South East London Integrated Care System

Children and Young People (CYP)

NHS South East London

Overview of our current system

Children and young people (CYP) account for approximately 22% of our South East London population. Many long term conditions, such as asthma and diabetes, develop in childhood and continue to adulthood. Asthma is the most common long term condition in children and affects a locally reported 3.5% of the total children and young people aged between 0-24 years in South East London; it is one of the top ten reasons for admission to emergency departments in England. Service provision for children and young people's services varies across the six Places in South East London due to historic differences in commissioning and the provider landscape.

Strengths / opportunities

- Strong provider landscape with two tertiary children and young people's centres in the geography with pockets of excellent practice. Opportunity to harness this skill and expertise to expand services, develop and test new and alternative models of care, and consider services that are best delivered at scale.
- Through partnership working, opportunity to focus on early years and family approaches provide early intervention and reduce the burden of disease over the life course. CYP will be an area of focus within the ICP strategy providing further opportunities to consider the wider determinants of health.
- Development of integrated child health teams, linked to the Fuller Review, to support children and young people through primary care and to join up care across health, social care and education including for both physical and mental health.

Challenges

- Pattern of long term conditions in children and young people, with higher levels of long term conditions seen in children and young people from more deprived backgrounds.
- Impact of the wider determinants of health including housing and education which impact particularly the management of long-term conditions.
- Ensuring parity for children and young people across the system. Historic disproportionate investment into children and young people's services with the majority of health care funding allocated to adult services.
- Complexity of children and young people's services with different system partners involved in care, and the ability to share routine data and information effectively.
- High dependency on the emergency pathway for children and young people, with high levels of attendances at our emergency departments and 111 calls.

What we've heard from the public

Children and Young People tell us they are often not involved in decisions about their care. They find healthcare difficult to access especially if they have a disability or learning disability and they sometimes don't feel listened to or valued. Young People would like mental health prioritised, more choice over their healthcare and better consideration/understanding of diversity. Young people and healthcare professionals also need educating about child rights

CYP - Our vision and objectives

Our vision

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

Our key objectives – what we want to achieve over the next five years

Over the next five years, we want to:

1. **Work in partnership to ensure every baby and child receives the best possible start to life**, through a joined-up approach to support and care in the early years, bringing together services for babies, mothers and families.

2. Embed population health management approaches to **provide holistic, family-based approaches to care**, tailored to local need and demographics, supported by **high quality and timely care pathways** which facilitate step-up and step down care with secondary and tertiary health services.

3. Develop **integrated models of care for children and young people at a neighbourhood level** that bring together health and care services across specialist health services, primary and community services, mental health, and local authorities including education to improve care co-ordination and support for families and reduce health inequalities.

4. **Promote and develop the self-management of long-term conditions** in children and young people, supported by their families, to enable them to better manage their conditions now and into adulthood and to **develop clinical services** to support CYP in managing their health.

5. Work in partnership to embed models of care which **enable safe transition** into adult services.

6. Review and develop **urgent and emergency care pathways** to ensure CYP services are appropriately accessed and responsive to need.

South East London Integrated Care System

CYP - Our priority actions

NHS South East London

Our priority actions – what we will do

The ICS wide CYP transformation programme will set out a programme of work to deliver on the objectives described below, working collaboratively with system partners, Local Care Partnerships and other ICS wide transformation programmes as required. Core to any CYP transformation will be the principles of Population Health Management and learning from areas of best practice within South East London.

1. **Early Years** - Develop a model of care that brings together the provision of services for babies, mothers and families to support early years including school readiness.
2. **Addressing inequality** - Deliver a consistent and sustainable service offer for children's community services across South East London.
3. **Integration and inequality** - Implement and expand the provision of integrated child health models across South East London.
4. **Long Term Conditions** - Ensure effective long term condition management for children and young people including asthma, epilepsy, diabetes, obesity and sickle cell, embedding population health management approaches into service design and delivery and meeting the requirements of Core20PLUS5 and for our SEND population.
5. **Transition** - Develop models of care that support transition into adult services for those aged 16-25 years of age.
6. **Urgent and emergency care** - Develop pathways and services that support safe, effective and appropriate CYP access to Urgent and Emergency Care including Emergency Departments.
7. **CYP mental health and wellbeing** - Deliver improvements in children and young people's mental health and emotional wellbeing.*

**** Priority also included within the SEL ICS Mental Health Programme and therefore detailed actions are not included in this section.***

CYP priority action 1 – Early Years

Early Years

★ ICS Strategic Priority

To develop a model of care that brings together the provision of services for babies, mothers and families to support early years including school readiness.

How we will secure delivery

Actions for 23/24

- Series of workshops to be held bringing together leads from across the LMNS and the CYP transformation board to agree scope for the work for 2023/24 and 2024/25, including approach to developing an ICS approach for 0-5 yrs.
- Four of the six local care partnerships to develop models for Family Hubs, supported by an agreed core offer for health input to support these hubs.
- Expansion of parental support offers (inc. perinatal mental health, maternal mental health and other local support initiatives supported by digital).

Actions for 24/25

N.B Actions to be defined in 2023/24, in line with the agreed work programme.

Intended outcomes in 5 years time

- Agreed co-designed 'start for life' core offer in place between local authorities, health providers and Voluntary, community and social enterprise sector (VCSE). Digital, virtual and telephone services designed around needs of babies, parents and carers fully implemented and embedded as part of this offer.
- Health input to support first 1001 days available in Family Hubs across South East London.
- Joint common dataset for early years across health and care including across social services, maternity and children's services. This captures improvements in metrics related to maternity services including rates of smoking in expectant mothers and breastfeeding rates.
- 100% of all CYP to receive a review at one years of age and at 2 years of age.
- Increased access to parenting support programmes including for mental health and wider (linked to the actions included under CYP mental health)
- Increase in the number of under 2s accessing a dentist resulting in a reduction in the number of attendances at A&E as a result of oral decay.

CYP priority action 2 – Children's Community Services

Consistent and Sustainable Children's Community Services

Deliver a consistent and sustainable service offer for children's community services across South East London, resulting in improved access, reduced variation and increases capacity in community-based services for children, young people and their families.

How we will secure delivery

Actions for 23/24

- Finalise the common standards and expectations for neurodevelopmental diagnosis and post diagnostic support across all delivery partners in the ICS.
- Agree a programme of work under the umbrella of the Community Provider Network to deliver core standards and outcomes for community paediatric services.
- Establishment of a SEN workstream bringing together mental health and LDA services.

Actions for 24/25

- Implementation of the common standards and expectations for neurodevelopmental diagnosis and post diagnostic support across all delivery partners in the ICS (n.b there may be a phased approach to delivery across the six boroughs).

Intended outcomes in 5 years time

- At least 80% of all CYP community services to have agreed common service standards which includes a common set of outcome measures that be reported both a local and system level.
- At least 70% of the developed common service standards to be implemented through Local Care Partnerships.
- Reduction of inequality in health outcomes CYP in South East London (NB. exact definition to be considered as the common standards for each service are developed).
- Planned winter response and reduction in emergency attendance for CYP between December and February (annually).
- Establishment and delivery of a clear transformation programme for children with SEN.

CYP priority action 3 – Integrated Child Health Models

Integrated Child Health Models

Develop integrated models of care (Local Child Health Clinics) for children and young people at a neighbourhood level that bring together health and care services across specialist health services, primary and community services, mental health, and local authorities including education to improve care co-ordination, support for families and reduce health inequalities.

How we will secure delivery

Actions for 23/24

- Development of an ICS-wide dashboard for agreed metrics for the Local Child Health Teams (LCHT) to demonstrate impact.
- LCHT fully operational in each place within 1 PCN with learning for further roll out to cover 50% of PCNs by June 2024.
- Evaluation to establish minimum standards / core offer for LCHT across SEL
- Place based plans for extending the LCHT at place to 100% PCN coverage
- Develop plans for enhanced LCHT to bring together other health and care partners, for example mental health as per Southwark and Lambeth work

Actions for 24/25

- Roll out LCHT at place to provide 100% PCN coverage
- Implementation of the enhanced LCHT in 50% of PCNs
- Working in partnership with Local Authority, explore opportunities for an extended LCHT in Family hubs
- Pilot extended LCHT.

Intended outcomes in 5 years time

- All places to have full PCN coverage of integrated child health models and have considered/implemented use of extended model

- Overall shift in activity from hospital based to community based care, resulting in improved health outcomes in CYP population and care delivered in the most appropriate setting. This translates into a reduction in
  - CYP contacts through emergency departments.
  - Non elective hospital admissions.
  - Increased CYP and family experience of care.

NB. Baseline measures and improvements to be defined during the course of 2023/24 through the development of the ICS-wide dashboard.

CYP priority action 4 – Effective Long Term Condition Management

Effective Long Term Condition Management

To ensure effective long term condition management for children and young people including asthma, epilepsy, diabetes , obesity and sickle cell, incorporating population health management approaches into service design and delivery and meeting the requirements of Core20PLUS5 and our SEND population.

How we will secure delivery

Actions for 23/24

- Define response to Core20PLUS5 for CYP at Place and South East London wide
- National Bundle of Care for CYP with asthma implementation commenced including the asthma framework.
- For diabetes, review current data on real time continuous glucose monitoring use and develop model for increased annual health checks.
- Scoping to begin to understand the common standards and outcomes required for epilepsy, and obesity, ensuring a family-based approach to care).

Actions for 24/25

- Ongoing roll out of the asthma framework, linked to the National Bundle of Care for CYP with asthma.
- Agreement and implementation (part year) of a framework for Sout East London to increase remote glucose monitoring and uptake of annual health checks.
- Development of common standards and frameworks from 2023/24 for epilepsy
- Definition of the common standards and outcomes for sickle cell disease.
- Engagement with CYP and their families to develop approaches to self care and management.

Intended outcomes in 5 years time

Asthma

- Reduction in over-reliance on reliever medications for Asthma (reduce % of CYP with a reliever: preventor ration greater than 1:6)
- Decrease in number of asthma attacks (reduce unplanned hospital admissions, presentations in ED, prescriptions of oral steroids)

Diabetes

- Increase real time continuous glucose monitoring and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds
- Increase in proportion of CYP with type2 diabetes receiving annual health checks

Epilepsy

- Increased access to epilepsy speciality nurses
- Access to first year of care for CYP with LD or autism

NB Patient reported measures to be defined for each long-term condition as the common standards and outcomes are defined.

CYP priority action 5 – Transition

Transition

Develop models of care that support transition into adult services for those aged 16-25 years of age

How we will secure delivery

Actions for 23/24

- To complete a scoping exercise to understand and agree across system partners, and working with CYP and their families: (i) the definition of transition; (ii) the cohorts of patients impacted;(ii) what 'good' looks like for CYP and their families; and (iv) learning and best practice on transition.
- As a result of the work above, to develop and agree principles for transition as part of an ICS wide approach to transition and as part of wider framework-based approach.

Actions for 24/25

N.B Actions to be defined in 2023/24, in line with the agreed work programme.

Intended outcomes in 5 years time

- All providers and Places to have adopted the transition principles as part of their core offer for CYP and as business as usual for services.
- Improvements in the experience of care for young people transitioning through services - baseline measures and improvements to be defined during the course of 2023/24.

CYP priority action 6 – Urgent and Emergency Care

Urgent and Emergency Care

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

How we will secure delivery

Actions for 23/24

- Review and develop pathways and services that support safe, effective and appropriate CYP access to UEC including reviewing data, winter planning, and developing core pathways to address inequalities/access
- CYP to be included in the ICS wide communications plan (see UEC plan)
- Development of pathways and process for acute respiratory infections for paediatrics and CYP
- Support the relationship with local partners (e.g. pharmacies, GP practices) to support redirection of CYP that do not need UEC (see UEC plan)

Actions for 24/25

- Review of SDEC services to meet requirements of Paediatric Same Day Emergency Care (SDEC) requirements
- Review of 111 response to ensure timely access to paediatric advice
- Redesign of the 111 IUC offer with SEL partners to better integrate with local systems and improve patient care to include CYP (see UEC plan).

Intended outcomes in 5 years time

- Deliver A&E 4 hour target of 76%.
- All UEC and A&E will use South East London pathways to ensure CYP are appropriately accessing services via UEC/A&E through a South East London core offer which offers access to same day emergency care equitably across the geography.
- Reductions in presentations at A&E for certain patient groups through implementation of other UEC care – measurement to be defined during 2023/24, including the development of quality outcome measures to sit alongside any performance or activity measures.
- Each UEC contact is appropriate to level of patient acuity (audit)

South East London Integrated Care System

CYP enabler requirements

NHS South East London

Workforce

- Development an ICS-plan to support recruitment and retention into community paediatric services, linked to wider initiatives on AHP workforce development.
- Training and support for staff to ensure service delivery is anti-discriminatory and trauma informed.
- Organisational development support to build integrated teams across community and primary care settings, and across health and care services in line with the priorities set out for Integrated Child Health Models.

Digital

- Interoperability and the ability to better share data between primary and secondary health care services in order to build and expand Integrated Child Health Models. Over time, this needs to include access to local authority held data to support multi-agency and partnership working. This will also support the development of population health management approaches to improve care and outcomes for children and young people.
- Access to digital health passport for long term condition management both for individuals, their families and services. Linked digital health passports across service provider especially primary care and acute.

Estates

- Ability to co-locate multi-agencies and partnerships involved in the delivery of children and young people's services.
- Primary and community space in order to expand the integrated child health models across services.

Data

- Effective data sharing for clinical programmes and for partnership working across health based organisations and health and care.
- Ability to triangulate datasets for CYP bringing together maternity, acute, community and mental health datasets to provide a comprehensive understanding of children and young people's services, outcomes and care, to then better support the delivery of population health management approaches.
- Ability to easily share access to an ICS wide CYP dashboard which includes the metrics and datasets above.