# Children and Young People (1/6)

South East London Integrated Care System

## Vision

To deliver an integrated, informed and proactive model of care for children and young people with expert community and primary care services that enable CYP to stay well in their local communities, supported by timely access to high quality specialist services.

## Deliverables / Improvements since 2023/24

**Integrated models** – Implemented in Bromley, mental health integration piloted in Lambeth and Southwark

**Long Term Condition (LTC ) management**

- Asthma – assessment and review of asthma bundle and commenced implementation of the SEL Asthma plan.
  - Delivered the Clinical Effectiveness in South East London (CESEL) guidelines for GP's,
  - Developed the Asthma network meetings
  - Increased use of the Digital Health Passport (DHP) for CYP
  - Developed an All-Age Asthma dashboard
- Diabetes – Getting It Right First Time (GIRFT) review completed and recommendations received and workplan developed,
- Epilepsy - review in process to define workplan
- Obesity and Complications of Excess Weight (CEW) clinics continue to develop with expansion of the CEW clinics to offer a community-based service

**UEC** – Self assessment on NHSE Regional CYP UEC checklist completed, Task and Finish group set up and developed workplan which is being delivered

**Inequalities** – Delivery of core offers for community services for ASD diagnosis, continence and CYP Hospital at home. Work on core offers for community paediatrics

## Key Challenges / Opportunities Remaining

**Challenges**

- Embedding a CYP focus in all care pathways so care planning for CYP is considered alongside adult care pathways and takes into account requirements for young people transitioning between CYP and Adult services.
- Capacity across partners to delivery the full commitments set out for CYP
- Agreeing integrated and sustainable funding for delivery of local child health teams across partners.

**Opportunities**

- Move to integrated neighbourhood care for CYP with a focus on delivery in the community
- Development of all age care pathways that start with CYP and lead to adulthood.
- Delivery of national requirement such as Hybrid Closed Loop Systems for CYP
- Focused use of the system Mid term Financial Strategy (MTFS) which identifies CYP as a key priority area for investment
- Use of a locally developed Vital 5 programme for CYP as a lever to shift to prevention
- Explore patient empowerment/learning to extend the engagement agenda
- Linking with the SEL Women's and Girl's Health Hub model

# Children and Young People (2/6)

| | What are our priority areas for 2025/26 (Max 4) | Why has this been identified as a priority areas? |
|---|---|---|
| 1 | **Improve waiting times** for CYP into health services across acute services ( *Reforming elective care for patients)*, community-based care and mental health services (ref. Mental health programme) | Elective and community waits for CYP continue to increase and CYP are disproportionately affected.<br>'*Reforming elective care for patients'* sets out expectations for CYP elective care waits which need to be prioritised<br>Waiting times for Mental health services continue to be a priority |
| 2 | Develop pathways and services that support safe, effective and appropriate CYP **access to Urgent and Emergency Care (UEC)** (ref. UEC programme) | In SEL, most attendance at ED are self referrals, with around 51% of being classed as standard or non urgent. Around 77% are discharged home. 35% of attenders are aged 0-5 and 23% 20-24. A review of SEL CYP UEC/ED's was completed in 2023 and an action plan for improvement agreed with the clinical partners to change this picture |
| 3 | Develop and embed **population health management** approaches to support SEL CYP, including implementation of new models of care to proactively support CYP via prevention, and with LTC management | Reducing inequalities for CYP is a priority area and this links PHM with the CYP Core20+5 requirements and allows a targeted approach to those in most need and within identified groups<br>The Integration model and LTC management is identified within the sustainability and CYP programmes and enables us to provide a proactive model of care for the CYP most likely to experience inequalities in access, experience and outcomes |
| 4 | Ensuring we provide the best start in life for CYP by focusing on the impact of health in **early years and subsequent life course events** | Inequalities in health begin to develop in utero and continue to accumulate throughout the life course. These inequalities have lifelong impacts for individuals and societies. Intervening in the early years offers the greatest opportunity to disrupt the cycle of inequality and reduce their impact on both the individual and the system |

# Children and Young People (3/6)

South East London Integrated Care System

## Priority Area:

**Improve waiting times** for CYP into health services across acute services, community-based care and mental health services

## What are the actions we will deliver in 2025/26

- Develop and understanding of CYP waiting times in Acute and Community services
- Working with the CPN, develop a plan to reduce waiting times in key areas for community services
- Working with the APC, develop a plan to reduce elective waits for CYP in line with the relevant operational planning guidance
- Through the mental health programme, to continue to reduce waits for community CAMHS (ref. Mental Health programme)

## Population Health and Inequalities Impact

- Ensuring CYP are seen in a timely manner can reduce inequalities and ensure early treatment to prevent ongoing illness and health issues
- Integrated clinics can be managed as part of neighbourhood population health management process

## System Sustainability Impact

- Effective use and timely access to secondary care services (OPA)
- Proactive early intervention to reduce crisis attendance at UEC
- Increased school attendance

## Priority Area:

Develop pathways and services that support safe, effective and appropriate CYP **access to Urgent and Emergency Care (UEC)** (ref. UEC programme)

## What are the actions we will deliver in 2025/26

- Implementation of SDEC guidance across all sites
- Changes to ensure all sites meet the requirements of the NHSE Regional UEC checklist
- Review implementation of RCPCH guidance on managing CYP with complex medical needs
- Implementation of Healthier Together Website to support families and clinicians
- Develop a plan for UEC front door triage in SEL and work with community providers to provide out of hospital care to reduce attendance in ED

## Population Health and Inequalities Impact

- Ensuring CYP spend as little time in UEC as possible
- Improving access to information for CYP and families

## System Sustainability Impact

- Increased uptake of consultant connect/advice and guidance with aim of reducing inappropriate use of UEC
- Empowering GP's and community staff to direct families to relevant information to support decision making
- Increased community provision supporting CYP to leave UEC department

# Children and Young People (4/6)

South East London Integrated Care System

## Priority Area:

Develop and embed **population health management** approaches to support SEL CYP, including implementation of new models of care to proactively support CYP via prevention, and with LTC management

## What are the actions we will deliver in 2025/26

- Working with Primary, acute and community services, implement a model for integrated child health teams across SEL including a consistent funding model
- Implement the asthma and epilepsy bundles of care and the Diabetes HCL system
- Working with system partners to deliver the '5' element of Core 20+5
- Develop a health inequalities dashboard for place and/or SEL
- Linking to SEL Women's and Girl's Health Hub model

## Population Health and Inequalities Impact

- Core 20+5 focuses on the inequalities seen across Asthma, Epilepsy, Diabetes, Oral health and mental health

## System Sustainability Impact

- Proactive management and early intervention leads to reduced use of NHS services and increased school attendance for CYP

## Priority Area:

Ensuring we provide the best start in life for CYP by focusing on the impact of health in **early years and subsequent life course events**

## What are the actions we will deliver in 2025/26

- Focus on the health of parents pre-conception and services to support a healthy approach to pregnancy
- Developing healthy weight programmes to support reducing infant mortality
- Focus on dental health in CYP
- Development of a model of preventative and proactive care for teenagers in SEL including pre-conception health

## Population Health and Inequalities Impact

- 4/6 places in SEL have infant mortality rates above the England average and reductions in these rates have stalled.
- Ensuring equity of access to healthy weight support preconception and during pregnancy will decrease the risk of low birthweight and infant mortality.
- Preventing future health inequalities by intervening earlier e.g. work with teens

## System Sustainability Impact

- Early years interventions to impact on later life outcomes
- Improved healthy weight services will reduce the number of women who are obese or overweight when pregnant and reduce the risk of potential complications for both mother and infant

# Children and Young People (5/6)

South East London Integrated Care System

| Priority Area | What are the outcomes we are aiming to achieve? | How are we measuring out impact? |
|---|---|---|
| **Improve waiting times** for CYP into health services across acute services (*Reforming elective care for patients)*, community-based care and mental health services | Reduction in overall waiting times for elective, community and mental health services and reduction in numbers of CYP on waiting lists against set trajectories<br><br>Elimination of long waiters for paediatric elective care (recovery) in line with operating plan<br>• Eliminate 104+, 78+ and 65+ week waits (2025/2026)<br>• Progress towards 92% waiting less than 18 weeks for 1st appointment (2030)<br>Community Waits<br>• GSTT to be submitting data (2025/2026) | Using data to track progress against planned outcomes<br>• Elective recovery data<br>• CHS sitrep data<br>• Mental health data<br><br>• CYP Voice around impact of being on a waiting list |
| Develop pathways and services that support safe, effective and appropriate CYP **access to Urgent and Emergency Care (UEC) (**ref. UEC Programme) | • Improving access and flow into UEC services<br>• Access to CYP SDEC at each site<br>• Care pathways outside of hospital to reduce ED attendance<br>• Provision of single CYP platform for information for CYP/Families and increasing speed of response by UEC | • Audit of care pathways after implementation<br>• Audit of SDEC at sites<br>• Reduction in Attendances for specific pathways (to be defined)<br>• Audit departments for compliance with RCPCH CYP with complex medical needs<br>• Access and use of Healthier Together Website/app |
| Develop and embed **population health management** approaches to support SEL CYP, including implementation of new models of care to proactively support CYP via prevention, and with LTC management | • Full coverage of SEL using integrated child clinics<br>• Progress in delivery of the National bundles of care for Epilepsy and Asthma<br>• Implementation for HCL for all CYP with Type 1 diabetes<br>• Increase understanding of CYP inequalities through population data and insight to target resources and interventions using PHM approach | • LCT Dashboard and feedback<br>• Delivery of outcomes in action plans for Asthma and Epilepsy<br>• National data re HCL use |
| Ensuring we provide the best start in life for CYP by focusing on the impact of health in **early years and life** | • Short term - proxy indicators of improvements in maternal and infant health<br>• Medium term goal – slow the increase in infant mortality in areas where it is increasing<br>• Long term goal – achieve reductions in infant mortality so that all areas of SEL have infant mortality rates below the rates for England / London | • Infant mortality rates data |

# Children and Young People (6/6)

South East London Integrated Care System

## What do we need from enablers and partners to deliver?

- Ongoing prioritisation of CYP within other care pathway plans, borough based plans and individual provider plans.
- Development of sustainable funding approaches particularly for integrated child health teams, in line with the wider development of neighbourhood based care models
- Ongoing development of data sharing and BI platforms to support and monitor change aligned to the digital strategy
- Development of local CYP single platform via Healthier Together website
- Good links with programme boards across SEL including Mental Health, Maternity, Urgent and Emergency Care and Prevention Boards to deliver CYP priorities

## How will we work in collaboration with our system?

- Ensuring partners are on task and finish groups and involved in assessments and planning
- Engagement with the CYP Strategic Partnership Board
- Collaborative working with other SEL programmes
- Ensuring the voice of CYP is heard

## How will we engage with our population?

- Using CYP engagement CCPL to reach out to CYP and use of the CYP engagement model
- Introducing rights-based approach to participation using the Lundy Model
- Working with stakeholders to ensure CYP are engaged with service developments and co-produce new models

## How will we monitor and share progress?

- Through the CYP Strategic Partnership Board reporting to the ICB executive Committee as required
- Linking into UEC Programme Board
- Linking with LMNS board
- Linking with CPN and APC Boards
- Linking with the MH (CYP) Board
- Linking with the Prevention Board