University of Essex

Review of Models of Integrated Care for Children's Services

(Findings from desk research and interviews) January 2022

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Mid and South Essex Health and Care Partnership

Better Start Southend our children our community our future

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1. Background

Mid and South Essex Health and Care Partnership (MSEHCP) are developing a Children's Care Partnership Plan (CCPP). This will consider a range of opportunities, including:

1. Alignment and integration of a variety of local strategies (the STP and strategic plans of composite partnership and alliances).
2. Partnership and commissioning arrangements across the various local authority, community and CCG boundaries.
3. How to create the conditions and infrastructure for innovations and impact at scale across the region.

A Better Start Southend and the leadership of the MSEHCP asked the Dartington Service Design Lab and University of Essex to undertake work to provide an evidence base for the following over-arching question.

> *What approaches may:*
> *(a) ensure a robust, evidence-informed and consistent service offer for children and families across Mid- and South-Essex; whilst at the same time*
> *(b) ensure local flex at the community level, ensuring strategies and services adequately address contextual nuances and inequalities across the area.*

MSEHCP is therefore interested in different models that might be considered to drive up engagement, consistency and quality of existing service offers for children and families, and the infrastructures and forms of partnership working that could support innovation and impact across the region.

As part of this work, the University of Essex has undertaken a comparative overview of how other localities have developed and implemented partnership models of learning, improvement and innovation at scale. Initial desk research identified potential models/approaches which were then explored in more depth through interviews with key stakeholders in each area.

2. Executive Summary

Bristol, N Somerset and S Gloucestershire

Community Health Partnership

→ Includes health visiting, school nursing, CAMHS, speech and language therapy, OT and physiotherapy, and community paediatricians

→ Plus a range of dedicated services for vulnerable children

Sirona CIC care and health provides children's services while Avon and Wiltshire Mental Health Partnership NHS Trust provides child and adolescent mental health services

Connecting Care for Children (CC4C)

The model has three central components: Public and patient engagement; Specialist outreach; and Open access to specialist expertise.

Child health GP hubs

→ Vertical integration between GPs and paediatric services

→ Horizontal integration across various community agencies (e.g. health visitors, school nurses, CAMHS, schools, social care, children's centres)

Evelina

Children and Young People Health Teams

→ Includes GP's, paediatricians, psychiatrists and mental health workers, plus physical and mental health, health and social and education sectors

The model is said to be unique in the UK and across Europe in its cross-organisational, system-wide, transformative and academically rigorous approach to improving child health services. The approach comprises proactive case-finding and triage, specialist clinics, and transformative education and training for professionals working with children and young people.

Greater Manchester

The Framework provides co-ordination and oversight of children's health and care transformation and improvements across Greater Manchester

Children and Young People Health and Wellbeing Framework

→ Children, young people and families

→ Nine local authorities

→ Health organisations

→ Educational organisations and settings

→ Voluntary, Community and Social Enterprise and faith sectors

Hertfordshire/West Essex

There are different models of provision within Hertfordshire and West Essex. Hertfordshire's transformation journey is still in the early stages.
The West Essex model is seen as unique in that it includes community paediatric provision, health visiting, school nursing and children centres in one single contract.

Transformation into the ICS

→ Three partnerships responsible for delivering services in Herts Valley/ E and N Hertfordshire/ W Essex
→ Collaborative working with district councils and the voluntary sector plus integration of primary and community health services

One Vision Cornwall

Transformation framework

→ Shaping the integration of education, health and social care services
→ Includes local authorities, schools, CCG, hospitals, mental health services and voluntary sector

The Framework set out the key principles to plan, transform and commission services for children and young people across Cornwall and the Isles of Scilly. The core components are based on 'proportional universalism'. The aim is to develop a graduated, responsive service offer which builds the capacity of voluntary and community resources, integrates a response to additional needs and targets resource to those most vulnerable to poor outcomes.

Surrey First 1000 Days Programme

Partnership of health and care organisations

→ Includes local authorities, CCGs, hospitals, community services, primary care, residents, mental health services and voluntary and faith sector

The focus is on early intervention and prevention through: Universal support (maternity, health visiting, mental health and infant feeding); Universal + (specific inequalities and vulnerabilities for families); and a focus on families' holistic needs.

West Yorkshire

The vision for the Children, Young People and Families Programme is: to close the gap in health and well-being outcomes for all children and young people; to give all children and young people the best start in life and the support and healthcare needed; the voice of the child and young person will be at the heart of everything the Partnership does.

Children, Young People and Families Programme

→ Includes NHS organisations, local authorities, HealthWatch, charities and the community, voluntary and social enterprise sector

The models and programmes identified vary in their design, although they have some key principles/approaches in common:

- Person-centred approach – focus on needs of the child.
- Driving prevention and reduction in health inequalities.
- Evidence-based.
- Accessible and place-based services.
- Specialist knowledge/services in the community.
- Self-management of care.
- Collaboration or a system-wide workforce strategy.
- Public and patient engagement.

Several interviewees highlighted that the integrated care system and its public sector reform offers a real opportunity to bring a whole system agenda together to wrap around children and ensure that their health needs are not being separated out from all their other needs.

From all of the interviews, a number of common themes and learning have emerged.

Many interviewees identified a number of enablers for a model or transformation, including workforce, financing models, technology/digital transformation, data and governance.

Being child-centric is essential, as is ensuring that the views and experiences of children and families are embedded and put at the centre of work, by listening to and engaging with them. (CC4C, Cornwall, Evelina, GM, Hertfordshire/W Essex, Surrey, W Yorkshire). Co-production is an integral part of service design/redesign (Cornwall, GM, Surrey, W Yorkshire). Both GM and Surrey commission this from the voluntary sector who have expertise in this area. Obtaining voice data forms part of a dedicated work programme led by the voluntary sector. (GM)

Partner engagement and collaboration is a key success factor to ensure efficiency, improvement in services and integration, with a whole system approach including local authorities, health and the voluntary sector. (CC4C, Cornwall, Evelina, GM, Hertfordshire/W Essex, Surrey, West Yorkshire) It is important not to leave anybody out and ensure that membership is representative and correct. (Surrey) It is important to get frontline workers involved right at the very beginning, rather than presenting a plan to them, but it takes much more time to do this. (Hertfordshire/W Essex) Engagement and liaising with key partners, both at a strategic and “shop floor” level, is essential to understand how services should be designed. (GM) Engaging GPs is difficult but the key thing is not to try and target practices but to be flexible, start with willing ones and then grow via word of mouth. (CC4C) Not having difficult conversations at the Board meeting but having them outside to try and come to some agreement beforehand avoids creating tension in the boardroom. (Cornwall)

Building trust and relationships with partners is a difficult and time-consuming process but invaluable and essential to the progression of work. Engagement with professionals takes time and persistence and is based on personal contact and bringing people together to discuss common issues, including in informal coffee and chat session or “corridor conversations”. (CC4C, Cornwall, Evelina, GM, Hertfordshire/W Essex, Surrey, W Yorkshire) Building an understanding of the

different priorities, agendas and vocabulary of each partner is important to maintain relationships (Cornwall, GM) and building relationships inevitably builds trust. (Surrey) Being able to have open and honest conversations, even though they are difficult, is a good way to build relationships and trust. (Cornwall, Hertfordshire/W Essex, Surrey) It is important to build a culture where every part of the partnership agrees that the outcomes for children and young people need to be improved. (Cornwall, Evelina) Having somebody within the programme that can be a connector is useful, i.e. who has an understanding of the different agendas and how to try and make those work together to come to a solution. (GM)

It is important to **go slowly** and develop a model or programme incrementally rather than all at once: many have taken a year to 18 months to be developed before implementation as genuine transformation is complicated and difficult. (CC4C, Evelina, Surrey) Starting small, or with some quick wins, helps to build momentum and buy in, develop enthusiasm and engage with a wide range of partners. (Hertfordshire/W Essex)

Leadership, in terms of support and wide-ranging representativeness, is an important element, especially in building partner engagement and commitment. (Evelina, GM, Hertfordshire/W Essex, Surrey, W Yorkshire) The excellent working relationship between the two leads from health and the local authority, and the joint accountability, are a significant strength of the programme. (Surrey) Building relationships with senior leaders and elected members, as well as having elected members on the Board, is essential to build and maintain trust. (W Yorkshire) The Evelina model includes clinical, academic and management elements while its Board has three co-chairs - a provider, a commissioner and a parent. Children and young people are represented at a key Greater Manchester Executive Board and are happy to challenge what is being done, or not being done.

It is important to have **a clear focus, direction and vision**. (Cornwall, GM, Hertfordshire/W Essex) Having clarity of purpose and focus is important rather than trying to do everything at once (Cornwall, Surrey, W Yorkshire) as is being realistic about what can be done (GM). One way of breaking down barriers between organisations and workforces has been to focus on what the model is trying to achieve – i.e. achieving child health outcomes. (Evelina) Having agreement on the key outcomes for children and a shared vision can support difficult conversations between partners. (Cornwall) The key thing is to identify opportunities across the ICS to do something to add value, rather than business as usual. (Hertfordshire/W Essex)

Having an **ethos of learning and innovation**, and then being flexible - there is no one size fits all - is a key success factor. (CC4C, Cornwall, Evelina, Surrey) A culture of innovation was created through empowering people and encouraging them to work together while also taking risks, although the latter can create tension for some partners. (Cornwall) Innovation must be evidence-based and/or based upon what families are saying or what frontline workers are finding (Cornwall, GM, W Essex) while showcasing examples of good practice is very valuable. (GM, Hertfordshire)

Embedding a **quality improvement approach** is important. (GM, Evelina) Any newly implemented programmes are analysed for their influence on the system and how that works for each of the work streams. (W Yorkshire)

Having some start-up funding is very useful to allow breathing space for existing services to run in parallel for a time. (CC4C, Evelina) Systems have to be realistic about funding and, if change is to be achieved, that some degree of investment is needed for transformation until it becomes business as usual. (GM, Surrey)

Design should be **based on a needs assessment** to understand the patterns of met and unmet need. (Evelina)

Demonstrating an impact from this work is important. (Cornwall) It is important to ensure that the right metrics are measured, including experiential as well as outcome measures. (GM)

The **Adversity, Trauma and Resilience work stream** is a "game changer." (W Yorkshire)

Delivery may need to vary by place, while still having a consistent approach across the locality. (Cornwall, Hertfordshire/W Essex, Surrey, W Yorkshire)

Not designing and prescribing a model - but going out to commission a set of outcomes and allowing the providers to suggest a model – was felt to have worked very well. (W Essex)

A **longer length of contract** (up to ten years) gives more security to the provider and the service (Surrey, W Essex)

Developing a new "hybrid" workforce can support retention and the provision of more effective services for children and families. (Hertfordshire/W Essex). The workforce needs to develop skills around holistic care, requiring a training programme for physical health and mental health and social health skills. (Evelina)

Working with the voluntary sector was the biggest success factor for one locality and the programme has struggled when the voluntary sector has not been included. (Surrey)

Having systems and processes in place, including admin, PPI and data analysis, helps to maintain stability. (CC4C) It is important for staff and partners to have a firm understanding of the architecture and governance framework. (CC4C, GM)

Setting out far more clearly the technicalities of joint commissioning and how to agree how resources are shared/how resources are adapted should have been done at the start (Cornwall).

There are a number of **challenges around Information Governance and data sharing** that need to be resolved. (CC4C, Evelina, Surrey) Setting up a single client record system and dataset now was difficult and took much longer than expected to implement (W Essex).

Many interviewees also highlighted the need to address current **workforce challenges**, many of which have been exacerbated by the pandemic. (GM)

Other challenges identified were around: co-ordinating or pooling budgets within primary care and mental health (Evelina); implementing national programmes within the evolving integrated care system and how to link them into the Framework and other programmes of work (GM); overcoming the digital exclusion of families who cannot afford an internet connection (W Yorkshire); and that teams may have never met face to face, only virtually, which has affected teamwork during this time and setup (W Yorkshire).

3. Key Learning Points from Other Areas

Connecting Care for Children

- It is essential to start with children and families and then ensure their views and experiences are built in so the model remains patient-centric. It is better to tap into existing community networks rather than trying to start something new.
- The model was developed incrementally rather than all at once, with further work added in as a Hub grows in scope and take up: allow a year or 18 months for a model to evolve and then allow it to continuously evolve.
- Having an ethos of learning and of reciprocity, and then being flexible – as there is no one size fits all - is a key success factor.
- CC4C funds a small amount of start-up work but then looks to repurpose consultant time to support general practice. It is not commissioned but runs within existing budgets, making slight changes to the existing arrangements.
- Developing connections and relationships across the system leads to efficiency and quality improvements.
- Basing child health hubs in GP practices meant they were also integrating with a wide range of other organisations and professionals. MDTs create the opportunity for networking and “corridor conversations”. However, meeting virtually has enabled more professionals to attend an MDT meeting more easily.
- Engaging GPs is difficult but the key thing is not to try and target practices but to be flexible, start with willing ones and then grow via word of mouth.
- Rotating clinics around all the GPs in a practice creates trust and relationships between all members of the primary care team and the paediatrician, in effect developing a community of practice. Involving junior doctors and trainees in the community of practice that develops around the Hubs is very valuable.
- Having systems and processes in place helps to maintain stability, including having a permanent clinician as the lead in each practice plus admin support.
- It is very helpful to have PPI, administrative and data analysis/information reporting support from a central team.
- It is important not to be ambiguous about information governance and to state it very clearly.

Impacts seen so far:

- Improved experience of care, with outstanding feedback of patient and family experience.
- Initial evaluation of the asthma MDT pilot has shown some positive outcomes from both health professionals and patients.
- Reduced per-capita cost, including reductions in hospital activity from GP practices involved in a hub (39% reduction in hospital outpatient appointments, 22% reduction in ED attendances and 17% reduction in paediatric admissions for Hub patients) giving conservative net annual savings of £166k or £19.20 per child.
- Improved population health through preventative interventions.
- Improved staff experience and learning with strengthened relationships between primary and secondary care.

Evelina

- The majority of lessons learned were based on how the programme was run rather than the model itself, in terms of looking at the health system that the model has to fit into. Be beware of excessive simplicity as genuine transformation is complicated and difficult.
- The model was created following a health assessment to understand the patterns of need including met and unmet need and also a mapping of local services.
- A significant amount of time was spent at the start to identify and define the model's enablers, which include workforce, financing models, technology, data and governance – e.g. it has taken a year to resolve data sharing agreements.
- The model was fortunate to secure funding to develop the model so that it could "double run" existing services at the start, which allowed some breathing space.
- Building trust and relationships with external healthcare members is a difficult and time consuming process but essential to the progression of work. Engagement with professionals takes time and is based on personal contact.
- The clinical leadership group is wide-ranging with a GP lead, a paediatrician lead, a nurse lead, a mental health lead etc. These leads act as the trusted spokesmen or advocates for the model, and engage with their peers when there are issues.
- One way of breaking down barriers between organisations and workforces has been to focus on what the model is trying to achieve – i.e. achieving child health outcomes.
- The workforce needs to develop skills around holistic care, requiring a training programme for physical health and mental health and social health skills.
- Initially the model created its own clusters of GP practices, but it was difficult to keep up with changes and mergers so the model now uses the PCNs as the clusters.
- Innovation is a key element that is continually being brought into the model. Improvements in services for children are under constant evaluation.
- The structure of the partnership was set up to include clinical, academic and management elements.
- The Board has three co-chairs – a provider, a commissioner and a parent.
- Co-ordinating or pooling budgets within primary care and mental health remain difficult for elements of the partnership, particularly the two hospitals that under national legislation have to compete with each other.

Early impacts seen:

- Significant reductions in unplanned activity: 72% reduction in ED contacts for children with asthma, 30% for children with epilepsy and 15% for children with constipation.
- Increases in care quality seen.
- Net savings after five years running the new model of care, resulting from activity reductions, is projected to be £962,000. Cost savings per 100 asthma patients are estimated to be over £15,000, for epilepsy to be over £6,000 and for constipation to be just over £3,000.
- Of the first 200 patients in the ongoing conditions service, most were from socially deprived areas and 68% were from black or minority ethnic groups, suggesting that the model provides care for those with greatest health and social need.

- The average referral-to-treatment time for In-reach Child Health Clinics is 18 days.
- Families report more confidence in managing their child's condition out of the hospital environment.

Greater Manchester

- Enablers for the Framework include the voice of children, digital transformation, accountability and governance, strategic commissioning, and the workforce.
- Having a clear vision, a clear focus and a clear direction is vitally important to achieving outcomes, as is being realistic about what can be done.
- All work must be underpinned by the voice of children and young people with co-production seen as an integral part of service design/redesign. Obtaining voice data is part of a dedicated work programme led by the voluntary sector.
- Having the check and challenge from children and young people has been useful, particularly as they have representation at a key Executive Board and are happy to challenge what is being done, or not being done. The Young People's Agreement ("charter") comprises the principles and commitments that Framework programmes should adhere to. This is monitored by young inspectors.
- Leadership is essential, with an executive lead who has ownership of the children's programme so can champion this at executive level, as is bringing in multiple leads from across the system.
- Engagement and liaising with key partners - both at a strategic and "shop floor" level - is essential in terms of understanding how services should be designed.
- Having the right partners around the table is very important, as is building on the relationships already in existence. The existing collaboration and "philosophy of connection" across Greater Manchester provided a good foundation and allowed an "organic" development of relationships with opportunities to connect partners.
- Approaches that have worked well in obtaining representation from different professionals have been persistence and contacting the right people. Building on relationships formed via informal coffee and chats has been very helpful.
- It has taken time to identify the key staff across the wider system who are involved in a specific area. Having somebody within the programme that can be a connector is useful, i.e. who has an understanding of the different agendas and how to try and make those work together to come to a solution.
- Building an understanding of the different priorities, agendas and vocabulary of each partner is important to maintain relationships. Joint posts and combined budgets have arisen from the relationships developed where partners are discussing the same issues.
- Using strong evidence and examples of good practice is important. Learning sets often share innovation and good practice which are picked up for local implementation at the wider system level for spread and scale.
- Embedding a quality improvement approach to the programme and its development is important.
- The integrated care system and its public sector reform offers a real opportunity to bring a whole system agenda together to wrap around children and ensure that their health needs are not being separated out from all their other needs.

- Systems have to be realistic about funding and, if change is to be achieved, that some degree of investment is needed for transformation until it becomes business as usual.
- It is important for staff and partners to have a firm understanding of what the architecture and governance should look like and work in ways that allow them to meet the targets of the Framework.
- More work is required in terms of addressing workforce challenges, in terms of identifying gaps and areas where the workforce needs to be strengthened.
- It is important to ensure that the right metrics are measured, including experiential as well as outcome measures.
- A challenge within the evolving integrated care system is about implementing national programmes and how to link them into the Framework and other programmes of work.

Early impacts seen so far:

- Some measures of improvement were evident prior to the Covid-19 pandemic (for example a reduction in asthma admissions and improvements in neonatal and maternity data). However, it has been difficult to monitor these during the pandemic and during the current transition towards integrated care.
- Some positive improvements on school readiness.
- The national target for children and young people with a diagnosable mental health condition receiving treatment from an NHS-funded community mental health service has been exceeded.
- Fewer children admitted to hospital for Asthma, Epilepsy or Diabetes.

Hertfordshire and West Essex

- The key thing is to identify opportunities across the ICS to do something to add value, rather than business as usual.
- The ICS would like to have an equitable service provision for children across Hertfordshire and West Essex, while allowing for different arrangements in different localities – but with the “golden thread” of better outcomes for children.
- It is unhelpful having an ICS footprint that is not a local authority footprint.
- It is important to get frontline workers involved right at the very beginning, rather than presenting a plan to them, but it takes much more time to do this.
- Starting small, or with some quick wins, helps to build momentum and buy in, develop enthusiasm and engage with a wide range of partners.
- The strength of the relationship between partners, and the trust built up between them (after spending a lot of time getting to know each other’s backgrounds, motivations etc.) is seen as a key success factor. Face-to-face interactions and spending time together is important.
- Being able to have open and honest conversations, even though they are difficult, is a good way to build relationships and trust.
- Joint working has been successful, as has the creation of forums to discuss key issues as this helps to build networks and personal contacts.
- Having good leaders from within the system involved in the programme works very well, as this helps to generate enthusiasm and commitment.
- It is important to have a direction and a vision.

- Engaging with families and parents to understand their actual experiences is extremely important. For West Essex this included ethnographic work, shadowing health visitors, going to children's centres and talking to families.
- Innovation within West Essex must be evidence-based and/or based upon what families are saying or what frontline workers are finding. An interviewee in Hertfordshire said that showcasing examples of good practice is very valuable.
- West Essex did not design and prescribe a model but went out to commission a set of outcomes and allowed the providers to suggest a model: this was felt to have worked very well. The resulting contract should be kept as simple as possible.
- West Essex has various practitioners who work with families depending on their need for support. Some work which traditionally would have been undertaken by health visitors is now undertaken by others, allowing 'health visitors' to work with families and children for longer. Hertfordshire is also looking at a new "hybrid" workforce.
- Virgin/Barnado's has a single client record system and dataset now, but this was difficult and took much longer than expected to implement.
- The safe transfer of some services in West Essex took much longer than expected.

Early impacts seen:

- Before the pandemic, West Essex was seeing improvements in school readiness and some of the key developmental milestones at pre-school.

One Vision Cornwall

- It is essential to focus on building a culture where every part of the partnership agrees that the outcomes for children and young people need to be improved.
- It is important to keep to a clear vision while being adaptable and flexible. This is the same when commissioning services where consistency in the offer is important even when place variations are required.
- Listening to children and young people, as well as parents, is very important.
- It is very important to have really strong relationships with partners. This is not always easy, and requires constant attention and hard work. One element has been through demonstrating that everyone has an equal role to play within the system.
- Regular meetings have helped to build trust and stability across the various partners, as well as setting time aside to have individual conversations with people and maintain the relationships, which enables others to do the same.
- Demonstrating an impact from this work is important.
- Taking time to understand the nuances of different partners' language is important or misunderstandings can arise.
- Listening when people think that you are not going in the right direction, and being flexible and adaptable, is also important.
- Not having difficult conversations at the Board meeting but having them outside to try and come to some agreement beforehand avoids creating tension in the boardroom.

- Having agreement on the key outcomes for children and a shared vision can support difficult conversations between partners.
- A culture of innovation was created through empowering people and encouraging them to work together while also taking risks, although the latter can create tension for some partners.
- A key part of innovation is about looking at the evidence and examples of good practice to learn from them and implement best practice.
- One thing that could have been done differently when setting up the One Vision Framework would have been to set out far more clearly the technicalities of joint commissioning and how to agree how resources are shared/how resources are adapted.

Early impacts seen:

- Safeguarding referrals have not fallen during Covid, unlike a lot of other areas.
- Cornwall has begun to see a reduction in its waiting lists for CAMHS.

Surrey First 1000 Days Programme

- A key lesson learnt was not to leave anybody out and ensuring that membership is representative and correct.
- The biggest success factor was working with the voluntary sector, which has a seat on all of the strategic boards: the programme has struggled when the voluntary sector has not been included.
- Partner engagement and collaboration is a key success of the programme, including joint working and integration with the local authority.
- Very strong clinical and management engagement within the programme Board from a range of leaders within the ICS has worked well in building partnerships.
- The excellent working relationship between the two leads from health and the local authority, and the joint accountability between health and the local authority, are a significant strength of the programme.
- There is a real principle around culture and taking time to build relationships, which then inevitably builds trust.
- The children's social care improvement programme has strengthened relationships, mainly a result of many joint meetings between commissioners and providers where plans and decisions are made jointly and there is constructive and open debate. This has broken down barriers and allowed different cultures and structures to come together around the key principle of "positive intent".
- Children's principles have been embedded at every layer and the programme makes sure they put the child at the centre of everything that is done.
- The Citizen's Ambassador for the programme is commissioned through HealthWatch and has been the programme's main route into co-production.
- Having clarity of purpose and focus is important rather than trying to do everything at once.

- The programme has very good place engagement and recognises that delivery needs to vary by place because of the demographics of the population.
- Things that have not gone well have been when the programme has rushed into things, and not really taken time to debate and understand so that decisions have been taken in isolation. The programme learnt from Public Health's experience of integrating into the local authority and therefore took a year to integrate the two children's commissioning teams in order to build up relationships.
- The programme aims to continuously innovate by formulating ideas, producing a proposal for the children's steering group, testing them and learning from this.
- The majority of posts are fixed term using transformation funds, but the aim is to start creating substantive posts.
- A new Mindworks contract is delivered through a consortium of voluntary organisations/charities as a seven years plus three contract, giving more security.
- The programme has a large digital team working to resolve challenges around Information Governance and IT equipment.
- The programme has recently employed a business analyst to help develop its dashboards. It wants to do something more dynamic, such as a data insight hub, but has not yet got the basics in place.

Early impacts seen:

- Breadth of partner engagement, collaboration and clinical insight.
- Clinical leadership and insight across the programme, resulting in a higher profile for children's services.
- Best Beginnings Partnership (embedding the Baby buddy app).
- Peer support scheme with Home Start.
- Psychotherapist support for families with babies in the Neonatal Intensive Care Unit with good initial feedback from mothers.
- New maternal mental health service for trauma and loss.
- Reduction in the number of Education Health and Care Plans for children under four.
- Qualitative feedback from parents who feel a lot more supported.

West Yorkshire

- The voice of the child and young person is at the heart of everything the programme does. Co-production is an important element for work, especially with at-risk groups.
- The key success factor for the programme is having a whole system approach, including local authorities, health and the voluntary sector who are fully invested in the work. Making the partnership central to everything is important.
- Being able to build on existing relationships between health, local authorities and providers is very useful in developing an integrated approach. Bringing people together allows a collective approach to be agreed with shared outcomes and the best direction going forward. It helps to build relationships, trust and a fundamental understanding of different approaches being taken.
- Building relationships with senior leaders and elected members within the partnership, as well as having elected members on the Board, is essential to build and maintain trust.

- Leadership is a key element within the ICS with elected members involved alongside leaders on a partnership Board.
- Any newly implemented programmes are analysed for their influence on the system and how that works for each of the work streams.
- Getting commissioners within the partnership together on issues has been very helpful. The aim of this is to create a consistent approach that still takes the needs of each locality into consideration rather than commissioning the same service across the whole area.
- Having clarity at the very beginning of the process has allowed feedback to be taken and changes to be made. This has been very helpful as people are clear about what they are trying to achieve and are able to better understand their role, wherever they are placed in the system.
- The principle of subsidiarity is applied to work which can only be carried out at a West Yorkshire level: work is carried out on the basis of agreement with each locality and where value can be added.
- The Adversity, Trauma and Resilience work stream is a “game changer.”
- Linking into the ICS’ digital programme is essential to overcome the digital exclusion of families who cannot afford an internet connection.
- A key challenge is that teams may have never met face to face, only virtually, which has affected teamwork during this time and setup.

Outcomes seen so far:

- The Child Health in the Community programme has been going for 18 months and there has been a reduction in A&E attendances by children and young people plus reduced length of stays in hospital.
- Stillbirths and neonatal deaths have been reduced by 10% across West Yorkshire and Harrogate.
- Wakefield services have been assessed as making sufficient progress to improve autism services for children and young people, with a reduction in waiting times for autism spectrum disorder assessments.
- Evaluation of learners’ progress at Wakefield and 5 Towns Recovery College found that 29% of students have self-reported a decrease in their contact with health services and 18% have gone into employment, volunteering or education since attending the college.

4. Methodology

A literature search online was undertaken to identify examples of integrated care models and systems/frameworks for children's services. This initial desk research identified 46 models or frameworks that could be of interest, and after consultation with MSEHCP this was reduced to a shortlist of 12 examples:

- 4 models of care for children's services: Bristol, North Somerset and South Gloucestershire; CC4C; Evelina; and Suffolk.
- 3 frameworks for the transformation of services for children and young people: Cornwall; Greater Manchester; and West Yorkshire.
- 1 Health and Care Partnership focusing on first 1,000 days: Surrey.
- 1 Accountable Care Partnership for all ages with children and young people as a priority: Sheffield
- 3 Health and Care Partnerships for all ages with a children and young people strand within it: Hertfordshire and West Essex; Northamptonshire; and Sussex.

The desk research was then supplemented by interviews with key stakeholders in 8 of these areas. Interviews were carried out between November 2021 and February 2022, as follows:

- 4 interviewees in Bristol, North Somerset and South Gloucestershire.
- 2 interviewees and 1 webinar attended for CC4C.
- 1 interviewee in Cornwall.
- 1 interviewee for Evelina.
- 3 interviewees in Greater Manchester.
- 3 interviewees in Hertfordshire/W Essex.
- 1 interviewee in Surrey.
- 1 interviewee in West Yorkshire.

Population by area

The population of children and young people[1] in each local authority area is shown in the table below with the comparable population in Mid and South Essex.

Table 1: Population of 0-18 years olds within each area

	Number of children and young people aged 0-18
Bristol, N Somerset and S Gloucestershire	207,201
Connecting Care 4 Children	124,645
Cornwall	114,813
Evelina	133,221
Greater Manchester	676,394
Hertfordshire and West Essex	394,012
Northamptonshire	180,106

[1] Population figures are ONS mid-year estimates 2019.

Sheffield	124,647
Suffolk	161,278
Surrey	277,628
Sussex	297,190
West Yorkshire	559,314
Mid and South Essex	274,293

5. Models/Frameworks Explored in Detail

5.1 Bristol, N Somerset and S Gloucestershire

5.1.1 Background

The Children's Community Health Partnership (CCHP) services is a partnership commissioned from and led by Sirona care & health CIC working with Avon and Wiltshire Mental Health Partnership NHS Trust, University Hospital Bristol NHS Foundation Trust, Weston NHS Foundation Trust (UHBW), Barnardo's and Off The Record. All community child health and child and adolescent mental health services for Bristol, North Somerset and South Gloucestershire are provided through this partnership.

5.1.2 Service Model

The services that fall within children's community services include:

- Health visiting.
- School nursing.
- Child and adolescent mental health.
- Speech and language therapy.
- Occupational therapy and physiotherapy.
- Community paediatricians.
- A range of dedicated services for vulnerable children, including children in care, children with learning disabilities, children with life-limiting conditions and children with drug and alcohol problems.

For each of the regions listed above, Sirona care and health provides children's services while Avon and Wiltshire Mental Health Partnership NHS Trust provide child and adolescent mental health services. The CCHP has multiple services and specialities, and currently employs more than 800 staff including:

- Community Paediatrics.
- Children's Therapists.
- Health Visitors.
- School Health Nurses.
- Children's mental health teams.

Each professional team works closely with parents, carers, teachers, and local authority staff to improve the wellbeing of children and adolescents. This makes the delivery of a truly integrated approach central to the CCHP's success.

The service operates to a set of clear, core values, and focuses upon early intervention and prevention. These values are:

- Respect for the unique worth of each child and young person.
- Outcome-focused and innovative.
- Child and young person at the centre.
- Accessible and equitable services.
- Service user participation at all levels.

Barnardo's have introduced a new scheme called HYPE (Helping Young People (children and families) to Engage) which work with the CCHP supporting children and families to have a say. HYPE works with both health workers and managers in the CCHP to support the involvement of children in delivering its missions:
INVOLVE, INCLUDE and LISTEN to EVERYONE

5.1.3 Young People Friendly

The CCHP is committed to providing excellent quality health services in a way that young people appreciate. One method of making this possible is through the Young People Friendly Association. Each service under this scheme has achieved certain standards to meet the needs of young people aged 11-18 years of age. Accredited services under this scheme include:

- Children Looked After Nurse Service (CLAN).
- East Central Community Children and Adolescent Mental Health Service.
- Hospital Children and Adolescent Mental Health Service.
- Specialist Service for Children with Learning Disabilities.
- South Bristol Community Children and Adolescent Mental Health Service.
- South Gloucestershire Community Children and Adolescent Mental Health Service.
- Thinking Allowed – Children and Adolescent Mental Health Service specifically for children in care.
- Young Peoples Substance Misuse Treatment Service.
- Youth Offending Team Health Services.

5.2 Connecting Care for Children

5.2.1 Background

Connecting Care for Children (CC4C) is a paediatric integrated care model which has been used to implement whole system change and to improve the way children's care is commissioned, delivered and experienced across north west London. It was set up to address the disproportionately high rates of paediatric A&E and paediatric outpatient attendance across the region.

> *"This is not one organisation, it's a whole collaborative, and we've been going for more than ten years."*

Since 2014, this work has been driven by paediatricians at Imperial College Healthcare NHS Trust working with local GPs, commissioning leads and social care partners. The main partners have changed over time but include:

- Imperial College Healthcare NHS Trust
- Health Education England
- Central London Clinical Commissioning Group
- Ealing Clinical Commissioning Group
- Hammersmith and Fulham Clinical Commissioning Group
- West London Clinical Commissioning Group

5.2.2 Model rationale

The rationale was to develop a collaborative integrated child health system, placing general practice at its heart and reinforcing the role of the GP. CC4C is a 'whole population' model of care delivering wrap-around support for children and young people across six segments, including the healthy child, children with complex health needs, vulnerable children with social needs and children with long term conditions.

> *"There is also this very strong recognition that child health and healthcare in general has moved from being a reactive thing - where somebody who's well becomes unwell, comes into hospital to get better, goes home again - has gone, and people are now living with long-term conditions so it's much more about helping them to manage themselves, it's about reducing inequalities in all those social determinants, trying to get in early."*

The drivers for change included the "arcane" outpatients system that relies on letter-based communication between practitioners. However, more recently Covid has provided another driver for change.

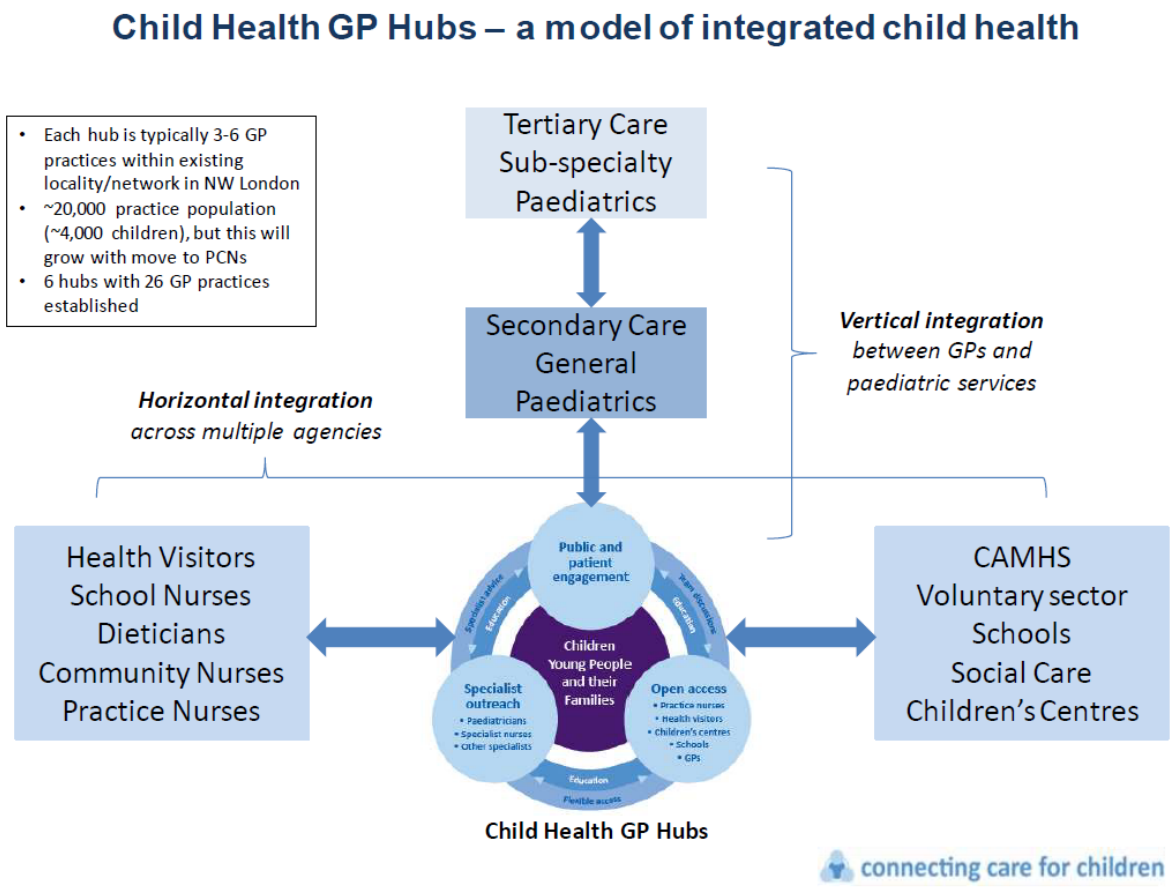
> *"The other thing about we must change is to remind ourselves that actually our outpatients is a Victorian entity. We still run a health system where we are basically writing letters from one practitioner to another, weeks later the patient gets seen, and weeks later the GP gets a letter back, it's arcane."*

5.2.3 Service Model

The model has three central components:

1. **Public and patient engagement** - enabling primary, secondary and community care professionals to work cohesively with the local population. We have set up a growing network of practice champions who work with hospital paediatricians, GP practices and their patients to improve services and encourage collaboration and learning.
2. **Specialist outreach** – transferring specialist knowledge from the hospital to the community. Hospital paediatricians work closely with GPs so that children receive the best possible advice and care within home and community settings. We have developed child health GP hubs to support this work. Hospital paediatricians visit the hubs to support practices, and run specialist clinics.
3. **Open access** - making the expertise of paediatricians in hospitals much more widely available. We have set up a GP hotline which, primary and community healthcare professionals can call when they need specialist advice.

GP practices and Primary Care Networks (PCNs) are the core “place of change”.



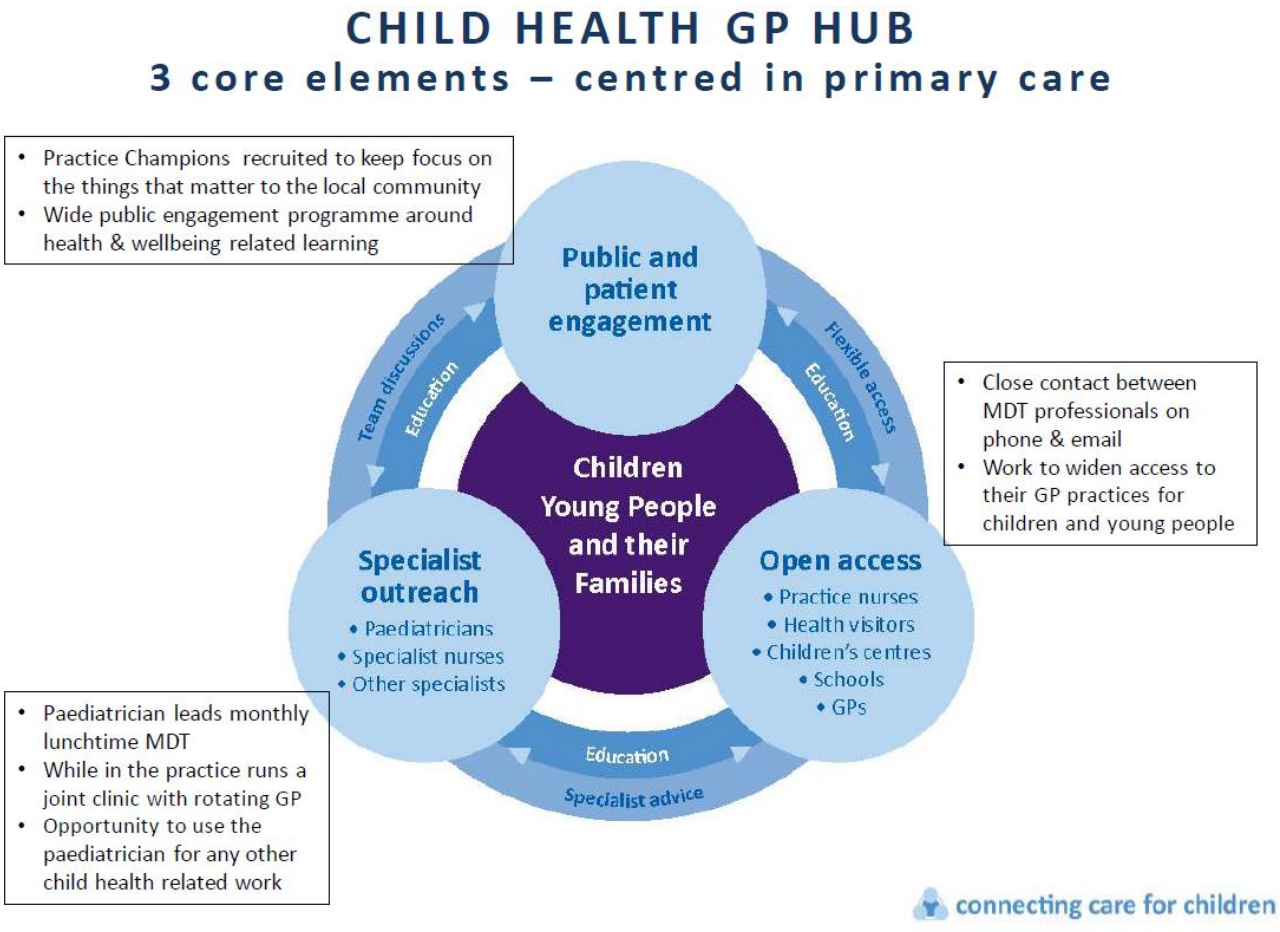
There are currently 24 practices forming seven hubs over three CCGs (West London, Central London, Hammersmith & Fulham), with coverage of approximately 30,000 to 40,000 children and young people.

Child health GP hubs, which consist of four to five local GP practices and a visiting paediatric consultant, transfer specialist knowledge from the hospital to the community. Hospital paediatricians work closely with GPs so that children receive the best possible advice and care within home and community settings. There is a vertical linkage between GPs and paediatric services and a horizontal linkage with CAMHS, children's centres and schools.

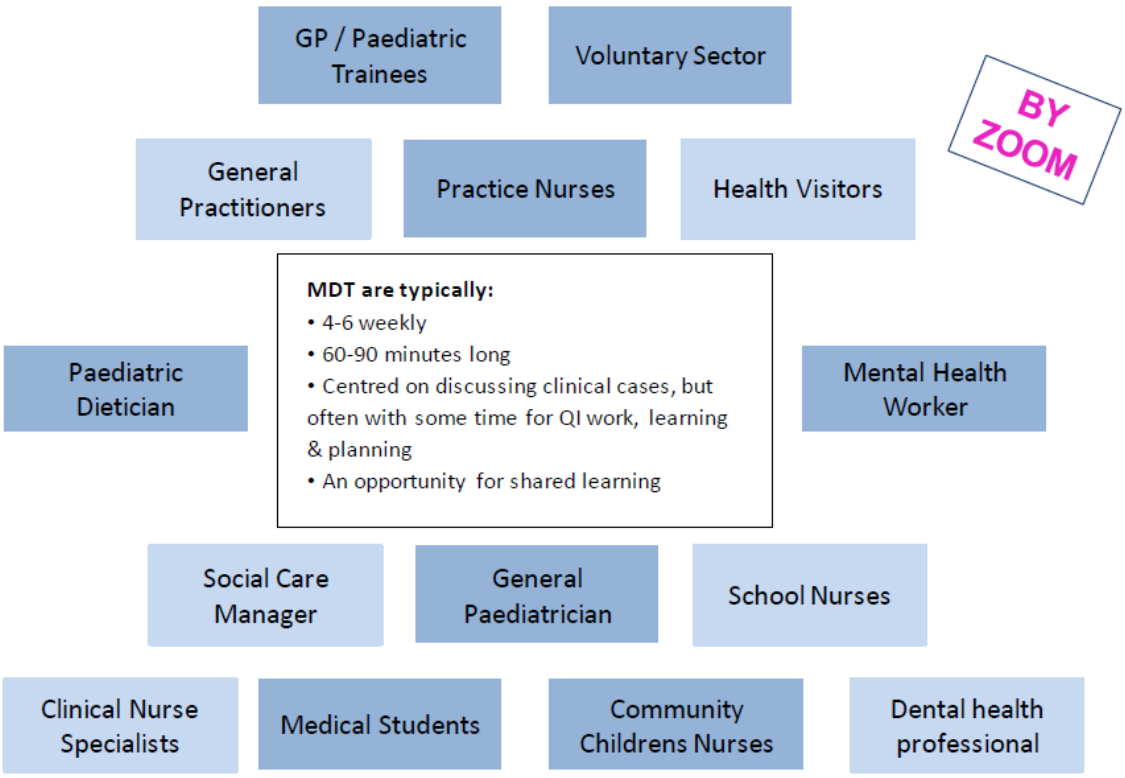
> *"When a secondary care paediatrician at a local hospital comes into the GP practice, they are immediately pulling in tertiary expertise. So I might come back from my meeting and go and knock on the door of my paediatric neurology consultant colleague, and say: 'I've just been to a GP about that child you look after who has epilepsy. The GP was wondering about changing the drug, increasing the dose, what do you think?' And that's another corridor conversation that means that there is no need for that formal referral."*

When developing the model, staff considered whether to set it up in GP practices or children's centres, but in the end felt that as paediatricians they were more closely aligned with GPs. However, being based in the GP practices meant that they were also integrating with a wide range of other organisations and professionals.

> *"It's a very different dynamic, there are far fewer barriers, when you're already in primary care."*



A paediatric consultant visits the child health GP hub every four to six weeks to take part in a child health focused, multidisciplinary team meeting where they are able to advise without the patient needing to be referred to them separately. Multi-disciplinary teams (MDTs) vary from hub to hub and contributing professionals tend to grow over time. All hubs have most of the professionals below but none have all of them:



The MDT meetings initially started with just a GP, health visitor and paediatrician, but over time has grown *"to some extent organically"* bringing in further professionals.

> *"You might have a case where you say actually it'd be really good to have the community dietician here. And you invite them in, and once they've come once or twice they want to stay and they want to keep coming."*

Meeting virtually during the pandemic has enabled more professionals to attend an MDT meeting more easily. GPs were asked what they felt about virtual MDT meetings compared to face-to-face, and most of them wanted to continue with video MDTs with the majority saying it should be a mixture of video and face-to-face.

None of the hubs and MDT meetings have all of the professionals above attending but, for example, a speech and language therapist may attend once a year to talk through a few cases. The mental health professional is one of the most valued members of the group, and the early help professional from social care is also a powerful presence.

> *"A little case study to bring that to light. Here's a child who has developed abnormal movements, the GP is worried, thinks it might be epilepsy, in the old days it would have been referral to outpatients, the child would have been*

seen a few weeks later, and the paediatrician would have said to the parents, 'can you get a video and come back in another three months?' Well in this case it was a conversation between the GP and the paediatrician, the GP then got the parents to do a video, the GP checked the blood pressure which isn't a critical thing to do, and they were going to see the patient again two weeks later when there was a hub clinic coming up, but actually the video was very reassuring, the symptoms settled, and a hospital visit was avoided."

One of the best uses of the MDT meetings is proactive case finding and encouraging each member to think about the children/families that they work with and that they can bring to the MDT.

"You want to try and increase the voices of those who are not doctors in the room and encouraging the doctors in the room to be aware of that and handing the microphone, if you like, to the others."

In addition to the MDT meeting, a specialist clinic is held during the paediatrician's visit so that patients can be seen by a GP and the paediatric consultant at the practice, if needed. A different GP sits in with the paediatrician in a clinic every time, so any one GP might sit in once a year to 18 months, plus (pre-Covid) a trainee also attends.

"It is very easy for a GP to feel very isolated, very alone managing this population of patients, and all the complexity that they have. What we do by having these multidisciplinary meetings is we start to give that GP the possibility and the understanding that they can actually draw in a whole lot of resource for their patients from a wide range of organisations and professionals."

At the core of the model is supporting healthcare education and training. CC4C ensures primary and community healthcare professionals in North West London have the information they need to provide care locally. It runs education events for patients and families so that they can learn how to stay healthy and what health care services are available to them.

CC4C has also made the expertise of paediatricians in hospitals much more widely available through a GP hotline which primary and community healthcare professionals can call when they need specialist advice.

"And the signposting that happens in the MDT meetings is phenomenal. Connections and relationships, building that trust. When you talk about cases together, it's a really strong thing that creates a relationship that you use for months and years to come. It's about education and improving the capability and the child health know-how of the people in the room."

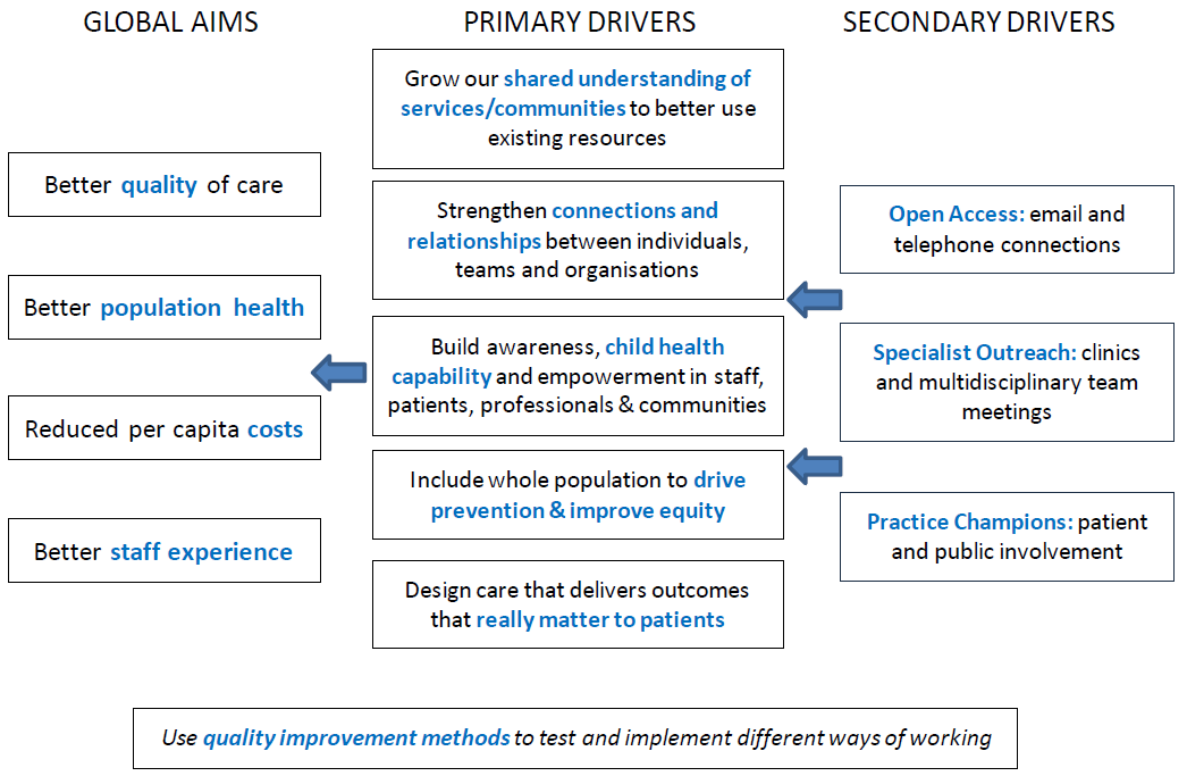
One of the starting points for the model is to look at local data. Packs are created for PCNs showing some of the local demographics and some of the local challenges: *"because I think it really is so helpful when people see data that they can relate to"*.

5.2.4 Designing the model

The overall aim of the model was to improve the child health landscape "in the round" with improved quality of care, improved population health, reduced costs, and improved staff experience. The three core elements of the child health hub model are: open access, specialist outreach and practice champions.

> *"What are we actually achieving when we do these things, and that was where we realised that these primary drivers which we think of as fundamentally important, so this is not about reducing children's attendance to A&E, which is a big driver that a lot of people had. Because that follows if you get this right. And it is about helping people understand what's going on."*

The logic behind the model is:



The starting point for the model was to get paediatricians from the local hospital to see patients in a GP practice. This creates the opportunity for networking and "corridor conversations" and gives a strong message to families that their GP practice is somewhere that is good for child health.

> *"Same patients, but just in a different place, and that tiny device puts a paediatrician, takes them out of the hospital into the GP practice, and creates the opportunity for corridor conversations. It's a minute change,"*

A slight development from this was to add on a lunchtime MDT meeting (i.e. at the end of the morning clinic or the beginning of the afternoon clinic) where the paediatrician and the professionals in the practice meet and discuss cases. When

they have met in meetings, they are much more likely to subsequently phone and speak to each other.

> *"They discuss cases that are coming to clinic, but there's always: 'while you're here, can I just ask you about'... So this is a wholesale change that has come from a tiny little shift in the way that we work, which makes it cheap...It's a really interesting, simple phenomenon, and that means we create open access."*

The design principles of the model are:

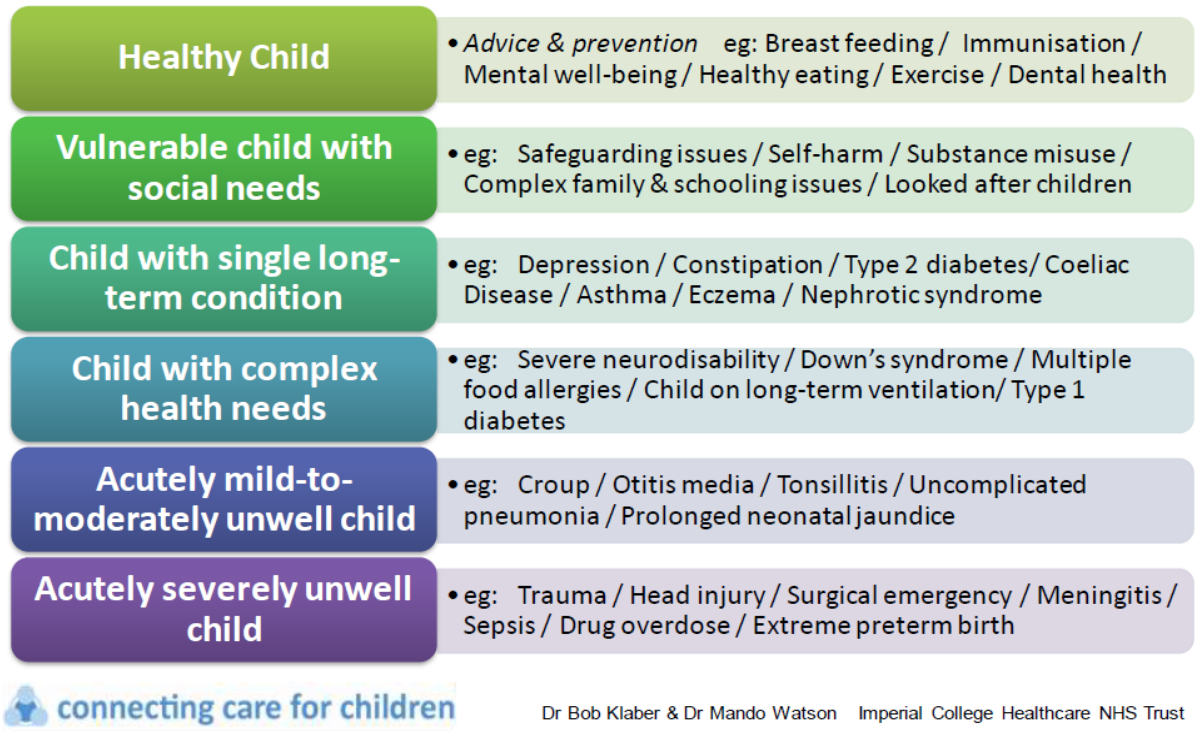
1. New approaches to care to be co-designed with children, young people, parents, carers and communities.
2. Focus on outcomes that really matter to patients.
3. Focus on connections and relationships; NHS services can be minimally changed, while their capability and capacity are maximised.
4. Harness existing strengths: put GP practices at the heart of new care models - specialist services are drawn out of the hospital to provide support and to help connect services across all of health, social care and education.
5. Include the whole population (using segmentation to create bundles of care) to drive prevention and improve equity.
6. Health seeking behaviours improve through peer-to-peer support.
7. Use education and development, for the whole multi-professional team, as a key way to build relationships and finding new ways to work together.

A key principle behind the model is about how to change the system for the benefit of the whole population of children.

> *"I've seen far too many people say let's do integrated care for paediatric diabetes. Or let's do integrated care for children. That's just nuts. One is too small and one is too big. So this is a piece of work that we did to try and bundle different aspects of child health into sensible groups. So what are we doing for the healthy child to keep them healthy, and how do we organise ourselves better to do that?"*

The model aims to support all children and "child health in the round", which means segmenting children into different categories.

> *"What you do with a single long term condition is probably to support the GP to be better able to manage it. Whereas a child with complex health needs probably needs much more direct specialists. And then how do we manage the acutely unwell child? But thinking about a different solution for the one who's actually mild to moderately unwell, with focuses on self-management, and a different one for a severely unwell child."*



5.2.5 Developing the model further

The model was developed incrementally rather than all at once, with further work added in as a Hub grows in scope and take up.

> *"This doesn't happen in one go, you don't just parachute in something that works. You start with something small, you start with a regular meeting between the health visitor, the GP and the paediatrician, and then you grow. In our case, we started with general paediatrics, but within that there's a lot of other specific population groups that need something specific. Autism is a really good example, and we've done some lovely things in the hub where we've brought in some autism experts and helped the GPs who in turn help the families."*

Recently work has been done within the Hubs focusing on specific conditions. This work is run by foundation doctors.

> *"You can tailor MDTs and use the hubs to give that specialised support. In this case asthma, but it could be for anything like diabetes for example, and offer that support in the same integrated care model. And I also want to say that it's quite an opportunity for myself as an F1, it's not the kind of opportunity you'd get normally as an F1, so it's really quite nice with integrated care to get juniors involved, and have the opportunity to help them to run these programmes."*

One area is asthma, where CC4C has looked at data to highlight GP practices that might want some asthma support and then offered an option of asthma MDT meetings. These meetings go through cases with GPs, offer tailored teaching and

specialised pharmaceutical advice, and contact with the asthma specialist nurse in their area. Afterwards, they are offered a specialised tutorial.

> *"The MDTs offer this package of case discussions, tailored teaching, and then patient feedback as well."*

Initial evaluation of the asthma MDT pilot has shown some positive outcomes from both health professionals and patients. A patient-centred feedback questionnaire sent via text message is providing the patient perspective in terms of whether they feel they are managing their asthma, things they would want improved, and things that they think help them engage in the asthma care. GPs have reported greater confidence in investigating asthma, diagnosing it, asthma inhaler techniques and identifying high risk patients.

5.2.6 Commissioning and funding arrangements

The model has evolved from a *"provider, purchaser, money driven system"* to one that is much more around understanding how existing resources are best used.

> *"This has to wash its face and the data that we have suggests that it does cover its costs and generate some savings."*

What the model does is fund a small amount of start-up work that might include some back fill time for the GP or a receptionist or administrator. It is also very helpful to have some funded patient engagement resource: *"somebody who will generate that PPI momentum and keep it going"*.

The model in operation now is about repurposing consultant time to reduce the number of outpatient slots and the amount of capacity in hospital-based outpatients, and repurpose this time to support general practice. Seed funding previously was from a mixture of sources including charity, innovation funding and Health Education England.

> *"There have been occasional years when the CCG funded GP time but actually we're very, very reluctant to fund anyone's time because we believe that if the model is effective and working, people would choose to spend time at the MDT. We believe that the time that the GP spends once every year, once every two years, sitting in on a clinic is something that they will use their CPD budget for. The only person whose time resource needs to be funded, if you like, is the consultant but in that repurposing way."*

The model is not in reality commissioned but runs within the existing budgets, and takes the existing arrangements and slightly changes them to work in a slightly different way.

> *"We're very keen not to create a third layer, or an in between layer, between this hospital specialist and the GP… That middle layer actually you don't need it and you're just creating another interface. If you get the integration right between the hospital service and the GP, actually it's seamless and works very well."*

The commissioning arrangement is a memorandum at the moment between the hospital and CCGs that includes a memorandum of understanding around information sharing and clinical governance. A key concern around integration is the blurring of boundaries around who has clinical responsibility for patient.

> *"[The memorandum] articulates that if they're seen face-to-face, it's the paediatrician, if they're not seen face-to-face, it's the GP or the dietitian or the health visitor or whoever made that, not referral, but raised the case for discussion."*

The model is based on developing connections and relationships across the system, which lead to efficiency and quality improvements despite the significant financial disincentives in the system (e.g. payment by results or current commissioning approaches).

5.2.7 Building the partnership

Engaging GPs is difficult as they are so busy, but can be done by starting with an enthusiastic GP willing to participate and then bringing others on board through word peer to peer influence.

> *"[The first] went so well that you start to get GPs talking to each other and saying: 'do you know what happens, we get the paediatrician coming in, it's really good,' and then you start to have other practices going: 'can we have what they've got?' And it grows, that peer to peer influence is phenomenal, and very important."*

The key thing is not to try and target practices with populations of greatest need, but to be flexible, start with willing ones and then grow via word of mouth.

> *"We had a really interesting experience… the commissioner said: 'right we're going to look at the highest referrers and get them to do this'. And tried to impose it on GP practices, and it was really interesting watching these practices go: 'what, are you telling us that we're doing something wrong?' They became terribly defensive and put up enormous barriers. But if you do it in a different way and say: 'OK, one case that actually it would be really helpful for me to come and see that case in your practise. And then do you want me to see a few more next time?' And it grows. And helping the GPs to realise that they can benefit from it, and their patients can benefit from it. And it's whatever they want. So you have to be very flexible with your model."*

Maintaining stability across all of the partners can be difficult as the hubs can be unstable: the more stable hubs tend to have continuity of people. However, having systems and processes in place helps, for example collating who was present at every clinic and then contacting a specific professional who has not attended for several months.

It is helpful to have someone based in the GP practice who is a clinician/GP who is nominally the lead but who is a permanent member of staff plus someone nominated from the admin team who can schedule and support the clinics.

> *"If it's not owned by a member of the permanent body of GPs it will then tend to disappear as that individual moves on. So it's quite important to get a member of the permanent clinical staff who has nominal responsibility. It doesn't take any of their time, frankly."*

Rotating clinics around all the GPs in a practice creates trust and relationships between all members of the primary care team and the paediatrician, instead of it being a one off or transactional activity. In effect, it is developing a community of practice.

From a system perspective it is very helpful to have administrative and data analysis/information reporting support from a central team.

5.2.8 Community engagement

Interviewees felt that it is essential to start with patients, families and the public and then ensure that their views and experiences are built into the model.

> *"When we started and co-produced this with them, they built themselves into the model, and that's been fantastic, so it's not about a one-off engagement, but it's using our patients, our citizens, as equal partners. And I suppose we very quickly realised that we could change the way we were working as professionals as much as we wanted, but if we didn't bring patients with us, they would always carry on doing what they were always doing. So that is very important."*

> *"Just really keeping that focus on what really matters to patients is extremely important."*

CC4C has a post that supports engagement and co-production with children and families. They have built up a wide network of individuals and organisations to work with them, including Maternity Champions and local Community Champions, who are integral to the model. The model originally hoped for strong involvement from practice champions (recruited from the practice population or from existing public health sponsored roles). However, despite a lot of effort from CC4C, the champions were not being "owned" or led by the GP practices, and so the work was stopped.

> *"I think it must have been a combination of the GP's not feeding ownership of it or not having the time and resource to build it and then also that there were already existing community groups. So maybe it was a bit of duplication. You could be a Community Champion if you had those interests and maybe you might already be involved with that. I think better to, or at least from our learning, for us it's better to tap into what's existing rather than trying to start something new."*

CC4C undertook work to identify the main concerns of parents at the start of the pandemic and then provide them with answers from GPs and the wider child health community in the form of online FAQs/resources. This included a one-pager that could be shared on Whatsapp within local communities with an NHS accredited logo to show that the information was trustworthy. It was also shared with professional networks to pass it onto their own patients.

> *"That whole coproduction of resources that would help in this very difficult situation happened extremely quickly and easily, and I think once you've got a system up and running and you develop those relationships and that community of practice, actually then dealing with the unexpected becomes much easier and is done much better, and it felt as though we had actually created a very good system, and it was tested and it shows that it was resilient."*

CC4C held a workshop for families in spring 2021 to work with the local integrated care system to help them set what objectives they should have for children and young people. This comprised a representative group from across the eight boroughs CC4C serves in North West London including: children and young people with long term conditions, educational needs and disabilities; parents/carers; families and young people with English as a second language; looked after children; young people's health and wellbeing advocates; community volunteers; health research teams; and HealthWatch.

> *"We wanted to reflect on what we were doing, and how that was supporting our local families. I suppose most of all we wanted to hear what really matters to children and young people."*

Six key themes emerged from this workshop:

1. Access to mental health support.
2. Mental health support in schools.
3. Navigating the system.
4. Young people's ownership of their healthcare.
5. Pressures on parents.
6. Maintaining a healthy weight.

Under the theme of young people taking ownership of their healthcare, the workshop heard that they really wanted clear and concise communication from health professionals but that communication (either during an appointment or through letters) is often directed to the parent rather than the young person which makes them feel disengaged. As a result CC4C is now undertaking a project looking at how they can improve young people's ownership of healthcare, especially how young people can access healthcare and when they can do that independently.

> *"And we decided to focus on this partly because [parent's] oldest daughter had just turned 16 and was going through the transition into adult care, and facing a lot of bureaucratic admin issues and other issues, so we thought that was that real catalyst focus on this."*

Posters with QR codes link to the surveys on what young people feel around things like consent, confidentiality and owning own their healthcare, plus a survey for parents on health professionals. They are also doing some emotional mapping, asking a young person to tell their story/experience of healthcare, with the positives and negatives at each stage of their journey, to identify areas to focus on plus what really matters and brings value to them.

> *"There are some great quotes about when you actually feel listened to and looked at as a person, and what a difference that makes to a young person."*

CC4C is also supporting new mums about their concerns, queries and when to worry, to inform the children's health advice and tips sessions that are run.

> *"We also had longer conversations and parents sharing what a difference it meant to have contact with a healthcare professional, especially during the last year. And the reassurance of being able to get your questions answered, but also being able to share knowledge as a group and have that support from the group of parents. We're looking forward to continuing more of the chat sessions, and I think again it will be a mix of online and in-person sessions."*

5.2.9 Information and reporting

North West London has developed the Whole Systems Integrated Care (WSIC) data sharing system: for details, including the toolkit, click here) so that professionals treating or caring for an individual are able to view selected information about that individual's health, social care packages and their personal goals and aspirations. This is done via an integrated care record created using information from the range of care providers involved in an individual's treatment. It is stored in a data warehouse and its use is governed by a legal document, the Whole Systems Integrated Care NWL Digital Information Agreement.

Additionally, there is a suite of tools available to clinicians and care professionals who are providing direct care to patients - the WSIC Dashboards. These provide a linked integrated summary of a patient's health and social care which can be used to case find and case manage patients who require more targeted and proactive care. The Dashboards aim to support clinical staff in improving timeliness and quality of care for patients across North West London.

> *"The whole systems integrated care shared data set system that we are quite lucky in North West London, it's quite well developed, it's been around for a long time, and there's something like 98% agreement from patients to have their records shared. And that enables us to look at activity in the round, and you start to see children who are frequent attenders of A&E and GPs and a community service."*

WSIC currently shares only NHS data. The process to pull in local authority data to the WSIC system is just starting, beginning with safeguarding data on child protection and looked after children and then bringing in the height and weight programme. The aim is to then bring in other data such as housing, income benefits etc.

5.2.10 Wider determinants of health and wellbeing

Integrated care is often built around patient pathways. In stratifying children and young people, CC4C strongly advocates a 'whole population' approach, where broad patient 'segments' can be identified:

> *"It's about being able to be population health-based, and to think about the equalities, to improve access and equity. So rather than me or a paediatrician waiting in hospital and waiting for a child to get sick and come into the hospital, we can go into the GP practice and say: 'who are your children and how can we help?' It's a completely different dynamic."*

5.2.11 Lessons learned and advice

A significant lesson learnt is to not expect something to start on day one but allow a year or 18 months for it to evolve and then to allow it to continuously evolve.

> *"I think it's really important not to expect to make this happen overnight or in one step. You do a bit and it grows and changes and it embeds and then matures."*

> *"I think when we first started, people felt that once we've been operating in a GP practice for a year or two, that the GPs would be upskilled, and we'd do ourselves out of a job, but actually all you do is then manage more and more complexity and deal with more and more upstream change. So you start to anticipate those children and look at the population in the practice and say let's look at the children with autism and let's bring an autism specialist in and work with you to support those children. Let's look at the children who are on the looked after register and bring in the looked after children's nurse and help them to be better managed. There's always more that you can do."*

One of the main things that worked well in developing the CC4C model was involving parents and patients. It is important for the model to remain very patient centric in everything it does, and meaningful co-design with children, young people and their families is valued highly. However, it is better to tap into existing networks rather than trying to start something new.

Having an ethos of learning and of reciprocity, and then being flexible – as there is no one size fits all - is another key success factor.

Creating strong relationships across the system is of great value, as is the strength developed when a model of care reaches out to professionals from many different backgrounds. Creating pull from the GPs was a good way to involve them and get them engaged in the model.

> *"I do think that GPs are consistently bypassed in any sort of system change or they have stuff imposed on them. They're not used to saying this is actually what works for us, and we need more of this."*

Involving junior doctors and trainees in the community of practice that develops around the Hubs is very valuable.

> *"We need to within our ecosystem get tomorrow's doctor's working differently… Even just within the local GP and paediatric and health visitor and other training units, inviting them in to be part of that community of practice, really valuable."*

One key lesson is that it is difficult to instigate large-scale change with so many financial disincentives in the system.

One interviewee said that they have learnt not to be ambiguous about information governance and to state it very clearly.

> *"The thing about information governance as well, which is that if you're talking about children, but the parents haven't given permission for that, then you have to do it anonymously. When you're all there sharing information, that's what we want people to do, actually it's easy to slip up and not be rigorous about information governance. So that's quite important."*

5.2.12 Impacts seen so far

Impacts have been seen across four key domains.

1. Improved experience of care:
   - Outstanding feedback of patient and family experience.
   - Patients preferred appointments at the GP practice, gained increased confidence in taking their child to the GP and all respondents said they would recommend the service to family and friends.
   - As a result of being seen in the Child Health GP Hub 88% of parents felt more comfortable about taking their child to see their GP in the future.

   > *"We have some PREMs, patient report experience measures, that are very gratifying, really very strong feedback. I think patients generally are kind and generally do say nice things if you ask them. But the bit that we find very important here is that 88% of parents felt more comfortable about taking their child to see their GP in the future. So something about that thing about making the GP practice the 'happening' place, you don't have to go to hospital to get good child health support."*

2. Reduced per-capita cost:
   - Observed reductions in hospital activity from GP practices involved in a hub: 39% reduction in hospital outpatient appointments, 22% reduction in ED attendances and 17% reduction in paediatric admissions for Hub patients.
   - Initial economic evaluation conservatively assuming 30% reduction in outpatient, 8% reduction in ED and 2% reduction in admissions for **two** GP Hubs serving 8,672 children. Annual costs = £153K; Annual tariff savings from reduced hospital activity = £320K; net annual saving = £166K or £19.20 per child in the population. Within CC4C's more mature system, where there are

more Hubs in place and therefore better economies of scale, the system-wide savings are estimated to be £28 for each child in the population.

- Better use of existing resources through connecting care.

  "We shifted 40% of the activity from the hospital to the GP practice, so physical clinic patients, 40% of them were being seen in the GP practice. Another 40% came out of the hospital and disappeared altogether. So there's a total 80% shift out of hospital. But a 40% productivity if you like, because the parents felt more confident, the GP felt more confident, it was easy to deal with conversations through a quick conversation. So this more than funds itself."

3. Improved population health:
   - Segmentation model allows for specific preventative interventions – eg:
     - Focusing on all children with asthma having a clear action plan at home, school, GP & hospital.
     - Improving the proactive management of dental health.

4. Improved staff experience & learning:
   - Relationships strengthened between primary and secondary care. C4C trains and supports GPs in paediatrics and paediatricians in primary care.
   - Professionals valued the improvement in knowledge and learning and, most significantly, the development of trust and collaboration.
   - All GP trainees, First Year doctors and ST1-3 trainees in paediatrics at Imperial now get experience of the Hubs.
   - Relationships and connections are built through learning.
   - Described as *"the best CPD I have ever had", "the best three hours of my month"*.

     "It is a really good positive experience for the professionals involved. And the other evidence of that is that they keep coming, they're not paid to do this, but they will attend because they value it and it matters."

The Child Health Hub has been implemented elsewhere in the country, and the initial impacts in Hampshire and the Isle of Wight and in Northern Ireland are shown in the diagram below.

"A lot of people will say oh this works for London but it won't work for the countryside, or it's dependent on local one-off individuals. But it's not, it's happening across the board."

CC4C, A multi-site evaluation summary

The **Child Health GP** Hub has now been implemented across the country. What has been the experience of this new model of care? Here's some information about how it's worked in three very different locations across the UK (**Hampshire, London and Northern Ireland**)

Detailed information for each site is provided on the next page

Click the links in each bubble to find out more

	Hampshire and Isle of Wight Sustainability and Transformation Partnership	connecting care for children	Southern Health and Social Care Trust
What is the impact?	• A reduction in GP appointments, 13% • Reduction in first outpatient appointments, 20% • Evaluation data	• A reduction in outpatient appointments, 81% • Reduction in A&E attendances, 22% • Paediatric admissions, 17%	• Positive impacts reported by clinicians • Improved relationships between primary / secondary care
What do GPs think?	• Found the clinic/MDT useful • More informed about childhood health problems • Would recommend to colleagues	• Closer working in the system • Improved paediatric skills & management • Built on natural interest in Paediatrics	• They benefited from the Hub • Discussions were of a high quality • This would impact patient interactions a great deal
How do patients feel?	• A preference for the GP surgery • Involved in decisions • Would recommend the service	• Listened to • Involved in decisions • Confident in the care they were receiving	• Preferred being in a Hub • Felt they would recommend to others • Were happy seeing a GP with a paediatrician
What do paediatricians think?	• Positive about the ability to work as a team across primary / secondary care • How rewarding clinics were • Reduction in referrals	• Positive about the ability to work as a team across primary / secondary care • How rewarding clinics were • Reduction in referrals	• Hubs improved relationships with GPs • Provided a better understanding of social aspects • There was a positive impact
How do I find out more?	• Kate Pryde, Paediatrician • Email Kate • Alison Day, Commissioner • Email Alison • Video	• Mando Watson, Paediatrician • Email Mando • Rianne Steele, Programme Coordinator. Email Rianne • Email us; Video; Website	• Jonny Henderson, Paediatrician • Email Jonny

5.3 Evelina

5.3.1 Background

The Evelina Children and Young People's Health Partnership (CYPHP) is working in the London boroughs of Lambeth and Southwark, that are characterised by mixed ethnic populations and varying levels of deprivation. It is said to be unique in the UK and across Europe in its cross-organisational, system-wide, transformative and academically rigorous approach to improving child health services.

The Evelina CYPHP comprises the following organisations:

- South East London Clinical Commissioning Group.
- Kings College Hospital NHS Foundation Trust.
- Evelina London Children's Healthcare (part of Guy's & St Thomas' NHS Foundation Trust).
- South London and Maudsley NHS Foundation Trust.
- Lambeth Council.
- Southwark Council.
- King's College London.

The aim of the Partnership is to improve round the clock children's health care by:

- Improving primary care access to paediatric advice and skills - to have faster and easier access to specialist advice and care.
- Supporting children, young people and families to live the lives they choose, by helping them to fully manage their condition physically and mentally - improving the management of long term conditions and mental health, starting with asthma and epilepsy.
- Reviewing the needs of young people and seeing how services could better meet their needs - building on young person centric models and co-designing with young people a service that meets their health needs.
- Creating a virtual academy - supporting education, self-management and accessible information for children, young people and families, plus supporting a whole school approach to health and wellbeing. This aims to drive transformative changes in professional education and training, and support children, young people, and families to improve their own health and wellbeing.

The focus is on:

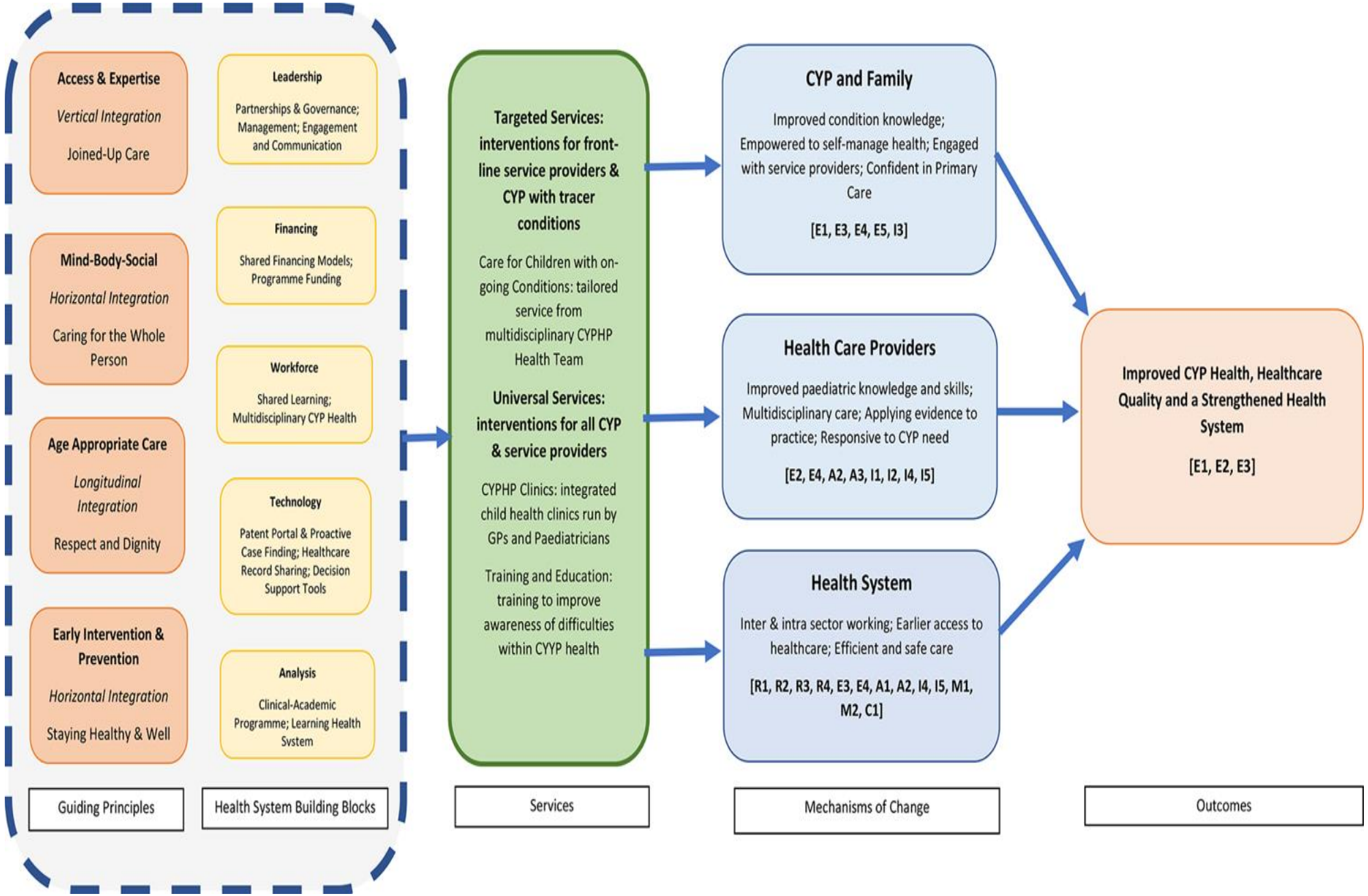
- Preventing ill health.
- Helping children and families to better manage their health.
- Building on existing services and strategies.
- Supporting staff to develop skills and approaches.
- To better help families and children.

The model of care is designed to deliver significantly better health, better healthcare outcomes, and better value for children and young people. Hosted by Evelina

London, CYPHP is an alliance of health professionals bringing care out of hospitals and into the community to intervene early and prevent long-term disease.

The CYPHP programme aims to produce:

- An evidence-based, clinically effective and cost effective, comprehensive day-to-day healthcare model for children and young people that meets current and evolving health needs.
- A learning healthcare system so that continuous improvement becomes part of everyday practice.
- Rigorous evaluation that builds the evidence base for improving children's healthcare and strengthening health systems.


Access & Expertise
Vertical Integration
Joined-Up Care
Mind-Body-Social
Horizontal Integration
Caring for the Whole Person
Age Appropriate Care
Longitudinal Integration
Respect and Dignity
Early Intervention & Prevention
Horizontal Integration
Staying Healthy & Well
Leadership
Partnerships & Governance; Management; Engagement and Communication
Financing
Shared Financing Models; Programme Funding
Workforce
Shared Learning; Multidisciplinary CYP Health
Technology
Patent Portal & Proactive Case Finding; Healthcare Record Sharing; Decision Support Tools
Analysis
Clinical-Academic Programme; Learning Health System
Targeted Services: interventions for front-line service providers & CYP with tracer conditions
Care for Children with on-going Conditions: tailored service from multidisciplinary CYPHP Health Team
Universal Services: interventions for all CYP & service providers
CYPHP Clinics: integrated child health clinics run by GPs and Paediatricians
Training and Education: training to improve awareness of difficulties within CYYP health
CYP and Family
Improved condition knowledge; Empowered to self-manage health; Engaged with service providers; Confident in Primary Care
[E1, E3, E4, E5, I3]
Health Care Providers
Improved paediatric knowledge and skills; Multidisciplinary care; Applying evidence to practice; Responsive to CYP need
[E2, E4, A2, A3, I1, I2, I4, I5]
Health System
Inter & intra sector working; Earlier access to healthcare; Efficient and safe care
[R1, R2, R3, R4, E3, E4, A1, A2, I4, I5, M1, M2, C1]
Improved CYP Health, Healthcare Quality and a Strengthened Health System
[E1, E2, E3]
Guiding Principles
Health System Building Blocks
Services
Mechanisms of Change
Outcomes

5.3.2 Service model

The integrated model of care is part of a health systems strengthening programme and comprises proactive case-finding and triage, specialist clinics and transformative education and training for professionals working with children and young people. Services are delivered by multi-disciplinary health teams with an emphasis on increased coordination across primary, community and hospital settings and integration of physical and mental healthcare that accounts for the children and young people's social context.

Children and young people health teams work together across settings and professions in the best interests of children, young people, and families. They work as closely as possible to where children and young people are – home, school and community health settings and, when necessary, hospitals. Children and young people health teams include:

- GP's.
- Paediatricians.
- Psychiatrists and mental health workers.
- Physical and mental health workers within health, social care and education.

Everyday healthcare is about improving the quality of care for common and minor illnesses:

- Children and young people health teams and clinics working in primary care.
- Bio-psycho-social assessments for children and young people-centred care.
- Paediatric hotlines for real-time specialist support to primary care.
- Decision-support tools and guidelines integrated into GP IT systems.
- Young people friendly access to healthcare.
- Children and young people friendly technology and support for behaviour change.
- Special focus on looked after children.
- Transformative education and training for health professionals, youth and social workers, teachers, parents and carers.
- Health promotion as core to healthcare.
- Everyday healthcare links with local Hospital at Home services and Children's Acute Referral and Ambulatory Care Services.

Long term condition care is comprehensive care that considers the body, mind, and social circumstances of children and young people with chronic conditions such as asthma or epilepsy:

- Children and young people Health Teams and Clinics in primary, secondary healthcare and community settings.
- Bio-psycho-social assessments for children and young people-centred care.
- Schools are part of health teams.
- Behaviour support change.
- Medication reviews by pharmacists.
- Social and youth workers.
- Health promotion is a core part of care.

CYPHP is part of a Learning Healthcare System for children and young people. It uses the best available evidence to shape and deliver care, and evaluate its work as part of a cycle of continuous improvement.

The work of health professionals at CYPHP is based on three primary commitments:

1. A **child and young person centred approach** to care.
2. Making every day healthcare for children and young people **efficient and effective**.
3. Using and creating the **best available evidence** to improve children's health.

These things are achieved by:

- Creating children's health teams working together delivering everyday care closer to home and school.
- Promoting good health, delivering proactive care, and empowering children and families.
- Fostering a culture of equity in healthcare.

5.3.3 Values and behaviours

Evelina have selected the following values with regards to leadership behaviour amongst their staff. These include:

- Leading with kindness.
- Remaining visible and engaged.
- Maintaining absolute focus.
- Being open and honest.
- Collaborating and connecting.

5.3.4 Designing the Model

This model of care was set up as a clinical academic partnership, designed to improve the evidence base for children's healthcare.

> *"I am interested in solving the problems that I've experienced as a general paediatrician, and I'm interested in informing a solution to those problems with evidence, as an academic, and evaluating what we're doing."*

Rather than being a managerially led transformation and improvement programme it was set up as an at scale clinical academic programme but: *"much more practical and embedded in the real world than research sometimes can be".* In effect, a complex intervention was designed and tested with a cluster randomized controlled trial across 12,000 children.

> *"Not led like a research project, led as a partnership. So, we found a kind of a different way of combining a practical approach to changing services with a research project that would generate evidence and that took a long while to figure out."*

The model was created following a health assessment to understand the patterns of need including met and unmet need and also a mapping of local services. Co-design work was then undertaken to design the model which has then evolved over time.

> *So, there was never a kind of this is what we're going to do and then we did it, no at all. So, it's been a kind of evolution as we've gone. And it took a few years to come up with what then became a fairly fixed, well not very fixed, but a clearly defined model."*

A significant amount of time was spent at the start to identify and define the model's enablers, which are based on the WHO health systems framework. The enablers include workforce, financing models, technology, data and governance.

> *"[It's] a health system strengthening initiative, it manifests as a model of care, but actually it's about the system. And so that was a really important lesson. You can't just say, well, we're going to do care this way without having made sure that your workforce is actually able to deliver that and be sustainably and appropriately trained and supported and connected."*

> *"[Electronic health records] have to communicate with each other, but how on earth do you do that? Really hard. And how do you overcome the situation whereby for example, if you were a general paediatrician employed by a hospital, but you're working in a primary care setting and you want to organize some tests for your patient back at the hospital, you have to refer to yourself!"*

When designing the model, the hypothesised active components of interventions were mapped against the 12 WHO domains, detailed below.

	CYPHP model of care		Enhanced usual care		
Domain	**CYPHP care for tracer conditions**	**CYPHP 'in-reach' clinics**	**CYPHP Health Checks for tracer conditions**	**Support tools and services for health professionals**	**Education and training**
Knowledge: an awareness of the existence of something	One-to-one appointments where patients can ask specific questions.	One-to-one learning in joint clinics where there is opportunity to learn knowledge.	Health Packs describe to patients the causes and triggers of their condition.	Evidence-based guidelines, algorithms and referral guidance for common conditions (eg, urinary tract infection, headache, allergies).	Training to improve awareness of difficulties within CYP's health to: ► General practices; ► Personal advisors; ► Teaching staff.
Skills: ability or proficiency acquired through practice	► Multidisciplinary working within health team fosters improved competence to tackle mental and social concerns of CYP. ► One-to-one visits with CYP helps improve self-management skills (eg, use inhaler correctly).	General practices working with consultant to impart skills in managing certain conditions.	Health Packs designed to provide valuable skills-based techniques in managing condition rather than simply provide information.		Training for: ► General practices on how to communicate more effectively with CYP. ► Personal advisors to better support CYP leaving care. ► Teachers on promoting emotional resilience in CYP.
Social or professional role and identity: a coherent set of behaviours and displayed personal qualities of an individual in a social or work setting	Multidisciplinary culture of health staff team places emphasis and responsibility on treating social and mental health concerns in addition to focusing on physical condition.				
Beliefs about capabilities: self-efficacy or acceptance of the truth, reality or validity about an ability, talent or facility that a person can put to constructive use	Encouraging CYP and families to better self-manage the child's condition.	Teaching other general practices how they can better manage a child's presentation of illnesses.			

	CYPHP model of care		Enhanced usual care		
Domain	**CYPHP care for tracer conditions**	**CYPHP 'in-reach' clinics**	**CYPHP Health Checks for tracer conditions**	**Support tools and services for health professionals**	**Education and training**
Beliefs about consequences: acceptance of the truth, reality or validity about outcomes of a behaviour in a given situation	Routine visits help encourage positive patterns of behaviour and deter negative patterns of behaviour by providing feedback by health team.		Information about what will happen if CYP do not better manage their condition.		Training on the lasting impact of not treating CYP mental and physical health early to general practices, teachers and personal advisors.
Motivation and goals: intention or mental representations of outcomes or end states that an individual wants to achieve	Goal-based outcomes used routinely as part of clinical care to help encourage CYP to manage condition for a reason that is salient to them.		Goal setting exercises help CYP realise why managing their condition is relevant.		
Memory attention and decision processes: the ability to retain information, focus selectively on aspects of the environment and choose between alternatives	Clinical templates to aid nurses to talk through physical, mental and social barriers for CYP not self-managing their condition effectively.		Health Pack material for CYP focuses on self-monitoring techniques (eg, take medication, plan for likely triggers).	► Clinical templates guide general practices on how to talk about issues commonly faced by teens. ► Guidelines advise appropriate actions.	
Environmental context and resources: any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence and adaptive behaviour	CYPHP nurses are flexible to allow some patients home visits so that they can better understand the triggers for poor health symptoms. Appointments also longer to allow time for CYP to express their concerns.	Patients can receive specialist advice, with their general practice, within practices close to home rather than having to go to secondary or tertiary settings.		Resources embedded into local general practice data systems so that they can be accessed easily during a consultation to help general practices provide evidence-based best practice.	
Social influences: those interpersonal processes that can cause individuals to change their thoughts, feelings or		CYPHP clinics designed to encourage interaction with health professional peers			

	CYPHP model of care		Enhanced usual care		
Domain	**CYPHP care for tracer conditions**	**CYPHP 'in-reach' clinics**	**CYPHP Health Checks for tracer conditions**	**Support tools and services for health professionals**	**Education and training**
Emotion: a complex reaction pattern, involving experiential, behavioural and physiological elements, by which the individual attempts to deal with a personally significant matter or event	CYPHP health team is trained to focus on the emotional impact of the condition and treat with equal emphasis as the physical condition.		Health Pack material has sections focused on techniques to manage mood and emotional concerns.	Clinical templates to guide care place focus on asking about any emotional concerns the CYP may be experiencing.	All training is focused on the emotional concerns of CYP.
Behavioural regulation: anything aimed at managing or changing objectively observed or measured actions	Clinical templates promote standardised way of documenting care delivered and received.			Clinical templates and guidelines provide framework to guide clinical care.	
Nature of the behaviours: description of how the behaviour is conducted	Documented procedures on how to manage the physical, social and emotional concerns of CYP.	Behaviours taught through collaborative clinics will be taken by general practices to use in regular practice.	Visual information on how to conduct positive self-management behaviours.	Guidance on appropriate behaviours to follow in providing support.	Training to discourage maladaptive behaviours and foster new patterns.

The Evelina model was fortunate to secure funding to develop the model while still running existing services at the start, which allowed some breathing space.

> *"In order to develop a model like this from nothing, you need a period of double running. You can't stop a service and put in a new service, that doesn't work that way… So, we were in a very fortunate position to secure funding that allowed us to do that, so we could pay for the clinical staff separately. While the existing, current model of care was being delivered, that was very important to allow us a bit of space to breathe and so on."*

There were a number of principles for the intervention that Evelina wanted to deliver:

1. Care tailored to each child's physical and mental health needs in the context of their family and social conditions.
2. Children and young people health teams provide early intervention, health promotion, and care for the *whole child.*
3. Multi-disciplinary, integrated Children and Young People health teams plan and deliver care in the child's home, or primary and community health settings.
4. Health Checks and Health Packs provide supported self-management advice for families.
5. In-reach child health clinics delivered by GPs and paediatricians working together in place-based system of GP clinics within network multidisciplinary care with linked "patch paediatricians".
6. Emotional resilience building and mental health first aid at school.
7. Age-appropriate care for young people.
8. Support for parents and professionals in managing common problems and minor illnesses.
9. Training health and non-health professionals, including teachers, to identify and address the physical and emotional needs of children.

> *"We wanted our care model to be about bio psycho social health, i.e., not the asthma, but the child with the asthma, for example, so that you know, a child with a long-term condition, for example, will have a lot of mental and emotional issues, quite frequently. And then there's the social context of that child and their condition that matters hugely. So, the start point was their physical condition, but very mindful of their emotional world and their social world."*

The workforce needed to have skills around this kind of holistic care, so a training programme was developed. The clinical leadership team (which includes doctors, nurses and allied health professionals) required physical health and mental health and social health skills, i.e., from the local authority and public health.

> *"We started working together to think about what it would be like to deliver care that was that sort of joined up comprehensive and holistic. And how do you do that with that mix of people?"*

For example, a nurse role and training were developed that are different from the existing ones, being much broader and more comprehensive.

"We started with the community children's nurse who has usually got a background in something like health visiting or school nursing. So, they were very good at universal services and health promotion and so on. But they're also quite expert in paediatrics and sometimes in specialist things. Then they would develop more expertise in long-term condition management and also in mental health care… not trained mental health workers in this sort of model, but to be sensitive to, aware of and able to do a little bit of intervention, low level, sort of sub referral threshold, which is the commonest. And to be aware of and be able to deal with social things, so as a clinician, to be able to talk about housing and poverty, for example, in the same consultation where you're talking about asthma or constipation or whatever else it is, that was important."

5.3.5 Developing the model further

Changes from the original design of model have been quite substantial, largely as a result of changes in both primary care networks (PCN) and the integrated care system (ICS). Initially the model created its own clusters of GP practices, but it was difficult to keep up with changes and mergers so the model now uses the PCNs as the clusters.

"So now we have a local child health team that sits in a primary care network but is connected into the hospital and connected into the surrounding GP practices, that was slightly different than the way it was done before."

New initiatives have included the introduction of new healthcare teams and a stronger neighbourhood focus. The model is now a local child health offer that encompasses secondary and primary care, mental and physical health, health promotion and early intervention.

"There is a local paediatrician that is attached to a neighbourhood and that's rather nice actually. And a local children's nurse was attached to a neighbourhood. And I'm very pleased with that, actually it happened because PCN has happened."

Innovation is a key element of the London Evelina model that is continually being brought into elements of general practice whenever new problems arise or opportunities can be seized.

"So, you have to be opportunistic, and you have to be flexible enough to move with the times and to innovate when there's a problem that you need to overcome."

Improvements in services for children are under constant evaluation, particularly in the area of mental health around prevention and low-level support.

"So there's for example, a local initiative about providing much better community-based mental health provision. Everybody's really very aware of the epidemic of children's mental health problems. So, there's a real

investment in prevention and low-level mental health support, at primary care and community levels."

Another element being introduced is social prescribing.

"We jumped on that as well and thought, okay, well that was really useful because, you know, we can align that with the sort of social side of our work."

5.3.6 Governance

The structure of the partnership was set up to include clinical, academic and management elements.

"Those are the skills that are really important to bring, to bear on this kind of a programme… those are the three pillars, so that's important."

Governance was considered another important element in building elements of the partnership. The Board has three co-chairs – a provider, a commissioner and a parent.

"So, I set up what is in some ways, a complicated governance structure. And that was a co-chair system of three chairs. One was from a provider, one was from a commissioner and then one was a parent chair. They work together as a triad and rotate chairing meetings."

Also important for the partnership Board is that it is comprised of people whose sole focus is on children and that the governance structure addresses accountability.

"I wanted us to be explicitly accountable to the people that we actually serve, which is not our commissioning or provider bosses, but the families and the parents and so on."

5.3.7 Commissioning and Funding Arrangements

The partnership was set up to improve health care quality and efficiency within the system in a cost-effective manner. Any money made was put into services focusing on prevention and health promotion.

"And the hypothesis that underlay that efficiency point is that I wanted to be able to make the model cost effective for a start, but also to generate enough savings to try to redirect money into prevention rather than the sort of firefighting element that the NHS has to be led by."

A large portion of funding for the programme was provided from a local charity but this has been gradually reduced following the increase in funding from commissioners.

"So, by the end of the programme, it was fully commissioned. So, we were obliged then that helped us generate this model of doing a programme

whereby we delivered evidence to the commissioners and mangers as we went."

The current commissioning plan is complicated due to changes in the commissioning landscape which is evolving continuously. At present, the model is commissioned from the children's commissioning budget which means having to negotiate with multiple organisations.

"In order to deliver it, we need GP children's leads and that comes out of a primary care budget. So, we have to negotiate across the piece."

Co-ordinating or pooling budgets within primary care and mental health remain difficult for elements of the partnership, particularly the two hospitals that under national legislation have to compete with each other.

"Not so much of a commissioning thing, but a kind of payment side of this sort of competing priorities between primary and secondary care and also between two different secondary care hospitals."

The model effectively was going against the business model of an acute trust so it was very important to understand and manage their expectations.

"Their whole business model was about revenue generating through activity, and here I was saying we were going to set up this huge project to reduce activity. So that required a bit of negotiation also."

The model is co-terminus with local authority boundaries which provides a stable denominator.

"So, we started with two London boroughs, so we could define the geographic perimeters and the resident population. And so we have a set number of GP practices. We have a local authority footprint, and that in fact actually helped a lot."

5.3.8 Building the partnership

The interviewee described how the way for the model to connect with local authorities was through the Public Health teams. However, there is much less engagement with social care and the interviewee was clear that this is a model to improve the health system for children rather than improving the determinants of health.

Workforce challenges were considerable right from the start when setting up the team to run the programme.

"Starting from nothing, we had to design a programme and figure out… What is the shape of the programme and what do you need to run a programme like that, so that takes a while to figure out."

Resistance to the model by health professionals was substantial at the start, with many GP's and paediatricians resistant to the concept of being "skilled-up".

> *"There was a lot of resistance. And I mean, we clearly still get it. You know, well, 'what's in it for me?' We still have conversations sometimes like that. You're going to give me yet another thing to do. I'm a busy GP, I can't..."*

Building trust and relationships with external healthcare members is a difficult and time consuming process but essential to the progression of work on this programme.

> *"It takes a lot of time and effort. You have to go and see people in their own space, talk to them, build trust. Part of the reason care is so fragmented is because of the kind of interesting historical and cultural contexts of the way that we deliver health care."*

5.3.9 Community engagement

At the start of the process, a parents' and children's group was set up where the members were very heavily involved with designing the model and setting outcome metrics etc. However, they have not had an input since the model was implemented, although the process will go back to them as the evaluation draws to an end.

5.3.10 Information and reporting

There is not a single reporting system although everyone at primary care level uses one system and everyone at secondary care level uses a different but the same system. The systems are not yet joined up but plans are being drawn up to change this.

> *"Do they talk to each other? No. But will they, I am told they will do it. I can't say it's perfect, but we've invented work around."*

It has taken a year to resolve data sharing agreements and identify who has the legal ability to sign them.

5.3.11 Lessons learned and advice

The majority of lessons learned were based on how the programme was run rather than the model itself, in terms of looking at the health system that the model has to fit into.

> *"You cannot just say, I want this model and plunk it down. You've got to think about the health system in which it sits, that's important. Otherwise, you're really setting yourself up to fail. So, I think that's the most important lesson".*

Building up commitment and engagement from the professionals involved in the model takes time and is based on personal contact. There are still some resistance

and misconceptions to overcome between hospital and primary care staff. This is particularly valid to break down the historical organisational barriers and cultural hierarchies arising from the fact that GPs and paediatricians are trained differently.

> *"Shoe leather is the short and silly answer. It takes a lot of time and effort. You have to go and see people in their own space, talk to them, build trust… You really need to meet people on their terms and you know, me and my exciting ideas. You have to actually become part of the landscape. And so, building trust and spending time on building partnerships is so important."*

There are clinical leads for various topics with a small group around them. However, the full clinical leadership group is wide-ranging with a GP lead, a paediatrician lead, a nurse lead, a mental health lead etc. These leads act as the trusted spokesmen or advocates for the model, and engage with their peers when there are issues.

> *"We were very deliberate and specific about who would be the right person to speak in this context. So, for example, when we had thorny issues with GPs it wouldn't be me who would go and see them, it would be the GP lead. We were very deliberate and thoughtful about who was the right person to go. It's not just what, professional background, but also the personal characteristics or the connections or whatever. And sometimes it came down to things like, well, this GP in this part of wherever, I went to medical school with them 30 years ago or more and I can WhatsApp them."*

One way of breaking down barriers between organisations and workforces has been to focus on what the model is trying to achieve – i.e. achieving child health outcomes.

> *"The whole programme has been grounded in fixing the problems of child health outcomes. And so that gives us a kind of a moral unity of purpose. And that's been actually very important."*

One piece of advice from the interviewee was to be beware of excessive simplicity as genuine transformation is complicated and difficult.

> *"You don't need to do it overly complicated, but if you really want to genuinely transform things and make statements, outcomes, are complicated and it's hard. So, there's no getting around that."*

5.3.12 Outcomes seen so far

- Significant reductions in unplanned activity, at both secondary and primary care level: 72% reduction in ED contacts for children with asthma, 30% for children with epilepsy and 15% for children with constipation.
- Increases in care quality seen.
- For a population of 120,000 children and young people, in two highly deprived inner London boroughs, the costs of running the service are approximately £685,000 per annum. Net savings after five years running the new model of care, resulting from activity reductions, is projected to be £962,000. Savings

projections were calculated against a “do-nothing” scenario of steadily increasing activity trends over the past five years.

- Applying a tariff of £216 per ED contact, cost savings per 100 asthma patients are estimated to be over £15,000, for epilepsy to be over £6,000 and for constipation to be just over £3,000.
- CYPHP’s population approach is improving equity of access to care. Of the first 200 patients in the ongoing conditions service, most were from socially deprived areas, 68% were from black or minority ethnic groups, suggesting that the CYPHP model provides care for those with greatest health and social need.
- The average referral-to-treatment time for In-reach Child Health Clinics is 18 days.
- Families report more confidence in managing their child’s condition out of the hospital environment.

5.4 Greater Manchester

5.4.1 Background

The Greater Manchester Children's Health and Wellbeing Board (GMCH&WB Board) was established by the GMHSCP in May 2017 to provide co-ordination and oversight of children's health and care transformation and improvements across Greater Manchester. The Board has been explicit in being open about the factors affecting the health of children and young people and constructed this Framework to respond to the full range of those challenges.

This Framework (introduced in 2018) aims to:

- Ensure better co-ordination of the response to developmental delay.
- Ensure more reliable, earlier responses to emotional distress.
- Harness the contribution of schools and their health and care partners to support physical and mental health of all children, and particularly those with the most complex needs.
- Improve the management and support of children with long-term conditions to avoid the need for them to go into hospital.
- Ensure this support assists young people into adulthood with hope.

The GMHSCP does not directly deliver this Framework in its totality, rather the aim is to deliver the Framework in partnership with the Greater Manchester system by harnessing the experience, strengths and statutory responsibilities of Greater Manchester-wide groups and organisations including:

- Children, young people, families and representatives.
- The local authorities of Bolton, Bury, Manchester City, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford & Wigan.
- The social care and education departments of the above authorities.
- Health organisations including commissioners, primary, secondary and tertiary healthcare providers and researchers.
- All education organisations and settings from nursery to university including special educational needs and disability.
- Voluntary, Community and Social Enterprise (VCSE) and faith sectors.

The objectives are:

1. Develop all relevant plans, policies and programmes with children and young people and their families, reflecting the realities of their experiences and based on upon a children's charter.
2. Support the early life course of a child, starting with pre-conception right through to a child's early years, enabling children to be school ready, especially those with special needs.
3. Invest in mental health and resilience for children and young people, from pre-school right through to young adulthood.
4. Protect children and families at risk and strive to ensure that disadvantaged children become healthy and resilient adults.
5. Work in partnership with schools to equip them to play a pivotal role in improving children's safety, physical and mental health and help children with special needs to achieve their goals.

6. Reduce unnecessary hospital attendance and admissions for children and young people, particularly those who have long-term conditions such as asthma, diabetes and epilepsy.
7. Ensure that transition of care for young people to adult services meets their needs and ensures continuity of high quality care.
8. Develop a modern, effective, safe and sustainable workforce that delivers children and young people's services, ensuring people with the right skills and values are in the right places.
9. Use the power of digital technology and a commitment to joining up services to give children, young people and their families more control over how and when they receive services.
10. Be transparent in sharing accessible information that will be useful for children, young people and their families in making choices about services.

The objectives listed above have been split into two groups based on the readiness and resource requirements of the work for implementation - delivery objectives (split into two further waves) and enabler objectives.

The work incorporated into Delivery Wave 1, some of which is already being implemented, centres around:

- **Objective 2** – Early years and school readiness
- **Objective 3** – Mental health and resilience
- **Objective 6** – Preventing avoidable admissions, particularly for long-term conditions

The work in Delivery Wave 2 still requires additional work with GM-wide organisations to be further developed and resources for delivery identified. This wave centres around:

- **Objective 4** – Supporting and protecting children and families at risk
- **Objective 5** – Working with schools to improve all children's safety, physical and mental health and especially those with special needs
- **Objective 7** – Transition of care for young people to adult services

The Enabler objectives are:

- **Objective 1** – Including children in planning based on a children's charter
- **Objective 8** – Delivering a modern, effective, safe and sustainable workforce
- **Objective 9** – Using the power of digital technology to join up services
- **Objective 10** – Sharing transparent and accessible data to hold us to account for performance

5.4.2 Designing the Model

At the time of devolution when Greater Manchester set up its Health and Social Care Partnership, there was no national children's programme. However, this was a good opportunity to reflect back on the past and where partners wanted to go in the future, and to ensure that the children's agenda was a key priority within Greater Manchester.

> *"At that point they agreed that as the Health and Social Care Partnership was starting and we were looking at what would be our priorities, children absolutely needed to be in there. The Greater Manchester Health and Care Board gave the mandate to establish a children's programme within the Health and Social Care Partnership to make sure the Partnership were doing was improving the offer to our children, young people and families"*

Initially, the Greater Manchester Children's Health and Wellbeing Board oversaw the development in 2018 of a document called the 'Greater Manchester Health and Wellbeing Framework'.

> *"That was a document of 10 objectives and in that framework we had a number of enablers as well; most importantly, the voice of the children, digital transformation, and accountability and governance as well as workforce.*

The Greater Manchester Combined Authority (GMCA) produced a Greater Manchester Children and Young People's Plan in 2019 to run until 2022 with a broader scope including public service reform and how this could improve the lives of children. Both the Plan and the Framework are currently due for review to bring them together into one GM Children's Plan.

> *"Where we are at the moment and with the evolving integrated care system is moving towards one Greater Manchester Children and Young People's Plan which will embed health - both physical and mental health. It will be embedded with the voice of children at its heart and families."*

Stakeholder forums were used to undertake a deep dive into each of the 10 objectives, each involving children and young people. A recent forum in January 2021 was on integrated care, in terms of what this looks like for Greater Manchester, and had national, regional, and local speakers. Another in July 2021 was entitled 'Eat Well, Move More, Feel Better' and brought together partners across the voluntary sector, health, education, universities, and children and young people to look at how, as a population, they can improve according to these themes.

> *"A very good way of getting stakeholders into a room, taking a theme and really doing a deep dive in to it and then influencing the framework."*

Since the Greater Manchester Children's Health and Wellbeing Framework and the GM Children's Plan were published, the national CYP Transformation Plans, as part of the NHS Long Term Plan, has also been published which echo the deliverables within the Greater Manchester Framework. These include:

- Reducing hospital admissions for children with asthma, epilepsy and diabetes.
- Mental health resilience and support.
- Learning difficulties and Autism.
- Health support for children with long term conditions.
- Transition to adult services.
- Obesity.

As of October 2019, the Children's Health and Wellbeing Board had commenced substantial programmes of work focused on the following areas.

School readiness: the project recognises the 1001 critical days starting at conception and includes pathways of support that aim to stop families from needing help and offer help earlier. A programme team within the Greater Manchester Combined Authority led delivery of the 2 year programme which focussed on three priority themes: delivering an evidence-based model; embedding best practice pathways; and developing enablers. The programme developed and implemented the following best practice pathways: speech, language and communication; families with complex needs; physical development; antenatal early intervention and prevention and emotional, social and behavioural. The programme worked closely with the development of the parent and infant mental health pathway.

Mental health and resilience: a co-ordinated approach to tackling mental health which aims not only to put mental health on an equal footing with physical health but to start to deliver Greater Manchester's vision of making sure no child who needs mental health support will be turned away.

- The Mentally Healthy Schools and Colleges (MHS&C) Programme was commissioned to look at new ways of preventing mental health issues in young people through school-based interventions (now working with 125 schools and colleges in Greater Manchester). They commissioned a joint approach between Youth Sport Trust, Alliance for Learning Teaching School, 42nd Street and Place2Be to look at how their evidence-based approaches could create a whole school approach to improving young people's mental health. This was done through developing their physical and emotional literacy and by providing the right training, support and resources for an adult and young person workforce.
- The University Mental Health Service Project to improve student mental health across Greater Manchester has an integrated, single pathway and hub for all higher education students within Greater Manchester. The pathway is based on the needs and choice of the child or young person rather than limited to diagnosis or severity. The universities' services and resources are focused on getting advice and signposting and offering outcomes focused interventions. Higher Education settings are focused on getting more help and risk support. There is a strong process for joint working and movement between strands.
- The Children and Young People (CYP) Crisis programme has developed a Greater Manchester-wide whole system crisis care pathway that provides a

high quality and timely response to young people in crisis and their families and is accessible across seven days. The pathway is fully inclusive, has open access, holistic and multi-agency and provides a timely and proportionate response based on need.

- Addressing the needs of children and young people within the youth justice services under the mental health programme: The Health and Justice strategy has children and young people as one of its priority cohorts. The strategy aims not only to provide better more integrated support for those children and young people already in contact with the criminal justice system as victims or offenders but is also intended to stimulate a more preventative model, which will seek to intervene earlier to reduce the likelihood of offending or being victimised. The strategy contains a number of objectives related to improved identification of mental health needs and enhanced support pathways; improved health models within youth justice settings and custody suites; a suite of interventions to reduce violent crime as part of the Violence Reduction Unit; upstream interventions to reduce first time entrants to the criminal justice system; and developing a trauma informed workforce.

Preventing avoidable admissions, particularly for long term conditions: children living in Greater Manchester, with asthma, epilepsy and diabetes, were more likely to attend hospital in an emergency, than children with the same conditions living in the rest of England. Greater Manchester has developed a set of ideas which have been proven to work in other parts of the country - a 'Preventing Avoidable Admissions Bundle' – which has been shared with every area in Greater Manchester; every area has begun to make some changes to health services as a result of adopting elements of the bundle. The Strategic Clinical Network has brought together nurses, doctors and other people in health to develop clinical pathways to standardise the offer to children with asthma and obesity. Each area across Greater Manchester comes together every two months to share good ideas and learn from each other in communities of practice. Greater Manchester has invested in two pilot areas to test new ways of working and are looking at how these have made a difference. They have pulled together a 'tool box' to support young people when they need to move on to adult services due to their age. They have asked 120 young people to design the key things that they would like in a long-term conditions passport and are working with digital to look at options.

More recently GM has invested in pilots to integrate services to support healthy weight within early years and to develop asthma friendly schools. In addition, the programme has worked with an external digital company to design and develop a user-facing asthma app which is being piloted in one locality prior to evaluation and spread and scale across GM.

Children with special educational needs (SEN): A dedicated SEN Board was set up with joint membership between Clinical Commissioning Groups, education and Local Authorities. Following a stocktake of the health offer to Greater Manchester's SEN population, a system-wide action plan was developed for delivery 2019-2021. This includes identification of good practice in joint commissioning for SEN, spread and adoption of joint commissioning, standardising the Designated Medical Officer role description and improving the quality of Education Health Care Plans (EHCPs).

Supporting and protecting children and families at risk: a comprehensive review of the health offer to children and young people who have left the care system or are currently looked after was undertaken. The recommendations in the report shaped an action plan to improve the outcomes for looked after children and care leavers in Greater Manchester.

Children with complex conditions: a review of the health offer for children with complex conditions was run alongside the above review using the same approach.

Sharing transparent and accessible data to hold Greater Manchester to account for performance: a set of outcome measures was agreed to be able to monitor the health outcome of children and young people across Greater Manchester. The outcome measures were developed from across the system to reflect the deliverables in the Framework and developed into a dashboard that all localities are able to see to be able to monitor their performance.

Using digital technology to join up services: Early Years is digitising the 'ages and stages, questionnaire and health visitor information for ages 0-5. Driving locality engagement with the Graphnet IDCR (Integrated Digital Care Record) remains a priority for the Partnerships Digital Collaborative. Work to develop a Greater Manchester -wide data sharing framework (due to be completed by the end of 2019) would significantly increase the amount of information shared within the system and therefore its use to clinicians.

5.4.3 Further developments of the model

What the model for children will look like within the new integrated care system is still in development.

> *"But we have people who are absolutely passionate to support the needs of children and inform and support the system. But just at the moment we're still in a transitional phase whilst the ICS is established, and once the appointments are made to the executive posts in the ICS, once we know who is going to be the executive lead for children in the GM ICS, we can ensure the governance and architecture for children's is embedded within the ICS. Our ongoing work through the development of one GM CYP plan will be key."*

The focus on children is a positive development arising from the Framework.

> *"I think the fact that we have a system wide Children and Young People's Framework that was developed when the partnership was established; children became a really important part of the priorities within the Partnership. So, in a sense the profile for children and young people increased and that was a real benefit and positive move. The Greater Manchester Strategy, which is a wider strategy for public service reform, and encompassing all ages, not just children, has taken a life course approach which is also really important."*

One interviewee highlighted that the integrated care system and its public sector reform offers a real opportunity to bring a whole system agenda together to wrap around children and ensure that their health needs are not being separated out from all their other needs.

One interviewee is involved in integrating services for asthma and described how they are developing multi-agency teams in providing care. This work is based on the national bundle for asthma which has strands from the environment to prevention including acute admissions, education, analysis of data and digital innovations.

> *"We have tried to collect information from the ten locality areas, as to what is happening there, what the services look like."*

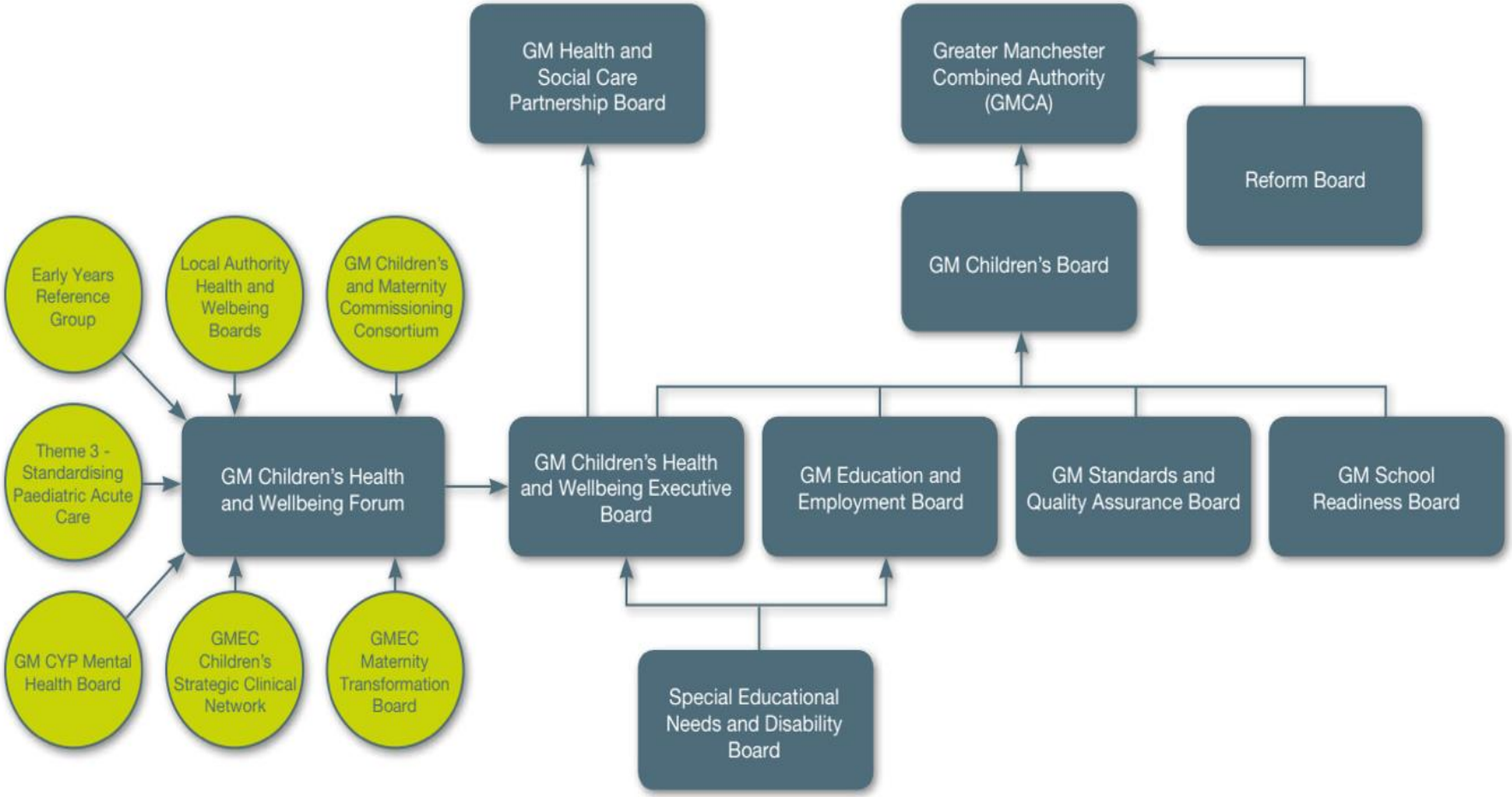
The work is linking into the National Asthma CYP Transformation Plans which is looking at what are the strands that would provide early wins nationwide. It is initially focusing on the provision of appropriate overarching strategies and action plans, and on gaining early, quick wins in terms of asthma management.

> *"We are looking at ways and means of how we provide appropriate management strategies to our children, so that the prescribers and the clinicians know what they are prescribing, what formulation they are prescribing, how are they going to monitor the Salbutamol (asthma reliever) use, how they are going to use the action plans."*

Work being done by the GM asthma working group includes creating an asthma guideline for each locality plus standardised information and resources for use throughout Greater Manchester, including educational leaflets for parents with a 'top ten tips' for asthma control. They are linking in with housing and smoking cessation and are working to outline what the Emergency Department role is in terms of follow up processes including referrals to the asthma clinic. Although a training bundle should be produced in mid-2022, for all professionals at level 3 (i.e. GPs, paediatricians) the group is devising a training package for use in the interim.

5.4.4 Governance

The Greater Manchester Children's Health and Wellbeing Board was set up in 2016 in shadow form before getting fully underway in 2017. This Executive Board was chaired by a Senior Responsible Officer (SRO) who was passionate about improving outcomes for children and who provided significant leadership to really embed the voice of children and their needs within the evolving model.


GM Health and Social Care Partnership Board
Greater Manchester Combined Authority (GMCA)
Reform Board
GM Children's Board
Early Years Reference Group
Local Authority Health and Welbeing Boards
GM Children's and Maternity Commissioning Consortium
Theme 3 - Standardising Paediatric Acute Care
GM Children's Health and Wellbeing Forum
GM Children's Health and Wellbeing Executive Board
GM Education and Employment Board
GM Standards and Quality Assurance Board
GM School Readiness Board
GM CYP Mental Health Board
GMEC Children's Strategic Clinical Network
GMEC Maternity Transformation Board
Special Educational Needs and Disability Board

The first task of the children's programme was to set out the Health and Wellbeing Framework outlining the commitments to be given locally to the population around improving outcomes for children, young people and families. A Children's Health and Wellbeing Executive Board was set up within the Health and Social Care Partnership to have oversight of this framework and the implementation of this framework. This Board includes multiple partners from education, local authorities and health and connects to the Greater Manchester Children's Board which is the board for the wider system (encompassing criminal justice, police, political leaders etc.) It reports into the Health and Care Board (about to become the Integrated Care Board).

Long-term conditions are managed through the Physical Health programme, aimed at reducing admissions for cases involving asthma, diabetes and epilepsy. This programme works in conjunction with and links to other programmes involved in the framework including the SEND programme, the early years' programme and the mental health programme.

The Greater Manchester Children's Health and Wellbeing Executive Board is currently accountable for the deployment of the physical elements of the Children's Health and Wellbeing Framework on behalf of the GMHSCP board and the Greater Manchester Children's Board. This board is supported to incorporate the needs of children with special educational needs and disability by the Greater Manchester SEND board. The Executive Board seeks to influence and support the work of the Greater Manchester Combined Authority in the development of the evolving Greater Manchester Children and Young People's Plan and in its wider programmes and through local organisations in, for example, addressing poverty, improving educational outcomes, promoting economic opportunity and securing better housing.

The Greater Manchester Children's Health and Wellbeing Stakeholder Forum draws together the widest possible input to help improve health outcomes and inform the decisions of the Greater Manchester Children's Health and Wellbeing Executive Board and the Greater Manchester Children's Board. The forum includes stakeholders from across Greater Manchester and most importantly children, young people, parents and carers with each forum deep dive being co-produced. The following groups who are delivering transformational change for children across Greater Manchester and are included in the Greater Manchester Children and Young People Stakeholder Forum include:

- Greater Manchester Children's and Maternity Commissioning Consortium.
- Local Authority Health and Wellbeing Boards.
- Early Years Reference Group.
- Transformation Unit Theme 3 – Standardising Paediatric Acute Care.
- Greater Manchester Children's Mental Health Board.
- Greater Manchester & Eastern Cheshire Children's Strategic Clinical Network.
- Greater Manchester & Eastern Cheshire Maternity Transformation Board.

Form July 2022 there will be a single ICS for Greater Manchester, encompassing the geographical areas of all of the nine boroughs within the region.

5.4.5 Commissioning and Funding Arrangements

One key enabler identified within the Framework is around strategic commissioning and how to bring the commissioning model together to be an integrated model. Work is currently underway on spatial planning and looking at what can be done at a Greater Manchester system wide level and what can be done at a neighbourhood and locality level.

Integrated commissioning is being implemented within certain areas such as healthy weight.

> *"We're very fortunate to get funding from NHS England for an integrated care pilot that we're setting up in Salford to look at healthy weight and that's bringing all parts of the system together... If that works as an integrated pilot then we would like to roll that out to other areas."*

The children's programme has been supported via Greater Manchester Transformation Funds from 2017 and investment in the early years and mental health strands have benefitted from these transformation funds. However, 2021/22 is the first year of receiving regional funding from the national children's programme that is allocated to the ICS. Additionally, with the system being brought together, there are other opportunities for resources that are contributing to the programme.

There is a memorandum of understanding for a virtual pooled budget for the programmes of work within the Greater Manchester Combined Authority. A current example is investment in an asthma programme that GMCA colleagues are being asked to endorse. Conversations on approving this are being held via groups that are already in existence, such as the chief finance officers or commissioners.

> *"We utilise existing governance routes to have those conversations to then lever further investment and flow of funds."*

The maternal medicine network is an example of a pooled budget and joint commissioning where the CCGs have come together to fund and commission at a Greater Manchester rather than locality level.

> *"The CCGs all had a minor funding in their baselines to commission a maternal medicine network, so we worked with the commissioners to undertake the service development at a GM level to do it once on a GM footprint rather than at nine different locality areas."*

From a health point of view, commissioning/service delivery is rarely done at a Combined Authority level but rather at the appropriate local level.

> *"We are very keen that it's at the right spatial level, and usually that is the closest to the patient as possible."*

Challenges arising from delivering services that are place-based and having an overarching outcome across the whole of the Combined Authority area are managed

through ongoing relationships and communication with key links to help build a consensus.

> *"Key links and relationships are key, for example collaboration between Directors of Children's Services, commissioners, clinicians, education leads, VCSE who all take a lead responsibility amongst their colleagues for children and young people. Those leads from across the organisational boundaries connecting together regularly in a two way flow of information and to champion consensus amongst peers with the voice of CYP and parents/ careers at the centre."*

5.4.6 Building the Partnership

There is an existing collaboration and "philosophy of connection" across Greater Manchester in terms of redesigning services. Two interviewees highlighted that this was fortunate for them as it provided a foundation to build on and meant that the programme was not starting from scratch. This allowed an "organic" development of relationships as opportunities to connect partners occurred before governance was officially established. A common understanding of the evidence base supporting the needs of children, young people and parents/carers led to a particular group within the Greater Manchester health system being developed or being given the mandate to lead on the improvement of child health outcomes.

One example where the Greater Manchester network was able to operate strategically in order to improve outcomes for children is the reconfiguration of maternity, neonatal and paediatric services between 2006 and 2012 under a review called 'Making it Better', when the number of acute paediatric inpatient units went from 12 to 8, a number of observation and assessment units were set up and the number of neonatal intensive care units was reduced from 3 to 2.

> *"It's very much about what can we do as a strategic organisation to improve outcomes for children, reduce variation and embed clinical leadership."*

Since the establishment of the Greater Manchester and Eastern Cheshire Strategic Clinical Network, increasing contact between this team and the Combined Authority (made up of the ten local authorities) alongside regular meetings with other key partners such as the Greater Manchester Provide and Commissioning Boards has led to much more mutual trust and understanding of the issues and language each use and to see where a system wide approach will benefit the Greater Manchester population of children and young people.

> *"The governance connects people as it should do, but then it's the fostering of those relationships is just down to those individuals reaching out to each other and encouraging those relationships."*

Building an understanding of the different priorities, agendas and vocabulary of each partner is important to maintain relationships. Having somebody within the programme that can be a connector, so who has an understanding of the different

agendas and how to try and make those work together to come to a solution, is useful.

More work is required in terms of addressing workforce challenges with regards to staff involved with the delivery of the Framework, in terms of identifying gaps and areas where the workforce needs to be strengthened. This work will look more widely at the child health workforce, so not just at paediatrics but also, for example, health visitors and school nurses.

Some areas (Salford in particular) have had joint posts and combined budgets across local authority and health for some time which work very well. These joint posts usually arise from the relationships where partners are discussing the same issues. For example, the early years midwife role is embedded in the local authority's early years' offer but attends regular meetings with midwives and obstetricians for peer support and to find out what is happening across the programme. A new SEND post is a tripartite one funded by local authorities, mental health and physical health that will sit within the local authority.

There will be a specific workforce theme within the revised Children and Young People's Plan and will link very closely to the ICS. The workforce theme will aim to bring challenges with staff closer to the agenda from a health perspective.

> *"I would say there are pockets of really good work going on but there's a way to go to try and get it joined up and to try and really extract the child health workforce or the wider children's health workforce. We have a real opportunity with the integrated care system with its statutory arrangements followed by systems and processes which we can work with and influence."*

Working cohesively and collaborating at a system level may be challenging following the integration of services, particularly as there is currently a low level of clarity over what the resulting model will look like.

> *"There's a historical and current culture across Greater Manchester of working together. There will be challenges of joining up, and currently there is really good work underway at the locality level, but with the CCG's going there's lack of clarity about what the future model will look like".*

It has taken time to identify the key staff for asthma/chronic diseases within each sector (including primary care, secondary and tertiary consultants, pharmacy groups and public health) and also within each of the ten boroughs in Greater Manchester. It has also been more challenging to engage with some colleagues due to the pandemic and pressures on the system.

> *"The difficulties we are having is trying to get the involvement of the relevant specialists in our asthma group. We do have some of the consultants, including tertiary specialists, but we do not have a representation from all ten areas."*

5.4.7 Information and Reporting

Reporting in terms of the integrated care system currently includes Covid recovery, asthma prevention and intervention, winter surge planning, and healthy weight. Additionally, there are close links to the programmes for early years, SEND, youth justice, looked after children, mental health, and population health. One interviewee felt that it is important to ensure that the right metrics are measured, including experiential as well as outcome measures.

> *"I'm passionate about it making sure we get the right metrics with this emerging GM children and young people's plan so that we make sure that we get, for example, experiential measures as well as outcome measures so that we get rich feedback on whether this plan is working for them and if not, why not and what do we need to do about it."*

Another interviewee felt that determining outcomes for children is very challenging due to the lack of data being collected for children. Therefore, the Greater Manchester Health and Wellbeing Framework aims to have an outcome for every commitment: some are easy to collect data on (e.g. admissions for asthma, avoidable admissions for asthma) while others are very difficult (e.g. transitions and how effective transitions have been).

The Greater Manchester Health and Social Care Partnership has the GM Tableau single information reporting system which encompasses all perspectives and contains data from each organisation. This currently mainly focuses on acute physical health and mental health data, although SEND data is being integrated into it at the moment. Both local authority and health leads have access to this.

This includes real time information for certain elements: for example, a new dashboard is currently in development, providing details of mental health beds available and shortages.

> *"They can look at the numbers of children who require mental health services on acute paediatric wards, so we've got something in real time as well which is really helpful, particularly with the winter surge planning."*

In addition, there is a Greater Manchester Combined Authority data analysis and business intelligence team which has their own data that they produce for the GMCA. Currently, this team obtains data from each organisation, but the aim is to integrate the various databases at some point.

> *"Currently we've got two dashboards across GM, but we work closely with each other. So, for example if my colleagues at the combined authority need information on asthma they'll come to us and we'll provide the information for them and I would say that will all come together as one. In principle, we've still got to get there".*

Greater Manchester does not have a single client management database (e.g. to identify families who might be receiving services from multiple partners). Salford local authority has developed the Assure platform for multiple agencies across

health, CAMHS, education, local authorities and criminal justice to share information to flag children and families that need some additional support. The national team has just provided integration funds that will be used to develop this further and then roll it out across all areas.

5.4.8 Community Engagement

Any work undertaken in Greater Manchester is underpinned specifically by the voice of children and young people, and it is seen as being very important.

> *"So, for each of those programs that I described in the framework it's really important that the voice is actually there, we're listening to their views, their needs and what they want and whether it's feasible as well and then it's a combination of the two".*

There is a co-production strategy in place across the programmes and co-production is seen as an integral part of service design/redesign.

> *"I think you have to set the bar high with this and to actually question even the statutory organisations and what they have to do. Why are you not co-producing? Why are you not listening to your children? Why are you not designing your approach or your language or your services according to the needs of children? And I think for quite a lot of professionals that's still very challenging, but I think we are seeing a shift in cultures and behaviours. Our ambition is to have co-production with CYP and families as the norm, and work is underway to "progress" this culture across all of the partner organisations."*

The aim is to ensure that co-production is seen as the norm, and work is underway to "push" this culture across all of the partner organisations.

> *"I'm a firm believer that we do need to co-produce. Anything that we do, it needs to be the right thing and make sense for our population and the only way we know that is to ask them what it is that they want."*

Currently, obtaining voice data is part of a dedicated work programme led by a voluntary sector children and young people's voice engagement lead, the CEO of Youth Focus North West, a lead clinician and the GMCA Programme Lead, supported by a GMCA programme manager, who sits on the Executive Board, together with a health manager and a local authority manager. They co-lead a Children and Young People's Voice Task and Finish group to inform and influence the evolving Greater Manchester Children and Young People's Plan. They are mapping out what voice groups already exist, using children and young people voice evaluations and the recommendations of the Greater Manchester Youth Combined Authority to inform the system at both Greater Manchester level and also at locality level. They are also developing a model of good practice for children and young people's engagement, using a child rights approach, and based on the Lundy model.

The voluntary sector already has the contacts, networks, and skills to undertake engagement and co-production work with children and young people. For example, Youth Focus North West is commissioned to engage with children and young people as they have well established links and champions that they work with to gather information, and its director sits on the Children's Board.

> *"Youth Focus North West are members of the GM Children's Health and Wellbeing Board and we remunerate their time on the board and to read board papers and then we separately commission, particular engagement pieces and co-production pieces. So, right at the we would commission Youth Focus North West to bring their children and young people together into a workshop where our children's programme and executives would be involved in including a Q&A session and a 'you said we did.'"*

A parent/carer forum feeds the parent voice into the SEND subgroup and some localities have SEND youth voice groups. There is a separate Greater Manchester Youth Voice Group and the Maternity Voices Partnership is commissioned to provide the maternity voice. It is felt to be very important that the voluntary sector's time for attending meetings is renumerated.

> *"We always have done, and we'll continue to utilise quite a chunk of that budget to make sure that we're working with our population."*

Information on the priorities for the Children and Young People's Plan are being analysed using data from surveys (such as the 'Big Ask', the Children's Commissioner's survey, and the #beewell survey being sent out to school pupils to ask about their wellbeing, their future, and their health) plus other appropriate research methodologies such as stakeholder forums, focus groups etc.

> *"It depends on what the question is and then we would apply what we think is the right method and we'd make sure that children and young people agreed with the method that was being used and then we'd collect whatever data or experiences that we required."*

A young people's charter was designed, but when children and young people did not like the word charter, it was changed to the Young People's Agreement. This comprises a number of principles and commitments that the Framework programme should adhere to. In order to monitor this, the young people have set up a young inspectors' programme and they have now done a number of assessments of health services. The young inspectors then produce a report, feed findings back to the organisations who 'traffic light' themselves and then compare this with the young inspector's traffic light system. This initiative has been kept going throughout the last 20 months with Covid.

> *"That's a way of saying 'you said, we did' and then they're coming back to assure it."*

5.4.9 Wider determinants of health

The integration agenda is bringing opportunities to include wider social determinants within the health and wellbeing agenda, as there is a shift from an interventionist strategy to a preventative one.

> *"A lot of what we need to do needs integration. So e.g. healthy weight and, asthma, are linked to the same social determinants such as poverty and deprivation. So, whilst health services can play their part, there needs to be a whole system approach and a shift from interventional to prevention through the life course to improve health outcomes."*

There are links between the Health and Wellbeing Executive Board and the Children's Board in the form of a Greater Manchester Children and Young People's steering group led by the GMCA that includes the lead representation for children's health (both physical and mental health), education, youth justice, social care, criminal justice and the voluntary sector. This group is providing system wide strategic oversight for the evolving Greater Manchester Children and Young People's Plan overall supporting and provides an 'air traffic control approach and signposting to the right part of the system' if urgent issues arise. The current refresh of the Greater Manchester Children's Plan is also providing an opportunity to make topics like asthma or healthy weight a Greater Manchester system priority. Within the emerging ICS, there is a need to ensure that children's priorities such as SEND, mental health, asthma, healthy weight, maternity and still births are in the locality plans.

> *"Lots of conversations at the minute trying to draw in those that have the responsibility and the influence of making sure that these priorities are reflected at all the spatial levels."*

5.4.10 Lessons Learned and Advice

Leadership was "absolutely essential" at the beginning to get the Greater Manchester Child Health & Wellbeing Board Framework and programme set up. Having an executive lead who has ownership of the children's programme and can then champion this at executive level is also essential, as is bringing in multiple leads from across the system.

> *"For example, we have a DCS and clinician co-chairing the Executive Board which, by spanning the different areas helps to deliver the outcomes needed. So, we need very much that senior leadership buy-in that children's is a priority across the different organisations, is critical to make sure that it's on the agenda when those conversations are happening. When strategic conversations are occurring, to have someone saying, 'But what about children's? What about what the children need?'"*

It is very important to include the views of children, young people and their families when starting to design or redesign services, and having strong advocacy on their behalf. Having the check and challenge from the voice of children and young people

has been useful, particularly as they have representation at the Greater Manchester Child Health & Wellbeing Board Executive Board and are happy to challenge what is being done, or not being done.

> *"They have absolutely no qualms in saying, 'Hang on we've raised this with you before. What have you done about it?' So, I think the co-production has been a critical factor as well."*

Having the right partners around the table is very important, as is building on the relationships already in existence. Engagement and liaising with key partners - both at a strategic and "shop floor" level - is essential in terms of understanding how services should be designed.

> *"Engagement with key partners is key really because it's not just the strategists, it's the people on the shop floor. You need to be listening to what they're saying to understand if you're going to design something."*

The development of relationships is key to making integration and the programme work.

> *"So, you can involve a DCS, you can involve a commissioner, you can involve the youth voice very, very quickly, and I think it's those relationships that get things done as well is essential."*

This was particularly important in the first years when there was very little funding for the programme.

> *"People need dedicated time to support the CYP programme in order to achieve the outcomes we would like to see. Demands on people's time is very pressured so having dedicated time and access to resource enables progress to be made."*

One interviewee highlighted that systems have to be realistic about funding and, if change is to be achieved, that some degree of investment is needed for transformation until it becomes business as usual.

Having a clear vision, a clear focus and a clear direction is vitally important to achieving outcomes, as is being realistic about what can be done. Motivating the staff involved and telling them what the group is aiming to achieve is seen as better than continuing to revisit the same issues time after time.

> *"I think we have got better at being tighter over the past couple of years, of really narrowing in what's going to make a difference and measuring it as well and being really tight on that."*

It is important for staff and partners to have a firm understanding of what the architecture and governance should look like and work in ways that allow them to meet the targets of the Framework.

> *"That would be working with partners to work out what we feel together would be the right model. Obviously you've got to work within the statutory*

boundaries, and I think where we've be able to get funding for certain programme or pilots or whatever and then we're able to roll that out, that's always an advantage".

Ensuring the right people are working together is something that is essential to consider when it comes to designing future models.

"It's always making sure you've got the right people in the room and if you haven't got the right people in the room then you suddenly find down the path there's a view coming in here and we didn't get that view."

The approaches that have worked well in terms of obtaining representation from different professionals on the asthma group have been persistence and contacting the right people (i.e. the organisational leads who know who to involve in their respective organisations). This has included early health teams, although they are not mentioned as a part of the national asthma bundle.

"The key process that we have succeeded at is ensuring that the admin team at the strategic clinical network, as well as the project managers and us, we link in with as many people who we know, to try and incorporate them into our group."

One challenge being faced is due to the other parts of the health system coming together in the evolving integrated care system, for example in terms of implementing national programmes and how to link them into the Greater Manchester Child Health & Wellbeing Board Framework and other programmes of work. Different programmes under the children and young people umbrella can have different funding flows and different deliverables, which can make delivery of a local improvement plan challenging. Having an agreed vision and set of objectives at a Greater Manchester level helps with this challenge and the new Greater Manchester Children's Plan will hopefully be an opportunity to develop this further.

All of the interviewees felt that using strong evidence is important, including examples of good practice or demonstrating evidence through examples of good practice. One interviewee said that the best lesson they have learnt is to identify examples of good practice happening in different areas and then incorporate the good elements into work streams.

"The best lesson personally is trying to get people to tell what the good things are that they're doing in that area. How successful have they been? Whether it has worked or not worked? Then using that model to incorporate into the strands."

Embedding a quality improvement approach to the programme and its development is important.

"Challenging yourself. If things aren't working, go back and look at why."

There are a lot of learning sets within Greater Manchester, where innovation and examples of good practice are shared. These are then either picked up for local

implementation or, if a Greater Manchester level is a more appropriate spatial level, they might be flagged to the wider system for spread and scale.

> *"Could you do anything at a GM level to adopt this, to support this? And that ask might be for financial investment, it might be for project management support around the PMO of it, it might just be support in bringing specific learning sets together around that piece of work but it would flag up, but also come back down through the system through the governance and the groups that we've got there already."*

One example of innovation currently is a patient facing asthma app which came out of a local priority and that is being tested and evaluated in one area. The Health and Wellbeing Executive will keep a close eye on this evaluation and will share it through the learning sets. If the evaluation says that it has been effective, then the topic will be discussed as something to roll out more widely.

In addition, innovation and examples of good practice, as well as areas of difficulty or challenge, are discussed at the monthly meeting of ICS leads in the region. For example, an asthma Community of Practice has been set up for the North West region.

5.4.11 Impacts so far

Some measures of improvement were evident prior to the Covid-19 pandemic (for example a reduction in asthma admissions and improvements in neonatal and maternity data). However, it has been difficult to monitor these during the pandemic and during the current transition towards integrated care.

The outcomes seen so far include:

- School readiness: Across GM, 68% of children achieved a good level of development (GLD) at the end of the early years' foundation stage, compared to 71.5% nationally in the academic year 2017/18. Despite having a higher number of families who may be struggling in their lives, Greater Manchester has seen positive improvements in outcomes for children in this group. Outcomes for pupils who receive Free School Meals have improved since 2015. Data for the 17/18 school year showed that Greater Manchester has closed the gap with the England average and that the work to support these children is beginning to have an impact.
- Mental health and resilience: the data shows that 45.8% of children and young people in Greater Manchester with a diagnosable mental health condition will have received treatment from an NHS-funded community mental health service by year end; delivering the national target of 35% for 2020/21 well ahead of ambition. In December 2018 Greater Manchester became the first place in the country to start collating and publishing publicly waiting times data for children and young people's mental health services and has committed to providing quarterly updates.

- Preventing avoidable admissions, particularly for long term conditions: In the first 12 months there were 154 fewer children that were admitted to hospital for Asthma, Epilepsy or Diabetes.

5.5 Hertfordshire and West Essex

Background

West Essex and Hertfordshire still have differences in the health, wellbeing and life expectancy for some of its residents. The Hertfordshire and West Essex partnership aims to create conditions for everyone to fulfil their potential and have a healthier future. The creation of the area's integrated care system, which is overseeing the transformation of health and care services, is an important step on the journey to improving the health and wellbeing for everyone in Hertfordshire and West Essex.

Service Model

The Hertfordshire and West Essex ICS – titled "A Healthier Future" – is responsible for the care of approximately 1.5 million people across Hertfordshire and West Essex (Harlow, Epping and Uttlesford). The ICS has the over-arching responsibility for getting the most for the population on a combined health and care budget of £3.2 billion, making the best use of skills of a workforce consisting of 56,000 members. It will provide clinical and professional leadership and ensure that the organisations pull in the same direction to help everyone – residents, service users, patients, staff – to achieve their potential.

The ICS is also responsible for setting the strategy and goals for improving health and care in the area and overseeing the quality and safety, decision making, governance and financial management of services. The goal is to create a health and care system fit for the future, with transformed services that join up around the people who use them.

The growing health and social care needs of the population can only be met using the funding available if the NHS and social care services work together with the individual to achieve this.

Four key challenges have been identified:

1. **Living well and preventing ill-health.**
2. **Transforming primary and community services.**
3. **Improving urgent and hospital services.**
4. **Providing health and care more efficiently and effectively.**

Organisations in the partnership include:

- East & North Hertfordshire Clinical Commissioning Group.
- Herts Valley Clinical Commissioning Group.
- West Essex Clinical Commissioning Group.

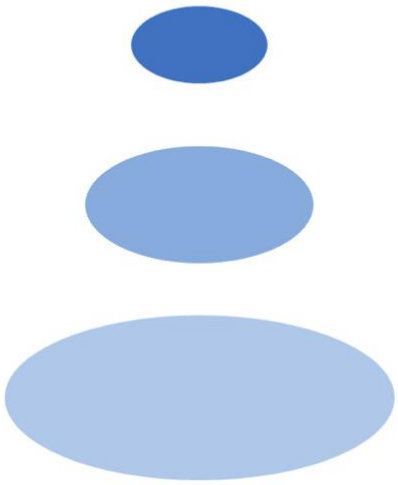
- Essex County Council.
- Hertfordshire County Council.
- District Councils of Broxbourne, Dacorum, East Hertfordshire, Hertsmere, North Hertfordshire, St Albans, Stevenage, Three Rivers, Watford, Welwyn Hatfield, Epping Forest, Harlow & Uttlesford.
- Hertfordshire Partnership University NHS Foundation Trust.
- Essex Partnership University NHS Foundation Trust.
- Hertfordshire Community NHS Trust and Central London Community Healthcare NHS Trust.
- West Hertfordshire NHS Hospitals Trust.
- East and North Hertfordshire NHS Trust.
- Princess Alexandra Hospital NHS Trust.
- 144 GP practises & 34 Primary Care Networks.
- East of England Ambulance Service NHS Trust.
- Hundreds of health and social care partners, including the private and independent sector, and voluntary and community sector.

Three integrated care partnerships are responsible for delivering services in Herts Valley, East and North Hertfordshire and West Essex – following strategic direction from the ICS and responding to local needs.

Collaborative working on proactive, preventative health schemes with district councils and the voluntary sector are a key focus, as is integration of services offered by primary and community health services providers.

The partnership also integrates specialist health services - such as those traditionally offered in larger, “acute” hospitals - into local areas.

The 34 primary care networks are clusters of GPs, nurses, and other key health professionals and services serving between 30,000 and 50,000 patients. They have a central role to play in the transformation of out of hospital care delivery on the ground. A summary of the entire ICS can be seen below.



Level	No.	Population	Role
Integrated Care System	1	1.5m	Strategic clinical and professional leadership for whole STP
Integrated Care Partnerships	3	316k 651k 628k	Local oversight and delivery in West Herts, East and North Herts and West Essex
Primary Care Networks	34	30-50k	Neighbourhood-level clusters of health and care professionals and services

Delivering on Children's Priorities

Maternity and Children's services have been identified as one of three strategic clinical care priorities. More specific targets in this field include:

- Reducing outcome inequality.
- Reducing stillbirth.
- Maternal mortality and neonatal mortality.
- Continuity of care.
- High quality perinatal mental healthcare.
- Strong start in life.

Evidence suggests adults and children living with the biggest health inequalities, including looked after children and those with serious mental illness or learning disabilities, live 10-20 years less on average compared to the local community.

Those who are most "at risk" – due to social vulnerabilities and their clinical needs – are prioritised for integrated care plans that are person, carer and whole-system owned. This includes groups of people who have the biggest inequalities in health such as looked after children, those with serious mental illness and people with learning disabilities, as well as those with a high frailty score.

Key priorities for children and young people include:

- Design and implementation of an integrated model of care for children and young people by redesigning pathways.
- Develop integrated datasets which will improve data quality and better support and information sharing and performance evaluation.
- Redesign children and young people's care plans with a strong focus on personalisation.
- Reduce unwarranted variation in maternity and other children's services.
- Further develop the Child and Adolescent Mental Health Services (CAMHS) strategy, building on the existing good work.
- Design a whole system multi-agency collaborative and co-ordinated approach for children with special educational needs and disabilities.
- Upskill the whole workforce, including schools, in the management and identification of child and adolescent mental health through a bespoke training package.
- Ensure services for disabled children and young people are the best in the country with joint commissioning underpinning the suitable delivery of integrated models of care.

Objectives

By 2023-24, the ICS aims to ensure that:

- 10,615 children and young people under 18 years of age and 464 young people aged 18-25 years of age will be able to access support every year through improvements in access to care.
- Increase the availability of mental health support for children and young people.
- The delivery of the CYP eating disorder service is continued.
- The development of 24/7 crisis provision for CYP through acute and community pathways, which combine intensive home treatment and acute alternative service models, is achieved.
- A 0-25 integrated children and young peoples service to address physical and mental needs, social care and educational needs in community settings, is developed through work with foundation trust providers and county councils
- National commitments to boost out of hospital care for children by operating a population health approach across the geography for under 18s are addressed.
- Personalisation and informed choice are provided to women through the delivery of the LMS programme. This will help to improve maternal and neonatal outcomes in women as well as improved confidence in the support and care they receive in ante-, inter- and post-partum care.
- The incidents of stillbirth, pre-term neonatal admissions and birth Brain injuries are reduced by monitoring progress in the three Trusts in achieving against the requirements in the Saving Babies Lives Care Bundles and the LMS Safety Forum.
- Implementation local targeted training and skill development through the role of maternity support assistants as a means of improving job satisfaction in midwives.

5.6 One Vision Framework in Cornwall

5.6.1 Background

The One Vision Partnership Plan set the transformation framework for Children and Young People's Services 2017-2020, to shape the integration of education, health and social care services for children, young people and their families in Cornwall and the Isles of Scilly. At the heart of the Plan is a commitment to integrated commissioning and provision, wherever there is evidence that it will improve outcomes for children and young people and reduce costs.

> *"What's been really important to us is about having an integrated One Vision for children and young people, and to get the language the same."*

The vision is that:

- All children and young people in Cornwall and the Isles of Scilly are safe, healthy, and have equal chances of accessing all available opportunities to achieve brighter futures.
- The gap between those who are doing well and those who are doing less well has been closed by targeting care and support to those children, young people and their families with the most pressing needs.
- We continually strive to develop and transform all services that children and young people may access, to enable one and all the best possible opportunities for excellent health and wellbeing, throughout their lives and particularly as they make the transition to adulthood.
- Too many children, young people and their families do not have these good opportunities and are worried about their futures. We are committed to working together to change this by collaborating with each other and with children, young people and their families to overcome the barriers to good opportunities and outcomes. This means making best use of our shared resources to achieve integrated agendas for change.

The One Vision Partnership Plan set a range of system outcomes and ambitions to improve outcomes for individual children, young people and families, under the overarching five priority outcomes:

1. Strengthening families and communities.
2. Promoting and protecting children's physical emotional and mental health.
3. Helping and protecting children from harm.
4. Raising aspiration and achievement, towards economic wellbeing.
5. Making a positive contribution to the community.

The One Vision Framework set out the key principles to plan, transform and commission services for children and young people across Cornwall and the Isles of Scilly. It built on the One Vision Partnership Plan by describing the core components of the service offer based on 'proportional universalism'. The aim was to develop a graduated, responsive service offer which builds the capacity of voluntary and community resources, integrates a response to additional needs and targets resource to those most vulnerable to poor outcomes, including those who experience trauma and family related difficulties and those with complex and life-long conditions.

Commissioners and providers involved include:

- Cornwall Council.
- The Council of the Isles of Scilly.
- Early years settings, schools and colleges.
- NHS Kernow (the Clinical Commissioning Group for Cornwall and the Isles of Scilly).
- Primary care services.
- Royal Cornwall Hospital Trust (RCHT)
- University Plymouth Hospital Trust (UPHT)
- Cornwall Partnership NHS Foundation Trust (mental health services).
- Voluntary and community sector.

5.6.2 Service model

There are an agreed set of principles that underpin the One Vision Framework and support the operating model:

1. Core offer – flexible to meet local need and responsive to change.
2. Universal offer with equity of access.
3. Targeting (positive action) according to identified need – narrowing the gap.
4. Quick and easy access to services.
5. Collaborative approach.
6. Whole Family Approach/Think Family – Together for Families.
7. Strengths-based and solution-focussed.
8. Family Hubs are at the heart of integrated place based services.
9. Locality data-based design and resourcing.
10. Highly trained and skilled workforce.
11. Evidence-based practice, focussed on outcomes for children and young people.
12. Learning culture and innovation.
    a. Seeking feedback.
    b. Learning between professionals.
    c. Sharing best practice.
    d. Generating ideas to improve the quality and impact of practice.
13. Multi-disciplinary, maintaining professional identity and perspective.
14. Success measures.
15. Multi-agency – shared responsibility, appropriate contribution and co-ordinated response.
16. Relationship-based approach.
    a. Knowing the people you're working with.
    b. Building relationships across the community.
    c. Mutual trust and respect.

The allocation of resources happens at a commissioner level and the deployment of resources takes place at a provider level, so it is essential that there is alignment between the priorities of commissioners and providers through a clear set of agreed principles. The Framework governs the relationships and processes across all contributors to the service offer under an enhanced One Vision Executive Board.

Within this there is an asset place-based approach to the planning, transformation and commissioning of services, recognising in particular the people working with children, young people, families and their community. This framework provides a place in which they clearly see their role and influence over the design and delivery of services.

Together For Families (children's services within Cornwall County Council) includes the health visiting and school nurse services. It also provides the service to the Isles of Scilly for children with special educational needs and disabilities plus most of the children's social care services.

5.6.3 Designing the model

There are 20 building blocks for the approach taken to transform services for children, young people and their families. These inform professionals and provide the basis of the Partnership's commissioning intentions:

1. Comprehensive and reliable needs data and analysis.
2. Integrated outcomes-based commissioning.
3. Participation of children and young people, parents and carers in the design, decision making and delivery of services.
4. Family strengths practice and approaches, including digital access to information, advice and guidance.
5. Maximising support from wider family and friends.
6. Optimising support from local volunteers, voluntary/community groups - working closely with universal and early help services.
7. Services targeted to families and communities where we can predict adverse childhood experiences.
8. Increasing the capacity and capability of targeted early help services – working closely with universal services.
9. Accessible universal and early help services - close to home and wherever possible in the home.
10. Culturally competent services and practice able to meet the needs of an increasingly diverse community.
11. Integrated single-access points for information, guidance and access to services.
12. Integrated pathways for assessment/diagnosis and support/treatment, including support during transition to adult services.
13. A single, integrated family plan.
14. A key worker as the single point of contact for the family.
15. Multi-disciplinary teams that work across organisational boundaries to deliver seamless support and care.
16. Investment in raising the status and expertise of frontline practitioners/clinicians.
17. Evidence-based practice and interventions.
18. Clear Quality Standards and Meaningful Measures.
19. Robust Quality Assurance, Performance and Contract Management.
20. Openness and Transparency in Reporting Performance, Evaluation and decisions to re/ de-commission services.

The core principles for service planning and transformational change have been identified as:

1. **Joint Governance for system accountability**: with a place-based strategy and an outcomes framework plus tactical commissioning to design services (including demand and capacity planning, procuring of services, monitoring and evaluating services, and managing and developing the market).
2. **Significant service changes will be done in collaboration with key partners**, to ensure the best use of resources, recognising the interdependencies between education, health and care provision and avoiding duplication and/or leaving unmet need.
3. **Joint governance for system operational change** via the One Vision Executive Group, to provide a forum for all significant change proposals for children and young people to be discussed with key delivery partners to ensure they are not negatively impacting each other and therefore on the experience and outcomes of children, young people and their families. The One Vision Executive Group also has responsibility for continuing to align and integrate provision where it benefits children, young people and their families. Conflicts of interest are managed openly, with appropriate alternative mechanisms within commissioning functions where procurement activity is being considered or developed.
4. **Service planning will be needs led, and involve children, young people and families**.
5. **Service planning and change will be outcome focussed: all change proposals must clearly demonstrate the improvement to outcomes**, whether that is system improvements and efficiencies, service user experience, improved quality or increased ability to support the individual outcomes of children, young people and families.
6. **All service planning and change will be evidence based**.
7. **Joint workforce development** to enable a system that:
    - Promotes trust, respect and understanding.
    - Respects professional roles and functions and values different professional contributions.
    - Enables evidence-based practice.
    - Jointly plans outcome based intervention.
    - Co-ordinates an integrated approach to meet the education, health and care needs of families with multiple and complex problems.
    - Works with adult colleagues to ensure young people transitioning into adult services are prepared and supported.
8. **A transparent approach to conflict resolution**, to help the Partnership learn from mistakes and identify areas for development and improvement.
9. **Cost effectiveness and continuous improvement** through developing sound relationships with providers that create mutually advantageous, flexible and long-term relationships based on better outcomes, value for money and continuous improvement. Value for money aims to strike the balance in optimising costs and benefits, whilst sustaining high quality practice and effective services.

The core principles for a system operating model are:

1. **Joint development of whole population prevention approaches** including collective responsibility for an offer of high quality Information and Advice, and working together to build capacity within the voluntary and community sector. This aims to support families to develop positive strategies for addressing common child developmental difficulties, common childhood illnesses and positive parenting strategies, as well as dealing with common challenges of parenting/caring and family life.
2. **Integrated place-based services** to ensure collaborative working between universal, early help and community based services. The aim is to identify additional needs earlier and get help to children, young people and their families quickly and easily to enable self-help, reduce harm and prevent the escalation of problems. As well as supporting positive outcomes for families, improving the quality of universal services and how they work effectively with early help services will reduce demand on specialist services. Through developing integrated place-based networks and governance, services should adapt and grow more responsive to local need through the sharing of professional intelligence, shared local data and service user feedback.
3. **Single point of access for enhanced or specialist support** including the creation of a health access system to triage those requiring mental health and neurodevelopmental services to determining the most appropriate assessment or intervention. Where needs are multiple and/or complex, assessments should be integrated with an ability to deliver support alongside diagnostic pathways with limited separate referral processes and waiting times.
4. A **graduated and integrated response to meet need**, including:
    a. Specialist information, advice or service support
    b. Offer of evidence-based interventions
    c. Specialist or statutory care plan to meet the needs of those with multiple, complex or longer term needs
    d. An integrated crisis response, planning and managing care together for those with high risk factors

Families say, and inspection has reinforced, that the most effective services are delivered by multi-disciplinary teams. The Partnership sees the key characteristics of integrated service provision as:

1. A high level of service user consent and participation in their assessment and care.
2. Information sharing between professionals in a timely way and to a purpose.
3. Joint policies and procedures
4. An integrated pathway for referral, assessment and plan for help/treatment.
5. A key worker acting as the single point of contact for the family.
6. Co-location of professionals working towards multi-disciplinary teams with single management.
7. A core curriculum and joint training where appropriate.
8. Pooled budgets, with resource decisions made through tripartite education, health and social care panels.

5.6.4 Further developing the model

The One Vision model is constantly evolving and being reviewed, whether this is about the membership or the required frequency of meetings. The partnership secretariat plays a key role in this, in terms of having: *"the antennae to be able to pick up when the partnership is beginning to just not quite work and identify what needs to happen, and what needs to change, and to keep things moving."*

The partnership is currently going through a review of the One Vision Plan and had a development day in October 2021 when partners physically came together and reminded themselves of the importance of One Vision and its priorities. Part of this conversation was to try and decide about commissioning and funding arrangements going forwards, including the areas to focus on first.

> *"We're at that point where there's some difficult decisions need to be made and we're trying to work out, where do we do that in the first place so that we model the best practice? We've had an example recently where we think that we could really revolutionise speech and language therapy, and actually really hone in on outcomes and improve outcomes. We know that the vast majority of children who are excluded from school – it's literacy, but it's communication, we've got a rise in autism, etc. And we've got speech and language therapy happening in a number of different places."*

There is a culture of innovation within Cornwall created through empowering people and encouraging them to work together while also taking risks, although the latter can create tension for some partners.

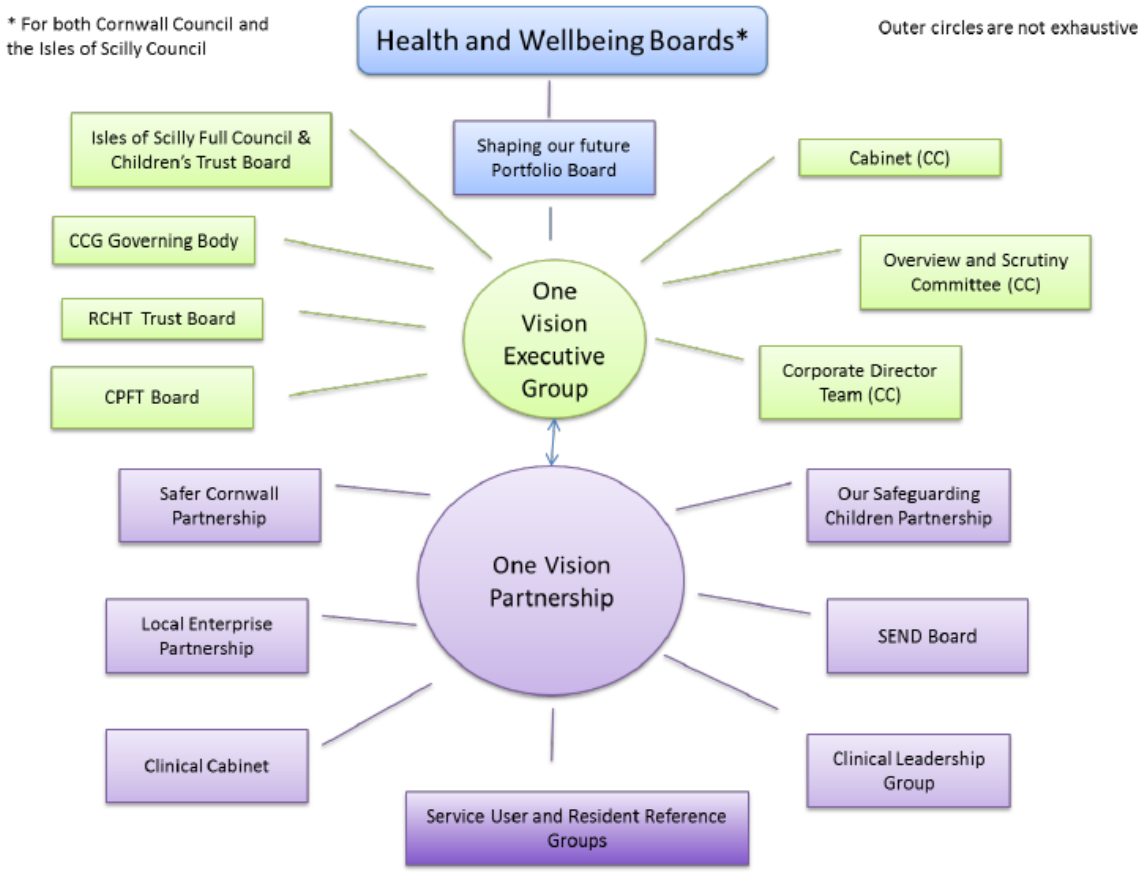
> *"We try to set a culture of empowering and expecting people to work together and then celebrating that. That sets a culture of innovation, I think, because it's not... I think we're quite willing to take risk. There's a bit of tension within that, because I think some partners are willing to take less risks than others, but we try and manage that."*

A key part of innovation is about looking at the evidence and examples of good practice to learn from them and implement best practice. However, this is still in relatively early days and the partnership has more to do still to drive change.

> *"Holding ourselves up to what's happening in other places in the country and really analysing that – looking at peer reviews, looking at practice that's taking place in other places."*

5.6.5 Governance

The diagram below provides a high-level explanation for how the Executive Group works together with other parts of the governance system (the outer circles are not exhaustive).



The Chair of the One Vision Board is responsible for the health outcomes of all children and young people within Cornwall County Council and the Isles of Scilly Council, as well as being the local authority accountable responsible person within the ICS.

The One Vision Board includes representation from the local authorities, schools, the two Foundation Trusts (hospital and mental health), the CCG, the police and the voluntary sector. This is supported by a much broader reference group that: *"sweeps up everybody who has anything to do with children and young people services".*

There are four priority areas underneath the One Vision Board:

1. Emotional Health and Wellbeing (led by the mental health trust's Director of Children and the Service Director for Children's Social Care).
2. Best Start in Life (led by maternity services in the hospital).
3. SEND (with a SEND commissioning board that sits underneath)
4. Resilient Families (that links to the Supporting Families early help work).

5.6.6 Commissioning and funding arrangements

Under the Devolution Deal for Cornwall and in line with the Sustainability and Transformation Plan, the Kernow CCG and Cornwall County Council agreed to take a more integrated approach to commissioning children's education, health and social care. They see the key characteristics of integrated commissioning as:

1. A **joint needs assessment** and analysis of need in different communities.
2. **Shared vision, values and principles**, agreed priorities and aligned methodology.
3. A **joint understanding of 'what works'** – drawing on the experience of service users and the expertise of practitioners and clinicians – based on evidence and best practice.
4. An **outcomes focus** and an agreed range of success measures.
5. A **shared commissioning toolkit**, along with a single procurement process.
6. An **integrated commissioning board**, making strategic commissioning decisions together.
7. **Information sharing** between professionals in a timely way and to a purpose.

There are some joint commissioning arrangements already in place (e.g. for SEND) but these are similar to what is in place elsewhere. Discussions are currently underway about modelling joint commissioning for a wider range of services, and agreeing which areas to focus on initially/over the next 12-18 months and how best to do this through the One Vision Framework.

> *"How do we make that step change, which is about trust, which is about ownership, which is also about ceding control and ceding power? Are we there? No, I think we've got the really good foundations for it, but that's the next step that we need to make. We've got pockets of it, but how do we do it collectively as an organisation?"*

5.6.7 Building the partnership

The interviewee highlighted that it is very important to have really strong relationships with partners. This is not always easy and requires constant attention.

> *"Because we are meeting regularly we also know each other personally in that sense of having those meetings. It allows, it just helps have those difficult conversations. It's not a magic wand, it's hard work, it's constant. It needs constant attention."*

Having agreement on the key outcomes for children and a shared vision can support difficult conversations between partners.

> *"Those high octane conversations that take place have to have that umbrella of agreement of what it is that we are doing and what the most important outcomes are, which is why we have the One Vision Board so we have a cleared, agreed statement of what our intent is. We have a clear plan of what we are doing, which then allows us to have some of those difficult conversations."*

There is a lot of joint training, and frontline staff already work well together and have a real understanding of integration.

> *"Part of the ethos within Cornwall is that we are about building relationships and about strength based models. So, really trying to find that strength in our partnerships and in our people."*

However, the area faces similar workforce issues as elsewhere around recruiting and retaining professionals such as social workers and mental health workers. Partners try and work together to do some recruitment and also try to find ways to "skill mix".

5.6.8 Community engagement

The county council works hard to listen to children and young people and sees it as very important. This ethos is being brought into the ICS and One Vision partnership.

> *"We are clear that we're a children's rights authority, so we work very hard at listening to children and young people. That's one of the things that I look to bring into the ICS and hold to account, is how we are actually listening to children and young people. Because actually all the decisions we make now have implications for our five-year-olds. They're actually the ones who, when the majority of our decisions will actually come into play, they'll be beginning to be the adults of the future."*

In addition, Healthwatch engages with parents through activities like the Parent Carer Council for children with complex needs and other parent groups.

Both co-design and co-production approaches are used for designing services while listening approaches tend to be used for influencing strategic leaders.

> *"There's a lot of listening, which is about influencing strategic leaders, whether that be elected members within the Council, whether that be the ICB Boards. But then throughout the processes it is about that co-design/co-production. There's really good examples of that across our system… It's making sure that we're listening – that the things that we can influence we're influencing. Then the things that it is important and meaningful that we're co-designing and co-producing, we're doing."*

One good example of co-design work has been improving maternity services for the Gypsy Roma and Traveller community where mortality rates are far higher than in the rest of the population. An example of listening is that within the Emotional Health and Wellbeing Board, young people who are either going through the process or have gone through the process are represented with real-time voices of what their experiences are.

One of the complexities for integrated care is that the medical model needs to be right but it will never be right if the entire system and the social model are not taken into consideration.

> *"So, how are we really intervening and preventing at an early stage? And sharing the resources to do that so that you haven't got that escalation at A&E which is crippling the entire system?"*

The interviewee was concerned that because the system is having to concentrate so much on specialist, high level/high need care there will be a number of health crises in the future, particularly for children and young people, which will be a real issue for all ICSs.

> *"Part of what the One Vision Board has to be doing is saying, 'Look. Yes, this is the issue now. But if we don't get this issue right here, then actually we've got worse health crises coming because you've got… two-year-olds who don't know how to go into shops without people wearing face masks and that's impacting on their language."*

5.6.9 Information and reporting

There is no single information reporting system across all partners, but health visitors and school nurses use Mosaic, which is seen as being one of the benefits of them being part of the local authority. Some clinical psychologists work for the local authority so have access to Mosaic too. However, the hospital and mental health trusts have their own data systems. Partners are sharing information appropriately and this will continue on a local basis.

> *"There's a sharing of information, but there's no one system. I'm not convinced that one system is the answer. I think it's about the sharing of information, if that makes sense."*

This includes sharing information on families in order to identify those that are receiving services from different areas, or who need additional support, which is done via a mixture of conversations and a sharing of information between (for example) a paediatrician and social workers.

> *"Within Supporting Families, that's about identifying families who need additional support. There's a different conversation that takes place in that arena, which involves the police, GPs, health visitors for under-fives. We're trying to set that culture which allows people to be professionally curious, and to really think about who they need to engage to support families in the best way possible, and to raise those issues at an early stage. But at the same time, not sharing so much information that you're being intrusive into family life. It's about getting that balance."*

There is a whole system dashboard that includes a range of social care, education, health and criminal justice measures. This is still under development with the aim of being able to really assess how the priorities are being delivered and achieved.

"What I want to do is to really ensure that we're not just looking at that, but we're making meaningful decisions that are across the system, which then influence that as well… It's really trying to identify the two or three things that we want to achieve over the next 18 months and really driving that change, rather than it being a collection of data."

5.6.10 Wider determinants of health and wellbeing

One Vision has to link through to the Health and Wellbeing Board in order to tackle the wider determinants of health, and staff are pulled into the Transformation Boards as and when this is appropriate. The One Vision Board within Cornwall is currently able to straddle both the ICS and the Health and Wellbeing Boards and have these types of conversations. However, there is still some tension that has not yet been worked through within the ICS in terms of where these relationships and conversations sit, and in getting partners to think about the whole system rather than a specific pathway.

"Part of my frustration is we'll have a conversation about an asthma pathway and it starts from the moment that the child goes to the GP and has breathing issues. Well yeah, that's a pathway. But actually, if we're not addressing the fact that child lives on the busiest road in Camborne, walks straight out that door and has petrol fumes, and their school is in..."

5.6.11 Lessons learned and advice

It is important to focus on building a culture where every part of the partnership agrees that the outcomes for children and young people need to be improved, or this will not work.

"That every practitioner's first question working with children and young people is, 'what am I doing that will improve outcomes for children and young people?' That's it. If that's not your culture, then you just have a Board and a system. For me, one of the biggest successes is that we are all thinking, 'What is it that we're doing that actually improves outcomes for children and young people?'"

The people around the table, the culture and the relationships are another of the key success factors for One Vision. Part of this is not to have difficult conversations at the Board meeting but to have them outside to try and come to some agreement beforehand, as this avoids creating tension in the boardroom. Part of this is working very hard to keep these relationships right, so that everyone is driving in the right direction, and also listening when people think that you are not going in the right direction and being flexible and adaptable.

"There's quite often a really good reason why somebody is saying, 'But this isn't right for this area'. How do you then adapt? I think it's that flexibility, agility, and adaptability is the lessons learned."

Building up the relationship between partners has taken a lot of time and effort through demonstrating that everyone has an equal role to play within the system.

> *"It's hard work and really making time for the conversations and really valuing people."*

Although everyone thinks they all speak the same language, this is not true so taking time to understand the nuances of language is important or misunderstandings can arise.

> *"Otherwise, you end up thinking that you've agreed something and you haven't agreed it. That again is about relationships and spending time with each other. Because if you don't understand what the differences are…"*

Covid has actually helped with this, since people attended virtual meetings and at the start of the pandemic met weekly for a collective response to the situation.

> *"We actually met on a weekly basis during the first weeks of Covid because we knew how important it was for us to work together as a system. And the fact that it was very much emphasised on older people, we collectively said, no, that health visitors couldn't go over to care for older people. We said that they needed to stay with children and with families. Because, actually, children were still being born. So, there were a number of effective wins that brought us together and really cemented that view that we were all going in the same direction. We might have different masters, but we're all going in the same direction. That then creates that culture where people feel they can try things. Then people would be coming and saying, 'Oh, we've worked together on this, we've done this together.'"*

Regular meetings have helped to build trust and stability across the various partners, as well as setting time aside to have individual conversations with people and maintain the relationships, which enables others to do the same. Demonstrating an impact from this work is also important.

> *"Almost making that a norm and an acceptance that you've got to go that slight extra mile in the day job to really make that partnership work. There is something as well about making sure that it does feel like it's having an impact, because nobody wants to go to a meeting where they just feel that they're having a conversation. It's got to have an impact."*

It is important to keep to a clear vision while adapting and being flexible. This is the same when commissioning services where consistency in the offer is important even when place variations are required.

> *"There are times when you can't even get across to the Isles of Scilly, so it has to be a different commissioned service. But you have to get that consistency as well. That is part of the rub and the conversations that we're constantly having. Yes absolutely, it's got to be both. How are we making sure that we're doing that?"*

One thing that could have been done differently when setting up the One Vision Framework would have been to set out far more clearly the technicalities of joint commissioning and how to agree how resources are shared/how resources are adapted.

The following primary risks were identified within the One Vision Plan, along with mitigating actions:

1. Single agency/organisational drivers, differing legal duties, freedoms, challenges and imperatives will detract from the over-arching commitment to integrating commissioning and service delivery.
2. The current fragmentation of commissioning and the different timescales for re-tendering services will undermine the ability of the key commissioners to integrate their commissioning intentions, market testing and procurement within the time allowed.
3. The pressures to make further budget cuts within tight timescales will acerbate tensions between organisations and limit the opportunity for collaboration and innovation.

The primary mitigation for these risks was collaborative and effective leadership:

- The Chief Officers made an unequivocal statement about working together to establish integrated commissioning and service provision for health and social care as the only way forward in the face of the challenges ahead.
- The Senior Responsible Officers for the Transformation Programme and the Business Change Managers for the partner organisations are alert to these risks and are fully committed to openness and transparency in the way they work together.
- The Programme Board is made up of sector leaders in commissioning and service provision. It includes all key stakeholders and Board members are fully committed to co-production.
- The programme will continue to have a fully dedicated Programme Manager.
- The governance arrangements for the Transformation Programme, although complex and time-consuming, are robust.

5.6.12 Impact seen so far

One thing that the One Vision Framework and partnership has done is to raise the visibility and profile of children and young people's services within the ICS.

> *"It is really easy within the health system and the ICS system for children and young people to really be not talked about, because in that sense it's a bit of a Cinderella service. It's the smallest amount of money, it's disparate, it's not held together. What the One Vision Board allows us to do is to really keep that profile of children and young people central to the ICS, so nobody can get away from – in any conversation – not thinking about the impact on children and young people."*

It is very difficult to demonstrate impacts so far, other than anecdotally, but work is underway to identify impacts and the differences being made.

Safeguarding referrals have not fallen during Covid, unlike a lot of other areas: while referrals from schools reduced, more referrals were made by the police and health. The interviewee ascribed this to the relationships of the One Vision Board and how they work together.

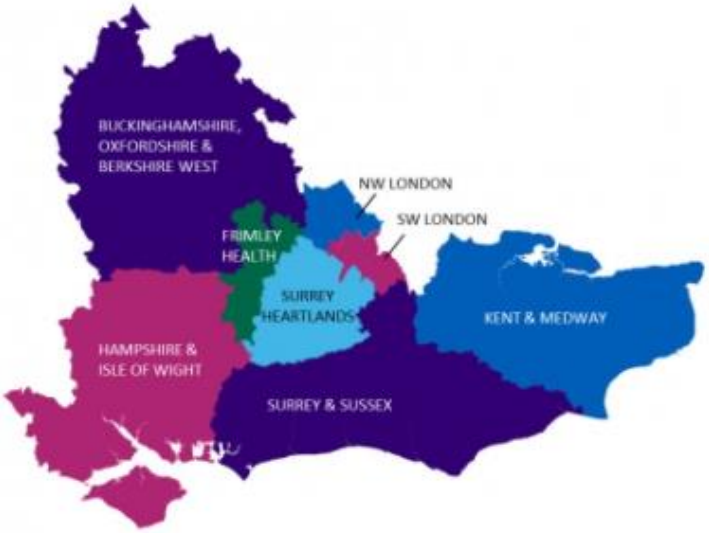
> *"When schools shut referrals stopped happening, and there was a real concern around the country that there was people behind closed doors suffering abuse. None of us can put our hands on our heart and say that didn't happen in Cornwall, but what we know is that our referral rates didn't drop."*

Cornwall has also begun to see a reduction in its waiting lists for CAMHS, attributed to the visibility of those conversations and keeping children's services as high profile.

5.7 Surrey First 1000 Days Programme

5.7.1 Background

Surrey Heartlands is a partnership of health and care organisations working together – with staff, patients, their carers, families and citizens – to transform local services and support people to live healthier lives. As an integrated care system (ICS), the partnership works with a population of 1.1 million people to start well, live well and age well.



The aim of the partnership is to achieve sustainable, high quality physical and mental health care for women and children across Surrey Heartlands. As well as providing care, the partnership wants to help people to avoid preventable ill-health. This will be achieved by enabling and empowering local people to make the right choices for them and their families through support, information and access to early intervention to stop physical and mental ill health at an early stage.

The partners involved include:

- Ashford & St Peter's Hospital NHS Foundation Trust.
- Central Surrey Health (community services).
- Epsom & St Helier University Hospitals NHS Trust.
- Royal Surrey County Hospital.
- South East Coast Ambulance Service NHS Foundation Trust.
- Surrey and Borders Partnership NHS Foundation Trust.
- Surrey County Council.
- Surrey Heartlands Clinical Commissioning Group.
- Surrey Heartlands GPs.

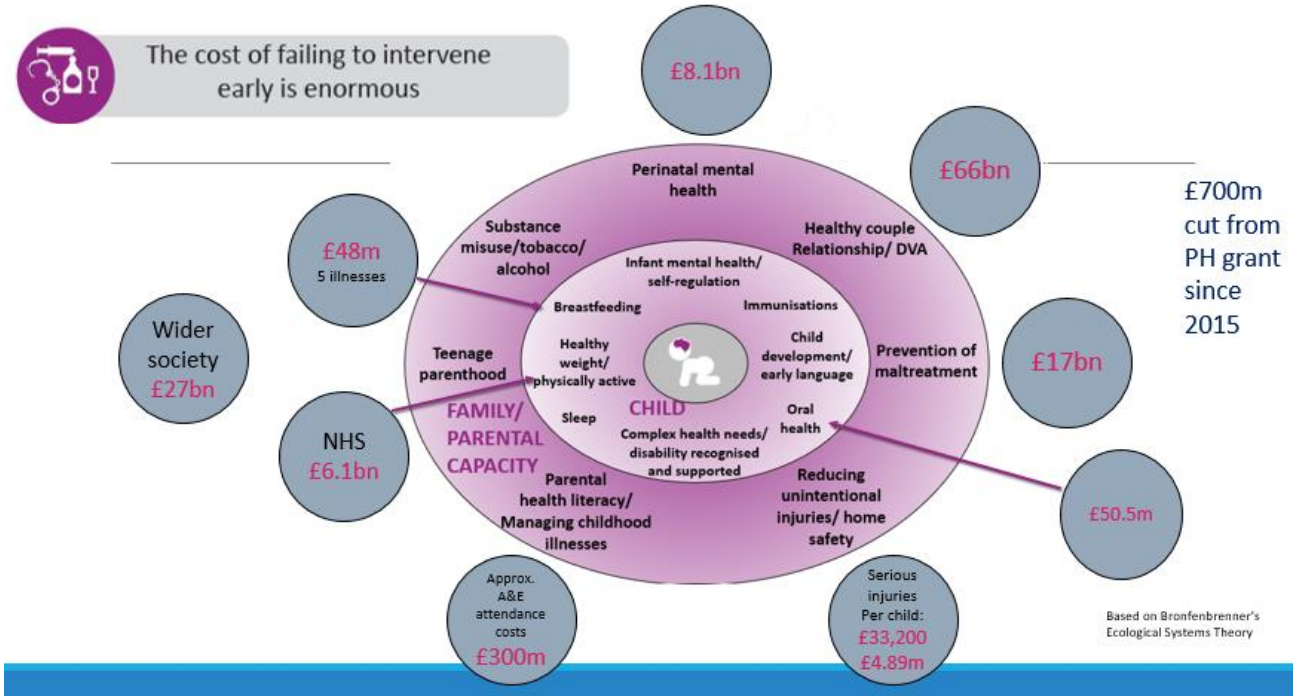
There is also a close working relationship with HealthWatch Surrey as well as the local voluntary, community and health sector. The partnership is also starting to work more closely with partners in East Surrey to look at how ways of working across the county can be shared and joined up together.

5.7.2 Programme Rationale

'Starting Well' was one of the top four priorities for the former Sustainability and Transformation Plan (STP). According to research across the world, the first 1000 days – from conception until two years – has a life-long impact. For a whole range of reasons, some people have different life experiences. A child's development is influenced by a wide range of factors, including such things as the mother's physical health and mental wellbeing, what the baby eats and drinks, to the child's physical surroundings and stimulation.

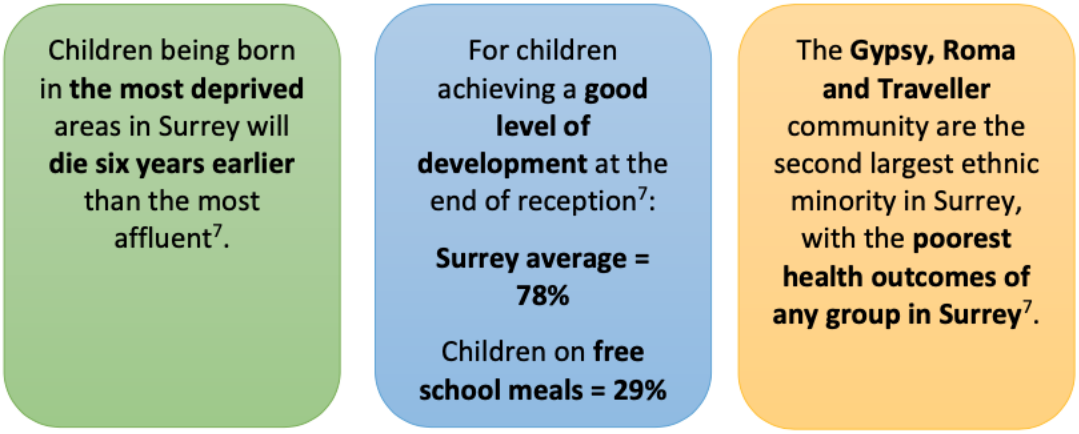
Failing to intervene in the first 1000 days of a child's life means:

- Increased likelihood of poor physical and mental health e.g. obesity and self-esteem.
- Poor attachment and bonding – lifelong impact on relationships.
- Developmental delays not identified early.
- Impact on brain development which impacts on wider life outcomes e.g. educational attainment and employment.



Although Surrey is a very affluent area overall, it has areas of deprivation and in these areas the health inequalities are worse than anywhere else in England:

- 8.8% of children are from low income families, but there are some areas that are significantly more affected by deprivation than others.
- Overall, 10% of children in Surrey are impacted by income deprivation, but this increases to over 40% in the worst affected areas.
- This deprivation and disparity has a significant impact on the outcomes of these children – both health-related and more widely.
- The county is a significant outlier on school readiness for children from deprived areas.
- It has a very high Gypsy/Roma/Traveller community.



Additionally, Surrey County Council has been rated as inadequate by Ofsted for at least ten years.

> *"We weren't doing well by our children and families in Surrey, so it became a priority."*

These inequalities need to be addressed to improve the outcomes for all children, parents and families in Surrey. The First 1000 Days programme is where this work has begun.

5.7.3 Service Model Design

The First 1000 Days programme aims to update and refocus a range of services to make life-long improvements for children as they grow into adulthood.

This programme focuses on the areas where the greatest effects to improve every Surrey child's first 1000 days of life can be made. Initial areas of focus include:

- Parental Attachment.
- Adverse Childhood Experiences.
- Safe and secure home environment.
- Personalised support for families with specific needs.

The approach for the First 1000 Days is as follows:

- **Universal**: universal support (maternity, health visiting, mental health and infant feeding). The parenthood journey is a universal experience for all families.
- **Universal +**: consideration about specific inequalities and vulnerabilities for families in planning and delivery.
- **Focus on families' holistic needs**: the importance of relationships within the family and consideration of the wider determinants of health.

Among initiatives developed is a family resilience model – often known as a "think family approach" – which looks at families as a whole and helps to pick up as many opportunities as possible to support family life. For example, pregnant women can

now access antenatal care outside of standard office hours. A telephone advice and triage line has also been introduced, allowing new and expectant mothers to access support from a midwife 24 hours a day.

Partners from across Surrey have committed to supporting the First 1000 Days Programme. This programme will take responsibility for delivering projects that will help the Partnership achieve the ambitions outlined in its strategy.

Five work streams were created, each suggested by families and professionals:

1. **The needs of the child, parents and family**: Building resilient, healthy and empowered families with a self-sustaining antenatal education model for maternity, relationship development (system principles) and psychotherapy support for families with babies in neonatal units.
2. **Families in the community**: There is accessible support to families from their local community and informal networks with peer support models (enabling families to connect), group antenatal contact (health visiting) and the Home Start postnatal support scheme.
3. **Closing the outcome gap**: Every child, irrespective of background, can reach their full potential through an equity strategy, engagement with the surrey Minority Ethnic forum and the PAUSE service (supporting women with repeat child removals).
4. **Information, communication and engagement**: Accessible Information, effective communication and meaningful engagement through improving engagement mechanisms for early years, a review of digital sources to improve access to information, and using the Baby Buddy app to improve information access (Best Beginnings).
5. **Developing the workforce across the system**: Statutory and non-statutory professionals work in a multi-disciplinary way across the system so families can be supported earlier through transitions/joint working with health visiting and maternity, social prescribing/improving referrals to the voluntary sector and supporting practitioners in baby rooms (the Early Years setting).

The programme recently changed its name from the First 1000 Days to the Better Start Transformation Programme as they have broadened its scope to 0-4 year olds. However, it continues to focus on the first 1000 days.

5.7.4 Designing the model

The system approach to the programme is:

- Culture change – a focus on prevention and early intervention.
- Relationships and collaboration.
- Commissioning intentions aligning to the programme's ambitions.
- System transformation.

The vision of Surrey Heartlands and the local authority was that *"no child should be left behind"*.

"It doesn't matter about their circumstances; every child should have the same opportunities."

Children's principles have been embedded at every layer so that the programme makes sure they put the child at the centre of everything that is done.

The partnership and its senior leadership decided to focus on early intervention and prevention, based on the needs of children, their parents and families.

"Because we had the clinical leadership – we had the strategic leadership behind us, saying 'we want to make this a priority, and we want to make sure that we have universal provision, and we target the families – that proportionate universalism is in place.'"

5.7.5 Further developing the model

The programme aims to continuously innovate by formulating ideas, producing a Project Initiation Document/proposal for the children's steering group, testing them and learning from this.

"We always encourage small ideas, big prototypes: try, fail fast, learn fast, etc. So, if an idea comes up – and loads did come up, during the pandemic, you know. We did a lot of brainstorming."

"So like Baby Buddy started off as a, 'oh we've heard about this it looks really good, how do we commission it?' Worked up a proposal and invited Baby Buddy in to come and talk to the children's strategic group. They sent us in a proposal, we had a look, and then we went in to the system to say, 'is there any transformation money that we can use to invest in that?'"

For many years Surrey Heartlands CCG and the county council have had a transformation funding stream. The First 1000 Days programme can use this and decide which "pot of money" would be best used for a project.

"There's a whole PMO process around how you bid for the particular funds. It's become much more Covid-related over the last two years, though. Supporting backlogs, waiting times, limited ways, technology."

The majority of posts in the programme are funded through transformation funds, and none of them are substantive yet: most roles, including the senior commissioning roles, are done as part of the regular "day job". The programme aims to make the full-time programme manager a substantive post, and then recruit some project officers and administration resource.

The programme has already used the transformation funding to set up a health inclusion team that supports homelessness, Gypsy/Roma/Traveller communities and Afghan asylum seekers. This started off as a very small team and has grown over the last three years, and the business case to make this team a substantive one is about to be signed off. However, the other projects such as Home Start peer work still have year-on-year funding. Making them substantively funded is difficult currently because of the recent financial regime.

> *"For any ICS to make longstanding commitments has been quite a struggle. You know, there was a clear message around, you focus on recovery rather than transformation during the pandemic, so that's been quite difficult. But they have extended – we have been able to extend programs until the financial regime is lifted and we're able to start functioning with more autonomy as a system. Then, we'll put the business cases forward… The whole system is signed up to early health and prevention."*

The interviewee felt that a significant change is that the programme has narrowed its focus as they understand the data better so that they understand what the need is and where the gaps are.

> *"Having a very broad plan when we first started out and wanting to kind of do everything, to being really focused now, and actually we do understand what our needs are."*

Areas of work have included looking at the gap in school readiness, at health inequalities, and children with special educational needs. The data has identified that there is a higher prevalence of boys with neurodiversity challenges than girls, and a higher prevalence of BAME children, so Surrey is able to be much more targeted in its provision around that. Surrey has a very high number of Education and Health Care Plans (over 10,000, of which a significant proportion are for under four year olds), but they are building more inclusive support by putting in early help provision rather than sending children to specialist nursery or school placements.

> *"That's why we've broadened it out to the Better Start Transformation Board to look at. We can often predict, or know, that these children will have some challenges by the time they start school. But we often wait for those challenges to present themselves before those children get any support. So what we're doing better, because now we know better, is being able to put much more targeted provision around early years funding, to help schools with children that may have some social communication delays."*

Surrey now has a Mindworks contract which is an i-THRIVE model framework around early help and getting support much earlier. This is being delivered not through an NHS provider but through a consortium of voluntary organisations and charities. Additionally, it is a seven years plus three contract so provides more security for the voluntary sector providers.

"It's very new, but there'll be much more early help and support, and that has meant that there are, where we've had big gaps in the First 1000 Days programme, some of those gaps are starting to be filled. Because the voluntary sector are much more present."

Funding cuts and workforce shortages had resulted in the antenatal and postnatal programmes being very minimal, especially during Covid and the lockdowns. One of the fallouts from the pandemic are social and communication delays for babies who have missed out on opportunities to socialise. Following feedback from new parents, the programme looked at how to close the gaps identified or provide the support that families wanted. This included:

- How to develop group antenatal contacts, rather than individual contacts, and how to bring in the voluntary sector such as Home-Start, postnatal support schemes etc.
- Supporting asylum seekers, including families from Afghanistan.
- Supporting women who have gone through repeat care proceedings.
- Providing information, communication and engagement with families, which has included commissioning the Baby Buddy app.
- Speech and language therapy, which used to be provided in early years settings.

The programme has set up a peer support scheme for new mothers and introduced psychotherapist support for families with babies in the Neonatal Intensive Care Unit (NICU). They have also developed a new mental health service for women who have suffered trauma and loss in pregnancy.

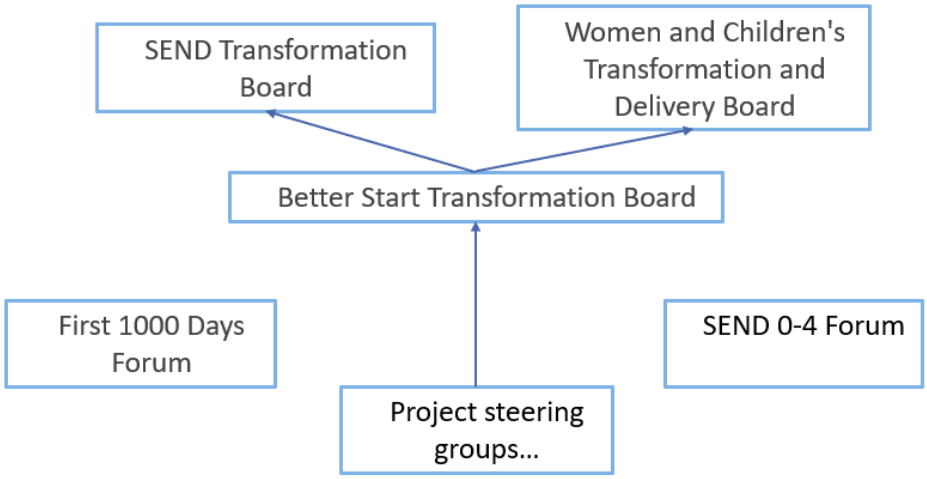
Other pieces of work during the pandemic were around BAME and pregnancy, including poor outcomes for Black women in pregnancy and childbirth, plus understanding the health inequalities agenda around vaccination. They now have a maternity hub that is focused on BAME communities and the BAME pathway.

The programme is now looking at social prescribing and improving referral pathways.

5.7.6 Governance

There is a Joint Better Start Transformation Board for the First 1000 Days and SEND 0-4 programmes. This enables:

- Alignment across the two programmes.
- Provision of a basis for a more joined up approach.
- Development and use of a shared language, understanding and approach.
- Possibility of expanding the Board scope over time.



The Director of Children's Services chairs the Children's Strategic Group, which also includes the Director of Family Resilience and Director of Commissioning within the local authority. Other members include the Chief Executive of the Surrey Youth Partnership (the umbrella organisation of all of the charities and voluntary sectors that provide services in Surrey), the chief executives of the Acute Trusts, a lead paediatrician, community providers, parents, young people and Family Voice (the group that represents families and children with special educational needs). The Children's Strategic Group reports into the new Integrated Board and also feeds into the Executive Professional Clinical Group.

> *"So we have a kind of, every layer, we have representation. And we have clinical leadership, so we have a clinical lead, who is a paediatrician, who supports the programme."*

The area covered by the programme is co-terminus with that of Surrey County Council, except that it includes an area of North East Hampshire (Frimley). There is a Surrey collaborative, which is a committee that members from the Frimley CCG attend.

> *"So all decisions that are made are inclusive of our Frimley colleagues. It can be a little bit complicated, but not as complicated as some areas that have got many surrounding ICSs."*

Frimley also has a Better Start programme, and works very closely with Surrey Heartlands, especially around learning disabilities and autism. There are also a number of regional meetings in different specialisms.

5.7.7 Commissioning and funding arrangements

In October 2021, after a year of planning and developing the operating model and roles, the children's commissioning teams in Surrey County Council and the CCG (now the ICS) became one team. This single, integrated commissioning team for

children's services sits underneath the Director of Commissioning for Surrey County Council and is overseen by the Director of Children's Services. The team will be co-located when they come back into the office.

> *"So she [Director of Children's Services] gets really good oversight and breadth of the totality of what's going on in Children's, from a provider and a commissioning element. Although, she's not accountable for the delivery."*

There will be an *"open book transparency process"* that is currently being worked through with a Transforming Outcomes for People (TOP) programme that is chaired by the Chief Executive of Surrey County Council and the Senior Accountable Officer for Surrey Heartlands. Within this there are enabling work streams around finance, contracts, workforce etc. so that they can put in place an infrastructure to develop section 75s and share budgets. The plan is for the scheme of designation to be transferred to the county council.

> *"While we're waiting for that infrastructure to take place and the lawyers to write the documents and the MOUs etc., they are doing an open book transparency, so we're just sharing spreadsheets basically. So what we are doing is making joint decisions around spend. But the function still sits within, the scheme of delegations still sits within the ICS at the moment, and the local authority. But the plan is that the scheme of delegation will be transferred across to the local authority."*

The commissioning team currently has a number of vacancies, and recruitment is advertising them as a joint role, with successful candidates being given a choice about whether they would prefer to be employed by the NHS or the local authority.

> *"I think that will be gradually phased out over time, but at the moment while we're still forming, that's the approach that's been taken. We haven't TUPE'd anybody – we haven't yet had to use TUPE."*

However, there are also a number of challenges around Information Governance and IT equipment, so the programme has a large digital team working to resolve the barriers.

> *"We*'ve got a big digital team that are trying to work on that, because as an ICS, that's going to be everybody's normal, isn't it? *You may be employed by one organisation but you work to the place or you work to the system. So we've got to get through those organisational barriers around IG and IT. I think the pandemic has helped significantly, because of Teams, and virtual folders – NHS Futures, for example, you can store things virtually, and have access and give access."*

5.7.8 Building the partnership

Organisations across Surrey are already working in partnership to improve outcomes in the first 1000 days. Working together across all parts of health and social care system is fundamental to achieving the ambitions of the programme.

The programme has already carried out a lot of organisational development work, with many partnerships already running such as the Children Family Health Surrey partnership (a consortium of several social enterprises and a mental health trust that are delivering children's physical health services) and Mindworks (the consortium of voluntary sector, Mental Health Trust and Emotional Health and Wellbeing Services).

In addition, Surrey Heartlands has run a leadership program called Surrey 500: *"which is particularly aimed at supporting staff to not think about the lanyards, and think about the place, or the areas or the systems they're working in."*

The First 1000 Days programme has been working on collaborative leadership for four years, which has really helped build trust and start to break down silos.

> *"You can always tell some success by – people don't say where they're from anymore… my colleague, she just says, 'I'm working on the First 1000 Days programme.' So people have already started to just talk about their portfolios rather than their organisation. So that organisational silo working has started to break down, and that's a really good sign of trust that's building up."*

There is a real principle in Surrey around culture and taking time to build relationships, which then inevitably builds trust.

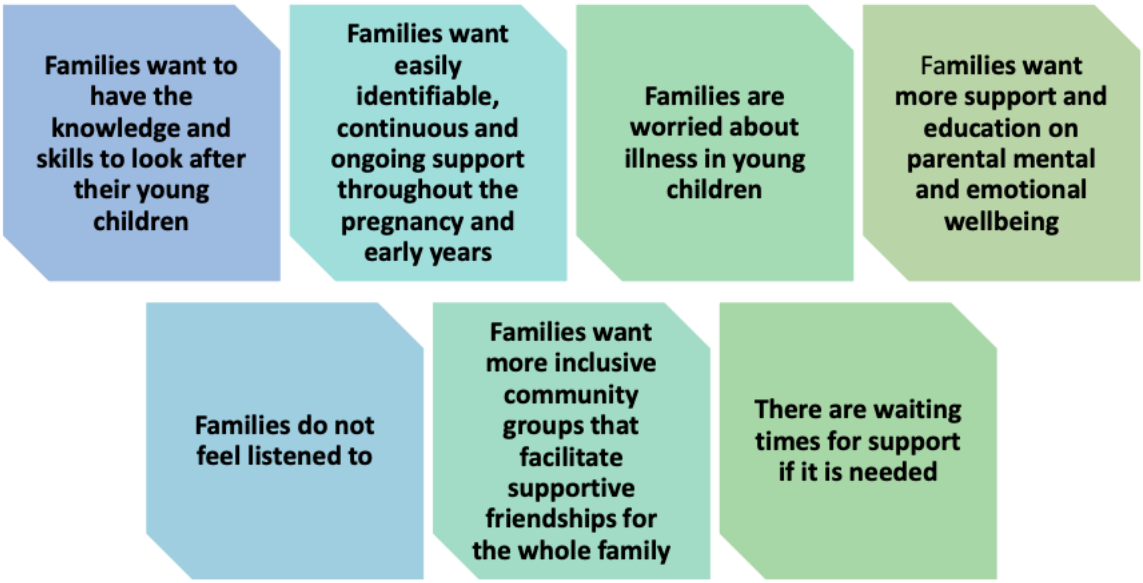
> *"We recognise that you can't just put a partnership together, and expect people to get on. Which is why we took a year to integrate the Children's Commissioning Team, because [we] both said it's about the relationships. You know, the kind of infrastructure, have you got your Sector 75, what laptops are people going to have, and who's going to line manage? They're all important stuff, but actually we spent much more time getting to know each other, and understanding what working patterns people wanted, and what kind of – you know, emotional health and wellbeing, and lifestyle."*

5.7.9 Community engagement

The programme held a conference with key stakeholders including new parents who provided their views on the gaps in services and what sort of support or early help they wanted.

> *"So, first-time mums, and the babies. So, they came in at lunchtime, and we had loads of mums turn up with babies. And we got really helpful insight into where they saw the gaps, around additional support or early help. And that helped design the programme really, in terms of what we wanted to do."*

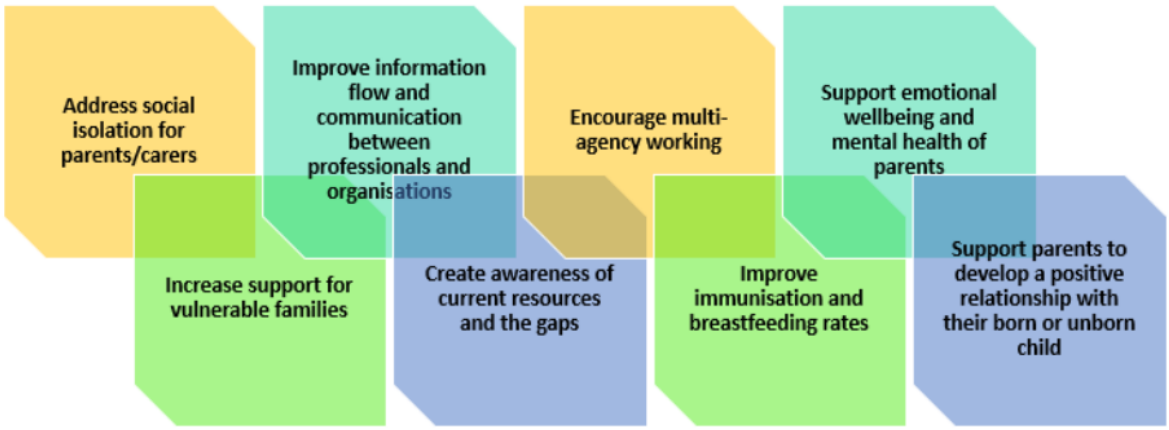
When asked about their experiences during their first 1000 days, families highlighted a number of areas where attention should be focused.



Support such as peer networking and meeting other new mothers was significantly reduced during lockdown, as was support for parents with premature babies, such as relationship development and psychotherapy support for families with babies in neonatal units.

> *"And families in the community – the peer support models, that's what families were really saying they missed, kind of connecting to other families."*

When asked about their experience when supporting families, healthcare professionals stated the following areas they would like to address to enhance services and support for families.



Over the last 18 months, the programme has held regular engagement sessions with the community via Facebook Live events and webinars. For example, a psychologist and child and mental health psychiatrist has run virtual events to get feedback on the Home-Start programmes and there is a reference group for psychological support in the NICU to check with parents that it is providing what they need. The Maternity Voices partnership has been testing a lot of the ideas, particularly around Baby Buddy. The programme is looking at how to widen the Maternity Voice partnership (currently around pregnancy in the very early days) to cover 0-5s as well.

The programme developed a board game to help them develop good engagement/ research tools to work with families and support them to determine the best methodology to use.

> *"We piloted it for NHSE, so it may not have, it may still be in the pilot stage. But it really helped us think about are we using the right tools to get the right information from parents, and using the right co-production tools in order to develop pathways that are going to meet the needs and the outcomes."*

The programme has moved from engaging with the community more towards co-production. The Citizen's Ambassador for the programme is commissioned through HealthWatch and has been the programme's main route into co-production.

5.7.10 Information and reporting

The programme does not have a single information reporting system across all partners, but has recently employed a business analyst to help develop its dashboard. This will pull together data from the Surrey care record (county council data), CAMHS data, primary care data and community health data so that staff can see all the different contacts that family may have had. The programme wants to do something more dynamic, such as a data insight hub, but have not yet got the basics in place. For example, while GPs and community providers mostly use one system, the hospitals and local authority have different systems.

> *"We need the fundamentals in place, so we need systems to be able to talk to each other in the first place, so that's what we're working on at the moment, is making sure that we have a single [hub]… But if they can all talk to each other we can then layer the information. So Surrey County Council are working on something quite exciting as we speak. I've seen some very early screenshots of what that would look like. So you could see, for example, if there's a child on a child protection plan, have they also got a mental health worker involved in their care? How many times have they been to A&E? Any self-harm issues? So that's what we're working towards."*

The programme is also developing a single performance framework within this work. Initial work is trying to build a performance framework and quality performance framework for one of the contracts (with the voluntary sector and the mental health trust) to replace spreadsheets from different partners.

5.7.11 Wider determinants of health and wellbeing

Through work with the local authority and Public Health, the programme has been looking at population health management and building a data system to help identify issues such as long-term conditions and where people with those conditions live. The only concrete piece of work so far is around respiratory conditions, where the programme has been working on health promotion work with schools around walking to school, cutting emissions and asthma care. However, the interviewee acknowledged that they still need to do more, especially in terms of housing and other issues.

> *"Recognising that actually only 20% of health interventions are going to make a significant difference in outcomes – 80% comes from the wider determinants of health. So what could we do as a programme to look at… We know that breastfeeding is great for mums and for babies, but we also know that isolation and housing and pollution has a significant impact."*

The programme has also been doing a lot of work with the voluntary sector around social isolation and supporting families on low incomes/living in poverty. They have just started to align the poverty strategy with the First 1000 Days programme.

The programme has been able to do more work within the districts that are already engaging well.

> *"We've been working in a multi-professional multi-agency way in some parts of Surrey, it's a massive county, so where we've got well engaged districts and boroughs, we've been doing a lot more… we've been doing quite a lot of work with the leisure centres on exercise and obesity, but not made as many inroads as we would like to do around housing, for example."*

5.7.12 Lessons learned and advice

One of the key lessons learnt was not to leave anybody out and ensuring that membership is representative and correct.

> *"When you have left a partner out, you spend a long time going back and re-engaging and bringing them back on board."*

The biggest success factor in Surrey was felt to be working with the voluntary sector, which has a seat on all of the strategic boards.

> *"They influence, they shape, they design, they co-produce, and they bring in a different lens. They bring in a different focus, they challenge us."*

The interviewee said that they have struggled somewhat when they have not included the voluntary sector: *"Because health was so stretched, and the local authority are so stretched. The voluntary sector knows the families really well."*

Things that have not gone well have been when the programme has rushed into things, and not really taken time to debate and understand so that decisions have been taken in isolation.

> *"We made some decisions in isolation without really taking time to think. Because we made the decision that it [maternal mental health hubs] sits in maternity, and actually that probably wasn't the best decision. So we've had to unpick a bit of that and gone back to the governance as well."*

Another key lesson is to really understand what the local needs are: Surrey is a large county and the programme could not do everything. The programme needs to be clear about what it is trying to achieve and not try to do everything at once.

"It's best to concentrate on two or three big ticket items, and get those done, which is what we said right at the beginning – what's our roadmap for three years? What are those top three things we want to do this year, and what's the clarity of purpose for each of those three things? And then we'll move onto second year and third year, and not try and do everything all at once."

The programme learnt from Public Health's experience of integrating into the local authority and therefore took a year to integrate the two children's commissioning teams in order to build up relationships.

"We had a session with Public Health to understand what it was like for them, and they said don't rush. Take your time. Because if you've got the relationships in place, if you mess it up, everybody's much more forgiving, aren't they? Because the relationships are there. So that's the approach we took."

One key area of development was around the workforce, in particular doing more joint working and integration with the local authority. The interviewee highlighted partner engagement and collaboration as a key success of the programme.

"In terms of what we've achieved, the partner engagement and the collaboration has been one of our key successes. So, everybody's been brought in and engaged in the programme of work."

The collective effort from across the partners has worked well and built on the existing relationships and understanding.

"It's not just been a health effort. So I think what's worked really well is the early years relationships we've got with the nurseries. So when we – for example when we had, I think we've got over 3000 now, asylum families in Surrey. We were able to mobilise things really quickly to support those families. So we already had the inclusion team, which we could expand and scale up very quickly and vaccinate those children. We had really good relationships in place with early years, very quickly early years came in and sourced places for those children. So I think having the relationships and the trust has enabled us to respond and recover more quickly from the pandemic. We really understand each other's worlds a little bit more."

The improvement programme for children's social care (as a result of the Ofsted requires improvement judgement) has strengthened the relationships across health and social care, creating a much more positive picture for the forthcoming Ofsted visit. This is mainly a result of many joint meetings between commissioners and providers where plans and decisions are made jointly and there is constructive and open debate.

"In the old days, pre-pandemic, you'd have CQRMs and CRMs which are your contractual meetings where you'd have a commissioner over here and a

provider over there. Now, we're all in it together, so commissioners, providers, we decision-make, we make decisions together, we plan together, we debate together, we disagree together. So it's all done collectively."

These meetings have broken down the barriers between organisations and allowed different cultures and structures to come together around the key principle of "positive intent".

"It's not been easy. We have two very different worlds that have collided and come together, but we've just held on to that principle of being a positive intent. So everybody's set to do the right thing, sometimes not very well but because we have trusted relationships and are able to call out when you're not happy or you don't feel you've been listened to, in a way that's non-challenging but helpful. That's what's worked really well."

One thing that has worked well in building partnerships is the very strong clinical engagement and management engagement within the programme Board from a range of leaders within the ICS, including the Chief Executive of Surrey County Council, the Senior Accountable Officer for Surrey Heartlands, the Chief Executive of Ashford and St. Peter's Hospital and the Executive Director of Quality Nursing.

"So wherever we can, we've tried to make sure that we've got an executive lead for the programme, and it's got a voice and a profile... And because it's a key priority, we have to do regular reports to the children's strategic group."

The interviewee also felt that the programme has very good place engagement. There are regular updates on places since they recognise that delivery needs to vary by place because of the demographics of the population.

The very good working relationship between the two leads from health and the local authority and the joint accountability between health and the local authority are a significant strength of the programme, In addition, having clarity of purpose and focus is important.

5.7.13 Outcomes so far

The Surrey Health and Wellbeing Strategy clearly identifies “Starting Well” as a priority. The outcomes to be delivered by the First 1000 Days programme are essential to the delivery of the broader Health and Wellbeing Strategy ambitions as outlined below.

Priority 1: Helping people live healthy lives

- Improved healthy life expectancy for children being born now, focusing in particular on tackling existing health inequalities in Surrey by focusing on prevention and the wider determinants of health.

Priority 2: Supporting the mental health and emotional wellbeing of people

- Supporting the emotional wellbeing of mothers and families throughout and after their pregnancy.
- Preventing isolation and enabling support for those who do feel isolated.

Priority 3: Supporting people to fulfil their potential

- Improved school readiness rates for children with free school meal status.

Although it is still early days, the programme has seen some early impact:

- ✓ Breadth of partner engagement, collaboration and clinical insight.
- ✓ Clinical leadership and insight across the programme, resulting in a higher profile for children’s services.
- ✓ Best Beginnings Partnership (embedding the Baby buddy app).
- ✓ Peer support scheme with Home Start.
- ✓ Psychotherapist support for families with babies in the Neonatal Intensive Care Unit with good initial feedback from mothers.
- ✓ New maternal mental health service for trauma and loss.
- ✓ Reduction in the number of Education Health and Care Plans for children under four.
- ✓ Qualitative feedback from parents who feel a lot more supported.

> *“It’s really difficult because of the masking from the pandemic. So things don’t feel any better, but they could have been so much worse if we had done nothing. And that’s the bit we’ve been talking to Public Health about, around how do we disaggregate from what would have happened without a pandemic vs the outcomes we’re seeing now? Because we are still seeing non-accidental injuries, breastfeeding rates have fallen, and that’s a result of, face-to-face contact wasn’t around, we weren’t able to do that. And we lost our ability to run groups and home visiting, for a period of time… we haven’t got the outcomes we thought we’d see. It’s not all because of the pandemic, but for 18 months, everything went remote and all group work stopped. And the things we did put in place – peer support programmes – were virtual, and when we were able to do some face-to-face visits, things started to pick up a little bit more.”*

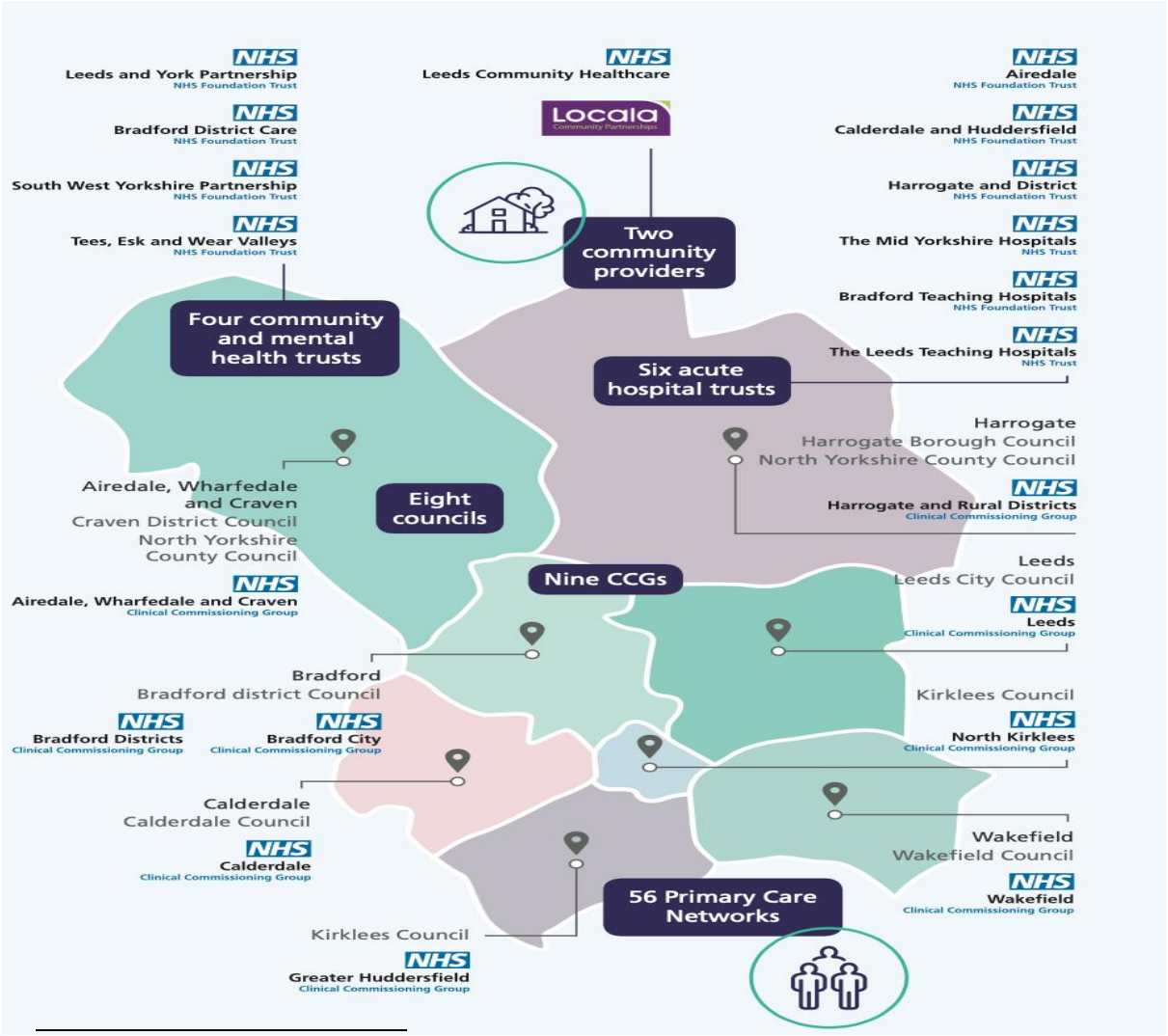
5.8 West Yorkshire

5.8.1 Background

West Yorkshire Health and Care Partnership is an integrated care system, working in partnership with NHS organisations, councils, HealthWatch, charities and the community, voluntary and social enterprise sector to improve the health and wellbeing of local people living in five places[2]:

- Bradford District & Craven.
- Calderdale.
- Kirklees.
- Leeds.
- Wakefield.

The partnership is the third largest in the country, serving an estimated 2.7 million people on a budget of £5.5 billion. Organisations in this partnership are listed in the map below.



[2] Harrogate originally formed part of the Health and Care Partnership but is not part of the ICS.

Children and young people between 0-18 years of age account for 23% of the total population of West Yorkshire and Harrogate, amounting to a population of 570,000.

- Rates of looked after children are higher in West Yorkshire compared to the national average (72.1 per 10,000 and 63.6 per 10,000 respectively).
- 62% of looked after children are in care because of abuse or neglect.
- 19.2% of children between 0-16 years of age are living in families in receipt of Child Tax Credit whose reported income is less than 60% of the median income or in receipt of Employment and Support Allowance/Jobseekers Allowance – higher than the national average of 17%.
- Infant death rates for England are declining, however in West Yorkshire the rates have been increasing year on year since 2012.

The programme's ambition is to close the gap in health and wellbeing outcomes for all children and young people across West Yorkshire, no matter where they were born, where they live or where they go to school. This is through a whole life course approach and that principle that good physical and mental health underpins everything that children and young people do.

> *"We've seen that, haven't we, in the pandemic, the impact of anxiety, mental health, physical issues, children with long Covid, etc. It's been huge. So, this is the underpinning principle is that good health and wellbeing for all children and young people. So, that's fundamental."*

There is a lot of deprivation within West Yorkshire, with some very affluent areas and some of the lowest deprived areas in the whole country as well.

> *"Closing those gaps in health and wellbeing outcomes is fundamental and it's something that's a principle that's applied right the way across the ICS."*

As part of the NHS Long-term plan, the West Yorkshire partnership devised the following ten ambitions to achieve by 2024:

1. Increase the years of life that people live in good health in West Yorkshire compared to the rest of England.
2. Achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population. Early support for children and young people will be a specific focus.
3. Address the health inequality gap for children living in households with the lowest incomes. This will include halting the trend in childhood obesity, including those children living in poverty.
4. Increase early diagnosis rates for cancer.
5. Reduce suicide across area by 10% by 2020/21 and a 75% reduction in targeted areas by 2022.
6. Achieve a 10% reduction in anti-microbial resistant infections.
7. Reduce rates of stillbirth, neonatal deaths and Brain injuries by 50%.
8. Have a more diverse leadership that better reflects the broad range of talent in West Yorkshire.
9. Become a global leader in responding to the climate emergency
10. Strengthen local economic growth by reducing health inequalities and improving skills.

5.8.2 Children, Young People and Families Programme

The vision for the Children, Young People and Families Programme is:

- To close the gap in health and well-being outcomes for all children and young people across West Yorkshire, irrespective of where they were born, where they live and go to school.
- All children and young people will have the best start in life and the support and healthcare needed to enable them to be safe from harm and to enjoy healthy lifestyles, to do well in learning and have skills for life.
- The voice of the child and young person will be at the heart of everything the Partnership does.

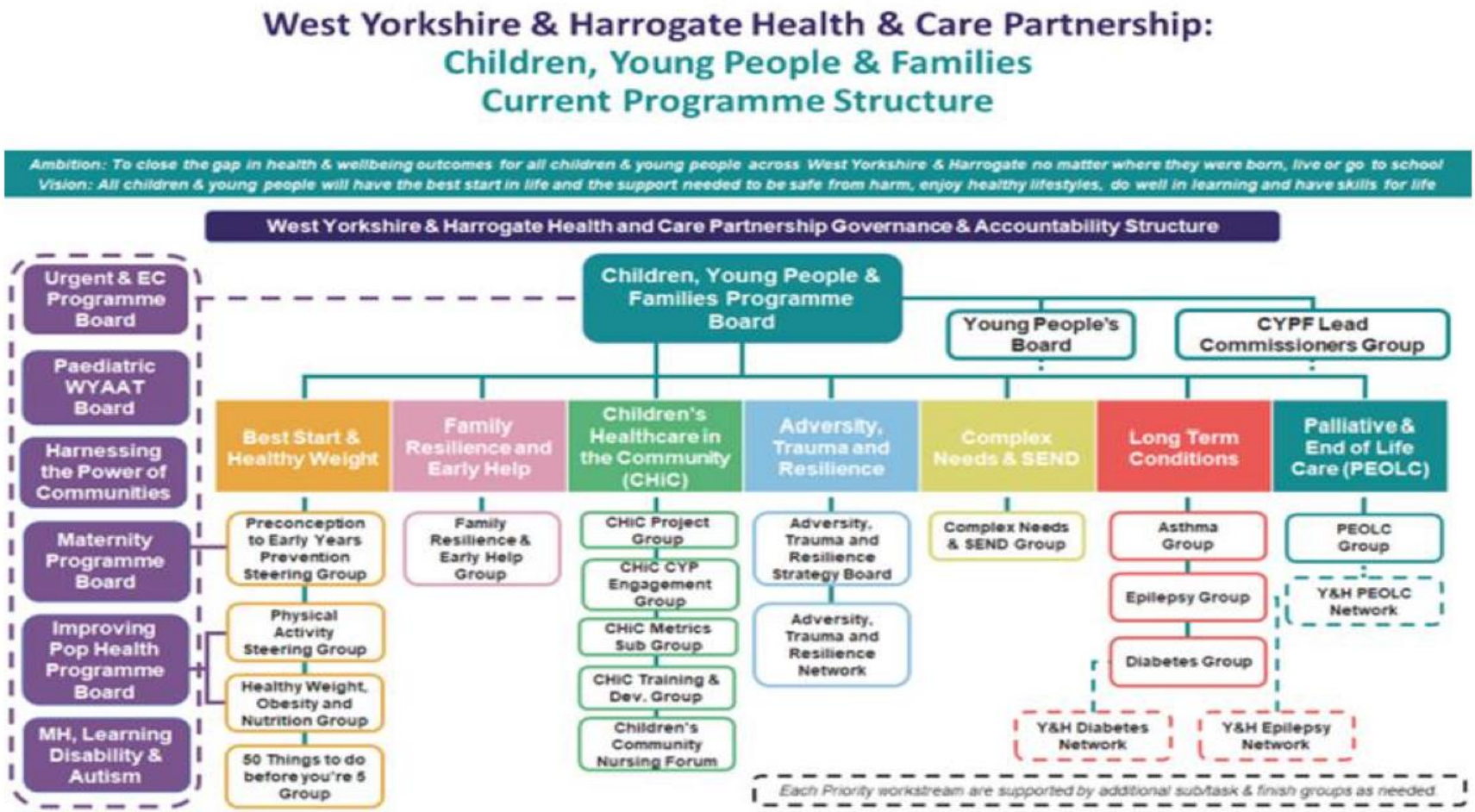
Specific priority work streams for children and young people are as follows:

- Acute Paediatrics.
- Best start in life and narrowing the obesity gap.
- Complex needs and special educational needs (SEND).
- Long-term health conditions.
- Mental health, learning disabilities and autism.
- Family resilience and early help.
- End of life and palliative care.

Working in partnership with the children and young people partners and the improving population health programmes to better understand their needs and those of their families, the aim is to create a 0-25 mental health service, which includes community and hospital services in line with national funding from 2021/22.

The ambitions for children, young people and families are as follows.

5.8.3 Service model



There is a separate programme in the ICS on mental health, learning disabilities and autism, which has a children's work stream within it that reports into the Children and Young People's Board.

The Best Start work stream is linked into the maternity programme and looks at all children having the best start - growing into healthy children who are safe, have healthy lifestyles, do well in learning and have very supportive families. This also links into the Healthy Weight, Nutrition and Food Resilience strand around healthy weight, weaning, breastfeeding and good nutrition in childhood, which links into how weight and support for families is managed.

The interviewee felt that the Adversity, Trauma and Resilience work stream is a *"game changer."* This links into early help - intervening early in the life of a problem – and is a trauma informed approach across the whole of the ICS, so works with both adult and children's services. One of the outcomes in this work stream is reducing the numbers of children coming into care: research in Leeds found that 40% of children were brought into care as a result of their parents' mental health issues.

The Children's Healthcare in the Community (CHIC) work stream focuses on acutely ill children and how the children get the right care in the right place at the right time plus how they will be supported to be happy, healthy and at home as much as possible with the best care as possible. Local data has shown that 92% of children who are admitted to hospital stay less than 24 hours.

> *"So, it's very much about parents getting extremely worried. At the moment, as we know, it's very difficult to get GP appointments quickly, so parents tend to be taking children into A&E where they seem to be admitted for observation and then the next day sent home again. So, we're looking at the right care and support and we've got a set of outcomes across the whole of the ICS around this, but each place is going to look at delivering it differently."*

The Complex Needs and SEND work stream is picking up on the developmental delay issues arising from the pandemic when many physiotherapists and occupational therapists were removed from children's services during the first lockdown and sent to work on adult services and the wards with people with Covid.

The Long-term Condition work stream is looking at how the ICS works with asthma, diabetes and epilepsy, with a working group for each of these three conditions. It is looking at an offer with improved access to psychology services for some children transitioning to adult services: this is a big issue particularly in diabetes. It is also looking at how children are supported in a learning environment.

> *"People with diabetes can have a sensor under their skin and they can monitor their blood sugar on their phones. So, there's a sensor. And what I've heard about is that some children that are diabetic and have got a sensor are not allowed to look at their phones during the day in school. So, what do they have to do to monitor their blood sugar? A pinprick test and draw blood. Now, what's the safest thing to do in school?"*

Work streams link into a number of programmes across the area, including Improving Population Health (an ICS-wide programme), the Harnessing Powers of Community programme, the Urgent and Emergency Care programme, the Family Resilience and Early Help group (local authority-led), and the Mental Health, Disability and Autism programme. Adult Mental Health providers provide an adult mental health worker within early help hubs to support families where there are concerns about parents' mental health. The programme also links to the Yorkshire and Humber Diabetes Network, Yorkshire and Humber Epilepsy and the Yorkshire and Humber Palliative Care Network, plus the West Yorkshire Association of Acute Trusts.

5.8.4 Designing the model

The design for the programme was "borrowed" from Leeds, where the children's work was based on the Every Child Matters format as a whole system and life course approach.

A lot of changes made since the implementation of the programme have been as a result of funding and capacity. These are resulting in positive early differences in the numbers of children attending urgent care settings as well as the time spent in urgent care.

> *"The Child Health in the Community Programme has been going for 18 months now and we have seen a reduction in A&E attendances by children and young people. And we have seen reduced length of stays as well in hospital."*

New initiatives are being considered for West Yorkshire, including the Healthier Together website that has been previously implemented in Hampshire and South Yorkshire.

> *"This is about where parents can log on, put in what their child's symptoms are, and they'll get advice and support which is very much based on the Royal College of Paediatrics and Child Health Information about how they can support that child."*

The only issue with the website development is the digital exclusion of families in the area who cannot afford an internet connection. The interviewee plans to link into the digital programme in the ICS to see how they can ensure that all families have got access to digital, *"because that's a really important part of what we'll be doing going forward."*

Since the implementation of the model, the work stream around palliative care has moved and is being carried out by Yorkshire and Humber. The Adversity, Trauma and Resilience work stream is new to the programme, having been implemented in the last six months.

5.8.5 Developing the model further

The transitions element of the programme is one that leaders within this partnership are still finding challenging, including for young people with diabetes and those with life limiting conditions.

Funding for palliative and end of life care is being pooled as a resource in the ICS that has been used to fund a specialist team at Leeds Children's Hospital who support all clinicians or anyone working with a child with a life limiting condition across the whole of the West Yorkshire area. Work is also being undertaken with adult hospices to formulate a transition plan into them.

The programme is looking at children's community nursing in order to extend the service to 8 am until 8 pm.

The partnership has recently experienced a loss of staff which is creating a significant issue alongside the reduction of health visiting during the pandemic. This has included therapists who have moved to private organisations as a number of parents pay for assessments of their children who need an Education, Health and Care Plan, rather than waiting.

A significant issue currently is that the organisations are in a transition phase as they move into formalised ICS arrangements, although more clarity about the position re the design and re-organisation of the ICS is now emerging.

> *"There's quite a lot of uncertainty at the moment and just getting a plan of how things are going to be from April onwards - we've got a plan and we've got some real clarity on what that will look like, but in terms of how we move forward with it, from a financial point of view, NHS England haven't really given us that detail yet."*

Any newly implemented programmes are analysed for their influence on the system and how that works for each of the work streams. Information regarding these factors is due to be reviewed soon. A spreadsheet is being developed for each work stream to provide information to the Board about how this is working for each of the work streams, what support is provided and what is delivered – the "so what question". A spreadsheet is being set up for each work stream lead to provide this information so that the Board can be kept fully informed about what difference the programme is making.

5.8.6 Governance

There are two senior responsible officers for the programme: the chief executive of a CCG and a director of a local authority children's service.

> *"Really important those links into local government because for children, school is a massive part of their lives, isn't it, and how things work in school. And their communities, as well. So, that's something that we're really focusing on: how we work in each place."*

5.8.7 Commissioning and funding arrangements

The commissioners have been brought together with the aim of creating a consistent approach rather than the prior commissioning of different services in different areas. Meetings with commissioners, where approaches are agreed on tasks to be done, are on a monthly basis. However, commissioning takes the needs of each locality into consideration rather than commissioning the same service across the whole area.

> *"For us as an ICS, the primacy of place is absolutely fundamental. So, it's not about us saying, 'we must do one thing and we must do it all in the same way, it is about, 'these are the outcomes that we're looking to achieve, and you need to determine how you do that at place'. Because we have got different models of provision and in one area we've got a private provider that provides community services for half of one trust and half of another trust."*

Some services are being jointly commissioned by the programme. For example, money provided to CCGs was used to set up the Night Owl Service – a telephone support service for children and people experiencing a mental health crisis. This can be accessed between 8pm-8am the following day. Anyone using this helpline will be linked to services in the ICS. Early indications (in the first 3-4 months) suggest the service is working well.

Additionally, a Tier 3 Children & Adolescent Mental Health Service (CAMHS) unit will be opened in Leeds early in 2022. This service will be employed as a joint approach across the ICS. The opening of this centre should lower the number of children being sent to others areas for this form of care.

There is also some pooling of budgets within the programme. For example, funding from NHS England has been placed into specific avenues of care (asthma) and is in the beginning stages of being implemented into the care model. The Yorkshire and Humber Palliative Care Network is linked into the Child Health in the Community programme. The funding that this network has received has been used to help fund local hospices.

The space and boundaries within other areas included within the West Yorkshire partnership is consistent and helpful for practice.

5.8.7 Building the partnership

The West Yorkshire Health and Care Partnership works in partnership across all health and care organisations, partners and communities.

> ***"T****he interconnectedness in terms of workforce is something that underpins everything we do."*

The principle of subsidiarity is applied to work which can only be carried out at a West Yorkshire level. This work is carried out on the basis of agreement with each locality and where value can be added by:

- Working at scale to ensure best possible health outcomes for people.
- Sharing good practice across the partnership.
- Working together to tackle complex issues.

The programme works very much as a whole system approach, including colleagues from local authorities, health and the voluntary sector. Being able to build on existing relationships between health, local authorities and providers is very useful in developing an integrated approach.

> *"I've learnt a lot from working at Leeds and the approach that we took in children's services which was very much an integrated approach. And we had really good relationships with our health partners, with providers and commissioners. And I think that's absolutely key and critical to the approach that we're looking at."*

Building relationships with senior leaders and elected members within the partnership, as well as having elected members on the board, is seen as essential to building and maintaining trust.

> *"[The new ICS chief executive] is absolutely passionate about the partnership element of it and he's built relationships with provider chief executives, commissioner chief executives, with elected members. And it's something that at a West Yorkshire level is part of our DNA."*

Leadership is a key element within the ICS with elected members involved alongside leaders on the partnership Board.

> *"We've got the chairs of all the health wellbeing boards. So, elected members are part of this as well". And we've also got the directors of adult social care involved and directors of children's services involved in our programme. And so, the partnership element is strong as an ICS in the approach that we're taking"*

5.8.8 Community engagement

The programme is "very passionate" about the voice of the child and young person being at the heart of everything that it does. The Youth Collective is a group of young people (some with additional needs, some with long-term conditions and some without any particular health requirements) across West Yorkshire who meet remotely. They steer and drive the programme's approach to how services are developed, and provide the lived experience of what it really feels like to be a young person in West Yorkshire.

The interviewee saw co-production as an important element of work involved in the partnership, especially with at-risk groups. This can help workers get a better understanding about the personal experiences of their patients and how these can be improved in the short- and long-term future.

> *"We want to really start to look at how we can support and ensure that these parents get the support they need."*

The community element is seen as being very importance to the partnership. Paediatricians from a range of providers attend meetings along with people working on the Children, Young People and Families Programme. In addition, the programme is also being linked to other programmes of care in the area which share a community focus.

> *"Harnessing powers of communities is another programme that we're linking to. So, that community element is really important. And the urgent and emergency care programme board links into the child health in the community work and how we engage with primary care."*

5.8.9 Information and reporting

Each work stream has, or will have, a set of agreed outcomes but how these outcomes are delivered will be determined at place.

> *"We're not going to dictate, 'you must do it like this' because in every place the context is different completely."*

A highlight report for each programme is presented to the Board, and the current focus is to improve the Board's understanding of what each programme is looking to achieve in terms of its outcomes and approach.

There is currently no single performance framework for the programme but a principle for sharing data has been agreed. This is being evolved as an approach going forward, with the help of a recently appointed data analyst and data emerging from certain areas of current work.

> *"And so, for example, with the Child Health in the Community Programme, we're getting data around A&E attendance of children and hospital admissions, length of stay. That kind of information is starting to come through now for that particular programme."*

Improvements in consistency of care for all people, irrespective of background, across the ICS are also a major target, with a reduction in waiting times a priority.

> *"What we want is a consistent approach. It shouldn't make a difference where you're born in terms of the service that you get.."*

5.8.10 Wider determinants of health and wellbeing

Certain schemes and groups have been set up to address issues in both housing and the environment in which a child grows up and how this may be linked a child's personal health.

> *"We have a housing and health group, which is jointly with local authorities. And I know there's been a lot of work done there."*

A large portion of work has been carried out by a housing and health group to tackle the background and social situation of child patients. The wider determinants of health are being addressed by the Improving Population Health Programme: this initiative involves a large variety of partners and consists of a collaborative movement in the region to identify new opportunities and projects that will make a long-term difference for improving the health of the local population.

> *"Particularly when we're looking at asthma, for some children who live in quite deprived circumstances, if their house is really damp and mouldy, then that's not great if you've got asthma."*

5.8.11 Lessons learned and advice

The interviewee felt that the key success factor for the programme is having a whole system approach, involving health, social care and the voluntary sector who are fully invested in the work.

> *"Bringing everybody together has been phenomenal. It really has. And people just really like being part of the approach that we're taking and like to influence and help to develop it as well, so it's going really well."*

An important lesson learnt is to maintain contact with the key people you are working with in some capacity (either directly or indirectly). Bringing people together allows a collective approach to be agreed with shared outcomes (including those that are influenced by children, young people and their parents) and the best direction going forward. It helps to build relationships, trust and a fundamental understanding of different approaches some may take in comparison to others.

> *"It's really about having relationships, building trust, shared outcomes, shared approaches and then having collective agreement about how we work together going forward."*

The interviewee felt that a key element that works well through the development of the programme is making the partnership central to everything.

> *"I think for me it is about partnership. It is about engaging with all aspects of the system and bringing people together to form an agreed approach and a way forward."*

Getting commissioners within the partnership together on issues has been very helpful, particularly within the area of special needs.

Having clarity at the very beginning of the process has allowed feedback to be taken and changes to be made. This has been very helpful as people are clear about what they are trying to achieve and are able to better understand their role, wherever they are placed in the system.

> *"Bringing the commissioners together has been phenomenal because what I've discovered in the special needs world is that each place works completely differently in terms of assessment and care planning."*

Throughout the last two years, working from home has made a massive change to how people work and the relationship with colleagues. A key challenge is that teams may have never met face to face, only virtually, which has affected teamwork during this time and setup.

> *"It was an open-plan office type of environment. And you'd just wander over to somebody's desk or ask them a question or say 'Can I just tell you about this?' And you miss that, don't you, when you're working remotely."*

5.8.12 Outcomes seen so far

- The Child Health in the Community programme has been going for 18 months and there has been a reduction in A&E attendances by children and young people plus reduced length of stays in hospital.
- Stillbirths and neonatal deaths have been reduced by 10% across West Yorkshire.
- Wakefield services have been assessed as making sufficient progress to improve autism services for children and young people. In June 2017, 614 children and young people aged between 0-14 years of age were waiting on average two years for their autism spectrum disorder assessments. By June 2019, this had drastically reduced to 112 children, with a waiting time of no more than 26 weeks for children under 14 years.
- Evaluation of learners' progress at Wakefield and 5 Towns Recovery College found that 29% of students have self-reported a decrease in their contact with health services and 18% have gone into employment, volunteering or education since attending the college. (Recovery colleges focus on developing people's strengths, helping them understand their own challenges and how they can best manage these in order to live fulfilling lives. They are developed and delivered by people with lived experience of health problems.)

6. Other Models Not Explored in Detail

6.1 Northamptonshire

6.1.1 Background

Northamptonshire Health and Care Partnership (NHCP) consists of key health and care organisations in the county. As a partnership, it works collaboratively with Northamptonshire's Health and Wellbeing Board, which is responsible for setting the local strategy for health and wellbeing.

The vision for the future of Northamptonshire's health and care services is for a positive lifetime of health, wellbeing and care in the community. The mission in working together, the reason for doing what they do, is to empower positive futures.

The NHCP is made up of the following organisations:

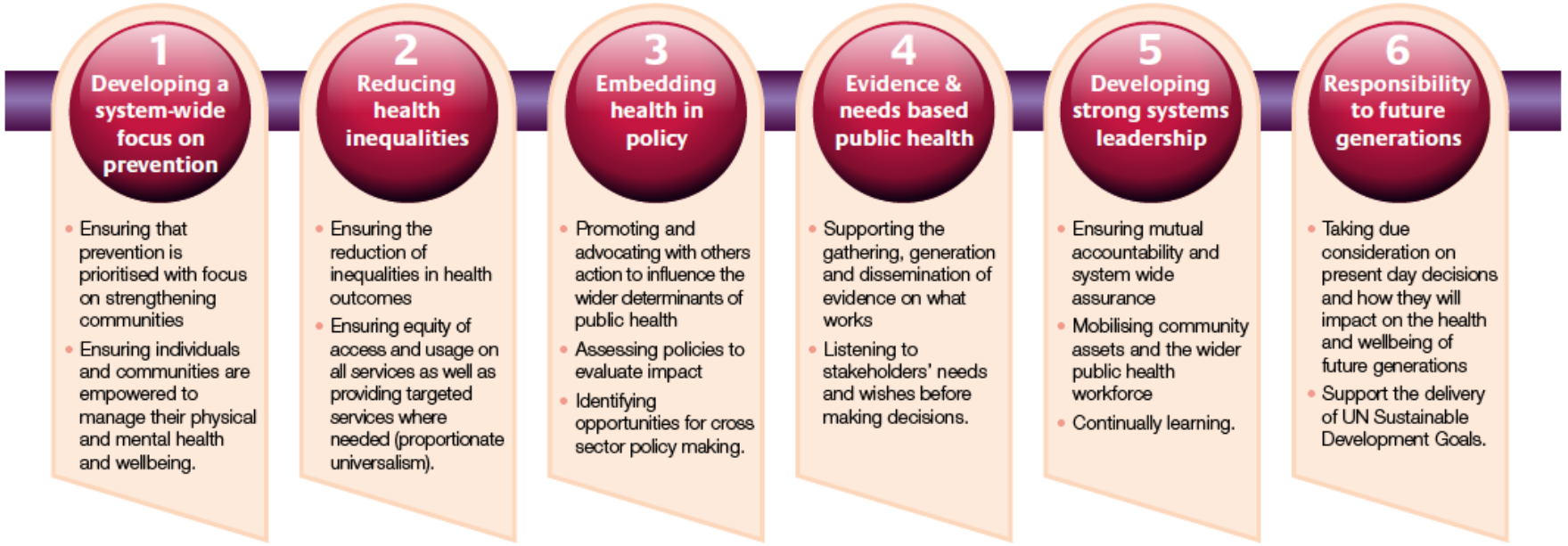
- Northampton General Hospital.
- Kettering General Hospital.
- Northamptonshire Healthcare NHS Foundation Trust.
- 3sixty Care Partnership.
- GP Alliance.
- PML Federation.
- Lakeside Healthcare Group.
- Northamptonshire County Council.
- North Northamptonshire Council.
- West Northamptonshire Council.
- East Midlands Ambulance Service.
- NHS Northamptonshire Clinical Commissioning Group.
- NHS England.

6.1.2 The Service Model

By working more closely in partnership, the Partnership is being ambitious about doing things differently and clear on its local priorities; so together they can improve the quality of care and the health and wellbeing of the community.

Key principles and actions

Quality should permeate everything we do; no single organisation can improve quality on their own. All public health systems are responsible for delivering the key public health functions of protecting and safeguarding health, improving health and reducing health inequalities and supporting the NHS and care system in their focus on individual and population health. The Public Health System Group has accepted a shared responsibility to support local public health systems to take steps to improve quality in the following priority areas.



6.1.3 Designing the Northamptonshire Integrated Care System

Having received Integrated Care System (ICS) designation in April 2021, Northamptonshire Health and Care Partnership is continuing to develop plans for Northamptonshire's emerging system, taking into account the recently published White Paper and the ongoing response and recovery from COVID-19. Among other things, the White Paper sets out proposals which will foster greater collaboration and partnership within systems – with the intention of providing significantly more joined-up health and care experiences for citizens.

NHCP is committed to putting in place the core components of the ICS by April 2022. In order to achieve this goal, they aimed to have designed the key elements of the system (and the interactions between them) by the summer 2021, for further iteration, testing and implementation in the second half of 2021.

The Partnership undertook an intensive design project to consider questions including:

- The overall 'shape' of the system – including what activities are best undertaken once across the county, and which should be more local.
- How county-wide ICS structures should relate to the two 'Places' in North and West Northamptonshire, including their links to local authority services.
- How providers of care (NHS, local authority and others) can best work together around the needs of the population.

6.1.4 Children and Young People

Nearly 70% of children in Northamptonshire are currently reaching an adequate level of development by reception. This figure falls to 50% for children receiving free school meals. Children living in the most deprived areas of the county lose on average 13 years of good health in comparison to those living in the least deprived areas. **Children and Young People** & **Learning Disabilities** were identified as two of the six main areas of work for the planning and delivery of local improvements.

Improving health and wellbeing outcomes for children and young people is a priority for NHCP. The Children and Young People Transformation Board has adopted the THRIVE network – an integrated, person centred, and needs led approach to delivering mental health services for children, young people and their families. The model is highlighted in the NHS Long Term Plan and conceptualises needs in five categories; Thriving, Getting Advice, Getting Help, Getting More Help and Getting Risk Support.

This has been adopted to underpin the programme vision to deliver collaborative innovation of services in Northamptonshire. The THRIVE framework can be applied to any child, young person or family to illustrate what support they may benefit from in order to THRIVE. Most children in the UK are thriving, which means that they consider themselves to be healthy, achieving well in education, and able to participate in social activity that they enjoy.

The Children and Young People Transformation Programme aims to promote positive outcomes using the THRIVE framework to help services know how to be, and what to do in response to differing needs. Meanwhile prevention and promotion are embedded throughout the framework to support every child to thrive.

The programme's next phase will consider the population health and experience of children, young people and their families in Northamptonshire to identify priority areas for transformation.

6.1.5 Transformation Pillars

The NHCP Children and Young People Transformation Programme is working to transform children's health and care services via four key areas of focus, or "pillars":

1. **Healthy Lifestyle**
   - Working together to help families confidently choose healthy lifestyles. Promoting lifestyles enriched with healthy eating, healthy levels of activity, healthy relationships and free from substance misuse will help our children to thrive throughout their lives.

2. **Complex Needs**
   - Working to improve the impact of complex needs, including long-term conditions, on children's health and wellbeing outcomes with a particular focus on looked-after children and care leavers. Taking action to reduce the prevalence of complex needs (including special education needs and disability) and improve the experience of those living with them. Bringing experts together with children, young people and families living with complex needs to plan and evaluate their experiences of changes.

3. **Healthy Minds, Healthy Brains**
   - Empowering children and young people to care for their own wellbeing and access help if and when it is needed. Enabling children, young people and families living with neurodiversity to thrive with good access to family-based support. Ensuring children and families experiencing emotional, wellbeing, mental health and neuro-developmental need are involved in improving services through co-production.

4. **Accessibility**
   - Creating a "no wrong door" culture in Northamptonshire by supporting our professionals and children, young people and families to navigate services, keeping children's needs at the forefront of every contact. Developing support for services through co-production to understand how children need them to

be, and ensure all stakeholders continue to develop a thriving community together.

Collectively the pillars provide the infrastructure for a strategic plan to identify needs and deliver joined-up, proactive and personalised services which provide high-quality care for children, young people and families at all levels of our integrated care system. The pillars are also the means by which Northamptonshire will deliver on the commitments set out nationally for children and young people in the NHS Long Term Plan and the Department of Health and Social Care's "The best start for life: a vision for the 1,001 critical days.

6.1.6 Mental Health

It's estimated that around 185,000 people in Northamptonshire will experience mental ill health at some point in their lifetime. Significant numbers of children are affected with more than 500 children referred to mental health services in the county every month.

Northamptonshire Healthcare NHS Foundation Trust is the county's mental health care provider. This trust works closely with service users and carers, mental health care providers and practitioners in the voluntary and community sectors, as well as with other providers of secure and community mental health care in the county and region.

6.2 Sheffield

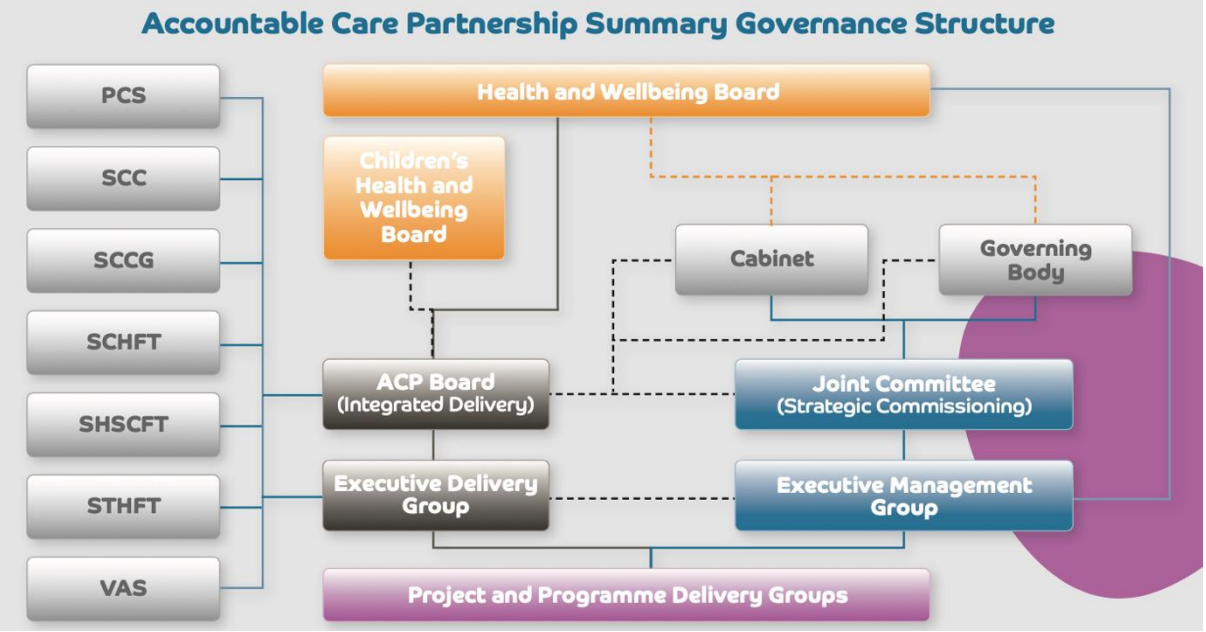
6.2.1 Background

The Sheffield Accountable Care Partnership (ACP) is a partnership between seven health, social care and voluntary sector organisations across the city of Sheffield that work together to coordinate and deliver care.

The organisations in this partnership include:

- Sheffield Children's NHS Foundation Trust
- Sheffield City Council
- NHS Sheffield Clinical Commissioning Group
- Primary Care Sheffield Ltd
- Sheffield Health and Social Care NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Voluntary Action Sheffield

The Sheffield Accountable Partnership is responsible for carrying out the 2019-2024 Shaping Sheffield plan. Organisations involved with health and social care have agreed collectively that a different approach is required. The starting point is a shared vision, aims, priorities, objectives and a set of principles that shape the way we work together. This is where the ACP comes in; to bring the organisations together more closely together to deliver "**prevention, wellbeing and great care together"**.



When focusing on children, two long-term ambitions of the 2019-2024 Shaping Sheffield Plan are:

- To develop an all age care system, involving greater integration between primary and specialist care; physical and mental health care; health and social care; and children's and adults care. Services will be organised around the individual rather than professional boundaries. The plan will promote prevention, focused on transforming the health and well-being of the population.
- To deliver a great start in life, to enable all children in the city to have the best life chances and families to be empowered to provide a healthy, stable and nurturing environment.

6.2.2 Current Care System

Great Practice: in care services for children include Safe Sleep Initiatives, The Young Carers' Strategy, Sheffield Eating Disorders Strategy, Future in Mind and Children's Pilot IAPT.
Holiday Hunger: Initiatives from the voluntary and community sector bringing food as well as skills.
Growing burden of mental health issues for children: Access to Child and Adolescent Mental Health Service is 94% within 18 weeks target, but deteriorating performance through 2018.
CQC & Ofsted Review of SEND found: lack of vision and strategy, inconsistent practise, a need for improved communication and a need for more effective multi-agency transitions.
Transition from children to adult mental health services: Key city improvement scheme.

6.2.3 Key Enablers

A set of key enablers to help transform the system have been agreed, in acknowledgement of the significant workforce, cultural, digital, financial and business change required to deliver the ACP's ambitions:

1. Developing a person centred approach.
2. Developing system leadership and culture.
3. Development of a system wide workforce strategy.
4. Developing a sustainable financial approach.
5. Digital transformation.
6. Communication strategy.

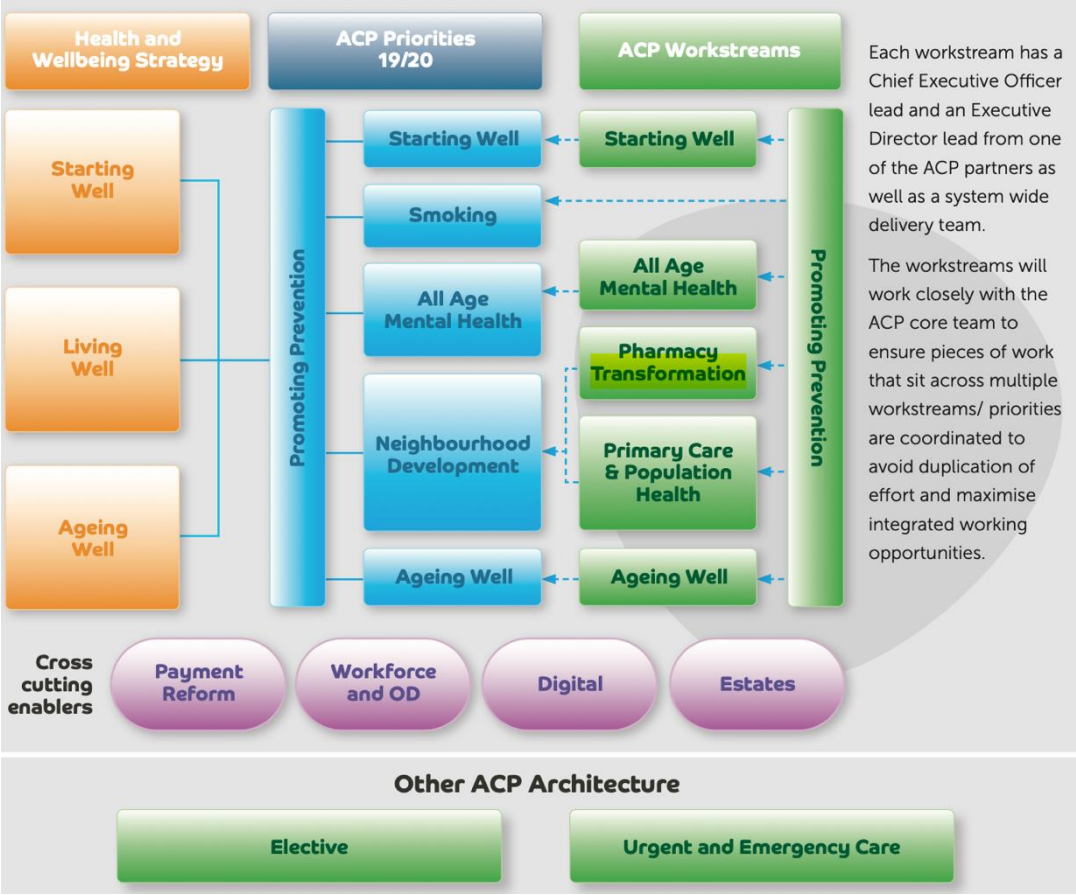
6.2.4 Starting Well

Starting Well is one of the ACP's delivery priorities The partnership wants to connect people to the right level of support at the right time through universal and targeted protection, early identification and early support. The goal is for:

- Every child to achieve a level of development in their early years for the best start in life.
- Every child to be included in their education and accessing their local school.
- Every young person to be equipped to be successful in the next stage of their life.

The Children and Young People Health and Wellbeing Board are committed to:

- Ensuring there is good quality and active engagement with children, young people, families, carers and professionals across the entire area of work to support, signpost and shape services and the workforce.
- Championing programmes of work that enable children in Sheffield to reach their potential irrespective of their vulnerabilities .
- Ensuring all transition points for children are seamless and agencies provide joined up care, developing shared data and information where possible and appropriate.
- Having robust government arrangements in place to oversee delivery and link with other work streams to ensure children and young people are actively involved and considered.
- Implement the written statement of action following the CQC and OFSTED SEND inspection.
- Support the delivery of a new all age eating disorders pathway and use the learning to deliver and inform future models of care for mental health.
- Implement a community nursing model to support the development of a locality based working approach, focussing on complex needs and palliative care as a priority.
- Finalise the community paediatric pathway with focus on autism and ADHD as a priority and use this learning to develop further pathways to support the development of locality working.
- Create a "Great Start in Life Strategy", a refresh of the Best Start Strategy.
- Undertake wide stakeholder engagement during 2019 in order to create a Children and Young People's Strategy for 2020-2023 which reflects the ambition of the NHS Long Term Plan for children and wider relevant strategies.
- Link with all other Accountable Care Partnership work streams and organisational priorities to ensure the prevention agenda and children and young people are priority.



Children and mental health has been cited as a greater focus within the Long Term Plan. The plan has committed £4.5 billion more for primary medical and community health by 2023/24 and £2.3 billion for mental health.

The Starting Well initiative will develop an Adverse Childhood Experiences (ACE) aware Sheffield; ensuring the Sheffield workforce understands how ACE can impact on families

6.3 Sussex

6.3.1 Background

The Sussex Health and Care Partnership (SHCP) is a new footprint which serves a large and varied population of 1.7 million people and is responsible for £4bn of health and care spending, delivered by over 30,000 staff.

Across Sussex, the NHS and local councils that look after social care and public health are working together to improve health and care. The SHCP brings together 13 organisations into an integrated care system (ICS). The aims of the ICS are to take collective action to improve the health of local people, ensure that health and care services are high-quality and to make the most efficient use of available resources.

The way of working is based on the priorities and outcomes that matter to local communities and allows all organisations to work together towards the same plan to improve health and wellbeing. This will help local people to stay health for longer, to receive more support and treatment at home and, if they do get ill, to ensure they get the right care in the right place at the right time.

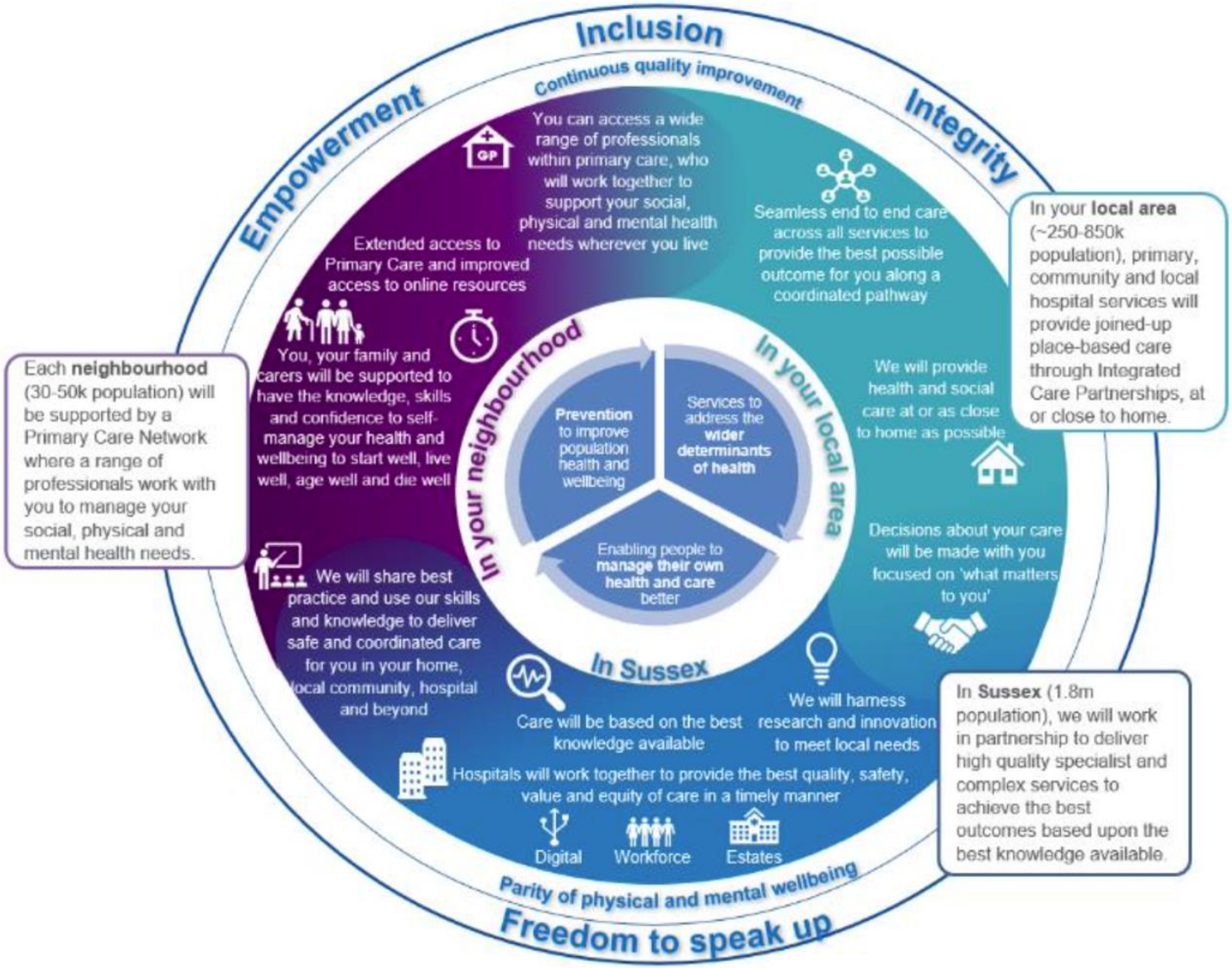
The SCHP is made up of the following organisations:

- Brighton & Hove City Council
- East Sussex County Council
- East Sussex Healthcare NHS Trust
- Brighton & Hove Clinical Commissioning Group
- East Sussex Clinical Commissioning Group
- West Sussex Clinical Commissioning Group
- Queen Victoria Hospital NHS Foundation Trust
- South East Coast Ambulance Service NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- University Hospitals Sussex NHS Foundation Trust
- West Sussex County Council

6.3.2 The Service Model

The Sussex model is based upon the principle of health and care being delivered at three levels:

- Neighbourhood.
- Local area.
- Sussex.


Inclusion
Continuous quality improvement
Empowerment
Integrity
Parity of physical and mental wellbeing
Freedom to speak up
You can access a wide range of professionals within primary care, who will work together to support your social, physical and mental health needs wherever you live
Extended access to Primary Care and improved access to online resources
Seamless end to end care across all services to provide the best possible outcome for you along a coordinated pathway
You, your family and carers will be supported to have the knowledge, skills and confidence to self-manage your health and wellbeing to start well, live well, age well and die well
We will provide health and social care at or as close to home as possible
Decisions about your care will be made with you focused on 'what matters to you'
We will share best practice and use our skills and knowledge to deliver safe and coordinated care for you in your home, local community, hospital and beyond
Care will be based on the best knowledge available
We will harness research and innovation to meet local needs
Hospitals will work together to provide the best quality, safety, value and equity of care in a timely manner
Digital
Workforce
Estates
In your neighbourhood
In your local area
In Sussex
Prevention to improve population health and wellbeing
Services to address the wider determinants of health
Enabling people to manage their own health and care better
Each neighbourhood (30-50k population) will be supported by a Primary Care Network where a range of professionals work with you to manage your social, physical and mental health needs.
In your local area (~250-850k population), primary, community and local hospital services will provide joined-up place-based care through Integrated Care Partnerships, at or close to home.
In Sussex (1.8m population), we will work in partnership to deliver high quality specialist and complex services to achieve the best outcomes based upon the best knowledge available.

6.3.3 Key Components of Model

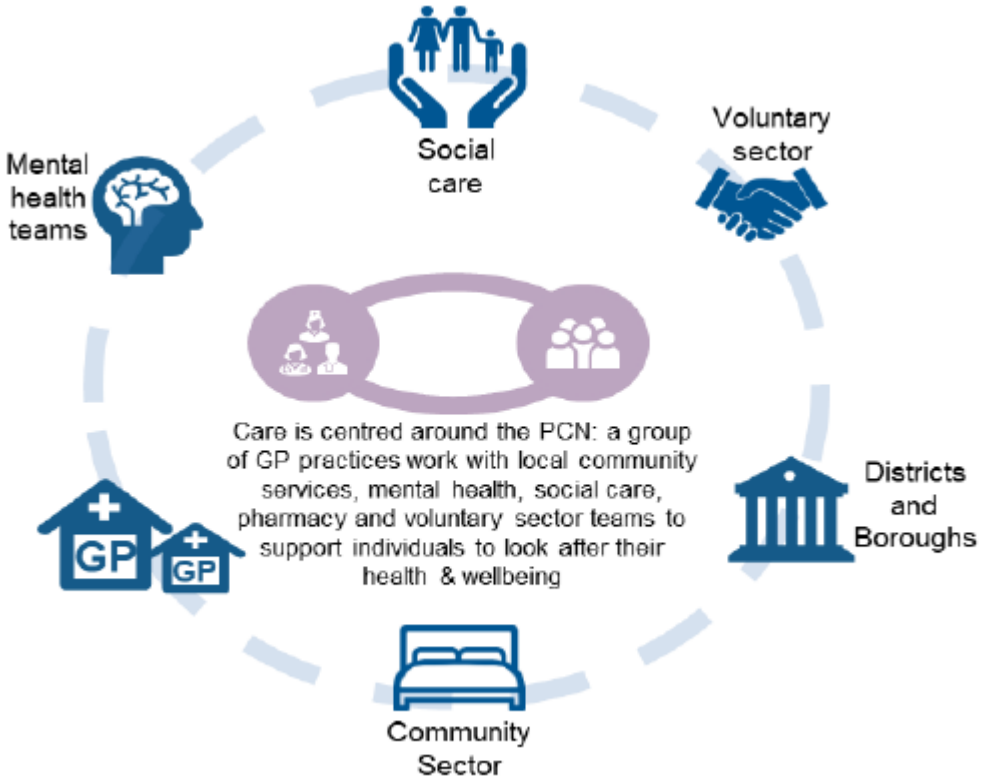
The model is underpinned by the three fundamental building blocks:

1. Prevention.
2. Services that address the wider determinants of health.
3. Enabling people to manage their own health and care.

- The impact of a person's social circumstances and environmental surroundings, including employment and housing, and factors such as loneliness and isolation, influence the uptake of unhealthy behaviours which go on to account for a high proportion of disease and disability.
- Many of the strongest predictors of health and wellbeing are wider determinants of health which drive inequalities. These include economic, social and environmental factors, which fall outside the scope of NHS and social care services.
- The poorest and most deprived people are more likely to be in poor health, have lower life expectancy and have a long term condition or disability. Some groups such as BAME, LGBT+, people with special educational needs and disabilities, people with long term mental health problems and carers, etc. may require more intensive support and additional help to access services.
- The four unhealthy behaviours of smoking, alcohol misuse, poor diet and physical inactivity, along with social isolation and poor emotional and mental wellbeing, are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions.
- Individual service prevention interventions improve health and wellbeing, and reduce inequalities. They also build stronger and more resilient communities and places which **support people to maintain independence, make healthier choices and manage their own health and wellbeing** across the course of their lives. These are important components of a whole system approach to prevention across the NHS, Local Authorities, the voluntary sector, community groups and wider stakeholders.

Each neighbourhood is supported by a Primary Care Network (PCN), where primary and community teams work with individuals to look after their health and wellbeing.

- Community and other local services are designed around neighbourhoods to ensure optimum integration of care – bringing social, physical and mental health together and delivery closer to home. PCNs work with social care and the voluntary sector, as well as neighbourhood health services, to coordinate and integrate delivery.
- Each neighbourhood is supported by the equivalent of 10-18 additional staff by 2023/24 through the new GP contract.
- Expanded neighbourhood teams comprise a broader range of staff including clinical pharmacists, physician associates, first contact physiotherapists, first contact community paramedics, community geriatricians, dementia workers, mental health practitioners and social prescribing link workers.
- The physical and mental health of the local population is supported by using data and involving local people and their feedback to appropriately target services, build an in depth understanding of health needs and inequalities, and develop multi-disciplinary, cross sector teams to take responsibility for these needs, e.g. when delivering social care.
- PCN teams are supported by easy access to and partnership with local hospices and specific secondary care expertise.



In the local area, primary, community and local hospital services will provide joined up, place-based care through Integrated Care Partnerships, at or close to home:

- Services are designed around individuals' holistic needs so that they can move seamlessly between primary and community health and social care, and local hospital services in a timely and efficient manner.

- Where it is safest and most effective, clinical services are designed around targeted populations at a local area level, seeking to deliver more care at home or in the local community.
- Integrated Care Partnerships (ICPs) take responsibility for actively planning services for the benefit of the population, segmented by health and care needs, whilst ensuring that there is not unwarranted variation in outcomes, e.g. with consistent urgent care models. This is undertaken in close collaboration with the public.
- ICPs are partnerships of “sovereign” providers, including Local Authorities, acute hospital trusts, community services and other providers within a Primary Care Network, that deliver end-to-end healthcare. This involves optimising whole care pathways, allocating resources against outcomes for the local population, and addressing local health inequalities.
- These partnerships lead to integrated care teams, whose composition depend upon the need of the specific local area and the outcomes that matter to that population.
- There is ongoing work to understand how relationships will be further built between PCNs, local commissioners and providers to effectively manage activity flows.

6.3.4 Objectives

A population health check in 2018-19 identified areas of concern for children within the county and where care provided was less than optimal. Focused effort is required to ensure that every child and young person has a strong start in life. This was identified as one of 10 key service transformation priorities under the partnership. The prevention board identified six key objectives to support the population at each stage of life. Specifically for children this includes “Supporting a good start in life, including delivering a whole systems approach to healthy weight, and promoting emotional wellbeing and good mental health in children and families.

The Sussex 2025 vision for a healthier future plan sets out five key priorities to achieve:

1. More people living across the county to live longer in good health.
2. Reduce health inequalities for the population.
3. Improve the experience of our populations when they access services.
4. Improve the experience of staff at work so they feel better supported.
5. Create a health and care system that is more affordable to run in the long-term.

The Sussex Strategy Delivery Plan (for the whole population of all ages) aims to:

- Strengthen the pivotal role of prevention from birth and the need to address the wider determinants of health. Our approach reflects the responsibilities of the whole system in addressing health and wellbeing – NHS, councils, police, education, voluntary sector, communities and individuals.
- Recognise the importance of health literacy, supporting people to have the knowledge, skills and confidence to self-manage, protect their own health, and engage in treatment/care plans both independently and in partnership with professionals.
- Address the need for responsive and flexible services, supported by effective use of technology.

- Address the growing number of people with long term conditions who want to have a key role in managing their own care.
- Improve access to urgent care for those who need a quick and effective response.
- Harness the potential of specialist services, as well as breakthroughs in medical science and use of data, to maximise the benefits to our whole population.

6.3.5 Starting Well

The SCHP identified targets to achieve through the Sussex 2025 vision under the key area of care known as “starting well”:

- Improved mother and baby health and wellbeing, especially for those most in need.
- Children growing in a safe and healthy home environment with supporting and nurturing parents and carers.
- Healthy lifestyles and resilience will be promoted, including in school and other education settings.
- Good mental health for all children.
- All children and young people leaving care are healthy and independent.

Success will be measured through the following parameters:

- Percentage of women who are smokers at the time of delivery.
- Percentage of infants partially or exclusively breastfed at 6 to 8 weeks.
- Percentage of children born with a low birth weight.
- Percentage of children living in low income households.
- Percentage of Reception and Year 6 children who are a healthy weight.
- Rate of hospital admissions for self-harm amongst children and young people.
- Rates of conception per 1,000 females aged 15-17.

Priority measurements include smoking status at time of delivery and hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years):

- Severe mental illness affected 25,000 individuals in Sussex, with many more affected by common mental health problems including anxiety and depression.
- Three quarters of first episodes of mental ill-health occurred in young people and yet mental health services for children and young people were under particular demand pressures.

This will be addressed with the implementation of the Children and Young People (CYP) Mental Health – including CYP Crisis workstream. Together with special commissioning, the SHCP will align the ambitions of the Children and Adolescent Mental Health Services Tier 4 Bed Capacity Plan and support delivery of the South East share of the National Accelerated Bed Plan with local ICS/STP mental health plans for children and young people.

6.3.6 Integrated care

The bedrock of the Sussex integrated care model is close and effective working between primary and urgent care, community and mental health services, social care and the voluntary sector, to ensure that all individuals receive the best care in the best environment, with high quality care delivered at every level.

At the neighbourhood level, one or more primary care networks bring together GPs to work with local community services, mental health, social care, pharmacy and voluntary sector teams, to provide integrated health and care for patients and the population, alongside promoting quality and safety. This aims to enable patients to experience well-planned services, appropriate to their needs, and seamless pathways.

Integrated Care Partnerships (ICPs) use the wealth of data that they have to understand the needs of, and actively plan services for the benefit of, the population. They work collaboratively to co-design and deliver care pathway solutions to address unwarranted clinical variation and improve outcomes. Fundamental to this is using integrated health and care records.

The population has been asked to identify the outcomes that matter to them, and the Partnership uses this information in assessing the performance of ICPs and to drive continuous improvement. These outcome measures inform the development of Integrated Care Teams which work with a defined population segment and account for outcomes that people have said matter to them.

To enable teams to work well together, the Partnership is re-defining its clinical, professional, operational and financial accountabilities to better reflect the scope of the Integrated Care Teams. Collaboration between urgent care and both neighbourhoods and ICPs is seen as fundamental to delivering the most effective and consistent outcomes at the appropriate level. Provision of integrated health and care records are also be central to successful delivery.

To deliver the Sussex Model, the ICS needs to work collaboratively with all health and care providers, who in turn must work closely with commissioners. For the model to be successful, all organisations must be financially sustainable. The financial framework must gradually increase the proportion of total resource spent on primary and community care without undermining performance in the acute setting.

6.3.7 Integrated commissioning

The local CCGs plan to strengthen local planning through organisational mergers, to avoid the fragmentation of the healthcare system. Integrated commissioning and care will be key to positive health and care outcomes and to effective delivery of this health and care strategic model. Health and Local Authority commissioners will work together on delivery of health and care services, as well as on a programme to address current inequalities, in order to improve the health and wellbeing of the population from birth to old age.

6.4 West Suffolk Integrated Community Paediatric Services

6.4.1 Background

West Suffolk NHS Foundation Trust (WSNFT) are the main provider of children's services in the West Suffolk region. Together with children's community services, the organisation caters for a population of around 50,000 children. The two primary aims of WSNFT are:

- To provide all children and young people with safe and good quality care.
- To ensure that the length of time a child or young person is in hospital for is as short as possible.

The partners are:

- Universal Services.
- Early Years settings.
- Schools.
- Social Care.
- Acute Trusts.
- Mental Health.
- Tertiary/Specialist Centres.

6.4.2 Service Model

The integrated community paediatric services model supports children and young people with additional needs, developmental concerns, medical and long-term health conditions, learning and physical disabilities. Care and work is coordinated as part of a multi-disciplinary team.

Many children on current caseloads remain on record with the service until transition to adulthood. The number of children with additional needs is expected to increase by up to 20% in the next two years.

The services are based in Ipswich and Bury St Edmunds and work across the county. There are eight core services and teams responsible for the provision of care within these services:

- Community Paediatric Audiology.
- Specialist Children's Nursing Team.
- Child and Family Psychology.
- Children's Community Medical Services.
- Paediatric Occupational Therapy.
- Children's Physiotherapy.
- Children's Speech and Language Therapy.
- Suffolk Communication Aids Resource Centre.

The shared philosophy for service delivery and future development is "**to provide a quality service to children and families with specialist and complex health needs in an equitable, timely, responsive and integrative way**"

6.4.3 Priorities

The priorities are to:

- Focus on safe, effective care of the child and family.
- Focus on setting achievable outcomes for the individual.
- Engagement – service users, stakeholders.
- Responding to national and local drivers.
- Focus on safety during organisational change.

6.4.4 Common principles for outcomes for children and young people

Although individual services will have specific service aims (e.g. improving communication, motor skills etc.), there are common core outcomes for all services.

- Focus on the needs of the child – assessment or intervention aims to enable each individual child to "be the best they can be".
- Achievement of developmental milestones – appropriate to condition.
  - Achieved specifically through the establishment of individual targets and measurement of outcomes.
- Enablement.
  - Achieved specifically through access to a safe home and education environment.
  - Families, carers and children are supported to understand and manage their condition.
- Resilience – Access to service only when needed (specialist support).
- The right to be a child – achieving educational attainment.
- Avoidance of harm – achieving health and/or preventing unnecessary deterioration in condition.

6.4.5 Challenges & Opportunities

Challenges are:

- Organisational change.
- Suffolk wide engagement across both CCGs.
- Referral pathways/processes.
- Pathway integration across provider services.

Opportunities are:

- New Provider organisation to support future developments with clear Paediatric focus.

- Development of IT systems to support systems/processes (e. g. referral routes, SPA).
- Dedicated, professional and innovative workforce.