

# Compendium: New models of care for acutely unwell children and young people



# Introduction

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## Purpose

Healthy London Partnership formed in April 2015. It has been working across health and social care, and with the Greater London Authority, Public Health England, NHS England, London's councils, clinical commissioning groups, and Health Education England. We have united to amplify the efforts of a growing community of people and organisations that believe it is possible to achieve a healthier, more livable global city by 2020. Healthy London Partnership is focused on transformation programmes, one of which is the Children and Young People's (CYP) Programme. Our vision is for an integrated system for health and care services, which promotes health and well-being and can be easily navigated by children, their families and health professionals to achieve the best outcomes.

## Audience

This document is aimed at commissioners and providers of out of hospital (OOH) health care services for children. This document describes the different services, so that they can better understand what other areas are doing. The document does not intend to provide an evaluation of these services, but when a service has carried out their own evaluation we have included this in the directory as a link or embedded document for further information.

## Inclusions

The information in this compendium has been taken from various sources, to describe the alternative models of care provided for children and young people across the country, with a particular focus on acute models of care.

## Strategic context

This document is part of a portfolio of out-of-hospital care products developed by the Healthy London Partnership Children and Young People's Programme team to drive improvements in quality.

- [Compendium: New models of care for acutely unwell children and young people](#)
- [Out-of-hospital standards for London's children and young people](#) - this is a set of robust standards bringing together information and national guidance to support clinical vision and future strategies for the delivery of health care in settings outside of hospital. These relate to the needs of children and young people who are acutely unwell, have an exacerbation of a long term condition or who have complex/continuing needs, and whose care can be provided safely outside of hospital. The purpose is to support commissioners and providers of children's out of hospital health services with what the expected minimum standards of care are for community children's/out of hospital services.<sup>i</sup>
- Opportunities for pharmacy to support out of hospital care (in development)
- New models of care (in development)

## Themes

This suite of documents will help organisations to develop place-based models of care treating the children and young people in the most appropriate location for their needs.

In order to differentiate between the models it is useful to categorise them by their overarching aim.

<b>A</b>	<b>Models that primarily prevent acute presentation to the Emergency Department and/or Admission to Hospital</b>
Example	Salford Children's Community Partnership <sup>19</sup> , which places Acute Paediatric Nurse Practitioners (APNPs) in the primary care setting to see CYP with acute illness and injury
<b>B</b>	<b>Models that primarily reduce length of stay in hospital</b>
Example	Whittington Hospital @ Home <sup>29</sup> which delivers a nurse-led acute Paediatric service delivered to families in their home, supported by the local hospital's acute paediatric team
<b>C</b>	<b>Models that aim to prevent both Emergency Department attendance/ admission to hospital AND reduce length of stay in hospital</b>
Example	C.O.A.S.T NHS Solent Trust <sup>2</sup> , a nurse-led team that can receive referrals from both primary and secondary care for home visits for children and young people
<b>D</b>	<b>Models that have a different aim but also impact on acute activity</b>
Example	Connecting care for children in North West London <sup>6</sup> which has three key components (specialist outreach, with specialists from the hospital working alongside primary care professionals; open access, with GPs having access to specialist advice via an email and telephone hotline; and patient and public engagement, built around practice champions who are working with the team to co-design services).
<b>E</b>	<b>Models supporting parents to self-manage minor illness</b>
Example	Bromley by Bow DIY Health <sup>1</sup> which delivers group learning sessions for parents, providing an opportunity to practice skills in a peer-led environment.

Theme A	Theme B	Theme C	Theme D	Theme E
<b>Models that primarily prevent acute presentation to hospital and prevent admissions</b>	<b>Models that primarily reduce length of stay in hospital</b>	<b>Models that aim to prevent both Emergency Department attendance/ admission to hospital AND reduce length of stay in hospital</b>	<b>Models that have a different aim but also impact on acute activity</b>	<b>Models supporting parents to self-manage minor illness</b>
C3	CANI	COAST	CC4C	Bromley by Bow
Cambridge	Sandwell & West Birmingham	Lewisham & Greenwich	Evelina	
CRAFT	Walsall	Luton	King's College	
Gloucester	Whittington	Manchester	North of Scotland	
Kingston		South Staffordshire	Partners in Paediatrics	
Nottingham		South Tyneside	Rotherham	
Salford		Warrington	The Bridge	
Smithdown		Worcestershire		
Taunton				
West Sussex				

## Case study details

It is useful to be able to assess each model both economically and qualitatively. Healthy London Partnership is also undertaking a process of financial modelling, to gain more of an understanding of the financial impact of such new acute models of care for Children and Young People. This will be published and available on our website shortly.

Each model has been described in terms of the following criteria:

- The year the model started
- Local contacts
- Location
- Initial motivation and history of the set-up process
- The service
  - Aims
  - Target patient groups
  - The service model
  - Days and hours of opening
  - Staffing
  - Who can refer
  - Who retains accountability for the patients
  - Resources e.g. buildings, equipment
  - Organisation providing funding
  - Level of patient/ family involvement
  - Level of integration in the system
- Evaluation
- Challenges/ Successes/ Lessons learned

All information provided has been fully approved by the local teams. We have also tried to include contact details for each service model, so that people can be contacted for more information if required. Details are correct as of August 2016.

There are other similar examples across the country of innovation and if you wish to be included in future versions of this document we would like to hear from you.

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# Case studies

## 1 Bromley-by-Bow: DIY Health

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A co-produced health education delivery model to empower parents in managing children's health

**Region: Bromley**  
**Geography: Urban**

### Background

It was noted that parents of children under the age of 5 were frequently re-attending St Andrew's Health Centre (one of three surgeries run by BBBHP) for support with managing self-limiting childhood problems. These group learning sessions aimed to empower the parents with knowledge, confidence and skills to manage minor ailments at home.

### Aims

To place health promotion in a learning environment, using participatory action surrounding key child health messages underpinned by principles of co-production

### Target groups

Parents of children under the age of 5 who were frequently re-attending St Andrew's Health Centre (one of three surgeries run by BBBHP) for support with managing self-limiting childhood problems.

### The service model

Group learning sessions for parents, which provide an opportunity to practice skills in a peer-led environment.

Support from local Children's Centre ensures that parents are able to attend the sessions in the absence of childcare arrangements for children under 5.

The initial phase of the project involved asking local parents of children under the age of 5 about managing children's health at home. This phase was led by Emma Cassells, who holds a unique role as a 'Patient First Manager' within BBBHP.

Six core topics identified locally:

- Cold and flu
- Diarrhoea and vomiting
- Fever
- Feeding
- Eczema

- Ear pain

## Opening times

- St Andrews Health Centre - 8am to 8pm 7 days a week
- DIY Health 2 hours a week for 12 weeks

## Staffing

Group sessions are facilitated by a Health Visitor (HV) and Adult Learning Specialist.

## Who can refer

Anyone, including self-referral

## Who is accountable for patients?

The host GP surgery

## Resources

A community venue, learning materials

## Funding organisation

### **Bromley by Bow Health Partnership**

This model was originally funded as a six-month pilot as part of the Tower Hamlets CCG Innovation Bursary Fund. The purpose of a multi-disciplinary team approach was partly to facilitate the journey of DIY Health being shared across a wide range of external organisations to generate interest around different ways of delivering health education, one of which was with the Children and Young People Programme Board at UCL Partners (UCLP). The innovative method of delivery led to a collaboration between the participating organisations to upscale and evaluate the original DIY Health model pilot, with a rigorous academic steer from UCLP led by Professor Monica Lakhanpaul, underpinned by funding from the North East London Foundation Trust. The second phase of the pilot project received funding from Health Education North Central and East London

## Level of patient/family involvement\*

DIY Health employs a co-produced methodology in which parents and families are involved in the design, delivery and evaluation of the service. The core content of each of the sessions is based on parent experiences and stories.

## Level of integration in the system\*\*

DIY Health aims to work horizontally across a range of stakeholders including local people, primary care, HV Services, Children's Centres and community and voluntary sector organisations. DIY Health also integrates across the population, offering preventative advice and health promotion to families and children.

## Evaluation

The second phase of the pilot project was evaluated in partnership with the Anna Freud Centre and colleagues from the University of Sheffield. Qualitative analysis showed an increase in knowledge, confidence and skills to manage a wide range of health issues for all parents involved, and high levels of co-production throughout the programmes. Preliminary quantitative results showed a reduction in GP attendances for parents who attended DIY Health sessions.

<http://uclpstoreneuprod.blob.core.windows.net/cmsassets/DIY%20Health%20Toolkit%20-%20October%202015.pdf>

## Challenges, successes, lessons learned and advice

Work with stakeholders, including local people, from the beginning to define, articulate and design a program that addresses a need

- Be flexible and open to problem solving in the sessions
- Ensure that all those involved share the same project ethos and values
- Measure what matters – do not place all the emphasis on reducing service use. Increases in resilience, confidence and skills are just as important
- If you want to measure health service use, do so across the health service (ED, primary care, HV) to get a true picture of what is happening for parents. Economic evaluation should include measures such as QALYs (quality adjusted life years) and SROIs (social return on investment).

Co-production takes time – for local people to develop as facilitators themselves or be involved in community organising, be prepared for this to happen outside the lifetime of structured sessions. More longer term funding will support this and should be considered when applications for funding are made.

[Downloads: DIY Health Evaluation report final.pdf](#)

## Contact for more information

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<http://www.uclpartners.com/our-work/academic-health-science-network/integrated-children-young-people-and-maternal-health/diy-health>



## 2 Coast

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### Children's Outreach Assessment and Support Team (COAST), Solent NHS Trust

**Started in 2008**

**Region: South East**

**Geography: Portsmouth and Southampton**

### Background

1. Facilitate early discharge from hospital
2. Reduce unnecessary attendances and admissions to hospital

### Aims

Providing a safe service which can assess and monitor a child during an acute episode of illness in their own homes, whilst also providing support and education to the family.

### Target patient groups

Acutely unwell children and young people

### The service model

- COAST is a distinct team of experienced paediatric nurses within the CCN service who have all completed a 'History taking and assessment' module
- 2 teams (Portsmouth and Southampton)
- Nurses provide assessment of a CYP during an acute episode of illness, whilst also providing support/education to family.
- COAST team manage 10 HRGs (Healthcare resource groups) -
  - Croup
  - Viral induced wheeze
  - Asthma
  - Chest infection
  - Tonsillitis
  - Bronchiolitis
  - Febrile convulsion
  - Gastroenteritis
  - Urinary tract infection
  - Viral upper respiratory tract infection (URTI)
- A traffic light assessment system is used to indicate the severity of illness

- The COAST team complete a rapid telephone assessment using a traffic light assessment within 2 hours of referral; following this assessment a home visit may be offered and completed (same day or next day). Telephone support is maintained throughout the admission. Signs and symptoms of deteriorating condition and safety net advice will be given and reiterated.
- If there are serious concerns, the family is advised to attend ED or referred to the Children's Assessment Unit at the local hospital

### Criterion for referral:

- The CYP must have had a 'face-to-face' assessment by a doctor/**accredited** practitioner
- They must have a working diagnosis which is 1 of the 10 conditions that COAST manages
- Practitioner is considering sending the child to hospital

### Opening times

- 7 days a week
- 364 days a year (not Christmas day)
- COAST East 8am -10pm Monday to Friday
- 9am -6pm Saturday, Sunday, bank holidays
- COAST West 10am-8pm Monday to Friday
- 9.30am -5.30pm Saturday, Sunday, bank holidays

### Staffing

- Team Leader - Band 7
- COAST nurse- Band 6
- COAST nurses - Band 5
- Trainee APNP – Band 5

### Who can refer

- GPs
- Out-of-hours GPs service
- Emergency department
- Paediatric in-patient wards (Portsmouth City only)

### Who is accountable for patients?

Referrers maintain medical accountability

### Funding organisation

Four different commissioning groups: Portsmouth, Fareham and Gosport, South East Hampshire and Southampton CCGs.

### Level of patient/family involvement

Form for feedback is sent to all families on discharge.

Participate in Friends and Family Test (FFT)

Revision of service work is now being co-designed.

## Level of integration in the system

Exploring beginnings of vertical integration by co-locating in hospital ED department and working with specific GP practices. Service line reconfiguring for managing child health and services for populations within own multi service child & family service, beginning vertical healthy child programme and Multi Agency Teams in Portsmouth City Council.

## Evaluation

- Total referral incidence of nearly 10,000 CYP
- There have been no clinical safety incidents
- There have been no complaints
- In a 6-month period, 876 CYP were referred to COAST East (297 of these would have been sent to hospital if COAST didn't exist)
- (Over these 6 months there was a theoretical saving of £49,335)

Commissioners report that there has been a 'flattening' of the number of referrals to hospital when compared to other CCGs without COAST

## Challenges, successes, lessons learned and advice

- One of the challenges for the team is being able to provide the reassurance that the CYP can be managed safely in their own home
- Capturing meaningful data to evidence that COAST is making a positive difference is challenging
- Engaging GPs and primary care to ensure they utilise the service appropriately has been an ongoing challenge
- There are challenges when working for different CCGs e.g. they fund different things
- It would be beneficial to expand/enhance the COAST model by providing partnership working with the Children's emergency department
- It would be good to continue to develop paediatric nurse practitioners within the COAST team, to work alongside primary care in support of the hospital avoidance target
- It is important to develop clear and meaningful outcome measures
- It is important to forge strong links with key individuals in primary and secondary care
- It is important to have 'champions' for the service
- It is crucial to recruit staff with the right skills and experience
- The development of robust evidence-based protocols, and continued auditing of these has ensured safety
- The continued maintenance of the assessment skills of the team has ensured safety

## Contact for more information

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## 3 Rapid referral clinic

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### Cambridge out patient department management to reduce emergency admissions

**Started: 2006**

**Region: Cambridge**

**Geography: Urban**

#### Background

- 1) Admission avoidance (referred patients)
- 2) Less than two week wait access to a senior paediatric opinion for primary care professionals

One stop clinic: Detailed written management plans enhancing primary care knowledge of management

#### Aims

Rapid access to senior staff, avoidance of admissions to hospital where safe and appropriate. Developing parent info on common conditions. Linking in with community teams where appropriate. Successful, rapid response to an urgent medical problem. Admission avoidance. Safety net for those patients discharged home to have a senior early clinical review.

#### Target patient groups

Those requiring urgent rather than emergency referral and those where admission can be avoided but an early review the following day can be made

#### The service model

The model was instigated by the trust and paid standard OPD tariff with no formal commissioning. One stop appointment and allow senior review of a child sent home from ED the previous day that might otherwise have needed to stay. Patients seen by senior staff and decisions made, often without requiring hospital follow up

#### Opening times

Five clinics per week

#### Staffing

Five consultants, one associate specialist and one senior SpR (Specialty registrar)

#### Who can refer

GP, HV, Midwife

## Who is accountable for patients

Named consultant

## Resources

Clinic space on in-patient ward

## Funding organisation

Cambridge University Hospital Foundation Trust

## Level of patient/family involvement

No recent PROM (patient recorded outcome measure)/PREM (patient rated experience measure) evaluation

## Level of integration in the system

One stop, timely assessment and advice for primary care professionals

## Evaluation

- More than 6+ children per day
- No recent PROM/PREM evaluation

Probably lowest conversion rate (ED attendances resulting in admission) and LoS (length of stay) for acute paediatrics in any of the hospitals in the East of England.

## Challenges, successes, lessons learned and advice

- Resources not keeping up with demand
- Lack of formal evaluation apart from outdated satisfaction survey

## Downloads:

## Contact for more information

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## 4 Close to home

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### Child Healthcare Closer to Home (C3), Calderdale and Huddersfield NHS Foundation Trust

**Started: May 2014**

**Region: Calderdale and Greater Huddersfield and who are registered at one of the listed pilot practices.**

#### Background

The journey of the child through acute care can be fragmented, with the focus being around a specific professional and building rather than the family.

Partners from Calderdale and Greater Huddersfield Health & Social care organisations have worked collectively to deliver improved services for local children, with the overall aim of developing enhanced paediatric provision and expertise closer to the child's home

#### Aims

1. Improve self-management
2. Empower families to have the confidence to manage their own health conditions and know when to seek help appropriately

Provide acute care for CYP closer to home

#### The service model

- Two multi-professional care clinics
- One of the clinics is based in a local GP surgery and the other is in a local children's centre in a deprived area
- Pilot sites refer through choose and book
- User and referrer experience is at the heart of the project
- Interventions are recorded via an electronic-shared record, which has aided timely communication across primary and secondary care
- The project is developing pathways of care, education and expertise for use within primary care

The C<sup>3</sup> initial model offered a five tier approach to delivery

- Self-Care - educating and encouraging children, young people and their families to maintain healthier lifestyles
- Universal offer - delivery of a co-ordinated campaign of health promotion and early interventions
- Community Nursing Plus - criteria based referral system from Primary Care to Community Nursing
- Community Specialists - Locality based Paediatric Care
- Cascaded Learning and Development – to include a programme of training – bridging gaps in Paediatric expertise.

## Opening times

- Offer services in 'family-friendly' hours –weekly between 4pm -8pm
- Clinics held on a 1-2 weekly rota afternoon/evenings

## Staffing

Consultant Paediatrician, GP, APNP and CCN.

## Who can refer

Referrals are accepted from pre-selected pilot site GPs

## Funding organisation

- CCG funded
- Host employer is Calderdale and Huddersfield Foundation Trust
- Applied for further funding from the Health Foundation
- 2nd six month evaluation is underway
- Working with Nuffield Trust to explore innovation in community delivered services

## Evaluation

- The most common reasons were musculoskeletal problems, Skin and Continence problems including constipation.
- Age ranged between 0-17, with babies under one being the highest.
- During initial 12 month pilot 1638 contacts with patients, 844 face to face or clinical telephone contact. Phase 378 new referrals for CYP and 12 follow-ups.
- Multi professional approach compared to a traditional consultant only delivered care in general outpatient's provision. In Calderdale 33% of patients were seen by a Consultant compared to 100% of care that would be offered in a traditional outpatient setting. 29% of the clinic activity was offered by a GP and 38% was delivered by an APNP.
- DNA 11.5% compared to 14% in hospital based general paediatric clinics.

The new to follow-up rate was 0.3 compared to 1.9 in a normal general paediatric clinic. Some of the variation will be due to the length of time clinic has been running and due to the fact that all the patients are new to this service rather than being existing patients with long term conditions. Anecdotal evidence suggests that practitioners are utilising telephone follow up, and discharging children and young people back to the care of GP when appropriate, which would validate the results.

## Challenges, successes, lessons learned and advice

- Hope to increase their activity in primary care, with a move towards 8am-8pm hours and weekend opening.
- It is important to establish good relationships and buy-in from commissioners and providers at the start.
- Change requires tenacity and enthusiasm.
- Effective communication is key.
- Strong administration support is required.

- The project has encouraged communication and shared learning between primary and secondary care.
- It has ensured that health and self-care is high on the agenda of community services, families and children's centres.

## Contact for more information

Cat Brown, Children's Community Nursing Sister

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<http://c3.cht.nhs.uk/>

## Notes

This project is finishing on 30/6/16 – commissioners in Huddersfield and Calderdale have chosen not to fund the service or extend the project time frame



# 5 Children's Acute Nursing Initiative (CANI), CCN Service, Children's Directorate of Newcastle Hospital NHS Foundation Trust

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**Started: 2008**

**Region: Newcastle Upon Tyne**

**Geography: Urban**

**Estimated local pop. 0-18 years: 64,100**

## Background

1. Prevent breaches in ED by freeing up beds in children's services
2. Free up beds in winter pressures and therapeutic community care for children with acute episodes of illness.

Initial pilot with Winter Pressure Money became substantive after pilot in 2008

## Aims

To facilitate much earlier hospital discharge for CYP with acute illnesses and exacerbations of long term conditions

## Target patient groups

Hospital at home care, acute episodes of illness at point of stable condition, any age from 0 – 19 years

## The service model

Nursing care by the CANI team includes

- Clinical monitoring, assessment and continued treatment
- IV (intravenous) medication for different conditions up to three times a day
- Support and advice to reduce parental anxiety

Further education and information, to empower parents to care for the CYP during the period of illness/recovery

## Opening times

8.00 am – 22.00 pm - 365 days a year

## Staffing

1 x Band 7 WTE (whole time equivalent), 1 x Band 6 0.5 WTE , 3 x Band 5 WTE, 1 x WTE Band 3

## Who can refer

Paediatric consultants at the Great North Children's Hospital (GNCH)

## Who is accountable for patients?

Paediatric consultants at the GNCH

## Resources

Shared Office space within GNCH and Children's Community Nursing Services Base.

Clinical monitoring equipment and 3 Infusion pumps, Children's Services Directorate provide a budget for disposable equipment supply and top up pharmacy supplies

## Funding organisation

Newcastle upon Tyne Hospitals NHS Foundation Trust

## Level of patient/family involvement

Regular family and friends' feedback at present. Previously when the service was initially set up we provided anonymous postal questionnaires to all service users.

## Level of integration in the system

Providing secondary care in the community setting often enabling children receiving therapeutic interventions to access education and social care provision.

## Evaluation

In the first year the service facilitated:

- The early discharge of 335 CYP
- Freed up to 2,318 acute bed days (1,372 were in cubicles)

During 2008/2009:

- 274 patients were referred from the hospital to care within the home
- This resulted in 1,996 potential bed/cubicle days saved, which is equivalent to £1.1 million in hospital costs

After accounting for CANI staffing/equipment costs, the potential saving to the trust amounted to £923,768

## Challenges, successes, lessons learned and advice

Winner of the National Health Service Journal (HSJ) award 2010 for Enhancing quality and efficiency in services for children and young people

The present challenge is that GNCH is a tertiary hospital caring for children from across the region. This has highlighted an inequality of CCN services across the region. Our challenge now is to develop this model to meet the demand and expedite the discharge of children from GNCH across the whole of the Northern Region

Advice to other teams would be that the success is dependent on ensuring the team need to be a regular presence; have very close links with the referring hospital; to ensure safe clinical

governance; responsive pathways in and out of the referring hospital and efficient use of the extended hours and service provision. In addition CANI is part of an established CCN service

## Contact for more information

Jocelyn Thompson, Community Matron, CCN Service

Emma Willey, Team Leader

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# 6 Connecting Care for Children (CC4C), North West London

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**Started: 2012**

**Region: North West London – urban; including populations of significant social deprivation**

**Geography: Urban**

**Estimated local pop. 0-18 years: 400,000 (eight CCGs).**

## Aims

To develop a collaborative integrated child health system, placing general practice at its heart and reinforcing the role of the GP

## Target patient groups

CC4C is a 'Whole Population' model of care, covering CHILDREN AND YOUNG PEOPLE across 6 segments, including the healthy child, children with complex health needs, vulnerable children with social needs and children with long term conditions.

## The service model

Developed with extensive stakeholder consultation and co-design

Three main elements that come together to form 'Child Health General Practice Hubs' (for optimal efficiency, a hub should ideally comprise of three to four 4 practices and serve a population of 20,000 – of which about 4,000 are children):

1. **Specialist outreach** – monthly joint clinics with GPs and hospital-based general paediatricians; together with multi-disciplinary team (MDT) meetings held in GP practices. Removes need for extensive hospital based follow-up
2. **Open access** – primary care clinicians are provided with prompt access via telephone hotline to paediatricians for advice/support; GPs provide ready access to their patients/families. Secure line for email advice allowing GPs to receive responses within 24 hours. Same day telephone appointments for CHILDREN AND YOUNG PEOPLE with GP or senior practice nurse and same day face to face appointments if required
3. **Public and patient involvement** – comprising education, empowerment and the development of 'Practice Champions' (volunteers from the GP practice population) to provide peer-support, encourage self-management, and support co-design of services

## Opening times

Fully connected into a 24/7 hospital-based service at St Mary's

## Staffing

Consultant General Paediatrician led, with input from the wide range of professionals the service connects.

## Who can refer

Any health professional with concerns about a child

## Who is accountable for patients?

The professional asking the question / bringing the case to an MDT / leading the discussion retains accountability. A small proportion of patients are physically seen by a paediatrician alongside a GP and here the accountability lies with the consultant paediatrician.

## Resources

Utilises existing resources in GP practices and children's centres / community centres (for learning activities).

## Funding organisation

Health Education North West London

West London CCG

NHS London Regional Innovation Funding (in 2012/13)

Imperial college Healthcare NHS Trust

## Level of patient/family involvement

The whole programme originated from children, young people, parents and carers coming together in a series of co-design events to design and plan this integrated child health system

## Level of integration in the system

Vertical – linking up GP and primary care, with secondary care and tertiary sub-specialty services

Horizontal – linking up the Child Health GP Hubs with a wide range of professionals from community services, mental health, schools, HV and social care

Population – using a whole population segmentation model to cover all children and young people within a hub's registered population; this enables professionals to take a longitudinal (ie life course), preventative approach to supporting care. An example of this would be specific hub work in increase the percentage of children with asthma who are on asthma management plans.

## Evaluation

- Currently 24 practices forming 9 hubs over 4 CCGs (West London, Central London, Hammersmith & Fulham and Ealing)
- 3 hubs were evaluated over the period of a year in the above paper, published in Archives of Disease in Childhood
- MDT meetings – in 59% of cases discussed, the referring community-based professional was given advice that enabled continued care in primary care; 21% were sent to the paediatric outreach clinic for an appointment within next month; in 20% of cases, the

professional discussing the case was asked to refer the patient to a specific named health professional (e.g. hospital specialty paediatricians, community dieticians, physiotherapists)

- Joint Clinics – 126 patients were seen in 24 outreach clinics. DNA rates were <5% (compared >15% for hospital out-patient clinics)
- 94% were managed and discharged without any formal follow-up
- 2% were advised to return to the joint clinic
- 17% were advised to be seen by another named health professional 6% were recommended for specialist investigation
- Analysis of HES (hospital episode statistics) data – In hub 1 they observed a 39% reduction in new patient hospital appointments; a *further* 42% of appointments were shifted from hospital to GP; in addition there was a 19% decrease in sub-specialty new patient appointments, a 17% reduction in paediatric admissions and a 22% decrease in ED attendances
- Patient experience – very positive; 100% of respondents reported that they would recommend the service to friends/family; reported that the atmosphere of the joint clinics was less threatening than a hospital appointment
- Professionals' experience – very positive response to MDTs; strengthened relationships between primary and secondary care. Noted the gain in social capital and the important impact on workforce development.
- Financial – when the programme was set up “break-even economic modelling predicted a 12-hub system would be cost neutral after 2 years and would deliver significant savings from year 3.” An analysis looking back over the last 12-18 months had commenced to take a retrospective view on this modelling.

## Challenges, successes, lessons learned and advice

This programme is all about developing connections and relationships across the system. The evaluation to date has shown that there are significant efficiency and quality improvements to be gained from this approach, despite the significant financial disincentives in the system (eg PbR (payment by results), current commissioning approaches). The growing development of the Practice Champions and a more proactive, population-based approach to the way in which the Child Health GP Hubs are run are exciting innovations that we feel will significantly change the way in which healthcare is delivered in the future.

### Key lessons

- The value of strong relationships across the system
- The importance of remaining very patient centric in everything we do
- The value of meaningful co-design with children, young people and their families
- How difficult it is to instigate large-scale change with so many financial disincentives in the system
- The strength that can be developed where a model of care reaches out horizontally across to professionals from many different backgrounds

The importance of us starting to move towards a Patient Centred Outcome Measure approach to commissioning and delivering care.

## Downloads:

[CC4C Child Health GP Hubs evaluation...](#)

[Whole pop integ child health moving beyond...](#)

[CC4C Demonstrating value...](#)

## Notes

CC4C hubs now implemented in four CCGs with coverage of approximately 30, 000 to 40,000 children and young people.

## Contact for more information

Dr Mando Watson, Clinical Lead and Dr Bob Klaber, Clinical Lead  
[Mando.Watson@imperial.nhs.uk](mailto:Mando.Watson@imperial.nhs.uk); [Robert.Klaber@imperial.nhs.uk](mailto:Robert.Klaber@imperial.nhs.uk)  
07789 941791 (Dr Bob Klaber)  
<http://www.cc4c.imperial.nhs.uk/>

# 7 CRAFT, Leicester Children's Rapid Assessment and Follow up Team

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## Background

Avoid CHILDREN AND YOUNG PEOPLE being admitted to hospital wherever possible and safe to do so

## The service model

- Provided:
  - clinical assessment and observations in their own home
  - clinical reviews
  - education and support for the CHILDREN AND YOUNG PEOPLE/family (e.g. management of fever, dehydration, wheeze)
  - medication advice
- Team delivered a telephone call to the family 2 hours from referral
- A visit was made within 4 hours if required
- Nurses could prescribe if necessary
- Could admit into hospital if required, or arranged open access to the Children's Assessment ward at Leicester Royal Infirmary

## Opening times

7 days per week, 10am – 8pm

## Staffing

Four experienced paediatric nurses

## Who can refer

- GPs
- ED
- Children's admissions unit for children with mild-moderate episodes of acute minor illness

## Evaluation

- They saw up to 8 CHILDREN AND YOUNG PEOPLE per day in their own home (plus others for telephone support-only)
- In Summer time – approx. 30-50 referrals in one month
- In Winter time – approx. 60-70 referrals in one month



## Notes

This service is no longer being commissioned. The team only covered the city so had a limited caseload. To ensure equality of provision across the county would have meant increased capacity and significant investment. Leicester have extended the hours of their community nursing team and are working on how they deal with rapid access and minor illness follow up.

## Contact for more information

No contact name provided

078 2434 3998

<http://www.leicspart.nhs.uk/OurServices-ChildrensRapidAssessmentandFollowUpTeamCRAFT.aspx>

# 8 Children and young people's health partnership (CYPHP), Evelina Children's Hospital

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**Started: Programme in Autumn 2016, Model live in January 2017**

**Region: Lambeth and Southwark**

**Geography: Urban**

**Estimated local pop. 0-18 years: 120,000**

## Background

To develop and test a new model of comprehensively integrated care, as part of a strengthened child-centred health system.

## Aims

To improve children and young people's health, improve the quality of healthcare, and strengthen the health system for all children and young people in Lambeth and Southwark.

## Target patient groups

0-24 years.

The model is designed to benefit *all* children and young people through a universal and targeted approach to improving the quality of Everyday healthcare and Long-term condition care.

## The service model

**Everyday Healthcare** is about improving the quality of care for common and minor illnesses.

- children and young people health teams and clinics working in primary care
- Bio-psycho-social assessments for children and young people-centred care
- Paediatric hotlines for real-time specialist support to primary care
- Decision-support tools and guidelines integrated into GP IT systems
- Young-people friendly access to healthcare
- children and young people-friendly technology and support for behaviour change
- Special focus on Looked-After-Children
- Transformative education and training for health professionals, youth and social workers, teachers, parents and carers.
- Health promotion as core to healthcare
- Everyday Healthcare links with local Hospital at Home services and Children's Acute Referral and Ambulatory Care Services.

**Long term condition care** is comprehensive care that considers the body, mind, and social circumstances of children and young people with chronic conditions such as asthma or epilepsy.

- children and young people Health Teams and Clinics in primary, secondary healthcare and community settings

- Bio-psycho-social assessments for children and young people-centred care
- Schools are part of health teams
- Behaviour change support
- Medication reviews by pharmacists
- Social and youth workers
- Health promotion is a core part of care

CYPHP is part of a Learning Healthcare System for CYP. We use the best available evidence to shape and deliver care, and evaluate our work as part of a cycle of continuous improvement.

## Opening times

The CYPHP model is about improving existing services, therefore is part of and operates according to usual NHS practice.

## Staffing

Specialist children's nurses, GPs, general paediatricians, child and adolescent mental health, youth workers, social workers, pharmacists, teachers.

## Who can refer

The CYPHP model is about improving existing services, therefore is part of and operates according to usual NHS practice.

## Who is accountable for patients?

The CYPHP model is about improving existing services, therefore is part of and operates according to usual NHS practice.

## Resources

CYPHP is designed to move care appropriately as close to home as possible. Clinics are held in primary, community, and secondary care settings, and CYPHP works in schools too.

## Funding organisation

Guy's and St Thomas' Charity

## Level of patient/family involvement

The CYPHP programme is co-chaired by a local parent. We have a parents and carers group and a young people's group; both have been closely involved in the design of the model, and are working with us in planning and delivering the evaluation of the programme.

## Level of integration in the system

Vertical: CYP Health Teams and Clinics are about delivering CYP-centred care, strengthening links between primary and secondary care and between physical and mental health. Access to care and age-appropriate care are important principles of this aspect of the model.

Horizontal: Health, schools, and social care are brought together in both Everyday Healthcare and Long-term Condition care, and by supporting teachers to build resilience among children at school.

Population: Health promotion is a core part of care, supported through guidelines, decision support tools, and education and training. The model of care is shaped according to population health need, and aligns and synergises with public health and local policy.

Longitudinal: age-appropriate care, for example young people-friendly services in primary and hospital care.

## Evaluation

CYPHP programme will launch in 2016, and the model will go live in early 2017. We have a comprehensive evaluation plan which will measure health, healthcare, and health system outcomes throughout the 4-year programme.

## Challenges, successes, lessons learned and advice

Implementation evaluation and analysis of lessons learned is a key part of the evaluation plan. We will share the results of these analyses as soon as they are available.

## Contact for more information

Ingrid Wolfe, Programme Director

[Ingrid.Wolfe@kcl.ac.uk](mailto:Ingrid.Wolfe@kcl.ac.uk)

02071882854

[www.cyphp.org](http://www.cyphp.org)

# 9 Gloucester Big 6

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## Background

There had been an increase in paediatric emergency admissions to the local Foundation Trust (FT) of 15% over the previous 3 years. Benchmarking data suggested that the rate of admissions for respiratory infections, bronchiolitis and gastroenteritis for under 2s were higher than other comparable demographic areas and Gloucester consistently has the highest rate of emergency admissions per 1000 practice population.

## Aims

Preventing emergency admissions due to the six common conditions for children within Gloucestershire

## Target patient groups

Children with the 6 target conditions

## The service model

Clinical guidelines and assessment tools within the big 6 have been developed for the six high volume conditions (bronchiolitis/croup, fever, gastroenteritis, head injury, wheezy child/asthma, abdominal pain). Assessment tools were developed using NICE (National Institute of Health and Care Excellence) and SIGN (Scottish intercollegiate guidelines network) publications alongside local policies and protocols and were subject to clinical scrutiny. Patient information leaflets produced, online tool and clear red/amber/green system with clinical parameters

## Evaluation

Information has been shared with all GPs, practice nurses, GP trainees, minor injury and illness unit nursing staff, junior ED staff and paramedics (SWAST). They have set up a series of educational events to share use of the guidance and clinical cases.

## Contact for more information

Jeremy Welch

[Jeremy.welch@nhs.net](mailto:Jeremy.welch@nhs.net)

# 10 Paediatric Ambulatory Service, King's College Hospital

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**Staged over several years: Rapid access clinic – 2009, Paediatric phone line – a 2014, Healthcare at Home – 2014, Short Stay Unit (SSU) – 2014**

**Region: London**

**Geography: Urban**

## Background motivation

To deliver high quality healthcare for children, streamlining their patient journey and thereby optimise their patient experience.

## The service model

Portfolio of clinical services targeted at meeting the needs of children and their families

1. **Education** – annual paediatric GP conference at King's College Hospital delivering interactive lectures on clinical topics of importance to GPs. The feedback collated is proactively utilised to refine the programme content, to ensure ongoing relevance to a primary care audience. There is also education provided at CCG-organised annual paediatric educational events – there are 3 dedicated, free events per annum for formal paediatric learning for local GPs from Lambeth and Southward CCGs.
2. **Paediatric Phone Line** – since June 2014 there has been a phone line for GPs to speak directly to a paediatric consultant between 8am-10pm on weekdays and 8am-5.30pm on weekends. This optimises patient care by enabling timely, reciprocal discussion with the most appropriate hospital-based paediatrician and thereby facilitates streamlining of outpatient referrals, a reduction in numbers of inappropriate paediatric emergency department (PED) attendances and stronger professional relationships between primary and secondary care. The phone line is also used by junior doctors who require senior advice from the duty paediatric consultant in the hospital, and this enables timelier decision-making in PED, improved clinical care and avoidance of unnecessary admissions.
3. **Rapid access clinic** – this has been running since 2009 and in July 2014 there was expansion to provide a clinic on every weekday. Referrals are accepted from primary care by phone, email or fax and patients are seen within 2 weeks of referral (although this can be expedited if required).
4. **Email advice** – using the established 'choose and book' system, local GPs can email enquiries for clinical advice to a consultant paediatrician. The response time during weekdays is 24 hours.
5. **Outreach clinics** – a consultant paediatrician delivers a monthly primary care clinic alongside a GP partner. They see patients together, who would otherwise have been referred to a hospital outpatient clinic. Each clinic is preceded by a lunchtime teaching session with the wider primary care team, and there is opportunity for discussion of specific patients' management following the clinic. The clinics provide reciprocal learning opportunities for both clinicians. Patient feedback is very positive
6. **Healthcare at Home (HAH)** – a clinical service providing consultant-led, nurse-delivered acute paediatric care and short term conditions in the home (or school). The HAH nurses are integral members of the general paediatrics team and they attend the morning general paediatric

handovers 7 days a week (this services to optimise the referral rate). Once the child has been referred they meet with the family whilst they are still inpatients (ensures continuity of care from hospital to home setting). The nurses can visit children up to 4 times/day to administer medication, provide wound care, perform observations and provide clinical reviews. Care episode notes are recorded electronically on tablets in the home and these notes are linked back to the hospital based electronic patient record. All patients are reviewed during a daily consultant-led virtual ward round, which is conducted in person between the HAH nurses and consultant. (The innovative use of IT facilities this and provides an accessible, continuous record of patient care until their discharge date.) The initial goal was to expedite discharge from hospital and this has been achieved. The service has subsequently evolved to facilitate direct admission to HAH from PED following a paediatric consultant review. This new pathway avoids hospital admission for some. Children are accepted onto the service based on clinical need and capacity.

7. **SSU** – This 48 hour 6-bedded, Consultant-led unit was opened in June 2014. It is complemented by strong nursing leadership. Paediatric patients with medical and/or surgical health needs are eligible for admission. All patients must be discussed with and/or reviewed by a consultant prior to admission. There are twice daily consultant led ward rounds. There is proactive discharge planning. Since opening the unit, they have found that there has been a significant reduction in elective paediatric surgical cancellations. It has also enabled optimised care for children with mental healthcare needs that are admitted.
8. **Hospital at Home**- an 18 month pilot program funded by Lambeth, Southwark and Lewisham CCGs. This nurse led service takes primarily referrals from the PED with a view to supporting families at home following their child's acute attendance. The nurses provide clinical assessment and advice regarding acute illnesses and health promotion advise with a view to positively impacting on modifying the family's healthcare

## Opening times

Paediatric Phone Line –8am-10pm on weekdays and 8am-5.30pm on weekends. Healthcare at Home-7 days a week 8am-10pm. Outreach clinic is monthly.

## Staffing

Five Paediatric Consultants

## Who can refer

GPs, Community midwives (via PED), PED clinicians.

## Who is accountable for patients?

The named Consultant Paediatrician

## Resources

Staff costs £ 1,838,063; Ward-related costs: £328,890; Total cost: £2,166,953 Total income from additional elective and outpatient activity: £ 1,619,980 Net cost: £ 546,973

## Funding organisation

King's College Hospital

## Level of patient/family involvement

Patient feedback collected for every child and family utilising the service

## Evaluation

Hospital at Home service has saved 841 inpatient bed days (£336K cost saving). 121 Paediatric ED attendances and 26 hospital admissions prevented by GP hotline. 466 patients admitted to Paediatric SSU with median length of stay of 18 hours. 33% reduction in PED 4 hr breaches. 37% reduction in paediatric surgery elective cancellations. Patient satisfaction questionnaires reported that 100% of families would recommend the short stay unit to their friends and family.

## Challenges, successes, lessons learned and advice

Consultant rota model needed modification to make it a long term sustainable work pattern.

Stakeholder engagement for some professional groups was a challenge but this rapidly improved once the service was in operation and the patient benefits were demonstrated.

## Contact for more information

Dr Omowunmi Akindolie, Consultant in Ambulatory Paediatrics

[Omowunmi.akindolie@nhs.net](mailto:Omowunmi.akindolie@nhs.net)

0203 2994697



# 11 Kingston Paediatric Outreach Nursing Team (PONT)

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**Started:**

**Region: Kingston**

**Geography: Urban**

**Estimated local pop. 0-18 years: 37,000**

## Background

Commissioned service by Kingston CCG to provide paediatric community service to all children and young people age 0-18 years registered with a Kingston GP.

## Aims

- To provide quality nursing care to children and their families.
- To reduce the need for ED attendance/hospital admission/ reviews in ambulatory care unit.

## Target patient groups

0-18 years in full time education

## The service model

Nursing care and advice for children at home, school and nursery that are under the care of a Kingston GP.

## Opening times

8am to 6pm Monday to Friday

8:30am to 4:30pm weekends & Bank Holidays

Service provided 365 days a year

## Staffing

Two full time

Two part time

## Who can refer

GPs, Tertiary hospitals, HVs, Members of the MDT

## Who is accountable for patients?

GP, Paediatric Consultants

## Resources

Office located in hospital site

## Resources:

- Saturation monitors
- Blood Pressure machine
- Suction units
- Syringe drivers
- Nebuliser
- Scales

## Services offered:

- Phlebotomy
- Administration of IV therapy
- Central venous access device (CVAD)
- Oncology care
- Care of patients with Cystic Fibrosis
- Enteral feeding
- Oxygen therapy
- Tracheostomy care
- Allergy/Anaphylaxis training
- Eczema care
- Asthma training
- Home traction
- Buccal Midazolam training
- Wound care
- Care of complex cardiac patients
- End of life care (24 hour on call service)
- Care of patients with complex health needs

## Funding organisation

Kingston CCG

## Level of patient/family involvement

All care delivered in partnership with the child and family

## Challenges, successes, lessons learned and advice

Ensure adequate staff, equipment and training to effectively meet the service users' needs. A seven-day service is key and need to consider the hours of service provided.

## Contact for more information

Jacqui Williams

Kate Kathirgamarajah          Outreach Sisters

Jayne Lambert

Sonja Timpson

[pont@kingstonhospital.nhs.uk](mailto:pont@kingstonhospital.nhs.uk)

020 8546 7711 ext: 2327

<https://www.kingstonhospital.nhs.uk/departments-services/clinical-services/paediatrics.aspx>

# 12 Lewisham and Greenwich Children's Community Nursing Team and Hospital@Home Team

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**Region: Lewisham, Lambeth and Southwark**

**Geography: Urban**

## Aims

To promote independence for families and facilitate earlier discharge from hospital, fewer re-admissions and reduce the number of hospital visits for the family. Enabling children to return to their home environment and be supported there whilst continuing with their usual lives where possible.

## Target patient groups

Children aged between 0-16 years and disabled young people up to 19 years who are still in full time education. All children and young people referred to the Team must be registered with a GP in Lewisham, Lambeth and Southwark.

## The service model

See children in their own homes and in a variety of community settings, including schools, nurseries and respite care facilities. Drug administration including iv antibiotics and some chemotherapy

- Wound dressings
- Blood tests – using a central venous access device or peripherally
- Monitoring treatment progress e.g. blood pressure monitoring
- Support with changing a tracheostomy
- Support with changing a naso-gastric tube or balloon enteral feeding device
- Oxygen therapy and saturation monitoring
- Sleep studies
- Teaching and education
- End of life care
- Rapid response
- Review of children presenting to ED
- Fluid challenges
- Respiratory assessments

## Opening times

7 days 9am -5pm CCNT 7 days 8am – 10pm H@H

## Staffing

Qualified Paediatric Nurses

## Who can refer

Open referral system. Referrals to the team can be made by anyone including hospital staff, GPs, community staff and parents

## Contact for more information

Alison Fagan lead Nurse CCNT and H@H

[LH.CCNT2@nhs.net](mailto:LH.CCNT2@nhs.net)

020 3049 3780 CCNT 020 3192 6130/6017 H@H

# 13 Luton (Children's Rapid Response Team phase 2)

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**Started: Jan 2014 (phase 1 started in April 2013)**

**Region: Luton**

**Geography: Urban**

**Estimated local pop. 0-18 years: 60,000**

## Background

A review of paediatric acute activity in 2008/9 identified that there were 6 high volume common conditions accounting for 85% of all children's emergency activity.

## Aims

Developed as a sustainable model of integrated working between acute and community services within Luton. To minimise time spent in hospital by children and to support GPs in the use of urgent care pathways.

## Target patient groups

- 0 to 18 year olds
- Child living in Luton area with a Luton GP
- Child living in Luton area without a registered GP

Presenting with-fever with or without a focus; bronchiolitis; gastroenteritis; head injury; asthma/viral induced wheeze; seizure and abdominal pain

## The service model

- Extension to out of hours and extend referral from GP practices
- Supports GPs' ED and PAU
- An urgent care pathway template to guide GPs

Telephone triage within 2 hours of referral

## Opening times

- 10am until 8pm - Monday to Friday
- 8am until 6pm - Saturday's and Sunday's

## Staffing

Four Community APNP roles

## Who can refer

- The Paediatric Emergency Department, Paediatric Assessment Unit
- Children's Inpatient Wards and the GP Urgent Clinic at Luton and Dunstable Hospital
- The Children's Community Nursing Teams
- The walk in Centre/GPs

## Who is accountable for patients?

Team hold accountability as all working as Band 7 nurse practitioners.

## Resources

Shared office with Luton Children's services: CCN, HV, School Nurses (SN) and other health professionals within children's services. Also a number of children's social care professionals within the same building. Equipment: tympanic thermometer, stethoscope, hand-held saturation monitor, auroscope, laptop computer (all patient records are electronic)

## Funding organisation

One year's funding from East of England Workforce Transformation to kick-start this phase. Savings will relate to admission avoidance for GP direct referrals/LTC (long term conditions).

## Level of patient/family involvement

- Parents consulted prior to establishing service.
- Parental feedback sought following discharge from the service

## Level of integration in the system

Vertical integration

## Evaluation

Breakdown of referral conditions include:

- 39% bronchiolitis
- 24% asthma and wheeze
- 23% fever
- 11% D&V (diarrhoea and vomiting)
- 2% abdominal pain
- 1% head injury

## Challenges, successes, lessons learned and advice

- Difficulty with engaging GPs in the use of the paediatric urgent care pathways
- Improved patient and user satisfaction, reported outcomes and quality of life
- Improved partnerships in provision of care
- Better use of resources and more effective and economic delivery system
- Improved relationships, governance and risk management

## Contact for more information

Lynn Fanning

[lynn.fanning@nhs.net](mailto:lynn.fanning@nhs.net)

0333 4050079

[www.cambscommunityservices.nhs.uk](http://www.cambscommunityservices.nhs.uk)

# 14 Manchester Community Children's Service

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**Region: Covers City wide Manchester**

**Geography: Urban**

**Estimated local pop. 0-18 years: 120,000**

## Aims

- Deliver nursing care closer to home for children and young people who are acutely ill, have long term conditions or who have complex health needs
- Reduce avoidable hospital admissions of acutely ill children and young people
- Facilitate early discharge from hospital after elective and non-elective admissions
- To improve access to health services for all children and young people according to their needs, particularly by co-locating services and developing integrated ways of working
- To improve health outcomes and life chances for all children and young people

## Objectives

- To provide more care closer to home, promoting the shift of service delivery (including staffing resources) from a hospital based to community based model.
- Care will be provided from a variety of community settings including the family home.
- Offer greater access to high quality child centred healthcare.
- Reduce inpatient admissions and length of stay
- Facilitate earlier discharge

## Target patient groups

- Age 0-16 years (and up to 18/19 for special needs or complex needs)

## The service model

Two interlocking services: home service and community clinic service.

Referrals are triaged by the team leader / shift coordinator. Families are contacted within 4 hours and arrangements made for visit or clinic appointment.

### Home service

- Hours 8am-10pm 365 days a year
- Can be referred once have a diagnosis (IV administration, chemotherapy, wound care, TPN - total parenteral nutrition)
- Seen at home if infected or infectious
- Also seen at school if possible
- Help to train SN e.g. stoma care
- Maximum frequency of visits is 6-hourly (3 times/day)

### Community nurse-led clinic service

- Various community clinics venues across the City of Manchester on a daily basis, Monday to Friday.

Alongside the acute team, the Community Nursing Service also incorporates complex care team, palliative care team, continence, epilepsy, asthma specialist teams and special needs community and school nursing. All teams are managed by the Head of Service for CCN service.

## Opening times

Hours 8am-10pm every day

## Staffing

A skill mix of Band 7 team leaders, Band 6, Band 5, Assistant Practitioners, and Band 2 and 3 clinical support workers and administrators

Who can refer Secondary care wards (ED, clinical decision units, oncology, day surgery, medical assessment unit, paediatric wards) from:

- Local DGH (district general hospital)
- Local specialist hospitals
- GP referrals
- HV referrals

## Resources

The acute team are based in a local health centre.

## Funding organisation

Funded by CCGs. Run by Central Manchester Foundation Trust

## Level of integration in the system

Horizontal linking – we work in collaboration with education and social care.

## Evaluation

The CCN acute team use the friends and family test currently, with results of over 90% who would recommend our service.

## Challenges, successes, lessons learned and advice

- Good communication (via letters) with GP, SN, case workers
- No conflict of interest for hospital trust expediting discharge, because it helps to create efficient patient flow
- Very helpful to have a co-coordinator who does RAG (red, amber, green) ratings to prioritise patients.

## Contact for more information

Heather Sutton

Team leader – Acute team

[Heather.Sutton@cmft.nhs.uk](mailto:Heather.Sutton@cmft.nhs.uk)

0161 248 8501



# 15 Paediatric Unscheduled Care (PUC) pilot, North of Scotland Planning Group

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**Started:**

**Region:** Rural areas of Scotland (25% of children in Scotland live in remote and rural settings)

**Geography:** Rural

**Estimated local pop. 0-18 years:**

## Background

To provide safe, sustainable paediatric care to rural areas of Scotland

## The service model

On-call paediatric consultant model, providing 14 rural general and community hospitals with single point of contact access to paediatric consultants 24/7 via videoconference.

(Project management provided by NHS24)

All on-call consultants are within 10 minutes of secure broadband access

Standardised SBAR (situation, background, assessment, recommendation) documentation used

There are 2 models in place within individual rural hospitals (after initial nurse triage):

1. Assessment by a Foundation year doctor or GP trainee. Many children are then referred on to the regional paediatric service without further evaluation. Although the rural adult physician has clinical responsibility for the care of the child whilst they are at the rural hospital and until they reach definitive care, they rarely get involved.
2. Evaluation by an experienced rural practitioner, who may carry out investigation and/or initiate management prior to referral for advice/transfer.

## Opening times

24 hours a day and 7 days a week

## Staffing

16 on-call consultants were recruited

## Who can refer

Clinicians at rural general and community hospitals

## Who is accountable for patients?

Referrer always responsible but Consultants are responsible for advice given

## Resources

Videoconference equipment access

Some already in place

## Level of patient/family involvement

Parents and carers provided feedback – universally positive

## Evaluation

230 referrals were made to PuC

- 152 of these were managed locally,
- 21 were retrieved
- 57 were transferred
- Independent evaluation by Centre for Rural Health – videoconferencing enhances clinical assessment and supports decision-making of clinicians in remote locations
- Parents and carers find videoconferencing helpful
- Even if the child requires transfer, the early assessment/management adds value
- External expert review by a rural GP – 33% of cases showed improved outcome
- Paediatric Intensive care unit Consultant – improved outcome in 20-25% of cases
- Avoids unnecessary admission/transfer/retrieval

## Challenges, successes, lessons learned and advice

Changes to practice always challenging for some individuals but even initial sceptics impressed with results as they “saw for themselves”

We are all becoming more familiar with this technology which helps

## Contact for more information

Dr Donald MacGregor, Consultant Paediatrician

[donaldmacgregor@nhs.net](mailto:donaldmacgregor@nhs.net)

07740 783845

# 16 Nottingham Children's Hospital Senior Telephone advice, Nottingham University Hospitals NHS Trust

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**Started: Formally in September 2015, Pilots and partial implementation from 2012/2013**

**Region: East Midlands – Nottingham City and South Nottinghamshire**

**Geography: Mixed**

**Estimated local pop. 0-18 years: Nottingham City 59,000, South Nottinghamshire 102,000**

## Background

A project team working on improving the pathway for emergency medical admissions identified that when a GP called with concerns about a child, the call was taken by a junior doctor and always resulted in the GP being advised to send the child into the Children's Assessment Unit (CAU).

The team hypothesised that if the calls were taken by someone senior, (with more extensive paediatric knowledge and experience than the GP making the call), it might be possible to have a more proactive discussion and identify some appropriate options which didn't involve a same-day attendance in the CAU.

## Aims

To ensure that acutely unwell children are managed in the appropriate setting with optimal management: either in primary care, rapid access outpatient clinics or as an acute attendance to hospital.

## Target patient groups

Under 19 year olds with a medical problem (usually acute)

## The service model

Using the 'hot-week' consultant rota for emergency admissions, this consultant also became responsible for taking the GP calls

Simple paperwork was developed using the SBAR format.

## Opening times

Monday to Thursday 0845-2115. Friday 0845-1915

## Staffing

As part of a complex hot week, second on week and third on week depending on the time of year.

Who can refer GPs (not nurse practitioners) and midwives if it is for jaundice or weight loss

## Who is accountable for patients?

GP or midwife unless sent to hospital

## Resources

iPhone

## Funding organisation

Local CCG now (previously 'Dragons Den funding')

## Level of patient/family involvement

No patient involvement

## Level of integration in the system

Vertical integration

## Evaluation

- The trial ran for one week and found that 30% of patients didn't need to attend the CAU that day.
- Some were diverted to routine outpatient or rapid-access clinics
- Some were managed by the GP with the advice from a consultant
- An additional, unexpected outcome was that 2 patients were escalated to a 999 ambulance call due to the telephone conversation
- In some practices, the clinical discussion prompted the GP to change practice or purchase equipment (e.g. pulse oximeter)
- Following trials, the change was fully implemented and analysis of the paediatric calls has shown:
  - 63% of calls are sent to the CAU
  - 13% of calls are referred to a rapid-access clinic
  - 4% of calls are referred to routine outpatient clinics
  - 15% of calls go on to be managed by the GP with the advice given by the consultant
  - 4% of calls are escalated

## Challenges, successes, lessons learned and advice

- Know what happens to your GP admissions
- Work out whether the attendances are appropriate
- Pilot it over a period of time and see if it changes the practice
- Implement it keeping figures
- GP phone calls tend to be clustered around 1030 – 1300 and then 1530-1830. Any service needs to be able to cope with these peak times
- A consultant cannot do a ward round and take GP calls simultaneously
- GP education has improved over time and the phone line allows discussion about every acutely unwell child that a GP wants to admit which in turn improves the general paediatric knowledge of GPs in a more consistent way than having a paediatrician based out in single

practices or groups of practices. In particular it becomes possible to identify which GPs struggle to manage acutely unwell children and allows further training

There is a danger that the service is used as a pharmacy information line, a GP trainee support system etc and so we make it clear if a phone call is inappropriate and suggest alternative ways to gain the knowledge (like a BNF!) and we always ensure that GP trainees have spoken to a qualified GP

**Downloads: 6 month review hotline lew**

**Contact for more information**

Louise Wells

Consultant paediatrician

[Louise.wells@nuh.nhs.uk](mailto:Louise.wells@nuh.nhs.uk)

01159249924 x62815

# 17 Partners in Paediatrics (PiP), University Hospital North Staffordshire (now known as University Hospitals of North Midlands)

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## Upskilling GPs and Nurses in the clinical management of children with acute health problems

**Started: 2010**

**Region: West Midlands**

**Geography: Mixed**

### Background

The hospital identified that the number of children with acute health problems admitted to paediatric wards was about twice the admission rate of other hospitals in similar communities

There were top 10 conditions where children referred into the hospital by a GP were discharged within 4 hours without active clinical intervention

### Aims

Educational aims to ‘upskill’ primary care clinicians:

1. To increase the competence and confidence of GPs and nurses in the clinical management of children with acute health problems
2. To reverse the year-on-year rise in inappropriate referrals to the Paediatric Assessment Unit by primary care clinicians
3. To improve the patient experience, particularly providing services closer to patient homes

### Target patient groups

Children

### The service model

10 master-class sessions, run by paediatric consultants were held in Spring/Summer 2011 for primary care clinicians

Approximately 250 clinicians took part, including 114 GPs (40% of the local GP cohort), 79 nurses and participants from other clinical backgrounds (student doctors, clinical educators, community midwives)

Master-class topics –

- Respiratory problems
- Failure to thrive
- Gastroenteritis
- Abdominal pain

- Constipation
- Fever management/febrile child
- Fits, faints, funny turns
- Rashes and skin problems
- Mixture of acute admissions

Paediatric pre-referral guidelines and urgent care referral guidelines were produced and made readily available to all of primary care.

## Staffing

GPs & Practice Nurses

## Evaluation

Very positive overall response to the programme – most GPs that took part felt that the master-classes had increased their ability and confidence in the clinical care of acutely unwell children.

Participants welcomed the teaching and the locally developed guidelines

After 18 months, GP and nurse participants indicated that they felt more competent and confident in the clinical management of children with acute health problems; that they were retaining more patient care within primary care; and that they were referring more appropriately; they also felt better able to advise/support parents/carers.

Specific changes in practice that were identified included the use of pulse oximetry for respiratory paediatric cases

**Downloads: [Upskilling-re-evaluation-report.pdf](#)**

## Contact for more information

Partners in Paediatrics

[enquiries@partnersinpaediatrics.org](mailto:enquiries@partnersinpaediatrics.org)

07583 351214

[www.partnersinpaediatrics.org](http://www.partnersinpaediatrics.org)

# 18 Rapid Access Clinic, Rotherham Hospital

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**Started: 1995**

**Region: Rotherham**

**Geography: Urban**

**Estimated local pop. 0-18 years: 62,000**

## Background

To provide an immediate consultant appointment for GP and emergency department referrals for children <16 years (who are not acute emergencies but can't wait for a routine outpatient appointment).

## Aims

To see urgent GP referrals (less than 16 yrs) who are not acute emergencies but cannot wait for a clinic appointment.

## Target patient groups

0-16 years

## The service model

Rapid-access clinic is located within a children's clinic on the hospital site

Full access to pharmacy, laboratory and imaging services

Access to inpatient facilities if required

30 minute appointments

Bookings are only made 2-working days in advance

If no slots available, the clinic staff member re-directs the call to the on-call paediatric registrar, who can discuss alternatives (children's assessment unit, routine clinic appointment, specialist nurses)

The referrer is expected to fax a letter. ED clinicians tend to call as well.

There are no triage criteria for the referral and there is no clinician responsible for this process. Waits for routine outpatient appointments are usually 4-6 weeks, but can be up to 9-12 weeks). An audit has recently shown that 82% of referrals were appropriate.

## Opening times

Clinics originally ran from Tuesday to Friday (1.30pm -3.30pm) – 4 appointments/day

Due to GP feedback, Monday appointments (x4) are being offered and 3 appointments each of the rest of the days of the week.



## Staffing

Consultant paediatrician, rostered to the clinic, as part of their job plan. 50% of the clinic time is given additionally as admin time)

## Who can refer

- GP (mostly), ED clinicians and Consultant Paediatricians
- Referring clinician telephones a dedicated number

## Who is accountable for patients?

Outpatient clinic in the main hospital premises

## Resources

Outpatient clinic in the main hospital premises

## Funding organisation

The Rotherham Foundation Trust

## Level of patient/family involvement

None in design/production

Patient feedback and audit is carried out periodically

## Level of integration in the system

Plans to set up outreach rapid access clinics

## Evaluation

July 2013 – 38 case notes retrospectively reviewed

- 55% were <12 months age
- 29% were 1-5 years age

Mostly seen for medical conditions

- 79% were referred by GPs
- 8% were referred by ED
- Remaining 13% came from consultants, asthma nurses, HV

Outcomes of these 38 patients:

- 2 admitted
- 7 discharged
- 23 investigated and/or given medication
- 25 had follow-up arranged

No official evaluation/publication, but have carried out some audits.

Good feedback from GPs, but no official feedback evaluation.

It is financially beneficial for the trust because it has led to an increase in 'new patient' referrals (most of which are subsequently discharged)

They have a lower DNA rate (6%) than the regular outpatient clinics

## Challenges, successes, lessons learned and advice

- Important to consult with stakeholders prior to developing a rapid-access clinic (GPs, commissioners, clinic staff, consultants, trainees)
- Important to identify availability of clinic rooms/scheduling
- Ensure have written set of simple guidelines for referral (including why, what, where, when, how) and would run more efficiently if there is an official triage system
- The GPs didn't want a structured referral letter (takes too much time to complete), so they currently fax a letter to the hospital.
- Ensure the 48 hour booking rule (otherwise it isn't a rapid access clinic)
- Monitor, evaluate, audit, implement change and repeat
- Patient satisfaction surveys provide useful feedback on the service
- A few years ago they changed the clinic to be Registrar-led, but this didn't work so well – it needed to be led by a senior clinician i.e. Consultant
- There also used to be a Consultant hotline for GPs to discuss patients (for one hour during week Mon-Fri), but this was rarely used (?perhaps it wasn't at a convenient time for GPs)
- The hospital also has a community nursing team to expedite discharge
- The hospital also organises regular events for GPs (with funding support from CCGs) in which they have protected-time teaching. In these clinical scenarios are discussed.
- Many referrals are due to parental anxiety

## Contact for more information

Dr Sanjay Suri, Paediatric Consultant (The service was set up by his predecessors; He also chairs a local 'Care closer to Home' steering group for multiple stakeholders since 2012)

[sanjay.suri@rothgen.nhs.uk](mailto:sanjay.suri@rothgen.nhs.uk)

(01709)424521

# 19 Salford Children's Community Partnership (SCCP)

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**Started: Phase I (proof of concept): April 2011 – June 2014; Phase II (proof of scale): July 2014- June 2016**

**Region: Little Hulton (Greater Manchester).**

**Geography: Urban**

**Estimated local pop. 0-18 years: Little Hulton total population (2011 Census) = 12,851**

## Background

The project was designed as a **community-based alternative** for the management of acute childhood illness in order to address the issues of:

- High rates of paediatric accident and emergency attendances
- Significant expenditure on children's unplanned short-stay admissions
- Care quality issues with regard to children's services in primary care
- A lack of community-based alternatives to higher cost secondary care services that were able to keep unwell children at home (whenever it was safe and possible to do so)

A void in the wider NHS health economy of a scalable and effective model of general practice-based management of acute (paediatric) hospital admission avoidance

## Aims

The main aims of the project were to:

1. improve the quality of childhood acute illness management in the general practice setting;
2. decrease the children's ED and acute admission spend.

## Target patient groups

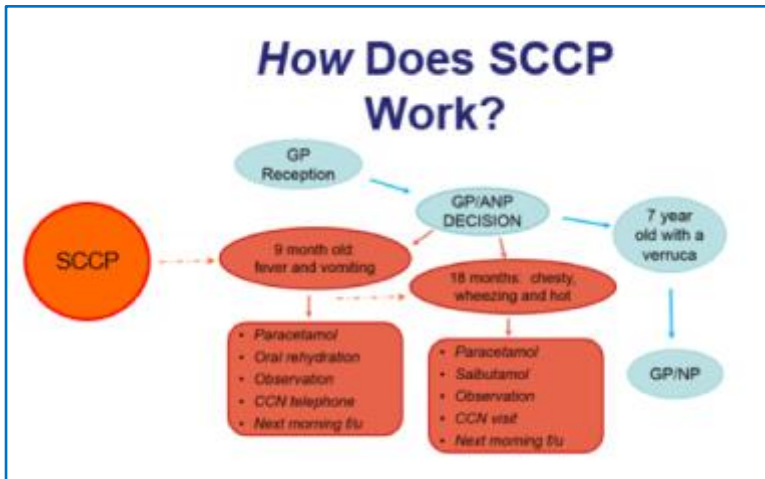
Infants and children from 0-16 years of age

## The service model

### PHASE I (proof of concept):

The service placed an APNP within the Little Hulton general practice site of Salford Health Matters in order to provide an expanded offer of care for children's acute illness management/hospital avoidance (**Figure 1**). For example:

- A child that is 'wheezy, febrile and chesty' is assessed, started on bronchodilators and observed in the practice for a short period by the APNP. If the child's clinical response allows, he/she is discharged home with follow-up provided into the evening hours by the CCN with return to the SCCP in the morning
- If the family/carer contacted the surgery with a **non-acute complaint**, the consultation would be conducted by the Little Hulton, general practice staff



**Figure 1: SCCP (Phase I) - A general practice-based model of an expanded offer for 2 common acute childhood presentations**

**NB:** If the child’s initial response was not satisfactory, i.e. the APNP felt the child’s was not responding adequately, or the child’s initial presentation is deemed by the APNP to require immediate secondary care intervention, the family is sent directly to the local paediatric observation and assessment unit for further management/evaluation.

**PHASE II (proof of scale):**

Phase II of the project is an expansion of the original service configuration as it includes children from 4 other general practice sites in Little Hulton; thereby creating a federated model of delivery, encompassing all the locality general practice sites.

The service model and objectives remain the same (i.e. improved quality of acute childhood illness management in general practice and paediatric unplanned hospital admission avoidance). The only changes to the model in Phase II are the use of a shared appointment booking system and a more robust inclusion and inclusion criteria for SCCP attendance (**Figure 2**). Families/carers of unwell children in Phase II contact their own practice, which then decides whether SCCP attendance is appropriate or not (**Figures 3 and 4**). If the child does not meet the SCCP<sup>2</sup> inclusion criteria, the child is seen at their registered practice. The shared booking system is web-based, secure, and shared synchronously across all practice sites.



## Salford Children's Community Partnership: Phase II (SCCP<sup>2</sup>)

### OBJECTIVES

- Improve the quality of children's acute illness management in general practice
- Reduce A/E attendances and the costs associated with children's unplanned illness admissions

INCLUSION	EXCLUSION
<p><i>Childhood acute illness or injury that with some initial (practice-based) management (antipyretics, oral hydration, bronchodilators), a short period of observation, and more in-depth parent education an A/E visit or short stay admission can be safely avoided</i></p> <ul style="list-style-type: none"> <li>• Age is from newborn → 15 years of age (up until 16<sup>th</sup> birthday)</li> <li>• Acute illness → unwell with symptoms present for &lt; 5 days</li> <li>• Acute injury → injury of &lt; 5 days duration that is unlikely to require an x-ray</li> <li>• Child(ren) from a family with a history of frequent A/E attendances or short stay admissions for minor illnesses/injuries</li> </ul>	<p><i>Childhood illness or injury that would be considered part of routine general practice/primary care</i></p> <ul style="list-style-type: none"> <li>• <b>A PAEDIATRIC EMERGENCY OR VERY UNWELL CHILD</b></li> <li>• Age is 16 years and over</li> <li>• Non-acute illness → symptoms present for &gt; 5 days</li> <li>• Acute injury that is likely to require an x-ray</li> <li>• Gynaecological/pregnancy related complaints</li> <li>• Development or behavioural complaints</li> <li>• Safeguarding evaluations</li> </ul>
<p><b>EXAMPLES</b></p> <ul style="list-style-type: none"> <li>• 2 year old vomiting (trial oral fluids?)</li> <li>• Febrile 9 month old, feeding but with bad cough</li> <li>• Newborn that is handling well and interactive but vomiting</li> <li>• 6 year old that started wheezing last night</li> </ul>	<p><b>EXAMPLES</b></p> <ul style="list-style-type: none"> <li>• 9 month old that seems to have an infected toenail</li> <li>• A 7 year old that is afebrile but has a runny nose</li> <li>• A 10 year old with intermittent leg pain over the last 6 months</li> <li>• A 15 year old that requires CAMHS intervention</li> </ul>

### TOP TIPS TO REMEMBER

- **THEY NEED TO COME THROUGH YOU TO GET TO US**
- **SEND children who would benefit from some added observation, support and starting treatment in the surgery (or they'll head to A/E)**
- **SEND children who often end up in A/E for minor illnesses (frequent flyers)**

April 2015 Katie Barnes

Figure 2: SCCP Phase II: Inclusion and Exclusion Criteria

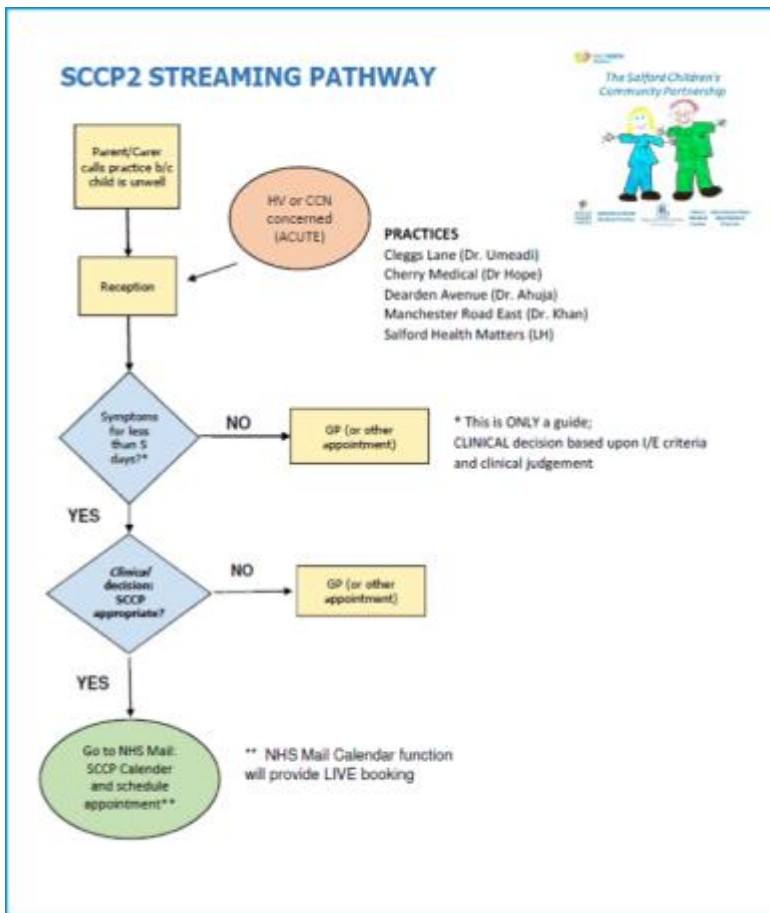


Figure 3: SCCP Phase II: Streaming Pathway

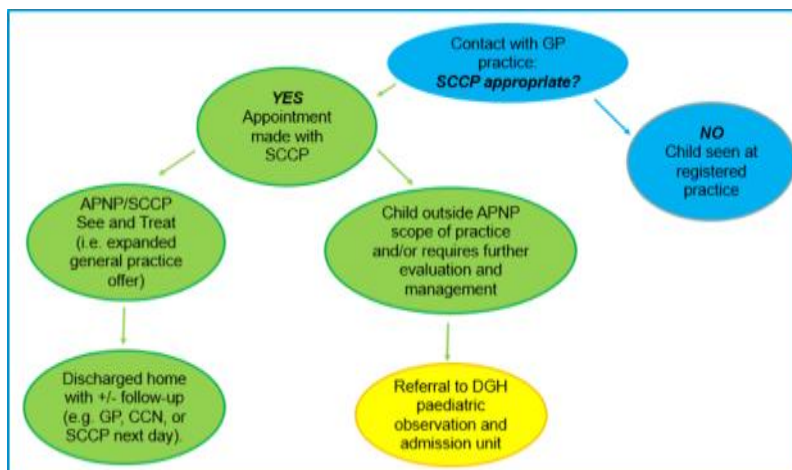


Figure 4: SCCP Phase II: Care Model

## Opening times

8am -6.30pm Monday to Friday

## Staffing

The clinic is led APNPs; MSc-prepared Advanced Nurse Practitioners, specialising in ambulatory care for infants, children and young people

## Who can refer

GPs from any one of the 5 collaborating practices (NB: after phone review)

## Who is accountable for patients?

The APNPs function under the clinical governance of Salford Health Matters for clinical care as part of the SCCP consultation; as such, all treatment and management decisions outside of those relating to the SCCP episode of care (e.g. sub-specialty cardiology referral) remain the responsibility of the registered practice. NB: the APNPs document all SCCP-delivered care (synchronously) in the clinical system of the practice at which the patient is registered with. Specifically, recording of SCCP consultation (and the need for any further follow-up) is communicated electronically to the registered practice immediately after the conclusion of the SCCP consultation.

## Resources

2 x General Practice -based consulting rooms

2 x paediatric pulse oximetry capability, automated paediatric blood pressure machine, wide angle Welch-Allyn oto-ophthalmoscopes

2 x Child play pens

Infant and paediatric scales

Child-friendly play space (reception area)

Child-friendly play space (consultation room)

Basic pharmaceuticals: Large volume spacers, salbutamol, prednisolone, ibuprofen, paracetamol, dexamethasone, steri-strip, fluorescein stain, some basic dressing supplies

Child friendly, infection control compatible toys

## Funding organisation

Phase I Funding: provided by a 3 year DH innovation grant

Phase II Funding: provided through a CCG innovation grant

## Level of patient/family involvement

Exception service-user feedback:

FFT for SCCP Project = 100% recommended (March 2016)

## Level of integration in the system

Population

## Evaluation

### Safety

- CQC (Care Quality Commission) inspection of SCCP → outstanding rating
- SCCP with no adverse events
- SCCP with no near misses
- SCCP with a safety culture:
  - Safety Walk Rounds
  - APNP communication
  - strong team working
  - Datix SE reporting → transparency

### Effectiveness

Salford Health Matters Little Hulton only					
Year	DOC Admissions	Cost (£)	Registered Patients (<17)	Admission Rates/1000	Average Cost/Child
2010/2011	112	£87,933	1544	73	£57
2011/2012	82	£60,175	1640 ↑ 6%	50 ↓ 31%	£37 ↓ 36%
2012/2013	96	£54,216	1736 ↑ 12%	55 ↓ 24%	£31 ↓ 45%
2013/2014	80	£52,983	1808 ↑ 17%	44 ↓ 39%	£29 ↓ 49%
2014/2015	93	£55,342	1876 ↑ 22%	50 ↓ 32%	£30 ↓ 48%
2015/2016/	87	£53,352	2104 ↑ 36%	41 ↓ 43%	£25 ↓ 55%

/: 2015-2016 data includes predicted values (November – March 2016)

The SCCP project was recognised by HSJ and General Practice Awards (2013) for excellence in children's service delivery, primary care innovation, quality and productivity.

### Patient experience

- Exception service-user feedback:
- FFT for SCCP Project = 100% recommended (January 2016)

See larger proportion of under-fives, acutely unwell, fever, respiratory, GI (gastro-intestinal) complaints. 15-20 children a day with 1.4 APNP providing cover

## Challenges, successes, lessons learned and advice

1. CYP/families have access to a high quality service, improved access, paediatric expertise and a level of care which is often times only available in a hospital setting. Their feedback suggests that families will defer immediate ED access for a high quality, child specific service in general practice with excellent/very good access.
2. Streaming, (i.e. ensuring acutely unwell children go to the SCCP service whilst non-acute childhood complaints such as behavioural issues, constipation, non-specific mild illness are



- managed by the wider general practice team), appears to be fundamental in maximising the specialised expertise of the SCCP and changing default ED behaviour in the community.
3. The SCCP model of an expanded offer of primary care paediatrics needs to be placed within a general practice footprint that is large enough to maximise the efficiency of the resource.
  4. Intensive outreach is required to access those families not considered to be early adopters of the scheme.
  5. IT challenges related to the synchronous nature of access to the clinical systems of all practices.

## Contact for more information

Neil Turton, Chief Executive, Salford Health Matter CIC

[Neil.turton@nhs.net](mailto:Neil.turton@nhs.net)

Katie Barnes, Project Development Lead, Kids' Health Matters CIC

[Katie@kidshealthmatters.org.uk](mailto:Katie@kidshealthmatters.org.uk)

0161 212 5815

<http://www.salfordccg.nhs.uk/>

<http://www.salfordhealthmatters.co.uk/>

# 20 Sandwell and West Birmingham Hospitals NHS Trust integrated paediatric services – Community Children’s Nursing & Therapies Service

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**Started: Set up as a Pilot Project 2004**

**Region: Sandwell, West Midlands**

**Geography: Urban**

**Estimated local pop. 0-18 years: 76,867**

## Background

Integrated CCN services across acute wards and in the community. This service was set up for those children with nursing needs to receive specialist care by appropriately qualified staff in their own home Initially team consisted of traditional CCNs. now includes CCN in special schools, CCN in focus provision & mainstream schools, palliative care, complex care for those who require care packages

## Aims

Deliver a service to children & young people in the acute and community setting

## Target patient groups

0-16 years (19 special needs) chronic & acute conditions

## The service model

- Children with chronic illness being seen by the same team of professionals in both hospital and community
- Facilitate direct access and admission to hospital
- Multi-disciplinary working
- Working with consultants in clinics located in hospitals, homes and schools
- CCNs have specialist interests and skills in dermatology, asthma, epilepsy, haemoglobinopathy, endocrinology

## Opening times

Monday –Friday 0800-1800 excluding Bank Holidays. Saturdays 0800-1600 Emergencies only

## Staffing

24.0 WTE of which 5.26WTE are traditional CCN

Who can refer Referrals are only taken if the CYP has a paediatrician and a Sandwell GP. We do not take referrals from Primary Care

## Who is accountable for patients?

Paediatric Consultant

## Resources

We are part of Sandwell & West Birmingham NHS Trust and we are based at Sandwell hospital. CCN special schools are based at the schools. We have a small budget for equipment, consumables, but the complex care packages are commissioned by CCG so equipment, staffing, etc is included in the price of the care package.

## Funding organisation

Complex Care packages are funded by Sandwell & West Birmingham CCG, the rest of funding is Sandwell and West Birmingham NHS Trust.

## Level of patient/family involvement

The team provides the highest quality of individual holistic care to the child and family. We respect the views, rights and individuality of each child and young person, and will be treated as that first. Care will always be family centred and takes into consideration their different background, cultures, family structure and beliefs. The CCN team works closely together and respects each other experience and knowledge. We reflect on our practice and are open to new ideas and are flexible to negotiated care, which is responsive to the child and family's needs. We evaluate the service offered using questionnaires when they are discharged from the service.

## Level of integration in the system

There is integration on all levels, as we are linked with schools, tertiary care, social care, voluntary sector, primary care, education.

## Challenges, successes, lessons learned and advice

Integrated discharge planning; effective communication between acute and community; outreach to schools including mainstream; working across teams; shared resources

## Downloads:

[Community\\_Nursing\\_Team\\_Operational\\_Po...](#)

[Intravenous Therapy Administration in Child...](#)

[Acute Assessment Document to be comp...](#)

## Contact for more information

Jackie Williams, Community Children's Nurse Team Leader

[jackie.williams12@nhs.net](mailto:jackie.williams12@nhs.net)

0121 507 2633

# 21 Smithdown Children's Walk-in Centre, Liverpool Community Health NHS Trust

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**Started: 2005**

**Region: Liverpool Merseyside**

**Geography: Urban**

**Estimated local pop. 0-18 years:**

## Background

- Developed through a redesign of the Minor Injuries Unit that had been built due to the impact of the closure of Myrtle street Children's hospital and the need for a service near to an area of high deprivation.
- Driven by national child health policy and the Primary Care Trust's local delivery plan objectives
- To reduce the significant volume of consultations for children's minor illness and injury seen in primary and secondary care (general practice, walk-in-centre, ED, paediatrics)

## Aims

- Early identification and intervention
- Family and child-centred care
- Self-management and family support
- Safeguarding children
- Improved access
- Decreased inequalities

## Target patient groups

<16 years

## The service model

- It is a stand-alone unit but has close links with the other general Liverpool Walk-In Centres.
- Entirely nurse-led.
- 'Safety-net' is in place for the staff to discuss treatment and management, if required, with direct telephone access to consultant advice in the children's ED department.
- Offers assessment, diagnosis and management of children's unplanned minor illness and injury.
- Use local policies and guidelines, which follow national guidelines.

## Opening times

8am -8pm on weekdays

10am- 4pm weekends/ Bank Holidays

## Staffing

- Led by APNPs, who have an MSc in Paediatric Ambulatory Care.
- Paediatric Nurse Practitioner (PNP).
- With support from paediatric nurses and healthcare assistants.
- Provides placements for pre- and post- registration students (nurses, paramedics, APNPs).
- Robust training provided to staff – must achieve clinical competencies and attend a CPD course on paediatric minor illness and undergo a clinical exam at one of the local higher education institutions.
- Need to continually update the staff and clinical pathways/guidelines.

## Who can refer

Open access

## Evaluation

- 23,348 consultations between Nov 2012 – Oct 2013
- 72% were minor illness and 22% were minor injury
- 32% reported that they would have gone to ED instead if Smithdown didn't exist; 15% would have gone to GP; 42% would have gone to another walk-in-centre (WIC)
- 92% were treated at Smithdown and 7% were referred on to another service after assessment
- Patient experience surveys – consistently positive with patients/families reporting an excellent experience
- Received an outstanding CQC report in November 2012
- Use of Smithdown is rising, whilst ED attendances at the children's hospital are falling
- Year on year increases in activity has increased the workload for staff

Although the service was designed for urgent care, it also deals with large volume of routine illness which could be treated in primary care. 2015-2016 Attendances reached 27,620 and plan for 2016-2017 is 27,499

## Contact for more information

Nicola Gourley, Clinical Nurse Manager, Smithdown Children's Walk-in Centre

[nicky.gourley@LiverpoolCH.nhs.uk](mailto:nicky.gourley@LiverpoolCH.nhs.uk)

0151 285 4820

## 22 The South Staffordshire Service

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### Started:

Region: South Staffordshire, Burton, East Staffordshire, including Uttoxeter. Also just across the County border, if registered with GP practices in South Derbyshire.

Geography: Urban and rural

Estimated local pop. 0-18 years:

### Background

GPs who wanted to reduce hospital admissions

### Aims

- Hospital avoidance
- Care close to home
- Early hospital discharge

### Target patient groups

Referrals are for:

- Acutely unwell CYP (bronchiolitis, gastroenteritis)
- CYP with exacerbation of LTC (asthma, oncology)
- Children with complex and long term conditions

### The service model

- Single point of access (in-hours) and mobile contact for out-of-hours.
- A nurse visits/contacts family within 3 hours of receipt of a referral.
- The nurse does telephone triage & prioritises the referral Home visit by nurse if appropriate.
- Nurses have skyguard with GPS tracking for security whilst on home visit.
- Nurses can refer patient directly secondary care if clinical conditions dictates.
- IV antibiotics- no more than twice daily, normally request for children to be once a day ceftriaxone if poss. They have done three times a day but this is difficult (down to capacity).
- Children with complex care are managed with in the same team.

### Opening times

(West) team 7 days per week 9am – 10pm and bank holidays 9am-5pm (initially it was 24 hrs, but this was reduced following an audit as there wasn't enough demand for overnight care).

East team 9am to 8pm Mon-Fri , 9-5 pm Weekends and Bank Holidays.

## Staffing

### West

Staff group	Banding	WTE
Nurse	7	0.9
Nurse	6	6.2
HCA	3	0.8
Admin	3	0.6
Nurse	8a	1.0

## Who can refer

- The caseload takes acute referrals from GP practices with the aim being to avoid hospital referral but are able to refer them into CAU directly if any concerns.
- West team - Referrals are made by health professionals, including GPs, hospital staff, HV. Referrals are generally made by telephone, letter or fax. The service covers children and young people who live in South Staffordshire area and are registered with a South Staffordshire GP.
- East team - referrals for children registered with GP practices in Burton and the surrounding locality of East Staffordshire, including Uttoxeter. In addition, referrals for children just across the County border, registered with GP practices in South Derbyshire.

## Who is accountable for patients?

Each professional involved is accountable for their clinical decision making related to the child's care.

## Funding organisation

CCG currently block contract

## Level of patient/family involvement

- Friends and family cards
- Meridian Survey via website
- Bi annual NICE Audit

## Challenges, successes, lessons learned and advice

- Service needs experienced nurses
- Flexible working
- 24 hour end of life care (named patient basis)
- Identify funding for equipment and consumables
- Additional services: phlebotomy clinic, nurse led dermatology
- nurse led constipation clinic

## Contact for more information

Kathryn Wilson Team leader (West)

Heather Parr Team Leader (East)

[kathryn.wilson@sssft.nhs.uk](mailto:kathryn.wilson@sssft.nhs.uk)

[heather.parr@sssft.nhs.uk](mailto:heather.parr@sssft.nhs.uk)

Tel 01785 229032 07980 897866

<http://ccn.sssft.nhs.uk/>



23 South Tyneside Community Children's Nursing Team, 7-Day CCNT

**Started: 1998**

**Region: South Shields, Jarrow, Hebburn, Cleadon and Whitburn**

**Geography: Coastal region mainly urban**

**Estimated local pop. 0-18 years: 0-15 population is 26,385**

## Background

Service is to provide nursing care, education, support and liaison for population of South Tyneside. The aim is to prevent, avoid or reduce hospital admission where it is safe and in the child's interest to do so.

Started as an acute intervention in 1998 as a pilot scheme

## Aims

1. Prevent hospital admission
2. Reduce length of stay

## Target patient groups

- CYP with an acute illness
- CYP with a LTC
- CYP who require palliative care

## The service model

- It provides direct nursing care and education in the community, to support families with children during acute, chronic and palliative phases of illness
- Link in with Consultant-led rapid review clinic
- Referral criteria for acute respiratory illness – oxygen saturations must be >94%, unless there is a cardiology element where this is not the norm.

Referral criteria for IV antibiotics – depends on capacity, but usually can't administer more than twice a day; encourage clinicians to transfer to once daily Ceftriaxone whenever clinically possible

## Opening times

8am – 6pm, 365 days a year

## Staffing

All CCN staff are sick children trained. Senior staff have the BSc Hons. in community health care and the independent and supplementary nurse prescribing qualification. All qualified staff have, plan to or are presently doing the clinical skills and history-taking course.

## Who can refer

The CYP must live within the borough and be within the specified age range - 0 – 16 or 19 to those with special needs

Receives referrals from:

- Local hospitals
- Specialist teams from Regional hospitals
- GOSH (Great Ormond Street Hospital), Birmingham children's hospital, Alder Hey, St James etc.
- HV, SN, District nurses, physiotherapists etc.

## Who is accountable for patients?

The discharging clinician until local care is agreed. The CCN would seek advice from the most appropriate clinician, and or GP

## Resources

Linked with Emergency care for children department (EEC)

## Funding organisation

CCG funded via acute hospital trust block budget

## Level of patient/family involvement

Families are involved throughout the process. The patient experience is assessed through the friends and family questionnaire process. There is a link team member for the CAPI team which is care and patient involvement champion.

## Evaluation

Results from CAPI team taken and analysed from patient feedback forms. Complaints and compliments audit are also completed.

## Challenges, successes, lessons learned and advice

Please come and talk to us, we are happy to share our experiences. Part of the wider paediatric team is essential.

## Contact for more information

Gill Gunn, Team Leader

[gill.gunn@stft.nhs.uk](mailto:gill.gunn@stft.nhs.uk)

0191 202 2183

# 24 Taunton

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**Started:**

**Region: Plymouth**

**Geography: Rural**

**Estimated local pop. 0-18 years:**

## Background

- 20% year on year increases in referral rate
- To improve integration with primary care

## Target patient groups

0-18 year

## The service model

Reducing avoidable admissions centred around three main strategies:

1. Putting expertise at front end of pathway e.g. senior on admission phone, consultants on shop floor etc
2. Planning the unplanned e.g. safeguarding clinic, bronchiolitis pathways etc
3. Integrating with primary care e.g. HANDi Smartphone App, primary care paediatric, advice and guidance service.
  - HANDi Smartphone App (see Google play or App Store): an info support tool for parents and professionals dealing with 5 common conditions (D&V, fever, wheezy, newborn, gastro pain). It was pump primed by the SCN (Strategic Clinical Network) and is available to others as a “skin” to personalise.
  - Primary care paediatric clinics: each GP practice cluster has a session every 8 weeks.
  - Advice and guidance service: all outpatient referral forms are seen and triaged the same day. 40% can be managed by advice and guidance (with red flags in letter to share governance)

## Who can refer

GPs

## Who is accountable for patients?

The clinician who sees the patient

## Funding organisation

- HANDi pump-primed by SCN.
- Consultant on lates is CCG funded but the senior advice line is not yet funded.

## Level of patient/family involvement

Patient involvement as part of being an FT. Newspaper articles on 6 common conditions and invited patient feedback. Comms team in FT regularly involve patients. GP practices have posters with QR (quick response) codes and info on TV screens with practices. FT has posters with QR codes.

## Level of integration in the system

Vertical

## Evaluation

Currently gathering data on outpatient referrals comparing GP practices with the primary care paediatric clinics and those without.

HANDI app-there are analytics within the app to see which condition is most searched. Average of 3000 searches per month – this is not just use in Taunton as has been reskinned.

Sarah keen for others in the NHS to make use of this app and happy for her app to be skinned. It has been reskinned for Derriford and Plymouth, Royal Devon and Exeter and Barnstable and United Bristol Healthcare Trust. Currently working with Swindon and Bath and Cornwall on reskinning.

## Contact for more information

Sarah Bridges

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07837 682855

# 25 The Bridge – An integrated community virtual ward for children with complex needs in Tower Hamlets

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**Started: 2014**

**Region: Tower Hamlets, North East London**

**Geography: Urban**

**Estimated local pop. 0-18 years: 90,000**

## Background

The Bridge began as a pilot project at Barts Health NHS Trust under the Darzi Fellowship scheme and ran from March 2014 until July 2014. It was developed with engagement of the specialist community children's teams and in consultation with parents of some of the children with complex needs in the Borough of Tower Hamlets. 20 CYP with the most complex needs in the borough were offered to be on the virtual ward.

This consisted of weekly MDT meetings attended by representatives from secondary care, community nursing, physiotherapy, school nurses, school teachers, occupational therapists and community paediatrics doctors and coordinated by an integrated care professional. Parents were contacted before each meeting to identify specific concerns which could be brought to meeting.

The pilot was then extended by a project grant from the CCG which runs until March 2017. This enabled employment of a dedicated Integrated Care Childrens health professional to take on the care coordination role and a Band 5 administrator to support the service.

## Aims

- Early intervention for unwell children which has avoided admission to hospital.
- Co-ordination of care between the GP, acute services, education and social care.
- Improved palliative care facilitation.
- A more informed process for review of care packages for families.
- Better information sharing across organisations in health, education and social care.
- Reduce care contacts spread out across the community and providing a point of contact.
- Accessible support for parents with children with complex cared needs – Improving care experience

## Target patient groups

CYP 0-16 years of age with complex health, mental health, learning disability and or social issues. The children were identified by clinical teams in the hospital and community setting and through special schools. Many were known to the borough continuing care teams. They were stratified using admission and length of stay data. Currently the cohort consists of 50 children.

## The service model

1. Virtual ward model of MDT meetings where the key professionals involved with CYP and families meet to discuss the progress of the children on The Bridge. Representatives include secondary care,

community nursing, physiotherapy, school nurses, school teachers, occupational therapists and community paediatrics doctors. The intervention is a personalised care plan which can be responsive to the CYP needs. This improves quality and experience of care and aims to address day to day problems in real time. The Bridge also aims to encourage advance planning for families and facilitate discussions with palliative and social services so that care is considered holistically and not just medically.

2. Care coordination lead by a senior nurse/health professional. The Integrated care professional provides a single point of contact for the team involved with the CYP ensuring the most appropriate services are being accessed. The CCL helps to manage early discharges by organising increased community support as needed.
3. Education and empowerment of the CYP, their families and the professionals around them is supported by the CCL. This enables the virtual ward to remain dynamic and continually address the needs of the most vulnerable complex children in the borough.

## Opening times

Monday-Friday 09.00-17.00

The service is part of the Children's Community Nursing Team and as such benefits from their extended opening hours which are 08.00-20.00 weekdays and 10.00-14.00 weekends.

All the CYP on the ward are known to the Royal London Hospital with 24/7 access to emergency care

## Staffing

- Band 7 Integrated Care Children's Nurse/AHP
- Band 5 Ward administrator

## Who can refer

Any healthcare professional within the Borough, Children's Social work teams, mental health professionals.

All referrals are assessed against referral criteria and a decision regarding acceptance onto the ward is made within 5 working days

## Who is accountable for patients?

The referrer retains clinical accountability

## Resources

The Virtual ward meetings take place in the setting most appropriate for the CYP. This includes special schools, specialist children's community centre and acute hospital setting. The team are based at Mile End Hospital collocated with the CCNT and children's therapy teams.

## Funding organisation

- THCCG

- Barts Health NHS Trust
- Tower Hamlets Together (Multi Speciality Community Provider Vanguard)

## Level of patient/family involvement

Healthwatch evaluation to provide an understanding of key themes and issues underlying the opinions and perceptions of patients and their families of service provision across health and social care; and provide feedback from patients and their families about their expectations, experiences, and outcomes of the new programme (final report currently in draft)

Internal validation data collected on a weekly basis by the Bridge team assessing the impact of the MDT intervention on each family

## Level of integration in the system

- Horizontal: linking the members of the team around the child from many designations
- Vertical: ability to obtain rapid access to primary or secondary care teams in times of crisis
- Longitudinal: focus on the achievable outcomes for an individual child and an ability to support their progress over time and through the education system

## Evaluation

- Evaluation data from 2014-2016 reported to THCCG
- 21% reduction in A&E attendance
- 31% decrease in emergency admissions
- 7% decrease in hospital Outpatient attendances
- 50% reduction in OP DNA rates
- 29% reduction in hospital LOS
- We are currently mapping individual progress data for the CYP on the ward (much as they do in education) to give a more meaningful assessment of impact.
- Healthwatch final evaluation due to report Oct 2016
- Internal validation data from parent and professional feedback attached including:
  - % MDT attendance from all invited health Care Professionals .
  - Positive feedback from parents on care experience (Qualitative measures)
  - % Completion of the actions from MDTM

## Challenges, successes, lessons learned and advice

Successes: tangible impact experienced by all agencies involved in the project achieved through supportive relationships from the CCG through the Children's Integrated Care Steering Group

### Lessons learned

- The key to success is through strong supportive relationships and leadership at all levels.
- Engagement with stakeholders and CYP and their families to shape the service at the onset.
- Interventions which focus on the progress of the individual break down the barriers between the health systems around them

### Challenges: identifying the agents of change within a complex system

- Making connections with people in other agencies as there are many political, commissioning and cultural barriers to overcome (but it is worth the effort!)

### Downloads:

[The Bridge Service Specification 2016-20...](#)

[The Bridge Project Referral Form.docx](#)

[Terms of Reference for meetings.docx](#)

[Parents & professionals feedback](#)

### Contact for more information

Jo Webster, CCNT Team Leader, Barts Health NHS Trust

Anna Riddell, Clinical Lead, Barts health NHS Trust

Cheryl Rehal, Head Of Children's Commissioning THCCG

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0208 121 4420; 02035941629; 0203 688 1843

N/A



# 26 Walsall Paediatric Hospital at Home Service, 'Building Better Health'

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**Started: 2008**

**Region: Walsall**

**Geography: Urban**

**Estimated local pop. 0-18 years:**

## Background

Reconfiguration of local hospital services, with need to reduce in-hospital paediatric beds from 36 to 21 prior to the move

## Aims

Reduce the need for in-hospital paediatric beds

- Eliminate unnecessary admissions to hospital if care can be provided at home
- Reduce LOS if care can be provided at home
- Work in a collaborative way with existing community services to care for children with acute illness in their own homes

Support/educate parents to improve their confidence in managing a sick child at home

## Target patient groups

- The acutely unwell CYP (only population segment initially)

CYP with LTC (inc. Oncology, Paediatric Palliative Care) managed by Community Children's Nursing Service

## The service model

Initially several target clinical conditions, with referral protocols

## Opening times

- 8am until 4:30pm Monday –Friday
- 8am – 4pm Saturday/Sunday/ Bank Holidays

## Staffing

Part of Community Children’s Nursing Service

## Who can refer

- Direct referrals from all children’s wards within the hospital.

The PAU generated the largest proportion of the activity to the HAH. There were 165 referrals made from the PAU - assumed that if the HAH team had not been established these referrals may have led to in-patient admissions.

## Who is accountable for patients?

Remained with paediatrician

## Resources

Managed by Community Children’s Nursing Service based in the community

## Funding organisation

- Initially was a community led model
- Since 2012 it became integrated with the acute hospital

## Level of integration in the system

Vertical integration linking primary and secondary care.

## Evaluation

During 12 months from Nov 2008 to Oct 2009, the HAH team

- 912 visits (300 new referrals and 612 follow-ups)
- Referral rate fluctuated from month to month with Nov - May busiest
- 100% parent satisfaction found in a telephone survey
- 978 telephone contacts from the initial referrals to prevent readmission to the hospital, provide support and teaching and enhance parents’ skills to care for their child in their own environment
- “Other conditions” largest numbers of referrals and then children with wheezing episodes, then vomiting and diarrhoea
- 12% inappropriate referral rate – redirected to other services

- 165 patients avoided need for direct admission to hospital and were managed instead at home (=3 patients/week avoiding an admission)
- Based on 2008/9 tariffs (and by applying a tariff for the telephone contacts), PCT saved £66K during the 12 months (based on avoided hospital admissions or reduction of LoS)
- Data of number of referrals has been collected by the Community Children's Nursing service since Jan 2013 & data recorded for number of referrals for IVs, Bronchiolitis & gastroenteritis.
- In 2013 No. of referrals 158. IVs – 38, Bronchiolitis – 30, Gastro – 25.
- In 2014 No. of referrals 152, IVs – 57, Bronchiolitis – 36, Gastro – 8.
- In 2015 No. of referrals 138, IVs 62, Bronchiolitis – 20, Gastro – 11.

## Challenges, successes, lessons learned and advice

- Needed to work with the acute trust to avoid any loss of income to them
- Since 2012/3 the service is more integrated with the CCN service and covers 3 conditions/services- gastroenteritis, IV antibiotics and bronchiolitis.
- Patients are referred in from the paediatric ward or PAU (paediatric assessment unit) (which are 1 unit).

During 2015 winter one of the paediatric nurses worked in ED as there was no paediatric service. This helped improve referrals. The service runs each day until 8pm but most visits complete by 6pm. There are 3 nurses who have undertaken physical assessment courses and 1 nurse prescriber.

## Contacts

Jola Forys

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01922 603 814

# 27 Paediatric Acute Response Team (PART), Bath Street Clinic, Warrington

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**Started: October 2013**

**Region: North West England – Cheshire & Merseyside**

**Geography: Urban**

**Estimated local pop. 0-18 years: 48,800**

## Background

- Warrington consistently has non-elective admission rates which are higher than the national average.
- Warrington has a higher expenditure on trauma and injury admissions compared with comparator CCGs.

## Aims

- To divert inappropriate attendances and admissions of 0-18 year olds from secondary to primary care.
- To improve patient experience through extending urgent care paediatric response in the community.

## Target patient groups

- 0 – 18 years
- Acute paediatric attendances

## The service model

Community-based service that ran for a period of 6 months as a pilot project in 2013. It was then established as part of the paediatric urgent care transformation programme plan for 2013/15.

An acute community paediatric nursing response, wrapped around primary care with, initially, an experienced paediatric nurse at the front end in ED.

Seven of Warrington's 26 GP practices agreed to participate in the pilot – initially this was planned to be those with the highest profile of ED attendances and unplanned admissions, but it was decided to go for a federation approach, plus one practice close to the hospital. Follow-up review appointments are also seen by the service (patients referred from ED and PAU at Warrington Hospital).

Initially hoped to be a service to prevent hospital presentations (and take referrals from GPs), but low uptake from GPs so became more about expediting discharge from hospital services.

Relationship with PAU - the aim of the referrals from PAU was to facilitate early discharge and prevent an inpatient admission by offering follow-up telephone advice and/or a clinic appointment.

As the model has progressed increased numbers of patients requiring wound/burn follow-up from either ED or the ward have been referred to the service reducing the need to re-attend at secondary care and improving the quality of care provided.

Screening for babies with neonatal physiological jaundice is now carried out at PART, enabling an efficient, more convenient service to parents and following the pathways advocated within NICE Neonatal Jaundice Guideline (2010).

## Opening times

- Weekdays 10am – 7pm, with flexibility to accommodate appointments up to 8pm if required.
- Saturday session 9am- 1pm.

## Staffing

Jointly staffed by experienced nurses from an acute trust and community provider. This joint nursing approach has a positive impact, enhancing the variety and quality of skills within the team, delivering an integrated care service.

## Who can refer

Referrals into the service come predominantly from primary and secondary care. Sources of referral are GPs, ED/PAU/ward and community services within Warrington CCG.

Initial evaluation identified:

- 38% of first contacts were referred from ED; 25% were referred from PAU or the paediatric ward, facilitating early discharge and
- 19% of first contacts were referred from GPs (the majority of these were from one practice only).

Most recent figures (April 2016) identify:

- 15% from ED; 19% from ward/PAU; 38% from GPs with a greater spread of practices accessing the service.
- Since December 2015 referrals from midwives for babies identified with physiological jaundice – 16%.

## Who is accountable for patients?

The patient's own GP remains accountable for those patients referred from a primary care practice. Admitting Consultants keep accountability for those referred from PAU, the ward or ED.

## Resources

Based at Bath Street Health & Wellbeing Centre, equipment sourced as part of the pilot (investigation purposes and consumables for dressings). IT equipment for collating electronic patient records.

## Funding organisation

Costs provided in the Young People Transformation Programme business case calculated the total annual operating cost for PART to be £155,464 (based on the original operating model and opening hours).

The financial analysis anticipated that PART would make gross annual savings of £140,763, based on the cumulative impact of diverting activity to PART from GP admissions to PAU and ED admissions to PAU.

This would give a projected cost of approximately £15,000 in the first year.

There is limited data to assess the actual financial impact of PART, but it is suggestive that savings have been less than expected, and the net cost of the service in the first year was likely to be approximately £38,000.

## Level of patient/family involvement

Patient involvement not included in planning stage, but evaluation of service carried out towards the end of the pilot by Public Health Knowledge and Intelligence included evidence collated from parental feedback.

## Level of integration in the system

Vertical

## Evaluation

- Qualitative and quantitative evaluation carried out in February 2014.
- Stakeholder feedback – overwhelmingly positive; strong belief amongst stakeholders that patients have benefitted from being seen in Bath Street instead of hospital setting.
- Patient/family experience surveys – overwhelmingly positive.
- Impact of the service on managing demand in primary and secondary care has not yet been felt.
- Service is operating below capacity
- Low activity – in 17 week period that was analysed, there were 243 contacts (regarding 122 individual patients) made to the PART team i.e. only approx. 14 contacts/week (despite extending the opening hours)
- Of the 243 contacts, 52% were first contacts and the remaining were follow-up
- Children under 5 years are majority of contacts – 32%, but those aged 15+ yrs accounted for almost 28% of contacts
- 62% of the activity was due to wound dressing/packing.

- In the year to 30<sup>th</sup> April there were 2142 face to face contacts (average of 41 per week) plus 1032 telephone follow up contacts (19 per week). Seasonal variation is evident, but during the busier winter months the service now runs at near full capacity.

## Challenges, successes, lessons learned and advice

- Concerns initially raised that unless activity increased, the use of staff/resources to operate PART may not be justified. The increase in activity over previous months has ameliorated this concern.
- Successful features – ease of access to the service; timeliness of the PART response; mechanisms in place for identifying referrals from within the hospital
- Strong links between PART nursing staff and paediatric staff in secondary care have greatly benefited the efficient delivery of the service
- Many participants feel the service has benefitted from having joint acute and community staff in the service
- Raising awareness and increasing understanding of the service amongst GPs has been a key factor for increasing referrals
- Changes to the service have resulted in the core activity for the service being for planned follow-up activity from ED review clinics, PAU, and the paediatric ward; rather than the unplanned activity originally anticipated
- Community nursing staff were keen to maintain their primary focus on working with children with complex needs
- If there was an APNP included as part of the team, it would increase the range of conditions that could be referred to PART, and would reduce the need to rely on clinicians as gatekeepers to the service.

## Contact for more information

Janet Bedford – Project Lead and Team Leader

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01925 843639

<http://www.warringtonccg.nhs.uk/news-and-events/A-new-Warrington-pilot-scheme-for-sick-children.htm>

# 28 West Sussex CYP care network acute care pathways

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**Started: South East Coast**

**Region: Mixed**

**Geography:**

**Estimated local pop. 0-18 years:**

## Background

Pathways were developed to improve confidence and competence of primary care including GPs to avoid unnecessary referrals to hospital and to identify children most at risk earlier.

## Aims

Reduction in unnecessary referrals to hospital. Prompt identification of unwell children

## Target patient groups

Up to 5 years

## The service model

Aimed at all primary care settings and pathways also shared with parents and families, and ambulance staff. Pathways adopted by the SCN which sponsored their development and distribution.

## Staffing

None required

## Funding organisation

NHS England SCN sponsored the development

## Level of patient/family involvement

Parents involved in the groups which developed each guideline / pathway

## Level of integration in the system

Vertical especially primary and secondary care

## Evaluation

No



## Challenges, successes, lessons learned and advice

The key is to embed the pathways through engaging GPs especially to use them, preferably by making them useful and supportive. We have tried to meet with as many GP practices as possible and make them easy to access and in paper copy

## Contact for more information

Ryan Watkins

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0773 9431349

[http://www.institute.nhs.uk/quality\\_and\\_value/high\\_volume\\_care/pathway\\_tools.html](http://www.institute.nhs.uk/quality_and_value/high_volume_care/pathway_tools.html)

# 29 Whittington Hospital @ Home

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**Started: 2014**

**Region: Islington CCG, North Central London**

**Geography: Urban**

**Estimated local pop. 0-18 years: 40,500**

## Background

- 8 months of planning prior to opening service
- Commissioners of local CCG involved from start of planning phase

## Aims

To reduce LoS of admissions to Whittington Hospital

## Target patient groups

Acutely unwell CYP (respiratory is the main referral)

## The service model

### Hospital at Home

- Add-on to the existing Children's community nursing service
- The nurses attend most morning ward rounds at Whittington and 2 WR/week at UCLH, to help to identify suitable patients for their service.
- Average of 3-5 visits per shift
- Communicate between shifts via a generic handover sheet that is emailed

### Children's nurses in primary care: this is a separate service and an add on to CCNT provision

- CCNT run primary care clinics to support the education of practice nurses – Mon-Fri 9-5 and evenings to 7.30pm
- Cover 4 conditions (asthma, eczema, wheeze, reflux)
- GPs refer CYP to the service
- Work in 4 GP hubs across Islington
- Weekend clinics too
- Patients can have a 1 hour education session in the surgery

## Opening times

- 8am-10pm
- 2 shifts each day – 8am-4pm or 2pm-10pm
- Originally commissioned until midnight, but staff assessed that wasn't necessary beyond 10pm
- Last visit starts at 9pm

## Staffing

Provides ongoing hospital type care at home until GP based community provision can take over.  
Recruitment took up most of planning time

### H@H team

- 1 nurse per shift (Nurses are flexible and work across services during quieter times)
- 2 nurses
- 1 x band 4
- Part-time matron
- 0.5 WTE Consultant (0.2 WTE is sufficient)
- Initially part-time pharmacist to assist electronic prescribing (now no longer required)
- Staff have a different skills-mix (some community and some acute based) and they learn from each other

In total the CCNT have:

- 17.5 WTE nurses
- 1.5 WTE administrative support
- 0.5 WTE consultant paediatrician

Nursing team consist of band 6 and above nurses from ED and community background; majority have worked in acute paediatric setting. 2 nurses are advanced practitioners with aim that all members over time will achieve this status. All have received training in assessing acutely unwell child and each nurse is paired with acute paediatric consultant for ongoing reciprocal learning and mentoring programme.

## Who can refer

Referrals are from UCLH and Whittington paediatric wards. A referral criterion is that the child must have a working diagnosis and physical signs and symptoms within set parameters. Any diagnoses not on the list will be considered after discussion with hospital or nurse on shift and attending consultant.

Most common referrals:

- IV antibiotics (up to 3 times/day)
- Breast-feeding support (+/- use of nasogastric feeding)
- Asthma exacerbations (once req. inhalers max of 3-hourly)
- Cellulitis – particularly peri-orbital
- Neonatal jaundice (req. phototherapy & twice daily bloods)
- Infected eczema (IV antibiotics and eczema education)
- Bronchiolitis (for nasogastric feeding support at home and illness monitoring)
- Gastroenteritis (monitoring for up to 48hrs of rehydration)

## Who is accountable for patients?

The CYP continues to be under the overall care of a named Paediatric consultant at the hospital

Discharge is nurse-led.

## Resources

Equipment necessary for operation:

- Apple iPad configured to the same image as that used for the Adult hospital at home service which includes access to programs and systems at the hospital with wireless/3G access
- Mobile phone
- Cool bags to carry medication which needs to be kept cold
- Sphygmomanometer
- Stethoscope
- Backpack of similar size and design used by Adult hospital at home service
- Bilirubin blanket

Members of staff carry the Lone Working Device which monitors where the member of staff is to a central security system and allows member of staff to send an alert if in danger which results in police attendance.

## Funding organisation

Islington CCG

## Level of patient/family involvement

Since the service is at home, the parents are supported at home to look after their children.

## Level of integration in the system

Currently integrated into the community care nursing program and the ED paediatric services at Whittington Hospitals.

## Evaluation

From August –December 2014:

- 107 referrals
- 376 face-to-face contacts
- Positive feedback from patient/parent surveys

## Challenges, successes, lessons learned and advice

- Improved liaison with the SN – can share same treatment plan.
- Good staff motivation and retention – the staff are developed, highly skilled and keep their acute skills up to date.
- Continuity of care – from ward to house and holistic approach – can review other risk/health factors in the home and safeguarding strengthened.
- May reduce the need for future presentations if educate well re: disease e.g. asthma and eczema.

- Initially there was resistance from doctors during the set-up phase and during the design of protocols. In order to build trust, the H@H service paired nurses with registrars/consultants, to demonstrate their physical assessment skills – this helped to build trust and increase confidence.
- Safety of workers is a concern, as lone-workers. Management have an on-call system to check the last person has left work and they use Skyguards.
- Limited uptake from GPs – planned to have GP referrals as part of the model, but GPs don't refer. Perhaps should have had more GPs involved in the planning process stakeholder group. Most of the design work came from secondary care.
- There is a disincentive for the hospital to refer too many patients into the service.
- In order to be effective, the parent needs to be engaged, be prepared to be educated and trained about the illness and how to look after them. About 10 families have chosen to not take part because of lack of confidence.
- Should have started the model with a staff consultation and ensured everyone had the same job description. Would be good to have more staff on the rota, to ensure cover for leave/sickness and to share the late shifts out. A diverse workforce enables mutual learning and regular refreshing of skills.
- Connectivity was so poor that electronic prescribing wasn't possible.
- Be reasonable in your expectations.
- Research how other services have developed their service and adapt local pathways.
- Find a paediatrician to champion the service.
- Consider involving other services e.g. physiotherapy and dietetics.
- Coding could be improved – based on ICD-10 codes and for ease many doctors use term 'other' – this has made analysis very difficult and a process of re-coding was necessary. Would have been beneficial to have an economist to guide the start/coding process.

## Contact for more information

- Annette Langseth, Consultant Lead (Locum)
- Dolores D'Souza, Lead Nurse (The Whittington Hospital NHS Trust) (pending new Matron appt) or
- Bernadette O'Gorman (The Whittington Hospital NHS Trust)
- Sabina Ilya, Islington CCG GP lead
- Catherine Lad, Children's Commissioning Manager (Islington Clinical Commissioning Group)
- [whh-tr.PaedsHospitalathome@nhs.net](mailto:whh-tr.PaedsHospitalathome@nhs.net)
- [alangseth@nhs.net](mailto:alangseth@nhs.net)
- [catherine.lad@islington.gov.uk](mailto:catherine.lad@islington.gov.uk)

020 3316 1950

<http://www.whittington.nhs.uk/default.asp?c=20049>

# 30 Worcestershire Acute Hospitals – Acute Community Children’s Nursing Team – Orchard Service (provided By Worcestershire Health and Care Trust)

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**Started: 1996**

**Region: South Worcester & Wyre Forest and Redditch & Bromsgrove**

**Geography: Areas of urbanisation but with large rural areas**

**Estimated local pop. 0-18 years:**

## Background

Initially acute service promoting early discharge preventing admission. Additional funding over a number of years to develop a comprehensive community Children’s Nursing Service. This includes the above and care of children with complex and life threatening and limiting conditions.

## Aims

To prevent unnecessary admission to hospital and promote early discharge. To enable children with complex, life threatening and limiting conditions to achieve their full health potential to maximise their psychosocial and educational outcomes.

## Target patient groups

0-18years

## The service model

Experienced children’s trained nurses who visit sick children in their own home, school or other setting to ensure their health needs are supported.

- Assessment of sick babies, children and young people.
- Planning of care in a co-produced manner with children/YP and their families.
- Provision of treatment to children and YP with training and support to families to maximise independence.
- Support and advice to parents and carers.
- Education regarding management of common illnesses.
- Management of symptoms.
- Provision of information to enable safe care at home.
- Provision of contact details of who to contact if in the event of changes in a child/YP’s condition.
- Signposting to additional services if appropriate to meet individual need.
- Enable your child to be admitted direct to hospital if it is necessary.

The team works closely with HV, SN, Midwives, Hospital Doctors and Nurses, General Practitioners, Social Care, Education and voluntary agencies

## Opening times

- South Worcester & Wyre Forest 9am-8pm (7 days a week)
- Redditch & Bromsgrove 9am-8pm (Mon-Fri) 9am-5pm (Sat-Sun)

## Staffing

Experienced children's trained nurses. Support for families team is available for children and young people and their families who have life limiting/ threatening condition including bereavement support to children and adults within the family.

## Who can refer

Acute care: currently paediatricians only. Complex care: anyone

## Who is accountable for patients?

- Acute care –Named Consultant Paediatrician
- Long term- GP or community Paediatrician

## Resources

Based in premises outside main hospital building but with easy access in a vehicle

## Funding organisation

Children's Commissioning Team, Worcestershire County Council on behalf of 3 locality CCGs

## Level of patient/family involvement

Friends and Family Test and family events held at least once per year. Opportunities when families provided feedback or identified any concern with their child's care whether informal or formal and involving them in solutions with information re shared learning.

## Level of integration in the system

Good virtual and horizontal integration

## Challenges, successes, lessons learned and advice

A comprehensive service is more sustainable and reduces duplication or boundaries / barriers to care delivery. It also provides continuity of care throughout the child and families journey.

## Contact for more information

Stephanie Courts Children's Nurse consultant and complex care manager

South Worcester & Wyre Forest: 01905 681590

Redditch & Bromsgrove: 01527 503030

<http://www.hacw.nhs.uk/our-services/childrens-community-health-services/orchard-service/>

## Appendix 1: Glossary

Acronym	Description
APNP	Acute paediatric nurse practitioner
BBBHP	Bromley-by-Bow health partnership
C <sup>3</sup>	Child healthcare closer to home
CAMHS	Child and adolescent mental health services
CANI	Children's acute nursing initiative
CAU	Children's assessment unit
CC4C	Connecting care for children
CCGs	Clinical Commissioning Groups
CCN	Community children's nurse
CCNT	Community children's nursing team
COAST	Children's outreach assessment and support team
CRAFT	Children's rapid assessment and follow up team
CYP	Children and young people
CYPHP	Children and young people's health partnership
D&V	Diarrhoea and vomiting
DGH	District general hospital
DH	Department of Health
DIY	Do it yourself
DNA	Did not attend
ED	Emergency department



Acronym	Description
FFT	Friends and Family Test
FT	Foundation Trust
GI	Gastro-intestinal
GNCH	Great North Children's Hospital
GP	General Practitioner
HAH	Healthcare at Home
HES	Hospital episode statistics
HLP	Healthy London Partnership
HRG	Healthcare resource group
HSJ	Health Service Journal
HV	Health Visitors
IV	Intravenous
LoS	Length of stay
LTC	Long term conditions
MDT	Multi-disciplinary team
NICE	National Institute of Health and Care Excellence
OOH	Out of hospital
OPD	Outpatient department
PART	Paediatric acute response team
PAU	Paediatric assessment unit
PbR	Payment by results

Acronym	Description
PED	Paediatric emergency department
PiP	Partners in paediatrics
PNP	Paediatric nurse practitioner
PONT	Paediatric outreach nursing team
PREM	Patient rated experience measure
PROM	Patient recorded outcome measure
PuC	Paediatric unscheduled care
QALY	Quality adjusted life year
QR	Quick response
SBAR	Situation, background, assessment, recommendation
SCCP	Salford children's community partnership
SCN	Strategic clinical network
SN	School nurse
SSU	Short stay unit
SIGN	Scottish intercollegiate guidelines network
SpR	Specialty registrar
SROI	Social return on investment
UCL	University College London
UCLP	University College London Partners
URTI	Upper respiratory tract infection
WIC	Walk-in-centre

Acronym	Description
WTE	Whole time equivalent

## Appendix 2: Additional reading

NHS England (2014) *Five Year Forward View* <https://www.england.nhs.uk>

NHS England London (2014) *Transforming Primary Care in London: A Strategic Commissioning Framework* <https://www.england.nhs.uk>

NHS London Strategic Clinical Networks (2014) *Children and young people's health services in London: A Case for Change* <http://www.londonscn.nhs.uk>

Nuffield Trust (2016) *The future of child health services: new models of care* <http://www.nuffieldtrust.org.uk/publications/future-child-health-services-new-models-care>

RCPCH *Facing the Future: Together for child health* (2015) <http://www.rcpch.ac.uk/facing-future-together-child-health>

Platt et al. *The Welfare of children in Hospital* (1959) *Br Med J.* 1959 Jan 17; 1(5115): 166, 167-169

DH (2011) *NHS at Home: Community Children's Nursing Services* [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215708/dh\\_124900.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215708/dh_124900.pdf)

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<sup>i</sup> Healthy London Partnership Children and Young People's Programme (2016) London's out of hospital standards for children and young people