



Healthy London Partnership

Improving children and young people's out-of-hospital care

Connecting Care for Children (CC4C), North West London

Started: 2012

Region: North West London – urban; including populations of significant social deprivation

Geography: Urban

Estimated local pop. 0-18 years: 400,000 (eight CCGs)

Aims

To develop a collaborative integrated child health system, placing general practice at its heart and reinforcing the role of the GP

Target patient groups

CC4C is a 'Whole Population' model of care, covering CHILDREN AND YOUNG PEOPLE across 6 segments, including the healthy child, children with complex health needs, vulnerable children with social needs and children with long term conditions.

The service model

Developed with extensive stakeholder consultation and co-design

Three main elements that come together to form 'Child Health General Practice Hubs' (for optimal efficiency, a hub should ideally comprise of three to four practices and serve a population of 20,000 – of which about 4,000 are children):

1. **Specialist outreach** – monthly joint clinics with GPs and hospital-based general paediatricians; together with multi-disciplinary team (MDT) meetings held in GP practices. Removes need for extensive hospital based follow-up
2. **Open access** – primary care clinicians are provided with prompt access via telephone hotline to paediatricians for advice/support; GPs provide ready access to their patients/families. Secure line for email advice allowing GPs to receive responses within 24 hours. Same day telephone appointments for CHILDREN AND YOUNG PEOPLE with GP or senior practice nurse and same day face to face appointments if required
3. **Public and patient involvement** – comprising education, empowerment and the development of 'Practice Champions' (volunteers from the GP practice population) to provide peer-support, encourage self-management, and support co-design of services

Opening times

Fully connected into a 24/7 hospital-based service at St Mary's

Staffing

Consultant General Paediatrician led, with input from the wide range of professionals the service connects.

Who can refer

Any health professional with concerns about a child

Who is accountable for patients?

The professional asking the question / bringing the case to an MDT / leading the discussion retains accountability. A small proportion of patients are physically seen by a paediatrician alongside a GP and here the accountability lies with the consultant paediatrician.

Resources

Utilises existing resources in GP practices and children's centres / community centres (for learning activities).

Funding organisation

- Health Education North West London
- West London CCG
- NHS London Regional Innovation Funding (in 2012/13)
- Imperial college Healthcare NHS Trust

Level of patient/family involvement

The whole programme originated from children, young people, parents and carers coming together in a series of co-design events to design and plan this integrated child health system

Level of integration in the system

Vertical – linking up GP and primary care, with secondary care and tertiary sub-specialty services

Horizontal – linking up the Child Health GP Hubs with a wide range of professionals from community services, mental health, schools, HV and social care

Population – using a whole population segmentation model to cover all children and young people within a hub's registered population; this enables professionals to take a longitudinal (ie life course), preventative approach to supporting care. An example of this would be specific hub work in increase the percentage of children with asthma who are on asthma management plans.

Evaluation

- Currently 24 practices forming 9 hubs over 4 CCGs (West London, Central London, Hammersmith & Fulham and Ealing)
- 3 hubs were evaluated over the period of a year in the above paper, published in Archives of Disease in Childhood
- MDT meetings – in 59% of cases discussed, the referring community-based professional was given advice that enabled continued care in primary care; 21% were sent to the paediatric outreach clinic for an appointment within next month; in 20% of cases, the professional discussing the case was asked to refer the patient to a specific named health professional (e.g. hospital specialty paediatricians, community dieticians, physiotherapists)
- Joint Clinics – 126 patients were seen in 24 outreach clinics. DNA rates were <5% (compared >15% for hospital out-patient clinics)
- Analysis of HES (hospital episode statistics) data – In hub 1 they observed a 39% reduction in new patient hospital appointments; a *further* 42% of appointments were shifted from hospital to GP; in addition there was a 19% decrease in sub-specialty new patient appointments, a 17% reduction in paediatric admissions and a 22% decrease in ED attendances
- Patient experience – very positive; 100% of respondents reported that they would recommend the service to friends/family; reported that the atmosphere of the joint clinics was less threatening than a hospital appointment
- Professionals' experience – very positive response to MDTs; strengthened relationships between primary and secondary care. Noted the gain in social capital and the important impact on workforce development.
- Financial – when the programme was set up “break-even economic modelling predicted a 12-hub system would be cost neutral after 2 years and would deliver significant savings from year 3.” An analysis looking back over the last 12-18 months had commenced to take a retrospective view on this modelling.

Challenges, successes, lessons learned and advice

This programme is all about developing connections and relationships across the system. The evaluation to date has shown that there are significant efficiency and quality improvements to be gained from this approach, despite the significant financial disincentives in the system (eg PbR (payment by results), current commissioning approaches). The growing development of the Practice Champions and a more proactive, population-based approach to the way in which the Child Health GP Hubs are run are exciting innovations that we feel will significantly change the way in which healthcare is delivered in the future.

Key lessons

- The value of strong relationships across the system
- The importance of remaining very patient centric in everything we do
- The value of meaningful co-design with children, young people and their families

- How difficult it is to instigate large-scale change with so many financial disincentives in the system
- The strength that can be developed where a model of care reaches out horizontally across to professionals from many different backgrounds

The importance of us starting to move towards a Patient Centred Outcome Measure approach to commissioning and delivering care.

Downloads:

[CC4C - Demonstrating value outcomes and benefits](#)

[BMJ article - Whole population integrated child](#)

[Evaluation - CC4C Child health GP hubs](#)

Notes

CC4C hubs now implemented in four CCGs with coverage of approximately 30, 000 to 40,000 children and young people.

Contact for more information

Dr Mando Watson, Clinical Lead and Dr Bob Klaber, Clinical Lead

Mando.Watson@imperial.nhs.uk; Robert.Klaber@imperial.nhs.uk

07789 941791 (Dr Bob Klaber)

<http://www.cc4c.imperial.nhs.uk/>

