Connecting Care Children's Hubs Project and Lessons Learnt Report

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As hospital-based care has become increasingly specialised, a void has opened up between GPs and our hospital colleagues which can have a negative impact on patient care.

The NHS is trying to deliver more care in the community and closer to people's homes, but there is little to be gained by simply moving a service from one place to another. The innovation that has transpired from this project is that the clinics are based in general practice, delivered by Consultant Paediatricians working with GPs, where possible using the GP record, ending the session with an MDT for all to meet, discuss and address the issues of local children.

There are gains on so many levels:

- Improving access and care of children
- Transforming the way care is delivered moving away from a traditional OPD approach
- Breaking down barriers between Consultants and GPs, hospitals and communities
- Improving relationships, communication and collaborative working
- Upskilling GPs and at the same time give Consultants a greater understanding of the issues GPs have to deal with
- Providing an opportunity for GPs to develop a specialist skill and a portfolio career helping with workforce retention and workload
- Offers an opportunity to roll out good practice; not only should this model be implemented across the STP; it could also be transferred to other specialities and builds on the establishment of Primary Care Networks

The Paediatric hubs are good for patients and their relatives, for the clinicians looking after those patients and also the healthcare system within which we all work.

Dr Nigel Watson MBE MBBS FRCGP
GP Arnewood Practice
Chief Executive Wessex Local Medical Committees Ltd
Independent Chair, GP Partnership Review, Department of Health and Social Care

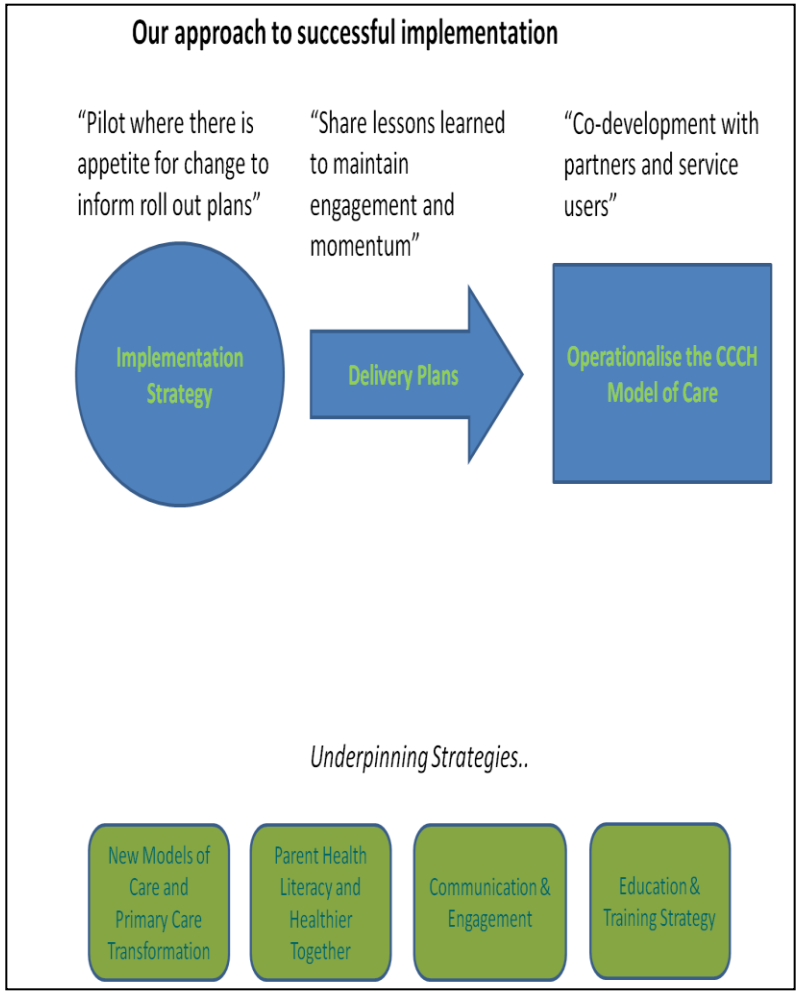
Background

The Connecting Care Children's Hubs project aimed to improve the delivery of urgent care to children through increasing the connections between primary, community and secondary care. The project was led by the Hampshire Isle Of Wight (HIOW) Sustainability, Transformation Partnership children's programme team and funded for the first 6 months using NHSE Urgent & Emergency Care monies then HIOW CCG's funding until March 2019. The evaluation report describes the process and impact of the CCCH project.

The HIOW Connecting Care Hub model was designed based on documented learning from the Connecting Care for children model (Imperial College London), the Children Young People Health Partnership programme(Evelina Children's Hospital Lambeth & Southwark), delivery of the model in Taunton, Somerset and experience of four paediatric 'drag and drop' secondary care clinics based across Hampshire.

Children and young people account for 25% of emergency department attendances and are the most likely age group to attend A&E. Many of these attendances could be managed effectively in primary care or community settings. The NHS Long term Plan (2019**)**

A 2010 review from The King's Fund, entitled "Avoiding hospital admissions: what does the research say?" identified three broad interventions that appear effective at reducing presentations to primary care and emergency admissions: integrating health and social care, integrating primary and secondary care, and patient self-management. The CCCH model primarily focuses on the second and third of these interventions.



Connecting Care Hub Model Rationale

Aim

To improve the health and well-being of children and young people in HIOW through strengthening and sustaining relationships between community based healthcare professionals and secondary care clinicians:
Encouraging partnership working between primary, community, secondary care and other networks by moving specialist care out of hospitals into the community.
Providing workplace based learning for professionals.
Development of local referral pathways
Strengthening access to high quality primary care services
Building confidence in parents to manage common illnesses, improve their experience of primary care services and positively impact on health seeking behaviours
Reducing urgent care activity in both primary and secondary care settings

Potential Service Benefits and Quality Improvements

If successfully implemented, CCCH's could result in;-
Improved quality of care
Better population health
Reduced per capita costs
Better staff experiences

Based on national CCCH data, the expected impact of the model was a

- Reduction in emergency department presentations by 10%
- Reduction in children's assessment unit/paediatric assessment unit /acute admissions by 10%
- Reduction in out patient referrals by 25%
- Reduce the demand on primary care workload

Connecting Care Children's Hub Model Description

A CCCH, which has three core elements, is centred in primary care and built around a monthly multi-disciplinary team (MDT) meeting and clinic. The key to successful implementation is that although the model is supported by secondary care clinicians it is 'owned' and delivered by primary care:

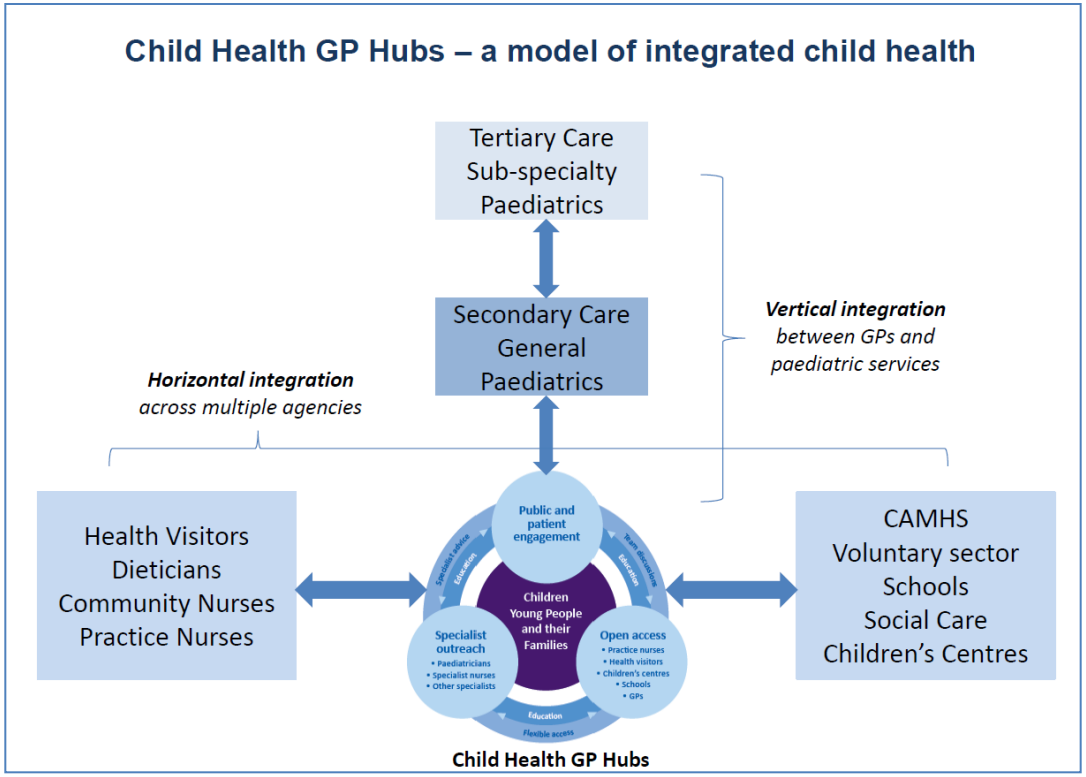
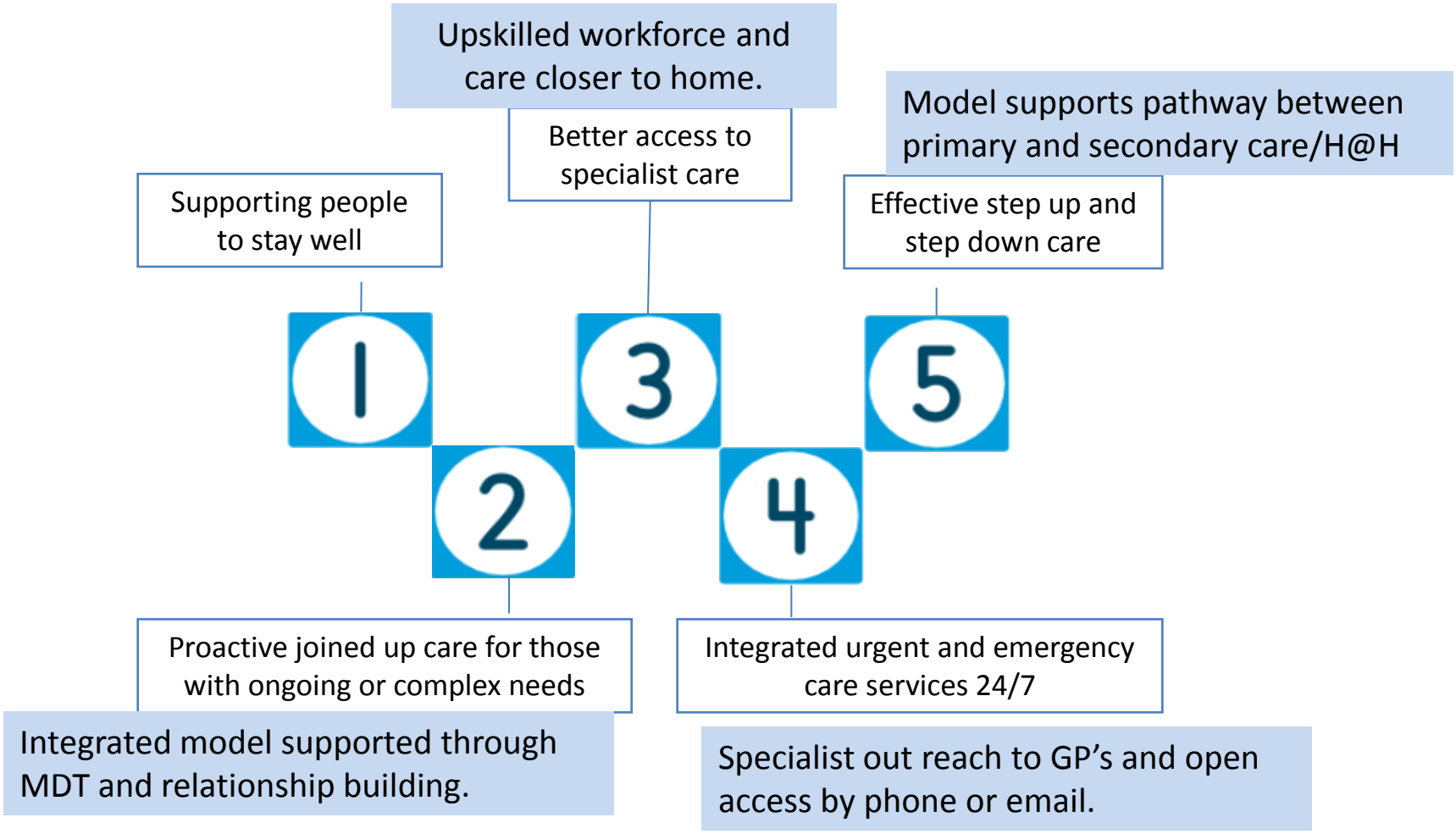
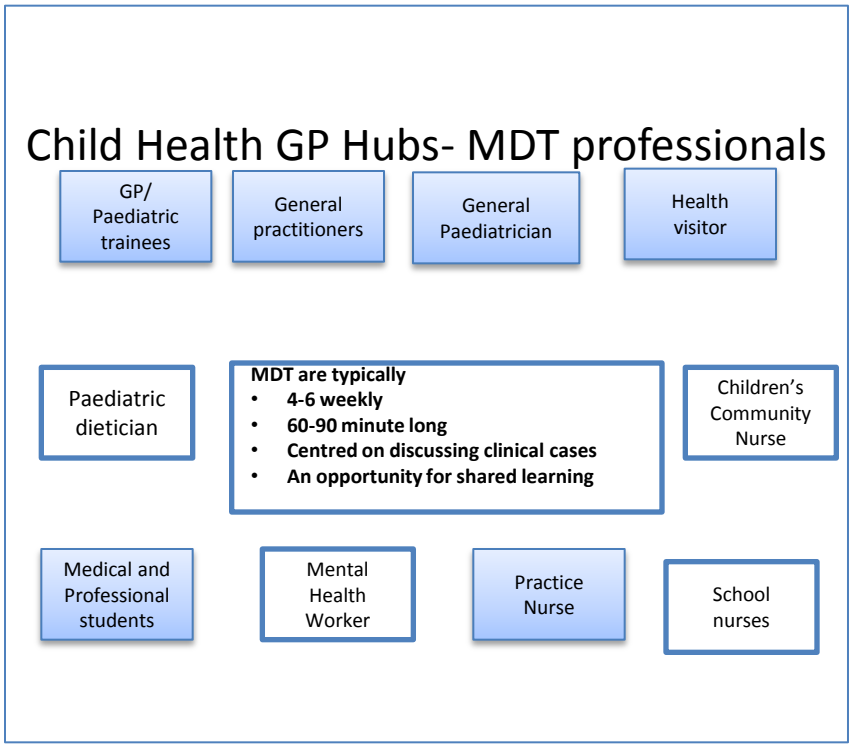


Diagram indicates Connecting Care for Children (CC4C) paediatric integrated care model

Consistent with Integrated Models of Care Core Components





The blue boxes indicate the professionals that have typically been present , although this has not been consistent across HIOW.

Multi-disciplinary Team Meeting approach

One hour monthly MDT meeting co-ordinated by the Primary Care Network, centred on discussing clinical cases that can be brought by any member of the MDT.

MDT membership will be driven by local needs and ideally include a Consultant Paediatrician, patients GP, other GP's from the practice, GP's from the primary care network (utilising technology), Health Visitor, School Nurse, Community Children's Nurse, Dietician, Primary Care Mental Health worker, Practice Nurse, trainees and professional students.

The MDT meeting will allow the development of closer working relationships between a named paediatrician and a group of GPs and other community based staff (as above) This may be extended to include the sharing of telephone details and emails to allow rapid discussion of the most appropriate care for children.

GPs from any practice within the cluster will be invited to attend the MDT session to enhance their knowledge and understanding of the management of patients. This would also be a good environment for attached Foundation Year 2 , GP ST doctors to attend to further their paediatric training and professional students.

GPs and HVs can bring cases from other colleagues and discuss frequent attenders identified from general practice data and the reason for their attendance.

Clinic

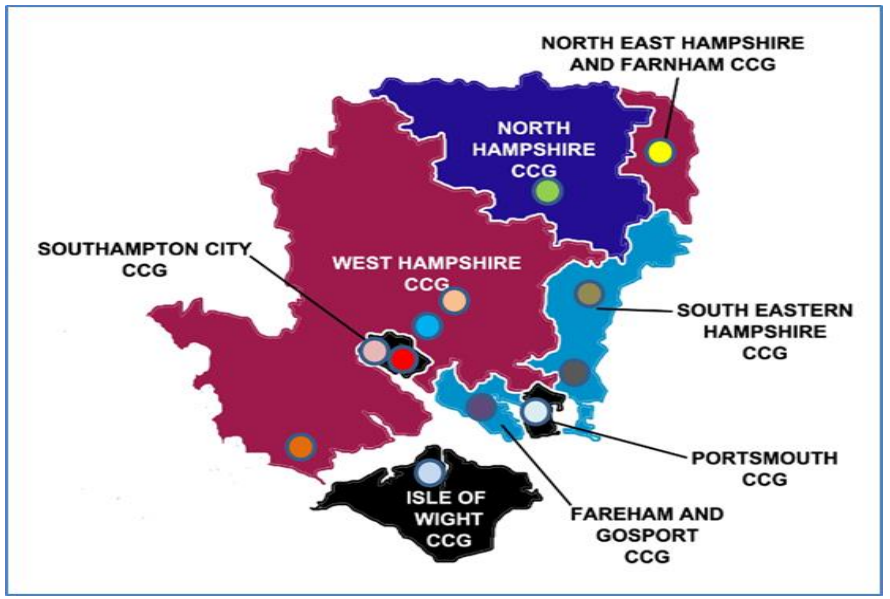
One, three hour clinic per month providing 6-8 appointments for children and their family, run by the GP and Consultant Paediatrician for new referrals or complex children where review in the community would be beneficial . The clinic may be rotated round the identified practices within a Primary Care Network (PCN)

GPs can book directly into these slots and they would only be available for patients from the primary care network. Other professionals from health, social care or education involved with the family would be welcome to attend the appointment and to jointly input into the clinical discussion and plan.

The GP who attends the clinic or follow up appointment will disseminate the learning in order to both enhance his/her personal professional development and the primary care network's understanding of paediatric medicine and also to facilitate a more collaborative approach to the 'out of hospital' care and management of their patient. The paediatric consultant may be accompanied by paediatricians in training or professional students to enable those in training to experience more collaborative ways of working and learn from experienced GP's knowledge of managing families within a local community.

Implementation of the CCCH model across HIOW

- Following a successful bid in October 2017, NHSE awarded 190K to fund a pilot of the CCCH model.
- Twelve CCCH's were planned and implemented across eight CCG's reflecting the landscape of HIOW in 2017. It was acknowledged that due to the limited time for planning based on the NHSE imposed 5 month time line for implementation that hubs were located in areas based on local leadership, goodwill and ability to implement at speed rather than local population needs.
- Portsmouth City CCG utilised their funding to deliver a planned multi disciplinary education and pathway review programme.
- Funding of £8,251 was provided to each of the hubs to enable implementation and delivery of the hub model for 6 months



CCCH models across HIOW 2018

Hampshire and Isle of Wight Sustainability and Transformation Partnership

Table demonstrates the significant commitment of clinicians across HIOW to test an integrated care model

CCG	Locality	Population size (0-18)	First Meeting	GP Lead	Consultant Paediatrician
NEH&F CCG	Oakley Group 3 practices	8202	April 2018	Dr Vicky Goodall	Dr P Maltby Frimley
North Hampshire CCG	Whitewater Loddon 3 practices	5925	December 2017	Dr Roisin Ward	Dr Ed Hinds HHFT
West Hampshire CCG	Eastleigh 4 practices	7496	March 2018	Dr Roland Fowler	Dr Ian Rodd HHFT
West Hampshire CCG	Chandlers Ford 5 practices	8448	March 2018	Dr Roland Fowler	Dr Simon Struthers HHFT
West Hampshire CCG	New Milton 3 practices	5425	January 2019	Dr Hannah Rycroft	Dr Emma Grainger Allen UHS
Southampton City CCG	Cluster 1/2 4 practices	5928	December 2017	Dr Sanjeet Kumar	Dr Kate Pryde UHS
Southampton City CCG	Cluster 3/4 6 practices	6269	December 2017	Dr Nicola Robinson	Dr Katrina Cathie UHS
IOW CCG	Dower Group 3 practices	6615	December 2018	Dr Tim Wheeler	Dr Bettina Harns St Marys
SE Hants CCG	Petersfield 8 practices	15,943	April 18	Dr K Bannell	Dr Hannah Buckley PHT
SE Hants CCG	Waterlooville 3 practices	10,253	April 18	Dr Duncan Pickup	Dr A Freeman PHT
Fareham & Gosport CCG	Fareham 3 practices	8768	April 18	Dr Donal Collins	Dr Simon Birch PHT
Portsmouth City CCG	MDT for education and pathway knowledge	46,334	February 18	Dr Rummi Chappia	Dr Jo Borbone PHT

Finances

Staff Costs to deliver the Child Health GP Hub December 2017			
Role	PTE	Band	6 month cost
GP	5 hours per month		2,546
Paediatric Consultant	5 hours per month		2,546
Health Visitors	2 hours per month	6	734
Children's Community Nurse	1 hour per month	6	367
Dietician	1 hour per month	6	367
Primary Care MH Worker	1 hour per month	6	367
School Nurse	1 hour per month	6	367
Admin Support	1 hour per month	3	207
Non Pay			750
			8,251

In July 2018 the HIOW CCGs agreed to continue to fund the existing hubs enabling twelve months evaluation and learning to be collected and analysed to identify if the CCCH model had been of benefit as anticipated.

Based on the learning there was an increase from 1 hour to 8 hours per month for Admin support in recognition of their pivotal role required to deliver the MDT meeting and clinic

The aspiration was that local delivery system leaders would support sustainability of the model to ensure children are seen at the right time, by the right person and in the right place following completion of the STP CCCH transformation project on 31st March 2019.

Evaluation and Monitoring

The HIOW Urgent and Emergency Care Paediatric Dashboard

This was was designed and developed utilising the NHSE monies to generate three reports from February 18 to March 2020 for local and system analysis;-

- Quarterly child health dashboard
- Quarterly patient cohort evaluation
- Annual national benchmarking report
- The dashboard is hosted on the Healthier Together website.

Data to be collected by professionals;-

The Cohort specific evaluation forms were completed by the lead (acute) provider paediatrician for the hub. Anonymised cohort specific information collected on the number of cases discussed within the hubs supported pre, post CCCH intervention analysis by Clinical Support Unit with quarterly reports.

Cohort specific evaluation forms were completed ;-

- Patients NHS number
- Date and location of the CCCH; MDT and clinic
- Attendances register for the MDT and clinic completed, indicating who had attended that meeting.

Qualitative data

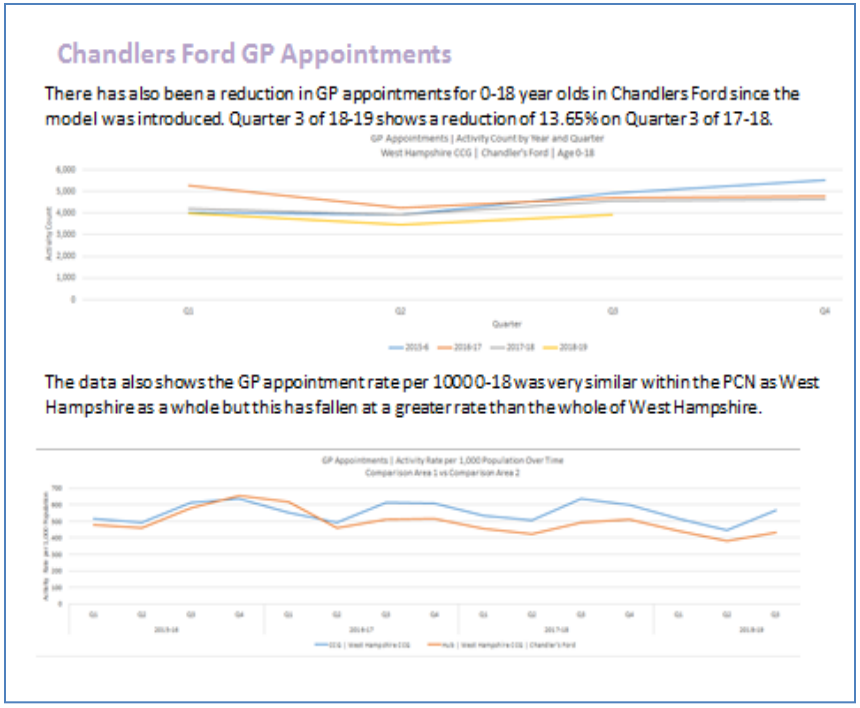
- Parent confidence and satisfaction (clinic) evaluation forms were completed by every parent and or child following a hub appointment.
- Healthcare professional satisfaction (MDT and clinic) evaluation form were completed by every MDT professional once they have attended a meeting/clinic for internal evaluation

Realising the benefits from evidence to date

- The emerging qualitative and quantitative data from the hubs that have actively engaged in evaluation suggests reductions in emergency department presentations and referrals to out-patients.
- The evaluation suggests reductions in primary care urgent presentations and this will contribute to supporting the sustainability of primary care networks.
- Feedback from families who have accessed the service and primary, community, secondary care professionals has been very positive.

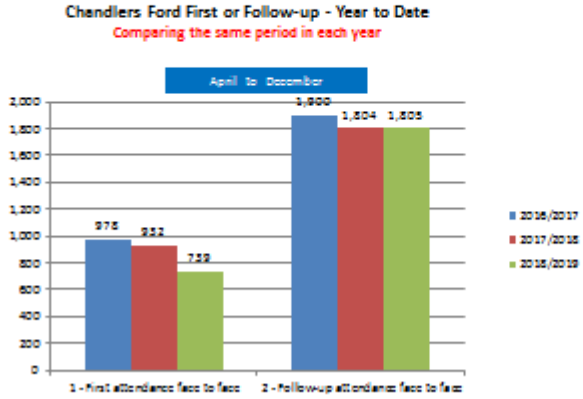
Chandlers Ford is the Primary Care Network (PCN) pilot area which has been running with full model fidelity since April 2018 having started a MDT and drag and drop clinic in January 2017.

The following data shows:
13% reduction of GP appointments for 0-18 year olds from Qu 3 17/18 to Qu3 18/19
Rate of GP appointments for 0-18 year olds dropping compared to West Hampshire as a whole
20% reduction of paediatric first outpatient appointments YTD
7% reduction of all paediatric outpatient appointments YTD (first appointment & follow up combined)
6.96% reduction in non-elective admission YTD
3.11% reduction in A&E attendance YTD
Analysis looking at specific patients who have been seen in a clinic (tracked via NHS number) shows significant reduction of 999- Hear treat/See treat/convey; emergency department attendance and emergency admission



Chandlers Ford Outpatient Data

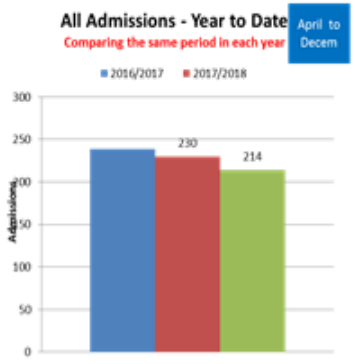
Chandlers Ford is the PCN within the South West of Hampshire which has been operating with model fidelity for the full pilot period*. There is a reduction in first outpatient appointments – a reduction of over 20% of first appointments YTD. There has been a reduction of just over 7% for FA and FU combined over the same period.



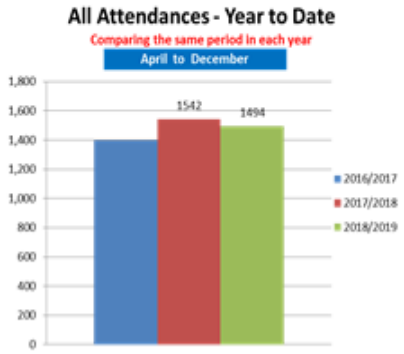
* The Eastleigh PCN MDT has been running for the duration of the pilot but the new model clinic was not adopted until November due to existing HHFT outpatient clinics. The New Milton MDT and Clinic did not start until January 2019 due to delays in organising the release of the paediatric consultant from acute clinics which have now been resolved.

Chandlers Ford Non-elective admission data

We can see a reduction in non-elective admission of just under 7% YTD and 3.11% reduction in A&E attendance.



Non elective admissions



A and E attendances

Qualitative data summary

The Qualitative benefits from feedback of patients and health professionals participating in the pilot hubs have shown they are beneficial for shared learning, interactive working, and patient centred care. The qualitative data has demonstrated;-

•Self-reported empowerment of parents to confidently manage common illnesses
•The value of workplace based, multi professional education and learning particularly clinical case discussion, dissemination of the learning to colleagues across system's
•That CCCHs are providing a forum for collaboration between primary, community and secondary care professionals which are highly valued by staff

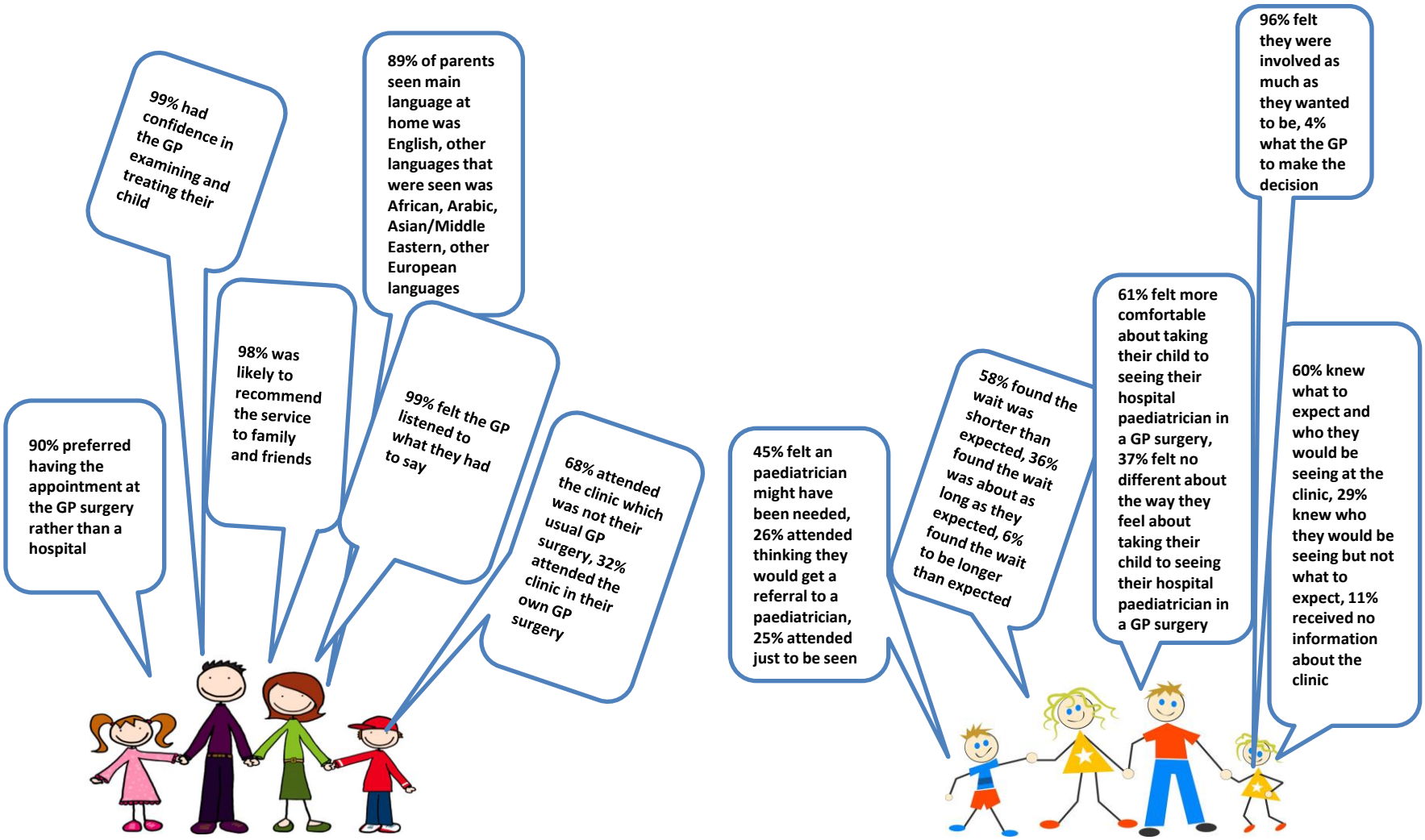
From the attendee's responses:

- 89% indicated they found the MDT useful or very useful, 7% found it was useful/not useful the others found it not useful or didn't respond. Of these 56% found the case discussions most useful, 15% found the educational content most useful, 14% found the shared learning most useful, 4% found all of it was useful, the other 11% was split between specific pathways, diagnostic tools, contacts or no response was given
- 93% indicated they would recommend the MDTs to their colleagues
- 89% indicated the MDT was useful for the care of the children and families discussed
- 43% indicated the format of the MDT worked, 41% didn't respond the other 16% suggest change or additional topics
- 88% indicated that they are likely to put into action the learning from their attendance at the MDT

Additional responses:

- 91% indicated they found the clinic useful for their education of childhood health problems
- 91% indicated they would recommend the clinic to their colleagues
- 100% indicated that they are likely to put the action the learning from their attendance at the clinic
- 59% found the case discussions most useful, 14% found the specific pathways most useful, 9% found all of clinic most useful, other 18% indicated either interaction between families & professionals, shared expertise, pathways or no response
- 40% found nothing least useful within the clinic, 20% found the accommodation least useful, 20% found inappropriate referrals least useful, 20% found the organisation of the clinic least useful
- 45% felt it could be improved by additional topics discussed, wider publicity, being more frequent, GP education or referral process, 55% didn't respond

Feedback from children and families that were seen in a connecting care hub



Clinician Feedback

Dr Rosin Ward, Lead GP for the Basingstoke Hub

'*From a GP perspective it has been invaluable to have a paediatrician's input on our more common problems that we have become stuck with but by sitting in and picking up ways of explaining, history taking and managing. I believe this has led to improvement in approach of all GPs in consultations outside the Clinic forum to account for the drop in referral rate. The MDT format has worked well to trouble shoot more minor issues and empower a way forward for GPs stuck with the next steps in management. The link with Ed has helped to break the physical barrier between primary and secondary care and allowances ease of two way communication that all have felt the benefit of*'

Dr Edward Hinds, Paediatrician at Hampshire Hospitals Foundation Trust

'*From my point of view as the Paediatric Consultant involved, these clinics and meetings have improved communication with the GPs and other professionals in the practices involved and have meant we can discuss difficult cases much more easily. My understanding of how things work in Primary care has improved, including resources available, pressures and a better insight into how things can be managed. Knowing that the evidence shows reduced referrals to secondary care since the pilot started, and that there is a high level of patient and parent satisfaction, I find the clinics rewarding on a personal level too.*'

Clinician Feedback

Simon Struthers, Paediatrician at Hampshire Hospitals Foundation Trust

I'm really pleased with the Andover Hub. I have met so many GPs, who come to the MDTs with good cases to discuss and good topics to review. The presence of a HV lead has also been very positive. I think we have all learnt a lot from each other. Already I feel that we are working together as a team to look after children in the area, and that the communication gap between primary and secondary care has been broken down. We have seen 24 new patients in three clinic and the ability of Ruth and her team to organise this has been amazing. There have been no DNAs which is unheard of in Andover HHFT OPD in the local hospital where DNA rates have sat at high levels -10-20%.

There has been really good engagement with the cluster GP practices. Andover has reassured me that the Hub style paediatric model is the way forward and will improve care for children and improve the way we work with children.

One key message we need to convey is that whilst GPs and Health Visitors need to invest time initially, in the long term it will save time and effort. It is also important to recognise that communication is crucial – easy communication routes between all individuals and teams must be embedded within the model.

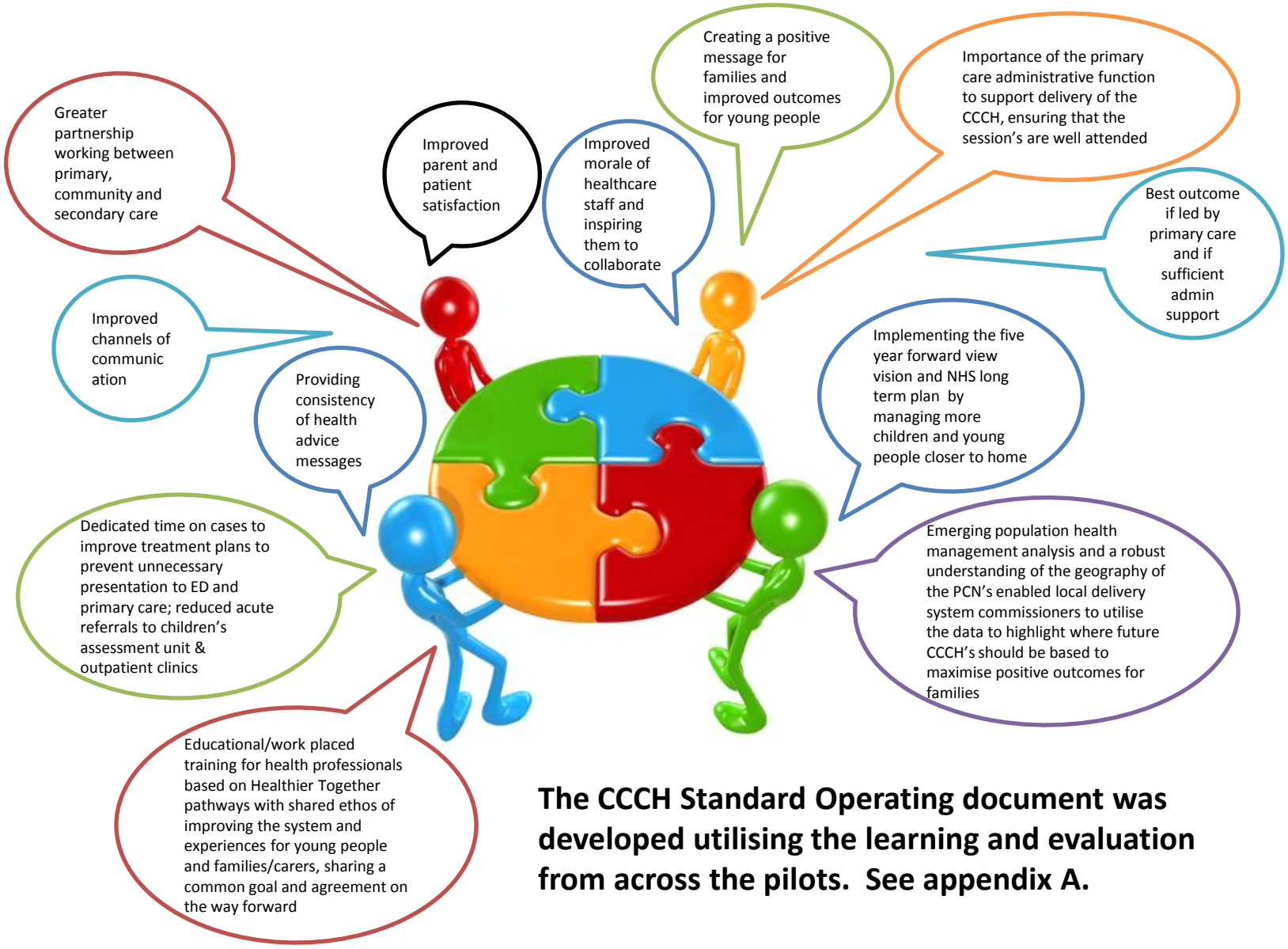
Additional feedback

Additional Professional Feedback*:*
Helpful to understand things we can do, investigate,
Paediatrician opinion on cases referred as a GP
Good opportunity to ask questions, helpful to have both primary and secondary care opinion
Good to confirm current practice in line with others
Really helpful to talk through cases informally and get advice on specific cases without needed to do a full referral
Good to have different doctors thoughts
Useful from a trainee perspective as much to learn and understand, options for treatment/management when explained through
Variety of cases discussed, excellent learning opportunity
Helpful to talk through cases, patients seem appreciate being seen in the community as easier to get to then hospital

Additional Parent feedback:
It was great to have the opportunity to see the consultant so quickly and conveniently rather than waiting months for a referral to hospital
Excellent service, felt very confident with outcome
Great to have a team approach and my child felt listened to and that they were kind and explained their findings well
Very important and appreciated
A great service with such reassuring advice

Commissioner Feedback: creative services to format
From a commissioner visit to the North Hants MDT and Clinic recently showed:
Clinic - it is clear of the 5 children they reviewed almost certainly it has prevented 5 PBR first appointments into an acute clinic, this would have been to a cost value of circa £1250 depending on type of clinic
MDT – Discussed 2 cases which would have probably have caused referral into paediatrics and CAMHs.
The predicted diverted cost saving of £1750 as above could cover the operational costs

What are our successes and learning



The CCCH Standard Operating document was developed utilising the learning and evaluation from across the pilots. See appendix A.

What has been Challenging

- HIOW Strategy has developed throughout the duration of the project, this created the risk that competing priorities could reduce the commitment to develop and sustain CCCH models e.g. New models of care and GP forward view programme expressed the strategy as hubs, clusters and now primary care networks.
- Capacity of identified professionals to attend the CCCH sessions as agreed and funded
- Project team not being sent feedback forms from MDT meetings/clinics and NHS numbers of patients discussed/seen not been sent to the CSU as specified in the service level agreement despite regular reminders
- Variable digital enablement, interoperability within primary care to facilitate a greater number of professionals contributing to the MDT meeting
- Capacity of identified local primary care leaders to drive, champion the CCCH ensuring forward momentum
- Information governance process not operating at system level
- Benefits are yet to be fully understood and cascaded to professionals and commissioners due to the time duration of programmes – full impact may take months/years to be realised at place and system level

Sustainability

The CCCH project team worked closely with local delivery system commissioners and GP clinical leads to develop and present business cases to ensure sustainability of existing hubs and identify through a population needs analysis approach where paediatric specialist expertise would add most value. 10 existing CCCH will be delivered across 31 practices with an additional 5 hubs planned across HIOW in 2019/20. Monitoring of current activity levels and analysis of the impact will continue to inform plans and further co design for 20/21 onwards. The 35 primary care networks and local delivery system emerging Integrated Care Partnerships will support the opportunity to consolidate and further transform children's expanded primary, community and specialist multi – disciplinary locality teams. The NHS Long term Plan describes offering primary care networks a new shared saving scheme so that they can benefit from actions to reduce avoidable A&E attendances, admissions and delayed discharge and streamlining patient pathways to reduce available outpatient visits

South West Hampshire

- Eastleigh 4 practices
- Chandlers Ford 5 practices
- New Milton 3 Practices
- Avon Valley 4 practices
- Eastleigh Southern Parishes to roll out 19/20 practices

Southampton City CCG

- Cluster 1 and 2 -4 practices
- Cluster 3 and 4 -6 practices
- 1 additional hub to roll out

North East Hampshire and Farnham

- Oakley Group 3 practices

Connecting Care Childrens Hubs 19/20
55 practices

North and Mid Hampshire

- Whitewater 3 practices
- Acorn 3 practices
- Andover 5 practices
- Avon 4 practices
- 1 additional hub to roll out

South East Hampshire

- Havant Emsworth and Hayling Island 8 practices

Isle of Wight

- Cowes Medical centre, 3 practices

Finances

19/20 costs have been negotiated locally as part of the business case and contract process. For example one acute trust has agreed to support the Hubs based upon the provision of 6 months pump priming, followed by this being included within the main contract after 6 months. This is on the basis that after 6 months, they will see a reduction in outpatient referrals and can therefore drop an outpatient session and use this to support the Hub.

Local commissioners will work with other acute trusts and primary care to see if it is possible to reduce funding as the model's impact is evidenced and demand on acute and primary care provision reduces.

Role	PTE	Average cost
GP	1 session per month	£4,074
Paed. Consultant	1.5 session per month	£3,500
Health Visitors	1 hour per month (+0.5hr prep)	£369
School Nurse	1 hour per month (+0.5hr prep)	£369
Admin Support	8 hours per month	£1,147
Non Pay		£1,716
Annual cost		£11,175

Rolling out CCHs– modelling the impact and cost saving of CCH within Primary Care Networks in West Hampshire CCG

Primary Care Network	Total Reg	0-19 years	0-19 as % of total	A&E Apr-Dec 18	FA Outpatient Apr-Dec 18	5% reduction in A&E (£93 tariff)	10% reduction in FA outpatient (£203 tariff)	Modelled saving
EASTLEIGH	31,406	7,506	23.90%	2086	1,230	£9,700	£24,969	£34,669
EASTLEIGH SOUTHERN PARISHES	49,958	11,577	23.17%	2960	739	£13,764	£15,002	£28,766
AVON VALLEY	39,983	7,688	19.23%	1551	1,046	£7,212	£21,234	£28,446
CHANDLERS FORD	25,320	5,915	23.36%	1494	880	£6,947	£17,864	£24,811
WATERSIDE	42,697	8,927	20.91%	2186	636	£10,165	£12,911	£23,076
TOTTON	38,082	7,940	20.85%	2024	557	£9,412	£11,307	£20,719
NEW MILTON	33,919	5,623	16.58%	1675	625	£7,789	£12,688	£20,476
LYMINGTON	35,251	6,252	17.73%	1702	594	£7,914	£12,058	£19,973
ROMSEY	41,902	8,667	20.69%	1984	461	£9,226	£9,358	£18,584
ANDOVER	59,689	13516	22.6%	3422	959	£15,912	£19,468	£35,380

Utilising primary care network data to identify future continuing CCCH's

Eastleigh Southern Parishes(ESP) Primary Care Network

0-18 population (11,578) makes up
23.18% of total registered population

Accident & Emergency

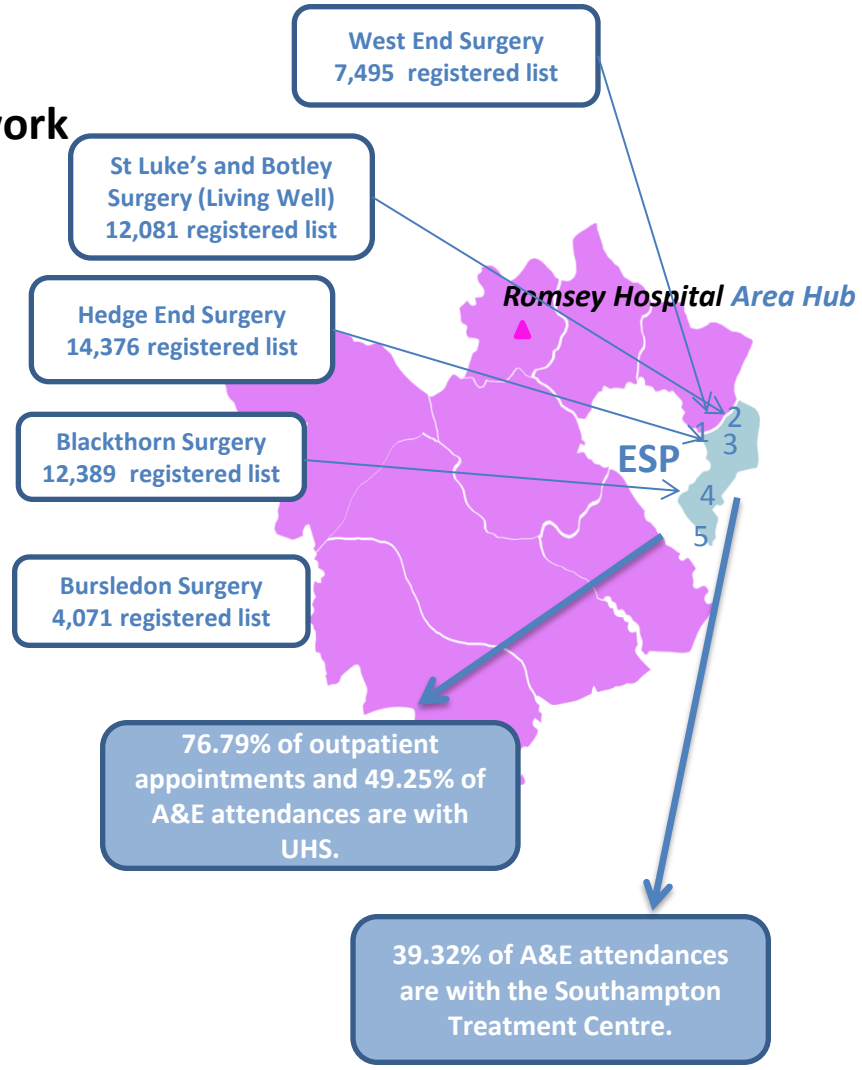
- 2,960 A&E attendances (256 per 1,000 population)
- 62.33% discharged with no follow up needed

Outpatient

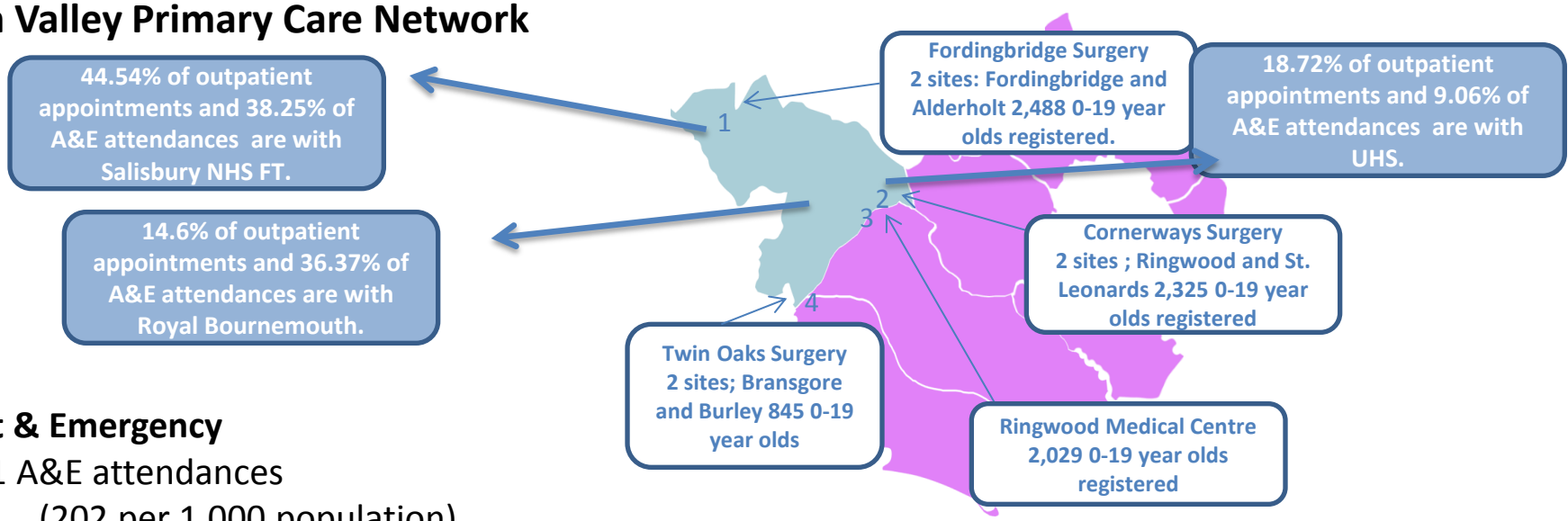
- 2,900 outpatient appointments (250 per 1,000 population
- 880 first appointments (30.34% of all appointments)
- 757 (26.10%) of appointments led to discharge

Acute Flow

Over ¾ of outpatient appointments are with UHS as are nearly half A&E attendances with a further 39% attending the Southampton Treatment Centre.



Avon Valley Primary Care Network



Accident & Emergency

- 1,551 A&E attendances
  (202 per 1,000 population)
- 73.69% discharged with no follow up needed

Outpatient

- 3,109 outpatient appointments (404 per 1,000 population
- 1,230 first appointments (39.56% of all appointments)
- 1,143 (29.11%) of appointments led to discharge

0-18 population (7,688) makes up 19.23% of total registered population

Acute Flow

44.54% of outpatient appointments are with Salisbury, 18.72% with UHS, and 14.6% at Royal Bournemouth and 11.72% at Poole. 38.25% of A&E attendances are at Salisbury, 36.37% attend Royal Bournemouth and 9.06% at both UHS and Poole.

National results

Since Connecting Care 4 Children (CC4C) was established in North West London the model has been adopted by other CCGs, trusts and GP practices across the UK. The CC4C team won the 2018 acute-specialist services award. (Health Service Journal)

Evaluation

In one hub, 39% of new patient hospital appointments were avoided altogether and a further 42% of appointments were shifted from hospital to GP practice. In addition, there was a 19% decrease in sub-specialty referrals, a 17% reduction in admissions and a 22% decrease in A&E attenders.

2018 data showed the most mature hub delivered a reduction of 81% in outpatient appointments, 22% reduction in A&E attendances and 17% fewer admissions

North West London have calculated that if the hub model were to be implemented across the North West London STP area anticipated savings would be £8.8m.

Conclusion

The CCCH project has provided the opportunity to consider what Integrated Care for children means across HIOW; how we develop integrated care interface with primary secondary and community services, changing the way that children and families access services and improving families experiences so that they only use acute specialist care when they really need to.

Focusing on prevention, well being and mental health in future Integrated care CCCH's will be key to the success of the next phase, determined by the needs of the system, place and neighbourhood.

Thinking differently about the health and wellbeing of children and young people
www.what0-18.nhs.uk

Healthier Together

HIOW CCCH video https://youtu.be/jimtLyzp-OM

https://www.youtube.com/watch?v=GE6jStGLvJM Imperial London

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