Healthy London Partnership
Children & Young People’s Programme

Transforming care for children and young people in primary care

April 25, 2017
Overview

Healthy London Partnership’s Children and Young People’s Programme

Russell Viner, Clinical Director, Children and Young People’s Programme

Tracy Parr, Head of Children and Young People’s Programme

Transforming London’s health and care together
Welcome and communications

www.menti.com

Question 1 code 98 83 38

Question 2 code 98 83 38

#LdnCYPPC

@HealthyLDN
Who is in the room today?

What kind of organisation do you work in?

- Primary care (general practice): 10
- Primary care (other): 1
- Commissioning organisation: 19
- Healthy London Partnership: 2
- Community provider: 2
- Other: 5

Total respondents: 34
Expectations

What are you hoping to gain from today's event?
Healthy London Partnership – Children and Young People’s programme

Key facts

- **8.2 million** people live in London, of which **2,049,576** are children aged 0-19.
- **134,186** live births in London in 2012.
- **600,000** of London’s children live in poverty.
- Mental Health conditions affect **1 in 8** children.
- Emotional and behavioural problems affect **1 in 5** children.
- **20%** of 4-year-olds are overweight or obese.
- **25%** of 15-year-olds first smoked **AGED 13** or younger.
- **40%** of 15-year-olds drink alcohol once a week.
- **20%** of 13-year-olds drink alcohol once a week.
- **LESS THAN HALF** of 11-15 year olds do an hour of exercise each day.
What do children, young people and families think?

- I need rapid access to someone I can talk to when I feel depressed.
- We need easier access to healthcare.
- Make sure the school can look after my son when he has an asthma attack.
- Services are not joined up.
- I want to know that my GP is experienced in caring for children.
- I need rapid access to someone I can talk to when I feel depressed.
- I am worried about what will happen next year when I am too old for the children’s clinic.
- Make sure the school can look after my son when he has an asthma attack.
### Goal – London to be world’s healthiest global city

#### 10 programme aims from London Health Commission

<table>
<thead>
<tr>
<th>Aim</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give all London’s children a healthy, happy start to life</td>
<td>Enable Londoners to do more to look after themselves</td>
</tr>
<tr>
<td>Get London fitter with better food, more exercise and healthier living</td>
<td>Ensure that every Londoner is able to see a GP when they need to and at a time that suits them</td>
</tr>
<tr>
<td>Make work a healthy place to be in London</td>
<td>Create the best health and care services of any world city, throughout London and on every day</td>
</tr>
<tr>
<td>Help Londoners to kick unhealthy habits</td>
<td>Fully engage and involve Londoners in the future health of their city</td>
</tr>
<tr>
<td>Care for the most mentally ill in London so they live longer, healthier lives</td>
<td>Put London at the centre of the global revolution in digital health</td>
</tr>
</tbody>
</table>
# Delivering value and sustainability across the whole system

<table>
<thead>
<tr>
<th>A radical upgrade in prevention and public health</th>
<th>Preventing ill health and making Londoners healthier</th>
</tr>
</thead>
</table>

| Designing care around Londoners’ needs | Giving London’s children and young people the best start in life | Transforming care for Londoners experiencing mental illness | All Londoners to be able to access the best cancer care in the world | Joining up to transform the lives of the homeless |

| Transforming how care is delivered to every Londoner | Transforming London’s urgent and emergency care system | Transforming London’s primary care | Creating world class specialised care services |

| Making change happen | Connecting Londoners and health and care providers to allow for real time access to records and information | Ensuring Londoners are engaged and involved in their own health and the health of their city | Aligning funding and incentives to promote transformation of care (scoping) | Developing London’s workforce to enable transformation of care (scoping) | Transforming London’s estate to deliver high quality care (scoping) |
Whole system approach to transformation for children and young people’s health

System Leadership (CYP Board and clinical leadership group)

- **Long Term Conditions**
  - Asthma standards
  - Asthma toolkit
  - Asthma baseline audit
  - Epilepsy standards

- **Prevention and self care**
  - NHSGo
  - Community Pharmacies
    - Audit of CYP with asthma
    - Online learning hub for MURs
    - Audit CYP with dental pain
    - Role of pharmacists CYP health

- **Urgent and emergency care**
  - Acute care standards
  - Peer review
  - PAU standards
  - L1 and 2 PCC standards and education

- **Schools**
  - Models of school nursing
  - Guidance for management CYP asthma and diabetes

- **Primary care**
  - GP federation pilot model care CYP
  - Toolkit for GP federations

- **Mental health**
  - LTP refresh support
  - Guidance for mental health crisis
  - Models of liaison psychiatry
  - Benchmarking/KPIs
  - Eating disorders CoP
  - Thrive (Mayor)
  - Learning disability (theatres)

- **Out of hospital care**
  - Compendium models of care
  - Standards for OOH care
  - Modelling impact different models

- **CDOP**
  - Baseline audit
  - Suicide prevention
  - Bereavement
  - Sharing data and learning
  - Cluster level working

**Improved integration of care across the system for children and young people**

**Place-based care and planning (data packs, support for networks)**

**Workforce**

January 2017

**Commissioning development programme**

**System-wide enablers**
Healthy London Partnership Children and Young People Programme Governance

London Health Board
- Prevention Board
- Primary Care Board
- U and EC Board
- Mental Health Board
- Specialised Services Board

London Transformation Group (London’s CCGs and NHS England)

HLP C&YP Transformation Board

- CCG SRO & SEL SPG (Martin Wilkinson)
- NHSE SRO (Will Huxter)
- CYP Clinical Director (Russell Viner)
- CCG Clinical Lead (Nicola Burbidge)
- SPG rep SWL (Chris Elliott)
- SPG rep BHR (Louise Mitchell)
- SPG rep WELC (Satbinder Sanghera)
- SPG rep NCL (tbc)
- SPG rep NWL (Nicola Burbidge)
- DPH (Dagmar Zeuner)
- PHE (Marilena Korkodolis)
- DCSS (tbc)
- CYP/family rep (Emma Rigby)
- Programme Manager (Tracy Parr)
- GP lead (Eugenia Lee)
- NHSE asthma lead (Dave Finch)

CYP Clinical Leadership Group
- CYP Commissioning Advisory Group
- Young People’s Steering Group
- Parent and Carer Group
- CYP Mental Health and Wellbeing Implementation Group
- Asthma Implementation Group
- Peer Review of Acute Care Services Steering Group
- CDOP Implementation Group

Out of Hospital Care Clinical Leadership Group
- Primary Care Clinical Leadership Group
- Surgery Clinical Leadership Group
- CYP MHW Clinical Leadership Group
- Asthma Clinical Leadership Group
- Critical Care Education Programme Steering Group
- London & SEC Diabetes Partnership Board
- Epilepsy Task and Finish Group

CYP & Families Engagement throughout
NHSGo – designed by young people for young people

- NHS Choices content
- Chosen by young people – survey/focus groups
- IoS and Android
- Social media and you tuber marketing campaign
- 40,000 downloads
- 400,000 page views
- Sexual health and mental health top visited pages
- Now linking into 111 DoS
Children and young people make up over 40% of the primary care workload.

Lack of well developed models of care for children and young people in the primary care setting.

HLP has launched a new project working with GP hubs/federations to develop a toolkit to support them in addressing the health needs of children and young people in their population.

HLP GP leads group made up of each CCG’s children and young people GP lead with a workplan looking at primary care issues.

Please speak to the team if you are interested in joining the group or working up another pilot.
Making primary care work for young people

Emma Rigby, Chief Executive, Association for Young People’s Health
Making primary care work for young people

Emma Rigby, Chief Executive, Association for Young People’s Health
About AYPH

• Bridges the world of policy, practice and evidence to promote better understanding of young people’s health needs.

• Supports young people’s participation in health and wellbeing

• Supports the development of youth friendly health services and improved practice

• Collates and disseminates useful information in reader-friendly formats for practitioner and policy audiences (Key Data on Adolescence)

• Works with our members to share innovative examples of work in the field (events, twitter, publications)

We are a membership organisation for individuals and organisations working in the young people’s health field.

www.ayph.org.uk
Why focus on young people?

- Important to think about children and young people
- 0-25 years is a huge age range and there are significant differences in how young people need to access primary care
- How many young people are in our population?
- Why is it important that we get primary care right for them?
Chart 2.2
Proportion of population by age group in the UK, 2013

Some key issues for young people and primary care

• GPs tell us they see ‘very few young people’

• Yet young people are frequent users of primary care – young women visit their GP four times a year and young men two times a year on average.

• Age group least satisfied with GP with shortest consultation times

• Twice as likely to attend A&E or Walk-In

“It doesn’t feel like they listen, just fob you off with medication, and the Drs don’t communicate between each other.”

Young Person
What GPs learnt from young people

• Technology isn’t always good
• Waiting room = stress
• Take concerns seriously
• Allow time to build up trust
• Won’t ‘disclose’ on first visit

“Working with the voluntary sector encourages you to be more flexible towards young people and more tolerant if they run late, are loud, or turn up to an appointment with a gang of friends”
Reaching marginalised young people

www.ayph.org.uk/reaching-marginalised-young-people
Six principles to shape our thinking about young people’s health

The evidence tells us that treating different, specific health issues separately will not tackle the overall wellbeing of this generation of young people. Young people’s mental and physical health are intertwined, and at the heart of health and wellbeing are their relationships with others. Young people think about their health holistically. They want an integrated, youth friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope.

Building on the research of what works for this age group, we have identified six core principles that cut across health topics to develop holistic approaches to meet needs. These build on concepts of resilience and are presented in a way that commissioners and service providers can use.

Improving young people’s health and wellbeing
A framework for public health

Importance of an holistic approach

Making a practice YP friendly

1. Appoint a 'champion' in the practice for young people's health

2. Let young people register with a GP

3. Accessible and flexible appointments

4. Make the waiting room more welcoming for young people

5. Listen to young people and give them time

6. See young people on their own, with no lower age limit
Making a practice YP friendly

7. Book a follow up appointment

8. Feel comfortable around confidentiality (patient records)

9. Record your data accurately

10. Use data to see where improvements can be made

11. Gather feedback and complaints

12. Involve young people in patient participation groups
YOU’RE WELCOME

PILOT 2017

All young people are entitled to receive appropriate health care wherever they access it. The You’re Welcome quality criteria for making health services young people friendly lay out principles that will help health services – community and primary care, secondary care and wider health services – to ‘get it right’ for young people.

www.ayph.org.uk/yourewelcome
“Very often there’s no help available until the problem has become totally unmanageable”  Young Person

“Young People don’t want to be sent to a different service for every different problem they are dealing with. They want someone to help them through a variety of different issues, recognising that they’re often connected.”

Be Healthy Advocates

emma@youngpeopleshealth.org.uk
www.ayph.org.uk
@AYPHcharity
Child Health General Practice Hubs

Dr Mando Watson, General Paediatrician, St Mary’s Imperial

connecting care for children (C4CC)
connecting care for children

Child Health
General Practice Hubs

Invested in by:

Imperial College Healthcare

Supported by:

London Boroughs of H&F, K&C and Westminster City Council
Paddington Development Trust & CLCH NHS Trust
Starting with patients and citizens…

• “My health visitor told me to do one thing and the hospital told me something else. It’s confusing”
• “I only found out how to use my son’s inhaler properly when he had an asthma attack and was on the children’s ward”
• “No one seems to know who’s doing what. My [severely disabled] son has 3-4 appointments a week and I don’t think any of these [professionals] talk to each other!”
• “I think young people need help” – a practice champion who supported mindfulness training for her local community
• “I prefer to see my GP – I know him and he’s looked after all my family for years”
Connecting Care for Children; 3 core elements focused on Primary Care, coming together as a ‘Child Health GP Hub’

**Parent:** ‘I hope it will continue like this – it’s much easier and more comfortable because I know all the people at the GP practice, it is so quick to get an appointment. What I like the most is that the GP and I hear the plan together so I don’t have to go back and tell them. The game of Chinese Whispers is finally over. I am so pleased my practice has this service.’

**GP:** ‘I have much more confidence in talking to the Paediatricians because I now know them, I don’t feel scared to email, write or telephone and I know they will answer my queries. The clinics are phenomenal, they are the best three hours of my month, I feel the patients get exactly what they need, I learn a great deal which I can then use in all my general practice consultations. Thank you for empowering me and helping me deliver the best service to our patients.’

**Paediatrician:** ‘The ability to work in true partnership, and to co-create care plans with families and GPs has been enormously enhanced by my seeing patients in primary care.’

**GP Child Health Hubs are typically:**
3-4 GP practices within an existing network / village / locality
~20,000 practice population
~4,000 registered children
Built around a monthly MDT and clinic
Child Health GP Hubs – a model of integrated child health

**Horizontal integration** across multiple agencies

**Vertical integration** between GPs and paediatric services

- Tertiary Care Sub-specialty Paediatrics
- Secondary Care General Paediatrics

**Child Health GP Hubs**

- Health Visitors
- Dieticians
- Community Nurses
- Practice Nurses

**CAMHS Voluntary sector Schools Social Care Children’s Centres**

- Public and patient engagement
- Specialist outreach
  - Paediatricians
  - Specialist nurses
  - Other specialists
- Open access
  - Practice nurses
  - Health visitors
  - Children’s centres
  - Schools
  - GPs

**Children Young People and their Families**

**Flexible access**
Child Health GP Hubs – MDT Professionals

MDT are typically:
- 4-6 weekly
- 60-90 minutes long
- Centred on discussing clinical cases
- An opportunity for shared learning
Child Health GP Hubs – MDT Professionals

GP / Paediatric Trainees
Voluntary Sector

General Practitioners
Practice Nurses
Health Visitors

Paediatric Dietician

MDT are typically:
• 4-6 weekly
• 60-90 minutes long
• Centred on discussing clinical cases
• An opportunity for shared learning

Mental Health Worker

Social Care Manager
General Paediatrician
School Nurses

Medical Students
Student HVs & Dieticians
Dental trainees

connecting care for children
Case Hunting

Cases for discussion at the MDT may be identified through case hunting criteria.

Examples include:

**Midwives:** pregnant ladies with drug use, medical problems, domestic violence

**Health visitors:** failure to thrive, maternal low mood, speech & language problems, developmental concerns, crossing centiles, unusual volume/ content of questions

**School nurse:** pupils with frequent absence, medical concerns, signs of safeguarding issues, mental health problems

**Dietician:** those on special formulas, obesity, failure to thrive

**Social services:** safeguarding, housing problems / entire caseload.

**Practice nurse:** those that have missed immunisations, unusual interactions between parents & children

**GPs:** frequent A&E attendances, those with medical problems, maternal anxiety etc., frequent GP attendance, high anxiety parents

**Paediatrician:** patterns of referral, children and young people with long term conditions for transition e.g. severe disability, children and young people with long term conditions for discussion with specialist nurse (diabetes, epilepsy, ISW, sickle)
A Whole Population Approach: Patient Segments in Child Health

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

<table>
<thead>
<tr>
<th>Segment</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Healthy Child</strong></td>
<td>Advice &amp; prevention: Breast feeding, Immunisation, Mental well-being, Healthy eating, Exercise, Dental health</td>
</tr>
<tr>
<td><strong>Vulnerable child with social needs</strong></td>
<td>Safeguarding issues, Self-harm, Substance misuse, Complex family &amp; schooling issues, Looked after children</td>
</tr>
<tr>
<td><strong>Child with single long-term condition</strong></td>
<td>Depression, Constipation, Type 2 diabetes, Coeliac Disease, Asthma, Eczema, Nephrotic syndrome</td>
</tr>
<tr>
<td><strong>Child with complex health needs</strong></td>
<td>Severe neurodisability, Down’s syndrome, Multiple food allergies, Child on long-term ventilation, Type 1 diabetes</td>
</tr>
<tr>
<td><strong>Acutely mild-to-moderately unwell child</strong></td>
<td>Croup, Otitis media, Tonsillitis, Uncomplicated pneumonia, Prolonged neonatal jaundice</td>
</tr>
<tr>
<td><strong>Acutely severely unwell child</strong></td>
<td>Trauma, Head injury, Surgical emergency, Meningitis, Sepsis, Drug overdose, Extreme preterm birth</td>
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</tbody>
</table>

Dr Bob Klaber & Dr Mando Watson    Imperial College Healthcare NHS Trust
A Whole Population Approach: Patient Segments in Child Health

There are a number of cross-cutting themes that can be found within many or all of the segments. Examples include safeguarding, mental health, educational issues around school and transition.
A Whole Population Approach: Patient Segments in Child Health

This segmentation model also allows the activity and spend on a population of children and young people within a defined locality, and split into age groups, to be assessed and analysed. This presents the opportunity for utilising different payment and contracting mechanisms for child health.

Healthy Child
Vulnerable child with social needs
Child with single long-term condition
Child with complex health needs
Acutely mild-to-moderately unwell child
Acutely severely unwell child

Dr Bob Klaber & Dr Mando Watson  Imperial College Healthcare NHS Trust
Volunteer for your local community
become a Practice Champion and help shape children’s healthcare

Your Practice would like to invite you to join us as a Practice Champion. We want to improve the healthcare of children and young adults in our community. Practice Champions use their experience, skills and passion to help design healthcare services for children and families. Training will be provided.

For more information please ask for a volunteer application form at reception or call/text Bea on 07852176747
**Demonstrating Value, Outcomes and Benefits**

**Connecting Care for Children Ethos**
Patients will be seen by the right person, in the right place, first time

**Better use of hospital services**
In the 3-practice Child Health GP Hub at HRHC (West London CCG) 39% of new patient appointments were avoided altogether through MDT discussion and improved care coordination. A further 42% of appointments were shifted from hospital to GP practice.

In addition, there was a 19% decrease in sub-specialty new patient appointments, a 17% reduction in paediatric admissions and a 22% decrease in A&E attendees.

**Evidence for Practice Champions....**
National evidence (Altogether Better) indicates that Practice Champions will deliver a positive return on investment of up to £12 for every £1 invested in training and support

**More accessible for patients**
The Hubs mean that fewer working hours are lost by parents, and anxiety is reduced

**Reduced Bureaucracy**
The Hub uses fewer referral letters, appointment letters and responses

**Positive Patient Reported Experience**
90% of patients and carers said that having been seen in the outreach clinic within their registered practice they would now be more likely than before to see the GP for future medical issues in their children

**Workforce development**
‘This is the best CPD I’ve ever had’ Hub GP

**Health Economists...**
...calculate a break even point by the end of year 2: based on assumed reductions in hospital activity (that are being surpassed in the pilot work) and a roll out of 6 new hubs per year
Child Health General Practice Hubs: a service evaluation

Sarah Montgomery-Taylor, Mando Watson, Robert Klaber

ABSTRACT

Objective: To evaluate the impact of an Integrated Child Health system.

Design: Mixed methods service evaluation.

Setting and patients: Children, young people and their families registered with Child Health General Practitioner (GP) Hubs where groups of GP practices came together to form Hubs.

Interventions: Hospital paediatricians and GPs participating in joint clinics and multidisciplinary team (MDT) meetings in GP practices, a component of an ‘Insider-Out’ change known as ‘Connecting Care For Children’ (CC4C).

Main outcome measures: Cases seen in clinic or discussed at MDT meetings and their follow-up needs, hospital hospital days and outpatient and inpatient activity and A&E attendance. Patients’ experience measures and professionals’ feedback.

Results: In one hub, 33% of new patient hospital appointments were avoided altogether and a further 42% of appointments were shifted from hospital to GP practice. In addition, there was a 19% decrease in inpatient activity, a 12% reduction in A&E admissions and a 22% decrease in A&E attenders. Smaller hubs running at lower capacity in early stages of implementation had less impact on hospital activity. Patients preferred appointments at the GP practice, gained increased confidence in taking their child to the GP and all respondents said they would recommend the service to family and friends. Professionals valued the improvement in knowledge and learning and, most significantly, the development of trust and collaboration.

Conclusions: Child Health GP Hubs increase the connection between secondary and primary care, reduce secondary care usage and maintain high patient satisfaction ratings while providing learning for professionals.

BACKGROUND

"Children represent the future, and ensuring their healthy growth and development ought to be a prime concern of all societies." As individuals we value our children above all, but as nations we neglect children and young people, who are often left off the agenda for health improvement. European data show significant variability across developed and developing countries in child mortality rates and outcomes for children with long-term conditions.

UK health services are not well connected, and children are not being seen by the right person, in the right place, at the right time. Patients report that the current healthcare system prevents continuity of care, and the numbers of A&E admissions and hospital outpatient attendances in those aged 0–16 are rising year on year, leading to an increasing financial and workload burden. Recent nationwide and city-wide reports have placed improved health for our nation’s children high on their list of priorities. They emphasise the need for new models of care that support parents as individuals through integrated care to suit their needs. Care in the community is often preferred by families. Care from the general practitioner (GP), who knows the child in a wider social context, plays an important role in overall health. An on-and-off hospital paediatric specialist service supports this ideal. Previous studies have demonstrated the potential for paediatric outpatient services to be moved to the community, but identified that this needed to be as part of wider efforts to improve patient engagement. These challenges formed significant drivers for change.

Fortuitously anticipating the policy direction set by the Five Year Forward View, paediatricians at Imperial College Healthcare NHS Trust and colleagues in local Clinical Commissioning Groups (CCGs) have established a collaborative integrated child health system: Connecting Care For Children (CC4C). This system has been developed with extensive stakeholder consultation and in partnership with a wide range of service users. Break-even economic modelling predicted a 12-hub system would be cost neutral after 2 years and would
Impact of CC4C Child Health GP Hubs on Outpatient Activity

Combining the outreach appointments into the total we still see a very significant decline (39%) in St Mary’s appointments in FY 14/15.

Annual: First appointments, general paediatricians, St Mary’s

- FY 12/13: 1200 appointments
- FY 13/14: 1400 appointments
- FY 14/15: 1000 appointments

- Now managed in Primary Care / Increased self-care
- Moved to local outreach clinic

Practice Locations: All practices in CC4C Hubs
Referred type: First appointment
Referred to: General Paediatrician
Hospital referred to: St Mary’s

connecting care for children
Demonstrating Value, Outcomes and Benefits

What we saw happening in our Hubs ...

*Observed* reduction in activity:
- Outpatient: 39%
- A&E: 22%
- Admissions: 17%

Putting a conservative estimate of activity changes...

*Modelled* reduction in activity:
- Outpatient: 30%
- A&E: 8%
- Admissions: 2%

Into an economic evaluation ...

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Hubs</th>
<th>Child Population Covered</th>
<th>Total costs of the CC4C Child Health GP Hubs</th>
<th>Total savings from reduced hospital activity</th>
<th>Net Economic Benefit</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>8672</td>
<td>£153,220</td>
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<td>£794,896</td>
<td>£3,901,895</td>
<td>£3,107,000</td>
</tr>
</tbody>
</table>

Cumulative Financial Impact (over 5 years): **£8,881,102**
Child Health GP Hubs in North West London

Imperial and Ealing CCG: Cloister Road Surgery

Imperial and Hammersmith & Fulham CCG: Parkview Health & Wellbeing Centre

Imperial and West London CCG: 3 multi-practice Hubs

Imperial and Central London CCG: 4 multi-practice hubs

Evelina (GSTT) and Central London CCG: One 4 multi-practice Hub

West Middlesex and Hounslow CCG: 1 GP practice pilot

Chelsea and West. & West London CCG: Two 3 GP practice hubs
A map of trusts, CCGs and other organisations now involved with the CC4C programme
How does it work?

Better **Quality** Services
- Safe
- Timely
- Efficient
- Equitable
- Patient-centred

Improved **Outcomes**
- Health
- Vulnerable
- Single LTC
- Complex needs
- Acute

- Shared knowledge about **how services work and how to access them**

**Social capital and trust** – how practitioners and community support each other in promoting child health

- Parents and professionals capability – **knowledge, skills, confidence in child health issues**

- Professional support – **MDT case review, email and telephone**

- Professional education packages – **shared guidelines, joint study days**

- **Patient support and education** – Practice Champions, Fix Freddie, Patient Academy
New Care Models in children – Design Principles

What is the learning from local & national work on new care models?

1. Focus on connections and relationships; NHS services can be minimally changed, while their capability and capacity are maximised

2. Put GP practices at the heart of new care models - specialist services are drawn out of the hospital to provide support & to help connect services across all of health, social care and education

3. A whole population approach facilitates more focus on prevention

4. Health seeking behaviours improve through peer-to-peer support

5. Co-design new approaches to care with children, young people, parents, carers and communities

6. Focus on outcomes that really matter to patients

7. Learning and development, for the whole multi-professional team, is a key way to building relationships and finding new ways to work together
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robert.klaber@imperial.nhs.uk

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Extras...

- https://vimeo.com/117572439
- https://www.cc4c.imperial.nhs.uk/
- http://datasyrup.net/examples/cc4c-program/
- https://www.dropbox.com/s/zfav9x0hn2wxh96/Mapping%20services%20framework%20v06.xlsx?dl=0
Utilising Whole Population Segmentation in Child Health

This figure illustrates 5 important stages of work that need to be undertaken to utilise the segments. This will help us to move towards models of care commissioned for patient-centred outcomes:

1. **Coding, activity & finance** – Where do patients go?
2. **Attitudinal surveys** – Where would patients go?
3. **Map existing indicators and outcome measures to each segment**
4. **Develop Patient Centred Outcome Measures (PCOMs) for each segment**
5. **Outcomes-based commissioning for each segment**
Impact of CC4C Child Health GP Hubs – Patient Feedback

Patients/parents felt

• really listened to (99%)
• involved in decisions (88%)
• very confident in the care they were receiving (99%)
• satisfied concerns were addressed & that they had received clear explanations (96%)

Most (70%) had initially presented to their GP thinking a hospital referral would be needed. After the Hub clinic, none had a preference to be seen in hospital

As a result of the appointment, 88% felt more comfortable taking their child to see their GP

100% would recommend the service to friends and family
Participants ‘agreed’ or ‘strongly agreed’ that the hubs had helped them to:

• gain knowledge of local services (28/28)
• improve collaboration and professional relationships (28/28)
• increase professional capability (25/28 with three neutral responses)

The benefit most strongly identified by professionals was the development of trust, reciprocity and collaboration.
Bexley Asthma Assessment Project in Pharmacies

Dr Karen Upton – Bexley CCG Clinical Lead for Children and Young People
Number of Asthma Emergency Admissions by CCGs in London 2013/14 and 2014/15
(Source data: HES)
Why is asthma important in Bexley?

- In Bexley patients asthma admissions in children under the age of 18 years
- 2015/16 there were 88
- 2016/17 first two quarters 61
- An estimated 75% of hospital admissions for asthma are thought to be avoidable.
- As many as 90% of deaths from asthma thought to be preventable.
Why Bexley Asthma Assessment in the Community Pharmacy

• **Co-ordinating care with the GP:**
  • Non-attendance for asthma reviews at GP Practice
  • Patients often attend asthma reviews at GP Practice without their inhalers
  • Large patient cohorts – help GP practice to stratify the patients
  • Part gather data in the pharmacy which will support patient records in the GP Practice – QOF and in asthma reviews

• **What the pharmacist sees and GP does not:**
  • Requests for inhalers in an emergency scenario
  • Non-collection of prescriptions for inhalers (patient only wants the reliever inhaler)
  • Inappropriate self care by asthma patients e.g. cough & cold symptoms
1. Enhance communication between pharmacists and GPs. This would be via an asthma template which all would use and become familiar with. This will be developed and trialled during the project with input from all stakeholders.

2. Enhance the value of MURs to include evaluation and education of patients in inhaler technique, in a way that there is consistency in the message between all health care providers.

3. Education and upskilling of all clinicians (GPs, Practice nursing staff and pharmacists)
   
a. Concerning issues specific to children and young people to include communication and development.

b. In asthma management generally
Overriding Principle

Inclusion of pharmacies in Bexley asthma management pathway

“Take what currently exists and work with what you have got... in many cases systems of care just need to join up more effectively as opposed to overlaying a whole new intervention or pathway”

Mando Watson Consultant Paediatrician, Imperial College Healthcare NHS Trust
Bexley Q1 - Asthma Action Plan - % Contacts (0-18yrs)

- 55% Yes
- 44% No
- 1% Don't know
Asthma Assessment in the Pharmacy

What we **ARE** asking pharmacies to do

• Competent in
  – understanding the management of asthma
  – promoting good inhaler technique in children & adults
  – promoting effective use of appropriate spacers devices
  – providing MURs, NMS
  – performing inhaler surveillance (quality payment)

• Learn how to use an e-template to record information and send it to the GP

• Talk to your local GPs and Practice Nurses about your referrals

• Follow up with patients

• Participate in evaluation of the service

• Service continuity and remain engaged
Asthma assessment in the Pharmacy

What we are **NOT** asking pharmacies to do

- Diagnose Asthma
- Specialists in asthma management in children & adults
- Retrain as specialist pharmacists
- Be a Prescribers
- Read long and complicated service specifications
- Spend excessive amounts of time studying and preparing for a service
On-line Asthma Toolkit

• Support across the system to improve asthma care
• https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit
Timelines, Next Steps, Evaluation

12 month project

- **Timelines**
- Start date 02.05.17 (world Asthma Day)
- Quarterly reviews
- Darsi Fellow to support the review – academic publications etc
- Support within Healthy London Partnerships
- **Next Step**
- Feedback from pharmacists
- MDT meeting in April with Local GP Practices
Evaluation

Co-designing – need local input to identify measurable outcomes

GP Practice
• Impact on patient care & local practice
• Quality and relevance of the information

Pharmacy
• Ease of administration
• Use of the eTemplate
• Service model based on Pi, MUR, NM & quality payments
• Training & competence

Patients
• Satisfaction with the service
• Access
• Benefits to health and well being
• Consider trends and admissions for asthma over the coming year and onwards.
Films to demonstrate what we are doing

- Overarching asthma toolkit film: https://www.youtube.com/watch?v=ikdAB9qyk9U
- Hospital care: https://www.youtube.com/watch?v=UK8wHN0sdJ0
- Schools: https://www.youtube.com/watch?v=blb80lOjoO8
- Pharmacy: https://www.youtube.com/watch?v=kCAzCml-R_k
- Primary and community care: https://www.youtube.com/watch?v=A2iNQE7utRE
- Parents and carers: https://www.youtube.com/watch?v=iNPSFal0OIM
04

Making Child Health a Local Priority: The Role of GP Federations

Dr Chad Hockey,
Hammersmith and Fulham GP Federation
Children in H&F

North H&F - up to 45% child poverty
Overall, H&F ranked as 23rd worst borough in England

Who coordinates strategy?
Who Translates Strategy in the Community?

H&F Locality Area Arrangement

H&F GP Network Arrangement

Network 1
Network 2
Network 3 - South Fulham Group
Network 4 - Small Practice Collaborative
Network 5

---

London Borough of Hammersmith & Fulham
CHILDREN’S SERVICES
LOCALITY AREAS

---

Who Translates Strategy in the Community?
Natural Neighbourhood Model
GP Skill-mix and Practice Size in H&F (2016)

H&F GP Federation Represents Every GP Practice in the Borough
Developing GP Leads for Child Health…

<table>
<thead>
<tr>
<th>Clinical Skills</th>
<th>Leadership Skills</th>
<th>Service Transformation</th>
</tr>
</thead>
<tbody>
<tr>
<td>36 unplanned care sessions</td>
<td>18 Community project sessions</td>
<td>Collaboration and coordination</td>
</tr>
<tr>
<td>18 outpatient sessions</td>
<td>Supported leadership development</td>
<td>Clinical support and education</td>
</tr>
<tr>
<td>In-house teaching</td>
<td>QSIR practitioner</td>
<td>Network formation</td>
</tr>
</tbody>
</table>

HEE Funded Initiative, run via local CEPN program
Application: asthma...

Service Transformation
Collaboration and coordination
Clinical support and education
Network formation

Prevalence finder
Asthma annual review
Learning needs assessment

Need an Appointment
GP, HV, SN

Need a Connection
Specialist Therapists

Walk-in and wait
UCC CAU ED

Active Promotion of Self Care
Asthma plans
Group sessions
School initiatives

Self Care
Resources
Time Finances
Confidence
Expectations

Get Advice
Online
Face to face

Informal
Friends Champions

Telephone
Children’s centre
GP reception
Pharmacist

Get Seen
UCC CAU ED

Developing Service Delivery
Across ages and settings
Asthma dashboard
Model Summary

• Hub as touch-point between networks
• GPs as conduits for strategy across sectors
• Single model applicable to multiple scenarios
• Future-proofed for MCP structure
• Investment in staff resources
Islington Paediatric Integrated Networks

Catherine Lad, CYP Commissioner and Dr Sabin Khan, GP lead Islington CCG
Islington
Paediatric Integrated Networks
The ‘Islington Children and Young People’s Health Strategy’ underpins all our work for children and young people in Islington, with a priority to improve integration for CYP around primary care.

In 2013 Islington became an integrated pioneer.

Adult and children’s MDT Teleconferencing was commenced, which brings together a core team of professionals in a weekly – monthly teleconference.

Adults have gone on to develop 12 integrated networks with face to face meetings, with groupings of 2 – 4 GP practices covering total populations of between 7000 – 30,000.

There were 4 localities, but this is beginning to evolve into 3 localities covering total populations of approximately 90,000 (CHINs: Care Closer to Home Networks).

CHINs will be supported by Quality and Intelligence Support Teams (QISTs).
PROPOSED INTEGRATED NETWORK TEAM

Wider MDT
Clinical Nurse Specialists
Discharge Nurse
Social Worker
Pharmacists
Dietician
SENCO
SHINE
Physio
SLT
OT

Speciality Teams/Services

Integrated Network

Child and Family

Primary Care
Voluntary Sector
Voluntary Sector

Families First
Health Visitor
INC Admin Manager

Children's Centres

Secondary Care
Paediatrician
School Nurse
Community Nurse
Community Services

Schools

Secondary Care

GP

CAMHS

Social Services
JOINT CLINICS
• Paediatrician provides an outreach clinic in primary care, attended by GPs.
• Children referred to the clinic are those usually referred to OP, those seen in secondary care and any child that a GP would like to refer to the clinic.

VOLUNTARY SECTOR
• Releasing community assets through public and patient participation
• Peer to peer support
• Practice champions
• Parent champions
• Social prescribing
What kind of health economy do you want to leave our children? The role of primary care in making it happen

Prof Albert Mulley, Dartmouth Institute for Health Policy and Clinical Practice
WHAT KIND OF HEALTH ECONOMY DO YOU WANT TO LEAVE OUR CHILDREN WITH?
THE ROLE OF PRIMARY CARE IN MAKING IT HAPPEN

Healthy London Partnership: Children and Young People
25 April 2017, London
Professor Albert Mulley, MD, MPP
Dartmouth Institute for Health Policy and Clinical Practice
The Role of the Primary Care in Realising the Five Year Forward View

Designing New Care Models from Top Down and from Bottom Up

The Goals of the Forward View
- A radical upgrade in prevention and public health through ‘full engagement’
- People and patients with far greater control over their health care and health
- New options for the workforce with skills leveraged by innovation and technology
- Better care experiences, better health for people and populations, and lower cost

The Way Forward
- A triple integration of primary and acute care; physical and mental health services; and health and social care
- A joining up of provision and funding
- New care models that integrate service delivery around people’s needs and wants

The Leadership
- National leadership showing respect for diversity and local context and knowledge
- Place-based local leadership engaging with and learning from the people served
LEARNING FROM VARIATION TO DELIVER WHAT IS VALUED
Challenging Assumptions to Think and Do Things Differently

**Prevailing Assumptions**

Higher levels of health care produce higher levels of health & wellbeing for people and populations;

Clinical evidence tells us what is the right thing to do for people in need of health care;

Health care is delivery of services by professionals to people unable to understand or do for themselves.

**Evidence to the Contrary**

Health care contributes less to health than social circumstances, including education and behaviour;

Evidence is insufficient; patients’ preferences matter in decisions to deliver services that produce value;

Much of health care is exchange of information about achieving what is possible and most valued.
LEARNING FROM VARIATION TO DELIVER WHAT IS VALUED
Challenging Assumptions to Think and Do Things Differently

<table>
<thead>
<tr>
<th>Resistance to Thinking Differently</th>
<th>New Models to Do Differently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bias toward biomedical vs social science; specialism vs general knowledge; most proximate cause;</td>
<td>Integrate services around patients’ needs and wants addressing more broadly the determinants of health;</td>
</tr>
<tr>
<td>Bias toward the objective and generalizable; neglect of context at the level of the individual patient;</td>
<td>Engage, inform, and support patients in identifying and acting upon their needs and wants;</td>
</tr>
<tr>
<td>Bias toward expertise, capabilities, and agency of professionals with neglect of that of patients / people.</td>
<td>Leverage joint assets of people and professionals to co-produce better health and wellbeing at lower cost.</td>
</tr>
</tbody>
</table>
With higher intensity and cost:
• No better outcomes in mortality & function
• More difficulty for patients seeing doctors, longer waits
• More difficulty for doctors admitting to hospitals and obtaining referrals
• Poorer patient relationships, ability to provide quality care

Sources of waste and harm:
• Failure to deliver effective health care safely (outcome variation)
• Overuse and underuse of preference-sensitive care (uninformed clinical decisions)
• Overuse of supply-sensitive care (uninformed investments in health system capacity)
When Linda was diagnosed with breast cancer, she was devastated. She was 58. She quickly found support from others who had dealt with the disease. Nonetheless, her anxieties as she awaited surgery nearly overwhelmed her. Linda’s operation went well. However….

When Susan was diagnosed with breast cancer, she was more stoical than Linda. She was 78, other members of her family had had breast cancer, and she had already been treated for a serious illness – heart failure. She dreaded having surgery, but her surgeon was insistent. Susan’s mastectomy was routine….
Learning from Variation in Patients’ Preferences
Evidence is Necessary but Not Sufficient – Patients’ Preferences Matter

Treatment of early-stage disease

Treatment of metastatic disease
The Strategic Intent: Learning from Variation to Deliver What is Valued
Learning from Patients’ Preferences for System Reform

*Giving System Leaders the Data they Need to Hold Themselves Accountable*

- **Policy Makers**
- **Patients and Family**
- **Health Professionals**

**Voice**
- Preferences for Commissioning and System Design
- Feedback

**Compact**
- Accountability for Engagement
- Feedback

**Evidence: What is Possible**

**Preference: What is Valued**

**Decision Aid**

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Learning from Variation to Deliver What is Valued

Overcoming Conceptual and Operational Barriers

Learn from Variation

Processes
Costs
Outcomes
Preferences

Bring the Discipline of Science

Organize for Innovation

Deliver with Teams

Be Guided by Simple Rules

Deliver What is Valued

Summary

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Redefining Roles for a Knowledge-Intensive Service Model
Supporting and Measuring the Teamwork Needed to Achieve Value

- Shared Goals
- Shared Knowledge
- Mutual Respect
- Mutual Trust
Primary Care Service Models Designed Around Teams

Co-Creating Value in a Knowledge Intensive Service Delivery Model

Socios En Salud in Lima Norte

South → North Service Innovation

©Socios En Salud 2007

Dartmouth Health Connect

A Dartmouth-Hitchcock/Alora Health Primary Care Practice

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Delivering health with integrity of purpose
Health systems must learn how to co-produce and deliver services that patients and the public value

Albert Mulley director¹, Tessa Richards senior editor/patient partnership², Kamran Abbasi international editor²

¹Dartmouth Center for Healthcare Delivery Science, Hanover, New Hampshire, USA; ²The BMJ

The Care They Need and Want – No Less But No More

Children and Adolescents with Mental and Behavioral Health Needs
iTHRIVE: Understanding a Priority Population’s Needs and Wants

- A National Innovation Accelerator bringing together the model of care for children & young people’s mental health called THRIVE with tools to support SDM; CollaboRATE, InteGRATE and Option Grids.
- This will enable the implementation (i) of THRIVE using the SDM tools.
The BMJ-Dartmouth Initiative
Challenging Assumptions and Testing Hypotheses on a Global Scale

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The Care They Need and Want – No Less But No More

Children and Adolescents with Mental and Behavioral Health Needs

People who Need Support to be Productively Employed in their Middle Years

People who Need Care and Compassion due to Frailty or when Death is Near
"Another event at Elsterhorst had a marked effect on me. The Germans dumped a young Soviet prisoner in my ward late one night. The ward was full, so I put him in my room as he was moribund and screaming and I did not want to wake the ward.

I examined him. He had obvious gross bilateral cavitation and a severe pleural rub. I thought the latter was the cause of the pain and the screaming. I had no morphia, just aspirin, which had no effect.

I felt desperate. I knew very little Russian then and there was no one in the ward who did. I finally instinctively sat down on the bed and took him in my arms, and the screaming stopped almost at once. He died peacefully in my arms a few hours later.

It was not the pleurisy that caused the screaming but loneliness. It was a wonderful education about the care of the dying.

I was ashamed of my misdiagnosis and kept the story secret."
Some Closing Questions for Discussion

1. Which of these ideas are most relevant to primary care at scale in the Healthy London Partnership?
2. Which are most relevant to transforming care for children and young people in primary care?
3. What would primary care teams look like if they were designed to learn the wants and needs of children and young people?
4. What support would you need to design and implement such teams to deliver primary care at scale in the Healthy London Partnership?
5. What are the ‘social care sensitive conditions’ you would want to identify to test the ‘sustainability hypothesis’ among children and adolescents?
The following are back-up slides for responses to questions and discussion.
Learning Objectives Measures & Tools for Mutual Accountability

**WORKSHOP 1**
Using Logic for Learning
- Confirm vanguards' intended impact logic including any revisions
- Identify metrics and tools needed to drive change
- Identify priorities for learning and evaluation
- Assess relevance of experience sourced from UK, US, other countries

**WORKSHOP 2**
Learning from Variation
- In process & outcome to improve quality/safety
- In practice & preferences to improve co-production
- In needs & wants of patients to improve value and health
- In local area contexts to implement innovation & adapt to achieve scale

**WORKSHOP 3**
Delivering What is Valued
- Focus on vanguards' front line learning priorities for quality/safety & value
- Examine logic for local context and beneficiaries
- Identify opportunities for high value co-production
- Assess relevance of experience sourced from UK, US, other countries

**WORKSHOP 4**
Measuring What Matters
- Focus on patient-reported measures including needs and preferences
- Measure decision quality as well as process quality
- Measure engagement and co-production of care
- Achieve real-time data & feedback to learn & adapt while innovating for value

**WORKSHOP 5**
Delivering with Teams
- Design microsystem teams for learning and meeting patients’ needs & wants
- Fill each role with people working at highest & best use of skills and training
- Leverage skills with IT to support co-production
- Measure & reward care coordination by providers

**WORKSHOP 6**
Organizing for Innovation
- Distinguish innovation from improvement
- Hold dedicated innovation team leaders responsible for learning & adapting
- Ensure innovation leaders flexibility to define new roles within care models
- Identify and learn from similar efforts elsewhere

**WORKSHOP 7**
Leading for Accountability
- Agree design principles for organizations & systems
- Focus on outcomes with improvement in quality & total cost of care
- Support patient choice & accommodate diversity
- Measure competencies & capabilities for risk based payment models

**WORKSHOP 8**
Governing for Stewardship
- Build IT for continued learning & improvement
- Govern with accountability for stewardship goals
- Lead with integrity of purpose and transparency in reporting to stakeholders
- Sustain system impact & value through reallocation of resources as needed
Measures & Management Tools for Mutual Accountability Across Health and Care Systems

Frontlines of Delivery

System Leadership

Tools: Value Compass
- Microsystem Tools

Tools: Right Care
- NHS Atlas
- 3-Box thinking

Measures to Assess Health Organisations’ Readiness to Deliver Accountable Care

Tools to Partner for New Care Models Across Health & Other Sectors with Needed Capabilities

Tools to Partner for New Care Models Across Health Services with Needed Capabilities

Value Compasses: Measures of Quality & Cost with Focus on What Matters to People Served

Measures of Engagement to Agree Goals, Needs & Wants

Patient & Clinician Reported Measures

Patient & Clinician Reported Measures of Care Coordination & Teamwork

Measures and Tools for Quality & Efficiency Improvement in Clinical Microsystems

Tools to Guide Implementation of Innovation, Learning from Success & Failure

Tools: Right Care
- NHS Atlas
- 3-Box thinking

Tools: Value Compass
- Microsystem Tools

Tools: CollaborATE
- IntegRATE

System Dynamics Models to Test Impact and ROI Assumptions about Cross-Sector Investments

Tools: ReThink Health
- STRAT: Readiness Assessment for Health Care Organisations
- New Care Model Canvas for Health Care Organisations

Patient & Clinician Reported Measures of Engagement to Agree Goals, Needs & Wants

# of stakeholders with role interdependences

Confidential Draft for Discussion

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Learning from Variation to Deliver What is Valued

Overcoming Conceptual and Operational Barriers

Processes
Costs
Outcomes
Preferences

Learn from Variation

Bring the Discipline of Science

Organize for Innovation

Deliver with Teams

Deliver What is Valued

Be Guided by Simple Rules

Summary

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Integrating Acute with Primary Care Across the Patient Journey

From the Perspectives of Patients Experiencing a Heart Attack

At Risk

- Population at Risk
  - 1st Prevention (No known LTCs)
  - 2nd Prevention (Known LTCs)
  - Patients with Known LTCs And Complex Needs

Acute

- Acute Illness Associated with LTCs
  - Chest pain diagnosed as a heart attack

Post Acute

- Post Acute Rehabilitation & Support
  - Getting better - learning self-care

Recovery

- ‘uncomplicated’ patient
  - Living with heart disease planning for the future

Community Health Center

- Acute Care Hospital

- Long-Term Care Center

- Community Health Center

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What Can Be Achieved By Delivering High Value Care to Patients

Specialist Diabetes Visits: 90%
Outpatient Procedures: 23%
Emergency Room Visits: 48%
Hospital Admissions: 41%
Hospital Readmissions: *72%
Hospital Length-of-Stay: *10%

*Improvements in Patient Satisfaction
Diabetes Control
Smoking Cessation

12.3% reduction in costs per person
$2,100 per year net after subtracting $600 for the cost of SCC services including medicines provided

*against benchmarks

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New approaches to measurement and management for high integrity health systems

We need better tools to achieve the next generation reforms essential for delivering care that matters most to patients, say Albert Mulley and colleagues

Albert Mulley professor¹, Angela Coulter senior research scientist², Miranda Wolpert professor³, Tessa Richards senior editor/patient partnership⁴, Kamran Abbasi international editor⁴
High integrity mental health services for children: focusing on the person, not the problem

M Wolpert and colleagues discuss how the principles of high integrity healthcare can improve mental health services for children and young people

M Wolpert professor in evidence based practice¹, P Vostanis professor of child mental health², K Martin director³, S Munk children and young people mental health and resilience strategic lead,⁴ R Norman school improvement adviser⁵, P Fonagy professor of contemporary psychoanalysis and developmental science¹, A Feltham adviser³
Systems Balancing Acute Care with Community Health Care
07
Q&A / Panel discussion

Transforming London’s health and care together
Using data to support change

Dr Dagmar Zeuner, Director of Public Health, Merton
Improving health outcomes for CYP through Primary Care

Using **data** to support change

How can local **Public Health** help?

Dr Dagmar Zeuner
Director of Public Health, London Borough of Merton
HLP CYP event, April 2017
Purpose & format

• **Purpose** – Exchanging learning, perspective, resources

• **Part 1 – Setting the scene**
  – Context, concepts → **Key points**
  – Reference material (illustrative only)

• **Part 2 – Examples of using data to support change**
  – Joint commissioning (Healthy Child Programme)
  – Leadership and advocacy (Childhood obesity)
  – Surveillance (Immunisation)
  – Shared learning (child deaths overview panel)
  → **Improved outcome / or proxy**

• **Conclusions**
Primary Care - Strategic Context

• Public sector funding ↓, demand/need ↑
  = health & care system unsustainable

• NHS response: FYFV (incl GP FYFV, FYFV next steps)
  – Practices working together (30-50,000 population)
    • GP federations, hubs, networks
  – New care models, experience from vanguards (MCP, PACT etc)
  – STPs / accountable care systems

→ Focus on population health, prevention & integration
How can **PH** help – PH duties in LA

Aim: protecting & improving population health and reducing inequalities through concerted efforts of society

- **Strategic / system leadership for health**
  - Health & wellbeing board; JSNA; APHR

- **Commissioning defined range of services**
  - Health visitors; school nurses; sexual health services; drugs & alcohol services; healthy lifestyle services

- **Commissioning support for local CCG**
  - Needs assessment; strategy development; service & pathway redesign; evaluation

- **Oversight of local health protection arrangements**
  - Screening; immunisations; infection control; emergency planning

→ **Data are essential PH tools but there is more that PH offers; Use it all!**
CYP health & wellbeing outcomes

• Overall significant health improvement **BUT**
  – Persistent inequalities (child poverty; see RCPCH report)
  – Prevention opportunities ++ (early yrs, obesity, immunisations, risk taking, injuries)
  – Disability
  – Emotional & mental wellbeing
  – Safeguarding / maltreatment

→ Prevention starts with CYP
→ CYP 20-25% of current population, 100% future
→ They need your explicit leadership & advocacy
Navigating services for CYP → it is a maze!

<table>
<thead>
<tr>
<th>Service type</th>
<th>Provider</th>
<th>Commissioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity services</td>
<td>NHS hospital trust</td>
<td>CCG</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td><strong>GP practices</strong></td>
<td><strong>CCG / NHSE</strong></td>
</tr>
<tr>
<td>0-19 HCP; FNP</td>
<td>Community health care trust</td>
<td>LA PH / CS</td>
</tr>
<tr>
<td>CHIS; imms; screening</td>
<td>Community /acute trust</td>
<td>NHSE</td>
</tr>
<tr>
<td>Children’s acute health care</td>
<td>NHS hospital trust</td>
<td>CCG / NHSE for specialist services</td>
</tr>
<tr>
<td>Community paediatrics</td>
<td>Hospital/ community trust</td>
<td>CCG</td>
</tr>
<tr>
<td>CAMHs</td>
<td>Mental health trust</td>
<td>CCG (NHSE for tier 4)</td>
</tr>
<tr>
<td>Dental; oral health promotion</td>
<td>NHS/private dentists; community dental services</td>
<td>NHSE / PHE (on behalf of LA)</td>
</tr>
<tr>
<td>Drugs and alcohol services</td>
<td>Mental health trust, vol sector</td>
<td>LA PH</td>
</tr>
<tr>
<td>Children’s centres/early yrs/children social care</td>
<td>LA, schools, vol sector</td>
<td>LA CS</td>
</tr>
<tr>
<td>Sexual health services</td>
<td>Acute / community trusts</td>
<td>LA PH</td>
</tr>
</tbody>
</table>
Data

- Oxford dictionary:
  - ‘Known facts used in inference or for reckoning’
- Data types (for needs assessment / service reviews)
  - Populations (registered, resident, school children)
  - Demography (age, ethnicity, projections)
  - Determinants of health; distribution of risk & resilience factors & diseases; service utilisation / performance / cost
  - Assets (not just deficit focus)
  - ‘Voice’ (Patient / public / community views & experience)
  - ‘What works’ (NICE guidance, evidence reviews etc)
- Importance of comparators (what does it mean?)
  - Trends, benchmarks (variation), standards; controls
- What is your question?
  - Why do you want to know / what difference will it make?
  - Data needs to be turned into intelligence
  - Data is essential but not a magic bullet for difficult decisions
  - Keep a mind-set of triangulation, checking, myth-busting

Good read: B Goldacre *Bad science*; M Syed *Black box thinking*
Data sources

- PHE finger tips tools – Child & maternal health
  fingertips.phe.org.uk/profile-group/child-health
  - Life course stage (pregnancy & birth; early yrs; school-age; young people)
  - Themes (breastfeeding; mental health; health behaviours; mortality; LTC & complex health needs; obesity; injuries; immunisation; vulnerable children; PH & NHS outcomes frameworks; health care use)
  - Overview; maps; trends; profiles

- PHE finger-tips tool – General practice profiles (update 17/18)
  fingertips.phe.org.uk/profile/general-practice

- NHSE right care – CCG data packs (incl maternity & early yrs pathway)
  www.england.nhs.uk/rightcare/intel/cfv/data-packs/london

- HLP – STP CYP data pack
  www.healthylondon.org/children-and-young-people/resources

- LA – JSNA; APHR
  www.merton.gov.uk
Child health profile

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Merton</th>
<th>Region England</th>
<th>England</th>
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<tbody>
<tr>
<td>Under 18 conceptions</td>
<td>2014</td>
<td>60</td>
<td>19.7</td>
<td>21.5</td>
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<tr>
<td>Emergency admissions (aged 0-4)</td>
<td>2014/15</td>
<td>1,665</td>
<td>104.3</td>
<td>105.9*</td>
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<tr>
<td>Hospital admissions for accidental and deliberate injuries in children (aged 0-4)</td>
<td>2015/16</td>
<td>196</td>
<td>122.3</td>
<td>97.6</td>
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<tr>
<td>Infant mortality</td>
<td>2013 - 2015</td>
<td>25</td>
<td>2.5</td>
<td>3.4</td>
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<td>Low birth weight of term babies</td>
<td>2015</td>
<td>79</td>
<td>2.5%</td>
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<tr>
<td>Reception: Prevalence of overweight (including obese)</td>
<td>2015/16</td>
<td>420</td>
<td>18.8%</td>
<td>22.0%</td>
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<tr>
<td>Smoking status at time of delivery</td>
<td>2015/16</td>
<td>130</td>
<td>4.8%</td>
<td>5.0%*</td>
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<tr>
<td>A&amp;E attendances (0-4 years)</td>
<td>2015/16</td>
<td>9,959</td>
<td>621.7</td>
<td>706.7</td>
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<tr>
<td>Breastfeeding prevalence at 6-8 weeks after birth - current method</td>
<td>2015/16</td>
<td>1,992</td>
<td>*</td>
<td>43.2%*</td>
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<tr>
<td>Breastfeeding prevalence at 6-8 weeks after birth - previous method</td>
<td>2014/15</td>
<td>1,485</td>
<td>*</td>
<td>43.8%*</td>
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<tr>
<td>Population vaccination coverage - MMR for two doses (5 years old)</td>
<td>2015/16</td>
<td>2,570</td>
<td>80.0%</td>
<td>81.7%</td>
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<tr>
<td>Children achieving a good level of development at the end of reception</td>
<td>2015/16</td>
<td>1,915</td>
<td>71.2%</td>
<td>69.3%</td>
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</tbody>
</table>

Source: PHE Early Years Profile – Merton: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-early-years
Maternity & early yrs pathway

Maternity and early years pathway


http://pathways.nice.org.uk/
Further Information Link:
HLP STP data packs

Healthy London Partnership
Children & Young People’s Dashboard

South West London STP area
April 2016
Local example (1)

• 0-19 healthy child programme (HV, SN, FNP) – data use for effective joint commissioning
  – Joint commissioning (with other health services such as community therapies) - informed by NA
  – Clinical input from primary care
  – Clear service specs focussed on high impact areas
  – Disciplined contract management
  – Co-production relationship with community provider, primary care & LA CS (shared ‘think family approach)

→ Improved KPIs → Improved health outcomes
## 0-19 healthy child programme

<table>
<thead>
<tr>
<th>CM07</th>
<th>HVs: NBV within 14 days</th>
<th>90%</th>
<th>Numerator</th>
<th>191</th>
<th>257</th>
<th>248</th>
<th>253</th>
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<th>277</th>
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<td>Denominator</td>
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<td>230</td>
<td>270</td>
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<td>Performance</td>
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<td>83.0%</td>
<td>95.2%</td>
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<tr>
<td>CM33</td>
<td>HVs: 6- to 8-week reviews by 8 weeks</td>
<td>95%</td>
<td>Numerator</td>
<td>137</td>
<td>147</td>
<td>180</td>
<td>207</td>
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<td></td>
<td>Performance</td>
<td></td>
<td>56.8%</td>
<td>62.0%</td>
<td>69.8%</td>
<td>74.7%</td>
<td>92.7%</td>
<td>92.0%</td>
<td>96.4%</td>
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<tr>
<td>CM37</td>
<td>HVs: breastfeeding status recorded at 6- to 8-week review</td>
<td>95%</td>
<td>Numerator</td>
<td>133</td>
<td>147</td>
<td>180</td>
<td>207</td>
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<tr>
<td>CM53</td>
<td>HVs: totally or partially breastfed at 6- to 8-week review</td>
<td>70%</td>
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<td>46.5%</td>
<td>48.5%</td>
<td>52.3%</td>
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<td>69.0%</td>
<td>69.96%</td>
<td>73.3%</td>
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<td>75.7%</td>
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<td>CM25</td>
<td>HVs: 12-month reviews by 12 months</td>
<td>75%</td>
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<td>145</td>
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<td></td>
<td>Performance</td>
<td></td>
<td>49.2%</td>
<td>57.4%</td>
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<tr>
<td>CM26</td>
<td>HVs: 12-month reviews by 15 months</td>
<td>80%</td>
<td>Numerator</td>
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<td>144</td>
<td>172</td>
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<td>73.7%</td>
<td>74.7%</td>
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<td>CM27a</td>
<td>HVs: 2.5-year reviews by 2.5 years</td>
<td>80%</td>
<td>Numerator</td>
<td>5</td>
<td>8</td>
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<td>57.2%</td>
<td>62.7%</td>
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</tr>
</tbody>
</table>
Local example (2)

- Childhood obesity – **data use for leadership & advocacy** (for comprehensive prevention approach)
  - Great weight debate (political mandate for environmental changes to promote healthy choices at population level, not just services)
  - APHR (facts, figures, costs, evidence what works)
  - Child healthy weight action plan (what to do)

→ **HWBB priority** (incl GP members and chair)
→ **Reduction in obesity inequality by 2020**
Childhood obesity
Local example (3)

• Childhood immunisation – **data use for surveillance**
  – NHSE is commissioner, primary care is provider
  – PHE is monitoring infectious diseases ie measles
  – LBM O&S committee review because of low coverage
  → **Strengthened local action plan** (Immunisation steering group chaired by primary care nurse, top tips for GPs, immunisation promotion by HVs and health champions etc)
  → **Improvement of coverage** (from low baseline)
### Table 1 – Annual performance trends 2013/14 to 2015/16

<table>
<thead>
<tr>
<th></th>
<th>Diphtheria, Tetanus, Polio Pertussis, Haemophilus influenza type b (DTaP/IPV/Hib) Age 1</th>
<th>Hib/Men C booster Age 2</th>
<th>MMR1 Age 2</th>
<th>Pneumococcal infection (PCV booster) Age 2</th>
<th>Diphtheria, Tetanus, Polio Pertussis (DTaP/IPV – preschool booster) Age 5</th>
<th>MMR2 Age 5</th>
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<tr>
<td>Merton Annual 15/16</td>
<td>91.8%</td>
<td>86%</td>
<td>86.3%</td>
<td>85.5%</td>
<td>68.7%</td>
<td>80%</td>
</tr>
<tr>
<td>Merton Annual 14/15</td>
<td>93.3%</td>
<td>87.9%</td>
<td>88.8%</td>
<td>87.7%</td>
<td>71.7%</td>
<td>80.4%</td>
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<tr>
<td>Merton Annual 13/14</td>
<td>82.1%</td>
<td>81%</td>
<td>82.1%</td>
<td>82.8%</td>
<td>64.8%</td>
<td>72.3%</td>
</tr>
<tr>
<td>London average 15/16</td>
<td>89.2%</td>
<td>85.9%</td>
<td>86.4%</td>
<td>85.6%</td>
<td>78.3%</td>
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<tr>
<td>England average 15/16</td>
<td>93.6%</td>
<td>91.6%</td>
<td>91.9%</td>
<td>91.5%</td>
<td>86.3%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Merton Annual 15/16</td>
<td><strong>2.6%</strong></td>
<td><strong>0.1%</strong></td>
<td><strong>0.1%</strong></td>
<td><strong>0.1%</strong></td>
<td><strong>9.6%</strong></td>
<td><strong>1.7%</strong></td>
</tr>
</tbody>
</table>

Source: NHS England and NHS Digital
Local example (4)

• Child death overview panel – data use for shared learning
  – CDOP currently statutory function of LCSB
  – All child deaths (unexpected = rapid review)
  – Immediate sharing and annual report with themes
  – Pattern recognition difficult with small numbers (in response children & social work bill will change arrangements)
  – HLP pan London CDOP work stream (SUDI, asthma, neonatal deaths, bereavement)

→ Prevention of avoidable child deaths
In this issue:
Button Battery Warnings
Uncooked Jelly cubes
Child Car Seats
Conclusions

Improving CYP health & wellbeing outcomes in primary care

- Data are essential and powerful tools but need to be turned into intelligence that matters
- Primary care is at the heart of future new care models as:
  - Provider, commissioner & place shaper
- Shared business with PH / LA
  - Population health, prevention and integration
  - Help with data / intelligence
  - Local influence (HWBB, DCS, Cllr as CYP advocate, community)
- Invest in relationships and capability now
09

How can primary care support the mental health of children, young people and families?

Alex Goforth, Programme Lead, London & South East CYP IAPT Learning Collaborative
What are the issues?

• Referrals are not accept by CYP Mental Health Services
  – 60% referrals from GPs do not progress to treatment (Pulse, 2016)
  – Third are not assessed (Pulse, 2016)
• Referral protocols and pathways need improvement
  – GP referrals 3x more likely to be rejected (Hinrichs, et al. 2012)
• Inadequate signposting/lack of information (Future in Mind, 2015)
• Lack of knowledge of CYP mental health issues (Hinrichs, et al. 2012)
• Additional pressures...
What needs to be done?

• Increase capacity and capability
  – Better, earlier specialist treatment (underway)
  – Better and more preventative work, based in GP surgeries, schools, youth clubs,
• Build resilience amongst young people from an early age
• Get better at spotting potential issues earlier, e.g. through primary and secondary schools
• Find innovative ways of engaging young people outside of the system, e.g. TIM
• Increased liaison with GPs
• Increased interventions in primary care, e.g. CWPs
Research by Eastern Cheshire CCG group & STITCH

• Recommendations by Eastern Cheshire CCG group & STITCH:
  – Improve the referral process – agreed protocol between CAMHS and GPs
  – Create an information hub with access to support and information, for young people, parents, carers, schools and GP’s can go to access up to date, relevant information, advice and signposting, which develops into a platform for delivering treatment

Further recommendations were:
  1. Education in schools
  2. Mental health roadshows
  3. Parent helpline & SMS service
  4. Central referral hub
What are the opportunities?
What is CYP IAPT?!

• Funded by NHSE and HEE
• Transforming existing services through:
  – high quality, funded and salary supported training in evidence based interventions
  – System-wide and whole service transformational outreach
  – Pan-collaborative learning events

• Five principles for transformation:
  – Accountability
  – Evidence based practice
  – Participation
  – Awareness
  – Accessibility
Therapist, supervisor and service leadership trainings

THERAPY TRAININGS

PGDip in CBT for anxiety disorders and depression
PGDip in Parenting training for conduct problems (3 to 10 year olds)
PGDip in IPT-A for adolescents with depression
PGDip in System Family Practice for depression, conduct disorders and self harm
PGCert in Evidence Based Counselling
PGDip in 0-5s
PGCert Combinations Therapies (prescribing and talking therapies)
PGDip in Evidence Based Psychological Therapies for Children and Young People with Autism and / or Learning Disability
How can CYP IAPT help?

• Increase capacity and capability through Recruit to Train staff based in GPs surgeries + implementation support
• Increase capacity and capability through CWPs based in primary care (more in a moment)
• Interventions guided by goals, outcomes and young people’s preferences, are generally briefer
• Support improved referral protocols and communication
  – Progress updates including feedback and outcomes
Children & Young People’s Wellbeing Practitioners

- National pilot of young people’s version of adult PWP, through CYP IAPT programme
- For young people who otherwise wouldn’t reach thresholds for CYP MH services
- New service model, linked with CYP MH services
- 15 pilot sites in London & South East with 60 (band 4) CWPs with high quality supervision
- Offering low intensity guided self-help for:
  - Anxiety
  - Low mood
  - Self-harm
  - Behavioural issues
- Based in VS, LA, schools, primary care, etc
- Applications for second cohort from September 2017
A few examples of what’s already happening...
How are you feeling?

If you’re a young person, MindMate can help you understand the way you’re feeling and find the right advice and support.

Advice for young people ➔

What’s new
Eat yourself happier

Did you know that what you eat affects your mood as well as your body?

Learn about eating happy ➔

What’s in Leeds for me?

Games

https://www.mindmate.org.uk/
WHAT ARE SKYCasts?
SkyCasts are free and informal online workshops, designed to provide practical help and information about key issues you might be struggling with in your life.

11/05/2017 @ 19:00
What is 'Depression'?
For Young People
MENTAL HEALTH
Often people may say they're feeling depressed, but what is depression? If you have depression you're not 'just' sad or upset, it can leave you feeling lost, alone and not sure who you are anymore.
Join us and other young people to chat about what depression is, and what it means for you.

WHAT IS SKYLINE?
SkyLine offers free online counselling, giving you one-to-one support to help you through tough times.

I WANT TO TALK TO A SKYLINE COUNSELLOR

I NEED HELP NOW!
I WANT TO GIVE FEEDBACK
I NEED HELP ON THE SITE

FIND US ON TWITTER
Bromley Wellbeing hub

- Voluntary Sector counselling organisation
- Joined CYP IAPT in 2012, and continuously trained staff in evidence based interventions + CWPs (2017)
- Selected by local CCG as Single Point of Access for all CYP mental health services
  - YP up to 18 years, or 25 if subject to an Education, Care and Health Plan
  - Assessment within 72 hours
  - 2,206 referrals in 2015-16, of which 1491 seen by Bromley Y
  - > 80% cases are showing reliable improvement on SDQ & ~80% on RCADs
- Recently accredited by [CORC](https://www.corc.org.uk) for their feedback and outcomes measurement
The Integrate Movement seeks to support services to:

- Co-produce (doing with, not for)
- Reach out to people in their place and at their pace
- Deliver psychologically informed services
Schools Link Pilot

• 22 pilot sites led by CCGs to improve links between schools and CYP MH services.

• Quantifiable improvements in:
  – Frequency of contact
  – Satisfaction with communications and working relationships
  – Understanding of referral routes
  – Knowledge and awareness of issues affecting YP

• Some sites found increased direct referrals from schools to CYP MH services, rather than indirect referrals from GPs

• Phase 2 has been commissioned for a further 20 CCGs and up to 1200 schools – May 2017
Evidence Based Treatment Pathways

• Community Eating Disorders Services

• Crisis Care

• Generic Pathways
Participation

• CYP MH services engage young people in their transformation through innovative, creative activities
• Young people learn skills, gain confidence and meet peers
• Some young people say the participation activities have helped them more than treatment

• Setting up participation groups in primary care?
• Young people co-producing pathways between GP and CYP mental health services
Debating Programme

• Collaboration between Collaborative, SWLSTG & English Speaking Union
• Young people with experience of mental health services trained in debating over 12 weeks beginning end October 2016
  – Culminating in 1 day of competition at a prestigious venue
• Propositions around mental health, service provision, social media
• 7 groups of young people from across the Collaborative already involved
• Objectives:
  – New skills and confidence for young people
  – Engaging young people in service transformation
  – Valuable feedback for services
AMPLIFIED: National Participation Programme

- Four year NHSE programme to increase young people and parent/carer involvement in CYP MH services
- Led by Young Minds and NEL CSU
- Developing networks in IRL and online
- Connecting CYP MH services with GPs
Hackathons

Young people + Software Developers = Clinicians

Transformation from Current State to Future State

Android App on Google Play
App: Breath with Me

https://breathe-with-me.github.io/user-test/
Grow

ADD A GOAL +

Achieve my dreams

Manage my goals

Work well with others
To chat/find out more:
@LDNSECYPIAAPT
alex.goforth@annafreud.org
www.cypiapt.com
The Well Centre and Teen Health Check: an integrated approach to adolescent health

Dr Stephanie Lamb, GP, The Well Centre
The Well Centre and Teen Health Check: an integrated approach to adolescent health

Improving Care for Children and Young People in Primary Care

HLP - 25th April 2017

Dr Stephanie Lamb
The Well Centre and Teen Health Checks

Double click on icon on desktop
WHY IT MATTERS?

• 80% of lifetime cannabis and alcohol use is initiated by the age of 20

• 50% of lifetime mental illness starts by age 15

• 8/10 obese teenagers become obese adults

• 8/10 adult smokers start as teenagers

• Strong links between different risk-taking behaviours: <16 yrs who are sexually active are more likely to abuse substances

MORE REASONS WHY IT MATTERS:

• 70% of adult preventable deaths are the result of behaviours initiated or reinforced in adolescence.
• Adolescents get shorter consultations than adults ...

• And in the recent HBSC survey, although 80% had visited their GP in the last 12 months

• 48% felt uncomfortable discussing personal issues with the GP
WHY FOCUS ON ADOLESCENT HEALTH?

• Timely interventions at this developmental stage can have long term benefits in all aspects of life

• Healthy behaviours can be established

• Long term mental health problems can be prevented

• Appropriate use of health services can be encouraged
Teen Health Check

- Biopsychosocial assessment based on validated HEADSSS model
- Adapted for use at the Well Centre
- Abridged version developed for Primary Care consultation – Emis, read coded
Vulnerability Indicators

• Confidentiality explained

• Home
• Education/Employment
• Carer?
• Social service involvement?
Health risk factors

- Smoking
- Alcohol
- Substance misuse
- Diet and exercise – BMI /centile
- Sexual activity – HPV
- Mental health – sleep/mood/self harm
New Section 1
- Sexual Activity: Sexually active 08-Dec-2015
- Sexual Orientations: 08-Dec-2015
- HPV Status: 08-Dec-2015

New Section 2
- History of chlamydia: No previous entry
- Chlamydia Screening: 08-Dec-2015
- Long acting reversible contraception: 15-Dec-2015

New Section 3
- Health education - safe sex: 08-Dec-2015
- Health education - sexual health: 08-Dec-2015
- Contraceptive Advice: 06-Oct-2014
Resources/follow up

- Links to local/national services

- Care plan – pt’s mobile number/facilitate review.
Any questions?

- [Stephanielamb@nhs.net](mailto:Stephanielamb@nhs.net)
Table discussion
Table discussion

• What can Healthy London Partnership do to support better care of children and young people in primary care at scale?

• What can we do at organisation level and as individuals?
Feedback/ Q&A/ Panel discussion
Next steps for the programme

Eugenia Lee, GP lead, Healthy London Partnership’s Children and Young People’s Programme
Lunch and close

Thank you for attending

Please complete an evaluation form