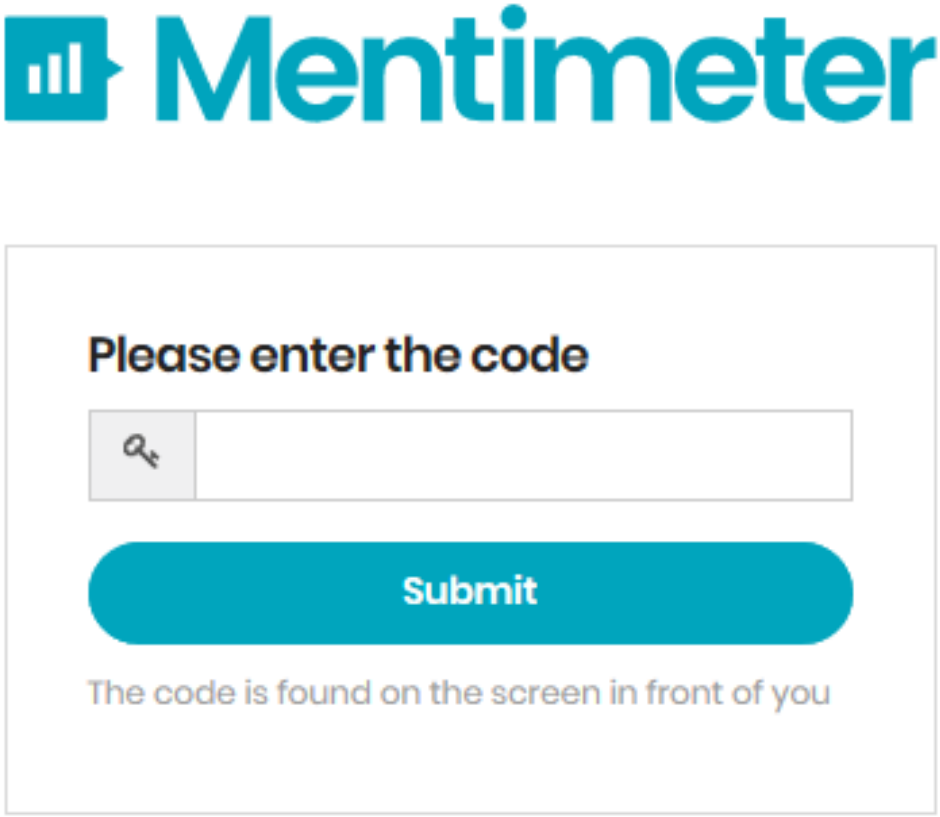
Mentimeter

www.menti.com



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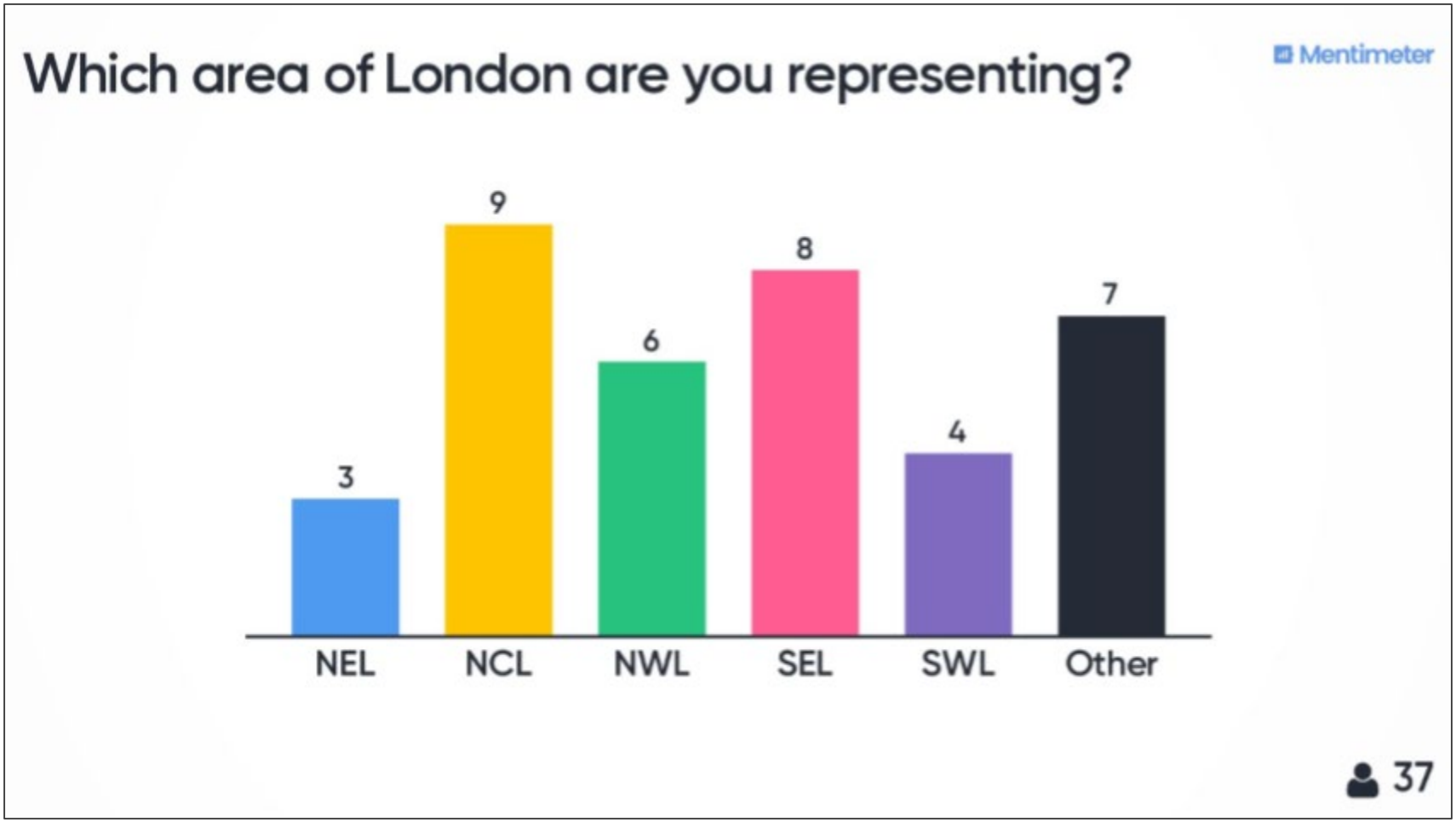

Which area of London are you representing?
Mentimeter
9
8
7
6
4
3
NEL
NCL
NWL
SEL
SWL
Other
37

Mentimeter


What are you hoping to get out of today?
Mentimeter
from birth
networks
qi ideas
learning
infirmation
connecting with others
inspire
advice
update on projects
learning from others
challenge
clarity
cyp projects
inspiration
sdec
cola oration
shared knowledge
network
information
enthusiasm
best practice
collaboration
coordination
understanding
shared learning
joined up
innovations
a husband
patient centred
hearing what people are d
connections
ideas
sharing good practice
energy
patient focused ideas
insight of hlp cyp plans
improvement ideas
new ideas
implementation plans
networking
decision
streamlining
insights
improving outcomes
share
new collaborators
sharing
friends
an understanding
overview
care
40

Healthy London Partnership

Healthy London Partnership Children and Young People's Strategic Leaders Transformation Forum

Pan-London Event

26th June 2019

Supported by and delivering for:

Public Health England

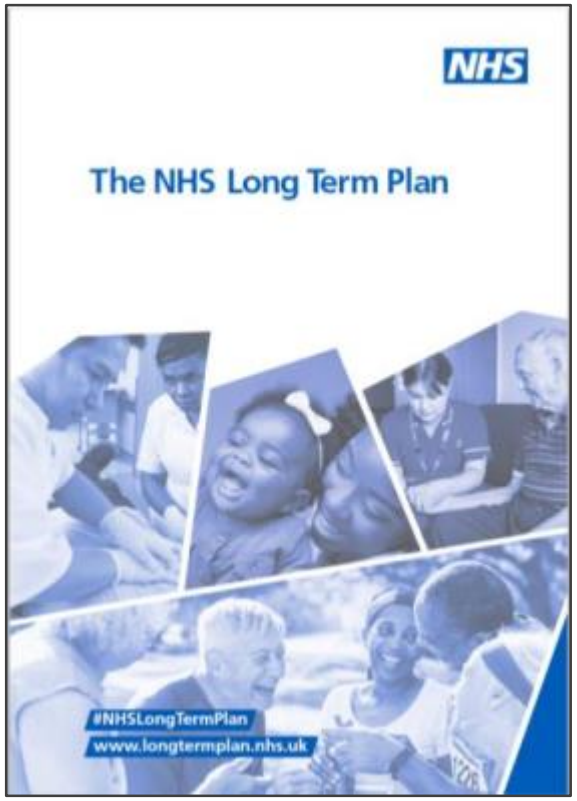
NHS

SUPPORTED BY MAYOR OF LONDON

London's NHS organisations include all of London's CCGs, NHS England and Health Education England

Tracy Parr,
Director of Transformation,
Healthy London Partnership

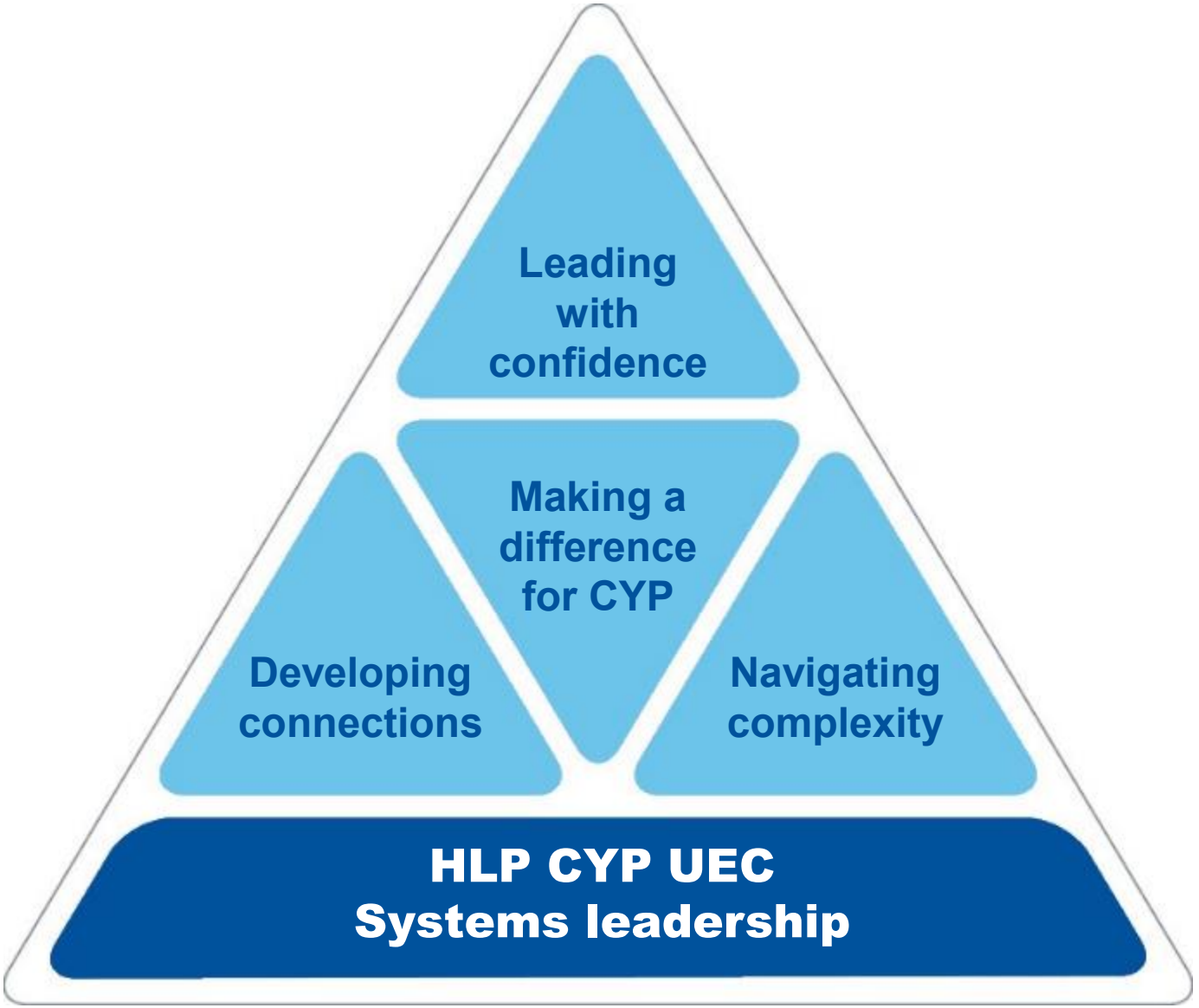
NHS Long Term Plan and UEC



"Local areas will design and implement models of care that are age appropriate, closer to home and bring together physical and mental health services. These models will provide holistic care across local authority and NHS services"

"CYP experiencing mental health crisis will be able to access services they need"

What has brought us here?

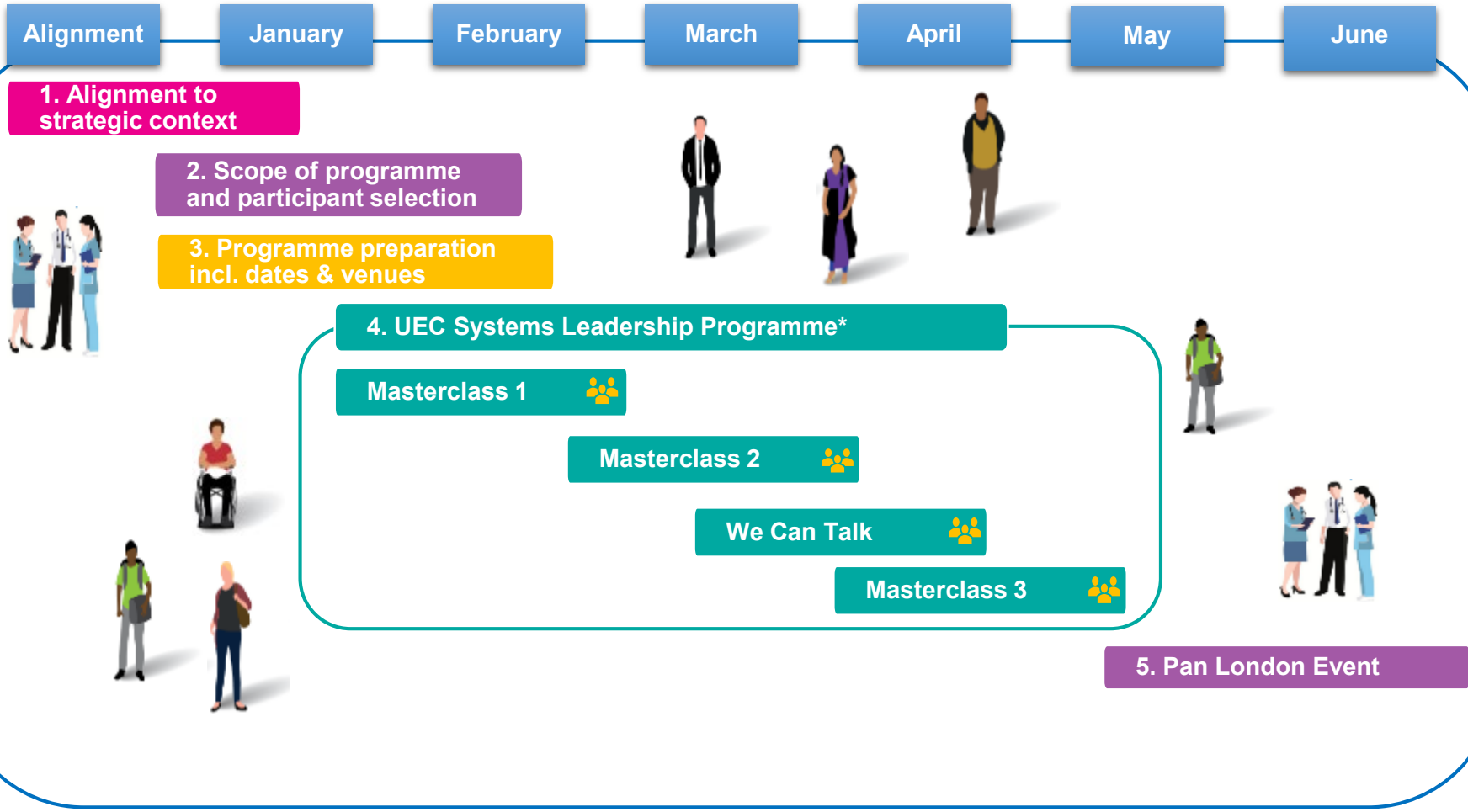


“Applied” Systems Leadership Development

3 half day masterclasses per STP plus a “We Can Talk” session.

Systems leadership training across urgent and emergency care (UEC) services for clinicians, managers and commissioners.

Those involved in leading, managing, delivering and developing children and young people’s UEC physical and/or mental health services.



Areas of focus

- Treatment at the right time, in the right place
- Community services and community support
- Complex needs
- Long term conditions (asthma)
- CYP Urgent and Emergency Care service provision
- Healthy body, happy mind
- Oral health
- Developing clinical support networks and MDT clinics
- Hospital@Home
- Improving the Single Point of Access to Care 24/7
- The CAMHS Emergency Care Service
- Improving information sharing

What have we achieved?

Months

"We Can Talk" workshops

Multi-professional strategic leadership workshops

Over

Systems leaders involved (that's you!)

With thanks to funding from HEE!

Vin Diwakar,
Medical Director,
NHS England & NHS Improvement

Healthy London Partnership

Strategic leaders transformation forum

Vin Diwaker, Medical Director,
NHS England and NHS Improvement

26th June 2019

Supported by and delivering for:

Public Health England

NHS

LONDON COUNCILS

SUPPORTED BY MAYOR OF LONDON

Why important to focus on CYP

Focus of the Long term Plan: Children and young people account for 25% of emergency department attendances and are the most likely age group to attend UEC unnecessarily.

Often because their long-term condition has not been well-managed, with impacts on their health their families and their wider outcomes, as well as on capacity in the system.

Rising admissions- Hospital admissions of less than 24 hours have doubled in last decade.

There is always great interest in the UEC system

But little focus on Children and Young People

Mental health of London's children and young people

25% of London's population is under 18 years of age

8.8 million total population

2.2 million under 18

London's 5 to 19 year olds

9% have a mental health disorder

10.6% **7.4%**

2.2% autism spectrum, eating and other less common disorders

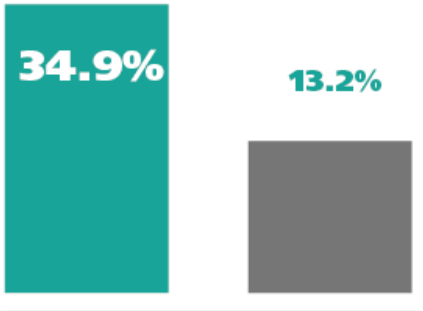
2% **2.3%**

1/2 of all mental health problems manifest by **age 14**

75% manifest by **age 24**

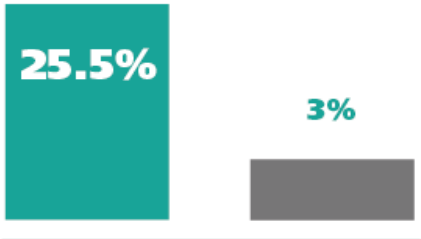
14-19 year olds

Mental disorder of young people identifying as lesbian, gay, bisexual, or another sexual identity

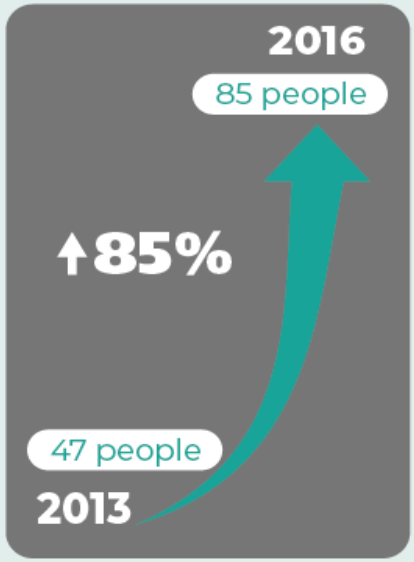


11-16 year olds

Self-harm of young people diagnosed with a mental disorder



Suicide has increased for young people **aged 10-14**

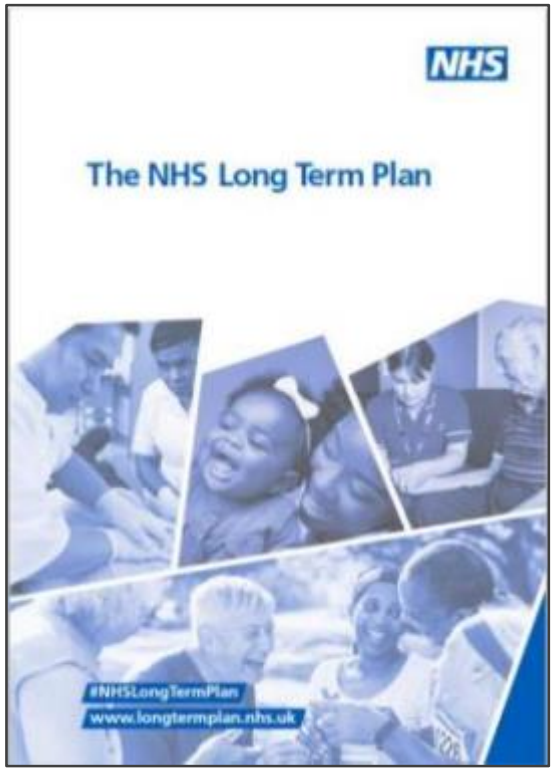


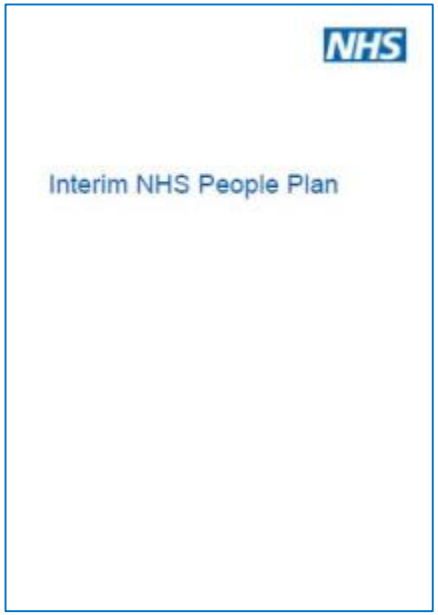
International comparisons 10-24 (Nuffield Trust) 2019)

Table S.1: Summary of the results

Indicator (and age range)	The UK relative to comparator countries (unless otherwise specified)	The UK trend over the past decade (unless otherwise specified)
Young people as a proportion of the total population (10–24)	Similar	Stable
Obesity prevalence (15–19)	Worse	Worsening
Longstanding illness (16–24)	Worse	Worsening
Exercise (England and Wales) (11)	Worse**	Worsening
Severe material deprivation (15–24)	Worse	Worsening
Adolescent birth rate (15–19)	Worse	Improving
Asthma death rate (10–24)	Worse	Improvement halted
Adolescent all-cause DALY rate (10–24)	Worse*	Improvement halted
Diabetes DALY rate (10–24)	Worse*	Stable
Not in education, employment or training (15–19)	Worse*	Improving
All-cause cancer mortality rate (10–24)	Similar	Improving
Daily smoking (18–24)	Similar	Improving
Alcohol consumption at least once a week (15)	Similar**	Improving
Cannabis use in the past 30 days (15)	Similar**	Improving
Suicide death rate (15–24)	Similar	Improvement halted
Adolescent mortality rate (10–19)	Better	Improvement halted
Road traffic injury death rate (10–24)	Better	Improvement halted
Road traffic injury DALY rate (10–24)	Better	Improving

Long term plan





Local areas will design and implement models of care that are age appropriate, closer to home and bring together physical and mental health services. These models will provide holistic care across local authority and NHS services,

CYP experiencing mental health crisis will be able to access services they need

CYP in the Long Term Plan

CYP commitments:

- CYP Transformation Programme
- 0-25 services
- Mental health
- Learning disability and autism
- Cancer
- Public health
- Health inequalities
- Maternity services
- Support for carers and vulnerable families

Overarching changes:

- Roll out of Integrated Care Systems
- Decision making and accountability
- Primary Care Networks
- Changes to how care is delivered
- Workforce
- Legislative change

Wider CYP commitments

Invest in additional support for the most vulnerable CYP in, or at risk of being in, contact with the **youth justice system**

Better support for those with **Autistic Spectrum Disorders or Learning Disabilities** (reducing waiting times for specialist services, designated key worker)

Endorse a number of **digital technologies** that deliver digitally-enabled models of therapy for depression and anxiety disorders… expand to **include therapies for children and young people**

Commitment to improve outcomes for the most vulnerable young people, including **care leavers**

London vision statements

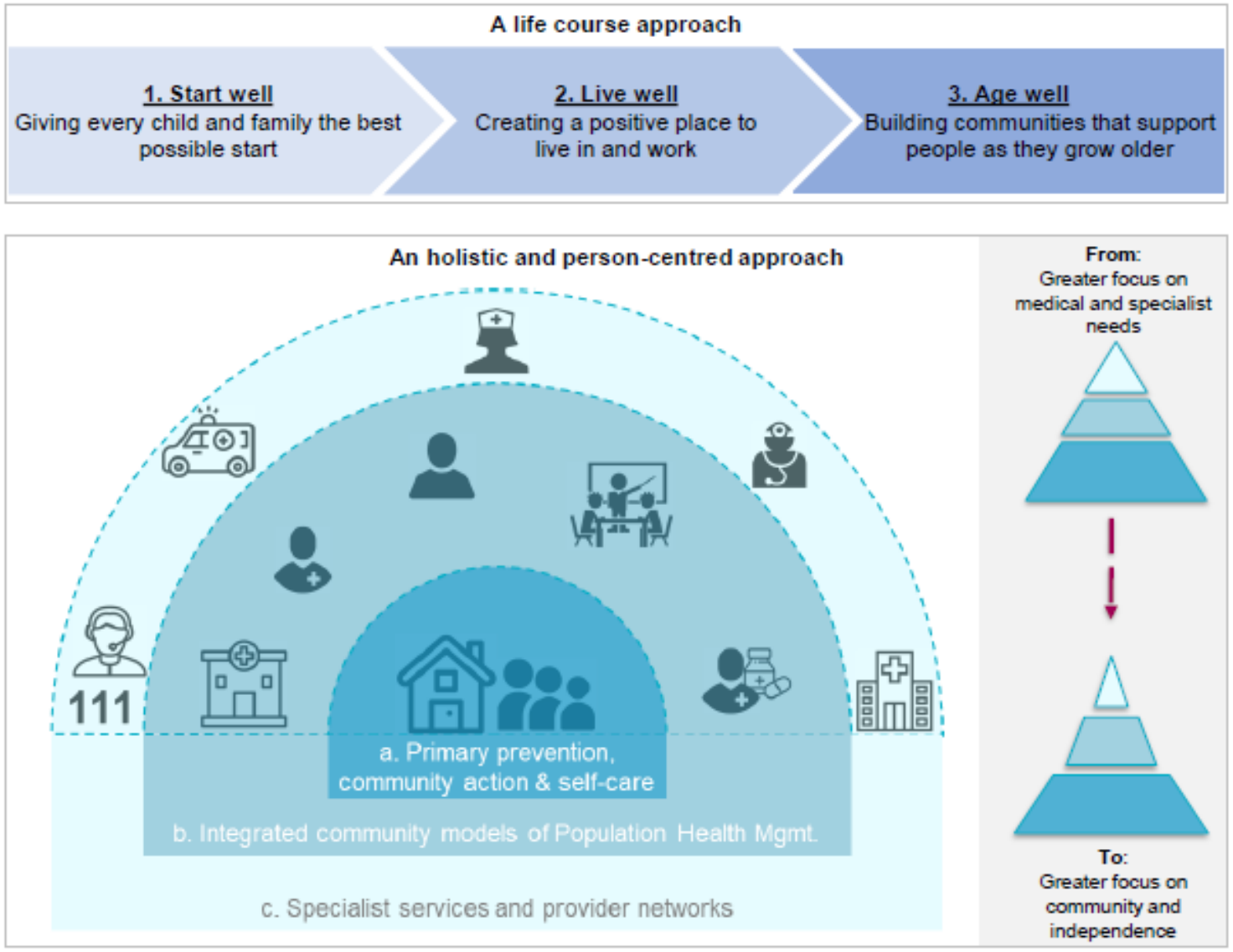
	Primary prevention, community action and self-care	Integrated community models	Specialist services and networks
Start well 	Our environment, communities, early years and schools promote and nurture the health and well being of children and families and reach out to the most vulnerable	Schools, health and care services with others working together to provide a seamless service and equip families and children with the tools to manage their own physical and mental health and prevent further ill health and unnecessary hospital attendances and admissions.	Children and young people have access to high quality specialist care when they need it, from maternity services to services covering mental health, obesity and cancer as well as supported transition to adult services for London's young people.
Live well 	Our environment, communities and work places support Londoners to kick unhealthy habits and lifestyles and Londoners feel comfortable talking about mental health, not ever feel stigmatised and never feel like suicide is the only option.	Early support for health issues that fits with Londoners' lifestyles are consistently available, realising true parity of esteem between physical and mental health and addressing the needs of London's most vulnerable population groups.	Londoner's have access to high quality 24/7 emergency mental and physical health care with care plans and on-going support in place to support recovery.
Age well 	Londoners are supported to manage their long term conditions and maintain their independence with no barriers to community participation, particularly vulnerable groups such as the elderly and carers.	As people grow older they are supported in their community with seamless care between organisations	When hospital care is needed it is consistent, of high quality and safe by ensuring Londoner's are supported to get in and out of hospital as fast as they can to avoid deconditioning and maintain independence

Enabled by

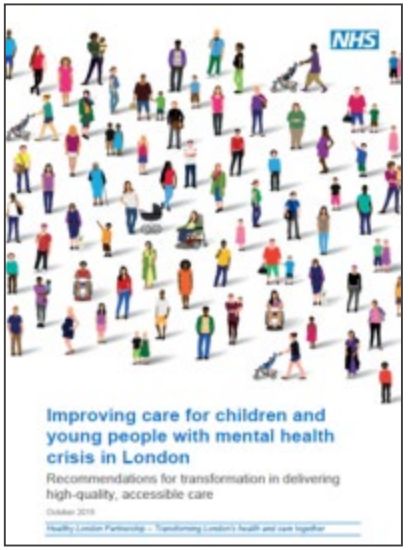
Ensuring Londoners are engaged in their own health	Connecting London's health and care providers	Delivering London's workforce	Transforming London's estate

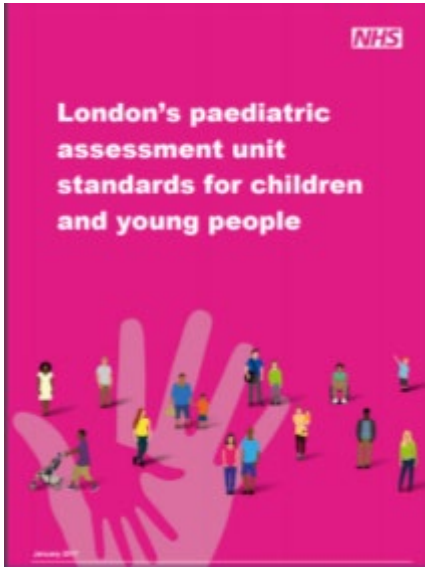
DRAFT

London Vision - set within a simple framework



HLP resources further available here





Collaboration across common themes

	CYP user engagement to co-design local UEC needs	Healthy Child (mind & body, self care, peer support and group consultations)	Strengthening community support to manage LTCs/MH needs	Hospital@Home and ambulatory care minimum offer across the STP	Managing CYP with highly complex physical, mental health or neurodevelopment needs (right care right place)	Integrated partnership and MDT working across primary and secondary care (e.g. networks, child health hubs or MDT session etc.)	Working collaboratively with local UEC Board to progress CYP agenda
NWL	✓	✓	✓	✓	✓	✓	✓
NCL	✓	✓	✓	✓	✓	✓	✓
NEL	✓		✓			✓	✓
SEL	✓	✓	✓	✓	✓	✓	✓
SWL	✓		✓		✓	✓	

What do we need for collaboration?

- Keeping children at the heart of all we do
- Shared vision, priorities and goals driven by needs, views and experiences of children in our area
- Strong partner relationships, positive support and challenge
- Good whole systems governance and oversight of impact
  - knowing ourselves well
  - sharing of quantitative and qualitative data, intelligence and children's views
  - shared understanding of impact of efforts on outcomes for children
  - Letting go of old ways of thinking and working that haven't helped our CYP

STP connections and information exchange

STP connections and information exchange

Penton Room: NWL, NCL, NEL

Blue Hall: SWL, SEL

Café/market place style conversations.
The following are some ideas for you to explore with the STPs:

- What are you doing that's the same?
- What are you doing that's different?
- How did you approach it?

	CYP user engagement to co-design local UEC needs	Healthy Child (mind & body, self care, peer support and group consultations)	Strengthening community support to manage LTCs/MH needs	Hospital@Home and ambulatory care minimum offer across the STP	Managing CYP with highly complex physical, mental health or neurodevelopment needs (right care right place)	Integrated partnership and MDT working across primary and secondary care (e.g. networks, child health hubs or MDT session etc.)	Working collaboratively with local UEC Board to progress CYP agenda
NWL	✓	✓	✓	✓	✓	✓	✓
NCL	✓	✓	✓	✓	✓	✓	✓
NEL	✓		✓			✓	✓
SEL	✓	✓	✓	✓	✓	✓	✓
SWL	✓		✓		✓	✓	

STP connections and information exchange

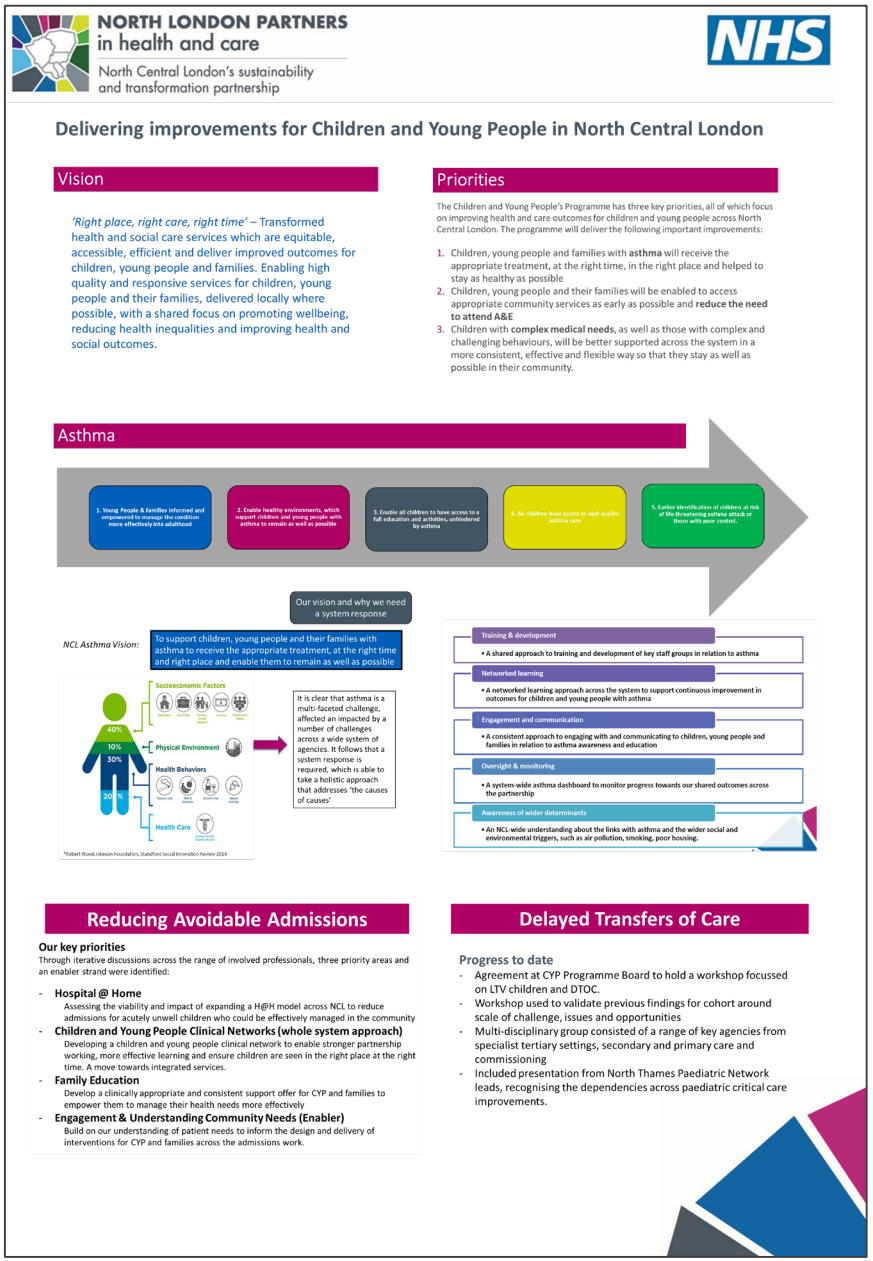
NCL

Focus areas:

- CYP and families with asthma will receive the appropriate treatment, at the right time, in the right place and helped to stay as healthy as possible
- CYP and their families will be enabled to access appropriate community services as early as possible and reduce the need to attend A&E
- CYP with complex medical needs, as well as those with complex and challenging behaviours, will be better supported across the system in a more consistent, effective and flexible way so that they stay as well as possible in their community.

STP connections and information exchange

NCL



NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

Delivering improvements for Children and Young People in North Central London

Vision

'Right place, right care, right time' – Transformed health and social care services which are equitable, accessible, efficient and deliver improved outcomes for children, young people and families. Enabling high quality and responsive services for children, young people and their families, delivered locally where possible, with a shared focus on promoting wellbeing, reducing health inequalities and improving health and social outcomes.

Priorities

The Children and Young People's Programme has three key priorities, all of which focus on improving health and care outcomes for children and young people across North Central London. The programme will deliver the following important improvements:

1. Children, young people and families with **asthma** will receive the appropriate treatment, at the right time, in the right place and helped to stay as healthy as possible
2. Children, young people and their families will be enabled to access appropriate community services as early as possible and **reduce the need to attend A&E**
3. Children with **complex medical needs**, as well as those with complex and challenging behaviours, will be better supported across the system in a more consistent, effective and flexible way so that they stay as well as possible in their community.

Asthma

1. Young People & Families informed and empowered to manage the condition more effectively into adulthood
2. Enable healthy environments, which support children and young people with asthma to remain as well as possible
3. Enable all children to have access to a full education and activities, unhindered by asthma
4. All children have access to high quality asthma care
5. Earlier identification of children at risk of life threatening asthma attack or those with poor control.

Our vision and why we need a system response

NCL Asthma Vision: To support children, young people and their families with asthma to receive the appropriate treatment, at the right time and right place and enable them to remain as well as possible

It is clear that asthma is a multi-faceted challenge, affected an impacted by a number of challenges across a wide system of agencies. It follows that a system response is required, which is able to take a holistic approach that addresses 'the causes of causes'

Training & development
- A shared approach to training and development of key staff groups in relation to asthma

Networked learning
- A networked learning approach across the system to support continuous improvement in outcomes for children and young people with asthma

Engagement and communication
- A consistent approach to engaging with and communicating to children, young people and families in relation to asthma awareness and education

Oversight & monitoring
- A system-wide asthma dashboard to monitor progress towards our shared outcomes across the partnership

Awareness of wider determinants
- An NCL-wide understanding about the links with asthma and the wider social and environmental triggers, such as air pollution, smoking, poor housing.

Reducing Avoidable Admissions

Our key priorities

Through iterative discussions across the range of involved professionals, three priority areas and an enabler strand were identified:

- **Hospital @ Home**
  Assessing the viability and impact of expanding a H@H model across NCL to reduce admissions for acutely unwell children who could be effectively managed in the community
- **Children and Young People Clinical Networks (whole system approach)**
  Developing a children and young people clinical network to enable stronger partnership working, more effective learning and ensure children are seen in the right place at the right time. A move towards integrated services.
- **Family Education**
  Develop a clinically appropriate and consistent support offer for CYP and families to empower them to manage their health needs more effectively
- **Engagement & Understanding Community Needs (Enabler)**
  Build on our understanding of patient needs to inform the design and delivery of interventions for CYP and families across the admissions work.

Delayed Transfers of Care

Progress to date

- Agreement at CYP Programme Board to hold a workshop focussed on LTV children and DTOC.
- Workshop used to validate previous findings for cohort around scale of challenge, issues and opportunities
- Multi-disciplinary group consisted of a range of key agencies from specialist tertiary settings, secondary and primary care and commissioning
- Included presentation from North Thames Paediatric Network leads, recognising the dependencies across paediatric critical care improvements.

STP connections and information exchange

NEL

Focus areas:

- CYP Urgent and Emergency Care service provision
- Strengthening the community support for CYP with ongoing health needs
- Care coordination and joint management across the system for CYP and families dealing with Asthma
- Mental health support for CYP outside of mental settings

STP connections and information exchange

NEL

East London Health & Care Partnership

NEL 0-25 Children and Young People Programme
2019/20 and beyond

STP connections and information exchange

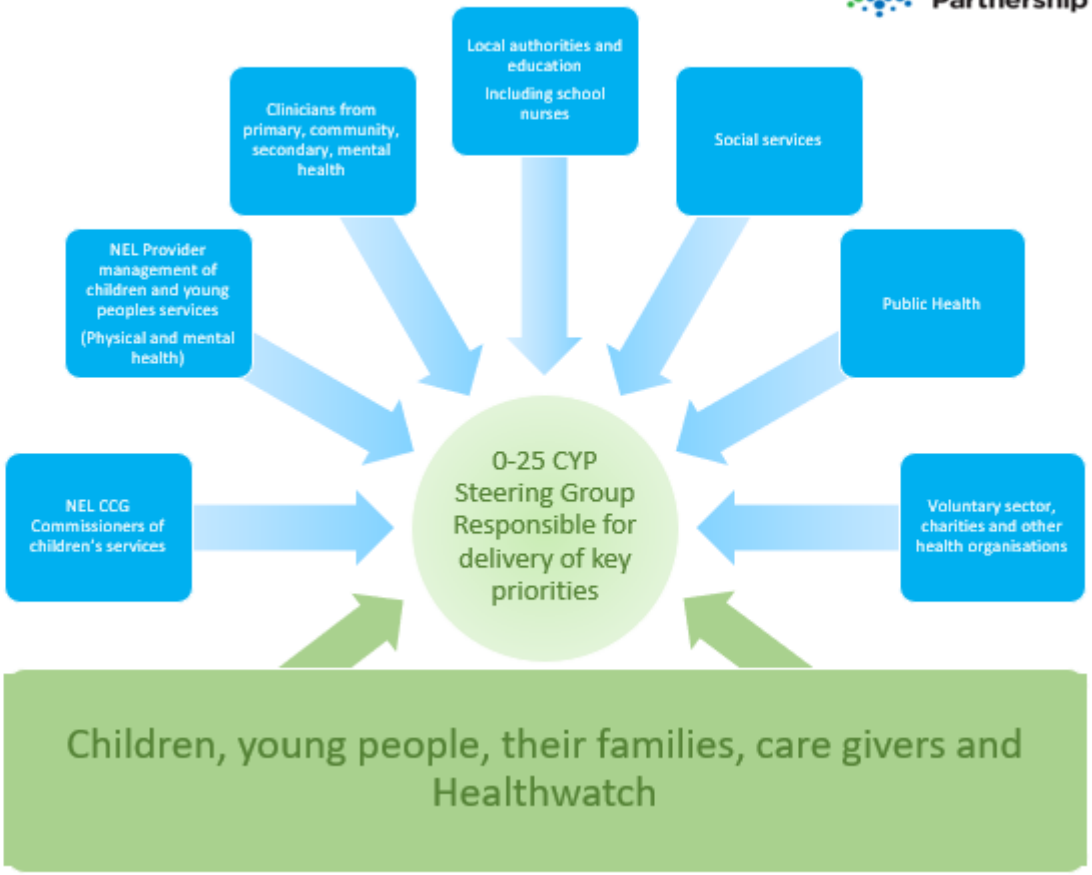
NEL

STP working

– What's important:

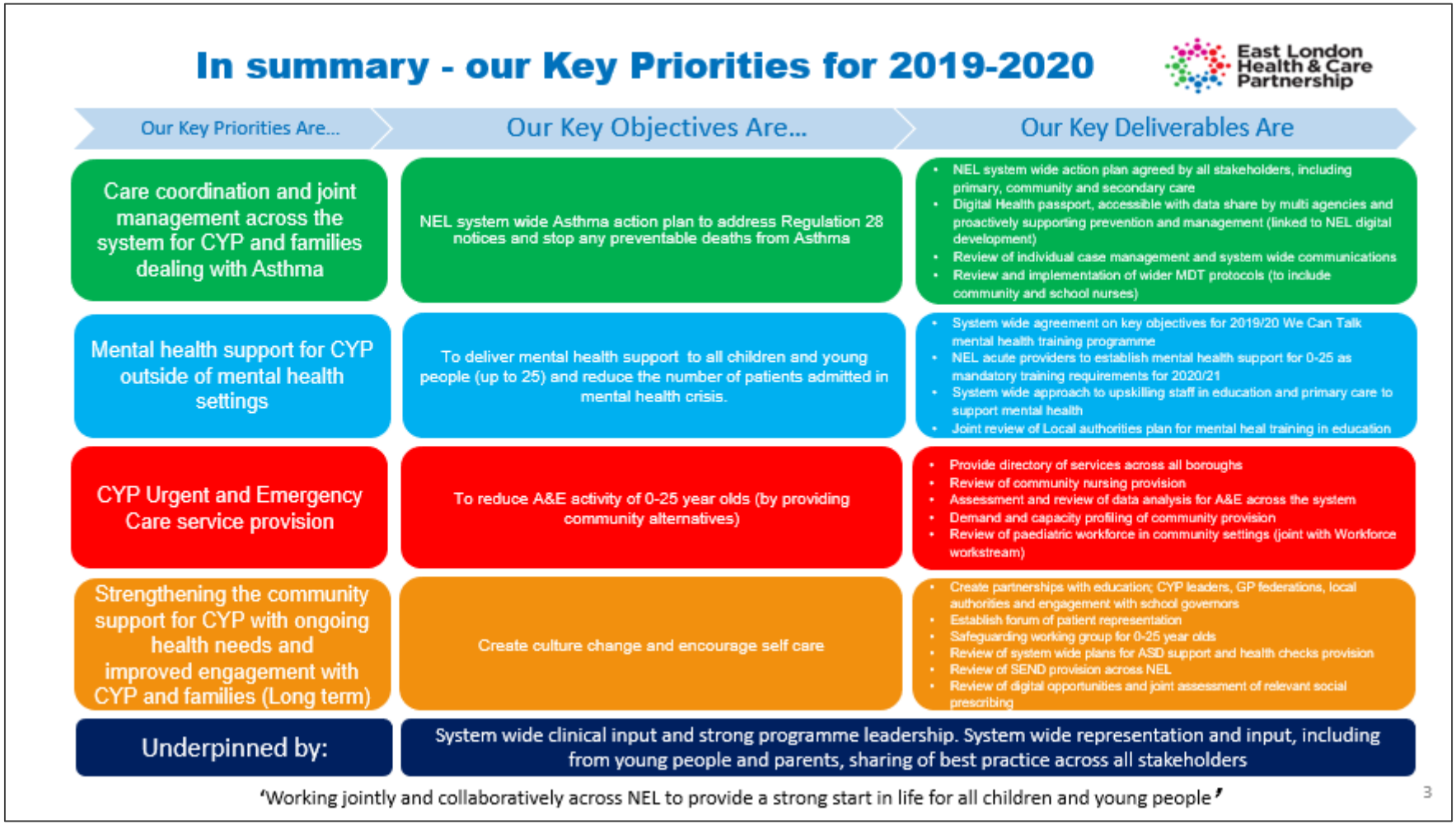
- A key element of the STP CYP work is a collaborative network of commissioners, clinicians, managers and all other stakeholders from across the North East London STP that's maturing.
- Stakeholders offering absolute transparency and sharing their local agendas and how they work to resolve and address challenges.
- It's a growing community that offers inspiration and support as we all work jointly to progress child health outcomes with children, young people and families right across the system.
- Really listening to our children, young people and their families to address issues and offer improvements to areas where they tell us it's needed.
- Address areas of risk to our local children and young people and their health and well being.
- Work with other workstreams to deliver wider priorities to the system.

East London Health & Care Partnership



STP connections and information exchange

NEL



STP connections and information exchange

NEL

East London Health & Care Partnership

NEL CYP priorities headlines and STP progress

Care coordination and joint management across the system for CYP and families dealing with Asthma

2019/20 Objective

NEL system wide Asthma action plan to address Regulation 28 notices and stop any preventable deaths from Asthma

Priority headlines:

Respiratory care transformation - Asthma

- The NEL Asthma Board has come together in response to an identified need for system wide changes and improvements required to the way CYP Asthma cases are managed across NEL.
- The board has representation and consistent engagement from all community, primary care, acute providers, specialist nurses, LAS and Local Authorities.
- An action plan has been agreed and forms the 'backbone' of the system delivery plan for 2019/20 across the wider NEL system.
- The action plan links to service delivery and pathways across every provider in the system and crosses primary and secondary care and links in to local authorities.
- Work to date already includes the sharing of secondary care discharge notes to schools and school nurses as well as primary care; in addition to system wide joint patient reviews for 'at risk' patients.

Work in progress at NEL level

Respiratory - Asthma

- Significant improvements have already been made across the STP and continues to be made every day.
- To ensure that improvements continue to happen the ELHCP and NEL Asthma Board is actively driving conversations with Digital workstreams and HLP to develop an electronic passport for CYP with Asthma.
    - This development is imperative in constructing system wide visibility of at risk cases,
        - Enabling systematic management of all cases and shared information between all agents of care; Schools and school nurses, primary care, pharmacies, community and specialist nurses as well as secondary care.
        - Although full plans are still in development, a planned benefit is that the passport can be shared with other care agents if granted permission by either a parent/guardian or the young person. The passport also links directly to the wider digital developments for all patient records both nationally and across NEL.

Other work in process of development includes:

- Review of individual case management and system wide communications (all agents of care);
- Review and implementation of wider MDT protocols (to include community and school nurses);
- NHS coding of Asthma cases;
- Training for schools;
- Review of prevention/inhaler training for CYP;
- Review of wider prevention engagement including pharmacy repeat prescriptions and parents/guardian training;
- Review of consistency of pathways across NEL

STP connections and information exchange

NEL

East London Health & Care Partnership

NEL CYP priorities headlines and STP progress

Mental health support for CYP outside of mental health settings

2019/20 Objective

To deliver mental health support to all children and young people (up to 25) and reduce the number of patients admitted in mental health crisis.

Priority headlines:

CYP Mental Health support in non-mental health settings - We Can Talk

- The 'We Can Talk programme' is a training programme reaching across the NEL STP footprint to improve the competency of professionals caring for children and young people with mental health needs, especially when in crisis.
- The training focused on providing frontline and paediatric staff with improved skills and knowledge in the experience of dealing with young people with mental health issues attending acute hospital due to their physical health and improving communication with children and young people with learning difficulties and with SEND.
- The 'We Can Talk' programme which was co-produced with hospital staff, mental health professionals and children and young people, gives staff the necessary education and competency training to provide safe and effective clinical and emotional care to all our children and young people
- The funding received from NHSE to deliver the pilot programme covered training for 800 staff across 6 NEL sites. This includes an allocation for additional dedicated 'Train the Trainer' support and future training materials.

Work in progress at NEL level

CYP Mental Health support in non-mental health settings

- Following on from the very successful delivery of the We Can Talk programme the ELHCP Communications team have been requested to compile a series of case studies for sharing with wider stake holders (commissioners and providers) as well as public.
- The work undertaken to date and the training undertaken across all of NEL was also showcased at the 6th June stakeholder engagement event hosted by ELHCP.
- The PMO has proposed the need for a NEL youth steering group to ensure that young people's voices are heard and reflected in the transformation process. This group should follow on from the completion of the We Can Talk programme and be assembled beginning of 2019/20 to reflect and represent all children and young people across NEL. The CYP steering group has agreed this approach.
- Reviews have commenced to ascertain the effectiveness of existing training programmes in schools and primary care across NEL. This will be completed via a NEL wide survey to establish the desire and or the need for a 'We Can Talk' style programme for Local Authorities and or primary care.
- The key objective is a consistent approach to upskilling existing staff to be knowledgeable, capable, and confident to help identify young people with increasing mental health needs at the onset of deterioration and to provide consistent support to CYP with mental health issues, learning disabilities and or on the autism spectrum.

STP connections and information exchange

NEL

NEL CYP priorities headlines and STP progress

East London Health & Care Partnership

CYP Urgent and Emergency Care service provision

2019/20 Objective
Reduce A&E activity of 0-25 year olds.

Priority headlines:

Urgent and Emergency Care (UEC)

- Work has commenced to identify key issues causing the increasing activity pressures in A&E
- Pathway reviews will also be undertaken to identify the root causes of CYP activity with multiple entry points
- Transformational work will also be focussed on identifying key points of requirements for improvements across the system

Work to be delivered at NEL level:

Urgent and Emergency Care (UEC)

- In conjunction with HLP and J9 3 CYP UEC workshops have been delivered.
- This series of workshops was developed to specifically identify the shortfalls and or additional requirements across the NEL system to treat and manage CYP cases in primary and community care, with its key objective being to reduce numbers of CYP accessing A&E.
- CYP should have the opportunity for a UEC initial assessment 24/7
- Including remotely, in the evening or at home (some practices provide an assessment up to 8pm at night).
- Streaming to the most appropriate place of care.
- Service users need to have trust and confidence in their health care provider at the clinical point of access.
- Education needed for CYP & family to access the right care at the right time in the right place.
- Up to date and accurate information about care services should be provided in the most appropriate medium.
- Principles agreed should be adapted to suit the needs in a local context.

STP connections and information exchange

NEL

NEL CYP priorities headlines and STP progress

East London Health & Care Partnership

Strengthening the community support for CYP with ongoing health needs (long term)

2020/21 Objective
Create culture change and encourage self care

Priority headlines:

Improved 0-25 and family engagement for improved education of health care (Long term)

- Create partnerships with education; CYP leaders, GP federations, local authorities and engagement with school governors
- Integration with schools agenda
- Establish forum of patient representation
- Plan for safeguarding working group for 0-25 year olds
- Review of system wide plans for ASD support and health checks provision
- Review of SEND provision across NEL
- Create links with all local stakeholders to ensure input from all areas and system wide roll out
- Create directory of services
- Joint work to review social prescribing for 0-25 year olds and families and create mapping of services
- Review of digital opportunities and joint assessment of relevant social prescribing

Work to be delivered at NEL level:

Improved 0-25 and family engagement for improved education of health care (Long term)

- Complete service mapping and explore using the outputs as part of social prescribing offer
- Opportunity to standardise health education and training including school nurses, nurse prescribing – explore Capital Nurse Project
- Learn from success of asthma and epilepsy pathway programmes, engaging across sectors and look at how this could be applied to improve other LTCs e.g. eczema, SEND and autism
- Set up a working group to understand the demand for and variation in provision and benchmarking of autism services – what support can be provided before a formal diagnosis?
- Organise a workshop to bring the different agencies, CYP and their families together to explore what works well and agree improvements – agree who to invite and make connections with existing groups e.g. SEND (possible led by education)

STP connections and information exchange

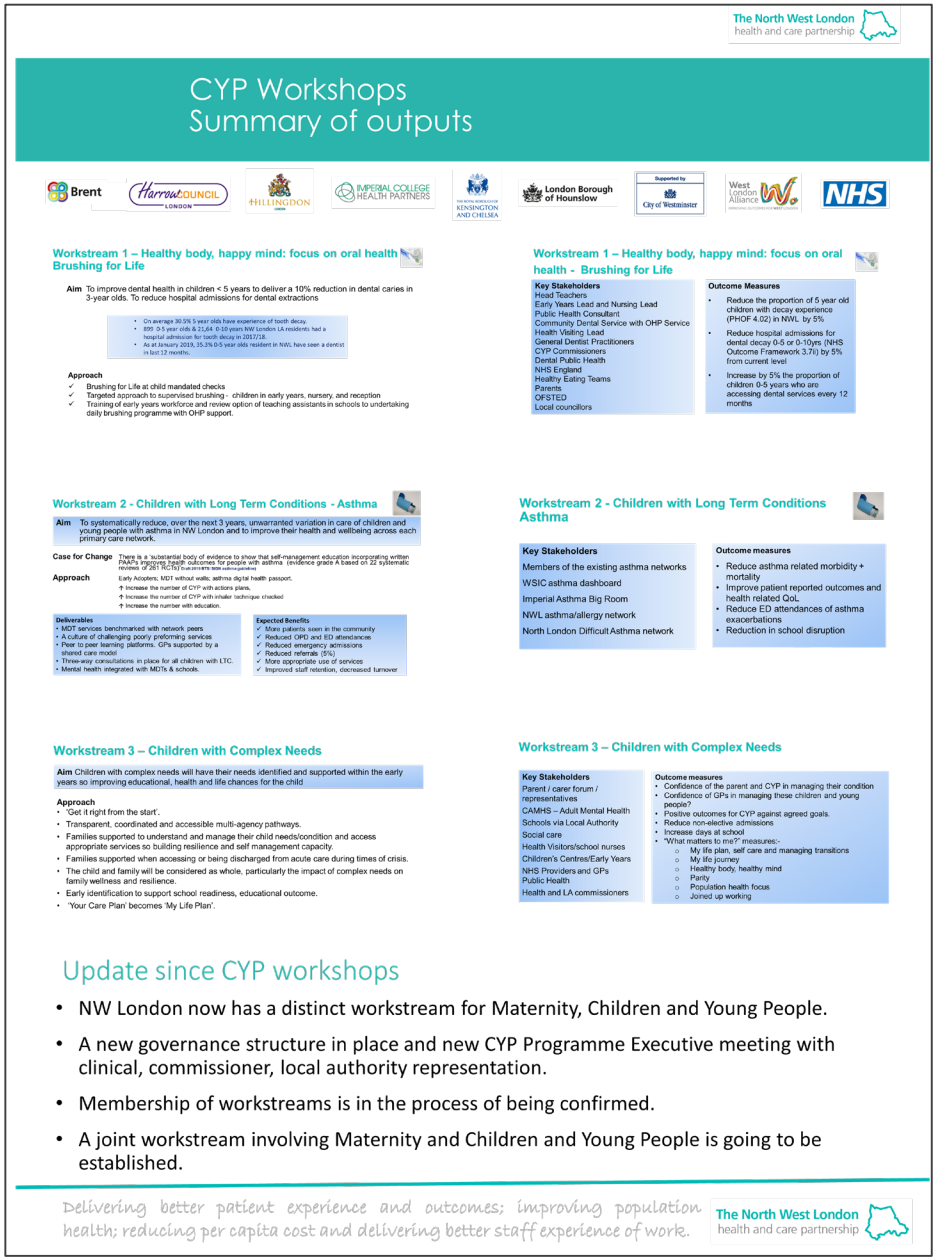
NWL

Focus areas:

- Happy body, healthy mind (focus on oral health)
- Children with long-term conditions (asthma)
- Children with complex needs

STP connections and information exchange

NWL



The North West London health and care partnership

CYP Workshops Summary of outputs

Brent · Harrow Council · Hillingdon · Imperial College Health Partners · Royal Borough of Kensington and Chelsea · London Borough of Hounslow · Supported by City of Westminster · West London Alliance · NHS

Workstream 1 – Healthy body, happy mind: focus on oral health Brushing for Life

Aim To improve dental health in children < 5 years to deliver a 10% reduction in dental caries in 3-year olds. To reduce hospital admissions for dental extractions

- On average 30.5% 5 year olds have experience of tooth decay.
- 899 0-5 year olds & 21,64 0-19 years NW London LA residents had a hospital admission for tooth decay in 2017/18.
- As at January 2019, 35.3% 0-5 year olds resident in NWL have seen a dentist in last 12 months.

Approach

- ✓ Brushing for Life at child mandated checks
- ✓ Targeted approach to supervised brushing - children in early years, nursery, and reception
- ✓ Training of early years workforce and review option of teaching assistants in schools to undertaking daily brushing programme with OHP support.

Workstream 1 – Healthy body, happy mind: focus on oral health - Brushing for Life

Key Stakeholders
Head Teachers
Early Years Lead and Nursing Lead
Public Health Consultant
Community Dental Service with OHP Service
Health Visiting Lead
General Dentist Practitioners
CYP Commissioners
Dental Public Health
NHS England
Healthy Eating Teams
Parents
OFSTED
Local councillors

Outcome Measures

- Reduce the proportion of 5 year old children with decay experience (PHOF 4.02) in NWL by 5%
- Reduce hospital admissions for dental decay 0-5 or 0-10yrs (NHS Outcome Framework 3.7ii) by 5% from current level
- Increase by 5% the proportion of children 0-5 years who are accessing dental services every 12 months

Workstream 2 - Children with Long Term Conditions - Asthma

Aim To systematically reduce, over the next 3 years, unwarranted variation in care of children and young people with asthma in NW London and to improve their health and wellbeing across each primary care network.

Case for Change There is a 'substantial body of evidence to show that self-management education incorporating written PAAPs improves health outcomes for people with asthma (evidence grade A based on 22 systematic reviews of 281 RCTs)'

Approach
Early Adopters: MDT without walls; asthma digital health passport.
↑ Increase the number of CYP with actions plans,
↑ Increase the number of CYP with inhaler technique checked
↑ Increase the number with education.

Deliverables

- MDT services benchmarked with network peers
- A culture of challenging poorly preforming services
- Peer to peer learning platforms. GPs supported by a shared care model
- Three-way consultations in place for all children with LTC.
- Mental health integrated with MDTs & schools.

Expected Benefits

- ✓ More patients seen in the community
- ✓ Reduced OPD and ED attendances
- ✓ Reduced emergency admissions
- ✓ Reduced referrals (5%)
- ✓ More appropriate use of services
- ✓ Improved staff retention, decreased turnover

Workstream 2 - Children with Long Term Conditions Asthma

Key Stakeholders
Members of the existing asthma networks
WSIC asthma dashboard
Imperial Asthma Big Room
NWL asthma/allergy network
North London Difficult Asthma network

Outcome measures

- Reduce asthma related morbidity + mortality
- Improve patient reported outcomes and health related QoL
- Reduce ED attendances of asthma exacerbations
- Reduction in school disruption

Workstream 3 – Children with Complex Needs

Aim Children with complex needs will have their needs identified and supported within the early years so improving educational, health and life chances for the child

Approach

- 'Get it right from the start'.
- Transparent, coordinated and accessible multi-agency pathways.
- Families supported to understand and manage their child needs/condition and access appropriate services so building resilience and self management capacity.
- Families supported when accessing or being discharged from acute care during times of crisis.
- The child and family will be considered as whole, particularly the impact of complex needs on family wellness and resilience.
- Early identification to support school readiness, educational outcome.
- 'Your Care Plan' becomes 'My Life Plan'.

Workstream 3 – Children with Complex Needs

Key Stakeholders
Parent / carer forum / representatives
CAMHS – Adult Mental Health
Schools via Local Authority
Social care
Health Visitors/school nurses
Children's Centres/Early Years
NHS Providers and GPs
Public Health
Health and LA commissioners

Outcome measures

- Confidence of the parent and CYP in managing their condition
- Confidence of GPs in managing these children and young people?
- Positive outcomes for CYP against agreed goals.
- Reduce non-elective admissions
- Increase days at school
- "What matters to me?" measures:-
  - My life plan, self care and managing transitions
  - My life journey
  - Healthy body, healthy mind
  - Parity
  - Population health focus
  - Joined up working

Update since CYP workshops

- NW London now has a distinct workstream for Maternity, Children and Young People.
- A new governance structure in place and new CYP Programme Executive meeting with clinical, commissioner, local authority representation.
- Membership of workstreams is in the process of being confirmed.
- A joint workstream involving Maternity and Children and Young People is going to be established.

Delivering better patient experience and outcomes; improving population health; reducing per capita cost and delivering better staff experience of work.

The North West London health and care partnership

STP connections and information exchange

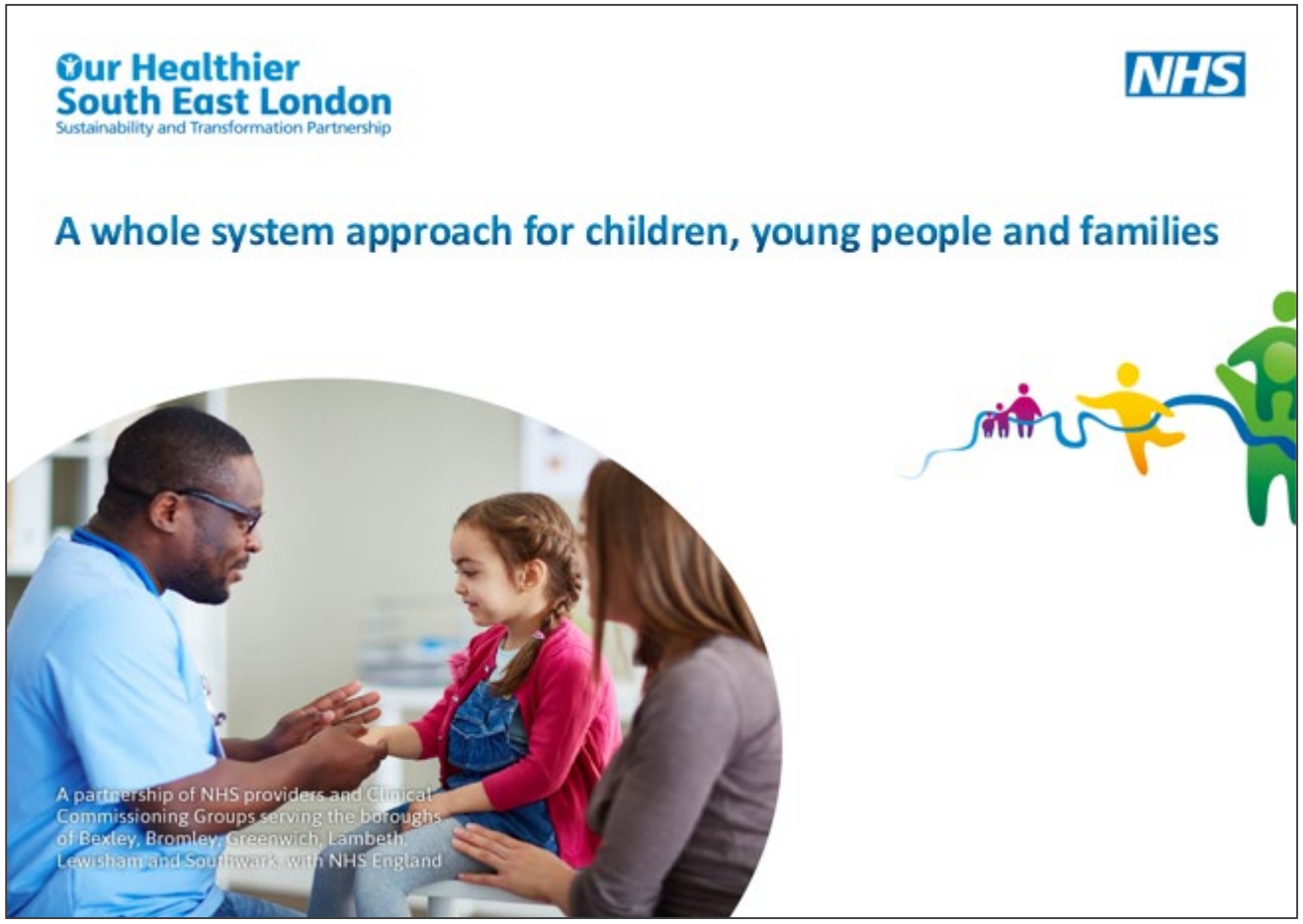
SEL

Focus areas:

- Strengthening community support
- Developing clinical support networks and joint MDT clinics
- Hospital@Home

STP connections and information exchange

SEL



STP connections and information exchange

SEL

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

Workshop 1: Urgent and emergency care / long-term conditions

Vision

Children and young people (CYP) get seen and managed locally by confident and skilled professionals as a result of;

- A minimum offering in place for hospital at home across South East London
- Integrated partnership working within the Primary Care Networks (PCNs) between hospital specialists and primary care clinicians (MDT) to confidently manage CYP with a range of health care needs in the community
- To develop integrated and joint MDT clinics and shared learning forums
- CYP confident in managing their condition

STP connections and information exchange

SEL

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

Priority areas:

- **Mental health and wellbeing**
- **Urgent and emergency care and long-term conditions**
- **Special Educational Needs and Disability and Autism**

If successful we will see:

- better physical and emotional support for families
- more joined-up health and care services
- easy access to the right services first time
- reduced emergency admissions
- shorter inpatient stays in hospital
- sstraightforward transition into adult services for mental health and long-term conditions

STP connections and information exchange

SEL

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

Workshop 2: Urgent and emergency care / long-term conditions

Three workstream areas identified to take forward:

Minimum offer of hospital at home

- Needs assessment - resources, and requirements within boroughs
- Key milestones for measuring benefits e.g. quality of care, patient satisfaction, financial benefits etc.
- Dedicated service lead responsible for oversight Network of stakeholders

Strengthening community support to enhance LTC and self-management

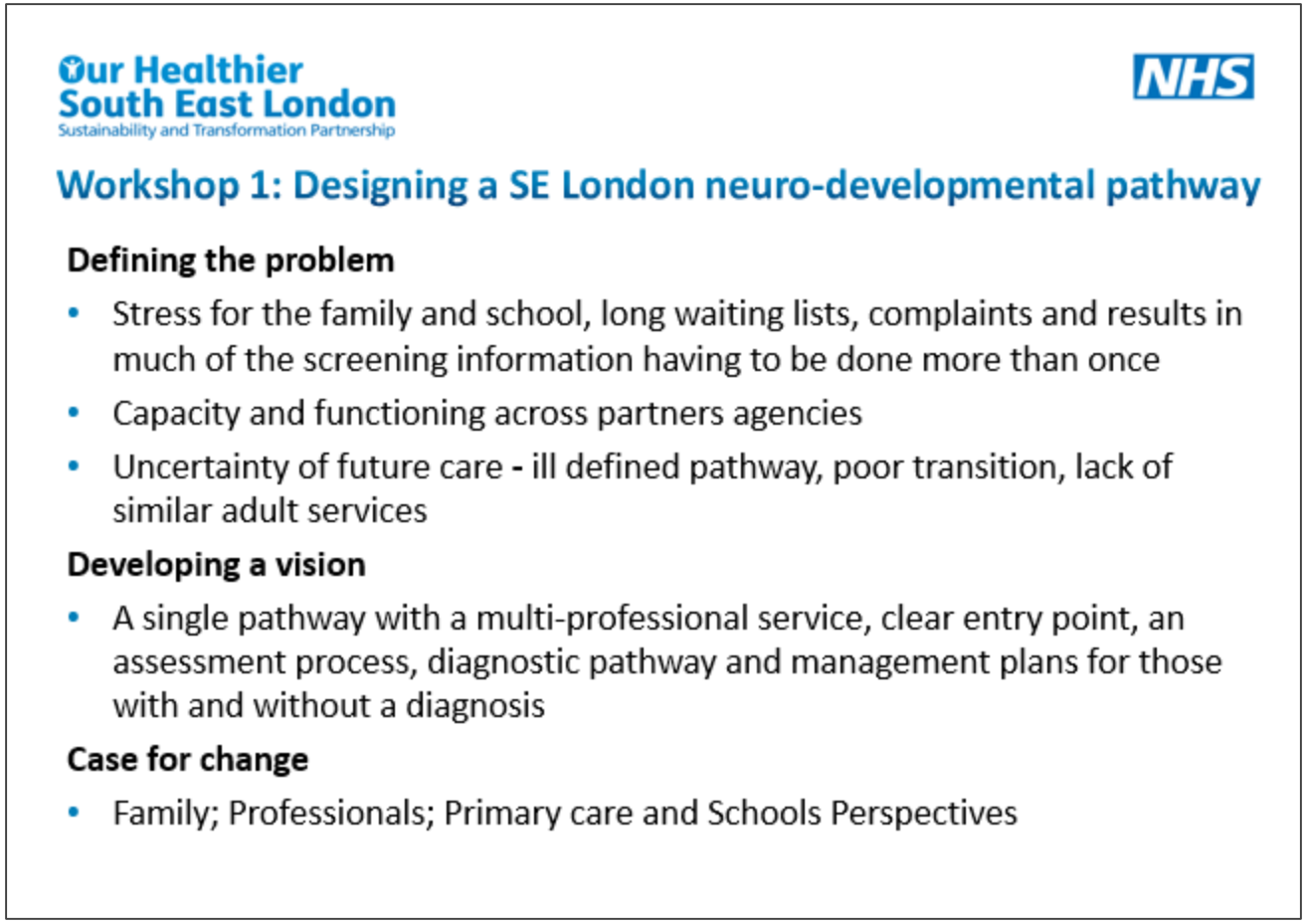
- Nurse-led assessment and treatment hubs
- Integrated community nursing teams
- Community nursing ANP and prescribing
- Transdisciplinary therapies
- Neonatal outreach
- Peer support for LTCs
- Role of pharmacy

Develop clinical support networks and clinics

- Influence primary care networks (PCN) to ensure CYP focus and resource in framework
- Shared/joint or paeds-led clinics in primary care
- MDT shared learning events to support knowledge and skills transfer
- CYP champions in each PCN
- Data collection and analysis (population data), financial and quality benefits + opportunities within each PCN
- Analysis to inform local model and target CYP by referral condition
- Establish STP/PCN learning network to distribute learning and encourage further adoption
- Economic impact assessment 6 + 12m post implementation at PCN and STP level

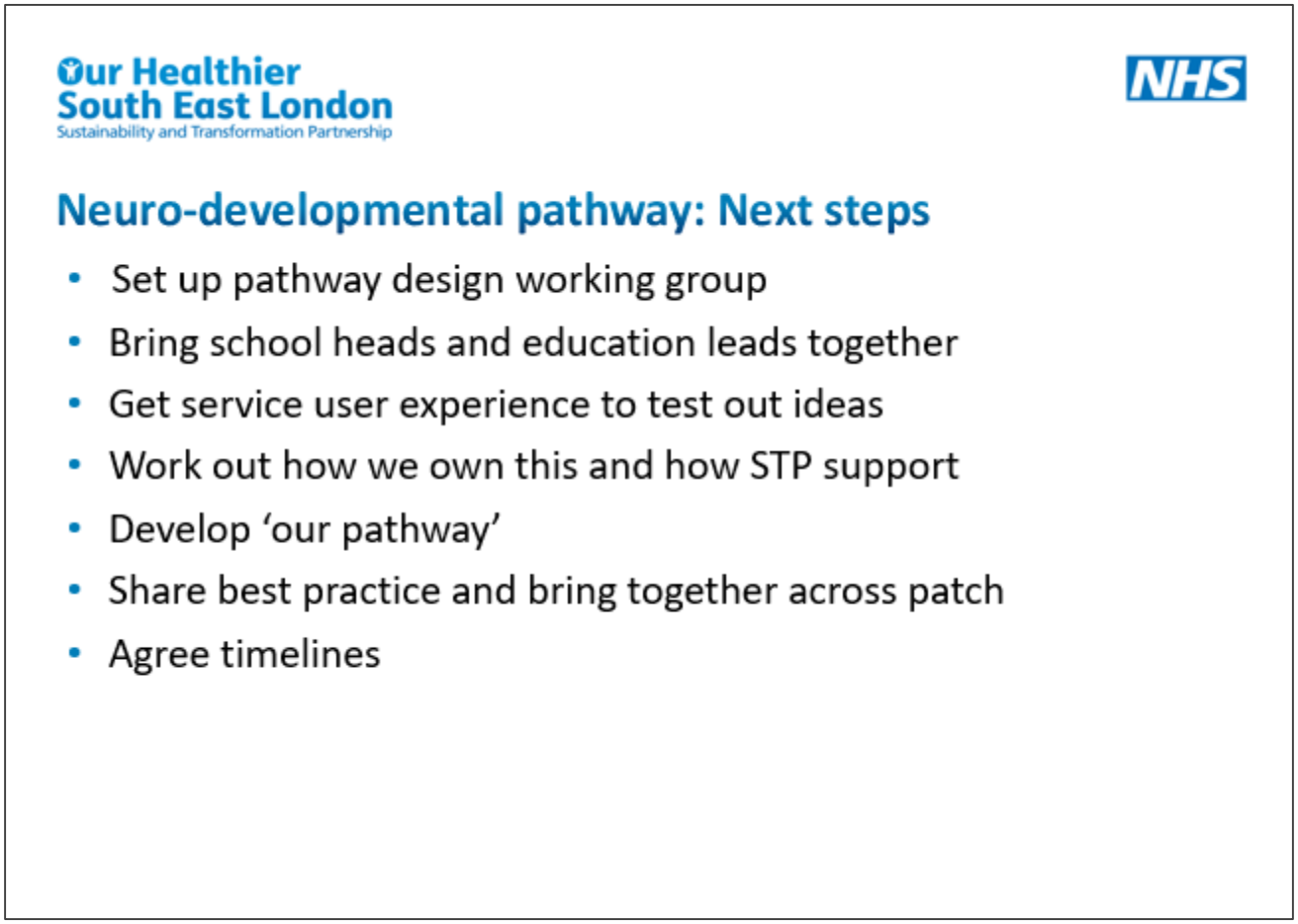
STP connections and information exchange

SEL



STP connections and information exchange

SEL



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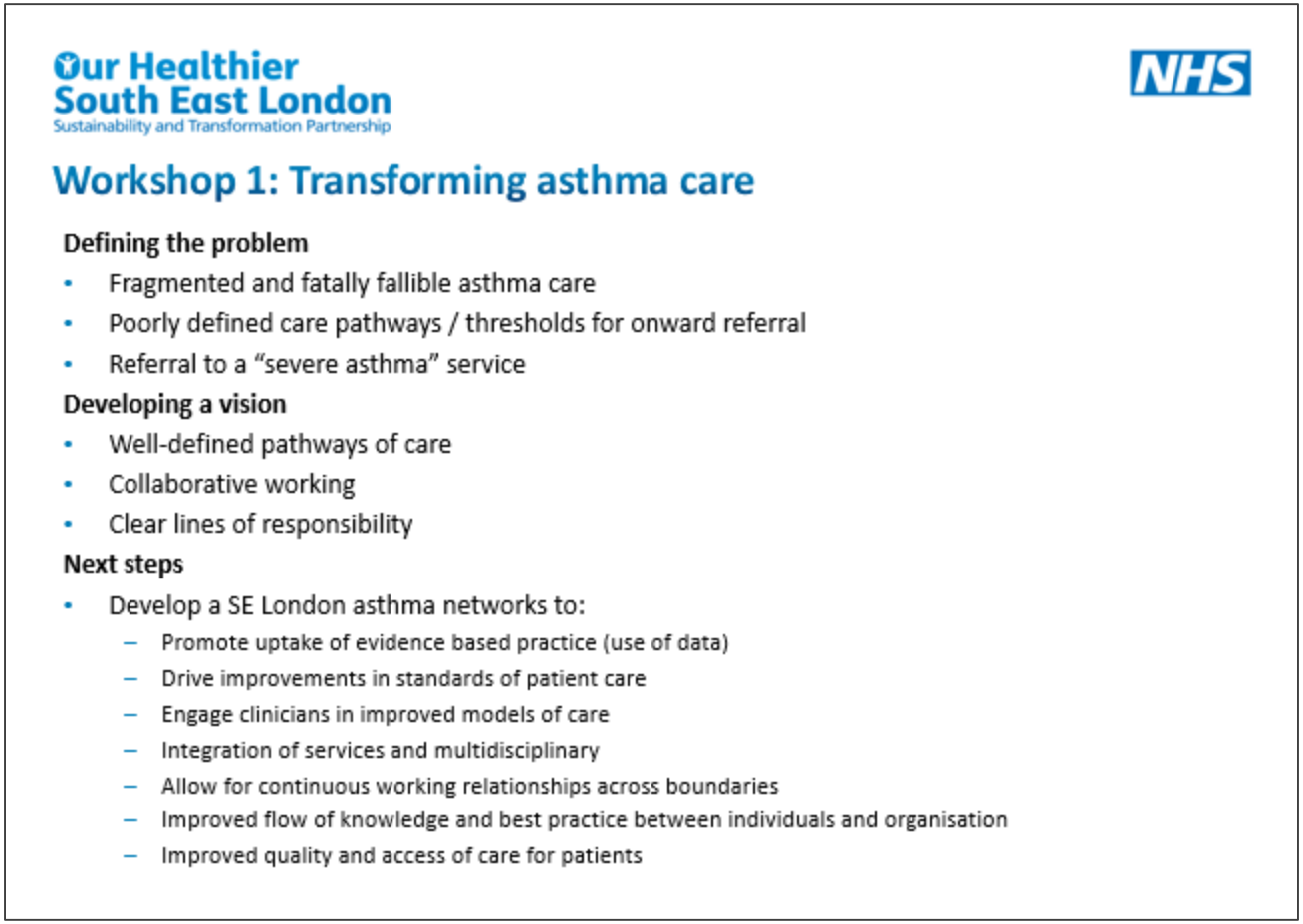


Our Healthier South East London
Sustainability and Transformation Partnership

NHS

Workshop 1: Transforming asthma care

Defining the problem

- Fragmented and fatally fallible asthma care
- Poorly defined care pathways / thresholds for onward referral
- Referral to a "severe asthma" service

Developing a vision

- Well-defined pathways of care
- Collaborative working
- Clear lines of responsibility

Next steps

- Develop a SE London asthma networks to:
  - Promote uptake of evidence based practice (use of data)
  - Drive improvements in standards of patient care
  - Engage clinicians in improved models of care
  - Integration of services and multidisciplinary
  - Allow for continuous working relationships across boundaries
  - Improved flow of knowledge and best practice between individuals and organisation
  - Improved quality and access of care for patients

STP connections and information exchange

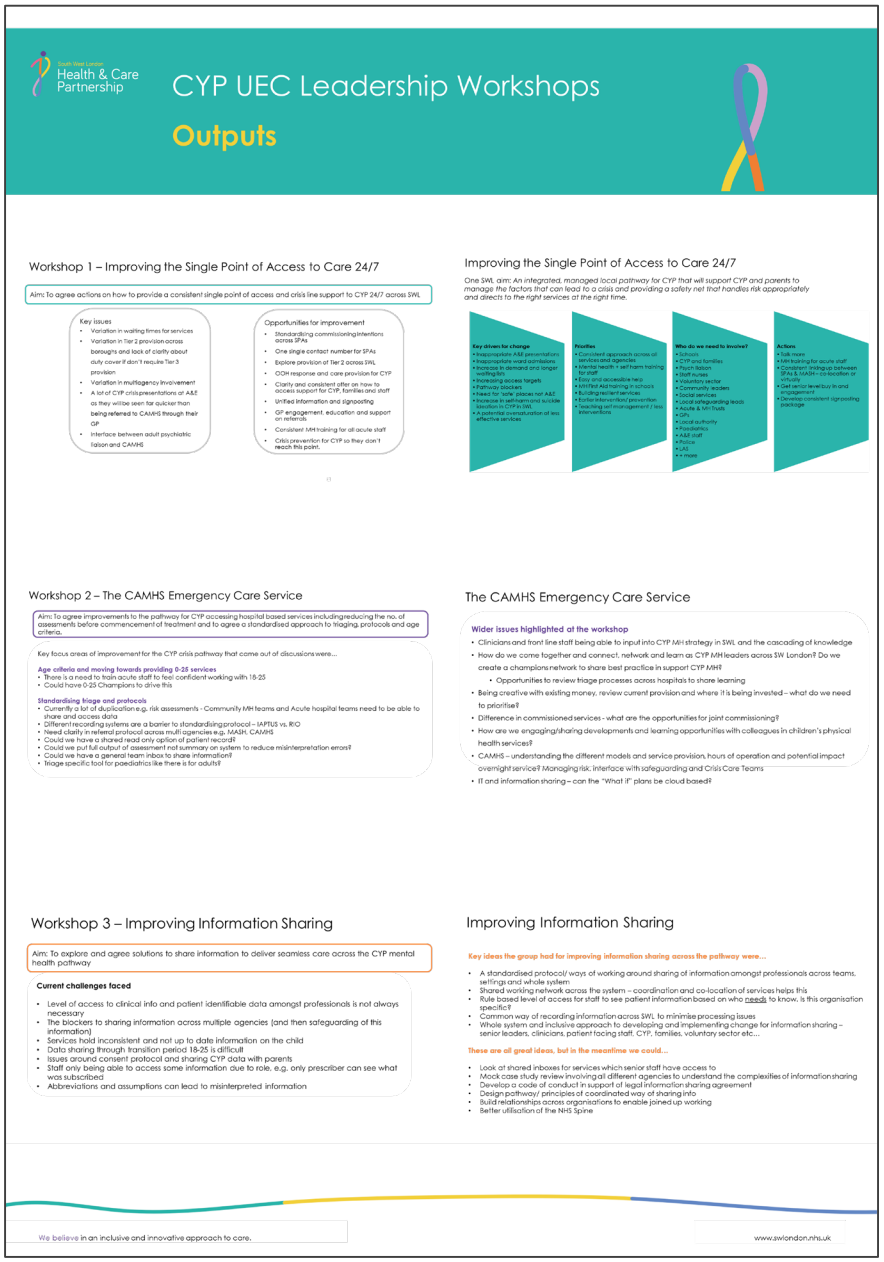
SWL

Focus areas:

- Improving the Single Point of Access to Care 24/7
- The CAMHS Emergency Care Service
- Improving information sharing

STP connections and information exchange

SWL



South West London Health & Care Partnership

CYP UEC Leadership Workshops

Outputs

Workshop 1 – Improving the Single Point of Access to Care 24/7

Aim: To agree actions on how to provide a consistent single point of access and crisis line support to CYP 24/7 across SWL

Key Issues

- Variation in waiting times for services
- Variation in Tier 2 provision across boroughs and lack of clarity about duty cover if don't require Tier 3 provision
- Variation in multiagency involvement
- A lot of CYP crisis presentations at A&E as they will be seen for quicker than being referred to CAMHS through their GP
- Interface between adult psychiatric liaison and CAMHS

Opportunities for improvement

- Standardising commissioning intentions across SPAs
- One single contact number for SPAs
- Explore provision of Tier 2 across SWL
- OOH response and care provision for CYP
- Clarity and consistent offer on how to access support for CYP, families and staff
- Unified information and signposting
- GP engagement, education and support on referrals
- Consistent MH training for all acute staff
- Crisis prevention for CYP so they don't reach this point.

Improving the Single Point of Access to Care 24/7

One SWL aim: An integrated, managed local pathway for CYP that will support CYP and parents to manage the factors that can lead to a crisis and providing a safety net that handles risk appropriately and directs to the right services at the right time.

Key driven for change
- Inappropriate A&E presentations
- Inappropriate ward admissions
- Increase in demand and longer waiting lists
- Increasing access targets
- Pathway blockers
- Need for 'safe' places not A&E
- Increase in self-harm and suicide ideation in CYP in SWL
- A potential overstimulation of less effective services

Priorities
- Consistent approach across all services and agencies
- Mental health + self harm training for staff
- Easy and accessible help
- MHFirst Aid training in schools
- Building resilient services
- Earlier intervention/ prevention
- Teaching self management / less interventions

Who do we need to involve?
- Schools
- CYP and families
- Psych liaison
- Staff nurses
- Voluntary sector
- Community leaders
- Social services
- Local safeguarding leads
- Acute & MH Trusts
- GPs
- Local authority
- Paediatrics
- A&E staff
- Police
- LAS
- + more

Actions
- Talk more
- MH training for acute staff
- Consistent findings up between SPAs & MASH – co-location or virtually
- Get senior level buy in and engagement
- Develop consistent signposting package

Workshop 2 – The CAMHS Emergency Care Service

Aim: To agree improvements to the pathway for CYP accessing hospital based services including reducing the no. of assessments before commencement of treatment and to agree a standardised approach to triaging, protocols and age criteria.

Key focus areas of improvement for the CYP crisis pathway that came out of discussions were...

Age criteria and moving towards providing 0-25 services
- There is a need to train acute staff to feel confident working with 18-25
- Could have 0-25 Champions to drive this

Standardising triage and protocols
- Currently a lot of duplication e.g. risk assessments - Community MH teams and Acute hospital teams need to be able to share and access data
- Different recording systems are a barrier to standardising protocol – IAPTUS vs. RiO
- Need clarity in referral protocol across multi agencies e.g. MASH, CAMHS
- Could we have a shared read only option of patient record?
- Could we put full output of assessment not summary on system to reduce misinterpretation errors?
- Could we have a general team inbox to share information?
- Triage specific tool for paediatrics like there is for adults?

The CAMHS Emergency Care Service

Wider issues highlighted at the workshop
- Clinicians and front line staff being able to input into CYP MH strategy in SWL and the cascading of knowledge
- How do we come together and connect, network and learn as CYP MH leaders across SW London? Do we create a champions network to share best practice in support CYP MH?
  - Opportunities to review triage processes across hospitals to share learning
- Being creative with existing money, review current provision and where it is being invested – what do we need to prioritise?
- Difference in commissioned services - what are the opportunities for joint commissioning?
- How are we engaging/sharing developments and learning opportunities with colleagues in children's physical health services?
- CAMHS – understanding the different models and service provision, hours of operation and potential impact overnight service? Managing risk. Interface with safeguarding and Crisis Care Teams
- IT and information sharing – can the "What if" plans be cloud based?

Workshop 3 – Improving Information Sharing

Aim: To explore and agree solutions to share information to deliver seamless care across the CYP mental health pathway

Current challenges faced
- Level of access to clinical info and patient identifiable data amongst professionals is not always necessary
- The blockers to sharing information across multiple agencies (and then safeguarding of this information)
- Services hold inconsistent and not up to date information on the child
- Data sharing through transition period 18-25 is difficult
- Issues around consent protocol and sharing CYP data with parents
- Staff only being able to access some information due to role, e.g. only prescriber can see what was subscribed
- Abbreviations and assumptions can lead to misinterpreted information

Improving Information Sharing

Key ideas the group had for improving information sharing across the pathway were...
- A standardised protocol/ ways of working around sharing of information amongst professionals across teams, settings and whole system
- Shared working network across the system – coordination and co-location of services helps this
- Rule based level of access for staff to see patient information based on who needs to know. Is this organisation specific?
- Common way of recording information across SWL to minimise processing issues
- Whole system and inclusive approach to developing and implementing change for information sharing – senior leaders, clinicians, patient facing staff, CYP, families, voluntary sector etc...

These are all great ideas, but in the meantime we could...
- Look at shared inboxes for services which senior staff have access to
- Mock case study review involving all different agencies to understand the complexities of information sharing
- Develop a code of conduct in support of legal information sharing agreement
- Design pathway/ principles of coordinated way of sharing info
- Build relationships across organisations to enable joined up working
- Better utilisation of the NHS Spine

We believe in an inclusive and innovative approach to care.

www.swlondon.nhs.uk

Breakout sessions

Breakout 1: The Penton Room

Breakout 2: The Blue Hall

Breakout 3: The Chapel Room

Breakout session 1 – The Penton Room

Learning from the development of the HLP CYP MH Workforce Strategy

This session will explore the approach taken to the development of the HLP CYP MH Workforce Strategy to ensure meaningful engagement and co-production with CYP, their families and the workforce.

It will share the key themes that emerged with good practice examples and the importance of developing a healthy and resilient workforce. There will be opportunity to reflect on the findings and the implications generally for CYP services and share what else is happening across London.

Jess Simpson
Healthy London Partnership

Healthy London Partnership

Breakout Session 1

Learning from the development of the HLP CYP MH Workforce Strategy

Aims

- Discuss the approach to having meaningful engagement with CYP, their families and the workforce
- Share the key themes that have emerged and good practice examples of addressing these themes
- Discuss the importance of developing a healthy and resilient workforce
- Opportunity to reflect on the findings and the general implications for CYP services and share what else is happening across London

Engagement across the system

Survey

- Survey developed with young people from Hearts & Minds
- Two versions; one for children and young people, one for parents and carers
- Engagement with CYP over half term in each STP to increase reach
- Links circulated to wide distribution and promoted through social media

Workshops

6 workshops co-designed and delivered with Youth Access and Debating Mental Health to identify common themes across different parts of the workforce;

- Local authority, voluntary and community providers
- Education providers
- NHS/independent providers
- All providers who employ nurses
- Launch event 30th May

Learning points…

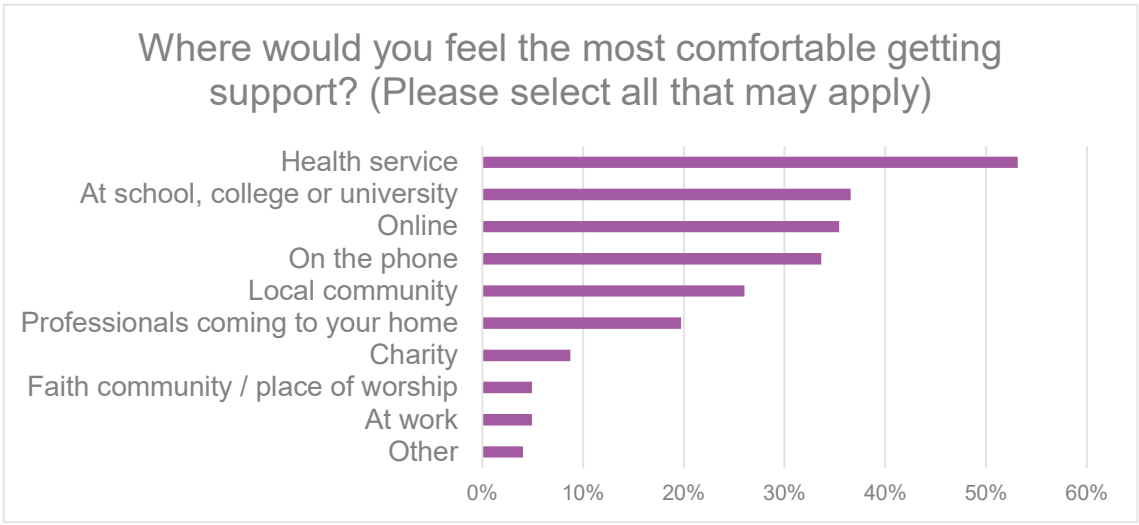
- Survey the workforce, workshop with CYP!
- Events somewhere fun
- Small level of funding needed – for survey and to reimburse your experts

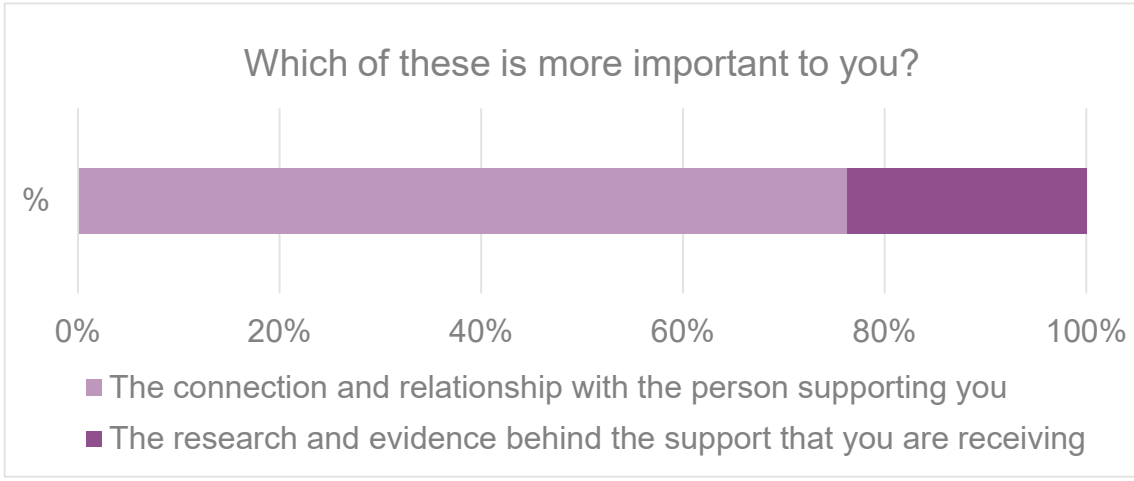
Learning through listening

Results from the survey

565 responses from CYP

166 responses from parents and carers





The CYPMH Workforce Challenges

1. *Recognition*
2. *Recruitment*
3. *Retention*
4. *Skills and Training*
5. *Fragmentation and awareness*
6. *Staff wellbeing and supervision*
7. *Wider system*

Learning from case studies

- All workshop attendees, wide distribution list and virtual advisory group asked to submit case studies
- 13 case studies included in the strategy linked to the 7 challenges that emerged
- Challenge in focus: staff wellbeing and supervision
  - Universally raised as an issue across the workshops
  - Resonated with CYP when testing challenges back
  - Case studies included in the strategy;
    - Enfield Youth Offending Unit – Space 2 Be group
    - Mersey Care NHS Foundation Trust – Employee support programme
    - NAViGO CIC – consultation with staff to reduce sickness levels

Recommendations

1. *Need to highlight the CYPMH system as an area of growth and opportunity.*
2. *Services need to continue to listen, meaningfully engage with and respond to what CYP, parents and carers tell us they want from the workforce.*
3. *A forum across the CYPMH system is needed to support discussions and a movement toward collective recruitment.*
4. *Time in CYPMH workforce job roles should be formally allocated for development.*
5. *The workforce needs to understand itself and it's shared core skills and values.*

Recommendations

6. *A London-wide digital map of support services across sectors would help increase awareness and decrease fragmentation.*
7. *STPs have an opportunity to build supervision networks across organisations to share skills and increase awareness.*
8. *London-wide staff wellbeing opportunities would help ensure people living locally but working in other parts of London could access support.*
9. *Implementation of new roles should include robust evaluations and consider impact on the workforce.*
10. *Resources and support are needed to enable co-production of services and support for staff to adapt to new models being rolled out at pace.*

Group activity

- So what does this mean for my role as a CYP leader?
- How are we building meaningful relationships and co-producing services with CYP, their families and our workforce?
- How do I make connections to learn from good practice and share my learning?

Breakout session 2 – The Blue Hall

Developing child health hubs and multi-professional working

A networked approach to integration, the business case for change, tips for implementation and lessons learned.

This session will look at two different child health hub models and will focus on the practicalities of how to get started with implementation, including getting engagement in primary care (GPs), in the Trust (other consultants and MDTs) and with commissioners. It will also consider governance, accountability, funding and return on investment.

Mando Watson, Consultant Paediatrician, St Mary's Hospital

Chloe Macaulay, Consultant Paediatrician, Evelina Children's Hospital

connecting care for children

CONNECTING CARE FOR CHILDREN:

A partnership between

CCGs, hospital and community health providers, GP federations, local authority, charity, patients, citizens and more

---

Mando Watson
Consultant Paediatrician, St Mary's Hospital, Imperial College Healthcare &
Children's Clinical Director, Central London Community Healthcare

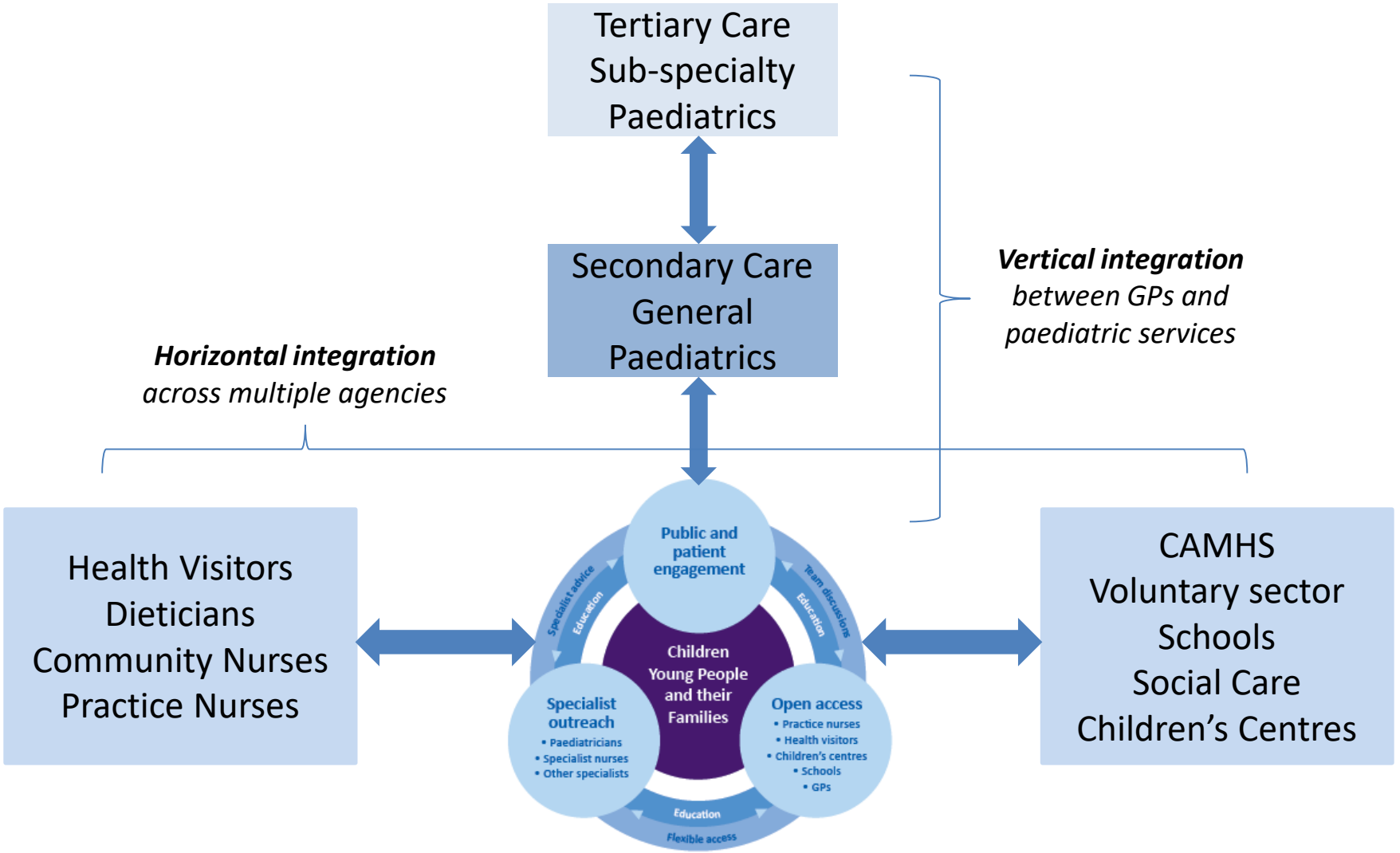
HEALTHY LONDON PARTNERSHIP
CHILDREN & YOUNG PEOPLE'S STRATEGIC LEADERS TRANSFORMATION FORUM
26.6.19

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

Child Health GP Hubs – a model of integrated child health

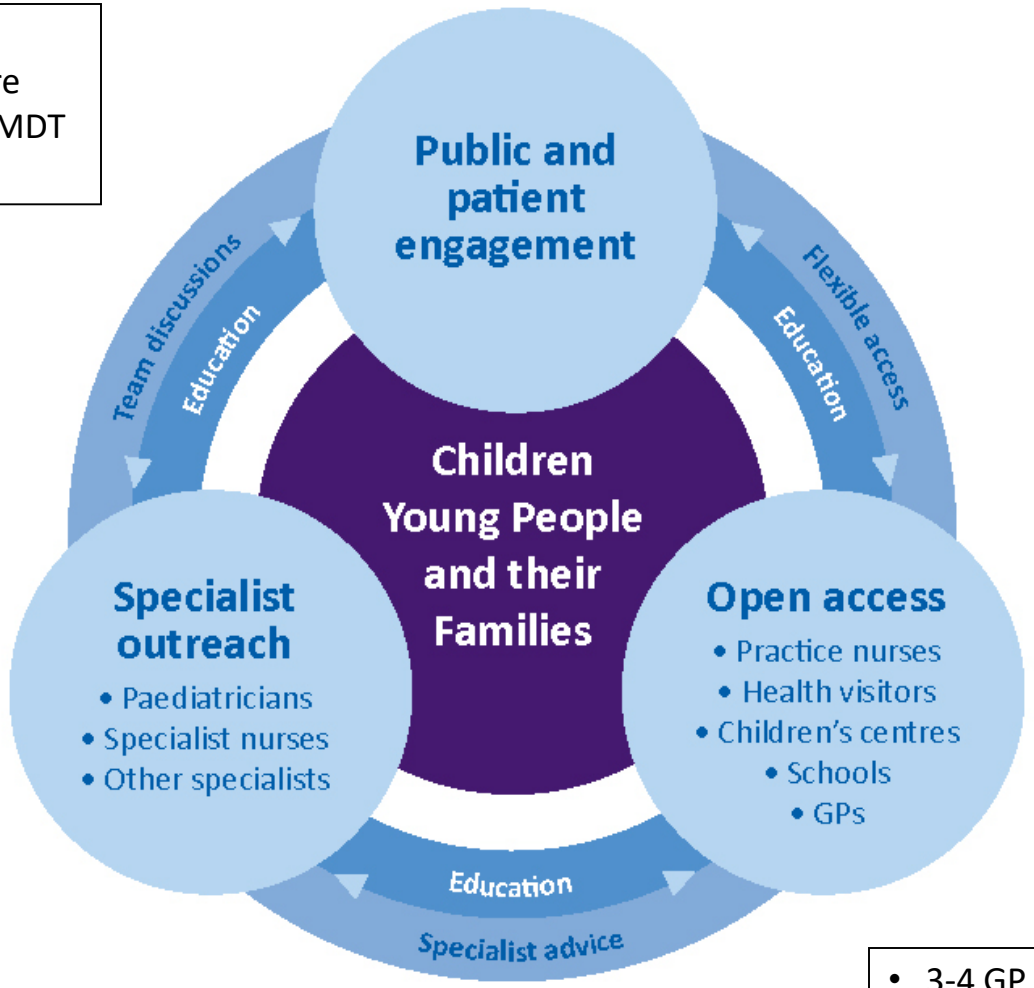


Child Health GP Hubs

connecting care for children

CHILD HEALTH GP HUB

- 3 core elements
- Centred in primary care
- Built around monthly MDT and clinic



- 3-4 GP practices within existing locality
- ~20,000 practice population, (~4,000 children)

EMAIL AND PHONE ADVICE

GP emails paediatrician:

child with abnormal movements – next steps?

Paediatrician advises:

- Parents to video
- Check BP
- Appt in 2 weeks at hub clinic or sooner in hospital?

GP replies:

Sooner as parent anxiety → urgent in hospital review that week

STARTING WITH PATIENTS

"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"

NHS

Volunteer for your local community

become a Practice Champion and help shape children's healthcare

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

For more information please ask for a volunteer application form at reception or call/text Bea on 07852176747

PRACTICE CHAMPIONS

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

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

Clinical Nurse Specialists

Medical Students

Community Childrens Nurses

Dental health professional

CASE HUNTING

Midwives	• Drug use in pregnancy • Domestic violence
Health visitors	• Failure to thrive • Anxious parents • Developmental concerns
School nurse	• Mental health problems • Frequent absences
Dietician	• Obesity • Special formulas
Social services	• Safeguarding • Housing problems
Practice nurse	• Missed immunisations
GPs	• Frequent appointments • High A&E attendance • Multiple medical problems
Paediatrician	• Referral patterns • Long term conditions • Transitioning

ASTHMA RADAR

Whole Systems Integrated Care | Asthma Radar

Identify patients with asthma who may be at high risk and/or in need of review

Click on a traffic light to view details of the selected patient

GP Practice: (All)

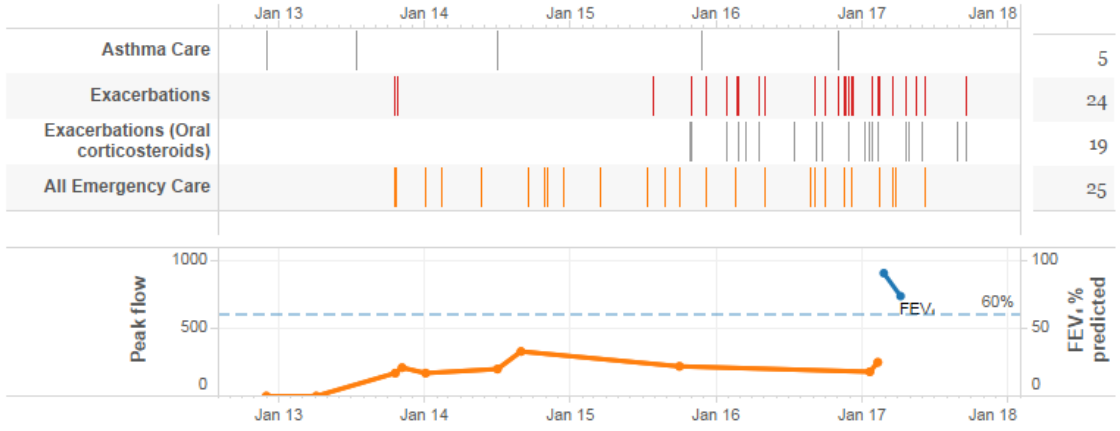
Patient Segment: Children

RCP Review Filter: No filter selected

Sort by...: Number of Exacerbations

9,165 patients on list

Age	Number of Risk Factors	Number of A&E/UCC Attendances (past 12 months)	Number of Exacerbations: Exacerbations	Number of Prescriptions (past 12 months): Short-Acting β-Agonists	Number of Prescriptions (past 12 months): Inhaled Corticosteroids	Asthma Care: Asthma Review	Asthma Care: Inhaler technique	Asthma Care: Symptom Control Test	Asthma Care: Personal asthma plan	Lung Function: Peak Flow	Lung Function: FEV1
16	1	6	17	15	10						
10	1	0	15	1	0						
5	0	10	11	5	7						
15	2.1	4	10	12	3						
15	3	6	9	4	6						



Latest practice update: 25/02/2017 ...

Risk Factors

Multiple courses of oral corticosteroids

Click to highlight traffic lights of that colour

Green Flag | Amber | Red Flag | Neutral/Unknown

A Whole Population Approach: Patient Segments in Child Health

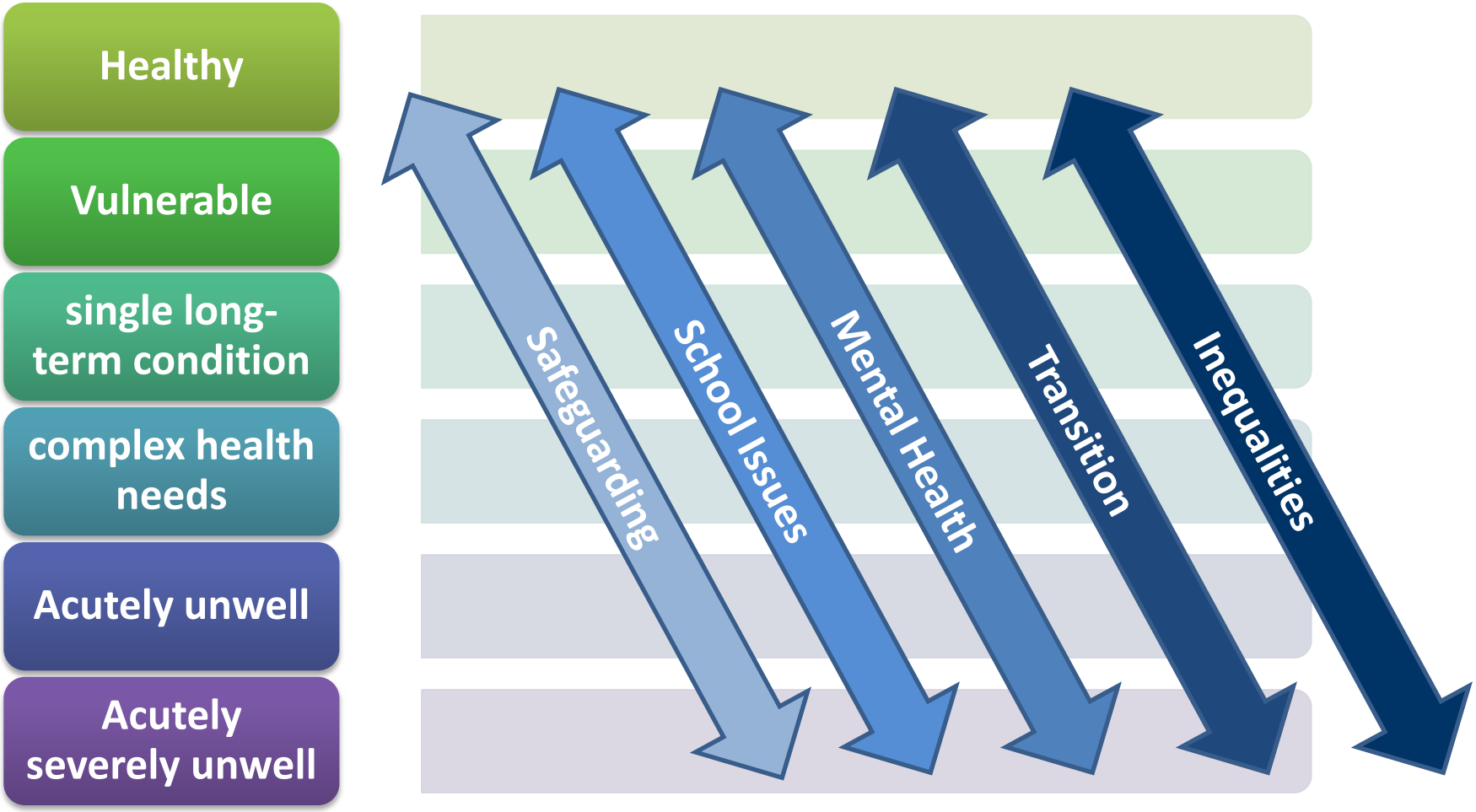
Integrated care is often built around patient pathways. In stratifying children and young people we strongly advocate a 'whole population' approach, where broad patient 'segments' can be identified:

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.



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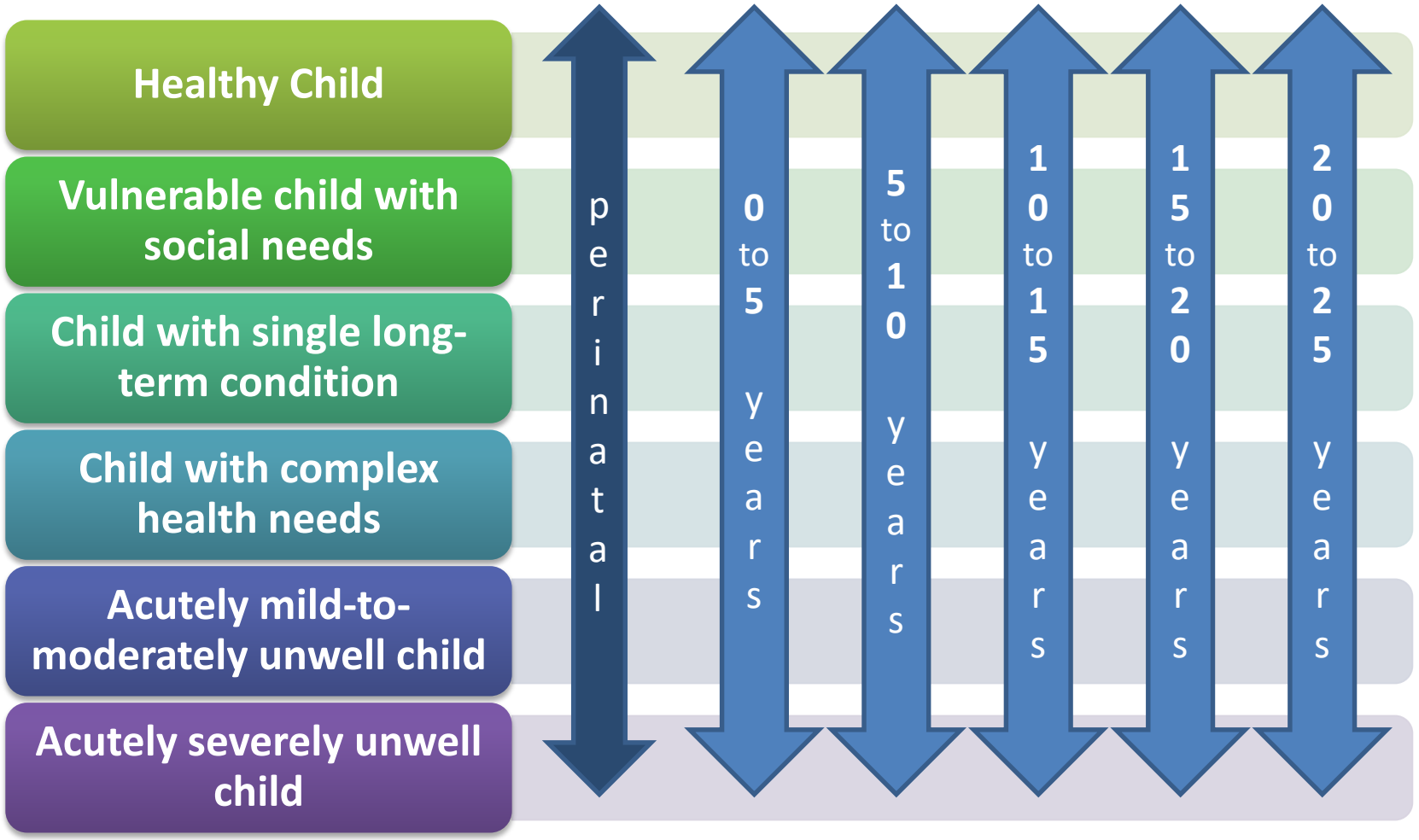
A Whole Population Approach: Patient Segments in Child Health

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

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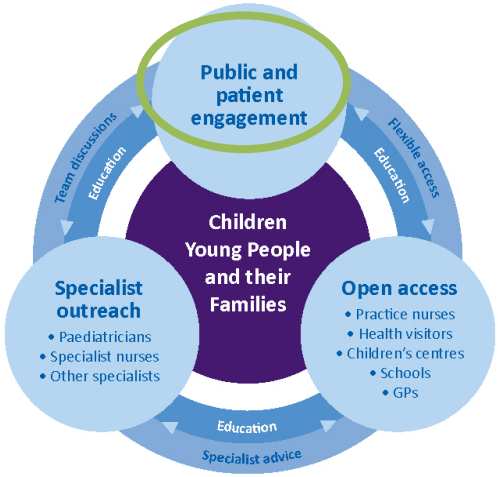
Healthy child, who through good health promotion and advice will stay healthy (e.g. immunisation, healthy eating, exercise, dental hygiene)

Parent is registered with GP practice and attends occasionally with child.



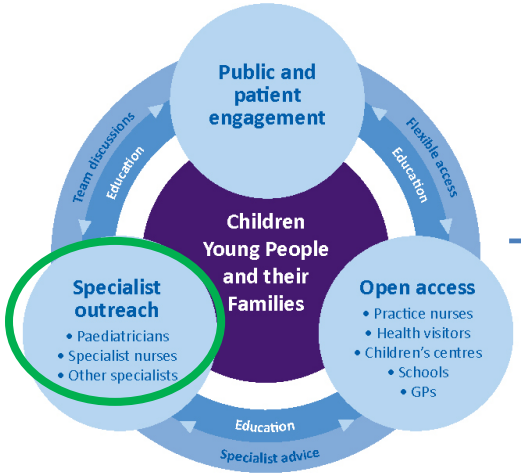
Parent and child are **invited to participate in the practice** Hub (e.g. focus groups, practice champions).

Parents are **better informed** about health promotion advice and opportunities, with better uptake of interventions e.g. immunisation.

Parent starts to **see the GP practice as the best place** to take their infant for healthcare (rather than the hospital where the baby was born).

Child with social needs (e.g. safeguarding issue or teenage self-harm)

Parent presents to GP with child with social needs.

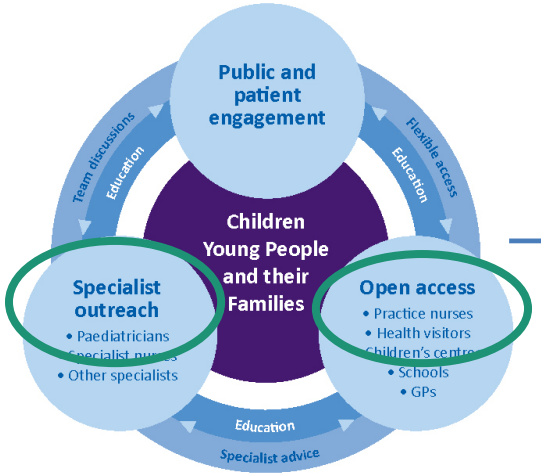


GP/ health visitor use informal discussion at multidisciplinary team meeting (MDT) to access paediatric safeguarding expertise and advice.

Increase in team confidence and skills to identify and manage child social needs, and **refer safeguarding concerns appropriately** (contributing to Continuing Professional Development).

Child with complex health needs (e.g. severe neuro-disability, Down's syndrome, multiple food allergies)

Parent presents to GP or emergency department (ED) with child with complex health need.



GPs take over from general paediatrician as coordinator of specialist services. **GPs and family have confidence to manage minor inter-current illnesses** despite complex background picture.

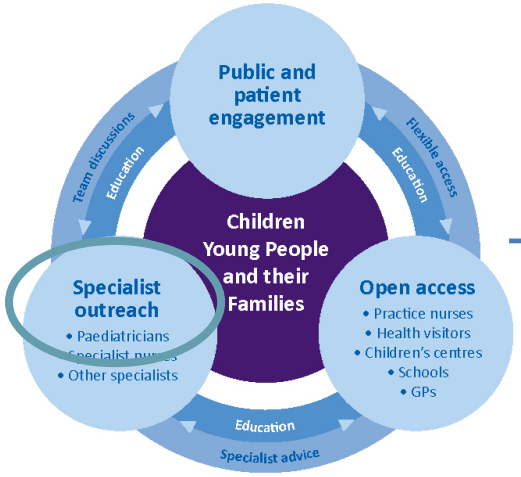
Benefits include **fewer ED attendances** and **smoother transition to adult care**.

Discussion at MDT enables care coordination to be planned and managed between secondary care, primary care and patient.

Nurse /Allied Health Professional **Specialist links** with GP Hub to provide condition-specific advice and support.

Child with long-term single condition (e.g. chronic constipation, coeliac disease, eczema or depression)

Parent presents to GP or ED with child with long-term single condition (mental health).



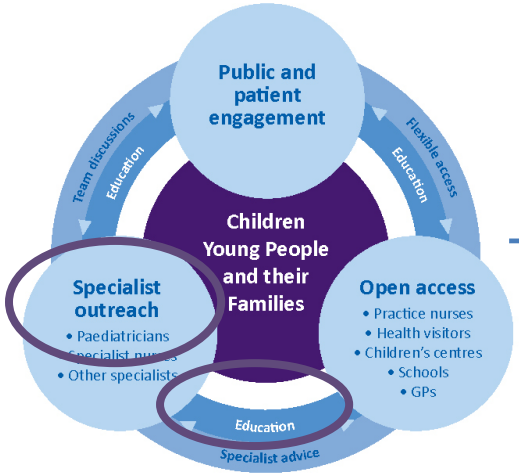
Mental health handled successfully by outreach, with GPs and family having confidence to manage mental health in the community.

Management of depression/ **mental health issues is discussed** at MH-specific MDT, with input from mental health professional.

Acutely severely unwell child

(e.g. sepsis, trauma, meningitis, surgical emergency)

Parent presents to GP with acutely severely unwell child, e.g. meningitis, vomiting as sign of brain tumour.

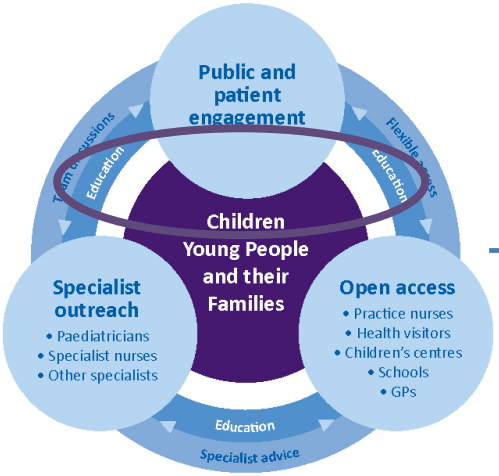


MDT professionals gain skills in identifying and accurately diagnosing acutely severely unwell children requiring hospital admission, **reducing the number of cases where care may be delayed** due to warning signs being missed or misdiagnosed.

All paediatric admissions for this pathway are **discussed at MDTs**, enabling GPs to understand early warning signs and to gain skills in identifying potential early interventions to prevent deterioration – i.e. risk identification and appropriate, rapid referral.

Acutely mild to moderately unwell child (e.g. tonsillitis, pneumonia or otitis media)

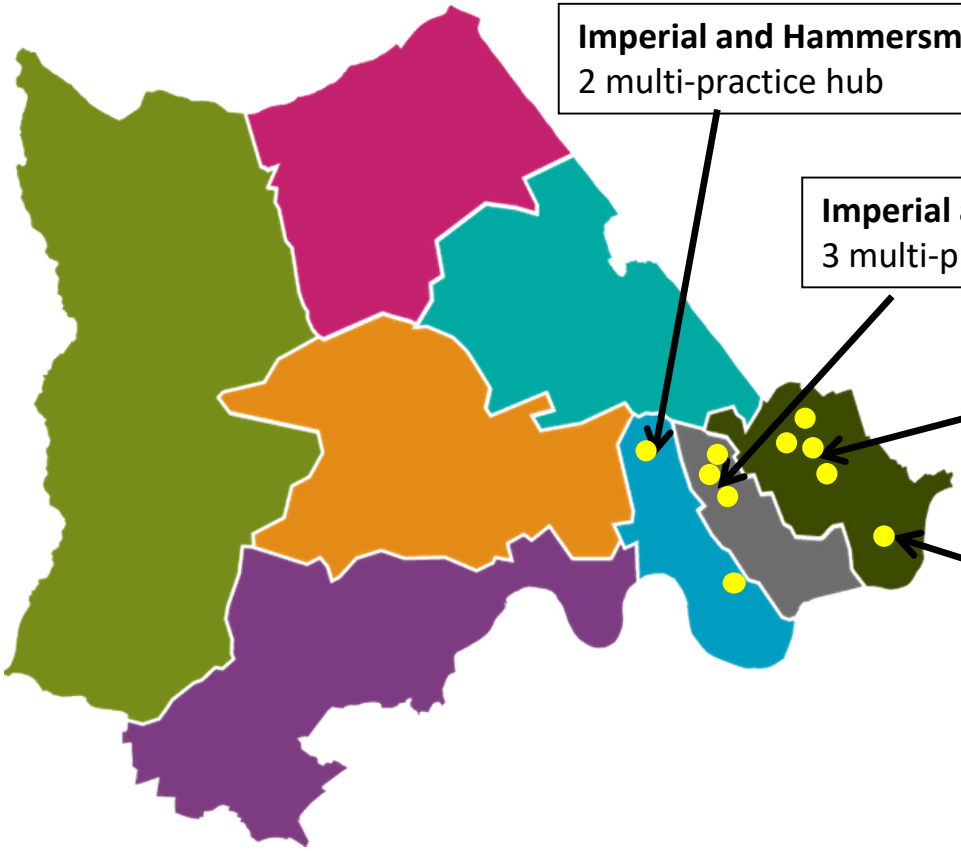
Parent is registered with GP practice and attends occasionally with child.



Parents are better informed about childhood illness and feel **more confident that they know what to do in an emergency**

Parent and child are invited to a **Basic Life Support Training session at the practice**

NORTH WEST LONDON



Imperial and Hammersmith & Fulham CCG:
2 multi-practice hub

Imperial and West London CCG:
3 multi-practice hubs

Imperial and Central London CCG:
2 multi-practice hubs

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

Each dot represents a team of people doing similar work that have contacted us / visited / talked to us

OUTCOMES FROM CHILD HEALTH GP HUBS

Improved experience of care

Outstanding feedback of patient & family experience

As a result of being seen in the Child Health GP Hub 88% of parents felt more comfortable about taking their child to see their GP in the future

Reduced per-capita cost

Observed reductions in hospital activity from GP practices involved in a hub:

39% reduction in outpatients
22% reduction in ED
17% reduction in admissions

Better use of existing resources through connecting care

Improved population health

Segmentation model allows for specific preventative interventions – eg:

- Focusing on all children with asthma having a clear action plan at home, school, GP & hospital
- Improving the proactive management of dental health

Improved staff experience & learning

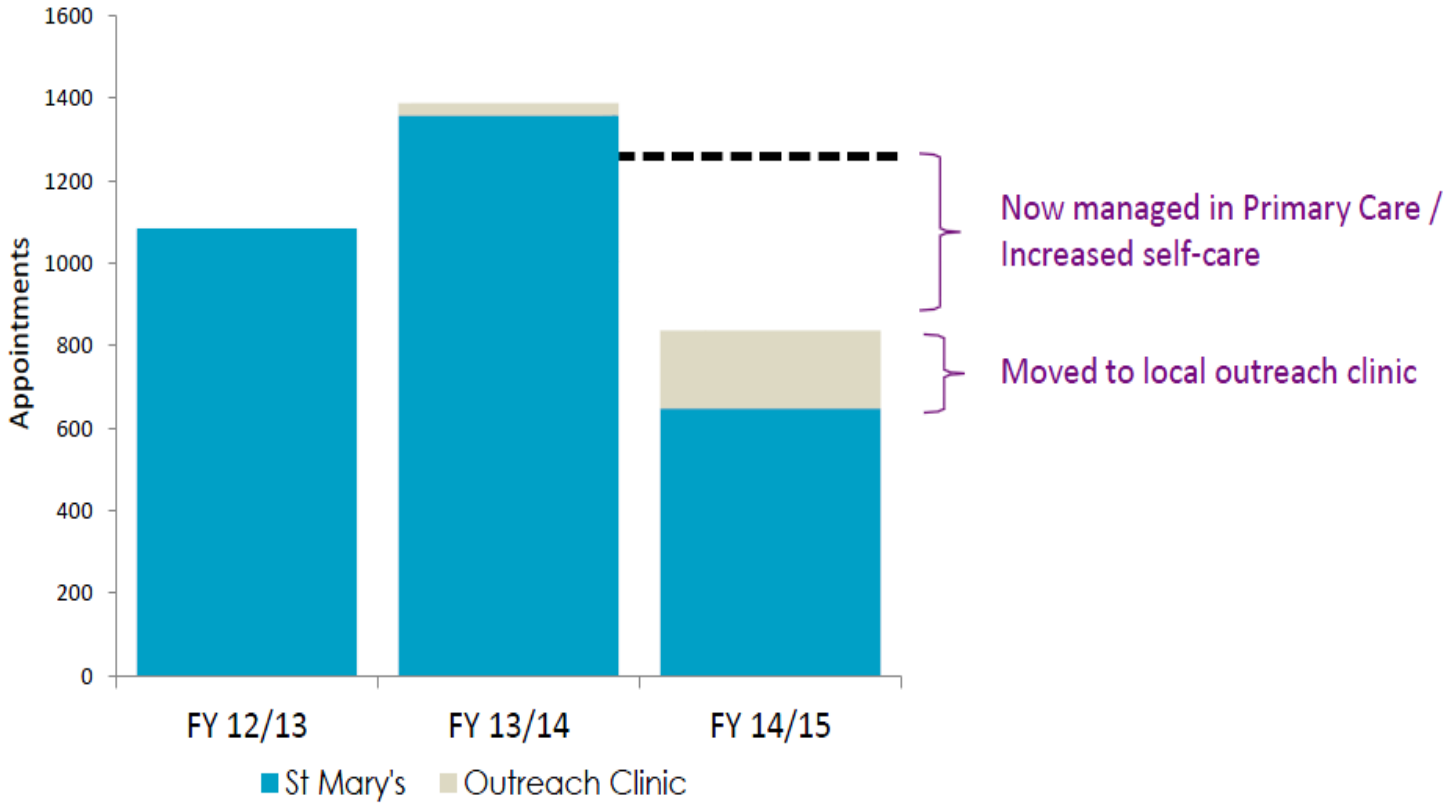
GPs at heart of model

All GP trainees, FY doctors and ST1-3 trainees in paeds at Imperial now get experience of the hubs

Relationships & connections are built through learning

Described on many occasions as “the best CPD I have ever had”

USE OF HOSPITAL SERVICES



Reference: Montgomery-Taylor, S., Watson, M., & Klaber, R. (2016). Child health general practice hubs: a service evaluation. *Archives of disease in childhood*, *101*(4), 333-337.

Demonstrating Value, Outcomes and Benefits

The cost of a conventional NHS outpatient pathway
Patient sees their GP
GP dictates letter
Letter typed
Referral sent to hospital
Patient given outpatient appointment
Consultant agrees to outpatient
Patient travels to hospital
Patient books into reception
Weight and height taken
Sees consultant
Letter dictated
Letter typed
Letter checked
Letter sent out
GP scans letter onto system

The cost of the Child Health GP Hub
Patient sees their GP
GP books into Hub Clinic or MDT discussion
Patient receives SMS or letter from practice
Patient seen/discussed at Hub & GP briefed
Clinical notes made direct into GP patient record

Demonstrating Value

What we saw happening in our Hubs …

Observed reduction in activity:

- Outpatient 81%
- A&E 22%
- Admissions 17%

[from Y1 evaluation written up in ADC paper]

Taking a more conservative estimate of activity changes (where scale could be achieved)…

Modelled reduction in activity:

- Outpatient 30%
- A&E 8%
- Admissions 2%

into an economic evaluation …

Place	Number of Hubs	Child Population Covered	Total costs of the CC4C Child Health GP Hubs *(based on previous slides)*	Total savings from reduced hospital activity *(based on PbR tariff)*	Net Economic Benefit
Pilot	2	8672	£153,220	£319,822	**£166,602**
Hammersmith & Fulham	8	34,690	£332,803	£1,236,029	**£903,226**
Westminster	9	38,494	£374,403	£1,390,533	**£1,016,129**
Kensington & Chelsea	7	26,076	£291,202	£1,081,525	**£790,323**
Inner North West London	24	99,260	£644,832	£3,461,539	**£2,816,706**
North West London	100	417,602	£2,686,802	£14,423,078	**£11,736,276**
London	400	1,228,135	£10,747,207	£57,692,311	**£46,945,104**

CHALLENGES

How to have clear clinical governance: integration blurs the boundaries

***How to use the MDT*:** personalities and heirarchy may inhibit participation

***How to safeguard against confidentiality breaches*:** the broader the MDT, the easier to cross the information governance line

How to share learning: each Hub has it's own flavour, strengths and weaknesses

How to make it the GP practice's Hub: create pull not push

THE LOGIC BEHIND THE MODEL:
ACTION EFFECT DIAGRAM

Action Effect Diagram - Adapted June 2018 from CC4C/CLAHRC 2014
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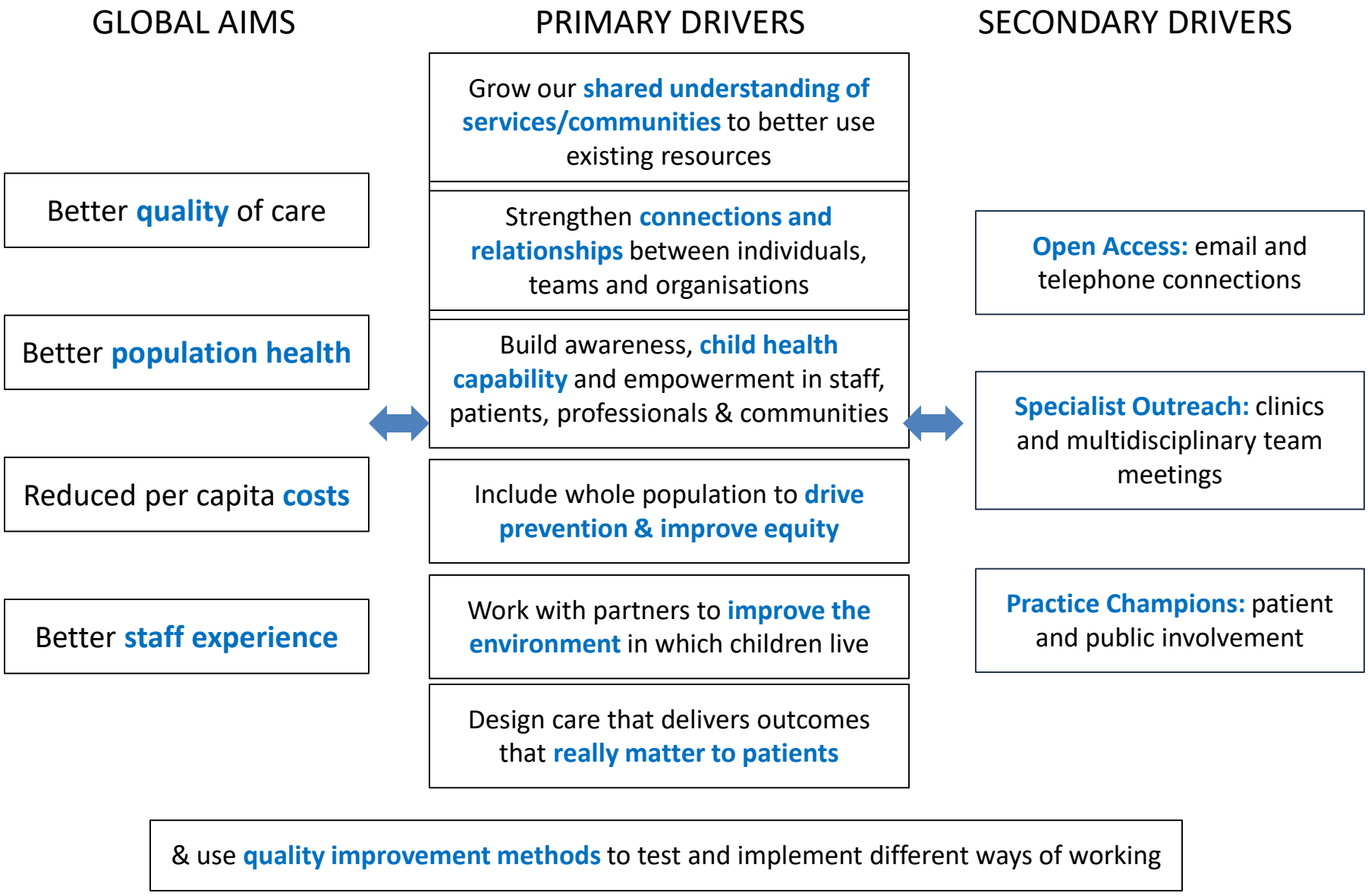
Bob.Klaber@nhs.net



GETTING IN TOUCH

WEBINAR: next date 19th July 2019

EMAIL: mando.watson@nhs.net
imperial.cc4c@nhs.net

TWITTER: @CC4CLondon

WEBSITE: www.cc4c.imperial.nhs.uk

connecting care for children

Developing child health hubs and multiprofesisonal working: CYPHP model of care

Chloe Macaulay
Paediatrics Lead CYPHP, Consultant Paediatrician Evelina
June 2019

KING'S College LONDON

Evelina London Children's Hospital

CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP

A health system strengthening approach to improving quality of care for children.

- The Children and Young People's Health Partnership is a clinical-academic partnership in South London.

- Partnership:
  - Hospitals, primary care, commissioners, local government, University
  - 2 inner London boroughs
  - Child population = 120,000

We are testing *at scale* new ways of delivering better care for children, using a whole systems population approach.

CYPHP aims to:

Improving **child health** outcomes

- As measured by service evaluation
- Inferred by health service use

Improving **children's healthcare quality** and experience

- By integrated collaborative team-based working and sharing knowledge and skills
- As measured by process evaluation

Improving **health service use**

- As measured by fewer GP attendances and outpatient referrals

The CYPHP Model of Care

You are in a pilot cluster – what does that mean?

- **Universal offer**
  - Patch Paediatricians
  - CYPHP clinics - joint GP/PP clinics in Primary Care
  - **Inreach lunch and learn/MDT discussion**
  - Mind/body approach

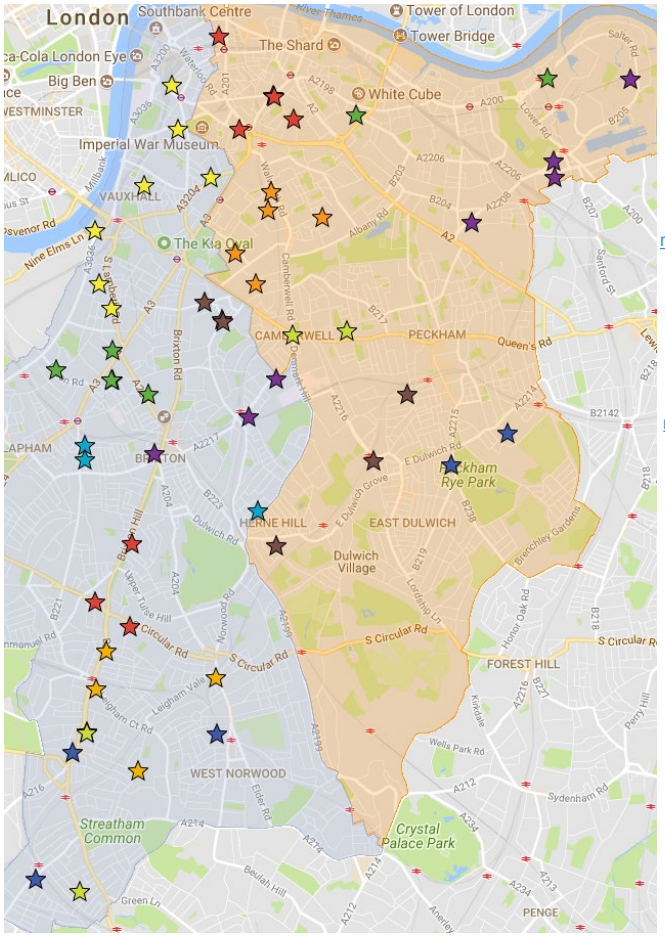
- **Ongoing conditions** asthma, epilepsy, constipation, or eczema
  - Heath check and support pack – active case finding
  - Nurses and mental health teams
  - Supported by/connecting to secondary care teams

Provide closer working together; responsive care close to home; sharing learning

CYPHP health team and clinics are currently available to:

Lambeth

Patch Paediatrician	Cluster	Clinics
Dr Alice Roueche alice.roueche@nhs.net	Lam01	Hurley Clinic Lambeth Walk Group Practice Mawbey Group Practice Riverside Medical Centre South Lambeth Road Practice Vauxhall Surgery Waterloo Health Centre
Dr Claire Lemer clairelemer@nhs.net	Lam02	Beckett House Practice Binfield Road Surgery The Grantham Practice Springfield Medical Centre Stockwell Group Practice
Dr Mike Wacks michael.wacks@nhs.net	Lam03	Sandmere Practice Hetherington Group Practice Herne Hill Group Practice
Dr Bianca Tiesman b.tiesman@nhs.net	Lam04	Akerman Medical Practice Minet Green Health Practice Vassall Medical Centre
Dr Ajanta Kamal ajantakamal@nhs.net	Lam06	Brixton Hill Group Practice Palace Road Surgery Streatham Place Surgery
Dr Diana Stan diana.stan@nhs.net	Lam08	The Deerbrook Surgery Edith Cavell Surgery Streatham Hill Group Practice Valley Road Surgery
Dr Trisha Radia trisharadia@nhs.net	Lam10	The Corner Surgery Herne Hill Road Medical Practice Pavilion Medical Centre
Dr Sharon Roberts sharon.roberts28@nhs.net	Lam11	The Exchange Surgery Knights Hill Surgery Dr Masterton & Partners The Vale Surgery
Dr Bianca Tiesman b.tiesman@nhs.net	Lam14	Streatham Common Practice Streatham High Practice



Southwark

Patch Paediatrician	Cluster	Clinics
Dr Sharon Roberts sharon.roberts28@nhs.net	Swk01	Blackfriars Medical Practice Borough M.C. - Dr. Misra Borough M.C. - Dr. Sharma Princess Street Group Practice Falmouth Road Surgery
Dr Rohana Ramachandran rohana.ramachandran@nhs.net	Swk02	Maddock Way Surgery Manor Place Surgery Penrose Surgery Sir John Kirk Close Surgery Villa Street Medical Centre
Dr Chloe Macaulay chloe.macaulay@nhs.net	Swk04	Bermondsey & Lansdowne ... Albion Street Group Practice Avicenna Health Centre
Dr Rohana Ramachandran rohana.ramachandran@nhs.net	Swk05	Silverlock Medical Centre Park Medical Centre Surrey Docks Health Centre
Dr Trisha Radia trisharadia@nhs.net	Swk08	Camberwell Green Surgery St. Giles Surgery- Dr. Begley
Dr Diana Stan diana.stan@nhs.net	Swk11	The Gardens Surgery The Nunhead Surgery DMC Chadwick Road
Dr Mike Wacks michael.wacks@nhs.net	Swk12	Melbourne Grove M.P. Elm Lodge Surgery

Evelina (ELCH) Advice/Guidance
general.paediatrics@nhs.net

Variety CH@KCH Advice/Guidance
kch-tr.ambulatorypaediatrics@nhs.net

v.1.1 18/10/2018

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CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP

CYPHP clinics - how do they work?

- Who:
  - “Patch Paediatrician” – building relationships
  - GP – rotating – CPD, local know how
- Where:
  - Cluster model – monthly clinic in each cluster
  - Patients from adjacent practices
- How:
  - Replaces general paediatrics appointment. Email advice/referral to PP
  - Booked within EMIS by GP admin
  - Notes on EMIS/GP system – data sharing agreement
  - Lunch and learn
  - Virtual MDT – case discussions

CYPHP ongoing conditions health team - how do they work?

- Who:
  - Asthma/eczema./constipation/epilepsy nurses
  - Mental health team
- Where:
  - In GP practices/childrens centres/health cetres/homes
- How:
  - Gp referral/self referral/PP referral
  - Health check case finding
  - Seen in one of locations
  - Discussed in MDTs
  - Link in with primary care
  - Notes on EMIS
  - Accessible contact

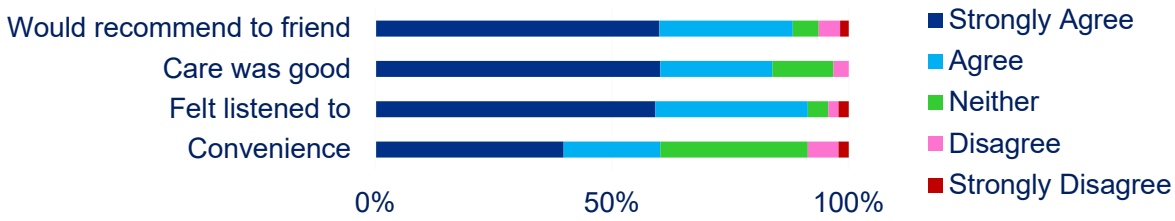
Funding and organisation

- Initial and ongoing funding from pilot study money
  - 16 patches
  - 10 Paediatricians – KCH/Evelina
  - 8 nurses
  - 3 mental health team
  - Managers/admin/evaluation team
- Going forward –
  - tapering to “BAU”
  - Admin absorbed into “business as usual”
  - Clinical would be part of block contract

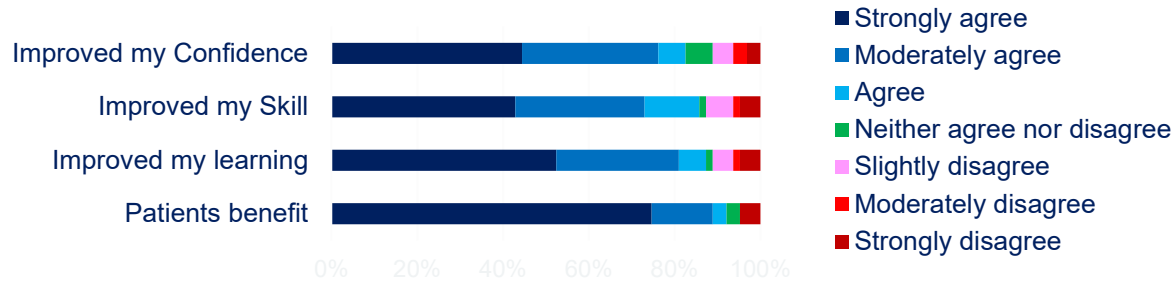
- Next steps…Aligning to Primary Care networks

Outcomes of CYPHP clinics

- Patient feedback



- GP feedback



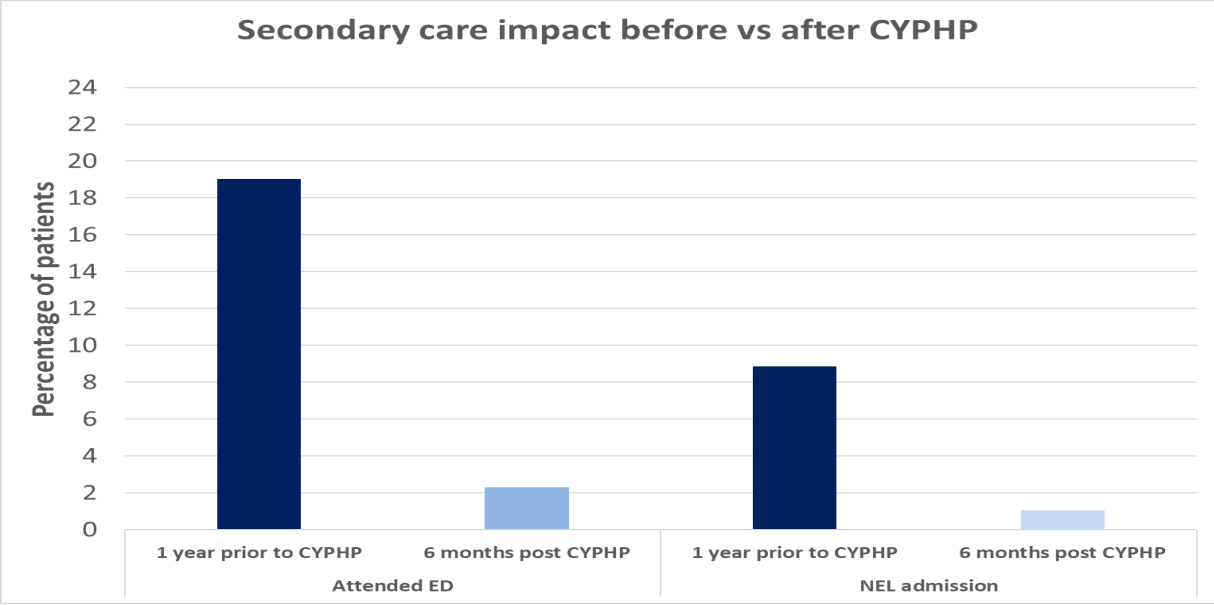
- Follow up rate 13.5% vs 38.5% (ELCH)
- 24% reduction in further referrals within 12 months
- Patient journeys

Early results: improving outcomes

Better healthcare quality

- Asthma written care plan: now 93% of patients
- Goal based outcomes

Reduced acute activity



The percentage of CYPHP patients with emergency department (ED) attendance or non-elective admission (NEL) one year before CYPHP, and six months after CYPHP services.

	Number of patients	Number of patients attending ED	Number of patients who were admitted	Statistical significance (Chi square test) p value
Year prior to CYPHP	226	43	20	.001
6 months post CYPHP	89	5	1	.008

Early results: reducing acute activity

	Patients	ED contacts avoided	NEL	Total cost avoided	Multi-Professional Team costs	Savings
2018	306	583	211	320k	308k	-12k
YTD	121	230	84	125k	97k	28k
2019	321	623	226	337k	231k	106k

- Current year to date (YTD) and predicted clinical activity, with current and predicted ED attendances and NEL admissions avoided using *our current understanding of how much activity translates to how much impact*.
- Costs avoided calculated using average tariffs (ED attendance £138-216; NEL admission £1000)

Early results: understanding health needs helps us to shape care

- The first wave of active case finding **reached 90% eligible population** (n=2084)
  - Population health approach to UHC and high quality care
- 73% of the Health Checks were completed by people from ethnic minorities
  - Improving equity of access
- Most children had clinically important symptoms needing care
  - **62%** of children with asthma had **poorly controlled symptoms**
  - **72%** of children with constipation had **significant problems**
  - **76%** of children with eczema had **moderate to severe symptoms**
  - Across all conditions, **28%** of CYP had **high to very high scores on their mental health** questionnaire
  - Early intervention and biopsychosocial *whole child* care
- High levels of need in families and communities
  - **12% of parents** expressed concerns regarding their **own mental health**
  - **38%** of parents report **housing concerns**
  - **68%** do not have enough **access to food**
  - **11%** have problems **paying bills**
  - Holistic care for the child, family, and community

Challenges of CYPHP clinics

- GP buy in
  - “top down” approach of large scale pilot
  - Not aligned to natural relationships
  - Spreading the word – avoiding ERS referrals.
  - Push back from GPs around time needed for clinics

- Logistics and administration
  - Vetting of clinics – EMIS/emailing
  - “double booking on systems”
  - Prescribing
  - Clinic letters

- “Ownership”

Challenges of ongoing conditions service

- Workforce
- Caseload
  - Numbers of patients
  - Complexity
- Location for clinics
- Logistics and administration
- “Supervision”

Learning and top tips

- Buy in from all sectors/stake holders is essential – bring them all on the journey
- IT solutions take a long time
- Money talks – data collection important
  - Value of quantitative **and** qualitative
  - Quick wins vs the long game
- Relationships are key
- Align to local landscapes
- Get started – small or large scale - both have +/-

Care pathway

Urgent
- Consultant Connect
- Ambulatory acute care
- A&E

Specialised
- Hospital referral

Self-referral
- For ongoing conditions
- via Health Check portal
- Call/Re-call invitation

Non-Urgent
General child health

- **Phone/Email CYP Local Health Team for advice**
- **Referral**
- **Signpost to online Health Check portal**

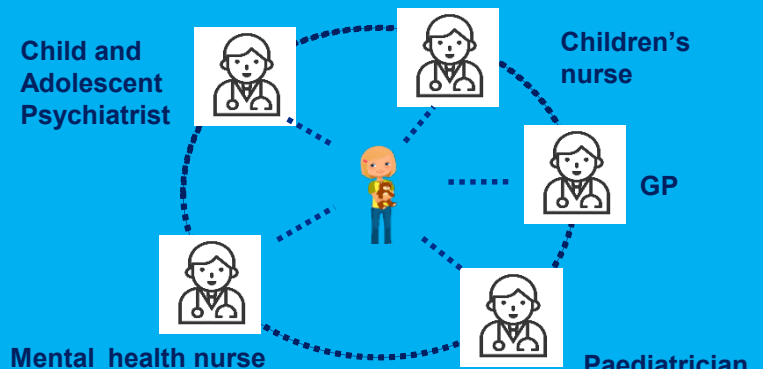
Online Portal Health Check

Self-referral and Call/Recall
- Enables early intervention
- Increases equity

MDT working promotes:
- Care for the *whole child*
- Tailored care planning
- Learning and improvement
- Population health

Services
- Nurse-led care for ongoing conditions and minor illness
- GPs, paediatricians, CAMHS
- Team and service tailored to child and family need

Local CYP Health Team



Health Check provides bio-psycho-social pre-assessment

Health Pack supports self management promotes health

Local CYP Health Team
- For place-based care
- Triages and plans care
- Provides care for the whole child
- Care delivered at home or clinic
- Aligns with health visitor, school nurse, social work

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CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP

Patient journeys…what added benefits do CYPHP teams /patch paediatricians offer?

Case 1: Benefits of Patch Paediatrician relationship and inreach clinics.

Difficult constipation (which probably isn't that difficult but is just poorly managed).

A 4 year old girl Claire has had constipation for a long time. She has been backwards and forwards to the GP several times in the last few years and is given laxatives but doesn't like taking them, and her parents are concerned that if she is on them too long she will get reliant on them.
(Touch points/activity – 4 GP visits. Lots of parental worry, and child's discomfort)

One day she ends up in ED with terrible tummy aches and the ED doctor suggests that the GP refer her on to the hospital for further input. He writes this in the discharge letter. When the GP gets the letter a week or so later, she refers her to gastroenterology via ERS. The next appointment isn't for 12 weeks. This is vetted by the gastro team who feel that the girl should actually be seen by the General Paediatrics team. This is redirected to General Paediatrics.
(Activity: 1 ED visit. 1 ED letter to GP. 1 referral letter by GP. 1 redirected referral letter by Gastro consultant. 1 accepted referral by Gen Paeds. Parental worry ongoing. Child discomfort ongoing)

She is seen 3 months later in a general Paediatrics clinic at the hospital. Physiology explained. Time spent discussing Diet and Medication plan. Letter dictated to GP asking for GP to review at one month. Typed up by admin 1-2 weeks later. Signed by Paediatrician. Sent to GP. GP admin adds to notes. GP reads 3 weeks after appointment.
(Touch points/activity: one hospital appointment. Letter writing and reading. GP appointment)

By time of follow up - next appointment 2- 3 weeks later - family have forgotten details of diet discussion and medication plan. Symptoms are similar. GP not sure what to do next so asks for a follow up appointment form hospital….and so on….

Patient journeys…what added benefits do CYPHP teams /patch paediatricians offer?

OR

A 4 year old girl Claire has had constipation for a long time. She has been backwards and forwards to the GP several times in the last few years and is given laxatives but doesn't like taking them, and her parents are concerned that if she is on them too long she will get reliant on them.

GP emails Patch Paediatrician (PP) whom she knows, and asks for advice. PP gives advice over email on treatment and arranges for child to be seen in next in reach appointment. Within a month. GP and PP see child together discuss diet and medication. Write in patient's notes directly. GP arranges follow up appointment then and there for patient in 4 weeks' time. When child is reviewed GP emails PP directly and discusses progress and next steps.

The next time the GP sees a child with a similar condition s/he knows what management steps to take, and has easy access to PP for further support.

Patient journeys…what added benefits do CYPHP teams /patch paediatricians offer?

Case 2: Benefits of CYPHP MDT working - Primary Care nurses and mental health team

Constipation, soiling, safeguarding, developmental and behavioural problems

A 7 year old boy Ricky has had constipation for a long time. He is now soiling most days. He has been backwards and forwards to the GP several times in the last few years and is given laxatives but doesn't like taking them. His behaviour is also difficult to manage. He was on a Child Protection Plan but now his grandmother looks after him by way of a Special Guardianship Order. Because of this they no longer have Social Care input.

He is booked into inreach/CYPHP clinic by the GP. A plan is made in clinic but the constipation is obviously very longstanding and will take some time to address, and the PP feels that there are also social issues and development issues contributing. PP emails Constipation nurses and asks for them to review. They do a home visit and discover lots of difficult social issues, and grandmother struggling. Also realise that she doesn't read. They engage Social Care and school nurses and review regularly either jointly with school nurse, or in GP practice with PP. The Social Care case is reopened and the grandmother starts to get some more support. Family regularly discussed with GP via email, and in 2 monthly in reach lunch and learn meetings. Tertiary referral into Gastroenterology team via email facilitated when symptoms do not improve with management. Clear communication between all individuals involved around management plans, updates and prescribing as all notes on GP system.

Chloe.macaulay@gstt.nhs.uk

Breakout session 3 – The Chapel Room

Managing children with complex needs – a focus on neurodevelopment

A thought leadership explorative session on how we can manage children with complex neuro-developmental needs, e.g. ASD and ADHD, in a different way.

This session will encourage collaboration and blue sky thinking to look at the opportunities we have to reduce complexity for CYP and their families when navigating the system.

Simon Diggins OBE,
CAMHS CAG,
South London and Maudsley NHS Trust

simon.diggins@slam.nhs.uk

Managing children with complex needs – a focus on neurodevelopment

Simon Diggins OBE,
CAMHS CAG,
South London and Maudsley NHS Trust

Commissioning Services for Children with Co-morbid ASD, ADHD, Mental Health and Early Developmental Trauma

A CAMHS Consultant Child and Adolescent Psychiatrist perceptive.

Dr Rani Samuel

Consultant Child and Adolescent Psychiatrist

Lewisham CAMHS

Commissioning Services for Children with Co-morbid ASD, ADHD, Mental Health and Early Developmental Trauma

A CAMHS Consultant Child and Adolescent Psychiatrist perceptive.

Background

I have worked as a Consultant Psychiatrist in Lewisham CAMHS for 6 years; prior to that I worked in: South West London and St. Georges NHS Trust, Surrey and Borders NHS Foundation and Hertfordshire NHS Foundation Trust. I have been a Consultant Child and Adolescent psychiatrist for 9 years

This think-piece arose from an informal discussion on the concerns of how children referred to CAMHS teams with neurodevelopmental difficulties can struggle to get timely care. This conversation has been summarised for the South-East London STP and is a contribution to a wider Healthy London Partnership seminar. The intent is to record my views and to stimulate thinking on how best to serve our communities. It has benefitted from discussion with colleagues, and with SLaM's CAMHS Clinical Director, but does not pretend to be definitive nor to represent a collective position.

The Challenge

In any single CAMHS team, 40% to 50% of referrals are to do with behavioural difficulties, usually with a question regarding ADHD (400/ 500 referrals/ year in a team receiving 1000 referrals per year) and with about 40% of these (150-200/ year) having co-morbid ASD and ADHD. These figures are only estimates and it varies in each borough across the country, depending on the population needs and local commissioning arrangements and access to specialist, Tier 4 services vary hugely.

On an average, **40% of children with ADHD will also have ASD and vice versa. Across different services these children can wait on either Paeds or CAMHS waiting list for prolonged periods of time from 12 to 18 months, depending on the borough and the demands in an area, during crucial years in primary/ secondary school or during transition periods.** 18 months for a 12-year old, is 12.5% of their life to date; the equivalent for a 70-year old is 8.75 years and no-one would expect a 70-year old to wait that long.

Current Position

The four boroughs SLaM serves, (Lewisham, Lambeth, Southwark and Croydon), are all commissioned differently in terms of assessment and treatment pathways: that applies across the board for all services but this variation presents a particular challenge for the delivery of services for children co-morbid with ASD, ADHD, Mental Health and Early Development Trauma services; given the very similar demographic in each borough, this is perhaps surprising, to say the least. For a parent of a child who has these disorders, who then has to move boroughs – hardly uncommon - navigating these differences is nightmarish. As a clinician, it is painful to see some of these children, who are referred to the generic CAMHS service, the SEN (Special Educational Needs) panel and the Looked

After and adopted Children's (LAC) service, waiting for long periods of time on different waiting lists, unnecessarily, and all dependent on the commissioning arrangements in a borough.

Often these services belong to different NHS Trusts eg the Paeds/CAMHS split, to Local authorities, or to educational authorities, which makes notes-sharing, clinical space-sharing and management supervision, all difficult.

Making It Better

These children need a service where professionals can come together. It is not possible to sustain joint working across disciplines through good will alone, even though most clinicians want to work together. **So, at the CCG/LA-level, jointly commissioned services are essential to bring professionals together.**

Operationally, a psychiatrist/ paediatrician along with psychologist/ Speech and Language Therapist is the most useful combinations. In children with mental health co-morbidity, along with early developmental trauma, in addition to ASD and ADHD, would particularly benefit from a psychiatrist and psychologist jointly working. An Ed Pysch can often add real value too and should be either part of an MDT, or readily available.

There are no short cuts. A joint ASD/ ADHD assessment takes 8 to 10 hours per child, including collating information, parent interview, child observation and any additional tests, such as cognitive assessments and report writing. This can be up to 10 to 12 hours if this includes co-morbid depression, anxiety, developmental trauma or if a young person is looked after, adopted/ in the youth justice system, mainly to account for getting essential collateral history.

Children in care (CLA/ LAC)

In case of children in local authority care, early diagnosis saves family/ placement breakdowns with better understanding of the child and less stress on adoptive and foster carers. Additionally, getting an appropriate educational placement would mean the child is not seen as 'naughty' or 'difficult', but supported appropriately at home and school.

If assessed and treated early, prognosis and trajectory is much better for this group of children with better educational attainments, better self-esteem and most importantly prevention of co-morbidities such as anxiety/ depression in girls and behavioural difficulties such as oppositional and conduct disorders in boys developing, though these are not specific to genders.

Looked after and adopted children have high levels of neuro-developmental disorders but these can be overlooked for long periods, due to lack of expertise and poorly commissioned services, especially in relation to availability of psychiatrist, psychologist and other trained professionals in a service.

Conclusions

Commissioning joint services, across disciplines that have skill sets to assess both ASD and ADHD for a child where they are co-morbid, is key. In some children, these can co-exist with mental health conditions and early childhood emotional difficulties and trauma. In some boroughs, these services are spread across NHS trusts. From a CAMHS psychiatrist point of view, a service for roughly 150 to 200 children/ 1000 referrals per year will need a joint service in addition to already existing services. This is over and above services for children with just one disorder such as ADHD or ASD without the overlap.

The figures used here are only estimates and need closer look for each borough and have not been drawn from any borough. Combinations of professionals from different disciplines such as psychiatry, psychology, SLT, paediatrics are needed depending on the child's need.

Commissioning such a joint service would be money well spent having a positive impact on the child, family, CAMHS/ Paeds services; but also, education, hospital school, social care and youth justice systems.

Thank you

Dr Rani Samuel
Consultant Child and Adolescent Psychiatrist
Lewisham CAMHS

If you would like to comment on this think-piece, please contact Simon Diggins, CAMHS CAG, South London and Maudsley NHS Trust at:

simon.diggins@slam.nhs.uk

Breakout session 4 – The Penton Room

Primary Care Networks: An integrated community approach

This breakout session with HLP explores taking an integrated approach to primary care networks, in particular hearing from Dr Oliver Anglin (CYP Clinical Lead for Camden CCG and NCL) who has led a programme of work at CCG and STP level.

The session will include key principles for success and considerations for local adaptation.

Georgie Herskovits & Chris Kirkpatrick,
Programme Managers,
Healthy London Partnership

Dr Oliver Anglin,
Clinical Lead for Children and Young People - Camden CCG,
Clinical Lead for CYP STP - North London Partners

Healthy London Partnership

Primary Care Networks for CYP an integrated community approach

26th June 2019

Supported by and delivering for:

Public Health England

NHS

LONDON COUNCILS

SUPPORTED BY MAYOR OF LONDON

London's NHS organisations include all of London's CCGs, NHS England and Health Education England

01

Welcome and introductions

Christine Kirkpatrick, Georgie Herskovits
Healthy London Partnership

PCNs: Working together at scale

“Working together" - ttps://www.youtube.com/watch?v=wlJvkeRpvqc&feature=youtu.be

NHS Long Term Plan

"We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services"

Primary Care Networks

- GP practices covering 30-50,000 people funded to work together to extend the range of local services, with integrated teams of GPs, community health and social care staff
- GPs, pharmacists, district nurses, community paediatricians, and geriatricians, youth workers and AHPs such as physiotherapists and podiatrists/ chiropodists, joined by social care and the voluntary sector
- Multi-year contract changes for individual practices - network contracts - a designated single fund for all network resources
- New 'shared savings' scheme so networks benefit from actions to reduce avoidable A&E attendances, admissions and delayed discharge, streamlining patient pathways to reduce avoidable outpatient visits and eg. overmedication through pharmacist review
- Workforce - flexible options for GPs and wider primary care teams within a network

There is an opportunity to build on current work being undertaken on primary care networks for CYP

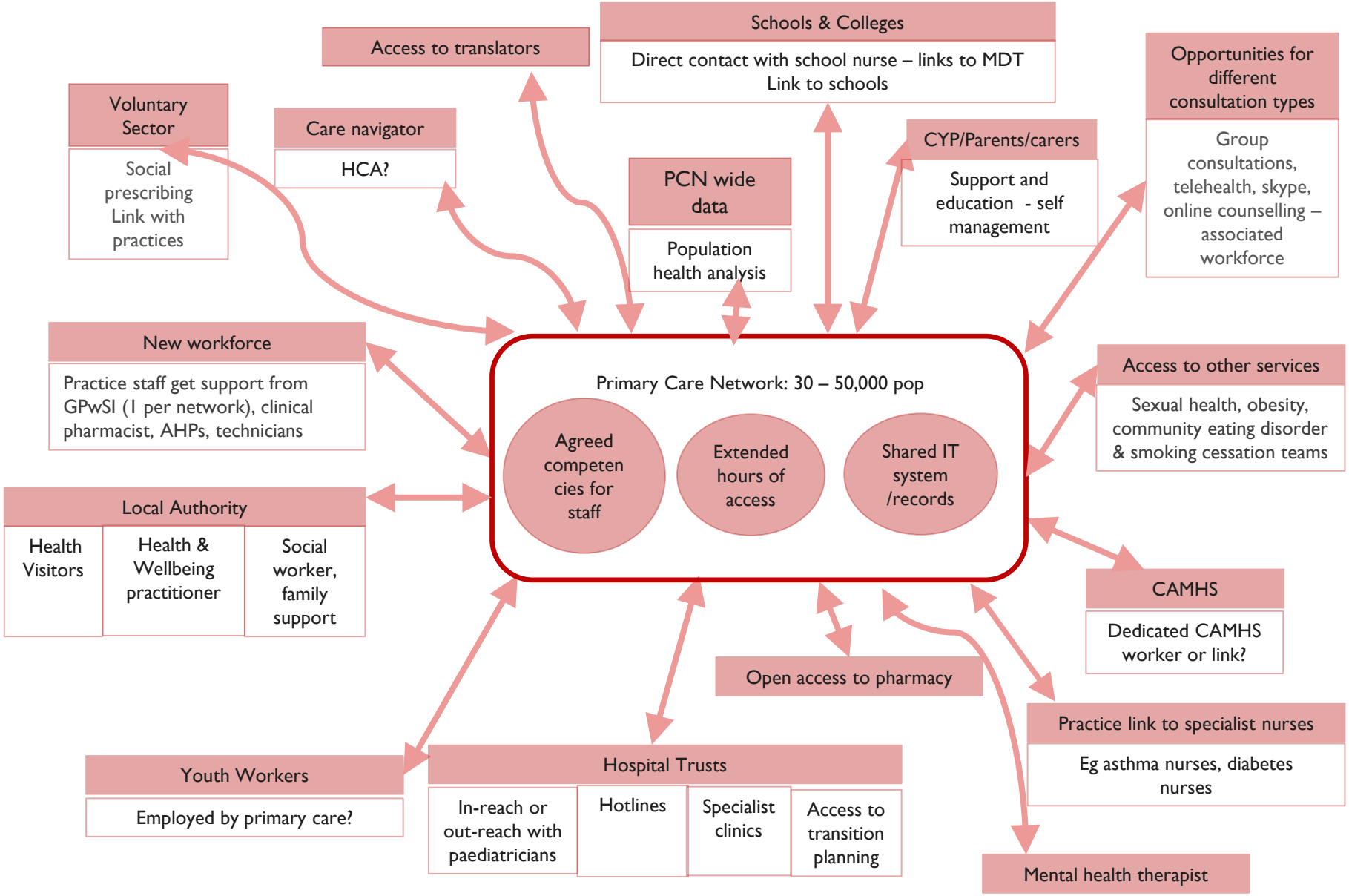
Principles

- Determining the components of the network from the start is key
- New workforce roles are needed to ensure the right people treat the patient at the right time
- Competencies for roles needs to be consistent
- Support delivery and training needs of staff
- Clear local offer (details of everything, including social prescribing, that is available for CYP locally) that GPs and others can access easily
- Higher capacity to deal with CYP at a lower threshold, especially for mental health issues
- Consistent process and message across the area
- Allow reciprocity across boundaries so that CYP are not limited to accessing care within their locality
- How to create a CYP-friendly environment should be considered

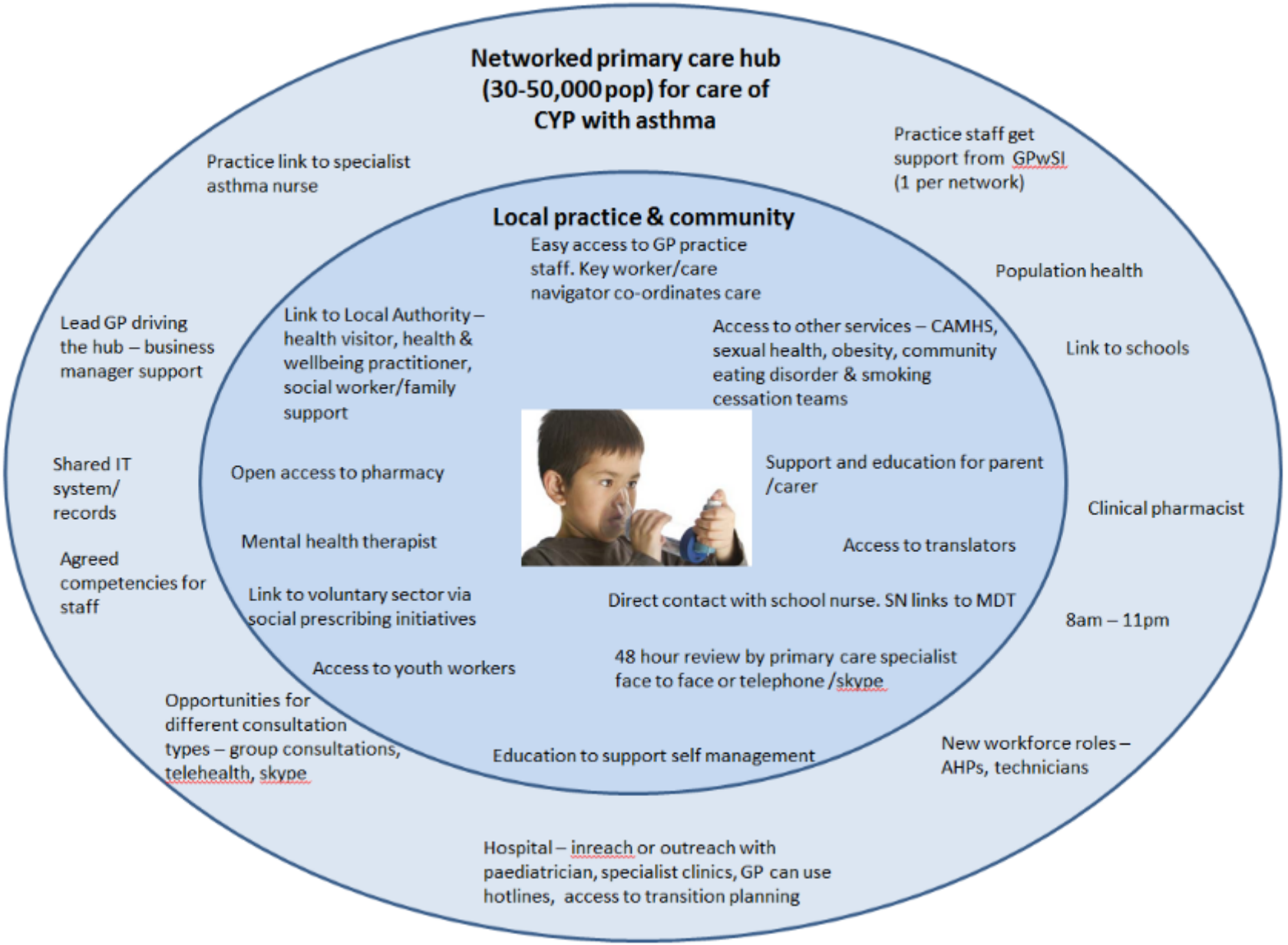
What does this really mean for CYP?

- CYP to be seen at a time that suits them and their families – no more missing school
- CYP and parents to have the tools for self care leading to less appointments and more empowerment of the patient
- Patient to be at the centre of the services rather than going to different services when it suits them
- Less chance of people “slipping through the net” as key worker/care navigators co-ordinate patients
- More skilled staff working together leading to motivated staff with improved job satisfaction
- More opportunities for social prescribing
- Improved and easier to facilitate links to voluntary sector, local authorities, sexual health and mental health services
- With shared care record, less need for patient to repeat their story

Linkages


Schools & Colleges
Direct contact with school nurse – links to MDT
Link to schools
Access to translators
Voluntary Sector
Social prescribing
Link with practices
Care navigator
HCA?
PCN wide data
Population health analysis
CYP/Parents/carers
Support and education - self management
Opportunities for different consultation types
Group consultations, telehealth, skype, online counselling – associated workforce
New workforce
Practice staff get support from GPwSI (1 per network), clinical pharmacist, AHPs, technicians
Primary Care Network: 30 – 50,000 pop
Agreed competencies for staff
Extended hours of access
Shared IT system /records
Access to other services
Sexual health, obesity, community eating disorder & smoking cessation teams
Local Authority
Health Visitors
Health & Wellbeing practitioner
Social worker, family support
CAMHS
Dedicated CAMHS worker or link?
Open access to pharmacy
Practice link to specialist nurses
Eg asthma nurses, diabetes nurses
Youth Workers
Employed by primary care?
Hospital Trusts
In-reach or out-reach with paediatricians
Hotlines
Specialist clinics
Access to transition planning
Mental health therapist

Draft model: PCN for CYP with asthma



02

Learning from emerging PCNs: perspective from Camden

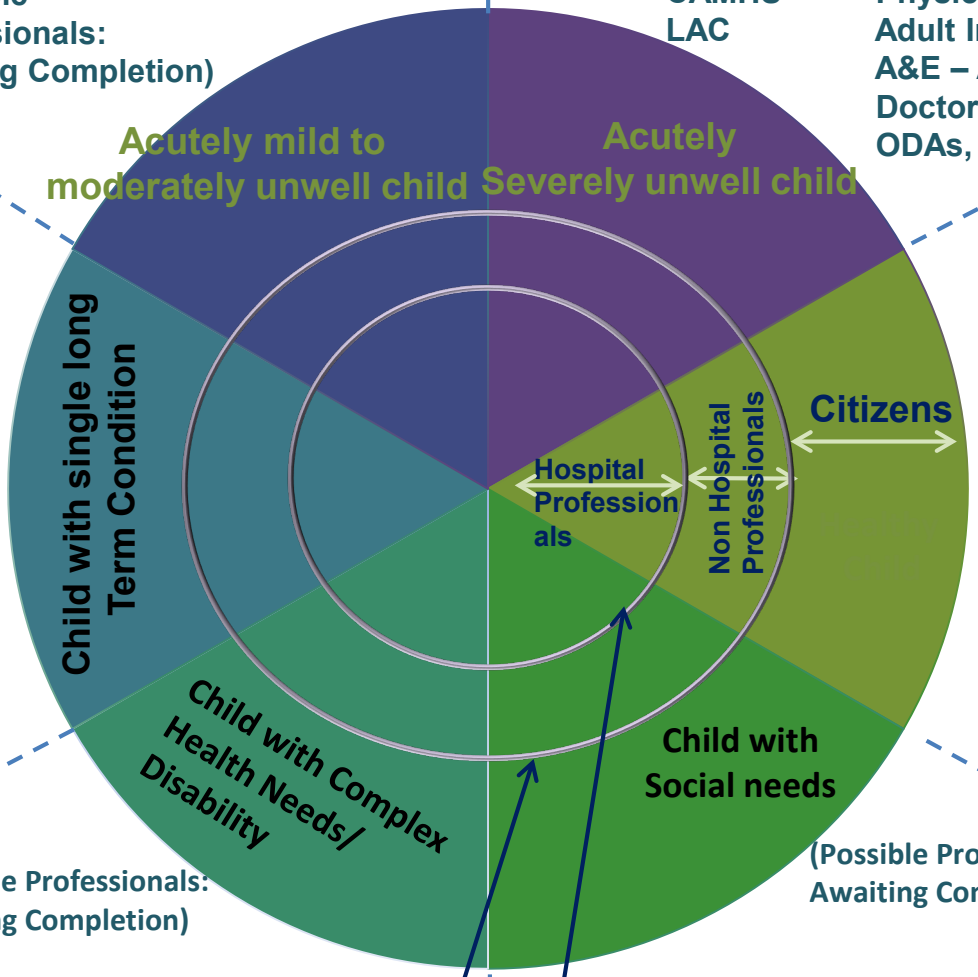
Oliver Anglin, CYP Clinical Lead for Camden and NCL

Slide reproduced with thanks to Mando Watson, St Mary's and CC4C

Workforce defined by skills not titles

(Possible Professionals: Awaiting Completion)

Possible Professionals:
ANPs
PICU/NICU
CAMHS
LAC
Physiotherapy
Respiratory Technicians
Physicians Associates
Adult Intensive Care
A&E – Adult/Paeds } Nurses, Doctors etc.
ODAs, pharmacy



Possible Professionals:

Citizens
CNSs
GPs
Practice Nurses
Paramedics
CAMHS
Health Care Scientists
Therapists – Speech
– Occ
Therapy
– Physio

(Possible Professionals: Awaiting Completion)

(Possible Professionals: Awaiting Completion)

(Possible Professionals: Awaiting Completion)

Workforce development plan will be different depending on the local landscape

Constructed Interface e.g. Practice Champion

Constructed Interface e.g. Specialist Outreach Clinic & MDT

Sense of belonging…

…& Fluidity

03

Group session

Questions:

Group 1

- What could you take from this locally?
- What do you need to do differently to deliver an increasingly integrated approach to CYP care?

Group 2

- List people that you would involve within your area/borough (interest vs. influence)
- How can we use our workforce differently to achieve our aims?

All

- How are you going to start?

04

Next steps and close

g.herskovits@nhs.net
christine.kirkpatrick@nhs.net
oliveranglin@nhs.net

Breakout session 5 – The Blue Hall

Developing Paediatric Ambulatory Care at Home

This interactive session will explore how to make the clinical and business case for change, including the drivers, barriers and challenges to leading transformation, and the achievements of multi-disciplinary working, developing community capacity and capability, and building professional and public confidence, resulting in improved satisfaction and resilience for CYP and their families.

Dr Omowunmi Akindolie,
Consultant in Ambulatory Paediatrics,
King's College Hospital NHS Foundation Trust

Aims

This interactive session will explore:

- how to make the clinical and business case for change
- drivers, barriers and challenges to leading transformation
- achievements of multi-disciplinary working
- developing community capacity and capability
- building professional and public confidence
- improving satisfaction and resilience for CYP and their families

Developing Paediatric Ambulatory Care at Home
The Camberwell Story

Dr Mo Akindolie
Consultant in Ambulatory Paediatrics

Healthy London Partnership Strategic Leaders Transformation Forum
26th June 2019

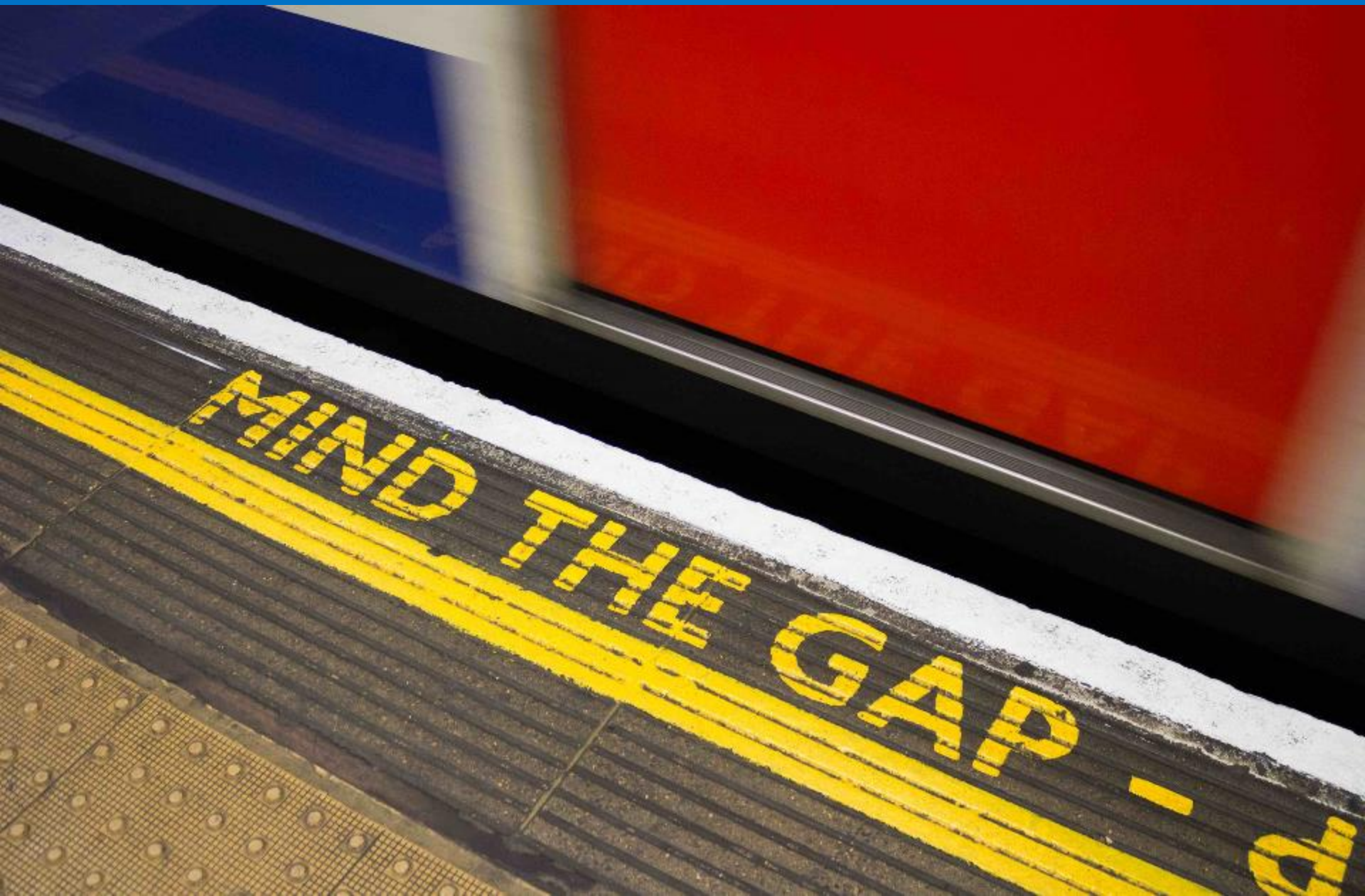
Overview

- Patient story
- Service development journey
- Spotlight on other services

Ambulatory Paediatrics-Overall Ethos

- Optimise care delivered to local children and families
- Develop professional relationships to integrate the primary-secondary care interface
- Deliver care as close to home as possible


Price
Quality
Speed
Accuracy


MIND THE GAP

Paediatric Ambulatory Service

- GP telephone line

- Rapid access clinics

- Short stay unit

- Hospital at home

Plan A

- Collaborate with PCTs for commissioned service
- Expand existing CCNT
- Deliver acute care in the home

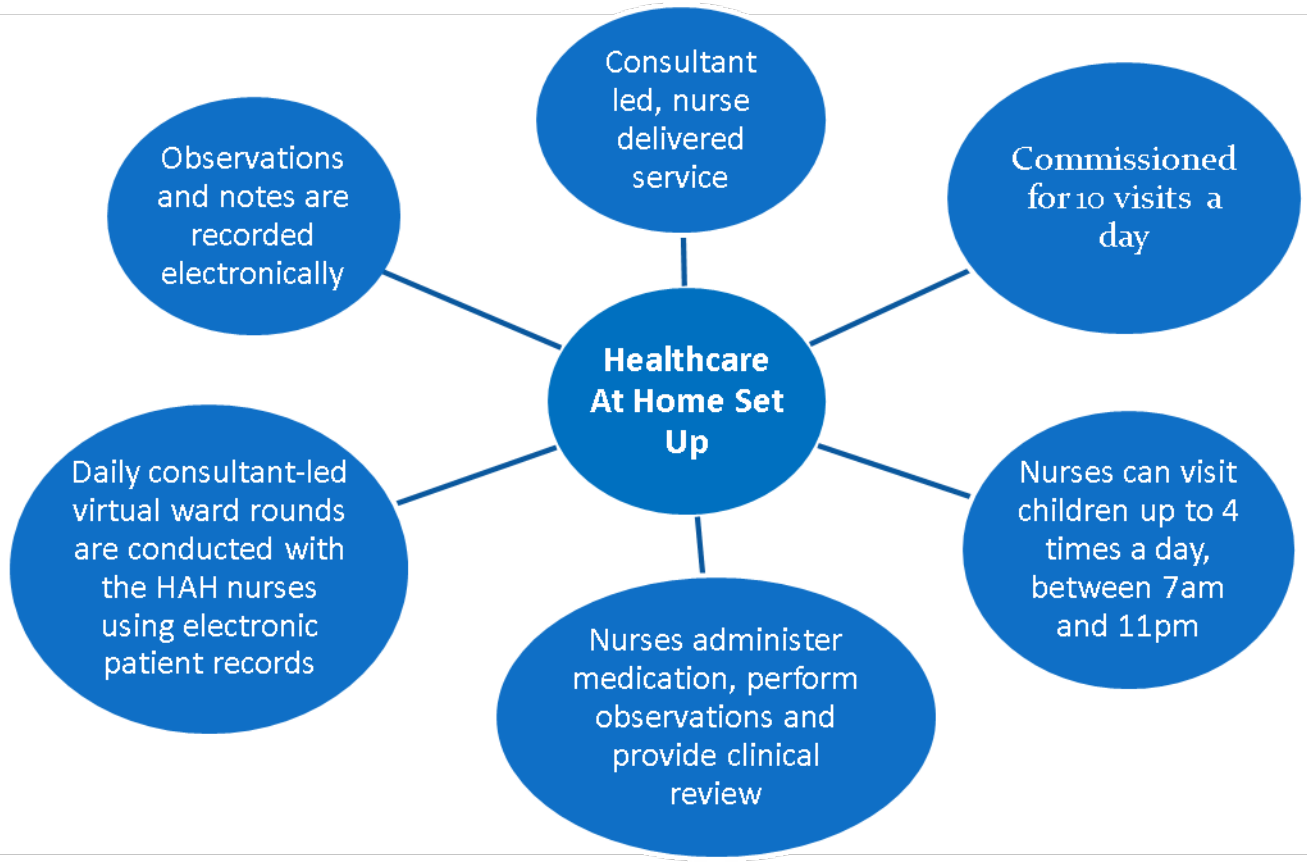
Context

- 28% increase in emergency attendances
- 52% increase in hospital admissions for children < 1 yr
- Treat and transfer of 2-3 children per day

Plan B

- Point of prevalence study
- Collaboration with a private provider Healthcare at Home
- Business case submitted
- Implemented within 6 months

Hospital at Home Service Overview



Evaluation

- 33% reduction in PED breaches
- 37% reduction in elective surgical cancellations
- 98% reduction in treat and transfer rate
- Net saving of 841 inpatient bed days- cost saving of £336,400
- 100% of patients would recommend to their friends and family

"I've learned that people may forget what you said, people may forget what you did, but people will never forget how you made them feel."

Maya Angelou

Patient Experience

"HAH was perfect for us. We were much more comfortable at home. We were able to sleep in our own beds and cuddle up on our own sofa, and my son was much happier. The nurses were lovely too!"

"This has been a fantastic service. My daughter was able to recover much more quickly surrounded by her family in a peaceful environment. All the Nurses were fantastic at their job and had a very good way of communicating with children (and parents)"

"Flexible… went above the call of duty.. Wonderful team of nurses"

Challenges

- Resistance from some specialty teams
- Project management resource
- Rapid rate of implementation
- Staff safety
- Equity of access

Enablers

- Engaged stakeholders
- Supportive local primary care teams
- Enthusiastic and flexible staff
- Robust IT systems
- Darzi fellow for evaluation
- Positive impact immediately evident

Whittington Hospital at Home

- Commissioner involvement from the outset
- Expansion of existing CCNT
- Partnership medical and nursing leadership model
- Islington CCG funded evaluation

Learning Points

- Patient participation
- Co production development model
- Always have a Plan B
- Shape service for local context
- Embed high quality data collection
- Enjoy the process
- Celebrate successes small and large

Further Resources

- https://www.healthylondon.org/resource/acutely-unwell-children-young-people-compendium/
- http://www.londonsenate.nhs.uk/wp-content/uploads/2017/01/Hospital-@-Home-UCLP-evaluation.pdf
- https://www.rcpch.ac.uk/resources/facing-future-standards-paediatric-care/best-practice-examples

Thank You

Group activity

- How are you developing ambulatory and hospital at home services for your locality?
- What are your greatest achievements?
- What have been the challenges and how are you working to overcome these?
- What are the opportunities to further develop services?

Healthy London Partnership

Thank you

J9

CONSULTING & EXECUTIVE

COACHING

RELEASING BRILLIANCE

Breakout session 6 – The Blue Hall

North and South Thames Paediatric Networks - what are they doing now and planning for the future together

This session will focus on the role of the Operational Delivery Networks (ODNs) and provide an update on their current key work. It will provide the opportunity to discuss the main priorities and issues for both providers and commissioners, assess what is working well and identify where improvement is needed, to ensure that there is joint planning for the future specialist healthcare for children.

Victoria Santer, North Thames Paediatric Network
Sally Watts, South Thames Paediatric Network

Healthy London Partnership Children and Young People's Strategic Leaders Transformation Forum

Wednesday, 26 June 2019

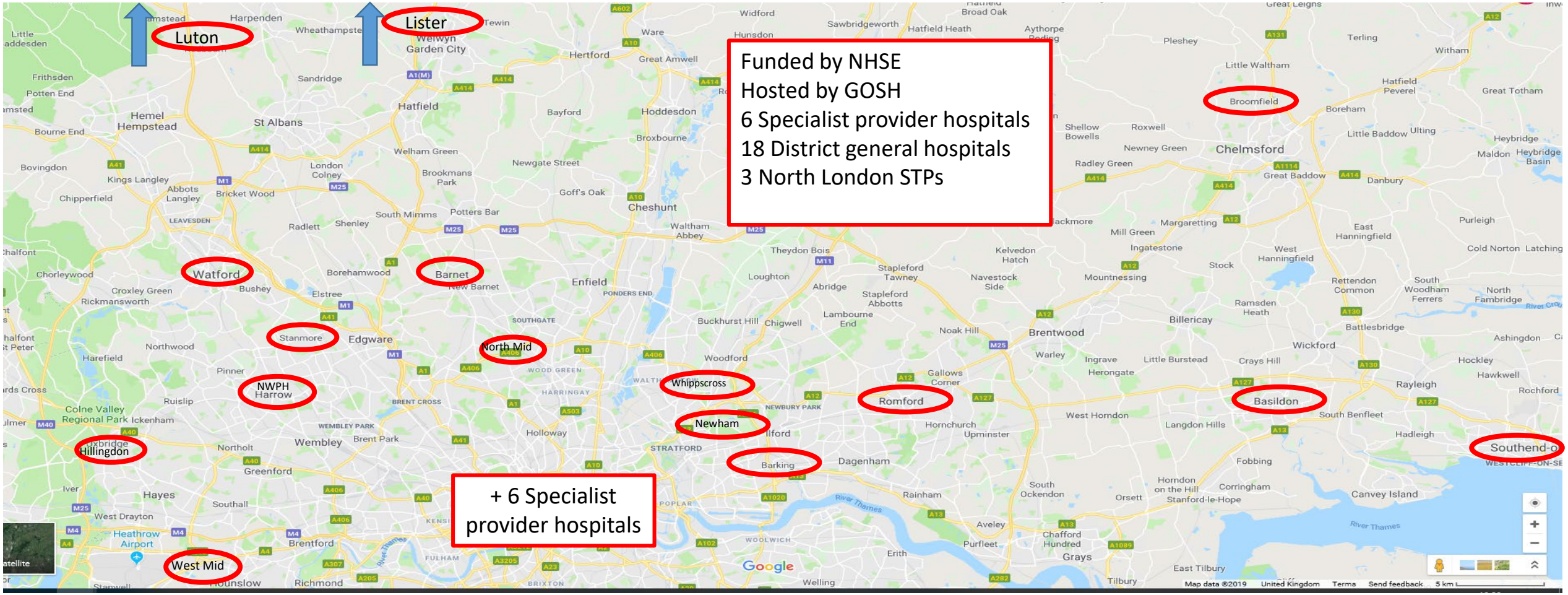
Specialist Paediatric Networks -planning for the future together

North Thames Paediatric Network
for specialist paediatric services

Network Manager: Victoria Santer
Clinical Directors: Dr Hermione Lyall / Mamta Vaidya
england.ntpn@nhs.net

South Thames Paediatric Network

Locum Network Manager: Sally Watts
Network Director : Dr Marilyn McDougall
england.stpn@nhs.net



North Thames Paediatric Network

for specialist paediatric services

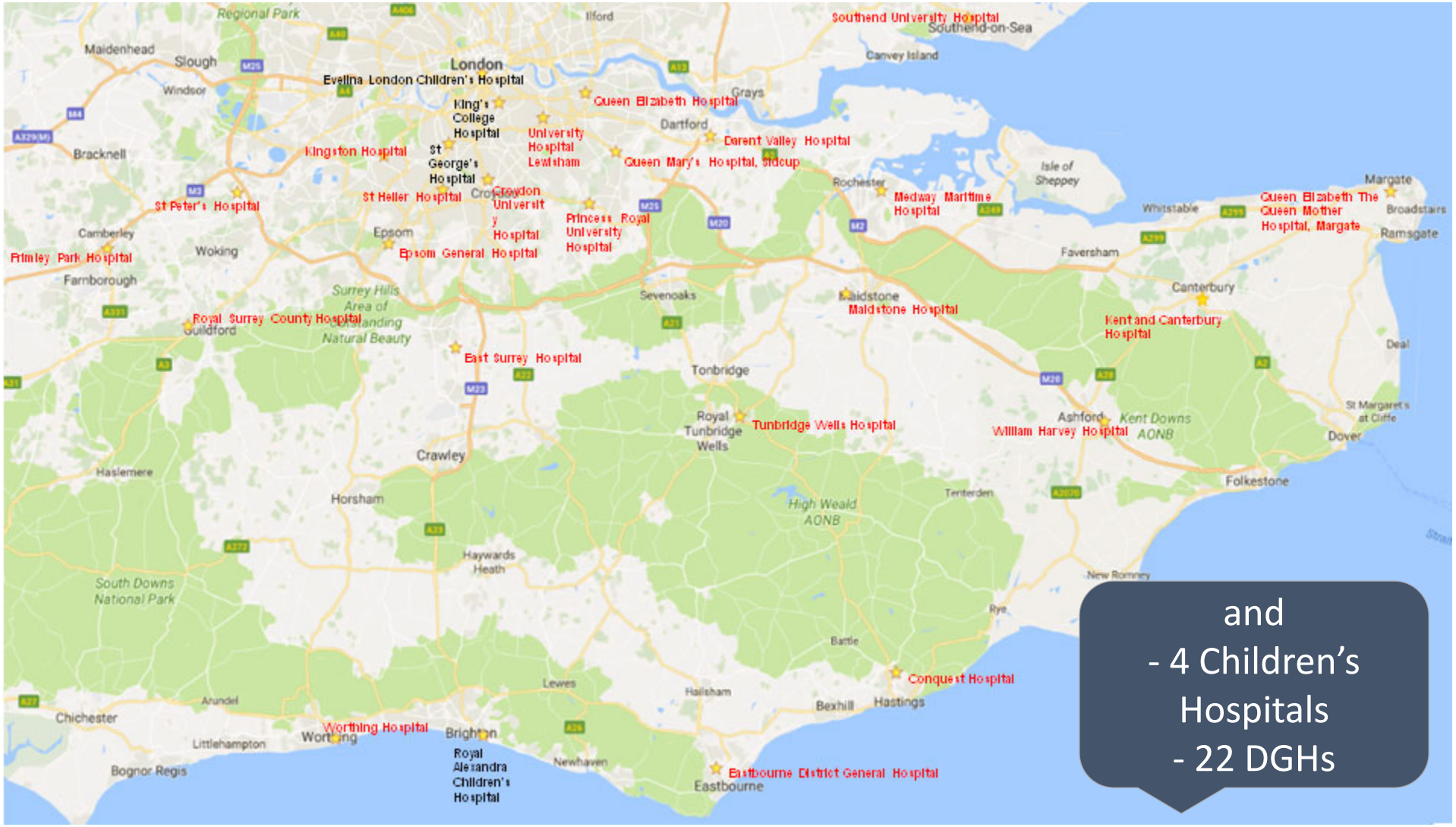
Specialist provider hospitals

→

Royal Brompton
St Mary's (ICHT)
Chelsea & West

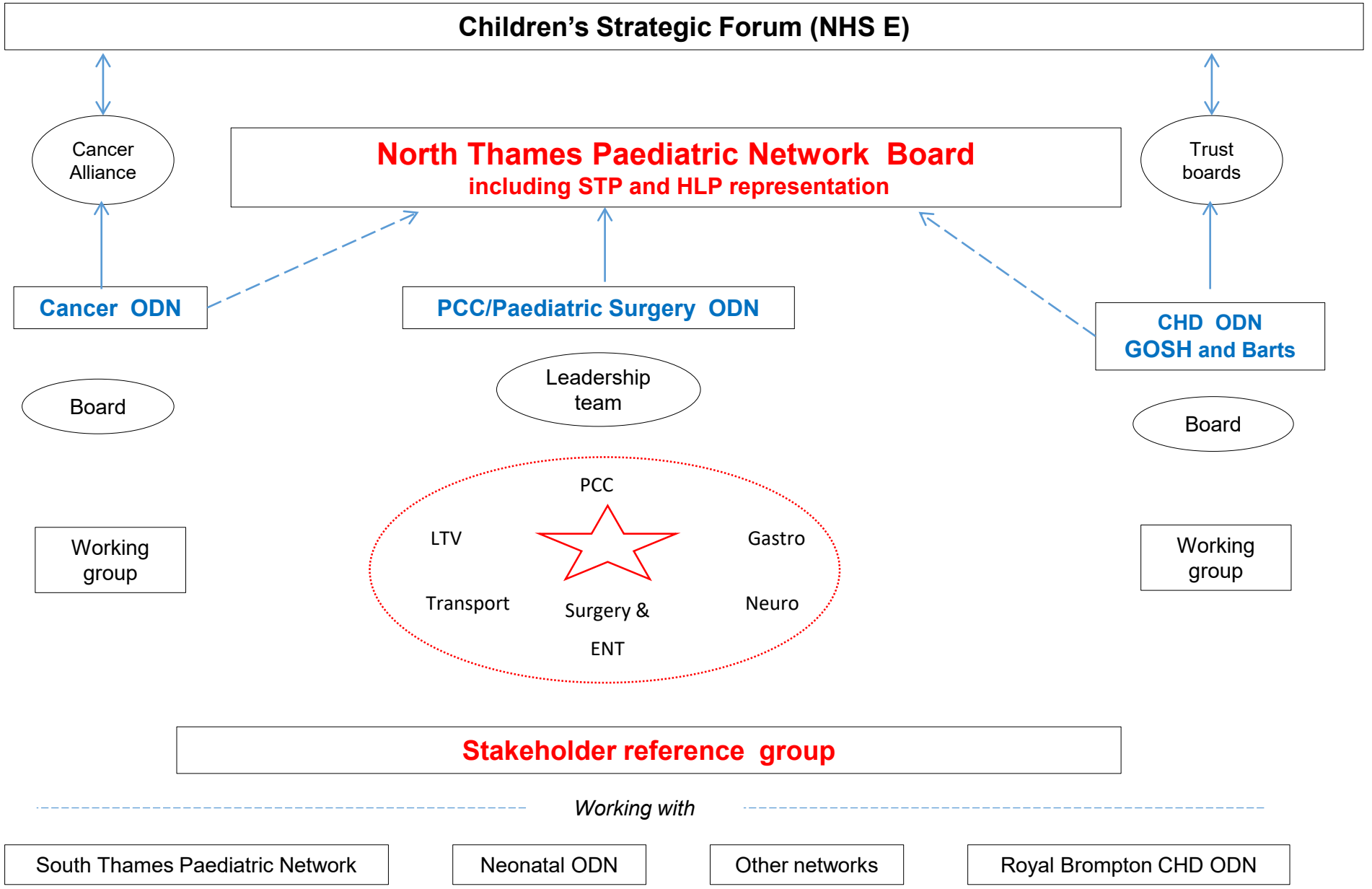
Royal London
GOSH
UCLH

South Thames Network covers 5 STPs



and
- 4 Children's Hospitals
- 22 DGHs

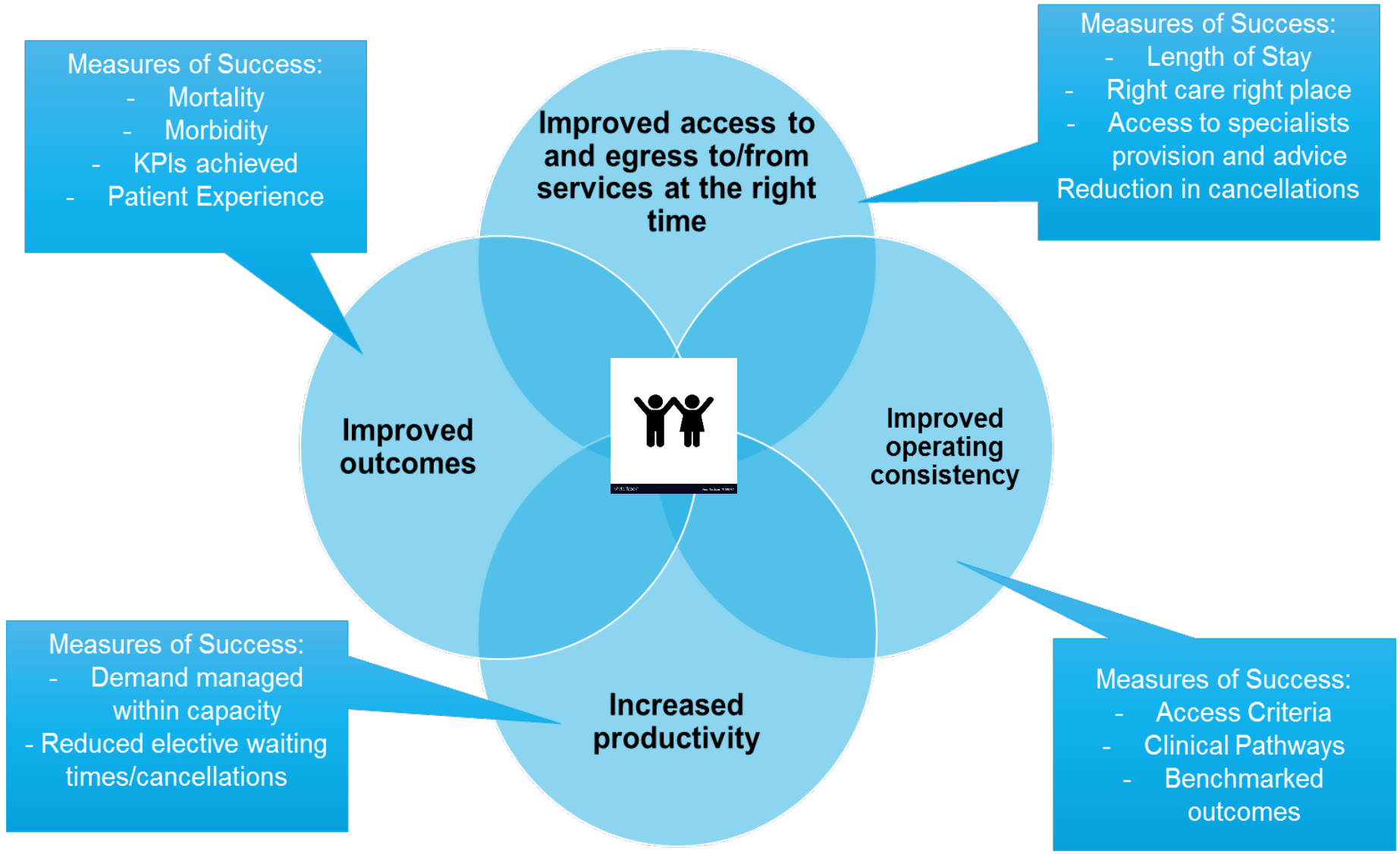
North Thames Paediatric Network (similar for South Thames Paediatric Network)



Overall aims of a regional paediatric specialist network

- Provide a whole-system view of the change required
- Drive clinically led improvements in specialist care
- Develop reliable and responsive pathways
- Improve outcomes and quality of patient care
- Facilitate standardisation of agreed pathways to provide efficiency and effectiveness
- Share learning across partners and both networks
- Improve transfer of care
- Provide value for money/economic healthcare
- Work across organisational boundaries
- Consider wider aspects e.g. Education
- Develop digital solutions

Indicators of success and how these are measured should be agreed at the start of the network development process



The five stages of ODN development

NHS England

1 Kicking off the network

- What geographical area will the ODN cover?
- Who are the key stakeholders?
- Who will lead and manage the ODN's development and operations?
- What key parameters (e.g. criteria for acuity levels) should you first align on?

2 Understanding the local case for change

- What are demand and capacity levels now?
- What will they be in the future?
- Do providers in your ODN area see variation in e.g. workforce skill level, quality and access to care?
- Are these variations warranted?
- What are the area's strengths and opportunities?
- What are the economic considerations?

3 Developing local solutions

- What challenges and opportunities in the case for change will the ODN address?
- What are the economic considerations?
- How do you adopt the model of care locally?

4 Operational & Clinical Governance

- What is the role of the ODN in overseeing quality and activity across the network?
- How can the ODN ensure alignment with national governance structures?
- How can patient flow be facilitated via governance structures, e.g. Transition

- What are the ODN approaches to ethics & equalities?

5 Measure impact and improve

- Where can metrics for data measuring the performance of the network be found?
- How will the network monitor continuous improvement?

What makes an ODN succeed?

NHS England

Case studies show four factors have a particular impact on a network's success. They explain why the recommended process is both consultative and goal-driven, and should help you plan how to communicate and work with stakeholders. A separate document with a wide variety of case studies is available.

Commitment and buy-in	▪ Communicate and engage with **commissioners, clinicians, providers and all other key stakeholders** to win their commitment and buy-in – Well-established networks are often built on **existing working relationships** – These frequently **grow out of collaborations on training and education**
Defined strategy	▪ Have **clearly-defined strategy**, goals, and vision from beginning to end to focus the network on relevant action ▪ Ensure there is **clarity over the contribution each stakeholder brings** to the successful delivery of this strategy, including how this will be measured
Investment in clinical leadership	▪ **Clinical leaders' engagement is crucial:** appoint senior clinicians to spearhead development and running of the ODN ▪ Their input **gives providers confidence** in the ODN's design and ensures the design **targets frontline priorities**
Independence	▪ **Make sure the process is both independent and perceived to be independent** of individual member organisations to keep all members engaged and accountable ▪ Ensure ODNs and providers involved in them are **supported to have a priority focus on the needs of the local and national system**.

Benefits for patient and family

Children benefit by having

- •Reduced duplication and repetition in procedures and advice
- • Only have to attend one (maximum two) specialist centres
- • Increased confidence in local clinicians
- • Increased access to specialist care locally
- • Reduced variation in care across the region
- •Reduced travel and time off school / work

Hospitals and Community can provide

- Improved communication with specialist centres for DGHs
- Improved transfer to specialist centres and discharge home
- Specialist centres no longer competing
- Networked clinicians sharing learning and best practice
- Appropriately commissioned service and appropriate income for activity

NTPN – Current priorities	STPN – Current Priorities
24/7 rapid access to specialist advice: one phone call (consultant level). Backed up by Telemedicine / virtual MDTs.	Consolidation of Critical Care Education- formal and hands on experience
Simplified bed finding system - one phone call	Electronic referral system
Paediatric Critical Care, including long-term ventilation	**LTV standardisation of care and avoiding delayed discharge**
General paediatric surgery: capacity and capability within DGHs	Surgery in Children – emergency pathways
Gastroenterology : IBD pathway	Gastroenterology – high cost drugs and standardisation of care
Neurology: stroke pathway ; developmental delay guidelines; scoping neuroimaging (CT and MRI) capacity and expertise ;	Out of hours ENT emergency care
Infection Control barriers to repatriation of children: network guidance (being developed)	**Infection Control barriers to repatriation of children: network guidance (being developed)**
Non-critical care transport	Updating DGH demographics and data collection
Business Intelligence; to inform planning	Digital solution for live mapping of bed availability

Any questions?

Break out session

1. Divide into small groups – about 6 people per group
2. Each group to look at one scenario
3. Discuss
    - What are the priorities from your viewpoint?
    - What issues would be relevant to your role/specialty?
    - What works work for you?
    - What works less well?
    - What do you consider is the role of the Networks?
    - How would you like to communicate with the Networks?
4. Feedback one key point for each of the above questions per group

Scenario 1

George was born preterm at 29 weeks. He was been diagnosed with a Ventricular Septal Defect and Lung Immaturity and has had a long hospital stay with many complications. He is now stable, requiring non invasive ventilation and the team are planning his discharge home.

Scenario 2

Annie is a 12 year old girl who was diagnosed aged 3 years with developmental delay and mild epilepsy. She presented to her local DGH with abdominal pain and was diagnosed with appendicitis. She underwent surgery at the DGH but required transfer to a tertiary centre due to combined complications of the surgery and her underlying condition.

Feedback

Thank you for your help

Closing summary

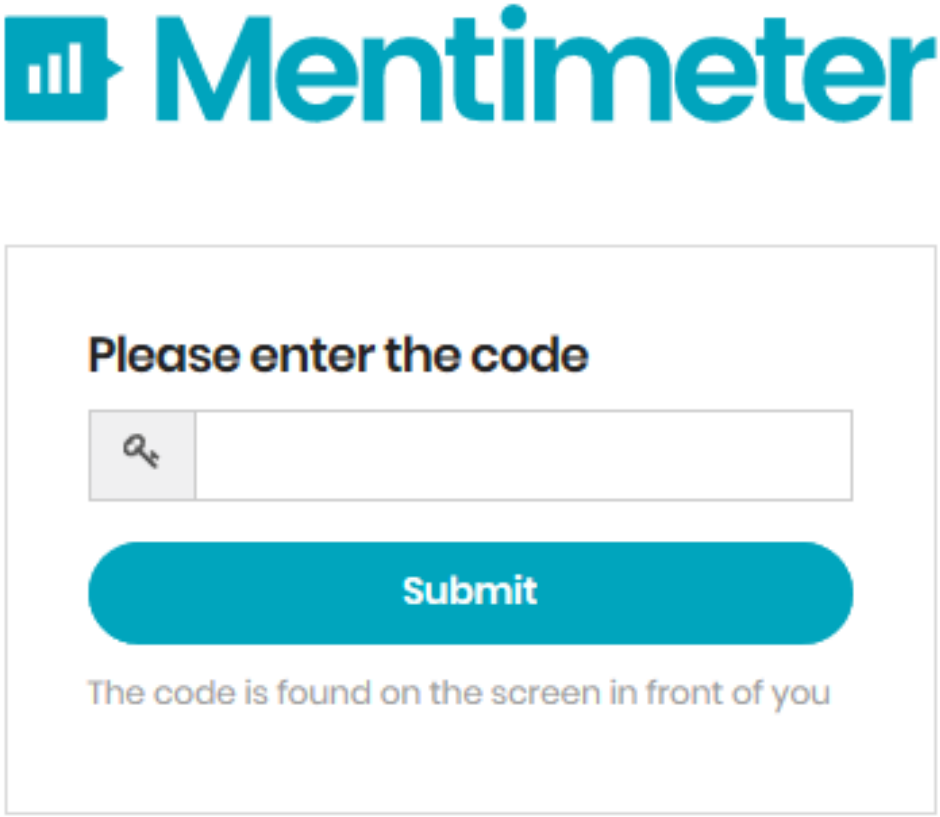
Dr Omowunmi Akindolie,

Clinical Director,

Healthy London Partnership

Mentimeter

www.menti.com



Mentimeter


What one thing will you do you differently in the next month as a result of today?
Mentimeter
workforc
engagement
champion
hold the space
keep going
outcomes not process
creative models
start conversations
focus on mobilisation
engage with others
link with primary care
ed children
patient involvement
leadership 4 school aged
link into pcn discussions
primary care links
network more
champion cyp
collaboration
include dentistry
find my pcns and where th
influence the system
exploring workforce needs
more networking
recognise difficult is ok
continue networking
engage
investigate needs of home
community workforce
work across boundaries
connect with pharmacy
more engagement
oral health focus
27

Healthy London Partnership

Optional networking – please feel free to continue your conversations!

Thank you

J9

CONSULTING & EXECUTIVE

COACHING

RELEASING BRILLIANCE