Staff experiences and perspectives of delivering an integrated child health and social care service in community settings: A qualitative exploration using the SELFIE framework

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Introduction

It's suggested that integrated care is well-placed to address the prevalence of chronic conditions, obesity, and mental ill health in children and young people living in minoritized and economically-marginalised communities in high-income countries. This work describes staff perspectives of delivering an integrated place-based service providing multidisciplinary clinical care and early intervention social support to children and young people in an ethnically diverse and economically disadvantaged community in the UK.

Materials and Methods,

We conducted a qualitative exploration of the experiences of staff delivering the service and used a directed content analysis to populate and present the results within the Sustainable integrated chronic care model for multi-morbidity: delivery, financing, and performance

(SELFIE) framework. The first part of the analysis presented here focusses on the domain of *Service delivery*, relating to the availability and access of care.

Results

A total of 14 staff were interviewed including clinicians from primary and secondary care, social care providers, local voluntary groups, and school-based family mentors. Staff described at a *Micro*- level how the service increased engagement of families and facilitated referral to social support and preventative care; at a *Meso*- level the benefits of collocation, collaborative working, and community outreach were described. Finally at the *Macro* level, improvements to the access and availability of appropriate care were observed despite limited engagement by the local care system.

Conclusions

The pilot appeared to deliver multiple benefits for both patients and staff and the broader health economy particularly through collocating health care and social support. However, to implement truly integrated care, greater institutional commitment and leadership are needed.

Keywords: Integrated care; Health inequalities; Primary care; Children and young people; Community engagement

Introduction

Children, young people (CYP) and their families living in high income countries face mounting challenges to their health and well-being, as the prevalence of chronic conditions, obesity, and mental ill health continues to increase (1). These challenges are exacerbated in underserved populations i.e., minoritized, and economically (and culturally) marginalized communities (2, 3), by a range of socio-economic and cultural pressures that inhibit and utilisation of primary or preventative health care services (4-7). These social determinants of health (SDOH) include income, housing, and food insecurity and medical institutions in many high income countries are beginning to fully understand the importance of their being addressed (8, 9). To this end policymakers and commissioners in multiple health systems are encouraging collaboration between health services, social care providers, local authorities, voluntary, community and faith sector (VCFS) groups and other agencies to improve health and reduce health inequalities (10-12).

New models of integrated health and social care are emerging in Australia (13), North America (14, 15), and Europe (16). In the UK National Health Service England (NHSE) has been reorganised under the Health and Care Act 2022 to facilitate closer collaboration between health and social care organisations. (17, 18). This includes prioritizing and funding localised service delivery that integrates several strands of health and social care and places a greater emphasis on public and preventative health (10, 19-25).

One such example is the Sparkbrook Children's Zone (SCZ), a pilot clinic where General practitioners, family support workers, mental health outreach, dentists and paediatricians work side-by-side in a low-income area of Birmingham to deliver placed-based care with preventive health. The SCZ is described in a service blueprint differentiating between the visible elements involving the contact between patients and providers and the invisible processes and infrastructure that support its delivery (see Figure 1). Its intention is to treat and manage acute and chronic health care alongside the necessary social support for CYP and their families that can help mitigate the social determinants of ill-health (26, 27).

Despite the introduction of pilot programmes such as the SCZ and widespread policy initiatives encouraging localised integrated care there is little high quality evidence for children to suggest they increase accessibility to health and social care (28); which integrated models are most effective (29-31) and ultimately improve health equity (31, 32). The work presented here describes staff experiences from a range of health and social care organisations as well as the voluntary and community sector on the delivery and reception of the SCZ. The findings are presented within an *a priori* framework designed to examine and support integrated care offering structured insight into the facilitators, barriers, and benefits of delivering integrated place-based health and social care in the UK.

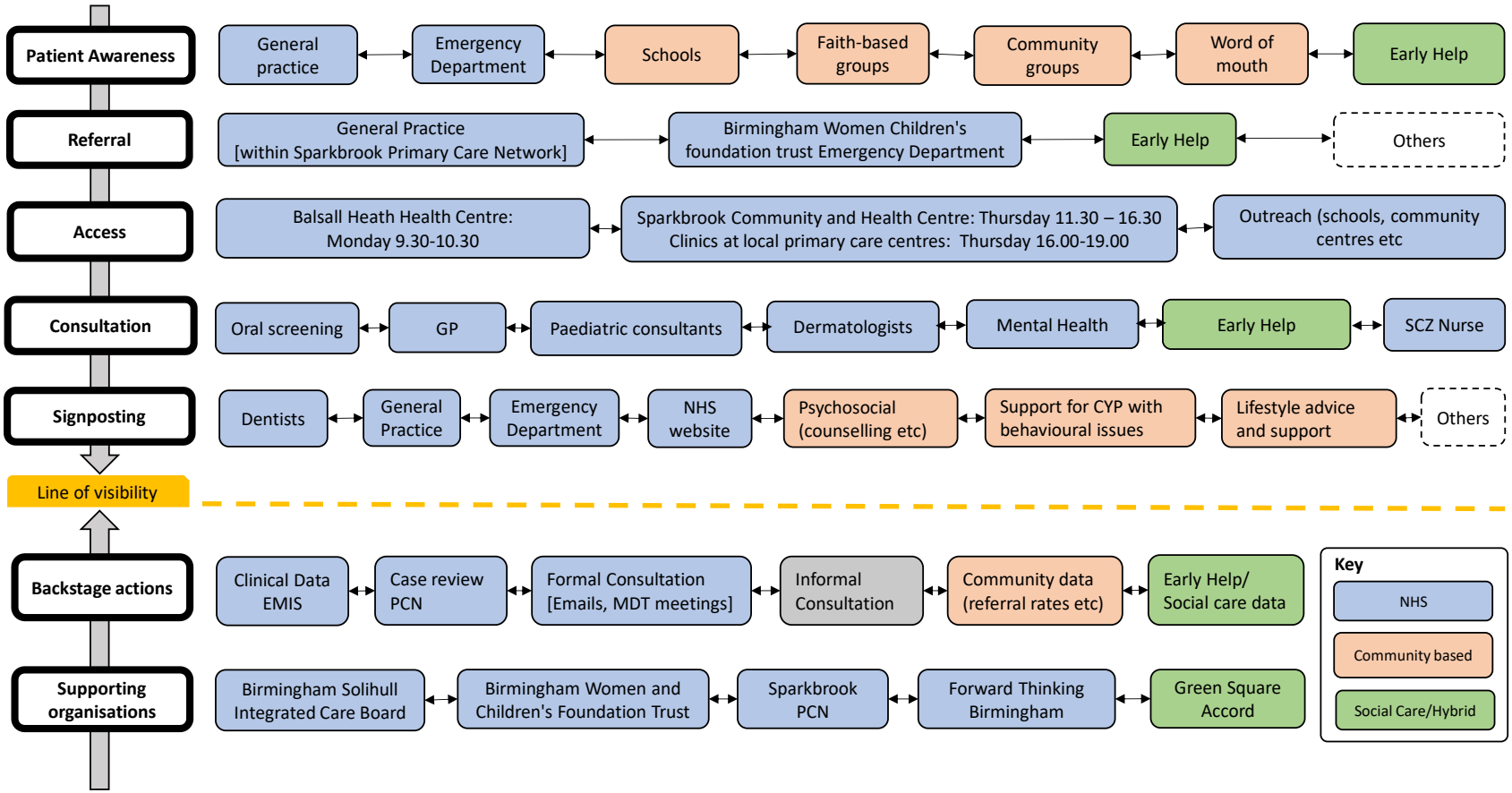

Figure 1: Service blueprint outlining Sparkbrook Children's Zone integrated service

Methods

Study design

The work is qualitative and consists of a series of semi-structured interviews with a range of staff responsible for delivering the service. To provide a structured exploration of this complex integrated care model we used the "*Sustainable intEgrated chronic care modeLs for multi-morbidity: delivery, Financing, and performance"* developed through a Horizon2020 funded EU initiative incorporating eight organisations from across Europe coordinated by the Netherlands (www.selfie2020.eu). The SELFIE framework consists of a number of coordination concepts from micro- through to macro-levels incorporated within six key components (see Supplementary File 1) informed by the six domains of the World Health Organisation's interpretation of healthcare systems (33). The work presented here specifically explores the domain of *Service delivery*, relating to the availability and access of care (see Table 2) (34). This allowed for a in-depth analysis of the influences on the delivery of the service. The data exploring the infrastructural and organisational factors underpinning the delivery of the SCZ are explored in our sister paper including the SELFIE domains of *Leadership & governance*, *Workforce*, and *Financing* [unpublished].

Population/recruitment

The SCZ is based in Sparkbrook & Balsall Heath East ward in Birmingham a large and diverse city in the UK's midlands. It is the second most populous ward in the city, has the second highest level of deprivation and a superdiverse, young population with high rates of unemployment infant mortality in England. It is also disproportionately affected by childhood

obesity, child criminal and sexual exploitation, poor housing, chronic disease, and high levels of universal needs around housing, food, clothing, sanitary products, and essential supplies (35).

All staff involved in developing, managing and delivering the SCZ were eligible for inclusion. They were approached by [1st author] and [4th author] who were unknown to potential participants, all were supplied with a participant information sheet, opportunity to ask questions and ultimately provided informed consent before the interview commenced. We aimed to carry out interviews with 5-6 service providers from each organisation (including service leads, those actively delivering the service and administrative/support staff) to reach a total of 25 interview sufficient to provide a rich and representative data set (36).

Data Collection:

Semi-structured interviews were conducted online (via Teams or Zoom), face-to-face in a room at the clinic, or via telephone by [First author] and [Third author]. They are experienced qualitative researchers who were previously unknown to the participants. Informed consent was required before the commencement of either. The topic guide was informed by the existing literature and covered a range of themes including experiences of the service, barriers and facilitators to engaging with the SCZ, and recommendations for further and future development (please see Supplementary File 1: Summary topic guide). Audio recordings were transcribed verbatim by an approved third-party transcription service and the data were managed using nVivo vers 12.

Data analysis:

Two authors [first author] and [third author] independently coded each transcript fitting the data within each of the six themes of the SELFIE framework using the best principles of directed content analysis (37). This included the identification and inclusion of emerging domains, constructs or sub-constructs (38). Any differences in coding were discussed and a consensus arrived at. The final allocation of the data within the coding framework was agreed by all authors. To confirm, the data coded into the "Service Delivery" domain are presented here.

Results

Characteristics of participants

We interviewed 14 participants over 13 interviews (two participants were interviewed at the same time). The interview lasted between 18 and 70 minutes. Of the 14 participants five were from primary care, three secondary care, two from social support, one that worked in local education, and one for a children's charity.

Table 1 Characteristics of participants

Participant ID	***Sector***	***Role/Job Title***
01	Secondary care	Senior staff
02	Education	Family mentor
03	Primary Care	GP
04	Secondary Care	Consultant
05	Secondary Care	Consultant
06	Primary Care	GP
07	Social support	Family Support
08	Integrated care system	Operations manager
09	Primary care	Health Care Associate
10	Primary care	Health Care Associate
11	Children's charity	Service lead
12	Primary care	GP
13	Social support	Project manager
14	Social support	Service lead

Qualitative data

Below we present our findings within each of the relevant constructs within the Service Delivery domain at Micro -, Meso-, and Macro- levels. They are described alongside exemplar quotes identified by participant ID, and Job role. These findings are summarised in Table 2.

Table 2 Summary of SELFIE informed analytical framework and emerging themes (34)

Domain	***Definition***	***Level***	**Construct**	**Emerging themes**
Service Delivery	The provision of equitable and timely access to safe and appropriate care (including preventative health and social support)	*Micro*	Caregiver involvement	• Developing trust with patients
			Pro-active/preventative health	• Health promotion • Referrals to preventative health
			Tailored/person centred care	• Health literacy • Sensitive to individual needs
		Meso	Structural and organisational integration	• Multi-agency working (Incorporating schools, children's services, and social care) • Developing links with community groups • Co-location
		Macro	Policies to integrate care	• Lack of engagement of local health authority • Support local authority's priorities
			Service availability and access	• Reaching target populations • Streamlined referral • Integrating interpretation

Micro-

Caregiver involvement

Clinicians and social support providers understood the importance of fostering trust and developing a collaborative alliance with parents. This included the understanding that (frequently attending) parents often needed time to talk about the wider challenges they face:

> "I think sometimes the patients present to medical practitioners because they don't always feel listened to, and they present with symptoms that really don't need medical attention…they then come to Early Help, we have a long conversation with them, and they go away feeling better because they actually feel like they've had their problems and issues listened to…"
>
> P07, Social Support, Family Support

Pro-active/Preventative health

Clinicians in the SCZ seized the opportunity to engage parents in health promotion by using the responses to a wider set of contextual questions to link to patients directly with preventative health offers:

> "because the clinicians are looking more broadly at health and wellbeing of that child - in its place, in the family, and in the community… the family is learning things that maybe it didn't even know were available…[SCZ] is able to say, "Oh, this is something that you could do now, it could help your child lose weight, this could help your child brush his teeth better…"

P01, Secondary Care, Consultant

Tailored and personalised care

The way in which the SCZ was designed meant that consultations were longer, and clinicians were able to understand and address the specific needs of individual families:

> "…we can also educate our parents of how to help themselves so they become more resilient, and have an understanding of how best to parent their child, care for their child, meet their child's needs, where to gain the support when it is needed, and break down those barriers as well."
>
> P07, Social Support, Family Support

Meso-

Structural and organisational integration

Staff described how offering joined-up health and social support allowed them to more holistically address the needs of the patients:

> "…families present to GPs at the children's zone, but often they're coming to have symptoms treated, where actually the underlying cause isn't always medical, sometimes it's more of an Early Help need…if we can address both of those things, treat the symptoms and hopefully the cause, it will result in less presentations in the future."
>
> P07, Social Support, Family Support

A significant partner in the SCZ's attempt to reach target populations were local schools. This included the SCZ both proactively arranging sessions on a predesignated issue and responding to requests from schools to meet families they were concerned about:

> "We will contact a school, and then we'll say, "Can we come in and talk about picky eating?" And then we'll say… or diabetes, or some kind of health thing, and then they'll pick their families, so they know, or more successfully schools will then say, "We're seeing there's a really… there's low attendance with some of our children, and we don't really know why, they say it's health related but we don't really know why, can you come in?"
>
> P13, Social Support, Project Manager

Not all of the organisational integration was formal and the location of the service within the communities they serve helped create informal networks with local groups based on the benefits of establishing relationships in person:

> "…we've done work with the youth centre, which is about two/three minutes' walk away, and so we've been able to share the stuff that we know about the [SCZ] with the youth centre, and it just all starts to make… create a professional network. It's not formal, it doesn't have to meet round a Teams meeting, but it's just being in a community and in a space, and learning about what's on offer…"
>
> P11, Children's Charity, Service Lead

The benefits of collocating organisations and members of the multi-disciplinary team were reported by patients who appreciated the ability of the SCZ to address multiple issues in one visit:

> "We had [secondary care consultant] … walk a family over to the drop-in [mental health drop-in clinic], and they were given support there and then, and mum and child were absolutely amazed that they could from having a meeting that was scheduled that week with a GP to having attended that, and within - I think it was an hour - having had the intervention, that the GP has signposted to. I think that slightly blew mum's mind…being like 'That doesn't normally happen! How is this…?"
>
> P11, Children's Charity, Service Lead

The colocation also enabled staff to deliver better care by being more aware of what each service provided and being able to consult with colleagues from other settings in-person:

> "I get to discuss them [the patients] with the consultant who's just next door …we don't really get that opportunity as GPs, we sit in our own room, doors are closed, we have the patients come in, we want to get advice we speak to a paediatrician over the phone. It's not the same as actually discussing with someone who's right there physically, who can actually walk into my room and see my patient in front of me. It's completely different, it's an invaluable experience… you can't replicate that experience over a phone call"
>
> P12, Primary Care, GP

Macro-

Policies to integrate services

The original idea for the SCZ came from emergency department clinicians at the local children's hospital attempting to address the disproportionate numbers of parents presenting from the most deprived wards in the city. Despite its meeting key priorities of the local health authority (in the UK these are known as Integrated Care Service (ICS)) the same clinicians continued to be responsible for the ongoing management of the service including securing funding:

> "…I feel like the leadership for this has been largely on the backs of the doctors running the service…this is a service that reduces health inequalities, this is the priority for the ICS…the ICS has not enabled them in the way that if this was a real priority you'd see more leadership I think from within the ICS for developing this."
>
> P01, Secondary Care, Consultant

It was understood that the SCZ would also help inform the local authority's approach to developing cross-sector support for underserved families:

> "In two or three ways this model is essentially very good. One is the [council] is thinking about family hubs so this model is really working on family hub level, and it is doing exactly what family hubs are supposed to do, bring a range of services together in one area. So this model could be a good pilot, an idea for a family hub, how health and non-health actually works together."

P03, Primary Care, General Practitioner

Service availability and access

Local schools were understood to be a valuable means of accessing marginalised populations that otherwise faced multiple barriers to engaging with health care:

> "…at our school we've got a lot of Arabic Yemeni, we've got a recent migration of parents from Somalia and Nigeria. So it's a lot about maybe targeted groups such as parents who may not have English as their first language, and may be hesitant about going to the doctors…these initiatives… can really help to reach out to our families who may be more deprived or isolated within society."

P02, Education, Family Mentor

The further engagement of these families was supported by holding more informal joint consultations in the familiar, non-clinical school environment:

> "The reason why [parents attend] is because… a) it's in a relaxed environment, it was a coffee morning, so it wasn't a doctor's surgery, it wasn't an intimidating environment, it was a safe known environment to parents, and also it was done in a bit of a group discussion. … it was nice the fact that they were actually able to speak to the doctor and if they didn't understand anything Doctor [GP's name] was brilliant at explaining - for example there was something about birth marks…"

P02, Education, Family Mentor

- s

The colocation of social support and clinical care meant parents could not only access the clinical care for which they were referred but also social support without the associated stigma:

> "...and that is critical for Sparkbrook Children's Zone, because there's no shame in taking your children to the doctor. That is… going to the doctor is a safe and legitimate activity. So, I think that's even though not everybody going to the doctor needs support, there is a way of… that is one of the benefits."
>
> P14, Social support, Service Lead

Streamlined referral processes

The integration of the referral process between the various elements of the service made it easier for families with competing priorities that might otherwise be unable to make additional appointments and further visits:

> "I don't need to do a long several page referral into Early Help. As a doctor I'm saying, "There you go, you can just go next door"…that's a service that the family would have been able to access by picking up the phone… I think we know that families' motivation and resilience can be so low when they are struggling with lots and lots of different things in your life… that they're not going to pick up the phone."
>
> P04, Secondary care, Consultant

Interpreters as a routine part of the service

Staff valued the ability of the service to provide the majority of parents and patients with interpreters and the opportunity to ensure that they understood what was happening as they were referred between services within the SCZ:

> "There are obviously some language needs, which we have met through our telephone interpreting service, which has been really good...Some of the [referring] GP practices have been really good at booking in advance interpreters for patients and their parents and carers so that they've got no language barrier when they come to clinic, which is especially excellent. It doesn't always happen, but we've always got a service that will be able to translate, which is really nice."
>
> P05, Secondary care, Consultant

Discussion

General findings

The SCZ is one of the first integrated health and social care services for CYP to be delivered in the UK. Its novel combination of primary, secondary care, social support and allied children's services and preventative health offers was developed to provide a more holistic care service capable of addressing the social determinants of health. Using the service delivery domain of the SELFIE framework proved a valuable means of unpicking the various benefits, barriers and facilitators of the delivered integrated service. At *Micro* level these included increased engagement of families, improved referral to preventative care services, and personalised health care; at *Meso* level the benefits of collocation, collaborative working and community

outreach were described. Finally at the *Macro* level, the lack of engagement of the local care system was observed as were improvements to the access and availability of health and social care.

Specific findings

Micro-

Caregiver involvement

Its acknowledged that the voices of service users should be, but are not always, heard when decisions are made about their or their child's medical care (39, 40). Staff in the SCZ described how they consciously took time to explore individual patients and their family's context and concerns, to better understand needs, wishes and feelings and gain parental consent, a key element for Early Help and service coproduction, and enshrined in the Care Act (2014)(41). Existing evidence describes how exhibiting such an interest in, and understanding of, patients cultural background primary language, and ‑cultural and faith practices, can help establish trust in the service particularly amongst those previously suspicious of mainstream healthcare including underserved populations (10, 42-45).

Pro-active/preventative health

The aim of policymakers everywhere is to implement primary care that supports communities to increase control over the factors that influence health (46, 47). However exerting this control is inhibited in underserved populations by institutional, societal, and environmental

barriers (48) and by the GPs responsible reporting a lack of confidence and time in delivering such care and support (49, 50). Despite these issues the promotion of healthy living and preventative care appeared a successful element of the SCZ where staff described how their increased understanding of patients meant they could directly refer patients to the most appropriate programmes.

Oral health was another key offer of the SCZ particularly important in a national health service where many children struggle to access the dental care they need (51). The effectiveness of providing community routes of access to oral health care is recognised (52) particularly amongst CYP(53) and the SCZ was able to link CYP to oral care through their partners in neighbourhood schools, another recognised route to accessing oral health care (54).

Tailored/personalised care

Clinicians described how they took the time to understand not only the individual but also community context, accommodating these cultural needs, preferences and broader social and cultural values is an integral element in successfully delivering personalised care (55, 56). The focus on the relationship with the patient (and family) and the additional discretionary effort displayed by clinicians in the SCZ is also known to support personalised care (40) alongside improved compliance and clinical outcomes (57, 58).

Meso-

Structural and organisational integration

Multi-agency working (Incorporating preventative children's services, and social care)

Staff described how the multi-disciplinarity of the SCZ meant they were better able to address complex health problems and the structural challenges and social determinants of individual and population health, as witnessed in similar service offers elsewhere (47, 59-61). These include an increase in inter-agency referrals (13) improved food security (14) access to care and patient experience, and greater confidence and trust from CYP and their families (15, 29, 62, 63).

School outreach

School-based outreach appeared a particularly useful means of the SCZ engaging more marginalised families supported by the non-clinical familiar environment for group consultations, a format recommended by NHSE for empowering disenfranchised patients (64). In the UK, the Department for Education flagged the importance of schools being a safe and reliable point of access for health and social care, and engaging families and communities in the health and well-being of their children (65-68). More broadly the potential of schools to serve youth in low-income, underserved communities is recognised by WHO (69) and schools are regularly used in the United States and other High-Income countries to engage families and provide support for mental health, chronic conditions, and preventative healthcare including physical activity and oral hygiene (70-75).

Collaboration with local communities /networking

Participants described how delivering care in localised facilities enabled a better understanding of active community groups and initiatives. In the UK there has been a renewed push to strengthen place-based partnership working as part of the integrational reforms associated with the 2022 Health and Care Act (76, 77). Working with local communities ensures health and social care services are context-specific (78), accommodating community cultural and social norms (79) and helping to build trust within the community (77, 80, 81).

Co-location

Staff described the benefits to teamwork and professional development of sharing a space with colleagues. The literature describes how collocating multi-disciplinary teams promotes efficient teamwork and collaborative communication (82-85). Other benefits of colocation reported in the SCZ are its ability to promote recognition of other professionals' skills and contribution (59, 86) and reinforce shared beliefs and values (87).

Macro-

Policies to integrate care

The NHS Health and Care Act of 2022 and a myriad of policies in advance of that were developed to deliver a more unified health and social care service capable of addressing the social determinants of health (SDoH) (8). In the UK the introduction of integrated care systems

were intended to drive true integration however, participants reported a lack of ownership and leadership by the local integrated care system (88). Not only in Birmingham but nationally, health and social care systems have been under immense financial pressure, with the resulting lack of capacity precluding prolonged institutional support to the pilot. This reluctance of the regional system to actively engage with integrated health and social care has been witnessed previously and looks set to continue in the absence of concerted evidence and realistic funding (12, 60, 89). Within this context CYP are further disproportionately disadvantaged by inequitable representation and attention in service design and resourcing.

Streamlining referral processes

Typical referral process can challenge underserved populations due to a range of personal, community, and policy-level factors (90, 91). This is particularly true for referrals designed to address unmet social needs where issues associated with competing life priorities, such as work, chronic disease and caring responsibilities are manifest (92, 93). There have been recent calls to improve pathways connecting citizens with unmet needs to social resources (94, 95) and the SCZ's multi-disciplinary colocation improved attendance by enabling same day/location referrals. There is evidence elsewhere that describes how streamlined referrals and those associated with a shorter follow-up period significantly improve connection rates (39, 90), including for CYP (96).

Translation/interpreter services

The value and impact of interpreters in improving the care and outcomes for culturally and linguistically diverse populations observed in the SCZ has been widely recognised previously (97, 98) including for children (99). In the UK the NHS has released guidance for the commission of interpreting and translation services in primary care (100) with opportunities to integrate interpreting more formally into the navigator role (101).

Strengths and limitations

The SELFIE framework proved a valuable tool in unpicking the experiences of delivering a collocated cross-sector community-based service and we used best practice in directed content analysis. The number of interviews (n=14) is in keeping with consensual theory where experts asked about a defined area where "experts" with shared knowledge about the topic under discussion are more likely to exhibit common values (102). Not every element of service delivery described in the SELFIE's 'Service Delivery' domain were identified in our data set though they may be relevant to other integrated service offers. Participants were representative of the organisations involved in delivering the service and we also plan to interview service users (CYP and their families) to understand their experiences of the new service.

Conclusions

Integrated health and social care is considered key to the future maintenance of health in the UK and beyond. This in-depth exploration of the SCZ pilot service appears to demonstrate multiple benefits of a collocated place-based integrated service for CYP. Participants believe

the pilot has brought notable benefits to CYP through linking social support, health care, and preventative health. However, to implement truly integrated care, greater institutional commitment, time and leadership are needed.

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