Integrated Care Systems and the health needs of babies, children and young people

A report from the Children and Young People's Health Policy Influencing Group

January 2024

Alström Syndrome UK
Strength for today, hope for the future

Ambitious about Autism

AUDITORY VERBAL UK
Creating a sound future for deaf children

ayph

BAMT BRITISH ASSOCIATION FOR MUSIC THERAPY

Believe in children
Barnardo's

best beginnings
for every parent, for every child

Better Breastfeeding

Body & Soul
transforming trauma with love

brook

CARERS TRUST

Children & Young People's Mental Health Coalition

CHF

contact
For families with disabled children

coram BAAF
adoption • fostering • kinship

Children's Alliance
Better starts, brighter futures

CHILDHOOD BEREAVEMENT NETWORK

COUNCIL FOR DISABLED CHILDREN

Cystic Fibrosis Trust

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

Disabled Children's Partnership

DOWN'S SYNDROME ASSOCIATION

epilepsy action

family action

HOME START

iHV Institute of Health Visiting
Excellence in Practice

NATIONAL CHILDREN'S BUREAU

National Deaf Children's Society

Our Time
for children of parents with a mental illness

NHS
King's College Hospital
NHS Foundation Trust

NSPCC

Parent-Infant FOUNDATION

PCF PAEDIATRIC CONTINENCE FORUM

RAINBOW TRUST
SUPPORTING FAMILIES WITH A SERIOUSLY ILL CHILD

RACC-UK

ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS

RCOT Royal College of Occupational Therapists

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

SAPHNA
SCHOOL AND PUBLIC HEALTH NURSES ASSOCIATION

SoR 100 YEARS
THE SOCIETY OF RADIOGRAPHERS

Speech and Language UK

STARLIGHT

The Children's Society

The Health Foundation

together for short lives

V O D G
Voluntary Organisations Disability Group

Young Epilepsy

YOUNG LIVES vs CANCER

YOUNGMINDS
fighting for young people's mental health

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Amanda Allard	Council for Disabled Children
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Contents

Glossary

Acronyms:

HPIG: Health Policy Influencing Group

ICS: Integrated Care System

ICP: Integrated Care Partnership

ICB: Integrated Care Board

JFP: 5 Year Joint Forward Plan

VCSE: Voluntary, Community and Social Enterprise

LAs: Local Authorities

NHS: National Health Service

NHSE: NHS England

DHSC: Department of Health and Social Care

DfE: Department for Education

Definitions:

Intersectionality: An approach that considers how different aspects of one's social and political identity overlap with each other to create new categories for discrimination, disadvantage or privilege.

Inclusion health: describes action to improve health and care for people who are socially excluded, experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma) and stigma and discrimination. Inclusion health groups typically include: people experiencing homelessness, including people who sleep rough; vulnerable migrants; Gypsy, Roma and Traveller communities; victims of modern slavery; people with drug and alcohol dependency; and people in touch with the criminal justice system.

Co-production: working in partnership with those who use services to design, develop and deliver services to ensure their needs are best met. In this report, we are considering evidence of the extent and quality of engagement with children, young people and families, and how this has informed decisions. This means that diverse groups of babies, children, young people and their family networks/care/caregivers have been given the opportunity to feedback, direct and influence service and strategy development. Steps have been taken to ensure contributors are given the necessary knowledge, time and environment to respond.

Major conditions: In this report, major conditions refer to six groups of conditions identified by the Department of Health and Social Care (DHSC) as cancers, cardiovascular disease (CVD) (including stroke and diabetes), musculoskeletal disorders (MSK), mental ill-health, dementia, and chronic respiratory disease (CRD).[1]

Long-term conditions: As defined by DHSC, a long-term condition is one which "cannot, at present, be cured, but is controlled by medication and/or other treatment/therapies".[2] This definition will be maintained when referring to long-term conditions in the report.

In the report, we will use the term 'major and long-term conditions' together to refer to both types of conditions. These may also be alternatively referred to by some as 'life-limiting and life-threatening conditions'.

System: Throughout this report we will refer to 'system' when we are talking at the scale of the Integrated Care System (ICS). The term 'sector' will be used to describe all 42 ICSs.

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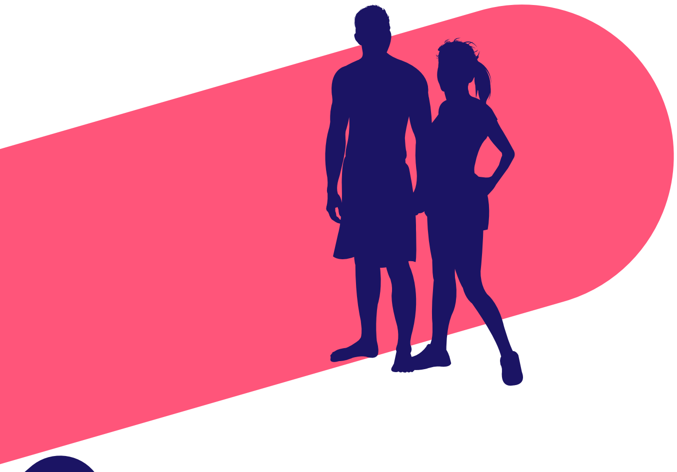
[1] Major conditions strategy: case for change and our strategic framework – GOV.UK (www.gov.uk)

[2] Main heading (publishing.service.gov.uk)

Introduction and purpose of this report

The Children and Young People's Health Policy Influencing Group (HPIG) is a strong, independent voice advocating for improvements to the health of babies, children and young people. As a group of influential charities and Royal Colleges, we look to ensure that the particular and unique health needs of babies, children and young people are a focus for the health system.

This report reflects that goal and focus. It provides a snapshot of how the newly formed Integrated Care Systems (ICSs) are enacting their duties for strategic planning as outlined in the Health and Care Act 2022. In particular, the requirements for Integrated Care Partnerships (ICPs) to produce an integrated care strategy and for Integrated Care Boards (ICBs) to produce a five-year joint forward plan (JFP). To create this report, we analysed almost three-quarters of ICS strategies and plans to determine the extent to which they have reflected the needs of babies, children and young people within them.



This report recognises the good work that is developing in ICSs and where they are effectively reflecting the needs of babies, children and young people in their strategic planning. It also highlights a number of areas where there is significant room for improvement, including co-production with children and young people, integration with education and children's social care, and greater clarity on leadership and accountability. We acknowledge this is the first year that ICSs have been required to publish a strategy and JFP, and that it will take time to get things right.

We hope this report will give national government a chance to reflect on where it might wish to offer greater support and guidance to ICSs, as well as an opportunity for ICSs to learn from each other and consider additional areas as they refresh their strategies and plans in the coming year.

The Health and Care Act 2022 and children

The Health and Care Act 2022 is the legislation that formalised ICSs as legal entities with statutory powers and responsibilities.

HPIG led the children's sector's activity in influencing the Act, working with Ministers, civil servants and parliamentarians to push for a greater focus on babies, children and young people in the legislation and supporting guidance.

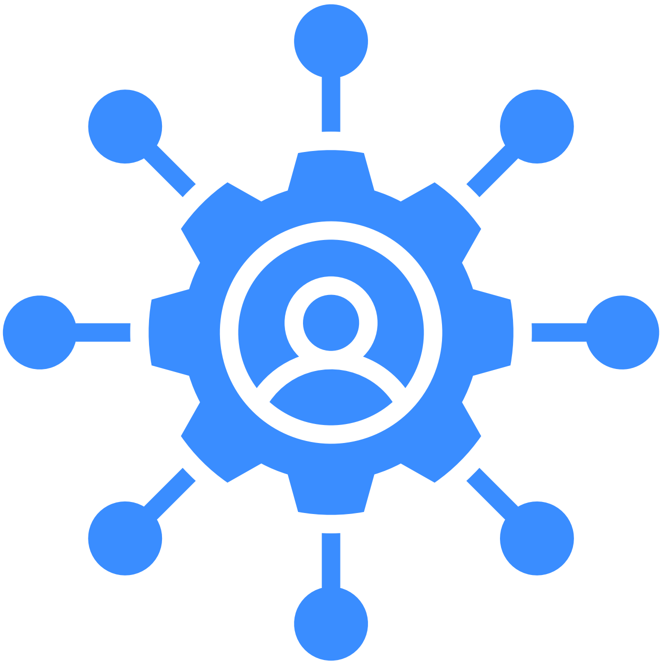
Following a powerful intervention by members of the House of Lords, the health needs of babies, children and young people were included in the primary legislation and further statutory guidance. ICBs replaced Clinical Commissioning Groups across the country from 1 July 2022. ICBs are required by the Act to set out the steps they will take to address the needs of children and young people under the age of 25 in their five-year JFPs. Children and young people are one of only two groups singled out by the primary legislation in this way.

Further positive changes to the Act included new statutory guidance, produced by NHS England (NHSE), that required ICBs to nominate an Executive Children's Lead, responsible for ensuring the ICB sets out clearly the steps it will take to address the needs of those aged 0–25. ICBs are required to consult with local leaders as they draw up their plans, and they should have closely involved children and families themselves.

Finally, and crucially, ICBs are also required to report annually on how well they are delivering their duty to safeguard children. This responsibility should have been delegated to an Executive Lead, as ICBs will be lead partners in local child safeguarding arrangements, together with the police and local authorities (LAs).

This report is part of HPIG's work to monitor the extent to which ICSs implement these requirements and ensuring the health needs of babies, children and young people are met in practice.

What are ICSs?



ICSs are partnerships of organisations (NHS, LAs and others) that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. They take collective responsibility for planning services, improving health and reducing inequalities across geographical areas.

What are the requirements on ICSs?

ICSs are required to take the following steps:

- ICPs must produce an integrated care strategy. This must set out how the assessed needs (from Joint Strategic Needs Assessments) can be met through the exercise of the functions of the ICB, partner LAs or NHSE. The ICP strategy sets the direction for the system and explains how different aspects of the health system will work together to provide multi-agency, personal and preventative care to its population.
- ICBs must produce a 5-year JFP. The JFP is supposed to illustrate how the ICB will meet its population's diverse health needs with regard to its relevant ICP strategy.
- The JFP must include the steps the ICB will take to address the particular needs of children and young people under the age of 25.
    - Children and young people are one of the only groups singled out in the Act.
    - This also included a duty to involve young carers in the planning and changing of services as well as prevention, diagnosis and care relating to anyone they care for.[3]
- ICBs must nominate an Executive Children's Lead, responsible for ensuring the ICB sets out clearly the steps it will take to address the needs of those aged 0–25. ICBs are required to consult with local leaders as they draw up their plans, and they should closely involve children and families themselves.
- ICBs are required to identify named executive board member leads for safeguarding and special educational needs and disabilities (SEND), and for children and young people's services.

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[3] Section 25 of the Act, with clarification from Ministers that the term "carers" refers to unpaid carers as well as both young carers and parent carers of disabled children.

Report methodology

Design

HPIG monitored the publication of ICP strategies and ICB JFPs throughout the year and, as of September 2023, completed a review of those ICSs that had publicly published their strategies and JFPs. We analysed 31 strategies and 31 JFPs from the same ICSs, a reach of 74% of the total sector.

The design of our review was based on criteria agreed by HPIG members as to what ICSs should be considering in their strategies and JFPs in relation to babies, children and young people. Members of HPIG who volunteered to support with the analysis were each assigned up to two ICSs and asked to read the ICP strategy and ICB JFP for each ICS. They then responded to a consistent survey that enabled us to consider the national picture as a whole.

The questions were categorized under our seven pre-agreed criteria for analysis:

1. **Population health**
2. **Leadership**
3. **Co-production**
4. **Workforce**
5. **Information and data**
6. **Integration**
7. **Inequalities**

Further information on the indicators under each of these criteria is in the Appendix.

None of the questions in the survey were mandatory to allow participants to answer those questions most applicable to their strategies and plans. A mixed-survey method was developed to strike an appropriate balance between ensuring consistency and introducing nuance in analysis. While the questions were primarily quantitative to help capture trends across the sector, the comment box for every theme allowed for more detailed and written insight into each ICS.

For quantitative questions, the 'Red, Amber, Green' (RAG) system was used as the multiple-choice option for each question. The question options were 'Yes', 'To some extent' and 'No' with the following advice given to volunteers when reading strategies and plans:

● **Yes**

- The strategy or plan has comprehensively considered the aspect of the question.
- For this option, most of the following must be true:
    - The information is clear and detailed.
    - The question area is explicitly referenced and focused on.
    - The strategy or plan related to the question area is evidenced and examples are given.

● **To some extent**

- Some mention is given to the question area, but it is not given much attention, or it is quite hard to discern what the strategy or plan intends to do.
- For this option, the following would be true:
    - The information is partial and details are loose.
    - There is vague reference to the question area.
    - The content for the area is implied and no examples are given in practice.

● **No**

- This would be chosen if none of the above has been achieved.
- For this option, the following would be true:
    - There is no mention of question area or passing mention with no attempt at additional detail.

Limitations

This analysis provides a snapshot of how well a cross-section of ICSs reflected the needs of babies, children and young people in their strategies and JFPs. This provides a very important, but partial view of ICS activity. Therefore we have not named specific ICSs and wish to make clear this analysis cannot be used to make judgements on the actual delivery or quality of services on the ground.

We have limited our analysis to strategies and JFPs. We acknowledge further content may be available in other documents including place-based strategies, separately published strategies that cover a particular theme in detail, or formal meeting notes that highlight developments in ICSs.

Due to capacity constraints, we reviewed 31 out of the 42 ICSs. Whilst this is a potential limitation, it is 74% of the system and we consider our findings to still be significant.

Key findings

Our findings highlight summaries of the survey questions as well as observations based on the comments included in the survey. Where we have added a comment to the finding, it has been to offer additional feedback and analysis in relation to the finding.

1. Population health

Findings

1.1 Every ICP strategy recognised babies, children and young people as a distinct group, however some did not identify children and young people as a distinct group up to the age of 25.

Comment

Overall, strategies recognised the value and importance of addressing the specific needs of babies, children and young people as a core part of achieving their overarching health objectives for their local population.

Findings

1.2 There was variation in whether babies, children and young people were covered in their own section or whether they were threaded through other areas of the strategies and plans.

Comment

Many strategies had a discrete section that focused solely on the needs of babies, children and young people up to 25. Where this was the case, babies, children and young people were often included under a strategic priority of 'Best start in life'. Some strategies did not have discrete sections and embedded babies, children and young people throughout all-age parts of the strategy.

Without a dedicated section to babies, children and young people, it was harder to draw out exactly how they were being considered by the strategy and the JFP.

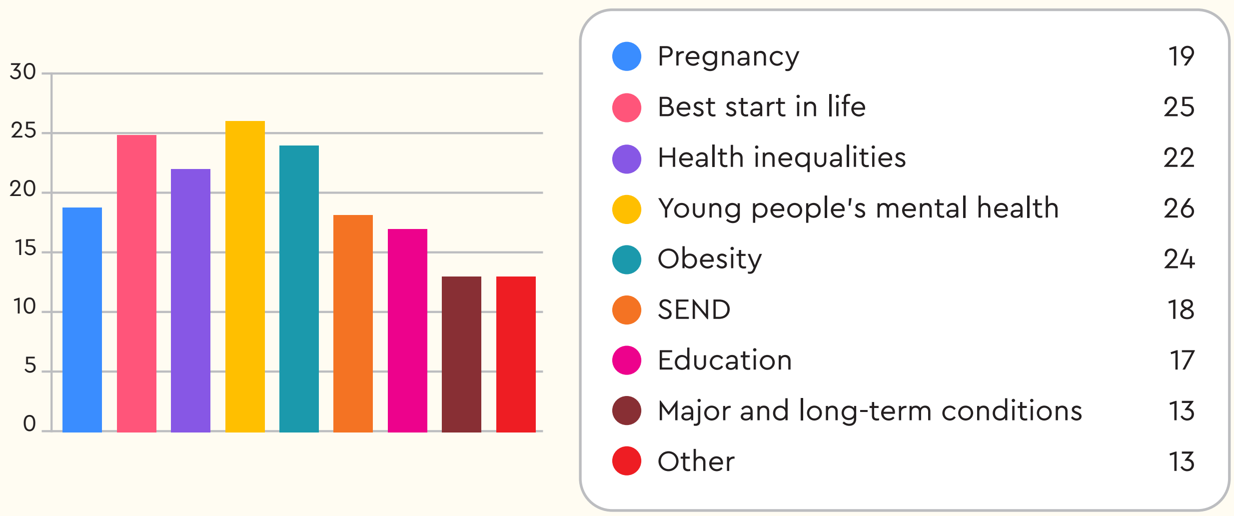
Whilst babies, children and young people being embedded throughout ensures appropriate consideration is given to them at all levels, a summary section would also help ensure that the unique needs of babies, children and young people are given appropriate attention.

Findings

1.3 There were significant differences in the way the needs of babies, children and young people were highlighted, but a majority of strategies and plans prioritised children's mental health, obesity, early years, special educational needs and disabilities (SEND) and inequalities.

Figure 1: Integrated Care Partnership strategies (31 out of 31 respondents)

Priority areas identified by Integrated Care Partnership strategies



Comment

The link between the population data of the local area and the consequential justification for a particular focus in the strategy often seemed lacking. The reason for prioritising a certain area over another was often not articulated. Whilst we observed that there was inclusion of population data that was in a similar theme to resulting priority areas (for example, Child and Adolescent Mental Health Services waiting list times), whether this was the reason for a particular focus was unclear. It would be helpful if future strategies articulated greater rationale for their decision-making process when it comes to prioritising and what factors they are taking into account (for example, patient voice, level of need, impact, cost, solution potential). This would also help clarify whether gaps in data and understanding of population needs contributed to different prioritisation.

Findings

1.4 More than half of strategies did not explicitly reference the needs of babies, children and young people with major and long-term conditions as a specific population health group.

As highlighted in the graph above, major and long-term conditions was the only main category that did not feature in a majority of strategies. We observed that this was also consistent in JFPs with limited examples in comments around babies, children and young people with major and long-term conditions.

Comment

Alongside major and long-term conditions, we believe more attention should be given to the following groups, including how they overlap with each other:

- Children with interactions with children's social care
- Children with care experience
- Neurodivergent children and young people
- Children with life threatening conditions or requiring palliative care
- Young carers
- Children from diverse ethnic and cultural backgrounds
- Children who are persistently absent from school
- Unaccompanied asylum-seekers and refugees
- Children in contact with the youth justice system
- Young people in the LGBTQ+ community

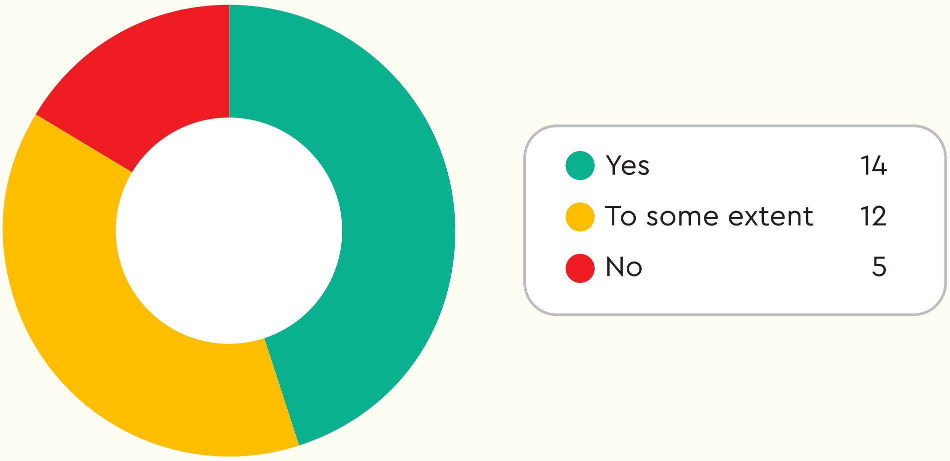
Findings

1.5 Priorities identified in the strategy led to clearly articulated actions in JFPs.

The relationship between the strategy and the JFP seemed positive and many of the JFPs referenced the objectives articulated in the strategy with further detail and next steps. Nevertheless, there was variation, 58% of JFPs directly linked the priorities with actions (35% did to some extent), and 45% of JFPs included immediate actions that would have a positive impact on babies, children and young people (39% did to some extent):

Figure 2: Integrated Care Board joint forward plans (31 out of 31 respondents)

Has the plan highlighted actions that will have a direct positive impact on the current health and wellbeing experience of babies, children and young people?



We observed inconsistency in timeframes, with some JFPs highlighting actions for one year through to five years whilst others made no mention of timeframe.

Comment

There was variation in the types of actions articulated in JFPs. Some JFPs saw the plan as an opportunity to outline new plans for innovation in their services, such as developing a "DadPad" service to support new fathers as part of postnatal care. Whilst others appeared to see the role of the plan to further outline the outcomes they were hoping to achieve, for example increasing the vaccination rate.

Case study:
Speech, language and communication needs

The Royal College of Speech and Language Therapists (RCSLT) carried out an analysis of ICB JFPs to understand how ICBs are considering the speech, language and communication needs (SLCN) and eating, drinking and swallowing difficulties of their populations.

A sample of 13 JFPs were analysed qualitatively, and RCSLT's analysis identified the following findings:

- A third of the JFPs referred to children and young people's SLCN.
    - One JFP considered in detail the needs of their children and young people's SLCN, outlining their operational plan in this area.
- Just one JFP specifically mentioned speech and language therapy – this was not in relation to children and young people.
- Six JFPs considered allied health professionals (AHPs) within their workforce/clinical leadership discussions – again, this was not in relation to children and young people.
- None of the JFPs analysed addressed the eating, drinking and swallowing needs of their populations.

Context

- More than 10% of children and young people have long-term SLCN which create barriers to communication or learning.
    - SLCN is the most common type of special educational need; 344,883 children with SEND in England have SLCN as their primary need, representing nearly a quarter of all pupils with SEND.
- SLCN is a health inequalities issue: in some areas of social deprivation, around 50% of children start school with language difficulties (Law et al, 2011; Locke et al, 2002).
- NHSE data from September 2023 shows 65,057 children waiting to be seen by speech and language therapy; more than 4,000 children had been waiting over a year.
- A recent survey by the RCSLT found an average vacancy rate of 25% in children's speech and language therapy services in England.

About speech and language therapy

- Speech and language therapists are an integral part of the children's workforce, working alongside parents and carers, and with other professionals across education, health and social care, to support children with SLCN, and those with eating, drinking and swallowing difficulties.
- Speech and language therapists also have a key role in enabling universal approaches to supporting speech and language development for all children, and planning targeted interventions for those at increased risk.

Recommendations

For government and arms-length bodies:

- As part of a wider strategy for childhood, DHSC, working with other government departments, should select a small number of child health priorities that all ICSs must explicitly address in strategies and JFPs. This should complement Core20PLUS5.

- DHSC should consider how babies, children and young people with major and long-term conditions should be more clearly considered in updated ICP strategies and ICB JFPs.

For ICSs:

- The rationale for prioritising particular population health areas of focus, including specifically the areas of focus within the children and young people population, should be clearly articulated by ICP strategies, and ICB JFPs should clearly link timebound actions with these to support local understanding of decision making.
  - Where there are gaps in data and knowledge of population need, plans should clearly highlight how they intend to address these gaps.
  - This could benefit from a centrally created audit tool.

2. Leadership in relation to babies, children and young people

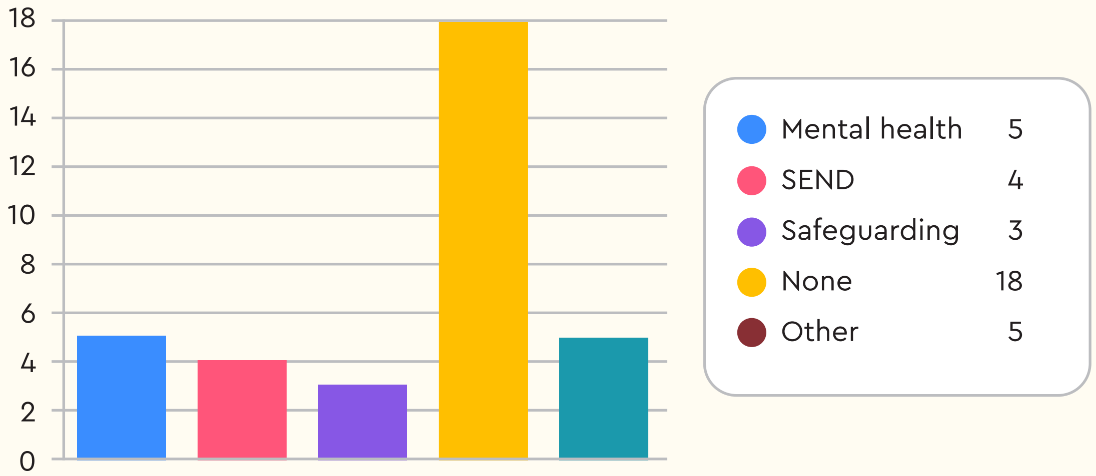
Findings

2.1 Many ICSs did not set out who led their work on babies, children and young people. 57% of JFPs did not clearly identify the Executive Lead for Children and fewer had a named SEND or safeguarding lead.

There was an absence of evidence of strategies highlighting how developing leadership will be embedded within the ICS for babies, children and young people nor evidence of clear roles and responsibilities in relation to babies, children and young people.

Figure 3: Integrated Care Partnership strategies (28 out of 31 respondents)

In which areas has the strategy demonstrated leadership for babies, children and young people?



This translated across to the JFPs where 57% did not identify who the ICB Executive Lead for Children is, 57% did not name a SEND lead and 69% did not name a safeguarding lead (of those that did, 55% did not consider safeguarding in relation to children).

Findings

2.2 Providing clear leadership appeared to be an ambition for many of the strategies and plans but specifics on what that looked like were lacking in general.

We observed that some strategies and JFPs spoke about creating a 'culture of leadership' and a 'community of practice' to help develop leadership, but that clarity around accountability and what leadership looked like at a local and system level for babies, children and young people was often missing. The apparent lack of transparency around who the Executive Leads are and what their roles are focusing on is an illustration of the absence of leadership detail in the strategies and plans.

Other observations include:

- The Executive Chief Nurse often seemed to be taking on the role of Executive Lead for safeguarding, SEND, and babies, children and young people.
- Leadership to support working together was an ambition and there was some suggestion of LAs and children's services being part of the non-executive board.
- Additional strategies, such as learning and autism strategies, may hold further detail around leadership in specific areas such as SEND.

Recommendations

For government and arms-length bodies:

- NHSE should facilitate a national network of ICB Executive Leads for Children with an annual development budget, and be chaired by the National Clinical Director for Children and Young People.

For ICSs:

- The names of ICB Executive Leads for Children, and SEND and safeguarding leads, should be made publicly available, and include a way for members of the public to make contact.
- ICSs should make publicly available an overview of the different roles and responsibilities of individuals within the system and who should be contacted for particular matters.

3. The extent to which co-production took place with children

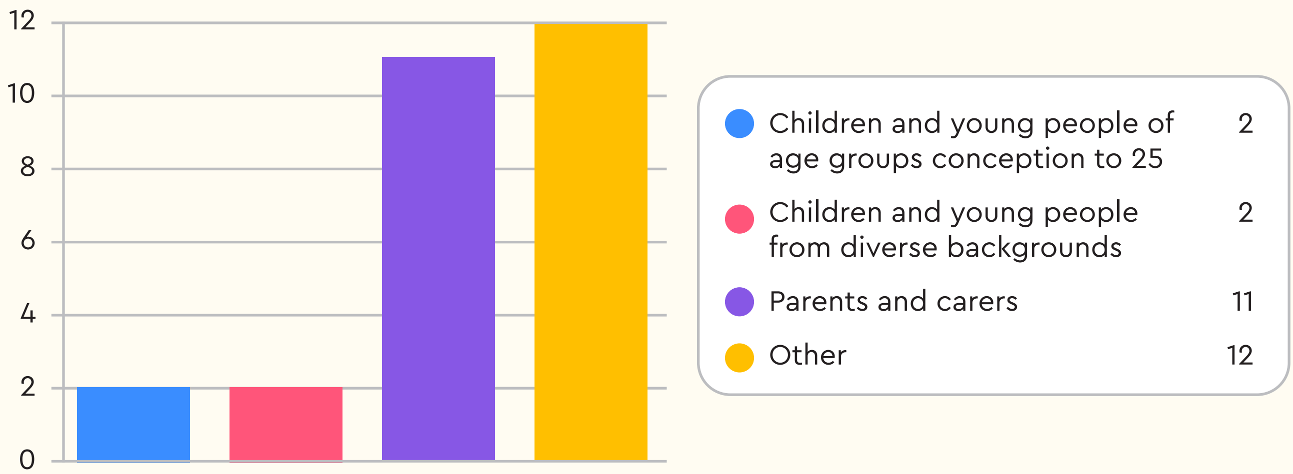
Findings

3.1 52% of strategies highlighted that some engagement took place, but it was more likely that parents and carers were involved than children and young people

A majority of strategies (52%) made reference to good levels of engagement, with a further 29% doing so to some extent. Those strategies that did provide further detail (14 of the 31) consulted significantly more with parents and carers than children and young people from different age groups and diverse backgrounds.

Figure 4: Integrated Care Partnership strategies (14 out of 31 respondents)

Is there evidence of engaging with any of the following groups?

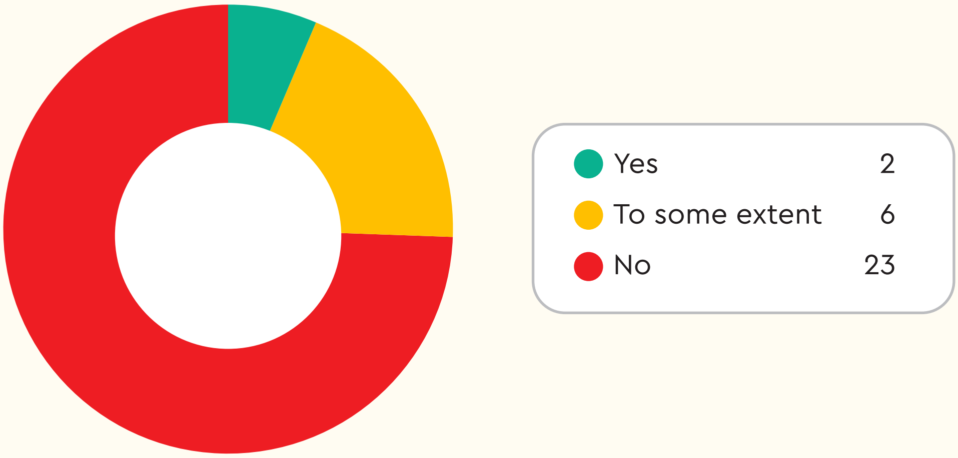


Findings

3.2 Only 6% of strategies and 17% of JFPs highlighted how engagement influenced the strategy and plan.

Figure 5: Integrated Care Partnership strategies (31 out of 31 respondents)

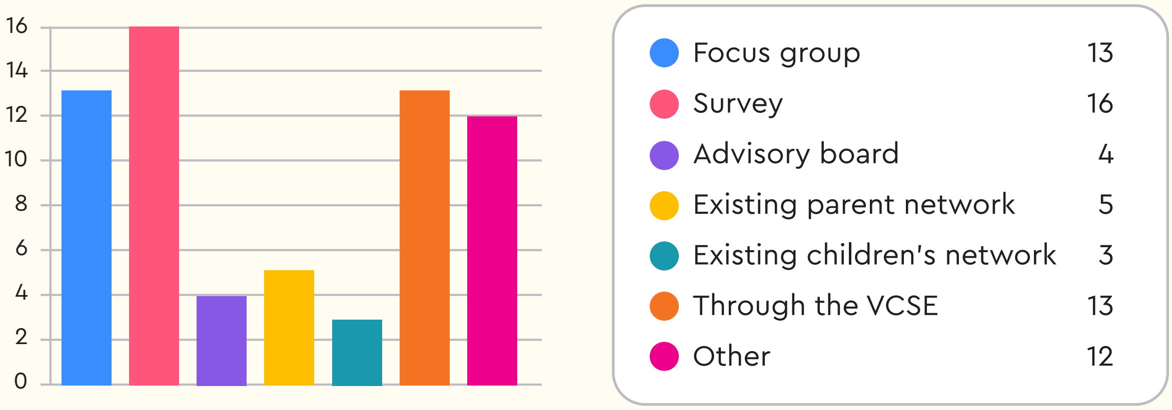
Has the strategy highlighted how the voice of babies, children, young people and families influenced their strategy?



This changed for JFPs where 45% referred to the impact of engagement on their plan to some extent. There was variety in the type of engagement and the voluntary, community and social enterprise (VCSE) sector played a significant role. As shown in the graph below, a majority of strategies utilised a survey as their method of engagement, whilst a significant number also used focus groups and the support of the VCSE sector.

Figure 6: Integrated Care Partnership strategies (25 out of 31 respondents)

What type of engagement does the strategy reference?



Within this graph, 'other' modes of engagement included citizens panels, place-based people panels, multiple stakeholder groups and experts by experience groups.

Comment

We observed that whilst there was 'engagement', it did not lead to 'co-production' of the strategy and plan as children and families did not fully participate in the design and development of them. They may have provided feedback to professionals but, without direct reference to the influence of this and feedback loops, it is hard to say confidently that the strategies and plans were co-produced.

This is highlighted by the fact that evidence for engagement was not immediately obvious, it was not always directly referenced in the strategies or plans and detail on the methodology for engagement and what was learnt was lacking. Some ICPs also published separate 'engagement' strategies which highlighted details about how co-production with communities was organised.

If ICPs listed addressing high numbers of children in social care, improving school readiness or access to mental health as some of their most common strategic priorities for children and young people, then, it is not known if those directly affected by these concerns were able to feedback on the strategies and plans for the ICS.

Findings

3.3 Future plans for engagement were focused on existing parent and children's networks, or establishing representative boards.

There was ambition for greater child focused engagement in the JFPs with 24 JFPs highlighting a desire to engage with children from all-age groups on an equal footing with parents and carers. This engagement also appeared to be on a more long-term basis through the establishment of boards and networks.

Figure 7: Integrated Care Board joint forward plans (24 out of 31 respondents)

Is there evidence of engaging with any of the following groups?

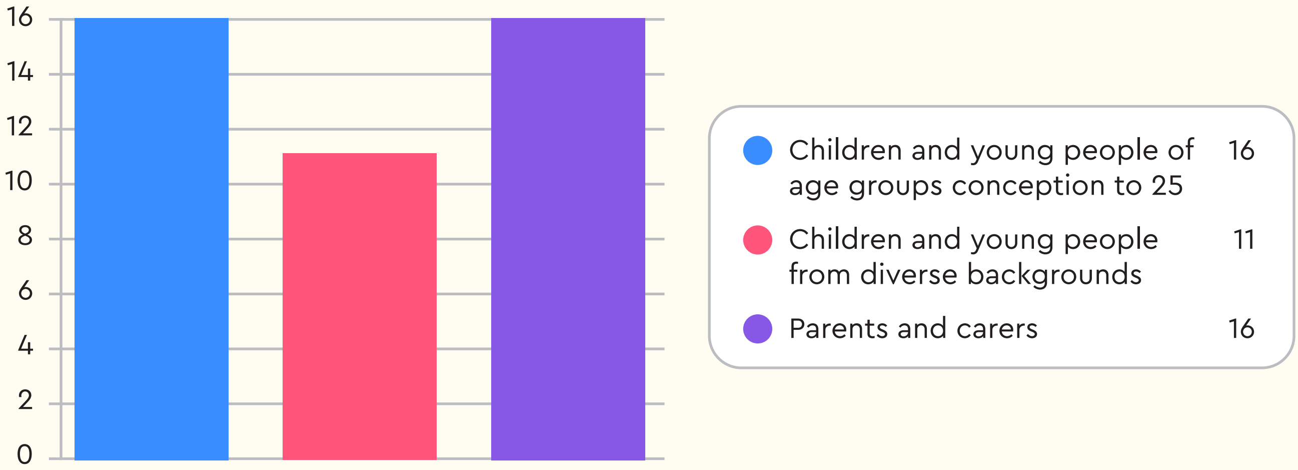
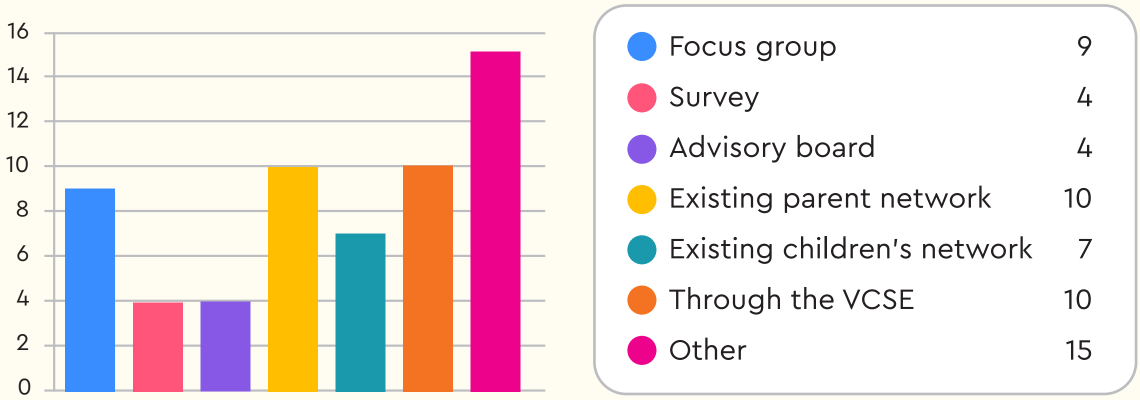


Figure 8: Integrated Care Board joint forward plans (27 out of 31 respondents)

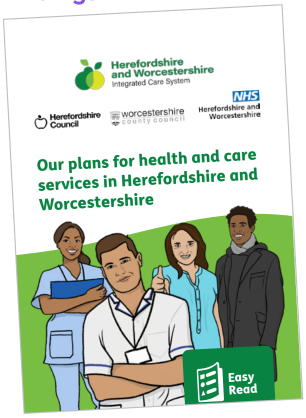
What type of engagement does the plan intend to do in the future?



In this graph options within 'other' included through the LA, expert-by-experience groups, an online library collating feedback, community meetings and existing place-based people panels.

3.4 Only 48% of strategies included an easy read or accessible version.

Findings


Herefordshire and Worcestershire
Integrated Care System

Herefordshire Council
worcestershire county council
NHS Herefordshire and Worcestershire

Our plans for health and care services in Herefordshire and Worcestershire

Easy Read

Herefordshire and Worcestershire's easy to read version of its ICP strategy is a good example of how ICSs can make strategies and plans more accessible. This version provided explanations of complex language and technical jargon, attached relevant links to words which require additional context, and colourful pictures accompanied the text in the strategy. These versions are particularly helpful for children and young people and for those with additional needs.

Case study: Young carers

In the ICS guidance, there is no specific mention of the requirement to consult young carers on the planning and delivery of services for them, which has led to a postcode lottery. Whilst some areas have had strong engagement with young carers, other areas have failed to engage with the young carers in their area meaningfully.

ICBs have a legal duty to consult with young carers across two separate duties. One is within their duty to consult young carers as young people, and the second in their duty to consult carers of all ages in service design and provision. However, despite these two duties, there have been mixed results as to which ICSs have considered the needs of young carers in their strategies and in practice.

One example of where an ICB has worked with young carers is Norfolk and Waveney. The ICB worked closely with the Norfolk Young Carers Forum, run by local carers charity Caring Together, to better understand the needs of young carers. To help achieve this, the Chief Executive of the ICB met with young carers in a dedicated roundtable at a location the young people chose – a local burger restaurant. On the back of this, the ICB then had a specific focus on young carers at its launch event and funded carer awareness work to improve awareness of young carers across the ICS and ensure they were included within other ICS activity.

Recommendations

For government and arms-length bodies:

- Updated ICS guidance should strengthen expectations on strategies providing details on how engagement took place, who was consulted, and what was changed as a result.
- Networks of Executive Leads could be used to share good practice and identify areas of challenge within co-production where further central NHSE support would be beneficial.

For ICSs:

- ICSs should adopt an inclusive and intersectional approach to co-production and co-design in both plans and strategies, with a particular focus on those population groups facing health inequalities.
  - ICSs should acknowledge the importance of engaging with children and young people themselves, as well as with parents and carers and put this into practice.
- ICSs should clearly differentiate where they have a) involved parents and carers and b) where they have involved children.
- All strategies and JFPs should have an easy read or accessible version.

4. The children's workforce

Findings

4.1 The majority (61%) of strategies did not consider the ICS's current children's workforce capacity. JFPs took greater steps to carry out a risk analysis with 63% considering the impact of workforce constraints on its plans to some extent.

Figure 9: Integrated Care Partnership strategies (31 out of 31 respondents)

Has the strategy considered the capacity of its current workforce to meet the demands and needs of babies, children and young people?

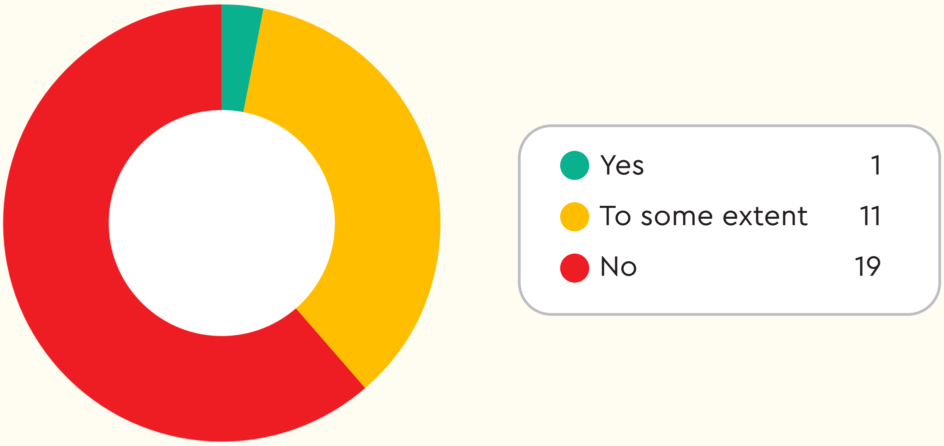
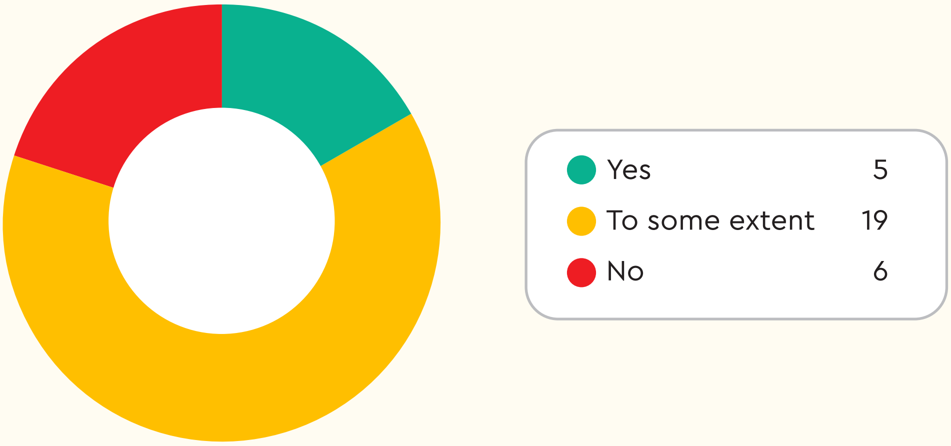


Figure 10: Integrated Care Board joint forward plans (30 out of 31 respondents)

Has the plan carried out a risk analysis for its ability to carry forward its plans in light of workforce constraints?



Workforce constraints included wider pressures on the workforce as well as the specific constraints facing the children's workforce.

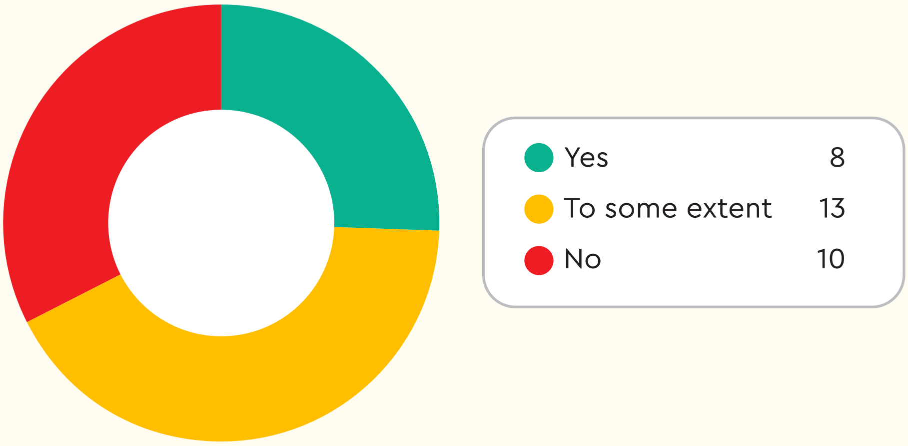
Findings

4.2 There was general recognition of the need to address workforce challenges within a particular geographical footprint but there was a lack of focus on specific practitioners, especially within the children's workforce.

Workforce was largely considered by ICSs as an area for development, however, a lack of clear, strategic priorities to improve workforce capacity was observed. 32% of ICP strategies had not considered how they will meet context specific workforce needs in a particular geographical area.

Figure 11: Integrated Care Partnership strategies (31 out of 31 respondents)

Has the strategy considered how it will meet context specific workforce needs in a particular geographical area?



Comment

Strategies and plans acknowledged the challenges facing the workforce, both in terms of capacity of the services but also in terms of workload pressures and burnout for the current workforce. Strategies and plans often considered the workforce as a whole, raising concerns about the extent to which practitioners solely serving babies, children and young people's health will be prioritised. This reflects the absence of a specific children's health workforce section in the NHS Long Term Workforce Plan.

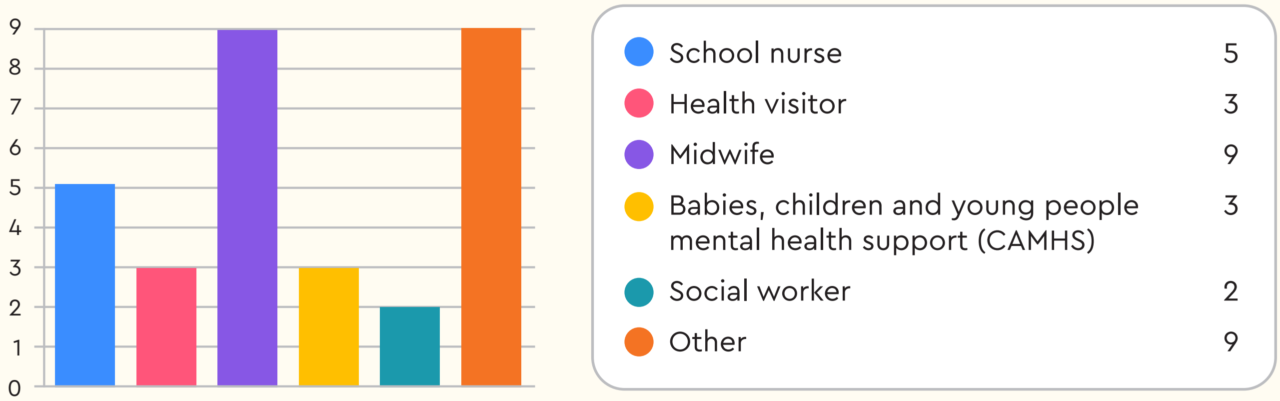
Findings

4.3 77% of strategies and 45% of JFPs did not identify specific practitioners. When plans were mentioned, there was a focus on school nursing and midwives.

In the graph below, midwives and school nurses were the two most mentioned practitioners, with nine strategies mentioning midwives and five mentioning school nursing.

Figure 12: Integrated Care Board joint forward plans (15 out of 31 respondents)

Where strategies for specific practitioners and workforce are mentioned, which practitioners are included?



Within the 'other' category, plans mentioned GPs, the maternity and neonatal workforce and the immunisation workforce.

Comment

The lack of responses on the questions above also highlights the difficulties faced by HPIG members in identifying specific workforce information in strategies and plans.

Findings

4.4 Some strategies mentioned alternative 'Workforce' or 'People' strategies where more detail may be found.

We observed that within the comments on workforce, HPIG members highlighted some other form of strategy for workforce across 16 strategies and plans as part of a 'workforce development plan'.

Examples include:

- Establishing an ICS Academy to discuss workforce needs.
- A five-year maternity and neonatal strategy.
- A health and care workforce strategy that supports integration and collaboration.

It is worth noting that these were not necessarily children specific workforce strategies, but that greater attention may be given to the children's workforce within them. Especially as there was some acknowledgement across strategies and plans of the particular challenges that face the children's workforce and the impact that low workforce capacity has on babies, children and young people and their families.

Findings

4.5 When workforce was mentioned, inclusivity and creating a culturally sensitive workforce were highlighted.

We observed that some plans acknowledged the value of developing an inclusive workforce both as part of recruitment plans but also to support with retention. The positive impact on care offered by a diverse workforce was highlighted. When training plans were detailed, there was some focus on culture sensitivity. For example, midwife training on implicit racial bias when caring for mothers and babies.

Comment

A lack of an inclusive and/or trauma-informed workforce were also sometimes highlighted as challenges facing the workforce. However, there was scarce mention of trauma-informed training to overcome this challenge.

Recommendations

For government and arms-length bodies:

- DHSC should set expectations for how ICP strategies and ICB JFPs make reference to and evidence local work that aligns with national plans such as the NHS Long Term Workforce Plan.
  - This should include measurable targets for the extent to which ICSs are implementing 'one workforce' actions.
- DHSC and the Department for Education (DfE) should develop a children's workforce strategy that supports ICSs in their understanding of workforce developments across health, children's social care and education.
  - This strategy should appoint a national lead or advisory group to support and oversee child health workforce planning and development.

For ICSs:

- ICSs should continue to prioritise the development of a diverse, inclusive, and representative workforce to enable nuanced approaches in health and care, build reflexivity and connect with local communities.
- Strategies and plans should consider the children's workforce in the widest sense as part of their risk analysis for plans, including the workforce of other children's services (such as children's social care, education, youth justice) and workload pressures across the system.
- ICB JFPs should explicitly consider the children's health workforce required to meet the needs of babies, children and young people in their area when considering workforce capacity across the population.

5. Data and information sharing across children's health, care and education services

Findings

5.1 A majority of strategies drew on education (55%) and children's social care data (61%) to inform their strategy development to some extent. Where it was used, education or social care data did inform decisions about prioritisation.

Education data was fully used by 10% of strategies and by 45% to some extent. Social care data was fully used by 13% of strategies and by 48% to some extent.

Comment

We observed that this data was often part of how the strategy outlined the demographic context of its population and represented areas where interventions could lead to improved outcomes. For example, data around school readiness and number of children in care were often referenced as measurable outcomes they hoped to improve. We observed that this could then lead to an increased focus on bringing them in line with national standards.

Findings

5.2 There was a general recognition of the importance of information sharing between agencies and the use of technology to support this, but there was little detail of the specific information sharing challenges faced by service providers for babies, children and young people.

Some strategies acknowledged that challenges in service delivery were created by poor information sharing between service providers, but any focus on improving information sharing was usually focused on improving information sharing between health services rather than all partners within the ICS. This is of particular importance for babies, children and young people who benefit most significantly from multi-agency work.

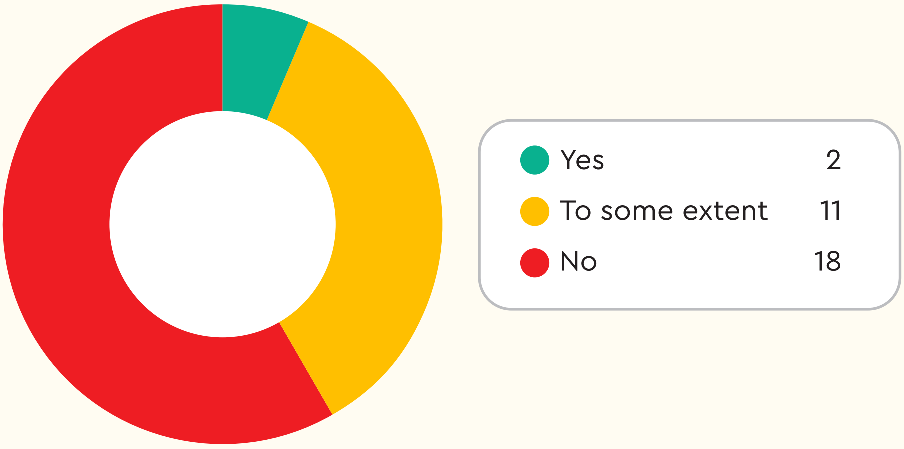
Details on what improved information sharing would look like in practice and how it would be facilitated were lacking, although improving connected digital technologies was seen as an enabler for information sharing.

Findings

5.3 Only 6% of JFPs specifically looked to address the challenges around data and information sharing for babies, children and young people (with 35% doing so to some extent).

Figure 13: Integrated Care Board joint forward plans (31 out of 31 respondents)

Does the plan specifically look to address the challenges around data and information sharing for babies, children and young people?



Comment

We observed this also extended to safeguarding and there was scarce mention of the importance of information sharing for safeguarding purposes.

Findings

5.4 Developing better data sources and feedback loops to support with targeting health interventions and reducing health inequalities were seen as important for ICBs in their 'population health management'. What this meant for children's health was often not included.

20% of JFPs, with 43% doing so to some extent, considered utilising data as part of their planning for the future.

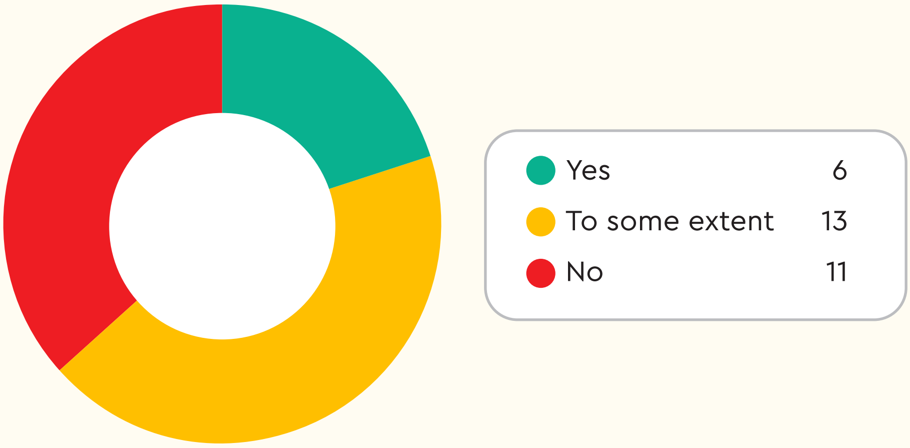
We observed that this appeared to come in the form of understanding population needs better through 'population health management' and utilising 'linked data sets' to support with personalisation of care and targeting interventions to reduce inequalities. Feedback from local people was also mentioned and the value of using data to communicate with the local community and provide updates on the work of the ICS were highlighted.

Figure 14: Integrated Care Board joint forward plans (30 out of 31 respondents)

Does the plan consider how it will develop feedbackback loops to utilise evidence to ensure it is learning for its future plans?

Feedback loops = the extent to which the ICB intends to utilise data and outcomes, plus feedback on its current plan to inform the drafting of its future updated plan.

For this question, please add a comment if children and young people are **not** mentioned in wider plans for data and information sharing.



We observed that there was a lack of mention of babies, children and young people within feedback loop plans.

Recommendations

For government and arms-length bodies:

- The government should make a firm commitment to a consistent child identifier (CCI) that will allow ICSs to consider how they may start to implement the infrastructure necessary for a CCI and greater interoperability within their future ICB JFPs.
- NHSE should set specific health and wellbeing outcome metrics for children and young people that ICSs must collect data on, this should align with the Healthcare Inequalities Improvement Dashboard.

For ICSs:

- ICSs should develop a tailored local outcomes dashboard that reflects national expectations for outcome metrics and supports local population understanding for how future strategies and plans build on from previous work.
    - This could align with the children's social care outcomes dashboard.
- Expectations for information sharing between children's services and how barriers will be overcome should be clearly outlined within strategies and plans and aligned with DHSC guidance, such as Information sharing advice for safeguarding practitioners - GOV.UK (www.gov.uk).
    - This should also include a focus on when children and young people transition between children's, teenage and young adult, and adult services.

6. Integration across children's health, care and education services

Findings

6.1 Very few ICP strategies fully articulated the role of LA children's services or education settings.

Strategies made limited reference to how they would engage with children's social services or education settings, with 42% doing so to some extent with regard to LA children's services and 32% doing so to some extent with regard to education.

Figure 15: Integrated Care Partnership strategies (31 out of 31 respondents)

Does the strategy make reference to how it will engage local authority children's services?

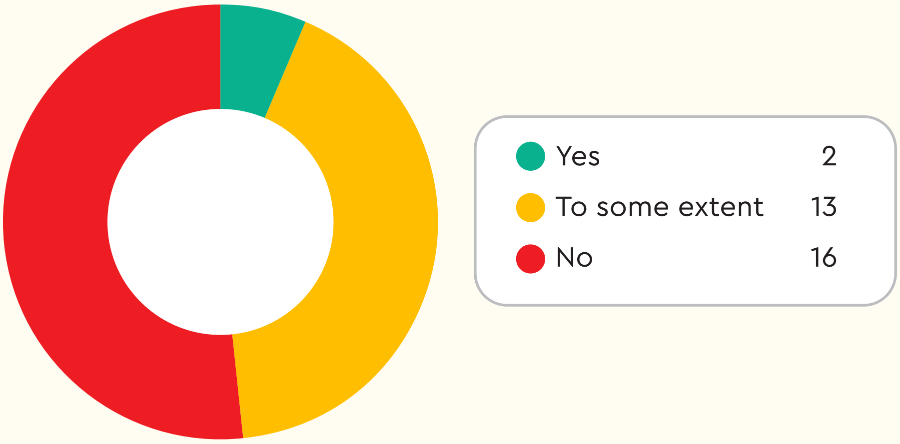
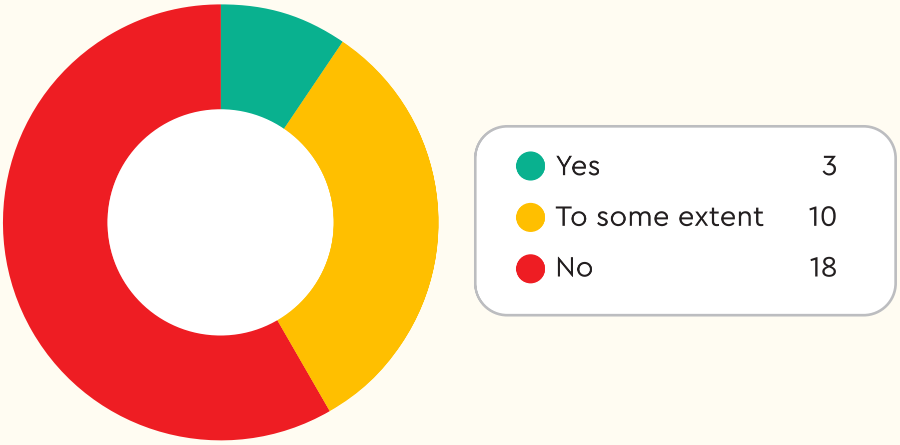


Figure 16: Integrated Care Partnership strategies (31 out of 31 respondents)

Does the strategy make reference to how it will engage with education (early education, schools, colleges)?



Comment

This is not to say that there was no recognition of the need for greater coordination and integration, in particular with relation to those in the population with complex needs. These findings suggest that whilst strategies recognised the importance of partners, in particular education and social care, how they intend to ensure they are active and valued members of the ICP was not clear. It appeared to be that ICPs were utilising education and social care data to understand their local population and inform their work, including acknowledgement of the wider determinants of health and the impact that these had on health outcomes. However, planning for joint working and integration at a practice level appeared to be lacking.

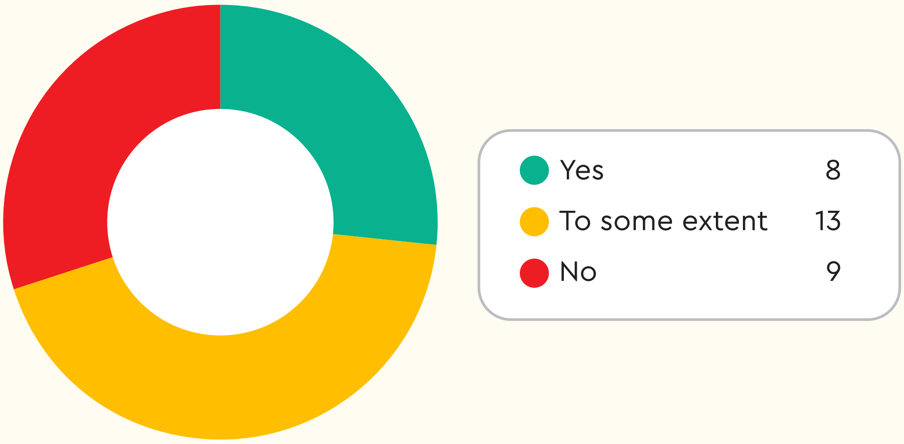
Findings

6.2 There was some evidence of ambition for new infrastructure and teams to support with multi-agency work, but on the whole, this was not a significant part of how ICSs looked to promote integration.

48% of strategies made no reference to new infrastructure or teams. However, JFPs made more concrete commitments towards new infrastructure or teams to enable integration, with 27% highlighting actionable steps and 43% doing so to some extent.

Figure 17: Integrated Care Board joint forward plans (30 out of 31 respondents)

Does the plan make concrete and actionable steps towards new infrastructure or teams that enable integration?



Joined-up working was also a focus for JFPs with 70% of JFPs considering a joined-up approach to their actions to some extent.

Examples of joined-up working and the creation of new infrastructure include:

- Developing asthma friendly schools.
- Mentally healthy schools.

Findings

6.3 The VCSE sector was considered a key partner within many strategies and plans.

We observed that the VCSE sector were mentioned as key partners for developing 'thriving communities'.

Comment

The integration of the VCSE sector into plans appeared to stem from an acknowledgment of the value of multiple partners supporting those with complex needs, especially with transitions between services.
It also represented an increased focus on social prescribing.

Recommendations

For government and arms-length bodies:

- The Better Care Fund, which provides support to ICSs and LAs to pool budgets and further integrate their health and care provision, should have an additional explicit focus on integration for children.
- Good practice for multi-agency working should be highlighted and shared across systems.

For ICSs:

- When they next update their ICP strategies and ICB JFPs, ICSs should review the extent to which integration across all children's services, including education settings, could be strengthened at different geographical levels.
    - This should include evidence of engagement with the full range of statutory agencies with responsibility for children and young people as part of the development of the ICP strategies and ICB JFPs.
    - This could also include reference to where section 75 joint commissioning agreements would be valuable.

7. Inequalities and babies, children and young people

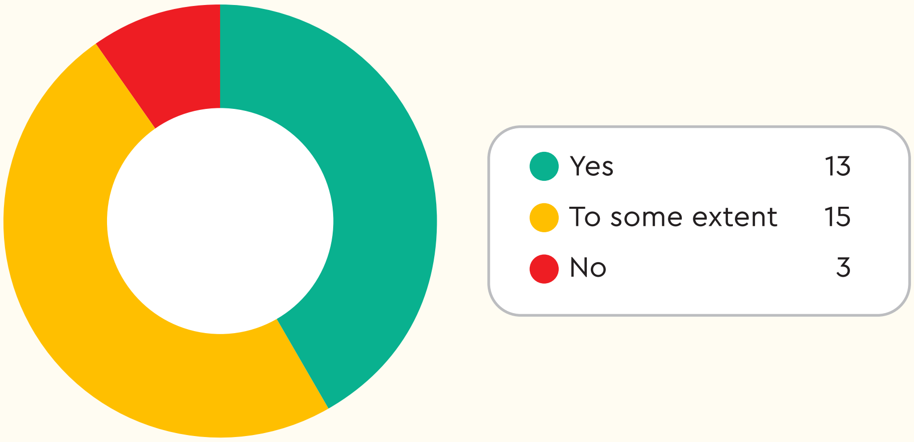
Findings

7.1 Addressing inequalities within the population was a significant theme for strategies and JFPs, and this often extended to babies, children and young people with 42% of JFPs focusing on inequalities for children as a priority (with 48% doing so to some extent).

Recognising and setting objectives to address inequalities within the population was a significant part of most strategies as they utilized local population data from Joint Strategic Needs Assessments and Health and Wellbeing Boards to identify areas of need. Economic inequality and the gap in life expectancy between the poorest and wealthiest in their ICS were indicators that were often highlighted. Children were recognised as being impacted by inequalities as well with 35% of strategies identifying inequalities in childhood specifically (and 39% doing so to some extent):

Figure 18: Integrated Care Board joint forward plans (31 out of 31 respondents)

Does the plan focus on specific inequalities in relation to babies, children and young people as a priority?



The link between local population data and the need therefore to address inequalities as a priority appeared to be a common approach taken by strategies. As such, there was also recognition that gaps in data and information had an impact on the ability to prioritise effectively and that this was an area for improvement.

Comment

It may be that supporting ICPs to collect better data on babies, children and young people would enhance their ability to recognize and therefore respond to inequalities within children as a population group. Co-production and effective engagement with children would also support this endeavour.

Findings

7.2 Specific groups of children were focused on as a priority, with close to 50% of strategies highlighting vulnerabilities for children with SEND and children looked after. However, this did not translate to JFPs with SEND remaining the sole group that a majority of plans looked at.

35% of strategies identified specific groups of children who were most likely to experience negative outcomes, with a further 45% of strategies doing so to some extent. However, the groups that were identified were different for strategies compared to plans:

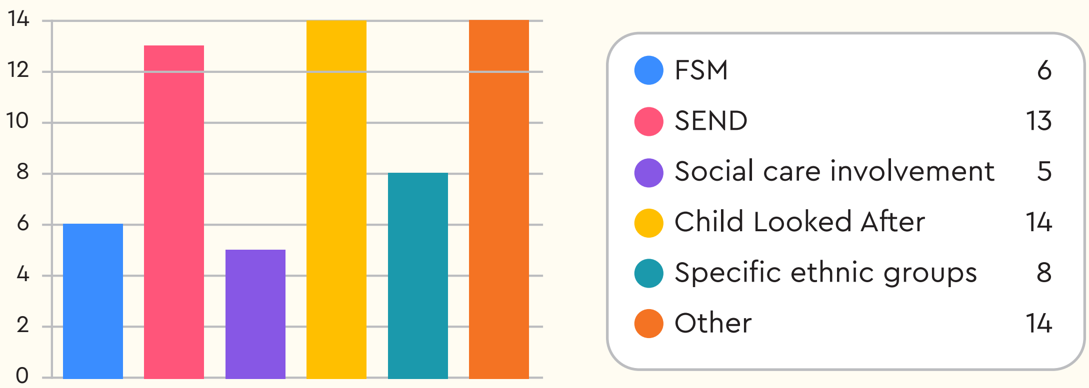


Figure 19: Integrated Care Partnership strategies (26 out of 31 respondents)

Which groups of young people are identified?

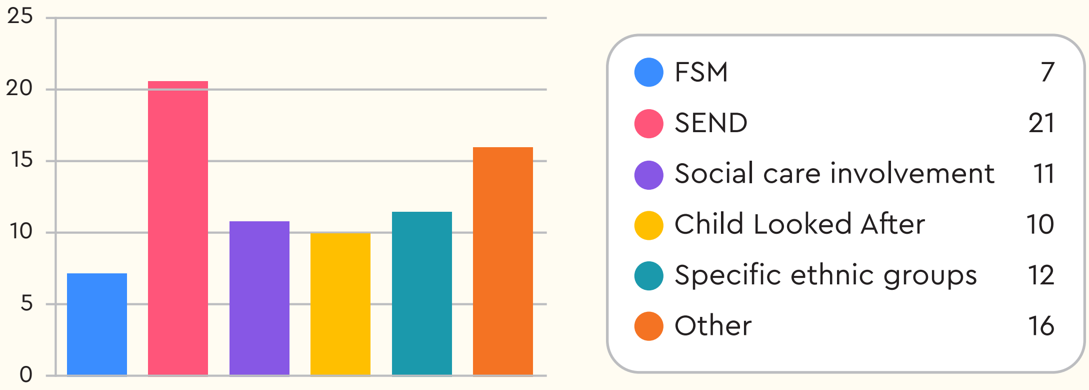


Figure 20: Integrated Care Board joint forward plans (29 out of 31 respondents)

Strategies most commonly identified children looked after (CLA) as the group that experience significant inequalities, followed closely by children with SEND. However, this was not consistent for plans and the number that identified CLA as a population group for interventions reduced from 14 ICSs to 10 ICSs whereas the number focusing on interventions for SEND increased from 13 to 21.

Notably, whilst economic inequality tended to feature heavily in strategies this did not necessarily translate to a greater focus on child poverty and children on free school meals (FSM). With only six strategies and seven JFPs picking out this group of children as a priority group with vulnerabilities. Inequalities experienced due to race and ethnicity were also a focus, although comments in our survey highlighted a lack of additional detail around which ethnicities (beyond the acronym BAME) experienced particular inequalities in their local area.

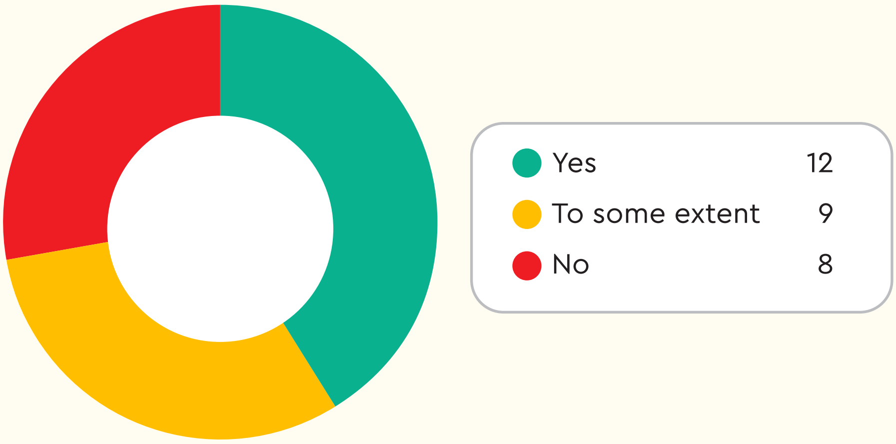
Groups that were identified within the 'other' category of the graph reflected significant diversity, with the following groups highlighted as being vulnerable or experiencing worse health outcomes:

- Care leavers;
- Children living in poverty;
- Young carers;
- Young people involved in the justice system;
- Long-term physical health problems;
- People from socially excluded groups (homeless, vulnerable migrants, gypsies and travellers, sex workers);
- LGBTQ+;
- Birthweight and early birth;
- Refugees and migrants;
- And those with adverse childhood experiences.

Many of the strategies (10% fully and 42% to some extent) and JFPs (41% fully and 31% to some extent) that highlighted inequalities experienced by children went on to set some targets to addressing these to improve health outcomes.

Figure 21: Integrated Care Board joint forward plans (29 out of 31 respondents)

Does the plan set specific targets for addressing inequalities to improve health outcomes?



Comment

We observed that targets that were set tended to focus on improving availability of mental health services and early years services, and to see improvement in reducing variation in school readiness. It may be that the health system does not see itself as fully responsible for responding to the needs of children in the care system, hence the drop off in actions within the JFP. This is an area that would benefit from further exploration.

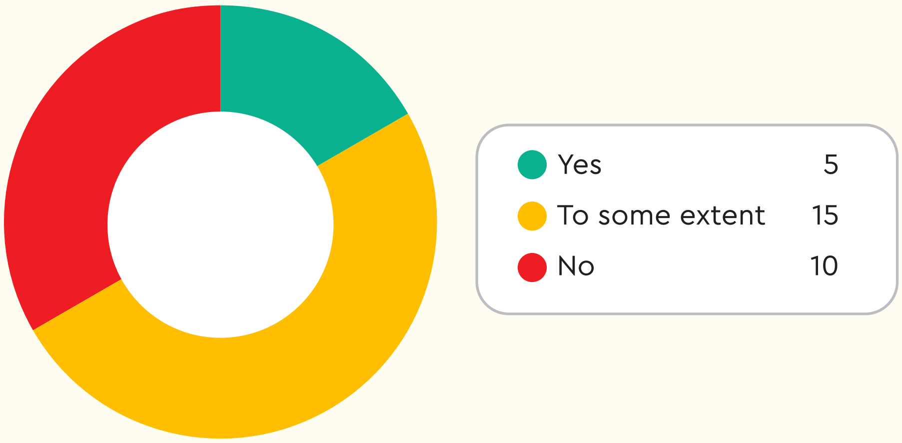
Findings

7.3 Most JFPs did not look to address specific barriers to accessing services nor did they take an intersectional approach to addressing inequalities.

We observed a lack of detailed exploration into some of the contributing factors to inequalities in health outcomes, such as the barriers that people may face due to a vulnerability or their identity impacting their ability to access services. 33% of JFPs did not explore this in any capacity.

Figure 22: Integrated Care Board joint forward plans (30 out of 31 respondents)

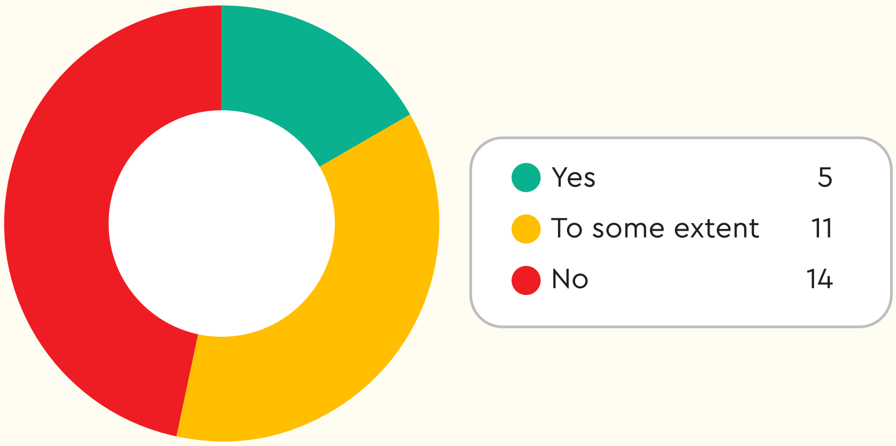
Does the plan propose approaches to tackle health inequalities as a barrier to accessing health services? For example, disability, digital divide, linguistic or cultural barriers could hinder a young person's access to their local services.



And 47% did not utilise an intersectional approach when considering health inequalities.

Figure 23: Integrated Care Board joint forward plans (30 out of 31 respondents)

Does the plan use an intersectional approach in analysing health inequalities and their impact on health outcomes?



Comment

We observed that those that did take an intersectional approach and thought about barriers to accessing services, in particular for children and young people (often seemingly as a result of consultations with them) highlighted actions such as supporting young people to travel independently (especially in rural areas) and to ensure that services interacting with children looked after were trauma-informed.

7.4 Core20PLUS5 was mentioned in eight strategies and JFPs.

Findings

We asked HPIG members to look out for whether Core20PLUS5 was mentioned in strategies and plans. It was explicitly mentioned in eight strategies and JFPs however, it is possible that other strategies and JFPs were influenced by the approach without directly referencing it.

Whilst this is not a significant percentage of plans, it appears to highlight the value of guidance in an area that may be complex.

The Barnado's Children and Young People's Health Equity Collaborative was also mentioned, and you can find further information on this in the case study below.

Case study:
Understanding health inequality through the Child Health Equity Collaborative

The Child Health Equity Collaborative (CHEC) is an ongoing 3-year partnership between Barnardo's, the Institute of Health Equity and three ICSs. Drawing across a wide range of expertise, they are developing a framework that reconsiders how health inequalities in children and young people can be better identified and measured at a local level. Once developed, the framework will guide unique interventions in each ICS, tailored to tackle the drivers of health inequalities in children within the local context.

A critical partner in the Collaborative are children and young people themselves. A core group of 'Child Health Equity Champions' will be involved in the design, delivery and evaluation of the framework and interventions that ICSs put in place.

During the development of the project's health inequalities framework, the team conducted workshops with over 300 children and young people, exploring what a healthy place to live in means to them. The feedback from these sessions highlighted the importance of safety, relationships and community to children and young people's health.

Partnership working

The Child Health Equity Collaborative moves beyond traditional provider-commissioner-advisor relationships, bringing together a wide range of voices including those of the VCSE sector, LA, public health, academia, private sector, and children and young people. This has promoted reflection and challenge for all partners regarding their approach to children and young people, in particular when system decision-makers have been engaged in conversations. Though early in the project, ICSs are changing practice as a result:

- In one of the ICSs, presentations on the Collaborative's work promoted discussion and a reassessment of the metrics used to determine the 'social value' scoring of tender proposals to better address health inequalities.

- Results from this wider engagement include one ICS partner allocating system spending to child oral-health projects and another ICS allocating additional resources for SEND: clear indications of the embedding of child health as a system-wide priority.

While valuable, collaboration at times has proved tricky, especially when navigating the different time and geographic scales of partners. What has been central to mitigating these differences has been hearing directly from children and young people who have acted as indispensable partners, finding common ground for all.

Better using data to address the needs of children and young people
Data has been key to the collaboratives work. In the development of the health equity framework, the team are bringing together a wide range of data sets to create a holistic view of the drivers of children and young people's health. In addition, the voices of children and young people have been crucial to ensuring that the framework better reflects children and young people's priorities for their own health and wellbeing:

- Recurring themes from children and young people included the importance of a sense of love, mattering, belonging and safety in their environments, including home, school and the community.

NHS and wider system-partner datasets often overlook such person-centred, relational metrics of what makes a community and child healthy: what matters to children and young people is not always what we measure. This suggests there is a need to reconsider what data is collected to adequately understand, and improve, lived experiences of health for children and young people. The framework developed as part of the collaborative will provide the foundations for this.

Key transferrable learning from the project to date: improving outcomes for children's health requires understanding, engaging and acting on the voice of children.

Recommendations

For government and arms-length bodies:

- DHSC should publish an annual report on health inequalities among babies, children and young people, summarising existing sources and identifying gaps.

For ICSs:

- Future strategies and plans should consider adopting the Child Health Integrated Learning and Delivery System (CHILDS) framework to support with targeted early intervention and integrated biopsychosocial care to children with major and long-term conditions and everyday child health problems.

What does good look like in strategies and plans?

What are we looking for?

We looked for evidence of good approaches to ICP strategies and ICB JFPs in relation to our seven themes – population health, leadership, co-production, workforce, integration, data and information, and health inequalities.

We asked HPIG members to consider the following questions when highlighting good practice:

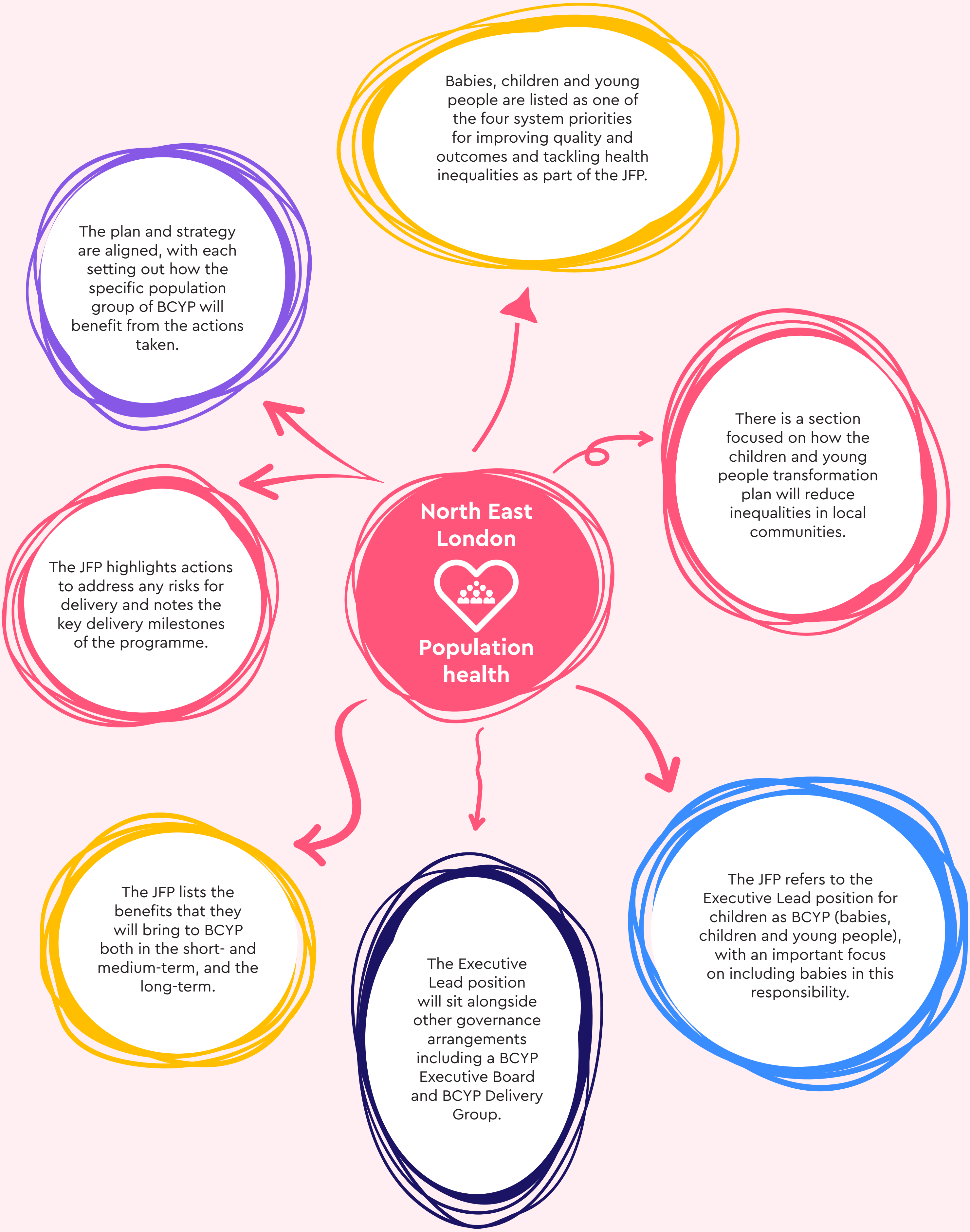
- What makes you believe 'X' theme is considered well by your strategy and plan? Some things to consider:
    - Inclusion
    - Clarity and simplicity
    - Thoroughness
    - Focus
    - Interconnectedness with other areas of work
- Are babies, children and young people considered as a whole population group within the theme?
- How much attention are babies, children and young people given in relation to this theme?
- Are specific and unique needs of certain groups of young people considered within the theme?

What did we find?

We identified some plans and strategies that clearly set out how ICSs proposed to take action to improve children and young people's health in line with our seven themes. These examples included a greater level of evidence and proposals that answered the key questions underpinning our methodology.

As a caveat, please note that our list is not exhaustive, and our analysis may not include examples of good approaches that exist in ICSs but are not mentioned in their integrated care strategies or their JFPs.

It is also important to remember that a good strategy and plan does not necessarily mean an ICS is delivering a good service to its population. The relationship between the strategy, plan and service delivery will be a crucial next stage of analysis.



North East London

Population health

Babies, children and young people are listed as one of the four system priorities for improving quality and outcomes and tackling health inequalities as part of the JFP.

There is a section focused on how the children and young people transformation plan will reduce inequalities in local communities.

The JFP refers to the Executive Lead position for children as BCYP (babies, children and young people), with an important focus on including babies in this responsibility.

The Executive Lead position will sit alongside other governance arrangements including a BCYP Executive Board and BCYP Delivery Group.

The JFP lists the benefits that they will bring to BCYP both in the short- and medium-term, and the long-term.

The JFP highlights actions to address any risks for delivery and notes the key delivery milestones of the programme.

The plan and strategy are aligned, with each setting out how the specific population group of BCYP will benefit from the actions taken.

Cambridgeshire and Peterborough

Leadership

The strategy goes beyond listing the statutory safeguarding duties that the ICS has, highlighting areas of working that they have, or will undertake to improve their safeguarding function.

The strategy outlines that reporting for safeguarding has been standardised with agreed metrics.

They will create a dashboard for visibility on where things are going well and what areas need further development.

They commit to standardising policies, training, and the audit process.

Recognising the important role of sharing knowledge and learning, the strategy explains the function of a new Head of Safeguarding meeting across the NHS trusts.

The ICS has prioritised career pathways into safeguarding roles through the creation of a Safeguarding Support Officer Apprenticeship within the ICB, the first in the country.

Mid and South Essex

Health inequalities

There is a named senior responsible owner and clinical need for meeting the ICS ambition in relation to health inequality.

The JFP includes provision of a health inequalities impact assessment in all programmes. It commits to continued engagement with communities to understand their experiences of inequality and to engaging them in meaningful coproduction.

The strategy considers health inequalities both across the population and specifically for babies, children, and young people, primarily within the context of NHS Core20PLUS5.

The strategy refers to 'We' statements and 'I' statements. 'We' statements refer to what the ICS will do as a collaborative to address health inequalities and 'I' statements refer to what individuals can expect to see from the ICS in terms of progress against its goals.

Health inequalities have a specific chapter in the strategy and JFP, supported by the promise of investment.

There is clear accountability with the strategy stating specifically what partners within the ICS and individuals in Mid and South Sussex can expect from the ICS.

The strategy discusses the need to collect a wide range of data regarding children and young people and the different datasets to use compared to adults. For example, it states that measuring health inequalities in children and young people will require the Index of Multiple Deprivation as well as wider sources including the child mortality platform and Fingertips dashboard.

In the JFP, there is a short analysis of possible barriers to improvement in inequalities, including workforce pressures.

The strategy and plan identify lack of quality data as a potential barrier and the plan sets targets with dates attached for improving data across the ICS.

The strategy and plan specifically note intersectionality in health inequalities with the plan identifying geographical areas and specific at-risk communities within the ICS that experience inequalities.

In identifying PLUS groups as part of Core20PLUS5, the strategy lists potential target populations including ethnic minority communities, people with a learning disability and autism, coastal communities and pockets of deprivation, people with multimorbidity and protected characteristics. It also specifically considers possible groups of children and young people including young carers, children in and leaving care, and those in contact with the criminal justice system. The strategy also suggests a focus on children and young people in families experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, victims of modern slavery, and other socially excluded groups.

Area for improvement:

The ICS could do more to develop its position in relation to babies and early years and to acknowledge the role of early intervention in reducing health inequalities.

Birmingham and Solihull

Co-production

The strategy has direct quotes from children and young people as well as parents and carers which highlight their challenges with the system.

An engagement report includes feedback from engagement with the community and other stakeholders.

The Birmingham Voluntary Service Council was commissioned by the ICS to undertake engagement work. Citizens, partner organisations and frontline professionals from across Birmingham and Solihull were consulted.

Engagement leads were provided with necessary information (PowerPoint presentation, online surveys, FAQs) to support engagement work.

The ICP commissioned a video explaining what an ICS is and the purpose of the 10-year strategy in six different languages (English, Urdu, Punjabi, Bengali, Polish and Pahari).

Their engagements report identifies gaps or areas of concern through engagement and co-production. It further highlights how such engagement helps in developing measurable goals for improving services. For example, one of the concerns was the strategy's lack of focus on children and young people. As a result, measurable metrics for children and young people are identified, including reducing children on child protection plans, improving vaccination uptake for children in care, or even reducing hospital admissions caused by injuries and asthma in <16s.

The demographic of survey respondents was clearly highlighted in the engagement report and both qualitative and quantitative feedback was included to produce measurable outcomes as goals for the ICS.

Both online and in-person events were held, with the online content produced in six languages.

The engagement report highlights how the voices of communities were included in developing the strategy.

Case study: Joint working

The North East and North Cumbria ICP strategy has a focus on enabling people with a learning disability to have better access to physical health care.

"I have been involved with North Tyneside place to improve young people's uptake of their annual health check with their GP (target is at least 75% of people with a learning disability). There have been monthly network meetings over the last two years led by the ICB, involving health partners and local authority partners which has really encouraged joined-up working. The special school nursing team has worked with the LA SEND participation team to involve and consult with young people about what adjustments need to be in place to encourage them to attend this appointment at their GP practice. This has fed into training for GP practices and resources for young people to raise their awareness."

Feedback from Team Lead of Special School Nursing Service

Some further specific ICS-led initiatives as examples of good approaches

Birmingham and Solihull's JFP emphasises the culturally appropriate prevention of diabetes, signifying an intersectional approach to health and care.

Frimley's JFP considers health inequalities in relation to each of its other themes and sets specific action-oriented goals under every theme.

Herefordshire and Worcestershire highlights strategic objectives to facilitate data and information sharing. It also identifies areas where national data is poor including child obesity, infant mortality, pregnancy, and emotional needs of pupils in primary and secondary schools.

Coventry and Warwickshire's JFP mentions concerns around complex pregnancies.

South Yorkshire commits to the development of a care model and funding model for children's palliative care and end-of-life care to meet national standards.

Herefordshire and Worcestershire align their ICP strategy priorities directly with the top five priorities for Mental Health Collaboratives (MHC) in 2023/24.

Devon's JFP also includes diversity and inclusion (D&I) targets for building an inclusive workforce.

Birmingham and Solihull, Coventry and Warwickshire, and Frimley ICP strategies highlight the significance of cultural competence in service provision, particularly for mental health services.

Conclusion and list of recommendations

This report highlights that in the first year of ICSs approaching the task of developing strategies and plans, they have made significant attempts to meet their statutory duties in relation to babies, children and young people. It is clear from our findings that babies, children and young people have not just been an afterthought in planning but are recognised as a significant population in their own right and as important for achieving the ICSs long-term health outcomes.

Nevertheless, there remain significant areas for improvement. Most notably in ensuring that minority and vulnerable groups of children are given additional direct attention, such as those with major and long-term conditions, that greater clarity is given to leadership and accountability for children, that further work is done to ensure children themselves provide input and feedback loops are established, and that additional attention is given to how information sharing and integration across children's health, care and education services can be improved.

Addressing these areas and other recommendations below will be crucial to ensure that variations between ICSs are not exacerbated and inequalities, as a result, deepened.

We also recognise that the strategies and plans are just those at the moment and a vital next piece will be considering how the commitments made in strategies and JFPs are implemented and carried out in practice.

We have summarised each of the recommendations from the thematic areas below and made some overarching recommendations.

Overarching recommendations

For government and arms-length bodies:

- The Major Conditions Strategy should acknowledge the centrality of child health in preventing illness across the life course and recommend steps that future ICP strategies and JFPs should consider to increase investment towards preventing ill-health in childhood.

- Government should give particular focus to addressing accountability concerns and how the legislative duties for strategies and plans could be upheld.
  - This should include an expectation on ICBs to clearly identify executive leadership for children and young people, SEND and safeguarding and for all strategies and plans to lay out the leaders accountable for ensuring the needs of these groups are met.

For ICSs:

- A specific section for babies, children and young people should be included within ICP strategies and ICB JFPs summarising the priorities and actions relevant to them.

- Preventing ill-health and poor wellbeing in babies, children and young people should be a priority in and of itself as well as a core tenet of an early intervention agenda and improving health outcomes and quality of life later in life.

Population health recommendations

For government and arms-length bodies:

- As part of a wider strategy for childhood, DHSC, working with other government departments, should select a small number of child health priorities that all ICSs must explicitly address in strategies and JFPs. This should complement Core20PLUS5.
- DHSC should consider how babies, children and young people with major and long-term conditions should be more clearly considered in updated ICP strategies and ICB JFPs.

For ICSs:

- The rationale for prioritising particular population health areas of focus, including specifically the areas of focus within the children and young people population, should be clearly articulated by ICP strategies, and ICB JFPs should clearly link timebound actions with these to support local understanding of decision making.
  - Where there are gaps in data and knowledge of population need, plans should clearly highlight how they intend to address these gaps.
  - This could benefit from a centrally created audit tool.

Leadership recommendations

For government and arms-length bodies:

- NHSE should facilitate a national network of ICB Executive Leads for Children with an annual development budget, and be chaired by the National Clinical Director for Children and Young People.

For ICSs:

- The names of ICB Executive Leads for Children, and SEND and safeguarding leads, should be made publicly available, and include a way for members of the public to make contact.
- ICSs should make publicly available an overview of the different roles and responsibilities of individuals within the system and who should be contacted for particular matters.

Co-production recommendations

For government and arms-length bodies:

- Updated ICS guidance should strengthen expectations on strategies providing details on how engagement took place, who was consulted, and what was changed as a result.

- Networks of Executive Leads could be used to share good practice and identify areas of challenge within co-production where further central NHSE support would be beneficial.

For ICSs:

- ICSs should adopt an inclusive and intersectional approach to co-production and co-design in both plans and strategies, with a particular focus on those population groups facing health inequalities.
  - ICSs should acknowledge the importance of engaging with children and young people themselves, as well as with parents and carers and put this into practice.

- ICSs should clearly differentiate where they have a) involved parents and carers and b) where they have involved children.

- All strategies and JFPs should have an easy read or accessible version.

Workforce recommendations

For government and arms-length bodies:

- DHSC should set expectations for how ICP strategies and ICB JFPs make reference to and evidence local work that aligns with national plans such as the NHS Long Term Workforce Plan.
  - This should include measurable targets for the extent to which ICSs are implementing 'one workforce' actions.
- DHSC and DfE should develop a children's workforce strategy that supports ICSs in their understanding of workforce developments across health, children's social care and education.
  - This strategy should appoint a national lead or advisory group to support and oversee child health workforce planning and development.

For ICSs:

- ICSs should continue to prioritise the development of a diverse, inclusive, and representative workforce to enable nuanced approaches in health and care, build reflexivity and connect with local communities.
- Strategies and plans should consider the children's workforce in the widest sense as part of their risk analysis for plans, including the workforce of other children's services (such as children's social care, education, youth justice) and workload pressures across the system.
- ICB JFPs should explicitly consider the children's health workforce required to meet the needs of babies, children and young people in their area when considering workforce capacity across the population.

Data and information sharing recommendations

For government and arms-length bodies:

- The government should make a firm commitment to a consistent child identifier (CCI) that will allow ICSs to consider how they may start to implement the infrastructure necessary for a CCI and greater interoperability within their future ICB JFPs.
- NHSE should set specific health and wellbeing outcome metrics for children and young people that ICSs must collect data on, this should align with the Healthcare Inequalities Improvement Dashboard.

For ICSs:

- ICSs should develop a tailored local outcomes dashboard that reflects national expectations for outcome metrics and supports local population understanding for how future strategies and plans build on from previous work.
  - This could align with the children's social care outcomes dashboard.
- Expectations for information sharing between children's services and how barriers will be overcome should be clearly outlined within strategies and plans and aligned with Government guidance, such as **Information sharing advice for safeguarding practitioners – GOV.UK (www.gov.uk)**.
  - This should also include a focus on when children and young people transition between children's, teenage and young adult, and adult services.

Integration recommendations

For government and arms-length bodies:

- The Better Care Fund, which provides support to ICSs and LAs to pool budgets and further integrate their health and care provision, should have an additional explicit focus on integration for children.
- Good practice for multi-agency working should be highlighted and shared across systems.

For ICSs:

- When they next update their ICP strategies and ICB JFPs, ICSs should review the extent to which integration with children's services and education settings could be strengthened at different geographical levels.
    - This should include evidence of engagement with the full range of statutory agencies with responsibility for children and young people as part of the development of the ICP strategies and ICB JFPs.
    - This could also include reference to where section 75 joint commissioning agreements would be valuable.

Inequalities recommendations

For government and arms-length bodies:

- DHSC should publish an annual report on health inequalities among babies, children and young people, summarising existing sources and identifying gaps.

For ICSs:

- Future strategies and plans should consider adopting the Child Health Integrated Learning and Delivery System (CHILDS) framework to support with targeted early intervention and integrated biopsychosocial care to children with major and long-term conditions and everyday child health problems.

Appendix

Indicators we considered as part of the survey in relation to each theme:

Population health

What indicators did we consider:

- Whether the ICP strategy recognised babies, children and young people as a distinct population health group from conception to 25.
- The common objectives and goals for babies, children and young people or ones they were included within.
- Whether the strategy and plan had explicit mention of babies, children and young people with a focus on the unique challenges they face as a group and priorities that focused on addressing their needs.
- Whether the JFP enacted on this by directly proposing actions to meet the needs of babies, children and young people as a distinct population group and whether this would have any immediate positive impact.

Leadership

What indicators did we consider:

- Whether an Executive Lead for Children and Young People had been appointed and clearly identified.
- Whether the strategy provided clarity on how it would show leadership in the areas of children's mental health, SEND and safeguarding.
- Whether the JFP named a lead for SEND and safeguarding and outlined clearly how it would meet its statutory responsibilities.
- Whether there was a clear route for accountability.

Co-production

What indicators did we consider:

- Whether there was evidence of co-production influencing the strategy and the JFP and what form this engagement took.
- Whether co-production included evidence of engaging with children and young people of different age groups from conception to 25, with children from diverse backgrounds and with parents and carers.
- Whether there was a clear articulation of how the voice of babies, children, young people and their families influenced their strategy and concurrently the JFP.
- Whether the JFP outlined plans for future engagement and co-production and what this looked like if so.
- Whether an easy read and/or accessible/summary version of the strategy was created by the ICP.

Workforce

What indicators did we consider:

- Whether the strategy and JFP outlined clearly how they intended to build and strengthen the children's workforce.
- Whether this included a strategy for specific practitioners and if so, which practitioners.
- Whether the strategy considered how it would meet context specific workforce needs in a particular geographical area.
- Whether the strategy had considered the current capacity of its children's workforce and if the JFP carried out a risk analysis on the impact of workforce capacity to meet the needs of babies, children and young people.

Data and information sharing

What indicators did we consider:

- Whether there was evidence of joined-up use of multi-agency data to drive planning, prioritisation, and commissioning.
- Whether there was evidence of JFPs attempting to address the challenges to data and information sharing for babies, children and young people.
- When we considered multi-agency data, we specifically looked to see if strategies and plans had drawn upon local education and social care data.
- Whether feedback loops had been considered by JFPs so that data, feedback and outcomes from the current plan could be utilised to inform the development of future JFPs.

Integration

What indicators did we consider:

- Whether the ICP strategy showed evidence of engaging with a full range of statutory agencies with responsibility for children and young people, in particular children's social services and educational bodies (early education through to higher education).
- Whether other agencies and services had an influence on the direction of the strategy and the JFP and whether there was clear articulation of how other agencies would continue to feed into the strategy and JFP.
- Whether there were clear goals set out articulating a joint approach to delivery of services and whether any new infrastructure, approach or teams were being suggested to enable integration.

Inequalities

What indicators did we consider:

- Whether health inequalities in relation to babies, children and young people were recognised and which groups of young people were identified as being particularly vulnerable.
- Whether barriers to accessing health services were considered in relation to inequalities and whether the strategy and JFP looked to address these.
- Whether targets were set to address health inequalities for babies, children and young people.
- The role that Core20PLUS5 played in influencing the direction of health inequalities.
- Whether intersectionality was considered when analysing health inequalities and their impact on health outcomes.

NATIONAL CHILDREN'S BUREAU

COUNCIL FOR DISABLED CHILDREN

Written and researched by Ben Fraser and Rhea Singhvi

United for a better childhood

The National Children's Bureau brings people and organisations together to drive change in society and deliver a better childhood for the UK. We interrogate policy, uncover evidence and develop better ways of supporting children and families.

Let's work together: 020 7843 6000 | info@ncb.org.uk

London: 23 Mentmore Terrace, London, E8 3PN

Belfast: The NICVA Building, 61 Duncairn Gardens, BT15 2GB

Design: conordiverdesign.com

Part of the family
NATIONAL CHILDREN'S BUREAU