

Collaborative Healthcare in England:

Delivering the services
children need in the
community



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For too long, children's community services have been overlooked in the post-covid recovery agenda. These services care for the most vulnerable children in the country: conducting safeguarding medical assessments, supporting unaccompanied asylum-seeking children and providing care for children with complex health needs and disabilities. It is unacceptable that these services are lagging so far behind both the rest of the health system and adult community services. There is a need for urgent investment and a clear message to ICSs to prioritise community child health services.

Dr Ronny Cheung, RCPCH Officer for Health Services

Introduction

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.

Average waiting times for community child health services are now some of the longest of any part of the health system, and there is a significant disparity between adult and children's community services, and their recovery post-pandemic. The current state of children's community services is unsustainable. Failure to address pressures will worsen the health and wider societal outcomes of the most vulnerable children and their families. Long delays to community care have a particularly acute impact on children as many treatments are age or developmental stage critical.

Improving care in the community is beneficial particularly for children and young people (CYP). Not only will it enhance health outcomes, but it can also be highly cost effective and reduce pressures elsewhere in the system, for example reducing unnecessary Emergency Department attendance and the growing economic burden on families. NHS Confed have estimated that for every £1 invested in community or primary care, there is a £14 return¹.



Community care always appears to be looked at last even though poor community care has a direct impact on hospital admissions and waiting times. Therefore, early intervention community care and preventing ill health are intertwined and must be viewed as such. They impact each other. Preventing ill health through education and support starts in the community it is too late by the time the patient reaches hospital admission.

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What is community paediatrics?

Community Child Health (CCH) is the largest paediatric sub-specialty focussing on the care of vulnerable children and families, children with long-term conditions and child public health. This includes children with:

- developmental disorders and disabilities,
- complex health needs (including end of life care)
- behavioural presentations of neurodevelopmental disorders (e.g. Autism, ADHD)
- safeguarding concerns, who are “Looked After” or being adopted.

Community paediatricians usually work in multidisciplinary teams and across agencies with therapists, nurses and colleagues from schools, social services, the voluntary sector and local authorities. They have a vital role in planning and implementing local strategies to improve the health of all children in their area including safeguarding policy, universal and targeted lifestyle programmes and tackling local social determinants of health. A number of statutory roles are also usually provided by community paediatricians relating to child protection and child deaths, looked after children and those with special educational needs and disability (SEND).

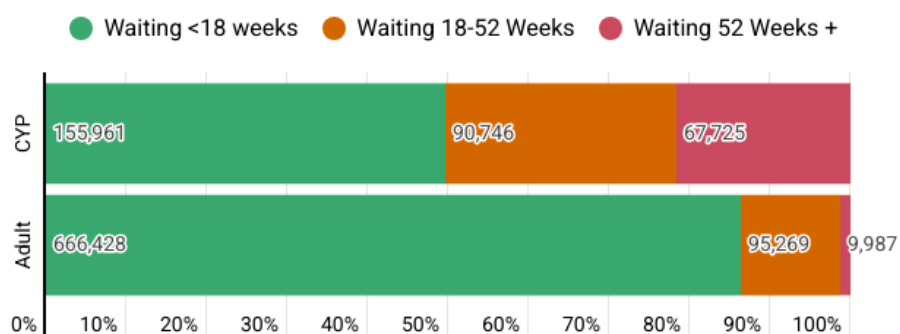
The nature and relative volumes of childhood illness have changed in recent decades with more mental health and neurodevelopmental disorders such as autism and ADHD being diagnosed, greater reporting and awareness of safeguarding issues and more emphasis on children in public care. These, together with additional statutory duties in recent years have added to the volume and complexity of community paediatric roles.

The Evidence

In England, there is inequity between children and young people's (CYP) and adult's community health services.

- As of March 2025, there are now over **314,000**ⁱ CYP waiting for community health services.
- CYP service waits have shown no improvement over the past year and waiting lists are growing (with a concerning 5% rise from February 2025 to March 2025, translating to an additional 16,000 CYP waiting).
- The data shows that CYP are being left behind when compared to adults in efforts to reduce waiting lists. From April 2024 to March 2025, the overall adult community services waiting list has decreased by 2%, while the CYP list has increased by 11% over the same time period.
- CYP are waiting significantly longer than adults to access community health services, with 21.5% of those currently waiting 52+ weeks. In comparison, 1.3% of adults are waiting 52+ weeks.
- 86% of adults are being seen within the 18 week target but only 49.6% of CYP - meaning that almost 160,000 CYP are waiting more than 18 weeks for access to community health services.

i [The Community Health Services \(CHS\) SitRep](#) collects monthly data on waiting lists and waiting times. Data from this report is based off the May data release, which reports up to March 2025.



Those who need care the most are often the least likely to receive itⁱⁱ, which is particularly evident for children and young people. CYP from Black, Asian and minoritised ethnic backgrounds, CYP seeking asylum and refugees, and CYP from low-income households are more likely to experience barriers in accessing all healthcare, including care in the community.

- There are fewer GPs per population head in areas of higher deprivation compared to areas of lower deprivation⁴.
- Asian, Black, Chinese or Mixed-Race children have a higher likelihood of missing out on mandated health visiting checks than white children⁵.
- NHS charging regulations contributing to delays in or denials of healthcare to migrant and undocumented children and pregnant women⁶.

The Impact

Children and young people (CYP) are waiting longer than adults to access healthcare in England. Paediatric services are not recovering at the same rates as adult services, and there is a growing gap between demand and capacity.

RCPCH have outlined some of the key issues in our blueprint for child health² including:

- Long waits for community care are unacceptable for any patient but are even more **harmful for children**.
- Delays may lead to **irreparable harm if care is not initiated** before a particular developmental window closes. Many children are unsupported during these waits, with little access to therapeutic interventions. This can mean children continue to miss key developmental milestones, with the gap between them and their peers widening.
- There is potential for **lifelong impacts** on speech, mobility, physical and social development, and missed learning.
- Long-wait times for community care also places **strain on the wider health system**, with many families reaching out for help repeatedly to GPs and Emergency Departments while waiting in limbo.
- Long waiting lists for children and young people are **detrimental for economic productivity**, including the direct impact of school absence on long term attainment outcomes, plus the indirect loss of productivity experienced by carers taking time off paid employment for childcare.
- Children with **neurodevelopmental conditions** often face significant waits for their first appointment, which can be across community health services or mental health services³. This is enhanced by several **health inequalities** – with some families able to pay for private assessment and support.

ii Inverse care Law principles: <https://www.health.org.uk/reports-and-analysis/reports/tackling-the-inverse-care-law>

Recommendations

In the context of shifting care closer to home, we urgently need transformational change in children's community services. Since the publication of our Blueprint for Child Health Services in September 2024, we have seen little progress against our recommendations for these critical services, and **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 of care into the community.**

Overarching Policy Recommendations

- **Introduce a distinct waiting times target for community waits to match the referral-to-treatment target**, with 92% of patients in England seen for treatment within 18 weeks by 2029 in a standard and equitable way. We want to see this target go further and faster for children in community waits. No child should be waiting longer than 18 weeks for care.
- **Introduce a Children's Health Investment Standard** to address the investment gap between child and adult health services, requiring ICBs to increase their spending on children's health services, particularly community health services, at a faster rate than their spending on other services, and gradually move towards more equitable service funding.
- **Ensure national prioritisation categories and risk frameworks take into account the differential risks experienced by children.** This should include consideration of the proportion of life spent waiting, and the impact of long waits in childhood when prioritising resources.
- **Restore the public health grant** and 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.
- **Establish principles for good community service design and models of care** and showcase these in order to ensure resource is not allocated away from such services.

In parallel with the rest of the UK, in the remainder of this report, we discuss and highlight five key thematic areas in need of urgent attention to see improvement in child health outcomes::

- 1** The urgent need for data
- 2** Creating a sustainable child health workforce
- 3** Collaborative care
- 4** Positive transitions to adult services
- 5** Neurodevelopmental services

The Case for Change

1 The urgent need for data

The quality of data on children's health and care needs in the UK is poor, with notable gaps around community health data, health needs in school, and childhood disabilities, to the extent that we do not know how many children in this country have a disability, and which services they are known to². This is compounded by incomplete data on waiting times in England and the prevalence of non-reporting from trusts and ICBs on community waiting times, which is compounded by different ways community and mental health services data is collected.

Despite new guidance on standardising community health services in England⁷, there is provider uncertainty on the definition of community health services. There are also barriers to data sharing across the whole health system, including challenges with data interoperability, with different 'identifiers' assigned by different agencies and ambiguity around data sharing between organisations.

Recommendations:

- **Establish clear national oversight of Integrated Care System performance for children and young people**
- **Standardise data collection and sharing between community health services.**

Establish clear national oversight of Integrated Care System performance for children and young people

- Implement mandatory data reporting from all providers to ensure a full and accurate picture of community health services waits and of the number of children on the waiting lists.
- Develop a high-quality data source that enables inequalities in waiting times to be explored at system, place, trust and specialty level. Data coding could be through reporting on income, ethnicity and deprivation to understand at what point people are experiencing access to service barriers.
- Develop new metrics that can reflect the complex nature of physical and mental health services delivered in the community, including effective patient and staff experience measures, and measures that can demonstrate quality of care and improvement in outcomes⁸.

Standardise data collection and sharing between community health services.

- Break down and clarify the different services that are feeding into the overall dataset on 'community paediatrics'. Disaggregating this data away from one service line ('community paediatrics') will enhance understanding for providers when reporting as well as build a better data picture for comparing services.
- Implement the NHS number as a Single Unique Identifier (SUI) for children, which is crucial to enable data linkage between community healthcare providers on children's health, care and safeguarding needs.
- Ensure the digital red book is taken forward and goes beyond growth charts and vaccine records to provide all professionals with a full picture of a child's health.
- Provide patient-facing information that outlines who within the community multi-disciplinary team

has access to patient data records and how to grant or revoke access to digital systems, unless in contravention of information sharing for safeguarding. Not all CYP want everyone to have access to everything and want information to be clear and accessible on information sharing, information governance, access and data protection.



High quality data is the bedrock of service planning, assurance and quality improvement, and rightly has been prioritised by the NHS and public services at large over the past few decades. It is shocking that community services, and in particular those serving children and young people, fall so far short of this standard. We cannot expect them to continue to work in the dark.

Dr Ronny Cheung, RCPCH Officer for Health Services

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Creating a Sustainable Child Health Workforce

While the demands on community services have increased, there has been no comparable rise in workforce numbers. The College has warned that there are not enough community paediatricians to meet demand for services: in 2017 RCPCH estimated a 25% increase was needed, and now estimate that a 50% increase in community paediatricians is needed to meet current levels of demand⁹. Other professions such as CYP speech and language therapists and occupational therapists also face significant recruitment and retention challenges. There are long-term pressures looming on the horizon, with the average community paediatrician aged 52, over half now working less than full time, and many signalling their intention to retire in the next few years. It must be ensured that services are taking account of rising demand, growing complexity and survivorship of children seen in community paediatrics in their service planning..

There are also challenges in wider health workforce capability in providing care tailored for children, 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.

Recommendations:

- **Prioritise the child health workforce in national workforce planning.**
- **Invest in the training, skills and support needed to deliver paediatric care and new service models in the community.**

Prioritise the child health workforce in national workforce planning.

- 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.
- 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. The LTWP modelling should consider

- the increased demand and complexity of child health, and address that need is outstripping supply.
- Develop a child health workforce strategy. This should take a whole system approach to the recruitment and retention of the child health workforce.
- Commit to expanding training places for paediatricians and the wider child health workforce. This is essential for delivery of services which can safely meet children's health needs.

Invest in the training, skills and support needed to deliver paediatric care and new service models in the community.

- Implement postgraduate training on children's health as a core part of GP and wider practice staff training. NHSE should work with Royal College of General Practitioners (RCGP) and RCPCH to develop a training framework in children's health competencies for all GPs, to ensure they have the knowledge, experience and confidence to manage common paediatric presentations.
- Re-invest in health visiting and school nurses. This will provide earlier help for children and families and reduce the reliance on specialist or urgent health services when these are not needed.
- ICB's must support innovative models of care delivery in the community to meet current and anticipated demand, and to achieve sustainable reduction in waiting lists. This should include adequate expansion of the workforce to ensure these sub-specialist roles are adequately supported.
- Travel and administrative time should be accurately reflected in job plans where care is delivered across a range of locations and/or in a large catchment area. Flexible working and e-rostering will help to optimise skill mix and support staff to develop in their professional roles.
- Support staff to enhance efficiency within new service models in the community, using technology. For example, through proper provision for remote assessment; commissioning to reflect the value of group interventions.



Re-training staff not to assume that just because we are young, everything is okay physically. Stopping signs early prevents bigger problems as we age.

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3 Collaborative care

Integrated care does not simply mean collaboration, but a seamless joining of services for children and their families. Joined-up care within the health system and between health services and local authorities, education and other key partners is vital to providing better care for children and young people, who have many of their health and wellbeing needs met by services in the community and outside of the NHS. Considering the demands on the child health workforce and related services, it is crucial that children and young people receive care from professionals with the right expertise. This approach ensures that the care provided is tailored to the unique needs of each patient, whether it comes from community paediatricians or other healthcare providers.

RCPCH welcomes the NHSE Guidance on neighbourhood multidisciplinary teams for children and young people¹⁰, which ensures MDT working to provide integrated care that provides timely access to specialist advice, including paediatric and mental health expertise, through primary care-led team working.

Recommendations

- **Develop a joint child health action plan**
- **Invest in new models of working**
- **Prioritise early intervention**

Develop a joint child health action plan

- Develop a joint health action plan which includes education and social care workforce strategy for disabled children, children with special educational needs, and neurodivergent children³.

Invest in new models of working

- Develop models of joint working between primary care and paediatric teams. Every Integrated Care System and Primary Care Network should be supported to do this, using examples of best practice such as the Child Health GP Hub model.
- Provide dedicated investment for innovations to support service improvement, including the NHSE Guidance on neighbourhood multidisciplinary teams for children and young people.

Prioritise early intervention

- Urgently prioritise and invest in early intervention services: There must be 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. In particular:
 - Remove barriers to vaccination uptake by expanding access to and capacity of vaccine appointments to provide more flexible options¹ to families, such as vaccination during home visits², to ensure 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.
- Provide comprehensive support services for families: Ensure funding for rolling out family hubs/best start for life programmes across all local authorities. Invest in improving the quality and accessibility of online health information and resources for families, for example the successful paediatric exemplar, Healthier Together.
- ICB funding and commissioning models should provide flexibility to community care providers to enable the increase of availability of community care and appointments outside of school hours. This will reduce the cumulative disadvantage faced by children and young people with multiple or long-term health conditions that need to access this care.



Make sure support is co-located with other services “someone I know here”.

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Positive transition to adult services

Transitioning to adult services can be difficult for young people, often creating barriers to accessing care. This can result in longer wait times for services, especially in community care. Often the referral criteria and assessment capacity can be different in adult services, meaning young people transitioning out of children's services face even longer waits. Children with disabilities often face disruptive transitions in health services. The age at which a CYP transitions to an adult service can vary depending on location and service. There is often a gap for CYP when transitioning from CAMHS to Adult Mental Health Services in the UK. Adult services who look after young people with a neurodisability are sparse and variable, which means CYP services often have no equivalent service to which they can transition.

Transition of care is an issue for those young people already known to a paediatric service. But some 16- and 17-year-olds who have not yet been seen by secondary care services face additional barriers to receiving healthcare. There is variation across the country regarding the age at which new patients are accepted into adult and paediatric services, ranging from 16th to 18th birthdays, and some with additional provisions around whether they are in full time education. This can be confusing for young people, families and referrers, and can result in longer waits at a crucial time for their development into adulthood. Worse still, in some situations the referral for their care is made but is then refused by both services, leaving them without the required healthcare until they reach their 18th birthday.

For children and young adults with special educational needs (SEN), local authorities in England (and Wales) have a legal requirement to provide a local resource for children and young people from birth to 25 years. However, while some areas have 0 to 25 neurodevelopmental disorder assessment pathways,³ many services continue to operate up to 16 years in the physical health space and 18 in the mental health space, and young people then have to transition to adult services, experiencing the same challenges outlined above.

Recommendations

- **Ensure good transition planning principles**
- **Prioritise a collaborative approach to transition planning**
- **Ensure local clarity and service responsibility for the care of young people aged 16 and 17 years**

Ensure good transition planning principles

- There should be provisions in place for a smooth transition from children to adult services to ensure the best quality care is maintained.
- ICBs should establish a shared protocol around the principles of smooth transition for CYP, particularly when on a waiting lists. For instance, when children on the waiting list transition to adult services, their original referral date should remain throughout the transition and the process for transfer to the adult list should be agreed to ensure there is no cliff edge in support for children who turn 18 while waiting and have to rejoin waiting lists³.

Prioritise a collaborative approach to transition planning

- Young people should be involved in the planning of their transition between CYP and adult services¹⁴ and individual needs should be discussed in young people friendly terms. Examples like Ready,

Steady, Go¹⁵ - Southampton Children's Hospital show how co-produced transition plans can provide a structure and support for the young person to track their journey in a gradual way. It encourages children's and adults' services to work together at earlier stages.

Ensure local clarity and service responsibility for the care of young people aged 16 and 17 years

- ICBs are responsible for ensuring that local services do not leave young people aged 16 and 17 years without a responsible service to which their care should be referred. Whether paediatric or adult services delivers this care may vary from service to service, and by region, based on local expertise, but no young person should be left without a responsible clinical team to lead their care.



Improve “teenage” demographic services- in between paediatric and adult services, having a smoother transition between the two.

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Neurodevelopmental services

Autism assessments for children and adolescents happen in two types of NHS service, child and adolescent mental health (CAMHS) services and community paediatric services which undertake neurodevelopmental assessment. The Children's Commissioner for England has highlighted the long waiting times for assessment and support for autism³, ADHD and other neurodevelopmental conditions:

- It is estimated 400,000 children were still waiting at the end of the year (2022-23) to receive their first contact with community health services associated with neurodevelopmental conditions
- Children are sometimes waiting years for a diagnosis with the median wait for a diagnosis for a neurodevelopmental condition at 2 years and 3 months. Almost a quarter (23%) of children waited over 4 years (208 weeks) between being referred to community health services and being diagnosed with ADHD, and almost a sixth (15%) of children waited over 4 years to be diagnosed as autistic in community health services.



Faster wait times for assessments for neurodivergent conditions. Our mental health is suffering due to the severe underfunding of the NHS and we need more support.

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Recommendations

- **Ensure timely access to neurodevelopmental services and support**
- **Invest in the training, skills and support needed for neurodevelopmental services in paediatric care**
- **Provide support for children and families**

Ensure timely access to neurodevelopmental services and support

- Ensure support for children in all settings (education, local authorities and short break providers) is needs-led and does not require a diagnosis to access. This includes a fairer system of resource allocation in the SEND system, such as access to assessment, therapies and school places – which are currently subject to a postcode lottery.
- ICBs should establish a shared protocol for movements of children between waiting lists. Ensure that if children move from one local area to another (which is often necessary to access the support they need, such as a particular school), they do not go to the bottom of a waiting list in that area³
- Introduce a distinct waiting times target for access to neurodevelopmental services.

Invest in the training, skills and support needed for neurodevelopmental services in paediatric care

- Early identification and support through accurate advice and information for parents and carers on neurodevelopmental conditions.
- Provide regularly refreshed training to the community workforce on neurodiversity³.

Provide support for children and families

- Accessible resources (language, literacy, digital exclusion and other barriers) and communication is required so that children, young people, and their families do not feel abandoned while waiting for assessment. CYP and families should have sufficient information about neurodiversity, local assessment pathways, management advice, peer support, and services³
- Offer CYP and families appropriate emotional and mental health support when their child has complex needs, in addition to formal support (such as an EHCP). This may include providing relevant information and advice, signposting them to peer support groups and organisations.
- It is more important than ever that appropriate community based mental health support is available for children, with one in five children thought to have a diagnosable mental health disorder. ICB's should have a local strategy which ensures children are able to access community support early, and crisis service coverage must be available for every postcode.



Reduce waiting lists for ADHD and ASD assessment. Provide ADHD coaching, better support at schools, and easy access to medication and therapy. Have a 360 approach to the neurodivergent conditions as they affect many aspects of a young person's life.

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Conclusion

The case for better joined up community care is clear, and that is especially true for children, where needs can be met at the earliest opportunity, before they become more complex or impact development. Despite the benefits, children's community health services have been overlooked for too long with serious implications for the health of our children, health service and economy.

It is positive that the UK Government has made shifting care from hospital to the community a priority as part of the 10 Year Health Plan process. In this report, RCPCH repeats its call for a greater focus on and

investment in children's community health services. More widely, we reiterate the importance of listening to children's voice and respecting their rights.

The recommendations we make offer an opportunity to build a stronger service in the community for children and young people and, alongside action to prevent illness and address the wider determinants of health, to help ensure the UK Government is able to realise its ambition to create the healthiest generation of children ever.

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About RCPCH

The Royal College of Paediatrics and Child Health is the membership body for paediatricians and we have over 24,000 members across the UK and internationally. We are responsible for education, training and setting professional standards and informing research and policy. We work to transform child health through knowledge, research and expertise, to improve the health and wellbeing of infants, children and young people across the world.

This report was produced by the RCPCH Health Policy Team in collaboration with the RCPCH Officer for Health Services and Vice President for Policy.

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