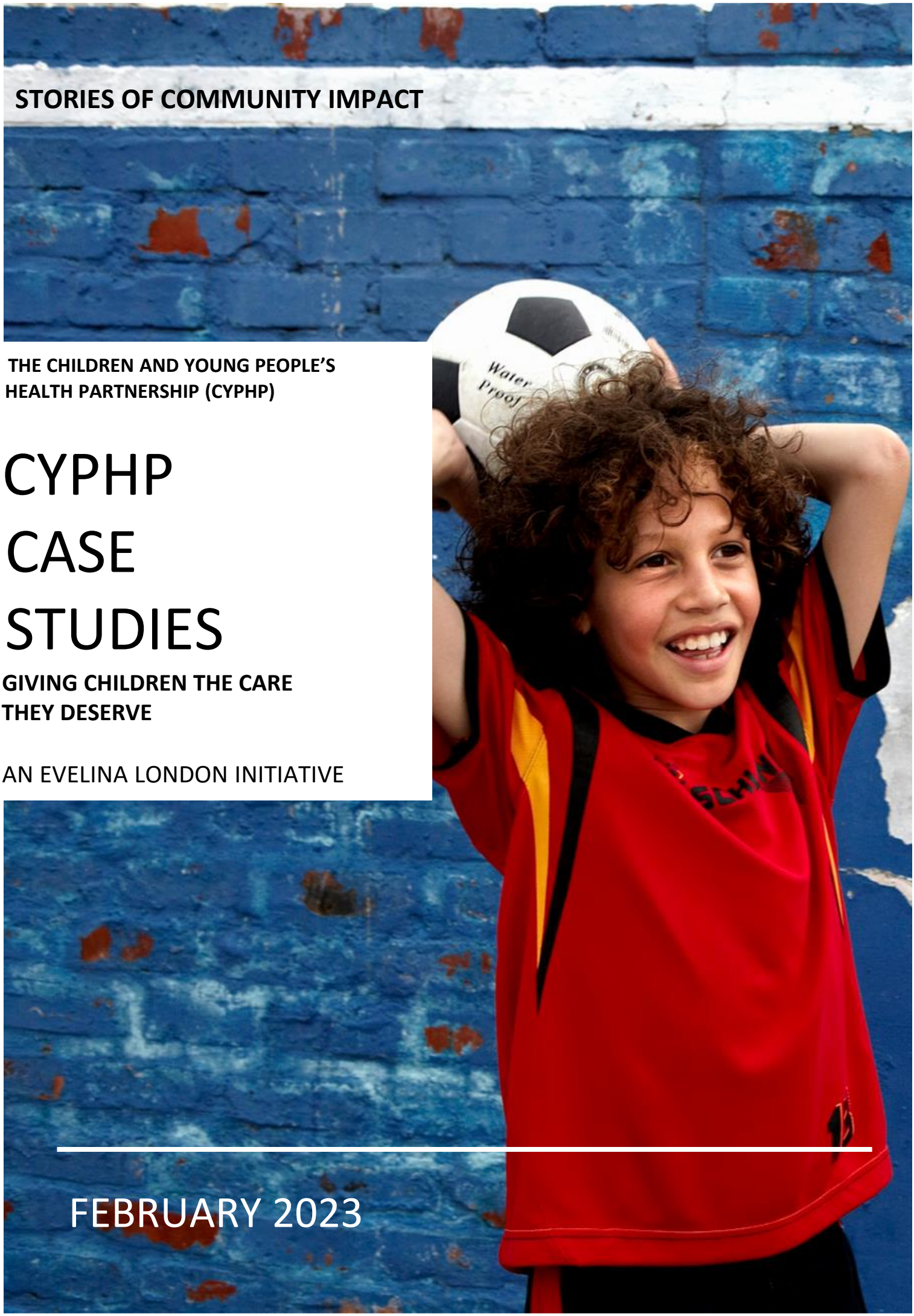
STORIES OF COMMUNITY IMPACT




**THE CHILDREN AND YOUNG PEOPLE'S HEALTH PARTNERSHIP (CYPHP)**

# CYPHP CASE STUDIES

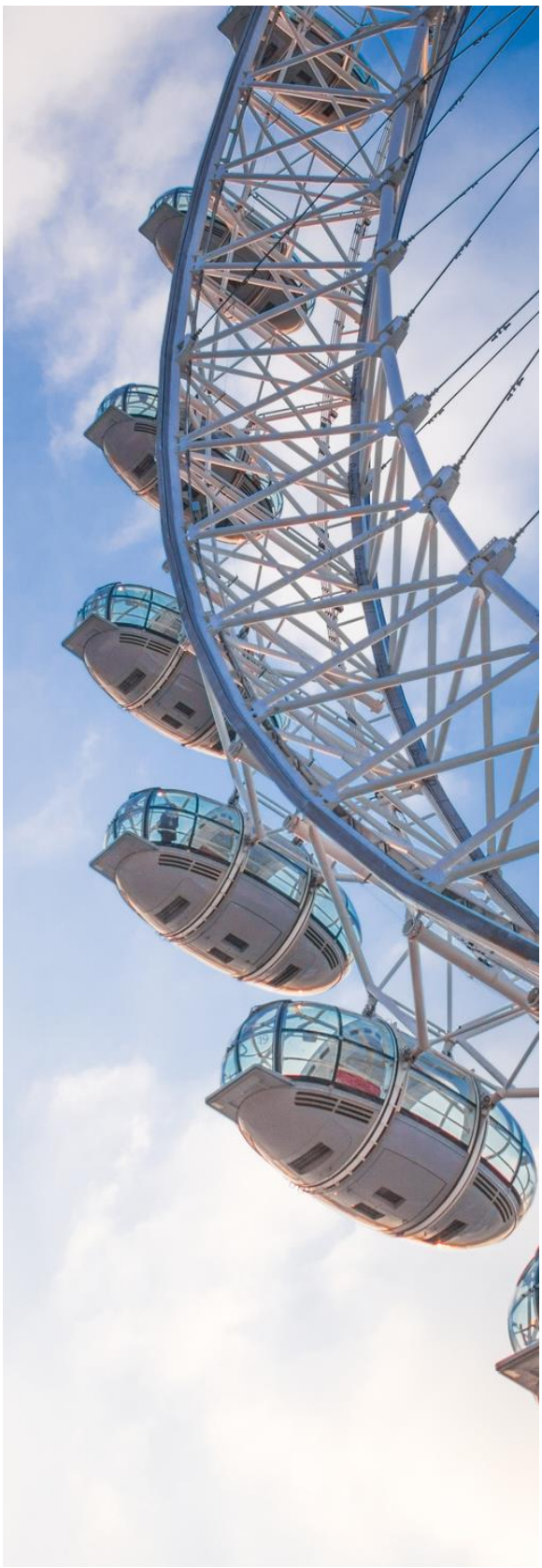
**GIVING CHILDREN THE CARE THEY DESERVE**

AN EVELINA LONDON INITIATIVE

FEBRUARY 2023

# THE CHILDS APPROACH

## OUR FIVE-STEP PROCESS TO CARE



The CHILDS Framework is composed of simple processes 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;

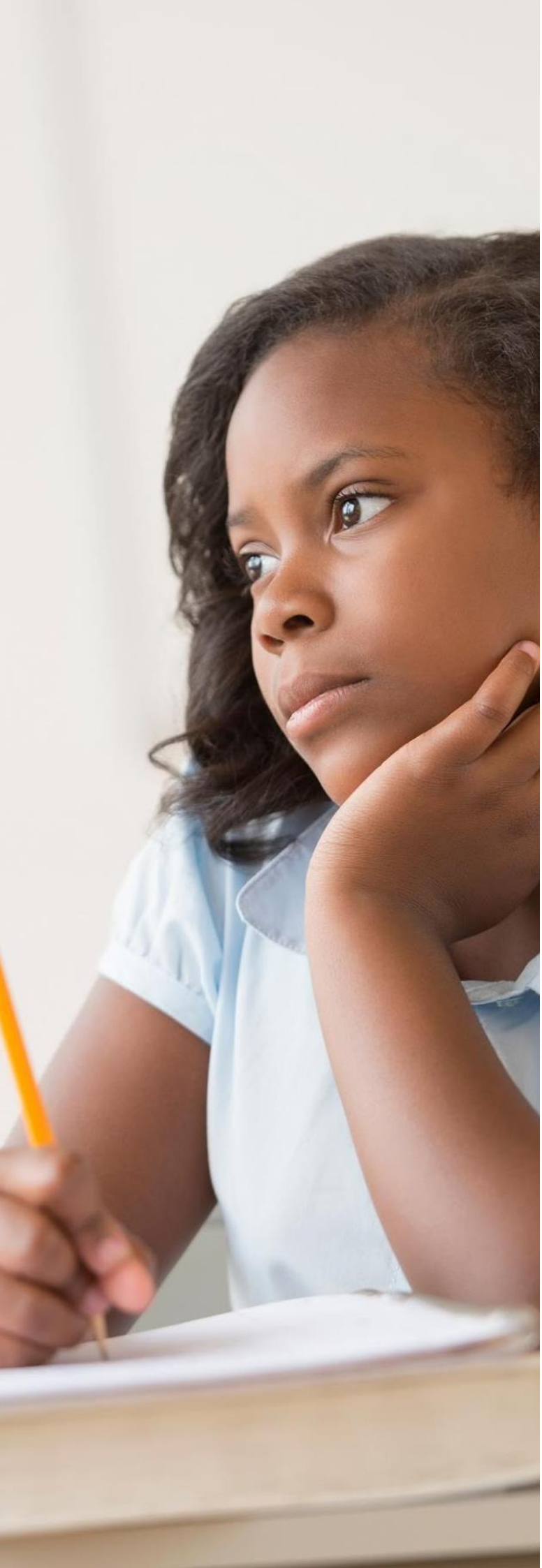
- **Health check assessment** – Parents and children complete a health and wellbeing pre-assessment questionnaire on the portal that includes aspects of physical health, mental wellness, social issues and family wellbeing, to identify child needs;

- **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 (MDT).

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 8,000 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.

# THE CYPHP CASE STUDY

The CYPHP (Children & Young People's Health Partnership) is an initiative that is designed by clinicians and researchers in order to reduce health inequalities and deliver proportionate and universal care in Lambeth and Southwark.

CYPHP leverages existing NHS data and advanced analytics and takes a proactive approach to identify children and families in the local population who would benefit from the CYPHP service (early intervention using a call-recall method), gaining a deeper understanding of children's physical, mental, and social health needs so that we can tailor a personalised care package. The CYPHP approach was initially applied to the tracer conditions of asthma, constipation and eczema but it can be adapted to other long-term conditions according to context and needs of the local population and health system.

# CYPHP CASE STUDIES

## CASE STUDY 1: PATIENT JOINTLY DIAGNOSED AND SUPPORTED BY LOCAL PAEDIATRICIAN AND GP

Martha[1] is an 18 month old girl who at a year was showing signs of developmental delay. She was seen by her local GP on two occasions, observed for progress and investigated. She was found by the local paediatrician to have a genetic mutation which is associated with mild developmental delay.

This news was conveyed sensitively to the parents with their GP present. The family are being followed up by the local paediatrician and team who can arrange further referrals to therapies and community teams if and when she requires.

The family continue to be supported without needing hospital intervention.

## CASE STUDY 2: UNNECESSARY EMERGENCY DEPARTMENT ATTENDANCE AVOIDED BY LOCAL CHILD CLINICS

A GP practice got in touch with the local paediatrician on a Friday afternoon to discuss a patient. They had a 4-month-old patient with persisting unconjugated jaundice and wondered whether the child should go to the hospital Emergency Department.

The Local Child Health Team knew the child well and that they had a prolonged jaundice screen at 3 weeks of age. The local paediatrician asked the GP to repeat blood tests on the following Monday, and then followed them up. Since the child still had unconjugated hyperbilirubinemia, the local paediatrician arranged to see the patient in a Local Child Health Clinic within two weeks.

The mother described a family history of Gilbert's. The Local Child Health Team did a genetics test and found that the child had Gilbert's. The local paediatrician reassured and explained the condition to the child's parents, avoiding an Emergency Department attendance and a hospital outpatient appointment.

[1]*All names have been changed for the purpose of this case study*

# CYPHP CASE STUDIES

## CASE STUDY 3: CLOSE COLLABORATION AND PSYCHIATRIC SUPPORT HELPED FAMILY TO DEAL WITH UNKNOWN ILLNESSES

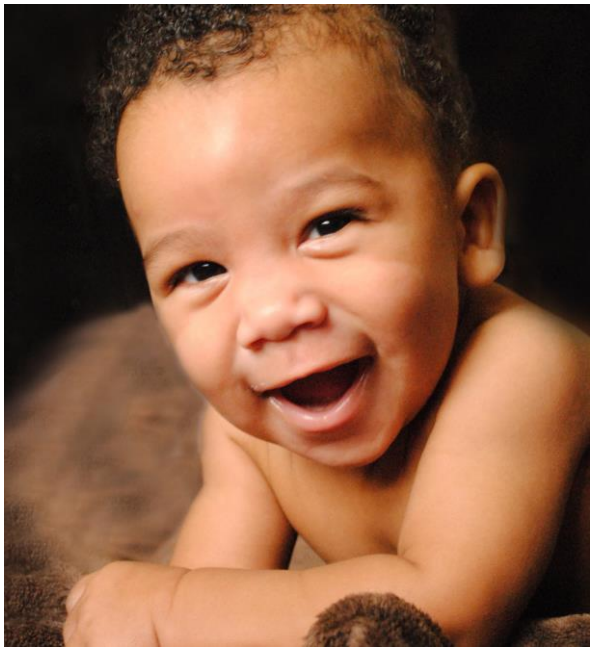
Jade[1] is a 14-year-old girl with a two-year history of abdominal pain, blackouts, and headaches. She then presented with unusual movements. She was picked up by her local paediatrician for follow-up after she was admitted overnight to King's College Hospital and had an MRI brain scan.

Her local paediatrician and GP were able to coordinate all her prior investigations, liaise with relevant specialty teams who have seen her, and explain to Jade and her parents that while these are functional symptoms for which an organic cause hasn't been found, and which do not need medication. They will work closely with specialty teams including mental health to support her and her family, whilst liaising with school regarding her return to school and developing the family's coping mechanisms for supporting their daughter.

The Local Child Health Team continue to support Jade and her family in the community. She is now back at school and is doing well.

## CASE STUDY 4: INTEGRATED CARE DELIVERED IN A VIRTUAL SETTING

A five-month-old boy was brought in with reflux and a degree of oral aversion to food. He was on omeprazole, Gaviscon, and had been through lots of changes of formula. There was a high level of maternal anxiety. The patient was discussed in the Local Child Health Team meeting and seen virtually with the GP.



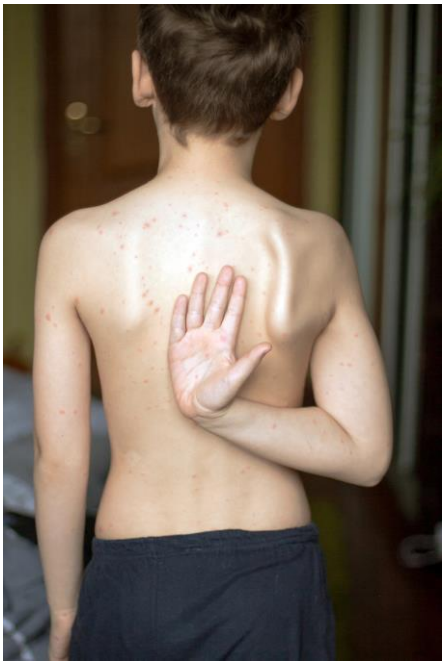
The Local Child Health Team spoke with the family about the natural history of reflux, weaning, and developing positive feeding behaviours. The patient was followed up by the GP who also addressed the mother's anxiety. The baby and mother are now much better, off medications, and on normal diet.

Hospital appointments and tests were avoided and the child continues to thrive at home.

[1]*All names have been changed for the purpose of this case study*

# CYPHP CASE STUDIES

## CASE STUDY 5: LIAISING WITH HOUSING TO SUPPORT CHILDREN WITH ECZEMA



Chantelle[1] lives in a two-bedroom flat in South London, with her five children. The flat was provided by the council, but is now too small for Chantelle's large family. Her children sleep in a bed surrounded by damp. Chantelle's son, Max, has eczema, he can't stop scratching at night, and his bedsheets are covered in blood. Max shares a bed with his two sisters, making it hard for anyone to get a good night's sleep.

After repeatedly visiting her GP, Chantelle finally receives a referral to the CYPHP Team. A CYPHP Nurse offered to visit Chantelle and Max at home. Although initially scared of what a stranger may think of their small flat, Chantelle was desperate and decided to let the nurse in. Chantelle learned that the damp in their home could be making Max's skin worse. Together they develop a care plan which includes some creams for Max.

The CYPHP nurse supported Chantelle to escalate the housing issues to the council, environmental health and her MP.

The council cleaned and repainted Chantelle's flat which offers a temporary solution. Chantelle is now on a higher priority on the rehousing register, and hopes to find more suitable accommodation in the near future.

## CASE STUDY 6: SUPPORTING BEHAVIOUR CHANGE IN A TEENAGER WITH ASTHMA

Emily's[1] son, Theo, has had asthma since he was a child. Theo is now 14-years old and is taking more responsibility for his medications. Emily is worried, as Theo doesn't like to take his inhaler and is not honest about taking his preventer inhaler when she reminds him. Theo is struggling and has recently had several asthma attacks during his football games at school.

The school nurse refers Emily and Theo into the CYPHP service. As Emily is busy working, the CYPHP Nurse offers to visit Theo in school. Theo knows it is important to take his preventer medication but forgets his morning dose frequently. Theo finds it embarrassing to carry his spacer around the football pitch.

The CYPHP nurse shows Theo how to set an alarm reminder for his preventer medications on his phone. The CYPHP nurse speaks with Emily for her to also use alarm reminders to help support Theo to become more independent.

The CYPHP nurse discusses inhaler options with Theo to promote adherence and patient preference. Theo is prescribed an Easi-Breathe reliever device that fits in his pocket. He finds this much less embarrassing to carry around and is happier using this medication.

[1]*All names have been changed for the purpose of this case study*

# STORIES OF COMMUNITY IMPACT

**THANK YOU FOR YOUR INTEREST IN THE CHILDS FRAMEWORK.**

## Join us to help children get the care they deserve!


**FOR FURTHER INFORMATION PLEASE CONTACT:**

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