

PROGRAMME FOR INTEGRATED CHILD HEALTH PROJECT SUMMARIES 2016-2017



PICH Yearbook 2016-17

Welcome to our year book.

The Programme for Integrated Child Health (PICH) was developed by the London School of Paediatrics in 2014. Paediatric training has often been focused on hospital rather than out of hospital care, acute rather than long term conditions, and based around organisations, rather than the child. Over recent years it has become clear that this separation, this way of working in a non-joined up way, does not provide the best care for anyone, least of all children, and it is as a response to this that PICH was developed- with a particular focus on integration and joined up working between sectors, be that Primary/Secondary, education/Health, Social Care/Health.

In 2016/17 PICH was adapted to incorporate participation from 15 GP trainees in addition to 15 paediatric trainees. Each was allocated a PICH mentor, someone with some expertise in integrated care or working differently, and were required to work through several themes, getting involved, or leading on projects that would enable them to get some understanding of those themes. The mentors consist of paediatric consultants and GPs with an interest in child health or care that cross boundaries.

The themes of PICH are:

1. What is integrated care
2. Using data to drive change
3. Patient experience and involvement
4. Working clinically in an integrated way
5. Leading on the development of integrated services

This book contains a summary of some of the work that participants have been involved in over the year. It represents an enormous amount of very varied work, which has been completed alongside trainees' normal clinical posts, on-call shifts, family life etc. We are very impressed by what the participants have achieved this year. Watch this space - these are the people who will transform the child health landscape.

For more information on PICH, please see www.pich.org.uk

2016/17 PICH team

PICH Leads:

Chloe Macaulay, Mando Watson, Jo Yong

Faculty and Development:

Kate Dharmarajah, Melanie Menden, Becky Hewitson, Niamh McLaughlin

PICH Mentors:

Mitch Blair, Fran Cleugh, Michelle Heys, Bob Klaber, Claire Lemer, Tasha Malik, Niamh McLaughlin, Simon Roth, Lisa Salazar

Understanding Young People with Diabetes: Using Experience Based Co-Design to Provide a Patient-Centred Diabetes Transition Service - Arpana Soni

My PICH Journey:

Building relationships and establishing cross boundary communication pathways is what I believe lies at the heart of establishing integrated child health care, but of course there is more. I embarked upon the PICH programme to facilitate my learning and provide me with the tools to understand how we can practice and develop patient centred integrated health services. Through the seminars, group discussions, learning from each other and my own project experience I complete the year with more passion and enthusiasm and a greater understanding of how I can shape my training to facilitate my career as an Integrated Paediatrician.

For the 4 years prior to starting PICH, I had been involved in the learning together programme run from Barnet hospital, working towards improving integration across primary and secondary care boundaries. For my PICH project, I decided to focus on integration across different secondary care boundaries and the experience of young people.

My PICH Project:

Aim: To use experience based co-design to improve the Diabetes Transition Service.

Design: Young people with diabetes (type 1 and 2) managed by a district general Paediatric Diabetes Team, were invited to attend a focus group.

The focus group, held in a local café, afterschool, was facilitated by 2 members of the Paediatric Diabetes team and the Diabetes Psychologist.

A graphic designer attended to support the young people to visually explore and communicate their experiences and ideas.

Results: 5 young people attended the group, ages 15-17 years.

Each attendee was invited to tell their diabetes story, followed by facilitated individual and group discussions about the transition service and health and social wellbeing of young people in relation to diabetes.

Recurrent themes that emerged included: promotion of independence, consistency of care, access to information and support via email and the internet, and the desire for peer-support opportunities.

Changes in administration at the time of transition was highlighted to promote self-advocacy. The attendees strongly preferred physicians to be direct in their communication styles and to be seen individually by each member of the diabetes multidisciplinary team. They emphasised the need for after-school appointments (but not late evenings) and agreed that the hospital was a convenient location.

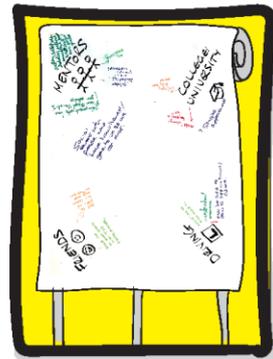
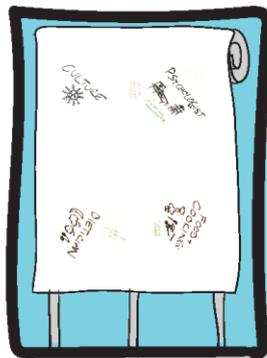
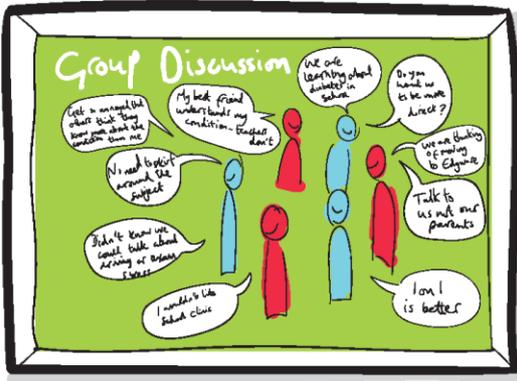
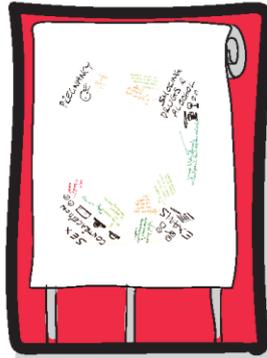
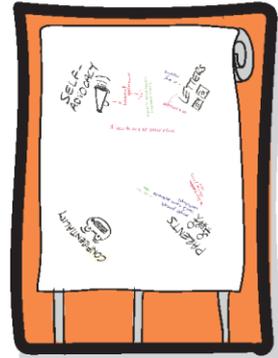
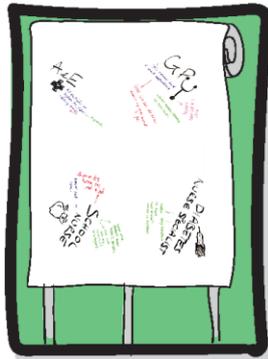
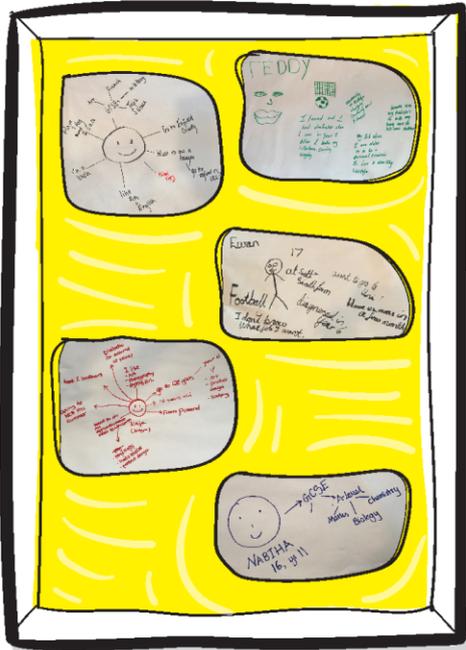
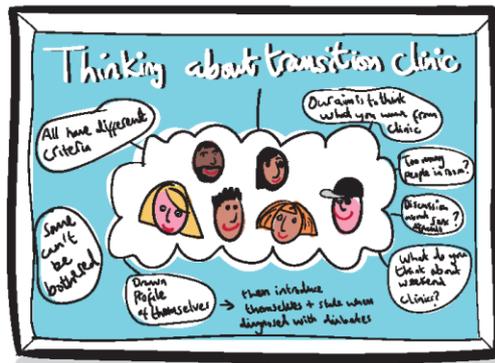
The attendees were all keen on receiving information about diabetes and driving, alcohol, drugs, exam stress, contraception and pregnancy, some indicating a preference for written information (leaflets/website links) and others face to face discussions.

All attendees identified a strong desire for the team to facilitate email contact and social events with others transitioning and those who have transitioned.

100% of the young people said that they would attend another focus group.

Conclusion: This focus group wants a diabetes transition service that promotes self-advocacy and independence, allows them to see the same consultant who communicates openly and directly, have access to information about how diabetes affects issues facing young people, and a service that provides them with ongoing peer-support.

Experience based co-design can ensure that diabetes transition services provide young people with a patient-centred service, that promotes ongoing health and social wellbeing well in to adulthood



ST3 St George's Hospital - Catherine Sikorski

Project – sexual health workshops at a Saturday youth group for young refugees:

Having looked with interest through the wealth of local data on health outcomes and health service use for Wandsworth, one clear local need was sexual health. In particular, the data showed high prevalence of sexually transmitted infections compared with other areas, perhaps reflecting the borough's relatively young demographic. The Joint Strategic Needs Assessment (2014) acknowledged this concern, with STIs being one priority. Local commissioning intentions for 2016-17 included sexual health and also refugee services.

At around this time I had the opportunity to visit the Saturday Group at CARAS (Community Action for Refugees and Asylum Seekers) – a local Tooting organisation. Together with a small group of colleagues, predominantly GP trainees but also a midwife, we were asked by the organisation to design and deliver a series of sexual health workshops for the young people at the youth group. This need had been identified by the organisation and we wanted to hear what the young people felt about it. We spent time attending the group over a number of weeks to get to know the young people and to try to begin a conversation about what they felt they needed, or how best we could work together to create something helpful. These conversations were surprisingly difficult to have, partly limited by language, partly by shyness between young people, but mostly by our new presence in the group and presumably also our 'otherness'. And so, not wanting to push an agenda, the 'co-design' aspect of the workshops could have been better. To allow for this we tried to design workshops that although structured and fun also had free space for questions and flexibility of content.

We delivered three interactive workshops attended by up to 20 young people, divided by gender. They were well received by participants and feedback suggested that subjective knowledge had improved. The workshop materials will be available to the organisation for future years. In an attempt to initiate a link to the local paediatric department I invited the head of the organisation to talk about refugee health at a governance meeting. I had also invited a young refugee to speak at a safeguarding meeting but this proved perhaps too intimidating – again something I could have done better. Next time I won't presume that people must come into the hospital to meet us!

For me, however, the more exciting aspect of being a part of the PICH programme has been the excuse to be curious, to ask questions, to meet people. To listen and to think about the questions without pressure to find answers (yet!). My reflections fall into two broad camps:

The 'architecture' of child health – community, spaces, structures:

I spent a day at an early years centre (hub for health professionals) and at a children's centre (predominantly education focussed). This got me thinking about 'hubs' – both altering the geography of our work so that corridor conversations can shape our thinking, but also providing a number of services under one roof to simplify care for patients. I visited the Bromley by Bow Centre and heard from Sam Everington about its approach. I was heartened to hear him talk of the importance of creativity for health, as well as the more obvious issues of housing, education and work. I also visited Sydenham Garden, a therapeutic working garden, and will soon visit Roots and Shoots, a similar project working with young people. These social prescribing projects led me to an online RCGP course in social prescribing and community development. I remain interested by and focused on what these approaches have to offer child health, in particular the idea of peer and group support. I have started to volunteer at my local community kitchen, which often caters for families with children, and I have arranged to meet our local asset-based community development (ABCD) worker to try to learn more about this method. I also attended a symposium at the Foundling Museum on public spaces for play.

Teams for child health – learning from others and working together:

I am interested in the richness that comes from the multidisciplinary team. I attended a GP hub MDT (part of CC4C) and I think I learned more about paediatrics in that short session than in weeks of clinical work! The coming together of experience and ideas was inspiring – perfect proof that we cannot have as great an impact on child health when working in silos. I attended a ‘melting pot lunch’ – a conversation between diverse professionals across health and social care, organised by Kaleidoscope Healthcare. I joined a meeting of teachers at a local school and discussed pastoral care, mental health and safeguarding processes. I also met with individuals – I quizzed our local care group lead about structures, priorities and changes. During the course of my clinical work I spent time with early years advisors, play specialists and youth workers, as well as doctors and nurses. I asked questions about integrated care and tried to understand their perspectives and the strengths their role has to offer. I plan to spend a day with a school nurse in the near future.

I very much hope this is just the beginning of a longer conversation. Thank you PICCH team!

Leading the Development of Integrated Services - Dr Emily Derrick

Inspired by my involvement with the PICH programme, I got involved in an integrated care initiative which also complemented my speciality, paediatric allergy– the Camden Atopy Working Group. In 2015 Camden undertook a review of children’s services, called All Together Better. It recommended developing a system wide strategy for managing children with atopic conditions in Camden. The Camden Atopy working group was set up to deliver this strategy and in particular to develop a service specification for the role of a community based atopy nurse service. The group was included stakeholders involved in delivering care to atopic children in primary and secondary care and included representatives from the clinical commissioning group, general practice, secondary care paediatrics, community nursing, school nursing and pharmacy.

My role in the group was to help develop pathways for the management of asthma and eczema in children in a primary care and community setting which integrated the role of this community nurse. To do this involved the following:

1. **Mapping out the existing service provision:** Through a brainstorming session during a working group session and an email survey of working group members.
2. **Stakeholder analysis:** I conducted an email survey to establish how individuals stakeholders would like their services to improve and develop and what they envisaged the role of a community atopy nurse would be to facilitate this.
3. **Patient/parent feedback:** Parents of children who attended outpatients for allergy clinic appointments were interviewed. They were asked about their patient journey and also what they thought a community atopy nurse should do.
4. **Defining the role of the atopy nurse:** The role of the atopy nurse was defined according to the aims and scope of the business case but then refined using feedback from stakeholders and families.
5. **Defining how the pathways integrate with local and national guidance:** Local and national guidance on the management of asthma and eczema was examined and integrated into the pathways to ensure guideline standards were met.
6. **Creating a process map:** All the above information was put together and used to create process maps for asthma and eczema. These outlined the steps on the patient pathway for management of these conditions and the interactions with different healthcare providers and agencies that take place and integrated the role of a community atopy nurse into this system.

Reflections on this experience:

1. The patient journey involves a very complex series of interactions between the patient, healthcare professionals and other agencies. Trying to map out this process is therefore very challenging but really helped me to understand the patient’s journey in the wider context of their healthcare and social environment.
2. Attending the group meetings and getting feedback from the members gave me access to enormous amounts of expertise and experience and highlighted what a valuable resource other people can be. It made me think about different ways of delivering healthcare that I have previously underused.
3. A recurrent theme from the feedback provided by stakeholders and families was the difficulties they experienced in accessing services and communicating with different agencies. In part this is due to the fact that patient information systems between different healthcare and social settings are not integrated. The feedback also demonstrated a need for education to be delivered to families and schools early in the patient journey. It will be interesting to see if an a community atopy nurses is able to resolve these issues and the impact that has on the patient experience.

My PICH journey - Dr Hannah Davies

After attending a few seminars at the beginning of PICH and trying to grasp the key concepts I realized that there was a huge amount of integrated paediatric care happening in my GP practice and local to my GP practice already. I wanted to better understand the primary care side of the story and how care can be integrated in this setting.

I started by understanding my local services better by attending a joint health visitor/nurse/Doctor baby clinic, a baby psychotherapy clinic, a joint consultant paediatrician/GP clinic followed by an MDT in my practice as part of a local CCG pilot, a local CCG meeting about a new paediatric atopy service and a local joint paediatric allergy clinic. We also have a charity based in our practice called the free space project that runs various projects and is very involved in social prescribing involving children and parents.

I wanted to understand better how these already existing services evolved and what made them sustainable and also identify some common principles.

Data gathering

I used the fingertips data on <https://fingertips.phe.org.uk/> to better understand my local population and how my practice compared to others. I then decided to collect some qualitative data in the form of semi structured interviews with the managing partner of my practice, my practice manager, the lead of our local charity the free space project and the Camden paediatric CCG lead.

Key findings

I established that there are some key principles in these existing services. All services needed to build relationships to foster change. It seemed that the most sustainable services were those that tried to pull services closer together rather than trying to create a whole new integrated service. I also discovered that to make any service work you need to take administrative staff on the journey with you. I discovered that a key way to ensure engagement with a project whether is to provide lunch, this allowed much better engagement at the paediatric MDT as well as other projects in my practice! Co-locating different services under one roof can really enable integration but is not always the whole answer.

My PICH journey is still evolving. In the process of carrying out the first part of my project I have identified a QIP I would like to carry out looking at care of severe childhood eczema. I have started by gathering qualitative data from 2 families with children suffering from severe eczema which is dramatically affecting their quality of life. I am hoping this will lead to our practice working in a more integrated way with all the services these families come into contact with.

The PICH Programme has opened my eyes to a different way of thinking and potentially working, I will be able to put more of what I have learnt into practice as a salaried GP in my practice this year.

PICCH Project 2016/17: Barnet Baby Resus - Lucy Fullerton and Sacha Dhanjal

Introduction: Children under 10 comprise 3% of the practice population at Longrove Surgery, Barnet.

We conducted 10 phone interviews in this age group to determine parents health anxieties about their children.

We identified that the major concerns parents shared were regarding respiratory compromise, choking and head injuries and all of them felt that a BLS session would be useful.

Methods: We recruited 12 parents through advertising with posters and patient leaflets, providing details opportunistically during appointments and through utilizing social media including Facebook and Twitter.

Parents were given 2 questionnaires to complete (pre and post session questionnaires) to determine their level of knowledge and confidence.

The session was held at lunchtime on the 17th May 2017 with two parts: BLS and management of choking. We did a large group demonstration followed by small group work enabling each parent to practice the resus manoeuvres. We held a brief Q&A and focus group at the end of the session and provided parents with certificates and information leaflets.

Results: The pre and post questionnaires showed a significant improvement in parental confidence (as measured by a Likert scale) and all parents rated the session as 'excellent' or 'very good.'

The verbal feedback on the session was positive and parents had asked for further education on emergencies such as head injuries and post resus care.

They had also requested for additional time for individual practice.

Conclusions: Our project highlighted a demand for parental BLS sessions with provision of educational teaching.

Further work would include running longer quarterly BLS sessions followed by 15 minute sessions on topics such as head injuries, rashes and vomiting.

We would also aim to provide sessions in the evenings for more fathers to attend and even look at engaging parents antenatally by working with midwives.



My PICH Journey

The patient pathway:

From referral to attendance at the food challenges unit - Rosy Wells (Paeds Trainee)

Background

Children are referred for food challenges from allergy OP clinic. The referral pathway is complicated and involves the patient awaiting the clinic letter and then contacting the administrator to book a slot.

The information leaflet about challenges is sent by post to patients and any questions about the challenge are answered by contacting nurses by telephone. Cancellations for food challenges are common and are frustrating for both staff and patients.

Patient Experience

After feeling inspired by the patient experience module, I started my PICH journey by talking to some patients/carers attending our food challenge unit. The problems reported and some of the themes brought up inspired me (along with a medical student) to collect data via a patient experience questionnaire.

Using Data to Influence Change

We collected data via a questionnaire from 48 patients (or their parent/carers) attending food challenge unit. This data went on to help influence the decision to change current booking system and to work towards creating a patient information video to view prior to attendance at the food challenge unit (still in progress).

Integrated working

With other staff

Throughout the project, I worked closely with other members of the MDT in the allergy service to establish the current problems in the system and to work towards solutions.

Data collated by admin staff and dieticians about attendance at food challenges and reasons for cancellation helped contribute to the project.

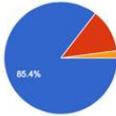
The members of the whole MDT were involved in the design/focus group for improving the booking system and are involved in the design and development of the video.

With patients

Working with patients (and parents/carers) with the emotional mapping and then collating patient experience data gave me a clearer insight into the importance of involving patients in decision making and development of services.

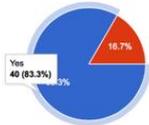
Parents and carers were involved with the focus group and brainstorming of ideas for the development of a new booking system for the food challenge unit. Patients will also be involved in the design and making of the information video for the food challenge unit.

Did you read through the information leaflet before your visit?



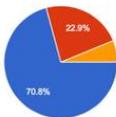
Yes, fully	41	85.4%
Yes, more than half	6	12.5%
Yes, less than half	1	2.1%
No	0	0%
Don't know/Can't remember	0	0%

Did it give you a good understanding of food challenges/supervised feeds and what to expect in the appointment?



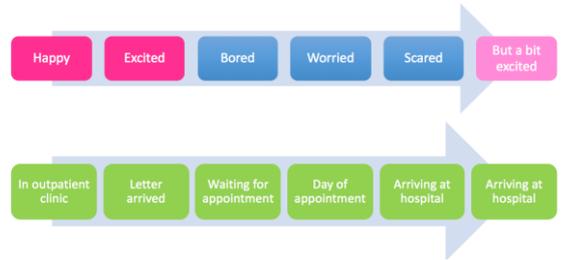
Yes	40	83.3%
Yes, to some extent	8	16.7%
No	0	0%

Did it answer any concerns/questions you may have had about food challenges/supervised feeds?

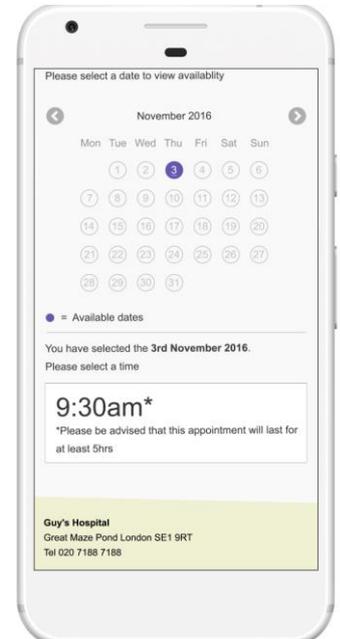
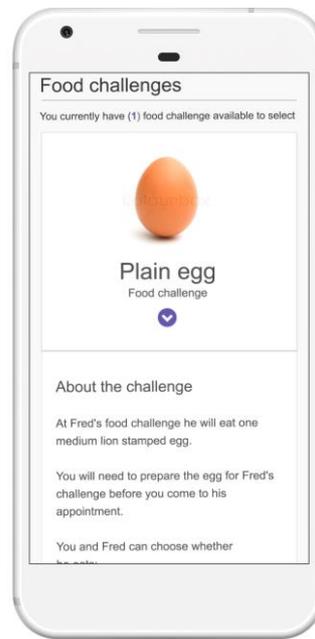
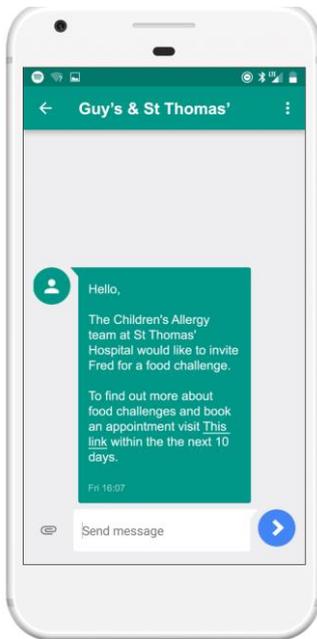


Yes, definitely	34	70.8%
Yes, to some extent	11	22.9%
No	3	6.3%

Emotional mapping Female 8 years having nut challenge



Emotional mapping Mother of child having nut challenge



PICH – Child Protection Project, GPST3 Whittington scheme - Dr Charlotte Iveson

Why PICH

I decided to do PICH after experiencing healthcare services first hand after my 3 year old daughter had necrotising fasciitis. I was very frustrated with regards to many aspects of her care, but one of them was the lack of integration and communication:

- Between healthcare and us as a family.
- Between multiple teams- not just on tertiary level but also between tertiary and secondary care.
- Between the hospitals and the GP.

I began thinking - if I am finding this difficult as a doctor then how are so many families that don't know how the healthcare system works navigating these systems?

I was initially quite overwhelmed with where exactly to start and what to focus on. While waiting for inspiration I looked into:

- A & E attendances over a month of children at the practice and why they attended.
- Met up with Dr Oliver Anglin – Clinical Lead for Paediatrics in Camden, and attended a meeting at the RFH about transferring all paediatric outpatients into Community hubs (atopy pathway)
- Attended CIDR meeting- Camden Integrated Digital Care record and how this was going to be rolled out for Paediatrics

My inspiration

I was involved in a complex safeguarding case, which is still ongoing, of a woman who was pregnant and had one child already, and involved in domestic violence. It was the initial interaction with her, Social Services (SS) and Multi Agency Safeguarding Hub (MASH) team that made me want to explore our Practice's Safeguarding processes, the children on a child protection plan (CPP) and child in need plan (CIN), and how we communicate with them.

My project and experience

It turns out this was much more complex than I thought! This involved looking at how we code CPP and CIN children, and how up to date this information was. We had no set way of doing this, partly due to the EMIS system. We also have different children listed to the list held by social services.

I also looked at how children on a CPP use the GP compared to all children in the practice. It showed they are much more likely to be seen in urgent appointments rather than routine appointments. They also used the GP much less than those not on a CPP.

I spent some time at child protection conferences, talking to social workers and school nurses. I attended a talk by 'Me First', an organisation aimed at improving communication between children and professionals. This motivated me to set up a system to regularly review children on a CPP in our practice, to make sure we are meeting their needs, and help improve communication between our practice and these vulnerable families and children. I want to set up a structure that is in some way similar to the chronic health reviews for e.g. heart failure, where you have more time with the patients as well.

I am now in the process of organising and trialing this new system of reviews. I hope to present the findings to my Practice.

PICCH – Project Planning – Alice Bell

A Project planning sheet should be completed for any project you are doing. This form should help you to record that process and highlight things you would like to discuss with your mentor for additional learning, support and direction. Remember the learning outcomes as you work through your project.

Project Title: Trends in health seeking behaviour for colic symptoms between two boroughs

1. Project details.
 - a) 27/10/16
 - a. Try to establish trends in child population in current and future GP practices – is there a trend? Is there a pattern to what children experience/parents experience?
 - b. Try to set up some learning together clinics
 - b) 15/12/16 – meeting with HV Gemma Shields, Hornsey Central Health Centre, f2f
 - a. She has worked in both areas (Haringey and Camden). Trends she has noticed includes far more allergy and reflux in Haringey compared to Camden; far more pressure to breast feed in Haringey; better integrated care in Camden compared to Haringey,
2. What might be the impact for patients? How could you measure this?
 - a) 27/10/16
 - a. The impact could potentially be that children and parents have less anxiety about going to the hospital, more familiarity with surroundings at GP practice etc. The impact could also be that either patient group (e.g. current group vs future group) could learn from one another, or could expose themes associated with different patient demographics.
 - b) 15/12/16
 - a. The impact would be stress levels for parents, visits to secondary care, relationships between children and their parents, perceived effects on health. I could measure objectively the number of children e.g. prescribed ranitidine in each practice, then number coded with “allergy” and perhaps those coded with reflux.
3. Project steps
 - a. Who needs to be involved - my current practice, my new practice, UCLH learning together clinic consultants
 - b. What needs to happen first – I need to contact the UCLH learning together consultants; I need to access data using online databases. Update 19/12/16 – I am not able to set up a clinic until at least the New Year. I have been in contact with the Paeds consultant who runs this as well as the practice manager at James Wigg to see if I could join them there.
 - c. I need to ask partners where I work if they have noticed a particular theme amongst children. Update 19/12/15 – I have asked about this and no theme could be found.
 - d. Instead, I have met the local health visitor (see above)
 - e. Update 19/12/16 – I now need to get some data about numbers of children e.g. under 1 diagnosed with reflux/allergy (I am not sure which would give me more patients) and prescribed ranitidine. I will then try to contact a patient I have met with these symptoms. I would then try to elicit some themes from their experience. I would then do the same in Ampthill practice.

WORK IN PROGRESS