**Developing, implementing and evaluating integrated care models for Infants, children, young people and their families**

**Carol Iris Ewing** FRCP, FRCPCH, MD, MBChB, BSc (Hons)

Consultant Paediatrician, Royal Manchester Children’s Hospital

Central Manchester University Hospitals NHS Foundation Trust

Vice President, Health Policy, Royal College of Paediatrics and Child Health

**Stephen Andrew Cropper** PhD, BSc (Hons)

Professor of Management, School of Social Science & Public Policy

and Research Centre for Social Policy, Keele University, Keele, Staffordshire, UK

Academic Advisor - Partners in Paediatrics, West Midlands.

**Timothy Bremner Horsburgh,** MRCGP, MBChB, BSc (Hons)

Clinical Lead – Partners in Paediatrics, West Midlands

Clinical Lead for Commissioning of Infants, Children and Young People’s Services

Dudley Clinical Commissioning Group

**Address for Correspondence**

Dr Carol Ewing

Royal Manchester Children’s Hospital

Oxford Road

Manchester M13 9WL

**carol.ewing@cmft.nhs.uk**

**Tel +441617010678**

**Fax+441617015421**

**Tel 07968230349**

**CONTRIBUTORS**

All three authors contributed to the first draft. All three editors have commented and improved successive drafts, with Dr Ewing having editorial control.

**KEY WORDS**

Child, Policy, Integration, Change, Evaluation

**WORD COUNT 1210**

From the perspectives of the patient, commissioner, provider and regulator, ‘joining up’ of pathways of care, delivered through integrated service models, is an essential goal.

It is refreshing, therefore, that this publication ‘*Integrating primary and secondary care for children and young people: sharing practice’* (1) is in a format with which the children’s workforce can identify and use. The paper makes reference to integrated care being ‘*an umbrella term to describe initiatives which aim to address fragmentation of care between and within public services’*. It draws attention to experiments which are making moves towards integration in infant, children and young people’s (ICYP) health services. It calls for investment in informed design, evaluation and research to develop a sound evidence base. Four key recommendations are made from five case studies about common foundations for innovation and change: stronger connections between paediatricians and primary care professionals, shared professional responsibility, workforce development, particularly in primary care, and new settings for specialist practice.

Despite continued advocacy and evidence for a more equitable focus on ICYP services (2[[1]](#endnote-1)) these projects are not, in the main, centrally sponsored, and may be moving against the tide as implementation of the Health and Social Care Act 2012 may be further exacerbating fragmentation of care.

First of all, we examine the signals and support in policy and practice to progress intelligent experimentation and adoption of effective integrated practice.

* NHS England’s Five Year Forward View certainly invites integration and radical new delivery models, but mainly in adult and elderly care services. Many of the principles apply to ICYP but, particularly for those with long term conditions and complex needs, models of integrated care require more extensive partnership working beyond social care to include youth justice and education systems so that ICYP grow up to be resilient adults. Only one of 14 Multi-speciality Community Provider (MCP) model Vanguard sites is using a multidisciplinary team (MDT) approach for care planning and delivery for ICYP with long term conditions and disabilities, within their social and home environment, and to enable their best educational attainment.
* The Royal College of Paediatrics and Child Health (RCPCH) ‘Facing the Future’ series of standards (3[[2]](#endnote-2)) provides both acute inpatient service standards and unscheduled care pathway standards for ICYP in primary and secondary care for commissioners, providers and regulators to use. This is against a backdrop of rising admissions for children under five years of age with respiratory infection and infants with feeding difficulty, and attendance rates at emergency departments are 40% higher in 2011/12 than in 2007/8 (1).
* Health Education England is undertaking a system transformation project to plan for a fit for purpose children’s workforce.
* The Cities and Devolution Bill may mean that health and social care budgets are devolved from central government to local councils. Much will depend on effective orchestration of change at regional and local levels if outcomes for ICYP are to be improved.
* Two years ago, the Strategic Clinical Networks (SCNs) (4[[3]](#endnote-3)), seemed to be ideally placed to facilitate whole system transformation: created as ‘engines for change’ to reduce inconsistency of care and improve outcomes for children, the SCNs continue to have an essential role (Table 1) whether covering a remote isolated or inner city landscape, although the approach may differ e.g. using IT and telemedicine in remote areas.

**Table 1 – The role of the SCNs**

|  |
| --- |
| * Embed clinical leadership in whole system transformation projects
* Support collaborative working between health professionals
* Act as a conduit to share information on models of care
* Be partners in NHS England Vanguard projects
* Collaborate with the Academic Health Science Networks on research and other projects, and disseminate outputs
* Influence commissioners and providers to use RCPCH and other service standards
* Develop quality dashboards against a set of outcomes and use e.g. standards, audit, geographical variation in health care and wellbeing indicators
* Share patient experiences, and integrate the views of children, young people and families into SCN and other quality improvement programmes through collaborations e.g. with the RCPCH patient voice platform *&Us*

In so doing the SCNs can:* Learn from and influence NHS England Vanguards in their area
* Support clinical leaders and the range of stakeholders, particularly commissioners, to develop and implement whole system service transformation
* Influence national policy
 |

The accompanying paper raises many issues, but we focus on four themes.

Embedding leadership and investing in teambuilding within a robust accountability framework is a necessary foundation for change. With those foundations laid, professionals can ‘get on with it’ by taking on shared responsibilities for their patients. Long term care planning can be assisted by patients and families enhancing their skills in self-care and in building their resilience, and by professionals sharing and disseminating their learning experiences.

More in depth policy research involving front line staff and families is needed, as services are developed and delivered in innovative ways. In addition to collating evidence of integrated care models in its next Workforce Census for 2017, the RCPCH is encouraging trainees and trained staff to become involved in research. It has set up the UK Child Health Research Collaboration (UKCHRC) so that funders of child health research now have an organisational partnership framework. Practice, however, is often ahead of the evidence, and theory-based evaluation is a valuable approach when there is rapid and varied change. Early, ‘real-time’ work to elicit core principles and essential practices can set benchmarks for stronger checks on the most plausible interventions, and on the limits of innovation. Surfacing, inferring or reconstructing practitioner theories of change using frameworks such as realistic evaluation’s Context-Mechanism-Outcome configurations, as described in the accompanying paper, can assist in service commissioning, design, delivery and evaluation. The paper raises a question about the level of detail required to design and assess new models of care and to make meaningful comparisons between the different configurations of service? The paper’s supplementary table suggests that some simple, shared principles can generate significant variety of practice and so mapping variations at a more detailed level of resolution may well be an important step in accumulating knowledge for practice. The paper helps to generate further questions (Table 2), to explore dimensions and limits to service innovation.

**Table 2 – Indicative questions to use in undertaking a more in depth evaluation of integrated care models**

|  |
| --- |
| * What constraints are taken as absolute and which might be ‘broken’ to achieve radical change and why?
* If the final outcomes are similar across all four models e.g. fewer Emergency department presentations or admissions, reduced costs, or more resilient children and families, what are the mechanisms of greatest importance to each of these, or to an acceptable or sustainable balance between them?
* Which data would help to monitor early progress and to evaluate effectiveness?
* At what stage following its implementation might any model of service reasonably be judged against the final outcomes of importance?
 |

A third linked theme, again not new (5[[4]](#endnote-4)), but pertinent to both the Vanguard programme and wider experimentation, is about sharing experiences of the process of change from current to new configurations of services. The RCPCH is considering ways of collating evidence of the range of integrated care models so that this information can be shared with its members and with the wider health care community. Establishing and implementing change to services by shifting workforce resources with little new money is challenging; the learning by commissioners and providers must be shared. Successful MCP models require cross-boundary buy in, ownership by clinical and service leaders, and a collaborative mind-set. Investment in project management support and backfill for clinicians provides necessary ‘headroom’ for service delivery planning. Early on, system-wide joint outcomes must be agreed, and the disincentives of Payment By Results and contractual arrangements need to be addressed ([[5]](#endnote-5)).

Finally, the paper cites a concern among research participants that integration might result in hospital services closing. This could be a barrier but, equally, could be an opportunity. Fewer hospitals delivering inpatient care, well-aligned with integrated care services (primary and secondary) delivering more care out of hospital, could be a sustainable long term solution. Managed clinical networks remain to be developed for many top-end secondary/tertiary specialties, and are also required to secure effective, sustainable pathways of care across primary, secondary and tertiary care.

This paper provides valuable food for thought at local and national levels, and indicates how front line staff can work with research organisations to conduct high value policy research through innovative health care service design and evaluation.

To achieve effective integrated care, fundamental systemic and institutional redesign of the organisation and resourcing of services and the children’s workforce is required. Any change will impact on other care services and challenge long-established, taken-for-granted patterns of responsibility, expertise and practice. This has to include the traditional idea of ‘healthcare’ being seen as separate from other contexts and activities through the ICYP’s life course e.g. family, friendship networks, school/college, work, youth justice system. Radical system change is about revolution as much as evolution for all involved in the NHS in England, from policy development to frontline practice.

**COMPETING INTERESTS**

Dr Carol Ewing is also a Clinical Adviser to the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network.

**ACKNOWLEDGEMENTS**

We would like to thank Professor Anne Greenough Vice-President (Science and Research), Royal College of Paediatrics and Child Health (RCPCH), and the RCPCH Health Policy team, in particular Isobel Howe, Head of Health Policy, for comments on previous drafts.

**REFERENCES**

1 Woodman, J. Lewis H., Cheung, R. et al. Integrating primary and secondary care for children and young people: sharing practice. Arch. Dis. Child. Publichsed Online First: 20 Oct 2015 doi: 10.1136/archdischild-2015-308558

1. 2. Lewis I, Lenehan C, and Shribman S. Report of the Children and Young People’s Health Outcomes Forum 2014/15. 2015. <https://www.gov.uk/government/publications/children-and-young-peoples-health-outcomes-forum-2014-to-2015> [↑](#endnote-ref-1)
2. 3. Royal College of Paediatrics and Child Health*.* Facing the Future: Standards for Acute General Paediatric Services. 2015. [www.rcpch.ac.uk/facingthefuture](http://www.rcpch.ac.uk/facingthefuture); Facing the Future: Together for Child Health.2015. [www.rcpch.ac.uk/togetherforchildhealth](http://www.rcpch.ac.uk/togetherforchildhealth) [↑](#endnote-ref-2)
3. 4. Spencer A, Ewing C and Cropper S. Making sense of Strategic Clinical Networks. Arch Dis Child.2013; 98:843- 845: <http://adc.bmj.com/content/early/2013/07/25/archdischild-2013-303976.full.pdf> . [↑](#endnote-ref-3)
4. 5. Peile E. The future of primary care paediatrics and child health.Arch Dis Child2004;89:113- 115. [↑](#endnote-ref-4)
5. 5. Appleby J, Harrison T, Hawkins L and Dixon A. Payment by Results: How can payment systems help to deliver better care. 2012 <http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/payment-by-results-the-kings-fund-nov-2012.pdf> [↑](#endnote-ref-5)