DELIVERING THE HEALTH THAT CHILDREN DESERVE THROUGH BETTER INTEGRATED CARE

January 28th 2021

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THE CONTEXT

THE SYSTEM ISN'T WORKING FOR CHILDREN

THE PROBLEMS WE ARE ADDRESSING

Many children in the UK suffer from poverty, emotional trauma, mental health issues, and physical health challenges. These problems reinforce each other and require a coordinated approach.

The system isn't working well enough for children. Built-in health inequalities continue to challenge the system, as does unnecessary service usage that drives up the cost.

As a community, we can do better. CYPHP is part of a growing movement that aims to build a better system for children by addressing these systemic challenges.

COMMON BARRIERS

- Children's conditions are not caught early enough
- Disconnect between primary and secondary care, health and children's social care
- Lack of coordinated care close to home
- System structured to deliver reactive, instead of proactive, care to families
- Failure to apply data and knowledge to improve health
- The under-appreciated impact of mental health, emotional trauma, hunger and other issues on children's health.

WHY COULD MANCHESTER BENEFIT FROM THE EVELINA LONDON (CYPHP) FRAMEWORK?

WE ACHIEVE OUTCOMES VIA TARGETED PREVENTATIVE AND HOLISTIC CARE

WE UNDERSTAND THE SOCIAL, PHYSICAL, AND MENTAL HEALTH NEEDS OF CHILDREN IN OUR COMMUNITIES

Our Population Health Management system means we understand the social, physical, and mental health of local children. Knowing more about children's health and lives means we can shift the system to deliver targeted preventive integrated care.

45% of children who have a physical health condition are in contact with social care

Over **a third** of their parents have physical and/or mental health conditions of their own.

Over **a third** of families report insecure housing and more than **10%** have financial difficulties that affect family life

Over **5%** of parents or carers report concerns about being able to provide sufficient food for their children.

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WHAT BENEFITS TO MANCHESTER COULD THE FRAMEWORK BRING?

WE INCREASE ACCESS TO CARE FOR THOSE WHO NEED IT MOST

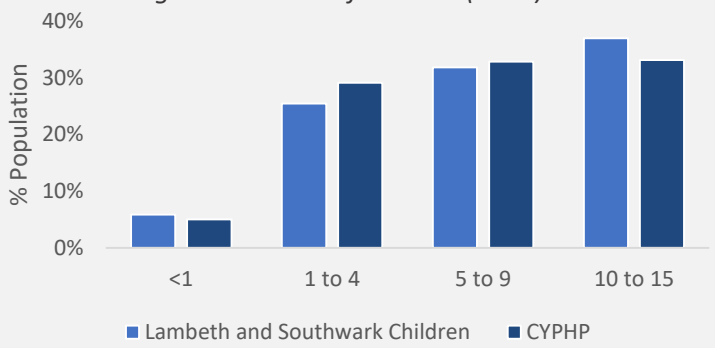
01 Our model delivers population coverage and reach.

We have now **delivered care proactively to children in Lambeth and Southwark** who had previously unmet needs. For example, using our **population health management tools** we have systematically contacted all of Lambeth and Southwark's children who have asthma, delivering proactive care to 40% who needed **early intervention and care** tailored for each child's individual needs.

03 Equity of coverage: we engage actively with adolescents to deliver holistic biopsychosocial care.

The Evelina London (CYPHP) service reaches children approximately **matching the pattern of age distribution.** We are delivering a service that appropriately **reaches adolescents**; an improvement from usual care.

Age distribution of children (2019)

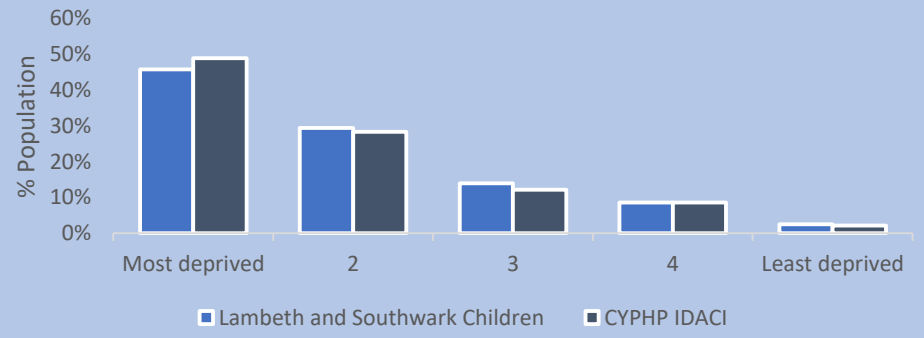


Distribution of age among Evelina London (CYPHP) patients and children living in Lambeth and Southwark

02 We reach children living in deprived conditions to deliver early intervention

The Evelina London (CYPHP) service is accessed by more children from the **most deprived backgrounds**. This mirrors the population demographics of the borough and primary care data – demonstrating that we are delivering an **equitable service. Thus, we are improving equity** compared with usual care which is described by the **Inverse Care Law** (patients most in need are least likely to access care).

Children accessing CYPHP by Income Deprivation Affecting Children Index (IDACI 2019)



Distribution of deprivation among Evelina London (CYPHP) patients and children living in Lambeth and Southwark

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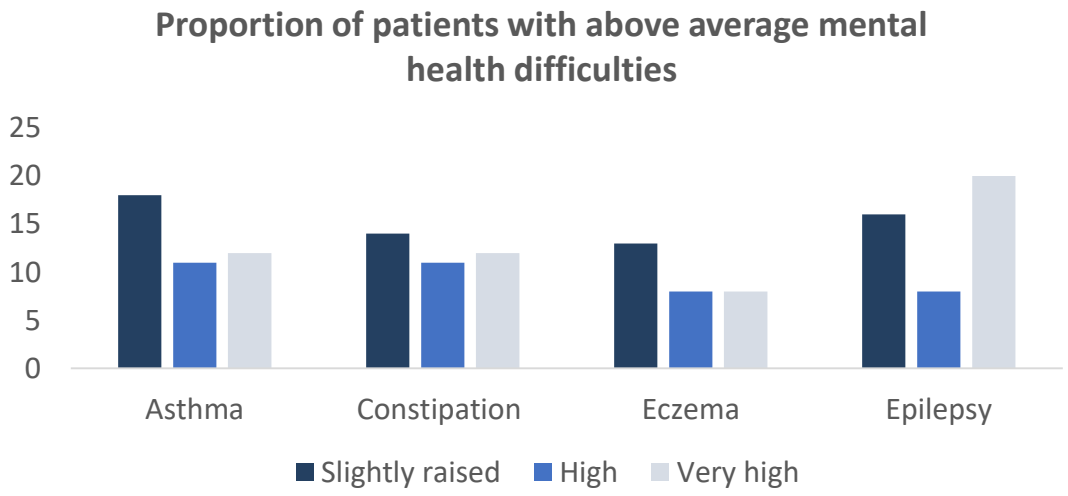
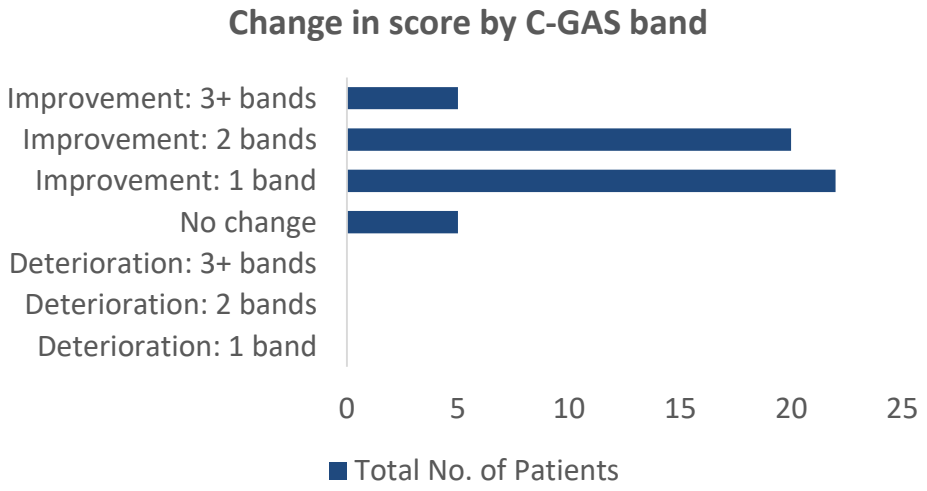
CARE FOR EVERYDAY CONDITIONS IN MANCHESTER WOULD IMPROVE

WE INCREASE ACCESS TO CARE FOR THOSE WHO NEED IT MOST





The Evelina London (CYPHP) model of care delivers significantly improved clinical outcomes and mental health for children with long-term conditions and addresses social determinants too

- At entry to the service, over half of children (52%) with asthma have uncontrolled symptoms score; 65% of children with eczema had moderate or severe symptoms and 66% of children had severe symptoms of constipation as measured using standardised tests.
- Prior to engagement with the CYPHP service these children had already been seen by primary and or hospital based care. This shows that current services are not meeting the needs of children.
- Across conditions there was a **significant improvement in clinical symptoms**: for asthma, severe symptoms reduced from 52% of the population at entry to 28% at exit from the service.
- At entry to the service, 76% of children with eczema have moderate or severe symptoms, reducing to only 22% with moderate symptoms at the time of discharge.
- Similarly, 66% of children with constipation had severe symptoms when they enter the service, but only 10% of children have any clinical need remaining at discharge.

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COST SAVINGS

THE EVELINA LONDON (CYPHP) MODEL OF CARE DELIVERS REDUCTIONS IN ACUTE CARE ACTIVITY

- Early results show we have achieved **urgent activity reductions that offset the cost of the model**, and deliver savings – proportionate to activity.
    - 49 ED attendances per 100 patients seen
    - 45 fewer NEL per 100 patients seen
- Cost neutrality is achieved at approximately 500 patients seen per year, and savings when 30-40% population coverage is achieved for tracer conditions.
- Our model avoids produces savings **double the costs** of the multidisciplinary CYP health team.
- These analyses will be replicated using our definitive cRCT evaluation.

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OUTCOMES: IMPROVED CONFIDENCE AND PATIENT SATISFACTION

BOTH GPs AND PATIENTS HAVE EXPRESSED HIGH LEVELS OF SATISFACTION WITH OUR MODEL

Patient satisfaction with the Evelina London (CYPHP) model of care is high; families particularly value our holistic approach to care.

Very personalised. I could ask lots of questions as there was enough allocated time, didn't feel rushed. Based in local community

The service was) very individual and personal to each individual child. Fantastic knowledge and advice given

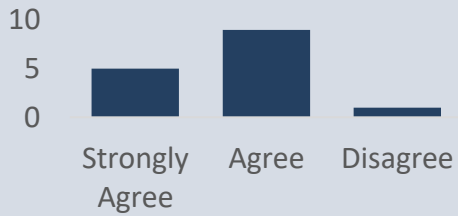
I know that the people at the end of the phone for advice and they call me regularly

I was listened to, given good advice, and made me feel I could come to them when needed

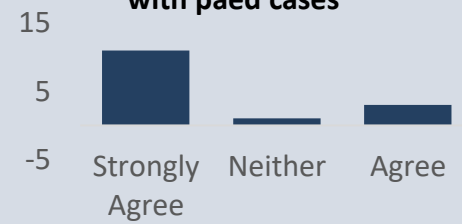
A long enough appointment to explain a complicated history. Seeing a specialist at the local GP rather than at the hospital meant a much nicer environment too

GPs enjoy working as part of Evelina London (CYPHP) services, reporting improved confidence and knowledge.

My paediatric knowledge has improved



Access to a named paediatrician supports my clinical practice with paed cases



Excellent resource. Excellent dialogue with paediatrician in clinic

Quick and near to patient specialist advice. Patients' parents love it

Excellent communication with and advice from our link paediatrician. Reassurance for parents and clinicians

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WHAT GOOD LOOKS LIKE: EVELINA LONDON (CYPHP)

THE BENEFITS OF THE EVELINA LONDON (CYPHP) FRAMEWORK

A SIMPLE AND EFFECTIVE APPROACH TO BRINGING THE BEST CARE TO CHILDREN

A FRAMEWORK FOR ANY CONDITION

The CYPHP model has been designed around asthma, eczema and constipation, however **it can be developed to support any condition**

POPULATION HEALTH APPROACH

We **reduce health inequalities** through using existing data to proactively identify children most in need and provide care early

BETTER CONTROL

We **empower families** to take charge of their own care, and provide more responsive care so parents can self-refer when they are worried

DATA AND RESEARCH DRIVEN

We **make care smarter** through academic evaluation and continuous learning and improvement in real time

CARE CLOSE TO HOME

We **bring together the right specialists** for the child, based on their specific needs, providing care close to home

WHOLE CHILD APPROACH

We **conduct a detailed assessment** of each child's physical, mental, and social wellbeing needs

PROACTIVE OUTREACH

We don't wait for children and their families to come to us – **we go out to them**

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THE EVELINA LONDON (CYPHP) FRAMEWORK

USING DATA TO IMPROVE HEALTH AND REDUCE HEALTH INEQUALITIES

GOAL

To create a model that gives children the quality of health care that they deserve, by focusing support on children who are at a disproportionate disadvantage and embedding data and analytics into clinical delivery through a Learning Health System.

FOCUS

PHYSICAL | MENTAL | SOCIAL

PARTNERS

LAMBETH/SOUTHWARK CCGs, COUNCILS, GPs | KING'S COLLEGE HOSPITAL | EVELINA LONDON | SOUTH LONDON MAUDSLEY | KING'S COLLEGE LONDON

TOOLS

Joined up data | Call-recall case finding | Online portal | Pre-assessment | Shared clinical notes | Prevention | Personalised care

POPULATION HEALTH FRAMEWORK

SEGMENT THE POPULATION: FIND THE CHILDREN WITH NEED → **STRATIFY AND ASSESS RISKS AND ASSETS** → **DESIGN WHOLE CHILD SUPPORT AND CARE** → **DELIVER PERSONALISED CARE** → **EVALUATE, LEARN, IMPROVE**

CARE PATHWAY AND PROCESS

- Decide the target population and percentage coverage target to reach;
- Review data against criteria for early intervention;
- Measure individual and population need;
- Identify children and families for intervention

- Invite families to visit portal;
- Pre-assessment questionnaire;
- Evaluation of need, multi-disciplinary triage process;
- Inclusion of data into database =pre-assessment data, clinical and system level data, research data;
- Send Health Pack to family for supported self-management and prevention;

- Child assessed across mental, physical and social needs;
- Multidisciplinary 'CYP Health Team' working in primary care networks and community settings
- Joined-up management planned via shared interoperable clinical notes;
- Care planned around needs of child and family

- Child provided with holistic care package that includes mental, physical and social;
- Child is supported via an integrated care system that cuts across primary and secondary care;
- MDT nurses and doctors engaged;
- Care delivered locally, in settings that children are familiar with including local GP and school;

- Child progress and outcomes fed into analytics and joined-up data set including NHS and university for continuous improvement and learning;
- Approach and on-going support for family refined based on results and inputs from mental, social and physical support updated to optimise health outcomes;

OUTCOMES

Measurably improved health | **Reduced urgent health care use** | **Reduced health inequalities** | **Improved patient experience** | **Improved quality of care** | **Improved knowledge of population health** | **Cost effective**

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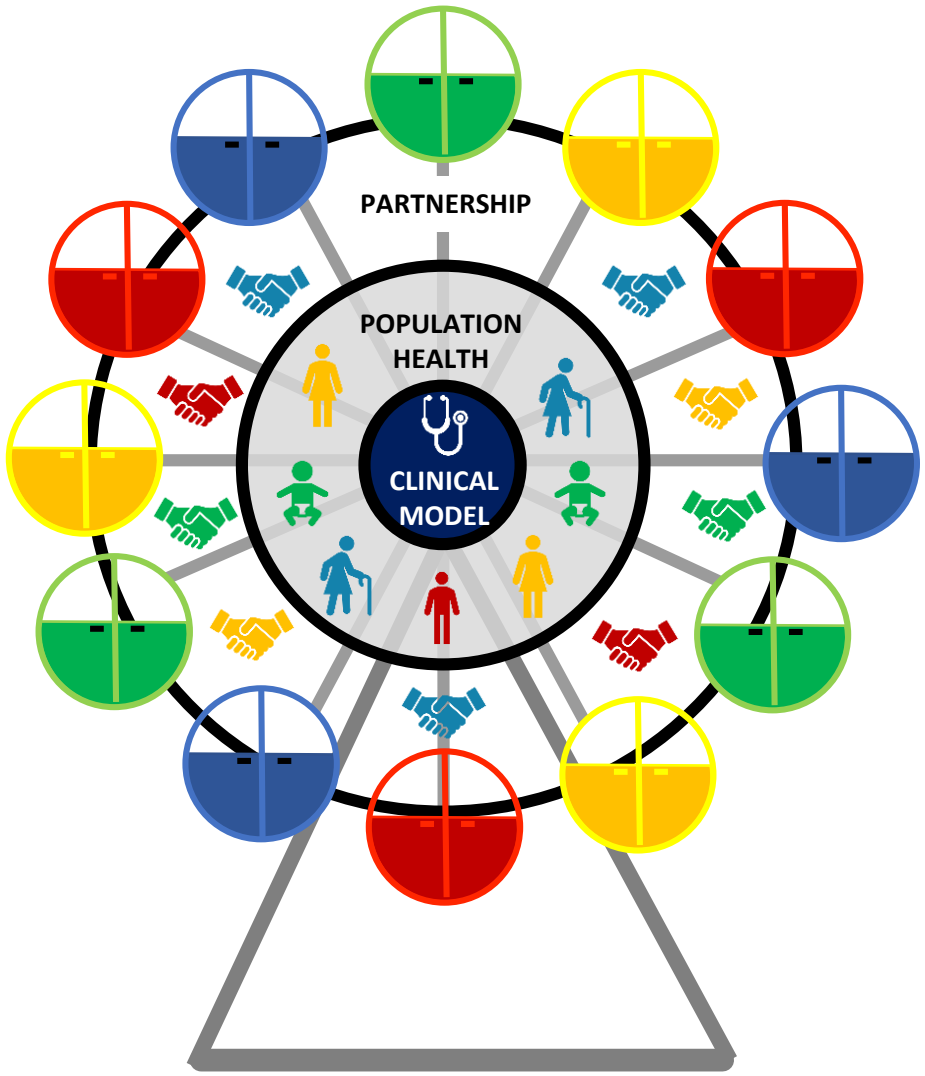
THE CORE COMPONENTS

EMBEDDING AND CHANGING CLINICAL PRACTICE



- **A CLINICAL MODEL:** to deliver care and support to CYP and families by working in partnership with parents/carers and families to provide care and support to meet the individual child's needs
- **A POPULATION HEALTH TEAM:** to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population
- **THE UNIQUE PARTNERSHIP STRUCTURE:** to spread, scale and enable the value proposition of the model and the work we've done on health system strengthening that sits behind it

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THE TOOLS TO MAKE IT A SUCCESS

A NUMBER OF COMPONENTS NEED TO BE IN PLACE IN ORDER TO MAKE THIS FRAMEWORK EFFECTIVE

	Segment population	Stratify assets and risks	Design 'whole child' care	Deliver personalized care
DATA	Linked GP and other data sets	Linked NHS and academic database	Biopsychosocial analysis	Shared clinical notes
TECHNOLOGY	Call-recall	Online portal	Joined-up database (re-ass data, clinical team, research database)	Joined-up database (re-ass data, clinical team, research database)
WORKFORCE	PHM team	PHM team linked to academic child health team	CYP multi-disciplinary team	Triage system across primary and secondary care
TOOL	Early intervention criteria based on system priorities	Pre-assessment questionnaire bespoke for targeted population	Health pack	Approach for personalizing care

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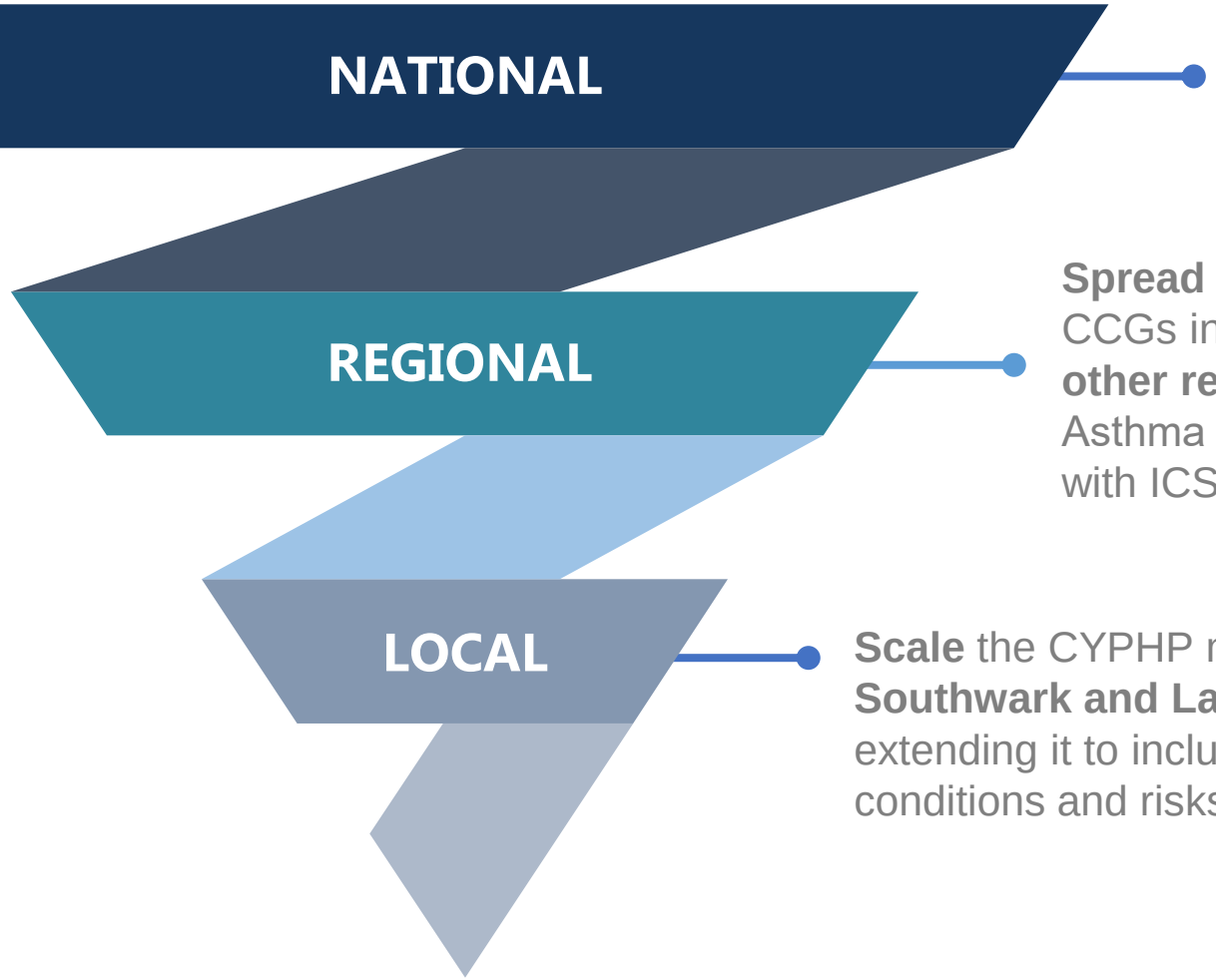
OUR AMBITIONS FOR THE EVELINA LONDON (CYPHP) FRAMEWORK

WE HOPE TO SHARE OUR LEARNING

SHARE

SPREAD

SCALE



Share CYPHP model at a national level by **legitimatizing it as an effective model for PHM delivery.**

Spread the CYPHP model to other CCGs in **Southeast London and other regions.** Focus first on Asthma across the 6 CCG's. Work with ICS on developing PHM

Scale the CYPHP model across **Southwark and Lambeth** by extending it to include care for other conditions and risks.

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BENEFITS OF THE EVELINA LONDON (CYPHP) FRAMEWORK

A FLEXIBLE DATA-DRIVEN APPROACH TO INTEGRATED CARE THAT IMPROVES OUTCOMES FOR PATIENTS AND POPULATION

BETTER FOR CHILDREN AND FAMILIES

Proactive

We don't wait for children and their families to come to us – we go to them, for anticipatory care and early intervention.

Whole child approach

We conduct a detailed pre-assessment of each child's biopsychosocial needs, so we can tailor care according to need – and track outcomes.

BETTER FOR FAMILIES

More control

Parents can self-refer when they feel they need care. Relationships are formed with local team, so telephone support works.

Care close to home

Integrated whole child care delivered in primary care settings, schools, community health, and home.

BETTER FOR THE SYSTEM

Supportive and enabling

Professionals enjoy working in this model of care, it empowers, connects, and improves competence and confidence.

Improves the system

Data and research-driven makes care smarter and enables continuous learning.

Population health approach saves money and improves health.

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LEVERAGING THIS MODEL IN GREATER MANCHESTER

WE BELIEVE THAT GREATER MANCHESTER HAS THE RIGHT CULTURE TO ADOPT A FRAMEWORK LIKE CYPHP

AN INNOVATIVE MINDSET

Best practice hub

Greater Manchester is a leader in best practice methodologies, pioneering new ways of working across the NHS workforce, medical research and patient care. This is the mindset required to encourage the provision of new frameworks and models of care.

A TRUE PARTNERSHIP STRUCTURE

Greater Manchester Health and Social Care Partnership

A health and social care partnership

Greater Manchester is an exemplar of a true health and social care partnership. This joined up way of working creates a better and more responsive care system that facilitates more holistic and unified solutions to health and wellbeing issues.

GREATER AUTONOMY AND DECISION MAKING POWER

The devolution system allows Greater Manchester more autonomy and decision-making power in the way they spend their money across the NHS, local government and third sectors. This allows them to direct their funding to health and social approaches that are proven to deliver improved outcomes and more equitable services for patients.

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THANK YOU