Nottingham and Nottinghamshire ICS System Children & Young People Clinical and Community Services Strategy December 2019

Contents

1. Executive Summary

The Integrated Care System (ICS) ambition across Nottinghamshire is to both increase the duration of people's lives and to improve the quality of those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The aim of the Clinical and Community Services Strategy (CCSS) is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models, to a pro-active approach of prevention and early intervention, delivered in families homes or in community locations where more appropriate, with a long term view of beyond 5 years.

Children and young people represent a third of our country and their needs are diverse and often complex. Their health and wellbeing will determine our future. Radical and transformational investment in children and family services will deliver long term benefits to health outcomes to the whole community and reduce further burden on health and social care.

The National Health Service (NHS) Long Term Plan (LTP) recognises that the health of children and young people (CYP) is determined by far more than healthcare. Household income, education, housing, stable and loving family life and a healthy environment all significantly influence young people's health and life chances. By itself, better healthcare can never fully compensate for the health impact of wider social and economic influences. The long term plan focuses on improved prevention, improved mental health, complex disability and improved experiences of transition for our CYP and young adults, by providing integrated multi-agency whole family care.

This CYP service review has been undertaken as part of the ICS CCSS work stream. It has been supported by clinical and professional experts as well as other stakeholders in the development of place based service models for the future to support the long term needs of our families, children, young people and young adults. We need to embed prevention prevalence and wellness in our population over the next 5-10 years by shifting our culture from one of illness, to one of healthier lifestyles and self-care.

The strategy identifies key themes and transformational opportunities, which include: prevention strategies to promote a healthy start in life, improving the whole health of our children and young people and promoting independence and reduce avoidable admissions into a hospital setting by providing appropriate care nearer to home.

Key areas of focus that form the key themes include: reducing obesity, increasing the uptake of vaccinations; increasing the amount of children ready to start school and to develop a pro-active long term 'Whole Families' prevention strategy; integrated models of care to meet the mental health & emotional wellbeing of children and families; developmentally appropriate healthcare in both paediatric and adult services 0-25 years across the ICS; that young people are at the centre of well planned, integrated and supported transition; child-centred multi-agency co-ordinated services provision for disabled children and young people.

A transformation 'Bridge to the Future' highlights current service offers across the ICS and identifies some potential long term steps that can be taken to achieve the identified opportunities with proposed timelines and the expected outcome for our families and children and young people of Nottinghamshire.

The recommended next steps are vital in keeping the momentum of change in the future offer of improved prevention and better health for our families and children and young people; providing the right tools for our population to support their wellbeing; providing strong communication links for our staff is vital to enable them to provide the best care for our families and children and young people; the most appropriate models of care in acute settings, neighbourhood and home need to be provided equitably across the ICS and be provided using best evidence, in a flexible and patient centred way for them to fulfil their maximum potential throughout their lifetime.

2. Introduction

Background and Purpose	In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable. However, our health and care system faces change and this will impact on our services, for example, the growing prevalence of long-term health conditions places new strains on our system. There is inequality evident in both the location of challenges and in access to services. In some areas, it is easier to access a GP than in others, or to find things to do to enable citizens to stay active and fit. The ICS ambition across Nottinghamshire is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The requirement for a CCSS came from the recognition that to achieve this ambition the system has to change as a whole, rather than just in its individual acute, primary care, community and social care elements. It is recognised that only by working together to describe changes in how care is provided across the system, rather than through individual organisations, will we deliver the scale of change required.
The ICS Clinical and Community Services Strategy	The aim of the CCSS is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention. This should be delivered closer to people's homes or in community locations where this enables better prevention, more supported self-care and earlier intervention to support citizens. The Strategy recognises that achieving this change is a long term programme that will be delivered over the next 5 years and beyond. This is also necessary to enable a necessary long term investment in the health and care buildings and infrastructure in the system. An overall CCSS whole life model framework has been developed to focus on the need to support people through their lives from living healthy, supporting people with illness and urgent and emergency care through to end of life care. Citizens can experience different parts of the system at different stages in their lives. With the development of the overall Strategy framework the next phase of work is to review the 20 areas of service across the ICS that collectively form approximately 80% of the volume of clinical work in the ICS. This will ensure that overall the Strategy is described as a coherent whole and generates a programme of change for the whole ICS. This review of CYP services is one such review and is part of the first phase of work.
NHS Long Term Plan	The NHS LTP is clear that to meet the challenges that face the NHS it will increasingly need to be: more joined up and coordinated in its care; more proactive in the services it provides; more differentiated in its support offer to its individuals. The ICS has focused on describing 5 areas of focus for the delivery of the NHS LTP. These requirements are reflected in each of the service reviews that collectively will describe the Clinical and Community Services Strategy: **1. Prevention and the wider determinants of health -** More action on and improvements in the upstream prevention of avoidable illness and its exacerbations **2. Proactive care, self management and personalisation -** Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation **3. Urgent and emergency care -** Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting **4. Mental health** - Re-shape and transform services and other interventions so they better respond to the mental health and care needs of our population **5. Value, resilience and sustainability -** Deliver increased value, resilience and sustainability across the system (including estates)

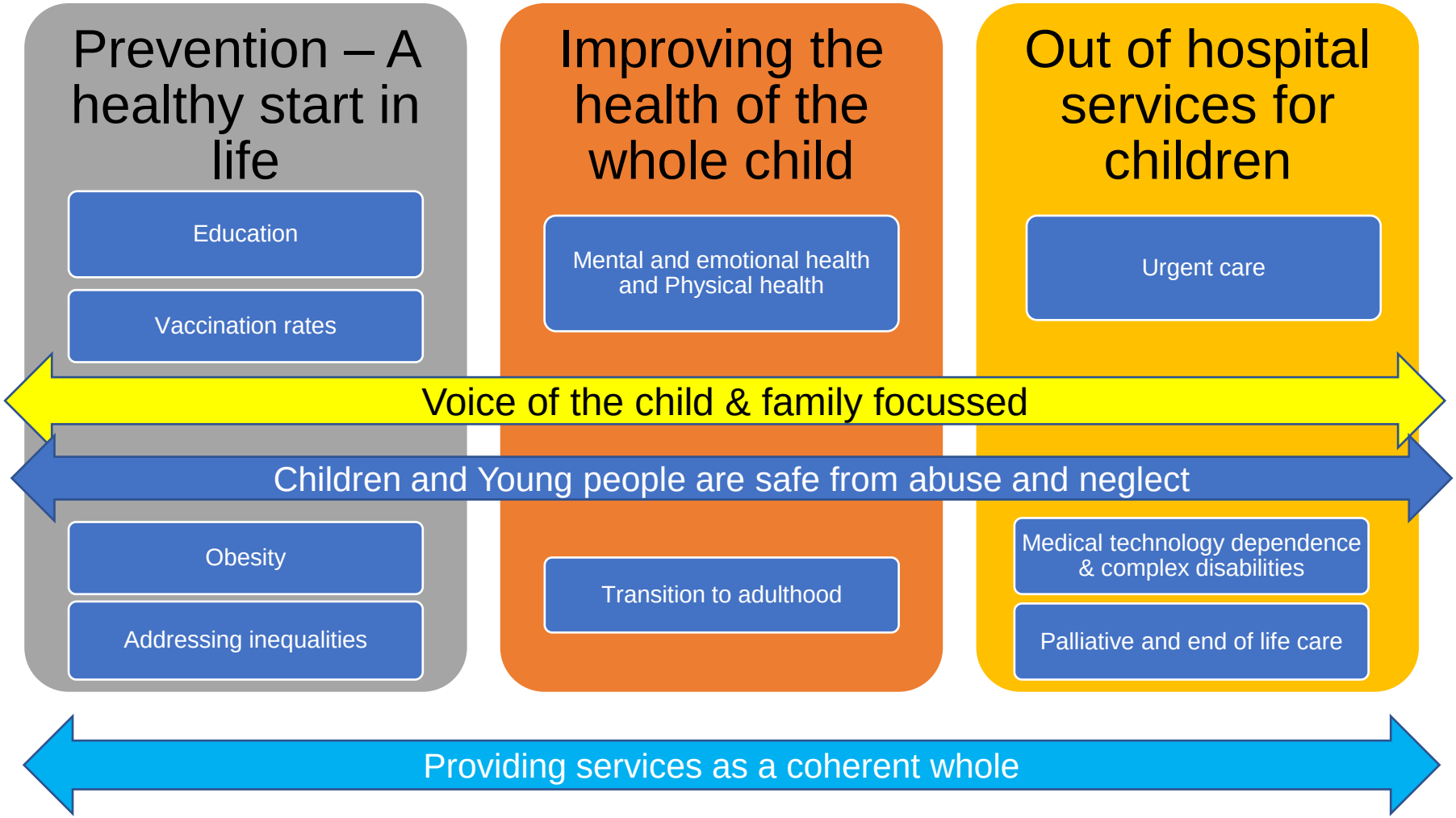
3. Scope and Approach

Approach	This strategy has been developed through an open and inclusive process which weaves together the expertise of clinicians and care experts with commissioners and citizens in determining the future shape of services across the system. There have been a variety of stakeholder and service user events to develop a clinical and community services model. An extensive system wide piece of work is taking place across a minimum of 20 services. The CCSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the prioritisation of five service reviews. These include; Cardiovascular Disease (CVD) to Stroke ; Respiratory – Asthma and COPD; Frailty; CYP; Maternity and Neonates. This document discusses the approach, scope, the key issues and potential transformational opportunities within CYP services across the ICS. Health, social care, public health and the voluntary sectors have all been considered through reviewing the current service offer across the ICS. The service review was taken over approximately 24 weeks and there were two workshops held with stakeholders across the ICS. An evidence review pack was developed which considered national and local best practice to inform the development of potential themes and new models of care where transformational change may take place across the ICS in the future.
Scope	**In scope** of the service review included: • Families • All children and young people aged 0-25 years across the ICS
Engagement	The CYP services review has been supported by an overarching Clinical Design Group of clinical professionals and social care representative in the ICS and CYP tailored steering group comprising of stakeholders and clinical experts from across the ICS. They have provided expert advice, guided, confirmed and challenged assumptions throughout the period of review and connected to other work streams. These two groups have formed part of the development process along with the ICS Clinical and Community Services Strategy Programme Board consisting of senior leaders in the ICS who oversee the work. Three workshops have been held which enabled a wide breadth of stakeholders (Clinicians, AHP, Nurses, Heads of Service, Social Care, Public Health, Commissioners, Education, Mental Health and others) to be proactively involved in re-evaluating current service offers across the ICS in developing potential themes and agreeing transformational change for the future clinical and community services strategy. Family, children and young people involvement has been co-ordinated through the Community Voluntary sector to gain views on the themes identified and the proposed transformational opportunities and co-design focus groups that tooke place in September/October 2019 to inform future service changes across the ICS.

4. Contents

Strategy Development	This Strategy Document consists of five key elements. These have been developed through a process of design and iteration at the two workshops and steering groups. The strategy has been developed with reference to the Evidence Review document and the patient focus groups that have been held.
Priorities for Change	The work of the Steering Group and the first workshop identified four key areas of focus that need to change in the ICS for CYP services. These were based on a review of the current issues facing the ICS and the views of the Steering Group and workshop attendees.
Proposed Future Care System	Following the evidence review at workshop 2 attendees started to develop the future to address the priorities of CYP services for Change. The future care system is described against two dimensions: • **Location** split between - Home (usual place of residence) – Acute Hospital with 24/7 medical presence – Neighbourhood representing all community/primary care and ambulatory care settings. • **Urgency** split between - **Emergency/Crisis** requiring a service provided 24/7 to avoid crisis or risk to life – **Urgent** requiring a service 7/7 but not 24/7 to meet urgent care needs – **Scheduled** reflecting any arrangement where an appointment is agreed between a professional and a citizen. The intention of the system model is to focus future care delivery closer to home and also with greater levels of scheduled care to best use the available resources and reduce demand on urgent and emergency care services. The new system to address the Priorities for Change is presented for each location and then summarised overall for the ICS.
Transformation Proposal	The Transformation proposal described the key initiatives or programmes that are required to deliver this new model. It shows: • **Priority** – What is the priority of the initiative in the view of the steering group and workshop attendees. • **Alignment** – At what level of the system should we aim to deliver each initiative. In most instances this is ICP level but there are some where the recommendation is for delivery to be at ICS level where the greater value is perceived to be in an overall approach. For some it is PCN level where differential delivery would be of benefit to meet the needs of very local populations. • **Enabling Requirements** – This indicates what is required from a range of enablers to support each Programme to deliver. This includes workforce, technology, estate or service configuration. There are also requirements of culture or finance and commissioning where a key change required is for the system to work together differently. • **Benefits and Costs** – Where available the key benefits of the initiative at system level are summarised.
Bridge to the Future	The 'Bridge to the Future' was generated at an extended steering group meeting prior to workshop 3. It summarises the current challenges for the CYP service in the ICS now (Priorities for Change), where we would like to be and how we plan to get there. Progress with the 'Bridge to the Future' and the partnering vision can be returned to with stakeholders as the work develops to ensure the work remains on track

Children and Young People key features in Nottingham and Nottinghamshire



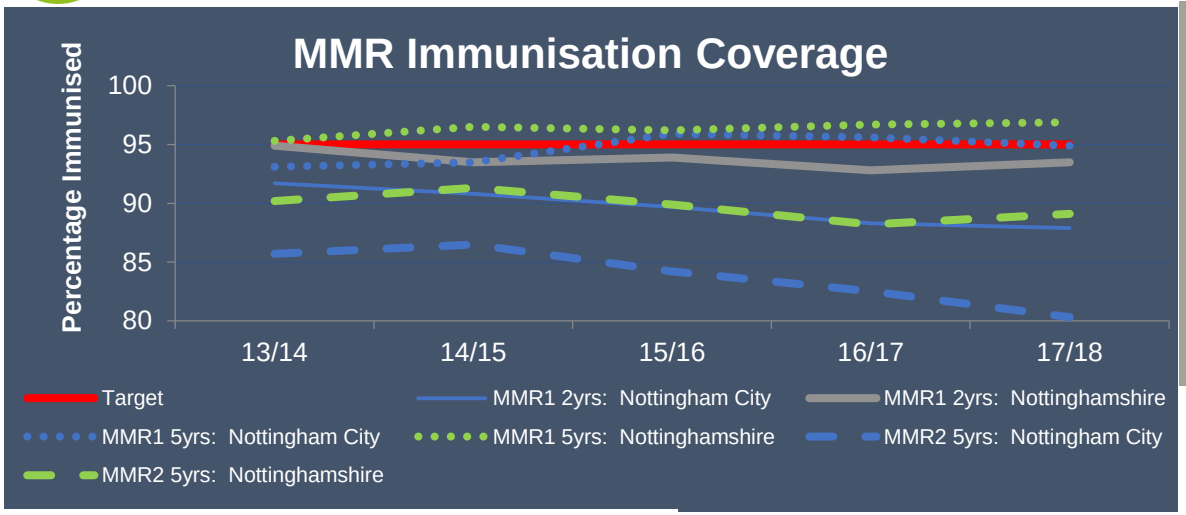
5. Priorities for Change

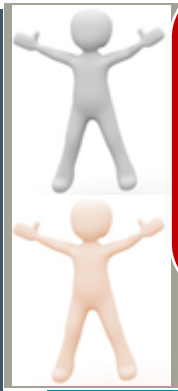
The workshops identified 3 key themes and potential areas of change which include: Prevention (a healthy start in life), improving the health of the whole child and out of hospital services. While prevention is embedded through the overarching Clinical and Community Services Strategy, specific prevention focus on obesity, vaccination uptake and health inequalities were felt to be of particular importance within children and young persons services, set out below:

Prevention – A healthy start in life	Children and young people represent a third of our country and their health and wellbeing will determine our future. While recent years have seen improvements in certain services which have been singled out for action there still remains a mixed picture overall (NHS Long Term Plan, 2019). The overarching expectations of the Clinical and Community Services Strategy review of CYP services across Nottingham and Nottinghamshire are that we will build on providing a child centred, family approach to wellbeing, to influence and support change in attitudes, behaviours and culture. We will make every contact count (MECC), with particular emphasis on reducing health inequalities, obesity, smoking and excess alcohol consumption and related harm, increasing immunisation and improving emotional wellbeing and sexual health. Evidence recognises that the health of children and young people is determined by far more than healthcare. Household income, education, housing, stable and loving family life and a healthy environment all significantly influence young people's health and life chances. On its own better healthcare can never fully compensate for the health impact of wider social and economic influences. The main challenges to the ICS and where prevention strategies need to address a consistent approach across the ICS are: • Obesity, as we know that the rate of severe obesity is increasing in Nottingham city at a greater rate than England, with prevalence of obesity at reception and year 6 higher than England averages in certain districts in Nottinghamshire • School readiness, as it is estimated that 50% of children in areas of deprivation start school with language delay; this equates to 1,850 reception children in Nottingham per annum. 30% of Nottinghamshire children and 32% of Nottingham City children are not achieving a good level of development at the end of reception, both worse than the England average • There is a decrease trend of vaccination uptake across the system, Nottingham City is below the national average at 87.9% (MMR 1 dose) • It is also recognised that there is wide variation in free nursery uptake for 2 year olds (Early learning programme) across the City and County • While the ICS has made some in roads in pro-actively moving prevention forward it is felt that a long term 'Whole Families' prevention strategy would meet national and local population needs co-designed by families, children, young people and young adults
Improving the health of the whole child **Transition**	'Transitions' are changes or movement from one position or stage to another in a child's or young person's life. Transitions can be gradual or sudden, can affect different aspects of the child or young persons life and may last for various lengths of time. All children experience changes in their life at certain points, but it depends on their personality, the nature of transition and the support they receive from family and school, how they react to these turning points. Currently across the ICS there is inconsistency in how children, young people, young adults and their families receive mental health, physical health, social and educational interventions for their different stages of developmental maturity and how they transition through young people's services into young adult services. Transition has become a National concern and there are some National and Local projects being implemented across the ICS, with SFHFT being part of Wave 1 working with NHSE on transition with children and young people with diabetes. For people with a learning disability or Autism, transitions can be particularly complex, with poor transitions a contributing factor in some hospital admissions. There is a need for the ICS to consider future health, social care and educational models that offer person-centred and appropriate care based on developmental age as evidence suggests.

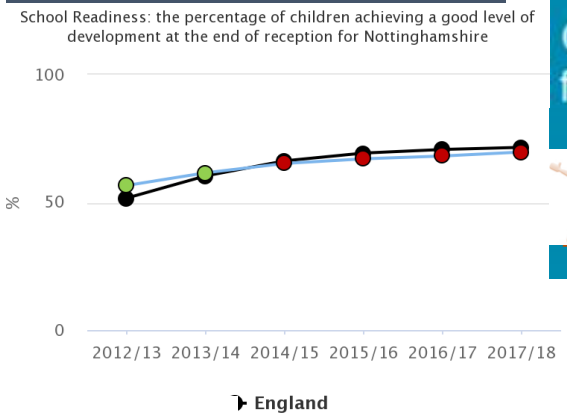
Out of hospital services **Urgent care**	CYP account for 25% of emergency department attendances and are the most likely age group to attend ED unnecessarily. Many of these attendances could be managed effectively in primary care or community settings. In the NHS plan it is expected that local areas will design and implement models of care that are age appropriate, closer to home and bring together physical and mental health services (NHS Long Term Plan, 2019). Currently in the ICS demand on ED and crisis care services is increasing and while there have been some positive progress across the ICS in tackling this demand by providing services in different ways, there are further requirements to make this sustainable: • Explore why CYP attend ED with minor physical ailments that could have been managed in primary care. • Increase equity of access to emotional and behavioural diagnosis and support services and post diagnosis support (audit of services against National Institute for Health and Care Excellence (NICE) guidance, provision of evidence-based support and parenting programmes). • Reduced attendance in ED for CYP with mental distress as alternatives to attendance are commissioned and evaluated (audit, proportion of ED attendances for mental distress).
Out of hospital services **Complex care**	In the past ten years, the prevalence of severe disability and complex needs has risen in children and young people. This is due to a number of factors, which include: increased survival of pre-term babies and increased survival of children after severe trauma or illness. There are up to 6,000 children living at home who are dependent on assistive technology. In recent years life expectancy of children and young people with life limiting conditions, such as cystic fibrosis, have improved. Children, young people and adults with a learning disability, autism or both, with the most complex needs, have the same rights to live fulfilling lives supported in the community or in their homes. There are inconsistencies in provision across the ICS with a mixture of NHS and private provider provision. This creates a challenge in being able to provide a consistent package of care that is inclusive and meets physical, mental health, behavioural wellbeing, social care, housing, financial, educational and care support for families, children and young people. The Transforming Care programme has been supporting the development of community services to ensure people with a learning disability and/or autism can be supported closer to home and this work continues. In Nottingham and Nottinghamshire Long Term Ventilation (LTV) admissions into children's hospital services has seen a year on year increase in hospital admissions, with longer lengths of stay. The cost of caring for these children are high and require an intense level of support that needs to consider all physical, emotional, social needs of the children and their families. There can often be significant delays in children being cared for in their home, due to the complexity of the care package required to enable the family to be supported and safely care for the child in a home setting. The delays in discharge impact on the services offered within the children's hospital.

5. Priorities for Change



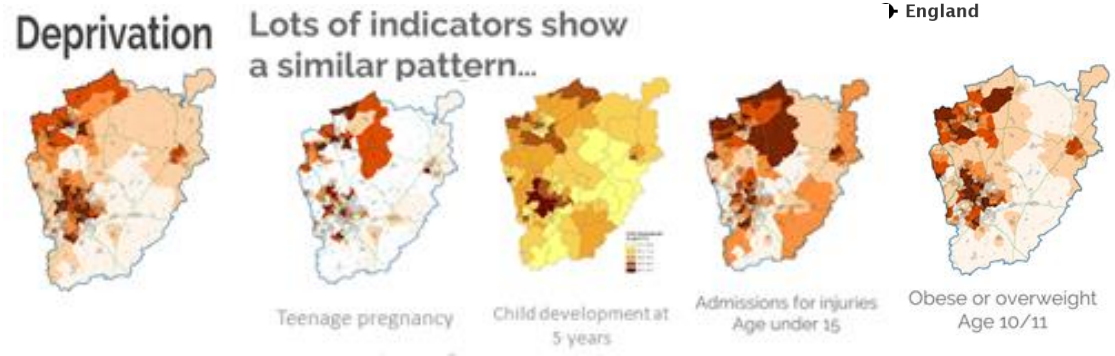


50% of children in areas of deprivation start school with language delays



1 IN 10

Children need support or treatment for mental health problems



75% of **mental health** problems in adult life

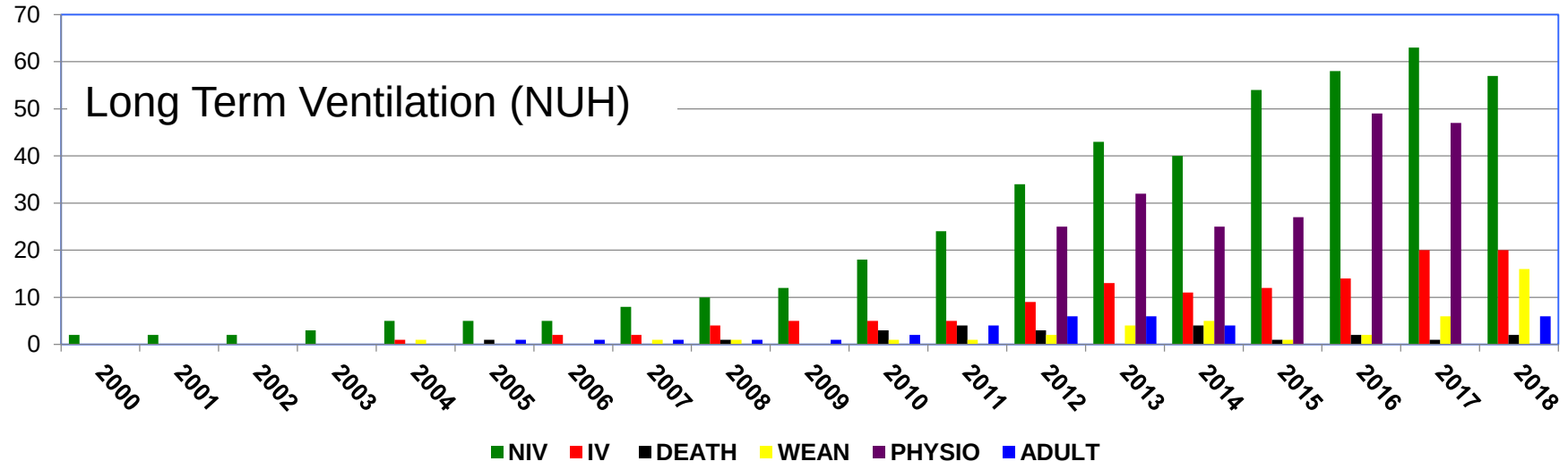
(excluding dementia)

start by the age of 18

Children & Young People ED attendances Nottinghamshire ICS

A&E attends	Age on arrival		
	0-9	10-19	20-29
ENGLAND	3,201,534	2,337,150	3,219,169
% England A&E attends by age banding	15%	11%	15%
Nottingham University Hospitals NHS Trust	32,395	22,435	32,005
Sherwood Forest Hospitals NHS Foundation Trust	15,455	13,560	16,320
Nottingham and Nottinghamshire ICS	47,850	35,995	48,325
% ICS A&E attends by age banding	15%	11%	15%

LTV Complex Hospital Admissions & Length of Stay



6. Proposed Future Care System

Integrated Care System
Nottingham & Nottinghamshire

Home

www.healthandcarenotts.co.uk @NHSNottingham

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

Planned/Scheduled

Prevention – a healthy start in life

- Parents and families understand and feel enabled to support a 'healthy start in life'
- Co-designed communication tools e.g. daily mile
- Appropriate signposting tools
- Play based activities
- Children's Centres open access sessions support parenting
- Play & Youth provision as prevention
- Early intervention
- Use of social media
- Consistent message campaigns

Improving the health of the whole child

- Healthy weight pathway from prevention to targeted and specialist
- Early help assessments, including for autism and ADHD, meet NICE guidance and are coupled with appropriate support services
- Eating disorders services are provided based on need not BMI
- Use of assistive technology
- Services work together to ensure children are ready to learn at two and ready for school at five including through provision of speech and language support

Out of hospital services

- Continued care at home, school and in communities for children with LTC & disabled children and their families
- Access to emotional support services to prevent crisis situation

Urgent – 24 hours

Prevention – a healthy start in life

- One central service/single point of access for urgent physical, mental health and social support e.g. dentist, GP, mental health services, urgent care services, safeguarding concerns etc.
- Support for parents and families by extended hours services and telephone support

Improving the health of the whole child

- Physical and mental health are given equal priority e.g. equally easy to obtain support around physical and mental health concerns

Out of hospital services

- Services support care at home including at the end of life
- Care follows the child including when the child is at home
- Access to emotional support services to prevent crisis situation

Emergency/Crisis – 4 hours

Prevention – a healthy start in life

- A whole family approach to the admission of a CYP
- Integrated service offer in the assessment & treatment of physical, mental, social and educational health.

Improving the health of the whole child

- Parents and families are aware of who to contact in an emergency around physical and related to physical and/or emotional health

Out of hospital services

- Access to mental health crisis services 7/7 including at home
- Access to emotional support services

KEY to information source: Steering Group/ Workshops Evidence Document/ Guideline Patient Focus Groups

6. Proposed Future Care System

Neighbourhood

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

Planned/Scheduled	Urgent – 24 hours	Emergency/Crisis – 4 hours
Prevention – a healthy start in life • Education, emotional wellbeing and behaviour change programmes are tailored with a focus on reducing health inequalities • Targeted services to prevent and 'treat' obesity • Evidence-based Parenting programmes • Play based activities • Promotion of healthy social environment, embedded in schools, colleges and nurseries including through evidence based initiatives • System wide awareness of ACEs • Joint, coordinated action to increase vaccination uptake	**Prevention – a healthy start in life** • Open access, Children's Centre service model delivered in community hubs recognised in the community as a source of timely support	**Prevention – a healthy start in life** • Families are aware of and access 999 & 111 services that understand the needs of children, young people and families
Improving the health of the whole child • Community based one stop shop for health drop ins • Evidence-based pathway to support behavioural and emotional health for children and parents incl. through parenting programmes • Social prescribing with a focus on the needs of Children and Young People and Families (CYPF) • Access to behavioural / emotional health services • Improved access for face to face counselling and psychological therapies • Improved access to ADHD & ASC support pre and post diagnosis • Getting ready to learn at two and ready for school at five	**Improving the health of the whole child** • Timely emotional support after abuse or traumatic experience • Key worker allocated for children and families with complex and physical health needs.	**Improving the health of the whole child** • Timely emotional support after abuse or traumatic experience • Services for CYPF are provided closer to home
Out of hospital services • Transition service pathways for GP support 0-25 years • Improved access to mental health teams • Improved access to SALT services and other therapy services • Emotional wellbeing services e.g. community networks to support pre-crisis interventions and promote resilience in families and children • Play based activities	**Out of hospital services** • One central navigation service • Access to escalate concerns for CYP with LTC • Improved access to mental health teams • Services that provide support for families and children to build resilience to support wellness and improved mental health • Seamless handover / signposting into support services	**Out of hospital services** • Call for care or first responder support • Improved access to mental health teams • Seamless handover / signposting into support services

KEY to information source: Steering Group/ Workshops Evidence Document/ Guideline Patient Focus Groups

6. Proposed Future Care System

Acute Hospital

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Planned/Scheduled

Prevention – a healthy start in life

- Family/self-care awareness and support for CYP with LTC
- CYPF recognise approaches to improve health and wellbeing
- System wide understanding of ACEs

Improving the health of the whole child

- Transition service pathways including young person and adult services 0-25 years

Out of hospital services

- Access to specialist support via outpatients
- Improved access to mental health teams
- Mental health and behavioural support for children with Long Term Conditions (includes access to psychologists)
- Access to specialist outreach at home

Urgent – 24 hours

Prevention – a healthy start in life

- Access to information of local services e.g. directory of service or one central number for a navigation hub

Improving the health of the whole child

- Access to mental health and crisis care services
- Improved care assessment and co-ordination for the family and child/young person.

Out of hospital services

- Complex needs support team
- Urgent care response
- Integration of mental/physical health teams
- Care closer to home including at the end of life

Emergency/Crisis – 4 hours

Prevention – a healthy start in life

- MECC embedded for CYP and their families
- Everyone's business to be aware of mental health
- 24 hour access to mental health services

Improving the health of the whole child

- Mental health triage in children's emergency department
- Mental health nurses in ED and on wards

Out of hospital services

- Improved care roles to support families and CYP to prevent delays in discharge
- MDT access to decide with individual families future plans of support/care and end of life
- Integration of mental/physical health teams

KEY to information source: Steering Group/ Workshops Evidence Document/ Guideline Patient Focus Groups

6. Proposed Future Care System

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CYP Services

Level of Care

Availability

Level of Care	Availability	Acute Hospital	Neighbourhood	Home
4 hours or less	24/7	• MECC embedded • Everyone's business to be aware of mental health • 24 hour access to mental health services • Mental health triage in children's emergency department – • Mental health nurses in ED and on wards • Improved care roles to support families and CYP to prevent delays in discharge • MDT access to decide with individual families future plans of support/care prior to discharge • Integration of mental/physical health teams	• Families are aware of and access 999 & 111 services that understand the needs of CYP • Timely emotional support after abuse or traumatic experience • Call for care support • Improved access to mental health teams • Key worker access • One central navigation service • Access to escalate concerns for CYP with LTC • Improved access to mental health teams • Open access community model in hubs	• A whole family approach to the admission of a CYP • Integrated service offer in the assessment & treatment of physical, mental, social and educational health. • Access to crisis services 7/7 at home
24 hours/Walk up and wait	7 days	• Access to mental health and crisis care services • Improved care assessment and co-ordination for the family and child/young person. • Complex needs support team • Urgent care response • Integration of mental/physical health teams	•Education, emotional wellbeing and behaviour change programmes, •Targeted prevention and 'treatment' of obesity •Evidence-based parenting programmes e.g. daily mile •Play based activities •Promotion of evidence-based healthy social environment, embedded in schools, colleges and nurseries •System wide awareness of ACE •Coordinated approach to increase vaccination uptake and reduce inequality in uptake •One stop shop for health drop ins •Behavioural and emotional health support for CYP and parents including through evidence-based parenting programmes •Social prescribing that recognises the needs of CYP •Access to diagnostic services for autism and ADHD that meet NICE guidance and post diagnosis support •Improved access for face to face counselling and psychological therapies •Support so children are ready to learn at two and ready for school at five •Transition service pathways for GP support 0-25 years •Improved access to mental health teams •Improved access to targeted and specialist SALT services	• One central service to access for urgent physical, mental health and social support e.g. dentist, GP, mental health services, urgent care services, safeguarding concerns etc. • Increased family knowledge and confidence • Co-designed communication tools • Appropriate signposting tools • Play based activities • Children's Centres • Play & Youth provision as prevention • Early intervention • Use of social media • Consistent message campaigns • Healthy weight pathway from prevention to tier 3 • Early help assessments & appropriate support services • Eating disorders service based on need not BMI • Use of assistive technology • Getting ready to learn at two and ready for school at five • Continued care at home for LTC & disabled children and their families
Scheduled	Intervention	• Family/self-care awareness and support for CYP with LTC • Transition service pathways between young person and adult services 0-25 years • Access to specialist support via outpatients • Improved access to mental health teams		

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

Prevention A family approach to wellbeing and a healthy start in life is adopted across the ICS	A model of care should be commissioned which is child centred, that takes a family approach to wellbeing which will transform, influence and support change in attitudes, behaviours and culture, MECC, with particular emphasis on reducing health inequalities, obesity, smoking and excess alcohol consumption and related harm, increasing immunisation and improving emotional wellbeing and sexual health. This will include: - An approach to commissioning that enables and ensures services for children, young people and families work together to perform early help assessments and provide ongoing support, that incorporates a **key worker approach** with defined child health service providers agreeing the role and scope of the key worker. - Focus on the development of **open access children's centres** that support 'healthy' parenting, including through the provision of evidence-based programmes, with a wider range of defined all age services. - Working with education, pre-school to post 16, to embed emotional wellbeing, resilience and behaviour change programmes that promote healthy social environments, through evidence based initiatives and investment. - A **system wide awareness of ACEs** with evidence of incorporation within policy and individual care planning **including trauma informed/smart practice/care**. - Increasing vaccination uptake and improving oral health across the system and reducing inequalities in uptake. - Reducing teenage pregnancy and working together to support the specific needs of young people who are teenage parents using a key worker approach. - Support relationships and sex education in schools (to include pre and long term pregnancy health education). **Alignment:** The development of prevention services across the ICS will require alignment of commissioning intentions and current services across Public Health, Social Care, Mental Health, Education , NHS and voluntary sector functions and will be driven by population health management and it will be the responsibility of the Integrated Care Partnerships (ICP) and Primary Care Networks (PCNs) within the ICS to provide flexible services that will meet the prevention agenda in relation to the key areas of focus identified. **Benefits:** Early intervention is be effective and is cost effective if child adversity and trauma are reduced and will positively impact on families, children and future generations in the long term.
Improving the health of the whole child An integrated model of care will be adopted to meet the mental health & emotional wellbeing of children and families across the ICS	An integrated model of care should be commissioned and provided for children, young people and their families and carers, working together with physical health, social care and education services. This will include: - That a MECC principle is adopted so that all children's health, schools and care professionals have appropriate levels of understanding of mental health so they can recognise when **early support for mental distress** is required and systems which allow this to be offered timely and in schools or universal services and what their ongoing role can entail (including early in life). - Mental health services are suitably resourced and responsive to provide early, evidenced based support when mental health difficulties are recognised to support emotional health and resilience in children and families. - Crisis services should be available to children and young people at the point of need, 7 days per week, including those not already known to services and should not rely on presentation to Emergency Departments, which demonstrates a system failure. - That a resilience charter is developed to support mental health and emotional health for children and families. **Alignment:** An integrated model would require the ICS to align commissioning intentions and current services across all sectors and it will be the responsibility of the Integrated Care Partnerships (ICP) to provide services for their populations. **Benefits:** Integrated models improve outcomes for children and families and has a wider impact when training is provided to our workforce and wider communities. There may also be financial benefits long term.

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Improving the health of the whole child Developmentally appropriate healthcare in both paediatric and adult services will be provided across the ICS	That services across the ICS provide developmentally appropriate healthcare, social care and educational care across both paediatric and adult services. Young people and young adults are supported to move from children services into adult services in a planned individualised journey through integrated commissioned services across the ICS. Key features include: - Tapered transition experience to the age of 25 years based on the developmental needs of the individual young person and a shared understanding and collaborative engagement from young people and adult services. - Consideration of how GP care is commissioned, where a young person is moving from paediatric services to GP care, rather than adult secondary care. - Commissioned seamless pathways for children and young people into adult services. **Alignment:** This will be the responsibility of the Integrated Care Partnerships (ICP) and Primary Care Networks (PCNs) within the ICS to provide flexible services that will maximise the scheduled care response across the ICS allowing a degree of flexibility to meet the needs of their local children, young people and young adult population. **Benefits:** That children and young people across the ICS receive a responsive service both in children and adult health, social care and education services that meets their developmental needs from 0-25 years. Good transition leads to healthy adults.
Out of hospital services Our young people are at the centre of well planned, integrated and supported transition	That there is a stratified approach and service provision across the ICS to support urgent/crisis care in order to avoid unnecessary attendance or admission. These include: - Crisis services should be available to children and young people at the point of need, 7 days a week, including those not already known to services, and should not rely on presentation to Emergency Departments. - There will be pathways in place to offer support to **prevent escalation and crisis presentations to acute providers.** - Call for care or first response type services to help navigate services and support continued care in the home or earlier discharge. **Alignment :** This will be the responsibility of the Integrated Care Partnerships (ICP) and Primary Care Networks (PCNs) within the ICS to provide flexible services that will maximise the scheduled care response across the ICS which will allow a degree of flexibility to meet the needs of their local children, young people and young adult population. **Benefits:** Young people increase their ability to stay in education, in work, to live independently and achieve their personal goals. There may also be some long term savings across the ICS.
Out of hospital services Disabled children and young people receive child-centred multi-agency co-ordinated services	That all physical, emotional, social and needs of the families with children, young people and young adults who have complex disabilities needs are met nearer to their home in a timely, co-ordinated and integrated approach. Key features: - Care workers are recruited and trained to support multiple care groups to reduce the delay for hospital discharge. - Commissioned and provided services for whole population, whole system pathways for children with long term conditions and/or complex care. - Support and pay recognition to the role of expert families, carers, parents and siblings and invest in them e.g. peer support for other families. **Alignment:** This will be the responsibility of the Integrated Care Partnerships (ICP) and Primary Care Networks (PCNs) within the ICS. **Benefits: T**hat the ICS provides multi-agency transition planning and services that focus on meeting the hopes, aspirations and potential of disabled young people and their families, including maximising inclusive provision, education, training and employment opportunities.

7. Transformation Proposal

	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)	Workforce	Technology	Estate/ Configuration	Culture	Finance/ Commissioning	Benefits	Costs
Early adoption of a child centred, family approach to wellbeing to influence and support change in attitudes, behaviours and culture, MECC, with particular emphasis on reducing health inequalities, obesity, alcohol harm and smoking, increase in immunisation and emotional wellbeing and improved sexual and oral health - Timely early help assessments and ongoing support, that incorporates a key worker with defined responsibilities. - Focus on development of open access children's centres to support healthy parenting practices with a wider range of defined all age services. - Education, emotional wellbeing and behaviour change programmes in home, school and the community. - Promotion of evidence-based initiatives to create healthy social environments are embedded in schools, colleges and nurseries - A system awareness of ACEs with evidence of incorporation within policy and individual care planning including trauma informed care. - Focus on influencing wider vaccination take up across the system and reducing inequalities in uptake. - Reduce teenage pregnancy and recognise the specific needs of young parents	High	ICS	Key worker roles Review of workforce skills & need Shared and integrated use of workforce across system where appropriate Specialist practice and knowledge celebrated & recognised for their roles Training & confidence in communication skills Capacity to implement in practice Working better with schools and other partnerships Recognise that everyone cannot do everything – need for different roles	Connectivity across the ICS Integrated systems with social care MECC apps Web base DOS More mental health training for frontline practitioners supported with digital offers Internet based digital offer Explore online offers for families re behaviour change Apps and digital platforms for children and parents	Locality based Community Hubs to be open 7 days a week with extended hours Facilities in schools and colleges Open access community venues	Integrated social care, health and PHM & education model Developing trust programme across different settings and roles Adopt the principles of MECC' Family focused Prevention is not just public health's role and it should be everyone's business Remove any barriers to working across/with partners Willingness to test new models Alignment of expectation and understanding across physical emotional CYP and adult provision	Commissioning reflects the integrated child health service review plan An approach to the commissioning of services that ensures the child and families are central to the model Influencing local policies Implementation of national policy & initiatives in an integrated manner Stop cross charging for use of rooms buildings have a central budget at ICS level Pooled /aligned budgets to enable better spend across the pathway Costs upstream – shared responsibility Reviewing thresholds Working more collaboratively Integrated models of care should be commissioned for CYP and families Shift of resources to early intervention	Increased confidence and skills of children, young people and families. Less health conditions, such as diabetes, later in life Reduced admissions to hospital, escalated admissions and length of stay Care provided closer to home Investment in early childhood can yield 10-to-one benefit ratio in health, social and economic benefits Evidence of cost benefits in adult health Investment in early childhood can yield 10-to-one benefit ratio in health, social and economic benefits. The Early Intervention Foundation analysis (2016) found the total cost of late interventions is £198M in Nottinghamshire or £246 per person.	
Families and carers working together with physical health, social care and education services: - Adoption of MECC - Schools and care professionals have appropriate level of mental health understanding & recognise when early support for mental distress is required - Timely interventions are provided - Early evidenced based responses by mental health services when mental health difficulties are recognised, including early in life. - Crisis services should be available to children and young people at the point of need,	High	ICS	Balance between level of mental health understanding for generic/universal practitioners Specialist practice and knowledge celebrated Working better with schools in joint roles Flexible workforce	MECC apps Web base Directory of Service More mental health training for frontline practitioners supported with digital offers /e-learning	Facilities in schools – space?			Integrated models improve outcomes for children and families. There may also be financial benefits long term across the health and care system Appropriate parent involvement (young people and their parents happy with the level and type of involvement) economic analysis has shown this may be financially beneficial.	

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7. Transformation Proposal

	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)	Workforce	Technology	Estate/ Configuration	Culture	Finance/ Commissioning	Benefits	Costs
Developmentally appropriate healthcare in both paediatric and adult services is provided across the ICS: - Young people and young adults are supported to move from children's services into adult services in a planned individualised journey - Tapered transition experience to the age of 25 years based on the developmental needs of the individual young person (this may require an overlap with young person and adult services). - GP care is commissioned where a young person is moving from paediatric services to GP care rather than adult secondary care.	High	ICS	Need for increased knowledge skills to enable care and support into early adulthood Workforce will need whole system change Capacity issues need to reduce big case loads Transferable skills diversity of workforce	Interoperability e.g. IT systems that communicate with each other	N/A	Integrated social care, health and PHM & education model Developing trust programme across different settings and roles Adopt the principles of MECC Family focused Prevention is not just public health's role and it should be everyone's business Remove any barriers to working across/with partners Willingness to test new models Alignment of expectation and understanding across physical emotional CYP and adult provision	Commissioning of joint CYP/Adult services Commissioning of GP services to improve transition journeys for young people CYP vs adult commissioning Parity in health presentation Needs money from adult for 18-25 to shift to CYP services	Increased confidence and skills of children, young people and families. Reduced admissions to hospital, escalated admissions and length of stay Care provided closer to home	
The ICS to support urgent/crisis care in order to avoid unnecessary attendance or admission. - Crisis services should be available to children and young people at the point of need, 7 days a week. - Pathways in place to offer support, prevent escalation and crisis presentations to acute providers. - Call for care type services to help navigate services and support continued care in the home or earlier discharge.	High	ICP	Capacity and willingness of providers	Increase knowledge of services available e.g. via app or help-link	Community hubs be open long days 7 days per week with extended hours		Commissioning of 7 day services across the ICS Consider different commissioning arrangements when ending contracts and the impact by NHSE .e.g. CCG saving organisation leads to increased work in another e.g. CAHMS tier 3 to 4	Community based care will realise costs savings Decrease pressure on inpatient care	
All physical, emotional, social and needs of the families with children, young people and young adults who have complex disabilities, needs are met nearer to their home in a timely, co-ordinated and integrated approach. - Care workers are recruited and trained to support multiple care groups to reduce the delay for hospital discharge. - Provision of services for whole population, whole system pathways for children with long term conditions and/or complex care.	High	ICP	Community hubs need to be sufficiently specialised Skills mix and easy transition between services	Integrated IT system to enable flexible access to services	Review of estates to provide urgent/crisis care away from Emergency Departments Call for care / navigation service Improved access to crisis beds Disabled access friendly Pram friendly		Instability and vulnerability or charity funded services & future sustainability In adults services there is a need to improve cross system funding Governance - willingness to accept change Risk appetite	Less pressure on urgent / crisis care Less escalated admissions	

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8. Workstream Requests

Workforce	The following are key areas that need to be considered to enhance the future: • A review of skill mix is undertaken across the ICS • The development of a workforce long term strategy to identify 'new ways' of working • The development of an integrated workforce working across different organisational boundaries • Upskilling front line staff • Review long term training requirements to sustain a long term workforce • Develop a tiered workforce – Tier 1 – everyone's business to promote a healthier start in life; Tier 2 – sub-specialty skills to support children, young people and families; Tier 3 – specialist roles
Technology	The following are key enablers to ensure the sustainability of the proposed transformational opportunities and will aid all themes identified: • Electronic shared care health records • Visibility and access to have the ability to update assessments • Telemedicine advice links and access to tele care and internet based digital offer • Investment in assistive technology, automated workflows, citizen access to digital information, data analytics • Investment in IT equipment for staff groups • Links to housing and social care IT systems
Estate	It is recognised that the acute services are fixed points and that ED services will continue to be provided at the two acute trusts, below highlights some areas where there may be additional estates required: • Co-located service • Locality based hubs • Communication accessibility • Ensure financial charging systems between providers for community estate support service provision
Culture	• An approach to commissioning that enables and ensures services for children, young people and families work together to perform: • Early help assessments. • Provide ongoing support, that incorporates a key worker approach. • Healthy outcomes prioritised in planning commissioning and delivery. • Ensure commissioning for children's services has a holistic approach • Shared and/or pooled budgets • Embedding MECC approach within all sectors of children and young person services • Embed a whole family approach across the ICS • Co-design all service with families, children and young people and young adults • Integrated and equitable access to services across the ICS

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11. Future Vision

CYP Services Vision: that all families', children and young peoples' health, education and social equity needs are met, where all communities are thriving and all people have what they need to be healthy now and in the future.

From…	Phase 1 1st year	Phase 2 2-3 years	Phase 3 5 years +	To…
Prevention - a healthier start in life • High proportion of overweight/obese children in year 6 and this is increasing • Too many children are not 'ready for school' (EYFS) • There are inequalities in uptake of childhood vaccinations • There is not a system wide awareness of ACEs and trauma informed approaches • The whole family and the voice of the child are not routinely considered.	- Develop a pathway from prevention to 'treatment' for overweight /obese CYP - Pathways are developed and commissioned to support children, includes those with SEND, to be ready for school - NHS England identified communities with low vaccination uptake and supports activity to increase uptake - Mapping of services ACE trained and trauma informed	- Pilot and evaluate interventions to reduce overweight/obesity in CYP - Interventions to improve school readiness prioritised in commissioning - Specific groups are targeted through enhanced vaccination services - Year on year increase in proportion of services ACE trained and trauma informed	- A whole system approach to reducing obesity in CYP embedded - Review of strategies to increase school readiness and recommissioning based on findings - CYPF are able to access vaccination in a range of settings based on choice - Less pressure on services as they become trauma informed	• Reduction in proportion CYP overweight/obese • A greater proportion of children are 'ready for school' • Increased vaccination rates and reduction in inequalities in vaccination uptake • System wide awareness of ACEs • CYP services across the ICS will be co-designed by and for CYP and families
Improving the health of the whole child • Absence of targeted services for CYP who are obese. • Inequitable access to diagnosis of ASC and ADHD and evidence based parenting programmes e.g. NFFP & Cygnet. • Lack of knowledge among health, social care and education in recognising mental distress and emotional wellbeing • Lack of coordinated transition from children's into adult services • Lack of a tapered transition experience to the age of 25 years based on the developmental needs of the individual • Services working in isolation e.g. education, mental health & social care • The whole family and the voice of the child are not routinely considered.	- 'Treatment' pathway developed for obese CYP - BEH services that diagnose ASC and ADHD that meet NICE guidance are commissioned equitably and post diagnosis and parenting support provided - Training needs analysis re CYP MH - Independent exploration of issues with transition - Fragmentation identified and service redesign proposed based on pooled budgets -scoping MECC approach for CYP& Families	- Interventions to 'treat' obesity evaluated - Evaluation of new diagnosis and support model for ASC and ADHD - Training commissioned/ provided to increase knowledge of CYP MH - Service redesign to improve transition proposed and agreed - Pooled budgets enable commissioning across the pathway to avoid fragmentation	- System wide approach to 'treating' obesity embedded BEH services sustainably commissioned based on evaluation findings - Evaluation of MH training for CYP workforce - Services commissioned on developmental need not chronological age - Evaluation of service redesign - Develop/implement training and systems for MECC/family approach linked with social prescribing	• Reduction in proportion of CYP obese and these CYP becoming obese adults with LTCs • CYP receive timely diagnosis, through a clear pathway and post diagnosis support. Improving outcomes for CYPF • Workforce better informed re CYP mental health and better able to offer support • Seamless transition to adult services support provision of better care • Fragmented commissioning reduced enabling better care • Think family approach taken across the system for child and parental presentations
Out of hospital services • There are increased levels of ED attendances with CYP who are experiencing mental health concerns. • There is a lack of care co-ordination navigation and signposting for whole families • Physical, emotional, social and needs of the families with children, young people and young adults who have complex disabilities, needs are not met in a timely, co-ordinated and integrated approach. • Some services are provided in hospital that could be undertaken in the community due to current commissioning agreements	- Pilot alternative to ED service based on findings - Identify issues with care coordination and navigation for CYPF - Including those with complex disabilities - Identify which services are provided in hospital that could be better provided in the community	- Review CYP attending ED with mental health concerns to identify what service could better meet their need - Pilot care coordination model that provides a graduated response based on need including CYP with complex disabilities - Pilot a range of additional services better provided in the community rather than hospital using pooled budgets	- Evaluate alternative to ED service and recommission based on findings - Evaluate care coordination and recommission based on findings - Evaluate additional services provided in the community rather than hospital and recommission	• CYP are seen in the most appropriate place and ED attendances are reduced improving the care experience • Care is better coordinated reducing ED attendances, hospital admissions and family distress • Care provided closer to home, reducing costs and improving experience

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10. Conclusions and Next Steps

Conclusions	The review of CYP services as part of the development of a Clinical and Community Services Strategy for Nottingham and Nottinghamshire has been undertaken using a co-design model where patients, families, carers, key stakeholders and have collaboratively worked together to shape a vision for a future care system for CYP services in Nottingham and Nottinghamshire. The three key themes for improvement identified were: prevention (a healthy start in life), improving the health of the whole child and out of hospital services. The review describes a future care system in different care settings and with care provided at different levels of urgency and envisages 5 high priority programmes to transform care: • **High Priority** - A whole family approach to wellbeing and a healthy start in life is adopted across the ICS particularly for childhood obesity. • **High Priority** - An integrated model of care will be adopted to meet the mental health & emotional wellbeing of children and families across the ICS vaccination uptake. • **High Priority** - Developmentally appropriate healthcare across both paediatric and adult services will be provided across the ICS. • **High Priority** - Our young people are at the centre of well planned, integrated and supported transition. • **High Priority** - Disabled children and young people receive child-centred multi-agency co-ordinated services **.** To achieve these there are a range of enabling requirements for the ICS across workforce, estate, technology, culture and financial systems. Collectively these initiatives can transform and provide long term health improvement and sustainability in the areas of CYP services in Nottingham and Nottinghamshire.
Next Steps	This strategy sets the future direction of development for Families and CYP care in the ICS and it is proposed it will shape future work of the ICS in a number of ways:` • The identified priorities and programmes should be used to inform commissioning, ICS, ICP and PCN activity. • The enabling activities require development and inclusion in the relevant ICS workstreams to inform their work programmes and areas of focus. • The estate and configuration changes proposed require inclusion in a programme of pre-consultation business case development alongside the service changes recommended from other reviews. • The aggregate impact of the collective suite of service reviews should be used to shape focus of future service provision in acute and community settings in the ICS.

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11. List of Abbreviations

1°, 2° Care	Primary, Secondary Care	IT	Information Technology
A&E	Accident and Emergency	LTC	Long Term Conditions
ACE	Adverse Childhood Experience	LTP	Long Term Plan
ACP	Advanced Care Practitioner	LTV	Long Term Ventilation
ADHD	Attention Deficit Hyperactivity Disorder	MDT	Multi-Disciplinary Team
ASC	Autism Spectrum Conditions	MECC	Make Every Contact Count
BEH	Behavioural and Emotional Health	MH	Mental Healthcare
BMI	Body Mass Index	MMR	Measles, Mumps, Rubella
CBT	Cognitive Behaviour Therapy	NHS	National Health Service
CCG	Clinical Commissioning Group	NHSE	National Health Service England
CCSS	Clinical and Community Services Strategy	NHSI	National Health Service Improvement
COPD	Chronic Obstructive Pulmonary Disease	NICE	National Institute for Health and Care Excellence
CYP	Children and Young People	NRCP	National Register of Certified Professionals
CYPF	Children, Young People and Families	NRT	Nicotine Replacement Therapy
DOS	Directory of Service	NUH	Nottingham University Hospitals
ED	Emergency Department	PCN	Primary Care Network
EMAS	East Midlands Ambulance Service	PH	Public Health
EoL	End of Life	PHE	Public Health England
eSCR	Electronic Shared Care Record	PHM	Population Health Management
FT	Foundation Trust	PID	Project Initiation Document
GP	General Practitioner	QALY	Quality Adjusted Life Years
GPRCC	General Practice Repository for Clinical Care	QIPP	Quality, Innovation, Productivity and Prevention
HCP	Healthcare Professional	QMC	Queen's Medical Centre
HES	Hospital Episode Statistics	SALT	Speech and Language Therapy
ICP	Integrated Care Partnership	SEND	Special Educational Needs and Disabilities
ICS	Integrated Care System	SFH	Sherwood Forest Hospitals

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12. Data Sources

Data Sources	Local Data from GGCs – HES data. Local Data from NUH and SFHFT. PHE Health Matters NHS Long Term Plan NICE guidance Fingertips Department for Health & Social Care & Cabinet Office Office of National Statistics NHS England

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13. Appendix – Activity Data

	Inpatient CYP (0-25) 2018-19			
Emergency	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	1,089	17,808	8,655	2,288
Bed Days	2,938	15,221	4,524	11,895
Cost	£1,847,177	£21,339,549	£8,041,249	£3,451,342
Elective				
Activity	2,645	9,341	2,971	5,708
Bed Days	980	4,014	580	12,757
Cost	£2,779,452	£14,018,198	£2,730,041	£6,741,825
Daycase	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	2,228	7,377	2,222	4,662
Cost	£1,651,073	£7,141,041	£1,928,121	£3,298,727

	Inpatient 2018-19 %CYP(0-25)			
Emergency	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	5%	24%	20%	25%
Bed Days	4%	8%	4%	14%
Cost	3%	14%	9%	21%
Elective	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	3%	23%	7%	8%
Bed Days	4%	23%	8%	13%
Cost	3%	27%	7%	10%
Daycase	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	3%	23%	6%	8%
Cost	5%	29%	8%	8%

	Outpatient CYP (0-25) 2018-19			
	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	20,406	122,569	49,376	59,204
Cost	£1,309,540	£9,276,173	£3,701,707	£4,247,221

	Outpatient 2018-19 %CYP			
	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	6%	29%	15%	14%
Cost	4%	34%	15%	13%

	A& E CYP (0-25) 2018-19		
	NUH QMC	SFH Kings Mill	Other
Activity	64730	24497	44225
Cost	£7,115,733	£2,806,545	£2,911,197

	A& E CYP (0-25) 2018-19		
	NUH QMC	SFH Kings M	Other
Activity	37%	28%	42%
Cost	30%	23%	40%

- 31% of Nottingham and Nottinghamshire ICS are aged 0-25 years.
- Children and Young People (CYP) account for 34% of the QMC Outpatient costs as it has a children's hospital.
- 15% of Kings Mill Outpatient costs and activity as they offer some children's services.
- 37% of A&E activity is for 0-25s at QMC and 28% at Kings Mill.
- 1/4 of QMC inpatient activity (across day-case, elective and emergency) is for children and young people.
- 1/5 Kings Mill's emergency inpatient activity is for CYP with 7% elective and 6% of day-cases are for 0-25 year olds.

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