[22]
- Rates of poor mental health for CYP are rising: 15.7% of 8-10s, 22.6% of 11 to 16s and 23.3% of 17-19 year olds had a probable mental health disorder in 2023. [23] For children living in the poorest 20% of households, they are four times more likely to develop a mental disorder than those from the wealthiest 20%.[24]
- Air pollution has overtaken high blood pressure and smoking as the leading contributor to global disease.[25] Exposure to air pollution is the second leading

risk factor for death in children under 5, both globally and in the UK.[26] Exposure to air pollution during gestation, infancy, childhood and adolescence affects developing organs and increases the risk for chronic disease in adulthood.[27]

This growing incidence of preventable ill health is contributing to an **increased demand for children's health services.** This leads to long waiting lists to access care due to the lack of adequate funding for children's health services to meet demand. The long waiting lists mean CYP do not have timely access to support, which is preventing early diagnosis of illnesses and further exacerbating health problems. This can have a significant impact on their lifelong healthy development.[28]

While a shift from treatment to prevention within the NHS is welcome, a focus on secondary prevention without considering the importance of primary prevention and addressing the role of the wider determinants of health alongside it, means success in improving the health of the population and reducing demand on the NHS will be limited. Ongoing **cuts to the public health grant,** estimated to be 28% in real terms since 2015[29], present further challenges in tackling the causes of ill health. The grant funds vital prevention services, including health visiting and school nursing, which means families lose out on key services that can help detect early signs of illnesses or early intervention care to support health.

The enablers to spotting illnesses earlier and tackling the causes of ill health focus on ensuring a life course approach to prevention. The ambition to prevent ill health must be informed by a wider cross-governmental approach that considers the role of each department in tackling the causes of ill health and reducing health inequalities.

We recommend:

- **Investing in health visiting and school nurses:** Provide sufficient resource to increase the capacity of health visitors and school nurses to enable them to provide vital early intervention and prevention services to children and families, which will reduce the reliance on specialist or urgent health services. (NB: this sits alongside the community health workforce investment recommendation in the hospital to community shift).
- **Expanding prevention services:**
    - Remove barriers to vaccination uptake by expanding access to and capacity of vaccine appointments to provide more flexible options[30] to families, such as vaccination during home visits[31], while ensuring equity of access to underserved communities.

    - Ensure all children are seen by a dentist by the age of one to support good oral health development by expanding children's oral health services, with a focus on equity of access with underserved communities.
    - Provide greater investment in Child and Adolescent Mental Health Services (CAMHS) to improve access to mental health support, reduce the long waits for care, and reduce the growing number of CYP who are reaching crisis point and ending up in emergency care settings while waiting for mental health support.
- **Prioritising a clean air future:** The NHS should lead by example by mandating the implementation of the Clean Air Hospital Framework across all NHS organisations.
- **Applying a sustainability lens to prevention:** We support the UK Health Alliance on Climate Change recommendation: A sustainability lens should be applied to prevention giving particular emphasis to preventative interventions that deliver combined health, environmental, financial and social benefits and ensuring that these wider benefits are measured, tracked and reported to inform future decision-making and prioritisation.
- **Restoring the public health grant:** Urgently increase public health funding to Local Authorities based on local population need, including restoring the 28% real-terms cut to the public health grant since 2015.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in.

Below we have summarised our specific policy ideas for change taken from across this submission. We firmly believe that all of these should be prioritised in the 10 Year Plan to achieve the re-balancing of the health system that is needed to ensure sufficient focus on children and young people and reduce the current inequity that exists between children's health services and adult care.

RCPCH Recommendation	Description
	Short Term (under 2 years)
Make devolution to Integrated Care Systems work better for children	- Establish clear national oversight of Integrated Care System performance for CYP. - Set clearer expectations for Integrated Care Systems through a CYP waiting times standard, and offer dedicated support and guidance to Integrated Care Boards to tackle long waits in childhood and ensure no child is left waiting for over 18 weeks for care.
Invest in health visiting and school nurses	Provide sufficient resource to increase the capacity of health visitors and school nurses to enable them to provide vital early intervention and prevention services to children and families.
Expand prevention services	- Remove barriers to vaccination uptake by expanding access to and capacity of vaccine appointments to provide more flexible options to families, while ensuring equity of access to underserved communities. - Ensure all children are seen by a dentist by the age of one to support good oral health development, with a focus on equity of access with underserved communities. - Provide greater investment in Child and Adolescent Mental Health Services (CAMHS) to improve access to mental health support.

Restore the public health grant	Urgently increase public health funding to Local Authorities based on local population need, including restoring the 28% real-terms cut to the public health grant since 2015.
Address the current long waits in children's community health services	This should be central to the new elective recovery plan, and dedicated support and guidance should be provided for ICBs and Trusts to reduce their long waits, and ensure no child is left waiting for over 18 weeks for healthcare.
Fully consider children and child health services in national plans to develop a digital health record, a key part of which is the digitisation of the red book.	The development of a digital red book should be accelerated, and it should go beyond growth charts and vaccine records to provide a full picture of a child's health. The red book should remain accessible to parents, and should be integrated into wider plans for the digital health record that will follow a child throughout their life course.
Prioritise the inclusion of all CYP, particularly underserved populations, in the shift to digital care	Steps should be taken to ensuring CYP have suitable WiFi or funding mobile data as needed. CYP must also be offered a face-to-face option for medical consultations, rather than only a digital option to mitigate confidentiality or safeguarding concerns.
Use appropriate guidance for paediatric dosages	The British National Formulary for Children (BNFC) standardised dose based on age, weight, body surface area should be used for EPMA systems to calculate paediatric dosages and must be checked by an appropriate clinician. Local guidelines should supplement the BNFC, preserving governance clarity and consistency for paediatric dosages.
Medium Term (2-5 years)	
Ensure fair funding for children	Introduce a Children's Health Investment Standard to address the investment gap between child and adult health services.

Prioritise children's health in national plans	- Rebalance away from acute metrics against which systems have historically been assessed, towards metrics which consider community provision, holistic care, and health outcomes. - National prioritisation categories and risk frameworks must take into account the differential risks experienced by CYP.
Prioritise a clean air future	The NHS should lead by example by mandating the implementation of the Clean Air Hospital Framework across all NHS organisations.
Apply a sustainability lens to prevention	A sustainability lens should be applied to prevention giving particular emphasis to preventative interventions that deliver combined health, environmental, financial and social benefits and ensuring that these wider benefits are measured, tracked and reported to inform future decision-making and prioritisation.
Develop a training framework on children's health for all GPs	NHSE WT&E should work with Royal College of General Practitioners (RCGP) and RCPCH to develop a training framework in children's health competencies for all GPs.
Implement the NHS number as a Single Unique Identifier (SUI) for children	Having a SUI is crucial to enable data linkage on children's health, care and safeguarding needs[32]. Implementing the NHS number as a SUI will support better identification of risks and enable more joined-up care between the NHS and health and care provision that takes place elsewhere e.g. in schools, early years settings, social care providers, local authority SEN teams, and other agencies.
Invest in improving the quality and accessibility of online health information and resources for families	This can be achieved through improvements to NHS online, with digital resources designed with children and families in mind, with paediatric input and a focus on inclusivity, accessibility and interactivity. The CYP 'arm' of NHS online could be replaced with the successful paediatric exemplar, Healthier Together[33]. Evidence from this programme shows that these resources can increase the likelihood of self-care,

	improve health literacy, and reduce unnecessary Emergency Department attendance for minor complaints, and can lead to cost-savings.
Invest in the community child health workforce	This includes addressing the growing workforce gaps for community paediatricians, speech and language therapists, occupational therapists and physiotherapists.
Embed models of joint working between primary care and paediatric teams.	Models of joint working between primary care and paediatric teams should be implemented by every Integrated Care System and Primary Care Network. The degree of joint working can flex based on local need and working arrangements.
Long – Term (5 years plus)	
Ensure plans for neighbourhood health teams will work for CYP, and safely meet their needs.	Plans for 'neighbourhood health teams' must apply equally to CYP as they do to adults, and the development of these teams must consider the needs of CYP, and how the children's health workforce will be included. The teams should cover CYP of all ages and recognise the different workforces involved.
Support a sustainable child health workforce	- Review the modelling on children's health which underpins the NHSE Long Term Workforce Plan. Investment in the workforce should be evidence-based and fair, and should consider the increased demand and complexity of child health. - Develop a national child health workforce strategy which takes a whole system approach to recruitment and retention. - Commit to expanding training places for paediatricians and the wider child health workforce, with a focus on the community child health workforce.

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