STORIES OF COMMUNITY IMPACT

THE CHILDREN AND YOUNG PEOPLE HEALTH PARTNERSHIP (CYPHP)

CYPHP CASE STUDIES

GIVING CHILDREN THE CARE THEY DESERVE

AN EVELINA LONDON INITIATIVE

MAY 2021

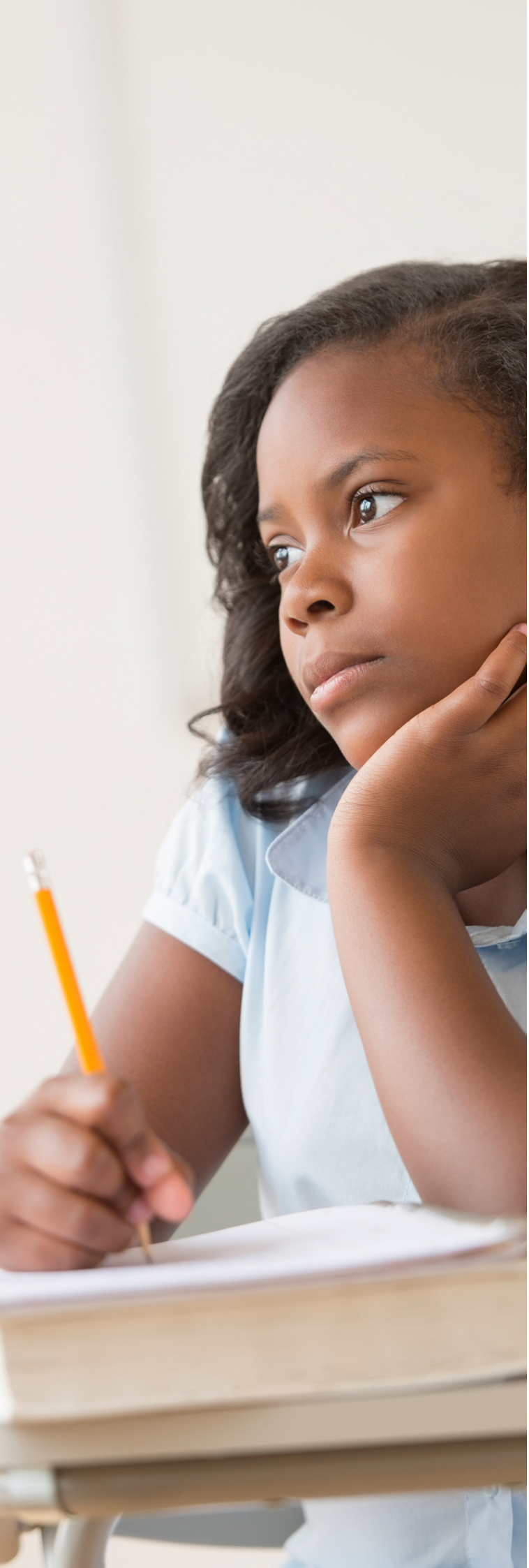
THE CHILDS APPROACH

OUR FIVE-STEP PROCESS TO CARE

The CHILDS Framework is composed of simple process through which children and their families are supported using a 'smart model' of integrated and personalized care:

- **Early support and care –** CYPHP analyses data from GP surgeries to identify children who may benefit from its approach and proactively reaches out to parents. Parents receive a message and/or letter, asking them to visit the CYPHP online portal. Parents may also self-refer - empowering families to take more control of their care;·
- **Health check assessment –** Parents and children complete a health and wellbeing pre-assessment questionnaire on the portal that includes aspects of physical health, mental wellness, social issues and family wellbeing, to identify child needs;·
- **Personalised package of care –** CYPHP uses pre-assessment data and other insights to tailor a package of care, supported by a multi-disciplinary team, for the individual child - including mental health support. The treatment timeline is dependent on needs of the child;·
- **Health pack –** Families receive a health pack relevant to the specific condition of their child. This pack creates and supports health and wellbeing, and signposts local resources;·
- **Child-specific health team support –** CYPHP provides on-going support and care close to home, delivered by a multi-disciplinary team.

Through this unique process CYPHP offers personalised, joined-up and proactive care, which is a game-changer for families tired of having the same conversation with different parts of the NHS system. Connecting academic excellence with clinical practice is at the heart of CYPHP's approach.



OUR IMPACT: REDUCING HEALTH INEQUALITIES

IMPACT OF CYPHP

Data collection and analysis are key to the CYPHP process and our partners' values. We've changed the system and introduced routine measurement of health outcomes and quality. This means we can know how good the care is that CYPHP patients are receiving, and we continuously learn and improve. Based on our work to date, our evidence suggests that CYPHP results in an over 60% improvement in children's health outcomes, and these outcomes are clinically measurable. We believe that this is due to the proactive, holistic and personalised nature of the CYPHP approach.

Since we measure holistic needs, we now also know that 26% of patients with a physical condition also score at high risk of mental health difficulties, with the most common being children with asthma (40%), and constipation (20%). These findings are an example, but we believe speak to the fact that a holistic approach should be embraced more widely.

Most importantly, the CYPHP process has proven that reduced health inequalities can be achieved in a cost-effective way, using a population health management approach and MDT care. For example, with asthma, the CYPHP approach achieves cost neutrality at <500 patients per year. Since there are over 8000 children with asthma in our local area, the service quickly delivers value.

For integrated general child health, we have witnessed a 14% reduction in ED, 7% reduction in NEL. The CYPHP approach achieves an overall reduction in service use, with nearly 50% of non-elective admissions and ED attendances avoided per 100 in children with longer-term conditions, as well as a 13% reduction in emergency department contacts and 7% reduction in emergency hospital admissions.

MINA'S STORY

MINA'S HEALTH HISTORY

Mina was born in the UK, after her parents immigrated from Poland. She has eczema, constipation, severe allergies and uncontrolled asthma. Her uncontrolled asthma has led to a number of hospital admissions. Mina's parents are concerned that her emotional reactions can be very extreme - sometimes continuing for hours. Mina's emotional reactions can interfere with daily routines. Mina's school attendance is a concern, She likes learning but has spoken to her teacher about feeling 'bad inside.'

COMPREHENSIVE ASSESSMENT

CYPHP's nurses meet with Mina and her parents and seek further information from school to inform an assessment of Mina's mental health and wellbeing. The patterns of strengths and concerns emerges.

LIAISON WITH ALL PROFESSIONALS

CYPHP's team organises a review of Mina's health needs in her local CYPHP clinic. A care plan, taking into account Mina's emotional wellbeing, is shared with her family/GP.

With consent, strategies to identify and communicate about her worries are shared with Mina's school. Her teacher and mina begin 15 minute 'catch-up times', two times per week.

INTEGRATED CARE PLANNING

THE CYPHP health team share their assessment with the parents. Her parents also reflect on the challenges posed by Mina's health needs and are given strategies to support her to understand her worries and emotions. Her parents are signposted to parenting groups and online resources.

MARY'S STORY

MARY STOPPED SELF-HARMING AND IS NO LONGER SUICIDAL. HER ADHERENCE WITH ASTHMA TREATMENT IMPROVED CONSIDERABLY, AS WELL AS HER SCHOOL ATTENDANCE AND ENGAGEMENT LEARNING

MARY'S HEALTH HISTORY

Mary has uncontrolled asthma and struggles to take her medication regularly. She has had several emergency admissions and has been self-harming (cutting her arms and legs) for a couple of years. Her mother is concerned about Mary's mood and suicidal feelings. She feels unable to discuss Mary's health and mental health concerns with her, as Mary can often be aggressive and threatening.

COMPREHENSIVE ASSESSMENT

A CYPHP asthma nurse discusses Mary's and her mother's mental health concerns as part of the asthma assessment. They gain consent for a mental health assessment. A CYPHP consultant psychiatrist meets Mary and her mum and establishes that she is depressed and suicidal. The consultant proposes a safety plan.

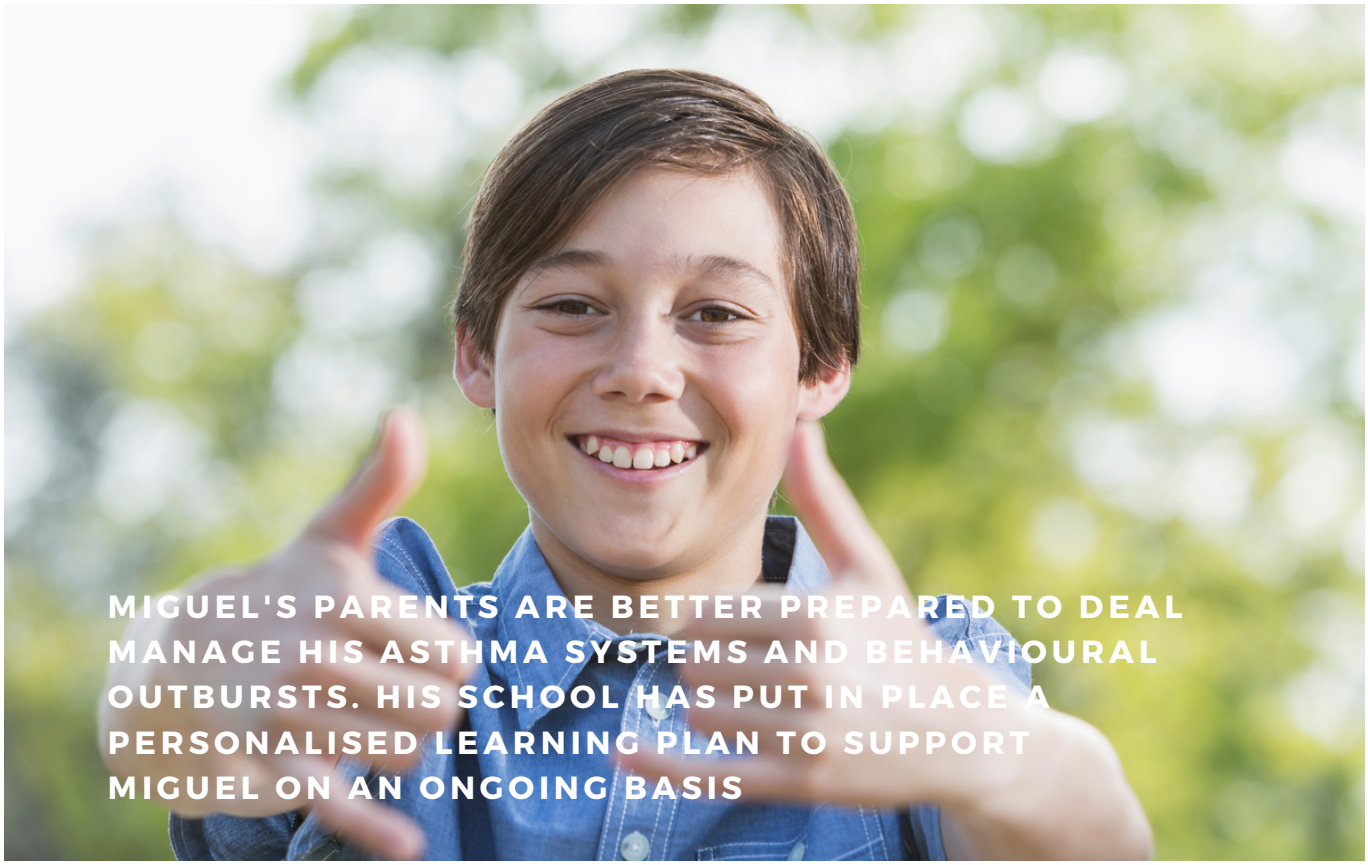
LIAISON WITH ALL PROFESSIONALS

With consent, the CYPHP mental health team liaises with Mary's school to recommend further assessment of her learning needs, and support for peer interactions. Assessments confirm dyslexia. The school and Mary's family agree to an Individual Learning Plan and pastoral support.

INTEGRATED CARE PLANNING

Mary and her mum agree to meet with the CYPHP family therapist to work on their relationship. Over a few months, they are able to address feelings of guilt, rejection and anger that have undermined their relationship. CYPHP's consultant child psychiatrist continues to work with Mary individually on managing her emotions and alternatives to self-harm.

MIGUEL'S STORY



MARY'S HEALTH HISTORY

Miguel has asthma, which has been difficult to manage. He was bullied in. primary school and struggled with attendance due to health issues, He is often described as very distractible and active, often receiving sanctions for being rude, verbally aggressive and forgetting homework. Miguel's parents struggle to manage his outbursts, as he gets angry and frustrated easily and can be aggressive to his sister.

COMPREHENSIVE ASSESSMENT

A CYPHP asthma nurse provides Miguel with an asthma management plan with clear reminders and behavioural incentives to support him and his parents in managing symptoms. They also refer Miguel to a CYPHP mental health specialist. The CYPHP mental health team meet with Miguel and his family. An assessment confirms ADHD and ODD diagnoses.

LIAISON WITH ALL PROFESSIONALS

With consent, the CYPHP mental health team liaises with Miguel's school and gather detailed information about behavioural challenges and triggers. They gain a better understanding of Miguel's learning needs and strengths.

INTEGRATED CARE PLANNING

CYPHP's mental health team meets with the parents and school SENCo to share the assessment report, including detailed recommendations for school-based strategies. His parents meet with CYPHP mental health team to reflect on their parenting styles, and discuss implementing behavioural strategies at home. CYPHP's parents are signposted to parenting groups for further support.

LOUISE'S STORY

BETTER COMMUNICATION BETWEEN PRIMARY AND SECONDARY CARE LED TO FASTER DIAGNOSIS AND BETTER HEALTH OUTCOMES FOR LOUISE

LOUISE'S HEALTH HISTORY

Louise was suffering from labial fusion; a condition that sometimes occurs as a result of a simple infection, such as vulvovaginitis.

REFERRAL TO CHILDS TEAM PAEDIATRICIAN

Her condition required a simple treatment with an estradiol gel. However, GPs professionals are unable to prescribe this gel to children in primary care. The CHILDS team paediatrician was able to see that Louise had been examined through the referral notes and felt happy with the diagnosis.

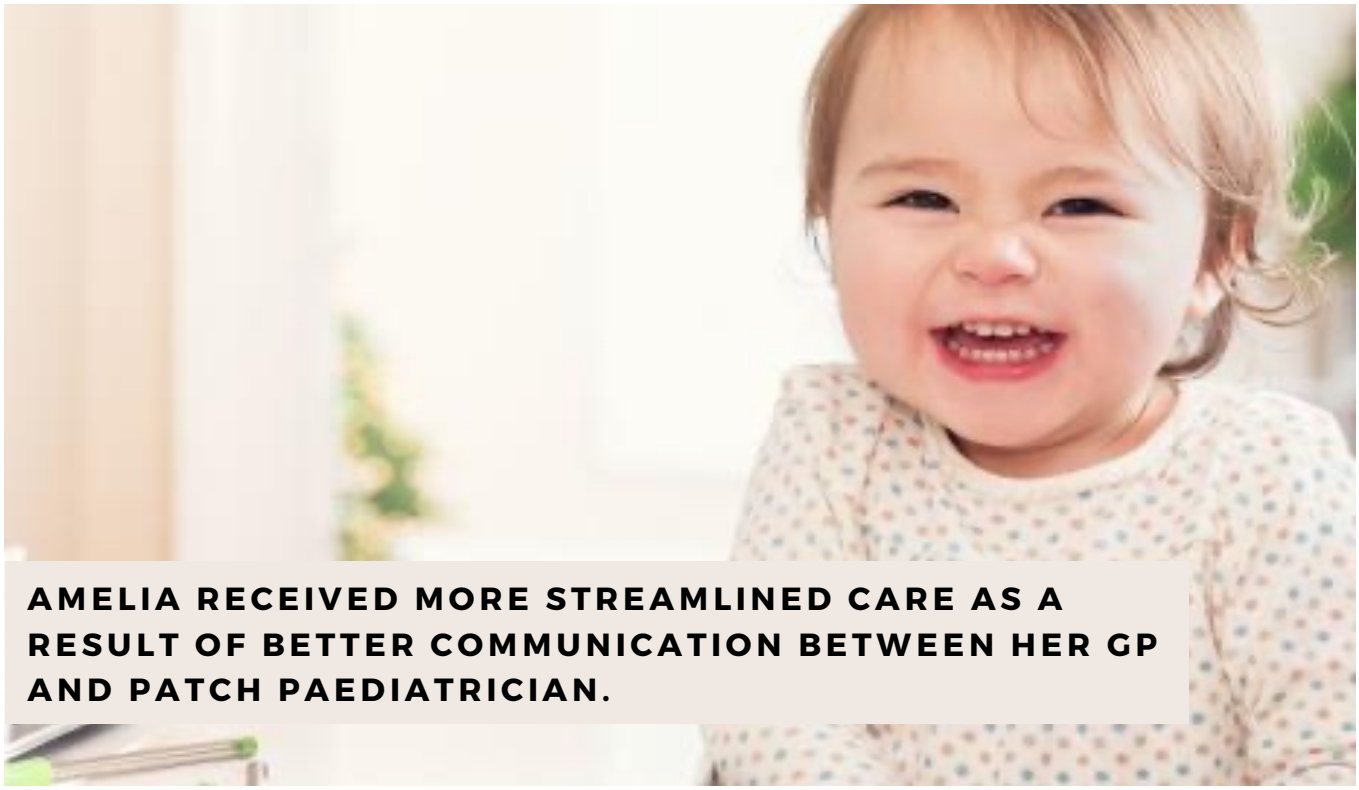
INTEGRATED CARE PLANNING

The CHILDS team paediatrician communicated back to the GP that they agreed with their diagnosis and provided a prescription for the estradiol gel via EMIS, within the primary care system. They also provided Louise with brochures on how to manage her condition.

LOUISE'S OUTCOMES

Louise and her family were able to receive treatment for her condition without further examinations or unnecessary trips to the hospital.

AMELIA'S STORY



AMELIA RECEIVED MORE STREAMLINED CARE AS A RESULT OF BETTER COMMUNICATION BETWEEN HER GP AND PATCH PAEDIATRICIAN.

AMELIA'S HEALTH HISTORY

Amelia - a one year old child from Southwark - was brought into see her GP because she was experiencing signs of wheezing. Amelia had been experiencing these symptoms for a long time and there did not appear to be any obvious cause triggering the condition.

REFERRAL TO PATCH PAEDIATRIC

Concerned about Amelia's condition, the GP referred Amelia to a patch paediatrician using EMIS Remote. In the referral notes, she mentioned that Amelia was experiencing continuous trouble breathing and requested further review by a paediatrician.

LIAISON WITH ALL PROFESSIONALS

The patch paediatrician requested more information from the GP - including a video of Amelia's wheeze - so that they could understand more about what could be causing Amelia's condition. The GP shared the video directly with the patch paediatric via EMIS remote.

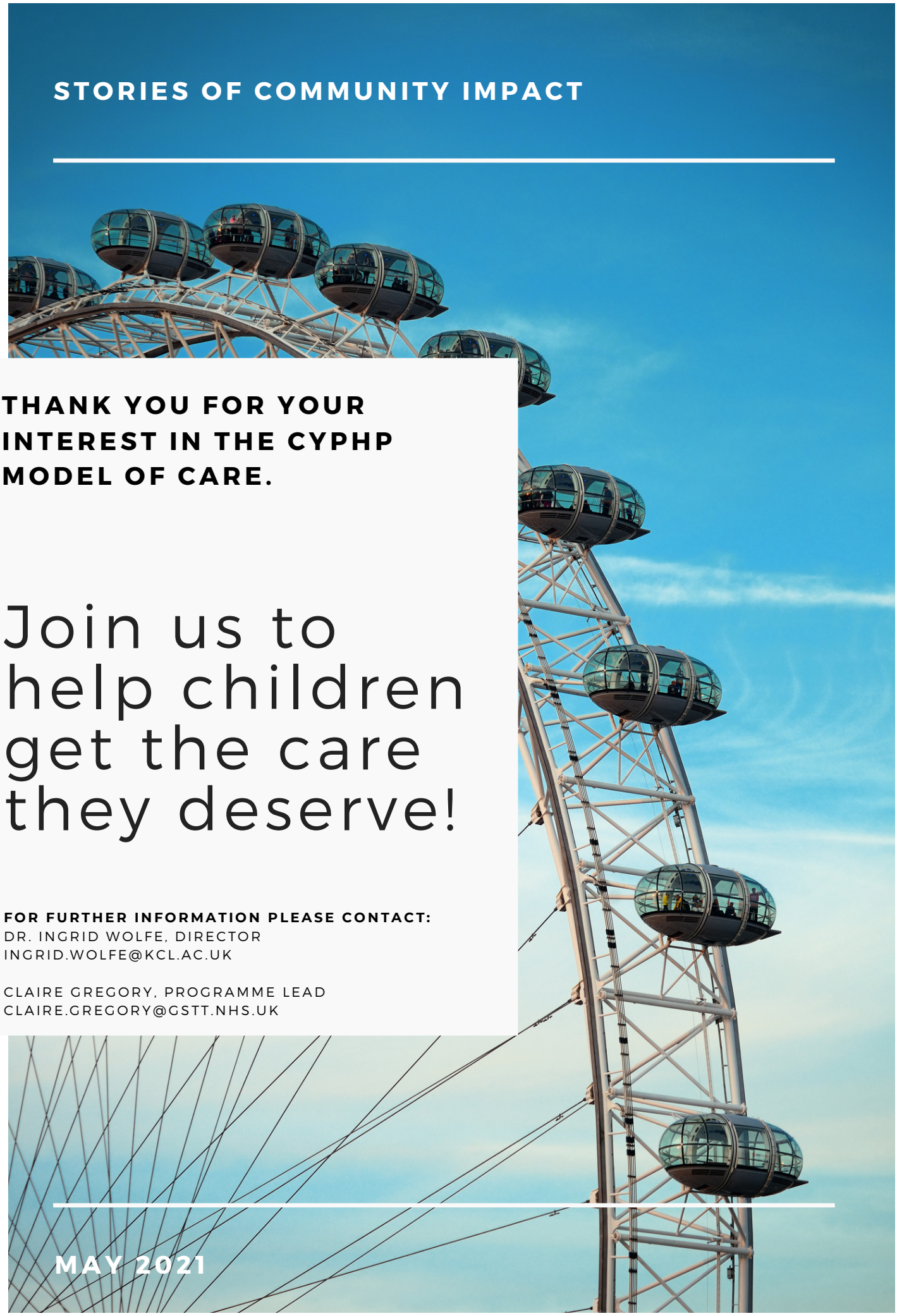
INTEGRATED CARE PLANNING

The patch paediatrician was concerned that Amelia may have a fixed airway problem and forwarded the video onto a respiratory specialist in the ENT department. Within a week, the ENT team conducted a virtual review of Amelia and within two weeks, Amelia was booked in for an operation. In normal circumstances, Amelia may have had to wait up to six weeks to see a paediatrician and even longer to see a respiratory specialist.

AMELIA'S OUTCOMES

Amelia and her family were able to receive treatment faster and without unnecessary trips back and forth to GP and hospital

STORIES OF COMMUNITY IMPACT



THANK YOU FOR YOUR INTEREST IN THE CYPHP MODEL OF CARE.

Join us to help children get the care they deserve!

FOR FURTHER INFORMATION PLEASE CONTACT:
DR. INGRID WOLFE, DIRECTOR
INGRID.WOLFE@KCL.AC.UK

CLAIRE GREGORY, PROGRAMME LEAD
CLAIRE.GREGORY@GSTT.NHS.UK

MAY 2021