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 Childre and Young People's Programme

Welcome and communications

www.menti.com

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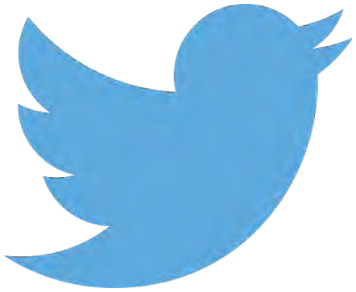
Question 2 code 98 83 38



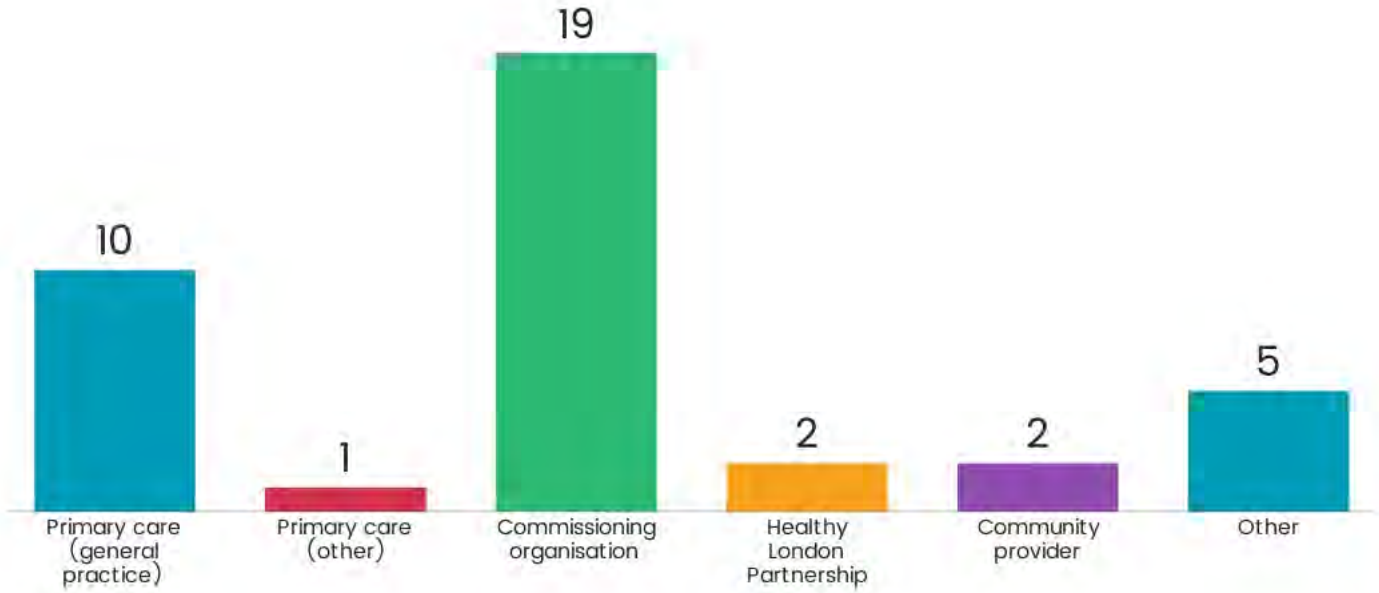
#LdnCYPPC

@HealthyLDN

Who is in the room today?

What kind of organisation do you work in?

Mentimeter



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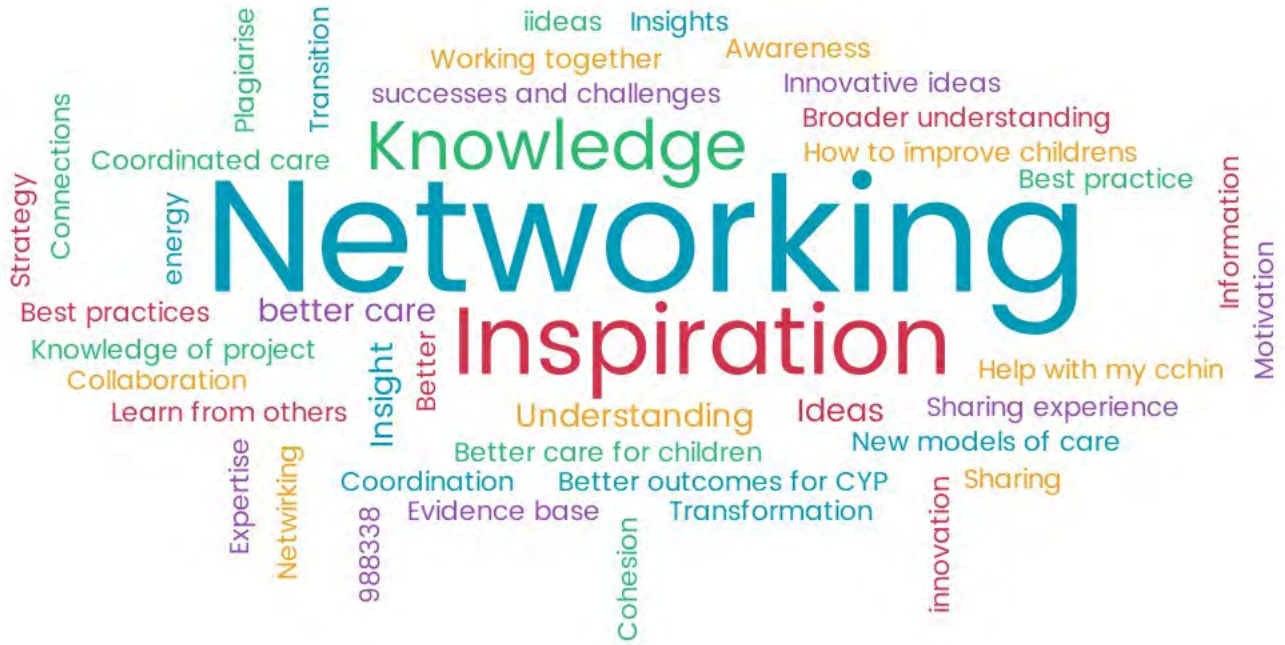
Expectations

What are you hoping to gain from today's event?

Mentimeter



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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

600,000

of London's children live in poverty

20% of 4-year-olds are overweight or obese

Mental Health conditions affect

1 in 8

Children

Emotional and behavioural problems affect

1 in 5

Children

134,186

live births in London in 2012

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

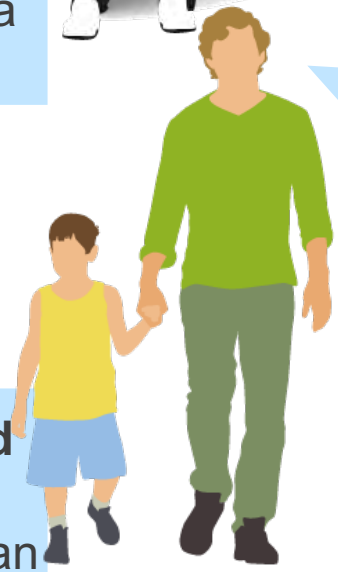
LESS THAN HALF of 11-15 year olds do an hour of exercise each day

What do children, young people and families think?

I want to know that my **GP is experienced** in caring for children

Make sure the **school can look after my son** when he has an asthma attack

We need **easier access** to healthcare



Services are **not joined up**

I am worried about what will happen next year when I am **too old for the children's clinic**

I need **rapid access** to someone I can talk to when I feel depressed

London Health Commission

Healthy London Partnership –
The delivery arm of the London Health Commission

Goal – London to be world's healthiest global city

10 programme aims from London Health Commission

Give all London's children a healthy, happy start to life

Enable Londoners to do more to look after themselves

Get London fitter with better food, more exercise and healthier living

Ensure that every Londoner is able to see a GP when they need to and at a time that suits them

Make work a healthy place to be in London

Create the best health and care services of any world city, throughout London and on every day

Help Londoners to kick unhealthy habits

Fully engage and involve Londoners in the future health of their city

Care for the most mentally ill in London so they live longer, healthier lives

Put London at the centre of the global revolution in digital health

Delivering value and sustainability across the whole system

A radical upgrade in prevention and public health	Preventing ill health and making Londoners healthier				
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
Marketing campaign
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

Healthy London Partnership

NHS

Primary care
GP federation pilot model care CYP
Population based data
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

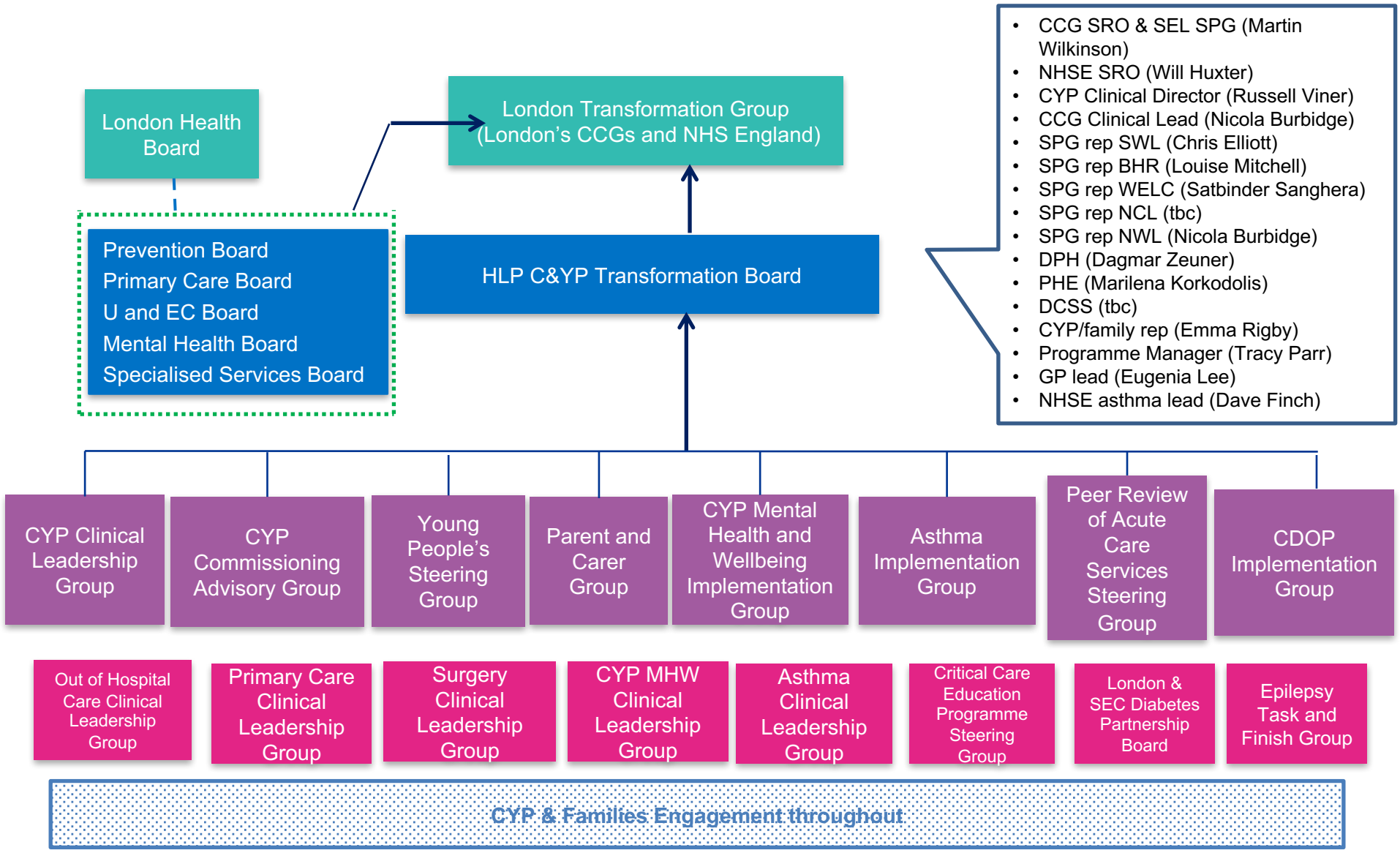
Place-based care and planning (data packs, support for networks)

Workforce

January 2017 **Commissioning development programme**

System-wide enablers

Healthy London Partnership Children and Young People Programme Governance



KEY

Accountable

Information sharing/ endorsement

Programme alignment

Publications

Healthy London Partnership Children an
Young People's Programme

Social Prescribing for Children, Young People and Families: A Guide for Commissioners

Driving consistency in outcomes across the capital

NHS

London schools' guide for the care of children and young people with asthma

Pre-school, primary and secondary school years

April 2016

Compendium: New models of care for acutely unwell children and young peop

October 2016

Healthy London Par

London acute care standards for children and young people

Driving consistency in outcomes across the capital

Revised May 2016

Healthy London Partnership

NHS

Healthy London Partnership Children and Young People's

Commissioning leadership development programme

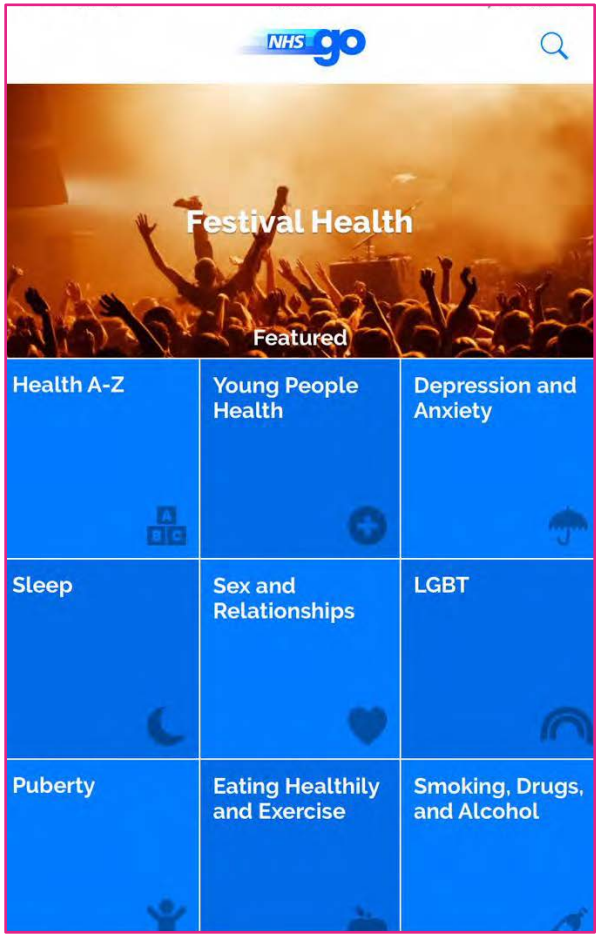
Welcome guide

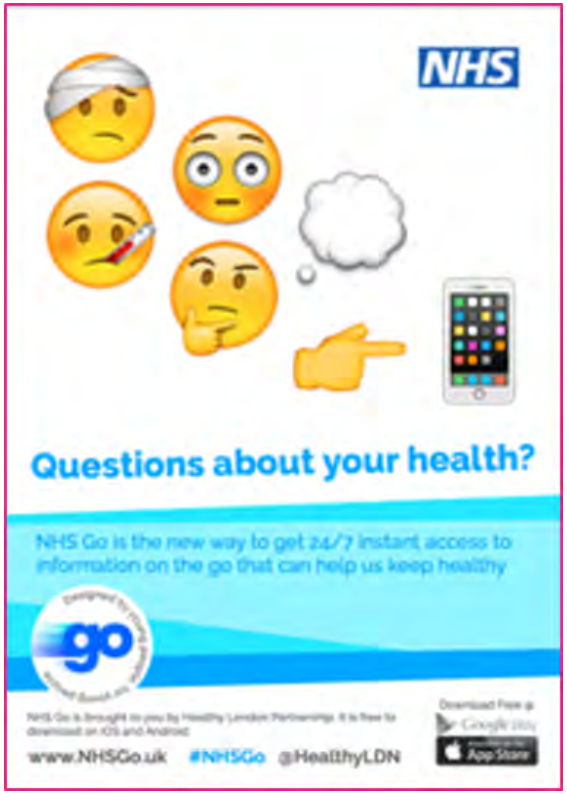
Healthy London Partnership – Children and Young People's Programme

Improving care for Children and Young People with mental health crisis in London: Recommendations for transformation in delivering high quality accessible care

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 in primary care

- 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 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

01

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)

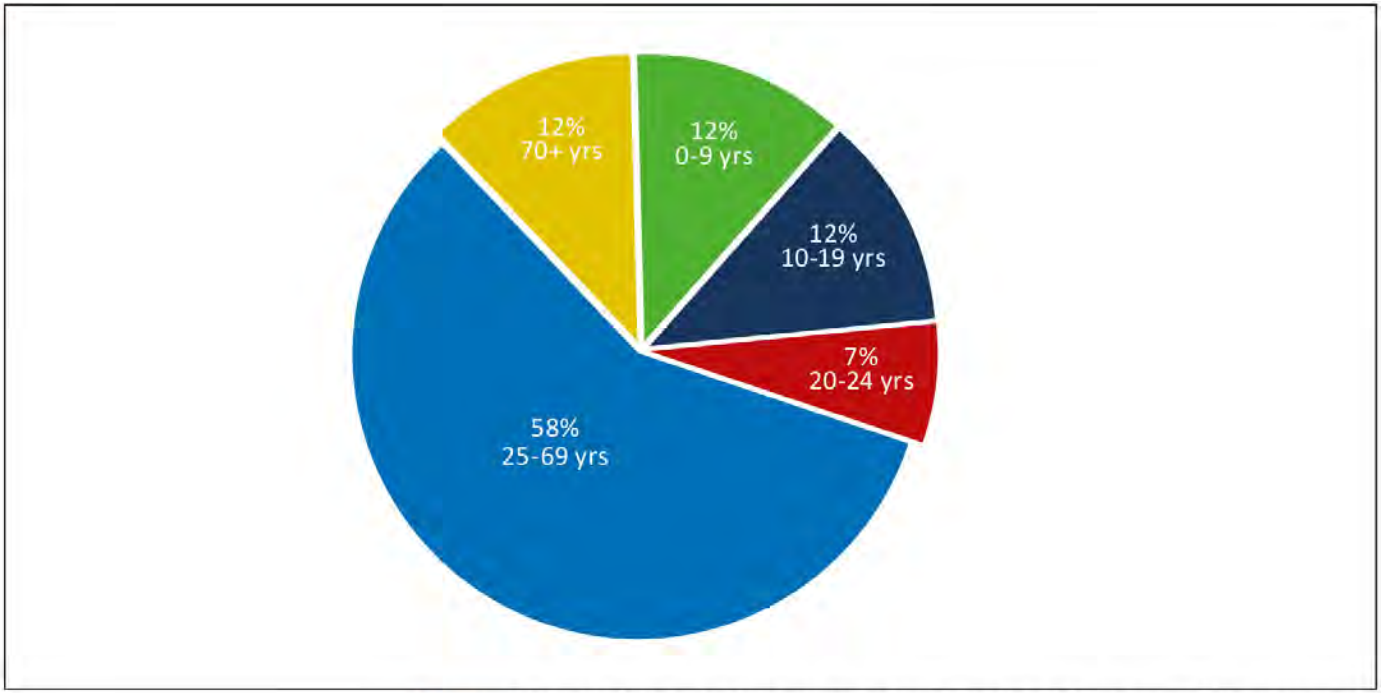
We are a membership organisation for individuals and organisations working in the young people's health field.

www.ayph.org.uk

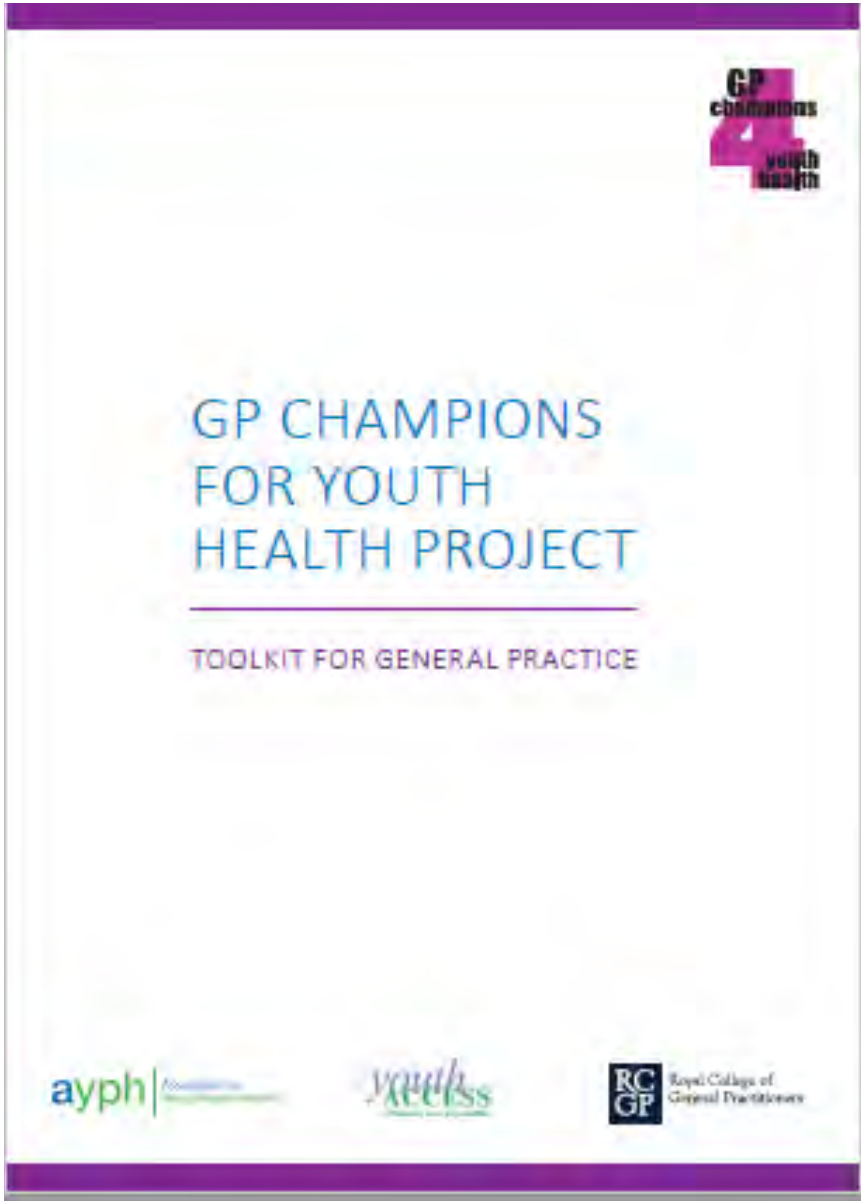
Why focus on young people?

- 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



Source: Office for National Statistics/National Records of Scotland, 2011 census data
Annual Mid-Year Population Estimates for the UK, Office for National Statistics, 2014



GP champions 4 youth health

http://www.youngpeopleshealth.org.uk/our-work/practice/gp-champions

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

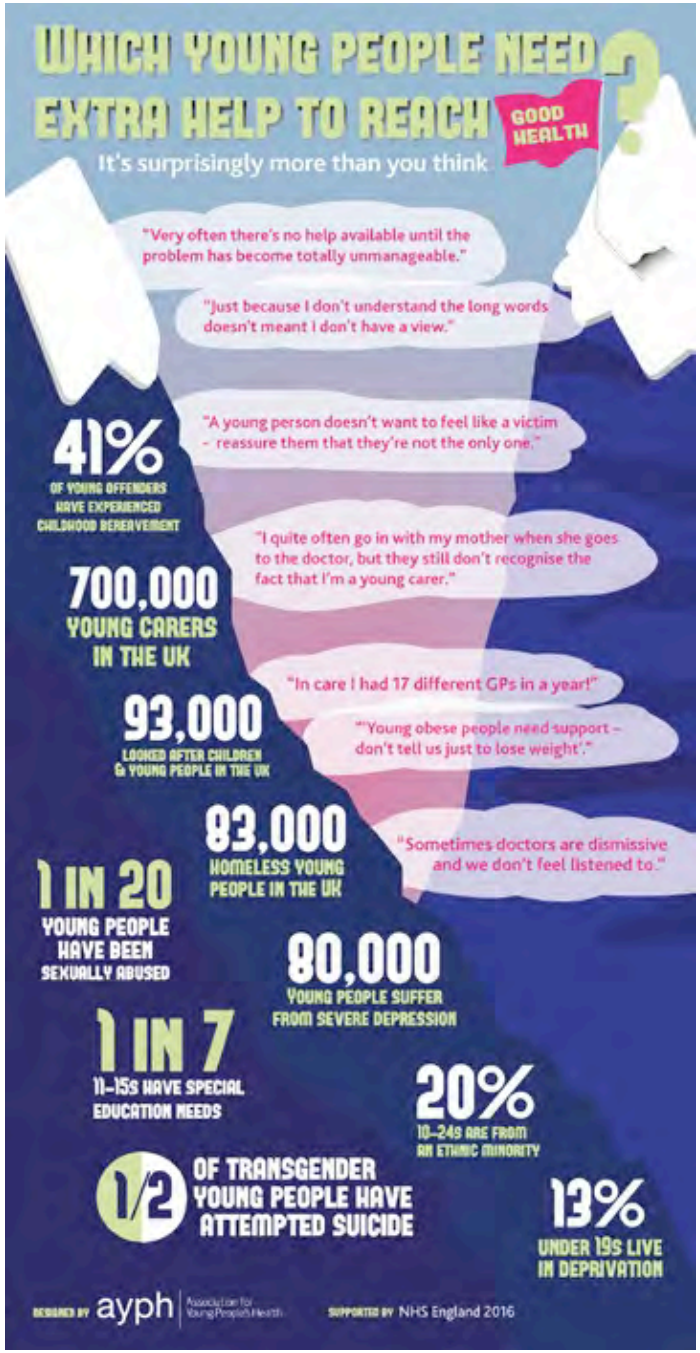
“It doesn’t feel like they listen, just fob you off with medication, and the Drs don’t communicate between each other.”

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"



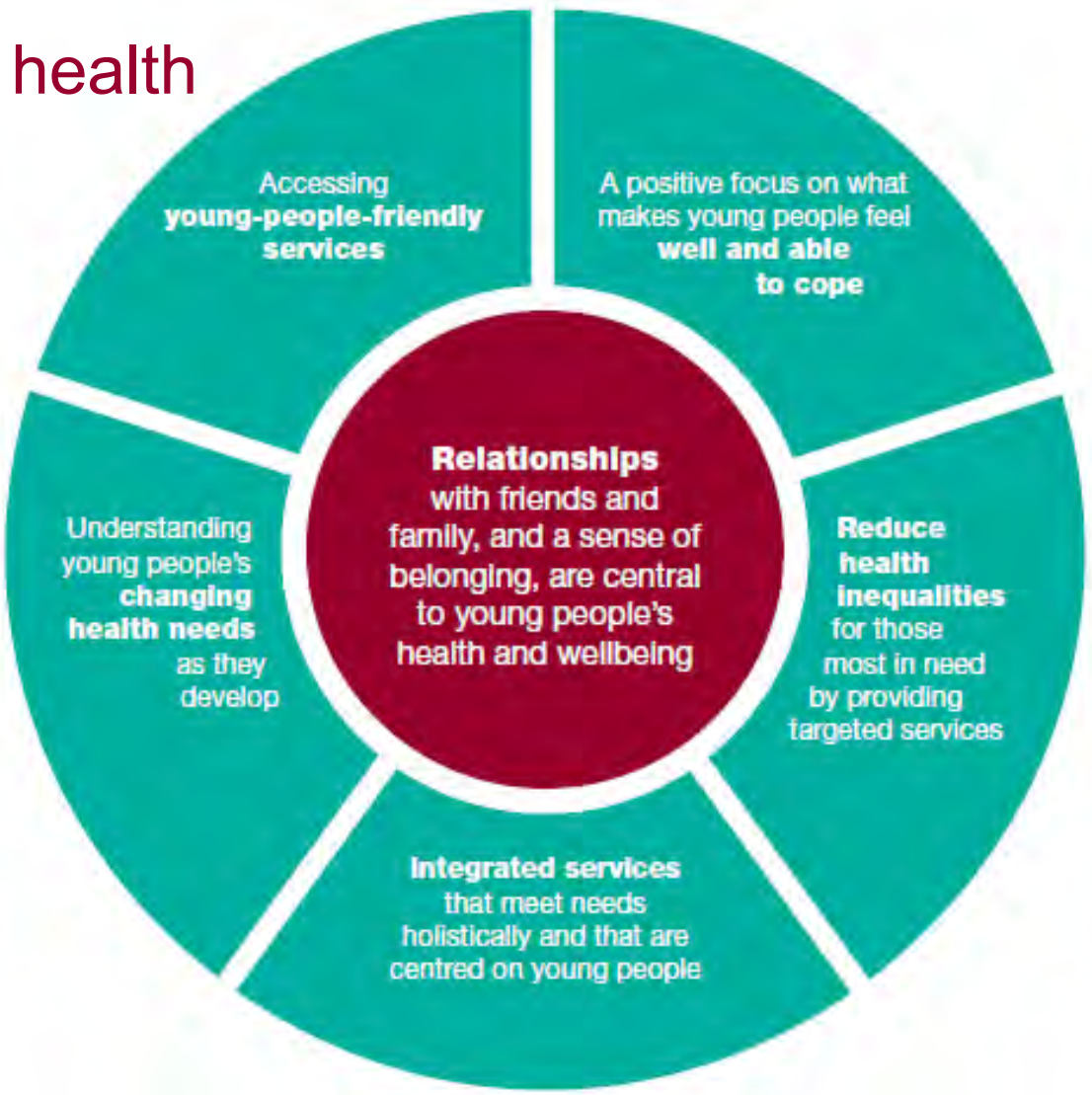
Reaching marginalised young people

www.ayph.org.uk/reaching-marginalised-young-people

Improving young people's health and wellbeing

A framework for public health

Importance of an holistic approach



Public Health England

https://www.gov.uk/government/publications/improving-young-peoples-health-and-wellbeing-a-framework-for-public-health

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

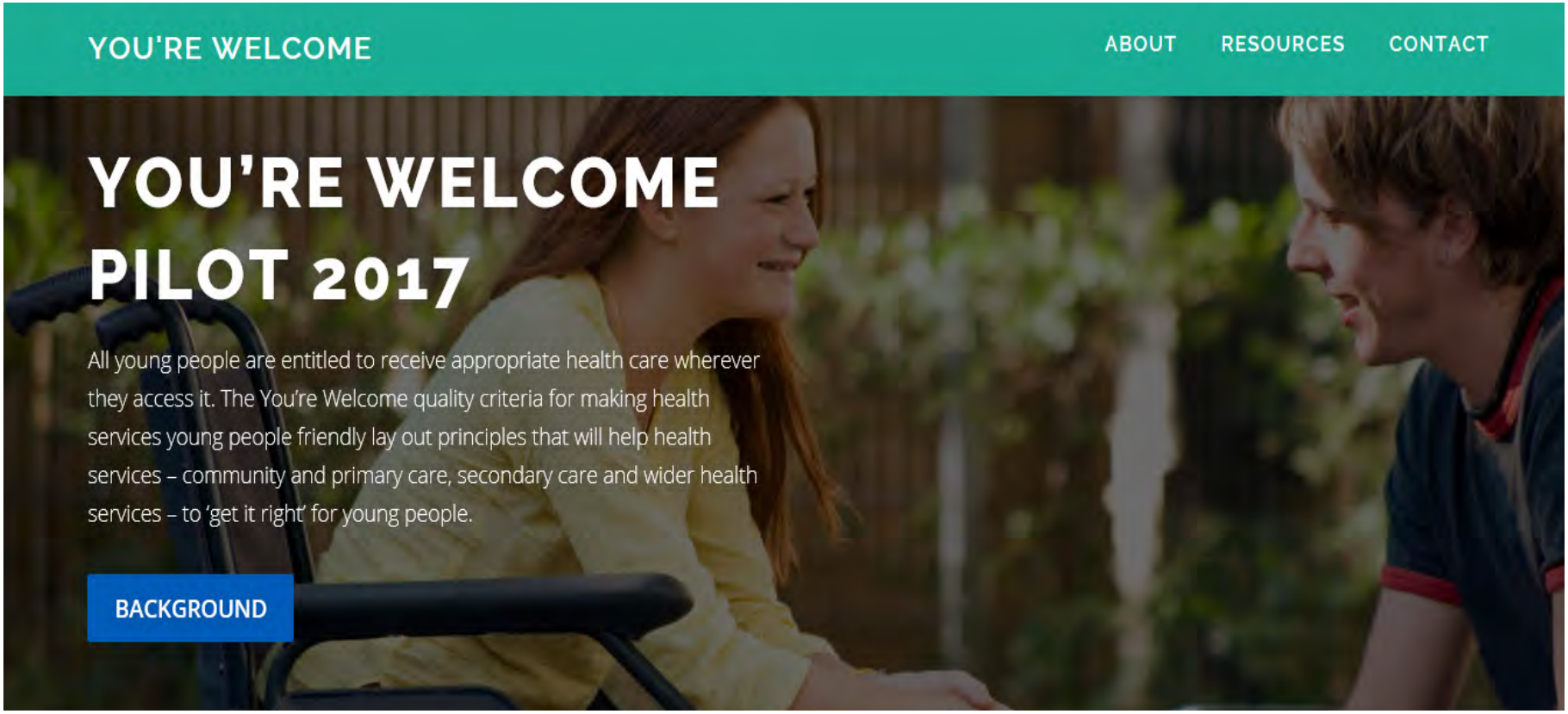
8. Feel comfortable around confidentiality (patient records)

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



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

02

Child Health General Practice Hubs

Dr Mando Watson, General Paediatrican, St Mary's Imperial

connecting care for children (C4CC)

connecting care for children

Child Health
General Practice Hubs

Invested in by:

NHS
Health Education
North West London

NHS
Central London Clinical Commissioning Group

Imperial College Healthcare NHS
NHS Trust

NHS
West London
Clinical Commissioning Group

NHS
Ealing
Clinical Commissioning Group

NHS
Hammersmith and Fulham
Clinical Commissioning Group

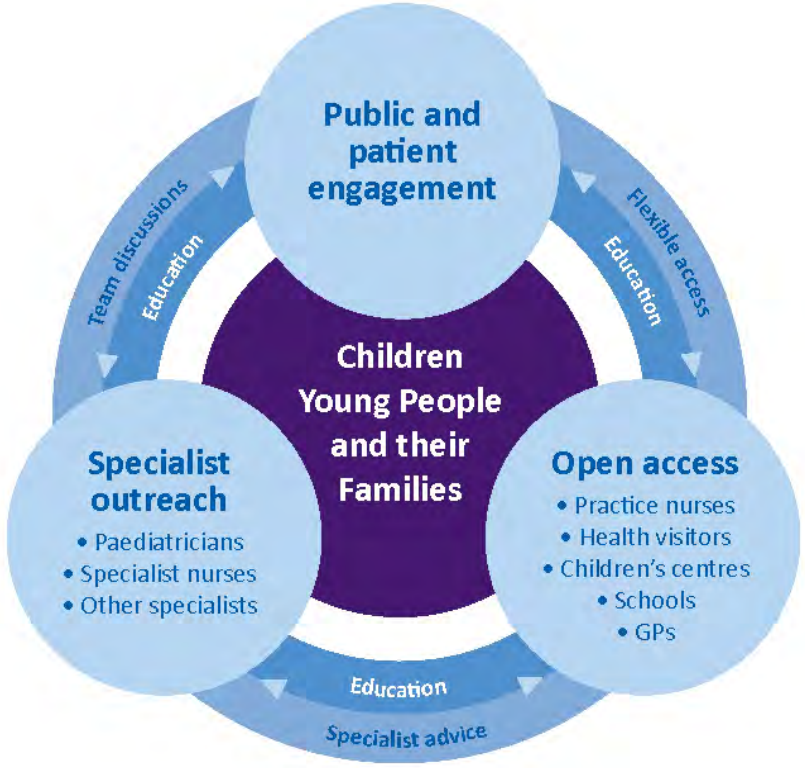
Supported by:

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'



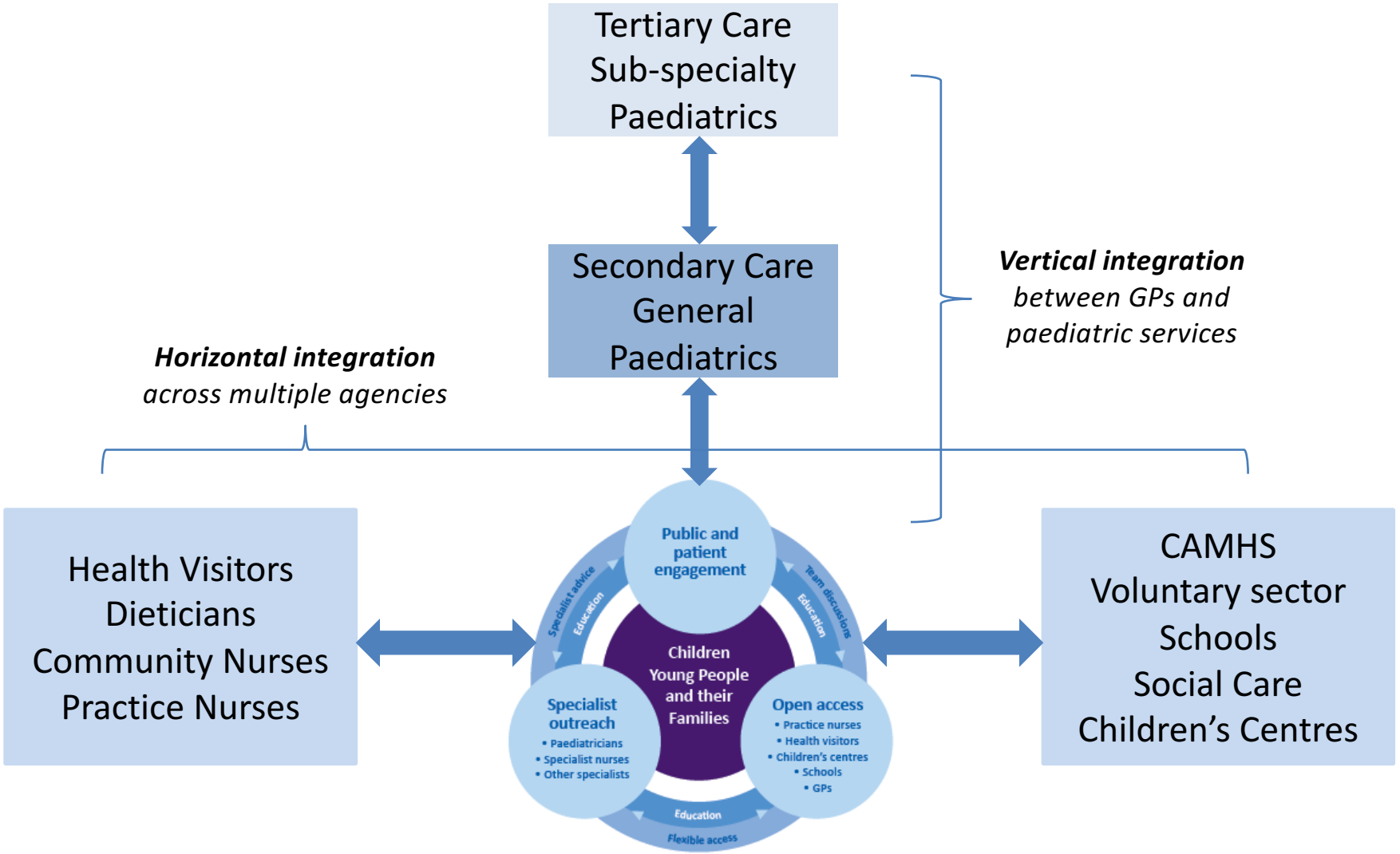
GP Child Health Hubs are typically:
3-4 GP practices within an existing network / village / locality
~20,000 practice population
~4,000 registered children
Built around a monthly MDT and clinic

***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.'

Child Health GP Hubs – a model of integrated child health



Child Health GP Hubs

connecting care for children

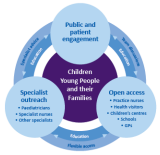
Child Health GP Hubs – MDT Professionals

General Practitioners

Health Visitors

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

General Paediatrician



connecting care for children

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

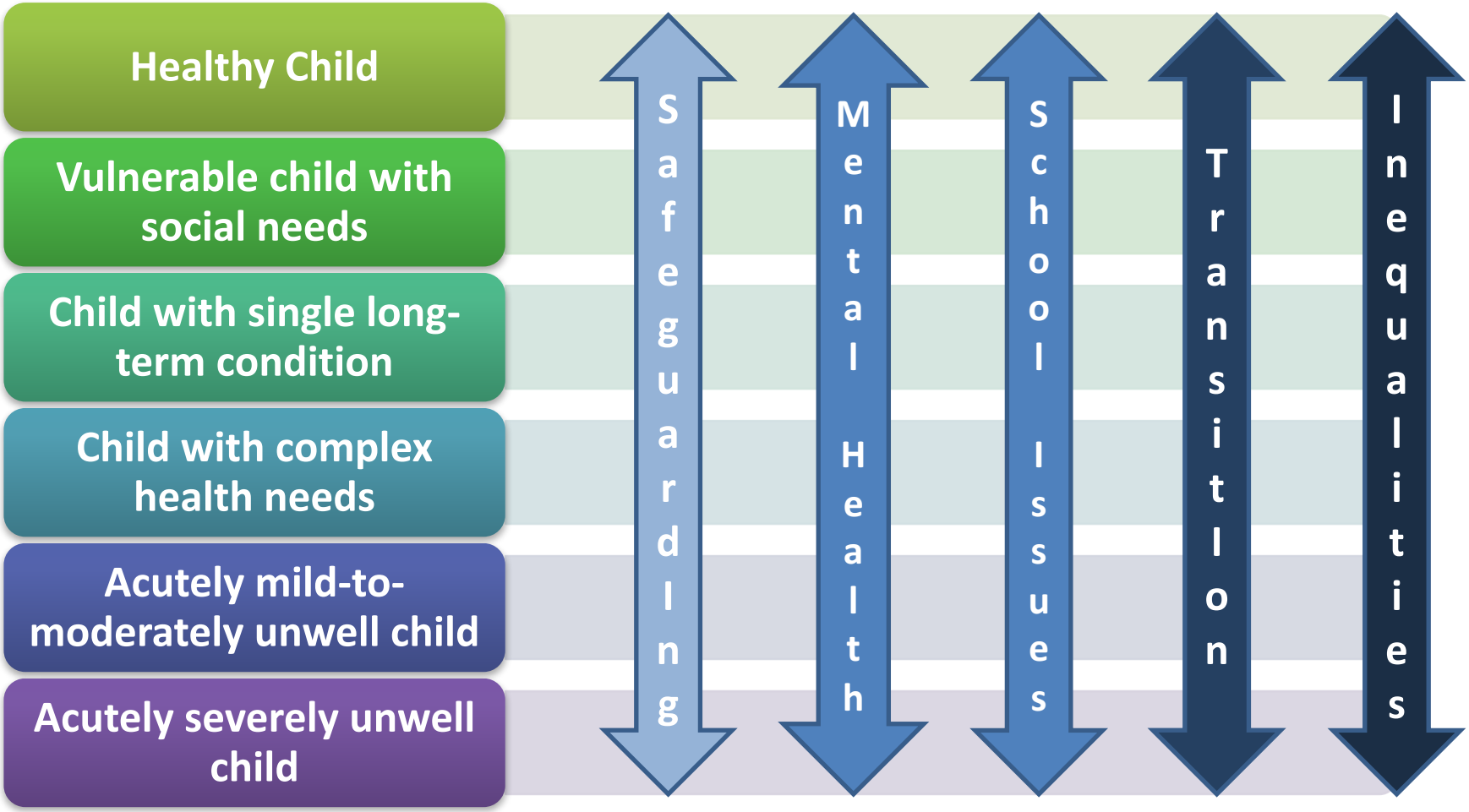
Integrated care is often built around patient pathways. In stratifying children and young people we strongly advocate a 'whole population' approach, where broad patient 'segments' can be identified:

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

Dr Bob Klaber & Dr Mando Watson Imperial College Healthcare NHS Trust

A Whole Population Approach: Patient Segments in Child Health

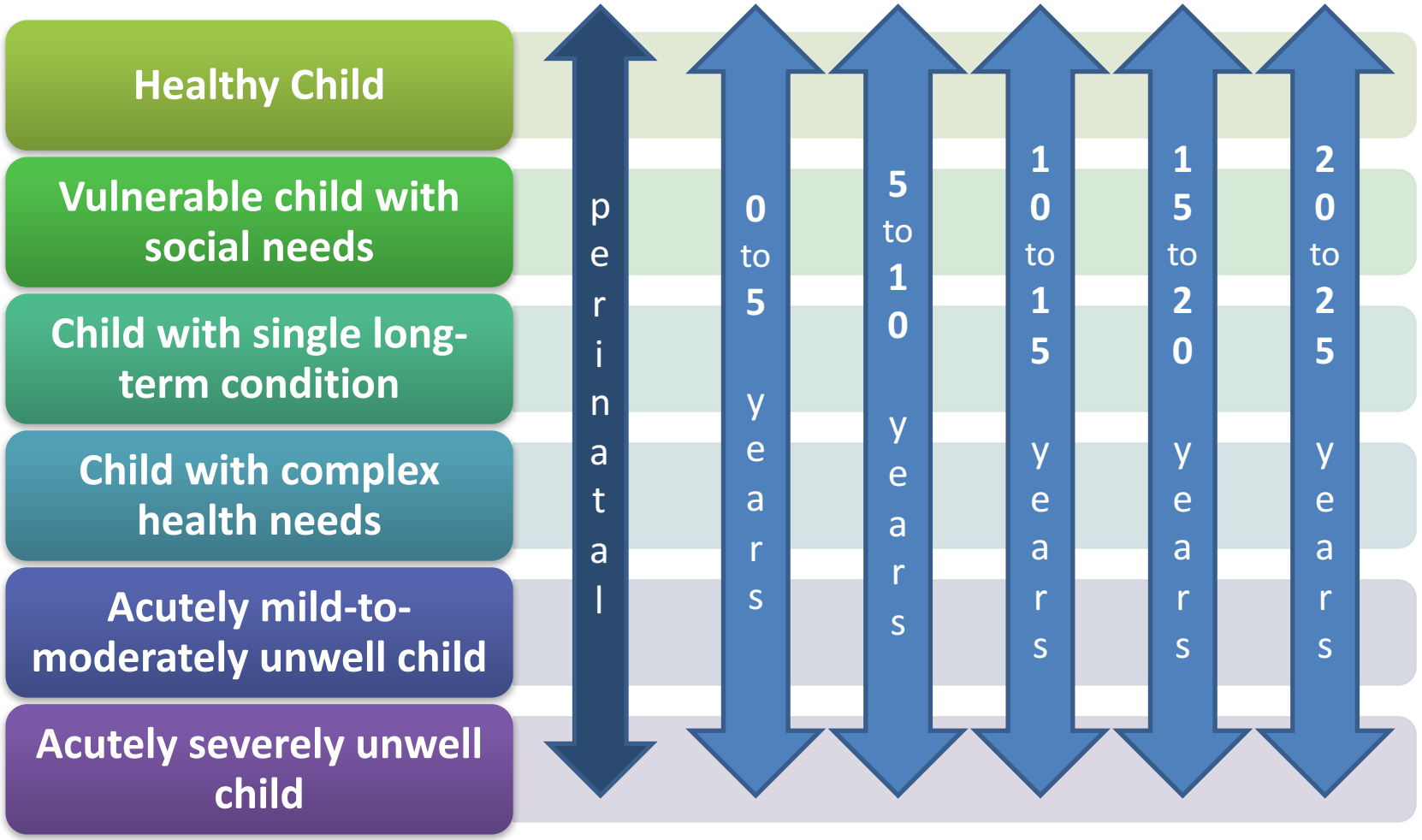
There are a number of cross-cutting themes that can be found within many or all of the segments. Examples include safeguarding, mental health, educational issues around school and transition.



Dr Bob Klaber & Dr Mando Watson Imperial College Healthcare NHS Trust

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.



connecting care for children

Dr Bob Klaber & Dr Mando Watson Imperial College Healthcare NHS Trust

Practice Champions

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

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Child Health General Practice Hubs: a service evaluation

Sarah Montgomery-Taylor, Mando Watson, Robert Klaber

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/archdischild-2015-308910).

Department of Paediatrics, Imperial College Healthcare NHS Trust, London, UK

Correspondence to
Dr Sarah Montgomery-Taylor, Department of Paediatrics, Imperial College Healthcare NHS Trust, St Mary's Hospital, Praed Street, London W2 1NY, UK; sarah.montgomerytaylor@gmail.com

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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 in Child Health General Practitioner (GP) Hubs where groups of GP practices come 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 'Inside-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 Episode data: outpatient and inpatient activity and A&E attendance. Patient-reported experience measures and professionals' feedback.

Results In one hub, 39% 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 sub-specialty referrals, a 17% reduction in 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 connections between secondary and primary care, reduce secondary care usage and receive high patient satisfaction ratings while providing learning for professionals.

What is already known on this topic

- There is an increasing awareness of the need to shift more care to the community
- Out of hospital specialist presence is important to facilitate this
- Novel service models are needed to integrate primary and secondary care

What this study adds

- Child Health General Practitioner Hubs help to shift more care to the community and reduce secondary care usage
- Patients prefer being seen in the community and value collaboration between primary and secondary care
- Professionals value the hubs for increased learning and the formation of networks and social capital

BACKGROUND

"Children represent the future, and ensuring their healthy growth and development ought to be a prime concern of all societies".[1] 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.[2] Europe-wide data show significant variability across developed and developing economies in child mortality rates and outcomes for children with long-term conditions.[3]

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.[4] Patients report that the current healthcare system prohibits continuity of care,[5] and the numbers of A&E admissions and hospital outpatient attendances in those aged 0–16 are rising year on year[6] leading to an increasing financial and workforce burden.

Recent nationwide[7] and city-wide[8] 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 patients as individuals through integrating care to suit their needs. Care in the community is often preferred by families.[5] Care from the general practitioner (GP), who knows the child in a wider social context, plays an important role in overall health. An out-of-hospital paediatric specialist presence supports this ideal.[9] Previous studies have demonstrated the potential for paediatric outpatient clinics to be moved to the community, but identified that this needed to be as part of wider efforts to improve patient engagement.[10] 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

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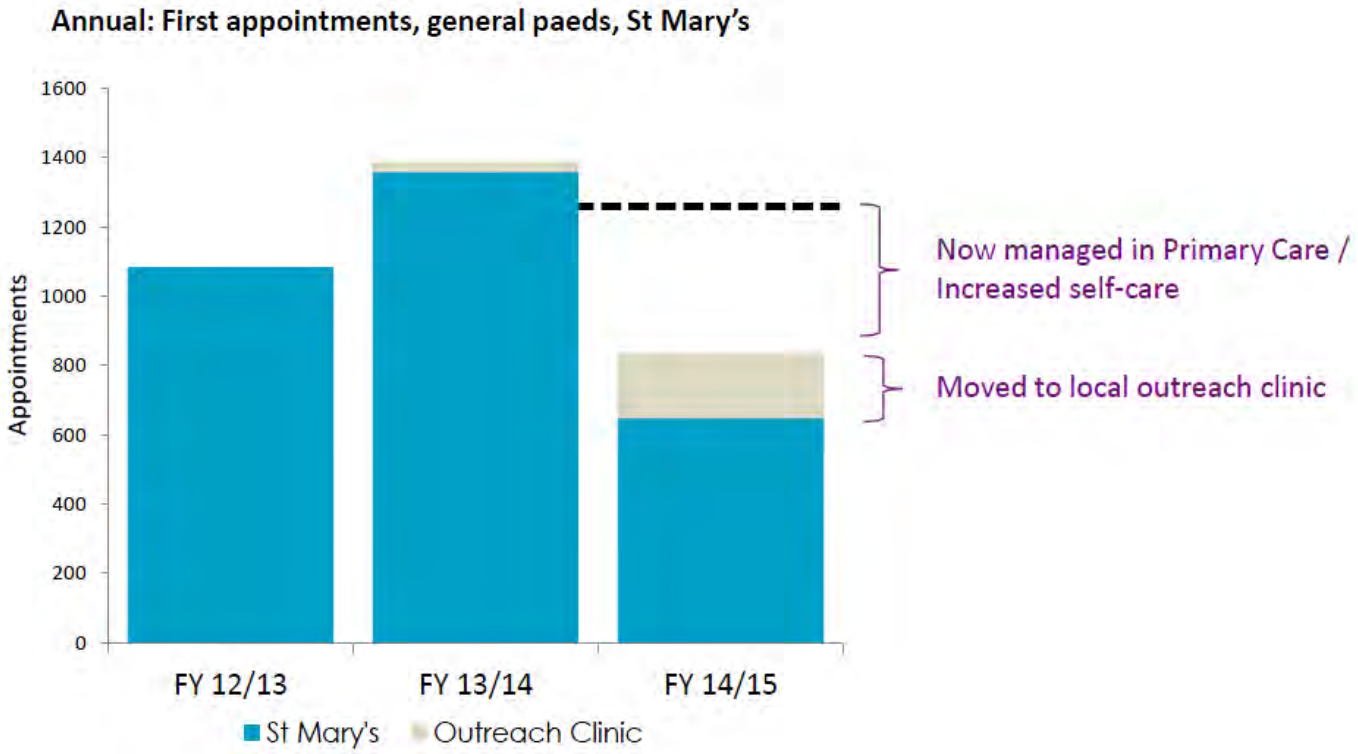
Impact of CC4C Child Health GP Hubs on Outpatient Activity

datasyrup

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



Practice Locations: All practices in cc4c Hubs
Referral type: First appointment
Referred to : General Paeds
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 …

Year	Number of Hubs	Child Population Covered	Total costs of the CC4C Child Health GP Hubs	Total savings from reduced hospital activity	Net Economic Benefit
1	2	8672	£153,220	£319,822	**£166,602**
2	8	34690	£332,803	£1,236,029	**£903,226**
3	16	69379	£500,894	£2,388,462	**£1,887,567**
4	24	104069	£644,832	£3,461,539	**£2,816,706**
5	28	121414	£794,896	£3,901,895	**£3,107,000**
				Cumulative Financial Impact (over 5 years):	**£8,881,102**

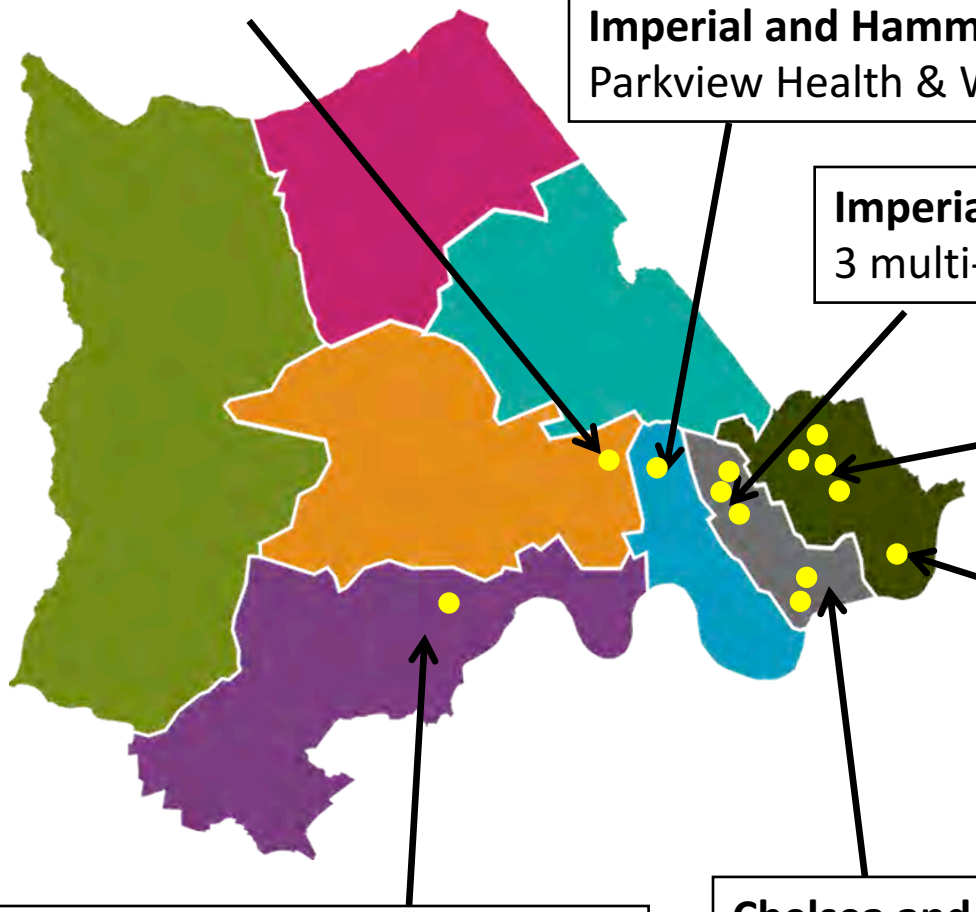
connecting care for children

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

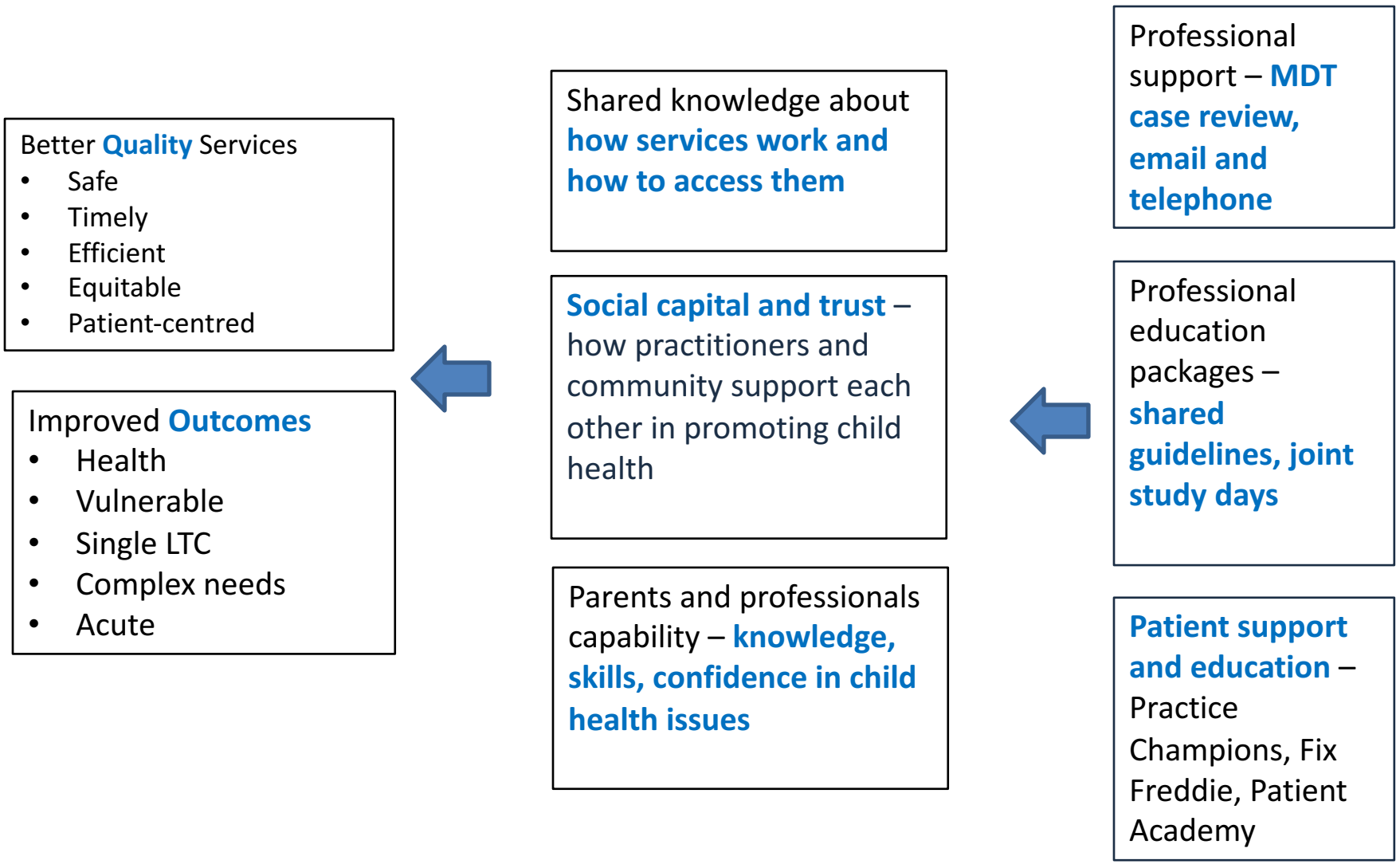
West Middlesex and Hounslow CCG:
1 GP practice pilot

Chelsea and West. & West London CCG:
Two 3 GP practice hubs

connecting care for children

A map of trusts, CCGs and other organisations now involved with the CC4C programme

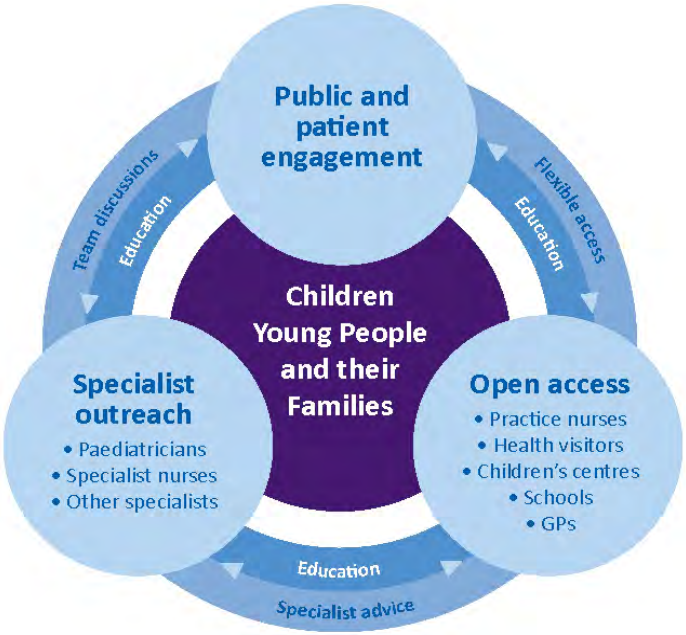
How does it work?

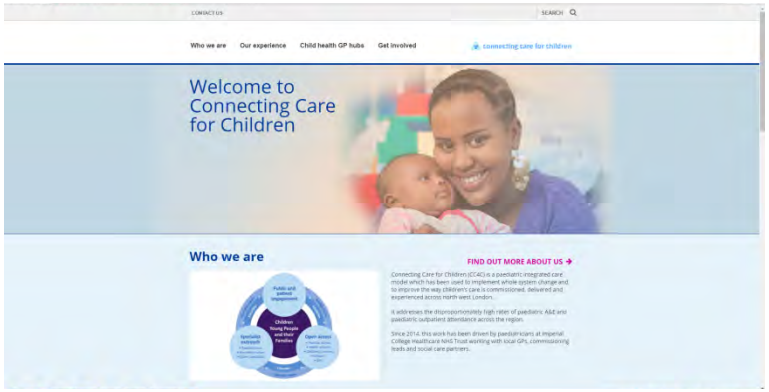


New Care Models in children – Design Principles

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





mando.watson@imperial.nhs.uk
robert.klaber@imperial.nhs.uk

www.cc4c.imperial.nhs.uk

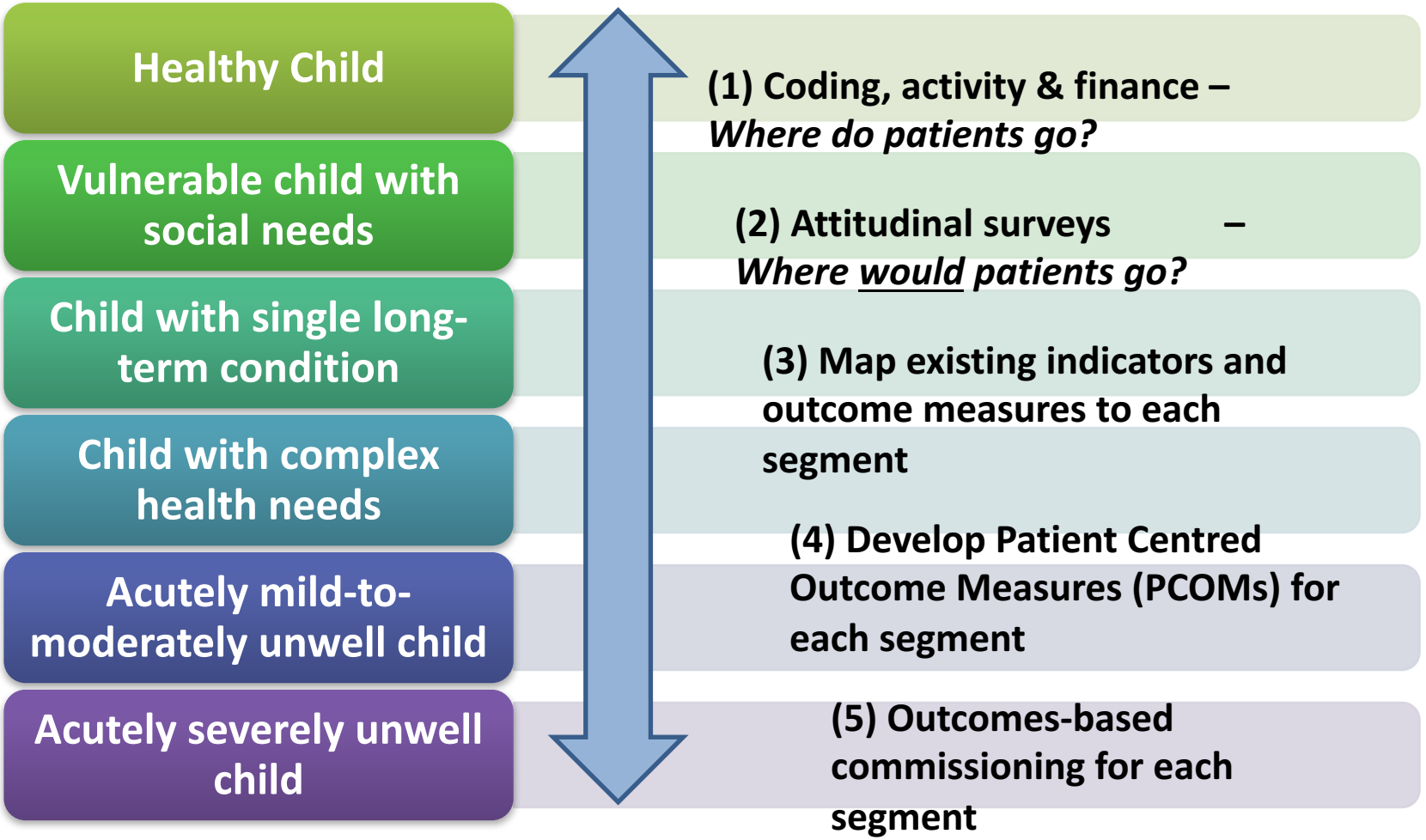
@CC4CLondon

Extras…

- http://www.cleanvideosearch.com/media/action/yt/watch?v=2MbJcM6TX48&feature=youtu.be
- 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:



connecting care for children

Dr Bob Klaber & Dr Mando Watson Imperial College Healthcare NHS Trust

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

Impact of CC4C Child Health GP Hubs – Professionals Feedback

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*)

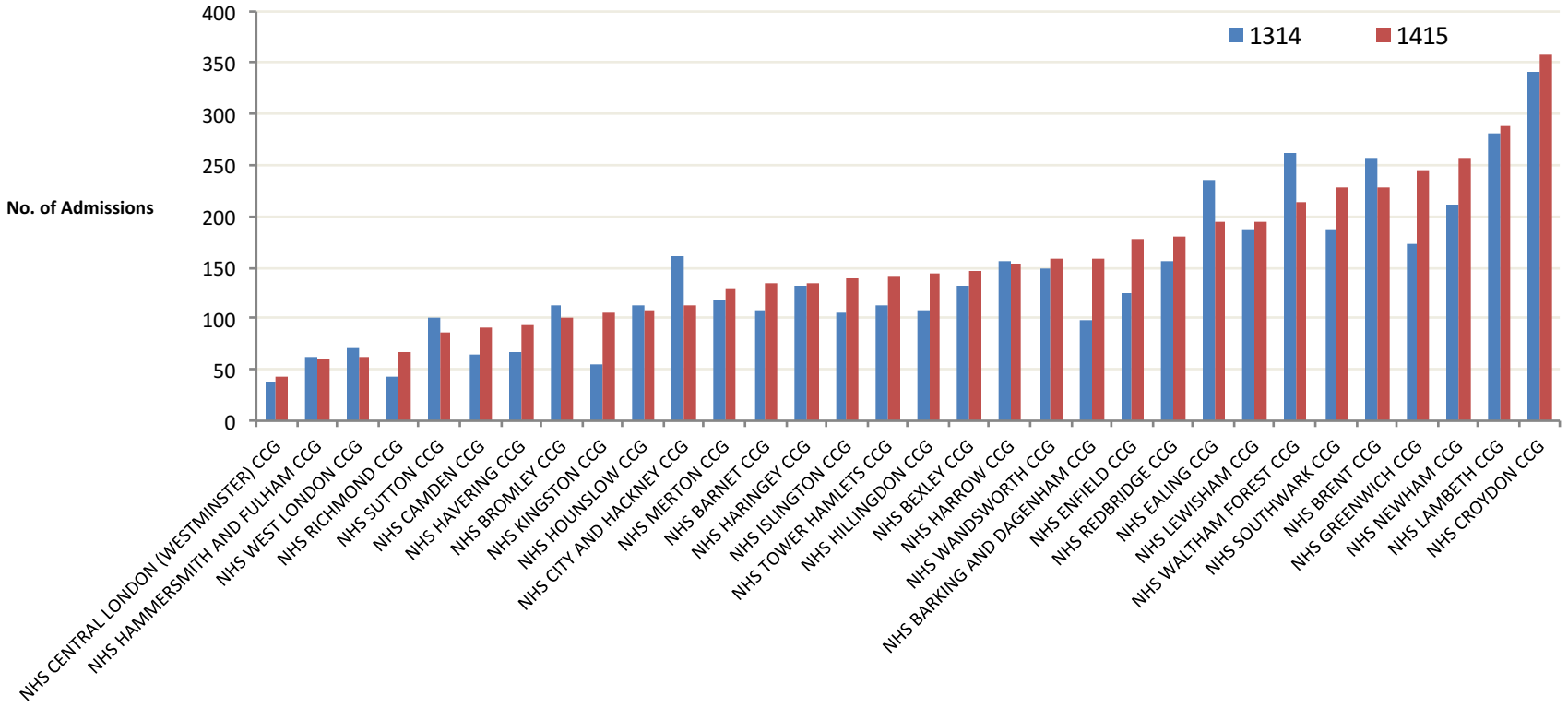
The benefit most strongly identified by professionals was the development of trust, reciprocity and collaboration

03

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

Aims & Objectives

Bexley Asthma Assessment Project in Pharmacies

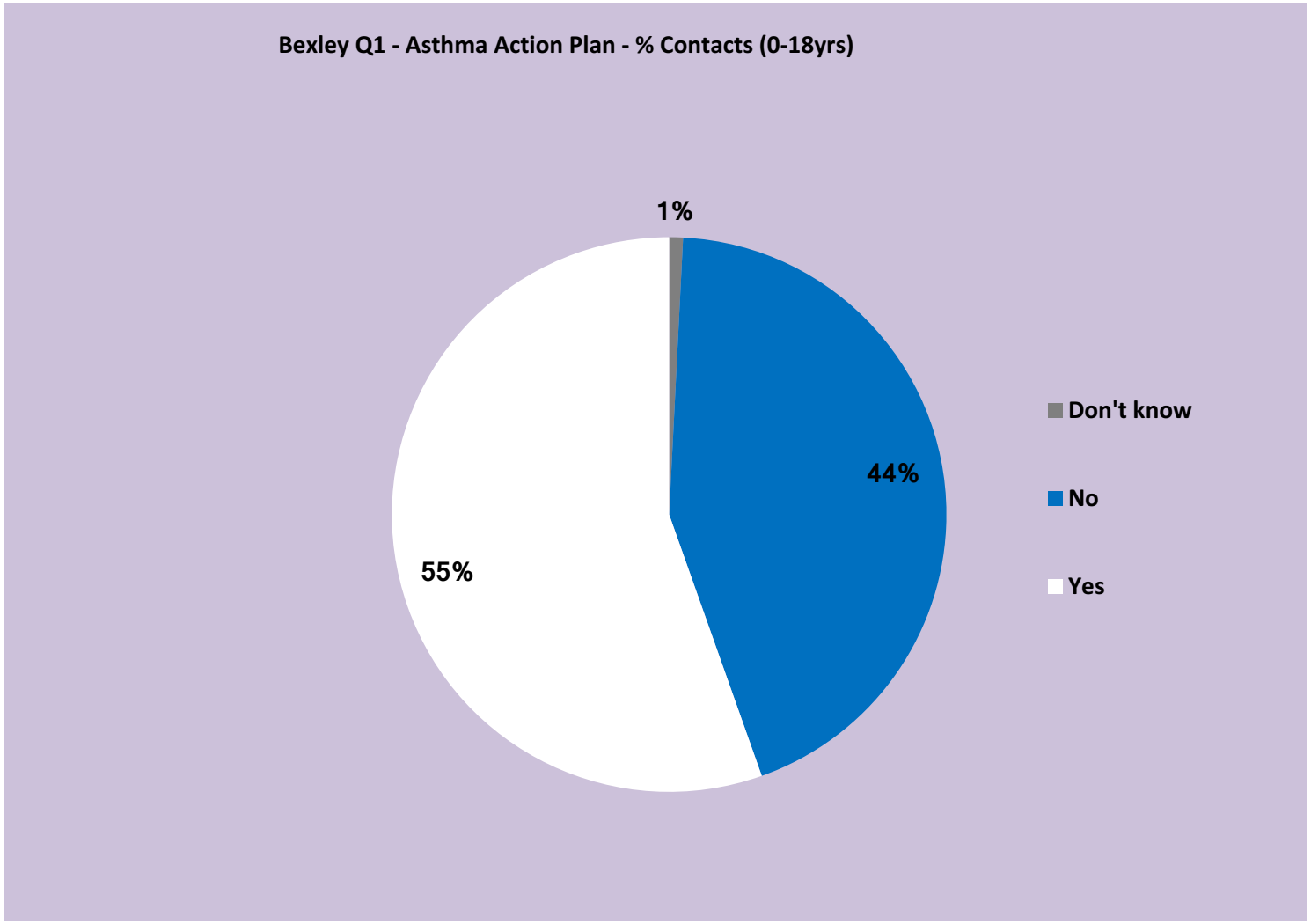
1. Enhance communication between pharmacists and GPs. This would be via an asthma template which all would use and become familiar with. This will be developed and trialled during the project with input from all stakeholders.
2. Enhance the value of MURs to include evaluation and education of patients 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

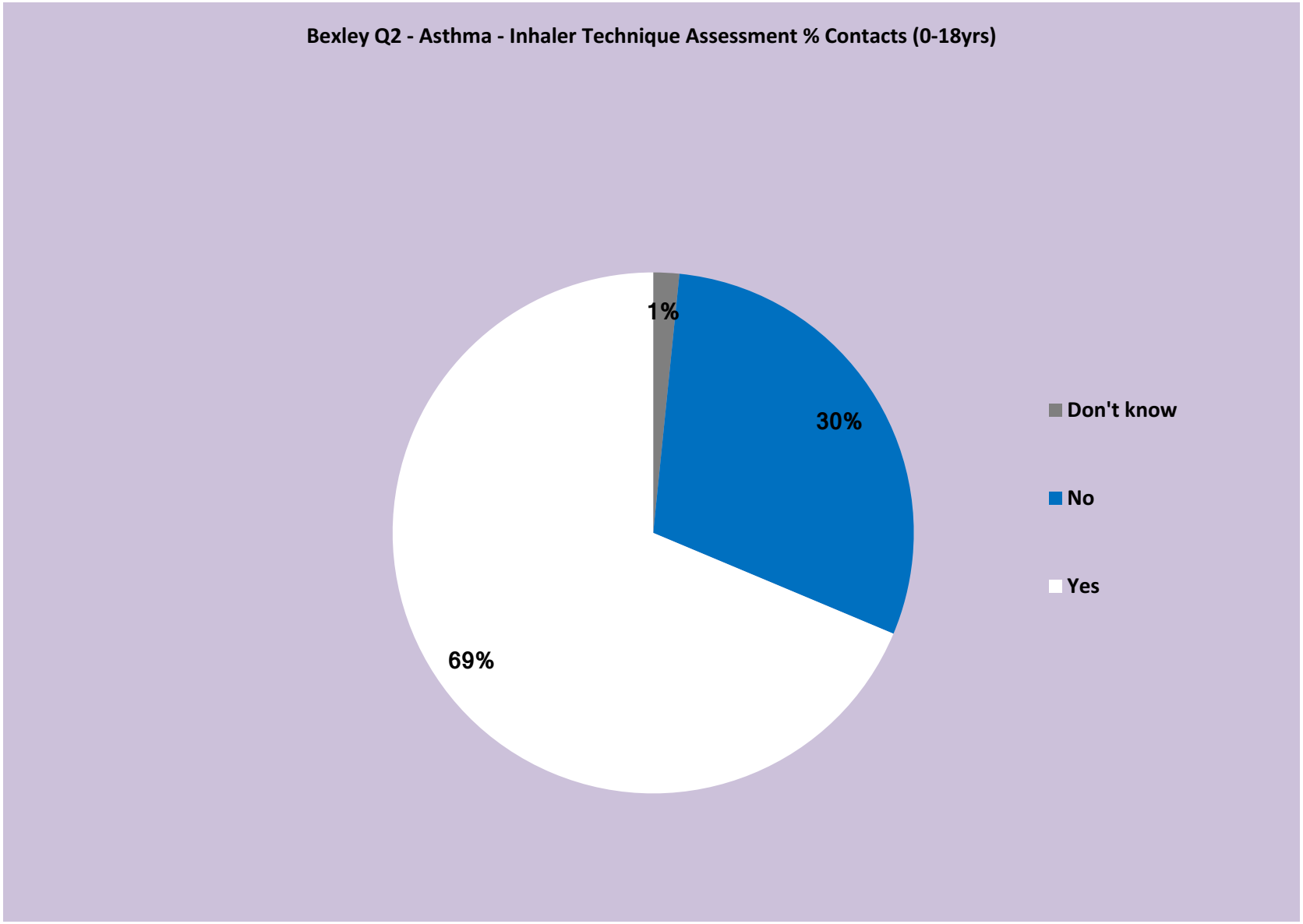
Overriding Principle

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 Paediatrian , Imperial College Healthcare NHS Trust


Bexley Q1 - Asthma Action Plan - % Contacts (0-18yrs)
1%
44%
55%
Don't know
No
Yes


Bexley Q2 - Asthma - Inhaler Technique Assessment % Contacts (0-18yrs)
1%
30%
69%
Don't know
No
Yes

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, NMs & quality payments
- Training & competence

Patients

- Satisfaction with the service
- Access
- Benefits to health and well being

Evaluation of effectiveness

CCG statistics

- 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=bIb80lOjoO8
- Pharmacy: https://www.youtube.com/watch?v=kCAzCmI-R_k
- Primary and community care: https://www.youtube.com/watch?v=A2iNQE7utRE
- Parents and carers: https://www.youtube.com/watch?v=iNPSFal0OIM

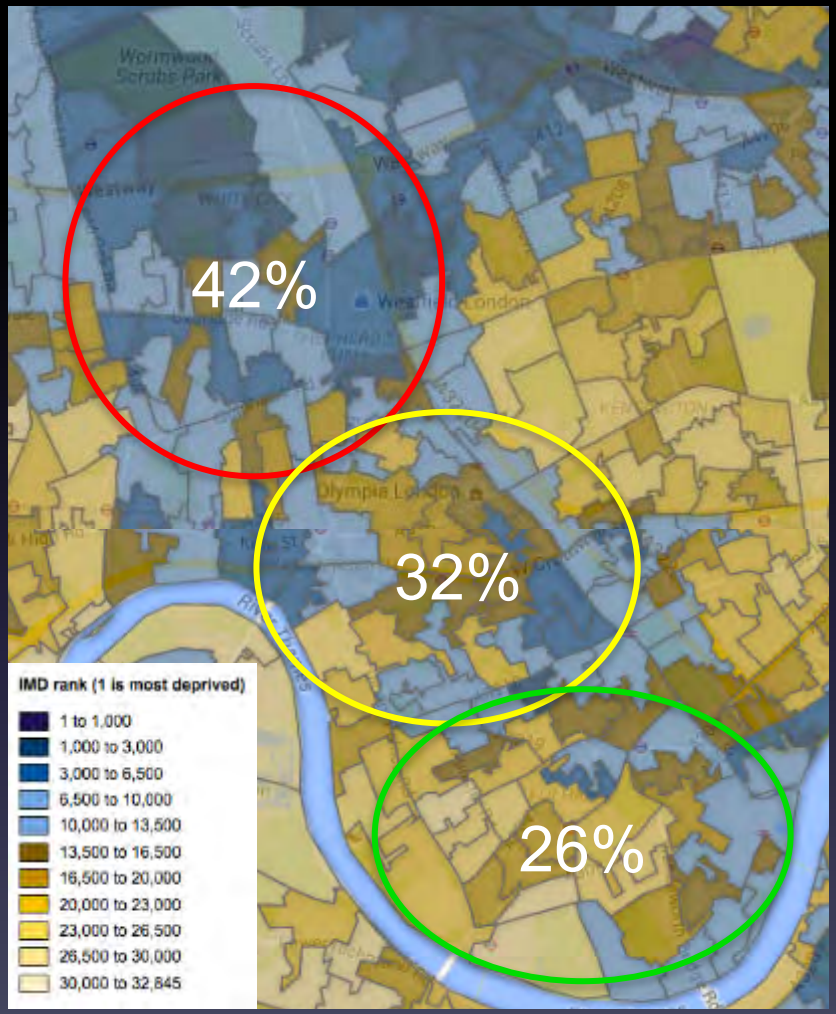
04

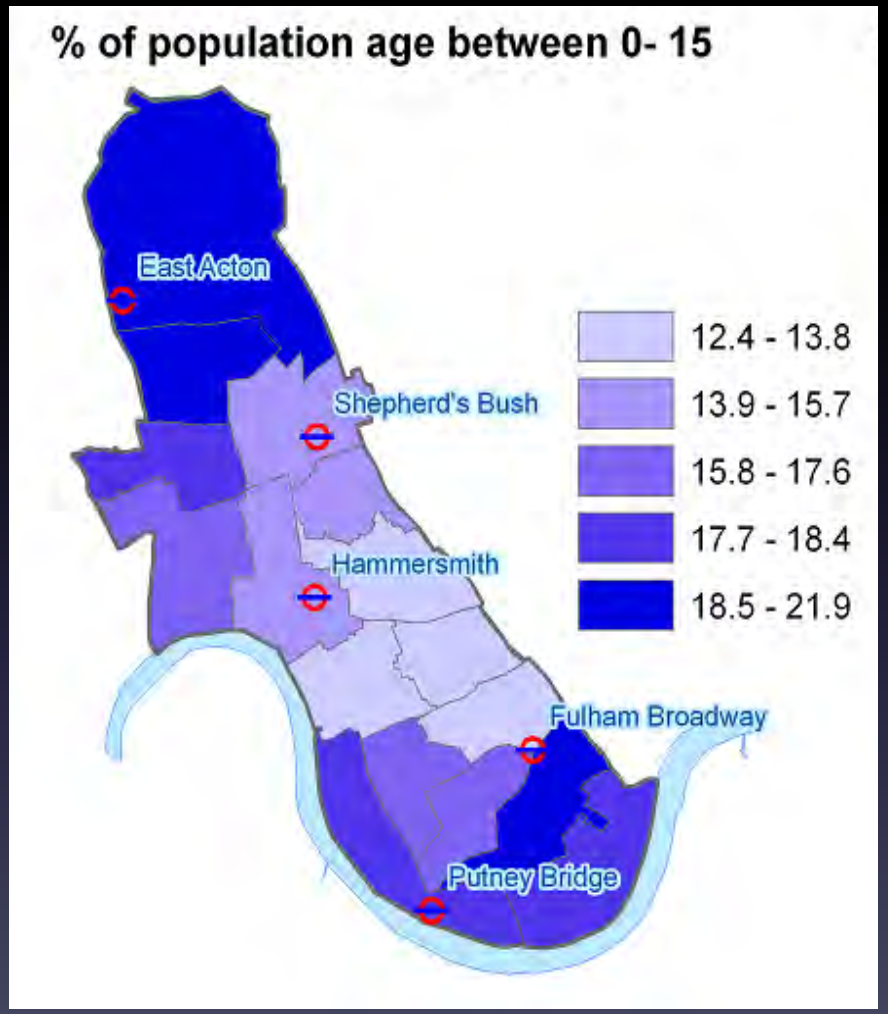
Making Child Health a Local Priority: The Role of GP Federations

Dr Chad Hockey,

Hammersmith and Fulham GP Federation

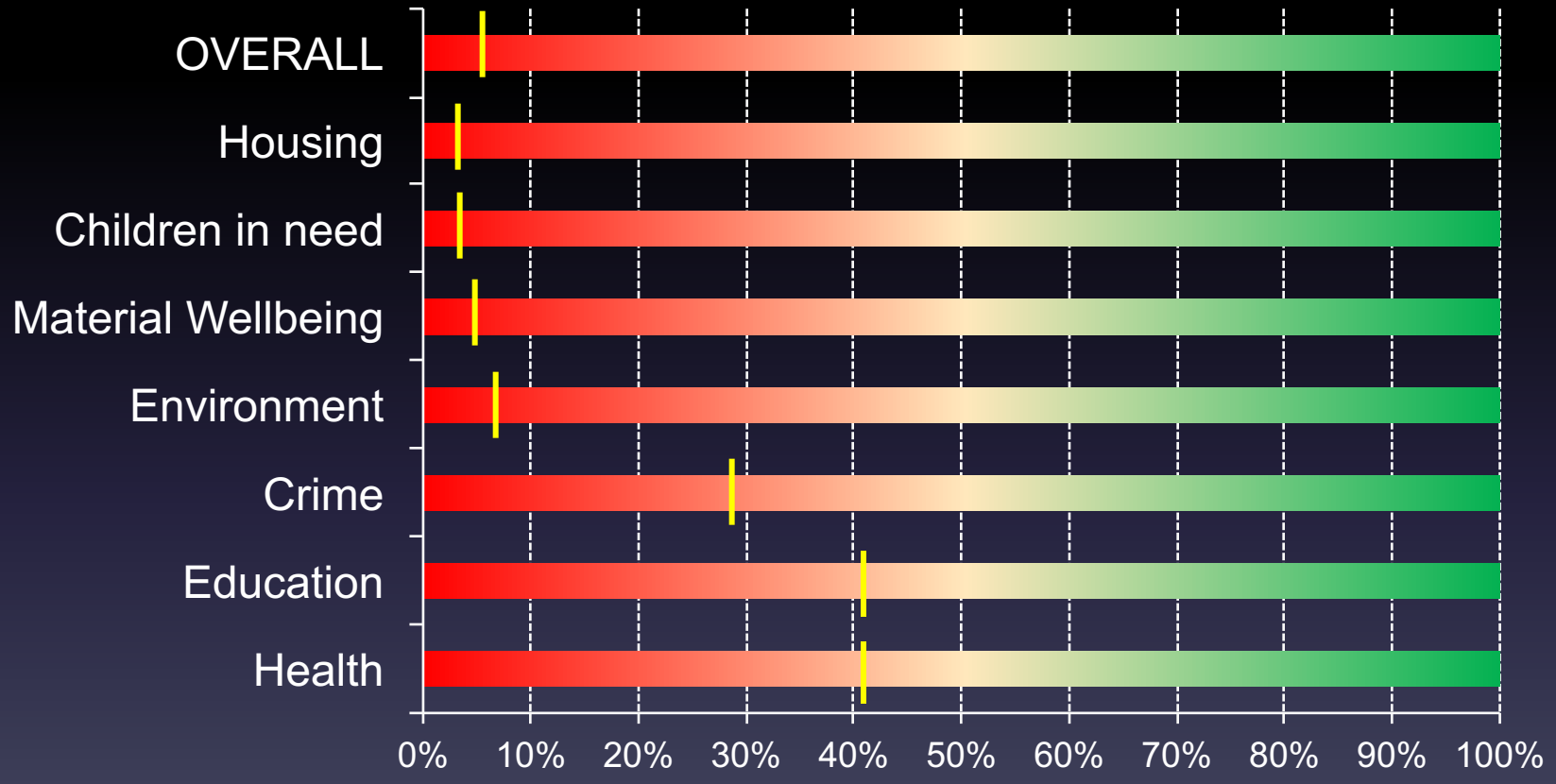
Children in H&F





North H&F- up to 45% child poverty

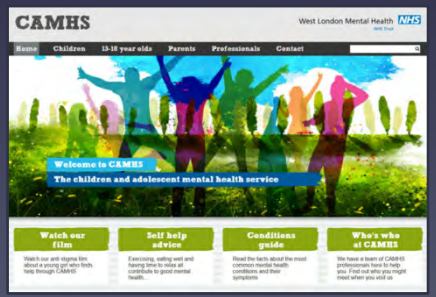
Child Wellbeing Index (2009)

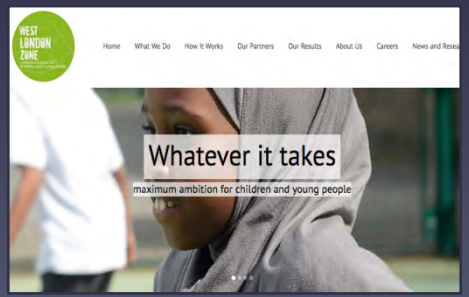


Overall, H&F ranked as 23rd worst borough in England

http://webarchive.nationalarchives.gov.uk/20100410180038/http:/communities.gov.uk/publications/communities/childwellbeing2009

Who coordinates strategy?

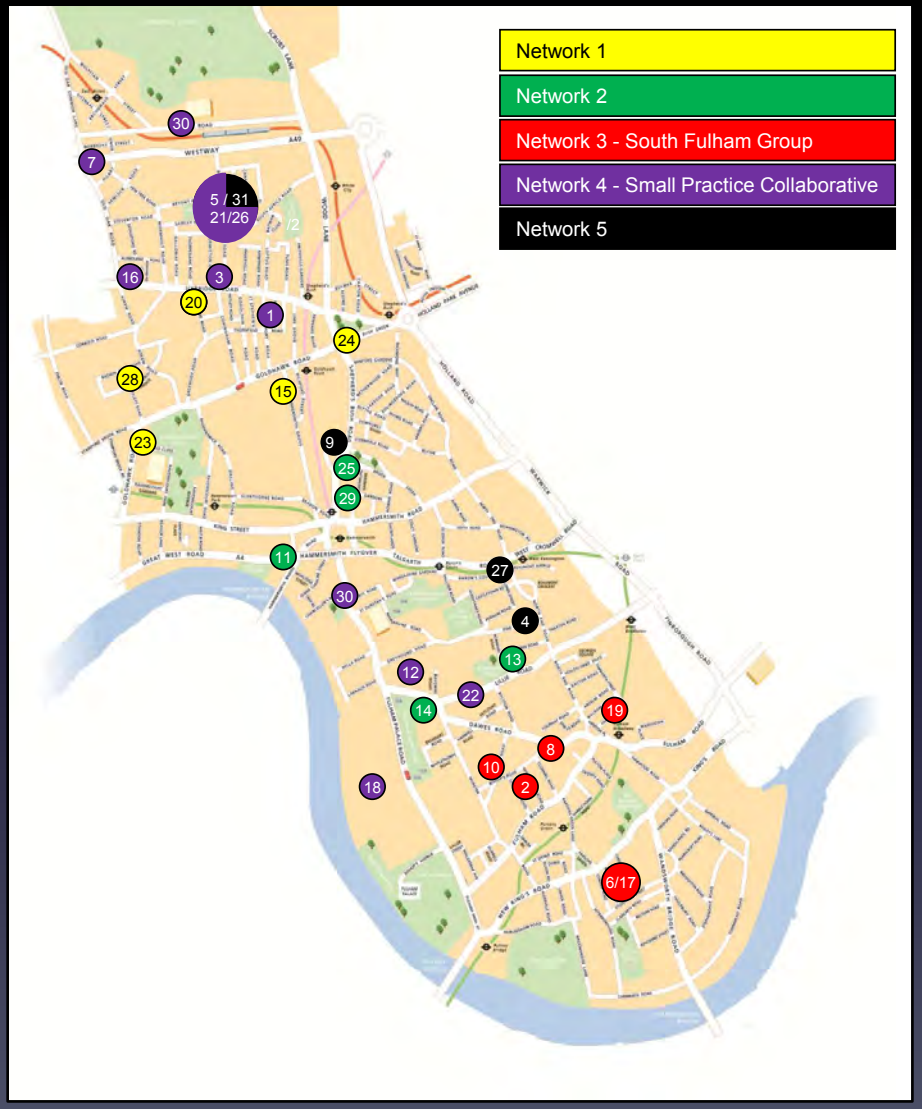




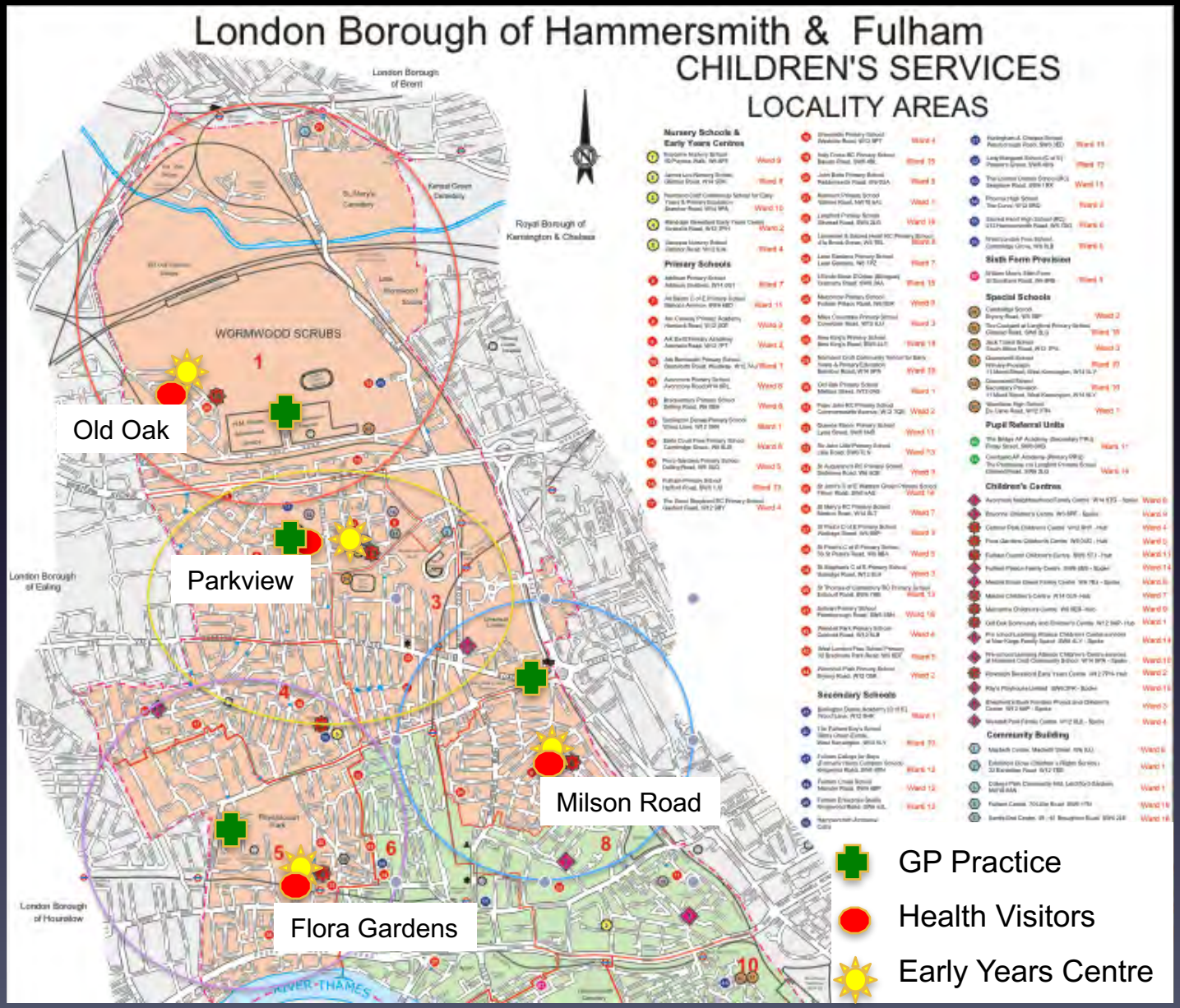
Who Translates Strategy in the Community?

H&F Locality Area Arrangement

H&F GP Network Arrangement

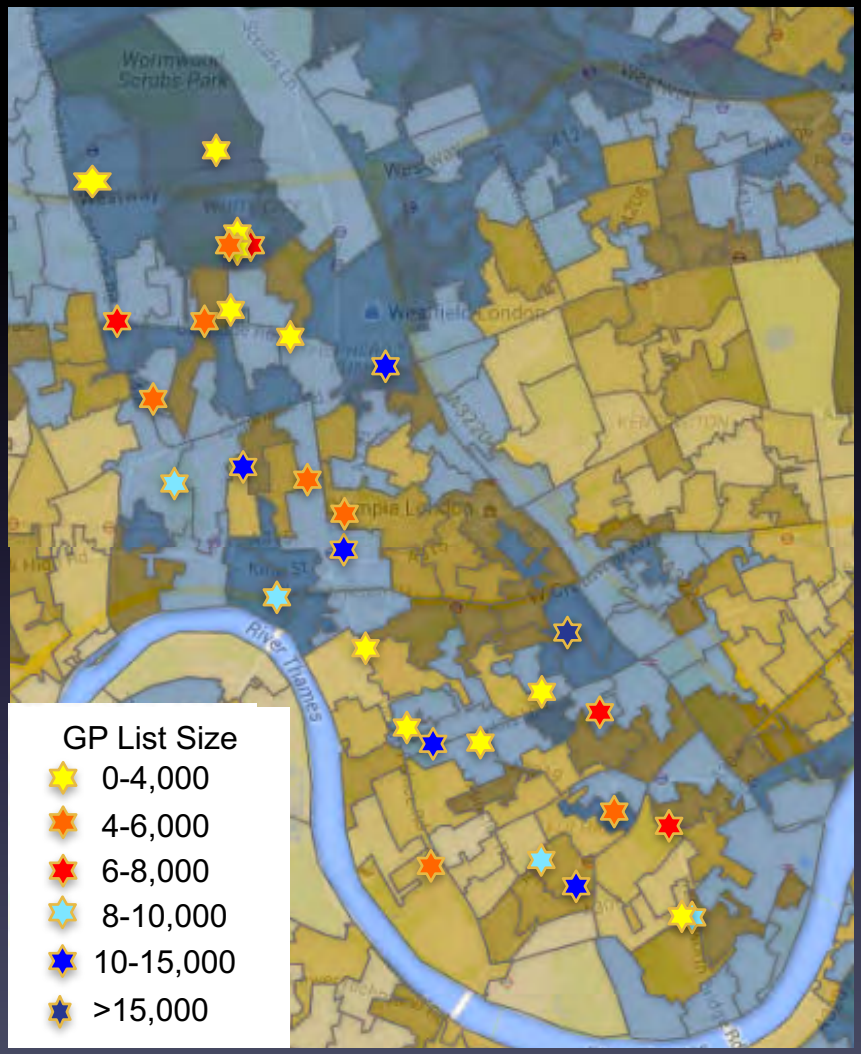


Natural Neighbourhood Model

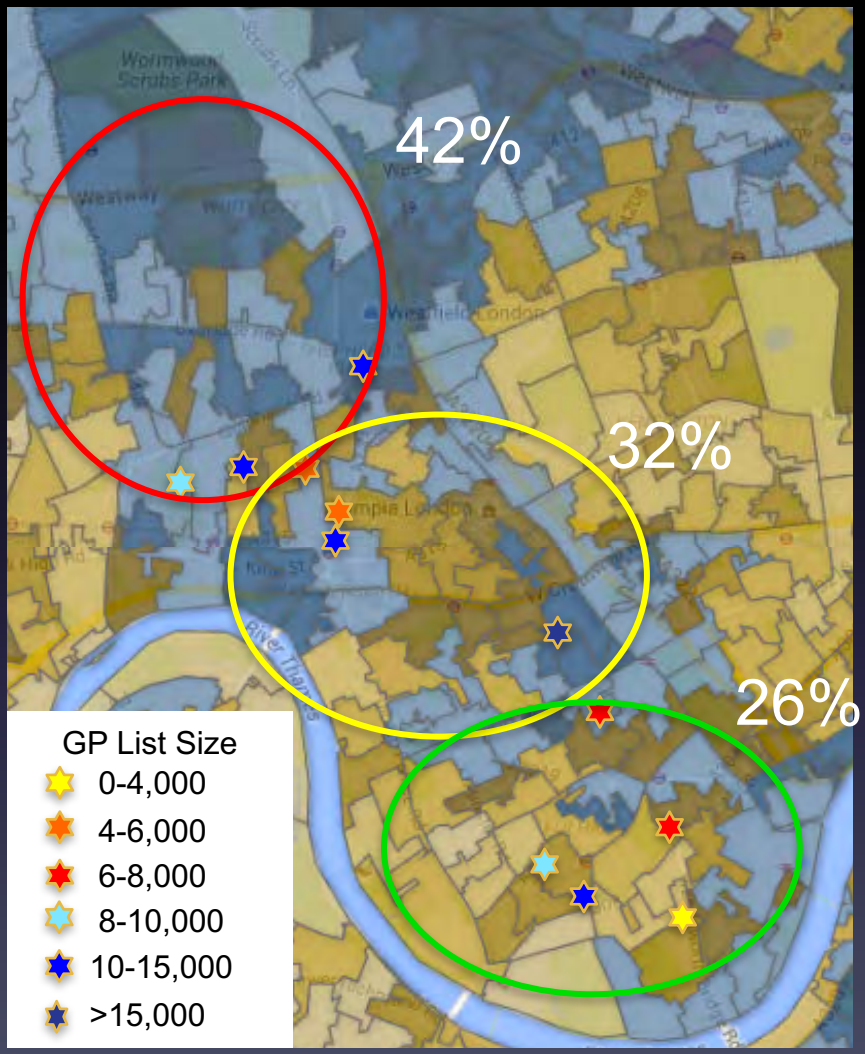


GP Skill-mix and Practice Size in H&F (2016)

All H&F GP Practices

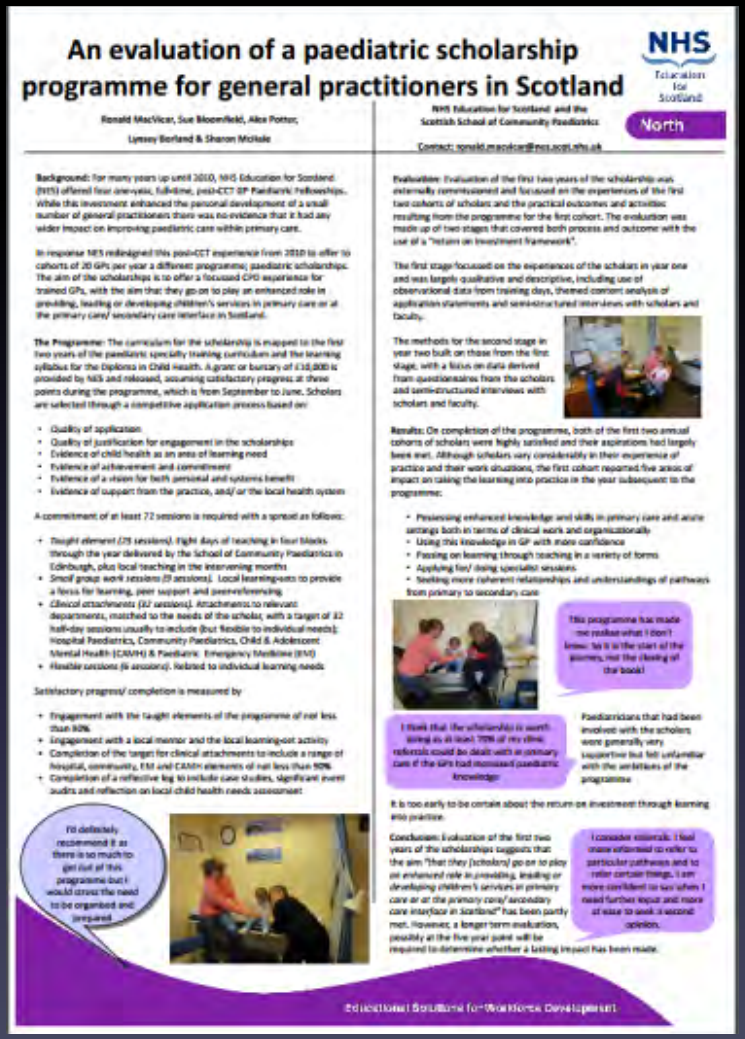


H&F Practices where GP has Diploma Child Health



H&F GP Federation Represents Every GP Practice in the Borough

Developing GP Leads for Child Health…



An evaluation of a paediatric scholarship programme for general practitioners in Scotland

NHS Education for Scotland

North

Ronald MacVicar, Sue Bloomfield, Alex Potter, Lynsey Borland & Sharon McHale

NHS Education for Scotland and the Scottish School of Community Paediatrics

Contact: ronald.macvicar@nes.scot.nhs.uk

Background: For many years up until 2010, NHS Education for Scotland (NES) offered four one-year, full-time, post-CCT GP Paediatric Fellowships. While this investment enhanced the personal development of a small number of general practitioners there was no evidence that it had any wider impact on improving paediatric care within primary care.

In response NES redesigned this post-CCT experience from 2010 to offer to cohorts of 20 GPs per year a different programme; paediatric scholarships. The aim of the scholarships is to offer a focussed CPD experience for trained GPs, with the aim that they go on to play an enhanced role in providing, leading or developing children's services in primary care or at the primary care/ secondary care interface in Scotland.

The Programme: The curriculum for the scholarship is mapped to the first two years of the paediatric specialty training curriculum and the learning syllabus for the Diploma in Child Health. A grant or bursary of £10,000 is provided by NES and released, assuming satisfactory progress at three points during the programme, which is from September to June. Scholars are selected through a competitive application process based on:

- Quality of application
- Quality of justification for engagement in the scholarships
- Evidence of child health as an area of learning need
- Evidence of achievement and commitment
- Evidence of a vision for both personal and systems benefit
- Evidence of support from the practice, and/ or the local health system

A commitment of at least 72 sessions is required with a spread as follows:

- *Taught element (25 sessions).* Eight days of teaching in four blocks through the year delivered by the School of Community Paediatrics in Edinburgh, plus local teaching in the intervening months
- *Small group work sessions (9 sessions).* Local learning-sets to provide a focus for learning, peer support and peer-referencing
- *Clinical attachments (32 sessions).* Attachments to relevant departments, matched to the needs of the scholar, with a target of 32 half-day sessions usually to include (but flexible to individual needs): Hospital Paediatrics, Community Paediatrics, Child & Adolescent Mental Health (CAMH) & Paediatric Emergency Medicine (EM)
- *Flexible sessions (6 sessions).* Related to individual learning needs

Satisfactory progress/ completion is measured by

- Engagement with the taught elements of the programme of not less than 80%
- Engagement with a local mentor and the local learning-set activity
- Completion of the target for clinical attachments to include a range of hospital, community, EM and CAMH elements of not less than 90%
- Completion of a reflective log to include case studies, significant event audits and reflection on local child health needs assessment

I'll definitely recommend it as there is so much to get out of this programme but I would stress the need to be organised and prepared

Evaluation: Evaluation of the first two years of the scholarship was externally commissioned and focussed on the experiences of the first two cohorts of scholars and the practical outcomes and activities resulting from the programme for the first cohort. The evaluation was made up of two stages that covered both process and outcome with the use of a "return on investment framework".

The first stage focussed on the experiences of the scholars in year one and was largely qualitative and descriptive, including use of observational data from training days, themed content analysis of application statements and semi-structured interviews with scholars and faculty.

The methods for the second stage in year two built on those from the first stage, with a focus on data derived from questionnaires from the scholars and semi-structured interviews with scholars and faculty.

Results: On completion of the programme, both of the first two annual cohorts of scholars were highly satisfied and their aspirations had largely been met. Although scholars vary considerably in their experience of practice and their work situations, the first cohort reported five areas of impact on taking the learning into practice in the year subsequent to the programme:

- Possessing enhanced knowledge and skills in primary care and acute settings both in terms of clinical work and organizationally
- Using this knowledge in GP with more confidence
- Passing on learning through teaching in a variety of forms
- Applying for/ doing specialist sessions
- Seeking more coherent relationships and understandings of pathways from primary to secondary care

This programme has made me realise what I don't know. So it is the start of the journey, not the closing of the book!

I think that the scholarship is worthwhile as at least 75% of my clinic referrals could be dealt with in primary care if the GPs had increased paediatric knowledge

Paediatricians that had been involved with the scholars were generally very supportive but felt unfamiliar with the ambitions of the programme

It is too early to be certain about the return on investment through learning into practice.

Conclusion: Evaluation of the first two years of the scholarships suggests that the aim "that they (scholars) go on to play an enhanced role in providing, leading or developing children's services in primary care or at the primary care/ secondary care interface in Scotland" has been partly met. However, a longer term evaluation, possibly at the five year point will be required to determine whether a lasting impact has been made.

I consider externally I feel more informed to refer to particular pathways and to refer certain things. I am more confident to say when I need further input and more at ease to seek a second opinion.

Educational Solutions for Workforce Development

Clinical Skills

36 unplanned care sessions

18 outpatient sessions

In-house teaching

Leadership Skills

18 Community project sessions

Supported leadership development

QSIR practitioner

Service Transformation

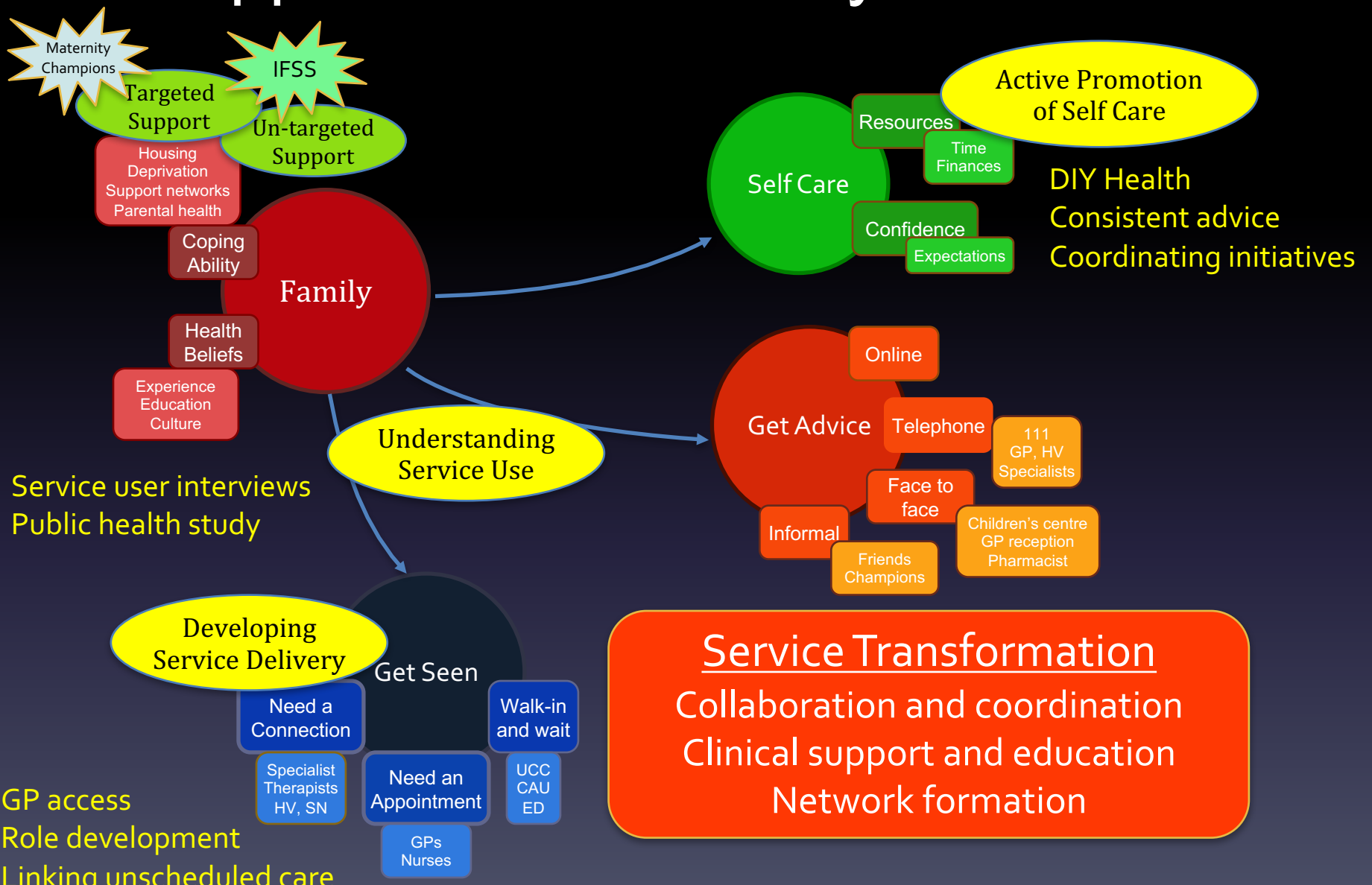
Collaboration and coordination

Clinical support and education

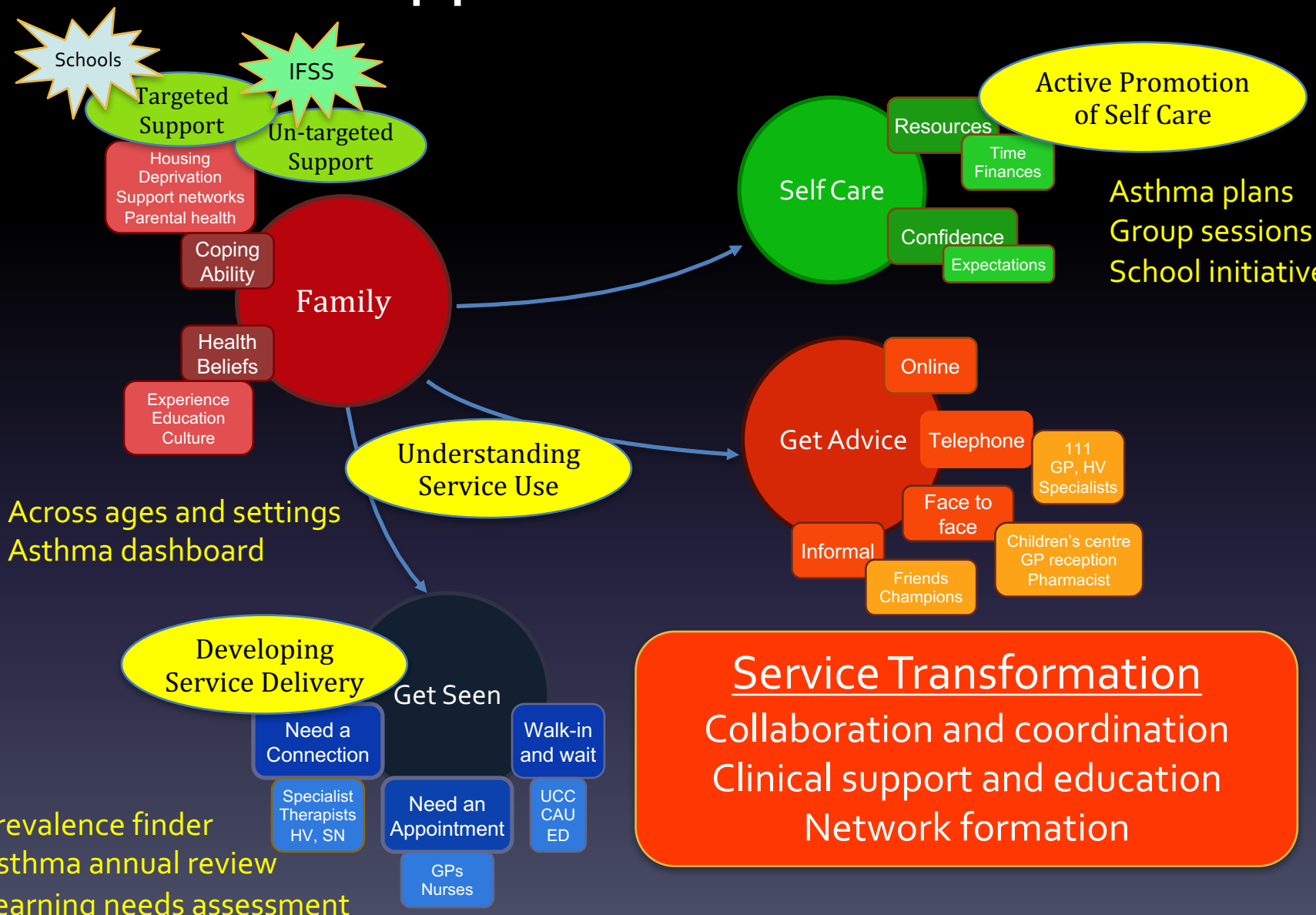
Network formation

HEE Funded Initiative, run via local CEPN program

Application: same day access…



Application: asthma…



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

05

Islington Paediatric Integrated Networks

Catherine Lad, CYP Commissioner and Dr Sabin Khan, GP lead Islington CCG

ISLINGTON
INTEGRATED CARE

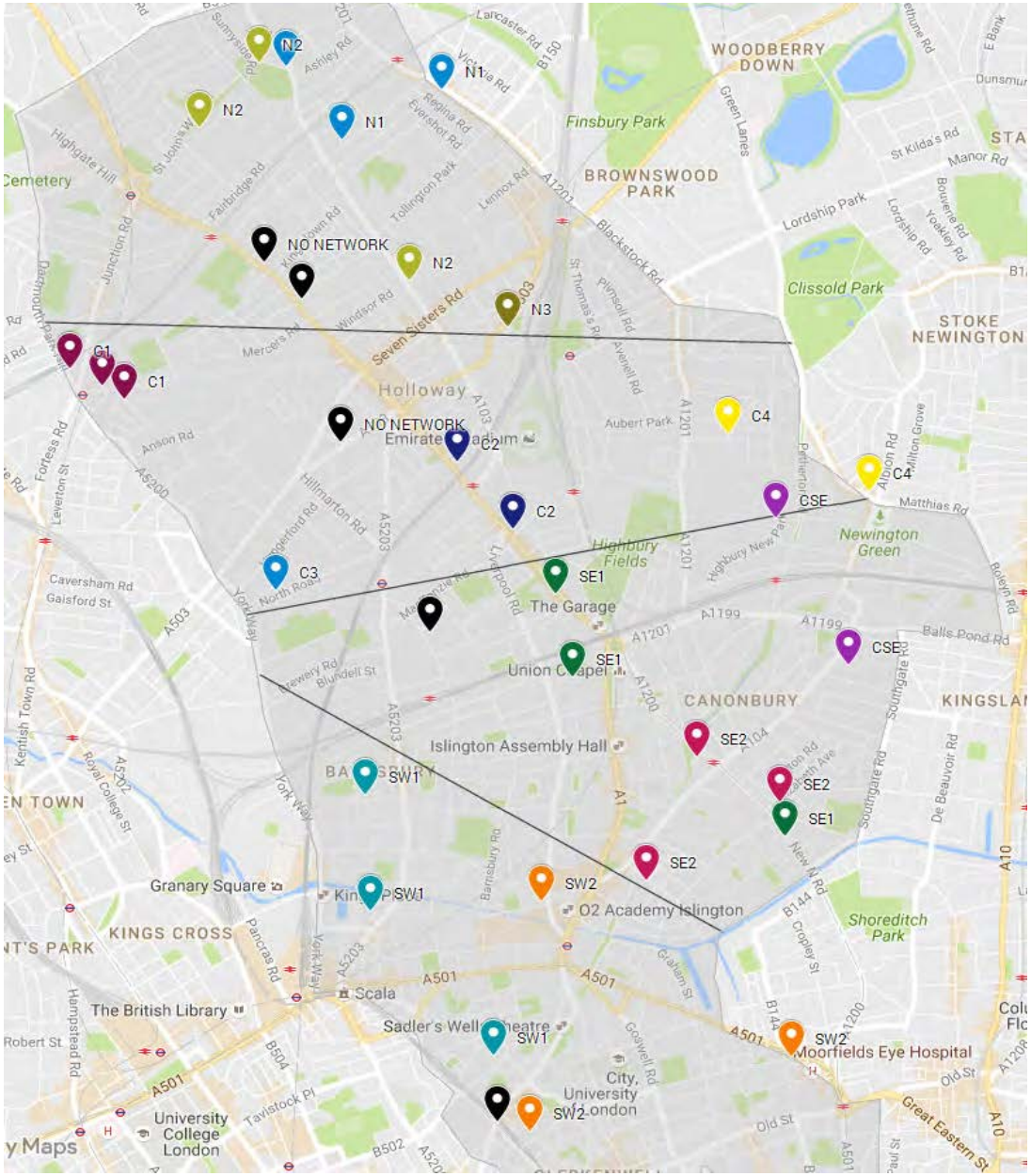
NHS
Islington
Clinical Commissioning Group

Islington
Paediatric Integrated Networks

ISLINGTON BACKGROUND

- 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)

CURRENT INTEGRATED CARE NETWORK MAP



No network

North 3 — 7515 0-18 – 1,372

Central 2 — 8311 0-18 – 1,420

Central 1 — 9765 0-18 – 1,535

Central 3 — 12,924 0-18 – 2,262

Central 4 — 15,171 0-18 – 3,392

Central South East — 15,516 0-18 – 2,608

North 1 — 17,404 0-18 – 2,917

North 2 — 21,201 0-18 – 4,608

South East 1 — 24,082 0-18 – 4,028

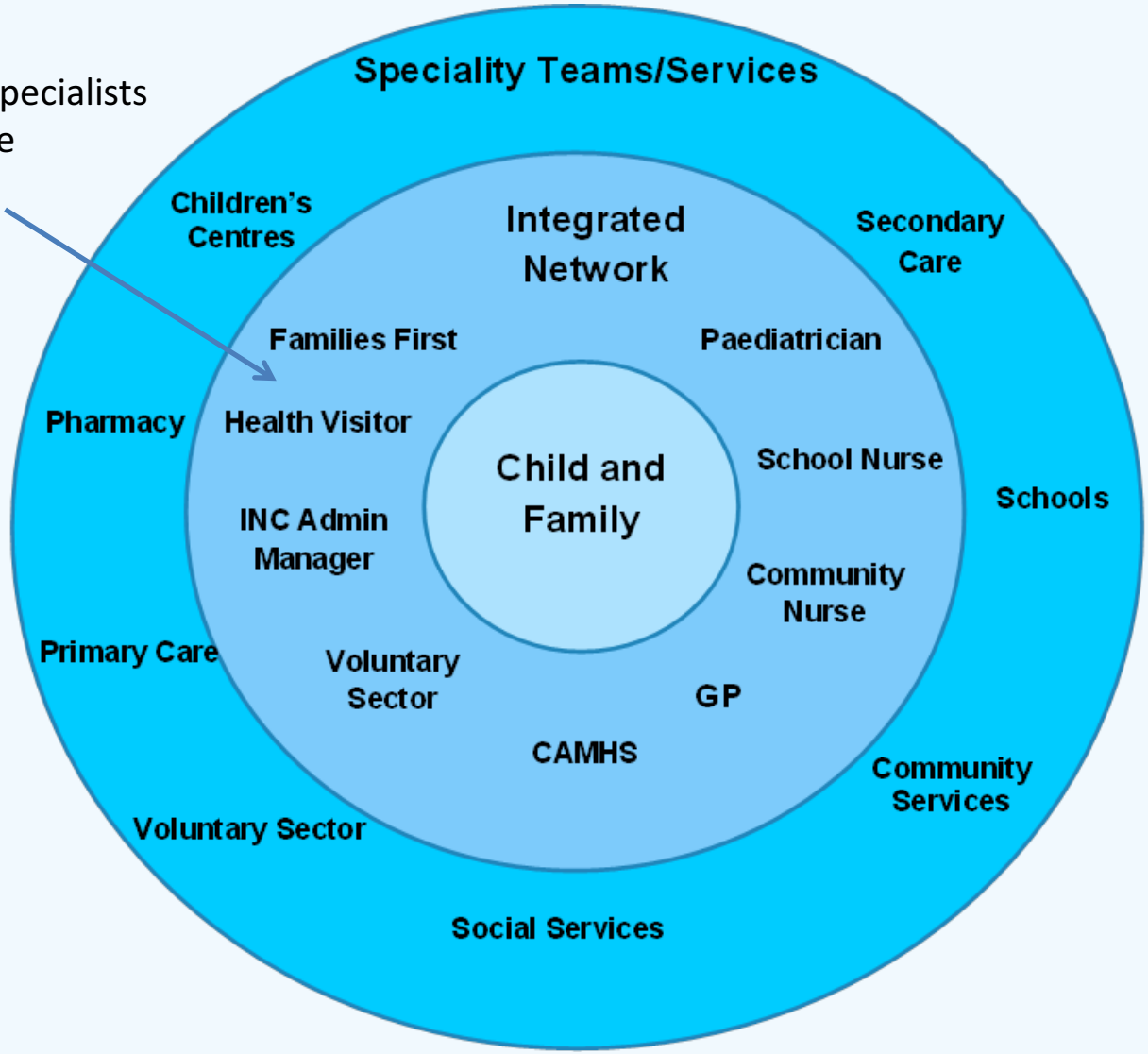
South West 1 — 24,789 0-18 – 4,310

South East 2 — 28,680 0-18 – 4,879

South West 2 — 30,955 0-18 – 4,651

PROPOSED INTEGRATED NETWORK TEAM

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



JOINT CLINICS AND THE VOLUNTARY SECTOR

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

06

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

NHS

Dartmouth

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	*Evidence to the Contrary*
Higher levels of health care produce higher levels of health & wellbeing for people and populations;	Health care contributes less to health than social circumstances, including education and behaviour;
Clinical evidence tells us what is the right thing to do for people in need of health care;	Evidence is insufficient; patients' preferences matter in decisions to deliver services that produce value;
Health care is delivery of services by professionals to people unable to understand or do for themselves	Much of health care is exchange of information about achieving what is possible and most valued.

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LEARNING FROM VARIATION TO DELIVER WHAT IS VALUED

Challenging Assumptions to Think and Do Things Differently

Resistance to Thinking Differently	*New Models to Do Differently*
Bias toward biomedical vs social science; specialism vs general knowledge; most proximate cause;	Integrate services around patients' needs and wants addressing more broadly the determinants of health;
Bias toward the objective and generalizable; neglect of context at the level of the individual patient;	Engage, inform, and support patients in identifying and acting upon their needs and wants;
Bias toward expertise, capabilities, and agency of professionals with neglect of that of patients / people.	Leverage joint assets of people and professionals to co-produce better health and wellbeing at lower cost.

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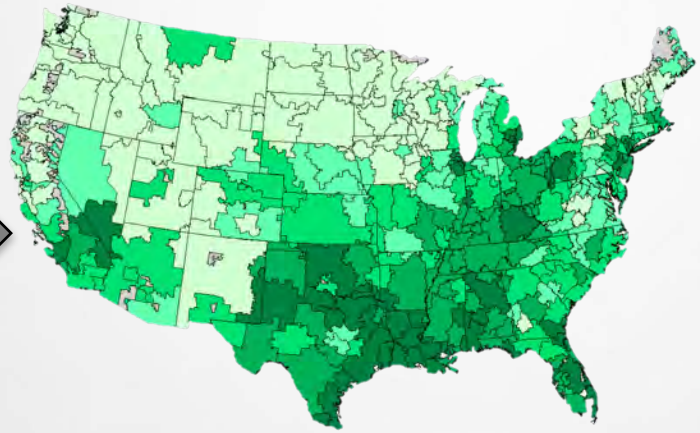
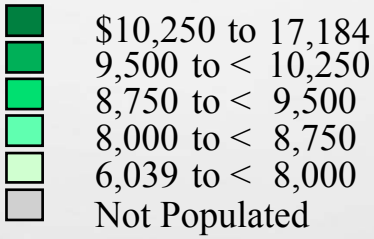
Learning from Variation in the United States and the United Kingdom

Vermont, 1973

10-fold Variation in Surgery Rates



United States, 1996 - 2012



- 3-fold variation among 152 PCTs in per capita costs for cancer and heart disease care

- 8-fold variation in stents for stable heart disease after NHS Plan capacity building

United Kingdom, 2010

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)

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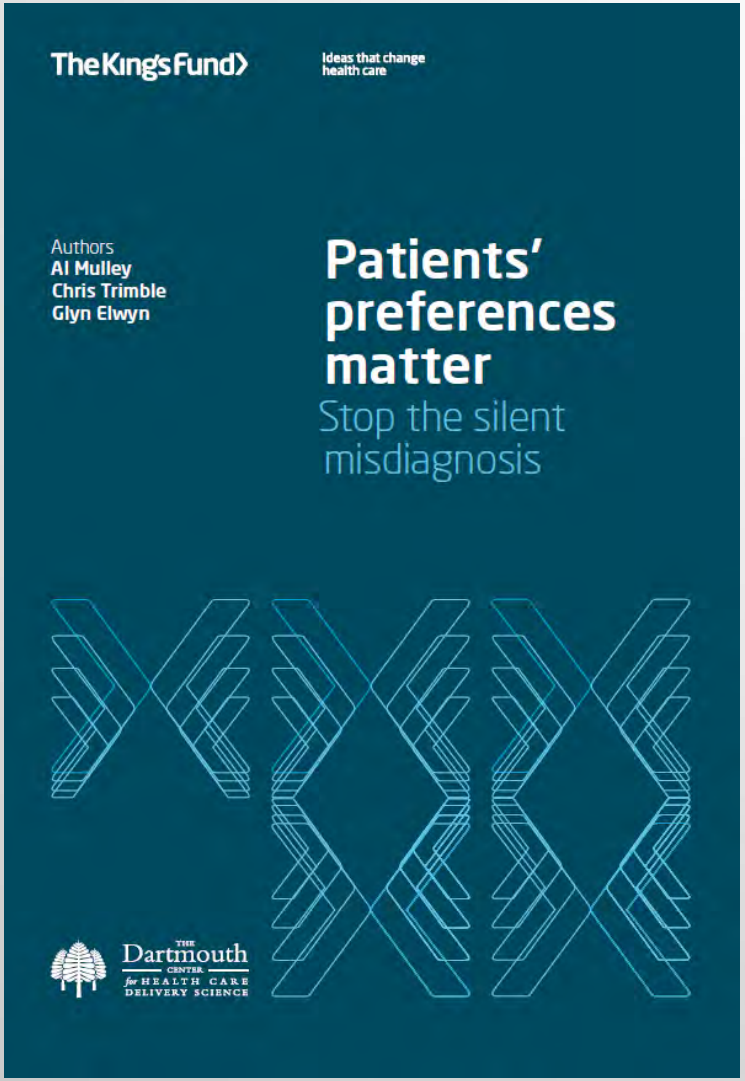
Learning from Variation in Patients' Preferences

Evidence is Necessary but Not Sufficient – Patients' Preferences Matter



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….

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Learning from Variation in Patients' Preferences

Evidence is Necessary but Not Sufficient – Patients' Preferences Matter

Treatment of early-stage disease

Treatment of metastatic disease

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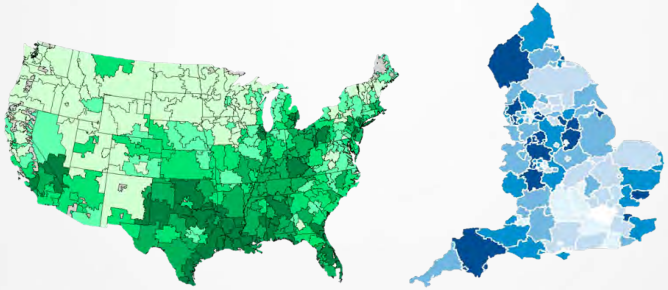
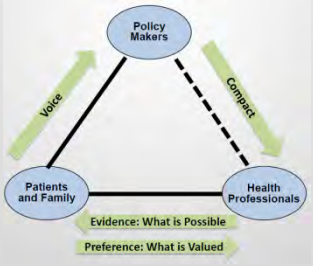
The Strategic Intent: Learning from Variation to Deliver What is Valued



Learn from Variation

Processes
Costs
Outcomes
Preferences



Deliver What is Valued

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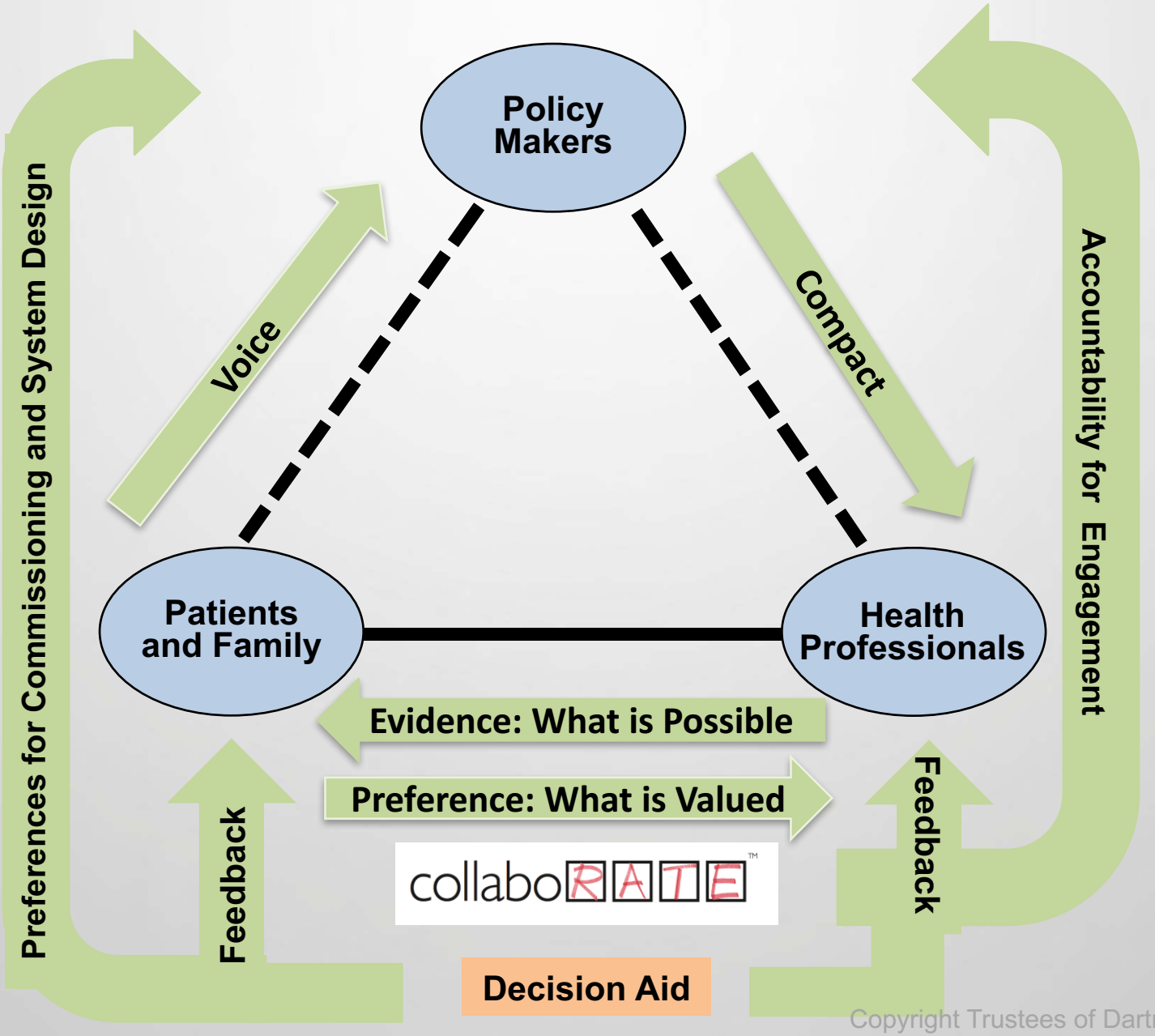
Learning from Patients' Preferences for System Reform

Giving System Leaders the Data they Need to Hold Themselves Accountable



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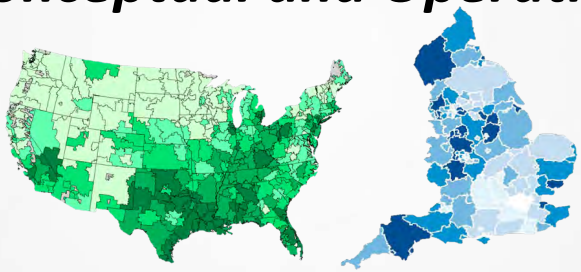
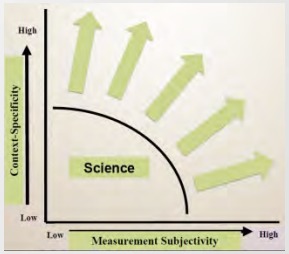
Learning from Variation to Deliver What is Valued
Overcoming Conceptual and Operational Barriers

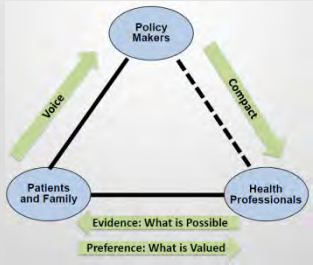


[Learn from Variation]

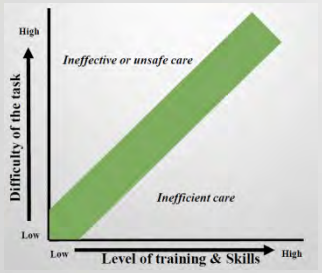


[Bring the Discipline of Science]

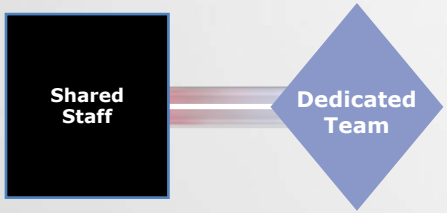
[Be Guided by Simple Rules]



[Deliver What is Valued]



[Deliver with Teams]



[Organize for Innovation]

Processes
Costs
Outcomes
Preferences

[Summary]

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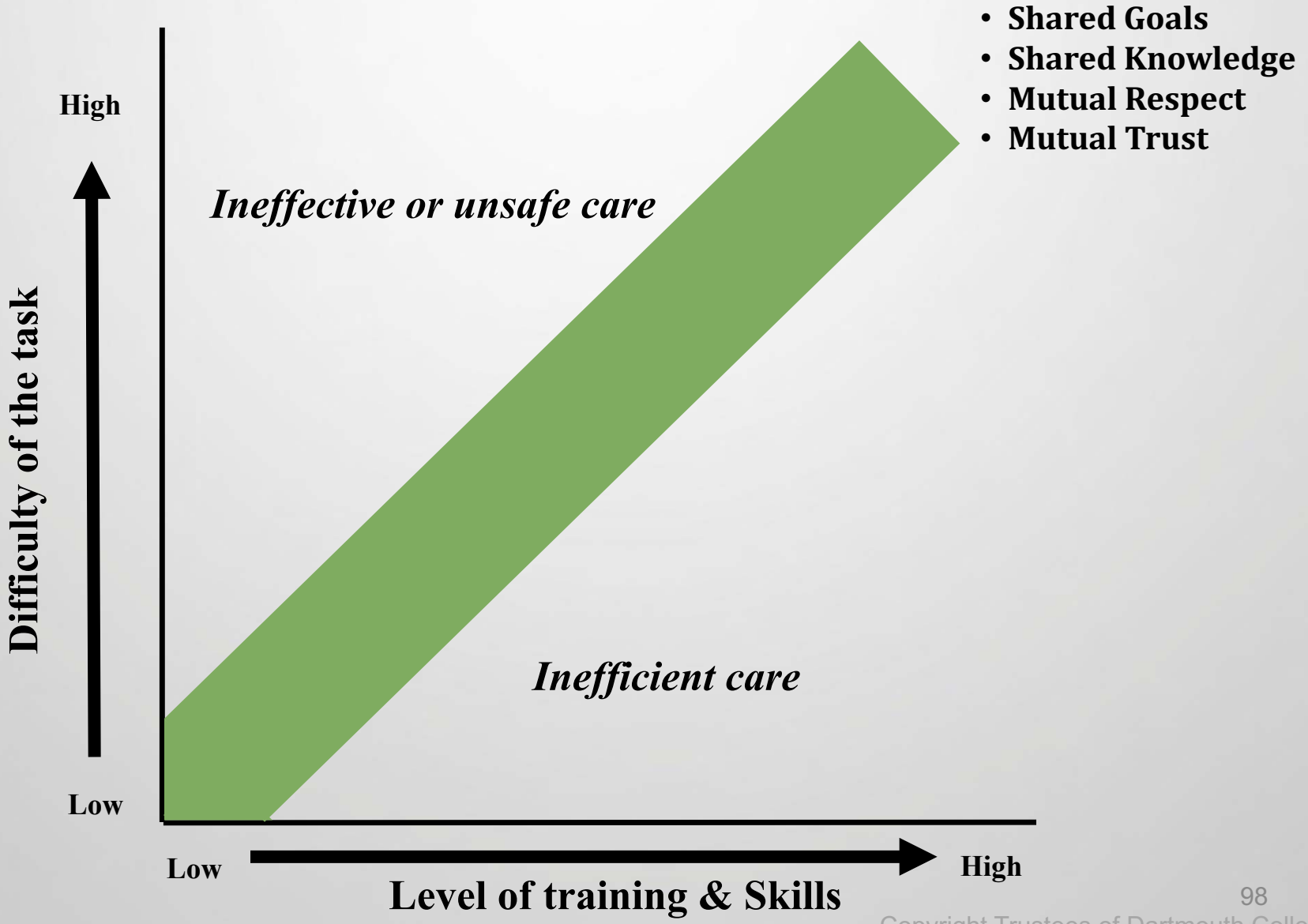
Redefining Roles for a Knowledge-Intensive Service Model

Supporting and Measuring the Teamwork Needed to Achieve Value



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Primary Care Service Models Designed Around Teams

Co-Creating Value in a Knowledge Intensive Service Delivery Model

Socios En Salud in Lima Norte

©Socios En Salud 2007

South → North Service Innovation

Dartmouth HEALTH CONNECT

A Dartmouth-Hitchcock/Iora Health Primary Care Practice

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The BMJ-Dartmouth Initiative

Challenging Assumptions and Testing Hypotheses on a Global Scale

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 *director*[1], Tessa Richards *senior editor/patient partnership*[2], Kamran Abbasi *international editor*[2]

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

thebmj EDITORIALS

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

Children and Adolescents with Mental and Behavioral Health Needs

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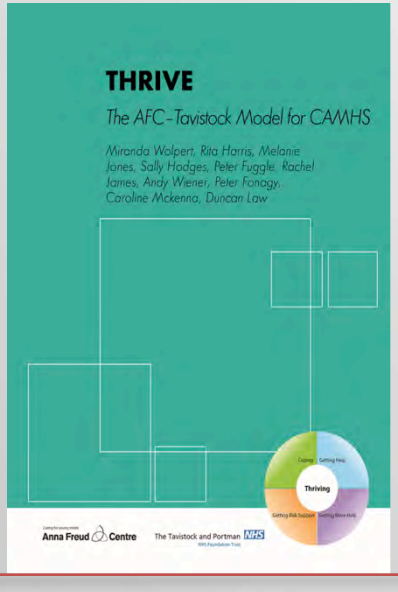
iTHRIVE: Understanding a Priority Population's Needs and Wants

- 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.

Conceptual Framework



+

Tools Supporting SDM Implementation

option grid

collaboRATE™

integRATE™

=

Combined Innovation – new model care

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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

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Archie Cochrane's Education at Elsterhorst: A Silent Misdiagnosis

"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."

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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 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 ?

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The following are back-up slides for responses to questions and discussion.

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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

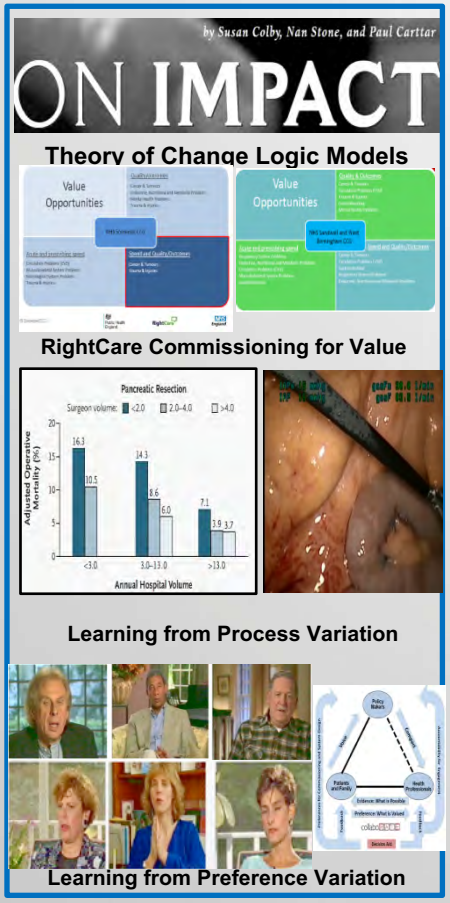
- Distinguish innovation from improvement
- Hold dedicated innovation team leaders responsible for learning & adapting
- Ensure innovation leaders flexibility to define new roles within care models
- Identify and learn from similar efforts elsewhere

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



Theory of Change Logic Models

RightCare Commissioning for Value

Learning from Process Variation

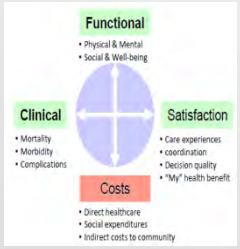
Learning from Preference Variation

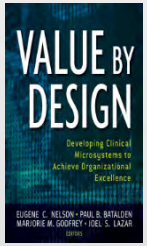
coope RATE
collaboRATE

Learning What is Valued

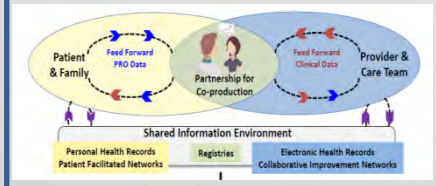
integRATE

PREMs for Integration & Coordination



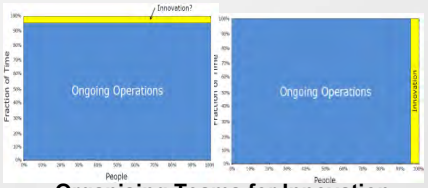


Value Compass for Population Health



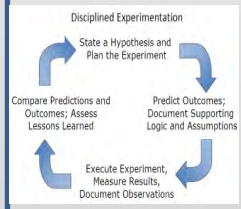
Person Centred Learning Network

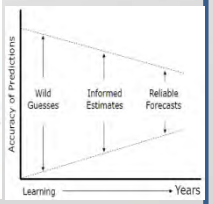
Measures & Tools for Teamwork



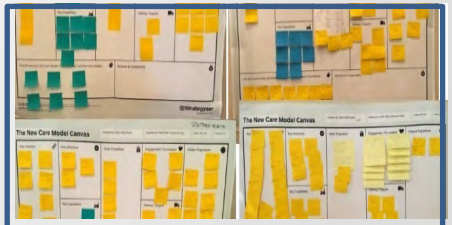
Organising Teams for Innovation

Understanding Delivery Innovation ROI

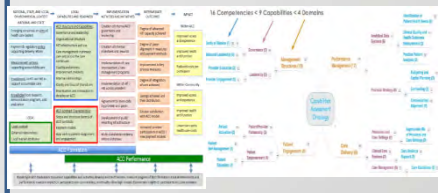




Innovators' Accountability for Learning



New Care Model Canvas for Connections



Strat Organisational Readiness Tool

ReThink Health & Wellbeing ROIs

Recognising Complementary Assets

Confidential Draft for Discussion

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Measures & Management Tools for Mutual Accountability Across Health and Care Systems

of stakeholders with role interdependences

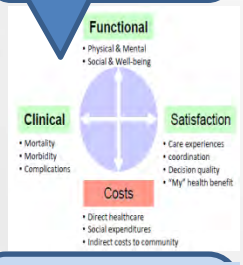
Tools:
CollaboRATE
IntegRATE

integRATE
collaboRATE

Patient & Clinician Reported Measures of Care Coordination & Teamwork

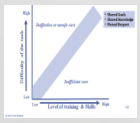
Patient & Clinician Reported Measures of Engagement to Agree Goals, Needs & Wants

Tools:
- Value Compass
- Microsystem Tools



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

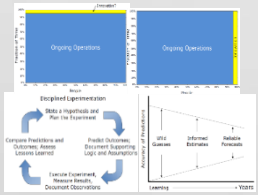
Measures and Tools for Quality & Efficiency Improvement in Clinical Microsystems



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

Measures to Learn from Variation in Outcomes & Costs ; in Preferences & Personal Value

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

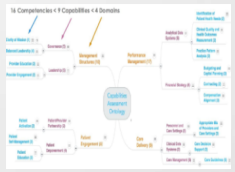


Measures to Assess Health Organisations' Readiness to Deliver Accountable Care

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

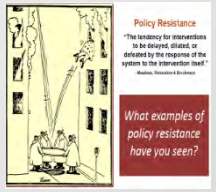
Tools to Assess Health & Care Organisations' Readiness to Deliver Accountable Care

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



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

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



Tool:
ReThink Health

Frontlines of Delivery — System Leadership

Confidential Draft for Discussion

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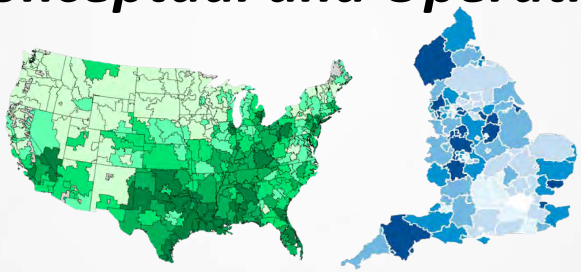
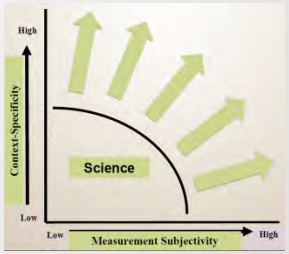
Learning from Variation to Deliver What is Valued
Overcoming Conceptual and Operational Barriers

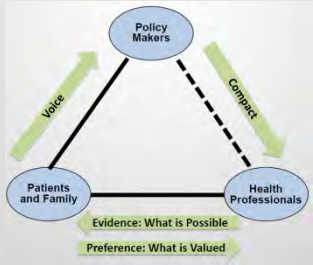


[Learn from Variation]

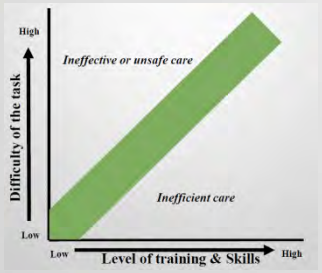


[Bring the Discipline of Science]

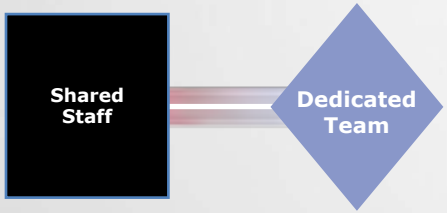
[Be Guided by Simple Rules]



[Deliver What is Valued]



[Deliver with Teams]



[Organize for Innovation]

Processes
Costs
Outcomes
Preferences

[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 | **Acute** | **Post Acute** | **Recovery**

Population at Risk

1^0 Prevention
(No known LTCs)

2^0 Prevention
(Known LTCs)

Patients with Known LTCs And Complex Needs

Acute Illness Associated with LTCs

Post Acute Rehabilitation & Support

Whole Person LTCs Care Planning & Management

'uncomplicated' patient

'complex' patient

Chest pain diagnosed as a heart attack

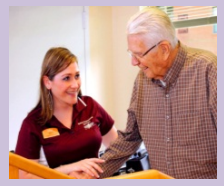
Getting better – learning self-care

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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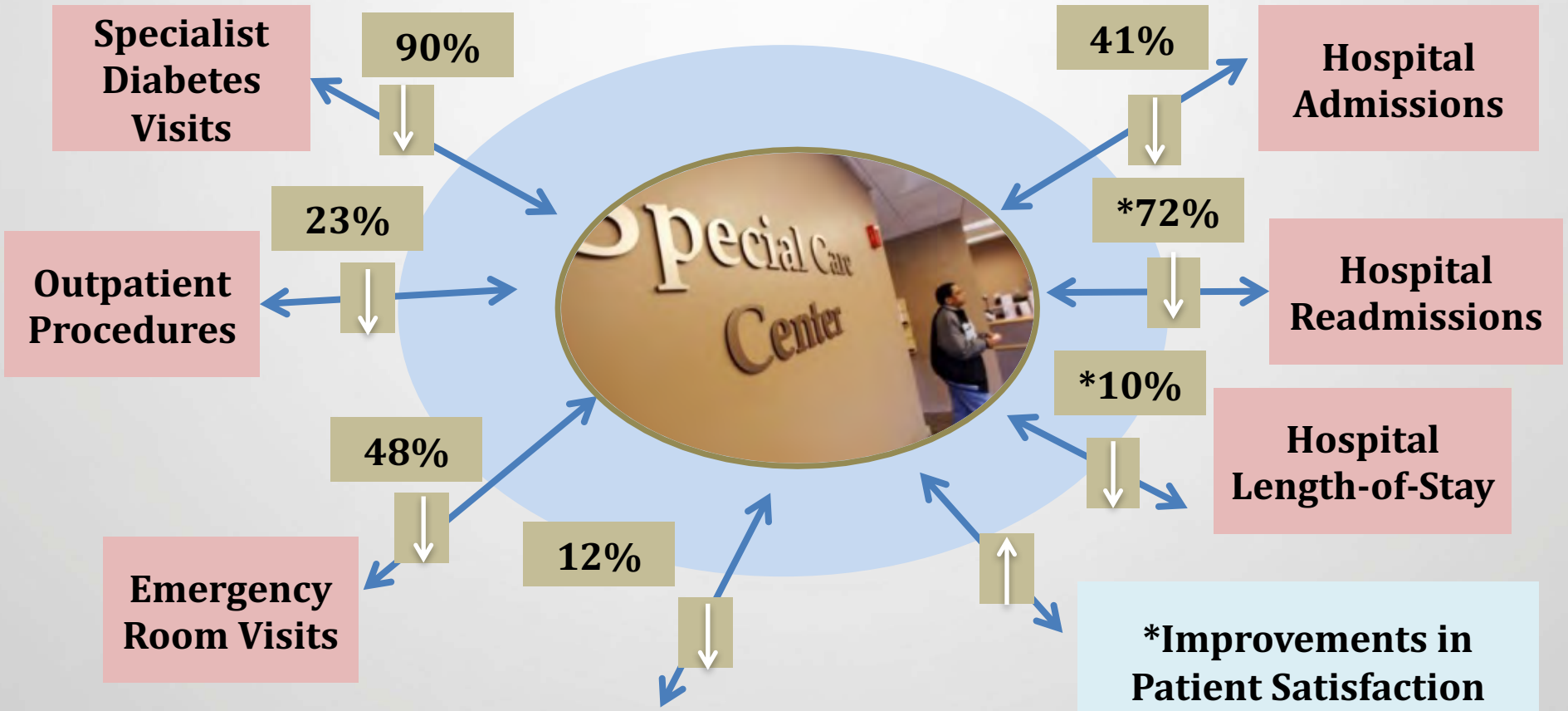
What Can Be Achieved By Delivering High Value Care to Patients



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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The BMJ-Dartmouth Initiative

Challenging Assumptions and Test the Sustainability Hypothesis

thebmj

BMJ 2017;356:j1401 doi: 10.1136/bmj.j1401 (Published 2017 March 30)

Check for updates

ANALYSIS

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 *professor*[1], Angela Coulter *senior research scientist*[2], Miranda Wolpert *professor*[3], Tessa Richards *senior editor/patient partnership*[4], Kamran Abbasi *international editor*[4]

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The BMJ-Dartmouth Initiative

Challenging Assumptions and Testing the Sustainability Hypothesis

thebmj

BMJ 2017;357:j1500 doi: 10.1136/bmj.j1500 (Published 2017 April 03)

Check for updates

ANALYSIS

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 practice*[1], P Vostanis *professor of child mental health*[2], K Martin *director*[3], S Munk *children and young people mental health and resilience strategic lead*, [4], R Norman *school improvement adviser*[5], P Fonagy *professor of contemporary psychoanalysis and developmental science*[1], A Feltham *adviser*[3]

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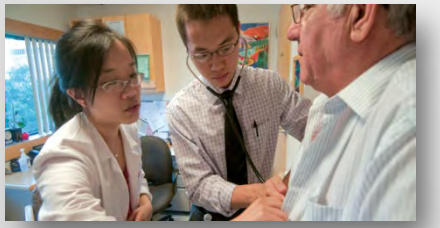
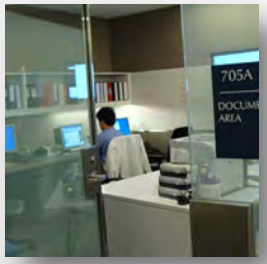
Systems Balancing Acute Care with Community Health Care

Tertiary Acute Care Hospital

Tertiary Acute Care Hospital





Primary Care Residency Training

Health Care Delivery Science Research

Continuing Clinical Education

Health Care Management Training

Community Health Centers

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07

Q&A / Panel discussion

Q&A / PANEL DISCUSSION

TEA & COFFEE

08

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

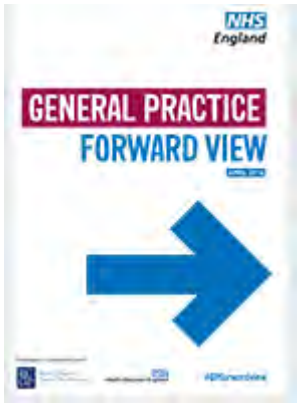
- **Conclusions**

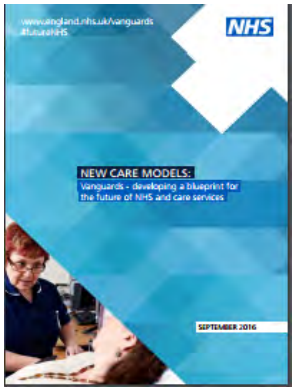
Primary Care - Strategic Context

- 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

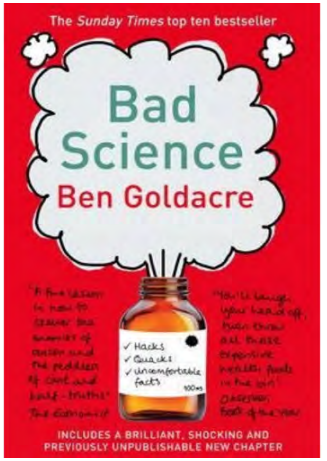
→ CYP 20-25% of current population, 100% future

→ They need your explicit leadership & advocacy

Navigating services for **CYP→ it is a maze!**

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

Data

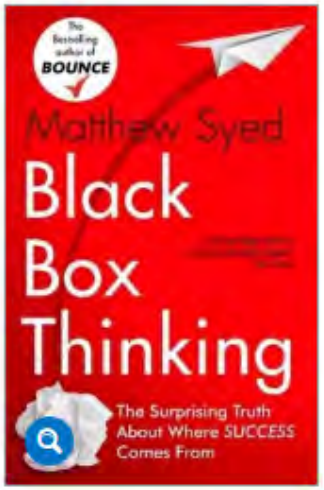


- Oxford dictionary:
  - *' Known facts used in inference or for reckoning'*
- Data types (for needs assessment / service reviews)
  - Populations (registered, resident, school children)
  - Demography (age, ethnicity, projections)
  - Determinants of health; distribution of risk & resilience factors & 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**

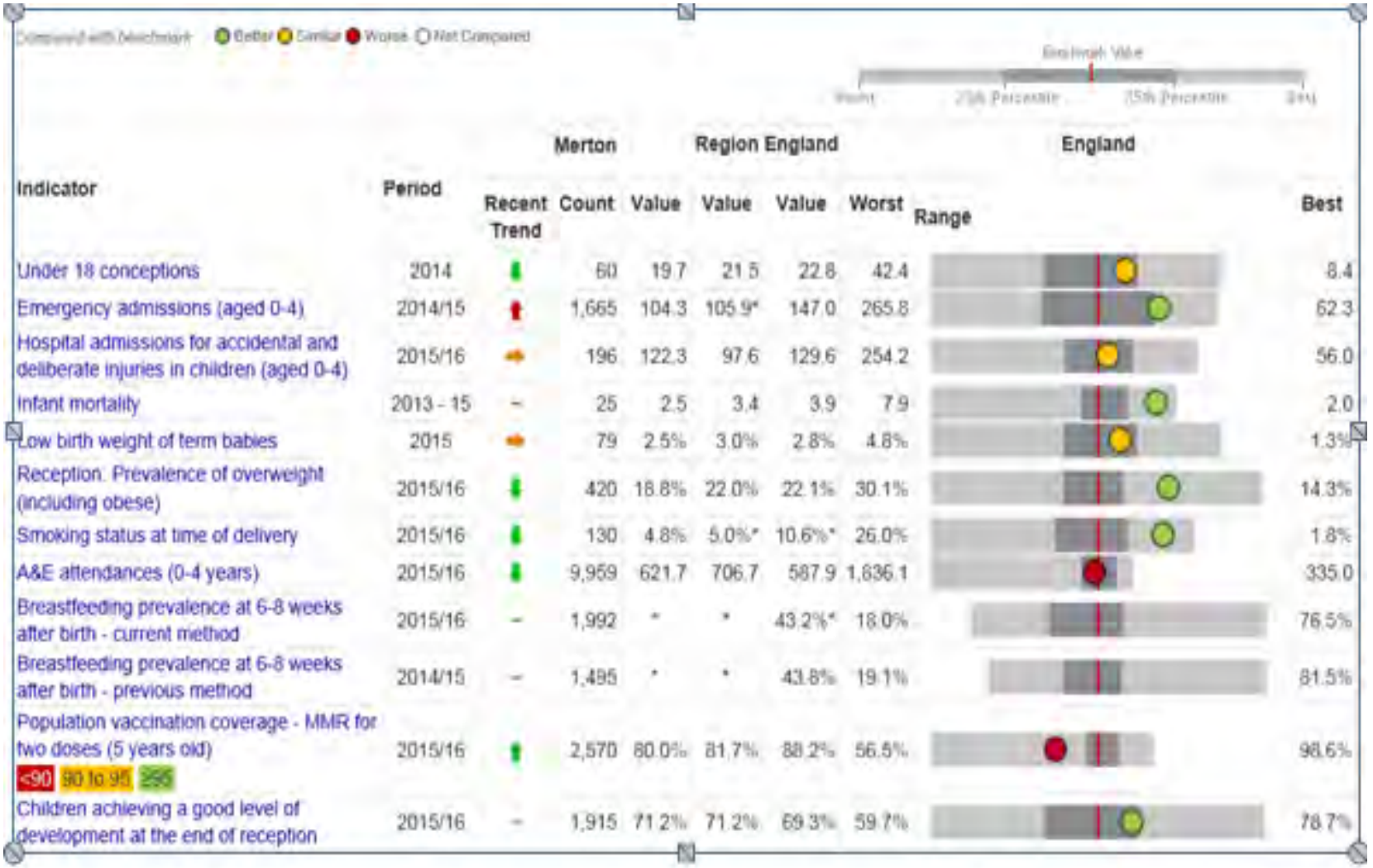


Good read: B Goldacer *Bad science*; M Syed *Black box thinking*

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



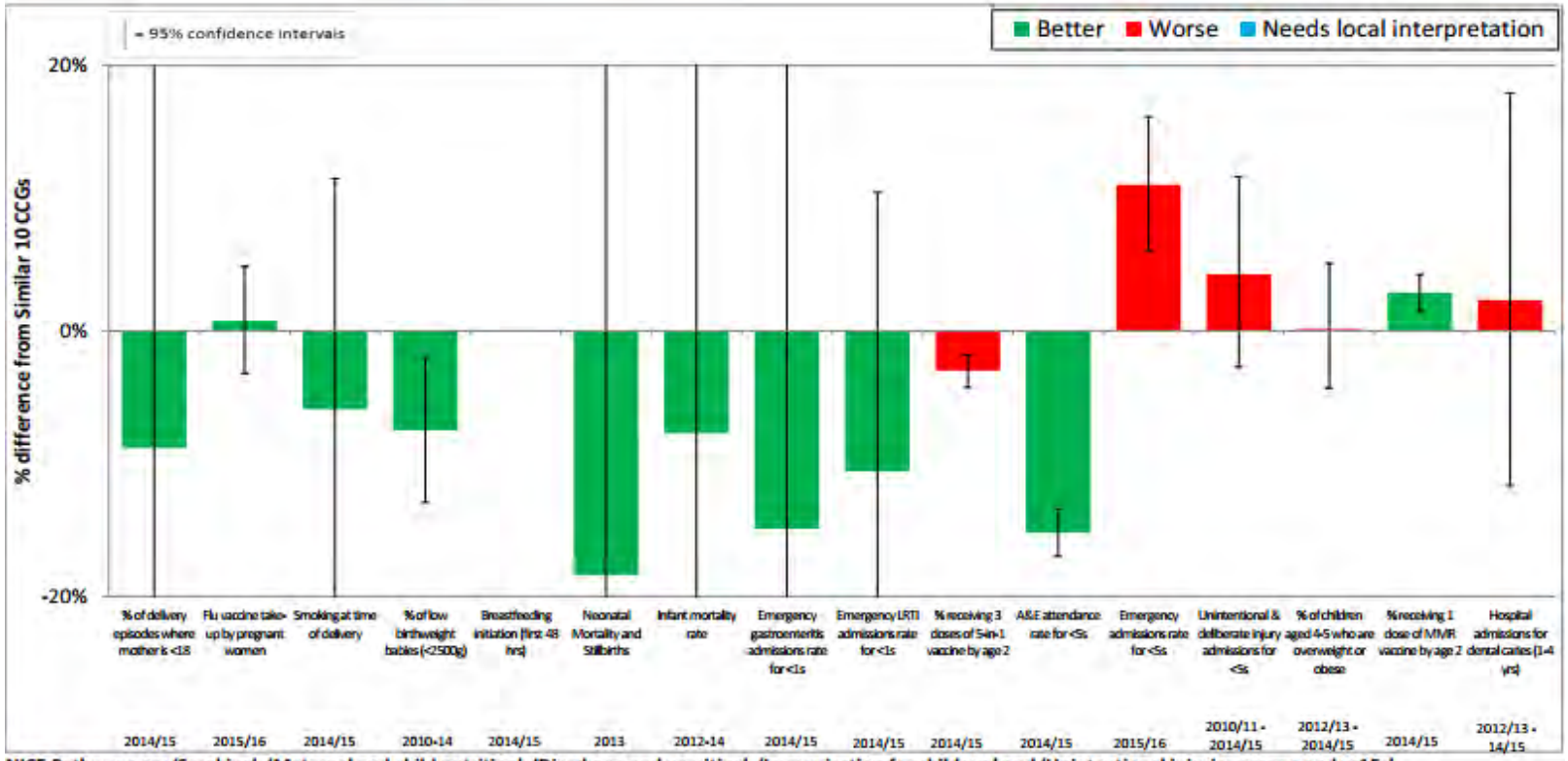
Indicator	Period	Recent Trend	Merton Count	Merton Value	Region England Value	England Value	England Worst	England Range	England Best
Under 18 conceptions	2014	↓	60	19.7	21.5	22.8	42.4		8.4
Emergency admissions (aged 0-4)	2014/15	↑	1,665	104.3	105.9*	147.0	265.8		62.3
Hospital admissions for accidental and deliberate injuries in children (aged 0-4)	2015/16	→	196	122.3	97.6	129.6	254.2		56.0
Infant mortality	2013 - 15	-	25	2.5	3.4	3.9	7.9		2.0
Low birth weight of term babies	2015	→	79	2.5%	3.0%	2.8%	4.8%		1.3%
Reception: Prevalence of overweight (including obese)	2015/16	↓	420	18.8%	22.0%	22.1%	30.1%		14.3%
Smoking status at time of delivery	2015/16	↓	130	4.8%	5.0%*	10.6%*	26.0%		1.8%
A&E attendances (0-4 years)	2015/16	↓	9,959	621.7	706.7	587.9	1,636.1		335.0
Breastfeeding prevalence at 6-8 weeks after birth - current method	2015/16	-	1,992	*	*	43.2%*	18.0%		76.5%
Breastfeeding prevalence at 6-8 weeks after birth - previous method	2014/15	-	1,495	*	*	43.8%	19.1%		81.5%
Population vaccination coverage - MMR for two doses (5 years old) <90 90 to 95 ≥95	2015/16	↑	2,570	80.0%	81.7%	88.2%	56.5%		98.6%
Children achieving a good level of development at the end of reception	2015/16	-	1,915	71.2%	71.2%	69.3%	59.7%		78.7%

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

NHS RightCare



NICE Pathways on: 'Smoking', 'Maternal and child nutrition', 'Diarrhoea and vomiting', 'Immunisation for children ' and 'Unintentional injuries among under 15s'
http://pathways.nice.org.uk/

Further Information Link:
https://sustain.sharepoint.com/Documents/HCP%20Integrated%20Com%20and%20Del%20toolkit%20final.pdf

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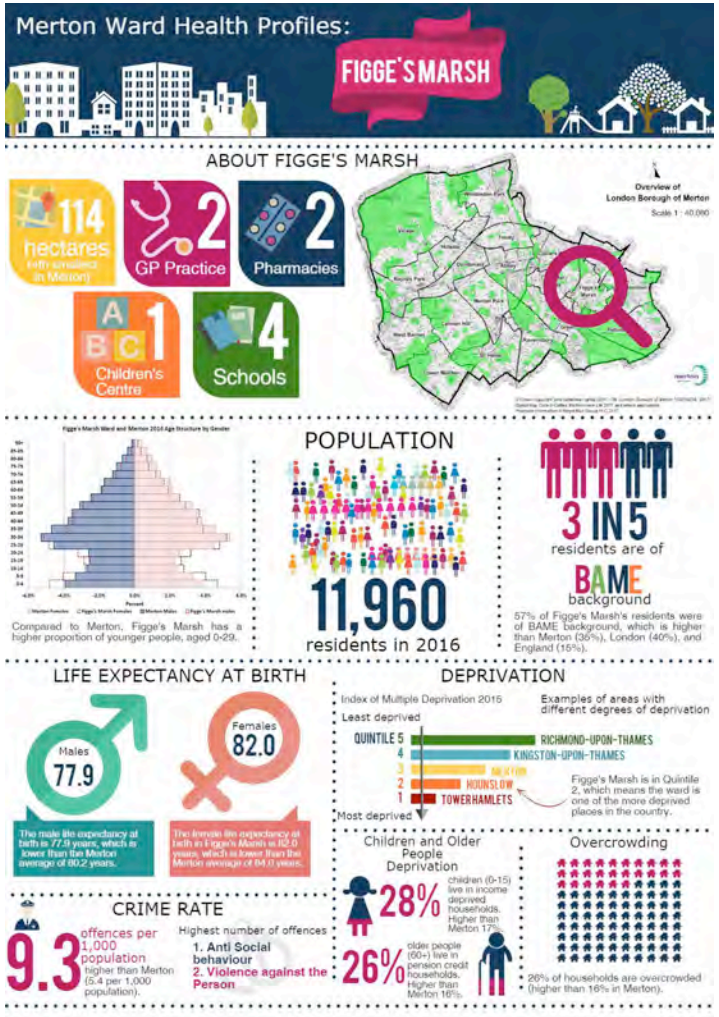
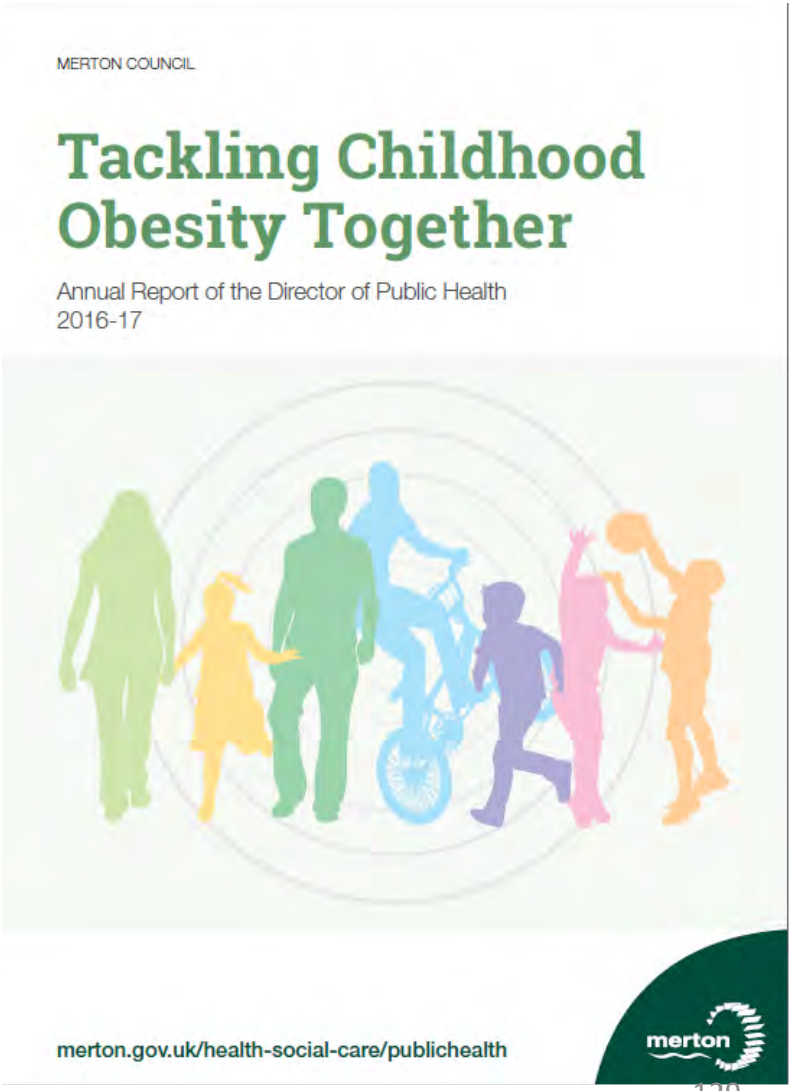
HLP STP data packs

Merton JSNA & APHR





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

CM07	HVs: NBV within 14 days	90%	Numerator	191	257	248	253	246	277	273	248	265	239	228
			Denominator	230	270	267	254	252	284	280	258	271	242	233
			Performance	83.0%	95.2%	92.9%	99.6%	97.6%	97.5%	97.5%	96.1%	97.8%	98.8%	97.9%
CM33	HVs: 6- to 8-week reviews by 8 weeks	95%	Numerator	137	147	180	207	215	242	271	249	263	249	219
			Denominator	241	237	258	277	232	263	281	263	276	261	229
			Performance	56.8%	62.0%	69.8%	74.7%	92.7%	92.0%	96.4%	94.7%	95.3%	95.4%	95.6%
CM37	HVs: breasfeeding status recorded at 6- to 8-week review	95%	Numerator	133	147	180	207	214	240	271	249	263	249	219
			Denominator	241	237	258	277	232	263	281	263	276	261	229
			Performance	55.2%	62.0%	69.8%	74.7%	92.2%	91.3%	96.4%	94.7%	95.3%	95.4%	95.6%
CM53	HVs: totally or partially breastfed at 6- to 8-week review	70%	Numerator	112	115	135	147	160	184	206	193	209	179	169
			Denominator	241	237	258	277	232	263	281	263	276	261	229
			Performance	46.5%	48.5%	52.3%	53.1%	69.0%	69.96%	73.3%	73.4%	75.7%	68.6%	73.8%
CM25	HVs: 12-month reviews by 12 months	75%	Numerator	130	162	145	166	149	148	171	181	209	204	234
			Denominator	264	282	270	296	256	272	261	293	292	267	268
			Performance	49.2%	57.4%	53.7%	56.1%	58.2%	54.4%	65.5%	61.8%	71.6%	76.4%	87.3%
CM26	HVs: 12-month reviews by 15 months	80%	Numerator	189	144	172	164	174	183	187	168	178	193	218
			Denominator	275	233	279	266	284	279	297	264	273	262	292
			Performance	68.7%	61.8%	61.6%	61.7%	61.3%	65.6%	63.0%	63.6%	65.2%	73.7%	74.7%
CM27a	HVs: 2.5-year reviews by 2.5 years	80%	Numerator	5	8	27	53	94	158	161	162	147	167	146
			Denominator	277	259	252	249	252	268	266	274	267	292	233
			Performance	1.8%	3.1%	10.7%	21.3%	37.3%	59.0%	60.5%	59.1%	55.1%	57.2%	62.7%

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

Map 2: Index of Deprivation Affecting Children Index (IDACI) in Merton and exces
weight in Year 6 by ward

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)

Childhood immunisations

Table 1 – Annual performance trends 2013/14 to 2015/16

	Diphtheria, Tetanus, Polio Pertussis, Haemophilus influenza type b (DTaP/IPV/Hib) Age 1	Hib/Men C booster Age 2	MMR1 Age 2	Pneumococcal infection (PCV booster) Age 2	Diptheria, Tetanus, Polio, Pertussis (DTaP/IPV – pre school booster) Age 5	MMR2 Age 5
Merton Annual 15/16	91.8%	86%	86.3%	85.5%	68.7%	80%
Merton Annual 14/15	93.3%	87.9%	88.8%	87.7%	71.7%	80.4%
Merton Annual 13/14	82.1%	81%	82.1%	82.8	64.8	72.3
London average 15/16	89.2%	85.9%	86.4%	85.6%	78.3%	81.7%
England average 15/16	93.6%	91.6%	91.9%	91.5%	86.3%	88.2%
Merton Annual 15/16 vs London Annual 15/16	⇧2.6%%	⇧0.1%	⇩0.1%	⇩0.1%	⇩9.6%	⇩1.7%

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**

Child death overview panel (CDOP)

Child Death Overview Panel Newsletter (November 2015)

In this issue:

Asthma in children

Alcohol poisoning by Hand Sanitizer

Children and Mental Health

Asthma in children

There are 1.1. million children with Asthma in the UK. It is the most common disease of childhood. Asthma is often accompanied by food and environmental allergies, eczema and hay fever.

There were over 240, and 212 hospital admissions for Respiratory Infections in Merton and Sutton respectively in 2011-12. There were 18 child deaths from Asthma in England for 2011-12.

Community professionals should encourage parents to support and educate their children to:-

(a) Understand what triggers their Asthma how to use their medication and to make sure they always have adequate supplies of their medication at home.

(b) Parents should get an up to date asthma action plan from their health professional and have it reviewed at least once yearly.

(c) Ensuring all agencies in contact with the child e.g. school, after school activities, sports are aware of the condition and the child's Asthma care plan.

(d) To educate children who have Asthma to know what to do if they suffer an attack in a public place or at school. Schools should have an Asthma Policy and know all their children who suffer from Asthma and are taking long term medication for allergies.

Encourage parents to follow recommendations from their Asthma care management providers such as their GP's. Asthma charities also offer information on care and management of the condition.
For more information click on links:

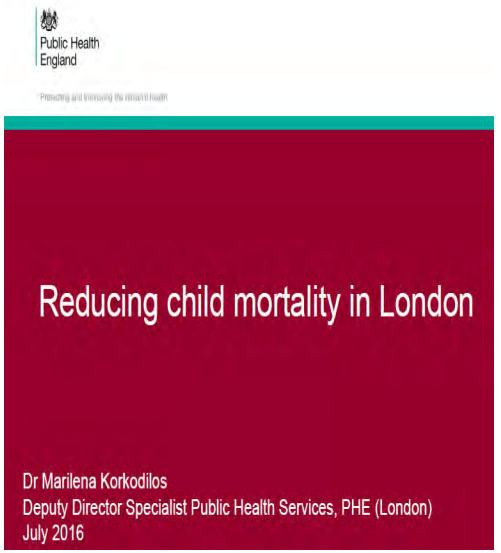
http://www.asthma.org.uk/advice-manage-your-asthma

Alcohol poisoning by hand sanitizers

Hand sanitizer has been identified in a number of cases as a source of alcohol poisoning where small children have accessed the product while tasting it on their hands, attracted by flavoured brands.
Hand Sanitizer has also become a dangerous new trend of teenagers consuming the product as a potent source of alcohol. The alcohol content is higher than wines and spirits which range to 50% proof at its highest levels. Hand sanitizer contains 65% ethyl alcohol making it 120% proof. The product is also made more potent by mixing it with salt.

Child Death Overview Panel Newsletter (June 2015)

In this issue:
Button Battery Warnings
Uncooked Jelly cubes
Child Car Seats



Drowning in baths a risk for young children warns PHE - GOV.UK
https://www.gov.uk/.../news/drowning-in-baths-a-risk-for-young-children-warns-phe
2 Feb 2015 - PHE is raising awareness of the dangers of accidental child drowning involving the use of bath 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 // for eating disorders

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

UCL

KING'S College LONDON

Anna Freud National Centre for

London and South East CYP-IAPT Learning Collaborative

How can CYP IAPT help?

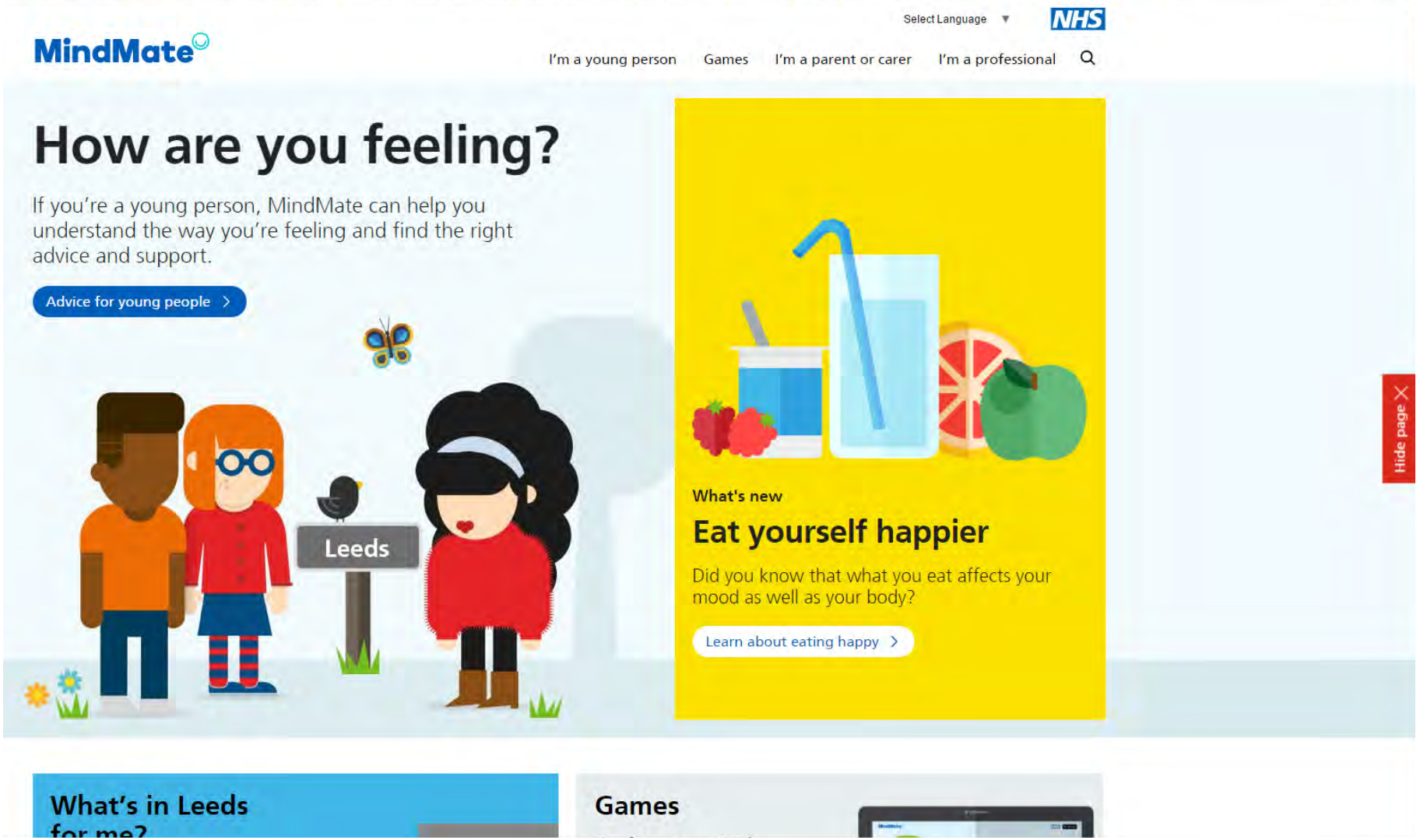
- Increase capacity and capability through Recruit to Train staff based in GPs surgeries + implementation support
- Increase capacity and capability through CWPs based in primary care (more in a moment)
- Interventions guided by goals, outcomes and young people's preferences, are generally briefer
-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

Children & Young People's Wellbeing Practitioners

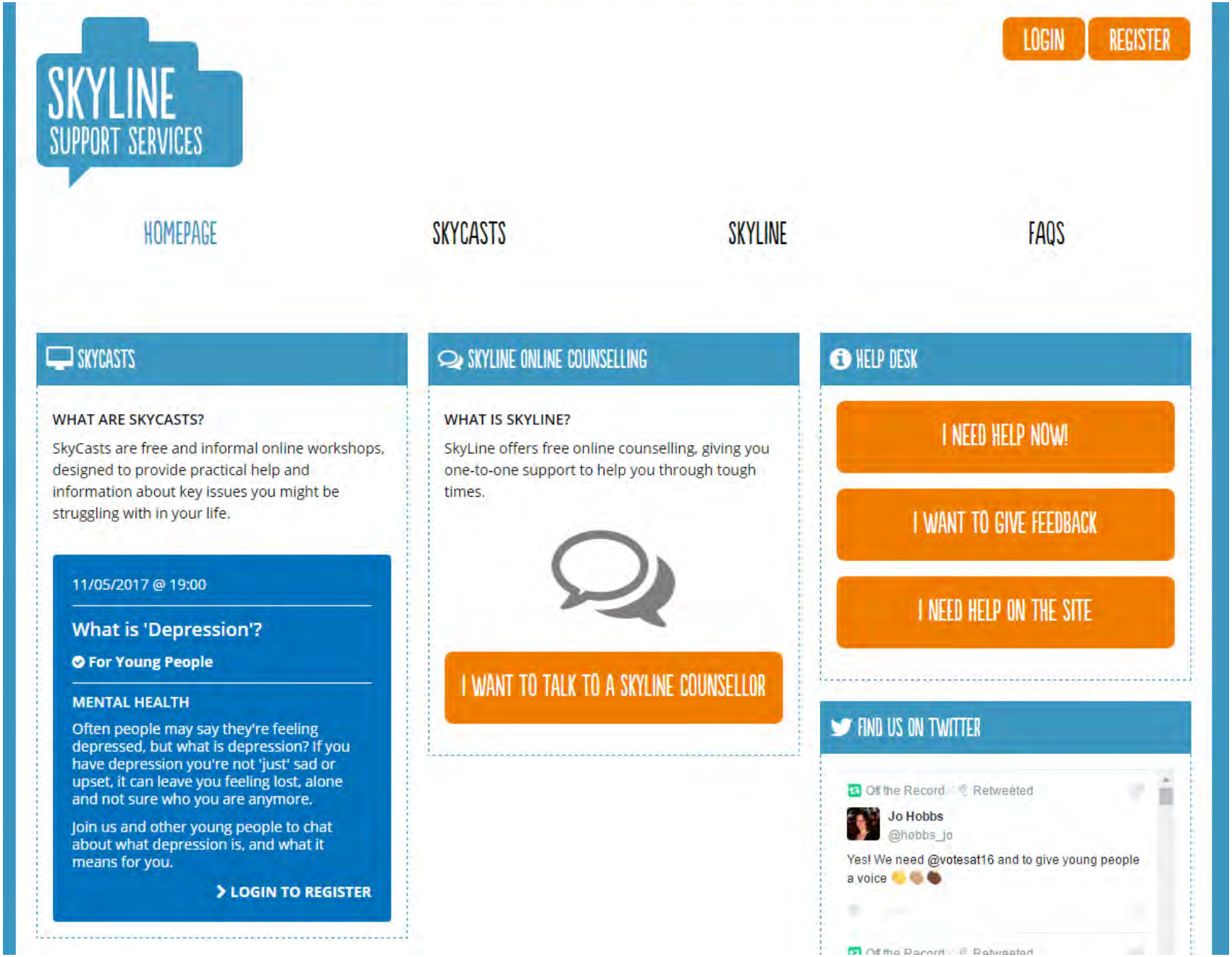
- National pilot of young people's version of adult PWP, through CYP IAPT programme
- For young people who otherwise wouldn't reach thresholds for CYP MH services
- New service model, linked with CYP MH services
- 15 pilot sites in London & South East with 60 (band 4) CWPs with high quality supervision
- 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…

MindMate



https://www.mindmate.org.uk/

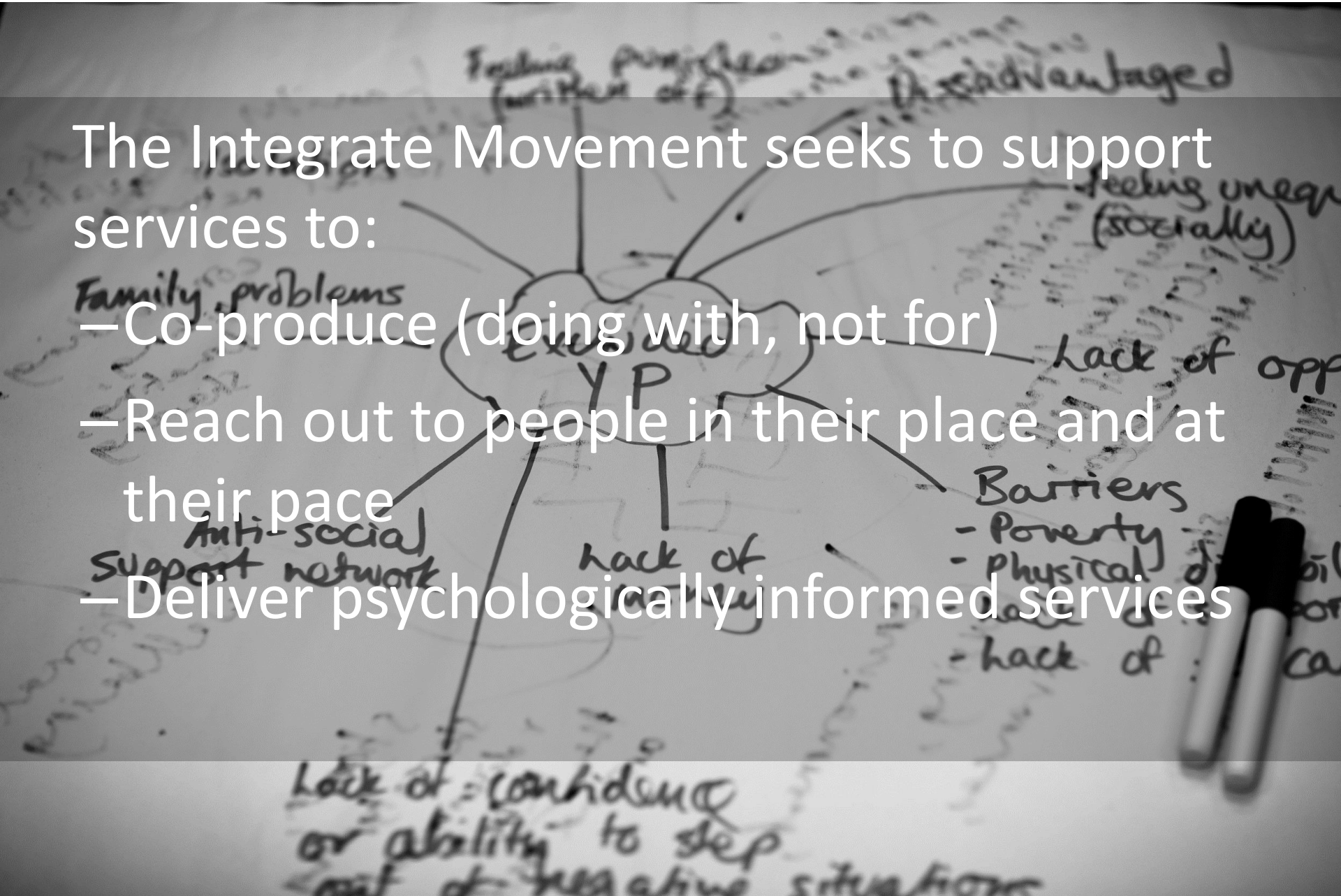


https://www.skylinesupport.org/

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 18years, 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 for their feedback and outcomes measurement

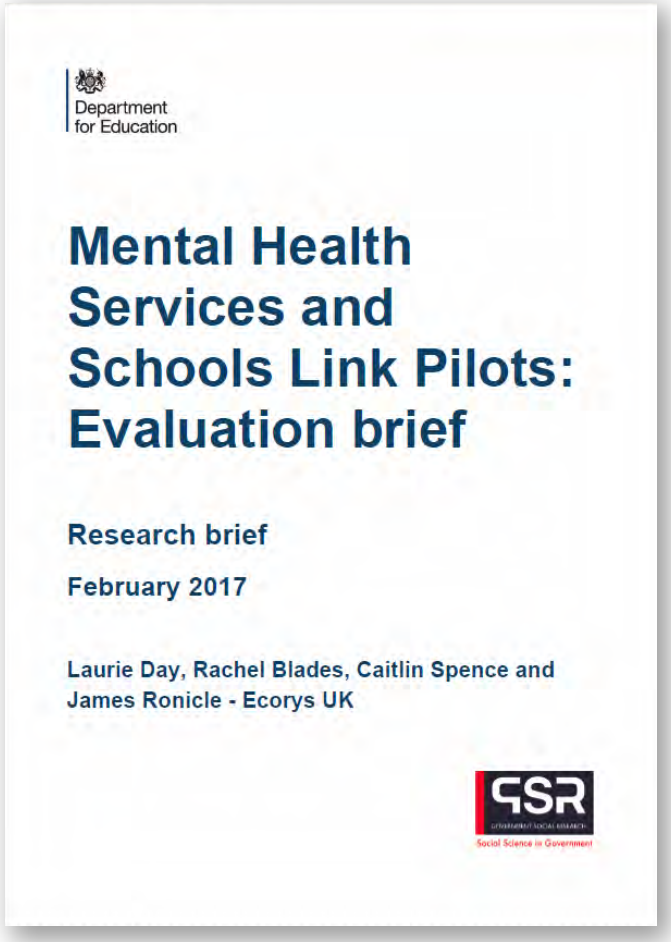
The Integrate Movement



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

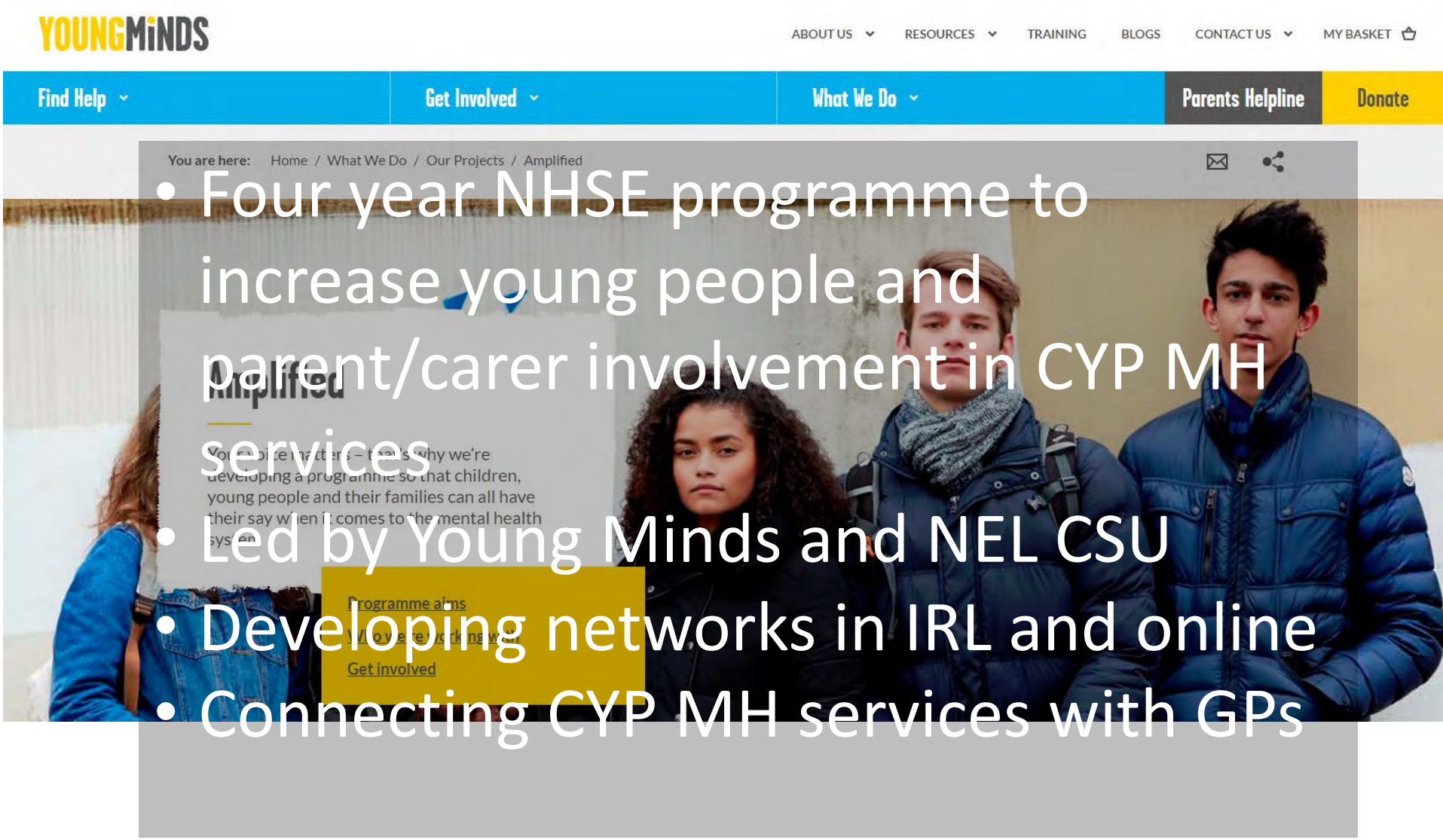
- Collaboration between Collaborative, SWLSTG & English Speaking Union
- Young people with experience of mental health services trained in debating over 12 weeks beginning end October 2016
  - Culminating in 1 day of competition at a prestigious venue
- Propositions around mental health, service provision, 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

The English-Speaking Union

South West London and St George's NHS Mental Health NHS Trust

London and South East CYP-IAPT Learning Collaborative

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

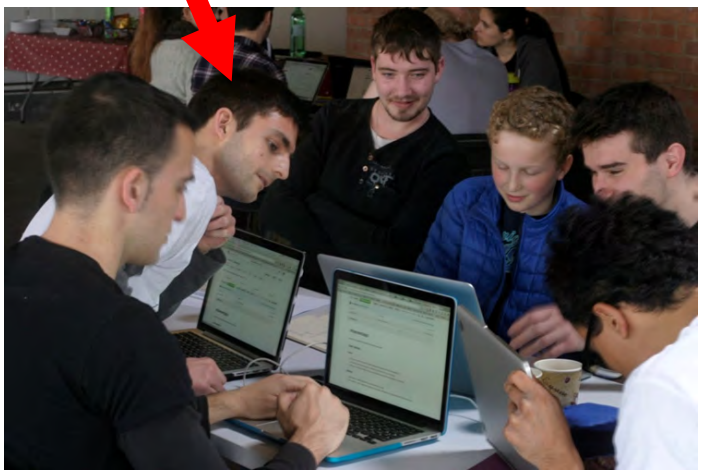
Hackathons

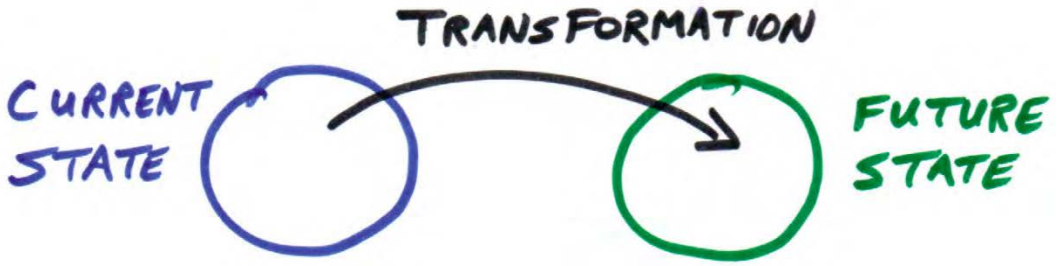
Young people

Software Developers

Clinicians

+





=

App: Breath with Me

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

Grow

ADD A GOAL +

London and South East
CYP-IAPT Learning Collaborative

Home | What is the Lea… Collaborative? | What is CYP IAPT | How do we Transform Services? | Transformation Resources | Contact Us | Opportunities

To chat/find out more:

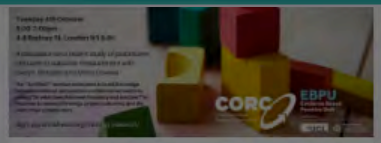
@LDNSECYPIAPT

alex.goforth@annafreud.org

www.cypiapt.com

requirement for all recommended CYP outcome […]

VIEW MORE



So what?": Attitudes … adolescent mental health services seminar

VIEW MORE

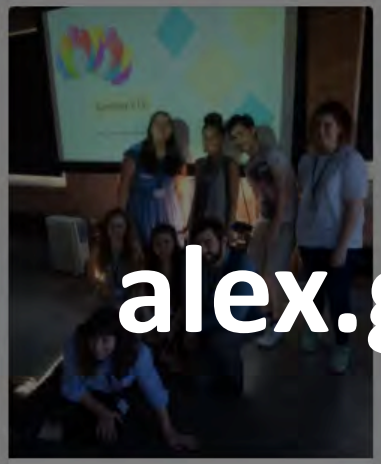
A Personal Message from Duncan Law, Clinical Lead for the London & South East CYP IAPT …

VIEW MORE

The Anna Freud Centre, 4-8 Rodney St N1 9JH

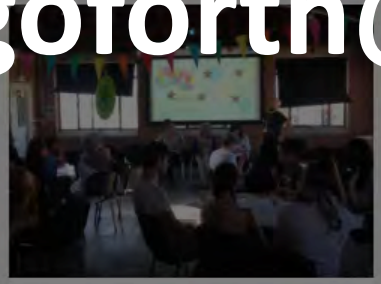
Service Leadership Course Starts
November 28, 2016

Social



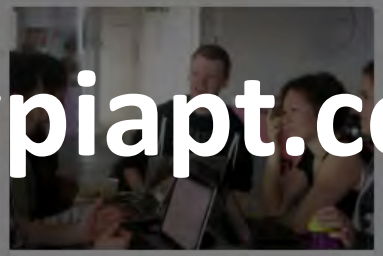
New Young Advisors

At the end of August we said goodbye to three of our young advisors: Ben, Maisy and Fran have left in pursuit of new adventures, and we wish them all the best for the future.



… Summer …

On the 26th August 2016, participation workers and young …



Follow me on Twitter

Tweets by @CYP_IAPT_LDNSE

CYP IAPT LondonSE
@CYP_IAPT_LDNSE
Great article written by Maisy, showing us why #participation is so important! #cypiapt @cypiaptyadvisor twitter.com/AFNCCF/status/…
12 Oct

CYP IAPT LondonSE
@CYP_IAPT_LDNSE
The importance of using goals to measure outcomes #worldmentalhealthday #WMHD16

10

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.

AND YET?

CYPHP
www.cyphp.org

- 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

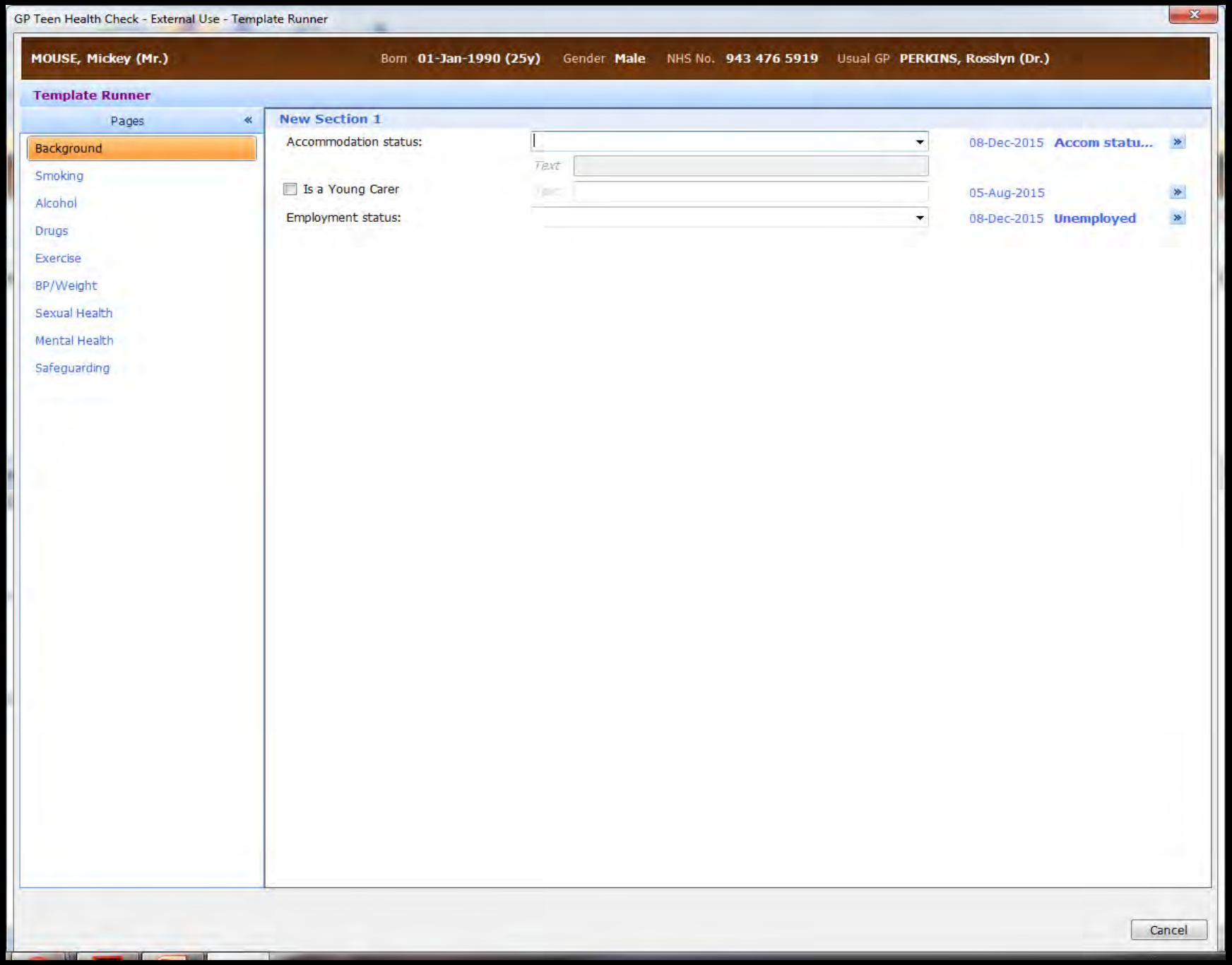
Teen Health Check

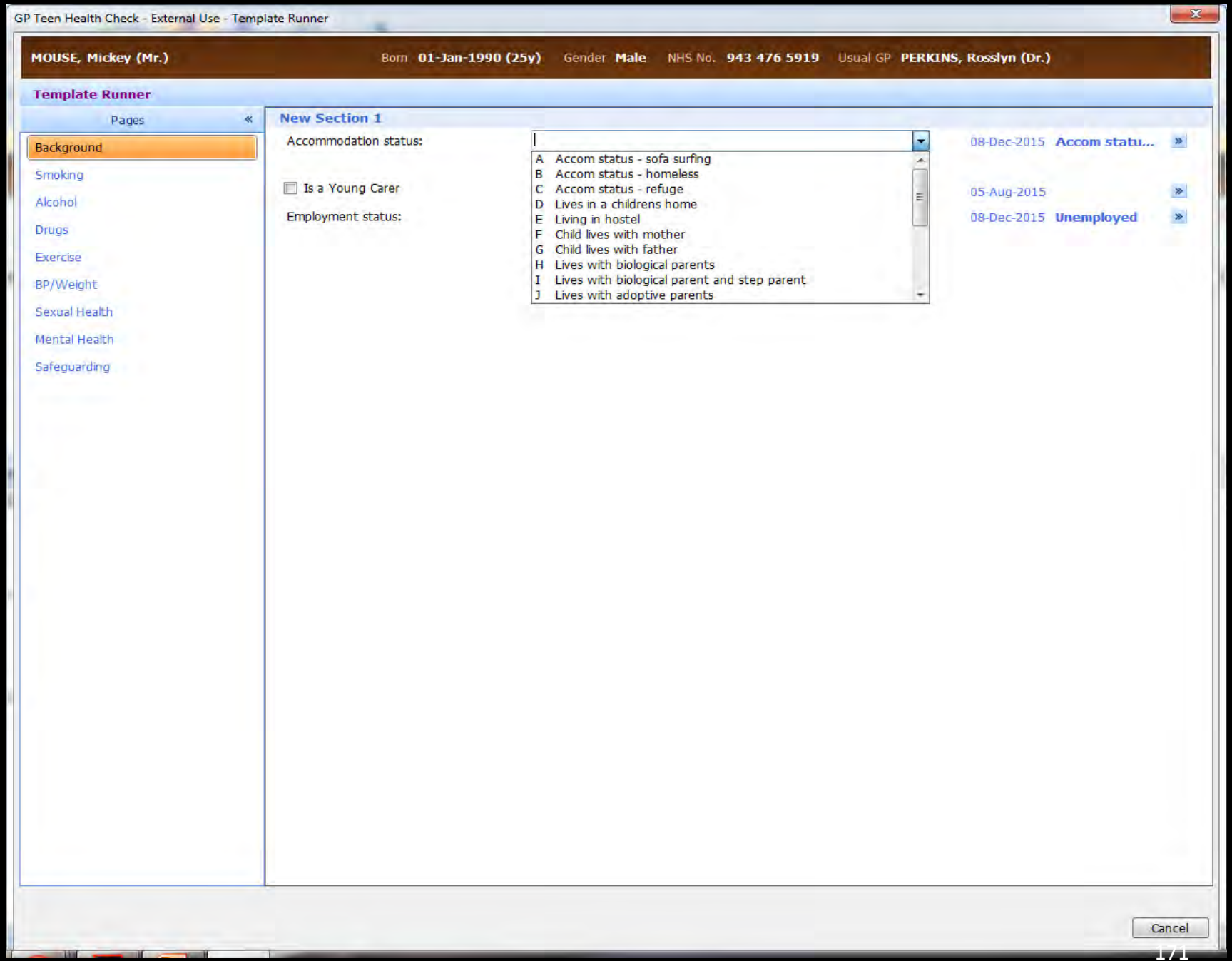
- Biopsychosocial assessment based on validated HEADSSS model
- Adapted for use at the Well Centre
- Abridged version developed for Primary Care consultation – Emis, read coded

Vulnerability Indicators

- Confidentiality explained

- Home
- Education/Employment
- Carer?
- Social service involvement?


GP Teen Health Check - External Use - Template Runner
MOUSE, Mickey (Mr.) Born 01-Jan-1990 (25y) Gender Male NHS No. 943 476 5919 Usual GP PERKINS, Rosslyn (Dr.)
Template Runner
Pages
Background
Smoking
Alcohol
Drugs
Exercise
BP/Weight
Sexual Health
Mental Health
Safeguarding
New Section 1
Accommodation status:
08-Dec-2015 Accom statu...
Text
Is a Young Carer
05-Aug-2015
Employment status:
08-Dec-2015 Unemployed
Cancel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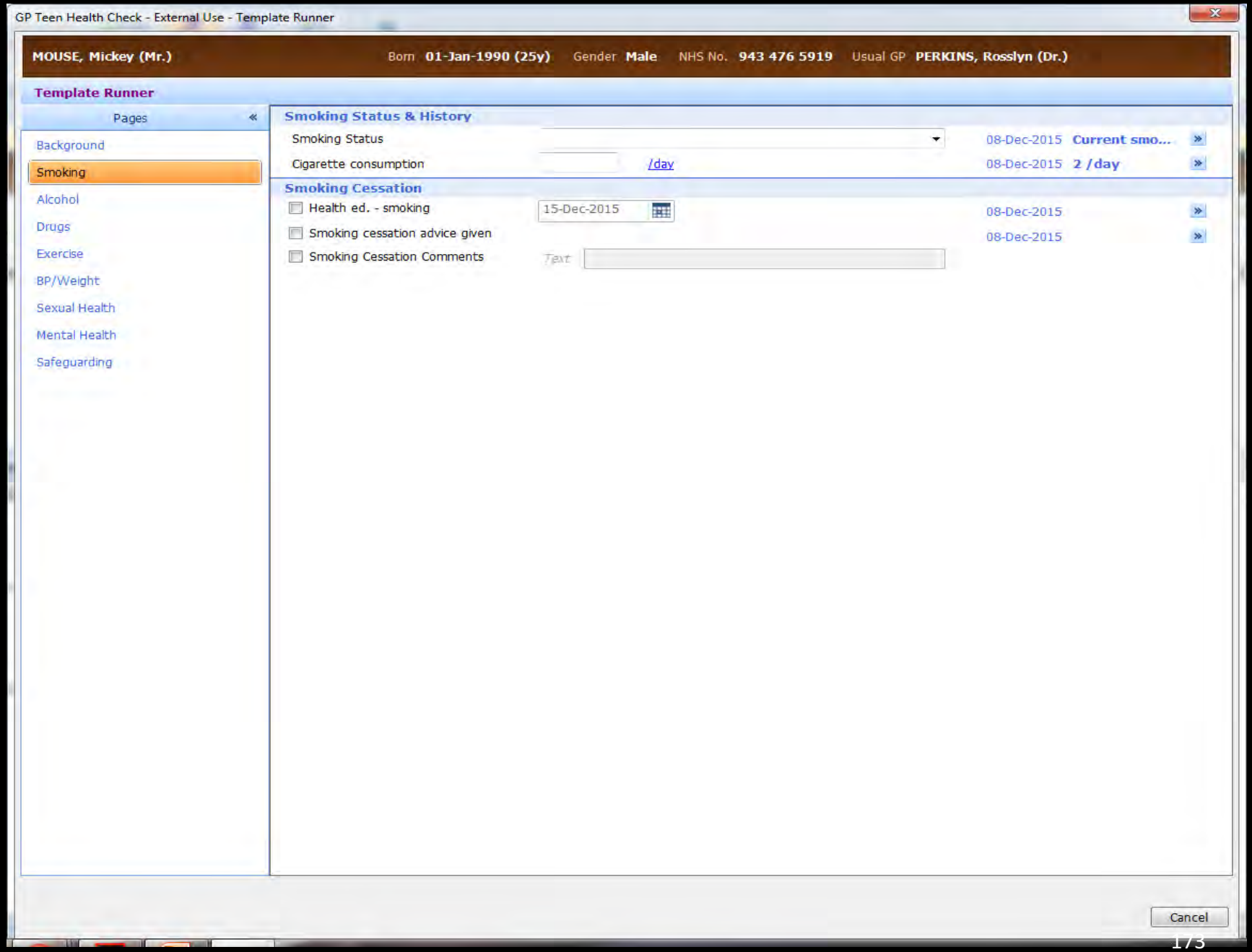
Template Runner
Pages
Background
Smoking
Alcohol
Drugs
Exercise
BP/Weight
Sexual Health
Mental Health
Safeguarding
New Section 1
Accommodation status:
A Accom status - sofa surfing
B Accom status - homeless
C Accom status - refuge
D Lives in a childrens home
E Living in hostel
F Child lives with mother
G Child lives with father
H Lives with biological parents
I Lives with biological parent and step parent
J Lives with adoptive parents
08-Dec-2015 Accom statu...
Is a Young Carer
05-Aug-2015
Employment status:
08-Dec-2015 Unemployed
Cancel

Health risk factors

- Smoking
- Alcohol
- Substance misuse
- Diet and exercise – BMI /centile
- Sexual activity – HPV
- Mental health – sleep/mood/self harm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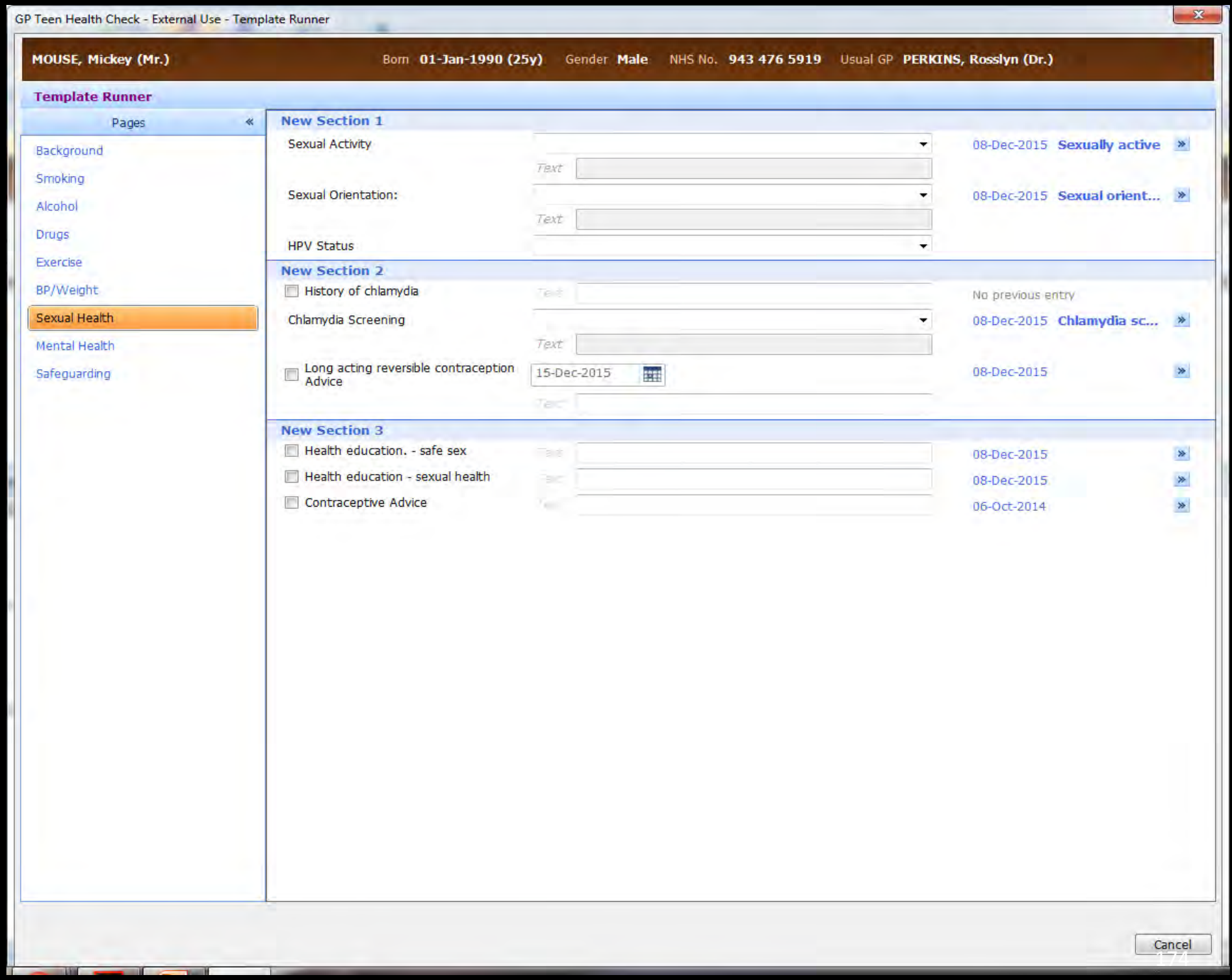
MOUSE, Mickey (Mr.) Born 01-Jan-1990 (25y) Gender Male NHS No. 943 476 5919 Usual GP PERKINS, Rosslyn (Dr.)
Template Runner
Pages
Background
Smoking
Alcohol
Drugs
Exercise
BP/Weight
Sexual Health
Mental Health
Safeguarding
Smoking Status & History
Smoking Status
08-Dec-2015 Current smo...
Cigarette consumption
/day
08-Dec-2015 2 /day
Smoking Cessation
Health ed. - smoking
15-Dec-2015
08-Dec-2015
Smoking cessation advice given
08-Dec-2015
Smoking Cessation Comments
Text
Cancel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Template Runner
Pages
Background
Smoking
Alcohol
Drugs
Exercise
BP/Weight
Sexual Health
Mental Health
Safeguarding
New Section 1
Sexual Activity
08-Dec-2015 Sexually active
Text
Sexual Orientation:
08-Dec-2015 Sexual orient...
Text
HPV Status
New Section 2
History of chlamydia
No previous entry
Chlamydia Screening
08-Dec-2015 Chlamydia sc...
Text
Long acting reversible contraception Advice
15-Dec-2015
08-Dec-2015
New Section 3
Health education. - safe sex
08-Dec-2015
Health education - sexual health
08-Dec-2015
Contraceptive Advice
06-Oct-2014
Cancel

Resources/follow up

- Links to local/national services

- Care plan – pt's mobile number/facilitate review.

Any questions?

CYPHP
www.cyphp.org

- Stephanielamb@nhs.net

11

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?

12

Feedback/ Q&A/ Panel discussion

13

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