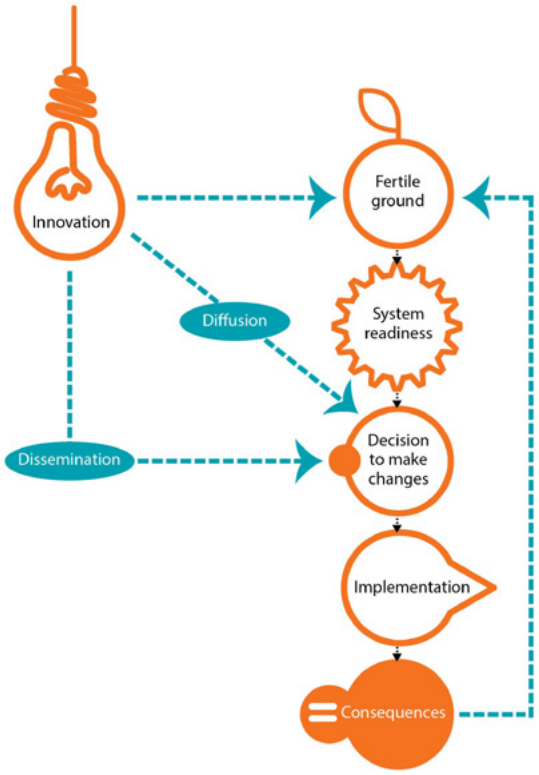
Camden's Journey towards an Integrated Model of Care

Implementation science

Implementation science is the study of methods that promote the uptake of research findings and other evidence-based practices into routine practice, and hence, improves the quality and effectiveness of health services and care. It focuses on the barriers and enablers to policy implementation. Despite central government's strong encouragement for local areas to jointly commission, progress remains slower than expected. We thought it would be helpful to set out this case study on Camden's Integrated Children's Service using an implementation science framework and highlighting in detail those factors that supported the success of the endeavour.

We have adapted the model to make it more accessible, and the figure below is based on work done by Greenhalgh et al[1] to map out those factors that support successful implementation of change.



Camden Integrated Children's Service (CICS)

The London Borough of Camden and four NHS trusts - Whittington Health NHS Trust, Tavistock and Portman NHS Foundation Trust, the Royal Free London NHS Foundation Trust and Central and North West London (CNWL) NHS Foundation Trust – came together to form CICS.

1 Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations. Trisha Greenhalgh, Glenn Robert, Fraser Macfarlane, Paul Bate, Olivia Kyriakidou, Milbank Q. 2004 Dec; 82(4): 581–629

The innovation (the change being sought):

There were some overall outcomes to be achieved:

- Children's healthcare needs are identified early so that the right support can be put in place quickly to help children get better or to manage their conditions effectively
- Children and parents report an improvement in their quality of life as a result of a health intervention
- The majority of severely disabled children continue to live with their families at home and as part of their local community
- Children are supported to access education in the most appropriate setting for their needs and they achieve their potential at school.

To achieve those outcomes we felt some things needed to change:

- Children and young people in Camden with developmental concerns, disability or additional healthcare needs aged 0-18 years access a network of high quality and safe community services appropriate to their needs:
    - There are clear clinical outcomes set for each child and consistent ways to assess that these are met across services.
    - Children are seen by the right service quickly; waiting times are no more than 8 weeks across all services and below this wherever possible.
    - There is a consistent approach across services to making sure families are satisfied with care provided and feel fully engaged in planning, reviewing and implementing it.
- Disciplines work together and with primary care, hospital services, education, social care, children's centres and other services to create and maintain single care plans on a single patient records system for all children receiving input for more than six months and from more than one service. Parents/carers and young people have up to date summaries of care available to them so families are clear what they can expect, from whom and when.
- There is a single clinical leadership structure across services responsible for:
    - Implementing, maintaining and monitoring integrated care and ways of working
    - Planning resources across services in line with children's needs as opposed to individual service requirements
    - Developing the workforce so that skills and expertise are shared across disciplines.
- Delivering these objectives requires strong collaborative working arrangements between clinicians from different disciplines, between providers and commissioners, and between the NHS Trusts themselves.

Fertile ground (the organisation or system is well placed to implement the innovation and there is a belief that change is needed)

The providers and the local authority were already used to working together, joint commissioning was well established in the borough and the partners understood each other well. We had a wealth of local knowledge and stability amongst the clinical leads, and senior leaders respected the relative strengths of partner organisations. This meant that the starting point was one of mutually recognising what each provider could bring to the table in order to make the whole better, rather than viewing it as a competition.

For the most part services worked well and were well received by families, but providers were largely working in parallel. Knowing that all partners wanted to further improve the outcomes for children and young people, everyone was signed up to the assumption that change to a more integrated approach was possible and that people were ready.

We had a history of partnership working with economies of scale and we already trusted each other at an operational level, for example:

- Speech and Language Therapy for deaf children was provided across Camden and Islington as one, rather than building 2 discrete services.
- Public health is delivered across Camden and Islington.
- Whittington Health (WH) was delivering end of life care across the sector and continuing care across Camden and Islington.
- The 4 providers on the ground had established a single point of referral (SPOR) into all services for additional needs, despite the organisational boundaries. Commissioning funded the administrative function, and service leads were already working together across organisations to join this up as the right thing to do for CYP and families.

Improving safety was a key driver for all organisations, underpinned by the 'Every Camden Child' vision which we had held in the borough for some time, and that we felt we could and should do more on to ensure the vision was central to the way services were delivered.

System readiness (the organisation or system has made a commitment to change and allocated the necessary resources to make it happen, including leadership oversight)

- Facilitated by commissioners who demonstrated flexibility and allocated resource to giving things a go.
- All providers were engaged in collaboratively developing the financial model and this model ensured that each organisation kept its financial stake, nobody lost out.
- Operations leads from the 4 NHS trusts spent a year discussing how to achieve the outcomes through partnership.

- CNWL gave access to its electronic patient record in return for an operational leadership function which attracted some funding, a Head of Children & Young People Services post and funded the back-office performance management functions. This included CNWL feeding back performance information to the partners.
- Clear accountability and oversight was set up (covered in the governance section at the end of this case study).

Decision to make change (the process of getting everyone onboard with the change)

- Getting people on board: Reward-based commissioning helped, all providers were keen to receive the additional income to improve services.
- Everyone compromised because no provider wanted to lose out and we made some key changes.
- Central and North West London TUPEd (Transfer of Undertakings, Protection of Employment) its small number of children's occupational therapists and physios over to the Royal Free London NHS Foundation Trust which meant that all disciplines sat within professional groups in the providers with clear professional leadership, this improved the clinical safety of the service.

Timeline

- **2012-13** discussions about changes to the model / parallel work going on to develop a SPOR regardless of the organisational boundaries
- **November 2013** approved by senior managers from the 4 NHS trusts
- **December 2013** signed off by Clinical Commissioning Group
- **End March 2014** financial and operational leadership model agreed
- **October 2014** model becomes operational
- **December 2014** Head of Service appointed
- **January 2015** governance in place

Implementation (making the change, and continuing to modify based on feedback collected on impact)

Working with local NHS providers, Camden Clinical Commissioning Group and the London Borough of Camden jointly commissioned an outcomes-based integrated service incorporating many of the services for children and young people with additional needs in Camden. The four NHS providers maintain their commissioned services, and are all equal partners under the terms of the Alliance Agreement.

Staff are employed according to profession by different providers, for example all children's Speech & Language Therapists are employed by Whittington Health and children's

Occupational Therapists are employed by Royal Free London. This model ensures strong professional leadership and accountability, and clinical safety as a result.

CNWL has an operational lead role, providing the electronic patient record, performance information and clinical leadership to align integrated working between professions.

All staff use CNWL's electronic patient record, SystmOne, as the single community record for children in Camden. This is achieved through a process of honorary contracts which provide the governance to allow access across providers.

All partners are expected to achieve the same outcomes, outlined in five KPIs.

Issues arising

- 2017 - For the first 2 years the Reward Grant was allocated equally between providers every quarter, based on performance. This was a challenge because some providers brought more clinical services to the partnership than others, some services were bigger than others, and some services had more increasing demands than others. In 2017 we agreed a change to the Alliance Agreement to bring any accrued reward grant into a single pot each quarter and introduced a bidding process for the funds based on service needs. In this way each service was able to identify particular shortfalls or improvement projects that needed support at intervals throughout the year, and by articulating the expected benefits and outcomes would bid for a share of the Reward Grant. This made a more equitable way of allocating the additional income.
- 2018 – We have good coordination of the under 5s MDTs in MOSAIC, but we had been struggling with coordination of the MDT at our special school. The special school roll is 260, and we have an on-site NHS team of 30 staff from 3 of the NHS providers. An example of good use of Reward Grant has been that Clinical Leads Group agreed to fund a clinical coordinator 1 day a week of a highly specialist clinician Band 8A therapist, which has helped improve communication within the NHS team and between the team and the school. Having this post in place has enabled the various NHS teams to work together on service improvements, parental engagement and engagement within the school's leadership team, all of which improves outcomes for the learners. The school find the post a welcome addition to the smooth running of the school.
- 2019 – A decision was agreed between commissioners and local providers to TUPE the Camden based adult and child dietetics and bladder and bowel services from the existing provider to CNWL. Because the children's dieticians were already using CNWL's electronic patient record it was a smooth and easy transfer, as they were so well linked into systems and processes already. TUPEs can be very stressful for staff, and this was very easy for staff and the provider alike.
- 2019 – We launched a single clinical outcome tool across all services, the Goal Based Measure. The launch followed 2 years of work between the partners and professions in which we had assessed the efficacy of a range of clinical outcome measures used by the various professions. Agreeing a single outcome system took time. Regardless of profession we were all 'talking the same language' with this particular tool and it was another step towards recognising children, young people and families as partners in the care being agreed and delivered.

Consequences (collecting accurate and timely information about the impact of implementation)

The KPIs were set to try to ensure that services were sighted on the outcomes that Camden wanted to achieve:

1. Children and young people and parents say they would recommend the service to friends and family.
2. Children and young people within every discipline are seen within 8 weeks of referral.
3. Children and young people with long-term input from more than one discipline have a multi-disciplinary or multi-agency care plan in place.
4. Children and young people with long-term input achieve agreed goals as measured at review or discharge in every discipline.
5. Children and young people aged 14 who are eligible for adult services have a transition plan in place.

Consequences are clearly written into the Alliance Agreement.

In ANNEX A. KEY PERFORMANCE INDICATORS, methods of measurement, thresholds expected and consequences are set out. The breach consequences of not reaching threshold target for each KPI is listed as Remedial Action Plan and Non-payment of incentive payment (p. 14 Alliance Agreement).

In ANNEX B. PRICES and PAYMENTS the parameters for the incentive payment are set out and it is stated that 'Non-achievement of percentage threshold by one provider will result in non-payment for all providers' (p. 15 Alliance Agreement).

There has been no room for complacency. In order to maintain our journey of improvement the KPIs have developed iteratively over the course of the alliance:

1. In addition to the mandatory Friends and Families Test (FFT) question we also now ask families about the impact of the support they have received on their confidence to manage their child's condition.
2. As achievement against the waiting time target was strong, we agreed to stretch the performance further and the expectation is now that most children and young people attend a first appointment within 6 weeks of referral. The exception is for YP with suspected autism, for whom in line with NICE guidance we expect to start assessments within 12 weeks of referral.
3. Transition plans for the most complex children and young people are now expected to be in place at age 14, in line with legislation.

Similarly, we continue to work together within the partnership to develop and refine the quality of the clinical and measuring tools themselves. A good example has been the introduction of a single outcome tool which is now used across all services. We spent 2 years collaborating with families and together to agree to a single tool which would:

1. measure progress and outcomes
2. have children and young people and families at the centre of goal setting

3. demonstrate an integrated service approach to families
4. be easily recordable on SystmOne

The 'Goal Based Measure'[2] meets these needs and is now well embedded within services.

Measuring performance:

The provider operational lead is accountable for the following aspects of performance:

- Collating performance of the 5 KPIs quarterly
- Collating an activity and outcomes dashboard across all services

Quality Governance - incidents, complaints, compliments are reported in an annual quality learning report. This includes developing, implementing and monitoring a variety of family feedback mechanisms. An example of this is an annual deep dive that we conduct to ascertain parent perspectives of the whole service, as opposed to feedback on single services or a single appointment. It allows us to ask the FFT question and then drill down into the reasons for parents' feedback to see if there is anything we can change in order to improve services. Specifically, to do more of what makes things work for families and less of what doesn't work. Each year we use clinicians not involved in the service to telephone a random sample of 30 families to interview them about their experiences, and the feedback forms the basis of an annual action plan for the Clinical Leads. The questions we ask are:

- how likely are they to recommend our service to friends and family if they needed similar care or treatment?
- why would you recommend it/ what do you like about the service?
- why would you not recommend it/ what did you not like about the service?
- how can we improve what we do?

The feedback contributes to our annual learning plan, so that together with other feedback, including complaints and learning from incidents, we can improve the service we offer. See powerpoint My Goal not Yours.

Governance

We agreed lines of accountability between the providers. Clinical Leads of professions remained employed and line managed within their own organisations, and have a dotted line to the operational lead Head of Children and Young People and Family Services for performance and quality.

2 Law D & Jacob J (2015) Goals and Goal Based Outcomes; some useful information 3rd edition CAMHS Press

1. Clinical Leads Group

The Clinical Leads Group meets every 6 weeks and is responsible for developing, implementing and overseeing multi-disciplinary shared practice and developing services to address local and national strategic priorities. The Clinical Leads Group is responsible for identifying and resolving operational, practice-focused issues that are complex or multi-disciplinary in nature. The group is task-focused and delivers specific pieces of work, and is tasked to:

- Lead clinical and/or operational planning and service development as it relates directly to cross-disciplinary practice.
- Identify, implement and monitor any necessary changes to ways of working which are complex and multi-disciplinary in nature, making recommendations to the CICS Partnership Board where these have significant resourcing implementations.
- Act as first point of resolution for any issues or challenges arising between disciplines or affecting multiple disciplines.
- Lead NHS Services input into planning in response to local and national strategic developments, co-ordinating responses and implementing service changes as necessary.
- Undertake regular reviews of multi-disciplinary and multi-agency services, panel and teams to ensure they continue to meet the needs of children and their families.

2. Performance and Quality Group

The Clinical Leads meet quarterly to review performance and agree narrative before this is presented to the Partnership Board

The group highlights risks as appropriate through line management within the Lead's employing organisation and via the Head of Children, Young People and Family Services.

It implements the agreed policies and procedures for the management of risk as outlined in employing organisations.

3. The Partnership Board

The Partnership Board is chaired by Camden Clinical Commissioning Group and London Borough of Camden and meets quarterly. The Board holds accountability for the work of the Performance and Quality Governance Group and the performance of the partner agencies participating in the integrated services agreement.

Each organisation is represented in the Board's membership. Key duties include:

- To promote excellence in patient care by staying abreast of developments and making recommendations for strategic change.
- To oversee the delivery of the service model, identifying and resolving any issues that arise.
- To monitor quarterly performance against shared indicator sets and performance dashboards and identify any proposed changes to service delivery as necessary.

- To oversee and take responsibility for effective joint working across Trusts, including establishing leadership structures and ensuring joint working arrangements are implemented across all services
- To receive annual learning report from the CICs Quality Governance Group concerning the quality and safety of services being delivered
- To scrutinise and challenge any assurances given to the Board
- To implement shared ways of working such as establishing consistent user engagement mechanisms, ensuring recommended best practice for involving families is incorporated into service working, including service design
- To ensure that the Quality Governance Group develops a strategy for the involvement of parents, carers, children and young people.

Information Governance

Typically NHS staff use their employing organisation's electronic patient record (EPR). In bringing together the staff from 4 NHS providers to use a single EPR we were able to improve safety and experience for children and families, by virtue of better information sharing.

We established a system of honorary contracts for staff, which enabled NHS staff from the partner providers to use CNWL's EPR as the primary NHS care record for every child. The honorary contract process provided CNWL, and ultimately families, with the assurance that the staff accessing the EPR were competent, safe and principled.

The process involves administrative, HR and registration authority engagement.

- Service managers send details of new starter (in a spreadsheet template) to project support/administrators 4 weeks before they are due to start.
- Project support/administration draw up honorary contract and send it to new employee for signing (must be returned within 2 weeks).
- Once signed copy received, project support/admin send the contract to HR for validation.
- Project support/admin send honorary contract evidence, including the spreadsheet, with smart card numbers to the Head of Children, Young People and Family Services for approval. Once approved, spreadsheet is sent to Registration Authority (smart card team).
- Registration Authority (smart card team) inform project support/admin and cc in new starters manager when access has been authorised.
- Staff can book into SystmOne Training by contacting the SystmOne helpdesk.
- New starter to contact the SystmOne helpdesk after they have logged into SystmOne with their smart card to allow them to make the final adjustments to their login.

Service Managers to inform project support/admin (in advance) of staff leaving the service or going/returning from maternity/long term sick leave (with dates). Project support/admin will inform the Registration Authority who will remove/amend access rights accordingly

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