Healthy London Partnership

Children and Young People's Strategic Leaders Transformation Forum

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J9 CONSULTING & EXECUTIVE COACHING

Supported by and delivering for:

Public Health England

NHS

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Introduction

On 26th June 2019, J9 Consulting, working with Healthy London Partnership, hosted a pan-London event to allow a discussion of how each STP is progressing with their CYP priority programmes of work, following a series of workshops undertaken by system leaders. It was also an opportunity for participants to network and share their ideas on a whole system approach to mobilising change in order to transform services for CYP across London and to ensure that the right care is provided, in the right place, at the right time,

During the breakout sessions, the participants wrote up their thoughts and ideas, which are presented below.

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Breakout 1: Learning from the development of the HLP CYP MH Workforce Strategy

What does this mean for my role as CYP leader?

Engagement.

Role of ambassadors.

Reframe questions through CYP eyes.

Questions about demographics/diversity of those who completed survey.

Workforce who attended workshops – was this encompassing whole workforce?

How are we building meaningful relationships and co-producing services with CYP, their families and our workforce?

Importance of social media to engage – but do we have the subject matter expertise?

Need to take the time.

Need to understand what it is you want to know.

Need to budget for engagement.

How do I make connections to learn from good practice and share my learning?

Importance of coming together, but doesn't always need to be face to face (e.g. NCL Newsletter).

Need to better understand how to disseminate HLP resources (as an example) to a wider range (time and permission).

STP-level networks? Ask the questions – need wider network.

What one thing can I do differently?

Use 3rd party organisations for expertise (e.g. social media).

Learning creative/innovative to adopt new approaches (governance-heavy!).

Third person.

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Breakout 2: Developing child health hubs and multi-professional working

How do you get paediatricians out of the hospital?

Target a senior registrar: minimal cost to Trust (wanted to learn), and provides a proof of concept.

Create a business case for the impact on the financial bottom line: often the finance mechanism does not exist.

Some challenge with GPs supporting that agenda.

Have a clear financial case.

Practicalities of a clinical spot

½ hour slots, 20-minute appointments.

Lunchtime appointments.

Other considerations

First gain confidence and buy-in from stakeholders.

Having a case study helps.

A GP-led approach, rather than pushed on to GPs.

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Breakout 3: Managing children with complex needs – a focus on neurodevelopment

If we had a blank canvas how would we design our services to meet the needs of CYP (and their families) with neurodevelopmental needs?

Engagement with families – SEND/CAMHS – social emotional mental health.

Pre-diagnosis support – guidelines (best practice) and things that might help whilst waiting.

Expectation of schools – single named worker. Importance of completion of appropriate paperwork. Language – labelling/tiers confusing.

What are people entitled to, what to expect.

Joint commissioning.

Design holistic joined-up service with no fragmentation where child can move along pathway that is easily navigated.

What do CYP/families think?

Specialist.

Flexible to individual needs – time, location, who etc.

Short waits, intervention whilst waiting.

Alliance of providers – standard/consistent.

Coordination, key worker – wider services, e.g. housing, welfare.

Single child plan – telling story once (including social care).

Transitioning – smooth.

Moves between one borough to another -CYP in the middle, care coordinator.

Lead professionals allocated i.e. once referred into services, lead professional (is this consistent?).

Division health/CAMHS 5+ i.e. need for OT – remove that barrier, merging health and mental health services. Do not move into different systems – services for CYP with autism and 0-25.

Make school life easier – EI pilot, coping strategies, parental and school support.

Islington – MDT, register (monthly basis).

Youth offending.

Wider support family i.e. PHB potential.

Housing – every child with autism – external balcony.

Ensure that professionals have a good understanding of neurodevelopment across all disciplines.

Early intervention, life planning.

Normalisation of need.

Neurological dynamic multidisciplinary pathway.

Lead professional – consistency of care, manages transition.

Remove barriers – MH & PH, Paediatricians.

Making school easy.

Coping strategies (for parents, wider family support) – Islington.

Vision – holistic, joined up services, move along a pathway.

Single named worker.

Pre-diagnosis support.

Listen to parental common sense.

Flexible service – GP diagnosis.

Single plan for all professionals.

Use of agreed pathways – annual reviews.

Role of YOS/Youth Justice.

Trained multi-agency workforce – understand each other's expertise, break down silos!

SPA to universal pool system, use "queue theory".

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What myths do we need to bust about what we can and can't do?

Social care giving personal budgets but no carers available.

Lack of people skilled in autism training.

That there is one single point of access/front door – currently confusing and lacking MDT.

Tell your story once!

We can transform anything!

System is easy to navigate (understanding landscape).

Diagnosis-led provision – need for diagnosis to access services.

Support needs to come from "medical" team.

Unable to adapt services – too difficult – had a universal responsibility.

Roles and responsibilities – myths regarding what/who can do what.

Money – all our money, i.e. get it right/across education – PES to make change. Pooling the money.

Pathways – too rigid/EY more support available. Order of pathway needs to be looked at. Do we need pathways?

Diagnosis – identify needs –plenty of evidence, use it! Once diagnosis received, loads of support.

School – environmental changes. Too hard to adapt/"expert".

Do we need a diagnosis? Do we need a threshold? Look at CVP's needs/aspirations.

Too hard to adapt for CVP with complex needs.

Diagnosis needs to come from a medical team.

Once you have a diagnosis, the door is open.

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Managing expectations…

We can't do it because of boundaries.

We can't do it because of no funding for that pathway (compare with Canada).

We need experts.

How might we do this?

Managing parents' expectations.

Have one front door – as much as possible.

Have good advice/signposting and advocacy/support to help understand system.

What one thing are you personally going to do differently to improve the way we help CYP with neurodevelopmental needs?

Complete mapping exercise – with focus for different DX (Barnett).

Better engagement in schools (transdisciplinary working) – Lewisham.

Working with SLT more – childminders.

HLP – coproduction, consistency – toolkit/materials/connections workshops.

To do:

- Workshop.
- Connect/co-production.
- Integrated care system.
- Home-educated children – do we understand?

Need HLP support:

- Better education for stakeholders.
- Connect leads on issues – improve/better practice.
- “Quick wins”.
- Best results/practice share.

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Breakout 4: Primary Care Networks – an integrated community approach

What could you take from this locally?

Pharmacy hubs – health monitoring and promotion – upskilling, shared aims, i.e. CQUINs.

Mapping patient flow in and out of a service like PICU/NICU.

Reorganisation.

Relationships – build.

Map out local needs/vision/facilities.

Involve all health/education/social care professionals. Start with the CYP – engagement, design, co-production.

LA borough definitions vs PCN populations.

Whole systems representation.

Boundaries – of organisation; of focus; of power; of resource.

List people that you would involve within your area/borough (interest vs. influence)

HCA.

Local Authority.

Pharmacy.

Local community get togethers.

Patients' voice.

Do children really use GPs? How does the PCN determine whether children are a priority?

Links between health providers, dental services, GPs, schools, pharmacies, dental services, other services for children, health visitors – what are the relationships with GPs for these groups?

Who are the experts in children's services? Schools, children's centres, health visiting.

Public health linked to primary care – is this working? How should it relate to primary care networks?

Clinical leads.

Commissioners – LA CCGs.

Public Health.

Trusts and Community Services – CAMHS.

Parents and families.

Education.

Social care – YOT, LAC.

NHSE, PHE, HLP.

Pharmacies.

Dentists – linking into pathways.

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How can we use our workforce differently to achieve our aims?

One single case navigator.

Not being constrained by organisational boundaries.

Sharing good practice.

Training.

How are you going to start?

Talking to local steering groups.

Where are we now? How does it work?