Child Health and Wellbeing in north east London

25% of population are BCYP*
Rate of low birth weight term babies is above the England average (except in Waltham Forest)

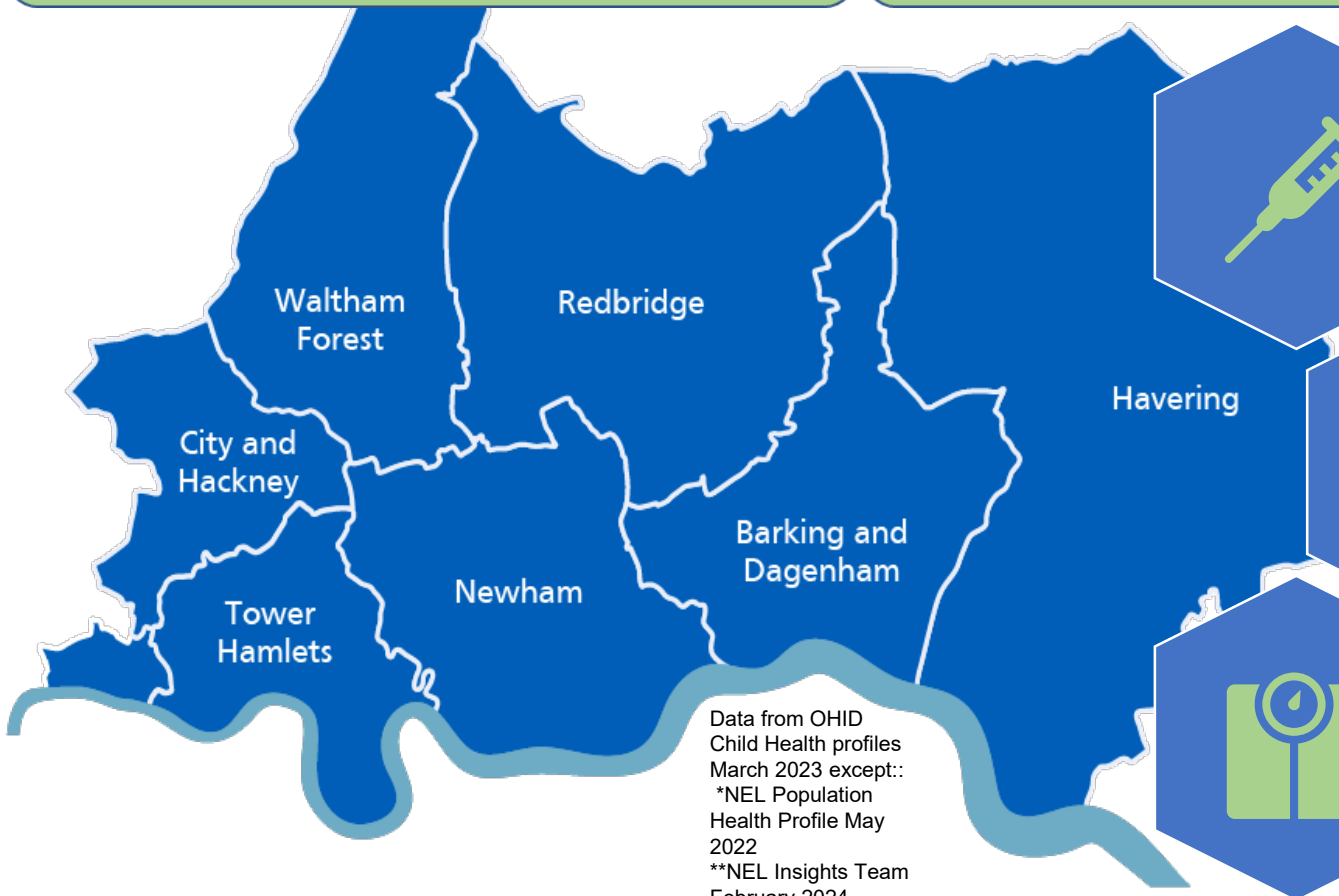
56% of BCYP in B&D** are in the most deprived quintile
(43% C&H, 33% TH, 26% N, 18% WF 4% R)

Estimated 64,540 (13%) children with SEND
Special Educational Needs and/or Disabilities.

Health and Wellbeing is mixed
(except for Havering where it is better than England average)

Higher % of school children from minority ethnic groups
than the London and England averages

Child deaths: average number each year:
B&D:4; C&H: 5; H:3; N:11; R:10; TH:7; WF:8



All NEL places do not meet the recommended coverage of MMR immunisations

%of children achieving the expected level of development at 2-2 ½ years is lower in B&D, R and WF, similar in N and higher in C&H and TH

Dental health is worse than the England average in B&D, N, R and TH

The rate of hospital admissions for asthma is above the England average (except Newham)

Levels of obesity in reception and year 6 are worse than the England average in B&D, C&H, N and R

A&E attendances (0-4 Years) are above the England average in Newham and Tower Hamlets

Data from OHID Child Health profiles March 2023 except::
*NEL Population Health Profile May 2022
**NEL Insights Team February 2024

Babies, Children and Young People have a right to high quality care: Model of Integrated Care. Building a foundation for life

LTCs Pathways

Tackling Health Inequalities

Prevention

Promoting Wellbeing

Understanding the needs of our BCYP population:
- PHM
- Community Insights

0-19 Universal Healthy Child programme

Health Promotion and Lifestyles:
- Violence Reduction
- Healthy Weight
- Immunisations

Implement Care Leavers Compact

Safeguarding

Maternal Health

Prevention of child deaths strategy

Local Authorities, Public Health and Integrated Neighbour-hood Teams

Clinical and Professional Leadership

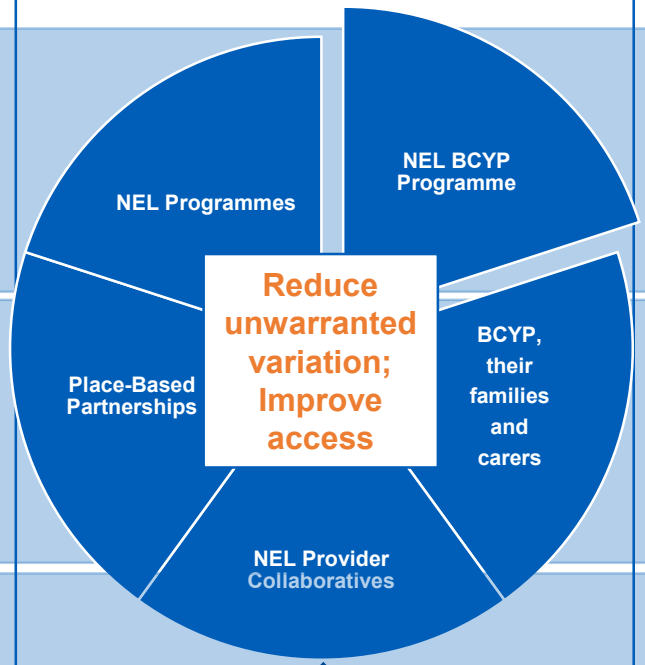
Care Closer to Home

SEND – CHS waits

Proactive Anticipatory Care:
- Child Health Integrated Care Pilots
- Family Hubs
- Youth Friendly Primary Care

Core20+5 areas of focus:
- Asthma –e.g. asthma friendly schools
- Diabetes –e.g. transition pilot
- Epilepsy – e.g. Epilepsy Specialist Nurses
- Oral Health – e.g fluoride varnish
- Mental Health – e.g. self-harm prevention project

Hospital@Home Children's Community Nursing 7/7



Clinical and Professional Leadership

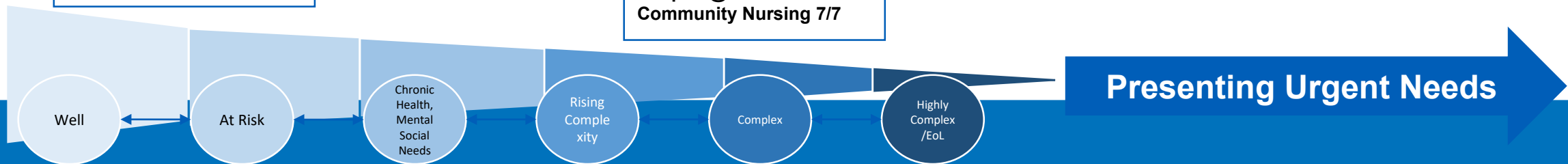
Acute Care

Planned care – elective recovery e.g. address audiology and addressing backlog of tooth extractions

Peer Review of Paediatric Emergency Departments/Urgent Treatment Centres

Implement Mental Health Champions

System-wide Paediatric Observations Tracking roll out



NHS
North East London

Draft Babies, Children and Young People's Plans 2024/25 across north east London

February 2024

NHS
North East London

NEL BCYP Programme Plan 24/25

Regional Priorities
Transformation for Babies, Children and Young People's Health

Asthma
To reduce avoidable harm to children and young people from asthma and improve their quality of life

Diabetes
To empower children and young people with diabetes and their families and carers to work in partnership with health-care professionals to establish a pathway of care that enhances and improves their health and control of diabetes

Epilepsy - North and South Thame Paediatric Network
Work with the North Paediatric networks to ensure improvements in the four areas of focus are delivered and aligned

Addressing Health Inequalities

Weight Management
To work collaboratively with whole system across the capital to support CYP and families to achieve healthy weight

Interdependencies

CYP Mental Health
Primary Care
Urgent and Emergency Care
Keeping Children Well
Transition
Complex Needs
Data and Digital

Workforce
Develop networked care, simplify pathways to improve access and delivery of services with the triple aim at the core of decision making

Voice and Co-Production
Publish and cascade results of National NHS Youth Forum Youth-led project and strengthen links with NHS Youth Forum

Early Years
Improve the health and well-being of all London's current and future population through early years intervention

Integration
To develop what good looks like, to improve access and quality of care for children, young people and their families and carers.

Cancer
To develop networked care and seek views to inform improvements in care alongside the reconfiguration of services

Improving Quality-Secondary & Tertiary Care
Develop networked care, simplify pathways to improve access and delivery of services with the triple aim at the core of decision making

Elective Recovery
Deliver a targeted campaign to accelerate progress of elective recovery pathways and create focus on CYP service recovery as a key deliverable of wider Elective Recovery efforts

NEL Babies, Children, Young People Programme – Vision, Mission, Strategic alignment and priorities

Vision

- To provide the best start in life for the babies, children and young people of North East London.

Mission

- The BCYP Programme aims to reduce unwarranted variation and inequality in health and care outcomes, increase access to services and improve the experience of babies, children, young people, families and carers and strengthen system resilience.

Strategic alignment:

- Working across and with Acute. Community Health, Primary Care, MHLDA provider collaboratives
- Working across and with all PLACEs
- Working across programmes including Long Term Conditions, Urgent and Emergency Care, Planned Care etc

Improving outcomes for **vulnerable children** and young people across NEL; 0-24 years and address inequalities and service issues faced by those young people transitioning to adult services

Improving integrated support for Special Educational Needs and Disability (**SEND**). Improving access, waiting times and outcomes, through co-production and pathway redesign

Increase capacity for **community-based care**. Reduce unnecessary unplanned admissions. Sustain and spread new models of integrated care, strengthening integration focusing on those who are most vulnerable including BCYP with long term conditions

Improve **mental health** outcomes by aligning with Mental Health/Learning Disabilities and Autism Collaborative

Babies, Children, Young People and Families – NEL Integrated Care Board Statutory Responsibilities (Health and Care Act 2022)

Children Act (2004)
Working Together to Safeguard Children (2018)

Safeguarding Children*
NHSE Safeguarding Assurance and Accountability Framework

Special Educational Needs and Disabilities*
NHSE SEND Statutory Guidance

Children and Families Act (2014)

Children Act (2004)

Looked After Children*
Promoting the Health and Well-being of Looked-After Children (2015)

Children in the Justice System
Modern Youth Offending Partnership Guidance

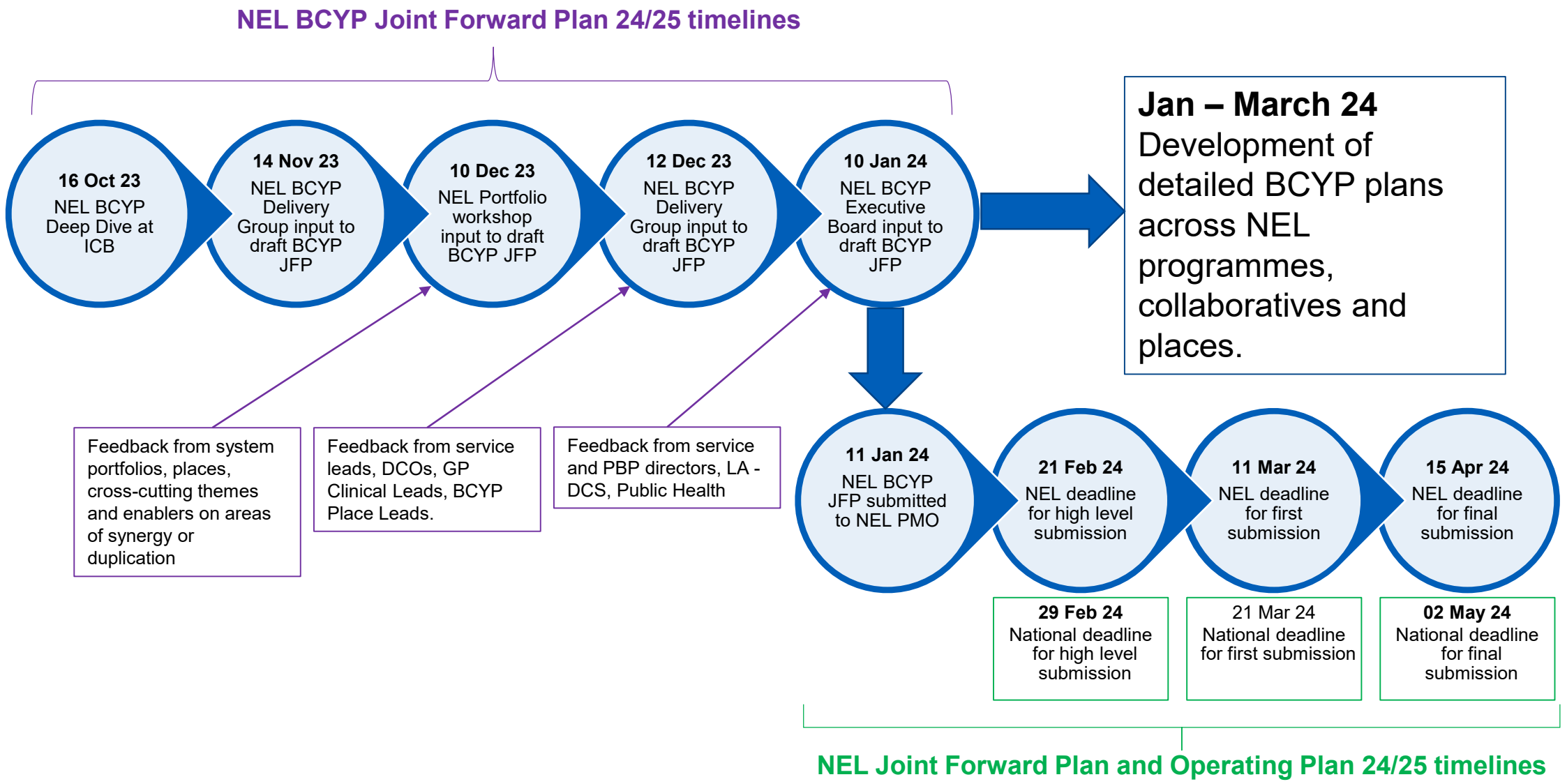
Crime and Disorder Act (1998)

Mental Health
Code of Practice (2015)

NHS Act (2006)
Mental Health Act (1983)

***ICB Executive Lead for Children and Young People/SRO –** Diane Jones (Chief Nursing Officer)

NEL System Planning Process – Babies, Children and Young People



Babies, Children and Young People Joint Planning

Joint planning approach working in partnership to agree system and local priorities, address risks and inform decision making. BCYP Plans tracker of discussions:

Group or Programme/Collaborative/Place Lead	Date
Acute Provider Collaborative BCYP Clinical Board	26.01.24
Planned Care	02.02.24
Specialised services	02.02.24
Population Health and Integration Committee	07.02.24
BCYP Delivery Board – BCYP Place Leads	13.02.24
Newham Intelligence and Insights meeting	15.02.24
Community Health Services Delivery Board	16.02.24
Long Term Conditions	TBC
Urgent and Emergency Care	TBC
Primary Care	TBC
Mental Health/Learning Difficulties and Autism	TBC

Jan – March 24
Development of detailed BCYP plans across NEL programmes, collaboratives and places.

Developing our plan for 24/25

Directors: Pauline Goffin (PG) – BCYP and Community Health Services. Dan Burningham (DB) – BCYP Mental Health/Learning Disabilities and Autism. Charlotte Stone (CS) - LTCs
Clinical Lead – Kath Evans (KE) - BCYP. Cathy Lavell (CL) – MHLDA. Senior Project Manager – Siobhan Hawthorne (SH)

Key NEL Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
BCYP Community Health Services (CHS)	• Children's Community Nursing • Speech and Language Therapy • Community Paediatrics • End of life/Palliative Care	✓ ✓	• Establish CCN Improvement Network, explore hub and spoke and workforce models • SLT community of practice plan and next steps, pre and post support offer for BCYP & families on waiting list • Scope opportunities for working with CCN and integration (Fuller) • TBC	PG/BCYP (CHS) Project Manager PG, Sarah Wilson /Jubada Akhtar-Arif* PG/BCYP (CHS) PM TBC	• 7/7 08.00-18.00 CCN Service NEL-wide • Reduced SLT waiting lists • Reduced Community Paediatrics waiting lists • TBC
BCYP Mental Health/ Learning Disabilities and Autism (MHLDA)	• Special Educational Needs and Disabilities Inspection Readiness • Neurodiversity • MH Champions/Practice Educators • Self-harm prevention project	✓ ✓	• SIRG Group –plan next steps, Partners in Neurodiversity in Schools delivery plan. • Develop ASD/ADHD pre and post diagnostic support offer. Plan and next steps – links with place, SIRG and BCYP CHS • See BCYP Acute • Mobilisation of working groups and scoping of ongoing initiatives at borough, regional and national levels.	Sarah Darcy (BCYP C&H)/SH CL,DB,PG/Jubada Akhtar-Arif* then BCYP (MHLDA) PM CL/Dale Greenwood	• Meet requirements of SEND code of practice and NHSE asks- SEND dashboard, • Reduced ASD/ADHD waiting lists. • Reduced rates of self-harm
BCYP Long Term Conditions (LTC)	• Diabetes • Asthma • Epilepsy	✓ ✓ ✓	• Whole pathway approach. Join-up across acute, community health, LTC and primary care programmes. • Transition and Young Adult diabetes service pilot (Barts) • Strengthen business cases for levelling up care for transition and increasing capacity at Bart's Health to meet increasing demand. Embed Networks. • Whole pathway approach. Join-up across acute, community health, LTC and primary care programmes. Asthma practitioner roles. • Implement key areas of improvement: MH screening and access to psychological support, access to tertiary services, transition, reduced variation in care. Recruit and mobilise epilepsy specialist nurses.	CS,PG/BCYP (LTC) PM CS, PG/James Courtney (BCYP TH), BCYP (LTC) PM CS, PG/North Thames Paediatric Network, BCYP (LTC) PM	• Improved outcomes for CYP living with diabetes and levelled up of service provision across NEL • Improved outcomes for CYP living with asthma. • Improved outcomes for CYP living with epilepsy

*till 31 March 24

Developing our plan for 24/25

Directors: Pauline Goffin (PG) – BCYP and Community Health Services. Fiona Ashridge (FA) – Urgent and Emergency Care. Sarah See (SA) – Primary Care.
Clinical Lead – Kath Evans (KE) - BCYP. Senior Project Manager – Siobhan Hawthorne (SH)

Key NEL Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
BCYP Complications of excess weight 	• CEW clinics pilots Bart's (with Kings) • Family Support Worker in LBBD (NELFT) -linked to CEW clinic	✓ ✓	• Implement model of care and pathways • Improve access for children with complications relating to excess weight, understand demographic of referred children and describe impact of holistic approach.	PG/SH, Gin Thian Peh (Bart's) PG/SH, Ronan Fox	• Reduced co-morbidities from complications of excess weight, reduced cost to system of managing complications
BCYP Urgent and Emergency Care (UEC) 	• UEC paediatric deaths • Hospital@home (Virtual wards workstream) • Urgent Community Response • Family Support workers in Emergency Departments pilot	✓ ✓	• **Implement NEL peer review and checklist in EDs and UTCs.** • Roll-out of hospital@home across NEL. • Identify BCYP needs and tailor care, link with hospital@home (virtual wards) and Community Health , • Implement pilot at Homerton. Support onboarding and report against key metrics.	PG, FA/TBC PG, FA/Provider Leads, Place Leads PG, FA/BCYP PM (UEC-CHS) TBC/Provider Leads, Barnardos	• Reduced BCYP mortality in UEC • Hospital@home in every borough • Reduced BCYP unplanned admissions to hospital • Improved outcomes for BCYP/families and ED staff
BCYP Acute and Planned Care (APC) 	• System-wide Paediatric Observations Tracking • Mental Health Champions and Mental Health Practice Educators • Marta's rule • Planned care • Allergy	✓ ✓ ✓ ✓	• Implementation of Paediatric Early Warning System in each acute provider site across NEL. • Mobilisation of roles in each acute provider with paediatric inpatient beds. Link to MHLDA programme. • Implement Marta's rule • Improve elective recovery - make links to specialised commissioning devolution and Further Faster/GIRFT programme • Level-up planned care for BCYP allergy across NEL	TBC/BCYP PM, Provider Leads TBC/BCYP PM, Provider Leads TBC/TBC TBC/TBC TBC/TBC	• Improved BCYP outcomes • Increased parity of physical and mental health. Joined-up acute and mental health services for CYP. • Greater voice for CYP and families. • Reduced waiting lists • Improved outcomes/level up service provision for BCYP with allergies

Developing our plan for 24/25

Directors: Pauline Goffin (PG) – BCYP and Community Health Services. Carl Edmonds (CE) – Primary Care. Moira Coughlan (MC) - Immunisations
Clinical Lead – Kath Evans (KE) - BCYP. Senior Project Manager – Siobhan Hawthorne (SH)

Key NEL Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
BCYP Primary and Integrated Care (PIC) 	• Integrated child health pilots • BCYP unregistered with a GP • Youth Friendly Primary Care		• Mobilisation, evaluation and sustainability of each place's integrated child health pilots. Link with integrated neighbourhood teams/Fuller • Scope and understand reasons for non-registration. Describe ways to improve registration. • Improve access to adolescent integrated health hub and implement "You're Welcome' standards. • Implement care leavers compact	PG, CE/SH, Place BCYP Leads PG, DJ/NEL Imms Team CE/TBC PG/SH, BCYP PM	• Joined up care for BCYP and families across NEL • Improved access to primary care for BCYP/families. • Improved outcomes for young people
BCYP Prevention 	• Oral Health • Healthy weight • Physical Activity	✓ ✓	• Scope evidenced based prevention services improve access for BCYP and their families. • As above • Test Sheffield approach (Consultant in Physical Activity)	TBC/TBC TBC/TBC TBC/TBC	• Reduced rates of dental decay • Reduced levels of excess weight and obesity • As above
BCYP Vulnerable Children 	• Child Sexual Abuse Hub • Care Leavers Compact	✓	• Developing the CSA Sunrise brand and Vision, Programme planning for next 2 years. Establishing estates requirements. Developing a minimum dataset. Implementing joint referral forms across CAMHS & SC • Implement care leavers compact	TBC/SH TBC/SH	• Improved NEL CSA knowledge. Improved referral process • Improved outcomes for care leavers. • Improved retention of staff
BCYP Workforce 	• Recruitment and retention CCNs and AHPs in Community Health • Skill mix/workforce models • Technology		• Clear workforce delivery plan for CHS link to NEL workforce strategy. Plan to include smaller providers Evaluate interventions. Wider support for retention schemes i.e. sign on bonuses etc. Describe opportunities e.g. ARRS roles and rotational training • Develop skill mix/workforce models. Improve access to E&T funds. University partnerships to ensure skills match need. Joint system Preceptorship • Scope E&T technology	TBC/TBC TBC/TBC	• Increased capacity of workforce • Joined up E&T across NEL

Developing our plan for 24/25

Directors: Pauline Goffin (PG) – BCYP and Community Health Services. Carl Edmonds (CE) – Primary Care. Moira Coughlan (MC) - Immunisations
Clinical Lead – Kath Evans (KE) - BCYP. Senior Project Manager – Siobhan Hawthorne (SH)

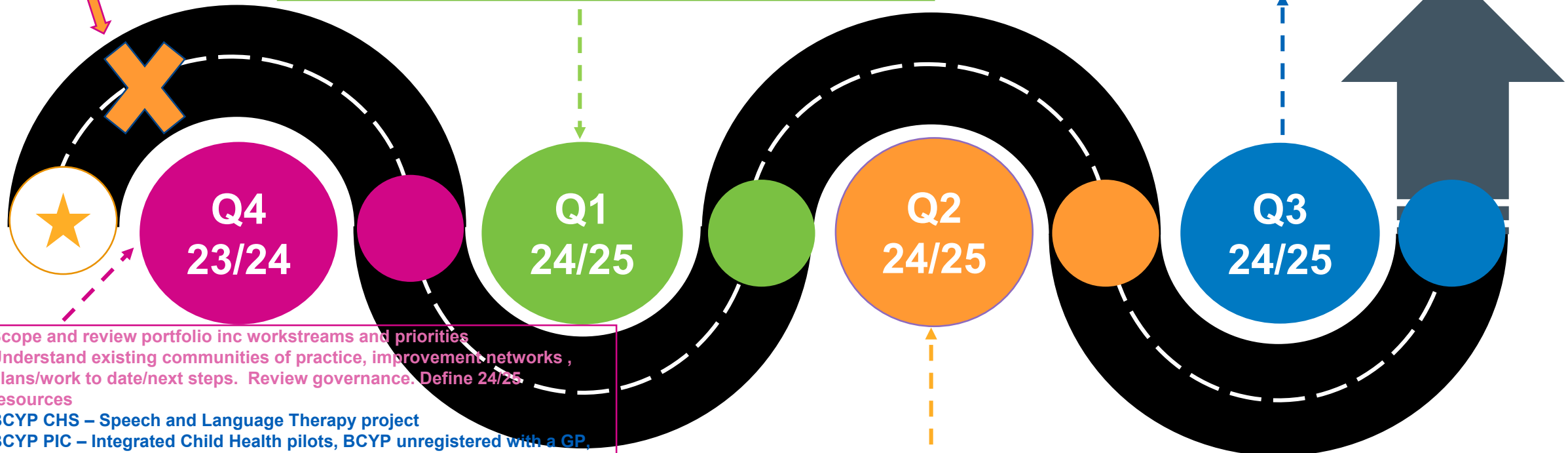
Key NEL Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
BCYP Digital 	• Digital Child Health Record • Digital BCYP online resources • Digital 'Tiny Apps'		• Replacement for eRedbook. Develop options appraisal Link to NEL Digital Strategy. • Make case for online resource for families and professionals e.g. Healthier Together website • Develop asthma passport	TBC/TBC TBC/TBC TBC/Bill Jenks	• Supports continuity of care • Improved quality of care • As above

Timeline Proposal

We are here

- Finalise 24/25 programme/collab resources
- Agree matrix reporting and workstreams. Progress/start improvement networks etc. Agree new governance
- Initiate BCYP CHS Children's Community Nursing and Community Paediatrics projects
- Initiate BCYP UEC Paediatric Deaths Project
- BCYP UEC Hospital@home (Virtual wards workstream)
- Initiate BCYP CHS/UEC Urgent Community Response project
- BCYP UEC Family Support workers in Emergency Departments pilot
- BCYP APC - System-wide Paediatric Observations Tracking and Mental Health Champions next steps
- Initiate BCYP APC Panned Care project

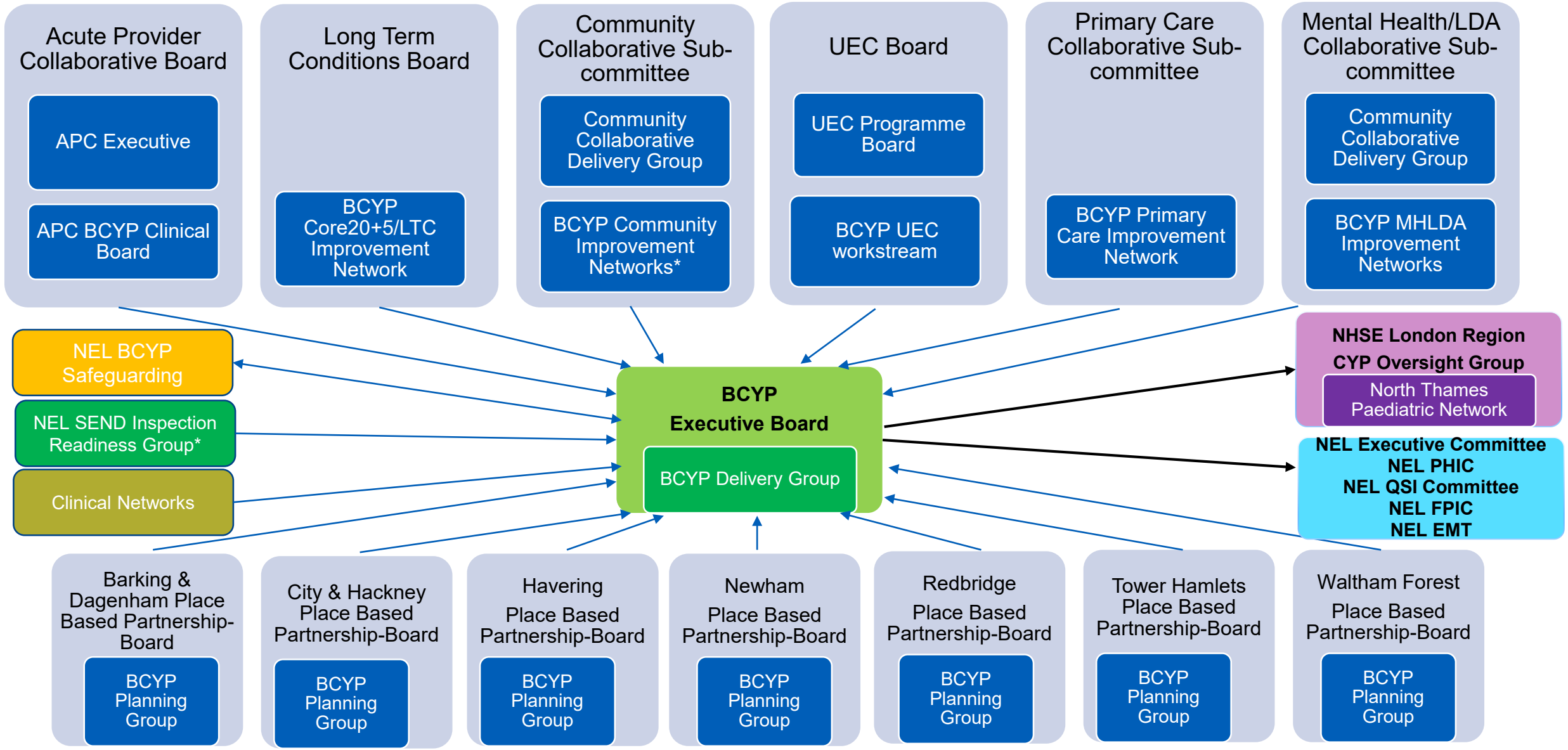
- Initiate BCYP Digital - Digital Child Health Record and Digital BCYP online resources projects
- Initiate BCYP Prevention - Oral Health and Healthy weight projects



- Scope and review portfolio inc workstreams and priorities
- Understand existing communities of practice, improvement networks , plans/work to date/next steps. Review governance. Define 24/25 resources
- BCYP CHS – Speech and Language Therapy project
- BCYP PIC – Integrated Child Health pilots, BCYP unregistered with a GP, Care Compact (Care Leavers) projects
- BCYP MHLDA – Self-harm Prevention, SEND Inspection Readiness and Neurodiversity projects
- BCYP LTC Asthma, Diabetes and Epilepsy projects
- BCYP Complications of Excess Weight – CEW clinics and Family Support Worker (LBBD) projects

- Initiate BCYP APC Marta's Rule project
- Initiate BCYP APC Allergy project
- Initiate BCYP PIC Youth Friendly Primary Care project
- Initiate BCYP Workforce Recruitment and retention CCNs and AHPs in Community Health and Skill mix/workforce models projects

BCYP Portfolio Governance



*includes communities of practice

BCYP Portfolio Outcomes Framework: Community-based care (SEND and Vulnerable Children outcome indicators to be developed)

Key:

- Intermediat eindicators
- Process indicators
- Outcome Indicators

*New proposed primary and integrated care indicators – Dec 23

- Reduction in the % of children with unplanned admissions or referrals to hospital
- Percentage change in lengths of stay in hospital
- Rate of emergency admissions for asthma, epilepsy and diabetes
- Percentage change in the BMI and average weight of children across NEL.
- A reduction in % of Infant mortality across each borough in NEL
- Oral health – number of hospital extractions and rates of dental decay
- Percentage uptake of universal care plans for children with medical complexity

CBC System-wide indicators

- Patient Reported Experiences Measures (PREMs)
- CCN 08.00 – 18.00 7/7 service operational in each place
- Hospital@Home operational in each place
- Percentage of people who fit the clinical criteria, who are able to access hospital at home when they choose to
- Workforce indicators: turn-over rate, vacancy rate

Children's Community Nursing

Hospital@Home

- Percentage of children achieving a good level of development at the end of reception.
- Percentage of children achieving a good level of development at 2 to 2 ½ years.
- Breast feeding prevalence at 6-8 weeks after birth.
- Percentage of children by ethnicity represented in early help.
- Percentage of early health recipients by age and borough.
- Workforce indicators: turn-over rate, vacancy rate

Specialist Community Public Health Nursing

- % vaccinated at 5 years
- GP registered population (by age group)*
- Clinical care encounter rate compared to list size (by age group)*
- 111 contacts (by age group)*
- Percentage of completed 48 hour GP review for children who have attended ED or been admitted to hospital with wheeze or asthma
- Child health pilots operational in each place

Primary and Integrated Care

- Percentage of children/families who achieved their preferred place of death.
- Percentage of eligible children/families able to access hospice respite or end-of-life care when they need it.
- Percentage of children on end-of-life pathways going into the hospices for emergency symptom management rather than hospitals.
- Number of children discharged from hospital to hospice.
- Roll out of advanced care planning

End of life/palliative care

- Core20+5 Framework for CYP
- National CYP Framework
- Fingertips/Public Health Framework
- Waiting list data (acute and community)
- Local maternity and neonatal system data
- Local Incentive Schemes Outcomes data
- CYP Mental Health workstreams data
- NEL Primary Care Dashboard

Links to complementary frameworks/data

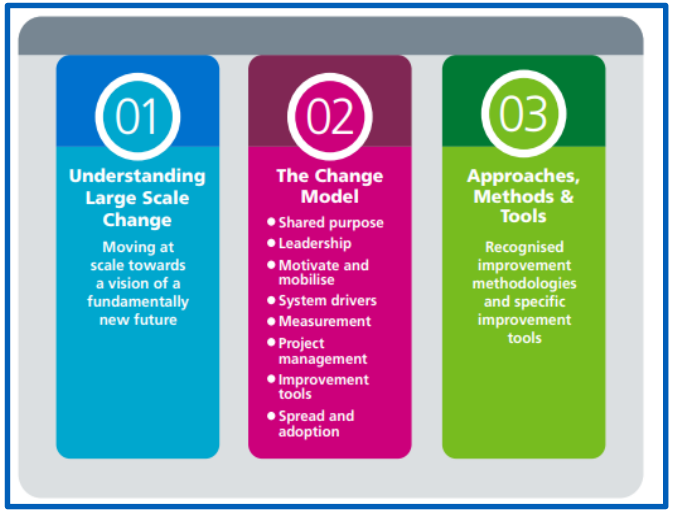
NHS
North East London

NEL BCYP Plans 24/25

Approach to system change and quality improvement

System Change and transformation methodology

There are times when more structured approach is needed to improvement the NHS change model can be a useful guide to follow when dealing with more complex, large scale, system or structural change



The organising framework brings together three critical elements, the **large-scale change model**, the **change model for health and care** and **established improvement approaches, methods and tools**. Utilising the framework and models may increase the likelihood of sustainable, large-scale change.

The improvement network approach to **leadership** may vary depending on the group of individuals involved this may be clinicians, patients, managers and/or wider stakeholders. Critical to success is the shared purpose across this leadership group – time spent in this space **developing trust, relationships and a shared purpose** is essential to the overall success.

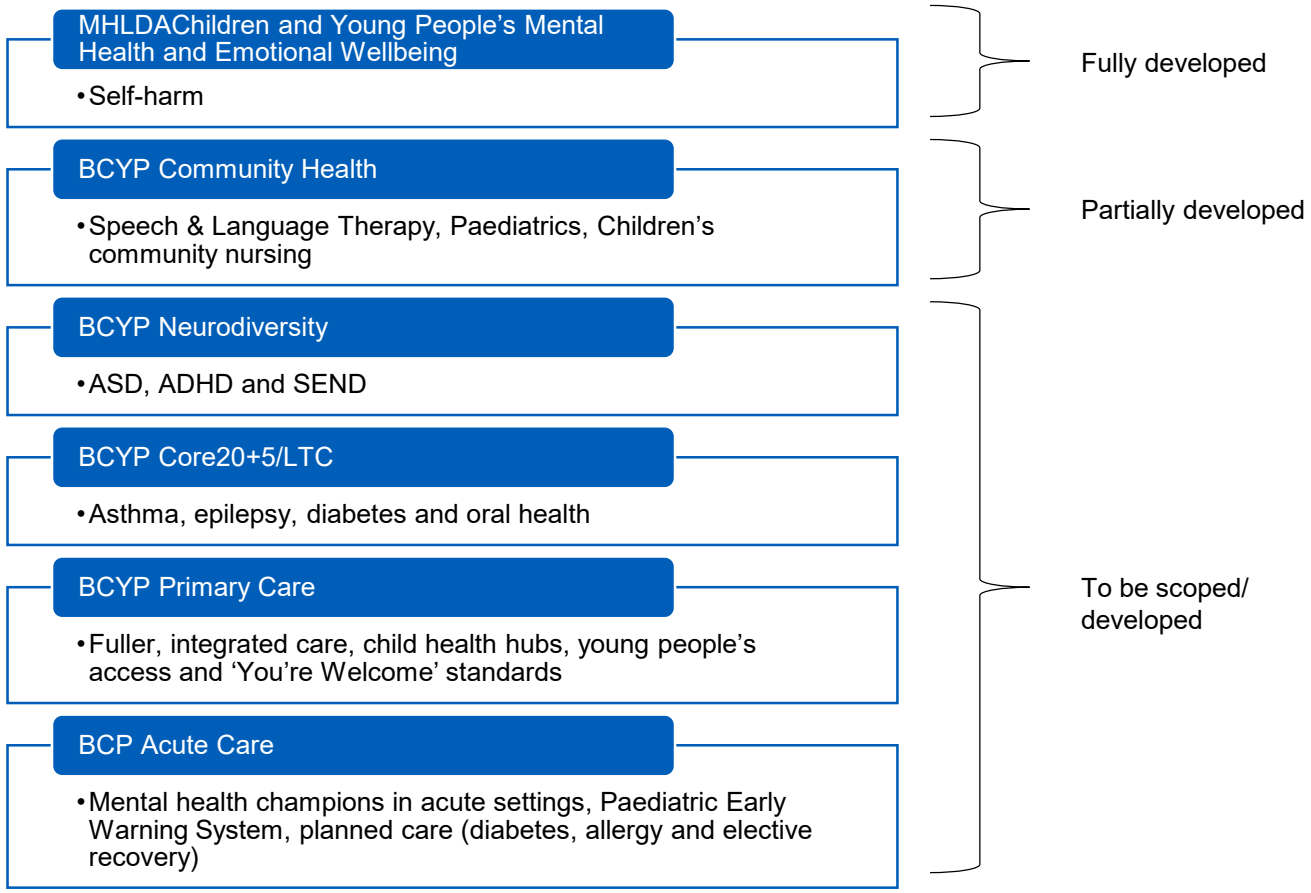
change-model-guide-v5.pdf (england.nhs.uk)

Introduction to improvement networks

We believe that improvement across the system requires strong **clinical and lived experience leadership**. Using QI tools and techniques (based on IHI improvement science) we have developed **improvement networks** to lead the programmes of work that are best delivered at scale, with a key focus on sharing learning, reducing unwarranted variation, and tackling health inequalities within and between borough populations.

Improvement networks rely on the development of a **trusting environment** where we can challenge and learn from each other, involving service users, carers and partners across the system, every step of the way. Networks are already driving innovative approaches to service improvement, with great examples emerging from our more mature networks.

BCYP Improvement Networks

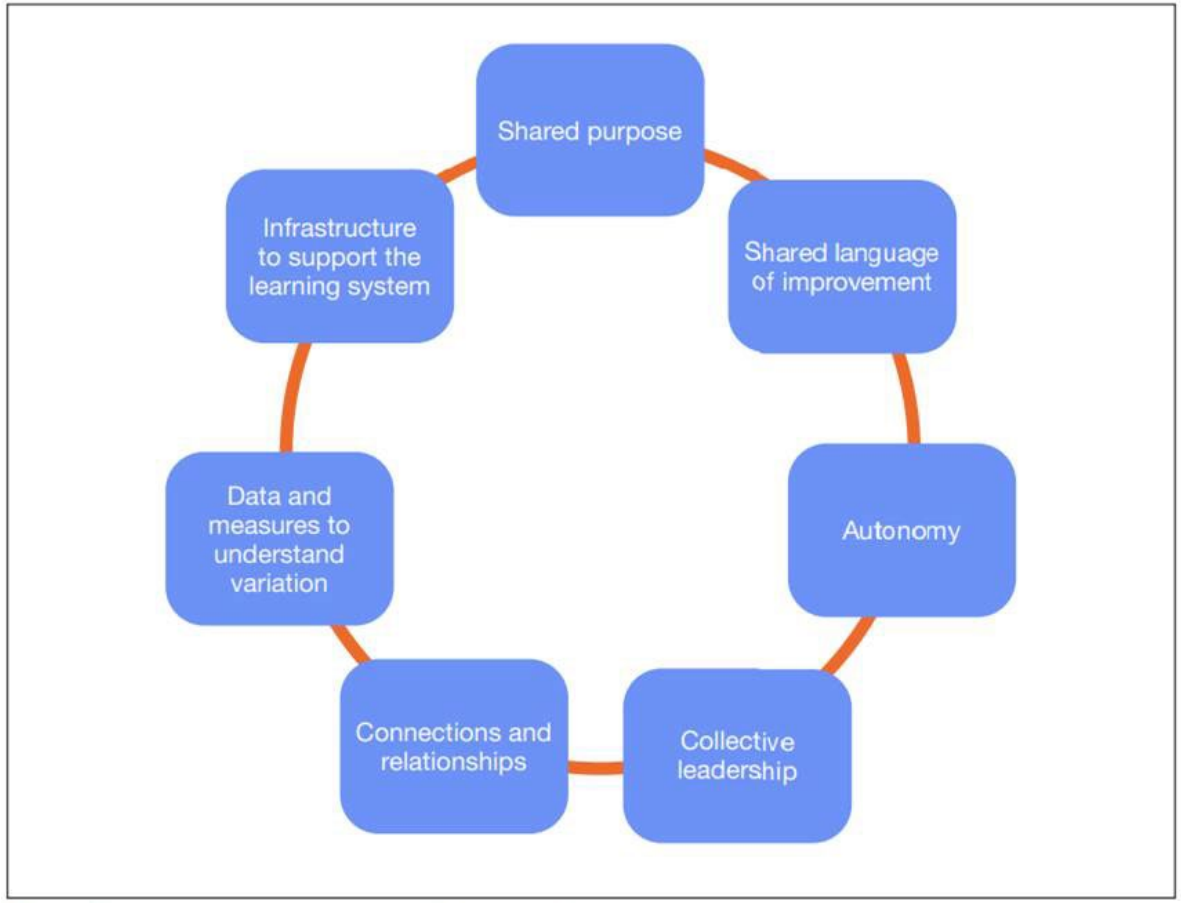


Key components of an improvement network

Improvement networks within our collaborative tend to focus on discrete populations, but all have the following things in common:

1. They have a coproduced purpose / shared aim
2. Those involved have established the need / want to collaborate and learn together, acting as a community
3. They have diversity of involvement e.g. clinical, operational, lived experience, and research experts, ideally across different kinds of organisations (health, social care, VCSE etc.)
4. They have an intentional design / structure, and use data to measure improvement and variation
5. They have a coordinating infrastructure to organise the meetings / work, and to support the learning function (drawing heavily upon the model, right)

Key components required to support learning systems



https://qi.elft.nhs.uk/wp-content/uploads/2021/08/BJHM-Creating-learning-systems.pdf

North East London Health & Care Partnership

NHS North East London

North East London Community Health Collaborative Planning Round 24/25 Summary

Barts Health NHS Trust

NHS Homerton Healthcare NHS Foundation Trust

NELFT NHS NHS Foundation Trust

Barking, Havering and Redbridge University Hospitals NHS Trust

NHS East London NHS Foundation Trust

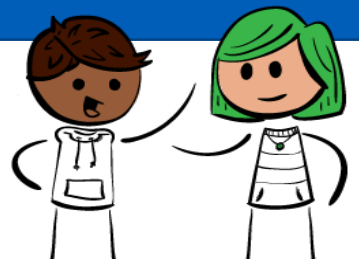
What is the strategic purpose and objectives of the CHS/ Community Collaborative portfolio for NEL residents and to what extent does it align with local Place priorities, system focus and regional and national priorities?

Vision

- Develop a consistent community services offer across NEL
- Improve population health and healthcare working closely with residents (voice)
- Supporting neighbourhoods and PLACES to enable people to stay well and independent for as long as possible, wherever they call home
- Tackling unequal outcomes and access to community services, across NEL
- Creating wider health value by unlocking system productivity gains

Mission

- Use evidence to understand the totality of services, outcomes and resources across NEL, identifying opportunities for improved outcomes
- Agree and implement a consistent community services offer with equal access for all NEL residents
- Create and facilitate collaborative partnerships with local authorities, primary care, health providers and the independent , voluntary and charitable sector to reduce inequalities
- Co-develop and design service pathways with residents and their carers based on high quality outcomes
- Support wider acute system pressures through most effective investment into community services
- Use Improvement networks to develop whole system pathway change through a Quality Improvement lense to ensure a better experience for NEL residents



Improving access, waiting times and outcomes, through co-production and pathway redesign with users and carers

Using digital and PHM to enable better interoperability across services and improve outcomes and get value for residents

Delivering better patient experience ensuring residents receive integrated health and support in right place, right time

Opportunity to significantly reduce unnecessary admissions, wait times, access issues and build

Community Collaborative Joint Planning Opportunities

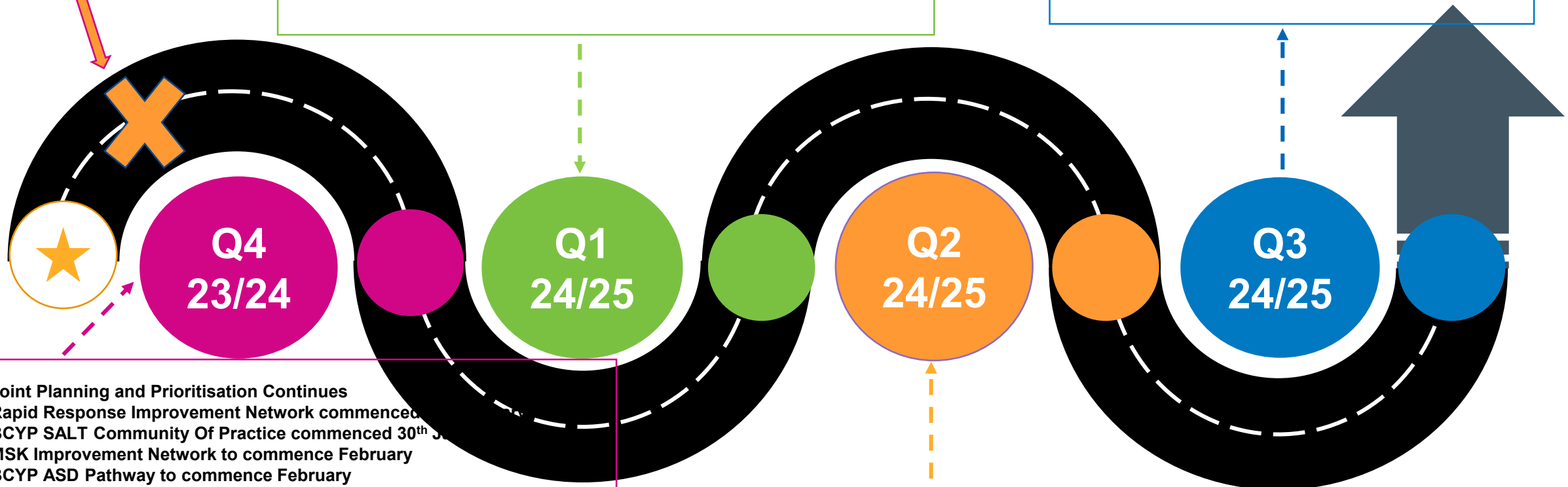
- **Joint approach to planning across PLACES and providers**, working in partnership to agree system and local priorities, address risks and make difficult decisions
- Develop our own **NEL strategic objectives**
- Define and differentiate **Babies, Children and Young People** from **Adult** priorities
- Define a consistent **NEL Community Services Offer** and **2024/25 Community Collaborative Plan**
- By Qtr. 4 23/24, we were planning to procure a comprehensive **System Diagnostic** for Community Services, which will help us to spend our money wisely to meet growing demand, ensure equity, and support our staff however this has had to put on hold due to financial system pressures this needs to be an area of priority for 24/25
- Given the scope and scale of the diagnostic we anticipate this will have a greater role to play in the development of the MHLDA Collaborative Plan in 2025-26 than it will this year.

Improvement Networks

We are here

- Improvement Networks for Adult Podiatry, Dietetics, SALT to commence
- Finalise 24/25 programme/collab resources
- Rapid Response. MSK, BCYP ASD and SALT to continue
- Agree matrix reporting and workstreams. Progress/start improvement networks etc. Agree new governance
- Falls Improvement Network to commence
- Virtual Care Strategy to continue
- First set of service contracts to be reviewed
- Scope BCYP Community Nursing Opportunities

- TBC



- Joint Planning and Prioritisation Continues
- Rapid Response Improvement Network commenced
- BCYP SALT Community Of Practice commenced 30th J
- MSK Improvement Network to commence February
- BCYP ASD Pathway to commence February
- Adult productivity (dietetics, SALT. Podiatry being reviewed – recommendations end of March)
- Falls being scoped
- Contractual Best Value approach being scoped
- T and F group for adult and BCYP waiting times to commence Feb

- Commence BCYP Community Nursing Improvement Network
- Commence Adult Community Nursing Improvement Network
- Continue with other Improvement networks as appropriate

NEL Community Collaborative/ CHS Improvement Networks – Status Report

Developing Improvement Network

- 10 Improvement Network areas being established or re-established, with clinical, ops, PLACES

Joint Planning for 2023/24

- Collab leading planning
- Prioritisation underway with clear themes emerging re CYP investment and waiting list pressures

Enablers

- Digital
- Workforce

Strategic Alignment

- Working across and with Acute. Primary Care, MHLDA provider collaboratives
- Working across and with all PLACEs
- Working across programmes inc Long Term Conditions, Planned Care etc

Active projects

Projects	Update	Impact
1. BCYP Productivity	• Waiting List pressures for ASD, Community Nursing. SALT, Paediatrics • **SALT Community of practice 30/1** • **ASD pre assessment support/pathway Improvement Network** to **Feb 24** • T and F group with Operational leads re waiting lists commencing **Feb 24** • BCYP community nursing offer to be reviewed Qtr 3 • Opportunities to build on Child Health hubs with Fuller/Integrated Neighbourhood Teams	• Improve CYP wait times for residents • Reduce 54 week waits/ poor outcomes • More support for BCYP and families waiting • Ensure 1st wave of INTS focus on BCYP integration opportunities
2. Falls	• Falls group will go live by **April 24** and will focus on Falls prevention services reviews including the way the models and pathways were developed • Falls prevention in care homes is a focus area that has been picked up at London • Discussion underway regarding role of place	• Reduce unnecessary falls into Hospital • Support system resilience and preventing UEC attendances
3. Community Rapid Response Transformation / UCR	• **RR improvement Network commenced 29/1** • Reducing variation /moving to a core consistent offer is a core focus • Improve capacity issues to support system resilience and hospital admission avoidance • Link with UEC around Virtual Care models aligning Virtual Wards, Rapid Response./Hospital At Home • Opportunity to improve 15% of people admitted to UEC who could be supported at home • Progress potential of Single Point Of Access	• New Rapid Response model for NEL • Improved interface with UEC • Better resident Care and outcomes • Integrated approach across UEC and CHS to reducing admissions
4. Adult Productivity	• T and F group with Ops and BI **leads Feb 24 to** better understand Waiting times pressures • Moving to consistent datasets • Progressing to agreeing outcomes framework and population health approaches across PLACEs • Review of Dietetics, SALT and Podiatry with recommendations **end of March** • **Improvement Networks for Dietetics. .SALT and Podiatry April 24 onwards**	• New models of care • Better data position on waiting times • Improved • Implementation of pathways more accessible to residents

Active projects

Projects	Update	Impact
5.MSK	• Joint approach re wholescale pathway redesign with Planned Care Team • Initial **Improvement Network being planned Feb'24**	• Decrease MSK waiting times • Increase value for money and productivity • Streamline /consistent offer
6. Community Nursing Model Transformation	• Improvement networks across UEC and Rapid Response will inform direction • Discussions with UEC on Virtual Care underway • To commence Improvement Networks **Qtr 3**, building on work in MSE etc • Move to consistent community nursing offer	• Support our teams to streamline processes • aligning best practice processes and alleviating unnecessary bureaucracy • Opportunities for digital intersystem and operability
7. Long Term Conditions	• Under discussion – diabetes management, CVD, respiratory, covid etc. core pathways	• Reduced inefficiency • Better optimisation in community
8. CHS Contractual Best Value Opportunities	• Progress ERF opportunities • Defining suggested approach re streamlining contracts against specific group of service S(ie podiatry) • Prioritise current contracts at risk/needing renewal • Streamline with Improvement Network/pathway redesign opportunities • Initial group being established with PLACE contracts, finance, to Identify best value opportunities	• New pathways agreed to improve better outcomes for residents by March 2025
9. Specialised Services Transformation	• Stroke Neuro Rehab identified as core areas of work for review and synergy • Being scoped jointly with Long Term Conditions colleagues	• Transformation of services
10. Intermediate Care	• To be scoped	

NHS
North East London

NEL Children and Young people's Mental Health and Emotional Wellbeing Improvement Network

Priorities 24/25

The top four priorities, as voted for by CYP and their families…

1

Choice, control, and support

"I want to be able to decide how my family are involved in my support, and they might also need support"

2

Big changes in my life

"I want to feel like professionals care as I move between different stages of my life"

3

People who help me

"I want to be able to access different support from different people, including those with lived experience, when and where I need it"

4

Joined-up care

"I want professionals to work together so that I tell my story once and be involved in deciding what support will suit me and my family's goals and needs"

Clinical priorities

The clinical priorities for the network have been coproduced by clinicians and care professionals across primary care, the community and inpatient services. They have also been mapped against the **service user and carer priorities** to help us identify the areas that have the biggest alignment

Support to CYP with neurodevelopmental needs

- Social care pathways, how to streamline, reduce waits, and agree common approach to assessment
- Pre and post-diagnosis offer – what should we be able to consistently provide to all CYP (PBS / sensory / OT / SLT?) and what support is available to families?
- Complex cases – how to share the approach across agencies (joint panels?)
- Behavioural support packages, separate to diagnosis
- SEND offer

Broadening access to support for children and young people

- Digital access
- Providing more specialist support to primary care clinicians so that they can provide more support to children and young people in emotional distress
- Early intervention offer – what does good look like?
- THRIVE

Supporting children and young people in crisis

- Need to develop alternative means of responding when CYP are self-harming (over-medicalisation is unhelpful and can be harmful), which requires exploring different means of supporting GPs and young people themselves
- How can non-mental health professionals support CYP better?
- Improve crisis support services in and out of hours (for both mental health and neurodiverse CYP)

NHS
North East London

NEL Place-based BCYP Plans 24/25

Place-based BCYP Joint Forward Plans 2024/25

Barking and Dagenham	City and Hackney	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest
Improving outcomes for CYP with SEND with a focus on therapy support, ASD diagnosis and pre- and post-diagnostic support, mental health in schools **Tackling childhood obesity** leveraging the opportunities through family and community hubs for prevention	**Start Well** – CAMHS / Improving wellbeing and MH (ACEs), improving outcomes for CYP with SEND, complex health needs, ASD and LD, increasing immunisations and vaccinations, reducing maternity inequalities and improving perinatal mental health	**Start Well**; Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives	**Family hubs –** integrated services, Offer of support for families from conception-2, also providing support for children 0-19 or up to 25 for those with SEND needs. **Complex Needs –** greater MDT working to jointly plan and deliver good outcomes **Speech & Language Therapy -** integrated needs based service offer	**Start Well:** Hospital at Home, Paediatric Integrated Nursing Service (PINs), Learning Disability Key workers, Integrated child health hubs, Special Education Needs & Disability (SEND), Children & Young People Asthma one stop shop	Ensuring that Babies, Children and Young People are supported to get the best start in life.	To publish a children's health strategy , improve access to therapies and reduce the need for children to attend hospital.

Barking and Dagenham

Key Barking & Dagenham Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
CYP SEND	• SEND improvement plan		• Improving access to therapy support. Increase capacity to meet demand (increasing EHCPs) and measures to reduce waiting lists • Secure sustainable funding to enhance therapy support • BHR Autism diagnosis pathway, pre and post diagnosis workstream development and increase investment. • Two mental health in schools teams are in place with a further expansion planned. • Key worker pilot for learning disabilities and autism	B&D SEND Area Board	• Reduced waiting lists
BCYP Complications of excess weight	• B&D Obesity Task and Finish Group		• Family support worker- linked to CEW clinic - support the 10-30 most complex children and young people cases in B&D	Task and Finish Group	• Reduced co-morbidities from complications of excess weight, reduced cost to system of managing complications
BCYP immunisations and vaccinations	• Optimise uptake of the MMR and flu vaccines		• A dedicated Task and Finish group was put in place, chaired by the Director of Public Health • Increased the number of vaccination clinics to four in Barking and Dagenham • Vaccination UK are targeting “missing” children and young people from the list.	Task and Finish Group	• Increased CYP immunisation coverage • Reduced unplanned admissions to hospital
BCYP Long Term Conditions (LTC)	• Asthma		• Asthma and allergy friendly school co-ordinator	TBC	• Prevent unnecessary attendances and/or admissions to hospital

North East London Health & Care Partnership

Barking and Dagenham

B&D Partnership Priorities for 2024/25 CHILDRENS

CHILDRENS

	Current Status	Planned Activities	Metrics/ KPIs	Outcome/s
Neurodiversity	• BHR ASD Diagnostic Pathway soft launch from Jan 2023 • Pre diagnostic – Phoenix Service • 16 WTE recruited across BHR • Waiting times in B&D reduced from 28 **months** to 17 weeks • ADHD Nurse & Pharmacist recruited in B&D • Gap identified in post diagnostic support	• Phase 2 BC being completed – to complete full funding • Co-ordinate pre and post diagnostic service offer • Autism – support for parents. • Using resources differently to scale up Phoenix Project - making links for support and drawing in other staff • Increased liaison with education on EHCP process	• NICE compliant waiting times • Quality Metrics – complaints. Personalised plans • Financial – agency/bank usage • Timely input into EHCP process • Reducing backlog of cases including inappropriate referral for ASD diagnostic, therefore impacting on other part of the health system	• Quantity per months clinical referrals, positive referrals. Medical investigations etc • Meet referral demand rate and plan requirements to address the clinical backlog; • Support accessible and consistent ASD care pathway across BHR (improving MA working efficiency effectiveness & safety; & better data mgt); • CYP receiving timely EHCP as appropriate • Reduction in inequalities for CYP with neurodiversity and reducing attainment gap
EMHWB - CYP	• MHST in schools • Digital – Kooth etc • SEMH guidance for B&D developed with MA input • CAMHS community investment in B&D • Hot Clinics – Vulnerable CYP • B&D Health sub group (reports to SEND Board) • SEF and SEND Inspection Prep	• SEND Inspection Preparation • CAMHS recruitment challenges for additional investment • Mental health in Schools workers – additional funding wave applied for and subsequent mobilisation activities • Improving Education, health, schools join up. • Pathways to Adulthood/transitions – Post 16 opportunities – (workshops & spring-term focus). AP from SEND away day.	• CAMHS Access for CYP • Reducing waiting times for CYP accessing EMHWB services (not just CAMHS) • Improving Local Offer • Data collection • Joint working	• Improved integrated offer / 5 year - reduction in EHCPs • Improved SEMH for CYP • Families better equipped to managed CYP EMHWB
Speech Language & Communication	• BC additional investment agreed in principle for SLT/OT/Physio in B&D • NELFT recruiting at risk pending 24/25 financial allocations • STEPS in schools investment • Lack of system wide leadership on SLCN from 0-19	• Gap with 0-5s (development of SLC) • Temporarily Start for Life/Family Hubs Provision • Recruitment at Risk • Supporting & expanding STEPs approach & resource.	• Reducing developmental gap • Meet statutory obligations under SEND • Supporting EHCP process as appropriate • Reduced complaints and reputational risks • Increasing number of children having one and two year checks in 0-19 service, • Increasing number of children accessing Start for Life HLE/SLC programmes • More children receiving early support with SLC delays • Reduced SLT waiting lists	• Increasing number of children achieving communication and socialisation milestones at 2-2.5 years & having a good level of development (GLD) in EYFS assessments • Increasing educational attainment & school readiness • High rates of school attendance with low rates of absence and a reduction in number of exclusions for all children and young people • To tackle inequalities in outcomes, experience and access • Improved cognition & communication for our BCYP.

SEND is a key focus through all priority areas

North East London Health & Care Partnership

Barking and Dagenham

B&D Partnership Priorities for 2024/25 CHILDRENS

	Current Status	Planned Activities	Metrics/ KPIs	Outcome/s
CHILDRENS **Obesity**	• Amongst the highest rates of childhood overweight and obesity in london. • Two Year CEWS pilot started - CYP Obesity FSW to be re-recruited. Links to CEWS (Clinical Excess Weight Service) and BHRUT • NCMP being undertaken annually by 0-19 service • LBBD Tier 2 weight management being redesigned and reprocured over coming 12 months • No Tier 3 weight management service in place • Focused work on Physical Activity starting with London Sport • Good Food plan being delivered to improve the food environment and reduce the drivers of obesity • S4L funding breast feeding and starting solids workstream – peer support service set up • Healthy schools team active	• CEWS Service SOP being developed. • Core offer in place • Links to Youth Zone • B&D MDT is being established – specialist health weight practitioner post recruitment over coming 3-6 months – work programme set up under them • To identify gaps and provisions and develop a new model for supporting obese children and their families. • Interim Tier 2 service designed and commissioned to ensure no gap in provision • Recruitment of an IBCLC and infant feeding practitioner under 0-19 service (funded by S4L to increase breastfeeding and improve introduction to solids) • Recruitment of an oral health co-Ordinator and a programme of oral health promotion work planned. • More schools to achieve healthy schools status (or next level up)	• Links to wider local offer • Reduction in reception & Y6 obesity for participants on the programme • Engagement with families & CYP with excess weight & co-morbidities • Maintaining & reducing BMI • Increased activity • Increased breastfeeding rates (at initiation,at new birth visit (10-14 days), 6-8 weeks and 6-9 months) • Improved offer of infant feeding support • Improved rates of physical activity • Better oral health • Number of schools achieving ‘healthy school awards’ (across the different levels)	• Improved identification and support provided to BCYP overweight and severely overweight • Improved referral process and pathways for BCYP people to be efficiently referred to services. • Equitable access to weight management services • Improved involvement of GP’s to support longer-term weight maintenance. • Increase of eligible/appropriate BCYP attending more targeted or specialist weight management service. • Reduction in children having health-complications related to excess weight. • Family-centred approach to health promotion, empowering families to identify where they can take more control. • Reduction in A&E attendances linked to excess weight • Reduced obesity in Year R and Year 6
CHILDRENS **Family Hubs**	• Programme of support being mobilised around: infant feeding, parenting support, perinatal mental health, and Home Learning Environment • Family Hubs being vehicle to deliver more integrated working, improved quality of services, and many of the Best Chance outcomes • Links to maternity, early help, HV/SN, wider family support. This includes workstreams on parenting; perinatal mental health, SLC / HLE, and infant feeding.	• Implement and develop service offer • 3 x family Hubs established • Developing support services – maternity, HV, VCSE, social Workers & Early Help • Developing Digital Offer focused on Start for Life	• 1 year - fully functioning and monthly increase in families engaging with the hubs, • year 2 onwards - practice integrated into business as usual, continuation of effective services funded from other sources / 5 year - increase in community wellbeing	• Range of CYP anf family health outcomes including school readiness, breast feeding rates, childhood obesity rates, perinatal mental health outcomes, vaccinations, parental confidence and resilience, maternal health outcomes, reduction in those escalating to social care intervention, better connection for families • More families in receipt of support that they are entitled and an increasing number of children receiving timely Early Help interventions that are successful and minimise exposure to ACEs

SEND is a key focus for all priority areas

North East London Health & Care Partnership

Barking and Dagenham

B&D Partnership Priorities for 2024/25 Mental Health

		Current Status	Planned Activities	Metrics/ KPIs	Outcome/s
MH	**SMI Physical Health Checks**	• Variable picture across PCNs and different practices • September 23 data 49.53% of eligible cohort receiving healthcheck; ICS target 70%	• Set up a small working group to agree detailed workplan • Short term - deployment of Wozan Point of Care (POC) kits • Mid to long term – looking at targeted projects to improve rates across PCNs and practices	• **Key metric:** the number of people on the General Practice SMI register at the end of each quarter, and of these how many received a comprehensive physical health check in the 12-months to the end of the reporting period. • Further development of metrics to determine positive behavioural change or further intervention following the health check	• Short Term: Health Check uptakes, possibly referrals • Medium term: Life expectancy inequality for people with SMI; ? Limit the percentage of people with SMI with comorbid physical health LTCs
MH	**Improving pathways between Primary & Secondary Care**	• Mental Health and Wellness Teams now established across B&D • Integrated functions in primary and secondary care (e.g. ARRS workers, social prescribers) • Pathways and integrated models still at an embryonic stage	• To capitalise on the work being undertaken in the B&D (NELFT) forum • Agree a detailed workplan that is endorsed by local stakeholders • Workstream around the development of the role and function of existing Mental Health and Wellness teams on improving referral and discharge pathways between primary and secondary care and MH promotion/community support and primary care level. • Additional work focussed on wider determinants of mental health offer for those with MH conditions - through development of the role and function of existing Mental Health and Wellness teams	• TBC – These will need to be determined through further work with key stakeholders	• **Short term**: reduction in waiting times for secondary mental health care appointments; improved patient experience/wellbeing outcomes • **Medium term**: reduction in rate of mental health crisis admissions ; reduction in secondary mental health caseload - could also consider less patients ending up in crisis that are not known to secondary care
MH	**NEL – wide SMI working groups**	• Part of the MHLDA NEL networks	• Support and advice to place teams	• NHSE – National measure for Health Checks	• To see improvement in performance
MH	**NELFT – Transformation (SMI-integration)**	• NELFT wide transformation group and Local B&D group – both meet regularly	• Guiding the implantation of the new model	• TBC	• A more integrated approach to MH and wellbeing at place

City and Hackney

Key City & Hackney Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
BCYP Emotional Health	• Emotional Health and Wellbeing Partnership. • Youth hub • THRIVE • 16-26 strategy • Single point of Access (SPA) • Mental Health offer to Youth Offending Team • Neurodevelopment Team		• Continuation and growth of system-wide initiatives underway (Neighbourhoods, Family Hubs) continue alignment exercises to mitigate risk of duplication. • Implementation of Super Youth Hub recruitment to posts • Ambition that all services adhere to whole system THRIVE principles • Continue with objectives for 16-25 strategy. • SPA refinement • Continued development of the Mental Health Offer to the YOT as part of integrated health offer. • NDT review	Amy Wilkinson, Greg Condon, Sophie McElroy, Mariona Garcia, Chris Pelham, Julie Proctor, Holly Howlett	• See outcomes associated with strategic priorities
CYP with Complex health needs, SEND, LDA	• Budget planning 24/25 • Looked After Children with complex needs • CYP Health Needs Assessment • Partnership for Neurodiversity in Schools • SEND dashboard	✓	• Following priorities to be included in budget planning for 24/25: ➢ Recurrent uplift to 0-5s ASD as previously approved by the C&H FPSC ➢ Recurrent budget for joint funding (agreed in principle with Finance, mirroring the baseline block and activity based process for adults joint funding) • Review of recent looked after children with complex needs to assure interface with continuing care assessment pathways and developing S117 agreement • Health Needs Assessment to be concluded • Leadership of PINs work across NEL (improving inclusion in primary schools) • Development of London wide SEND dashboard informed by Place needs	Amy Wilkinson, Sarah Darcy, Joe Wilson, Chris Pelham and Donna Thomas	• See outcomes associated with strategic priorities

City and Hackney

Key City & Hackney Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
CYP with Complex health needs, SEND, LDA *continued*	• Preparing for Adulthood (As part of the place-based Hackney SEND Strategy and 3 year SEND Action Plan, the Preparing for Adulthood (PfA) workstream is delivering to improve and align systems and processes for transitioning to adulthood for CYP with Education, Health and Care Plans and those receiving SEN Support.)	✓	• Start consultation of draft strategy • Finalise Transition Process Guide in collaboration with system partners • Continue planning for PfA Stakeholder event in Spring 2024 • Continue GP LD Annual Health Check review work • Continue to engage ASC around pathways work • Identify Adult Mental Health partners for collaboration on pathways work • Continue fact-finding to identify further areas for improvement around PfA	Amy Wilkinson, Sarah Darcy, Joe Wilson, Nadia Sica, Paul Richardson	• See outcomes associated with strategic priorities
Improving uptake of childhood immunisations and vaccinations	• Public facing 2024-2027 Vaccination and Immunisation Strategic action plan • Primary care improvement plan • MMR working group • Childhood immunisations programme		• Finalise Immunisations action plan, ready for sign off in Q1 24/25 • Support primary care with flu/covid outreach events • Continued delivery of the polio/MMR child immunisation campaign • Initiate training provision for early year providers on immunisations. Supporting NEL deliver a new data dashboard, to see real time immunisation uptake. Development of a schools sub group to work through flu campaign feedback and make improvements for next campaign	Bryn White, Carolyn Sharpe, Sarah Darcy, Richard Bull,	• See outcomes associated with strategic priorities
Childhood Adversity, Trauma and Resilience	• Workforce training • Evaluation Framework • Resources		• ChATR Training Launched on CHSCP Training Platform • Roll-out of Train-the-Trainer Programme • Consideration of Commissioning-focused training • Finalisation of Evaluation Framework in collaboration with City and Hackney Population Health Hub • Formal Launch of CHATR Online Resource Portal	Matt Hopkinson and Teresa Cleary	• See outcomes associated with strategic priorities

City and Hackney

Key City & Hackney Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
Looked after children and safeguarding 	• Safeguarding • Looked After Children		• Second SG and Quality restructure to be undertaken. • Safeguarding review of school age specification • Support submitted business case for increased funding to health input to MASH in line with national review. • Consider how to support increased funding requirement for MARAC liaison service • Looked after children capacity for clinics being scoped • Allocated nurse for CoL will provide oversight of the looked After Children placed out of Borough. • Dissemination of dental audit recommendations to Medical & Nursing staff	Mary Lee, Sam Martin and Anna Jones, with Rory McCallum and Chris Pelham	• See outcomes associated with strategic priorities
Neighbourhoods 	• Neighbourhood leadership group plans • Evaluation Framework and Pan • Children and Family Hubs • Child Health pilots • Children, Young People, Maternity and Families		• Deliver workshops and embed learning from a Neighbourhood level pilot project focussed on the Hackney Downs Neighbourhood to strengthen its universal early language offer • Development of an outcomes framework that links to the Theory of Change. • Work through opportunities arising from the alignment of Children and Family Hubs • Support with the planning and identifying outcomes for the child health hub pilots. • Support a range of CYPMF services planning to transform towards Neighbourhoods models.	Rachel Wicks, Annabelle Burns, Chris Pelham	• See outcomes associated with strategic priorities

PbP Outcomes associated with our local strategic priorities
Giving children and young people the best start in life: summary

Improvements in the health of the population
• Reduce infant mortality rate • Reduce rate of neonatal mortality and stillbirths • Increase CYP immunisation coverage • Increase % children achieving a good level of development (Foundation Stage) • Reduced childhood obesity • Reductions in crisis mental health presentations to ED (and especially repeat presentations) for children and young people • Reduction in unplanned pregnancies and increasing access to contraception • Increasing identification and support re. domestic abuse • CYP access to services (narrative on access and barriers) • Placeholder: safeguarding • Placeholder: oral health

Reductions in inequalities
• Reduce inequalities in maternity and birth outcomes for children and families (women from global majority backgrounds) • Improve patient experience and outcomes for groups experiencing inequalities in maternity and perinatal mental health care (women from global majority backgrounds) • Improved health and educational outcomes for those at risk of exclusion (Black Caribbean and mixed heritage boys) • Improved health and educational outcomes for those with complex health needs, and those with SEND, LD and autism. • Improvements in mental health and wellbeing outcomes for specific communities (young black men, Orthodox Jewish groups) • Increases in Looked After Children's health: more timely annual and review health assessments, increases in uptake of immunisations and vaccinations and oral health checks.

Blue text = outcome included in 2022-23 IDP and a focus for the next 12m

Our Immediate Priorities

Partners have held a series of workshops, scrutinising data, the JSNA, and what local people have fed back to us around what means most to them and the areas that they feel need greatest improvement, to identify our top priorities for each life course area for 2023/24:

Start Well Immediate Priorities
Work with parents and families to build their resilience; meeting the needs of families at home without the need for more intensive interventions later along their journey
Increase identification of and support for children and young people who provide informal and unpaid care for family members
Build on and improve the mental health offer for schools, working with young people
Increase the number of children receiving timely Autism Spectrum Disorder (ASD) diagnosis and integrated family support
Reduce the wait time of children for Special Educational Needs therapy provision

Start Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Reduce the number of children and their families attending Emergency Departments for non-emergency care	Increase the number of Children and Young People receiving support for their emotional wellbeing through Primary Care	Increase the number of children and their families receiving best practice End of Life Care provision
Reduce the number of Children and Young People attending Emergency Departments in emotional or mental health crisis	Increase the number of children receiving timely Autism Spectrum Disorder (ASD) diagnosis and integrated family support	
Improve access to services and reduce wait times, particularly for Primary Care, non-elective care, and other services	Reduce the wait time of children for Special Educational Needs therapy provision	
Reduce spend on care for those with more complex needs by looking at innovative and local solutions for placements	Increase the use of Child Health Hubs to deliver integrated community care for children and their families	
Deliver greater value for money through joint commissioning of contracts where possible, which will also deliver more seamless, integrated services for local people	Reduce the percentage of children who are physically inactive and/or obese	
	Reduce the number of children and young people living in cold, damp or mouldy homes	

Havering

Key Workstreams in Progress

- Asthma One Stop Hub
- Asthma Friendly Schools
- End of Life Pathway
- Complex Nursing Needs in Education
- Harmful Sexual Behaviour
- Continence Provision
- Child Health Hubs
- Hospital at Home
- Infant Feeding Coordinator

Summary of our challenges

The summary below outlines current challenges shared in a recent BCYP workshop:

Challenges due to rise in BCYP

- Resources have not risen in line with this, placing significant pressure on our current resources
- Example includes Children in Care – increasing number and they are more complex. Key challenge is where children live out of Borough and relying on others to undertake assessments
- Increase need for school places / special school provision
- Increase request for home education and school absence
- High waiting lists for children's services

Emotional and Mental Health

- CAMHS – capacity issues given the rising number of referrals
- What can be delivered in schools prior to specialist service?
- Havering Emotional Health in Schools Team (HEST) has excellent feedback but does not cover all schools
- Need for wider CAMHS and emotional health and wellbeing support including early intervention and support outside school

SEND

- Meeting requirements of Education, Health and Care plans eg therapy provision due to capacity, meeting legislated time frames
- Meeting complex nursing needs of children in education
- Children and young people who require intensive support packages but who don't meet children's CHC criteria/no clear funding/commissioning allocation

General System Challenges

- Investing in prevention given the current need and financial challenges
- Joining up data and information and integrating and sharing this in the best way
- Monitoring and managing our key risks as a Partnership

Other:

Challenges in Health Visiting / School Nursing / Special School Nursing Services

Child Sexual Health services – taking learning from Child Sexual Abuse Review

Young Carers

Numbers of Was Not Brought In/ Did Not Attend appointments

Summary of our Key Emerging Priorities and Next Steps

- Develop a **'starting well'** plan; including a clear vision and story
- **Map current service provision**, and look at challenges, gaps and priorities, as well as opportunities for us to streamline commissioning and build on good work
- SEND provision needs to be considered
- Mental wellbeing of Children and Young People to be addressed, particularly work around prevention and lower level support
- Building resilience and school readiness should be a key area of focus
- Building the voice of children and young people, alongside care givers and parents into service design and improvement
- Map our current risks in the system around Babies, Children and Young People into a risk register for 'Start Well' that can be shared /escalated to the Place based Partnership Board as needed
- Capturing better outcomes so that we can demonstrate that the services that we're putting in place are leading to improved outcomes

Top priorities that we need to address

- Capacity issues
- The voice of children and parents into developing and shaping our services
- Special Educational Needs and Disability (SEND)
- Health Visiting / School Nursing / Special School Nursing
- Emotional Health and Wellbeing including CAMHS
- Children in care health both those placed out of borough and other LA's placing here
- Resilience
- School readiness
- Safer sleeping
- Picking up recommendations from our Independent Scrutiny reports

Further workshops (including face to face) are planned to progress these next steps

Newham

2023/24 JFP Extract	2023/24 Progress & Outcomes	2024/25 Plans
Integration of speech and language therapy services providing a joined up easy to access service offering clear universal, targeted and specialist support	• Integrated service model agreed – April 2023 • School age SLT needs assessment completed – July 2023 • Commissioning approach agreed for an integrated service including funding responsibilities – September 2023 • Develop integrated service specification with shared outcomes / KPIs – December 2023 (in progress) • Engagement with stakeholders on model – January / February 2024 (engagement activity already taken place to inform model) • Develop business case (ICB and LBN) and secure recurrent funding for SLT service – March 2024 (in progress)	• Roll out model in shadow form – April 2024 • Implement full model – September 2023 • Evaluate impact of model – 2024/25
Roll out family hubs with a range of integrated services that better collectively respond to children and family needs	• Family hubs programme developed in Newham with several hub sites identified and now in operation – September 2023 • Various enhanced VCSF contracts bolstered by family hubs investment including maternity mates and parents in mind – November 2023 • Refreshed discussions taking place with health services with a focus on maternity to look at opportunities to strengthen links across and into family hubs – November 2023 • Governance in place for family hubs – more to do to embed health services leads in programme to enhance integrated offer – March 2024	• Develop plans for health services to be co-located – September 2024 • Develop plans for signposting to and from family hub services – September 2024 • Widely publicise family hubs offer in health (primary care, neighbourhood, PCNs) – September 2024
Continued improvement of the SEND support offer with a focus on outcomes	• SEND outcomes framework developed – July 2023 • SEND and inclusion strategy develop – 2023, with launch planned December 2023 • SEND self-evaluation re-drafted and WSOA updated with progress – 2023, shared with DHSC, DfE, Ofsted and CQC who not positive progress	• Increase annual review compliance • Implement digital EHCP hub • Embed outcomes framework into all contracts and engagement • Continued reduction in wait times (health – funding dependent)

Note priorities are draft and pending finalisation of the Joint Forward Plan

Newham

2023/24 JFP Extract	2023/24 Progress & Outcomes	2024/25 Plans
Improve outcomes for women, birth people and babies with a focus on inequalities	• Roll out of healthy start via maternity services – impact increased uptake – 2023/24 • Review of national guidance and reviews on outcomes for BME women and birthing people – October 2024 • Identification of further opportunities for impact that can be prioritised in our 50 steps refresh – March 2024 • Wider NEL maternity health inequity programme in place to deepen impact (ongoing) • Change to MVNP provider to Healthwatch – July 2023 • Additional HI funding for Newham Nurture programme (2023 onwards)	• Deliver against agreed priorities embedded into 50 steps refresh (maternity) (priorities TBC) • Extension to maternity mates contract (peer support for vulnerable families) – by September 2024
Develop our support offer including for those with the most complex needs	• Workshop across multi-agency partners to develop baseline of needs, service offers, development completed – January 2023 • Social care audits completed – July 2023 • Monthly working group – from September 2023 • Multi-agency audits – December 2023 • Secure short term funding for intensive support team (IST) – secured for 2023/24 pilot • Roll out of key worker programme across NEL – October 2023 • Secure long term funding for IST – March 2024	• Develop residential step down / short breaks offer – ongoing • Further review and evaluation of offer including prevention and early intervention e.g. through early help
Integrate care across primary, community and secondary care with a focus on LTCs, MDTs and our youth zone offer	• Model developed and funding secured to pilot a health youth zone in Stratford – June 2023. • Engagement on offer with CYP – August 2023 • Building works and recruitment of health staff – December 2023 • Go live date January 2024	• Evaluate impact – 2024/25 • Secure further funding – January 2025

Note priorities are draft and pending finalisation of the Joint Forward Plan

Emerging priorities

- Understanding the impact of population growth and ensuring outcomes are embedded within the BCYP life stage to deliver long-term health outcomes into adulthood in line with priority health areas identified (for example, obesity, long-term conditions)
- Refresh of the BCYP governance across the Partnership (ICB and London Borough of Newham), establishing a bi-monthly forum that will replace the current Newham Centre of Excellence Board

Newham

Key Newham Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
Maternity and early years	• Maternity and Neonatal Voices Partnership (MNVP		• Health Watch has developed and commenced implementation of action plan to ensure that the voices of maternity service users are at the heart of decision making in maternity and neonatal services.	TBC	• Improved outcomes for women, birthing people and babies and reduced maternal and infant health inequalitities
	• Culturally Competent Genetic Services		• Close Relative Marriage Midwife • Genomic Associate for the Regional Genomic Centre • Health Improvement Practitioner	TBC	
Family Hubs	• Developing integrated family hubs		• Infant Feeding - two infant feeding posts community-based infant feeding peer support offer • Family hubs - Two more hubs are coming on line in 2024. • integrated programmes and services including perinatal mental health, early language development, peer support for vulnerable parents and infant feeding support.		• Increased rates of breast feeding
CYP Special Educational Needs and / or Disability (SEND)	• Strengthening SEND offer and outcomes		• Integration of SLT commissioning, funding and delivery • Roll out of new SLT model from Apr 24, full implementation from September 24 • Sustainability of SLT and OT resource • Delivery of statutory SEND requirements	TBC	• Reduced waiting times
CYP Mental Health	• Violence Reduction Vanguard & Knife crime project		• Embed local and national learning and evaluation around impact and consider options for a wider NEL offer	TBC	
	• Emotional wellbeing single point of access		• improve response times in regards to patient presentation, reduce duplication and streamline the Newham CYP MH pathway of identifying suitable and appropriate interventions.	TBC	

Newham

Key Newham Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
BCYP Primary and Integrated Care (PIC)	• Youth Zone • Respiratory		• Deliver primary care in a way that is accessible to young people by being at a youth centre • Pilot is expected to begin in Spring 2024 • Acute respiratory infections (ARI) hub live from Jan 2024 additional capacity and divert from primary care over the winter period • Diagnostic clinic for asthma, delivering lung function pilot –Spring/Summer 24 • training being rolled out across primary care, community and acute teams to improve asthma knowledge in line with the National Bundle of Care for asthma. • Pharmacists having targeted conversations around air quality and the impact on asthma pilot	Marie Trueman-Abel/Ellie Duncan TBC	• Improved access to primary care

Redbridge

Start Well POAP – 2024/25 PRIORITIES

By 2023/24 we will deliver

- Improved system communications and integrated system priorities
- A system vision of wider Redbridge BCYP needs through establishment of effective integrated working structures
- An agreed system data requirements and structures for collation and use
- An agreed Governance structure able to mobilise system resources to reflect the needs of the BCYP agenda

2024/25 KEY PRIORITY PROJECTS

Access to Universal and Community services

This working group will seek to systemically meet the need to deliver a best practice universal offers in a manner best suited to the service users

Services within this include (but not exclusively):

- 0-19 Provisions such as Mainstream School Nursing and Health Visiting
- Early Years including Childrens Centres
- Immunisations and Vaccinations
- Oral Health
- Maternity services
- Child Developmental Centes
- Speech and Language
- Occupational and Physio Therapy

In addition the programme of work will look to ensure that points of access for health and care are working in an integrated manner and that they are addressing the needs of the family and the child holistically

Workstreams in support of this programme include:

- Child Health Hubs within Primary Care with dedicated resource able to use an MDT approach to addressing Health and Care needs of the whole family
- Improved system links between maternity and early years provisions especially for those with language or cultural needs

SEND and Complex Needs

This workstream will move forward on the common issues affecting delivery of effective SEND and complex needs provisions including:

- Workforce Development and retention
- Integrated and flexible service models with reviews of effective practice
- Inspection readiness and strong partnership working
- Review of statutory provisions and EHCP quality and quantity
- Early interventions and system holistic working

Understanding Redbridge and system data

This work stream will support all programmes and workstreams

The partnership will agree the multiple data requirements able to inform system change. Partners will hold each other to account for the timeliness and accuracy of data

Data will be brought to a single point of access and be used a single resource. Wherever possible there will be commonality around need with multiple workstreams supporting agreed system outcomes

Holistic and Early Years Provision

There is a recognition that health and care provision can be difficult to understand and navigate. The experience of children young people and their families is variable and fragmented.

This workstream will utilise the new BCYP integrated working processes to ensure that services will:

- Hear the voice of children young people and their families
- Think about their communication style, language and methods and use different approaches when required
- Address the wider determinants of health and the impact of the cost-of-living crisis and poverty
- Be creative and innovative
- Close the gaps between partners that arise in areas such as Maternity and Early Years and Primary Care and familial support in the community

Additional Workstreams

- Peri-natal Health
- Long Term Conditions and pathway design
- Alternative provision and services outside of the mainstream

Emotional Wellbeing and Mental Health

The outcomes of the Regulation 28 around CAMHS provisions within Redbridge will facilitate a fundamental review of how EWMH services are delivered between partners
This workstream will maximise the opportunities offered through integrated provision including:

- Expansion of pastoral and MHST provision in education
- Partnership delivery of the Thrive lower quadrant requirements including strong CVS involvement
- Phase 2 of the ASD and ADHD programme and increased system use of the Dynamic Support Register to reduce escalation and use of crisis provisions
- Increased support for targeted schemes delivering early and holistic interventions

Looked After Children

Recognition of LAC as a growing cohort who require an integrated system response to include:

- Accelerated waiting times
- Targeted placement support for physical and emotional needs
- Effective whole system inputs into Preparing for Adulthood (PFA) including health, emotional and practical needs

Children and Families Priorities

Children and Families 2023/24 Priorities for Integration and Transformation

LCG	Priority
Children & Families	Enhancing mental health & emotional wellbeing access and outcomes for children and young people
	Improving our SEND services, experience and outcomes
	Promoting healthy childhood weight
	Achieving more integrated ways of working together to improve outcomes, with a focus on early years
	Mitigating poverty and economic hardship for children, young people and their families
Living Well	Localities and Neighbourhoods Programme: 1. Developing system-wide health Intelligence ("data") for localities and primary care networks/neighbourhoods 2. Strengthening Locality & PCN structures to address health inequalities 3. Engaging communities to improve health and wellbeing 4. Long-term conditions prevention and management: improving pathways between communities and preventative services
	Improving access to services for disabled residents

LCG	Priority
Promoting Independence	Delivering proactive care through care co-ordination and MDT working to improve outcomes
	Working in partnership to improve and streamline our discharge to assess pathway
	Reviewing and refreshing our model and approach for providing Community Health Services
	Providing support to carers through delivering the Carer's Action Plan
	Enhancing and extending our personalisation of care offer
Mental Health	Reducing health inequalities in access, experience and outcomes
	Creating paid employment opportunities
	Improving neurodevelopmental pathways to improve outcomes for Autism and ADHD
	Promoting and developing a more preventative approach
	Improving the experience and outcomes for young people transitioning to adult services

Waltham Forest

Key Waltham Forest Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
BCYP Strategy	• Waltham Forest Integrated BCYP Partnership Strategy (2024-2029)		• Develop the Partnership Vision and Priorities for BCYP in Waltham Forest • Action plans, JSNA and BCYP and families engagement	Waltham Forest Health and Care Partnership Board	• BCYP priorities agreed and action plans in place
Maternity and early years	• TBC		• TBC	Maternity and early years sub-group	• TBC
CYP Mental Health	• Children and Adolescent Mental Health Services (CAMHS)		• Earlier access to emotional and mental health support in non-clinical settings. • Develop pre and post diagnostic support - move post diagnostic support services from CAMHS to delivery by teachers/early help • Introduce I-thrive model across the WF partnership in order to meet needs at an early stage for children developing anxiety. • The Dynamic Support Register (DSR) – focus on transition of children to adults without LD.	CYP Mental Health sub-group	• Improved CYP mental health outcomes
CYP Special Educational Needs and / or Disability (SEND)	• Local Area SEND plan		• Waiting times for SLT, OT, Neurodevelopmental Diagnostic Pathway for under 5s • Accessing health care services - phlebotomy and A&E. • Supporting children with Social, Emotional and Mental Health (SEMH) needs in Alternative Provision settings. • Transition to adult health services • Improve young people's participation in the development of wider health services • 6-week compliance of health reports • Commissioning approaches for the LA re: SLT	SEND sub-group	• Reduced waiting times • Improved access to healthcare services • Improved health outcomes for SEMH and transition

Waltham Forest

Key Waltham Forest Priority Programmes	Projects	National/ regional priority	Activities	Strategic/ Programme Lead	Impact
BCYP Long Term Conditions (LTC)	• Frequent attenders project		• Family liaison nurse running sessions to families and staff at Lloyd Park Family hub • Weekly meetings with ED consultant • Data deep dive	LTC sub-group	• Reduced BCYP frequent attenders at the Children's Emergency Department at Whipps Cross
Looked after children and safeguarding	• Children Looked After (CLA) services		• Timeliness of initial and review health assessments. • identification of health needs and relevant pathways to increase health awareness during work on Pupil Education Plans (PeP). • Analysis of all CLA with Education and Health Care Plans (EHCP) with joint training provided to SEN and CLA teams to better meet these identified needs	TBC	• Increased percentage of children receiving an initial health assessment within the 28-day time frame • Increased percentage of children receiving review health assessment within 12 months • Immunisations up to date • Dental assessment • SDQs completed

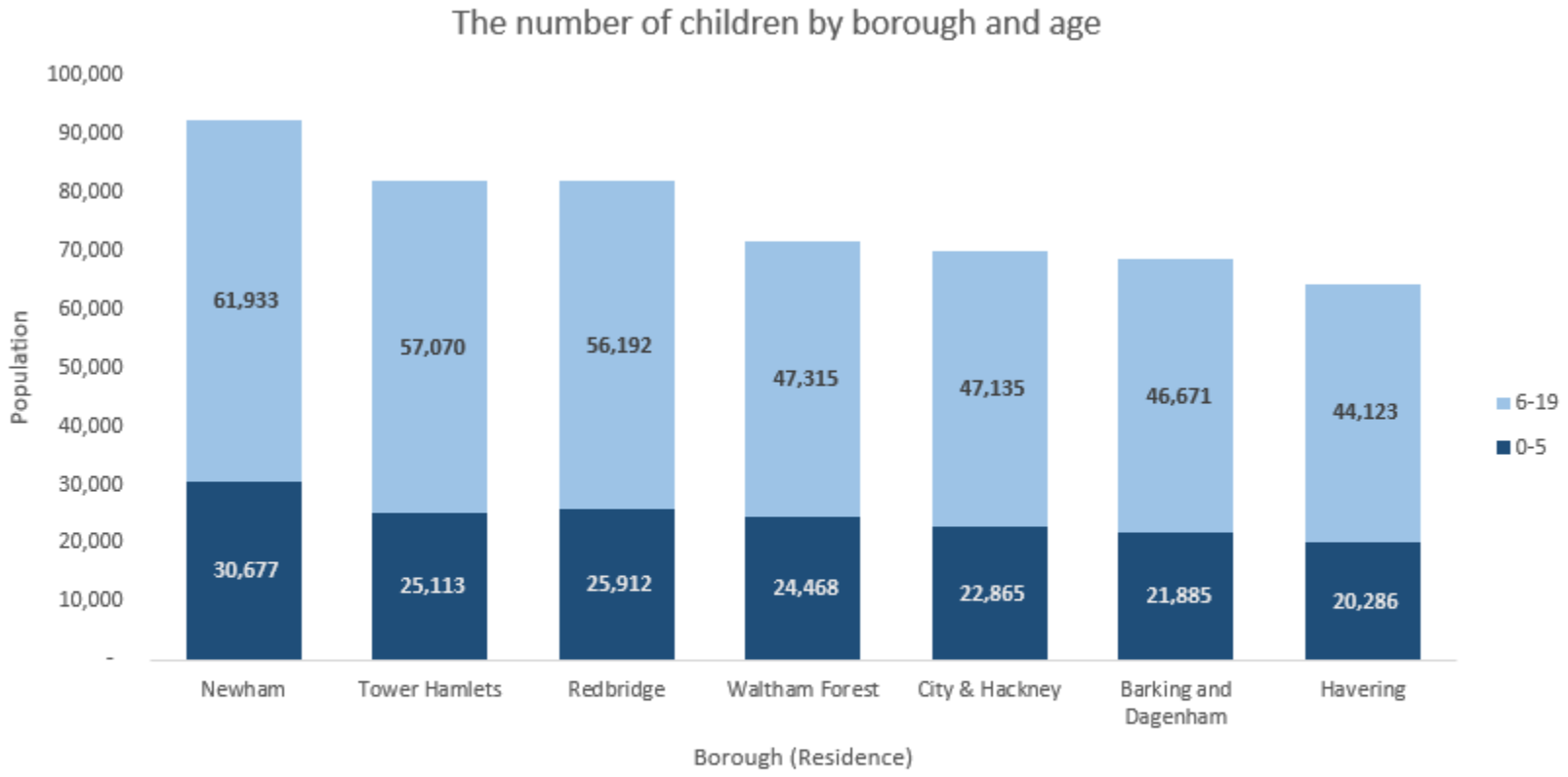
North East London Health & Care Partnership

NHS North East London

NEL's 0-19's population – Rapid profile

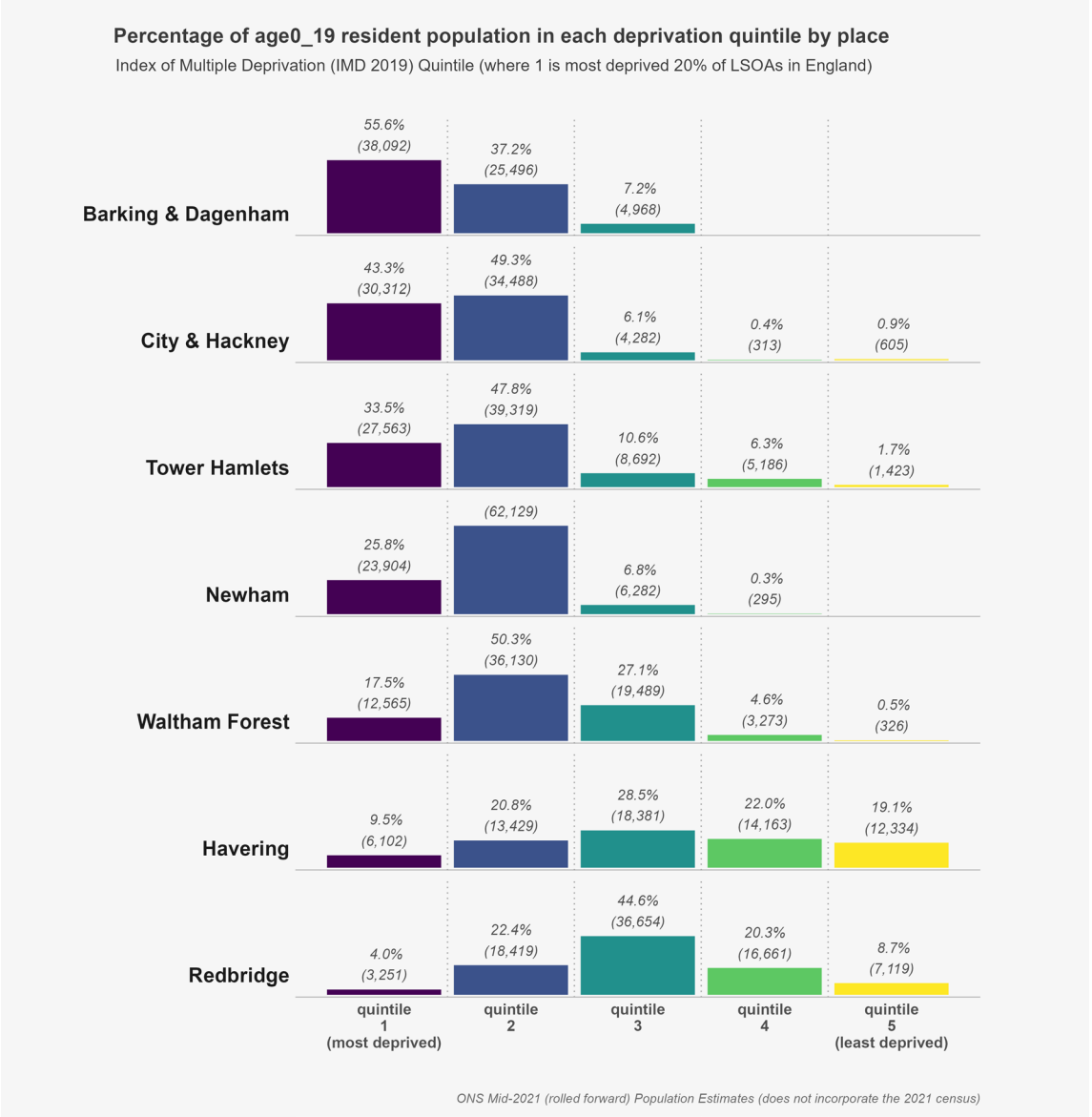
1 February 2024

Children in NEL – 0-5, 6-19s



Borough	Newham	Tower Hamlets	Redbridge	Waltham Forest	City & Hackney	Barking and Dagenham	Havering
Total	92,610	82,183	82,104	71,783	70,000	68,556	64,409

IMD deprivation by place for 0-19 population



OHID Child health profiles – selection of indicators

Admissions for lower respiratory tract infections (2 to 4 years) 2021/22

Crude rate - per 10,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	5,049	26.9	26.2	27.6
NEL Counties 21/21-22/23	–	-	-	-	-
Hackney	–	45	47.5*	33.8	62.4
Tower Hamlets	–	40	36.1	26.5	50.2
Waltham Forest	–	30	27.2	16.9	36.7
Newham	–	30	21.2	13.7	29.4
Havering	–	20	19.8	11.3	29.3
Redbridge	–	25	19.6	12.1	28.0
Barking and Dagenham	–	20	18.9	12.3	30.4
City of London	–	-	*	-	-

Hospital admissions for asthma (under 19 years) 2021/22

Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	16,310	131.5	129.5	133.6
NEL Counties 21/21-22/23	–	-	-	-	-
Hackney	–	100	168.8*	137.4	205.3
Waltham Forest	–	105	160.0	129.4	192.0
Barking and Dagenham	–	105	158.1	132.0	194.7
Redbridge	–	125	155.7	129.6	185.5
Tower Hamlets	–	100	147.5	121.3	181.0
Havering	–	90	146.5	117.8	180.1
Newham	–	115	130.4	106.6	155.3
City of London	–	-	*	-	-

Percentage of 5 year olds with experience of visually obvious dentinal decay 2021/22

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	23.7	23.3	24.0
NEL Counties 21/21-22/23	–	-	-	-	-
Newham	–	-	33.6	28.9	38.7
Barking and Dagenham	–	-	30.6	25.4	36.3
Tower Hamlets	–	-	29.6	24.5	35.3
Redbridge	–	-	28.8	24.0	34.2
Havering	–	-	24.8	19.7	30.8
Hackney	–	-	22.4	17.5	28.1
Waltham Forest	–	-	21.2	16.7	26.5
City of London	–	-	*	-	-

Population vaccination coverage: MMR for one dose (2 years old) 2022/23

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	538,404	89.3	89.3	89.4
NEL Counties 21/21-22/23	↓	22,882	79.5*	79.0	79.9
Havering	→	2,935	86.4	85.2	87.5
Waltham Forest	→	3,286	82.2	81.0	83.3
Tower Hamlets	↓	3,257	81.9	80.7	83.1
Redbridge	↓	3,628	80.5	79.3	81.6
Newham	↓	4,414	79.1	78.0	80.2
Barking and Dagenham	↓	2,677	79.0	77.6	80.4
Hackney	↓	2,685	68.1*	66.7	69.6
City of London	–	-	*	-	-

Children in relative low income families (under 16s) 2021/22

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	2,087,494	19.9	19.9	20.0
NEL Counties 21/21-22/23	–	89,262	21.4*	21.3	21.6
Tower Hamlets	–	15,385	26.7	26.2	27.2
Newham	–	18,028	24.1	23.7	24.5
Barking and Dagenham	–	13,574	23.9	23.4	24.4
Hackney	–	11,886	23.6*	23.1	24.2
Waltham Forest	–	11,541	20.5	20.1	21.0
Redbridge	–	11,402	16.7	16.4	17.1
Havering	–	7,446	14.2	13.8	14.7
City of London	–	-	*	-	-

School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception 2021/22

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	495,083	79.5	79.4	79.6
NEL Counties 21/21-22/23	–	-	-	-	-
City of London	–	38	90.5	77.9	96.2
Waltham Forest	–	2,795	81.3	79.9	82.5
Havering	–	2,692	79.7	78.3	81.0
Hackney	–	2,198	78.7	77.1	80.2
Redbridge	–	3,268	78.3	77.1	79.6
Newham	–	3,660	77.8	76.6	79.0
Barking and Dagenham	–	2,623	75.5	74.1	77.0
Tower Hamlets	–	2,501	73.2	71.7	74.7

Children in care 2022

Crude rate - per 10,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	82,170	70	69	70
NEL Counties 21/21-22/23	–	-	-	-	-
Hackney	–	415	74*	67	81
Barking and Dagenham	–	413	65	59	72
Waltham Forest	–	329	52	47	59
Tower Hamlets	–	332	52	46	58
Newham	–	431	52	47	57
Havering	–	264	45	40	51
Redbridge	–	287	38	33	42
City of London	–	-	*	-	-

Children in care immunisations 2022

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	49,710	85.0	84.9	85.5
NEL Counties 21/21-22/23	↓	1,002	65.1*	62.7	67.5
Tower Hamlets	↑	176	90.0	84.8	93.3
Barking and Dagenham	→	230	87.0	82.9	90.9
Havering	–	114	76.0	68.6	82.1
Newham	↑	183	72.0	66.5	77.5
Hackney	↓	161	55.0*	49.4	60.7
Waltham Forest	↓	90	40.0	34.1	46.9
Redbridge	↓	48	30.0	23.3	37.3
City of London	–	-	*	-	-

Source: (Fingertips) Child and Maternal Health - Data - OHID (phe.org.uk)

North East London
Integrated Care Board

Attachment 3 – Place Initiatives

Havering Start Well priorities

We have established the Havering BCYP Board that meets monthly to oversee the development of BCYP schemes. Dr. Richard Burack is the childrens clinical lead. In January we undertook a recruitment process for the Associate Director of Start Well role and they are expected to be in post soon.

Havering is currently seeing one of the largest increases in percentage terms in the population of babies, children and young people in London. This changing demographic is driving demand for corresponding services.

We are establishing a series of workshops with partners at place to develop our local plan for strengthening our approach to start well, which will feed into our five year Partnership Strategy, with clear objectives and KPIs that we're all working towards. Our current priorities in our interim strategy include:

- Work with parents and families to build their resilience; meeting the needs of families at home without the need for more intensive interventions later along their journey
- Increase identification of and support for children and young people who provide informal and unpaid care for family members
- Build on and improve the mental health offer for schools, working with young people
- Increase the number of children receiving timely Autism Spectrum Disorder (ASD) diagnosis and integrated family support
- Reduce the wait time of children for Special Educational Needs therapy provision

With regards to the BCYP priorities identified in the ICS strategy, we have focussed on building on current services and identifying gaps that we are driving resource towards.

BCYP 1. Reduce proportion of babies born with low birth weight in our population.
We're in the process of creating a service that will provide maternal and paternal support for expectant parents and parents of newborn babies who have mental health problems, particularly with the early detection of postnatal depression.

BCYP 2. Identify children living in poverty within our communities and ensure they are receiving the support they need to live a healthy life including equitable access to and outcomes from our health and care services
In Havering, we are creating a new Infant Feeding Coordinator post (Grade 5, 1.0 FTE) within the London Borough of Havering (LBH) Early Help Service to facilitate an improved offer of support to parents around infant feeding, the scheme targets the most deprived as there are significantly poorer breastfeeding rates and engagement with services by those form deprived backgrounds.

BCYP 3. Strengthen our focus on prevention, reducing levels of childhood obesity and dental decay, and increasing uptake of childhood immunisation
Childhood obesity is a significant problem in Havering, based on the latest data almost 25% of children start reception above a healthy weight, at year 6 this rises to 36%.
The prevalence of obesity is not evenly distributed across the borough, children from areas of highest deprivation are twice as likely to be obese than those from lowest area of

deprivation. To support children who are overweight or obese already, NICE guideline 47 recommends local authorities to Commission a family-based, multi-component lifestyle weight management service. The lack of service was highlighted as one element which needed addressing in a recent learning review for a child death related to obesity in Havering.

We have therefore commissioned an evidence-based, multi-component, lifestyle weight management service in Havering. The service launched in September 2023. The service is targeted towards the three key areas in Havering with high levels of deprivation (Rainham, Romford, Harold Hill). The service provides a holistic approach to support families help their children achieve a healthy weight. A coordinator was recruited to coordinate the service delivery. The service provides parents of identified children with an 8 week programme, targeted at supporting the parents who have children aged 5-11 with an unhealthy weight. The programme works with parents, to help manage/improve behaviours that lead to unhealthy weights.

BCYP 4. Strengthen our support for children living with long term conditions and address health inequalities by reducing the number of asthma attacks, increasing access to prevention and self-management for children and young people with diabetes (particularly those living in poverty or deprivation and those from black and ethnic minority backgrounds), increasing access to specialist epilepsy support for children, including those with learning disabilities and autism and supporting all children better through the transition to adult services

We're currently in the process of recruiting to a 0.5WTE non clinical asthma friendly schools coordinator post who will help schools become asthma friendly accredited and have the following in place:
• policy for use of inhalers
• named person responsible for asthma
• record of all children with asthma
• emergency kit and policy for emergency inhaler use
• system in place to identify children missing school or PE because of asthma
• staff completing 'Asthma Management in Schools' training
• pupils known to have asthma recorded as having asthma care plans

Those from the most deprived backgrounds in Havering have higher rates of asthma. The programme will start by targeting schools in deprived areas.
With regards to diabetes, we're currently taking a business case through the ICB governance processes to fund the recruitment of a 0.6WTE childrens diabetes nurse specialist who will see and treat children diagnosed with diabetes within the expected timeframes (as well as improve access to Continuous Glucose Monitoring and Pumps). Newly diagnosed children should be seen by the Diabetes team within 2 weeks of referral. The current waiting time is 3 months. Patients requiring follow up appointment – ideally 3 monthly, are having to wait 4 months at least. 280 patients are currently waiting from Havering. The additional post will help reduce the backlog and provide the basis of a case to demonstrate the need to increase the capacity of our current service.

To support children that have multiple long terms conditions and are currently acutely ill, we have commission a 'hospital at home' service that provides nursing care in the home environment for our cohort of acutely ill children and young people, the scheme is support those children to stay well at home and avoid admissions and reduce length of stay. The team consists of skilled nurses with paediatrician oversight who provide care 7 days a week.

BCHP 5. Improve access to children and young people's mental health services, and support young people better through the transition to adult mental health services.

In Havering, we have identified a growing cohort of young homeless people who would really benefit from bespoke support, we are in the process of commissioning 25 days of Educational Psychologist support to:

- Provide resources & training to schools, to support them with supporting young homeless students
- Provide consultations for pastoral/mental health leads in schools
- Formal assessment of young homeless people to support planning of their mental health needs
- Create coffee groups for parents of homeless households
- Create peer support groups for young homeless people

BCYP 6. Reduce the number of young people reporting that they feel lonely and isolated

In Havering we have funded a project supporting children & young people, that feel lonely or isolated and who may also have mental health needs. The age of children targeted is those between 10 and 17 as this is where we are locally seeing an increase in mental health cases amongst BCYP population post pandemic, during the cost of living crisis and in general with the BCYP population increase. We are currently out to advert for a youth working who will establish a youth steering group. The youth steering group will be made up of all those children who wish to take part, the youth worker will empower them to oversee the development of their own schemes that will support them with loneliness, isolation and mental health. A 0.5WTE post has been created within LBH to support the project development, children will be incentivised to attend and participate in the steering group through £10 vouchers being made available.

BCYP 7. Collaborate between education, health and social care to ensure school readiness for all children and to meet the needs of children with special educational needs and disability

We're in the process of employing a full time counsellor for 12 months, who would support 65 children and young people with neurodevelopmental conditions, each likely to be receiving 12 x 1 hour sessions. We're working towards a September 2024 launch due to the restructure that is also taking place within Havering Local Authority.
We're also in the process of establishing Child Health Hubs. The key elements of the Child Health Hub model are to host clinics and multi-disciplinary team (MDT) meetings alongside having patient champions. Central to this is the introduction of 3 Child Health Hub coordinators – 1 Band 6 and 2 Band 5s and these will cover all 4 PCNs in Havering.
The hub will create vertical and horizontal communication ie up and down between acute providers and GPs , and horizontal across GPs and social care/ health eg health visitors/ school nurses/ social workers etc.

Tower Hamlets: Children and Families priorities

Children and Families 2023/24 Priorities for Integration and Transformation

LCG	Priority
Children & Families	Enhancing mental health & emotional wellbeing access and outcomes for children and young people
	Improving our SEND services, experience and outcomes
	Promoting healthy childhood weight
	Achieving more integrated ways of working together to improve outcomes, with a focus on early years
	Mitigating poverty and economic hardship for children, young people and their families
Living Well	Localities and Neighbourhoods Programme: 1. Developing system-wide health Intelligence ("data") for localities and primary care networks/neighbourhoods 2. Strengthening Locality & PCN structures to address health inequalities 3. Engaging communities to improve health and wellbeing 4. Long-term conditions prevention and management: improving pathways between communities and preventative services
	Improving access to services for disabled residents

LCG	Priority
Promoting Independence	Delivering proactive care through care co-ordination and MDT working to improve outcomes
	Working in partnership to improve and streamline our discharge to assess pathway
	Reviewing and refreshing our model and approach for providing Community Health Services
	Providing support to carers through delivering the Carer's Action Plan
	Enhancing and extending our personalisation of care offer
Mental Health	Reducing health inequalities in access, experience and outcomes
	Creating paid employment opportunities
	Improving neurodevelopmental pathways to improve outcomes for Autism and ADHD
	Promoting and developing a more preventative approach
	Improving the experience and outcomes for young people transitioning to adult services

We have been enhancing access to mental health and wellbeing services for children and young people by ensuring schools have a comprehensive framework of support. The Barnardo's school's contract is being reviewed and we are going to extend mental health and wellbeing support for children in care and through care services responding to demand from the service. We are still in talks with the provider, but this is with the aim of eliminating the barriers to services for this cohort and in line with being Care Experienced now a protected characteristic in Tower Hamlets, this proactively seeks to reduce inequalities and improve health outcomes. This is expanded from the THEWS (Tower Hamlets Education and Wellbeing Service) currently available to all secondary schools and 31 primary schools. Barnardo's and Kooth services are also available to school aged children. In addition, a Barnardo's worker is embedded in the Youth Justice Service (YJS), offering dedicated MH support to a minimum of 50 children and young people per year as well as advice to staff. This has improved communication and operational interface with the all age liaison and diversion service based in custody to enable prompt support and interagency collab for young people in custody.

Youth Justice Services Speech & Language Therapy has been strengthened. An audit has been undertaken to identify SEND needs in caseload. Initial results show two-thirds of cohort have SEND needs which is in line with national comparators. It also shows previous under identification and the importance of screening and then directing service users to treatment/support. The new YJS Nurse will screen for SEND needs going forwards to support identification and treatment. Youth Justice Service and Children's Integrated Commissioning are developing a proposal for an expanded Speech and Language Therapy Offer that covers both the Youth Justice Service and Young Tower Hamlets. Proposal is being supported by Designated Clinical Officer for SEND. Existing SLT arrangement runs until end of March 2024- it is likely a further extension will be needed to allow for procurement/commissioning activity. A new Designated Social Care Officer for SEND has been recruited to and the SEND JSNA being led by public health is being completed and will inform work going forward.

Newham Growing Well Update - January 2024

Newham Health and Care Partnership identified babies, children and young people as a priority area of focus, aligning with the ICB/ICS priority to support all babies and children to have the best start in life and grow up into happy and healthy adults.

We have four existing partnership priorities and are in the process of reviewing these and refreshing our partnership governance to further build on our existing strong relationships and integration activities. Our current priorities focus on:

1. Reducing maternal and infant inequalities through improving outcomes for women, birthing people and babies with a focus on black and Asian and vulnerable people
2. Developing integrated family hubs – Newham was selected to be a vanguard site for this national programme, securing £4.5m to implement this.
3. Strengthening our SEND offer and outcomes, with a particular focus on integration of SLT commissioning, funding and delivery
4. Developing our mental health offer including for children and young people with the most complex needs and those with lower needs (Thrive model)
5. Integrating care across primary, community and secondary care with a focus on LTCs, MDTs and our youth zone offer

The below provides a flavour of some of our key pieces of work in train in Newham linked to the above priorities.

Maternity and Neonatal Voices Partnership (MNVP) (priority 1)

The Newham, Tower Hamlets and Waltham Forest MNVP contract transitioned to a new provider (Health Watch) in 2023. Since then, Health Watch has developed and commenced implementation of an action plan to ensure that the voices of maternity service users are at the heart of decision making in maternity and neonatal services. New guidance has recently been published, requiring MNVP to also engage with neonatal services. Health Watch is currently developing action plan to support this new requirement.

Culturally Competent Genetic Services (priority 1)

In 2023, NHSE provided eight ‘high need’ areas across England with funding to support the Borough with improving understanding about genetic inheritance and ensuring equitable access to genetic information and services for affected families. The funding received has since be used to resource:

- A Close Relative Marriage Midwife, who is responsible for having encouraging conversations with families, identifying and referring at risk families to relevant support services and acting as the main point of contact between Newham University Hospital and the wider system
- A Genomic Associate for the Regional Genomic Centre who liaises with families, prepares them for their appointment and supports them throughout the testing process
- A Health Improvement Practitioner (Genetic Literacy) who runs groups and 1:1 health promotion sessions with at-risk communities.

In the most recent quarter, 12 midwives were trained on close relative marriage (1 month into the start in role of the Close Relative Marriage Midwife and 9 health promotion sessions were run by the Health Improvement Practitioner, attended by 21 adults.

Infant Feeding (priority 1 and 2)

The Newham team has contributed to the research and development of plans to support the infant feeding work stream of the new Family Hubs programme. This has involved over 14 co-production sessions with a wide range of partners such as Newham's Maternity Services, Health Visiting, early years, VCSF partners and residents. As a result of these sessions, Newham's infant feeding offer was mapped and gaps were identified and used to inform how and where the Family Hubs funding would be invested across the borough's infant feeding system. This has resulted in the recruitment of two infant feeding posts (12-month fixed term contracts) at Newham University Hospital, which will increase infant feeding support in the hospital from 5 day to 7 day coverage. Funding is also being provided to commission a community-based infant feeding peer support offer to support families with their infant feeding goals once discharged from Maternity Services. This is particularly important as parents have requested more support and as breastfeeding rates reduce significantly once discharged from hospital.

Family Hubs (priority 2)

One family hub is now live with second going live in February 2024. Two more hubs are coming on line in 2024. Funding is also supporting integrated programmes and services including perinatal mental health, early language development, peer support for vulnerable parents and infant feeding support.

SEND & SLT (priority 3)

Outcomes framework and SEND and inclusion strategy developed and launched December 2023.
https://search3.openobjects.com/mediamanager/newham/directory/files/newham_send_strategy.pdf

Following investment, we've recruited over 20 SLT staff and maintained high levels of staffing levels in in contrast to regional and national challenges – over 95% of therapy services posts are filled. Adoption of an innovative skill mix to ensure best value for money when planning staffing resource including use of therapy assistants. ELFT cultivated a staff development programme that has proven effective in enhancing recruitment alongside promotion of our commitment to high quality and integrated SLTs services.

Achieved continued reduction in waiting times, despite increasing levels of referrals (33-38% increase since April 2022). As at quarter 2, 2023/24:

- SLT early years – 21 week wait referral to treatment (RTT)
- SLT complex needs – 11w RTT
- SLT dysphagia – 4w RTT
- SLT school – 20w wait for assessment (excluding requests for ELHP SLT assessment where the nationally mandated target is 6 weeks)
- Waits previously surpassed 40 weeks for SLT assessment, except in the most complex presentations.

We've also made significant progress in developing our model for an integrated SLT service, having agreed funding responsibilities across partners, undertaken a school age needs assessment, quantified provision needed to meet SEND legislative requirements and developed an integrated service model and specification between ICB, LA and ELFT. Critically we have embedded feedback from families and schools into the model such as

school-based teams and named SLT leads. School based teams with staff on site has halted increasing referral levels in our OT service, which we hope to replicate with the new SLT model. We anticipate roll out of the model from April 2024 with full implementation from September 2024. Our increased capacity in early years (0-5) enabled us to adopt an earlier intervention approach promoting school readiness.

We do have a significant risk in Newham regarding sustainability of the above impact and outcomes due to short term funding of our additional SLT and OT resource. This has been flagged, escalated and prioritised through the planning round for 2024/25. There are similar risks to delivery of our statutory SEND requirements across NEL.

Violence Reduction Vanguard & Knife crime project (priority 4)

The NEL violence reduction "vanguard programme" is hosted by Newham place-based partnership team. The vanguard is delivered in Newham and Waltham Forest and will be extended for a further 4 years up to September 2028 providing a total programme delivery period of 7 years. This is significant as many VR programmes are delivered on a short-term basis. The funding allocation aligns with the Glasgow public health approach to violence reduction which has seen great impact.

To date we have received 290 referrals and provided support to over 200 young people and many families. We have received the highest number of referrals, supported the most young people, provided the largest number parenting programmes and supported the highest number of professionals of all three vanguards in London despite only delivering across two boroughs. Additionally, we have recently provided vanguard and health inequalities funding to the West Ham United Foundation Knife Crime Reduction Project which facilitates a referral pathway for young people via their GPs. This link to primary care provides greater access for CYP to access mentoring and therapeutic intervention. Our next steps are to embed local and national learning and evaluation around impact and consider options for a wider NEL offer.

Emotional wellbeing single point of access (priority 4)

The Newham Integrated Front Door/Single Point of Access is a joint initiative between LBN, ELFT CAMHS and the ICB. It is a pilot in East Ham locality testing a new approach to multi-agency understanding and review of CYP emotional wellbeing and MH needs. It aims to improve response times in regards to patient presentation, reduce duplication and streamline the Newham CYP MH pathway of identifying suitable and appropriate interventions.

The multi-agency/disciplinary team performs twice weekly referral triage and assessment for 5-18 patients in the CYP MH pathway experiencing a range of MH presentations. The team then signposts the referral onto a suitable team within the system reducing unnecessary referrals to multiple partners and speeds up access to intervention and support via VCSF and schools for earlier intervention and low-level identified needs.

The initiative has been jointly funded by the LA and ICB, the latter utilising health inequality funding to pilot the model to enable greater access to the breadth of support available.

Youth Zone (priority 5)

The youth zone pilot is focused on the replicating successful Health Spot model from Tower Hamlets, aiming to deliver primary care in a way that is accessible to young people by being

at a youth centre, facilitated by wrap-around support from youth workers, and integrated with mental health, sexual health and substance misuse support. Engagement work with both general and specific cohorts (such as LGBTQIA+) has been used to develop a model that ensures confidentiality and offers the support young people say they want. The CAMHS offer will be co-produced with the young people using the setting to provide creative, accessible intervention projects. The pilot is expected to begin in Spring 2024.

Respiratory (priority 5)

- Acute respiratory infections (ARI) hub live from Jan 2024 to offer additional capacity and divert from primary care over the winter period. This is in direct response to high numbers of respiratory presentations in A&E, particularly for the under 5's.
- A pilot is planned from Spring/Summer 2024 to offer a diagnostic clinic for asthma, delivering lung function (spirometry and FeNO). This will provide a service that is currently not available in Newham and will assist with upskilling local practitioners.
- Training project completed around upskilling a group of primary care clinicians in identifying children and carrying out 48hr reviews post an A&E attendance for asthma. Further training being rolled out across primary care, community and acute teams to improve asthma knowledge in line with the National Bundle of Care for asthma.
- Pilot ongoing to facilitate pharmacists having targeted conversations around air quality and the impact on asthma.

Barking and Dagenham: Best Chance for Babies, Children and Young People

The Barking and Dagenham partnership priorities are guided by the Best Chance Strategy for babies, children, young people and their families. Demographic growth is presenting pressures on all of our services for children and young people.

A significant focus of work at place has been on improving outcomes for children and young people with SEND with an improvement plan being overseen by the B&D SEND Area Board.

1 Improving access to therapy support has been identified as a priority – a SEND health needs assessment has pointed to a significant increase in the number of children and young people on Education, Health and Care plans (EHCP) and a deficit in therapy capacity to meet current demand. This is manifested in high caseloads and long waiting times for therapy support, particularly speech and language therapy.

2 Non-recurrent funding was secured in 23/24 to enhance therapy support and this has been prioritised as a cost pressure for 24/25

3 The BHR Autism diagnosis pathway, pre and post diagnosis workstream was launched in January 2023 with some investment. 90% recruitment achieved across BHR, new pathway and data system operational but still under development. Further investment will be required to meet demand

4 Two mental health in schools teams are in place with a further expansion planned

5 The key worker pilot for learning disabilities and autism is in place, which has enabled a more integrated approach across health and care to support those with more complex needs

We have recruited a B&D Obesity Family Support Worker, funded through NHSE via Royal London, who works as part of the multi-disciplinary team with the Royal London Hospital, links to support the 10-30 most complex children and young people cases in B&D. A task and finish group is in place with all key partners. The scheme is funded until March 2025.

As part of our winter plan, we have implemented a number of actions to prevent unnecessary attendances and/or admissions to hospital through taking a proactive approach. The key highlights are:

- Optimise uptake of the MMR and flu vaccines
    - A dedicated Task and Finish group was put in place, chaired by the Director of Public Health
    - Increased the number of vaccination clinics to four in Barking and Dagenham
    - Vaccination UK are targeting "missing" children and young people from the list.
    - Asthma and allergy friendly school co-ordinator funded jointly by the ICB and Local Authority

City and Hackney: Strategic priorities Growing up Well in NEL

Immunisations

City and Hackney remains particularly **vulnerable to large outbreaks of measles** due to low MMR vaccination coverage, having the lowest MMR coverage in the country.

Data from 2022/23 showed that, in City & Hackney, 81% of 5-year-olds had their first dose of the MMR vaccine and 56% were fully immunised (against a herd immunity target of 95%).

Hackney's low immunisation coverage can be, at least in part, explained by population factors. Population groups that have lower vaccination uptake levels compared to the general population include those living in the most deprived areas; those with large families; certain ethnic groups for example, Black Caribbean, Somali, White Irish and White Polish populations, and Orthodox Jewish populations. Uptake also tends to be lower in more urban areas.

The **Charedi community** is c.30% of the 0-5s population in Hackney and since 2016/17 the CCG/ICB has non-recurrently funded additional clinic capacity, targeted communications via community leaders and the Jewish press, and more recently additional call and recall capacity. Families will often immunise but outside of the schedule, and targeted efforts have seen an increase in the proportion fully immunised at 5 years. Learning from community work during Covid, it's recognised that a community-wide approach to vaccine hesitancy is required, and an increase in the domiciliary offer via the NE Hackney PCNs supports a personalised approach enabling family-wide decision making and opportunistic immunisation. The NHSE - funded immunisations coordinator has focused on engagement work in the Orthodox Jewish community, a vital factor in sustaining engagement; and the ICB is non-recurrently funding an immunisations Programme Manager who is both coordinating the development of the C&H Strategic Delivery Plan in response to the NEL Immunisations and Vaccinations Strategy, and providing QI leadership across and with practices.

<u>This is a strategic and investment priority for Start Well in C&H, with a need for strategy to be Place specific in 24/25 to inform approach once responsibilities are delegated to the ICB as planned in 2025.</u>

Early identification of Needs: SEND

Much of the transformation work in C&H enables earlier and integrated identification of needs, particularly in relation to Emotional Health and Wellbeing and Special Educational Needs and Disabilities (SEND).

In alignment with the Hackney SEND Graduated Approach and the City SEND Ranges the principle driving the work is support being available based on needs and not diagnosis.

A **neighbourhood**'s approach to early language development for under 5s has been piloted through Neighbourhoods, and via NEL BCYP Child Health Practitioner funding C&H schools are piloting **Verbo**, a digital platform that skills up school staff through a universal approach, with training resources, tools, and function to screen, set targets and measure outcomes for children. Much of the content can be shared directly with families. The platform enables skilling up to delivery earlier interventions freeing up therapists' time for where specialist intervention is required.

As this is a Homerton- developed product which has been commissioned across the country, including other parts of NEL, there is an opportunity here for the ICB to champion an approach consistently with costs (currently c. £40 for C&H) expected to further reduce and option to extend the model to include OT and physio -mitigating gaps in offers across NEL.

Post-pandemic non-school engagement and **Emotional-based School Avoidance** (EBSA) is a shared priority with LBH who have co-produced work with parents for those with entrenched school avoidance. Via ICB (Child Health Practitioner) funding we are piloting an early intervention offer across CAMHS and education for children attending c.80%.

The **whole school approach** is consistent throughout key community services including Speech and Language Therapy (SALT) and CAMHS.

In SALT we are seeking recurrent funding (£150k p.a) for a hugely successful jointly delivered (HHFT and Children Ahead) ***Talking Together*** offer to independent Charedi schools. Following pilots across boys and girls schools, we have a costed model that would deliver an equitable offer as is currently commissioned for the mainstream schools, also with the option for a 'top up' traded service. Via the HHFT's 'Launchpad for Language' programme within the pilot, in one year the % of (38) children with age appropriate skills jumped from 29% to 66%. This approach both supports immediate outcomes for children and the longer term rebalancing of the SEND system.

This work has wider impact outside of the service given the trusted relationships developed between the schools, statutory and Charedi community providers.

Across the ICB and LBH there is a commitment to meet the needs of all resident and registered children regardless of the status of their education setting, evidenced through CAMHS (e.g Wellbeing and Mental Health in Schools (**WAMHS**); NCMP screening and LBH Delivering Better Value (SEND) strategy). The challenge here is commitment to recurrent funding.

Emotional health and Wellbeing / Mental health
C&H has established an Emotional Health and Wellbeing Partnership with a 3-year Action Plan currently being refreshed, and the principle that a system response is required to meet demand.

Meeting neurodevelopmental needs (not based on a diagnosis) is a strategic and investment priority given both BAU diagnosis pathway funding and Intensive Support Team (IST or Tier 3.5) pilot funding (CETR caseload those at risk of a tier 4 admission) ends in March 24.

HHFT and ELFT are committed to working with the ICB team to improve integration of delivery, which can also be seen in the CAMHS Single Point of Access (SPA) which is reducing the time from referral to allocation across the CAMHS pathways.

Creating safe and accessible spaces for integrated advice and service delivery is a transformation priority across C&; with the development of both the **Family Hubs and the Super Youth Hub**, pilot due for soft launch in 2024.

There is huge opportunity to expand this approach and build on the rich youth offer and VCS assets in C&H. However a challenge is funding to include a sustained **Social Prescribing Offer.**

Primary Care
We have a long history of investment in primary care via two contracts:

- **Early Years** (antenatal and postnatal appointments with a focus on the vulnerable womens pathway, enabling a consistent relationship with the practice from pre-conception; resource to enhance capacity of Link meetings with HVs and midwifes to review and agree action plans for Universal Partnership Plus 0-5s; maintenance of a young carers register and referral for support)
- **Children's Long Term Conditions** (register of CYP with asthma with annual review of action plans; follow up within 72hrs of asthma and Viral induced Wheeze unplanned attendances and an an 'annual care contact' appt for CYP with sickle cell, diabetes and epilepsy. These contracts support integrated care and enhanced communication with secondary care.

Maternity
We continue to focus on addressing the inequalities experienced by our vulnerable women.
NEL Local Maternity and Neonatal System (LMNS) maternity Equality & Equity audit findings for Hackney: It is one of the 3 boroughs in which stillbirths to Black and Asian women are **concentrated – 3** per **1000** births and mainly to Black and Asian ethnicity women – stillbirths to women of Asian ethnicity highest at **6.5** in every **1000** births.

The proportion of babies born with low birth weight born to Black and Asian women is nearly **three times as high** as for White women (**14%** and **15% versus 5%)**

Babies born to Black women are twice as likely to be admitted to neonatal care than those to White women (**20%** versus **9%)**

We launched an Equity & Equality Sub Group in November 2023 and have set up a Perinatal MH Taskforce in June 2023 to review data, access to PNMH services, and are refreshing and investing in a new infant feeding strategy, in line with the early start trailblazer work.

We invest in targeted antenatal provision for specific community groups.

Our **co-production** activities are a priority. C&H is currently an outlier in NEL re Maternity Voices partnership (MVP) investment with £5k compared to £55k required.

Ways of Working: Strategic Needs Assessments, Co-production, and STAR

Across **Youth Justice** and **SEND** we have been conducting Health Needs Assessments to inform our planning. We know that we need to improve our data recording for vulnerable groups so that data can be disaggregated (e.g for SEND, and for City SEND children). This is needed at Place but also a consistent approach across NEL to inform development of e.g a NEL ICB SEND data dashboard (London region dashboard currently in development).
A priority across all our transformation programmes, current areas of work include joint commissioning of additional resource for the Hackney Parent Carer Forum (SEND); co-production of jointly commissioned Preparing for Adulthood Strategy and Transition Guide (SEND) and ongoing work with LBH to address the disproportionate outcomes for Young Black Men.

Our work is underpinned with the developing LBH **STAR** approach – Systemic, Trauma Informed and Anti-Racist. These principles can be evidenced in our work with specific communities and for example the HSJ award winning **Tree of Life** – a project that aims to empower CYP from African and Caribbean communities.

Waltham Forest Babies, Children and Young People (BCYP)

This briefing summarises current BCYP areas of focus in Waltham Forest which align with the 'Growing up Well in NEL' strategic priority.

1) Waltham Forest Integrated BCYP Partnership Strategy (2024-2029).

This will provide the Partnership Vision and Priorities for BCYP in Waltham Forest. It has been in development for over a year and details what is important to families in the borough through engagement work and a Joint Strategic Needs Assessment (JSNA) alongside action plans to address these needs. Identified priority sub-groups:

1. Maternity and Early Years
2. Children and Young People's Mental Health
3. Children and Young People with Special Educational Needs and / or Disability (SEND)
4. Children and Young People with Long Term Conditions and Wider Physical Health Needs

The draft document was presented to the Waltham Forest Health and Care Partnership Board in October 2023 where it was received positively with the request of some amendments. A revised document incorporating associated actions plans for each priority area will seek final sign-off and approval for publication in April 2024.

2) Special Educational Needs and / or Disability (SEND).

A SEND inspection announcement is expected imminently with a SEND Strategy and Self Evaluation Framework being finalised. New interim Directors of Children's Services and Education have recently started at the council. Key health areas of concern from the January 2024 Local Area SEND Plan include:

- Waiting times for Speech and Language Therapy
- Waiting times for Occupational Therapy
- Waiting times to reduce on the Neurodevelopmental Diagnostic Pathway for under 5's

- Accessing health care services such as hospital and GP services has reported to be a challenge for families and children with disabilities, specifically services such as phlebotomy and A&E.
- The Youth and Family Resilience Service (YFRS) and North East London NHS Foundation Trust (NELFT) are looking at supporting children with SEMH needs in Alternative Provision settings.
- Transition to adult health services can be difficult.
- Improve young people's participation in the development of wider health services.
- 6-week compliance of health reports, for all professional groups in the health teams continues to be an area of challenge due to high volumes of referrals for reports.
- Commissioning approaches for the LA re: SLT are becoming an issue where the school has not commissioned from NELFT and therefore does not have over sight of the SLT services in a child's EHC plan.

Improvements

- OT Clinical lead has significantly improved retention and recruitment.
- Integrated OT pathways under development with advice/challenge from the Waltham Forest parent / carer forum and now includes a digital offer.
- Pathways now BAU following transfer of 268 children, some of whom had been waiting 18 months to be seen,
- Waiting times starting to improve with very few informal complaints and no formal ones.
- SLT had a recent quality check from NELFT quality team and were judged good in terms of quality/outcomes.
- The SLT service is trailing outcomes using the TOMS (therapy outcome measures scale). PT and OT are piloting use of goal attainment scaling outcome measures with a view to using this on RIO to be able to run outcome reports.
- Compliance to 6-week deadline of completion of EHC reports was excellent last month at 75/80% for majority of services however compliance highly dependent on volumes of requests for EHC needs assessment.

3) Children Looked After (CLA) services.

There are ongoing performance issues re the timeliness of initial and review health assessments.

Key Performance Indicators and Dental services as presented to the Waltham Forest Corporate Parenting Board – Jan 2024:

	Target		Achievement
October figures only available for IHA	85%	Percentage of children receiving an initial health assessment within the 28-day time frame	61.8%
November figures	95%	Percentage of children receiving review health assessment within 12 months	62.9%

	90%	Immunisations up to date	68.3%
	90%	Dental assessment	78.1%
	99%	SDQs completed	98.8%

(Source: Waltham Forest LA data November 2023)

Improvements

- The above performance represents improvement from the previous quarter and is likely to improve as discrepancies between LA and NELFT sharing of data has been addressed by respective information teams both in terms of information sharing and how it can support the statutory reporting for both organisations and give assurance on the outcomes of the health needs of CLA.
- Training delivered to virtual school on identification of health needs and relevant pathways to increase health awareness during work on Pupil Education Plans (PeP).
- Analysis of all CLA with Education and Health Care Plans (EHCP) with joint training provided to SEN and CLA teams to better meet these identified needs.

4) Children and Adolescent Mental Health Services (CAMHS).

Waiting times continue to be an issue especially re ADHD and ASD assessment as well as crisis pathways.

Achievements

- Two-year contract award to new VSC community provider – Groundworks. This will provide earlier access to emotional and mental health support in non-clinical settings. Currently in mobilisation period with service delivery expected from April 2024.
- Multi-agency working party including teachers/CAMHS and member of the WF parent carers forum are working on pre and post diagnostic support - including moving the post diagnostic support services from CAMHS to delivery by teachers/early help. Innovation fund has funded training to teaching staff/Early Help and an apprentice will support implementation of change over to Early Help hosting post diagnostic support for children with ASD. This will free up clinical sessions from CAMHS to increase capacity for diagnosis.
- Dedicated project manager has started work on introducing the I-thrive model across the WF partnership in order to meet needs at an early stage for children developing anxiety.
- The Dynamic Support Register (DSR) is instigating change for the most complex children and key working recently introduced as part of the offer, highlights that WF is largely compliant with new legislation with the exception of transition of children to adults for those without LD – there is a NEL wide meeting booked to look at this issue.

5) Frequent Attenders Project.

- This 12-month pilot project has recruited a Family liaison nurse (FLN) to help reduce BCYP frequent attenders at the Children's Emergency Department at Whipps Cross Hospital. The post has been funded from the Innovation Fund leading on Health promotion and links with community services thorough Family hubs. A space at a Family Hub (Lloyd Park) has also been confirmed and the FLN will be running

sessions to staff/parents twice a month starting February 2024. Weekly meetings with ED consultant and data deep dives are also in place.

- January update findings: 353 children (0-15 years old) were identified for the period (Oct 22 to Oct 23) with 5 or more attendances at Whipps Cross hospital ED department. 251 of the children identified are Waltham Forest residents (71%), 72 (or 21%) children are Redbridge residents and the remaining 8% are residents of other London Boroughs. Most of the children identified are aged 0 to 4 years old (67%). Letters to GP practices of the highest number attendees (24) have been prepared and awaiting sign off to be sent out. Of those 24 children, the majority (88%) had attended ED with respiratory issues.

Redbridge – approach to determining priorities and our plan on a page

Where we are now:

- **Difficult to understand and navigate** – we have some overlaps and gaps in provision
    - *We need to map and understand our service provision*
- **Workforce recruitment and retention** – across health and care is impacting on our service provision and delivery (speech and language therapy, school nursing and health visiting)
    - *We need to collate and map workforce data and correlate with current provision*
- **Backlogs and long waiting times** – huge pressures in mental health, community services, SEND and neurodiversity pathways
    - *We need to understand the impact of these delays on the child's development and life opportunities*
- **Experience of children young people and their families** is variable and fragmented provision, especially at interfaces and transitions of care, means they have to keep repeating their story, eroding confidence and trust
    - *We need to hear their voices and stories and understand what matters to them*

Focus on prevention and early intervention:

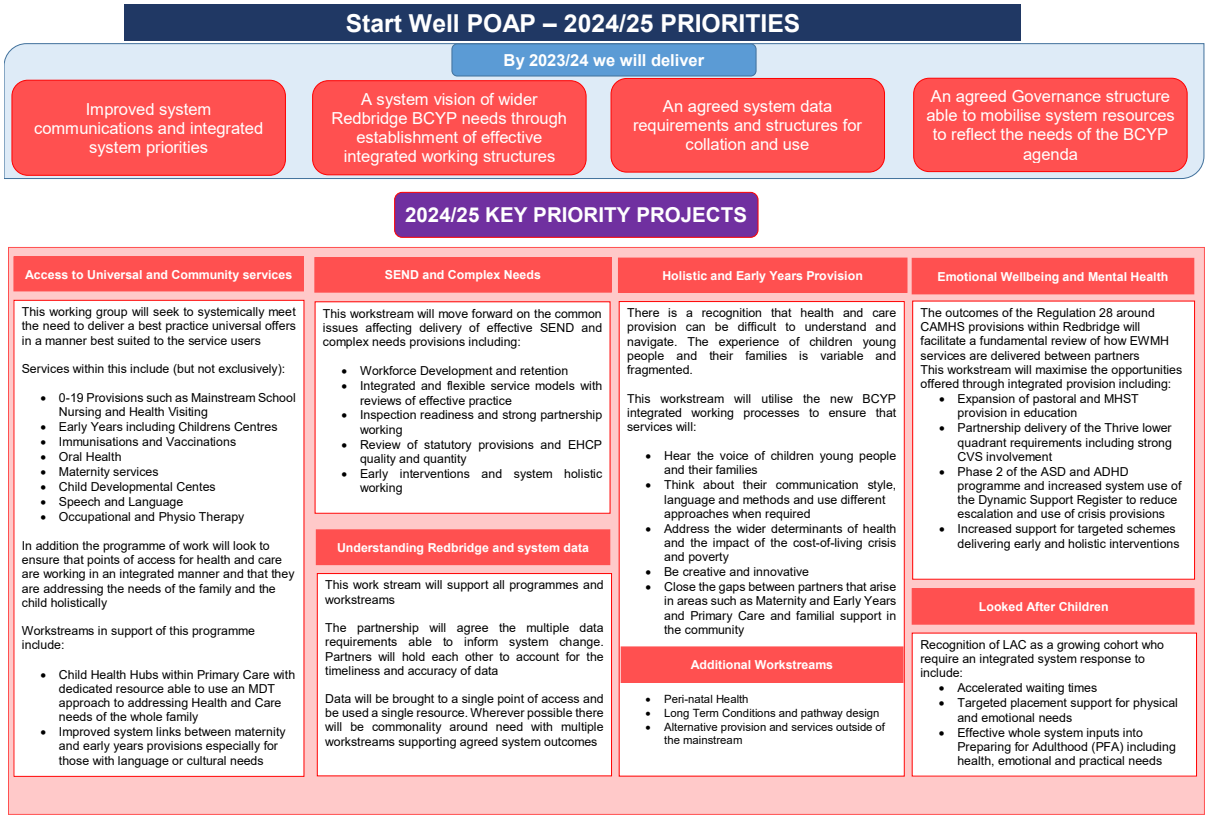
- Children, young people and their families will understand and be able and supported to navigate and access the services they need to start well
- There will be improved uptake of, and trust in universal services that support families and communities to build capability, capacity and resilience for self-management and self-care that enables babies, children and young people to thrive
- There will be timely needs-based access to specialist services
- Children, young people and their families will experience well planned, coordinated and integrated services as seamless care pathways across the interfaces of health, social care and third sector providers

Prevention of escalation and crisis:

- An agreed (small) number of priorities to ensure we deliver with strong joint planning
- We might approach this as: 'Joint vision – Joint services - Joint roles'
- Support multi-disciplinary and multi-agency working - by initially removing the "barriers" preventing this currently and then by building trusting and mutually supportive relationships across statutory and third sector providers who understand and can help navigate and signpost to services
- Flexible thinking around obligations including: SEND services, workforce, Fuller principles and community provisions

- Focus on simplifying our services and pathways - removing barriers to access e.g. diagnosis (although we need to streamline the diagnostic pathway), pay attention to transitions and handoffs
- Build and improve access to universal and preventive services
- Peri-natal health and well-being (physical, mental and social) – this will have the greatest impact on a child's health and life chances
- Improving mental and emotionally wellbeing for all children and young people
- CAHMS
- Child health needs assessment
- Oral health
- Early Years provision
- SEND
- Looked After Children (high number of out of area looked after children)
- Families with multiplicity of need, deprivation and chaotic lifestyles

Redbridge Start Well Plan on a Page:



NHS
North East London

Community Waiting Lists November 2023 data

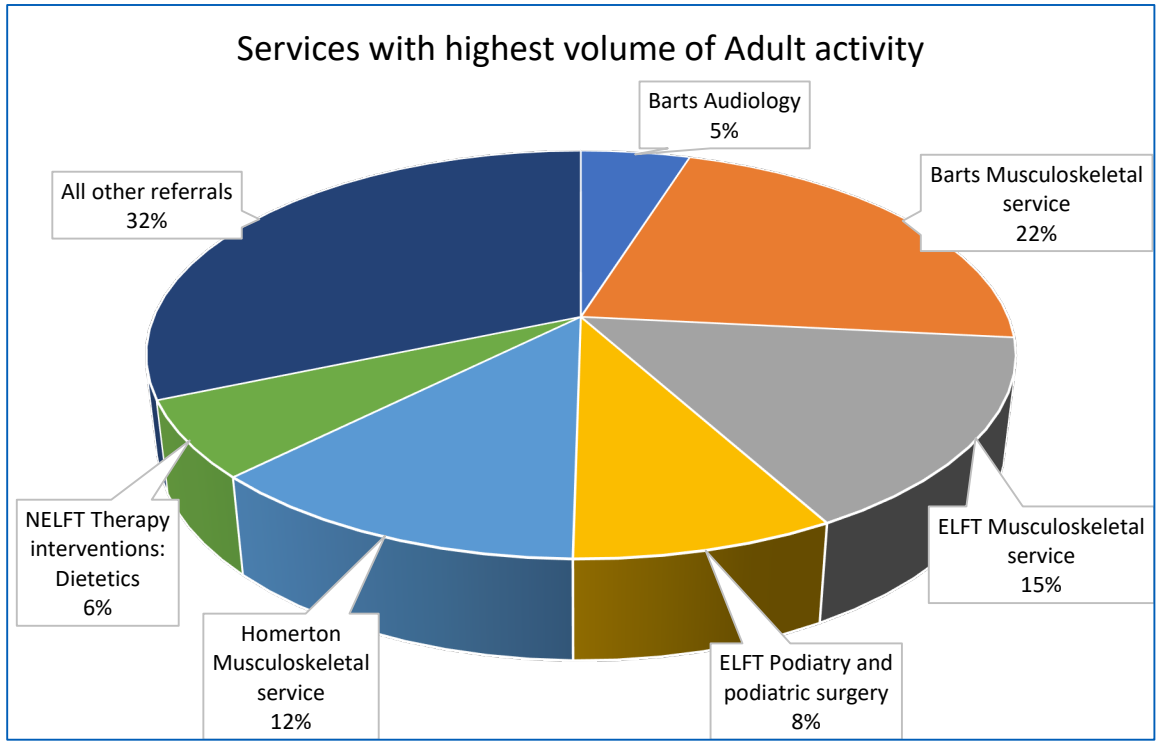
Lauren Jones Planning & Performance Manager

Overview

- The data in this report is from the Community Health Services Sitrep report, latest data as of **November 2023**. https://future.nhs.uk/CommunityHealthServices/view?objectId=104122757
- The report provides data for Barts, Accelerate CIC, NELFT, ELFT, Homerton and Mildmay community waiting lists for adults and children & young people.
- The data is broken down by provider and service.
- The data reflects the number of referrals to each service, this may mean that individual patients have more than one referral.
- *The data in this report must be heavily caveated as it is at provider level and not patient level, therefore if a provider serves more than one ICB this will not be shown, the provider will only be mapped to one ICB.*

Adults Summary November data

- For adult referrals NEL ICB is 10th out of 42 ICBs, a slight improvement from 9th position. Adult referrals decreased by 7% to 23,343 above the average of 17,407.
- For November there were 119 adult referrals waiting between 52-104 weeks, this is a 14% increase from last month.
- There were 2,211 adult referrals waiting between 18-52 weeks a 5% decrease compared to October.
- There are zero referrals waiting over 104 weeks.



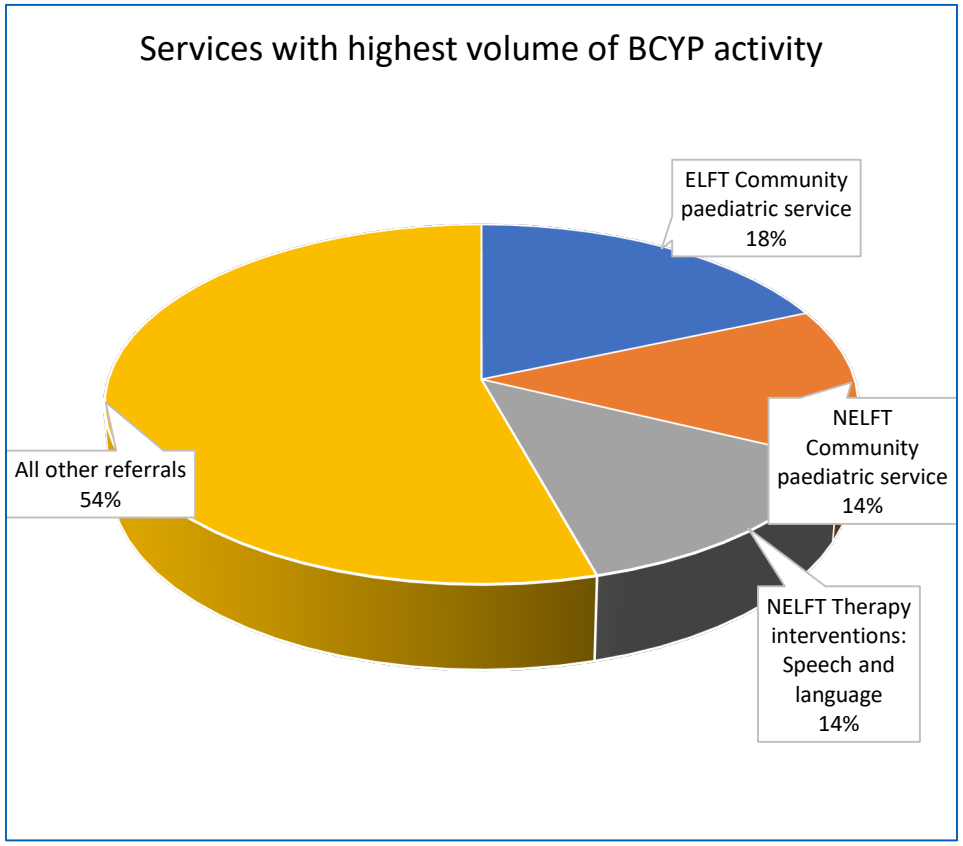
Areas of concern:
MSK services across providers and especially Barts MSK service.

Adults	Service	Number of Referrals
Services with highest volume of activity	Barts Audiology	1,132
	Barts Musculoskeletal service	5,086
	ELFT Musculoskeletal service	3,584
	ELFT Podiatry and podiatric surgery	1,926
	Homerton Musculoskeletal service	2,859
	NELFT Therapy interventions: Dietetics	1,420
Number of referrals >52-104 weeks	Barts Audiology	8
	Barts Nursing and Therapy support for LTCs: Respiratory/COPD	8
	ELFT Musculoskeletal service	7
	ELFT Podiatry and podiatric surgery	6
	NELFT Therapy interventions: Speech and language	3
	NELFT Therapy interventions: Dietetics	87
Services with the highest number of referrals >18-52	Barts Nursing and Therapy support for LTCs: Respiratory/COPD	445
	ELFT Podiatry and podiatric surgery	561
	NELFT Therapy interventions: Dietetics	383

BCYP Summary November data

- For child referrals NEL ICB remains at 10th position but referrals decreased by 2% to 8,390 above the average of 5,556.
- There were 6 referrals waiting over 104 weeks, a 40% decrease compared to last month.
- There were 924 referrals waiting between 52-104 weeks a 7% increase compared to October.
- There were 2,343 child referrals waiting between 18-52 weeks a 10% decrease compared to October.

Areas of Concern: ELFT & NELFT community paediatric service make up 32% of all BCYP referrals.

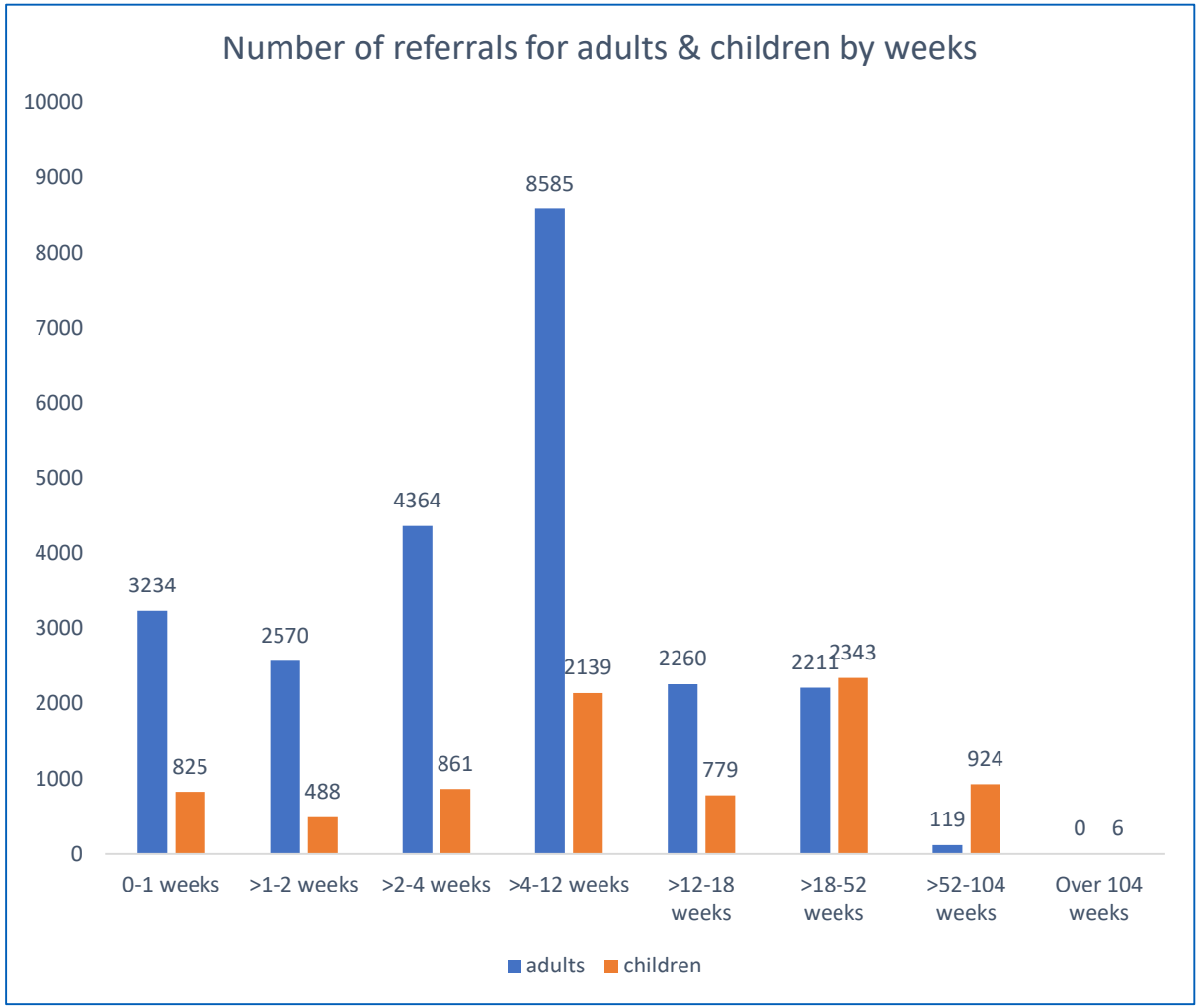


BCYP	Service	Number of Referrals
Services with highest volume of activity	ELFT Community paediatric service	1554
	NELFT Community paediatric service	1145
	NELFT Therapy interventions: Speech and language	1135
Number of referrals >104 weeks	ELFT Community paediatric service	5
	NELFT Therapy interventions: Occupational therapy	1
Number of referrals >52-104 weeks	Barts Therapy interventions: Speech and language	2
	ELFT Community paediatric service	617
	ELFT Looked after children teams	9
	ELFT Therapy interventions: Speech and language	1
	ELFT Therapy interventions: Occupational therapy	2
	Homerton Vision screening	2
	NELFT Community paediatric service	28
	NELFT Therapy interventions: Physiotherapy	1
	NELFT Therapy interventions: Speech and language	29
	NELFT Therapy interventions: Occupational therapy	91
	NELFT Therapy interventions: Dietetics	142
Number of referrals >18-52 weeks	ELFT Community paediatric service	591
	ELFT Therapy interventions: Speech and language	130
	Homerton Community paediatric service	274
	NELFT Community paediatric service	345
	NELFT Therapy interventions: Speech and language	204
	NELFT Therapy interventions: Occupational therapy	304
	NELFT Therapy interventions: Dietetics	228

Number of referrals for adults and children waiting by weeks in November 2023

Provider	Adults	Compared to October 23	CYP	Compared to October 23
Barts	7,178	12%	134	3%
ELFT	6,837	6%	2,756	5%
Homerton	4,874	1%	1,023	0.4%
NELFT	4,109	5%	4,477	0.6%
Mildmay UK	11	57%		
Accelerate CIC	334	5%		
Total	23,343	7%	8,390	2%

The number of referrals to adult services at 4-12 weeks has decreased by 0.2% in November but remains an outlier- what services are contributing to this? What can be done at provider/system level to alleviate this?



NEL

ICB benchmarking for total number of patient referrals on waiting lists November 2023