South East London Children and Young People Integrated Neighbourhood Teams Framework

Final Report

January 2026

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1. Executive Summary

Executive Summary

Introduction

The South East London (SEL) Children and Young People (CYP) Integrated Neighbourhood Teams (INT) Framework was developed between October and December 2025, driven by multiple stakeholders at Place and involving over 100 colleagues from across the SEL system. The Framework builds on the good work already underway at Place such as the development of Child Health Teams, Family Hubs and the Family Help Service. The Framework describes a way of working at neighbourhood level that will help to optimise these existing (and emerging) developments. Places can incorporate the Framework as part of local development of INTs, use it to share success across Places and develop a consistent offer for SEL, recognising different starting points and need for local variation.

The Framework mainly considers CYP from school age to young adulthood, although many of the recommended ways of working apply across the whole age range. The Framework is not just health focused. It encompasses the holistic and wider factors that contribute to CYP health and wellbeing. The framework is aligned with the wider work underway in SEL on INTs and aligns with national best practice such as that advocated by the King's Fund and the RCPCH.

Why change is needed

There are compelling reasons for developing a new framework in support of improving care for CYP, for example:

- The case load for Mental Health (MH) services attributable to anxiety, depression and neuro-developmental conditions has tripled in 6 years and waiting lists have doubled. The CYP population represent a disproportionately high burden on these services

- There is a high prevalence of obesity in SEL. Obesity is a strong marker of other psycho-socio-economic needs within the family and wider community

- A growing proportion of need cuts across health, education, social care and community settings — yet support remains fragmented and reactive

- CYP and families themselves report difficulty in navigating services, repeated assessments, delayed help without support and lack of clarity about where to go

- Evidence shows that earlier identification, coordinated neighbourhood working and community-based support can prevent escalation, reduce avoidable demand and improve experience — but this requires a different way of working.

Executive Summary

The CYP INT Framework

Adopting a population health-led and holistic lens, a needs-based segmentation approach underpins the framework in which demographics, complexity and (rising) risk are the key dimensions of segmentation. The Framework is also underpinned by ten fundamental values and principles which include knowing your population, being needs-led, acting early, working holistically, connecting and not working in silos and empowering families and CYP. The Framework comprises 10 key functions or delivery components:

1. Population health management (data, intel and action)

2. Active identification and family-centred early intervention

3. Universal health and care provision

4. Multi-agency coordination and working

5. Direct care delivery

6. Managing escalations, urgent or unexpected needs

7. Longitudinal care and transition at 18+

8. 'Flourish', ongoing support and optimising potential

9. 'Waiting well' or 'unwell'

10. Engaging VCSE as trusted delivery partners.

For each of these function the report describes key ways of working that enable the delivery of timely, holistic and family focused care, accompanied by a real-life example of where this is already in place elsewhere. A single, overarching diagram also captures all 10 functions and other elements that make up the scope of the Framework. 'Zack's story' then provides an illustration of what care and support would look like for a 15-year-old boy once the Framework is implemented, contrasting this with how Zack's care looks today.

A range of enablers have also been identified as critical to the delivery of the framework and a brief description of each is given. These include workforce development, multi-agency teamwork approaches/facilities, meaningful co-production with families, culture change, information governance, IT systems and data and the required commissioning shift.

Executive Summary

How will we know we are making a difference?

Outcomes that can be used to monitor and evaluate the success of the framework have been defined in areas such as active/early identification and prevention, improved access, improved multi-agency working and improved health and wellbeing outcomes. Potential key performance indicators for each outcome are listed, to be refined further.

How will we implement the Framework?

Key success principles for implementing the framework are described, based on learning from elsewhere. The key to successful delivery is a strong focus on people – for example, creating meaning, engaging and taking people on the journey, developing the right skills and motivations and providing strong leadership that inspires and establishes clear accountability. Building blocks for implementation are described including engagement and mobilisation at Place, developing a shared purpose and priorities, demand and capacity modelling and effective measurement.

An implementation roadmap outlines a 3-phase 'test and learn' approach as follows.

- Phase One (2026/7) sees a neighbourhood model actively tested and in delivery across all Places.
- Phase Two (2027/28) focuses on growing and strengthening the approach.
- Phase Three (2028/29) focuses on embedding the change and making continuous improvements.

A systematic approach to delivery across all Places is also described, recognising different starting points and levels of maturity. Implementation will need to be supported by a robust project delivery team and clarity on what support will be provided to Places. A QI methodology will be required that enables real-time learning and improvement and sharing of success between Places.

Next steps

Continued work is now required to support Places to adopt the Framework as part of local design, planning and delivery. This includes broadening the engagement and socialisation of the model, Place led self-assessment against the framework to assess gaps / opportunities for development and creation of Place roadmaps for implementation.

Appendices

A set of appendices are provided which include further detail on what we heard from CYP and families and a breakdown of stakeholders who took part in the work.

2. Introduction

Introduction

- This report reflects the work that took place between October and December 2025, involving a wide range of stakeholders across SEL in developing the SEL CYP INT framework. The work to deliver the framework will require continued stakeholder engagement and understanding, enabling Places to utilise it as part of local design, planning and delivery.

- A great deal of work is already underway at Place to develop care and support for CYP and families. Much of this work is informed by existing initiatives that sit front and centre such as Family Hubs, Child Health Teams, the Family Help Service and the Healthy Child Programme. This framework builds upon that work.

- This report outlines a consistent framework for SEL places to use when developing their CYP INT's and captures key elements and principles expressed by SEL colleagues alongside recognised best practices. It will enable achievement of local aims at an accelerated pace, sharing of 'what good looks like' between Places and greater parity of provision as part of a unified approach – recognising the need for local variation.

- The framework focuses on describing a way of working at neighbourhood that will help optimise and enhance existing (and emerging) developments. The recommendations describe the coordinated functions needed within the CYP INT to deliver more seamless, coordinated care that is truly holistic and family-focused.

''We must improve links between currently fragmented and siloed CYP services. What can we do together to be more proactive, to intervene earlier and respond to the whole picture as one team with clear leadership?'

'We need a shared vision of how we work together to deliver the 'must do's', speaking the same language; all knowing as much as each other'

Objectives

Objectives

Deliver a unified, evidence-based Framework for CYP INTs that:

- Applies across all boroughs.

- Provides clarity on priority cohorts and targeted interventions.

- Builds on existing data, insight, and engagement.

- Enables alignment to deliver better outcomes, reduce inequalities, and strengthen proactive, prevention-focused care.

Guiding Ambition

- Adopt a population health-led and holistic lens.

- Design a family-oriented and outcomes-led approach.

- Tackle inequality and variation while respecting local context.

- Embed recognised best practice and a common understanding of 'what good looks like'.

Core Principles

Collaborative by design
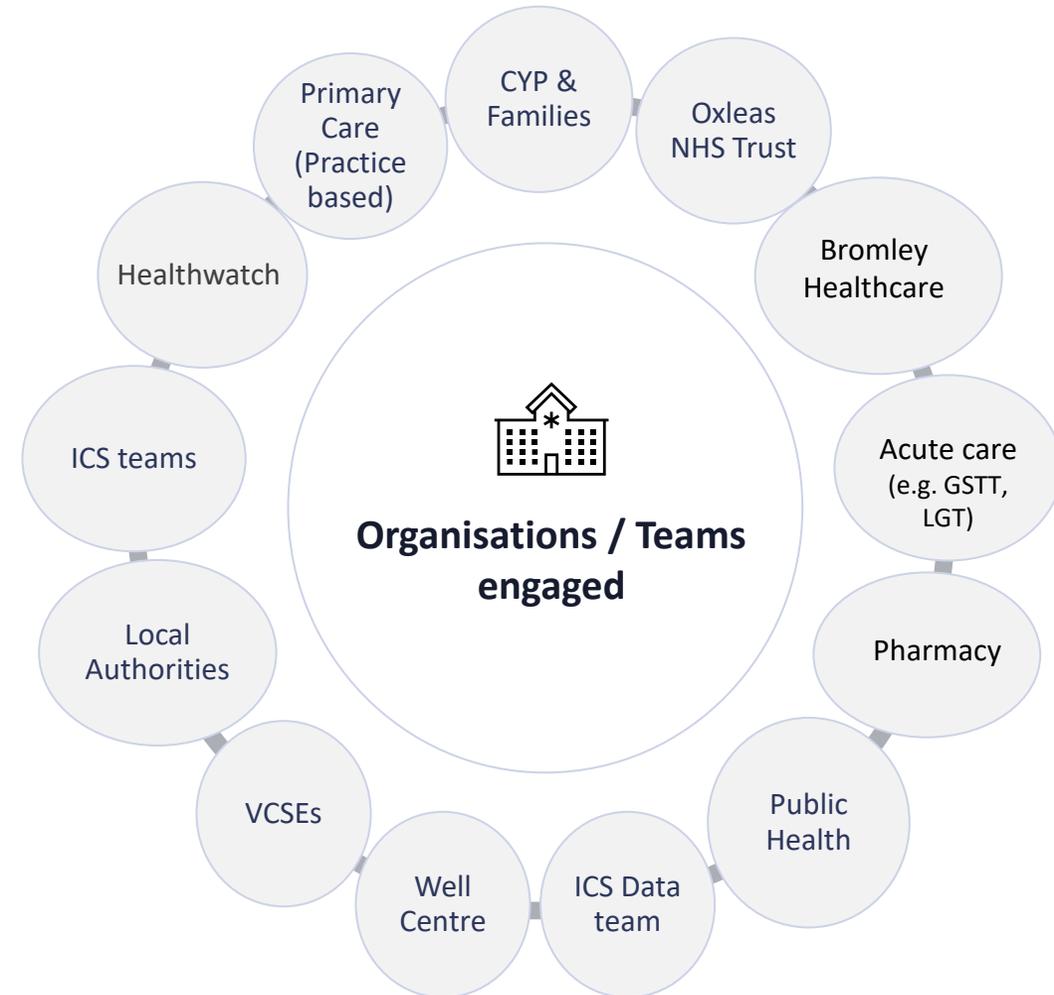Strong local ownership

Build on existing progress
Integrate ongoing initiatives and learning

Provider-led and operationally realistic
Deliverable within current resources

Our Methodology: 3 Phases, Co-produced, Evidence-based

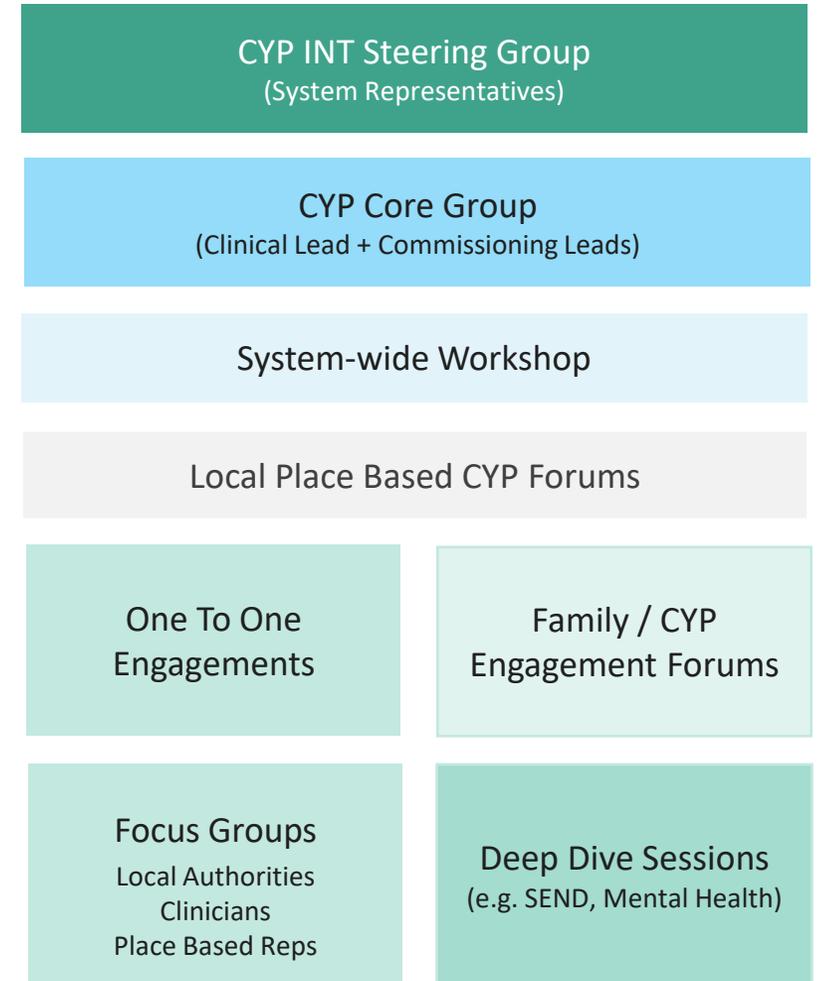| Phases			
Phases	Oct 2025 – Nov 2025 **Data Triangulation & Insight Generation** Establish a shared, system-wide understanding of need, segmentation, and challenges.	Nov 2025 – Dec 2025 **Co-design & Solution Building** Define framework components, interventions, and enablers through deep multi-stakeholder engagement.	Dec 2025 **Testing & Implementation Planning** Refine and test the framework through governance validation and pilot implementation planning.
Core Activities	• Data Analysis and CYP segmentation to identify high-priority cohorts. • Gather qualitative insights from key stakeholders • Review existing plans and guidance.	• Conduct **3 focus groups** (Clinicians, Local Authorities and Place based reps) • Capture voices of CYPs and their families with lived experiences • Explore priorities and barriers using Phase 1 insights. • Ratify framework structure in a **Co-design Workshop.**	• Validate draft framework through governance and feedback. • Develop local adaptation and implementation plans. • Identify pilot sites for initial rollout.
Outputs	• Baseline *as-is* analysis and segmentation summary • Initial insight summary for Steering Group validation	• Draft CYP INT Framework including vision, principles, priorities, and enablers	• Final, system-endorsed CYP INT Framework • Implementation plan with delivery milestones, KPIs, and ownership model

More than 100 stakeholders from across the system, including service users, have been engaged the co-design process for the framework

Organisations / Teams engaged

- CYP & Families
- Oxleas NHS Trust
- Bromley Healthcare
- Acute care (e.g. GSTT, LGT)
- Pharmacy
- Public Health
- ICS Data team
- Well Centre
- VCSEs
- Local Authorities
- ICS teams
- Healthwatch
- Primary Care (Practice based)

Type Of Stakeholders

- Frontline Practitioners
- Clinicians (CCPLs/GPs/ Paediatricians /Paediatric Nursing
- Operations and Management
- Service Users, Carers & Representatives
- Pharmacists
- Commissioners
- Service Leads
- Voluntary Sector partners

Mechanism Of Engagement

CYP INT Steering Group (System Representatives)

CYP Core Group (Clinical Lead + Commissioning Leads)

System-wide Workshop

Local Place Based CYP Forums

One To One Engagements

Family / CYP Engagement Forums

Focus Groups Local Authorities Clinicians Place Based Reps

Deep Dive Sessions (e.g. SEND, Mental Health)

3. What do our SEL residents and parents say?

A range of parallel activities took place involving residents to ensure their voice is reflected in the framework

1. Distilling themes from engagement work done so far

2. Connecting with CYP and their families to understand their needs, pains and priorities

3. Continued engagement at Place

SEL has done significant work around engagement across all age groups and communities in the past few years. It was important that we capture and distil key themes that needed to be incorporated in the framework.

Meeting with CAMHS service users

Meeting with parents of CYP in CAMHS

Focus group with CYP with SEND (f2f)

Focus Group with CYP with learning disabilities (f2f)

Meeting with CYP at The Well Centre

Meeting with Lambeth Shadow Board

There shall be continued hyper local engagement at Place to ensure care delivered locally is in line with the needs of the local population

Connected with residents across SEL to understand the challenges they face, their experience, expectations and how they want the future services to look like.

What we heard from children, young people and their families?

Lack of coordination

Families experience care as disjointed, each agency expecting others to "fix it", highlighting siloed responsibilities. The call for peer navigators and care coordinators echoes the wider strategic gap around roles to ensure care continuity across multiple agencies.

"We have to dig to find the support for ourselves. We have to navigate. We used to have a care coordinator to address anything not working, which worked brilliantly"

Information, education and awareness

Front-line professionals lack up-to-date knowledge of local pathways, leading to inappropriate advice or signposting and avoidable escalation. Families also want practical education for employers, schools, siblings, children and parents, ideally delivered by people with lived experience.

"GPs are not aware of pathways but it's critical they give the right information. We were told by our GP to take our child to A&E because he wouldn't go to school on a particular day."

Waiting and managing expectations

Long waits for neurodevelopmental and mental health services are not just an access issue; the absence of interim support allows needs to escalate and family resilience to erode. Parents ask for honest information about who is doing what, realistic waiting times, clarity on offer/limits, and better communication.

"Provide support while we are waiting for 2 years for a service, to minimise the effects of the wait."

Environments and experience of care

Families see current emergency pathways as unsafe and traumatising for CYP, particularly neurodiverse children. They need choice of setting (home, community, groups) and psychologically safe environments with follow-up after diagnosis.

"Avoid A&E. It's overwhelming and overstimulating, especially for neurodiverse children. Children see things they shouldn't see. Do video conferencing instead, or have a children's A&E."

Transition of care to adult services

Transition is experienced as a cliff edge: responsibility abruptly shifts to young people with minimal preparation, reassurance or continuity. Families want transition to be actively managed, with detailed information transfer and practical "hints and tips".

"The attitude it's on you now that you are 18, we won't baby you anymore and so deal with it on your own."

4. The need for change

Zack's story

Zack, 14-year-old male

Academically struggling and is currently on the waiting list for ASD assessment (not picked up in primary school). History of severe bullying at school.

History of asthma, which is challenging to manage and is known to the community nursing team. Multiple sporadic exacerbations of asthma since age 6, requiring hospital admission.

- Father is absent, mother has significant Mental Health (MH) problems.
- Substantial financial issues, resulting in risk of eviction.
- Zack is known to Social care, however no current involvement as it was stepped down in the past.
- Referrals to housing have been made but were not successful.

Please note that this patient story is sourced from a combination of multiple real patient scenarios. Names and facts have been altered for patient confidentiality. The main purpose of the story is to highlight the opportunities for improving care in the current system.

Zack's story

Zack has been seen by the GP for asthma reviews; however, he has missed the follow-up appointments. He has previously demonstrated poor inhaler technique and inconsistent medication adherence, leading to multiple hospital admissions for exacerbations of his asthma.

Zack has been on the waiting list for an ASD assessment for 6 months. During this time, he has experienced increasing difficulties at school, including reduced concentration in lessons and poor performance in assessments, leading to social withdrawal and disengagement from learning.

He has a limited support network and experiences difficulties forming friendships, leading to social isolation and a negative impact on his MH. His mother is unable to support him, due to her own MH challenges and faces additional barriers in accessing services due to language difficulties and limited awareness to available information.

Zack's asthma starts to flare up again in winter. His mother contacts the GP but was unable to get an appointment and did not feel his condition warranted a visit to A&E.

A week later his cough is much worse, and he has developed wheezing. Zack ends up in A&E with another exacerbation of asthma. Unfortunately, he continues to wait for a formal ASD assessment and doesn't engage well at school.

Observations

Did not pre-empt and act: Signs of recurring and increasing issues were an opportunity to act before it was too late.

Multiple siloed pathways: Looking at the child through a health lens, instead of the ability to consider the whole picture of physical and mental health, school and home problems. Lack of person-centred holistic assessment and multi-agency care planning that genuinely address the multifactorial issues faced by the child/family.

No mechanism for coordination between multiple agencies: Agencies not getting to the root of the problems and creating one understanding.

Missed opportunity: To sum it all up, this child's case shows how we as a system could be far more efficient in providing coordinated and meaningful care.

Key gaps and challenges that were identified during engagement with local clinicians and professionals resonated with Zach's story

Gaps

Needs-Led Child Centric Approach

Prioritise child-centred models over health/condition silos or 'labels'

Meaningful Outcomes

Clarify meaningful purpose, benefits, and shared outcomes

Holistic Coordinated Care

Deliver more coordinated care spanning acute/community/LA/VCSE for seamless support.

Strong Navigator Roles

Deploy navigators for signposting, support, and coordinating family-wide care.

Family Context Approach

Adopt whole-family lens, avoiding child-parent separation in interventions.

Neurodiversity Specialism

Address growing autism/ADHD/neuro needs through needs-led pre-diagnosis support.

Secure Transitions

Smooth transitions of care, avoiding cliff-edge to adulthood.

Expand VCSE/Faith Role

Leverage VCSE/faith/creative health for MH prevention in underserved communities.

Prevention & Determinants

Target upstream prevention addressing wider social/health determinants proactively.

Integrated Contracts and Knowledge

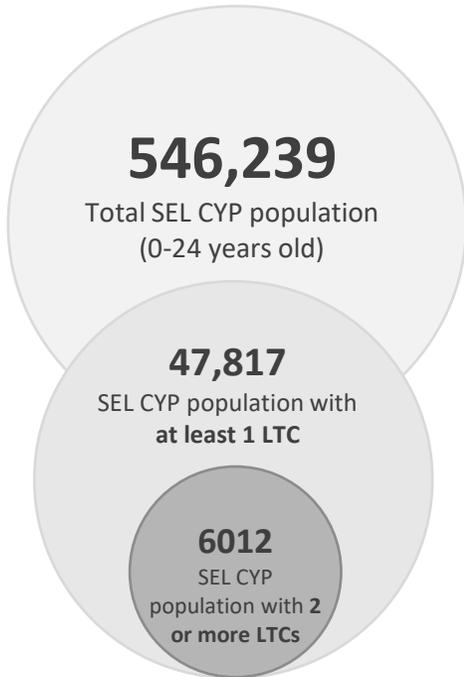Develop contractual mechanisms and knowledge-sharing for seamless multi-agency working.

Resources and facilities

Understanding our resources and facilities, how to optimise them and address the gaps

Challenges

- Siloed working lacking coordinator roles
- Pillar-to-post referrals without clarity or continuity
- Poor data flows across health, LA, schools, VCSEs
- Lack of service knowledge, and existing resources and facilities
- High entry thresholds for services
- Fragmented focus on holistic care
- Rising MH/neuro/Emotionally Based School Avoidance (EBSA) demand
- Scaling proven initiatives
- Inappropriate A&E use
- Parental lack of trust in the health service

1 in 13 CYP live with a Long-Term Condition (LTC): Asthma has a high prevalence, Epilepsy has a high rate of A&E attendance

546,239
Total SEL CYP population
(0-24 years old)

47,817
SEL CYP population with
at least 1 LTC

6012
SEL CYP
population with **2
or more LTCs**

105,663
CYP population in deprivation (core20)

Prevalence of LTC over time

- Diabetes Prevalence
- Epilepsy Prevalence
- Asthma Prevalence
- Obesity Prevalence

A&E attendances of among CYP with LTCs (2024-25)

- Total AE attendance
- unique attendances per registered population

7.5% of all children are living with at least one LTC

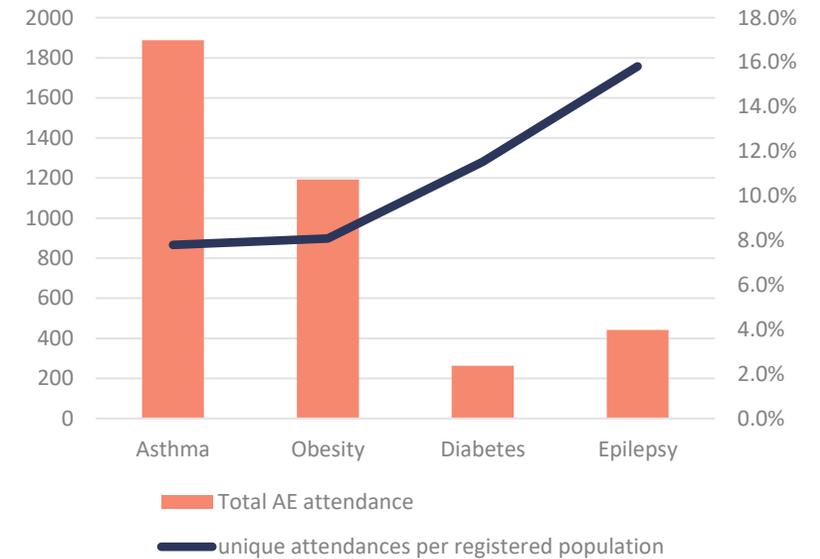(diabetes, epilepsy, asthma and obesity)

It does not include other potential diagnosis
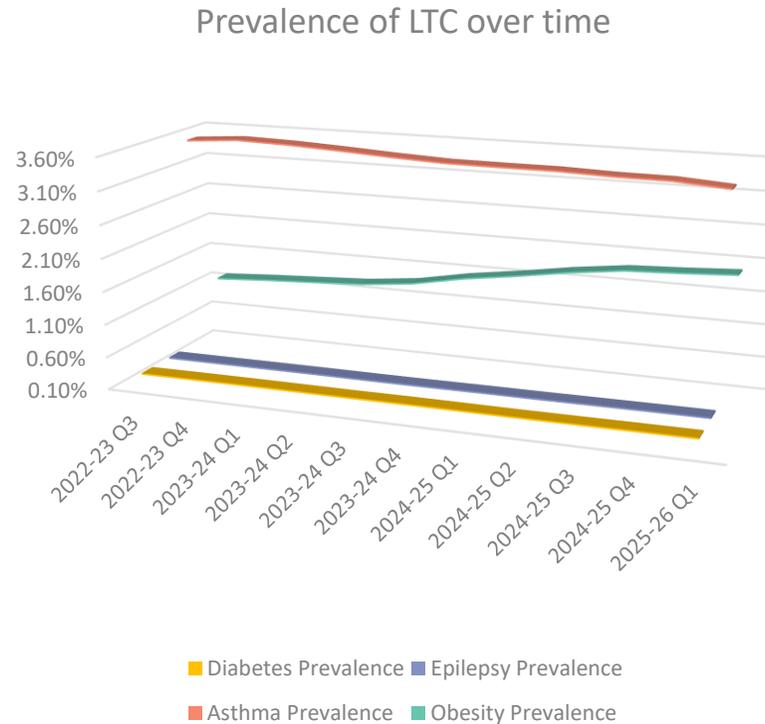
Prevalence of asthma is showing decreasing trend* while obesity is showing increasing trend

*Underdiagnosis and service challenges may lead to under-reporting of demand

**The overall A&E attendance is high for CYP with asthma and obesity due to their high prevalence.**

Please note obesity is not a direct cause of A&E attendance but co-exists with other co-morbidities and issues.

Data source: South East London ICB dashboard for CYP

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30% of all A&E attendances in 2024-25 were attributed to CYP with fever and abdominal pain as the most common known presentations

60% of the total A&E attendances for SEL CYP in 2024-25 were from 2 to 19 years age-group

Total A&E attendances for SEL CYP population across SEL for 2024-25 were 346,630
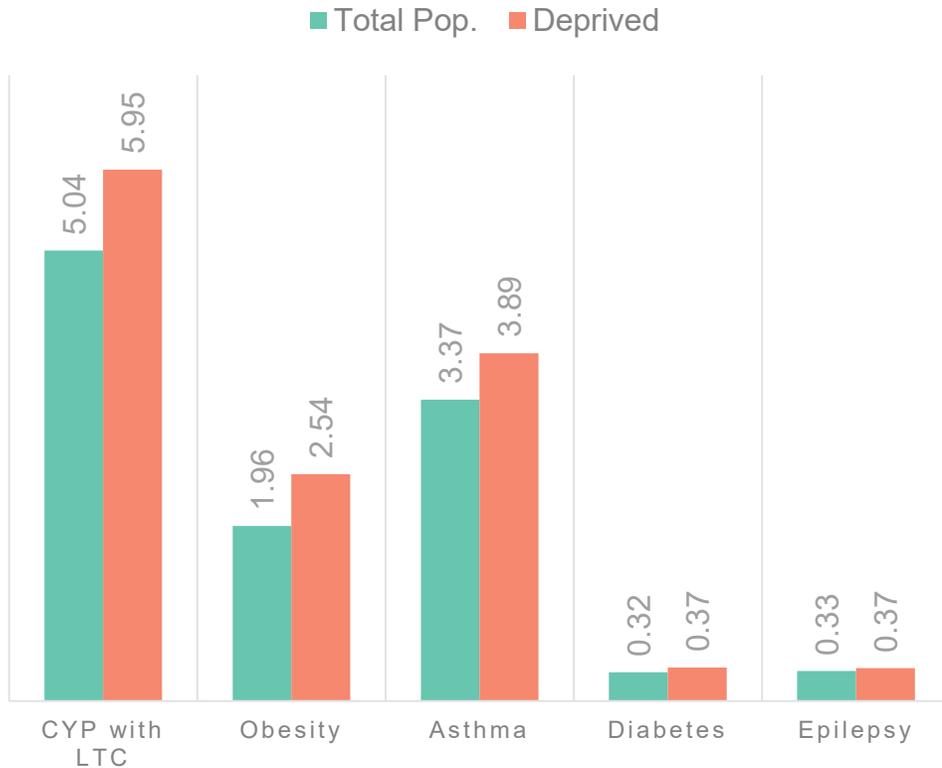
Share of AE attendance by age for 2024/25

Pie chart legend:
- 0-1
- 2-5
- 6-9
- 10-15
- 16-19
- 20-24

Pie values: 17%, 17%, 11%, 17%, 14%, 24%
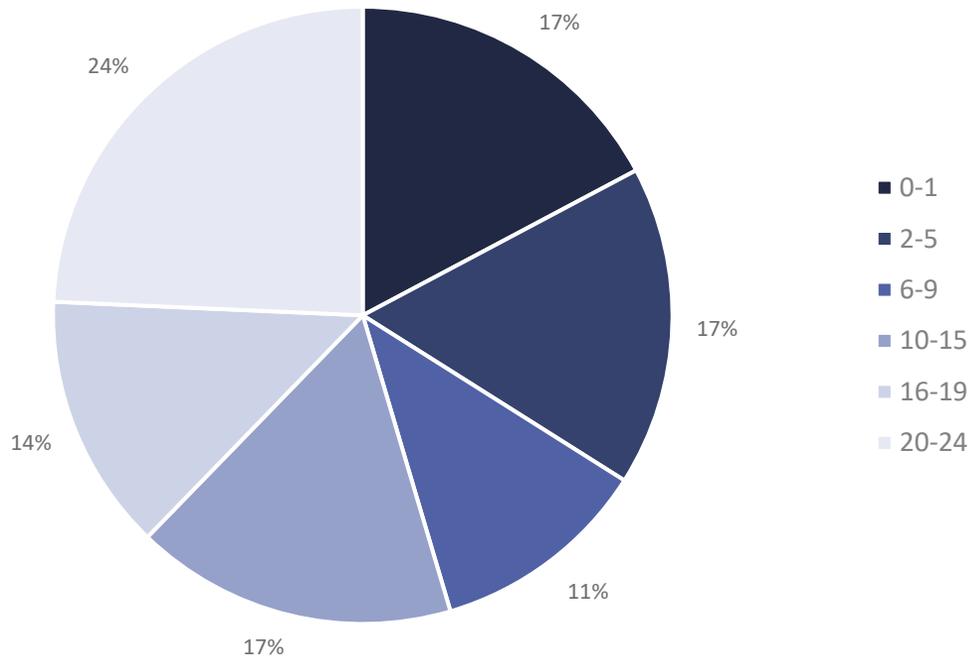
Top 5 reasons for A&E attendance by age group in 2024-25

0-1yrs	2-5 yrs	6-9 yrs
Fever (18%)	**Unknown (16%)**	**Unknown (18%)**
Unknown (13%)	**Fever (16%)**	**Fever (8%)**
Dyspnoea	Cough	Abdominal pain
Eruption	Dyspnoea	Eruption
Vomiting	Injury of head	Injury of lower extremity

10-15 yrs	16-17 yrs	18-19 yrs	20-24 yrs
Unknown (19%)	**Unknown (23%)**	**Unknown (25%)**	**Unknown (25%)**
Abdominal pain (7%)	**Abdominal pain (7%)**	**Abdominal pain (8%)**	**Abdominal pain (9%)**
Injury of upper extremity	Chest pain	Chest pain	Chest pain
Injury of lower extremity	Injury of lower extremity	Sore throat	Injury of lower extremity
Fever	Injury of upper extremity	Injury of lower extremity	Headache

Source: SEL ICB Urgent and Emergency Care Reporting Dashboard

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Living in Deprivation significantly amplifies health inequalities for children and young people

Prevalence of LTCs (%) vs deprivation

Legend: ■ Total Pop. ■ Deprived

Category	Total Pop.	Deprived
CYP with LTC	5.04	5.95
Obesity	1.96	2.54
Asthma	3.37	3.89
Diabetes	0.32	0.37
Epilepsy	0.33	0.37

In populations living in deprivation, the prevalence of LTC and obesity is markedly higher (18% higher for LTC and 30% higher for obesity)

- Significant oral health inequalities with 2.8x higher tooth extraction rates in children living in the most deprived areas
- Higher emergency admission rates in the most deprived areas - up to 3x higher for some

Average increase in A&E attendances

When comparing per A&E attendance rate (per 1000) for children living with obesity, asthma, diabetes, epilepsy, we see a higher rate of attendance in children from areas of greatest deprivation. The increase in rate is as follows:

Obesity : 84%	Asthma : 51%
Diabetes : 184%	Epilepsy : 263%

For e.g. children living with diabetes in deprived communities attend A&E 2.8 times more as compared with total population.

High prevalence of obesity, particularly among children in year 6 & females

High prevalence of obesity in children (year 6), higher than London (23.2%) and National (22.2%) average noted in 4 out of 6 boroughs
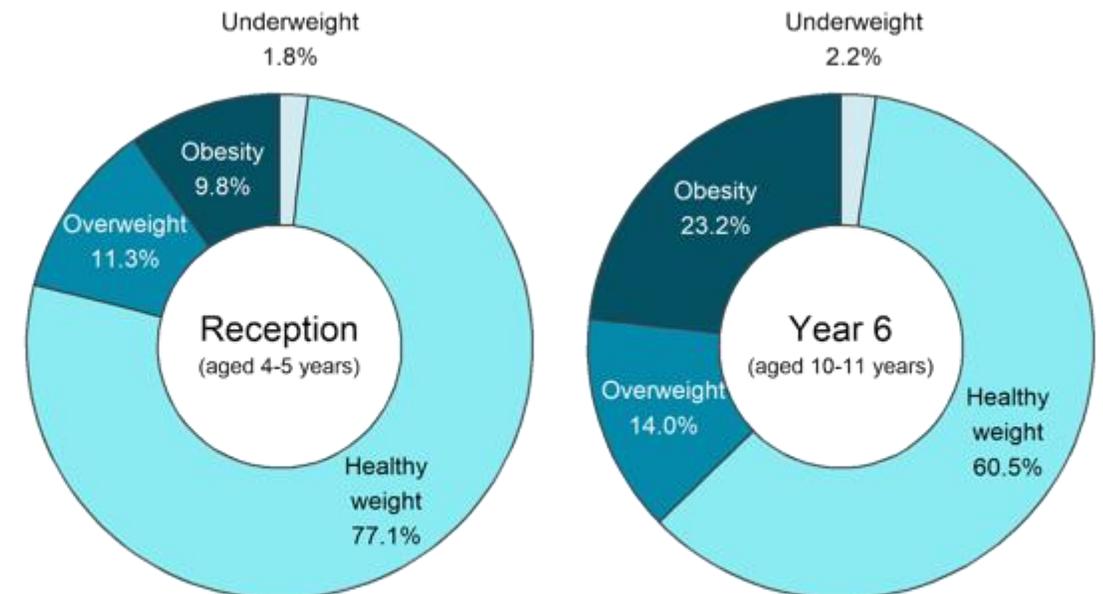
Prevalence of obesity among Children in year 6 (aged 10-11 years) in 2024-25
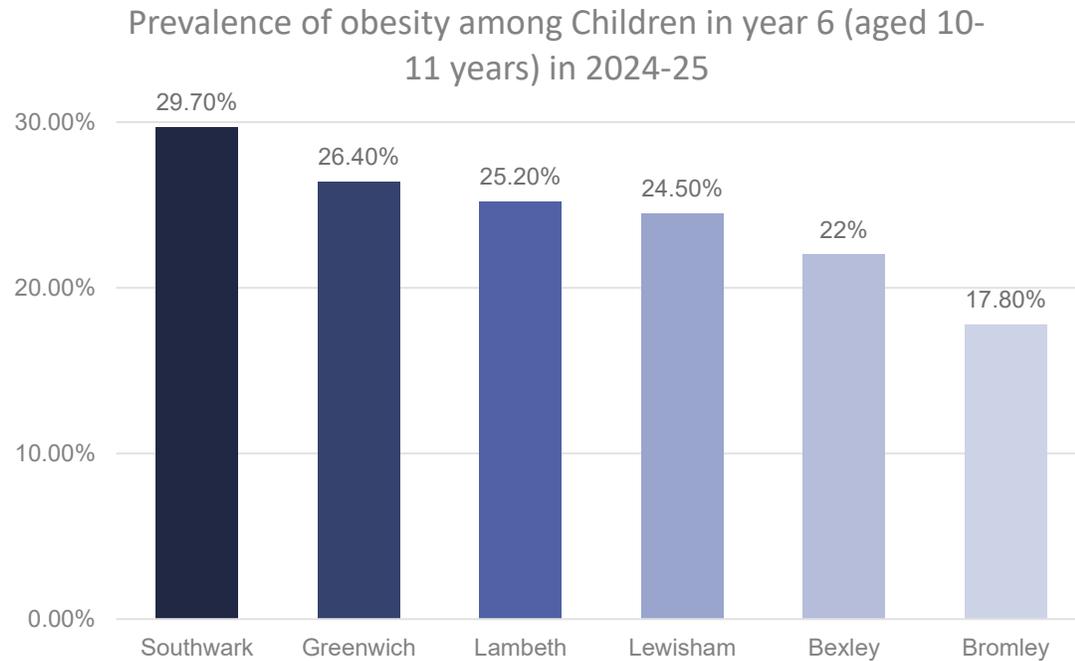
Prevalence of obesity has risen from 1.2% to 2% across South East London in last 3 years

(Q3 2022/23 to Q1 2025/26)

1 in 3 children is considered overweight by the age of 11 years across London

Prevalence of obesity doubles in children in year 6 compared to reception (across London)

Reception (aged 4-5 years)
- Underweight 1.8%
- Obesity 9.8%
- Overweight 11.3%
- Healthy weight 77.1%

Year 6 (aged 10-11 years)
- Underweight 2.2%
- Obesity 23.2%
- Overweight 14.0%
- Healthy weight 60.5%

Data source: South East London ICB dashboard for CYP, National Child Measurement Programme 2025

Obesity is a marker of other psycho-socio-economic issues within the family and wider community

Deprivation	Children living in the most deprived areas are more than twice as likely to be obese compared to those in the least deprived areas (12.9% vs. 6.0% at school entry), across England.
Family	Parental obesity, mental illness, stress, poor awareness educational attainment, absence of one parent, and punitive parenting are shown to be associated with childhood obesity and its persistence into adulthood.
Wider Community	NHS and government evidence repeatedly highlight that childhood obesity clusters with other adverse experiences, including social services involvement, homelessness risk, and special educational needs.

Obesity can have wide ranging physical and psychological effects in children and young people

Emotional & Behavioural
- Stigmatisation
- Bullying
- Low self esteem

Education
- School Absence

Physical Health
- High cholesterol
- High blood pressure
- Pre-diabetes
- Bone & joint problems
- Breathing difficulties

Long Term
- Increased risk of being overweight adults
- Risk ill health and premature mortality

The NHS spends around £6.5 billion a year on treating obesity-related ill health across all age groups in England

Long-term cohort studies show that childhood obesity persists into adulthood (up to 85% remain obese), amplifying health system costs and morbidity over the life course.

https://research.uhs.nhs.uk/news/soaring-childhood-obesity-from-pandemic-will-cost-uk-billions-study-finds
National Child Measurement Programme report 2025 - https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2023-24-school-year

https://www.bmj.com/company/newsroom/newsroom-2019-2021/22710-2/
https://www.gov.uk/government/news/government-acts-to-tackle-rising-childhood-obesity-epidemic
https://www.england.nhs.uk/2024/09/one-in-eight-toddlers-and-primary-school-aged-children-obese/

Caseload for mental health services attributed to anxiety, depression, "in crisis" and neuro-developmental conditions have more than tripled in last 6 years

Caseload for these 4 chief complaints is at a 5-year peak as of 2025

Caseload related to mental health has increased multiple folds for the following chief complaints between 2019 and 2025 –

- **2X** for "In crisis"

- **8X** for Neurodevelopmental conditions (excluding Autism Spectrum Disorder)

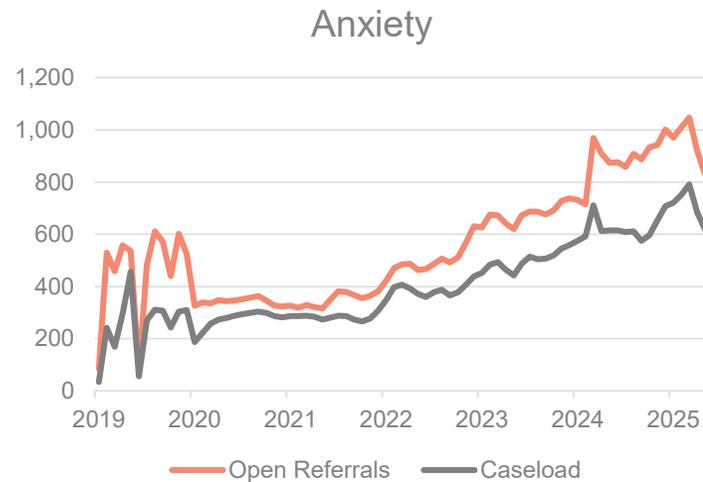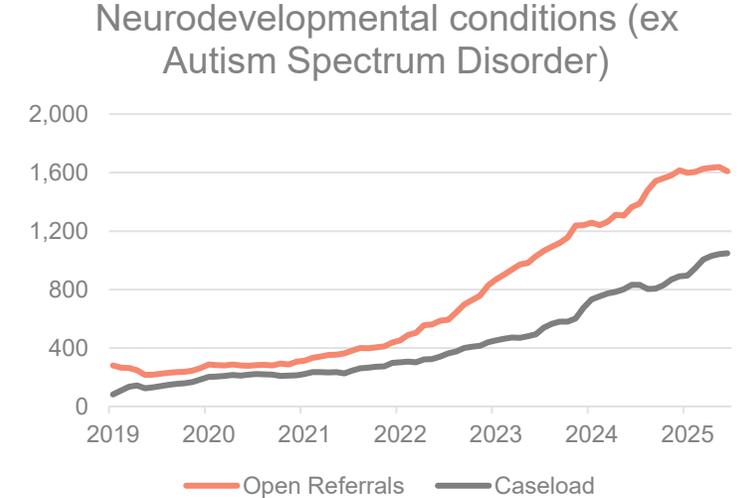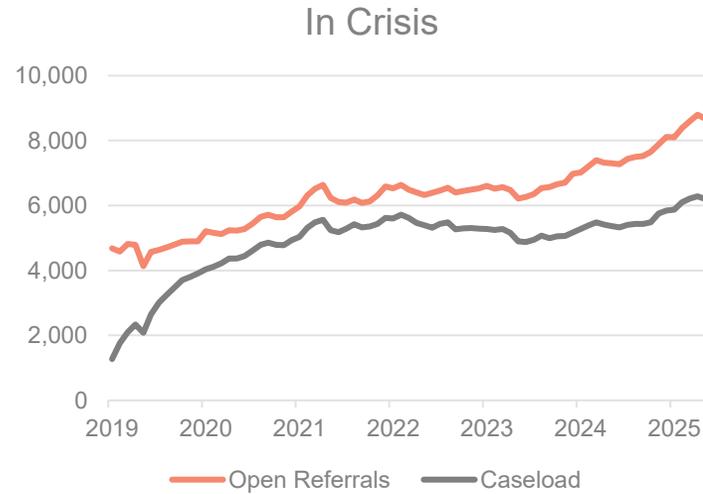- **3X** for Anxiety

- **3X** for Depression

Definitions

Caseload
The number of referrals still open at the end of the month

Open referrals
The number of referrals still open at the end of the month, with at least one contact

In Crisis

### Neurodevelopmental conditions (ex Autism Spectrum Disorder)


Anxiety
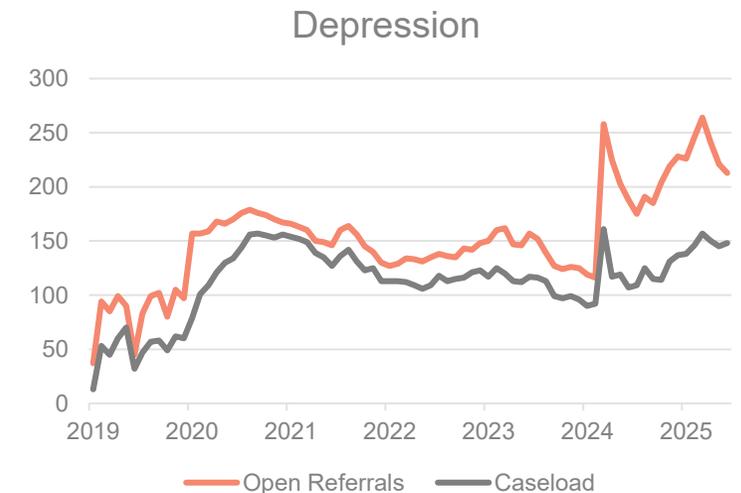
Depression

Wait lists for cases for anxiety, depression, "in crisis" and neuro-developmental conditions have also more than doubled in last 6 years

Wait times for these 4 chief complaints is at a 5-year peak as of 2025

Waiting times as measured by the number of CYP waiting for their first contact for **over 52 weeks** for mental health services they are referred to, has increased multiple folds for the following chief complaints between 2019 and 2025 –

- **8X** for "In crisis"

- **4X** for Neurodevelopmental conditions (excluding Autism Spectrum Disorder)

- **2X** for Anxiety

- **2.5X** for Depression

In Crisis

Neurodevelopmental conditions (ex Autism Spectrum Disorder)

Anxiety

Depression

24
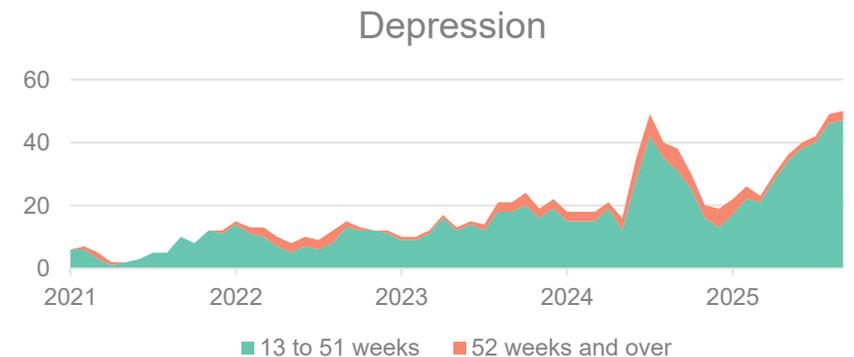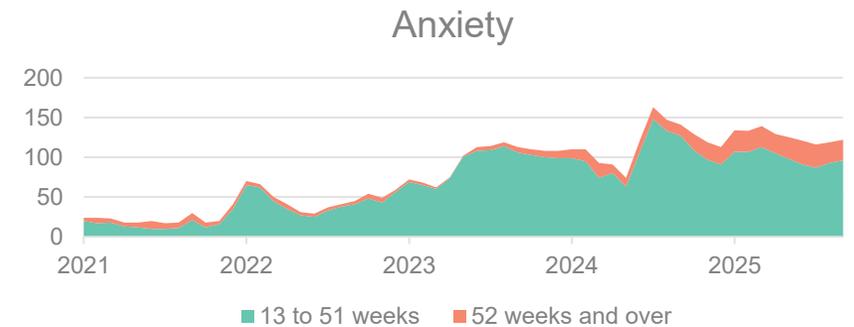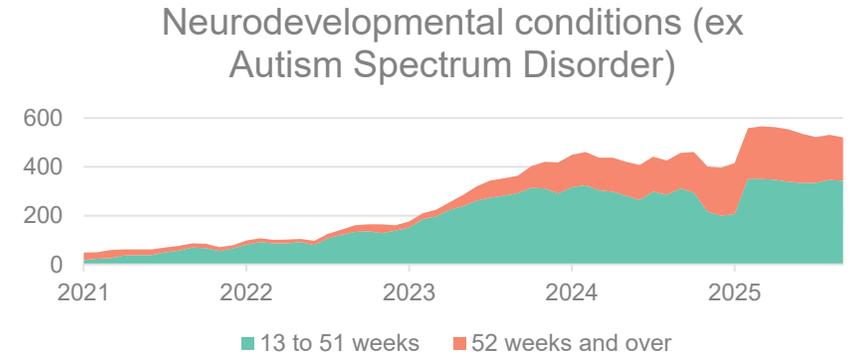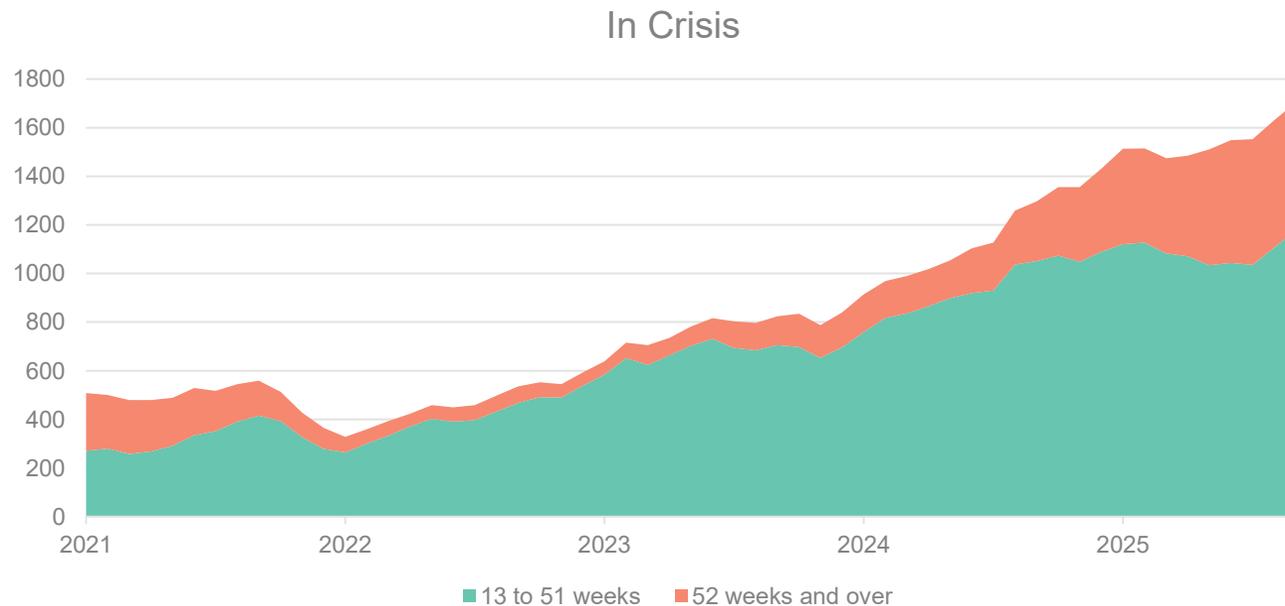
Children aged 10 to 15 years and 40% experiencing the most deprivation present a disproportionately high burden on mental health services

More than 50% of the all the CYP caseload in mental health services across SEL are of children aged 10 to 15 years
Over 80% of the all the CYP caseload in mental health services across SEL are of children aged 5 to 15 years

Over 50% of all the CYP caseload in mental health services across SEL are of those from the 40% most deprived communities (in 2024-25)

Caseload distribution across age groups 2024/25
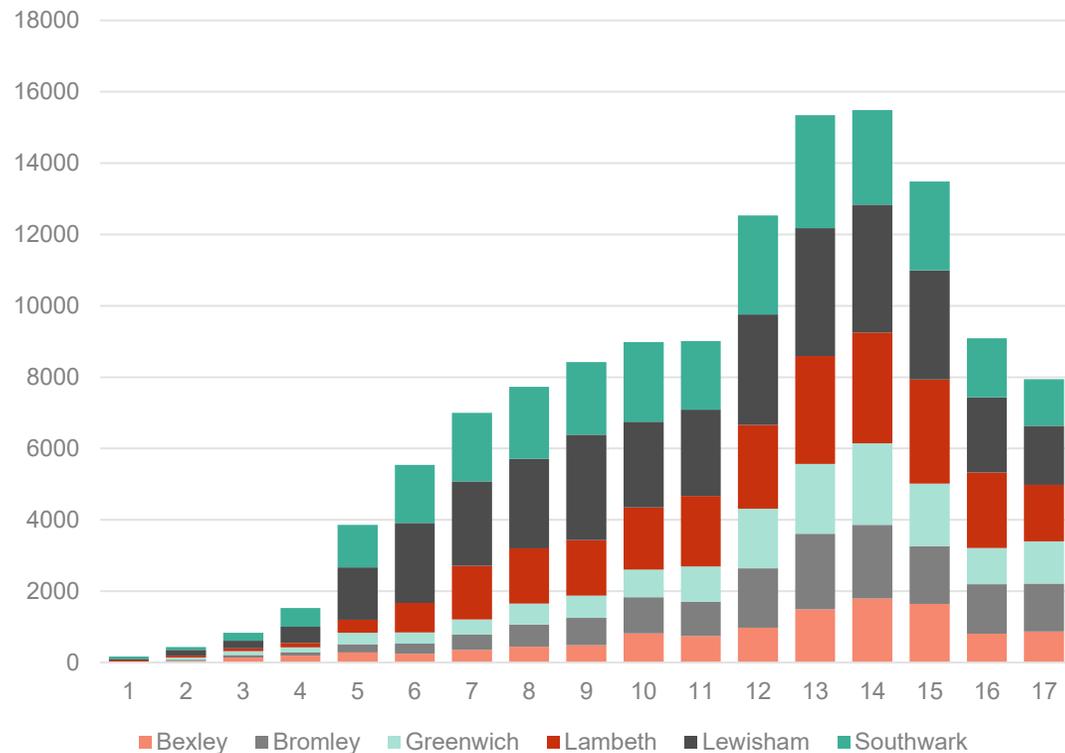
Caseload among deprived population in 2024-25

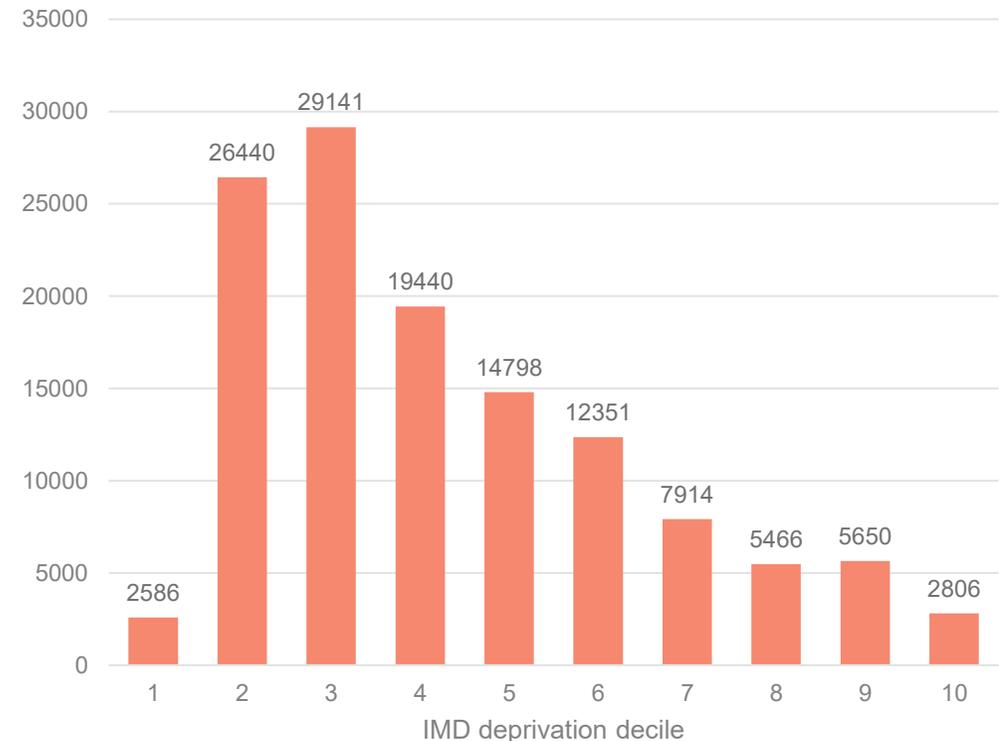# We need to shift the focus to early proactive prevention

Age 5- 16 years

'Silent disease'....

Consistent reported increases in presentations (not including invisible cases) related to a range of issues including:

- ○ **Anxiety**
- ○ **Non-school attendance**
- ○ **EBSA**
- ○ **Behavioural challenges**
- ○ **Sleep disorders**
- ○ **Disability**

Age 16- 24 years

One in every seven young people (in UK) ...

- The number of young people aged 16-24 classified as Not in Education, Employment or Training (NEET) is close to **one million** – an increase of 250,000 in 3 years

- More than a quarter of NEET's cite **long term sickness or disability** as a barrier to participation compared with 12% in 2013-14

- The number young people claiming health related universal credit and employment support has risen by more than 50% in five years with **80% of recipients reporting mental health or a neurodevelopmental condition such as ADHD**

The priority must be to shift the focus to prevention, and to ensure that children and young people receive **timely proactive intervention and support** at the **earliest opportunity,** so they are empowered to remain engaged in the community, education, then employment, or training.

1 mile

3 miles

5 miles
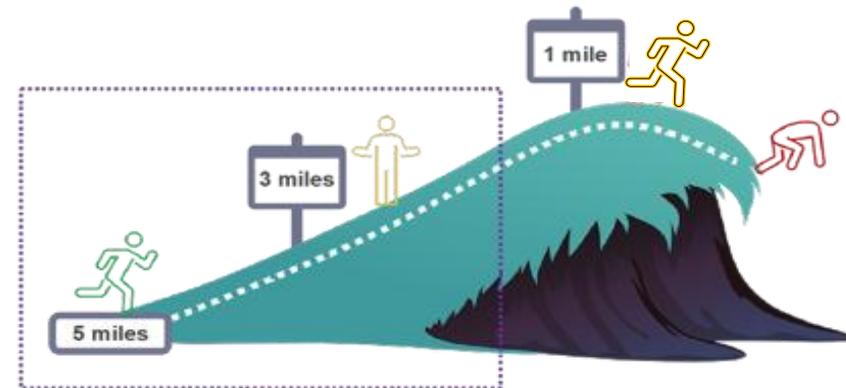
5. CYP Population segments and priorities

Effective segmentation should be grounded in need, while being informed by equity, prevention, and whole-system responsibility.

The SEL CYP ambition is 'CYP will receive proactive, coordinated services across health and care settings which are designed around their identified needs and the wider needs of the population to ensure that they achieve their best outcomes in childhood and into adulthood'

This will be achieved when:

- The environment and services are are purposefully and actively configured around the holistic, bio-psychosocial needs of the CYP population and all its segments/cohorts.

- Responsibility and accountability for CYP population health and healthcare is clear.

- The social, commercial and environmental determinants impacting the health of the population are considered and acted on.

- Relative needs are the basis for service configuration, integration, governance, outcomes, and resource allocation for the population.

Guiding ambition for segments

Population Need as the Foundation

Need—encompassing health, social, and wider determinants—must be the foundation of all segmentation decisions.

Seamless transition across segments

CYP and families should be able to access care close to home with seamless movement between clinical services and transitions to segments.

Be orientated around the child/young person and their family

CYP and families are active partners in decisions, with support shaped around their goals, strengths and lived experience.

Whole-System & Community-Led

Segments should acknowledge CYP health and wellbeing is a shared responsibility requiring multiagency partnership, collective system alignment and local ownership

Demographics, complexity and (rising) risk form the key dimensions for need based segmentation

Demographics

The bio-psycho-social needs of CYP are closely linked to demographics, most obvious of which are age, ethnicity, deprivation (including that which is 'hidden') and geography.

Deprivation	**Age**
Ethnicity	**Geography**

Complexity

Complexity of need determines the complexity of integration/ co-ordination, intervention and services required. Complexity ranges from "universal needs" through to "complex health needs".

Universal	
Chronic	**Complex**
Unexpected	

(Rising) risk

Rising risk is the likelihood of deterioration and/or increased needs and/or increased requirement for integration/ co-ordination, intervention or services. It helps enable targeted preventive interventions and support. At risk groups are *those at rising risk of not being able to live their best and healthiest lives possible.*
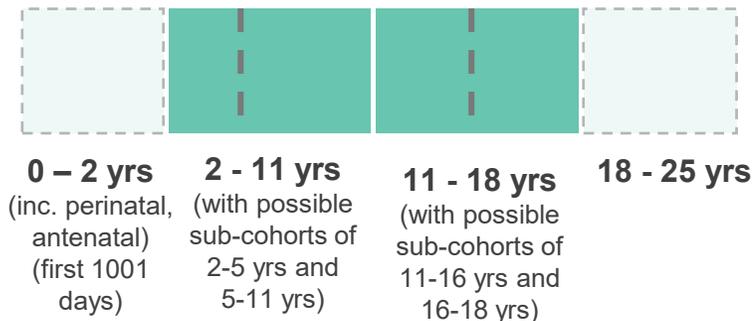
Demographics, Complexity, and (Rising) Risk: Key Dimensions for Needs-Based Segmentation

Demographics

The **bio-psycho-social** needs of CYP are closely linked to demographics, one of the most obvious of which is age.

Age and key life stages – early years, school age, adolescence and young adulthood – each associated with different developmental tasks, risks, and service requirements

Ethnicity shapes patterns of risk, experiences of discrimination, and trust in services, all of which influence access and outcomes.

0 – 2 yrs
(inc. perinatal, antenatal)
(first 1001 days)

2 - 11 yrs
(with possible sub-cohorts of 2-5 yrs and 5-11 yrs)

11 - 18 yrs
(with possible sub-cohorts of 11-16 yrs and 16-18 yrs)

18 - 25 yrs

Complexity

Complexity of need determines the complexity of intervention and services required.

Proposed complexity subdivisions:

- **Universal** health and care needs – the needs of everyone (including those considered 'well')

Within the population with universal health needs, are three particular groups:

- Those with **chronic** health and/ or care needs

- Those with **complex** health and/or care needs (inc. vulnerable with social needs)

- **Unexpected** injury or illness or other need (requiring UEC) – which can happen to anyone (with two subgroups: mild and severe)

Rising Risk/ Unmet Need

Within each identified segment, particular groups of rising risk are identified as those at rising risk... of not being able to live their best and healthiest lives possible.
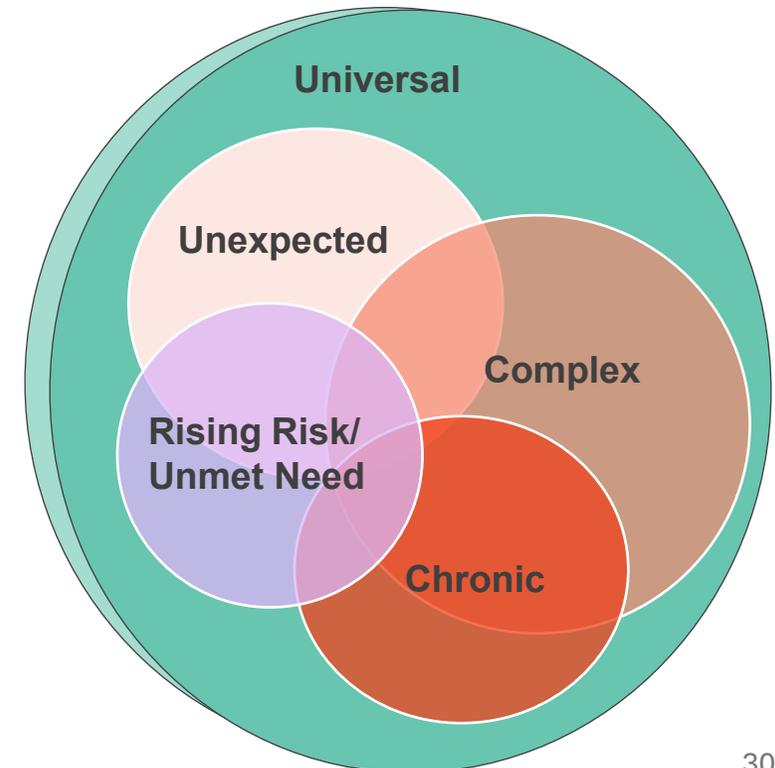
Four categories of need complexity

Universal	Chronic	Complex	Unexpected
These are the everyday needs of the whole CYP population, which may be addressed largely through self-care, family and community assets, and universal services.	These are ongoing needs for instance, linked to one or more long-term condition or disability, manageable through planned, proactive care within the community.	These are multi-faceted, interacting and sometimes invisible needs and disabilities, may involve instability, and require a higher degree of coordinated, multi-agency care.	These needs may arise suddenly or out of a crisis and are not necessarily about ongoing chronicity or complexity. They may be mild or severe.

Domains

Universal
- Physical and mental wellbeing
- Social determinants and inclusion
- Primary & Universal Health Care
- Preventive health & care
- Growth & development
- Smooth transition into puberty and adulthood
- Whole family/carer focus

Chronic
- Long-term physical or mental health
- Functional abilities for daily living and caring responsibilities.
- Behaviour change and self-management skills.

Complex
- Broadened definition of complexity
- Co existing multiple long-term conditions either physical, mental or both
- Social complexity (e.g., housing, domestic abuse, child protection, poverty, caring strain).
- Safeguarding, legal and rights issues

Unexpected
- Acute physical or mental health
- Social or safeguarding
- Timely access to urgent care
- Easy access to signposting information
- Continuing support

Needs with varying complexities exist across and within each demography

Within any single demographic group, there will be CYP who are generally well and only need universal care and support, while some will have ongoing chronic needs, and some with highly complex physical, mental, and social needs that require intensive, multi agency support. Further, each of these groups can have varying risk profile.

This produces overlapping segments (e.g. "stable LTC", "neurodiverse with school-based distress") rather than mutually exclusive groups.

To illustrate, each of the discs (in green) stacked together represent a demography. Within each demography, sub-groups of varying needs and risk not only exist but overlap with each other. (see diagram)

Robust segmentation must therefore accurately reflect this spectrum of need and design proportionate responses.
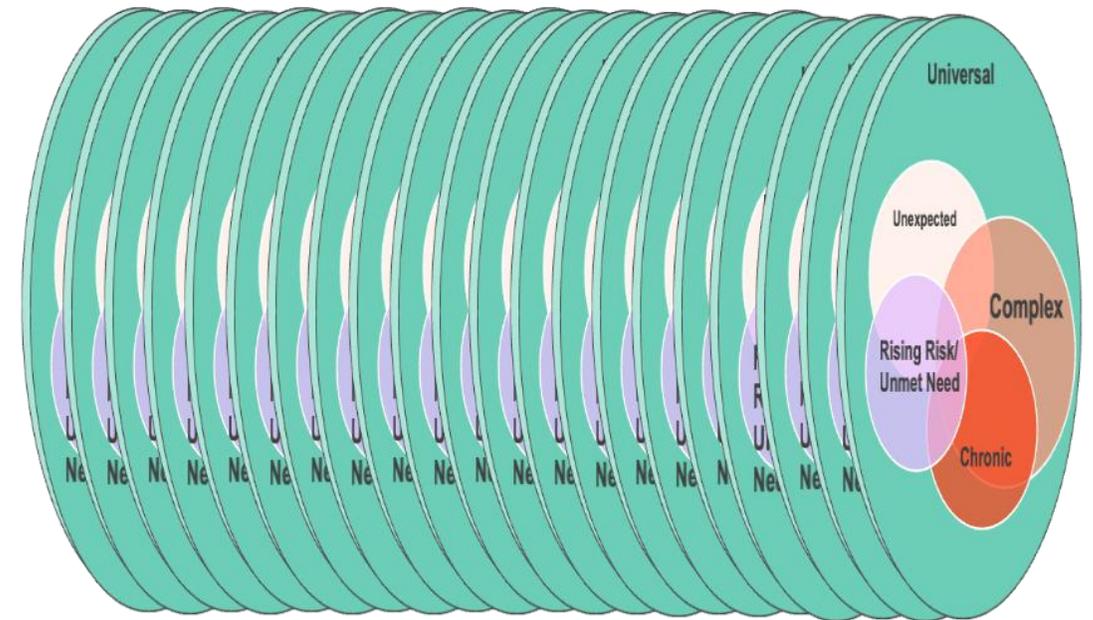
Geography	Borough or neighbourhood			
Age	Age: 0 – 2 yrs	Age : 2 – 5 yrs Age : 5 – 11 yrs	Age : 11 – 16 yrs Age : 16 – 18 yrs	Age : 18 – 25 yrs
Deprivation				
Ethnicity				

6. CYP INT Framework

CYP INT Framework - things to note

- This framework captures the priorities and ambitions of SEL colleagues and acts as a guide rather than a strict formula.

- Each Borough has existing developments underway and will start from a unique point. The framework describes a way of working at neighbourhood that will help optimise these developments and support a consistent approach.

- Local communities can use the framework to evaluate their current level of development and build upon existing strengths and achievements.

- Implementation will differ; the goal is to tailor the model to the local context instead of duplicating a single approach.

- The process will take time and should be carried out in phases in alignment with The 10 Year Plan.

- Some elements require consideration for a SEL approach, while others can be managed locally.

- Neighbourhoods act as the main delivery units—local areas determine how to put the framework into practice, reallocate resources, focus on early successes, and plan the rollout.

Our approach to developing the SEL INT CYP Framework

Strategic priorities & best practice learnings

Local SEL data

Patient and staff feedback & engagement

The SEL CYP INT Framework was co-designed with over 90 stakeholders and informed by patient and staff experience and feedback, as well as utilising local population data sets to identify priority areas of focus. This was supplemented by a comprehensive review of relevant best practice learnings which were incorporated within the SEL CYP INT framework. The framework integrates these resources to optimise outcomes for the local population, while remaining aligned to the national strategic direction of travel.

Fundamental values and principles that underpin the framework

1.	Know your population

Understand need (including invisible need), risk and lived experience.

2.	Be needs-led, not diagnosis- led

Get to root causes, avoid medicalising where needs are unmet.

3.	Act early

Proactive intervention before escalation through prevention and timely support.

4.	Work holistically

Wrap coordinated multi-agency support around children, young people and families.

6.	Empower and enable families and CYP

Foster agency, control involvement, choice and the ability to trigger support.

5.	Connect, don't silo

Align schools, health, social care, housing and VCSE around shared goals, supported by data/digital tools that connect and provide oversight

7.	Build trusted relationships, good communication and knowledge sharing

Between sectors, professionals, families and communities.

8.	Treat people with dignity and respect

Listen, tailor support, see care closer to home. Recognise individual's unique identity/culture.

9.	Embed equity and access

Reduce variation, shorten waits, make services easy to access and navigate. Recognise how language, culture & socioeconomic factors amplify hidden needs.

10.	Focus on maximising life chances

Improve wellbeing, outcomes and long-term potential.

SEL CYP INT FRAMEWORK

1. POPULATION HEALTH MANAGEMENT | A. Data Collation and Intelligence Gathering | B. Two-Way Communication Channels. | C. Building the right infrastructure

2. UNIVERSAL PROVISION

A. Targeted Information

B. Targeted prevention

C. Other ways to connect

Range of CYP services (few examples shown)

- SEND
- Hospital
- Schools
- Early yrs and Early help
- Family Hub
- VCSE
- Primary care (incl GP)
- Housing
- CYP community services

3. ACTIVE IDENTIFICATION

A. Use of Data / MECC / Two-Way Channels

B. Simplified Access

C. Outreach Identification

D. Framework of action

POINT(S) OF ACCESS

Triage / signposting

4. MULTIAGENCY COORDINATION AND WORKING

Specialist Input

Coordination of all Care

Multi-agency working

Cultural change

Local child health teams

Flexible teams wrap around CYP/family

CYP INTEGRATED NEIGHBOURHOOD TEAM(S)

- GP
- Social care
- Specialist
- SEND
- Education
- Housing
- VCFSE
- Mental health
- Care Coordinator
- Social prescriber

Family hubs and Children centres

5. DIRECT CARE DELIVERY

6. MANAGING ESCALATIONS / UNEXPECTED NEEDS
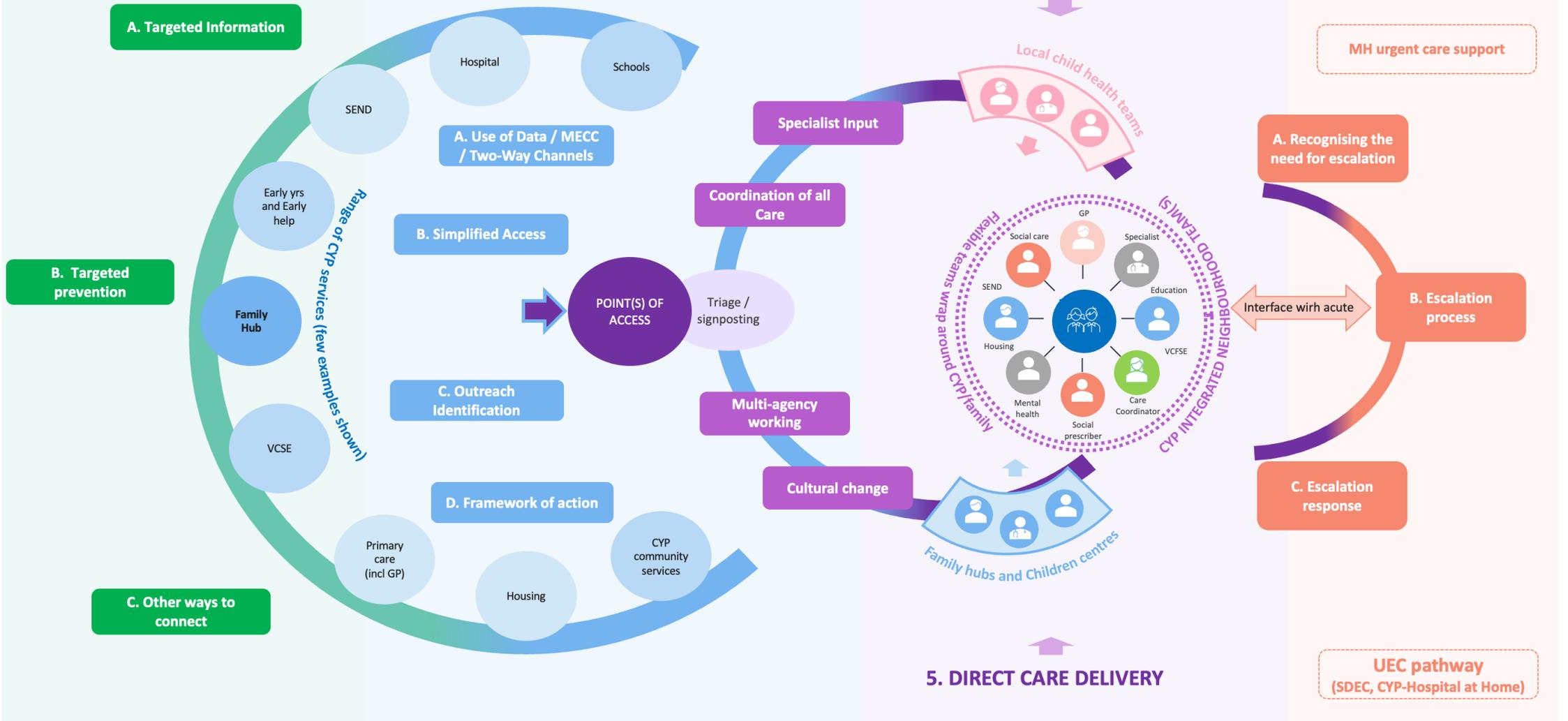
MH urgent care support

A. Recognising the need for escalation

B. Escalation process

Interface wirh acute

C. Escalation response

UEC pathway (SDEC, CYP-Hospital at Home)

7. LONGITUDINAL CARE AND TRANSITION

D. Create a governance framework led by local people where neighbourhood partners collaborate with local families and CYP to make decisions

The SEL CYP INT framework – key functions/delivery components

1. Population Health Management (data, intelligence and action)

2. Universal health and care provision	**3. Active identification and family-centred early intervention**	**4. Multiagency coordination and working**	**5. Direct care delivery** (clinical, psychological, social, environmental, lifestyle support)
6. Managing escalations, urgent or unexpected needs	**7. Longitudinal care and transition (18+)**	**8. "Flourish", ongoing support and optimising potential**	**9. Waiting 'well' or 'unwell' (needs led rather than diagnosis)**

10. Engaging VCSE as trusted delivery partners

Supported by QI (feedback, learning) and cultural change

Function 1

Population Health Management (PHM) (data, intelligence and action)

Systematically using data and intel, and moving beyond surveillance to actionable insight, informing how we shape delivery (e.g., trigger outreach, shape workforce priorities and target resources to families most at risk).

A. Data collection and intelligence gathering

B. Two-way communication channels

C. Building the right infrastructure

D. Create a governance framework led by local people where neighbourhood partners collaborate with local families and CYP to make decisions

1. Population Health Management (data, intelligence and action)

A. Data Collation and Intelligence Gathering

- Real-time understanding of local children and families (who do and do not access services) by combining linked datasets, public health analysis, school and Family Hub intelligence, VCSE insights, and MDT discussions.

- Not just data collection, it becomes an active learning and decision-making infrastructure for 'finding families'

- In future, finding a mechanism by which all partners across SEL can adopt a unique identifier for CYP.

- Obtaining intel at multiple levels including:

  o Individual patient level: a cross- service view of needs.

  o Neighbourhood: Utilising community driven data intelligence, PHM solutions and EMIS/Ardens searches at neighbourhood level

  o System population health: working across boundaries to provide population view of data.
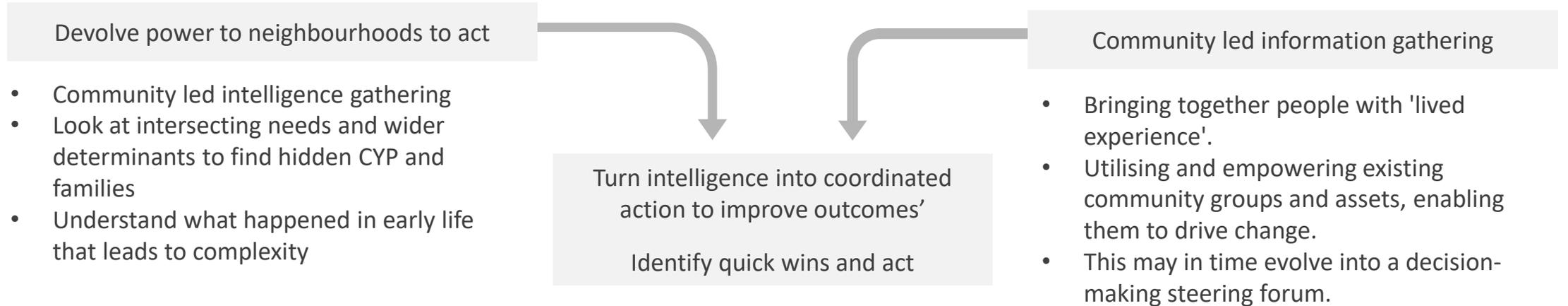
B. Two-Way Communication Channels

- Build structured channels where partners such as schools can flag emerging risks and promote prevention. Linking services across health, Local authority, VCSE, public health etc.

- Create feedback loops with families, youth workers, digital platforms and frontline services.

- Insight continuously flows into local decision-making and action.

- Linking in community connectors to the right services e.g. health services or family hubs.

C. Building the right infrastructure

- Integrating datasets between heath and care providers to obtain full view of CYP population

- Real-time risk dashboard featuring built-in stratification and algorithms (incl. ability to detect 'hidden' CYP).

- AI-driven algorithm designed to send notifications to the appropriate team or initiate actions and workflows.

1. Population Health Management (data, intelligence and action)

D. Create a governance framework led by local people where neighbourhood partners collaborate with local families and CYP to make decisions

Devolve power to neighbourhoods to act

- Community led intelligence gathering
- Look at intersecting needs and wider determinants to find hidden CYP and families
- Understand what happened in early life that leads to complexity

Turn intelligence into coordinated action to improve outcomes'

Identify quick wins and act

Community led information gathering

- Bringing together people with 'lived experience'.
- Utilising and empowering existing community groups and assets, enabling them to drive change.
- This may in time evolve into a decision-making steering forum.

Enablers

- Information governance: Strategic review of information governance limitations and solutions.
- IG input into the process to improve data sharing across health systems.
- Building trust to share records across health and social care.

- Having strategic offer of support at SEL/ Place to provide activity data and solutions for support with a coordinated approach.
- Strategic commissioning playing a role in the integration of datasets.
- 'Real data' sits with LA and VCSE, therefore need to create a link.

West End Morecambe Big Local

Population Health Management (data, intelligence and action) - Example

- West End Morecambe – Big Local (WEM) is **resident-led community partnership**, working to help improve the local area by tackling the issues the community face, including mental health and poverty.

- Their work is shaped through **local knowledge** and brings about change to **improve the health outcomes** in the community.

- They have created a **youth advisory group**, comprising of 45 members, all aged between 12-18. This group is supported to administer mental health funding for services and engages in **community decision-making**.

- **Partnership of local organisations** has been established, with **projects driven by residents** themselves, and delivered within the local community centre.

- Through tracking health metrics and seeking regular community feedback, Wet End Morecambe Big Local has been able to evidence building social capital and improving health outcomes in the local community, as well as alleviating the impacts of poverty.

Function 2

Universal health and care provision

Universal health and care provision is the foundation of the neighbourhood model, ensuring every child, young person and family has access to the core entitlements that keep them healthy, supported and connected to community life. Provision of information/knowledge is key.

A. Targeted information that reaches resonates and enables action

B. Targeted prevention

C. Other ways to connect

D. Universal service offer

2. Universal health and care provision

A. Targeted information that reaches, resonates, and enables action

Information delivered in culturally sensitive ways
Using language, channels and framing that reflect family identity, youth culture and community values.

Community connectors as trusted messengers
VCSE workers, school staff, midwives, health visitors, Family Hub teams and youth practitioners sharing tailored messages (e.g., oral health, infant feeding, nutrition, emotional wellbeing).

Information that goes beyond 'health topics'
Recognising that issues like housing, finance, isolation or safety often sit behind health needs, so signposting families to the help that truly matters. Providing clear and 'simplified' communication.

Targeted content for specific groups
e.g., teen health, post-birth, families with SEND, migrants and those with language barriers. Working with informal leaders within the community (champions) to drive information e.g., religious leaders.

B. Targeted prevention

Increase visibility and uptake
Understand where preventative services are under-used and target those groups through trusted channels to improve awareness, engagement and reach including GP practice triggered messages.

Proactively identify and work with Core20 and other vulnerable groups
CYP across SEL show concerning levels of mental health needs, obesity, and developmental challenges, with stark inequalities between deprivation quartiles e.g. higher obesity, high ED admission, digital exclusion and cultural diversity. Early experiences of inequality creating lifelong health disadvantages

Target specific needs through schools and community settings
Work with schools to create mechanisms that promote mental wellbeing, provide early support, and enable timely intervention, applying similar approaches for obesity, oral health and other priority areas.

Continued enabling proactive support within the community
To avoid future exacerbation and escalation through an environment of support, regular review and connection back to community groups.

2. Universal health and care provision, cont'd

C. Other ways to connect

Hyper-local social media campaign
A hyper-local social media campaign delivers tailored messages to specific neighbourhood audiences.

Search-driven signposting to local support
Using SEO (search engine optimisation) and SEM (search engine marketing) ensures local families searching online are proactively directed to local community support and services.

Peer networks (allyship)
Creating local peer groups whether for SEND, healthy weight, diabetes or other needs, brings parents together to share lived experience, offer mutual support and build confidence, creating a trusted community resource that complements professional services.

D. Universal service offer

Utilising overarching universal preventative services

- Recognising and advocating the use of existing universal offers that are available to residents, including free school meals, dental services, GP, pharmacies, family hubs, immunisation, etc.

- Building upon the existing universal preventative services, offer and assets.

- Easy and accessible information about local offers (LA websites) and to the Healthier Together website for SEL https://www.healthiertogether.nhs.uk

- Reviewing thresholds for entry to services to enable earlier support

Enablers

- Working across SEL in an agile way, to provide universal health and care interventions at the earliest opportunity e.g., working with minoritised communities to increase uptake of immunisations and/or vaccines.

- Co-production in neighbourhoods with CYP, families and professionals to enable delivery of health services and connection with communities in the right way.

- Building trust by utilising community assets to drive information.

- Understanding the current resources available at Place

- Understanding how hyper-local offers work alongside universal offers to deliver value for money and ensuring there is no overlap or duplication leading to inefficiencies.

Hi Anxiety (Digital Youth Campaign)

Targeted Information that reaches, resonates and enables action

Universal health and care provision - Example

- Launched in 2019 on Instagram and YouTube to help young people manage everyday anxiety.

- Built an audience of more than 200,000 users through relatable, youth-centred content rather than clinical messaging.

- Used pastel visuals and authentic storytelling from influencers to normalise conversations about anxiety.

- Analysed engagement trends to ensure messages reached the right audiences on the platforms they already used.

- Trained community managers responded to comments using a **validate → inquire → refer** model, directing users to helplines, therapy and support resources.

- Evaluation showed the campaign not only raised awareness but triggered **real help-seeking behaviour**.

- Demonstrates how **targeted, co-designed communication can reach, resonate, and activate support pathways,** offering a transferable model for neighbourhood-level messaging and early intervention.

Function 3

Active identification and family-centred early intervention

Adopting a single, proactive approach to identifying emerging issues at the earliest possible opportunity, using early indicators and intelligence to inform timely intervention. Access to services should be clear for CYP and their families, ensuring they are connected to the right practitioner at the right time.

A. Use of Data / Make Every Contact Count / Two-Way Channels

B. Simplified Access

C. Outreach Identification

D. Neighbourhood based framework of action for those identified

3. Active identification and family-centred early intervention

A. Use of Data / Make Every Contact Count / Two-Way Channels

Population level predictive insight

- Use linked datasets, school intelligence, safeguarding trends and attendance patterns. "The right data, at the right time, with the right people". Adopt one shared approach across partners.
- Identify rising-risk cohorts early (hidden CYP and families, non-attenders, high A&E users). Consider utilising additional data sources, such as housing to identify those at rising risk (e.g., children in temporary accommodation). Increase LA involvement in approach.

Learning from early signals: risk detection and proactive case finding

- Track missed appointments, persistent absence from school, housing stress, family breakdown. Treat these as escalation indicators

Opportunistic identification in everyday settings and establishing two-way channels of communication

- Create channels for practitioners (e.g., school nursing) and community connectors to flag concerns directly to neighbourhood teams or via family hubs (exact operating model to be defined locally)
- Intervening and providing information at the earliest opportunity, including across maternity services. Sports clubs and youth centres also play a vital role in opportunistic identification.
- Conducting home visits to identify health issues, social isolation and needs for other services e.g., housing, benefits (Brazil health model).

SOS/"If You See It, Act On It"

- Equip neighbourhood teams to recognise early signs of risk
- Enable brief intervention, signposting and onward referral through trusted community or professional routes.

3. Active identification and family-centred early intervention

B. Simplified Access

Families know where to go, get held wherever they show up, and reach the right support without friction or delay

Point(s) of access for people

- Bolstering existing routes of entry (in-person and virtual) such as family hubs, well centres. Each Neighbourhood to define whether they bolster their current access points or to create new ones.

Single front door for concerns and referrals

- A clear, visible access point (digital, phone or in-person) where practitioners, schools, VCSE partners or families can raise concerns about rising risk, request support or refer children with more complex needs, without navigating multiple pathways.

No wrong door experience

- Wherever a child or family enters the system (school, GP, Family Hub, youth club, VCSE organisation), they are held, not redirected — and seamlessly guided to the neighbourhood INT without repetition or delay.

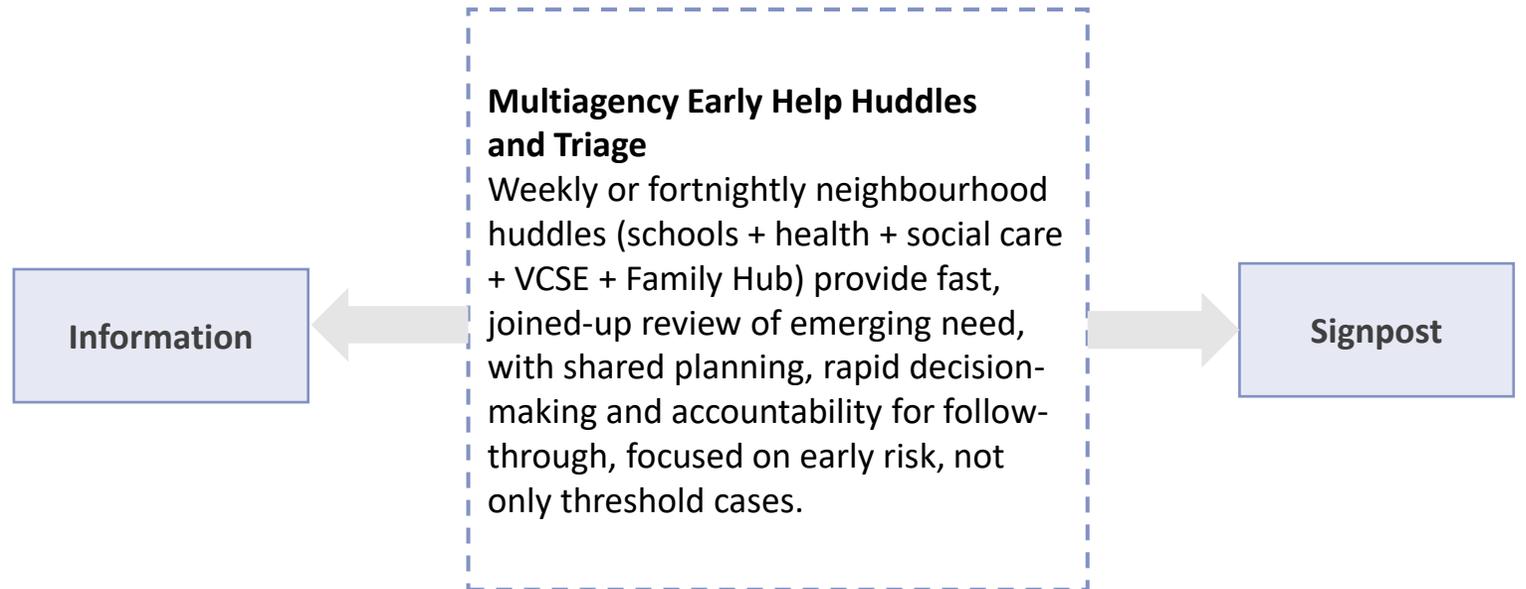**Right practitioner, right time**

- Triage ensures families reach the most appropriate practitioner early, whether that is a family support worker, mental health, early help worker or GP.

3. Active identification and family-centred early intervention

C. Outreach Identification

D. Neighbourhood based framework of action for those identified

Learning from LEAP, where relationships were prioritised, trusted community partners to identify hidden families not in statutory systems - young carers, unregistered migrants or rising risk. Proactive outreach to complement this by targeting families who do not attend universal offers through doorstep conversations and parent champions. Neo-natal outreach to identify and address issues

Information ⟵ **Multiagency Early Help Huddles and Triage**
Weekly or fortnightly neighbourhood huddles (schools + health + social care + VCSE + Family Hub) provide fast, joined-up review of emerging need, with shared planning, rapid decision-making and accountability for follow-through, focused on early risk, not only threshold cases. ⟶ **Signpost**

Enablers

- Information governance and data sharing drives active identification and early intervention, as well as building trust and relationships between services including schools.

- Use of national mandated integrated reviews (progress check at age 2) to identify any issues early.

Community Services: Well Centre - Lambeth

Active identification and family-centred early intervention - Example

- Young person's health and wellbeing hub (11-20 years old), bringing **services together in one place**, enabling easy **simplified access to care**, allowing discussion of health concerns in a safe and confidential space.

- The Well Centre **comprises of multiple professionals** including mental health nurses, GPs, youth workers, occupational therapists, psychiatrists, voluntary sector staff, psychologists, social workers and peer supporters.

- **Open access referrals** come from various sources, including **schools, self-referral**, GPs, social services etc.

- Flexible service delivery helps to support young people with their health and wellbeing, by **providing advice** as well as **signposting** to more specialist organisations, if required. This service offers an opportunity to present confidentially and have their needs assessed.

- A **holistic assessment** and **tailored plan** are developed, additionally allowing for opportunistic questions, hence **uncovering broader issues.** Services include **health education**, interventions around **substance misuse, diet, mental or sexual health** (may need appropriate onward referral).

- **82%** attending the centre have shown improvement in their WHO-5 Wellbeing Index scores.

Function 4

Multi-agency coordination and working

Effective CYP INT's will be built on relational, values-based collaboration, not transactional referral routes. The focus is on a shared vision, accountability and language across agencies so that practitioners understand each other's roles, trust one another, and work as one 'communicative' system around the child and family.

A. Access and Referral Into the Neighbourhood

B. Triage and signposting

C. Multi-agency working

D. Coordination of all care and named worker

E. Specialist Input

F. Professional knowledge sharing with wider community and cultural change

G. Establishing enabling factors

4. Multi-agency coordination and working

A. Access and Referral into the INT

- One simplified access route ensures CYP and families are not bounced between services.
- Population health insight helps proactively identify those needing support.
- Schools, VCSE, Family Hubs and community actors can flag concerns directly into the neighbourhood.
- Each neighbourhood defines its priority cohort (e.g., rising risk, complex needs, SEND, safeguarding vulnerability) based on local data and context.

C. B. Triage and signposting

- A small neighbourhood coordination team receives referrals, triages cases, and allocates support.
- CYP not requiring multi-agency input are matched to a named worker (e.g., family support worker, youth practitioner, SEND navigator) for brief intervention, guidance or community-based help.
- Cases needing multi-agency input are placed into a shared caseload for discussion within the MDT.
- The aim is right help, first time — signposting, coaching, or escalation without delay.

C. Multi-agency working

- Focus on holistic understanding of need (biopsychosocial), not service-led problem definition. Look at the family as a whole
- Earlier intervention and smoother pathways, reducing "referral bounce" and fragmentation.
- Monthly or fortnightly virtual MDT huddles review cases, triage concerns and agree coordinated action.
- Core membership typically includes GPs, paediatricians, CYPMH/MHST practitioners, Family Hub staff, SEND leads, school nurses and VCSE partners, with members flexed to need.
- CYP/family have one assessment and don't have to tell their story twice.

4. Multi-agency coordination and working

D. Coordination of all Care and named worker

- Each professional is responsible for building relationships and communication needed for coordinating care.

- When required, CYP have a named coordinator, consistent with neighbourhood MDT practice.

- Improves family- and CYP- centredness, continuity, reduces system strain and builds family voice and agency.

- Improving information sharing between teams avoids the family having to 'tell the story multiple times'.

- Having 'connectors' such as family navigators working at all levels is vital.

E. Specialist Input

- Timely access to child health hubs, SEND services, general paediatrics, CYPMH teams, speech and language and nutrition specialists, neurodevelopmental pathways and transition services when required.

- Early access avoids escalation and excessive waits.

- Specialist in-reach to enable care closer to home in familiar setting e.g., paediatrician or specialist nurse clinic in GP surgery – preventing hospital or A&E attendance

F. Professional knowledge sharing with wider community

- Learning loops, shared supervision, networked improvement approaches and reflective practice sessions ensure continual skill growth, aligned with LEAP's finding that holistic practice flourished when infrastructure supported learning.

4. Multi-agency coordination and working

G. Establishing Enabling factors

- Multi-agency case conferencing enables joint analysis, shared solutions and relational accountability.

- Co-location/virtual co-location, integrated working days, job shadowing and informal contact strengthen trust and speed decisions.

- Improving access overall by having services accessible after school hours.

- Requires relational, values-based leadership — modelling behaviours, resolving friction and maintaining shared purpose.

- Building robust relationships with a shared passion, purpose and outcomes, with equity of input and shared buy in.

- Focus on workforce supervision, training, carer pathways and building new skills is imperative to success, enabling staff to feel valued and supported. Training should include understanding each other's roles as well as delivering feedback to improve ways of working.

- Sharing of assets within the neighbourhood, eliminating siloed working.

- Bringing programmes together to drive efficiency (family hubs, family first programme, youth strategy and local child health teams).

- Sharing data/knowledge between teams by use of shared systems and data, with shared governance.

Connected Care Network (CCN), Birmingham

Multiagency coordination and working - Example

- CCN was established in North Solihull, Birmingham and delivers **integrated, digitally enabled care** across health, education, social care and the VCSE sector, aiming to **deliver holistic, integrated care** within the community, **harnessing local relationships**.

- The service operates by an **open referral** system for professionals via the **Joy App** (primary care, schools, youth justice, VCSEs etc.). There are **weekly multi-disciplinary meetings** with the health and well-being coordinators, GP clinical lead, operational lead and VCSE organisation representatives, thus providing a holistic lens. Outcome plans are shared via the Joy App. All recommended referrals are completed by this MDT.

- **25% fewer referrals** into community CYPMHS, **40% fewer referrals** to autism assessment services, **27% fewer referrals** to community paediatrics.

- Estimated costs (in April 2024) include **569 GP appointments saved** (saving approx. **£17,000**), 5,124 hours of support provided outside clinical and therapeutic support (saving over **£400,000**).

https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/

Function 5

Direct Care

Delivering coordinated multi-agency care that brings together experts to provide holistic and integrated support to improve outcomes for CYP. Providing better access by bringing CYP services into the community and enhancing the core offer and support by expert peer led groups and practice champions for example.

A. Joint clinics

B. Access routes

C. Group consultation and group coaching

D. Outreach clinics

E. Practice champions

F. Expert peer led groups

G. Direct care environment

H. Key worker for complex cases

5. Direct care

A. Joint clinics

- Neighbourhood MDT brings together a needs based multi-agency team (GPs, paediatricians, mental health, schools, social care, youth worker, sleep practitioner) for holistic, joined-up care in community settings, especially for complex needs like obesity, EBSA or mental health issues. Clinics reduce hospital waits, providing personalised care.

- Making efficient use of professionals' time by having the right professionals within the 'team of teams'.

- Utilising a 'core team' of experts with access to a wider range of professionals within the neighbourhood MDT, that are tailored to the CYP needs.

- Having 'themed weeks' where the MDT brings Mental health cases, or ASD for example, thereby ensuring the right professionals are present and are making efficient use of their time.

B. Access routes

- Current access routes and thresholds need to be reviewed to enable earlier needs-based care for certain CYP populations. E.g. referral for ASD assessments could also go via schools as opposed to community paediatrics.

- Points of access: utilising care coordinator roles to flag any rising risk and identify review from appropriate teams/ professionals within the multi-agency team.

C. Group consultation and group coaching

- Group consultations/ coaching for a small group of CYP with similar needs to share experiences, learn about self-management, and consult with facilitators, ideally *'who are like me'.* Typical 90 min face to face session, fostering peer support, connection and motivation.

D. Outreach clinics

- Bringing CYP services out into the community, offering support for mental health, physical health and specific CYP groups often at local community spots, preventing hospital stays and supporting independence.

5. Direct care

E. Practice champions

- Internal staff members or volunteers (including adolescents) working in practices championing mental health and wellbeing, connecting services, promoting holistic care, and driving improvements in mental health often focusing on early intervention/health promotion.

F. Expert peer led groups

- Supportive communities with shared experiences (mental health challenges, addiction, or chronic illness) guide each other, leveraging lived wisdom for empowerment, skill-building, and recovery, offering hope, belonging, and practical strategies. These groups provide safe spaces for sharing, reduce stigma, and foster resilience sometimes including trained experts who enhance discussions.

G. Direct care environment

- Waiting rooms that are comfortable, child friendly, with CYP artwork and activities, motivational quotes, soft furnishings, colour and space for the wider family to attend. Avoiding mixed ages and conditions waiting in the same space, which can be unsettling.

H. Key worker for complex cases

- A consistent point of contact responsible for coordinating support across e.g., health, education, social care, youth justice. A bridge between CYP/family and often-complex systems of support, ensuring a personalised and joined-up approach.

Enablers

- Providing information and tools to CYP and their families regarding direct care and the professionals involved.
- Combining functions between professionals with similar roles/ building on current roles to support families more efficiently.

Sparkbrook Children's Zone (SCZ), Birmingham – an integrated Early Help Model

Direct care - Example

- Partnership project between Birmingham Children's Hospital, a local Early Help team and a PCN.

- The pilot offers **co-location** of Early Help support services, mental health service, **improved accessibility** with an out of hours clinic from 5pm-8pm.

- The workforce comprises of specialists including a **paediatric consultant** lead, **GP lead**, **paediatric nurse**, an **Early Help lead** and other professionals from the Early Help team.
  - Identification via EMIS and self-referral via GP. This model enables all cases referred to be **offered direct facing care**.
  - A **well child check**, **oral and health screening**, **immunisation check** and **feeding and toileting concerns** are all addressed, with an extended clinical assessment being carried out by the paediatrician or GP.
  - **A third** of CYP, family and carers are identified to have needs that could benefit from support from the Early Help service (MH, housing, neurodiversity and behaviour or sleep issues).

- Outcomes include:
  - **94% do not require onward escalation to social services support**, hence highlighting how effective this intervention is.
  - Access to a clinic with **paediatric input in 1 week,** a significantly reduced wait compared to 7 months in Birmingham Children's hospital.

https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/

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Function 6

Managing escalations

INTs need straightforward, aligned and timely approaches to triggering and managing escalation, agreed and understood between multi-agency partners, to prevent issues from becoming critical events. This applies where there are concerns about individual CYP and families (such as deterioration, risk of exacerbation or behaviour such as frequent A&E attendance) and/or about gaps or problems with care delivery itself.

A. Recognising the need for escalation

B. Escalation process

C. Escalation response

6. Managing escalations

A. Recognising the need for escalation

Practical tools for recognising and reporting escalation

Use of Early Warning Scores (EWS), Paediatric Early Warning System (PEWS), Situation, Background, Assessment, Recommendation (SBAR). Awareness of these early warning tools across the system is required. Dynamic support register for people with a learning disability or Autism who are at risk of admission to hospital.

Clear timely protocols for escalation and data sharing

To be available within and between services (e.g., escalating from primary care to specialist paediatrics team or from health to social care and vice versa). Data sharing between services to ensure consistent messaging to families.

Supporting families and access to information

Direct contact to support families earlier and prevent referrals e.g., consultant connect, Local Child Health Teams. Ease of access to information 24/7 for CYP and their families (who can they contact if in need?).

Health inequalities

Particular focus on health inequalities to be considered which may be achieved through stronger links with schools and VSCE's.

B. Escalation process

Rapid mobilisation of multi-agency team

Ability to quickly mobilise multi-agency team assessment of an escalation where needed, with access to the CYP/family history to support 360-degree decision-making.

Patient centred care and involvement

Involvement of the CYP/family in decision-making and creating management plans with the family and their needs in mind. Ability of the CYP/family to trigger an escalation or MDT meeting.

Local knowledge of teams/ services available to respond in crisis

Up to date knowledge of the teams able to respond to an escalation (e.g., knowledge of safe house, crisis café, SDEC, outreach team) and how to reach them (sharing knowledge about resources and local offers).

6. Managing escalations

C. Escalation response

Timely response to crisis

Timely response e.g., GP needs to speak to acute specialist or community nurse, social worker/VCSE worker need to escalate to a rapid response team – immediate or 2-hour response for urgent issues. Care coordinator to support with this.

Skilled workforce responding to escalation

Skilled and confident staff who can make appropriate and proportionate decisions in response to an escalation and set effective actions in motion.

Interface with secondary care environment

Involvement with bed management is required, to ensure CYP are in the 'correct' spaces within the hospital setting.

Use of technology to enhance support

Use of technology, such as video-conferencing as an alternative to presenting at A&E or need for a CYP to travel to a health setting, especially on public transport when displaying disturbed behaviour.

Enablers

- A culture of open communication, trust and responsiveness is fundamental to managing escalations.

- Ability for individuals and teams to speak up and act on instinct where they are concerned, and to be trusted and taken seriously, without fear of reprisal.

- Mechanism of monitoring and feedback on escalations to ensure continuous improvement.

The Cheshire and Merseyside Tier 4 CAMHS gateway model

Managing escalations - Example

- This is a **clinician-led, multi-agency approach** to respond to the needs of children and young people at risk of admission to tier 4 CAMHS or receiving inpatient mental health care.

- An **SBAR tool** was developed for professionals which provided consistent, evidence-based approach to safeguarding concerns, actions, legal frameworks, contingency planning and timescales.

- **Gateway meetings** took place to discuss SBARs and meet needs of young people with moderate to severe mental health difficulties or those at risk of self-harm and suicide.

- The results show that since Feb 2022, 8 of 9 Local Authority places established Gateway meetings. During this period, 67 Gateway meetings reviewed **138 SBARs with multi-agency discussion. This reduced the need for escalation beyond professionals at Place** as the unmet needs are discussed and addressed within the Gateway meetings. This **suggests fewer avoidable admissions**, and this correlation is currently being explored.

Example

https://pmc.ncbi.nlm.nih.gov/articles/PMC10345543/

Function 7, 8 & 9

7. Longitudinal care and transition

Providing coordinated, non-fragmented care over time for individuals with complex needs, ensuring continuity of support and promoting wellness goals, focusing on what matters to the CYP and their families.

8. 'Flourish;' ongoing support and optimising potential

Having a clear understanding of CYP's goals, values and ambitions and embedding these within the care planning and delivery. CYP and their families will be actively supported to take a leading role in their own care, enabling informed decision making, with a strong focus on activities and factors that promote their wellbeing.

9. Waiting well or unwell

CYP may experience extended waiting periods for assessment, diagnosis or intervention, often leaving them at risk of deterioration or escalation. Provision should be made for interim support, helping to prevent or address issues that may arise. This may include specific, tailored short-term interventions and/or navigation to wider support offers making use of community assets that can help promote wellbeing.

6. Longitudinal care & transition (18+)

Longitudinal care

Unbroken coordinated care over time (instead of stop/start episodic or fragmented care) for specific chronic/complex cases to ensure continuity that helps optimise independence, prevent exacerbation/escalation.

- CYP INT produce longitudinal integrated care plan that includes Multi Agency Working arrangements for health, social care and VCSE including response to exacerbation/crisis prevention.

- 'Living plan' is regularly updated. Professionals emphasise wellness goals, relationship building and what and who matters to the CYP and family.

- Empowering parents/ family and keeping them involved, with carers able to access care record (where appropriate and required) to ensure their needs are being reflected.

- Optimising independence by empowering CYP to have their own voice, understand their rights on data sharing, confidentiality and autonomy.

Transition (18+)

Ensuring transition is seamless, well managed and proactively supported with hand-holding and advice so that the CYP/family are not left struggling to confront challenges and join all the dots, including practical help navigating e.g., bureaucracy. Consider a 'passport' for transition.

8. 'Flourish', ongoing support and optimising potential

<div align="center">

Longitudinal care

</div>

A key function of the CYP INT in addition to addressing immediate care and support needs is to help optimise a CYP's life chances and potential. This is supported by an approach to care that includes:

- Understanding individuals' strengths, goals, values and ambitions and reflecting these in personalised care planning, care interactions and delivery.
- Supporting CYP/families to be in the driving seat of their own care, making their own choices and decisions.
- Encouraging and supporting CYP to take opportunities to build skills e.g., through education and learning opportunities and contributing to the community.
- Connecting CYP to activities that inspire them e.g. creative health, sports and activities offered by youth services.
- Providing emotional support, to enable better management of stress and self-doubt and to build hope.
- Ensuring continuity of relationships that help build trust in professionals and services
- Building in the ability of CYP/families to self-refer to access timely support.

9. Waiting well or unwell

<div style="text-align: center">**Support while waiting**</div>

For CYP facing a long wait for assessment, diagnosis or appointment:

- Provide targeted, timely, open support to prevent exacerbation/escalation, alleviating symptoms by addressing root causes.
- Example issues that lead to 'waits' include MH/anxiety, neurodiversity, school non-attendance, EBSA, difficult behaviours, substance use, isolation, bullying, school problems, sleep problems.

Example interventions/offers include:

- Easier ability for those waiting to talk to professionals (e.g., access to a GP in schools).
- Regular screening while on the ASD waiting list to identify any early support needs.
- Setting clearer expectations with the family about wait times, and what to expect e.g., being on the wait list for an ASD assessment may NOT mean an ASD diagnosis.
- Pre-diagnostic workshops (e.g., peer support network for families awaiting an assessment – Bexley model).
- Short course of CBT e.g., to address increasing anxiety or school problems
- Access to social prescribing and navigation to faith groups, youth and sports groups and VCSE offers (e.g., creative health).

- Access to advice and care e.g., nutrition and sleep, SALT, occupational therapy, MH advice.
- Reduced thresholds for more timely access to CAMHS support for key issues.
- Ability in A&E to directly refer to a waiting well/unwell pathway to avoid long A&E waits.
- Specific role to get ASD/ADHD waiting lists down e.g., Lewisham Band 7 model.
- Educating parents about early warning signs and triggers and how to access the waiting well/unwell offer.
- Ability of professionals to be able to talk to each other about a CYP who does not yet have a diagnosis.

Children and young people's social prescribing service- Stort Valley and Villages PCN

Waiting well or unwell - Example

- Due to CAMHS and other tier 2 services being overwhelmed, Stort Valley and Villages PCN developed the **children and young people's social prescribing service (CYPSPS)** to support people within primary care. This model focuses on being **patient–centred** and provides a non-medicalised approach.

- The **CYPSP has built connections to local services** from MIND, schools, art groups and support for young carers.

- An OT within the MDT, **supports people with traits associated with autism and ADHD**. This isn't a diagnostic service, but is offered to those **who are currently waiting for a diagnosis and require support** with traits such as sensory overload, or trouble concentrating, hence enabling them to best manage while waiting to be seen.

- There is **support available for parents** where possible including a mental health coach to educate them on supporting their children and addressing any behaviour that may be aggravating their condition.

- Results:
  - **Less than 5% of referrals** are being sent through to CAMHS, hence **reducing the strain** on the wider system
  - **Schools have reported improvements** in student's anxiety and performance.
  - **GP workload has reduced**, due to a reduction in repeat presentations for MH.
  - CYP have reported **feeling supported** and **less isolated.**

Function 10

Engaging VCSE as trusted delivery partners

It's known (and plentiful evidence proves) that the VCSE offer is highly effective for CYP - helping for example, to address the growing prevalence of mental health and neurodiverse challenges that young people face.

A. Embedding VCSE partners as core to CYP INT delivery

10. Engaging VCSE as trusted delivery partners

A. Embedding VCSE partners as core to INT delivery

Change the way we commission:

- Bring all partners together to understand what is out there, agree priorities and best way to leverage these

- Pump prime investment into VCSE to establish a baseline model of support

- Establish longer (2-3 year) and consistent funding cycles, that enable players to build assets and services and more smaller players to take part. Avoid piecemeal, stop/start commissioning

- Leverage economies of scale e.g., through cross-borough VCSE delivery models and arrangements.

- Articulate clear benefits of the offer to change thinking and culture (e.g., in addressing lower intensity needs to prevent escalation)

Develop information on the richness of the offer:

- Create and maintain a directory of VCSE services and give all settings and key roles access to the directory and understanding of how to use it.

Establish clear entry points and access:

- Develop a digital front door for VCSE services

- Train CYP INT staff in the offer, how to utilise it and how to access it (especially link workers and social prescriber roles)

Create the right infrastructure for sustainability and scaling of the offer:

- Bring players together to form a local collaborative that meet regularly, with a shared vision, objectives, agenda and priorities

- Join up VCSE data with health and LA data to create a richer picture (DPIA)

- Define shared, meaningful outcomes and KPIs

- Agree a single continuous improvement / QI approach

- Consider governance e.g., how to manage safeguarding/clinical supervision

- Coordinate VCSE offers to prevent duplication/overlap

- Support professional development of VCSE players e.g., provide OD support, include teams in joint training, use of shadowing, etc.

SPACE Hertfordshire: supporting families of CYP with neurodiverse conditions

Example: Engaging VCSE as trusted delivery partners

Award winning charity supporting families of children and young people who are neurodivergent. An example of how they support families is shown below, detailing the story of a 13-year-old child who was waiting for autism/ADHD diagnosis for over 27months:

Actions taken by SPACE family support	Outcomes following SPACE family support
• Regular telephone and email support tailored to family's needs. • Development of action plan addressing key challenges. • Information for parents regarding strategies for understanding and managing their child's behaviours including de-escalating techniques. • Referrals made to CAMHS, PALMS, Children's Services (IFST) and ARC interventions for specialised support. • Participation in multi-agency meetings to develop a plan for MH support and liaised with various health and service professionals to expedite their needs.	• An Education, Health, and Care Plan (EHCP) is now in process. • Family feels more confident and empowered to manage difficult situations. • The family has had successful experiences that help them prepare for future challenges. • The mother has engaged in workshops and courses to better understand her child's needs. • Carer's assessment is in progress, and mentoring support has been commissioned to help the CYP access school and community activities. • The family is now receiving Disability Living Allowance (DLA) and enjoying more positive moments together. • SPACE continues to support the family alongside the IFST team.

The SEL CYP INT Framework is aligned with the national strategic direction (pls refer to appendix for more details)

NHS Multidisciplinary teams for CYP (2025) [1]

- The aim is to deliver a coordinated, timely and integrated offer that is closer to home, enabling access to paediatric and mental health expertise, through teams led by primary care.
- Reduce referrals to secondary care, A&E and waiting times by strengthening early intervention and prevention.
- 5 core components are: case identification, MDT case discussion and triage, direct care, professional knowledge sharing, engagement and health promotion.
- Extended MDT should be locally determined and include education, social care and VCSE partners to provide holistic support.

NHS 10 year Health Plan (2025) [2]

- Prevention by early intervention e.g. Tobacco and Vapes Bill, restricting junk food advertising, ban the sale of high-caffeine energy drinks to under 16-year-olds, expanding free school meals for those eligible.
- The neighbourhood health service: shifting to a model that is equipped to provide continuous, accessible and integrated care. Bringing care into local communities and professionals into patient-centred teams to end fragmentation and silo working. The aim is to, in the future, provide predictive and preventative care that anticipates need, rather than reactive care.
- Digital shift to encompass care for CYP: Managing children's healthcare through "My children" app.
- Expand mental health support teams in schools and colleges, to reach full coverage by 2029/30.
- Working in partnership with the Department for Education to implement a single unique identifier (NHS number) for every child, enabling proactive and joined up care.

DCMS Your national youth strategy (2025) [3]

The Department of Culture, Media and Sport issued a policy paper in Dec 2025 outlining the 10 key changes planned as part of the national youth strategy. Some examples include:

- Strengthening the workforce: joining up and collaborative working. Improving local offers for services, young futures hubs, investment in more youth workers.
- 'Richer lives' with more high-quality activities including sports, art, music and volunteering, with clearer information about access.
- Health and wellbeing: Mental health support teams in schools and colleges and wellbeing advice in young futures hubs.

We align our approach with national and international strategic priorities, embedding and integrating evidence-based best practice within our SEL CYP INT framework.

1. https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/
2. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
3. https://www.gov.uk/government/publications/youth-matters-your-national-youth-strategy

Case study: Zack's new story

What his journey could look like once the SEL CYP INT Framework is implemented

✓ Early support and timely intervention: The MH team in Zack's school identifies the rising risk at an early stage, informing the school link worker regarding the issues of bullying, non-attendance, isolation and poor performance.

✓ Aware that Zack suffers from asthma and is awaiting an assessment for ASD, the school link worker contacts the child's GP who triggers an MDT discussion.

✓ Contacts the child's GP who ensures Zack is seen by the specialist asthma team, a medication review is undertaken by the pharmacy and a personalised asthma action plan is agreed with Zack.

Key functions

❖ **Active identification intervention**
❖ **Prevention of escalation**

✓ The neighbourhood MDT includes the school link worker, GP, paediatrician, practice nurse, CAMHS, housing, support worker and involvement of Zack and his mother. The focus is holistic care and understanding and addressing issues around asthma, poor school performance, isolation, housing and his mother's MH problems.

✓ The discussion is centred on building trust and fostering open communication to identify root causes and achieve shared buy-in and co-production of a plan with the child and his mother.

✓ Zack is seen by the specialist asthma team, a medication review is undertaken by the pharmacy.

✓ A personalised asthma action plan is agreed with Zack supported by a community support worker appointed to coordinate and provide ongoing, hands-on support to the family. The support worker, able to socially prescribe, also liaises regularly with professionals to ensure progress is maintained and actions remained aligned.

Key functions

❖ **Multiagency coordination and working**
❖ **Direct care delivery**

Case study: Zack's new story

What his journey could look like once the SEL CYP INT Framework is implemented

Key functions

- ❖ 'Flourish', on- going support and optimising potential
- ❖ Waiting 'well' or 'unwell'
- ❖ Engaging VCSE as trusted delivery partners
- ❖ Universal health & care provision

The holistic MDT co-produced plan includes:

- ✓ Initial MH assessment and access to interim support whilst awaiting ASD assessment e.g. adjustments at school.

- ✓ Signposting to pre-diagnostic workshops e.g. peer support network for families awaiting an assessment.

- ✓ Prompt consultation with practice nurse and follow ups to assess inhaler technique and inhaler adherence.

- ✓ Navigation to local offers including youth/ community clubs to build confidence and reduce social isolation e.g. sports.

- ✓ Strategy agreed with school to address bullying and to support Zack with his performance at school.

- ✓ Investigation by housing into issues leading to eviction and provision of financial/ benefits advice for his mother.

- ✓ Visit by housing to the property to check for possible environmental causes triggering exacerbations of asthma e.g. damp and mould.

- ✓ Consultation with Zack's mother regarding her MH, assessment for talking therapy and agreeing a plan to prevent exacerbation for both herself and Zack. This includes providing information regarding access, navigation to local community support groups and ability to provide respite care if needed.

7. Enablers

A range of enablers have been identified as critical to the delivery of the framework

Workforce: Staff must feel valued and be supported through professional development that enhances skills by appropriate supervision and training, promotes understanding of roles, and provides clearly defined career pathways. Integrating and expanding overlapping professional roles can further improve efficiency and strengthen support for families.

1

Teamwork: Multi-agency case conferencing facilitates joint analysis, shared solutions and accountability. Co-location (including virtual), integrated working days, job shadowing strengthen trust and accelerate decision making. Building this trust and agile working, enables effective asset sharing across neighbourhoods, reducing siloed working.

2

CYP & Families: Co-production is needed to enable delivery of targeted health services and meaningful community engagement.

3

Information governance: A strategic review of information governance limitations and solutions is required, with early IG input to strengthen data sharing across health systems. Effective information governance supports proactive identification, early intervention, and trusted relationships between services, including schools.

4

IT systems and data: A strategic offer of support at SEL/Place to provide activity data to enable a coordinated approach. As relevant data is held across Local Authority and VCSE partners, improved integration and data sharing is necessary. This should be supported by effective data-sharing agreements and a robust governance framework to enable consistent knowledge exchange across teams.

5

A range of enablers have been identified as critical to the delivery of the framework

6 — **Culture:** Strong relationships built on shared purpose and passion with equity of input and collective ownership. A culture of open communication, trust and responsiveness enables individuals to raise concerns and act with confidence, without fear of reprisal.

7 — **Culturally sensitive adjustments:** Understanding the barriers to access services and adapting to enable engagement with CYP and their families that we struggle to connect with.

8 — **Local knowledge:** A clear understanding of existing Place based resources, and how hyper-local offers complement universal provision, is essential to ensure value for money and avoid duplication or inefficiency.

9 — **QI:** Continuous quality improvement cycles, with a mechanism of monitoring and feedback.

10 — **Left Shift – Resource Reallocation**: Funding and investment must progressively shift from resource-intensive, reactive services into community-based, preventative and early-intervention support. Delivering this left shift requires robust demand and capacity modelling to understand current system use, identify opportunities for reinvestment, and identify any initial double running and establish a robust business case.

The framework informs the commissioning shift needed to enable a needs-based and outcomes-focused approach to care, delivered through more collaborative, coordinated working

Bringing resources together to focus on longer term, meaningful outcomes for CYP is a core ambition of the framework. The commissioning approach should include:

A joint exercise to understand where existing resources and facilities sit and what opportunities exist to better leverage these resources e.g., through streamlining, simplifying and deduplicating – as well as understanding the gaps

Joint commissioning for longer-term holistic, child-centred outcomes (as opposed to transactional events) that foster collaboration and brings teams together around shared goals

Recognising 'what can be done once for SEL to support neighbourhoods – for example, the delivery of PHM tools and approaches and sorting out IG issues. Doing things once can free up resources to address gaps in capacity at neighbourhood level

Pump priming and adopting 2/3 year commissioning cycles for VCSE, that better empower players, rather than piecemeal stop/start projects (that can also tend to preclude smaller organisations)

Use of pooled budgets including strengthening alignment in the use of Better Care Fund resources

Commissioning that encourages innovation in practice, not just refining what we already do, for example, the use of AI

Developing the right tools to achieve effective oversight of CYP services and how they are performing, in order to inform and improve commissioning

Commissioning 'in the gaps' - for example ensuring provision is accessible for those already on a long waiting list (see waiting well/unwell pathway)

8. How will we know if we are making a difference?

Introduction

- The following slides outline a list of outcomes developed through engagement with stakeholders across all boroughs in SEL, encompassing a wide range of professionals (e.g. clinical, social, managerial) and care settings (voluntary sector, local authorities).

- The goal is to establish a unified set of outcomes across SEL that reflects progress and achievements of neighbourhoods, however this list will evolve and align with the development of other programmes.

- To keep it practical and meaningful, it is important that there is a finite number of indicators that can show the overall impact in line with the aspirations of the Children and Young People Integrated Neighbourhood Team Framework.

The domains and indicators reflect:

- The core functions of INTs
- National NHS expectations for neighbourhood working
- The SEL ambition to reduce inequality, improve experience and intervene earlier

INTs are expected to:

- Be actively involved in agreeing outcomes for children and young people, including locally defined priority cohorts
- Align neighbourhood activity and multi-agency working to those outcomes
- Routinely review evidence of their contribution, using process and outcome measures

- Overall, this framework provides a practical and consistent way for neighbourhoods in SEL to understand whether INT working is making a difference to the health and wellbeing of children and young people and addressing what matters most to them and their families.

Key outcome domains

7. System sustainability

Reducing demand from resource intensive areas such as secondary care, shifting focus into the community and neighbourhood.

1. Active/early identification and prevention

Children and young people with emerging needs are identified early and supported through targeted preventative interventions, reducing escalation to crisis.

6. Improved multi-agency working & cultural change

A positive experience and supportive environment to improve staff wellbeing and job satisfaction overall. Improving multi-agency working by local knowledge of services available within SEL to support CYP.

8. Reduction in inequalities

Reducing health inequalities so children, young people and their families achieve equal outcomes across all population groups.

2. Improved access that is based on need

Children, young people and families can access timely, support based on need, reducing escalation to crisis or specialist intervention and improving equitable access for those least likely to self-present, including Core20 groups.

3. Voice of CYP and family

Making every contact count, avoiding repetition and having to tell their story several times. They feel heard in decisions, trust services and experience care as supportive and joined up.

5. Improved health and well-being outcomes

Children and young people are healthier overall, with improved physical and mental wellbeing, fewer crises/escalations, higher uptake of preventative care and earlier identification and support for additional needs.

4. Children and families are empowered (able to flourish)

Children, young people and families trust services, can easily access and navigate to the right support, and experience coordinated care as required.

How we will know if we are making a difference
Outcomes to monitor and evaluate

Outcome domains	Key outcomes	Potential Indicators Long list at this stage - to be refined further
1 **Active/early identification and prevention**	• Children and young people with rising or unmet needs are identified early through population insight, frontline observation and community intelligence, before escalation to crisis or statutory thresholds. • Preventative activity is focused on priority cohorts and neighbourhoods, improving reach to families least likely to self-present and reducing inequalities.	• Improvement in uptake of key preventative activities supported by the neighbourhood (e.g. immunisations, health reviews, screenings). • Proportion of CYP with emerging SEND / neurodevelopmental needs identified and supported earlier (pre-diagnosis). • Greater identification of children with long-term conditions including asthma. • Uptake of community outreach interventions (including those from specific groups including Core20 ethnicities). • Referral to INT from other services e.g. school nursing/ health visiting
2 **Improved access that is based on need**	• Children, young people and families can access support aligned to their level of need, without unnecessary barriers. • Support is timely, enabling early help and reducing avoidable escalation to crisis or specialist thresholds. • Access is equitable, with improved reach into Core20 groups and families least likely to self-present.	• Proportion of CYP triaged to the right level of support first time (no onward referral required). • Reduction in escalations from universal/early help into crisis pathways. • Proportion of children identified and receiving support within an agreed neighbourhood. • Reduction in number of CYP in MH crisis in A&E waiting 12, 24, 48h for onward placement • Reduction in overall CYP A&E attendances and re-attendances. • Reduction in subsequent GP appointments for children and young people who have been discussed in the MDT.

How we will know if we are making a difference
Outcomes to monitor and evaluate

	Outcome domains	Key outcomes	Potential Indicators Long list at this stage - to be refined further
3	**Voice of CYP and family**	• Making every contact count, avoiding repetition and having to tell their story several times. • Children and families feel heard in decisions that affect them, trust services, and experience care as supportive and joined-up.	• Proportion of CYP and families (on INT caseload) reporting they were listened to and involved in decisions about support using qualitative feedback (survey/case reviews). • *Our services have been co-designed with CYP, hence representing their emerging needs and views.*
4	**CYP and families are connected and empowered (able to flourish)**	• Children, young people and families feel listened to, trust services, can easily access and navigate to the right support, and experience coordinated care as required.	• Increased uptake of VCSE e.g. creative health / sports. • Reduced number of children on child protection plans • Reduced number of children going into care • *Parent/carer satisfaction scores (Not an INT marker).*

How we will know if we are making a difference
Outcomes to monitor and evaluate

Outcome domains	Key outcomes	Potential Indicators Long list at this stage - to be refined further

5 **Improved health and well-being outcomes**	• Children are physically healthy, with fewer preventable conditions escalating (e.g. asthma exacerbations, obesity-related harm).
	• Children experience improved emotional and mental wellbeing, with fewer crisis presentations.
	• Increased uptake of universal and preventative offers (immunisations, screenings, reviews).
	• Children with additional needs (SEND, neurodiversity) are identified earlier and supported sooner.
		• Healthy Child Programme (HCP) KPIs including
		  • % of new mothers breastfeeding at 6-8 weeks,
		  • % of children achieving developmental milestones
		  • vaccination uptake (e.g., MMR, HPV),
		  • rates of childhood obesity rates/healthy weight achievement,
		  • school readiness scores at entry
		• Increased rates of school attendance.
		• Reduced rates of mental health crisis and presentations.
		• Reduction in prevalence of select conditions e.g. asthma, tooth decay.

6 **Improved multi-agency working and cultural change**	• A more positive experience and supportive environment for all staff. • Improved staff wellbeing and job satisfaction. • Increased knowledge of services that are available locally to support CYP and their families.	• Staff surveys to demonstrate a positive experience working within the team and provide qualitative feedback regularly. • QI learning events. • Increased staff retention.

How we will know if we are making a difference
Outcomes to monitor and evaluate

	Outcome domains	Key outcomes	Potential Indicators Long list at this stage - to be refined further
7	**System sustainability**	• Are we reducing demand from resource intensive areas such as hospital and shifting focus of care into community and neighbourhoods.	• Reduced overall GP attendances. • Reduction in number of acute mental health presentations in crisis. • Reduction in outpatient referrals for certain specialties, such as general paediatrics. • Reduced rates of A&E attendance and non-elective (NEL) admissions. • Reduction in waiting times for outpatient appointments
8	**Reduction in inequalities**	• Are the outcomes the same in all resident/population groups i.e., gender, ethnicity and deprivation level (IMD).	• Rate of use of Neighbourhood offer by population groups. • Rates of immunisation. • Rates of A&E / non-elective (NEL) attendance and outpatient (OP) by population groups. • Increased uptake of VCSE e.g. creative health / sports.

9. How will we implement the framework?

First principle: the biggest proportion of effort in implementing the CYP INT framework should be on people

Nearly two thirds of healthcare change projects fail and less than 5% deliver what they are supposed to[1]

Common pitfalls include insufficient focus on:

→ Creating meaning and purpose

→ Engaging and taking people/partners on the journey

→ Having the right team, skills and knowledge for the job

→ Visible leadership championing the work

→ Tapping into values, feelings and attitudes

→ Creating trust, ownership and accountability

→ Tracking, reporting and promoting success

→ Project methods that drive delivery at scale and pace

Most healthcare transformations under invest in the human dimension

Proportion of effort showing less focus on people led change

People 15%

Process 50%
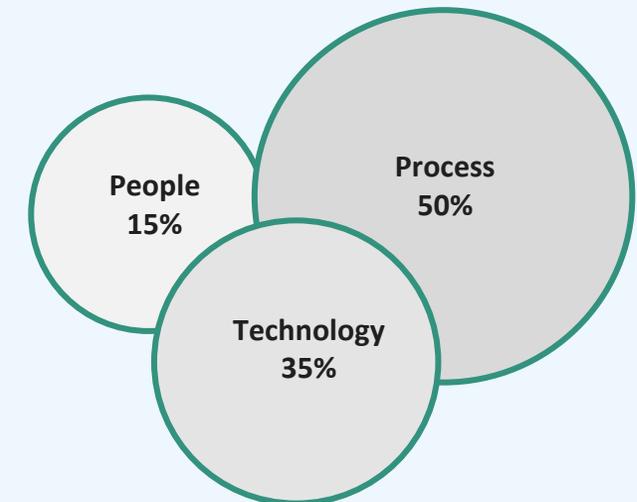
Technology 35%

Change dominated by process and technology only achieves around a 10% level of adoption [2]

1. NCBI 2022
2. Ian Gotts. Common Approach, Uncommon Results 2007

Building blocks of implementation

Engagement and mobilisation at Place (building on existing work underway)
Neighbourhoods mobilise existing partnerships, relationships and delivery to engage CYP, families, VCSE, schools and practitioners around shared priorities.

Shared purpose and priority focus
Partners align around a clear shared purpose and agree an initial priority cohort or pathway to focus neighbourhood effort and learning.

Leadership, resources and skills
Strong, values-based leadership supports multi-agency working, role clarity and decision-making at neighbourhood level.

Delivery and change management
Neighbourhoods adopt a phased, test-and-learn approach to implementation, supported by clear delivery ownership and cultural change.

Demand and capacity modelling
D/C modelling to understand current baseline and requirements for new operating model.
This informs how existing resources can be reconfigured and where additional capacity or double-running may be required.

System outcomes dashboard
A shared dashboard will bring together a small set of agreed outcomes, indicators and activity measures at neighbourhood and SEL level. Supports transparency, learning and accountability for impact.

Measurement and funding
Measurement focussing on outcomes most directly influenced by neighbourhood working, alongside key process and access measures. Funding and resources to progressively left shift

Working on enablers
Implementation to be supported by system enablers including workforce, data and digital, information governance, culture and quality improvement.
SEL-level support to ensure consistency, shared learning and scale.

Implementation roadmap

This roadmap sets out a phased, **test-and-learn** approach to implementation, enabling neighbourhood teams to build confidence, strengthen relationships and embed new ways of working overtime. By the end of year one, a neighbourhood model will be actively tested and in delivery across all Places. While boroughs may take different approaches to reflect local context, the focus is on learning through delivery, consistent practice and a shared culture of neighbourhood working across South East London.

Phase 1: Test 2026/27	Phase 2: Grow 2027/28	Phase 3: Embed 2028/29
• Launch test neighbourhoods in each Place (minimum one per Place). • Define priority cohorts for initial focus, based on local need. • Map existing services, assess demand and capacity, and develop an initial operating model. • Pilot neighbourhood working, MDT arrangements and access routes. • Capture learning to inform refinement.	• Use learning from test sites to refine and standardise the operating model. • Embed multi-agency working, relationships and cultural change. • Expand test sites to widen priority cohorts and bring additional neighbourhoods on board. • Strengthen enablers (workforce, data, governance, funding flows).	• All neighbourhoods come on board across SEL. • Operating model, governance and outcomes framework are fully embedded. • Neighbourhood working becomes business as usual, with continuous improvement in place. • Full delivery at each neighbourhood (March 2029)

Roadmap for implementation: Neighbourhoods should follow a systematic approach while adapting to different starting points and levels of maturity

Phase 1: Test (2026/27)

1. Socialising the framework at Place

- Bring together system stakeholders, including CYP, families and community representatives.
- Map current practice and local assets against the neighbourhood functions (e.g. active identification, MDT working).

3. Defining the Operating Model

- Each Place and neighbourhood defines how the operating model works locally, building on existing assets (e.g. Family Hubs).
- Work systematically through each function to clarify roles, workflows and interfaces, centred on the agreed priority cohort.

5. Outcomes dashboard

- Agree a small set of clear outcomes and indicators that demonstrate impact.
- Define system-level dashboards and data points at both Place and SEL level.
- Use regular (e.g. monthly) reporting to support real-time learning and adjustment.

2. Understanding your local population and agree priority for test phase

- Neighbourhoods need to start with a bite-size focus. Year 1 is about testing the concept with one cohort or pathway
- Each neighbourhood to look at their local population data, connect with VCSE, communities, professionals and agree the local priority.
- Priority could be a population cohort (e.g. complex, SEND) or a pathway (mental health crisis, rising risks)

4. Demand and capacity modelling

- For the priority cohort define the baseline for demand and capacity. As neighbourhoods do that, identify the biggest crunch points.
- Use the operating model to define total demand and capacity required to support priority cohort.
- Ramp up demand in stages.
- Define/decide: how do to reallocate existing capacity/resources.
- Final demand and capacity model aligned with the framework operating model.

6. Phased implementation plan

- Develop a clear, phased implementation plan with defined stages, deliverables and timelines.
- Establish a robust delivery group representing neighbourhood, Place and SEL partners to support coordination and problem-solving.
- Set out clear expectations for SEL-level enablers and support to Places (e.g. data, learning, facilitation).
- Agree a shared communication approach for transparency and engagement across partners.

7. QI - Test and learn

- Embed a Quality Improvement (QI) approach, including named quality champions, regular QI cycles and monthly learning sessions using a PDSA methodology.
- Put in place proportionate governance and oversight, including meaningful involvement of CYP and family voice.
- Create system-wide learn and share events at SEL and most importantly, acknowledge efforts and celebrate success

10. Appendices

Appendix I

# Good practices and guidance for CYP care

The SEL CYP INT Framework has been developed by embedding learnings from best practice guidance

In recent years, children's health and wellbeing has declined in the UK, leading to some of the worst health outcomes in Europe. Without urgent action, today's children are at risk of becoming an unhealthy adult population, with long term implications for their own health, our economy, our health service and society overall[1]. Leading national and international models, research bodies and policymakers were examined to inform the implementation of evidence-based approaches within the framework, to improve outcomes for children and young people across SEL.
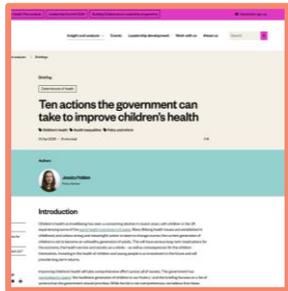
Kings Fund: Ten Actions the government can take to Improve Children's Health (2025) [1]

- Reducing barriers to access e.g., reducing waiting times for children's community and mental health services.
- Addressing health inequalities and allocating a more equitable share of health service funding to children.
- Empowering CYP and families with improved access to information e.g. health and nutrition online information.
- Addressing shortages in workforce including school nurses, consultant paediatricians & improving staff retention.
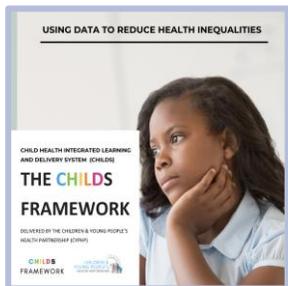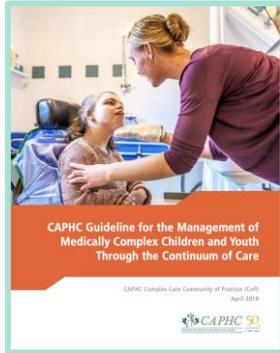
Child Health Integrated Learning and Delivery System (CHILDS) Framework (2025) [2]

- Innovative PHM framework to deliver universal care, targeted risk management & integrated biopsychosocial services.
- Access: LTC care- early intervention and personalised care (use of NHS data and advanced analytics to identify CYP).
- Care planning: biopsychosocial, holistic, person-centred approach, with treatment delivered by a multidisciplinary team.
- Health promotion: support self-management via a health pack – signposting to local resources and helping with housing etc.
- Personalised care: Delivery of care in familiar setting – GP centre, school, youth centre.

Resources:
1. https://www.kingsfund.org.uk/insight-and-analysis/briefings/ten-actions-government-improve-childrens-health
2. https://childsframework.org/childs-framework

The SEL CYP INT Framework has been developed by embedding learnings from best practice guidance

Canadian Association of Paediatric Health Centres (CAPHC) National complex care guideline for management of complex children and youth through the continuum of care (2018) [3]

- Building capacity within the system to deliver holistic, coordinated, family-centred care, that is close to home.
- Key workers to facilitate service planning and care delivery in collaboration with the family.
- Shared care plan, which is accessible with clear ownership.
- Empowering families to develop the skills and confidence to advocate for their child.
- Transition strategy: smooth transitions across settings and life stages.

RCPCH Transforming child health services in England: a blueprint (2024) [4]

- 7 key themes to guide transformational change required nationally:

  1. Fair funding for children.
  2. Prioritise children in ICS.
  3. Support a sustainable workforce.
  4. Improve data and digital innovation.
  5. Reduce pressure on urgent and emergency care.
  6. Reinvest in community health services.
  7. Improve the interface between primary and secondary care.

- This policy report specifically addresses prioritising community services to tackle elective waiting lists and waiting times, developing models of joint working between primary care and paediatric teams, supporting children in all settings (education, LA).

Resources:

3. https://www.childrenshealthcarecanada.ca/media/yzanrkxm/caphc-national-complex-care-guideline-2018_final.pdf
4. https://www.rcpch.ac.uk/resources/transforming-child-health-services-england-blueprint

References and further reading

- Johns Hopkins Patient Needs Groups

- HSE Vision for Children and Young People

- World Health Organisation (April 2023): https://www.who.int/health-topics/child-health#tab=tab_1

- Whole population integrated child health - segmentation model (NHS UK Nov 2021)

- A Population Health System (A Vision for Population Health: Towards a healthier future. Kings Fund, 2019)

- CAPHC Guideline for the Management of Medically Complex Children and Youth Through the Continuum of Care - 2018 ([Link](#))

- London Plus - The Creative Health Impact Framework - 2025 ([Link](#))

- Monetising the impact of culture and heritage on health and wellbeing – 2024 ([Link](#))

- Integrated Care Systems and Youth Voice and action: A national conversation – 2025

- National Academy for Social Prescribing - Connecting the System - CYP Flipbook 2025 ([Link](#))

- Bi-Borough Integrated Delivery Model for CYP

- NHSE Strategic Commissioning Framework 2025 ([Link](#))

- The Best Start for Life - A Vision for the 1,001 Critical Days

Alignment of the framework with SEL ICS INT principles

The INT CYP Framework aligns with core principles that SEL has already developed for integrated neighbourhood team working

1.Holistic, person-centred care: considering the physical, emotional, and social needs of CYP and families

2.Earlier intervention: Early identification and anticipatory intervention, reducing dependency and crisis

3.Integrated multi-disciplinary working: improved coordination between health, care and wellbeing services

4.Community engagement: leveraging assets, empowering families, achieving inclusion and trust

5. Lifelong health: Improved physical/mental health, seamless & coordinated transitions, reduced long-term risk

6.Empowered CYP/families: Active involvement in decisions, services shaped by need and lived experience

7.Access and health outcomes: Closing the gap in variation of outcomes, outreach and inclusive services

8.Data Sharing/ digital enablement: Access to shared records/data to support care coordination and evaluation

9.Sustainable, resilient workforce: secure funding models, training and skills, replication of success across INTs

10. Innovation and Scalability: Space to test and embed and structures to scale new ways of working

What have we heard from CYP and their families?

What have we heard from CYP and their families?

Lack of coordination

Education think CAMHS should fix it and CAMHS think Education should fix it and Social Care think Health should fix it. We go round in circles

We have to dig to find the support for ourselves. We have to navigate. We used to have a care coordinator to address anything not working, which worked brilliantly

Why do I have to chase the referral? The GP claimed the referral had been sent but it had not.

Employ more people who are like me to deliver the care

Don't make neighbourhood teams just another part of the fragmentation. Bouncing from one professional to another erodes trust and stops engagement

Have peer navigators who steer you and offer support, like ambassadors at school

Please get schools and healthcare to talk to each other. It would be easier to get my child into school if they did.

What have we heard from CYP and their families?

Waiting and managing expectations

Provide support while we are waiting for 2 years for a service, to minimise the effects of the wait

Get rid of separate waiting lists for different needs – they are all connected!

Speed up decision making. Community teams have to accept and endorse things which takes months

Be clear and honest about what a service can offer, what I can expect and what the limitations are – what is going to go on?

Provide parents with clear information on who is doing what and honest waiting times. Knowing when things will happen will reduce our anxiety

Information, Education And Awareness

Employers need education. My child was sacked from a job due to an episode and there were no second chances.

GPs are not aware of pathways but it's critical they give the right information. We were told by our GP to take our child to A&E because he wouldn't go to school on a particular day.

Employ more people who are like me to deliver the care e.g., ADHD workshops run by people with ADHD, not a 'teacher'

There needs to be more appreciation of how it impacts the whole family and more space and support for siblings

Run drop-ins for kids and parents to learn about their condition

What have we heard from CYP and their families?

Environments and experience of care

We need a mental health ambulance. I can't get my child to a safe place on public transport if he is having an episode

After the diagnosis there was not much follow up help, no one reached out and I felt isolated

Make waiting rooms more homely and friendly; use young people's art, soft furnishings, simpler information and separate out little ones from older ones

Rushed appointments, not listening to me but talking over me

Provide options for where I receive care – at a centre, at home, in a group setting

Avoid A&E. It's overwhelming and overstimulating, especially for neurodiverse children. Children see things they shouldn't see. Do video conferencing instead, or have a children's A&E

Transition to adult services at age 18

The neighbourhood team must better manage and provide assurance around transition, providing advice, hints and tips. Don't assume we can manage it all – its' major!

The attitude it's on you now that you are 18; we won't baby you anymore and so deal with it on your own

Information passed across to adult services needs to be more detailed

What we have learned from CYP and families - Further insights

Collated by The Well Centre from their Youth Participation Group meeting – December 2025

What works well already and what does not work well that needs to be improved in services for Children and Young People?

- *The staff are friendly and welcoming. This is important as young people want to feel comfortable in a new space and when interacting with a new service for the first time (this is often people's first time having therapy). Practitioners should be carding and should want to understand the young person and their personal experience as a lot of places do not fully listen. It should feel like there is a good dynamic between staff and young people but also between staff. This is present at TWC and that energy is noticed when waiting for sessions.*

- *Some services do not provide enough training to the staff – this could be those who work with young people or those that do not (e.g. admin). One young person shared that sometimes when a staff member is covering another person's job they do not feel they are qualified in listening, using the right terminology or showing the same care to the young person, which can impact safeguarding (they did state this was their experience elsewhere and not at TWC). These things could have a domino effect on the young person, such as making them less likely to engage in the service or more reluctant to open up. There was also reference to a lot of buildings not being well services/maintained/tidied. Communication from services to young people can often be better, for example one service sent a reminder message 15 minutes before her appointment every time which didn't provide her enough time to attend.*

What we have learned from CYP and families - Further insights

Collated by The Well Centre from their Youth Participation Group meeting – December 2025

What do you value in CYP services? What makes the biggest difference to you?

- *CYP expressed valuing staff who show an interest in them, are welcoming and understanding and are empathetic. CYP also value communication and consistency in appointments/sessions, for example they feel adults are often not considerate of their need for regular structure and routine and being able to have an appointment at the same time each week with the same person for 9 weeks helps them feel a sense of consistency and allows them to better manage other areas of their life; they expressed that most services do not do this.*

- *CYP expressed that there are not enough places that diagnose health conditions or neurodivergence. For example, CYP feel frustrated that they have to wait on a CAMHS waitlist for session based support but may sometimes not be able to receive a diagnosis there so will be signposted elsewhere. This leads to having t reshare information with various parties. This also contributes towards longer waitlists which can be challenging for young people as so much can change in the period that they are waiting for support/diagnoses.*

- *It can be difficult to find services online as a young person. How do they know where to look, what is a good service, whether websites are in date, what waiting times are, etc. This can increase reluctance to engage in services as it can be confusing and unclear.*

What is most frustrating about how care and support is provided today and what must change?

- ***Communication** – most CYP feel communication from services is poor, e.g. late notice of appointments, late changes to appointments, no ability to directly contact a practitioner. There should be more channels for positive communication in services.*

- ***Listening** – most services do not actually listen to the needs of young people and no change is made as a consequence. This can apply from a service wide perspective or in intervention work. CYP want to feel seen and heard.*

What we have learned from CYP and families - Further insights

From meeting with CYP Shadow Board, Lambeth - January 2026

It's important to set a goal (how I want to live my life) for myself and for staff to understand what's needed to achieve it and agree what I can manage myself, so I am not given a cookie cutter approach.

Be realistic and not over-optimistic. Tell me what will improve and what won't. Tt's not bad when something isn't achieved.

Don't put things in my education plan (EHC) that can't then be funded. Over-promising leads to frustration.

Be kinder. As a child, it' s difficult to seek help and it takes a lot to get here. So don't tell me I'm 'chasing symptoms'. Take me seriously and believe what I say. Staff get de-sensitised but for us it's the first time.

Consistency and reliability is important; having the same staff and familiar faces and not having to tell my story over again, gives comfort.

I think as a young person, being listened to and taken seriously is very important. Sometimes when I've been told that a problem is just because I'm young, when, in reality, there was an underlying medical issue causing it.

What we have learned from CYP and families - Further insights

From meeting with CYP Shadow Board, Lambeth - January 2026

There have been times when professionals have not been patient enough when opening up and seeking support, almost rushing, which may be hard for some people.

Referrals are affected by inefficient communication between services. I know many young people who have been passed back and forth between GP, hospitals and clinics, more specialists and GPs again, because of communications being unclear or rushed with little progress being made.

One thing I'd change is maybe having more support for people when it comes to invasive procedures and anxiety around healthcare. Paramedics and professionals in the hospital are more understanding and empathetic compared to professionals at the GP or in school

What works well is the call appointments because the doctors only take only a couple hours to two/three days to call back instead of waiting weeks in person

GP receptionists taking people seriously as most of the time it feels like they are trying hang

Extra training for some staff on how to treat others and how to manage their lack of emotions or indifference to patients' problems.

What we have learned from CYP and families - Further insights

Discussion group by Healthwatch Greenwich with parents of CYP with SEN and complex health needs - January 2026

What is important to parents and carers in how they receive care and support from Children and Young People's services?

Parents and carers were clear that the most important thing in how they receive care and support is being genuinely listened to, believed, and taken seriously. Many described feeling invisible within the system, using words such as *"forgotten", "delayed",* and *"always waiting"* to capture their overall experience. Several parents spoke about the emotional labour involved in repeatedly explaining their child's needs, often without seeing any resulting change. One parent described the experience as *"hard work",* while another summarised it simply as *"not feeling supported".*

Parents were frustrated by what they experienced as repetitive and meaningless assessment processes. One parent explained, *"Every year the same thing – someone comes, ticks the box, leaves, and nothing happens."* This left families feeling that their time, energy, and expertise were being taken without any tangible benefit for their child. Parents were clear that they were not asking for special treatment, but for fair and respectful access to services. As one parent stated, *"I am not asking for charity, just to be treated as a service user."*

Clear and honest communication was central to what matters to families. Parents said that uncertainty and false reassurance were more damaging than long waits themselves. One parent explained, *"Just tell me upfront if the wait is four years."* Unrealistic promises were described as harmful, raising hope only for families to experience repeated disappointment when nothing materialised. Parents expressed a preference for honesty, even when the message is difficult, as this allows them to plan, cope, and advocate more effectively for their child.

Parents' priorities are not primarily about accessing services, but about how systems and services engage with them. Parents' narratives suggests a perception of systemic disengagement rather than isolated service failure. Most described not just single poor interactions, but a prolonged relationship with services that families experience as distant, procedural, and unresponsive and a pattern of process-driven practice without outcome-driven accountability. For parents, this implies a system that prioritises evidencing activity over delivering change, which in turn undermines trust and confidence.

What we have learned from CYP and families - Further insights

Discussion group by Healthwatch Greenwich with parents of CYP with SEN and complex health needs - January 2026

What is important to parents and carers in how they receive care and support from Children and Young People's services? (continued...)

Parents' touched on power and legitimacy. Families perceive that they must justify their entitlement to support repeatedly, rather than being recognised as rights-holders within services and systems. This framing positions parents as petitioners rather than partners, which shapes interaction with services.

What do parents and carers value, and what would make the biggest difference in how they are treated?

Parents value respect, honesty, and recognition of their expertise. Many described feeling dismissed, pitied, or treated as an irritation. One parent said bluntly, **"They treat you like you are a nuisance. They don't see your reality."** Another reflected that services often appear more focused on managing parents than supporting children/young people, stating, **"They want to keep you quiet. They don't care about solving problems."**

Parents rejected narratives that position them as passive or dependent. One parent said, **"I am not a victim; I am a fighter. Services treat you with pity, pretend they listen, but nothing happens."** This highlights a desire to be engaged as active participants in decisions, rather than recipients of sympathy or tokenistic interactions.

The biggest difference, parents said, would come from professionals genuinely recognising parents as experts in their own children/young people and involving them meaningfully in decision-making. Parents want professionals to explain decisions clearly, follow up on actions, and respond to communication. Being treated as an individual family, rather than as a "case" or a set of forms, was repeatedly identified as key to creating trust and building positive relationships with services.

Parents valued respect, honesty, and recognition of expertise, and these are experienced as more impactful than the specific type or volume of support offered. Parents are articulated a desire for agency and partnership and rejected approaches they felt from some systems and processes that frame disability and caring through pity rather than rights, competence, and collaboration.

What we have learned from CYP and families - Further insights

Discussion group by Healthwatch Greenwich with parents of CYP with SEN and complex health needs - January 2026

What works well currently, and what does not work well, and why?

Parents were clear that what works well is defined less by the type of service and more by how it behaves. Responsiveness emerged as the strongest indicator of good practice. Where services responded promptly, communicated clearly, and treated families with respect, parents reported positive experiences even within constrained systems. Direct payments and prepaid cards were consistently praised because they give families control and flexibility. Specialist schools for CYP with SEN, (particularly Willow Dene), were highlighted as examples of good practice due to responsive staff and strong communication, with parents noting the value of having a dedicated nursing team on site.

Other services that were described positively included council (Greenwich) occupational therapy, school-based dental services, incontinence teams, and some GP practices that prioritised children with complex needs. Parents also spoke highly of individual professionals, such as a particular respiratory consultant at Queen Elizabeth Hospital and epilepsy specialists, describing them as exceptional. However, parents were clear that these examples felt like exceptions rather than the norm, and that good experiences were often dependent on individual staff rather than reliable systems and processes.

In contrast, many aspects of the health and care system were described as not working well. Queen Elizabeth Hospital was repeatedly raised as a significant concern, with parents describing it as *"the worst hospital ever".* Long A&E waiting times of up to seven hours were reported, alongside overcrowded environments that were described as unsuitable and unsafe for children with special educational needs. Parents also raised concerns about infection risks and the lack of appropriate spaces for neurodiverse children who struggle with sensory overload.

Mental health, occupational therapy, and specialist services were described as unresponsive, with waiting lists of up to two years. Parents reported referrals being made but never followed up, and difficulty contacting services, with phones not being answered. One parent described the experience of navigating services as a *"constant battle",* with no clear accountability when support failed to materialise.

What we have learned from CYP and families - Further insights

Discussion group by Healthwatch Greenwich with parents of CYP with SEN and complex health needs - January 2026

What works well currently, and what does not work well, and why? (continued...)

Parents also raised concerns about conflicting professional advice. One parent explained, *"If you see two professionals, they don't even agree with each other."* This lack of joined-up care left families feeling forced into the role of mediator between services, increasing stress and undermining confidence in professional expertise.

Analysis of what parents identified as working well shows consistency: responsiveness is the key feature of positive experience. Certain services were valued not because they are flawless, but because they respond, explain, and adapt. This suggests that quality is experienced relationally, not structurally.

Parents emphasised that good practice is fragile and individualised. described as *"the exception rather than the norm",* indicating that positive experiences are not embedded systemically. This reliance on individual goodwill rather than organisational design creates inequity, as access to good care becomes dependent on who a family happens to encounter.

Areas described as not working well share common themes: long waits, poor communication, lack of follow-up, and environments unsuitable for children with SEN. Conflicting advice suggests a lack of system integration and shared accountability, forcing parents into the role of coordinator and arbiter between services. Analytically, this shifts risk and responsibility away from institutions and onto families.

What we have learned from CYP and families - Further insights

Discussion group by Healthwatch Greenwich with parents of CYP with SEN and complex health needs - January 2026

How well do services make reasonable adjustments for children and young people with special educational needs, and what more is needed?

Parents consistently reported that reasonable adjustments are not made well or consistently for children and young people with special educational needs. Many described services and processes as designed around neurotypical children, with adjustments treated as optional rather than essential. Clinical environments were often described as overcrowded, noisy, and distressing, making long waits particularly challenging and sometimes unmanageable.

Parents felt that services rely too heavily on families to request adjustments repeatedly, rather than anticipating needs as standard practice. This places the burden on families, who must repeatedly request adjustments, explain needs, and manage the consequences when adjustments are not made.

Parents said that better support would require services to plan proactively for SEN needs, including more flexible appointment structures, quieter waiting areas, longer consultations where needed, and communication tailored to the child and family. Parents want a proactive, anticipatory approach where SEN needs are planned for. Without this, reasonable adjustments remain inconsistent, and children with SEN and their families experience services as hostile or inaccessible.

Families emphasised that SEN is not a single category and that adjustments must be individualised. They felt that without these changes, their children are effectively excluded from services. Analytically, this represents a failure to embed equality and accessibility into service design. Parents' experiences suggest that this not only limits access to care but actively increases distress and frustration.

What we have learned from CYP and families - Further insights

Discussion group by Healthwatch Greenwich with parents of CYP with SEN and complex health needs - January 2026

What one thing needs to change to improve the experience of care and support?

Parents were united in identifying that the one thing that needs to change is for services to genuinely listen and act on what families say. Listening was described as meaningful only when it leads to change. Parents expressed frustration that feedback often appears to result in worse outcomes rather than improvements. One parent said, *"Stop playing with us. Every time we give feedback; we get less in return."* For parents it indicates a perception that feedback mechanisms are not neutral, but risky.

This fear has led some parents to avoid raising concerns, particularly around short breaks and respite care, due to worries that support will be reduced. Parents want reassurance that speaking up will lead to problem-solving, not punishment.

This suggests that current feedback and engagement processes may inadvertently function as control mechanisms, where families fear negative consequences for speaking honestly. As a result, systems lose access to accurate intelligence about what is not working, reinforcing cycles of poor performance and mistrust.

Why is this one change so important?

Parents explained that not being listened to has cumulative and harmful effects. Delays and inaction can worsen children's needs and significantly increase parental stress and burnout. Many parents described having *"no emotional or mental capacity left"*, alongside guilt about the impact on siblings and fear about their child's future, particularly around transitions to adulthood.

The transition to adult services was described as especially distressing. When this topic was raised, several parents became visibly emotional and some cried immediately. One parent described the experience starkly: *"Up until 18, parents are included. Then suddenly the child turns 18 and parents are excluded."* This sense of a *"cliff edge"* reinforced fears about loss of support and exclusion from decision-making.

Parents stressed that when they are listened to, even limited resources can be used more effectively. Respectful communication, honesty, and follow-through restores trust, reduces conflict, and improves outcomes. Families are exhausted, and trying to navigate systems that too often work against them rather than with them.

What we have learned from CYP and families - Further insights

Discussion group by Healthwatch Greenwich with parents of CYP with SEN and complex health needs - January 2026

Implications for Commissioners and System Leaders

The evidence from this discussion group highlights that many of the issues experienced by parents and carers are systemic rather than service-specific, and therefore require action at commissioning, leadership, and system-design level. Long waiting times, poor communication, lack of follow-up, and inconsistent reasonable adjustments are not isolated failures, but recurring features across multiple services. This suggests that performance management focused solely on activity, throughput, or compliance risks missing what matters most to families: responsiveness, continuity, and outcomes.

Parents' experiences show that good practice is currently fragile and overly dependent on individual professionals rather than embedded expectations. This creates inequity, as families' experiences vary significantly depending on who they encounter.

The findings also indicate a need to re-examine how feedback and engagement mechanisms operate. When families perceive that raising concerns leads to reduced support, engagement becomes unsafe and intelligence about system failure is lost.

Overall, the findings underline that listening and acting on family insight is a core determinant of quality, equity, safeguarding, and effective use of resources. Without addressing these systemic issues, commissioning additional services alone is unlikely to improve lived experience or outcomes for children and families.

What we have learned from CYP and families - Further insights

Two one-to-one Interviews with Mothers of Children with SEN by Healthwatch Greenwich - January 2026

The one-to-one interviews aligned with what parents said in the group discussion: feeling listened to and respected is the most important driver of having a positive experience. Both mothers described times when their concerns were dismissed or ignored and said this made them feel like a problem rather than a partner in their child's care. They also said that when professionals responded quickly, listened properly, and explained things clearly, it made a big positive difference to their experience.

The interviews confirmed ongoing concerns about delays and difficulty accessing services. Parents described long waits for assessments, therapy and follow-up appointments. While the discussion group spoke about delays in general terms, the interviews gave more detail, for instance, a two-year wait for a paediatric assessment. In some cases, parents said that strong advocacy from GPs helped to speed things up.

The one-to-one interviews also showed how challenges can either be made worse or improved by how services respond in practice. One mother described the role of the Local Authority in supporting her son's move from a school that could not meet his needs to one that could. She felt the positive outcome was not just because of the new school, but because the Local Authority took an active role — assessing need, supporting the transition, and making sure specialist support was in place.

Both mothers spoke about the importance of individual professionals in shaping their experiences. Specific doctors, hospital staff and voluntary sector workers were described as making a positive difference. This reinforced that feeling listened to and supported often depends more on how people engage than on the type of service offered.

What we have learned from CYP and families - Further insights

Two one-to-one Interviews with Mothers of Children with SEN by Healthwatch Greenwich - January 2026

One mother described how involvement from social services, even when intended to help, left her feeling anxious and judged. She felt unsure about the possible consequences and less secure about her position as a parent. This shows that support can sometimes add stress, particularly when it feels unclear or carries stigma.

The interviews also showed that parents often have to manage support from both hospital services and community health services at the same time, and that these services do not always work well together. Parents described having to navigate different systems with different rules and expectations. Doing this required a lot of emotional effort and organisation, often with little coordination between services.

The interviews also raised new issues that did not come out in the group discussion. One mother highlighted how important community and voluntary sector support was for her child and expressed concern about what would happen if these services were no longer available.

Finally, the interviews again highlighted the need for earlier assessment and support, particularly for conditions such as ADHD, and for more consistent inclusive support across schools.

Appendix IV

Governance

Governance

Neighbourhood Based Care Board

Final approval

Steering Group
Representatives from ICB, clinical leadership

Core Group
Representatives from ICB, clinical leadership

Children's Board
Representatives from ICB, clinical leadership

Local CYP Place Forums

Lambeth	Southwark	Bromley
Bexley	Greenwich	Lewisham

Appendix V

Stakeholder Engagement

Stakeholder engagement

Colleagues from across the SEL system have participated in the development of the framework, including from the ICS, Local Authorities, Public Health, Primary Care, community-based care, VCSE, acute care and mental health. Colleagues were involved in extensive discussions sharing valuable insights, perspectives and suggestion. The engagements culminated into a co-design workshop with 48 attendees to help shape the framework. Overall, in the design of the framework -

- A total of approximately 95 colleagues from across South East London were engaged.

- Additionally, approximately 30 children, young people and their parents were also engaged.

13 **1-to-1 sessions**	**Weekly** **Core Group meetings**	**4** **Steering Group meetings**
6 **Place based sessions**	**3** **Focus group sessions#**	**4** **deep dive sessions***

Co-design Workshop

CYP and Parents voice sessions

- Meeting with CAMHS service users

- Meeting with parents of CYP in CAHMS

- Focus group with CYP with SEN (f2f)

- Focus Group with CYP with learning disabilities (f2f)

- Meeting with CYP at The Well Centre

- Meeting with Lambeth Shadow Board

Clinical and Healthcare professionals, Local Authorities, and Place based representative including VCSEs
* Mental health, SEND, Public Health and Creative arts in mental health support

Appendix VI

List of stakeholders

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
1	SEL ICS	Alison Roberts	AD, CYP Planning
2	SEL ICS	Clive Moss	Transformation Lead
3	SEL ICS	Rupinder Dev	Director CYP, MH
4	SEL ICS	Dr Bhumika Mittal	CYP Clinical Lead SEL And GP
5	KCH NHS Trust	Dr Shahid Karim	Consultant Paediatrician
6	LGT NHS Trust	Dr Ben Cahill	CYP UEC Lead SEL, Paediatrics ED
7	GSTT NHS Trust	Eleanor Wylie	Programme Manager – CHILDS
8	LGT NHS Trust	Dr Brindha Dhandapani	Consultant Community Paediatrician
9	Oxleas NHS Trust	Jenny Ioseliaini	Service Director – Children And Young People Services
10	Community Services	Dr. Bidisha Lahoti	Clinical Director – Children's Services Ops Director
11	Greenwich	Dr Helen Buttivant	Associate Director – Public Health
12	Lewisham	Pinaki Ghoshal	Director Of Children Services, Lewisham
13	SEL ICS	Tal Rosenzweig	Director Of VCSE Collaboration And Partnerships
14	CYP Engagement	Becks Mortimer	CYP CCPL - Engagement
15	SEL ICS	Nic Morris	AD, Analytics - Business Intelligence
16	Lewisham	Simon Whitlock	Head Of Service - Joint Commissioning CYP
17	Bromley	Anthony Harris	Head Of CYP Commissioning
18	Lewisham	Ann Guindi	CCPL – CYP And Safeguarding Lead
19	Lambeth	David Borland	Director Of Integrated Commissioning
20	SEL ICS	Jacqui Kempen	Associate Director Of Maternity And Neonatal, SEL
21	Lewisham	Simon Boote	Programme Director CYP Alliance
22	SEL ICS	Carol Ann Murry	AD LDA And SEND
23	SEL ICS	Carol Yates	MH Planning And Improvement Manager -CYP

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
24	SEL ICS	Gemma Dawson	Programme Director, Community Provider Network
25	Bromley Healthcare	Victoria Soper	Director Of Children And Young People Services
26	GSTT	Alghali Abdulrahman	General Manager, Children's Community Services
27	Bexley	Dr Mohammad (Asad) Rahman	Clinical Lead - CYP
28	Greenwich	Dr Adebisi Olunloyo	Clinical Lead - CYP
29	Southwark	Nicola Hanson	Clinical Lead - CYP
30	LGT NHS Trust	Dr Joanne Lawrence	Consultant Diabetologist
31	SEL ICS	Jane Waite	Head Of CHC/CYPCC & QIPP
32	GSTT	Sukeshi Makhecha	Consultant Pharmacist In Paediatric Asthma & Respiratory Medicine
33	Pharmacy alliance	Reena Patel	Community Pharmacist
34	GSTT	Chloe Macauley	Paediatrician
35	GSTT	Sarah Henderson	Director Of Strategy
36	Bromley Healthcare	Cait Lewis	Head Nurse - Bromley Healthcare
37	Oxleas	Sabitha Sridhar	Consultant Psychiatrist And Clinical Director CYP, Oxleas
38	VCSE	Fiona Small	Young Mums Support Network
39	Well Centre	Angelika Slon	Service Manager, Well Centre
40	Pharmacy Alliance	Ashfaq Khan	Community Pharmacist
41	Greenwich and Lewisham	Rachel Olanike Lanlokun	Designated Nurse For LAC
42	Southwark	Yvette Newman	Designated Nurse For LAC
43	Greenwich	Jacqueline Alby	Designated Clinical Officer
44	SEL ICS	Rebecca Saunders	SEL Designated Nurse, Safeguarding

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
45	SEL ICS	Margaret Mansfield	SEL Designated Nurse, Safeguarding
46	Lambeth	Dr Raj Mitra	Clinical Lead - CYP
47	Lewisham	Angelique Lewis	Head Of Service - Prevention And Early Help
48	Bromley	Rachel Dunley	Head Of Service, Early Intervention And Family Support, Bromley
49	VCSE	Laura Bassett	Founder – Bug Bears And Director Of Partnerships, Oval Learning
50	SEL ICS	Ann Lorek	Consultant Community Paediatrician & Designated Doctor Safeguarding CYP
51	VCSE	Daniel Fulvio	Director Of Community Partnerships, Rambert
52	Greenwich	Sharne McClean	Head Of Early Years & Childcare (Including Family Hubs)
53	Greenwich	Alexander Lee-Daniels	Strategic Lead, Children With Disabilities Social Care Teams
54	Lambeth	Daniel Stoten	Director Of Integrated Commissioning
55	Lewisham	Sara Rahman	Director Of Integrated Commissioning
56	Bromley	Johanna Dench	Senior Commissioning Manager – CYP MH & Wellbeing
57	Lambeth	Alex Murphy	Lead Commissioner For SEND And Health (CYP Mental Health)
58	Bexley	Katie Farrer Daniels	CYP Commissioner
59	Lewisham	Paul Creech	CYP Commissioner

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
60	Greenwich	Roneeta Campbell-butler	CYP Commissioner
61	Lambeth	Laura Griffin	CYP Commissioner
62	Southwark	Jubin Mama	CYP Commissioner
63	Greenwich	Samantha Bennett	Public Health Consultant
64	Greenwich	Claire Bennett	Public Health Consultant
65	Bromley	Elliot Ward	INT Lead
66	SEL ICS	Melissa Howie	Maternity Lead
67	GSTT	Dulmini Kariyawasam	Diabetes Consultant, GSTT
68	VCSE	Sandra Igwe	Founder And CEO, Motherhood Group
69	VCSE	Yeukai Taruvinga	Founder And CEO, Active Horizons
70	VCSE	Alex Brierley	Director Of Creative Engagement, Southbank Centre
71	VCSE	Anthony Johnson	Representative from Lambeth's voluntary community groups working with young people
72	VCSE	Sabrine Dixon	Founder And CEO, Social Inclusion Recovery. Group
73	Healthwatch	Joy Beishon	CEO Of Healthwatch Greenwich
74	Bromley	Angela Bhan	Executive Director, Bromley
75	Bromley	Sean Rafferty	Director Of Integrated Commissioning, Bromley
76	Bromley	Mark Cheung	Programme Director - Bromley Local Care Partnership

List of stakeholders who participated in framework development

No.	Place or Team/Org	Name	Role
77	Southwark	Darren Summers	Executive Director, Southwark
78	Southwark	Stacey John-Legere	CYP CCPL - Southwark
79	Southwark	Claire Belgard	Director of Integrated Commissioning, Southwark ICS
80	Southwark	Russell Jones	Associate Director integrated commissioning
81	Southwark	Rachel Tebay	Project Manager System Delivery Partnership Southwark
82	SEL ICS	Robert Davidson	Clinical Lead, NHS SEL ICB
83	SEL ICS	Laura Jenner	Director of System Development, South East London ICS (Lewisham)
84	Lambeth	Laura Griffin	Associate Director Integrated Children's Commissioning, Lambeth
85	SEL ICS	Maria Higson	Director of Transformation and Delivery SEL and leads PHM approach for SEL
86	Well Centre	Stephanie Lamb	Clinical Director - The Well Centre, GP lead CHILDS Transformation Programme
87	Southwark	Geetika Singh	Partnership Southwark INT lead
88	SEL ICS	Clare Ross	System development manager, Primary Care Lead
89	Bromley	Jenny Selway	Public health Consultant
90	SEL ICS	Jessica Roe	Head of Analytics, BI SEL ICS
91	Greenwich	Dr Elizabeth Palmer	Clinical lead in Greenwich CAMHS and Consultant psychiatrist
92	SEL ICS	Hayley Ormandy	Director, Prevention, Wellbeing and Equity and Long-Term Conditions, SEL ICS
93	Southwark	Liz Brutus	Consultant in Public Health in Southwark, BCYP Strategic Lead
94	GSTT	Ayesha Ali	Consultant in Public Health and Lead for Population Health Management Hub at GSTT

End of report